Statewide Executive Summary Report
HealthChoice participating organizations
HEDIS® 2018 Results

Prepared for:

Maryland Department of Health

(This document includes results of measures not designated for public reporting. This report is not for public distribution.)

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INTRODUCTION

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

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

BACKGROUND

The Maryland Medicaid program implemented HealthChoice, a comprehensive managed care program, in June of 1997 after receiving a waiver from the Centers for Medicare and Medicaid Services (CMS) of the requirements in §1115 of the Social Security Act. HealthChoice allows eligible Medicaid recipients to enroll in the participating managed care organization of their choice. There are currently eight organizations participating in HealthChoice, with a total of 1,182,879 enrollees as of December 31, 2017.

Within Maryland Department of Health (MDH), the HealthChoice & Acute Care Administration is responsible for the quality oversight of the HealthChoice program. MDH continues to measure HealthChoice program clinical quality performance and enrollee satisfaction using initiatives including HEDIS and Consumer Assessment of Healthcare Providers Systems (CAHPS®) reporting. Performance is measured at both the organization level and on a statewide basis. HEDIS and CAHPS results are incorporated annually into a HealthChoice Health Plan Performance Report Card developed to assist HealthChoice enrollees to make comparisons when selecting a health plan. All eight HealthChoice organizations reported HEDIS in 2018.

For HEDIS 2018, MDH required HealthChoice managed care organizations to report the complete HEDIS measure set for services rendered in calendar year 2017 to Maryland Medical Assistance HealthChoice enrollees. These measures provide meaningful managed care organization comparative information and they measure performance relative to MDH's priorities and goals.

ACCREDITATION

All Health organizations participating in the HealthChoice program as of January 1, 2013, were required to be accredited by the NCQA no later than January 1, 2015, as per COMAR §10.09.65.02. In addition, according to COMAR §10.09.64.08, any HealthChoice organizations that joined the HealthChoice program after January 1, 2013, are required to be NCQA accredited within two years of their effective date as a HealthChoice organization. Current accreditation status for all HealthChoice organizations is listed in the *Organizations Reporting HEDIS in 2018* table.

Organizations Reporting HEDIS in 2018

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

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

NCQA Accreditation Levels*
Excellent: NCQA awards its highest status of Excellent to organizations with programs for service and clinical quality that meet or exceed rigorous requirements for consumer protection and quality improvement. HEDIS/CAHPS results are in the highest range of national performance.
Commendable: NCQA awards a status of Commendable to organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement. Organizations with this status may not have had their HEDIS/CAHPS results evaluated. If HEDIS/CAHPS results were evaluated, organizations must take further action to achieve higher accreditation status.
Accredited: NCQA awards a status of Accredited to organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations with this status may not have had their HEDIS/CAHPS results evaluated. If HEDIS/CAHPS results were evaluated, organizations must take further action to achieve higher accreditation status.
Provisional: NCQA awards a status of Provisional to organizations with programs for service and clinical quality that meet some, but not all, basic requirements for consumer protection and quality improvement. Organizations awarded this status need to improve their processes as well as clinical and service quality to achieve a higher accreditation status.
Interim: NCQA awards a status of Interim to organizations with basic structure and processes in place to meet expectations for consumer protection and quality improvement. Organizations awarded this status will need to undergo a Full Survey within 18 months to demonstrate they have executed those processes effectively.
Denied: NCQA awards a status of Denied Accreditation to organizations whose programs for service and clinical quality do not meet NCQA requirements.

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

SECTION ONE - MEASURES DESIGNATED FOR REPORTING

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

Measures selected by MDH for HealthChoice Reporting
MDH required Health Choice managed care organizations to report 45 HEDIS measures for services rendered in calendar year 2017. The required set reflected two first-year HEDIS measures for reporting. The two new measures include Use of Opioids at High Dosage; and Use of Opioids from Multiple Providers.

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

Effectiveness of Care (EOC): (28 measures)

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

**First Year Measures*

Access/Availability of Care (AAC): (3 measures)
- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Children and Adolescents' Access to Primary Care Practitioners (CAP)
- Prenatal and Postpartum Care (PPC)

Utilization and Risk Adjusted Utilization (URR): (8 measures)
- 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: Total (AMB)
- Frequency of Selected Procedures (FSP)
- Standardized Healthcare-Associated Infection Ratio (HAI)
- Inpatient Utilization: Total (IPUA)
- Antibiotic Utilization: Total (ABX)

Health Plan Descriptive Information: (6 measures)
- Board Certification (BCR)
- Enrollment by Product Line: Total (ENPA)
- Enrollment by State (EBS)
- Language Diversity of Membership (LDM)
- Race/ Ethnicity Diversity of Membership (RDM)
- Total Membership (TLM)

Measures Collected From the Adult CAHPS Survey: (2 measures)
- Flu Vaccinations for Adults Ages 18-64 (FVA)
- Medical Assistance with Smoking and Tobacco Use Cessation (MSC) (advising Smokers and Tobacco Users to Quit Rate Only)

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

The NB designation is utilized for measures where MDH has contracted with outside vendors for coverage of certain services. MetaStar and HealthChoice Organizations do not have access to the data. So that plans are not penalized, NCQA allows the health plans to report these measures with a NB designation. The following 14 measures are reported NB and do not appear in measure specific findings of this report.

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

Measures not reported by MDH for HealthChoice Reporting
There are two categories of measures that MDH does not utilize for HealthChoice Reporting. They include Measures Exempt from Reporting and Measures that have been suspended by NCQA for HEDIS 2018.

Measures Exempt from Reporting

- Comprehensive Diabetes Care
  - HbA1c Control (<7.0%)
- Ambulatory Care
  - Dual Eligibles (AMBB)
  - Disabled (AMBC)
  - Other (AMBD)
- Inpatient Utilization
  - General Hospital/Acute Care: Dual Eligibles (IPUB)
  - General Hospital/Acute Care: Disabled (IPUC)
  - General Hospital/Acute Care: Other (IPUD)
- Identification of Alcohol and Other Drug Services
  - Dual Eligibles (IADB)
  - Disabled (IADC)
  - Other (IADD)

- Antibiotic Utilization
  - Dual Eligibles (ABXB)
  - Disabled (ABXC)
  - Other (ABXD)
- Enrollment by Product Line
  - Dual Eligibles (ENPB)
  - Disabled (ENPC)
  - Other (ENPD)
- Depression Screening and Follow-Up for Adolescents and Adults (DSF)
- Utilization of the PHQ-9 to Monitor Depression Systems for Adolescents and Adults (DMS)
- Depression Remission or Response for Adolescents and Adults (DRR)
- Unhealthy Alcohol Use Screening and Follow-Up (ASF)
- Pneumococcal Vaccination Coverage for Older Adults (PVC)

NCQA Suspended Measures for HEDIS 2018

- Relative Resource Use for People with Diabetes (RDI)
- Relative Resource Use for People with Cardiovascular Conditions (RCA)
- Relative Resource Use for People with Hypertension (RHY)
- Relative Resource Use for People with COPD (RCO)
- Relative Resource Use for People with Asthma (RAS)

Measures Retired for HEDIS 2018: (1 Measure)

- Frequency of Prenatal Care (FPC)

SECTION TWO - HEDIS METHODOLOGY

The HEDIS-reporting organization follows guidelines for data collection and specifications for measure calculation described in *HEDIS 2018 Volume 2: Technical Specifications.*

Data collection

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

Administrative Data:

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

Supplemental Data

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

Medical Record Data

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

SECTION THREE – MEASURE SPECIFIC FINDINGS EXPLANATION

Three years of HealthChoice results are displayed in Table A, along with the 2018 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 NHM has also been removed from each table. An "arrow" has been added to indicate if the HealthChoice's performance score is above, below, or equal to the NHM. Measure-specific descriptions and five-year historical results are located on the pages that follow Tables A and A1.

Reference Sources

Description
The source of the information is NCQA's *HEDIS 2018 Volume 2: Technical Specifications*.

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

Summary of Changes for HEDIS 2018 – The source of the text, is the HEDIS 2018 Volume 2: Technical Specifications, incorporating additional changes published in the HEDIS 2018 Volume 2: "October" Technical Update.

TABLE A – HealthChoice Organizations HEDIS 2018 Results

HEDIS 2018 Results, (Page 1 of 4)	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2018
HealthChoice Organizations	**ACC**			**JMS**			**KPMAS**			**MPC**			**MSFC**			**PPMCO**			**UHC**			**UMHP**			**MARR**
Adult BMI Assessment **(ABA)**	85.2%	91.0%	92.0%	96.6%	98.0%	98.5%	100.0%	98.0%	98.1%	82.4%	89.3%	87.8%	90.3%	90.6%	96.2%	86.1%	89.6%	91.2%	92.7%	90.3%	93.7%	85.4%	88.6%	92.9%	93.8%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis **(AAB)**	25.9%	30.0%	31.8%	33.0%	37.0%	43.6%	NA[1]	57.1%	71.2%	19.5%	21.3%	26.5%	22.8%	20.7%	30.0%	22.2%	25.5%	30.0%	26.0%	25.9%	31.2%	23.1%	25.0%	33.2%	37.2%
Childhood Immunization Status **(CIS)** – Combination 2 (DTaP, IPV, MMR, HiB, Hep B, VZV)	83.1%	85.0%	85.2%	88.7%	91.0%	85.4%	79.5%	73.1%	72.5%	84.7%	79.9%	66.2%	85.9%	84.4%	84.2%	84.5%	83.5%	79.8%	83.5%	79.8%	74.5%	80.9%	80.8%	76.6%	78.0%
Childhood Immunization Status **(CIS)** – Combination 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV)	81.9%	83.0%	82.5%	87.3%	88.0%	83.7%	78.2%	70.0%	70.3%	82.1%	78.5%	64.5%	83.2%	81.8%	82.7%	83.0%	82.6%	77.9%	80.5%	77.9%	70.8%	80.2%	79.3%	75.2%	75.9%
Childhood Immunization Status **(CIS)** – Combination 4 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A)	78.9%	80.0%	80.1%	86.8%	88.0%	83.3%	78.2%	69.5%	70.1%	78.0%	75.7%	62.5%	80.5%	79.3%	81.3%	79.7%	80.9%	76.4%	75.7%	74.7%	67.4%	78.2%	76.6%	73.7%	74.3%
Childhood Immunization Status **(CIS)** – Combination 5 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV)	68.3%	70.0%	69.8%	76.4%	73.0%	71.2%	68.0%	55.0%	62.3%	59.9%	59.5%	52.6%	67.9%	67.9%	67.9%	69.0%	69.5%	68.1%	61.6%	65.2%	57.4%	58.0%	60.6%	58.6%	63.5%
Childhood Immunization Status **(CIS)** – Combination 6 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Influenza)	52.6%	42.0%	48.7%	47.6%	57.0%	64.4%	52.6%	46.3%	55.7%	41.8%	42.4%	34.1%	47.9%	49.6%	47.7%	59.7%	48.8%	50.9%	42.6%	44.8%	41.6%	41.0%	41.4%	46.7%	48.7%
Childhood Immunization Status **(CIS)** – Combination 7 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV)	65.7%	68.0%	67.9%	76.4%	73.0%	71.2%	68.0%	55.0%	62.0%	57.8%	57.9%	51.3%	65.7%	66.2%	67.2%	67.3%	68.4%	67.4%	58.9%	63.5%	55.5%	56.7%	59.6%	57.9%	62.5%
Childhood Immunization Status **(CIS)** – Combination 8 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, Influenza)	51.4%	42.0%	47.7%	47.2%	57.0%	64.4%	52.6%	46.0%	55.7%	40.1%	41.4%	33.1%	47.2%	48.2%	47.5%	57.5%	48.4%	50.9%	40.9%	43.1%	40.4%	40.3%	40.6%	45.7%	48.2%
Childhood Immunization Status **(CIS)** – Combination 9 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV, Influenza)	46.8%	37.0%	44.3%	42.5%	49.0%	55.8%	46.2%	37.5%	49.9%	32.5%	32.9%	27.7%	40.2%	43.8%	41.1%	51.1%	42.6%	46.5%	35.0%	39.7%	36.7%	30.0%	34.1%	37.2%	42.4%
Childhood Immunization Status **(CIS)** – Combination 10 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, Influenza)	45.6%	36.0%	43.3%	42.5%	49.0%	55.8%	46.2%	37.5%	49.9%	31.6%	32.2%	27.0%	39.4%	42.3%	40.9%	50.0%	42.3%	46.5%	33.8%	38.7%	35.8%	29.4%	38.8%	36.7%	42.0%
Immunizations for Adolescents **(IMA)** – Combination 1 (Meningococcal, Tdap/Td)	86.8%	88.0%	89.1%	82.1%	89.0%	89.7%	82.7%	80.5%	83.7%	85.4%	88.2%	84.7%	80.0%	84.2%	88.6%	89.2%	89.1%	87.1%	84.8%	86.7%	87.4%	82.7%	80.5%	87.5%	87.2%
Immunizations for Adolescents **(IMA)** Combination 2 (Meningococcal, Tdap, HPV)	N/A	28.94%	48.9%	N/A	52.69%	72.2%	N/A	26.69%	47.5%	N/A	21.30%	37.7%	N/A	24.09%	35.5%	N/A	26.85%	38.4%	N/A	22.87%	36.5%	N/A	17.37%	30.4%	43.4%
Well-Child Visits in the First 15 months of Life **(W15)** – No well-child visits [2]	0.9%	1.0%	0.5%	4.4%	5.0%	0.5%	2.0%	3.6%	2.0%	1.2%	1.4%	2.0%	3.5%	3.2%	2.0%	1.5%	1.5%	5.0%	2.5%	0.3%	2.4%	8.5%	8.5%	2.0%	2.0%
Well-Child Visits in the First 15 months of Life **(W15)** – MDH Five or more visits (constructed by combining HEDIS rates for five and six-or-more visits)	88.9%	88.7%	88.8%	82.4%	80.7%	85.9%	78.2%	78.4%	86.9%	85.9%	83.6%	84.2%	82.7%	82.7%	86.5%	82.2%	82.0%	76.5%	87.2%	87.1%	87.6%	67.0%	74.2%	81.0%	84.7%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life **(W34)**	85.8%	88.0%	88.8%	90.9%	90.0%	91.3%	82.6%	79.6%	77.6%	88.7%	79.9%	76.6%	85.5%	79.5%	77.1%	85.2%	81.0%	85.6%	80.7%	82.6%	81.5%	62.3%	69.8%	70.3%	81.1%
Adolescent Well-Care Visits **(AWC)**	67.9%	69.0%	73.0%	82.6%	84.0%	80.7%	57.1%	56.0%	59.1%	73.2%	72.7%	54.7%	64.0%	55.8%	59.7%	72.8%	64.4%	65.7%	64.8%	62.6%	63.8%	42.6%	52.6%	56.7%	64.2%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents **(WCC)** – BMI Percentile- Total Rate	56.4%	73.0%	73.2%	92.7%	92.0%	95.9%	98.6%	100.0%	100.0%	56.7%	60.8%	53.0%	62.4%	74.7%	81.1%	70.1%	68.5%	76.4%	61.0%	76.5%	75.7%	32.1%	54.5%	68.1%	77.9%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents **(WCC)** – Counseling for Nutrition – Total Rate	66.0%	79.0%	75.7%	97.6%	95.0%	97.6%	94.5%	94.3%	100.0%	66.7%	64.0%	62.3%	73.5%	71.9%	85.3%	74.3%	73.4%	73.7%	69.5%	76.0%	77.1%	36.7%	63.8%	67.6%	79.9%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents **(WCC)** – Counseling for Physical Activity – Total Rate	58.1%	72.0%	68.1%	93.4%	91.0%	96.6%	94.5%	100.0%	100.0%	63.9%	56.8%	53.0%	65.5%	69.9%	80.2%	70.1%	67.4%	66.2%	62.8%	70.9%	71.8%	30.4%	53.8%	62.0%	74.7%
Appropriate Testing for Children with Pharyngitis **(CWP)**	82.4%	81.0%	79.6%	85.6%	83.0%	92.2%	98.3%	93.4%	91.9%	86.3%	88.3%	87.7%	94.5%	92.2%	93.7%	85.9%	86.0%	86.2%	86.6%	87.8%	89.3%	87.1%	84.0%	86.7%	88.4%
Lead Screening in Children **(LSC)**	79.4%	80.0%	80.0%	92.1%	91.0%	88.6%	64.5%	66.1%	68.5%	73.8%	72.2%	74.7%	82.6%	84.8%	83.0%	75.7%	78.6%	80.1%	74.9%	73.0%	72.0%	67.7%	70.6%	74.5%	77.7%
Non-Recommended Cervical Cancer Screening in Adolescent Females **(NCS)** [2]	3.9%	3.0%	2.1%	1.9%	2.0%	2.0%	0.6%	0.1%	0.0%	2.0%	1.8%	1.4%	1.9%	1.3%	1.1%	2.4%	2.0%	1.4%	3.2%	3.0%	2.5%	4.0%	1.9%	1.3%	1.5%
Medication Management for People With Asthma **(MMA)** – Total 50% of treatment period	48.5%	47.0%	50.0%	73.9%	77.0%	75.0%	NA[1]	50.5%	61.5%	61.5%	64.4%	60.5%	48.8%	50.1%	53.7%	46.8%	48.1%	49.6%	54.0%	53.6%	55.7%	64.5%	55.9%	59.9%	58.2%
Medication Management for People With Asthma **(MMA)** – Total 75% of treatment period	25.1%	21.0%	23.8%	51.4%	52.0%	51.0%	NA[1]	28.4%	33.3%	35.6%	38.3%	34.1%	25.8%	25.2%	29.4%	23.7%	24.5%	25.2%	28.5%	28.4%	31.5%	48.4%	31.2%	34.8%	32.9%
Appropriate Treatment for Children with Upper Respiratory Infection **(URI)**	89.4%	91.0%	92.0%	97.1%	97.0%	98.0%	97.5%	97.25	98.1%	88.7%	88.7%	88.6%	90.0%	92.2%	91.5%	90.6%	90.8%	92.0%	88.8%	89.6%	90.1%	85.5%	88.0%	87.7%	92.2%
Asthma Medication Ratio **(AMR)**	63.0%	67.0%	63.2%	61.9%	70.0%	70.7%	NA[1]	72.6%	77.9%	64.0%	63.6%	63.1%	69.3%	67.9%	64.6%	64.7%	62.2%	58.9%	64.0%	63.6%	62.7%	52.4%	47.3%	60.1%	65.2%

