Statewide Executive Summary
HealthChoice Participating Organizations
HEDIS® 2015

Prepared for:

Maryland Department of Health and Mental Hygiene

September 2015

Prepared by:

HealthcareData Company, LLC
600 Bent Creek Blvd., Suite 160
Mechanicsburg, PA 17050
(800) 472-5382
www.HDCdata.com

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

No duplication or distribution of the NHM outside of this report is permitted. Additionally, this report cannot be placed on any website for access by any outside authority.

Table of Contents

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. HealthChoice plans 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.

DHMH contracted with HealthcareData Company, LLC (HDC), 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 1,059,088 enrollees as of December 31, 2014.

Within DHMH, the HealthChoice & Acute Care Administration is responsible for the quality oversight of the HealthChoice program. DHMH 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 2015.

For HEDIS 2015, DHMH required HealthChoice managed care organizations to report all HEDIS measures applicable to a Medicaid line of business, except where the measure is exempted by the Department or carved out for services rendered in calendar year 2014 to Maryland Medical Assistance HealthChoice enrollees. These measures provide meaningful managed care organization comparative information and they measure performance relative to DHMH's priorities and goals.

Organizations reporting HEDIS in 2015

Acronym used in this report	HealthChoice Organization Name
ACC	AMERIGROUP Community Care
JMS	Jai Medical Systems
KPMAS	Kaiser Permanente of the Mid-Atlantic States
MPC	Maryland Physicians Care
MSFC	MedStar Family Choice
PP	Priority Partners
RHMD	Riverside Health Plan
UHC	UnitedHealthcare

I. MEASURES DESIGNATED FOR REPORTING

Annually, DHMH determines the set of measures required for HEDIS reporting. DHMH selects these measures because they provide meaningful managed care organization comparative information and they measure performance pertinent to DHMH's priorities and goals.

Measures selected by DHMH for HealthChoice Reporting

DHMH required HealthChoice managed care organizations to report all HEDIS measures applicable to a Medicaid line of business except where the measure is exempted by the Department or carved out. This was a total of 53 HEDIS measures including 21 additional measures for services rendered in calendar year 2014. The 21 new measures are as follows:

Lead Screening in Children (LSC)
Human Papillomavirus Vaccine for Female Adolescents (HPV)
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)
Antidepressant Medication Management (AMM)
Follow-Up Care for Children Prescribed ADHD Medication (ADD)
Adherence to Antipsychotics Medications for Individuals with Schizophrenia (SAA)
Follow-Up Care after Hospitalization for Mental Illness (FUH)
Frequency of Selected Procedures (FSP)
Inpatient Utilization- General Hospital/Acute Care (IPU)
Mental Health Utilization (MPT)
Antibiotic Utilization (ABX)
Board Certification (BCR)
Enrollment by Product Line (ENP)
Enrollment by State (EBS)
Language Diversity of Membership (LDM)
Race/ Ethnicity Diversity of Membership (RDM)
Weeks of Pregnancy at Time of Enrollment (WOP)
Total Membership (TLM)

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

Effectiveness of Care (EOC) Domain: 30 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 good control (<7.0%)
Use of Appropriate Medications for People with Asthma (ASM)
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)

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
Lead Screening in Children (LSC) **New**
Human Papillomavirus Vaccine for Female Adolescents (HPV) **New**
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) **New**
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) **New**
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) **New**
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) **New**
Antidepressant Medication Management (AMM) **New**
Follow-Up Care for Children Prescribed ADHD Medication (ADD) **New**
Adherence to Antipsychotics Medications for Individuals with Schizophrenia (SAA) **New**

Access/Availability of Care (AAC) Domain: 5 measures
Adults' Access to Preventive/Ambulatory Health Services (AAP)
Children and Adolescents' Access to Primary Care Practitioners (CAP)
Prenatal and Postpartum Care (PPC)
Call Answer Timeliness (CAT)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

Utilization and Relative Resource Use (URR) Domain: 18 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)
Identification of Alcohol and Other Drug Services (IAD)
Follow-Up Care after Hospitalization for Mental Illness (FUH) **New**
Frequency of Selected Procedures (FSP) **New**
Inpatient Utilization- General Hospital/ Acute Care (IPU) **New**
Mental Health Utilization (MPT) **New**
Antibiotic Utilization (ABX) **New**
Board Certification (BCR) **New**
Enrollment by Product Line (ENP) **New**
Enrollment by State (EBS) **New**
Language Diversity of Membership (LDM) **New**
Race/ Ethnicity Diversity of Membership (RDM) **New**
Weeks of Pregnancy at Time of Enrollment (WOP) **New**
Total Membership (TLM) **New**

No Benefit (NB) Measure Designations
The NB designation is utilized for measures where DHMH has contracted with outside vendors for coverage of certain services. The vendor-generated claims/services are calculated outside of the IDSS (NCQA's Interactive Data Submission System), and HDC and the plans do not have access to the data. So that plans are not penalized, NCQA allows health plans to report these measure with a NB designation. The following ten 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)
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)

II. HEDIS METHODOLOGY

The HEDIS-reporting organization follows guidelines for data collection and specifications for measure calculation described in *HEDIS 2015 Volume 2: Technical Specifications*.

Data collection: The organization pulls together all data sources, typically into a data warehouse, against which HEDIS software programs are applied to calculate measures. Plans can calculate measures using three sources of data, the use of each type determined by specifications for the measure, as listed below. All measures allow use of supplemental and administrative data. Only some measures allow the hybrid option which involves a search through medical records for data missing from claims or supplemental sources.

 Administrative data: Data from transaction systems (claims, encounters, enrollment, and practitioner) provide the majority of administrative data. Organizations may receive encounter files from pharmacy, laboratory, vision, and behavioral health vendors.

 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 medical record-derived databases.

 Medical record data: Data abstracted from paper or electronic medical records may be applied to certain measures, using the NCQA-defined hybrid method. HEDIS specifications describe statistically sound methods of sampling, so that only a subset of the eligible population's medical records needs to be chased. NCQA specifies hybrid calculation methods, in addition to administrative methods, for several measures selected by DHMH 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.

III. MEASURE-SPECIFIC FINDINGS – EXPLANATION

Three years of HealthChoice results are displayed in Table A, along with the 2015 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:

<u>**Description**</u> – The source of the information is NCQA's *HEDIS 2015 Volume 2: Technical Specifications*.

<u>**Rationale**</u> – For all measures, except Call Answer Timeliness (CAT) the source of the information is the Agency for Healthcare Research and Quality (AHRQ) citations of NCQA as of 2015. These citations appear under the *Brief Abstract* on the Web site of the National Quality Measures Clearinghouse, http://www.qualitymeasures.ahrq.gov/. For CAT the rationale was adapted from *HEDIS 2004 Vol. 2: Technical Specifications*, Appendix 2.

<u>**Summary of Changes for HEDIS 2015**</u> – The source of the text, is the *HEDIS 2015 Volume 2: Technical Specifications*, incorporating additional changes published in the *HEDIS 2015 Volume 2: "October" Technical Update.*

Table A – HealthChoice Organizations HEDIS 2015 Results

HEDIS 2014 Results, page one of five	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2015
HealthChoice Organizations		ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC		MARR
Adult BMI Assessment (ABA)	61.3%	72.0%	82.4%	90.7%	80.2%	98.5%			98.4%	48.7%	70.2%	84.9%	76.4%	82.6%	86.4%	59.9%	82.9%	89.6%		NA[1]	NA[1]	49.1%	68.9%	81.9%	88.9%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	20.6%	23.88%	24.5%	35.5%	35.2%	34.1%			NA[1]	19.9%	22.0%	21.9%	14.1%	15.2%	19.9%	18.9%	23.94%	24.4%		NA[1]	NA[1]	16.0%	20.8%	23.7%	24.7%
Childhood Immunization Status (CIS) – Combination 2 (DTaP, IPV, MMR, HiB, Hep B, VZV)	84.7%	81.3%	83.8%	86.1%	86.5%	88.4%			NA[1]	76.9%	73.7%	70.8%	85.4%	88.1%	81.8%	86.8%	83.1%	83.6%		NA[1]	50.0%	70.3%	73.0%	77.4%	76.5%
Childhood Immunization Status (CIS) – Combination 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV)	83.5%	78.2%	81.9%	83.70%	86.1%	87.6%			NA[1]	74.3%	72.1%	68.2%	83.70%	85.9%	79.3%	83.8%	80.8%	80.1%		NA[1]	43.8%	66.7%	71.3%	73.7%	73.5%
Childhood Immunization Status (CIS) – Combination 4 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A)	75.9%	73.6%	77.6%	80.9%	84.8%	85.2%			NA[1]	67.4%	62.8%	64.7%	80.3%	81.3%	76.6%	73.8%	69.4%	78.5%		NA[1]	43.8%	58.9%	66.2%	67.9%	70.6%
Childhood Immunization Status (CIS) – Combination 5 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV)	61.3%	63.9%	63.7%	59.4%	71.7%	68.0%			NA[1]	55.3%	47.0%	57.1%	56.0%	70.1%	64.5%	59.6%	54.6%	68.5%		NA[1]	37.5%	52.0%	56.9%	60.1%	59.9%
Childhood Immunization Status (CIS) – Combination 6 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Influenza)	49.7%	49.3%	53.0%	39.0%	47.8%	46.8%			NA[1]	42.4%	37.7%	40.6%	55.2%	59.4%	51.6%	51.5%	49.5%	54.2%		NA[1]	28.1%	38.2%	44.3%	48.4%	46.1%
Childhood Immunization Status (CIS) – Combination 7 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV)	57.8%	60.7%	61.3%	59.0%	71.3%	67.2%			NA[1]	51.4%	44.0%	55.0%	54.3%	66.7%	62.5%	56.2%	50.7%	68.5%		NA[1]	37.5%	47.2%	54.7%	57.4%	58.5%
Childhood Immunization Status (CIS) – Combination 8 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, Influenza)	47.3%	47.9%	50.9%	39.0%	47.4%	45.6%			NA[1]	38.7%	34.9%	38.5%	53.5%	56.2%	49.4%	48.3%	44.4%	53.5%		NA[1]	28.1%	35.3%	41.4%	46.2%	44.6%
Childhood Immunization Status (CIS) – Combination 9 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV, Influenza)	38.5%	42.4%	43.5%	29.5%	40.9%	36.4%			NA[1]	33.8%	28.4%	34.3%	38.7%	49.9%	44.3%	41.1%	36.3%	48.4%		NA[1]	23.4%	31.6%	37.0%	41.4%	38.8%
Childhood Immunization Status (CIS) – Combination 10 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, Influenza)	37.1%	41.2%	42.1%	29.5%	40.9%	36.0%			NA[1]	31.0%	27.7%	33.0%	37.7%	47.0%	42.8%	39.7%	34.3%	48.4%		NA[1]	23.4%	29.2%	35.3%	40.2%	38.0%
Immunizations for Adolescents (IMA) – Combination 1 (Meningococcal, Tdap/Td)	65.0%	69.4%	74.8%	70.66%	75.5%	76.7%			NA[1]	57.6%	62.7%	74.07%	70.69%	70.7%	72.4%	67.4%	74.5%	74.07%		NA[1]	64.7%	56.4%	63.4%	66.2%	71.9%
Well-Child Visits in the First 15 months of Life (W15) – No well-child visits [2]	1.00%	1.0%	2.1%	2.7%	3.1%	1.9%			NA[1]	1.11%	0.5%	1.56%	1.01%	1.2%	3.5%	1.14%	1.1%	1.59%		NA[1]	10.9%	2.2%	1.9%	0.9%	3.2%
Well-Child Visits in the First 15 months of Life (W15) – DHMH Five or more visits (constructed by combining HEDIS rates for five and six-or-more visits)	86.1%	88.9%	85.1%	85.9%	84.4%	81.6%			NA[1]	77.8%	83.6%	84.9%	89.2%	86.0%	82.8%	84.3%	83.7%	81.9%		NA[1]	56.6%	82.1%	87.4%	83.6%	79.5%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	83.6%	83.9%	83.7%	87.7%	88.9%	90.6%			84.6%	87.5%	88.8%	87.0%	79.6%	83.5%	86.7%	80.7%	83.8%	86.8%		NA[1]	57.4%	83.8%	75.0%	79.2%	82.0%
Adolescent Well-Care Visits (AWC)	68.1%	67.9%	64.7%	76.9%	76.7%	80.3%			63.5%	60.2%	68.8%	68.3%	69.4%	67.8%	61.2%	67.6%	61.6%	68.8%		NA[1]	31.8%	59.7%	60.8%	58.5%	62.1%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – BMI Percentile- Total Rate	[4]	49.5%	60.9%	[4]	92.2%	94.7%			99.0%	[4]	46.5%	58.3%	[4]	59.8%	67.3%	[4]	52.1%	72.5%	[4]	NA[1]	41.5%	[4]	45.5%	57.9%	69.0%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate	[4]	59.0%	71.5%	[4]	94.4%	97.6%			98.1%	[4]	54.4%	66.4%	[4]	74.1%	72.9%	[4]	54.2%	73.6%	[4]	NA[1]	50.8%	[4]	67.6%	64.5%	74.4%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate	[4]	51.4%	61.3%	[4]	89.8%	91.2%			98.1%	[4]	58.8%	60.0%	[4]	72.9%	67.8%	[4]	44.7%	70.1%	[4]	NA[1]	43.1%	[4]	60.6%	63.0%	69.3%
Appropriate Testing for Children with Pharyngitis (CWP)	75.9%	78.36%	79.8%	75.3%	70.8%	80.2%			NA[1]	77.4%	78.42%	82.9%	85.2%	86.9%	90.5%	78.2%	80.5%	83.1%		NA[1]	76.4%	79.8%	83.1%	86.0%	82.7%
Lead Screening in Children (LSC)		[5]	77.1%		[5]	87.2%		[5]	NA[1]		[5]	70.0%		[5]	88.6%		[5]	71.9%		[5]	53.1%		[5]	68.6%	73.8%
Human Papillomavirus Vaccine for Female Adolescents (HPV)		[5]	23.7%		[5]	33.9%		[5]	NA[1]		[5]	21.8%		[5]	24.3%		[5]	17.7%		[5]	NA[1]		[5]	15.1%	22.8%
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) [2]		[5]	5.3%		[5]	2.1%		[5]	1.9%		[5]	4.2%		[5]	2.9%		[5]	3.7%		[5]	5.2%		[5]	5.8%	3.9%

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[2] A lower rate indicates better performance.
[3] HEDIS specifications changed in 2012, and this age range is no longer reported. For 2013-2015, this rate is being calculated by HDC.
[4] New measure for HEDIS 2014.
[5] New measure for HEDIS 2015.
* Sub-measure retired by NCQA for HEDIS 2015.

