Comagine Health

Supporting Documentation

Technical Appendix for the Comagine Health Oregon Data Collaborative Performance Reporting Portal (PRP)

Version: Provider Organization User Guide Version 4.0
Release: June 2024

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Comagine Health Oregon Data Collaborative

Comagine Health, formerly Qualis Health and HealthInsight, is a national, nonprofit, healthcare consulting firm. We work collaboratively with patients, providers, payers, and other stakeholders to reimagine, redesign, and implement sustainable improvements in the healthcare system. As a trusted, neutral party, we work in our communities to address key, complex health and healthcare delivery problems.

Comagine Health is the sponsoring organization for the Oregon Data Collaborative. Founded in 2000, Comagine Health 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. The Oregon Data Collaborative has aggregated claims to produce quality and utilization data since 2008, adding cost data in 2015. Delivered through a public website, reporting portal- Data Connect, and direct reporting to clinics, health plans, state agencies and other healthcare stakeholders, this unbiased information is one of the ways the Oregon Data Collaborative delivers on its commitment to transparent, community-wide reporting on the healthcare provided to Oregonians.

The Oregon Healthcare Quality Reporting System

The Oregon Data Collaborative (ODC) 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 Comagine Health, covers more than 80 percent of all Oregonians and effectively informs many of Comagine Health'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 ODC Performance Reporting Portal (PRP), 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 Comagine Health'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 ODC PRP currently contains data for approximately 3.1 million Oregonians aggregated and reconciled across commercial, Medicaid, and Medicare plans and attributable to more than 7,353 individual providers, 1,186 clinics, and 545 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 ODC 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 ODC 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 ODC PRP – an overview of its key components, features, functionality, and recommended workflow – see the *User Guide for the ODC Performance Reporting Portal*, located in the portal's documentation section. For questions, please contact the Comagine Health administrator via email or telephone (OregonData@comagine.org | 503-382-3946).

In the pages that follow, the underlying methods and measures used to generate the analyses displayed in the ODC PRP are explained in greater detail. Comagine Health'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. Comagine Health's goal for the ODC PRP is to build a culture of team-based care coordination and payment transformation.

Data Source & Intended Audience

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

User Types

The ODC PRP consists of two primary user types developed to meet required reporting needs: (1) provider organization and (2) 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 for rolling 12-month periods. Three months of additional claims data are used for paid "run-out" to maintain consistency and standardization of reporting across health plans and throughout time due to the general (and known) lag between a claim's date of service and when the same claim was 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). Comagine Health 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 as consistent and reliable as possible.

Data Modifications, Limitations, & Exclusions Requirements

The data used in these reports come exclusively from the commercial, Medicaid, and Medicare health plans participating in the ODC 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 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 time span.

Patient-to-Provider Attribution

For each round of reporting posted to the ODC PRP, Comagine Health performs a claims-based, patient- to-provider attribution that identifies all claims for all patients meeting a distinct definition of a "primary care visit" (including both claim line- and provider-specific requirements) and identifies the rendering and/or attending provider(s) associated with those claims. Comagine Health algorithms next determine a single attributed provider for each patient per reporting period, applying tie-breaker logic when necessary.

Comagine Health attribution is based on Evaluation and Management coding, primary care taxonomy codes as reported by the National Plan and 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.

Understanding Providers' Affiliated Organizational Attributions

The ODC 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 ODC-participating clinic organizations, Comagine Health 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 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 subsequent application of provider-to-organization attribution tie-breaker logic. For providers who did not serve concurrently at multiple clinics during a single period of time, 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 tie-breaker logic, Provider A will 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 at 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 subsequent application of provider-to-organization attribution tie-breaker logic. For providers who served concurrently at multiple clinics during a single period of time, 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 the logic therefore 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 tie-breaker logic, Provider A's reported organizational attribution to either Clinic 1 or Clinic 2 will 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 for a sufficient length of time 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 had a condition but it was not coded in a claim
- They were 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

Member Reporting Restrictions

Although Comagine Health 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, Comagine Health has therefore excluded from its measurement processes members who have an unknown age (less than 0.09% of total members per average reporting period), an unknown gender (less than 0.0006% of total members per average reporting period), or an unknown name (less than 0.12% of total members per average reporting period) in the data set.

ICD Code Set Transition

Effective 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 healthcare 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 was required of any organization covered by HIPAA.

