Improving Quality and Patient Experience

THE STATE OF HEALTH CARE QUALITY 2013

NCQA
Measuring quality.
Improving health care.

Improving Quality and Patient Experience

THE STATE OF HEALTH CARE QUALITY 2013

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† *As part of the Pediatric Quality Measures Program, states are working with AHRQ and CMS to report Children's Initial Core Set measures at the state level in order to assess the quality of Medicaid and CHIP. These measures are in the Children's Initial Core Set.*

INTRODUCTION

NCQA produces *The State of Health Care Quality Report* every year to call attention to key quality issues the United States faces and to drive improvement in the delivery of evidence-based medicine. This report documents performance trends over time, tracks variation in care and recommends quality improvements.

Thousands of consumers, health insurance executives, benefits managers, policy makers, academics, consultants and journalists read this report. More than 1,000 health plans voluntarily disclose the clinical quality, customer experience and resource use data that are the report's foundation. All data are rigorously audited. Consumer experience information is independently collected and verified.

We commend all the health plans that contributed data for this report, and for the commitment to accountability and quality improvement they show by disclosing their performance.

Electronic copies of this report are available free of charge at NCQA's Web site, www.ncqa.org.

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We appreciate your interest in these topics and we welcome your feedback. You can reach us at **communications@ncqa.org**.

EXECUTIVE SUMMARY

NCQA's 2013 *State of Health Care Quality Report* summarizes Healthcare Effectiveness Data and Information Set (HEDIS) results from calendar year 2012 from health plans covering a record 136 million people, or 43 percent of the U.S. population.

The 2013 report's key discoveries:

- Stagnant or declining performance in appropriate use of antibiotics.
- Continued improvement in childhood obesity measures.
- Mixed results regarding childhood immunization.
- Sustained decline in initiation of alcohol and drug treatment.
- Better experience of care in Medicaid HMOs.

The State of Health Care Quality Report comes at a pivotal time, amid implementation of the Affordable Care Act (ACA) and that law's diverse effects on access and quality. On October 1, consumers began shopping for health care coverage on Exchanges (Marketplaces), available in each state. Medicare and Medicaid payment initiatives continue to advance, calling on health plans and providers to improve quality while reducing waste and overuse.

Findings

Corroborating CDC Concerns on Antibiotics

The September 2013 CDC report, *Antibiotic Resistance Threats in the United States, 2013*, documents antibiotic-resistant bacteria as a public health menace that sickens 2 million people and kills 23,000 every year in the U.S. The CDC noted that such infections can increase hospitalizations and require extensive treatment, adding "considerable and avoidable" costs to the health care system.

The latest HEDIS results show little or no progress on overuse of antibiotics, the main cause of antibiotic resistance.

Rates on the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* HEDIS measure are strikingly and perpetually low. (This measure is not one where low rates indicate better

performance.) In seven years, the rate has never exceeded 30 percent in any product line. Performance in 2012 was essentially flat, compared with the year before.

Over five years, the only statistically significant changes have been performance declines. The commercial HMO rate fell from 28.7 percent in 2006 to 24.6 percent in 2012. The commercial PPO rate fell from 29.3 percent to 21.4 percent in the same period. The child version of this measure, *Appropriate Treatment for Children With Upper Respiratory Infection,* has higher performance, but also has not improved.

NCQA applauds the CDC for calling attention to the urgent problem of inappropriate use of antibiotics. We also remind clinicians that quality health care involves bringing sound science to bear for the good of individuals and populations. That includes prescribing antibiotics only when indicated.

Improvement in Childhood Obesity Measures

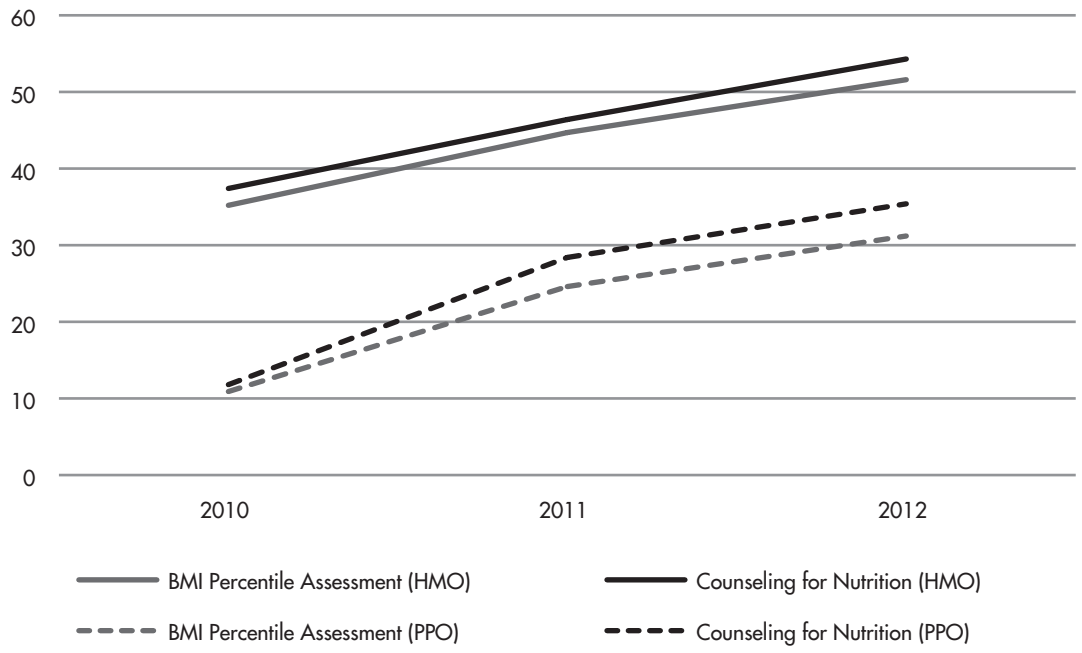
Measures related to childhood obesity have improved for the second year in a row.

Reducing obesity starts with determining its prevalence, something that measuring children's body mass index (BMI) helps accomplish. *BMI Percentile Assessment (3–17 Years)* improved for the second consecutive year by double-digit percentages across all product lines.

For the first time, the "right" thing happened in more than half of cases: the proportion of children enrolled in commercial and Medicaid HMOs who got the recommended BMI assessments exceeded 50 percent. Rates for *BMI Percentile Assessment (3–17 Years)* rose 6.8 percentage points in commercial HMOs, to 51.6, and 5.8 percentage points in Medicaid HMOs, to 51.8.

Results for a measure evaluating whether health care providers counseled children on proper nutrition increased for both Medicaid and commercial product lines. A measure of whether health care providers advised children on physical activity also saw marked improvement across all product lines, especially in commercial HMOs, where the rate climbed 7.4 percentage points, to 50.4. To an extent, these gains might be the result of a change in reporting methods: better data collection techniques often drive improvements in new measures such as these.

MEASURES RELATED TO CHILDHOOD OBESITY



Nevertheless, recent news that childhood obesity is dropping reinforces the optimism we take from these results. We see encouraging confirmation that the health care system is responding to the grave threat posed by childhood obesity to the nation's long-term health. Reducing childhood obesity requires many sectors of the economy to do their part. We are encouraged to see the health care system embrace its role in this important, collaborative effort.

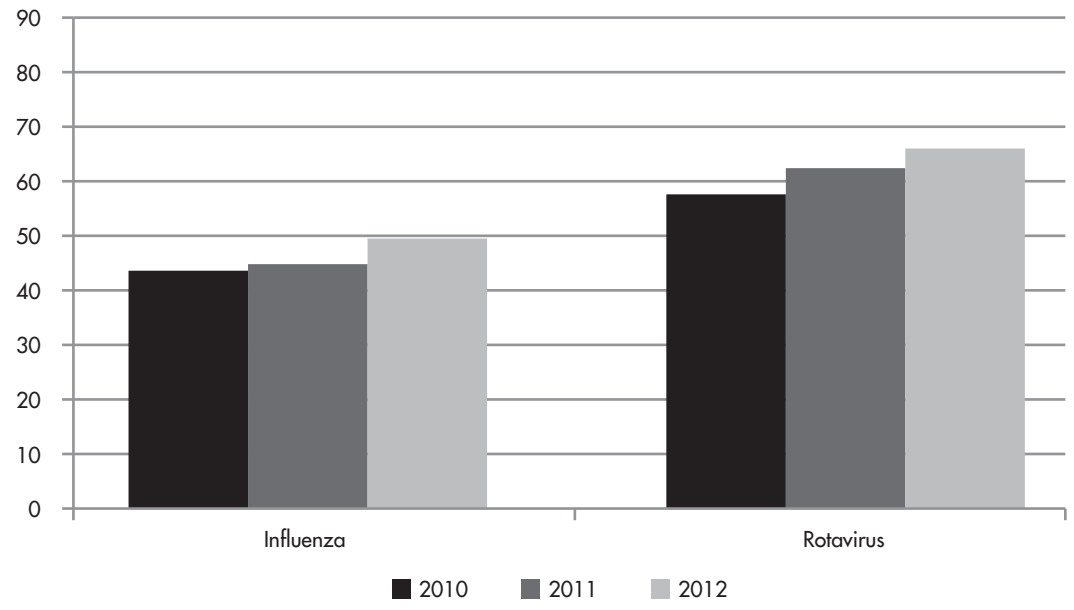
Good, and Not-So-Good, News on Childhood Vaccinations

Many diseases, such as polio and mumps, are at their lowest levels in U.S. history because of high immunization rates among children. Vaccines work best when they are given at recommended ages, especially during early childhood.

We are encouraged that childhood immunization rates for flu and rotavirus have increased in commercial and Medicaid HMOs.

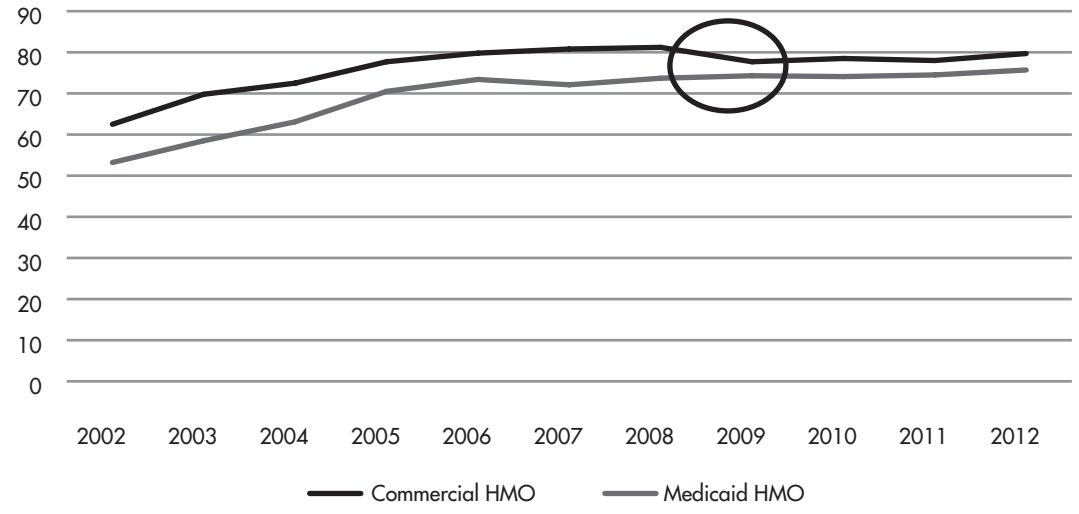
- Since 2010, improvements in *Childhood Immunization Status–Influenza* include the 6.2 percentage point increase in commercial HMOs, to 63.3, and the 8.7 percentage point increase in commercial PPOs, to 59.8. A 5.9 point increase brought the Medicaid HMO rate to 49.5 over the same period.
- The rotavirus causes inflammation of the stomach and intestines, causing severe diarrhea in babies and young children. Since 2010, *Childhood Immunization Status—Rotavirus* the rotavirus immunization rate has risen by 13.2 percentage points in commercial HMOs, to 76.7, and by 17.9 points in commercial PPOs, to 69.8. Two-thirds of children in Medicaid HMOs who met the rotavirus immunization eligibility criteria received the vaccination in 2012, an 8.4 point increase over three years.

IMPROVING CHILDHOOD IMMUNIZATION STATUS (MEDICAID HMOS)



Because childhood vaccination is so important, we continue to be concerned that the sudden drop we reported three years ago, of Combination 2 vaccination rates in commercial plans, has not fully reversed. The alarming decline of 3.5 percentage points in 2009, to 77.7, was the first decrease in the history of the measure. By contrast, the Medicaid rate increased .6 percentage points that year, to 74.3.

COMBINATION 2 IMMUNIZATION HAS NOT RECOVERED



We suggested at the time commercial and Medicaid vaccination rates were headed in opposite directions because parents in commercial plans may have been more likely to refuse vaccines for their children based on misinformation—found on the Internet and promulgated by some celebrities—that vaccines cause autism. The Combination 2 rate in commercial plans still has not returned to its 2008 high, whereas the Medicaid rate has continued its steady improvement.

Myths relating vaccines to autism have been further discredited in recent years. In a widely publicized rebuke of the anti-vaccine movement, in 2010 the British medical journal *The Lancet* retracted a seminal research paper linking vaccines to autism.

We call on health care professionals to remain committed to medical evidence and public health by supporting vaccination and discrediting untruths that harm children. Clinicians play a vital role engaging and educating parents on the importance of having their children vaccinated.

Continued Improvement in Medicare

Performance continues to improve in measures that are part of the Medicare Star Ratings pay-for-performance program.

In 2012, Medicare began making higher payments to health plans with better quality performance. Payments to high-performing plans by a Department of Health and Human Services demonstration project are also part of the much-needed transition from a health care system that rewards volume, to one that rewards value.

Measures where we see the largest gains are in the table below.

NOTABLE IMPROVEMENTS IN MEDICARE HMOS

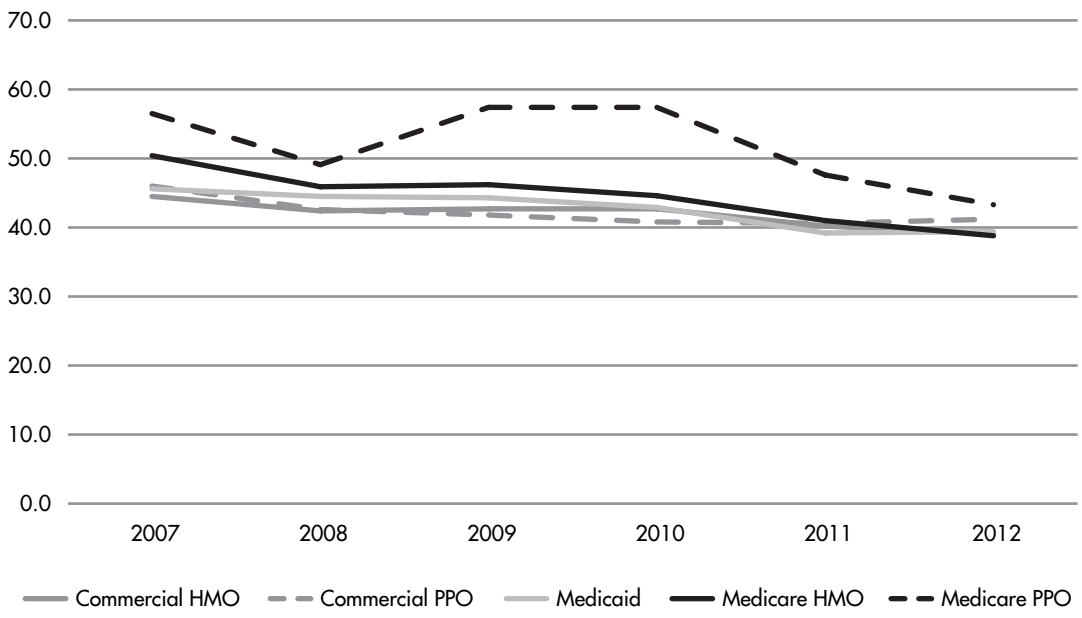
Measure	2010	2011	2012
Colorectal Cancer Screening	57.6	60.0	62.1
Persistence of Beta-Blocker Treatment After a Heart Attack	83.1	87.3	88.9
Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate*	23.3	21.7	20.0

**Lower rates signify better performance*

Decline in Alcohol and Drug Treatment

Since 2007, on an absolute and relative basis, *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* has seen some of the steepest declines of any measure. The decline is most notable among Medicare PPOs, where the rate has dropped 13.2 percentage points, to 43.3 percent.

DECLINING RATES FOR INITIATION OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT



Because this measure is not part of the Medicare Star Ratings, it does not receive the media and policy attention that Star Ratings measures do. We believe performance would improve if it was included in the Star Ratings, and thus had more visibility.

The measure's eligible population—those with a new episode of alcohol or other drug dependence—has ballooned in Medicare plans. In Medicare PPOs, for example, it has grown by 70 percent since 2009. One reason for the increase in the eligible population could be the increase in prescription drug abuse, particularly opioids. The growth of screening and treatment within primary care is also likely to play a role.

Medicare has introduced a new payment code for "screening, brief intervention, and treatment" by primary care providers. As screening increases, so do the number of people identified for treatment. Some of those patients may be less ill and less motivated to receive treatment than those who were identified with alcohol and drug dependence when screening was less common.

Given these new realities of enhanced screening within primary care, finding new ways to improve access to treatment for chemical dependency is a critical area for improvement efforts.

Better Experience of Care in Medicaid

This report finds encouraging signs that clinicians and health plans are improving patients' experience of care, particularly in Medicaid plans.

The measure *Rating of Personal Doctor: 9 or 10* from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey improved across commercial, Medicaid and Medicare product lines. The 1.3 percentage point gain among Medicaid HMOs, to 63.1 percent, exceeded the gains in Medicare and commercial plans. Since 2009 the Medicaid rate has climbed 3 percentage points. The growing share of physicians receiving the highest possible rating from their patients means that more physicians are delighting patients with the care they deliver. A recent report from the Association for Community Affiliated Plans shows enrollees in Medicaid are more likely to be satisfied than their counterparts in commercial plans.

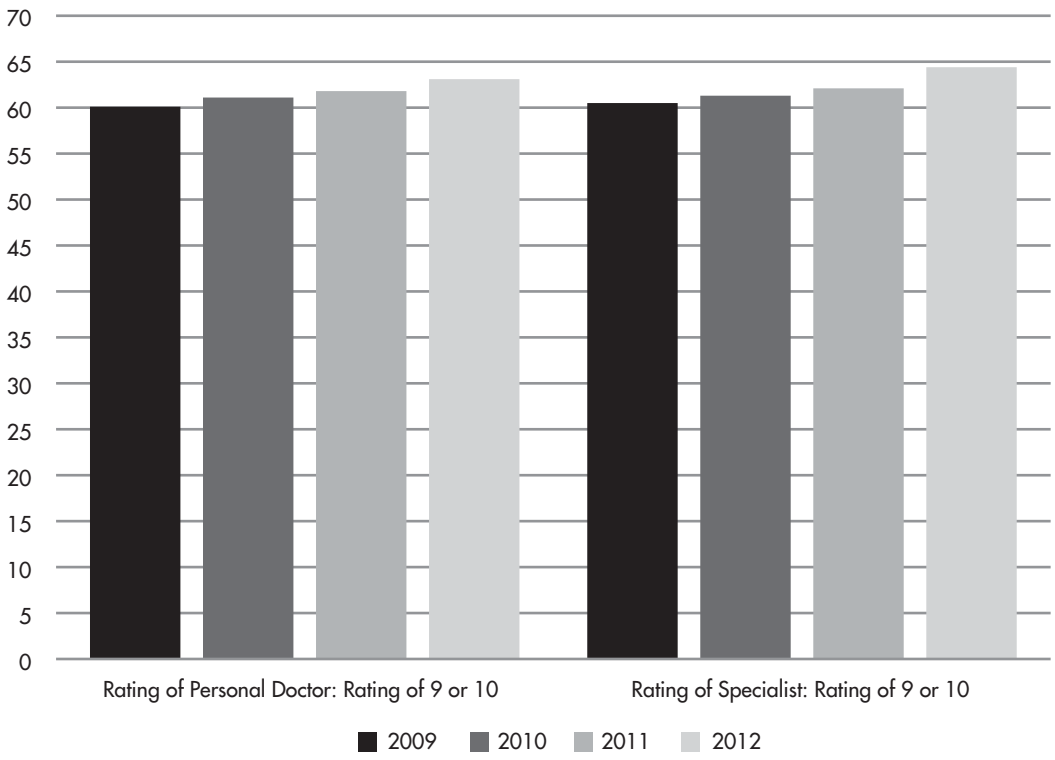
Primary care physicians are not the only ones receiving better CAHPS ratings from Medicaid HMO members. The measure *Rating of Specialist: 9 or 10* improved 2.3 percentage points, to 64.4. Medicaid gains on these measures since 2009 have also led all product lines.

We attribute these improvements mainly to federal and state officials' increased focus on quality measurement.

The Affordable Care Act has expanded Medicaid's role as a key partner in Americans' health care. We believe efforts to raise the Medicaid reimbursement rate send an important signal to providers that caring for Medicaid patients is financially attractive—a move that likely produced a more engaged primary care network for the safety-net system.

States' commitment to quality also plays an important role. New York, for example, has invested in diverse quality improvement initiatives, from Medicaid pay-for-performance to support for patient-centered medical homes. At the same time, New York's already strong Medicaid HEDIS results have gotten even stronger.

IMPROVED CONSUMER SATISFACTION IN MEDICAID HMOS



Another possible driver for improved Medicaid CAHPS scores may be economic strains that have brought new populations into Medicaid and reduced use of services. Medicaid enrollment among existing plans has grown during the recession.

In a difficult economy, members may be happy to have insurance and to be able see a doctor—any doctor. Members who enrolled in Medicaid after they became unemployed and lost commercial insurance may feel particularly positive about being able to receive care while unemployed.

We encourage quality advocates in the public sector to continue their efforts to improve Medicaid. As promising as these latest CAHPS figures are, Medicaid plans have a long way to go to match commercial and Medicare rates for these measures. The Medicaid rate for *Rating of Personal Doctor: 8, 9 or 10* lags the commercial rate by almost 6 percentage points and the

Medicare rate by more than a dozen. We applaud the strides Medicaid plans are taking to close these gaps.

New Highs in Measurement and Transparency

The number of people enrolled in health plans held accountable by HEDIS reporting has doubled since 2006, to reaching 136 million covered lives in 2012—more than 40 percent of the U.S. population.

We credit industry and policy leaders' sincere and sustained interest in quality improvement for making measurement and transparency widespread. We also credit many purchasers for using HEDIS and other performance measures to gauge the quality of health plans, physicians, accountable care organizations and other health care entities. The Medicare Star Ratings system is an example of what can be accomplished through measurement, transparency and pay-for-performance. We are also encouraged that plans participating in Exchanges must report quality measures such as HEDIS and CAHPS, as required by the Affordable Care Act.

Analysis and Recommendations

The Importance of Patient Experience to Assessing Quality

The improvements in patient experience reported for Medicaid plans are heartening and meaningful. They underscore the salience of patient experience in measuring quality of care more generally.

The Institute of Medicine's *Crossing the Quality Chasm* identifies "patient-centeredness"—a core component of which is experience of care—as one of the six key dimensions of quality. NCQA has incorporated consumer assessment and experience into its evaluation of health plan performance since 1999.

The "Consumer Assessment of Health Plans" survey is a standardized tool with exacting standards that ensure results represent the enrolled population and the surveys avoid bias. The Centers for Medicare & Medicaid Services use the same tool for Medicare plans for consumer reporting and as part of a pay-for-performance program called for in the Affordable Care Act. Most Medicaid programs use this tool, as well.

Assessing patient experience is important for several reasons.

- **Results Are Useful.** Like all quality measurement, information on patient experience helps providers and plans benchmark their performance. Consumers also rely on this type of information when they have a choice of providers or plans, whether it is gleaned from family or friends or from rigorous tools. The growing popularity of ratings on Web sites underscores the value that consumers place on information based on other consumers' assessments.

  A recent study found that consumers use Star Ratings (which incorporate both clinical quality and consumer experience) to choose Medicare Advantage plans.[1]

- **Results Are Understandable.** Research has shown that consumers can assess and report on important aspects of their care.[2]

- **Results Motivate.** Reporting on consumer experience spurs organizations to focus on and improve this aspect of care.

- **Results Are Credible.** If quality ratings were based strictly on clinical quality and patients had poor experiences of care (perhaps due to issues like difficulty scheduling care or poor communication), the public could lose faith in quality ratings' validity.

- **Results Matter.** How patients feel—both in terms of their symptoms and in terms of their care—is central to medicine's mission as a helping profession. Furthermore, research shows that patients who are more engaged in their health care (which would be expected as more likely among patients with better experiences) have better health outcomes.[3]

The federal government will publish consumer ratings information and health plan accreditation status as the two main pieces of quality information about health plans in the new Health Benefit Exchanges.

The Relationship Between Clinical Quality and Patient Experience

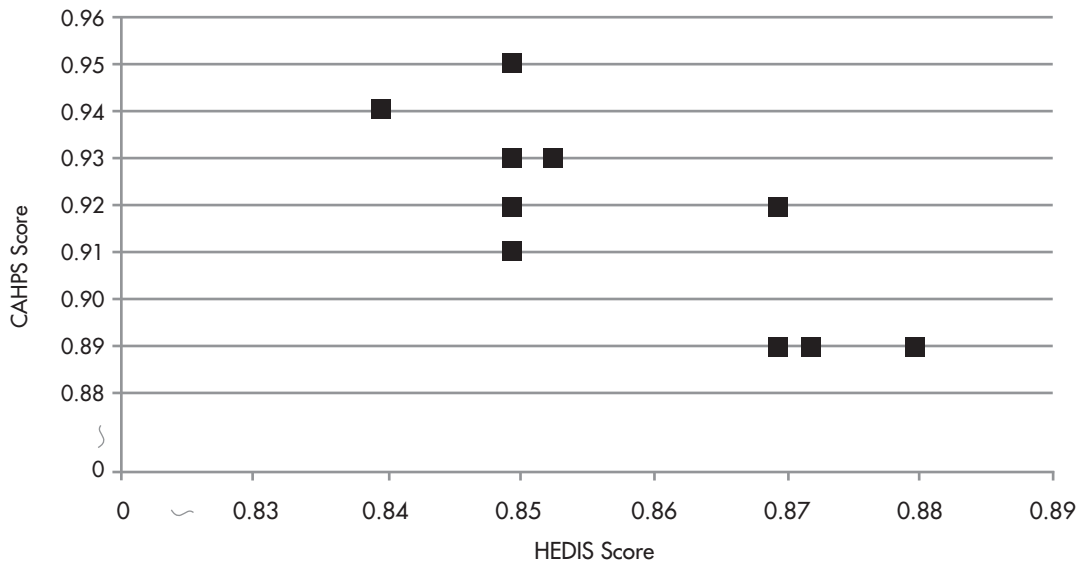
NCQA's Health Insurance Plan Rankings 2013–2014 show that some plans have strong clinical performance (HEDIS scores) and patient experience (CAHPS scores). But it is more common at a given level of HEDIS or CAHPS performance for the variation on the other measure to be wide.

At the mean and mode HEDIS score of .74, CAHPS scores range from .83 to .91—a variation of 8 percentage points.

At the mean and mode CAHPS score of .88, HEDIS scores range from .62 to .86—a variation of a 24 percentage points.

This divergence between HEDIS and CAHPS performance exists in microcosm even among the best plans. All plans in the top 10 have strong HEDIS and CAHPS results, but none is the best at both. This variation suggests that the two types of scores capture different aspects of care.

VARIATION AMONG BEST HEDIS, CAHPS SCORES: TOP 10 COMMERCIAL PLANS NCQA HEALTH PLAN RANKINGS 2013–2014



Health Plans' Influence on Member Assessment of Primary Care and Specialty Providers

Health plans can influence their members' experience with doctors. First, they can choose (and retain) doctors with high ratings to be part of their network. Second, they can train doctors and reward them for high patient experience ratings.

Many health plans are sponsoring initiatives to improve primary care through programs like the patient-centered medical home. Designed to improve access, care coordination and clinical quality, these programs also hold the promise of improving patient experience, as patients begin to encounter care that is better coordinated and organized around their goals and circumstances. This is the heart of true patient-centeredness.

Measurement's New Frontier: Measuring Patient Outcomes

While outcome measurement is difficult and cannot always be used as an accountability tool, there are examples where we could use patient outcome measures more effectively to create a health care system that contains costs, improves quality and enhances patient experience.

Outcomes That Matter to Patients. For several years, quality measurement experts have been developing measures that capture patient and caregiver reports about treatment outcomes; for example, better functioning or fewer symptoms associated with a health problem. NCQA and others are working to collect more such measures.

A recent commentary that appeared in the *Journal of the American Medical Association,* co-authored by NCQA Vice President Phyllis Torda, describes the state of the research on this topic, as well as some of the challenges ahead.[4] Next steps for measure development include:

- Learn how to collect information from standardized functional-status assessments, which are generally not used in clinical practice.
- Learn whether to vary the measurement approach for procedures vs. chronic conditions.
- Learn how to incorporate outcome information into electronic medical records.

Goal Setting, Dual-Eligibles and People With Special Needs. Another important area for measurement is most relevant for people with disabilities or dual eligibility for Medicare and Medicaid, or who need long-term services and supports. Goal setting is a strategy used in primary care to motivate and engage patients to work with their clinicians to improve health or manage chronic diseases (e.g., changes in exercise and diet that can reduce risk or symptoms).

Goals might be broader for people who use long-term services and supports—such as being able to attend church or a grandchild's graduation. NCQA is researching measures that would capture how well patients' goals are met. The work is challenging, but it holds the potential to depict important outcomes in an area where there is little clinical evidence to support traditional quality measures.

Conclusion

When it comes to health care quality, is the glass half full or is it half empty? We believe the answer is "both."

Quality advocates want improvement to come faster than it does, and lament when performance stalls or drops from one year to the next.

But we should internalize the quality movement's emphasis on *continuous* improvement as a reminder to take the long view. Annual studies like *The State of Health Care Quality* confirm that care is better in many ways than it was 10 years ago—or even 5 years ago. For all the complexity and political partisanship that roils health care today, it is encouraging to see how far we have come.

We are also encouraged by many possibilities that indicate a bright future for quality and value. From the advent of health insurance Exchanges to the public and private sectors' growing interest in creating a health care system where payers "get what they pay for," many positive changes are underway.

HEDIS MEASURES OF CARE

About HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) is a comprehensive tool used by most HMO and PPO health plans to measure performance on important dimensions of care and service. By providing objective, clinical performance measures based on a detailed set of criteria, HEDIS data helps purchasers and consumers compare health plans' performance. HEDIS measures address a broad range of important health issues:

- Appropriate antibiotic use.
- Asthma.
- Behavioral health.
- Breast, cervical and colorectal cancers.
- Cardiovascular disease.
- Care for older adults.
- Childhood and adolescent immunizations.
- COPD.
- Diabetes.
- High blood pressure.
- Hospital readmissions.
- Medication management.
- Musculoskeletal conditions.
- Prenatal and postpartum care.
- Smoking and tobacco use cessation.
- Weight assessment and counseling.
- Patient experience (CAHPS).
- Flu shots for adults and older adults (CAHPS).

HEDIS includes the CAHPS 5.0 Survey. The CAHPS survey measures consumers' experiences with their health care in areas such as claims processing and getting needed care quickly, and asks them to rate their health plan on a scale of 0–10.

HEDIS 2013 data collected for this report generally reflect services delivered during calendar year 2012. To ensure validity of HEDIS results, certified analysts audit all data, using a process NCQA designed. See the appendices for more details about national averages and performance trends.

HOS Measures

Medicare Health Outcomes Survey (HOS) measures evaluate the physical and mental health of seniors enrolled in Medicare. HOS measures are the first quality measures for elderly populations that are based on patients' self-reported health status. Including HOS as part of HEDIS measurement creates a broad way to evaluate the quality of care that health plans provide to Medicare beneficiaries. This report includes four HOS measures:

- *Fall Risk Management.*
- *Management of Urinary Incontinence in Older Adults.*
- *Osteoporosis Testing in Older Adults.*
- *Physical Activity in Older Adults.*

Terms

NA: Measure rates have no available data. In some instances, data are not collected for a measure in a product line.

Rate: Unless otherwise stated, the statistical mean for reported data. Each measure is described by an average rate for each applicable product line.

A Note on Medicare Survey Data

Medicare CAHPS survey data and HEDIS measures collected through the survey (such as *Flu Shots for Adults* and *Medical Assistance With Smoking and Tobacco Use Cessation*) are not available when NCQA prints *The State of Health Care Quality Report* in October. NCQA will include those data in an updated version of this report in November.

AVOIDANCE OF ANTIBIOTIC TREATMENT IN ADULTS WITH ACUTE BRONCHITIS

Acute bronchitis, or chest cold, is a cough that lasts approximately two weeks.[1] The majority of acute bronchitis infections are caused by viruses, but antibiotics continue to be prescribed despite strong recommendations against using antibiotics for routine treatment.[2] The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure evaluates the number of adults who were appropriately treated for acute bronchitis.

- Acute bronchitis is among the top 10 conditions that result in a visit to the doctor.[3] Each year, approximately 5 percent of U.S. adults self-report cases of acute bronchitis; 90 percent of those seek medical attention, accounting for more than 10 million office visits.[3]
- Although almost all acute bronchitis infections are caused by viruses, more than 60 percent of patients are treated with antibiotics.[2,3,4] Use of antibiotics in treating acute bronchitis has not been found to be effective.[5,6]

The Case for Improvement

- Acute bronchitis is the cause of a large number of emergency department (ED) visits. In a two-year span, more than 2 million cases of bronchitis were diagnosed by ED physicians.[7] Bronchitis was more likely to be treated with an antibiotic than any other respiratory condition.[7]
- Antibiotic use contributes to the growing problem of antibiotic-resistant bacteria. The U.S. spends approximately $55 billion in related health service costs and lost productivity.[6]
- No studies have found antibiotics to be effective in cases of viral infection,[3] but providers often feel pressured to prescribe them to patients with acute bronchitis to meet their expectations and increase satisfaction.[7]

HEDIS Measure Definition

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

The Bottom Line

Reducing the amount of antibiotics prescribed for acute bronchitis is necessary to address the growing public health issue of antibiotic-resistant bacteria. Better communication between providers and patients can help patients understand the appropriate uses and risks of antibiotics.

AVOIDANCE OF ANTIBIOTIC TREATMENT IN ADULTS WITH ACUTE BRONCHITIS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	24.6	21.4	24.2	–	–
2011	23.5	21.5	24.3	–	–
2010	22.5	21.3	23.5	–	–
2009	24.0	22.6	25.6	–	–
2008	24.6	26.8	25.8	–	–
2007	25.4	29.3	25.9	–	–
2006	28.7	29.7	28.0	–	–

USE OF IMAGING STUDIES FOR LOW BACK PAIN

Back pain is one of America's most common medical problems and is the fifth most cited reason for all physician visits.[1,2] An estimated 75 percent–85 percent of Americans will experience back pain at some point,[1] and approximately 25 percent of Americans will experience at least one day of back pain during any three-month period.[3]

Although imaging is commonly used to diagnose the cause of low back pain, it is costly and often ineffective, and contributes to overuse. Less than 1 percent of radiographs identify a specific cause of low back pain.[4] The *Use of Imaging Studies for Low Back Pain* measure assesses the number of patients with lower back pain who did not get an X-ray, MRI or CT scan as part of their treatment.

