OREGON HEALTH CARE QUALITY CORPORATION

Dear Clinic Administrator or Medical Director,

Q Corp is pleased to release its second round of Clinic Comparison Reports. This report includes claims incurred from January 2014 to December 2014. As a reminder, the goal of the Clinic Comparison Report is to demonstrate clinic variation in cost and quality compared to a state average. The Clinic Comparison Report displays information based on claims data for commercial patients attributed to a primary care clinic. The report includes:

- Cost, resource utilization, and price index at the clinic level.
- Detail for inpatient, outpatient, professional and pharmacy claims.
- A statewide average for all measures.

Some key findings from ABC Clinic's report:

Risk Score

The Clinic Risk Score represents the morbidity burden of a subset of patients in your clinic. Q Corp uses the Johns Hopkins Adjusted Clinical Groups (ACG) System which measures morbidity burden based on disease patterns, age and gender using diagnoses found in claims data.

Summary by Service Category

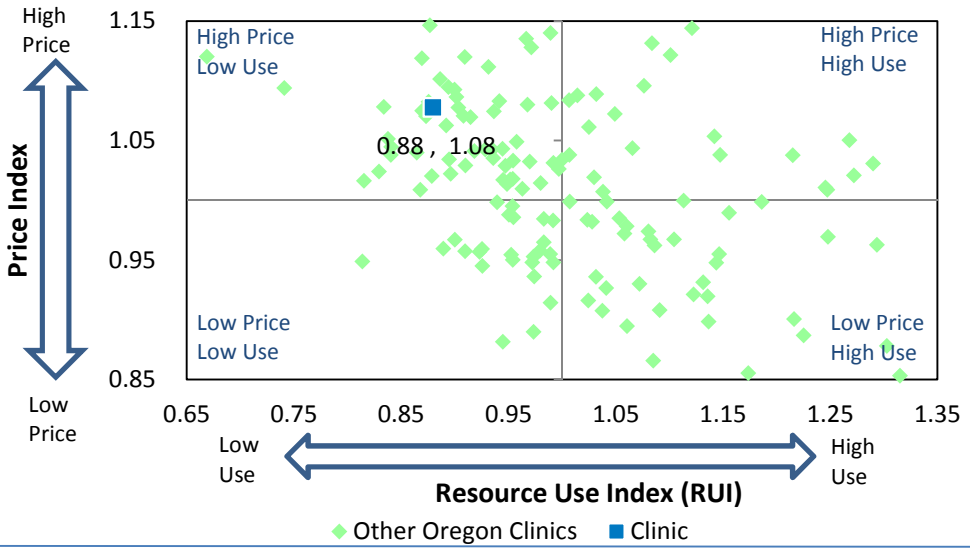
	TCI	=	RUI	x	Price Index
Professional	**1.07**		0.97		1.10
Outpatient Facility	**0.71**		0.72		1.00
Inpatient Facility	**1.10**		0.93		1.19
Pharmacy	**0.88**		0.87		1.01
Overall	**0.95**		0.88		1.08

A Total Cost Index, Price Index or Resource Use Index value greater than 1.00 means the clinic's score is higher than the Oregon average score for the measure.

For more information see the Total Cost of Care Definitions page.

Price vs. Resource Use Comparison

This chart shows your clinic's price and resource use compared to other clinics across Oregon. Clinics that are lower in price and resource use appear in the lower left quadrant.



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Additionally, we are including a page in this report that displays year over year changes in a clinic's scores from 2012, 2013, and 2014.

The Clinic Comparison Reports are based on HealthPartners' cost of care measures which have been endorsed by the National Quality Forum (NQF). These measures use various criteria to ensure that the populations are similar enough for comparisons to be made. The criteria used for these adult reports include:

- Clinics meet the minimum patient threshold of 600.†
- Patients are enrolled in a commercial plan for at least 9 months.
- Adults 18-64 (patients 65 years old and over are excluded).
- Costs over $100,000 for any individual patient are excluded.

To ensure the reports are as useful as possible, Q Corp will continue to solicit input regarding the content and format from multiple stakeholders and partners. More information about Q Corp's Cost of Care work, can be found on our website at: http://q-corp.org/our-work/costofcare.

Questions? Please contact a member of the cost of care team at costofcare@q-corp.org or 503-241-3571.

Thank you,

Mylia Christensen
Executive Director

Attachments:

1. Total Cost of Care Definitions and Glossary, 2 pages
2. Clinic Comparison Report, 9 pages
3. Frequently Asked Questions (FAQ), 7 pages

The Oregon Health Care Quality Corporation is an independent, nonprofit organization that leads community collaborations and produces unbiased information. We work with the members of our community—consumers, providers, employers, policymakers, and health insurers—to improve the health of all Oregonians.

† Clinics that received reports previously are receiving reports even if their number of patients falls below the minimum patient threshold.

Adult Clinic Comparison Report: Quality, Utilization & Cost

Segment: Commercially Insured Adults age 18-64

Reporting Period: Jan 2014 – Dec 2014

Total Cost of Care Definitions & Glossary Page 1

About this report

This report shows clinic-specific data on cost, utilization, quality and resource use measures, comparing your clinic to others in Oregon.

Patient Population: Cost and utilization reports use Q Corp's commercially insured adult (18-64) population for claims incurred January 1, 2014 – December 31, 2014 with 3 months run-out. Annual costs over $100,000 for any individual patient are excluded. Other quality and resource use measures use Q Corp's commercially insured population in its entirety for the same period.

Patient Attribution: Patients are assigned to a primary care provider (PCP) contained in the Q Corp provider directory based on having specific types of primary care visits with that PCP. PCPs and their patients are then assigned to a clinic. Attribution to a PCP is based on the following:

- A patient is attributed to the PCP the patient has seen the most across the two-year attribution period (January 1, 2013 – December 31, 2014).
- A patient is attributed to a single PCP. If there is a tie in the number of visits, the patient will be attributed to the most recently seen PCP.
- Patients who received care solely from specialists, urgent care clinics or other providers not included in the provider directory are not assigned a primary care provider (*unattributed*). In addition, if a patient did not have one of the specific types of visits based on CPT codes, the patient is not attributed.

Overall Summary by Service Category for ABC Clinic

	Clinic		OR Average			
	Raw PMPM	**Adj PMPM**	PMPM	**TCI**	= RUI	Price x Index
Professional	**$234.52**	**$207.60**	$194.45	**1.07**	0.97	1.10
Outpatient Facility	**$97.59**	**$86.39**	$120.83	**0.71**	0.72	1.00
Inpatient Facility	**$89.62**	**$79.33**	$71.94	**1.10**	0.93	1.19
Pharmacy	**$84.41**	**$74.72**	$85.37	**0.88**	0.87	1.01
Overall	**$506.13**	**$448.05**	$472.59	**0.95**	0.88	1.08

See Definitions Page 2 for a description of Service Categories (Professional, Outpatient Facility, etc)

Raw PMPM: Raw Per Member Per Month (PMPM) is the total allowed amount (payments from the health plan and the member combined) paid to the clinic for all attributed patients, divided by the number of member months. Annual per member costs are capped at $100,000.

Adj PMPM: Adjusted PMPM is the clinic's retrospective risk-adjusted PMPM allowed amount, normalized to the Oregon average. Q Corp uses the Johns Hopkins ACG System which groups patient populations by disease pattern, age and gender. The risk-adjusted amount allows comparison to other clinics regardless of a clinic's illness burden. If the Adjusted PMPM is higher than the Raw PMPM, that indicates that the clinic has a panel with a lower illness burden than the Oregon average.

Risk Adjusted PMPM = Raw PMPM / Risk Score

OR Average: The Oregon average is the average of all patients in the peer group, in this case commercial patients in Oregon between the ages of 18 and 64 who have been attributed to a clinic receiving these reports. OR Average is shown in comparison to the clinic's adjusted PMPM.

TCI: Total Cost Index (TCI) is a risk-adjusted measure of the *overall cost effectiveness* of managing patient health relative to the Oregon average. This measure includes both the frequency and price of services provided.

RUI: Resource Use Index (RUI) is a risk-adjusted measure of the *frequency and intensity* of the services used to manage patient health relative to a benchmark. RUIs are calculated based on standard weights for each service in a service category:

Inpatient: MS-DRG (Medicare Diagnosis-Related Grouper)
Outpatient: APC (Ambulatory Payment Classification)
Professional: RVU (Relative Value Units)
Pharmacy: NDC (National Drug Code) Average Wholesale Price

Price Index: Price Index is a risk-adjusted measure of the *price component* of managing patient health relative to the Oregon Average. The Price Index is affected by fee schedules, referral patterns and place of service.

Price Index = TCI / RUI

OR Average is the average for the patients attributed to clinics receiving these reports.

