Medicare Special Needs Plans Performance Results: HEDIS 2014

September 28, 2014

Prepared for

Susan Radke, COR
Centers for Medicare & Medicaid Services
Medicare Drug and Health Plan Contract Administration Group
7500 Security Boulevard, Mail Stop C3-23-05
Baltimore, MD 21244-1850

Prepared by

National Committee for Quality Assurance
1100 13th Street, NW, Suite 1000
Washington, DC 20005

CMS Contract No. HHSM-500-2011-00079C
Deliverable 4.2

Table of Contents

Executive Summary

Overview

This report provides results of measurement of care provided by Special Needs Plans (SNP) to Medicare beneficiaries using Healthcare Effectiveness Data and Information Set (HEDIS®[1]) measures. (See Appendix A for additional information about HEDIS.)

As of February 2014, the Centers for Medicare & Medicaid Services (CMS) identified 451 SNPs. Of this number, a total of 353 SNPs were required to submit data for this report. Ninety eight (98) SNPs had fewer than 30 beneficiaries and were not required to report HEDIS because of their small enrollment. Results for this review period cover 34 HEDIS measures: 28 clinical performance measures, 4 board certification measures and 2 utilization measures. All measures were selected for their relevance to SNP populations. As required, results were audited by NCQA-Certified HEDIS Compliance Auditors. HEDIS data reflect care provided in 2013 and reported in HEDIS 2014. The report compares HEDIS 2014 results with those reported in 2012 and 2013. The report also compares performance among different SNP types as well as compares SNP performance to the performance of the Medicare Advantage (MA) program as a whole.

Findings

All SNPs reporting in any of the three years (Table 4a). Program wide results for all SNPs were mixed. Less than half of the measures improved in a statistically significant manner over the 3 years (HEDIS 2012–2014). Ten measures showed statistically significant improvement from HEDIS 2013–2014, while 12 measures showed improvement, though not statistically significant, for the entire 3-year period. Eight measures showed a statistically significant decline from HEDIS 2013–2014 and six showed a decline for the entire 3-year period.

Three of the *Care for Older Adults* measures (*Advance Care Planning, Medication Review, Functional Status Assessment*) showed the largest increase; an average of 17.6 percentage points, respectively, from HEDIS 2012–2014. *Active Board Certification—Geriatrics* rates dropped the most (18.3 percentage points) over the 3-year period.

Highest and Lowest Rates (Table 3a). The measures with the highest and lowest overall HEDIS 2014 rates were:

Highest Five:

1. *Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring* (96.0%).
2. *Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications* (4.8%). (Lower values signify better performance; this is equivalent to 95.2 %.)
3. *Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring* (94.7%).
4. *Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring* (94.5%).
5. *Annual Monitoring for Patients on Persistent Medications—Total Rate* (93.5%).

Lowest Five:

1. *Osteoporosis Management in Women Who Had a Fracture* (28.2%).
2. *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge* (32.8%).
3. *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* (33.1%).
4. *Medication Reconciliation Post-Discharge* (34.3%).
5. *Potentially Harmful Drug-Disease Interactions—Dementia* (61.1%). (Lower values signify better performance; this is equivalent to 38.9 %.)

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

Four out of the 5 measures with the highest performance are *Annual Monitoring for Patients on Persistent Medications* indicators. All 5 measures in the highest five are medication management measures.

Largest Significant Changes (Table 3a). Listed below are measures showing the largest significant performance changes, positive or negative, from HEDIS 2012–2014. The measures with the largest increases showed a 3.5 percentage point or greater rate increase. The measures with the largest decreases showed a 3.0 percentage point or greater rate decrease.

Largest Increase:

1. *Care for Older Adults—Advance Care Planning* (23 percentage points)
2. *Care for Older Adults—Functional Status Assessment* (15.9 percentage points)
3. *Care for Older Adults—Medication Review* (13.8 percentage points)
4. *Colorectal Cancer Screening* (7.7 percentage points).
5. *Glaucoma Screening In Older Adults*[2] (6.9 percentage points)

Largest Decrease:

1. *Active Board Certification—Geriatrics* (18.3 percentage points)
2. *Active Board Certification—Family Medicine* (7.2 percentage points)
3. *Active Board Certification—Other Physician Specialists* (6.7 percentage points)
4. *Active Board Certification—Internal Medicine* (4.6 percentage points)
5. *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge* (3.2 percentage points)

Three of the 5 measures with the largest increase are *Care for Older Adults* measures, which only SNPs collect. Four of the 5 measures with the largest decreases are for *Active Board Certification*.

Measures only SNPs report (3a). There are five HEDIS measures that only SNPs report *(Care for Older Adults—Advance Care Planning, Care for Older Adults—Functional Status Assessment, Care for Older Adults—Medication Review, Care for Older Adults—Pain Screening, Medication Reconciliation Post-Discharge)*. Overall performance rates for these measures are generally lower than for the other measures in the SNP reporting set. These measures rely on medical record review. Three *Care for Older Adults* measures *(Advance Care Planning, Medication Review, Functional Status Assessment)* showed significant improvement from 2012–2014. The overall rate for all three measures improved significantly from HEDIS 2012–2014 (23 percentage points; 13.8 percentage points; 15.9 percentage points, respectively).

The fifth SNP-only measure, *Medication Reconciliation Post-Discharge,* showed a statistically significant increase (10.5 percentage points) in overall rate between HEDIS 2013 and HEDIS 2014 and a 2.5 percentage point increase from HEDIS 2012–2014.

SNPs reporting HEDIS 2012–2014 (Table 3b). For SNPs that reported in all 3 years, results were slightly better than for plans that reported in any of the 3 years. Fourteen measures (more than half) with trendable data showed statistically significant improvement over the entire period and 12 measures showed significant improvement between from 2013–2014. Four measures showed statistically significant decline over the entire period and six measures showed significant decline from HEDIS 2013–2014.

Three of the *Care for Older Adults* measures (*Advance Care Planning, Medication Review, Functional Status Assessment*) rose by an average of 16.7 percentage points over the period. The *Active Board Certification—Geriatrics* measure showed the largest significant decrease (6.3 percentage points) in performance during this period.

SNP and MA program performance (Table 4). While SNPs outperformed MA program on 7 measures, overall, the MA program continued to perform statistically higher on 13 HEDIS 2014 measures. For the

[2] Starting with HEDIS 2015, NCQA is retiring the Glaucoma Screening In Older Adults measure as a result of a recent U.S. Preventive Services Task Force (USPSTF) recommendation. In July 2013, the USPSTF concluded that the current evidence is insufficient to assess the balance of benefits and harms of screening for glaucoma in adults.

following measures, MA plans increased the performance gap between them and SNPs: *Controlling High Blood Pressure* measure, all of the *Potentially Harmful Drug-Disease Interactions in the Elderly* measures and *Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications.*

Important Note: *MA plans report HEDIS measures at the contract level, which may include SNP beneficiaries because some MA contracts include SNP plan benefit packages. However, these represent a small portion of the overall MA population, as indicated by the eligible population data for each measure.*

Program performance by SNP type (Table 5). Overall for HEDIS 2014, I-SNPs had higher rates on 23 measures than the other SNP types, compared to 8 measures for the D-SNPs and 3 measures for C-SNP.

- I-SNPs showed statistically significant improvement for three measures (*Medication Reconciliation Post-Discharge, Care for Older Adults—Medication Review* and *Care for Older Adults—Functional Status Assessment)* and statistically significant decreases in performance for three measures *(Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring, Anticonvulsant Monitoring, Total Rate).*
- D-SNPs showed statistically significant performance improvement for 10 measures and statistically significant decreases in performance for seven measures. The largest significant gains were for *Medication Reconciliation Post-Discharge* and three *Care for Older Adults* measures (*Advance Care Planning, Medication Review* and *Functional Status Assessment*).
    - Improvement: *Colorectal Cancer Screening, Glaucoma Screening in Older Adults, Pharmacotherapy of COP Exacerbation—Dispensing Systematic Corticosteroids Within 14 Days of Event, Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring, Annual Monitoring for Patients on Persistent Medications—Total Rate, Medication Reconciliation Post-Discharge, Care for Older Adults—Advanced Care Planning, Care for Older Adults—Medicare Review, Care for Older Adults—Functional Status Assessment, Use of High-Risk Medications in the Elderly—At Lead One High Risk Medication.*
    - Decrease: *Antidepressant Medication Management—Acute Phase, Antidepressant Medication Management—Continuation Phase, Follow-Up After Hospitalization for Mental Illness—30 Days of Discharge, Follow-Up After Hospitalization for Mental Illness—7 Days of Discharge, Active Board Certification—Family Medicine, Active Board Certification—Internal Medicine, Active Board Certification—Geriatrics.*
- C-SNPs showed statistically significant improvement on four measures (*Colorectal Cancer Screening, Glaucoma Screening in Older Adults, Medication Reconciliation Post-Discharge* and *Use of High Risk Medications in the Elderly—At Least Two Different High-Risk Medications*) and statistically significant decreases in performance on six measures (*Antidepressant Medication Management—Acute Phase, Antidepressant Medication Management—Continuation Phase,* all four *Active Board Certification* measures).

Plan benefit package-level performance (Table 7). In addition to the aggregate performance analyses, NCQA evaluates performance at the benefit package-level. Analyses represent results from individual plan performance. Data show a wide distribution of performance within each measure. The average difference between the 10th and 90th percentile is 24.7 percentage points, a decrease of 3.3 percentage points from 2013, showing that the gap between the highest and lowest performers for any measure is slightly narrowing.

Objectives and Background

Objectives

This report presents results for SNPs reporting HEDIS 2014 performance measures. The report displays SNP performance in a table format and discusses performance results, provides an overview of the criteria used to select the measures and examines the data collection and validation process. The *Data Limitations* section considers the challenges and constraints of SNP assessment.

SNP Overview

SNPs were created by Congress in the Medicare Modernization Act (MMA) of 2003, as a new type of Medicare managed care plan that focus on certain vulnerable groups of Medicare beneficiaries. Unlike other types of MA plans, SNPs can limit enrollment to the following subgroups (See Table 1 for further comparison of SNPs to MA plans):

- *Dual-Eligible SNPs (D-SNP)* enroll beneficiaries eligible for Medicare and Medicaid.
- *Institutional SNPs (I-SNP)* enroll beneficiaries who are institutionalized or are determined by use of a State assessment tool, to meet institutional level of care. Those that meet the institutional level of care can live in the community and be enrolled in the I-SNP.
- *Chronic SNPs (C-SNP)* enroll beneficiaries with certain chronic or disabling conditions.

The MMA stated that SNPs should emphasize monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries maintain or improve their health status. Originally, SNP authority was set to expire in December 2008, but Congress has subsequently acted to revise and extend the program beyond that period.

The Medicare Improvement and Patient Protection Act (MIPPA) and the Patient Protection and Affordable Care Act (ACA):

- Extended SNPs through 2013.
- Changed MA payments for all MA plans (including SNPs) by reducing them differentially by county and adding a quality bonus payment (QBP) system based on quality rating.
- Charged CMS with exploring different approaches to risk adjustment for certain types of SNPs.
- Called for SNPs to disenroll individuals who did not meet certain eligibility requirements or have specific severe chronic or disabling conditions.
- Delayed the requirement that dual SNPs contract with states until 2012, for new SNPs, and until 2013, for existing SNPs operating in the same service areas.
- Added a requirement that SNPs must submit their Model of Care (MOC) to CMS for NCQA review and approval in accordance with CMS guidance.

Section 607 of the American Taxpayer Relief Act of 2012 (ATRA) extended the SNP program through 2014. Section 1107 of the Bipartisan Budget Act of 2013 extended the SNP program through 2015. “The Protecting Access to Medicare Act of 2014” (H.R. 4302) reauthorizes SNPs through December 31, 2016.

Table 1. Key Differences between SNPs and Standard MA Plans[3]

Categories	SNPs	MA plans
Enrollment	• Must limit enrollment to targeted special needs individuals (i.e., dual eligible beneficiaries, those with specific chronic or disabling conditions, or living in or eligible for residing in an institutional setting). • May target specific subsets of special needs populations (e.g., beneficiaries with congestive heart failure or diabetes). • Dual-eligible and institutionalized beneficiaries may enroll and disenroll throughout the year. Chronic care beneficiaries have a one-time enrollment option outside of standard enrollment periods.	• Must be open to all Medicare-eligible beneficiaries. • Lock-in provision for all enrollees with an annual open-enrollment period.
Benefits	• Standard MA benefits. • Must offer Part D prescription drug coverage.	• Standard MA benefits. • Part D coverage is voluntary.
Payments	• Standard MA geographic payment schedule, with PMPM payments risk-adjusted by hierarchical condition category (HCC) scores.	
Marketing	• May target special needs populations in the market area. • May target specific subsets of special needs populations (on a case-by-case basis) in the market area.	• Must include all Medicare-eligible beneficiaries in the market area.

Historical SNP Enrollment Changes

The SNP program began with 11 SNPs in 2004 and grew to 702 by February 2008. The number of SNP benefit packages reporting HEDIS was lower for several years (369 in 2011 and 368 in 2012). The number of SNP plans required to report HEDIS data increased in 2013, with 415 SNPs reporting, but decreased to 353 in 2014.

Despite the fluctuation in the number of plans, the total population covered by SNPs has continued to increase annually (Table 2). From 2011–2013, enrollment grew by 26 percent. Overall, SNPs added 198,197 enrollees from February 2012–February 2013—more than twice the amount of enrollees added during the previous one-year period. The majority of growth came from D-SNPs, which added more than 150,000 enrollees in 2013. C-SNPs increased enrollment by 35,000 and I-SNPs grew by 2,730 enrollees.

Most SNP enrollees are in D-SNPs. Enrollment within D-SNP plan benefit packages ranges from 18 enrollees to more than 86,000 enrollees. The total number of D-SNP plans increased from 253 in 2012 to 274 in 2013. The number of C-SNPs increased by nearly 40 percent (74 to 103) from 2012 to 2013. C-SNP enrollment also increased by 20 percent from 2012–2013. I-SNPs decreased from 59 plans in 2013 to 40 plans in 2014.

Starting in 2009, CMS required every SNP benefit package (identified by a CMS Plan ID) with 30 or more enrollees to submit audited HEDIS results each year. SNPs listed in the February *SNP Comprehensive Report* as having 29 enrollees or fewer are not required to submit HEDIS measures the following year. For example, 343 SNPs had 30 or more enrollees in the February 2013 *SNP Comprehensive Report;* and therefore, reported HEDIS 2014 measures.

[3] CMS. *Special Needs Plans—Fact Sheet & Data Summary*. http://www.cms.hhs.gov/SpecialNeedsPlans/Downloads/FSNPFACT.pdf

Table 2. SNP Enrollment as of February 2012, 2013 and 2014

SNP Type and Year	SNPs Required to Report HEDIS Measures	
	Number of SNPs	Subtotal Enrollment
2012		
Chronic or Disabling Condition	68	153,148
Dual-Eligible	253	999,111
Institutional	47	80,414
2012 Total	**368**	**1,232,673**
2013		
Chronic or Disabling Condition	92	182,969
Dual-Eligible	274	1,107,508
Institutional	49	46,545
2013 Total	**415**	**1,337,022**
2014		
Chronic or Disabling Condition	68	283,068
Dual-Eligible	245	1,534,024
Institutional	40	48,936
2014 Total	**353**	**1,866,028**

Table 2 illustrates the total submissions for HEDIS measures during the last three data collection periods. As SNP organizations with low enrollment consolidated benefit packages , the percentage of SNPs required to report HEDIS increased steadily for several years as overall growth in the number of SNPs participating in the program slowed: 67 percent in 2009, 85 percent in 2010, 87 percent in 2011, 93 percent in 2012 and 92 percent in 2013. For 2014, the percentage of SNPs meeting the reporting requirements dropped to 78 percent. The recent growth in the number of SNPs in the program most likely explains this decline, as many new plans tend to have low enrollment. However, overall enrollment in the SNP program has continued to increase throughout this period.

For each measure, NCQA requires a denominator of at least 30 enrollees. Measures that have a broader reach (e.g., screening measures such as *Colorectal Cancer Screening* and *Glaucoma Screening in Older Adults)* tend to have a larger percentage of plans able to report; measures with a more narrow specification (e.g., measures requiring a specific medication or test, such as *Persistence of Beta-Blocker Treatment After a Heart Attack, Osteoporosis Management in Older Women*) tend to have a lower percentage of plans able to report. Table 11a later in this report shows the total number and percentage of plans reporting each measures and the number and percentage of plans with denominators above or below 30 for each measure.

HEDIS Results

SNP Program Performance Changes, HEDIS 2012 2014 (Tables 3a and 3b)

Tables 3a and 3b show a three-year trend in SNP performance on HEDIS measures. The two tables differ as follows:

- **Table 3a shows results aggregated across plans for the SNP program as a whole (2012-2014**). It includes all 34 measures and results from all SNPs that reported in any of the three years. For the analysis presented in this table, results for statistical significance tests between HEDIS 2012 and 2014 and between HEDIS 2013 and 2014 were based on a non-paired t-test ($p < 0.05$).
- **Table 3b shows results only for SNPs that reported HEDIS measures in all three reporting years (2012–2014)**. It includes the results for statistically significant differences between HEDIS 2012 and HEDIS 2014 and between HEDIS 2013 and HEDIS 2014, using a paired t-test ($p < 0.05$) to illustrate performance differences among the same group of SNPs between different time periods.

Although there are 34 HEDIS measures collected in HEDIS 2014, year-to-year statistical comparison was not possible for the *Plan All-Cause Readmissions* measures; therefore, performance analyses across years exclude this measure. Additionally, we do not include data for measures where changes in the specifications make year-to-year analyses impossible. There are a total of 34 measures, of which 9 had some form of trend break due to a change in specification that prevent a comparison across the three-year period.

All SNPs reporting in any of the three years (Table 3a). Program wide results for all SNPs were mixed. Less than half of the measures improved in a statistically significant manner over the 3 years (HEDIS 2012–2014). Ten measures showed statistically significant improvement from HEDIS 2013–2014, while 12 measures showed improvement, though not statistically significant, for the entire 3-year period. Eight measures showed a statistically significant decline from HEDIS 2013–2014 and six showed a decline for the entire 3-year period.

Three of the *Care for Older Adults* measures (*Advance Care Planning, Medication Review, Functional Status Assessment*) showed the largest increase; an average of 17.6 percentage points, respectively, from HEDIS 2012–2014. *Active Board Certification—Geriatrics* rates dropped the most (18.3 percentage points) over the 3-year period.

Highest and Lowest Rates (Table 3a). The measures with the highest and lowest HEDIS 2014 rates were:

Highest Five:

1. *Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring* (96.0%).
2. *Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications* (4.8%). (Note: Lower values signify better performance; this is equivalent to 95.2%.)
3. *Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring* (94.7%).
4. *Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring* (94.5%).
5. *Annual Monitoring for Patients on Persistent Medications—Total Rate* (93.5%).

Lowest Five:

1. *Osteoporosis Management in Women Who Had a Fracture* (28.2%).
2. *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge* (32.8%).
3. *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* (33.1%).
4. *Medication Reconciliation Post-Discharge* (34.3%).
5. *Potentially Harmful Drug-Disease Interactions—Dementia* (61.1%). (Lower values signify better performance; this is equivalent to 38.9%.)

Four out of the 5 measures with the highest performance are *Annual Monitoring for Patients on Persistent Medications* indicators. All 5 measures in the highest five are medication management measures.

Largest Significant Changes (Table 3a). Listed below are measures showing the largest significant changes, positive or negative, from HEDIS 2012–2014. The measures with the largest increases showed a 3.5 percentage point or greater rate increase. The measures with the largest decreases showed a 3.0 percentage point or greater rate decrease.

