OREGON HEALTH CARE QUALITY CORPORATION

Supporting Documentation

Technical Appendix: Q Corp Reporting Portal

This document was prepared by
August 2017

ONPOINT Health Data

The Oregon Health Care Quality Corporation

The Oregon Health Care Quality Corporation (Q Corp) is an independent, nonprofit organization dedicated to improving the quality and affordability of health care in Oregon by leading community collaborations and producing unbiased information. Q Corp works with members of its community – including consumers, provider organizations, providers, employers, policymakers, and health insurers – to improve the health of all Oregonians.

Founded in 2000, Q Corp plays a unique role as an independent multi-stakeholder organization that leads community-based initiatives focused on improving the quality, affordability and patient experience of health care in Oregon. Q Corp has aggregated claims to produce quality and utilization data since 2008, adding cost data in 2015. Delivered through a public website, performance reporting portal, and direct reporting to clinics, health plans, state agencies and other health care stakeholders, this unbiased information is one of the ways Q Corp delivers on its commitment to transparent, community-wide reporting on the health care provided to Oregonians.

The Q Corp Data Collaborative

The Q Corp Data Collaborative is a statewide, voluntary collaboration among major commercial health plans in Oregon, the Division of Medical Assistance Programs (DMAP; the state's Medicaid agency), and the U.S. Centers for Medicare and Medicaid Services' Qualified Entity (CMS QE) program. The multi-payer claims data warehouse, which is managed by Q Corp and its data partner, Onpoint Health Data, covers more than 80 percent of all Oregonians and effectively informs many of Q Corp's analytic solutions that are delivered to key stakeholder audiences through the generation of value-add services and performance metrics.

Essential to delivering this valuable information to its diverse group of stakeholders is Q Corp's performance reporting portal powered by Onpoint, a secure, web-based application that provides a role-based interface to health plans, provider organizations, and providers to view both summary- and patient-level reporting across a carefully curated set of measures enriched by benchmark metrics and actionable filters. Core functionality allows users to quickly customize dashboard visualizations, drill down into a suite of sophisticated reporting, request "reconsideration," and manage relevant input to Q Corp's master provider directory. The end result: A data set that most accurately reflects the quality and affordability of care provided to patients across health plans in the region.

The Data Collaborative's performance reporting portal currently contains data for approximately 3.8 million Oregonians aggregated and reconciled across commercial, Medicaid, and Medicare plans and attributable to more than 4,500 providers, 850 clinics, and 530 medical groups. By implementing a comprehensive reporting, reconsideration, and roster management mechanism, credentialed users are given the opportunity not only to identify variations and gaps in care but also to help refine the underlying claims data and supplement the data set with details regarding patients' actual experiences, prior to the information being released more broadly.

Health plans, provider organizations, and providers alike can leverage the performance reporting portal for several reasons – from comparing their organization's performance to statewide and national benchmarks to identifying variations in care within and across their organizational hierarchy settings to accessing patient-level detail information for follow-on actions (e.g., identifying patients in need of key services or screenings). The platform enables access to actionable information stored in the Data Collaborative for downstream decision-making and prioritization of tasks by providing neutral, unbiased, multi-payer information directly into the hands of key audiences.

For additional information on the performance reporting portal powered by Onpoint – an overview of its key components, features, functionality, and recommended workflow – see *User Guide*, located in the portal's documentation section. For questions, please contact the Q Corp administrator via email or telephone (QCorpinfo@healthinsight.org | 503-241-3571 x 118).

In the pages that follow, the underlying methods and measures used to generate the analyses displayed in the portal are explained in greater detail. Q Corp's methodology has been carefully developed to help inform provider organizations and providers alike on the quality and utilization of health care delivery. Q Corp's goal for the performance reporting portal is to build a culture of team-based care coordination and payment transformation.

Data Source & Intended Audience

The performance reporting portal and supporting analyses were developed through a collaborative process between Q Corp and Onpoint and were informed by feedback from key stakeholders. The reports use eligibility, medical claims, and pharmacy claims data supplied to the Data Collaborative for members who were enrolled in one of the participating health plans and attributed to one of the participating clinics during the defined reporting period. Ten of Oregon's largest commercial health plans, including Medicare Advantage plans, Medicaid plans, including those from Coordinated Care Organization and Fee for Service programs, and CMS QE Medicare (i.e., Medicare Fee for Service), contributed data for the reporting periods displayed in the portal.