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

Table A – HealthChoice Organizations HEDIS 2015 Results

HEDIS 2014 Results, page two of five	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2015
HealthChoice Organizations		ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC		MARR
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 5–11	88.7%	90.3%	90.0%	91.4%	93.59%	91.4%			NA[1]	92.30%	91.4%	92.5%	93.7%	93.62%	93.5%	92.30%	91.6%	92.0%		NA[1]	NA[1]	96.1%	91.9%	90.8%	91.7%
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 12–18	86.2%	87.8%	87.1%	92.9%	86.0%	86.3%			NA[1]	92.3%	90.4%	91.5%	90.2%	94.2%	91.6%	89.6%	88.5%	89.5%		NA[1]	NA[1]	93.4%	88.0%	88.6%	89.1%
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 19–50	79.5%	73.7%	73.1%	93.3%	81.3%	89.4%			NA[1]	81.8%	80.1%	77.9%	76.8%	75.2%	77.6%	80.7%	76.8%	74.9%		NA[1]	NA[1]	88.0%	72.9%	73.7%	77.8%
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 51–64	77.7%	68.6%	79.0%	82.0%	71.4%	83.8%			NA[1]	78.5%	76.3%	80.9%	77.1%	NA	NA	77.0%	73.0%	77.6%		NA[1]	NA[1]	94.1%	79.0%	72.8%	78.8%
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 5–64	86.5%	86.29%	86.3%	90.7%	83.6%	87.9%			NA[1]	88.7%	86.97%	87.3%	88.8%	90.1%	89.0%	88.9%	87.02%	87.1%		NA[1]	NA[1]	94.0%	86.28%	84.11%	87.0%
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 5–50 [3]	86.7%	86.8%	83.4%	92.5%	86.4%	89.0%			NA[1]	89.2%	87.53%	87.3%	89.4%	90.1%	87.6%	89.3%	87.6%	85.4%		NA[1]	NA[1]	94.0%	86.6%	84.3%	87.51%
Medication Management for People With Asthma (MMA) – Total 50% of treatment period	44.8%	45.8%	48.8%	53.2%	49.4%	59.6%			NA[1]	49.4%	57.9%	57.9%	52.4%	51.9%	49.9%	40.3%	43.3%	44.5%		NA[1]	NA[1]	47.3%	49.9%	48.4%	51.5%
Medication Management for People With Asthma (MMA) – Total 75% of treatment period	24.1%	22.9%	23.2%	28.9%	24.5%	34.8%			NA[1]	26.6%	32.9%	34.0%	28.7%	26.6%	24.1%	19.7%	20.0%	20.5%		NA[1]	NA[1]	26.7%	27.8%	25.2%	27.0%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	85.1%	86.5%	88.03%	85.2%	83.0%	92.4%			NA[1]	86.1%	86.6%	85.6%	86.1%	84.3%	89.5%	85.0%	86.0%	89.0%		NA[1]	86.4%	80.1%	82.0%	85.2%	88.00%
Asthma Medication Ratio (AMR)	[4]	68.6%	56.54%	[4]	60.5%	56.50%			NA[1]	[4]	69.1%	65.0%	[4]	73.7%	68.1%	[4]	69.6%	63.8%	[4]	NA[1]	NA[1]	[4]	69.8%	63.4%	62.2%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	[4]	25.8%	23.6%	[4]	26.3%	32.6%			NA[1]	[4]	21.1%	20.8%	[4]	34.5%	29.2%	[4]	23.7%	27.2%	[4]	NA[1]	NA[1]	[4]	25.6%	25.6%	26.5%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate	[4]	73.6%	69.0%	[4]	69.2%	73.6%			NA[1]	[4]	72.6%	72.1%	[4]	76.3%	72.2%	[4]	69.7%	69.7%	[4]	NA[1]	78.1%	[4]	78.2%	73.0%	72.5%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate	[4]	87.5%	84.8%	[4]	82.5%	85.4%			NA[1]	[4]	84.9%	85.1%	[4]	90.3%	92.4%	[4]	84.0%	85.0%	[4]	NA[1]	81.3%	[4]	84.9%	86.3%	85.7%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–24 months	97.5%	97.8%	97.7%	91.1%	94.7%	96.2%			100.0%	97.1%	96.5%	96.9%	96.6%	96.4%	93.9%	90.3%	89.8%	97.6%		NA[1]	87.8%	96.7%	96.3%	96.6%	95.8%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months–6 years	92.6%	92.8%	93.1%	90.4%	88.7%	91.8%			98.0%	89.0%	90.0%	90.3%	90.3%	89.8%	88.4%	92.5%	93.5%	93.3%		NA[1]	69.4%	91.1%	91.1%	91.3%	89.5%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7–11 years	93.9%	94.3%	95.3%	93.30%	93.8%	92.7%			98.4%	91.5%	92.1%	92.61%	92.50%	93.5%	92.58%	92.50%	92.7%	94.4%		NA[1]	NA[1]	93.30%	93.1%	93.6%	94.2%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–19 years	89.5%	90.5%	91.9%	91.7%	90.8%	92.9%			94.2%	87.7%	88.5%	89.7%	92.5%	92.7%	91.7%	92.0%	91.9%	92.5%		NA[1]	NA[1]	89.2%	90.1%	90.9%	92.0%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 years	79.7%	79.4%	79.4%	74.8%	72.9%	71.0%			92.9%	81.4%	81.1%	80.9%	79.9%	79.7%	76.3%	83.5%	81.7%	82.3%		NA[1]	63.6%	80.2%	80.4%	80.0%	78.3%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years	86.4%	87.2%	86.7%	87.8%	86.6%	86.75%			95.7%	86.8%	87.80%	87.4%	86.2%	86.9%	85.1%	0.0%	0.0%	89.0%		NA[1]	75.9%	87.5%	87.80%	88.0%	86.82%
Breast Cancer Screening (BCS)	49.1%	58.1%	66.0%	60.8%	69.4%	72.1%			87.2%	43.9%	48.5%	65.9%	56.8%	64.4%	63.4%	51.5%	57.0%	62.5%		NA[1]	NA[1]	48.4%	52.7%	58.1%	67.9%
Cervical Cancer Screening (CCS)	73.6%	79.64%	67.8%	80.9%	79.5%	66.8%			90.8%	74.0%	79.58%	65.75%	70.9%	74.0%	66.2%	75.0%	75.9%	74.4%		NA[1]	35.5%	69.8%	62.8%	58.8%	65.76%
Chlamydia Screening in Women (CHL) – Age 16–20 years	62.6%	62.4%	61.4%	81.1%	86.7%	87.6%			76.9%	58.1%	58.2%	58.9%	59.6%	54.8%	57.2%	61.8%	61.5%	59.2%		NA[1]	61.1%	56.9%	55.4%	55.2%	64.7%
Chlamydia Screening in Women (CHL) – Age 21–24 years	72.5%	71.9%	71.7%	63.9%	72.3%	65.0%			80.8%	67.6%	67.1%	67.3%	74.0%	68.4%	66.5%	68.9%	69.9%	68.0%		NA[1]	58.7%	63.7%	64.8%	63.2%	67.7%
Chlamydia Screening in Women (CHL) – Total (16–24) years	65.97%	66.0%	66.0%	74.2%	81.2%	77.3%			79.5%	62.3%	62.0%	62.6%	65.0%	60.1%	61.3%	64.6%	64.8%	62.7%		NA[1]	59.7%	59.5%	59.0%	58.8%	65.97%

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[2] A lower rate indicates better performance.
[3] HEDIS specifications changed in 2012, and this age range is no longer reported. For 2013-2015, this rate is being calculated by HDC.
[4] New measure for HEDIS 2014.
[5] New measure for HEDIS 2015.
* Sub-measure retired by NCQA for HEDIS 2015.

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

Table A – HealthChoice Organizations HEDIS 2015 Results

HEDIS 2014 Results, page three of five	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR
HealthChoice Organizations	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2015
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	87.8%	84.2%	85.7%	82.9%	85.8%	83.2%			88.0%	86.28%	84.9%	80.3%	86.28%	85.4%	79.2%	89.3%	90.9%	88.2%		52.2%	73.3%	84.7%	87.1%	84.1%	82.8%
Prenatal and Postpartum Care (PPC) – Postpartum Care	71.5%	71.6%	66.0%	83.7%	78.5%	83.6%			86.0%	68.4%	71.9%	65.0%	74.4%	72.0%	71.1%	72.5%	75.6%	70.7%		43.5%	47.4%	60.3%	63.8%	62.5%	69.0%
Frequency of Ongoing Prenatal Care (FPC) – Less than 21% of expected visits [2]	4.2%	8.2%	5.9%	3.6%	2.2%	4.5%			7.7%	10.6%	5.6%	6.9%	2.7%	4.4%	7.6%	4.4%	4.4%	9.3%		37.0%	17.4%	12.1%	5.8%	6.8%	8.2%
Frequency of Ongoing Prenatal Care (FPC) – Greater than or equal to 81% of expected visits	72.2%	75.5%	72.6%	75.8%	70.8%	64.0%			56.9%	60.1%	70.6%	69.8%	79.3%	71.3%	64.6%	78.8%	78.8%	61.7%		21.7%	55.0%	70.8%	73.2%	74.5%	64.9%
Controlling High Blood Pressure (CBP)	47.0%	49.0%	63.9%	52.3%	56.2%	69.3%			87.8%	23.9%	46.8%	61.4%	70.5%	65.5%	69.2%	59.1%	57.0%	59.5%		NA[1]	32.1%	43.1%	42.3%	50.9%	61.8%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	4	NA[1]	91.5%	4	NA[1]	NA[1]			NA[1]	4	87.5%	90.2%	4	NA[1]	NA[1]	4	86.1%	84.6%	4	NA[1]	NA[1]	4	82.9%	87.8%	88.5%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)		5	NA[1]		5	NA[1]		5	NA[1]		5	NA[1]		5	NA[1]		5	NA[1]		5	NA[1]		5	NA[1]	NA[1]
Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing	81.1%	83.4%	88.7%	89.8%	89.1%	90.7%			96.4%	76.0%	79.5%	87.9%	83.5%	84.7%	88.0%	82.4%	78.1%	89.4%		NA[1]	84.6%	78.1%	79.1%	85.9%	89.0%
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%) [2]	44.0%	38.8%	38.5%	35.4%	31.0%	37.2%			21.8%	52.6%	48.6%	40.8%	35.3%	37.2%	44.5%	41.7%	48.1%	35.6%		NA[1]	60.8%	54.3%	45.5%	41.1%	40.1%
Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)	47.1%	51.4%	51.4%	54.7%	61.5%	52.4%			60.0%	39.9%	43.3%	50.8%	58.9%	54.0%	43.5%	49.1%	44.3%	54.3%		NA[1]	38.8%	38.9%	46.5%	46.2%	49.7%
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed	69.3%	65.4%	48.6%	80.1%	79.6%	64.1%			87.3%	64.6%	72.0%	65.7%	72.8%	71.1%	54.0%	78.1%	71.0%	69.0%		NA[1]	44.8%	57.7%	56.9%	58.6%	61.5%
Comprehensive Diabetes (CDC) – LDL-C Screening	76.0%	76.9%	*	88.5%	87.8%	*			*	69.2%	72.9%	*	77.4%	78.4%	*	73.1%	70.1%	*		NA[1]	*	74.2%	77.4%	*	*
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy	73.6%	75.7%	80.3%	93.6%	93.1%	93.4%			100.0%	74.4%	75.3%	75.9%	78.8%	82.7%	80.9%	77.6%	73.8%	82.5%		NA[1]	74.8%	74.2%	75.9%	81.5%	83.7%
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)	48.4%	55.6%	65.3%	59.1%	60.4%	69.7%			83.6%	47.1%	55.4%	56.4%	73.7%	70.1%	69.0%	63.3%	64.2%	60.7%		NA[1]	39.9%	47.0%	51.6%	55.2%	62.5%
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		5	76.7%		5	NA[1]		5	NA[1]		5	NA[1]		5	NA[1]		5	68.7%		5	NA[1]		5	74.6%	73.4%
Use of Imaging Studies for Low Back Pain (LBP)	77.8%	76.7%	74.2%	70.9%	77.2%	69.2%			NA	75.2%	76.6%	76.7%	73.1%	73.3%	71.8%	75.0%	75.2%	75.0%		NA[1]	78.1%	74.8%	73.4%	74.3%	74.2%
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	61.8%	60.0%	62.8%	NA	NA	NA			NA	71.9%	73.8%	65.8%	NA	NA	89.2%	69.5%	67.6%	72.5%		NA[1]	NA[1]	73.3%	67.7%	61.5%	70.3%
Annual Monitoring for Patients on Persistent Medications (MPM) – Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)	90.1%	89.0%	89.4%	95.8%	95.1%	94.4%			95.0%	88.9%	87.0%	88.4%	87.6%	90.2%	90.0%	88.22%	88.1%	88.1%		NA[1]	86.1%	88.22%	88.6%	89.2%	90.1%
Annual Monitoring for Patients on Persistent Medications (MPM) – Members on digoxin	95.8%	95.7%	59.5%	NA2	NA2	NA[1]			NA[1]	91.4%	92.2%	54.9%	NA2	NA2	NA[1]	91.5%	88.9%	44.9%		NA[1]	NA[1]	93.4%	86.4%	57.7%	54.2%
Annual Monitoring for Patients on Persistent Medications (MPM) – Members on diuretics	88.2%	86.9%	88.42%	94.3%	94.1%	93.9%			NA[1]	88.04%	86.2%	86.5%	88.02%	88.5%	89.0%	87.2%	87.4%	87.9%		NA[1]	90.5%	87.8%	87.5%	88.40%	89.2%
Annual Monitoring for Patients on Persistent Medications (MPM) – Members on anticonvulsants	66.0%	66.3%	*	64.8%	75.6%	*			*	69.9%	70.4%	*	58.1%	67.1%	*	73.3%	68.3%	*		NA[1]	*	72.4%	75.0%	*	*
Annual Monitoring for Patients on Persistent Medications (MPM) – Total rate	86.2%	85.4%	88.9%	93.1%	94.1%	94.0%			94.2%	88.0%	86.3%	87.2%	84.1%	86.6%	89.3%	87.3%	87.3%	87.8%		NA[1]	87.9%	87.5%	87.7%	88.7%	89.7%

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[2] A lower rate indicates better performance.
[3] HEDIS specifications changed in 2012, and this age range is no longer reported. For 2013-2015, this rate is being calculated by HDC.
[4] New measure for HEDIS 2014.
[5] New measure for HEDIS 2015.
* Sub-measure retired by NCQA for HEDIS 2015.

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

Table A – HealthChoice Organizations HEDIS 2015 Results

HEDIS 2014 Results, page four of five	ACC 2013	ACC 2014	ACC 2015	JMS 2013	JMS 2014	JMS 2015	KPMAS 2013	KPMAS 2014	KPMAS 2015	MPC 2013	MPC 2014	MPC 2015	MSFC 2013	MSFC 2014	MSFC 2015	PP 2013	PP 2014	PP 2015	RHMD 2013	RHMD 2014	RHMD 2015	UHC 2013	UHC 2014	UHC 2015	MARR 2015
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation 13–17 Years	42.0%	37.7%	43.72%	NA2	NA2	NA¹			NA¹	42.3%	38.9%	35.4%	5.0%	30.9%	31.0%	38.4%	41.8%	33.0%		NA¹	NA¹	42.9%	44.3%	43.67%	37.3%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation 18+ Years	41.9%	38.8%	53.9%	37.1%	45.4%	47.2%			NA¹	43.1%	37.3%	34.9%	29.2%	43.2%	35.3%	38.5%	37.0%	34.2%		NA¹	44.0%	47.9%	45.7%	48.4%	42.6%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation Overall Ages	41.9%	38.6%	52.7%	36.8%	45.2%	47.2%			NA¹	43.0%	37.5%	34.9%	27.4%	41.7%	35.1%	38.5%	37.5%	34.1%		NA¹	43.4%	47.3%	45.5%	48.2%	42.2%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement 13–17 Years	27.7%	24.1%	24.7%	NA2	NA2	NA¹			NA¹	26.5%	22.1%	24.8%	2.5%	19.8%	20.2%	22.6%	27.6%	20.9%		NA¹	NA¹	24.0%	30.3%	28.6%	23.8%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement 18+ Years	18.2%	17.9%	21.0%	15.4%	17.0%	22.5%			NA¹	20.5%	19.8%	19.6%	5.5%	21.6%	18.0%	17.0%	17.2%	16.3%		NA¹	22.0%	17.8%	20.8%	26.1%	20.8%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement Overall Ages	19.7%	18.8%	21.4%	15.4%	16.9%	22.4%			NA¹	21.0%	20.0%	20.0%	5.3%	21.4%	18.1%	17.6%	18.4%	16.6%		NA¹	21.8%	18.5%	21.6%	26.2%	20.9%
Identification of Alcohol and Other Drug Services (IAD) – Any	2.6%	2.7%	5.7%	15.8%	16.9%	25.1%			3.7%	6.3%	6.0%	7.0%	3.1%	4.3%	5.6%	5.2%	5.0%	6.3%		14.9%	10.4%	3.6%	4.7%	9.1%	9.1%
Identification of Alcohol and Other Drug Services (IAD) – Inpatient	0.6%	0.5%	1.1%	3.8%	4.0%	4.5%			0.8%	1.3%	0.95%	0.9%	0.90%	0.8%	0.97%	0.94%	0.9%	0.95%		1.6%	0.99%	0.94%	1.03%	1.6%	1.5%
Identification of Alcohol and Other Drug Services (IAD) - Intensive Outpatient/Partial Hospitalization	0.3%	0.3%	0.97%	2.5%	2.5%	4.6%			0.3%	0.8%	0.7%	1.00%	0.18%	0.5%	0.6%	0.7%	0.6%	0.8%		1.3%	1.2%	0.22%	0.0%	1.26%	1.34%
Identification of Alcohol and Other Drug Services (IAD) - Outpatient/ED	2.4%	2.5%	5.4%	14.5%	15.6%	23.7%			3.2%	5.8%	5.6%	6.6%	2.5%	3.9%	5.0%	4.9%	4.6%	5.9%		11.9%	9.6%	3.0%	4.2%	8.46%	8.49%
Ambulatory Care (AMB) – Outpatient visits per 1,000 member months	363.6	365.1	356.01	373.9	340.8	315.5			404.4	385.3	365.3	365.02	361.6	344.5	360.0	407.8	386.6	390.7		269.8	296.8	374.2	373.3	381.6	358.8
Ambulatory Care (AMB) – Emergency department (ED) visits per 1,000 member months 3	59.8	56.2	58.2	93.4	90.1	96.4			23.2	79.3	74.6	70.9	70.8	62.66	57.4	66.0	62.70	62.0		66.0	64.9	65.2	62.1	63.1	62.0
Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery /1000 MM 45-64 F		5	0.05		5	0.02		5	0.00		5	0.056		5	0.07		5	0.055		5	0.038		5	0.043	0.05
Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery /1000 MM 45-64 M		5	0.00		5	0.016		5	0.00		5	0.00		5	0.00		5	0.01		5	0.04		5	0.018	0.02
Frequency of Selected Procedures (FSP) – Tonsillectomy /1000 MM 0-9 T		5	0.42		5	0.18		5	0.13		5	0.47		5	0.39		5	0.60		5	0.21		5	0.43	0.35
Frequency of Selected Procedures (FSP) – Tonsillectomy /1000 MM 10-19 T		5	0.16		5	0.05		5	0.20		5	0.21		5	0.17		5	0.24		5	0.09		5	0.19	0.17
Frequency of Selected Procedures (FSP) – Hysterectomy, abdominal /1000 MM 45-64 F		5	0.46		5	0.44		5	0.01		5	0.50		5	0.53		5	0.35		5	0.45		5	0.47	0.53
Frequency of Selected Procedures (FSP) – Hysterectomy, vaginal /1000 MM 45-64 F		5	0.188		5	0.02		5	0.00		5	0.16		5	0.17		5	0.20		5	0.11		5	0.191	0.15
Frequency of Selected Procedures (FSP) – Cholecystectomy, open /1000 MM 30-64 M		5	0.047		5	0.03		5	0.00		5	0.08		5	0.06		5	0.055		5	0.00		5	0.04	0.05
Frequency of Selected Procedures (FSP) – Cholecystectomy, open /1000 MM 45-64 F		5	0.07		5	0.063		5	0.00		5	0.037		5	0.056		5	0.061		5	0.00		5	0.040	0.05
Frequency of Selected Procedures (FSP) – Laparoscopic/1000 MM 30-64 M		5	0.21		5	0.11		5	0.172		5	0.34		5	0.172		5	0.193		5	0.12		5	0.191	0.19
Frequency of Selected Procedures (FSP) – Laparoscopic/1000 MM 45-64 F		5	0.49		5	0.19		5	0.00		5	0.67		5	0.69		5	0.65		5	0.34		5	0.60	0.52
Frequency of Selected Procedures (FSV) – Back Surgery /1000 MM 45-64 F		5	0.41		5	0.58		5	0.00		5	0.66		5	0.56		5	0.78		5	0.30		5	0.55	0.55
Frequency of Selected Procedures (FSP) – Back Surgery /1000 MM 45-64 M		5	0.43		5	0.42		5	0.00		5	0.65		5	0.52		5	0.66		5	0.39		5	0.62	0.53
Frequency of Selected Procedures (FSP) – Mastectomy /1000 MM 15-44 F		5	0.022		5	0.030		5	0.00		5	0.026		5	0.016		5	0.036		5	0.00		5	0.041	0.03
Frequency of Selected Procedures (FSP) – Mastectomy /1000 MM 45-64 F		5	0.16		5	0.04		5	0.00		5	0.14		5	0.11		5	0.21		5	0.19		5	0.20	0.15
Frequency of Selected Procedures (FSP) – Lumpectomy /1000 MM 15-44 F		5	0.15		5	0.00		5	0.00		5	0.14		5	0.18		5	0.16		5	0.11		5	0.13	0.14
Frequency of Selected Procedures (FSP) – Lumpectomy /1000 MM 45-64 F		5	0.365		5	0.21		5	0.01		5	0.29		5	0.41		5	0.49		5	0.27		5	0.372	0.43