Largest Increase:

1. *Care for Older Adults—Advance Care Planning* (23 percentage points)
2. *Care for Older Adults—Functional Status Assessment* (15.9 percentage points)
3. *Care for Older Adults—Medication Review* (13.8 percentage points)
4. *Colorectal Cancer Screening* (7.7 percentage points).
5. *Glaucoma Screening In Older Adults*[4] (6.9 percentage points)

Largest Decrease:

1. *Active Board Certification—Geriatrics* (18.3 percentage points)
2. *Active Board Certification—Family Medicine* (7.2 percentage points)
3. *Active Board Certification—Other Physician Specialists* (6.7 percentage points)
4. *Active Board Certification—Internal Medicine* (4.6 percentage points)
5. *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge* (3.2 percentage points)

Three of the 5 measures with the largest increase are *Care for Older Adults* measures, which only SNPs collect. Four of the 5 measures with the largest decreases are for *Active Board Certification*.

Measures only SNPs report (3a). There are five HEDIS measures that only SNPs report *(Care for Older Adults—Advance Care Planning, Care for Older Adults—Functional Status Assessment, Care for Older Adults—Medication Review, Care for Older Adults—Pain Screening, Medication Reconciliation Post-Discharge)*. Overall performance rates for these measures are generally lower than for the other measures in the SNP reporting set. These measures rely on medical record review. There is the potential that the measure results may understate performance if SNPs did not vigorously pursue obtaining medical charts. Three *Care for Older Adults* measures *(Advance Care Planning, Medication Review, Functional Status Assessment)* showed significant improvement from 2012–2014. The overall rate for all three measures improved significantly from HEDIS 2012–2014 (23 percentage points; 13.8 percentage points; 15.9 percentage points, respectively).

The fifth SNP-only measure, *Medication Reconciliation Post-Discharge,* showed a statistically significant increase (10.5 percentage points) in overall rate between HEDIS 2013 and HEDIS 2014 and a 2.5 percentage point increase from HEDIS 2012–2014.

SNPs reporting HEDIS 2012–2014 (Table 3b). For SNPs that reported in all 3 years, results were slightly better than for plans that reported in any of the 3 years. Fourteen measures (more than half) with trendable data showed statistically significant improvement over the entire period and 12 measures showed significant improvement between from 2013–2014. Four measures showed statistically significant decline over the entire period and six measures showed significant decline from HEDIS 2013–2014.

Three of the *Care for Older Adults* measures (*Advance Care Planning, Medication Review, Functional Status Assessment*) rose by an average of 16.7 percentage points over the period. The *Active Board Certification—Geriatrics* measure showed the largest significant decrease (6.3 percentage points) in performance during this period.

[4] Starting with HEDIS 2015, NCQA is retiring the Glaucoma Screening In Older Adults measure as a result of a recent U.S. Preventive Services Task Force (USPSTF) recommendation. In July 2013, the USPSTF concluded that the current evidence is insufficient to assess the balance of benefits and harms of screening for glaucoma in adults.

Table 3a. HEDIS Performance for SNP Program, HEDIS 2012, 2013 and 2014

This table includes all SNP results combined, for all plans that reported in any of the three years.

Measure	HEDIS 2012	HEDIS 2013	HEDIS 2014		CHANGE	
	Overall Rate	Overall Rate	Eligible Population	Overall Rates	2012-2014	2013-2014
Colorectal Cancer Screening	59.0	62.8	535,939	66.7	7.7**	3.9**
Glaucoma Screening in Older Adults	68.5	72.4	604,922	75.4	6.9**	3.0**
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	33.8	33.3	34,431	33.1	-0.7	-0.2
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	63.1	64.4	32,269	67.3	4.2**	2.9**
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	79.4	79.9	32,269	80.9	1.4	1.0
Controlling High Blood Pressure	59.6	58.1	655,087	59.0	-0.6	0.9
Persistence of Beta-Blocker Treatment After a Heart Attack	86.7	88.5	6,561	88.8	2.1**	0.3
Osteoporosis Management in Women Who Had a Fracture	21.9	25.0	13,311	28.2	6.3**	3.2
Antidepressant Medication Management—Acute Phase	NA	62.7	49,418	60.2	NA	-2.5**
Antidepressant Medication Management—Continuation Phase	NA	49.3	49,418	46.0	NA	-3.3**
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	55.1	55.8	23,632	53.0	-2.1	-2.8**
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	36.1	36.2	23,632	32.8	-3.2**	-3.4**
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	93.5	94.0	595,369	94.5	1.0**	0.5**
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	95.2	95.7	23,351	96.0	0.8**	0.3
Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring	93.8	94.3	404,189	94.7	0.9**	0.4
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	72.4	69.9	47,662	69.3	-3.1**	-0.6
Annual Monitoring for Patients on Persistent Medications—Total Rate	92.6	93.0	1,070,571	93.5	0.8**	0.4**
Medication Reconciliation Post-Discharge	31.7	23.8	222,260	34.3	2.5	10.5**
Care for Older Adults—Advance Care Planning	32.6	48.3	849,100	55.6	23.0**	7.3**
Care for Older Adults—Medication Review	68.9	78.1	853,023	82.7	13.8**	4.6**
Care for Older Adults—Functional Status Assessment	55.8	66.2	853,023	71.6	15.9**	5.4**
Care for Older Adults—Pain Screening	NA	NA	853,023	81.6	NA	NA
Active Board Certification—Family Medicine	70.0	66.9	472,072	62.8	-7.2**	-4.1**
Active Board Certification—Internal Medicine	76.3	74.3	835,776	71.6	-4.6**	-2.7**

Measure	HEDIS 2012	HEDIS 2013	HEDIS 2014		CHANGE	
	Overall Rate	Overall Rate	Eligible Population	Overall Rates	2012-2014	2013-2014
Active Board Certification—Geriatrics	67.7	58.1	24,084	49.4	18.3**	-8.7**
Active Board Certification—Other Physician Specialists	76.0	72.4	1,721,670	69.4	-6.7**	-3.0**
Potentially Harmful Drug-Disease Interactions—History of Falls*	NA	NA	44,803	54.1	NA	NA
Potentially Harmful Drug-Disease Interactions—Dementia*	NA	NA	73,108	61.1	NA	NA
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure*	NA	NA	30,573	17.1	NA	NA
Potentially Harmful Drug-Disease Interactions—Total Rate*	NA	NA	148,484	49.9	NA	NA
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*	NA	27.1	852,038	23.2	NA	3.9**
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications*	NA	NA	852,038	4.8	NA	NA
Plan All-Cause Readmissions (O/E Ratio—≥65)* †	0.94	0.88	170,381	0.82	0.11	0.05
Plan All-Cause Readmissions* (O/E Ratio—<65)* †	0.91	0.87	84,489	0.83	0.08	0.04

*Lower values signify better performance.
**Denotes a statistically significant difference (p<0.05) between years when rates are compared.
†No statistical testing is done for differences in the *Plan All-Cause Readmissions* measure because risk-adjusted comparisons cannot be made using a t-test. A proper test requires the availability of plan-level confidence intervals for each O/E ratio. Because total variance was not collected in 2012 and was not reported properly by most plans in 2014, statistical tests for *Plan All-Cause Readmissions* are not possible
Cells that are shaded and have NA (Not Applicable) represent years for which there is a trend break and comparisons across years cannot be made.

Table 3b. HEDIS Performance for Three-Year Reporting SNPs, HEDIS 2012, 2013 and 2014

This table shows population-based results only for SNPs that reported HEDIS 2012, 2013 and 2014 results.

Measure	HEDIS 2012	HEDIS 2013	HEDIS 2014		CHANGE	
	Overall Rate	Overall Rate	Eligible Population	Overall Rate	2012-2014	2013-2014
Colorectal Cancer Screening	59.6	63.1	506,501	66.8	7.2**	3.6**
Glaucoma Screening in Older Adults	68.7	72.3	574,214	75.2	6.5**	2.9**
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	34.3	33.4	32,816	32.9	-1.4	-0.5**
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	62.3	63.8	29,709	66.9	4.6**	3.1**
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	79.0	79.5	29,709	80.8	1.7**	1.3
Controlling High Blood Pressure	59.9	58.3	599,004	59.4	-0.5	1.1**
Persistence of Beta-Blocker Treatment After a Heart Attack	86.4	88.4	6,086	88.6	2.2**	0.2
Osteoporosis Management in Women Who Had a Fracture	22.5	25.1	12,639	27.8	5.3**	2.7**
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	55.6	56.5	21,568	52.7	-2.8	-3.7**
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	36.4	36.6	21,568	32.5	-4.0**	-4.2**
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	93.5	94.0	555,049	94.4	0.9**	0.4**
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	95.1	95.7	21,551	96.0	0.8**	0.3
Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring	93.8	94.4	376,236	94.7	0.9**	0.3**
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	72.4	69.8	44,625	69.3	-3.1**	-0.5
Annual Monitoring for Patients on Persistent Medications—Total Rate	92.6	93.1	997,461	93.4	0.8**	0.4**
Medication Reconciliation Post-Discharge	30.6	24.2	198,483	35.1	4.5**	10.9**
Care for Older Adults—Advance Care Planning	33.3	49.5	790,560	55.4	22.0**	5.9**
Care for Older Adults—Medication Review	69.7	78.6	773,838	82.9	13.2**	4.3**
Care for Older Adults—Functional Status Assessment	56.2	67.0	775,070	71.0	14.8**	4.0**
Active Board Certification—Family Medicine	69.7	68.6	290,093	67.2	-2.5	-1.4**
Active Board Certification—Internal Medicine	76.5	76.2	486,882	74.9	-1.5**	-1.3**

Measure	HEDIS 2012	HEDIS 2013	HEDIS 2014		CHANGE	
	Overall Rate	Overall Rate	Eligible Population	Overall Rate	2012-2014	2013-2014
Active Board Certification—Geriatrics	65.3	62.8	15,208	58.9	-6.3**	-3.8**
Active Board Certification—Other Physician Specialists	75.5	75.3	1,135,912	74.5	-1.0	-0.8
Plan All-Cause Readmissions (O/E Ratio—≥65)*†	0.9	0.9	154,719	0.8	0.1	0.1
Plan All-Cause Readmissions (O/E Ratio—<65)*†	0.9	0.9	73,903	0.8	0.1	0.1

*Lower values signify better performance.
**Denotes a statistically significant difference ($p<0.05$) between years when rates are compared.
†No statistical testing is done for differences in the *Plan All-Cause Readmissions* measure because risk-adjusted comparisons cannot be made using a t-test. A proper test requires the availability of plan-level confidence intervals for each O/E ratio. Because total variance was not collected in 2012 and was not reported properly by most plans in 2014, statistical tests for *Plan All-Cause Readmissions* are not possible

SNP Program and MA Program Performance (Table 4)

SNP and MA program performance. Data in Table 4 show SNP program performance for the measures SNP and MA plans are required to report, in the context of overall MA program performance. SNPs report a subset of the full MA HEDIS measures set, so this report compares only the measures that all non-SNP MA plans and SNPs report.

For HEDIS 2014, non-SNP MA plans outperformed SNPs on 13 measures. SNPs statistically significantly outperformed MA plans on 7 of the required measures; however, there was no statistically significant difference in performance between SNPs and MA plans on 7 other measures in HEDIS 2014.

Measures with the largest performance gaps between the MA and SNP programs plans included: *Controlling High Blood Pressure* (9.4 percentage points), all *Potentially Harmful Drug-Disease Interactions in the Elderly* measures (average gap of 8.6 percentage points) and *Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications* (6.9 percentage points).

On measures where the SNPs outperformed MA plans, the largest performance gaps included the following: *Glaucoma Screening in Older Adults* (3.1 percentage points) and *Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring* (2.9 percentage points).

Note: *MA plans report HEDIS measures at the contract level, which may include SNP beneficiaries because some MA contracts include SNP plan benefit packages. However, these represent a small portion of the MA population, as indicated by the eligible population data for each measure. Results were analyzed for statistically significant differences ($p < 0.05$) between SNP and other MA plan results.*

Table 4. HEDIS 2014 Performance for SNP Program and MA Program

This table shows population-based performance for all SNPs and all MA plans.

Measures	SNPs		MA Organizations		Performance Gap in Rates (SNP—MA)	
	Eligible Population	Overall Rate	Eligible Population	Overall Rate	2013	2014
Colorectal Cancer Screening	535,939	66.7	6,033,008	69.5	-4.6**	-2.8**
Glaucoma Screening in Older Adults	604,922	75.4	8,718,967	72.3	1.1	3.1**
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	34,431	33.1	283,660	37.9	-5.4**	-4.8**
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	32,269	67.3	147,542	71.1	-4.9**	-3.8**
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	32,269	80.9	147,542	78.8	1.6**	2.1**
Controlling High Blood Pressure	655,087	59.0	5,905,542	68.4	-7.6**	-9.4**
Persistence of Beta-Blocker Treatment After a Heart Attack	6,561	88.8	49,726	89.9	-0.7	-1.2
Osteoporosis Management in Women Who Had a Fracture	13,311	28.2	145,407	31.7	-2.8	-3.5
Antidepressant Medication Management—Acute Phase	49,418	60.2	284,212	67.3	-8.6**	-7.2**
Antidepressant Medication Management—Continuation Phase	49,418	46.0	284,212	52.7	-9.1**	-6.7**
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	23,632	53.0	68,179	53.9	-1.5	-1.0
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	23,632	32.8	68,179	33.7	-1.1	-0.8
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	595,369	94.5	4,833,487	93.2	1.3**	1.3**
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	23,351	96.0	203,293	94.9	1.3**	1.1**
Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring	404,189	94.7	3,455,737	93.3	1.4**	1.4**
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	47,662	69.3	165,359	66.4	2.6**	2.9**
Annual Monitoring for Patients on Persistent Medications—Total Rate	1,070,571	93.5	8,657,876	92.8	0.7**	0.7**
Medication Reconciliation Post-Discharge	222,260	34.3	***	***	***	***

Measures	SNPs		MA Organizations		Performance Gap in Rates (SNP—MA)	
	Eligible Population	Overall Rate	Eligible Population	Overall Rate	2013	2014
Care for Older Adults—Advance Care Planning	849,100	55.6	***	***	***	***
Care for Older Adults—Medication Review	853,023	82.7	***	***	***	***
Care for Older Adults—Functional Status Assessment	853,023	71.6	***	***	***	***
Care for Older Adults—Pain Screening	853,023	81.6	***	***	***	***
Potentially Harmful Drug-Disease Interactions—History of Falls*	44,803	54.1	490,761	46.7	--	-7.4**
Potentially Harmful Drug-Disease Interactions—Dementia*	73,108	61.1	492,901	49.7	--	-11.4**
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure*	30,573	17.1	216,613	10.3	--	-6.8**
Potentially Harmful Drug-Disease Interactions—Total Rate*	148,484	49.9	1,200,275	41.3	--	-8.6**
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*	852,038	23.2	10,005,893	16.3	-8.0**	-6.9**
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications*	852,038	4.8	10,005,893	2.6	--	-2.1**
Active Board Certification—Family Medicine	472,072	62.8	938,458	66.8	-2.5**	-3.9**
Active Board Certification—Internal Medicine	835,776	71.6	1,360,796	72.3	0.1	-0.6
Active Board Certification—Geriatrics	24,084	49.4	45,852	52.9	2.1	-3.5
Active Board Certification—Other Physician Specialists	1,721,670	69.4	3,216,354	71.4	0.4	-2.1
Plan All-Cause Readmissions (O/E Ratio—≥65)*†	170,381	0.82	1,624,350	0.82	-0.01	-0.01
Plan All-Cause Readmissions (O/E Ratio—<65)*†	84,489	0.83	279,358	0.82	-0.01	-0.01

*Lower values signify better performance.

**Denotes a statistically significant difference ($p < 0.05$) between MA and SNP rates.

***Not reported by MA plans.

†No statistical testing is done for differences in the *Plan All-Cause Readmissions* measure between SNP program and MA program because risk-adjusted comparisons cannot be made using a t-test. A proper test requires the availability of plan-level confidence intervals for each O/E ratio. Because total variance was not collected in 2012 and was not reported properly by most plans in 2014, statistical tests for *Plan All-Cause Readmissions* are not possible

SNP Program Performance by SNP Type (Table 5)

In 2014, I-SNPs had higher rates on 23 measures, compared to 8 for D-SNPs and 3 for C-SNPs.

- I-SNPs showed statistically significant improvement for three measures (*Medication Reconciliation Post-Discharge, Care for Older Adults—Medication Review* and *Care for Older Adults—Functional Status Assessment)* and showed statistically significant decreases in performance for three measures (*Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring; Anticonvulsant Monitoring; and Total Rate).*
- D-SNPs showed statistically significant performance improvement for 10 measures and showed statistically significant decreases in performance for seven measures. The largest gains were on *Medication Reconciliation Post-Discharge* and three *Care for Older Adults* measures *(Advance Care Planning, Medication Review, Functional Status Assessment).*
    - Improvement: *Colorectal Cancer Screening, Glaucoma Screening in Older Adults, Pharmacotherapy of COP Exacerbation—Dispensing Systematic Corticosteroids Within 14 Days of Event, Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring, Annual Monitoring for Patients on Persistent Medications—Total Rate, Medication Reconciliation Post-Discharge, Care for Older Adults—Advanced Care Planning, Care for Older Adults—Medicare Review, Care for Older Adults—Functional Status Assessment, Use of High-Risk Medications in the Elderly—At Lead One High Risk Medication.*
    - Decrease: *Antidepressant Medication Management—Acute Phase, Antidepressant Medication Management—Continuation Phase, Follow-Up After Hospitalization for Mental Illness—30 Days of Discharge, Follow-Up After Hospitalization for Mental Illness—7 Days of Discharge, Active Board Certification—Family Medicine, Active Board Certification—Internal Medicine, Active Board Certification—Geriatrics.*
- C-SNPs showed statistically significant improvement on four measures *(Colorectal Cancer Screening, Glaucoma Screening in Older Adults, Medication Reconciliation Post-Discharge, Use of High Risk Medications in the Elderly—At Least Two High-Risk Medications).* Conversely, C-SNPs showed statistically significant decreases in performance for six measures (*Antidepressant Medication Management—Acute Phase, Antidepressant Medication Management—Continuation Phase,* all four *Active Board Certification* measures).

Table 5. SNP Overall Program Performance by SNP Type, HEDIS 2013 and 2014

This table displays program wide results for all SNPs, by SNP type.

