Statewide Executive Summary

HealthChoice Participating Organizations

HEDIS® 2016

Prepared for:

Maryland Department of Health and Mental Hygiene

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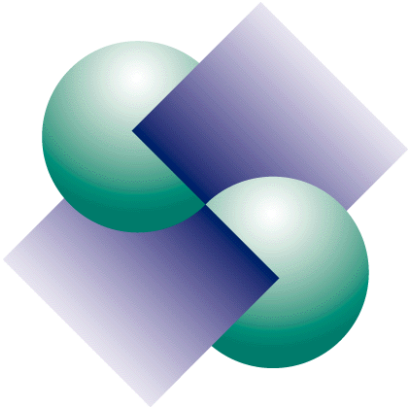

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INTRODUCTION

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

DHMH contracted with HealthcareData Company, LLC (HDC), a NCQA-Licensed Organization, to conduct HEDIS Compliance Audits of all HealthChoice organizations and to summarize the results.

BACKGROUND

The Maryland Medicaid program implemented HealthChoice, a comprehensive managed care program, in June of 1997 after receiving a waiver from the Centers for Medicare and Medicaid Services (CMS) of the requirements in §1115 of the Social Security Act. HealthChoice allows eligible Medicaid recipients to enroll in the participating managed care organization of their choice. There are currently eight organizations participating in HealthChoice, with a total of 990,487 enrollees as of December 31, 2015.

Within DHMH, the HealthChoice & Acute Care Administration is responsible for the quality oversight of the HealthChoice program. DHMH continues to measure HealthChoice program clinical quality performance and enrollee satisfaction using initiatives including HEDIS and Consumer Assessment of Healthcare Providers Systems (CAHPS®) reporting. Performance is measured at both the organization level and on a statewide basis. HEDIS and CAHPS results are incorporated annually into a HealthChoice Health Plan Performance Report Card developed to assist HealthChoice enrollees to make comparisons when selecting a health plan. All eight HealthChoice organizations reported HEDIS in 2016.

For HEDIS 2016, DHMH required HealthChoice managed care organizations to report the complete HEDIS measure set for services rendered in calendar year 2015 to Maryland Medical Assistance HealthChoice enrollees. These measures provide meaningful managed care organization comparative information and they measure performance relative to DHMH's priorities and goals.

Several plans began participation in the HealthChoice program recently and will only have information reported for the relevant reporting years in Sections V and VI. Performance data for Riverside Health of Maryland will only be available beginning HEDIS 2014 reporting. Performance data for Kaiser Permanente will only be available beginning HEDIS 2015 reporting.

Accreditation

All Health organizations participating in the HealthChoice program as of January 1, 2013 were required to be accredited by the NCQA no later than January 1, 2015 as per COMAR §10.09.65.02. In addition, according to COMAR §10.09.64.08, any HealthChoice organizations that joined the HealthChoice program after January 1, 2013 are required to be NCQA accredited within 2 years of their effective date as a HealthChoice organization. Current accreditation status for all HealthChoice organizations is listed in the *Organizations Reporting HEDIS in 2016* table.

Organizations Reporting HEDIS in 2016

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

NCQA Accreditation

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

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

* Source: NCQA (2016). *What Accreditation Levels Can a Plan Achieve?* Retrieved from: http://www.ncqa.org/Programs/Accreditation/health-plan-hp/Accreditation-Levels

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. A table showing the history of DHMH reporting for each measure is included in Appendix 1.

Measures selected by DHMH for HealthChoice Reporting

DHMH required Health Choice managed care organizations to report 48 HEDIS measures for services rendered in calendar year 2015 (including two Experience of Care measures which are not within the scope of this report; Flu Vaccinations for Adults Ages 18-64 (FVA) & Medical Assistance with Smoking and Tobacco Use Cessation (MSC). The required set reflected 2 first-year HEDIS measures for reporting. The 2 new measures are Statin Therapy for Patients with Cardiovascular Disease (SPC) and Statin Therapy for Patients with Diabetes (SPD). Results for these new measures will not be publicly reported until HEDIS 2017.

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

Effectiveness of Care (EOC): 27 measures
Childhood Immunization Status (CIS)
Immunizations for Adolescents (IMA)
Breast Cancer Screening (BCS)
Cervical Cancer Screening (CCS)
Comprehensive Diabetes Care (CDC), *all indicators except HbA1c Control (<7.0%)*
Statin Therapy for Patients with Diabetes (SPD) *New*
Appropriate Treatment for Children with Upper Respiratory Infection (URI)
Appropriate Testing for Children with Pharyngitis (CWP)
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
Chlamydia Screening in Women (CHL)
Use of Imaging Studies for Low Back Pain (LBP)
Annual Monitoring for Patients on Persistent Medications (MPM)
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
Medication Management for People with Asthma (MMA)
Controlling High Blood Pressure (CBP)
Adult BMI Assessment (ABA)
Asthma Medication Ratio (AMR)
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
Pharmacotherapy Management of COPD Exacerbation (PCE)
Persistence of Beta Blocker Treatment after a Heart Attack (PBH)
Statin Therapy for Patients with Cardiovascular Disease (SPC) *New*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
Lead Screening in Children (LSC)
Human Papillomavirus Vaccine for Female Adolescents (HPV)
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

Access/Availability of Care (AAC): 4 measures
Adults' Access to Preventive/Ambulatory Health Services (AAP)
Children and Adolescents' Access to Primary Care Practitioners (CAP)
Prenatal and Postpartum Care (PPC)
Call Answer Timeliness (CAT)

Utilization and Risk Adjusted Utilization (URR): 8 measures
Frequency of Ongoing Prenatal Care (FPC)
Well-Child Visits in the First 15 Months of Life (W15)
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
Adolescent Well-Care Visits (AWC)

Ambulatory Care (AMB) *Report Only "a" Level of Measure*
Frequency of Selected Procedures (FSP)
Inpatient Utilization- General Hospital/ Acute Care (IPU) *Report Only "a" Level of Measure*
Antibiotic Utilization (ABX) *Report Only "a" Level of Measure*

Health Plan Descriptive Information: 7 measures
Board Certification (BCR)
Enrollment by Product Line (ENP) *Report Only "a" Level of Measure*
Enrollment by State (EBS)
Language Diversity of Membership (LDM)
Race/ Ethnicity Diversity of Membership (RDM)
Weeks of Pregnancy at Time of Enrollment (WOP)
Total Membership (TLM)

No Benefit (NB) Measure Designations: 12 Measures
The NB designation is utilized for measures where DHMH has contracted with outside vendors for coverage of certain services. HDC and HealthChoice Organizations do not have access to the data. So that plans are not penalized, NCQA allows the health plans to report these measures with a NB designation. The following twelve measures are reported NB and do not appear in measure specific findings of this report.

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

II. HEDIS METHODOLOGY

The HEDIS-reporting organization follows guidelines for data collection and specifications for measure calculation described in *HEDIS 2016 Volume 2: Technical Specifications*.

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

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

Supplemental data: NCQA defines supplemental data as atypical administrative data, i.e., not claims or encounters. Sources include immunization registry files, laboratory results files, case management databases, and electronic health record databases. There are three classes of supplemental data with varying requirements for proof-of-service. The most stable form is Standard Supplemental Data which is from a database with a constant form that does not change over time. Nonstandard Supplemental Data is in a less stable form and may be manipulated by human intervention and interaction. It must be substantiated by proof-of-service documentation and is subject to primary source verification. Member-reported services are subject to the same scrutiny as nonstandard supplemental data, but are gathered directly from MCO members.

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

III. MEASURE-SPECIFIC FINDINGS – EXPLANATION

Three years of HealthChoice results are displayed in Table A, along with the 2016 Maryland Average Reportable Rate (MARR). Table A1 shows three years of the MARR for the past three years. Due to NCQA licensing restrictions, the National HEDIS Mean (NHM) can no longer be displayed on Table A. In the report, the NHM has also been removed from each table. An "arrow" has been added to indicate if the HealthChoice plan's performance score is above, below, or equal to the NHM.

Measure-specific descriptions and five-year historical results are located on the pages that follow Tables A and A1.

Reference Sources:

Description – The source of the information is NCQA's *HEDIS 2016 Volume 2: Technical Specifications*.

Rationale – For all measures, except Call Answer Timeliness (CAT) the source of the information is the Agency for Healthcare Research and Quality (AHRQ) citations of NCQA as of 2016. These citations appear under the *Brief Abstract* on the Web site of the National Quality Measures Clearinghouse, http://www.qualitymeasures.ahrq.gov/. For CAT the rationale was adapted from *HEDIS 2004 Vol. 2: Technical Specifications*, Appendix 2.

Summary of Changes for HEDIS 2016 – The source of the text, is the *HEDIS 2015 Volume 2: Technical Specifications*, incorporating additional changes published in the *HEDIS 2016 Volume 2: "October" Technical Update.*

HEDIS 2016 Results, page one of five	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2016
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR
Prevention and Screening - Adult																									
Adult BMI Assessment (ABA)	72.0%	82.4%	85.2%	80.2%	98.5%	96.6%		98.4%	100.0%	70.2%	84.9%	82.4%	82.6%	86.4%	90.3%	82.9%	89.6%	86.1%	NA[1]	NA[1]	85.4%	68.9%	81.9%	92.7%	89.8%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	23.88%	24.5%	25.9%	35.2%	34.1%	33.0%		NA[1]	NA[1]	22.0%	21.9%	19.5%	15.2%	19.9%	22.8%	23.94%	24.4%	22.2%	NA[1]	NA[1]	23.1%	20.8%	23.7%	26.0%	24.6%
Childhood Immunization Status (CIS) – Combination 2 (DTaP, IPV, MMR, HiB, Hep B, VZV)	81.3%	83.8%	83.1%	86.5%	88.4%	88.7%		NA[1]	79.5%	73.7%	70.8%	84.7%	88.1%	81.8%	85.9%	83.1%	83.6%	84.5%	NA[1]	50.0%	80.9%	73.0%	77.4%	83.5%	83.5%
Childhood Immunization Status (CIS) – Combination 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV)	78.2%	81.9%	81.9%	86.1%	87.6%	87.3%		NA[1]	78.2%	72.1%	68.2%	82.1%	85.9%	79.3%	83.2%	80.8%	80.1%	83.0%	NA[1]	43.8%	80.2%	71.3%	73.7%	80.5%	82.1%
Childhood Immunization Status (CIS) – Combination 4 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A)	73.6%	77.6%	78.9%	84.8%	85.2%	86.8%		NA[1]	78.2%	62.8%	64.7%	78.0%	81.3%	76.6%	80.5%	69.4%	78.5%	79.7%	NA[1]	43.8%	78.2%	66.2%	67.9%	75.7%	79.5%
Childhood Immunization Status (CIS) – Combination 5 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV)	63.9%	63.7%	68.3%	71.7%	68.0%	76.4%		NA[1]	68.0%	47.0%	57.1%	59.9%	70.1%	64.5%	67.9%	54.6%	68.5%	69.0%	NA[1]	37.5%	58.0%	56.9%	60.1%	61.6%	66.1%
Childhood Immunization Status (CIS) – Combination 6 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Influenza)	49.3%	53.0%	52.6%	47.8%	46.8%	47.6%		NA[1]	52.6%	37.7%	40.6%	41.8%	59.4%	51.6%	47.9%	49.5%	54.2%	59.7%	NA[1]	28.1%	41.0%	44.3%	48.4%	42.6%	48.2%
Childhood Immunization Status (CIS) – Combination 7 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV)	60.7%	61.3%	65.7%	71.3%	67.2%	76.4%		NA[1]	68.0%	44.0%	55.0%	57.8%	66.7%	62.5%	65.7%	50.7%	68.5%	67.3%	NA[1]	37.5%	56.7%	54.7%	57.4%	58.9%	64.6%
Childhood Immunization Status (CIS) – Combination 8 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, Influenza)	47.9%	50.9%	51.4%	47.4%	45.6%	47.2%		NA[1]	52.6%	34.9%	38.5%	40.1%	56.2%	49.4%	47.2%	44.4%	53.5%	57.5%	NA[1]	28.1%	40.3%	41.4%	46.2%	40.9%	47.1%
Childhood Immunization Status (CIS) – Combination 9 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV, Influenza)	42.4%	43.5%	46.8%	40.9%	36.4%	42.5%		NA[1]	46.2%	28.4%	34.3%	32.5%	49.9%	44.3%	40.2%	36.3%	48.4%	51.1%	NA[1]	23.4%	30.0%	37.0%	41.4%	35.0%	40.5%
Childhood Immunization Status (CIS) – Combination 10 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, Influenza)	41.2%	42.1%	45.6%	40.9%	36.0%	42.5%		NA[1]	46.2%	27.7%	33.0%	31.6%	47.0%	42.8%	39.4%	34.3%	48.4%	50.0%	NA[1]	23.4%	29.4%	35.3%	40.2%	33.8%	39.8%
Immunizations for Adolescents (IMA) – Combination 1 (Meningococcal, Tdap/Td)	69.4%	74.8%	86.8%	75.5%	76.7%	82.1%		NA[1]	82.7%	62.7%	74.07%	85.4%	70.7%	72.4%	80.0%	74.5%	74.07%	89.2%	NA[1]	64.7%	82.7%	63.4%	66.2%	84.8%	84.2%
Well-Child Visits in the First 15 months of Life (W15) – No well-child visits [2]	1.0%	2.1%	0.9%	3.1%	1.9%	4.4%		NA[1]	2.0%	0.5%	1.56%	1.2%	1.2%	3.5%	3.5%	1.1%	1.59%	1.5%	NA[1]	10.9%	8.5%	1.9%	0.9%	2.5%	3.1%
Well-Child Visits in the First 15 months of Life (W15) – DHMH Five or more visits (constructed by combining HEDIS rates for five and six-or-more visits)	88.9%	85.1%	88.9%	84.4%	81.6%	82.4%		NA[1]	78.2%	83.6%	84.9%	85.9%	86.0%	82.8%	82.7%	83.7%	81.9%	82.2%	NA[1]	56.6%	67.0%	87.4%	83.6%	87.2%	81.8%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	83.9%	83.7%	85.8%	88.9%	90.6%	90.9%		84.6%	82.6%	88.8%	87.0%	88.7%	83.5%	86.7%	85.5%	83.8%	86.8%	85.2%	NA[1]	57.4%	62.3%	75.0%	79.2%	80.7%	82.7%
Adolescent Well-Care Visits (AWC)	67.9%	64.7%	67.9%	76.7%	80.3%	82.6%		63.5%	57.1%	68.8%	68.3%	73.2%	67.8%	61.2%	64.0%	61.6%	68.8%	72.8%	NA[1]	31.8%	42.6%	60.8%	58.5%	64.8%	65.6%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – BMI Percentile- Total Rate	49.5%	60.9%	56.4%	92.2%	94.7%	92.7%		99.0%	98.6%	46.5%	58.3%	56.7%	59.8%	67.3%	62.4%	52.1%	72.5%	70.1%	NA[1]	41.5%	32.1%	45.5%	57.9%	61.0%	66.3%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate	59.0%	71.5%	66.0%	94.4%	97.6%	97.6%		98.1%	94.5%	54.4%	66.4%	66.7%	74.1%	72.9%	73.5%	54.2%	73.6%	74.3%	NA[1]	50.8%	36.7%	67.6%	64.5%	69.5%	72.4%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate	51.4%	61.3%	58.1%	89.8%	91.2%	93.4%		98.1%	94.5%	58.8%	60.0%	63.9%	72.9%	67.8%	65.5%	44.7%	70.1%	70.1%	NA[1]	43.1%	30.4%	60.6%	63.0%	62.8%	67.3%
Appropriate Testing for Children with Pharyngitis (CWP)	78.36%	79.8%	82.4%	70.8%	80.2%	85.6%		NA[1]	98.3%	78.42%	82.9%	86.3%	86.9%	90.5%	94.5%	80.5%	83.1%	85.9%	NA[1]	76.4%	87.1%	83.1%	86.0%	86.6%	88.3%
Lead Screening in Children (LSC)	[5]	77.1%	79.4%	[5]	87.2%	92.1%	[5]	NA[1]	64.5%	[5]	70.0%	73.8%	[5]	88.6%	82.6%	[5]	71.9%	75.7%	[5]	53.1%	67.7%	[5]	68.6%	74.9%	76.3%
Human Papillomavirus Vaccine for Female Adolescents (HPV)	[5]	23.7%	30.9%	[5]	33.9%	46.2%	[5]	NA[1]	NA[1]	[5]	21.8%	26.6%	[5]	24.3%	23.1%	[5]	17.7%	28.0%	[5]	NA[1]	14.1%	[5]	15.1%	26.3%	27.9%
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) [2]	[5]	5.3%	3.9%	[5]	2.1%	1.9%	[5]	1.9%	0.6%	[5]	4.2%	2.0%	[5]	2.9%	1.9%	[5]	3.7%	2.4%	[5]	5.2%	4.0%	[5]	5.8%	3.2%	2.5%