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[2] A lower rate indicates better performance.
[3] HEDIS specifications changed in 2012, and this age range is no longer reported. For 2013-2015, this rate is being calculated by HDC.
[4] New measure for HEDIS 2014.
[5] New measure for HEDIS 2015.
* Sub-measure retired by NCQA for HEDIS 2015.

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

Table A – HealthChoice Organizations HEDIS 2015 Results

HEDIS 2014 Results, page five of five	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2015
HealthChoice Organizations		ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC		MARR
Inpatient Utilization - General Hospital Acute Care (IPU) – Total Inpatient: Total Discharges /1000 MM		[5]	5.95		[5]	9.89		[5]	6.40		[5]	6.47		[5]	7.01		[5]	6.61		[5]	6.73		[5]	7.17	7.03
Inpatient Utilization - General Hospital Acute Care (IPU) – Total Inpatient: Total Average Length of Stay		[5]	3.96		[5]	4.12		[5]	4.59		[5]	3.66		[5]	4.03		[5]	3.85		[5]	3.72		[5]	4.12	4.01
Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics (aaattot)		[5]	0.87		[5]	0.88		[5]	0.68		[5]	1.03		[5]	0.86		[5]	0.97		[5]	0.77		[5]	0.98	0.88
Antibiotic Utilization (ABX) – Average Days Supplied per Antibiotic Script (acattot)		[5]	9.29		[5]	8.983		[5]	8.977		[5]	9.40		[5]	9.23		[5]	9.39		[5]	9.21		[5]	9.26	9.22
Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics of Concern (adattot)		[5]	0.35		[5]	0.29		[5]	0.27		[5]	0.41		[5]	0.34		[5]	0.39		[5]	0.32		[5]	0.43	0.35
Antibiotic Utilization (ABX) – Percentage of Antibiotics of Concern of all Antibiotics (apttot)		[5]	40.4%		[5]	33.0%		[5]	40.5%		[5]	39.8%		[5]	40.2%		[5]	40.4%		[5]	42.1%		[5]	43.2%	39.9%
Call Answer Timeliness (CAT)	81.9%	89.7%	82.9%	95.0%	93.4%	92.7%			69.6%	87.7%	89.2%	86.7%	89.4%	91.3%	77.3%	84.9%	71.0%	43.5%		NA[1]	80.4%	92.4%	89.4%	84.3%	77.2%

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[2] A lower rate indicates better performance.
[3] HEDIS specifications changed in 2012, and this age range is no longer reported. For 2013-2015, this rate is being calculated by HDC.
[4] New measure for HEDIS 2014.
[5] New measure for HEDIS 2015.
* Sub-measure retired by NCQA for HEDIS 2015.

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

Table A1 – Health Plan Descriptive Information (New measures for 2015)

	ACC	JMS	KPMAS	MPC	MSFC	PP	RHMD	UHC
Board Certification (BCR) – Family Medicine: Number of Physicians	616	47	170	595	262	569	468	780
Board Certification (BCR) – Family Medicine: Number Board Certified	449	44	162	243	150	533	290	598
Board Certification (BCR) – Family Medicine: Percent Board Certified	72.9%	93.6%	95.3%	40.8%	57.3%	93.7%	62.0%	76.7%
Board Certification (BCR) – Internal Medicine: Number of Physicians	2288	558	385	1239	441	846	762	2370
Board Certification (BCR) – Internal Medicine: Number Board Certified	1698	526	364	740	293	792	448	1866
Board Certification (BCR) – Internal Medicine: Percent Board Certified	74.2%	94.3%	94.6%	59.7%	66.4%	93.6%	58.8%	78.7%
Board Certification (BCR) – Pediatrician: Number of Physicians	1295	161	94	930	164	845	734	1249
Board Certification (BCR) – Pediatrician: Number Board Certified	1054	143	92	631	66	806	450	1073
Board Certification (BCR) – Pediatrician: Percent Board Certified	81.4%	88.8%	97.9%	67.9%	40.2%	95.4%	61.3%	85.9%
Board Certification (BCR) – OB/GYN: Number of Physicians	668	100	156	568	309	666	393	822
Board Certification (BCR) – OB/GYN: Number Board Certified	512	83	140	143	130	636	242	721
Board Certification (BCR) – OB/GYN: Percent Board Certified	76.7%	83.0%	89.7%	25.2%	42.1%	95.5%	61.6%	87.7%
Board Certification (BCR) – Geriatricians: Number of Physicians	86	33	0	42	10	38	21	86
Board Certification (BCR) – Geriatricians: Number Board Certified	51	23	0	16	4	36	12	59
Board Certification (BCR) – Geriatricians: Percent Board Certified	59.3%	69.7%	0.0%	38.1%	40.0%	94.7%	57.1%	68.6%
Board Certification (BCR) – Other Specialists: Number of Physicians	5344	1691	810	4723	2121	10040	2627	6139
Board Certification (BCR) – Other Specialists: Number Board Certified	3997	1362	757	2819	1210	9474	1408	4973
Board Certification (BCR) – Other Specialists: Percent Board Certified	74.8%	80.5%	93.5%	59.7%	57.1%	94.4%	53.6%	81.0%
Enrollment by Product Line (ENP) – Shows only total member months for Female	1742194	145745	19019	1301131	392920	1592290	121547	1437400
Enrollment by Product Line (ENP) – Shows only total member months for Male	1474078	162349	15183	963862	305301	1245933	116604	1216858
Enrollment by Product Line (ENP) – Shows only total member months Total	3216272	308094	34202	2264993	698221	2838223	238151	2654258
Enrollment by State (EBS) – Maryland Only	266373	25252	10326	194943	65967	242549	26881	223438

	ACC	JMS	KPMAS	MPC	MSFC	PP	RHMD	UHC
Language Diversity (LDM) – Spoken - Non-English Number	4268	68	816	0	0	0	0	2186
Language Diversity (LDM) – Spoken - Non-English Percent	1.3%	0.2%	7.5%	0.0%	0.0%	0.0%	0.0%	0.8%
Language Diversity (LDM) – Spoken - Unknown Number	322935	0	387	236460	83128	289174	37399	282513
Language Diversity (LDM) – Spoken - Unknown Percent	98.7%	0.0%	3.5%	100.0%	100.0%	100.0%	100.0%	99.2%
Language Diversity (LDM) – Spoken - Declined Number	0	0	7	0	0	0	0	0
Language Diversity (LDM) – Spoken - Declined Percent	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Race/Ethnicity Diversity (RDM) – White / Total	63296	5117	2513	81776	26341	118701	12821	99723
Race/Ethnicity Diversity (RDM) – White / Percent	19.3%	14.7%	23.0%	34.6%	31.7%	41.1%	34.3%	35.0%
Race/Ethnicity Diversity (RDM) – Black / Total	156434	26066	5968	107872	38268	125657	15030	123919
Race/Ethnicity Diversity (RDM) – Black / Percent	47.8%	75.0%	54.5%	45.6%	46.0%	43.45%	40.2%	43.53%
Race/Ethnicity Diversity (RDM) – American Indian & Alaska Native / Total	0	117	11	0	0	8	0	0
Race/Ethnicity Diversity (RDM) – American Indian & Alaska Native / Percent	0.0%	0.3%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Race/Ethnicity Diversity (RDM) – Asian / Total	14210	749	526	7947	4280	9954	1867	14044
Race/Ethnicity Diversity (RDM) – Asian / Percent	4.3%	2.2%	4.8%	3.36%	5.2%	3.44%	5.0%	4.9%
Race/Ethnicity Diversity (RDM) – Native Hawaiian - Pacific Islander / Total	259	34	7	0	0	0	48	257
Race/Ethnicity Diversity (RDM) – Native Hawaiian - Pacific Islander / Percent	0.08%	0.10%	0.06%	0.0%	0.0%	0.0%	0.13%	0.09%
Race/Ethnicity Diversity (RDM) – Other / Total	0	0	149	0	0	0	0	0
Race/Ethnicity Diversity (RDM) – Other / Percent	0.0%	0.0%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%
Race/Ethnicity Diversity (RDM) – 2+ Races / Total	0	0	4	0	0	0	0	0
Race/Ethnicity Diversity (RDM) – 2+ Races / Percent	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Race/Ethnicity Diversity (RDM) – Unknown / Total	93013	2652	1737	38865	14239	34854	2425	46759
Race/Ethnicity Diversity (RDM) – Unknown / Percent	28.4%	7.6%	15.9%	16.4%	17.1%	12.1%	6.5%	16.4%
Race/Ethnicity Diversity (RDM) – Declined / Total	0	0	33	0	0	0	5208	0
Race/Ethnicity Diversity (RDM) – Declined / Percent	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	13.9%	0.0%
Week of Pregnancy at Time of Enrollment (WOP) – 13-27 weeks	29.6%	20.5%	NR	25.6%	30.9%	28.0%	37.5%	32.6%
Week of Pregnancy at Time of Enrollment (WOP) – 28+ weeks	13.3%	11.8%	NR	11.3%	17.7%	13.1%	23.8%	14.5%
Week of Pregnancy at Time of Enrollment (WOP) – Unknown	4.7%	0.0%	NR	4.2%	4.9%	4.6%	16.6%	4.8%
Total Membership – Total membership numbers for each plan	266363	25263	16040	195088	66532	242828	26926	223613

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[2] A lower rate indicates better performance.
[3] HEDIS specifications changed in 2012, and this age range is no longer reported. For 2013-2015, this rate is being calculated by HDC.
[4] New measure for HEDIS 2014.
[5] New measure for HEDIS 2015.
* Sub-measure retired by NCQA for HEDIS 2015.

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

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 the second leading cause of preventable death in the United States (U.S.). It is a complex, multifaceted, chronic disease that is affected by environmental, genetic, physiological, metabolic, behavioral and psychological components. Approximately 127 million American adults are overweight, 60 million are obese and 9 million are severely obese. Obesity affects every ethnicity, socioeconomic class and geographic region in the U.S. This disease has been growing by epidemic proportions with the prevalence increasing by approximately 50 percent per decade. Obesity's impact on individual overall health has drastically increased as well. It increases both morbidity and mortality rates and the risk of conditions such as diabetes, coronary heart disease (CHD) and cancer. It has a substantial negative effect on longevity, reducing the length of life of people who are severely obese by an estimated 5–20 years. Overweight and obesity are also contributing causes to more than 50 percent of all-cause mortality among American adults aged 20–74, which results in a significant economic impact— approximately $99.2 billion is spent annually on obesity-related medical care and disability in the U.S.

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 (MQIC), 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.

Summary of Changes to HEDIS 2015:

- Clarified that documentation of >99% or <1% meet criteria for BMI percentile

Adult BMI Assessment (ABA)

	2011*	2012*	2013	2014	2015	NHM
ACC			61.3%	72.0%	82.4%	↑
JMS			90.7%	80.2%	98.5%	↑
KPMAS					98.4%	↑
MPC			48.7%	70.2%	84.9%	↑
MSFC			76.4%	82.6%	86.4%	↑
PP			59.9%	82.9%	89.6%	↑
RHMD				NA	NA□	NA
UHC			49.1%	68.9%	81.9%	↑
MARR			65.1%	76.1%	88.9%	↑

* This measure was added by DHMH for reporting in HEDIS 2013.
□ 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.

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 2015:

- No changes to this measure

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

	2011*	2012	2013	2014	2015	NHM
ACC		23.7%	20.6%	23.88%	24.5%	↓
JMS		21.9%	35.5%	35.2%	34.1%	↑
KPMAS					NA▫	NA
MPC		19.7%	19.9%	22.0%	21.9%	↓
MSFC		16.1%	14.1%	15.2%	19.9%	↓
PP		21.1%	18.9%	23.94%	24.4%	↓
RHP				NA	NA▫	NA
UHC		19.6%	16.0%	20.8%	23.7%	↓
MARR		20.5%	20.4%	23.5%	24.7%	↓

* This measure was added by DHMH for reporting in HEDIS 2012.
▫ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

Childhood Immunization Status (CIS)

Description: The percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four Pneumococcal Conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza 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
Combination 2	X	X	X	X	X	X				
Combination 3	X	X	X	X	X	X	X			
Combination 4	X	X	X	X	X	X	X	X		
Combination 5	X	X	X	X	X	X	X		X	
Combination 6	X	X	X	X	X	X	X			X
Combination 7	X	X	X	X	X	X	X	X	X	
Combination 8	X	X	X	X	X	X	X	X		X
Combination 9	X	X	X	X	X	X	X		X	X
Combination 10	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 one of the safest and most effective ways to protect children from potentially serious childhood diseases. In spite of established guidelines and well-known benefits of vaccination, nearly 25 percent of children 19 to 35 months still had not received recommended immunizations.

Summary of Changes to HEDIS 2015:
- Revised value sets and value set names:
    - For measles, mumps, rubella, hepatitis B, VZV and hepatitis A, value sets were split into two, one to identify the antigen and one to identify a history of the illness.
    - For all antigens, names for value sets containing codes that identify the antigen now include the terminology "vaccine administered."
    - For MMR, VZV and influenza optional exclusions, Lymphoreticular Cancer Value Set, Multiple Myeloma Value Set and Leukemia Value Set were combined into a single value set: Malignant Neoplasm of Lymphatic Tissue Value Set.
    - Hepatitis B Diagnosis Value Set was renamed Hepatitis B Value Set.
    - Immunodeficiency Value Set was renamed Disorders of the Immune System Value Set.
- Deleted the optional exclusion for Anaphylactic Reaction Due to Serum Value Set (with date of service prior to October 1, 2011).

