HealthQualityCT

RESPONSE TO PUBLIC COMMENTS

Introduction

The Office of Health Strategy (OHS) received four public comments on the approach developed for the design, attribution, benchmarks, scoring and risk adjustment for HealthQualityCT, the public Scorecard currently being developed as part of the SIM initiative (hereafter "Scorecard"). The Scorecard will provide an annual performance assessment of Advanced Networks (ANs) and Federally Qualified Health Centers (FQHCs) in Connecticut using a set of measures identified by the SIM Quality Council. This information will be displayed on a web-based platform accessible to a broad set of stakeholders including patients, providers, and policymakers. The UConn Health SIM Evaluation Team is developing the scorecard methods and web platform in close communication with multiple partners, including the SIM Quality Council, the CT Office of Health Strategy, the Healthcare Innovation Steering Committee, Yale University, and other provider and consumer groups. The CT Scorecard supports the aim of Connecticut's State Innovation Model to increase transparency related to healthcare cost and quality by disseminating information through a public online healthcare quality scorecard.

The CT Scorecard process, as with all aspects of the SIM project, is built on substantial engagement with stakeholders representing providers, payers, consumers and government leaders. Given that organizational and provider participation is essential to the calculation of quality metrics that are accurate, timely, and relevant, we are grateful to the stakeholders that reviewed and commented on the documents describing the Scorecard methodology. In reviewing these comments, several consistent themes emerged. Providers identified the need to establish an attribution methodology that accurately and transparently connects patients receiving primary care services to their providers, and those service providers to the healthcare networks that employ them. Given the complexity of healthcare utilization, it is crucial that this attribution process achieve the highest level of reliability to accurately assess the quality of the primary care services provided by Connecticut's health care networks.

Further, providers raised questions related to patient risk assessment to balance the quality scores of organizations providing care to the lowest and highest risk patient populations within Connecticut. Others stressed the importance of transparent measure definitions and increasing organizational access to robust quality data over the course of the year, to facilitate improved healthcare quality over time. Finally, some commenters emphasized the importance of better integration of primary care with community supports to address social determinant risks, health equity, pediatric health, and behavioral health integration.

Some aspects of the Scorecard methodology have been modified in response to these comments. In all cases, and moving forward, the comments will inform the development of the Scorecard to be published in Fall 2018, and the evolution of the Scorecard in subsequent iterations.

Please note that all comments included herein are provided in full as submitted to OHS, except that formatting has not been preserved and citations have been removed. All of the public comments received can be accessed in their original form below.

The UConn Health evaluation team has prepared the following response to comments and questions on the behalf of the Quality Council, highlighting the prominent themes reflected in the written comments and in the conversations that the OHS has had with various stakeholders.

Yale New Haven Medical Group (a.k.a. Northeast Medical Group): I am writing to present feedback on the attribution model for the SIM project. My concern with the attribution method is on step 5 where it indicates that if there is no match for a PCP or OB/GYN (steps 1-4) in the last 12 months, the patient may be assigned based on a specialist visit within that 12-month period. In our experience, the pattern of behavior with the commercial population is different than Medicare and often these patients may not see their PCP for 12 months or longer. In some cases, guidelines do not support the need for a healthy individual to be seen within 12 months. This logic then increases the likelihood that a multispecialty practice may have patients attributed to them because the patient has been seen by one of the group's specialists, but they are really participating in another Medical Home for primary care. Recommendation: Change step 5 to look back another 12 months (totaling 24 month) before attributing to a specialist.

Response: Based on this comment, discussion with other ANs and with the Quality Council, and a review of the APCD data, we have altered our attribution strategy to eliminate attribution to specialists other than OB/GYNs. The data suggest that there may be considerable ambiguity regarding the affiliations between specialists and ANs that could make attribution to specialists problematic. We agree that a 24 month look back to establish patient attribution will capture those patient populations who do not see their PCPs on an annual schedule or who are being seen more often by specialty providers. Therefore, the attribution look-back has been revised to be a 24-month period prior to attribution to an OB/GYN, which is reflected in the revised attribution methodology, which can be found here.

