



# **Medicare Special Needs Plans Performance Results: HEDIS 2018**

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## 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<sup>®1</sup>) measures. (See Appendix A for information about HEDIS.)

For HEDIS 2018, 694 SNPs participated in the program; 505 were required to report HEDIS 2018 results by the Centers for Medicare & Medicaid Services (CMS). NCQA also received submissions from two SNPs that were not required to report for a total of 507 HEDIS submissions. Results for this review period cover 28 HEDIS measures: 22 clinical performance measures, 4 board certification measures and 2 utilization measures<sup>2</sup>. 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 primarily provided in 2017 and reported in HEDIS 2018. This report compares HEDIS 2018 results with results reported in 2016 and 2017. It also compares performance among different SNP types and compares SNP performance to the performance of the Medicare Advantage (MA) program as a whole.

### Trending

**HEDIS Trending Determination Summary (Table ES.1).** Due to measure specification changes that impacted SNP required measures for HEDIS 2018, we have included trending determinations by measures in this year's report. NCQA makes trending determinations based on specification changes that may cause a fluctuation in results when comparing over years.

In Table-ES.1, *Trend Break* is used to indicate when trending to prior year's measure result is broken and should not be performed. Within the HEDIS Results tables of this report, shaded cells that contain "NA" (Not Applicable) represent a trend break.

In this report we also include *Trend Caution*, to indicate when trending to the prior year's measure is allowed with caution, since specification changes may cause fluctuations in results. For example, additional fracture codes were added to the Hip Fractures Value Set for *Potentially Harmful Drug-Disease Interactions in the Elderly*. Within the HEDIS Results tables of this report, "#" denotes that trending should be performed with caution for the years of comparison.

Of 28 measures collected from SNPs, 20 could be trended through all 3 years; however, 6 of these measures are trend with caution. Eight measures have trend breaks. Between HEDIS 2017 and HEDIS 2018, 25 measures could be trended with 8 of these measures being trend with caution. In the HEDIS 2017 to HEDIS 2018 period, there are three measures with trend breaks.

The measure *Annual Monitoring for Patients on Persistent Medications*, which was previous reporting by SNPs, was not collected for HEDIS 2018. NCQA removed this measure from Medicare reporting because plan performance was extremely high and the distribution in performance among plans was narrow.

<sup>1</sup>HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

<sup>2</sup> For the purposes of this report, the term "measure" is used to mean any rate reported by a SNP plan. A HEDIS measure may have multiple indicators or rates, e.g. Antidepressant Medication Management has two rates, Acute Phase and Continuation Phase.

**Table-ES.1: Measures with Trend Breaks**

<b>Measures</b>	<b>HEDIS 2016 – HEDIS 2017</b>	<b>HEDIS 2017 – HEDIS 2018</b>	<b>HEDIS 2016 – HEDIS 2018</b>
Colorectal Cancer Screening	Trend Break	Trend Caution	Trend Break
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	Trend Caution	Trend Caution	Trend Caution
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	Trend Caution	Trend Caution	Trend Caution
Osteoporosis Management in Women Who Had a Fracture	—	Trend Break	Trend Break
Antidepressant Medication Management—Acute Phase	—	Trend Caution	Trend Caution
Antidepressant Medication Management—Continuation Phase	—	Trend Caution	Trend Caution
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	—	Trend Break	Trend Break
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	—	Trend Break	Trend Break
Potentially Harmful Drug-Disease Interactions—History of Falls*	Trend Caution	Trend Caution	Trend Caution
Potentially Harmful Drug-Disease Interactions—Dementia*	Trend Break	—	Trend Break
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure*	Trend Caution	Trend Caution	Trend Caution
Potentially Harmful Drug-Disease Interactions—Total Rate*	Trend Break	Trend Caution	Trend Break
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*	Trend Break	—	Trend Break
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications*	Trend Break	—	Trend Break

Trend Break: Do not allow trending by breaking the link to the prior year’s measure results. Shaded cells that contain “NA” (Not Applicable) represent a trend break where year-to-year comparison is not possible.

Trend Caution: Allow trending with caution; specification changes may cause a fluctuation in results compared with the prior year. “#” Denotes that trending should be performed with caution for the years of comparison.

\*A lower rate is better.

## Findings

**All SNPs reporting in any of the three years (Table 3a).** Program-wide results for all SNPs were positive looking at the three-year trend but are mixed when looking at the two-year trend. Small improvements (even below 1 percentage point) can be statistically significant, given the large number of observations collected.

- **HEDIS 2016: 2018 (Three-Year Trend)**
  - Statistically significant improvements: 14 out of 20 measures.
  - Statistically significant declines: 0 out of 20 measures.
- **HEDIS 2017: 2018 (Two-Year Trend)**
  - Statistically significant improvements: 6 out of 25 measures.
  - Statistically significant declines: 2 out of 25 measures.

**Highest and Lowest Rates (Table 3a).** The measures with the highest and lowest HEDIS 2018 rates from SNPs that reported in any of the three years were:

### Highest Five

1. *Care for Older Adults—Pain Screening* (94.0%).
2. *Care for Older Adults—Medication Review* (93.3%).
3. *Persistence of Beta-Blocker Treatment After a Heart Attack* (89.6%).
4. *Care for Older Adults—Functional Status Assessment* (88.3%).
5. *Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications\**<sup>3</sup>(12.6%). (Lower values signify better performance; this is equivalent to 87.4%.)

### Lowest Five

1. *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge* (29.6%).
2. *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* (33.9%).
3. *Potentially Harmful Drug-Disease Interactions—Dementia\** (56.5%). (Lower values signify better performance; this is equivalent to 43.5%.).
4. *Potentially Harmful Drug-Disease Interactions—History of Falls<sup>#4</sup>* (55.7%). (Lower values signify better performance; this is equivalent to 44.3%.).
5. *Medication Reconciliation Post-Discharge* (45.3%).

Three of the five measures with the highest performance are *Care for Older Adults* measures, which only SNPs collect.

<sup>3</sup> \* - Throughout the report an asterisk denotes measures where a lower rate is better performance.

<sup>4</sup> # - Throughout the report a hashmark “#” denotes measures where trending should be performed with caution for the years of comparison.

**Largest Significant Changes (Table 3a).** The measures listed below show the largest statically significant changes, positive or negative, from HEDIS 2016–2018.

Largest Five Increase Among All Reporters

1. *Medication Reconciliation Post-Discharge* (22.8 percentage points).
2. *Board Certification—Family Medicine* (5.4 percentage points).
3. *Care for Older Adults—Functional Status Assessment* (5.2 percentage points).
4. *Care for Older Adults—Advance Care Planning* (4.7 percentage points).
5. *Care for Older Adults—Geriatrics* (4.2 percentage points).

Largest Five Decrease Among All Reporters

Not applicable—No measures showed a statistically significant decrease.

Three of the five measures with the largest increase are *Care for Older Adults* measures, which only SNPs collect.

**SNPs reporting HEDIS 2016–2018 (Table 3b).** Table 3a includes all reported HEDIS results; Table 3b includes HEDIS results only from SNPs that reported in HEDIS 2016, 2017 and 2018. Results for SNPs that reported in all three years were about the same as plans that reported in any of the three years. Small improvements (even below 1 percentage point) can be statistically significant, given the large number of observations collected.

• **HEDIS 2016: 2018 (Three-Year Trend)**

- Statistically significant improvements: 10 out of 20 measures.
- Statistically significant declines: 5 out of 20 measures.

• **HEDIS 2017: 2018 (Two-Year Trend)**

- Statistically significant improvements: 14 out of 25 measures.
- Statistically significant declines: 5 out of 25 measures.

**Highest and Lowest Rates (Table 3b).** The measures with the highest and lowest HEDIS 2018 rates from SNPs that reported in all three years were:

Highest Five

1. *Care For Older Adults—Pain Screening* (93.6%).
2. *Care For Older Adults—Medication Review* (92.9%).
3. *Persistence of Beta-Blocker Treatment After a Heart Attack* (90.2%)
4. *Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications* (12.0%). (Lower values signify better performance; this is equivalent to 88.0%.)
5. *Care For Older Adults—Functional Status Assessment* (87.5%).

Lowest Five

1. *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge* (30.9%).
2. *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* (34.4%).
3. *Potentially Harmful Drug-Disease Interactions—Dementia* (55.1%). (Lower values signify better performance; this is equivalent to 44.9%.)
4. *Potentially Harmful Drug-Disease Interactions—History of Falls<sup>\*\*</sup>* (54.7%). (Lower values signify better performance; this is equivalent to 45.3%.)
5. *Medication Reconciliation Post-Discharge* (49.0%).

**(Table 3b).** The measures listed below show the largest statistically significant changes, positive or negative, from HEDIS 2016–2018, among three-year reporters.

Largest Five Improvements Among Three-Year Reporters

1. *Medication Reconciliation Post-Discharge* (24.2 percentage points)
2. *Care for Older Adults—Functional Status Assessment* (4.2 percentage points).
3. *Care for Older Adults—Medication Review* (3.5 percentage points).
4. *Care for Older Adults—Advance Care Planning* (3.3 percentage points).
5. *Antidepressant Medication Management—Acute Phase<sup>#</sup>* (3.0 percentage points).

Largest Five Declines Among Three-Year Reporters

1. *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* (1.5 percentage points).
2. *Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event<sup>#</sup>* (1.2 percentage points).
3. *Board Certification—Other Physician Specialists* (0.8 percentage points).
4. *Potentially Harmful Drug-Disease Interactions—History of Falls<sup>\*\*</sup>* (0.4 percentage points).
5. *Board Certification—Internal Medicine* (0.4 percentage points).

**SNP and MA program performance (Table 4).** This table shows 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 includes the 24 measures that are commonly reported at the SNP benefit-package level and at the MA contract level.

The MA program performance was higher than the SNP program performance on 22 of 24 HEDIS 2018 measures, with statistically significant differences for 18 measures. The greatest difference in performance was 16.5 percentage points.

The SNP program performance was higher than the MA program on 2 of 24 HEDIS 2018 measures, with statistically significant differences for 1 measure. The greatest statistically significant difference in performance was 2.7 percentage points.

The HEDIS 2018 measures with the largest performance gaps between the MA and SNP programs included:

- *Medication Reconciliation Post-Discharge* (16.5 percentage points).
- *Controlling High Blood Pressure* (14.4 percentage points).
- *Potentially Harmful Drug-Disease Interactions—Dementia<sup>\*</sup>* and *History of Falls<sup>\*</sup>* (9.3 and 8.0 percentage points, respectively).

In HEDIS 2018 measures where the SNPs outperformed MA plans, the largest performance gaps included:

- *Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event* (2.7 percentage points).
- *Osteoporosis Management in Women Who Had a Fracture* (2.0 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 overall 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.

**Program performance by SNP type (Table 5).** Overall for HEDIS 2018, I-SNPs had higher performance than the other SNP types on 17 measures. D-SNPs had higher rates on 7 measures than the other SNP types and C-SNPs had higher rates on only 4 measures than other SNP types.

Table 5 also compares HEDIS 2018 results to HEDIS 2017 results. The findings of these comparisons are below.

Performance improved across all SNP types on 5 measures:

- *Antidepressant Medication Management—Acute Phase<sup>#</sup> and Continuation Phase<sup>#</sup>.*
- *Board Certification—Family Medicine, Internal Medicine and Other Physician Specialists.*

Performance declined across all SNP types for 2 measures:

- *Potentially Harmful Drug-Disease Interactions—History of Falls<sup>#</sup>.*
- *Plan All Cause Readmissions—Risk-Adjusted Average  $\geq 65^*$*

D-SNPs showed statistically significant performance improvement on six measures and showed statistically significant decreases in performance on two measures.

D-SNP Significant Improvements

- *Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event and Dispensed Bronchodilator Within 30 Days of Event<sup>#</sup>.*
- *Antidepressant Medication Management—Acute Phase<sup>#</sup>.*
- *Board Certification—Family Medicine, Internal Medicine and Geriatrics.*

D-SNP Significant Declines

- *Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication<sup>\*</sup> and At Least Two Different High-Risk Medications<sup>\*</sup>.*

I-SNPs showed statistically significant improvement on one measure and showed statistically significant decreases in performance on one measure.

I-SNP Significant Improvements

- *Colorectal Cancer Screening<sup>#</sup>.*

I-SNP Significant Declines

- *Care for Older Adults—Pain Screening.*

C-SNPs showed statistically significant improvement on three measures and statistically significant decreases in performance on three measures.

C-SNP Significant Improvements

- *Antidepressant Medication Management—Acute Phase<sup>#</sup> and Continuation Phase<sup>#</sup>.*
- *Board Certification—Family Medicine.*

C-SNP Significant Declines

- *Use of Spirometry Testing in the Assessment and Diagnosis of COPD.*
- *Medication Reconciliation Post-Discharge.*
- *Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications<sup>\*</sup>.*

**Plan program performance by enrollment size (Table 6).** This table displays program-wide performance for all SNPs by enrollment. The <99 enrollment category had the least plans (31 in 2018) and the  $\geq 2,500$  category had the most plans (187 plans in 2018). Table 6 compares HEDIS 2018 results to HEDIS 2017 results. The findings of these comparisons are below.

<99 Enrollment

- There were statistically significant improvements on one measure: *Medication Reconciliation Post-Discharge* (10.9 percentage points).
- There were statistically significant declines on three measures:
  - *Board Certification—Family Medicine* (8.9 percentage points).
  - *Board Certification—Geriatrics* (11.2 percentage points).
  - *Board Certification—Other Physician Specialists* (8.4 percentage points).

100–499 Enrollment

- There were statistically significant improvements on two measures: *Antidepressant Medication Management—Acute Phase<sup>#</sup>* (5.6 percentage points) and *Board Certification—Family Medicine* (4.6 percentage points).
- There were statistically significant declines on one measure: *Controlling High Blood Pressure* (4.8 percentage points).

500–999 Enrollment

- There were statistically significant improvements on four measures:
  - *Medication Reconciliation Post-Discharge* (7.4 percentage points).
  - *Board Certification—Family Medicine* (8.8 percentage points).
  - *Board Certification—Geriatrics* (14.3 percentage points).
  - *Board Certification—Other Physician Specialists* (6.7 percentage points).
- There were no statistically significant declines.

1,000–2,499 Enrollment

- There were statistically significant improvements on four measures:
  - *Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event<sup>#</sup>* (4.2 percentage points).
  - *Antidepressant Medication Management—Acute Phase<sup>#</sup>* (3.4 percentage points).
  - *Medication Reconciliation Post-Discharge* (12.0 percentage points).
  - *Board Certification—Family Medicine* (4.8 percentage points).
- There were no statistically significant declines.

≥2,500 Enrollment

- There were statistically significant improvements on two measures:
  - *Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event<sup>#</sup>* (2.8 percentage points).
  - *Medication Reconciliation Post-Discharge* (1.4 percentage points).
- There were statistically significant declines on two measures:
  - *Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication\* and At Least Two Different High-Risk Medications\** (1.6 and 0.9 percentage points, respectively).

**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 percentiles is 29.4 percentage points. Seven 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.

## Objectives and Background

### Objectives

This report presents results for SNPs reporting HEDIS 2018 performance measures. It displays SNP performance in 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 focuses on certain vulnerable groups of Medicare beneficiaries. Unlike other types of MA plans, SNPs may limit enrollment to the following subgroups:

- *Dual-Eligible SNPs (D-SNP)*: Beneficiaries who are eligible for Medicare and Medicaid.
- *Institutional SNPs (I-SNP)*: Beneficiaries who are institutionalized or determined by use of a state assessment tool to meet institutional level of care. Beneficiaries who meet the institutional level of care can live in the community and be enrolled in the I-SNP.
- *Chronic SNPs (C-SNP)*: Beneficiaries who have 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.

**Table 1. Key Differences Between SNPs and Standard MA Plans**

Categories	SNPs	MA Plans
Enrollment	<ul style="list-style-type: none"> <li>• 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).</li> <li>• May target specific subsets of special needs populations (e.g., beneficiaries with congestive heart failure or diabetes).</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Must be open to all Medicare-eligible beneficiaries.</li> <li>• Lock-in provision for all enrollees with an annual open-enrollment period.</li> </ul>
Benefits	<ul style="list-style-type: none"> <li>• Standard MA benefits.</li> <li>• Must offer Part D prescription drug coverage.</li> </ul>	<ul style="list-style-type: none"> <li>• Standard MA benefits.</li> <li>• Part D coverage is voluntary.</li> </ul>
Payments	<ul style="list-style-type: none"> <li>• Standard MA geographic payment schedule, with PMPM payments risk-adjusted by hierarchical condition category (HCC) scores.</li> </ul>	
Marketing	<ul style="list-style-type: none"> <li>• May target special needs populations in the market area.</li> <li>• May target specific subsets of special needs populations (on a case-by-case basis) in the market area.</li> </ul>	<ul style="list-style-type: none"> <li>• Must include all Medicare-eligible beneficiaries in the market area.</li> </ul>

## CMS SNP HEDIS Reporting Requirement

Since 2009, CMS has 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 HEDIS 2018, 505 of 694 SNPs were required to submit data for this report. Two SNPs that were not required to report also submitted HEDIS results.

**Table 2. SNP Enrollment as of February 2015, 2016 and 2017<sup>5</sup>**

SNP Type and Year	SNPs Required to Report HEDIS Measures	
	Number of SNPs	Enrollment
<b>2015 (Reported HEDIS 2016)</b>		
Chronic or Disabling Condition	113	284,019
Dual-Eligible	269	1,491,557
Institutional	31	31,631
<b>2015 Total</b>	<b>413</b>	<b>1,807,207</b>
<b>2016 (Reported HEDIS 2017)</b>		
Chronic or Disabling Condition	103	298,532
Dual-Eligible	308	1,666,087
Institutional	53	55,189
<b>2016 Total</b>	<b>464</b>	<b>2,019,808</b>
<b>2017 (Reported HEDIS 2018)</b>		
Chronic or Disabling Condition	110	324,838
Dual-Eligible	336	1,902,145
Institutional	61	62,645
<b>2017 Total</b>	<b>507<sup>6</sup></b>	<b>2,289,628</b>

For a plan's measure result to be publicly reported, NCQA requires a denominator of at least 30 enrollees. Denominators below this size do not support public reporting of individual plan rates. Measures that have a broader reach (e.g., screening measures such as *Colorectal Cancer Screening*) tend to have a larger percentage of publicly reportable plans; measures with a narrower specification (e.g., measures requiring a specific condition or event, such as *Persistence of Beta-Blocker Treatment After a Heart Attack*, *Osteoporosis Management in Women Who Had a Fracture*) tend to have a lower percentage of publicly reportable plans.

<sup>5</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDenrolData/Special-Needs-Plan-SNP-Data.html>

<sup>6</sup> Two SNPs submitted HEDIS 2018 data although they were not required to submit HEDIS measures one due to small enrollment size and one due to lack of total enrollment. The number required to report was 505.

## HEDIS Results

### SNP Program Performance Changes HEDIS 2016–2018 (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 (2016–2018).** It includes measure 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 2016 and 2018 and between HEDIS 2017 and 2018 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 (2016–2018).** It includes results for statistically significant differences between HEDIS 2016 and HEDIS 2018 and between HEDIS 2017 and HEDIS 2018, using a paired t-test ( $p < 0.05$ ) to illustrate performance differences among the same group of SNPs between different periods.

