Statewide Executive Summary

HealthChoice and Primary Adult Care Participating Organizations
HEDIS® 2014

Prepared for:

Maryland Department of Health and Mental Hygiene

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Prepared by:

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

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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 seven organizations participating in HealthChoice, with a total of 910,232 enrollees as of December 31, 2013.

In July 2006, the Maryland Department of Health and Mental Hygiene (DHMH) combined two of its programs, Maryland Pharmacy Assistance and Maryland Primary Care, to form a new Medical Assistance program called Primary Adult Care (PAC). PAC offers healthcare services to low-income Maryland residents, 19 years of age and older, who are not eligible for full Medicaid benefits. Four organizations currently participate in PAC, with a total of 1,065 enrollees as of December 31, 2013. The PAC program ended December 31, 2013 and HEDIS 2014 will be the last audit year. The PAC program ended as a result of the implementation of the Affordable Care Act (ACA), which provided for Medicaid expansion and transferred former PAC recipients to full Medicaid benefits.

Within DHMH, the HealthChoice & Acute Care Administration is responsible for the quality oversight of the HealthChoice and PAC programs. DHMH continues to measure HealthChoice program clinical quality performance and enrollee satisfaction using initiatives including Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Health Plans Survey (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. In 2007, DHMH announced its intention to collect HEDIS results from each organization offering PAC for a subset of the HEDIS measures already being reported by HealthChoice organizations. All seven HealthChoice organizations reported HEDIS in 2014. Four PAC organizations reported HEDIS in 2014.

Organizations reporting HEDIS in 2014

Acronym used in this report	Organization name	HealthChoice	PAC
ACC	AMERIGROUP Community Care	X	X
JMS	Jai Medical Systems	X	X
MPC	Maryland Physicians Care	X	
MSFC	MedStar Family Choice	X	
PP	Priority Partners	X	X
RHP*	Riverside Health Plan	X	
UHC	UnitedHealthcare	X	X

*New HealthChoice MCO in HEDIS 2014.

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HEDIS is one of the most widely used sets of healthcare performance measures in the United States. The program is developed and maintained by the National Committee for Quality Assurance (NCQA). NCQA develops and publishes specifications for data collection and results calculation in order to promote a high degree of standardization of HEDIS results. NCQA requires that the reporting entity register with NCQA and undergo a HEDIS Compliance Audit™. To ensure a standardized audit methodology, only NCQA-licensed organizations using NCQA-certified auditors may conduct a HEDIS Compliance Audit. The audit conveys sufficient integrity to HEDIS data, such that it can be released to the public to provide consumers and purchasers with a means of comparing healthcare organization performance.

DHMH contracted with HealthcareData Company, LLC (HDC), a NCQA-Licensed Organization, to conduct HEDIS Compliance Audits of all HealthChoice and PAC organizations and to summarize the results. CAHPS is also sponsored by NCQA. DHMH contracted with an NCQA-certified HEDIS survey vendor to administer the survey to a random selection of HealthChoice and PAC enrollees.

I. Measures Designated for Reporting

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

Measures selected by DHMH for HealthChoice Reporting

DHMH required HealthChoice managed care organizations to report 32 HEDIS measures for services rendered in calendar year 2013. This required set reflected five additional measures for reporting from prior year:

- 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),
- and Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC).

Effectiveness of Care

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

Access/Availability of Care

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

Utilization and Relative Resource Use

Frequency of Ongoing Prenatal Care (FPC)
Well-Child Visits in the First 15 Months of Life (W15)
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
Adolescent Well-Care Visits (AWC)
Ambulatory Care (AMB)
Identification of Alcohol and Other Drug Services (IAD)

Measures selected by DHMH for Primary Adult Care (PAC) Performance Reporting

DHMH required Primary Adult Care (PAC) organizations to report five HEDIS measures for services rendered in calendar year 2013. This required set reflected no change from the prior year.

Effectiveness of Care

Breast Cancer Screening (BCS)
Cervical Cancer Screening (CCS)
Comprehensive Diabetes Care (CDC), all indicators except HbA1c good control (<7.0%)
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)

Access/Availability of Care

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

II. HEDIS Methodology

The HEDIS-reporting organization follows guidelines for data collection and specifications for measure calculation described in *HEDIS 2014 Volume 2: Technical Specifications*.

Data collection: The organization pulls together all data sources, typically into a data warehouse, against which HEDIS software programs are applied to calculate measures. Three approaches may be taken for data collection:

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

Supplemental data: NCQA defines supplemental data as atypical administrative data, i.e., not claims or encounters. Sources include immunization registry files, laboratory results files, case management databases, and medical record-derived databases.

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

NCQA specifies hybrid calculation methods, in addition to administrative methods, for several measures selected by DHMH for HEDIS reporting:

- Childhood Immunization Status (CIS)
- Immunizations for Adolescents (IMA)
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care (CDC)—HbA1c testing; HbA1c poor control >9.0; HbA1c control <8.0*
- Comprehensive Diabetes Care (CDC)—Eye exam (retinal) performed
- Comprehensive Diabetes Care (CDC)—LDL-C screening; LDL-C control <100mg/dL*
- Comprehensive Diabetes Care (CDC)—Medical attention for nephropathy
- Comprehensive Diabetes Care (CDC)—Blood pressure control <140/90 mm Hg;
- Comprehensive Diabetes Care (CDC)—Blood pressure control <140/80 mm Hg*
- Prenatal and Postpartum Care (PPC)
- Frequency of Ongoing Prenatal Care (FPC)
- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)
- Adult BMI Assessment (ABA)
- Controlling High Blood Pressure (CBP)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

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.

* An organization must use the same method for the group of indicators.

III. Measure-specific Findings

Three years of HealthChoice results are displayed in Table A, along with the 2014 Maryland Average Reportable Rate (MARR). Table A1 shows three years of PAC results, along with the MARR for the past three years. Due to NCQA licensing restrictions, the National HEDIS Mean (NHM) can no longer be displayed on Table A. In the report, the NMH has also been removed from each table. An "arrow" has been added to indicate if the HealthChoice's performance score is above, below, or equal to the NHM.

Measure-specific descriptions and five-year historical results are located on the pages that follow Table A.

Table A HealthChoice Organizations HEDIS 2014 Results

Table A – HealthChoice Organizations HEDIS 2014 Results, page one of four	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2014
	ACC			JMS			MPC			MSFC			PP			RHP			UHC			MARR
Adult BMI Assessment (ABA)	[1]	61.3%	72.0%	[1]	90.7%	80.2%	[1]	48.7%	70.2%	[1]	76.4%	82.6%	[1]	59.9%	82.9%	[1]		NA[2]	[1]	49.1%	68.9%	76.1%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	23.7%	20.6%	23.88%	21.9%	35.5%	35.2%	19.7%	19.9%	22.0%	16.1%	14.1%	15.2%	21.1%	18.9%	23.94%			NA[2]	19.6%	16.0%	20.8%	23.5%
Childhood Immunization Status (CIS) – Combination 2 (DTaP, IPV, MMR, HiB, Hep B, VZV)	85.6%	84.7%	81.3%	80.6%	86.1%	86.5%	81.8%	76.9%	73.7%	89.5%	85.4%	88.1%	86.0%	86.8%	83.1%			NA[2]	82.7%	70.3%	73.0%	80.9%
Childhood Immunization Status (CIS) – Combination 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV)	81.9%	83.5%	78.2%	78.7%	83.7%	86.1%	80.8%	74.3%	72.09%	87.6%	83.7%	85.9%	83.7%	83.8%	80.8%			NA[2]	78.8%	66.7%	71.3%	79.1%
Childhood Immunization Status (CIS) – Combination 4 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A)	39.1%	75.9%	73.6%	33.3%	80.9%	84.8%	32.8%	67.4%	62.8%	41.6%	80.3%	81.3%	38.8%	73.8%	69.4%			NA[2]	37.2%	58.9%	66.2%	73.0%
Childhood Immunization Status (CIS) – Combination 5 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV)	59.7%	61.3%	63.9%	57.9%	59.4%	71.7%	53.5%	55.3%	47.0%	63.3%	56.0%	70.1%	55.1%	59.6%	54.6%			NA[2]	57.2%	52.0%	56.9%	60.7%
Childhood Immunization Status (CIS) – Combination 6 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Influenza)	48.6%	49.7%	49.3%	33.3%	39.0%	47.8%	39.2%	42.4%	37.7%	57.4%	55.2%	59.4%	51.4%	51.5%	49.5%			NA[2]	41.8%	38.2%	44.3%	48.0%
Childhood Immunization Status (CIS) – Combination 7 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV)	30.1%	57.8%	60.7%	25.5%	59.0%	71.3%	20.2%	51.4%	44.0%	31.1%	54.3%	66.7%	25.3%	56.2%	50.7%			NA[2]	28.2%	47.2%	54.7%	58.0%
Childhood Immunization Status (CIS) – Combination 8 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, Influenza)	25.7%	47.3%	47.9%	21.3%	39.0%	47.4%	17.0%	38.7%	34.9%	28.2%	53.5%	56.2%	24.2%	48.3%	44.4%			NA[2]	21.7%	35.3%	41.4%	45.4%
Childhood Immunization Status (CIS) – Combination 9 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV, Influenza)	38.2%	38.5%	42.4%	25.0%	29.5%	40.9%	29.2%	33.8%	28.4%	43.8%	38.7%	49.9%	38.8%	41.1%	36.3%			NA[2]	32.8%	31.6%	37.0%	39.1%
Childhood Immunization Status (CIS) – Combination 10 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, Influenza)	20.6%	37.1%	41.2%	18.1%	29.5%	40.9%	12.2%	31.0%	27.7%	22.1%	37.7%	47.0%	17.9%	39.7%	34.3%			NA[2]	17.5%	29.2%	35.3%	37.7%
Immunizations for Adolescents (IMA) Combination 1 (Meningococcal, Tdap/Td)	56.7%	65.0%	69.4%	73.2%	70.66%	75.5%	51.1%	57.6%	62.7%	70.7%	70.69%	70.7%	52.0%	67.4%	74.5%			NA[2]	48.4%	56.4%	63.4%	67.2%
Well-Child Visits in the First 15 months of Life (W15) – No well-child visits[3]	1.6%	1.0%	1.012%	0.87%	2.7%	3.1%	1.4%	1.11%	0.5%	1.3%	1.013%	1.2%	1.1%	1.14%	1.1%			NA[2]	0.9%	2.2%	1.9%	1.5%
Well-Child Visits in the First 15 months of Life (W15) – DHMH Five or Six-or-more visits (rate constructed by adding together HEDIS five visits and six-or-more visits rates)	87.3%	86.1%	88.9%	84.0%	85.9%	84.4%	89.9%	77.8%	83.6%	88.2%	89.2%	86.0%	84.3%	84.3%	83.7%			NA[2]	86.8%	82.1%	87.4%	85.7%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	86.4%	83.6%	83.9%	88.9%	87.7%	88.9%	89.1%	87.5%	88.8%	82.3%	79.6%	83.5%	82.4%	80.7%	83.8%			NA[2]	83.1%	83.8%	75.0%	84.0%
Adolescent Well-Care Visits (AWC)	61.9%	68.1%	67.9%	79.9%	76.9%	76.7%	75.8%	60.2%	68.8%	67.7%	69.4%	67.8%	66.1%	67.6%	61.6%			NA[2]	55.7%	59.7%	60.8%	67.3%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - BMI Percentile- Total Rate	[5]	[5]	49.5%	[5]	[5]	92.2%	[5]	[5]	46.5%	[5]	[5]	59.8%	[5]	[5]	52.1%	[5]	[5]	NA[2]	[5]	[5]	45.5%	57.6%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate	[5]	[5]	59.0%	[5]	[5]	94.4%	[5]	[5]	54.4%	[5]	[5]	74.1%	[5]	[5]	54.2%	[5]	[5]	NA[2]	[5]	[5]	67.6%	67.3%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate	[5]	[5]	51.4%	[5]	[5]	89.8%	[5]	[5]	58.8%	[5]	[5]	72.9%	[5]	[5]	44.7%	[5]	[5]	NA[2]	[5]	[5]	60.6%	63.0%
Appropriate Testing for Children with Pharyngitis (CWP)	68.8%	75.9%	78.36%	74.5%	75.3%	70.8%	76.9%	77.4%	78.42%	85.9%	85.2%	86.9%	74.5%	78.2%	80.5%			NA[2]	76.4%	79.8%	83.1%	79.7%

