



**Statewide Executive Summary Report**  
**HealthChoice participating organizations**  
**HEDIS® 2017 Results**

*Prepared for:*  
**Maryland Department of Health**  
*(This document includes results of measures not designated for public reporting.  
This report is not for public distribution.)*

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## INTRODUCTION

Healthcare Effectiveness Data and Information Set (HEDIS®) is one of the most widely used sources of healthcare performance measures in the United States. The program is maintained by the National Committee for Quality Assurance (NCQA). NCQA develops and publishes specifications for data collection and result-calculation in order to promote a high degree of standardization of HEDIS measures. Reporting entities are required to register with NCQA and undergo an annual NCQA HEDIS Compliance Audit™. To ensure audit consistency, only NCQA-licensed organizations using NCQA certified auditors may conduct a HEDIS Compliance Audit. The audit conveys sufficient integrity to HEDIS data, such that it can be released to the public to provide consumers and purchasers with a means of comparing healthcare organization performance.

Maryland Department of Health (MDH) contracted with MetaStar, Inc. (MetaStar), a NCQA-Licensed Organization, to conduct HEDIS Compliance Audits of all HealthChoice organizations and to summarize the results.

## BACKGROUND

The Maryland Medicaid program implemented HealthChoice, a comprehensive managed care program, in June of 1997 after receiving a waiver from the Centers for Medicare and Medicaid Services (CMS) of the requirements in §1115 of the Social Security Act. HealthChoice allows eligible Medicaid recipients to enroll in the participating managed care organization of their choice. There are currently eight organizations participating in HealthChoice, with a total of 1,133,369 enrollees as of December 31, 2016.

Within MDH, the HealthChoice & Acute Care Administration is responsible for the quality oversight of the HealthChoice program. MDH continues to measure HealthChoice program clinical quality performance and enrollee satisfaction using initiatives including HEDIS and Consumer Assessment of Healthcare Providers Systems (CAHPS®) reporting. Performance is measured at both the organization level and on a statewide basis. HEDIS and CAHPS results are incorporated annually into a HealthChoice Health Plan Performance Report Card developed to assist HealthChoice enrollees to make comparisons when selecting a health plan. All eight HealthChoice organizations reported HEDIS in 2017.

For HEDIS 2017, MDH required HealthChoice managed care organizations to report the complete HEDIS measure set for services rendered in calendar year 2016 to Maryland Medical Assistance HealthChoice enrollees. These measures provide meaningful managed care organization comparative information and they measure performance relative to MDH's priorities and goals.

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NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).  
CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

## ACCREDITATION

All Health organizations participating in the HealthChoice program as of January 1, 2013 were required to be accredited by the NCQA no later than January 1, 2015 as per COMAR §10.09.65.02. In addition, according to COMAR §10.09.64.08, any HealthChoice organizations that joined the HealthChoice program after January 1, 2013 are required to be NCQA accredited within 2 years of their effective date as a HealthChoice organization. Current accreditation status for all HealthChoice organizations is listed in the *Organizations Reporting HEDIS in 2017* table.

**Organizations Reporting HEDIS in 2017**

Acronym used in this report	HealthChoice Organization Name	Accreditation Status
ACC	AMERIGROUP Community Care	Commendable
JMS	Jai Medical Systems	Excellent
KPMAS	Kaiser Permanente of the Mid-Atlantic States	Accredited
MPC	Maryland Physicians Care	Commendable
MSFC	MedStar Family Choice	Commendable
PPMCO	Priority Partners MCO	Commendable
UHC	UnitedHealthcare	Accredited
UMHP	University of Maryland Health Partners	Accredited

Accreditation is based on a combination of adherence to accreditation standards, plus a comprehensive evaluation and analysis of clinical performance and consumer experience. A total of 100 points is possible with 50 points based on standards and 50 points on performance and consumer experience. The accreditation levels are used to rate the quality of care provided by health plans to their members. Based on the total number of points achieved, NCQA assigns a level of accreditation as described below:

NCQA Accreditation Levels*
<b>Excellent:</b> NCQA awards its highest accreditation status of Excellent to organizations with programs for service and clinical quality that meet or exceed rigorous requirements for consumer protection and quality improvement.
<b>Commendable:</b> NCQA awards a status of Commendable to organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement.
<b>Accredited:</b> NCQA awards an accreditation status of Accredited to organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations with this status may not have had their HEDIS/CAHPS results evaluated.
<b>Provisional:</b> NCQA awards a status of Provisional to organizations with programs for service and clinical quality that meet some, but not all, basic requirements for consumer protection and quality improvement.
<b>Interim:</b> NCQA awards a status of Interim to organizations with basic structure and processes in place to meet expectations for consumer protection and quality improvement.
<b>Denied:</b> NCQA denies Accreditation to organizations whose programs for service and clinical quality did not meet NCQA requirements during the Accreditation survey.

\* Source: NCQA (2017). *What Accreditation Levels Can a Plan Achieve?* Retrieved from: <http://www.ncqa.org/Programs/Accreditation/health-plan-hp/Accreditation-Levels>

## SECTION ONE - MEASURES DESIGNATED FOR REPORTING

Annually, MDH determines the set of measures required for HEDIS reporting. MDH selects these measures because they provide meaningful managed care organization comparative information and they measure performance pertinent to MDH's priorities and goals. A table showing the history of MDH reporting for each measure is included in Appendix 1.

### **Measures selected by MDH for HealthChoice Reporting**

MDH required Health Choice managed care organizations to report 59 HEDIS measures for services rendered in calendar year 2016. The required set reflected four first-year HEDIS measures for reporting. The four new measures include Follow-Up After Emergency Department Visit for Mental Illness; Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence; Standardized Healthcare-Associated Infection Ratio; and Depression Remission or Response for Adolescents and Adults.

The total reportable measures within four NCQA domain categories are as follows:

### **Effectiveness of Care (EOC): (26 measures)**

- Childhood Immunization Status (CIS)
- Immunizations for Adolescents (IMA)\*
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care (CDC), all indicators except HbA1c Control (<7.0%)
- Statin Therapy for Patients with Diabetes (SPD)
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Appropriate Testing for Children with Pharyngitis (CWP)
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
- Chlamydia Screening in Women (CHL)
- Use of Imaging Studies for Low Back Pain (LBP)
- Annual Monitoring for Patients on Persistent Medications (MPM)
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
- Medication Management for People with Asthma (MMA)
- Controlling High Blood Pressure (CBP)
- Adult BMI Assessment (ABA)
- Asthma Medication Ratio (AMR)
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
- Pharmacotherapy Management of COPD Exacerbation (PCE)
- Persistence of Beta Blocker Treatment after a Heart Attack (PBH)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Lead Screening in Children (LSC)
- Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
- Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

\*Measure contains a first-year numerator (Combination 2) that will not be publically reported for HEDIS 2017.

### **Access/Availability of Care (AAC): (3 measures)**

- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Children and Adolescents' Access to Primary Care Practitioners (CAP)
- Prenatal and Postpartum Care (PPC)

### **Utilization and Risk Adjusted Utilization (URR): (9 measures)**

- Frequency of Ongoing Prenatal Care (FPC)
- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)
- Ambulatory Care (AMB)
  - Report Only “a” Level of Measure (Total)
- Frequency of Selected Procedures (FSP)
- **Standardized Healthcare-Associated Infection Ratio (HAI) – New\*\***
- Inpatient Utilization- General Hospital/ Acute Care (IPU)
  - Report Only “a” Level of Measure (Total)
- Antibiotic Utilization (ABX)
  - Report Only “a” Level of Measure (Total)

### **Health Plan Descriptive Information: (6 measures)**

- Board Certification (BCR)
- Enrollment by Product Line (ENP)
  - Report Only “a” Level of Measure (Total)
- Enrollment by State (EBS)
- Language Diversity of Membership (LDM)
- Race/ Ethnicity Diversity of Membership (RDM)
- Total Membership (TLM)

### **No Benefit (NB) Measure Designations: (14 Measures)**

The NB designation is utilized for measures where MDH has contracted with outside vendors for coverage of certain services. MetaStar and HealthChoice Organizations do not have access to the data. So that plans are not penalized, NCQA allows the health plans to report these measures with a NB designation. The following fourteen measures are reported NB and do not appear in measure specific findings of this report.

- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)
- Antidepressant Medication Management (AMM)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Follow-Up Care after Hospitalization for Mental Illness (FUH)
- **Follow-Up After Emergency Department Visit for Mental Illness (FUM) – New**
- **Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) - New**
- Mental Health Utilization (MPT)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
- Annual Dental Visit (ADV)
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- Identification of Alcohol and Other Drug Services (IAD)

\*\*First-year measure that will not be publically reported for HEDIS 2017.

## **Not Required (NQ) Measure Designations: (1 Measure)**

The NQ designation is utilized for measures which are not required to be reported.

- **Depression Remission or Response for Adolescents and Adults (DRR) New**

## **Measures not reported by MDH for HealthChoice Reporting**

There are two categories of measures that MDH does not utilize for HealthChoice Reporting. They include thirteen Measures Exempt from Reporting and two Measures that have been retired by NCQA for HEDIS 2017.

## **Measures Exempt from Reporting (13 Measures)**

- Comprehensive Diabetes Care
  - HbA1c Control (<7.0%)
- Ambulatory Care
  - Dual Eligibles (AMBB)
  - Disabled (AMBC)
  - Other (AMBD)
- Inpatient Utilization
  - General Hospital / Acute Care: Dual Eligibles (IPUB)
  - General Hospital / Acute Care: Disabled (IPUC)
  - General Hospital / Acute Care: Other (IPUD)
- Identification of Alcohol and Other Drug Services(
  - Dual Eligibles (IADB)
  - Disabled (IADC)
  - Other (IADD)
- Antibiotic Utilization
  - Dual Eligibles (ABXB)
  - Disabled (ABXC)
  - Other (ABXD)
- Relative Resource Use for People with Diabetes (RDI)
- Relative Resource Use for People with Cardiovascular Conditions (RCA)
- Relative Resource Use for People with Hypertension (RHY)
- Relative Resource Use for People with COPD (RCO)
- Relative Resource Use for People with Asthma (RAS)
- Enrollment by Product Line
  - Dual Eligibles (ENPB)
  - Disabled (ENPC)
  - Other (ENPD)
- Utilization of the PHQ-9 to Monitor Depression Systems for Adolescents and Adults (DMS)
- Depression Remission or Response for Adolescents and Adults (DRR)

## **Measures Retired for HEDIS 2017 (2 Measures)**

- Call Answer Timeliness (CAT)
- Weeks of Pregnancy (WOP)



## SECTION TWO - HEDIS METHODOLOGY

The HEDIS-reporting organization follows guidelines for data collection and specifications for measure calculation described in *HEDIS 2017 Volume 2: Technical Specifications*.

### **Data collection**

The health plan pulls together all data sources to include administrative data, supplemental data, and medical record data, typically into a data warehouse, against which HEDIS software programs are applied to calculate measures. The three approaches that may be utilized are defined below:

#### **Administrative Data:**

Refers to data that is collected, processed, and stored in automated information systems. Administrative data includes enrollment or eligibility information, claims information, and managed care encounters. Examples of claims and encounters include hospital and other facility services, professional services, prescription drug services, and laboratory services. Administrative data are readily available, are inexpensive to acquire, are computer readable, and typically encompass large populations.

#### **Supplemental Data**

NCQA defines supplemental data as atypical administrative data, (i.e., not claims or encounters). Sources include immunization registry files, laboratory results files, case management databases, and electronic health record databases. There are two distinct categories of supplemental data with varying requirements for proof-of-service. The most stable form is Standard Supplemental Data which is from a database with a constant form that does not change over time. Nonstandard Supplemental Data is in a less stable form and may be manipulated by human intervention and interaction. Non-standard Supplemental Data must be substantiated by proof-of-service documentation and is subject to primary source verification yearly.

#### **Medical Record Data**

Data abstracted from paper or electronic medical records may be applied to certain measures, using the NCQA-defined hybrid methodology. HEDIS specifications describe statistically sound methods of sampling, so that only a subset of the eligible population's medical records need to be chased. NCQA specifies hybrid calculation methods, in addition to administrative methods, for several measures selected by MDH for HEDIS reporting. Use of the hybrid method is optional. NCQA maintains that no one approach to measure calculation or data collection is considered superior to another. From organization to organization, the percentages of data obtained from one data source versus another are highly variable, making it inappropriate to make across-the-board statements about the need for, or positive impact of, one method versus another. In fact, an organization's yield from the hybrid method may impact the final rate by only a few percentage points, an impact that is also achievable through improvement of administrative data systems.

## SECTION THREE – MEASURE SPECIFIC FINDINGS EXPLANATION

Three years of HealthChoice results are displayed in Table A, along with the 2017 Maryland Average Reportable Rate (MARR). Table A1 shows three years of the MARR for the past three years. Due to NCQA licensing restrictions, the National HEDIS Mean (NHM) can no longer be displayed on Table A.

In the report, the NMH has also been removed from each table. An “arrow” has been added to indicate if the HealthChoice’s performance score is above, below, or equal to the NHM. Measure-specific descriptions and five-year historical results are located on the pages that follow Tables A and A1.

### **Reference Sources**

#### **Description**

The source of the information is NCQA’s *HEDIS 2017 Volume 2: Technical Specifications*.

#### **Rationale**

For all measures, the source of the information is the Agency for Healthcare Research and Quality (AHRQ) citations of NCQA as of 2017. These citations appear under the Brief Abstract on the Web site of the National Quality Measures Clearinghouse, <http://www.qualitymeasures.ahrq.gov/>

**Summary of Changes for HEDIS 2017** – The source of the text, is the HEDIS 2017 Volume 2: Technical Specifications, incorporating additional changes published in the HEDIS 2017 Volume 2: “October” Technical Update.







HEDIS 2017 Results, (Page 4 of 4)	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017	2017
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PPMCO			UHC			UMHP			MARR
Inpatient Utilization - General Hospital Acute Care (IPU) – Total Inpatient: Total Discharges /1000 MM	5.95	5.83	5.23	9.89	10.06	9.53	6.40	5.49	5.33	6.47	6.84	6.58	7.01	6.67	6.83	6.61	6.75	6.49	7.17	6.60	4.91	6.73	8.59	6.91	6.48
Inpatient Utilization - General Hospital Acute Care (IPU) – Total Inpatient: Total Average Length of Stay	3.96	4.14	4.17	4.12	4.81	4.47	4.59	3.34	3.36	3.66	3.75	3.87	4.03	4.22	4.18	3.85	4.06	4.09	4.12	4.23	4.40	3.72	3.47	3.51	4.01
Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics (aaattot)	0.87	0.85	0.84	0.88	0.87	0.79	0.68	0.67	0.58	1.03	1.10	1.09	0.86	0.88	0.90	0.97	0.97	0.98	0.98	0.92	0.91	0.77	0.85	0.86	0.87
Antibiotic Utilization (ABX) – Average Days Supplied per Antibiotic Script (acattot)	9.29	9.35	9.28	8.983	9.00	8.67	8.977	9.46	9.29	9.40	9.32	9.30	9.23	9.10	8.94	9.39	9.42	9.32	9.26	9.35	9.09	9.21	9.28	9.32	9.15
Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics of Concern (adattot)	0.35	0.35	0.34	0.29	0.29	0.26	0.27	0.25	0.22	0.41	0.45	0.45	0.34	0.35	0.36	0.39	0.39	0.40	0.43	0.41	0.40	0.32	0.38	0.38	0.35
Antibiotic Utilization (ABX) – Percentage of Antibiotics of Concern of all Antibiotics (apptot)	40.4%	40.8%	40.35%	33.0%	33.7%	33.08%	40.5%	37.8%	38.16%	39.8%	40.8%	41.26%	40.2%	40.1%	40.49%	40.4%	40.7%	41.51%	43.2%	44.3%	43.74%	42.1%	44.6%	44.32%	40.36%

<sup>1</sup> When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

<sup>2</sup> A lower rate indicates better performance.

ACC: AMERIGROUP Community Care  
PPMCO: Priority Partners

JMS: Jai Medical Systems  
UHC: UnitedHealthcare

KPMAS: Kaiser Permanente of the Mid-Atlantic States  
UMHP: University of Maryland Health Partners

MPC: Maryland Physicians Care  
MARR: Maryland Average Reportable Rate

MSFC: MedStar Family Choice  
NHM: National HEDIS Mean

**Table A1 – Health Plan Descriptive Information**

	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Board Certification (BCR) – Family Medicine: Number of Physicians	739	79	154	624	290	635	800	645
Board Certification (BCR) – Family Medicine: Number Board Certified	456	66	140	384	186	621	572	517
Board Certification (BCR) – Family Medicine: Percent Board Certified	61.7%	83.5%	91.0%	61.5%	64.1%	97.8%	71.5%	80.2%
Board Certification (BCR) – Internal Medicine: Number of Physicians	2985	592	353	1335	506	955	2453	766
Board Certification (BCR) – Internal Medicine: Number Board Certified	2168	548	323	990	340	913	1863	593
Board Certification (BCR) – Internal Medicine: Percent Board Certified	72.6%	92.6%	91.5%	74.2%	67.2%	95.6%	76.0%	77.5%
Board Certification (BCR) – OB/GYN: Number of Physicians	631	144	129	611	177	800	877	566
Board Certification (BCR) – OB/GYN: Number Board Certified	479	119	104	442	88	771	737	387
Board Certification (BCR) – OB/GYN: Percent Board Certified	75.9%	82.6%	80.6%	72.3%	49.7%	96.4%	84.0%	68.4%
Board Certification (BCR) – Pediatrician: Number of Physicians	1486	179	90	952	372	872	1450	574
Board Certification (BCR) – Pediatrician: Number Board Certified	1174	169	87	789	181	849	1175	447
Board Certification (BCR) – Pediatrician: Percent Board Certified	79.0%	94.4%	96.7%	82.3%	48.7%	97.4%	81.0%	77.9%
Board Certification (BCR) – Geriatricians: Number of Physicians	136	33	4	43	15	42	89	35
Board Certification (BCR) – Geriatricians: Number Board Certified	78	31	4	22	7	41	56	27
Board Certification (BCR) – Geriatricians: Percent Board Certified	57.4%	93.9%	100%	51.2%	46.7%	97.6%	62.9%	77.1%
Board Certification (BCR) – Other Specialists: Number of Physicians	5000	1912	901	4676	2341	12045	6004	3321
Board Certification (BCR) – Other Specialists: Number Board Certified	3766	1734	832	3180	1290	11446	4751	1970
Board Certification (BCR) – Other Specialists: Percent Board Certified	75.3%	91.0%	92.3%	68.0%	55.1%	95.0%	79.1%	59.3%
Enrollment by Product Line (ENP) – Shows only total member months for Female	1720867	132283	291712	1263033	488031	1738876	1035557	192278
Enrollment by Product Line (ENP) – Shows only total member months for Male	1445267	146062	247619	1001830	403224	1382957	883879	195134
Enrollment by Product Line (ENP) – Shows only total member months Total	3166134	278345	539331	2264863	891225	3121833	1919436	387412
Enrollment by State (EBS) – Maryland Only	278111	24997	54070	200663	79581	280575	89497	37064

<sup>1</sup> When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

<sup>2</sup> A lower rate indicates better performance.

