THE HEALTH COLLABORATIVE
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Qualified Entity Reporting

The Health Collaborative Qualified Entity Public Reporting of Primary Care Practices

Measurement Period: January 2015-December 2015

The Health Collaborative Qualified Entity Project

The Greater Cincinnati region is one of only fifteen regions in the United States to have been selected by the U.S. Centers for Medicare & Medicaid Services (CMS) to receive standardized extracts of Medicare claims data under parts A, B, and D, per section 10332, subsection (e), of the Affordable Care Act's amendment of section 1874 of the Social Security Act. Those recipients, better known as Qualified Entities (QEs), may use the information obtained under section 1874(e) of the Social Security Act, in conjunction with claims data from sources other than Medicare, for the purpose of generating reports to evaluate the performance of their regions' providers and suppliers.

The QE public report includes data provided by CMS through the QE Certification Program, Ohio Medicaid, and seven commercial insurance plans that have agreed to support more than 70 participating primary care practices representing more than 250 physicians. Participating practices are located across 12 counties in southwest Ohio and northern Kentucky.

We thank and acknowledge these physicians and health systems for their willingness to take this next step in providing data by which consumers can ultimately evaluate their performance. Comparing performance across practices and counties is complicated. The general health of the population in the county, the availability of resources, the expertise of the physicians and their willingness/capability to care for sicker patients all contribute to possible reasons why some practices perform better than others. While we adjust the data for some of these factors, the methods we use cannot adjust for all contingencies. It is important to recognize this effort as *a first step* to provide preliminary data by which:

- **Physician practices can improve their performance,**
- **Payers can increase their understanding of provider performance,**
- **Consumers can begin to learn how to best use this new information,**
- **While we all continue to adjust the data to better account for variations in practice demographics toward a better reflection of true performance.**

To guide their efforts in creating a critical resource for evaluating the overall effectiveness, The Health Collaborative has partnered with Onpoint Health Data, a health data management and analytics firm with expertise in data integration and claims-based reporting, to build a "Shared Data Platform." This multi-payer claims database begins with data collection and aggregation followed by enhancement, performance measurement, analysis, and reporting.

The analysis and reporting, which is provided and explained in greater detail in the following pages, have been developed to help achieve CMS's objective of improving quality and reducing costs in Medicare and The Health Collaborative's goal of building a regional culture of team-based care coordination and payment transformation. Please see Appendix I for additional detail about The Health Collaborative QE project's reporting methodology.

Public Reporting – Comparison of Greater Cincinnati QE Primary Care Practices

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The following report presents data on healthcare quality and utilization metrics for all QE-participating primary care practices located in the Greater Cincinnati region. For additional information on the QE measure set, including definitions, please see Appendix I, Table 3.

The Health Collaborative is continuing its efforts in building the capacity for merging costs across payers. It is anticipated that all QE expenditure metrics will be published within a year of the current report's release as part of a second phase of THC's QE public reporting.

Table 1. Comparison of All QE Primary Care Practices by Measure Type

	UTILIZATION MEASURES*		QUALITY MEASURE*		
	Inpatient Discharges (Per 1,000 member years)	Emergency Department Visits (Per 1,000 member years)	HEDIS Plan All-Cause Readmission (Observed to Expected Ratio)		
Measurement Year	2015	2015	2013	2014	2015
All Participating Practices (Avg.)	100.90	294.30	0.90	0.94	1.02
Kettering Health Network					
Integrated Medical	109.60	353.30	1.31	0.98	1.16
South Dayton Internists	96.64	336.10	0.87	0.84	0.68
PriMed Physicians					
Beavercreek	78.30	296.60	1.07	0.87	0.97
Lincoln Park	95.67	315.60	0.87	0.77	1.22
Middletown	82.46	319.60	0.64	0.90	0.72
Patterson Woods	101.10	327.00	0.49	0.75	0.92
Springboro	86.58	287.90	1.00	1.25	0.72
Vandalia	74.89	299.10	0.93	1.27	0.64
Woodbury	74.11	255.90	1.00	0.87	0.61
Providence Medical Group					
Beavercreek Commons	101.20	369.70	0.66	1.17	1.06
Farmersville Medical Center	100.60	303.20	0.42	1.05	0.87
Germantown Medical Associates	70.38	270.70	**	0.49	**
Lugo Family Practice	91.25	296.70	0.93	0.43	0.53
Northeast Family Practice	85.93	373.90	1.20	1.25	0.61
Suburban Family Practice – Bennett	115.00	465.10	1.21	1.85	1.29
Sugarcreek Family Practice	89.21	261.50	1.16	1.30	1.31
The Heights	114.00	342.80	0.69	1.66	1.19