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

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

Table A – HealthChoice Organizations HEDIS 2016 Results

HEDIS 2016 Results, page two of five	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2016
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR
Respiratory Conditions - Adult and Child																									
Use of Appropriate Medications for People with Asthma (ASM)** – Total Ages 5–11	90.3%	90.0%	**	93.59%	91.4%	**		NA[1]	**	91.4%	92.5%	**	93.62%	93.5%	**	91.6%	92.0%	**	NA[1]	NA[1]	**	91.9%	90.8%	**	**
Use of Appropriate Medications for People with Asthma (ASM)** – Total Ages 12–18	87.8%	87.1%	**	86.0%	86.3%	**		NA[1]	**	90.4%	91.5%	**	94.2%	91.6%	**	88.5%	89.5%	**	NA[1]	NA[1]	**	88.0%	88.6%	**	**
Use of Appropriate Medications for People with Asthma (ASM)** – Total Ages 19–50	73.7%	73.1%	**	81.3%	89.4%	**		NA[1]	**	80.1%	77.9%	**	75.2%	77.6%	**	76.8%	74.9%	**	NA[1]	NA[1]	**	72.9%	73.7%	**	**
Use of Appropriate Medications for People with Asthma (ASM)** – Total Ages 51–64	68.6%	79.0%	**	71.4%	83.8%	**		NA[1]	**	76.3%	80.9%	**	NA	NA	**	73.0%	77.6%	**	NA[1]	NA[1]	**	79.0%	72.8%	**	**
Use of Appropriate Medications for People with Asthma (ASM)** – Total Ages 5–64	86.29%	86.3%	**	83.6%	87.9%	**		NA[1]	**	86.97%	87.3%	**	90.1%	89.0%	**	87.02%	87.1%	**	NA[1]	NA[1]	**	86.28%	84.11%	**	**
Use of Appropriate Medications for People with Asthma (ASM)** – Total Ages 5–50 [3]	86.8%	83.4%	**	86.4%	89.0%	**		NA[1]	**	87.53%	87.3%	**	90.1%	87.6%	**	87.6%	85.4%	**	NA[1]	NA[1]	**	86.6%	84.3%	**	**
Medication Management for People With Asthma (MMA) – Total 50% of treatment period	45.8%	48.8%	48.5%	49.4%	59.6%	73.9%		NA[1]	NA[1]	57.9%	57.9%	61.5%	51.9%	49.9%	48.8%	43.3%	44.5%	46.8%	NA[1]	NA[1]	64.5%	49.9%	48.4%	54.0%	56.9%
Medication Management for People With Asthma (MMA) – Total 75% of treatment period	22.9%	23.2%	25.1%	24.5%	34.8%	51.4%		NA[1]	NA[1]	32.9%	34.0%	35.6%	26.6%	24.1%	25.8%	20.0%	20.5%	23.7%	NA[1]	NA[1]	48.4%	27.8%	25.2%	28.5%	34.1%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	86.5%	88.03%	89.4%	83.0%	92.4%	97.1%		NA[1]	97.5%	86.6%	85.6%	88.7%	84.3%	89.5%	90.0%	86.0%	89.0%	90.6%	NA[1]	86.4%	85.5%	82.0%	85.2%	88.8%	91.0%
Asthma Medication Ratio (AMR)	68.6%	56.54%	63.0%	60.5%	56.50%	61.9%		NA[1]	NA[1]	69.1%	65.0%	64.0%	73.7%	68.1%	69.3%	69.6%	63.8%	64.7%	NA[1]	NA[1]	52.4%	69.8%	63.4%	64.0%	62.7%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	25.8%	23.6%	30.0%	26.3%	32.6%	34.9%		NA[1]	NA[1]	21.1%	20.8%	25.5%	34.5%	29.2%	30.8%	23.7%	27.2%	28.0%	NA[1]	NA[1]	NA[1]	25.6%	25.6%	31.2%	30.1%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate	73.6%	69.0%	70.3%	69.2%	73.6%	73.3%		NA[1]	NA[1]	72.6%	72.1%	74.4%	76.3%	72.2%	71.0%	69.7%	69.7%	75.7%	NA[1]	78.1%	70.3%	78.2%	73.0%	70.2%	72.2%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate	87.5%	84.8%	84.9%	82.5%	85.4%	88.6%		NA[1]	NA[1]	84.9%	85.1%	87.4%	90.3%	92.4%	84.5%	84.0%	85.0%	83.7%	NA[1]	81.3%	86.1%	84.9%	86.3%	80.8%	85.1%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–24 months	97.8%	97.7%	97.9%	94.7%	96.2%	91.5%		100.0%	91.3%	96.5%	96.9%	97.2%	96.4%	93.9%	95.3%	89.8%	97.6%	97.8%	NA[1]	87.8%	84.9%	96.3%	96.6%	97.0%	94.1%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months–6 years	92.8%	93.1%	94.1%	88.7%	91.8%	93.0%		98.0%	89.1%	90.0%	90.3%	91.6%	89.8%	88.4%	90.0%	93.5%	93.3%	94.2%	NA[1]	69.4%	77.5%	91.1%	91.3%	92.6%	90.3%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7–11 years	94.3%	95.3%	96.1%	93.8%	92.7%	93.8%		98.4%	98.1%	92.1%	92.61%	93.5%	93.5%	92.58%	92.0%	92.7%	94.4%	95.3%	NA[1]	NA[1]	76.8%	93.1%	93.6%	94.4%	92.5%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–19 years	90.5%	91.9%	93.0%	90.8%	92.9%	94.2%		94.2%	96.6%	88.5%	89.7%	91.6%	92.7%	91.7%	90.6%	91.9%	92.5%	93.7%	NA[1]	NA[1]	75.2%	90.1%	90.9%	92.1%	90.9%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 years	79.4%	79.4%	79.7%	72.9%	71.0%	69.3%		92.9%	82.7%	81.1%	80.9%	82.8%	79.7%	76.3%	75.8%	81.7%	82.3%	82.6%	NA[1]	63.6%	69.3%	80.4%	80.0%	79.0%	77.7%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years	87.2%	86.7%	88.2%	86.6%	86.75%	87.8%		95.7%	87.0%	87.80%	87.4%	89.4%	86.9%	85.1%	85.7%	0.0%	89.0%	90.0%	NA[1]	75.9%	79.6%	87.80%	88.0%	88.0%	87.0%
Breast Cancer Screening (BCS)	58.1%	66.0%	65.9%	69.4%	72.1%	72.6%		87.2%	88.5%	48.5%	65.9%	72.1%	64.4%	63.4%	66.0%	57.0%	62.5%	68.3%	NA[1]	NA[1]	63.8%	52.7%	58.1%	62.3%	70.0%
Cervical Cancer Screening (CCS)	79.64%	67.8%	67.5%	79.5%	66.8%	77.3%		90.8%	79.2%	79.58%	65.75%	65.2%	74.0%	66.2%	61.5%	75.9%	74.4%	69.3%	NA[1]	35.5%	41.1%	62.8%	58.8%	60.1%	65.1%
Chlamydia Screening in Women (CHL) – Age 16–20 years	62.4%	61.4%	61.0%	86.7%	87.6%	87.6%		76.9%	69.2%	58.2%	58.9%	56.8%	54.8%	57.2%	52.2%	61.5%	59.2%	57.5%	NA[1]	61.1%	49.5%	55.4%	55.2%	52.1%	60.8%
Chlamydia Screening in Women (CHL) – Age 21–24 years	71.9%	71.7%	68.6%	72.3%	65.0%	72.8%		80.8%	84.7%	67.1%	67.3%	68.7%	68.4%	66.5%	65.3%	69.9%	68.0%	67.5%	NA[1]	58.7%	61.2%	64.8%	63.2%	65.4%	69.3%
Chlamydia Screening in Women (CHL) – Total (16–24) years	66.0%	66.0%	64.2%	81.2%	77.3%	80.3%		79.5%	79.6%	62.0%	62.6%	62.0%	60.1%	61.3%	58.6%	64.8%	62.7%	61.5%	NA[1]	59.7%	56.3%	59.0%	58.8%	57.9%	65.1%

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[4] New measure for HEDIS 2014.
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**Measure Retired by NCQA for HEDIS 2016

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Table A – HealthChoice Organizations HEDIS 2016 Results

HEDIS 2016 Results, page three of five	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2016
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR
Prenatal and Postpartum Care																									
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	84.2%	85.7%	83.9%	85.8%	83.2%	87.2%		88.0%	92.9%	84.9%	80.3%	81.5%	85.4%	79.2%	84.5%	90.9%	88.2%	90.3%	52.2%	73.3%	74.5%	87.1%	84.1%	80.7%	84.4%
Prenatal and Postpartum Care (PPC) – Postpartum Care	71.6%	66.0%	73.7%	78.5%	83.6%	88.0%		86.0%	83.8%	71.9%	65.0%	68.9%	72.0%	71.1%	69.2%	75.6%	70.7%	73.7%	43.5%	47.4%	62.3%	63.8%	62.5%	66.2%	73.2%
Frequency of Ongoing Prenatal Care (FPC) – Less than 21% of expected visits [2]	8.2%	5.9%	5.2%	2.2%	4.5%	3.5%		7.7%	5.8%	5.6%	6.9%	5.6%	4.4%	7.6%	3.2%	4.4%	9.3%	8.5%	37.0%	17.4%	12.2%	5.8%	6.8%	5.2%	6.1%
Frequency of Ongoing Prenatal Care (FPC) – Greater than or equal to 81% of expected visits	75.5%	72.6%	73.4%	70.8%	64.0%	66.7%		56.9%	72.4%	70.6%	69.8%	65.3%	71.3%	64.6%	71.8%	78.8%	61.7%	62.7%	21.7%	55.0%	55.0%	73.2%	74.5%	75.8%	67.9%
Controlling High Blood Pressure (CBP)	49.0%	63.9%	54.1%	56.2%	69.3%	76.4%		87.8%	86.0%	46.8%	61.4%	55.9%	65.5%	69.2%	71.2%	57.0%	59.5%	60.2%	NA[1]	32.1%	48.2%	42.3%	50.9%	56.9%	63.6%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA[1]	91.5%	84.9%	NA[1]	NA[1]	NA[1]		NA[1]	NA[1]	87.5%	90.2%	84.3%	NA[1]	NA[1]	67.7%	86.1%	84.6%	85.7%	NA[1]	NA[1]	NA[1]	82.9%	87.8%	77.9%	80.1%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	[5]	NA[1]	NA[1]	[5]	NA[1]	NA[1]	[5]	NA[1]	NA[1]	[5]	NA[1]	NA[1]	[5]	NA[1]	NA[1]	[5]	NA[1]	NA[1]	[5]	NA[1]	NA[1]	[5]	NA[1]	NA[1]	[6]
Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing	83.4%	88.7%	87.4%	89.1%	90.7%	94.3%		96.4%	94.5%	79.5%	87.9%	85.9%	84.7%	88.0%	87.8%	78.1%	89.4%	89.4%	NA[1]	84.6%	88.3%	79.1%	85.9%	82.5%	88.8%
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%) [2]	38.8%	38.5%	42.2%	31.0%	37.2%	26.6%		21.8%	28.2%	48.6%	40.8%	40.8%	37.2%	44.5%	31.6%	48.1%	35.6%	35.6%	NA[1]	60.8%	39.2%	45.5%	41.1%	39.7%	35.5%
Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)	51.4%	51.4%	49.2%	61.5%	52.4%	60.4%		60.0%	57.6%	43.3%	50.8%	49.7%	54.0%	43.5%	59.9%	44.3%	54.3%	55.1%	NA[1]	38.8%	48.2%	46.5%	46.2%	51.6%	54.0%
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed	65.4%	48.6%	53.9%	79.6%	64.1%	71.9%		87.3%	84.7%	72.0%	65.7%	65.8%	71.1%	54.0%	52.6%	71.0%	69.0%	62.9%	NA[1]	44.8%	35.0%	56.9%	58.6%	55.2%	60.2%
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy	75.7%	80.3%	90.7%	93.1%	93.4%	96.9%		100.0%	95.3%	75.3%	75.9%	89.9%	82.7%	80.9%	91.0%	73.8%	82.5%	89.4%	NA[1]	74.8%	90.8%	75.9%	81.5%	91.2%	91.9%
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)	55.6%	65.3%	60.0%	60.4%	69.7%	76.8%		83.6%	87.1%	55.4%	56.4%	55.2%	70.1%	69.0%	67.6%	64.2%	60.7%	62.6%	NA[1]	39.9%	36.5%	51.6%	55.2%	46.0%	61.5%
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	[5]	76.7%	68.9%	[5]	NA[1]	NA[1]	[5]	NA[1]	NA[1]	[5]	NA[1]	65.5%	[5]	NA[1]	NA[1]	[5]	68.7%	68.7%	[5]	NA[1]	NA[1]	[5]	74.6%	72.2%	68.8%
Use of Imaging Studies for Low Back Pain (LBP)	76.7%	74.2%	74.6%	77.2%	69.2%	77.7%		NA[1]	71.5%	76.6%	76.7%	75.5%	73.3%	71.8%	72.7%	75.2%	75.0%	76.0%	NA[1]	78.1%	74.2%	73.4%	74.3%	73.2%	74.4%
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	60.0%	62.8%	78.0%	NA[1]	NA[1]	NA[1]		NA[1]	NA[1]	73.8%	65.8%	67.5%	NA	89.2%	77.4%	67.6%	72.5%	83.1%	NA[1]	NA[1]	NA[1]	67.7%	61.5%	69.8%	75.2%
Annual Monitoring for Patients on Persistent Medications (MPM)– Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)	89.0%	89.4%	90.5%	95.1%	94.4%	96.5%		95.0%	92.8%	87.0%	88.4%	89.0%	90.2%	90.0%	90.3%	88.1%	88.1%	89.0%	NA[1]	86.1%	86.1%	88.6%	89.2%	88.7%	90.4%
Annual Monitoring for Patients on Persistent Medications (MPM) – Members on digoxin	95.7%	59.5%	58.3%	NA2	NA[1]	NA[1]		NA[1]	NA[1]	92.2%	54.9%	47.5%	NA2	NA[1]	NA[1]	88.9%	44.9%	58.1%	NA[1]	NA[1]	NA[1]	86.4%	57.7%	52.9%	54.2%
Annual Monitoring for Patients on Persistent Medications (MPM) – Members on diuretics	86.9%	88.42%	89.6%	94.1%	93.9%	95.6%		NA[1]	90.8%	86.2%	86.5%	88.5%	88.5%	89.0%	88.32%	87.4%	87.9%	88.30%	NA[1]	90.5%	84.4%	87.5%	88.40%	87.8%	89.2%
Annual Monitoring for Patients on Persistent Medications (MPM) – Total rate	85.4%	88.9%	89.9%	94.1%	94.0%	95.9%		94.2%	91.8%	86.3%	87.2%	88.6%	86.6%	89.3%	89.4%	87.3%	87.8%	88.5%	NA[1]	87.9%	85.2%	87.7%	88.7%	88.1%	89.7%