[1] New measure for HEDIS 2013.
[2] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[3] A lower rate indicates better performance.
[5] New measure for HEDIS 2014.
MARR = Maryland Average Reportable Rate
ACC = AMERIGROUP Community Care JMS = Jai Medical Systems MPC = Maryland Physicians Care MSFC = MedStar Family Choice PP = Priority Partners RHP = Riverside Health Plan UHC = UnitedHealthcare

Table A – HealthChoice Organizations HEDIS 2014 Results, page two of four	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2014
	ACC			JMS			MPC			MSFC			PP			RHP			UHC			MARR
Use of Appropriate Medications for People with Asthma (ASM) – Ages 5–11	91.4%	88.7%	90.3%	94.2%	91.4%	93.59%	93.0%	92.3%	91.4%	96.7%	93.7%	93.62%	91.7%	92.3%	91.6%			NA[2]	95.7%	96.1%	91.9%	92.1%
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 12–18	88.2%	86.2%	87.8%	100.0%	92.9%	86.0%	91.1%	92.3%	90.4%	93.3%	90.2%	94.2%	90.8%	89.6%	88.5%			NA[2]	96.6%	93.4%	88.0%	89.1%
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 19–50	78.0%	79.5%	73.7%	91.3%	93.3%	81.3%	82.8%	81.8%	80.1%	85.2%	76.8%	75.2%	77.9%	80.7%	76.8%			NA[2]	95.1%	88.0%	72.9%	76.7%
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 51–64	71.2%	77.7%	68.6%	83.7%	82.0%	71.43%	81.7%	78.5%	76.3%	NA	77.1%	NA	69.2%	77.0%	73.0%			NA[2]	95.0%	94.1%	79.0%	73.7%
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 5–64	89.1%	86.5%	86.29%	95.7%	90.7%	83.6%	90.7%	88.7%	86.97%	95.5%	88.8%	90.1%	89.3%	88.9%	87.02%			NA[2]	96.7%	94.0%	86.28%	86.7%
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 5–50 [4]	88.5%	86.7%	86.8%	93.9%	92.5%	86.4%	89.8%	89.2%	87.53%	93.6%	89.4%	90.1%	88.9%	89.3%	87.6%			NA[2]	95.9%	94.0%	86.6%	87.51%
Medication Management for People With Asthma (MMA) – Total 50% of treatment period	[1]	44.8%	45.8%	[1]	53.2%	49.4%	[1]	49.4%	57.9%	[1]	52.4%	51.9%	[1]	40.3%	43.3%	[1]		NA[2]	[1]	47.3%	49.9%	49.7%
Medication Management for People With Asthma (MMA) – Total 75% of treatment period	[1]	24.1%	22.9%	[1]	28.9%	24.5%	[1]	26.6%	32.9%	[1]	28.7%	26.6%	[1]	19.7%	20.0%	[1]		NA[2]	[1]	26.7%	27.8%	25.8%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	86.13%	85.1%	86.5%	89.8%	85.2%	83.0%	86.08%	86.06%	86.6%	89.0%	86.13%	84.3%	86.01%	85.0%	86.0%			NA[2]	80.2%	80.1%	82.0%	84.7%
Asthma Medication Ratio (AMR)		[5]	68.59%		[5]	60.5%		[5]	69.1%		[5]	73.7%		[5]	69.6%		[5]	NA[2]		[5]	69.8%	68.56%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)		[5]	25.8%		[5]	26.3%		[5]	21.1%		[5]	34.5%		[5]	23.7%		[5]	NA[2]		[5]	25.6%	26.2%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate		[5]	73.6%		[5]	69.2%		[5]	72.6%		[5]	76.3%		[5]	69.7%		[5]	NA[2]		[5]	78.2%	73.3%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate		[5]	87.5%		[5]	82.5%		[5]	84.93%		[5]	90.3%		[5]	84.0%		[5]	NA[2]		[5]	84.88%	85.7%
Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 12–24 months	97.45%	97.5%	97.8%	92.9%	91.1%	94.7%	96.8%	97.1%	96.5%	96.6%	96.6%	96.4%	91.4%	90.3%	89.8%			NA[2]	97.41%	96.7%	96.3%	96.6%
Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 25 months–6 years	92.8%	92.6%	92.8%	89.3%	90.4%	88.7%	90.7%	89.0%	90.0%	91.4%	90.3%	89.8%	92.9%	92.5%	93.5%			NA[2]	92.1%	91.1%	91.1%	90.8%
Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 7–11 years	93.6%	93.9%	94.3%	94.0%	93.3%	93.8%	92.0%	91.5%	92.1%	92.9%	92.5%	93.5%	90.9%	92.5%	92.7%			NA[2]	93.0%	93.3%	93.1%	93.5%
Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 12–19 years	89.3%	89.5%	90.5%	92.4%	91.7%	90.8%	88.4%	87.7%	88.5%	90.9%	92.5%	92.7%	79.6%	79.9%	79.7%			NA[2]	88.5%	89.2%	90.1%	90.7%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 years	80.4%	79.7%	79.4%	75.5%	74.8%	72.9%	81.2%	81.4%	81.1%	79.6%	79.9%	79.7%	85.9%	86.2%	86.9%			NA[2]	80.3%	80.2%	80.36%	79.2%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years	87.0%	86.4%	87.2%	88.8%	87.8%	86.58%	87.28%	86.8%	87.8%	85.9%	86.2%	86.9%	0.0%	0.0%	0.0%			NA[2]	87.31%	87.5%	87.8%	87.5%
Breast Cancer Screening (BCS)	48.5%	49.1%	58.1%	63.9%	60.8%	69.4%	43.6%	43.9%	48.5%	54.5%	56.8%	64.4%	49.9%	51.5%	57.0%			NA[2]	46.6%	48.4%	52.7%	58.3%
Cervical Cancer Screening (CCS)	75.71%	73.6%	79.64%	78.5%	80.9%	79.5%	73.6%	74.0%	79.58%	75.74%	70.9%	74.0%	73.9%	75.0%	75.9%			NA[2]	69.5%	69.8%	62.8%	75.2%
Chlamydia Screening in Women (CHL) – Age 16–20 years	61.1%	62.6%	62.4%	84.0%	81.1%	86.7%	58.5%	58.1%	58.2%	57.4%	59.6%	54.8%	62.6%	61.8%	61.5%			NA[2]	57.1%	56.9%	55.4%	63.2%

[1] New measure for HEDIS 2013.
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[5] New measure for HEDIS 2014.
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Table A – HealthChoice Organizations HEDIS 2014 Results page three of four	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2014
	ACC			JMS			MPC			MSFC			PP			RHP			UHC			MARR
Chlamydia Screening in Women (CHL) – Age 21–24 years	70.6%	72.5%	71.9%	77.4%	63.9%	72.3%	66.6%	67.6%	67.1%	70.5%	74.0%	68.4%	69.8%	68.9%	69.9%			NA[2]	64.8%	63.7%	64.8%	69.1%
Chlamydia Screening in Women (CHL) – Total (16–24) years	64.8%	66.4%	66.0%	81.3%	74.2%	81.2%	62.0%	62.3%	62.0%	62.5%	65.0%	60.1%	65.4%	64.6%	64.8%			NA[2]	60.0%	59.5%	59.0%	65.5%
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	90.4%	87.8%	84.2%	86.2%	82.9%	85.8%	82.1%	86.279 %	84.9%	87.7%	86.280 %	85.4%	87.1%	89.3%	90.9%			52.2%	83.8%	84.7%	87.1%	81.5%
Prenatal and Postpartum Care (PPC) – Postpartum Care	70.7%	71.5%	71.6%	78.1%	83.7%	78.5%	71.3%	68.4%	71.9%	74.0%	74.4%	72.0%	73.0%	72.5%	75.6%			43.9%	64.7%	60.3%	63.8%	68.2%
Frequency of Ongoing Prenatal Care (FPC) – Less than 21% of expected visits [3]	3.4%	4.2%	8.2%	2.8%	3.6%	2.2%	5.7%	10.6%	5.6%	2.9%	2.7%	4.4%	7.7%	4.4%	4.4%			37.0%	5.4%	12.1%	5.8%	9.7%
Frequency of Ongoing Prenatal Care (FPC) – Greater than or equal to 81% of expected visits	80.3%	72.2%	75.5%	76.9%	75.8%	70.8%	69.6%	60.1%	70.6%	82.7%	79.3%	71.3%	64.7%	78.8%	78.8%			21.7%	72.2%	70.8%	73.2%	66.0%
Controlling High Blood Pressures (CBP)	[1]	47.0%	49.0%	[1]	52.3%	56.2%	[1]	23.9%	46.8%	[1]	70.5%	65.5%	[1]	59.1%	57.0%	[1]		NA[2]	[1]	43.1%	42.3%	52.8%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)		[5]	NA		[5]	NA		[5]	87.5%		[5]	NA		[5]	86.1%		[5]	NA[2]		[5]	82.9%	85.5%
Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing	78.8%	81.1%	83.4%	90.5%	89.8%	89.1%	77.1%	76.0%	79.5%	88.1%	83.5%	84.7%	81.9%	82.4%	78.1%			NA[2]	75.9%	78.1%	79.1%	85.5%
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%) [3]	43.3%	44.0%	38.8%	33.6%	35.4%	31.0%	56.7%	52.6%	48.6%	27.5%	35.3%	37.2%	38.3%	41.7%	48.1%			NA[2]	51.1%	54.3%	45.5%	41.5%
Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)	48.4%	47.1%	51.4%	56.2%	54.7%	61.5%	37.0%	39.9%	43.3%	57.7%	58.9%	54.0%	50.8%	49.1%	44.3%			NA[2]	42.1%	38.9%	46.47%	50.2%
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed	62.2%	69.3%	65.4%	80.8%	80.1%	79.6%	76.2%	64.6%	72.0%	75.7%	72.8%	71.1%	71.6%	78.1%	71.0%			NA[2]	60.8%	57.7%	56.9%	69.3%
Comprehensive Diabetes (CDC) – LDL-C Screening	77.4%	76.0%	76.9%	89.4%	88.5%	87.8%	71.3%	69.2%	72.9%	81.7%	77.4%	78.4%	74.9%	73.1%	70.1%			NA[2]	72.3%	74.2%	77.4%	77.2%
Comprehensive Diabetes (CDC) – LDL-C Control (<100 mg/dL)	35.9%	36.2%	36.0%	48.7%	44.2%	45.26%	27.0%	28.0%	30.5%	44.6%	41.1%	39.9%	36.1%	44.5%	45.28%			NA[2]	35.0%	30.7%	35.0%	38.7%
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy	79.7%	73.6%	75.7%	94.7%	93.6%	93.1%	75.2%	74.4%	75.3%	89.6%	78.8%	82.7%	79.0%	77.6%	73.8%			NA[2]	72.7%	74.2%	75.9%	79.4%
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/80 mm Hg)	31.1%	29.1%	34.4%	34.1%	38.0%	39.2%	24.1%	30.3%	32.0%	46.3%	55.7%	44.3%	42.2%	42.6%	44.1%			NA[2]	33.8%	25.3%	32.4%	37.7%
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)	54.6%	48.4%	55.6%	54.74%	59.1%	60.4%	45.7%	47.1%	55.4%	73.3%	73.7%	70.1%	65.1%	63.3%	64.2%			NA[2]	54.74%	47.0%	51.6%	59.5%
Use of Imaging Studies for Low Back Pain (LBP)	78.5%	77.8%	76.7%	81.6%	70.9%	77.2%	76.8%	75.2%	76.6%	74.5%	73.1%	73.3%	74.7%	75.0%	75.2%			NA[2]	75.5%	74.8%	73.4%	75.4%
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	[1]	61.8%	60.0%	[1]	NA	NA	[1]	71.9%	73.8%	[1]	NA	NA	[1]	69.5%	67.6%	[1]		NA[2]	[1]	73.3%	67.7%	67.3%
Annual Monitoring for Patients on Persistent Medications (MPM) - members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).	[1]	90.1%	89.0%	[1]	95.8%	95.1%	[1]	88.9%	87.0%	[1]	87.6%	90.2%	[1]	88.224 %	88.1%	[1]		NA[2]	[1]	88.222 %	88.6%	89.7%