Childhood Immunization Status (CIS) – Combination 2 (DTaP, IPV, MMR, HiB, Hep B, VZV)

	2011	2012	2013	2014	2015	NHM
ACC	79.4%	85.6%	84.7%	81.3%	83.8%	↑
JMS	88.4%	80.6%	86.1%	86.5%	88.4%	↑
KPMAS					NA▫	NA
MPC	84.9%	81.8%	76.9%	73.7%	70.8%	↓
MSFC	86.6%	89.5%	85.4%	88.1%	81.8%	↑
PP	83.0%	86.0%	86.8%	83.1%	83.6%	↑
RHMD				NA	50.0%	↓
UHC	71.0%	82.7%	70.3%	73.0%	77.4%	↑
MARR	79.9%	82.5%	80.2%	80.9%	76.5%	↑

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

Childhood Immunization Status (CIS) – Combination 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV)

	2011	2012	2013	2014	2015	NHM
ACC	73.8%	81.9%	83.5%	78.2%	81.9%	↑
JMS	85.9%	78.7%	83.7%	86.1%	87.6%	↑
KPMAS					NA▫	NA
MPC	81.3%	80.8%	74.3%	72.09%	68.2%	↓
MSFC	84.7%	87.6%	83.7%	85.9%	79.3%	↑
PP	79.8%	83.7%	83.8%	80.8%	80.1%	↑
RHMD				NA	43.8%	↓
UHC	66.7%	78.8%	66.7%	71.3%	73.7%	↑
MARR	76.3%	79.7%	77.7%	79.1%	73.5%	↑

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

Childhood Immunization Status (CIS) – Combination 4 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A)

	2011	2012	2013	2014	2015	NHM
ACC	28.9%	39.1%	75.9%	73.6%	77.6%	↑
JMS	36.1%	33.3%	80.9%	84.8%	85.2%	↑
KPMAS					NA▫	NA
MPC	30.2%	32.8%	67.4%	62.8%	64.7%	↔
MSFC	29.2%	41.6%	80.3%	81.3%	76.6%	↑
PP	25.8%	38.8%	73.8%	69.4%	78.5%	↑
RHMD				NA	43.8%	↓
UHC	34.3%	37.2%	58.9%	66.2%	67.9%	↑
MARR	30.6%	36.2%	71.8%	73.0%	70.6%	↑

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

Childhood Immunization Status (CIS) – Combination 5 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV)

	2011	2012	2013	2014	2015	NHM
ACC	54.4%	59.7%	61.3%	63.9%	63.7%	↑
JMS	58.9%	57.9%	59.4%	71.7%	68.0%	↑
KPMAS					NA▫	NA
MPC	53.8%	53.5%	55.3%	47.0%	57.1%	↔
MSFC	53.5%	63.3%	56.0%	70.1%	64.5%	↑
PP	37.5%	55.1%	59.6%	54.6%	68.5%	↑
RHMD				NA	37.5%	↓
UHC	47.4%	57.2%	52.0%	56.9%	60.1%	↑
MARR	49.4%	56.2%	56.3%	60.7%	59.9%	↑

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

Childhood Immunization Status (CIS) – Combination 6 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Influenza)

	2011	2012	2013	2014	2015	NHM
ACC	40.5%	48.6%	49.7%	49.3%	53.0%	↑
JMS	40.2%	33.3%	39.0%	47.8%	46.8%	↑
KPMAS					NA▫	NA
MPC	37.5%	39.2%	42.4%	37.7%	40.6%	↓
MSFC	49.1%	57.4%	55.2%	59.4%	51.6%	↑
PP	47.4%	51.4%	51.5%	49.5%	54.2%	↑
RHMD				NA	28.1%	↓
UHC	36.5%	41.8%	38.2%	44.3%	48.4%	↑
MARR	40.9%	44.0%	45.7%	48.0%	46.1%	↑

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

Childhood Immunization Status (CIS) – Combination 7 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV)

	2011	2012	2013	2014	2015	NHM
ACC	23.1%	30.1%	57.8%	60.7%	61.3%	↑
JMS	28.6%	25.5%	59.0%	71.3%	67.2%	↑
KPMAS					NA▫	NA
MPC	21.2%	20.2%	51.4%	44.0%	55.0%	↑
MSFC	21.9%	31.1%	54.3%	66.7%	62.5%	↑
PP	14.6%	25.3%	56.2%	50.7%	68.5%	↑
RHMD				NA	37.5%	↓
UHC	24.6%	28.2%	47.2%	54.7%	57.4%	↑
MARR	22.1%	26.3%	53.6%	58.0%	58.5%	↑

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

Childhood Immunization Status (CIS) – Combination 8 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, Influenza)

	2011	2012	2013	2014	2015	NHM
ACC	17.8%	25.7%	47.3%	47.9%	50.9%	↑
JMS	20.7%	21.3%	39.0%	47.4%	45.6%	↑
KPMAS					NA▫	NA
MPC	16.3%	17.0%	38.7%	34.9%	38.5%	↓
MSFC	18.0%	28.2%	53.5%	56.2%	49.4%	↑
PP	17.27%	24.2%	48.3%	44.4%	53.5%	↑
RHMD				NA	28.1%	↓
UHC	21.7%	21.7%	35.3%	41.4%	46.2%	↑
MARR	18.4%	22.4%	43.6%	45.4%	44.6%	↑

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

Childhood Immunization Status (CIS) – Combination 9 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV, Influenza)

	2011	2012	2013	2014	2015	NHM
ACC	32.4%	38.2%	38.5%	42.4%	43.5%	↑
JMS	27.8%	25.0%	29.5%	40.9%	36.4%	↔
KPMAS					NA▫	NA
MPC	25.1%	29.2%	33.8%	28.4%	34.3%	↓
MSFC	33.1%	43.8%	38.7%	49.9%	44.3%	↑
PP	25.5%	38.8%	41.1%	36.3%	48.4%	↑
RHMD				NA	23.4%	↓
UHC	27.7%	32.8%	31.6%	37.0%	41.4%	↑
MARR	28.1%	33.8%	35.5%	39.1%	38.8%	↑

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

Childhood Immunization Status (CIS) – Combination 10 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, Influenza)

	2011	2012	2013	2014	2015	NHM
ACC	15.5%	20.6%	37.1%	41.2%	42.1%	↑
JMS	17.0%	18.1%	29.5%	40.9%	36.0%	↑
KPMAS					NA▫	NA
MPC	10.9%	12.2%	31.0%	27.7%	33.0%	↓
MSFC	13.87%	22.1%	37.7%	47.0%	42.8%	↑
PP	10.7%	17.9%	39.7%	34.3%	48.4%	↑
RHMD				NA	23.4%	↓
UHC	15.8%	17.5%	29.2%	35.3%	40.2%	↑
MARR	13.95%	17.7%	34.2%	37.7%	38.0%	↑

▫ 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 2015:

- T Meningococcal Value Set was renamed Meningococcal Vaccine Administered Value Set
- Tdap Value Set was renamed Tdap Vaccine Administered Value Set
- Td Value Set was renamed Td Vaccine Administered Value Set
- Tetanus Value Set was renamed Tetanus Vaccine Administered Value Set
- Diphtheria Value Set was renamed Diphtheria Vaccine Administered Value Set

Combination 1 (Meningococcal, Tdap/Td)

	2011	2012	2013	2014	2015	NHM
ACC	46.1%	56.7%	65.0%	69.4%	74.8%	↑
JMS	71.6%	73.2%	70.66%	75.5%	76.7%	↑
KPMAS					NA▫	NA
MPC	52.1%	51.1%	57.6%	62.7%	74.070%	↑
MSFC	57.2%	70.7%	70.69%	70.7%	72.4%	↑
PP	56.9%	52.0%	67.4%	74.5%	74.070%	↑
RHMD				NA	64.7%	↓
UHC	38.6%	48.4%	56.4%	63.4%	66.2%	↓
MARR	51.8%	57.4%	63.8%	67.2%	71.9%	↑

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

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. DHMH 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.

Rationale: This measure looks at the adequacy of well-child care for infants. 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.

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. The American Academy of Pediatrics (AAP) 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.

Summary of Changes to HEDIS 2015:
   • T Meningococcal Value Set was renamed Meningococcal Vaccine Administered Value Set

Well-Child Visits in the First 15 months of Life (W15) – No well-child visits*

	2011	2012	2013	2014	2015	NHM
ACC	0.8%	1.6%	1.012%	1.0%	2.1%	↔
JMS	2.4%	0.87%	2.7%	3.1%	1.9%	↔
KPMAS					NA▫	NA
MPC	1.1%	1.4%	1.11%	0.5%	1.56%	↑
MSFC	2.2%	1.3%	1.013%	1.2%	3.5%	↔
PP	0.9%	1.1%	1.14%	1.1%	1.59%	↑
RHMD				NA	10.9%	↓
UHC	2.05%	0.88%	2.2%	1.9%	0.9%	↑
MARR	1.95%	1.5%	1.6%	1.5%	3.2%	↔

* A lower rate indicates better performance.
▫ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

Well-Child Visits in the First 15 months of Life (W15) – DHMH Five or Six-or-more visits (rate constructed by adding together HEDIS five visits and six-or-more visits rates)

	2011	2012	2013	2014	2015	NHM
ACC	87.2%	87.3%	86.1%	88.9%	85.1%	
JMS	83.4%	84.0%	85.9%	84.4%	81.6%	
KPMAS					NA▫	
MPC	86.0%	89.9%	77.8%	83.6%	84.9%	
MSFC	84.7%	88.2%	89.2%	86.0%	82.8%	
PP	87.1%	84.3%	84.3%	83.7%	81.9%	
RHMD				NA	56.6%	
UHC	83.6%	86.8%	82.1%	87.4%	83.6%	
MARR	82.4%	85.0%	83.9%	85.7%	79.5%	

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

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.

Rationale: This measure looks at the use of routine check-ups by preschool and early school-age children. 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 AAP recommends annual well-child visits for two- to six-year-olds.

Summary of Changes to HEDIS 2015:

- No changes to this measure

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

	2011	2012	2013	2014	2015	NHM
ACC	86.6%	86.4%	83.6%	83.9%	83.7%	↑
JMS	89.3%	88.9%	87.7%	88.9%	90.6%	↑
KPMAS					84.6%	↑
MPC	86.3%	89.1%	87.5%	88.8%	87.0%	↑
MSFC	73.5%	82.3%	79.6%	83.5%	86.7%	↑
PP	78.3%	82.4%	80.7%	83.8%	86.8%	↑
RHMD				NA	57.4%	↓
UHC	75.2%	83.1%	83.8%	75.0%	79.2%	↑
MARR	80.7%	85.0%	82.2%	84.0%	82.0%	↑

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.

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.

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.

Summary of Changes to HEDIS 2015:

- No changes to this measure

Adolescent Well-Care Visits (AWC)

	2011	2012	2013	2014	2015	NHM
ACC	63.1%	61.9%	68.1%	67.9%	64.7%	↑
JMS	79.7%	79.9%	76.9%	76.7%	80.3%	↑
KPMAS					63.5%	↑
MPC	72.1%	75.8%	60.2%	68.8%	68.3%	↑
MSFC	63.5%	67.7%	69.4%	67.8%	61.2%	↑
PP	60.0%	66.1%	67.6%	61.6%	68.8%	↑
RHMD				NA	31.8%	↓
UHC	49.8%	55.7%	59.7%	60.8%	58.5%	↑
MARR	62.8%	67.0%	65.4%	67.3%	62.1%	↑

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 2015:

- Clarified that documentation of >99% or <1% meet criteria for BMI percentile

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - BMI Percentile- Total Rate

	2011*	2012*	2013*	2014	2015	NHM
ACC				49.5%	60.9%	↑
JMS				92.2%	94.7%	↑
KPMAS					99.0%	↑
MPC				46.5%	58.3%	↑
MSFC				59.8%	67.3%	↑
PP				52.1%	72.5%	↑
RHMD				NA	41.5%	↓
UHC				45.5%	57.9%	↔
MARR				57.6%	69.0%	↑

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

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate

	2011*	2012*	2013*	2014	2015	NHM
ACC				59.0%	71.5%	↑
JMS				94.4%	97.6%	↑
KPMAS					98.1%	↑
MPC				54.4%	66.4%	↑
MSFC				74.1%	72.9%	↑
PP				54.2%	73.6%	↑
RHMD				NA	50.8%	↓
UHC				67.6%	64.5%	↑
MARR				67.3%	74.4%	↑

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

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate

	2011*	2012*	2013*	2014	2015	NHM
ACC				51.4%	61.3%	↑
JMS				89.8%	91.2%	↑
KPMAS					98.1%	↑
MPC				58.8%	60.0%	↑
MSFC				72.9%	67.8%	↑
PP				44.7%	70.1%	↑
RHMD				NA	43.1%	↓
UHC				60.6%	63.0%	↑
MARR				63.0%	69.3%	↑

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

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.

Summary of Changes to HEDIS 2015:

- No changes to this measure

Appropriate Testing for Children with Pharyngitis (CWP)

	2011	2012	2013	2014	2015	NHM
ACC	61.5%	68.8%	75.9%	78.36%	79.8%	↑
JMS	76.3%	74.51%	75.3%	70.8%	80.2%	↑
KPMAS					NA□	NA
MPC	74.0%	76.9%	77.4%	78.42%	82.9%	↑
MSFC	81.0%	85.9%	85.2%	86.9%	90.5%	↑
PP	69.5%	74.46%	78.2%	80.5%	83.1%	↑
RHMD				NA	76.4%	↑
UHC	70.8%	76.4%	79.8%	83.1%	86.0%	↑
MARR	71.1%	75.7%	79.9%	79.7%	82.7%	↑

□ 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 (Centers for Disease Control and Prevention [CDC], 2005). 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.

Summary of Changes to HEDIS 2015:

- No changes to this measure

Lead Screening in Children (LSC)

	2011*	2012*	2013*	2014*	2015	NHM
ACC					77.1%	↑
JMS					87.2%	↑
KPMAS					NA▫	NA
MPC					70.0%	↑
MSFC					88.6%	↑
PP					71.9%	↑
RHMD					53.1%	↓
UHC					68.6%	↑
MARR					73.8%	↑

* This measure was added by DHMH for reporting in HEDIS 2015.
▫ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

Human Papillomavirus Vaccine for Female Adolescents (HPV)

Description: The percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

Rationale: Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States (Daley et al., 2010). According to the Centers for Disease Control and Prevention (CDC, 2010), at least 50 percent of all sexually active people will have genital HPV at some point during their lifetime. Approximately 20 million Americans are infected with genital HPV, which is responsible for nearly 70 percent of cases of cervical cancer and 90 percent of cases of anogenital warts. This is a growing global concern, especially considering that the number of morbidities and death associated with HPV infections could be prevented through vaccination.

Administering widespread vaccination for HPV could reduce cervical cancer deaths around the world by as much as two-thirds of all young, sexually active women received the vaccine and if protection turns out to be long-term. The HPV vaccine could reduce the need for medical care, biopsies, and invasive procedures associated with follow-up from abnormal Pap tests, therefore reducing health care costs from abnormal Pap tests and follow-up procedures (National Cancer Institute [NCI], 2009).

Summary of Changes to HEDIS 2015:

- HPV Value Set was renamed HPV Vaccine Administered Value Set

Human Papillomavirus Vaccine for Female Adolescents (HPV)

	2011*	2012*	2013*	2014*	2015	NHM
ACC					23.7%	↑
JMS					33.9%	↑
KPMAS					NA▫	NA
MPC					21.8%	↑
MSFC					24.3%	↑
PP					17.7%	↓
RHMD					NA▫	NA
UHC					15.1%	↓
MARR					22.8%	↑

* This measure was added by DHMH 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.

Summary of Changes to HEDIS 2015:

- Revised the exclusion criteria. Exclusions are required and must be removed from the eligible population.
- Immunodeficiency Value Set was renamed Disorders of the Immune System Value Set.

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

	2011*	2012*	2013*	2014*	2015	NHM
ACC					5.3%	↔
JMS					2.1%	↑
KPMAS					1.9%	↑
MPC					4.2%	↑
MSFC					2.9%	↑
PP					3.7%	↑
RHMD					5.2%	↔
UHC					5.8%	↔
MARR					3.9%	↓

* This measure was added by DHMH for reporting in HEDIS 2015.
** A lower rate indicates better performance.