	UTILIZATION MEASURES*		QUALITY MEASURE*		
	Inpatient Discharges (Per 1,000 member years)	Emergency Department Visits (Per 1,000 member years)	HEDIS Plan All-Cause Readmission (Observed to Expected Ratio)		
Measurement Year	2015	2015	2013	2014	2015
Waynesville Healthcare	99.95	300.60	0.87	1.35	1.04
St. Elizabeth Physicians (North)					
Bellevue	120.10	244.10	0.61	0.78	0.77
Covington	106.10	257.00	0.99	0.87	1.06
Fort Mitchell	107.90	233.40	0.80	1.13	1.12
Hebron Medical Arts	115.40	241.20	1.24	0.92	1.14
Litton Lane	116.20	236.60	0.77	1.11	0.89
Turfway	116.80	243.30	0.91	0.99	1.11
St. Elizabeth Physicians (South)					
Crittenden	149.10	349.40	1.07	0.86	1.47
Dry Ridge	146.50	425.30	0.79	1.19	1.18
Florence Ewing	121.80	231.80	1.07	0.63	0.95
Independence	105.20	228.00	1.11	1.22	1.14
Mt. Zion	111.20	226.10	0.52	0.96	0.95
Taylor Mill	110.20	256.20	0.88	0.74	1.22
Walton	104.50	222.80	0.86	0.67	0.63
Williamstown	109.70	324.60	1.14	1.27	1.30
The Christ Hospital					
Compton	85.72	252.80	1.21	0.77	1.29
Delamerced	132.10	358.40	1.18	0.65	1.00
Delhi	96.44	260.30	0.84	0.99	0.91
Forest Hills	110.60	258.70	1.13	0.79	0.80
Hyde Park	77.52	193.20	0.67	0.66	0.73
Hyde Park Internists	81.31	226.00	1.10	0.95	1.39
Madeira	91.98	243.60	0.63	0.80	0.64
Mason	58.77	228.80	0.71	0.66	**
Medical Office Building (MOB) #334	91.35	274.80	0.78	0.99	0.79
Medical Office Building (MOB) #440	124.60	292.10	0.87	1.16	0.77
Norwood Family Medicine	85.37	291.00	0.90	1.11	0.79
Norwood Internal Medicine	106.00	336.80	0.66	1.00	1.23

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	Inpatient Discharges (Per 1,000 member years)	Emergency Department Visits (Per 1,000 member years)	HEDIS Plan All-Cause Readmission (Observed to Expected Ratio)		
Measurement Year	2015	2015	2013	2014	2015
Red Bank Internal Medicine	88.19	259.70	1.00	0.70	0.42
Rookwood Internal Medicine	79.90	231.60	0.94	0.97	1.16
Walnut	94.73	276.00	1.48	0.82	1.08
Westside Internal Medicine	72.10	281.10	0.93	0.83	1.23
TriHealth (East)					
Group Health – Clifton	105.20	314.00	0.79	0.97	1.19
Group Health – Kenwood	100.80	273.90	0.99	0.95	1.00
Health First Physicians – Loveland	101.20	233.60	0.68	1.09	0.87
Health First Physicians – Mason	108.10	281.90	1.12	0.90	1.66
Health First Physicians – Mariemont	75.22	222.10	0.84	0.76	0.78
Queen City Physicians – Hyde Park	94.24	222.10	0.82	1.03	0.96
Queen City Physicians – Madeira	88.65	244.10	0.66	0.65	0.96
TriHealth Physician Partners – Bethesda Group Practice	87.36	253.90	0.73	0.73	1.22
TriHealth Physician Partners –Bethesda Group Practice, Arrow Springs	108.10	299.80	0.96	1.05	0.96
TriHealth Physician Partners –Deerfield Family Practice	69.03	317.10	1.02	0.49	0.57
TriHealth Physician Partners – Moreira & Robles Internal Medicine Associates	104.70	247.90	1.39	1.02	1.56
TriHealth (West)					
Group Health – Finneytown	81.57	232.60	0.75	0.84	1.26
Group Health – West Chester (Springdale)	92.82	262.30	0.93	0.95	0.61
Queen City Physicians – Western Hills Internal Medicine	103.70	311.20	0.95	1.00	0.91
Queen City Physicians – Western Ridge Internal Medicine	109.10	290.30	0.98	0.86	1.25
TriHealth Physician Partners – Physician Associates of Good Samaritan Hospital	61.83	198.90	0.68	0.96	1.03
TriHealth Physician Partners – West Chester Medical Group	82.78	318.80	0.92	1.24	1.11

