OREGON HEALTH CARE QUALITY CORPORATION

Supporting Documentation

Technical Appendix for the Oregon Health Care Quality Reporting System Performance Reporting Portal (PRP)

Version: Oregon Health Care Quality Corporation; Provider Organization User Guide (v.2.0)

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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 healthcare in Oregon by leading community collaborations and producing unbiased information. Q Corp works with members of its community – including consumers, provider organizations, individual 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 healthcare 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, 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 Oregon Healthcare Quality Reporting System

The Oregon Healthcare Quality Reporting System (OHQRS) 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 the OHQRS Performance Reporting Portal (PRP) powered by Onpoint, a secure, web-based application that provides a role-based interface to health plans, provider organizations, and individual providers to view both summary- and patient-level (when authorized) 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 OHQRS PRP 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 individual 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 individual providers alike can leverage the OHQRS PRP 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 OHQRS 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 OHQRS PRP – an overview of its key components, features, functionality, and recommended workflow – see *User Guide for the OHQRS Performance Reporting Portal*, 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).

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

Data Source & Intended Audience

The OHQRS PRP and supporting analyses were developed through a collaborative process between Q Corp and Onpoint and informed by feedback from key stakeholders. The reports use eligibility, medical claims, and pharmacy claims data supplied to the OHQRS for members enrolled in one of the participating commercial, Medicare, or Medicaid health plans and attributed to one of the participating clinics during the reporting period.

User Types

The OHQRS PRP consists of two primary user types developed to meet required reporting needs: Provider Organization and Health Plan. Please refer to the Provider Organization and Health Plan user guides for additional detail for each of these user types.

Reporting Periods

Quality measures are calculated using claims during rolling 12-month periods. Three months of additional, paid run-out claims data are 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.

Data Modifications, Limitations, & Exclusions Requirements

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

Attribution Methodology

Attribution is the process of assigning patients to individual 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.

Patient-to-Provider Attribution

For each round of reporting posted to the OHQRS PRP, Onpoint performs a claims-based, patient-to-provider attribution methodology, which 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, applying tie-breaker logic when necessary.

Onpoint's attribution is based on Evaluation and Management coding, primary care taxonomy codes as reported by the National Plan Provider Enumeration System (NPPES), and a hierarchical step-down based on pluralities of visits and other related factors available in the claims data. These algorithms also account for the varying billing rules for primary care visits when provided by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Critical Access Hospitals (CAHs) and billed to either CMS, State Medicaid programs, or commercial plans.

One OHQRS-participating health plan provides Onpoint with a special eligibility assignment file, which effectively attributes its members 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, though defaults to the latter if a member cannot be attributed using the special eligibility assignment file.

Understanding Providers' Affiliated Organizational Attributions

The OHQRS PRP's master provider directory makes a distinct difference between "affiliated" organizational attribution and "reported" organizational attribution. Whereas *affiliated*

organizational attribution refers to the potentially many relationships that an individual provider may have with clinics during a single reporting period, *reported* organizational attribution refers to the unique relationship between a provider and one of their potentially many affiliated organizational attributions during a single reporting period (ultimately indicating the clinic to which the provider is assigned for reporting purposes in the portal).

Provider-to-Clinic Attribution

For the attribution of individual providers to OHQRS-participating clinic organizations, Onpoint, with the assistance of Q Corp, established a foundational provider-to-clinic roster. This roster was then further supplemented with relationship information among clinics, medical groups, and health systems.

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. A few scenarios in which administrative 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, and the outcomes of those actions, are outlined below:

- **Scenario #1** – When the most recent reporting period becomes available on the portal, Provider A is affiliated with only Clinic 1 during the 12-month span. However, an administrative user of Clinic 2 wants to supplement Provider A's list of affiliated organizations since Provider A served at Clinic 2 for a portion of time during the same reporting period prior to joining Clinic 1.

  Provider A therefore served at both Clinic 1 and Clinic 2 during the reporting period, although their effective and termination dates at each clinic *do not* overlap (i.e., Provider A *did not* serve concurrently at both Clinic 1 and Clinic 2 during the particular period of time).

