THE HEALTH COLLABORATIVE
Technology Powered by HealthBridge

Qualified Entity Reporting

The Health Collaborative Qualified Entity Public Reporting of Primary Care Practices

Measurement Period: July 2015-June 2016

The Health Collaborative Qualified Entity Project

The Greater Cincinnati region is one of the selected regions in the United States to be designed by 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 built 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.

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

Measurement Period	Inpatient Discharges (Per 1,000 member years)*	Inpatient Cost Per Member Per Year*	Emergency Department Visits (Per 1,000 member years)*	Emergency Department Cost Per Member Per Year*	HEDIS Plan All-Cause Readmission (Observed to Expected Ratio)*	Total Cost of Care Per Member Per Year*
	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2
All Participating Practices (Avg.)	90.46	$1,358.69	280.09	$179.27	1.28	$5,514.85
All Participating Practices in Dayton (Avg.)	85.04	$1,472.41	312.31	$256.02	1.15	$6,156.21
All Participating Practices in Cincinnati (Avg.)	89.86	$1,327.38	249.44	$158.64	1.27	$5,341.98
Kettering Health Network						
South Dayton Internists	91.89	$1,514.84	335.73	$296.25	0.89	$6,830.88
Integrated Medical	95.48	$1,706.15	354.25	$237.51	1.73	$6,958.11
PriMed Physicians						
Beavercreek	73.45	$1,227.81	283.16	$202.28	1.43	$6,150.85
Lincoln Park	82.21	$1,441.47	284.24	$236.75	1.54	$6,015.11
Middletown	78.87	$1,428.34	321.70	$249.95	1.05	$5,607.45
Patterson Woods	97.09	$1,643.44	303.67	$245.86	1.07	$6,317.52
Springboro	80.68	$1,432.99	287.68	$217.19	0.59	$6,256.02
Vandalia	73.37	$1,519.22	256.52	$219.27	1.26	$5,592.22
Woodbury	75.16	$1,436.98	258.04	$265.83	0.86	$5,992.74
Providence Medical Group						
Beavercreek Commons	95.23	$1,209.64	368.55	$275.25	1.34	$5,797.27
Farmersville Medical Center	74.92	$1,199.34	287.53	$277.66	0.54	$5,438.18
Germantown Family Medicine	72.10	$1,121.72	259.05	$210.30	**	$5,173.18
Lugo Family Practice	97.21	$1,931.05	282.23	$210.19	1.23	$6,515.56
Northeast Family Practice	80.57	$1,436.86	368.92	$278.47	0.54	$6,385.64
Suburban Family Practice-Bennett	103.69	$1,700.13	444.50	$372.80	1.61	$6,342.02
Suburban Family Practice-Koren	84.70	$1,517.47	347.45	$351.27	2.21	$6,318.02

Measurement Period	Inpatient Discharges (Per 1,000 member years)*	Inpatient Cost Per Member Per Year*	Emergency Department Visits (Per 1,000 member years)*	Emergency Department Cost Per Member Per Year*	HEDIS Plan All-Cause Readmission (Observed to Expected Ratio)*	Total Cost of Care Per Member Per Year*
	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2
Sugarcreek Family Practice	87.18	$1,621.74	274.69	$209.30	1.23	$6,093.32
Waynesville Healthcare	88.67	$1,415.35	270.47	$209.72	0.89	$5,729.87
Upper Valley Family Care						
Piqua	83.45	$1,632.40	298.26	$255.12	0.97	$6,214.62
Troy	88.28	$1,337.95	311.33	$263.06	1.25	$6,451.78
Independent Practices						
Generations	68.40	$1,377.11	285.93	$241.93	1.05	$6,874.26
Springfield Health Care Center	92.63	$1,387.64	332.85	$253.28	1.00	$5,878.84
Summit Family Physicians Inc.	88.30	$1,611.75	332.77	$280.36	1.17	$6,566.43
St. Elizabeth Physicians						
Bellevue	112.09	$1,530.09	220.72	$137.92	1.10	$5,300.17
Covington	103.40	$1,283.01	254.14	$148.18	1.59	$5,152.55
Crittenden	111.30	$1,578.72	315.27	$186.79	1.59	$5,344.66
Dry Ridge	118.09	$1,769.55	422.84	$245.83	1.10	$5,963.51
Florence Ewing	109.09	$1,467.60	227.97	$150.70	1.49	$5,321.83
Fort Mitchell	90.26	$1,194.16	219.57	$145.66	1.61	$4,975.66
Hebron Medical Arts	102.47	$1,341.89	214.07	$132.00	1.34	$5,360.11
Independence	93.15	$1,330.96	238.94	$152.03	1.34	$5,468.80
Litton Lane	109.67	$1,604.64	242.72	$154.20	1.55	$5,710.15
Mt. Zion	101.06	$1,480.32	216.54	$138.98	1.73	$5,514.57
Taylor Mill	104.53	$1,539.39	255.41	$155.78	1.25	$5,569.22
Turfway	97.99	$1,397.43	235.25	$161.73	1.53	$5,305.60
Walton	109.22	$1,546.14	214.08	$137.20	1.92	$5,866.45
Williamstown	109.79	$1,790.56	310.83	$190.58	1.97	$5,641.39
The Christ Hospital						
Compton	80.58	$1,215.55	235.57	$157.85	1.29	$5,257.32