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Table A – HealthChoice Organizations HEDIS 2014 Results – page four of four	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2014
	ACC			JMS			MPC			MSFC			PP			RHP			UHC			MARR
Annual Monitoring for Patients on Persistent Medications (MPM) - members on digoxin	[1]	95.8%	95.7%	[1]	NA[2]	NA[2]	[1]	91.4%	92.2%	[1]	NA[2]	NA[2]	[1]	91.5%	88.9%	[1]		NA[2]	[1]	93.4%	86.4%	90.8%
Annual Monitoring for Patients on Persistent Medications (MPM) - members on diuretics.	[1]	88.2%	86.9%	[1]	94.3%	94.1%	[1]	88.04%	86.2%	[1]	88.02%	88.5%	[1]	87.2%	87.4%	[1]		NA[2]	[1]	87.8%	87.5%	88.4%
Annual Monitoring for Patients on Persistent Medications (MPM) - members on anticonvulsants	[1]	66.0%	66.3%	[1]	64.8%	75.6%	[1]	69.9%	70.42%	[1]	58.1%	67.1%	[1]	73.3%	68.3%	[1]		NA[2]	[1]	72.4%	75.0%	70.44%
Annual Monitoring for Patients on Persistent Medications (MPM) - Total rate	[1]	86.2%	85.4%	[1]	93.1%	94.1%	[1]	88.0%	86.3%	[1]	84.1%	86.6%	[1]	87.3%	87.3%	[1]		NA[2]	[1]	87.5%	87.7%	87.9%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation 13–17 Years	41.0%	42.0%	37.7%	NA[2]	NA[2]	NA[2]	49.7%	42.3%	38.9%	19.5%	5.0%	30.9%	47.4%	38.4%	41.8%			NA[2]	49.8%	42.9%	44.3%	38.7%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation 18+ Years	47.4%	41.9%	38.8%	46.7%	37.1%	45.4%	47.7%	43.1%	37.3%	36.6%	29.2%	43.2%	42.8%	38.5%	37.0%			NA[2]	47.3%	47.9%	45.7%	41.2%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation Overall Ages	46.4%	41.9%	38.6%	46.5%	36.8%	45.2%	47.9%	43.0%	37.45%	35.5%	27.4%	41.7%	43.4%	38.5%	37.49%			NA[2]	47.6%	47.3%	45.5%	41.0%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement 13–17 Years	26.5%	27.7%	24.1%	NA[2]	NA[2]	NA[2]	33.2%	26.5%	22.1%	9.8%	2.5%	19.8%	29.2%	22.6%	27.6%			NA[2]	31.5%	24.0%	30.3%	24.8%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement 18+ Years	20.7%	18.2%	17.9%	19.5%	15.4%	17.0%	24.0%	20.5%	19.8%	8.3%	5.5%	21.6%	18.7%	17.0%	17.2%			NA[2]	17.0%	17.8%	20.8%	19.1%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement Overall Ages	41.0%	42.0%	37.7%	NA[2]	NA[2]	NA[2]	49.7%	42.3%	38.9%	19.5%	5.0%	30.9%	47.4%	38.4%	41.8%			NA[2]	49.8%	42.9%	44.3%	38.7%
Identification of Alcohol and Other Drug Services (IAD) – Any	2.5%	2.6%	2.7%	16.7%	15.8%	16.9%	6.2%	6.3%	6.0%	3.3%	3.1%	4.3%	5.2%	5.2%	5.0%			14.9%	4.0%	3.6%	4.7%	7.9%
Identification of Alcohol and Other Drug Services (IAD) – Inpatient	0.6%	0.6%	0.5%	4.1%	3.8%	4.0%	1.3%	1.3%	0.95%	2.2%	0.90%	0.8%	1.1%	0.943%	0.9%			1.6%	0.9%	0.941%	1.03%	1.4%
Identification of Alcohol and Other Drug Services (IAD) - Intensive Outpatient/Partial Hospitalization	0.33%	0.3%	0.3%	2.9%	2.5%	2.5%	0.94%	0.82%	0.7%	0.34%	0.18%	0.5%	0.8%	0.7%	0.6%			1.3%	0.43%	0.22%	0.0%	1.0%
Identification of Alcohol and Other Drug Services (IAD) - Outpatient/ED	2.2%	2.4%	2.5%	15.2%	14.5%	15.6%	5.7%	5.8%	5.6%	2.5%	2.5%	3.9%	4.8%	4.9%	4.6%			11.9%	3.5%	3.0%	4.2%	6.9%
Ambulatory Care (AMB) – Outpatient visits per 1,000 member months	370.88	363.6	365.1	347.4	373.9	340.8	386.8	385.3	365.3	370	361.6	344.5	415.9	407.8	386.6			269.8	381	374.2	373.3	349.3
Ambulatory Care (AMB) – Emergency department (ED) visits per 1,000 member months [3]	60.7	59.8	56.2	91.3	93.4	90.1	78.8	79.3	74.6	72.3	70.8	62.66	65.7	66	62.7			66	65.8	65.2	62.1	67.8
Call Answer Timeliness (CAT)	78.9%	81.9%	89.7%	93.1%	95.0%	93.4%	91.1%	87.7%	89.2%	89.2%	89.4%	91.3%	73.1%	84.9%	71.0%			NA[2]	85.5%	92.4%	89.4%	87.3%

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Table A1 HealthChoice Organizations Reporting PAC HEDIS 2014 Results

Table A1 – HealthChoice Organizations Reporting PAC HEDIS 2014 Results – page one of one	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014
	ACC PAC			JMS PAC			PP PAC			UHC PAC			MARR PAC		
Adult BMI Assessment (ABA)	32.6%	23.2%	25.0%	15.2%	NA[2]	NA[2]	30.7%	39.7%	23.9%	19.9%	22.8%	27.6%	24.4%	27.3%	25.5%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 years	70.6%	71.5%	65.1%	72.8%	71.8%	65.3%	65.2%	64.0%	63.6%	69.8%	71.4%	67.2%	68.1%	66.7%	65.3%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years	80.5%	81.1%	79.6%	82.1%	82.6%	77.6%	76.8%	78.2%	79.3%	81.4%	82.5%	81.5%	78.7%	76.9%	79.5%
Breast Cancer Screening (BCS)	41.2%	42.5%	49.5%	52.6%	52.5%	63.2%	34.4%	37.5%	43.3%	38.0%	41.1%	48.0%	40.8%	40.3%	51.0%
Cervical Cancer Screening (CCS)	37.8%	39.8%	32.8%	66.1%	61.7%	52.6%	40.3%	40.2%	43.5%	38.9%	39.0%	34.3%	44.5%	42.8%	40.8%
Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing	80.9%	82.0%	81.9%	91.5%	86.6%	84.9%	78.5%	78.6%	79.2%	77.4%	78.8%	79.8%	81.6%	79.9%	81.5%
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%) [3]	49.8%	50.3%	53.0%	32.1%	38.1%	40.8%	52.2%	58.2%	57.6%	44.0%	57.5%	61.9%	45.5%	51.8%	53.4%
Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)	44.0%	42.5%	37.8%	58.6%	52.2%	49.8%	40.3%	35.8%	34.6%	47.4%	36.6%	31.1%	46.7%	41.0%	53.4%
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed	34.9%	31.7%	37.7%	66.2%	62.1%	49.1%	31.0%	33.4%	33.2%	42.3%	35.1%	35.6%	40.7%	37.6%	38.9%
Comprehensive Diabetes (CDC) – LDL-C Screening	74.6%	74.5%	76.4%	90.5%	87.3%	82.1%	68.1%	70.2%	71.1%	73.2%	75.0%	72.4%	76.2%	74.5%	75.5%
Comprehensive Diabetes (CDC) – LDL-C Control (<100 mg/dL)	29.7%	30.4%	29.7%	45.7%	44.9%	41.0%	26.3%	45.9%	46.0%	40.1%	28.1%	22.2%	34.5%	35.1%	34.7%
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy	80.4%	76.1%	80.9%	94.4%	90.7%	89.3%	73.5%	77.3%	79.0%	79.5%	79.1%	77.3%	81.5%	79.4%	81.7%
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/80 mm Hg)	0.0%	0.0%	13.7%	33.8%	34.2%	30.5%	2.4%	0.0%	1.6%	24.8%	0.2%	0.1%	17.5%	8.6%	11.5%
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)	0.0%	0.0%	21.1%	56.4%	53.5%	52.9%	4.4%	0.0%	2.4%	42.8%	0.2%	0.1%	29.6%	17.0%	19.1%

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Prevention and Screening-Adult

Adult BMI Assessment (ABA)

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

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

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.
- Clarified that ranges and thresholds do not meet numerator criteria.

Adult BMI Assessment (ABA)

	2010*	2011*	2012*	2013	2014	NHM
ACC				61.3%	72.0%	↑
JMS				90.7%	80.2%	↑
MPC				48.7%	70.2%	↑
MSFC				76.4%	82.6%	↑
PP				59.9%	82.9%	↑
RHP					NA**	
UHC				49.1%	68.9%	↑
MARR				65.1%	76.1%	↑

* This measure was added by DHMH for reporting in HEDIS 2013.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

Description: The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

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

	2010*	2011*	2012	2013	2014	NHM	2010* PAC	2011* PAC	2012 PAC	2013 PAC	2014 PAC
ACC			23.7%	20.6%	23.88%	↓			32.6%	23.2%	25.0%
JMS			21.9%	35.5%	35.2%	↑			15.2%	NA**	NA**
MPC			19.7%	19.9%	22.0%	↓			23.7%	23.4%	
MSFC			16.1%	14.1%	15.2%	↓					
PP			21.1%	18.9%	23.94%	↓			30.7%	39.7%	23.9%
RHP					NA**						
UHC			19.6%	16.0%	20.8%	↓			19.9%	22.8%	27.6%
MARR			20.5%	20.4%	23.5%	↓			24.4%	27.3%	25.5%

* This measure was added by DHMH for reporting in HEDIS 2012.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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 H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four Pneumococcal Conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

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

Rationale: A basic method for prevention of serious illness is immunization. Childhood immunizations help prevent serious illnesses such as polio, tetanus and hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases like mumps and measles. Even preventing "mild" diseases saves hundreds of lost school days and work days, and millions of dollars.

Immunizations are one of the safest and most effective ways to protect children from potentially serious childhood diseases. In spite of established guidelines and well-known benefits of vaccination, nearly 25 percent of children 19 to 35 months still had not received recommended immunizations.