Cornell Scott Hill Health Center:

Measures

1. For all measures that will be on the CT Scorecard, DSS should ensure that the rated organizations (PEs and ANs) have ongoing access to their monthly performance data throughout the year (e.g. through CareAnalyzer and other data sources) so that they can gauge their progress in meeting the measure.
2. For some measures to be included on the CT Scorecard as outlined in the Project Overview's Appendix B (e.g. all-cause readmission, follow-up care for children on ADHD medications, and others), no data is available to the rated organizations to gauge their progress. Rated organizations' must know the source(s) and the formula(s) that will be used to measure their progress.
3. For all measures that will be on the CT Scorecard, the Connecticut Office of Health Strategy (OHS) should ensure that PE and AN organizations have access to all measure definitions and formula(s) as appropriate. This is particularly true for proprietary measures such as Reporting Set Measure 2 which is defined by HEDIS 0443.
4. What is the difference in how "Core Measures" and "Reporting Measures" discussed in the Scorecard Project Overview proposal be presented and weighed for the CT Scorecard?
5. For some of the measures listed in the Scorecard Project Overview proposal on page 4 are inappropriate for measuring PE and AN organization service to patients. For example, Reporting Measure 2 (Plan all-cause readmission) assumes organizations are aware of all of a patient's primary care, *mental health, and substance use disorder* hospitalizations. In Connecticut, this data is not readily available to a provider who is not providing the mental health and/or substance use disorder care.

Rating

1. Per the Benchmark, Rating and Risk Adjustment proposal, PE and AN performance will be stratified by payer type. Will OHS be obtaining claims data from all commercial payers in the State?

2. We recommend that there be minimum volume thresholds for the reporting and rating of each measure.

Risk Adjustment

1. The OHS proposal entitled Benchmark, Rating and Risk Adjustment states on page 3 that “Analysis will follow the risk adjustment specifications of each measure. Most measures call for no risk adjustment, while two measures do call for risk adjustment.” The proposal further states on page 1 the intention of stratifying ratings by payer category. We consider this small degree of risk stratification to be woefully inadequate.
2. Publishing available quality scorecards with measures that are not risk-adjusted threatens to create a “death spiral” of patient selection to care sites. In other words, PE and AN organizations with lower risk and more health literate populations will have higher ratings. When patients with low health risk and high health literacy view the scorecard, they may further self-select to these highest-rated organizations, which will further artificially improve the ratings of those organizations and conversely worsen the ratings of organizations caring for the highest risk patients.
3. By not risk-adjusting quality measure performance on the proposed CT Scorecard, the ratings among organizations will lose much of their practical value. The real-life effect of publishing non-risk-adjusted ratings will be primarily to dishearten PE and AN organizations caring for the highest risk patients, which will often appear as under-performers on many measures.

Attribution

1. Per the Attribution Methodology proposal on page 2, OHS states that Advanced Practice Registered Nurses (APRN) and Physician Assistants (PA) in specific specialties will be considered Primary Care Providers. How will OHS determine the specialty of an APRN or a PA to determine whether they are a PCP? (Is this data that PEs and ANs will provide to the State?)
2. Will Certified Nurse Midwives (CNMs) be classified as Primary Care Providers? Will CNMs be attributed to the specialty Obstetrics/Gynecology?
3. How is a “Multispecialty clinic or group practice” defined? If a patient has no PCP or OB/GYN but has 5 visits with a Cardiologist in Practice A, 4 visits with a Psychiatrist in Practice B, and 2 visits with a Neurologist in Practice B, which physician would be responsible for this patient’s primary care?

Response: Currently, the Scorecard is published annually, and the results will remain publicly available throughout the year, but will not be updated in the interim. The Scorecard will include claims from all Connecticut’s commercial, Medicaid, and Medicare payers. The only claims that will not be included are those associated with self-funded plans, which are not submitted to the APCD. All data used to compile the Scorecard are available via the Connecticut All Payer Claims Database (APCD), and these data are available via an application process. We agree that access to hospital admissions data is an important metric for patients, hospitals, and the system at large, and we encourage networks to pursue opportunities to establish relationships with their collaborating hospitals and organizations across the state in order to gain access to these data. There are several performance improvement projects in development within the SIM initiative that are available to assist organizations in data monitoring and quality initiatives outside of the Scorecard.

The measures included in the Scorecard were determined by the Quality Council and other stakeholders. The Core Measures are those recommended for performance monitoring and inclusion in value-based payment, while the Reporting Measures are those recommended for performance monitoring, but not recommended for incentives or value-based payment. All measures included in the Scorecard follow HEDIS standards, the specifications of which are proprietary and available via purchase through NCQA. However, all measure definitions and methods will be made publicly available, and we encourage organizations to raise specific questions about the measures throughout the Scorecard development process.