ACC: AMERIGROUP Community Care      JMS: Jai Medical Systems      KPMAS: Kaiser Permanente of the Mid-Atlantic States  
MPC: Maryland Physicians Care      MSFC: MedStar Family Choice      PPMCO: Priority Partners  
UHC: UnitedHealthcare      UMHP: University of Maryland Health Partners  
MARR: Maryland Average Reportable Rate      NHM: National HEDIS Mean

	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Language Diversity (LDM) – Spoken - English Number	0	0	283	57918	0	0	0	0
Language Diversity (LDM) – Spoken - English Percent	0	0	0.43%	24.5%	0	0	0	0
Language Diversity (LDM) – Spoken - Non-English Number	0	0	1870	4342	0	0	0	67
Language Diversity (LDM) – Spoken - Non-English Percent	0	0	2.9%	1.8%	0	0	0	0.14%
Language Diversity (LDM) – Spoken - Unknown Number	322744	31389	65278	236729	98737	323427	202734	48450
Language Diversity (LDM) – Spoken - Unknown Percent	100%	100%	96.7%	74.0%	100%	100%	100%	99.9%
Language Diversity (LDM) – Spoken - Declined Number	0	0	1	0	0	0	0	0
Language Diversity (LDM) – Spoken - Declined Percent	0%	0%	0%	0%	0%	0%	0%	0%
Race/Ethnicity Diversity (RDM) – White / Total	59098	4041	11305	86844	27779	99958	15248	69338
Race/Ethnicity Diversity (RDM) – White / Percent	18.3%	12.8%	17.3%	36.7%	28.1%	30.9%	34.2%	31.5%
Race/Ethnicity Diversity (RDM) – Black / Total	128080	19880	33147	101356	0	120165	87436	17269
Race/Ethnicity Diversity (RDM) – Black / Percent	39.7%	63.3%	50.8%	42.8%	0%	37.2%	43.1%	35.6%
Race/Ethnicity Diversity (RDM) – American Indian & Alaska Native / Total	0	126	136	49	0	2	0	0
Race/Ethnicity Diversity (RDM) – American Indian & Alaska Native / Percent	0%	.40%	.21%	.02%	0%	0%	0%	0%
Race/Ethnicity Diversity (RDM) – Asian / Total	13104	732	4039	8600	4841	0	11425	1991
Race/Ethnicity Diversity (RDM) – Asian / Percent	4.1%	2.3%	6.2%	3.6%	4.9%	0%	5.6%	4.1%
Race/Ethnicity Diversity (RDM) – Native Hawaiian - Pacific Islander / Total	372	35	45	37	0	11439	256	64
Race/Ethnicity Diversity (RDM) – Native Hawaiian - Pacific Islander / Percent	.12%	.11%	.07%	.02%	0%	3.5%	.13%	.13%
Race/Ethnicity Diversity (RDM) – Other / Total	0	0	1256	0	784	0	0	0
Race/Ethnicity Diversity (RDM) – Other / Percent	0%	0%	1.9%	0%	.80%	0%	0%	0%
Race/Ethnicity Diversity (RDM) – 2+ Races / Total	0	0	7	0	0	0	0	0
Race/Ethnicity Diversity (RDM) – 2+ Races / Percent	0%	0%	.01%	0%	0%	0%	0%	0%
Race/Ethnicity Diversity (RDM) – Unknown / Total	317983	31320	58373	29523	901	323427	0	34345
Race/Ethnicity Diversity (RDM) – Unknown / Percent	100%	100%	100%	100%	100%	100%	100%	0%
Race/Ethnicity Diversity (RDM) – Declined / Total	0	0	117	0	0	0	0	13314
Race/Ethnicity Diversity (RDM) – Declined / Percent	0%	0%	.31%	0%	0%	0%	0%	27.48%
Total Membership – Total membership numbers for each plan	39826390	25009	652697	200861	134360	280884	159829	41181

## SECTION FOUR - MEASURE SPECIFIC FINDINGS

### PREVENTION AND SCREENING-ADULT

#### Adult BMI Assessment (ABA)

##### Description

The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

##### Rationale

Obesity is one of the most pervasive, chronic diseases in the United States and a leading cause of mortality, morbidity, disability, healthcare utilization and healthcare costs. The high prevalence of obesity continues to strain the United States healthcare system. It is a complex, multifaceted, chronic disease that is affected by environmental, genetic, physiological, metabolic, behavioral and psychological components. Obesity is a disease that affects more than one-third of the U.S. adult population, which has been steadily increasing since 1960. Today, approximately 69% of U.S. adults are categorized as being affected by obesity or having excess weight. According to the CDC, an estimated 112,000 excess deaths per year are associated with obesity. Obesity puts individuals at risk for more than 30 chronic health conditions including but not limited to Type 2 diabetes, high cholesterol, hypertension, gallstones, heart disease, sleep apnea, heart failure, and numerous cancers. Healthcare costs of American adults with obesity amount to approximately \$190 billion dollars per year. (Obesity Society, 2016) If current trends continue, total health care costs attributable to obesity could reach \$861 to \$957 billion by 2030 accounting for 16 to 18 percent of U.S. health expenditures (Go et al., 2013)

Guidelines from various organizations, including the Institute for Clinical Systems Improvement (ICSI); the U.S. Preventive Services Task Force (USPSTF); the National Heart, Lung, and Blood Institute (NHLBI); and the Michigan Quality Improvement Consortium, indicate that the first step in weight management is assessment of height and weight in order to calculate a patient's body mass index (BMI). BMI is considered the most efficient and effective method for assessing excess body fat; it is a starting point for assessing the relationship between weight and height, and it is the most conducive method of assessment in the primary care setting (NHLBI, 2001).

##### Summary of Changes to HEDIS 2017

- No changes were made to this measure for HEDIS 2017.

Adult BMI Assessment (ABA)						
	2013	2014	2015	2016	2017	NHM
ACC	61.3%	72.0%	82.4%	85.2%	91.0%	↑
JMS	90.7%	80.2%	98.5%	96.6%	98.0%	↑
KPMAS			98.4%	100.0%	98.0%	↑
MPC	48.7%	70.2%	84.9%	82.4%	89.3%	↑
MSFC	76.4%	82.6%	86.4%	90.3%	90.6%	↑
PPMCO	59.9%	82.9%	89.6%	86.1%	89.6%	↑
UHC	49.1%	68.9%	81.9%	92.7%	90.3%	↑
UMHP		NA <sup>□</sup>	NA <sup>□</sup>	85.4%	88.6%	↑
MARR	65.1%	76.1%	88.9%	89.8%	91.9%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).



## Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)

### Description

The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. This measure assesses whether antibiotics were inappropriately prescribed for healthy adults 18 to 64 years of age with bronchitis and builds on an existing HEDIS measure that targets inappropriate antibiotic prescribing for children with upper respiratory infection (URI).

### Rationale

Antibiotics are most often inappropriately prescribed for adults with acute bronchitis. Antibiotics are not indicated in clinical guidelines for treating adults with acute bronchitis who do not have a co-morbidity or other infection for which antibiotics may be appropriate. Inappropriate antibiotic treatment of adults with acute bronchitis is of clinical concern, especially since misuse and overuse of antibiotics lead to antibiotic drug resistance. Acute bronchitis consistently ranks among the 10 conditions that account for the most ambulatory office visits to United States (U.S.) physicians; furthermore, despite that the vast majority of acute bronchitis cases (more than 90 percent) have a nonbacterial cause, antibiotics are prescribed 65 percent to 80 percent of the time.

### Summary of Changes to HEDIS 2017:

- Revised the allowable gap and anchor date criteria.
- Added instructions to identify ED visits and observation visits that result in an inpatient stay.
- Added two value sets to step 3 of the event/diagnosis criteria (HIV Type 2 Value Set; Disorders of the Immune System Value Set).
- Added a requirement to not include denied claims in the numerator.

<b>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	20.6%	23.88%	24.5%	25.9%	30.0%	↑
<b>JMS</b>	35.5%	35.2%	34.1%	33.0%	37.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	NA <sup>□</sup>	57.1%	↑
<b>MPC</b>	19.9%	22.0%	21.9%	19.5%	21.3%	↓
<b>MSFC</b>	14.1%	15.2%	19.9%	22.8%	20.7%	↓
<b>PPMCO</b>	18.9%	23.94%	24.4%	22.2%	25.5%	↓
<b>UHC</b>	16.0%	20.8%	23.7%	26.0%	25.9%	↓
<b>UMHP</b>		NA <sup>□</sup>	NA <sup>□</sup>	23.1%	25.0%	↓
<b>MARR</b>	20.4%	23.5%	24.7%	24.6%	30.3%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

# PREVENTION AND SCREENING - CHILD

## Childhood Immunization Status (CIS)

### Description

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

	DTaP	IPV	MMR	HiB	Hep B	VZV	PCV	Hep A	RV	Influenza
<b>Combination 2</b>	X	X	X	X	X	X				
<b>Combination 3</b>	X	X	X	X	X	X	X			
<b>Combination 4</b>	X	X	X	X	X	X	X	X		
<b>Combination 5</b>	X	X	X	X	X	X	X		X	
<b>Combination 6</b>	X	X	X	X	X	X	X			X
<b>Combination 7</b>	X	X	X	X	X	X	X	X	X	
<b>Combination 8</b>	X	X	X	X	X	X	X	X		X
<b>Combination 9</b>	X	X	X	X	X	X	X		X	X
<b>Combination 10</b>	X	X	X	X	X	X	X	X	X	X

### Rationale

A basic method for prevention of serious illness is immunization. Childhood immunizations help prevent serious illnesses such as polio, tetanus and hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like mumps and measles. Even preventing "mild" diseases saves hundreds of lost school days and work days, and millions of dollars. Immunizations are considered one of the most successful and cost-effective public health interventions and are responsible for dramatically reducing pediatric morbidity and mortality in the U.S. (DHHS & ODPHP, 2013; Centers for Disease Control and Prevention [CDC], 2012). Although U.S. childhood immunization rates are generally high, some areas remain vulnerable to outbreaks of infection, such as measles (IOM, 2013). In 2013, 159 measles cases were reported in the U.S. – 37 percent in children younger than 5 years (Malani, 2013)

### Summary of Changes to HEDIS 2017:

- Added CVX codes to the measure.
- Added HIV Type 2 Value Set to the optional exclusions.
- Added optional exclusions for the rotavirus vaccine.

<b>Childhood Immunization Status (CIS) Combination 2 (DTaP, IPV, MMR, HiB, Hep B, VZV)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	84.7%	81.3%	83.8%	83.1%	85.0%	↑
<b>JMS</b>	86.1%	86.5%	88.4%	88.7%	91.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	79.5%	73.1%	↑
<b>MPC</b>	76.9%	73.7%	70.8%	84.7%	79.9%	↑
<b>MSFC</b>	85.4%	88.1%	81.8%	85.9%	84.4%	↑
<b>PPMCO</b>	86.8%	83.1%	83.6%	84.5%	83.5%	↑
<b>UHC</b>	70.3%	73.0%	77.4%	83.5%	79.8%	↑
<b>UMHP</b>		NA <sup>□</sup>	50.0%	80.9%	80.8%	↑
<b>MARR</b>	80.2%	80.9%	76.5%	83.8%	82.2%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Childhood Immunization Status (CIS) Combination 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	83.5%	78.2%	81.9%	81.9%	83.0%	↑
<b>JMS</b>	83.7%	86.1%	87.6%	87.3%	88.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	78.2%	70.0%	↑
<b>MPC</b>	74.3%	72.09%	68.2%	82.1%	78.5%	↑
<b>MSFC</b>	83.7%	85.9%	79.3%	83.2%	81.8%	↑
<b>PPMCO</b>	83.8%	80.8%	80.1%	83.0%	82.6%	↑
<b>UHC</b>	66.7%	71.3%	73.7%	80.5%	77.9%	↑
<b>UMHP</b>		NA <sup>□</sup>	43.8%	80.2%	79.3%	↑
<b>MARR</b>	77.7%	79.1%	73.5%	82.1%	80.1%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Childhood Immunization Status (CIS) Combination 4 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	75.9%	73.6%	77.6%	78.9%	80.0%	↑
<b>JMS</b>	80.9%	84.8%	85.2%	86.8%	88.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	78.2%	69.5%	↑
<b>MPC</b>	67.4%	62.8%	64.7%	78.0%	75.7%	↑
<b>MSFC</b>	80.3%	81.3%	76.6%	80.5%	79.3%	↑
<b>PPMCO</b>	73.8%	69.4%	78.5%	79.7%	80.9%	↑
<b>UHC</b>	58.9%	66.2%	67.9%	75.7%	74.7%	↑
<b>UMHP</b>		NA <sup>□</sup>	43.8%	78.2%	76.6%	↑
<b>MARR</b>	71.8%	73.0%	70.6%	79.5%	78.1%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Childhood Immunization Status (CIS)</b>						
<b>Combination 5 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	61.3%	63.9%	63.7%	68.3%	70.0%	↑
<b>JMS</b>	59.4%	71.7%	68.0%	76.4%	73.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	68.0%	55.0%	↓
<b>MPC</b>	55.3%	47.0%	57.1%	59.9%	59.5%	↑
<b>MSFC</b>	56.0%	70.1%	64.5%	67.9%	67.9%	↑
<b>PPMCO</b>	59.6%	54.6%	68.5%	69.0%	69.5%	↑
<b>UHC</b>	52.0%	56.9%	60.1%	61.6%	65.2%	↑
<b>UMHP</b>		NA <sup>□</sup>	37.5%	58.0%	60.6%	↑
<b>MARR</b>	56.3%	60.7%	59.9%	66.1%	65.1%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Childhood Immunization Status (CIS)</b>						
<b>Combination 6 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Influenza)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	49.7%	49.3%	53.0%	52.6%	42.0%	↑
<b>JMS</b>	39.0%	47.8%	46.8%	47.6%	57.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	52.6%	46.3%	↑
<b>MPC</b>	42.4%	37.7%	40.6%	41.8%	42.4%	↑
<b>MSFC</b>	55.2%	59.4%	51.6%	47.9%	49.6%	↑
<b>PPMCO</b>	51.5%	49.5%	54.2%	59.7%	48.8%	↑
<b>UHC</b>	38.2%	44.3%	48.4%	42.6%	44.8%	↑
<b>UMHP</b>		NA <sup>□</sup>	28.1%	41.0%	41.4%	↑
<b>MARR</b>	45.7%	48.0%	46.1%	48.2%	46.5%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Childhood Immunization Status (CIS)</b>						
<b>Combination 7 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	57.8%	60.7%	61.3%	65.7%	68.0%	↑
<b>JMS</b>	59.0%	71.3%	67.2%	76.4%	73.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	68.0%	55.0%	↑
<b>MPC</b>	51.4%	44.0%	55.0%	57.8%	57.9%	↑
<b>MSFC</b>	54.3%	66.7%	62.5%	65.7%	66.2%	↑
<b>PPMCO</b>	56.2%	50.7%	68.5%	67.3%	68.4%	↑
<b>UHC</b>	47.2%	54.7%	57.4%	58.9%	63.5%	↑
<b>UMHP</b>		NA <sup>□</sup>	37.5%	56.7%	59.6%	↑
<b>MARR</b>	53.6%	58.0%	58.5%	64.6%	63.9%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Childhood Immunization Status (CIS)</b>						
<b>Combination 8 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, Influenza)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	47.3%	47.9%	50.9%	51.4%	42.0%	↑
<b>JMS</b>	39.0%	47.4%	45.6%	47.2%	57.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	52.6%	46.0%	↑
<b>MPC</b>	38.7%	34.9%	38.5%	40.1%	41.4%	↑
<b>MSFC</b>	53.5%	56.2%	49.4%	47.2%	48.2%	↑
<b>PPMCO</b>	48.3%	44.4%	53.5%	57.5%	48.4%	↑
<b>UHC</b>	35.3%	41.4%	46.2%	40.9%	43.1%	↑
<b>UMHP</b>		NA <sup>□</sup>	28.1%	40.3%	40.6%	↑
<b>MARR</b>	43.6%	45.4%	44.6%	47.1%	45.8%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Childhood Immunization Status (CIS)</b>						
<b>Combination 9 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV, Influenza)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	38.5%	42.4%	43.5%	46.8%	37.0%	↑
<b>JMS</b>	29.5%	40.9%	36.4%	42.5%	49.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	46.2%	37.5%	↑
<b>MPC</b>	33.8%	28.4%	34.3%	32.5%	32.9%	↓
<b>MSFC</b>	38.7%	49.9%	44.3%	40.2%	43.8%	↑
<b>PPMCO</b>	41.1%	36.3%	48.4%	51.1%	42.6%	↑
<b>UHC</b>	31.6%	37.0%	41.4%	35.0%	39.7%	↑
<b>UMHP</b>		NA <sup>□</sup>	23.4%	30.0%	34.1%	↑
<b>MARR</b>	35.5%	39.1%	38.8%	40.5%	39.6%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Childhood Immunization Status (CIS)</b>						
<b>Combination 10 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, Influenza)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	37.1%	41.2%	42.1%	45.6%	36.0%	↑
<b>JMS</b>	29.5%	40.9%	36.0%	42.5%	49.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	46.2%	37.5%	↑
<b>MPC</b>	31.0%	27.7%	33.0%	31.6%	32.2%	↓
<b>MSFC</b>	37.7%	47.0%	42.8%	39.4%	42.3%	↑
<b>PPMCO</b>	39.7%	34.3%	48.4%	50.0%	42.3%	↑
<b>UHC</b>	29.2%	35.3%	40.2%	33.8%	38.7%	↑
<b>UMHP</b>		NA <sup>□</sup>	23.4%	29.4%	33.8%	↑
<b>MARR</b>	34.2%	37.7%	38.0%	39.8%	39.0%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## Immunizations for Adolescents (IMA)

### Description

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

### Rationale

Adolescent immunization rates have historically lagged behind early childhood immunization rates in the United States. The American Academy of Pediatrics (AAP) reported that three million adolescents failed to receive at least one recommended vaccination. Low immunization rates among adolescents have the potential to cause outbreaks of preventable diseases and to establish reservoirs of disease in adolescents that can affect other populations including infants, the elderly and individuals with chronic conditions. Immunization recommendations for adolescents have changed in recent years. In addition to assessing for immunizations that may have been missed, there are new vaccines targeted specifically to adolescents.

### Summary of Changes to HEDIS 2017:

- Added the HPV vaccine.
- Added Combination 2 (meningococcal, Tdap, HPV).
- Removed the tetanus, diphtheria toxoids (Td) and meningococcal polysaccharide vaccines.
- Added CVX codes to the measure.

<b>Immunizations for Adolescents (IMA)</b>						
<b>Combination 1 (Meningococcal, Tdap/Td)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	65.0%	69.4%	74.8%	86.8%	88.0%	↑
<b>JMS</b>	70.66%	75.5%	76.7%	82.1%	89.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	82.7%	80.5%	↑
<b>MPC</b>	57.6%	62.7%	74.1%	85.4%	88.2%	↑
<b>MSFC</b>	70.69%	70.7%	72.4%	80.0%	84.2%	↑
<b>PPMCO</b>	67.4%	74.5%	74.1%	89.2%	89.1%	↑
<b>UHC</b>	56.4%	63.4%	66.2%	84.8%	86.7%	↑
<b>UMHP</b>		NA <sup>□</sup>	64.7%	82.7%	80.5%	↑
<b>MARR</b>	63.8%	67.2%	71.9%	84.2%	85.8%	↑

<sup>□</sup> This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Immunizations for Adolescents (IMA) Combination 2 (Meningococcal, Tdap, HPV)*</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM*</b>
<b>ACC</b>					28.94%	
<b>JMS</b>					52.69%	
<b>KPMAS</b>					26.69%	
<b>MPC</b>					21.30%	
<b>MSFC</b>					24.09%	
<b>PPMCO</b>					26.85%	
<b>UHC</b>					22.87%	
<b>UMHP</b>					17.37%	
<b>MARR</b>					27.60%	

\*No benchmark data available, Combination 2 is a newly reported numerator for HEDIS 2017.