RESPIRATORY CONDITIONS – ADULT AND CHILD

Use of Appropriate Medications for People with Asthma (ASM)

Description: The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

Rationale: Asthma is one of the nation's most costly and high-impact diseases. It has become increasingly common over the past two decades. Approximately 34.1 Americans have been diagnosed with asthma and each year nearly 5,000 Americans die of it. Many asthma-related hospitalizations, emergency room visits and missed work and school days can be avoided if patients have appropriate medications and medical management. Medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

Summary of Changes to HEDIS 2015:

- Clarified the definition of injection dispensing event

Use of Appropriate Medications for People with Asthma (ASM) – Ages 5–11

	2011	2012	2013	2014	2015	NHM
ACC	91.90%	91.4%	88.7%	90.3%	90.0%	↔
JMS	91.94%	94.2%	91.4%	93.59%	91.4%	↑
KPMAS					NA▫	NA
MPC	93.1%	93.0%	92.3%	91.4%	92.5%	↑
MSFC	92.8%	96.7%	93.7%	93.62%	93.5%	↑
PP	93.6%	91.7%	92.3%	91.6%	92.0%	↑
RHMD				NA	NA	NA
UHC	93.2%	95.7%	96.1%	91.9%	90.8%	↔
MARR	92.0%	92.8%	91.8%	92.1%	91.7%	↑

* This indicator was included by DHMH for reporting in HEDIS 2012.
▫ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 12–18

	2011*	2012	2013	2014	2015	NHM
ACC		88.2%	86.2%	87.8%	87.1%	↔
JMS		100%	92.9%	86.0%	86.3%	↔
KPMAS					NA▫	NA
MPC		91.1%	92.3%	90.4%	91.5%	↑
MSFC		93.30%	90.2%	94.2%	91.6%	↑
PP		90.8%	89.6%	88.5%	89.5%	↑
RHMD				NA	NA	NA
UHC		96.6%	93.4%	88.0%	88.6%	↑
MARR		93.34%	91.6%	89.1%	89.1%	↑

* This indicator was included by DHMH for reporting in HEDIS 2012.
▫ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 19–50

	2011*	2012	2013	2014	2015	NHM
ACC		78.0%	79.5%	73.7%	73.1%	↓
JMS		91.3%	93.3%	81.3%	89.4%	↑
KPMAS					NA▫	NA
MPC		82.8%	81.8%	80.1%	77.9%	↑
MSFC		85.2%	76.8%	75.2%	77.6%	↑
PP		77.9%	80.7%	76.8%	74.9%	↔
RHMD				NA	NA▫	NA
UHC		95.1%	88.0%	72.9%	73.7%	↔
MARR		85.05%	83.5%	76.7%	77.8%	↑

* This indicator was included by DHMH for reporting in HEDIS 2012.
▫ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 51–64

	2011*	2012	2013	2014	2015	NHM
ACC		71.2%	77.7%	68.6%	79.0%	↑
JMS		83.7%	82.0%	71.43%	83.8%	↑
KPMAS					NA▫	NA
MPC		81.7%	78.5%	76.3%	80.9%	↑
MSFC		NA	77.1%	NA	NA	NA
PP		69.2%	77.0%	73.0%	77.6%	↑
RHMD				NA	NA▫	NA
UHC		95.0%	94.1%	79.0%	72.8%	↑
MARR		80.1%	81.1%	73.7%	78.8%	↑

* This indicator was included by DHMH for reporting in HEDIS 2012.
▫ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 5–64

	2011*	2012	2013	2014	2015	NHM
ACC		89.1%	86.5%	86.29%	86.3%	↑
JMS		95.7%	90.7%	83.6%	87.9%	↑
KPMAS					NA▫	NA
MPC		90.7%	88.7%	86.97%	87.3%	↑
MSFC		95.5%	88.8%	90.1%	89.1%	↑
PP		89.3%	88.9%	87.02%	87.1%	↑
RHMD				NA	NA▫	NA
UHC		96.7%	94.0%	86.28%	84.11%	↔
MARR		93.1%	89.4%	86.7%	87.0%	↑

* This indicator was included by DHMH for reporting in HEDIS 2012.
▫ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 5–50*

	2011	2012*	2013	2014	2015	NHM
ACC	90.1%	88.5%	86.7%	86.8%	83.4%	↓
JMS	93.3%	93.9%	92.5%	86.4%	89.0%	↑
KPMAS					NA▫	NA
MPC	90.6%	89.8%	89.2%	87.53%	87.3%	↑
MSFC	91.1%	93.6%	89.4%	90.1%	87.6%	↑
PP	90.4%	88.9%	89.3%	87.6%	85.4%	↑
RHMD				NA	NA▫	NA
UHC	90.2%	95.9%	94.0%	86.6%	84.3%	↑
MARR	90.8%	91.2%	89.9%	87.51%	87.51%	↑

* HEDIS specifications changed in 2012 and this age range is no longer reported. For 2012 and 2013, this rate was being calculated by HDC for DHMH to use in the VBP program.
▫ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

Medication Management for People with Asthma (MMA)

Description: The percentage of members 5-64 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: Appropriate medication adherence could ameliorate the severity of many asthma-related symptoms. 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. 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.

Summary of Changes to HEDIS 2015:

- Clarified the definition of injection dispensing event

Medication Management for People with Asthma (MMA) – Total 50% of treatment period

	2011*	2012*	2013	2014	2015	NHM
ACC			44.8%	45.8%	48.8%	↓
JMS			53.2%	49.4%	59.6%	↑
KPMAS					NA▫	NA
MPC			49.4%	57.9%	57.9%	↑
MSFC			52.4%	51.9%	49.9%	↓
PP			40.3%	43.3%	44.5%	↓
RHMD				NA	NA▫	NA
UHC			47.3%	49.9%	48.4%	↓
MARR			46.3%	49.7%	51.5%	↓

* This measure was added by DHMH for reporting in HEDIS 2013.
▫ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

Medication Management for People with Asthma (MMA) – Total 75% of treatment period

	2011*	2012*	2013	2014	2015	NHM
ACC			24.1%	22.9%	23.2%	↓
JMS			28.9%	24.5%	34.8%	↑
KPMAS					NA▫	NA
MPC			26.6%	32.9%	34.0%	↑
MSFC			28.7%	26.6%	24.1%	↓
PP			19.7%	20.0%	20.5%	↓
RHMD				NA	NA▫	NA
UHC			26.7%	27.8%	25.2%	↓
MARR			24.3%	25.8%	27.0%	↓

* This measure was added by DHMH for reporting in HEDIS 2013.
▫ 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 2015:

- No changes to this measure

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

	2011	2012	2013	2014	2015	NHM
ACC	87.0%	86.13%	85.1%	86.5%	88.03%	↑
JMS	93.8%	89.8%	85.2%	83.0%	92.4%	↑
KPMAS					NA▫	NA
MPC	85.6%	86.08%	86.06%	86.6%	85.6%	↔
MSFC	88.6%	89.0%	86.13%	84.3%	89.5%	↑
PP	88.5%	86.01%	85.0%	86.0%	89.0%	↑
RHMD				NA	86.4%	↑
UHC	83.3%	80.2%	80.1%	82.0%	85.20%	↔
MARR	87.5%	86.20%	84.4%	84.7%	88.00%	↑

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

Asthma Medication Ratio (AMR)

Description: The percentage of members 5–64 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. 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 2015:

- Clarified the definition of injection dispensing event
- Clarified how to count inhalers and injections in the definition of units of medication

Asthma Medication Ratio (AMR)

	2011*	2012*	2013*	2014	2015	NHM
ACC				68.59%	56.54%	↓
JMS				60.5%	56.50%	↓
KPMAS					NA▫	NA
MPC				69.1%	65.0%	↔
MSFC				73.7%	68.1%	↑
PP				69.6%	63.8%	↓
RHMD				NA	NA▫	NA
UHC				69.8%	63.4%	↓
MARR				68.56%	62.2%	↓

* This measure was added by DHMH 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.

Summary of Changes to HEDIS 2015:

- No changes to this measure

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

	2011*	2012*	2013*	2014	2015	NHM
ACC				25.8%	23.6%	↓
JMS				26.3%	32.6%	↑
KPMAS					NA▫	NA
MPC				21.1%	20.8%	↓
MSFC				34.5%	29.2%	↓
PP				23.7%	27.2%	↓
RHMD				NA	NA▫	NA
UHC				25.6%	25.6%	↓
MARR				26.2%	26.5%	↓

* This measure was added by DHMH 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 within 14 days of the event.

2. Dispensed a bronchodilator 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 if they meet the continuous enrollment criteria.

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 2015:

- No changes to this measure

Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate

	2011*	2012*	2013*	2014	2015	NHM
ACC				73.6%	69.0%	↑
JMS				69.2%	73.6%	↑
KPMAS					NA▫	NA
MPC				72.6%	72.1%	↑
MSFC				76.3%	72.2%	↑
PP				69.7%	69.7%	↑
RHMD				NA	78.1%	↑
UHC				78.2%	73.0%	↑
MARR				73.3%	72.5%	↑

* This measure was added by DHMH 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) – Bronchodilator Rate

	2011*	2012*	2013*	2014	2015	NHM
ACC				87.5%	84.8%	↑
JMS				82.5%	85.4%	↑
KPMAS					NA▫	NA
MPC				84.93%	85.1%	↑
MSFC				90.3%	92.4%	↑
PP				84.0%	85.0%	↑
RHMD				NA	81.3%	↔
UHC				84.88%	86.3%	↑
MARR				85.7%	85.7%	↑

* This measure was added by DHMH for reporting in HEDIS 2014.
▫ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

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

Description: The percentage of members 12 months–19 years of age that 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: While the access to primary care has been shown to correlate with reduced hospital use while preserving quality, this measure does not explicitly measure a member's access to primary care. However, studies show that inappropriate care and overuse of new technologies can be reduced through shared decision-making between well-informed physicians and patients.

Summary of Changes to HEDIS 2015:

- No changes to this measure

Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 12–24 months

	2011	2012	2013	2014	2015	NHM
ACC	97.7%	97.45%	97.5%	97.8%	97.7%	↑
JMS	94.3%	92.9%	91.1%	94.7%	96.2%	↔
KPMAS					100.0%	↑
MPC	96.5%	96.8%	97.1%	96.5%	96.9%	↔
MSFC	95.2%	96.6%	96.6%	96.4%	93.9%	↓
PP	97.9%	98.1%	97.8%	97.6%	97.6%	↑
RHMD				NA	87.8%	↓
UHC	96.8%	97.41%	96.7%	96.3%	96.6%	↔
MARR	96.1%	96.1%	95.6%	96.6%	95.8%	↔

Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 25 months–6 years

	2011	2012	2013	2014	2015	NHM
ACC	92.7%	92.8%	92.6%	92.8%	93.1%	↑
JMS	90.59%	89.3%	90.4%	88.7%	91.8%	↑
KPMAS					98.0%	↑
MPC	89.8%	90.7%	89.0%	90.0%	90.3%	↑
MSFC	88.9%	91.4%	90.3%	89.8%	88.4%	↔
PP	92.3%	93.0%	92.8%	92.6%	93.3%	↑
RHMD				NA	69.4%	↓
UHC	91.7%	92.1%	91.1%	91.1%	91.3%	↑
MARR	90.57%	90.9%	90.3%	90.8%	89.5%	↑

Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 7–11 years

	2011	2012	2013	2014	2015	NHM
ACC	93.6%	93.6%	93.9%	94.3%	95.3%	↑
JMS	94.5%	94.0%	93.3%	93.8%	92.7%	↑
KPMAS					98.4%	↑
MPC	92.8%	92.0%	91.5%	92.1%	92.61%	↑
MSFC	93.4%	92.86%	92.5%	93.50%	92.58%	↑
PP	94.1%	93.9%	94.3%	94.4%	94.4%	↑
RHMD				NA	NA□	NA
UHC	93.1%	93.0%	93.3%	93.1%	93.6%	↑
MARR	92.6%	92.86%	92.7%	93.52%	94.2%	↑

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

Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 12–19 years

	2011	2012	2013	2014	2015	NHM
ACC	88.6%	89.3%	89.5%	90.5%	91.9%	↑
JMS	92.02%	92.4%	91.7%	90.8%	92.9%	↑
KPMAS					94.2%	↑
MPC	89.5%	88.4%	87.7%	88.5%	89.7%	↑
MSFC	91.98%	90.9%	92.5%	92.7%	91.7%	↑
PP	90.8%	91.6%	92.0%	91.9%	92.5%	↑
RHMD				NA	NA□	NA
UHC	89.90%	88.5%	89.2%	90.1%	90.9%	↑
MARR	89.86%	89.8%	89.8%	90.7%	92.0%	↑

□ 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 of age and older who had an ambulatory or preventive care visit during the measurement year.

Rationale: While access to primary care has been shown to correlate with reduced hospital use while preserving quality, this measure does not explicitly measure a member's access to primary care. However, studies show that inappropriate care and overuse of new technologies can be reduced through shared decision-making between well-informed physicians and patients.

Summary of Changes to HEDIS 2015:

- No changes to this measure

Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 years

	2011	2012	2013	2014	2015	NHM
ACC	79.6%	80.4%	79.7%	79.4%	79.4%	↓
JMS	79.0%	75.5%	74.8%	72.9%	71.0%	↓
KPMAS					92.9%	↑
MPC	80.9%	81.2%	81.4%	81.1%	80.9%	↔
MSFC	79.22%	79.6%	79.9%	79.7%	76.3%	↓
PP	83.0%	83.7%	83.5%	81.7%	82.3%	↑
RHMD				NA	63.6%	↓
UHC	79.23%	80.3%	80.2%	80.36%	80.0%	↔
MARR	79.7%	80.0%	79.9%	79.2%	78.3%	↓

Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years

	2011	2012	2013	2014	2015	NHM
ACC	85.0%	87.0%	86.4%	87.2%	86.7%	↔
JMS	89.2%	88.8%	87.8%	86.58%	86.75%	↔
KPMAS					95.7%	↑
MPC	87.4%	87.28%	86.8%	87.8%	87.4%	↔
MSFC	84.6%	85.9%	86.2%	86.9%	85.1%	↓
PP	88.5%	89.4%	89.4%	88.4%	89.0%	↑
RHMD				NA	75.9%	↓
UHC	85.9%	87.31%	87.5%	87.8%	88.0%	↔
MARR	85.3%	86.5%	86.4%	87.5%	86.82%	↔

Breast Cancer Screening (BCS)

Description: The percentage of women 40–69 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. 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% among women 40 and older. Mammography screening for women ages 50 to 69 can reduce breast cancer mortality up to 35%.

The U.S. Preventive Services Task Force, the American Academy of Family Physicians and the American College of Preventive Medicine recommend mammograms as the most effective method for detecting breast cancer when it is most treatable. When high-quality equipment is used and well-trained radiologists read the x-rays, 85% to 90% of cancers are detectable.

Summary of Changes to HEDIS 2015:

- Revised optional exclusion criteria so that two unilateral mastectomies must have service dates 14 or more days apart

- Added a data element to collect the number of optional exclusions to the Data Elements for Reporting table

Breast Cancer Screening (BCS)

	2011	2012	2013	2014	2015	NHM
ACC	46.0%	48.5%	49.1%	58.1%	66.0%	↑
JMS	62.3%	63.9%	60.8%	69.4%	72.1%	↑
KPMAS					87.2%	↑
MPC	42.8%	43.6%	43.9%	48.5%	65.9%	↑
MSFC	54.6%	54.5%	56.8%	64.4%	63.4%	↑
PP	48.0%	49.9%	51.5%	57.0%	62.5%	↑
RHMD				NA	NA▫	NA
UHC	45.3%	46.6%	48.4%	52.7%	58.1%	↔
MARR	48.3%	50.3%	51.0%	58.3%	67.9%	↑

▫ 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 is the second most common cancer worldwide and the third leading cause of cancer-related deaths. Although rates of cervical cancer in the U.S. have decreased, it remains the tenth leading cause of cancer in females. Most importantly, when detected and treated early, cervical cancer is one of the most treatable cancers. For women under 50 years old, cervical cancer is diagnosed in the early stages 62% of the time.

An annual or biannual routine Papanicolaou (Pap) smear is recommended by the U.S. Preventive Services Task Force and the American Cancer Society for detecting cervical cancer at the pre-cancerous stage.

Summary of Changes to HEDIS 2015:

- Hysterectomy Value Set was renamed Absence of Cervix Value Set

- Added an example to step 2 of the Numerator in the Administrative Specification

- Clarified that cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year meets optional exclusion criteria in the Hybrid Specification

Cervical Cancer Screening (CCS)

	2011	2012	2013	2014	2015	NHM
ACC	76.6%	75.71%	73.6%	79.64%	67.8%	↑
JMS	79.7%	78.5%	80.9%	79.5%	66.8%	↑
KPMAS					90.8%	↑
MPC	69.7%	73.6%	74.0%	79.58%	65.75%	↑
MSFC	76.4%	75.74%	70.9%	74.0%	66.2%	↑
PP	69.4%	73.9%	75.0%	75.9%	74.4%	↑
RHMD				NA	35.5%	↓
UHC	70.3%	69.5%	69.8%	62.8%	58.8%	↓
MARR	73.2%	73.1%	73.7%	75.2%	65.76%	↑

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. 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 (20-24) women.

Three-fourths of infected women do not realize they have the infection, as there are no symptoms until one to three weeks after infection. Pregnant women who have a chlamydial infection may have adverse pregnancy outcomes, such as miscarriage, premature rupture of membranes, preterm labor, low birth weight and infant mortality. Chlamydia can be passed from mother to infant during childbirth, and is a leading cause of conjunctivitis (pink eye) and pneumonia in newborns. Chlamydia can also lead to reproductive health problems such as miscarriages, ectopic pregnancies and pelvic pain. Untreated Chlamydia can damage a woman's reproductive organs, possibly causing permanent and irreversible damage to the fallopian tubes and uterus leading to infertility.

