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2022 Hospital and Surgery Center Cost Assessment

Methodology Overview Background:

The objective of HealthPartners' hospital and surgery center cost assessment is to compare the cost of a facility including the inpatient and outpatient services provided. The overall cost index is case mix adjusted (DRG, APC, RVUs) and place of service case mix adjusted (IP vs. OP). The cost index for each facility is indexed to the aggregate 13 county metro Total Cost Index.

Criteria Applied to Analysis

1. Dates of service: 1/2019 to 12/2019
2. Outliers excluded
3. Commercial product
4. COB admissions excluded
5. Paid amounts adjusted to 2020 contracts

13 County benchmark

1. Minnesota counties included in the benchmark – Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington and Wright
2. Wisconsin counties included in the benchmark – Pierce and St. Croix

Cost Assessment Methodology

1. Facility case mix is adjusted by DRG for inpatient admissions and APC and RVUs for outpatient visits.
2. The inpatient/outpatient case mix is adjusted by facility. (the cost index from IP and OP will be weighted by the percent of business in each component by facility)

Cost Assessment Details

1. Hospital admission and outpatient encounter service dates between 1/2019 and 12/2019
2. Outliers excluded
    - All admissions and outpatient encounters with TCI's outside of the normal range are excluded
    - Admissions with a LOS outside the normal range for the same DRG are excluded
3. Commercial products included
    - Includes fully insured and self-insured
4. COB admissions and encounters excluded
    - Only admissions and encounters that are paid 100% by HealthPartners are evaluated
5. Paid amounts adjusted to 2020 contracts
    - Prospectively price all major facilities to their 2020 contracts.
6. Facilities with a minimum of 30 inpatient admissions or 200 outpatient encounters are evaluated

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2022 Primary Care Cost Assessments

Cost Assessment Methodology Overview

Based on NQF endorsed Total Cost of Care Measure

1. Only providers that meet minimum number of attributed members are included.
2. Providers with less than minimum number of attributed members are excluded, and follow default rules.
3. Cost tier placement is based on the provider specific risk adjusted PMPM indexed against the overall risk adjusted PMPM for all 13-county metro primary care providers.

Criteria Applied to Analysis

1. Attributed Provider
2. Outlier members truncated
3. ACG Risk adjustment applied
4. Paid amounts adjusted to 2020 contract rates
5. Commercial product only
6. Claims dates between January 2019 and December 2019
7. Babies age less than one and members 65 and over are excluded
8. Members must be continuously enrolled for a minimum of 9 months to be included

13 County benchmark

1. Minnesota counties included in the benchmark – Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington and Wright
2. Wisconsin counties included in the benchmark – Pierce and St. Croix

Further explanations of the above criteria:

1. Attributed Provider
   A member is assigned to a medical group that provides the majority of the primary care office visits
   - Office visits are identified though the place of service code that indicates a clinic site (11, 50)
   - Primary care specialty is determined by the servicing physician
   - Primary care specialties include: family practice, internal medicine, pediatrics, geriatrics, nurse practitioner, physician assistant and OB/GYN
   - Individuals that do not have a primary care office visit are excluded

2. Outlier members truncated
   - A member's combined medical and pharmacy costs are truncated at $125,000

3. ACG Risk adjustment
   - Adjusted Clinical Groups (or ACGs) were developed by Johns Hopkins University and allow comparisons between populations with varying illness burdens.
   - A member's medical claims are ACG risk adjusted based on diagnoses, age, and gender

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2022 Specialty Cost Assessments

Cost Assessment Methodology Overview

1. Only providers that meet minimum number of episodes requirement are included.
2. Providers with less than minimum number of episodes are excluded, and follow default rules.
3. Cost evaluation is based on the provider specific indexed TCI against the overall TCI for all 13-county metro providers.

Specialties Evaluated for Tiering

1. Cardiology
2. Orthopedics
3. ENT
4. OB/GYN

Specialties Evaluated for Transparency

1. Allergy & Immunology
2. Dermatology
3. Endocrinology
4. Gastroenterology
5. Neurology
6. Podiatry
7. Pulmonary Medicine
8. Rheumatology
9. Surgery
10. Urology

Criteria Applied to Analysis

1. Paid amounts adjusted to 2020 contract rates
2. Cost evaluation methodology
3. Significant Contributor
4. Chronic/acute case mix adjustment applied
5. Episode dates between Oct 2017 and Sept 2019
6. Outlier episodes removed
7. Completed episodes
8. Commercial product
9. Continuously enrolled members only
10. Rx Proxy applied
11. Patient-Centered outliers
12. Provider/Specialty ETG threshold
13. ETG Severity Risk Adjusted
14. Trauma/transplant episodes removed

13 County benchmark

1. Minnesota counties included in the benchmark – Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington and Wright
2. Wisconsin counties included in the benchmark – Pierce and St. Croix

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Further explanation of the criteria:

1. Paid amounts adjusted to 2020 contract rates
    - Prospectively priced all claims to their 2020 contracts
2. Cost evaluation methodology
    - The episode grouper creates clinically homogenous events (conditions/procedures) that are risk adjusted allowing for a provider's cost experience to be compared to a benchmark
    - The benchmark is created by specialty and condition/procedures using a peer group that is similar to the provider being measured
    - The resulting comparison is an actual to expected value that presents as a cost index relative to the peer group average.
3. Significant Contributor
    - HealthPartners assigns providers to episodes where the provider represents 25% or greater of the management or surgery resources within a given specialty. Resources are defined as HealthPartners' Total Care Relative Resource Value rather than actual paid as the TCRRV are not influenced by contracted rates and is a fair comparison.
    - The provider must have 25% of the Management and Surgery TCRRV to be attributed the episode (this is industry standard)
    - Multiple provider groups can be the significant contributor on the same episode (up to 4 providers, 25% each)
    - Some specialties do not direct the management of care, therefore they cannot be significant contributors (i.e. Anesthesiology, Radiology, etc.)
4. Chronic/Acute Case Mix Adjustment
    - A factor was generated to weight the ETGs based on their level of completeness to effectively evaluate a provider's true case mix of services delivered.
    - The factor is applied to the number of episodes, actual paid amount & the expected paid amount.
    - This factor adjusts the impact an ETG's TCI has on aggregate TCI.
5. Episode dates between Oct 2017 and Sept 2019
6. Outlier episodes removed
    - Episodes are excluded where the total medical costs are not within the predefined trim points.
7. Completed Episodes
    - An episode is considered complete when there is an absence of treatment through a "clean period"
8. Commercial product
    - Includes fully and self-insured
9. Continuously enrolled members only
    - Member must have coverage for the duration of the episode
10. Rx Proxy applied
    - A network average Rx cost is applied for episodes where employers carve out pharmacy benefit
11. Patient-Centered outliers
    - Removed any patient who had 12 or more ETGs in the evaluation period
12. Provider ETG Threshold
    - A provider must have 10 or more episodes within an ETG for that ETG to be included in their profile
13. ETG Severity Risk Adjusted
    - Episodes are risk adjusted to account for patient's full illness burden
14. Trauma and transplant episodes removed
    - Trauma episodes are defined by the presence of a trauma DRG and are excluded
    - Patients that have had or are scheduled for a transplant are excluded

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2022 Quality Assessments

Principles for Assessing Primary Care/Specialty and Hospital Quality Performance

Quality assessments are conducted based upon the following over-arching principals:

- Performance assessment should represent a reasonable cross section of conditions or procedures within the usual scope of practice
- Performance assessment should sufficiently reflect the spectrum of care (e.g., prevention and health promotion, chronic illness, acute care and procedures (diagnostic and surgical).
- Performance assessment should be assessed using a sufficient combination of cost/efficiency, patient experience, process, structural, and risk-adjusted outcome measures
- Performance assessment set of metrics should reflect multiple available data sources to incorporate all perspectives and viewpoints (external, internal, chart, admin, hybrid, self-report, patient exp, etc).
- Quality domains should reflect the strength and breadth of the underlying measures and scope of practice of the provider.
- The significance and comparative performance benchmarks as calculated by external measurement organizations will be leveraged for determining performance. This means comparative groups will vary by measure.
- Performance assessments should be shared with the physicians or hospitals prior to public reporting with a reasonable comment period to address any provider concerns.
- Significant provider and member feedback & complaints should be addressed within a reasonable time period.
- Complete descriptions of all measures, criteria, algorithms, methodologies, and data sources should be made available to all stakeholders.
- Physicians and consumer's feedback and collaboration regarding the design, selection of measures, methodology, and display formats will be considered through appropriate advisory and collaboration forums.

Measure Inclusion in Quality Assessment scoring

Measures are selected for Quality Assessments based upon the following measurement selection principles:

- Measures selected should represent a reasonable cross section of conditions or procedures within the usual scope of practice of a provider group or hospital.
- Measures selected should have followed HealthPartners' Measurement Development Policy reflecting reliable, valid based on sound scientific evidence, and accurate and timely as possible.
- Measures should be based on where there has been consensus among stakeholders and when possible, predictive of overall quality performance.
- Measures should be important and relevant to stakeholders, including physicians, consumers, health plans, and purchasers.
- Measures should reflect appropriateness and/or processes of care that provider groups or hospitals can influence or impact.
- As available, measures selected should be endorsed by nationally or locally recognized quality measurement organizations such as NQF, AQA, ACC, ICSI, MNCM, etc. HealthPartners will supplement with internally developed or provider self-reported measures.
- Measures of appropriateness of care should be utilized whenever possible.