Reporting Period Definitions

For the initial release of reporting to the performance reporting portal, there are several reporting periods that will be displayed for end users' review. These reporting periods capture eligibility and claims history from July 2014 through June 2016 and break down into the following periods (see Table 1):

Table 1. Definition of Reporting Periods by Incurred & Paid Dates of Service

Definition of Reporting Period*	Incurred Dates of Service (Start Date)**	Incurred Dates of Service (End Date)	Paid-Date Run-out (End Date)
July 2014 – June 2015	July 1, 2014	June 30, 2015	September 30, 2015

Definition of Reporting Period*	Incurred Dates of Service (Start Date)**	Incurred Dates of Service (End Date)	Paid-Date Run-out (End Date)
October 2014 – September 2015	October 1, 2014	September 30, 2015	December 31, 2015
January 2015 – December 2015	January 1, 2015	December 31, 2015	March 31, 2016
April 2015 – March 2016	April 1, 2015	March 31, 2016	June 30, 2016
July 2015 – June 2016*	July 1, 2015	June 30, 2016	September 30, 2016

** All performance measures included in the Data Collaborative's measure set are calculated for all defined reporting periods with the exception of the Breast Cancer Screening (BCS) measure, which is run on only the most recent reporting period (i.e., July 2015 through June 2016). This measure cannot be generated accurately for prior reporting periods due to insufficient look-back periods.*

*** Incurred dates of service (start date) may vary by measure per reporting period.*

Three months of additional, paid run-out claims data is used to maintain consistency and standardization of reporting across health plans and throughout time due to the general (and known) lag between the claim's date of service and when the same claim is paid and/or further processed. This lag time depends on the particular supplier processing the claim as well as on the type of claim being processed and may be impacted by new laws and policies issued over time (e.g., Medicare reimbursement rules). Onpoint establishes a three-month paid run-out window per reporting period to ensure that comparisons of patient-level measure results across historical reporting periods and current reporting periods are consistent and reliable.

Performance Reporting Portal User Types

For the performance reporting portal, a variety of user types have been developed to meet diverse reporting needs. Provider organizations have been organized into a hierarchical arrangement, where the "Health System" user type represents the highest-ranking reporting level, followed by the "Medical Group" then the "Clinic" user types and reporting levels, followed by the "Provider" user type and reporting level. Health plans, on the other hand, exist as a standalone user type and reporting level. For more information on user types and their relationship to various reporting levels, see Table 2; for definitions of the different types of reporting levels, see Table 3.

- **Provider Organization** – Health System, Medical Group, Clinic, and Provider user types exist in a hierarchical arrangement defined by the Data Collaborative's master provider directory.

  Descending in the hierarchy – from the Health System user type to the Provider user type – there is a one-to-many relationship. For example, a single health system may be comprised of several medical groups; each individual medical group may be comprised of several clinics, etc. However, ascending in the hierarchy – from the Provider user type to the Health System user type – there is a one-to-one relationship. For example, a single provider can be reported only by a single clinic; each individual clinic can be reported only within a single medical group, etc.

User access to view various reporting levels' performance measures descend in the hierarchy. For example, while a Health System user type can view measurement and roster displays for its self-reporting level and each organizational, provider, and patient reporting levels to which they are associated, a Provider user type can only view their measurement, including the corresponding patient data set.

- **Health Plan** – A health plan with access to the performance reporting portal exists as a standalone user type and reporting level. Using data provided solely by the health plan receiving the report, this user type can view measurement displays for its self-reporting level, as well as each organizational and provider reporting levels for which the health plan has attributed members per reporting period. In addition, the Health Plan user type will be able to access the same information aggregated across all contributing data suppliers.

Table 2. User Permissions to View Different Reporting Levels

User Type *(i.e., I am this type of user)*	Reporting Level *(i.e., I can see this level of information)*			
	Self	Organization	Provider	Patient
Health Plan				
Health System				
Medical Group				
Clinic				
Provider				

Table 3. Definitions of Reporting Levels

Reporting Level Type	Description
Self	Summary-level measure results for the user's own setting; all users have access to this level of reporting *Example: As a medical group user, I can view my own organization's summary level measure results.*
Organizational	Summary level measure results for each of the user's attributed organizations *Example: As a medical group user, I can view measure results for each of my organization's attributed clinics.*
Provider	Summary-level measure results for each of the user's attributed providers. *Example: As a medical group user, I can view measure results for each of my organization's attributed providers.*

Reporting Level Type	Description
Patient	Patient-detail measure results corresponding to the underlying performance of each of the summary-level measure results per reporting level to which the user has access; all users have access to this level of reporting *Example: As a medical group user, I can view the underlying patient-detail performance contributing to my self-, organizational, and provider-reporting levels' respective summary measure results.*

Data Modifications, Limitations, & Exclusions Requirements

The data used in these reports come exclusively from the health plans participating in the Data Collaborative and represent only those members who can be attributed to a provider belonging to one of the participating clinic organizations during a particular reporting period. The following sections outline and provide greater detail regarding several data modifications, limitations, and Health Insurance Portability and Accountability Act (HIPAA) requirements involved in this round of reporting.

Attribution Methodologies

Attribution is the process of assigning patients to providers and those providers to various clinics, as well as identifying the hierarchical arrangements among the distinct types of provider organizations within a particular region and duration of time. Methodologies for defining how exactly to tie a set of patients to a single provider or logically deciding a provider's primary clinic location or distinguishing which clinics belong to which medical groups often vary across clients depending on their program preferences and objectives. For the purposes of the Data Collaborative's performance reporting portal, each of these scenarios entails a dynamic process performed collaboratively among Q Corp, Onpoint, and the individual users of the performance portal.