## Well-Child Visits in the First 15 Months of Life (W15)

### Description

The percentage of members who turned 15 months old during the measurement year who had the following number of well-child visits with a primary care practitioner (PCP) during their first 15 months of life: no well-child visits; one, two, three, four, five, six- or-more well-child visits.

MDH also calculates the percentage of members receiving five or six-or-more visits by adding together the HEDIS results for five and for six-or-more visits.

Note: This measure is based on the Centers for Medicare & Medicaid Services (CMS) and American Academy of Pediatrics (AAP) guidelines for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits.

### Rationale

This measure looks at the adequacy of well-child care for infants. It measures the percentage of children who had between one and six or more well-child visits by the time they turned 15 months of age. The American Academy of Pediatrics (AAP) (2000) recommends six well-child visits in the first year of life: the first within the first month of life, and then at around 2, 4, 6, 9, and 12 months of age. These visits are of particular importance during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination and social and emotional growth. Regular check-ups are one of the best ways to detect physical, developmental, behavioral and emotional problems. They also provide an opportunity for the clinician to offer guidance and counseling to the parents. Studies show that children with delayed development who receive early intervention are more likely to graduate high school, hold a job, live independently and avoid teen pregnancy, delinquency and violent crimes—representing a saved cost to society of between \$30,000 and \$100,000 per child (Glascoe & Shapiro, 2007).

### Summary of Changes to HEDIS 2017:

- Clarified that services specific to the assessment or treatment of an acute or chronic condition do not count toward the measure.

<b>Well-Child Visits in the First 15 months of Life (W15) – No well-child visits*</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	1.012%	1.0%	2.1%	0.9%	1.0%	↑
<b>JMS</b>	2.7%	3.1%	1.9%	4.4%	5.0%	↓
<b>KPMAS</b>			NA <sup>□</sup>	2.0%	3.6%	↓
<b>MPC</b>	1.11%	0.5%	1.56%	1.2%	1.4%	↓
<b>MSFC</b>	1.013%	1.2%	3.5%	3.5%	3.2%	↓
<b>PPMCO</b>	1.14%	1.1%	1.59%	1.5%	1.5%	↑
<b>UHC</b>	2.2%	1.9%	0.9%	2.5%	0.3%	↑
<b>UMHP</b>		NA <sup>□</sup>	10.9%	8.5%	8.5%	↓
<b>MARR</b>	1.6%	1.5%	3.2%	3.1%	3.1%	↓

\* A lower rate indicates better performance.

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).



<b>Well-Child Visits in the First 15 months of Life (W15) – MDH Five / Six-or-more visits</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	86.1%	88.9%	85.1%	88.9%	88.7%	↑
<b>JMS</b>	85.9%	84.4%	81.6%	82.4%	80.7%	↑
<b>KPMAS</b>			NA <sup>□</sup>	78.2%	78.4%	↑
<b>MPC</b>	77.8%	83.6%	84.9%	85.9%	83.6%	↑
<b>MSFC</b>	89.2%	86.0%	82.8%	82.7%	82.7%	↑
<b>PPMCO</b>	84.3%	83.7%	81.9%	82.2%	82.0%	↑
<b>UHC</b>	82.1%	87.4%	83.6%	87.2%	87.1%	↑
<b>UMHP</b>		NA <sup>□</sup>	56.6%	67.0%	74.2%	↓
<b>MARR</b>	83.9%	85.7%	79.5%	81.8%	82.2%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

\*There is no NCQA benchmark for this composite measure.

## **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)**

### **Description**

The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.

Note: This measure is based on the Centers for Medicare & Medicaid Services (CMS) and American Academy of Pediatrics (AAP) guidelines for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits.

### **Rationale**

This measure looks at the use of routine check-ups by preschool and early school-age children. It assesses the percentage of children 3, 4, 5 and 6 years of age who received at least one well-child visit with a primary care practitioner during the measurement year. Well-child visits during the preschool and early school years are particularly important. A child can be helped through early detection of vision, speech and language problems. Intervention can improve communication skills and avoid or reduce language and learning problems. The American Academy of Pediatrics (AAP) (2000) recommends annual well-child visits for 2 to 6 year-olds.

### **Summary of Changes to HEDIS 2017:**

- Clarified that services specific to the assessment or treatment of an acute or chronic condition do not count toward the measure.

<b>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	83.6%	83.9%	83.7%	85.8%	88.0%	↑
<b>JMS</b>	87.7%	88.9%	90.6%	90.9%	90.0%	↑
<b>KPMAS</b>			84.6%	82.6%	79.6%	↑
<b>MPC</b>	87.5%	88.8%	87.0%	88.7%	79.9%	↑
<b>MSFC</b>	79.6%	83.5%	86.7%	85.5%	79.5%	↑
<b>PPMCO</b>	80.7%	83.8%	86.8%	85.2%	81.0%	↑
<b>UHC</b>	83.8%	75.0%	79.2%	80.7%	82.6%	↑
<b>UMHP</b>		NA <sup>□</sup>	57.4%	62.3%	69.8%	↓
<b>MARR</b>	82.2%	84.0%	82.0%	82.7%	81.3%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## Adolescent Well-Care Visits (AWC)

### Description

The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Note: This measure is based on the Centers for Medicare & Medicaid Services (CMS) and American Academy of Pediatrics (AAP) guidelines for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits.

### Rationale

This measure looks at the use of regular check-ups by adolescents. Adolescents benefit from an annual preventive health care visit that addresses the physical, emotional and social aspects of their health. Adolescence is a time of transition between childhood and adult life and is accompanied by dramatic changes. Accidents, homicide and suicide are the leading causes of adolescent deaths. Sexually transmitted diseases, substance abuse, pregnancy and antisocial behavior are important causes of, or result from, physical, emotional and social adolescent problems. Among adolescents, the primary causes of morbidity and mortality tend to result from engaging in risky behaviors. In 2013, about 40 percent of high school students had tried cigarettes and 66 percent had had at least one drink of alcohol (Centers for Disease Control and Prevention [CDC], 2013). The American Medical Association's *Guidelines for Adolescent Preventive Services*, the federal government's Bright Futures program and the AAP's guidelines all recommend comprehensive annual check-ups for adolescents. Well-care visits provide an opportunity for providers to influence health and development. A well-care visit is a critical opportunity for screening and counseling. Assessing changes in physical and social circumstances can help lessen the risk of serious and long-term health effects.

### Summary of Changes to HEDIS 2017:

- Clarified that services specific to the assessment or treatment of an acute or chronic condition do not count toward the measure.

Adolescent Well-Care Visits (AWC)						
	2013	2014	2015	2016	2017	NHM
ACC	68.1%	67.9%	64.7%	67.9%	69.0%	↑
JMS	76.9%	76.7%	80.3%	82.6%	84.0%	↑
KPMAS			63.5%	57.1%	56.0%	↑
MPC	60.2%	68.8%	68.3%	73.2%	72.7%	↑
MSFC	69.4%	67.8%	61.2%	64.0%	55.8%	↑
PPMCO	67.6%	61.6%	68.8%	72.8%	64.4%	↑
UHC	59.7%	60.8%	58.5%	64.8%	62.6%	↑
UMHP		NA <sup>□</sup>	31.8%	42.6%	52.6%	↑
MARR	65.4%	67.3%	62.1%	65.6%	64.6%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)**

### **Description**

The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

1. BMI percentile documentation\*
2. Counseling for nutrition
3. Counseling for physical activity

*\*Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.*

### **Rationale**

One of the most important developments in pediatrics in the past two decades has been the emergence of a new chronic disease: obesity in childhood and adolescence. The rapidly increasing prevalence of obesity among children is one of the most challenging dilemmas currently facing pediatricians. In addition to the growing prevalence of obesity in children and adolescents, overweight children at risk of becoming obese are also of great concern. The Centers for Disease Control and Prevention (CDC) states that overweight children and adolescents are more likely to become obese as adults. For example, one study found that approximately 80 percent of children who were overweight at 10–15 years of age were obese adults at age 25. Another study found that 25 percent of obese adults were overweight as children; it also found that if overweight begins before 8 years of age, obesity in adulthood is likely to be more severe. Body mass index (BMI) is a useful screening tool for assessing and tracking the degree of obesity among adolescents. Screening for overweight or obesity begins in the provider's office with the calculation of BMI. Providers can estimate a child's BMI percentile for age and gender by plotting the calculated value of BMI with growth curves published and distributed by the CDC. Medical evaluations should include investigation into possible endogenous causes of obesity that may be amenable to treatment, and identification of any obesity-related health complications. Because BMI norms for youth vary with age and gender, BMI percentiles rather than absolute BMI must be determined. The cut-off values to define the heaviest children are the 85th and 95th percentiles. In adolescence, as maturity is approached, the 85th percentile roughly approximates a BMI of 25, which is the cut-off for overweight in adults. The 95th percentile roughly approximates a BMI of 30 in the adolescent near maturity, which is the cut-off for obesity in adults. The cut-off recommended by an expert committee to define overweight (BMI greater than or equal to 95th percentile) is a conservative choice designed to minimize the risk of misclassifying non-obese children. About two-thirds of young people in grades 9–12 do not engage in recommended levels of physical activity. Daily participation in high school physical education classes dropped from 42 percent in 1991 to 33 percent in 2005. In the past 30 years, the prevalence of overweight and obesity has increased sharply for children. Among young people, the prevalence of overweight increased from 5.0 percent to 13.9 percent for those aged 2–5 years; from 6.5 percent to 18.8 percent for those aged 6–11 years; and from 5.0 percent to 17.4 percent for those aged 12–19 years. In 2000, the estimated total cost of obesity in the U.S. was about \$117 billion. Promoting regular physical activity and healthy eating, as well as creating an environment that supports these behaviors, is essential to addressing the problem.

### **Summary of Changes to HEDIS 2017:**

- Included examples of services specific to the assessment or treatment of an acute or chronic condition that do not count toward the “Counseling for nutrition” and “Counseling for physical activity” indicators.
- Replaced “Each of the 3 rates” with “✓” for the “Measurement year” row in Table WCC-1/2.

<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - BMI Percentile- Total Rate</b>						
	<b>2013*</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>		49.5%	60.9%	56.4%	73.0%	↑
<b>JMS</b>		92.2%	94.7%	92.7%	92.0%	↑
<b>KPMAS</b>			99.0%	98.6%	100.0%	↑
<b>MPC</b>		46.5%	58.3%	56.7%	60.8%	↓
<b>MSFC</b>		59.8%	67.3%	62.4%	74.7%	↑
<b>PPMCO</b>		52.1%	72.5%	70.1%	68.5%	↑
<b>UHC</b>		45.5%	57.9%	61.0%	76.5%	↑
<b>UMHP</b>		NA□	41.5%	32.1%	54.5%	↓
<b>MARR</b>		57.6%	69.0%	66.3%	75.0%	↑

\* This measure was added by MDH for reporting in HEDIS 2014.

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate</b>						
	<b>2013*</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>		59.0%	71.5%	66.0%	79.0%	↑
<b>JMS</b>		94.4%	97.6%	97.6%	95.0%	↑
<b>KPMAS</b>			98.1%	94.5%	94.3%	↑
<b>MPC</b>		54.4%	66.4%	66.7%	64.0%	↑
<b>MSFC</b>		74.1%	72.9%	73.5%	71.9%	↑
<b>PPMCO</b>		54.2%	73.6%	74.3%	73.4%	↑
<b>UHC</b>		67.6%	64.5%	69.5%	76.0%	↑
<b>UMHP</b>		NA□	50.8%	36.7%	63.8%	↑
<b>MARR</b>		67.3%	74.4%	72.4%	77.2%	↑

\* This measure was added by MDH for reporting in HEDIS 2014.

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate</b>						
	<b>2013*</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>		51.4%	61.3%	58.1%	72.0%	↑
<b>JMS</b>		89.8%	91.2%	93.4%	91.0%	↑
<b>KPMAS</b>			98.1%	94.5%	100.0%	↑
<b>MPC</b>		58.8%	60.0%	63.9%	56.8%	↑
<b>MSFC</b>		72.9%	67.8%	65.5%	69.9%	↑
<b>PPMCO</b>		44.7%	70.1%	70.1%	67.4%	↑
<b>UHC</b>		60.6%	63.0%	62.8%	70.9%	↑
<b>UMHP</b>		NA□	43.1%	30.4%	53.8%	↑
<b>MARR</b>		63.0%	69.3%	67.3%	72.7%	↑

\* This measure was added by MDH for reporting in HEDIS 2014.

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## Appropriate Testing for Children with Pharyngitis (CWP)

### Description

The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group-A streptococcus (strep) test for the episode. A higher rate represents better performance.

### Rationale

Pharyngitis is the only condition among upper respiratory infections (URIs) whose diagnosis is easily and objectively validated through administrative and laboratory data, and it can serve as an important indicator of appropriate antibiotic use among respiratory tract infections. Overuse of antibiotics has been directly linked to the prevalence of antibiotic resistance in the community; promoting judicious use of antibiotics is important to reducing levels of antibiotic resistance. Pediatric clinical practice guidelines recommend that only children with diagnosed group-A strep pharyngitis based on appropriate lab tests be treated with antibiotics. A strep test (rapid assay or throat culture) is the definitive test of group-A strep pharyngitis. Excess use of antibiotics is highly prevalent for pharyngitis; about 35 percent of the total nine million antibiotics prescribed for pharyngitis were estimated to be in excess. Pharyngitis caused by bacteria accounts for only about 30 percent of all cases of pharyngitis in children (Huang et al., 2014). Despite improvements in antibiotic prescribing for children with pharyngitis, a substantial number of patients still receive inappropriate antibiotic treatment (Shulman et al., 2012). Treating pharyngitis in children costs the United States approximately \$224 to \$539 million each year (Pfoh et al., 2008).

### Summary of Changes to HEDIS 2017:

- Added instructions to identify ED visits and observation visits that result in an inpatient stay.

Appropriate Testing for Children with Pharyngitis (CWP)						
	2013	2014	2015	2016	2017	NHM
ACC	75.9%	78.36%	79.8%	82.4%	81.0%	↑
JMS	75.3%	70.8%	80.2%	85.6%	83.0%	↑
KPMAS			NA <sup>□</sup>	98.3%	93.4%	↑
MPC	77.4%	78.42%	82.9%	86.3%	88.3%	↑
MSFC	85.2%	86.9%	90.5%	94.5%	92.2%	↑
PPMCO	78.2%	80.5%	83.1%	85.9%	86.0%	↑
UHC	79.8%	83.1%	86.0%	86.6%	87.8%	↑
UMHP		NA <sup>□</sup>	76.4%	87.1%	84.0%	↑
MARR	79.9%	79.7%	82.7%	88.3%	87.0%	↑

<sup>□</sup> This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## Lead Screening in Children (LSC)

### Description

The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

### Rationale

The National Health and Nutrition Examination Survey (NHANES), an ongoing series of cross-sectional surveys on the health and nutrition of the United States (U.S.) population, reports on the blood lead levels (BLL) of children and adults. Children 1 to 5 years of age have the highest prevalence of elevated blood levels of any age group in the U.S., although the prevalence has declined over the past several decades. Even with these decreases, an estimated 310,000 children in this country remain at risk for exposure to harmful levels of lead. BLLs of African American children and among low-income families remain significantly higher than those of other races and those of other income status.

Lead poisoning in childhood primarily affects the central nervous system, the kidneys, and the blood-forming organs. Adverse effects in young children have been noted at levels as low as 10 µg/dL and include impairment in cognitive function and initiation of various behavioral disorders (Committee on Measuring Lead in Critical Populations & National Research Council, 1993). Recent studies have noted effects of lead on cognitive ability at levels even below the level of concern of 10 µg/dL.

Elevated BLLs are not just important from a health standpoint; they also have significant financial impact. One study estimated the economic benefit of decreased lead exposure in a 3.8 million person cohort of children aged 2 years in 2000. Based on the reduction in lead exposure since the 1970s, the estimated increase in earnings for the cohort of children would be between \$110 billion and \$319 billion over their lifetimes. Another study estimated that the avoidable medical costs per child with an elevated BLL to be \$1,300. In addition, an elevated BLL was associated with avoidable special education costs of \$3,331 per child and a 1 µg/dL increase in BLL resulted in a decreased lifetime earnings of \$1,147.

### Summary of Changes to HEDIS 2017:

- No changes were made to this measure for HEDIS 2017.

<b>Lead Screening in Children (LSC)</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			77.1%	79.4%	80.0%	↑
<b>JMS</b>			87.2%	92.1%	91.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	64.5%	66.1%	↓
<b>MPC</b>			70.0%	73.8%	72.2%	↑
<b>MSFC</b>			88.6%	82.6%	84.8%	↑
<b>PPMCO</b>			71.9%	75.7%	78.6%	↑
<b>UHC</b>			68.6%	74.9%	73.0%	↑
<b>UMHP</b>			53.1%	67.7%	70.6%	↑
<b>MARR</b>			73.8%	76.3%	77.0%	↑

\* This measure was added by MDH for reporting in HEDIS 2015.

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## **Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)**

### **Description**

The percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer.

### **Rationale**

There are multiple medical societies and evidence-based guidelines which recommend against cervical cancer screening in a general population of females under 21 years of age; however, fewer than 25 percent of clinicians provide care consistent with guidelines. Although screening has been shown to be highly effective in the 21 to 65 age group, the U.S. Preventive Services Task Force (USPSTF) determined there is adequate evidence that screening women younger than 21—regardless of sexual history—does not reduce the incidence and mortality of cervical cancer, compared with beginning screening at 21. The USPSTF found evidence that screening in the younger age group leads to more harm than benefit because abnormal test results are likely to be transient and to resolve on their own, and resulting treatment may have an adverse effect on future child-bearing. Thus, the USPSTF specifically recommends against screening women under 21 years of age.

This measure has the potential to decrease the use of non-recommended cervical cancer screening in adolescent females and to ensure that providers follow recommended guidelines. Adherence to guidelines could prevent adolescent females from experiencing harm, including more-frequent testing and invasive diagnostic procedures (such as colposcopy and cervical biopsy), in addition to short-term increase in anxiety and distress that results from abnormal test results. Additionally, this measure has the potential to decrease the financial burden associated with inappropriate screening practices. (Hawkes et al., 1996).

### **Summary of Changes to HEDIS 2017:**

- Added HIV Type 2 Value Set to the required exclusions.

<b>Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) **</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			5.3%	3.9%	3.0%	↓
<b>JMS</b>			2.1%	1.9%	2.0%	↑
<b>KPMAS</b>			1.9%	0.6%	0.1%	↑
<b>MPC</b>			4.2%	2.0%	1.8%	↑
<b>MSFC</b>			2.9%	1.9%	1.3%	↑
<b>PPMCO</b>			3.7%	2.4%	2.0%	↑
<b>UHC</b>			5.8%	3.2%	3.0%	↓
<b>UMHP</b>			5.2%	4.0%	1.9%	↑
<b>MARR</b>			3.9%	2.5%	1.9%	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

\*\* A lower rate indicates better performance.



