CONNECTICUT HEALTHCARE QUALITY SCORECARD

Attribution Methodology

In 2014, the Center for Medicare & Medicaid Innovation awarded Connecticut a four-year, $45 million State Innovation Model (SIM) Test Grant. Connecticut's SIM is working to improve Connecticut's healthcare system for the majority of residents by establishing a whole-person-centered healthcare system that improves community health and eliminates health inequities; ensures superior access, quality and care experiences; empowers individuals to actively participate in their health and healthcare; and improves affordability by reducing healthcare costs.

One aim of Connecticut's SIM is to increase transparency related to healthcare cost and quality and improve access to information about provider performance in these areas by disseminating information through a public healthcare quality scorecard (hereafter "CT Scorecard").

The CT Scorecard will assess the performance of Advanced Networks (ANs) and Federally Qualified Health Centers (FQHCs) in Connecticut on a set of measures utilizing two data sources: health insurance claims reported to the All Payer Claims Database (APCD) and administered by the Office of Health Strategy and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys administered by contractors for Yale University (commercial beneficiaries) and the CT Department of Social Services (Medicaid beneficiaries). The CT Scorecard measures were recommended by the SIM Quality Council and encompass a wide range of health care quality domains such as prevention, chronic disease management and behavioral health management.

The CT Scorecard will be housed on a web-based platform accessible to a broad set of stakeholders including patients, providers, and policymakers. The CT Scorecard will present scores for Connecticut's ANs and FQHCs via interactive tables and graphs. Users will be able to search, sort and filter by entity, measure, demographic characteristics and fiscal year. The data will be updated annually with changes in scores presented in subsequent years.

To facilitate user understanding of the results and ratings presented on the scorecard, supplemental text, notes, and links to external content will be provided. Text will be brief and written at a 5th grade level when possible and provided in both English and Spanish. Supporting text will provide instructions on how to use the site and present a detailed discussion of methodology, including an overview of data sources, measure and score definitions, attribution methods, risk adjustment and scoring methods.

Attribution

Attribution is the assignment of a patient to a provider who is accountable for the patient's quality and cost of care[1]. The UConn Health Evaluation Team has reviewed existing attribution models (see appendix A) and is recommending a strategy based on the TREO/3M attribution model. The TREO/3M attribution model is widely used in the healthcare industry, employing a straightforward approach that is based on the preponderance of evaluation and management (E&M) services (99201-99499) a patient receives from primary care physicians. TREO also allows for some customization in providers to whom patients can be attributed and in the time period used to determine attribution.

Proposed Attribution Method and Decision Points

The proposed CT Scorecard attribution model utilizes the available data in the CT APCD to rate the performance of ANs and FQHCs to whom patients are attributed. The proposed CT Scorecard attribution model has been developed in collaboration with the SIM Quality Council and has been discussed with the CT Office of Health Strategy which is developing CT's Core Data Analytics Solution (CDAS). Although the data available and the goals of CDAS differ from those of the CT Scorecard, all parties agree that the two groups can work collaboratively to achieve consistency in the attribution methods used for the CT Scorecard and CDAS. The proposed attribution model meets this criterion.

The method proposed for the CT Scorecard and key decision points are as follows:

1. *Define which provider types are considered PCPs and thus eligible for patient attribution.* The UConn Health Evaluation Team's proposed model attributes a patient to a PCP based on the most E&M visits in the given time period. A PCP is defined as Family Medicine, Internal Medicine, Pediatrics, or General Practice.

- **Decision Point 1:** Should OB/GYNs, Geriatric Medicine, Nurse Practitioners and/or Physician Assistants be included as a PCP?

2. *Can specialists have attributed patients?* If no E&M services are found with a PCP during the given time period, the UConn Health Evaluation Team recommends the patient be attributed to a defined set of specialists.
   - **Decision Point 2:** If no E&M services are found with a PCP in the given time period, should attribution be made to a specialist? If so, which specialties are eligible? Under Medicare SSP rules[3] the following specialties are considered eligible for the attribution of patients:
     a. Cardiology
     b. Osteopathic manipulative medicine
     c. Neurology
     d. Sports Medicine
     e. Physician medicine and rehabilitation
     f. Psychiatry
     g. Geriatric psychiatry
     h. Pulmonary disease
     i. Nephrology
     j. Endocrinology
     k. Multispecialty clinic or group practice
     l. Addiction medicine
     m. Hematology
     n. Hematology/oncology
     o. Preventative medicine
     p. Neuropsychiatry
     q. Medical oncology
     r. Gynecology/oncology

3. *Define the time period for eligible services.* The UConn Health Evaluation Team proposes the time period for attribution be the previous 12 months. If a patient has any E&M visits with a PCP in the previous 12 months then the patient is attributed to a PCP based on a preponderance of visits. If a patient has no E&M services with a PCP during the 12-month period then there are two options:

   - **Decision Point 3:**
     a. The patient is attributed to an eligible specialist if they had at least one E&M visit during the 12-month time period. If the patient has not seen a PCP or eligible specialist for E&M services during the previous 12 months, then the patient is attributed to a PCP seen for an E&M visit during the previous 13 to 24 months.
     b. The patient is attributed to a PCP for any E&M visit in the previous 24-month time period. Only in a situation where a patient has no E&M visits with a PCP in the past 24-month period would they be attributed to a specialist.

4. *Attribute each patient to a physician.* The patient is attributed to the physician determined above. If a tie-breaker is required, the provider with the most non-E&M services is selected followed by the provider with the most dates of service and then the most recent date of service.

5. *Attribute to an AN or FQHC.* Attribution is rolled up into ANs and FQHCs using billing NPI or site of care.

6. *Unattributed.* Any patient without an E&M visit in the past 24 months will remain unattributed.

---

[1] Pantely SE. Whose patient is it? Patient attribution in ACOs. Milliman Healthcare Reform Briefing Paper. 2011 Jan

[2] What can go wrong with PCP attribution and how it can be prevented downloaded from https://www.3mhisinsideangle.com/blog-post/what-can-go-wrong-with-pcp-attribution-and-how-it-can-be-prevented/ Downloaded 12/10/2017.

[3] 42 C.F.R. §425.402

APPENDIX A. Attribution Methods Used by Other Entities

Entity	Attribution Method	Comments
Other scorecards	• Submitting organization attributes patients (CA, WA, Medicaid)	• Not feasible for commercial or Medicare claims
	• Patient attributed to provider if ≥ 2 associated claims within previous 2 years and at least 1 claim within previous year (WI)	• Patients can be attributed to more than one provider
	• Patients attributed to provider with most claims (MN, WA)	• Can result in misattribution to non-PCP providers (e.g. radiologists)
CMS Medicare SSP	• Patients attributed to PCP provider(s) within entity (ACO) that charged the most for primary care services • Uses prospective attribution with retrospective reconciliation.	• Driven by cost of services rather than frequency • Prospective attribution not feasible for Scorecard • Complex
Treo Solutions/3M approach	• Define PCPs/identify physician groups • Patients attributed to the group with most E&M services • Fine-tuned two-step tie-breaking process	• Needs to be adapted for CT scorecard since scorecard is rating ANs/FQHCs, not providers

CONNECTICUT HEALTHCARE QUALITY SCORECARD

Attribution Methodology