Measure	DUAL SNPS					INSTITUTIONAL SNPS					CHRONIC SNPS				
	2014		2013		2014 vs 2013	2014		2013		2014 vs 2013	2014		2013		2014 vs 2013
	#	Rate	#	Rate	Change	#	Rate	#	Rate	Change	#	Rate	#	Rate	Change
Colorectal Cancer Screening	245	67.3	274	64.0**	3.3**	40	39.5**	49	38.1**	1.4	68	65.7	92	58.0**	7.7**
Glaucoma Screening in Older Adults	245	74.9	274	72.0	2.9**	40	80.3	49	75.4	4.9	68	76.9	92	73.4	3.6**
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	245	32.4**	274	33.0**	-0.7	40	14.6**	49	13.7**	1.0	68	40.0**	92	39.4**	0.6
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	245	67.8	274	64.7	3.2**	40	42.5**	49	45.1**	-2.6	68	66.1	92	64.8	1.4
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	245	82.4	274	80.8	1.6	40	76.9	49	77.7	-0.8	68	74.0	92	75.2	-1.1
Controlling High Blood Pressure	245	61.7	268	61.1	0.5	40	54.6	49	61.2	-6.6	68	47.4	87	43.4	4.0
Persistence of Beta-Blocker Treatment After a Heart Attack	245	89.5	274	89.0	0.5	40	93.8	49	92.7	1.1	68	85.8	92	86.2	-0.4
Osteoporosis Management in Women Who Had a Fracture	245	29.8	273	26.5	3.3	40	14.3**	49	13.6**	0.8	68	27.8	92	25.4	2.4
Antidepressant Medication Management—Acute Phase	245	59.6	274	61.8	-2.1**	40	79.4**	49	79.9**	-0.5	68	60.7	92	65.6	-4.9**
Antidepressant Medication Management—Continuation Phase	245	45.3	274	48.2	-2.9**	40	71.4**	49	70.8**	0.6	68	46.7	92	51.9	-5.3**
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	245	53.3	274	56.3	-3.1**	40	28.7	49	29.8	-1.0	68	50.6	92	52.0	-1.4
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	245	33.3	274	36.6	-3.3**	40	16.1	49	21.4	-5.3	68	27.9	92	32.7	-4.8
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	245	94.1**	274	93.6**	0.6**	40	97.0	49	98.0**	-1.0	68	95.7	92	95.5**	0.1
Annual Monitoring for Patients on Persistent Medications—Digoxin	245	95.7	274	95.2**	0.5	40	98.1	49	98.4**	-0.3	68	96.2	92	96.4**	-0.1

Measure	DUAL SNPS					INSTITUTIONAL SNPS					CHRONIC SNPS				
	2014		2013		2014 vs 2013	2014		2013		2014 vs 2013	2014		2013		2014 vs 2013
	#	Rate	#	Rate	Change	#	Rate	#	Rate	Change	#	Rate	#	Rate	Change
Monitoring															
Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring	245	94.3**	274	93.9**	0.5	40	97.6	49	98.6**	-0.9**	68	95.9	92	95.8**	0.2
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	245	67.4	274	67.5	-0.1	40	90.6**	49	95.9**	-5.3**	68	63.5	92	66.1	-2.6
Annual Monitoring for Patients on Persistent Medications—Total Rate	245	93.0**	274	92.4**	0.6**	40	96.3	49	98.0**	-1.6**	68	95.3	92	95.2**	0.1
Medication Reconciliation Post-Discharge	245	37.1	270	26.7	10.4**	40	37.8	49	20.6	17.2**	68	21.9	88	12.1	9.8**
Care for Older Adults—Advance Care Planning	244	52.5**	273	43.4**	9.1**	40	83.2**	49	88.0**	-4.8	68	64.0**	92	60.8**	3.2
Care for Older Adults—Medication Review	245	83.1	272	77.6	5.4**	40	95.7**	49	88.7**	6.9**	68	78.7	91	77.5	1.2
Care for Older Adults—Functional Status Assessment	245	70.0	272	63.3**	6.8**	40	97.1**	49	92.2**	4.9**	68	73.8	91	72.8**	1.0
Care for Older Adults—Pain Screening	245	81.9**	NA	NA	NA	40	97.5**	NA	NA	NA	68	76.8**	NA	NA	NA
Potentially Harmful Drug-Disease Interactions—History of Falls*	244	53.3	NA	NA	NA	40	66.4**	NA	NA	NA	68	53.8	NA	NA	NA
Potentially Harmful Drug-Disease Interactions—Dementia*	244	62.5**	NA	NA	NA	40	58.2	NA	NA	NA	68	55.0	NA	NA	NA
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure*	244	18.7**	NA	NA	NA	40	8.2**	NA	NA	NA	68	14.0**	NA	NA	NA
Potentially Harmful Drug-Disease Interactions—Total Rate*	244	51.1	NA	NA	NA	40	54.3	NA	NA	NA	68	41.9**	NA	NA	NA
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*	245	22.8	274	26.6**	3.7**	40	17.3	49	19.8**	2.4	68	26.0**	92	31.3**	5.3**
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications*	245	4.8	NA	NA	NA	40	2.3**	NA	NA	NA	68	5.0	NA	NA	NA
Active Board Certification—Family	231	61.3	259	64.6**	-3.3**	40	77.5**	48	74.8	2.7	66	60.3	90	70.5	-10.1**

Measure	DUAL SNPS					INSTITUTIONAL SNPS					CHRONIC SNPS				
	2014		2013		2014 vs 2013	2014		2013		2014 vs 2013	2014		2013		2014 vs 2013
	#	Rate	#	Rate	Change	#	Rate	#	Rate	Change	#	Rate	#	Rate	Change
Medicine															
Active Board Certification—Internal Medicine	231	70.9	257	73.5	-2.6**	40	78.2**	48	78.6	-0.4	66	71.6	90	75.1	-3.5**
Active Board Certification—Geriatrics	229	48.1	257	53.3**	-5.2**	40	64.0**	48	67.4	-3.4	65	44.3	90	66.2	-21.9**
Active Board Certification—Other Physician Specialists	231	67.5	257	69.5**	-2.0	40	82.1**	48	80.4	1.7	66	68.4	90	76.8	-8.5**
Plan All-Cause Readmissions (O/E Ratio—≥65)*†	243	0.84	271	0.88	0.04	40	0.59	49	0.61	0.02	68	0.77	91	0.91	0.14
Plan All-Cause Readmissions (O/E Ratio—<65)*†	242	0.85	272	0.87	0.03	40	0.70	49	0.68	-0.02	68	0.77	91	0.90	0.13

*Lower values signify better performance.

**Denotes a statistically significant difference ($p < 0.05$) between SNP types.

† No statistical testing is done for differences in the *Plan All-Cause Readmissions* measure between SNP program and MA program because risk-adjusted comparisons cannot be made using a t-test. A proper test requires the availability of plan-level confidence intervals for each O/E ratio. Because total variance was not collected in 2013 and was not reported properly by most plans in 2014, statistical tests for *Plan All-Cause Readmissions* are not possible.

Cells that are shaded and have NA (Not Applicable) represent years for which there is a trend break and comparisons across years cannot be made.

SNP Program Performance by Enrollment Size (Table 6)

This table displays program wide performance for all SNPs by enrollment. Statistically significant changes are displayed by enrollment size categories and denote a change from HEDIS 2013–2014 within a specific enrollment category. Because statistical significance is a function of effect size and sample size, NCQA did not test for statistical significance of the differences among SNP sizes because of the wide variation in SNP enrollment sizes. Should such testing be performed, the mean of the larger SNPs would dominate the mean of the sizes against which comparisons are made. It should be noted that as enrollment size increases, it is more likely that statistically significant differences will be found for progressively smaller effect sizes that may not be clinical significant.

Overall, the category with the largest number of plans in the SNP program and SNP enrollees (≥2,500 enrollees) showed the most improvement from HEDIS 2013–2014, with 7 measures increasing significantly. Two measures showed significant improvement in the mid-sized plans (500–999 enrollees); the remaining categories each showed improvement on 4–6 measures.

The 0–99 enrollment category had the least amount of plans (15 in 2014) and the ≥2,500 category had the most plans (126 plans in 2014).

- Plans with enrollment between 0–99 enrollees had significant changes in 6 measures.
  - Significant changes greater than 10 percentage points: *Medication Reconciliation Post Discharge, Active Board Certification*, *Pharmacotherapy of COPD Exacerbation.*
  - The eligible populations within this category are small; thus, large fluctuations are more likely within these plans. Additionally, none of these smallest plans had a reportable rate (denominator ≥ 30) for *Osteoporosis Management in Women* Who Had a Fracture for HEDIS 2014.
- Plans with enrollment of 100–499 enrollees had significant increases in 6 measures and significant decreases in all four *Active Board Certification* measures.
  - Significant changes above 10 percent: *Osteoporosis Management in Women Who Had a Fracture, Active Board Certification—Geriatrics*.
- Plans with enrollment of 500–999 enrollees had significant increases in 2 measures and a significant decrease in *Antidepressant Medication Management—Continuation Phase*.
- Plans with enrollment of 1,000–2,499 enrollees had significant increases in 4 measures and significant decreases in 2 measures.
  - Significant changes above 10 percent: *Medication Reconciliation Post-Discharge*.
- Plans with enrollment greater than 2,500 had significant increases in 7 measures, including *Medication Reconciliation Post-Discharge,* which had a significant change of 10.6 percent, and a significant decrease in one measure *(Antidepressant Medication Management—Continuation Phase).*

The two categories with the smallest plans and mid-sized plans with 1,000–2,499 enrollees had significant decreases in the *Active Board Certification* measures.

Table 6. SNP Overall Program Performance by Enrollment Size, HEDIS 2013 and 2014

RATE BY SNP ENROLLMENT SIZE															
	0–99			100–499			500–999			1,000–2,499			≥2,500		
Measure	2014 Rate	2013 Rate	2014 vs 2013 Change	2014 Rate	2013 Rate	2014 vs 2013 Change	2014 Rate	2013 Rate	2014 vs 2013 Change	2014 Rate	2013 Rate	2014 vs 2013 Change	2014 Rate	2013 Rate	2014 vs 2013 Change
Total SNPs	**15**	**21**		**64**	**80**		**52**	**65**		**96**	**112**		**126**	**137**	
Colorectal Cancer Screening	58.2	50.8	7.5	67.2	61.3	5.9	67.8	64.8	3.0	63.6	61.0	2.7	67.1	63.0	4.1**
Glaucoma Screening in Older Adults	77.8	69.5	8.3	78.3	73.8	4.5	79.0	75.5	3.5	77.0	75.3	1.7	75.1	71.9	3.2**
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	30.8	13.6	17.1	36.8	31.8	4.9	33.8	31.6	2.2	34.5	33.7	0.8	32.9	33.4	-0.5
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	72.7	42.1	30.6**	70.1	69.2	0.9	70.1	67.0	3.2	68.6	67.2	1.4	66.9	63.9	3.1**
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	95.5	57.9	37.6**	83.6	84.3	-0.7	83.8	82.9	1.0	82.3	83.1	-0.8	80.5	79.3	1.2
Controlling High Blood Pressure	63.9	45.0	18.9**	66.2	61.8	4.4**	60.3	60.8	-0.4	58.9	59.5	-0.7	58.9	57.8	1.1
Persistence of Beta-Blocker Treatment After a Heart Attack	75.0	50.0	25.0	93.6	90.5	3.1	87.0	92.1	-5.1	88.9	92.3	-3.3**	88.8	87.8	0.9
Osteoporosis Management in Women Who Had a Fracture	NA	45.5	NA	30.1	17.8	12.3**	31.5	28.9	2.5	24.4	22.1	2.2	28.7	25.6	3.1
Antidepressant Medication Management—Acute Phase	69.2	80.0	-10.8	69.9	73.2	-3.3	66.0	70.4	-4.4	63.3	67.0	-3.7	59.4	61.7	-2.3
Antidepressant Medication Management—Continuation Phase	74.4	65.0	9.4	60.1	59.9	0.3	51.8	59.1	-7.3**	49.8	53.9	-4.1	45.1	48.1	-3.1**
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	28.6	26.3	2.3	48.6	43.8	4.8	44.5	43.5	1.0	53.5	54.2	-0.7	53.2	56.7	-3.5
Follow-Up After Hospitalization for	14.3	21.1	-6.8	26.2	25.7	0.4	26.3	23.9	2.4	31.7	36.6	-4.9	33.3	36.8	-3.5

RATE BY SNP ENROLLMENT SIZE															
	0–99			100–499			500–999			1,000–2,499			≥2,500		
Measure	2014 Rate	2013 Rate	2014 vs 2013 Change	2014 Rate	2013 Rate	2014 vs 2013 Change	2014 Rate	2013 Rate	2014 vs 2013 Change	2014 Rate	2013 Rate	2014 vs 2013 Change	2014 Rate	2013 Rate	2014 vs 2013 Change
Total SNPs	**15**	**21**		**64**	**80**		**52**	**65**		**96**	**112**		**126**	**137**	
Mental Illness—Follow-Up Within 7 Days of Discharge															
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	94.6	96.9	-2.3	95.9	95.3	0.6	94.6	94.9	-0.2	95.1	95.0	0.1	94.4	93.8	0.5
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	100.0	97.7	2.3	96.7	98.2	-1.5	95.3	95.5	-0.2	97.2	97.0	0.2	95.8	95.4	0.4
Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring	95.2	97.3	-2.1	96.4	95.4	1.0	95.0	95.1	-0.1	95.2	95.3	-0.2	94.6	94.2	0.5
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	80.0	87.8	-7.8	80.2	82.2	-2.0	75.5	76.5	-1.0	76.2	79.7	-3.6	67.6	67.6	0.0
Annual Monitoring for Patients on Persistent Medications—Total	94.2	96.4	-2.3	95.1	94.5	0.6	93.9	94.1	-0.2	94.0	94.3	-0.3	93.4	92.8	0.6
Medication Reconciliation Post-Discharge	43.8	16.2	27.6**	42.9	34.1	8.8**	39.2	33.6	5.6	38.0	26.5	11.5**	33.4	22.8	10.6**
Care for Older Adults—Advance Care Planning	53.1	50.2	3.0	66.2	62.0	4.1	59.2	58.0	1.1	59.0	57.4	1.6	54.9	46.3	8.6**
Care for Older Adults—Medication Review	74.8	68.3	6.6	89.3	85.0	4.4**	86.7	81.1	5.6**	86.5	78.6	7.9**	82.0	77.8	4.2**
Care for Older Adults—Functional Status Assessment	73.9	64.2	9.7	85.8	78.3	7.5**	81.1	74.4	6.7	78.2	70.6	7.6**	70.2	65.0	5.2
Care for Older Adults—Pain Screening	78.6	NA	NA	90.4	NA	NA	86.4	NA	NA	87.4	NA	NA	80.5	NA	NA
Active Board Certification—Family Medicine	67.7	77.8	-10.1**	59.5	65.9	-6.4**	59.7	65.2	-5.5	64.3	66.2	-1.9	65.5	67.7	-2.2
Active Board Certification—Internal Medicine	74.6	78.0	-3.4	69.3	73.2	-3.9**	68.6	71.7	-3.1	72.5	75.0	-2.5	74.4	75.7	-1.4
Active Board Certification—	57.6	76.5	-18.9**	38.1	51.0	-12.9**	40.6	49.1	-8.5	50.5	58.6	-8.1**	60.9	64.8	-3.9

RATE BY SNP ENROLLMENT SIZE															
	0–99			100–499			500–999			1,000–2,499			≥2,500		
Measure	2014 Rate	2013 Rate	2014 vs 2013 Change	2014 Rate	2013 Rate	2014 vs 2013 Change	2014 Rate	2013 Rate	2014 vs 2013 Change	2014 Rate	2013 Rate	2014 vs 2013 Change	2014 Rate	2013 Rate	2014 vs 2013 Change
Total SNPs	**15**	**21**		**64**	**80**		**52**	**65**		**96**	**112**		**126**	**137**	
Geriatrics															
Active Board Certification—Other Physician Specialists	64.6	77.8	-13.3	61.1	67.2	-6.1**	65.2	69.5	-4.3	71.8	72.1	-0.3	74.9	76.8	-1.9
LOWER VALUES SIGNIFY BETTER PERFORMANCE FOR THESE RATES															
Potentially Harmful Drug-Disease Interactions—History of Falls*	55.9	NA	NA	61.4	NA	NA	57.3	NA	NA	57.5	NA	NA	53.3	NA	NA
Potentially Harmful Drug-Disease Interactions—Dementia*	64.2	NA	NA	56.5	NA	NA	58.3	NA	NA	58.7	NA	NA	61.7	NA	NA
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure*	19.2	NA	NA	15.1	NA	NA	16.1	NA	NA	12.8	NA	NA	17.8	NA	NA
Potentially Harmful Drug-Disease Interactions—Total Rate*	48.5	NA	NA	50.2	NA	NA	48.4	NA	NA	50.1	NA	NA	49.9	NA	NA
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*	22.8	25.2	2.4	20.1	25.5	5.4**	20.2	25.3	5.1**	20.3	25.4	5.1**	23.7	27.4	3.7**
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications*	3.5	NA	NA	3.5	NA	NA	3.3	NA	NA	3.5	NA	NA	5.0	NA	NA
Plan All-Cause Readmissions (O/E Ratio—≥65)* †	0.77	0.86	0.09	0.81	0.90	0.09	0.79	0.83	0.04	0.71	0.77	0.06	0.84	0.89	0.05
Plan All-Cause Readmissions (O/E Ratio—<65)* †	1.02	0.43	-0.59	0.90	0.87	-0.03	0.79	0.84	0.05	0.81	0.83	0.03	0.84	0.88	0.05

*Lower values signify better performance.

**Denotes the rate for that plan size is statistically different ($p < 0.05$) from 2013–2014.

† No statistical testing is done for differences in the *Plan All-Cause Readmissions* measure across years within enrollment size categories because risk-adjusted comparisons cannot be made using a t-test. A proper test requires the availability of plan-level confidence intervals for each O/E ratio. Because total variance was not collected in 2013 and was not reported properly by most plans in 2014, statistical tests for *Plan All-Cause Readmissions* are not possible.

Cells that are shaded and have NA (Not Applicable) represent years for which there is a trend break and comparisons across years cannot be made

SNP Benefit Package Performance (Table 7)

This section focuses on individual SNP benefit package performance ("plan benefit packages" [PBP]) and how performance on each measure is distributed.

Distribution is based on the performance of SNPs with at least 30 enrollees who are eligible for the measure. A minimum sample size is defined as a denominator of 30 or higher; therefore, we only report results for individual SNPs with a denominator of at least 30 for each measure.

Table 7 includes the mean, the standard deviation, the performance distribution (10th–90th percentiles) and the minimum and maximum HEDIS scores for SNPs that met the minimum sample size. The number of SNPs able to report each measure ranged from 347 for *Annual Monitoring for Patients on Persistent Medications—Total Rate,* to 55 for *Persistence of Beta-Blocker Treatment After a Heart Attack.*

Data show a wide distribution of performance within each measure. The average difference between the 10th and 90th percentile is 24.7 percentage points, a decrease of 3.3 percentage points from 2013, indicating that the gap between the highest and lowest performers is slightly narrowing. The standard deviation ranges from 0.22 percentage points (*Plan All-Cause Readmissions—O/E Ratio —≥65* and *O/E Ratio—<65*) to 26.8 percentage points *(Care for Older Adults—Advance Care Planning)*, demonstrating that the spread around the mean score varies substantially, depending on the measure. The smallest gaps (less than 10 percentage points) between the 10th and 90th percentiles were found for the following measures:

- *Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications* (6.6 percentage points).
- *Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring* (7.9 percentage points).
- *Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring* (8.2 percentage points).
- *Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring* (7.9 percentage points).
- *Annual Monitoring for Patients on Persistent Medications—Total Rate* (9.3 percentage points).

Six measures had large percentage point differences (40 points or more) between SNPs scoring in the 10th percentile and those in the 90th percentile:

- *Active Board Certification-Geriatrics* (74.5 percentage points).
- *Care for Older Adults- Advance Care Planning* (73.3 percentage points)
- *Care for Older Adults—Functional Status Assessment* (59.1 percentage points)
- *Osteoporosis Management in Older Women* (57.1 percentage points).
- *Medication Reconciliation Post-Discharge* (52.8 percentage points).
- *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge* (40.8 percentage points).
- *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge* (40.5 percentage points).

Twelve measures showed a large difference (at least 18 percentage points) between the 90th percentile and the mean score, and thus present the greatest areas for overall improvement.