A subset of the ODC PRP's historical reporting periods span the ICD-10 transition period. As such, 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 updated 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 ODC PRP has been collaboratively designed and informed by Comagine Health, its stakeholders and its Leadership Advisory and Analytics Advisory Committees. All participating health plans, provider organizations, and individual providers with at least one attributed patient per measure are included in the ODC PRP measurement and reporting.

Measure Selection & Accreditation

Comagine Health's now-retired Measurement and Reporting Committee identified principles for measure selection closely tied to the national standards set forth by the National Quality Forum (NQF). Accordingly, the Committee chose most 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 Comagine Health itself, each of which is 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 1 provides an overview of the Comagine Health Leadership Advisory and Analytics Advisory Committee's 2021 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 are used in the generation of ODC PRP measurement and reporting, the CMS QE Medicare Fee-for-Service (FFS) data is used in generating only a subset of the measures per CMS QE program rules and requirements. Table 1 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 ODC PRP therefore reflect unadjusted, crude rates unless noted otherwise.

Furthermore, most measures provided in the ODC 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.

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 ODC 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 Comagine Health'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 and provides an objective method for comparing care against performance levels already achieved by "best-in-class" clinics within Oregon.

Reconsiderations

The ODC 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 Comagine Health as necessary. As part of the review and reconsideration process, Comagine Health provides 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.
Comagine Health closely evaluates all formal reconsideration requests requiring further review and audits 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 ODC health plans so that the information becomes validated, trusted, and useful for all. In the sections that follow, detailed instructions are provided to demonstrate how users can request reconsideration and monitor and review Comagine Health's feedback through the portal.

Per the ODC 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 specifications, 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 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 to consider the provider's other affiliated organizational attributions for subsequent reporting periods.

Table 1. Comagine Health Measurement & Reporting Measure Set (2022)

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

Abbreviation	Detailed Name	Steward	Specifications	Age Band(s)	Reporting Unit	Definition
AHU-SUR	Acute Hospital Utilization – Surgical	NCQA/HEDIS	2021	Total	Rate per 1,000 Member-Years	For patients 18 years of age and older, the number of observed acute inpatient discharges (surgical) during the measurement year.
AHU-TTL	Acute Hospital Utilization – Total	NCQA/HEDIS	2021	Total	Rate per 1,000 Member-Years	For patients 18 years of age and older, the number of observed acute inpatient discharges (total) during the measurement year.
AHU-MED	Acute Hospital Utilization – Medical	NCQA/HEDIS	2021	Total	Rate per 1,000 Member-Years	For patients 18 years of age and older, the number of observed acute inpatient discharges (medical) during the measurement year.
AMB-AVOIDEDV	Ambulatory Care – Avoidable Emergency Department Visits	OHA	2019	0-17 18+ Total	Rate per 1,000 Member-Years	Assesses children and young adults in three age bands (0-17, 18+ and total (0-18+))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.
BCS	Breast Cancer Screening	NCQA/HEDIS	2021	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.
CCS	Cervical Cancer Screening	NCQA/HEDIS	2021	Total	Percentage	Assesses women 21–64 years of age who were screened for cervical cancer using either of the following criteria: (a) Women ages 21–64 who had cervical cytology performed every 3 years; or (b) Women ages 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Abbreviation	Detailed Name	Steward	Specifications	Age Band(s)	Reporting Unit	Definition
CDC-HBA1C	Comprehensive Diabetes Care – HbA1c Testing	NCQA/HEDIS	2021	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.
CHL	Chlamydia Screening in Women	NCQA/HEDIS	2021	16-20 21-24 Total	Percentage	Assesses women in three age bands (16-20, 21-24 and total (16-24)) who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
COL	Colorectal Cancer Screening	NCQA/HEDIS	2022	45-75	Percentage	Assesses adults 45-75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, stool DNA test every 3 years. This measure includes Medicare Fee for Service data made available through the Medicare Qualified Entity program.
CWP	Appropriate Testing for Pharyngitis	NCQA/HEDIS	2021	3-17 18-64 65+ Total	Percentage	Assesses children 3-18 years of age, and adults 18 years of age and older 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).
DEV-CH	Developmental Screening in the First Three Years of Life	OHA	2019	Total	Percentage	Assesses whether children are screened by their first, second, or third birthdays for risk of developmental, behavioral, and social delays.
ECU	Effective Contraceptive Use	OHA	2019	15-17 18-50 Total (women)	Percentage	Assesses women in three age bands (15-17, 18-50 and total (15-50)) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year.
EDU	Emergency Department Utilization	NCQA/HEDIS	2021	Total	Rate per 1,000 Member-Years	For patients 18 years of age and older, the observed rate of emergency department (ED) visits in the measurement year.
EDU-MI	Emergency Department Utilization among Members with Mental Illness	OHA	2019	18+	Rate per 1,000	Number of ED visits per 1,000 member months for adult members enrolled within the organization who are identified as having experienced mental illness.