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Provider Inclusion in Quality Assessment scoring

Providers are included in quality assessment scoring if they meet the following criteria:

- Obstetrics and Gynecology Providers must have at least 600 episodes
- Other specialty care providers must have at least 300 episodes
- Providers that primarily serve PMAP members are excluded
- Providers' scope of services should be representative of the specialty being assessed
- Members must have direct access to the provider
- Measurement results for the provider must represent the spectrum of quality domains (clusters) defined for each specialty.
    - Providers must have at least 50% of available measures within a quality domain in order for the domain to be included in their overall quality assessment. For clusters that have a break between child and adult measures – the quality domain will be included if the provider has 50% of Adult measures, 50% of pediatric measures, or a 50% combination between adult and pediatric measures. For hospitals, the Helping Patients Get Better cluster is broken down into 6 sub-clusters. Hospitals must have 50% of available measures within 3 of the 6 sub-clusters in order for the domain to be included.
    - Providers must have quality domains representing at least 40% of the total quality domain weights in order to calculate an overall quality assessment score/tier placement.

Provider Mergers

- Due to the fact that measurement & system changes typically lag & require time to reflect merged providers, adjustments to cost and quality measures may need to be accommodated to provide the most accurate profiles.
    - When possible, quality results will be rolled up at the measure level, to reflect the current merged provider. When this is not possible an 80/20 rule will apply. If one provider under the new merger accounts for 80% of the business, that provider's quality assessment will be used.
    - In other cases, quality assessment will be calculated will be calculated separately for each merged entity, and then weighted based on percentage of business and combined for their final quality assessment. When one of the merged providers lacks sufficient quality measures to be scored, the remaining provider's quality assessment will represent the merged entities' quality performance. In some cases system limitations may only allow for the display of one set of cost/quality data for a merged provider. In this case, the larger entities information will be displayed.

Individual Measure Scoring

Sampled Population Measures

- A sampled measure is a measure based on a subset of a population. This is done when measuring the full population is not possible or impractical.
- Examples of sampled measures:
    - Preventive Services - Adult (sourced from HealthPartners Clinical Indicators Report;
    - High Blood Pressure (sourced from Minnesota Community Measurement)
- Performance Level Scoring:
    - Confidence intervals for sampled measures are leverages when determining performance level scoring.
    - Score assignments for sampled measures are as follows:
        - Significantly above quality target threshold = 1 point
        - Not significantly above or below quality target threshold = 0.5 points
        - Significantly below quality target threshold = 0 points

Full-Population Measures

- Significance is not appropriate for full-population measures since no error rate is introduced due to sampling. Each measure is individually reviewed to determine provider performance levels; 1) high performer, 2) solid performer, or 3) lower performer.
- Performance Level Scoring:
    - Providers are assigned a score based on their performance to set quality threshold(s).
    - Score assignments for full-population measures are as follows:
        - Above top quality target = 1 point
        - Between top and bottom quality targets = 0.5 points
        - Below bottom quality target = 0 points

Clustering & Weighting

- All measures are clustered into meaningful categories (quality domains) that closely align with NCQA and NQF categories. Categorizing measures into clusters balances a provider's performance across a spectrum of care. For Primary Care the following quality domain clusters were utilized:
    - Patient Experience
    - Clinical Quality
- In general, measures all have equal weights (1.0). However, it is possible for new measures, or topically similar measures to be weighted differently in specific circumstances. In some cases this is done to essentially composite several measures into one with a total weight of 1.0.
- In 2021, the following measures had special weights assigned:
    - Safety: Immunizations for influenza – 0.5 (1/2)
    - Safety: Healthcare workers given influenza vaccination – 0.5 (1/2)
    - Safety: Door to diagnostic evaluation – 0.333 (1/3)
    - Safety: ER: Median time to pain medication for long bone fractures – 0.333 (1/3)
    - Safety: Head CT results within 45 minutes – 0.333 (1/3)
    - Safety: Abdomen CT use of contrast material – 0.5 (1/2)
    - Safety: Thorax CT use of contrast material – 0.5 (1/2)
    - Hospital surgical care infection prevention measures each weighted 0.166 (1/6)

    In the event that a provider is missing one or more of the specially weighted measures, the measure weights of the measure present re-calibrate to a weighting that adds to 1. For example, if a provider is missing the MNCM chlamydia screening measure, the weight assigned to the MNCM cervical and breast cancer screening measures would be 1/2 each instead of 1/3.

Decimal Rules

- All calculations used in Quality Assessments will be rounded until the quality assessments are determined. Final quality assessment indices will be truncated at 3-decimals. Tier assignments will only be applied after the truncation has occurred.