## **RESPIRATORY CONDITIONS – ADULT AND CHILD**

### **Medication Management for People with Asthma (MMA)**

#### **Description**

The percentage of members 5-85 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period
2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period

#### **Rationale**

Asthma is a treatable, reversible condition that affects more than 25 million people in the United States. Managing this condition with appropriate medications could save the United States billions of dollars in medical costs (Centers for Disease Control and Prevention [CDC], 2011). Appropriate medication adherence could ameliorate the severity of many asthma-related symptoms (Akinbami et al., 2009). According to the Asthma Regional Council, two-thirds of adults and children who display asthma symptoms are considered "not well controlled" or "very poorly controlled" as defined by clinical practice guidelines (Asthma Regional Council, 2010). Pharmacologic therapy is used to prevent and control asthma symptoms, improve quality of life, reduce the frequency and severity of asthma exacerbations, and reverse airflow obstruction (National Heart Lung and Blood Institute & National Asthma Education and Prevention Program, 2007). The United States spent approximately \$56 billion on total medical costs for asthma in 2007, a 6 percent increase from 2002 (CDC, 2011). In 2010, 25.7 million Americans had asthma: 7 million children, 15.6 million adults under 65 and 3.1 million adults 65 and older (Akinbami et al., 2012). Asthma is responsible for 3,000 deaths annually (American Lung Association [ALA], 2012). More than 53 percent of asthmatic patients had an asthma attack in 2008 (CDC, 2011). In 2009, there were 479,300 asthma-related hospitalizations and 1.9 million asthma related emergency room (ER) visits (CDC, 2013). The prevalence and cost of asthma have increased over the past decade, demonstrating the need for better access to care and medication. Appropriate medication management for patients with asthma could reduce the need for rescue medication—as well as the costs associated with ER visits, inpatient admissions and missed days of work or school.

#### **Summary of Changes to HEDIS 2017:**

- No changes were made to this measure for HEDIS 2017.

<b>Medication Management for People with Asthma (MMA) – Total 50% of treatment period</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	44.8%	45.8%	48.8%	48.5%	47.0%	↓
<b>JMS</b>	53.2%	49.4%	59.6%	73.9%	77.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	NA <sup>□</sup>	50.5%	↓
<b>MPC</b>	49.4%	57.9%	57.9%	61.5%	64.4%	↑
<b>MSFC</b>	52.4%	51.9%	49.9%	48.8%	50.1%	↓
<b>PPMCO</b>	40.3%	43.3%	44.5%	46.8%	48.1%	↓
<b>UHC</b>	47.3%	49.9%	48.4%	54.0%	53.6%	↓
<b>UMHP</b>		NA <sup>□</sup>	NA <sup>□</sup>	64.5%	55.9%	↓
<b>MARR</b>	46.3%	49.7%	51.5%	56.9%	55.8%	↓

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Medication Management for People with Asthma (MMA) – Total 75% of treatment period</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	24.1%	22.9%	23.2%	25.1%	21.0%	↓
<b>JMS</b>	28.9%	24.5%	34.8%	51.4%	52.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	NA <sup>□</sup>	28.4%	↓
<b>MPC</b>	26.6%	32.9%	34.0%	35.6%	38.3%	↑
<b>MSFC</b>	28.7%	26.6%	24.1%	25.8%	25.2%	↓
<b>PPMCO</b>	19.7%	20.0%	20.5%	23.7%	24.5%	↓
<b>UHC</b>	26.7%	27.8%	25.2%	28.5%	28.4%	↓
<b>UMHP</b>		NA <sup>□</sup>	NA <sup>□</sup>	48.4%	31.2%	↓
<b>MARR</b>	24.3%	25.8%	27.0%	34.1%	31.1%	↓

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## Appropriate Treatment for Children with Upper Respiratory Infection (URI)

### Description

The percentage of children 3 months to 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

### Rationale

The common cold (or URI) is a frequent reason for children visiting the doctor's office. Though existing clinical guidelines do not support the use of antibiotics for the common cold, physicians often prescribe them for this ailment. Pediatric clinical practice guidelines do not recommend antibiotics for a majority of upper respiratory tract infections because of the viral etiology of these infections, including the common cold.

A performance measure of antibiotic use for URI sheds light on the prevalence of inappropriate antibiotic prescribing in clinical practice and raises awareness of the importance of reducing inappropriate antibiotic use to combat antibiotic resistance in the community.

### Summary of Changes to HEDIS 2017:

- Added instructions to identify ED visits and observation visits that result in an inpatient stay.
- Added a requirement to not include denied claims in the numerator.

<b>Appropriate Treatment for Children with Upper Respiratory Infection (URI)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	85.1%	86.5%	88.0%	89.4%	91.0%	↑
<b>JMS</b>	85.2%	83.0%	92.4%	97.1%	97.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	97.5%	97.2%	↑
<b>MPC</b>	86.06%	86.6%	85.6%	88.7%	88.7%	↑
<b>MSFC</b>	86.13%	84.3%	89.5%	90.0%	92.2%	↑
<b>PPMCO</b>	85.0%	86.0%	89.0%	90.6%	90.8%	↑
<b>UHC</b>	80.1%	82.0%	85.2%	88.8%	89.6%	↑
<b>UMHP</b>		NA <sup>□</sup>	86.4%	85.5%	88.0%	↑
<b>MARR</b>	84.4%	84.7%	88.0%	91.0%	91.8%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## Asthma Medication Ratio (AMR)

### Description

The percentage of members 5–85 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

### Rationale

Medications for asthma are usually categorized into long-term controller medications used to achieve and maintain control of persistent asthma and quick-reliever medications used to treat acute symptoms and exacerbations. The United States spent approximately \$56 billion on total medical costs for asthma in 2007, a 6 percent increase from 2002 (CDC, 2011). In 2010, 25.7 million Americans had asthma: 7 million children, 15.6 million adults under 65 and 3.1 million adults 65 and older (Akinbami et al., 2012). Asthma is responsible for 3,000 deaths annually (American Lung Association [ALA], 2012). More than 53 percent of asthmatic patients had an asthma attack in 2008 (CDC, 2011). In 2009, there were 479,300 asthma-related hospitalizations and 1.9 million asthma related emergency room (ER) visits (CDC, 2013). Appropriate ratios for these medications could potentially prevent a significant proportion of asthma-related costs (hospitalizations, emergency room visits, missed work and school days).

### Summary of Changes to HEDIS 2017:

- No changes were made to this measure for HEDIS 2017.

<b>Asthma Medication Ratio (AMR)</b>						
	<b>2013*</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>		68.59%	56.54%	63.0%	67.0%	↑
<b>JMS</b>		60.5%	56.50%	61.9%	70.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	NA <sup>□</sup>	72.6%	↑
<b>MPC</b>		69.1%	65.0%	64.0%	63.6%	↑
<b>MSFC</b>		73.7%	68.1%	69.3%	67.9%	↑
<b>PPMCO</b>		69.6%	63.8%	64.7%	62.2%	↑
<b>UHC</b>		69.8%	63.4%	64.0%	63.6%	↑
<b>UMHP</b>		NA <sup>□</sup>	NA <sup>□</sup>	52.4%	47.3%	↓
<b>MARR</b>		68.56%	62.2%	62.7%	64.3%	↑

\* This measure was added by MDH for reporting in HEDIS 2014.

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

### Description

The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

### Rationale

Chronic obstructive pulmonary disease (COPD) is a major cause of chronic morbidity and mortality throughout the world and in the United States (U.S.). COPD defines a group of diseases characterized by airflow obstruction, and includes chronic bronchitis and emphysema. Symptoms of COPD range from chronic cough and sputum production to severe, disabling shortness of breath, leading to significant impairment of quality of life. COPD afflicts nearly 16 million adults in the U.S. COPD is the fourth leading cause of death in the U.S., and is projected to move to third place by 2020.

Spirometry is a simple test that measures the amount of air a person can breathe out and the amount of time it takes to do so. Both symptomatic and asymptomatic patients suspected of COPD should have spirometry performed to establish airway limitation and severity. Though several scientific guidelines and specialty societies recommend use of spirometry testing to confirm COPD diagnosis and determine severity of airflow limitation, spirometry tests are largely underutilized. Earlier diagnosis using spirometry testing might protect against worsening symptoms and decrease the number of exacerbations. The majority of patients diagnosed with COPD have moderate or severe disease (50 percent and 31 percent, respectively) (Mapel et al., 2011). Adults with more severe COPD tend to have higher costs of care and increased exacerbations (GOLD, 2014).

### Summary of Changes to HEDIS 2017:

- Clarified the allowable gap criteria for Medicaid beneficiaries whose enrollment is verified monthly.
- Clarified that the first admission date should be used (if the admission is followed by a direct transfer) when determining the negative diagnosis history in step 2.
- Added instructions to identify ED visits and observation visits that result in an inpatient stay.

<b>Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)</b>						
	<b>2013*</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>		25.8%	23.6%	30.0%	30.0%	↓
<b>JMS</b>		26.3%	32.6%	34.9%	32.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>
<b>MPC</b>		21.1%	20.8%	25.5%	31.5%	↑
<b>MSFC</b>		34.5%	29.2%	30.8%	40.7%	↑
<b>PPMCO</b>		23.7%	27.2%	28.0%	29.9%	↓
<b>UHC</b>		25.6%	25.6%	31.2%	32.9%	↑
<b>UMHP</b>		NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>
<b>MARR</b>		26.2%	26.5%	30.1%	32.8%	↑

\* This measure was added by MDH for reporting in HEDIS 2014.

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## **Pharmacotherapy Management of COPD Exacerbation (PCE)**

### **Description**

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:

1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event

*Note: The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.*

### **Rationale**

While other major causes of death have been decreasing, COPD mortality has risen, making it the fourth leading cause of death in the United States. COPD is characterized by airflow limitation that is not fully reversible, is usually progressive and is associated with an abnormal inflammatory response of the lung to noxious particles or gases. COPD defines a group of diseases that includes chronic bronchitis and emphysema, and patients are prone to frequent exacerbations of symptoms that range from chronic cough and sputum production to severe disabling shortness of breath, leading to significant impairment of quality of life.

In addition to being a major cause of chronic disability, COPD is a driver of significant health care service use. The disease results in both high direct and high indirect costs, and exacerbations of COPD account for the greatest burden on the health care system, though studies have shown that proper management of exacerbations may have the greatest potential to reduce the clinical, social and economic impact of the disease. Pharmacotherapy is an essential component of proper management.

### **Summary of Changes to HEDIS 2017:**

- Added instructions to identify ED visits that result in an inpatient stay (step 1).
- Deleted the direct transfer exclusion and added a requirement to use the discharge date from the last admission (step 3).
- Added instructions to identify direct transfers (step 3).
- Deleted the exclusion of Episode Dates when there was a readmission or an ED visits within 14 days (formerly step 4).

<b>Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate</b>						
	<b>2013*</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>		73.6%	69.0%	70.3%	68.0%	↑
<b>JMS</b>		69.2%	73.6%	73.3%	65.0%	↓
<b>KPMAS</b>			NA□	NA□	NA□	NA□
<b>MPC</b>		72.6%	72.1%	74.4%	73.9%	↑
<b>MSFC</b>		76.3%	72.2%	71.0%	71.6%	↑
<b>PPMCO</b>		69.7%	69.7%	75.7%	66.7%	↓
<b>UHC</b>		78.2%	73.0%	70.2%	65.0%	↓
<b>UMHP</b>		NA□	78.1%	70.3%	80.7%	↑
<b>MARR</b>		73.3%	72.5%	72.2%	70.1%	↑

\* This measure was added by MDH for reporting in HEDIS 2014.

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate</b>						
	<b>2013*</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>		87.5%	84.8%	84.9%	81.0%	↑
<b>JMS</b>		82.5%	85.4%	88.6%	86.0%	↑
<b>KPMAS</b>			NA□	NA□	NA□	NA□
<b>MPC</b>		84.93%	85.1%	87.4%	86.9%	↑
<b>MSFC</b>		90.3%	92.4%	84.5%	87.3%	↑
<b>PPMCO</b>		84.0%	85.0%	83.7%	81.5%	↑
<b>UHC</b>		84.88%	86.3%	80.8%	81.5%	↑
<b>UMHP</b>		NA□	81.3%	86.1%	89.3%	↑
<b>MARR</b>		85.7%	85.7%	85.1%	84.8%	↑

\* This measure was added by MDH for reporting in HEDIS 2014.

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## MEMBER ACCESS

### Children and Adolescents' Access to Primary Care Practitioners (CAP)

#### Description

The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.

1. Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.
2. Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year

#### Rationale

Access to primary care is important for the health and well-being of children and adolescents. High-quality primary care services have been found to significantly reduce children's non-urgent emergency room (ER) visits (Bloom et al., 2012). A recent national survey showed that almost 5 million children experienced a need for medical care in the last year but did not receive it. In the same survey, 2.3 million children were described as having "fair to poor" health (Child and Adolescent Health Measurement Initiative [CAHMI], 2011). More than 7 million children do not have a personal doctor or nurse, and more than 6 million young people do not have a consistent place to receive care when they get sick (CAHMI, 2011). In 2011, 16 percent of children 6 to 17 years of age had one or more ER visits (National Center on Health Statistics [NCHS], 2012). Without a patient visit, members do not receive counseling on diet, exercise, smoking cessation, seat belt use and behaviors that put them at risk. If the organization's services are not being used, are there barriers to access? Maintaining access to care requires more than making providers and services available—it involves analysis and systematic removal of barriers to care.

#### Summary of Changes to HEDIS 2017:

- No changes were made to this measure for HEDIS 2017.

<b>Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–24 months</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	97.5%	97.8%	97.7%	97.9%	98.0%	↑
<b>JMS</b>	91.1%	94.7%	96.2%	91.5%	93.0%	↓
<b>KPMAS</b>			100.0%	91.3%	92.5%	↓
<b>MPC</b>	97.1%	96.5%	96.9%	97.2%	96.4%	↑
<b>MSFC</b>	96.6%	96.4%	93.9%	95.3%	94.3%	↓
<b>PPMCO</b>	97.8%	97.6%	97.6%	97.8%	97.0%	↑
<b>UHC</b>	96.7%	96.3%	96.6%	97.0%	96.2%	↑
<b>UMHP</b>		NA <sup>□</sup>	87.8%	84.9%	89.2%	↓
<b>MARR</b>	95.6%	96.6%	95.8%	94.1%	94.6%	↓

<sup>□</sup> This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).



<b>Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months–6 years</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	92.6%	92.8%	93.1%	94.1%	93.0%	↑
<b>JMS</b>	90.4%	88.7%	91.8%	93.0%	92.0%	↑
<b>KPMAS</b>			98.0%	89.1%	87.5%	↑
<b>MPC</b>	89.0%	90.0%	90.3%	91.6%	90.8%	↑
<b>MSFC</b>	90.3%	89.8%	88.4%	90.0%	87.6%	↑
<b>PPMCO</b>	92.8%	92.6%	93.3%	94.2%	93.1%	↑
<b>UHC</b>	91.1%	91.1%	91.3%	92.6%	92.0%	↑
<b>UMHP</b>		NA <sup>□</sup>	69.4%	77.5%	83.5%	↓
<b>MARR</b>	90.3%	90.8%	89.5%	90.3%	89.9%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7–11 years</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	93.9%	94.3%	95.3%	96.1%	96.0%	↑
<b>JMS</b>	93.3%	93.8%	92.7%	93.8%	94.0%	↑
<b>KPMAS</b>			98.4%	98.1%	92.5%	↑
<b>MPC</b>	91.5%	92.1%	92.61%	93.5%	94.0%	↑
<b>MSFC</b>	92.5%	93.50%	92.58%	92.0%	92.8%	↑
<b>PPMCO</b>	94.3%	94.4%	94.4%	95.3%	95.4%	↑
<b>UHC</b>	93.3%	93.1%	93.6%	94.4%	94.8%	↑
<b>UMHP</b>		NA <sup>□</sup>	NA <sup>□</sup>	76.8%	83.5%	↓
<b>MARR</b>	92.7%	93.52%	94.2%	92.5%	92.9%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–19 years</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	89.5%	90.5%	91.9%	93.0%	94.0%	↑
<b>JMS</b>	91.7%	90.8%	92.9%	94.2%	95.0%	↑
<b>KPMAS</b>			94.2%	96.6%	91.5%	↑
<b>MPC</b>	87.7%	88.5%	89.7%	91.6%	91.8%	↑
<b>MSFC</b>	92.5%	92.7%	91.7%	90.6%	90.7%	↑
<b>PPMCO</b>	92.0%	91.9%	92.5%	93.7%	94.1%	↑
<b>UHC</b>	89.2%	90.1%	90.9%	92.1%	93.4%	↑
<b>UMHP</b>		NA <sup>□</sup>	NA <sup>□</sup>	75.2%	85.0%	↓
<b>MARR</b>	89.8%	90.7%	92.0%	90.9%	91.9%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## Adults' Access to Preventive/Ambulatory Health Services (AAP)

### Description

The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.

### Rationale

Without a patient visit, members do not receive counseling on diet, exercise, smoking cessation, seat belt use and behaviors that put them at risk. If the organization's services are not being used, are there barriers to access? Maintaining access to care requires more than making providers and services available—it involves analysis and systematic removal of barriers to care.

### Summary of Changes to HEDIS 2017:

- No changes were made to this measure for HEDIS 2017.

<b>Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 years</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	79.7%	79.4%	79.4%	79.7%	76.0%	↓
<b>JMS</b>	74.8%	72.9%	71.0%	69.3%	68.0%	↓
<b>KPMAS</b>			92.9%	82.7%	75.3%	↓
<b>MPC</b>	81.4%	81.1%	80.9%	82.8%	79.9%	↑
<b>MSFC</b>	79.9%	79.7%	76.3%	75.8%	72.5%	↓
<b>PPMCO</b>	83.5%	81.7%	82.3%	82.6%	80.4%	↑
<b>UHC</b>	80.2%	80.36%	80.0%	79.0%	76.7%	↓
<b>UMHP</b>		NA <sup>□</sup>	63.6%	69.3%	65.4%	↓
<b>MARR</b>	79.9%	79.2%	78.3%	77.7%	74.3%	↓

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	86.4%	87.2%	86.7%	88.2%	86.0%	↑
<b>JMS</b>	87.8%	86.58%	86.8%	87.8%	86.0%	↑
<b>KPMAS</b>			95.7%	87.0%	82.1%	↓
<b>MPC</b>	86.8%	87.8%	87.4%	89.4%	87.3%	↑
<b>MSFC</b>	86.2%	86.9%	85.1%	85.7%	83.2%	↓
<b>PPMCO</b>	89.4%	88.4%	89.0%	90.0%	88.4%	↑
<b>UHC</b>	87.5%	87.8%	88.0%	88.0%	86.7%	↑
<b>UMHP</b>		NA <sup>□</sup>	75.9%	79.6%	77.5%	↓
<b>MARR</b>	86.4%	87.5%	86.8%	87.0%	84.6%	↓

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

# WOMEN'S HEALTH

## Breast Cancer Screening (BCS)

### Description

The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.

### Rationale

Breast cancer is the second most common type of cancer among American women, with approximately 178,000 new cases reported each year (American Cancer Society [ACS], 2007). It is most common in women over 50. Women whose breast cancer is detected early have more treatment choices and better chances for survival. Mammography screening has been shown to reduce mortality by 20 to 30 percent among women 40 and older. A mammogram can reveal tumors too small to be felt by hand; it can also show other changes in the breast that may suggest cancer.

The U.S. Preventive Services Task Force (USPSTF), the American Academy of Family Physicians (AAFP), and the American College of Preventive Medicine recommend mammograms as the most effective method for detecting breast cancer when it is most treatable (USPSTF, 2002; "AAFP periodic," 2005; Ferrini et al., 1996). When high-quality equipment is used and well-trained radiologists read the x-rays, 85 to 90 percent of cancers are detectable.

### Summary of Changes to HEDIS 2017:

- Clarified that diagnostic screenings are not included in the measure.

