Frequently asked Questions about the Providers of Distinction Program

Is the Provider of Distinction designation different this year?
Yes. As of January 1, 2024, the State of CT Providers of Distinction is now an individual provider program. Members of the State of CT plan will be given incentives to use these providers.

What do I need to do to be included?
You do not need to apply to be in this program. The State of CT's partner, Embold, has purchased claims on 160 million lives from various payers and creates statistically modeled scores for State of CT network providers.

How do I find out if I am on the list?
To view a list of included providers, go to https://carecompass.ct.gov/providers-pod/

When is the next list being published?

In the future, the provider review period runs from January 1- March 30 each year. Providers selected during this period will become Providers of Distinction, effective July 1. Provider data will be reviewed annually, and selections will be posted on this page before the end of the fiscal year.

How will the Provider of Distinction program be promoted?

The State will promote the Provider of Distinction program to its plan members through various marketing campaigns, including this member-facing URL https://carecompass.ct.gov/providersofdistinction/.

Also, a new “Find Provider” tool will launch soon for all State of Connecticut plan subscribers, helping them find providers as needed. This tool will display providers with a recognition if they are on the Provider of Distinction list. This is the message that will display:

Top-performing providers in Gastroenterology, Obstetrics, Orthopedics, and Spine Pain Management. By completing your care with a Provider of Distinction, for certain select services, you will be eligible for a cash incentive which is mailed to you after your service is complete. ***LEARN MORE HERE***

Who is Embold?
Embold Health was founded by a physician to measure provider performance around what really matters--those practice patterns shown to produce better care time and again. With the input of physicians and data scientists from leading academic institutions, we identify the quality measures that have the highest clinical impact and apply them across one of the largest and most diverse datasets in the country—providing unparalleled insight into what’s working with health care. And when existing measures fail to capture the most important elements of quality, we build new measures to measure what matters – including appropriateness of care.

Our methodology was peer-reviewed and results were discussed in the JAMA Network article: Physician Pattern Variations in Common Clinical Scenarios Within 5 US Metropolitan Areas.

Quick Start Guide to Embold data and scoring methodology used for the State of CT evaluation:

- The data period is four years, ending 9/30/2022.
- The source is “claims” and represents a sample of Commercial, Medicare Advantage, Medicaid Managed Care populations.
- Scores are relative compared to other specialists in the state.
- Scores are adjusted for risk, complicated conditions, and socioeconomic factors.
- Embold employs Bayesian statistics to provide the best indication of practice
- These are not all-or-nothing scores of the adjusted rate; they report only how much one does a practice compared to others in the cohort, the state.

Tell me more about the data source.

- Embold uses a data vendor, HealthVerity. They have the largest healthcare data ecosystem in the US, combining and standardizing traditionally disparate datasets. Compared to the Census Population, the set is nationally representative based on geography, age, and gender. This set includes various payers representing Commercial, Medicaid, and Medicare Advantage data; across four years of data, over 160 million individuals with Medical Coverage and over 119 million lives per year with Pharmacy coverage.
- Contracting for claims is done state-to-state, so we may not have all claims for all payers. We have a sample of all payors, which differs by state.
- We only use closed, final, post-adjudicated claims with an industry-standard three-month runout.

How do you know by claims when, clinically, someone really needed the test or procedure?

- It is important to note that Embold Health does not measure case-level appropriateness, as individual medical necessity can only be assessed through an evaluation of a particular patient’s history, symptoms, and diagnoses. Embold uses a relative scoring methodology based on how the provider performs compared to peers. Using relative scoring can reduce the impact of some conditions because that condition is seen across the cohort uniformly, such as the flu season and patient refusal of testing.

If the data period is 4 years are the measures or years weighted?

- Performance is not a measure of how you performed during a period but how likely you are to continue that trend based on past performance. Bayesian statistical modeling is used throughout the process and is a measure of confidence that the practice will continue. Recent data impacts that probability more.

Is this data risk-adjusted?