Quality Tier Definitions

- The following tier definitions will be used to designate providers as tier 1 or tier 2 for quality. These may be adjusted by specialty to account for other factors such as member access.
    - 2 Tier Model
        - Tier 1: Overall Quality Index >= 1.000
        - Tier 2: Overall Quality Index < 1.000
    - 3 Tier Model
        - Tier 1: Overall Quality Index >= 1.000
        - Tier 2: Overall Quality Index >= 0.5 and < 1.000
        - Tier 3: Overall Quality Index < 0.5

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Principles for Determining Provider/Hospital Benefit Levels/Tiers

Final Tier placements are determined based upon the following over-arching principals:

- Cost and quality must be available at the comparative specialty level (e.g. hospital, primary care, cardiology, orthopedics, OB/GYN and ENT) for tiering application.
- In general, better than average quality and cost performance is required to achieve tier 1 placement.
- Cost determines tier placement when provider volume in quality measures is not sufficient for comparative assessments.
- Tier placements may be adjusted due to access concerns related to geographic location and capacity. To avoid barriers to preventive services for Primary & OB/GYN care, a reasonable proportional split of historic episodes will help serve as a guide when considering tier adjustments.
- Public displays for will consumer transparency illustrate actual performance regardless of Tier placement.
- Primary care providers who do not submit to Minnesota Community Measurement will receive the lowest Tier placement.
- Employer groups may customize HealthPartner's standard Tier placements.
- Tier placements may be adjusted to recognize highly-specialized providers/facilities serving unique populations or conditions/procedures.

Final Tier Definitions

- 2 Tier Method- All specialties and hospital Tier 1 determined by average and better cost & quality (index TCI <=1 for cost and index Quality Index => 1 for quality)
- 3 Tier Methodology

  Primary Care, OB/GYN, Hospital
  - Tier 1 determined by TCI <= 1, QI => 1
  - Tier 2 determined by TCI <= 1.05, QI => 0.5
  - Tier 3 determined by TCI > 1.05, QI < 0.5

  All other specialties
  - Tier 1 determined by TCI <= 0.95, QI => 1
  - Tier 2 determined by TCI <= 1.05, QI => 0.5
  - Tier 3 determined by TCI > 1.05, QI < 0.5

Geographic Assessment

The east/west geographic distribution of Tier 1 providers is assessed to ensure reasonable access to Tier 1 providers by specialty and hospital. If there is limited access to Tier 1 providers, additional providers may be moved into Tier 1 using the following process:

- Only providers that meet the quality requirements to be eligible for Tier 1 are considered
- Of these providers, identify the provider in the geographic area that has the next best TCI— this provider would be moved into Tier 1.
- Identify any providers outside of the geographic area that have a TCI better than the group moving into Tier 1 and meet the quality requirements to be eligible for Tier 1. These identified groups would be moved into Tier 1 as well.

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2022 Metro Hospital Quality Scoring Specifics and Example:

Steps (1 – 4):

1. Selected measures that represent a broad domain of quality

- Centers for Medicare and Medicaid Services Outcomes Measures
- Minnesota Community Measurement/Minnesota Hospital Association
- Centers for Medicare and Medicaid Services HCAHPS Patient Satisfaction (experience) Surveys
- HealthPartners surgical procedure specific complications measures

2. For each of the measures, determine if the hospital was at threshold, or significantly above or below.

CMS HCAHPS measures
- Scoring based on thresholds using the linear average:
- Thresholds are informed by CMS star assignment groupings

CMS mortality and readmissions measures
- Scoring based on significance to thresholds
- Thresholds are informed by the regional distribution of hospital performance

CMS process of care measures
- Scoring based on performance rate thresholds

See appendix for hospital measure targets

3. Group measures into logical clusters or domains

- Patient Experience
- Helping Patients Get Better
  - Heart Care
  - Lung Care
  - OB Care
  - Stroke Care
  - Orthopedic Care
  - Safety

4. For each domain, calculate a quality score.

- A quality score is obtained by assigning a point value to each individual measure results within a quality domain based on significance.
- Below Threshold = 0 pts, At Threshold = 0.5 pts, Above Threshold = 1 pt
- The total number of points within each quality domain is calculated for each provider
- The total number of points for each cluster is divided by the total number of measures to produce the providers' actual to expected quality domain score

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Example for Hospital #1

Individual Measure Performance by Cluster:

Measures in Cluster/Sub Cluster	LCL/Rate/UCL	Threshold(s)	Symbol	Actual Point Value	Expected	Actual to Expected Score
Heart Bypass Surgery	90	200/100	○	0	1	=1.5/3
Heart Attack Mortality	14.5%/18%/20.5%	18%	◑	0.5	1	0.5
Heart Attack Readmissions	13%/16.5%/20%	22%	●	1	1	
Total				1.5	3	

1. Weight the Actual to Expected score for each quality domain by the cluster domain weight.

Quality Domain	Weighting	Actual to Expected Score	Weighted Score	Quality Index
Patient Experience	20%	0.80	0.16	
Helping Patients Get Better	80%	0.616	0.4928	=0.6528/0.5 1.3056
•Heart Care	25%	0.55		
•Lung Care	25%	0.50		
•OB Care	25%	0.667		
•Safety	25%	0.75		
Total			0.6528	

2. Calculate an overall quality index relative to the quality threshold for each hospital.

- Since scoring at threshold on all measures always equates to a 0.5 score, dividing the total weighted quality domain scores by 0.5 creates an overall quality index relative to the aggregate quality threshold. Using this, providers' scores represent a percent above or below threshold performance. Therefore, a score of 1.136 reflects 13.6% better than threshold performance.