Of 28 measures collected from SNPs, 20 could be trended through all 3 years; however, 6 of these measures are trend with caution. Eight measures have trend breaks. Between HEDIS 2017 and HEDIS 2018, 25 measures could be trended with 8 of these measures being trend with caution. In the HEDIS 2017 to HEDIS 2018 period, there are three measures with trend breaks.

**Highest and Lowest Rates (Table 3a).** The measures with the highest and lowest HEDIS 2018 rates from SNPs that reported in any of the three years were:

#### Highest Five

1. *Care for Older Adults—Pain Screening* (94.0%).
2. *Care for Older Adults—Medication Review* (93.3%).
3. *Persistence of Beta-Blocker Treatment After a Heart Attack* (89.6%).
4. *Care for Older Adults—Functional Status Assessment* (88.3%).
6. *Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications\** (12.6%). (Lower values signify better performance; this is equivalent to 87.4%).

#### Lowest Five

1. *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge* (29.6%).
2. *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* (33.9%).
3. *Potentially Harmful Drug-Disease Interactions—Dementia\** (56.5%). (Lower values signify better performance; this is equivalent to 43.5%).
4. *Potentially Harmful Drug-Disease Interactions—History of Falls\*\** (55.7%). (Lower values signify better performance; this is equivalent to 44.3%).
5. *Medication Reconciliation Post-Discharge* (45.3%).

Three of the five measures with the highest performance are *Care for Older Adults* measures, which only SNPs collect.

**Highest and Lowest Rates (Table 3b).** The measures with the highest and lowest HEDIS 2018 rates from SNPs that reported in all three years were:

Highest Five

1. *Care For Older Adults—Pain Screening* (93.6%).
2. *Care For Older Adults—Medication Review* (92.9%).
3. *Persistence of Beta-Blocker Treatment After a Heart Attack* (90.2%)
4. *Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications* (12.0%). (Lower values signify better performance; this is equivalent to 88.0%.)
5. *Care For Older Adults—Functional Status Assessment* (87.5%).

Lowest Five

1. *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge* (30.9%).
2. *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* (34.4%).
3. *Potentially Harmful Drug-Disease Interactions—Dementia* (55.1%). (Lower values signify better performance; this is equivalent to 44.9%.)
4. *Potentially Harmful Drug-Disease Interactions—History of Falls<sup>\*#</sup>* (54.7%). (Lower values signify better performance; this is equivalent to 45.3%.)
5. *Medication Reconciliation Post-Discharge* (49.0%).

**Largest Significant Changes (Table 3a).** The measures listed below show the largest statically significant changes, positive or negative, from HEDIS 2016–2018. The measures with the largest improvements showed a 5.4 percentage point or greater rate increase.

Largest Five Increase Among All Reporters

1. *Medication Reconciliation Post-Discharge* (22.8 percentage points).
2. *Board Certification—Family Medicine* (5.4 percentage points).
3. *Care for Older Adults—Functional Status Assessment* (5.2 percentage points).
4. *Care for Older Adults—Advance Care Planning* (4.7 percentage points).
5. *Care for Older Adults—Geriatrics* (4.2 percentage points).

Largest Five Decrease Among All Reporters

Not applicable—No measures showed a statistically significant decrease.

**Measures only SNPs report (3a).** There are four HEDIS measures that only SNPs report (*Care for Older Adults—Advance Care Planning, Functional Status Assessment, Medication Review, Pain Screening*). All showed statistically significant improvement for HEDIS 2018.

**Largest Significant Changes (Table 3b).** Results for SNPs that reported in all 3 years were about the same as plans that reported in any of the 3 years. Ten measures with data that could be trended showed statistically significant improvement over the entire period and 14 measures showed statistically significant improvement from 2017–2018. Five measures showed statistically significant decline over the entire period and 5 measures from showed statistically significant decline from 2017–2018.

The measures listed below show the largest statistically significant changes, positive or negative, from HEDIS 2016–2018, among three-year reporters.

Largest Five Increase Among Three-Year Reporters

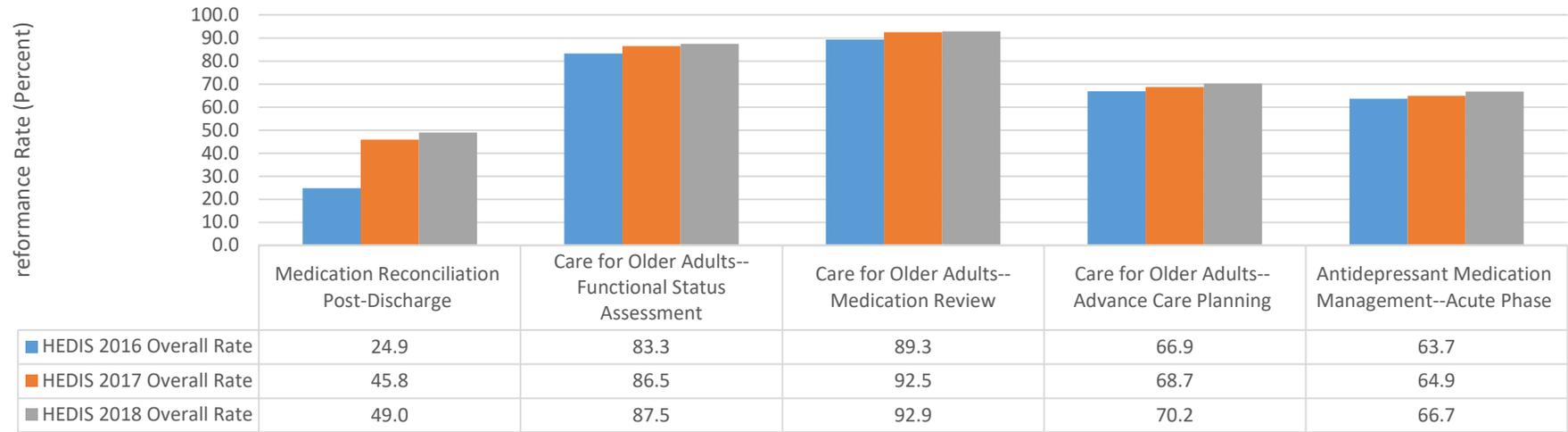
1. *Medication Reconciliation Post-Discharge* (24.2 percentage points)
2. *Care for Older Adults—Functional Status Assessment* (4.2 percentage points).
3. *Care for Older Adults—Medication Review* (3.5 percentage points).
4. *Care for Older Adults—Advance Care Planning* (3.3 percentage points).
5. *Antidepressant Medication Management—Acute Phase<sup>#</sup>* (3.0 percentage points).

Largest Five Decrease Among Three-Year Reporters

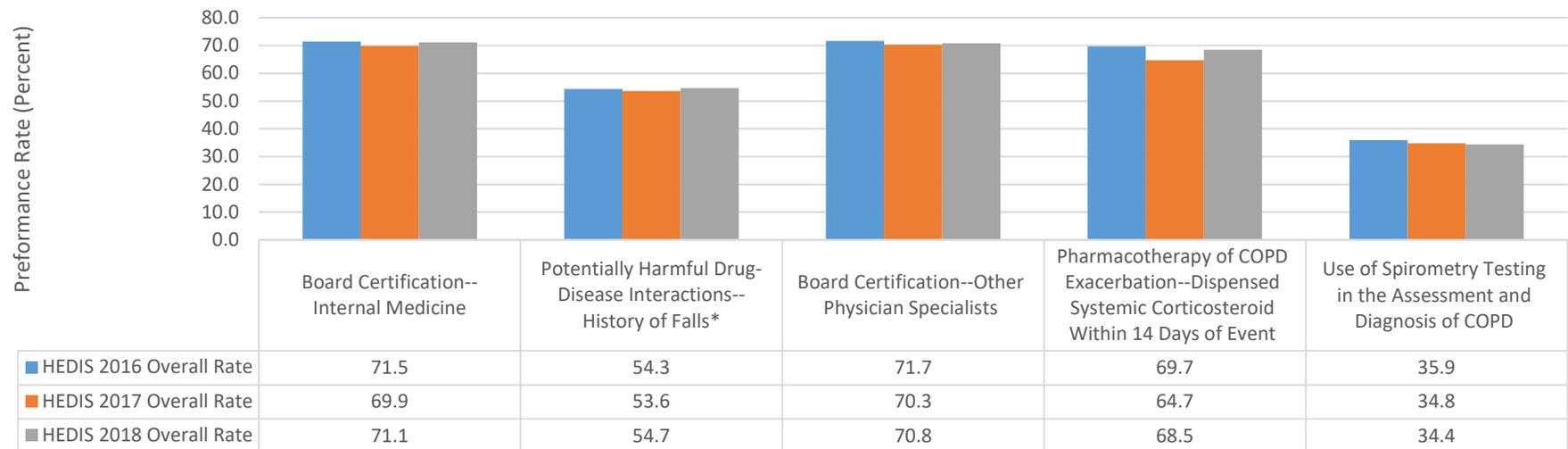
1. *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* (1.5 percentage points).
2. *Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event<sup>#</sup>* (1.2 percentage points).
3. *Board Certification—Other Physician Specialists* (0.8 percentage points).
4. *Potentially Harmful Drug-Disease Interactions—History of Falls<sup>\*\*</sup>* (0.4 percentage points).
5. *Board Certification—Internal Medicine* (0.4 percentage points).

The graphics on the next page represents the five measures with the largest improvements and declines among SNPs that reported in all three of the last periods (HEDIS 2016–2018).

### Measures with the Largest Significant Increase Among 3-Year Reporters



### Measures with the Largest Significant Decrease Among 3-Year Reporters



**Table 3a. HEDIS Performance for SNP Program HEDIS 2016, 2017 and 2018**

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

Measure	HEDIS 2016	HEDIS 2017	HEDIS 2018		CHANGE	
	Overall Rate	Overall Rate	Eligible Population	Overall Rate	2016–2018	2017–2018
Colorectal Cancer Screening	72.5	75.3	923,688	76.5	NA	1.2#
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	35.3	33.6	51,788	33.9	-1.4	0.4
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	68.4	64.6	79,521	67.4	-1.0#	2.8#**
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	80.9	79.6	79,521	81.4	0.5#	1.8#**
Controlling High Blood Pressure	60.3	63.8	1,033,090	63.7	3.4**	-0.1
Persistence of Beta-Blocker Treatment After a Heart Attack	90.0	90.5	10,964	89.6	-0.3	-0.9
Osteoporosis Management in Women Who Had a Fracture	47.0	45.9	11,237	51.9	NA	NA
Antidepressant Medication Management—Acute Phase	63.1	64.6	85,920	66.2	3.1#**	1.6#**
Antidepressant Medication Management—Continuation Phase	47.5	47.8	85,920	48.9	1.4#**	1.1#**
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	51.7	54.6	35,274	50.6	NA	NA
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	33.9	35.7	35,274	29.6	NA	NA
Medication Reconciliation Post-Discharge	22.5	42.9	508,395	45.3	22.8**	2.4
Care for Older Adults—Advance Care Planning	65.0	67.3	1,341,485	69.7	4.7**	2.4
Care for Older Adults—Medication Review	89.5	92.8	1,341,485	93.3	3.8**	0.5
Care for Older Adults—Functional Status Assessment	83.1	87.3	1,341,485	88.3	5.2**	1.0
Care for Older Adults—Pain Screening	91.0	93.4	1,341,485	94.0	3.0**	0.5
Board Certification—Family Medicine	58.8	60.7	1,852,661	64.3	5.4**	3.5**
Board Certification—Internal Medicine	69.8	71.2	2,428,816	72.5	2.7**	1.4**
Board Certification—Geriatrics	48.4	50.5	107,285	52.6	4.2**	2.0
Board Certification—Other Physician Specialists	69.4	71.6	7,366,418	72.5	3.0**	0.8
Potentially Harmful Drug-Disease Interactions—History of Falls*	54.7	54.6	96,244	55.7	-1.0#	-1.1#
Potentially Harmful Drug-Disease Interactions—Dementia*	57.9	56.0	119,563	56.5	NA	-0.4
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure*	16.8	16.6	57,242	15.9	1.0#	0.7#

Measure	HEDIS 2016	HEDIS 2017	HEDIS 2018		CHANGE	
	Overall Rate	Overall Rate	Eligible Population	Overall Rate	2016–2018	2017–2018
Potentially Harmful Drug-Disease Interactions—Total Rate*	47.6	47.1	273,049	47.7	NA	-0.6#
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*	10.3	19.2	1,341,269	20.7	NA	-1.5**
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications*	1.4	11.7	1,341,269	12.6	NA	-0.9**
Plan All-Cause Readmissions (Risk-Adjusted Average $\geq$ 65)*	15.60	14.60	323,881	14.91	0.7**	-0.3
Plan All-Cause Readmissions (Risk-Adjusted Average <65)*	19.18	18.48	168,177	18.34	0.8**	0.1

\*Lower values signify better performance.

\*\*Denotes a statistically significant difference ( $p < 0.05$ ) between years for which rates are compared.

Shaded cells that contain "NA" (Not Applicable) represent a trend break where year-to-year comparison is not possible.

**Table 3b. HEDIS Performance for Three-Year Reporting SNPs HEDIS 2016, 2017 and 2018**

This table shows population-based results only for SNPs that reported HEDIS 2016, 2017 and 2018 results.

Measure	HEDIS 2016	HEDIS 2017	HEDIS 2018		CHANGE	
	Overall Rate	Overall Rate	Eligible Population	Overall Rate	2016–2018	2017–2018
Colorectal Cancer Screening	72.6	74.2	665,716	75.5	NA	1.3#**
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	35.9	34.8	37,529	34.4	-1.5**	-0.4
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	69.7	64.7	52,761	68.5	-1.2#**	3.8#**
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	82.2	80.2	52,761	82.4	0.2#	2.1#**
Controlling High Blood Pressure	62.6	66.2	683,545	65.0	2.4**	-1.1
Persistence of Beta-Blocker Treatment After a Heart Attack	90.6	91.4	7,826	90.2	-0.3	-1.2
Osteoporosis Management in Women Who Had a Fracture	47.5	46.1	8,339	52.8	NA	NA
Antidepressant Medication Management—Acute Phase	63.7	64.9	62,159	66.7	3.0#**	1.8#**
Antidepressant Medication Management—Continuation Phase	47.8	48.0	62,159	49.4	1.5#	1.3#**
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	53.1	55.3	24,902	51.9	NA	NA
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	35.2	36.7	24,902	30.9	NA	NA
Medication Reconciliation Post -Discharge	24.9	45.8	357,768	49.0	24.2**	3.2**
Care for Older Adults—Advance Care Planning	66.9	68.7	958,719	70.2	3.3**	1.5**
Care for Older Adults—Medication Review	89.3	92.5	958,719	92.9	3.5**	0.4**
Care for Older Adults—Functional Status Assessment	83.3	86.5	958,719	87.5	4.2**	1.0**
Care for Older Adults—Pain Screening	90.9	93.2	958,719	93.6	2.7**	0.4**
Board Certification—Family Medicine	61.9	59.7	751,015	62.6	0.7	3.0**
Board Certification—Internal Medicine	71.5	69.9	936,685	71.1	-0.4**	1.3**
Board Certification—Geriatrics	53.2	49.7	41,592	53.3	0.1**	3.6
Board Certification—Other Physician Specialists	71.7	70.3	3,211,039	70.8	-0.8**	0.5**
Potentially Harmful Drug-Disease Interactions—History of Falls*	54.3	53.6	73,818	54.7	-0.4#**	-1.1#**

Measure	HEDIS 2016	HEDIS 2017	HEDIS 2018		CHANGE	
	Overall Rate	Overall Rate	Eligible Population	Overall Rate	2016–2018	2017–2018
Potentially Harmful Drug-Disease Interactions—Dementia*	57.3	54.8	86,744	55.1	NA	-0.2
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure*	16.9	16.4	40,816	15.7	1.2#**	0.7#**
Potentially Harmful Drug-Disease Interactions—Total Rate*	47.6	46.5	201,378	47.0	NA	-0.5#**
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*	9.6	18.0	951,169	19.2	NA	-1.3**
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications*	1.2	11.3	951,169	12.0	NA	-0.6**
Plan All-Cause Readmissions (Risk-Adjusted Average $\geq$ 65)*	15.38	14.48	207,921	14.76	0.6**	-0.3**
Plan All-Cause Readmissions (Risk-Adjusted Average $<$ 65)*	19.15	18.46	112,810	18.20	1.0	0.3

\*Lower values signify better performance.

\*\*Denotes a statistically significant difference ( $p < 0.05$ ) between years for which rates are compared.

Shaded cells that contain “NA” (Not Applicable) represent a trend break where year-to-year comparison is not possible.

#Denotes that trending should be performed with caution for the years of comparison.

## SNP Program and MA Program Performance (Table 4)

**SNP and MA program performance (Table 4).** This table shows 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 measures that are commonly reported at the SNP benefit-package level and at the MA contract-level.

The MA program performance was higher than the SNP program performance on 22 of 24 HEDIS 2018 measures, with significant differences for 18 measures. The greatest difference in performance was 16.4 percentage points.

The SNP program performance was higher than the MA program on 2 of 24 HEDIS 2018 measures, with statistically significant differences for 1 measure. The greatest statistically significant difference in performance was 2.7 percentage points.

Measures with the largest performance gaps between the MA and SNP programs plans included:

- *Medication Reconciliation Post-Discharge* (16.5 percentage points).
- *Controlling High Blood Pressure* (14.4 percentage points).
- *Potentially Harmful Drug-Disease Interactions—Dementia\** and *History of Falls\** (9.3 and 8.0 percentage points, respectively).