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HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR
Ambulatory Care (AMB) – Outpatient visits per 1,000 member months	365.1	356.01	372.6	340.8	315.5	345.1		404.4	324.9	365.3	365.02	406.4	344.5	360.0	358.6	386.6	390.7	406.5	269.8	296.8	332.6	373.3	381.6	378.1	365.6
Ambulatory Care (AMB) – Emergency department (ED) visits per 1,000 member months 3	56.2	58.2	55.1	90.1	96.4	94.0		23.2	24.9	74.6	70.9	71.0	62.66	57.4	56.1	62.70	62.0	60.1	66.0	64.9	89.8	62.1	63.1	59.5	63.8
Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery /1000 MM 45-64 F	[5]	0.05	0.05	[5]	0.02	0.00	[5]	0.00	0.00	[5]	0.056	0.068	[5]	0.07	0.10	[5]	0.055	0.06	[5]	0.038	0.12	[5]	0.043	0.04	0.074
Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery /1000 MM 45-64 M	[5]	0.00	0.0074	[5]	0.016	0.00	[5]	0.00	0.00	[5]	0.00	0.015	[5]	0.00	0.015	[5]	0.01	0.03	[5]	0.04	0.00	[5]	0.018	0.010	0.015
Frequency of Selected Procedures (FSP) – Tonsillectomy /1000 MM 0-9 T	[5]	0.42	0.48	[5]	0.18	0.13	[5]	0.13	0.00	[5]	0.47	0.55	[5]	0.39	0.45	[5]	0.60	0.64	[5]	0.21	0.31	[5]	0.43	0.51	0.44
Frequency of Selected Procedures (FSP) – Tonsillectomy /1000 MM 10-19 T	[5]	0.16	0.186	[5]	0.05	0.18	[5]	0.20	0.00	[5]	0.21	0.26	[5]	0.17	0.19	[5]	0.24	0.25	[5]	0.09	0.16	[5]	0.19	0.194	0.20
Frequency of Selected Procedures (FSP) – Hysterectomy, abdominal /1000 MM 45-64 F	[5]	0.46	0.31	[5]	0.44	0.36	[5]	0.01	0.00	[5]	0.50	0.32	[5]	0.53	0.47	[5]	0.35	0.45	[5]	0.45	0.23	[5]	0.47	0.28	0.35
Frequency of Selected Procedures (FSP) – Hysterectomy, vaginal /1000 MM 45-64 F	[5]	0.188	0.1510	[5]	0.02	0.00	[5]	0.00	0.00	[5]	0.16	0.24	[5]	0.17	0.22	[5]	0.20	0.31	[5]	0.11	0.17	[5]	0.191	0.1506	0.21
Frequency of Selected Procedures (FSP) – Cholecystectomy, open /1000 MM 30-64 M	[5]	0.047	0.022	[5]	0.03	0.0569	[5]	0.00	0.00	[5]	0.08	0.04	[5]	0.06	0.0574	[5]	0.055	0.03	[5]	0.00	0.00	[5]	0.04	0.018	0.039
Frequency of Selected Procedures (FSP) – Cholecystectomy, open /1000 MM 45-64 F	[5]	0.07	0.010	[5]	0.063	0.045	[5]	0.00	0.00	[5]	0.037	0.05	[5]	0.056	0.012	[5]	0.061	0.06	[5]	0.00	0.00	[5]	0.040	0.02	0.03
Frequency of Selected Procedures (FSP) – Laparoscopic/1000 MM 30-64 M	[5]	0.21	0.20	[5]	0.11	0.05	[5]	0.172	0.00	[5]	0.34	0.31	[5]	0.172	0.24	[5]	0.193	0.29	[5]	0.12	0.21	[5]	0.191	0.26	0.22
Frequency of Selected Procedures (FSP) – Laparoscopic/1000 MM 45-64 F	[5]	0.49	0.36	[5]	0.19	0.29	[5]	0.00	0.00	[5]	0.67	0.62	[5]	0.69	0.40	[5]	0.65	0.69	[5]	0.34	0.43	[5]	0.60	0.44	0.46
Frequency of Selected Procedures (FSV) – Back Surgery /1000 MM 45-64 F	[5]	0.41	0.46	[5]	0.58	0.56	[5]	0.00	0.00	[5]	0.66	0.81	[5]	0.56	0.67	[5]	0.78	0.74	[5]	0.30	0.43	[5]	0.55	0.60	0.61
Frequency of Selected Procedures (FSP) – Back Surgery /1000 MM 45-64 M	[5]	0.43	0.58	[5]	0.42	0.41	[5]	0.00	0.00	[5]	0.65	0.85	[5]	0.52	0.69	[5]	0.66	0.80	[5]	0.39	0.47	[5]	0.62	0.83	0.66
Frequency of Selected Procedures (FSP) – Mastectomy /1000 MM 15-44 F	[5]	0.022	0.0226	[5]	0.030	0.050	[5]	0.00	0.00	[5]	0.026	0.045	[5]	0.016	0.01	[5]	0.036	0.03	[5]	0.00	0.051	[5]	0.041	0.0233	0.034
Frequency of Selected Procedures (FSP) – Mastectomy /1000 MM 45-64 F	[5]	0.16	0.13	[5]	0.04	0.07	[5]	0.00	0.00	[5]	0.14	0.12	[5]	0.11	0.10	[5]	0.21	0.23	[5]	0.19	0.173	[5]	0.20	0.171	0.14
Frequency of Selected Procedures (FSP) – Lumpectomy /1000 MM 15-44 F	[5]	0.15	0.113	[5]	0.00	0.07	[5]	0.00	0.00	[5]	0.14	0.106	[5]	0.18	0.20	[5]	0.16	0.14	[5]	0.11	0.05	[5]	0.13	0.107	0.111
Frequency of Selected Procedures (FSP) – Lumpectomy /1000 MM 45-64 F	[5]	0.365	0.27	[5]	0.21	0.25	[5]	0.01	0.00	[5]	0.29	0.28	[5]	0.41	0.52	[5]	0.49	0.42	[5]	0.27	0.14	[5]	0.372	0.38	0.32

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[4] New measure for HEDIS 2014.
[5] New measure for HEDIS 2015.
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Table A – HealthChoice Organizations HEDIS 2016 Results

HEDIS 2016 Results, page five of five	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2016
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR
Ambulatory Care (Utilization) (continued)																									
Inpatient Utilization - General Hospital Acute Care (IPU) – Total Inpatient: Total Discharges /1000 MM	[5]	5.95	5.83	[5]	9.89	10.06	[5]	6.40	5.49	[5]	6.47	6.84	[5]	7.01	6.67	[5]	6.61	6.75	[5]	6.73	8.59	[5]	7.17	6.60	7.10
Inpatient Utilization - General Hospital Acute Care (IPU) – Total Inpatient: Total Average Length of Stay	[5]	3.96	4.14	[5]	4.12	4.81	[5]	4.59	3.34	[5]	3.66	3.75	[5]	4.03	4.22	[5]	3.85	4.06	[5]	3.72	3.47	[5]	4.12	4.23	4.00
Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics (aaattot)	[5]	0.87	0.85	[5]	0.88	0.87	[5]	0.68	0.67	[5]	1.03	1.10	[5]	0.86	0.88	[5]	0.97	0.97	[5]	0.77	0.85	[5]	0.98	0.92	0.89
Antibiotic Utilization (ABX) – Average Days Supplied per Antibiotic Script (acattot)	[5]	9.29	9.35	[5]	8.983	9.00	[5]	8.977	9.46	[5]	9.40	9.32	[5]	9.23	9.10	[5]	9.39	9.42	[5]	9.21	9.28	[5]	9.26	9.35	9.28
Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics of Concern (adattot)	[5]	0.35	0.35	[5]	0.29	0.29	[5]	0.27	0.25	[5]	0.41	0.45	[5]	0.34	0.35	[5]	0.39	0.39	[5]	0.32	0.38	[5]	0.43	0.41	0.36
Antibiotic Utilization (ABX) – Percentage of Antibiotics of Concern of all Antibiotics (apttot)	[5]	40.4%	40.8%	[5]	33.0%	33.7%	[5]	40.5%	37.8%	[5]	39.8%	40.8%	[5]	40.2%	40.1%	[5]	40.4%	40.7%	[5]	42.1%	44.6%	[5]	43.2%	44.3%	40.3%
Call Answer Timeliness (CAT)	89.7%	82.9%	86.6%	93.4%	92.7%	97.9%		69.6%	84.2%	89.2%	86.7%	88.2%	91.3%	77.3%	91.0%	71.0%	43.5%	58.0%	NA[1]	80.4%	87.9%	89.4%	84.3%	90.2%	85.5%

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Table A1 – Health Plan Descriptive Information

	ACC	JMS	KPMAS	MPC	MSFC	PP	RHMD	UHC
Board Certification (BCR) – Family Medicine: Number of Physicians	570	49	177	655	286	613	551	761
Board Certification (BCR) – Family Medicine: Number Board Certified	403	42	172	346	136	578	362	561
Board Certification (BCR) – Family Medicine: Percent Board Certified	70.70%	85.71%	97.18%	52.82%	47.55%	94.29%	65.70%	73.72%
Board Certification (BCR) – Internal Medicine: Number of Physicians	2,024	557	380	1,319	473	943	668	2,307
Board Certification (BCR) – Internal Medicine: Number Board Certified	1,464	519	369	928	298	887	412	1,756
Board Certification (BCR) – Internal Medicine: Percent Board Certified	72.33%	93.18%	97.11%	70.36%	63.00%	94.06%	61.68%	76.12%
Board Certification (BCR) – OB/GYN: Number of Physicians	584	113	171	714	360	758	515	836
Board Certification (BCR) – OB/GYN: Number Board Certified	448	95	150	310	139	723	266	720
Board Certification (BCR) – OB/GYN: Percent Board Certified	76.71%	84.07%	87.72%	43.42%	38.61%	95.38%	51.65%	86.12%
Board Certification (BCR) – Pediatrician: Number of Physicians	1,106	158	105	973	167	851	537	1,212
Board Certification (BCR) – Pediatrician: Number Board Certified	845	146	105	715	48	808	325	1,017
Board Certification (BCR) – Pediatrician: Percent Board Certified	76.40%	92.41%	100.00%	73.48%	28.74%	94.95%	60.52%	83.91%
Board Certification (BCR) – Geriatricians: Number of Physicians	84	37	2	49	15	40	32	88
Board Certification (BCR) – Geriatricians: Number Board Certified	53	34	2	33	5	38	23	57
Board Certification (BCR) – Geriatricians: Percent Board Certified	63.10%	91.89%	100.00%	67.35%	33.33%	95.00%	71.88%	64.77%
Board Certification (BCR) – Other Specialists: Number of Physicians	5,068	1,938	871	5,424	2,230	11,493	3,073	5,764
Board Certification (BCR) – Other Specialists: Number Board Certified	3,732	1,758	847	3,572	1,207	10,770	1,465	4,615
Board Certification (BCR) – Other Specialists: Percent Board Certified	73.64%	90.71%	97.24%	65.86%	54.13%	93.71%	47.67%	80.07%
Enrollment by Product Line (ENP) – Shows only total member months for Female	1,674,894	132,883	121,660	1,179,962	424,716	1,586,242	153,309	1,270,877
Enrollment by Product Line (ENP) – Shows only total member months for Male	1,405,128	145,122	101,136	904,595	341,526	1,253,413	151,157	1,062,926
Enrollment by Product Line (ENP) – Shows only total member months Total	3,080,022	278,005	222,796	2,084,557	766,242	2,839,655	304,466	2,333,803
Enrollment by State (EBS) – Maryland Only	253,373	21,969	29,598	178,113	66,346	241,869	26,456	170,806