Hospital	Total Weighted Score	Threshold	Quality Index
Hospital #1	0.6528	0.5	0.6528/0.5 = **1.3056**
Hospital #2	0.500	0.5	0.5/0.5 = **1.000**

3. Create quality tiers based on performance relative to threshold – as defined in the Quality Tiers Definitions section of this document.

4. Final tier placement is a function of cost and quality – as defined in the Final Tier Definitions section of this document.

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2022 Primary Care Quality Scoring Specifics and Example Steps (1 – 8)

1. Selected quality measures that represent a broad domain of quality

- Minnesota Community Measurement
- Patient Experience
- Several measures are composites.
- For some measures where a composite is not available, individual components were equally weighted to produce a composite equivalent.
    - Minnesota Community Measurement Depression care measures – each weighted 1/7th.
    - Minnesota Community Measurement Breast Cancer screening, cervical cancer, and chlamydia screening – each weighted 1/3rd.

2. For each of the measures, determine if the medical group was at threshold, or significantly above or below.

3. Group measures into logical clusters or domains

- Patient Experience
- Clinical Quality

4. For each domain, calculate a quality score.

- A quality score is obtained by assigning a point value to each individual measure result within a quality domain based on significance.
- Below Threshold = 0 pts, At Threshold = 0.5 pts, Above Threshold = 1 pt
- The total number of points within each quality domain is calculated for each provider
- The total number of points for each quality domain is divided by the total number of measures to produce the providers' actual to expected quality domain score

Example for Medical Group #1

Individual Measure Performance by Cluster:

Care for Chronic Conditions	UCL/Rate/LCL	Threshold(s)	Symbol	Actual Point Value	Expected
Optimal Vascular	62.5%/60.0%/56.5%	50%	●	1	1
Optimal Diabetes	42%/40%/38%	40%	◑	0.5	1
High Blood Pressure	90%/85%/80%	75%	●	1	1
Diabetic Eye Exam	55%	60/50%	◑	0.5	1
Use of Spirometry for COPD	55%/50%/45%	40%	●	1	1
Total				4	5

Actual to Expected Points Score
=4/5
0.8

5. Weight the Actual to Expected score for each quality domain by the cluster domain weight.

- Each cluster can be weighted differently
- Since scoring at threshold on all measures always equates to a 0.5 score, dividing the actual to expected score by 0.5 creates a quality index relative to the aggregate cluster quality threshold. Using this, providers' scores represent a percent above or below threshold. Therefore, an index of 1.260 reflects 26% better than threshold performance.
- Weighting for Primary Care

Quality Domain	Actual to Expected Score	Threshold	Quality Domain Index	Weighting	Weighted Actual to Expected Score
Patient Experience	0.750	0.5	1.500	20%	0.150
Clinical Quality	0.600	0.5	1.200	80%	0.480
Total	---	---	---	---	0.630

6. Calculate an overall quality index relative to the quality threshold for each provider.

- Since scoring at threshold on all measures always equates to a 0.5 score, dividing the total weighted quality domain scores by 0.5 creates an overall quality index relative to the aggregate quality threshold. Using this, providers' scores represent a percent above or below threshold. Therefore, a score of 1.092 reflects 9.2% better than threshold performance.

Provider	Total Weighted Score	Threshold	Quality Index
Medical Group #1	0.630	0.5	0.630/0.5 = **1.260**
Medical Group #2	0.500	0.5	0.5/0.5 = **1.000**

7. Create quality tiers based on performance relative to threshold – as defined in the Quality Tiers Definitions section of this document.

8. Final tier placement is a function of cost and quality – as defined in the Final Tier Definitions section of this document.

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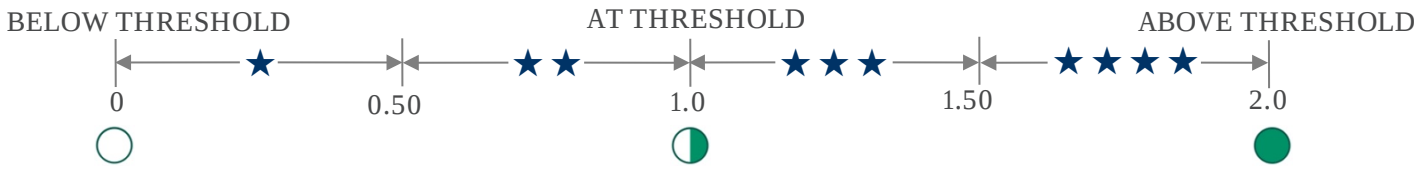
2022 Star / Dollar-Assignment Methodology

Star / Dollar-Assignment Methodology

Description – Overall quality star ratings are calculated for Primary Care, Cardiology, ENT, Obstetrics and Gynecology, and Orthopedics specialties, and Hospitals. In addition:

- Providers must have at least 50% of available measures within a quality domain in order for a star assignment to be calculated. For clusters that have a break between child and adult measures – the quality domain star rating will be calculated if the provider has 50% of Adult measures, 50% of pediatric measures, or a 50% combination between adult and pediatric measures.
- Providers must have star ratings in all Primary care or Hospital quality domains in order to calculate an overall quality star rating.