- *Colorectal Cancer Screening.*
- *Use of Spirometry Testing in the Assessment and Diagnosis of COPD.*
- *Osteoporosis Management in Women Who Had a Fracture.*
- *Antidepressant Medication Management—Continuation Phase.*

- *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge.*
- *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge.*
- *Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring.*
- *Medication Reconciliation Post-Discharge.*
- *Care for Older Adults—Advance Care Planning.*
- *Care for Older Adults—Functional Status Assessment.*
- *Active Board Certification—Family Medicine.*
- *Active Board Certification—Geriatrics.*

Table 7. SNP Benefit Package Performance, HEDIS 2014

Measures	Total SNPs	Mean	Std. Dev.	PERCENTILE DISTRIBUTION OF PERFORMANCE						
				Min	P10	P25	P50	P75	P90	Max
Colorectal Cancer Screening	321	62.7	15.1	19.4	45.2	54.1	63.4	73.6	81.8	92.3
Glaucoma Screening in Older Adults	319	74.9	11.1	27.0	61.4	68.2	75.7	83.6	88.0	98.3
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	175	34.9	15.4	1.0	19.6	25.0	33.3	42.7	52.9	85.0
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	175	68.8	10.5	26.5	57.3	63.9	70.5	75.5	79.2	87.9
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	175	82.6	8.8	35.1	71.4	78.6	84.7	88.4	91.5	97.1
Controlling High Blood Pressure	306	60.5	13.5	10.0	43.0	53.5	62.8	68.8	76.3	91.7
Persistence of Beta-Blocker Treatment After a Heart Attack	55	89.4	6.2	72.0	80.7	84.7	90.4	94.1	96.6	100.0
Osteoporosis Management in Women Who Had a Fracture	104	26.7	21.4	0.0	6.2	12.0	21.9	31.7	63.3	93.7
Antidepressant Medication Management—Acute Phase	220	62.1	11.5	29.2	49.0	54.6	60.9	68.6	78.7	97.8
Antidepressant Medication Management—Continuation Phase	220	48.6	13.2	18.1	35.2	40.3	46.2	55.8	68.3	87.9
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	129	49.4	15.5	14.3	31.1	37.5	47.7	62.8	71.6	82.8
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	129	30.1	14.6	6.7	13.3	18.8	26.3	38.5	54.1	70.6
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	338	94.5	3.8	66.2	90.7	93.0	94.9	96.9	98.6	100.0
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	163	96.3	3.1	85.3	91.8	94.4	96.9	98.7	100.0	100.0
Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring	335	94.8	3.8	65.2	90.8	93.3	95.4	97.3	98.7	100.0
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	206	70.3	13.3	38.6	56.0	62.5	68.9	77.3	91.5	100.0
Annual Monitoring for Patients on Persistent Medications—Total Rate	347	93.6	4.2	64.1	88.7	91.4	94.1	96.3	98.0	100.0
Medication Reconciliation Post-Discharge	303	36.9	21.4	0.9	10.2	19.1	34.7	53.5	63.1	96.1
Care for Older Adults—Advance Care Planning	341	54.4	26.8	4.2	17.5	31.9	55.6	78.6	90.8	100.0
Care for Older Adults—Medication Review	342	84.8	13.3	26.8	66.4	79.6	88.2	94.8	98.1	100.0
Care for Older Adults—Functional Status Assessment	342	74.6	22.2	6.6	39.7	58.3	80.9	93.3	98.8	100.0
Care for Older Adults—Pain Screening	342	84.6	14.5	18.7	65.6	77.9	88.3	95.7	99.0	100.0

Measures	Total SNPs	Mean	Std. Dev.	PERCENTILE DISTRIBUTION OF PERFORMANCE						
				Min	P10	P25	P50	P75	P90	Max
Potentially Harmful Drug-Disease Interactions—History of Falls*	210	55.0	10.4	84.6	68.3	61.1	55.3	48.3	41.4	29.2
Potentially Harmful Drug-Disease Interactions—Dementia*	237	58.2	9.6	84.4	71.1	63.8	57.9	52.9	46.7	24.4
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure*	174	15.6	8.0	47.9	26.2	19.8	14.8	9.7	6.3	0.0
Potentially Harmful Drug-Disease Interactions—Total Rate*	277	48.1	9.2	74.9	60.4	53.9	48.3	41.8	35.8	23.5
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*	342	21.4	7.2	50.5	31.7	26.0	20.3	16.2	13.0	6.4
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications*	342	4.0	2.9	20.6	7.8	5.1	3.3	2.0	1.2	0.0
Active Board Certification—Family Medicine	333	68.8	16.7	1.3	49.6	59.1	72.6	80.3	86.8	98.6
Active Board Certification—Internal Medicine	333	74.5	12.7	7.8	64.0	66.2	75.4	82.5	87.4	100.0
Active Board Certification—Geriatrics	300	61.9	25.4	0.0	19.5	46.4	66.7	78.1	93.9	100.0
Active Board Certification—Other Physician Specialists	333	75.0	14.2	21.7	49.6	71.9	79.8	84.5	88.2	96.0
Plan All-Cause Readmissions (O/E Ratio—≥65)*	297	0.78	0.22	1.55	1.06	0.93	0.77	0.65	0.50	0.00
Plan All-Cause Readmissions (O/E Ratio—<65)*	231	0.81	0.22	1.55	1.05	0.94	0.80	0.67	0.55	0.11

*Lower values signify better performance.

SNP Benefit Package Performance Changes, HEDIS 2012 2014 (Table 8; Figure 1)

Table 8 analyzes performance by benefit package, showing the percentage of benefit packages that improved or decreased performance from 2012–2014 and from 2013–2014. As in Table 8, results are shown from SNPs that met the minimum sample size of 30 or more. Comparisons between 2012 and 2014 were based on plans with submissions in all three years; comparisons between 2013 and 2014 were based on plans with submissions in those years.

Of the 28 measures where a comparison can be made, more than 50 percent of SNPs showed improvement on 17 measures from 2013–2014 (Figure 14). Conversely, there were 9 measures where more than 50 percent of SNPs showed decreased performance from 2013–2014.

Table 8. SNP Benefit Package Performance Changes, HEDIS 2012–2014

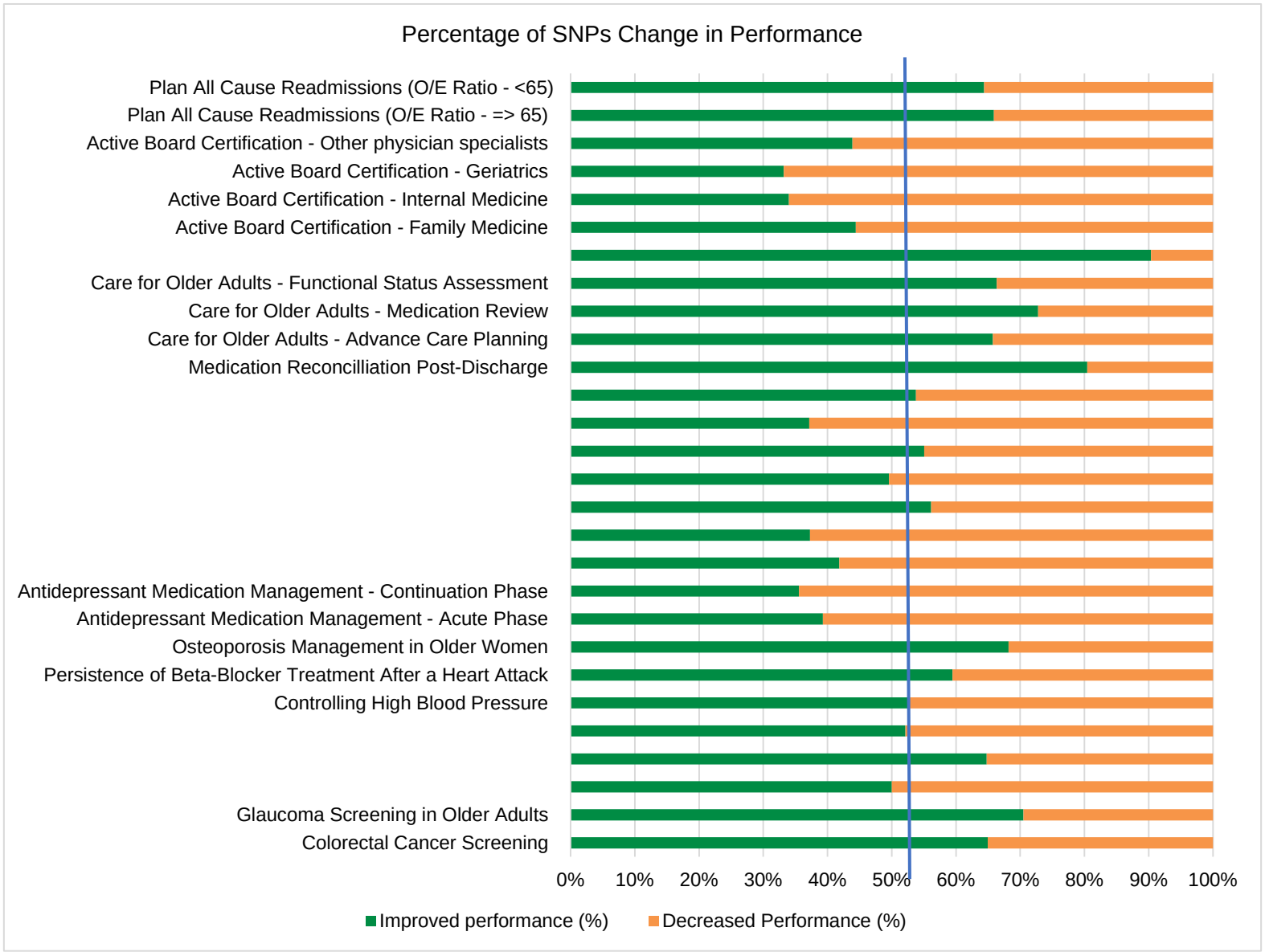
Measures	Percentage of SNPs With Changes in Performance 2012–2014*		Percentage of SNPs With Changes in Performance 2013–2014**	
	Improved Performance	Decreased Performance	Improved Performance	Decreased Performance
Colorectal Cancer Screening	84.5	15.5	64.9	35.1
Glaucoma Screening in Older Adults	82.3	17.7	70.3	29.4
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	47.2	51.9	49.7	49.7
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	70.6	29.4	64.8	35.2
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	59.6	40.4	52.1	47.9
Controlling High Blood Pressure	49.6	50.0	52.2	46.8
Persistence of Beta-Blocker Treatment After a Heart Attack	70.0	30.0	59.5	40.5
Osteoporosis Management in Women Who Had a Fracture	64.1	35.9	68.2	31.8
Antidepressant Medication Management—Acute Phase	--	--	39.3	60.7
Antidepressant Medication Management—Continuation Phase	--	--	35.6	64.4
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	39.4	59.6	41.8	58.2
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	36.2	63.8	37.3	62.7

Measures	Percentage of SNPs With Changes in Performance 2012–2014*		Percentage of SNPs With Changes in Performance 2013–2014**	
	Improved Performance	Decreased Performance	Improved Performance	Decreased Performance
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	63.2	35.3	55.2	43.2
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	56.3	33.9	44.7	45.5
Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring	63.3	35.6	54.0	44.1
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	29.6	69.7	36.5	61.8
Annual Monitoring for Patients on Persistent Medications—Total Rate	58.1	41.6	53.8	46.2
Medication Reconciliation Post-Discharge	65.9	34.1	79.9	19.4
Care for Older Adults—Advance Care Planning	65.7	33.2	65.3	34.1
Care for Older Adults—Medication Review	78.4	20.1	72.3	27.0
Care for Older Adults—Functional Status Assessment	68.4	29.0	64.5	32.7
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*	--	--	90.3	9.7
Active Board Certification—Family Medicine	45.5	54.5	44.4	55.6
Active Board Certification—Internal Medicine	44.5	55.1	33.8	65.6
Active Board Certification—Geriatrics	40.4	51.6	30.0	60.4
Active Board Certification—Other Physician Specialists	51.8	48.2	43.9	56.1
Plan All-Cause Readmissions (O/E Ratio—≥65)	73.8	26.2	65.9	34.1
Plan All-Cause Readmissions (O/E Ratio—<65)	67.7	32.3	64.4	35.6

*Includes only SNPs that reported rates in all three years, 2012–2014.
**Includes only SNPs that reported rates in 2013 and 2014.

Note: The sum of SNPs with Improved Performance and Decreased Performance does not always equal 100% because there are SNPs that had no change in performance.

Figure 1. Visual Representation of SNP PBP Performance Changes (HEDIS 2013–2014)



SNP HEDIS Data Submissions by Measure (Tables 9a and 9b)

Tables 9a and 9b show the number of SNPs reporting each HEDIS measure and categorize reasons for some SNPs being unable to report valid rates for certain measures. A total of 353 SNPs were required to submit HEDIS measure results.

NCQA Certified HEDIS Auditors categorized each measure as follows.

- Did Report Categories (Table 9a):
  - *Denominator ≥30* is designated as a *Reportable Rate* for individual plans.
  - *Denominator <30* receives a *Not Applicable (NA)* audit designation, denoting SNPs with fewer than 30 enrollees in the denominator for the measure. These rates are not considered *individually* reportable.
- Did Not Report Categories (Table 9b):
  - *Materially Biased* is a determination made by NCQA Certified HEDIS Auditors. HEDIS measure rates generally have a 95 percent confidence interval. If auditors determine that a measure's rate is likely to be biased by more than ±5 percentage points because of data errors, the auditors designate the rate as materially biased. There were 68 instances when a SNP did not report a given measure because it was found to be materially biased.
  - *Chose Not to Report* indicates that the SNP chose not to report a specific measure. In only 7 instances, a SNP chose not to report.
  - *Benefit Not Offered* indicates that the SNP did not offer the benefit required for the measure. No SNPs qualified for this category.

Table 9a reports the number of submissions by measure; Table 9 reports the rationale for SNPs not reporting a specific measure.

There were 18 measures for which more than 80 percent of the SNPs had a sufficient population (denominator of at least 30 enrollees) to report. *Annual Monitoring for Patients on Persistent Medications—Total Rate* had the largest number (347, or 98.3 percent) of SNPs with a sufficient population, followed by three *Care for Older Adults* measures and *Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication* (an average of 342 SNPs, or 96.9 percent) were able to report.

SNPs are less able to report measures that address new condition or incident (e.g., hospitalized and discharged with a heart attack during a defined period) or less prevalent conditions, because there are fewer patient encounters or actions to meet the numerator requirement. *Persistence of Beta-Blocker Treatment After a Heart Attack* had the lowest number of SNPs with reportable rates (55, or 15.6 percent). *Osteoporosis Management in Women Who Had a Fracture* had low reportable rates, as well (104, or 29.5 percent).

Table 9. SNP HEDIS 2014 Data Submission—Did Report

Measures	Total Submissions		Denominator ≥30		Denominator <30	
	N	%	N	%	N	%
Colorectal Cancer Screening	353	100.0	321	90.9	32	9.1
Glaucoma Screening in Older Adults	353	100.0	319	90.4	34	9.6
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	353	100.0	175	49.6	178	50.4
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	353	100.0	175	49.6	178	50.4
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	353	100.0	175	49.6	178	50.4
Controlling High Blood Pressure	353	100.0	306	86.7	47	13.3
Persistence of Beta-Blocker Treatment After a Heart Attack	353	100.0	55	15.6	298	84.4
Osteoporosis Management in Women Who Had a Fracture	353	100.0	104	29.5	249	70.5
Antidepressant Medication Management—Acute Phase	353	100.0	220	62.3	133	37.7
Antidepressant Medication Management—Continuation Phase	353	100.0	220	62.3	133	37.7
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	353	100.0	129	36.5	224	63.5
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	353	100.0	129	36.5	224	63.5
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	353	100.0	338	95.8	15	4.2
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	353	100.0	163	46.2	190	53.8
Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring	353	100.0	335	94.9	18	5.1
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	353	100.0	206	58.4	147	41.6
Annual Monitoring for Patients on Persistent Medications—Total Rate	353	100.0	347	98.3	6	1.7
Medication Reconciliation Post-Discharge	353	100.0	303	85.8	50	14.2
Care for Older Adults—Advance Care Planning	352	99.7	341	96.6	11	3.1
Care for Older Adults—Medication Review	353	100.0	342	96.9	11	3.1
Care for Older Adults—Functional Status Assessment	353	100.0	342	96.9	11	3.1
Care for Older Adults—Pain Screening	353	100.0	342	96.9	11	3.1
Potentially Harmful Drug-Disease Interactions—History of Falls	352	99.7	210	59.5	142	40.2
Potentially Harmful Drug-Disease Interactions—Dementia	352	99.7	237	67.1	115	32.6
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure	352	99.7	174	49.3	178	50.4
Potentially Harmful Drug-Disease Interactions—Total Rate	352	99.7	277	78.5	75	21.2

Measures	Total Submissions		Denominator ≥30		Denominator <30	
	N	%	N	%	N	%
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication	353	100.0	342	96.9	11	3.1
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications	353	100.0	342	96.9	11	3.1
Active Board Certification—Family Medicine	337	95.5	333	94.3	4	1.1
Active Board Certification—Internal Medicine	337	95.5	333	94.3	4	1.1
Active Board Certification—Geriatrics	334	94.6	300	85.0	34	9.6
Active Board Certification—Other Physician Specialists	337	95.5	333	94.3	4	1.1
Plan All-Cause Readmissions (O/E Ratio—≥65)	351	99.4	297	84.1	54	15.3
Plan All-Cause Readmissions (O/E Ratio—<65)	350	99.2	231	65.4	119	33.7

Table 9b. SNP HEDIS 2014 Data Submission—Did Not Report

Measure	DID NOT REPORT CATEGORIES									
	Materially Biased		Chose Not to Report		Benefit Not Offered		Out of Scope		Not Required	
	N	%	N	%	N	%	N	%	N	%
Colorectal Cancer Screening	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Glaucoma Screening in Older Adults	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Controlling High Blood Pressure	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Persistence of Beta-Blocker Treatment After a Heart Attack	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Osteoporosis Management in Women Who Had a Fracture	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Antidepressant Medication Management—Acute Phase	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Antidepressant Medication Management—Continuation Phase	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Annual Monitoring for Patients on Persistent Medications—ACE/ARB Monitoring	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Annual Monitoring for Patients on Persistent Medications—Digoxin Monitoring	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Annual Monitoring for Patients on Persistent Medications—Diuretic Monitoring	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Annual Monitoring for Patients on Persistent Medications—Anticonvulsant Monitoring	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Annual Monitoring for Patients on Persistent Medications—Total Rate	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Medication Reconciliation Post-Discharge	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

*Lower values signify better performance.

Measure	DID NOT REPORT CATEGORIES									
	Materially Biased		Chose Not to Report		Benefit Not Offered		Out of Scope		Not Required	
	N	%	N	%	N	%	N	%	N	%
Care for Older Adults—Advance Care Planning	1	0.3	0	0.0	0	0.0	0	0.0	0	0.0
Care for Older Adults—Medication Review	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Care for Older Adults—Functional Status Assessment	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Care for Older Adults—Pain Screening	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Potentially Harmful Drug-Disease Interactions—History of Falls*	1	0.3	0	0.0	0	0.0	0	0.0	0	0.0
Potentially Harmful Drug-Disease Interactions—Dementia*	1	0.3	0	0.0	0	0.0	0	0.0	0	0.0
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications*	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Active Board Certification—Family Medicine	16	4.5	0	0.0	0	0.0	0	0.0	0	0.0
Active Board Certification—Internal Medicine	16	4.5	0	0.0	0	0.0	0	0.0	0	0.0
Active Board Certification—Geriatrics	16	4.5	3	0.8	0	0.0	0	0.0	0	0.0
Active Board Certification—Other Physician Specialists	16	4.5	0	0.0	0	0.0	0	0.0	0	0.0
Plan All-Cause Readmissions (O/E Ratio—≥65)*	0	0.0	2	0.6	0	0.0	0	0.0	0	0.0
Plan All-Cause Readmissions (O/E Ratio—<65)*	1	0.3	2	0.6	0	0.0	0	0.0	0	0.0

*Lower values signify better performance.

Data Limitations

Analysis provides information about how well SNPs performed in key quality areas described in the body of this report. An important limitation is that there are limited results from small plans, which affects analysis. As of February 2014, CMS had contracted with a total of 451 SNPs, 98 of which had fewer than 30 enrollees and were not required to report HEDIS because of their small enrollment.

To provide a complete picture of the SNP environment, analyses systematically distinguished aggregate program performance from benefit package performance. Program-level analysis includes data from all SNP submissions, regardless of size, to generate a complete picture of the SNP program.

HEDIS reporting guidelines also have a size limitation: they require a minimum denominator of 30 for each measure. With a smaller number, the reliability and stability of rates for individual plans are below statistically acceptable levels. Some SNPs did not have 30 enrollees for any individual measure, although they had more than 30 enrollees overall; therefore, NCQA could not include those SNPs in the analysis that compares results of individual SNPs (benefit package performance). NCQA includes results by measure of all SNPs in the overall program performance, regardless of size. The limitation in number of SNPs that could report any measure was comparable to that in 2013.

There are trend breaks for some measures in the report, the result of year-to-year changes in the specifications for reportable measures. Trend breaks also result from the introduction of new measures during the three-year analysis period or from measures that were no longer required, resulting in no trendable data for those measures during the review period.

HEDIS Exclusions for Nonacute Admissions

All HEDIS measures that SNPs are required to report apply to I-SNPs. Exclusions in specific HEDIS measures for enrollees admitted to non-acute inpatient facilities probably have a disproportionate impact on I-SNPs, compared to other types of plans. Two measures have optional exclusions; two have non-optional exclusions for enrollees who are admitted to non-acute inpatient facilities. These exclusions apply to all SNP types and also apply to other MA plans, commercial and Medicaid plans.