	ACC	JMS	KPMAS	MPC	MSFC	PP	RHMD	UHC
Language Diversity (LDM) – Spoken - English Number	10	32,808	30,858	0	0	0	0	4
Language Diversity (LDM) – Spoken - English Percent	0.00%	99.76%	81.82%	0.00%	0.00%	0.00%	0.00%	0.00%
Language Diversity (LDM) – Spoken - Non-English Number	5,338	79	3,777	0	0	0	0	2,382
Language Diversity (LDM) – Spoken - Non-English Percent	1.60%	0.24%	10.01%	0.00%	0.00%	0.00%	0.00%	0.91%
Language Diversity (LDM) – Spoken - Unknown Number	327,965	0	3,058	236,314	97,250	311,467	45,494	260,034
Language Diversity (LDM) – Spoken - Unknown Percent	98.40%	0.00%	8.11%	100.00%	100.00%	100.00%	100.00%	99.09%
Language Diversity (LDM) – Spoken - Declined Number	0	0	21	0	0	0	0	0
Language Diversity (LDM) – Spoken - Declined Percent	0.00%	0.00%	0.06%	0.00%	0.00%	0.00%	0.00%	0.00%
Race/Ethnicity Diversity (RDM) – White / Total	63,072	3,806	7,220	82,652	0	107,710	15,327	92,373
Race/Ethnicity Diversity (RDM) – White / Percent	18.92%	11.57%	19.14%	34.98%	0.00%	34.58%	33.69%	35.20%
Race/Ethnicity Diversity (RDM) – Black / Total	141,924	16,625	19,118	104,253	0	123,299	17,152	113,988
Race/Ethnicity Diversity (RDM) – Black / Percent	42.58%	50.55%	50.69%	44.12%	0.00%	39.59%	37.70%	43.44%
Race/Ethnicity Diversity (RDM) – American Indian & Alaska Native / Total	0	93	90	13	0	4	0	0
Race/Ethnicity Diversity (RDM) – American Indian & Alaska Native / Percent	0.00%	0.28%	0.24%	0.01%	0.00%	0.00%	0.00%	0.00%
Race/Ethnicity Diversity (RDM) – Asian / Total	13,950	629	2,444	8,311	5,075	10,917	2,160	14,447
Race/Ethnicity Diversity (RDM) – Asian / Percent	4.19%	1.91%	6.48%	3.52%	5.22%	3.51%	4.75%	5.51%
Race/Ethnicity Diversity (RDM) – Native Hawaiian - Pacific Islander / Total	335	27	32	12	0	0	64	296
Race/Ethnicity Diversity (RDM) – Native Hawaiian - Pacific Islander / Percent	0.10%	0.08%	0.08%	0.01%	0.00%	0.00%	0.14%	0.11%
Race/Ethnicity Diversity (RDM) – Other / Total	0	0	649	0	0	0	0	0
Race/Ethnicity Diversity (RDM) – Other / Percent	0.00%	0.00%	1.72%	0.00%	0.00%	0.00%	0.00%	0.00%
Race/Ethnicity Diversity (RDM) – 2+ Races / Total	0	0	5	0	0	0	0	0
Race/Ethnicity Diversity (RDM) – 2+ Races / Percent	0.00%	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%
Race/Ethnicity Diversity (RDM) – Unknown / Total	114,032	11,707	8,058	41,073	92,175	69,537	1,486	41,316
Race/Ethnicity Diversity (RDM) – Unknown / Percent	34.21%	35.60%	21.37%	17.38%	94.78%	22.33%	3.27%	15.74%
Race/Ethnicity Diversity (RDM) – Declined / Total	0	0	98	0	0	0	9,305	0
Race/Ethnicity Diversity (RDM) – Declined / Percent	0.00%	0.00%	0.26%	0.00%	0.00%	0.00%	20.45%	0.00%
Week of Pregnancy at Time of Enrollment (WOP) – 13-27 weeks	28.96%	18.12%	36.54%	24.01%	32.12%	29.01%	28.29%	26.76%
Week of Pregnancy at Time of Enrollment (WOP) – 28+ weeks	17.49%	16.72%	18.95%	16.24%	20.68%	19.35%	18.97%	16.01%
Week of Pregnancy at Time of Enrollment (WOP) – Unknown	4.78%	0.00%	5.11%	4.14%	0.00%	3.71%	15.64%	3.80%
Total Membership – Total membership numbers for each plan	253,373	21,993	38,584	178,253	116,374	242,133	26,494	170,957

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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 (American Obesity Association [AOA], 2005). 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 to 20 years. Overweight and obesity are also contributing causes to more than 50 percent of all-cause mortality among American adults aged 20 to 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, indicate that the first step in weight management is assessment of height and weight in order to calculate a patient's body mass index (BMI). BMI is considered the most efficient and effective method for assessing excess body fat; it is a starting point for assessing the relationship between weight and height, and it is the most conducive method of assessment in the primary care setting (NHLBI, 2001).

Summary of Changes to HEDIS 2016:

- Revised the age criteria for BMI and BMI percentile in the numerator.
- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Adult BMI Assessment (ABA)

	2012*	2013	2014	2015	2016	NHM
ACC		61.3%	72.0%	82.4%	85.2%	⇧
JMS		90.7%	80.2%	98.5%	96.6%	⇧
KPMAS				98.4%	100.0%	⇧
MPC		48.7%	70.2%	84.9%	82.4%	⇧
MSFC		76.4%	82.6%	86.4%	90.3%	⇧
PP		59.9%	82.9%	89.6%	86.1%	⇧
RHMD			NA▫	NA▫	85.4%	⇧
UHC		49.1%	68.9%	81.9%	92.7%	⇧
MARR		65.1%	76.1%	88.9%	89.8%	⇧

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

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

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

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

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

Summary of Changes to HEDIS 2016:

- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012	2013	2014	2015	2016	NHM
ACC	23.7%	20.6%	23.88%	24.5%	25.9%	⇩
JMS	21.9%	35.5%	35.2%	34.1%	33.0%	⇧
KPMAS				NA▫	NA▫	
MPC	19.7%	19.9%	22.0%	21.9%	19.5%	⇩
MSFC	16.1%	14.1%	15.2%	19.9%	22.8%	⇩
PP	21.1%	18.9%	23.94%	24.4%	22.2%	⇩
RHMD			NA▫	NA▫	23.1%	⇩
UHC	19.6%	16.0%	20.8%	23.7%	26.0%	⇩
MARR	20.5%	20.4%	23.5%	24.7%	24.6%	⇩

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

Childhood Immunization Status (CIS)

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

	DTaP	IPV	MMR	HiB	Hep B	VZV	PCV	Hep A	RV	Influenza
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 2016:

- Added a Note to MMR clarifying that the “14-day rule” does not apply to this vaccine.
- Added a new value set to the administrative method to identify Hepatitis B vaccines administered at birth.
- Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012	2013	2014	2015	2016	NHM
ACC	85.6%	84.7%	81.3%	83.8%	83.1%	⇧
JMS	80.6%	86.1%	86.5%	88.4%	88.7%	⇧
KPMAS				NA▫	79.5%	⇧
MPC	81.8%	76.9%	73.7%	70.8%	84.7%	⇧
MSFC	89.5%	85.4%	88.1%	81.8%	85.9%	⇧
PP	86.0%	86.8%	83.1%	83.6%	84.5%	⇧
RHMD			NA▫	50.0%	80.9%	⇧
UHC	82.7%	70.3%	73.0%	77.4%	83.5%	⇧
MARR	82.5%	80.2%	80.9%	76.5%	83.8%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	81.9%	83.5%	78.2%	81.9%	81.9%	⇧
JMS	78.7%	83.7%	86.1%	87.6%	87.3%	⇧
KPMAS				NA▫	78.2%	⇧
MPC	80.8%	74.3%	72.09%	68.2%	82.1%	⇧
MSFC	87.6%	83.7%	85.9%	79.3%	83.2%	⇧
PP	83.7%	83.8%	80.8%	80.1%	83.0%	⇧
RHMD			NA▫	43.8%	80.2%	⇧
UHC	78.8%	66.7%	71.3%	73.7%	80.5%	⇧
MARR	79.7%	77.7%	79.1%	73.5%	82.1%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	39.1%	75.9%	73.6%	77.6%	78.9%	⇧
JMS	33.3%	80.9%	84.8%	85.2%	86.8%	⇧
KPMAS				NA▫	78.2%	⇧
MPC	32.8%	67.4%	62.8%	64.7%	78.0%	⇧
MSFC	41.6%	80.3%	81.3%	76.6%	80.5%	⇧
PP	38.8%	73.8%	69.4%	78.5%	79.7%	⇧
RHMD			NA▫	43.8%	78.2%	⇧
UHC	37.2%	58.9%	66.2%	67.9%	75.7%	⇧
MARR	36.2%	71.8%	73.0%	70.6%	79.5%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	59.7%	61.3%	63.9%	63.7%	68.3%	⇧
JMS	57.9%	59.4%	71.7%	68.0%	76.4%	⇧
KPMAS				NA▫	68.0%	⇧
MPC	53.5%	55.3%	47.0%	57.1%	59.9%	⇧
MSFC	63.3%	56.0%	70.1%	64.5%	67.9%	⇧
PP	55.1%	59.6%	54.6%	68.5%	69.0%	⇧
RHMD			NA▫	37.5%	58.0%	⇔
UHC	57.2%	52.0%	56.9%	60.1%	61.6%	⇧
MARR	56.2%	56.3%	60.7%	59.9%	66.1%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	48.6%	49.7%	49.3%	53.0%	52.6%	⇧
JMS	33.3%	39.0%	47.8%	46.8%	47.6%	⇧
KPMAS				NA▫	52.6%	⇧
MPC	39.2%	42.4%	37.7%	40.6%	41.8%	⇩
MSFC	57.4%	55.2%	59.4%	51.6%	47.9%	⇧
PP	51.4%	51.5%	49.5%	54.2%	59.7%	⇧
RHMD			NA▫	28.1%	41.0%	⇩
UHC	41.8%	38.2%	44.3%	48.4%	42.6%	⇔
MARR	44.0%	45.7%	48.0%	46.1%	48.2%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	30.1%	57.8%	60.7%	61.3%	65.7%	⇧
JMS	25.5%	59.0%	71.3%	67.2%	76.4%	⇧
KPMAS				NA▫	68.0%	⇧
MPC	20.2%	51.4%	44.0%	55.0%	57.8%	⇧
MSFC	31.1%	54.3%	66.7%	62.5%	65.7%	⇧
PP	25.3%	56.2%	50.7%	68.5%	67.3%	⇧
RHMD			NA▫	37.5%	56.7%	⇧
UHC	28.2%	47.2%	54.7%	57.4%	58.9%	⇧
MARR	26.3%	53.6%	58.0%	58.5%	64.6%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	25.7%	47.3%	47.9%	50.9%	51.4%	⇧
JMS	21.3%	39.0%	47.4%	45.6%	47.2%	⇧
KPMAS				NA▫	52.6%	⇧
MPC	17.0%	38.7%	34.9%	38.5%	40.1%	⇩
MSFC	28.2%	53.5%	56.2%	49.4%	47.2%	⇧
PP	24.2%	48.3%	44.4%	53.5%	57.5%	⇧
RHMD			NA▫	28.1%	40.3%	⇩
UHC	21.7%	35.3%	41.4%	46.2%	40.9%	⇩
MARR	22.4%	43.6%	45.4%	44.6%	47.1%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	38.2%	38.5%	42.4%	43.5%	46.8%	⇧
JMS	25.0%	29.5%	40.9%	36.4%	42.5%	⇧
KPMAS				NA▫	46.2%	⇧
MPC	29.2%	33.8%	28.4%	34.3%	32.5%	⇩
MSFC	43.8%	38.7%	49.9%	44.3%	40.2%	⇧
PP	38.8%	41.1%	36.3%	48.4%	51.1%	⇧
RHMD			NA▫	23.4%	30.0%	⇩
UHC	32.8%	31.6%	37.0%	41.4%	35.0%	⇩
MARR	33.8%	35.5%	39.1%	38.8%	40.5%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	20.6%	37.1%	41.2%	42.1%	45.6%	⇧
JMS	18.1%	29.5%	40.9%	36.0%	42.5%	⇧
KPMAS				NA▫	46.2%	⇧
MPC	12.2%	31.0%	27.7%	33.0%	31.6%	⇩
MSFC	22.1%	37.7%	47.0%	42.8%	39.4%	⇧
PP	17.9%	39.7%	34.3%	48.4%	50.0%	⇧
RHMD			NA▫	23.4%	29.4%	⇩
UHC	17.5%	29.2%	35.3%	40.2%	33.8%	⇩
MARR	17.7%	34.2%	37.7%	38.0%	39.8%	⇧

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

Immunizations for Adolescents (IMA)

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

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

Summary of Changes to HEDIS 2016:

- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Combination 1 (Meningococcal, Tdap/Td)

	2012	2013	2014	2015	2016	NHM
ACC	56.7%	65.0%	69.4%	74.8%	86.8%	⇧
JMS	73.2%	70.66%	75.5%	76.7%	82.1%	⇧
KPMAS				NA▫	82.7%	⇧
MPC	51.1%	57.6%	62.7%	74.1%	85.4%	⇧
MSFC	70.7%	70.69%	70.7%	72.4%	80.0%	⇧
PP	52.0%	67.4%	74.5%	74.1%	89.2%	⇧
RHMD			NA▫	64.7%	82.7%	⇧
UHC	48.4%	56.4%	63.4%	66.2%	84.8%	⇧
MARR	57.4%	63.8%	67.2%	71.9%	84.2%	⇧

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

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

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

Rationale: This measure looks at the adequacy of well-child care for infants. It measures the percentage of children who had between one and six or more well-child visits by the time they turned 15 months of age.

The American Academy of Pediatrics (AAP) (2000) recommends six well-child visits in the first year of life: the first within the first month of life, and then at around 2, 4, 6, 9, and 12 months of age. These visits are of particular importance during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination and social and emotional growth. Regular check-ups are one of the best ways to detect physical, developmental, behavioral and emotional problems. They also provide an opportunity for the clinician to offer guidance and counseling to the parents.