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HEDIS 2018 Results, (Page 2 of 4)	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2018
HealthChoice Organizations	**ACC**			**JMS**			**KPMAS**			**MPC**			**MSFC**			**PPMCO**			**UHC**			**UMHP**			**MARR**
Use of Spirometry Testing in the Assessment and Diagnosis of COPD **(SPR)**	30.0%	30.0%	30.5%	34.9%	32.0%	40.7%	NA[1]	50.0%	NA	25.5%	31.5%	32.0%	30.8%	40.7%	38.9%	28.0%	29.9%	31.1%	31.2%	32.9%	32.2%	NA[1]	37.5%	36.9%	34.6%
Pharmacotherapy Management of COPD Exacerbation **(PCE)** – Systemic Corticosteroid Rate	70.3%	68.0%	68.2%	73.3%	65.0%	68.4%	NA[1]	55.2%	78.6%	74.4%	73.9%	70.8%	71.0%	71.6%	74.8%	75.7%	66.7%	61.8%	70.2%	65.0%	69.0%	70.3%	80.7%	78.2%	71.2%
Pharmacotherapy Management of COPD Exacerbation **(PCE)** – Bronchodilator Rate	84.9%	81.0%	82.3%	88.6%	86.0%	87.9%	NA[1]	75.9%	83.3%	87.4%	86.9%	85.8%	84.5%	87.3%	88.7%	83.7%	81.5%	80.9%	80.8%	81.5%	80.4%	86.1%	89.3%	88.7%	84.7%
Children and Adolescents' Access to Primary Care Practitioners **(CAP)** – Age 12–24 months	97.9%	98.0%	97.5%	91.5%	93.0%	92.5%	91.3%	92.5%	95.7%	97.2%	96.4%	96.1%	95.3%	94.3%	95.5%	97.8%	97.0%	93.6%	97.0%	96.2%	96.8%	84.9%	89.2%	94.0%	95.2%
Children and Adolescents' Access to Primary Care Practitioners **(CAP)** – Age 25 months–6 years	94.1%	93.0%	93.5%	93.0%	92.0%	91.8%	89.1%	87.5%	86.3%	91.6%	90.8%	88.7%	90.0%	87.6%	86.9%	94.2%	93.1%	89.5%	92.6%	92.0%	90.5%	77.5%	83.5%	83.4%	88.8%
Children and Adolescents' Access to Primary Care Practitioners **(CAP)** – Age 7–11 years	96.1%	96.0%	96.0%	93.8%	94.0%	94.3%	98.1%	92.5%	91.7%	93.5%	94.0%	92.4%	92.0%	92.8%	91.9%	95.3%	95.4%	90.9%	94.4%	94.8%	93.9%	76.8%	83.5%	84.3%	91.9%
Children and Adolescents' Access to Primary Care Practitioners **(CAP)** – Age 12–19 years	93.0%	94.0%	93.6%	94.2%	95.0%	93.8%	96.6%	91.5%	90.4%	91.6%	91.8%	89.9%	90.6%	90.7%	89.2%	93.7%	94.1%	89.6%	92.1%	93.4%	92.1%	75.2%	85.0%	83.5%	90.3%
Adults' Access to Preventive/Ambulatory Health Services **(AAP)** – Age 20–44 years	79.7%	76.0%	74.3%	69.3%	68.0%	64.4%	82.7%	75.3%	73.7%	82.8%	79.9%	75.7%	75.8%	72.5%	71.1%	82.6%	80.4%	76.5%	79.0%	76.7%	75.1%	69.3%	65.4%	65.6%	72.0%
Adults' Access to Preventive/Ambulatory Health Services **(AAP)** – Age 45–64 years	88.2%	86.0%	84.6%	87.8%	86.0%	83.7%	87.0%	82.1%	81.5%	89.4%	87.3%	85.1%	85.7%	83.2%	81.9%	90.0%	88.4%	86.0%	88.0%	86.7%	86.1%	79.6%	77.5%	77.9%	83.3%
Breast Cancer Screening **(BCS)**	65.9%	66.0%	69.2%	72.6%	74.0%	77.5%	88.5%	87.9%	81.5%	72.1%	68.2%	59.2%	66.0%	65.5%	67.1%	68.3%	69.2%	68.5%	62.3%	60.2%	59.9%	63.8%	67.3%	74.9%	69.7%
Cervical Cancer Screening **(CCS)**	67.5%	66.0%	62.5%	77.3%	73.0%	76.8%	79.2%	79.2%	80.4%	65.2%	66.3%	56.7%	61.5%	55.9%	54.3%	69.3%	64.7%	64.0%	60.1%	68.6%	59.6%	41.1%	45.3%	45.3%	62.4%
Chlamydia Screening in Women **(CHL)** – Age 16–20 years	61.0%	62.0%	63.9%	87.6%	89.0%	91.0%	69.2%	69.8%	71.3%	56.8%	57.6%	56.4%	52.2%	56.0%	59.1%	57.5%	60.0%	60.7%	52.1%	56.0%	57.4%	49.5%	50.1%	55.1%	64.4%
Chlamydia Screening in Women **(CHL)** – Age 21–24 years	68.6%	70.0%	71.8%	72.8%	85.0%	81.7%	84.7%	82.1%	80.2%	68.7%	68.7%	66.0%	65.3%	66.3%	68.2%	67.5%	68.0%	68.0%	65.4%	65.4%	67.2%	61.2%	60.4%	67.6%	71.3%
Chlamydia Screening in Women **(CHL)** – Total (16–24) years	64.2%	66.0%	67.4%	80.3%	87.0%	86.6%	79.6%	77.5%	77.0%	62.0%	62.8%	61.1%	58.6%	61.3%	64.0%	61.5%	63.6%	64.0%	57.9%	60.0%	61.6%	56.3%	56.3%	62.5%	68.0%
Prenatal and Postpartum Care **(PPC)** – Timeliness of Prenatal Care	83.9%	89.0%	87.4%	87.2%	79.0%	78.3%	92.9%	96.7%	93.7%	81.5%	89.5%	82.7%	84.5%	83.6%	78.%	90.3%	89.3%	84.4%	80.7%	87.6%	85.2%	74.5%	86.4%	88.3%	84.9%
Prenatal and Postpartum Care **(PPC)** – Postpartum Care	73.7%	73.7%	72.0%	88.0%	81.3%	83.6%	83.8%	84.1%	85.2%	68.9%	67.1%	69.1%	69.2%	71.2%	74.0%	73.7%	71.3%	69.1%	66.2%	70.6%	66.4%	62.3%	71.0%	74.0%	74.2%
Controlling High Blood Pressure **(CBP)**	54.1%	63.0%	62.0%	76.4%	72.0%	74.9%	86.0%	84.4%	85.2%	55.9%	68.7%	46.2%	71.2%	72.8%	72.8%	60.2%	51.1%	53.3%	56.9%	64.9%	64.7%	48.2%	NA	52.3%	62.7%
Persistence of Beta-Blocker Treatment After a Heart Attack **(PBH)**	84.9%	71.0%	65.2%	NA[1]	87.0%	68.8%	NA[1]	90.5%	81.8%	84.3%	83.2%	81.6%	67.7%	80.5%	80.8%	85.7%	75.0%	72.3%	77.9%	81.0%	77.6%	NA[1]	81.0%	70.0%	74.8%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia **(SMC)**	NA[1]	77.0%	NA	NA[1]	NA	NA	NA[1]	53.9%	NA	NA[1]	76.9%	NA	NA[1]	75.0%	NA	NA[1]	57.1%	66.7%	NA[1]	70.8%	NA	NA[1]	NA	NA	66.7%
Statin Therapy for Patients With Cardiovascular Disease (**SPC**) – Received Statin Therapy – Total	66.0%	70.1%	68.3%	78.4%	80.8%	82.1%	N/A	89.5%	93.0%	72.2%	75.4%	75.1%	77.5%	80.2%	78.6%	72.1%	72.1%	75.7%	71.0%	73.5%	73.8%	N/A	71.9%	74.5%	77.6%
Statin Therapy for Patients With Cardiovascular Disease (**SPC**) – Statin Adherence 80% - Total	76.5%	48.7%	53.6%	56.7%	54.6%	53.7%	NA	44.1%	46.3%	66.8%	64.6%	64.3%	55%	44.4%	50.0%	74.7%	50.2%	52.6%	45.1%	48.0%	55.4%	NA	56.5%	55.9%	54.0%
Comprehensive Diabetes **(CDC)** – Hemoglobin A1c (HbA1c) Testing	87.4%	85.0%	90.5%	94.3%	95.0%	94.9%	94.5%	92.7%	91.6%	85.9%	88.7%	80.8%	87.8%	91.7%	90.0%	89.4%	89.3%	88.1%	82.5%	86.1%	85.9%	88.3%	82.5%	81.8%	87.9%
Comprehensive Diabetes **(CDC)** – HbA1c Poor Control (>9.0%) [2]	42.2%	40.0%	34.1%	26.6%	27.0%	29.9%	28.2%	27.8%	28.0%	40.8%	34.4%	47.9%	31.6%	29.5%	31.4%	35.6%	34.0%	38.9%	39.7%	35.55%	35.5%	39.2%	42.1%	49.2%	36.9%
Comprehensive Diabetes **(CDC)** – HbA1c Control (< 8.0%)	49.2%	52.0%	59.4%	60.4%	63.0%	61.1%	57.6%	60.0%	60.9%	49.7%	56.5%	46.0%	59.9%	58.1%	56.7%	55.1%	53.5%	49.6%	51.6%	51.1%	54.5%	48.2%	48.7%	42.6%	53.8%
Comprehensive Diabetes **(CDC)** – Eye Exam (Retinal) Performed	53.9%	49.9%	55.7%	71.9%	74.0%	75.7%	84.7%	87.8%	84.5%	65.8%	51.9%	42.8%	52.6%	49.8%	63.7%	62.9%	55.7%	38.4%	55.2%	56.9%	62.3%	35.0%	31.2%	39.2%	57.8%
Comprehensive Diabetes **(CDC)** – Medical Attention for Nephropathy	90.7%	87.0%	90.5%	96.9%	94.0%	94.2%	95.3%	94.2%	92.2%	89.9%	87.9%	86.4%	91.0%	92.4%	91.0%	89.4%	99.8%	86.9%	91.2%	90.3%	89.8%	90.8%	85.6%	88.1%	89.9%
Comprehensive Diabetes **(CDC)** – Blood Pressure Control (<140/90 mm Hg)	60.0%	64.0%	64.7%	76.8%	78.0%	76.5%	87.1%	84.5%	82.3%	55.2%	55.6%	49.9%	67.6%	62.9%	69.8%	62.6%	55.5%	56.7%	46.0%	59.9%	65.2%	36.5%	41.6%	58.6%	65.5%

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HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PPMCO			UHC			UMHP			MARR
Diabetes Monitoring for People with Diabetes and Schizophrenia **(SMD)**	68.9%	74.0%	66.7%	NA[1]	77.0%	82.9%	NA[1]	NA	NA	65.5%	62.7%	60.1%	NA[1]	58.6%	66.0%	68.7%	70.2%	65.0%	72.2%	75.4%	76.3%	NA[1]	57.7%	59.5%	59.5%
Statin Therapy for Patients With Diabetes (**SPD**) – Received Statin Therapy	58.3%	59.4%	60.0%	59.4%	63.3%	65.3%	79.1%	84.4%	78.9%	59.3%	59.2%	59.1%	58.8%	59.5%	62.9%	57.6%	58.6%	59.2%	59.0%	58.2%	60.3%	50.5%	53.8%	57.8%	62.9%
Statin Therapy for Patients With Diabetes (**SPD**) – Statin Adherence 80%	54.1%	49.2%	44.9%	49.5%	50.7%	43.7%	55.9%	50.3%	52.1%	60.0%	59.7%	58.6%	54.3%	48.8%	47.4%	50.6%	48.9%	46.1%	48.6%	48.7%	48.7%	58.3%	57.9%	55.7%	49.6%
Use of Imaging Studies for Low Back Pain **(LBP)**	74.6%	76.0%	76.7%	77.7%	69.0%	79.9%	71.5%	76.9%	77.1%	75.5%	72.7%	75.0%	72.7%	66.1%	72.7%	76.0%	77.8%	77.7%	73.2%	73.3%	75.4%	74.2%	70.4%	70.4%	75.6%
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis **(ART)**	78.0%	80.0%	74.7%	NA[1]	73.0%	69.7%	NA[1]	93.6%	87.8%	67.5%	69.3%	70.1%	77.4%	78.9%	82.5%	83.1%	77.6%	78.3%	69.8%	72.1%	69.9%	NA[1]	73.5%	62.8%	74.5%
Annual Monitoring for Patients on Persistent Medications **(MPM)**– Members on angiotensin converting enzyme **(ACE)** inhibitors or angiotensin receptor blockers **(ARB)**	90.5%	90.0%	88.9%	96.5%	97.0%	94.7%	92.8%	92.0%	90.3%	89.0%	88.5%	86.2%	90.3%	89.3%	90.0%	89.0%	88.4%	88.1%	88.7%	89.4%	89.3%	86.1%	85.6%	85.2%	89.1%
Annual Monitoring for Patients on Persistent Medications **(MPM)** – Members on diuretics	89.6%	89.0%	88.0%	95.6%	95.0%	93.7%	90.8%	90.5%	88.6%	88.5%	88.0%	86.0%	88.32%	87.5%	88.3%	88.30%	88.2%	88.3%	87.8%	88.8%	88.0%	84.4%	86.6%	84.9%	88.2%
Annual Monitoring for Patients on Persistent Medications **(MPM)** – Total rate	89.9%	89.9%	88.5%	95.9%	96.0%	94.2%	91.8%	91.4%	89.6%	88.6%	88.1%	86.1%	89.4%	88.4%	89.3%	88.5%	88.1%	88.2%	88.1%	88.9%	88.7%	85.2%	85.9%	85.1%	88.7%
Ambulatory Care **(AMB)** – Outpatient visits per 1,000 member months	372.6	366.86	354.3	345.1	350.64	328.7	324.9	336.59	315.9	406.4	420.4	397.5	358.6	359.78	356.2	406.5	NA	390.3	378.1	367.49	345.1	332.6	247.26	332.2	352.5
Ambulatory Care **(AMB)** – Emergency department (ED) visits per 1,000 member months 3	55.1	53.43	50.6	94.0	93.62	83.0	24.9	26.28	26.6	71.0	68.5	61.9	56.1	55.64	53.5	60.1	NA	58.0	59.5	56.84	51.7	89.8	86.43	60.7	55.7
Frequency of Selected Procedures **(FSP)** – Bariatric weight loss surgery /1000 MM 45-64 F	0.05	0.05	0.1	0.00	0.59	0.0	0.00	0.05	0.1	0.068	0.04	0.0	0.10	0.07	0.1	0.06	0.03	0.0	0.04	0.05	0.0	0.12	0.07	0.0	0.0
Frequency of Selected Procedures **(FSP)** – Bariatric weight loss surgery /1000 MM 45-64 M	0.0074	0.01	0.0	0.00	0.50	0.0	0.00	NA	0.0	0.015	0.01	0.0	0.015	0.01	0.0	0.03	NA	0.0	0.010	0.01	0.0	0.00	NA	0.0	0.0
Frequency of Selected Procedures **(FSP)** – Tonsillectomy /1000 MM 0-9 T	0.48	0.48	0.5	0.13	0.21	0.1	0.00	0.23	0.3	0.55	0.62	0.6	0.45	0.48	0.5	0.64	0.58	0.6	0.51	0.51	0.5	0.31	0.37	0.4	0.4
Frequency of Selected Procedures **(FSP)** – Tonsillectomy /1000 MM 10-19 T	0.186	0.14	0.2	0.18	0.17	0.1	0.00	0.20	0.1	0.26	0.26	0.2	0.19	0.24	0.2	0.25	0.24	0.2	0.194	0.20	0.2	0.16	0.34	0.2	0.2
Frequency of Selected Procedures **(FSP)** – Hysterectomy, abdominal /1000 MM 45-64 F	0.31	0.27	0.3	0.36	0.31	0.2	0.00	0.26	0.3	0.32	0.27	0.2	0.47	0.30	0.3	0.45	0.26	0.3	0.28	0.28	0.2	0.23	0.32	0.4	0.3
Frequency of Selected Procedures **(FSP)** – Hysterectomy, vaginal /1000 MM 45-64 F	0.1510	0.15	0.1	0.00	0.02	0.0	0.00	0.20	0.2	0.24	0.19	0.1	0.22	0.27	0.2	0.31	0.17	0.2	0.1506	0.17	0.1	0.17	0.17	0.1	0.1
Frequency of Selected Procedures **(FSP)** – Cholecystectomy, open /1000 MM 30-64 M	0.022	0.04	0.0	0.0569	0.02	0.1	0.00	0.03	0.0	0.04	0.07	0.0	0.0574	0.06	0.0	0.03	0.04	0.0	0.018	0.04	0.0	0.00	0.05	0.0	0.0
Frequency of Selected Procedures **(FSP)** – Cholecystectomy, open /1000 MM 45-64 F	0.010	0.51	0.0	0.045	0.05	0.0	0.00	0.02	0.0	0.05	0.08	0.0	0.012	0.04	0.0	0.06	0.03	0.0	0.02	0.04	0.0	0.00	0.05	0.1	0.0
Frequency of Selected Procedures **(FSP)** – Laparoscopic/1000 MM 30-64 M	0.20	0.19	0.2	0.05	0.06	0.0	0.00	0.12	0.1	0.31	0.29	0.2	0.24	0.15	0.1	0.29	0.23	0.2	0.26	0.22	0.2	0.21	0.18	0.2	0.2
Frequency of Selected Procedures **(FSP)** – Laparoscopic/1000 MM 45-64 F	0.36	0.51	0.5	0.29	0.19	0.3	0.00	0.24	0.4	0.62	0.55	0.5	0.40	0.56	0.3	0.69	0.51	0.5	0.44	0.42	0.4	0.43	0.32	0.6	0.4
Frequency of Selected Procedures **(FSP)** – Back Surgery /1000 MM 45-64 F	0.46	0.53	0.5	0.56	0.59	0.3	0.00	0.14	0.1	0.81	0.86	0.7	0.67	0.58	0.5	0.74	0.62	0.7	0.60	0.54	0.6	0.43	0.39	0.5	0.5
Frequency of Selected Procedures **(FSP)** – Back Surgery /1000 MM 45-64 M	0.58	0.42	0.5	0.41	0.50	0.6	0.00	0.16	0.2	0.85	0.84	0.7	0.69	0.68	0.7	0.80	0.82	0.8	0.83	0.70	0.6	0.47	0.39	0.5	0.6
Frequency of Selected Procedures **(FSP)** – Mastectomy /1000 MM 15-44 F	0.0226	0.03	0.0	0.050	0.00	0.0	0.00	0.00	0.0	0.045	0.02	0.0	0.01	0.04	0.1	0.03	0.02	0.0	0.0233	0.03	0.0	0.051	0.04	0.0	0.0
Frequency of Selected Procedures **(FSP)** – Mastectomy /1000 MM 45-64 F	0.13	0.18	0.1	0.07	0.02	0.0	0.00	0.15	0.1	0.12	0.08	0.1	0.10	0.06	0.1	0.23	0.11	0.1	0.171	0.13	0.1	0.173	0.07	0.1	0.1
Frequency of Selected Procedures **(FSP)** – Lumpectomy /1000 MM 15-44 F	0.113	0.09	0.1	0.07	0.05	0.1	0.00	0.6	0.0	0.106	0.12	0.1	0.20	0.12	0.1	0.14	0.12	0.1	0.107	0.11	0.1	0.05	0.08	0.1	0.1
Frequency of Selected Procedures **(FSP)** – Lumpectomy /1000 MM 45-64 F	0.27	0.33	0.3	0.25	0.19	0.1	0.00	0.41	0.3	0.28	0.37	0.3	0.52	0.36	0.4	0.42	0.32	0.3	0.38	0.29	0.3	0.14	0.37	0.3	0.3
Standardized Healthcare-Associated Infection Ratio **(HAI)** – Central line – associated blood stream infection (CLABSI) – Plan Weighted SIR	N/A	1.05	0.9	N/A	0.93	0.6	N/A	1.37	1.0	N/A	0.15	1.0	N/A	0.98	0.7	N/A	0.01	0.0	N/A	1.04	0.9	N/A	1.25	1.0	0.8
Standardized Healthcare-Associated Infection Ratio **(HAI)** – Catheter – Associated Urinary Tract Infection (CAUTI) – Plan Weighted SIR	N/A	0.79	0.9	N/A	0.78	0.7	N/A	0.80	0.6	N/A	0.18	1.0	N/A	1.04	1.1	N/A	0.01	0.0	N/A	1.04	1.0	N/A	1.08	0.9	0.8
Standardized Healthcare-Associated Infection Ratio **(HAI)** – MRSA bloodstream infection (MRSA) – Plan Weighted SIR	N/A	0.83	0.8	N/A	1.23	0.9	N/A	0.77	0.5	N/A	0.28	1.1	N/A	1.03	1.1	N/A	0.01	0.0	N/A	0.62	1.0	N/A	0.97	0.9	0.8
Standardized Healthcare-Associated Infection Ratio **(HAI)** – Clostridium Difficile Intestinal Infection (CDIFF) – Plan Weighted SIR	N/A	1.03	0.9	N/A	0.89	0.6	N/A	1.44	1.2	N/A	0.42	1.0	N/A	0.98	0.9	N/A	0.01	0.0	N/A	1.38	0.9	N/A	1.21	0.9	0.8