Breast Cancer Screening (BCS)						
	2013	2014	2015	2016	2017	NHM
ACC	49.1%	58.1%	66.0%	65.9%	66.0%	↑
JMS	60.8%	69.4%	72.1%	72.6%	74.0%	↑
KPMAS			87.2%	88.5%	87.9%	↑
MPC	43.9%	48.5%	65.9%	72.1%	68.2%	↑
MSFC	56.8%	64.4%	63.4%	66.0%	65.5%	↑
PPMCO	51.5%	57.0%	62.5%	68.3%	69.2%	↑
UHC	48.4%	52.7%	58.1%	62.3%	60.2%	↑
UMHP		NA <sup>□</sup>	NA <sup>□</sup>	63.8%	67.3%	↑
MARR	51.0%	58.3%	67.9%	70.0%	69.8%	↑

<sup>□</sup> This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## Cervical Cancer Screening (CCS)

### Description

The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

1. Women age 21–64 who had cervical cytology performed every 3 years.
2. Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

### Rationale

Cervical cancer can be detected in its early stages by regular screening using a Pap (cervical cytology) test. A number of organizations, including the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA) and the American Cancer Society (ACS), recommend Pap testing every one to three years for all women who have been sexually active or who are over 21 (ACOG, 2003; Hawkes et al., 1996; Saslow et al., 2002).

### Summary of Changes to HEDIS 2017:

- Clarified that reflex testing does not meet criteria in step 2 of the hybrid specification.

<b>Cervical Cancer Screening (CCS)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	73.6%	79.64%	67.8%	67.5%	66.0%	↑
<b>JMS</b>	80.9%	79.5%	66.8%	77.3%	73.0%	↑
<b>KPMAS</b>			90.8%	79.2%	79.2%	↑
<b>MPC</b>	74.0%	79.58%	65.75%	65.2%	66.3%	↑
<b>MSFC</b>	70.9%	74.0%	66.2%	61.5%	55.9%	↑
<b>PPMCO</b>	75.0%	75.9%	74.4%	69.3%	64.7%	↑
<b>UHC</b>	69.8%	62.8%	58.8%	60.1%	68.6%	↑
<b>UMHP</b>		NA <sup>□</sup>	35.5%	41.1%	45.3%	↓
<b>MARR</b>	73.7%	75.2%	65.76%	65.1%	64.9%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## Chlamydia Screening in Women (CHL)

### Description

The percentage of 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.

### Rationale

Chlamydia trachomatis is the most common sexually transmitted disease (STD) in the United States (U.S.). The Centers for Disease Control and Prevention (CDC) estimates that approximately three million people are infected with chlamydia each year. Risk factors associated with becoming infected with chlamydia are the same as risks for contracting other STDs (e.g., multiple sex partners). Chlamydia is more prevalent among adolescent (15 to 19) and young adult (20 to 24) women.

Screening is essential because the majority of women who have the condition do not experience symptoms. The main objective of chlamydia screening is to prevent pelvic inflammatory disease (PID), infertility, and ectopic pregnancy, all of which have very high rates of occurrence among women with untreated chlamydia infection. The specifications for this measure are consistent with current clinical guidelines, such as those of the U.S. Preventive Services Task Force (USPSTF) (2001).

### Summary of Changes to HEDIS 2017:

- No changes were made to this measure for HEDIS 2017.

<b>Chlamydia Screening in Women (CHL) – Age 16–20 years</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	62.6%	62.4%	61.4%	61.0%	62.0%	↑
<b>JMS</b>	81.1%	86.7%	87.6%	87.6%	89.0%	↑
<b>KPMAS</b>			76.9%	69.2%	69.8%	↑
<b>MPC</b>	58.1%	58.2%	58.9%	56.8%	57.6%	↑
<b>MSFC</b>	59.6%	54.8%	57.2%	52.2%	56.0%	↑
<b>PPMCO</b>	61.8%	61.5%	59.2%	57.5%	60.0%	↑
<b>UHC</b>	56.9%	55.4%	55.2%	52.1%	56.0%	↑
<b>UMHP</b>		NA <sup>□</sup>	61.1%	49.5%	50.1%	↓
<b>MARR</b>	63.8%	63.17%	64.7%	60.8%	62.6%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Chlamydia Screening in Women (CHL) – Age 21–24 years</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	72.5%	71.9%	71.7%	68.6%	70.0%	↑
<b>JMS</b>	63.9%	72.3%	65.0%	72.8%	85.0%	↑
<b>KPMAS</b>			80.8%	84.7%	82.1%	↑
<b>MPC</b>	67.6%	67.1%	67.3%	68.7%	68.7%	↑
<b>MSFC</b>	74.0%	68.4%	66.5%	65.3%	66.3%	↑
<b>PPMCO</b>	68.9%	69.9%	68.0%	67.5%	68.0%	↑
<b>UHC</b>	63.7%	64.8%	63.2%	65.4%	65.4%	↑
<b>UMHP</b>		NA <sup>□</sup>	58.7%	61.2%	60.4%	↓
<b>MARR</b>	69.1%	69.1%	67.7%	69.3%	70.7%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Chlamydia Screening in Women (CHL) – Total (16–24) years</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	66.4%	66.0%	65.97%	64.2%	66.0%	↑
<b>JMS</b>	74.2%	81.2%	77.3%	80.3%	87.0%	↑
<b>KPMAS</b>			79.5%	79.6%	77.5%	↑
<b>MPC</b>	62.3%	62.0%	62.6%	62.0%	62.8%	↑
<b>MSFC</b>	65.0%	60.1%	61.3%	58.6%	61.3%	↑
<b>PPMCO</b>	64.6%	64.8%	62.7%	61.5%	63.6%	↑
<b>UHC</b>	59.5%	59.0%	58.8%	57.9%	60.0%	↑
<b>UMHP</b>		NA <sup>□</sup>	59.7%	56.3%	56.3%	↑
<b>MARR</b>	66.1%	65.5%	65.97%	65.1%	66.8%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

# Prenatal and Postpartum Care

## Prenatal and Postpartum Care (PPC)

### Description

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

1. **Timeliness of Prenatal Care:** The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester *or* within 42 days of enrollment in the organization.
2. **Postpartum Care:** The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

### Rationale:

The American College of Obstetricians and Gynecologists (ACOG) (American Academy of Pediatrics [AAP] & ACOG, 2002) recommends that women see their health care provider at least once between 4 and 6 weeks after giving birth. The first postpartum visit should include a physical examination and is an opportunity for the health care practitioner to answer parents' questions, and give family planning guidance and counsel on nutrition.

Timeliness of Prenatal Care: Preventive medicine is fundamental to prenatal care. Healthy diet, counseling, vitamin supplements, identification of maternal risk factors and health promotion must occur early in pregnancy to have an optimal effect on outcome. Poor outcomes include spontaneous abortion, low-birth-weight babies, large-for-gestational-age babies and neonatal infection. Early prenatal care is also an essential part of helping a pregnant woman prepare to become a mother. Ideally, a pregnant woman will have her first prenatal visit during the first trimester of pregnancy. Some women enroll in an organization at a later stage of pregnancy; in this case, it is essential for the health plan to begin providing prenatal care as quickly as possible.

Postpartum Care: The American College of Obstetricians and Gynecologists recommends that women see their healthcare provider at least once between four and six weeks after giving birth. The first postpartum visit should include a physical examination and an opportunity for the healthcare practitioner to answer parents' questions and give family planning guidance and counseling on nutrition.

### Summary of Changes to HEDIS 2017:

- Clarified that the prenatal visit for the Timeliness of Prenatal Care numerator can occur on the date of enrollment.
- Clarified in the Note that the EDD must be on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.
- Added a Note explaining that the organization may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.
- Replaced “Each of the 2 rates” with a “□” for the “Measurement year” row in Table PPC-1/2.

<b>Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	87.8%	84.2%	85.7%	83.9%	89.0%	↑
<b>JMS</b>	82.9%	85.8%	83.2%	87.2%	79.0%	↓
<b>KPMAS</b>			88.0%	92.9%	96.7%	↑
<b>MPC</b>	86.279%	84.9%	80.3%	81.5%	89.5%	↑
<b>MSFC</b>	86.280%	85.4%	79.2%	84.5%	83.6%	↑
<b>PPMCO</b>	89.3%	90.9%	88.2%	90.3%	89.3%	↑
<b>UHC</b>	84.7%	87.1%	84.1%	80.7%	87.6%	↑
<b>UMHP</b>		52.2%	73.3%	74.5%	86.4%	↑
<b>MARR</b>	85.8%	74.0%	82.8%	84.4%	87.6%	↑

<b>Prenatal and Postpartum Care (PPC) – Postpartum Care</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	71.5%	71.6%	66.0%	73.7%	73.7%	↑
<b>JMS</b>	83.7%	78.5%	83.6%	88.0%	81.3%	↑
<b>KPMAS</b>			86.0%	83.8%	84.1%	↑
<b>MPC</b>	68.4%	71.9%	65.0%	68.9%	67.1%	↑
<b>MSFC</b>	74.4%	72.0%	71.1%	69.2%	71.2%	↑
<b>PPMCO</b>	72.5%	75.6%	70.7%	73.7%	71.3%	↑
<b>UHC</b>	60.3%	63.8%	62.5%	66.2%	70.6%	↑
<b>UMHP</b>		43.9%	47.4%	62.3%	71.1%	↑
<b>MARR</b>	70.0%	61.9%	69.0%	73.2%	73.8%	↑



## **Frequency of Ongoing Prenatal Care (FPC)**

### **Description**

The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits: less than 21% of expected visits, 21% to 40% of expected visits, 41% to 60% of expected visits, 61% to 80% of expected visits, and greater than or equal to 81% of expected visits.

### **Rationale**

This measure looks at the use of prenatal care services. It tracks Medicaid-enrolled women who had live births during the past year to determine the percentage of recommended prenatal visits they had.

Complications can arise at any time during pregnancy. For that reason, continued monitoring throughout pregnancy is necessary. Frequency and adequacy of ongoing prenatal visits are important factors in minimizing pregnancy problems. The American College of Obstetricians and Gynecologists recommends that prenatal care begin as early as possible in the first trimester of pregnancy. Although many women experience uncomplicated pregnancies, timely and adequate prenatal care can prevent poor birth outcomes (Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2012). The American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) (2012) recommend that a woman with an uncomplicated pregnancy be examined every 4 weeks for the first 28 weeks of pregnancy, every 2 to 3 weeks until 36 weeks of gestation and weekly thereafter. Nearly 30 percent of pregnant women 25 years of age and older do not receive timely prenatal care (Maternal and Child Health Bureau [MCHB], 2011). Pregnancies with limited prenatal care have twice the risk of preterm birth and infant mortality than pregnancies with sufficient care (Centers for Disease Control and Prevention [CDC], 2013). Appropriate perinatal services and education are crucial components of a healthy birth. Understanding how to stay healthy is important for preventing complications that can affect the health of both mother and baby before, during and after pregnancy.

### **Summary of Changes to HEDIS 2017:**

- Clarified the example calculation in step 2.

<b>Frequency of Ongoing Prenatal Care (FPC) – Less than 21% of expected visits*</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	4.2%	8.2%	5.9%	5.2%	3.0%	↑
<b>JMS</b>	3.6%	2.2%	4.5%	3.5%	9.0%	↑
<b>KPMAS</b>			7.7%	5.8%	0.3%	↑
<b>MPC</b>	10.6%	5.6%	6.9%	5.6%	3.0%	↑
<b>MSFC</b>	2.7%	4.4%	7.6%	3.2%	5.9%	↑
<b>PPMCO</b>	4.4%	4.4%	9.3%	8.5%	9.6%	↑
<b>UHC</b>	12.1%	5.8%	6.8%	5.2%	3.5%	↑
<b>UMHP</b>		37.0%	17.4%	12.2%	5.8%	↑
<b>MARR</b>	6.3%	9.7%	8.2%	6.1%	5.0%	↑

\* A lower rate indicates better performance.

<b>Frequency of Ongoing Prenatal Care (FPC) – Greater than or equal to 81% of expected visits</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	72.2%	75.5%	72.6%	73.4%	79.0%	↑
<b>JMS</b>	75.8%	70.8%	64.0%	66.7%	56.0%	↓
<b>KPMAS</b>			56.9%	72.4%	83.3%	↑
<b>MPC</b>	60.1%	70.6%	69.8%	65.3%	70.3%	↑
<b>MSFC</b>	79.3%	71.3%	64.6%	71.8%	77.1%	↑
<b>PPMCO</b>	78.8%	78.8%	61.7%	62.7%	61.2%	↑
<b>UHC</b>	70.8%	73.2%	74.5%	75.8%	73.1%	↑
<b>UMHP</b>		21.7%	55.0%	55.0%	67.9%	↑
<b>MARR</b>	71.5%	66.0%	64.9%	67.9%	71.0%	↑

# Cardiovascular Conditions

## Controlling High Blood Pressure (CBP)

### Description

The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:

1. Members 18–59 years of age whose BP was <140/90 mm Hg
2. Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg
3. Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

Use the Hybrid Method for this measure.

### Rationale

Known as the "silent killer," high blood pressure, or hypertension, increases the risk of heart disease and stroke, which are the leading causes of death in the United States (U.S) (Centers for Disease Control and Prevention [CDC], 2012). Approximately 67 million Americans have high blood pressure (Centers for Disease Control and Prevention [CDC], 2012). Treatment to improve hypertension includes dietary and lifestyle changes, as well as appropriate use of medications. Controlling high blood pressure is an important step in preventing heart attacks, stroke and kidney disease, and in reducing the risk of developing other serious conditions (James et al., 2014). Health care providers and plans can help individuals manage their high blood pressure by prescribing medications and encouraging low-sodium diets, increased physical activity and smoking cessation.

The specifications for this measure are consistent with current clinical guidelines, such as those of the United States Preventive Services Task Force (USPSTF) and the Joint National Committee (James et al., 2014).

### Summary of Changes to HEDIS 2017:

- Added a Note clarifying the intent when confirming the diagnosis of hypertension.
- Revised Table CBP-1/2/3 to include the medical record data elements only.

<b>Controlling High Blood Pressure (CBP)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	47.0%	49.0%	63.9%	54.1%	63.0%	↑
<b>JMS</b>	52.3%	56.2%	69.3%	76.4%	72.0%	↑
<b>KPMAS</b>			87.8%	86.0%	84.4%	↑
<b>MPC</b>	23.9%	46.8%	61.4%	55.9%	68.7%	↑
<b>MSFC</b>	70.5%	65.5%	69.2%	71.2%	72.8%	↑
<b>PPMCO</b>	59.1%	57.0%	59.5%	60.2%	51.1%	↓
<b>UHC</b>	43.1%	42.3%	50.9%	56.9%	64.9%	↑
<b>UMHP</b>		NA <sup>□</sup>	32.1%	48.2%	BR <sup>1</sup>	BR <sup>1</sup>
<b>MARR</b>	49.8%	52.8%	61.8%	63.6%	68.1%	↑

BR<sup>1</sup> Biased Rate. The calculated rate was materially biased.

## Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)

### Description

The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

### Rationale

According to results of large-scale clinical trials, beta-blockers consistently reduce subsequent coronary events, cardiovascular mortality, and all-cause mortality by 20 percent to 30 percent after an acute myocardial infarction (AMI) when taken indefinitely. Literature suggests that adherence to beta-blockers declines significantly within the first year.

About half of AMI survivors who are eligible for beta-blocker therapy do not receive it. Test data reveal significant underutilization of beta-blockers 180 days post-myocardial infarction (MI). There is evidence suggesting that around 2,900 to 5,000 lives are lost in the United States in the first year following AMI, from under-prescribing of beta-blockers.

In 2004, the American College of Cardiology (ACC)/American Heart Association (AHA) updated the Guidelines for the Management of Patients with Acute Myocardial Infarction and indicated that long-term beta-blocker therapy should begin as early as possible after the event for all patients without a contraindication to beta-blockers and continue indefinitely.

### Summary of Changes to HEDIS 2017:

- Removed language instructing organizations to use only facility claims to identify discharges and diagnoses for denominator events. This is now addressed in General Guideline 46.
- Added instructions to identify direct transfers.

<b>Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)</b>						
	<b>2013*</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>		NA <sup>□</sup>	91.5%	84.9%	71.0%	↓
<b>JMS</b>		NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>
<b>KPMAS</b>			NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>
<b>MPC</b>		87.5%	90.2%	84.3%	83.2%	↑
<b>MSFC</b>		NA <sup>□</sup>	NA <sup>□</sup>	67.7%	80.5%	↔
<b>PPMCO</b>		86.1%	84.6%	85.7%	75.0%	↓
<b>UHC</b>		82.9%	87.8%	77.9%	81.0%	↑
<b>UMHP</b>		NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>
<b>MARR</b>		85.5%	88.5%	80.1%	78.1%	↓

\* This measure was added by MDH for reporting in HEDIS 2014.

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## **Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)**

### **Description**

The percentage of members 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

### **Rationale**

Patients with schizophrenia are likely to have higher levels of blood cholesterol and are more likely to receive less treatment. Patients with schizophrenia and elevated blood cholesterol levels are prescribed statins at approximately a quarter of the rate of the general population. Furthermore, certain atypical antipsychotic drugs increase total and low-density lipoprotein (LDL) cholesterol and triglycerides, and decrease high-density lipoprotein (HDL) cholesterol, which increases the risk of coronary heart disease (Hennekens et al., 2005).

Among patients with co-occurring schizophrenia and metabolic disorders, rates of non-treatment for hyperlipidemia and hypertension were 62.4 percent for hypertension and 88.0 percent for hyperlipidemia (Nasrallah et al., 2006). Atypical antipsychotic medications elevate the risk of metabolic conditions, relative to typical antipsychotic medications (Nasrallah, 2008).

### **Summary of Changes to HEDIS 2017:**

- Replaced all references to BH ED POS Value Set with ED POS Value Set (the codes in these value sets are the same).

<b>Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>
<b>JMS</b>			NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>
<b>KPMAS</b>			NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>
<b>MPC</b>			NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>
<b>MSFC</b>			NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>
<b>PPMCO</b>			NA <sup>□</sup>	NA <sup>□</sup>	57.1%	↓
<b>UHC</b>			NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>
<b>UMHP</b>			NA <sup>□</sup>	NA <sup>□</sup>	N/A	NA <sup>□</sup>
<b>MARR</b>			No MARR	No MARR	57.1%	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## **Statin Therapy for Patients With Cardiovascular Disease (SPC)**

### **Description**

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1. Received Statin Therapy. Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year.
2. Statin Adherence 80%. Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.

## **Rationale**

Cardiovascular disease is the leading cause of death in the United States. More than 85 million American adults have one or more types of cardiovascular disease (Mozaffarian et al., 2015). It is estimated that by 2030, more than 43 percent of Americans will have a form of cardiovascular disease (Heidenreich et al., 2011). In 2011, the total cost of cardiovascular disease and stroke in the United States was estimated to be \$320 billion. This total includes direct costs such as the cost of physicians and other health professionals, hospital services, prescribed medications and home health care, as well as indirect costs due to loss of productivity from premature mortality.

Interventions to address cardiovascular disease are increasing: since 2000, the number of inpatient cardiovascular operations and procedures increased by 28 percent, from 5,939,000 to 7,588,000 (Mozaffarian et al., 2015). By 2030, direct medical costs for cardiovascular disease are projected to increase to nearly \$918 billion (Heidenreich et al., 2011).

Statins (3-hydroxy-3-methylglutaryl-coenzyme [HMG-CoA] reductase inhibitors) are a class of drugs that lower blood cholesterol. Statins work in the liver by preventing the formation of cholesterol, thus lowering the amount of cholesterol in the blood (American Heart Association [AHA], 2014). Statins are most effective in lowering low-density lipoprotein cholesterol (LDL-C). The amount of cholesterol-lowering effect is based on statin intensity, which is classified as either high, moderate or low.