Thresholds – Star assignment performance levels are set such that a provider must have 1/2 of their measures within a quality domain above threshold with the other 1/2 at threshold to achieve a 4 star rating. To achieve a 1 star rating a provider must have greater than 1/2 of their measures below threshold with the remaining measures at threshold. For the overall quality star assignment rating, the total weighted quality score is used against this same scale.



Example of Quality Star Rating Calculations

Quality Domain	Quality Index	Quality Domain Star Rating	Weighting	Weighted Index
Patient Experience	1.50	1.50 <= **1.50** < 2.0 = ★★★★	20%	0.30
Clinical Quality	1.20	1.00 <= **1.200** < 1.5 = ★★★	80%	0.96
Total				1.260

Total Weighted Quality Domain Indices	Overall Quality Star Rating
1.260	1.0 <= **1.260** < 1.50 = ★★★

Dollar Ratings Description – For 2022, overall dollar sign ratings are calculated for Primary Care, Cardiology, ENT, Obstetrics and Gynecology, and Orthopedics specialties, and Hospitals and Surgery Centers. Dollar sign ratings are based on each provider's TCI within each specialty compared to set thresholds as described below.

Thresholds – Dollar ratings are assigned as follows.

Total Cost Index (TCI)	Dollar Rating
TCI <0.90	$
0.90 <= TCI < 1.0	$$
1.0<= TCI < 1.1	$$$
TCI >= 1.10	$$$$

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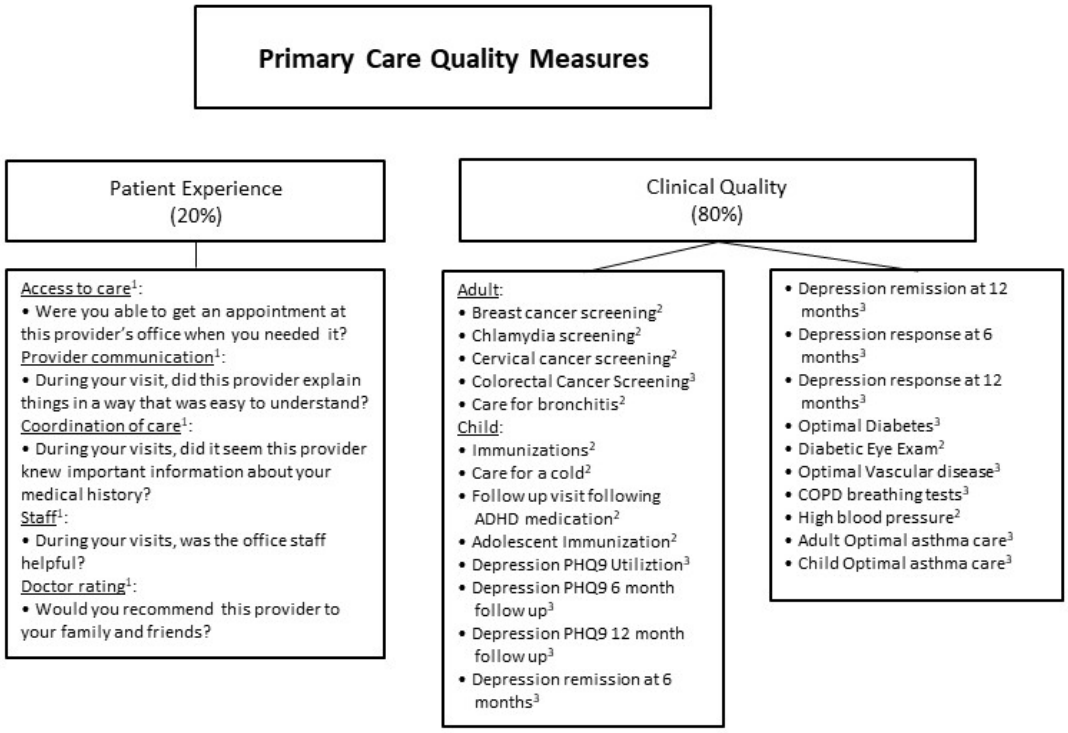

Sources:

1. HealthPartners Patient Experience Digital Survey
2. Minnesota Community Measurement Health Care Quality Report
3. Minnesota Community Measurement Direct Data Submission Results