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HEDIS 2018 Results, (Page 4 of 4)	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2018
HealthChoice Organizations	**ACC**			**JMS**			**KPMAS**			**MPC**			**MSFC**			**PPMCO**			**UHC**			**UMHP**			**MARR**
Inpatient Utilization - General Hospital Acute Care **(IPU)** – Total Inpatient: Total Discharges /1000 MM	**5.83**	**5.23**	**5.1**	**10.06**	**9.53**	**9.2**	**5.49**	**5.33**	**5.6**	**6.84**	**6.58**	**6.5**	**6.67**	**6.83**	**6.6**	**6.75**	**6.49**	**6.8**	**6.60**	**4.91**	**5.6**	**8.59**	**6.91**	**7.2**	**6.6**
Inpatient Utilization - General Hospital Acute Care **(IPU)** – Total Inpatient: Total Average Length of Stay	**4.14**	**4.17**	**4.2**	**4.81**	**4.47**	**4.6**	**3.34**	**3.36**	**3.4**	**3.75**	**3.87**	**2.5**	**4.22**	**4.18**	**4.8**	**4.06**	**4.09**	**4.4**	**4.23**	**4.40**	**4.4**	**3.47**	**3.51**	**3.5**	**4.0**
Antibiotic Utilization **(ABX)** – Average Scrips PMPY for Antibiotics (aaattot)	**0.85**	**0.84**	**0.8**	**0.87**	**0.79**	**0.8**	**0.67**	**0.58**	**0.6**	**1.10**	**1.09**	**1.0**	**0.88**	**0.90**	**0.9**	**0.97**	**0.98**	**0.9**	**0.92**	**0.91**	**0.8**	**0.85**	**0.86**	**0.8**	**0.8**
Antibiotic Utilization **(ABX)** – Average Days Supplied per Antibiotic Script (acattot)	**9.35**	**9.28**	**9.3**	**9.00**	**8.67**	**7.7**	**9.46**	**9.29**	**9.3**	**9.32**	**9.30**	**9.2**	**9.10**	**8.94**	**8.9**	**9.42**	**9.32**	**9.3**	**9.35**	**9.09**	**9.3**	**9.28**	**9.32**	**9.2**	**9.0**
Antibiotic Utilization (**ABX**) – Average Scrips PMPY for Antibiotics of Concern (adattot)	**0.35**	**0.34**	**0.3**	**0.29**	**0.26**	**0.3**	**0.25**	**0.22**	**0.2**	**0.45**	**0.45**	**0.4**	**0.35**	**0.36**	**0.3**	**0.39**	**0.40**	**0.4**	**0.41**	**0.40**	**0.4**	**0.38**	**0.38**	**0.3**	**0.3**
Antibiotic Utilization (**ABX**) – Percentage of Antibiotics of Concern of all Antibiotics (apttot)	**40.8%**	**40.35%**	**38.8%**	**33.7%**	**33.08%**	**32.5%**	**37.8%**	**38.16%**	**35.9%**	**40.8%**	**41.26%**	**40.4%**	**40.1%**	**40.49%**	**39.0%**	**40.7%**	**41.51%**	**39.3%**	**44.3%**	**43.74%**	**41.6%**	**44.6%**	**44.32%**	**42.2%**	**38.7%**

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Table A1 – Health Plan Descriptive Information

	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Board Certification **(BCR)** – Family Medicine: Number of Physicians	798	78	208	623	290	656	791	704
Board Certification **(BCR)** – Family Medicine: Number Board Certified	472	63	192	396	203	622	565	565
Board Certification **(BCR)** – Family Medicine: Percent Board Certified	59.15%	80.77%	92.31%	63.56%	70.00%	94.82%	71.43%	80.26%
Board Certification **(BCR)** – Internal Medicine: Number of Physicians	3083	597	454	1294	477	1012	2442	853
Board Certification **(BCR)** – Internal Medicine: Number Board Certified	2229	533	436	979	325	955	1873	672
Board Certification **(BCR)** – Internal Medicine: Percent Board Certified	72.30%	89.28%	96.04%	75.66%	68.13%	94.37%	76.70%	78.78%
Board Certification **(BCR)** – OB/GYN: Number of Physicians	697	208	183	814	152	846	800	638
Board Certification **(BCR)** – OB/GYN: Number Board Certified	527	170	156	436	85	797	673	431
Board Certification **(BCR)** – OB/GYN: Percent Board Certified	75.61%	81.73%	85.25%	53.56%	55.92%	94.21%	84.13%	67.55%
Board Certification **(BCR)** – Pediatrician: Number of Physicians	1588	194	110	1021	311	882	1507	628
Board Certification **(BCR)** – Pediatrician: Number Board Certified	1243	176	101	792	194	849	1213	485
Board Certification **(BCR)** – Pediatrician: Percent Board Certified	78.27%	90.72%	91.82%	77.57%	62.38%	96.26%	80.49%	77.23%
Board Certification **(BCR)** – Geriatricians: Number of Physicians	133	37	5	19	8	50	91	36
Board Certification **(BCR)** – Geriatricians: Number Board Certified	81	34	5	15	7	49	56	26
Board Certification **(BCR)** – Geriatricians: Percent Board Certified	60.90%	91.89%	100%	78.95%	87.50%	98.00%	61.54%	72.22%
Board Certification **(BCR)** – Other Specialists: Number of Physicians	5271	2477	1112	4759	1924	12803	5870	4147
Board Certification **(BCR)** – Other Specialists: Number Board Certified	4080	2119	1063	3363	1267	11934	4568	2354
Board Certification **(BCR)** – Other Specialists: Percent Board Certified	77.40%	85.55%	95.59%	70.67%	65.85%	93.21%	77.82%	56.76%
Enrollment by Product Line **(ENP)** – Shows only total member months for Female	1787702	143292	373694	1412334	556051	1914988	985663	231236
Enrollment by Product Line **(ENP)** – Shows only total member months for Male	1517147	163317	321102	1146162	466059	1542521	858840	241940
Enrollment by Product Line **(ENP)** – Shows only total member months Total	3304849	306609	694796	2558496	1022110	3457509	1844503	473176
Enrollment by State **(EBS)** – Maryland Only	275302	26342	64778	216647	89923	298740	151443	43709

	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Language Diversity **(LDM)** – Spoken - English Number	10	21658	66554	248957	0	0	10703	0
Language Diversity **(LDM)** – Spoken - English Percent	0.0%	67.2%	88.2%	96.3%	0.0%	0.0%	5.7%	0.0%
Language Diversity **(LDM)** – Spoken - Non-English Number	13260	0	8693	2363	0	0	3991	0
Language Diversity **(LDM)** – Spoken - Non-English Percent	4.1%	0.0%	11.5%	0.9%	0.0%	0.0%	2.1%	0.0%
Language Diversity **(LDM)** – Spoken - Unknown Number	311616	10578	186	7161	111000	347187	172769	55575
Language Diversity **(LDM)** – Spoken - Unknown Percent	96%	33%	0.25%	2.77%	100%	100%	92%	100.00%
Language Diversity **(LDM)** – Spoken - Declined Number	0	0	32	0	0	0	0	0
Language Diversity **(LDM)** – Spoken - Declined Percent	0%	0%	0%	0%	0%	0%	0%	0%
Race/Ethnicity Diversity **(RDM)** – White / Total	57491	4103	14397	84767	29346	105277	61302	16300
Race/Ethnicity Diversity **(RDM)** – White / Percent	17.70%	12.73%	19.08%	32.79%	26.44%	30.32%	32.70%	29.33%
Race/Ethnicity Diversity **(RDM)** – Black / Total	123759	19349	42260	93905	0	122749	78956	19152
Race/Ethnicity Diversity **(RDM)** – Black / Percent	38.09%	60.02%	56.00%	36.33%	0%	35.36%	42.12%	34.46%
Race/Ethnicity Diversity **(RDM)** – American Indian & Alaska Native / Total	0	137	159	0	0	2	0	0
Race/Ethnicity Diversity **(RDM)** – American Indian & Alaska Native / Percent	0%	0.42%	0.21%	0.00%	0%	0%	0%	0%
Race/Ethnicity Diversity **(RDM)** – Asian / Total	14050	962	5674	9136	5802	0	11135	2486
Race/Ethnicity Diversity **(RDM)** – Asian / Percent	4.32%	2.98%	7.52%	3.53%	5.23%	0%	5.94%	4.47%
Race/Ethnicity Diversity **(RDM)** – Native Hawaiian - Pacific Islander / Total	409	44	49	327	0	13327	281	98
Race/Ethnicity Diversity **(RDM)** – Native Hawaiian - Pacific Islander / Percent	0.13%	0.14%	0.06%	0.13%	0%	3.84%	0.15%	0.18%
Race/Ethnicity Diversity **(RDM)** – Other / Total	0	0	1678	744	881	0	0	0
Race/Ethnicity Diversity **(RDM)** – Other / Percent	0%	0%	2.22%	0%	0.79%	0%	0%	0%
Race/Ethnicity Diversity **(RDM)** – 2+ Races / Total	0	0	366	0	0	0	0	0
Race/Ethnicity Diversity **(RDM)** – 2+ Races / Percent	0%	0%	0.48%	0%	0%	0%	0%	0%
Race/Ethnicity Diversity **(RDM)** – Unknown / Total	129177	7641	10643	69602	74469	2390	35789	472
Race/Ethnicity Diversity **(RDM)** – Unknown / Percent	40%	24%	14%	27%	67%	1%	19%	1%
Race/Ethnicity Diversity **(RDM)** – Declined / Total	0	0	239	0	502	103442	0	17067
Race/Ethnicity Diversity **(RDM)** – Declined / Percent	0%	0%	0.32%	0%	0%	30%	0%	30.71%
Total Membership – Total membership numbers for each plan	324886	32236	75465	258481	111000	347187	187463	55575

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SECTION FOUR - MEASURE SPECIFIC FINDINGS

PREVENTION AND SCREENING - ADULT

Adult BMI Assessment (ABA)

Description
The percentage of members 18 to74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year.

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

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

Summary of Changes to HEDIS 2018
- Clarified that the pregnancy optional exclusion should be applied to only female members.
- Revised the Data Elements for Reporting table to reflect removal of the Final Sample Size (FSS) when reporting using the hybrid methodology.

Adult BMI Assessment (ABA)						
	2014	2015	2016	2017	2018	NHM
ACC	72.0%	82.4%	85.2%	91.0%	92.0%	⇧
JMS	80.2%	98.5%	96.6%	98.0%	98.5%	⇧
KPMAS		98.4%	100.0%	98.0%	98.1%	⇧
MPC	70.2%	84.9%	82.4%	89.3%	87.8%	⇧
MSFC	82.6%	86.4%	90.3%	90.6%	96.2%	⇧
PPMCO	82.9%	89.6%	86.1%	89.6%	91.2%	⇧
UHC	68.9%	81.9%	92.7%	90.3%	93.7%	⇧

Adult BMI Assessment (ABA)						
	2014	2015	2016	2017	2018	NHM
UMHP	NA▫	NA▫	85.4%	88.6%	92.9%	⇧
MARR	76.1%	88.9%	89.8%	91.9%	93.8%	⇧

▫ 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 to 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 U.S. physicians; furthermore, despite that the vast majority of acute bronchitis cases (more than 90 percent) have a non-bacterial cause, antibiotics are prescribed 65 percent to 80 percent of the time.

Summary of Changes to HEDIS 2018:

- Clarified how to identify an ED visit or observation visit that resulted in an inpatient stay.
- Replaced medication table references with references to medication lists.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)						
	2014	2015	2016	2017	2018	NHM
ACC	23.88%	24.5%	25.9%	30.0%	31.8%	⇧
JMS	35.2%	34.1%	33.0%	37.0%	43.6%	⇧
KPMAS		NA▫	NA▫	57.1%	71.2%	⇧
MPC	22.0%	21.9%	19.5%	21.3%	26.5%	⇩
MSFC	15.2%	19.9%	22.8%	20.7%	30.0%	⇩
PPMCO	23.94%	24.4%	22.2%	25.5%	30.0%	⇩
UHC	20.8%	23.7%	26.0%	25.9%	31.2%	⇧
UMHP	NA▫	NA▫	23.1%	25.0%	33.2%	⇧
MARR	23.5%	24.7%	24.6%	30.3%	37.2%	⇧

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

PREVENTION AND SCREENING - CHILD

Childhood Immunization Status (CIS)

Description

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

	DTaP	IPV	MMR	HiB	Hep B	VZV	PCV	Hep A	RV	Influenza
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 considered one of the most successful and cost-effective public health interventions and are responsible for dramatically reducing pediatric morbidity and mortality in the U.S. (DHHS & amp; ODPHP, 2013; Centers for Disease Control and Prevention [CDC], 2012). Although U.S. childhood immunization rates are generally high, some areas remain vulnerable to outbreaks of infection, such as measles (IOM, 2013). In 2013, 159 measles case were reported in the U.S. – 37 percent in children younger than five years (Malani, 2013).

Summary of Changes to HEDIS 2018:

- Revised the Data Elements for Reporting table to reflect removal of the Final Sample Size (FSS) when reporting using the hybrid methodology.