- *Controlling High Blood Pressure.* Optional exclusion of enrollees who had admission to a non-acute inpatient setting.
- *Persistence of Beta-Blocker Treatment.* Exclude enrollees who were hospitalized for AMI but transferred directly to non-acute care facilities for any diagnosis.
- *Follow-Up After Hospitalization for Mental Illness.* Exclude enrollees who are discharged to nonacute care facilities after being hospitalized for mental illness.
- *Annual Monitoring for Patients on Persistent Medications.* Optional exclusion of enrollees who had acute or non-acute inpatient stays.

All submissions were reviewed by HEDIS Compliance Auditors, even if the outcome was that there were no enrollees in the measure denominator after the exclusion. Results for I-SNPs indicate that there were enrollees living in the community (I-SNP enrollees must be at risk for institutionalization, but not necessarily institutionalized) or that some SNPs chose not to implement the optional exclusions.

Appendix A: HEDIS Background

About HEDIS

HEDIS is a comprehensive set of standardized performance measures designed to provide purchasers and consumers with the information they need for reliable comparison of the performance of health plans. The HEDIS measurement set is sponsored, supported and maintained by NCQA. Measures relate to many significant public health issues, such as cancer, heart disease, smoking, asthma and diabetes. NCQA Certified HEDIS Compliance Auditors verify all results using a process designed by NCQA. SNPs can use HEDIS performance data to identify opportunities for improvement, monitor the success of quality improvement initiatives, track improvement and provide a set of measurement standards that allow comparison with other plans. Data allow identification of performance gaps and establishment of realistic targets for improvement.

The development of a HEDIS measure involves multiple steps; each potential measure is refined and evaluated at several points in the process. NCQA's Committee on Performance Measurement (CPM) oversees the evolution of the measurement set and includes representation by purchasers, consumers, health plans, health care providers and policy makers. Measurement Advisory Panels (MAP) provide the clinical and technical knowledge required to develop the measures. Additional HEDIS Expert Panels and the Technical Measurement Advisory Panel (TMAP) provide invaluable assistance by identifying methodological issues and giving feedback on new and existing measures.

Measure Selection

With guidance from the Geriatric MAP, NCQA recommended to CMS a subset of HEDIS measures to be reported by SNPs. Starting with measures reported by MA plans at the contract level, the subset was then defined by one of the following qualities:

1. An upper age limit above 75 years of age, because measures with an upper age limit below 75 would exclude many SNP beneficiaries, ***or***
2. Measures focus on overall health management rather than on one disease or condition, and are therefore appropriate for a population with multiple comorbid conditions.

SNPs reported the following measures in HEDIS 2014:

- *Colorectal Cancer Screening.*
- *Glaucoma Screening in Older Adults.*
- *Care for Older Adults.*
- *Use of Spirometry Testing in the Assessment and Diagnosis of COPD.*
- *Pharmacotherapy of COPD Exacerbation.*
- *Controlling High Blood Pressure.*
- *Persistence of Beta-Blocker Treatment After a Heart Attack.*
- *Annual Monitoring for Patients on Persistent Medications.*
- *Medication Reconciliation Post-Discharge.*
- *Potentially Harmful Drug-Disease Interactions in the Elderly.**
- *Use of High-Risk Medications in the Elderly.**
- *Osteoporosis Management in Older Women.*
- *Antidepressant Medication Management.*

- Follow-Up After Hospitalization for Mental Illness.
- Board Certification.
- Plan All-Cause Readmission.*

*Lower rate indicates better performance.

Appendix 2, which is provided under separate cover, contains the technical specifications for these measures.

Note: *HEDIS 2014 results are reported in 2014 and primarily cover services delivered in 2013.*

Data Collection & Validation Process

To submit HEDIS measures, SNPs used NCQA's Web-based Interactive Data Submission System, which has extensive data validation checks. Before the submission process, NCQA collected SNP benefit package profile data to determine reporting eligibility. HEDIS measures were reported by SNPs with an enrollment of ≥30 enrollees as of CMS' February 2014 SNP Comprehensive Report, which has enrollment figures for mid-January 2014.

Before data were submitted to NCQA, every SNP benefit package submission underwent a HEDIS Compliance Audit™. The NCQA HEDIS Compliance Audit is a two-part program that consists of an overall assessment of information systems capabilities (IS standards), followed by an evaluation of a plan's ability to comply with HEDIS specifications (HD standards). NCQA Certified Auditors reviewed systems, policies and procedures, and final data results, ensuring that measures were correctly calculated and reported.

Appendix B: HEDIS® 2014 Technical Specifications

This appendix contains the HEDIS 2014 technical specifications for the HEDIS measures SNPs were required to report.

© 1994-2013 by NCQA, 1100 13th Street, NW, Suite 1000, Washington, D.C. 20005. All rights reserved. Reprinted with the permission of NCQA. Inclusion of NCQA performance measures or specifications in any commercial product requires permission of NCQA and is subject to a license at the discretion of NCQA. NCQA performance measures and specifications are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures. HEDIS® is a registered trademark of NCQA.

Colorectal Cancer Screening (COL)

Summary of Changes to HEDIS 2014

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

Description

The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Eligible Population

Product lines	Commercial, Medicare (report each product line separately).
Ages	51–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator The eligible population.

Numerator One or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test (FOBT Value Set) during the measurement year. For administrative data, assume the required number of samples were returned regardless of FOBT type.
- Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set) during the measurement year or the four years prior to the measurement year.
- Colonoscopy (Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year.

Exclusion *(optional)*

Either of the following any time during the member's history through December 31 of the measurement year:

- Colorectal cancer (Colorectal Cancer Value Set).
- Total colectomy (Total Colectomy Value Set

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerator One or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following:

- FOBT during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.

Medical record Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (iFOBT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance.

- If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
- If the medical record does not indicate the type of test and the number of returned samples is specified, the member meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the member does not meet the screening criteria for inclusion.
- iFOBT tests may require fewer than three samples. If the medical record indicates that an iFOBT was done, the member meets the screening criteria, regardless of how many samples were returned.
- If the medical record indicates that a gFOBT was done, follow the scenarios below.
  - *If the medical record does not indicate the number of returned samples,* assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
  - *If the medical record indicates that three or more samples were returned,* the member meets the screening criteria for inclusion in the numerator.
  - *If the medical record indicates that fewer than three samples were returned,* the member does not meet the screening criteria.

Do not count *digital rectal exam* as evidence of a colorectal screening because it is not specific or comprehensive enough to screen for colorectal cancer.

Exclusion *(optional)*

Refer to *Administrative Specification* for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history through December 31 of the measurement year.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table COL-2/3: Data Elements for Colorectal Cancer Screening

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)	--	✓
Current year's administrative rate (before exclusions)	--	✓
Minimum required sample size (MRSS) or other sample size	--	✓
Oversampling rate	--	✓
Final sample size (FSS)	--	✓
Number of numerator events by administrative data in FSS	--	✓
Administrative rate on FSS	--	✓
Number of original sample records excluded because of valid data errors	--	✓
Number of administrative data records excluded	--	✓
Number of medical records excluded	--	✓
Number of employee/dependent medical records excluded	--	✓
Records added from the oversample list	--	✓
Denominator	--	✓
Numerator events by administrative data	✓	✓
Numerator events by medical records	--	✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

Glaucoma Screening in Older Adults (GSO)

Summary of Changes to HEDIS 2014

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

Description

The percentage of Medicare members 65 years and older who received a glaucoma eye exam by an eye care professional for early identification of glaucomatous conditions.

Eligible Population

Product line	Medicare.
Age	67 years and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerator	One or more eye exams for glaucoma (Glaucoma Screening Value Set) by an eye care professional (i.e., ophthalmologist, optometrist) during the measurement year or the year prior to the measurement year.

Exclusion *(optional)*

Glaucoma (Glaucoma Value Set) any time during the member's history through December 31 of the measurement year.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table GSO-3: Data Elements for Glaucoma Screening in Older Adults

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Care for Older Adults (COA)

Summary of Changes to HEDIS 2014

- Removed coding tables and replaced all coding table references with value set references.
- Revised the definition for the medication list to clarify that the list may include prescription dosages and frequency.*
- Replaced "pain screening" with "pain assessment" throughout the specification.
- Clarified that hearing, vision and speech must be assessed to meet the *Sensory ability* component in the Functional Status Assessment indicator.
- Revised the medical record documentation requirements for the Pain Assessment indicator to indicate that any documentation of a pain assessment (including positive or negative findings) is acceptable.
- Removed "Evidence of a pain management plan" as compliant for the Pain Assessment indicator.

**This is not a new requirement for the Medication review indicator. The definition was revised to provide greater detail. A list that only includes medication names is sufficient for the medication list component of the indicator.*

Description

The percentage of adults 66 years and older who had each of the following during the measurement year:

- Advance care planning.
- Medication review.
- Functional status assessment.
- Pain assessment.

Definitions

Medication list	A list of the member's medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.
Medication review	A review of all a member's medications, including prescription medications, OTC medications and herbal or supplemental therapies.

Eligible Population

Product line	Medicare SNP.
Ages	66 years and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year.

Anchor date December 31 of the measurement year.

Benefit Medical.

Event/diagnosis None.

Administrative Specification

Denominator The eligible population.

Numerators

Advance Care Planning Evidence of advance care planning during the measurement year (Advance Care Planning Value Set).

Medication Review Both of the following on the same date of service during the measurement year:

- At least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist.
- The presence of a medication list in the medical record (Medication List Value Set).

Functional Status Assessment At least one functional status assessment (Functional Status Assessment Value Set) during the measurement year.

Pain Assessment At least one pain screening or pain management plan (Pain Assessment Value Set) during the measurement year.

Hybrid Specification

Denominator A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerators

Advance Care Planning Evidence of advance care planning as documented through either administrative data or medical record review.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record **Advance care planning** is a discussion about preferences for resuscitation, life-sustaining treatment and end of life care. Evidence of advance care planning must include one of the following:

- The presence of an advance care plan in the medical record.
- Documentation of an advance care planning **discussion** with the provider *and* the date when it was discussed. The documentation of discussion must be noted during the measurement year.
- Notation that the member previously executed an advance care plan.

Examples of an advance care plan

- **Advance directive.** Directive about treatment preferences and the designation of a surrogate who can make medical decisions for a patient who is unable to make them (e.g., living will, power of attorney, health care proxy).
- **Actionable medical orders.** Written instructions regarding initiating, continuing, withholding or withdrawing specific forms of life-sustaining treatment.
- **Living will.** Legal document denoting preferences for life-sustaining treatment and end-of-life care.
- **Surrogate decision maker.** A written document designating someone other than the member to make future medical treatment choices.

Examples of an advance care planning discussion

- Notation in the medical record of a discussion with a provider or initiation of a discussion by a provider during the measurement year.
- **Oral statements.** Conversations with relatives or friends about life-sustaining treatment and end-of-life care, documented in the medical record. Patient designation of an individual who can make decisions on behalf of the patient. Evidence of oral statements must be noted in the medical record during the measurement year.

Medication Review

At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record, as documented through either administrative data or medical record review.

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record

Documentation must come from the same medical record and must include the following:

- A medication list in the medical record, ***and*** evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed.
- Notation that the member is not taking any medication and the date when it was noted.

A review of side effects for a single medication at the time of prescription alone is not sufficient.

An outpatient visit is not required to meet criteria.

Functional Status Assessment

At least one functional status assessment during the measurement year, as documented through either administrative data or medical record review.

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record

Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed.

Notations for a complete functional status assessment must include one of the following:

- Notation that Activities of Daily Living (ADL) were assessed (includes bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking).
- Notation that Instrumental Activities of Daily Living (IADL) were assessed (includes shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances).
- Result of assessment using a standardized functional status assessment tool, not limited to:
  - SF-36®.
  - Assessment of Living Skills and Resources (ALSAR).
  - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale.
  - Bayer Activities of Daily Living (B-ADL) Scale.
  - Barthel Index.
  - Extended Activities of Daily Living (EADL) Scale.
  - Independent Living Scale (ILS).
  - Katz Index of Independence in Activities of Daily Living.
  - Kenny Self-Care Evaluation.
  - Klein-Bell Activities of Daily Living Scale.
  - Kohlman Evaluation of Living Skills (KELS).
  - Lawton & Brody's IADL scales.
- Notation that at least three of the following four components were assessed:
  - Cognitive status.
  - Ambulation status.
  - Sensory ability (including hearing, vision and speech).
  - Other functional independence (e.g., exercise, ability to perform job).

A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the measurement year.

Pain Assessment

At least one pain assessment during the measurement year, as documented through either administrative data or medical record review.

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record Documentation in the medical record must include evidence of a pain assessment and the date when it was performed.

Notations for a pain assessment must include one of the following:

- Documentation that the patient was assessed for pain (which may include positive or negative findings for pain).
- Result of assessment using a standardized pain assessment tool, not limited to:
  - Numeric rating scales (verbal or written)
  - Face, Legs, Activity, Cry Consolability (FLACC) scale.
  - Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory).
  - Pain Thermometer.
  - Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale).
  - Visual analogue scale.
  - Brief Pain Inventory.
  - Chronic Pain Grade.
  - PROMIS Pain Intensity Scale.
  - Pain Assessment in Advanced Dementia (PAINAD) Scale.

Note

- *Notation of a pain management plan alone does not meet criteria.*
- *Notation of a pain treatment plan alone does not meet criteria.*
- *Notation of screening for chest pain alone or documentation of chest pain alone does not meet criteria.*
- *Refer to Appendix 3 for the definition of* clinical pharmacist *and* prescribing practitioner*.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table COA-3: Data Elements for Care for Older Adults

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)	--	*Each of the 4 rates*
Current year's administrative rate (before exclusions)	--	*Each of the 4 rates*
Minimum required sample size (MRSS) or other sample size	--	✓
Oversampling rate	--	✓
Final sample size (FSS)	--	✓
Number of numerator events by administrative data in FSS	--	*Each of the 4 rates*
Administrative rate on FSS	--	*Each of the 4 rates*
Number of original sample records excluded because of valid data errors	--	✓
Number of employee/dependent medical records excluded	--	✓
Records added from the oversample list	--	✓
Denominator	--	✓

Numerator events by administrative data	*Each of the 4 rates*	*Each of the 4 rates*
Numerator events by medical records	--	*Each of the 4 rates*
Reported rate	*Each of the 4 rates*	*Each of the 4 rates*
Lower 95% confidence interval	*Each of the 4 rates*	*Each of the 4 rates*
Upper 95% confidence interval	*Each of the 4 rates*	*Each of the 4 rates*

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

Summary of Changes to HEDIS 2014

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

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.

Definitions

Intake Period	A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures the first COPD diagnosis.
IESD	Index Episode Start Date. The earliest date of service for an eligible visit (outpatient, ED or acute inpatient) during the Intake Period with any diagnosis of COPD. *For an outpatient claim/encounter,* the IESD is the date of service. *For an acute inpatient claim/encounter,* the IESD is the date of discharge. *For a transfer or readmission*, the IESD is the discharge date of the original admission.
Negative Diagnosis History	A period of 730 days (2 years) prior to the IESD (inclusive) when the member had no claims/encounters containing any diagnosis of COPD. *For an acute inpatient IESD*, use the date of admission to determine the Negative Diagnosis History.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	42 years or older as of December 31 of the measurement year.
Continuous enrollment	730 days (2 years) prior to the IESD through 180 days (6 months) after the IESD.
Allowable gap	One gap in enrollment of up to 45 days is allowed in each of the 12-month periods prior to the IESD or in the 6-month period after the IESD, for a maximum of two gaps total. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	IESD.
Benefit	Medical.

Event/ diagnosis The first visit with a diagnosis of COPD during the Intake Period. Follow the steps below to identify the eligible population for the measure.

Step 1 Identify all members who had an outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set), an ED visit (ED Value Set) or an acute inpatient encounter (Acute Inpatient Value Set) , during the Intake Period, with any diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set).

If the member had more than one eligible visit, include only the first visit.

Step 2 Test for Negative Diagnosis History. Exclude members who had an outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set), an ED visit (ED Value Set) or an acute inpatient encounter (Acute Inpatient Value Set) during the 730 days (2 years) prior to the IESD, with a diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set).

For an acute inpatient IESD, use the date of admission to determine the Negative Diagnosis History.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled in the organization 730 days (2 years) prior to the IESD through 180 days (6 months) after the IESD.

Administrative Specification

Denominator The eligible population.

Numerator At least one claim/encounter for spirometry (Spirometry Value Set) during the 730 days (2 years) prior to the IESD through 180 days (6 months) after the IESD.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table SPR-1/2/3: Data Elements for Use of Spirometry Testing in the Assessment and Diagnosis of COPD

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Pharmacotherapy Management of COPD Exacerbation (PCE)

Summary of Changes to HEDIS 2014

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

Description

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

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

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

Definitions

Intake Period	An 11-month period that begins on January 1 of the measurement year and ends on November 30 of the measurement year. The Intake Period captures eligible episodes of treatment.
Episode Date	The date of service for any acute inpatient discharge or ED claim/encounter during the Intake Period with a principal diagnosis of COPD. *For an acute inpatient claim/encounter,* the Episode Date is the date of discharge. *For an ED claim/encounter,* the Episode Date is the date of service.
Active prescription	A prescription is considered **active** if the "days supply" indicated on the date the member filled the prescription is the number of days or more between that date and the relevant date. *For an acute inpatient claim/encounter,* the relevant date is the date of admission. *For an ED claim/encounter,* the relevant date is the date of service.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	40 years or older as of January 1 of the measurement year.
Continuous enrollment	Episode Date through 30 days after the Episode Date.
Allowable gap	None.
Anchor date	Episode Date.
Benefits	Medical and pharmacy.

Event/ diagnosis A COPD exacerbation as indicated by an acute inpatient discharge or ED encounter with a principal diagnosis of COPD.

Follow the steps below to identify the eligible population.

Step 1 Identify all members who during the Intake Period had an acute inpatient discharge (Acute Inpatient UB Revenue Value Set) or an ED visit (ED Value Set) with a primary diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set).

Do not include ED visits that result in an inpatient admission.

Note: *The denominator for this measure is based on acute inpatient discharges and ED visits, not on members. Only UB Revenue codes are used to identify acute inpatient discharges because using other codes could result in double-counting.*

Step 2 Identify all COPD Episode Dates. For each member identified in step 1, identify all acute inpatient discharges and ED visits. Do not include ED visits that result in an inpatient admission.

Step 3 Test for transfers. Exclude Episode Dates when the member was transferred directly to an acute or nonacute care facility for any diagnosis.

Step 4 Test for readmission and additional ED visits. Exclude Episode Dates when the member was readmitted to an acute or nonacute care facility for any diagnosis within 14 days after the Episode Date. Exclude Episode Dates when the member had an ED visit for any diagnosis within 14 days after the Episode Date.

Step 5 Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from the Episode Date through 30 days after the Episode Date.

Note: *All Episode Dates that were not excluded should remain in the denominator. The denominator for this measure is based on acute inpatient discharges and ED visits, not members.*

Administrative Specification

Denominator The eligible population.

Numerators

Systemic corticosteroid Dispensed prescription for systemic corticosteroid (Table PCE-C) on or 14 days after the Episode Date. The organization may count systemic corticosteroids that are active on the relevant date.

Table PCE-C: Systemic Corticosteroids

Description	Prescription			
Glucocorticoids	• Betamethasone • Dexamethasone	• Hydrocortisone • Methylprednisolone	• Prednisolone • Prednisone	• Triamcinolone

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Bronchodilator Dispensed prescription for a bronchodilator (Table PCE-D) on or 30 days after the Episode Date. The organization may count bronchodilators that are active on the relevant date.