Patient-to-Provider Attribution

For each round of reporting posted to the portal, Onpoint performs a claims-based patient-to-provider attribution methodology, which effectively identifies all claims for all patients meeting a distinct definition of a "primary care visit" (including both claim line- and provider-specific requirements), and the rendering and/or attending provider(s) associated with those claims. Onpoint's algorithms next determine each patient's single attributed provider per reporting period; tie-breaker logic is applied when necessary. If a patient is attributed to a provider through Onpoint's claims-based methodology who is not found in the master provider directory, the patient is not included in the portal's reporting for the particular reporting period in question; the next identified rendering and/or attending provider for the patient is not considered for attribution purposes.

One participating health plan provides Onpoint with a special eligibility assignment file, which effectively attributes patients to providers in the health plan's network. Per Q Corp specifications, preference is given to this eligibility-based attribution methodology over Onpoint's claims-based logic. If a patient can be attributed to a provider found in the master provider directory using the health plan's special eligibility assignment file, such attribution will be applied when generating the particular reporting period. If, however, a patient cannot be attributed to a provider using the special eligibility assignment file, Onpoint will use its claims-based methodology to identify the most reliable match.

Users within the performance reporting portal are given the opportunity to verify the accuracy of these methodologies' patient-to-provider attribution results during "reconsideration" review periods. Should a user's request for the adjustment of a patient-to-provider attribution arrangement be approved, a flag will be applied in Onpoint's systems to indicate that the patient's next identified rendering and/or attending provider should be considered in Onpoint's subsequent generation of both claims- and eligibility-based attribution methodologies. All approved requests for reconsideration of the master provider directory are applied to the impacted period of reporting in the portal's next scheduled refresh.

Affiliated Attributions Versus Primary Attributions

In the explanations to follow, there is a key difference between "affiliated" organizational attribution and "reported" organizational attribution. Whereas "affiliated" organizational attributions refer to the potentially one-to-many relationships that an individual provider may have with clinics during a particular reporting period (i.e., a list containing all of the clinic locations where the provider may practice during a particular reporting period), "reported" organizational attributions refer to the one-to-one relationship between a provider and one of their potentially many affiliated organizational attributions indicating the clinic within which the provider is reported in the reporting portal (i.e., a list outlining the single clinic within which the provider is reported in the portal per defined reporting period).

Provider-to-Clinic Attribution

For the attribution of individual providers to clinic organizations, Onpoint, with the assistance of Q Corp, has established foundational relationships based on Q Corp's experience with and knowledge of its participating provider organizations and affiliated providers. Those relationships are reflected in the current version of the master provider directory and have been applied to the portal's initial release of reporting.

On an ongoing basis, all provider-to-clinic organization relationships will be maintained through the portal's master provider directory management system and applied in each of the portal's scheduled refreshes. Scenarios that illustrate situations in which users may decide to use the portal's master provider directory management system as a means of adjusting and modifying provider-to-clinic organization relationships may include:

- **Scenario #1** – Provider A is reported by Practice 1 in the portal for a particular reporting period. However, a user knows that Provider A also served at Practice 2 at some point during that same period of time before they joined Practice 1. Provider A therefore served with both Practice 1 and Practice 2 during the same reporting period, although their effective and termination dates at each practice *do not* overlap.

  Since Onpoint PRP's attribution logic requires a one-to-one reporting relationship between providers and practices, Provider A is assigned only to Practice 1 in the portal. However, the user believes that Provider A's reporting relationship for the reporting period in question should instead be with Practice 2.

  - **Action** – The user may either request reconsideration of Provider A's reporting relationship with Practice 1 or add Practice 2 as one of Provider A's affiliated organizations for the reporting period in question and mark that affiliation as Provider A's *primary practice location*.

  - **Outcome** – The user's request will be processed and considered in Onpoint's subsequent application of provider-to-organization attribution tie-breaker logic. This logic will select the primary practice location as either Practice 1 or Practice 2 for Provider A during the reporting period in question by choosing the affiliated organization to which Provider A belonged at the end of the reporting period.

    The outcome of the tie-breaker logic on Provider A's reported organizational attribution for the reporting period in question will be applied in the portal's next scheduled refresh.

- **Scenario #2** – Provider A is reported by Practice 1 in the portal for a particular reporting period. However, a user knows that Provider A also served concurrently at Practice 2 during the same period of time. Provider A therefore served with both Practice 1 and Practice 2 during the same reporting period, and their effective and termination dates at each practice *do* overlap.

  Since Onpoint PRP's attribution logic requires a one-to-one reporting relationship between providers and practices, Provider A is assigned only to Practice 1 in the portal. However, the user believes that Provider A's reporting relationship for the reporting period in question should instead be with Practice 2.

  - **Action** – The user may either request reconsideration of Provider A's reporting relationship with Practice 1 or add Practice 2 as one of Provider A's affiliated organizations during the reporting period in question and mark that affiliation as Provider A's *primary practice location.*

- **Outcome** – The user's request will be processed and considered in Onpoint's subsequent application of provider-to-organization attribution tie-breaker logic. This logic respects the following procedure:

    1. Identify whether one of Provider A's affiliated practices during the reporting period in question is marked as their *primary practice location*.