- A variety of minor injuries and conditions can lead to back pain. Most acute low back pain is benign and imaging studies fail to prove useful for a diagnosis.[3,5]
- Studies have shown that patients treated without imaging experience no difference in health outcomes.[6,7] Abnormalities discovered through imaging are as common in individuals without back pain as they are in individuals with low back pain.[6]
- Imaging for early, acute low back pain can lead to surgery. Complications from unnecessary surgery can prolong back pain or lead to permanent disability.[7,8]

The Case for Improvement

- On average, patients with low back pain have higher overall medical costs. Over a two-year period, patients with back pain spend an average of $7,211, while comparable patients without back pain spend an average of $2,400. Patients with low back pain who opt for surgery incur an average of $34,000 in direct medical costs.[6,9]
- According to the Agency for Healthcare Research and Quality (AHRQ), almost 18,000 Americans sought medical attention for low back pain in 2008. Medical care for these individuals cost approximately $35 billion dollars, with imaging driving much of the cost.[6,9]

HEDIS Measure Definition

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

The Bottom Line

Costly imaging studies fail to produce positive health outcomes for patients with low back pain. X-ray, MRI and CT scans should be used primarily for patients with neurologic deficits or other serious underlying conditions.

IMAGING STUDIES FOR LOW BACK PAIN

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	75.3	74.2	75.6	–	–
2011	74.4	73.7	75.8	–	–
2010	74.2	73.3	75.5	–	–
2009	73.9	72.7	76.1	–	–
2008	73.1	72.3	75.7	–	–
2007	74.6	73.3	77.3	–	–
2006	73.9	72.1	78.3	–	–
2005	75.4	72.6	79.0	–	–

ADULT BMI ASSESSMENT

"Obesity" refers to body weight that is greater than what is considered healthy for an individual's height.[1] Obesity is a leading cause of preventable death: studies estimate that obesity contributes to 1 in 10 deaths in the United States each year.[2]

Body mass index (BMI) is a commonly used weight-for-height screening tool that identifies potential weight problems in adults, as well as their risk for developing other serious health complications associated with being overweight or obese.[3,4]

The *Adult BMI Assessment* measure evaluates whether adults had their BMI measured at least once in the past two years to assess their risk for being overweight or obese and their risk for developing health-related complications.

- Currently, more than two-thirds of U.S. adults (68.8 percent) are considered overweight and more than one-third (35.7 percent) are considered obese.[5,6]
- Obesity is associated with a number of serious health complications, including diabetes, high blood pressure, high blood cholesterol, heart disease, some cancers, gallbladder disease, liver disease, lung diseases, arthritis, sleep disorders and premature death.[1,3,5,7]
- The U.S. Preventive Services Task Force recommends that clinicians screen all adults for obesity (a BMI of ≥30 kg/m^2) and offer intensive, multicomponent behavioral interventions to promote weight loss. Evidence suggests such interventions could help obese adults lose weight and improve glucose tolerance and other physiologic risk factors for cardiovascular disease.[8]
- Fewer than 20 percent of U.S. adults get the amount of physical activity recommended.[9] According to the Centers for Disease Control and Prevention (CDC), adults need at least 2.5 hours of moderate-intensity aerobic activity (e.g., brisk walking) and at least 1 hour and 15 minutes of vigorous-intensity aerobic activity (e.g., jogging or running) every week, or an equivalent mix of moderate- and vigorous-intensity aerobic activity and muscle-strengthening activities 2 or more days every week.[10]

The Case for Improvement

- It is estimated that 51 percent of the U.S. population will be obese by 2030. According to a recent study, keeping obesity rates from rising could save nearly $550 billion in medical expenditures over the next two decades.[11,12]
- Twelve states have an adult obesity rate over 30 percent, and no state has an obesity rate less than 20 percent.[5,13] The U.S. Department of Health and Human Services set a national goal to reduce adult obesity rates to 30 percent in every state in the U.S. by 2020.[13]
- Even modest weight loss, such as 5 percent–10 percent of total body weight, can improve blood pressure, blood cholesterol and blood sugars, and can decrease risk factors for chronic diseases related to obesity.[14]

HEDIS Measure Definition

The percentage of adults 18–74 years of age who had an outpatient visit where their BMI was documented in the past two years.

The Bottom Line

According to the CDC, BMI is one of the best methods for population assessment of obesity.[15] Monitoring BMI can help health care providers identify at-risk adults and offer focused advice or services to help them reach and maintain a healthy body weight.

ADULT BMI ASSESSMENT RATE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	66.1	35.2	67.5	80.8	75.3
2011	55.4	26.3	52.6	68.2	62.2
2010	40.7	11.6	42.2	50.4	36.6
2009	41.3	15.7	34.6	38.8	24.1

BREAST CANCER SCREENING

Breast cancer is one of the most commonly diagnosed cancers; it accounts for a quarter of all new cancer diagnoses among women in the U.S.[1] The *Breast Cancer Screening* measure assesses whether women between 40 and 69 years of age received a mammogram screening for breast cancer.

- Breast cancer is the second leading cause of cancer deaths in women, accounting for nearly 40,000 deaths in 2012.[2]
- The most significant risk factor for breast cancer in women is age. In the U.S., a woman has about a 12 percent, or 1 in 8, risk of developing breast cancer over the course of her lifetime.[1]
- About 85 percent of breast cancers occur in women who have no family history of breast cancer. Mammography is especially valuable to these women, often detecting breast cancer at an early stage, when treatment is more effective and a cure is more likely.[1]
- According to the CDC, mammography is the best method to detect breast cancer early.[3]

The Case for Improvement

- Screening can improve outcomes: the decline in breast cancer deaths has been attributed to improvements in early detection, primarily through mammography screening.[4]
- The total costs related to breast cancer add to nearly $7 billion per year in the U.S., including $2 billion spent on late-stage treatment. As breast cancer progresses from stage to stage, the associated treatment becomes longer, more difficult and more expensive.[5]
- The five-year survival rate for women who are diagnosed early is 98.6 percent, compared with women who are not diagnosed early. Their survival rate is 24.3 percent.[6]

HEDIS Measure Definition

The percentage of women 40–69 years of age who had at least one mammogram to screen for breast cancer in the past two years.

The Bottom Line

Early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower health care costs.[7]

BREAST CANCER SCREENING RATE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	70.3	66.5	51.9	69.9	67.5
2011	70.5	66.7	50.4	68.9	65.8
2010	70.8	67.0	51.3	68.5	65.8
2009	71.3	67.1	52.4	69.3	65.5
2008	70.2	66.0	50.8	68.0	65.2
2007	69.1	64.6	49.8	67.3	64.5
2006	68.9	63.5	49.1	69.5	68.6
2005	72.0	63.9	53.9	71.6	69.0
2004	73.4	–	54.1	74.0	–
2003	75.3	–	55.9	74.0	–
2002	74.9	–	56.0	74.5	–
2001	75.5	–	55.1	75.3	–
2000	74.5	–	–	–	–
1999	73.4	–	–	–	–

CERVICAL CANCER SCREENING

Cervical cancer was once the most common type of cancer affecting women in the U.S. Although incidence and death rates have decreased because of cervical cancer screening, rates are still high in populations with limited access to screening.[1] In the U.S., about 12,000 women are diagnosed with cervical cancer each year and more than 4,000 women die from it.[2,3] The *Cervical Cancer Screening* measure assesses whether women between 21 and 64 years of age received screening for cervical cancer using a Pap test.

- For women in whom precancerous lesions were detected through Pap tests, the likelihood of survival is nearly 100 percent with appropriate evaluation, treatment and follow-up.[4]

The Case for Improvement

- In 2010, the direct cost for cervical cancer care in the U.S. was $1.55 billion.[5]
- Regular screening is critical to detecting precancerous cellular changes early, before they lead to cervical cancer.[6,7]
- Despite the success of cervical cancer screening, roughly 50 percent of newly diagnosed invasive cancers in the U.S. are in women who have never had a Pap test, and an additional 10 percent are in women who have not had a Pap test in the past 5 years.[6]
- In 2010, the prevalence of recent Pap test use was lowest among women with no health insurance and recent immigrants.[4]

HEDIS Measure Definition

The percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer in the past three years.

The Bottom Line

Cervical cancer incidence and mortality rates have decreased more than 50 percent over the past three decades. Most of the reduction can be attributed to the Pap test, which detects cervical cancer and precancerous lesions.[4]

CERVICAL CANCER SCREENING RATE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	75.5	73.6	64.5	–	–
2011	76.5	74.4	66.7	–	–
2010	77.0	74.5	67.2	–	–
2009	77.3	74.6	65.8	–	–
2008	80.7	74.0	66.0	–	–
2007	81.7	73.5	64.8	–	–
2006	81.0	72.6	65.7	–	–
2005	81.8	74.6	65.2	–	–
2004	80.9	–	64.7	–	–
2003	81.8	–	64.0	–	–
2002	80.5	–	62.2	–	–
2001	80.0	–	61.1	–	–
2000	78.1	–	–	–	–
1999	71.8	–	–	–	–

COLORECTAL CANCER SCREENING

In 2012, an estimated 141,210 men and women were diagnosed with colon cancer and approximately 49,380 died from it, making it the second leading cause of cancer-related deaths in the U.S.[1,2] The incidence and mortality rates for colorectal cancer have decreased due to routine preventive screening.[3]

The *Colorectal Cancer Screening* measure assesses whether adults 50–75 years of age received evidence-based screening for colorectal cancer.[4]

- Symptoms of colorectal cancer often do not manifest until the disease has progressed and chances of survival have decreased, which is why early screening is important. Treatment in the disease's earliest stage is highly successful, with a five-year survival rate of 74 percent.[2,3]
- Most colorectal cancers occur in people without a family history of colorectal cancer. The lifetime risk of being diagnosed with cancer of the colon or rectum is about 5 percent for both men and women in the U.S.[3]

The Case for Improvement

- Despite evidence supporting the effectiveness of colorectal cancer screening and the availability of various screening tests, only about half of the U.S. population 50 and older has been tested for recommended testing. Screening rates for colorectal cancer lag behind other cancer screening rates.[2,3]
- The annual medical expenditure for colorectal cancer was estimated at $14 billion in 2010. Costs were highest in the initial phase of care.[5]
- Medical expenditures for people with cancer are high on an individual and aggregate basis.[5] Additional costs include absenteeism, lost productivity, short- and long-term disability[6] and life insurance payout.[5]

HEDIS Measure Definition

The percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer with any of the following tests: fecal occult blood test during the measurement year; flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year; or colonoscopy during the measurement year or in any of the nine years prior to the measurement year.

The Bottom Line

Colorectal cancer screening in asymptomatic adults between 50 and 75 can catch polyps before they become cancerous, or can detect colorectal cancer in its early stages, when treatment is most effective.

COLORECTAL CANCER SCREENING RATE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	63.3	55.8	–	62.1	58.4
2011	62.4	54.6	–	60.0	55.2
2010	62.6	47.6	–	57.6	41.0
2009	60.7	47.0	–	54.9	40.1
2008	58.6	45.3	–	53.1	41.8
2007	55.6	42.5	–	50.4	39.5
2006	54.5	42.1	–	53.3	47.1
2005	52.3	43.4	–	54.0	49.7
2004	49.0	–	–	52.6	–

FLU SHOTS

Influenza (flu) is a common respiratory infection caused by a set of viruses.[1] The flu can cause mild to severe illness and even death.[2] Approximately 5 percent to 20 percent of Americans get the flu each year,[3] resulting in about 200,000 hospitalizations and 36,000 deaths.[4] The *Flu Shots for Adults Ages 50–64* and *Flu Shots for Older Adults* measures assess whether adults received an annual flu vaccination.

- The Advisory Committee on Immunization Practices (ACIP) recommends that all adults receive an annual flu vaccination.[5]
- Adults 65 and older and adults with chronic health problems are at a higher risk of experiencing complications from the flu.[3] During a regular flu season, it is estimated that 90 percent of deaths occur in people who are 65 and older.[6]
- According to the Center for Disease Control's 2011-2012 National Flu Survey, approximately 51 percent of adults 50–64 years of age and 70.8 percent of adults 65 and older received the annual flu shot in the flu season of 2011–2012.[9]
- Over the course of an average flu season, more than 15,000 lives could be saved with 90 percent vaccination coverage.[10]

The Case for Improvement

- The national economic burden of the flu season is about $87.1 billion each year.[7] The most effective method of preventing infection is to get an annual flu shot.[2]
- The shot costs a person between $12 and $29, and prevents 31.4 million outpatient visits and 3.1 million hospital stays a year.[7,8]

HEDIS Measure Definition

The flu measures assess reporting of flu shots for two different products lines.

- *Flu Shots for Adults Ages 50–64.* A rolling average represents the percentage of commercial members 50–64 years of age who received an influenza vaccination between September 1 of the measurement year and the date when the CAHPS 4.0H survey was completed.

- *Flu Shots for Older Adults.* The percentage of Medicare members 65 years of age and older as of January 1 of the measurement year who received an influenza vaccination between September 1 of the measurement year and the date when the Medicare CAHPS survey was completed.

The Bottom Line

Getting an annual flu shot protects against contracting and spreading the flu virus. Not only does the shot save thousands of lives, but it also contributes to significant direct and indirect cost savings.

FLU SHOTS FOR ADULTS AGES 50–64

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2011	53.3	51.4	–	–	–
2010	52.5	51.6	–	–	–
2009	51.3	50.5	–	–	–
2008	49.8	49.2	–	–	–
2007	48.6	48.1	–	–	–
2006	45.6	44.5	–	–	–
2005	36.2	37.1	–	–	–
2004	38.9	–	–	–	–
2003	47.9	–	–	–	–
2002	44.0	–	–	–	–
2001	30.3	–	–	–	–

FLU SHOTS FOR OLDER ADULTS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2011	–	–	–	68.8	69.5
2010	–	–	–	68.8	69.4
2009	–	–	–	64.5	65.1
2008	–	–	–	65.8	66.7
2007	–	–	–	68.6	68.9
2006	–	–	–	67.8	68.2
2005	–	–	–	70.3	69.9
2004	–	–	–	74.8	–
2003	–	–	–	74.4	–
2002	–	–	–	72.5	–
2001	–	–	–	71.2	–

MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION

Tobacco use is the largest cause of preventable death in the United States each year.[1] Tobacco use and secondhand exposure cause 443, 000 premature deaths each year. In addition to cigarettes, other types of tobacco use, such as cigars, pipes and smokeless tobacco, have deadly health risks.[2] The *Medical Assistance With Smoking and Tobacco Use Cessation* measure assesses whether adults who use tobacco products receive counseling, medications and strategies to help them quit.

- Although the number of people who are heavy smokers (i.e., smoke a pack or more each day) has dropped significantly,[3] the number of people who smoke one to nine cigarettes a day has significantly increased.[4]
- In 2011, approximately 19 percent of adults were smokers.[4]
- Tobacco use costs the American health care system nearly $200 billion in medical care each year.[5]

The Case for Improvement

- Approximately 69 percent of current smokers have expressed interest in quitting. Although about 52 percent attempted to stop smoking in the past year, only 6 percent were successful.[6]
- Smoking can cause an increased risk of coronary heart disease, heart attack, stroke and other chronic diseases.[7]

HEDIS Measure Definition

The three components of this measure assess different facets of providing medical assistance for smoking and tobacco use cessation.

- *Advising Smokers and Tobacco Users to Quit.* A rolling average represents the percentage of adults 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year.
- *Discussing Cessation Medication.* A rolling average represents the percentage of adults 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
- *Discussing Cessation Strategies.* A rolling average represents the percentage of adults 18 years of age and older who are current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

The Bottom Line

Tobacco use is a behavior that leads to greater health risks and health care costs. Health care providers can play an important role in supporting smokers' efforts to quit and reduce harm to themselves and others.

DISCUSSING CESSATION STRATEGIES

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	47.9	37.3	41.1	–	–
2011	47.6	40.1	40.3	–	–
2010	45.0	39.0	38.5	–	–
2008	49.7	43.3	40.8	–	–
2007	48.0	44.2	39.2	–	–
2006	43.2	42.6	36.7	–	–
2005	38.9	35.1	33.9	–	–
2004	36.8	–	32.7	–	–
2003	36.0	–	32.3	–	–

DISCUSSING CESSATION MEDICATIONS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	52.9	44.6	45.8	–	–
2011	53.1	47.9	44.3	–	–
2010	52.4	47.2	42.7	–	–
2008	54.4	50.9	40.6	–	–
2007	50.9	49.6	38.7	–	–
2006	43.9	43.8	35.1	–	–
2005	39.4	36.7	31.8	–	–
2004	37.8	–	31.3	–	–
2003	37.6	–	31.5	–	–

USE OF SPIROMETRY TESTING IN ASSESSMENT AND DIAGNOSIS OF COPD

Chronic obstructive pulmonary disease (COPD) is a preventable and treatable disease characterized by persistent airflow limitation, and is largely associated with exposure to tobacco smoke.[1] COPD is a leading cause of morbidity and mortality in the United States, but although it is a progressive disease, it is possible to treat and slow its progression with early detection, treatment and avoidance of common COPD triggers.[2] The *Use of Spirometry Testing in Assessment and Diagnosis of COPD* evaluates the use of spirometry to confirm an initial diagnosis of COPD.

- COPD is the third leading cause of death in the United States, affecting 6.3 percent (approximately 15 million) of adults overall; however, adults 65 years and older have a higher incidence (11.6 percent) of COPD.[3]
- More than 12 million Americans remain undiagnosed[2] and there are very low rates of early-stage diagnosis.[4] Early diagnosis and awareness of the disease can lead to earlier behavior modifications, such as tobacco use cessation; avoiding environmental triggers; obtaining influenza and pneumococcal vaccinations; initiating pharmacological or other therapy and preventive measures; and reducing COPD flare-ups.[5]
- The U.S. Preventive Services Task Force recommends using spirometry in diagnosing COPD.[5] Spirometry results can predict the risk of the disease worsening and mortality and can determine disease severity.[2,6,7]

The Case for Improvement

- In the U.S., direct medical costs of COPD are approximately $29.5 billion each year, and an additional $20.4 billion is lost due to indirect costs of missed work days and lost wages.[2] COPD flare-ups account for the largest financial share of the total COPD burden on the health care system,[2] making early disease detection an economic priority.
- Increasing COPD severity places a burden on health care providers from physician visits, emergency department (ED) visits and hospitalizations.[2] Because exacerbation risk increases as the disease progresses,[8] early detection and disease control are essential in reducing these costs.

HEDIS Measure Definition

This measure assesses the percentage of adults 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received spirometry testing to confirm the diagnosis.

The Bottom Line

Using spirometry to identify COPD in its early stages greatly improves the ability to control the disease, and can slow progression and reduce the cost of care related to worsening symptoms.

SPIROMETRY TESTING RATE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	43.5	41.5	31.5	36.8	35.0
2011	42.9	40.5	32.0	36.3	35.6
2010	41.7	40.2	31.3	33.9	35.3
2009	38.8	36.7	28.6	28.5	28.8
2008	37.6	36.4	29.3	27.7	26.5
2007	35.7	33.7	28.4	27.2	25.4
2006	36.1	33.7	27.3	26.2	30.2

PHARMACOTHERAPY MANAGEMENT OF COPD EXACERBATION

Chronic obstructive pulmonary disease (COPD) is a group of progressive diseases characterized by airflow limitation, and includes both chronic bronchitis and emphysema.[1] As the third leading cause of death in the U.S., COPD poses a significant economic burden to the health care system, largely because of improper care and management, which can cause the condition to worsen.[2] If managed properly, pharmacotherapy for COPD is cost-effective and prevents hospitalizations.[3]

The *Pharmacotherapy Management of COPD Exacerbation* measure evaluates appropriate treatment following an exacerbation by ensuring continuation of proper medication management that can prevent further exacerbation and complications.

- COPD flare-ups can be caused by lack of adherence to medication, environmental triggers and respiratory-related infections.[1,2] In 2007, only 48.1 percent of people diagnosed with COPD reported daily use of their medications, illustrating the need for improved management and communication between patients and providers.[4]
- Use of bronchodilators and inhaled corticosteroids can reduce the risk of exacerbation by 15 percent–20 percent; a combination of these treatments can reduce the risk by an additional 10 percent.[5]
- COPD is highly undertreated. Rescue medications are the most commonly filled respiratory medication, but 66.3 percent of adults do not receive maintenance medications to manage the disease.[6]

The Case for Improvement

- The total direct health care cost of COPD is approximately $29.5 billion.[2] COPD flare-ups and related emergency department (ED) visits or hospitalizations account for nearly 70 percent of this amount.[7]
- Despite the significant cost and health risks posed by exacerbations, 66 percent of patients are prescribed medications inconsistent with their disease stage and severity.[8] Improper maintenance of pharmacotherapy has been shown to result in greater costs and in more hospitalizations and ED visits.[7]

- Correct medication and adherence to guidelines outlined by the Global Initiative for Chronic Obstructive Pulmonary Disease can result in an average savings of between $3,000 and $10,000 per patient, depending on combination of prescriptions used.[8] This demonstrates the importance of proper management in order to reduce health care costs.

HEDIS Measure Definition

Pharmacotherapy Management of COPD Exacerbation evaluates whether adults 40 years of age and older received appropriate medical treatment with corticosteroids and bronchodilators after an exacerbation event, and assesses effective outpatient management of COPD.

The Bottom Line

Proper pharmacotherapy management for adults with COPD not only reduces flare-ups, but also relieves the burden on providers and patients associated with hospitalizations and ED visits resulting from improper prescribing of medications.

USE OF BRONCHODILATORS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	80.8	77.7	81.5	80.4	76.8
2011	79.9	76.8	80.4	78.4	75.9
2010	77.8	73.5	82.1	78.2	76.1
2009	78.0	75.0	80.7	76.2	74.9
2008	76.1	68.1	78.2	74.1	71.3

USE OF SYSTEMIC CORTICOSTEROIDS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	73.5	70.8	65.4	69.1	69.8
2011	71.3	69.5	64.1	66.8	68.8
2010	69.8	66.2	65.3	66.6	69.6
2009	66.1	64.1	61.8	60.9	64.2
2008	67.0	58.2	61.7	60.0	60.8

USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA AND MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA

Asthma is a chronic respiratory disease characterized by wheezing, breathlessness, chest tightness and coughing.[1] Although asthma is a costly, lifelong disease, improved self-management and use of correct medications can improve control and reduce associated increasing health care costs.[1] The *Use of Appropriate Medications for People With Asthma* measure assesses whether patients with asthma are receiving the appropriate prescriptions to treat and manage their symptoms and the *Medication Management for People With Asthma* measure builds upon *Use of Appropriate Medications* to evaluate whether patients are adhering to the medications they are prescribed.

- More than 23 million people in the United States currently have asthma.[2] Its prevalence rose by 12.3 percent from 2001–2009 and is projected to increase.[3]
- Asthma control is essential for preventing asthma attacks, but approximately 70 percent of patients are classified as having either "not well controlled" or "very poorly controlled" asthma.[4]
- In addition to patient education to identify and manage asthma triggers, the National Asthma Education and Prevention Program (NAEPP) recommends two classes of medication to control asthma: long-term control medications, for maintaining disease control, and quick-relief medications, for asthma attacks.[5]

The Case for Improvement

- Asthma costs total approximately $56 billion per year, including medical costs and costs associated with lost productivity.[6] Asthma attacks and related hospitalizations or emergency department (ED) visits account for approximately 80 percent of this amount.[7]
- Approximately 50 percent of patients with asthma in the U.S. reported an asthma attack in the past year; those patients also reported higher rates of missing school or work, more ED and urgent care visits and poorer health.[3]
- Only one-third of children or adults with asthma use long-term control medicine,[3] demonstrating a significant need to emphasize the importance of adherence to prescriptions and controller medications in managing and reducing asthma attacks.

HEDIS Measure Definition

Use of Appropriate Medications for People With Asthma
The percentage of adults and children 5–64 years of age during the measurement year who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year.

Medication Management for People With Asthma
The percentage of adults and children 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate asthma controller medications that they remained on for at least 75 percent of their treatment period.

The Bottom Line
Prescribing appropriate medications for children and adults with asthma can improve disease control drastically and thus reduce the burden that asthma attacks can have on their daily lives. Better adherence to asthma control medications can reduce the related health care utilization and costs.

ASTHMA MEDICATION RATE (5–11 YEARS)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	95.5	95.7	89.6	–	–
2011	96.0	96.6	90.5	–	–
2010	96.7	97.0	91.8	–	–
2009	96.6	97.0	91.8	–	–

ASTHMA MEDICATION RATE (12–18 YEARS)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	92.2	92.2	85.6	–	–
2011	92.7	93.1	86.6	–	–

ASTHMA MEDICATION RATE (19–50 YEARS)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	88.2	87.4	73.9	–	–
2011	89.1	88.3	74.7	–	–

ASTHMA MEDICATION RATE (51–64 YEARS)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	92.4	92.2	71.4	–	–
2011	93.2	93.0	72.9	–	–

ASTHMA MEDICATION RATE (OVERALL)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	91.2	90.7	83.9	–	–
2011	91.9	91.6	85.0	–	–
2010	92.9	93.0	88.4	–	–
2009	92.7	92.8	88.6	–	–
2008	92.4	92.7	88.7	–	–
2007	92.3	92.9	86.9	–	–
2006	91.6	92.7	87.1	–	–
2005	89.9	91.6	85.7	–	–
2004	72.9	–	64.5	–	–
2003	71.4	–	64.1	–	–
2002	67.9	–	62.5	–	–
2001	65.6	–	60.1	–	–
2000	62.6	–	–	–	–
1999	57.7	–	–	–	–

75% COMPLIANCE RATE (5–11 YEARS)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	32.4	34.5	25.3	–	–

75% COMPLIANCE RATE (12–18 YEARS)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	32.0	34.1	25.1	–	–

75% COMPLIANCE RATE (19–50 YEARS)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	39.7	42.1	34.3	–	–

75% COMPLIANCE RATE (51–64 YEARS)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	52.6	55.6	50.3	–	–

75% COMPLIANCE RATE (OVERALL)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	41.8	43.5	28.9	–	–

CHOLESTEROL MANAGEMENT FOR PATIENTS WITH CARDIOVASCULAR CONDITIONS

High cholesterol puts people at increased risk for heart disease when fatty deposits bind to artery walls and decrease blood flow. Reduced blood flow limits the amount of oxygen reaching the heart, which could lead to heart failure, and low blood circulation to the brain could lead to a stroke.[1] More than 83 million American adults have one or more cardiovascular diseases.[2] Each year nearly 600,000 die, making heart disease the leading cause of death in the United States.[3] The *Cholesterol Management for Patients With Cardiovascular Conditions* measure assesses whether adults who have cardiovascular conditions are screened for high cholesterol.

- High cholesterol has no symptoms, making screening vital to diagnosing and treating this silent indicator of heart disease.
- Reducing LDL-C ("bad" cholesterol) levels can lower the occurrence of adverse cardiovascular events.[4]

The Case for Improvement

- Researchers from the American Heart Association predict that by 2030, more than 40 percent of the U.S. population will have some form of cardiovascular disease. The estimated direct medical costs to treat these individuals will triple by then from $273 billion to $818 billion annually.[5]
- Lowering the level of bad cholesterol in patients with coronary heart disease reduces the risk that they will suffer another cardiac event or stroke.[6] Lifestyle changes, such as physical activity and a low-fat diet, and drug therapy, such as statins, can be effective in lowering LDL cholesterol.[7,8]
- Fewer than 50 percent of adults with high LDL-C receive treatment.[9] Each 10 percent increase in the number of adults treated for high cholesterol could result in 8,000 fewer deaths each year.[10]

HEDIS Measure Definition

The percentage of adults 18–75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary intervention (PCI) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and had each of the following during the measurement year:

- LDL-C screening.
- LDL-C control (<100 mg/dL).

The Bottom Line

Many high cholesterol cases are unknown threats to patients' heart health, especially for those who have already suffered from heart trouble. Proper screening helps doctors and patients initiate lifestyle and medication changes to reduce bad cholesterol levels and prevent future heart problems.

LDL SCREENING RATE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	88.3	83.7	81.5	89.3	87.6
2011	88.1	83.5	82.0	88.8	88.3
2010	88.9	81.3	82.0	88.5	87.1
2009	88.4	80.2	80.7	88.4	86.7
2008	88.9	75.2	79.6	88.6	85.6
2007	88.2	74.4	76.3	87.9	84.4
2006	87.5	68.2	75.5	88.0	84.6

LDL CONTROL RATE (<100 MG/DL)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	59.9	49.7	41.3	56.6	53.2
2011	59.8	50.1	42.1	56.5	56.6
2010	59.9	45.2	42.8	56.7	50.6
2009	59.2	42.3	41.2	55.7	47.2
2008	59.7	17.3	40.1	56.7	27.4
2007	58.7	13.4	38.3	55.9	23.2
2006	56.6	16.8	35.5	56.0	28.0

CONTROLLING HIGH BLOOD PRESSURE

High blood pressure, or hypertension, is the excess force of blood against artery walls. This increase in pressure leads to greater risk of heart disease. High blood pressure may not have symptoms, so screening is important for diagnosis and treatment.[1] The *Controlling High Blood Pressure* measure assesses whether adults with high blood pressure manage their condition by taking steps to lower their blood pressure and keep their scores within the normal range.

- Approximately 1 in 3 (33.5 percent) Americans have been diagnosed with high blood pressure.[2] Fewer than 50 percent of people with high blood pressure have their condition under control.[3]
- High blood pressure weakens blood vessel walls, increases risk of blood clots and can damage kidneys.[4,5] Hypertension increases risk for heart disease and stroke, the leading causes of death in the United States.[6,7]
- Although the risk of developing hypertension increases with age, nearly 10 percent of young adults between the ages of 18 and 39 have high blood pressure. Of these, only 40 percent have their condition under control.[8]

The Case for Improvement

- Approximately 69 percent of people who suffer a first heart attack, 74 percent of people with chronic heart failure and 77 percent of people who have a stroke have high blood pressure.[9]
- Life expectancy for people with hypertension is 5.1 years shorter for men and 4.9 years shorter for women, compared with individuals who have normal blood pressure.[10]
- Reducing sodium intake is an effective method to prevent or control high blood pressure.[11]
- A reduction of sodium consumption from the average of 3,300 mg per day to 2,300 mg per day may decrease hypertension cases by 11 million people and save $18 billion in medical care annually.[12]
- By 2015, hypertension will cost Americans $91.4 billion in direct medical costs and $27.2 billion in lost productivity.[13]

HEDIS Measure Definition

The percentage of adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.

The Bottom Line

Managing high blood pressure is an important step in preventing cardiovascular disease. Lifestyle changes to lower blood pressure can be an effective way to improve overall wellness and reduce deterioration of health.

CONTROLLING HIGH BLOOD PRESSURE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	63.0	57.4	56.3	63.6	58.6
2011	65.4	58.4	56.8	64.0	60.6
2010	63.4	56.7	55.6	61.9	55.7
2009	64.1	48.3	55.3	59.8	54.8
2008	63.4	–	55.8	58.5	–
2007	62.2	–	53.5	57.6	–
2006	59.7	48.9	53.1	56.8	51.2
2005	68.8	60.9	61.5	66.4	60.6
2004	66.8	–	61.4	64.6	–
2003	62.2	–	58.6	61.4	–
2002	58.4	–	52.3	56.9	–
2001	55.4	–	53.0	53.6	–
2000	51.5	–	–	–	–
1999	39.0	–	–	–	–

PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

Heart attacks are caused by obstructive blood clots in the main blood vessel that feeds the heart. Loss of blood flow may permanently damage the heart tissue due to the lack of oxygen-carrying blood cells.[1] Each year, an estimated 715,000 Americans suffer a heart attack. Of these, 190,000 have had at least one heart attack before, and 525,000 are first-time heart attacks.[2] The *Persistence of Beta-Blocker Treatment After a Heart Attack* measure reports the number of people who had a heart attack and received beta-blocker treatment during the six months following their discharge from the hospital.

- Beta-blockers are heart medications that slow and control the heartbeat and prevent an abnormal heart rhythm.[3] A normal heart rhythm helps the heart beat at a slower pace and makes the heart muscle work less.[4]
- Treatment with beta-blockers after a heart attack can help reduce blood pressure.[5] Around 70 percent of people who have one heart attack also have high blood pressure.[2]

The Case for Improvement

- Nearly every 34 seconds in the U.S., a person has a heart attack.[6]
- Although beta-blockers can reduce chest pain and decrease the event of a future heart attack, only 52 percent of heart-attack patients adhere to their beta-blocker treatment after six months.[5,7]
- About 7.2 million American adults have suffered from a heart attack in their life.[7] Use of beta-blocker treatment is proven to decrease the likelihood of sudden cardiac death.[8]

HEDIS Measure Definition

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

The Bottom Line

Use of beta-blockers is a proven method to improve health after a cardiac event and prevent future death from heart attack. The *Persistence of Beta-Blocker Treatment After Heart Attack* measure provides awareness of the number of heart-attack patients receiving appropriate medication.

PERSISTENCE OF BETA-BLOCKER TREATMENT RATE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	83.9	79.5	82.0	88.9	88.5
2011	81.3	77.0	80.5	87.3	86.2
2010	75.5	71.3	76.3	83.1	82.5
2009	74.4	69.6	76.6	82.6	78.9
2008	75.0	68.8	73.6	79.7	76.7
2007	71.9	62.9	62.0	75.5	70.4
2006	72.5	65.5	68.1	69.6	70.9
2005	70.2	64.3	69.8	65.4	58.5

COMPREHENSIVE DIABETES CARE

As the seventh leading cause of death in the U.S., diabetes kills nearly 70,000 people a year.[1,2] Diabetes is a group of diseases marked by high blood glucose levels, resulting from the body's inability to produce or use insulin.[1,3] Especially when unmanaged, diabetes can cause serious health complications, including heart disease and stroke, hypertension, blindness, kidney disease, nervous system disease, amputations, dental disease and pregnancy complications.[4] The *Comprehensive Diabetes Care* measure assesses whether adults are receiving guideline-recommended care to help manage their diabetes through appropriate screenings and are achieving controlled levels of blood sugar, cholesterol and blood pressure.

- Nearly 26 million people in the U.S.—8.3 percent of the population—have diabetes. Of those, 7 million are undiagnosed.[1]
- Type 2 diabetes is the most common form of diabetes, accounting for 90 percent–95 percent of all cases, and is often associated with older age and obesity.[5,6]
- A healthy meal plan and exercise program; losing excess weight; and insulin and oral medication to lower blood glucose levels are critical components of treating and managing diabetes. Patient education and self-care are also important to help people with diabetes lead normal lives.[5]

The Case for Improvement

- In 2012, diabetes cost the U.S. an estimated $245 billion: $176 billion in direct medical costs and $69 billion in reduced productivity. This is a 41 percent increase from the estimated $174 billion spent on diabetes in 2007.[7]
- On average, people with diagnosed diabetes spend approximately twice as much on medical expenses than those without diabetes. Average medical expenditures incurred by people with diabetes is about $13,700 per year, $7,900 of which is directly attributed to their diabetes.[7]
- If current trends continue, the CDC estimates that one in three U.S. adults could have diabetes by 2050.[8]

HEDIS Measure Definition

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

- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%).
- HbA1c control (<8.0%).
- HbA1c control (<7.0%) for a selected population*.