Statins are among the most commonly prescribed medications in the United States, accumulating \$17 billion in sales in 2012 (Consumer Reports, 2014). According to recent blood cholesterol treatment guidelines from the American College of Cardiology (ACC) and AHA, statins of moderate or high intensity are recommended for adults with established clinical atherosclerotic cardiovascular disease (ASCVD). Many studies support the use of statins to reduce ASCVD events in primary and secondary prevention.

One meta-analysis of data from 170,000 patients in 26 randomized controlled trials found that intensive statin therapy reduces major vascular events by 15 percent (Cholesterol Treatment Trialists' [CTT] Collaboration, 2010). The study also found a 13 percent reduction in coronary death or nonfatal myocardial infarction, a 19 percent reduction in coronary revascularization and a 16 percent reduction in ischemic stroke (CTT Collaboration, 2010).

Another systematic review and meta-analysis estimates that long term statin therapy reduces the risk for ASCVD events by 25 percent to 45 percent (Law, Wald, & Rudnicka, 2003).

Research shows that adherence to statin medications is poor in the United States. In a randomized trial of medication coverage, 50 percent of patients in the control group (usual coverage) stopped using statin medications within one year of starting treatment (Choudhry et al., 2011). National Committee for Quality Assurance (NCQA) seeks to improve statin adherence in patients with cardiovascular disease and thereby reduce the risk for cardiovascular related mortality.

The ACC/AHA guidelines state "adherence to both medication and lifestyle regimens are required for ASCVD risk reduction" (Stone et al., 2013). This measure uses the proportion of days covered (PDC) to assess adherence. According to the Pharmacy Quality Alliance, a PDC threshold of 80 percent is considered highly adherent for most classes of chronic medications (Nau, 2012).

The impact of adherence on statin efficacy has been shown: each 25 percent increase in statin adherence is associated with an approximate 3.8 mg/dL reduction in low-density lipoprotein cholesterol (Ho, Bryson, & Rumsfeld, 2009). Non-adherence to statin therapy can result in an

increased risk for mortality. One study found a 12 percent to 25 percent increase in the risk for mortality with non-adherence to statins after an acute myocardial infarction (Rasmussen, Chong, & Alter, 2007).

Guideline recommendations: ACC/AHA. For men and women 21 to 75 years of age with a diagnosis of clinical ASCVD, high-intensity statin therapy is recommended. If high-intensity therapy is contraindicated, or when adverse effects are present, moderate-intensity statin therapy should be used (Stone et al., 2013).

**Summary of Changes to HEDIS 2017:**

- Added a Note section.

<b>Statin Therapy for Patients With Cardiovascular Disease (SPC) – Received Statin Therapy – Total</b>						
	<b>2013</b>	<b>2014</b>	<b>2015*</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>				66.0%	70.1%	↓
<b>JMS</b>				78.4%	80.8%	↑
<b>KPMAS</b>				NA <sup>□</sup>	89.5%	↑
<b>MPC</b>				72.2%	75.4%	↑
<b>MSFC</b>				77.5%	80.2%	↑
<b>PPMCO</b>				72.1%	72.1%	↑
<b>UHC</b>				71.0%	73.5%	↑
<b>UMHP</b>				NA <sup>□</sup>	71.9%	↑
<b>MARR</b>				72.9%	76.7%	↑

\* This measure was added by MDH for reporting in HEDIS 2016

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

\*\*NCQA Benchmarks will not be available until HEDIS 2018 when there are two years of valid data.

<b>Statin Therapy for Patients With Cardiovascular Disease (SPC) – Statin Adherence 80% - Total</b>						
	<b>2013</b>	<b>2014</b>	<b>2015*</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>				76.5%	48.7%	↓
<b>JMS</b>				56.7%	54.6%	↓
<b>KPMAS</b>				NA□	44.1%	↓
<b>MPC</b>				66.8%	64.6%	↓
<b>MSFC</b>				55%	44.4%	↓
<b>PPMCO</b>				74.7%	50.2%	↓
<b>UHC</b>				45.1%	48.0%	↓
<b>UMHP</b>				NA□	56.5%	↓
<b>MARR</b>				62.5%	51.4%	↓

\* This measure was added by MDH for reporting in HEDIS 2016.

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

\*\*NCQA Benchmarks will not be available until HEDIS 2018 when there are two years of valid data.



# Diabetes

## Comprehensive Diabetes Care (CDC)

### Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

1. Hemoglobin A1c (HbA1c) testing
2. HbA1c poor control (>9.0%)
3. HbA1c control (<8.0%)
4. HbA1c control (<7.0%) for a selected population\*
5. Eye exam (retinal) performed
6. Medical attention for nephropathy
7. BP control (<140/90 mm Hg)

\* Additional exclusion criteria are required for this indicator that will result in a different eligible population from all other indicators. This indicator is only reported for the commercial and Medicaid product lines.

### Rationale

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States (U.S.). Approximately 26.5 million Americans have diabetes, and seven million of these cases are undiagnosed. Complications from the disease cost the country nearly \$245 billion annually. In addition, diabetes is the seventh leading cause of death in the U.S. (American Diabetes Association, 2013). Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages.

### Summary of Changes to HEDIS 2017:

- Added an administrative method and new value set to identify negative eye exams in the year prior to the measurement year.
- Added glycohemoglobin, glycated hemoglobin and glycosylated hemoglobin as acceptable HbA1c tests.
- Clarified documentation requirements for a negative eye exam.
- Replaced “Each of the 7 rates” with a “✓” for the “Measurement year” row in Table CDC-1/2/3.

<b>Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing</b>						
	<b>2013</b>	<b>2014</b>	<b>2015*</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	81.1%	83.4%	88.7%	87.4%	85.0%	↓
<b>JMS</b>	89.8%	89.1%	90.7%	94.3%	95.0%	↑
<b>KPMAS</b>			96.4%	94.5%	92.7%	↑
<b>MPC</b>	76.0%	79.5%	87.9%	85.9%	88.7%	↑
<b>MSFC</b>	83.5%	84.7%	88.0%	87.8%	91.7%	↑
<b>PPMCO</b>	82.4%	78.1%	89.4%	89.4%	89.3%	↑
<b>UHC</b>	78.1%	79.1%	85.9%	82.5%	86.1%	↑
<b>UMHP</b>		NA□	84.6%	88.3%	82.5%	↓
<b>MARR</b>	81.2%	85.5%	89.0%	88.8%	88.9%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Comprehensive Diabetes (CDC) – HbA1c Poor Control (&gt;9.0%)*</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	44.0%	38.8%	38.5%	42.2%	40.0%	↑
<b>JMS</b>	35.4%	31.0%	37.2%	26.6%	27.0%	↑
<b>KPMAS</b>			21.8%	28.2%	27.8%	↑
<b>MPC</b>	52.6%	48.6%	40.8%	40.8%	34.4%	↑
<b>MSFC</b>	35.3%	37.2%	44.5%	31.6%	29.5%	↑
<b>PPMCO</b>	41.7%	48.1%	35.6%	35.6%	34.0%	↑
<b>UHC</b>	54.3%	45.5%	41.1%	39.7%	35.5%	↑
<b>UMHP</b>		NA□	60.8%	39.2%	42.1%	↑
<b>MARR</b>	44.3%	41.5%	40.1%	35.5%	33.8%	↑

\* A lower rate indicates better performance.

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Comprehensive Diabetes (CDC) – HbA1c Control (&lt; 8.0%)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	47.1%	51.4%	51.4%	49.2%	52.0%	↑
<b>JMS</b>	54.7%	61.5%	52.4%	60.4%	63.0%	↑
<b>KPMAS</b>			60.0%	57.6%	60.0%	↑
<b>MPC</b>	39.9%	43.3%	50.8%	49.7%	56.5%	↑
<b>MSFC</b>	58.9%	54.0%	43.5%	59.9%	58.1%	↑
<b>PPMCO</b>	49.1%	44.3%	54.3%	55.1%	53.5%	↑
<b>UHC</b>	38.9%	46.47%	46.2%	51.6%	51.1%	↑
<b>UMHP</b>		NA□	38.8%	48.2%	48.7%	↑
<b>MARR</b>	47.8%	50.2%	49.7%	54.0%	55.3%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	69.3%	65.4%	48.6%	53.9%	49.0%	↕
<b>JMS</b>	80.1%	79.6%	64.1%	71.9%	74.0%	↑
<b>KPMAS</b>			87.3%	84.7%	87.8%	↑
<b>MPC</b>	64.6%	72.0%	65.7%	65.8%	51.9%	↕
<b>MSFC</b>	72.8%	71.1%	54.0%	52.6%	49.8%	↕
<b>PPMCO</b>	78.1%	71.0%	69.0%	62.9%	55.7%	↑
<b>UHC</b>	57.7%	56.9%	58.6%	55.2%	56.9%	↑
<b>UMHP</b>		NA <sup>□</sup>	44.8%	35.0%	31.2%	↕
<b>MARR</b>	69.6%	69.3%	61.5%	60.2%	57.0%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	73.6%	75.7%	80.3%	90.7%	87.0%	↕
<b>JMS</b>	93.6%	93.1%	93.4%	96.9%	94.0%	↑
<b>KPMAS</b>			100.0%	95.3%	94.2%	↑
<b>MPC</b>	74.4%	75.3%	75.9%	89.9%	87.9%	↕
<b>MSFC</b>	78.8%	82.7%	80.9%	91.0%	92.4%	↑
<b>PPMCO</b>	77.6%	73.8%	82.5%	89.4%	99.8%	↑
<b>UHC</b>	74.2%	75.9%	81.5%	91.2%	90.3%	↑
<b>UMHP</b>		NA <sup>□</sup>	74.8%	90.8%	85.6%	↕
<b>MARR</b>	77.7%	79.4%	83.7%	91.9%	91.4%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Comprehensive Diabetes (CDC) – Blood Pressure Control (&lt;140/90 mm Hg)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	48.4%	55.6%	65.3%	60.0%	64.0%	↑
<b>JMS</b>	59.1%	60.4%	69.7%	76.8%	78.0%	↑
<b>KPMAS</b>			83.6%	87.1%	84.5%	↑
<b>MPC</b>	47.1%	55.4%	56.4%	55.2%	55.6%	↕
<b>MSFC</b>	73.7%	70.1%	69.0%	67.6%	62.9%	↑
<b>PPMCO</b>	63.3%	64.2%	60.7%	62.6%	55.5%	↕
<b>UHC</b>	47.0%	51.6%	55.2%	46.0%	59.9%	↑
<b>UMHP</b>		NA <sup>□</sup>	39.9%	36.5%	41.6%	↕
<b>MARR</b>	57.3%	59.5%	62.5%	61.5%	62.7%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## **Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)**

### **Description**

The percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

### **Rationale**

Prevalence rates of metabolic syndrome in people with schizophrenia is 42.6 percent for males and 48.5 percent for females, compared with rates in the general population (24 percent for males, 23 percent for females) (Cohn et al., 2004).

People with diabetes and schizophrenia or bipolar disorder have a 50 percent higher risk of death than diabetics without a mental illness (Vinogradova et al., 2010). Among patients with co-occurring schizophrenia and metabolic disorders, the non-treatment rate for diabetes is approximately 32 percent (Nasrallah et al., 2006). In addition to general diabetes risk factors, diabetes is promoted in patients with schizophrenia by initial and current treatment with olanzapine and mid-potency first-generation antipsychotics (FGA), as well as by current treatment with low-potency FGAs and clozapine (Nielsen, Skadhede, & Correll, 2010). •In 2007, diabetes was estimated to cost the U.S. economy \$174 billion. Of this, \$116 billion was attributed to medical care and \$58 billion to disability, work loss and premature death (Roger et al., 2011).

Improving blood sugar control has shown to lead to lower use of health care services and better overall satisfaction with diabetes treatment (Asche, LaFleur, & Conner, 2011). People who control their diabetes also report improved quality of life and emotional well-being (Saatci et al., 2010).

### **Summary of Changes to HEDIS 2017:**

- Replaced all references to BH ED POS Value Set with ED POS Value Set (the codes in these value sets are the same).
- Clarified the criteria for optional exclusions.

<b>Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			76.7%	68.9%	74.0%	↑
<b>JMS</b>			NA□	NA□	77.0%	↑
<b>KPMAS</b>			NA□	NA□	NA□	NA□
<b>MPC</b>			NR□□	65.5%	62.7%	↓
<b>MSFC</b>			NA□	NA□	NA□	NA□
<b>PPMCO</b>			68.7%	68.7%	70.2%	↑
<b>UHC</b>			74.6%	72.2%	75.4%	↑
<b>UMHP</b>			NA□	NA□	NA□	NA□
<b>MARR</b>			73.4%	68.8%	71.8%	↑

\* This measure was added by MDH for reporting in HEDIS 2015.

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

□□ This measure is Not Reportable due to bias in the data.

## **Statin Therapy for Patients With Diabetes (SPD)**

### **Description**

The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria.

Two rates are reported:

1. Received Statin Therapy. Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

### **Rationale**

Diabetes is a complex group of diseases marked by high blood sugar due to the body's inability to make or use insulin. Diabetes can lead to serious complications (Centers for Disease Control and Prevention [CDC], 2014). Twenty-nine million (9.3 percent) of Americans had diabetes in 2012 and 1.7 million adults were newly diagnosed with diabetes (American Diabetes Association [ADA], 2014). Patients with diabetes have elevated cardiovascular risk, thought to be due in part to elevations in unhealthy cholesterol levels. Having unhealthy cholesterol levels places patients at a significant risk for developing atherosclerotic cardiovascular disease (ASCVD) (ADA, 2015).

Primary prevention for cardiovascular disease is an important aspect of diabetes management. The risk of an adult with diabetes developing cardiovascular disease is two to four times higher than that of an adult without diabetes (American Heart Association [AHA], 2012). In addition to being at a higher risk for developing cardiovascular disease, patients with diabetes tend to have worse survival after the onset of cardiovascular disease (Stone et al., 2014). The CDC estimates that adults with diabetes are 1.7 times more likely to die from cardiovascular disease than adults without diabetes (CDC, 2014).

Numerous studies have demonstrated the efficacy of statins in reducing cardiovascular risk. The use of statins for primary prevention of cardiovascular disease in patients with diabetes, based on their age and other risk factors, is recommended by guidelines from the ADA (2015) and the American College of Cardiology/American Heart Association (ACC/AHA) (Stone et al., 2014).

Statins (3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors) are a class of drugs that decrease low-density lipoprotein cholesterol (LDL-C) levels. Statins can decrease LDL-C levels by as much as 50% and could have additional benefit on high-density lipoprotein cholesterol (HDL-C) and triglyceride levels (Spratt, 2009). The amount of cholesterol lowering effect is based on statin intensity, which is classified as either high, moderate or low intensity.

Cholesterol lowering medications, such as statins, are among the most commonly prescribed drugs in America, accumulating \$17 billion in sales in 2012. In the United States, 22 percent of adults (45 and older) take statins (CDC, 2014). Evidence shows statin use decreases cardiovascular mortality in patients with established cardiovascular disease, and total mortality rates. Primary and secondary prevention trial data strongly support starting lipid-lowering therapy with a statin in most patients with type 2 diabetes (Spratt, 2009).

In a systematic review and meta-analysis of 12 studies conducted to evaluate the clinical benefit of lipid-lowering drug treatment in primary and secondary prevention, researchers found statins were equally effective in patients with and without diabetes (Costa et al., 2006). However, after adjusting for baseline risk, patients with diabetes had greater benefit in both the primary and secondary prevention of death due to coronary artery disease, nonfatal myocardial infarction, revascularization and stroke. Another meta-analysis by the American College of Physicians on lipid-lowering therapy for type 2 diabetes patients found a 22 percent reduction of cardiovascular events with primary prevention and a 24 percent reduction for secondary prevention (Spratt, 2009).

The total cost of diabetes care in the United States was \$245 billion in 2012—a 41 percent increase from \$175 billion in 2007. The cost of care to treat patients with diabetes includes direct costs (\$176 billion) from office visits, hospital care and medications. Indirect costs to treat patients with diabetes are estimated to be \$69 billion and includes costs for absenteeism, reduced productivity, unemployment due to disability and loss of productivity due to premature mortality. Research also shows that more than 1 in 10 dollars spent on health care in the United States are spent on the care of patients with diabetes and its complications (ADA, 2013).

The ACC/AHA guidelines state, "Adherence to both medication and lifestyle regimens are required for ASCVD risk reduction" (Stone et al., 2014). This measure uses the proportion of days covered (PDC) to assess adherence. According to the Pharmacy Quality Alliance, a PDC threshold of 80 percent is considered highly adherent for most classes of chronic medications (Nau, 2012).

The impact of adherence on statin efficacy has been shown: each 25 percent increase in statin adherence is associated with an approximate 3.8 mg/dL reduction in low-density lipoprotein cholesterol (Ho, Bryson, & Rumsfeld, 2009). Nonadherence to statin therapy can result in an increased risk for morbidity and mortality. One study found a 12 percent to 25 percent increase in the risk for mortality with nonadherence to statins after an acute myocardial infarction (Rasmussen, Chong, & Alter, 2007).

**Summary of Changes to HEDIS 2017:**

- Clarified that optional exclusions are excluded from the denominator for both rates.
- Added a Note.

<b>Statin Therapy for Patients With Diabetes (SPD) – Received Statin Therapy</b>						
	<b>2013</b>	<b>2014</b>	<b>2015*</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>				58.3%	59.4%	↑
<b>JMS</b>				59.4%	63.3%	↑
<b>KPMAS</b>				79.1%	84.4%	↑
<b>MPC</b>				59.3%	59.2%	↑
<b>MSFC</b>				58.8%	59.5%	↑
<b>PPMCO</b>				57.6%	58.6%	↑
<b>UHC</b>				59.0%	58.2%	↑
<b>UMHP</b>				50.5%	53.8%	↓
<b>MARR</b>				60.3%	62.1%	↑

\* This measure was added by MDH for reporting in HEDIS 2016.

\*\*NCQA Benchmarks will not be available until HEDIS 2018 when there are two years of valid data.

<b>Statin Therapy for Patients With Diabetes (SPD) – Statin Adherence 80%</b>						
	<b>2013</b>	<b>2014</b>	<b>2015*</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>				54.1%	49.2%	↓
<b>JMS</b>				49.5%	50.7%	↓
<b>KPMAS</b>				55.9%	50.3%	↓
<b>MPC</b>				60.0%	59.7%	↑
<b>MSFC</b>				54.3%	48.8%	↓
<b>PPMCO</b>				50.6%	48.9%	↓
<b>UHC</b>				48.6%	48.7%	↓
<b>UMHP</b>				58.3%	57.9%	↑
<b>MARR</b>				53.9%	51.8%	↓

\* This measure was added by MDH for reporting in HEDIS 2016.

\*\*NCQA Benchmarks will not be available until HEDIS 2018 when there are two years of valid data.

# Musculoskeletal Conditions

## Use of Imaging Studies for Low Back Pain (LBP)

### Description

The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

### Rationale

Low back pain is a pervasive problem that affects two thirds of adults at some time in their lives. It ranks among the top 10 reasons for patient visits to internists and is the most common and expensive reason for work disability in the United States (U.S.) (Jarvik & Deyo, 2002). Back problems are second only to cough among symptoms of people who seek medical care at physician offices, outpatient departments and emergency rooms (Center for the Advancement of Health, 2000).

Back pain is among the most common musculoskeletal conditions, afflicting approximately 31 million Americans, and is the number one cause of activity limitation in young adults. For most individuals, back pain quickly improves. Nevertheless, approximately 15 percent of the U.S. population reports having frequent low back pain that lasted for at least two weeks during the previous year. Persistent pain that lasts beyond 3 to 6 months occurs in only 5 to 10 percent of patients with low back pain (Lawrence et al., 1998). According to the American College of Radiology (n.d.), uncomplicated low back pain is a benign, self-limited condition that does not warrant any imaging studies. The majority of patients are back to their usual activities in 30 days.