In measures where the SNPs outperformed MA plans, the largest performance gaps included:

- *Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event* (2.7 percentage points).
- *Osteoporosis Management in Women Who Had a Fracture* (2.0 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 overall 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 2018 Performance for SNP Program and MA Program

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

Measures	SNPs HEDIS 2018		MA Organizations HEDIS 2018		Performance Gap in Rates (SNP—MA)	
	Eligible Population	Overall Rate	Eligible Population	Overall Rate	HEDIS 2017	HEDIS 2018
Colorectal Cancer Screening	923,688	76.5	8,655,816	77.0	-0.7**	-0.5**
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	51,788	33.9	361,125	36.6	-2.7**	-2.6**
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	79,521	67.4	296,480	70.6	-2.2**	-3.2**
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	79,521	81.4	296,480	78.7	3.7**	2.7**
Controlling High Blood Pressure	1,033,090	63.7	8,246,387	78.1	-13.0**	-14.4**
Persistence of Beta-Blocker Treatment After a Heart Attack	10,964	89.6	69,677	90.8	-0.2	-1.1**
Osteoporosis Management in Women Who Had a Fracture	11,237	51.9	111,027	50.0	1.7	2.0
Antidepressant Medication Management—Acute Phase	85,920	66.2	438,889	71.6	-5.7**	-5.4**
Antidepressant Medication Management—Continuation Phase	85,920	48.9	438,889	55.5	-6.7**	-6.6**
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	35,274	50.6	98,542	52.0	-0.1	-1.3
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	35,274	29.6	98,542	30.8	0.7	-1.2
Medication Reconciliation Post-Discharge	508,395	45.3	2,992,100	61.7	-13.3**	-16.5**
Care for Older Adults--Advance Care Planning***	1,341,485	69.7	***	***	—	—
Care for Older Adults--Medication Review***	1,341,485	93.3	***	***	—	—
Care for Older Adults--Functional Status Assessment***	1,341,485	88.3	***	***	—	—
Care for Older Adults--Pain Screening***	1,341,485	94.0	***	***	—	—
Board Certification—Family Medicine	1,852,661	64.3	1,169,456	67.8	-3.7**	-3.6**
Board Certification—Internal Medicine	2,428,816	72.5	1,468,374	74.5	-1.7**	-2.0**
Board Certification—Geriatrics	107,285	52.6	63,399	56.5	-3.9**	-3.9**
Board Certification—Other Physician Specialists	7,366,418	72.5	4,743,797	73.8	-1.5	-1.4

Measures	SNPs HEDIS 2018		MA Organizations HEDIS 2018		Performance Gap in Rates (SNP—MA)	
	Eligible Population	Overall Rate	Eligible Population	Overall Rate	HEDIS 2017	HEDIS 2018
Potentially Harmful Drug-Disease Interactions—History of Falls*	96,244	55.7	889,614	47.6	-7.7**	-8.0**
Potentially Harmful Drug-Disease Interactions—Dementia*	119,563	56.5	755,236	47.2	-9.3**	-9.3**
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure*	57,242	15.9	343,635	9.8	-6.7**	-6.1**
Potentially Harmful Drug-Disease Interactions—Total Rate*	273,049	47.7	1,988,485	40.9	-6.9**	-6.8**
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*	1,341,269	20.7	13,553,645	14.5	-5.9**	-6.2**
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications*	1,341,269	12.6	13,553,645	8.9	-3.3**	-3.7**
Plan All-Cause Readmissions (Risk-Adjusted Average $\geq 65$ )*	323,881	14.91	2,194,046	12.27	-2.38**	-2.64**
Plan All-Cause Readmissions (Risk-Adjusted Average $< 65$ )*	168,177	18.34	471,008	17.21	-1.43**	-1.13**

\*Lower values signify better performance.

\*\*Denotes a statistically significant difference ( $p < 0.05$ ) between years for which rates are compared.

\*\*\*Data are not reported by MA plans.

Cells with a dash (—) indicate that there were no data for calculation.

## SNP Program Performance by SNP Type (Table 5)

**Program performance by SNP type (Table 5).** Overall for HEDIS 2018, D-SNPs had higher rates on 7 measures than the other SNP types (17 measures for I-SNPs; 4 measures for C-SNPs). Table 5 also compares HEDIS 2018 results to HEDIS 2017 results. The findings of these comparisons are below.

Performance increased across all SNP types on 5 measures:

- *Antidepressant Medication Management—Acute Phase<sup>#</sup> and Continuation Phase<sup>#</sup>.*
- *Board Certification—Family Medicine, Internal Medicine and Other Physician Specialists.*

Performance decreased across all SNP types for 2 measures:

- *Potentially Harmful Drug-Disease Interactions—History of Falls<sup>\*\*</sup>.*
- *Plan All Cause Readmissions—Risk-Adjusted Average  $\geq 65^*$ .*

D-SNPs showed statistically significant performance improvement on six measures and showed statistically significant decreases in performance on two measures.

### D-SNP Significant Improvements

- *Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event<sup>#</sup> and Dispensed Bronchodilator Within 30 Days of Event<sup>#</sup>.*
- *Antidepressant Medication Management—Acute Phase<sup>#</sup>.*
- *Board Certification—Family Medicine, Internal Medicine and Geriatrics.*

### D-SNP Significant Declines

- *Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication<sup>\*</sup> and At Least Two Different High-Risk Medications<sup>\*</sup>.*

I-SNPs showed statistically significant improvement on one measure and showed statistically significant decreases in performance on one measure.

### I-SNP Significant Improvements

- *Colorectal Cancer Screening<sup>#</sup>.*

### I-SNP Significant Declines

- *Care for Older Adults—Pain Screening.*

C-SNPs showed statistically significant improvement on three measures and statistically significant decreases in performance on three measures.

### C-SNP Significant Improvements

- *Antidepressant Medication Management—Acute Phase<sup>#</sup> and Continuation Phase<sup>#</sup>.*
- *Board Certification—Family Medicine.*

C-SNP Significant Declines

- *Use of Spirometry Testing in the Assessment and Diagnosis of COPD.*
- *Medication Reconciliation Post-Discharge.*
- *Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications\*.*

**Table 5. SNP Overall Program Performance by SNP Type HEDIS 2017–2018**

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

Measure	DUAL SNPs					INSTITUTIONAL SNPs					CHRONIC SNPs				
	HEDIS 2017		HEDIS 2018		2017 vs 2018	HEDIS 2017		HEDIS 2018		2017 vs 2018	HEDIS 2017		HEDIS 2018		2017 vs 2018
	#	Rate	#	Rate	Change	#	Rate	#	Rate	Change	#	Rate	#	Rate	Change
<b>Total SNPs</b>	<b>308</b>		<b>336</b>			<b>53</b>		<b>61</b>			<b>103</b>		<b>110</b>		
Colorectal Cancer Screening	308	74.5	335	76.0	1.5#	53	70.5	55	82.3	11.8#**	103	79.2	110	78.8	-0.4#
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	308	32.4**	335	34.2	1.8	53	9.1**	61	5.8**	-3.3	103	41.0**	110	35.1	-5.9**
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	308	64.8	336	67.9	3.2#**	53	52.9	61	52.7	-0.3#	103	64.3	110	64.9	0.7#
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	308	80.4	336	82.7	2.3#**	53	87.2	61	84.4	-2.8#	103	74.0	110	72.8	-1.2#
Controlling High Blood Pressure	299	65.7	333	65.2	-0.5	48	74.2	55	40.9	-33.3	103	55.9	104	57.0	1.1
Persistence of Beta-Blocker Treatment After a Heart Attack	308	90.6	336	89.9	-0.7	53	88.2	61	89.1	0.9	103	90.2	110	88.8	-1.3
Osteoporosis Management in Women Who Had a Fracture	308	44.5**	335	51.5	NA	53	19.8**	61	50.0	NA	103	54.6**	110	53.5	NA
Antidepressant Medication Management—Acute Phase	308	64.3	336	65.7**	1.4#**	53	77.4	61	83.7**	6.3#	103	66.7	110	69.5**	2.8#**
Antidepressant Medication Management—Continuation Phase	308	47.4	336	48.3**	0.9#	53	73.6**	61	75.6**	2.1#	103	49.3	110	52.1**	2.8#**
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	306	55.0	334	51.1	NA	53	19.7**	61	12.7**	NA	103	51.6	110	47.6	NA
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	306	36.0	334	30.0	NA	53	15.8	61	7.3	NA	103	32.9	110	25.4	NA

Measure	DUAL SNPS					INSTITUTIONAL SNPS					CHRONIC SNPS				
	HEDIS 2017		HEDIS 2018		2017 vs 2018	HEDIS 2017		HEDIS 2018		2017 vs 2018	HEDIS 2017		HEDIS 2018		2017 vs 2018
	#	Rate	#	Rate	Change	#	Rate	#	Rate	Change	#	Rate	#	Rate	Change
Medication Reconciliation Post-Discharge	307	43.3	335	46.3	3.0	53	30.7	61	41.1	10.4	103	41.7	110	40.1	-1.5**
Care for Older Adults—Advance Care Planning	307	66.6	335	69.0**	2.4	53	97.5**	61	95.7**	-1.8	103	65.6	110	68.3**	2.7
Care for Older Adults—Medication Review	307	92.0**	335	92.7	0.7	53	98.2	61	96.6	-1.6	103	95.1	110	95.4	0.3
Care for Older Adults—Functional Status Assessment	307	86.2**	335	87.5**	1.3	53	98.9	61	97.9	-1.0	103	90.1	110	90.1	0.0
Care for Older Adults—Pain Screening	307	92.8**	335	93.6	0.8	53	98.8	61	96.1	-2.7**	103	95.2	110	95.3	0.1
Board Certification—Family Medicine	290	57.3	317	62.1	4.8**	49	70.7**	54	72.2**	1.4	102	52.4	109	57.8	5.4**
Board Certification—Internal Medicine	289	68.9	317	71.2	2.2**	49	75.4**	54	76.1**	0.7	102	66.1	109	67.9	1.7
Board Certification—Geriatrics	290	45.8**	317	50.8**	5.0**	49	61.4**	54	60.4**	-1.1	102	34.4**	109	38.2**	3.8
Board Certification—Other Physician Specialists	290	67.8	317	69.8	2.0	49	81.3**	54	81.5**	0.2	102	66.1	109	66.3	0.2
Potentially Harmful Drug-Disease Interactions—History of Falls*	308	54.2	335	55.3	-1.1#	53	63.2**	61	64.0**	-0.8#	103	54.7	110	56.1	-1.4#
Potentially Harmful Drug-Disease Interactions—Dementia*	308	57.4**	335	57.9**	-0.5	53	51.8	61	50.5	1.3	103	51.0	110	52.5	-1.5
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure*	308	18.6**	334	17.8**	0.8#	53	5.5**	61	5.5**	-0.1#	103	12.4**	110	11.8**	0.7#
Potentially Harmful Drug-Disease Interactions—Total Rate*	308	48.6	335	49.1	-0.5#	53	48.5	61	47.8	0.7#	103	40.1**	110	41.5**	-1.4#
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*	308	19.9**	336	21.4**	-1.5**	53	13.9	61	13.9**	0.0	103	17.1	110	18.6**	-1.5

Measure	DUAL SNPS					INSTITUTIONAL SNPS					CHRONIC SNPS				
	HEDIS 2017		HEDIS 2018		2017 vs 2018	HEDIS 2017		HEDIS 2018		2017 vs 2018	HEDIS 2017		HEDIS 2018		2017 vs 2018
	#	Rate	#	Rate	Change	#	Rate	#	Rate	Change	#	Rate	#	Rate	Change
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications*	308	12.2	336	13.0	-0.8**	53	11.2	61	11.2	0.1	103	9.9	110	11.0	-1.1**
Plan All-Cause Readmissions (Risk-Adjusted Average ≥65)*	307	15.05**	335	15.28**	-0.23	53	8.56**	61	9.67**	-1.11	101	13.49**	110	13.93**	-0.44
Plan All-Cause Readmissions (Risk-Adjusted Average <65)*	308	18.73	335	18.48	0.24	53	14.20	61	12.83**	1.37	102	17.17	109	17.66	-0.49

\*Lower values signify better performance.

\*\*Denotes a statistically significant difference (p<0.05) between years or between a particular SNP and other SNPs for which rates are compared.

#Denotes that trending should be performed with caution for the years of comparison.

Shaded cells that contain “NA” (Not Applicable) represent a trend break where year-to-year comparison is not possible.

Cells with a dash (—) indicate that there were no data for calculation.

## 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 2017–2018 within a specific enrollment category. Because statistical significance is a function of effect size and number of observations, NCQA did not test for statistical significance of the differences among SNP sizes because of the wide variation in SNP enrollment sizes. If such testing were 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 clinically significant.

**Plan program performance by enrollment size (Table 6).** This table displays program-wide performance for all SNPs by enrollment. The <99 enrollment category had the least plans (31 in 2018) and the ≥2,500 category had the most plans (187 plans in 2018).

### <99 Enrollment

- There were statistically significant improvements on one measure: *Medication Reconciliation Post-Discharge* (10.9 percentage points).
- There were statistically significant declines on three measures:
  - *Board Certification—Family Medicine* (8.9 percentage points).
  - *Board Certification—Geriatrics* (11.2 percentage points).
  - *Board Certification—Other Physician Specialists* (8.4 percentage points).

### 100–499 Enrollment

- There were statistically significant improvements on two measures: *Antidepressant Medication Management—Acute Phase<sup>#</sup>* (5.6 percentage points) and *Board Certification—Family Medicine* (4.6 percentage points).
- There were statistically significant declines on one measure: *Controlling High Blood Pressure* (4.8 percentage points).

### 500–999 Enrollment

- There were statistically significant improvements on four measures:
  - *Medication Reconciliation Post-Discharge* (7.4 percentage points).
  - *Board Certification—Family Medicine* (8.8 percentage points).
  - *Board Certification—Geriatrics* (14.3 percentage points).
  - *Board Certification—Other Physician Specialists* (6.7 percentage points).
- There were no statistically significant declines.

### 1,000–2,499 Enrollment

- There were statistically significant improvements on four measures:
  - *Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event<sup>#</sup>* (4.2 percentage points).
  - *Antidepressant Medication Management—Acute Phase<sup>#</sup>* (3.4 percentage points).
  - *Medication Reconciliation Post-Discharge* (12.0 percentage points).
  - *Board Certification—Family Medicine* (4.8 percentage points).
- There were no statistically significant declines.

≥2,500 Enrollment

- There were statistically significant improvements on two measures:
  - *Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event*<sup>#</sup> (2.8 percentage points).
  - *Medication Reconciliation Post-Discharge* (1.4 percentage points).
- There were statistically significant declines on two measures:
  - *Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*<sup>\*</sup> and *At Least Two Different High-Risk Medications*<sup>\*</sup> (1.6 and 0.9 percentage points, respectively).

Table 6. SNP Overall Program Performance by Enrollment Size HEDIS 2017–2018

Measure	RATE BY SNP ENROLLMENT SIZE														
	≤99			100–499			500–999			1,000–2,499			≥2,500		
	HEDIS 2017 Rate	HEDIS 2018 Rate	2017 vs 2018 Change	HEDIS 2017 Rate	HEDIS 2018 Rate	2017 vs 2018 Change	HEDIS 2017 Rate	HEDIS 2018 Rate	2017 vs 2018 Change	HEDIS 2017 Rate	HEDIS 2018 Rate	2017 vs 2018 Change	HEDIS 2017 Rate	HEDIS 2018 Rate	2017 vs 2018 Change
<b>Total SNPs</b>	<b>40</b>	<b>31</b>		<b>97</b>	<b>130</b>		<b>66</b>	<b>67</b>		<b>88</b>	<b>91</b>		<b>173</b>	<b>187</b>	
Colorectal Cancer Screening	69.1	67.2	-1.9#	67.1	68.4	1.4#	73.4	71.7	-1.7#	70.3	73.6	3.3#	75.7	76.8	1.1#
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	40.0	32.4	-7.6	25.0	27.4	2.4	36.9	32.1	-4.8	31.3	31.1	-0.2	33.7	34.2	0.5
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	58.9	64.3	5.4#	64.5	63.7	-0.8#	65.5	67.1	1.6#	66.1	70.3	4.2#**	64.5	67.3	2.8#**
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	80.8	82.1	1.3#	78.7	79.9	1.2#	77.8	78.7	0.9#	81.4	83.2	1.8#	79.5	81.4	1.9#
Controlling High Blood Pressure	54.2	59.9	5.7	67.2	62.5	-4.8**	68.3	63.3	-4.9	67.5	66.2	-1.3	63.4	63.6	0.2
Persistence of Beta-Blocker Treatment After a Heart Attack	91.7	87.5	-4.2	89.6	87.1	-2.4	86.3	88.2	1.9	90.4	89.6	-0.9	90.6	89.7	-0.9
Osteoporosis Management in Women Who Had a Fracture	33.3	40.0	NA	43.0	34.1	NA	48.9	49.8	NA	36.4	49.7	NA	46.7	52.4	NA
Antidepressant Medication Management—Acute Phase	75.4	64.3	-11.1#	66.9	72.5	5.6#**	70.7	67.9	-2.8#	66.4	69.8	3.4#**	64.3	65.9	1.5#
Antidepressant Medication Management—Continuation Phase	62.3	52.4	-9.9#	52.9	55.3	2.5#	53.9	52.1	-1.7#	50.3	53.2	3.0#	47.4	48.5	1.1#
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	33.3	26.9	NA	40.8	40.8	NA	46.0	45.9	NA	49.8	48.2	NA	55.5	51.2	NA
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	27.5	15.4	NA	23.4	23.8	NA	29.0	26.5	NA	30.4	26.1	NA	36.5	30.1	NA

RATE BY SNP ENROLLMENT SIZE															
Measure	≤99			100–499			500–999			1,000–2,499			≥2,500		
	HEDIS 2017 Rate	HEDIS 2018 Rate	2017 vs 2018 Change	HEDIS 2017 Rate	HEDIS 2018 Rate	2017 vs 2018 Change	HEDIS 2017 Rate	HEDIS 2018 Rate	2017 vs 2018 Change	HEDIS 2017 Rate	HEDIS 2018 Rate	2017 vs 2018 Change	HEDIS 2017 Rate	HEDIS 2018 Rate	2017 vs 2018 Change
Medication Reconciliation Post-Discharge	23.8	34.8	10.9**	38.3	41.3	3.0	35.6	43.0	7.4**	37.0	49.0	12.0**	43.8	45.2	1.4**
Care for Older Adults—Advance Care Planning	63.2	66.1	2.9	58.5	62.0	3.5	63.9	66.1	2.2	65.5	70.7	5.2	67.7	69.9	2.2
Care for Older Adults—Medication Review	85.5	87.4	1.9	90.8	89.6	-1.2	92.4	91.8	-0.6	90.7	93.4	2.7	93.0	93.4	0.4
Care for Older Adults—Functional Status Assessment	82.9	81.5	-1.4	87.4	87.4	0.0	89.4	89.7	0.4	87.0	89.3	2.3	87.3	88.2	0.9
Care for Older Adults—Pain Screening	86.7	81.3	-5.4	91.8	88.5	-3.3	93.7	94.0	0.4	92.5	94.0	1.5	93.5	94.1	0.5
Board Certification—Family Medicine	65.8	56.9	-8.9**	61.4	66.1	4.6**	53.6	62.4	8.8**	56.2	61.0	4.8**	64.1	65.7	1.6
Board Certification—Internal Medicine	73.7	69.8	-3.9	71.6	73.4	1.8	66.1	70.0	3.9	68.3	71.0	2.7	72.8	73.4	0.6
Board Certification—Geriatrics	55.9	44.7	-11.2**	51.1	53.5	2.4	37.8	52.2	14.3**	42.1	47.1	5.0	56.2	54.8	-1.5
Board Certification—Other Physician Specialists	75.0	66.6	-8.4**	71.7	74.1	2.4	62.8	69.5	6.7**	67.2	68.6	1.4	75.8	74.4	-1.3
Potentially Harmful Drug-Disease Interactions—History of Falls*	54.6	60.2	-5.6#	59.3	57.7	1.7#	56.1	56.7	-0.6#	57.1	58.1	-1.1#	54.2	55.4	-1.2#
Potentially Harmful Drug-Disease Interactions—Dementia*	50.0	46.1	3.9	52.0	53.2	-1.2	51.4	52.3	-0.9	53.1	52.1	1.0	56.5	57.0	-0.5
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure*	15.2	13.3	1.8#	12.6	10.4	2.3#	14.4	12.9	1.5#	12.4	14.0	-1.6#	17.1	16.2	0.8#
Potentially Harmful Drug-Disease Interactions—Total Rate*	45.4	45.8	-0.4#	45.8	45.7	0.1#	43.2	45.0	-1.8#	45.9	46.3	-0.4#	47.3	47.9	-0.6#
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*	17.8	16.6	1.2	17.4	17.4	0.1	17.2	19.0	-1.8	18.1	18.2	-0.1	19.4	21.0	-1.6**

RATE BY SNP ENROLLMENT SIZE															
Measure	≤99			100–499			500–999			1,000–2,499			≥2,500		
	HEDIS 2017 Rate	HEDIS 2018 Rate	2017 vs 2018 Change	HEDIS 2017 Rate	HEDIS 2018 Rate	2017 vs 2018 Change	HEDIS 2017 Rate	HEDIS 2018 Rate	2017 vs 2018 Change	HEDIS 2017 Rate	HEDIS 2018 Rate	2017 vs 2018 Change	HEDIS 2017 Rate	HEDIS 2018 Rate	2017 vs 2018 Change
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications*	12.4	10.8	1.6	11.2	11.5	-0.4	11.3	12.6	-1.2	11.7	11.7	0.0	11.7	12.7	-0.9**
Plan All-Cause Readmissions (Risk-Adjusted Average ≥65)*	15.93	17.34	-1.40	12.89	13.72	-0.82	14.08	15.24	-1.16	13.45	13.25	0.19	14.72	15.02	-0.30
Plan All-Cause Readmissions (Risk-Adjusted Average <65)*	20.35	12.91	7.45	15.99	16.92	-0.94	18.07	18.45	-0.37	16.95	17.49	-0.54	18.62	18.42	0.20

\*Lower values signify better performance.