- Eye exam (retinal) performed.
- LDL-C screening.
- LDL-C control (<100 mg/dL).
- Medical attention for nephropathy.
- Blood pressure control (<140/80 mm Hg).
- Blood pressure control (<140/90 mm Hg).

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

The Bottom Line

With support from health care providers and others, people with diabetes can reduce their risk of serious complications by controlling their levels of blood glucose, their blood pressure and their blood lipids, and by receiving preventive screenings in a timely manner.[1] Studies have shown the following benefits of properly managing diabetes:

- Reducing A1c blood test results by 1 percentage point (e.g., from 8.0 percent to 7.0 percent) reduces the risk of microvascular complications (eye, kidney and nerve diseases) by as much as 40 percent.[1]
- Blood pressure control reduces the risk of cardiovascular disease by as much as 50 percent and the risk of microvascular complications by 33 percent.[1]
- Improved LDL cholesterol control reduces cardiovascular complications by as much as 50 percent.[1]

BLOOD PRESSURE CONTROL (<140/80 mm Hg)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	44.3	37.5	37.8	48.4	47.3
2011	44.2	38.1	39.4	48.2	46.5

BLOOD PRESSURE CONTROL (<140/90 mm Hg)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	66.5	58.3	58.9	63.3	61.2
2011	65.8	59.4	60.9	63.1	60.3
2010	65.7	51.1	60.4	62.3	55.6
2009	65.1	46.3	59.8	60.5	49.0
2008	65.6	0.3	56.9	59.5	0.3
2007	63.9	0.1	55.6	58.9	0.3

EYE EXAMS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	56.8	48.8	53.2	66.8	64.6
2011	56.9	48.4	53.3	66.0	63.8
2010	57.7	45.5	53.1	64.6	62.3
2009	56.5	42.6	52.7	63.5	59.4
2008	56.5	35.8	52.8	60.8	52.2
2007	55.0	34.0	49.8	62.7	50.4
2006	54.6	36.1	51.4	62.3	53.8
2005	54.8	42.7	48.6	66.5	53.8
2004	50.9	–	44.9	67.2	–
2003	48.8	–	45.0	64.9	–
2002	51.7	–	46.8	68.4	–
2001	52.1	–	46.4	66.0	–
2000	48.1	–	–	–	–
1999	45.3	–	–	–	–

HBA1C SCREENING

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	90.1	87.2	83.0	91.4	91.0
2011	90.0	87.0	82.5	91.0	91.1
2010	89.9	85.2	82.0	90.4	90.6
2009	89.2	83.3	80.6	89.6	89.3
2008	89.0	79.5	80.5	88.3	85.7
2007	88.1	75.6	77.3	88.1	81.9
2006	87.5	72.1	78.0	87.2	83.3
2005	87.5	82.8	76.1	88.9	80.0
2004	86.5	–	75.9	89.1	–
2003	84.6	–	74.8	87.9	–
2002	82.6	–	73.0	85.0	–
2001	81.4	–	71.6	85.7	–
2000	78.4	–	–	–	–
1999	75.0	–	–	–	–

HBA1C <7% FOR A SELECTED POPULATION

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	43.2	36.0	34.0	–	–
2011	42.2	36.4	35.4	–	–
2010	42.5	28.2	34.7	–	–
2009	42.1	30.3	33.9	–	–
2008	43.3	13.5	32.9	–	–
2007	43.1	10.0	31.4	–	–

HBA1C CONTROL (<8.0%)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	61.3	54.5	46.5	64.3	62.8
2011	61.2	55.2	48.1	65.2	63.2
2010	62.3	50.2	46.9	65.6	57.3
2009	61.6	48.0	45.7	63.7	51.8

POOR HBA1C CONTROL (>9.0%) — LOWER RATES SIGNIFY BETTER PERFORMANCE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	28.5	35.2	44.7	27.1	29.3
2011	28.3	33.5	43.0	26.5	28.8
2010	27.3	46.6	44.0	25.9	35.2
2009	28.2	44.6	44.9	28.0	41.3
2008	28.4	74.4	44.8	29.4	67.0
2007	29.4	84.1	48.0	29.0	74.7
2006	29.6	75.9	48.7	27.3	71.8
2005	29.7	55.4	49.2	23.6	27.3
2004	30.7	–	48.6	22.3	–
2003	32.0	–	48.6	23.4	–
2002	33.9	–	48.9	24.5	–
2001	36.9	–	48.3	26.8	–
2000	42.5	–	–	–	–
1999	44.9	–	–	–	–

LDL CHOLESTEROL SCREENING

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	85.4	81.7	75.5	88.0	86.6
2011	85.3	81.2	75.0	88.3	86.7
2010	85.6	79.9	74.7	87.8	86.3
2009	85.0	78.6	74.2	87.3	85.5
2008	84.8	74.7	74.1	86.3	82.3
2007	83.9	72.7	70.8	85.7	80.0
2006	83.3	67.4	71.1	84.8	79.4
2005	92.3	87.0	80.6	93.3	87.1
2004	91.0	–	79.6	93.5	–
2003	88.4	–	75.9	91.1	–
2002	85.1	–	70.8	87.9	–
2001	81.4	–	66.5	85.7	–
2000	76.5	–	–	–	–
1999	69.0	–	–	–	–

LDL CHOLESTEROL CONTROL (<100 MG/DL)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	48.4	41.7	33.9	51.5	49.6
2011	48.1	41.8	35.2	52.5	50.9
2010	47.7	37.3	34.6	52.1	45.9
2009	47.0	36.8	33.5	50.0	40.5
2008	45.5	14.8	33.8	48.7	24.3
2007	43.8	10.4	31.3	46.8	22.4
2006	43.0	14.4	30.6	46.9	20.4
2005	43.8	24.4	32.7	50.0	48.4
2004	40.2	–	30.6	47.6	–

MONITORING NEPHROPATHY

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	84.3	78.6	78.4	90.0	88.3
2011	83.8	77.9	77.8	89.9	88.1
2010	83.6	74.3	77.7	89.2	87.3
2009	82.9	69.9	76.9	88.6	85.2
2008	82.4	65.9	76.6	87.9	82.1
2007	80.6	64.2	74.3	85.7	81.7
2006	79.7	60.7	74.6	85.4	83.0
2005	55.1	44.4	48.9	60.3	51.5
2004	52.0	–	46.7	58.6	–
2003	48.2	–	43.7	53.6	–
2002	51.8	–	48.2	57.3	–
2001	46.3	–	42.3	51.9	–
2000	41.3	–	–	–	–
1999	36.0	–	–	–	–

DISEASE-MODIFYING ANTI-RHEUMATIC DRUG THERAPY IN RHEUMATOID ARTHRITIS

Rheumatoid arthritis (RA) is a chronic inflammatory disease in which the immune system attacks healthy joints.[1,2] It causes joint destruction, bone erosion and damage to muscles, kidneys and other organs. RA affects 1.3 million Americans, and affects nearly three times as many women as men.[2] The *Disease-Modifying Anti-Rheumatic Drug Therapy (DMARD) in Rheumatoid Arthritis* measure assesses whether RA patients receive medications that slow the disease's progression and help them maintain functional capacity longer.

- People with persistent RA are at greater risk for premature death. In particular, people with RA die from heart-related problems at higher rates than people without RA.[3]
- Arthritis and other rheumatic conditions are the most common causes of disability in the U.S. Approximately 850,000 adults report being disabled by RA—more than blindness, deafness, bone fracture, cancer and diabetes combined.[1,2]
- Although there is no cure for RA, DMARDs may effectively protect joints and minimize inflammation in other organs, slowing progression of the disease and reducing pain.[1,2]

The Case for Improvement

- Despite evidence-based guidelines recommending early pharmacological treatment of active RA, recent population-based studies of DMARD utilization in RA patients report consistently low rates of receipt.[4]
- Arthritis and related conditions, including RA, cost the U.S. economy $128 billion each year. Direct costs, like medical expenses, are estimated at $81 billion; indirect costs, such as lost wages and disability payments, are estimated at $47 billion.[5] In 2009, RA was the principal diagnosis in more than 16,000 hospitalizations. On average, each visit lasted four days and cost nearly $36,000.[5]
- People with RA have poor functional status. Approximately 60 percent of people with RA become too ill to work after 10 years of the disease.[1,5]

HEDIS Measure Definition

The percentage of diagnosed adults with rheumatoid arthritis who were dispensed at least one ambulatory prescription for a DMARD.

The Bottom Line

RA is a debilitating disease affecting more than 1 million Americans. Although there is no cure for RA, treatment with DMARDs can slow the disease's progression, reduce pain and lower medical and disability costs.

DMARD TREATMENT RATE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	87.9	87.2	69.9	75.5	78.8
2011	87.6	86.7	68.9	72.7	77.2
2010	87.7	87.0	70.1	72.8	77.8
2009	86.4	86.6	70.5	72.3	76.4
2008	85.7	81.5	69.4	70.4	75.1
2007	85.3	78.9	68.1	68.7	73.5
2006	84.8	82.3	67.6	68.2	69.7

ANTIDEPRESSANT MEDICATION MANAGEMENT

Appropriate dosing and continuation of medication therapy through short-term and long-term treatment of depression decrease its recurrence.[1,2,3] Clinical guidelines for depression emphasize the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness and identifying and managing side effects.[1,2,3] Evaluating the duration of medication use is an important indicator in promoting patient compliance. The *Antidepressant Medication Management* measure assesses short-term and long-term adherence rates for adults with major depression who are newly treated with an antidepressant medication.

- In a given year, major depression affects about 6.7 percent of the U.S. population 18 years of age and older (approximately 14.8 million American adults).[4]
- Left untreated, depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy and self-esteem, and can lead to suicide (the 10th leading cause of death in the U.S.).[5]

The Case for Improvement

- Although there are known, effective treatments for depression, less than half of those affected with depression receive treatment.[6] Even in some high-income countries, people with depression are not always correctly diagnosed, and therefore go untreated.[6]
- Chronic depression can become a serious health condition, affecting family, school and work relationships.[6]
- Researchers believe that more than half of people who commit suicide suffer from depression.[5]
- The severity of major depression is significantly associated with increased medication use and related health care costs, unemployment, disability and poor work performance.[7] Poor work productivity costs the U.S. up to $2 billion monthly.[7]

HEDIS Measure Definition

This measure assesses the percentage of adults 18 years of age and older with a diagnosis of major depression, who were newly treated with antidepressant medication and remained on an antidepressant medication treatment.

Two rates are reported:

- *Effective Acute Phase Treatment.* The percentage of newly treated people who remained on an antidepressant medication for at least 84 days (12 weeks).

- *Effective Continuation Phase Treatment.* The percentage of newly treated people who remained on an antidepressant medication for at least 180 days (6 months).

The Bottom Line

Effective medication treatment of major depression can improve a person's daily functioning and well-being, and can reduce the risk of suicide. With proper management of depression, the overall economic burden on society can be alleviated, as well.

EFFECTIVE ACUTE PHASE TREATMENT

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	69.1	68.9	52.8	69.4	72.6
2011	65.6	64.9	51.1	66.3	70.8
2010	64.7	64.3	50.7	65.0	67.4
2009	62.9	63.2	49.6	63.7	63.4
2008	63.1	63.1	48.2	62.5	61.6
2007	62.9	63.8	42.8	61.2	61.0
2006	61.1	63.6	42.9	58.2	56.7
2005	61.3	65.6	45.1	55.0	49.2
2004	60.9	–	46.4	56.4	–
2003	60.7	–	46.2	53.3	–
2002	59.8	–	47.5	52.1	–
2001	56.9	–	45.5	51.2	–
2000	57.4	–	–	–	–
1999	58.8	–	–	–	–

EFFECTIVE CONTINUATION PHASE TREATMENT

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	53.6	53.4	36.7	56.9	61.0
2011	49.4	48.8	34.4	53.3	58.4
2010	48.3	48.1	34.4	51.9	55.7
2009	46.2	46.4	33.0	50.6	51.0
2008	46.3	46.4	31.8	49.3	48.9
2007	46.1	47.6	27.4	48.7	48.7
2006	45.1	46.6	27.5	45.1	40.9
2005	45.0	48.4	29.7	41.1	31.1
2004	44.3	–	30.4	42.4	–
2003	44.1	–	29.3	39.2	–
2002	42.8	–	32.4	37.7	–
2001	40.1	–	30.0	36.8	–
2000	40.1	–	–	–	–
1999	42.1	–	–	–	–

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Approximately one in four adults in the U.S. suffer from mental illness.[1,2] People with a mental illness are less likely to use medical care and follow treatment plans.[2] The *Follow-Up After Hospitalization for Mental Illness* measure assesses whether patients 6 years of age and older who were hospitalized for treatment of selected mental health disorders were seen by a mental health provider.

- In an opinion survey on mental health, the majority of persons with mental health symptoms and persons without symptoms agreed that treatment for a mental health condition can lead to a more normal life.[3]
- Approximately 1 household in 10 includes a person who has had difficulty receiving proper mental health care. For households without health insurance, the number increases to 2 in 10.[4]
- Suicide is the 11th leading cause of death in the U.S., accounting for 30,000 deaths each year; one reason could be untreated depression.[5]

The Case for Improvement

- The leading cause of disability in the United States is mental health disorders. Around 45 percent of persons with a mental health disorder suffer from two or more diagnosable disorders.[6]
- In 2010, there were almost 3 million hospital discharges due to stays for a mental health disorder.[7]
- Each year, more than 60 percent of adults and 70 percent of children do not receive mental health services when they need them.[8]
- Mental health care and treatment services cost the health care system $113 billion annually.[8] Mental health costs increase to $300 billion annually when including health care and treatment services, lost earnings and wages and disability benefits.[9]

HEDIS Measure Definition

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. The measure identifies the percentage of members who received follow-up within 7 days of discharge and within 30 days of discharge.

The Bottom Line

Good mental health is an important factor in health and well-being. Proper follow-up care can improve health outcomes for adults and children.

FOLLOW-UP WITHIN 7 DAYS POST-DISCHARGE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	57.9	53.0	43.7	38.1	37.7
2011	58.9	54.0	46.5	38.0	38.7
2010	59.7	54.2	44.6	37.4	39.1
2009	58.7	52.6	42.9	37.3	40.6
2008	57.2	49.8	42.6	38.1	37.3
2007	55.6	41.9	42.5	37.0	33.3
2006	56.7	48.3	39.1	36.9	38.5
2005	55.8	49.9	39.2	39.2	47.1
2004	55.9	–	38.0	40.1	–
2003	54.4	–	37.7	38.8	–
2002	52.7	–	37.2	38.7	–
2001	51.3	–	33.2	37.2	–
2000	48.2	–	–	–	–
1999	47.4	–	–	–	–

FOLLOW-UP WITHIN 30 DAYS POST-DISCHARGE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	76.0	72.2	63.6	56.4	60.6
2011	76.5	72.7	65.0	56.1	60.6
2010	77.4	74.1	63.8	55.4	61.2
2009	76.8	72.1	60.2	54.8	60.5
2008	76.1	71.4	61.7	56.5	55.5
2007	74.0	63.4	61.0	54.4	50.2
2006	75.8	68.1	57.7	56.3	58.3
2005	75.9	70.7	56.8	59.4	60.1
2004	75.9	–	54.9	60.7	–
2003	74.4	–	56.4	60.3	–
2002	73.6	–	56.7	60.6	–
2001	73.2	–	52.2	60.6	–
2000	71.2	–	–	–	–
1999	70.1	–	–	–	–

ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS

"Adverse drug event" refers to any kind of harm caused by medications. Adverse drug events result in 700,000 emergency department (ED) visits and approximately 120,000 hospitalizations a year. Older adults are seven times more likely to be hospitalized after an ED visit, compared with the rest of the population.[1] The *Annual Monitoring for Patients on Persistent Medications* measure assesses whether adults were properly monitored for selected medications that were usually prescribed for long-term use.

- Adults over 65 consume more health care than any other age group and prescribing medications to the elderly is the most common clinical decision doctors make.[2] Although the rate of adverse drug events is highest in older adults, it is also a concern for the broader adult population.[3]
- Taking a high number of daily medications puts a patient at greater risk for adverse drug events.[3,4]

The Case for Improvement

- Potentially preventable adverse drug events are responsible for $4 billion in medical costs annually.[5]
- Adverse drug events present a public health concern as over-the-counter drugs become more available and more drugs are prescribed in an outpatient setting.[6]
- One study showed that patients brought to the ED with adverse drug events caused by outpatient medications spend between two and eight more days in the hospital in the six-month period after an ED visit, compared with patients admitted to the ED for other reasons.

HEDIS Measure Definition

This measure assesses the percentage of adults 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for the following therapeutic agents during the measurement year, and received at least one therapeutic monitoring event for the therapeutic agent in the measurement year:

- Angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).
- Digoxin.
- Diuretics.
- Anticonvulsants.

A combined rate is also reported.

The Bottom Line

When patients use long-term medications, they are at risk of having an adverse drug event that results in increased use of both inpatient and outpatient resources.[7] Continued monitoring for a medication's effectiveness and possible side effects reduces the likelihood of adverse drug events.[8]

MONITORING FOR PATIENTS USING ACE INHIBITORS OR ARBS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	82.9	79.2	86.3	92.0	91.6
2011	82.5	78.8	85.9	91.3	91.4
2010	81.6	78.4	86.0	90.7	90.8
2009	80.8	77.6	85.9	89.6	89.8
2008	79.4	76.4	84.8	86.7	88.8
2007	77.2	75.6	82.5	84.8	87.8
2006	74.8	66.3	79.9	82.7	83.9

MONITORING FOR PATIENTS USING ANTICONVULSANTS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	58.8	56.3	65.8	66.7	66.3
2011	60.5	56.9	65.2	67.4	68.5
2010	60.4	57.9	67.7	68.2	69.1
2009	62.0	59.2	68.7	69.7	68.5
2008	61.7	59.0	68.7	67.5	70.0
2007	59.6	56.3	65.9	65.1	66.0
2006	59.4	49.8	63.6	63.6	64.9

MONITORING FOR PATIENTS USING DIGOXIN

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	86.5	80.6	90.2	94.5	93.2
2011	85.4	79.2	90.3	93.4	93.2
2010	84.6	79.1	89.7	93.1	92.7
2009	83.6	77.9	88.9	92.0	92.2
2008	81.9	76.6	88.5	90.4	91.1
2007	79.7	75.7	84.9	87.9	90.4
2006	77.3	64.2	83.0	86.2	87.1

MONITORING FOR PATIENTS USING DIURETICS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	82.5	78.7	86.0	92.2	91.9
2011	82.1	78.4	85.4	91.6	91.8
2010	81.0	78.1	85.5	90.9	91.2
2009	80.4	77.2	85.4	89.8	90.3
2008	79.1	76.1	84.2	87.1	89.1
2007	76.8	75.2	81.3	84.8	87.6
2006	74.4	65.7	79.1	83.0	84.1

MONITORING FOR PATIENTS ON COMBINED PERSISTENT MEDICATIONS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	82.3	78.5	84.5	91.4	91.3
2011	81.9	78.2	83.9	90.9	91.2
2010	80.9	77.8	83.9	90.2	90.6
2009	80.3	77.0	83.2	89.2	89.7
2008	78.9	75.8	82.6	86.3	88.6
2007	76.6	74.9	80.1	84.3	87.2
2006	74.3	65.6	77.7	82.2	83.6

INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

Alcohol and other drug (AOD) dependence is common across many age groups and is one of the most preventable health conditions. Adolescents who abuse drugs often act out, do poorly academically, drop out of school and are at greater risk of unplanned pregnancies, violence and infectious diseases.[1] Adults who abuse drugs often develop poor social behaviors, and their work performance and personal relationships consequently suffer.[1] The *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* measure monitors whether adolescents and adults with an episode of AOD dependence had one or more inpatient or outpatient visits shortly after they were diagnosed with AOD dependence.

- An estimated 22.5 million Americans 12 or older have used an illicit drug, and 17.1 percent of adults 18 or older engage in binge drinking.[1,2]
- The majority of alcohol-dependent individuals use other drugs in combination with alcohol.[3]
- Behavioral health counseling interventions are effective in reducing drug use and heavy drinking episodes in adults.[4]

The Case for Improvement

- In 2011, an estimated 21.6 million Americans (8.4 percent) needed treatment for a problem related to drugs or alcohol, but only about 2.3 million people (less than 1 percent) received treatment.[1]
- Abuse of alcohol and illicit drugs is costly, adding up to over $400 billion annually in costs related to crime, lost work productivity and health care.[5]
- Every year, the abuse of illicit drugs and alcohol contributes to the death of more than 100,000 Americans.[1]

HEDIS Measure Definition

This measure assesses the percentage of adolescents and adults with a new episode of AOD dependence who received the following care.

- *Initiation of AOD Treatment.* The percentage of people who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.
- *Engagement of AOD Treatment.* The percentage of people with a diagnosis of AOD use or dependence who initiated treatment and had 2 or more additional services within 30 days of the initiation visit.

The Bottom Line

There is strong evidence that treatment for AOD dependence can improve health, productivity and social outcomes. With more deliberate efforts to reach those affected and with more effective treatment, the nation can save millions of dollars on health care and other related costs.

INITIATION OF AOD TREATMENT

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	39.1	41.2	39.4	38.8	43.3
2011	40.2	40.6	39.2	41.0	47.6
2010	42.7	40.8	42.9	44.6	57.4
2009	42.7	41.8	44.3	46.2	57.4
2008	42.4	42.6	44.5	45.9	49.1
2007	44.5	46.0	45.6	50.4	56.5
2006	43.2	49.0	43.3	50.3	50.0
2005	44.5	45.8	40.7	50.9	52.3
2004	45.9	–	45.7	52.6	–

ENGAGEMENT OF AOD TREATMENT

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	13.6	14.6	10.8	3.1	3.0
2011	15.2	16.0	11.9	3.7	3.8
2010	15.6	16.0	14.2	3.7	4.8
2009	16.1	15.7	12.3	4.6	4.2
2008	16.2	16.2	12.4	4.3	9.4
2007	15.2	15.2	14.4	4.5	6.3
2006	13.8	16.0	11.7	4.5	7.0
2005	14.1	15.3	9.7	4.7	3.2
2004	15.5	–	11.9	7.1	–

WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS

Over the last three decades, childhood obesity has more than doubled in children and tripled in adolescents.[1] According to a statement released by the Surgeon General in 2004, if obesity rates continue to increase, it is possible we may see a generation of people with a shorter life expectancy than their parents.[2,3]

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure evaluates the percentage of children and adolescents who are regularly screened for weight problems and who have received counseling about healthy eating and physical activity.

- More than one third of children and adolescents in the U.S. are currently overweight and approximately 17 percent are obese.[1,4]
- Obesity, defined as having excess body fat, has both immediate and long-term effects on children's health and well-being, including high blood pressure and cholesterol; increased risk of impaired glucose tolerance, insulin resistance and type 2 diabetes; breathing problems and asthma; joint problems and musculoskeletal discomfort. Childhood obesity can also cause fatty liver disease, gallstones, gastroesophageal reflux, adult obesity, heart disease, stroke, several types of cancer and osteoarthritis.[1,5,6]
- Obese children and adolescents are at greater risk of developing social and psychological problems, such as discrimination and poor self-esteem, which can continue into adulthood.[5,6]

The Case for Improvement

- Annual direct medical costs of childhood obesity in the U.S. are estimated to be at least $14.3 billion.[7,8,9,10,11]
- Dietary and physical activity behaviors of children and adolescents can be influenced by their schools, families and communities.[6,12]
- According to a national survey from 2011, only 77 percent of children 9–13 years of age report participating in daily free-time physical activity.[13] Fewer than 3 in 10 high school students reported participating in at least 60 minutes of physical activity every day (the minimum recommended by the American Heart Association and the CDC).[14,15,16]

HEDIS Measure Definition

The percentage of children and adolescents 3–17 years of age who had an outpatient visit with a primary care practitioner or OB/GYN during the measurement year and who had evidence of:

- BMI percentile documentation.
- Counseling for nutrition.
- Counseling for physical activity.

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

The Bottom Line

Healthy lifestyle habits, including healthy eating and physical activity, can lower the risk of becoming obese and developing related diseases.[1] Because obesity can become a lifelong health issue, it is important to monitor weight problems in children and adolescents and provide guidance for maintaining a healthy weight and lifestyle.[17]

BMI PERCENTILE ASSESSMENT (3–17 YEARS)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	51.6	31.2	51.8	–	–
2011	44.7	24.6	46.0	–	–
2010	35.2	10.9	37.3	–	–
2009	35.4	17.4	30.3	–	–

COUNSELING FOR NUTRITION (3–17 YEARS)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	54.3	35.4	55.0	–	–
2011	46.4	28.4	50.1	–	–
2010	37.4	11.8	45.6	–	–
2009	41.0	20.3	41.9	–	–

COUNSELING FOR PHYSICAL ACTIVITY (3–17 YEARS)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	50.4	32.6	44.2	–	–
2011	43.0	25.7	40.6	–	–
2010	35.3	10.5	36.7	–	–
2009	36.5	17.6	32.5	–	–

CHILDHOOD IMMUNIZATION STATUS

Childhood vaccines protect children by providing immunity against serious and potentially life-threatening diseases early in life, before they are exposed to diseases such as diphtheria, measles, meningitis, polio, tetanus and whooping cough.[1,2] The *Childhood Immunization Status* measure assesses whether children received immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) by their second birthday.

- Vaccines are considered one of the safest and most effective public health interventions and are responsible for dramatically reducing pediatric morbidity and mortality in the U.S.[3,4]
- Vaccine-preventable childhood disease cases, such as polio and diphtheria, are at record lows due to current vaccination practices.[5]
- Childhood vaccinations not only protect the child receiving them, but also protect others who may not be able to receive them because of their age, severe allergies, weakened immune systems or other reasons.[6]

The Case for Improvement

- Approximately 300 children die each year in the U.S. from vaccine-preventable diseases.[7]
- Although there is substantial evidence supporting their safety and effectiveness, thousands of U.S. parents refuse or delay recommended vaccinations for their children, due in large part to concerns about potential side effects.[3,8]
- It is estimated that for each cohort of children vaccinated, 14 million cases of disease are prevented, direct health care costs are reduced by $9.9 billion and $33.4 billion in indirect costs is saved.[7]

HEDIS Measure Definition

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

The Bottom Line

Immunizations are a core component of disease prevention in the U.S. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.[9]

DIPHTHERIA, TETANUS, ACELLULAR PERTUSSIS (DTAP/DT)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	87.2	80.0	80.9	–	–
2011	86.5	76.8	79.8	–	–
2010	86.3	64.7	80.2	–	–
2009	85.4	59.9	79.6	–	–
2008	87.2	47.7	78.6	–	–
2007	86.9	42.4	77.8	–	–
2006	87.2	39.2	79.3	–	–
2005	86.1	62.8	76.9	–	–
2004	85.9	–	75.6	–	–
2003	84.3	–	72.6	–	–
2002	80.1	–	69.4	–	–
2001	81.5	–	71.2	–	–
2000	80.4	–	–	–	–
1999	78.7	–	–	–	–

HEPATITIS B (HEP B)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	89.2	77.3	89.5	–	–
2011	87.9	74.7	88.8	–	–
2010	90.2	58.7	90.1	–	–
2009	90.1	53.7	89.1	–	–
2008	91.8	38.7	88.3	–	–
2007	91.3	35.8	87.2	–	–
2006	91.0	31.1	88.4	–	–
2005	90.0	57.7	85.4	–	–
2004	87.2	–	81.9	–	–
2003	85.8	–	79.5	–	–
2002	81.9	–	76.2	–	–
2001	79.9	–	75.4	–	–
2000	77.9	–	–	–	–
1999	75.5	–	–	–	–

The large increases in this measure's rates are due to a change in measure specifications that halved the required frequency of vaccination. We believe measure rates are stabilizing to new norms in reaction to the specification change.

HAEMOPHILUS INFLUENZA TYPE B (HIB)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	94.3	88.3	92.0	–	–
2011	94.1	86.1	91.0	–	–
2010	94.3	75.5	90.3	–	–
2009	94.8	74.8	93.7	–	–
2008	94.8	66.3	93.4	–	–
2007	93.1	53.6	87.7	–	–
2006	93.4	49.2	89.1	–	–
2005	92.9	72.6	86.8	–	–
2004	87.7	–	79.1	–	–
2003	86.1	–	77.7	–	–
2002	83.2	–	73.8	–	–
2001	83.4	–	74.9	–	–
2000	82.7	–	–	–	–
1999	80.7	–	–	–	–

INACTIVATED POLIO VIRUS (IPV)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	92.8	86.3	91.6	–	–
2011	92.4	83.4	90.5	–	–
2010	91.8	71.1	90.8	–	–
2009	91.1	65.3	89.0	–	–
2008	92.1	52.6	87.9	–	–
2007	91.5	47.5	87.3	–	–
2006	91.4	43.0	87.9	–	–
2005	90.3	66.7	84.7	–	–
2004	90.1	–	84.8	–	–
2003	88.7	–	83.1	–	–
2002	86.0	–	80.3	–	–
2001	85.4	–	79.1	–	–
2000	84.2	–	–	–	–
1999	82.6	–	–	–	–

MEASLES, MUMPS, RUBELLA (MMR)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	91.8	88.3	91.6	–	–
2011	91.5	86.9	90.9	–	–
2010	90.8	82.7	90.6	–	–
2009	90.6	80.5	91.2	–	–
2008	93.5	76.4	90.9	–	–
2007	93.5	76.3	90.4	–	–
2006	93.6	75.0	91.1	–	–
2005	93.0	86.2	89.6	–	–
2004	92.3	–	88.1	–	–
2003	91.5	–	87.4	–	–
2002	90.1	–	84.4	–	–
2001	89.4	–	83.7	–	–
2000	88.4	–	–	–	–
1999	87.0	–	–	–	–

VARICELLA (VZV)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	91.6	88.0	91.1	–	–
2011	91.3	86.9	90.5	–	–
2010	90.8	82.2	90.0	–	–
2009	90.6	79.7	90.6	–	–
2008	92.0	74.8	89.7	–	–
2007	91.9	74.4	88.7	–	–
2006	90.9	72.0	88.9	–	–
2005	89.9	82.0	86.6	–	–
2004	87.5	–	84.7	–	–
2003	85.7	–	81.8	–	–
2002	82.0	–	76.4	–	–
2001	75.3	–	73.6	–	–
2000	70.5	–	–	–	–
1999	63.8	–	–	–	–

PNEUMOCOCCAL CONJUGATE (PCV)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	86.7	78.9	80.1	–	–
2011	87.0	77.7	79.3	–	–
2010	85.6	65.6	79.4	–	–
2009	84.6	60.1	77.6	–	–
2008	84.8	47.8	75.6	–	–
2007	83.6	42.3	73.8	–	–
2006	72.8	37.1	68.3	–	–

HEPATITIS A (HEP A)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	65.5	61.1	76.4	–	–
2011	39.0	32.3	39.2	–	–
2010	35.4	28.6	36.5	–	–

ROTAVIRUS (RV)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	76.7	69.8	66.0	–	–
2011	75.1	67.2	62.4	–	–
2010	63.5	51.9	57.6	–	–

INFLUENZA

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	63.3	59.8	49.5	–	–
2011	61.1	57.3	44.8	–	–
2010	57.1	51.1	43.6	–	–

CHILDHOOD IMMUNIZATION COMBINATION 2 (DTAP, IPV, MMR, HIB, HEPATITIS B AND VZV)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	79.7	68.1	75.7	–	–
2011	78.0	64.8	74.5	–	–
2010	78.5	48.5	74.1	–	–
2009	77.7	43.1	74.3	–	–
2008	81.2	30.6	73.7	–	–
2007	80.8	30.1	72.1	–	–
2006	79.8	24.5	73.4	–	–
2005	77.7	54.8	70.5	–	–
2004	72.5	–	63.1	–	–
2003	69.8	–	58.5	–	–
2002	62.5	–	53.2	–	–
2001	57.6	–	52.5	–	–
2000	53.5	–	–	–	–
1999	47.5	–	–	–	–

CHILDHOOD IMMUNIZATION COMBINATION 3 (DTAP, IPV, MMR, HIB, HEPATITIS B, VZV AND PCV)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	76.8	65.8	72.1	–	–
2011	75.7	63.1	70.6	–	–
2010	75.1	46.1	69.9	–	–
2009	73.4	40.4	69.4	–	–
2008	76.6	28.5	67.6	–	–
2007	75.5	27.6	65.4	–	–
2006	65.7	22.4	60.9	–	–

CHILDHOOD IMMUNIZATION COMBINATION 10 (DTAP, IPV, MMR, HIB, HEPATITIS A, HEPATITIS B, VZV, PCV, ROTA

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	37.9	29.5	31.4	–	–
2011	22.9	17.0	17.3	–	–
2010	18.5	10.4	15.2	–	–

IMMUNIZATIONS FOR ADOLESCENTS

Receiving recommended vaccinations is the best defense against vaccine-preventable diseases.[1,2] However, as children get older, the protection they received from some of their childhood vaccinations begins to wear off and they need booster shots. Adolescents are also at risk for vaccine-preventable diseases (e.g., meningococcal meningitis) they are not typically vaccinated against as children.[3] The *Immunizations for Adolescents* measure assesses whether adolescents were vaccinated against four vaccine-preventable diseases: meningococcal meningitis, tetanus, diphtheria and pertussis (whooping cough).

- The tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine is given to adolescents as a booster shot to increase the protection they received in childhood vaccinations.[2]
- Diphtheria, tetanus and pertussis are serious diseases that can cause life-threatening illnesses. Diphtheria can cause breathing difficulties, heart problems, nerve damage, pneumonia and even death. Tetanus can cause seizures and severe muscle spasms that can be strong enough to cause bone fractures of the spine, and causes death in 30 percent–40 percent of cases. Pertussis can cause severe coughing spells that can interfere with breathing, as well as pneumonia, long-lasting bronchitis, seizures, brain damage and death.[4]
- Meningococcal disease occurs when the protective membranes covering the brain and spinal cord become infected and swell, and can cause serious complications, such as brain damage, hearing loss or learning disabilities.[5,6,7] Meningococcal disease is caused by the bacterium *neisseria meningitides,* or meningococcus, and is the leading cause of bacterial meningitis in the U.S.[8]
- A meningococcal infection can spread quickly, killing an otherwise healthy adolescent in 48 hours.[9] Although not all cases of meningococcal disease progress into meningitis, 15 percent of the cases that do progress, result in death.[5,10]

The Case for Improvement

- Each year, many adolescents miss their recommended vaccinations, leaving them needlessly vulnerable to disease, suffering and death.[9]
- Vaccine-preventable diseases are expensive for society as a whole, costing more than $10 billion in direct medical costs and indirect societal costs.[9]

- In 2012, pertussis outbreaks were reported in a majority of states, with more than 32,000 cases and 16 deaths.[9] Outbreaks can occur in workplaces, schools and homes, and can result in physical, economic and social costs.[11]

- Bacterial meningitis remains a major global health threat, with an estimated 500,000 cases reported worldwide each year, accounting for at least 50,000 deaths.[12] According to preliminary data, meningitis was responsible for 606 deaths in the U.S. in 2011.[12]

HEDIS Measure Definition

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one Tdap vaccine or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.

