Diamond Designation™ Program

PROGRAM YEAR 2025

METHODOLOGY WHITE PAPER

Introduction

OVERVIEW

The Diamond Designation Program (the "Program") evaluates specialist groups in two key areas: quality of care provided ("Quality") and efficiency of care provided ("Efficiency"). Quality is emphasized over Efficiency in the Program. The primary purpose of the Diamond Designation Program is to make information available to primary care practitioners who refer our members to specialty care providers.

Quality and Efficiency results are generated approximately every year from the Program using the most updated and contemporary data available. These updates are known as "Program Years". Results are based on the evaluation of services rendered within a three-year period (the "Evaluation Period"). For Program Year 2025, the Evaluation Period is Jan. 2021 through Dec. 2023. A listing of Diamond Designated providers in the Buckeye Health Plan Medicaid network of providers will also be available to Medicaid and 'MyCare Ohio' (Medicare-Medicaid Plan) members in Ohio.

For Program Year 2025, evaluations focus exclusively on 14 specialty types, listed in Table 1 below. Specialty type is determined by the category of the individual providers' primary taxonomy as listed in the National Plan and Provider Enumeration System (NPPES) National Provider Registry. See Appendix 1 for the full list of evaluated taxonomy codes. Individual providers in these 14 specialty types ("Specialists") are attributed to practice groups ("Specialist Groups"). A Specialist Group is defined as a group of Specialists with common specialty taxonomies within a tax identification number ("TIN"). Quality and Efficiency results are generated at a Specialist Group level.

Table 1: Program Year 2025 Specialty Types

SPECIALTY TYPES			
✓ Cardiology*	✓ General Surgery	✓ Ophthalmology	✓ Psychology
✓ Counseling	✓ Nephrology*	✓ Orthopedic Surgery	✓ Pulmonology
✓ Endocrinology*	✓ Neurology*	✓ Podiatry	
✓ Gastroenterology*	✓ Obstetrics/Gynecology	✓ Psychiatry	

**Evaluation of providers excludes care of pediatric members (<18 years of age).*

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The Program evaluates both Medicare and Medicaid providers in certain geographies that participate in our networks. Availability of the Program in a particular geographic area is dependent upon several factors, including: the size of the specialty care network; the adequacy of claims volume; the distinguishability of specialty care performance within given areas; and the extent of interest by primary care providers to use information from the Program. *(See Appendix 2 for Program availability details across different states.)*

DATA AND LIMITATIONS

Evaluations for both Quality and Efficiency largely rely on health plan claims data. Members and their associated claims are excluded from evaluations when there is either: 1.) a lack of adequate health plan enrollment during necessary timeframes; 2.) a different health plan or payer that is known to be the primary payer; or 3.) a partial or limited benefit coverage only (e.g., only behavioral health coverage).

The Diamond Designation Program has certain limitations, including the following:

- Quality and Efficiency evaluations are primarily based on member claims, and do not include information on outcomes for members of other health plans. In many cases, a Specialist Group's total patient panel has health coverage across many different health plans and payers.
- Program quality measures do not measure the quality of all possible types of care provided within each specialty. Specialist Groups who provide enough services for the Program's specific quality measures can be evaluated for Quality using quality measures.
- Some encounters and/or claims are billed independently or are paid by members directly, other health plans, the Veterans Administration, or other third parties. The Program does exclude members and their associated claims from evaluation when there is a different known primary payer.
- Some claims are aggregated when submitted for adjudication. Sometimes the cost attributed to each service within these claims may be distributed proportionally based on the claim's total cost.
- It is not feasible to evaluate some geographic areas due to an inadequate volume of claims and/or an insufficient number of different Specialist Groups within a given specialty type. Similarly, some Specialist Groups are unable to be assessed due to limited member and/or claim volume.

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Quality Methodology

There are two ways Specialist Groups can achieve Diamond Designation for Quality based on if either of the following criteria are met.