\*\*Denotes the rate for that plan size is statistically different (p <0.05) from 2017–2018.

#Denotes that trending should be performed with caution for the years of comparison.

Shaded cells that contain “NA” (Not Applicable) represent a trend break where year-to-year comparison is not possible.

## 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 performance of SNPs with at least 30 enrollees in the measure denominator—the minimum denominator size for reporting individual HEDIS rates.

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 denominator size. The number of SNPs able to report each measure ranged from 488 (for *Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication and At Least Two Different High-Risk Medications*) to 101 (for *Persistence of Beta-Blocker Treatment After a Heart Attack and Osteoporosis Management in Women Who Had a Fracture*).

The average difference between the 10th and 90th percentiles is 29.4 percentage points.

The standard deviation ranges from 2.84 percentage points (*Plan All-Cause Readmissions [Risk-Adjusted Average  $\geq 65$ ]\**) to 25.0 percentage points (*Care for Older Adults—Advance Care Planning*), demonstrating that the spread around the mean score varies substantially by measure.

The smallest gaps (less than 18 percentage points) between the 10th and 90th percentiles were found for the following measures:

- *Plan All-Cause Readmissions [Risk-Adjusted Average  $< 65$ ]\** (7.2 percentage points).
- *Plan All-Cause Readmissions [Risk-Adjusted Average  $\geq 65$ ]\** (7.5 percentage points).
- *Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications* (12.6 percentage points).
- *Persistence of Beta-Blocker Treatment After a Heart Attack* (14.3 percentage points).
- *Care for Older Adults—Pain Screening* (16.9 percentage points).
- *Care for Older Adults—Medication Review* (17.3 percentage points).

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

- *Care for Older Adults—Advance Care Planning* (68.3 percentage points).
- *Board Certification—Geriatrics* (66.8 percentage points).
- *Osteoporosis Management in Women Who Had a Fracture* (53.7 percentage points).
- *Medication Reconciliation Post-Discharge* (52.2 percentage points).
- *Board Certification—Family Medicine* (46.8 percentage points).

Seven 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.

- *Care for Older Adults—Advance Care Planning* (32.8 percentage points).
- *Osteoporosis Management in Women Who Had a Fracture* (29.1 percentage points).
- *Board Certification—Geriatrics* (28.4 percentage points).
- *Medication Reconciliation Post-Discharge* (25.5 percentage points).
- *Board Certification—Family Medicine* (23.6 percentage points).
- *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge and Follow-Up Within 30 Days of Discharge* (20.6 and 18.7 percentage points, respectively).

Table 7. SNP Benefit Package Performance HEDIS 2018

Measures	Total SNPs	Mean	Std. Dev.	PERCENTILE DISTRIBUTION OF PERFORMANCE						
				Min	P10	P25	P50	P75	P90	Max
Colorectal Cancer Screening	422	72.7	11.4	20.7	58.9	66.2	73.8	80.6	86.2	97.5
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	224	33.2	12.9	0.0	18.9	25.2	32.2	39.7	50.4	75.2
Pharmacotherapy of COPD Exacerbation--Dispensed Systemic Corticosteroid Within 14 Days of Event	285	67.9	10.8	0.0	56.5	63.9	69.9	74.4	78.6	93.6
Pharmacotherapy of COPD Exacerbation--Dispensed Bronchodilator Within 30 Days of Event	285	81.9	10.0	24.5	69.7	78.3	83.7	87.9	91.4	97.4
Controlling High Blood Pressure	413	64.5	14.1	6.1	46.7	57.1	66.1	73.8	80.7	92.6
Persistence of Beta-Blocker Treatment After a Heart Attack	101	89.5	5.5	73.2	81.6	86.0	89.6	93.2	95.9	100.0
Osteoporosis Management in Women Who Had a Fracture	101	54.2	20.5	9.7	29.6	38.3	52.4	69.1	83.3	96.1
Antidepressant Medication Management--Acute Phase	283	67.6	8.7	47.2	57.1	61.4	67.0	73.2	79.1	96.9
Antidepressant Medication Management--Continuation Phase	283	50.8	9.3	29.6	39.6	44.4	50.0	55.3	62.2	84.6
Follow-Up After Hospitalization for Mental Illness--Follow-Up Within 30 Days of Discharge	190	48.9	14.7	12.3	33.0	39.6	46.5	57.6	67.6	93.3
Follow-Up After Hospitalization for Mental Illness--Follow-Up Within 7 Days of Discharge	190	28.1	13.7	0.0	13.9	19.0	25.0	34.6	48.7	80.0
Medication Reconciliation Post-Discharge	447	47.2	19.5	0.0	20.5	32.4	47.6	62.0	72.7	95.0
Care for Older Adults--Advance Care Planning	487	65.5	25.0	0.0	30.0	46.5	68.1	87.8	98.3	100.0
Care for Older Adults--Medication Review	487	91.6	12.0	0.7	82.2	89.7	94.9	98.0	99.5	100.0
Care for Older Adults--Functional Status Assessment	487	87.9	14.1	0.0	69.9	83.2	93.3	97.1	99.3	100.0
Care for Older Adults--Pain Screening	487	91.8	13.9	5.5	82.7	90.8	96.3	98.3	99.6	100.0
Board Certification--Family Medicine	479	62.6	19.7	1.2	39.5	47.6	69.0	75.4	86.3	97.2
Board Certification--Internal Medicine	479	68.9	16.4	7.4	50.9	61.8	71.8	79.1	86.0	100.0
Board Certification--Geriatrics	462	54.4	24.0	0.0	16.0	36.5	60.0	68.0	82.8	100.0
Board Certification--Other Physician Specialists	479	72.0	16.4	8.3	54.5	57.8	77.6	82.4	87.3	97.8
Potentially Harmful Drug-Disease Interactions--History of Falls*	289	56.5	10.3	83.7	68.8	63.6	57.2	50.0	43.6	22.5
Potentially Harmful Drug-Disease Interactions--Dementia*	310	53.8	9.8	81.6	66.7	60.1	53.1	47.0	41.8	26.1
Potentially Harmful Drug-Disease Interactions--Chronic Renal Failure*	259	14.9	8.5	52.7	26.5	18.8	14.1	8.8	4.6	0.0
Potentially Harmful Drug-Disease Interactions--Total Rate*	382	46.6	9.2	86.7	58.2	51.8	46.1	40.3	35.5	23.9

Measures	Total SNPs	Mean	Std. Dev.	PERCENTILE DISTRIBUTION OF PERFORMANCE						
				Min	P10	P25	P50	P75	P90	Max
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*	488	19.3	7.0	41.0	29.0	24.0	18.7	14.0	11.0	0.0
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications*	488	12.6	4.9	30.3	19.3	15.5	12.0	9.1	6.7	0.0
Plan All-Cause Readmissions (Risk-Adjusted Average $\geq$ 65)*	259	14.11	2.84	22.74	17.71	16.08	14.38	12.31	10.21	5.11
Plan All-Cause Readmissions (Risk-Adjusted Average $<$ 65)*	183	18.11	2.89	25.01	21.67	20.63	18.04	16.32	14.46	8.36

\*Lower values signify better performance.

### SNP Benefit Package Performance Changes HEDIS 2016–2018 (Table 8)

Table 8 analyzes performance by benefit package, showing the percentage of benefit packages that improved or decreased performance from 2016–2018 and from 2017–2018. As in Table 7, results are shown from SNPs that met the minimum sample size of 30 or more. Comparisons between HEDIS 2016 and HEDIS 2018 were based on plans with submissions in all three years; comparisons between HEDIS 2017 and HEDIS 2018 were based on plans with submissions in 2017 and 2018.

Of the 25 measures (which includes trend with caution measures), where a comparison can be made from 2017–2018, more than 50% of SNPs showed improvement on 16 measures. Conversely, there were 9 measures where more than 50% of SNPs showed decreased performance from 2017–2018.

**Table 8. SNP Benefit Package Performance Changes HEDIS 2016–2018**

Measures	Percentage of SNPs With Changes in Performance 2016–2018*		Percentage of SNPs With Changes in Performance 2017–2018**	
	Improved Performance	Decreased Performance	Improved Performance	Decreased Performance
Colorectal Cancer Screening	NA	NA	69.2#	30.2#
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	36.9	63.1	47.5	52.5
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	40.8#	58.5#	55.3#	44.7#
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	41.5#	58.5#	55.7#	43.4#
Controlling High Blood Pressure	59.4	40.6	52.0	46.8
Persistence of Beta-Blocker Treatment After a Heart Attack	42.9	55.1	40.8	57.9
Osteoporosis Management in Women Who Had a Fracture	NA	NA	NA	NA
Antidepressant Medication Management—Acute Phase	64.4#	35.0#	66.9#	33.1#
Antidepressant Medication Management—Continuation Phase	58.9#	40.6#	61.4#	38.6#
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	NA	NA	NA	NA
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	NA	NA	NA	NA
Medication Reconciliation Post-Discharge	94.0	6.0	67.2	32.8
Care for Older Adults—Advance Care Planning	69.5	28.2	63.4	33.9
Care for Older Adults—Medication Review	68.5	29.2	57.7	39.6
Care for Older Adults—Functional Status Assessment	70.5	28.2	57.2	38.3
Care for Older Adults—Pain Screening	67.1	29.9	56.5	38.6
Board Certification—Family Medicine†	42.3	57.7	61.7	38.0
Board Certification—Internal Medicine†	37.5	62.5	58.8	40.9
Board Certification—Geriatrics†	34.1	63.8	33.8	59.2
Board Certification—Other Physician Specialists†	36.4	63.6	61.4	38.4

Measures	Percentage of SNPs With Changes in Performance 2016–2018*		Percentage of SNPs With Changes in Performance 2017–2018**	
	Improved Performance	Decreased Performance	Improved Performance	Decreased Performance
Potentially Harmful Drug-Disease Interactions—History of Falls*	40.6#	59.4#	36.0#	64.0#
Potentially Harmful Drug-Disease Interactions—Dementia*	NA	NA	45.5	54.5
Potentially Harmful Drug-Disease Interactions—Chronic Renal Failure*	58.1#	41.9#	55.9#	41.8#
Potentially Harmful Drug-Disease Interactions—Total Rate*	NA	NA	41.0#	58.4#
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication*	NA	NA	36.0	64.0
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications	NA	NA	36.0	64.0
Plan All-Cause Readmissions (Risk-Adjusted Average ≥65)	65.6	34.4	48.1	51.9
Plan All-Cause Readmissions (Risk-Adjusted Average <65)	68.7	31.3	56.6	43.4

\*Includes only SNPs that reported rates in all three years, 2016–2018.

\*\*Includes only SNPs that reported rates in 2017 and 2018.

#Denotes that trending should be performed with caution for the years of comparison.

†Denotes no minimum sample size applied to the *Board Certification* measure.

Shaded cells that contain “NA” (Not Applicable) represent a trend break where year-to-year comparison is not possible.

**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.

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

Tables 9a and 9b show the number of SNPs reporting each HEDIS measure and rationales for SNPs that were unable to report valid rates for certain measures. A total of 507 SNPs submitted HEDIS measure results; 505 were required to submit HEDIS measure results.

NCQA changed the audit requirement for the *Board Certification* measure beginning in HEDIS 2016: Measures and indicators are only required to be audited once every three years. If an organization's results were audited for HEDIS 2015, data are not required to be audited again until HEDIS 2018. Plans were not required to have the measures audited for HEDIS 2018 if data were audited for HEDIS 2017.

NCQA-Certified HEDIS Auditors categorized each measure as follows:

### Did Report Categories (Table 9a)

- Denominator  $\geq 30$  is designated as a Reportable Rate for individual plans.
- Denominator  $< 30$  receives an NA audit designation. These rates are not considered individually reportable.

### Did Not Report Categories (Table 9b)

- HEDIS measure rates generally have a 95% confidence interval. If NCQA-Certified HEDIS Auditors determine that a rate is likely to be biased by more than  $\pm 5$  percentage points because of data errors, they designate the rate Materially Biased.
- "Chose Not to Report" indicates that the SNP chose not to report a specific measure.
- "Benefit Not Offered" indicates that the SNP does not offer the health benefit required by the measure
- "Exceeded Tier 3 Validation Limits" indicates that NCQA's final level of validation, a reviews rates at the indicator level against NCQA established standards, identified the rate as an outlier.

Table 9a reports the number of submissions by measure; Table 9b reports the rationale for SNPs that did not have reportable measure results<sup>7</sup>. Measures not listed in this table had complete results across all five "did not report" categories.

As mentioned above, measure results must have denominators  $\geq 30$  to be considered reliable for individual SNP reporting. NCQA used measure results with denominators  $\geq 30$  for the SNP PBP-level performance analysis (Table 7). Measure results based on denominators  $< 30$  were not used in this analysis.

There were 12 measures for which more than 80% of the SNPs had a sufficient population to allow individual SNP-level reporting. *Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication* and *At Least Two Different High-Risk Medications\** had the largest number (488 [96.3%]) of SNPs with a sufficient population, followed by all the *Care for Older Adults* measures (487 [96.1%]).

There were 130 instances, 108 from *Board Certification* measures, when a SNP did not report a measure because it was found to be materially biased.

SNPs were more likely to have denominators  $< 30$  for measures that address a new condition or incident (e.g., hospitalized and discharged with a heart attack during a defined period) or less prevalent

<sup>7</sup> Eight SNPs mistakenly submitted as "Not Required to Report" for *Controlling High Blood Pressure* or *Colorectal Cancer Screening*, or both. These plans had no eligible members for these measures because of their small enrollment and/or exclusions. For example, for *Controlling High Blood Pressure* there is an optional exclusion for members with evidence of end-stage renal disease (ESRD), which significantly impacted a C-SNP focused on ESRD. The plans should have submitted information to NCQA on the numerators and denominators for these measures even if they were zeros.

conditions, because there are fewer patient encounters or actions to meet the numerator requirement. *Persistence of Beta-Blocker Treatment After a Heart Attack* and *Osteoporosis Management in Women Who Had a Fracture* both had the smallest number of SNPs with denominators  $\geq 30$  (101 [19.9%]).

Table 9a. SNP HEDIS 2018 Data Submission—Did Report

Measures	Total Submissions		Denominator ≥30 <sup>8</sup>		Denominator <30	
	N	%	N	%	N	%
Colorectal Cancer Screening	500	98.6	422	83.2	78	15.4
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	506	99.8	224	44.2	282	55.6
Pharmacotherapy of COPD Exacerbation—Dispensed Systemic Corticosteroid Within 14 Days of Event	507	100.0	285	56.2	222	43.8
Pharmacotherapy of COPD Exacerbation—Dispensed Bronchodilator Within 30 Days of Event	507	100.0	285	56.2	222	43.8
Controlling High Blood Pressure	492	97.0	413	81.5	79	15.6
Persistence of Beta-Blocker Treatment After a Heart Attack	507	100.0	101	19.9	406	80.1
Osteoporosis Management in Women Who Had a Fracture	506	99.8	101	19.9	405	79.9
Antidepressant Medication Management—Acute Phase	507	100.0	283	55.8	224	44.2
Antidepressant Medication Management—Continuation Phase	507	100.0	283	55.8	224	44.2
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days of Discharge	505	99.6	190	37.5	315	62.1
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge	505	99.6	190	37.5	315	62.1
Medication Reconciliation Post-Discharge	506	99.8	447	88.2	59	11.6
Care for Older Adults—Advance Care Planning	506	99.8	487	96.1	19	3.7
Care for Older Adults—Medication Review	506	99.8	487	96.1	19	3.7
Care for Older Adults—Functional Status Assessment	506	99.8	487	96.1	19	3.7
Care for Older Adults—Pain Screening	506	99.8	487	96.1	19	3.7
Board Certification—Family Medicine†	480	94.7	—	—	—	—
Board Certification—Internal Medicine†	480	94.7	—	—	—	—
Board Certification—Geriatrics†	480	94.7	—	—	—	—
Board Certification—Other Physician Specialists†	480	94.7	—	—	—	—
Potentially Harmful Drug-Disease Interactions--History of Falls	506	99.8	289	57.0	217	42.8
Potentially Harmful Drug-Disease Interactions—Dementia	506	99.8	310	61.1	196	38.7
Potentially Harmful Drug-Disease Interactions--Chronic Renal Failure	505	99.6	259	51.1	246	48.5

<sup>8</sup> Two measures, Board Certification and Plan All-Cause Readmissions have a denominator limit of 1 in HEDIS 2018.

Measures	Total Submissions		Denominator $\geq 30^8$		Denominator $< 30$	
	N	%	N	%	N	%
Potentially Harmful Drug-Disease Interactions—Total Rate	506	99.8	382	75.3	124	24.5
Use of High-Risk Medications in the Elderly—At Least One High-Risk Medication	507	100.0	488	96.3	19	3.7
Use of High-Risk Medications in the Elderly—At Least Two Different High-Risk Medications	507	100.0	488	96.3	19	3.7
Plan All-Cause Readmissions (Risk-Adjusted Average $\geq 65$ )	506	99.8	259	51.1	247	48.7
Plan All-Cause Readmissions (Risk-Adjusted Average $< 65$ )	506	99.8	183	36.1	323	63.7

†Denotes no minimum sample size applied to the *Board Certification* measure.

Cells with a dash (—) indicate that there were no data for calculation.