The Bottom Line

Vaccines are a safe and effective way to protect adolescents against potentially deadly diseases and help them develop into healthy adults. Vaccines can protect their family and their community, as well.[3,9,11]

MENINGOCOCCAL (MCV4)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	66.0	57.1	69.4	–	–
2011	61.9	51.4	63.2	–	–
2010	55.2	43.8	56.3	–	–

TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS (TDAP/TD)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	79.2	69.9	81.3	–	–
2011	77.0	65.4	75.8	–	–
2010	69.5	55.3	67.8	–	–

ADOLESCENT IMMUNIZATION COMBINATION 1 (MENINGOCOCCAL, TDAP/TD)

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	63.7	54.3	67.2	–	–
2011	59.4	48.2	60.5	–	–
2010	51.6	39.4	52.2	–	–

LEAD SCREENING IN CHILDREN

Lead exposure can cause a range of health problems, especially in children, including damage to the brain, kidneys, nerves and blood. Lead can also cause behavioral problems, learning disabilities, seizures and death.[1] Approximately 500,000 children under 5 years of age have elevated blood lead levels, as defined by the Centers for Disease Control and Prevention (CDC).[2] Because children in low-income households are at greatest risk for elevated lead levels, the *Lead Screening in Children* measure assesses the number of children covered by Medicaid who were tested for lead poisoning before they turned 2 years of age.

- In May 2012, the CDC updated its definition of "level of concern" for children 1–5 years of age, from BLLs ≥10 µg/dL to BLLs ≥5 µg/dL, allowing earlier detection and treatment.[3]
- Most children with elevated blood lead levels do not show signs or symptoms of lead poisoning, so screening is important to reduce the chances of physical and mental impairment.[2]
- The two most common methods of screening children for lead poisoning are venous blood sampling (inserting a needle into a vein) and capillary blood sampling (using a finger or a heel stick).[4]

The Case for Improvement

- Exposure to lead-based paint and lead-contaminated dust has decreased since the 1970s, when paints of this kind were banned. However, 24 million homes in the U.S.—4 million of them, homes to young children—still contain lead paint.[5]
- The total annual costs of diseases from environmental causes are estimated to be $76.6 billion, or 3.5 percent of U.S. health care costs. Of this, $50.9 billion in lost economic productivity from lower cognitive potential is attributed to childhood lead exposure.[6]
- Children in low-income households, non-Hispanic African American children and children who live in housing built before 1960 are disproportionally affected by lead poisoning.[7]

HEDIS Measure Definition

This measure assesses the percentages of children 2 years of age who had one or more blood tests for lead poisoning by their second birthday.

The Bottom Line

Lead poison is entirely preventable. If it is not detected early, it can have damaging effects on children's physical and mental health. Screening is an inexpensive way to detect the presence of lead in a child's environment and reduce further exposure.

LEAD SCREENING RATE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	67.5	–	–
2011	–	–	67.8	–	–
2010	–	–	66.2	–	–
2009	–	–	66.4	–	–
2008	–	–	66.7	–	–

CHLAMYDIA SCREENING IN WOMEN

Chlamydia is the most commonly reported bacterial sexually transmitted disease in the U.S., occurring most often among adolescent and young adult females.[1,2] Chlamydia is often known as a "silent" disease because most infected people are asymptomatic.[1] Untreated chlamydia infections can lead to serious and irreversible complications, including pelvic inflammatory disease (PID), infertility and increased risk of becoming infected with HIV.[1,3]

The *Chlamydia Screening in Women* measure looks at the percentage of non-pregnant, sexually active women 24 years of age and younger, who are screened annually for chlamydia, as recommended by the U.S. Preventive Services Task Force.[4]

- Approximately 75 percent of chlamydia infections in women and 95 percent in men are asymptomatic, resulting in delayed medical care and treatment.[5]
- Between 10 percent and 15 percent of untreated chlamydia infections result in symptomatic PID, which can lead to ectopic pregnancy and infertility.[1] As many as 15 percent of women with PID will become infertile.[6]

The Case for Improvement

- The total lifetime direct medical cost of chlamydia infections is an estimated $517 million.[7]
- Chlamydia is easily detected and treated, but screening remains underutilized. Challenges affecting annual screening rates include lack of patient awareness and social stigma about seeking or discussing screening.[2,8]
- Multiple chlamydia infections increase a woman's risk of serious reproductive health complications.[2]

HEDIS Measure Definition

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

The Bottom Line

If the chlamydia screening rate for sexually active young women increased to 90 percent, as many as 30,000 cases of PID could be prevented annually.[9]

CHLAMYDIA SCREENING RATE (16–20 YEARS)					
	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	41.1	38.9	53.5	–	–
2011	41.5	39.6	54.9	–	–
2010	40.8	38.1	54.6	–	–
2009	41.0	37.7	54.4	–	–
2008	40.1	36.7	52.7	–	–
2007	36.4	32.4	48.6	–	–
2006	36.2	29.4	50.5	–	–
2005	34.4	26.2	49.2	–	–
2004	32.6	–	45.9	–	–
2003	30.4	–	44.3	–	–
2002	26.7	–	40.8	–	–
2001	24.5	–	39.6	–	–
2000	23.6	–	–	–	–
1999	18.5	–	–	–	–

CHLAMYDIA SCREENING RATE (21–24 YEARS)					
	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	49.2	45.5	63.6	–	–
2011	48.4	44.9	63.4	–	–
2010	45.7	41.9	62.3	–	–
2009	45.4	41.4	61.6	–	–
2008	43.5	39.4	59.4	–	–
2007	39.2	34.9	54.0	–	–
2006	38.0	31.2	55.0	–	–
2005	35.2	27.6	52.5	–	–
2004	31.7	–	49.0	–	–
2003	29.1	–	46.0	–	–
2002	24.5	–	41.5	–	–
2001	22.1	–	41.1	–	–
2000	20.7	–	–	–	–
1999	16.0	–	–	–	–

CHLAMYDIA SCREENING RATE (TOTAL RATE)					
	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	45.1	42.3	57.1	–	–
2011	45.0	42.4	58.0	–	–
2010	43.1	40.0	57.5	–	–
2009	43.1	39.5	56.7	–	–
2008	41.7	38.0	54.9	–	–
2007	38.1	33.8	50.7	–	–
2006	37.3	30.4	52.4	–	–
2005	34.9	26.9	50.7	–	–
2004	32.2	–	47.2	–	–
2003	29.7	–	44.9	–	–
2002	25.4	–	40.9	–	–
2001	23.1	–	40.4	–	–

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

For more than 10 years, the Centers for Disease Control and Prevention (CDC) has increased efforts to promote the appropriate use of antibiotics to treat respiratory infections, particularly pharyngitis. Pharyngitis, or sore throat, is common among children and adolescents and can be caused by bacteria or by a virus.[1]

The *Appropriate Testing for Children With Pharyngitis* measure evaluates whether children and adolescents are treated for pharyngitis *after* undergoing diagnostic testing, thereby ensuring that treatment is provided as recommended and preventing the development of resistance to drugs used for treatment.

- Pharyngitis affects a large number of individuals and is responsible for 12 million primary care visits each year in the U.S.[2]
- The bacteria most commonly associated with pharyngitis (group A streptococcus) is responsible for up to 30 percent of pharyngitis cases in children.[3] In winter and early spring, as many as 20 percent of school-age children may carry the bacteria without displaying symptoms.[4]

The Case for Improvement

- Pharyngitis has a significant financial burden on children and adults alike, costing an estimated $224 million–$539 million and resulting in 1,300 deaths every year.[5]
- Pharyngitis is often diagnosed and treated with antibiotics even if a patient does not have a positive diagnosis for strep. Clinical guidelines strongly recommend performing both rapid antigen detection testing (RADT) and throat cultures before starting treatment.[6]
- Infections resulting from pharyngitis can affect lifestyle and productivity, as both children and parents can be absent from school and work during the course of illness.[4]
- Inappropriate use of antibiotics contributes significantly to the development of drug-resistant strains of pharyngitis.[4]

HEDIS Measure Definition

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

The Bottom Line

Antibiotic treatment is rarely appropriate for pharyngitis. The availability of RADT has made diagnostic testing easier, thereby reducing use of antibiotics and preventing the spread of drug-resistant strains of pharyngitis.[4]

APPROPRIATE TESTING RATE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	80.2	78.9	68.0	–	–
2011	80.2	79.3	66.7	–	–
2010	77.6	76.6	64.9	–	–
2009	77.4	75.5	62.3	–	–
2008	75.6	74.1	61.4	–	–
2007	74.7	73.5	58.7	–	–
2006	72.7	69.4	56.0	–	–
2005	69.7	64.5	52.0	–	–
2004	72.6	–	54.4	–	–

APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION

Upper respiratory infection (URI), or the common cold, is an infection of the lining in the throat and nose that causes congestion, coughing, fever and other symptoms that typically last one to two weeks. Despite the viral origins of most URIs, antibiotics continue to be inappropriately prescribed for many children.[1] Overuse of antibiotics not only causes individual harm, it can also pose risks to society by increasing the prevalence of antibiotic-resistant bacteria.[1] The *Appropriate Treatment for Children With Upper Respiratory Infection* measure evaluates appropriate treatment of URI in children.

- Approximately 500 million noninfluenza-related viral respiratory tract infections occur annually.[2] Physicians often prescribe antibiotics based on parental expectations that they will alleviate the infection, but there is no evidence that antibiotics are beneficial in cases of viral infection.[3]
- After initial antibiotic use, antibiotic-resistant bacteria can reside in the throat for up to three months, which can result in widespread exposure to the resistant bacteria in schools, nurseries or day care centers.[3]

The Case for Improvement

- Antibiotics are one of the most essential tools to combat bacterial disease, but inappropriate use of antibiotics contributes to antibiotic resistance, which has become one of the largest threats to public health.[4]
- Inappropriate prescribing of antibiotics to children with acute respiratory infections account for more than 10 million physician visits annually.[5] The annual estimated cost of noninfluenza-related viral respiratory tract infections is almost $40 billion, including costs associated with antibiotics, physician encounters and missed days of work for the caregiver.[2]
- The number of infection-related hospitalizations from antibiotic resistance has increased in all age groups, but has increased most drastically (395 percent between 1997 and 2006) in children under 18 years of age.[6]

HEDIS Measure Definition

The percentage of children 3 months–18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.

The Bottom Line

Despite campaigns to reduce the overuse of antibiotics in treatment of viral URIs, inappropriate prescription of antibiotics continues. Increased awareness of the dangers associated with antibiotic-resistant bacteria and effective communication between patients and providers can improve treatment and reduce unnecessary use of antibiotics.

APPROPRIATE TREATMENT RATE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	84.0	82.3	85.1	–	–
2011	83.9	82.0	85.3	–	–
2010	85.1	83.7	87.2	–	–
2009	84.1	82.5	86.0	–	–
2008	83.9	83.3	85.5	–	–
2007	83.5	83.0	84.1	–	–
2006	82.8	82.1	83.4	–	–
2005	82.9	81.9	82.4	–	–
2004	82.7	–	79.9	–	–

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION

Attention-deficit/hyperactivity disorder (ADHD) is one of the most common mental disorders affecting children. 8 percent of American children have been diagnosed with ADHD, whose main features are hyperactivity, impulsiveness and an inability to sustain attention or concentration. The average age for childhood ADHD diagnosis is 7 years.[1,2] Children 6–12 years of age who visit a mental health practitioner are more likely to receive appropriate medication.[3] The *Follow-Up Care for Children Prescribed ADHD Medication* measure assesses whether children prescribed ADHD medication have a follow-up visit with their provider.

The Case for Improvement

- Symptoms of ADHD often occur at levels that cause significant distress and impairment, and cause disruption in the classroom or problems with schoolwork.[4]
- Among children who have been prescribed medication for ADHD, approximately 2.5 percent are not taking their medications.[5]
- Between 70 percent and 80 percent of children with ADHD respond to medications and exhibit an improved attention span, better performance on tasks and less impulsive behavior.[4]
- Children with ADHD add a higher annual cost to the U.S. education system—on average, $5,000 each year for each student with ADHD.[6]
- Studies suggest that there is an increased risk for drug use disorders in adolescents with untreated ADHD.[7]

HEDIS Measure Definition

The two rates of this measure assess follow-up care for children prescribed an ADHD medication:

- *Initiation Phase*. The percentage of children between 6 and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.
- *Continuation and Maintenance Phase*. The percentage of children between 6 and 12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days, and had at least two follow-up visits with a practitioner in the 9 months subsequent to the Initiation Phase.

The Bottom Line

When managed appropriately, medication for ADHD can effectively control symptoms of hyperactivity, impulsiveness and inability to sustain concentration. To ensure that medication is being prescribed and managed correctly, it is important that children be monitored by a pediatrician with prescribing authority.

FOLLOW-UP CARE AFTER INITIATION OF TREATMENT

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	38.6	38.1	39.0	–	–
2011	39.4	39.4	38.8	–	–
2010	38.8	38.1	38.1	–	–
2009	36.6	35.4	36.6	–	–
2008	35.8	34.1	34.4	–	–
2007	33.7	31.8	33.5	–	–
2006	33.0	30.6	31.8	–	–

FOLLOW-UP CARE DURING CONTINUATION OF TREATMENT

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	45.7	44.9	45.3	–	–
2011	44.2	44.9	45.9	–	–
2010	43.4	43.3	43.9	–	–
2009	41.7	39.0	41.7	–	–
2008	40.2	37.1	39.5	–	–
2007	38.7	34.2	38.9	–	–
2006	38.1	30.0	34.0	–	–

CHILDREN AND ADOLESCENTS' ACCESS TO PRIMARY CARE PRACTITIONERS

Access to primary care is important for the health and wellness of children and adolescents. The *Children and Adolescents' Access to Primary Care Practitioners* measure assesses whether children and adolescents visited a primary care practitioner (PCP), such as a family doctor, internist, pediatrician or general practitioner.

- In 2011, 2.5 million children did not have their medical needs met. In the same year, 2 million children were described as having "fair to poor" health.[1]
- More than 1 million children do not receive necessary medical care due to costs. Nearly 5.5 million children in the United States have not seen a medical provider in more than a year. Around 2 million have not seen a health care provider in more than two years.[2]

The Case for Improvement

- Over 18 percent of all emergency department (ED) visits in 2011 were for those under age 18.[3] High-quality primary care services have been found to significantly reduce children's nonurgent ED visits.[4]
- Improving access to primary care services can lead to reduced expenses for hospitalizations and help slow rising health care costs.[5]
- More than 7 million children do not have a personal doctor or nurse, and more than 6 million young people do not have a consistent place to receive care when they get sick.[1]

HEDIS Measure Definition

The percentage of children and young adults 12 months–19 years of age who had a visit with a PCP. The measure reports on four separate percentages:

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

The Bottom Line

Access to a primary care setting leads to improved health outcomes for children and adolescents. Primary care can best serve the need for screening, appropriate treatment and preventive services for children and adolescents.

ACCESS TO PRIMARY CARE CHILDREN 12–24 MONTHS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	97.9	97.0	96.0	–	–
2011	97.9	97.2	96.1	–	–
2010	97.5	96.9	96.1	–	–
2009	97.5	96.2	95.2	–	–
2008	96.7	95.4	95.0	–	–
2007	96.9	93.7	93.4	–	–
2006	97.0	94.2	94.1	–	–
2005	97.0	95.0	92.6	–	–
2004	96.8	–	92.3	–	–
2003	96.3	–	92.4	–	–
2002	95.7	–	91.1	–	–
2001	95.2	–	90.7	–	–
2000	92.5	–	–	–	–
1999	91.2	–	–	–	–

ACCESS TO PRIMARY CARE CHILDREN 25 MONTHS–6 YEARS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	91.6	90.1	88.3	–	–
2011	91.9	90.3	88.2	–	–
2010	91.2	89.1	88.3	–	–
2009	91.6	89.1	88.3	–	–
2008	89.7	87.4	87.2	–	–
2007	89.4	86.3	84.3	–	–
2006	89.3	86.3	84.9	–	–
2005	89.3	85.7	83.1	–	–
2004	88.1	–	81.9	–	–
2003	88.5	–	82.1	–	–
2002	87.2	–	80.0	–	–
2001	85.7	–	79.3	–	–
2000	82.4	–	–	–	–
1999	81.3	–	–	–	–

ACCESS TO PRIMARY CARE CHILDREN 7–11 YEARS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	92.2	90.5	89.9	–	–
2011	91.9	90.1	89.5	–	–
2010	91.6	89.4	90.2	–	–
2009	91.4	89.0	90.3	–	–
2008	89.9	87.4	87.8	–	–
2007	89.5	86.8	85.9	–	–
2006	89.2	85.7	85.9	–	–
2005	88.6	83.4	83.4	–	–
2004	88.5	–	82.5	–	–
2003	88.5	–	82.1	–	–
2002	87.4	–	80.3	–	–
2001	85.8	–	79.3	–	–
2000	83.6	–	–	–	–
1999	82.6	–	–	–	–

ACCESS TO PRIMARY CARE ADOLESCENTS 12–19 YEARS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	89.7	87.6	88.4	–	–
2011	89.3	87.3	87.9	–	–
2010	89.2	86.8	88.1	–	–
2009	89.0	86.1	87.9	–	–
2008	87.3	84.2	85.3	–	–
2007	86.9	83.4	82.7	–	–
2006	86.6	82.3	83.2	–	–
2005	86.1	79.8	80.9	–	–
2004	85.5	–	79.3	–	–
2003	85.8	–	79.6	–	–

CHILD AND ADOLESCENT WELL-CARE VISITS

Childhood and adolescence is a vital time for growth and development, and it is also when well-child care can affect the future for children and for their families. Well-care visits are an effective way for health care providers to evaluate physical, emotional and social development.[1] The *Well-Child* and *Adolescent Well-Care Visits* measures assess the number of children and adolescents who had a well-care visit at key ages.

- The 2011/2012 National Survey of Children's Health showed that an estimated 11 million children age 0–17 years of age did not have any preventive medical care visits in the past year.[2] These years are an important time for health care providers to promote healthy behaviors and provide anticipatory guidance on a variety of topics, including injury prevention, physical activity and nutrition.[1]

- Many adult chronic diseases begin in childhood, when eating habits and physical activity levels are established.[3] For example, in 2010 more than one-third of children and adolescents were overweight or obese. Without early prevention, obesity can lead to type 2 diabetes, heart and other diseases and certain cancers.[4]

- Among adolescents, the primary cause of morbidity and mortality tends to be engaging in risky behaviors. In 2011, almost 45 percent of high school students had tried cigarettes and 70.8 percent had had at least one drink of alcohol in their life.[5] Health care providers may present the best opportunity for identifying risky behavior among adolescents, promoting and guiding family involvement and establishing interventions.[6]

The Case for Improvement

- In 2011, 89 percent of children under 6 years of age received a well-child check-up in the past year, compared with 84 percent in 2000.[7]

- Although approximately 12 percent–16 percent of children experience developmental problems, only one-third are identified in pediatric practices before they begin school.[8] Over the course of a lifetime, untreated developmental delays and disabilities are estimated at $417,000 in direct medical costs and indirect costs from lost productivity, per child.[9]

- Health care spending for preventable health issues is a growing problem for children and adolescents. Every year, nearly 9 million children ages 0–19 are treated for injuries in emergency departments (ED) and more than 225,000

require hospitalization, at a cost of around $87 billion in medical and societal costs related to childhood injuries.[10]

- Well-care visits are an effective way for health care providers to give timely and relevant advice to children and adolescents.[11] Advice from health care providers can lead to improvement in health behaviors. For example, studies have shown that a provider's advice to quit smoking is an important motivator for smokers attempting to quit.

HEDIS Measure Definition

Well-Child Visits in the First 15 Months of Life
The percentage of children who turned 15 months old during the measurement year and had the following number of well-child visits with a primary care physician during the first 15 months of life:

- No well-child visits.
- One well-child visit.
- Two well child visits.
- Three well-child visits.
- Four well-child visits.
- Five well-child visits.
- Six or more well-child visits.

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
The percentage of children 3–6 years of age who received one or more well-child visits with a primary care physician during the measurement year.

Adolescent Well-Care Visits
The percentage of enrolled adolescents and young adults 12–21 years of age who had at least one comprehensive well-care visit with a primary care physician or an OB/GYN practitioner during the measurement year.

The Bottom Line
Through regular check-ups, providers and parents can influence child and adolescent health and development. Changes in physical and social circumstances can put young people at increased risk for serious and long-term health effects. A well-care visit is a critical opportunity for screening and counseling, and is important for maintaining health.

SIX OR MORE WELL-CHILD VISITS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	78.2	76.4	63.6	–	–
2011	78.0	76.1	61.8	–	–
2010	76.3	72.8	60.2	–	–
2009	74.5	71.9	59.4	–	–
2008	75.2	69.0	58.8	–	–
2007	72.8	63.1	52.9	–	–
2006	72.9	65.4	55.6	–	–
2005	71.1	59.7	49.1	–	–
2004	68.7	–	47.4	–	–
2003	66.6	–	45.2	–	–
2002	64.4	–	43.0	–	–
2001	59.6	–	37.3	–	–
2000	55.2	–	–	–	–
1999	50.7	–	–	–	–

ONE OR MORE WELL-CHILD VISITS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	72.9	69.9	72.0	–	–
2011	72.5	69.8	72.0	–	–
2010	71.6	67.8	71.9	–	–
2009	70.3	66.0	71.6	–	–
2008	69.8	63.6	69.7	–	–
2007	67.8	60.7	65.3	–	–
2006	66.7	61.6	66.8	–	–
2005	65.6	54.5	63.6	–	–
2004	64.4	–	62.4	–	–
2003	62.7	–	60.7	–	–
2002	60.4	–	58.2	–	–
2001	57.5	–	56.0	–	–
2000	54.2	–	–	–	–
1999	51.3	–	–	–	–

AT LEAST ONE COMPREHENSIVE WELL-CARE VISIT					
	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	43.3	40.1	49.7	–	–
2011	43.2	40.6	49.7	–	–
2010	42.7	39.2	48.1	–	–
2009	42.5	38.3	47.7	–	–
2008	42.9	36.2	45.9	–	–
2007	41.8	34.7	42.1	–	–
2006	40.3	34.6	43.6	–	–
2005	38.8	29.3	40.7	–	–
2004	38.2	–	40.0	–	–
2003	37.1	–	37.5	–	–
2002	35.8	–	37.1	–	–
2001	33.1	–	32.6	–	–
2000	30.9	–	–	–	–
1999	28.9	–	–	–	–

PRENATAL AND POSTPARTUM CARE

Almost 4 million babies were born in the United States in 2011.[1] Regular prenatal care is an important way women can promote a healthy pregnancy, and postpartum care assesses a woman's physical health and mental well-being following delivery.[2,3,4] The *Prenatal and Postpartum Care* and *Frequency of Ongoing Prenatal Care* measures assess whether women have access to timely and consistent prenatal and postpartum care.

- Common pregnancy complications include ectopic pregnancy, preterm labor, low birth weight, gestational diabetes, hypertension, group B strep (the leading cause of infections in newborns) and Rh Negative disease.[5,6]
- Low birth-weight babies are at high risk for respiratory infections, blindness, learning disabilities, cerebral palsy and heart infections.[5]
- Regular prenatal care provides an opportunity for pregnant women to discuss their pregnancy with their care provider, and to talk about diet and exercise recommendations, potentially harmful substances to avoid and other issues. Prenatal care also helps women control existing conditions, such as high blood pressure and diabetes, in order to avoid serious complications in pregnancy such as preeclampsia.[2]

The Case for Improvement

- Approximately 30 percent of pregnant women 25 years and older do not receive early prenatal care.[6]
- In 2011, the preterm birth rate was 11.7 percent and the low birth-weight rate was 8.1 percent.[1] Preterm births cost the U.S. health care system more than $26 billion each year.[7]
- An estimated 25,000 infants die each year in the U.S. before they reach their first birthday. Common causes of infant mortality include birth defects, being born too early and too small, sudden infant death syndrome (SIDS), maternal complications of pregnancy and injuries (e.g., suffocation). These leading causes of infant mortality accounted for 57 percent of all infant deaths in the U.S. in 2010.[7]

HEDIS Measure Definition

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

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

Frequency of Ongoing Prenatal Care
The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year where there was <21 percent, 21 percent–40 percent, 41 percent–60 percent, 61 percent–80 percent or ≥81 percent of the expected number of prenatal care visits, adjusted for gestational age and the month when the woman enrolled in the organization. This measure uses the same denominator as the *Prenatal and Postpartum Care* measure.

The Bottom Line

Maintaining good health before conception, during pregnancy and after having a baby is an important way women can prevent complications that can affect their health and the health of their baby.

<21% OF EXPECTED VISITS					
	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	12.3	–	–
2011	–	–	10.0	–	–
2010	–	–	10.4	–	–
2009	–	–	10.3	–	–
2008	–	–	11.9	–	–
2007	–	–	12.4	–	–
2006	–	–	13.5	–	–
2005	–	–	16.7	–	–
2004	–	–	17.9	–	–
2003	–	–	21.3	–	–
2002	–	–	27.6	–	–
2001	–	–	33.1	–	–

21%–40% OF EXPECTED VISITS					
	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	5.9	–	–
2011	–	–	6.5	–	–
2010	–	–	6.9	–	–
2009	–	–	6.3	–	–
2008	–	–	6.9	–	–
2007	–	–	6.6	–	–
2006	–	–	6.0	–	–
2005	–	–	5.9	–	–
2004	–	–	6.7	–	–
2003	–	–	7.2	–	–
2002	–	–	7.9	–	–
2001	–	–	7.5	–	–

41%–60% OF EXPECTED VISITS					
	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	7.7	–	–
2011	–	–	8.2	–	–
2010	–	–	8.1	–	–
2009	–	–	8.0	–	–
2008	–	–	8.6	–	–
2007	–	–	7.7	–	–
2006	–	–	7.8	–	–
2005	–	–	7.8	–	–
2004	–	–	8.0	–	–
2003	–	–	8.6	–	–
2002	–	–	9.4	–	–
2001	–	–	7.3	–	–

61%–80% OF EXPECTED VISITS					
	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	13.6	–	–
2011	–	–	14.4	–	–
2010	–	–	13.6	–	–
2009	–	–	13.9	–	–
2008	–	–	14.0	–	–
2007	–	–	13.8	–	–
2006	–	–	14.1	–	–
2005	–	–	13.7	–	–
2004	–	–	14.2	–	–
2003	–	–	14.4	–	–
2002	–	–	13.8	–	–
2001	–	–	10.5	–	–

≥81% OF EXPECTED VISITS					
	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	60.4	–	–
2011	–	–	60.9	–	–
2010	–	–	61.1	–	–
2009	–	–	61.6	–	–
2008	–	–	58.7	–	–
2007	–	–	59.6	–	–
2006	–	–	58.6	–	–
2005	–	–	55.8	–	–
2004	–	–	51.5	–	–
2003	–	–	48.2	–	–
2002	–	–	41.0	–	–
2001	–	–	39.2	–	–

TIMELINESS OF PRENATAL CARE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	89.6	80.9	82.9	–	–
2011	91.0	81.9	82.7	–	–
2010	91.0	75.7	83.7	–	–
2009	93.1	61.9	83.4	–	–
2008	92.4	55.5	81.9	–	–
2007	91.9	46.0	81.5	–	–
2006	90.6	61.9	81.2	–	–
2005	91.8	74.6	79.6	–	–
2004	90.8	–	78.2	–	–
2003	89.4	–	76.5	–	–
2002	86.7	–	70.4	–	–
2001	85.1	–	72.9	–	–

POSTPARTUM CARE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	80.1	70.0	63.0	–	–
2011	80.6	71.3	64.1	–	–
2010	80.7	65.9	64.4	–	–
2009	83.6	54.1	64.1	–	–
2008	82.8	45.8	62.6	–	–
2007	82.0	41.6	58.6	–	–
2006	79.9	46.3	59.1	–	–
2005	81.5	62.8	57.2	–	–
2004	80.6	–	56.5	–	–
2003	80.3	–	55.3	–	–
2002	77.0	–	52.1	–	–
2001	77.0	–	53.0	–	–

PHYSICAL ACTIVITY IN OLDER ADULTS

Regular physical activity is essential for healthy aging.[1] In the United States, very few older adults achieve the minimum amount of recommended physical activity and 28 percent–34 percent of adults 65–74 years of age are inactive.[2]

Physical activity in older adults is an important part of preventing and managing chronic diseases such as diabetes, osteoporosis, depression and high blood pressure.[3] The *Physical Activity in Older Adults* measure uses a survey to assess whether older adults have discussed their level of physical activity with a health care provider and, if necessary, have received advice to start, increase or maintain their level of physical activity.

- Physical activity tends to decrease with age. By the age of 75, approximately one in three men and one in two women will not engage in physical activity.[4]

The Case for Improvement

- Regular physical activity not only improves health, it also increases independence.[5] It is recommended that older adults complete at least 150 minutes (2.5 hours) of moderate physical activity a week; at least 2 days of strength training a week; and balance training exercises 3 or more days a week.[1]
- Lack of physical activity can lead to conditions that result in more visits to the doctor, more hospitalizations and a higher use of medications for a variety of illnesses.[5] One study of a health plan with 1.5 million adults (18 and older) estimated the cost from physical inactivity at $83.6 million, or $56 per member.[6]
- Approximately 80 percent of older adults have at least one chronic condition and 50 percent have two or more conditions.[7] Regular physical activity reduces risk of developing numerous chronic conditions and diseases, including cardiovascular disease, stroke, hypertension, type 2 diabetes, osteoporosis, obesity, colon cancer, breast cancer, cognitive impairment, anxiety and depression.[8]

HEDIS Measure Definition

This survey-based measure assesses the percentage of Medicare adults 65 years of age and older who had a doctor's visit in the past 12 months and who:

- Spoke with a doctor or other health provider about their level of exercise or physical activity.
- Received advice to start, increase or maintain their level of exercise or physical activity.

The Bottom Line

Engaging in physical activity as an older adult reduces the risk of developing certain chronic conditions and increases quality of life. Health care providers can help older adults attain and maintain optimal levels of physical activity by providing advice on appropriate types and level of activity.[1]

PHYSICAL ACTIVITY DISCUSSION

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	–	54.5	55.5
2011	–	–	–	53.0	53.7
2010	–	–	–	52.3	53.9
2009	–	–	–	51.3	54.4
2008	–	–	–	51.5	54.0
2007	–	–	–	51.1	53.0
2006	–	–	–	50.3	53.6
2005	–	–	–	50.6	53.7

PHYSICAL ACTIVITY ADVICE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	–	50.1	48.9
2011	–	–	–	48.7	47.6
2010	–	–	–	47.9	47.6
2009	–	–	–	46.9	47.8
2008	–	–	–	47.0	47.1
2007	–	–	–	46.1	46.7
2006	–	–	–	45.2	48.8
2005	–	–	–	43.7	46.3

PNEUMOCOCCAL VACCINATION STATUS FOR OLDER ADULTS

Pneumococcal infection is a common illness and cause of death in the elderly and in persons with certain underlying conditions.[1] The *Pneumococcal Vaccination Status for Older Adults* survey measure asks patients 65 years of age and older if they have ever received a pneumococcal vaccination (also referred to as a "pneumonia shot"). The current Advisory Committee on Immunization Practices (ACIP) guideline recommends that people 65 years of age and older receive a pneumococcal vaccination if they have not had one in more than five years.

- There were approximately 37,000 cases of pneumococcal infection in 2011, which resulted in 4,000 deaths.[2]
- Older adults have higher rates of pneumococcal infection than other groups. The presence of underlying health conditions puts older adults at further risk of infection.[1]

The Case for Improvement

- Availability of the pneumonia shot during the past 20 years has been associated with decreased mortality from pneumonia, especially for older adults.[3]
- Among the Hispanic population, rates of pneumococcal vaccination are 21 percent lower than in the White population; for Asian/Pacific Islanders and Blacks, rates are 17 percent lower.[4]
- Improved rates of vaccination would lessen the cost of care by reducing avoidable hospitalizations.[5]

HEDIS Measure Definition

The percentage of adults 65 years of age and older who ever received a pneumococcal vaccination.

Survey Question: "Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."

The Bottom Line

Older adults are at increased risk of death and complications from pneumonia, and infections can be prevented with vaccination.

PNEUMONIA VACCINATION FOR OLDER ADULTS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2011	–	–	–	69.4	71.7
2010	–	–	–	69.0	70.0
2009	–	–	–	65.4	66.7
2008	–	–	–	63.8	66.5
2007	–	–	–	65.1	65.6
2006	–	–	–	66.1	66.0
2005	–	–	–	70.7	66.4
2004	–	–	–	68.7	–
2003	–	–	–	68.4	–
2002	–	–	–	67.6	–
2001	–	–	–	66.8	–

GLAUCOMA SCREENING IN OLDER ADULTS

Glaucoma is a group of diseases that can damage the eye's optic nerve and result in vision loss and blindness.[1] There are many types of glaucoma, but open-angle glaucoma (OAG) is the most common type of the disease and affects more than 2.5 million people in the U.S. It is estimated that more than half of those who have glaucoma are undiagnosed because they have no warning signs or symptoms until the disease worsens.[2] The *Glaucoma Screening in Older Adults* measure assesses whether older adults received one or more eye exams to check for glaucoma.

- Glaucoma is the second leading cause of blindness in the United States.[3] Damage is irreversible, so early detection can prevent severe vision loss and a lower quality of life.[2]
- Glaucoma screening is an objective of Healthy People 2020, an initiative from the Department of Health and Human Services, which aims to increase the number of adults who have a comprehensive eye examination and to reduce visual impairments caused by glaucoma.[4]
- Although anyone older than 60 is at higher risk for developing glaucoma,[3] the risk is slightly higher for African Americans: 4.6 percent of African American adults have glaucoma, whereas 1.6 percent of Caucasian adults have glaucoma.[2] Hispanic Americans over 65 are also at increased risk of glaucoma.[5]

The Case for Improvement

- Glaucoma impacts the quality of life and the ability to function independently. There is no cure for glaucoma, but steps (e.g., medications, laser therapy, surgery) can be taken to ensure a better quality of life.[6] In the United States, glaucoma is estimated to account for $2.9 billion of direct medical costs for adults.[7] Specifically, vision loss in the United States accounts for a total economic impact of $51 billion.[8]
- The financial burden of glaucoma increases as disease severity increases. The average annual direct cost of glaucoma treatment per patient is $1,795 by stage. If glaucoma is caught early, the average cost per patient is $623; if glaucoma is caught late, the average cost per patient is $2,511.[7]

HEDIS Measure Definition

The percentage of Medicare adults 65 years of age and older who did not have a prior diagnosis of glaucoma or glaucoma suspect and who received an eye exam by an eye care professional for early identification of glaucomatous conditions.