	UTILIZATION MEASURES*		QUALITY MEASURE*		
	Inpatient Discharges (Per 1,000 member years)	Emergency Department Visits (Per 1,000 member years)	HEDIS Plan All-Cause Readmission (Observed to Expected Ratio)		
Measurement Year	2015	2015	2013	2014	2015
TriHealth Physician Partners – Western Family Physicians	92.13	243.70	0.99	0.84	0.78
TriHealth Physician Partners – White Oak Family Practice	99.11	265.90	0.70	0.83	0.99
Upper Valley Family Care					
Piqua	97.37	315.00	0.91	1.16	1.15
Troy	96.28	310.90	0.51	0.68	1.17
Independent Practices					
Generations	80.98	322.10	0.47	0.86	1.42
Lawrence P Wang, MD, LLC	87.38	215.80	0.47	0.59	0.93
Maineville Family Physicians	87.80	293.10	0.87	0.97	1.15
Springfield Health Care Center Inc.	109.00	315.40	0.74	1.12	0.90
Summit Family Physicians Inc.	108.40	336.50	0.79	0.85	1.07

* Measure includes claims data from CMS Medicare in addition to all QE-participating (7) commercial plans and Ohio Medicaid.

** Data not presented where practices have <30 eligible members.

*** Measure results under review.

Appendix I – THC QE Public Report Supporting Documentation

Reporting Style, Data Source, & Intended Audience

THC Qualified Entity (THC QE) project's public reporting of primary care practices was developed through a collaborative process between The Health Collaborative and Onpoint Health Data, and informed by feedback from all key stakeholders. The reports use eligibility and medical and pharmacy claims data supplied to the initiative's Shared Data Platform and represent only adult members, ages 18 years and older, who were enrolled in one of the project's participating health plans and attributed to a primary care practice participating in The Health Collaborative's Comprehensive Primary Care (CPC) initiative during the specified measurement year. In addition to CMS Medicare, all participating commercial plans, including those with Medicare Advantage plans and Medicaid commercially insured plans, as well as Ohio Medicaid, contributed data for this report.

This public comparative report includes claims data for incurred dates of service beginning January 2015 through December 2015, with paid-date runout through March 2016, for all metrics. Eligibility data is limited to records beginning October 2015 through December 2015. Additionally, for the HEDIS Plan All-Cause Readmission metric, rates are trended across 2013, 2014, and 2015 measurement years.

Data within the public report's familiar tabular interface are parsed out by metric type (i.e., utilization and quality measures). Within this limit, data is further organized by primary care practice organization and displayed for each organization's respective QE-participating primary care practice. An average rate for all QE-participating primary care practices is also provided. Data is not presented for practices that have less than 30 attributed members.

Data Modifications, Limitations, & HIPAA Requirements

The data used in this report come exclusively from the payers participating in the THC QE project and represent only those members who can be attributed to a primary care practice participating in The Health Collaborative's Comprehensive Primary Care (CPC) initiative during the particular measurement year. All reporting is based on the primary payer denoted in the data submitted by each payer (secondary payers were not included). The following sections outline and provide greater detail around several data modifications, limitations, and HIPAA requirements implicating this report.