Table 9b. SNP HEDIS 2018 Data Submission—Did Not Report

Measures	DID NOT REPORT CATEGORIES							
	Materially Biased		Chose Not to Report		Benefit Not Offered		Exceeded Tier 3 Validation Limits	
	N	%	N	%	N	%	N	%
Colorectal Cancer Screening	1	0.2	0	0.0	0	0.0	0	0.0
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	1	0.2	0	0.0	0	0.0	0	0.0
Controlling High Blood Pressure	7	1.4	0	0.0	0	0.0	0	0.0
Osteoporosis Management in Women Who Had a Fracture	1	0.2	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	2	0.4	0	0.0
Follow-Up After Hospitalization for Mental Illness--Follow-Up Within 7 Days of Discharge	0	0.0	0	0.0	2	0.4	0	0.0
Medication Reconciliation Post-Discharge	1	0.2	0	0.0	0	0.0	0	0.0
Care for Older Adults--Advance Care Planning	1	0.2	0	0.0	0	0.0	0	0.0
Care for Older Adults--Medication Review	1	0.2	0	0.0	0	0.0	0	0.0
Care for Older Adults--Functional Status Assessment	1	0.2	0	0.0	0	0.0	0	0.0
Care for Older Adults--Pain Screening	1	0.2	0	0.0	0	0.0	0	0.0
Board Certification--Family Medicine	27	5.3	0	0.0	0	0.0	0	0.0
Board Certification--Internal Medicine	27	5.3	0	0.0	0	0.0	0	0.0
Board Certification--Geriatrics	27	5.3	0	0.0	0	0.0	0	0.0
Board Certification--Other Physician Specialists	27	5.3	0	0.0	0	0.0	0	0.0
Potentially Harmful Drug-Disease Interactions--History of Falls*	1	0.2	0	0.0	0	0.0	0	0.0
Potentially Harmful Drug-Disease Interactions--Dementia*	1	0.2	0	0.0	0	0.0	0	0.0
Potentially Harmful Drug-Disease Interactions--Chronic Renal Failure*	2	0.4	0	0.0	0	0.0	0	0.0
Potentially Harmful Drug-Disease Interactions--Total Rate*	1	0.2	0	0.0	0	0.0	0	0.0
Plan All-Cause Readmissions (Risk-Adjusted Average => 65)*	1	0.2	0	0.0	0	0.0	0	0.0
Plan All-Cause Readmissions (Risk-Adjusted Average <65)*	1	0.2	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. Limited results from small plans affects analysis. For HEDIS 2018, there were 694 SNPs participating in the program; 505 were required by CMS to report; and NCQA received 507 submissions. 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 program.

HEDIS reporting guidelines 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 measure, although they had more than 30 enrollees overall and were therefore included in the analysis comparing benefit package performance. SNP overall program performance is included by measure, regardless of enrollment size.

Trend breaks for some measures in the report are the result of year-to-year changes in specifications for reportable measures.

### **HEDIS Exclusions for Nonacute Admissions**

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For clinically appropriate reasons, there are exclusions in some HEDIS measures for enrollees admitted to nonacute inpatient facilities. Therefore, I-SNPs, which should have a higher percentage of membership in facilities, have more enrollees excluded from those measures than other types of plans. Two measures have optional exclusions; one has nonoptional exclusions for enrollees who are admitted to nonacute inpatient facilities. Exclusions apply to all SNP types and to other MA, commercial and Medicaid plans.

- *Controlling High Blood Pressure.* Optional exclusion of enrollees admitted to a nonacute inpatient setting.
- *Persistence of Beta-Blocker Treatment.* Optional exclusion of enrollees hospitalized for AMI but transferred directly to nonacute care facilities for any diagnosis.
- *Follow-Up After Hospitalization for Mental Illness.* Exclude enrollees discharged to nonacute care facilities after being hospitalized for mental illness.

All submissions were reviewed by HEDIS Compliance Auditors, even if there were no enrollees in the measure denominator after the exclusion. I-SNP results 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 health plan performance. 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. 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. NCQA-Certified HEDIS Compliance Auditors verify all measure results using a process designed by NCQA.

Development of a HEDIS measure involves multiple steps of refinement and evaluation. NCQA's Committee on Performance Measurement (CPM), which oversees evolution of the measurement set, 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 measures. Additional HEDIS Expert Panels and the Technical Measurement Advisory Panel (TMAP) identify methodological issues and give 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 2018:

- *Colorectal Cancer Screening<sup>#</sup>.*
- *Care for Older Adults.*
- *Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD).*
- *Pharmacotherapy of COPD Exacerbation.*
- *Controlling High Blood Pressure.*
- *Persistence of Beta-Blocker Treatment After a Heart Attack.*
- *Medication Reconciliation Post-Discharge.*
- *Potentially Harmful Drug-Disease Interactions in the Elderly\*.*
- *Use of High-Risk Medications in the Elderly\*.*
- *Osteoporosis Management in Women Who Had a Fracture.*
- *Antidepressant Medication Management.*
- *Follow-Up After Hospitalization for Mental Illness.*
- *Board Certification.*

- *Plan All-Cause Readmission\**.

\*Lower rate indicates better performance.

Appendix B contains the technical specifications for these measures.

**Note:** *HEDIS 2018 results are reported in 2018 and primarily cover services delivered in 2017.*

### **Data Collection and 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. CMS required SNPs with an enrollment of  $\geq 30$  enrollees as of the CMS February 2017 SNP Comprehensive Report, which has enrollment figures for mid-January 2017, to submit HEDIS 2018 results.

Before data were submitted to NCQA, every SNP benefit package submission underwent a HEDIS Compliance Audit™. The audit consisted 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 HEDIS Auditors reviewed systems, policies and procedures and final data results to ensure that measures were correctly calculated and reported.

## Appendix B: Reporting Plan All-Cause Readmissions

**Reporting Plan All-Cause Readmissions.** In 2017 we modified the display of the *Plan All-Cause Readmissions* measure. The change was made to enhance interpretability of results and put this measure on the same 0%–100% scale as other HEDIS measures. The new display—the calibrated risk-standardized rate—is directly linked to how we historically report data using observed-to-expected (O/E) ratios.

- *Calibration* sets the average O/E ratio as the reference point for each reporting unit to correct for aging of risk weights (NCQA calculates weights on a three-year schedule) and differences between the data sample used to generate risk weights and the population of reporting units (the sample NCQA uses to generate the weights is a non-random sample of all MA reporting units).
- *Risk standardization* rescales the measure from O/E performance to 30-day readmissions. In the example in Table ES.1, the reporting unit has a risk-standardized rate of 16%, which is 11.1% better than the national average performance of 18%.

This approach lets us calculate significance testing for changes in measure performance.

**Table C.1. Calculating the calibrated risk-standardized rate for Plan All-Cause Readmissions.**

Step	Explanation	Example
<b>Step 1</b>	Obtain each reporting unit's O/E ratio.	Assume this unit is $(O/E)_{unit} = 0.8$
<b>Step 2</b>	Calibrate the O/E ratio to the national average O/E: $(O/E)_{calibrated} = (O/E)_{unit} / (O/E)_{Avg.}$	$(O/E)_{Avg.} = 0.9$ $(O/E)_{calibrated.} = 0.8 / 0.9$ $= 0.8889$
<b>Step 3</b>	Calculate the national average observed performance rate. $Observed_{Avg} = \sum Observed_i / N$	Assume the average of all units is: $Observed_{Avg} = 18.0\%$
<b>Step 4</b>	Convert to risk standardized rate. $Rate = (O/E)_{calibrated} \times Observed_{Avg}$	$Rate = 0.8889 \times 18.0\% = 16\%$

## Appendix C: HEDIS 2018 Technical Specifications

This appendix contains the HEDIS 2018 technical specifications for the HEDIS measures that SNPs were required to report.

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## Colorectal Cancer Screening (COL)

### Summary of Changes to HEDIS 2018

- Added required exclusions to the Medicare product line for members 65 years of age and older living long-term in institutional settings.
- Revised the Data Elements for Reporting table to reflect removal of the Final Sample Size (FSS) when reporting using the Hybrid Methodology.

### Description

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

### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 20: Members in Hospice.

<b>Product lines</b>	Commercial, Medicare (report each product line separately).
<b>Ages</b>	51–75 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The measurement year and the year prior to the measurement year.
<b>Allowable gap</b>	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	None.
<b>Required exclusion</b>	Exclude from Medicare reporting members age 65 and older as of January 1 of the measurement year who meet either of the following: <ul style="list-style-type: none"> <li>• Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.</li> <li>• Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Medicare Part C monthly membership file.</li> </ul>

### Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerator</b>	One or more screenings for colorectal cancer. Any of the following meet criteria: <ul style="list-style-type: none"> <li>• 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.</li> </ul>

- 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.
- CT colonography (CT Colonography Value Set) during the measurement year or the four years prior to the measurement year.
- FIT-DNA test (FIT-DNA Value Set) during the measurement year or the two 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.
- CT colonography during the measurement year or the four years prior to the measurement year.
- FIT-DNA during the measurement year or the two 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).

A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria.

For pathology reports that do not indicate the type of screening and for incomplete procedures:

- Evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy.
- Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy.

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (FIT). 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.
- FIT tests may require fewer than three samples. If the medical record indicates that an FIT 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 exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

### **Exclusion (optional)**

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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. Cells with a dash (—) indicate data are not required.

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

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of required exclusions (Medicare only)	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)	—	✓
Current year's administrative rate (before exclusions)	—	✓
Minimum required sample size (MRSS)	—	✓
Oversampling rate	—	✓
Number of oversample records	—	✓
Number of numerator events by administrative data in MRSS	—	✓
Administrative rate on MRSS	—	✓
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	—	✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

## Care for Older Adults (COA)

### Summary of Changes to HEDIS 2018

- Clarified that codes must be on the same claim for the *Medication Review* indicator (*Administrative Specification*).
- Added the continence ADL to the list of acceptable ADLs for medical record documentation of the Functional Status Assessment numerator.
- Clarified that notation alone that cranial nerves were assessed does not meet criteria for the sensory ability component for the Functional Status Assessment numerator.
- Clarified the requirements for the speech component (sensory ability) for the Functional Status Assessment numerator.
- Revised the Data Elements for Reporting table to reflect removal of the Final Sample Size (FSS) when reporting using the Hybrid Methodology.

### 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

<b>Medication list</b>	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.
<b>Medication review</b>	A review of all a member's medications, including prescription medications, OTC medications and herbal or supplemental therapies.

### Eligible Population

**Note:** *Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 20: Members in Hospice.*

<b>Product line</b>	Medicare SNP, MMP.
<b>Ages</b>	66 years and older as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The measurement year.

<b>Allowable gap</b>	No more than one gap in continuous enrollment of up to 45 days during the measurement year.
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	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** Either of the following meet criteria.

- Both of the following on the same claim during the measurement year where the provider type is a prescribing practitioner or clinical pharmacist:
  - At least one medication review (Medication Review Value Set).
  - The presence of a medication list in the medical record (Medication List Value Set).
- Transitional care management services (Transitional Care Management Services Value Set) during the measurement year.

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

**Pain Assessment** At least one pain assessment (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, health care power of attorney, health care proxy).
- **Actionable medical orders.** Written instructions regarding initiating, continuing, withholding or withdrawing specific forms of life-sustaining treatment (e.g., Physician Orders for Life Sustaining Treatment [POLST], Five Wishes).
- **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.
  - Documentation that a provider asked the member if an advance care plan was in place and the member indicated a plan was not in place is not considered a discussion or initiation of a discussion.
- **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. A medication list, signed and dated during the measurement year by the appropriate practitioner type (prescribing practitioner or clinical pharmacist), meets criteria (the practitioner's signature is considered evidence that the medications were reviewed).

**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 one of 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 or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking, continence.
- Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: 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 ADL (B-ADL) Scale.
  - Barthel Index.
  - Extended ADL (EADL) Scale.
  - Independent Living Scale (ILS).
  - Katz Index of Independence in ADL.
  - Kenny Self-Care Evaluation.
  - Klein-Bell ADL Scale.
  - Kohlman Evaluation of Living Skills (KELS).
  - Lawton & Brody’s IADL scales.
  - Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales.

- Notation that at least three of the following four components were assessed:
  - Cognitive status.
  - Ambulation status.
  - Hearing, vision and speech (i.e., sensory ability).
  - 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.

**Note:** Notation alone that cranial nerves were assessed does not meet criteria for the sensory ability component. Documentation of assessment of cranial nerves corresponding specifically to hearing (cranial nerve VIII), vision (cranial nerve II) and speech (cranial nerve XII) with a result or finding meets criteria for this component.

Notation that the member spoke with the provider during a visit (e.g., documentation that states the member “reports,” “denies,” “stated” or “discussed”) does not meet criteria for the speech (sensory ability) component. The intent is to find documentation that the provider performed a qualitative assessment of the member’s speech functioning.

**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 alone of a pain management plan does not meet criteria.
- Notation alone of a pain treatment plan does not meet criteria.
- Notation alone of screening for chest pain or documentation alone of chest pain 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. Cells with a dash (—) indicate data are not required.

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

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	Each of the 4 rates	Each of the 4 rates
Eligible population	Each of the 4 rates	Each of the 4 rates
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)	—	Each of the 4 rates
Oversampling rate	—	Each of the 4 rates
Number of oversample records	—	Each of the 4 rates
Number of numerator events by administrative data in MRSS	—	Each of the 4 rates
Administrative rate on MRSS	—	Each of the 4 rates
Number of original sample records excluded because of valid data errors	—	Each of the 4 rates
Number of employee/dependent medical records excluded	—	Each of the 4 rates
Records added from the oversample list	—	Each of the 4 rates
Denominator	—	Each of the 4 rates
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
Numerator events by supplemental data	Each of the 4 rates	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 2018**

- Clarified how to identify an ED visit or observation visit that resulted in an inpatient stay.

### **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**

<b>Intake Period</b>	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.
<b>IESD</b>	<p>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.</p> <p><i>For an outpatient, observation or ED visit, the IESD is the date of service.</i></p> <p><i>For an acute inpatient discharge, the IESD is the date of discharge.</i></p> <p><i>For an acute inpatient discharge with a direct transfer, the IESD is the discharge date of the original admission.</i></p>
<b>Negative Diagnosis History</b>	<p>The 730 days (2 years) prior to the IESD, when the member had no claims/encounters containing any diagnosis of COPD.</p> <p><i>For an acute inpatient IESD, use the IESD date of admission to determine the 730 days prior to the IESD.</i></p>

### **Eligible Population**

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 20: Members in Hospice.

<b>Product lines</b>	Commercial, Medicaid, Medicare (report each product line separately).
<b>Ages</b>	42 years or older as of December 31 of the measurement year.
<b>Continuous enrollment</b>	730 days (2 years) prior to the IESD through 180 days (6 months) after the IESD.
<b>Allowable gap</b>	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) 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.

**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 any of the following during the Intake Period.

- An outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) with any diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set).
  - Do not include ED visits or observation visits that result in an inpatient stay (Inpatient Stay Value Set). When an ED or observation visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the admission date for the inpatient stay occurs on the ED/observation date of service or one calendar day after. An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.
- An acute inpatient discharge with any diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set). To identify acute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.

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 any of the following during the 730 days prior to the IESD:

- An outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) with any diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set).
  - Do not include ED visits or observation visits that result in an inpatient stay (Inpatient Stay Value Set). When an ED or observation visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the admission date for the inpatient stay occurs on the ED/observation date of service or one calendar day after. An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.
- An acute inpatient discharge with any diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set). To identify acute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.

For an acute inpatient IESD, use the IESD date of admission to determine the 730 days prior to the IESD.

For direct transfers, use the admission date of the original admission to determine the 730 days prior to the IESD.

- 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	✓
Numerator events by supplemental data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

## Pharmacotherapy Management of COPD Exacerbation (PCE)

### Summary of Changes to HEDIS 2018

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

### Description

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

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

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

### Definitions

<b>Intake Period</b>	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.
<b>Episode Date</b>	The date of service for any acute inpatient discharge or ED visit during the Intake Period with a principal diagnosis of COPD.  <i>For an acute inpatient discharge, the Episode Date is the date of discharge.</i>  <i>For direct transfers (to acute or nonacute settings), the Episode Date is the discharge date from the transfer admission.</i>  <i>For an ED visit, the Episode Date is the date of service.</i>
<b>Active prescription</b>	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.  <i>For an acute inpatient stay, the relevant date is the date of admission.</i>  <i>For an ED visit, the relevant date is the date of service.</i>

## Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 20: Members in Hospice.

**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 had either of the following during the Intake Period:
- An ED visit (ED Value Set) with a principal 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 stay (Inpatient Stay Value Set). When an ED visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the admission date for the inpatient stay occurs on the ED date of service or one calendar day after. An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.
  - An acute inpatient discharge with a principal diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set). To identify acute inpatient discharges:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
    3. Identify the discharge date for the stay.
- Step 2** Identify all COPD Episodes. For each member identified in step 1, identify all acute inpatient discharges and ED visits.
- Step 3** Test for direct transfers. For episodes with a direct transfer (to an acute or nonacute setting for any diagnosis, the Episode Date is the discharge date from the last admission.

A **direct transfer** is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify admissions to and discharges from inpatient settings.

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission and discharge dates for the stay.

**Step 4** 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 Episodes that were not excluded 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 (Systemic Corticosteroid Medications List) on or 14 days after the Episode Date. Count systemic corticosteroids that are active on the relevant date.

**Systemic Corticosteroid Medications**

Description	Prescription
Glucocorticoids	<ul style="list-style-type: none"> <li>• Betamethasone</li> <li>• Dexamethasone</li> <li>• Methylprednisolone</li> <li>• Prednisone</li> <li>• Cortisone-acetate</li> <li>• Hydrocortisone</li> <li>• Prednisolone</li> <li>• Triamcinolone</li> </ul>

**Bronchodilator** Dispensed prescription for a bronchodilator (Bronchodilator Medications List) on or 30 days after the Episode Date. Count bronchodilators that are active on the relevant date.

**Bronchodilator Medications**

Description	Prescription
Anticholinergic agents	<ul style="list-style-type: none"> <li>• Albuterol-ipratropium</li> <li>• Ipratropium</li> <li>• Umeclidinium</li> <li>• Acclidinium-bromide</li> <li>• Tiotropium</li> </ul>
Beta 2-agonists	<ul style="list-style-type: none"> <li>• Albuterol</li> <li>• Formoterol-glycopyrrolate</li> <li>• Olodaterol hydrochloride</li> <li>• Arformoterol</li> <li>• Indacaterol</li> <li>• Olodaterol-tiotropium</li> <li>• Budesonide-formoterol</li> <li>• Indacaterol-glycopyrrolate</li> <li>• Pirbuterol</li> <li>• Fluticasone-salmeterol</li> <li>• Levalbuterol</li> <li>• Salmeterol</li> <li>• Fluticasone-vilanterol</li> <li>• Mometasone-formoterol</li> <li>• Umeclidinium-vilanterol</li> <li>• Formoterol</li> <li>• Metaproterenol</li> </ul>
Methylxanthines	<ul style="list-style-type: none"> <li>• Aminophylline</li> <li>• Theophylline</li> <li>• Dyphylline</li> </ul>
Antiasthmatic combinations	<ul style="list-style-type: none"> <li>• Dyphylline-guaifenesin</li> <li>• Guaifenesin-theophylline</li> </ul>

## 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	<i>Each of the 2 rates</i>
Numerator events by supplemental data	<i>Each of the 2 rates</i>
Reported rate	<i>Each of the 2 rates</i>
Lower 95% confidence interval	<i>Each of the 2 rates</i>
Upper 95% confidence interval	<i>Each of the 2 rates</i>

## Controlling High Blood Pressure (CBP)

### Summary of Changes to HEDIS 2018

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

### Description

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

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

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

### Definitions

#### Adequate control

Adequate control is defined as meeting any of the following criteria:

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

#### Representative BP

The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is “not controlled.”