1. The Specialist Group scores within the top 60% of all same-specialty Specialist Groups evaluated by the Program in the Quality Measurement methodology described later in this document OR
2. At least 50% of the Specialist Group's specialty practitioners have achieved recognition through one or more of the following NCQA Recognition Programs:
   - ✓ Diabetes Recognition Program
   - ✓ Heart and Stroke Recognition Program
   - ✓ Patient Centered Specialty Practice Program

Practitioners get credit for any of the three recognition programs if the start date of that recognition is within the Program's Evaluation Period.

The display categories for Quality are shown in Table 2. Specialist Groups who are not evaluated on Quality are described as "not evaluated" in associated display results. We collaborate in value-based care arrangements with some providers to improve healthcare outcomes for our members. Such providers agree to be evaluated based on these arrangements. Specialist Groups having affiliations with such providers can be considered for Diamond Designation. The Specialist Groups must practice in one of the included specialty types evaluated under the Program and have attributed respective members in their patient panel.

Table 2: Quality Display Categories

QUALITY DESIGNATION DISPLAY	DESCRIPTION
	Diamond Designation *Meets Criteria*
	Does Not Meet Criteria
Not Evaluated	Not evaluated on Quality for one or more reasons, including sample size limitations

QUALITY MEASUREMENT OVERVIEW

Quality measures were primarily derived from those endorsed by national organizations such as:

- Agency for Healthcare Research and Quality (AHRQ)
- The National Committee for Quality Assurance (NCQA)
- The Centers for Medicare and Medicaid Services (CMS)

Quality measurements are attributed to Specialist Groups using measure-specific attribution logic appropriate for the type of measure. Each Specialist Group is evaluated by calculating a Quality Index ("QI") score, which compares actual non-compliance to risk-adjusted expected non-compliance.

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QUALITY MEASUREMENT REQUIREMENTS

- ✓ Each measure has its own enrollment requirements for member evaluation. When members do not meet the enrollment requirements, the measurement is excluded.
- ✓ Members must have either a Chronic Disease and Illness Payment System (CDPS) score or a CMS-Hierarchical Condition Category (HCC) score available to use, relative to the defined measure timeframe for the measurement to be included.

PROVIDER ATTRIBUTION

Measurements can be attributed to Specialist Groups using either event-based or longitudinal attribution.

Event Attribution — A Specialist Group is attributed to a measurement based on a service they provided that triggers an anchor event. Anchor events initiate a measure's measurement period. Examples of anchor events include procedure dates, diagnosis dates, and medication fill dates.

There are two types of event-based provider attribution:

- **Diagnosing Provider:** Attributed when a diagnosis is made by the provider triggering a measurement anchor event.
- **Servicing Provider:** Attributed when a procedure is performed by the provider triggering a measurement anchor event.

Longitudinal Attribution — Longitudinal attribution is used for certain quality measures with calendar year measurement periods. Longitudinal attribution assigns a member to a Specialist Group within a calendar year when both of the following are true:

- The member has at least the minimum number of separate encounters with the Specialist Group where the Specialist Group provided certain outpatient services within the measurement period. These "Qualified" encounters are identified by claims with services billed with select procedure codes (see Figure 1). The threshold number of Qualified encounters varies by specialty type as listed in Table 3.
- The member has more Qualified encounters with the Specialist Group than the member did with any other Specialist Group of the same specialty during the measurement period.

Figure 1: Codes Used to Identify Qualified Encounters for Longitudinal Attribution

CPT® Evaluation and Management Code Set LESS 13 codes that do not often require engagement with the patient* PLUS The following codes for specific specialties:		
Nephrology	End-Stage Renal Disease Services	CPT® 90951-90970
Ophthalmology	General Ophthalmology Services and Procedures	CPT® 92002-92287
Behavioral Health	Health Behavior Assessment and Intervention Procedures	HPCS H0001-H2037
	Adaptive Behavior Services Psychiatry Services and Procedures	CPT® 90791-90880, 96156-97158

*See Appendix 3 for listing of excluded E&M codes.