  - **Action** – The administrative user of Clinic 2 adds their organization as one of Provider A's affiliated organizations for the latest reporting period and marks that affiliation as Provider A's *primary clinic location* since Provider A spent the majority of their time and/or served the majority of their patients at Clinic 2 prior to joining Clinic 1.
  - **Outcome** – The request by the administrative user of Clinic 2 will be processed and considered in Onpoint's subsequent application of provider-to-organization attribution tie-breaker logic. For providers who do not serve concurrently at multiple clinics during a single period of time, Onpoint's tie-breaker logic selects a provider's reported organizational attribution during a particular reporting period by choosing the affiliated clinic at which the provider was serving at the end of that 12-month duration.

    In the portal's next scheduled refresh, upon the execution of Onpoint's tie-breaker logic, Provider A would therefore be reported by Clinic 1 during the reporting

period in question – the clinic at which Provider A served most recently during the 12-month duration.

- **Scenario #2** – When the most recent reporting period becomes available on the portal, Provider A is affiliated with only Clinic 1 during the 12-month duration. However, an administrative user of Clinic 2 wants to supplement Provider A's list of affiliated organizations since Provider A served concurrently at Clinic 2 during the same period of time.

  Provider A therefore served at both Clinic 1 and Clinic 2 during the reporting period, and their effective and termination dates at each clinic *do* overlap (i.e., Provider A served simultaneously at both Clinic 1 and Clinic 2 during the particular period of time).

  - **Action** – The administrative user of Clinic 2 adds their organization as one of Provider A's affiliated organizations for the latest reporting period and marks that affiliation as Provider A's *primary clinic location* if they believe that Provider A spent the majority of their time and/or served the majority of their patients at Clinic 2 (rather than Clinic 1) during the reporting period's 12-month duration.
  - **Outcome** – The request by the administrative user of Clinic 2 request will be processed and considered in Onpoint's subsequent application of provider-to-organization attribution tie-breaker logic. For providers who do serve concurrently at multiple clinics during a single period of time, Onpoint's tie-breaker logic includes the following steps:

    1. Identify whether one of Provider A's affiliated clinics during the reporting period is marked as their *primary clinic location*.

       If either Clinic 1 or Clinic 2 is marked as such, Provider A will be attributed to that organization for reporting purposes during the reporting period.

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

    3. If Provider A joined Clinic 1 and Clinic 2 at the same time, and therefore the logic results in another tie, Provider A will be attributed to the clinic whose name comes first in alphabetical order from A to Z.

    In the portal's next scheduled refresh, upon the execution of Onpoint's tie-breaker logic, Provider A's reported organizational attribution to either Clinic 1 or Clinic 2 would be decided per the above steps.

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 in health insurance (regardless of plan) and any 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.

A subset of the OHQRS PRP'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).

Measurement & Reporting

The methodology used in generating the many measurement displays found throughout the OHQRS PRP 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 individual providers with at least one attributed patient per measure are included in the OHQRS PRP measurement and reporting.

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, each of which are 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 2018 measure set, with detailed information on each measure's steward, specification year, component type, age band, unit of measurement, and definition.

Measurement Calculations & Units

While all participating commercial and Medicaid health plans' eligibility and claims data is used in the generation of OHQRS PRP measurement and reporting, the CMS QE Medicare Fee-for-

Service (FFS) data is used in generating only a subset of the measure set per CMS QE program rules and requirements. Table 4 provides explicit definitions of those measures that include CMS QE Medicare FFS data.

Aside from adjustments made for age and gender as advised by the measure steward and specifications per measure, more rigorous risk adjustment methodologies were not employed. The results provided in the OHQRS PRP therefore reflect unadjusted, crude rates unless noted otherwise.

Furthermore, the majority of measures provided in the OHQRS PRP are reported as the percentage of patients who experienced a particular health event and received the appropriate treatment or follow-up. NCQA HEDIS definitions for the eligible population (i.e., the denominator) consist of patients who satisfied all specified criteria including age, diagnosis, continuous enrollment, and event or anchor-date requirements. Utilization measures are reported as rates instead of percentages. Each of these measures reports the rate of visits per 1,000 member-years.

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

Comparative benchmarks are included to help users interpret their summary measure results, identify opportunities for improvement, and recognize areas of high performance. Benchmarks included in the OHQRS PRP 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 of the small, rural clinics added to Q Corp's directory during the 2011 expansion, providing a more comprehensive picture of the care being delivered by clinics across the state.