The Bottom Line

Glaucoma screening is essential in older adults to identify the onset of the disease and prevent irreversible damage to the eyes and severe vision loss.

GLAUCOMA SCREENING RATE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	–	68.2	68.8
2011	–	–	–	65.8	66.6
2010	–	–	–	63.8	65.1
2009	–	–	–	62.3	63.7
2008	–	–	–	59.8	62.2
2007	–	–	–	59.5	62.6
2006	–	–	–	62.2	63.3
2005	–	–	–	61.5	64.5

FALL RISK MANAGEMENT

Falls are the leading cause of severe injury in older adults and can increase the risk of early death.[1,2] Every year, one in three adults 65 and older will fall.[1] About 20 percent–30 percent of people who fall will have lacerations, hip fractures or head traumas.[2]

The *Fall Risk Management* survey measure asks adults 65 years of age and older who are at risk of falling, if they discussed their problem with their practitioner and, if necessary, if they received an appropriate intervention.

Older adults can reduce their chances of falling by:

- Using a vitamin D supplement. Vitamin D can help reduce the loss of bone strength among older adults and prevent falls.[3]
- Exercising regularly to increase leg strength and balance.[2]
- Having a doctor or pharmacist review current medications to identify those that cause dizziness or drowsiness.[2]
- Visiting the eye doctor.[2]
- Making the home environment safer and free from tripping hazards.[2]

The Case for Improvement

- In 2009, there were 2.4 million nonfatal, fall-related injuries in the older adult population. Of these injuries, 662,000 resulted in hospitalization.[4]
- The average cost of one hospitalization due to a fall is $17,500.[4] The cost is expected to reach $54.9 billion by 2020.[4] If more older adults participate in intervention programs such as exercise, falls will decrease and the average health care costs per person will decrease as well, by an estimated $2,000.[3]
- Many adults who fall develop a fear of falling. This fear can cause them to limit their normal daily activities, which will lead to reduced mobility and may increase their risk of falling.[2]

HEDIS Measure Definition

The two components of this survey measure assess different facets of fall risk management.

- *Discussing Fall Risk.* The percentage of Medicare-enrolled adults 65 years of age and older with balance or walking problems or a fall in the past 12 months, who were seen by a practitioner in the past 12 months and who discussed falls or problems with balance or walking with the practitioner.
- *Managing fall Risk.* The percentage of Medicare-enrolled adults 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received fall risk intervention from the practitioner.

The Bottom Line

Falls are the leading cause of unintentional injury death among adults 65 years and older.[3] A majority of falls are preventable. Initiating discussions with patients about future risk of falls, and interventions to reduce that risk, is imperative to lowering the number of injuries and deaths from falls.

FALL RISK DISCUSSION

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	–	33.8	31.4
2011	–	–	–	32.8	30.7
2010	–	–	–	32.8	31.1
2009	–	–	–	31.1	30.3
2008	–	–	–	31.3	30.7
2007	–	–	–	29.4	28.1
2006	–	–	–	27.5	26.9

FALL RISK INTERVENTION

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	–	62.0	56.8
2011	–	–	–	60.2	54.6
2010	–	–	–	60.1	55.3
2009	–	–	–	57.7	54.7
2008	–	–	–	57.8	54.6
2007	–	–	–	55.8	53.4
2006	–	–	–	56.0	54.2

MANAGEMENT OF URINARY INCONTINENCE IN OLDER ADULTS

Urinary incontinence (UI) is defined as, "the involuntary loss of urine."[1] Approximately 25 million Americans suffer from UI.[2] Severity ranges from occasionally leaking urine during a cough or sneeze (stress incontinence) to having an urge to urinate that is so sudden and strong (urge incontinence) that there is no time to get to a bathroom.[3] The *Management of Urinary Incontinence in Older Adults* survey measure assesses whether adults 65 and older with UI were asked about their symptoms and received appropriate treatment.

- UI is a prevalent condition among older adults, particularly older women. Between 30 percent and 60 percent of older women, and between 10 percent and 35 percent of older men, are affected by UI.[4]
- Many older adults do not receive treatment for UI. Previous studies have identified a number of reasons for this, including embarrassment, belief that UI is a normal part of aging and low expectations that treatment will help.[5]

The Case for Improvement

- UI poses a significant financial burden to family caregivers. One study estimated the national annual indirect cost of family caregiving related to UI at $6 billion.[6]
- About half of UI patients talk with their provider about their condition.[7] Discussing UI with a provider helps identify effective treatments, which can reduce symptoms by 50 percent–75 percent in most individuals.[8]
- UI puts adults at further risk for falls, fractures and functional impairment. It is associated with poor self-rated health, diminished quality of life, social isolation, depressive symptoms and dependence on caregivers.[9]

HEDIS Measure Definition

This patient-reported survey measure assesses the condition and management of UI in older adults.

- *Discussing UI.* The percentage of Medicare adults 65 years of age and older who reported having a problem with urine leakage in the past six months and who discussed their urine leakage problem with their current practitioner.
- *Receiving UI Treatment.* The percentage of Medicare adults 65 years of age and older who reported having a urine leakage problem in the past six months and who received treatment for their current urine leakage problem.

The Bottom Line

UI in older adults can be diagnosed and managed effectively by a practitioner. Discussing UI with a practitioner is the first step toward providing appropriate treatment and increased quality of life.

URINARY INCONTINENCE DISCUSSION

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	–	57.7	56.2
2011	–	–	–	57.3	56.9
2010	–	–	–	58.2	57.9
2009	–	–	–	57.1	58.2
2008	–	–	–	57.3	58.0
2007	–	–	–	57.8	57.7
2006	–	–	–	56.8	57.3
2005	–	–	–	56.0	55.8

OSTEOPOROSIS TESTING IN OLDER WOMEN

Osteoporosis is a disease characterized by low bone mass and structural deterioration of bone tissue, leading to bone fragility and an increased susceptibility to fractures. Disease development is gradual, progressing without symptoms until a minor fall or activity fractures a bone.[1] The *Osteoporosis Testing in Older Women* measure assesses whether women 65 years of age and older reported receiving a bone density test.

- According to the National Osteoporosis Foundation, about 9 million Americans have osteoporosis and approximately 48 million are at risk for osteoporosis. About 80 percent of those affected are women.[1]
- One in two women and one in four men over 50 will have an osteoporosis-related fracture in their lifetime, most commonly of the hip, wrist or spine.[1,2]

The Case for Improvement

- The annual direct medical costs of osteoporosis and fractures ranges from $17 billion–$22 billion. By 2025, annual fractures and costs are expected to rise by almost 50 percent, most rapidly among people 65–74 years of age.[3,4]
- Osteoporosis is responsible for more than 1.5 million fractures each year and results in 500,000 hospital admissions, 800,000 emergency room visits, 2.6 million physician visits and 180,000 nursing home admissions annually.[4,5]
- Despite being a covered service under Medicare with no out-of-pocket costs, bone density tests are underutilized by elderly, at-risk populations. In 2005, only an estimated 30 percent of Medicare women beneficiaries received a bone density test.[5]

HEDIS Measure Definition

This survey-based measure assesses the percentage of Medicare women 65 years of age and older who report ever having received a bone density test to check for osteoporosis.

The Bottom Line

Bone density screenings are an important strategy for reducing the rate of fractures among women 65 and older.[6,7]

BONE DENSITY TESTING RATE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	–	72.1	75.4
2011	–	–	–	71.0	75.0
2010	–	–	–	68.5	73.4
2009	–	–	–	68.0	72.8
2008	–	–	–	66.7	72.0
2007	–	–	–	65.7	70.3
2006	–	–	–	64.4	71.3

TESTING/TREATMENT RATE IN WOMEN WHO HAD A FRACTURE

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	–	25.0	19.1
2011	–	–	–	22.8	19.3
2010	–	–	–	20.7	18.5
2009	–	–	–	20.7	18.1
2008	–	–	–	20.7	18.0
2007	–	–	–	20.4	17.8

MEDICATION MANAGEMENT IN THE ELDERLY

In spite of medical consensus that certain drugs increase the risk of harm for elderly people with certain medical conditions,[1] these drugs are prescribed frequently. The *Potentially Harmful Drug-Disease Interactions in the Elderly* measure assesses how often patients with a specific diagnosis are prescribed medications that are deemed high-risk due to their association with the diagnosis.

- Approximately 15 percent of adverse drug events occur in the elderly. These events are potentially preventable up to 50 percent of the time.[2]
- Adults 65 and older are twice as likely as their younger counterparts to experience adverse drug events, and are almost seven times more likely to be hospitalized due to an adverse drug event.[3]

The Case for Improvement

- Reducing the number of inappropriate prescriptions can lead to improved patient safety and significant cost savings. Costs associated with prescriptions of potentially inappropriate medications in the elderly average $7.2 billion a year.[4]
- An aging U.S. population will mean increased medication use in older adults as new drugs are developed and new therapeutic and preventive uses for medications are discovered.[5] It is therefore important that providers and payers understand the potential harms of specific drugs used in the elderly with certain conditions and risk factors.

HEDIS Measure Definition

Potentially Harmful Drug-Disease Interactions in the Elderly
The percentage of adults 65 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. Conditions of interest are:

- Chronic renal failure.
- Dementia.
- History of falls.

The Bottom Line

The most recent review of potentially inappropriate medications in the elderly, adapted for use in this measure, identifies drugs that should be avoided in the elderly at a population level.[6] Adverse drug events due to cognitive decline or frailty are more common in older adults, and providers and patients should be vigilant in their recommendation and use of these potentially harmful drugs.

POTENTIALLY INAPPROPRIATE MEDICATIONS FOR PATIENTS WITH CHRONIC RENAL FAILURE*

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	–	11.0	10.8
2011	–	–	–	11.7	10.0
2010	–	–	–	11.6	11.7
2009	–	–	–	11.5	11.5
2008	–	–	–	11.7	9.9
2007	–	–	–	10.5	12.2

POTENTIALLY INAPPROPRIATE MEDICATIONS FOR PATIENTS WITH DEMENTIA*

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	–	24.4	24.3
2011	–	–	–	27.0	25.6
2010	–	–	–	28.7	27.3
2009	–	–	–	28.6	27.3
2008	–	–	–	28.2	27.0
2007	–	–	–	27.3	26.1

POTENTIALLY INAPPROPRIATE MEDICATIONS FOR PATIENTS WITH FALLS*

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	–	15.5	15.5
2011	–	–	–	15.6	15.3
2010	–	–	–	17.1	16.3
2009	–	–	–	16.7	16.6
2008	–	–	–	16.2	16.9
2007	–	–	–	16.2	18.0

OVERALL RATE*

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	–	20.0	19.9
2011	–	–	–	21.7	20.6
2010	–	–	–	23.3	21.8
2009	–	–	–	23.2	21.8
2008	–	–	–	23.0	21.7
2007	–	–	–	21.8	21.5

**Lower rates signify better performance.*

RELATIVE RESOURCE USE

Relative Resource Use (RRU) measures indicate how health plans use health care resources (e.g., doctor visits, hospital stays, surgical procedures and medications), compared with other plans (at both the national and regional levels) and adjusted for the population of patients served. When combined with HEDIS quality measures, RRU measures reveal *value* by relating use of health care services to quality.

RRU measures help purchasers identify health plans that deliver high-quality care while managing associated resources. The table below is a hypothetical example of RRU results for plans in one region for patients with diabetes. Scores above 1.0 indicate higher-than-average use; scores below 1.0 indicate lower-than-average use. In this example, Plan D is highlighted because it offers an appealing combination of above-average quality and below-average resource use.

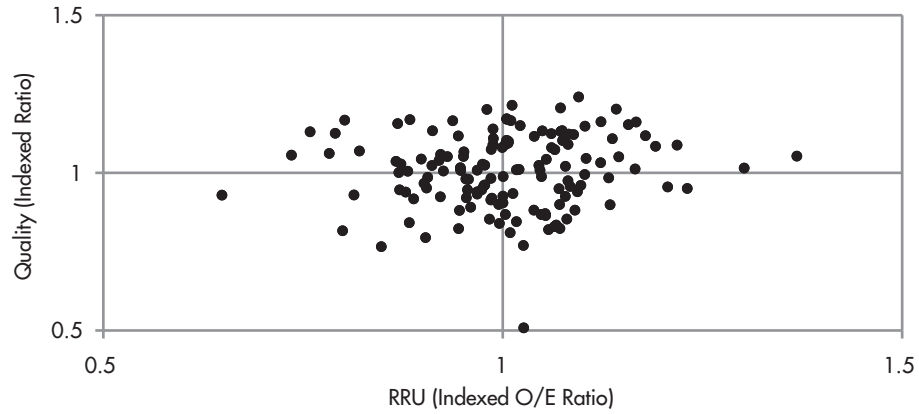
NCQA collects RRU data for five chronic conditions that account for a major portion of all health spending: asthma, cardiovascular disease, COPD, diabetes and hypertension.

To allow fair comparison of plans, RRU measures feature risk adjustment and price standardization of services. The goal of risk adjustment is to eliminate sources of variation that neither health plans nor providers can control. Factors used in risk adjustment include age, gender and the presence of serious health conditions. Standardized prices are assigned to each unit of service delivered to patients covered by health plans and reported by service category (i.e., inpatient hospital care, evaluation and management, surgery and other procedures, diagnostic lab and imaging, prescription drugs) for each of the five conditions.

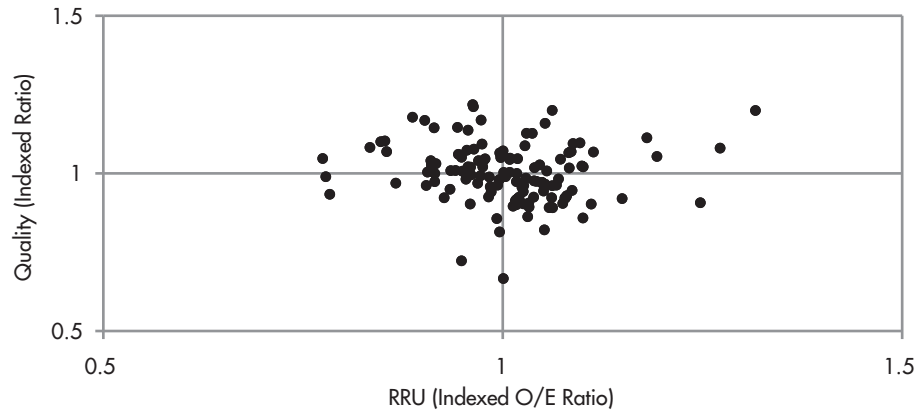
Looking at quality and resource use scores together, purchasers should be most interested in plans that are high in quality and low in resource use. As depicted in the following scatterplots, scores that place health plans in the upper left quadrant are generally considered desirable (above-average quality, below-average resource use). Health plans in the lower right quadrant are less desirable (below-average quality, above-average resource use). Overall, RRU results reveal that the amount of services used to treat people often has little correlation to the quality of care.

This report focuses on the three RRU measures where discrepancies between plans' resource use and resulting quality are most pronounced: hypertension, diabetes and certain cardiovascular conditions.

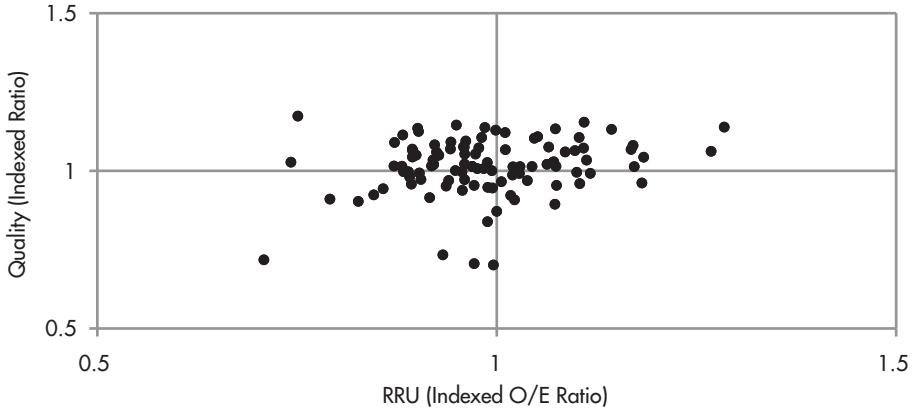
COMMERCIAL HMOS: DIABETES



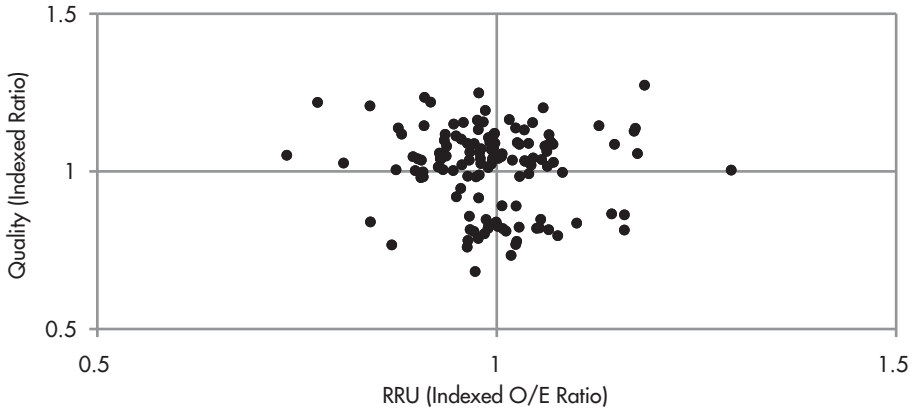
COMMERCIAL PPOS: DIABETES



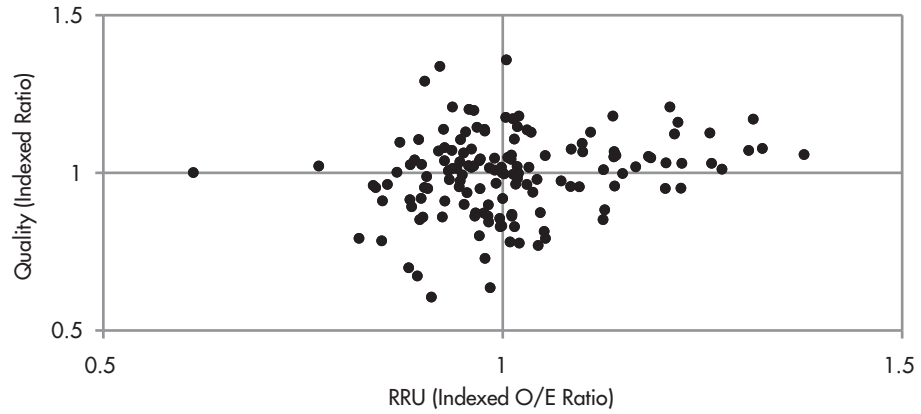
COMMERCIAL HMOS: CARDIOVASCULAR



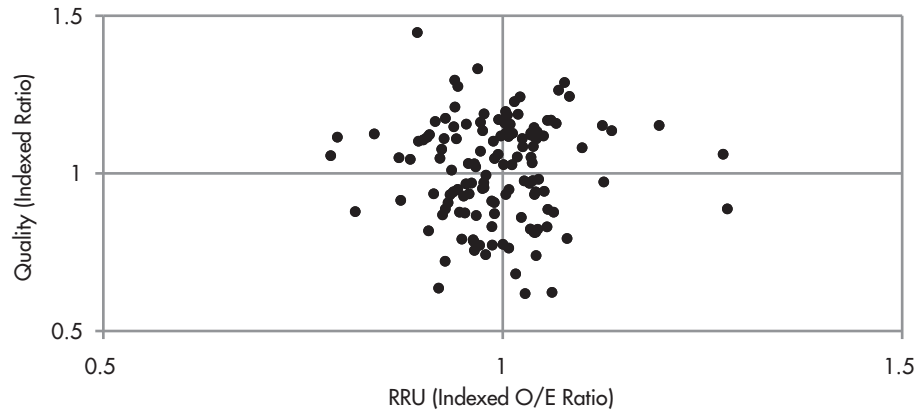
COMMERCIAL PPOS: CARDIOVASCULAR



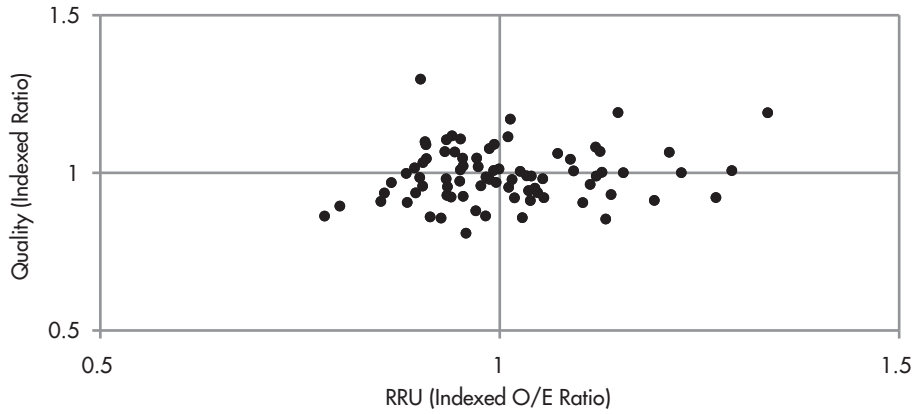
COMMERCIAL HMOS: HYPERTENSION



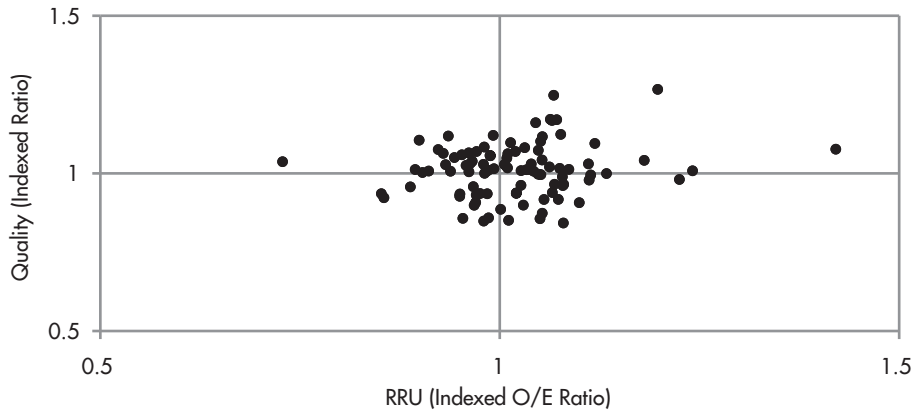
COMMERCIAL PPOS: HYPERTENSION



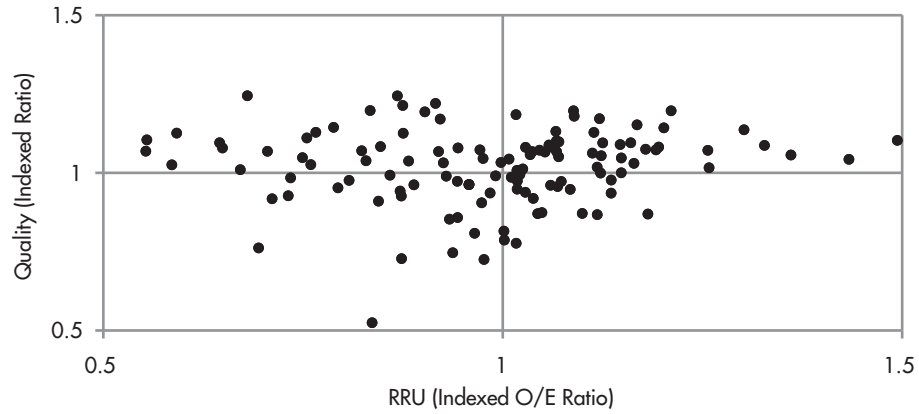
COMMERCIAL HMOS: COPD



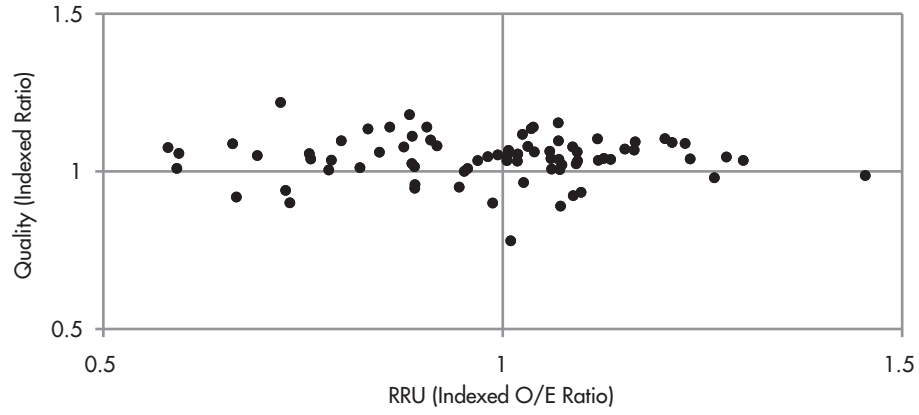
COMMERCIAL PPOS: COPD



MEDICARE HMOS: DIABETES



MEDICARE HMOS: CARDIOVASCULAR



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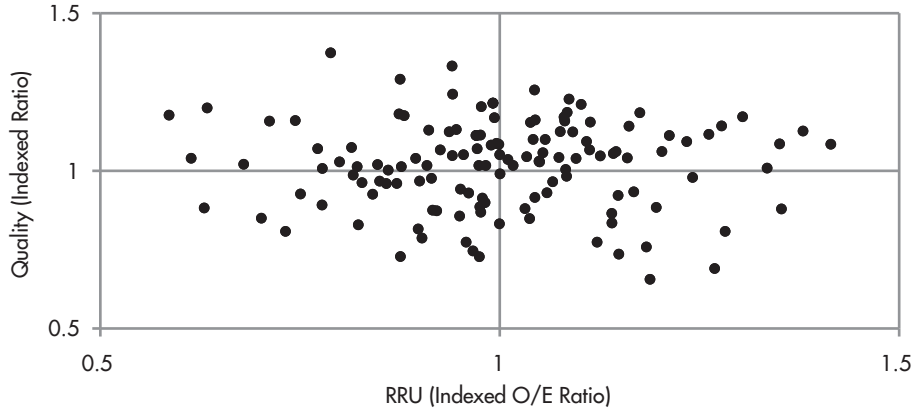
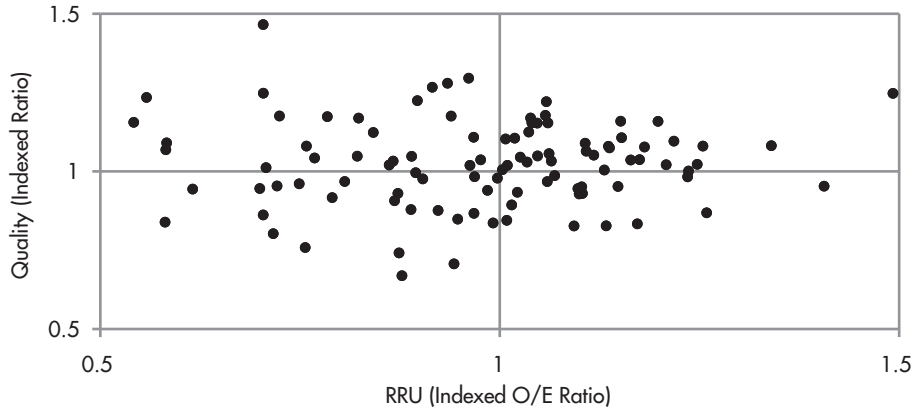
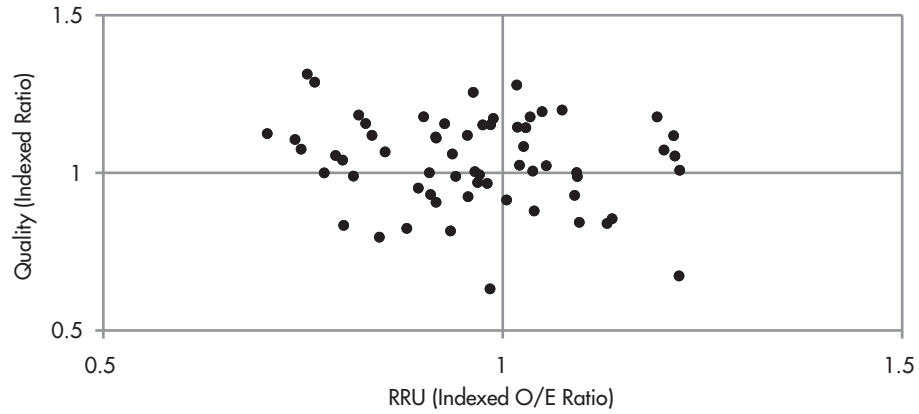


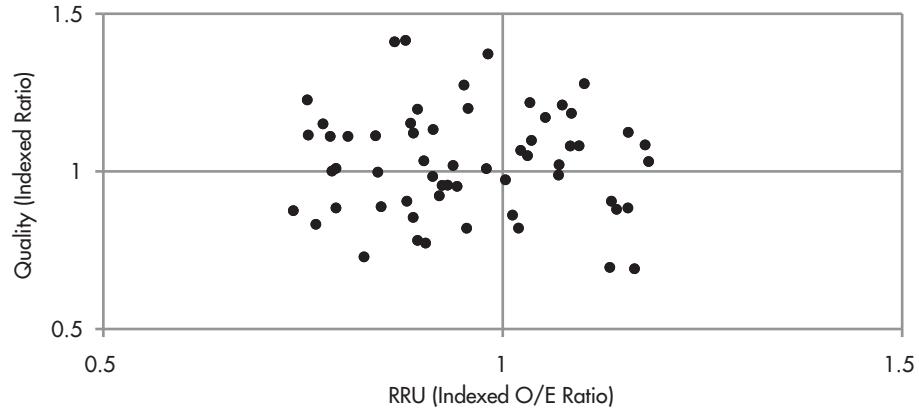
MEDICARE HMOS: COPD



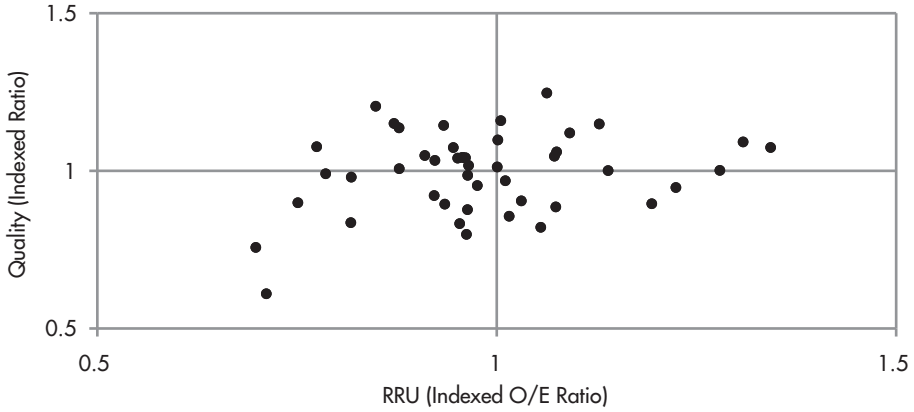
MEDICAID HMOS: DIABETES



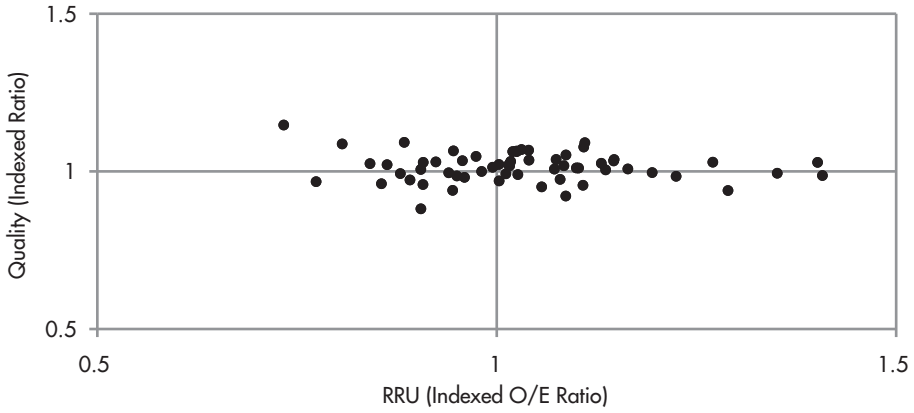
MEDICAID HMOS: HYPERTENSION



MEDICAID HMOS: COPD



MEDICAID HMOS: ASTHMA



PLAN ALL-CAUSE READMISSIONS

A readmission is when a patient is discharged from the hospital and then admitted back into the hospital within a short period of time. Readmissions occur when patients develop complications related to their initial diagnosis or acquire new disease conditions or complications after leaving the hospital. Although not all readmissions can be avoided, many are preventable.[1]

Avoiding unnecessary readmissions begins in the hospital and carries over into the discharge and post-discharge periods. Some factors that contribute to potentially preventable readmissions are inadequate follow-up care, lack of appropriate support at home and in the community, poor discharge planning and medical errors or substandard care during the initial hospitalization.[2] Health plans can play an important role in improving care coordination post-discharge and providing appropriate support in the home and community in order to reduce readmissions.

- Approximately 2.6 million seniors are readmitted to a hospital within 30 days, at a cost of $26 billion annually.[3]
- One study estimated that 23 percent of readmissions could be avoided.[4]

The Case For Improvement

- A study on Medicare patients with heart failure found that readmission rates have increased over the past 14 years.[5]
- Regional variation in readmission rates remains even after controlling for differences in the underlying health of the patient population. This suggests that some regions have room for improvement.[1]
- In one study, more than half of patients readmitted to the hospital within 30 days of discharge had no evidence of a follow-up visit of any kind between discharge and readmission.[6]

HEDIS Measure Definition

The rate of adult acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days after discharge. As well as reporting observed rates, NCQA also specifies that plans report a predicted probability of readmission in order to account for the prior and current health of the member, in addition to other factors.

The Bottom Line

Some readmissions can be prevented through improved coordination of care after discharge and increased support for patient self-management.[7]

READMISSION RATE (18–64 YEARS)*

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	0.9	0.8	–	0.8	0.9
2011	0.8	0.8	–	–	–

READMISSION RATE (65 YEARS AND OLDER)*

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	–	–	–	0.9	0.9
2011	–	–	–	0.9	0.9

**Lower rates signify better performance.*

CONSUMER AND PATIENT ENGAGEMENT AND EXPERIENCE

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a public/private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care in commercial and Medicaid plans. Surveys were developed with the Agency for Healthcare Research and Quality (AHRQ). CAHPS data address areas such as patient ease of obtaining information from a health plan; timeliness of service; and speed and accuracy of claim processing.

CAHPS results offer an indication of how well health care organizations meet member expectations.

Rating of Health Plan

Respondents were asked to give their health plan an overall rating, with 0 equaling "worst health plan possible" and 10 equaling "best health plan possible." The tables below represent the percentage of respondents who rated their health plan 8, 9 or 10.