There is no compelling evidence to justify substantial deviation from the diagnostic strategy published in clinical guidelines, which indicate that for most patients with acute low back pain, diagnostic imaging is usually unnecessary. Although patients may have a perceived need for imaging studies, efforts to educate patients on appropriate indications for imaging are within a provider's capacity.

### Summary of Changes to HEDIS 2017:

- Replaced the Low Back Pain Value Set with the Uncomplicated Low Back Pain Value Set in step 1 of the event/diagnosis.
- Added instructions to identify ED visits and observation visits that result in an inpatient stay.
- Renamed the Osteopathic Manipulative Treatment Value Set to Osteopathic and Chiropractic Manipulative Treatment Value Set in step 1 of the event/diagnosis.
- Added the Physical Therapy Value Set to step 1 of the event/diagnosis.
- Added the Telehealth Value Set to step 1 of the event/diagnosis.
- Replaced the Low Back Pain Value Set with the Uncomplicated Low Back Pain Value Set in step 3 of the event/diagnosis.
- Revised the look back period to exclude members with recent trauma from 12-months to 3-months in step 4 of the event/diagnosis.
- Added required exclusions and the following value sets: HIV Value Set, Spinal Infection Value Set, Organ Transplant Other Than Kidney Value Set, Kidney Transplant Value Set to step 4 of the event/diagnosis.
- Added a required exclusion for prolonged use of corticosteroids to step 4 of the event/diagnosis.
- Replaced the Low Back Pain Value Set with the Uncomplicated Low Back Pain Value Set in the numerator.
- Added a requirement to not include denied claims in the numerator.



<b>Use of Imaging Studies for Low Back Pain (LBP)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	77.8%	76.7%	74.2%	74.6%	76.0%	↑
<b>JMS</b>	70.9%	77.2%	69.2%	77.7%	69.0%	↓
<b>KPMAS</b>			NA <sup>□</sup>	71.5%	76.9%	↑
<b>MPC</b>	75.2%	76.6%	76.7%	75.5%	72.7%	↓
<b>MSFC</b>	73.1%	73.3%	71.8%	72.7%	66.1%	↓
<b>PPMCO</b>	75.0%	75.2%	75.0%	76.0%	77.8%	↑
<b>UHC</b>	74.8%	73.4%	74.3%	73.2%	73.3%	↓
<b>UMHP</b>		NA <sup>□</sup>	78.1%	74.2%	70.4%	↓
<b>MARR</b>	74.9%	75.4%	74.2%	74.4%	72.8%	↓

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

### Description

The percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).

### Rationale

Disease modifying anti-rheumatic drugs (DMARDs) modify the disease course of rheumatoid arthritis (RA) through attenuation of the progression of bony erosions, reduction of inflammation and long-term structural damage. The utilization of DMARDs is also expected to provide improvement in functional status.

RA is a chronic autoimmune disorder often characterized by progressive joint destruction and multisystem involvement. It affects approximately 2.5 million Americans, and affects women disproportionately (Hochberg & Spector, 1990; McDuffie, 1985; Alarcon, 1995). There is no cure; consequently, the goal of treatment is to slow the progression of the disease and thereby delay or prevent joint destruction, relieve pain, and maintain functional capacity.

Evidence-based guidelines support early initiation of DMARD therapy in patients diagnosed with RA. These guidelines include the American College of Rheumatology (ACR) Subcommittee on Rheumatoid Arthritis Guidelines: Guidelines for the Management of Rheumatoid Arthritis (Harris & Zorab, 1997). All patients with RA are candidates for DMARD therapy, and the majority of the newly diagnosed should be started on DMARD therapy within three months of diagnosis.

The American Pain Society's Guideline for the Management of Pain in Osteoarthritis, Rheumatoid Arthritis, and Juvenile Chronic Arthritis (2002) notes that almost all people with RA require pharmacotherapy with a DMARD.

### Summary of Changes for HEDIS 2017:

- Added the HIV Type 2 Value Set to the optional exclusions.

<b>Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	61.8%	60.0%	62.8%	78.0%	80.0%	↑
<b>JMS</b>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	73.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	NA <sup>□</sup>	93.6%	↑
<b>MPC</b>	71.9%	73.8%	65.8%	67.5%	69.3%	↓
<b>MSFC</b>	NA <sup>□</sup>	NA <sup>□</sup>	89.2%	77.4%	78.9%	↑
<b>PPMCO</b>	69.5%	67.6%	72.5%	83.1%	77.6%	↑
<b>UHC</b>	73.3%	67.7%	61.5%	69.8%	72.1%	↑
<b>UMHP</b>		NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	73.5%	↑
<b>MARR</b>	69.1%	67.3%	70.3%	75.2%	77.3%	↑

<sup>□</sup> This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

# Medication Management

## Annual Monitoring for Patients on Persistent Medications (MPM)

### Description

The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the four rates separately and as a total rate.

1. Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
2. Annual monitoring for members on digoxin
3. Annual monitoring for members on diuretics
4. Total rate (the sum of the four numerators divided by the sum of the four denominators)

### Rationale

Patient safety is highly important, especially for patients at increased risk of adverse drug events from long-term medication use. Persistent use of these drugs warrants monitoring and follow-up by the prescribing physician to assess for side-effects and adjust drug dosage/therapeutic decisions accordingly. The drugs included in this measure have deleterious effects in the elderly.

The costs of annual monitoring are offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications. The total costs of drug-related problems due to misuse of drugs in the ambulatory setting has been estimated to exceed \$76 billion annually (Johnson & Bootman, 1995).

Appropriate monitoring of drug therapy remains a significant issue to guide therapeutic decision making and provides largely unmet opportunities for improvement in care for patients on persistent medications (Classen, 2003). Although there are no specific clinical guideline recommendations on the frequency of monitoring for the drugs identified in the measure, annual monitoring represents a conservative standard of care and is supported by U.S. Food and Drug Administration (FDA) drug labeling recommendations for each drug.

### Summary of Changes for HEDIS 2017:

- No changes were made to this measure for HEDIS 2017.

<b>Annual Monitoring for Patients on Persistent Medications (MPM) - members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	90.1%	89.0%	89.4%	90.5%	90.0%	↑
<b>JMS</b>	95.8%	95.1%	94.4%	96.5%	97.0%	↑
<b>KPMAS</b>			95.0%	92.8%	92.0%	↑
<b>MPC</b>	88.9%	87.0%	88.4%	89.0%	88.5%	↑
<b>MSFC</b>	87.6%	90.2%	90.0%	90.3%	89.3%	↑
<b>PPMCO</b>	88.224%	88.1%	88.1%	89.0%	88.4%	↑
<b>UHC</b>	88.222%	88.6%	89.2%	88.7%	89.4%	↑
<b>UMHP</b>		NA <sup>□</sup>	86.1%	86.1%	85.6%	↓
<b>MARR</b>	89.5%	89.7%	90.1%	90.4%	90.0%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Annual Monitoring for Patients on Persistent Medications (MPM) - members on digoxin</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	95.8%	95.7%	59.5%	58.3%	44.0%	↓
<b>JMS</b>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>
<b>KPMAS</b>			NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>
<b>MPC</b>	91.4%	92.2%	54.9%	47.5%	43.9%	↓
<b>MSFC</b>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>
<b>PPMCO</b>	91.5%	88.9%	44.9%	58.1%	43.6%	↓
<b>UHC</b>	93.4%	86.4%	57.7%	52.9%	48.3%	↓
<b>UMHP</b>		NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>	NA <sup>□</sup>
<b>MARR</b>	93.1%	90.8%	54.2%	54.2%	44.9%	↓

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Annual Monitoring for Patients on Persistent Medications (MPM) - diuretics</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	88.2%	86.9%	88.42%	89.6%	89.0%	↑
<b>JMS</b>	94.3%	94.1%	93.9%	95.6%	95.0%	↑
<b>KPMAS</b>			NA <sup>□</sup>	90.8%	90.5%	↑
<b>MPC</b>	88.04%	86.2%	86.5%	88.5%	88.0%	↑
<b>MSFC</b>	88.02%	88.5%	89.0%	88.32%	87.5%	↔
<b>PPMCO</b>	87.2%	87.4%	87.9%	88.30%	88.2%	↑
<b>UHC</b>	87.8%	87.5%	88.40%	87.8%	88.8%	↑
<b>UMHP</b>		NA <sup>□</sup>	90.5%	84.4%	86.6%	↓
<b>MARR</b>	88.1%	88.4%	89.2%	89.2%	89.2%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

<b>Annual Monitoring for Patients on Persistent Medications (MPM) - Total rate</b>						
	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>	86.2%	85.4%	88.9%	89.9%	89.0%	↑
<b>JMS</b>	93.1%	94.1%	94.0%	95.9%	96.0%	↑
<b>KPMAS</b>			94.2%	91.8%	91.4%	↑
<b>MPC</b>	88.0%	86.3%	87.2%	88.6%	88.1%	↑
<b>MSFC</b>	84.1%	86.6%	89.3%	89.4%	88.4%	↑
<b>PPMCO</b>	87.3%	87.3%	87.8%	88.5%	88.1%	↑
<b>UHC</b>	87.5%	87.7%	88.7%	88.1%	88.9%	↑
<b>UMHP</b>		NA <sup>□</sup>	87.9%	85.2%	85.9%	↓
<b>MARR</b>	87.1%	87.9%	89.7%	89.7%	89.5%	↑

□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

## Ambulatory Care (utilization)

### Ambulatory Care (AMB)

#### Description

Utilization of ambulatory care in the following categories:

- Outpatient visits
- Emergency department (ED) visits

#### Rationale

Measures in the HEDIS Use of Services domain gather information about how organizations manage the provision of member care and how they use and manage resources. Use of services is affected by many member characteristics, which can vary greatly among organizations, and include age and sex, current medical condition, socioeconomic status and regional practice patterns. This measure assesses member use of two kinds of ambulatory services. Outpatient visits include office visits or routine visits to hospital outpatient departments. Emergency rooms often deliver nonemergency care.

#### Summary of Changes to HEDIS 2017:

- Clarified the example calculation in step 2.

Ambulatory Care (AMB) – Outpatient visits per 1,000 member months						
	2013	2014	2015	2016	2017	NHM
ACC	363.6	365.1	356.0	372.6	366.86	↑
JMS	373.9	340.8	315.5	345.1	350.64	↓
KPMAS			404.4	324.9	336.59	↓
MPC	385.3	365.3	365.0	406.4	420.40	↑
MSFC	361.6	344.5	360.0	358.6	359.78	↑
PPMCO	407.8	386.6	390.7	406.5	NA <sup>□</sup>	NA
UHC	374.2	373.3	381.6	378.1	367.49	↑
UMHP		269.8	296.8	332.6	247.26	↓
MARR	370.3	349.3	358.8	365.6	349.86	↓

Ambulatory Care (AMB) – Emergency department (ED) visits per 1,000 member months						
	2013	2014	2015	2016	2017	NHM
ACC	59.8	56.2	58.2	55.1	53.43	↓
JMS	93.4	90.1	96.4	94.0	93.62	↑
KPMAS			23.2	24.9	26.28	↓
MPC	79.3	74.6	70.9	71.0	68.50	↑
MSFC	70.8	62.66	57.4	56.1	55.64	↓
PPMCO	66.0	62.70	62.0	60.1	NA <sup>□</sup>	NA
UHC	65.2	62.1	63.1	59.5	56.84	↓
UMHP		66.0	64.9	89.8	86.43	↑
MARR	74.2	67.8	62.0	63.8	62.96	↓

## **Frequency of Selected Procedures (FSP)**

### **Description**

This measure summarizes the utilization of the following frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization:

- Tonsillectomy
- Bariatric weight loss surgery
- Hysterectomy
- Cholecystectomy
- Back surgery
- Percutaneous coronary intervention (PCI)
- Cardiac catheterization
- Coronary artery bypass graft (CABG)
- Prostatectomy
- Total hip replacement
- Total knee replacement
- Carotid endarterectomy
- Mastectomy
- Lumpectomy

### **Rationale**

This measure lists several frequently performed procedures (mostly surgical) that contribute substantially to overall cost. Wide variations among geographic regions in medical procedure rates appear to have little correlation with health outcomes. The reasons for this are unclear. Some variation is because of unnecessary procedures; conversely, some procedures may not be performed often enough. These rates are likely to be strongly influenced by how the organization manages care. Variation in procedure rates presents a starting point in examining the kind of care that is being rendered to members. Coding practices, epidemiology, demographics and practice patterns may be responsible for variation. Examining these measures may help eliminate unwarranted variation in the delivery of medical care.

### **Summary of Changes to HEDIS 2017:**

- No changes were made to this measure for HEDIS 2017.

Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery / 1000 MM 45 - 64 F						
	2013	2014*	2015	2016	2017	NHM
ACC			0.05	0.05	0.05	↓
JMS			0.02	0.00	0.00	↓
KPMAS			0.00	0.00	0.05	↓
MPC			0.05	0.068	0.04	↓
MSFC			0.07	0.10	0.07	↓
PPMCO			0.05	0.06	0.03	↓
UHC			0.04	0.04	0.05	↓
UMHP			0.03	0.12	0.07	↓
MARR			0.04	0.074	0.05	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery / 1000 MM 45 - 64 M						
	2013	2014*	2015	2016	2017	NHM
ACC			0	0.007	0.01	↓
JMS			0.016	0.00	0.02	↔
KPMAS			0	0.00	0.00	↓
MPC			0	0.015	0.01	↓
MSFC			0	0.015	0.01	↓
PPMCO			0.01	0.03	0.00	↓
UHC			0.018	0.010	0.01	↓
UMHP			0.04	0.00	0.00	↓
MARR			0.02	0.015	0.01	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

Frequency of Selected Procedures (FSP) – Tonsillectomy / 1000 MM 0 - 9						
	2013	2014*	2015	2016	2017	NHM
ACC			0.42	0.48	0.48	↓
JMS			0.18	0.13	0.21	↓
KPMAS			0.13	0.00	0.23	↓
MPC			0.47	0.55	0.62	↑
MSFC			0.38	0.45	0.48	↓
PPMCO			0.60	0.64	0.58	↓
UHC			0.42	0.51	0.51	↓
UMHP			0.20	0.31	0.37	↓
MARR			0.35	0.44	0.44	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

<b>Frequency of Selected Procedures (FSP) – Tonsillectomy / 1000 MM 10 - 19</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			0.15	0.186	0.14	↓
<b>JMS</b>			0.5	0.18	0.17	↓
<b>KPMAS</b>			0.20	0.00	0.20	↓
<b>MPC</b>			0.20	0.26	0.26	↓
<b>MSFC</b>			0.17	0.19	0.24	↓
<b>PPMCO</b>			0.24	0.25	0.24	↓
<b>UHC</b>			0.19	0.194	0.20	↓
<b>UMHP</b>			0.9	0.16	0.34	↓
<b>MARR</b>			0.16	0.20	0.22	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

<b>Frequency of Selected Procedures (FSP) – Hysterectomy, abdominal / 1000 MM 45 - 64 F</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			0.45	0.31	0.27	↓
<b>JMS</b>			0.43	0.36	0.31	↔
<b>KPMAS</b>			0.01	0.00	0.26	↓
<b>MPC</b>			0.49	0.32	0.27	↓
<b>MSFC</b>			0.53	0.47	0.30	↓
<b>PPMCO</b>			0.352	0.45	0.26	↓
<b>UHC</b>			0.46	0.28	0.28	↓
<b>UMHP</b>			0.45	0.23	0.32	↑
<b>MARR</b>			0.52	0.35	0.28	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

<b>Frequency of Selected Procedures (FSP) – Hysterectomy, vaginal / 1000 MM 45 - 64 F</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			0.18	0.1510	0.15	↓
<b>JMS</b>			0.2	0.00	0.02	↓
<b>KPMAS</b>			0.0	0.00	0.20	↓
<b>MPC</b>			0.15	0.24	0.19	↓
<b>MSFC</b>			0.16	0.22	0.27	↑
<b>PPMCO</b>			0.19	0.31	0.17	↓
<b>UHC</b>			0.19	0.1506	0.17	↓
<b>UMHP</b>			0.11	0.17	0.17	↓
<b>MARR</b>			0.14	0.21	0.17	↓

\* This measure was added by MDH for reporting in HEDIS 2015.



<b>Frequency of Selected Procedures (FSP) – Cholecystectomy, open / 1000 MM 30 - 64 M</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			0.04	0.022	0.02	↓
<b>JMS</b>			0.031	0.0569	0.02	↓
<b>KPMAS</b>			0.0	0.00	0.03	↔
<b>MPC</b>			0.07	0.04	0.07	↑
<b>MSFC</b>			0.06	0.0574	0.06	↑
<b>PPMCO</b>			0.05	0.03	0.04	↑
<b>UHC</b>			0.04	0.018	0.04	↑
<b>UMHP</b>			0.0	0.00	0.05	↑
<b>MARR</b>			0.05	0.039	0.04	↑

\* This measure was added by MDH for reporting in HEDIS 2015.

<b>Frequency of Selected Procedures (FSP) – Cholecystectomy, open / 1000 MM 45 - 64 F</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			0.04	0.022	0.04	↑
<b>JMS</b>			0.031	0.0569	0.02	↑
<b>KPMAS</b>			0.0	0.00	0.03	↓
<b>MPC</b>			0.07	0.04	0.07	↑
<b>MSFC</b>			0.06	0.0574	0.06	↑
<b>PPMCO</b>			0.05	0.03	0.04	↔
<b>UHC</b>			0.04	0.018	0.04	↑
<b>UMHP</b>			0.0	0.00	0.05	↑
<b>MARR</b>			0.05	0.039	0.04	↑

\* This measure was added by MDH for reporting in HEDIS 2015.

<b>Frequency of Selected Procedures (FSP) – Cholecystectomy, Laparoscopic / 1000 MM 30 - 64 M</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			0.04	0.022	0.04	↓
<b>JMS</b>			0.031	0.0569	0.02	↓
<b>KPMAS</b>			0.0	0.00	0.03	↓
<b>MPC</b>			0.07	0.04	0.07	↔
<b>MSFC</b>			0.06	0.0574	0.06	↓
<b>PPMCO</b>			0.05	0.03	0.04	↓
<b>UHC</b>			0.04	0.018	0.04	↓
<b>UMHP</b>			0.0	0.00	0.05	↓
<b>MARR</b>			0.05	0.039	0.04	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

Frequency of Selected Procedures (FSP) – Cholecystectomy, Laparoscopic / 1000 MM 45 - 64 F						
	2013	2014*	2015	2016	2017	NHM
ACC			0.48	0.36	0.51	↓
JMS			0.18	0.29	0.19	↓
KPMAS			0.0	0.00	0.24	↓
MPC			0.668	0.62	0.55	↓
MSFC			0.68	0.40	0.56	↓
PPMCO			0.65	0.69	0.51	↓
UHC			0.59	0.44	0.42	↓
UMHP			0.34	0.43	0.32	↓
MARR			0.51	0.46	0.41	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

Frequency of Selected Procedures (FSP) – Back Surgery / 1000 MM 45 - 64 F						
	2013	2014*	2015	2016	2017	NHM
ACC			0.41	0.46	0.53	↑
JMS			0.58	0.56	0.59	↑
KPMAS			0.0	0.00	0.14	↓
MPC			0.65	0.81	0.86	↑
MSFC			0.56	0.67	0.58	↑
PPMCO			0.77	0.74	0.62	↑
UHC			0.54	0.60	0.54	↑
UMHP			0.3	0.43	0.39	↓
MARR			0.54	0.61	0.53	↑

\* This measure was added by MDH for reporting in HEDIS 2015.