- **Oregon Average** – This benchmark is the calculated mean of best 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 OHQRS PRP's reconsideration component is a corrections-and-appeals tool that offers users the opportunity to verify the accuracy of reported information, including patient-detail measure results, patient-to-provider attribution, and provider-to-clinic attribution. The tool as well as the policy that it upholds are intended to ensure a transparent process by establishing consistent criteria by which data will be reconsidered/recalculated.

The reconsideration process is administered by Q Corp in consultation with Onpoint as necessary. As part of the review and reconsideration process, Q Corp will provide a clear review period and deadline by which reconsideration requests via the portal's feedback mechanism must be received for consideration prior to the portal's next scheduled refresh. Q Corp will closely evaluate all formal reconsideration requests requiring further review and audit those requests that automatically enter approval/refusal statuses per their defined protocol and workflow.

The reconsideration tool offers users the option to verify the accuracy of the data submitted by OHQRS health plans to Onpoint so that the information becomes validated, trusted, and useful for all. In the sections that follow, detailed instructions will be provided to demonstrate how users can request reconsideration and monitor and review Q Corp feedback through the portal's designated component.

Per the OHQRS reconsideration workflow and protocol, the category of reasons provided to users include:

- **Patient-Level Measure Result Inquiries** – These reconsideration reasons offer users the option to identify patient-detail performance measure results that may be inaccurate.

  Example: If a patient is in compliance with the breast cancer screening measure for a particular reporting period in the portal, but the clinic administrator identifies that patient as having previously received a double-mastectomy procedure, thereby excluding them from the measure's specification, the clinic administrator may request reconsideration to remove the patient from the measure's inclusion for the current, and all subsequent, reporting periods.

- **Patient-to-Provider Attribution Inquires** – These reconsideration reasons offer users the option to indicate that the reported patient-to-provider attribution for an individual patient may have changed.

  Example: If a patient is unknown to the clinic or has changed providers since the last reporting period, the clinic administrator may request Onpoint to match the patient with the next rendering and/or attending provider identified in the claims data for the subsequent reporting period.

- **Provider-to-Organization Attribution Inquiries** – This reconsideration reason offers users the option to indicate that the reported provider-to-organization attribution for an individual provider may need updating.

  Example: If a provider has changed clinics since the last reporting period, the clinic administrator may request Onpoint to consider the provider's other affiliated organizational attributions for subsequent reporting periods.

Table 4. Q Corp Measurement & Reporting Measure Set (2018)

Note: The measures and specifications listed below reflect the measure set of the most recent reporting period in the PRP.

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
AWC	Adolescent Well-Care Visits	NCQA/HEDIS	2018	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.
AMB-AVOIDEDV	Ambulatory Care - Avoidable Emergency Department Visits	OHA	2017	0-17	Percentage	Assesses children and young adults 0-17 years of age 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	2017	18+	Percentage	Assesses adults 18 years of age and older 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	2017	Total	Percentage	Assesses members of all ages 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-AVOIDEDV	Ambulatory Care - Avoidable Emergency Department Visits	OHA	2017	0-17	Rate per 1,000 Member-Years	Assesses children and young adults 0-17 years of age 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	2017	18+	Rate per 1,000 Member-Years	Assesses adults 18 years of age and older 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	2017	Total	Rate per 1,000 Member-Years	Assesses members of all ages 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-EDV	Ambulatory Care - Emergency Department Visits	NCQA/HEDIS	2016	Total	Rate per 1,000 Member-Years	Assesses children 0-17 years of age and adults 18 years of age and older 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.

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
AMB-EDV	Ambulatory Care - Emergency Department Visits	NCQA/HEDIS	2016	0-17	Rate per 1,000 Member-Years	Assesses children 0-17 years of age 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-EDV	Ambulatory Care - Emergency Department Visits	NCQA/HEDIS	2016	18+	Rate per 1,000 Member-Years	Assesses adults 18 years of age and older 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	Total	Rate per 1,000 Member-Years	Assesses children 0-17 years of age and adults 18 years of age and older who utilized ambulatory care for the outpatient 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	Rate per 1,000 Member-Years	Assesses children 0-17 years of age who utilized ambulatory care for the outpatient 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	18+	Rate per 1,000 Member-Years	Assesses adults 18 years of age and older 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	2018	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

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
						event for the therapeutic agent during the measurement year.
MPM-DGXN	Annual Monitoring for Patients on Persistent Medications - Digoxin	NCQA/HEDIS	2017	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	2018	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).
AMM-ACUTE	Antidepressant Medication Management	NCQA/HEDIS	2018	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-CONT	Antidepressant Medication Management	NCQA/HEDIS	2018	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	2018	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).