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Table 3: Longitudinal Attribution Qualified Encounter Thresholds by Specialty

MINIMUM OF 3	MINIMUM OF 2		MINIMUM OF 1
✓ Counseling	✓ Cardiology	✓ Nephrology	✓ Ophthalmology
✓ Psychiatry	✓ Endocrinology	✓ Obstetrics & Gynecology	
✓ Psychology	✓ Gastroenterology	✓ Podiatry	
	✓ Neurology	✓ Pulmonology	

Note: General Surgery and Orthopedic Surgery Specialty Groups do not get attributed to quality measures using the longitudinal method.

MEASURES

Quality evaluation leverages distinct measures (Table 4) attributable to providers within the specialty types included for Program Year 2025. A given measure can be used across more than one specialty type. For more details on these measures reference Appendix 5.

All measure specifications including numerators, denominators, exclusions, diagnostic and procedure codes, data sources, and other details are available upon request by emailing **ContactUs@DiamondDesignation.com**.

Table 4: List of Quality Measures

MEASURE NAME	MEASURE SOURCE	APPLICABLE SPECIALTY	APPENDIX 4 LINK
14-Day C-Section Complications	CAB	Obstetrics & Gynecology	**Link to detail**
14-Day Total Hysterectomy Complications	CAB	Obstetrics & Gynecology	**Link to detail**
7-Day Hospital Visit Rate After Appendectomy	CAB	General Surgery	**Link to detail**
7-Day Hospital Visit Rate After Endoscopic Retrograde Cholangiopancreatography (ERCP)	CAB	Gastroenterology	**Link to detail**
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	CMS (NCQA)	Psychiatry	**Link to detail**
Adult Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery	American Academy of Ophthalmology	Ophthalmology	**Link to detail**
All-Cause Unplanned Readmission Following Hospitalization in an Inpatient Psychiatric Facility (31 to 90-Day Post Discharge)	CMS	Psychiatry, Psychology, Counseling	**Link to detail**
Antidepressant Medication Management (AMM)	NCQA	Psychiatry	**Link to detail**

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MEASURE NAME	MEASURE SOURCE	APPLICABLE SPECIALTY	APPENDIX 4 LINK
Asthma in Younger Adults Admission Rate	AHRQ	Pulmonology	**Link to detail**
Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	American College of Cardiology	Cardiology	**Link to detail**
Bloodstream Infection in Hemodialysis Members	CDC	Nephrology	**Link to detail**
Bunionectomy Redos	CAB	Podiatry	**Link to detail**
Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	Heart Rhythm Society	Cardiology	**Link to detail**
Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	American Academy of Ophthalmology	Ophthalmology	**Link to detail**
Cervical Spine Procedure Complication: Unplanned Return to Operating Room	The Joint Commission	Orthopedic Surgery	**Link to detail**
Chlamydia Screening in Women (CHL)	NCQA	Obstetrics & Gynecology	**Link to detail**
Chronic Kidney Disease (CKD) Related ED Visits in Members with CKD	CAB	Nephrology	**Link to detail**
Continuity of Pharmacotherapy for Opioid Use Disorder	University of Southern California (Battelle)	Psychiatry	**Link to detail**
Diabetes Long-Term Complications Admission Rate	AHRQ	Endocrinology	**Link to detail**
Diabetes Short-Term Complications ED Visit Rate	AHRQ	Endocrinology	**Link to detail**
Diabetic Members Having a Diabetic Foot-Related Inpatient Admission or ED Visit	CAB	Podiatry	**Link to detail**
Discharge on Statin Medication Post Ischemic Stroke	The Joint Commission	Neurology	**Link to detail**
Epileptic Members Having an Epilepsy-Related Inpatient Admission	CAB	Neurology	**Link to detail**
Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	CMS	Gastroenterology	**Link to detail**
Functional Status Assessment for Total Hip Replacement	CMS	Orthopedic Surgery	**Link to detail**
Functional Status Assessment for Total Knee Replacement	CMS	Orthopedic Surgery	**Link to detail**
Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Members with Cirrhosis	American Gastroenterological Association	Gastroenterology	**Link to detail**