Childhood Immunization Status (CIS) Combination 2 (DTaP, IPV, MMR, HiB, Hep B, VZV)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	81.3%	83.8%	83.1%	85.0%	85.2%	⇧
JMS	86.5%	88.4%	88.7%	91.0%	85.4%	⇧
KPMAS		NA▫	79.5%	73.1%	72.5%	⇩
MPC	73.7%	70.8%	84.7%	79.9%	66.2%	⇩
MSFC	88.1%	81.8%	85.9%	84.4%	84.2%	⇧
PPMCO	83.1%	83.6%	84.5%	83.5%	79.8%	⇧
UHC	73.0%	77.4%	83.5%	79.8%	74.5%	⇧
UMHP	NA▫	50.0%	80.9%	80.8%	76.6%	⇧
MARR	80.9%	76.5%	83.8%	82.2%	78.0%	⇧

▫ 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)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	78.2%	81.9%	81.9%	83.0%	82.5%	⇧
JMS	86.1%	87.6%	87.3%	88.0%	83.7%	⇧
KPMAS		NA▫	78.2%	70.0%	70.3%	⇧
MPC	72.09%	68.2%	82.1%	78.5%	64.5%	⇩
MSFC	85.9%	79.3%	83.2%	81.8%	82.7%	⇧
PPMCO	80.8%	80.1%	83.0%	82.6%	77.9%	⇧
UHC	71.3%	73.7%	80.5%	77.9%	70.8%	⇧
UMHP	NA▫	43.8%	80.2%	79.3%	75.2%	⇧
MARR	79.1%	73.5%	82.1%	80.1%	75.9%	⇧

▫ 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)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	73.6%	77.6%	78.9%	80.0%	80.1%	⇧
JMS	84.8%	85.2%	86.8%	88.0%	83.3%	⇧
KPMAS		NA▫	78.2%	69.5%	70.1%	⇧
MPC	62.8%	64.7%	78.0%	75.7%	62.5%	⇩
MSFC	81.3%	76.6%	80.5%	79.3%	81.3%	⇧
PPMCO	69.4%	78.5%	79.7%	80.9%	76.4%	⇧
UHC	66.2%	67.9%	75.7%	74.7%	67.4%	⇧
UMHP	NA▫	43.8%	78.2%	76.6%	73.7%	⇧
MARR	73.0%	70.6%	79.5%	78.1%	74.3%	⇧

▫ 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)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	63.9%	63.7%	68.3%	70.0%	69.8%	⇧
JMS	71.7%	68.0%	76.4%	73.0%	71.2%	⇧
KPMAS		NA▫	68.0%	55.0%	62.3%	⇧
MPC	47.0%	57.1%	59.9%	59.5%	52.6%	⇩
MSFC	70.1%	64.5%	67.9%	67.9%	67.9%	⇧
PPMCO	54.6%	68.5%	69.0%	69.5%	68.1%	⇧
UHC	56.9%	60.1%	61.6%	65.2%	57.4%	⇩
UMHP	NA▫	37.5%	58.0%	60.6%	58.6%	⇧
MARR	60.7%	59.9%	66.1%	65.1%	63.5%	⇧

▫ 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)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	49.3%	53.0%	52.6%	42.0%	48.7%	⇧
JMS	47.8%	46.8%	47.6%	57.0%	64.4%	⇧
KPMAS		NA▫	52.6%	46.3%	55.7%	⇧
MPC	37.7%	40.6%	41.8%	42.4%	34.1%	⇩
MSFC	59.4%	51.6%	47.9%	49.6%	47.7%	⇧
PPMCO	49.5%	54.2%	59.7%	48.8%	50.9%	⇧
UHC	44.3%	48.4%	42.6%	44.8%	41.6%	⇧
UMHP	NA▫	28.1%	41.0%	41.4%	46.7%	⇧
MARR	48.0%	46.1%	48.2%	46.5%	48.7%	⇧

▫ 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)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	60.7%	61.3%	65.7%	68.0%	67.9%	⇧
JMS	71.3%	67.2%	76.4%	73.0%	71.2%	⇧
KPMAS		NA▫	68.0%	55.0%	62.0%	⇧
MPC	44.0%	55.0%	57.8%	57.9%	51.3%	⇩
MSFC	66.7%	62.5%	65.7%	66.2%	67.2%	⇧
PPMCO	50.7%	68.5%	67.3%	68.4%	67.4%	⇧
UHC	54.7%	57.4%	58.9%	63.5%	55.5%	⇩
UMHP	NA▫	37.5%	56.7%	59.6%	57.9%	⇧
MARR	58.0%	58.5%	64.6%	63.9%	62.6%	⇧

▫ 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)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	47.9%	50.9%	51.4%	42.0%	47.7%	⇧
JMS	47.4%	45.6%	47.2%	57.0%	64.4%	⇧
KPMAS		NA▫	52.6%	46.0%	55.7%	⇧
MPC	34.9%	38.5%	40.1%	41.4%	33.1%	⇩
MSFC	56.2%	49.4%	47.2%	48.2%	47.5%	⇧
PPMCO	44.4%	53.5%	57.5%	48.4%	50.9%	⇧
UHC	41.4%	46.2%	40.9%	43.1%	40.4%	⇧
UMHP	NA▫	28.1%	40.3%	40.6%	45.7%	⇧
MARR	45.4%	44.6%	47.1%	45.8%	48.2%	⇧

▫ 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)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	42.4%	43.5%	46.8%	37.0%	44.3%	⇧
JMS	40.9%	36.4%	42.5%	49.0%	55.8%	⇧
KPMAS		NA▫	46.2%	37.5%	49.9%	⇧
MPC	28.4%	34.3%	32.5%	32.9%	27.7%	⇩
MSFC	49.9%	44.3%	40.2%	43.8%	41.1%	⇧
PPMCO	36.3%	48.4%	51.1%	42.6%	46.5%	⇧
UHC	37.0%	41.4%	35.0%	39.7%	36.7%	⇧
UMHP	NA▫	23.4%	30.0%	34.1%	37.2%	⇧
MARR	39.1%	38.8%	40.5%	39.6%	42.4%	⇧

▫ 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)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	41.2%	42.1%	45.6%	36.0%	43.3%	⇧
JMS	40.9%	36.0%	42.5%	49.0%	55.8%	⇧
KPMAS		NA▫	46.2%	37.5%	49.9%	⇧
MPC	27.7%	33.0%	31.6%	32.2%	27.0%	⇩
MSFC	47.0%	42.8%	39.4%	42.3%	40.9%	⇧
PPMCO	34.3%	48.4%	50.0%	42.3%	46.5%	⇧
UHC	35.3%	40.2%	33.8%	38.7%	35.8%	⇧
UMHP	NA▫	23.4%	29.4%	33.8%	36.7%	⇧
MARR	37.7%	38.0%	39.8%	39.0%	42.0%	⇧

▫ 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 conjugate vaccine, one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

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 2018:

- Added a two-dose HPV vaccination series.
- Revised the Data Elements for Reporting table to reflect removal of the Final Sample Size (FSS) when reporting using the hybrid methodology.

Immunizations for Adolescents (IMA) Combination 1 (Meningococcal, Tdap/Td)						
	2014	2015	2016	2017	2018	NHM
ACC	69.4%	74.8%	86.8%	88.0%	89.1%	⇧
JMS	75.5%	76.7%	82.1%	89.0%	89.7%	⇧
KPMAS		NA▫	82.7%	80.5%	83.7%	⇧
MPC	62.7%	74.1%	85.4%	88.2%	84.7%	⇧
MSFC	70.7%	72.4%	80.0%	84.2%	88.6%	⇧
PPMCO	74.5%	74.1%	89.2%	89.1%	87.1%	⇧
UHC	63.4%	66.2%	84.8%	86.7%	87.4%	⇧
UMHP	NA▫	64.7%	82.7%	80.5%	87.5%	⇧
MARR	67.2%	71.9%	84.2%	85.8%	87.2%	⇧

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

Immunizations for Adolescents (IMA) Combination 2 (Meningococcal, Tdap, HPV)*						
	2014	2015	2016	2017	2018	NHM*
ACC				28.94%	48.9%	⇧
JMS				52.69%	72.2%	⇧
KPMAS				26.69%	47.5%	⇧
MPC				21.30%	37.7%	⇧
MSFC				24.09%	35.5%	⇧
PPMCO				26.85%	38.4%	⇧
UHC				22.87%	36.5%	⇧

Immunizations for Adolescents (IMA) Combination 2 (Meningococcal, Tdap, HPV)*						
	2014	2015	2016	2017	2018	NHM*
UMHP				17.37%	30.4%	⇧
MARR				27.60%	43.4%	⇧

*No benchmark data available, Combination 2 was a newly reported numerator with HEDIS 2017.

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

Description

The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life:

- No well-child visits.
- One well-child visit.
- Two well-child visits.
- Three well-child visits.
- Four well-child visits.
- Five well-child visits.
- Five and 6 or more well child visits (custom).
- Six or more well-child visits.

Note

- This measure has the same structure as measures in the Effectiveness of Care domain. The organization must follow the Guidelines for Effectiveness of Care Measures when calculating this measure.
- Only the Administrative Method of data collection may be used when reporting this measure for the commercial population.

Rationale

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

Summary of Changes to HEDIS 2018:

- Revised the Data Elements for Reporting table to reflect the removal of the Final Sample Size (FSS) when reporting using the hybrid methodology for the Medicaid product line.

Well-Child Visits in the First 15 months of Life (W15) – No well-child visits*						
	2014	2015	2016	2017	2018	NHM
ACC	1.0%	2.1%	0.9%	1.0%	0.5%	⇧
JMS	3.1%	1.9%	4.4%	5.0%	0.5%	⇧

Well-Child Visits in the First 15 months of Life (W15) – No well-child visits*						
	2014	2015	2016	2017	2018	NHM
KPMAS		NA▫	2.0%	3.6%	2.0%	⇧
MPC	0.5%	1.56%	1.2%	1.4%	2.0%	⇧
MSFC	1.2%	3.5%	3.5%	3.2%	2.0%	⇧
PPMCO	1.1%	1.59%	1.5%	1.5%	5.0%	⇩
UHC	1.9%	0.9%	2.5%	0.3%	2.4%	⇧
UMHP	NA▫	10.9%	8.5%	8.5%	2.0%	⇧
MARR	1.5%	3.2%	3.1%	3.1%	2.0%	⇧

* 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) – MDH Five/Six-or-more visits						
	2014	2015	2016	2017	2018	NHM
ACC	88.9%	85.1%	88.9%	88.7%	88.8%	NA
JMS	84.4%	81.6%	82.4%	80.7%	85.9%	NA
KPMAS		NA▫	78.2%	78.4%	86.9%	NA
MPC	83.6%	84.9%	85.9%	83.6%	84.2%	NA
MSFC	86.0%	82.8%	82.7%	82.7%	86.5%	NA
PPMCO	83.7%	81.9%	82.2%	82.0%	76.5%	NA
UHC	87.4%	83.6%	87.2%	87.1%	87.6%	NA
UMHP	NA▫	56.6%	67.0%	74.2%	81.0%	NA
MARR	85.7%	79.5%	81.8%	82.2%	84.7%	NA

▫ This measure is Not Applicable due to an insufficient eligible population, (e.g. <30 members).
*There is no NCQA benchmark for this composite measure.

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

Description

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

Note

- This measure has the same structure as measures in the Effectiveness of Care domain. The organization must follow the Guidelines for Effectiveness of Care Measures when calculating this measure.
- Only the Administrative Method of data collection may be used when reporting this measure for the commercial population.

Rationale

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

Summary of Changes to HEDIS 2018:

Revised the Data Elements for Reporting table to reflect the removal of the Final Sample Size (FSS) when reporting using the hybrid methodology for the Medicaid product line.

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	83.9%	83.7%	85.8%	88.0%	88.8%	⇧
JMS	88.9%	90.6%	90.9%	90.0%	91.3%	⇧
KPMAS		84.6%	82.6%	79.6%	77.6%	⇧
MPC	88.8%	87.0%	88.7%	79.9%	76.6%	⇧
MSFC	83.5%	86.7%	85.5%	79.5%	77.1%	⇧
PPMCO	83.8%	86.8%	85.2%	81.0%	85.6%	⇧
UHC	75.0%	79.2%	80.7%	82.6%	81.5%	⇧
UMHP	NA▫	57.4%	62.3%	69.8%	70.3%	⇩
MARR	84.0%	82.0%	82.7%	81.3%	81.1%	⇧

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

Adolescent Well-Care Visits (AWC)

Description

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

Note

- This measure has the same structure as measures in the Effectiveness of Care domain. The organization must follow the Guidelines for Effectiveness of Care Measures when calculating this measure.
- Only the Administrative Method of data collection may be used when reporting this measure for the commercial population.

Rationale

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

Summary of Changes to HEDIS 2018:

- Revised the Data Elements for Reporting table to reflect the removal of the Final Sample Size (FSS) when reporting using the hybrid methodology for the Medicaid product line.

Adolescent Well-Care Visits (AWC)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	67.9%	64.7%	67.9%	69.0%	73.0%	⇧
JMS	76.7%	80.3%	82.6%	84.0%	80.7%	⇧
KPMAS		63.5%	57.1%	56.0%	59.1%	⇧
MPC	68.8%	68.3%	73.2%	72.7%	54.7%	⇧
MSFC	67.8%	61.2%	64.0%	55.8%	59.7%	⇧
PPMCO	61.6%	68.8%	72.8%	64.4%	65.7%	⇧
UHC	60.8%	58.5%	64.8%	62.6%	63.8%	⇧
UMHP	NA▫	31.8%	42.6%	52.6%	56.7%	⇧
MARR	67.3%	62.1%	65.6%	64.6%	64.2%	⇧

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

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

Description

The percentage of members 3 to 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.

- BMI percentile documentation*.
- Counseling for nutrition.
- 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 to 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 eight years of age, obesity in adulthood is likely to be more severe.

Body mass index 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 to12 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 to 5 years; from 6.5 percent to 18.8 percent for those aged 6 to11 years; and from 5.0 percent to 17.4 percent for those aged 12 to 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 2018:

- Clarified that the pregnancy optional exclusion should be applied to only female members.

- Clarified in the Notes that documentation related to a member's "appetite" does not meet criteria for Counseling for nutrition.
- Revised the Data Elements for Reporting table to reflect removal of the Final Sample Size (FSS) when reporting using the hybrid methodology.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - BMI Percentile- Total Rate						
	2014	2015	2016	2017	2018	NHM
ACC	49.5%	60.9%	56.4%	73.0%	73.2%	⇧
JMS	92.2%	94.7%	92.7%	92.0%	95.9%	⇧
KPMAS		99.0%	98.6%	100.0%	100.0%	⇧
MPC	46.5%	58.3%	56.7%	60.8%	53.0%	⇩
MSFC	59.8%	67.3%	62.4%	74.7%	81.1%	⇧
PPMCO	52.1%	72.5%	70.1%	68.5%	76.4%	⇧
UHC	45.5%	57.9%	61.0%	76.5%	75.7%	⇧
UMHP	NA▫	41.5%	32.1%	54.5%	68.1%	⇩
MARR	57.6%	69.0%	66.3%	75.0%	77.9%	⇧

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

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate						
	2014	2015	2016	2017	2018	NHM
ACC	59.0%	71.5%	66.0%	79.0%	75.7%	⇧
JMS	94.4%	97.6%	97.6%	95.0%	97.6%	⇧
KPMAS		98.1%	94.5%	94.3%	100.0%	⇧
MPC	54.4%	66.4%	66.7%	64.0%	62.3%	⇩
MSFC	74.1%	72.9%	73.5%	71.9%	85.3%	⇧
PPMCO	54.2%	73.6%	74.3%	73.4%	73.7%	⇧
UHC	67.6%	64.5%	69.5%	76.0%	77.1%	⇧
UMHP	NA▫	50.8%	36.7%	63.8%	67.6%	⇧
MARR	67.3%	74.4%	72.4%	77.2%	79.9%	⇧

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

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate						
	2014	2015	2016	2017	2018	NHM
ACC	51.4%	61.3%	58.1%	72.0%	68.1%	⇧
JMS	89.8%	91.2%	93.4%	91.0%	96.6%	⇧
KPMAS		98.1%	94.5%	100.0%	100.0%	⇧
MPC	58.8%	60.0%	63.9%	56.8%	53.0%	⇩
MSFC	72.9%	67.8%	65.5%	69.9%	80.2%	⇧
PPMCO	44.7%	70.1%	70.1%	67.4%	66.2%	⇧
UHC	60.6%	63.0%	62.8%	70.9%	71.8%	⇧

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
UMHP	NA▫	43.1%	30.4%	53.8%	62.0%	⇧
MARR	63.0%	69.3%	67.3%	72.7%	74.7%	⇧

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

Appropriate Testing for Children with Pharyngitis (CWP)

Description

The percentage of children 3 to 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, (i.e., appropriate testing).

Rationale

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

Summary of Changes to HEDIS 2018:

- Revised the episode date to allow for multiple diagnoses of pharyngitis and to exclude members who had other diagnoses on the same date of service.
- Clarified how to identify an ED visit or observation visit that resulted in an inpatient stay.
- Replaced medication table references with references to medication lists.

Appropriate Testing for Children with Pharyngitis (CWP)						
	2014	2015	2016	2017	2018	NHM
ACC	78.36%	79.8%	82.4%	81.0%	79.6%	⇧
JMS	70.8%	80.2%	85.6%	83.0%	92.2%	⇧
KPMAS		NA▫	98.3%	93.4%	91.9%	⇧
MPC	78.42%	82.9%	86.3%	88.3%	87.7%	⇧
MSFC	86.9%	90.5%	94.5%	92.2%	93.7%	⇧
PPMCO	80.5%	83.1%	85.9%	86.0%	86.2%	⇧
UHC	83.1%	86.0%	86.6%	87.8%	89.3%	⇧
UMHP	NA▫	76.4%	87.1%	84.0%	86.7%	⇧
MARR	79.7%	82.7%	88.3%	87.0%	88.4%	⇧

▫ 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 two 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 one to five years of age have the highest prevalence of elevated blood levels of any age group in the U.S., although the prevalence has declined over the past several decades. Even with these decreases, an estimated 310,000 children in this country remain at risk for exposure to harmful levels of lead. BLLs of African American children and among low-income families remain significantly higher than those of other races and those of other income status.

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

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

Summary of Changes to HEDIS 2018:

- Revised the Data Elements for Reporting table to reflect removal of the Final Sample Size (FSS) when reporting using the hybrid methodology.

Lead Screening in Children (LSC)						
	2014*	2015	2016	2017	2018	NHM
ACC		77.1%	79.4%	80.0%	80.0%	⇧
JMS		87.2%	92.1%	91.0%	88.6%	⇧
KPMAS		NA▫	64.5%	66.1%	68.5%	⇧
MPC		70.0%	73.8%	72.2%	74.7%	⇧
MSFC		88.6%	82.6%	84.8%	83.0%	⇧
PPMCO		71.9%	75.7%	78.6%	80.1%	⇧
UHC		68.6%	74.9%	73.0%	72.0%	⇧
UMHP		53.1%	67.7%	70.6%	74.5%	⇧
MARR		73.8%	76.3%	77.0%	77.6%	⇧

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

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

Description

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

Note: A lower rate indicates better performance.

Rationale

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

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

Summary of Changes to HEDIS 2018:

- No changes to this measure.