This work is based on the patented algorithm of HealthPartners, Inc. (Bloomington, MN) and is used with their permission

Total Cost of Care Definitions & Glossary Page 2

Service Category Definitions

Professional: Includes all costs for professional services delivered in any setting; inpatient, outpatient, or in a clinic, lab, or imaging center. It also includes ancillary services (lab, radiology, DME, etc.) delivered outside a hospital facility.
Outpatient Facility: Includes only services billed by a hospital facility. Professional services for surgeons, hospitalists or other providers billed by a medical group are included in the Professional Service Category.
Inpatient Facility: Includes only services billed by a hospital facility. Professional services that are billed by a medical group are included in the Professional Service Category.
Pharmacy: Includes all drugs covered by the patient's pharmacy benefit.

PMPM: Per Member Per Month (PMPM) refers to the ratio of some services or cost divided into the number of members in a particular group on a monthly basis. For example, if an HMO has 10,000 members that spend $20,000 on cardiovascular surgery in one month, the cost on a PMPM basis would be $20,000 divided by 10,000 equaling $2 per member per month.

Specialist Services: All services, including office visits and procedures, provided by a specialist.

TCI, RUI and Price Index: Oregon averages for TCI, Price Index and RUI are set at 1.0. The Oregon average is the average score for all patients attributed for clinics receiving these reports. A clinic's score indicates to what extent the attributed patients differ from the Oregon average. Values below 1.0 indicate the clinic's panel has lower cost or resource use than average; above 1.0 means the clinic's panel is higher than average.

Clinic Comparison Report Glossary

AMI:	Acute Myocardial Infarction
APC:	Ambulatory Payment Classification
CC:	Complicating or Comorbid Condition
CDE:	Common Bile Duct Exploration
CT:	Computed Tomography
DNRI:	Dopamine & Norepinephrine Reuptake Inhibitor
ED:	Emergency Department
GI:	Gastrointestinal
HbA1c:	Hemoglobin A1c
LDL-C:	Low Density Lipoprotein Cholesterol
MCC:	Major Complicating or Comorbid Condition
MRI:	Magnetic Resonance Imaging
MS- DRG:	Medicare Diagnosis Related Grouper
MV:	Mechanical Ventilation
NDC:	National Drug Code
OP:	Outpatient
OR:	Operating Room
OT:	Occupational Therapy
PET:	Positron Emission Tomography
PMPM:	Per Member Per Month
PT:	Physical Therapy
RVU:	Relative Value Units
ST:	Speech Therapy
SSRI:	Selective Serotonin Reuptake Inhibitor

MS-DRG: The Medicare Diagnosis Related Grouper (MS-DRG) is a statistical system of classifying any inpatient stay into groups for the purposes of payment. The DRG classification system divides possible diagnoses into more than 20 major body systems and subdivides them into almost 500 groups for the purpose of Medicare reimbursement.
APC: The Ambulatory Payment Classification (APC) is a system for reimbursing acute care facilities (hospitals) for outpatient services for Medicare patients.
RVU: Relative Value Units (RVUs) are units assigned to individual CPT codes which, when multiplied by a conversion factor and geographical adjustment, creates the compensation level for a particular service.
NDC: The National Drug Code (NDC) is a unique product identifier used in the United States for drugs intended for human use.

OR Average is the average for the patients attributed to clinics receiving these reports.

ABC Clinic

Adult Clinic Comparison Report: Quality, Utilization & Cost

Segment: Commercially Insured Adults age 18-64

Reporting Period: Jan 2014 – Dec 2014

OREGON HEALTH CARE QUALITY CORPORATION

Overview

Patient Demographics

	Clinic		Oregon Average Scaled to Clinic's size	
	Number	Percent	Number	Percent
Attributed patients (Benchmark is average number per clinic)	**3,938**		3,938	
Average Age (approximate)	**48.3**		**46.2**	
% Male	**2,008**	**51.0%**	1,822	46.3%
% Female	**1,930**	**49.0%**	2,116	53.7%
No Chronic Condition Indicated	**1,621**	**41.2%**	2,328	59.1%
Chronic Condition	**2,317**	**58.8%**	1,610	40.9%
Major psychosis	**1**		3	
Severe dementia	**1**		1	
Active cancer	**158**		104	
Renal failure - post transplant	**14**		15	
Liver disease (Hepatitis, Cirrhosis) – post transplant	**32**		18	
HIV	**-**		4	
Severe rheumatic & other connective tissue disease	**44**		32	
Severe heart failure/transplant/rheumatic heart disease	**33**		32	
Hemophilia & sickle cell & chronic blood disorders	**5**		2	
Both Coronary Artery Disease & diabetes	**13**		7	
Coronary Artery Disease without diabetes	**146**		29	
Diabetes without Coronary Artery Disease	**153**		184	
Hypertension (Includes stroke & peripheral vascular disease)	**425**		268	
Chronic obstructive pulmonary disease (COPD)	**10**		10	
Asthma	**163**		145	
Neurologic disorders	**154**		116	
Mental retardation/disability congentia anomaly	**8**		6	
Chronic musculosketetal/osteo arthritis/osteporosis	**312**		163	
Other mental health	**70**		105	
Gastrointestinal disorders	**141**		93	
Thyroid disorders	**116**		87	
Dermatologic disorders	**12**		18	
Other chronic conditions	**306**		169	

Chronic Conditions: Q Corp uses Milliman's proprietary Chronic Condition Hierarchical Groups (CCHG) for chronic conditions. Each patient is assigned to one CCHG according to a hierarchical algorithm developed by Milliman. Patients with comorbidities will be **reported under the CCHG that falls highest in the hierarchy**. The CCHGs may represent an approximation of your clinic's risk, however, the actual risk adjustment in this report uses the Johns Hopkins ACG risk adjusters.

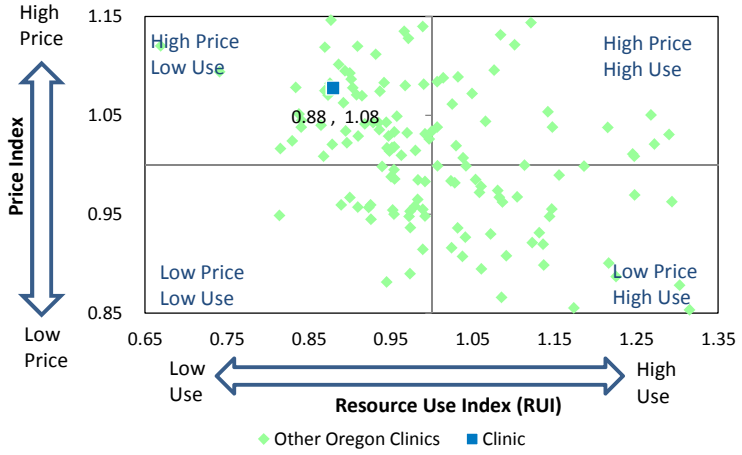
Overall Summary by Service Category

	Clinic Raw PMPM	Clinic Adj PMPM	OR Average PMPM	TCI	=	RUI	x	Price Index
Professional	**$234.52**	**$207.60**	$194.45	**1.07**		0.97		1.10
Outpatient Facility	**$97.59**	**$86.39**	$120.83	**0.71**		0.72		1.00
Inpatient Facility	**$89.62**	**$79.33**	$71.94	**1.10**		0.93		1.19
Pharmacy	**$84.41**	**$74.72**	$85.37	**0.88**		0.87		1.01
Overall	**$506.13**	**$448.05**	$472.59	**0.95**		0.88		1.08

Blue highlight indicates index values 10% or more above the Oregon Average.

A TCI, RUI or Price Index value greater than 1.00 means the clinic 's score is higher than the Oregon adult average score for the measure.

Price vs. Resource Use Comparison by Clinic



OR Average is the average for the patients attributed to clinics receiving these reports.

This work is based on the patented algorithm of HealthPartners, Inc. (Bloomington, MN) and is used with their permission.