Summary of Changes to HEDIS 2015:

- Revised value sets used for the Event/diagnosis criteria to ensure that supplemental data (e.g., LOINC codes) is not used to identify the denominator. Deleted Pregnancy Tests Value Set and Chlamydia Tests Value Set from the Event/diagnosis criteria and added appropriate (e.g., CPT, UB Revenue) codes from these value sets to the Sexual Activity Value Set

- Added a data element to collect the number of optional exclusions to the Data Elements for Reporting table

Chlamydia Screening in Women (CHL) – Age 16–20 years

	2011	2012	2013	2014	2015	NHM
ACC	62.8%	61.1%	62.6%	62.4%	61.4%	↑
JMS	89.2%	84.0%	81.1%	86.7%	87.6%	↑
KPMAS					76.9%	↑
MPC	60.6%	58.5%	58.1%	58.2%	58.9%	↑
MSFC	56.2%	57.4%	59.6%	54.8%	57.2%	↑
PP	62.1%	62.6%	61.8%	61.5%	59.2%	↑
RHMD				NA	61.1%	↑
UHC	55.9%	57.1%	56.9%	55.4%	55.2%	↑
MARR	63.0%	62.8%	63.8%	63.17%	64.7%	↑

Chlamydia Screening in Women (CHL) – Age 21–24 years

	2011	2012	2013	2014	2015	NHM
ACC	69.8%	70.6%	72.5%	71.9%	71.7%	↑
JMS	78.6%	77.4%	63.9%	72.3%	65.0%	↑
KPMAS					80.8%	↑
MPC	65.1%	66.6%	67.6%	67.1%	67.3%	↑
MSFC	67.2%	70.5%	74.0%	68.4%	66.5%	↑
PP	68.8%	69.8%	68.9%	69.9%	68.0%	↑
RHMD				NA	58.7%	↓
UHC	62.1%	64.8%	63.7%	64.8%	63.2%	↑
MARR	69.0%	70.1%	69.1%	69.1%	67.7%	↑

Chlamydia Screening in Women (CHL) – Total (16–24) years

	2011	2012	2013	2014	2015	NHM
ACC	65.5%	64.8%	66.4%	66.0%	65.970%	↑
JMS	85.3%	81.3%	74.2%	81.2%	77.3%	↑
KPMAS					79.5%	↑
MPC	62.4%	62.0%	62.3%	62.0%	62.6%	↑
MSFC	60.1%	62.5%	65.0%	60.1%	61.3%	↑
PP	64.6%	65.4%	64.6%	64.8%	62.7%	↑
RHMD				NA	59.7%	↑
UHC	58.2%	60.0%	59.5%	59.0%	58.8%	↑
MARR	65.6%	65.9%	66.1%	65.5%	65.970%	↑

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:

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 2015:

- Reversed step 6 and step 7 in the diagram
- Removed the Note allowing registered nurses to conduct prenatal and postpartum visits

Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care

	2011	2012	2013	2014	2015	NHM
ACC	87.7%	90.4%	87.8%	84.2%	85.7%	↑
JMS	89.2%	86.2%	82.9%	85.8%	83.2%	↑
KPMAS					88.0%	↑
MPC	83.9%	82.1%	86.279%	84.9%	80.3%	↓
MSFC	90.7%	87.7%	86.280%	85.4%	79.2%	↓
PP	87.9%	87.1%	89.3%	90.9%	88.2%	↑
RHMD				52.2%	73.3%	↓
UHC	85.7%	83.8%	84.7%	87.1%	84.1%	↑
MARR	86.9%	86.3%	85.8%	74.0%	82.8%	↔

Prenatal and Postpartum Care (PPC) – Postpartum Care

	2011	2012	2013	2014	2015	NHM
ACC	66.3%	70.7%	71.5%	71.6%	66.0%	↑
JMS	80.2%	78.1%	83.7%	78.5%	83.6%	↑
KPMAS					86.0%	↑
MPC	75.2%	71.3%	68.4%	71.9%	65.0%	↑
MSFC	71.7%	74.0%	74.4%	72.0%	71.1%	↑
PP	68.2%	73.0%	72.5%	75.6%	70.7%	↑
RHMD				43.9%	47.4%	↓
UHC	62.5%	64.7%	60.3%	63.8%	62.5%	↑
MARR	69.1%	70.6%	70.0%	61.9%	69.0%	↑

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. Visits should follow a schedule: every four weeks for the first 28 weeks of pregnancy, every two to three weeks for the next seven weeks, and weekly thereafter until delivery.

Summary of Changes to HEDIS 2015:

- Added a Note to the description clarifying that the Guidelines for Effectiveness of Care Measures must be followed when calculating this measure

- Removed the Note allowing registered nurses to conduct prenatal visits

Frequency of Ongoing Prenatal Care (FPC) – Less than 21% of expected visits*

	2011	2012	2013	2014	2015	NHM
ACC	3.49%	3.4%	4.2%	8.2%	5.9%	↑
JMS	1.4%	2.8%	3.6%	2.2%	4.5%	↑
KPMAS					7.7%	↑
MPC	4.2%	5.7%	10.6%	5.6%	6.9%	↑
MSFC	1.8%	2.9%	2.7%	4.4%	7.6%	↑
PP	3.50%	7.7%	4.4%	4.4%	9.3%	↑
RHMD				37.0%	17.4%	↓
UHC	3.6%	5.4%	12.1%	5.8%	6.8%	↑
MARR	3.7%	4.9%	6.3%	9.7%	8.2%	↑

* A lower rate indicates better performance.

Frequency of Ongoing Prenatal Care (FPC) – Greater than or equal to 81% of expected visits

	2011	2012	2013	2014	2015	NHM
ACC	71.4%	80.3%	72.2%	75.5%	72.6%	↑
JMS	82.4%	76.9%	75.8%	70.8%	64.0%	↑
KPMAS					56.9%	↑
MPC	74.0%	69.6%	60.1%	70.6%	69.8%	↑
MSFC	79.6%	82.7%	79.3%	71.3%	64.6%	↑
PP	77.9%	64.7%	78.8%	78.8%	61.7%	↑
RHMD				21.7%	55.0%	↔
UHC	75.8%	72.2%	70.8%	73.2%	74.5%	↑
MARR	74.2%	74.4%	71.5%	66.0%	64.9%	↑

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: Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensives, who are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease (CHD).

Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee.

Summary of Changes to HEDIS 2015:

- Revised the definition of adequate control to include two different BP thresholds based on age and diagnosis
- Added a Diabetes Flag and corresponding value sets in the event/diagnosis criteria
- Renamed the Hypertension Value Set to Essential Hypertension Value Set
- Revised the optional exclusion for nonacute inpatient admissions
- Deleted the Nonacute Care Value Set; organizations use facility and proprietary coding to identify nonacute inpatient admissions
- Revised the Numerator to include the different BP thresholds in the Hybrid Specification

Controlling High Blood Pressure (CBP)

	2011*	2012*	2013	2014	2015	NHM
ACC			47.0%	49.0%	63.9%	↑
JMS			52.3%	56.2%	69.3%	↑
KPMAS					87.8%	↑
MPC			23.9%	46.8%	61.4%	↑
MSFC			70.5%	65.5%	69.2%	↑
PP			59.1%	57.0%	59.5%	↑
RHMD				NA	32.1%	↓
UHC			43.1%	42.3%	50.9%	↓
MARR			49.8%	52.8%	61.8%	↑

* This measure was added by DHMH for reporting in HEDIS 2013.

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 alive 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 2015:

- Removed the term "discharged alive" throughout the specification
- Clarified the event/diagnosis criteria to state that professional claims may not be used to identify readmissions or transfers
- Added a definition for 180-day measurement interval
- Added a data element to collect the number of optional exclusions to the Data Elements for Reporting table

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

	2011*	2012*	2013*	2014	2015	NHM
ACC				NA	91.5%	↑
JMS				NA	NA▫	NA
KPMAS					NA▫	NA
MPC				87.5%	90.2%	↑
MSFC				NA	NA▫	NA
PP				86.1%	84.6%	↔
RHMD				NA	NA▫	NA
UHC				82.9%	87.8%	↑
MARR				85.5%	88.5%	↑

* This measure was added by DHMH 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.

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. Atypical antipsychotic medications elevate the risk of metabolic conditions, relative to typical antipsychotic medications.

Summary of Changes to HEDIS 2015:

- No changes to this measure

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

	2011*	2012*	2013*	2014*	2015	NHM
ACC					NA▫	NA
JMS					NA▫	NA
KPMAS					NA▫	NA
MPC					NR▫▫	NA
MSFC					NA▫	NA
PP					NA▫	NA
RHMD					NA▫	NA
UHC					NA▫	NA
MARR					No MARR	NA

* This measure was added by DHMH 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.

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 leading causes of death and disability in the United States (U.S.). Approximately 24 million Americans, or close to 8% of the population, have the disease and with the rise in the number of persons overweight and obese in the U.S., the number of diabetics are on the rise, most regrettably among younger age groups. Much of the burden of illness and cost of diabetes is related to potentially preventable long-term complications that include heart disease, blindness, kidney disease and stroke. Timely screening and careful treatment can significantly reduce and delay the onset of complications of diabetes.

Summary of Changes to HEDIS 2015:

- Retired the following indicators: LDL-C screening, LDL-C control (<100 mg/dL) and BP control (<140/80 mm Hg).
- Revised the ED visit requirement for claim/encounter data in the event/diagnosis criteria.
- Added dapagliflozin to the description of "Sodium glucose cotransporter 2 (SGLT2) inhibitor" in Table CDC-A.
- Added albiglutide to the description of "Glucagon-like peptide-1 (GLP1) agonists" in Table CDC-A.
- CHF Value Set was renamed Chronic Heart Failure Value Set.
- Clarified the denominator requirements for the HbA1c Control <7% for a Selected Population indicator in the Hybrid Specification.
- Gestational or Steroid-Induced Diabetes Value Set was renamed Diabetes Exclusions Value Set.

Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing

	2011	2012	2013	2014	2015	NHM
ACC	76.2%	78.8%	81.1%	83.4%	88.7%	↑
JMS	89.4%	90.5%	89.8%	89.1%	90.7%	↑
KPMAS					96.4%	↑
MPC	79.6%	77.1%	76.0%	79.5%	87.9%	↑
MSFC	83.7%	88.1%	83.5%	84.7%	88.0%	↑
PP	78.5%	81.9%	82.4%	78.1%	89.4%	↑
RHMD				NA	84.6%	↔
UHC	73.2%	75.9%	78.1%	79.1%	85.9%	↑
MARR	77.6%	81.0%	81.2%	85.5%	89.0%	↑

Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%)*

	2011	2012	2013	2014	2015	NHM
ACC	49.3%	43.3%	44.0%	38.8%	38.5%	↑
JMS	38.0%	33.6%	35.4%	31.0%	37.2%	↑
KPMAS					21.8%	↑
MPC	51.1%	56.7%	52.6%	48.6%	40.8%	↑
MSFC	37.0%	27.5%	35.3%	37.2%	44.5%	↑
PP	46.0%	38.3%	41.7%	48.1%	35.6%	↑
RHMD				NA	60.8%	↓
UHC	56.2%	51.1%	54.3%	45.5%	41.1%	↑
MARR	47.6%	42.4%	44.3%	41.5%	40.1%	↑

* A lower rate indicates better performance.

Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)

	2011	2012	2013	2014	2015	NHM
ACC	41.1%	48.4%	47.1%	51.4%	51.4%	↑
JMS	52.7%	56.2%	54.7%	61.5%	52.4%	↑
KPMAS					60.0%	↑
MPC	41.6%	37.0%	39.9%	43.3%	50.8%	↑
MSFC	52.8%	57.7%	58.9%	54.0%	43.5%	↓
PP	46.2%	50.8%	49.1%	44.3%	54.3%	↑
RHMD				NA	38.8%	↓
UHC	37.5%	42.1%	38.9%	46.47%	46.2%	↔
MARR	44.1%	48.3%	47.8%	50.2%	49.7%	↑

Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed

	2011	2012	2013	2014	2015	NHM
ACC	62.3%	62.2%	69.3%	65.4%	48.6%	↓
JMS	79.7%	80.8%	80.1%	79.6%	64.1%	↑
KPMAS					87.3%	↑
MPC	74.5%	76.2%	64.6%	72.0%	65.7%	↑
MSFC	73.7%	75.7%	72.8%	71.1%	54.0%	↔
PP	62.2%	71.6%	78.1%	71.0%	69.0%	↑
RHMD				NA	44.8%	↓
UHC	66.7%	60.8%	57.7%	56.9%	58.6%	↑
MARR	67.9%	71.0%	69.6%	69.3%	61.5%	↑

Comprehensive Diabetes (CDC) – LDL-C Screening[1]

	2011	2012	2013	2014	2015	NHM
ACC	71.6%	77.4%	76.0%	76.9%		
JMS	91.2%	89.4%	88.5%	87.8%		
KPMAS						
MPC	74.9%	71.3%	69.2%	72.9%		
MSFC	79.3%	81.7%	77.4%	78.4%		
PP	70.4%	74.9%	73.1%	70.1%		
RHMD				NA		
UHC	71.0%	72.3%	74.2%	77.4%		
MARR	74.3%	76.4%	75.7%	77.2%		

[1] This indicator was retired in 2015.

Comprehensive Diabetes (CDC) – LDL-C Control (<100 mg/dL)

	2011	2012	2013	2014	2015	NHM
ACC	38.2%	35.9%	36.2%	36.0%		
JMS	47.8%	48.7%	44.2%	45.26%		
KPMAS						
MPC	32.4%	27.0%	28.0%	30.5%		
MSFC	39.2%	44.6%	41.1%	39.9%		
PP	37.2%	36.1%	44.5%	45.28%		
RHMD				NA		
UHC	27.0%	35.0%	30.7%	35.0%		
MARR	35.2%	36.9%	36.1%	38.7%		

[1] This indicator was retired in 2015.

Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy

	2011	2012	2013	2014	2015	NHM
ACC	78.8%	79.72%	73.6%	75.7%	80.3%	↑
JMS	93.6%	94.7%	93.6%	93.1%	93.4%	↑
KPMAS					100.0%	↑
MPC	77.6%	75.2%	74.4%	75.3%	75.9%	↓
MSFC	85.6%	89.6%	78.8%	82.7%	80.9%	↑
PP	80.1%	79.0%	77.6%	73.8%	82.5%	↑
RHMD				NA	74.8%	↓
UHC	73.5%	72.7%	74.2%	75.9%	81.5%	↑
MARR	79.5%	79.69%	77.7%	79.4%	83.7%	↑

Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/80 mm Hg)

	2011	2012	2013	2014	2015	NHM
ACC	41.3%	31.1%	29.1%	34.4%		
JMS	27.4%	34.1%	38.0%	39.2%		
KPMAS						
MPC	31.1%	24.1%	30.3%	32.0%		
MSFC	37.7%	46.3%	55.7%	44.3%		
PP	37.6%	42.2%	42.6%	44.1%		
RHMD				NA		
UHC	19.2%	33.8%	25.3%	32.4%		
MARR	31.9%	35.8%	36.4%	37.7%		

[1] This indicator was retired in 2015.

Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)

	2011	2012	2013	2014	2015	NHM
ACC	63.0%	54.6%	48.4%	55.6%	65.3%	↑
JMS	43.2%	54.74%	59.1%	60.4%	69.7%	↑
KPMAS					83.6%	↑
MPC	51.3%	45.7%	47.1%	55.4%	56.4%	↓
MSFC	59.6%	73.3%	73.7%	70.1%	69.0%	↑
PP	59.1%	65.1%	63.3%	64.2%	60.7%	↔
RHMD				NA	39.9%	↓
UHC	32.8%	54.74%	47.0%	51.6%	55.2%	↓
MARR	51.6%	58.9%	57.3%	59.5%	62.5%	↑

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).

Among patients with co-occurring schizophrenia and metabolic disorders, the non-treatment rate for diabetes is approximately 32 percent. 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.

Improving blood sugar control has shown to lead to lower use of health care services and better overall satisfaction with diabetes treatment. People who control their diabetes also report improved quality of life and emotional well-being.

Summary of Changes to HEDIS 2015:

- Revised the ED visit requirement for claim/encounter data in step 2 in the event/diagnosis criteria
- Gestational or Steroid-Induced Diabetes Value Set was renamed Diabetes Exclusions Value Set
- Added a data element to collect the number of optional exclusions to the Data Elements for Reporting table

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

	2011[*]	2012[*]	2013[*]	2014[*]	2015	NHM
ACC					76.7%	NA
JMS					NA□	NA
KPMAS					NA□	NA
MPC					NR□□	NA
MSFC					NA□	NA
PP					68.7%	NA
RHMD					NA□	NA
UHC					74.6%	NA
MARR					73.4%	NA

* This measure was added by DHMH 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.

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 U.S. Back problems are second only to cough among symptoms of people who seek medical care at physician offices, outpatient departments and emergency rooms.

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 frequently 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. According to the American College of Radiology, uncomplicated low back pain is a benign, self-limited condition that does not warrant any imaging studies. The majority of these 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 2015:

- Added a data element to collect the number of required exclusions to the Data Elements for Reporting table

Use of Imaging Studies for Low Back Pain (LBP)

	2011*	2012	2013	2014	2015	NHM
ACC		78.5%	77.8%	76.7%	74.2%	↓
JMS		81.6%	70.9%	77.2%	69.2%	↓
KPMAS					NA▫	NA
MPC		76.8%	75.2%	76.6%	76.7%	↑
MSFC		74.5%	73.1%	73.3%	71.8%	↓
PP		74.7%	75.0%	75.2%	75.0%	↔
RHMD				NA	78.1%	↑
UHC		75.5%	74.8%	73.4%	74.3%	↓
MARR		76.6%	74.9%	75.4%	74.2%	↓

* This measure was added by DHMH for reporting in HEDIS 2012.
▫ 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 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. 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*. 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* notes that almost all people with RA require pharmacotherapy with a DMARD.