Summary of Changes to HEDIS 2016:

- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012	2013	2014	2015	2016	NHM
ACC	1.6%	1.012%	1.0%	2.1%	0.9%	⇧
JMS	0.87%	2.7%	3.1%	1.9%	4.4%	⇩
KPMAS				NA▫	2.0%	⇔
MPC	1.4%	1.11%	0.5%	1.56%	1.2%	⇧
MSFC	1.3%	1.013%	1.2%	3.5%	3.5%	⇩
PP	1.1%	1.14%	1.1%	1.59%	1.5%	⇔
RHMD			NA▫	10.9%	8.5%	⇩
UHC	0.88%	2.2%	1.9%	0.9%	2.5%	⇔
MARR	1.5%	1.6%	1.5%	3.2%	3.1%	⇔

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

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

	2012	2013	2014	2015	2016	NHM
ACC	87.3%	86.1%	88.9%	85.1%	88.9%	⇧
JMS	84.0%	85.9%	84.4%	81.6%	82.4%	⇧
KPMAS				NA▫	78.2%	⇧
MPC	89.9%	77.8%	83.6%	84.9%	85.9%	⇧
MSFC	88.2%	89.2%	86.0%	82.8%	82.7%	⇧
PP	84.3%	84.3%	83.7%	81.9%	82.2%	⇧
RHMD			NA▫	56.6%	67.0%	⇧
UHC	86.8%	82.1%	87.4%	83.6%	87.2%	⇧
MARR	85.0%	83.9%	85.7%	79.5%	81.8%	⇧

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

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

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

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

Summary of Changes to HEDIS 2016:

- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012	2013	2014	2015	2016	NHM
ACC	86.4%	83.6%	83.9%	83.7%	85.8%	⇧
JMS	88.9%	87.7%	88.9%	90.6%	90.9%	⇧
KPMAS				84.6%	82.6%	⇧
MPC	89.1%	87.5%	88.8%	87.0%	88.7%	⇧
MSFC	82.3%	79.6%	83.5%	86.7%	85.5%	⇧
PP	82.4%	80.7%	83.8%	86.8%	85.2%	⇧
RHMD			NA▫	57.4%	62.3%	⇩
UHC	83.1%	83.8%	75.0%	79.2%	80.7%	⇧
MARR	85.0%	82.2%	84.0%	82.0%	82.7%	⇧

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

Adolescent Well-Care Visits (AWC)

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

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 2016:

- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Adolescent Well-Care Visits (AWC)

	2012	2013	2014	2015	2016	NHM
ACC	61.9%	68.1%	67.9%	64.7%	67.9%	⇧
JMS	79.9%	76.9%	76.7%	80.3%	82.6%	⇧
KPMAS				63.5%	57.1%	⇧
MPC	75.8%	60.2%	68.8%	68.3%	73.2%	⇧
MSFC	67.7%	69.4%	67.8%	61.2%	64.0%	⇧
PP	66.1%	67.6%	61.6%	68.8%	72.8%	⇧
RHMD			NA▫	31.8%	42.6%	⇩
UHC	55.7%	59.7%	60.8%	58.5%	64.8%	⇧
MARR	67.0%	65.4%	67.3%	62.1%	65.6%	⇧

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

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

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

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

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

Rationale: One of the most important developments in pediatrics in the past two decades has been the emergence of a new chronic disease: obesity in childhood and adolescence. The rapidly increasing prevalence of obesity among children is one of the most challenging dilemmas currently facing pediatricians. In addition to the growing prevalence of obesity in children and adolescents, overweight children at risk of becoming obese are also of great concern. The Centers for Disease Control and Prevention (CDC) states that overweight children and adolescents are more likely to become obese as adults. For example, one study found that approximately 80 percent of children who were overweight at 10–15 years of age were obese adults at age 25. Another study found that 25 percent of obese adults were overweight as children; it also found that if overweight begins before 8 years of age, obesity in adulthood is likely to be more severe.

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

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

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

Summary of Changes to HEDIS 2016:

- Removed the BMI value option for members 16–17 years of age from the numerator.
- Revised the physical activity requirement to indicate that notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations does not meet criteria.
- Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012*	2013*	2014	2015	2016	NHM
ACC			49.5%	60.9%	56.4%	⇩
JMS			92.2%	94.7%	92.7%	⇧
KPMAS				99.0%	98.6%	⇧
MPC			46.5%	58.3%	56.7%	⇩
MSFC			59.8%	67.3%	62.4%	⇩
PP			52.1%	72.5%	70.1%	⇧
RHMD			NA▫	41.5%	32.1%	⇩
UHC			45.5%	57.9%	61.0%	⇩
MARR			57.6%	69.0%	66.3%	⇧

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

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

	2012*	2013*	2014	2015	2016	NHM
ACC			59.0%	71.5%	66.0%	⇧
JMS			94.4%	97.6%	97.6%	⇧
KPMAS				98.1%	94.5%	⇧
MPC			54.4%	66.4%	66.7%	⇧
MSFC			74.1%	72.9%	73.5%	⇧
PP			54.2%	73.6%	74.3%	⇧
RHMD			NA▫	50.8%	36.7%	⇩
UHC			67.6%	64.5%	69.5%	⇧
MARR			67.3%	74.4%	72.4%	⇧

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

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

	2012*	2013*	2014	2015	2016	NHM
ACC			51.4%	61.3%	58.1%	⇧
JMS			89.8%	91.2%	93.4%	⇧
KPMAS				98.1%	94.5%	⇧
MPC			58.8%	60.0%	63.9%	⇧
MSFC			72.9%	67.8%	65.5%	⇧
PP			44.7%	70.1%	70.1%	⇧
RHMD			NA▫	43.1%	30.4%	⇩
UHC			60.6%	63.0%	62.8%	⇧
MARR			63.0%	69.3%	67.3%	⇧

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

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 2016:

- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Appropriate Testing for Children with Pharyngitis (CWP)

	2012	2013	2014	2015	2016	NHM
ACC	68.8%	75.9%	78.36%	79.8%	82.4%	⇧
JMS	74.51%	75.3%	70.8%	80.2%	85.6%	⇧
KPMAS				NA▫	98.3%	⇧
MPC	76.9%	77.4%	78.42%	82.9%	86.3%	⇧
MSFC	85.9%	85.2%	86.9%	90.5%	94.5%	⇧
PP	74.46%	78.2%	80.5%	83.1%	85.9%	⇧
RHMD			NA▫	76.4%	87.1%	⇧
UHC	76.4%	79.8%	83.1%	86.0%	86.6%	⇧
MARR	75.7%	79.9%	79.7%	82.7%	88.3%	⇧

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

Lead Screening in Children (LSC)

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

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

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

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

Summary of Changes to HEDIS 2016:

- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Lead Screening in Children (LSC)

	2012	2013	2014*	2015	2016	NHM
ACC				77.1%	79.4%	⇧
JMS				87.2%	92.1%	⇧
KPMAS				NA▫	64.5%	⇩
MPC				70.0%	73.8%	⇧
MSFC				88.6%	82.6%	⇧
PP				71.9%	75.7%	⇧
RHMD				53.1%	67.7%	⇔
UHC				68.6%	74.9%	⇧
MARR				73.8%	76.3%	⇧

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

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

Human Papillomavirus Vaccine for Female Adolescents (HPV)

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

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

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

Summary of Changes to HEDIS 2016:

- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Human Papillomavirus Vaccine for Female Adolescents (HPV)

	2012	2013	2014*	2015	2016	NHM
ACC				23.7%	30.9%	⇧
JMS				33.9%	46.2%	⇧
KPMAS				NA▫	NA▫	
MPC				21.8%	26.6%	⇧
MSFC				24.3%	23.1%	⇔
PP				17.7%	28.0%	⇧
RHMD				NA▫	14.1%	⇩
UHC				15.1%	26.3%	⇧
MARR				22.8%	27.9%	⇧

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

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

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

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

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

Summary of Changes to HEDIS 2016:

- Added a requirement to not include denied claims in the numerator.
- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012	2013	2014*	2015	2016	NHM
ACC				5.3%	3.9%	⇔
JMS				2.1%	1.9%	⇧
KPMAS				1.9%	0.6%	⇧
MPC				4.2%	2.0%	⇧
MSFC				2.9%	1.9%	⇧
PP				3.7%	2.4%	⇧
RHMD				5.2%	4.0%	⇔
UHC				5.8%	3.2%	⇔
MARR				3.9%	2.5%	⇩

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

Medication Management for People with Asthma (MMA)

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

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

Rationale: 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 2016:

- Expanded age range up to 85 years for the commercial product line.
- Added the Medicare product line.
- Added Table MMA-A: Asthma Medications and Table MMA-B: Asthma Controller Medications.
- Deleted all "Long-acting, inhaled beta-2 agonists" from Table MMA-A.
- Replaced all references of Table ASM-C to Table MMA-A in step 1.
- Replaced all references of Table ASM-D to Table MMA-B throughout the measure specification.
- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012*	2013	2014	2015	2016	NHM
ACC		44.8%	45.8%	48.8%	48.5%	⇩
JMS		53.2%	49.4%	59.6%	73.9%	⇧
KPMAS				NA▫	NA▫	
MPC		49.4%	57.9%	57.9%	61.5%	⇧
MSFC		52.4%	51.9%	49.9%	48.8%	⇩
PP		40.3%	43.3%	44.5%	46.8%	⇩
RHMD			NA▫	NA▫	64.5%	⇧
UHC		47.3%	49.9%	48.4%	54.0%	⇔
MARR		46.3%	49.7%	51.5%	56.9%	⇧

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

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

	2012*	2013	2014	2015	2016	NHM
ACC		24.1%	22.9%	23.2%	25.1%	⇩
JMS		28.9%	24.5%	34.8%	51.4%	⇧
KPMAS				NA▫	NA▫	
MPC		26.6%	32.9%	34.0%	35.6%	⇧
MSFC		28.7%	26.6%	24.1%	25.8%	⇩
PP		19.7%	20.0%	20.5%	23.7%	⇩
RHMD			NA▫	NA▫	48.4%	⇧
UHC		26.7%	27.8%	25.2%	28.5%	⇩
MARR		24.3%	25.8%	27.0%	34.1%	⇧

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

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

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

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

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

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

Summary of Changes to HEDIS 2016:

- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

	2012	2013	2014	2015	2016	NHM
ACC	86.13%	85.1%	86.5%	88.0%	89.4%	⇧
JMS	89.8%	85.2%	83.0%	92.4%	97.1%	⇧
KPMAS				NA▫	97.5%	⇧
MPC	86.08%	86.06%	86.6%	85.6%	88.7%	⇧
MSFC	89.0%	86.13%	84.3%	89.5%	90.0%	⇧
PP	86.01%	85.0%	86.0%	89.0%	90.6%	⇧
RHMD			NA▫	86.4%	85.5%	⇩
UHC	80.2%	80.1%	82.0%	85.2%	88.8%	⇧
MARR	86.20%	84.4%	84.7%	88.0%	91.0%	⇧

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

Asthma Medication Ratio (AMR)

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

Rationale: Medications for asthma are usually categorized into long-term controller medications used to achieve and maintain control of persistent asthma and quick-reliever medications used to treat acute symptoms and exacerbations. 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 2016:

- Expanded age range up to 85 years for the commercial product line.
- Added the Medicare product line.
- Replaced all references of Table ASM-C to Table MMA-A in step 1.
- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Asthma Medication Ratio (AMR)

	2012	2013*	2014	2015	2016	NHM
ACC			68.59%	56.54%	63.0%	⇧
JMS			60.5%	56.50%	61.9%	⇧
KPMAS				NA▫	NA▫	
MPC			69.1%	65.0%	64.0%	⇧
MSFC			73.7%	68.1%	69.3%	⇧
PP			69.6%	63.8%	64.7%	⇧
RHMD			NA▫	NA▫	52.4%	⇩
UHC			69.8%	63.4%	64.0%	⇧
MARR			68.56%	62.2%	62.7%	⇧

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

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 2016:

- Revised the method and value sets to identify acute inpatient events for steps 1 and 2 of the event/diagnosis.
- Clarified when to use admission or discharge dates when determining Negative Diagnosis History.
- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012	2013*	2014	2015	2016	NHM
ACC			25.8%	23.6%	30.0%	⇔
JMS			26.3%	32.6%	34.9%	⇧
KPMAS				NA▫	NA▫	
MPC			21.1%	20.8%	25.5%	⇩
MSFC			34.5%	29.2%	30.8%	⇔
PP			23.7%	27.2%	28.0%	⇩
RHMD			NA▫	NA▫	NA▫	
UHC			25.6%	25.6%	31.2%	⇔
MARR			26.2%	26.5%	30.1%	⇔

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

Pharmacotherapy Management of COPD Exacerbation (PCE)

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

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

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

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

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

Summary of Changes to HEDIS 2016:

- Revised the method and value sets to identify acute and nonacute inpatient events for steps 1, 3 and 4 of the event/diagnosis.
- Added olodaterol hydrochloride to the description of "Beta 2-agonists" in Table PCE-D.
- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012	2013*	2014	2015	2016	NHM
ACC			73.6%	69.0%	70.3%	⇧
JMS			69.2%	73.6%	73.3%	⇧
KPMAS				NA▫	NA▫	
MPC			72.6%	72.1%	74.4%	⇧
MSFC			76.3%	72.2%	71.0%	⇧
PP			69.7%	69.7%	75.7%	⇧
RHMD			NA▫	78.1%	70.3%	⇧
UHC			78.2%	73.0%	70.2%	⇧
MARR			73.3%	72.5%	72.2%	⇧

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

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

Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate

	2012	2013*	2014	2015	2016	NHM
ACC			87.5%	84.8%	84.9%	⇧
JMS			82.5%	85.4%	88.6%	⇧
KPMAS				NA▫	NA▫	
MPC			84.93%	85.1%	87.4%	⇧
MSFC			90.3%	92.4%	84.5%	⇧
PP			84.0%	85.0%	83.7%	⇧
RHMD			NA▫	81.3%	86.1%	⇧
UHC			84.88%	86.3%	80.8%	⇧
MARR			85.7%	85.7%	85.1%	⇧

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

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

MEMBER ACCESS

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

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

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

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

Summary of Changes to HEDIS 2016:

- No changes to this measure

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

	2012	2013	2014	2015	2016	NHM
ACC	97.45%	97.5%	97.8%	97.7%	97.9%	⇧
JMS	92.9%	91.1%	94.7%	96.2%	91.5%	⇩
KPMAS				100.0%	91.3%	⇩
MPC	96.8%	97.1%	96.5%	96.9%	97.2%	⇧
MSFC	96.6%	96.6%	96.4%	93.9%	95.3%	⇔
PP	98.1%	97.8%	97.6%	97.6%	97.8%	⇧
RHMD			NA▫	87.8%	84.9%	⇩
UHC	97.41%	96.7%	96.3%	96.6%	97.0%	⇧
MARR	96.1%	95.6%	96.6%	95.8%	94.1%	⇩

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

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

	2012	2013	2014	2015	2016	NHM
ACC	92.8%	92.6%	92.8%	93.1%	94.1%	⇧
JMS	89.3%	90.4%	88.7%	91.8%	93.0%	⇧
KPMAS				98.0%	89.1%	⇧
MPC	90.7%	89.0%	90.0%	90.3%	91.6%	⇧
MSFC	91.4%	90.3%	89.8%	88.4%	90.0%	⇧
PP	93.0%	92.8%	92.6%	93.3%	94.2%	⇧
RHMD			NA▫	69.4%	77.5%	⇩
UHC	92.1%	91.1%	91.1%	91.3%	92.6%	⇧
MARR	90.9%	90.3%	90.8%	89.5%	90.3%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	93.6%	93.9%	94.3%	95.3%	96.1%	⇧
JMS	94.0%	93.3%	93.8%	92.7%	93.8%	⇧
KPMAS				98.4%	98.1%	⇧
MPC	92.0%	91.5%	92.1%	92.61%	93.5%	⇧
MSFC	92.86%	92.5%	93.50%	92.58%	92.0%	⇧
PP	93.9%	94.3%	94.4%	94.4%	95.3%	⇧
RHMD			NA▫	NA▫	76.8%	⇩
UHC	93.0%	93.3%	93.1%	93.6%	94.4%	⇧
MARR	92.86%	92.7%	93.52%	94.2%	92.5%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	89.3%	89.5%	90.5%	91.9%	93.0%	⇧
JMS	92.4%	91.7%	90.8%	92.9%	94.2%	⇧
KPMAS				94.2%	96.6%	⇧
MPC	88.4%	87.7%	88.5%	89.7%	91.6%	⇧
MSFC	90.9%	92.5%	92.7%	91.7%	90.6%	⇧
PP	91.6%	92.0%	91.9%	92.5%	93.7%	⇧
RHMD			NA▫	NA▫	75.2%	⇩
UHC	88.5%	89.2%	90.1%	90.9%	92.1%	⇧
MARR	89.8%	89.8%	90.7%	92.0%	90.9%	⇧