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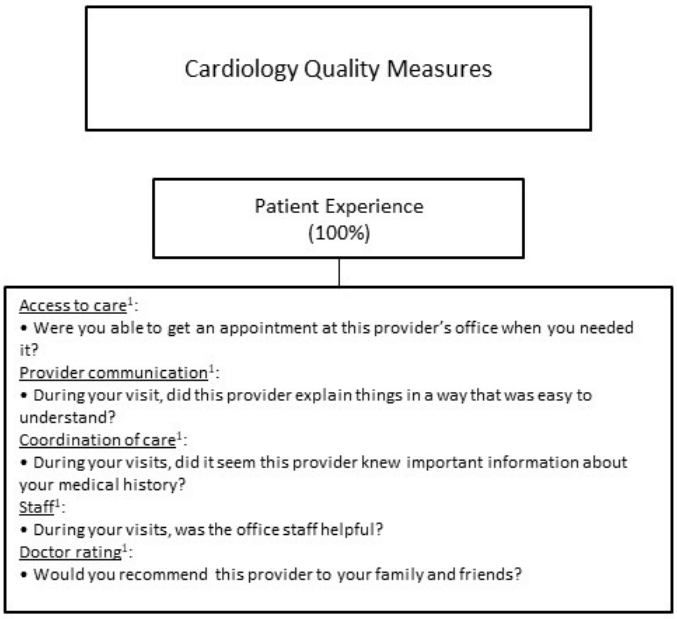

Sources:

1. HealthPartners Patient Experience Digital Survey

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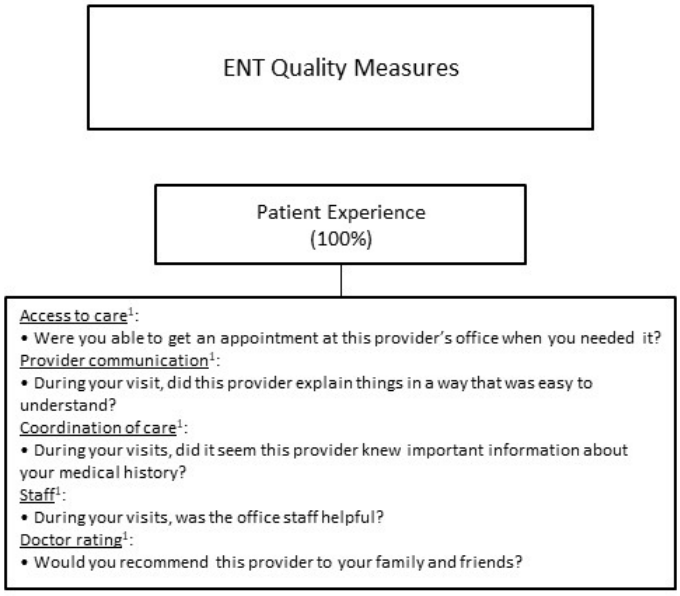

Sources:

1. HealthPartners Patient Experience Digital Survey

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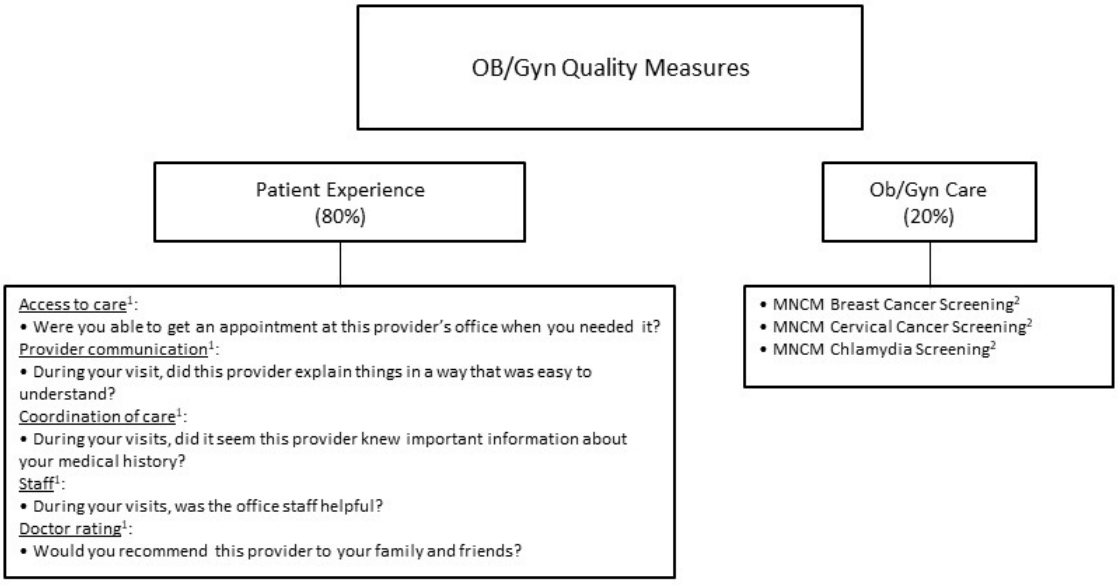

Sources:

1. HealthPartners Patient Experience Digital Survey
2. MNCM Health Care Quality Report

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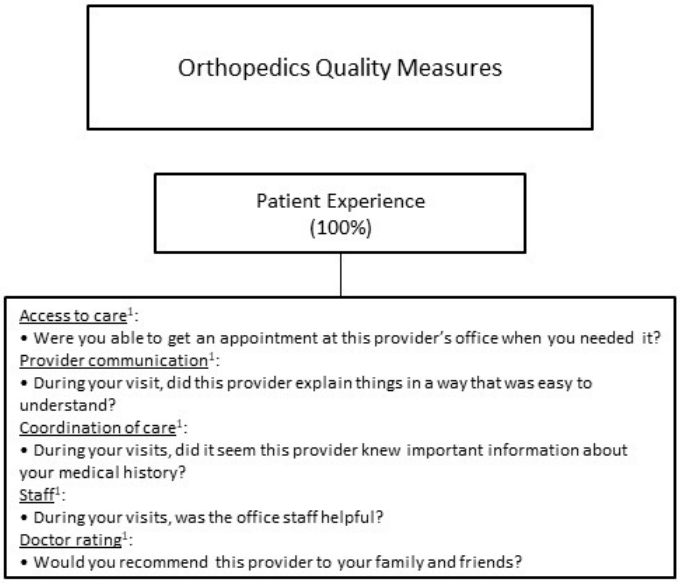

Sources:

1. HealthPartners Patient Experience Digital Survey

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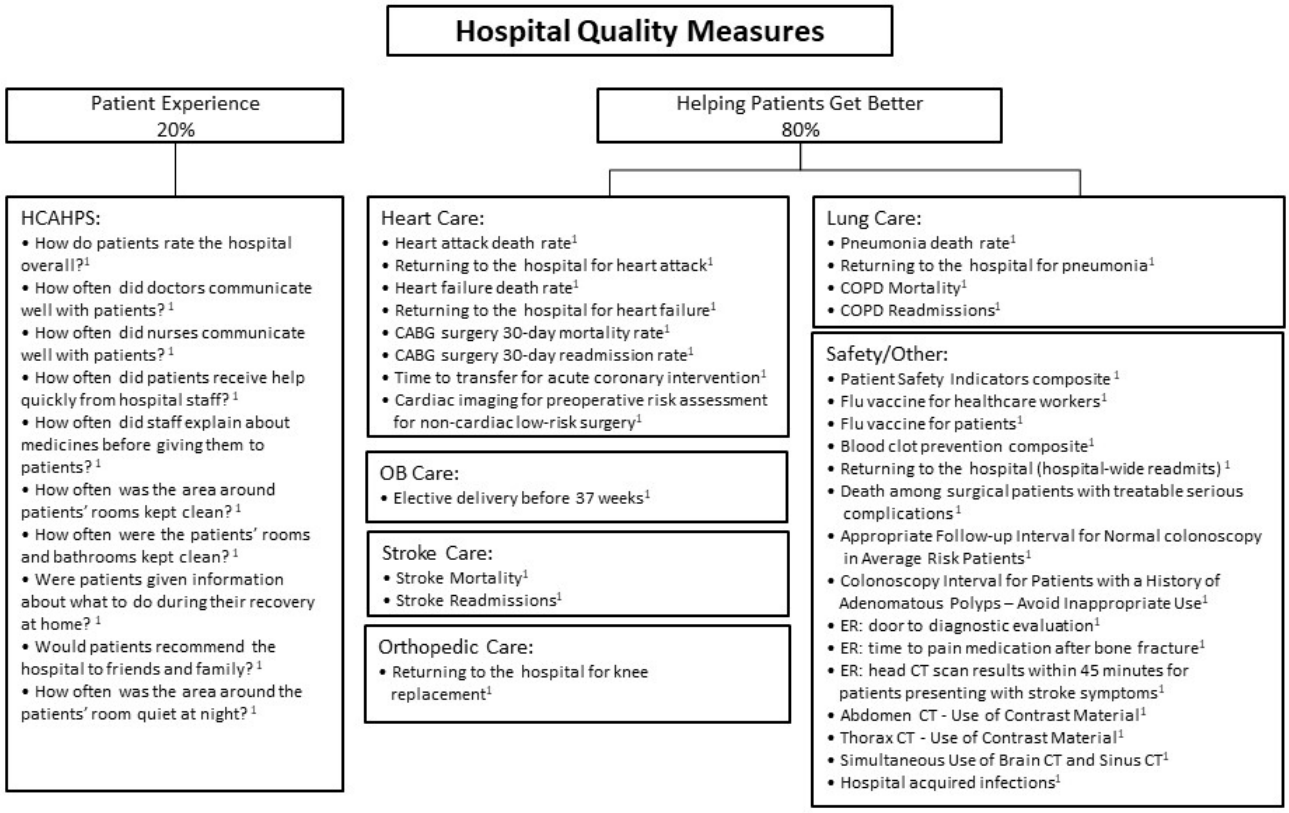

1. CMS: http://data.medicare.gov