Summary of Changes for HEDIS 2015:

- Added a data element to collect the number of optional exclusions to the Data Elements for Reporting table

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

	2011*	2012*	2013	2014	2015	NHM
ACC			61.8%	60.0%	62.8%	↓
JMS			NA	NA	NA▫	NA
KPMAS					NA▫	NA
MPC			71.9%	73.8%	65.8%	↓
MSFC			NA	NA	89.2%	↑
PP			69.5%	67.6%	72.5%	↑
RHMD				NA	NA▫	NA
UHC			73.3%	67.7%	61.5%	↓
MARR			69.1%	67.3%	70.3%	↔

* This measure was added by DHMH for reporting in HEDIS 2013.

▫ 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 also have more 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.

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.

Summary of Changes for HEDIS 2015:

• Retired the annual monitoring for members on anticonvulsants rate

• Revised the numerator for the ACE inhibitors and ARB, digoxin and diuretics rates to no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring

• Revised the numerator for the digoxin rate to add monitoring of serum digoxin level

• Added a data element to collect the number of optional exclusions to the Data Elements for Reporting table

Annual Monitoring for Patients on Persistent Medications (MPM) - members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)

	2011*	2012*	2013	2014	2015	NHM
ACC			90.1%	89.0%	89.4%	↑
JMS			95.8%	95.1%	94.4%	↑
KPMAS					95.0%	↑
MPC			88.9%	87.0%	88.4%	↔
MSFC			87.6%	90.2%	90.0%	↑
PP			88.224%	88.1%	88.1%	↔
RHMD				NA	86.1%	↓
UHC			88.222%	88.6%	89.2%	↑
MARR			89.5%	89.7%	90.1%	↑

* This measure was added by DHMH for reporting in HEDIS 2013.

Annual Monitoring for Patients on Persistent Medications (MPM) - members on digoxin

	2011*	2012*	2013	2014	2015	NHM
ACC			95.8%	95.7%	59.5%	↓
JMS			NA	NA	NA□	NA
KPMAS					NA□	NA
MPC			91.4%	92.2%	54.9%	↓
MSFC			NA	NA	NA□	NA
PP			91.5%	88.9%	44.9%	↓
RHMD				NA	NA□	NA
UHC			93.4%	86.4%	57.7%	↓
MARR			93.1%	90.8%	54.2%	↓

* This measure was added by DHMH for reporting in HEDIS 2013.
□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

Annual Monitoring for Patients on Persistent Medications (MPM) - members on diuretics

	2011*	2012*	2013	2014	2015	NHM
ACC			88.2%	86.9%	88.42%	↔
JMS			94.3%	94.1%	93.9%	↑
KPMAS					NA□	NA
MPC			88.04%	86.2%	86.5%	↓
MSFC			88.02%	88.5%	89.0%	↑
PP			87.2%	87.4%	87.9%	↔
RHMD				NA	90.5%	↑
UHC			87.8%	87.5%	88.40%	↔
MARR			88.1%	88.4%	89.2%	↑

* This measure was added by DHMH for reporting in HEDIS 2013.
□ This measure is Not Applicable due to an insufficient eligible population (e.g. <30 members).

Annual Monitoring for Patients on Persistent Medications (MPM) - members on anticonvulsants[1]

	2011*	2012*	2013	2014	2015	NHM
ACC			66.0%	66.3%		
JMS			64.8%	75.6%		
KPMAS						
MPC			69.9%	70.42%		
MSFC			58.1%	67.1%		
PP			73.3%	68.3%		
RHMD				NA		
UHC			72.4%	75.0%		
MARR			67.5%	70.44%		

[1] This indicator was retired in 2015.

Annual Monitoring for Patients on Persistent Medications (MPM) - Total rate

	2011*	2012*	2013	2014	2015	NHM
ACC			86.2%	85.4%	88.9%	↑
JMS			93.1%	94.1%	94.0%	↑
KPMAS					94.2%	↑
MPC			88.0%	86.3%	87.2%	↑
MSFC			84.1%	86.6%	89.3%	↑
PP			87.3%	87.3%	87.8%	↑
RHMD				NA	87.9%	↑
UHC			87.5%	87.7%	88.7%	↑
MARR			87.1%	87.9%	89.7%	↑

* This measure was added by DHMH for reporting in HEDIS 2013.

BEHAVIORAL HEALTH

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

Description: The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following:

1. Initiation of AOD Treatment: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis

2. Engagement of AOD Treatment: The percentage of members who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit

Rationale: There are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition. Treatment of medical problems caused by substance abuse places a huge burden on the healthcare system.

Identifying individuals with AOD disorders is an import ant first step in the process of care, but the identification often does not lead to the initiation of care. Reasons an individual may not initiate treatment include the social stigma associated with AOD disorder, denial of the problem, noncompliance with treatment, or lack of immediately available treatment services. This measure is designed to ensure that treatment is initiated once the need has been identified, and will permit comparison of effectiveness in initiating care.

Treatment engagement is an intermediate step between initially accessing care (the first visit) and completing a full course of treatment. Numerous studies indicate that individuals who remain in treatment for a longer duration of time have improved outcome, but the 1990 Drug Service Research Survey suggested that many clients (52 percent) with AOD disorders leave treatment prematurely. This measure is an important intermediate indicator, closely related to outcome. In fact, studies have tied the frequency and intensity of engagement as important in treatment outcomes and reducing drug-related illnesses.

Summary of Changes to HEDIS 2015:

- Replaced "facility code" with "inpatient discharge" in the event/diagnosis criteria

- Clarified that an inpatient admission in combination with a diagnosis of AOD meets criteria when identifying initiation and engagement

- Clarified that initiation events may not include inpatient detoxification or detoxification codes

- Clarified that the member is removed from the denominator for both indicators if the initiation event was an inpatient stay with a discharge date after December 1 of the measurement year

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation 13–17 Years

	2011	2012	2013	2014	2015	NHM
ACC	47.6%	41.0%	42.0%	37.7%	43.72%	↑
JMS	NA	NA	NA	NA	NA▫	NA
KPMAS					NA▫	NA
MPC	49.5%	49.7%	42.3%	38.9%	35.4%	↓
MSFC	19.6%	19.5%	5.0%	30.9%	31.0%	↓
PP	50.0%	47.4%	38.4%	41.8%	33.0%	↓
RHMD				NA	NA▫	NA
UHC	52.0%	49.8%	42.9%	44.3%	43.67%	↑
MARR	43.7%	41.5%	34.1%	38.7%	37.3%	↓

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation 18+ Years

	2011	2012	2013	2014	2015	NHM
ACC	51.5%	47.4%	41.9%	38.8%	53.9%	↑
JMS	48.9%	46.7%	37.1%	45.4%	47.2%	↑
KPMAS					NA▫	NA
MPC	50.8%	47.7%	43.1%	37.3%	34.9%	↓
MSFC	33.1%	36.6%	29.2%	43.2%	35.3%	↓
PP	48.4%	42.8%	38.5%	37.0%	34.2%	↓
RHMD				NA	44.0%	↑
UHC	50.1%	47.3%	47.9%	45.7%	48.4%	↑
MARR	46.3%	44.1%	40.5%	41.2%	42.6%	↑

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation Overall Ages

	2011	2012	2013	2014	2015	NHM
ACC	50.9%	46.4%	41.9%	38.6%	52.7%	↑
JMS	48.8%	46.5%	36.8%	45.2%	47.2%	↑
KPMAS					NA▫	NA
MPC	50.6%	47.9%	43.0%	37.45%	34.9%	↓
MSFC	32.2%	35.5%	27.4%	41.7%	35.1%	↓
PP	48.6%	43.4%	38.5%	37.49%	34.1%	↓
RHMD				NA	43.4%	↑
UHC	50.3%	47.6%	47.3%	45.5%	48.2%	↑
MARR	46.0%	43.9%	40.1%	41.0%	42.2%	↑

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement 13–17 Years

	2011	2012	2013	2014	2015	NHM
ACC	33.3%	26.5%	27.7%	24.1%	24.7%	↑
JMS	NA	NA	NA	NA	NA▫	NA
KPMAS					NA▫	NA
MPC	33.6%	33.2%	26.5%	22.1%	24.8%	↑
MSFC	8.7%	9.8%	2.5%	19.8%	20.2%	↑
PP	32.4%	29.2%	22.6%	27.6%	20.9%	↑
RHMD				NA	NA▫	NA
UHC	25.4%	31.5%	24.0%	30.3%	28.6%	↑
MARR	26.7%	26.0%	20.7%	24.8%	23.8%	↑

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement 18+ Years

	2011	2012	2013	2014	2015	NHM
ACC	23.8%	20.7%	18.2%	17.9%	21.0%	↑
JMS	21.7%	19.5%	15.4%	17.0%	22.5%	↑
KPMAS					NA▫	NA
MPC	25.0%	24.0%	20.5%	19.8%	19.6%	↑
MSFC	10.4%	8.3%	5.5%	21.6%	18.0%	↑
PP	22.3%	18.7%	17.0%	17.2%	16.3%	↑
RHMD				NA	22.0%	↑
UHC	14.7%	17.0%	17.8%	20.8%	26.1%	↑
MARR	20.4%	18.6%	16.4%	19.1%	20.8%	↑

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

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement Overall Ages

	2011	2012	2013	2014	2015	NHM
ACC	25.3%	21.6%	19.7%	18.8%	21.4%	↑
JMS	22.0%	19.4%	15.4%	16.9%	22.4%	↑
KPMAS					NA▫	NA
MPC	25.9%	24.9%	21.0%	20.0%	20.0%	↑
MSFC	10.3%	8.4%	5.3%	21.4%	18.1%	↑
PP	23.6%	19.9%	17.6%	18.4%	16.6%	↑
RHMD				NA	21.8%	↑
UHC	16.0%	18.8%	18.5%	21.7%	26.2%	↑
MARR	21.2%	19.3%	16.9%	19.5%	20.9%	↑

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

Identification of Alcohol and Other Drug Services (IAD)

Description: The number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year:

1. Any services
2. Inpatient
3. Intensive outpatient or partial hospitalization
4. Outpatient or ED

Rationale: There are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition. Treatment of medical problems caused by substance abuse places a huge burden on the healthcare system.

Summary of Changes to HEDIS 2015:

- No changes to this measure

Identification of Alcohol and Other Drug Services (IAD) – Any

	2011	2012	2013	2014	2015	NHM
ACC	2.5%	2.5%	2.6%	2.7%	5.7%	↓
JMS	17.1%	16.7%	15.8%	16.9%	25.1%	↓
KPMAS					3.7%	↓
MPC	6.0%	6.2%	6.3%	6.0%	7.0%	↓
MSFC	4.4%	3.3%	3.1%	4.3%	5.6%	↓
PP	5.3%	5.2%	5.2%	5.0%	6.3%	↓
RHMD				14.9%	10.4%	↓
UHC	3.9%	4.0%	3.6%	4.7%	9.12%	↓
MARR	6.4%	6.2%	6.0%	7.9%	9.11%	↓

Identification of Alcohol and Other Drug Services (IAD) – Inpatient

	2011	2012	2013	2014	2015	NHM
ACC	0.6%	0.6%	0.6%	0.5%	1.1%	↓
JMS	4.4%	4.1%	3.8%	4.0%	4.5%	↓
KPMAS					0.84%	↓
MPC	1.4%	1.3%	1.3%	0.95%	0.89%	↓
MSFC	1.5%	2.2%	0.90%	0.8%	0.97%	↓
PP	1.2%	1.1%	0.943%	0.9%	0.95%	↓
RHMD				1.6%	0.99%	↓
UHC	0.9%	0.9%	0.941%	1.03%	1.6%	↓
MARR	1.6%	1.6%	1.3%	1.4%	1.5%	↓

Identification of Alcohol and Other Drug Services (IAD) - Intensive Outpatient/Partial Hospitalization

	2011	2012	2013	2014	2015	NHM
ACC	0.3%	0.33%	0.3%	0.3%	0.97%	↓
JMS	3.1%	2.9%	2.5%	2.5%	4.6%	↓
KPMAS					0.3%	↓
MPC	0.88%	0.94%	0.82%	0.7%	1.00%	↓
MSFC	0.4%	0.34%	0.18%	0.5%	0.6%	↓
PP	0.87%	0.8%	0.7%	0.6%	0.8%	↓
RHMD				1.3%	1.16%	↓
UHC	0.6%	0.43%	0.22%	0.0%	1.26%	↓
MARR	1.0%	0.87%	0.7%	1.0%	1.34%	↓

Identification of Alcohol and Other Drug Services (IAD) - Outpatient/ED

	2011	2012	2013	2014	2015	NHM
ACC	2.2%	2.2%	2.4%	2.5%	5.4%	↓
JMS	15.4%	15.2%	14.5%	15.6%	23.7%	↓
KPMAS					3.2%	↓
MPC	5.37%	5.7%	5.8%	5.6%	6.6%	↓
MSFC	3.9%	2.5%	2.5%	3.9%	5.0%	↓
PP	4.7%	4.8%	4.9%	4.6%	5.9%	↓
RHMD				11.9%	9.6%	↓
UHC	3.4%	3.5%	3.0%	4.2%	8.46%	↓
MARR	5.8%	5.5%	5.5%	6.9%	8.49%	↓

AMBULATORY CARE (UTILIZATION)

Ambulatory Care (AMB)

Description: Utilization of ambulatory care in the following categories:

- Outpatient visits
- Emergency department (ED) visits

Rationale: Outpatient visits include office visits or routine visits to hospital outpatient departments. Emergency rooms often deliver nonemergency care. An organization that promotes effective ambulatory treatment of patients should be able to keep the number of emergency room visits relatively low.

Summary of Changes to HEDIS 2015:

- No changes to this measure

Ambulatory Care (AMB) – Outpatient visits per 1,000 member months

	2011	2012	2013	2014	2015	NHM
ACC	366.8	370.88	363.6	365.1	356.0	↓
JMS	347.4	347.4	373.9	340.8	315.5	↓
KPMAS					404.4	↑
MPC	373.9	386.8	385.3	365.3	365.0	↔
MSFC	364.4	370.0	361.6	344.5	360.0	↓
PP	395.0	415.9	407.8	386.6	390.7	↑
RHMD				269.8	296.8	↓
UHC	361.1	381.0	374.2	373.3	381.6	↑
MARR	361.4	370.88	370.3	349.3	358.8	↓

Ambulatory Care (AMB) – Emergency department (ED) visits per 1,000 member months

	2011	2012	2013	2014	2015	NHM
ACC	59.0	60.7	59.8	56.2	58.2	↓
JMS	88.8	91.3	93.4	90.1	96.4	↑
KPMAS					23.2	↓
MPC	72.5	78.8	79.3	74.6	70.9	↑
MSFC	70.3	72.3	70.8	62.66	57.4	↓
PP	64.0	65.7	66.0	62.70	62.0	↓
RHMD				66.0	64.9	↑
UHC	63.7	65.8	65.2	62.1	63.1	↔
MARR	71.8	74.2	74.2	67.8	62.0	↓

Frequency of Selected Procedures (FSP)

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

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 2015:

- For hysterectomy, clarified to count multiple codes on the same date of service as one procedure

Frequency of Selected Procedures (FSP) - Bariatric weight loss surgery / 1000 MM 45 - 64 F

	2011*	2012*	2013*	2014*	2015	NHM
ACC					5.1%	↓
JMS					2.1%	↓
KPMAS					0.0%	↓
MPC					5.6%	↓
MSFC					7.0%	↓
PP					5.5%	↓
RHMD					3.8%	↓
UHC					4.3%	↓
MARR					4.8%	↓

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

Frequency of Selected Procedures (FSP) Bariatric weight loss surgery / 1000 MM 45 - 64 M

	2011*	2012*	2013*	2014*	2015	NHM
ACC					0.00%	↓
JMS					1.6%	↓
KPMAS					0.00%	↓
MPC					0.00%	↓
MSFC					0.00%	↓
PP					0.8%	↓
RHMD					3.9%	↓
UHC					1.8%	↓
MARR					2.0%	↓

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

Frequency of Selected Procedures (FSP) Tonsillectomy / 1000 MM 0 - 9 T

	2011*	2012*	2013*	2014*	2015	NHM
ACC					42.4%	NA
JMS					18.5%	NA
KPMAS					13.1%	NA
MPC					47.0%	NA
MSFC					38.6%	NA
PP					60.0%	NA
RHMD					20.6%	NA
UHC					42.9%	NA
MARR					35.4%	NA

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

Frequency of Selected Procedures (FSP) Tonsillectomy / 1000 MM 10 - 19 T

	2011*	2012*	2013*	2014*	2015	NHM
ACC					15.7%	NA
JMS					5.3%	NA
KPMAS					20.1%	NA
MPC					20.9%	NA
MSFC					17.3%	NA
PP					24.5%	NA
RHMD					9.0%	NA
UHC					19.2%	NA
MARR					16.5%	NA

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

Frequency of Selected Procedures (FSP) Hysterectomy, abdominal / 1000 MM 45 - 64 F

	2011*	2012*	2013*	2014*	2015	NHM
ACC					45.6%	↑
JMS					43.9%	↑
KPMAS					0.01%	↑
MPC					49.9%	↑
MSFC					53.3%	↑
PP					35.2%	↑
RHMD					45.4%	↑
UHC					46.6%	↑
MARR					52.8%	↑