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

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

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

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

Summary of Changes to HEDIS 2016:

- No changes to this measure

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

	2012	2013	2014	2015	2016	NHM
ACC	80.4%	79.7%	79.4%	79.4%	79.7%	⇔
JMS	75.5%	74.8%	72.9%	71.0%	69.3%	⇩
KPMAS				92.9%	82.7%	⇧
MPC	81.2%	81.4%	81.1%	80.9%	82.8%	⇧
MSFC	79.6%	79.9%	79.7%	76.3%	75.8%	⇩
PP	83.7%	83.5%	81.7%	82.3%	82.6%	⇧
RHMD			NA▫	63.6%	69.3%	⇩
UHC	80.3%	80.2%	80.4%	80.0%	79.0%	⇔
MARR	80.0%	79.9%	79.2%	78.3%	77.7%	⇩

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

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

	2012	2013	2014	2015	2016	NHM
ACC	87.0%	86.4%	87.2%	86.7%	88.2%	⇧
JMS	88.8%	87.8%	86.58%	86.8%	87.8%	⇧
KPMAS				95.7%	87.0%	⇔
MPC	87.28%	86.8%	87.8%	87.4%	89.4%	⇧
MSFC	85.9%	86.2%	86.9%	85.1%	85.7%	⇔
PP	89.4%	89.4%	88.4%	89.0%	90.0%	⇧
RHMD			NA▫	75.9%	79.6%	⇩
UHC	87.3%	87.5%	87.8%	88.0%	88.0%	⇧
MARR	86.5%	86.4%	87.5%	86.8%	87.0%	⇔

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

Breast Cancer Screening (BCS)

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

Rationale: Breast cancer is the second most common type of cancer among American women, with approximately 178,000 new cases reported each year. 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 2016:

- Added new value sets to identify bilateral mastectomy.
- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Breast Cancer Screening (BCS)

	2012	2013	2014	2015	2016	NHM
ACC	48.5%	49.1%	58.1%	66.0%	65.9%	⇧
JMS	63.9%	60.8%	69.4%	72.1%	72.6%	⇧
KPMAS				87.2%	88.5%	⇧
MPC	43.6%	43.9%	48.5%	65.9%	72.1%	⇧
MSFC	54.5%	56.8%	64.4%	63.4%	66.0%	⇧
PP	49.9%	51.5%	57.0%	62.5%	68.3%	⇧
RHMD			NA▫	NA▫	63.8%	⇧
UHC	46.6%	48.4%	52.7%	58.1%	62.3%	⇧
MARR	50.3%	51.0%	58.3%	67.9%	70.0%	⇧

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

Cervical Cancer Screening (CCS)

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

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

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

Summary of Changes to HEDIS 2016:

- Added an example to the optional exclusions of the hybrid specification.
- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Cervical Cancer Screening (CCS)

	2012	2013	2014	2015	2016	NHM
ACC	75.7%	73.6%	79.64%	67.8%	67.5%	⇧
JMS	78.5%	80.9%	79.5%	66.8%	77.3%	⇧
KPMAS				90.8%	79.2%	⇧
MPC	73.6%	74.0%	79.58%	65.75%	65.2%	⇧
MSFC	75.7%	70.9%	74.0%	66.2%	61.5%	⇧
PP	73.9%	75.0%	75.9%	74.4%	69.3%	⇧
RHMD			NA▫	35.5%	41.1%	⇩
UHC	69.5%	69.8%	62.8%	58.8%	60.1%	⇔
MARR	73.1%	73.7%	75.2%	65.76%	65.1%	⇧

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

Chlamydia Screening in Women (CHL)

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

Rationale: Chlamydia trachomatis is the most common sexually transmitted disease (STD) in the United States. 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.

Screening is essential because the majority of women who have the condition do not experience symptoms. The main objective of chlamydia screening is to prevent pelvic inflammatory disease (PID), infertility, and ectopic pregnancy, all of which have very high rates of occurrence among women with untreated chlamydia infection.

Summary of Changes to HEDIS 2016:

- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012	2013	2014	2015	2016	NHM
ACC	61.1%	62.6%	62.4%	61.4%	61.0%	⇧
JMS	84.0%	81.1%	86.7%	87.6%	87.6%	⇧
KPMAS				76.9%	69.2%	⇧
MPC	58.5%	58.1%	58.2%	58.9%	56.8%	⇧
MSFC	57.4%	59.6%	54.8%	57.2%	52.2%	⇧
PP	62.6%	61.8%	61.5%	59.2%	57.5%	⇧
RHMD			NA▫	61.1%	49.5%	⇩
UHC	57.1%	56.9%	55.4%	55.2%	52.1%	⇔
MARR	62.8%	63.8%	63.17%	64.7%	60.8%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	70.6%	72.5%	71.9%	71.7%	68.6%	⇧
JMS	77.4%	63.9%	72.3%	65.0%	72.8%	⇧
KPMAS				80.8%	84.7%	⇧
MPC	66.6%	67.6%	67.1%	67.3%	68.7%	⇧
MSFC	70.5%	74.0%	68.4%	66.5%	65.3%	⇧
PP	69.8%	68.9%	69.9%	68.0%	67.5%	⇧
RHMD			NA▫	58.7%	61.2%	⇧
UHC	64.8%	63.7%	64.8%	63.2%	65.4%	⇧
MARR	70.1%	69.1%	69.1%	67.7%	69.3%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	64.8%	66.4%	66.0%	65.970%	64.2%	⇧
JMS	81.3%	74.2%	81.2%	77.3%	80.3%	⇧
KPMAS				79.5%	79.6%	⇧
MPC	62.0%	62.3%	62.0%	62.6%	62.0%	⇧
MSFC	62.5%	65.0%	60.1%	61.3%	58.6%	⇧
PP	65.4%	64.6%	64.8%	62.7%	61.5%	⇧
RHMD			NA▫	59.7%	56.3%	⇧
UHC	60.0%	59.5%	59.0%	58.8%	57.9%	⇧
MARR	65.9%	66.1%	65.5%	65.97%	65.1%	⇧

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

Prenatal and Postpartum Care (PPC)

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

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

Rationale:

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

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

Summary of Changes to HEDIS 2016:

- Deleted the use of infant claims to identify deliveries.
- Clarified the tests that must be included to meet criteria for an obstetric panel in the hybrid specification.

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

	2012	2013	2014	2015	2016	NHM
ACC	90.4%	87.8%	84.2%	85.7%	83.9%	⇧
JMS	86.2%	82.9%	85.8%	83.2%	87.2%	⇧
KPMAS				88.0%	92.9%	⇧
MPC	82.1%	86.279%	84.9%	80.3%	81.5%	⇔
MSFC	87.7%	86.280%	85.4%	79.2%	84.5%	⇧
PP	87.1%	89.3%	90.9%	88.2%	90.3%	⇧
RHMD			52.2%	73.3%	74.5%	⇩
UHC	83.8%	84.7%	87.1%	84.1%	80.7%	⇩
MARR	86.3%	85.8%	74.0%	82.8%	84.4%	⇧

Prenatal and Postpartum Care (PPC) – Postpartum Care

	2012	2013	2014	2015	2016	NHM
ACC	70.7%	71.5%	71.6%	66.0%	73.7%	⇧
JMS	78.1%	83.7%	78.5%	83.6%	88.0%	⇧
KPMAS				86.0%	83.8%	⇧
MPC	71.3%	68.4%	71.9%	65.0%	68.9%	⇧
MSFC	74.0%	74.4%	72.0%	71.1%	69.2%	⇧
PP	73.0%	72.5%	75.6%	70.7%	73.7%	⇧
RHMD			43.9%	47.4%	62.3%	⇔
UHC	64.7%	60.3%	63.8%	62.5%	66.2%	⇧
MARR	70.6%	70.0%	61.9%	69.0%	73.2%	⇧

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 2016:

- Deleted the use of infant claims to identify deliveries.
- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012	2013	2014	2015	2016	NHM
ACC	3.4%	4.2%	8.2%	5.9%	5.2%	⇧
JMS	2.8%	3.6%	2.2%	4.5%	3.5%	⇧
KPMAS				7.7%	5.8%	⇧
MPC	5.7%	10.6%	5.6%	6.9%	5.6%	⇧
MSFC	2.9%	2.7%	4.4%	7.6%	3.2%	⇧
PP	7.7%	4.4%	4.4%	9.3%	8.5%	⇧
RHMD			37.0%	17.4%	12.2%	⇧
UHC	5.4%	12.1%	5.8%	6.8%	5.2%	⇧
MARR	4.9%	6.3%	9.7%	8.2%	6.1%	⇧

* A lower rate indicates better performance.

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

	2012	2013	2014	2015	2016	NHM
ACC	80.3%	72.2%	75.5%	72.6%	73.4%	⇧
JMS	76.9%	75.8%	70.8%	64.0%	66.7%	⇧
KPMAS				56.9%	72.4%	⇧
MPC	69.6%	60.1%	70.6%	69.8%	65.3%	⇧
MSFC	82.7%	79.3%	71.3%	64.6%	71.8%	⇧
PP	64.7%	78.8%	78.8%	61.7%	62.7%	⇧
RHMD			21.7%	55.0%	55.0%	⇔
UHC	72.2%	70.8%	73.2%	74.5%	75.8%	⇧
MARR	74.4%	71.5%	66.0%	64.9%	67.9%	⇧

CARDIOVASCULAR CONDITIONS

Controlling High Blood Pressure (CBP)

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

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

Use the Hybrid Method for this measure.

Rationale: Approximately 67 million Americans have high blood pressure (Centers for Disease Control and Prevention [CDC], 2012). Treatment to improve hypertension includes dietary and lifestyle changes, as well as appropriate use of medications.

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

Summary of Changes to HEDIS 2016:

- Revised a value set used to identify the event/diagnosis.
  - – Added HCPCS codes to identify outpatient visits.
  - – Renamed the Outpatient CPT Value Set to Outpatient Without UBREV Value Set.
- Clarified how to assign the diabetes flag.
- Removed the criteria for polycystic ovaries when assigning a flag of "not diabetic" in the event/diagnosis.
- Clarified the denominator section of the Hybrid Specification to state that if the hypertension diagnosis is not confirmed, the member is excluded and replaced by a member from the oversample.
- Added a method and value sets to identify nonacute inpatient admissions for optional exclusions.
- Added a Note to clarify when organizations may change the diabetes flag that was assigned based on administrative data.

Controlling High Blood Pressure (CBP)

	2012*	2013	2014	2015	2016	NHM
ACC		47.0%	49.0%	63.9%	54.1%	⇩
JMS		52.3%	56.2%	69.3%	76.4%	⇧
KPMAS				87.8%	86.0%	⇧
MPC		23.9%	46.8%	61.4%	55.9%	⇩
MSFC		70.5%	65.5%	69.2%	71.2%	⇧
PP		59.1%	57.0%	59.5%	60.2%	⇧
RHMD			NA▫	32.1%	48.2%	⇩
UHC		43.1%	42.3%	50.9%	56.9%	⇔
MARR		49.8%	52.8%	61.8%	63.6%	⇧

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

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

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

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

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

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

Summary of Changes to HEDIS 2016:

- Added a method and value sets to identify acute inpatient discharges and transfer setting (acute or nonacute inpatient) for the event/diagnosis.
- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012	2013*	2014	2015	2016	NHM
ACC			NA▫	91.5%	84.9%	⇧
JMS			NA▫	NA▫	NA▫	
KPMAS				NA▫	NA▫	
MPC			87.5%	90.2%	84.3%	⇔
MSFC			NA▫	NA▫	67.7%	⇩
PP			86.1%	84.6%	85.7%	⇧
RHMD			NA▫	NA▫	NA▫	
UHC			82.9%	87.8%	77.9%	⇩
MARR			85.5%	88.5%	80.1%	⇩

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

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

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

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

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

Summary of Changes to HEDIS 2016:

- Added a method and value sets to identify discharges for step 2 of the event/diagnosis.
- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012	2013	2014*	2015	2016	NHM
ACC				NA▫	NA▫	
JMS				NA▫	NA▫	
KPMAS				NA▫	NA▫	
MPC				NA▫	NA▫	
MSFC				NA▫	NA▫	
PP				NA▫	NA▫	
RHMD				NA▫	NA▫	
UHC				NA▫	NA▫	
MARR				No MARR	No MARR	

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

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

DIABETES

Comprehensive Diabetes Care (CDC)

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

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

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

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

Summary of Changes to HEDIS 2016:

- Added a method and value sets to identify discharges for the applicable required exclusions for the HbA1c Control (<7.0%) for a Selected Population indicator.
- Revised the requirements for urine protein testing for the Medical Attention for Nephropathy indicator; a screening or monitoring test meets criteria, whether the result is positive or negative.
- Removed the optional exclusion for polycystic ovaries.
- Added a Note clarifying optional exclusions.
- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012	2013	2014	2015	2016	NHM
ACC	78.8%	81.1%	83.4%	88.7%	87.4%	⇧
JMS	90.5%	89.8%	89.1%	90.7%	94.3%	⇧
KPMAS				96.4%	94.5%	⇧
MPC	77.1%	76.0%	79.5%	87.9%	85.9%	⇔
MSFC	88.1%	83.5%	84.7%	88.0%	87.8%	⇧
PP	81.9%	82.4%	78.1%	89.4%	89.4%	⇧
RHMD			NA▫	84.6%	88.3%	⇧
UHC	75.9%	78.1%	79.1%	85.9%	82.5%	⇩
MARR	81.0%	81.2%	85.5%	89.0%	88.8%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	43.3%	44.0%	38.8%	38.5%	42.2%	⇧
JMS	33.6%	35.4%	31.0%	37.2%	26.6%	⇧
KPMAS				21.8%	28.2%	⇧
MPC	56.7%	52.6%	48.6%	40.8%	40.8%	⇧
MSFC	27.5%	35.3%	37.2%	44.5%	31.6%	⇧
PP	38.3%	41.7%	48.1%	35.6%	35.6%	⇧
RHMD			NA▫	60.8%	39.2%	⇧
UHC	51.1%	54.3%	45.5%	41.1%	39.7%	⇧
MARR	42.4%	44.3%	41.5%	40.1%	35.5%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	48.4%	47.1%	51.4%	51.4%	49.2%	⇧
JMS	56.2%	54.7%	61.5%	52.4%	60.4%	⇧
KPMAS				60.0%	57.6%	⇧
MPC	37.0%	39.9%	43.3%	50.8%	49.7%	⇧
MSFC	57.7%	58.9%	54.0%	43.5%	59.9%	⇧
PP	50.8%	49.1%	44.3%	54.3%	55.1%	⇧
RHMD			NA▫	38.8%	48.2%	⇧
UHC	42.1%	38.9%	46.47%	46.2%	51.6%	⇧
MARR	48.3%	47.8%	50.2%	49.7%	54.0%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	62.2%	69.3%	65.4%	48.6%	53.9%	⇔
JMS	80.8%	80.1%	79.6%	64.1%	71.9%	⇧
KPMA				87.3%	84.7%	⇧
MPC	76.2%	64.6%	72.0%	65.7%	65.8%	⇧
MSFC	75.7%	72.8%	71.1%	54.0%	52.6%	⇩
PP	71.6%	78.1%	71.0%	69.0%	62.9%	⇧
RHMD			NA▫	44.8%	35.0%	⇩
UHC	60.8%	57.7%	56.9%	58.6%	55.2%	⇔
MARR	71.0%	69.6%	69.3%	61.5%	60.2%	⇧

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

[1] This indicator was retired in 2015.

Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy

	2012	2013	2014	2015	2016	NHM
ACC	79.72%	73.6%	75.7%	80.3%	90.7%	⇧
JMS	94.7%	93.6%	93.1%	93.4%	96.9%	⇧
KPMAS				100.0%	95.3%	⇧
MPC	75.2%	74.4%	75.3%	75.9%	89.9%	⇧
MSFC	89.6%	78.8%	82.7%	80.9%	91.0%	⇧
PP	79.0%	77.6%	73.8%	82.5%	89.4%	⇧
RHMD			NA▫	74.8%	90.8%	⇧
UHC	72.7%	74.2%	75.9%	81.5%	91.2%	⇧
MARR	79.69%	77.7%	79.4%	83.7%	91.9%	⇧

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

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

	2012	2013	2014	2015	2016	NHM
ACC	54.6%	48.4%	55.6%	65.3%	60.0%	⇩
JMS	54.74%	59.1%	60.4%	69.7%	76.8%	⇧
KPMAS				83.6%	87.1%	⇧
MPC	45.7%	47.1%	55.4%	56.4%	55.2%	⇩
MSFC	73.3%	73.7%	70.1%	69.0%	67.6%	⇧
PP	65.1%	63.3%	64.2%	60.7%	62.6%	⇔
RHMD			NA▫	39.9%	36.5%	⇩
UHC	54.74%	47.0%	51.6%	55.2%	46.0%	⇩
MARR	58.9%	57.3%	59.5%	62.5%	61.5%	⇔

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

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

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

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

Among patients with co-occurring schizophrenia and metabolic disorders, the non-treatment rate for diabetes is approximately 32 percent. In addition to general diabetes risk factors, diabetes is promoted in patients with schizophrenia by initial and current treatment with olanzapine and mid-potency first-generation antipsychotics (FGA), as well as by current treatment with low-potency FGAs and clozapine.

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

Summary of Changes to HEDIS 2016:

- Removed the optional exclusion for polycystic ovaries.
- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

	2012	2013	2014*	2015	2016	NHM
ACC				76.7%	68.9%	⇔
JMS				NA▫	NA▫	
KPMAS				NA▫	NA▫	
MPC				NR▫▫	65.5%	⇩
MSFC				NA▫	NA▫	
PP				68.7%	68.7%	⇔
RHMD				NA▫	NA▫	
UHC				74.6%	72.2%	⇧
MARR				73.4%	68.8%	⇔

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

Use of Imaging Studies for Low Back Pain (LBP)

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

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

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

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

Summary of Changes to HEDIS 2016:

- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Use of Imaging Studies for Low Back Pain (LBP)

	2012	2013	2014	2015	2016	NHM
ACC	78.5%	77.8%	76.7%	74.2%	74.6%	⇔
JMS	81.6%	70.9%	77.2%	69.2%	77.7%	⇧
KPMAS				NA▫	71.5%	⇩
MPC	76.8%	75.2%	76.6%	76.7%	75.5%	⇔
MSFC	74.5%	73.1%	73.3%	71.8%	72.7%	⇩
PP	74.7%	75.0%	75.2%	75.0%	76.0%	⇔
RHMD			NA▫	78.1%	74.2%	⇔
UHC	75.5%	74.8%	73.4%	74.3%	73.2%	⇩
MARR	76.6%	74.9%	75.4%	74.2%	74.4%	⇔

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

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

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

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

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

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

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

Summary of Changes for HEDIS 2016:

- Added a method and value sets to identify nonacute inpatient discharges for the event/diagnosis.
- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012*	2013	2014	2015	2016	NHM
ACC		61.8%	60.0%	62.8%	78.0%	⇧
JMS		NA▫	NA▫	NA▫	NA▫	
KPMAS				NA▫	NA▫	
MPC		71.9%	73.8%	65.8%	67.5%	⇩
MSFC		NA▫	NA▫	89.2%	77.4%	⇧
PP		69.5%	67.6%	72.5%	83.1%	⇧
RHMD			NA▫	NA▫	NA▫	
UHC		73.3%	67.7%	61.5%	69.8%	⇔
MARR		69.1%	67.3%	70.3%	75.2%	⇧

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

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

Annual Monitoring for Patients on Persistent Medications (MPM)

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

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

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

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

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

Summary of Changes for HEDIS 2016:

- Added value sets to identify acute and nonacute inpatient encounters for the optional exclusions.
- Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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

	2012*	2013	2014	2015	2016	NHM
ACC		90.1%	89.0%	89.4%	90.5%	⇧
JMS		95.8%	95.1%	94.4%	96.5%	⇧
KPMAS				95.0%	92.8%	⇧
MPC		88.9%	87.0%	88.4%	89.0%	⇧
MSFC		87.6%	90.2%	90.0%	90.3%	⇧
PP		88.224%	88.1%	88.1%	89.0%	⇧
RHMD			NA▫	86.1%	86.1%	⇩
UHC		88.222%	88.6%	89.2%	88.7%	⇧
MARR		89.5%	89.7%	90.1%	90.4%	⇧

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

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

	2012*	2013	2014	2015	2016	NHM
ACC		95.8%	95.7%	59.5%	58.3%	⇧
JMS		NA▫	NA▫	NA▫	NA▫	
KPMAS				NA▫	NA▫	
MPC		91.4%	92.2%	54.9%	47.5%	⇩
MSFC		NA▫	NA▫	NA▫	NA▫	
PP		91.5%	88.9%	44.9%	58.1%	⇧
RHMD			NA▫	NA▫	NA▫	
UHC		93.4%	86.4%	57.7%	52.9%	⇩
MARR		93.1%	90.8%	54.2%	54.2%	⇔

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

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

	2012*	2013	2014	2015	2016	NHM
ACC		88.2%	86.9%	88.42%	89.6%	⇧
JMS		94.3%	94.1%	93.9%	95.6%	⇧
KPMAS				NA▫	90.8%	⇧
MPC		88.04%	86.2%	86.5%	88.5%	⇧
MSFC		88.02%	88.5%	89.0%	88.32%	⇧
PP		87.2%	87.4%	87.9%	88.30%	⇧
RHMD			NA▫	90.5%	84.4%	⇩
UHC		87.8%	87.5%	88.40%	87.8%	⇔
MARR		88.1%	88.4%	89.2%	89.2%	⇧

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

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

	2012*	2013	2014	2015	2016	NHM
ACC		86.2%	85.4%	88.9%	89.9%	⇧
JMS		93.1%	94.1%	94.0%	95.9%	⇧
KPMAS				94.2%	91.8%	⇧
MPC		88.0%	86.3%	87.2%	88.6%	⇧
MSFC		84.1%	86.6%	89.3%	89.4%	⇧
PP		87.3%	87.3%	87.8%	88.5%	⇧
RHMD			NA▫	87.9%	85.2%	⇩
UHC		87.5%	87.7%	88.7%	88.1%	⇧
MARR		87.1%	87.9%	89.7%	89.7%	⇧

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

AMBULATORY CARE (UTILIZATION)

Ambulatory Care (AMB)

Description: Utilization of ambulatory care in the following categories:

- Outpatient visits
- Emergency department (ED) visits

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

Summary of Changes to HEDIS 2016:

- No changes to this measure

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

	2012	2013	2014	2015	2016	NHM
ACC	370.88	363.6	365.1	356.0	372.6	⇧
JMS	347.4	373.9	340.8	315.5	345.1	⇩
KPMAS				404.4	324.9	⇩
MPC	386.8	385.3	365.3	365.0	406.4	⇧
MSFC	370.0	361.6	344.5	360.0	358.6	⇔
PP	415.9	407.8	386.6	390.7	406.5	⇧
RHMD			269.8	296.8	332.6	⇩
UHC	381.0	374.2	373.3	381.6	378.1	⇧
MARR	370.88	370.3	349.3	358.8	365.6	⇧

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

	2012	2013	2014	2015	2016	NHM
ACC	60.7	59.8	56.2	58.2	55.1	⇩
JMS	91.3	93.4	90.1	96.4	94.0	⇧
KPMAS				23.2	24.9	⇩
MPC	78.8	79.3	74.6	70.9	71.0	⇧
MSFC	72.3	70.8	62.66	57.4	56.1	⇩
PP	65.7	66.0	62.70	62.0	60.1	⇩
RHMD			66.0	64.9	89.8	⇧
UHC	65.8	65.2	62.1	63.1	59.5	⇩
MARR	74.2	74.2	67.8	62.0	63.8	⇧

Frequency of Selected Procedures (FSP)

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

Rationale: This measure lists several frequently performed procedures (mostly surgical) that contribute substantially to overall cost. Wide variations among geographic regions in medical procedure rates appear to have little correlation with health outcomes. The reasons for this are unclear. Some variation is because of unnecessary procedures; conversely, some procedures may not be performed often enough. These rates are likely to be strongly influenced by how the organization manages care.

Variation in procedure rates presents a starting point in examining the kind of care that is being rendered to members. Coding practices, epidemiology, demographics and practice patterns may be responsible for variation. Examining these measures may help eliminate unwarranted variation in the delivery of medical care.

Summary of Changes to HEDIS 2016:

- Added new value sets to identify unilateral mastectomy.

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.05	0.05	⇩
JMS				0.02	0.00	⇩
KPMAS				0.00	0.00	⇩
MPC				0.05	0.068	⇩
MSFC				0.07	0.10	⇧
PP				0.05	0.06	⇩
RHMD				0.03	0.12	⇧
UHC				0.04	0.04	⇩
MARR				0.04	0.074	⇩

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0	0.007	⇩
JMS				0.016	0.00	⇩
KPMAS				0	0.00	⇩
MPC				0	0.015	⇩
MSFC				0	0.015	⇩
PP				0.01	0.03	⇧
RHMD				0.04	0.00	⇩
UHC				0.018	0.010	⇩
MARR				0.02	0.015	⇩

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.42	0.48	⇩
JMS				0.18	0.13	⇩
KPMAS				0.13	0.00	⇩
MPC				0.47	0.55	⇩
MSFC				0.38	0.45	⇩
PP				0.60	0.64	⇧
RHMD				0.20	0.31	⇩
UHC				0.42	0.51	⇩
MARR				0.35	0.44	⇩

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.15	0.186	⇩
JMS				0.5	0.18	⇩
KPMAS				0.20	0.00	⇩
MPC				0.20	0.26	⇩
MSFC				0.17	0.19	⇩
PP				0.24	0.25	⇩
RHMD				0.9	0.16	⇩
UHC				0.19	0.194	⇩
MARR				0.16	0.20	⇩

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.45	0.31	⇩
JMS				0.43	0.36	⇧
KPMAS				0.01	0.00	⇩
MPC				0.49	0.32	⇩
MSFC				0.53	0.47	⇧
PP				0.352	0.45	⇧
RHMD				0.45	0.23	⇩
UHC				0.46	0.28	⇩
MARR				0.52	0.35	⇩

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.18	0.1510	⇩
JMS				0.2	0.00	⇩
KPMAS				0.0	0.00	⇩
MPC				0.15	0.24	⇩
MSFC				0.16	0.22	⇩
PP				0.19	0.31	⇧
RHMD				0.11	0.17	⇩
UHC				0.19	0.1506	⇩
MARR				0.14	0.21	⇩

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.04	0.022	⇩
JMS				0.031	0.0569	⇧
KPMAS				0.0	0.00	⇩
MPC				0.07	0.04	⇧
MSFC				0.06	0.0574	⇧
PP				0.05	0.03	⇧
RHMD				0.0	0.00	⇩
UHC				0.04	0.018	⇩
MARR				0.05	0.039	⇧

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.06	0.010	⇩
JMS				0.06	0.045	⇧
KPMAS				0.0	0.00	⇩
MPC				0.03	0.05	⇧
MSFC				0.05	0.012	⇩
PP				0.06	0.06	⇧
RHMD				0.0	0.00	⇩
UHC				0.04	0.02	⇩
MARR				5.4	0.03	⇩

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.20	0.20	⇩
JMS				0.11	0.05	⇩
KPMAS				0.17	0.00	⇩
MPC				0.34	0.31	⇩
MSFC				0.17	0.24	⇩
PP				0.19	0.29	⇩
RHMD				0.11	0.21	⇩
UHC				0.19	0.26	⇩
MARR				0.18	0.22	⇩

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.48	0.36	⇩
JMS				0.18	0.29	⇩
KPMAS				0.0	0.00	⇩
MPC				0.668	0.62	⇩
MSFC				0.68	0.40	⇩
PP				0.65	0.69	⇧
RHMD				0.34	0.43	⇩
UHC				0.59	0.44	⇩
MARR				0.51	0.46	⇩

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.41	0.46	⇩
JMS				0.58	0.56	⇧
KPMAS				0.0	0.00	⇩
MPC				0.65	0.81	⇧
MSFC				0.56	0.67	⇧
PP				0.77	0.74	⇧
RHMD				0.3	0.43	⇩
UHC				0.54	0.60	⇧
MARR				0.54	0.61	⇧

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.43	0.58	⇩
JMS				0.42	0.41	⇩
KPMAS				0.0	0.00	⇩
MPC				0.65	0.85	⇧
MSFC				0.51	0.69	⇧
PP				0.65	0.80	⇧
RHMD				0.38	0.47	⇩
UHC				0.62	0.83	⇧
MARR				0.52	0.66	⇧

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.022	0.0226	⇩
JMS				0.03	0.050	⇧
KPMAS				0.00	0.00	⇩
MPC				0.026	0.045	⇧
MSFC				0.016	0.01	⇩
PP				0.036	0.035	⇧
RHMD				0.00	0.051	⇧
UHC				0.041	0.0233	⇩
MARR				0.028	0.034	⇧

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.16	0.13	⇩
JMS				0.4	0.07	⇩
KPMAS				0	0.00	⇩
MPC				0.14	0.12	⇩
MSFC				0.11	0.10	⇩
PP				0.21	0.23	⇧
RHMD				0.18	0.173	⇧
UHC				0.19	0.171	⇔
MARR				0.15	0.14	⇩

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.14	0.113	⇩
JMS				0.0	0.07	⇩
KPMAS				0.0	0.00	⇩
MPC				0.13	0.106	⇩
MSFC				0.18	0.20	⇧
PP				0.15	0.14	⇧
RHMD				0.10	0.05	⇩
UHC				0.12	0.107	⇩
MARR				0.14	0.111	⇩

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.365	0.27	⇩
JMS				0.21	0.25	⇩
KPMAS				0.10	0.00	⇩
MPC				0.29	0.28	⇩
MSFC				0.41	0.52	⇧
PP				0.49	0.42	⇧
RHMD				0.27	0.14	⇩
UHC				0.371	0.38	⇩
MARR				0.43	0.32	⇩

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

Inpatient Utilization - General Hospital/Acute Care (IPU)

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

1. Total inpatient
2. Maternity
3. Surgery
4. Medicine

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

This measure assesses the extent to which the organization's members receive inpatient hospital treatment because of pregnancy and childbirth, for surgery or for nonsurgical medical treatment.