## Eligible Population

**Note:** Members in hospice are excluded from the eligible population. If a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 20: Members in Hospice.

<b>Product lines</b>	Commercial, Medicaid, Medicare (report each product line separately).
<b>Ages</b>	18–85 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	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).
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefit</b>	Medical.
<b>Required exclusion</b>	Exclude from Medicare reporting members age 65 and older as of January 1 of the measurement year who meet either of the following: <ul style="list-style-type: none"> <li>• Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.</li> <li>• Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Medicare Part C monthly membership file.</li> </ul>

**Diabetes Flag for Numerator Assessment** After the Eligible Population is identified, assign each member either a **diabetic** or **not diabetic** flag using only administrative data and the steps below. The flag is used to determine the appropriate BP threshold to use during numerator assessment (the threshold for members with diabetes is different than the threshold for members without diabetes).

**Step 1** Assign a flag of **diabetic** to members identified as diabetic using claim/encounter data or pharmacy data. The organization must use both methods to assign the diabetes flag, but a member only needs to be identified by one method. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

*Claim/encounter data.* Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).

*Pharmacy data.* Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Diabetes Medications List).

**Diabetes Medications**

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empagliflozin-linagliptin • Empagliflozin-metformin	• Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin • Metformin-pioglitazone	• Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin • Sitagliptin-simvastatin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Dulaglutide • Exenatide	• Liraglutide	• Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	• Empagliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

**Step 2** From the members identified in step 1, assign a flag of **not diabetic** to members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year **and** who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

**Note:** Members classified as diabetic in step 1 based on pharmacy data alone and who had a diagnosis of gestational or steroid-induced diabetes as specified above are reclassified as **not diabetic** in this step.

**Step 3** Assign a flag of **not diabetic** to members who were not assigned a flag in step 1 or step 2.

## Hybrid Specification

### Denominator

A systematic sample drawn from the eligible population. 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 anytime during the member's history on or before June 30 of the measurement year:

- Hypertension.
- HTN.
- High BP (HBP).
- Elevated BP (↑BP).
- Borderline HTN.
- Intermittent HTN.
- History of HTN.
- Hypertensive vascular disease (HVD).
- Hyperpiesia.
- Hyperpiesis.
- A diagnosis code for essential hypertension (from the Essential Hypertension Value Set) documented in the medical record.

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 that is not part of the office visit note; see the **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,” “reactive 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.

If the diagnosis of hypertension cannot be confirmed, the member is excluded and replaced by the next member from the oversample.

### 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.

#### 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 a diagnosis of hypertension (Essential Hypertension Value Set) 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 (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year who were flagged with a diagnosis of diabetes and whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year who were flagged as not having a diagnosis of diabetes and whose BP was <150/90 mm Hg.

To determine if the 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 on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.

- Reported by or taken by the member.

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.

**Step 2** Determine numerator compliance based on the following criteria:

- Members 18–59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year who were flagged with a diagnosis of diabetes and whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year who were flagged as not having a diagnosis of diabetes and whose BP was <150/90 mm Hg.

The member is not compliant if the BP reading does not meet the specified threshold or is missing, 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).

**Step 3** A single rate is reported for all three groups. Sum the numerator events from step 2 to obtain the rate.

### Exclusions (optional)

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- 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 female 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 admission during the measurement year. To identify nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the admission date for the stay.

### Note

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- *When confirming the diagnosis of hypertension, the intent is to identify the date when the provider became aware of the hypertension diagnosis and documented the diagnosis of hypertension in the medical record (versus the time the patient acquired hypertension).*
- *Problem lists generally indicate established conditions; to discount undated entries might hinder confirmation of the denominator. If a problem list is found in an office visit note, it would be considered a dated problem list and the date of the visit must be used.*
- *Organizations generally require an oversample of 10 percent–15 percent to meet the MRSS for confirmed cases of hypertension.*
- *Only administrative data should be used to assign the diabetes flag. The intent of the flag is to determine the appropriate BP threshold to use for the member during numerator assessment. The*

only exception is if the member is flagged as a diabetic but medical record evidence contains information that classifies the member as a valid data error. To meet criteria as a valid data error, the medical record must contain no evidence of diabetes and include a notation that refutes the diagnosis, as described in *Substituting Medical Records in the Guidelines for Calculations and Sampling*. In this case, the diabetes flag may be changed to “not diabetic,” but the member may not be removed from the sample.

- *When excluding BP readings from the numerator, the intent is to identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet or a change in medication. For example (this list is just for reference, and is not exhaustive):*
  - *A colonoscopy requires a change in diet (NPO on the day of procedure) and a medication change (a medication is taken to prep the colon).*
  - *Dialysis, infusions and chemotherapy are all therapeutic procedures that require a medication regimen.*
  - *A nebulizer treatment with albuterol is considered a therapeutic procedure that requires a medication regimen (the albuterol).*
  - *Injection of lidocaine prior to mole removal is considered a diagnostic procedure (if the mole is being tested) or a therapeutic procedure (if removal of the mole is the treatment) that requires a change in medication (lidocaine administered for pain control during the procedure).*
  - *A patient forgetting to take regular medications on the day of the procedure is not considered a required change in medication, and therefore the BP reading is eligible.*
- *BP readings taken on the same day that the patient receives a common low-intensity or preventive procedure are eligible for use. For example, the following procedures are considered common low-intensity or preventive (this list is just for reference, and is not exhaustive):*
  - *Vaccinations.*
  - *Injections (e.g., allergy, vitamin B-12, insulin, steroid, toradol, Depo-Provera, testosterone).*
  - *TB test.*
  - *IUD insertion.*
  - *Eye exam with dilating agents.*

**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 required exclusions (Medicare only)	✓
Minimum required sample size (MRSS)	✓
Oversampling rate	✓
Number of oversample records	✓
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 medical records	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

**Note:** Because this is a hybrid only measure and medical record review is required, only the medical record data elements are included in the data reporting table and IDSS.

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

### Summary of Changes to HEDIS 2018

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

### Description

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

### Definition

<b>Treatment days (covered days)</b>	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).
<b>180-day measurement interval</b>	The 180-day period that includes the discharge date and the 179 days after discharge.

### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 20: Members in Hospice.

<b>Product lines</b>	Commercial, Medicaid, Medicare (report each product line separately).
<b>Ages</b>	18 years and older as of December 31 of the measurement year.
<b>Continuous enrollment</b>	Discharge date through 179 days after discharge.
<b>Allowable gap</b>	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).
<b>Anchor date</b>	Discharge date.
<b>Benefit</b>	Medical and pharmacy.
<b>Event/diagnosis</b>	An acute inpatient discharge with any diagnosis of AMI ( <u>AMI Value Set</u> ) from July 1 of the year prior to the measurement year through June 30 of the measurement year. To identify an acute inpatient discharge:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

If a member has more than one episode of AMI that meets the event/ diagnosis criteria, from July 1 of the year prior to the measurement year through June 30 of the measurement year, include only the first discharge.

*Direct transfers to an acute inpatient care setting.* If the member had a direct transfer to an acute inpatient setting (for any diagnosis), use the discharge date from the transfer setting, not the initial discharge. Exclude both the initial discharge and the direct transfer discharge if the transfer discharge occurs after June 30 of the measurement year. Use the instructions below to identify direct transfers and exclude nonacute inpatient stays using the Nonacute Inpatient Stay Value Set (step 2).

*Direct transfers to a nonacute inpatient care setting.* Exclude from the denominator, hospitalizations in which the member had a direct transfer to a nonacute inpatient care setting for any diagnosis. Use the instructions below to identify direct transfers and confirm the stay was for nonacute inpatient care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.

A **direct transfer** is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example: An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.

- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify admissions to and discharges from inpatient settings.

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. If needed, identify nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission and discharge dates for the stay.

### Administrative Specification

**Denominator** The eligible population.

**Numerator** At least 135 days of treatment with beta-blockers (Beta-Blocker Medications List) during the 180-day measurement interval. This allows gaps in medication treatment of up to a total of 45 days during the 180-day measurement interval.

Assess for active prescriptions and include days supply that fall within the 180-day measurement interval. For members who were on beta-blockers prior to admission and those who were dispensed an ambulatory prescription during their inpatient stay, factor those prescriptions into adherence rates if the actual treatment days fall within the 180-day measurement interval.

**Beta-Blocker Medications**

Description	Prescription		
Noncardioselective beta-blockers	<ul style="list-style-type: none"> <li>• Carvedilol</li> <li>• Labetalol</li> <li>• Nadolol</li> </ul>	<ul style="list-style-type: none"> <li>• Penbutolol</li> <li>• Pindolol</li> <li>• Propranolol</li> </ul>	<ul style="list-style-type: none"> <li>• Timolol</li> <li>• Sotalol</li> </ul>
Cardioselective beta-blockers	<ul style="list-style-type: none"> <li>• Acebutolol</li> <li>• Atenolol</li> </ul>	<ul style="list-style-type: none"> <li>• Betaxolol</li> <li>• Bisoprolol</li> </ul>	<ul style="list-style-type: none"> <li>• Metoprolol</li> <li>• Nebivolol</li> </ul>
Antihypertensive combinations	<ul style="list-style-type: none"> <li>• Atenolol-chlorthalidone</li> <li>• Bendroflumethiazide-nadolol</li> <li>• Bisoprolol-hydrochlorothiazide</li> </ul>		<ul style="list-style-type: none"> <li>• Hydrochlorothiazide-metoprolol</li> <li>• Hydrochlorothiazide-propranolol</li> </ul>

**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 ([Asthma Exclusions Medications List](#)).
- Intolerance or allergy to beta-blocker therapy ([Adverse Effect of Beta-Adrenoreceptor Antagonists Value Set](#)).

**Asthma Exclusions Medications**

Description	Prescription	
Bronchodilator combinations	<ul style="list-style-type: none"> <li>• Budesonide-formoterol</li> <li>• Fluticasone-vilanterol</li> </ul>	<ul style="list-style-type: none"> <li>• Fluticasone-salmeterol</li> <li>• Mometasone-formoterol</li> </ul>
Inhaled corticosteroids	<ul style="list-style-type: none"> <li>• Beclomethasone</li> <li>• Budesonide</li> <li>• Ciclesonide</li> </ul>	<ul style="list-style-type: none"> <li>• Flunisolide</li> <li>• Fluticasone</li> <li>• Fluticasone CFC free</li> <li>• Mometasone</li> </ul>

## 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	✓
Number of optional exclusions	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

## Medication Reconciliation Post-Discharge (MRP)

### Summary of Changes to HEDIS 2018

- Clarified in the hybrid specification that the current medication list must be documented in the outpatient medical record.
- Clarified in the hybrid specification that the process the prescribing practitioner, clinical pharmacist or registered nurse uses to identify the member's current medications is outside of the scope of the measure specification.
- Revised the Data Elements for Reporting table to reflect the removal of the Final Sample Size (FSS) when reporting using the Hybrid Methodology.

### Description

The percentage of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

### 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

*Note: Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 20: Members in Hospice.*

<b>Product line</b>	Medicare.
<b>Ages</b>	18 years and older as of December 31 of the measurement year.
<b>Continuous enrollment</b>	Date of discharge through 30 days after discharge (31 total days).
<b>Allowable gap</b>	None.
<b>Anchor date</b>	None.
<b>Benefit</b>	Medical.
<b>Event/ diagnosis</b>	An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. To identify acute and nonacute inpatient discharges: <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Identify the discharge date for the stay.</li> </ol>

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 inpatient care setting on the date of discharge through 30 days after discharge (31 total days), count only the last discharge. To identify readmissions and direct transfers during the 31-day period:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay (the admission date must occur during the 31-day period).
3. Identify the discharge date for the stay (the discharge date is the event date).

Exclude both the initial and the readmission/direct transfer discharges if the last discharge occurs after December 1 of the measurement year.

**Note:** *If a member remains in an acute or nonacute care setting through December 1 of the measurement year, a discharge is not included in the measure for this member, but 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 admitted based only on the absence of a discharge before December 1. If the organization is unable to confirm the member remained in the acute or nonacute care setting through December 1, disregard the readmission or direct transfer and use the initial discharge date.*

### Administrative Specification

**Denominator** The eligible population.

**Numerator** Medication reconciliation (Medication Reconciliation Value Set) conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days after discharge (31 total days).

### 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 the date of discharge through 30 days after discharge (31 total days).

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

**Medical record**

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

- Documentation of the current medications with a notation that the provider reconciled the current and discharge medications.
- Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
- Documentation of the member's current medications with a notation that the discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review.
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
- Notation that no medications were prescribed or ordered upon discharge.
- Only documentation in the outpatient medical record meets the intent of the measure, but an outpatient visit is not required.

**Note**

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- *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.*
- *This measure assesses whether medication reconciliation occurred. It does not attempt to assess the quality of the medication list documented in the medical record or the process used to document the most recent medication list in the medical record.*

**Data Elements for Reporting**

Organizations that submit HEDIS data to NCQA must provide the following data elements. Cells with a dash (—) indicate data are not required.

**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)	—	✓
Oversampling rate	—	✓
Number of oversample records	—	✓
Number of numerator events by administrative data in MRSS	—	✓
Administrative rate on MRSS	—	✓
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	—	✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

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

### Summary of Changes to HEDIS 2018

- Replaced medication table references with references to medication lists.

### 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, SSRIs, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics or tricyclic antidepressants.
- Dementia and a prescription for antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, tricyclic antidepressants, H<sub>2</sub> receptor antagonists 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 rates.

### Definitions

<b>IESD</b>	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.  <i>For an outpatient, observation or ED visit, the IESD is the date of service.</i> <i>For an inpatient stay, the IESD is the discharge date.</i> <i>For dispensed prescriptions, the IESD is the dispense date.</i>
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### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 20: Members in Hospice.

<b>Product line</b>	Medicare.
<b>Age</b>	67 years and older as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The measurement year and the year prior to the measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
<b>Anchor date</b>	Enrolled as of December 31 of the measurement year.

<b>Benefit</b>	Medical and pharmacy.
<b>Event/ diagnosis</b>	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, SSRIs, Antipsychotics, Benzodiazepines, Nonbenzodiazepine Hypnotics 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 any 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](#)) or an ED visit ([ED Value Set](#)) with a hip fracture ([Hip Fractures Value Set](#)).
- An acute or nonacute inpatient discharge with a hip fracture ([Hip Fractures Value Set](#)). To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays ([Inpatient Stay Value Set](#)).
  2. Identify the discharge date for the stay.
  3. Identify the IESD for each member.

**Step 2: Required Exclusions** Exclude members with a diagnosis of psychosis ([Psychosis Value Set](#)), schizophrenia ([Schizophrenia Value Set](#)), bipolar disorder ([Bipolar Disorder Value Set](#); [Other 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, or SSRI ([Potentially Harmful Drugs—Rate 1 Medications List](#)) or antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic antidepressant ([Potentially Harmful Drugs—Rate 1 and Rate 2 Medications List](#)) on or between the IESD and December 31 of the measurement year.

Do not include denied claims.

**Potentially Harmful Drugs—Rate 1 Medications**

Description	Prescription			
Anticonvulsants	<ul style="list-style-type: none"> <li>• Carbamazepine</li> <li>• Clobazam</li> <li>• Divalproex sodium</li> <li>• Ethosuximide</li> <li>• Ethotoin</li> <li>• Ezogabine</li> <li>• Felbamate</li> </ul>	<ul style="list-style-type: none"> <li>• Fosphenytoin</li> <li>• Gabapentin</li> <li>• Lacosamide</li> <li>• Lamotrigine</li> <li>• Levetiracetam</li> <li>• Mephobarbital</li> <li>• Methsuximide</li> </ul>	<ul style="list-style-type: none"> <li>• Oxcarbazepine</li> <li>• Phenobarbital</li> <li>• Phenytoin</li> <li>• Pregabalin</li> <li>• Primidone</li> <li>• Rufinamide</li> <li>• Tiagabine HCL</li> </ul>	<ul style="list-style-type: none"> <li>• Topiramate</li> <li>• Valproate sodium</li> <li>• Valproic acid</li> <li>• Vigabatrin</li> <li>• Zonisamide</li> </ul>
SSRIs	<ul style="list-style-type: none"> <li>• Citalopram</li> <li>• Escitalopram</li> </ul>	<ul style="list-style-type: none"> <li>• Fluoxetine</li> <li>• Fluvoxamine</li> </ul>	<ul style="list-style-type: none"> <li>• Paroxetine</li> <li>• Sertraline</li> </ul>	

**Potentially Harmful Drugs—Rate 1 and Rate 2 Medications**

Description	Prescription			
Antipsychotics	<ul style="list-style-type: none"> <li>• Aripiprazole</li> <li>• Asenapine</li> <li>• Brexpiprazole</li> <li>• Cariprazine</li> <li>• Chlorpromazine</li> <li>• Clozapine</li> <li>• Fluphenazine</li> <li>• Haloperidol</li> </ul>	<ul style="list-style-type: none"> <li>• Iloperidone</li> <li>• Loxapine</li> <li>• Lurasidone</li> <li>• Molindone</li> <li>• Olanzapine</li> <li>• Paliperidone</li> <li>• Perphenazine</li> <li>• Pimozide</li> </ul>	<ul style="list-style-type: none"> <li>• Quetiapine</li> <li>• Risperidone</li> <li>• Thioridazine</li> <li>• Thiothixene</li> <li>• Trifluoperazine</li> <li>• Ziprasidone</li> <li>•</li> </ul>	
Benzodiazepines	<ul style="list-style-type: none"> <li>• Alprazolam</li> <li>• Chlordiazepoxide products</li> <li>• Clonazepam</li> <li>• Clorazepate-dipotassium</li> </ul>	<ul style="list-style-type: none"> <li>• Diazepam</li> <li>• Estazolam</li> <li>• Flurazepam HCL</li> <li>• Lorazepam</li> <li>• Midazolam HCL</li> </ul>	<ul style="list-style-type: none"> <li>• Oxazepam</li> <li>• Quazepam</li> <li>• Temazepam</li> <li>• Triazolam</li> </ul>	
Nonbenzodiazepine hypnotics	<ul style="list-style-type: none"> <li>• Eszopiclone</li> </ul>	<ul style="list-style-type: none"> <li>• Zaleplon</li> </ul>	<ul style="list-style-type: none"> <li>• Zolpidem</li> </ul>	
Tricyclic antidepressants	<ul style="list-style-type: none"> <li>• Amitriptyline</li> <li>• Amoxapine</li> <li>• Clomipramine</li> </ul>	<ul style="list-style-type: none"> <li>• Desipramine</li> <li>• Doxepin (&gt;6 mg)</li> <li>• Imipramine</li> </ul>	<ul style="list-style-type: none"> <li>• Nortriptyline</li> <li>• Protriptyline</li> <li>• Trimipramine</li> </ul>	

**Rate 2: Drug-Disease Interactions—Dementia and Antipsychotics, Benzodiazepines, Nonbenzodiazepine Hypnotics, Tricyclic Antidepressants, H<sub>2</sub> Receptor Antagonists, 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 (Dementia Medications List) 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.