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

Frequency of Selected Procedures (FSP) Hysterectomy, vaginal / 1000 MM 45 - 64 F

	2011*	2012*	2013*	2014*	2015	NHM
ACC					18.8%	↓
JMS					2.1%	↓
KPMAS					0.0%	↓
MPC					15.6%	↓
MSFC					16.8%	↓
PP					19.8%	↓
RHMD					11.4%	↓
UHC					19.1%	↓
MARR					14.8%	↓

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

Frequency of Selected Procedures (FSP) Cholecystectomy, open / 1000 MM 30 - 64 M

	2011*	2012*	2013*	2014*	2015	NHM
ACC					4.7%	↑
JMS					3.1%	↓
KPMAS					0.0%	↓
MPC					7.5%	↑
MSFC					6.1%	↑
PP					5.5%	↑
RHMD					0.0%	↓
UHC					4.3%	↑
MARR					5.2%	↑

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

Frequency of Selected Procedures (FSP) Cholecystectomy, open / 1000 MM 45 - 64 F

	2011*	2012*	2013*	2014*	2015	NHM
ACC					6.6%	↑
JMS					6.3%	↑
KPMAS					0.0%	↓
MPC					3.7%	↓
MSFC					5.6%	↑
PP					6.1%	↑
RHMD					0.0%	↓
UHC					4.0%	↔
MARR					5.4%	↑

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

Frequency of Selected Procedures (FSP) Laparoscopic / 1000 MM 30 - 64 M

	2011*	2012*	2013*	2014*	2015	NHM
ACC					20.5%	↓
JMS					11.3%	↓
KPMAS					17.2%	↓
MPC					34.3%	↑
MSFC					17.2%	↓
PP					19.3%	↓
RHMD					11.7%	↓
UHC					19.1%	↓
MARR					18.8%	↓

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

Frequency of Selected Procedures (FSP) Laparoscopic / 1000 MM 45 - 64 F

	2011*	2012*	2013*	2014*	2015	NHM
ACC					48.7%	↓
JMS					18.8%	↓
KPMAS					0.0%	↓
MPC					66.8%	↓
MSFC					68.8%	↔
PP					65.4%	↓
RHMD					34.1%	↓
UHC					59.6%	↓
MARR					51.7%	↓

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

Frequency of Selected Procedures (FSP) Back Surgery / 1000 MM 45 - 64 F

	2011*	2012*	2013*	2014*	2015	NHM
ACC					41.1%	↓
JMS					58.5%	↓
KPMAS					0.0%	↓
MPC					65.5%	↑
MSFC					56.1%	↓
PP					77.5%	↑
RHMD					30.3%	↓
UHC					54.5%	↓
MARR					54.8%	↓

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

Frequency of Selected Procedures (FSP) Back Surgery / 1000 MM 45 - 64 M

	2011*	2012*	2013*	2014*	2015	NHM
ACC					43.0%	↓
JMS					42.2%	↓
KPMAS					0.0%	↓
MPC					65.0%	↓
MSFC					51.7%	↓
PP					65.6%	↓
RHMD					38.9%	↓
UHC					62.1%	↓
MARR					52.6%	↓

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

Frequency of Selected Procedures (FSP) Mastectomy / 1000 MM 15 - 44 F

	2011*	2012*	2013*	2014*	2015	NHM
ACC					2.2%	↑
JMS					3.0%	↑
KPMAS					0.0%	↓
MPC					2.6%	↑
MSFC					1.6%	↓
PP					3.6%	↑
RHMD					0.0%	↓
UHC					4.1%	↑
MARR					2.8%	↑

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

Frequency of Selected Procedures (FSP) Mastectomy / 1000 MM 45 - 64 F

	2011*	2012*	2013*	2014*	2015	NHM
ACC					16.2%	↓
JMS					4.2%	↓
KPMAS					0.0%	↓
MPC					14.4%	↓
MSFC					11.2%	↓
PP					21.4%	↑
RHMD					18.9%	↔
UHC					19.5%	↑
MARR					15.1%	↓

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

Frequency of Selected Procedures (FSP) Lumpectomy / 1000 MM 15 - 44 F

	2011*	2012*	2013*	2014*	2015	NHM
ACC					14.7%	↑
JMS					0.0%	↓
KPMAS					0.0%	↓
MPC					13.6%	↓
MSFC					18.2%	↑
PP					15.8%	↑
RHMD					10.7%	↓
UHC					12.7%	↓
MARR					14.3%	↑

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

Frequency of Selected Procedures (FSP) Lumpectomy / 1000 MM 45 - 64 F

	2011*	2012*	2013*	2014*	2015	NHM
ACC					0.365%	↓
JMS					0.21%	↓
KPMAS					0.10%	↑
MPC					0.29%	↓
MSFC					0.41%	↓
PP					0.49%	↑
RHMD					0.27%	↓
UHC					0.371%	↓
MARR					0.43%	↑

* This measure was added by DHMH 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:

1. Total inpatient

2. Maternity

3. Surgery

4. 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 2015:

• Clarified that newborn care rendered from birth to discharge home from delivery must be excluded from step 2

Inpatient Utilization - General Hospital/Acute Care (IPU) Total Inpatient: Total Discharges / 1000 Member Months (MM)

	2011*	2012*	2013*	2014*	2015	NHM
ACC					5.9	↓
JMS					9.9	↑
KPMAS					6.4	↓
MPC					6.5	↓
MSFC					7.01	↓
PP					6.6	↓
RHMD					6.7	↓
UHC					7.2	↓
MARR					7.03	↓

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

Inpatient Utilization - General Hospital/Acute Care (IPU) Total Inpatient: Total Average Length of Stay

	2011*	2012*	2013*	2014*	2015	NHM
ACC					3.96	↑
JMS					4.12	↑
KPMAS					4.59	↑
MPC					3.66	↓
MSFC					4.03	↑
PP					3.85	↔
RHMD					3.72	↓
UHC					4.12	↑
MARR					4.01	↑

* This measure was added by DHMH 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:

1. Total number of antibiotic prescriptions

2. Average number of antibiotic prescriptions per member per year (PMPY)

3. Total days supplied for all antibiotic prescriptions

4. Average days supplied per antibiotic prescription

5. Total number of prescriptions for antibiotics of concern

6. Average number of prescriptions PMPY for antibiotics of concern

7. Percentage of antibiotics of concern for all antibiotic prescriptions

8. Average number of antibiotics PMPY reported by drug class:

   a. For selected "antibiotics of concern"

   b. 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 2014:

• No changes to this measure

.**Antibiotic Utilization (ABX) -Average Scrips PMPY for Antibiotics**

	2011*	2012*	2013*	2014*	2015	NHM
ACC					0.87	↓
JMS					0.88	↓
KPMAS					0.68	↓
MPC					1.03	↓
MSFC					0.86	↓
PP					0.97	↓
RHMD					0.77	↓
UHC					0.98	↓
MARR					0.878	↓

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

Antibiotic Utilization (ABX) -Average Days Supplied per Antibiotic Script

	2011*	2012*	2013*	2014*	2015	NHM
ACC					9.29	↔
JMS					8.98	↓
KPMAS					8.99	↓
MPC					9.40	↑
MSFC					9.23	↔
PP					9.39	↔
RHMD					9.21	↓
UHC					9.26	↔
MARR					9.22	↔

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

Antibiotic Utilization (ABX) - Average Scrips PMPY for Antibiotics of Concern

	2011*	2012*	2013*	2014*	2015	NHM
ACC					0.350	↓
JMS					0.29	↓
KPMAS					0.27	↓
MPC					0.41	↓
MSFC					0.34	↓
PP					0.39	↓
RHMD					0.32	↓
UHC					0.43	↓
MARR					0.351	↓

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

Antibiotic Utilization (ABX) - Percentage of Antibiotics of Concern of all Antibiotics

	2011*	2012*	2013*	2014*	2015	NHM
ACC					40.39%	↓
JMS					33.0%	↓
KPMAS					40.5%	↓
MPC					39.8%	↓
MSFC					40.2%	↓
PP					40.38%	↓
RHMD					42.1%	↓
UHC					43.2%	↓
MARR					39.9%	↓

* This measure was added by DHMH 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 2015:

- No changes to this measure

Board Certification (BCR)

		Family Medicine	Internal Medicine	Pediatrician	OB/GYN	Geriatricians	Other Specialists
ACC	**# of Physicians**	616	2,288	1,295	668	86	5,344
	# Board Certified	449	1,698	1,054	512	51	3,997
	Percentage	72.9%	74.2%	81.4%	76.7%	59.3%	74.8%
JMS	**# of Physicians**	47	558	161	100	33	1,691
	# Board Certified	44	526	143	83	23	1,362
	Percentage	93.6%	94.3%	88.8%	83.0%	69.7%	80.5%
KPMAS	**# of Physicians**	170	385	94	156	0	810
	# Board Certified	162	364	92	140	0	757
	Percentage	95.3%	94.6%	97.9%	89.7%	0.0%	93.5%
MPC	**# of Physicians**	595	1,239	930	568	42	4,723
	# Board Certified	243	740	631	143	16	2,819
	Percentage	40.8%	59.7%	67.9%	25.2%	38.1%	59.7%
MSFC	**# of Physicians**	262	441	164	309	10	2,121
	# Board Certified	150	293	66	130	4	1,210
	Percentage	57.3%	66.4%	40.2%	42.1%	40.0%	57.1%
PP	**# of Physicians**	569	846	845	666	38	10,040
	# Board Certified	533	792	806	636	36	9,474
	Percentage	93.7%	93.6%	95.4%	95.5%	94.7%	94.4%
RHMD	**# of Physicians**	468	762	734	393	21	2,627
	# Board Certified	290	448	450	242	12	1,408
	Percentage	62.0%	58.8%	61.3%	61.6%	57.1%	53.6%
UHC	**# of Physicians**	780	2370	1249	822	86	6,139
	# Board Certified	598	1866	1073	721	59	4,973
	Percentage	76.7%	78.7%	85.9%	87.7%	68.6%	81.0%

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 2015:

- No changes to this measure

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

	Male	Female	Total
ACC	1,474,078	1,742,194	3,216,272
JMS	162,349	145,745	308,094
KPMAS	15,183	19,019	34,202
MPC	963,862	1,301,131	2,264,993
MSFC	305,301	392,920	698,221
PP	1,245,933	1,592,290	2,838,223
RHMD	116,604	121,547	238,151
UHC	1,216,858	1,437,400	2,654,258

Enrollment by State (EBS)

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

Summary of Changes to HEDIS 2015:

- No changes to this measure

Enrollment by State (EBS) – Maryland only

ACC	266,373
JMS	25,252
KPMAS	10,326
MPC	194,943
MSFC	65,967
PP	242,549
RHMD	26,881
UHC	223,438

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 2015:

- No changes to this measure

Language Diversity of Membership (LDM) - Spoken

		Non-English	Unknown	Declined
ACC	Number	4,268	322,935	0
	Percent	1.3%	98.7%	0.0%
JMS	Number	68	0	0
	Percent	0.2%	0.0%	0.0%
KPMAS	Number	816	387	7
	Percent	7.5%	3.5%	0.1%
MPC	Number	0	236,460	0
	Percent	0.0%	100.0%	0.0%
MSFC	Number	0	83,128	0
	Percent	0.0%	100.0%	0.0%
PP	Number	0	289,174	0
	Percent	0.0%	100.0%	0.0%
RHMD	Number	0	37,399	0
	Percent	0.0%	100.0%	0.0%
UHC	Number	2,186	282,513	0
	Percent	0.8%	99.2%	0.0%

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 2015:

- No changes to this measure

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
ACC	Number	63,296	156,434	0	14,210	259	0	0	93,013	0
	Percent	19.30%	47.80%	0.00%	4.30%	0.08%	0.00%	0.00%	28.40%	0.00%
JMS	Number	5,117	26,066	117	749	34	0	0	2652	0
	Percent	14.70%	75.00%	0.3%	2.2%	0.10%	0.00%	0.0%	7.6%	0.00%
KPMAS	Number	2,513	5,968	11	526	7	149	4	1,737	33
	Percent	23.00%	54.50%	0.1%	4.8%	0.06%	1.4%	0.0%	15.9%	0.3%
MPC	Number	81,776	107,872	0	7,947	0	0	0	38,865	0
	Percent	34.60%	45.60%	0.0%	3.36%	0.0%	0.00%	0.0%	16.4%	0.00%
MSFC	Number	26,341	38,268	0	4,280	0	0	0	14,239	0
	Percent	31.70%	46.00%	0.0%	5.2%	0.0%	0.00%	0.0%	17.1%	0.00%
PP	Number	118,701	125,657	8	9,954	0	0	0	34,854	0
	Percent	41.10%	43.45%	0.0%	3.44%	0.0%	0.00%	0.0%	12.1%	0.00%
RHMD	Number	12,821	15,030	0	1,867	48	0	0	2,425	5,208
	Percent	34.30%	40.20%	0.0%	5.0%	0.13%	0.00%	0.0%	6.5%	13.9%
UHC	Number	99,723	123,919	0	14,044	257	0	0	46,759	0
	Percent	35.00%	43.53%	0.0%	4.9%	0.09%	0.00%	0.0%	16.4%	0.00%

Weeks of Pregnancy at Time of Enrollment (WOP)

Description: The percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization, according to the following periods:

1. Prior to pregnancy (280 days or more prior to delivery)

2. The first 12 weeks of pregnancy, including the end of the 12th week (279–196 days prior to delivery)

3. The beginning of the 13th week through the end of the 27th week of pregnancy (195–91 days prior to delivery)

4. The beginning of the 28th week of pregnancy or after (≤90 days prior to delivery)

5. Unknown

Summary of Changes to HEDIS 2015:

*   No changes to this measure

. **Weeks of Pregnancy at Time of Enrollment (WOP)**

	13-27 weeks	**28+ weeks**	**Unknown**
ACC	29.6%	13.3%	4.7%
JMS	20.5%	11.8%	0.0%
KPMAS	NR	NR	NR▫▫
MPC	25.6%	11.3%	4.2%
MSFC	30.9%	17.7%	4.9%
PP	28.0%	13.1%	4.6%
RHMD	37.5%	23.8%	16.6%
UHC	32.6%	14.5%	4.8%

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

Total Membership (TLM)

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

Summary of Changes to HEDIS 2015:

- No changes to this measure

Total Membership (TLM) – Medicaid only

-	-
ACC	264,363
JMS	25,263
KPMAS	16,040
MPC	195,088
MSFC	66,532
PP	242,828
RHMD	26,926
UHC	223,613

CALL SERVICES

Call Answer Timeliness (CAT)

Description: The percentage of calls received by the organization's member services call centers (during operating hours) during the measurement year that were answered by a live voice within 30 seconds.

Rationale: Healthcare providers, organization members, and purchasers increasingly recognize the importance of customer service as a factor in patient satisfaction. The collected data will provide opportunities for organization comparisons, as well as quality improvement initiatives.

Summary of Changes to HEDIS 2015:

- No changes to this measure

Call Answer Timeliness (CAT)

	2011	2012	2013	2014	2015	NHM
ACC	76.1%	78.9%	81.9%	89.7%	82.9%	↓
JMS	86.6%	93.1%	95.0%	93.4%	92.7%	↑
KPMAS					69.6%	↓
MPC	85.7%	91.1%	87.7%	89.2%	86.7%	↑
MSFC	94.8%	89.2%	89.4%	91.3%	77.3%	↓
PP	84.4%	73.1%	84.9%	71.0%	43.5%	↓
RHMD				NA	80.4%	↓
UHC	79.6%	85.5%	92.4%	89.4%	84.3%	↔
MARR	85.6%	85.6%	87.5%	87.3%	77.2%	↓

IMPLICATIONS

Summary

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 2015 Highlights

- The MARR for Well-Child visits age 3-6 (W34) decreased by 2 percentage points from last year, and the MARR for Adolescent Well-Care Visits (AWC) decreased by 5 percentage points from last year.
- The MARR for all three categories of Weight Assessment and Counseling (WCC) improved significantly in 2015 over 2014, as did the Adult BMI Assessment (ABA).
- The MARR for Cervical Cancer Screening (CCS) decreased by nearly 10 percentage points from last year, while Breast Cancer Screening (BCS) increased by nearly 10 percentage points.
- The MARR for both categories of Prenatal and Postpartum Care (PPC) improved significantly in 2015 over 2014.
- The MARR for Ambulatory Care (AMB) for Outpatient Visits increased by 9 points, while ED Visits decreased by 5 points.

Discussion

Measures with the greatest percentage improvement belonged to the Effectiveness of Care domain and included: Weight management for both adults and children, breast cancer screening, diabetes monitoring and treatment for respiratory illness.

Measures with the greatest percentage decline involved all three domains (Effectiveness of Care, Utilization, and Access). Those measures in significant decline included: Child and adolescent prevention and screening, eye exam for diabetes, cervical cancer screening, medical management for dioxin and call answer timeliness.

The six plans that reported in each of the last three years had an average improvement rate of 51% meaning that, on average, each plan improved on 35 of 68 measures from 2013 to 2015.