HEALTH PLAN RATING OF 8, 9 OR 10

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	65.3	57.9	73.5	–	–
2011	66.1	58.4	73.5	88.5	87.7
2010	64.2	58.6	72.4	87.5	86.6
2009	62.7	57.3	70.7	84.4	81.9
2008	64.3	59.7	72.7	85.5	83.8
2007	61.9	56.8	70.7	85.9	82.6
2006	63.0	59.5	70.1	86.7	84.1
2005	65.2	67.1	71.9	87.7	84.2
2004	64.1	–	71.2	85.2	–
2003	61.8	–	69.9	81.4	–
2002	61.3	–	69.3	85.9	–
2001	61.8	–	51.4	86.6	–
2000	59.3	–	–	–	–

HEALTH PLAN RATING OF 9 OR 10

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	41.4	33.3	56.3	–	–
2011	42.1	33.9	55.6	63.9	58.5
2010	40.3	33.7	54.7	62.7	56.9
2009	38.3	32.4	52.5	59.0	52.2
2008	39.1	34.2	55.3	60.7	53.4
2007	37.1	31.8	53.3	61.1	52.9
2006	38.0	35.9	52.4	61.7	53.9
2005	39.8	43.1	54.0	61.3	54.2
2004	38.4	–	52.3	57.5	–
2003	36.7	–	51.7	53.3	–
2002	36.0	–	51.5	60.5	–
2001	37.4	–	69.1	62.4	–
2000	34.7	–	–	–	–
1999	32.6	–	–	–	–

Rating of Health Care

Respondents were asked to give their health care an overall rating, with 0 equaling "worst health care possible" and 10 equaling "best health care possible." The tables below represent the percentage of respondents who rated their health care 8, 9 or 10.

HEALTH CARE RATING OF 8, 9 OR 10

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	77.3	75.1	70.8	–	–
2011	77.6	76.2	69.9	86.5	89.3
2010	76.6	75.6	68.9	86.2	88.9
2009	74.9	74.3	67.3	84.2	87.0
2008	75.2	75.0	68.2	84.6	87.2
2007	73.8	73.6	67.1	84.4	86.2
2006	73.6	75.1	65.6	87.2	89.3
2005	77.9	80.8	72.8	92.5	95.2
2004	77.6	–	72.6	91.8	–
2003	76.2	–	72.1	91.0	–
2002	75.2	–	71.6	91.6	–
2001	73.2	–	52.6	91.6	–
2000	72.0	–	–	–	–

HEALTH CARE RATING OF 9 OR 10

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	51.5	47.6	50.9	–	–
2011	51.9	49.0	49.7	60.9	62.6
2010	50.7	48.1	48.8	60.3	61.8
2009	48.7	46.6	47.0	56.2	57.4
2008	48.7	46.7	48.1	56.2	56.4
2007	47.2	45.8	46.8	55.9	55.0
2006	47.0	48.3	46.2	62.0	62.7
2005	53.4	55.6	54.1	69.1	72.2
2004	52.1	–	53.5	68.7	–
2003	51.5	–	52.8	67.5	–
2002	49.4	–	53.0	67.8	–
2001	47.5	–	71.3	68.8	–
2000	45.6	–	–	–	–
1999	44.1	–	–	–	–

Getting Needed Care

The *Getting Needed Care* composite measures members' perception of how easy it was to get care from their doctor and from specialists in the last 12 months. Members were asked how often they were able to:

- See a specialist when they needed one.
- Obtain the care, tests or treatment they believed were necessary.

Responses were "Never," "Sometimes," "Usually" and "Always." The rates displayed represent the average percentage of health plan members nationwide who responded "Always."

GETTING NEEDED CARE: USUALLY OR ALWAYS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	87.3	88.5	80.6	–	–
2011	85.5	86.2	75.5	89.4	92.6
2010	86.2	86.6	76.0	89.9	92.8
2009	85.4	86.3	75.0	89.1	91.3
2008	85.3	86.4	75.7	88.6	90.8
2007	84.2	85.3	75.2	88.8	91.0
2006	84.2	85.3	74.2	89.3	91.7

GETTING NEEDED CARE: ALWAYS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	56.4	57.6	55.1	–	–
2011	54.1	53.8	50.4	64.1	66.6
2010	53.9	53.9	50.1	63.9	66.2
2009	52.9	52.7	48.5	63.6	64.4
2008	52.6	52.6	49.4	62.4	61.9
2007	50.4	49.5	48.7	62.0	63.4
2006	50.1	51.2	46.7	62.6	64.6
2005	80.1	84.7	73.4	95.9	97.0
2004	79.3	–	73.8	95.7	–
2003	78.4	–	72.1	94.9	–
2002	76.9	–	72.3	94.8	–
2001	76.7	–	75.4	94.9	–
2000	75.4	–	–	–	–

Getting Care Quickly

The *Getting Care Quickly* composite measures members' perception of how quickly they received care when it was sought in the last 12 months. Members were asked how often they were able to:

- Receive needed care right away.
- Get an appointment for health care at a doctor's office or clinic as soon as they thought care was needed.

Responses were "Never," "Sometimes," "Usually" and "Always." The rates displayed represent the average percentage of health plan members nationwide who responded "Always."

GETTING CARE QUICKLY: USUALLY OR ALWAYS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	86.0	86.7	81.2	–	–
2011	86.2	87.0	80.3	87.8	90.1
2010	86.5	87.1	80.6	88.1	90.6
2009	86.4	87.3	79.5	86.7	88.4
2008	86.3	87.2	80.1	86.3	88.9
2007	85.9	87.0	80.2	86.7	88.5
2006	86.1	87.1	78.7	87.2	89.5
2005	79.6	80.4	71.8	84.5	85.4
2004	79.3	–	72.3	84.2	–
2003	78.6	–	70.8	83.4	–
2002	77.6	–	71.9	81.9	–
2001	79.7	–	77.2	87.2	–
2000	78.3	–	–	–	–

GETTING CARE QUICKLY: ALWAYS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	60.5	60.5	59.0	–	–
2011	58.7	58.0	57.2	65.6	67.5
2010	58.2	57.7	56.2	65.4	68.2
2009	57.8	57.4	54.7	64.0	64.7
2008	57.6	56.2	55.7	63.7	64.6
2007	56.0	55.6	55.6	63.5	65.0
2006	56.8	57.5	53.4	65.4	67.0
2005	46.5	46.2	44.5	58.7	60.2
2004	45.5	–	44.2	58.5	–
2003	45.0	–	42.6	57.2	–
2002	43.9	–	44.1	55.8	–
2001	44.8	–	46.5	60.0	–
2000	45.8	–	–	–	–

How Well Doctors Communicate

The *How Well Doctors Communicate* composite measures members' perception of the quality of communication with their personal doctor in the last 12 months. Members were asked how often their doctor:

- Explained things in a way that was easy to understand.
- Listened carefully to them.
- Showed respect for what they had to say.
- Spent enough time with them.

Responses were "Never," "Sometimes," "Usually" and "Always." The rates displayed represent the average percentage of health plan members nationwide who responded "Always."

DOCTOR COMMUNICATION: USUALLY OR ALWAYS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	94.4	95.0	89.3	–	–
2011	94.0	94.6	87.8	94.2	95.5
2010	93.9	94.6	87.8	94.2	95.5
2009	93.4	94.2	87.0	93.5	94.6
2008	93.2	94.0	87.2	93.6	94.5
2007	92.8	93.8	86.7	93.6	94.9
2006	92.8	93.7	86.3	93.5	95.0
2005	92.1	92.8	85.9	94.0	95.4
2004	92.0	–	86.2	93.7	–
2003	91.5	–	85.7	93.3	–
2002	91.0	–	85.7	93.2	–
2001	90.7	–	85.8	93.1	–
2000	89.9	–	–	–	–

DOCTOR COMMUNICATION: ALWAYS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	74.8	75.2	71.5	–	–
2011	74.2	73.8	70.0	76.3	77.3
2010	73.5	73.5	69.1	75.6	76.9
2009	72.0	71.7	67.5	74.7	74.8
2008	71.1	70.7	68.0	75.3	74.8
2007	70.2	70.1	67.7	74.6	75.7
2006	70.3	71.5	66.7	75.0	76.2
2005	61.3	58.8	61.5	69.5	71.6
2004	60.2	–	60.8	69.0	–
2003	59.4	–	59.1	68.6	–
2002	57.7	–	59.9	68.0	–
2001	57.1	–	60.4	68.5	–
2000	58.4	–	–	–	–

Rating of Personal Doctor

Respondents were asked to give their personal doctor an overall rating, with 0 equaling "worst personal doctor possible" and 10 equaling "best personal doctor possible." The tables below represent the percentage of respondents who rated their personal doctor 8, 9 or 10.

PERSONAL DOCTOR RATING OF 8, 9 OR 10

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	84.2	83.2	78.4	–	–
2011	83.9	83.2	77.1	92.9	94.1
2010	83.2	82.8	76.4	92.6	94.0
2009	82.2	81.9	75.6	92.0	93.1
2008	81.9	82.0	76.2	92.3	93.2
2007	81.0	82.0	75.8	92.0	93.1
2006	81.1	83.0	75.6	92.4	93.9
2005	77.1	78.8	77.2	91.7	94.5
2004	77.0	–	77.0	91.1	–
2003	76.2	–	76.8	90.3	–
2002	75.0	–	76.0	90.2	–
2001	74.6	–	59.4	90.0	–
2000	74.3	–	–	–	–

PERSONAL DOCTOR RATING OF 9 OR 10

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	66.2	63.6	63.1	–	–
2011	66.0	63.7	61.8	74.6	76.1
2010	65.0	62.8	61.1	75.1	76.5
2009	63.2	61.2	60.1	73.3	73.9
2008	63.3	61.9	61.1	73.6	73.3
2007	62.1	61.7	60.4	73.6	73.8
2006	62.3	63.2	60.3	73.8	75.0
2005	52.8	54.0	59.2	67.8	70.9
2004	51.7	–	58.4	67.5	–
2003	51.9	–	58.9	66.4	–
2002	49.7	–	58.0	65.2	–
2001	50.5	–	76.5	65.8	–
2000	48.3	–	–	–	–
1999	47.0	–	–	–	–

Rating of Specialist

Respondents were asked to give their specialist an overall rating, with 0 equaling "worst specialist possible" and 10 equaling "best specialist possible." The tables below represent the percentage of respondents who rated their specialist 8, 9 or 10.

SPECIALIST RATING OF 8, 9 OR 10

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	83.9	82.4	79.4	–	–
2011	83.2	82.1	77.7	91.3	92.7
2010	82.3	81.6	76.9	90.9	92.8
2009	80.9	80.9	76.4	89.8	91.9
2008	81.0	81.0	76.4	89.8	91.7
2007	80.4	80.7	75.8	89.7	91.6
2006	79.9	81.0	75.2	90.6	92.7
2005	78.1	80.3	76.2	90.4	93.1
2004	77.8	–	76.0	89.5	–
2003	77.1	–	75.1	89.4	–
2002	76.0	–	74.1	89.6	–
2001	76.3	–	58.7	89.7	–
2000	76.3	–	–	–	–

SPECIALIST RATING OF 9 OR 10

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	66.4	63.1	64.4	–	–
2011	65.2	62.7	62.1	70.5	73.6
2010	64.1	61.9	61.3	71.9	74.1
2009	61.8	60.4	60.5	69.3	70.8
2008	62.3	60.5	60.7	68.9	69.9
2007	61.7	60.5	60.8	69.2	70.2
2006	60.7	62.4	59.3	70.7	73.0
2005	57.2	59.1	60.2	67.7	71.7
2004	56.2	–	59.2	67.5	–
2003	55.8	–	58.3	67.7	–
2002	54.4	–	57.8	67.7	–
2001	54.6	–	75.3	68.5	–
2000	53.7	–	–	–	–
1999	51.8	–	–	–	–

Customer Service

The *Customer Service* composite measures members' perception of the usefulness and quality of customer service they experienced in the last 12 months (for those who tried to get information or help from their plan's customer service). Members were asked how often their health plan's customer service:

- Gave them the information or help they needed.
- Treated them with courtesy and respect.

Responses were "Never," "Sometimes," "Usually" and "Always." The rates displayed represent the average percentage of health plan members nationwide who responded "Always."

CUSTOMER SERVICE: USUALLY OR ALWAYS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	88.2	86.0	86.2	–	–
2011	86.1	82.2	80.4	88.3	88.5
2010	84.5	83.0	79.7	88.5	88.7
2009	84.2	82.4	79.5	86.5	–
2008	83.8	82.6	80.1	86.6	90.0
2007	82.7	80.7	79.1	86.7	84.5
2006	81.2	80.3	75.1	–	–

CUSTOMER SERVICE: ALWAYS

	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	64.4	59.6	66.7	–	–
2011	62.1	54.8	60.9	68.9	68.3
2010	59.4	55.5	59.5	68.4	67.3
2009	57.9	54.5	57.9	66.4	–
2008	57.2	53.5	59.0	66.6	64.3
2007	55.4	50.7	57.3	66.5	62.5
2006	54.2	53.9	49.7	–	–
2005	71.2	69.7	68.6	91.5	87.7
2004	71.0	–	69.8	94.8	–
2003	70.8	–	69.7	94.5	–
2002	70.4	–	67.4	94.3	–
2001	67.2	–	67.5	94.8	–
2000	66.6	–	–	–	–

METHODOLOGY OVERVIEW

General Methods

Data in this report are from HEDIS year 2013, which is measure year 2012 (January 1–December 31, 2012). Unless otherwise noted, all references to "years" in charts and tables are to measure years, not HEDIS years.

Because *The State of Health Care Quality Report* focuses on health plan performance, summary tables are not weighted for the size of eligible populations. Most tables and appendices provide mean rates separately for each measure, or for each indicator in a measure.

In most tables and appendices, rate means are provided side-by-side for commercial, Medicare and Medicaid product lines. Results for HMO and PPO plans are shown in separate tables. HMO plans include HMOs, HMO/POS combined, HMO/PPO/POS combined, HMO/PPO combined and POS. Only plans with the sole designation of "PPO" are shown as PPOs in tables.

Some reporting periods are limited. For example, PPOs have reported substantial HEDIS data only since measure year 2005; Medicare and Medicaid performance data are reported only as far back as measure year 2001.

Best States

Identification of high-performing state cohorts is based on the state means of five measures: Diabetes (seven indicators), Hypertension (one indicator), Persistence of Beta-Blockers After a Heart Attack (one indicator) and Cholesterol Management for Patients With Cardiovascular Conditions (two indicators).

The unweighted average of all indicators across all plans in a state is calculated for each state. No distinction is made among plans with respect to product line or reporting type. The composite means are ranked in descending order. The top 10 states compose the "Best" cohort. In the Diabetes quality composite, the Poor Glycemic Control indicator is inverted before calculating the composite so that higher performance is indicated by a higher rate.

Composite Measure Means by Region

Analysis provides mean rates for several composite measures by U.S. Census region. The Childhood and Adolescent Immunizations summary rate comprises the rates for vaccinations appropriate to each age group. Childhood vaccinations included in the composite are DTaP/DT, hepatitis A, hepatitis B, HIB, IPV, MMR, pneumococcal conjugate and chicken pox vaccines,

rotavirus, influenza and combinations. Adolescent vaccinations included in the composite are meningococcal, Tdap/Td and combinations.

Consumer Experience is a summary of the following indicators: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Claims Processing, Customer Service, Rating of Personal Doctor, Rating of Specialist, Rating of All Health Care and Rating of Plan.

All rating summaries reflect ratings of 9 or 10 and all composites correspond to responses of "Always." The Diabetes composite summarizes the mean for the following indicators: Blood Pressure Control (<140/90 mm Hg), Eye Exams, HbA1c Screening, Poor Glycemic Control (>9%), LDL Cholesterol Screening, LDL Cholesterol Control (<100 mg/dL) and Medical Attention for Nephropathy.

The Heart Disease composite summarizes performance on the following indicators: Persistence of Beta-Blockers After a Heart Attack; Controlling High Blood Pressure; Cholesterol Screening; and Management for Patients With Cardiovascular Conditions.

The final rates presented are the unweighted averages of all indicators in the composites defined above, across all plans (by product line and reporting type) in each U.S. Census region. Plans that operate in more than one region are counted in each region summary. For example, a plan that operates in the Mountain and Pacific regions contributed data to the composite mean once for the Mountain region and once for the Pacific region.

Relative Resource Use

Health plans report case mix-adjusted measures of resource use related to five chronic illnesses: asthma, cardiovascular conditions, COPD, diabetes and hypertension. These measures incorporate cost and service frequency for each eligible member during the measurement year.

All services administered to members identified with one of these conditions are attributed to the RRU measure for that condition. Each of the five RRU measures summarizes a health plan's utilization of several service categories:

- Inpatient Facility.
- Evaluation and Management (E&M—Inpatient and Outpatient).
- Procedure and Surgery (Inpatient and Outpatient).
- Diagnostic Imaging Services.
- Diagnostic Laboratory Services.
- Ambulatory Pharmacy Services.

NCQA calculates an observed-to-expected (O/E) ratio for resource use for each health plan, as well as a quality composite. In order to facilitate comparison within regions and among reporting types, NCQA reports indexed O/E ratios (each health plan's O/E ratio is divided by the average O/E for all plans of the same type in a given region). The quality composite is also indexed in the same way (each plan's composite rate is divided by the average composite for plans of the same reporting type in the same region). The O/E ratio is a plan's actual resource use (the "observed"), divided by an estimate of the resource use the plan would have if its population was the same as the average population of all other plans submitting data to NCQA (the "expected").

For the resource use index, shown as the horizontal axis on RRU scatter plots, a value of 1.00 represents the average resource utilization for all HMOs or PPOs nationally. A value >1.00 represents higher-than-expected use; a value <1.00 represents lower-than-expected use.

For the quality index, otherwise known as the Effectiveness of Care index and shown as the vertical axis on RRU scatter plots, an index greater than 1.00 represents better-than-expected performance; an index less than 1.00 represents lower-than-expected performance. For example, a PPO with an index of 1.12 for quality and 1.15 for resource use delivered quality that was 12 percent better than the average PPO serving similar patients, and used 15 percent more resources than the PPO average.

Descriptive statistics are provided for composites with up to 10 indicators. With the exception of the COPD quality RRU composite, the summary statistics for composite measures are the simple, unweighted average of all measures and indicators in the composite. Since 2 of the 3 COPD indicators describe the same dimension of care (Pharmacotherapy Management), each indicator receives a weight of 1/2.

APPENDIX 1A: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: COMMERCIAL HMOS

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES COMMERCIAL HMO STATISTICS—2012			
MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Overuse and Appropriateness			
Imaging Studies for Low Back Pain	82.7	66.7	16.0
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	39.6	14.8	24.8
Screening, Prevention and Wellness			
Adult BMI Assessment	89.1	36.1	53.0
Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	86.8	68.0	18.8
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	62.1	35.4	26.6
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications	66.0	43.9	22.1
Flu Shots for Adults Ages 50–64	64.8	45.1	19.7
Breast Cancer Screening	78.7	63.0	15.6
Cervical Cancer Screening	81.9	69.2	12.7
Colorectal Cancer Screening	75.0	50.9	24.1
Chlamydia Screening in Women: 16–20 Years	56.6	29.7	27.0
Chlamydia Screening in Women: 21–24 Years	64.7	35.8	28.9
Chlamydia Screening in Women: Total Rate	61.1	32.9	28.2
Chronic Condition Management			
Aspirin Use and Discussion: Aspirin Use	55.7	39.6	16.0
Persistence of Beta-Blocker Treatment After a Heart Attack	93.3	73.4	19.9
Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg)	58.4	32.9	25.5
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	79.6	51.3	28.3
Comprehensive Diabetes Care: Eye Exams	75.1	38.4	36.7
Comprehensive Diabetes Care: HbA1c Screening	94.9	85.6	9.3
Comprehensive Diabetes Care: HbA1c <7% for a Selected Population	51.3	35.3	16.1
Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%)	71.4	50.9	20.5
Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)—Lower rates signify better performance	18.2	39.3	21.1
Comprehensive Diabetes Care: LDL Cholesterol Screening	91.0	79.7	11.3
Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL)	59.1	36.9	22.2
Comprehensive Diabetes Care: Medical Attention for Nephropathy	90.8	77.8	13.0
Controlling High Blood Pressure	74.9	50.3	24.7
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening	93.0	83.7	9.3

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
COMMERCIAL HMO STATISTICS—2012

MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL)	73.1	46.9	26.1
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	94.5	81.0	13.5
Use of Appropriate Medications for People With Asthma: 5–11 Years	98.6	91.7	6.9
Use of Appropriate Medications for People With Asthma: 12–18 Years	97.1	87.0	10.1
Use of Appropriate Medications for People With Asthma: 19–50 Years	92.7	83.1	9.6
Use of Appropriate Medications for People With Asthma: 51–64 Years	95.8	88.4	7.4
Use of Appropriate Medications for People With Asthma: Overall Rate	94.5	87.5	7.0
Medication Management for People With Asthma: 75% Compliance Rate (5–11 Years)	45.0	22.0	23.1
Medication Management for People With Asthma: 75% Compliance Rate (12–18 Years)	41.1	22.5	18.6
Medication Management for People With Asthma: 75% Compliance Rate (19–50 Years)	50.0	29.8	20.2
Medication Management for People With Asthma: 75% Compliance Rate (51–64 Years)	63.6	41.5	22.2
Medication Management for People With Asthma: 75% Compliance Rate (Overall)	53.0	32.3	20.7
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	57.3	33.6	23.7
Pharmacotherapy Management of COPD: Bronchodilators	87.9	73.3	14.6
Pharmacotherapy Management of COPD: Systemic Corticosteroids	81.2	63.9	17.3
Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs	87.5	78.1	9.5
Annual Monitoring for Patients on Persistent Medications: Anticonvulsants	69.7	48.5	21.2
Annual Monitoring for Patients on Persistent Medications: Digoxin	94.3	78.7	15.6
Annual Monitoring for Patients on Persistent Medications: Diuretics	87.2	77.8	9.4
Annual Monitoring for Patients on Persistent Medications: Combined	87.0	77.3	9.7
Antidepressant Medication Management: Acute Phase	78.3	60.5	17.8
Antidepressant Medication Management: Continuation Phase	62.6	44.0	18.6
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	75.4	39.4	36.0
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	88.0	62.0	26.0
Alcohol and Other Drug Dependence Treatment: Initiation	50.0	29.7	20.3
Alcohol and Other Drug Dependence Treatment: Engagement	19.6	7.3	12.3
Measures Targeted Toward Children and Adolescents			
Appropriate Testing for Children With Pharyngitis	92.3	65.4	26.9
Appropriate Treatment for Children With Upper Respiratory Infection	94.3	72.5	21.8
Childhood Immunization Status: DTaP/DT	93.3	81.8	11.5
Childhood Immunization Status: Hepatitis B	94.9	83.9	11.0
Childhood Immunization Status: HiB	97.8	91.0	6.8

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

COMMERCIAL HMO STATISTICS—2012

MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Childhood Immunization Status: IPV	96.8	89.1	7.7
Childhood Immunization Status: MMR	95.6	88.1	7.5
Childhood Immunization Status: Pneumococcal Conjugate (PCV)	93.2	80.3	12.9
Childhood Immunization Status: VZV	95.2	87.6	7.6
Childhood Immunization Status: Hepatitis A	89.3	32.1	57.2
Childhood Immunization Status: Rotavirus	85.2	67.7	17.4
Childhood Immunization Status: Influenza	76.2	49.2	26.9
Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	88.2	71.9	16.3
Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	86.3	67.7	18.5
Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza)	58.8	16.7	42.1
Immunizations for Adolescents: Meningococcal	87.1	46.3	40.8
Immunizations for Adolescents: Tdap/Td	94.3	58.3	36.0
Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td)	86.1	43.1	43.0
Follow-Up Care for Children Prescribed ADHD Medication: Initiation	49.0	29.2	19.8
Follow-Up Care for Children Prescribed ADHD Medication: Continuation	57.1	33.3	23.8
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years)	83.0	11.9	71.0
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years)	77.9	23.8	54.0
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years)	74.5	23.1	51.4
Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits	91.3	65.2	26.0
Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits	86.1	59.6	26.5
Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit	60.5	29.5	31.1
Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months	99.6	96.0	3.6
Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years	96.1	86.2	9.9
Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years	97.6	87.2	10.4
Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years	95.6	85.1	10.6
Other Access and Utilization			
Prenatal and Postpartum Care: Timeliness of Prenatal Care	97.1	78.7	18.4
Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery	90.5	68.3	22.2
Plan All-Cause Readmissions: 18–64 Years—Lower rates signify better performance*	0.68	0.96	0.28

**This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios <1.0 indicate lower-than-expected readmission rates, whereas ratios >1.0 indicate higher-than-expected readmission rates.*

APPENDIX 1B: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: COMMERCIAL HMOS

CAHPS MEMBER SATISFACTION MEASURES COMMERCIAL HMO STATISTICS—2012			
MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Consumer and Patient Engagement and Experience			
Rating of Health Plan: Rating of 8, 9 or 10	79.1	52.6	26.4
Rating of Health Plan: Rating of 9 or 10	59.5	27.9	31.6
Rating of Health Care: Rating of 8, 9 or 10	82.9	71.1	11.8
Rating of Health Care: Rating of 9 or 10	60.5	43.1	17.5
Getting Needed Care: Usually or Always	91.7	82.8	8.9
Getting Needed Care: Always	62.6	49.4	13.2
Getting Care Quickly: Usually or Always	90.5	81.0	9.5
Getting Care Quickly: Always	66.9	54.7	12.2
How Well Doctors Communicate: Usually or Always	96.5	91.9	4.6
How Well Doctors Communicate: Always	79.1	70.4	8.8
Rating of Personal Doctor: Rating of 8, 9 or 10	88.5	80.0	8.5
Rating of Personal Doctor: Rating of 9 or 10	73.9	59.3	14.5
Rating of Specialist: Rating of 8, 9 or 10	88.8	78.9	9.9
Rating of Specialist: Rating of 9 or 10	75.0	58.2	16.8
Customer Service: Usually or Always	92.9	83.1	9.7
Customer Service: Always	72.3	56.8	15.4
Claims Processing: Usually or Always	94.1	82.3	11.7
Claims Processing: Always	65.3	48.1	17.2

APPENDIX 2A: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: COMMERCIAL PPOS

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES COMMERCIAL PPO STATISTICS—2012			
MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Overuse and Appropriateness			
Imaging Studies for Low Back Pain	81.5	67.0	14.5
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	28.1	15.1	13.0
Screening, Prevention and Wellness			
Adult BMI Assessment	71.0	2.0	69.0
Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	77.5	65.4	12.1
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	47.0	29.7	17.3
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications	53.0	36.2	16.8
Flu Shots for Adults Ages 50–64	61.5	44.4	17.1
Breast Cancer Screening	72.1	61.7	10.4
Cervical Cancer Screening	78.3	68.4	9.9
Colorectal Cancer Screening	65.3	45.5	19.9
Chlamydia Screening in Women: 16–20 Years	50.0	30.1	19.9
Chlamydia Screening in Women: 21–24 Years	59.8	33.4	26.4
Chlamydia Screening in Women: Total Rate	54.9	31.7	23.2
Chronic Condition Management			
Aspirin Use and Discussion: Aspirin Use	54.5	40.8	13.6
Persistence of Beta-Blocker Treatment After a Heart Attack	88.3	70.3	18.0
Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg)	45.7	30.5	15.1
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	69.6	49.0	20.6
Comprehensive Diabetes Care: Eye Exams	60.2	33.2	27.0
Comprehensive Diabetes Care: HbA1c Screening	91.5	82.1	9.4
Comprehensive Diabetes Care: HbA1c <7% for a Selected Population	46.1	8.5	37.6
Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%)	65.7	43.3	22.4
Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)—Lower rates signify better performance	22.1	47.8	25.7
Comprehensive Diabetes Care: LDL Cholesterol Screening	87.5	74.8	12.7
Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL)	51.1	32.1	19.0
Comprehensive Diabetes Care: Medical Attention for Nephropathy	85.9	70.3	15.6
Controlling High Blood Pressure	65.2	48.9	16.3
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening	89.7	74.6	15.1

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

COMMERCIAL PPO STATISTICS—2012

MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL)	64.7	26.6	38.1
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	92.2	81.4	10.9
Use of Appropriate Medications for People With Asthma: 5–11 Years	98.2	93.2	5.0
Use of Appropriate Medications for People With Asthma: 12–18 Years	95.6	88.2	7.4
Use of Appropriate Medications for People With Asthma: 19–50 Years	91.4	82.0	9.5
Use of Appropriate Medications for People With Asthma: 51–64 Years	95.2	89.1	6.2
Use of Appropriate Medications for People With Asthma: Overall Rate	93.3	86.6	6.6
Medication Management for People With Asthma: 75% Compliance Rate (5–11 Years)	43.5	26.3	17.3
Medication Management for People With Asthma: 75% Compliance Rate (12–18 Years)	43.3	25.6	17.7
Medication Management for People With Asthma: 75% Compliance Rate (19–50 Years)	48.8	34.4	14.4
Medication Management for People With Asthma: 75% Compliance Rate (51–64 Years)	62.7	48.2	14.5
Medication Management for People With Asthma: 75% Compliance Rate (Overall)	49.8	37.2	12.5
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	48.9	34.6	14.3
Pharmacotherapy Management of COPD: Bronchodilators	86.5	68.8	17.7
Pharmacotherapy Management of COPD: Systemic Corticosteroids	79.1	60.3	18.7
Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs	83.6	74.1	9.5
Annual Monitoring for Patients on Persistent Medications: Anticonvulsants	62.7	48.9	13.8
Annual Monitoring for Patients on Persistent Medications: Digoxin	87.8	71.8	16.0
Annual Monitoring for Patients on Persistent Medications: Diuretics	83.3	74.1	9.3
Annual Monitoring for Patients on Persistent Medications: Combined	82.9	73.6	9.3
Antidepressant Medication Management: Acute Phase	75.0	62.5	12.5
Antidepressant Medication Management: Continuation Phase	61.6	45.9	15.7
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	67.2	37.3	30.0
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	82.6	61.0	21.6
Alcohol and Other Drug Dependence Treatment: Initiation	50.5	32.8	17.7
Alcohol and Other Drug Dependence Treatment: Engagement	20.0	9.0	11.0
Measures Targeted Toward Children and Adolescents			
Appropriate Testing for Children With Pharyngitis	89.5	67.5	22.1
Appropriate Treatment for Children With Upper Respiratory Infection	91.6	70.5	21.1
Childhood Immunization Status: DTaP/DT	90.5	60.7	29.8
Childhood Immunization Status: Hepatitis B	92.9	33.8	59.1
Childhood Immunization Status: HiB	96.5	72.5	24.0

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

COMMERCIAL PPO STATISTICS—2012

MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Childhood Immunization Status: IPV	95.5	68.9	26.6
Childhood Immunization Status: MMR	94.2	81.7	12.4
Childhood Immunization Status: Pneumococcal Conjugate (PCV)	90.5	60.1	30.5
Childhood Immunization Status: VZV	94.1	80.0	14.1
Childhood Immunization Status: Hepatitis A	85.6	29.7	55.9
Childhood Immunization Status: Rotavirus	82.5	55.5	27.0
Childhood Immunization Status: Influenza	73.1	46.5	26.6
Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	83.7	29.3	54.4
Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	80.5	34.6	46.0
Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza)	50.2	11.8	38.4
Immunizations for Adolescents: Meningococcal	79.9	38.3	41.5
Immunizations for Adolescents: Tdap/Td	90.2	49.7	40.5
Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td)	76.7	35.7	41.0
Follow-Up Care for Children Prescribed ADHD Medication: Initiation	48.6	29.4	19.2
Follow-Up Care for Children Prescribed ADHD Medication: Continuation	56.9	34.8	22.2
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years)	62.6	0.5	62.1
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years)	69.1	0.5	68.6
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years)	64.4	0.1	64.3
Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits	86.7	63.6	23.1
Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits	84.2	55.3	28.9
Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit	58.5	25.2	33.3
Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months	98.8	94.0	4.8
Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years	95.1	82.9	12.2
Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years	96.6	83.2	13.4
Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years	94.8	81.7	13.1
Other Access and Utilization			
Prenatal and Postpartum Care: Timeliness of Prenatal Care	95.6	49.8	45.8
Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery	85.9	42.4	43.5
Plan All-Cause Readmissions: 18–64 Years—Lower rates signify better performance*	0.68	0.87	0.18

**This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios <1.0 indicate lower-than-expected readmission rates, whereas ratios >1.0 indicate higher-than-expected readmission rates.*

APPENDIX 2B: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: COMMERCIAL PPOS

CAHPS MEMBER SATISFACTION MEASURES COMMERCIAL PPO STATISTICS—2012			
MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Consumer and Patient Engagement and Experience			
Rating of Health Plan: Rating of 8, 9 or 10	67.1	47.8	19.2
Rating of Health Plan: Rating of 9 or 10	42.4	24.3	18.1
Rating of Health Care: Rating of 8, 9 or 10	81.3	69.2	12.2
Rating of Health Care: Rating of 9 or 10	55.9	40.1	15.8
Getting Needed Care: Usually or Always	91.4	85.9	5.5
Getting Needed Care: Always	62.9	52.0	11.0
Getting Care Quickly: Usually or Always	90.1	82.8	7.3
Getting Care Quickly: Always	65.5	55.5	10.0
How Well Doctors Communicate: Usually or Always	96.7	93.2	3.5
How Well Doctors Communicate: Always	78.8	71.3	7.5
Rating of Personal Doctor: Rating of 8, 9 or 10	87.5	78.8	8.7
Rating of Personal Doctor: Rating of 9 or 10	69.7	56.8	12.9
Rating of Specialist: Rating of 8, 9 or 10	87.4	77.6	9.7
Rating of Specialist: Rating of 9 or 10	70.4	56.4	13.9
Customer Service: Usually or Always	90.7	81.6	9.1
Customer Service: Always	67.1	52.5	14.6
Claims Processing: Usually or Always	92.2	82.9	9.3
Claims Processing: Always	58.7	43.9	14.8

APPENDIX 3A: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: MEDICAID HMOS

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES MEDICAID HMO STATISTICS—2012			
MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Overuse and Appropriateness			
Imaging Studies for Low Back Pain	82.3	68.3	14.0
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	35.4	14.9	20.6
Screening, Prevention and Wellness			
Adult BMI Assessment	84.4	48.7	35.7
Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	81.3	69.9	11.4
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	50.7	33.4	17.3
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications	57.5	36.0	21.5
Breast Cancer Screening	62.9	41.7	21.2
Cervical Cancer Screening	76.6	47.2	29.4
Chlamydia Screening in Women: 16–20 Years	66.4	41.1	25.3
Chlamydia Screening in Women: 21–24 Years	73.5	51.5	21.9
Chlamydia Screening in Women: Total Rate	68.8	46.2	22.6
Chronic Condition Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	91.0	71.2	19.8
Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg)	50.6	27.4	23.2
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	74.6	45.7	28.9
Comprehensive Diabetes Care: Eye Exams	67.6	37.1	30.5
Comprehensive Diabetes Care: HbA1c Screening	91.0	75.9	15.1
Comprehensive Diabetes Care: HbA1c <7% for a Selected Population	43.2	24.0	19.3
Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%)	58.6	34.6	24.1
Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)—Lower rates signify better performance	31.1	59.5	28.3
Comprehensive Diabetes Care: LDL Cholesterol Screening	83.5	66.8	16.7
Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL)	43.8	21.8	22.0
Comprehensive Diabetes Care: Medical Attention for Nephropathy	85.8	69.8	16.1
Controlling High Blood Pressure	69.6	44.8	24.8
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening	88.8	73.6	15.3
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL)	54.1	28.2	25.9
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	82.6	57.1	25.4