ABC Clinic

Adult Clinic Comparison Report: Quality, Utilization & Cost

Segment: Commercially Insured Adults age 18-64

Reporting Period: Jan 2014 – Dec 2014

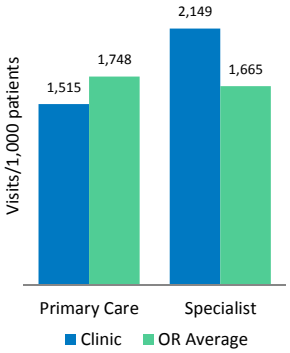
Professional Services

Professional PMPM by Service Category

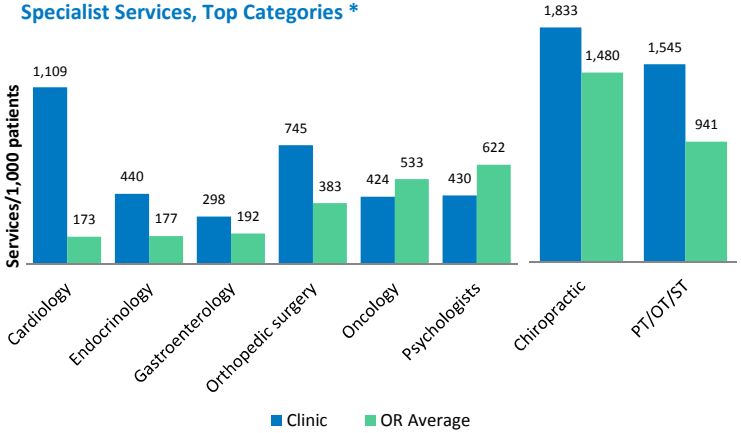
	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	Price x Index
Surgery & Anesthesia	**$37.99**	$34.57	**1.10**	1.03	1.07
PCP Office/Home Visits	**$24.98**	$28.31	**0.88**	0.75	1.18
Specialist Office/Home Visits	**$25.27**	$19.56	**1.29**	1.22	1.06
Radiology Professional Services	**$22.40**	$14.39	**1.56**	1.38	1.13
Physical Therapy	**$14.94**	$11.45	**1.30**	1.37	0.95
Office Administered Drugs	**$6.85**	$11.35	**0.60**	0.60	1.01
Pathology/Lab Professional Services	**$14.62**	$10.59	**1.38**	1.11	1.24
Behavioral Health	**$5.78**	$10.13	**0.57**	0.61	0.93
DME & Home Health	**$6.80**	$7.88	**0.86**	0.87	0.99
Preventive Physical Exams	**$7.73**	$7.77	**0.99**	0.92	1.08
Preventive Labs & Tests	**$7.97**	$6.70	**1.19**	1.17	1.02
Maternity (Deliveries)	**$1.53**	$3.91	**0.39**	0.39	1.00
ED Visits and Observation Care	**$2.88**	$3.29	**0.88**	0.62	1.42
Chiropractor	**$2.92**	$2.75	**1.06**	1.19	0.89
Preventive Immunizations	**$1.73**	$2.01	**0.86**	0.86	1.00
Inpatient Visits	**$1.34**	$1.87	**0.72**	0.62	1.16
Urgent Care Visits	**$5.82**	$1.69	**3.44**	2.89	1.19
Cardiovascular Diagnostics	**$2.43**	$1.69	**1.44**	1.23	1.17
All Others	**$13.62**	$14.56	**0.94**	0.91	1.03
Total	**$207.60**	$194.45	**1.07**	0.97	1.10

Primary and Specialty Care Utilization:

Evaluation & Management *

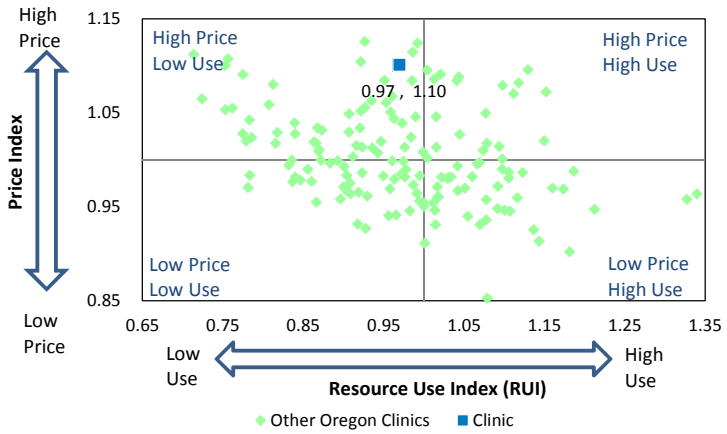


Specialist Services, Top Categories *



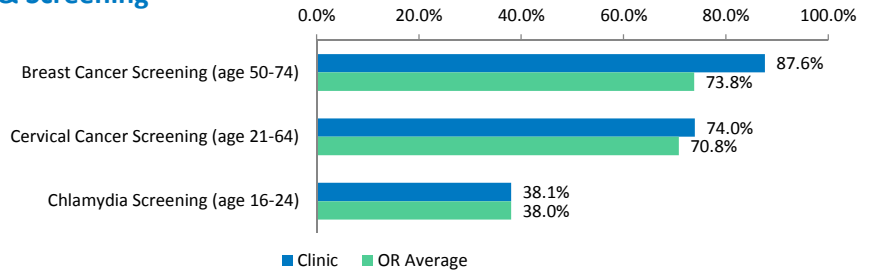
Note: Specialist utilization can be driven by a clinic's patient population. A higher risk score can drive higher utilization of specialists.

Professional Price vs. Resource Use Comparison by Clinic



Prevention & Screening

(higher is better)



Professional Services includes all costs for professional services delivered in any setting: inpatient, outpatient, or in a clinic, lab, or imaging center. It also includes ancillary services (lab, radiology, DME, etc.) delivered outside of a hospital facility.

*** Utilization and Quality measures are for commercial population only and are not risk adjusted.**
OR Average is the average for the patients attributed to clinics receiving these reports.

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Adult Clinic Comparison Report: Quality, Utilization & Cost

Segment: Commercially Insured Adults age 18-64

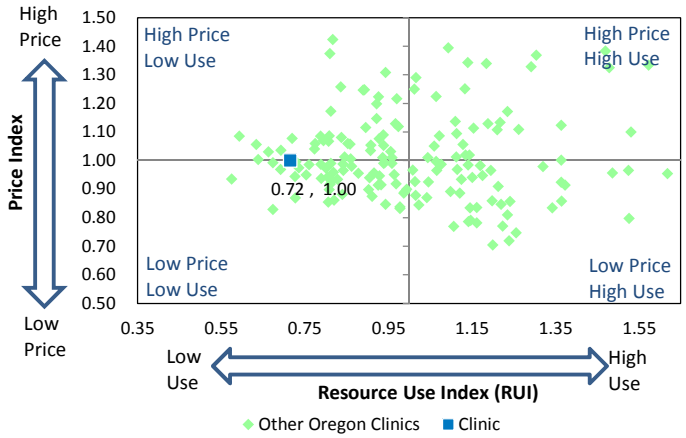
Reporting Period: Jan 2014 – Dec 2014

Outpatient Facility

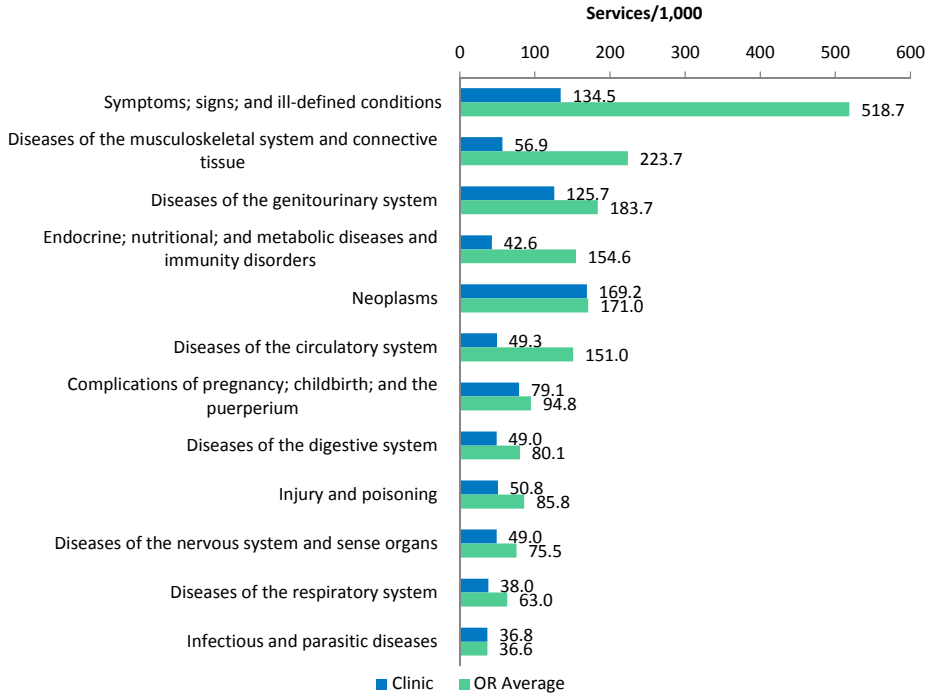
Outpatient Facility PMPM by Service Category

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	Price x Index
Outpatient Surgery	**$56.54**	$52.91	**1.07**	0.98	1.09
Emergency Room	**$13.73**	$19.53	**0.70**	0.60	1.18
Preventive	**$4.12**	$7.96	**0.52**	0.67	0.77
Radiology General	**$1.45**	$7.13	**0.20**	0.18	1.13
Pathology/Lab	**$2.76**	$6.67	**0.41**	0.33	1.26
Radiology - CT/MRI/PET	**$0.87**	$6.41	**0.14**	0.10	1.31
Pharmacy	**$1.50**	$6.23	**0.24**	0.17	1.41
Other	**$3.67**	$6.00	**0.61**	0.83	0.73
PT/OT/ST	**$0.59**	$4.14	**0.14**	0.16	0.91
Cardiovascular Diagnostics	**$1.03**	$3.07	**0.33**	0.33	1.02
Behavioral Health	**$0.13**	$0.78	**0.16**	0.01	26.61
Total	**$86.39**	$120.83	**0.71**	0.72	1.00

Outpatient Price vs. Resource Use Comparison by Clinic



Outpatient Facility Visits: Clinical Classifications (CCS) *



Outpatient Facility includes only services billed by a hospital facility. Professional services for surgeons, hospitalists or other providers billed by a medical group are included in the Professional Service Category.