       If either Practice 1 or Practice 2 is marked as such, Provider A will be attributed to that *primary* organization for the reporting period in question.

    2. If both or neither of Provider A's affiliated practices are marked as their *primary practice location*, then tie-breaker logic will select Provider A's reported organizational attribution for the reporting period in question by choosing the practice that Provider A joined most recently.

    3. If Provider A joined Practice 1 and Practice 2 at the same time, and therefore the logic results in another tie, Provider A will be attributed to the practice whose name falls lowest in alphabetical order.

       The outcome of the tie-breaker logic on Provider A's reported organizational attribution for the reporting period in question will be applied in the portal's next scheduled refresh.

Provider Organization-to-Organization Attribution

The hierarchical arrangements among distinct types of participating provider organizations (i.e., the relationships among clinics, medical groups, and health systems) have been established by Q Corp with the help of the organizations' self-reported relationships. Those relationships are reflected in the current version of the master provider directory and have been applied to the portal's initial release of reporting.

On an ongoing basis, all hierarchical provider organization arrangements and the creation of new provider organizations will be maintained by Q Corp and users through the portal's master provider directory management system and applied in each of the portal's scheduled refreshes.

Continuous Enrollment

The Healthcare Effectiveness Data and Information Set (HEDIS) performance measures require continuous enrollment in a health plan as part of patient eligibility criteria. These criteria were developed to ensure that patients are enrolled long enough to have an opportunity to establish a relationship with a provider and to receive quality care. It also ensures that the reporting entity has access to all claims data needed to calculate the measure correctly. Continuous enrollment and an allowable gap in enrollment are defined for each measure.

Despite the large number of claims in the data set, some providers and clinics may have a small number of patients for some measures. Depending on the period of time included for each measure, patients may have been "lost" since only patients who are continuously enrolled in health plans during the measurement period are counted in measurement calculations.

Additionally, some patients may not have been captured in measurement for any of the following reasons:

- They have a condition but it was not coded in a claim
- They are not members of a participating health plan
- They did not meet strict inclusion criteria
- They were attributed to a provider not included in the master provider directory or identified with a "primary care" specialty in claims- and/or eligibility-based attribution

Substance Abuse Record Exclusions

Per Oregon Administrative Rule 407-014-0020, information related to the receipt of substance abuse treatment will not be disclosed within the performance reporting portal. Both Onpoint and participating health plans identify substance abuse records for reporting exclusion per reporting period using the Oregon Health Authority's requirements for excluding claim line codes for the All-Payer All-Claims program. Following the processing of the health plans' claims data, Onpoint applies a series of data quality validation checks for the appropriate identification and omission of these related records to ensure that all have been identified and sequestered prior to measurement reporting.

Member Reporting Restrictions

Although Onpoint maintains a strict level of completeness and validity error thresholds for member attributes submitted by participating health plans, a small percentage of those elements were unable to be submitted and/or processed in adherence to such standards across health plans and reporting periods. For consistency and standardization of measurement and reporting, Onpoint has therefore excluded from its measurement processes members who have an unknown age (less than 0.09% of total members per reporting period), an unknown gender (less than 0.0006% of total members per reporting period), or an unknown name (less than 0.12% of total members per reporting period) in the data set.

ICD Code Set Transition

Effective as of October 1, 2015, the International Classification of Diseases (ICD) code set, a clinical cataloging system maintained by the World Health Organization, transitioned to its tenth edition (i.e., from 'ICD-9' to 'ICD-10') in an effort to qualitatively and quantitatively offer greater classification options than its predecessor. The code set is used widely by the health care industry, including providers, coders, IT professionals, health plans, and others, to properly

note diseases on health records, track epidemiological trends, and assist in medical reimbursement decisions. The ICD-10 transition is required by any organization covered by HIPAA.

Many of the performance reporting portal's historical reporting periods span the ICD-10 transition period. As such, Onpoint has updated all measures impacted by the transition to reflect revised specifications encompassing the ICD-10 code set. For example, any measure that ties back to diagnoses is based on modified HEDIS value sets, and all Prevention Quality Indicator (PQI) measures have been generated with new software released by the Agency for Healthcare Research and Quality (AHRQ).

One supplier was unable to transition their ICD code set accordingly in their data submissions to Onpoint and, as such, many of the codes for procedures incurred following the October 1, 2015 effective date still use the ICD-9 code set. These values are subsequently flagged as invalid codes in Onpoint's systems. Consequently, in the current generation of measurement for the performance reporting portal, many of the supplier's diagnosis and procedure codes following the transition's effective date are unable to be considered in the underlying measurement specifications.

Measure Set & Reporting

The methodology used in generating the many measurement displays found throughout the performance reporting portal has been collaboratively designed and informed by Q Corp, its stakeholders including the Measurement and Reporting Committee, and Onpoint. All participating health plans, provider organizations, and providers with at least one attributed patient per measure are included in the reporting portal.

Measure Selection & Accreditation

Q Corp's Measurement and Reporting Committee identifies principles for measure selection closely tied to the national standards set forth by the National Quality Forum (NQF). Accordingly, the Committee chooses the majority of its measures from the National Committee for Quality Assurance (NCQA) HEDIS measure set and the AHRQ measure set. A handful of other Committee-selected measures have been developed by the Oregon Health Authority (OHA) and Q Corp itself and are each fundamentally based on NCQA HEDIS specifications.