**Dementia Medications**

Description	Prescription
Cholinesterase inhibitors	<ul style="list-style-type: none"> <li>• Donepezil</li> <li>• Galantamine</li> <li>• Rivastigmine</li> </ul>
Miscellaneous central nervous system agents	<ul style="list-style-type: none"> <li>• Memantine</li> </ul>

**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; Other 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 antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic antidepressant (Potentially Harmful Drugs—Rate 1 and Rate 2 Medications List) or H2 receptor antagonist, or anticholinergic agent (Potentially Harmful Drugs—Rate 2 Medications List) on or between the IESD and December 31 of the measurement year.

Do not include denied claims.

**Potentially Harmful Drugs—Rate 2 Medications**

Description	Prescription
H <sub>2</sub> receptor antagonists	<ul style="list-style-type: none"> <li>• Cimetidine</li> <li>• Famotidine</li> <li>• Nizatidine</li> <li>Ranitidine</li> </ul>
Anticholinergic agents, antiemetics	<ul style="list-style-type: none"> <li>• Prochlorperazine</li> <li>• Promethazine</li> </ul>
Anticholinergic agents, antihistamines	<ul style="list-style-type: none"> <li>• Carbinoxamine</li> <li>• Chlorpheniramine</li> <li>• Hydroxyzine</li> <li>• Brompheniramine</li> <li>• Clemastine</li> <li>• Triprolidine</li> <li>• Cyproheptadine</li> <li>• Dimenhydrinate</li> <li>• Diphenhydramine</li> <li>• Meclizine</li> <li>• Dexbrompheniramine</li> <li>• Dexchlorpheniramine</li> <li>• Doxylamine</li> </ul>
Anticholinergic agents, antispasmodics	<ul style="list-style-type: none"> <li>• Atropine</li> <li>• Homatropine</li> <li>• Belladonna alkaloids</li> <li>• Dicyclomine</li> <li>• Hyoscyamine</li> <li>• Propantheline</li> <li>• Scopolamine</li> <li>• Clidinium-chlordiazepoxide</li> </ul>
Anticholinergic agents, antimuscarinics (oral)	<ul style="list-style-type: none"> <li>• Darifenacin</li> <li>• Fesoterodine</li> <li>• Solifenacin</li> <li>• Trospium</li> <li>• Flavoxate</li> <li>• Oxybutynin</li> <li>• Tolterodine</li> </ul>
Anticholinergic agents, anti-Parkinson agents	<ul style="list-style-type: none"> <li>• Benztropine</li> <li>• Trihexyphenidyl</li> </ul>
Anticholinergic agents, skeletal muscle relaxants	<ul style="list-style-type: none"> <li>• Cyclobenzaprine</li> <li>• Orphenadrine</li> </ul>
Anticholinergic agents, SSRIs	<ul style="list-style-type: none"> <li>• Paroxetine</li> </ul>
Anticholinergic agents, antiarrhythmic	<ul style="list-style-type: none"> <li>• Disopyramide</li> </ul>

**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 a Cox-2 selective NSAID or nonaspirin NSAID (Cox-2 Selective NSAIDs and Nonaspirin NSAIDs Medications List) on or between the IESD and December 31 of the measurement year.
- Do not include denied claims.

**Cox-2 Selective NSAIDs and Nonaspirin NSAIDs Medications**

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**

- Although denied claims are not included when assessing the numerators, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population for each rate.

**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
Number of required exclusions	Rate 1, Rate 2 and total
Numerator events by administrative data	For each of the 3 rates and total
Numerator events by supplemental 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 2018

- Replaced medication table references with references to medication lists.

### Description

- The percentage of Medicare members 66 years of age and older who had at least one dispensing event for a high-risk medication.
- The percentage of Medicare members 66 years of age and older who had at least two dispensing events for the same high-risk medication.

For both rates, a lower rate represents better performance.

### Eligible Population

*Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 20: Members in Hospice.*

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

### Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerator 1</b>	<p>Members who received at least one dispensing event for a high-risk medication during the measurement year.</p> <p>Follow the instructions for each medication table below to identify numerator compliance. If a member meets criteria for at least one of the following tables, they are compliant for Numerator 1. Include members who meet criteria for more than one table only once in the numerator.</p> <p>Do not include denied claims.</p> <p><b>High-risk medications</b> Identify members with at least one dispensing event (any days supply) during the measurement year for a medication in the <a href="#">High-Risk Medications List</a>.</p>

**High-risk medications with days supply criteria**

Identify members with a single dispensing event during the measurement year for a medication in the High-Risk Medications With Days Supply Criteria Medications List where days supply exceeds the days supply criteria listed for the medication. Assess each medication class (as identified in the “Description” column) separately. For example, include a member in the numerator who has a single dispensing event for an anti-infective that exceeds the “days supply” criteria and has a single dispensing event for a nonbenzodiazepine hypnotic that exceeds the “days supply” criteria. If a member has multiple dispensing events for an anti-infective, but has a single dispensing event for a nonbenzodiazepine hypnotic that exceeds the “days supply” criteria, include the member in the numerator (for meeting criteria for the nonbenzodiazepine hypnotic).

For medications dispensed during the measurement year include any days supply that extends beyond December 31 of the measurement year. For example, a prescription of a 90-days supply dispensed on December 1 of the measurement year counts as a 90-days supply.

**High-risk medications with average daily dose criteria**

Identify members with a single dispensing event during the measurement year for a medication in the High-Risk Medications With Average Daily Dose Criteria Medications List where average daily dose exceeds the average daily dose criteria listed for the medication. Assess each drug (as identified by the Drug ID field in the Medication List Directory of NDC codes) separately. For example, include a member in the numerator who has a single dispensing event for doxepin that exceeds the “average daily dose” criteria and has a single dispensing event for reserpine that exceeds the “average daily dose criteria.” If a member has multiple dispensing events for doxepin, but has a single dispensing event for reserpine that exceeds the “average daily dose” criteria, include the member in the numerator (for meeting criteria for reserpine).

To calculate average daily dose, multiply the quantity of pills dispensed by the dose of each pill and divide by the days supply. For example, a prescription for a 30-days supply of digoxin containing 15 pills, .250 mg each pill, has an average daily dose of 0.125 mg.

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

Do not round when calculating average daily dose.

**Numerator 2**

Members who received at least two dispensing events for the same high-risk medication during the measurement year.

Follow the instructions for each medication table below to identify numerator compliance. If a member meets criteria for at least one of the following tables, they are compliant for Numerator 2. Include members who meet criteria for more than one table only once in the numerator.

Do not include denied claims.

**High-risk medications**

Identify members with two or more dispensing events (any days supply) on different dates of service during the measurement year for a medication in the High-Risk Medications List. The dispensing events must be *for the same drug* as identified by the Drug ID field in the Medication List Directory of NDC codes.

**High-risk medications with days supply criteria**

For each member, identify all dispensing events during the measurement year for medications in the High-Risk Medications With Days Supply Criteria Medications List. Identify members with two or more dispensing events on different dates of service for medications in the same medication class (as identified in the “Description” column). For example, a prescription for zolpidem and a prescription for zaleplon are considered two dispensing events for medications in the same medication class (these drugs share the same description: nonbenzodiazepine hypnotics).

Sum the days supply for prescriptions in the same medication class. Identify members with two or more dispensing events for medications of the same medication class where the summed days supply exceeds the days supply criteria listed for the medication.

For medications dispensed during the measurement year sum the days supply and include any days supply that extends beyond December 31 of the measurement year. For example, a prescription of a 90-days supply dispensed on December 1 of the measurement year counts as a 90-days supply.

*Note: The intent is to identify all members who had multiple dispensing events where the summed days supply exceeds the days supply criteria; there is no requirement that each dispensing event exceed the days supply criteria.*

**High-risk medications with average daily dose criteria**

For each member, identify all dispensing events during the measurement year for medications in the High-Risk Medications With Average Daily Dose Criteria Medications List where average daily dose exceeds the average daily dose criteria listed for the medication. Identify members with two or more dispensing events on different dates of service that exceed the average daily dose criteria *for the same drug* as identified by the Drug ID field in the Medication List Directory of NDC codes.

To calculate average daily dose for each dispensing event, multiply the quantity of pills dispensed by the dose of each pill and divide by the days supply. For example, a prescription for a 30-days supply of digoxin containing 15 pills, .250 mg each pill, has an average daily dose of 0.125 mg.

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

Do not round when calculating average daily dose.

**High-Risk Medications**

Description	Prescription	
Anticholinergics, first-generation antihistamines	<ul style="list-style-type: none"> <li>• Brompheniramine</li> <li>• Carbinoxamine</li> <li>• Chlorpheniramine</li> <li>• Clemastine</li> <li>• Cyproheptadine</li> <li>• Dexbrompheniramine</li> <li>• Dexchlorpheniramine</li> </ul>	<ul style="list-style-type: none"> <li>• Diphenhydramine (oral)</li> <li>• Dimenhydrinate</li> <li>• Doxylamine</li> <li>• Hydroxyzine</li> <li>• Meclizine</li> <li>• Promethazine</li> <li>• Triprolidine</li> </ul>
Anticholinergics, anti-Parkinson agents	<ul style="list-style-type: none"> <li>• Benztropine (oral)</li> </ul>	<ul style="list-style-type: none"> <li>• Trihexyphenidyl</li> </ul>
Antispasmodics	<ul style="list-style-type: none"> <li>• Atropine (exclude ophthalmic)</li> <li>• Belladonna alkaloids</li> <li>• Clidinium-chlordiazepoxide</li> <li>• Dicyclomine</li> </ul>	<ul style="list-style-type: none"> <li>• Hyoscyamine</li> <li>• Propantheline</li> <li>• Scopolamine</li> </ul>
Antithrombotics	<ul style="list-style-type: none"> <li>• Dipyridamole, oral short-acting (does not apply to the extended-release combination with aspirin)</li> </ul>	<ul style="list-style-type: none"> <li>• Ticlopidine</li> </ul>
Cardiovascular, alpha agonists, central	<ul style="list-style-type: none"> <li>• Guanabenz</li> <li>• Guanfacine</li> </ul>	<ul style="list-style-type: none"> <li>• Methyl dopa</li> <li>•</li> </ul>
Cardiovascular, other	<ul style="list-style-type: none"> <li>• Disopyramide</li> </ul>	<ul style="list-style-type: none"> <li>• Nifedipine, immediate release</li> </ul>
Central nervous system, antidepressants	<ul style="list-style-type: none"> <li>• Amitriptyline</li> <li>• Clomipramine</li> <li>• Amoxapine</li> <li>• Desipramine</li> <li>• Imipramine</li> </ul>	<ul style="list-style-type: none"> <li>• Trimipramine</li> <li>• Nortriptyline</li> <li>• Paroxetine</li> <li>• Protriptyline</li> </ul>
Central nervous system, barbiturates	<ul style="list-style-type: none"> <li>• Amobarbital</li> <li>• Butabarbital</li> <li>• Butalbital</li> <li>• Mephobarbital</li> </ul>	<ul style="list-style-type: none"> <li>• Pentobarbital</li> <li>• Phenobarbital</li> <li>• Secobarbital</li> </ul>
Central nervous system, vasodilators	<ul style="list-style-type: none"> <li>• Ergot mesylates</li> </ul>	<ul style="list-style-type: none"> <li>• Isoxsuprine</li> </ul>
Central nervous system, other	<ul style="list-style-type: none"> <li>• Meprobamate</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
Endocrine system, estrogens with or without progestins; include only oral and topical patch products	<ul style="list-style-type: none"> <li>• Conjugated estrogen</li> <li>• Esterified estrogen</li> </ul>	<ul style="list-style-type: none"> <li>• Estradiol</li> <li>• Estropipate</li> </ul>
Endocrine system, sulfonylureas, long-duration	<ul style="list-style-type: none"> <li>• Chlorpropamide</li> </ul>	<ul style="list-style-type: none"> <li>• Glyburide</li> </ul>
Endocrine system, other	<ul style="list-style-type: none"> <li>• Desiccated thyroid</li> </ul>	<ul style="list-style-type: none"> <li>• Megestrol</li> </ul>
Pain medications, skeletal muscle relaxants	<ul style="list-style-type: none"> <li>• Carisoprodol</li> <li>• Chlorzoxazone</li> <li>• Cyclobenzaprine</li> </ul>	<ul style="list-style-type: none"> <li>• Metaxalone</li> <li>• Methocarbamol</li> <li>• Orphenadrine</li> </ul>
Pain medications, other	<ul style="list-style-type: none"> <li>• Indomethacin</li> <li>• Ketorolac, includes parenteral</li> </ul>	<ul style="list-style-type: none"> <li>• Meperidine</li> <li>• Pentazocine</li> </ul>

**High-Risk Medications With Days Supply Criteria Medications**

Description	Prescription	Days Supply Criteria	
Anti-Infectives, other	<ul style="list-style-type: none"> <li>• Nitrofurantoin</li> <li>• Nitrofurantoin macrocrystals</li> </ul>	<ul style="list-style-type: none"> <li>• Nitrofurantoin macrocrystals-monohydrate</li> </ul>	>90 days
Nonbenzodiazepine hypnotics	<ul style="list-style-type: none"> <li>• Eszopiclone</li> <li>• Zaleplon</li> </ul>	<ul style="list-style-type: none"> <li>• Zolpidem</li> </ul>	>90 days

**High-Risk Medications With Average Daily Dose Criteria Medications**

Description	Prescription	Average Daily Dose Criteria
Alpha agonists, central	<ul style="list-style-type: none"> <li>• Reserpine</li> </ul>	>0.1 mg/day
Cardiovascular, other	<ul style="list-style-type: none"> <li>• Digoxin</li> </ul>	>0.125 mg/day
Tertiary TCAs (as single agent or as part of combination products)	<ul style="list-style-type: none"> <li>• Doxepin</li> </ul>	>6 mg/day

**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	<i>For each of the 2 rates</i>
Numerator events by supplemental data	<i>For each of the 2 rates</i>
Reported rate	<i>For each of the 2 rates</i>
Lower 95% confidence interval	<i>For each of the 2 rates</i>
Upper 95% confidence interval	<i>For each of the 2 rates</i>

## Osteoporosis Management in Women Who Had a Fracture (OMW)

### Summary of Changes to HEDIS 2018

- Replaced medication table references with references to medication lists.
- Clarified how to identify an ED visit or observation visit that resulted in an inpatient stay.
- Clarified the definition of “direct transfer”: when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less.
- Added required exclusions to the Medicare product line for members 65 years of age and older living long-term in institutional settings.

### Description

The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

### Definitions

<b>Intake Period</b>	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.
<b>IESD</b>	Index Episode Start Date. The earliest date of service for any encounter during the Intake Period with a diagnosis of fracture. <i>For an outpatient, observation or ED visit, the IESD is date of service.</i> <i>For an inpatient stay, the IESD is the date of discharge.</i> <i>For direct transfers, the IESD is the discharge date from the last admission.</i>
<b>Negative Diagnosis History</b>	A period of 60 days (2 months) prior to the IESD when the member had no diagnosis of fracture. <i>For fractures requiring an inpatient stay, use the date of admission to determine Negative Diagnosis History.</i> <i>For direct transfers, use the first admission date to determine the Negative Diagnosis History.</i>
<b>Direct transfer</b>	A <b>direct transfer</b> is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example: <ul style="list-style-type: none"> <li>• An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.</li> <li>• An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.</li> <li>• An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.</li> </ul>

Use the following method to identify admissions to and discharges from inpatient settings.

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission and discharge dates for the stay.

**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 service date.

**Eligible Population**

*Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 20: Members in Hospice.*

<b>Product line</b>	Medicare.
<b>Age</b>	Women 67–85 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	12 months (1 year) before the IESD through 180 days (6 months) after the IESD.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.
<b>Anchor date</b>	IESD.
<b>Benefits</b>	Medical and pharmacy.
<b>Event/ diagnosis</b>	The earliest fracture during the Intake Period. Follow the steps below to identify the eligible population.

- Step 1** Identify all members who had either of the following during the Intake Period.
- An outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set), for a fracture (Fractures Value Set).
    - Do not include ED visits or observation visits that result in an inpatient stay (Inpatient Stay Value Set). When an ED or observation visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the admission date for the inpatient stay occurs on the ED/observation date of service or one calendar day after. An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.
  - An acute or nonacute inpatient discharge for a fracture (Fractures Value Set). To identify acute and nonacute inpatient discharges:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Identify the discharge date for the stay.

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

**Step 2** Test for Negative Diagnosis History. Exclude members who had either of the following during the 60-day (2 months) period prior to the IESD.

- An outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) for a fracture (Fractures Value Set).
  - Do not include ED visits or observation visits that result in an inpatient stay (Inpatient Stay Value Set). When an ED or observation visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the admission date for the inpatient stay occurs on the ED/observation date of service or one calendar day after. An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.
- An acute or nonacute inpatient discharge for a fracture (Fractures Value Set). To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
    - *For an acute or nonacute inpatient IESD*, use the IESD date of admission to determine the 60-day period.
    - *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 met any of the following criteria:  
**Required exclusions**

- Members who had a BMD test (Bone Mineral Density Tests Value Set) during the 730 days (24 months) prior to the IESD.
- Members who had a claim/encounter for osteoporosis therapy (Osteoporosis Medications Value Set) during the 365 days (12 months) prior to the IESD.
- Members who received a dispensed prescription or had an active prescription to treat osteoporosis (Osteoporosis Medications List) during the 365 days (12 months) prior to the IESD.
- Members who are enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
- Members living long-term in an institution any time during the measurement year as identified by the LTI flag in the Medicare Part C monthly membership file.
  - Organizations may use the LTI flag in the Medicare Part C monthly membership file.

*For an acute or nonacute inpatient IESD*, use the IESD date of admission to determine the number of days prior to the IESD.

*For direct transfers*, use the first admission date to determine the number of days 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), in any setting, on the IESD or in the 180-day (6-month) period after the IESD.
  - If the IESD was an inpatient stay, a BMD test (Bone Mineral Density Tests Value Set) during the inpatient stay.
  - Osteoporosis therapy (Osteoporosis Medications Value Set) on the IESD or in the 180-day (6-month) period after the IESD.
  - If the IESD was an inpatient stay, long-acting osteoporosis therapy (Long-Acting Osteoporosis Medications Value Set) during the inpatient stay.
  - A dispensed prescription to treat osteoporosis (Osteoporosis Medications List) on the IESD or in the 180-day (6-month) period after the IESD.

**Osteoporosis Medications**

Description	Prescription
Biphosphonates	<ul style="list-style-type: none"> <li>• Alendronate</li> <li>• Alendronate-cholecalciferol</li> <li>• Ibandronate</li> <li>• Risedronate</li> <li>• Zoledronic acid</li> </ul>
Other agents	<ul style="list-style-type: none"> <li>• Calcitonin</li> <li>• Denosumab</li> <li>• Raloxifene</li> <li>• Teriparatide</li> </ul>

**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	✓
Number of required exclusions	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

## Antidepressant Medication Management (AMM)

### Summary of Changes to HEDIS 2018

- Replaced medication table references with references to medication lists.
- Added telehealth modifiers and telephone visits to the required exclusions (step 2).