Attribution of Members to Providers & to Practices. The attribution of members to providers and to practices is performed by each commercial payer plus Ohio Medicaid, with the necessary assignment information reported in individual fields included in the eligibility files submitted by the payers to the Shared Data Platform. For fields concerning the attribution of members to providers, the payers are able to denote whether (a) the member attributed themselves to the primary care provider, (b) they [the payer] attributed the member to the primary care provider, or (c) the member's attribution methodology was unknown. As for the fields concerning the attribution of providers to practices, the payers complete the assignment using a provider-to-practice roster developed by the Health Collaborative and provided by Onpoint.

It is important to note that attribution for all Medicare members used in generating this report is not reported by the U.S. Centers for Medicare and Medicaid Services (CMS). It has therefore been performed by Onpoint using a claims-based method with a 24-month lookback period.

For these reasons, providers, practices, and payers are required to review all information disclosed in their private reports to ensure that no misrouted protected health information (PHI) has been included. Please see the privacy disclaimer on the "About this Report" page for more information.

Exclusion of Substance Abuse, Mental Health, & HIV Records. Per HIPAA privacy constraints and state and federal laws, Onpoint and QE-participating payers identified substance abuse, mental health, and HIV records for reporting exclusion. Onpoint provided QE payers with the necessary support documentation to exclude codes reported for multiple fields, including admitting diagnosis, principal diagnosis, secondary diagnosis, procedure code, and provider taxonomies that indicate accordant treatment. Following the processing of the payers' claims data, Onpoint applied additional data quality validation checks for the appropriate identification and omission of these related records. The total number of records removed from reporting based on these requirements resulted in less than 4% of all claims records attributed to the reporting period.

Transition of ICD Code Set. Effective as of October 1, 2015, the International Classification of Diseases (ICD) code set, a clinical cataloging system maintained by the World Health Organization, transitioned to its tenth edition (i.e., from 'ICD-9' to 'ICD-10') in an effort to qualitatively and quantitatively offer greater classification options than its predecessor. The code set is used widely by the healthcare industry (including providers, coders, IT professionals, health plans, etc.) to properly note diseases on health records, track epidemiological trends, and assist in medical reimbursement decisions. The ICD-10 transition is required by any organization covered by HIPAA.

This public report experiences the ICD-10 transition, with the inclusion of incurred claims through December 2015. As such, Onpoint updated all measures impacted by the transition to reflect revised specifications encompassing the ICD-10 code set. For example, any measure tying back to diagnoses is based on modified Healthcare Effectiveness Data and Information Set (HEDIS) value sets.

Risk-Adjusted Rates & Confidence Intervals

Demographic, major payer type, and health status information derived from the Shared Data Platform claims data serve as the primary inputs for the risk-adjustment methods used in generating the THC QE project's public reporting of primary care practices. Utilized components include a member's age, gender, and health status as measured by 3M™ Clinical Risk Groups (CRGs). Below, Table 1 provides an overview of the methods used for adjusting for risk by each measure. Adjustments also are made for the partial length of enrollment reported for some members during the particular measurement year.

Table 1. Methods for Adjusting for Risk by Measure

Domain	Measure	Methods for Adjusting for Risk
Quality	HEDIS Plan All-Cause Readmission	NCQA HEDIS
Utilization	Inpatient Discharges	Age, Gender, Major Payer Type, Health Status
Utilization	Emergency Department Visits	Age, Gender, Major Payer Type, Health Status

Demographics & Major Payer Type Adjustments. Due to both small cell-size constraints and the potential for interaction effects of age and gender in the current data, the risk-adjustment model combines age and gender stratifications into the following aggregated groupings: males aged 18-44 years, females aged 18-44 years, males aged 45-64 years, females aged 45-64 years, males aged 65 years and older, females aged 65 years and older. Members with an unknown age or gender are excluded from this model and therefore from the calculation of risk-adjusted rates.

Additionally, adjustments are made for major payer type due to a couple of reasons. Firstly, different payer types reimburse at different rates, resulting in different allowed amounts. Secondly, different payer types may offer different benefit packages and cover different services.