Since the Committee's first set of measures were reported to Oregon medical groups and providers in June 2009, the original measure set has expanded into a more robust collection for comprehensive reporting. Below, Table 4 provides an overview of the Q Corp Measurement and Reporting Committee's 2017 measure set, with detailed information on each measure's steward, specification year, component type, age band, unit of measurement, and definition.

Measurement Calculation, Units, & Confidence Intervals

Measurement Calculations

Aside from adjustments made for age and gender, as advised by the measure steward and specifications per measure, the 2017 measure set does not adjust for risk by each measure. The results provided in the performance reporting portal therefore reflect unadjusted, crude rates unless noted otherwise.

Furthermore, while all participating commercial and Medicaid health plans' eligibility and claims data is used in the generation of reporting, the CMS QE Medicare data is used in generating only a subset of the measure set per QE rules and requirements. Table 4 provides explicit definitions for those measures that include CMS QE Medicare data.

Measurement Units

The majority of results generated by the measure set are reported as the percentage of patients who are in need of a specific screening or care and who received the necessary service. NCQA's HEDIS definitions for the eligible population (denominator) consist of patients who satisfied all specified criteria, including age, diagnosis, continuous enrollment, and event or anchor-date requirements.

The measures of hospital admissions for ambulatory-care sensitive conditions are reported as rates instead of percentages. The majority of these measures are developed by AHRQ and belong to the set of Prevention Quality Indicators (PQIs), however the Ambulatory Care – Avoidable Emergency Department Visits measure is also included in this category. Each of these measures reports the rate of hospital admissions per 1,000 members, shedding light on those admissions that could have been avoided, at least in part, through better access to high-quality outpatient care. The NCQA HEDIS measures for Emergency Department Visits and Outpatient Facility Visits also report rates per 1,000 members for age bands that correspond to the pediatric and adult populations.

Confidence Intervals

Lower and upper confidence intervals of 95%, which are included in the reports, measure the degree of uncertainty in the generated rates.

Sample size is a primary factor for variability in confidence intervals. Clinics or providers with small patient populations typically demonstrate wider confidence intervals across measures compared to those with larger patient populations. In general, larger patient populations embody a more representative sample and therefore yield a greater chance of drawing the most accurate conclusions from tested measures.

In cases of small sample sizes, a clinic's and/or provider's entire patient population may demonstrate the same measure result. This will therefore cause the upper and lower limits of the confidence interval to be identical to the average rate.

Deductions about statistical significance are possible with the help of the confidence interval. For example, when comparing clinics and providers with one another, confidence intervals that do not overlap indicate that the difference in results is statistically significant while confidence intervals that do overlap indicate that the difference in results is not statistically significant.

Benchmark Metrics

Q Corp provides comparative benchmarks to help users interpret their summary measure results, identify opportunities for improvement, and recognize areas of high performance where best practices may be spread. Q Corp calculates two state benchmarks for Oregon and includes NCQA HEDIS national benchmarks when applicable. Reported averages include:

- **Oregon Clinic Average** – This benchmark is also known as the Oregon mean clinic score as it is calculated as the mean clinic score among clinics with at least 30 patients in the measure denominator, regardless of clinic size (i.e., the number of practicing providers). This calculation includes many small, rural clinics, providing a comprehensive picture of the care being delivered by clinics across the state.

- **Oregon Average** – This benchmark is the calculated mean of highest-performing Oregon clinics providing care to at least 10 percent of the patient population in the state. The calculation is based on the "Achievable Benchmark of Care" methodology developed at the University of Alabama at Birmingham, providing an objective method for comparing care against performance levels already achieved by "best-in-class" clinics within Oregon.

- **National Average** – This benchmark calculates the mean average across organizations nationally. The majority of measures for which this benchmark is populated draw on the NCQA HEDIS national benchmark, which is constructed by compiling clinical quality and resource use data from health plans nationwide who voluntarily disclose this information for NCQA's annual report, "The State of Health Care Quality."

Reconsiderations

The reporting portal includes a reconsideration component (i.e., a corrections and appeals tool) that offers users the opportunity to verify the accuracy of patient-level measure results and both provider-to-organization and patient-to-provider attribution arrangements prior to Q Corp's further use of the performance results and underlying claims data for both private and public program requirements. The tool and the policy that it upholds are intended to ensure a fair and transparent process by establishing consistent criteria by which data will be reconsidered/recalculated, providing a timely process for review, focusing on improvement of quality measurement, and ensuring the privacy and security of patients.

The reconsideration process is administered by Q Corp staff in consultation with Onpoint as necessary. As part of the reconsideration process, Q Corp provides a review period of 65 days and will communicate deadlines for each portal release. Reconsideration requests via the portal's feedback mechanism must be received for consideration prior to the deadline established for that round (i.e., prior to recalculation of patient-level measure results and attribution arrangements). Through the use of the portal's reconsideration management component, Q Corp applies a set of standard criteria to assess and accept feedback at the patient level for Onpoint's subsequent correction.