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Adult Clinic Comparison Report: Quality, Utilization & Cost

Segment: Commercially Insured Adults age 18-64

Reporting Period: Jan 2014 – Dec 2014

Radiology & Emergency

Radiology (Outpatient Facility and Professional Services)

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	Price x Index
Diagnostic	**$9.67**	$11.15	**0.87**	1.01	0.86
MRI	**$8.77**	$7.90	**1.11**	1.19	0.93
CT Scan	**$5.00**	$4.86	**1.03**	1.12	0.92
Therapeutic/Radiation Oncology	**$0.94**	$3.58	**0.26**	0.24	1.11
PET	**$0.33**	$0.44	**0.75**	1.00	0.75

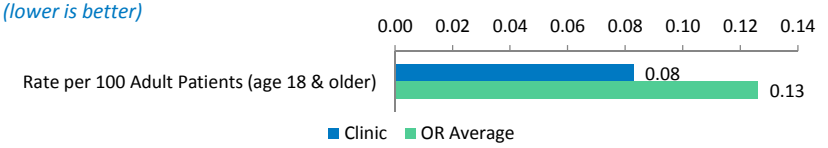
Emergency Department Utilization *

(lower is better)

	Clinic	Benchmark
ED Visits/1000 patients	**88.2**	120.3

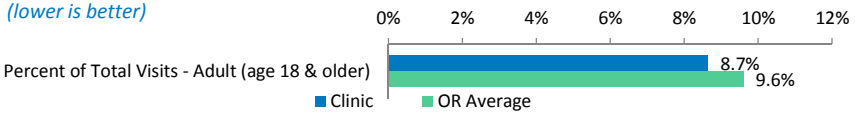
Rate per 100 of Potentially Avoidable ED Visits

(lower is better)



Potentially Avoidable ED Visits, % of Total ED Visits

(lower is better)



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Adult Clinic Comparison Report: Quality, Utilization & Cost

Segment: Commercially Insured Adults age 18-64

Reporting Period: Jan 2014 – Dec 2014

Inpatient Cost & Utilization

Inpatient PMPM by Service Category

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	Price x Index
Acute Admissions	**$79.33**	$71.53	**1.11**	0.93	1.19
Surgical	**$60.67**	$46.88	**1.29**	1.09	1.18
Medical	**$14.46**	$15.85	**0.91**	0.75	1.22
Maternity	**$3.77**	$7.77	**0.48**	0.39	1.24
Mental Health	**$0.44**	$1.02	**0.43**	0.52	0.81
Non-Acute	**$0.00**	$0.41	**-**	-	-
All Admisssions	**$79.33**	$71.94	**1.10**	0.93	1.19

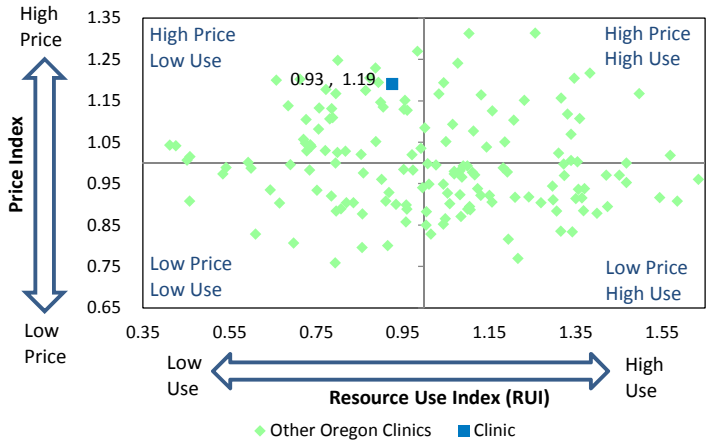
Inpatient Utilization *

(lower is better)

	Clinic	OR Average
Admits/1,000 Patients (Acute & Non-Acute)	**42.9**	50.7
30-day all cause readmissions, unadjusted	**4.4%**	9.5%

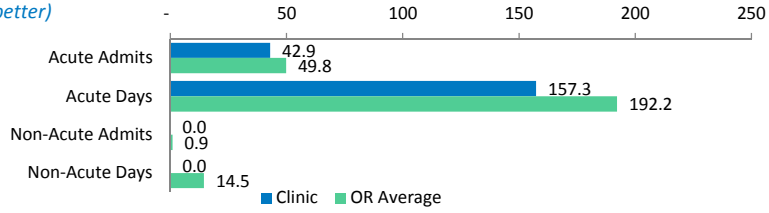
Note: Non-Acute Admissions are admission to and services provided in a Skilled Nursing, Subacute, or Rehabilitation Facility.

Inpatient Price vs. Resource Use Comparison by Clinic



Admissions & Inpatient Days per 1,000 Patients *

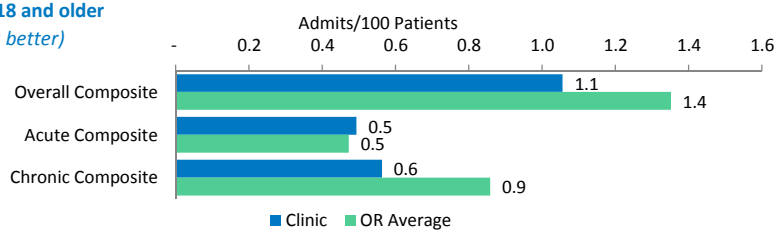
(lower is better)



Potentially Avoidable Hospital Admissions *

Age 18 and older

(lower is better)



Inpatient Facility includes only services billed by a hospital facility. Professional services that are billed by a medical group are included in the Professional Service Category.

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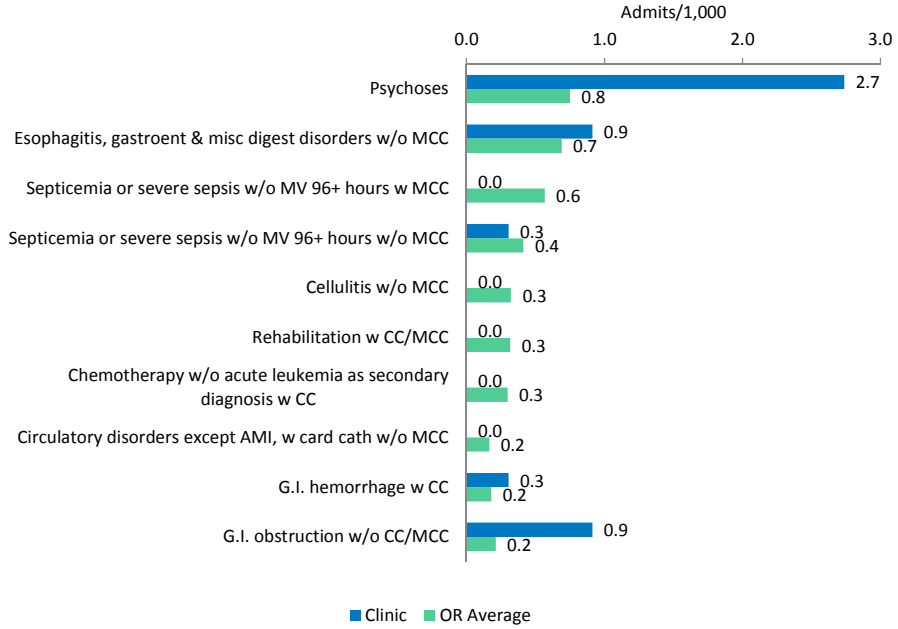
Adult Clinic Comparison Report: Quality, Utilization & Cost