### Description

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

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

### Definitions

<b>Intake Period</b>	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.
<b>IPSD</b>	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
<b>Negative Medication History</b>	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.
<b>Treatment days</b>	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

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 20: Members in Hospice.

<b>Product lines</b>	Commercial, Medicaid, Medicare (report each product line separately).
<b>Ages</b>	18 years and older as of April 30 of the measurement year.
<b>Continuous enrollment</b>	105 days prior to the IPSD through 231 days after the IPSD.
<b>Allowable gap</b>	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).

<b>Anchor date</b>	IPSD.
<b>Benefits</b>	Medical and pharmacy.
<b>Event/diagnosis</b>	Follow the steps below to identify the eligible population, which is used for both rates.
<b>Step 1</b>	Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication ( <u>Antidepressant Medications List</u> ) during the Intake Period.
<b>Step 2: Required exclusion</b>	<p>Exclude members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population:</p> <ul style="list-style-type: none"> <li>• An outpatient visit, ED visit, telehealth, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Any of the following code combinations meet criteria: <ul style="list-style-type: none"> <li>– <u>AMM Stand Alone Visits Value Set with Major Depression Value Set</u>, with or without a telehealth modifier (<u>Telehealth Modifier Value Set</u>).</li> <li>– <u>AMM Visits Value Set with AMM POS Value Set with Major Depression Value Set</u>, with or without a telehealth modifier (<u>Telehealth Modifier Value Set</u>).</li> <li>– <u>Telephone Visits Value Set with Major Depression Value Set</u>.</li> <li>– <u>ED Value Set with Major Depression Value Set</u>.</li> </ul> </li> <li>• An acute or nonacute inpatient stay with any diagnosis of major depression (<u>Major Depression Value Set</u>). To identify acute and nonacute inpatient stays: <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.</li> </ol> </li> </ul>
<b>Step 3</b>	Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD.
<b>Step 4</b>	Calculate continuous enrollment. Members must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

**Administrative Specification**

<b>Denominator</b>	The eligible population.
<b>Numerators</b>	
<b>Effective Acute Phase Treatment</b>	At least 84 days (12 weeks) of treatment with antidepressant medication ( <u>Antidepressant Medications List</u> ), beginning on the IPSD through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

**Antidepressant Medications**

Description	Prescription		
Miscellaneous antidepressants	• Bupropion	• Vilazodone	• Vortioxetine
Monoamine oxidase inhibitors	• Isocarboxazid • Phenelzine	• Selegiline • Tranylcypromine	
Phenylpiperazine antidepressants	• Nefazodone	• Trazodone	
Psychotherapeutic combinations	• Amitriptyline-chlordiazepoxide • Amitriptyline-perphenazine		• Fluoxetine-olanzapine
SNRI antidepressants	• Desvenlafaxine • Duloxetine	• Levomilnacipran • Venlafaxine	
SSRI antidepressants	• Citalopram • Escitalopram	• Fluoxetine • Fluvoxamine	• Paroxetine • Sertraline
Tetracyclic antidepressants	• Maprotiline	• Mirtazapine	
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin (>6 mg) • Imipramine	• Nortriptyline • Protriptyline • Trimipramine

**Effective Continuation Phase Treatment** At least 180 days (6 months) of treatment with antidepressant medication (Antidepressant Medications List), beginning on the IPSD through 231 days after the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

**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.

**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**

	<b>Administrative</b>
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Number of required exclusions	✓
Numerator events by administrative data	<i>Each of the 2 rates</i>
Numerator events by supplemental data	<i>Each of the 2 rates</i>
Reported rate	<i>Each of the 2 rates</i>
Lower 95% confidence interval	<i>Each of the 2 rates</i>
Upper 95% confidence interval	<i>Each of the 2 rates</i>

## Follow-Up After Hospitalization for Mental Illness (FUH)

### Summary of Changes to HEDIS 2018

- Revised the measure to no longer include visits that occur on the date of discharge.
- Added telehealth modifiers to the numerators.

### 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 a follow-up visit with a mental health practitioner. Two rates are reported:

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

### Eligible Population

*Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 20: Members in Hospice.*

<b>Product lines</b>	Commercial, Medicaid, Medicare (report each product line separately).
<b>Ages</b>	6 years and older as of the date of discharge.
<b>Continuous enrollment</b>	Date of discharge through 30 days after discharge.
<b>Allowable gap</b>	No gaps in enrollment.
<b>Anchor date</b>	None.
<b>Benefits</b>	Medical and mental health (inpatient and outpatient).
<b>Event/diagnosis</b>	<p>An acute inpatient discharge with a principal diagnosis of mental illness (<u>Mental Illness Value Set</u>) on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the discharge date for the stay.</li> </ol> <p>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.</p>
<b>Acute readmission or direct transfer</b>	If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal mental health diagnosis ( <u>Mental Health Diagnosis Value Set</u> ) within the 30-day follow-up period, count only the last discharge. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

To identify readmissions and direct transfers to an acute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

**Exclusions** Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the admission date for the stay.

Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions and direct transfers to an acute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

### Administrative Specification

**Denominator** The eligible population.

#### Numerators

**30-Day Follow-Up** A follow-up visit with a mental health practitioner within 30 days after discharge. Do not include visits that occur on the date of discharge.

**7-Day Follow-Up** A follow-up visit with a mental health practitioner within 7 days after discharge. Do not include visits 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, with or without a telehealth modifier (Telehealth Modifier Value Set).
- A visit (FUH Visits Group 1 Value Set with FUH POS Group 1 Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set).
- A visit (FUH Visits Group 2 Value Set with FUH POS Group 2 Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set).
- A visit in a behavioral healthcare setting (FUH RevCodes Group 1 Value Set).

- A visit in a nonbehavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a mental health practitioner.
- A visit in a nonbehavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set).
- Transitional care management services (Transitional Care Management Services Value Set), with or without a telehealth modifier (Telehealth Modifier 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
Numerator events by supplemental 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 2018

- 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.
- Pediatricians.
- Geriatricians.
- Internal medicine physicians.
- OB/GYN physicians.
- 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.
    - Hospitalists.
    - Radiologists.
    - Neonatologists.
    - Anesthesiologists.
    - 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. Count physicians listed under more than one category as many times as they are listed, and in each area of practice. For example, count a family medicine physician who also practices as a geriatrician in both the *Family Medicine* category and 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

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

- *Count as board certified:* A physician with recent board certification who has not completed a residency/fellowship.
- *Do not count as board certified:* A physician for whom there is confirmation by the appropriate certifying body that the physician is eligible for and has applied to a board-certification program.

### 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 2018

- Added the Medicaid product line.
- Replaced all references to “Average Adjusted Probability of Readmission” with “Expected Readmissions Rate.”
- Clarified the definition of “direct transfer”: when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less.
- Clarified in step 2 of the denominator (acute-to-acute direct transfers) that stays are excluded if the direct transfer’s discharge date is after December 1 of the measurement year.
- Clarified that the pregnancy required exclusion in step 4 of the denominator and step 3 of the numerator should be applied to female members.
- Added instructions to calculate the expected count of readmissions in step 6 of the Risk Adjustment Weighting.
- Added a note to step 3 of the numerator.
- Added a *Note* section.
- Added Count of Expected 30-day Readmissions as a data element to Table PCR-1 and Table PCR 2/3.

### Description

For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned 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. Expected Readmissions Rate.

**Note:** For commercial and Medicaid, report only members 18–64 years of age.

### Definitions

<b>IHS</b>	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.
<b>Index Admission Date</b>	The IHS admission date.
<b>Index Discharge Date</b>	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
<b>Index Readmission Stay</b>	An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.

<b>Index Readmission Date</b>	The admission date associated with the Index Readmission Stay.
<b>Planned Hospital Stay</b>	A hospital stay is considered planned if it meets criteria as described in step 5 (required exclusions) of the <i>Eligible Population</i> .
<b>Members with High Frequency of Index Hospital Stays</b>	Medicaid members with four or more index hospital stays on or between January 1 and December 1 of the measurement year.
<b>Classification Period</b>	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-MD-DischCC-Weight	Medicaid 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-MD-ComorbHCC-Weight	Medicaid 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
PCR-MD-OtherWeights	Medicaid 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, 2017, and posted to [www.ncqa.org](http://www.ncqa.org).

## Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 20: Members in Hospice.

<b>Product line</b>	Commercial, Medicare, Medicaid (report each product line separately).  <i>For only Medicaid, report the following stratifications and total for each age category:</i> <ul style="list-style-type: none"> <li>• Members with 1-3 Index Hospital Stays.</li> <li>• Members with 4+ Index Hospital Stays.</li> <li>• Total.</li> </ul>
<b>Ages</b>	<i>For commercial, ages 18–64 as of the Index Discharge Date.</i> <i>For Medicare, ages 18 and older as of the Index Discharge Date.</i> <i>For Medicaid, 18–64 years as of the Index Discharge Date.</i>
<b>Continuous enrollment</b>	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
<b>Allowable gap</b>	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.
<b>Anchor date</b>	Index Discharge Date.
<b>Benefit</b>	Medical.
<b>Event/ diagnosis</b>	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.  Follow the steps below to identify acute inpatient stays.

## Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Step 1</b>	Identify all acute inpatient discharges on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the discharge date for the stay.</li> </ol> <p>Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays.</p> <p>The measure includes acute discharges from any type of facility (including behavioral healthcare facilities).</p>

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

A **direct transfer** is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify acute-to-acute direct transfers:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission and discharge dates for the stay.

Exclude the hospital stay if the direct transfer's discharge date occurs after December 1 of the measurement year.

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

**Step 4:  
Required  
exclusions** Exclude hospital stays for the following reasons:

- The member died during the stay.
- Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

**Note:** For hospital stays where there was an acute-to-acute direct transfer (identified in step 2), use both the original stay and the direct transfer stay to identify exclusions in this step.

**Step 5:  
Required  
exclusions** For all acute inpatient discharges identified using steps 1–4, determine if there was a planned hospital stay within 30 days after the acute inpatient discharge. To identify planned hospital stays: identify all acute inpatient discharges on or between January 3 and December 31 of the measurement year:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.
4. Exclude any hospital stay as an Index Hospital Stay if the admission date of the **first** stay within 30 days meets any of the following criteria:
  - A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set).
  - A principal diagnosis of rehabilitation (Rehabilitation Value Set).

- An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set).
- A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

**Note:** For hospital stays where there was an acute-to-acute direct transfer (identified in step 2), use only the original stay to identify planned hospital stays in this step (i.e., do not use diagnoses and procedures from the direct transfer stay).

**Example 1** For a member with the following acute inpatient stays, exclude stay 1 as an Index Hospital Stay.

- Stay 1 (January 30–February 1 of the measurement year): Acute inpatient discharge with a principal diagnosis of COPD.
- Stay 2 (February 5–7 of the measurement year): Acute inpatient discharge with a principal diagnosis of maintenance chemotherapy.

**Example 2** For a member with the following acute inpatient stays, exclude stays 2 and 3 as Index Hospital Stays in the following scenario.

- Stay 1 (January 15–17 of the measurement year): Acute inpatient discharge with a principal diagnosis of diabetes.
- Stay 2 (January 30–February 1 of the measurement year): Acute inpatient discharge with a principal diagnosis of COPD.
- Stay 3 (February 5–7 of the measurement year): Acute inpatient discharge with an organ transplant.
- Stay 4 (February 10–15 of the measurement year): Acute inpatient discharge with a principal diagnosis of rehabilitation.

**Step 6** Calculate continuous enrollment.

**Step 7** Assign each acute inpatient stay to an age and stratification category using the *Reporting: Denominator* section. Refer to Table PCR-1, and Table PCR-2/3.

### Risk Adjustment Determination

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

<b>Surgeries</b>	Determine if the member underwent surgery during the inpatient stay. Download the list of codes from the NCQA website (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.
<b>Discharge Condition</b>	Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its primary discharge diagnosis, using Table PCR-DischCC. For acute-to-acute direct transfers, use the direct transfer's primary discharge diagnosis.  Exclude diagnoses that cannot be mapped to Table PCR-DischCC.
<b>Comorbidities</b>	Refer to the <i>Utilization Risk Adjustment Determination</i> in the <i>Guidelines for Risk Adjusted Utilization Measures</i> .

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## Risk Adjustment Weighting

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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, 2016.

**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.
- For Medicaid product lines: Use Table PCR-Medicaid-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.
- For Medicaid product lines: Use Table PCR-Medicaid-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.
- For Medicaid product lines: Use Table PCR-Medicaid-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).

**Expected count of readmissions.** Report the final expected count of readmissions for each age using the sum of all weights for each IHS from step 6. Round to four decimal places using the 0.5 rule and enter these values into the reporting table.

$$\text{Expected count of readmissions} = e^{(\sum \text{WeightsForIHS})}$$

**Step 7** Use the formula below to calculate the Expected Readmissions Rate based on the sum of the weights for each IHS.

$$\text{Expected Readmissions Rate} = \frac{e^{(\sum \text{WeightsForIHS})}}{1 + e^{(\sum \text{WeightsForIHS})}}$$

**OR**

Expected Readmissions Rate = [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 Expected Readmissions Rate calculated in step 7 to calculate the variance for each IHS.

$$\text{Variance} = \text{Expected Readmissions Rate} \times (1 - \text{Expected Readmissions Rate})$$

Example: If the Expected Readmissions Rate 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 cohort and age 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	Expected Readmission Count	Expected Readmission Rate	Variance
								Category	Weight	Category	Weight				
1250	1	-1.08883	67	Female	0.1000	-0.2800	250.4	15	0.0700	20	0.1400	-0.8600	0.4232	0.2976	0.2090
										25	0.2000				
4010	1	-1.08883	50	Male	0.1200	NA	007.4	5	0.0300	NA	NA	-0.9400	0.3906	0.2811	0.2021
4010	2	-1.08883	50	Male	0.1200	NA	298.00	77	0.0600	5	0.0100	-0.5700	0.5655	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 3 and December 31 of the measurement year. To identify acute inpatient admissions:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays. If an organization consolidates these stays into a single event (for any reason), the original distinct inpatient stays must be used.

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

A **direct transfer** is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify acute-to-acute direct transfers:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission and discharge dates for the stay.

**Step 3** Exclude acute inpatient hospital admissions for female members with a principal diagnosis of pregnancy (Pregnancy Value Set) or for any member (any gender) with a principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).

**Note:** For hospital stays where there was an acute-to-acute direct transfer (identified in step 2), use both the original stay and the direct transfer stay to identify exclusions in this step.

**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**

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

### **Reporting: Stratification (Medicaid only)**

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**Step 1** Determine the member's number of index hospital stays in only the Medicaid product line. Report Medicaid index hospital stays for members in one of these categories:

- Member had 1-3 index hospital stays attributed to Medicaid.
- Member had 4+ index hospital stays attributed to Medicaid.

**Step 2** Report Medicaid discharges based on the member's high frequency hospitalization status for each Medicaid index hospital stay.

### **Reporting: Risk Adjustment**

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**Step 1** Calculate the expected readmissions rate for each IHS for each stratification (Medicaid only), each age group and the overall total.

Organizations must calculate the probability of readmission for each hospital stay within the applicable stratification and age group to calculate the average (which is reported to NCQA).

**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 commercial and Medicare:
  - Identify all IHS by 18–44 year-olds and calculate the expected readmissions rate.
  - Identify all IHS by 44–54 year-olds and calculate the expected readmissions rate.
  - Identify all IHS by all 55–64 year-olds and calculate the expected readmissions rate.

- For Medicaid, in the first stratification (members with 1-3 index hospital stays per year):
  - Identify all IHS by 18–44 year-olds and calculate the expected readmissions rate.
  - Identify all IHS by 44–54 year-olds and calculate the expected readmissions rate.
  - Identify all IHS by all 55–64 year-olds and calculate the expected readmissions rate.

Repeat for each subsequent stratification and age group.

**Step 3** Calculate the total (sum) variance for each stratification (Medicaid only) and age.

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

***Reporting: Numerator***

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

***Reporting: Count of Expected Readmissions***

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

***Note***

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- *Because supplemental data may not be used to identify the eligible population, and the same events are used for the denominator and numerator, supplemental data may not be used for this measure.*

Table PCR-1: Plan All-Cause Readmissions Rates by Stratum (High Frequency Hospitalization) and Age (Medicaid, 18-64)

Stratum	Age	Count of Index Stays (Den)	Count of 30-Day Readmissions (Numerator)	Observed Readmission Rate (Num/Den)	Count of Expected 30-Day Readmissions	Expected Readmissions Rate (Expected Readmissions/Den)	Total Variance	O/E Ratio (Observed Readmissions/Expected Readmissions)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
Index Stays for people with 1-3 Index Stays per Year	18-44	_____	_____	_____	_____	_____	_____	_____	_____	_____
Index Stays for people with 1-3 Index Stays per Year	45-54	_____	_____	_____	_____	_____	_____	_____	_____	_____
Index Stays for people with 1-3 Index Stays per Year	55-64	_____	_____	_____	_____	_____	_____	_____	_____	_____
Total, Index Stays for people with 1-3 Index Stays per Year	<b>Total</b>									
Index Stays for people with 4+ Index Stays per Year	18-44	_____	_____	_____	_____	_____	_____	_____	_____	_____
Index Stays for people with 4+ Index Stays per Year	45-54	_____	_____	_____	_____	_____	_____	_____	_____	_____
Index Stays for people with 4+ Index Stays per Year	55-64	_____	_____	_____	_____	_____	_____	_____	_____	_____
Total, Index Stays for people with 4+ Index Stays per Year Disability	Total									

Stratum	Age	Count of Index Stays (Den)	Count of 30-Day Readmissions (Numerator)	Observed Readmission Rate (Num/Den)	Count of Expected 30-Day Readmissions	Expected Readmissions Rate (Expected Readmissions/Den)	Total Variance	O/E Ratio (Observed Readmissions/Expected Readmissions)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
Total	18-44									
Total	45-54									
Total	55-64									
Total	Total									

Table PCR-A-2/3: Plan All-Cause Readmissions Rates by Age and Risk Adjustment (commercial and Medicare)

Age	Count of Index Stays (Denominator)	Count of Observed 30-Day Readmissions (Numerator)	Observed Readmissions Rate (Num/Den)	Count of Expected 30-Day Readmissions	Expected Readmissions Rate (Expected Readmissions/Den)	Total Variance (O/E)	O/E Ratio (Observed Readmissions/Expected Readmissions)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
18-44	_____	_____	_____	_____	_____	_____	_____	_____	_____
45-54	_____	_____	_____	_____	_____	_____	_____	_____	_____
55-64	_____	_____	_____	_____	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____	_____	_____	_____	_____

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

Age	Count of Index Stays (Denominator)	Count of Observed 30-Day Readmissions (Numerator)	Observed Readmissions Rate (Num/Den)	Count of Expected 30-Day Readmissions	Expected Readmissions Rate (Expected Readmissions/Den)	Total Variance (O/E)	O/E Ratio (Observed Readmissions/Expected Readmissions)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
65-74	_____	_____	_____	_____	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____	_____	_____	_____	_____