Q Corp will closely evaluate all formal reconsideration requests that require further review and audit those requests that automatically enter approval/refusal statuses per their defined protocol and workflow. Reconsiderations do not require extensive documentation by users beyond a reconsideration reason description, impacted date range, and optional comments; however, Q Corp reserves the right to request additional documentation as deemed necessary to verify requests and the grounds for subsequent correction.

The reconsideration tool is meant to encourage users to verify the accuracy of the submitted claims data by health plans to Onpoint so that the information remains validated, trusted, and useful for all. At a high level, there are three primary motives that a user may elect to review their data and apply for reconsideration:

- **Patient-Level Measure Result Inquiries** – This reconsideration reason suggests that the underlying patient-detail performance measure result for an individual patient may warrant adjustment.

  Example: A user may request reconsideration of an individual patient's breast cancer screening compliance measure result if the patient had a double mastectomy procedure and the history of that procedure is not reflected in the supporting claims data.

- **Patient-to-Provider Attribution Inquires** – This reconsideration reason suggests that the reported patient-to-provider attribution for an individual patient may warrant adjustment.

  Example: A user may request reconsideration if the patient is unknown to the clinic or has since changed providers.

- **Provider-to-Organization Attribution Inquiries** – This reconsideration reason suggests that the reported provider-to-organization attribution for an individual provider may warrant adjustment.

  Example: A user may request reconsideration if the provider has since changed clinics or practices with a specialty not recognized by Q Corp's roster management logic.

Table 4. Q Corp Measurement & Reporting Measure Set (2017)

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
AWC	Adolescent Well-Care Visits	NCQA/HEDIS	2016	Total	Percentage	Assesses adolescents and young adults 12–21 years of age who had at least one comprehensive well-care visit during the measurement year. Q Corp does not require the visit be with a PCP or OB/Gyn, which is a deviation from the HEDIS measure specifications.
SBIRT	Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment	OHA	2016	12-17, 18+, 12+	Percentage	Assesses patientss 12 years of age and older who had an outpatient visit during the measurement year and were screened for alcohol or other substance abuse. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
AMB-AVOIDEDV	Ambulatory Care - Avoidable Emergency Department Visits	OHA	2016	0-17, 18+, Total	Percentage	Assesses patients who had a visit to the emergency department during the measurement year which, according to their primary diagnosis, was considered a potentially avoidable visit to the emergency department. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
AMB-AVOIDEDV	Ambulatory Care - Avoidable Emergency Department Visits	OHA	2016	0-17, 18+, Total	Rate per 1,000 Member-Years	Assesses patients who had a visit to the emergency department during the measurement year which, according to their primary diagnosis, was considered a potentially avoidable visit to the emergency department. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
AMB-EDV	Ambulatory Care - Emergency Department Visits	NCQA/HEDIS	2016	0-17, 18+, Total	Rate per 1,000 Member-Years	Assesses patients who utilized ambulatory care for the emergency department setting. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
AMB-OPV	Ambulatory Care - Outpatient Visits	NCQA/HEDIS	2016	0-17, 18+, Total	Rate per 1,000 Member-Years	Assesses patients who utilized ambulatory care for the outpatient setting. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
MPM-ACE	Annual Monitoring for Patients on Persistent Medications - ACE Inhibitors or ARBs	NCQA/HEDIS	2016	Total	Percentage	Assesses adults 18 years of age and older on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) who received at least 180 treatment days of ambulatory medication therapy and at least one therapeutic monitoring event for the therapeutic agent during the measurement year.
MPM-DGXN	Annual Monitoring for Patients on Persistent Medications - Digoxin	NCQA/HEDIS	2016	Total	Percentage	Assesses adults 18 years of age and older on digoxin who received at least 180 treatment days of ambulatory medication therapy and at least one therapeutic monitoring event for the therapeutic agent during the measurement year.
MPM-DIU	Annual Monitoring for Patients on Persistent Medications - Diuretics	NCQA/HEDIS	2016	Total	Percentage	Assesses adults 18 years of age and older on diuretics who received at least 180 treatment days of ambulatory medication therapy and at least one therapeutic monitoring event for the therapeutic agent during the measurement year.
MPM	Annual Monitoring for Patients on Persistent Medications - Total	NCQA/HEDIS	2017	Total	Percentage	Assesses adults 18 years of age and older on ACE inhibitors or ARBs, digoxin, and diuretics who received at least 180 treatment days of ambulatory medication therapy and at least one therapeutic monitoring event for the therapeutic agents during the measurement year. Reports the total rate of each detail therapeutic agent measurement (i.e., the sum of the three numerators divided by the sum of the three denominators).