Segment: Commercially Insured Adults age 18-64

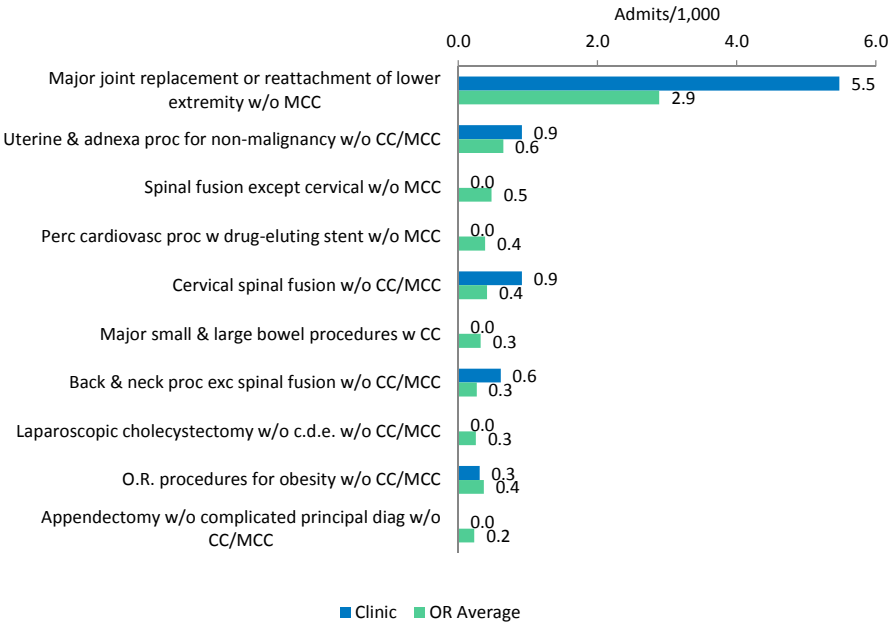
Reporting Period: Jan 2014 – Dec 2014

Inpatient Diagnoses

Non-Surgical Inpatient Admissions: Top 10 Most Frequent DRGs *

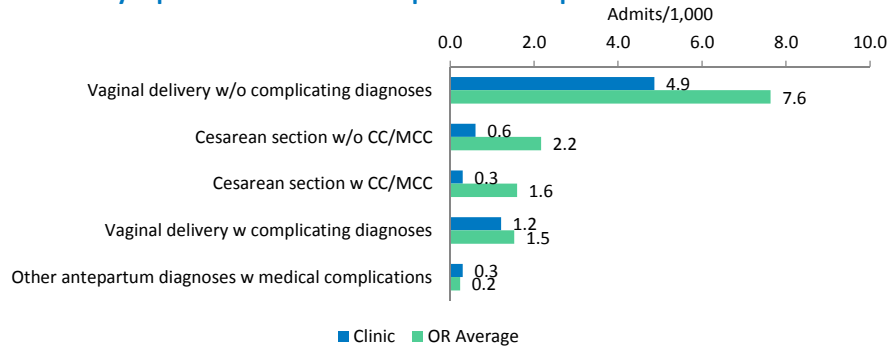


Surgical Inpatient Admissions: Top 10 Most Frequent DRGs *



CC - Complicating or comorbid condition
MCC - Major complicating or comorbid condition

Maternity Inpatient Admissions: Top 5 Most Frequent DRGs *



*** Utilization and Quality measues are for commercial population only and are not risk adjusted.**

OR Average is the average for the patients attributed to clinics receiving these reports.

This work is based on the patented algorithm of HealthPartners, Inc. (Bloomington, MN) and is used with their permission.

Adult Clinic Comparison Report: Quality, Utilization & Cost

Segment: Commercially Insured Adults age 18-64

Reporting Period: Jan 2014 – Dec 2014

Chronic Conditions

Chronic Condition Patient Summary

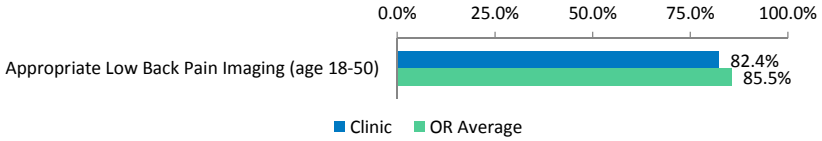
	Clinic		OR Average				
	Patients	Adj PMPM	PMPM	TCI	=	RUI	x Price Index
Active cancer	**158**	**$1,228.56**	$1,834.11	**0.67**		**0.65**	1.02
Liver disease (Hepatitis, Cirrhosis) – post transplant	**32**	**$619.30**	$1,229.26	**0.50**		**0.41**	1.22
Severe rheumatic & other connective tissue disease	**44**	**$1,379.57**	$1,534.82	**0.90**		**0.73**	1.23
Severe heart failure/transplant/rheumatic heart disease	**33**	**$1,459.52**	$1,529.01	**0.95**		**0.92**	1.04
Coronary Artery Disease without diabetes	**146**	**$800.07**	$1,184.04	**0.68**		**0.70**	0.97
Diabetes without Coronary Artery Disease	**153**	**$645.07**	$725.18	**0.89**		**0.78**	1.14
Hypertension (Includes stroke & peripheral vascular disease)	**425**	**$529.15**	$507.76	**1.04**		**0.84**	1.25
Asthma	**163**	**$474.91**	$505.45	**0.94**		**0.81**	1.16
Neurologic disorders	**154**	**$777.31**	$846.54	**0.92**		**0.84**	1.10
Chronic musculosketetal/osteo arthritis/osteporosis	**312**	**$611.78**	$798.70	**0.77**		**0.69**	1.12

Note: The Chronic Condition Patient Summary is limited to conditions with 30 or more attributed patients.

Chronic Conditions: Q Corp uses Milliman's proprietary Chronic Condition Hierarchical Groups (CCHG) for chronic conditions. Each patient is assigned to one CCHG according to a hierarchical algorithm developed by Milliman. Patients with comorbidities will be reported under the CCHG that falls highest in the hierarchy.

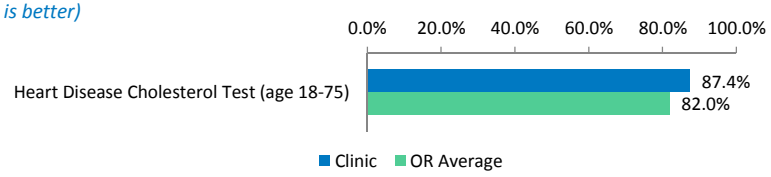
Musculoskeletal Conditons

(higher is better)



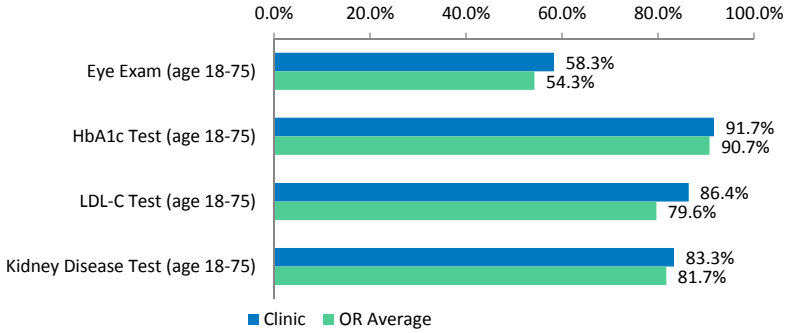
Care for Cardiovascular Conditions

(higher is better)



Comprehensive Diabetes Care

(higher is better)



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Adult Clinic Comparison Report: Quality, Utilization & Cost

Segment: Commercially Insured Adults age 18-64
Reporting Period: Jan 2014 – Dec 2014

OREGON HEALTH CARE QUALITY CORPORATION

Pharmacy

Pharmacy by Category

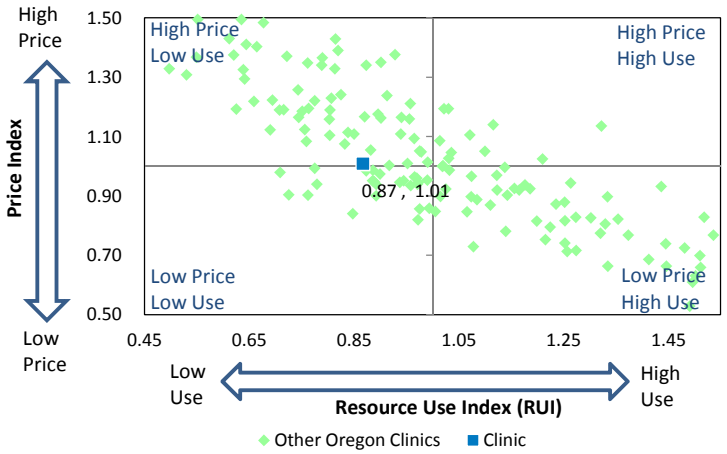
	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	x Price Index
Single Source Brand	**$47.29**	$49.35	**0.96**	0.95	1.01
Generic	**$22.78**	$27.68	**0.82**	0.86	0.96
Multi-Source Brand	**$4.65**	$8.34	**0.56**	0.50	1.11
Total	**$74.72**	$85.37	**0.88**	0.87	1.01

Single Source Brand: A prescription drug manufactured by only one company. No generic equivalent is available.
Multi-Source Brand: A prescription drug that is manufactured by more than one manufacturer. These drugs are available both as a brand-name and as a generic.