Table PCE-D: Bronchodilators

Description	Prescription		
Anticholinergic agents	• Albuterol-ipratropium • Aclidinium-bromide	• Ipratropium • Tiotropium	
Beta 2-agonists	• Albuterol • Arformoterol • Budesonide-formoterol • Fluticasone-salmeterol	• Formoterol • Indacaterol • Levalbuterol • Mometasone-formoterol	• Metaproterenol • Pirbuterol • Salmeterol
Methylxanthines	• Aminophylline • Dyphylline-guaifenesin • Guaifenesin-theophylline	• Dyphylline • Theophylline	

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table PCE-1/2/3: Data Elements for Pharmacotherapy Management of COPD Exacerbation

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	*Each of the 2 rates*
Reported rate	*Each of the 2 rates*
Lower 95% confidence interval	*Each of the 2 rates*
Upper 95% confidence interval	*Each of the 2 rates*

Controlling High Blood Pressure (CBP)

Summary of Changes to HEDIS 2014

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

Description

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

Definitions

Adequate control	Both a representative systolic BP <140 mm Hg and a representative diastolic BP <90 mm Hg (BP in the normal or high-normal range).
Representative BP	The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension was made). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, the lowest systolic and lowest diastolic BP reading should be used. If no BP is recorded during the measurement year, assume that the member is "not controlled."

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18–85 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.

Event/ diagnosis

Members are identified as hypertensive if there is at least one outpatient visit (Outpatient CPT Value Set) with a diagnosis of hypertension (Hypertension Value Set) during the first six months of the measurement year.

Note: *In order to increase the specificity of the eligible population, only CPT codes are used to identify outpatient visits.*

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for each product line whose diagnosis of hypertension is confirmed by chart review. The organization may reduce the sample size using the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

To confirm the diagnosis of hypertension, the organization must find notation of one of the following in the medical record on or before June 30 of the measurement year:

- HTN.
- High BP (HBP).
- Elevated BP (↑BP).
- Borderline HTN.
- Intermittent HTN.
- History of HTN.
- Hypertensive vascular disease (HVD).
- Hyperpiesia.
- Hyperpiesis.

The notation of hypertension may appear on or before June 30 of the measurement year, including prior to the measurement year. It does not matter if hypertension was treated or is currently being treated. The notation indicating a diagnosis of hypertension may be recorded in any of the following documents:

- Problem list (this may include a diagnosis prior to June 30 of the measurement year or an undated diagnosis; see ***Note*** at the end of this section).
- Office note.
- Subjective, Objective, Assessment, Plan (SOAP) note.
- Encounter form.
- Diagnostic report.
- Hospital discharge summary.

Statements such as "rule out HTN," "possible HTN," "white-coat HTN," "questionable HTN" and "consistent with HTN" are not sufficient to confirm the diagnosis if such statements are the *only* notations of hypertension in the medical record.

Identifying the medical record

Use one medical record for both the confirmation of the diagnosis of hypertension and the representative BP. All eligible BP measurements recorded in the record must be considered. If an organization cannot find the medical record, the member remains in the measure denominator and is considered noncompliant for the numerator.

Use the following steps to find the appropriate medical record to review.

Current Procedural Terminology © 2013 American Medical Association. All rights reserved.

Step 1 Identify the member's PCP.

If the member had more than one PCP for the time period, identify the PCP who most recently provided care to the member.

If the member did not visit a PCP for the time period or does not have a PCP, identify the practitioner who most recently provided care to the member.

If a practitioner other than the member's PCP manages the hypertension, the organization may use the medical record of that practitioner.

Step 2 Use one medical record to both confirm the diagnosis for the denominator and identify the representative BP level for the numerator. There are circumstances in which the organization may need to go to a second medical record to either confirm the diagnosis or obtain the BP reading, as in the following two examples.

If a member sees one PCP during the denominator confirmation period (on or before June 30 of the measurement year) and another PCP after June 30, the diagnosis of hypertension and the BP reading may be identified through two different medical records.

If a member has the same PCP for the entire measurement year, but it is clear from claims or medical record data that a specialist (e.g., cardiologist) manages the member's hypertension after June 30, the organization may use the PCP's chart to confirm the diagnosis and use the specialist's chart to obtain the BP reading. For example, if all recent claims coded with 401 came from the specialist, the organization may use this chart for the most recent BP reading. If the member did not have any visit with the specialist prior to June 30 of the measurement year, the organization must go to another medical record to confirm the diagnosis.

Numerator The number of members in the denominator whose most recent BP is adequately controlled during the measurement year. For a member's BP to be controlled, *both* the systolic and diastolic BP *must be* <140/90 (adequate control). To determine if a member's BP is adequately controlled, the representative BP must be identified.

Administrative None.

Medical record Follow the steps below to determine representative BP.

Step 1 Identify the most recent BP reading noted during the measurement year. The reading must occur after the date when the diagnosis of hypertension was confirmed. Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy).
- Reported by or taken by the member.

Step 2 Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

The member is not compliant if the BP reading is ≥140/90 or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

Exclusions *(optional)*

- Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.
- Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
- Exclude from the eligible population all members who had a nonacute inpatient encounter (Nonacute Care Value Set) during the measurement year.

Note

- *Organizations may use an undated notation of hypertension on problem lists. Problem lists generally indicate established conditions; to discount undated entries might hinder confirmation of the denominator.*
- *Organizations generally require an oversample of 10 percent–15 percent to meet the MRSS for confirmed cases of hypertension.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CBP-1/2/3: Data Elements for Controlling High Blood Pressure

	Hybrid
Measurement year	✓
Data collection methodology (Hybrid)	✓
Eligible population	✓
Number of numerator events by administrative data in eligible population (before exclusions)	✓
Current year's administrative rate (before exclusions)	✓
Minimum required sample size (MRSS) or other sample size	✓
Oversampling rate	✓
Final sample size (FSS)	✓
Number of numerator events by administrative data in FSS	✓
Administrative rate on FSS	✓
Number of original sample records excluded because of valid data errors	✓
Number of records excluded because of false-positive diagnoses	✓
Number of administrative data records excluded	✓
Number of medical record data records excluded	✓
Number of employee/dependent medical records excluded	✓

Records added from the oversample list	✓
Denominator	✓
Numerator events by administrative data	✓
Numerator events by medical records	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

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

Summary of Changes to HEDIS 2014

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

Description

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

Definition

Treatment days (covered days)	The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval (i.e., a prescription of a 90-day supply dispensed on the 100th day will have 80 days counted in the 180-day interval).

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	Discharge date through 180 days after discharge.
Allowable gap	No more than one gap in enrollment of up to 45 days within the 180 days of the event. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor date	Discharge date.
Benefit	Medical and pharmacy.
Event/diagnosis	Discharged alive from an acute inpatient setting with an AMI (AMI Value Set) from July 1 of the year prior to the measurement year through June 30 of the measurement year. Use only facility claims to identify AMI. Do not use diagnoses from professional claims to identify AMI. If a member has more than one episode of AMI from July 1 of the year prior to the measurement year through June 30 of the measurement year, organizations should only include the first discharge. *Transfers to acute facilities.* Include hospitalizations in which the member was transferred directly to another acute inpatient facility for any diagnosis. Count the discharge from the subsequent acute inpatient facility, not the initial discharge. The discharge date from the facility to which the member was transferred must occur on or before June 30 of the measurement year.

Transfers to nonacute facilities. Exclude from the denominator, hospitalizations in which the member was transferred directly to a nonacute care facility for any diagnosis.

Readmissions. If the member was readmitted to an acute or nonacute care facility for any diagnosis, include the member in the denominator and use the discharge date from the original hospitalization.

Administrative Specification

Denominator The eligible population.

Numerator A 180-day course of treatment with beta-blockers (Table PBH-B).

Identify all members in the denominator population whose dispensed days supply is ≥135 days in the 180 days following discharge. Persistence of treatment for this measure is defined as at least 75 percent of the days supply filled.

To determine continuity of treatment during the 180-day period, identify all prescriptions filled within 180 days of the discharge date, and add the number of allowed gap days to the number of treatment days for a maximum of 180 days (i.e., 135 treatment days + 45 gap days = 180 days).

To account for members who are on beta-blockers prior to admission, the organization should factor those prescriptions into adherence rates if the actual treatment days fall within the 180 days following discharge.

Table PBH-B: Beta-Blocker Medications

Description	Prescription		
Noncardioselective beta-blockers	• Carteolol • Carvedilol • Labetalol	• Nadolol • Penbutolol • Pindolol	• Propranolol • Timolol • Sotalol
Cardioselective beta-blockers	• Acebutolol • Atenolol	• Betaxolol • Bisoprolol	• Metoprolol • Nebivolol
Antihypertensive combinations	• Atenolol-chlorthalidone • Bendroflumethiazide-nadolol • Bisoprolol-hydrochlorothiazide		• Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-propranolol

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Exclusion *(optional)*

Members identified as having an intolerance or allergy to beta-blocker therapy. Any of the following anytime during the member's history through the end of the continuous enrollment period meet criteria:

- Asthma (Asthma Value Set).
- COPD (COPD Value Set).
- Obstructive chronic bronchitis (Obstructive Chronic Bronchitis Value Set).
- Chronic respiratory conditions due to fumes and vapors (Chronic Respiratory Conditions Due to Fumes/Vapors Value Set).
- Hypotension, heart block >1 degree or sinus bradycardia (Beta-Blocker Contraindications Value Set).
- A medication dispensing event indicative of a history of asthma (Table PBH-D).
- Intolerance or allergy to beta-blocker therapy.

Table PBH-D: Medications to Identify Exclusions (History of Asthma)

Description	Prescription		
Bronchodilator combinations	• Albuterol-ipratropium • Budesonide-formoterol	• Fluticasone-salmeterol • Mometasone-formoterol	
Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide	• Flunisolide • Fluticasone • Fluticasone CFC free	• Mometasone • Triamcinolone

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table PBH-1/2/3: Data Elements for Persistence of Beta-Blocker Treatment After a Heart Attack

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Annual Monitoring for Patients on Persistent Medications (MPM)

Summary of Changes to HEDIS 2014

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

Description

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

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

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefits	Medical and pharmacy.
Event/ diagnosis	Members on persistent medications (i.e., members who received at least 180 treatment days of ambulatory medication in the measurement year). Refer to Additional Eligible Population Criteria for each rate. Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 30 treatment days). Sum the days supply for all medications and subtract any days supply that extends beyond December 31 of the measurement year. ***Note:*** *Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.*

Administrative Specification

For each product line, report each of the four rates separately and as a combined rate. The total rate is the sum of the four numerators divided by the sum of the four denominators.

Rate 1: Annual Monitoring for Members on ACE Inhibitors or ARBs

Additional eligible population criteria

Members who received at least 180 treatment days of ACE inhibitors or ARBs, during the measurement year. Refer to Table CDC-L to identify ACE inhibitors and ARBs.

Note: *Members may switch therapy with any medication listed in Table CDC-L during the measurement year and have the days supply for those medications count toward the total 180 treatment days (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition for rate 1).*

Numerator

At least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test (Lab Panel Value Set).
- A serum potassium test (Serum Potassium Value Set) ***and*** a serum creatinine test (Serum Creatinine Value Set).
- A serum potassium test (Serum Potassium Value Set) ***and*** a blood urea nitrogen test (Blood Urea Nitrogen Value Set).

Note: *The tests do not need to occur on the same service date, only within the measurement year.*

Rate 2: Annual Monitoring for Members on Digoxin

Additional eligible population criteria

Members who received at least 180 treatment days of digoxin (Table MPM-B) during the measurement year.

Table MPM-B: Drugs to Identify Members on Digoxin

Description	Prescription
Inotropic agents	Digoxin

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Numerator

At least one serum potassium *and* either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test (Lab Panel Value Set).
- A serum potassium test (Serum Potassium Value Set) ***and*** a serum creatinine test (Serum Creatinine Value Set).
- A serum potassium test (Serum Potassium Value Set) ***and*** a blood urea nitrogen test (Blood Urea Nitrogen Value Set).

Note: *The tests do not need to occur on the same service date, only within the measurement year.*

Rate 3: Annual Monitoring for Members on Diuretics

Additional eligible population criteria

Members who received at least 180 treatment days of a diuretic (Table MPM-C), during the measurement year.

Note: *Members may switch therapy with any medication listed in Table MPM-C during the measurement year and have the days supply for those medications count toward the total 180 treatment days.*

Table MPM-C: Drugs to Identify Members on Diuretics

Description	Prescription		
Antihypertensive combinations	• Aliskiren-hydrochlorothiazide • Aliskiren-hydrochlorothiazide-amlodipine • Amiloride-hydrochlorothiazide • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-hydrochlorothiazide-valsartan • Atenolol-chlorthalidone • Benazepril-hydrochlorothiazide • Bendroflumethiazide-nadolol • Bisoprolol-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Chlorthalidone-clonidine • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide	• Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-methyldopa • Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-propranolol • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-spironolactone • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-triamterene • Hydrochlorothiazide-valsartan	
Loop diuretics	• Bumetanide • Ethacrynic acid	• Furosemide • Torsemide	
Potassium-sparing diuretics	• Amiloride • Eplerenone	• Spironolactone • Triamterene	
Thiazide diuretics	• Chlorothiazide • Chlorthalidone	• Hydrochlorothiazide • Indapamide	• Methyclothiazide • Metolazone

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Numerator

At least one serum potassium *and* either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test (Lab Panel Value Set).
- A serum potassium test (Serum Potassium Value Set) ***and*** a serum creatinine test (Serum Creatinine Value Set).
- A serum potassium test (Serum Potassium Value Set) ***and*** a blood urea nitrogen test (Blood Urea Nitrogen Value Set).

Note: *The tests do not need to occur on the same service date, only within the measurement year.*

Rate 4: Annual Monitoring for Members on Anticonvulsants

Additional eligible population criteria

Members who received at least 180 treatment days for an anticonvulsant (Table MPM-D) during the measurement year.

Note: *Members who are on multiple anticonvulsant drugs count toward the denominator multiple times if they meet the persistent medications criteria for each drug taken during the measurement year (i.e., a member who received at least 180 days of phenytoin and 180 days of valproic acid is counted twice in the denominator for Rate 4, once for each drug).*

Table MPM-D: Drugs to Identify Members on Anticonvulsants

Description	Drugs
Barbiturate anticonvulsants	• Phenobarbital
Dibenzazepine anticonvulsants	• Carbamazepine
Hydantoin anticonvulsants	• Phenytoin
Miscellaneous anticonvulsants	• Divalproex sodium • Valproic acid

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Numerator

At least one drug serum concentration level monitoring test for the prescribed drug during the measurement year as identified by the following value sets:

- Members prescribed phenobarbital must have at least one drug serum concentration for phenobarbital (Phenobarbital Level Value Set).
- Members prescribed carbamazepine must have at least one drug serum concentration for carbamazepine (Carbamazepine Level Value Set).
- Members prescribed phenytoin must have at least one drug serum concentration for phenytoin (Phenytoin Level Value Set).
- Members prescribed valproic acid or divalproex sodium must have at least one drug serum concentration for valproic acid (Valproic Acid Level Value Set).

If a member received only one type of anticonvulsant, the drug serum concentration level test must be for the specific drug taken as a persistent medication (i.e., a member on phenytoin received a drug serum test for phenytoin).

If a member persistently received multiple types of anticonvulsants, each anticonvulsant medication and drug monitoring test combination is counted as a unique event (i.e., a member on both phenytoin and valproic acid with at least 180 treatment days for each drug in the measurement year must separately show evidence of receiving drug serum concentration tests for each drug to be considered numerator-compliant for each drug).

Exclusion *(optional)*

Exclude members from each eligible population rate who had an inpatient (acute or nonacute) claim/ encounter during the measurement year.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table MPM-1/2/3: Data Elements for Annual Monitoring for Patients on Persistent Medications

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	*For each of the 4 rates and total*
Numerator events by administrative data	*For each of the 4 rates and total*
Reported rate	*For each of the 4 rates and total*
Lower 95% confidence interval	*For each of the 4 rates and total*
Upper 95% confidence interval	*For each of the 4 rates and total*

Medication Reconciliation Post-Discharge (MRP)

Summary of Changes to HEDIS 2014

- Removed coding tables and replaced all coding table references with value set references.
- Clarified that members who remain in an acute or nonacute facility through December 1 of the measurement year are not included in the measure.

Description

The percentage of discharges from January 1–December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.

Definition

Medication reconciliation	A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.

Eligible Population

Product line	Medicare SNP.
Ages	66 years and older as of December 31 of the measurement year.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	None.
Anchor date	Date of discharge.
Benefit	Medical.
Event/ diagnosis	An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.
Readmission or direct transfer	If the discharge is followed by a readmission or direct transfer to an acute or nonacute facility within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. ***Note:*** *If a member remains in an acute or nonacute facility through December 1 of the measurement year, a discharge is not included in the measure for this member. However, the organization must have a method for identifying the member's status for the remainder of the measurement year, and may not assume the member remained in the facility based only on the absence of a discharge before December 1.*

Administrative Specification

Denominator The eligible population.

Numerator Medication reconciliation (Medication Reconciliation Value Set) conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge.

Hybrid Specification

Denominator A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

The denominator is based on episodes, not on members. Members may appear more than once in the sample.

Numerator Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse, as documented through either administrative data or medical record review on or within 30 days of discharge.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record Documentation in the medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following evidence meets criteria:

- Notation that the medications prescribed or ordered upon discharge were reconciled with the current medications (in the outpatient record) by the appropriate practitioner type.
- A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications conducted by an appropriate practitioner type (the organization must be able to distinguish between the member's discharge medications and the member's current medications).
- Notation that no medications were prescribed or ordered upon discharge.

Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.

Note

- *The denominator is based on the discharge date found in administrative/claims data, but organizations may use other systems (including data found during medical record review) to identify data errors and make corrections.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table MRP-3: Data Elements for Medication Reconciliation Post-Discharge

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)	--	✓
Current year's administrative rate (before exclusions)	--	✓
Minimum required sample size (MRSS) or other sample size	--	✓
Oversampling rate	--	✓
Final sample size (FSS)	--	✓
Number of numerator events by administrative data in FSS	--	✓
Administrative rate on FSS	--	✓
Number of original sample records excluded because of valid data errors	--	✓
Number of employee/dependent medical records excluded	--	✓
Records added from the oversample list	--	✓
Denominator	--	✓
Numerator events by administrative data	✓	✓
Numerator events by medical records	--	✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)

Summary of Changes to HEDIS 2014

- Removed coding tables and replaced all coding table references with value set references.
- Revised drugs in all rates to align with AGS criteria (revised and renamed medication tables).
- Added bipolar disorder and seizure disorder to the Rate 1 required exclusions.
- Deleted dementia from the Rate 1 required exclusions.
- Added required exclusions to Rate 2.
- Replaced references of "chronic renal failure" to "chronic kidney disease" to account for chronic kidney disease stage 4 codes added to the additional eligible population criteria in Rate 3.

Description

The percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis.

Report each of the three rates separately and as a total rate.

- A history of falls and a prescription for anticonvulsants, nonbenzodiazepine hypnotics, SSRIs, antiemetics, antipsychotics, benzodiazepines or tricyclic antidepressants.
- Dementia and a prescription for antiemetics, antipsychotics, benzodiazepines, tricyclic antidepressants, H_2 Receptor Antagonists, nonbenzodiazepine hypnotics or anticholinergic agents.
- Chronic kidney disease and prescription for Cox-2 Selective NSAIDs or nonaspirin NSAIDs.
- Total rate (the sum of the three numerators divided by the sum of the three denominators).

Members with more than one disease or condition may appear in the measure multiple times (i.e., in each indicator for which they qualify). A lower rate represents better performance for all three rates.

Definitions

IESD Index Episode Start Date. The earliest diagnosis, procedure or prescription between January 1 of the year prior to the measurement year and December 1 of the measurement year.

For an outpatient claim/encounter, the IESD is the date of service.

For an inpatient claim/encounter, the IESD is the discharge date.

For dispensed prescriptions, the IESD is the dispense date.

Eligible Population

Product line	Medicare.
Age	67 years and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	Enrolled as of December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/ diagnosis	Members with at least one disease, condition or procedure in the measurement year or the year prior to the measurement year. Refer to *Additional Eligible Population Criteria* for each rate.

Administrative Specification

Report each rate separately and as a combined rate. The total rate is the sum of the three numerators divided by the sum of the three denominators.

Rate 1: Drug Disease Interactions—History of Falls and Anticonvulsants, Nonbenzodiazepine Hypnotics, SSRIs, Antiemetics, Antipsychotics, Benzodiazepines or Tricyclic Antidepressants

Additional eligible population criteria

An accidental fall or hip fracture* on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.

*Hip fractures are used as a proxy for identifying accidental falls.