We agree that it is crucial to have minimum volume thresholds for the measures included in the Scorecard. These thresholds have not yet be determined, but will be available via the HealthQualityCT website, and shared with the rated entities via webinar when they are available.

While we further agree that risk adjustment is an important consideration in quality measurement, the vast majority of the measures that have been selected for the Scorecard do not include risk adjustment in their calculation, as determined by the national guidelines and standards of the NCQA and NQF. As a result we are only providing risk adjustment for those measures that incorporate it in the measure specification, as written by the endorsing national organizations. We are continuing to examine the implications of risk adjustment for FQHCs, and will revisit this issue after the first of the year. Please note, however, that we are calculating and reporting measures separately for Medicaid, Medicare, and commercial populations, which provides an element of risk adjustment by comparing organizations within payer groups.

In terms of attributing patient claims to the appropriate medical provider, we will be including MD, PA, and APRN providers, which will be determined to be PCPs based on the services (determined via service codes) they provide. Midwives will not be classified as PCPs, and will not be attributed to OB/GYN provider practices. We are not defining multispecialty groups or clinics for the purposes of attribution, as they are not currently a target of ratings for the Scorecard.

Community Medical Group: Thank you for the opportunity to provide public comment on the SIM Quality Council's recent recommendations for the Public Scorecard. The important and high-quality work of the council members and the Office of Health Strategy is evident and plays an important role in moving forward Connecticut's effort at transforming care delivery.

First, I would express my strong support for the efforts to produce an open and transparent public scorecard. Access to accurate, reliable and timely data is critical for successful care transformation and quality improvement. The ability to provide this data across large and varied populations to patients, consumers and providers is an important step in engaging all stakeholders in this important work. After careful review of the council's recommendations I would respectfully make the following comments based upon our organization's six years of experiencing in managing multiple ACO and quality programs with direct relevance to the efforts under discussion.

<u>Attribution</u>

The proposed attribution model follows very closely with standard attribution models used in current value-based arrangement in the Connecticut market. The choice of a "PCP weighted" model is correct and will be most effective at yielding appropriate attribution to clinicians responsible for the selected quality measures. Inclusion of Obstetrics/Gynecology clinicians in the PCP track is appropriate and acknowledges the role they play as PCP's for many patients.

Attributing patients to other specialist may be problematic as it attributes patients to providers and groups that may not be managing the measures being utilized. It may also have the effect of attributing patients to multispecialty Advanced Networks due to the patients use of specialist clinicians within that group, while their PCP resides in another Advanced Network. Although we encourage each clinician to take an active role in comprehensive care of their patients, the reality is that many of these measures touch upon areas that are out of the scope of practice of many specialist and are better addressed by PCP's.

For initial development of this program I would recommend attributing patients to Advanced Networks using only PCP categories. Further iterations of these efforts can explore the appropriate way to begin to utilize specialist attribution, but I am concerned it will add unnecessary complications at this stage. I would also suggest consideration of extending the look-back window for pediatricians, internists and family practitioners to 24 months before attributing to other providers to better align patients with these categories.

Benchmarking

The choice of a benchmark for the scorecard is important to provide guidance to advanced network performance in the various quality measures. Various benchmarks are discussed in the proposal and are often used in provider performance analysis. However, each benchmark has its own method of data acquisition and analysis. Some of the proposed benchmarks utilize claims data *and* clinical chart review. They also may use representative samples of populations and may not be inherently designed to measure provider performance but rather other entities such as insurers. Also, if a benchmark is to be used the data and methodology must be publicly available for review.

The proposed scorecard will use population wide claims-based data for analysis without other supplemental data. Therefore, benchmarks should be applied that use the same methodologies. Unfortunately, there may be limited access to such benchmarks for segments of the population and some of the measures we are including.

Utilizing a benchmark derived from a state-wide analysis of our data set would insure that the benchmarks are derived from consistent data sets and analytic techniques.

Risk Adjustment

Risk adjustment is an important component of scorecard development. It will be important to utilize a well-established risk adjustment methodology that can accurately reflect the complexity of the populations under management across a host of factors, including social determinants.

