THE HEALTH COLLABORATIVE
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Qualified Entity Reporting

The Health Collaborative Qualified Entity Public Reporting

Measurement Period: July 2018 - June 2019

The Health Collaborative Qualified Entity Project

In August 2012, The Health Collaborative became a "qualified entity" in the Medicare Data Sharing for Performance Measure Program ("QE Program") for the Ohio region. The Greater Cincinnati region was 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 advantage of having the option to access Medicare FFS claims data across three states is a major foundation for our strategy to become an All Payer Claims Data (APCD) base to better serve our Data Aggregation customers. As a Qualified Entity, The Health Collaborative is required to integrate CMS data with other payor data to evaluate the performance of providers and suppliers and to generate public aggregated reports of performance. Over the past four years, as a QE, The Health Collaborative publicly reported six cost and utilization metrics on a per-member per-month (PMPM) basis using claims data from seven payers for 75 Comprehensive Primary Care (CPC) practices in Southwest Ohio. We commend the practices for their willingness to be transparent with their results. We will continue to engage them in future reports.

In 2019, The Health Collaborative found itself under a technical, organizational, and vendor re-structuring. The Health Collaborative therefore took a more simplistic approach this year, reporting only one measure (Emergency Department utilization) for three payers including CMS. The results are aggregated and reported by county for the seven counties in the Greater Cincinnati market.

In the next few years our restructuring will allow The Health Collaborative to make greater use of this capability and expand the uses of this data to better understand healthcare delivery while engaging physicians, health systems, health plans, and employers. We also anticipate working to obtain more CMS data to expand the territory over which we report.

We thank and acknowledge the physicians, health systems, and payers who enabled us by their participation in our past reports to arrive at this stage of our development. 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. A recent area of interest where we will be looking to incorporate additional refinement of the reports is the addition of Social Determinants of Health data and how it may influence the measures reported. It is important to recognize this effort as *a way* to provide preliminary data by which:

- **Physician practices can improve their performance,**
- **Payers can increase their understanding of provider performance,**
- **Communities can better assess where resources are needed, and**
- **Consumers can begin to learn how to best use this new information.**

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 on page 4 for additional detail about The Health Collaborative QE project's reporting methodology.

Emergency Department Visit Rate

The Health Collaborative has been collecting and publishing Emergency Department (ED) visit rates since 2015. In our experience with CPC, ED visit rates have been among the more difficult metrics to demonstrate improvement. Use rates of the emergency department are dependent on multiple factors and vary considerably among age groups and payor types. For example, the younger population is more motivated by convenience of access while the older population with a greater incidence of chronic disease appears to seek reassurance. Patient behavior around ED use is complex and seems to require a level of reassurance that is difficult to meet over the phone. For this reason, we anticipate that future reports will have more drill down capability to understand these variabilities in more depth.

Why it is important to measure

Emergency department utilization has been shown to directly correlate with hospital admission rates and higher cost of care. The increasing frequency of Emergency Department (ED) visits also directly burdens the ED availability. EDs are being asked to provide care for more patients resulting in overcrowding and longer wait times. Examining the uses of ED across different counties, some rural and some urban, provides a beginning point in the understanding of these dynamics. It is hoped that this data will be used to point to those regions that need to take a closer look at these patterns within their respective populations. ED utilization and associated wait times are two aspects of healthcare that directly affect patient satisfaction. As emergency departments struggle to meet the demand to treat patients in a timely manner it can lead to subpar quality of care and increase costs.

Table 1. *Emergency Department Visit Rate: Seven Ohio County Comparative Report (July 2018 – June 2019)*

	Butler County	Clark County	Greene County	Hamilton County	Miami County	Montgomery County	Warren County	Overall
ED Visit Rate (Per 1,000 Member Months)* *	43	43	41	39	48	47	38	42
**Measure calculated using claims data from CMS Medicare claims and other participating commercial and Medicaid Managed Care plans.*								
*** Measure results are adjusted using methodology described in Appendix I – THC QE Public Report Supporting Documentation*								

Appendix I – THC QE Public Report Supporting Documentation

Data Source

The Health Collaborative Qualified Entity (THC QE) public report combines eligibility and medical claims data contributed to THC CPC Plus data aggregation initiative by CMS, commercial plan(s) and Medicaid Managed Care plan(s).

This public comparative report includes claims data for incurred dates of service beginning July 1, 2018 through June 30, 2019.

Data presented in the public report is aggregated at county level. An average rate for all seven THC QE regions is calculated as benchmark.

Populations and Geographic Regions

THC QE public report includes data for about 41% of the 2.1 million Ohioans in the seven-county geographic region encompassing: Butler, Clark, Greene, Hamilton, Miami, Montgomery, and Warren counties.

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 Plus data aggregation initiative during the specific measurement period. All reporting is based on the primary payer denoted in the data submitted by each payer (secondary payers were not included).

Attribution of Members to Providers & to Practices

The measure results represent only adult members, ages 18 years and older, who were enrolled in one of the initiative's participating health plans and attributed to a primary care practice participating in The Health Collaborative's Comprehensive Primary Care Plus (CPC Plus) data aggregation initiative with at least six months of eligibility during the specified measurement year.

The attribution of members to providers and/or to practices is provided by participating data submitters.

Risk-Adjusted Rates & Confidence Intervals

The Emergency Room visit rate in the QE public report was adjusted using the Statistical Analysis System (SAS) software version 9.4. Adjusted rates for regions were produced by the 'STDRATE' procedure in SAS, a function specifically designed to calculate risk-adjusted rates.

Demographic, major payer type, and health status information serve as the primary inputs for the risk-adjustment method used in generating the THC QE project's public reporting. Utilized

components include a member's age groups (18-44, 45-64, and 65 and over), gender, and health status as measured by Johns Hopkins ACG™ System.

Additionally, adjustments are made for major payer type due to different benefit packages and coverages offered by different payer types.

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

- Commercial
- Medicare (CMS Medicare Fee-for-Service and Medicare Advantage)
- Medicaid Managed Care