Follow the steps below to identify the eligible population.

Step 1

Identify members who had an accidental fall or a hip fracture. Members with either of the following on or between January 1 of the year prior to the measurement year and December 1 of the measurement year meet criteria:

- An accidental fall (Falls Value Set).
- An outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set), an ED visit (ED Value Set), a nonacute inpatient encounter (Nonacute Inpatient Value Set) or an acute inpatient encounter (Acute Inpatient Value Set) with a hip fracture (Hip Fractures Value Set).

Step 2: Required Exclusions

Exclude members with a diagnosis of psychosis (Psychosis Value Set), schizophrenia (Schizophrenia Value Set), bipolar disorder (Bipolar Disorder Value Set) or seizure disorder (Seizure Disorders Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.

Numerator

Dispensed an ambulatory prescription for an anticonvulsant, nonbenzodiazepine hypnotic, SSRI (Table DDE-A) or antiemetic, antipsychotic, benzodiazepine or tricyclic antidepressant (Table DDE-B) on or between the IESD and December 31 of the measurement year.

Table DDE-A: Potentially Harmful Drugs—Rate 1

Description	Prescription			
Anticonvulsants	• Carbamazepine • Clobazam • Divalproex sodium • Ethosuximide • Ethotoin • Ezogabine • Felbamate	• Fosphenytoin • Gabapentin • Lacosamide • Lamotrigine • Levetiracetam • Mephobarbital • Methsuximide	• Oxcarbazepine • Phenobarbital • Phenytoin • Pregabalin • Primidone • Rufinamide • Tiagabine HCL	• Topiramate • Valproate sodium • Valproic acid • Vigabatrin • Zonisamide
Nonbenzodiazepine hypnotics	• Eszopiclone	• Zaleplon	• Zolpidem	
SSRIs	• Citalopram • Escitalopram	• Fluoxetine • Fluvoxamine	• Paroxetine • Sertraline	

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Table DDE-B: Potentially Harmful Drugs—Rate 1 and Rate 2

Description	Prescription			
Antiemetics	• Prochlorperazine	• Promethazine		
Antipsychotics	• Aripiprazole • Asenapine • Chlorpromazine • Clozapine • Fluphenazine • Haloperidol	• Iloperidone • Loxapine • Lurasidone • Molindone • Olanzapine • Paliperidone	• Perphenazine • Pimozide • Quetiapine • Risperidone • Thioridazine • Thiothixene	• Trifluoperazine • Ziprasidone • Promazine • Trifluprom azine
Benzodiazepines	• Alprazolam • Chlordiazepoxide products • Clonazepam • Clorazepate-Dipotassium	• Diazepam • Estazolam • Flurazepam HCL • Lorazepam • Midazolam HCL	• Oxazepam • Quazepam • Temazepam • Triazolam	
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin products • Imipramine	• Nortriptyline • Protriptyline • Trimipramine	

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Rate 2: Drug Disease Interactions—Dementia and Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H_2 Receptor Antagonists, Nonbenzodiazepine Hypnotics or Anticholinergic Agents

Additional eligible population criteria

Follow the steps below to identify the eligible population.

Step 1 Identify members with a diagnosis of dementia (Dementia Value Set) or a dispensed dementia medication (Table DDE-C) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Identify the IESD for each member.

Table DDE-C: Prescriptions to Identify Members With Dementia

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Step 2: Required exclusions Exclude members with a diagnosis of psychosis (Psychosis Value Set), schizophrenia (Schizophrenia Value Set) or bipolar disorder (Bipolar Disorder Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.

Numerator Dispensed an ambulatory prescription for an antiemetic, antipsychotic, benzodiazepine or tricyclic antidepressant (Table DDE-B) or H2 receptor antagonist, nonbenzodiazepine hypnotic or anticholinergic agent (Table DDE-D) on or between the IESD and December 31 of the measurement year.

Table DDE-D: Potentially Harmful Drugs—Rate 2

Description	Prescription
H_2 receptor antagonists	• Cimetidine • Famotidine • Nizatidine • Ranitidine
Nonbenzodiazepine hypnotics	• Zolpidem
Anticholinergic agents, antihistamines	• Carbinoxamine • Chlorpheniramine • Hydroxyzine products • Loratadine • Brompheniramine • Clemastine • Cyproheptadine • Dimenhydrinate • Diphenhydramine • Meclizine
Anticholinergic agents, antispasmodics	• Atropine products • Homatropine • Belladonna alkaloids • Dicyclomine • Hyoscyamine products • Propantheline • Scopolamine
Anticholinergic agents, antimuscarinics (oral)	• Darifenacin • Fesoterodine • Solifenacin • Trospium • Flavoxate • Oxybutynin • Tolterodine
Anticholinergic agents, anti-Parkinson agents	• Benztropine • Trihexyphenidyl
Anticholinergic agents, skeletal muscle relaxants	• Tizanidine • Carisoprodol • Cyclobenzaprine • Orphenadrine

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Rate 3: Drug Disease Interactions—Chronic Kidney Disease and Cox 2 Selective NSAIDs or Nonaspirin NSAIDs

Additional eligible population criteria	Chronic kidney disease as identified by a diagnosis of ESRD (ESRD Value Set), stage 4 chronic kidney disease (CKD Stage 4 Value Set) or kidney transplant (Kidney Transplant Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Identify the IESD for each member.
Numerator	Dispensed an ambulatory prescription for an NSAID or Cox-2 selective NSAID (Table DDE-E) on or between the IESD and December 31 of the measurement year.

Table DDE-E: Cox-2 Selective NSAIDs and Nonaspirin NSAIDs

Description	Prescription			
Cox-2 Selective NSAIDs	• Celecoxib			
Nonaspirin NSAIDs	• Diclofenac potassium • Diclofenac sodium • Etodolac • Fenoprofen • Flurbiprofen	• Ibuprofen • Indomethacin • Ketoprofen • Ketorolac • Meclofenamate	• Mefenamic acid • Meloxicam • Nabumetone • Naproxen • Naproxen sodium	• Oxaprozin • Piroxicam • Sulindac • Tolmetin

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table DDE-3: Data Elements for Potentially Harmful Drug-Disease Interactions in the Elderly

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	*For each of the 3 rates and total*
Numerator events by administrative data	*For each of the 3 rates and total*
Reported rate	*For each of the 3 rates and total*
Lower 95% confidence interval	*For each of the 3 rates and total*
Upper 95% confidence interval	*For each of the 3 rates and total*

Use of High-Risk Medications in the Elderly (DAE)

Summary of Changes to HEDIS 2014

- Clarified calculation of average daily dose for elixirs and concentrates in *Calculating average daily dose*.
- Revised criteria for numerator 2 for both medications with days supply criteria and medications with average daily dose criteria.
- Clarified that organizations may not round when calculating the average daily dose.

Description

- The percentage of Medicare members 66 years of age and older who received at least one high-risk medication.
- The percentage of Medicare members 66 years of age and older who received at least two different high-risk medications.

For both rates, a lower rate represents better performance.

Definitions

Calculating days supply

Calculate the days supply during the measurement year for medication classes in Table DAE-B. The intent is to sum the days supply for all medications (listed in the Prescription column) within a medication class (listed in the Description column). For example, a 30-days supply prescription for Zolpidem and a 30-days supply prescription for Zaleplon is equal to 60-days supply of a high-risk medication class.

Sum the days supply and subtract any days supply that extends beyond December 31 of the measurement year. For example, a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 30 days supply.

For Numerator 2, if the total days supply for all medications in a medication class is greater than 90 days, count as one high-risk medication. Assess each medication class separately.

Note: *Medications dispensed in the year prior to the measurement year with a days supply that extends into the measurement year count toward the total days supply.*

Calculating average daily dose

Calculate the average daily dose for medications in Table DAE-C. Multiply the quantity of pills dispensed by the dose of each pill and divide by days supply. For example, a prescription for digoxin containing 15 pills, .250 mg each pill, 30 days supply has an average daily dose of 0.125 mg.

To calculate daily dose for elixirs and concentrates, multiply the volume dispensed by dose and divide by days supply.

For Numerator 2, if a member has two prescriptions for the same medication that meet the average daily dose criteria, count as one high-risk medication. If a member has two prescriptions for different medications that meet the average daily dose criteria, count as two high-risk medications.

Do not round when calculating average daily dose.

Eligible Population

Product line	Medicare.
Age	66 years and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	Enrolled as of December 31 of the measurement year.
Benefits	Medical and pharmacy.
Event/ diagnosis	None.

Administrative Specification

Denominator

The eligible population.

Numerator 1

Members who received at least one high-risk medication during the measurement year.

Numerator 2

Members who received at least two different high-risk medications during the measurement year.

For both numerators, a high-risk medication is defined as any of the following:

- A dispensed prescription for a medication in Table DAE-A.
- Dispensed prescriptions that meet days supply criteria within a medication class in Table DAE-B.
- A dispensed prescription that meets average daily dose criteria in Table DAE-C.

Note: *For medications in Table DAE-A and DAE-C, identify different drugs using the Drug ID field located in the NDC list on NCQA's Web site (www.ncqa.org).*

Table DAE-A: High-Risk Medications

Description	Prescription	
Anticholinergics (excludes TCAs), First-generation antihistamines	• Brompheniramine • Carbinoxamine • Chlorpheniramine • Clemastine • Cyproheptadine • Dexbrompheniramine	• Dexchlorpheniramine • Diphenhydramine (oral) • Doxylamine • Hydroxyzine • Promethazine • Triprolidine
Anticholinergics (excludes TCAs), anti-Parkinson agents	• Benztropine (oral)	• Trihexyphenidyl
Antithrombotics	• Dipyridamole, oral short-acting (does not apply to the extended-release combination with aspirin)	• Ticlopidine
Cardiovascular, alpha agonists, central	• Guanabenz • Guanfacine	• Methyldopa
Cardiovascular, other	• Disopyramide	• Nifedipine, immediate release
Central nervous system, tertiary TCAs	• Amitriptyline • Clomipramine	• Imipramine • Trimipramine
Central nervous system, barbiturates	• Amobarbital • Butabarbital • Butalbital • Mephobarbital	• Pentobarbital • Phenobarbital • Secobarbital
Central nervous system, vasodilators	• Ergot mesylates	• Isoxsuprine
Central nervous system, other	• Thioridazine • Chloral Hydrate	• Meprobamate
Endocrine system, estrogens with or without progestins; include only oral and topical patch products	• Conjugated estrogen • Esterified estrogen	• Estradiol • Estropipate
Endocrine system, sulfonylureas, long-duration	• Chlorpropamide	• Glyburide
Endocrine system, other	• Desiccated thyroid	• Megestrol
Gastrointestinal system, other	• Trimethobenzamide	
Pain medications, skeletal muscle relaxants	• Carisoprodol • Chlorzoxazone • Cyclobenzaprine	• Metaxalone • Methocarbamol • Orphenadrine
Pain medications, other	• Indomethacin • Ketorolac, includes parenteral	• Meperidine • Pentazocine

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013. Combination drugs will be added to Table DAE-A with the release of the NDC list.*

Table DAE-B: High-Risk Medications With Days Supply Criteria

Description	Prescription		Days Supply Criteria
Anti-Infectives, other	• Nitrofurantoin • Nitrofurantoin macrocrystals	• Nitrofurantoin macrocrystals-monohydrate	>90 days
Nonbenzodiazepine hypnotics	• Eszopiclone • Zaleplon	• Zolpidem	>90 days

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Table DAE-C: High-Risk Medications With Average Daily Dose Criteria

Description	Prescription	Average Daily Dose Criteria
Alpha agonists, central	• Reserpine	>0.1 mg/day
Cardiovascular, other	• Digoxin	>0.125 mg/day
Tertiary TCAs (as single agent or as part of combination products)	• Doxepin	>6 mg/day

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table DAE-3: Data Elements for Use of High-Risk Medications in the Elderly

	Administrative
Measurement year	✓
Data collection method (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	*For each of the 2 rates*
Reported rate	*For each of the 2 rates*
Lower 95% confidence interval	*For each of the 2 rates*
Upper 95% confidence interval	*For each of the 2 rates*

Osteoporosis Management in Women Who Had a Fracture (OMW)

Summary of Changes to HEDIS 2014

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

Description

The percentage of women 67 years of age and older who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

Definitions

Intake Period — A 12-month (1 year) window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period is used to capture the first fracture.

IESD — Index Episode Start Date. The earliest date of service for any encounter during the Intake Period with a diagnosis of fracture.

For an outpatient or ED visit, the IESD is date of service.

For an inpatient encounter, the IESD is the date of discharge.

For direct transfers, the IESD is the discharge date from the second admission.

Negative Diagnosis History — A period of 60 days (2 months) prior to the IESD when the member had no diagnosis of fracture.

For fractures requiring an inpatient stay, use the date of admission to determine Negative Diagnosis History.

For direct transfers, use the first admission to determine the Negative Diagnosis History.

Eligible Population

Product line — Medicare.

Age — Women 67 years and older as of December 31 of the measurement year.

Continuous enrollment — 12 months (1 year) before the IESD through 180 days (6 months) after the IESD.

Allowable gap — No more than one gap in enrollment of up to 45 days during the continuous enrollment period.

Anchor date — IESD.

Benefits — Medical and pharmacy.

Event/ diagnosis — The earliest fracture during the Intake Period.

Follow the steps below to identify the eligible population.

Step 1 Identify all members who had an outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set), an ED visit (ED Value Set), a nonacute inpatient encounter (Nonacute Inpatient Value Set) or an acute inpatient encounter (Acute Inpatient Value Set) for a fracture (Fractures Value Set) during the Intake Period. If the member had more than one fracture, include only the first fracture.

Step 2 Test for Negative Diagnosis History. Exclude members with an outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set), an ED visit (ED Value Set), a nonacute inpatient encounter (Nonacute Inpatient Value Set) or an acute inpatient encounter (Acute Inpatient Value Set) for a fracture (Fractures Value Set) during the 60 days (2 months) prior to the IESD.

For fractures requiring an inpatient stay, use the admission date to determine Negative Diagnosis History.

For direct transfers, use the first admission to determine the Negative Diagnosis History.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled during the 12 months prior to the fracture through 180 days (6 months) post-fracture.

Step 4 Exclude members who had a BMD test (Bone Mineral Density Tests Value Set) or a claim/encounter for osteoporosis therapy (Osteoporosis Medications Value Set) or received a dispensed prescription to treat osteoporosis (Table OMW-C) during the 365 days (12 months) prior to the IESD.

For an inpatient encounter, use the admission date to determine the 365 days (12 months) prior to the IESD.

Administrative Specification

Denominator The eligible population.

Numerator Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria:

- A BMD test (Bone Mineral Density Tests Value Set) on the IESD or in the 180-day (6-month) period after the IESD.
- A BMD test (Bone Mineral Density Tests Value Set) during the inpatient stay for the fracture (applies only to fractures requiring hospitalization).
- Osteoporosis therapy (Osteoporosis Medications Value Set) on the IESD or in the 180-day (6-month) period after the IESD.
- A dispensed prescription to treat osteoporosis (Table OMW-C) on the IESD or in the 180-day (6-month) period after the IESD.

Table OMW-C: FDA-Approved Osteoporosis Therapies

Description	Prescription		
Biphosphonates	• Alendronate • Alendronate-cholecalciferol • Calcium carbonate-risedronate	• Ibandronate • Risedronate • Zoledronic acid	
Estrogens	• Conjugated estrogens • Conjugated estrogens synthetic • Esterified estrogens	• Estradiol • Estradiol acetate • Estradiol cypionate	• Estradiol valerate • Estropipate
Other agents	• Calcitonin • Denosumab	• Raloxifene • Teriparatide	
Sex hormone combinations	• Conjugated estrogens—medroxy-progesterone • Estradiol-levonorgestrel	• Estradiol-norethindrone • Estradiol-norgestimate • Ethinyl estradiol-norethindrone	

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Note

- *Fractures of finger, toe, face and skull are not included in this measure.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table OMW-3: Data Elements for Osteoporosis Management in Women Who Had a Fracture

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Antidepressant Medication Management (AMM)

Summary of Changes to HEDIS 2014

- Removed coding tables and replaced all coding table references with value set references.
- Deleted the IESD.
- Revised the Negative Medication History time frame.
- Revised the IPSD definition.
- Revised the continuous enrollment criteria.
- Revised the anchor date.
- Revised the event/diagnosis steps.

Description

The percentage of members 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.

- *Effective Acute Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
- *Effective Continuation Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Definitions

Intake Period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication during the Intake Period.
Negative Medication History	A period of 105 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	The actual number of calendar days covered with prescriptions within the specified 180-day (6-month) measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 80 days counted in the 231-day interval.

Eligible Population

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

Ages 18 years and older as of April 30 of the measurement year.

Continuous enrollment 105 days prior to the IPSD through 231 days after the IPSD.

Allowable gap One gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date IPSD.

Benefits Medical and pharmacy.

Event/ diagnosis Follow the steps below to identify the eligible population, which should be used for both rates.

Step 1 Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period.

Step 2: Required exclusion Exclude members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient or partial hospitalization setting during the 60 days prior to the IPSD (inclusive) through 60 days after the IPSD (inclusive). Members who meet any of the following criteria remain in the eligible population:

- An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria:
  - AMM Stand Alone Visits Value Set ***with*** Major Depression Value Set.
  - AMM Visits Value Set ***with*** AMM POS Value Set ***and*** Major Depression Value Set.
- An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set).
- An inpatient (acute or nonacute) encounter with any diagnosis of major depression (Major Depression Value Set).

For an inpatient (acute or nonacute) encounter, use the date of discharge.

For a direct transfer, use the discharge date from the facility where the member was transferred.

Step 3 Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD.

Step 4 Calculate continuous enrollment. Members must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

Administrative Specification

Denominator The eligible population.

Numerators

Effective Acute Phase Treatment At least 84 days (12 weeks) of continuous treatment with antidepressant medication (Table AMM-C) during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

Table AMM-C: Antidepressant Medications

Description	Prescription		
Miscellaneous antidepressants	• Bupropion	• Vilazodone	
Monoamine oxidase inhibitors	• Isocarboxazid • Phenelzine	• Selegiline • Tranylcypromine	
Phenylpiperazine antidepressants	• Nefazodone	• Trazodone	
Psychotherapeutic combinations	• Amitriptyline-chlordiazepoxide • Amitriptyline-perphenazine		• Fluoxetine-olanzapine
SSNRI antidepressants	• Desvenlafaxine • Duloxetine	• Venlafaxine	
SSRI antidepressants	• Citalopram • Escitalopram	• Fluoxetine • Fluvoxamine	• Paroxetine • Sertraline
Tetracyclic antidepressants	• Maprotiline	• Mirtazapine	
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin • Imipramine	• Nortriptyline • Protriptyline • Trimipramine

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2013.*

Effective Continuation Phase Treatment At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C) during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, there may be no more than 51 gap days. Count any combination of gaps (e.g., two washout gaps of 25 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

Note

- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period specified (e.g., during the Intake Period).*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table AMM-1/2/3: Data Elements for Antidepressant Medication Management

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	*Each of the 2 rates*
Reported rate	*Each of the 2 rates*
Lower 95% confidence interval	*Each of the 2 rates*
Upper 95% confidence interval	*Each of the 2 rates*

Follow-Up After Hospitalization for Mental Illness (FUH)

Summary of Changes to HEDIS 2014

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

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the member received follow-up within 30 days of discharge.
- The percentage of discharges for which the member received follow-up within 7 days of discharge.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	6 years and older as of the date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefits	Medical and mental health (inpatient and outpatient).
Event/ diagnosis	Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year. Use only facility claims to identify discharges. Do not use diagnoses from professional claims to identify discharges. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.
Mental health readmission or direct transfer	If the discharge is followed by readmission or direct transfer to an *acute facility* for a principal diagnosis of mental health (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a *nonacute facility* (Nonacute Care Value Set) for a principal diagnosis of mental health (Mental Health Diagnosis Value Set) within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place.

Non-mental health readmission or direct transfer Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a principal diagnosis of non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Administrative Specification

Denominator The eligible population.

Numerators

30-Day Follow-Up An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.