The organization reports how many hospital stays occurred during the measurement year and the length of hospitalization.

Summary of Changes to HEDIS 2016:

- Added a method and value sets to identify acute inpatient discharges in step 1.

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

	2012	2013	2014*	2015	2016	NHM
ACC				5.9	5.83	⇩
JMS				9.9	10.06	⇧
KPMAS				6.4	5.49	⇩
MPC				6.5	6.84	⇩
MSFC				7.01	6.67	⇩
PP				6.6	6.75	⇩
RHMD				6.7	8.59	⇧
UHC				7.2	6.60	⇩
MARR				7.03	7.10	⇩

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				3.96	4.14	⇧
JMS				4.12	4.81	⇧
KPMAS				4.59	3.34	⇩
MPC				3.66	3.75	⇩
MSFC				4.03	4.22	⇧
PP				3.85	4.06	⇧
RHMD				3.72	3.47	⇩
UHC				4.12	4.23	⇧
MARR				4.01	4.00	⇔

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

Antibiotic Utilization (ABX)

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

1. Total number of antibiotic prescriptions
2. Average number of antibiotic prescriptions per member per year (PMPY)
3. Total days supplied for all antibiotic prescriptions
4. Average days supplied per antibiotic prescription
5. Total number of prescriptions for antibiotics of concern
6. Average number of prescriptions PMPY for antibiotics of concern
7. Percentage of antibiotics of concern for all antibiotic prescriptions
8. Average number of antibiotics PMPY reported by drug class:
    a. For selected "antibiotics of concern"
    b. For all other antibiotics

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

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

Summary of Changes to HEDIS 2016:

- No changes to this measure

Antibiotic Utilization (ABX) -Average Scrips PMPY for Antibiotics

	2012	2013	2014*	2015	2016	NHM
ACC				0.87	0.85	⇩
JMS				0.88	0.87	⇩
KPMAS				0.68	0.67	⇩
MPC				1.03	1.10	⇧
MSFC				0.86	0.88	⇩
PP				0.97	0.97	⇔
RHMD				0.77	0.85	⇩
UHC				0.98	0.92	⇩
MARR				0.878	0.89	⇩

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				9.29	9.35	⇔
JMS				8.98	9.00	⇩
KPMAS				8.99	9.46	⇧
MPC				9.40	9.32	⇔
MSFC				9.23	9.10	⇩
PP				9.39	9.42	⇧
RHMD				9.21	9.28	⇔
UHC				9.26	9.35	⇔
MARR				9.22	9.28	⇔

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				0.350	0.35	⇩
JMS				0.29	0.29	⇩
KPMAS				0.27	0.25	⇩
MPC				0.41	0.45	⇔
MSFC				0.34	0.35	⇩
PP				0.39	0.39	⇔
RHMD				0.32	0.38	⇔
UHC				0.43	0.41	⇔
MARR				0.351	0.36	⇔

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

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

	2012	2013	2014*	2015	2016	NHM
ACC				40.39%	40.8%	⇩
JMS				33.0%	33.7%	⇩
KPMAS				40.5%	37.8%	⇩
MPC				39.8%	40.8%	⇩
MSFC				40.2%	40.1%	⇩
PP				40.38%	40.7%	⇩
RHMD				42.1%	44.6%	⇧
UHC				43.2%	44.3%	⇧
MARR				39.9%	40.3%	⇩

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

Board Certification (BCR)

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

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

Summary of Changes to HEDIS 2016:

- No changes to this measure

Board Certification (BCR)

		Family Medicine	Internal Medicine	OB/GYN	Pediatrician	Geria-tricians	Other Specialists
ACC	# of Physicians	570	2,024	584	1,106	84	5,068
	# Board Certified	403	1,464	448	845	53	3,732
	Percentage	70.70%	72.33%	76.71%	76.40%	63.10%	73.64%
JMS	# of Physicians	49	557	113	158	37	1,938
	# Board Certified	42	519	95	146	34	1,758
	Percentage	85.71%	93.18%	84.07%	92.41%	91.89%	90.71%
KPMAS	# of Physicians	177	380	171	105	2	871
	# Board Certified	172	369	150	105	2	847
	Percentage	97.18%	97.11%	87.72%	100.00%	100.00%	97.24%
MPC	# of Physicians	655	1,319	714	973	49	5,424
	# Board Certified	346	928	310	715	33	3,572
	Percentage	52.82%	70.36%	43.42%	73.48%	67.35%	65.86%
MSFC	# of Physicians	286	473	360	167	15	2,230
	# Board Certified	136	298	139	48	5	1,207
	Percentage	47.55%	63.00%	38.61%	28.74%	33.33%	54.13%
PP	# of Physicians	613	943	758	851	40	11,493
	# Board Certified	578	887	723	808	38	10,770
	Percentage	94.29%	94.06%	95.38%	94.95%	95.00%	93.71%
RHMD	# of Physicians	551	668	515	537	32	3,073
	# Board Certified	362	412	266	325	23	1,465
	Percentage	65.70%	61.68%	51.65%	60.52%	71.88%	47.67%
UHC	# of Physicians	761	2,307	836	1,212	88	5,764
	# Board Certified	561	1,756	720	1,017	57	4,615
	Percentage	73.72%	76.12%	86.12%	83.91%	64.77%	80.07%

Enrollment by Product Line (ENP)

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

Summary of Changes to HEDIS 2016:

- No changes to this measure

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

	Male	Female	Total
ACC	1,405,128	1,674,894	3,080,022
JMS	145,122	132,883	278,005
KPMAS	101,136	121,660	222,796
MPC	904,595	1,179,962	2,084,557
MSFC	341,526	424,716	766,242
PP	1,253,413	1,586,242	2,839,655
RHMD	151,157	153,309	304,466
UHC	1,062,926	1,270,877	2,333,803

Enrollment by State (EBS)

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

Summary of Changes to HEDIS 2016:

- No changes to this measure

Enrollment by State (EBS) – Maryland only

ACC	253,373
JMS	21,969
KPMAS	29,598
MPC	178,113
MSFC	66,346
PP	241,869
RHMD	26,456
UHC	170,806

Language Diversity of Membership (LDM)

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

Summary of Changes to HEDIS 2016:

- No changes to this measure

Language Diversity of Membership (LDM) - Spoken

		English	Non-English	Unknown	Declined
ACC	Number	10	5,338	327,965	0
	Percent	0.00%	1.60%	98.40%	0.00%
JMS	Number	32,808	79	0	0
	Percent	99.76%	0.24%	0.00%	0.00%
KPMAS	Number	30,858	3,777	3,058	21
	Percent	81.82%	10.01%	8.11%	0.06%
MPC	Number	0	0	236,314	0
	Percent	0.00%	0.00%	100.00%	0.00%
MSFC	Number	0	0	97,250	0
	Percent	0.00%	0.00%	100.00%	0.00%
PP	Number	0	0	311,467	0
	Percent	0.00%	0.00%	100.00%	0.00%
RHMD	Number	0	0	45,494	0
	Percent	0.00%	0.00%	100.00%	0.00%
UHC	Number	4	2,382	260,034	0
	Percent	0%	0.91%	99.09%	0%

Race/Ethnicity Diversity of Membership (RDM)

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

Summary of Changes to HEDIS 2016:

- No changes to this measure

Race/Ethnicity Diversity of Membership (RDM)

		White / Total	Black / Total	American Indian & Alaska Native / Total	Asian / Total	Native Hawaiian - Pacific Islander / Total	Other / Total	2+ Races / Total	Unknown / Total	Declined / Total
ACC	Number	63,072	141,924	0	13,950	335	0	0	114,032	0
	Percent	18.92%	42.58%	0.00%	4.19%	0.10%	0.00%	0.00%	34.21%	0.00%
JMS	Number	3,806	16,625	93	629	27	0	0	11,707	0
	Percent	11.57%	50.55%	0.28%	1.91%	0.08%	0.00%	0.00%	35.60%	0.00%
KPMAS	Number	7,220	19,118	90	2,444	32	649	5	8,058	98
	Percent	19.14%	50.69%	0.24%	6.48%	0.08%	1.72%	0.01%	21.37%	0.26%
MPC	Number	82,652	104,253	13	8,311	12	0	0	41,073	0
	Percent	34.98%	44.12%	0.01%	3.52%	0.01%	0.00%	0.00%	17.38%	0.00%
MSFC	Number	0	0	0	5,075	0	0	0	92,175	0
	Percent	0.00%	0.00%	0.00%	5.22%	0.00%	0.00%	0.00%	94.78%	0.00%
PP	Number	107,710	123,299	4	10,917	0	0	0	69,537	0
	Percent	34.58%	39.59%	0.00%	3.51%	0.00%	0.00%	0.00%	22.33%	0.00%
RHMD	Number	15,327	17,152	0	2,160	64	0	0	1,486	9,305
	Percent	33.69%	37.70%	0.00%	4.75%	0.14%	0.00%	0.00%	3.27%	20.45%
UHC	Number	92,373	113,988	0	14,447	296	0	0	41,316	0
	Percent	35.20%	43.44%	0.00%	5.51%	0.11%	0.00%	0.00%	15.74%	0.00%

Weeks of Pregnancy at Time of Enrollment (WOP)

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

1. Prior to pregnancy (280 days or more prior to delivery).
2. The first 12 weeks of pregnancy, including the end of the 12th week (279–196 days prior to delivery).
3. The beginning of the 13th week through the end of the 27th week of pregnancy (195–91 days prior to delivery).
4. The beginning of the 28th week of pregnancy or after (≤90 days prior to delivery).
5. Unknown.

Summary of Changes to HEDIS 2016:

- Deleted the use of infant claims to identify deliveries.

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

	13-27 weeks	28+ weeks	Unknown
ACC	28.96%	17.49%	4.78%
JMS	18.12%	16.72%	0.00%
KPMAS	36.54%	18.95%	5.11%
MPC	24.01%	16.24%	4.14%
MSFC	32.12%	20.68%	0.00%
PP	29.01%	19.35%	3.71%
RHMD	28.29%	18.97%	15.64%
UHC	26.76%	16.01%	3.80%

Total Membership (TLM)

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

Summary of Changes to HEDIS 2016:

- Added the EPO product.
- Added the Marketplace product line.
- Clarified that Medicare-Medicaid Plans (MMP) are included in the Medicare count.
- Clarified that this measure is reported for an organization in its entirety.

Total Membership (TLM) – Medicaid only

-	
ACC	253,373
JMS	21,993
KPMAS	38,584
MPC	178,253
MSFC	116,374
PP	242,133
RHMD	26,494
UHC	170,957

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 2016:

- No changes to this measure

Call Answer Timeliness (CAT)

	2012	2013	2014	2015	2016	NHM
ACC	78.9%	81.9%	89.7%	82.9%	86.6%	⇧
JMS	93.1%	95.0%	93.4%	92.7%	97.9%	⇧
KPMAS				69.6%	84.2%	⇧
MPC	91.1%	87.7%	89.2%	86.7%	88.2%	⇧
MSFC	89.2%	89.4%	91.3%	77.3%	91.0%	⇧
PP	73.1%	84.9%	71.0%	43.5%	58.0%	⇩
RHMD			NA	80.4%	87.9%	⇧
UHC	85.5%	92.4%	89.4%	84.3%	90.2%	⇧
MARR	85.6%	87.5%	87.3%	77.2%	85.5%	⇧

IMPLICATIONS

Summary

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

HealthChoice Plans: HEDIS Year 2016 Highlights

- The MARR for Childhood Immunization Status (CIS) Combinations 2,3,4,5, & 7 all increased by greater than five percentage points while Immunizations for Adolescents (IMA) Combination One increased by 12.3 points from HEDIS 2015 to 2016.
- All HealthChoice MCOs improved their Appropriate Testing for Children with Pharyngitis (CWP) Score resulting in an increase of over five percentage points to the MARR.
- The MARR improved by more than five percentage points for the Human Papillomavirus Vaccine for Female Adolescents (HPV) measure.
- The MARR improved by greater than 5 percentage points for both indicators (50% Total & 75% Total) of the Medication Management for People with Asthma (MMA) measure from 2015 to 2016.
- There was a significant increase (>8%) to Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy rate which may be partially attributable to a specification change allowing positive or negative results as long as a qualifying test was performed.
- The MARR experienced a significant decrease to the rate for Persistence of Beta-Blocker Treatment after a Heart Attack (PBH) from 2015 to 2016 without any changes to the specification.

Discussion

Measures with the greatest percentage improvement all belonged to the Effectiveness of Care (EOC) Domain with notable gains to the *Prevention and Screening* and *Respiratory Conditions* categories. Measures with the greatest degree of improvement include: Immunizations for both Adolescents and Children (CIS & IMA; +8.9% & +12.3%), Appropriate Testing for Children with Pharyngitis (CWP; +5.6%), Medication Management for People with Asthma- Total 50% of Treatment Period and Total 75% of Treatment Period (MMA; +5.4% & +7.1%), and Comprehensive Diabetes Care- Medical Attention for Nephropathy (CDC; +8.2%). Note that Call Answer Timeliness also experienced a significant rate increase in 2016, but was not included here since it was not audited in all cases as per changing NCQA requirements.

Measures with the greatest percentage decline were primarily Effectiveness of Care measures, but also included one Access/Availability of Care measure. Measures with the greatest rate decreases follow in declining order of degree: Persistence of Beta-Blocker Treatment after a Heart Attack (PBH; -8.4%), Chlamydia Screening in Women- Age 16-20 Years (CHL; -3.9%), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents- BMI Percentile Total Rate, Counseling for Nutrition Total Rate, and Counseling for Physical Activity Total Rate (WCC; -2.7%, -2%, -2%), Children and Adolescents Access to Primary Care Practitioners- Age 12–24 months, and Age 7-11 years (CAP; -1.7%, -1.7%).

The seven plans that reported in each of the last three years had an average improvement rate of nearly 61% meaning that, on average, each plan improved on 35 of 57 measures from 2014 to 2016.