Measurement Period	Inpatient Discharges (Per 1,000 member years)*	Inpatient Cost Per Member Per Year*	Emergency Department Visits (Per 1,000 member years)*	Emergency Department Cost Per Member Per Year*	HEDIS Plan All-Cause Readmission (Observed to Expected Ratio)*	Total Cost of Care Per Member Per Year*
	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2
Delamerced	123.16	$1,418.42	332.96	$173.78	1.66	$5,752.97
Delhi	86.52	$1,370.70	240.03	$156.14	1.00	$5,079.74
Forest Hills	96.02	$1,331.67	231.19	$157.75	0.98	$5,753.25
Hyde Park	63.64	$1,147.73	176.89	$123.33	0.92	$4,701.04
Hyde Park Internists	83.87	$1,280.40	214.77	$129.66	1.56	$5,382.28
MOB 334	77.32	$1,214.40	249.82	$153.29	1.10	$5,082.77
MOB 440	106.28	$1,549.13	277.02	$176.43	1.05	$6,095.27
Montgomery FM	83.99	$1,187.85	241.13	$139.92	1.70	$4,929.59
Montgomery IM	34.48	$850.61	179.69	$99.84	**	$4,113.11
Norwood Family Medicine	86.46	$1,149.92	283.98	$194.63	1.29	$5,026.93
Norwood Internal Medicine	90.29	$1,272.78	283.87	$182.68	1.63	$5,231.93
Red Bank IM	81.20	$1,117.21	239.60	$154.95	1.35	$5,271.52
Rookwood IM	70.51	$1,194.61	207.76	$126.53	0.80	$4,964.83
Walnut	71.64	$1,230.37	225.97	$125.52	0.96	$4,976.42
Westside IM	79.70	$1,131.20	230.28	$136.23	0.83	$5,656.93
TriHealth						
GH – Clifton	105.37	$1,556.59	286.03	$181.11	1.42	$5,485.33
GH – Finneytown	83.30	$1,301.61	216.25	$138.20	0.78	$5,435.54
GH – Kenwood	79.72	$1,194.43	248.29	$163.70	0.96	$5,410.60
GH - West Chester (Springdale)	80.50	$1,258.92	251.82	$175.26	0.82	$5,365.64
HFP – Loveland	90.07	$1,415.51	236.18	$141.33	1.36	$5,547.79
HFP – Mason	91.29	$1,205.05	267.18	$173.03	1.35	$5,841.83
Mariemont	70.41	$1,349.44	199.31	$130.39	1.09	$5,363.62
QCP - Hyde Park	73.03	$1,215.04	216.17	$130.35	1.20	$5,059.59
QCP – Madeira	75.32	$1,152.64	242.26	$149.38	1.24	$4,978.88

Measurement Period	Inpatient Discharges (Per 1,000 member years)*	Inpatient Cost Per Member Per Year*	Emergency Department Visits (Per 1,000 member years)*	Emergency Department Cost Per Member Per Year*	HEDIS Plan All-Cause Readmission (Observed to Expected Ratio)*	Total Cost of Care Per Member Per Year*
	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2	2015Q3 - 2016Q2
QCP - Western Hills Internal Medicine	99.97	$1,614.82	274.26	$178.07	1.12	$5,869.21
QCP - Western Ridge Internal Medicine	96.92	$1,439.24	274.75	$172.76	1.21	$5,568.69
TPP - Bethesda Group Practice	61.99	$928.41	250.83	$156.69	1.71	$4,819.92
TPP - Bethesda Group Practice, Arrow Springs	85.34	$1,257.28	291.54	$188.05	1.07	$5,711.42
TPP - Deerfield Family Practice	56.31	$615.57	309.31	$203.22	0.78	$4,600.62
TPP - Moreira & Robles Internal Medicine Associates	89.62	$1,113.21	217.58	$142.07	1.05	$5,046.56
TPP - Physician Associates of Good Samaritan Hospital	52.82	$792.84	204.31	$146.50	0.94	$4,611.63
TPP - West Chester Medical Group	74.34	$1,108.07	295.70	$170.14	0.89	$5,331.90
TPP - Western Family Physicians	78.68	$1,389.72	224.98	$143.80	1.43	$5,334.36
TPP - White Oak Family Practice	80.55	$1,200.05	249.95	$161.96	1.07	$5,079.29
Independent Practices						
Lawrence P Wang MD LLC	70.25	$951.81	184.26	$152.03	0.95	$4,630.22
Maineville Family Physicians	77.73	$1,253.11	274.43	$185.08	1.61	$5,129.27
*** Measure includes claims data from CMS Medicare in addition to all QE -participating (7) commercial plans & Ohio Medicaid.**						
**** Data not presented where practices have <30 eligible members.**						
***** Measure results under review.**						