7-Day Follow-Up An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit:

- A visit (FUH Stand Alone Visits Value Set) with a mental health practitioner.
- A visit (FUH Visits Group 1 Value Set ***and*** FUH POS Group 1 Value Set) with a mental health practitioner.
- A visit (FUH Visits Group 2 Value Set ***and*** FUH POS Group 2 Value Set) with a mental health practitioner.
- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a mental health practitioner.
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set).

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).*
- *Refer to Appendix 3 for the definition of* mental health practitioner.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUH-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	*Each of the 2 rates*
Reported rate	*Each of the 2 rates*
Lower 95% confidence interval	*Each of the 2 rates*
Upper 95% confidence interval	*Each of the 2 rates*

Board Certification (BCR)

Summary of Changes to HEDIS 2014

- No changes to this measure.

Description

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

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

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

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

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

***Organizations must* include:**

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

***Organizations must* exclude:**

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

- Physicians who practice exclusively within free-standing facilities and who provide care for members only as a result of members being directed to the facility; for example:
  - Mammography centers.
  - Urgent care centers.
  - Surgicenters.
- Dentists who do not provide care under the organization's medical benefits; for example:
  - Endodontists.
  - Oral surgeons.
  - Periodontists.
- Dentists who provide primary dental care under a dental plan or rider.

Categories Use Table BCR-A to identify physicians.

Table BCR-A: Identifying Physicians

Product Line	Family Medicine	Internal Medicine	Pediatricians	OB/GYN	Geriatricians	Other Physician Specialists
Commercial	✓	✓	✓	✓	✓	✓
Medicaid	✓	✓	✓	✓	✓	✓
Medicare	✓	✓	✓	✓	✓	✓

Definitions

Family medicine physician A physician who provides preventive and diagnostic health care services for individuals and families. Report general practitioners in the *Family Medicine* category.

Internal medicine physician A physician who provides long-term and comprehensive care and manages common and complex illness of adolescents, adults and the elderly.

Pediatrician A physician who provides preventive and diagnostic health care services for infants, children and adolescents.

OB/GYN physician A physician who provides medical and surgical care relating to the female reproductive system and associated disorders.

Geriatrician A family medicine or internal medicine physician who has special knowledge of the aging process and special skills in the diagnostic, therapeutic, preventive and rehabilitative aspects of illness in the elderly.

Other physician specialist Any other physician specialist or physician subspecialist not mentioned above.

Calculation of Board Certification

Number of physicians in each practice area

Refer to Table BCR-1/2/3. For each product line, identify the number of physicians (with active or inactive board certification) in each practice area, by type and number, with whom the organization contracted as of December 31 of the measurement year.

Physicians are assumed to practice in the clinical area or areas in which they are listed in an organization's *internal* directory or classification system. Physicians listed under more than one category should be counted as many times as they are listed and should be included in each area of practice. For example, a family medicine physician who also practices as a geriatrician should be reported in both the *Family Medicine* category and in the *Geriatrician* category.

Physicians do not have to be listed in the organization's external provider directory to be included in the measure.

Board certification number

Report the number of physicians in each practice area with active board certification. For example, to be counted as a board-certified geriatrician, a physician must have a specialty certification in geriatric medicine.

A physician with recent board certification who has not completed a residency/fellowship may be counted as board certified.

Confirmation by the appropriate certifying body that a physician is eligible for and has applied to a board-certification program may not be counted as board certification.

Board certification percentage

For each type of physician, calculate the percentage whose board certification is active by dividing the board certification number by the number of physicians in each practice area.

First, determine the number of areas of specialization and board certification status for each physician; then determine how to count them in the denominator (i.e., number of physicians in each practice area) and the numerator (i.e., number of active board-certified physicians) of the calculation.

A physician with only one specialty who is not board certified in the specialty counts as 1 in the denominator and 0 in the numerator.

A physician with only one specialty whose board certification is active in the specialty counts as 1 in the denominator and 1 in the numerator.

A physician with more than one specialty counts as 1 in the denominator for each specialty. Count in the numerator the number of specialty areas in which the physician has active board certification.

Example

A physician listed under both hematology and medical oncology counts as 2 in the denominator for *Other Physician Specialists*.

A physician whose board certification is active in both hematology and medical oncology counts as 2 in the numerator.

A physician whose board certification is active in only one of these two areas counts as 1 in the numerator.

A physician whose board certification is not active in either area counts as 0 in the numerator.

Note

- *The physician definitions for this measure are based on the American Board of Medical Specialties (ABMS) definitions for physician specialties.*
- *The numbers in the column* Number of Physicians in Each Practice Area *might not be the same as the organization's actual number of physicians because some physicians might practice in more than one area and will be counted in the denominators of several percentages.*
- *Reporting in the Pediatrician category is expected to be rare for the Medicare product line.*

Table BCR-1/2/3: Board Certification

Type of Physician	Number of Physicians in Each Practice Area	Active Board Certification	
		Number	Percentage
Family medicine	--	--	--
Internal medicine	--	--	--
Pediatrician	--	--	--
OB/GYN	--	--	--
Geriatrician	--	--	--
Other physician specialist	--	--	--

Plan All-Cause Readmissions (PCR)

Summary of Changes to HEDIS 2014

- Removed coding tables and replaced all coding table references with value set references.
- Clarified that the average adjusted probability and variance calculations should be rounded to four decimal places, using the .5 rule.

Description

For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator).
2. Count of 30-Day Readmissions (numerator).
3. Average Adjusted Probability of Readmission.

Note: *For commercial, only members 18–64 years of age are reported.*

Definitions

IHS	Index hospital stay. An acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Exclude stays that meet the exclusion criteria in the denominator section.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Classification Period	365 days prior to and including an Index Discharge Date.

Risk Adjustment Tables

Table	Table Description
HCC-Surg	Surgery codes for Risk Adjustment Determination
PCR-DischCC	Discharge Clinical Condition category codes for Risk Adjustment Determination
CC-Comorbid	Comorbid Clinical Condition category codes for Risk Adjustment Determination step 2
HCC –Rank	HCC rankings for Risk Adjustment Determination step 3
HCC-Comb	Combination HCCs for Risk Adjustment Determination step 5
PCR-MA-DischCC-Weight-Under65	MA and SNP primary discharge weights for Risk Adjustment Weighting step 2 for ages under 65
PCR-MA-DischCC-Weight-65plus	MA and SNP primary discharge weights for Risk Adjustment Weighting step 2 for ages 65 and older
PCR-Comm-DischCC-Weight	Commercial primary discharge weights for Risk Adjustment Weighting step 2
PCR-MA-ComorbHCC-Weight-Under65	MA and SNP comorbidity weights for Risk Adjustment Weighting step 3 for ages under 65
PCR-MA-ComorbHCC-Weight-65plus	MA and SNP comorbidity weights for Risk Adjustment Weighting step 3 for ages 65 and older
PCR-Comm-ComorbHCC-Weight	Commercial comorbidity weights for Risk Adjustment Weighting step 3
PCR-MA-OtherWeights-Under65	MA and SNP base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5 for ages under 65
PCR-MA-OtherWeights-65plus	MA and SNP base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5 for ages 65 and older
PCR-Comm-OtherWeights	Commercial base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5

Note: *The risk adjustment tables will be released on November 1, 2013, and posted to www.ncqa.org.*

Eligible Population

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

Ages For commercial, ages 18-64 as of the Index Discharge Date.

For Medicare, ages 18 and older as of the Index Discharge Date.

Continuous enrollment 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.

Allowable gap No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge date.

Anchor date Index Discharge Date.

Benefit Medical.

Event/ diagnosis An acute inpatient discharge on or between January 1 and December 1 of the measurement year.

The denominator for this measure is based on discharges, not members. Include all acute inpatient discharges for members who had one or more discharges on or between January 1 and December 1 of the measurement year.

The organization should follow the steps below to identify acute inpatient stays.

Administrative Specification

Denominator The eligible population.

Step 1 Identify all acute inpatient stays with a discharge date on or between January 1 and December 1 of the measurement year.

Include acute admissions to behavioral healthcare facilities. Exclude nonacute inpatient rehabilitation services, including nonacute inpatient stays at rehabilitation facilities.

Step 2 ***Acute-to–acute transfers:*** Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date.

Step 3 Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4 Exclude any acute inpatient stay with a discharge date in the 30 days prior to the Index Admission Date.

Step 5 Exclude stays for the following reasons:

- Inpatient stays with discharges for death.
- Acute inpatient discharge with a principal diagnosis of pregnancy (Pregnancy Value Set).
- Acute inpatient discharge with a principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set).

Step 6 Calculate continuous enrollment.

Step 7 Assign each acute inpatient stay to one age and gender category. Refer to Table PCR-A-2/3 and Table PCR-B-3.

Risk Adjustment Determination

For each IHS, use the following steps to identify risk adjustment categories based on presence of surgeries, discharge condition, comorbidity, age and gender.

Surgeries Determine if the member underwent surgery during the inpatient stay. Download the list of codes from the NCQA Web site (Table HCC-Surg) and use it to identify surgeries. Consider an IHS to include a surgery if at least one procedure code in Table HCC-Surg is present from any provider between the admission and discharge dates.

Discharge Condition Assign a discharge Clinical Condition (CC) category code to the IHS based on its primary discharge diagnosis, using Table PCR-DischCC. For acute-to-acute transfers, use the transfer's primary discharge diagnosis.

Exclude diagnoses that cannot be mapped to Table PCR-DischCC.

Comorbidities

Step 1 Identify all diagnoses for encounters during the classification period. Include the following when identifying encounters:

- Outpatient visits (Outpatient Value Set).
- Observation visits (Observation Value Set).
- Nonacute inpatient encounters (Nonacute Inpatient Value Set).

- Acute inpatient encounters (Acute Inpatient Value Set).
- ED visits (ED Value Set).

Exclude the primary discharge diagnosis on the IHS.

Step 2 Assign each diagnosis to one comorbid Clinical Condition (CC) category using Table CC—Comorbid.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For members with no qualifying diagnoses from face-to-face encounters, skip to the Risk Adjustment Weighting section.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

Step 3 Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.

For each stay's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group.
- The rank.
- The HCC.

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1.

Note: *One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.*

Step 4 Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the *Rank* column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

Example *Assume a stay with the following comorbid CCs*: CC-15, CC-19 and CC-80 (assume no other CCs).

- CC-80 does not have a map to the ranking table and becomes HCC-80.
- HCC-15 is part of Ranking Group 1 and HCC-19 is part of Ranking Groups Diabetes 1–Diabetes 4. Because CC-15 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-15 for Ranking Group 1. Because CC-19 is ranked higher in Ranking Groups Diabetes 2–4, the comorbidity is assigned as HCC-19 for these ranking groups.
- The final comorbidities for this discharge are HCC-15, HCC-19 and HCC-80.

Example: **Table HCC—Rank**

Ranking Group	CC	Description	Rank	HCC
NA	CC-80	Congestive Heart Failure	NA	HCC-80
Diabetes 1	CC-15	Diabetes With Renal or Peripheral Circulatory Manifestation	1	HCC-15
	CC-16	Diabetes With Neurologic or Other Specified Manifestation	2	HCC-16
	CC-17	Diabetes With Acute Complications	3	HCC-17
	CC-18	Diabetes With Ophthalmologic or Unspecified Manifestation	4	HCC-18
	CC-19	Diabetes Without Complications	5	HCC-19
Diabetes 2	CC-16	Diabetes With Neurologic or Other Specified Manifestation	1	HCC-16
	CC-17	Diabetes With Acute Complications	2	HCC-17
	CC-18	Diabetes With Ophthalmologic or Unspecified Manifestation	3	HCC-18
	CC-19	Diabetes Without Complication	4	HCC-19
Diabetes 3	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Ophthalmologic or Unspecified Manifestation	2	HCC-18
	CC-19	Diabetes Without Complication	3	HCC-19
Diabetes 4	CC-18	Diabetes With Ophthalmologic or Unspecified Manifestation	1	HCC-18
	CC-19	Diabetes Without Complication	2	HCC-19

Step 5 Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together. For example, when diabetes *and* CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each stay's list of unique HCCs to those in the *HCC* column in Table HCC—Comb and assign any additional HCC conditions.

For fully nested combinations (e.g., the diabetes/CHF combination is nested in the diabetes/ CHF/renal combination), use only the more comprehensive pattern. In this example, only the diabetes/CHF/renal combination is counted.

For overlapping combinations (e.g., the CHF, COPD combination overlaps the CHR/renal/ diabetes combination), use both sets of combinations. In this example, both CHF/COPD and CHF/renal/diabetes combinations are counted.

Based on the combinations, a member can have none, one or more of these added HCCs.

Example For a stay with comorbidities HCC-15, HCC-19 and HCC-80 (assume no other HCCs), assign HCC-901 in addition to HCC-15, HCC-19 and HCC-80. This *does not* replace HCC-15, HCC-19 or HCC-80.

Example: Table HCC—Comb

Combination: Diabetes and CHF			
Comorbid HCC	**Comorbid HCC**	**Comorbid HCC**	**Combination HCC**
HCC-15	HCC-80	NA	HCC-901
HCC-16	HCC-80	NA	HCC-901
HCC-17	HCC-80	NA	HCC-901
HCC-18	HCC-80	NA	HCC-901
HCC-19	HCC-80	NA	HCC-901

Risk Adjustment Weighting

For each IHS, use the following steps to identify risk adjustment weights based on presence of surgeries, discharge condition, comorbidity, age and gender.

Note: *The final weights table will be released on November 1, 2013.*

Step 1 For each IHS with a surgery, link the surgery weight.

- *For Medicare product lines ages 18–64:* Use Table PCR-MA-OtherWeights-Under65.
- *For Medicare product lines ages 65 and older:* Use Table PCR-MA-OtherWeights-65plus.
- *For commercial product lines:* Use Table PCR-Comm-OtherWeights.

Step 2 For each IHS with a discharge CC Category, link the primary discharge weights.

- *For Medicare product lines ages 18-64:* Use Table PCR-MA-DischCC-Weight-Under65.
- *For Medicare product lines ages 65 and older:* Use Table PCR-MA-DischCC-Weight-65plus.
- *For commercial product lines:* Use Table PCR-Comm-DischCC-Weight.

Step 3 For each IHS with a comorbidity HCC Category, link the weights.

- *For Medicare product lines ages 18–64:* Use Table PCR-MA-ComorbHCC-Weight-Under65.
- *For Medicare product lines ages 65 and older:* Use Table PCR-MA-ComorbHCC-Weight-65plus.
- *For commercial product lines:* Use Table PCR-Comm-ComorbHCC-Weight.

Step 4 Link the age and gender weights for each IHS.

- *For Medicare product lines ages 18–64:* Use Table PCR-MA-OtherWeights-Under65.
- *For Medicare product lines ages 65 and older:* Use Table PCR-MA-OtherWeights-65plus.
- *For commercial product lines:* Use Table PCR-Comm-OtherWeights.

Step 5 Identify the base risk weight.

- *For Medicare product lines ages 18–64:* Use Table PCR-MA-OtherWeights-Under65.
- *For Medicare product lines ages 65 and older:* Use Table PCR-MA-OtherWeights-65plus.
- *For commercial product lines:* Use Table PCR-Comm-OtherWeights to determine the base risk weight.

Step 6 Sum all weights associated with the IHS (i.e., presence of surgery, primary discharge diagnosis, comorbidities, age, gender and base risk weight).

Step 7 Use the formula below to calculate the adjusted probability of a readmission based on the sum of the weights for each IHS.

Adjusted probability of readmission = $\frac{e^{(\sum WeightsForIHS)}}{1+e^{(\sum WeightsForIHS)}}$

OR

Adjusted probability of readmission = [exp (sum of weights for IHS)] / [1 + exp (sum of weights for IHS)]

Note: *"Exp" refers to the exponential or antilog function.*

Step 8 Use the formula below and the adjusted probability of readmission calculated in step 7 to calculate the variance for each IHS.

Variance = Adjusted probability of readmission x (1 – Adjusted probability of readmission)

Example: If the adjusted probability of readmission is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881476.

Note: *The variance is calculated at the IHS level. Organizations must sum the variances for each age/gender and total category when populating the Total Variance cells in the reporting tables.*

Sample Table: PCR—Risk Adjustment Weighting

Member ID*	Admiss. Counter	Base Risk Weight	Age	Gender	Age and Gender Weight	Surgical Weight	ICD 9 Diagnosis Code	Discharge CC		HCC PCR		Sum of Weights	Adjusted Probability	Variance
								Category	Weight	Category	Weight			
1250	1	-1.08883	67	Female	0.1000	-0.2800	250.4	15	0.0700	20 25	0.1400 0.2000	-0.8600	0.2976	0.2090
4010	1	-1.08883	50.00	Male	0.1200	NA	007.4	5	0.0300	NA	NA	-0.9400	0.2811	0.2021
4010	2	-1.08883	50.00	Male	0.1200	NA	298.00	77	0.0600	5 47	0.0100 0.3300	-0.5700	0.3615	0.2308

*Each Member ID field with a value represents a unique IHS.

Numerator At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1 Identify all acute inpatient stays with an admission date on or between January 2 and December 31 of the measurement year.

Step 2 ***Acute-to-acute transfers:*** Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date.

Step 3 Exclude acute inpatient hospital discharges with a principal diagnosis of pregnancy (Pregnancy Value Set) or for a condition originating in the perinatal period (Perinatal Conditions Value Set).

Step 4 For each IHS, determine if any of the acute inpatient stays have an admission date within 30 days after the Index Discharge Date.

Reporting: Denominator

Count the number of IHS for each age, gender and total combination and enter these values into the reporting table.

Reporting: Risk Adjustment

Step 1 Calculate the average adjusted probability for each IHS for each age, gender and total combinations and the overall total.

Organizations must calculate the probability of readmission for each hospital stay within the applicable age and gender group to calculate the average (which is reported to NCQA). For the total age/gender category, the probability of readmission for all hospital stays in the age/gender categories must be averaged together; organizations cannot take the average of the average adjusted probabilities reported for each age/gender.

Step 2 Round to four decimal places using the .5 rule and enter these values into the reporting table.

Note: *Do not take the average of the cells in the reporting table.*

Example For the "18–44" age category:

- Identify all IHS by 18–44 year-old males and calculate the average adjusted probability.
- Identify all IHS by 18–44 year-old females and calculate the average adjusted probability.
- Identify all IHS by all 18–44 year-olds and calculate the average adjusted probability.

Repeat for each subsequent group.

Step 3 Calculate the total (sum) variance for each age, gender and total combinations and the overall total.

Step 4 Round to four decimal places using the .5 rule and enter these values into the reporting table.

Reporting: Numerator

Count the number of IHS with a readmission within 30 days for each age, gender and total combination and enter these values into the reporting table.

Note

- *Organizations may not use Risk Assessment Protocols to supplement diagnoses for calculation of the risk adjustment scores for this measure. The PCR measurement model was developed and tested using only claims-based diagnoses and diagnoses from additional data sources would affect the validity of the models as they are current implemented in the specification.*

Table PCR-A-2/3: Plan All-Cause Readmissions Rates by Age, Gender and Risk Adjustment

Age	Sex	Count of Index Stays (Denominator)	Count of 30 Day Readmissions (Numerator)	Observed Readmissions (Num/Den)	Average Adjusted Probability	Total Variance	O/E Ratio (Observed Readmissions/Average Adjusted Probability)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
18-44	Male						--	--	--
	Female						--	--	--
	Total:						--	--	--
45-54	Male						--	--	--
	Female						--	--	--
	Total:						--	--	--
55-64	Male						--	--	--
	Female						--	--	--
	Total:						--	--	--
Total	Male						--	--	--
	Female						--	--	--
	Total:								

Table PCR-B-3: Plan All-Cause Readmissions Rates by Age, Gender and Risk Adjustment

Age	Sex	Count of Index Stays (Denominator)	Count of 30 Day Readmissions (Numerator)	Observed Readmissions (Num/Den)	Average Adjusted Probability	Total Variance	O/E Ratio (Observed Readmissions/Average Adjusted Probability)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
65-74	Male						--	--	--
	Female						--	--	--
	Total:						--	--	--
75-84	Male						--	--	--
	Female						--	--	--
	Total:						--	--	--
85+	Male						--	--	--
	Female						--	--	--
	Total:						--	--	--
Total	Male						--	--	--
	Female						--	--	--
	Total:								