Quality Health First®
Program

Public Reporting Methodology

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Content

The quality measure reports published here provide information on the quarterly performance of practices/doctor's offices/clinics which are affiliated with the Quality Health First® Program (QHF®) of the Indiana Health Information Exchange (IHIE) in the state of Indiana on the selected HEDIS® measures and other nationally recognized organizations.

To be included in the IHIE public reports, medical practices must have a minimum of 30 patients in any measure. Medical Practices may be composed of several physicians, including internists, family practitioners, and pediatricians, as well as nurse practitioners, and physician assistants.

The clinical quality information on doctors/providers who are not associated with any publicly reported practice is only included in the overall QHF® average measure scores.

Attribution of Patients to Providers

There are many perspectives to the question, "Who is your doctor?" While a patient may know who their selected provider is, it is not generally recorded anywhere. A provider may have a record of a patient's previous visit, but it may not be current. The patient's insurance carrier may have a provider assigned to the patient (in the case of a Managed Care Organization), may have a provider identified by the patient, or have no record whatsoever.

Patients change providers often and linking patients to a particular provider is a complex process. This process becomes even more difficult as new providers are added to the QHF® program. On an average 1900 patients are attributed to a QHF® provider. Through reconciliation processes, providers can identify individual patients each quarter as "Not my patient" or "Never my patient".

QHF® currently creates reports only for Primary Care Providers (PCP). This broad grouping of providers includes (but is not limited to) family medicine, internal medicine, pediatrics, obstetrics and gynecology, among others. A patient is attributed to a single PCP.

After the attribution process has identified all of the patient records that belong to each provider, patient activity is summarized by provider for all patients who are alive at the end of the reporting period, using all clinical and claims data available that identify both the patient and servicing provider.

A two-pass attribution is performed. The first is completed by looking at the most recent patient activity within the previous 2½ years. A patient is attributed to the provider that had encounters with the patient on the most number of distinct dates within that timeframe. If that results in an equal attribution across multiple providers, then the patient is attributed to the provider that had encounters with the patient most recently. If that similarly results in an equal attribution across multiple providers, then the patient is attributed to the provider that had encounters with the patient for the longest period

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of time. If that also results in an equal attribution across multiple providers, then the provider who had the largest number of encounters with the patient is attributed.

If the preceding logic does not result in an attribution, then activity over the previous five years is examined utilizing the same process to determine patient/provider attribution. If an attribution is still unattained, the patient is considered unattributed to any provider.

Payer Mix Adjusted Rates

The QHF® measure scores that are being publicly reported have been adjusted based upon the average statewide payer mix for each measure. The three payer categories include Medicare, Commercial, and Indiana Medicaid health care programs. The adjusted rates account for differences in the provider site's patient population beyond the provider's control. The hypothesis is that this type of adjustment provides a more accurate reflection of performance by removing the anomalies introduced by the varying payer mix across practices.

The basic adjustment for payer mix is calculated by multiplying each site's score for each payer category by the statewide average distribution of patients by payer by measure.

An additional adjustment is applied to practice sites that have less than ten patients in a payer category for a measure. The statewide rate is integrated into the payer category rate in proportion to the number of patients under 10 in that payer category. For example, if a site has a population of 6, there would be a 60% site / 40% statewide proportion applied and then an adjustment by the payer mix rate. Likewise, if a site has a population of 3, there would be a 30% site / 70% statewide proportion applied and then an adjustment by the payer mix rate.

The following tables present an example of the payer mix adjustment methodology.

Example 1: Site A and Site B each have the same unadjusted performance scores for their patients who are insured by different payers: for a given measure each achieves 70% for commercial, 30% for Medicare and 50% for state public programs. However, because Site A and Site B serve different proportions of patients from each of these payers, their overall quality scores differ without the adjustment for payer mix: Site A's unadjusted score is 68%, and Site B's score is 50%, despite the fact that the two clinics are achieving similar outcomes for similar patient populations.

To apply the payer mix adjustment each site's commercial score is multiplied by 75%, the percentage of patients statewide with commercial insurance, the Medicare score is multiplied by 10%, the percentage of patients statewide with Medicare coverage, and the state public programs score is multiplied by 15%, the percentage of patients statewide with Medicaid insurance. After this adjustment is made, Site A and Site B achieve the same overall quality score (63%), which more accurately reflects the fact that they achieve the same results with similar populations.

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Example 1	Commercial	Medicare	Medicaid	Overall
Statewide				
Payer mix percentage	75.00%	10.00%	15.00%	100.00%
Unadjusted measure score	56.60%	63.20%	48.30%	55.80%
Site A				
Population	250	100	100	450
Unadjusted measure score	70.00%	30.00%	50.00%	68.00%
Measure score adjusted for payer mix	52.50%	3.00%	7.50%	63.00%
Site B				
Population	150	150	150	450
Unadjusted measure score	70.00%	30.00%	50.00%	50.00%
Measure score adjusted for payer mix	52.50%	3.00%	7.50%	63.00%

Example 2: Site D achieves higher unadjusted scores in each payer category compared to Site C, but the overall unadjusted scores are equal at 60%.

Applying the same payer mix adjustment as detailed in Example 1 a more accurate representation of the overall score is presented where Site D is actually about 8% higher than Site C.

Example 2	Commercial	Medicare	Medicaid	Overall
Statewide				
Payer mix percentage	75.00%	10.00%	15.00%	100.00%
Unadjusted measure score	56.60%	63.20%	48.30%	55.80%
Site C				
Population	250	100	100	450
Unadjusted measure score	60.00%	20.00%	68.00%	60.00%
Measure score adjusted for payer mix	45.00%	2.00%	10.20%	57.20%
Site D				
Population	150	150	150	450
Unadjusted measure score	65.00%	50.00%	75.00%	60.00%
Measure score adjusted for payer mix	48.75%	5.00%	11.25%	65.00%

Example 3: Site E has a Medicaid population of less than 10.

Again, the same payer mix adjustment as detailed in Example 1 is applied, however the state public program score is first modified by integrating the statewide measure score into the site measure score based upon the proportion of the number of patients under 10. In this example 70% (7 out of 10 patients) of the site unadjusted measure score is added to 30% (3 out of 10 patients) of the statewide unadjusted measure score, and that is multiplied by 25%, the percentage of patients statewide with Medicaid insurance.

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Example 3	Commercial	Medicare	Medicaid	Overall
Statewide				
Payer mix percentage	65.00%	10.00%	25.00%	100.00%
Unadjusted measure score	56.60%	63.20%	48.30%	55.80%
Site E				
Population	90	45	7	142
Unadjusted measure score	52.50%	30.00%	43.00%	45.00%
Measure score adjusted for payer mix	34.13%	3.00%	11.15%	48.27%

Payer Mix Adjustment Limitation: Payer mix adjustment may not significantly adjust reported results for most clinics. However, these adjustments will shift scores significantly from the unadjusted scores for clinics with unusually high or low percentages of commercial, Medicare or Medicaid patient populations or for sites whose performance with a particular population is mostly high or low.

Overall QHF® and Regional Average Calculation

Average state scores are the overall QHF® Program clinical quality scores calculated using IHIE's standard algorithm for each measure. Regional averages are calculated by averaging the adjusted clinical quality scores for all the sites in that region for each measure. Each average score includes all practice sites in the Quality Health First® program irrespective of number of patients, but only scores for opted in practice sites with a minimum of 30 patients in each measure are reported.

Disclaimer

Performance results reported by IHIE represent a select few aspects of care given by providers in relation to evidence based standards. They are not clinical guidelines and by no means establish overall standard of care.

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