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
AMM	Antidepressant Medication Management, Short Term	NCQA/HEDIS	2016	Total	Percentage	Assesses adults 18 years of age and older with a diagnosis of major depression, who were newly treated with antidepressant medication and remained on their antidepressant medications; Acute Phase.
AMM	Antidepressant Medication Management, Long Term	NCQA/HEDIS	2016	Total	Percentage	Assesses adults 18 years of age and older with a diagnosis of major depression, who were newly treated with antidepressant medication and remained on their antidepressant medications; Continuation.
CWP	Appropriate Testing for Children with Pharyngitis	NCQA/HEDIS	2016	Total	Percentage	Assesses children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus test for the episode; a higher rate represents better performance (i.e., appropriate testing).
URI	Appropriate Treatment for Children with Upper Respiratory Infection	NCQA/HEDIS	2016	Total	Percentage	Assesses children 3 months-18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription; a higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).
PQI-15	Asthma in Younger Adults Admission	AHRQ	v6.0	Total	Rate per 1,000 Member-Years	Assesses adults 18-39 years of age who had an admission for a principal diagnosis of asthma. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	NCQA/HEDIS	2016	Total	Percentage	Assesses adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription; a higher rate corresponds with better performance.
PQI-11	Bacterial Pneumonia Admission	AHRQ	v6.0	Total	Rate per 1,000 Member-Years	Assesses adults ages 18 years of age and older who had an admission for a principal diagnosis of bacterial pneumonia. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
BCS	Breast Cancer Screening	NCQA/HEDIS	2016	Total	Percentage	Assesses women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
CCS	Cervical Cancer Screening	NCQA/HEDIS	2016	Total	Percentage	Assesses women 21–64 years of age who were screened for cervical cancer using either of the following criteria: (a) Women age 21–64 who had cervical cytology performed every 3 years; or (b) Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.
CHL	Chlamydia Screening in Women	NCQA/HEDIS	2016	16-20, 21-24, 16-24	Percentage	Assesses women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
PQI-05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	AHRQ	v6.0	Total	Rate per 1,000 Member-Years	Assesses adults 40 years of age and older who had an admission for a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
CDC-EYE	Comprehensive Diabetes Care - Eye Exam Performed	NCQA/HEDIS	2016	Total	Percentage	Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed during the measurement period. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
CDC-HBA1C	Comprehensive Diabetes Care - HbA1c Testing	NCQA/HEDIS	2016	Total	Percentage	Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) testing during the measurement period. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
CDC-NEPH	Comprehensive Diabetes Care - Medical Attention for Nephrology	NCQA/HEDIS	2016	Total	Percentage	Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy during the measurement period. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
PQI-10	Dehydration Admission	AHRQ	v6.0	Total	Rate per 1,000 Member-Years	Assesses adults 18 years of age and older who had an admission for a principal diagnosis of dehydration. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
DEV-CH	Developmental Screening in the First Three Years of Life	CHIPRA	2016	Total	Percentage	Assesses whether children are screened by their first, second, or third birthdays for risk of developmental, behavioral, and social delays.
PQI-03	Diabetes Long-term Complications Admission Rate	AHRQ	v6.0	Total	Rate per 1,000 Member-Years	Assesses adults 18 years of age and older who had an admission for a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified). This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
PQI-01	Diabetes Short-term Complications Admission Rate	AHRQ	v6.0	Total	Rate per 1,000 Member-Years	Assesses adults 18 years of age and older who had an admission for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma). This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
ECU	Effective Contraceptive Use	OHA	2016	15-17, 18-50, 15-50	Percentage	Assesses adolescent women 15-50 years of age with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year.

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FUM30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up	NCQA/HEDIS	2017	Total	Percentage	Assesses children and adults 6 years of age and older who had a visit to the emergency department with a principal diagnosis of mental illness and who had a follow up visit for mental illness within 30 days of the ED visit.
FUM7	Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up	NCQA/HEDIS	2017	Total	Percentage	Assesses children and adults 6 years of age and older who had a visit to the emergency department with a principal diagnosis of mental illness and who had a follow up visit for mental illness within 7 days of the ED visit.
RXGNRC-ATD	Generic Prescription Fills: Antidepressants	Q Corp	2016	Total	Percentage	Assesses the percentage of prescriptions of antidepressant medications for adults 18 years of age and older that were filled with a generic drug; Total Generic Prescriptions.
RXGNRC-ATL	Generic Prescription Fills: Antihyperlipidemics	Q Corp	2016	Total	Percentage	Assesses the percentage of prescriptions of antihyperlipidemic (statin) medications for adults 18 years of age and older that were filled with a generic drug; Total Generic Prescriptions.
RXGNRC-AHT	Generic Prescription Fills: Antihypertensives	Q Corp	2016	Total	Percentage	Assesses the percentage of prescriptions of antihypertensive medications for adults 18 years of age and older that were filled with a generic drug; Total Generic Prescriptions.
PQI-08	Heart Failure Admission	AHRQ	v6.0	Total	Rate per 1,000 Member-Years	Assesses adults 18 years of age and older who had an admission for a principal diagnosis of heart failure. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
PQI-07	Hypertension Admission	AHRQ	v6.0	Total	Rate per 1,000 Member-Years	Assesses adults 18 years of age and older who had an admission for a principal diagnosis of hypertension. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.