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) **						
	2014*	2015	2016	2017	2018	NHM
ACC		5.3%	3.9%	3.0%	2.1%	⇩
JMS		2.1%	1.9%	2.0%	2.0%	⇧
KPMAS		1.9%	0.6%	0.1%	0.0%	⇧
MPC		4.2%	2.0%	1.8%	1.4%	⇧
MSFC		2.9%	1.9%	1.3%	1.1%	⇧
PPMCO		3.7%	2.4%	2.0%	1.4%	⇧
UHC		5.8%	3.2%	3.0%	2.5%	⇩
UMHP		5.2%	4.0%	1.9%	1.3%	⇧
MARR		3.9%	2.5%	1.9%	1.5%	⇧

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

RESPIRATORY CONDITIONS – ADULT AND CHILD

Medication Management for People with Asthma (MMA)

Description

The percentage of members 5 to 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

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

Summary of Changes to HEDIS 2018:

- Replaced medication table references with references to medication lists.
- Removed Medicare reporting.
- Removed commercial reporting for the 65 to 85 age group

Medication Management for People with Asthma (MMA) – Total 50% of treatment period						
	2014	2015	2016	2017	2018	NHM
ACC	45.8%	48.8%	48.5%	47.0%	50.0%	⇩
JMS	49.4%	59.6%	73.9%	77.0%	75.0%	⇧
KPMAS		NA▫	NA▫	50.5%	61.5%	⇧
MPC	57.9%	57.9%	61.5%	64.4%	60.5%	⇧
MSFC	51.9%	49.9%	48.8%	50.1%	53.7%	⇩
PPMCO	43.3%	44.5%	46.8%	48.1%	49.6%	⇩
UHC	49.9%	48.4%	54.0%	53.6%	55.7%	⇩
UMHP	NA▫	NA▫	64.5%	55.9%	59.9%	⇧
MARR	49.7%	51.5%	56.9%	55.8%	58.2%	⇩

▫ 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						
	2014	2015	2016	2017	2018	NHM
ACC	22.9%	23.2%	25.1%	21.0%	23.8%	⇩
JMS	24.5%	34.8%	51.4%	52.0%	51.0%	⇧
KPMAS		NA▫	NA▫	28.4%	33.3%	⇩
MPC	32.9%	34.0%	35.6%	38.3%	34.1%	⇩
MSFC	26.6%	24.1%	25.8%	25.2%	29.4%	⇩
PPMCO	20.0%	20.5%	23.7%	24.5%	25.2%	⇩
UHC	27.8%	25.2%	28.5%	28.4%	31.5%	⇩
UMHP	NA▫	NA▫	48.4%	31.2%	34.8%	⇩
MARR	25.8%	27.0%	34.1%	31.1%	32.9%	⇩

▫ 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–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 2018:
- Revised the episode date to allow for multiple diagnoses of URI and to exclude members who had other diagnoses on the same date of service.
- Clarified how to identify an ED visit or observation visit that resulted in an inpatient stay.
- Replaced medication table references with references to medication lists.

Appropriate Treatment for Children with Upper Respiratory Infection (URI)						
	2014	2015	2016	2017	2018	NHM
ACC	86.5%	88.0%	89.4%	91.0%	92.0%	⇧
JMS	83.0%	92.4%	97.1%	97.0%	98.0%	⇧
KPMAS		NA▫	97.5%	97.2%	98.1%	⇧
MPC	86.6%	85.6%	88.7%	88.7%	88.6%	⇧
MSFC	84.3%	89.5%	90.0%	92.2%	91.5%	⇧
PPMCO	86.0%	89.0%	90.6%	90.8%	92.0%	⇧
UHC	82.0%	85.2%	88.8%	89.6%	90.1%	⇧
UMHP	NA▫	86.4%	85.5%	88.0%	87.7%	⇩
MARR	84.7%	88.0%	91.0%	91.8%	92.2%	⇧

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

Summary of Changes to HEDIS 2018:

- Replaced medication table references with references to medication lists.
- Removed Medicare reporting.
- Removed commercial reporting for the 65 to 85 age group.

Asthma Medication Ratio (AMR)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	68.59%	56.54%	63.0%	67.0%	63.2%	⇧
JMS	60.5%	56.50%	61.9%	70.0%	70.7%	⇧
KPMAS		NA▫	NA▫	72.6%	77.9%	⇧
MPC	69.1%	65.0%	64.0%	63.6%	63.1%	⇧
MSFC	73.7%	68.1%	69.3%	67.9%	64.6%	⇧
PPMCO	69.6%	63.8%	64.7%	62.2%	58.9%	⇧
UHC	69.8%	63.4%	64.0%	63.6%	62.7%	⇧
UMHP	NA▫	NA▫	52.4%	47.3%	60.1%	⇩
MARR	68.56%	62.2%	62.7%	64.3%	65.2%	⇧

▫ 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 U.S.. COPD defines a group of diseases characterized by airflow obstruction, and includes chronic bronchitis and emphysema. Symptoms of COPD range from chronic cough and sputum production to severe, disabling shortness of breath, leading to significant impairment of quality of life. COPD afflicts nearly 16 million adults in the U.S. COPD is the fourth leading cause of death in the U.S., and is projected to move to third place by 2020.

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

Summary of Changes to HEDIS 2018:
- Clarified how to identify an ED visit or observation visit that resulted in an inpatient stay.

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	25.8%	23.6%	30.0%	30.0%	30.5%	⇩
JMS	26.3%	32.6%	34.9%	32.0%	40.7%	⇧
KPMAS		NA▫	NA▫	50.0%	NA	
MPC	21.1%	20.8%	25.5%	31.5%	32.0%	⇧
MSFC	34.5%	29.2%	30.8%	40.7%	38.9%	⇧
PPMCO	23.7%	27.2%	28.0%	29.9%	31.1%	⇩
UHC	25.6%	25.6%	31.2%	32.9%	32.2%	⇧
UMHP	NA▫	NA▫	NA▫	37.5%	36.9%	⇧
MARR	26.2%	26.5%	30.1%	35.6%	34.6%	⇧

▫ 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 through November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:

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

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

Rationale

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

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

Summary of Changes to HEDIS 2018:

- Replaced medication table references with references to medication lists.
- Clarified in steps 2 and 4 that the intent is to identify all episodes (multiple episodes on the same episode date are separate episodes).
- Clarified how to identify ED visits that resulted in an inpatient stay.
- Clarified the definition of "direct transfer": when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less.
- Added "Cortisone-acetate" to the description of Glucocorticoids in the Systemic Corticosteroid Medications List.

Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate						
	2014	2015	2016	2017	2018	NHM
ACC	73.6%	69.0%	70.3%	68.0%	68.2%	⇧
JMS	69.2%	73.6%	73.3%	65.0%	68.4%	⇧
KPMAS		NA▫	NA▫	55.2%	78.6%	⇧
MPC	72.6%	72.1%	74.4%	73.9%	70.8%	⇧
MSFC	76.3%	72.2%	71.0%	71.6%	74.8%	⇧
PPMCO	69.7%	69.7%	75.7%	66.7%	61.8%	⇩
UHC	78.2%	73.0%	70.2%	65.0%	69.0%	⇧
UMHP	NA▫	78.1%	70.3%	80.7%	78.2%	⇧
MARR	73.3%	72.5%	72.2%	68.3%	71.2%	⇧

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

Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate						
	2014	2015	2016	2017	2018	NHM
ACC	87.5%	84.8%	84.9%	81.0%	82.3%	⇧
JMS	82.5%	85.4%	88.6%	86.0%	87.9%	⇧
KPMAS		NA▫	NA▫	75.9%	83.3%	⇧
MPC	84.93%	85.1%	87.4%	86.9%	85.8%	⇧
MSFC	90.3%	92.4%	84.5%	87.3%	88.7%	⇧
PPMCO	84.0%	85.0%	83.7%	81.5%	80.9%	⇧
UHC	84.88%	86.3%	80.8%	81.5%	80.4%	⇩
UMHP	NA▫	81.3%	86.1%	89.3%	88.7%	⇧
MARR	85.7%	85.7%	85.1%	83.7%	84.7%	⇧

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

MEMBER ACCESS

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

Description

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

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

Rationale

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

Summary of Changes to HEDIS 2018:

- No changes to this measure.

Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–24 months						
	2014	2015	2016	2017	2018	NHM
ACC	97.8%	97.7%	97.9%	98.0%	97.5%	⇧
JMS	94.7%	96.2%	91.5%	93.0%	92.5%	⇩
KPMAS		100.0%	91.3%	92.5%	95.7%	⇧
MPC	96.5%	96.9%	97.2%	96.4%	96.1%	⇧
MSFC	96.4%	93.9%	95.3%	94.3%	95.5%	⇧
PPMCO	97.6%	97.6%	97.8%	97.0%	93.6%	⇩
UHC	96.3%	96.6%	97.0%	96.2%	96.8%	⇧
UMHP	NA▫	87.8%	84.9%	89.2%	94.0%	⇩
MARR	96.6%	95.8%	94.1%	94.6%	95.2%	⇧

Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months–6 years						
	2014	2015	2016	2017	2018	NHM
ACC	92.8%	93.1%	94.1%	93.0%	93.5%	⇧
JMS	88.7%	91.8%	93.0%	92.0%	91.8%	⇧
KPMAS		98.0%	89.1%	87.5%	86.3%	⇩
MPC	90.0%	90.3%	91.6%	90.8%	88.7%	⇧
MSFC	89.8%	88.4%	90.0%	87.6%	86.9%	⇩
PPMCO	92.6%	93.3%	94.2%	93.1%	89.5%	⇧
UHC	91.1%	91.3%	92.6%	92.0%	90.5%	⇧
UMHP	NA▫	69.4%	77.5%	83.5%	83.4%	⇩
MARR	90.8%	89.5%	90.3%	89.9%	88.8%	⇧

▫ 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 7–11 years						
	2014	2015	2016	2017	2018	NHM
ACC	94.3%	95.3%	96.1%	96.0%	96.0%	⇧
JMS	93.8%	92.7%	93.8%	94.0%	94.3%	⇧
KPMAS		98.4%	98.1%	92.5%	91.7%	⇧
MPC	92.1%	92.61%	93.5%	94.0%	92.4%	⇧
MSFC	93.50%	92.58%	92.0%	92.8%	91.9%	⇧
PPMCO	94.4%	94.4%	95.3%	95.4%	90.9%	⇧
UHC	93.1%	93.6%	94.4%	94.8%	93.9%	⇧
UMHP	NA▫	NA▫	76.8%	83.5%	84.3%	⇩
MARR	93.52%	94.2%	92.5%	92.9%	91.9%	⇧

▫ 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						
	2014	2015	2016	2017	2018	NHM
ACC	90.5%	91.9%	93.0%	94.0%	93.6%	⇧
JMS	90.8%	92.9%	94.2%	95.0%	93.8%	⇧
KPMAS		94.2%	96.6%	91.5%	90.4%	⇧
MPC	88.5%	89.7%	91.6%	91.8%	89.9%	⇧
MSFC	92.7%	91.7%	90.6%	90.7%	89.2%	⇧
PPMCO	91.9%	92.5%	93.7%	94.1%	89.6%	⇧
UHC	90.1%	90.9%	92.1%	93.4%	92.1%	⇧
UMHP	NA▫	NA▫	75.2%	85.0%	83.5%	⇩
MARR	90.7%	92.0%	90.9%	91.9%	90.3%	⇧

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

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

Description

The percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.

- Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year.
- Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

Rationale

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

Summary of Changes to HEDIS 2018:

- No changes to this measure.

Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 years						
	2014	2015	2016	2017	2018	NHM
ACC	79.4%	79.4%	79.7%	76.0%	74.3%	⇩
JMS	72.9%	71.0%	69.3%	68.0%	64.4%	⇩
KPMAS		92.9%	82.7%	75.3%	73.7%	⇩
MPC	81.1%	80.9%	82.8%	79.9%	75.7%	⇩
MSFC	79.7%	76.3%	75.8%	72.5%	71.1%	⇩
PPMCO	81.7%	82.3%	82.6%	80.4%	76.5%	⇩
UHC	80.36%	80.0%	79.0%	76.7%	75.1%	⇩
UMHP	NA▫	63.6%	69.3%	65.4%	65.6%	⇩
MARR	79.2%	78.3%	77.7%	74.3%	72.1%	⇩

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

Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years						
	2014	2015	2016	2017	2018	NHM
ACC	87.2%	86.7%	88.2%	86.0%	84.6%	⇩
JMS	86.58%	86.8%	87.8%	86.0%	83.7%	⇩
KPMAS		95.7%	87.0%	82.1%	81.5%	⇩
MPC	87.8%	87.4%	89.4%	87.3%	85.1%	⇧
MSFC	86.9%	85.1%	85.7%	83.2%	81.9%	⇩
PPMCO	88.4%	89.0%	90.0%	88.4%	86.0%	⇧
UHC	87.8%	88.0%	88.0%	86.7%	86.1%	⇧
UMHP	NA▫	75.9%	79.6%	77.5%	77.9%	⇩
MARR	87.5%	86.8%	87.0%	84.6%	83.3%	⇩

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

WOMEN'S HEALTH

Breast Cancer Screening (BCS)

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

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

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

Summary of Changes to HEDIS 2018:
- Added required exclusions to the Medicare product line for members 65 years of age and older living long-term in institutional settings.
- Added digital breast tomosynthesis as a method for meeting numerator criteria.
- Revised the Note section.

Breast Cancer Screening (BCS)						
	2014	2015	2016	2017	2018	NHM
ACC	58.1%	66.0%	65.9%	66.0%	69.2%	⇧
JMS	69.4%	72.1%	72.6%	74.0%	77.5%	⇧
KPMAS		87.2%	88.5%	87.9%	81.5%	⇧
MPC	48.5%	65.9%	72.1%	68.2%	59.2%	⇧
MSFC	64.4%	63.4%	66.0%	65.5%	67.1%	⇧
PPMCO	57.0%	62.5%	68.3%	69.2%	68.5%	⇧
UHC	52.7%	58.1%	62.3%	60.2%	59.9%	⇧
UMHP	NA▫	NA▫	63.8%	67.3%	74.9%	⇧
MARR	58.3%	67.9%	70.0%	69.8%	69.7%	⇧

▫ 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 to 64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21 to 4 years of age who had cervical cytology performed every three years.
- Women 30 to 64 years of age who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years.

Rationale

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

Summary of Changes to HEDIS 2018:

- Revised the Data Elements for Reporting table to reflect removal of the Final Sample Size (FSS) when reporting using the hybrid methodology.

Cervical Cancer Screening (CCS)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	79.64%	67.8%	67.5%	66.0%	62.5%	⇧
JMS	79.5%	66.8%	77.3%	73.0%	76.8%	⇧
KPMAS		90.8%	79.2%	79.2%	80.4%	⇧
MPC	79.58%	65.75%	65.2%	66.3%	56.7%	⇩
MSFC	74.0%	66.2%	61.5%	55.9%	54.3%	⇩
PPMCO	75.9%	74.4%	69.3%	64.7%	64.0%	⇧
UHC	62.8%	58.8%	60.1%	68.6%	59.6%	⇧
UMHP	NA▫	35.5%	41.1%	45.3%	45.3%	⇩
MARR	75.2%	65.76%	65.1%	64.9%	62.4%	⇧

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

Chlamydia Screening in Women (CHL)

Description
The percentage of women 16 to 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 U.S. CDC estimates that approximately three million people are infected with chlamydia each year. Risk factors associated with becoming infected with chlamydia are the same as risks for contracting other STDs, (e.g., multiple sex partners). Chlamydia is more prevalent among adolescent (15 to 19) and young adult (20 to 24) women.

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

Summary of Changes to HEDIS 2018:
- Replaced medication table references with references to medication lists.

Chlamydia Screening in Women (CHL) – Age 16–20 years						
	2014	2015	2016	2017	2018	NHM
ACC	62.4%	61.4%	61.0%	62.0%	63.9%	⇧
JMS	86.7%	87.6%	87.6%	89.0%	91.0%	⇧
KPMAS		76.9%	69.2%	69.8%	71.3%	⇧
MPC	58.2%	58.9%	56.8%	57.6%	56.4%	⇧
MSFC	54.8%	57.2%	52.2%	56.0%	59.1%	⇧
PPMCO	61.5%	59.2%	57.5%	60.0%	60.7%	⇧
UHC	55.4%	55.2%	52.1%	56.0%	57.4%	⇧
UMHP	NA▫	61.1%	49.5%	50.1%	55.1%	⇧
MARR	63.17%	64.7%	60.8%	62.6%	64.4%	⇧

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

Chlamydia Screening in Women (CHL) – Age 21–24 years						
	2014	2015	2016	2017	2018	NHM
ACC	71.9%	71.7%	68.6%	70.0%	71.8%	⇧
JMS	72.3%	65.0%	72.8%	85.0%	81.7%	⇧
KPMAS		80.8%	84.7%	82.1%	80.2%	⇧
MPC	67.1%	67.3%	68.7%	68.7%	66.0%	⇧
MSFC	68.4%	66.5%	65.3%	66.3%	68.2%	⇧
PPMCO	69.9%	68.0%	67.5%	68.0%	68.0%	⇧
UHC	64.8%	63.2%	65.4%	65.4%	67.2%	⇧
UMHP	NA▫	58.7%	61.2%	60.4%	67.6%	⇧
MARR	69.1%	67.7%	69.3%	70.7%	71.3%	⇧

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

Chlamydia Screening in Women (CHL) – Total (16–24) years						
	2014	2015	2016	2017	2018	NHM
ACC	66.0%	65.97%	64.2%	66.0%	67.4%	⇧
JMS	81.2%	77.3%	80.3%	87.0%	86.6%	⇧
KPMAS		79.5%	79.6%	77.5%	77.0%	⇧
MPC	62.0%	62.6%	62.0%	62.8%	61.1%	⇧
MSFC	60.1%	61.3%	58.6%	61.3%	64.0%	⇧
PPMCO	64.8%	62.7%	61.5%	63.6%	64.0%	⇧
UHC	59.0%	58.8%	57.9%	60.0%	61.6%	⇧
UMHP	NA▫	59.7%	56.3%	56.3%	62.5%	⇧
MARR	65.5%	65.97%	65.1%	66.8%	68.0%	⇧

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

Prenatal and Postpartum Care

Prenatal and Postpartum Care (PPC)

Description

The percentage of deliveries of live births on or 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.