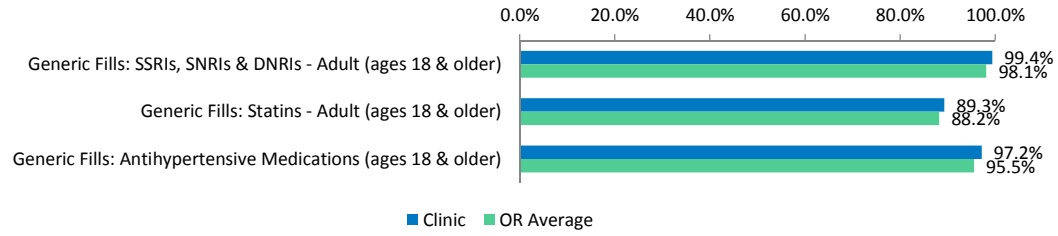
Top 10 Therapeutic Classes with % Generic Fills

	Clinic Adj PMPM	Clinic % Generic	OR Average PMPM	OR Average % Generic	TCI	= RUI	x Price Index
Analgesics - Anti-Inflammatory	**$8.53**	**81%**	$9.70	80%	**0.88**	0.87	1.02
Psychotherapeutic and Neurological Agents - Misc.	**$12.17**	**16%**	$8.41	11%	**1.45**	1.19	1.21
Antidiabetics	**$4.75**	**65%**	$8.22	65%	**0.58**	0.56	1.03
Antiasthmatic and Bronchodilator Agents	**$3.68**	**26%**	$5.13	28%	**0.72**	0.71	1.02
Antidepressants	**$3.29**	**95%**	$4.34	93%	**0.76**	0.79	0.96
Antivirals	**$0.50**	**89%**	$4.01	87%	**0.12**	0.23	0.55
Dermatologicals	**$3.29**	**84%**	$3.27	77%	**1.01**	1.07	0.94
Antihyperlipidemics	**$3.33**	**92%**	$3.06	82%	**1.09**	1.12	0.97
ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants	**$2.26**	**95%**	$3.00	94%	**0.75**	0.70	1.08
Analgesics - Opioid	**$2.19**	**82%**	$2.82	85%	**0.78**	0.76	1.03

Pharmacy Price vs. Resource Use Comparison by Clinic



Medication Management



Pharmacy includes all drugs covered by the patient's pharmacy benefit.

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Adult Clinic Comparison Report: Quality, Utilization & Cost

Segment: Commercially Insured Adults age 18-64
Reporting Period: Jan 2014 – Dec 2014

Year over Year Change Summary 2012 - 2014

Clinic Risk Adjustment Summary

Risk adjustment factors and costs are shown below. Risk adjustment factors are most affected by patients with the highest illness burden. A small number of patients can have an effect on these factors.

	2012	2013	2012 to 2013 change	2014	2013 to 2014 change
ACG Risk Adjuster					
Clinic	1.04	1.11	0.07	1.13	0.02
OR Average	1.00	1.00	0.00	1.00	0.00
Risk-Adjusted Allowed Amount PMPM					
Clinic	458.73	434.88	-5.2%	448.05	3.0%
OR Average	468.75	465.13	-0.8%	472.59	1.6%

Patient Characteristics

Below is the number of patients attributed to your organization that were used for the specified year to calculate the characteristics of your clinic. Also shown are the number of high cost patients for 2014. This detail was not available for 2012 or 2013 but will be included for each year going forward. This number can give you an idea of how patients with higher illness burden may be affecting the risk adjustment score.

	2012	2013	2012 to 2013 change	2014	2013 to 2014 change
Attributed Patients					
Clinic	3,175	3,395	6.9%	3,938	16.0%
OR Average	159,233	177,049	11.2%	178,136	0.6%
Number of High Cost Patients					
Annual costs over $100k	NA	NA	NA	24	NA

OR Average is the average for the patients attributed to clinics receiving these reports.
OR Average for TCI, RUI and Price indices are 1.00.
Per TCOC methodology, claims cost is capped at $100,000 per individual per year.

Year over Year Change Summary

Total Cost, Resource Use and Price Indices are shown below along with their year over year change. These indices can be affected by a number of factors, for example: changes in clinic practice, patient characteristics and patient risk adjustment. Q Corp is working to understand these causes and intends to include mitigating adjustments for future reporting.

	2012	2013	2012 to 2013 change	2014	2013 to 2014 change
Overall					
Total Cost Index (TCI)	0.98	0.93	-0.05	0.95	0.02
Resource Use Index (RUI)	0.97	0.90	-0.07	0.88	-0.02
Price Index	1.01	1.04	0.03	1.08	0.04

Year over Year Change Summary by Service Category

	2012	2013	2012 to 2013 change	2014	2013 to 2014 change
Professional					
Total Cost Index (TCI)	1.12	1.10	-0.02	1.07	-0.03
Resource Use Index (RUI)	1.03	0.99	-0.04	0.97	-0.02
Price Index	1.09	1.10	0.01	1.10	0.00
Outpatient Facility					
Total Cost Index (TCI)	0.71	0.66	-0.05	0.71	0.05
Resource Use Index (RUI)	0.79	0.68	-0.11	0.72	0.04
Price Index	0.90	0.96	0.06	1.00	0.04
Inpatient Facility					
Total Cost Index (TCI)	0.96	0.92	-0.04	1.10	0.18
Resource Use Index (RUI)	0.90	0.76	-0.14	0.93	0.17
Price Index	1.06	1.21	0.15	1.19	-0.02
Pharmacy					
Total Cost Index (TCI)	1.12	1.03	-0.09	0.88	-0.15
Resource Use Index (RUI)	1.08	1.02	-0.06	0.87	-0.15
Price Index	1.04	1.01	-0.03	1.01	0.00

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Q Corp Clinic Comparison Report FAQs

General FAQs

Why is Q Corp producing these reports?
Three years ago, Q Corp's Board of Directors and committee members made a bold decision to move beyond quality and utilization to add cost of care to its measurement initiative. Our shared goal is to help multiple stakeholders achieve the Triple Aim of better health, better quality of care and lower costs. Based on strong support, we set out to develop cost of care reports. These reports reflect an initial step on this journey. This is the second year Q Corp is sending out these reports to primary care clinics across the state.

How are these reports different from Q Corp's other reports?
These reports contain information on cost, utilization and quality. The quality measures should be familiar to clinics as they are the same measures which Q Corp runs and reports bi-annually in private reports to clinics on our provider portal: http://q-corp.org/reports/provider-reports. The Clinic Comparison reports allow clinics to review cost and utilization and make connections to the quality of care that patients are receiving.

What Clinic Comparison Report content will be reported to other audiences?
Q Corp believes that in order to reduce health care costs, all stakeholders must have access to more information about the cost of care. Q Corp has committed to sharing information with a broader audience after two rounds of private reporting.

- Health Plans: Within the next few months, Q Corp will be sharing the Clinic Comparison Reports with the health plans (Bridgespan, Moda Health, Oregon's Health CO-OP, PacificSource Health Plans, Providence Health Plans, Regence BlueCross BlueShield of Oregon, and Tuality Health Alliance) that voluntarily contributed their cost data to this effort. The Cost of Care Steering Committee has approved this important next step in working collaboratively to address health care costs in Oregon.
- Public Reporting: Q Corp currently reports quality and utilization metrics: http://q-corp.org/compare-your-care. Because this is a newer measure to Q Corp, we are testing and validating it, and will continue to do so until we are confident they reflect our mission to make accurate and reliable data available to the public. Q Corp will work directly with providers, consumers and other stakeholders to test the validity and utility of the measures in Oregon before any information is reported publicly. Clinic level public reporting will be reviewed by Q Corp's Measurement & Reporting Committee and Cost of Care Steering Committee before reporting.

How are these reports different from the Clinic Comparison Reports I received in April 2015?
These reports cover the period between January 2014 and December 2014, providing more up-to-date information. Also, Q Corp and its data vendor have made refinements to the calculations for the cost measures since the April 2015 pilot. Additionally, a new page showing 2012-2014 year over year changes has been added.

How is "cost" defined?
For purposes of the Clinic Comparison Reports, "cost of care" refers to the cost for the purchaser of care- the individual or organization paying for health care services- not the cost to a provider to deliver the care. Costs in the report are based on total allowed amounts, all payments from the health plan and the patient for one year.

Attribution FAQs

What information is included in the report?
Reports are based on commercial claims data from the Q Corp claims database, which includes claims data on 85% of the fully insured population and 23% of the self-insured population in Oregon, and uses a 12-month reporting period (January 2014-December 2014) with three months run-out.

Approximately what is the percent of my clinic's population covered by these reports?
For Oregon overall, Q Corp is calculating the Total Cost of Care measures for about 35% of the commercial population, excluding patients covered by Medicaid and Medicare. The cost measures are limited to patients between 1 and 64 years old, and some carriers are not allowing us to use their data for cost reporting. Your clinic may have a lower percentage of its total population represented in this report due to carrier mix or a higher percentage of Medicare and Medicaid patients.

How are patients and their costs attributed to my clinic?

- Clinic reports are limited to commercial patients.
- Patient panels are created using a claims-based attribution methodology. Patients are attributed to the Primary Care Provider (PCP) that they have had the most visits with over a 24 month period. In the event of a "tie," patients are attributed to the provider they have most recently seen. Clinics are able to review their lists of attributed patients upon request.
- Only patients assigned to PCPs in Q Corp's provider directory were included. If a patient received care solely from specialists, urgent care clinics or other providers not included in the provider directory, they were not assigned a PCP (unattributed).
- If there were no office visit claims for a PCP in Q Corp's provider directory, the patient is not attributed.
- Only commercially-insured patients ages 1-64 who were enrolled in coverage for at least nine months are included.
- There are separate reports for pediatric (ages 1-17) and adult (ages 18-64) populations.
- Annual costs over $100,000 for any individual patient are excluded.