Appendix I – THC QE Public Report Supporting Documentation

Data Source

THC Qualified Entity (THC QE) project's public reporting of primary care practices was developed with input and 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 July 2015 through June 2016 for all metrics.

Data within the public report's tabular interface is 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, all participating primary care practices in Dayton and Cincinnati regions are 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/or to practices is performed by each commercial payers, Medicare, and 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 CMS and maintained by The Health Collaborative.

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, substance abuse, mental health, and HIV records were excluded from

reporting. 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 From July 2015 through June 2016. As such, all measures impacted by the transition had been updated 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
Utilization	Inpatient Discharges	Age, Gender, Major Payer Type, Health Status
Utilization	Emergency Department Visits	Age, Gender, Major Payer Type, Health Status
Expenditure	Inpatient Cost	Age, Gender, Major Payer Type, Health Status
Expenditure	Emergency Department Cost	Age, Gender, Major Payer Type, Health Status
Expenditure	Total Cost of Care	Age, Gender, Major Payer Type, Health Status
Quality	HEDIS Plan All-Cause Readmission	NCQA HEDIS

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. 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 ratio is 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

Expenditure and 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 both expenditure and 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.

- **Expenditure (e.g., Total Cost of Care):** If the CPC-wide 99th percentile for the measure on total cost of care equals $125,000 for a particular reporting period and a patient has $750,000 in expenditures during that period, that patient's total expenditures are

capped at $125,000. That patient's results for the measure on total cost of care are accordingly flagged in the patient-detail data tab.

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
Utilization	Inpatient Discharges	Cap at the 99th Percentile
Utilization	Emergency Department Visits	Cap at the 99th Percentile
Expenditure	Inpatient Cost	Cap at the 99th Percentile
Expenditure	Emergency Department Cost	Cap at the 99th Percentile
Expenditure	Total Cost of Care	Cap at the 99th Percentile
Quality	HEDIS Plan All-Cause Readmission	Not Applicable

Expenditure Measures

Expenditure measures reported are risk adjusted and estimated "allowed amounts" based on the average difference between the health plan "paid amount" and the total allowed amount including patient "out-of-pocket" responsibilities as calculated by each individual payer. Variations on this estimated amount were necessarily present and more prominent in the commercial population. For this reason, expenditure measures in this report should not be interpreted as exact dollar amounts but rather as an indication of relative differences across practices and markets.

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
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.
Expenditure	Inpatient Cost	Actual costs associated with acute inpatient care, excluding mental health, chemical dependency, and maternity claims.	**How to read this measure**: The inpatient cost measure is given per member per year. **Example**: A result of $500 per member per year for inpatient cost measure indicates that on average, each member will cost $500 in inpatient cares over the course of a year.
Expenditure	Emergency Department Cost	Actual costs associated with emergency department (ED) visits, excluding mental health, chemical dependency, and maternity claims.	**How to read this measure**: The emergency department cost measure is given per member per year. **Example**: A result of $500 per member per year for emergency department cost measure indicates that on average, each member will cost $500 in emergency department cares over the course of a year.

Expenditure	Total Cost of Care	Actual costs associated with care for members attributed to a practice, including all covered professional, pharmacy, and hospital and ancillary care. The measure does not include costs associated with mental health, chemical dependency, maternity, acupuncture, vision services, or dental services. It is calculated as the sum of the reported paid amount + copay amount + coinsurance amount + deductible amount + fee for service (FFS) equivalent amount. The FFS equivalent amount is the amount that would have been paid by the healthcare claims processor for a specific service if the service had not been capitated or paid under a bundled or managed care withhold payment arrangement.	**How to read this measure**: The total cost of care measure is given per member per year. **Example**: A result of $5,000 per member per year for total cost of care measure indicates that on average, each member will cost $5,000 in all cares over the course of a year.
Quality	HEDIS Plan All-Cause Readmission	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 readmission rate to the expected readmission rate; in other words, it is the observed probability of readmissions divided by the expected probability of readmissions. **Example:** • An observed-to-expected ratio less than 1 indicates that a practice's members are re-admitted 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.


THE HEALTH
COLLABORATIVE
Technology Powered by HealthBridge