

## BENCHMARK, RATING AND RISK ADJUSTMENT

### PROJECT OVERVIEW

In 2014, the Center for Medicare and 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 by disseminating information through a public online healthcare quality scorecard (hereafter "CT Scorecard"). The CT Scorecard will:

- Allow healthcare organizations access to information on their performance relative to peers to drive quality improvement through transparency
- Provide CT policy makers, payers, and employers with information to assess CT healthcare performance
- Provide consumers access to healthcare quality information

The CT Scorecard will provide an annual performance assessment of CT health care organizations with at least one contract for value based payment 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.

### Benchmarks

The Scorecard will use comparative performance level benchmarks to assess healthcare organizations. A comparative benchmark is a way to measure performance of an entity against the performance of a larger group. This type of benchmark is the most common among other state scorecards. Benchmarks will be calculated annually.

#### Comparison Levels:

The scorecard will use multiple comparative levels to assess the performance of healthcare organizations:

- National Level. Two potential sources for national benchmarks, National Committee for Quality Assurance and the Medicaid Core set have been identified. These sources provide separate benchmarks for Medicare PPO, Medicare HMO, Medicaid HMO, commercial PPO and commercial HMO. The scorecard will assess healthcare organizations within payer type, but does not make a distinction between PPO and HMO plans.

Because many other states use national benchmarks, particularly the NCQA data, choosing a national benchmark will facilitate comparisons of CT rated healthcare

organizations to rated organizations in other states. However, neither source (nor both combined) provides a national benchmark for all of the Connecticut SIM measures. Nevertheless, national benchmarks provide a useful comparison for CT healthcare organizations.

- **State Level.** State level benchmarks involve calculating averages using all data in the All-Payer Claims Database (APCD) collectively for the state as a whole including nonrated healthcare organizations. This approach allows for more control over calculating benchmarks and the ability to calculate separate benchmarks for insurance type. This approach also allows for assessing the impact that year-to-year variations in providers who contribute data might have on state averages.
- **Rated Healthcare Organization Level.** A rated healthcare organization level benchmark involves calculating averages using only data from the healthcare organizations that are rated for the scorecard. This type of benchmark has similar benefits as the state level benchmarks. However, because there are relatively few rated entities results may be more sensitive to high and low performers. In addition, only using the performance of the rated organizations increases the probability that some organizations will be rated as below (or above) average regardless of their performance relative to the state and national benchmarks.

State level benchmarks will be displayed on the website as the default comparison for healthcare organization performance and will be used as the benchmark for rating. However, advanced views that provide additional options to display both national and rated healthcare organization benchmarks for comparison.

## Rating

Performance of healthcare organizations will be scored against the state average at the measure level. Performance will be stratified by payer type (commercial, Medicare and Medicaid.) For each measure the scorecard will display the organization performance (measure result) and a rating. Based on statistical analysis, measure results for each organization will be placed into one of three scoring categories: below average, average and above average. A summary page for each healthcare organization will display the number of measures for which the organization achieved ratings of below average, average, and above average as well as the number of measures for which ratings were unavailable.

## Risk Adjustment

Rated healthcare organizations are expected to have different patient profiles (demographics, health status, etc.) that may affect their performance relative to the state benchmark. In order to accurately score the performance of healthcare organizations risk adjustment takes the impact of these differing patient profiles into account. Two approaches to risk adjustment are available: adjustment for patient demographics and patient health status.



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:

- CAHPS (NQF 0005): adjust for age, education, and health status
- Plan All-Cause Readmissions (NQF 1768): adjust for age, surgery, comorbid conditions

However, scorecard ratings will be calculated separately by payer type (commercial, Medicaid, and Medicare) allowing for greater similarity among patient populations.