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

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

	2010	2011	2012	2013	2014	NHM
ACC	78.4%	79.4%	85.6%	84.7%	81.3%	↑
JMS	81.9%	88.4%	80.6%	86.1%	86.5%	↑
MPC	80.0%	84.9%	81.8%	76.9%	73.7%	↓
MSFC	86.6%	86.6%	89.5%	85.4%	88.1%	↑
PP	74.7%	83.0%	86.0%	86.8%	83.1%	↑
RHP					NA*	
UHC	83.9%	71.0%	82.7%	70.3%	73.0%	↓
MARR	80.2%	79.9%	82.5%	80.2%	80.9%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	73.5%	73.8%	81.9%	83.5%	78.2%	↑
JMS	80.8%	85.9%	78.7%	83.7%	86.1%	↑
MPC	76.2%	81.3%	80.8%	74.3%	72.09%	↑
MSFC	83.7%	84.7%	87.6%	83.7%	85.9%	↑
PP	68.4%	79.8%	83.7%	83.8%	80.8%	↑
RHP					NA*	
UHC	78.3%	66.7%	78.8%	66.7%	71.3%	↓
MARR	76.0%	76.3%	79.7%	77.7%	79.1%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	40.0%	28.9%	39.1%	75.9%	73.6%	↑
JMS	39.0%	36.1%	33.3%	80.9%	84.8%	↑
MPC	26.0%	30.2%	32.8%	67.4%	62.8%	↑
MSFC	28.0%	29.2%	41.6%	80.3%	81.3%	↑
PP	27.5%	25.8%	38.8%	73.8%	69.4%	↑
RHP					NA*	
UHC	52.1%	34.3%	37.2%	58.9%	66.2%	↑
MARR	34.5%	30.6%	36.2%	71.8%	73.0%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	45.9%	54.4%	59.7%	61.3%	63.9%	↑
JMS	55.4%	58.9%	57.9%	59.4%	71.7%	↑
MPC	40.1%	53.8%	53.5%	55.3%	47.0%	↓
MSFC	48.2%	53.5%	63.3%	56.0%	70.1%	↑
PP	46.2%	37.5%	55.1%	59.6%	54.6%	↓
RHP					NA*	
UHC	56.4%	47.4%	57.2%	52.0%	56.9%	↑
MARR	46.6%	49.4%	56.2%	56.3%	60.7%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	35.1%	40.5%	48.6%	49.7%	49.3%	↑
JMS	27.7%	40.2%	33.3%	39.0%	47.8%	↑
MPC	34.5%	37.5%	39.2%	42.4%	37.7%	↓
MSFC	40.9%	49.1%	57.4%	55.2%	59.4%	↑
PP	40.1%	47.4%	51.4%	51.5%	49.5%	↑
RHP					NA*	
UHC	48.4%	36.5%	41.8%	38.2%	44.3%	↑
MARR	37.6%	40.9%	44.0%	45.7%	48.0%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	27.4%	23.1%	30.1%	57.8%	60.7%	↑
JMS	29.4%	28.6%	25.5%	59.0%	71.3%	↑
MPC	16.1%	21.2%	20.2%	51.4%	44.0%	↓
MSFC	19.2%	21.9%	31.1%	54.3%	66.7%	↑
PP	19.5%	14.6%	25.3%	56.2%	50.7%	↑
RHP					NA*	
UHC	38.7%	24.6%	28.2%	47.2%	54.7%	↑
MARR	23.8%	22.1%	26.3%	53.6%	58.0%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	21.9%	17.8%	25.7%	47.3%	47.9%	↑
JMS	15.8%	20.7%	21.3%	39.0%	47.4%	↑
MPC	15.6%	16.3%	17.0%	38.7%	34.9%	↓
MSFC	15.1%	18.0%	28.2%	53.5%	56.2%	↑
PP	19.2%	17.27%	24.2%	48.3%	44.4%	↑
RHP					NA*	
UHC	34.3%	21.7%	21.7%	35.3%	41.4%	↑
MARR	19.8%	18.4%	22.4%	43.6%	45.4%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	23.8%	32.4%	38.2%	38.5%	42.4%	↑
JMS	19.8%	27.8%	25.0%	29.5%	40.9%	↑
MPC	20.0%	25.1%	29.2%	33.8%	28.4%	↓
MSFC	25.5%	33.1%	43.8%	38.7%	49.9%	↑
PP	26.8%	25.5%	38.8%	41.1%	36.3%	↑
RHP					NA*	
UHC	38.0%	27.7%	32.8%	31.6%	37.0%	↑
MARR	24.5%	28.1%	33.8%	35.5%	39.1%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	16.3%	15.5%	20.6%	37.1%	41.2%	↑
JMS	12.4%	17.0%	18.1%	29.5%	40.9%	↑
MPC	10.0%	10.9%	12.2%	31.0%	27.7%	↓
MSFC	10.7%	13.87%	22.1%	37.7%	47.0%	↑
PP	13.9%	10.7%	17.9%	39.7%	34.3%	↑
RHP					NA*	
UHC	27.3%	15.8%	17.5%	29.2%	35.3%	↑
MARR	14.3%	13.95%	17.7%	34.2%	37.7%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Immunizations for Adolescents (IMA)

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

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

Combination 1 (Meningococcal, Tdap/Td)

	2010	2011	2012	2013	2014	NHM
ACC	41.7%	46.1%	56.7%	65.0%	69.4%	↑
JMS	67.3%	71.6%	73.2%	70.66%	75.5%	↑
MPC	45.7%	52.1%	51.1%	57.6%	62.7%	↓
MSFC	45.7%	57.2%	70.7%	70.69%	70.7%	↑
PP	41.6%	56.9%	52.0%	67.4%	74.5%	↑
RHP					NA*	
UHC	42.3%	38.6%	48.4%	56.4%	63.4%	↓
MARR	45.2%	51.8%	57.4%	63.8%	69.4%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

Description: The percentage of members who turned 15 months old during the measurement year who had the following number of well-child visits with a primary care practitioner (PCP) during their first 15 months of life: no well-child visits; one, two, three, four, five, six- or-more well-child visits. DHMH also calculates the percentage of members receiving five or six-or-more visits by adding together the HEDIS results for five and for six-or-more visits.

Rationale: This measure looks at the adequacy of well-child care for infants. Regular check-ups are one of the best ways to detect physical, developmental, behavioral and emotional problems. They also provide an opportunity for the clinician to offer guidance and counseling to the parents.

These visits are of particular importance during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination and social and emotional growth. The American Academy of Pediatrics (AAP) recommends six well-child visits in the first year of life: the first within the first month of life, and then at around 2, 4, 6, 9, and 12 months of age.

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.
- Revised example in continuous enrollment to account for a year that is not a leap year.
- Clarified that visits must be on different dates of services for the numerators in the *Administrative Specification.*

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

	2010	2011	2012	2013	2014	NHM
ACC	1.2%	0.8%	1.6%	1.012%	1.0%	↑
JMS	2.8%	2.4%	0.87%	2.7%	3.1%	↓
MPC	1.5%	1.1%	1.4%	1.11%	0.5%	↑
MSFC	1.4%	2.2%	1.3%	1.013%	1.2%	↑
PP	0.6%	0.9%	1.1%	1.14%	1.1%	↑
RHP					NA**	
UHC	1.8%	2.05%	0.88%	2.2%	1.9%	↓
MARR	2.0%	1.95%	1.5%	1.6%	1.5%	↑

* A lower rate indicates better performance – an "up" arrow indicates rate is below the NHM.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	84.16%	87.2%	87.3%	86.1%	88.9%	↑
JMS	89.4%	83.4%	84.0%	85.9%	84.4%	↑
MPC	84.21%	86.0%	89.9%	77.8%	83.6%	↑
MSFC	86.2%	84.7%	88.2%	89.2%	86.0%	↑
PP	86.9%	87.1%	84.3%	84.3%	83.7%	↑
RHP					NA*	
UHC	85.1%	83.6%	86.8%	82.1%	87.4%	↑
MARR	83.2%	82.4%	85.0%	83.9%	85.7%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

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

Rationale: This measure looks at the use of routine check-ups by preschool and early school-age children. Well-child visits during the preschool and early school years are particularly important. A child can be helped through early detection of vision, speech and language problems. Intervention can improve communication skills and avoid or reduce language and learning problems. The AAP recommends annual well-child visits for two- to six-year-olds.

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

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

	2010	2011	2012	2013	2014	NHM
ACC	76.0%	86.6%	86.4%	83.6%	83.9%	↑
JMS	92.3%	89.3%	88.9%	87.7%	88.9%	↑
MPC	85.7%	86.3%	89.1%	87.5%	88.8%	↑
MSFC	79.2%	73.5%	82.3%	79.6%	83.5%	↑
PP	86.6%	78.3%	82.4%	80.7%	83.8%	↑
RHP					NA*	
UHC	82.4%	75.2%	83.1%	83.8%	75.0%	↑
MARR	81.8%	80.7%	85.0%	82.2%	84.0%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Adolescent Well-Care Visits (AWC)

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

Rationale: This measure looks at the use of regular check-ups by adolescents. Adolescents benefit from an annual preventive health care visit that addresses the physical, emotional and social aspects of their health.

Adolescence is a time of transition between childhood and adult life and is accompanied by dramatic changes. Accidents, homicide and suicide are the leading causes of adolescent deaths. Sexually transmitted diseases, substance abuse, pregnancy and antisocial behavior are important causes of, or result from, physical, emotional and social adolescent problems.

The American Medical Association's *Guidelines for Adolescent Preventive Services*, the federal government's Bright Futures program and the AAP's guidelines all recommend comprehensive annual check-ups for adolescents.

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

Adolescent Well-Care Visits (AWC)

	2010	2011	2012	2013	2014	NHM
ACC	52.2%	63.1%	61.9%	68.1%	67.9%	↑
JMS	79.9%	79.7%	79.9%	76.9%	76.7%	↑
MPC	64.7%	72.1%	75.8%	60.2%	68.8%	↑
MSFC	61.1%	63.5%	67.7%	69.4%	67.8%	↑
PP	64.9%	60.0%	66.1%	67.6%	61.6%	↑
RHP					NA*	
UHC	64.7%	49.8%	55.7%	59.7%	60.8%	↑
MARR	62.6%	62.8%	67.0%	65.4%	67.3%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

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

- 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 10–15 years of age were obese adults at age 25. Another study found that 25 percent of obese adults were overweight as children; it also found that if overweight begins before 8 years of age, obesity in adulthood is likely to be more severe.

Body mass index (BMI) is a useful screening tool for assessing and tracking the degree of obesity among adolescents. Screening for overweight or obesity begins in the provider's office with the calculation of BMI. Providers can estimate a child's BMI percentile for age and gender by plotting the calculated value of BMI with growth curves published and distributed by the CDC. Medical evaluations should include investigation into possible endogenous causes of obesity that may be amenable to treatment, and identification of any obesity-related health complications.

Because BMI norms for youth vary with age and gender, BMI percentiles rather than absolute BMI must be determined. The cut-off values to define the heaviest children are the 85th and 95th percentiles. In adolescence, as maturity is approached, the 85th percentile roughly approximates a BMI of 25, which is the cut-off for overweight in adults. The 95th percentile roughly approximates a BMI of 30 in the adolescent near maturity, which is the cut-off for obesity in adults. The cut-off recommended by an expert committee to define overweight (BMI greater than or equal to 95th percentile) is a conservative choice designed to minimize the risk of misclassifying non-obese children.

About two-thirds of young people in grades 9–12 do not engage in recommended levels of physical activity. Daily participation in high school physical education classes dropped from 42 percent in 1991 to 33 percent in 2005. In the past 30 years, the prevalence of overweight and obesity has increased sharply for children. Among young people, the prevalence of overweight increased from 5.0 percent to 13.9 percent for those aged 2–5 years; from 6.5 percent to 18.8 percent for those aged 6–11 years; and from 5.0 percent to 17.4 percent for those aged 12–19 years. In 2000, the estimated total cost of obesity in the U.S. was about $117 billion. Promoting regular physical activity and healthy eating, as well as creating an environment that supports these behaviors, is essential to addressing the problem.

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.
- Clarified that ranges and thresholds do not meet numerator criteria for BMI percentile.
- Clarified that members must receive educational materials during a face-to-face visit in order to meet criteria for the Hybrid Specification for the Counseling for nutrition and Counseling for physical activity indicators.

- Added that weight or obesity counseling count as numerator compliant for they Hybrid Specification for both the Counseling for nutrition and Counseling for physical activity indicators.
- Added a Note stating that a physical exam finding or observation alone is not compliant for Counseling for nutrition. (October Update)
- Clarified in the Note section that services specific to an acute or chronic condition do not count toward the Counseling for nutrition and Counseling for physical activity indicators.

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

	2010*	2011*	2012*	2013*	2014	NHM
ACC					49.5%	↓
JMS					92.2%	↑
MPC					46.5%	↓
MSFC					59.8%	↑
PP					52.1%	↑
RHP					NA**	
UHC					45.5%	↓
MARR					57.6%	↑

* This measure was added by DHMH for reporting in HEDIS 2014.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010*	2011*	2012*	2013*	2014	NHM
ACC					59.0%	↑
JMS					94.4%	↑
MPC					54.4%	↓
MSFC					74.1%	↑
PP					54.2%	↓
RHP					NA**	
UHC					67.6%	↑
MARR					67.3%	↑

* This measure was added by DHMH for reporting in HEDIS 2014.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010*	2011*	2012*	2013*	2014	NHM
ACC					51.4%	↑
JMS					89.8%	↑
MPC					58.8%	↑
MSFC					72.9%	↑
PP					44.7%	↑
RHP					NA**	
UHC					60.6%	↑
MARR					63.0%	↑

* This measure was added by DHMH for reporting in HEDIS 2014.
**When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Appropriate Testing for Children with Pharyngitis (CWP)

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

Rationale: Pharyngitis is the only condition among upper respiratory infections (URIs) whose diagnosis is easily and objectively validated through administrative and laboratory data, and it can serve as an important indicator of appropriate antibiotic use among respiratory tract infections.