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

Rationale:

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

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

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

Summary of Changes to HEDIS 2018:

- Updated the administrative numerator specification to indicate when codes must be on the same claim and when codes can occur on different dates of service.
- Revised the Data Elements for Reporting table to reflect the removal of the Final Sample Size (FSS) when reporting using the Hybrid Methodology.

Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	84.2%	85.7%	83.9%	89.0%	87.4%	⇧
JMS	85.8%	83.2%	87.2%	79.0%	78.3%	⇩

Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care						
	2014	2015	2016	2017	2018	NHM
KPMAS		88.0%	92.9%	96.7%	93.7%	⇧
MPC	84.9%	80.3%	81.5%	89.5%	82.7%	⇧
MSFC	85.4%	79.2%	84.5%	83.6%	79.0%	⇩
PPMCO	90.9%	88.2%	90.3%	89.3%	84.4%	⇧
UHC	87.1%	84.1%	80.7%	87.6%	85.2%	⇧
UMHP	52.2%	73.3%	74.5%	86.4%	88.3%	⇧
MARR	74.0%	82.8%	84.4%	87.6%	84.9%	⇧

Prenatal and Postpartum Care (PPC) – Postpartum Care						
	2014	2015	2016	2017	2018	NHM
ACC	71.6%	66.0%	73.7%	73.7%	72.0%	⇧
JMS	78.5%	83.6%	88.0%	81.3%	83.6%	⇧
KPMAS		86.0%	83.8%	84.1%	85.2%	⇧
MPC	71.9%	65.0%	68.9%	67.1%	69.1%	⇧
MSFC	72.0%	71.1%	69.2%	71.2%	74.0%	⇧
PPMCO	75.6%	70.7%	73.7%	71.3%	69.1%	⇧
UHC	63.8%	62.5%	66.2%	70.6%	66.4%	⇧
UMHP	43.9%	47.4%	62.3%	71.1%	74.0%	⇧
MARR	61.9%	69.0%	73.2%	73.8%	74.2%	⇧

Cardiovascular Conditions

Controlling High Blood Pressure (CBP)

Description

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

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

Note: Use the Hybrid Method for this measure. A single rate is reported and is the sum of all three groups.

Rationale

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

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

Summary of Changes to HEDIS 2018:

- Added required exclusions to the Medicare product line for members 65 years of age and older living long-term in institutional settings.
- Clarified that a diagnosis code for hypertension documented in the medical record may be used to confirm the diagnosis of hypertension.
- Clarified that the pregnancy optional exclusion should be applied to only female members.
- Replaced medication table references with references to medication lists.
- Revised the language in step 1 of the Numerator and added Notes clarifying the intent when excluding BP readings from the numerator.
- Revised the Data Elements for Reporting table to reflect the removal of the Final Sample Size (FSS) when reporting using the hybrid methodology.

Controlling High Blood Pressure (CBP)						
	2014	2015	2016	2017	2018	NHM
ACC	49.0%	63.9%	54.1%	63.0%	62.0%	⇧
JMS	56.2%	69.3%	76.4%	72.0%	74.9%	⇧
KPMAS		87.8%	86.0%	84.4%	85.2%	⇧
MPC	46.8%	61.4%	55.9%	68.7%	46.2%	⇩
MSFC	65.5%	69.2%	71.2%	72.8%	72.8%	⇧
PPMCO	57.0%	59.5%	60.2%	51.1%	53.3%	⇩
UHC	42.3%	50.9%	56.9%	64.9%	64.7%	⇧
UMHP	NA▫	32.1%	48.2%	NA▫	52.3%	⇩
MARR	52.8%	61.8%	63.6%	68.1%	63.9%	⇧

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

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

Description

The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (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 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 2018:

- Clarified the definition of "direct transfer": when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less.
- Replaced medication table references with references to medication lists.
- Clarified the calculation of treatment days in the numerator.

Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	NA▫	91.5%	84.9%	71.0%	65.2%	⇩
JMS	NA▫	NA▫	NA▫	87.0%	68.8%	⇩
KPMAS		NA▫	NA▫	90.5%	81.8%	⇧
MPC	87.5%	90.2%	84.3%	83.2%	81.6%	⇧
MSFC	NA▫	NA▫	67.7%	80.5%	80.8%	⇧
PPMCO	86.1%	84.6%	85.7%	75.0%	72.3%	⇩
UHC	82.9%	87.8%	77.9%	81.0%	77.6%	⇩
UMHP	NA▫	NA▫	NA▫	81.0%	70.0%	⇩
MARR	85.5%	88.5%	80.1%	81.1%	74.8%	⇩

▫ 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 to 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

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

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

Summary of Changes to HEDIS 2018:
- No changes to this measure.

Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)						
	2014*	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC		NA▫	NA▫	77.0%	NA	NA
JMS		NA▫	NA▫	NA▫	NA	NA▫
KPMAS		NA▫	NA▫	53.9%	NA	NA
MPC		NA▫	NA▫	76.9%	NA	NA
MSFC		NA▫	NA▫	75.0%	NA	NA
PPMCO		NA▫	NA▫	57.1%	66.7%	⇩
UHC		NA▫	NA▫	70.8%	NA	NA
UMHP		NA▫	NA▫	N/A	NA	NA▫
MARR		No MARR	No MARR	68.5%	66.7%	⇩

* This measure was added by MDH for reporting in HEDIS 2015.
▫ This measure is Not Applicable due to an insufficient eligible population, (e.g. <30 members).
**NCQA Benchmarks will not be available until HEDIS 2017 when there are two years of valid data.

Statin Therapy for Patients With Cardiovascular Disease (SPC)

Description

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

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

Rationale

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

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

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

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

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

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

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

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

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

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

Summary of Changes to HEDIS 2018:

- Clarified that the pregnancy required exclusion should be applied to only female members.
- Replaced medication table references with references to medication lists.

Statin Therapy for Patients With Cardiovascular Disease (SPC) – Received Statin Therapy – Total						
	2014	**2015***	**2016**	**2017**	**2018**	**NHM**
ACC			66.0%	70.1%	68.3%	⇩
JMS			78.4%	80.8%	82.1%	⇧
KPMAS			NA▫	89.5%	93.0%	⇧
MPC			72.2%	75.4%	75.1%	⇧
MSFC			77.5%	80.2%	78.6%	⇧
PPMCO			72.1%	72.1%	75.7%	⇧
UHC			71.0%	73.5%	73.8%	⇩
UMHP			NA▫	71.9%	74.5%	⇩
MARR			72.9%	76.7%	77.6%	⇧

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

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

Statin Therapy for Patients With Cardiovascular Disease (SPC) – Statin Adherence 80% - Total						
	2014	**2015***	**2016**	**2017**	**2018**	**NHM**
ACC			76.5%	48.7%	53.6%	⇩
JMS			56.7%	54.6%	53.7%	⇩
KPMAS			NA▫	44.1%	46.3%	⇩
MPC			66.8%	64.6%	64.3%	⇧
MSFC			55%	44.4%	50.0%	⇩
PPMCO			74.7%	50.2%	52.6%	⇩
UHC			45.1%	48.0%	55.4%	⇩
UMHP			NA▫	56.5%	55.9%	⇩
MARR			62.5%	51.4%	54.0%	⇩

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

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

Diabetes

Comprehensive Diabetes Care (CDC)

Description

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

- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%).
- HbA1c control (<8.0%).
- HbA1c control (<7.0%) for a selected population*.
- Eye exam (retinal) performed.
- Medical attention for nephropathy.
- BP control (<140/90 mm Hg).

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

Rationale

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

Summary of Changes to HEDIS 2018:

- Added bilateral eye enucleation to the Eye exam (retinal) performed indicator.
- Revised the language in step 1 of the BP Control <140/90 mm Hg Numerator and added Notes clarifying the intent when excluding BP readings from the numerator.
- Clarified the medical record requirements for evidence of ACE inhibitor/ARB therapy (for the Medical Attention for Nephropathy indicator).
- Replaced medication table references with references to medication lists.
- Added “sacubitril-valsartan” to the description of Antihypertensive combinations in the ACE Inhibitor/ARB Medications List.
- Revised the Data Elements for Reporting table to reflect the removal of the Final Sample Size (FSS) when reporting using the hybrid methodology.

Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing						
	2014	2015*	2016	2017	2018	NHM
ACC	83.4%	88.7%	87.4%	85.0%	90.5%	⇧
JMS	89.1%	90.7%	94.3%	95.0%	94.9%	⇧
KPMAS		96.4%	94.5%	92.7%	91.6%	⇧
MPC	79.5%	87.9%	85.9%	88.7%	80.8%	⇩
MSFC	84.7%	88.0%	87.8%	91.7%	90.0%	⇧
PPMCO	78.1%	89.4%	89.4%	89.3%	88.1%	⇧
UHC	79.1%	85.9%	82.5%	86.1%	85.9%	⇩
UMHP	NA▫	84.6%	88.3%	82.5%	81.8%	⇩
MARR	85.5%	89.0%	88.8%	88.9%	87.9%	⇧

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

Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%)*						
	2014	2015	2016	2017	2018	NHM
ACC	38.8%	38.5%	42.2%	40.0%	34.1%	⇧
JMS	31.0%	37.2%	26.6%	27.0%	29.9%	⇧
KPMAS		21.8%	28.2%	27.8%	28.0%	⇧
MPC	48.6%	40.8%	40.8%	34.4%	47.9%	⇩
MSFC	37.2%	44.5%	31.6%	29.5%	31.4%	⇧
PPMCO	48.1%	35.6%	35.6%	34.0%	38.9%	⇧
UHC	45.5%	41.1%	39.7%	35.5%	35.5%	⇧
UMHP	NA▫	60.8%	39.2%	42.1%	49.2%	⇩
MARR	41.5%	40.1%	35.5%	33.8%	36.9%	⇧

* A lower rate indicates better performance.

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

Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)						
	2014	2015	2016	2017	2018	NHM
ACC	51.4%	51.4%	49.2%	52.0%	59.4%	⇧
JMS	61.5%	52.4%	60.4%	63.0%	61.1%	⇧
KPMAS		60.0%	57.6%	60.0%	60.9%	⇧
MPC	43.3%	50.8%	49.7%	56.5%	46.0%	⇩
MSFC	54.0%	43.5%	59.9%	58.1%	56.7%	⇧
PPMCO	44.3%	54.3%	55.1%	53.5%	49.6%	⇧
UHC	46.47%	46.2%	51.6%	51.1%	54.5%	⇧
UMHP	NA▫	38.8%	48.2%	48.7%	42.6%	⇩
MARR	50.2%	49.7%	54.0%	55.3%	53.9%	⇧

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

Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed						
	2014	2015	2016	2017	2018	NHM
ACC	65.4%	48.6%	53.9%	49.0%	55.7%	⇧
JMS	79.6%	64.1%	71.9%	74.0%	75.7%	⇧
KPMAS		87.3%	84.7%	87.8%	84.5%	⇧
MPC	72.0%	65.7%	65.8%	51.9%	42.8%	⇩
MSFC	71.1%	54.0%	52.6%	49.8%	63.8%	⇩
PPMCO	71.0%	69.0%	62.9%	55.7%	38.4%	⇩
UHC	56.9%	58.6%	55.2%	56.9%	62.3%	⇧
UMHP	NA▫	44.8%	35.0%	31.2%	39.2%	⇩
MARR	69.3%	61.5%	60.2%	57.0%	57.8%	⇧

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

Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy						
	2014	2015	2016	2017	2018	NHM
ACC	75.7%	80.3%	90.7%	87.0%	90.5%	⇧
JMS	93.1%	93.4%	96.9%	94.0%	94.2%	⇧
KPMAS		100.0%	95.3%	94.2%	92.2%	⇧
MPC	75.3%	75.9%	89.9%	87.9%	86.4%	⇩
MSFC	82.7%	80.9%	91.0%	92.4%	91.0%	⇧
PPMCO	73.8%	82.5%	89.4%	99.8%	86.9%	⇩
UHC	75.9%	81.5%	91.2%	90.3%	89.8%	⇩
UMHP	NA▫	74.8%	90.8%	85.6%	88.1%	⇩
MARR	79.4%	83.7%	91.9%	91.4%	89.9%	⇧

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

Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)						
	2014	2015	2016	2017	2018	NHM
ACC	55.6%	65.3%	60.0%	64.0%	64.7%	⇧
JMS	60.4%	69.7%	76.8%	78.0%	76.5%	⇧
KPMAS		83.6%	87.1%	84.5%	82.3%	⇧
MPC	55.4%	56.4%	55.2%	55.6%	49.9%	⇩
MSFC	70.1%	69.0%	67.6%	62.9%	69.8%	⇧
PPMCO	64.2%	60.7%	62.6%	55.5%	56.7%	⇩
UHC	51.6%	55.2%	46.0%	59.9%	65.2%	⇧
UMHP	NA▫	39.9%	36.5%	41.6%	58.6%	⇩
MARR	59.5%	62.5%	61.5%	62.7%	65.5%	⇧

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

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

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

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

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

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

Summary of Changes to HEDIS 2018:
- Replaced medication table references with references to medication lists.

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)						
	2014*	2015	2016	2017	2018	NHM
ACC		76.7%	68.9%	74.0%	66.7%	⇩
JMS		NA▫	NA▫	77.0%	82.9%	⇧
KPMAS		NA▫	NA▫	NA▫	NA▫	NA
MPC		NR▫▫	65.5%	62.7%	60.1%	⇩
MSFC		NA▫	NA▫	58.6%	66.0%	⇩
PPMCO		68.7%	68.7%	70.2%	65.0%	⇩
UHC		74.6%	72.2%	75.4%	76.3%	⇧
UMHP		NA▫	NA▫	57.7%	59.5%	⇩
MARR		73.4%	68.8%	67.9%	68.1%	⇩

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

Statin Therapy for Patients With Diabetes (SPD)

Description

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

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

Rationale

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

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

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

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

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

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

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

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

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

Summary of Changes to HEDIS 2018:

- Clarified that the pregnancy required exclusion should be applied to female members.
- Replaced medication table references with references to medication lists.

Statin Therapy for Patients With Diabetes (SPD) – Received Statin Therapy						
	2014	2015*	2016	2017	2018	NHM
ACC			58.3%	59.4%	60.0%	⇩
JMS			59.4%	63.3%	65.3%	⇧
KPMAS			79.1%	84.4%	78.9%	⇧
MPC			59.3%	59.2%	59.1%	⇩
MSFC			58.8%	59.5%	62.9%	⇧
PPMCO			57.6%	58.6%	59.2%	⇩
UHC			59.0%	58.2%	60.3%	⇧
UMHP			50.5%	53.8%	57.8%	⇩
MARR			60.3%	62.1%	62.9%	⇧

* This measure was added by MDH for reporting in HEDIS 2016.
**NCQA Benchmarks will not be available until HEDIS 2018 when there are two years of valid data.

Statin Therapy for Patients With Diabetes (SPD) – Statin Adherence 80%						
	2014	2015*	2016	2017	2018	NHM
ACC			54.1%	49.2%	44.9%	⇩
JMS			49.5%	50.7%	43.7%	⇩
KPMAS			55.9%	50.3%	52.1%	⇩
MPC			60.0%	59.7%	58.6%	⇩
MSFC			54.3%	48.8%	47.4%	⇩
PPMCO			50.6%	48.9%	46.1%	⇩
UHC			48.6%	48.7%	48.7%	⇩
UMHP			58.3%	57.9%	55.7%	⇩
MARR			53.9%	51.8%	49.6%	⇩

* This measure was added by MDH for reporting in HEDIS 2016.
**NCQA Benchmarks will not be available until HEDIS 2018 when there are two years of valid data.

Musculoskeletal Conditions

Use of Imaging Studies for Low Back Pain (LBP)

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

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

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

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

Summary of Changes to HEDIS 2018:
- Replaced the Telehealth Value Set with the Telephone Visits Value Set and the Online Assessments Value Set (the value set was split, but codes are unchanged).
- Added telehealth modifiers.
- Replaced medication table references with references to medication lists.
- Clarified how to identify an ED visit or observation visit that resulted in an inpatient stay.

Use of Imaging Studies for Low Back Pain (LBP)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	76.7%	74.2%	74.6%	76.0%	76.7%	⇧
JMS	77.2%	69.2%	77.7%	69.0%	79.9%	⇧
KPMAS		NA▫	71.5%	76.9%	77.1%	⇧
MPC	76.6%	76.7%	75.5%	72.7%	75.0%	⇧
MSFC	73.3%	71.8%	72.7%	66.1%	72.7%	⇧
PPMCO	75.2%	75.0%	76.0%	77.8%	77.7%	⇧
UHC	73.4%	74.3%	73.2%	73.3%	75.4%	⇧
UMHP	NA▫	78.1%	74.2%	70.4%	70.4%	⇩
MARR	75.4%	74.2%	74.4%	72.8%	75.6%	⇧

▫ 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 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).

Rationale

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

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

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

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

Summary of Changes for HEDIS 2018:

- Clarified that the pregnancy optional exclusion should be applied to female members.
- Replaced medication table references with references to medication lists.

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
ACC	60.0%	62.8%	78.0%	80.0%	74.7%	⇧
JMS	NA▫	NA▫	NA▫	73.0%	69.7%	⇩
KPMAS		NA▫	NA▫	93.6%	87.8%	⇧
MPC	73.8%	65.8%	67.5%	69.3%	70.1%	⇩
MSFC	NA▫	89.2%	77.4%	78.9%	82.5%	⇧
PPMCO	67.6%	72.5%	83.1%	77.6%	78.3%	⇧
UHC	67.7%	61.5%	69.8%	72.1%	69.9%	⇩
UMHP	NA▫	NA▫	NA▫	73.5%	62.8%	⇩
MARR	67.3%	70.3%	75.2%	77.3%	74.5%	⇧

▫ 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 three rates separately and as a total rate.

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

Rationale

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

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

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

Summary of Changes for HEDIS 2018:

- Replaced medication table references with references to medication lists.
- Added “sacubitril-valsartan” to the description of Antihypertensive combinations in the ACE Inhibitor/ARB Medications List.