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
URI	Appropriate Treatment for Children with Upper Respiratory Infection	NCQA/HEDIS	2018	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	Assess 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	2018	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.
BCS	Breast Cancer Screening	NCQA/HEDIS	2018	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	2018	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.

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
CHL	Chlamydia Screening in Women	NCQA/HEDIS	2018	16-20	Percentage	Assesses women 16–20 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
CHL	Chlamydia Screening in Women	NCQA/HEDIS	2018	21-24	Percentage	Assesses women 16–21 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
CHL	Chlamydia Screening in Women	NCQA/HEDIS	2018	Total	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	2018	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	2018	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.
CDC-NEPH	Comprehensive Diabetes Care - Medical Attention for Nephrology	NCQA/HEDIS	2018	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.

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
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 (women)	Percentage	Assesses adolescent women 15-17 years of age with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year.
ECU	Effective Contraceptive Use	OHA	2016	18-50 (women)	Percentage	Assesses adult women 18-50 years of age with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year.
ECU	Effective Contraceptive Use	OHA	2016	Total	Percentage	Assesses women 15-50 years of age with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year.

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
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-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 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-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 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 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.

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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.
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	NCQA/HEDIS	2018	5-11	Percentage	Assesses children 5–11 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.
MMA	Medication Management for People with Asthma	NCQA/HEDIS	2018	12-18	Percentage	Assesses young adults 12–18 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.
MMA	Medication Management for People with Asthma	NCQA/HEDIS	2018	Total	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.
MMA	Medication Management for People with Asthma	NCQA/HEDIS	2018	5-11	Percentage	Assesses children 5–11 years of age who were identified as having persistent asthma and were dispensed appropriate asthma controller

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
						medications that they remained on for at least 50 percent of their treatment period.
MMA	Medication Management for People with Asthma	NCQA/HEDIS	2018	12-18	Percentage	Assesses young adults 12–18 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	NCQA/HEDIS	2018	Total	Percentage	Assesses children 12–18 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.
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 made available through the Medicare Qualified Entity program.

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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	2018	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.
SPC-ADH	Statin Therapy for Patients with Cardiovascular Disease - Rate 2; Adherence	NCQA/HEDIS	2018	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

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
						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	2018	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	2018	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	2018	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).
OHDMP	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer	PQA	2017	Total	Percentage	Examines high dosage opioid use from multiple providers, among individuals 18 years and older without cancer. Patients in hospice also are excluded. The denominator includes individuals with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is >= 15 during the treatment period. The proportion of individuals from the denominator receiving prescriptions for opioids with a daily dosage greater than 120 morphine milligram equivalents (MME) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.
OHD	Use of Opioids at High Dosage in Persons Without Cancer	PQA	2017	Total	Percentage	Examines high dosage opioid use from multiple providers, among individuals 18 years and older without cancer. Patients in hospice also are excluded. The denominator includes individuals with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is >= 15 during the treatment period. The proportion of individuals from the denominator receiving prescriptions for opioids with prescriptions for opioids with a daily dosage greater than 120 morphine milligram equivalents (MME) for 90 consecutive days or longer.
OMP	Use of Opioids from Multiple Providers in Persons Without Cancer	PQA	2017	Total	Percentage	Examines high dosage opioid use from multiple providers, among individuals 18 years and older without cancer. Patients in hospice also are excluded. The denominator includes individuals with two or more prescription claims for opioids filled on

Abbreviated Name	Detailed Name	Steward	Specifications	Age Band	Reporting Unit	Definition
						at least two separate days, for which the sum of the days supply is >= 15 during the treatment period. The proportion of individuals from the denominator receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.
W15	Well-Child Visits in the First 15 Months of Life	NCQA/HEDIS	2018	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	NCQA/HEDIS	2018	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	2018	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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