Qualified Entity Reporting

HEALTHCARE UTILIZATION MEASURES

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 Database (APCD) to better serve our Data Aggregation customers. As a Qualified Entity, The Health Collaborative (THC) 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 several years, as a QE, The Health Collaborative publicly reported on 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 2020 and 2021, The Health Collaborative found itself under a technical, organizational, and vendor restructuring that was accompanied by a global pandemic affecting all THC workflows in some fashion. The Health Collaborative therefore took a simplistic approach and is reporting one measure, Primary Care Provider (PCP) Visits per thousand for ten payers including CMS. The results are aggregated and reported at the state level for Ohio. 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 thank and acknowledge the physicians, health systems, and payers who enabled us by their participation in our current and past reports to arrive at this stage of our development.

About the Qualified Entity (QE) Public Report

To advance its efforts in expanding transparency and accountability across the Greater Cincinnati region's participating public and private payers and primary care practices, the Ohio Qualified Entity (OH QE) project has developed a public report of healthcare measures. This report, which presents data on healthcare utilization metrics for all QE-participating payers located in Ohio, seeks to help inform potential downstream opportunities for care delivery.

Public Reporting – Ohio Statewide Results for Primary Care Practices

The following report presents data on healthcare utilization measures for all QE-participating primary care practices and payers located in Ohio.

Public Reporting for Ohio Qualified Entity (QE)

THE HEALTH COLLABORATIVE

The following report presents data on healthcare utilization metrics for all QE-participating payers and primary practices located in Ohio.

Table 1. Utilization Measure

Region: Ohio		
Measurement Year		2019
Measure		
Primary Care Provider Visits (PCP)	(per 1,000)	2019.4

* Data not presented where practices have <30 eligible members

** Measure includes claims data from CMS Medicare in addition to all QE-participating (10) comercial health plans.

The Health Collaborative Public Report Supporting Documentation

Measure Description

Primary Care Provider (PCP) Visits per 1000: This measure summarizes the utilization of outpatient primary care provider utilization where provider taxonomy indicates one of the following specialties: Family Practice, General Practice, Geriatric Medicine, Internal Medicine, Nurse Practitioner, Pediatric Medicine, or Physician Assistant. It is represented as an observed rate per 1000 identifiable patients, aged 18 years and older.

Reporting Style, Data Source, & Intended Audience

The Ohio Qualified Entity project's public reporting of utilization measures was developed through a collaborative process between the Health Collaborative and participating payers in Ohio. The reports use eligibility, 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 Plus (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 contributed data for this report.

This public comparative report includes claims data for incurred dates of service beginning January 2019 through December 2019, with paid-date runout through March 2020, for all metrics.

Data Modifications, Limitations, & HIPAA Requirements

The data used in this report come exclusively from the payers participating in the OH 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 Plus (CPC+) initiative during the 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, 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 can 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.

Risk-Adjusted Rates & Confidence Intervals

Demographic, major payer type, and health status information derived from the CPC Plus Data Aggregation claims data serve as the primary inputs for the risk-adjustment methods. Utilized components include a member's age, gender, and health status as measured by Johns Hopkins ACG®.

Table 1 provides an overview of the methods used for adjusting for risk by each measure.

Table 1:

Domain	Measure	Methods for Adjusting for Risk
Utilization	Primary Care Provider Visits	Age, Gender, Major Payer Type, Health Status

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.

Additionally, adjustments are made for major payer type due to different payer types may offer different benefit packages and cover different services.

Johns Hopkins ACG® Resource Utilization Bands (RUB) are applied to the claims data to determine each member's health status during the reporting period. RUBs are a product of the Johns Hopkins ACG® System and are widely used in the United States as a method of risk-adjusting populations. The grouper based on the premise that clustering of morbidity is a better predictor of health care services resource use than the presence of specific diseases or disease hierarchies, the ACG System provides a multi-morbidity framework that is clinically logical, informative of future health care resources, easy to use and applicable to both financial and clinical managers (The ACG System Advantage).

Johns Hopkins ACG® Resource Utilization Bands (RUB) are developed and provided by Johns Hopkins ACG® System. The purpose of RUB is to provide a measure of relative resource use across classes and categories of members.

To account for the differences in reimbursement rates and benefits and coverage offered by major payer types, all measures are calculated separately for each major payer type. A final weighted average is then calculated.

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
- CMS Medicare Fee-for-Service plans

Reference:

The ACG System Advantage. (n.d.). Retrieved from https://www.hopkinsacg.org/advantage/#features