Data FAQs

Why is the data from 2014?
Multiple factors affect the timing and release of clinic reports.

- Claims Lag: The clinic reports released in spring 2016 reflect commercial claims data incurred January 2014 through December 2014 and paid through March 2015. There is a lag (i.e. run-out) of three months beyond the completion of the reporting period.
- Data Processing: Following the completion of claims run-out, the data suppliers must extract the records from their database and send them to our data vendor. Records must be checked for consistency and plausibility, and anomalies must be investigated and corrected, before the process of combining and cross-walking the data can begin. Measures must then be run on the data and validated. Finally, the reports must be produced. The process from receiving the completed data set to producing final reports typically takes 60 to 90 days.

Why are my clinic's results different from the Clinic Comparison Report I received in April 2015?
For cost and the cost indices (TCI, RUI), clinics will see changes from one reporting period to the next. The cost indices reduce variation by limiting to adult or pediatric populations, by capping costs for any individual and by limiting to a commercial population, but variation still exists. Changes in the services patients use for a particular condition or the price of those services will cause changes in the costs reported. Risk adjustment accounts for much of the variation in expected costs, but not all of it.

How are these reports different from performance reports clinics might be getting from health plans?
Data in these reports is aggregated across multiple commercial health plans, allowing a clinic to understand its data and identify practice patterns across a larger group of patients.

Why was a minimum panel size of 600 used for reporting?
HealthPartners® has tested the TCOC measures at various *n* sizes; however, they are National Quality Forum (NQF) endorsed at the 600 patient panel size. HealthPartners® recommends a minimum panel size of 600 attributed patients for reliable cost comparisons.

Are the costs in these reports risk-adjusted?
Yes. Costs are risk-adjusted at the member level using the Johns Hopkins ACG system, which weights patients based on disease patterns, age and gender.

How does risk adjustment work?
Risk adjustment is a method of using characteristics of a patient population to estimate the population's illness burden. Diagnoses, age and gender are characteristics that are often used. Although risk adjustment can be a helpful tool, it does not account for all variation between populations. As Q Corp has reviewed clinic risk adjuster scores and costs year over year, we see variation in some clinics. Q Corp is actively investigating methods to mitigate some of this variation.

What is the difference between the risk adjusted PMPM and the raw PMPM?
The raw PMPM (Per Member Per Month) amount is the total allowed amount (payments from the health plan and the patient combined) paid in health care costs for all attributed patients, divided by the number of member months. Annual per member costs are capped at $100,000. The adjusted PMPM is calculated using the raw PMPM and risk adjustment. The adjusted PMPM for different populations can then be compared regardless of differences in the populations' characteristics.

Why are the reports based only on commercial data?
The HealthPartners® Total Cost of Care methodology, which Q Corp is using for these reports, has only been endorsed by the NQF for use with commercial claims data. Q Corp is working with several regional and national partners to explore the feasibility of creating similar reports for the Medicare and/or Medicaid populations.

How are the items ordered in the PMPM by service category charts?
Service categories are arranged in descending order based on the Oregon Average PMPM.

What is the "Oregon Average" that is shown in the report?
The Oregon Average is calculated based on the combination of all the clinic panels in the report release. Separate averages are calculated for the Adult and Pediatric reports.

Why are certain numbers highlighted?
The blue highlights indicate that the number is at least 10% above the Oregon Average. This is approximately one standard deviation above the mean.

How are patients with multiple chronic conditions categorized?

- Q Corp uses Milliman's proprietary Chronic Condition Hierarchical Groups (CCHGs) to identify patients with chronic conditions.
- Each patient is assigned to **one** CCHG according to a hierarchical algorithm developed by Milliman.
- Patients with comorbidities will be reported under the CCHG that falls highest in the hierarchy. For example, suppose you have a patient with hypertension and a GI disorder. Since hypertension falls higher in the hierarchy than GI disorders, that patient will fall in the hypertension category.
- This categorization method is reflected on pages 1 and 7 of the report.
- The "Chronic Condition Patient Summary" on page 7 of the report shows up to 10 Chronic Conditions with the average costs for each condition. Conditions are shown in same hierarchy order as page 1 and must have at least 30 patients to be shown.

Why is 2013 cost information on the Year over Year page different than what I received last year?
Since the Clinic Comparison Reports were released last April, Milliman has made changes to how the Total Cost of Care measures are calculated, and Q Corp has been working with Milliman to ensure all specifications are being followed. Milliman has rerun the 2013 data and due to the changes made, PMPMs and the Total Cost Indices have changed.

Are there other changes in how results are calculated?
There was a change in the specifications for calculating the Pharmacy Resource Use Index and Price Index. For 2012 and 2013, pharmacy utilization was based on days' supply. For 2014, the specification changed to pill count.

Why are all the inpatient, outpatient, professional and pharmacy costs attributed to just PCPs?

- The HealthPartners® methodology uses a patient-centered attribution approach that includes all care given to a patient.
- While it is true that primary care providers may not have full control over total costs or resource use, they can influence and develop partnerships and processes with colleagues, specialists and hospitals to ensure care is coordinated.
- For more information regarding the method for attribution, please see the Cost of Care technical appendix online at http://www.q-corp.org/sites/qcorp/files/Total Cost of Care - Technical Appendix April 2016.pdf

Can my clinic have access to more detailed data?
Upon request, Q Corp can provide a clinic with a list of its attributed patients. If you are a medical group, an IPA, or an ACO, and are interested in receiving a custom report that includes information from multiple clinics, please email costofcare@q-corp.org.

Technical Assistance FAQs

Will specific technical assistance about how to use the reports within a clinic be provided?

- Our current round of funding allows for limited development of training and technical assistance solutions to assist clinics with using the reports in meaningful ways. Through both regional and national collaborations, Q Corp is exploring a variety of options to make this work understandable and informative to clinics. We are working with partners to develop solutions that will assist clinics in interpreting the results, conducting additional analysis and taking appropriate actions.
- We know there is a lot of work to do in this area, and we welcome and value ideas and suggestions about how to incorporate Oregon clinics in developing and testing these items. Q Corp has convened a workgroup to assist with these efforts. Potential solutions that have been prioritized include: group roll-up reports, webinars and newsletters, a Train the Trainer program, and customized reports on utilization. If you have suggestions, or are interested in receiving technical assistance related to analyzing or reducing costs, please email us at costofcare@q-corp.org.

Where can I find additional information about the Clinic Comparison Reports?
Additional information can be found on our website: http://q-corp.org/our-work/costofcare.

Examples

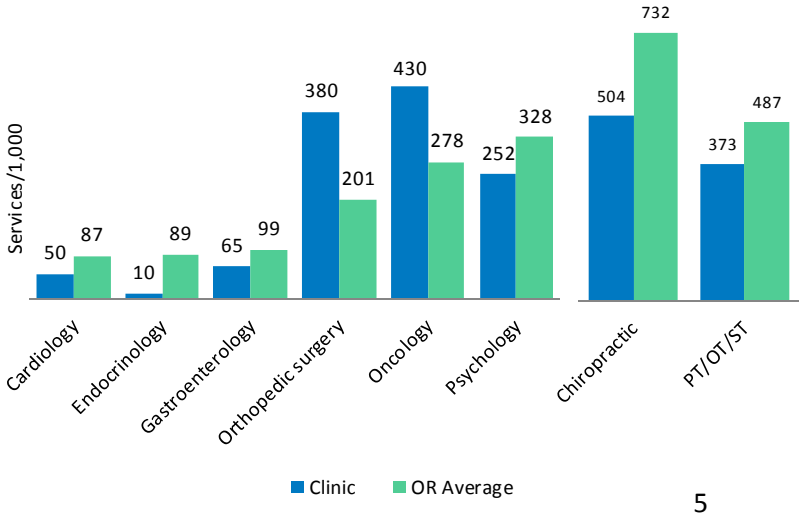
What do I do with these clinic reports? Where do I look for opportunities?
The goal of the Clinic Comparison Reports is to identify clinic variation in cost, quality and utilization. The measures are designed to give each clinic a detailed understanding of how the care their patients receives differs from the average, which enables practices to create action plans targeted at improving specific aspects of their patients' care. Some suggested starting points and areas to consider:

- Where do your clinic's TCI, Price Index and RUI differ substantially from the Oregon average?
- Are there areas where your clinic has a substantially higher Price Index than RUI? Higher RUI than Price Index?
- Are there known or suspected service categories of high cost to your clinic? If so, does the report reflect this and provide more detailed information?

Examples of where and how clinics can and have used the clinic report information:

1. Suppose that, on page 2 (see sample results to the right), your clinic's maternity RUI indicates average resource use and the TCI indicates higher-than-average cost. This may lead you to seek out lower cost, but still high-quality, facilities that your patients can use for maternity care.