Overuse of antibiotics has been directly linked to the prevalence of antibiotic resistance in the community; promoting judicious use of antibiotics is important to reducing levels of antibiotic resistance. Pediatric clinical practice guidelines recommend that only children with diagnosed group-A strep pharyngitis based on appropriate lab tests be treated with antibiotics. A strep test (rapid assay or throat culture) is the definitive test of group-A strep pharyngitis. Excess use of antibiotics is highly prevalent for pharyngitis; about 35 percent of the total nine million antibiotics prescribed for pharyngitis were estimated to be in excess.

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

Appropriate Testing for Children with Pharyngitis (CWP)

	2010	2011	2012	2013	2014	NHM
ACC	61.9%	61.5%	68.8%	75.9%	78.36%	↑
JMS	70.9%	76.3%	74.51%	75.3%	70.8%	↑
MPC	77.4%	74.0%	76.9%	77.4%	78.42%	↑
MSFC	82.7%	81.0%	85.9%	85.2%	86.9%	↑
PP	73.5%	69.5%	74.46%	78.2%	80.5%	↑
RHP					NA*	
UHC	68.8%	70.8%	76.4%	79.8%	83.1%	↑
MARR	71.1%	71.1%	75.7%	79.9%	79.7%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Respiratory Conditions – Adult and Child

Use of Appropriate Medications for People with Asthma (ASM)

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

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.
- Revised the definition of *Inhaler dispensing event*.

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

	2010	2011	2012	2013	2014	NHM
ACC	91.0%	91.90%	91.4%	88.7%	90.3%	↑
JMS	85.1%	91.94%	94.2%	91.4%	93.59%	↑
MPC	94.9%	93.1%	93.0%	92.3%	91.4%	↑
MSFC	92.9%	92.8%	96.7%	93.7%	93.62%	↑
PP	92.2%	93.6%	91.7%	92.3%	91.6%	↑
RHP					NA**	
UHC	91.3%	93.2%	95.7%	96.1%	91.9%	↑
MARR	91.2%	92.0%	92.8%	91.8%	92.1%	↑

* This indicator was included by DHMH for reporting in HEDIS 2010.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010*	2011*	2012	2013	2014	NHM
ACC			88.2%	86.2%	87.8%	↑
JMS			100%	92.9%	86.0%	↑
MPC			91.1%	92.3%	90.4%	↑
MSFC			93.30%	90.2%	94.2%	↑
PP			90.8%	89.6%	88.5%	↑
RHP					NA**	
UHC			96.6%	93.4%	88.0%	↑
MARR			93.34%	91.6%	89.1%	↑

* This indicator was included by DHMH for reporting in HEDIS 2010.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010*	2011*	2012	2013	2014	NHM
ACC			78.0%	79.5%	73.7%	↓
JMS			91.3%	93.3%	81.3%	↑
MPC			82.8%	81.8%	80.1%	↑
MSFC			85.2%	76.8%	75.2%	↑
PP			77.9%	80.7%	76.8%	↑
RHP					NA**	
UHC			95.1%	88.0%	72.9%	↓
MARR			85.05%	83.5%	76.7%	↑

* This indicator was included by DHMH for reporting in HEDIS 2010.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010*	2011*	2012	2013	2014	NHM
ACC			71.2%	77.7%	68.6%	↓
JMS			83.7%	82.0%	71.43%	↑
MPC			81.7%	78.5%	76.3%	↑
MSFC			NA**	77.1%	NA**	↑
PP			69.2%	77.0%	73.0%	↑
RHP					NA**	
UHC			95.0%	94.1%	79.0%	↑
MARR			80.1%	81.1%	73.7%	↑

* This indicator was included by DHMH for reporting in HEDIS 2010.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010*	2011*	2012	2013	2014	NHM
ACC			89.1%	86.5%	86.29%	↑
JMS			95.7%	90.7%	83.6%	↓
MPC			90.7%	88.7%	86.97%	↑
MSFC			95.5%	88.8%	90.1%	↑
PP			89.3%	88.9%	87.02%	↑
RHP					NA**	
UHC			96.7%	94.0%	86.28%	↑
MARR			93.1%	89.4%	86.7%	↑

* This indicator was included by DHMH for reporting in HEDIS 2010.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012*	2013	2014
ACC	89.2%	90.1%	88.5%	86.7%	86.8%
JMS	89.5%	93.3%	93.9%	92.5%	86.4%
MPC	91.2%	90.6%	89.8%	89.2%	87.53%
MSFC	92.7%	91.1%	93.6%	89.4%	90.1%
PP	90.3%	90.4%	88.9%	89.3%	87.6%
RHP					NA**
UHC	87.4%	90.2%	95.9%	94.0%	86.6%
MARR	90.7%	90.8%	91.2%	89.9%	87.51%

***** HEDIS specifications changed in 2012, and this age range is no longer reported. For 2013 and 2014, this rate is being calculated by HDC for DHMH to use in the VBP program.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Medication Management for People With Asthma (MMA)

Description: The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

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

Rationale: Appropriate medication adherence could ameliorate the severity of many asthma-related symptoms. According to the Asthma Regional Council, two-thirds of adults and children who display asthma symptoms are considered "not well controlled" or "very poorly controlled" as defined by clinical practice guidelines. Pharmacologic therapy is used to prevent and control asthma symptoms, improve quality of life, reduce the frequency and severity of asthma exacerbations, and reverse airflow obstruction.

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.
- Revised the definition of *Inhaler dispensing event*.
- Clarified that the PDC should be rounded to two decimal places, using the .5 rule, in step 4 of the numerator calculation.

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

	2010*	2011*	2012*	2013	2014	NHM
ACC				44.8%	45.8%	↓
JMS				53.2%	49.4%	↓
MPC				49.4%	57.9%	↑
MSFC				52.4%	51.9%	↑
PP				40.3%	43.3%	↓
RHP					NA**	
UHC				47.3%	49.9%	↓
MARR				46.3%	49.7%	↓

* This measure was added by DHMH for reporting in HEDIS 2013.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010*	2011*	2012*	2013	2014	NHM
ACC				24.1%	22.9%	↓
JMS				28.9%	24.5%	↓
MPC				26.6%	32.9%	↑
MSFC				28.7%	26.6%	↓
PP				19.7%	20.0%	↓
RHP					NA**	
UHC				26.7%	27.8%	↓
MARR				24.3%	25.8%	↓

* This measure was added by DHMH for reporting in HEDIS 2013.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

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

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

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

	2010	2011	2012	2013	2014	NHM
ACC	84.9%	87.0%	86.13%	85.1%	86.5%	↑
JMS	95.2%	93.8%	89.8%	85.2%	83.0%	↓
MPC	84.1%	85.6%	86.08%	86.06%	86.6%	↑
MSFC	85.7%	88.6%	89.0%	86.13%	84.3%	↓
PP	87.2%	88.5%	86.01%	85.0%	86.0%	↑
RHP					NA*	
UHC	79.6%	83.3%	80.2%	80.1%	82.0%	↓
MARR	85.3%	87.5%	86.20%	84.4%	84.7%	↓

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Asthma Medication Ratio (AMR)

Description: The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Rationale: Medications for asthma are usually categorized into long-term controller medications used to achieve and maintain control of persistent asthma and quick-reliever medications used to treat acute symptoms and exacerbations. Appropriate ratios for these medications could potentially prevent a significant proportion of asthma-related costs (hospitalizations, emergency room visits, missed work and school days).

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.
- Revised the definition of *Inhaler dispensing event*.

Asthma Medication Ratio (AMR)

	2010*	2011*	2012*	2013*	2014	NHM
ACC					68.59%	↑
JMS					60.5%	↑
MPC					69.1%	↑
MSFC					73.7%	↑
PP					69.6%	↑
RHP					NA**	
UHC					69.8%	↑
MARR					68.56%	↑

* This measure was added by DHMH for reporting in HEDIS 2014.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

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

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

Spirometry is a simple test that measures the amount of air a person can breathe out and the amount of time it takes to do so. Both symptomatic and asymptomatic patients suspected of COPD should have spirometry performed to establish airway limitation and severity. Though several scientific guidelines and specialty societies recommend use of spirometry testing to confirm COPD diagnosis and determine severity of airflow limitation, spirometry tests are largely underutilized.

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

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

	2010*	2011*	2012*	2013*	2014	NHM
ACC					25.8%	↓
JMS					26.3%	↓
MPC					21.1%	↓
MSFC					34.5%	↑
PP					23.7%	↓
RHP					NA**	
UHC					25.6%	↓
MARR					26.2%	↓

* This measure was added by DHMH for reporting in HEDIS 2014.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Pharmacotherapy Management of COPD Exacerbation (PCE)

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

1. Dispensed a systemic corticosteroid within 14 days of the event.
2. Dispensed a bronchodilator within 30 days of the event.

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

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

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

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

	2010*	2011*	2012*	2013*	2014	NHM
ACC					73.6%	↑
JMS					69.2%	↑
MPC					72.6%	↑
MSFC					76.3%	↑
PP					69.7%	↑
RHP					NA**	
UHC					78.2%	↑
MARR					73.3%	↑

* This measure was added by DHMH for reporting in HEDIS 2014.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate

	2010*	2011*	2012*	2013*	2014	NHM
ACC					87.5%	↑
JMS					82.5%	↑
MPC					84.93%	↑
MSFC					90.3%	↑
PP					84.0%	↑
RHP					NA**	
UHC					84.88%	↑
MARR					85.7%	↑

* This measure was added by DHMH for reporting in HEDIS 2014.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Member Access

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

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

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

Rationale: While the access to primary care has been shown to correlate with reduced hospital use while preserving quality (Bodenheimer 2005), this measure does not explicitly measure a member's access to primary care. However, studies show that inappropriate care and overuse of new technologies can be reduced through shared decision-making between well-informed physicians and patients. Physicians have a central role to play in fostering these quality-enhancing strategies that can help to slow the growth of healthcare expenditures (Bodenheimer 2005).

Continued rising healthcare costs in the U.S. affect all levels of the healthcare delivery system. Encouraging and making available access to primary care services is one potential strategy to lower hospital utilization while maintaining the quality of care delivered. Studies show that access to primary care is correlated with reduced hospital use while preserving quality (Bodenheimer 2005).

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

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

	2010	2011	2012	2013	2014	NHM
ACC	97.6%	97.7%	97.45%	97.5%	97.8%	↑
JMS	95.1%	94.3%	92.9%	91.1%	94.7%	↓
MPC	97.3%	96.5%	96.8%	97.1%	96.5%	↑
MSFC	97.2%	95.2%	96.6%	96.6%	96.4%	↑
PP	98.1%	97.9%	98.1%	97.8%	97.6%	↑
RHP					NA*	
UHC	96.7%	96.8%	97.41%	96.7%	96.3%	↑
MARR	96.2%	96.1%	96.1%	95.6%	96.6%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	92.7%	92.7%	92.8%	92.6%	92.8%	↑
JMS	90.3%	90.59%	89.3%	90.4%	88.7%	↑
MPC	91.8%	89.8%	90.7%	89.0%	90.0%	↑
MSFC	90.5%	88.9%	91.4%	90.3%	89.8%	↑
PP	93.1%	92.3%	93.0%	92.8%	92.6%	↑
RHP					NA*	
UHC	92.4%	91.7%	92.1%	91.1%	91.1%	↑
MARR	90.9%	90.57%	90.9%	90.3%	90.8%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	93.3%	93.6%	93.6%	93.9%	94.3%	↑
JMS	94.1%	94.5%	94.0%	93.3%	93.8%	↑
MPC	92.6%	92.8%	92.0%	91.5%	92.1%	↑
MSFC	93.4%	93.4%	92.86%	92.5%	93.50%	↑
PP	93.8%	94.1%	93.9%	94.3%	94.4%	↑
RHP					NA*	
UHC	93.2%	93.1%	93.0%	93.3%	93.1%	↑
MARR	92.2%	92.6%	92.86%	92.7%	93.52%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	87.7%	88.6%	89.3%	89.5%	90.5%	↑
JMS	90.9%	92.02%	92.4%	91.7%	90.8%	↑
MPC	89.0%	89.5%	88.4%	87.7%	88.5%	↑
MSFC	90.6%	91.98%	90.9%	92.5%	92.7%	↑
PP	89.5%	90.8%	91.6%	92.0%	91.9%	↑
RHP					NA*	
UHC	88.6%	89.90%	88.5%	89.2%	90.1%	↑
MARR	89.0%	89.86%	89.8%	89.8%	90.7%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

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

Rationale: While access to primary care has been shown to correlate with reduced hospital use while preserving quality (Bodenheimer, 2005), this measure does not explicitly measure a member's access to primary care. However, studies show that inappropriate care and overuse of new technologies can be reduced through shared decision-making between well-informed physicians and patients. Physicians have a central role to play in fostering these quality-enhancing strategies that can help to slow the growth of health care expenditures (Bodenheimer, 2005).