Frequency of Selected Procedures (FSP) – Back Surgery / 1000 MM 45 - 64 M						
	2013	2014*	2015	2016	2017	NHM
ACC			0.43	0.58	0.42	↓
JMS			0.42	0.41	0.50	↓
KPMAS			0.0	0.00	0.16	↓
MPC			0.65	0.85	0.84	↑
MSFC			0.51	0.69	0.68	↑
PPMCO			0.65	0.80	0.82	↑
UHC			0.62	0.83	0.70	↑
UMHP			0.38	0.47	0.39	↓
MARR			0.52	0.66	0.56	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

Frequency of Selected Procedures (FSP) – Mastectomy / 1000 MM 15 - 44 F						
	2013	2014*	2015	2016	2017	NHM
ACC			0.022	0.0226	0.03	↔
JMS			0.03	0.050	0.00	↓
KPMAS			0.00	0.00	0.00	↓
MPC			0.026	0.045	0.02	↓
MSFC			0.016	0.01	0.04	↑
PPMCO			0.036	0.035	0.02	↓
UHC			0.041	0.0233	0.03	↔
UMHP			0.00	0.051	0.04	↑
MARR			0.028	0.034	0.02	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

Frequency of Selected Procedures (FSP) – Mastectomy / 1000 MM 45 - 64 F						
	2013	2014*	2015	2016	2017	NHM
ACC			0.16	0.13	0.18	↓
JMS			0.4	0.07	0.02	↓
KPMAS			0	0.00	0.15	↓
MPC			0.14	0.12	0.08	↓
MSFC			0.11	0.10	0.06	↓
PPMCO			0.21	0.23	0.11	↓
UHC			0.19	0.171	0.13	↓
UMHP			0.18	0.173	0.07	↓
MARR			0.15	0.14	0.1	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

Frequency of Selected Procedures (FSP) – Lumpectomy / 1000 MM 15 - 44 F						
	2013	2014*	2015	2016	2017	NHM
ACC			0.14	0.113	0.09	↓
JMS			0.0	0.07	0.05	↓
KPMAS			0.0	0.00	0.06	↓
MPC			0.13	0.106	0.12	↑
MSFC			0.18	0.20	0.12	↑
PPMCO			0.15	0.14	0.12	↑
UHC			0.12	0.107	0.11	↔
UMHP			0.10	0.05	0.08	↓
MARR			0.14	0.111	0.09	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

<b>Frequency of Selected Procedures (FSP) – Lumpectomy / 1000 MM 45 - 64 F</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			0.365	0.27	0.33	↓
<b>JMS</b>			0.21	0.25	0.19	↓
<b>KPMAS</b>			0.10	0.00	0.41	↑
<b>MPC</b>			0.29	0.28	0.37	↓
<b>MSFC</b>			0.41	0.52	0.36	↓
<b>PPMCO</b>			0.49	0.42	0.32	↓
<b>UHC</b>			0.371	0.38	0.29	↓
<b>UMHP</b>			0.27	0.14	0.37	↓
<b>MARR</b>			0.43	0.32	0.33	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

## **Inpatient Utilization - General Hospital/Acute Care (IPU)**

### **Description**

This measure summarizes utilization of acute inpatient care and services in the following categories:

- Total inpatient
- Maternity
- Surgery
- Medicine

### **Rationale**

Measures in the HEDIS Use of Services domain gather information about how organizations manage the provision of member care and how they use and manage resources. Use of services is affected by many member characteristics, which can vary greatly among organizations, and include age and sex, current medical condition, socioeconomic status and regional practice patterns.

This measure assesses the extent to which the organization's members receive inpatient hospital treatment because of pregnancy and childbirth, for surgery or for nonsurgical medical treatment. The organization reports how many hospital stays occurred during the measurement year and the length of hospitalization.

### **Summary of Changes to HEDIS 2017:**

- No changes were made to this measure for HEDIS 2017.

<b>Inpatient Utilization - General Hospital/Acute Care (IPU) Total Inpatient: Total Discharges / 1000 Member Months (MM)</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			0.365	0.27	0.33	↕
<b>JMS</b>			0.21	0.25	0.19	↑
<b>KPMAS</b>			0.10	0.00	0.41	↕
<b>MPC</b>			0.29	0.28	0.37	↕
<b>MSFC</b>			0.41	0.52	0.36	↕
<b>PPMCO</b>			0.49	0.42	0.32	↕
<b>UHC</b>			0.371	0.38	0.29	↕
<b>UMHP</b>			0.27	0.14	0.37	↕
<b>MARR</b>			0.43	0.32	0.33	↕

\* This measure was added by MDH for reporting in HEDIS 2015.

<b>Inpatient Utilization - General Hospital/Acute Care (IPU) Total Inpatient: Total Average Length of Stay</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			3.96	4.14	4.17	↓
<b>JMS</b>			4.12	4.81	4.47	↑
<b>KPMAS</b>			4.59	3.34	3.36	↓
<b>MPC</b>			3.66	3.75	3.87	↓
<b>MSFC</b>			4.03	4.22	4.18	↓
<b>PPMCO</b>			3.85	4.06	4.09	↓
<b>UHC</b>			4.12	4.23	4.40	↑
<b>UMHP</b>			3.72	3.47	3.51	↓
<b>MARR</b>			4.01	4.00	4.01	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

## Antibiotic Utilization (ABX)

### Description

This measure summarizes the following data on outpatient utilization of antibiotic prescriptions during the measurement year, stratified by age and gender:

- Total number of antibiotic prescriptions
- Average number of antibiotic prescriptions per member per year (PMPY)
- Total days supplied for all antibiotic prescriptions
- Average days supplied per antibiotic prescription
- Total number of prescriptions for antibiotics of concern
- Average number of prescriptions PMPY for antibiotics of concern
- Percentage of antibiotics of concern for all antibiotic prescriptions
- Average number of antibiotics PMPY reported by drug class:
  - For selected “antibiotics of concern”
  - For all other antibiotics

### Rationale

Measures in the HEDIS Use of Services domain gather information about how organizations manage the provision of member care and how they use and manage resources. Use of services is affected by many member characteristics, which can vary greatly among organizations, and include age and sex, current medical condition, socioeconomic status and regional practice patterns.

This measure assesses the number of all antibiotic prescriptions to enrolled members, as well as antibiotics of concern, to encourage plans to reduce potential overuse, which may contribute to drug resistance.

### Summary of Changes to HEDIS 2017:

- No changes were made to this measure for HEDIS 2017.

<b>Antibiotic Utilization (ABX) – Average Scripts PMPY for Antibiotics</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			0.87	0.85	0.84	↓
<b>JMS</b>			0.88	0.87	0.79	↓
<b>KPMAS</b>			0.68	0.67	0.58	↓
<b>MPC</b>			1.03	1.10	1.09	↑
<b>MSFC</b>			0.86	0.88	0.90	↓
<b>PPMCO</b>			0.97	0.97	0.98	↓
<b>UHC</b>			0.98	0.92	0.91	↓
<b>UMHP</b>			0.77	0.85	0.86	↓
<b>MARR</b>			0.878	0.89	0.87	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

<b>Antibiotic Utilization (ABX) – Average Days Supplied per Antibiotic Script</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			9.29	9.35	9.28	↓
<b>JMS</b>			8.98	9.00	8.67	↓
<b>KPMAS</b>			8.99	9.46	9.29	↓
<b>MPC</b>			9.40	9.32	9.30	↓
<b>MSFC</b>			9.23	9.10	8.94	↓
<b>PPMCO</b>			9.39	9.42	9.32	↓
<b>UHC</b>			9.26	9.35	9.09	↓
<b>UMHP</b>			9.21	9.28	9.32	↓
<b>MARR</b>			9.22	9.28	9.15	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

<b>Antibiotic Utilization (ABX) – Average Scripts PMPY for Antibiotics of Concern</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			0.350	0.35	0.34	↓
<b>JMS</b>			0.29	0.29	0.26	↓
<b>KPMAS</b>			0.27	0.25	0.22	↓
<b>MPC</b>			0.41	0.45	0.45	↑
<b>MSFC</b>			0.34	0.35	0.36	↓
<b>PPMCO</b>			0.39	0.39	0.40	↓
<b>UHC</b>			0.43	0.41	0.40	↓
<b>UMHP</b>			0.32	0.38	0.38	↓
<b>MARR</b>			0.351	0.36	0.35	↓

\* This measure was added by MDH for reporting in HEDIS 2015.

<b>Antibiotic Utilization (ABX) – Average Scripts PMPY for Antibiotics of Concern</b>						
	<b>2013</b>	<b>2014*</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>NHM</b>
<b>ACC</b>			40.39%	40.8%	40.35	↓
<b>JMS</b>			33.0%	33.7%	33.08	↓
<b>KPMAS</b>			40.5%	37.8%	38.16	↓
<b>MPC</b>			39.8%	40.8%	41.26	↓
<b>MSFC</b>			40.2%	40.1%	40.49	↓
<b>PPMCO</b>			40.38%	40.7%	41.51	↓
<b>UHC</b>			43.2%	44.3%	43.74	↑
<b>UMHP</b>			42.1%	44.6%	44.32	↑
<b>MARR</b>			39.9%	40.3%	40.36	↓

\* This measure was added by MDH for reporting in HEDIS 2015.



## Board Certification (BCR)

### Description

The percentage of the following physicians whose board certification is active as of December 31 of the measurement year.

- Family medicine physicians
- Pediatricians
- Geriatricians
- Internal medicine physicians
- OB/GYN physicians
- Other physician specialist

### Summary of Changes to HEDIS 2017:

- No changes were made to this measure for HEDIS 2017.

## Board Certification (BCR)

		Family Medicine	Internal Medicine	OB/GYN	Pediatrician	Geriatricians	Other Specialists
	# of Physicians	739	2985	631	1486	136	5000
	# Board Certified	456	2168	479	1174	78	3766
	Percentage	61.71%	72.63%	75.91%	79.00%	57.35%	75.32%
	# of Physicians	79	592	144	179	33	1912
	# Board Certified	66	548	119	169	31	1734
	Percentage	83.54%	92.57%	82.64%	94.41%	93.94%	90.69%
	# of Physicians	154	353	129	90	4	901
	# Board Certified	140	323	104	87	4	832
	Percentage	90.91%	91.50%	80.62%	96.67%	100.00%	92.34%
	# of Physicians	624	1,335	611	952	43	4,676
	# Board Certified	384	990	442	789	22	3,180
	Percentage	61.54%	74.16%	72.34%	82.88%	51.16%	68.01%
	# of Physicians	290	506	177	372	15	2341
	# Board Certified	186	340	88	181	7	1290
	Percentage	64.14%	67.19%	49.72%	48.66%	46.67%	55.10%
	# of Physicians	635	955	800	872	42	12045
	# Board Certified	621	913	771	849	41	11446
	Percentage	97.80%	95.60%	96.38%	97.36%	97.62%	95.03%
	# of Physicians	800	2,453	877	1,450	89	6,004
	# Board Certified	572	1,863	737	1,175	56	4,751
	Percentage	71.50%	75.95%	84.04%	81.03%	62.92%	79.13%
	# of Physicians	645	766	566	574	35	3,321
	# Board Certified	517	593	387	447	27	1,970
	Percentage	80.16%	77.42%	68.37%	77.87%	77.14%	59.32%

## **Enrollment by Product Line (ENP)**

### **Description**

The total number of members enrolled in the product line, stratified by age and gender.

### **Summary of Changes to HEDIS 2017:**

- No changes were made to this measure for HEDIS 2017.

### **Enrollment by Product Line (ENP) (in member months)**

	<b>Male</b>	<b>Female</b>	<b>Total</b>
<b>ACC</b>	1,445,267	1,720,867	3,166,134
<b>JMS</b>	146,062	132,283	278,345
<b>KPMAS</b>	247,619	291,712	539,331
<b>MPC</b>	1,001,830	1,263,033	2,264,863
<b>MSFC</b>	403,224	488,031	891,255
<b>PPMCO</b>	1,382,957	1,738,876	3,121,833
<b>UHC</b>	883,879	1,035,557	1,919,436
<b>UMHP</b>	195,134	192,278	387,412

## **Enrollment by State (EBS)**

### **Description**

The number of members enrolled as of December 31 of the measurement year.

### **Summary of Changes to HEDIS 2017:**

- No changes were made to this measure for HEDIS 2017.

### **Enrollment by State (EBS) – Maryland only**

<b>ACC</b>	278,111
<b>JMS</b>	24,997
<b>KPMAS</b>	54,070
<b>MPC</b>	200,663
<b>MSFC</b>	79,581
<b>PPMCO</b>	280,575
<b>UHC</b>	89,497
<b>UMHP</b>	37,064

## **Language Diversity of Membership (LDM)**

### **Description**

An unduplicated count and percentage of members enrolled at any time during the measurement year by spoken language preferred for health care and preferred language for written materials.

### **Summary of Changes to HEDIS 2017:**

- No changes were made to this measure for HEDIS 2017.

### **Language Diversity of Membership (LDM) - Spoken**

		<b>English</b>	<b>Non-English</b>	<b>Unknown</b>	<b>Declined</b>
	Number	10	8,243	314,491	0
	Percent	0.00%	2.55%	97.44%	0.00%
	Number	31,255	61	73	0
	Percent	99.57%	0.19%	0.23%	0.00%
	Number	51,510	6,466	7,270	32
	Percent	78.91%	9.91%	11.14%	0.05%
	Number	0	0	236729	0
	Percent	0.00%	0.00%	100.00%	0.00%
	Number	0	0	98737	0
	Percent	0.00%	0.00%	100.00%	0.00%
	Number	0	0	323,427	0
	Percent	0.00%	0.00%	100.00%	0.00%
	Number	6	2,433	200,295	0
	Percent	0.00%	1.20%	98.80%	0.00%
	Number	0	0	48,450	0
	Percent	0.00%	0.00%	100.00%	0.00%

## Race/Ethnicity Diversity of Membership (RDM)

### Description

An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.

### Summary of Changes to HEDIS 2017:

- No changes were made to this measure for HEDIS 2017.

## Race/Ethnicity Diversity of Membership (RDM)

		White / Total	Black / Total	American Indian & Alaska Native / Total	Asian / Total	Native Hawaiian - Pacific Islander / Total	Other / Total	2+ Races / Total	Unknown / Total	Declined / Total
	Number	59,098	128,080	0	13,104	372	0	0	122,090	0
	Percent	18.31%	39.68%	0.00%	4.06%	0.12%	0.00%	0.00%	37.83%	0.00%
	Number	4,041	19,880	126	732	35	0	0	6,575	0
	Percent	12.87%	63.33%	0.40%	2.33%	0.11%	0.00%	0.00%	20.95%	0.00%
	Number	11,305	33,147	136	4,039	45	1,256	7	15,183	160
	Percent	17.32%	50.78%	0.21%	6.19%	0.07%	1.92%	0.01%	23.26%	0.25%
	Number	86,844	101,356	49	8,600	37	0	0	39,843	0
	Percent	36.68%	42.82%	0.02%	3.63%	0.02%	0.00%	0.00%	16.83%	0.00%
	Number	27,779	0	0	4,841	0	784	0	64,432	901
	Percent	28.13%	0.00%	0.00%	4.90%	0.00%	0.79%	0.00%	65.26%	0.91%
	Number	99,958	120,165	2	0	11,439	0	0	3,686	88,177
	Percent	30.91%	37.15%	0.00%	0.00%	3.54%	0.00%	0.00%	1.14%	27.26%
	Number	69,338	87,463	0	11,425	256	0	0	34,252	0
	Percent	34.20%	43.14%	0.00%	5.64%	0.13%	0.00%	0.00%	16.90%	0.00%
	Number	15,248	17,269	0	1,991	64	0	0	564	13,314
	Percent	31.47%	35.64%	0.00%	4.11%	0.13%	0.00%	0.00%	1.16%	27.48%

## **Total Membership (TLM)**

### **Description**

The number of members enrolled as of December 31 of the measurement year.

### **Summary of Changes to HEDIS 2017:**

- Clarified how to count dually enrolled members.
- Clarified that this measure reports a total unduplicated membership count.

### **Total Membership (TLM) – Medicaid only**

-	
<b>ACC</b>	276,538
<b>JMS</b>	25,009
<b>KPMAS</b>	65,575
<b>MPC</b>	200,778
<b>MSFC</b>	134,360
<b>PPMCO</b>	280,884
<b>UHC</b>	159,829
<b>UMHP</b>	37,147

## IMPLICATIONS & DISCUSSION

HEDIS consists of a set of performance measures utilized by more than 90 percent of American health plans. The HEDIS rates allow providers, employers and consumers to compare how well health plans perform in the areas of quality, access and member satisfaction. State purchasers of health care use the aggregated HEDIS rates to evaluate a managed care plan's ability to demonstrate an improvement in preventive health outreach to its members.

### HealthChoice Plans: HEDIS Year 2017 Highlights

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) saw marked increases in 2017. The University of Maryland Health Partners and Amerigroup experienced the most significant increases for all three numerators (BMI Percentile; Counseling for Physical Activity; and Counseling for Nutrition) out of all eight MCOs. UnitedHealthcare and MedStar Family Care also showed significant increases for the BMI percentile numerator.
  - BMI percentile – Total rate of Maryland Average Reported Rate increased 19% in 2017 (UMHP +70%; ACC +29%; UHC +25%; and MSFC +20%)
  - Counseling for Physical Activity – Total Rate increased 14%. (UMHP +77% and ACC +24%).
  - Counseling for Nutrition – Total Rate increased 12% (UMHP +74% and ACC +20%)
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) experienced an overall increase of 9%. MedStar Family Care (+32%) and Maryland Physicians Care (24%) showed the most notable increases. Modest gains were experienced by Priority Partners and UnitedHealthcare as well.
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) experienced an overall increase of 7%. Most MCOs saw impressive increases in 2017 with the exception of MedStar Family Care and UnitedHealthcare.
- Comprehensive Diabetes Care (CDC) specifically focused on the Retinal Eye Exam numerator showed an overall decrease of 6%. Maryland Physicians Care, Priority Partners, University of Maryland Health Plans, and Amerigroup all saw decreases of greater than 5%.
- Overall, utilization seems to have decreased for Inpatient, Emergency Department, and Outpatient settings.
  - Inpatient Utilization – General Hospital/Acute Care (IPU) showed decreased utilization overall across all MCOs with the exception of MedStar Family Care. Most notable decreases were seen by UnitedHealthcare (-26%) and University of Maryland Health Partners (-20%).

- Ambulatory Care (AMB) experienced an overall decrease in Emergency Department Visits of -14%. Kaiser Permanente was the only MCO to experience an increase for this numerator. A decrease of -15% was also seen for Outpatient visits, where the majority of MCOs experienced a decrease, Kaiser Permanente and Maryland Physicians Care experienced increases.
- Statin Therapy for Patients with Cardiovascular Disease (SPC), specifically the Statin Adherence 80% numerator experienced a -15% decrease. UnitedHealthcare was the only MCO who experienced an increase for 2017. Amerigroup (-36%), Priority Partners (-33%), and MedStar Family Care (-19%) experienced the greatest decreases for this numerator.
- Annual Monitoring for Patient on Persistent Medications (MPM), specifically the Digoxin numerator experienced an overall decrease of -21%, Most notable decreases were seen by Amerigroup (-25%) and Priority Partners (-25%).
- Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS), experienced an overall decrease of -27%. All MCOs decreased with the exception of Jai Medical. Most notable decreases include Kaiser Permanente (-82%), University of Maryland Health Partners (-53%), MedStar Family Care (-32%), and Amerigroup (-23%).