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	Price x Index
PCP Office/Home Visits	$25.82	$24.91	1.04	1.13	0.92
Surgery/Anesthesia	$24.55	$23.41	1.05	1.09	0.96
Specialist Office/Home Visits	$14.35	$17.58	0.82	0.86	0.95
Office Administered Drugs	$11.96	$10.11	1.18	1.17	1.01
Office Radiology	$7.04	$9.65	0.73	0.77	0.95
Physical Therapy	$9.51	$9.26	1.03	1.06	0.97
Office Pathology/Lab	$8.77	$8.45	1.04	1.21	0.86
Office Surgery	$9.71	$8.33	1.16	1.19	0.98
DME & Home Health	$6.29	$6.45	0.98	0.89	1.10
Preventive Physical/Well Baby Ex	$6.55	$6.35	1.03	1.13	0.91
Preventive Labs & Tests	$4.97	$5.27	0.94	0.96	0.98
Behavioral Health	$3.48	$5.11	0.68	0.75	0.91
Maternity	$8.49	$4.23	1.22	1.00	1.22
IP/OP Radiology/Pathology/Lab	$5.90	$4.13	1.43	1.34	1.07
ER Visits and Observation Care	$2.56	$3.06	0.84	0.93	0.90
Chiropractor	$3.81	$2.54	1.50	1.44	1.04
Preventive Immunizations	$1.45	$1.79	0.81	0.96	0.84
Inpatient Visits	$2.06	$1.73	1.19	1.13	1.05
Cardiovascular	$1.75	$1.58	1.11	1.01	1.11
Urgent Care Visits	$3.15	$1.23	2.57	2.75	0.93
All Others	$11.06	$11.96	0.93	0.94	0.98
Total	$173.24	$167.12	1.04	1.09	0.95

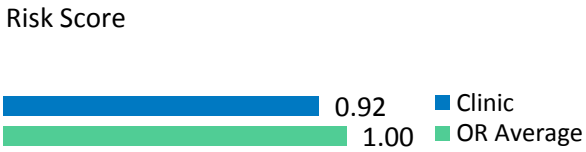


2. Specialty utilization (page 2) – are your patients using more or fewer specialist services than the state average? If they are using more, can you identify any specialty practices to which you often refer patients who might be treating patients more intensively than necessary?

3. Are there any outpatient costs (page 3) that are surprising? If you are looking at reports across clinics owned by the same medical group, are there differences in the patient populations that are being treated?

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	Price x Index
Outpatient Surgery	**$46.99**	$48.68	**0.97**	1.30	0.74
Emergency Room	**$16.23**	$18.25	**0.89**	0.99	0.90
Radiology - CT/MRI/PET	**$7.73**	$7.96	**0.97**	1.11	0.87
Pathology/Lab	**$8.02**	$7.56	**1.06**	1.10	0.96
Radiology General	**$7.28**	$7.41	**0.98**	1.46	0.67
Preventive	**$5.07**	$6.72	**0.75**	0.96	0.79
Other	**$1.88**	$5.84	**0.32**	0.36	0.89
Pharmacy	**$1.00**	$5.56	**0.18**	0.22	0.82
PT/OT/ST	**$2.31**	$4.25	**0.54**	0.55	0.99
Cardiovascular	**$1.63**	$2.81	**0.58**	0.70	0.82
Behavioral Health	**$0.14**	$0.50	**0.27**	0.22	1.24
Total	**$98.27**	$115.53	**0.85**	1.07	0.79

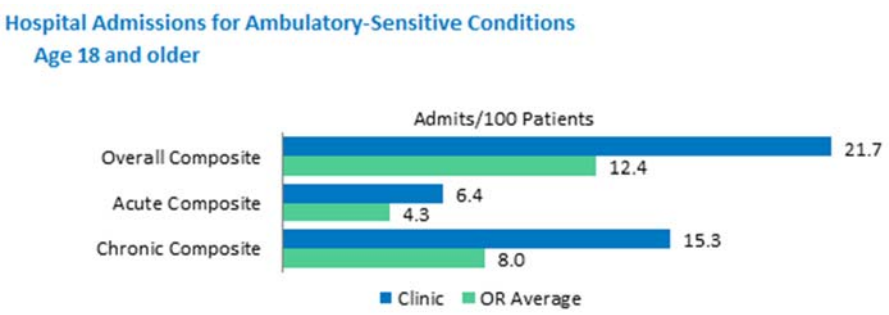
4. Your clinic's retrospective risk score is provided in the cover letter. Supposing this shows that your practice has a lower disease burden than the state average (see sample below), you might look at the rate of acute inpatient admits and days (see page 4 of the report). If your rate is higher than average, you might want to explore causes.



5. Suppose page 4 shows your clinic has high costs on imaging due to high CT utilization and a higher price, while MRI is lower price and has higher than average resource utilization. Are alternative locations for CT services available? It may be valuable to understand why more services are being delivered than the state average. Do you have a lot of patients with cancer? Are there any unnecessary or duplicative services you could avoid? Could the orthopedic surgeons to which your practice refers be using higher cost facilities or requesting multiple images?

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	Price x Index
Diagnostic	**$11.13**	$10.56	**1.05**	1.09	0.97
MRI	**$8.43**	$8.43	**1.00**	1.13	0.88
CT Scan	**$6.36**	$4.94	**1.29**	1.16	1.11
Therapeutic/Radiation Oncology	**$3.35**	$3.80	**0.88**	0.89	0.99
PET	**$0.50**	$0.48	**1.06**	0.98	1.08

6. Is your practice's Hospital Admissions for Ambulatory-Sensitive Conditions (page 4) admission rate higher than the average? There may be an opportunity to evaluate primary care protocols for these conditions and implement additional patient management strategies.



7. "The Chronic Condition Patient Summary" (page 7) may indicate differences in cost and utilization between your practice and the average for a list of clinical conditions. Does it cost more or less to manage musculoskeletal conditions in your practice? Are more or fewer resources being used than the state average? The sample clinic report below shows higher cost and resource use than the benchmark. Consider the quality of care being delivered. Does it reflect the higher intensity of care shown in the cost and resource use?

Chronic Condition Patient Summary

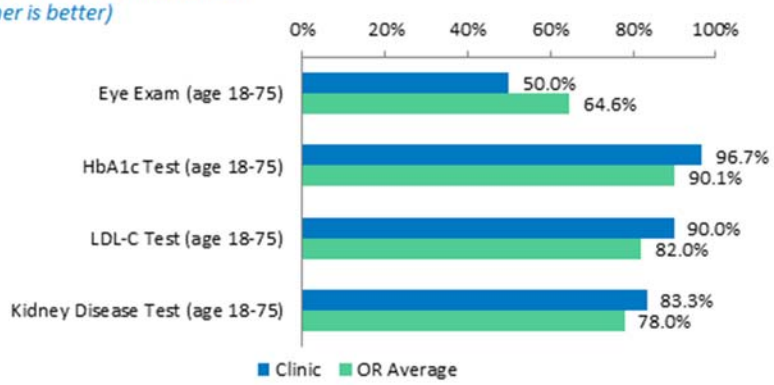
	Clinic				OR Average					
	Patients	Prevalence	Raw PMPM	Adj PMPM	Prevalence	Adj PMPM	TCI	= RUI	x	Price Index
Hypertension (Includes stroke & peripheral vascular disease)	70	2.0%	$1,204.37	$1,108.02	3.9%	$813.29	1.36	1.31		1.04
Diabetes without Coronary Artery Disease	38	1.1%	$2,740.71	$2,521.45	3.4%	$1,651.90	1.53	1.44		1.06
Chronic musculosketetal/osteo arthritis/osteporosis	32	0.9%	$3,899.52	$3,587.56	2.4%	$3,137.90	1.14	1.03		1.11
Other chronic conditions	31	0.9%	$1,504.88	$1,384.49	2.9%	$1,142.32	1.21	1.01		1.20

8. If your practice has higher-than-average ED rates (page 4), this may indicate an opportunity to educate patients on primary care access and appropriate emergency room use. Are there alternative primary care access points that could encourage improved primary care coordination?

Emergency Department Utilization *
(lower is better)

	Clinic	Benchmark
ED Visits/1000	260.1	131.8

Comprehensive Diabetes Care
(higher is better)



9. Are there any quality measures in which your clinic looks significantly different than the state average? If so, does this present an opportunity to develop quality improvement initiatives around these areas?

10. Suppose page 8 shows that your clinic has a higher than average resource use for Multi-Source Brand prescriptions. Are there opportunities to prescribe generic drugs in place of brand drugs?

Pharmacy by Category

	Clinic Adj PMPM	OR Average PMPM	TCI	= RUI	x Price Index
Single Source Brand	**$43.40**	$41.34	**1.05**	1.07	0.98
Generic	**$19.17**	$21.23	**0.90**	0.94	0.96
Multi-Source Brand	**$5.02**	$4.82	**1.04**	1.03	1.01
Total	**$67.59**	$67.39	**1.00**	1.01	1.00