Annual Monitoring for Patients on Persistent Medications (MPM) - members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)						
	2014	2015	2016	2017	2018	NHM
ACC	89.0%	89.4%	90.5%	90.0%	88.9%	⇧
JMS	95.1%	94.4%	96.5%	97.0%	94.7%	⇧
KPMAS		95.0%	92.8%	92.0%	90.3%	⇧
MPC	87.0%	88.4%	89.0%	88.5%	86.2%	⇩
MSFC	90.2%	90.0%	90.3%	89.3%	90.0%	⇧

Annual Monitoring for Patients on Persistent Medications (MPM) - members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)						
	2014	2015	2016	2017	2018	NHM
PPMCO	88.1%	88.1%	89.0%	88.4%	88.1%	⇔
UHC	88.6%	89.2%	88.7%	89.4%	89.3%	⇧
UMHP	NA▫	86.1%	86.1%	85.6%	85.2%	⇩
MARR	89.7%	90.1%	90.4%	90.0%	89.1%	⇧

▫ 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						
	2014	2015	2016	2017	2018	NHM
ACC	86.9%	88.42%	89.6%	89.0%	88.0%	⇧
JMS	94.1%	93.9%	95.6%	95.0%	93.7%	⇧
KPMAS		NA▫	90.8%	90.5%	88.6%	⇧
MPC	86.2%	86.5%	88.5%	88.0%	86.0%	⇩
MSFC	88.5%	89.0%	88.32%	87.5%	88.3%	⇧
PPMCO	87.4%	87.9%	88.30%	88.2%	88.3%	⇧
UHC	87.5%	88.40%	87.8%	88.8%	88.0%	⇧
UMHP	NA▫	90.5%	84.4%	86.6%	84.9%	⇩
MARR	88.4%	89.2%	89.2%	89.2%	88.2%	⇧

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

Annual Monitoring for Patients on Persistent Medications (MPM) - Total rate						
	2014	2015	2016	2017	2018	NHM
ACC	85.4%	88.9%	89.9%	89.0%	88.5%	⇧
JMS	94.1%	94.0%	95.9%	96.0%	94.2%	⇧
KPMAS		94.2%	91.8%	91.4%	89.6%	⇧
MPC	86.3%	87.2%	88.6%	88.1%	86.1%	⇩
MSFC	86.6%	89.3%	89.4%	88.4%	89.3%	⇧
PPMCO	87.3%	87.8%	88.5%	88.1%	88.2%	⇧
UHC	87.7%	88.7%	88.1%	88.9%	88.7%	⇧
UMHP	NA▫	87.9%	85.2%	85.9%	85.1%	⇩
MARR	87.9%	89.7%	89.7%	89.5%	88.7%	⇧

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

Ambulatory Care (utilization)

Ambulatory Care (AMB)

Description
This measure summarizes utilization of ambulatory care in the following categories:

- Outpatient Visits.
- ED Visits.

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

Summary of Changes to HEDIS 2018:
- Clarified how to identify an ED visit that resulted in an inpatient stay.
- Removed the AOD Rehab and Detox Value Set from the required exclusions (exclusions will be identified based on a principal diagnosis of chemical dependency).
- Revised the data elements tables to indicate that rates are calculated for the Visits/1,000 Member Months/ Years in the unknown category.

Ambulatory Care (AMB) – Outpatient visits per 1,000 member months						
	2014	2015	2016	2017	2018	NHM
ACC	365.1	356.0	372.6	366.86	354.32	⇩
JMS	340.8	315.5	345.1	350.64	328.72	⇩
KPMAS		404.4	324.9	336.59	315.93	⇩
MPC	365.3	365.0	406.4	420.40	397.45	⇧
MSFC	344.5	360.0	358.6	359.78	356.20	⇩
PPMCO	386.6	390.7	406.5	NA▫	390.27	⇧
UHC	373.3	381.6	378.1	367.49	345.15	⇩
UMHP	269.8	296.8	332.6	247.26	332.21	⇩
MARR	349.3	358.8	365.6	349.86	352.53	⇩

Ambulatory Care (AMB) – Emergency department (ED) visits per 1,000 member months						
	2014	2015	2016	2017	2018	NHM
ACC	56.2	58.2	55.1	53.43	50.59	⇩
JMS	90.1	96.4	94.0	93.62	82.98	⇧
KPMAS		23.2	24.9	26.28	26.63	⇩
MPC	74.6	70.9	71.0	68.50	61.86	⇩
MSFC	62.66	57.4	56.1	55.64	53.51	⇩
PPMCO	62.70	62.0	60.1	NA▫	57.99	⇩

Ambulatory Care (AMB) – Emergency department (ED) visits per 1,000 member months						
	2014	**2015**	**2016**	**2017**	**2018**	**NHM**
UHC	62.1	63.1	59.5	56.84	51.73	⇩
UMHP	66.0	64.9	89.8	86.43	60.71	⇩
MARR	67.8	62.0	63.8	62.96	55.75	⇩

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 2018:
- No changes to this measure.

Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery / 1000 MM 45 - 64 F						
	2014*	2015	2016	2017	2018	NHM
ACC		0.05	0.05	0.05	0.07	⇔
JMS		0.02	0.00	0.59	0.02	⇩
KPMAS		0.00	0.00	0.05	0.07	⇔
MPC		0.05	0.068	0.04	0.04	⇩
MSFC		0.07	0.10	0.07	0.05	⇩
PPMCO		0.05	0.06	0.03	0.05	⇩
UHC		0.04	0.04	0.05	0.04	⇩
UMHP		0.03	0.12	0.07	0.02	⇩
MARR		0.04	0.074	0.12	0.05	⇩

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

Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery / 1000 MM 45 - 64 M						
	2014*	2015	2016	2017	2018	NHM
ACC		0	0.007	0.01	0.00	⇩
JMS		0.016	0.00	0.50	0.00	⇩
KPMAS		0	0.00	NA▫	0.00	⇩
MPC		0	0.015	0.01	0.01	⇔
MSFC		0	0.015	0.01	0.00	⇩
PPMCO		0.01	0.03	NA▫	0.00	⇩
UHC		0.018	0.010	0.01	0.01	⇔

Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery / 1000 MM 45 - 64 M						
	2014*	2015	2016	2017	2018	NHM
UMHP		0.04	0.00	NA▫	0.00	⇩
MARR		0.02	0.015	0.11	0.00	⇩

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

Frequency of Selected Procedures (FSP) – Tonsillectomy / 1000 MM 0 - 9						
	2014*	2015	2016	2017	2018	NHM
ACC		0.42	0.48	0.48	0.53	⇩
JMS		0.18	0.13	0.21	0.11	⇩
KPMAS		0.13	0.00	0.23	0.26	⇩
MPC		0.47	0.55	0.62	0.58	⇩
MSFC		0.38	0.45	0.48	0.48	⇩
PPMCO		0.60	0.64	0.58	0.58	⇩
UHC		0.42	0.51	0.51	0.50	⇩
UMHP		0.20	0.31	0.37	0.36	⇩
MARR		0.35	0.44	0.44	0.42	⇩

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

Frequency of Selected Procedures (FSP) – Tonsillectomy / 1000 MM 10 - 19						
	2014*	2015	2016	2017	2018	NHM
ACC		0.15	0.186	0.14	0.16	⇩
JMS		0.5	0.18	0.17	0.05	⇩
KPMAS		0.20	0.00	0.20	0.14	⇩
MPC		0.20	0.26	0.26	0.20	⇩
MSFC		0.17	0.19	0.24	0.17	⇩
PPMCO		0.24	0.25	0.24	0.23	⇩
UHC		0.19	0.194	0.20	0.21	⇩
UMHP		0.9	0.16	0.34	0.22	⇩
MARR		0.16	0.20	0.22	0.17	⇩

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

Frequency of Selected Procedures (FSP) – Hysterectomy, abdominal / 1000 MM 45 - 64 F						
	2014*	2015	2016	2017	2018	NHM
ACC		0.45	0.31	0.27	0.28	⇔
JMS		0.43	0.36	0.31	0.16	⇩
KPMAS		0.01	0.00	0.26	0.25	⇩
MPC		0.49	0.32	0.27	0.24	⇩
MSFC		0.53	0.47	0.30	0.27	⇩

Frequency of Selected Procedures (FSP) – Hysterectomy, abdominal / 1000 MM 45 - 64 F						
	2014*	2015	2016	2017	2018	NHM
PPMCO		0.352	0.45	0.26	0.31	⇧
UHC		0.46	0.28	0.28	0.20	⇩
UMHP		0.45	0.23	0.32	0.36	⇧
MARR		0.52	0.35	0.28	0.26	⇩

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

Frequency of Selected Procedures (FSP) – Hysterectomy, vaginal / 1000 MM 45 - 64 F						
	2014*	2015	2016	2017	2018	NHM
ACC		0.18	0.1510	0.15	0.11	⇩
JMS		0.2	0.00	0.02	0.00	⇩
KPMAS		0.0	0.00	0.20	0.23	⇧
MPC		0.15	0.24	0.19	0.11	⇩
MSFC		0.16	0.22	0.27	0.17	⇩
PPMCO		0.19	0.31	0.17	0.20	⇔
UHC		0.19	0.15	0.17	0.12	⇩
UMHP		0.11	0.17	0.17	0.15	⇩
MARR		0.14	0.21	0.17	0.14	⇩

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

Frequency of Selected Procedures (FSP) – Cholecystectomy, open / 1000 MM 30 - 64 M						
	2014*	2015	2016	2017	2018	NHM
ACC		0.04	0.022	0.04	0.02	⇩
JMS		0.031	0.0569	0.02	0.05	⇧
KPMAS		0.0	0.00	0.03	0.02	⇩
MPC		0.07	0.04	0.07	0.04	⇧
MSFC		0.06	0.0574	0.06	0.03	⇔
PPMCO		0.05	0.03	0.04	0.03	⇔
UHC		0.04	0.018	0.04	0.03	⇔
UMHP		0.0	0.00	0.05	0.00	⇩
MARR		0.05	0.039	0.04	0.03	⇔

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

Frequency of Selected Procedures (FSP) – Cholecystectomy, open / 1000 MM 45 - 64 F						
	2014*	2015	2016	2017	2018	NHM
ACC		0.04	0.022	0.04	0.04	⇔
JMS		0.031	0.0569	0.02	0.02	⇩
KPMAS		0.0	0.00	0.03	0.00	⇩

Frequency of Selected Procedures (FSP) – Cholecystectomy, open / 1000 MM 45 - 64 F						
	2014*	2015	2016	2017	2018	NHM
MPC		0.07	0.04	0.07	0.04	⇔
MSFC		0.06	0.0574	0.06	0.03	⇩
PPMCO		0.05	0.03	0.04	0.04	⇔
UHC		0.04	0.018	0.04	0.03	⇩
UMHP		0.0	0.00	0.05	0.09	⇧
MARR		0.05	0.039	0.04	0.04	⇔

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

Frequency of Selected Procedures (FSP) – Cholecystectomy, Laparoscopic / 1000 MM 30 - 64 M						
	2014*	2015	2016	2017	2018	NHM
ACC		0.04	0.022	0.04	0.20	⇩
JMS		0.031	0.0569	0.02	0.04	⇩
KPMAS		0.0	0.00	0.03	0.07	⇩
MPC		0.07	0.04	0.07	0.24	⇩
MSFC		0.06	0.0574	0.06	0.14	⇩
PPMCO		0.05	0.03	0.04	0.21	⇩
UHC		0.04	0.018	0.04	0.19	⇩
UMHP		0.0	0.00	0.05	0.19	⇩
MARR		0.05	0.039	0.04	0.16	⇩

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

Frequency of Selected Procedures (FSP) – Cholecystectomy, Laparoscopic / 1000 MM 45 - 64 F						
	2014*	2015	2016	2017	2018	NHM
ACC		0.48	0.36	0.51	0.49	⇩
JMS		0.18	0.29	0.19	0.30	⇩
KPMAS		0.0	0.00	0.24	0.38	⇩
MPC		0.668	0.62	0.55	0.53	⇩
MSFC		0.68	0.40	0.56	0.27	⇩
PPMCO		0.65	0.69	0.51	0.53	⇩
UHC		0.59	0.44	0.42	0.36	⇩
UMHP		0.34	0.43	0.32	0.60	⇔
MARR		0.51	0.46	0.41	0.44	⇩

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

Frequency of Selected Procedures (FSP) – Back Surgery / 1000 MM 45 - 64 F						
	2014*	2015	2016	2017	2018	NHM
ACC		0.41	0.46	0.53	0.50	⇩

Frequency of Selected Procedures (FSP) – Back Surgery / 1000 MM 45 - 64 F						
	2014*	2015	2016	2017	2018	NHM
JMS		0.58	0.56	0.59	0.33	⇩
KPMAS		0.0	0.00	0.14	0.05	⇩
MPC		0.65	0.81	0.86	0.72	⇧
MSFC		0.56	0.67	0.58	0.46	⇩
PPMCO		0.77	0.74	0.62	0.69	⇧
UHC		0.54	0.60	0.54	0.55	⇧
UMHP		0.3	0.43	0.39	0.54	⇔
MARR		0.54	0.61	0.53	0.480	⇩

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

Frequency of Selected Procedures (FSP) – Back Surgery / 1000 MM 45 - 64 M						
	2014*	2015	2016	2017	2018	NHM
ACC		0.43	0.58	0.42	0.50	⇩
JMS		0.42	0.41	0.50	0.56	⇩
KPMAS		0.0	0.00	0.16	0.15	⇩
MPC		0.65	0.85	0.84	0.72	⇧
MSFC		0.51	0.69	0.68	0.71	⇧
PPMCO		0.65	0.80	0.82	0.77	⇧
UHC		0.62	0.83	0.70	0.63	⇧
UMHP		0.38	0.47	0.39	0.47	⇩
MARR		0.52	0.66	0.56	0.56	⇩

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

Frequency of Selected Procedures (FSP) – Mastectomy / 1000 MM 15 - 44 F						
	2014*	2015	2016	2017	2018	NHM
ACC		0.022	0.0226	0.03	0.04	⇧
JMS		0.03	0.050	0.00	0.00	⇩
KPMAS		0.00	0.00	0.00	0.00	⇩
MPC		0.026	0.045	0.02	0.04	⇧
MSFC		0.016	0.01	0.04	0.05	⇧
PPMCO		0.036	0.035	0.02	0.04	⇧
UHC		0.041	0.0233	0.03	0.03	⇔
UMHP		0.00	0.051	0.04	0.00	⇩
MARR		0.028	0.034	0.02	0.03	⇔

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

Frequency of Selected Procedures (FSP) – Mastectomy / 1000 MM 45 - 64 F						
	2014*	2015	2016	2017	2018	NHM
ACC		0.16	0.13	0.18	0.12	⇩
JMS		0.4	0.07	0.02	0.02	⇩
KPMAS		0	0.00	0.15	0.09	⇩
MPC		0.14	0.12	0.08	0.10	⇩
MSFC		0.11	0.10	0.06	0.11	⇩
PPMCO		0.21	0.23	0.11	0.12	⇩
UHC		0.19	0.171	0.13	0.10	⇩
UMHP		0.18	0.173	0.07	0.13	⇩
MARR		0.15	0.14	0.1	0.10	⇩

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

Frequency of Selected Procedures (FSP) – Lumpectomy / 1000 MM 15 - 44 F						
	2014*	2015	2016	2017	2018	NHM
ACC		0.14	0.113	0.09	0.10	⇩
JMS		0.0	0.07	0.05	0.06	⇩
KPMAS		0.0	0.00	0.06	0.04	⇩
MPC		0.13	0.106	0.12	0.10	⇩
MSFC		0.18	0.20	0.12	0.13	⇧
PPMCO		0.15	0.14	0.12	0.13	⇧
UHC		0.12	0.107	0.11	0.10	⇩
UMHP		0.10	0.05	0.08	0.08	⇩
MARR		0.14	0.111	0.09	0.09	⇩

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

Frequency of Selected Procedures (FSP) – Lumpectomy / 1000 MM 45 - 64 F						
	2014*	2015	2016	2017	2018	NHM
ACC		0.365	0.27	0.33	0.34	⇩
JMS		0.21	0.25	0.19	0.14	⇩
KPMAS		0.10	0.00	0.41	0.28	⇩
MPC		0.29	0.28	0.37	0.26	⇩
MSFC		0.41	0.52	0.36	0.45	⇧
PPMCO		0.49	0.42	0.32	0.35	⇔
UHC		0.371	0.38	0.29	0.33	⇩
UMHP		0.27	0.14	0.37	0.30	⇩
MARR		0.43	0.32	0.33	0.31	⇩

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

Standardized Healthcare-Associated Infection Ratio (HAI)

Description

Hospital-reported standard infection ratios (SIR) for four different healthcare-associated infections (HAI), adjusted for the proportion of members discharged from each acute care hospital. The measure reports the percentage of total discharges from hospitals with a high, moderate, low or unavailable SIR, next to a total plan-weighted SIR for each of the following infections:

- *HAI-1:* Central line-associated blood stream infections (CLABSI).
- *HAI-2:* Catheter-associated urinary tract infections (CAUTI).
- *HAI-5:* Methicillin-resistant Staphylococcus aureus (MRSA) blood laboratory-identified events (bloodstream infections).
- *HAI-6:* Clostridium difficile laboratory-identified events (intestinal infections) (CDIFF).

Note: A lower SIR indicates better performance. SIRs >1.0 indicate that more infections occurred than expected; SIRs <1.0 indicate fewer infections occurred than expected.

Rationale

CDC's National Healthcare Safety Network (NHSN) is the nation's most widely used healthcare-associated infection (HAI) tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate healthcare-associated infections.
NHSN allows healthcare facilities to track blood safety errors and important healthcare process measures such as healthcare personnel influenza vaccine status and infection control adherence rates. NHSN provides medical facilities, states, regions, and the nation with data collection and reporting capabilities needed to:

- identify infection prevention problems by facility, state, or specific quality improvement project
- benchmark progress of infection prevention efforts
- comply with state and federal public reporting mandates, and ultimately,
- drive national progress toward elimination of HAIs.