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
MEDICAID HMO STATISTICS—2012

MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Use of Appropriate Medications for People With Asthma: 5–11 Years	94.9	83.8	11.1
Use of Appropriate Medications for People With Asthma: 12–18 Years	92.2	78.9	13.3
Use of Appropriate Medications for People With Asthma: 19–50 Years	84.3	61.7	22.7
Use of Appropriate Medications for People With Asthma: 51–64 Years	82.6	56.0	26.6
Use of Appropriate Medications for People With Asthma: Overall Rate	89.8	77.3	12.5
Medication Management for People With Asthma: 75% Compliance Rate (5–11 Years)	36.0	16.2	19.8
Medication Management for People With Asthma: 75% Compliance Rate (12–18 Years)	35.9	15.7	20.3
Medication Management for People With Asthma: 75% Compliance Rate (19–50 Years)	44.7	24.1	20.6
Medication Management for People With Asthma: 75% Compliance Rate (51–64 Years)	63.1	38.1	24.9
Medication Management for People With Asthma: 75% Compliance Rate (Overall)	38.7	19.2	19.5
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	42.8	19.0	23.8
Pharmacotherapy Management of COPD: Bronchodilators	90.2	71.7	18.5
Pharmacotherapy Management of COPD: Systemic Corticosteroids	77.1	48.9	28.2
Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs	91.2	80.8	10.4
Annual Monitoring for Patients on Persistent Medications: Anticonvulsants	73.6	55.6	18.1
Annual Monitoring for Patients on Persistent Medications: Digoxin	94.9	83.7	11.2
Annual Monitoring for Patients on Persistent Medications: Diuretics	91.3	80.0	11.3
Annual Monitoring for Patients on Persistent Medications: Combined	89.0	79.3	9.7
Antidepressant Medication Management: Acute Phase	61.0	45.1	15.9
Antidepressant Medication Management: Continuation Phase	45.9	28.1	17.7
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	68.8	21.3	47.5
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	82.0	38.3	43.7
Alcohol and Other Drug Dependence Treatment: Initiation	48.2	28.6	19.6
Alcohol and Other Drug Dependence Treatment: Engagement	19.8	2.9	17.0
Measures Targeted Toward Children and Adolescents			
Appropriate Testing for Children With Pharyngitis	85.1	50.8	34.3
Appropriate Treatment for Children With Upper Respiratory Infection	93.0	77.0	16.0
Childhood Immunization Status: DTaP/DT	88.1	73.5	14.6
Childhood Immunization Status: Hepatitis B	95.5	81.5	13.9
Childhood Immunization Status: HiB	96.0	87.5	8.5
Childhood Immunization Status: IPV	96.1	86.8	9.3
Childhood Immunization Status: MMR	95.4	86.8	8.6
Childhood Immunization Status: Pneumococcal Conjugate (PCV)	88.1	73.3	14.8

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

MEDICAID HMO STATISTICS—2012

MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Childhood Immunization Status: VZV	95.1	85.6	9.5
Childhood Immunization Status: Hepatitis A	91.2	47.9	43.3
Childhood Immunization Status: Rotavirus	77.2	56.4	20.8
Childhood Immunization Status: Influenza	64.5	30.4	34.1
Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	85.4	66.0	19.4
Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	83.3	62.0	21.4
Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza)	45.7	16.1	29.6
Immunizations for Adolescents: Meningococcal	89.1	52.3	36.7
Immunizations for Adolescents: Tdap/Td	93.2	66.0	27.2
Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td)	85.6	50.9	34.7
Follow-Up Care for Children Prescribed ADHD Medication: Initiation	51.9	23.9	28.0
Follow-Up Care for Children Prescribed ADHD Medication: Continuation	63.8	25.0	38.8
Lead Screening in Children	87.0	36.6	50.4
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years)	80.2	22.9	57.4
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years)	75.2	31.0	44.2
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years)	64.7	20.9	43.8
Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits	77.4	49.7	27.7
Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits	82.1	60.8	21.3
Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit	65.5	37.3	28.2
Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months	98.5	92.4	6.1
Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years	93.6	82.8	10.8
Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years	95.3	83.4	11.8
Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years	93.8	81.3	12.4
Other Access and Utilization			
Frequency of Prenatal Care Visits: <21% of Expected Visits	27.4	2.3	25.1
Frequency of Prenatal Care Visits: 21–40% of Expected Visits	12.3	1.6	10.6
Frequency of Prenatal Care Visits: 41–60% of Expected Visits	13.0	3.9	9.1
Frequency of Prenatal Care Visits: 61–80% of Expected Visits	20.8	7.5	13.2
Frequency of Prenatal Care Visits: ≥81% of Expected Visits	80.1	36.3	43.9
Prenatal and Postpartum Care: Timeliness of Prenatal Care	92.8	70.6	22.2
Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery	73.8	50.7	23.1

APPENDIX 3B: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: MEDICAID HMOS

CAHPS MEMBER SATISFACTION MEASURES MEDICAID HMO STATISTICS—2012			
MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Consumer and Patient Engagement and Experience			
Rating of Health Plan: Rating of 8, 9 or 10	81.3	65.9	15.3
Rating of Health Plan: Rating of 9 or 10	65.5	46.8	18.7
Rating of Health Care: Rating of 8, 9 or 10	76.3	65.3	11.0
Rating of Health Care: Rating of 9 or 10	57.0	45.1	11.9
Getting Needed Care: Usually or Always	85.4	75.6	9.9
Getting Needed Care: Always	61.4	47.7	13.7
Getting Care Quickly: Usually or Always	85.4	76.0	9.4
Getting Care Quickly: Always	64.1	53.2	10.9
How Well Doctors Communicate: Usually or Always	92.6	86.3	6.3
How Well Doctors Communicate: Always	76.0	65.6	10.4
Rating of Personal Doctor: Rating of 8, 9 or 10	82.9	73.2	9.7
Rating of Personal Doctor: Rating of 9 or 10	69.3	55.9	13.4
Rating of Specialist: Rating of 8, 9 or 10	84.4	75.0	9.4
Rating of Specialist: Rating of 9 or 10	70.0	58.3	11.7
Customer Service: Usually or Always	89.5	82.2	7.3
Customer Service: Always	72.7	60.2	12.5

APPENDIX 4A: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: MEDICARE HMOS

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES MEDICARE HMO STATISTICS—2012			
MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Screening, Prevention and Wellness			
Adult BMI Assessment	95.4	65.0	30.4
Breast Cancer Screening	82.2	58.6	23.6
Colorectal Cancer Screening	77.0	47.2	29.8
Chronic Condition Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	95.6	81.1	14.4
Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg)	67.2	34.4	32.7
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	79.1	48.6	30.5
Comprehensive Diabetes Care: Eye Exams	80.9	53.0	27.8
Comprehensive Diabetes Care: HbA1c Screening	96.1	86.6	9.4
Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%)	78.3	46.9	31.5
Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)—Lower rates signify better performance	12.4	46.0	33.5
Comprehensive Diabetes Care: LDL Cholesterol Screening	94.1	81.1	13.0
Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL)	65.1	36.7	28.4
Comprehensive Diabetes Care: Medical Attention for Nephropathy	95.1	85.2	9.9
Controlling High Blood Pressure	76.9	51.2	25.7
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening	95.6	82.7	12.9
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL)	71.5	43.1	28.4
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	87.2	62.4	24.8
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	51.4	23.4	28.0
Pharmacotherapy Management of COPD: Bronchodilators	89.5	71.0	18.5
Pharmacotherapy Management of COPD: Systemic Corticosteroids	78.7	58.1	20.5
Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs	96.1	88.5	7.6
Annual Monitoring for Patients on Persistent Medications: Anticonvulsants	78.1	54.3	23.8
Annual Monitoring for Patients on Persistent Medications: Digoxin	98.0	90.6	7.5
Annual Monitoring for Patients on Persistent Medications: Diuretics	96.1	88.4	7.7
Annual Monitoring for Patients on Persistent Medications: Combined	95.5	87.2	8.3
Antidepressant Medication Management: Acute Phase	81.3	56.5	24.7
Antidepressant Medication Management: Continuation Phase	69.2	40.8	28.4
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	62.7	18.4	44.4

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
MEDICARE HMO STATISTICS—2012

MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	79.5	33.2	46.3
Alcohol and Other Drug Dependence Treatment: Initiation	54.1	21.2	32.8
Alcohol and Other Drug Dependence Treatment: Engagement	6.2	0.4	5.8
Measures Targeted Toward Older Adults			
Fall Risk Management: Discussion	45.6	26.4	19.1
Fall Risk Management: Management	73.2	52.7	20.6
Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS—Lower rates signify better performance	4.3	20.6	16.4
Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents—Lower rates signify better performance	16.2	33.6	17.4
Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents—Lower rates signify better performance	10.8	21.1	10.2
Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate—Lower rates signify better performance	13.7	28.0	14.3
Management of Urinary Incontinence: Discussion	65.4	49.7	15.8
Physical Activity in Older Adults: Discussion	62.7	47.0	15.8
Physical Activity in Older Adults: Advice	57.3	42.4	14.9
Osteoporosis Testing in Older Women	83.1	58.5	24.6
Osteoporosis Management in Women Who Had a Fracture	48.0	12.3	35.7
Glaucoma Screening in Older Adults	79.8	56.6	23.2
Other Access and Utilization			
Plan All-Cause Readmissions: 18–64 Years—Lower rates signify better performance*	0.62	1.06	0.45
Plan All-Cause Readmissions: 65 Years and Older—Lower rates signify better performance*	0.67	1.06	0.40

**This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios <1.0 indicate lower-than-expected readmission rates, whereas ratios >1.0 indicate higher-than-expected readmission rates.*

APPENDIX 4B: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: MEDICARE HMOS

CAHPS MEMBER SATISFACTION MEASURES MEDICARE HMO STATISTICS—2012			
MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Consumer and Patient Engagement and Experience			

APPENDIX 5A: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: MEDICARE PPOS

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES MEDICARE PPO STATISTICS—2012			
MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Screening, Prevention and Wellness			
Adult BMI Assessment	89.1	59.9	29.3
Breast Cancer Screening	78.7	56.9	21.8
Colorectal Cancer Screening	73.0	43.9	29.1
Chronic Condition Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	94.4	81.8	12.6
Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg)	56.8	37.4	19.4
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	72.6	52.1	20.5
Comprehensive Diabetes Care: Eye Exams	77.9	53.0	24.8
Comprehensive Diabetes Care: HbA1c Screening	94.5	87.6	6.9
Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%)	75.1	50.7	24.4
Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)—Lower rates signify better performance	15.3	43.6	28.3
Comprehensive Diabetes Care: LDL Cholesterol Screening	91.7	81.2	10.5
Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL)	61.3	38.0	23.4
Comprehensive Diabetes Care: Medical Attention for Nephropathy	92.2	84.7	7.5
Controlling High Blood Pressure	70.8	43.9	26.9
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening	92.9	82.1	10.9
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL)	66.7	37.7	29.0
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	86.7	71.3	15.4
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	44.0	23.5	20.4
Pharmacotherapy Management of COPD: Bronchodilators	84.3	69.4	14.9
Pharmacotherapy Management of COPD: Systemic Corticosteroids	77.0	61.8	15.1
Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs	94.5	88.0	6.5
Annual Monitoring for Patients on Persistent Medications: Anticonvulsants	78.8	54.0	24.7
Annual Monitoring for Patients on Persistent Medications: Digoxin	96.9	89.9	6.9
Annual Monitoring for Patients on Persistent Medications: Diuretics	94.4	88.6	5.7
Annual Monitoring for Patients on Persistent Medications: Combined	94.2	88.0	6.2
Antidepressant Medication Management: Acute Phase	81.1	61.9	19.2
Antidepressant Medication Management: Continuation Phase	69.8	50.0	19.8
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	52.4	23.3	29.1

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

MEDICARE PPO STATISTICS—2012

MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	75.6	44.2	31.4
Alcohol and Other Drug Dependence Treatment: Initiation	54.0	33.2	20.7
Alcohol and Other Drug Dependence Treatment: Engagement	5.6	0.8	4.8
Measures Targeted Toward Older Adults			
Fall Risk Management: Discussion	39.1	25.1	14.0
Fall Risk Management: Management	69.0	48.3	20.7
Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS—Lower rates signify better performance	5.6	17.3	11.8
Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents—Lower rates signify better performance	17.2	33.7	16.5
Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents—Lower rates signify better performance	11.7	20.0	8.3
Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate—Lower rates signify better performance	14.8	25.8	11.0
Management of Urinary Incontinence: Discussion	64.0	49.6	14.4
Physical Activity in Older Adults: Discussion	62.7	46.8	15.8
Physical Activity in Older Adults: Advice	55.3	40.8	14.6
Osteoporosis Testing in Older Women	84.3	63.3	21.0
Osteoporosis Management in Women Who Had a Fracture	27.6	12.0	15.6
Glaucoma Screening in Older Adults	79.7	59.6	20.2
Other Access and Utilization			
Plan All-Cause Readmissions: 18–64 Years—Lower rates signify better performance*	0.63	1.07	0.43
Plan All-Cause Readmissions: 65 Years and Older—Lower rates signify better performance*	0.66	1.01	0.35

**This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios <1.0 indicate lower-than-expected readmission rates, whereas ratios >1.0 indicate higher-than-expected readmission rates.*

APPENDIX 5B: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: MEDICARE PPOS

CAHPS MEMBER SATISFACTION MEASURES MEDICARE PPO STATISTICS—2012			
MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Consumer and Patient Engagement and Experience			

APPENDIX 6A: HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES: 2012 NATIONAL HMO AVERAGES

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES NATIONAL HMO AVERAGES—2012			
MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Overuse and Appropriateness			
Imaging Studies for Low Back Pain	75.3	–	75.6
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	24.6	–	24.2
Screening, Prevention and Wellness			
Adult BMI Assessment	66.1	80.8	67.5
Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	77.8	–	75.6
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	47.9	–	41.1
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications	52.9	–	45.8
Flu Shots for Adults Ages 50–64	55.3	–	–
Breast Cancer Screening	70.3	69.9	51.9
Cervical Cancer Screening	75.5	–	64.5
Colorectal Cancer Screening	63.3	62.1	–
Chlamydia Screening in Women: 16–20 Years	41.1	–	53.5
Chlamydia Screening in Women: 21–24 Years	49.2	–	63.6
Chlamydia Screening in Women: Total Rate	45.1	–	57.1
Chronic Condition Management			
Aspirin Use and Discussion: Aspirin Use	47.3	–	–
Persistence of Beta-Blocker Treatment After a Heart Attack	83.9	88.9	82.0
Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg)	44.3	48.4	37.8
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	66.5	63.3	58.9
Comprehensive Diabetes Care: Eye Exams	56.8	66.8	53.2
Comprehensive Diabetes Care: HbA1c Screening	90.1	91.4	83.0
Comprehensive Diabetes Care: HbA1c <7% for a Selected Population	43.2	–	34.0
Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%)	61.3	64.3	46.5
Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)—Lower rates signify better performance	28.5	27.1	44.7
Comprehensive Diabetes Care: LDL Cholesterol Screening	85.4	88.0	75.5
Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL)	48.4	51.5	33.9
Comprehensive Diabetes Care: Medical Attention for Nephropathy	84.3	90.0	78.4
Controlling High Blood Pressure	63.0	63.6	56.3
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening	88.3	89.3	81.5

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
NATIONAL HMO AVERAGES—2012

MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL)	59.9	56.6	41.3
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	87.9	75.5	69.9
Use of Appropriate Medications for People With Asthma: 5–11 Years	95.5	–	89.6
Use of Appropriate Medications for People With Asthma: 12–18 Years	92.2	–	85.6
Use of Appropriate Medications for People With Asthma: 19–50 Years	88.2	–	73.9
Use of Appropriate Medications for People With Asthma: 51–64 Years	92.4	–	71.4
Use of Appropriate Medications for People With Asthma: Overall Rate	91.2	–	83.9
Medication Management for People With Asthma: 75% Compliance Rate (5–11 Years)	32.4	–	25.3
Medication Management for People With Asthma: 75% Compliance Rate (12–18 Years)	32.0	–	25.1
Medication Management for People With Asthma: 75% Compliance Rate (19–50 Years)	39.7	–	34.3
Medication Management for People With Asthma: 75% Compliance Rate (51–64 Years)	52.6	–	50.3
Medication Management for People With Asthma: 75% Compliance Rate (Overall)	41.8	–	28.9
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	43.5	36.8	31.5
Pharmacotherapy Management of COPD: Bronchodilators	80.8	80.4	81.5
Pharmacotherapy Management of COPD: Systemic Corticosteroids	73.5	69.1	65.4
Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs	82.9	92.0	86.3
Annual Monitoring for Patients on Persistent Medications: Anticonvulsants	58.8	66.7	65.8
Annual Monitoring for Patients on Persistent Medications: Digoxin	86.5	94.5	90.2
Annual Monitoring for Patients on Persistent Medications: Diuretics	82.5	92.2	86.0
Annual Monitoring for Patients on Persistent Medications: Combined	82.3	91.4	84.5
Antidepressant Medication Management: Acute Phase	69.1	69.4	52.8
Antidepressant Medication Management: Continuation Phase	53.6	56.9	36.7
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	57.9	38.1	43.7
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	76.0	56.4	63.6
Alcohol and Other Drug Dependence Treatment: Initiation	39.1	38.8	39.4
Alcohol and Other Drug Dependence Treatment: Engagement	13.6	3.1	10.8
Measures Targeted Toward Children and Adolescents			
Appropriate Testing for Children With Pharyngitis	80.2	–	68.0
Appropriate Treatment for Children With Upper Respiratory Infection	84.0	–	85.1
Childhood Immunization Status: DTaP/DT	87.2	–	80.9
Childhood Immunization Status: Hepatitis B	89.2	–	89.5
Childhood Immunization Status: HiB	94.3	–	92.0

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
NATIONAL HMO AVERAGES—2012

MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Childhood Immunization Status: IPV	92.8	–	91.6
Childhood Immunization Status: MMR	91.8	–	91.6
Childhood Immunization Status: Pneumococcal Conjugate (PCV)	86.7	–	80.1
Childhood Immunization Status: VZV	91.6	–	91.1
Childhood Immunization Status: Hepatitis A	65.5	–	76.4
Childhood Immunization Status: Rotavirus	76.7	–	66.0
Childhood Immunization Status: Influenza	63.3	–	49.5
Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	79.7	–	75.7
Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	76.8	–	72.1
Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza)	37.9	–	31.4
Immunizations for Adolescents: Meningococcal	66.0	–	69.4
Immunizations for Adolescents: Tdap/Td	79.2	–	81.3
Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td)	63.7	–	67.2
Follow-Up Care for Children Prescribed ADHD Medication: Initiation	38.6	–	39.0
Follow-Up Care for Children Prescribed ADHD Medication: Continuation	45.7	–	45.3
Lead Screening in Children	–	–	67.5
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years)	51.6	–	51.8
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years)	54.3	–	55.0
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years)	50.4	–	44.2
Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits	78.2	–	63.6
Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits	72.9	–	72.0
Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit	43.3	–	49.7
Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months	97.9	–	96.0
Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years	91.6	–	88.3
Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years	92.2	–	89.9
Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years	89.7	–	88.4
Measures Targeted Toward Older Adults			
Fall Risk Management: Discussion	–	33.8	–
Fall Risk Management: Management	–	62.0	–

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
NATIONAL HMO AVERAGES—2012

MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS—Lower rates signify better performance	–	11.0	–
Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents—Lower rates signify better performance	–	24.4	–
Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents—Lower rates signify better performance	–	15.5	–
Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate—Lower rates signify better performance	–	20.0	–
Management of Urinary Incontinence: Discussion	–	57.7	–
Physical Activity in Older Adults: Discussion	–	54.5	–
Physical Activity in Older Adults: Advice	–	50.1	–
Osteoporosis Testing in Older Women	–	72.1	–
Osteoporosis Management in Women Who Had a Fracture	–	25.0	–
Glaucoma Screening in Older Adults	–	68.2	–
Other Access and Utilization			
Frequency of Prenatal Care Visits: <21% of Expected Visits	–	–	12.3
Frequency of Prenatal Care Visits: 21–40% of Expected Visits	–	–	5.9
Frequency of Prenatal Care Visits: 41–60% of Expected Visits	–	–	7.7
Frequency of Prenatal Care Visits: 61–80% of Expected Visits	–	–	13.6
Frequency of Prenatal Care Visits: ≥81% of Expected Visits	–	–	60.4
Prenatal and Postpartum Care: Timeliness of Prenatal Care	89.6	–	82.9
Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery	80.1	–	63.0
Plan All-Cause Readmissions: 18–64 Years—Lower rates signify better performance*	0.88	0.84	–
Plan All-Cause Readmissions: 65 Years and Older—Lower rates signify better performance*	–	0.86	–

**This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios <1.0 indicate lower-than-expected readmission rates, whereas ratios >1.0 indicate higher-than-expected readmission rates.*

APPENDIX 6B: CAHPS MEMBER SATISFACTION MEASURES: 2012 NATIONAL HMO AVERAGES

CAHPS MEMBER SATISFACTION MEASURES NATIONAL HMO AVERAGES—2012			
MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Consumer and Patient Engagement and Experience			
Rating of Health Plan: Rating of 8, 9 or 10	65.3	–	73.5
Rating of Health Plan: Rating of 9 or 10	41.4	–	56.3
Rating of Health Care: Rating of 8, 9 or 10	77.3	–	70.8
Rating of Health Care: Rating of 9 or 10	51.5	–	50.9
Getting Needed Care: Usually or Always	87.3	–	80.6
Getting Needed Care: Always	56.4	–	55.1
Getting Care Quickly: Usually or Always	86.0	–	81.2
Getting Care Quickly: Always	60.5	–	59.0
How Well Doctors Communicate: Usually or Always	94.4	–	89.3
How Well Doctors Communicate: Always	74.8	–	71.5
Rating of Personal Doctor: Rating of 8, 9 or 10	84.2	–	78.4
Rating of Personal Doctor: Rating of 9 or 10	66.2	–	63.1
Rating of Specialist: Rating of 8, 9 or 10	83.9	–	79.4
Rating of Specialist: Rating of 9 or 10	66.4	–	64.4
Customer Service: Usually or Always	88.2	–	86.2
Customer Service: Always	64.4	–	66.7
Claims Processing: Usually or Always	88.8	–	–
Claims Processing: Always	56.8	–	–

APPENDIX 7A: HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES: 2012 NATIONAL PPO AVERAGES

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES NATIONAL PPO AVERAGES—2012		
MEASURE	COMMERCIAL	MEDICARE
Overuse and Appropriateness		
Imaging Studies for Low Back Pain	74.2	–
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	21.4	–
Screening, Prevention and Wellness		
Adult BMI Assessment	35.2	75.3
Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	70.8	–
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	37.3	–
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications	44.6	–
Flu Shots for Adults Ages 50–64	53.7	–
Breast Cancer Screening	66.5	67.5
Cervical Cancer Screening	73.6	–
Colorectal Cancer Screening	55.8	58.4
Chlamydia Screening in Women: 16–20 Years	38.9	–
Chlamydia Screening in Women: 21–24 Years	45.5	–
Chlamydia Screening in Women: Total Rate	42.3	–
Chronic Condition Management		
Aspirin Use and Discussion: Aspirin Use	47.8	–
Persistence of Beta-Blocker Treatment After a Heart Attack	79.5	88.5
Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg)	37.5	47.3
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	58.3	61.2
Comprehensive Diabetes Care: Eye Exams	48.8	64.6
Comprehensive Diabetes Care: HbA1c Screening	87.2	91.0
Comprehensive Diabetes Care: HbA1c <7% for a Selected Population	36.0	–
Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%)	54.5	62.8
Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)—Lower rates signify better performance	35.2	29.3
Comprehensive Diabetes Care: LDL Cholesterol Screening	81.7	86.6
Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL)	41.7	49.6
Comprehensive Diabetes Care: Medical Attention for Nephropathy	78.6	88.3
Controlling High Blood Pressure	57.4	58.6
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening	83.7	87.6
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL)	49.7	53.2
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	87.2	78.8

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
NATIONAL PPO AVERAGES—2012

MEASURE	COMMERCIAL	MEDICARE
Use of Appropriate Medications for People With Asthma: 5–11 Years	95.7	–
Use of Appropriate Medications for People With Asthma: 12–18 Years	92.2	–
Use of Appropriate Medications for People With Asthma: 19–50 Years	87.4	–
Use of Appropriate Medications for People With Asthma: 51–64 Years	92.2	–
Use of Appropriate Medications for People With Asthma: Overall Rate	90.7	–
Medication Management for People With Asthma: 75% Compliance Rate (5–11 Years)	34.5	–
Medication Management for People With Asthma: 75% Compliance Rate (12–18 Years)	34.1	–
Medication Management for People With Asthma: 75% Compliance Rate (19–50 Years)	42.1	–
Medication Management for People With Asthma: 75% Compliance Rate (51–64 Years)	55.6	–
Medication Management for People With Asthma: 75% Compliance Rate (Overall)	43.5	–
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	41.5	35.0
Pharmacotherapy Management of COPD: Bronchodilators	77.7	76.8
Pharmacotherapy Management of COPD: Systemic Corticosteroids	70.8	69.8
Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs	79.2	91.6
Annual Monitoring for Patients on Persistent Medications: Anticonvulsants	56.3	66.3
Annual Monitoring for Patients on Persistent Medications: Digoxin	80.6	93.2
Annual Monitoring for Patients on Persistent Medications: Diuretics	78.7	91.9
Annual Monitoring for Patients on Persistent Medications: Combined	78.5	91.3
Antidepressant Medication Management: Acute Phase	68.9	72.6
Antidepressant Medication Management: Continuation Phase	53.4	61.0
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	53.0	37.7
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	72.2	60.6
Alcohol and Other Drug Dependence Treatment: Initiation	41.2	43.3
Alcohol and Other Drug Dependence Treatment: Engagement	14.6	3.0
Measures Targeted Toward Children and Adolescents		
Appropriate Testing for Children With Pharyngitis	78.9	–
Appropriate Treatment for Children With Upper Respiratory Infection	82.3	–
Childhood Immunization Status: DTaP/DT	80.0	–
Childhood Immunization Status: Hepatitis B	77.3	–
Childhood Immunization Status: HiB	88.3	–
Childhood Immunization Status: IPV	86.3	–
Childhood Immunization Status: MMR	88.3	–
Childhood Immunization Status: Pneumococcal Conjugate (PCV)	78.9	–

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
NATIONAL PPO AVERAGES—2012

MEASURE	COMMERCIAL	MEDICARE
Childhood Immunization Status: VZV	88.0	–
Childhood Immunization Status: Hepatitis A	61.1	–
Childhood Immunization Status: Rotavirus	69.8	–
Childhood Immunization Status: Influenza	59.8	–
Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	68.1	–
Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	65.8	–
Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza)	29.5	–
Immunizations for Adolescents: Meningococcal	57.1	–
Immunizations for Adolescents: Tdap/Td	69.9	–
Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td)	54.3	–
Follow-Up Care for Children Prescribed ADHD Medication: Initiation	38.1	–
Follow-Up Care for Children Prescribed ADHD Medication: Continuation	44.9	–
Lead Screening in Children	–	–
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years)	31.2	–
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years)	35.4	–
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years)	32.6	–
Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits	76.4	–
Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits	69.9	–
Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit	40.1	–
Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months	97.0	–
Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years	90.1	–
Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years	90.5	–
Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years	87.6	–
Measures Targeted Toward Older Adults		
Fall Risk Management: Discussion	–	31.4
Fall Risk Management: Management	–	56.8
Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS—Lower rates signify better performance	–	10.8
Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents—Lower rates signify better performance	–	24.3
Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents—Lower rates signify better performance	–	15.5

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
NATIONAL PPO AVERAGES—2012

MEASURE	COMMERCIAL	MEDICARE
Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate—Lower rates signify better performance	–	19.9
Management of Urinary Incontinence: Discussion	–	56.2
Physical Activity in Older Adults: Discussion	–	55.5
Physical Activity in Older Adults: Advice	–	48.9
Osteoporosis Testing in Older Women	–	75.4
Osteoporosis Management in Women Who Had a Fracture	–	19.1
Glaucoma Screening in Older Adults	–	68.8
Other Access and Utilization		
Frequency of Prenatal Care Visits: <21% of Expected Visits	–	–
Frequency of Prenatal Care Visits: 21–40% of Expected Visits	–	–
Frequency of Prenatal Care Visits: 41–60% of Expected Visits	–	–
Frequency of Prenatal Care Visits: 61–80% of Expected Visits	–	–
Frequency of Prenatal Care Visits: ≥81% of Expected Visits	–	–
Prenatal and Postpartum Care: Timeliness of Prenatal Care	80.9	–
Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery	70.0	–
Plan All-Cause Readmissions: 18–64 Years—Lower rates signify better performance*	0.78	0.88
Plan All-Cause Readmissions: 65 Years and Older—Lower rates signify better performance*	–	0.86

**This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios <1.0 indicate lower-than-expected readmission rates, whereas ratios >1.0 indicate higher-than-expected readmission rates.*

APPENDIX 7B: CAHPS MEMBER SATISFACTION MEASURES: 2012 NATIONAL PPO AVERAGES

CAHPS MEMBER SATISFACTION MEASURES NATIONAL PPO AVERAGES—2012		
MEASURE	COMMERCIAL	MEDICARE
Consumer and Patient Engagement and Experience		
Rating of Health Plan: Rating of 8, 9 or 10	57.9	–
Rating of Health Plan: Rating of 9 or 10	33.3	–
Rating of Health Care: Rating of 8, 9 or 10	75.1	–
Rating of Health Care: Rating of 9 or 10	47.6	–
Getting Needed Care: Usually or Always	88.5	–
Getting Needed Care: Always	57.6	–
Getting Care Quickly: Usually or Always	86.7	–
Getting Care Quickly: Always	60.5	–
How Well Doctors Communicate: Usually or Always	95.0	–
How Well Doctors Communicate: Always	75.2	–
Rating of Personal Doctor: Rating of 8, 9 or 10	83.2	–
Rating of Personal Doctor: Rating of 9 or 10	63.6	–
Rating of Specialist: Rating of 8, 9 or 10	82.4	–
Rating of Specialist: Rating of 9 or 10	63.1	–
Customer Service: Usually or Always	86.0	–
Customer Service: Always	59.6	–
Claims Processing: Usually or Always	88.0	–
Claims Processing: Always	51.5	–

APPENDIX 8A: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2012 COMMERCIAL HMOS

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL HMO AVERAGES—2012			
MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Overuse and Appropriateness			
Imaging Studies for Low Back Pain	75.4	73.0	2.4
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	24.9	21.1	3.8
Screening, Prevention and Wellness			
Adult BMI Assessment	67.1	53.5	13.6
Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	77.5	82.3	-4.8
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	47.7	51.7	-4.0
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications	52.6	57.2	-4.5
Flu Shots for Adults Ages 50–64	55.3	56.3	-1.0
Breast Cancer Screening	70.7	66.2	4.5
Cervical Cancer Screening	76.0	70.4	5.7
Colorectal Cancer Screening	63.9	57.1	6.8
Chlamydia Screening in Women: 16–20 Years	41.6	35.8	5.8
Chlamydia Screening in Women: 21–24 Years	49.8	42.1	7.8
Chlamydia Screening in Women: Total Rate	45.7	38.9	6.8
Chronic Condition Management			
Aspirin Use and Discussion: Aspirin Use	47.1	58.6	-11.5
Persistence of Beta-Blocker Treatment After a Heart Attack	84.4	76.3	8.1
Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg)	44.8	39.8	4.9
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	67.0	60.9	6.2
Comprehensive Diabetes Care: Eye Exams	58.3	42.9	15.4
Comprehensive Diabetes Care: HbA1c Screening	90.4	86.9	3.5
Comprehensive Diabetes Care: HbA1c <7% for a Selected Population	44.2	31.6	12.6
Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%)	62.2	53.5	8.7
Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)—Lower rates signify better performance	27.6	36.8	9.2
Comprehensive Diabetes Care: LDL Cholesterol Screening	85.8	81.7	4.1
Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL)	49.1	41.7	7.4
Comprehensive Diabetes Care: Medical Attention for Nephropathy	84.8	78.7	6.1
Controlling High Blood Pressure	63.7	56.2	7.6
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening	88.6	85.3	3.3
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL)	61.2	48.2	13.0
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	87.9	88.3	-0.5

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL HMO AVERAGES—2012

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Use of Appropriate Medications for People With Asthma: 5–11 Years	95.6	94.6	0.9
Use of Appropriate Medications for People With Asthma: 12–18 Years	92.4	89.9	2.5
Use of Appropriate Medications for People With Asthma: 19–50 Years	88.2	87.7	0.5
Use of Appropriate Medications for People With Asthma: 51–64 Years	92.4	91.8	0.6
Use of Appropriate Medications for People With Asthma: Overall Rate	91.3	90.1	1.3
Medication Management for People With Asthma: 75% Compliance Rate (5–11 Years)	32.8	25.5	7.3
Medication Management for People With Asthma: 75% Compliance Rate (12–18 Years)	32.6	23.9	8.7
Medication Management for People With Asthma: 75% Compliance Rate (19–50 Years)	40.0	35.3	4.7
Medication Management for People With Asthma: 75% Compliance Rate (51–64 Years)	52.9	48.0	4.9
Medication Management for People With Asthma: 75% Compliance Rate (Overall)	42.1	37.4	4.7
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	43.8	39.9	3.9
Pharmacotherapy Management of COPD: Bronchodilators	81.0	77.9	3.1
Pharmacotherapy Management of COPD: Systemic Corticosteroids	73.8	70.6	3.2
Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs	83.0	82.1	0.9
Annual Monitoring for Patients on Persistent Medications: Anticonvulsants	58.9	57.0	1.9
Annual Monitoring for Patients on Persistent Medications: Digoxin	86.5	86.8	-0.3
Annual Monitoring for Patients on Persistent Medications: Diuretics	82.5	81.7	0.9
Annual Monitoring for Patients on Persistent Medications: Combined	82.4	81.5	0.8
Antidepressant Medication Management: Acute Phase	69.4	66.7	2.7
Antidepressant Medication Management: Continuation Phase	53.8	51.5	2.3
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	58.8	47.1	11.7
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	76.7	67.8	8.9
Alcohol and Other Drug Dependence Treatment: Initiation	39.4	35.7	3.8
Alcohol and Other Drug Dependence Treatment: Engagement	13.9	9.7	4.2
Measures Targeted Toward Children and Adolescents			
Appropriate Testing for Children With Pharyngitis	81.2	69.5	11.7
Appropriate Treatment for Children With Upper Respiratory Infection	84.9	75.5	9.4
Childhood Immunization Status: DTaP/DT	87.8	80.7	7.1
Childhood Immunization Status: Hepatitis B	90.3	78.1	12.2
Childhood Immunization Status: HiB	94.6	91.0	3.6
Childhood Immunization Status: IPV	93.1	89.1	4.1
Childhood Immunization Status: MMR	91.9	90.6	1.4
Childhood Immunization Status: Pneumococcal Conjugate (PCV)	87.3	80.6	6.7
Childhood Immunization Status: VZV	91.7	90.4	1.3