Continued rising health care costs in the U.S. affect all levels of the health care delivery system. Encouraging and making available access to primary and preventive care services is one potential strategy to lower hospital utilization while maintaining the quality of care delivered. Studies show that access to primary care is correlated with reduced hospital use while preserving quality (Bodenheimer, 2005).

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

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

	2010	2011	2012	2013	2014	NHM	2010 PAC	2011 PAC	2012 PAC	2013 PAC	2014 PAC
ACC	79.4%	79.6%	80.4%	79.7%	79.4%	↓		77.1%	70.6%	71.5%	65.1%
JMS	78.6%	79.0%	75.5%	74.8%	72.9%	↓	71.9%	74.9%	72.8%	71.8%	65.32%
MPC	81.7%	80.9%	81.2%	81.4%	81.1%	↑	65.7%	67.6%	62.3%	54.6%	
MSFC	78.7%	79.22%	79.6%	79.9%	79.7%	↓					
PP	82.4%	83.0%	83.7%	83.5%	81.7%	↑	59.4%	65.1%	65.2%	64.0%	63.6%
RHP					NA*						
UHC	79.2%	79.23%	80.3%	80.2%	80.36%	↓	67.4%	68.5%	69.8%	71.4%	67.2%
MARR	79.5%	79.7%	80.0%	79.9%	79.2%	↓	66.1%	70.6%	68.1%	66.7%	65.29%

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM	2010 PAC	2011 PAC	2012 PAC	2013 PAC	2014 PAC
ACC	85.0%	85.0%	87.0%	86.4%	87.2%	↑		82.9%	80.5%	81.1%	79.6%
JMS	88.5%	89.2%	88.8%	87.8%	86.58%	↔	79.8%	82.1%	82.1%	82.6%	77.6%
MPC	87.3%	87.4%	87.28%	86.8%	87.8%	↑	75.27%	78.0%	72.8%	60.2%	
MSFC	84.6%	84.6%	85.9%	86.2%	86.9%	↑					
PP	88.3%	88.5%	89.4%	89.4%	88.4%	↑	70.3%	75.7%	76.8%	78.2%	79.3%
RHP					NA*						
UHC	87.1%	85.9%	87.31%	87.5%	87.8%	↑	75.9%	79.3%	81.4%	82.5%	81.5%
MARR	85.4%	85.3%	86.5%	86.4%	87.5%	↑	75.30%	79.6%	78.7%	76.9%	79.5%

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Women's Health

Breast Cancer Screening (BCS)

Description: The percentage of women 40–69 years of age who had a mammogram to screen for breast cancer.

Rationale: Breast cancer is the second most common type of cancer among American women, with approximately 178,000 new cases reported each year. It is most common in women over 50. Women whose breast cancer is detected early have more treatment choices and better chances for survival. Mammography screening has been shown to reduce mortality by 20% to 30% among women 40 and older. Mammography screening for women ages 50 to 69 can reduce breast cancer mortality up to 35%.

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.
- Revised the continuous enrollment time frame.
- Revised the age criterion to women 50–74 years of age.
- Revised the numerator time frame.

Breast Cancer Screening (BCS)

	2010	2011	2012	2013	2014	NHM	2010 PAC	2011 PAC	2012 PAC	2013 PAC	2014 PAC
ACC	43.7%	46.0%	48.5%	49.1%	58.1%	↑		NA*	41.2%	42.5%	49.5%
JMS	60.8%	62.3%	63.9%	60.8%	69.4%	↑	47.2%	55.6%	52.6%	52.5%	63.2%
MPC	44.5%	42.8%	43.6%	43.9%	48.5%	↓	38.4%	40.7%	38.03%	27.7%	
MSFC	63.4%	54.6%	54.5%	56.8%	64.4%	↑					
PP	45.4%	48.0%	49.9%	51.5%	57.0%	↑	NA*	33.8%	34.4%	37.5%	43.3%
RHP					NA*						
UHC	48.2%	45.3%	46.6%	48.4%	52.7%	↑	29.7%	36.7%	38.02%	41.1%	48.02%
MARR	49.5%	48.3%	50.3%	51.0%	58.3%	↑	38.4%	41.7%	40.8%	40.3%	51.0%

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Cervical Cancer Screening (CCS)

Description: The percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer.

Note: *Due to significant specification changes, NCQA will not publicly report this measure for HEDIS 2014.*

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

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.
- Added the hybrid reporting method for commercial plans.
- Added steps to allow for two appropriate screening methods of cervical cancer screening: cervical cytology performed every three years in women 21–64 years of age and cervical cytology/HPV co-testing performed every five years in women 30–64 years of age.

Cervical Cancer Screening (CCS)

	2010	2011	2012	2013	2014	NHM	2010 PAC	2011 PAC	2012 PAC	2013 PAC	2014 PAC
ACC	67.3%	76.6%	75.71%	73.6%	79.64%	↑		33.8%	37.8%	39.8%	32.8%
JMS	76.4%	79.7%	78.5%	80.9%	79.5%	↑	59.5%	62.6%	66.1%	61.7%	52.6%
MPC	67.9%	69.7%	73.6%	74.0%	79.58%	↑	37.4%	38.8%	39.4%	33.2%	
MSFC	67.65%	76.4%	75.74%	70.9%	74.0%	↑					
PP	67.71%	69.4%	73.9%	75.0%	75.9%	↑	29.8%	38.1%	40.3%	40.2%	43.5%
RHP					NA*						
UHC	64.4%	70.3%	69.5%	69.8%	62.8%	↓	41.4%	40.2%	38.9%	39.0%	34.3%
MARR	68.1%	73.2%	73.1%	73.7%	75.2%	↑	42.0%	42.7%	44.5%	42.8%	40.8%

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Chlamydia Screening in Women (CHL)

Description: The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

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

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

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

	2010	2011	2012	2013	2014	NHM
ACC	63.2%	62.8%	61.1%	62.6%	62.4%	↑
JMS	84.9%	89.2%	84.0%	81.1%	86.7%	↑
MPC	61.3%	60.6%	58.5%	58.1%	58.2%	↑
MSFC	57.1%	56.2%	57.4%	59.6%	54.8%	↑
PP	61.0%	62.1%	62.6%	61.8%	61.5%	↑
RHP					NA*	
UHC	57.9%	55.9%	57.1%	56.9%	55.4%	↑
MARR	63.5%	63.0%	62.8%	63.8%	63.17%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	71.3%	69.8%	70.6%	72.5%	71.9%	↑
JMS	75.4%	78.6%	77.4%	63.9%	72.3%	↑
MPC	66.1%	65.1%	66.6%	67.6%	67.1%	↑
MSFC	62.8%	67.2%	70.5%	74.0%	68.4%	↑
PP	67.9%	68.8%	69.8%	68.9%	69.9%	↑
RHP					NA*	
UHC	64.2%	62.1%	64.8%	63.7%	64.8%	↑
MARR	68.0%	69.0%	70.1%	69.1%	69.1%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	66.2%	65.5%	64.8%	66.4%	66.0%	↑
JMS	81.4%	85.3%	81.3%	74.2%	81.2%	↑
MPC	63.0%	62.4%	62.0%	62.3%	62.0%	↑
MSFC	58.8%	60.1%	62.5%	65.0%	60.1%	↑
PP	63.2%	64.6%	65.4%	64.6%	64.8%	↑
RHP					NA*	
UHC	59.9%	58.2%	60.0%	59.5%	59.0%	↑
MARR	65.2%	65.6%	65.9%	66.1%	65.5%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Prenatal and Postpartum Care

Prenatal and Postpartum Care (PPC)

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

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

Rationale:

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

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.
- Removed *Definition* section.
- Moved steps to identify the eligible population (previously steps 1 and 2 under the *Denominator* section in the *Administrative specification*) to the *Eligible Population* section.
- Removed references to “family practitioner” and “midwife” because these practitioners are included in the definitions of *PCP* and *OB/GYN and other prenatal care practitioners*, respectively.
- Consolidated the steps for identifying numerator events.
- Consolidated four decision rules (formerly in Table PPC-C) into three decision rules.

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

	2010	2011	2012	2013	2014	NHM
ACC	87.7%	87.7%	90.4%	87.8%	84.2%	↑
JMS	86.7%	89.2%	86.2%	82.9%	85.8%	↑
MPC	89.7%	83.9%	82.1%	86.279%	84.9%	↑
MSFC	89.6%	90.7%	87.7%	86.280%	85.4%	↑
PP	91.0%	87.9%	87.1%	89.3%	90.9%	↑
RHP					52.2%	↓
UHC	86.6%	85.7%	83.8%	84.7%	87.1%	↑
MARR	87.5%	86.9%	86.3%	85.8%	81.5%	↓

Prenatal and Postpartum Care (PPC) – Postpartum Care

	2010	2011	2012	2013	2014	NHM
ACC	66.67%	66.3%	70.7%	71.5%	71.6%	↑
JMS	79.2%	80.2%	78.1%	83.7%	78.5%	↑
MPC	72.2%	75.2%	71.3%	68.4%	71.9%	↑
MSFC	78.5%	71.7%	74.0%	74.4%	72.0%	↑
PP	66.67%	68.2%	73.0%	72.5%	75.6%	↑
RHP					43.9%	↓
UHC	63.4%	62.5%	64.7%	60.3%	63.8%	↑
MARR	69.4%	69.1%	70.6%	70.0%	68.2%	↑

Frequency of Ongoing Prenatal Care (FPC)

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

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

Complications can arise at any time during pregnancy. For that reason, continued monitoring throughout pregnancy is necessary. Frequency and adequacy of ongoing prenatal visits are important factors in minimizing pregnancy problems.

The American College of Obstetricians and Gynecologists recommends that prenatal care begin as early as possible in the first trimester of pregnancy. Visits should follow a schedule: every four weeks for the first 28 weeks of pregnancy, every two to three weeks for the next seven weeks, and weekly thereafter until delivery.

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.
- Revised example in step 2 of the numerator to account for a year that is not a leap year.

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

	2010	2011	2012	2013	2014	NHM
ACC	2.9%	3.49%	3.4%	4.2%	8.2%	↑
JMS	4.6%	1.4%	2.8%	3.6%	2.2%	↑
MPC	3.9%	4.2%	5.7%	10.6%	5.6%	↑
MSFC	2.1%	1.8%	2.9%	2.7%	4.4%	↑
PP	3.4%	3.50%	7.7%	4.4%	4.4%	↑
RHP					37.0%	↓
UHC	8.7%	3.6%	5.4%	12.1%	5.8%	↑
MARR	5.2%	3.7%	4.9%	6.3%	9.7%	↑

* A lower rate indicates better performance – an "up" arrow indicates rate is below the NHM.

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

	2010	2011	2012	2013	2014	NHM
ACC	71.0%	71.4%	80.3%	72.2%	75.5%	↑
JMS	80.4%	82.4%	76.9%	75.8%	70.8%	↑
MPC	77.8%	74.0%	69.6%	60.1%	70.6%	↑
MSFC	81.8%	79.6%	82.7%	79.3%	71.3%	↑
PP	80.7%	77.9%	64.7%	78.8%	78.8%	↑
RHP					21.7%	↓
UHC	73.8%	75.8%	72.2%	70.8%	73.2%	↑
MARR	74.8%	74.2%	74.4%	71.5%	66.0%	↑

Cardiovascular Conditions

Controlling High Blood Pressure (CBP)

Description: The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year. Use the Hybrid Method for this measure.

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

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.
- Removed "Telephone call record" as an acceptable method for confirming the hypertension diagnosis.
- Clarified step 2 of the numerator to state when a BP reading is not compliant.
- Revised the Optional Exclusion criteria to allow exclusion of all members who had a nonacute inpatient encounter during the measurement year (previously the exclusion was limited to nonacute inpatient *admissions*).