Beginning decades ago with 300 hospitals, NHSN now serves over 17,000 medical facilities tracking HAIs. Current participants include acute care hospitals, long-term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgery centers, and nursing homes, with hospitals and dialysis facilities representing the majority of facilities reporting data. Participation among the other facility types is expected to continue to grow in coming years.

Summary of Changes to HEDIS 2018:

- Removed all references to "contracted" throughout the measure specification and the definition of "contracted acute care hospital." The Guidelines for Utilization Measures state that only services for which the organization paid or expects to pay should be included in the measure.
- Clarified how to classify hospitals as "Unavailable" in the "Hospital classification criteria" definition.
- Clarified that organizations must use the Provider ID in Table HSIR to assign discharges in step 3 in the Calculation of Hospital Discharge Weight.

- Clarified how to report hospitals from which plans have discharges, but that are not identifiable in Table HSIR in step 3 in the Calculation of Hospital Discharge Weight.
- Clarified how to report hospitals with an "Unavailable" SIR in Table HAI-1/2/3 in step 7 of the Calculation of Weighted Standardized Infection Ratios (SIR).
- Revised Table HAI-1/2/3 and added a reporting column, "Number of Hospitals with Inpatient Discharges."

Standardized Healthcare-Associated Infection Ratio (HAI) – Central line – associated blood stream infection (CLABSI) – Plan Weighted SIR					
	2014	**2015**	**2016**	**2017**	**2018**
ACC				1.05	0.90
JMS				0.93	0.61
KPMAS				1.37	0.98
MPC				0.15	1.04
MSFC				0.98	0.73
PPMCO				0.01	0.01
UHC				1.04	0.93
UMHP				1.25	1.04
MARR				0.85	0.78
NHM			0.99	0.7385	
2017 NCQA Benchmarks	**25th**	**50th**	**75th**	**90th**	
	0.4209	**0.6576**	**0.9017**	**1.2444**	

Standardized Healthcare-Associated Infection Ratio (HAI) – Catheter – Associated Urinary Tract Infection (CAUTI) – Plan Weighted SIR					
	2014	**2015**	**2016**	**2017**	**2018**
ACC				0.79	0.92
JMS				0.78	0.74
KPMAS				0.80	0.65
MPC				0.18	1.03
MSFC				1.04	1.11
PPMCO				0.01	0.01
UHC				1.04	1.03
UMHP				1.08	0.94
MARR				0.72	0.80
NHM			0.93	0.7641	
2017 NCQA Benchmarks	**25th**	**50th**	**75th**	**90th**	
	0.4293	**0.6941**	**0.8425**	**1.1536**	

Standardized Healthcare-Associated Infection Ratio (HAI) – MRSA bloodstream infection (MRSA) – Plan Weighted SIR					
	2014	**2015**	**2016**	**2017**	**2018**
ACC				0.83	0.84
JMS				1.23	0.90
KPMAS				0.77	0.51
MPC				0.28	1.08
MSFC				1.03	1.14
PPMCO				0.01	0.01
UHC				0.62	0.99
UMHP				0.97	0.88
MARR				0.72	0.79
NHM			1.01	0.7264	
2017 NCQA Benchmarks*	**25th**	**50th**	**75th**	**90th**	
	0.3445	**0.612**	**0.9506**	**1.2485**	

Standardized Healthcare-Associated Infection Ratio (HAI) – Clostridium Difficile Intestinal Infection (CDIFF) – Plan Weighted SIR					
	2014	**2015**	**2016**	**2017**	**2018**
ACC				1.03	0.92
JMS				0.89	0.63
KPMAS				1.44	1.16
MPC				0.42	1.00
MSFC				0.98	0.94
PPMCO				0.01	0.02
UHC				1.38	0.94
UMHP				1.21	0.92
MARR				0.92	0.82
NHM			0.95	0.8075	
2017 NCQA Benchmarks*	**25th**	**50th**	**75th**	**90th**	
	0.4848	**0.7877**	**0.9273**	**1.154**	

Inpatient Utilization - General Hospital/Acute Care (IPU)

Description

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

- Total inpatient.
- Maternity.
- Surgery.
- Medicine.

Rationale

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

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

Summary of Changes to HEDIS 2018:

- Revised the data elements tables to indicate that rates are calculated for the Discharges/1,000 Member Months/Years in the unknown category.

Inpatient Utilization - General Hospital/Acute Care (IPU) Total Inpatient: Total Discharges / 1000 Member Months (MM)						
	2014*	2015	2016	2017	2018	NHM
ACC		5.9	5.83	5.23	5.05	⇩
JMS		9.9	10.06	9.53	9.19	⇧
KPMAS		6.4	5.49	5.33	5.62	⇩
MPC		6.5	6.84	6.58	6.46	⇩
MSFC		7.01	6.67	6.83	6.56	⇩
PPMCO		6.6	6.75	6.49	6.81	⇩
UHC		7.2	6.60	4.91	5.58	⇩
UMHP		6.7	8.59	6.91	7.20	⇩
MARR		0.43	0.32	0.33	6.56	⇩

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

Inpatient Utilization - General Hospital/Acute Care (IPU) Total Inpatient: Total Average Length of Stay						
	2014*	2015	2016	2017	2018	NHM
ACC		3.96	4.14	4.17	4.44	⇧
JMS		4.12	4.81	4.47	4.64	⇧
KPMAS		4.59	3.34	3.36	3.45	⇩
MPC		3.66	3.75	3.87	2.53	⇩
MSFC		4.03	4.22	4.18	4.78	⇧
PPMCO		3.85	4.06	4.09	4.44	⇧
UHC		4.12	4.23	4.40	4.44	⇧
UMHP		3.72	3.47	3.51	3.54	⇩
MARR		4.01	4.00	4.01	4.03	⇩

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

Antibiotic Utilization (ABX)

Description

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

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

Rationale

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

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

Summary of Changes to HEDIS 2018:

- Replaced medication table references with references to medication lists.

Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics

	2014*	2015	2016	2017	2018	NHM
ACC		0.87	0.85	0.84	0.79	⇩
JMS		0.88	0.87	0.79	0.80	⇩
KPMAS		0.68	0.67	0.58	0.60	⇩
MPC		1.03	1.10	1.09	1.01	⇧
MSFC		0.86	0.88	0.90	0.86	⇩
PPMCO		0.97	0.97	0.98	0.93	⇩
UHC		0.98	0.92	0.91	0.85	⇩
UMHP		0.77	0.85	0.86	0.81	⇩
MARR		0.878	0.89	0.87	0.83	⇩

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

Antibiotic Utilization (ABX) – Average Days Supplied per Antibiotic Script						
	2014*	2015	2016	2017	2018	NHM
ACC		9.29	9.35	9.28	9.26	⇩
JMS		8.98	9.00	8.67	7.74	⇩
KPMAS		8.99	9.46	9.29	9.28	⇩
MPC		9.40	9.32	9.30	9.24	⇩
MSFC		9.23	9.10	8.94	8.86	⇩
PPMCO		9.39	9.42	9.32	9.34	⇩
UHC		9.26	9.35	9.09	9.25	⇩
UMHP		9.21	9.28	9.32	9.22	⇩
MARR		9.22	9.28	9.15	9.02	⇩

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

Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics of Concern						
	2014*	2015	2016	2017	2018	NHM
ACC		0.350	0.35	0.34	0.31	⇩
JMS		0.29	0.29	0.26	0.26	⇩
KPMAS		0.27	0.25	0.22	0.22	⇩
MPC		0.41	0.45	0.45	0.41	⇔
MSFC		0.34	0.35	0.36	0.33	⇩
PPMCO		0.39	0.39	0.40	0.37	⇩
UHC		0.43	0.41	0.40	0.35	⇩
UMHP		0.32	0.38	0.38	0.34	⇩
MARR		0.351	0.36	0.35	0.32	⇩

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

Antibiotic Utilization (ABX) – Percentage of Antibiotics of Concern of all Antibiotics						
	2014*	2015	2016	2017	2018	NHM
ACC		40.39%	40.8%	40.35	38.80%	⇩
JMS		33.0%	33.7%	33.08	32.51%	⇩
KPMAS		40.5%	37.8%	38.16	35.93%	⇩
MPC		39.8%	40.8%	41.26	40.40%	⇩
MSFC		40.2%	40.1%	40.49	39.01%	⇩
PPMCO		40.38%	40.7%	41.51	39.31%	⇩
UHC		43.2%	44.3%	43.74	41.64%	⇩
UMHP		42.1%	44.6%	44.32	42.16%	⇧
MARR		39.9%	40.3%	40.36	38.72%	⇩

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

Board Certification (BCR)

Description

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

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

Board certification refers to the various specialty certification programs of the American Board of Medical Specialties and the American Osteopathic Association. Report each product separately as of December 31 of the measurement year.

Product lines

Commercial, Medicaid, Medicare (report each product line separately).

Physicians

This measure applies to independent physicians or group of physicians who provide care for members.

***Organizations must* include:**

- Physicians who have an independent relationship with the organization. An independent relationship exists when an organization selects and directs its members to see a specific physician or group of physicians. An independent relationship is not synonymous with an "independent contract." Physicians may contract with the organization directly or indirectly (e.g., physicians contract with an IPA).
- Physicians who are listed in the organization's directory.
- Physicians who see members outside of the inpatient hospital setting or outside of free-standing facilities.
- Physicians who are hospital based and who see members as a result of their independent relationship with the organization; for example:
  - Anesthesiologists with pain management practices.
  - Hospital-based cardiologists.
  - Hospital-based faculty (who meet the criteria above).

***Organizations must* exclude:**

- Physicians who practice exclusively within the inpatient hospital setting and who provide care for members only as a result of members being directed to the hospital; for example:
  - Pathologists.
  - Radiologists.
  - Anesthesiologists.
  - Hospitalists.
  - Neonatologists.
  - ED physicians.
- Chiropractors.
- Podiatrists.
- Physicians who practice exclusively within free-standing facilities and who provide care for members only as a result of members being directed to the facility; for example:
  - Mammography centers.
  - Urgent care centers.

- Surgicenters.

- Dentists who do not provide care under the organization's medical benefits; for example:
  - Endodontists.
  - Oral surgeons.
  - Periodontists.
- Dentists who provide primary dental care under a dental plan or rider.

Summary of Changes to HEDIS 2018:

- No changes to this measure.

Board Certification (BCR)

		Family Medicine	Internal Medicine	OB/GYN	Pediatrician	Geria-tricians	Other Specialists
ACC	# of Physicians	798	3083	697	1588	133	5271
	# Board Certified	472	2229	527	1243	81	4080
	Percentage	59.15%	72.30%	75.61%	78.27%	60.90%	77.40%
JMS	# of Physicians	78	597	208	194	37	2477
	# Board Certified	63	533	170	176	34	2119
	Percentage	80.77%	89.28%	81.73%	90.72%	91.89%	85.55%
KPMAS	# of Physicians	208	454	183	110	5	1112
	# Board Certified	192	436	156	101	5	1063
	Percentage	92.31%	96.04%	85.25%	91.82%	100.00 %	95.59%
MPC	# of Physicians	623	1294	814	1021	19	4759
	# Board Certified	396	979	436	792	15	3363
	Percentage	63.56%	75.66%	53.56%	77.57%	78.95%	70.67%
MSFC	# of Physicians	290	477	152	311	8	1924
	# Board Certified	203	325	85	194	7	1267
	Percentage	70.00%	68.13%	55.92%	62.38%	87.50%	65.85%
PPMCO	# of Physicians	656	1012	846	882	50	12803
	# Board Certified	622	955	797	849	49	11934
	Percentage	94.82%	94.37%	94.21%	96.26%	98.00%	93.21%
UHC	# of Physicians	791	2442	800	1507	91	5870
	# Board Certified	565	1873	673	1213	56	4568
	Percentage	71.43%	76.70%	84.13%	80.49%	61.54%	77.82%
UMHP	# of Physicians	704	853	638	628	36	4147
	# Board Certified	565	672	431	485	26	2354
	Percentage	80.26%	78.78%	67.55%	77.23%	72.22%	56.76%

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 2018:
- No changes to this measure.

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

	Male	Female	Total
ACC	1,517,147	1,787,702	3,304,849
JMS	163,317	143,292	306,609
KPMAS	321,102	373,694	694,796
MPC	1,146,162	1,412,334	2,558,496
MSFC	466,059	556,051	1,022,110
PPMCO	1,542,521	1,914,988	3,457,509
UHC	858,840	985,663	1,844,503
UMHP	241,940	231,236	473,176

Enrollment by State (EBS)

Description
The number of members enrolled as of December 31 of the measurement year, by state.

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Anchor Date December 31 of the measurement year.

Summary of Changes to HEDIS 2018:
- No changes to this measure.

Enrollment by State (EBS) – Maryland only

ACC	275,302
JMS	26,342
KPMAS	64,778
MPC	216,647
MSFC	89,923
PPMCO	298,740
UHC	151,443
UMHP	43,709

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 2018:

- No changes to this measure.

Language Diversity of Membership (LDM) – Spoken

		English	Non-English	Unknown	Declined
ACC	Number	10	13,260	311,616	0
	Percent	0.00%	4.08%	95.92%	0.00%
JMS	Number	21,658	0	10,578	0
	Percent	67.19%	0.00%	32.81%	0.00%
KPMAS	Number	66,554	8,693	186	32
	Percent	88.19%	11.52%	0.25%	0.04%
MPC	Number	248,957	2,363	7,161	0
	Percent	96.32%	0.91%	2.77%	0.00%
MSFC	Number	0	0	111,000	0
	Percent	0.00%	0.00%	100.00%	0.00%
PPMCO	Number	0	0	347,187	0
	Percent	0.00%	0.00%	100.00%	0.00%
UHC	Number	10,703	3,991	172,769	0
	Percent	5.71%	2.13%	92.16%	0.00%
UMHP	Number	0	0	55,575	0
	Percent	0.00%	0.00%	100.00%	0.00%

Race/Ethnicity Diversity of Membership (RDM)

Description

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

Summary of Changes to HEDIS 2018:

- 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	57,491	123,759	0	14,050	409	0	0	129,177	0
	Percent	17.70%	38.09%	0.00%	4.32%	0.13%	0.00%	0.00%	39.76%	0.00%
JMS	Number	4,103	19,349	137	962	44	0	0	7,641	0
	Percent	12.73%	60.02%	0.42%	2.98%	0.14%	0.00%	0.00%	23.70%	0.00%
KPMAS	Number	14,397	42,260	159	5,674	49	1,678	366	10,643	239
	Percent	19.08%	56.00%	0.21%	7.52%	0.06%	2.22%	0.48%	14.10%	0.32%
MPC	Number	84,767	93,905	0	9,136	327	744	0	69,602	0
	Percent	32.79%	36.33%	0.00%	3.53%	0.13%	0.29%	0.00%	26.93%	0.00%
MSFC	Number	29,346	0	0	5,802	0	881	0	74,469	502
	Percent	26.44%	0.00%	0.00%	5.23%	0.00%	0.79%	0.00%	67.09%	0.45%
PPMCO	Number	105,277	122,749	2	0	13,327	0	0	2,390	103,442
	Percent	30.32%	35.36%	0.00%	0.00%	3.84%	0.00%	0.00%	0.69%	29.79%
UHC	Number	61,302	78,956	0	11,135	281	0	0	35,789	0
	Percent	32.70%	42.12%	0.00%	5.94%	0.15%	0.00%	0.00%	19.09%	0.00%
UMHP	Number	16,300	19,152	0	2,486	98	0	0	472	17,067
	Percent	29.33%	34.46%	0.00%	4.47%	0.18%	0.00%	0.00%	0.85%	30.71%

Total Membership (TLM)

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

Summary of Changes to HEDIS 2018:

- No changes to this measure.

Total Membership (TLM) – Medicaid only

-	
ACC	279,955
JMS	26,356
KPMAS	65,054
MPC	219,585
MSFC	90,725
PPMCO	299,018
UHC	155,457
UMHP	44,752

IMPLICATIONS AND DISCUSSION

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

HealthChoice Plans: HEDIS Year 2018 Highlights

- The MARR for Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) increased by 6.9% from the prior year due to improved performance amongst all MCOs. Six out of eight MCOs experienced significant improvement of greater than 5% from the prior year.

- All MCOs, with the exception of MedStar Family Care and Kaiser experienced a decline in the reported rate for Childhood Immunizations Status- Combination 3 (CIS). The most significant declines were seen by UnitedHealthCare who had a 7.1% decline in rate from the prior year, and Maryland Physician Care whose performance declined 14% from the prior year.

- Immunizations for Adolescents-Combination 2 (IMA) saw improvement amongst all MCOs in 2017. There was a significant change made to the measure specification numerator criteria in 2017 that likely attributed to the improvement in performance. The updated specifications allow for two HPV vaccine, where prior specifications required three doses of the HPV vaccine.

- Persistence of Beta-Blocker Treatment after a Heart Attack (PBH) all MCOs except MedStar Family Care saw a decline in performance from the prior year. This decline in reported rates from the majority of MCOs caused the MARR to drop 6.3% for the 2017 measurement year. It should be noted, that while the eligible population for each MCO exceeded 30 members, the minimum number of members to report the measure, the eligible populations are still relatively small for each MCO, which can result in volatility of the reported rate year-to-year.

- Overall, utilization slightly increased for Inpatient and Outpatient settings, while Emergency Department utilization experienced a significant decline.
  - Inpatient Utilization – General Hospital/Acute Care (IPU) total discharges/1000 members months was stable in 2017 for seven of the eight MCOs experiencing only minor changes in reported rates from the prior year. UnitedHealthCare, experienced a significant change in the utilization rate. The United HealthCare reported rate increased by approximately 10% from the prior year.
  - Ambulatory Care (AMB) experienced a decrease in Emergency Department Visits for all MCOs except Kaiser Permanente. Jai Medical and University of Maryland experienced the most significant declines, each experiencing a greater than 10% change in the reported rate from the prior year. The decline in Emergency Department utilization amongst the MCOs resulted in an approximately 11% decrease to the MARR for this measure.
  - Ambulatory Care (AMB) Outpatient visits declined amongst all MCOs with the exception of University of Maryland Health Partners who experienced 34% increase in the number of outpatient visits per 1000 months.