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Abbreviation	Detailed Name	Steward	Specifications	Age Band(s)	Reporting Unit	Definition
PQI-01	Diabetes Short-term Complications Admission Rate	AHRQ	V2020	Total	Rate per 100,000 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).
PQI-03	Diabetes Long-term Complications Admission Rate	AHRQ	V2020	Total	Rate per 100,000 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).
PQI-05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma/COPD in Older Adults Admission Rate	AHRQ	V2020	Total	Rate per 100,000 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.
PQI-07	Hypertension Admission	AHRQ	V2020	Total	Rate per 100,000 Member-Years	Assesses adults 18 years of age and older who had an admission for a principal diagnosis of hypertension.
PQI-08	Heart Failure Admission	AHRQ	V2020	Total	Rate per 100,000 Member-Years	Assesses adults 18 years of age and older who had an admission for a principal diagnosis of heart failure.
PQI-10	Dehydration Admission	AHRQ	V2020	Total	Rate per 100,000 Member -Years	Assesses adults 18 years of age and older who had an admission for a principal diagnosis of dehydration.
PQI-11	Bacterial Pneumonia Admission	AHRQ	V2020	Total	Rate per 100,000 Member -Years	Assesses adults ages 18 years of age and older who had an admission for a principal diagnosis of bacterial pneumonia.
PQI-12	Urinary Tract Infection Admission	AHRQ	V2020	Total	Rate per 100,000 Member -Years	Assesses adults 18 years of age and older who had an admission for a principal diagnosis of urinary tract infection.
PQI-14	Uncontrolled Diabetes Admission	AHRQ	V2020	Total	Rate per 100,000 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.

Abbreviation	Detailed Name	Steward	Specifications	Age Band(s)	Reporting Unit	Definition
PQI-15	Asthma/COPD in Younger Adults Admission	AHRQ	V2020	18-39	Rate per 100,000 Member-Years	Assesses adults 18-39 years of age who had an admission for a principal diagnosis of asthma.
PQI-16	Lower-Extremity Amputation among Patients with Diabetes Rate	AHRQ	V2020	Total	Rate per 100,000 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).
PQI-90	Prevention Quality Overall Composite	AHRQ	V2020	Total	Rate per 100,000 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.
PQI-91	Prevention Quality Acute Composite	AHRQ	V2020	Total	Rate per 100,000 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.
PQI-92	Prevention Quality Chronic Composite	AHRQ	V2020	Total	Rate per 100,000 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.

Abbreviation	Detailed Name	Steward	Specifications	Age Band(s)	Reporting Unit	Definition
TEX-INP	Total Inpatient Expenditures	CPC	2019	Total	PMPM	This measure reports actual costs associated with inpatient care.
TEX-RX	Total Pharmaceutical Expenditures	CPC	2019	Total	PMPM	This measure reports actual costs associated with pharmaceutical cost.
TEX-SPEC	Total Specialty Expenditures	CPC	2019	Total	PMPM	This measure reports professional specialist cost. It includes both medical and surgical specialists.
TEX-TTL	Total Expenditures	CPC	2019	Total	PMPM	This measure reports actual costs associated with care for members attributed to a practice, including all covered professional, pharmacy, and hospital and ancillary care. It is calculated as the sum of the reported paid amount, the copay amount, the coinsurance amount, the deductible amount, and the pre-paid amount.
W30	Well-Child Visits in the First 30 Months of Life	NCQA/HEDIS	2021	Total	Percentage	Assesses children who turned 30 months old during the measurement year and had six or more well-child visits during their first 15 months of life. Comagine Health does not require that the well-child visit be with a PCP. This is a deviation from the HEDIS measure specifications.
WCV	Child and Adolescent Well Care Visits (3-21)	NCQA/HEDIS	2021	Total	Percentage	Assesses children and young adults 3-21 years of age who received one or more well-care visits during the measurement year. Comagine Health does not require that the well-child visit be with a PCP. This is a deviation from the HEDIS measure specifications.