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PQI-16	Lower-Extremity Amputation among Patients with Diabetes	AHRQ	v6.0	Total	Rate per 1,000 Member-Years	Assesses adults 18 years of age and older who had an admission for any-listed diagnosis of diabetes and any-listed procedure of lower-extremity amputation (except toe amputations). This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
MMA	Medication Management for People with Asthma, 50% of Treatment Period	NCQA/HEDIS	2016	5-11, 12-18, 5-18	Percentage	Assesses children 5–18 years of age who were identified as having persistent asthma and were dispensed appropriate asthma controller medications that they remained on for at least 50 percent of their treatment period.
MMA	Medication Management for People with Asthma, 75% of Treatment Period	NCQA/HEDIS	2016	5-11, 12-18, 5-18	Percentage	Assesses children 5–18 years of age who were identified as having persistent asthma and were dispensed appropriate asthma controller medications that they remained on for at least 75 percent of their treatment period.
PCR	Plan All-Cause Readmissions - Total	NCQA/HEDIS	2016	Total	Percentage	Assesses the rate of acute inpatient stays for adults 18 years of age and older that were followed by an unplanned acute readmission during the measurement year for any diagnosis within 30 days after discharge. Q Corp reports a raw unadjusted rate for this measure, which is a deviation from the HEDIS measure specifications. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
PQI-91	Prevention Quality Acute Composite	AHRQ	v6.0	Total	Rate per 1,000 Member-Years	Assesses the composite of acute conditions for adults 18 years of age and older who had an admission for a principal diagnosis of one of the following conditions: dehydration, bacterial pneumonia, or urinary tract infection. This measure includes Medicare Fee for Service data

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
						made available through the Medicare Qualified Entity program.
PQI-92	Prevention Quality Chronic Composite	AHRQ	v6.0	Total	Rate per 1,000 Member-Years	Assesses the composite of chronic conditions for adults 18 years of age and older who had an admission for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, or heart failure without a cardiac procedure. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
PQI-90	Prevention Quality Overall Composite	AHRQ	v6.0	Total	Rate per 1,000 Member-Years	Assesses the overall composite for adults 18 years of age and older who had an admission for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, dehydration, bacterial pneumonia, or urinary tract infection. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
SPC-RCVD	Statin Therapy for Patients with Cardiovascular Disease - Rate 1; Received Statin Therapy	NCQA/HEDIS	2016	Total	Percentage	Assesses adult males 21 to 75 years of age and adult females 40 to 75 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) during the measurement year and who were dispensed at least one high- or moderate-intensity statin medication during the measurement year.

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
SPC-ADH	Statin Therapy for Patients with Cardiovascular Disease - Rate 2; Adherence	NCQA/HEDIS	2016	Total	Percentage	Assesses adult males 21 to 75 years of age and adult females 40 to 75 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) during the measurement year, were dispensed at least one high- or moderate-intensity stain medication during the measurement year, and who remained on a high- or moderate-intensity statin medication for at least 80% of the treatment period.
SPD-RCVD	Statin Therapy for Patients with Diabetes - Rate 1; Received Statin Therapy	NCQA/HEDIS	2017	Total	Percentage	Assesses adults 40-75 years of age with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD), were dispensed at least one statin medication of any intensity during the measurement year, and who remained on a statin medication of any intensity for at least 80% of the treatment period.
SPD-ADH	Statin Therapy for Patients with Diabetes - Rate 2; Adherence	NCQA/HEDIS	2017	Total	Percentage	Assesses adults 40-75 years of age with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one statin medication of any intensity during the measurement year.
PQI-14	Uncontrolled Diabetes Admission	AHRQ	v6.0	Total	Rate per 1,000 Member-Years	Assesses adults 18 years of age and older who had an admission for a principal diagnosis of diabetes without mention of short-term (ketoacidosis, hyperosmolarity, or coma) or long-term (renal, eye, neurological, circulatory, or other unspecified) complications. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
PQI-12	Urinary Tract Infection Admission	AHRQ	v6.0	Total	Rate per 1,000 Member-Years	Assesses adults 18 years of age and older who had an admission for a principal diagnosis of urinary tract infection. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.

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LBP	Use of Imaging Studies for Low Back Pain	NCQA/HEDIS	2016	Total	Percentage	Assesses adults 18-50 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI or CT scan) within 28 days of the diagnosis (a higher score indicates better performance).
W15	Well-Child Visits in the First 15 Months of Life, 5+ Visits	NCQA/HEDIS	2017	Total	Percentage	Assesses children who turned 15 months old during the measurement year and had five or more well-child visits during their first 15 months of life. Q Corp does not require that the well-child visit be with a PCP. This is a deviation from the HEDIS measure specifications.
W15	Well-Child Visits in the First 15 Months of Life, 6+ Visits	NCQA/HEDIS	2017	Total	Percentage	Assesses children who turned 15 months old during the measurement year and had six or more well-child visits during their first 15 months of life. Q Corp does not require that the well-child visit be with a PCP. This is a deviation from the HEDIS measure specifications.
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	NCQA/HEDIS	2017	Total	Percentage	Assesses children 3-6 years of age who received one or more well-child visits during the measurement year. Q Corp does not require that the well-child visit be with a PCP. This is a deviation from the HEDIS measure specifications.

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