The following payer types are included in the QE project's risk adjustment model:

- Commercial health plans
- Commercial, Medicare Advantage plans
- Commercial, Medicaid Managed Care plans
- Medicaid Fee-for-Service plans
- CMS Medicare Fee-for-Service plans

NCQA HEDIS Adjustments. The HEDIS measure on Plan All-Cause Readmission (PCR), developed by the National Committee for Quality Assurance (NCQA), is risk-adjusted using tables provided by NCQA and implemented by Onpoint. The PCR measure looks at the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and with the predicted probability of an acute readmission.

Risk factors for the NCQA HEDIS PCR measure include presence of surgeries, discharge condition, comorbidity, age, and gender on the index hospitalization. The measure result is expressed as a ratio of the observed-to-expected readmissions, where the expected number of readmissions is risk adjusted. Because the risk probabilities for this measure are generated by NCQA, the QE-wide and national ratios are not 1.00.

Statistical Method of Risk-Adjustment. The model used for adjusting for risk for the quality and utilization measures used in the QE public report was implemented using version 9.3 of the Statistical Analysis System (SAS) software. Models include combined age and gender stratification groups, CRG status classification, and HEDIS adjustments per NCQA specifications. Adjusted rates for primary care practices were produced by the 'STDRATE' procedure in SAS, a function specifically designed to calculate risk-adjusted rates.

Risk-adjustment methods require a standard rate on which to base all adjustments. In the absence of a large, national standard rate, claims data from the Shared Data Platform for the specific measurement period are used to calculate that standard rate. This approach is the most common method in virtually all claims-based studies. Interpretation of the resulting variability in the risk-adjusted rates should therefore be compared only among participating QE entities and not against any national rate.

Treatment of Outlier Cases

Utilization measures are capped for outliers in the claims data using the 99th percentile for each measure. The example below demonstrates appropriate outlier capping for utilization measures:

- **Utilization (e.g., Outpatient Emergency Department Visits):** If the QE-wide 99th percentile for the measure on outpatient emergency department visits equals 8 visits for a particular measurement year and a patient has 12 outpatient emergency department visits during that period, that patient's total outpatient emergency department room visits are capped at 8 visits.

Quality measures are not capped for outliers; the HEDIS measures on PCR has a maximum value of '1' in the numerator. Table 2 provides an overview of the methods used for capping outliers by each measure.

Table 2. Methods for Capping Outliers by Measure

Domain	Measure	Methods for Capping Outliers
Quality	HEDIS Plan All-Cause Readmission	Not Applicable
Utilization	Inpatient Discharges	Cap at the 99th Percentile
Utilization	Emergency Department Visits	Cap at the 99th Percentile

Definitions of QE Measure Set

Below, Table 3 provides additional information about the measures used in the generation of the THC QE project's public reporting of primary care practices.

Table 3. Definitions of QE Measure Set

Domain	Measure	Definition	Interpretation
Quality	HEDIS Plan All-Cause Re-admissions	Number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days of discharge; indicates the predicted probability of an acute readmission.	**How to read this measure:** The rate for the HEDIS plan all-cause readmissions quality measure is given as a ratio of the observed re-admission rate to the expected re-admission rate; in other words, it is the observed probability of read-missions divided by the expected probability of readmissions.

Domain	Measure	Definition	Interpretation
			Example: • An observed-to-expected ratio less than 1 indicates that a practice's members are readmitted at a rate lower than expected. • An observed-to-expected ratio of 1 indicates that a practice's members experience exactly the same readmission rate as expected. • An observed-to-expected ratio greater than 1 indicates that a practice's members are readmitted at a rate higher than expected.
Utilization	Inpatient Discharges	Utilization of acute inpatient care, excluding mental health, chemical dependency, and maternity claims.	**How to read this measure:** The rate for the inpatient discharges utilization measure is given per 1,000 member-years. **Example:** A result of 500 per 1,000 member-years indicates that 1,000 members will have 500 inpatient discharges over the course of a year.
Utilization	Emergency Department Visits	Utilization of emergency department visits, excluding mental health, chemical dependency, and maternity claims.	**How to read this measure:** The rate for the emergency department visits utilization measure is given per 1,000 member-years. **Example:** A result of 500 per 1,000 member-years indicates that 1,000 members will have 500 emergency department visits over the course of a year.