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL HMO AVERAGES—2012

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Childhood Immunization Status: Hepatitis A	65.4	66.0	-0.6
Childhood Immunization Status: Rotavirus	77.1	72.7	4.4
Childhood Immunization Status: Influenza	64.0	56.7	7.3
Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	80.9	67.5	13.3
Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	78.2	64.0	14.2
Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza)	38.8	29.0	9.8
Immunizations for Adolescents: Meningococcal	66.4	61.2	5.2
Immunizations for Adolescents: Tdap/Td	79.6	74.4	5.2
Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td)	64.0	59.0	5.0
Follow-Up Care for Children Prescribed ADHD Medication: Initiation	39.0	33.6	5.4
Follow-Up Care for Children Prescribed ADHD Medication: Continuation	46.0	41.4	4.7
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years)	52.6	38.2	14.5
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years)	55.7	37.5	18.2
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years)	51.8	33.1	18.7
Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits	79.0	70.7	8.3
Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits	73.8	64.9	8.9
Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit	44.2	34.6	9.6
Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months	98.0	96.9	1.1
Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years	91.8	89.6	2.2
Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years	92.4	89.7	2.7
Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years	89.9	87.2	2.7
Other Access and Utilization			
Prenatal and Postpartum Care: Timeliness of Prenatal Care	90.4	82.3	8.1
Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery	81.4	67.9	13.5
Plan All-Cause Readmissions: 18–64 Years—Lower rates signify better performance*	0.87	0.97	0.10

**This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios <1.0 indicate lower-than-expected readmission rates, whereas ratios >1.0 indicate higher-than-expected readmission rates.*

APPENDIX 8B: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2012 COMMERCIAL HMOS

CAHPS MEMBER SATISFACTION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL HMO AVERAGES—2012			
MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Consumer and Patient Engagement and Experience			
Rating of Health Plan: Rating of 8, 9 or 10	65.5	62.6	2.9
Rating of Health Plan: Rating of 9 or 10	41.6	39.4	2.2
Rating of Health Care: Rating of 8, 9 or 10	77.4	75.5	1.9
Rating of Health Care: Rating of 9 or 10	51.8	49.4	2.4
Getting Needed Care: Usually or Always	87.6	84.6	3.0
Getting Needed Care: Always	56.6	53.6	3.0
Getting Care Quickly: Usually or Always	86.3	82.8	3.4
Getting Care Quickly: Always	60.8	57.8	3.1
How Well Doctors Communicate: Usually or Always	94.5	94.2	0.3
How Well Doctors Communicate: Always	75.0	73.4	1.5
Rating of Personal Doctor: Rating of 8, 9 or 10	84.2	84.0	0.2
Rating of Personal Doctor: Rating of 9 or 10	66.3	65.0	1.4
Rating of Specialist: Rating of 8, 9 or 10	84.0	83.0	1.0
Rating of Specialist: Rating of 9 or 10	66.5	65.1	1.4
Customer Service: Usually or Always	88.3	87.6	0.7
Customer Service: Always	64.4	65.0	-0.6
Claims Processing: Usually or Always	88.8	89.2	-0.5
Claims Processing: Always	56.8	57.2	-0.5

APPENDIX 9A: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2012 COMMERCIAL PPOS

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL PPO AVERAGES—2012			
MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Overuse and Appropriateness			
Imaging Studies for Low Back Pain	74.0	76.5	-2.5
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	21.2	23.5	-2.3
Screening, Prevention and Wellness			
Adult BMI Assessment	35.1	37.1	-2.0
Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	71.1	65.5	5.6
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	37.5	34.4	3.1
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications	44.7	42.3	2.4
Flu Shots for Adults Ages 50–64	53.9	51.2	2.7
Breast Cancer Screening	66.6	64.9	1.8
Cervical Cancer Screening	73.8	70.9	2.9
Colorectal Cancer Screening	56.0	51.5	4.5
Chlamydia Screening in Women: 16–20 Years	39.1	35.5	3.6
Chlamydia Screening in Women: 21–24 Years	45.7	42.7	3.0
Chlamydia Screening in Women: Total Rate	42.6	37.6	5.0
Chronic Condition Management			
Aspirin Use and Discussion: Aspirin Use	47.8	47.7	0.1
Persistence of Beta-Blocker Treatment After a Heart Attack	79.2	82.9	-3.7
Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg)	37.7	34.5	3.2
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	58.7	53.5	5.2
Comprehensive Diabetes Care: Eye Exams	48.8	48.5	0.3
Comprehensive Diabetes Care: HbA1c Screening	87.3	85.2	2.1
Comprehensive Diabetes Care: HbA1c <7% for a Selected Population	36.7	31.5	5.2
Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%)	55.0	47.1	7.9
Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)—Lower rates signify better performance	34.6	44.3	9.7
Comprehensive Diabetes Care: LDL Cholesterol Screening	81.8	79.7	2.1
Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL)	42.2	34.3	7.9
Comprehensive Diabetes Care: Medical Attention for Nephropathy	78.6	77.8	0.9
Controlling High Blood Pressure	57.8	52.4	5.4
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening	83.7	83.0	0.7
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL)	49.9	46.8	3.1

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL PPO AVERAGES—2012

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	87.3	86.2	1.1
Use of Appropriate Medications for People With Asthma: 5–11 Years	95.6	95.7	-0.1
Use of Appropriate Medications for People With Asthma: 12–18 Years	92.1	93.0	-0.9
Use of Appropriate Medications for People With Asthma: 19–50 Years	87.4	87.4	0.0
Use of Appropriate Medications for People With Asthma: 51–64 Years	92.3	91.7	0.5
Use of Appropriate Medications for People With Asthma: Overall Rate	90.7	90.3	0.4
Medication Management for People With Asthma: 75% Compliance Rate (5–11 Years)	34.6	32.0	2.6
Medication Management for People With Asthma: 75% Compliance Rate (12–18 Years)	34.5	27.4	7.1
Medication Management for People With Asthma: 75% Compliance Rate (19–50 Years)	42.5	36.9	5.6
Medication Management for People With Asthma: 75% Compliance Rate (51–64 Years)	56.0	48.9	7.1
Medication Management for People With Asthma: 75% Compliance Rate (Overall)	43.7	38.9	4.9
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	41.5	41.2	0.3
Pharmacotherapy Management of COPD: Bronchodilators	77.5	79.9	-2.3
Pharmacotherapy Management of COPD: Systemic Corticosteroids	70.8	70.3	0.6
Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs	79.2	79.2	0.0
Annual Monitoring for Patients on Persistent Medications: Anticonvulsants	56.2	57.9	-1.7
Annual Monitoring for Patients on Persistent Medications: Digoxin	80.5	82.2	-1.7
Annual Monitoring for Patients on Persistent Medications: Diuretics	78.8	78.4	0.3
Annual Monitoring for Patients on Persistent Medications: Combined	78.6	77.0	1.6
Antidepressant Medication Management: Acute Phase	68.8	70.1	-1.3
Antidepressant Medication Management: Continuation Phase	53.3	54.5	-1.1
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	53.3	47.9	5.4
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	72.4	68.4	4.1
Alcohol and Other Drug Dependence Treatment: Initiation	41.7	31.7	10.0
Alcohol and Other Drug Dependence Treatment: Engagement	14.9	9.6	5.2
Measures Targeted Toward Children and Adolescents			
Appropriate Testing for Children With Pharyngitis	78.8	82.1	-3.3
Appropriate Treatment for Children With Upper Respiratory Infection	82.2	85.3	-3.1
Childhood Immunization Status: DTaP/DT	80.1	78.2	1.9
Childhood Immunization Status: Hepatitis B	77.4	75.9	1.6
Childhood Immunization Status: HiB	88.4	87.2	1.2
Childhood Immunization Status: IPV	86.3	85.2	1.1
Childhood Immunization Status: MMR	88.5	85.8	2.7
Childhood Immunization Status: Pneumococcal Conjugate (PCV)	79.2	75.9	3.2
Childhood Immunization Status: VZV	88.3	84.0	4.3

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL PPO AVERAGES—2012

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Childhood Immunization Status: Hepatitis A	61.0	62.2	-1.2
Childhood Immunization Status: Rotavirus	69.9	67.4	2.6
Childhood Immunization Status: Influenza	60.1	56.2	3.9
Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	68.3	64.7	3.6
Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	66.2	60.8	5.4
Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza)	29.6	28.9	0.6
Immunizations for Adolescents: Meningococcal	57.2	54.9	2.3
Immunizations for Adolescents: Tdap/Td	69.9	71.2	-1.3
Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td)	54.4	52.3	2.1
Follow-Up Care for Children Prescribed ADHD Medication: Initiation	38.2	37.0	1.2
Follow-Up Care for Children Prescribed ADHD Medication: Continuation	45.4	38.3	7.1
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years)	31.1	33.5	-2.4
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years)	35.1	41.2	-6.1
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years)	32.3	37.8	-5.6
Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits	77.1	65.0	12.1
Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits	70.0	67.7	2.4
Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit	40.3	37.7	2.6
Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months	97.1	95.9	1.2
Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years	90.3	87.0	3.2
Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years	90.7	88.2	2.5
Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years	87.7	85.4	2.4
Other Access and Utilization			
Prenatal and Postpartum Care: Timeliness of Prenatal Care	81.4	73.1	8.2
Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery	70.2	68.1	2.1
Plan All-Cause Readmissions: 18–64 Years—Lower rates signify better performance*	0.78	0.79	0.01

**This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios <1.0 indicate lower-than-expected readmission rates, whereas ratios >1.0 indicate higher-than-expected readmission rates.*

APPENDIX 9B: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2012 COMMERCIAL PPOS

CAHPS MEMBER SATISFACTION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL PPO AVERAGES—2012			
MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Consumer and Patient Engagement and Experience			
Rating of Health Plan: Rating of 8, 9 or 10	58.1	54.2	3.9
Rating of Health Plan: Rating of 9 or 10	33.4	31.3	2.2
Rating of Health Care: Rating of 8, 9 or 10	75.1	74.2	0.9
Rating of Health Care: Rating of 9 or 10	47.7	45.3	2.4
Getting Needed Care: Usually or Always	88.5	88.6	-0.1
Getting Needed Care: Always	57.8	55.3	2.4
Getting Care Quickly: Usually or Always	86.8	86.0	0.8
Getting Care Quickly: Always	60.6	58.7	1.9
How Well Doctors Communicate: Usually or Always	95.0	94.6	0.4
How Well Doctors Communicate: Always	75.3	73.3	2.0
Rating of Personal Doctor: Rating of 8, 9 or 10	83.2	83.4	-0.2
Rating of Personal Doctor: Rating of 9 or 10	63.6	63.6	0.0
Rating of Specialist: Rating of 8, 9 or 10	82.3	83.4	-1.1
Rating of Specialist: Rating of 9 or 10	63.0	64.4	-1.4
Customer Service: Usually or Always	85.9	86.8	-0.9
Customer Service: Always	59.4	61.5	-2.1
Claims Processing: Usually or Always	87.9	89.4	-1.5
Claims Processing: Always	51.5	51.1	0.4

APPENDIX 10A: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2012 MEDICAID HMOS

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICAID HMO AVERAGES—2012			
MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Overuse and Appropriateness			
Imaging Studies for Low Back Pain	75.4	76.1	-0.7
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	24.4	23.5	0.9
Screening, Prevention and Wellness			
Adult BMI Assessment	69.3	60.8	8.5
Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	75.6	75.5	0.1
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	41.5	39.9	1.6
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications	46.2	44.6	1.6
Breast Cancer Screening	52.0	51.5	0.5
Cervical Cancer Screening	65.9	60.5	5.4
Chlamydia Screening in Women: 16–20 Years	53.3	54.1	-0.8
Chlamydia Screening in Women: 21–24 Years	63.6	63.4	0.2
Chlamydia Screening in Women: Total Rate	56.9	57.5	-0.5
Chronic Condition Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	82.7	79.4	3.3
Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg)	40.1	30.5	9.6
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	61.8	50.7	11.1
Comprehensive Diabetes Care: Eye Exams	54.0	51.3	2.7
Comprehensive Diabetes Care: HbA1c Screening	83.6	81.5	2.1
Comprehensive Diabetes Care: HbA1c <7% for a Selected Population	36.0	25.8	10.2
Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%)	48.5	41.3	7.2
Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)—Lower rates signify better performance	42.3	51.1	8.7
Comprehensive Diabetes Care: LDL Cholesterol Screening	75.7	75.2	0.5
Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL)	34.9	31.2	3.7
Comprehensive Diabetes Care: Medical Attention for Nephropathy	78.2	79.1	-0.9
Controlling High Blood Pressure	57.1	53.5	3.6
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening	81.3	82.1	-0.8
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL)	42.7	36.3	6.4
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	69.8	70.6	-0.9
Use of Appropriate Medications for People With Asthma: 5–11 Years	89.7	89.4	0.4
Use of Appropriate Medications for People With Asthma: 12–18 Years	85.8	84.9	1.0

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICAID HMO AVERAGES—2012

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Use of Appropriate Medications for People With Asthma: 19–50 Years	73.9	74.0	-0.1
Use of Appropriate Medications for People With Asthma: 51–64 Years	70.6	74.5	-3.9
Use of Appropriate Medications for People With Asthma: Overall Rate	83.9	83.8	0.0
Medication Management for People With Asthma: 75% Compliance Rate (5–11 Years)	25.7	24.1	1.6
Medication Management for People With Asthma: 75% Compliance Rate (12–18 Years)	25.4	24.1	1.3
Medication Management for People With Asthma: 75% Compliance Rate (19–50 Years)	33.9	35.9	-2.0
Medication Management for People With Asthma: 75% Compliance Rate (51–64 Years)	50.1	50.7	-0.6
Medication Management for People With Asthma: 75% Compliance Rate (Overall)	28.8	29.1	-0.3
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	30.8	34.0	-3.3
Pharmacotherapy Management of COPD: Bronchodilators	81.1	83.0	-1.9
Pharmacotherapy Management of COPD: Systemic Corticosteroids	65.6	64.5	1.1
Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs	86.1	87.0	-0.8
Annual Monitoring for Patients on Persistent Medications: Anticonvulsants	65.7	66.1	-0.5
Annual Monitoring for Patients on Persistent Medications: Digoxin	90.2	89.9	0.4
Annual Monitoring for Patients on Persistent Medications: Diuretics	85.8	86.6	-0.8
Annual Monitoring for Patients on Persistent Medications: Combined	84.1	85.5	-1.4
Antidepressant Medication Management: Acute Phase	52.5	53.7	-1.2
Antidepressant Medication Management: Continuation Phase	36.5	37.2	-0.7
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	45.9	36.9	9.0
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	65.4	57.8	7.6
Alcohol and Other Drug Dependence Treatment: Initiation	39.4	39.3	0.0
Alcohol and Other Drug Dependence Treatment: Engagement	11.5	9.3	2.2
Measures Targeted Toward Children and Adolescents			
Appropriate Testing for Children With Pharyngitis	68.3	67.2	1.1
Appropriate Treatment for Children With Upper Respiratory Infection	85.4	84.0	1.4
Childhood Immunization Status: DTaP/DT	81.3	79.9	1.4
Childhood Immunization Status: Hepatitis B	90.3	87.3	3.0
Childhood Immunization Status: HiB	92.3	91.1	1.2
Childhood Immunization Status: IPV	92.2	90.1	2.1
Childhood Immunization Status: MMR	91.7	91.2	0.5
Childhood Immunization Status: Pneumococcal Conjugate (PCV)	80.3	79.3	1.0
Childhood Immunization Status: VZV	91.2	90.8	0.4
Childhood Immunization Status: Hepatitis A	75.7	78.2	-2.5
Childhood Immunization Status: Rotavirus	66.3	64.9	1.4
Childhood Immunization Status: Influenza	49.5	49.5	0.1

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICAID HMO AVERAGES—2012

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	76.7	72.9	3.7
Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	72.9	69.8	3.1
Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza)	31.7	30.5	1.1
Immunizations for Adolescents: Meningococcal	69.9	67.8	2.1
Immunizations for Adolescents: Tdap/Td	82.4	78.4	4.0
Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td)	67.8	65.4	2.4
Follow-Up Care for Children Prescribed ADHD Medication: Initiation	40.1	35.8	4.3
Follow-Up Care for Children Prescribed ADHD Medication: Continuation	47.1	38.2	8.8
Lead Screening in Children	69.3	61.9	7.4
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years)	54.2	44.2	10.0
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years)	56.3	51.2	5.1
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years)	45.4	40.8	4.6
Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits	64.7	60.1	4.7
Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits	72.4	70.9	1.4
Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit	50.3	47.6	2.7
Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months	96.2	95.3	0.9
Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years	88.6	87.6	1.0
Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years	90.0	89.4	0.6
Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years	88.8	87.1	1.7
Other Access and Utilization			
Frequency of Prenatal Care Visits: <21% of Expected Visits	10.5	17.7	-7.2
Frequency of Prenatal Care Visits: 21–40% of Expected Visits	5.5	7.3	-1.9
Frequency of Prenatal Care Visits: 41–60% of Expected Visits	7.4	8.5	-1.1
Frequency of Prenatal Care Visits: 61–80% of Expected Visits	13.8	13.2	0.6
Frequency of Prenatal Care Visits: ≥81% of Expected Visits	62.8	53.3	9.6
Prenatal and Postpartum Care: Timeliness of Prenatal Care	84.3	79.6	4.7
Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery	64.8	58.7	6.1

APPENDIX 10B: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2012 MEDICAID HMOS

CAHPS MEMBER SATISFACTION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICAID HMO AVERAGES—2012			
MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Consumer and Patient Engagement and Experience			
Rating of Health Plan: Rating of 8, 9 or 10	74.3	70.8	3.5
Rating of Health Plan: Rating of 9 or 10	57.0	53.7	3.4
Rating of Health Care: Rating of 8, 9 or 10	71.1	70.1	1.0
Rating of Health Care: Rating of 9 or 10	50.9	50.9	0.0
Getting Needed Care: Usually or Always	81.2	78.5	2.8
Getting Needed Care: Always	55.0	55.5	-0.5
Getting Care Quickly: Usually or Always	81.5	79.8	1.7
Getting Care Quickly: Always	59.0	59.1	-0.1
How Well Doctors Communicate: Usually or Always	89.3	89.3	-0.1
How Well Doctors Communicate: Always	71.1	73.0	-1.8
Rating of Personal Doctor: Rating of 8, 9 or 10	78.4	78.3	0.1
Rating of Personal Doctor: Rating of 9 or 10	63.2	63.0	0.2
Rating of Specialist: Rating of 8, 9 or 10	79.4	79.3	0.1
Rating of Specialist: Rating of 9 or 10	64.6	63.6	1.0
Customer Service: Usually or Always	86.6	84.8	1.8
Customer Service: Always	66.9	66.0	0.9

APPENDIX 11A: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2012 MEDICARE HMOS

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICARE HMO AVERAGES—2012

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Screening, Prevention and Wellness			
Adult BMI Assessment	81.3	78.3	3.0
Breast Cancer Screening	70.7	66.2	4.5
Colorectal Cancer Screening	63.0	57.9	5.1
Chronic Condition Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	88.7	91.7	-3.0
Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg)	48.9	46.3	2.6
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	63.8	61.0	2.9
Comprehensive Diabetes Care: Eye Exams	66.9	66.4	0.5
Comprehensive Diabetes Care: HbA1c Screening	91.7	90.2	1.6
Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%)	65.4	59.3	6.2
Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)—Lower rates signify better performance	25.8	32.6	6.8
Comprehensive Diabetes Care: LDL Cholesterol Screening	88.5	86.0	2.5
Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL)	52.6	46.6	6.0
Comprehensive Diabetes Care: Medical Attention for Nephropathy	90.5	87.7	2.8
Controlling High Blood Pressure	63.9	62.3	1.6
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening	89.7	87.4	2.3
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL)	57.8	50.7	7.1
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	75.7	74.1	1.7
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	37.0	35.5	1.5
Pharmacotherapy Management of COPD: Bronchodilators	79.8	83.5	-3.7
Pharmacotherapy Management of COPD: Systemic Corticosteroids	69.1	69.0	0.2
Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs	92.1	91.8	0.3
Annual Monitoring for Patients on Persistent Medications: Anticonvulsants	66.0	69.6	-3.6
Annual Monitoring for Patients on Persistent Medications: Digoxin	94.3	95.4	-1.1
Annual Monitoring for Patients on Persistent Medications: Diuretics	92.2	91.9	0.3
Annual Monitoring for Patients on Persistent Medications: Combined	91.5	90.6	0.9
Antidepressant Medication Management: Acute Phase	70.1	65.6	4.5
Antidepressant Medication Management: Continuation Phase	57.7	52.5	5.2
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	38.9	33.8	5.1

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICARE HMO AVERAGES—2012

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	57.3	52.3	5.0
Alcohol and Other Drug Dependence Treatment: Initiation	38.8	38.5	0.4
Alcohol and Other Drug Dependence Treatment: Engagement	3.1	3.3	-0.2
Measures Targeted Toward Older Adults			
Fall Risk Management: Discussion	32.9	38.1	-5.2
Fall Risk Management: Management	61.4	65.6	-4.3
Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS—Lower rates signify better performance	10.8	12.5	1.7
Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents—Lower rates signify better performance	24.0	26.6	2.6
Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents—Lower rates signify better performance	15.0	17.8	2.7
Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate—Lower rates signify better performance	19.6	22.1	2.6
Management of Urinary Incontinence: Discussion	57.4	59.7	-2.3
Physical Activity in Older Adults: Discussion	55.0	52.1	2.9
Physical Activity in Older Adults: Advice	50.3	49.0	1.4
Osteoporosis Testing in Older Women	73.0	67.7	5.3
Osteoporosis Management in Women Who Had a Fracture	24.7	27.1	-2.4
Glaucoma Screening in Older Adults	68.4	67.2	1.2
Other Access and Utilization			
Plan All-Cause Readmissions: 18–64 Years—Lower rates signify better performance*	0.83	0.92	0.09
Plan All-Cause Readmissions: 65 Years and Older—Lower rates signify better performance*	0.85	0.91	0.07

**This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios <1.0 indicate lower-than-expected readmission rates, whereas ratios >1.0 indicate higher-than-expected readmission rates.*

APPENDIX 11B: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2012 MEDICARE HMOS

CAHPS MEMBER SATISFACTION MEASURES

PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICARE HMO AVERAGES—2012

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Consumer and Patient Engagement and Experience			

APPENDIX 12A: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2012 MEDICARE PPOS

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICARE PPO AVERAGES—2012

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Screening, Prevention and Wellness			
Adult BMI Assessment	75.2	76.6	-1.5
Breast Cancer Screening	67.6	66.6	1.0
Colorectal Cancer Screening	58.5	57.4	1.1
Chronic Condition Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	88.8	86.9	1.9
Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg)	47.3	47.3	0.1
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	61.4	59.6	1.8
Comprehensive Diabetes Care: Eye Exams	65.2	59.8	5.4
Comprehensive Diabetes Care: HbA1c Screening	91.0	90.9	0.1
Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%)	62.5	65.4	-2.9
Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)—Lower rates signify better performance	29.6	26.2	-3.4
Comprehensive Diabetes Care: LDL Cholesterol Screening	86.7	86.1	0.6
Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL)	49.6	49.6	0.0
Comprehensive Diabetes Care: Medical Attention for Nephropathy	88.4	87.6	0.8
Controlling High Blood Pressure	59.7	50.1	9.5
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening	87.6	87.3	0.3
Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL)	53.5	51.0	2.5
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	79.3	75.2	4.1
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	35.0	34.5	0.5
Pharmacotherapy Management of COPD: Bronchodilators	77.2	73.7	3.5
Pharmacotherapy Management of COPD: Systemic Corticosteroids	70.2	66.8	3.4
Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs	91.7	91.1	0.6
Annual Monitoring for Patients on Persistent Medications: Anticonvulsants	66.9	62.0	4.9
Annual Monitoring for Patients on Persistent Medications: Digoxin	93.4	92.2	1.1
Annual Monitoring for Patients on Persistent Medications: Diuretics	92.0	90.9	1.1
Annual Monitoring for Patients on Persistent Medications: Combined	91.4	90.6	0.8
Antidepressant Medication Management: Acute Phase	73.3	68.1	5.2
Antidepressant Medication Management: Continuation Phase	61.6	56.5	5.1
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	38.1	35.1	3.1

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICARE PPO AVERAGES—2012

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	60.9	58.8	2.1
Alcohol and Other Drug Dependence Treatment: Initiation	43.9	38.8	5.2
Alcohol and Other Drug Dependence Treatment: Engagement	3.2	1.7	1.5
Measures Targeted Toward Older Adults			
Fall Risk Management: Discussion	31.3	32.2	-0.9
Fall Risk Management: Management	56.6	58.2	-1.6
Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS—Lower rates signify better performance	10.0	15.7	5.7
Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents—Lower rates signify better performance	23.8	28.0	4.2
Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents—Lower rates signify better performance	15.3	16.5	1.2
Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate—Lower rates signify better performance	19.5	22.9	3.4
Management of Urinary Incontinence: Discussion	56.4	54.4	2.0
Physical Activity in Older Adults: Discussion	56.2	50.2	6.0
Physical Activity in Older Adults: Advice	49.1	47.6	1.5
Osteoporosis Testing in Older Women	76.2	69.2	7.0
Osteoporosis Management in Women Who Had a Fracture	18.5	23.5	-5.0
Glaucoma Screening in Older Adults	69.1	66.2	2.9
Other Access and Utilization			
Plan All-Cause Readmissions: 18–64 Years—Lower rates signify better performance*	0.88	0.91	0.03
Plan All-Cause Readmissions: 65 Years and Older—Lower rates signify better performance*	0.85	0.92	0.07

**This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios <1.0 indicate lower-than-expected readmission rates, whereas ratios >1.0 indicate higher-than-expected readmission rates.*

APPENDIX 12B: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2012 MEDICARE PPOS

CAHPS MEMBER SATISFACTION MEASURES

PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICARE PPO AVERAGES—2012

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Consumer and Patient Engagement and Experience			

APPENDIX 13A: HMOS VS. PPOS, COMMERCIAL PLANS

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES HMOS VS. PPOS: COMMERCIAL AVERAGES—2012			
MEASURE	HMO	PPO	DIFFERENCE
Overuse and Appropriateness			
Imaging Studies for Low Back Pain	75.3	74.2	1.1
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	24.6	21.4	3.2
Screening, Prevention and Wellness			
Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	77.8	70.8	7.0
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	47.9	37.3	10.5
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications	52.9	44.6	8.3
Flu Shots for Adults Ages 50–64	55.3	53.7	1.6
Breast Cancer Screening	70.3	66.5	3.8
Cervical Cancer Screening	75.5	73.6	1.9
Chlamydia Screening in Women: 16–20 Years	41.1	38.9	2.2
Chlamydia Screening in Women: 21–24 Years	49.2	45.5	3.6
Chlamydia Screening in Women: Total Rate	45.1	42.3	2.8
Chronic Condition Management			
Aspirin Use and Discussion: Aspirin Use	47.3	47.8	-0.5
Persistence of Beta-Blocker Treatment After a Heart Attack	83.9	79.5	4.4
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	87.9	87.2	0.7
Use of Appropriate Medications for People With Asthma: 5–11 Years	95.5	95.7	-0.1
Use of Appropriate Medications for People With Asthma: 12–18 Years	92.2	92.2	0.1
Use of Appropriate Medications for People With Asthma: 19–50 Years	88.2	87.4	0.8
Use of Appropriate Medications for People With Asthma: 51–64 Years	92.4	92.2	0.2
Use of Appropriate Medications for People With Asthma: Overall Rate	91.2	90.7	0.5
Medication Management for People With Asthma: 75% Compliance Rate (5–11 Years)	32.4	34.5	-2.1
Medication Management for People With Asthma: 75% Compliance Rate (12–18 Years)	32.0	34.1	-2.1
Medication Management for People With Asthma: 75% Compliance Rate (19–50 Years)	39.7	42.1	-2.5
Medication Management for People With Asthma: 75% Compliance Rate (51–64 Years)	52.6	55.6	-3.1
Medication Management for People With Asthma: 75% Compliance Rate (Overall)	41.8	43.5	-1.7
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	43.5	41.5	2.0
Pharmacotherapy Management of COPD: Bronchodilators	80.8	77.7	3.1
Pharmacotherapy Management of COPD: Systemic Corticosteroids	73.5	70.8	2.7
Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs	82.9	79.2	3.7
Annual Monitoring for Patients on Persistent Medications: Anticonvulsants	58.8	56.3	2.5
Annual Monitoring for Patients on Persistent Medications: Digoxin	86.5	80.6	5.9

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
HMOS VS. PPOS: COMMERCIAL AVERAGES—2012

MEASURE	HMO	PPO	DIFFERENCE
Annual Monitoring for Patients on Persistent Medications: Diuretics	82.5	78.7	3.7
Annual Monitoring for Patients on Persistent Medications: Combined	82.3	78.5	3.8
Antidepressant Medication Management: Acute Phase	69.1	68.9	0.2
Antidepressant Medication Management: Continuation Phase	53.6	53.4	0.2
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	57.9	53.0	4.9
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	76.0	72.2	3.8
Alcohol and Other Drug Dependence Treatment: Initiation	39.1	41.2	-2.0
Alcohol and Other Drug Dependence Treatment: Engagement	13.6	14.6	-1.0
Measures Targeted Toward Children and Adolescents			
Appropriate Testing for Children With Pharyngitis	80.2	78.9	1.3
Appropriate Treatment for Children With Upper Respiratory Infection	84.0	82.3	1.7
Follow-Up Care for Children Prescribed ADHD Medication: Initiation	38.6	38.1	0.5
Follow-Up Care for Children Prescribed ADHD Medication: Continuation	45.7	44.9	0.8
Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits	78.2	76.4	1.8
Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits	72.9	69.9	3.1
Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit	43.3	40.1	3.1
Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months	97.9	97.0	0.9
Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years	91.6	90.1	1.6
Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years	92.2	90.5	1.7
Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years	89.7	87.6	2.1
Other Access and Utilization			
Plan All-Cause Readmissions: 18–64 Years—Lower rates signify better performance*	0.88	0.78	-0.10

**This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios <1.0 indicate lower-than-expected readmission rates, whereas ratios >1.0 indicate higher-than-expected readmission rates.*

APPENDIX 13B: HMOS VS. PPOS, COMMERCIAL PLANS

CAHPS MEMBER SATISFACTION MEASURES HMOS VS. PPOS: COMMERCIAL AVERAGES—2012			
MEASURE	HMO	PPO	DIFFERENCE
Consumer and Patient Engagement and Experience			
Rating of Health Plan: Rating of 8, 9 or 10	65.3	57.9	7.4
Rating of Health Plan: Rating of 9 or 10	41.4	33.3	8.1
Rating of Health Care: Rating of 8, 9 or 10	77.3	75.1	2.2
Rating of Health Care: Rating of 9 or 10	51.5	47.6	4.0
Getting Needed Care: Usually or Always	87.3	88.5	-1.2
Getting Needed Care: Always	56.4	57.6	-1.3
Getting Care Quickly: Usually or Always	86.0	86.7	-0.7
Getting Care Quickly: Always	60.5	60.5	0.1
How Well Doctors Communicate: Usually or Always	94.4	95.0	-0.6
How Well Doctors Communicate: Always	74.8	75.2	-0.3
Rating of Personal Doctor: Rating of 8, 9 or 10	84.2	83.2	0.9
Rating of Personal Doctor: Rating of 9 or 10	66.2	63.6	2.6
Rating of Specialist: Rating of 8, 9 or 10	83.9	82.4	1.5
Rating of Specialist: Rating of 9 or 10	66.4	63.1	3.3
Customer Service: Usually or Always	88.2	86.0	2.3
Customer Service: Always	64.4	59.6	4.9
Claims Processing: Usually or Always	88.8	88.0	0.8
Claims Processing: Always	56.8	51.5	5.3

APPENDIX 14A: HMOS VS. PPOS, MEDICARE PLANS

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES HMOS VS. PPOS: MEDICARE AVERAGES—2012			
MEASURE	HMO	PPO	DIFFERENCE
Screening, Prevention and Wellness			
Breast Cancer Screening	69.9	67.5	2.4
Chronic Condition Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	88.9	88.5	0.4
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	75.5	78.8	-3.3
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	36.8	35.0	1.8
Pharmacotherapy Management of COPD: Bronchodilators	80.4	76.8	3.6
Pharmacotherapy Management of COPD: Systemic Corticosteroids	69.1	69.8	-0.7
Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs	92.0	91.6	0.4
Annual Monitoring for Patients on Persistent Medications: Anticonvulsants	66.7	66.3	0.4
Annual Monitoring for Patients on Persistent Medications: Digoxin	94.5	93.2	1.3
Annual Monitoring for Patients on Persistent Medications: Diuretics	92.2	91.9	0.3
Annual Monitoring for Patients on Persistent Medications: Combined	91.4	91.3	0.0
Antidepressant Medication Management: Acute Phase	69.4	72.6	-3.2
Antidepressant Medication Management: Continuation Phase	56.9	61.0	-4.1
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	38.1	37.7	0.4
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	56.4	60.6	-4.2
Alcohol and Other Drug Dependence Treatment: Initiation	38.8	43.3	-4.5
Alcohol and Other Drug Dependence Treatment: Engagement	3.1	3.0	0.1
Measures Targeted Toward Older Adults			
Fall Risk Management: Discussion	33.8	31.4	2.4
Fall Risk Management: Management	62.0	56.8	5.3
Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS—Lower rates signify better performance	11.0	10.8	-0.3
Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents—Lower rates signify better performance	24.4	24.3	-0.1
Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents—Lower rates signify better performance	15.5	15.5	0.0
Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate—Lower rates signify better performance	20.0	19.9	-0.1
Management of Urinary Incontinence: Discussion	57.7	56.2	1.5
Physical Activity in Older Adults: Discussion	54.5	55.5	-1.0
Physical Activity in Older Adults: Advice	50.1	48.9	1.2
Osteoporosis Testing in Older Women	72.1	75.4	-3.3

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

HMOS VS. PPOS: MEDICARE AVERAGES—2012

MEASURE	HMO	PPO	DIFFERENCE
Osteoporosis Management in Women Who Had a Fracture	25.0	19.1	6.0
Glaucoma Screening in Older Adults	68.2	68.8	-0.6
Other Access and Utilization			
Plan All-Cause Readmissions: 18–64 Years—Lower rates signify better performance*	0.84	0.88	0.04
Plan All-Cause Readmissions: 65 Years and Older—Lower rates signify better performance*	0.86	0.86	0.00

**This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios <1.0 indicate lower-than-expected readmission rates, whereas ratios >1.0 indicate higher-than-expected readmission rates.*

APPENDIX 14B: HMOS VS. PPOS, MEDICARE PLANS

CAHPS MEMBER SATISFACTION MEASURES HMOS VS. PPOS: MEDICARE AVERAGES—2012			
MEASURE	HMO	PPO	DIFFERENCE
Consumer and Patient Engagement and Experience			

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