Controlling High Blood Pressures (CBP)

	2010*	2011*	2012*	2013	2014	NHM
ACC				47.0%	49.0%	↓
JMS				52.3%	56.2%	↓
MPC				23.9%	46.8%	↓
MSFC				70.5%	65.5%	↑
PP				59.1%	57.0%	↑
RHP					NA**	
UHC				43.1%	42.3%	↓
MARR				49.8%	52.8%	↓

* This measure was added by DHMH for reporting in HEDIS 2013.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

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

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

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

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

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

	2010*	2011*	2012*	2013*	2014	NHM
ACC					NA**	
JMS					NA**	
MPC					87.5%	↑
MSFC					NA**	
PP					86.1%	↑
RHP					NA**	
UHC					82.9%	↑
MARR					85.5%	↑

* This measure was added by DHMH for reporting in HEDIS 2014.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Diabetes

Comprehensive Diabetes Care (CDC)

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

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- Eye exam (retinal) performed
- LDL-C screening
- LDL-C control (<100 mg/dL)
- Medical attention for nephropathy
- Blood Pressure (BP) control (<140/80 mm Hg)
- BP control (<140/90 mm Hg)

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.
- Added canagliflozin to the description of "Sodium glucose cotransporter 2 (SGLT2) inhibitor" in Table
  CDC-A.
- Clarified requirements for using the HbA1c Level 7.0–9.0 Value Set for the HbA1c Control (<8.0%) indicator.
- Clarified hybrid requirements for the HbA1c Control indicators.
- Clarified medical record documentation requirements for a negative retinal or dilated eye exam.
- Clarified that a finding (e.g., normal, within normal limits) is acceptable for the LDL-C Screening indicator.
- Clarified hybrid requirements for the LDL-C Control (<100 mg/dL) indicator.
- Clarified step 2 of the numerator for BP Control indicators in the *Hybrid Specifications* to state when a BP reading is not compliant.
- Clarified in the *Note* section that organizations must use the most recent result for indicators that require it, regardless of data source.

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

	2010	2011	2012	2013	2014	NHM	2010 PAC	2011 PAC	2012 PAC	2013 PAC	2014 PAC
ACC	74.0%	76.2%	78.8%	81.1%	83.4%	↑		71.4%	80.9%	82.0%	81.9%
JMS	91.6%	89.4%	90.5%	89.8%	89.1%	↑	85.8%	87.4%	91.5%	86.6%	84.9%
MPC	78.6%	79.6%	77.1%	76.0%	79.5%	↓	79.1%	75.4%	79.8%	73.6%	
MSFC	85.7%	83.7%	88.1%	83.5%	84.7%	↑					
PP	78.3%	78.5%	81.9%	82.4%	78.1%	↓	68.0%	76.70%	78.5%	78.6%	79.2%
RHP					NA*						
UHC	71.8%	73.2%	75.9%	78.1%	79.1%	↓	75.2%	72.7%	77.4%	78.8%	79.8%
MARR	77.1%	77.6%	81.0%	81.2%	85.5%	↑	77.0%	76.72%	81.6%	79.9%	81.5%

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM	2010 PAC	2011 PAC	2012 PAC	2013 PAC	2014 PAC
ACC	49.5%	49.3%	43.3%	44.0%	38.8%	↑		55.4%	49.8%	50.3%	53.0%
JMS	34.4%	38.0%	33.6%	35.4%	31.0%	↑	38.4%	39.0%	32.1%	38.1%	40.8%
MPC	53.0%	51.1%	56.7%	52.6%	48.6%	↓	41.6%	47.9%	49.4%	54.9%	
MSFC	27.6%	37.0%	27.5%	35.3%	37.2%	↑					
PP	44.8%	46.0%	38.3%	41.7%	48.1%	↓	97.9%	58.4%	52.2%	58.2%	57.6%
RHP					NA**						
UHC	51.6%	56.2%	51.1%	54.3%	45.5%	↓	49.6%	59.9%	44.0%	57.5%	61.9%
MARR	45.5%	47.6%	42.4%	44.3%	41.5%	↑	56.9%	52.1%	45.5%	51.8%	53.4%

* A lower rate indicates better performance – an "up" arrow indicates rate is below the NHM.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM	2010 PAC	2011 PAC	2012 PAC	2013 PAC	2014 PAC
ACC	42.8%	41.1%	48.4%	47.1%	51.4%	↑		33.0%	44.0%	42.5%	37.8%
JMS	54.2%	52.7%	56.2%	54.7%	61.5%	↑	50.4%	49.2%	58.6%	52.2%	49.8%
MPC	41.1%	41.6%	37.0%	39.9%	43.3%	↓	47.4%	43.3%	43.3%	37.7%	
MSFC	50.0%	52.8%	57.7%	58.9%	54.0%	↑					
PP	48.2%	46.2%	50.8%	49.1%	44.3%	↓	2.1%	35.5%	40.3%	35.8%	34.6%
RHP					NA*						
UHC	43.6%	37.5%	42.1%	38.9%	46.47%	↓	43.8%	32.4%	47.4%	36.6%	31.1%
MARR	45.1%	44.1%	48.3%	47.8%	50.2%	↑	35.9%	38.7%	46.7%	41.0%	53.4%

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM	2010 PAC	2011 PAC	2012 PAC	2013 PAC	2014 PAC
ACC	51.4%	62.3%	62.2%	69.3%	65.4%	↑		36.6%	34.9%	31.7%	37.7%
JMS	77.8%	79.7%	80.8%	80.1%	79.6%	↑	69.2%	60.5%	66.2%	62.1%	49.1%
MPC	74.0%	74.5%	76.2%	64.6%	72.0%	↑	43.1%	42.3%	29.0%	25.6%	
MSFC	75.1%	73.7%	75.7%	72.8%	71.1%	↑					
PP	65.0%	62.2%	71.6%	78.1%	71.0%	↑	27.8%	30.8%	31.0%	33.4%	33.2%
RHP					NA*						
UHC	71.3%	66.7%	60.8%	57.7%	56.9%	↑	38.9%	32.4%	42.3%	35.1%	35.6%
MARR	66.6%	67.9%	71.0%	69.6%	69.3%	↑	44.8%	40.5%	40.7%	37.6%	38.9%

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Comprehensive Diabetes (CDC) – LDL-C Screening

	2010	2011	2012	2013	2014	NHM	2010 PAC	2011 PAC	2012 PAC	2013 PAC	2014 PAC
ACC	69.3%	71.6%	77.4%	76.0%	76.9%	↑		70.5%	74.6%	74.5%	76.4%
JMS	93.1%	91.2%	89.4%	88.5%	87.8%	↑	89.1%	87.1%	90.5%	87.3%	82.1%
MPC	72.5%	74.9%	71.3%	69.2%	72.9%	↓	72.3%	69.3%	74.7%	65.6%	
MSFC	81.5%	79.3%	81.7%	77.4%	78.4%	↑					
PP	74.5%	70.4%	74.9%	73.1%	70.1%	↓	59.8%	68.1%	68.1%	70.2%	71.1%
RHP					NA*						
UHC	70.8%	71.0%	72.3%	74.2%	77.4%	↑	69.1%	69.2%	73.2%	75.0%	72.4%
MARR	74.9%	74.3%	76.4%	75.7%	77.2%	↑	72.6%	72.8%	76.2%	74.5%	75.5%

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM	2010 PAC	2011 PAC	2012 PAC	2013 PAC	2014 PAC
ACC	33.3%	38.2%	35.9%	36.2%	36.0%	↑		29.5%	29.7%	30.4%	29.7%
JMS	52.7%	47.8%	48.7%	44.2%	45.26%	↑	42.2%	43.5%	45.7%	44.9%	41.0%
MPC	32.4%	32.4%	27.0%	28.0%	30.5%	↓	35.5%	31.6%	30.7%	26.4%	
MSFC	42.1%	39.2%	44.6%	41.1%	39.9%	↑					
PP	39.4%	37.2%	36.1%	44.5%	45.28%	↑	0.0%	25.1%	26.3%	45.9%	46.0%
RHP					NA*						
UHC	31.1%	27.0%	35.0%	30.7%	35.0%	↑	29.2%	24.3%	40.1%	28.1%	22.2%
MARR	38.0%	35.2%	36.9%	36.1%	38.7%	↑	26.7%	30.8%	34.5%	35.1%	34.7%

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy

	2010	2011	2012	2013	2014	NHM	2010 PAC	2011 PAC	2012 PAC	2013 PAC	2014 PAC
ACC	74.4%	78.8%	79.72%	73.6%	75.7%	↓		72.3%	80.4%	76.1%	80.9%
JMS	93.1%	93.6%	94.7%	93.6%	93.1%	↑	91.0%	91.9%	94.4%	90.7%	89.3%
MPC	78.6%	77.6%	75.2%	74.4%	75.3%	↓	83.0%	79.1%	79.8%	73.8%	
MSFC	86.9%	85.6%	89.6%	78.8%	82.7%	↑					
PP	77.6%	80.1%	79.0%	77.6%	73.8%	↓	54.6%	74.9%	73.5%	77.3%	79.0%
RHP					NA*						
UHC	74.2%	73.5%	72.7%	74.2%	75.9%	↓	79.6%	74.6%	79.5%	79.1%	77.3%
MARR	79.2%	79.5%	79.69%	77.7%	79.4%	↑	77.0%	78.6%	81.5%	79.4%	81.7%

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010*	2011	2012	2013	2014	NHM	2010* PAC	2011 PAC	2012 PAC	2013 PAC	2014 PAC
ACC	*28.8%*	41.3%	31.1%	29.1%	34.4%	↓		0.0%	0.0%	0.0%	13.7%
JMS	*29.1%*	27.4%	34.1%	38.0%	39.2%	↑	*24.3%*	26.1%	33.8%	34.2%	30.5%
MPC	*22.9%*	31.1%	24.1%	30.3%	32.0%	↓	*23.1%*	25.8%	26.5%	17.8%	
MSFC	*36.0%*	37.7%	46.3%	55.7%	44.3%	↑					
PP	*31.4%*	37.6%	42.2%	42.6%	44.1%	↑	*0.0%*	3.2%	2.4%	0.0%	1.6%
RHP					NA**						
UHC	*30.9%*	19.2%	33.8%	25.3%	32.4%	↓	*21.2%*	0.0%	24.8%	0.2%	0.1%
MARR	30.3%	31.9%	35.8%	36.4%	37.7%	↓	*17.1%*	11.0%	17.5%	8.6%	11.5%

* Rates for 2010 shown in italics, are for Blood Pressure Control (<130/80 mm Hg)
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM	2010 PAC	2011 PAC	2012 PAC	2013 PAC	2014 PAC
ACC	53.5%	63.0%	54.6%	48.4%	55.6%	↓		0.0%	0.0%	0.0%	21.1%
JMS	54.0%	43.2%	54.74%	59.1%	60.4%	↑	49.0%	48.4%	56.4%	53.5%	52.9%
MPC	50.1%	51.3%	45.7%	47.1%	55.4%	↓	51.1%	46.0%	44.5%	31.5%	
MSFC	67.2%	59.6%	73.3%	73.7%	70.1%	↑					
PP	61.3%	59.1%	65.1%	63.3%	64.2%	↑	0.0%	6.5%	4.4%	0.0%	2.4%
RHP					NA*						
UHC	54.3%	32.8%	54.74%	47.0%	51.6%	↓	45.5%	0.0%	42.8%	0.2%	0.1%
MARR	57.5%	51.6%	58.9%	57.3%	59.5%	↑	36.4%	20.2%	29.6%	17.0%	19.1%

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Musculoskeletal Conditions

Use of Imaging Studies for Low Back Pain (LBP)

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

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

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

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

Use of Imaging Studies for Low Back Pain (LBP)

	2010*	2011*	2012	2013	2014	NHM
ACC			78.5%	77.8%	76.7%	↑
JMS			81.6%	70.9%	77.2%	↑
MPC			76.8%	75.2%	76.6%	↑
MSFC			74.5%	73.1%	73.3%	↓
PP			74.7%	75.0%	75.2%	↓
RHP					NA**	
UHC			75.5%	74.8%	73.4%	↓
MARR			76.6%	74.9%	75.4%	↓

* This measure was added by DHMH for reporting in HEDIS 2012.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

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

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

RA is a chronic autoimmune disorder often characterized by progressive joint destruction and multisystem involvement. It affects approximately 2.5 million Americans, and affects women disproportionately. There is no cure; consequently, the goal of treatment is to slow the progression of the disease and thereby delay or prevent joint destruction, relieve pain, and maintain functional capacity. Evidence-based guidelines support early initiation of DMARD therapy in patients diagnosed with RA. These guidelines include the American College of Rheumatology (ACR) Subcommittee on Rheumatoid Arthritis Guidelines: *Guidelines for the Management of Rheumatoid Arthritis*. All patients with RA are candidates for DMARD therapy, and the majority of the newly diagnosed should be started on DMARD therapy within three months of diagnosis.