> Adjustments are made for risk, socioeconomic status, specific conditions that indicate a more complicated case, and temporary COVID. Embold uses the DXCG risk model and AHRQ model for socioeconomic status (SES) using zip code-level social determinants of health. Condition-specific adjustments and control-related variables, such as radiculopathy in spinal measures, are controlled through statistical adjustment.

If you want to see your scores on the specific measures, go to For Physicians » Solutions » Embold Health.

Measures used in each Provider of Distinction Evaluation:

Colonoscopy and Upper Endoscopy

- ED visit within 7 days after colonoscopy
- Adenoma detection rate in screening colonoscopy
- ED visit within 7 days after upper endoscopy
- Admission within 7 days after upper endoscopy
- Repeat screening colonoscopy within 1 year.
- Upper and lower endoscopy on separate days
- Upper endoscopy overuse in GERD patients without alarm symptoms
- Upper endoscopy use in GERD patients with alarm symptoms

Maternity Care

- Cesarean delivery rate in low-risk delivery
- Percent of stays of 3 days or less
- Transfusion after delivery in low-risk pregnancy
- ICU admission within 30 days after delivery in low-risk pregnancy
- Infection after delivery in low-risk pregnancy
- ED visit or readmission within 30 days after delivery in low-risk pregnancy
- Overly frequent use of ultrasounds in low-risk pregnancy
- Receipt of appropriate prenatal testing
- Overly frequent use of forceps or vacuum in low-risk pregnancy.
- Overly frequent use of episiotomy in low-risk pregnancy
- Follow-up for behavioral health diagnosis

Hip Care and Hip Replacement

- PT within 4 months prior to hip or knee replacement
- Overly frequent use of preoperative stress testing
- MRI within 4 months prior to hip or knee replacement
- OT within 4 months prior to elective hip or knee arthroscopy
- SNF admission after hip or knee replacement
- Surgical revision after hip or knee replacement
- Hip or knee replacement within 1 year of new osteoarthritis diagnosis.
- MRI in the first year after diagnosis of hip or knee pain
- PT in the first 4 months of new hip or knee pain
- Opioid prescribing within 28 days in patients with new joint pain
- Complication rate after hip or knee replacement

Knee Care and Knee Replacement

- PT within 4 months prior to hip or knee replacement
- Overly frequent use of preoperative stress testing
- MRI within 4 months prior to hip or knee replacement
- PT within 4 months prior to elective hip or knee arthroscopy
- SNF admission after hip or knee replacement
- Surgical revision after hip or knee replacement
- Arthroscopy overuse in patients with new osteoarthritis

- Hip or knee replacement within 1 year of new osteoarthritis diagnosis.
- MRI in the first year after diagnosis of hip or knee pain
- PT in the first 4 months of new hip or knee pain
- Opioid prescribing within 28 days in patients with new joint pain
- Complication rate after hip or knee replacement

Spine Pain Management

- PT within 4 months prior to cervical spine surgery
- PT within 4 months prior to lumbar spine surgery
- Surgery within 1 year for new lumbar degenerative disc disease
- Surgery within 1 year for new cervical degenerative disc disease
- Surgery within 1 year for new lumbar pain
- Surgery within 1 year for new cervical pain
- PT in the first 4 months of new lumbar spine pain
- PT in the first 4 months of new cervical spine pain
- Opioid prescribing in patients with new lumbar spine pain
- Opioid prescribing in patients with new cervical spine pain.

Lumbar Spine Surgery

- PT within 4 months prior to lumbar spine surgery
- Skilled nursing facility admission after lumbar spine surgery
- Complication rate after lumbar spinal surgery
- Hardware removal after lumbar spine surgery
- Surgery within 1 year for spondylolisthesis
- Surgery within 1 year for new lumbar degenerative disc disease
- Surgery within 1 year for new lumbar pain
- PT in the first 4 months of new lumbar spine pain
- Opioid prescribing in patients with new lumbar spine pain

Details of each measure are available here.