Performing separate analysis and benchmarking for Medicare, Medicaid, and commercial populations will be helpful to clarify performance in these different populations. The report acknowledges two measures, CAHPS and All-Cause Readmission, which will be calculated using risk adjustment. I would propose that there may be value in considering how the risk score of the population affects the other measures being analyzed, and that performance in these measures may be appropriately affected by risk-score.

Response: As noted above, the attribution look-back period has been extended to 24 months based on this feedback. Additionally, we have removed specialists from our attribution model, with the exception of OB/GYNs. Attribution to an OB/GYN is possible if there are no PCP visits in the 24 month look-back period.

In terms of the benchmark, the state average for each measure is used as the primary visual reference and in scoring performance. This average will be will be calculated using the same methods and data as is used to calculate healthcare organization performance. National benchmarks will be offered in advanced views as an additional informational reference only. All benchmark methodologies will be made publicly available as they are determined.

As noted above, we agree that risk adjustment is an important consideration, particularly for CTs diverse populations. We will be reporting upon healthcare organizations separately for Medicaid, Medicare and commercial patients so that organizations can be compared on similar populations. However, we are following endorsed measure specifications that, with the exception of the CAHPS and All-Cause Readmission measures, do not call for risk adjustment.

Connecticut Voices for Children: Thank you for this opportunity to share our input on the Connecticut Public Scorecard. Connecticut Voices for Children has long advocated for quality health care for children and families including through evaluation of publicly available data. We appreciate the Connecticut State Innovation Model's efforts to evaluate the costs and quality of the state's health systems across payers in a publicly available format. This is an admirable goal and we urge the project to consider adjustments to the final product that may improve the ability of the CT Scorecard to inform policy changes. First, while health equity is a stated aim of the State Innovation Model projects, the proposed scorecard measures do not evaluate racial disparities in health. Such evaluation is crucial in order to adjust and improve our health systems. The Project Overview notes unspecified additional filters, which we suggest should include race/ethnicity wherever possible.

Further, State Innovation Model projects emphasize the importance of integrating traditional health services with community-based supports, but the proposed scorecard measures do not assess this integration. Progress towards health equity necessitates connecting families with the housing, environmental, nutritional, and community-based supports that affect health. National projects1 have developed specific outcomes and process indicators; these projects can guide the inclusion of quality measures that are feasible and reliable. Information on costs also is absent from the list of measures in the Project Overview Appendix B.

Finally, while the scorecard does include measures of child wellbeing, strengthening these indicators would provide a more actionable set of metrics for future policy changes. For example, tracking treatment for preventable illness and follow-up after positive screenings would provide a more robust picture of the gaps in our state's health systems for children. We recognize the complexity of developing a scorecard that is achievable and addresses the aims of the SIM projects. Consequently, we appreciate the Office of Health Strategy's efforts to create a CT Scorecard that will provide a robust evaluation of the state's progress toward a health system that promotes the wellbeing of all of the state's children and families.

<u>Response</u>: The intent of the SIM initiative is to develop a model that would substantially increase the investment in primary care, including pediatric primary care, as well as reducing costs and health disparities. The Quality Council engaged in a lengthy process to choose quality measures that reflected the goals of the SIM project at large, would provide useful information for various stakeholders, and were feasible given data availability. While reduction of costs is an important aim of the SIM project, cost measures were not chosen for inclusion in the current measure set given the focus on quality. In addition, the CT APCD is taking the leading role in the state calculating and publishing cost measures.

We enthusiastically agree with the recommendation that the Scorecard should ideally include measures of health equity, as the CT SIM is the only SIM initiative with reduction of disparities as a primary driver. However, race/ethnicity data are not currently available via the APCD, and so cannot currently be included in the Scorecard. We are working on methods to include this information in future iterations of the Scorecard. Particularly, we are currently working on a strategy to add race and ethnicity data to the APCD, which is the main data source for the Scorecard.

In terms of the inclusion of measures of child well-being, some additional measures are found in the universe of endorsed quality measures, but we are unable to include them in the Scorecard given the availability of data. Those measures could become feasible for inclusion in the future if electronic health record data are made available through the State HIT initiative and/or if the APCD is able to release additional data fields.

While we agree that "community integration" in an important component in a person-centered healthcare service delivery system, assessing that metric is beyond the scope of the current Scorecard.