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

Summary of Changes for HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.
- Added tofacitinib to the description of "Janus kinase (JAK) inhibitor" in Table ART-C.

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

	2010*	2011*	2012*	2013	2014	NHM
ACC				61.8%	60.0%	↓
JMS				NA**	NA**	
MPC				71.9%	73.8%	↑
MSFC				NA**	NA**	
PP				69.5%	67.6%	↓
RHP					NA**	
UHC				73.3%	67.7%	↓
MARR				69.1%	67.3%	↓

* This measure was added by DHMH for reporting in HEDIS 2013.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Medication Management

Annual Monitoring for Patients on Persistent Medications (MPM)

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

- 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.
- Annual monitoring for members on anticonvulsants.
- Total rate (the sum of the four numerators divided by the sum of the four denominators)

Rationale: Patient safety is highly important, especially for patients at increased risk of adverse drug events from long-term medication use. Persistent use of these drugs warrants monitoring and follow-up by the prescribing physician to assess for side-effects and adjust drug dosage/therapeutic decisions accordingly. The drugs included in this measure also have more deleterious effects in the elderly. The costs of annual monitoring are offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications. The total costs of drug-related problems due to misuse of drugs in the ambulatory setting has been estimated to exceed $76 billion annually.

Appropriate monitoring of drug therapy remains a significant issue to guide therapeutic decision making and provides largely unmet opportunities for improvement in care for patients on persistent medications.

Summary of Changes for HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

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

	2010*	2011*	2012*	2013	2014	NHM
ACC				90.1%	89.0%	↑
JMS				95.8%	95.1%	↑
MPC				88.9%	87.0%	↑
MSFC				87.6%	90.2%	↑
PP				88.224%	88.1%	↑
RHP					NA**	
UHC				88.222%	88.6%	↑
MARR				89.5%	89.7%	↑

* This measure was added by DHMH for reporting in HEDIS 2013.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010*	2011*	2012*	2013	2014	NHM
ACC				95.8%	95.7%	↑
JMS				NA**	NA**	
MPC				91.4%	92.2%	↑
MSFC				NA**	NA**	
PP				91.5%	88.9%	↓
RHP					NA**	
UHC				93.4%	86.4%	↓
MARR				93.1%	90.8%	↑

* This measure was added by DHMH for reporting in HEDIS 2013.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010*	2011*	2012*	2013	2014	NHM
ACC				88.2%	86.9%	↑
JMS				94.3%	94.1%	↑
MPC				88.04%	86.2%	↑
MSFC				88.02%	88.5%	↑
PP				87.2%	87.4%	↑
RHP					NA**	
UHC				87.8%	87.5%	↑
MARR				88.1%	88.4%	↑

* This measure was added by DHMH for reporting in HEDIS 2013.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010*	2011*	2012*	2013	2014	NHM
ACC				66.0%	66.3%	↑
JMS				64.8%	75.6%	↑
MPC				69.9%	70.42%	↑
MSFC				58.1%	67.1%	↑
PP				73.3%	68.3%	↑
RHP					NA**	
UHC				72.4%	75.0%	↑
MARR				67.5%	70.44%	↑

* This measure was added by DHMH for reporting in HEDIS 2013.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010*	2011*	2012*	2013	2014	NHM
ACC				86.2%	85.4%	↑
JMS				93.1%	94.1%	↑
MPC				88.0%	86.3%	↑
MSFC				84.1%	86.6%	↑
PP				87.3%	87.3%	↑
RHP					NA**	
UHC				87.5%	87.7%	↑
MARR				87.1%	87.9%	↑

* This measure was added by DHMH for reporting in HEDIS 2013.
** When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Behavioral Health

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

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

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

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

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

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

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.
- Clarified in the *Initiation of AOD Treatment* numerator that an IESD and initiation visit occurring on the same day must be with different providers.

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

	2010	2011	2012	2013	2014	NHM
ACC	38.9%	47.6%	41.0%	42.0%	37.7%	↓
JMS	NA*	NA*	NA*	NA*	NA*	
MPC	25.3%	49.5%	49.7%	42.3%	38.9%	↓
MSFC	23.1%	19.6%	19.5%	5.0%	30.9%	↓
PP	46.9%	50.0%	47.4%	38.4%	41.8%	↑
RHP					NA*	
UHC	41.3%	52.0%	49.8%	42.9%	44.3%	↑
MARR	35.1%	43.7%	41.5%	34.1%	38.7%	↓

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	51.1%	51.5%	47.4%	41.9%	38.8%	↓
JMS	44.2%	48.9%	46.7%	37.1%	45.4%	↑
MPC	46.9%	50.8%	47.7%	43.1%	37.3%	↓
MSFC	36.5%	33.1%	36.6%	29.2%	43.2%	↑
PP	46.8%	48.4%	42.8%	38.5%	37.0%	↓
RHP					NA*	
UHC	50.7%	50.1%	47.3%	47.9%	45.7%	↑
MARR	45.4%	46.3%	44.1%	40.5%	41.2%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	49.4%	50.9%	46.4%	41.9%	38.6%	↓
JMS	44.4%	48.8%	46.5%	36.8%	45.2%	↑
MPC	44.7%	50.6%	47.9%	43.0%	37.45%	↓
MSFC	35.6%	32.2%	35.5%	27.4%	41.7%	↑
PP	46.8%	48.6%	43.4%	38.5%	37.49%	↓
RHP					NA*	
UHC	49.7%	50.3%	47.6%	47.3%	45.5%	↑
MARR	44.5%	46.0%	43.9%	40.1%	41.0%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	23.7%	33.3%	26.5%	27.7%	24.1%	↑
JMS	NA*	NA*	NA*	NA*	NA*	↑
MPC	7.1%	33.6%	33.2%	26.5%	22.1%	↑
MSFC	10.3%	8.7%	9.8%	2.5%	19.8%	↑
PP	26.7%	32.4%	29.2%	22.6%	27.6%	↑
RHP					NA*	
UHC	13.1%	25.4%	31.5%	24.0%	30.3%	↑
MARR	16.2%	26.7%	26.0%	20.7%	24.8%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	21.0%	23.8%	20.7%	18.2%	17.9%	↑
JMS	15.7%	21.7%	19.5%	15.4%	17.0%	↑
MPC	13.3%	25.0%	24.0%	20.5%	19.8%	↑
MSFC	7.0%	10.4%	8.3%	5.5%	21.6%	↑
PP	16.6%	22.3%	18.7%	17.0%	17.2%	↑
RHP					NA*	
UHC	10.5%	14.7%	17.0%	17.8%	20.8%	↑
MARR	15.2%	20.4%	18.6%	16.4%	19.1%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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

	2010	2011	2012	2013	2014	NHM
ACC	21.4%	25.3%	21.6%	19.7%	18.8%	↑
JMS	16.0%	22.0%	19.4%	15.4%	16.9%	↑
MPC	12.7%	25.9%	24.9%	21.0%	20.0%	↑
MSFC	7.2%	10.3%	8.4%	5.3%	21.4%	↑
PP	17.9%	23.6%	19.9%	17.6%	18.4%	↑
RHP					NA*	
UHC	10.8%	16.0%	18.8%	18.5%	21.7%	↑
MARR	15.3%	21.2%	19.3%	16.9%	19.5%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

Identification of Alcohol and Other Drug Services (IAD)

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

- Any services
- Inpatient
- Intensive outpatient or partial hospitalization
- Outpatient or ED

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

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

	2010	2011	2012	2013	2014	NHM
ACC	2.3%	2.5%	2.5%	2.6%	2.7%	↓
JMS	17.6%	17.1%	16.7%	15.8%	16.9%	↑
MPC	4.9%	6.0%	6.2%	6.3%	6.0%	↑
MSFC	3.8%	4.4%	3.3%	3.1%	4.3%	↓
PP	4.6%	5.3%	5.2%	5.2%	5.0%	↑
RHP					14.9%	↑
UHC	3.3%	3.9%	4.0%	3.6%	4.7%	↓
MARR	6.0%	6.4%	6.2%	6.0%	7.9%	↑

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

	2010	2011	2012	2013	2014	NHM
ACC	0.7%	0.6%	0.6%	0.6%	0.5%	↓
JMS	4.9%	4.4%	4.1%	3.8%	4.0%	↑
MPC	1.57%	1.4%	1.3%	1.3%	0.95%	↓
MSFC	1.33%	1.5%	2.2%	0.90%	0.8%	↓
PP	1.30%	1.2%	1.1%	0.943%	0.9%	↓
RHP					1.6%	↑
UHC	0.9%	0.9%	0.9%	0.941%	1.03%	↓
MARR	1.8%	1.6%	1.6%	1.3%	1.4%	↓

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

	2010	2011	2012	2013	2014	NHM
ACC	0.3%	0.3%	0.33%	0.3%	0.3%	↓
JMS	2.7%	3.1%	2.9%	2.5%	2.5%	↑
MPC	0.66%	0.88%	0.94%	0.82%	0.7%	↓
MSFC	0.0%	0.4%	0.34%	0.18%	0.5%	↓
PP	0.8%	0.87%	0.8%	0.7%	0.6%	↓
RHP					1.3%	↑
UHC	0.4%	0.6%	0.43%	0.22%	0.0%	↓
MARR	0.73%	1.0%	0.87%	0.7%	1.0%	↑

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

	2010	2011	2012	2013	2014	NHM
ACC	1.9%	2.2%	2.2%	2.4%	2.5%	↓
JMS	15.9%	15.4%	15.2%	14.5%	15.6%	↑
MPC	4.1%	5.37%	5.7%	5.8%	5.6%	↑
MSFC	3.6%	3.9%	2.5%	2.5%	3.9%	↑
PP	4.0%	4.7%	4.8%	4.9%	4.6%	↑
RHP					11.9%	↑
UHC	2.8%	3.4%	3.5%	3.0%	4.2%	↑
MARR	5.3%	5.8%	5.5%	5.5%	6.9%	↑

Ambulatory Care (utilization)

Ambulatory Care (AMB)

Description: Utilization of ambulatory care in the following categories:

- Outpatient visits
- Emergency department (ED) visits

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

Summary of Changes to HEDIS 2014:

- Removed coding tables and replaced all coding table references with value set references.

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

	2010	2011	2012	2013	2014	NHM
ACC	388.5	366.8	370.88	363.6	365.1	↓
JMS	385.8	347.4	347.4	373.9	340.8	↓
MPC	400.4	373.9	386.8	385.3	365.3	↓
MSFC	389.5	364.4	370.0	361.6	344.5	↓
PP	415.9	395.0	415.9	407.8	386.6	↑
RHP					269.8	↓
UHC	391.2	361.1	381.0	374.2	373.3	↓
MARR	385.9	361.4	370.88	370.3	349.3	↓

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

	2010	2011	2012	2013	2014	NHM
ACC	66.1	59.0	60.7	59.8	56.2	↓
JMS	92.1	88.8	91.3	93.4	90.1	↑
MPC	81.4	72.5	78.8	79.3	74.6	↑
MSFC	80.1	70.3	72.3	70.8	62.66	↓
PP	70.0	64.0	65.7	66.0	62.70	↓
RHP					66.0	↑
UHC	68.9	63.7	65.8	65.2	62.1	↓
MARR	79.0	71.8	74.2	74.2	67.8	↑

Call Services

Call Answer Timeliness (CAT)

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

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

Summary of Changes to HEDIS 2014: No changes to this measure.

Call Answer Timeliness (CAT)

	2010	2011	2012	2013	2014	NHM
ACC	85.3%	76.1%	78.9%	81.9%	89.7%	↑
JMS	87.5%	86.6%	93.1%	95.0%	93.4%	↑
MPC	85.5%	85.7%	91.1%	87.7%	89.2%	↑
MSFC	96.1%	94.8%	89.2%	89.4%	91.3%	↑
PP	76.5%	84.4%	73.1%	84.9%	71.0%	↓
RHP					NA*	
UHC	82.3%	79.6%	85.5%	92.4%	89.4%	↑
MARR	85.9%	85.6%	85.6%	87.5%	87.3%	↑

* When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.