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MEASURE NAME	MEASURE SOURCE	APPLICABLE SPECIALTY	APPENDIX 4 LINK
Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization	CMS	Cardiology	**Link to detail**
Hospital 30-Day Risk-Standardized Readmission Rates following Percutaneous Coronary Intervention (PCI)	American College of Cardiology	Cardiology	**Link to detail**
Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	CMS	Pulmonology	**Link to detail**
Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization	CMS	Cardiology	**Link to detail**
Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate Following Pneumonia Hospitalization	CMS	Pulmonology	**Link to detail**
Hospital Visits After Hospital Outpatient Surgery	CMS	General Surgery	**Link to detail**
Hospital Visits After Ophthalmology Outpatient Surgery	CMS	Ophthalmology	**Link to detail**
Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures	CMS	Orthopedic Surgery	**Link to detail**
Hospital Visits After Podiatry Outpatient Surgery	CAB	Podiatry	**Link to detail**
Inflammatory Bowel Disease: Postoperative Monitoring for Recurrence of Crohn's Disease at 6 to 12 Months After Surgical Resection in Patients with Crohn's Disease	American Gastroenterological Association	Gastroenterology	**Link to detail**
Initiation and Engagement of Substance Use Disorder Treatment (IET) — Engagement	NCQA	Psychiatry	**Link to detail**
Initiation and Engagement of Substance Use Disorder Treatment (IET) — Initiation	NCQA	Psychiatry	**Link to detail**
Initiation of Medication Therapy for Patient with New Bipolar Diagnosis	CAB	Psychiatry	**Link to detail**
Knee Arthroscopy Complications	CAB	Orthopedic Surgery	**Link to detail**

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MEASURE NAME	MEASURE SOURCE	APPLICABLE SPECIALTY	APPENDIX 4 LINK
Laparoscopic Cholecystectomy Complications	CAB	General Surgery	**Link to detail**
Lumbar Spine Fusion Complications	CAB	Orthopedic Surgery	**Link to detail**
Management of Mild-to-Moderate Ulcerative Colitis	American Gastroenterological Association	Gastroenterology	**Link to detail**
Members Ages 18 to 65 Previously Diagnosed with Asthma Having an Asthma-Related ED Visit	CAB	Pulmonology	**Link to detail**
Members Previously Diagnosed with a Mental Health Disorder Having a Mental Health or Substance Abuse-Related ED Visit	CAB	Psychiatry, Psychology, Counseling	**Link to detail**
Members Previously Diagnosed with Chronic Headaches Having Multiple Headache-Related ED Visits	CAB	Neurology	**Link to detail**
Members Previously Diagnosed with Major Depressive Disorder Having a Depression-Related Acute Hospital Admission	CAB	Psychiatry, Psychology, Counseling	**Link to detail**
Members Previously Diagnosed with Self Harm or Suicide Attempt Having a Mental Health or Substance Abuse-Related ED Visit	CAB	Psychiatry, Psychology, Counseling	**Link to detail**
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	NCQA	Psychiatry	**Link to detail**
Non-Invasive Arterial Assessment of Patients with Lower Extremity Wounds or Ulcers for Determination of Healing Potential at the Initial Visit	US Wound Registry	Podiatry	**Link to detail**
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	NCQA	Obstetrics & Gynecology	**Link to detail**
Obstetric Trauma Rate — Vaginal Delivery with Instrument	AHRQ	Obstetrics & Gynecology	**Link to detail**
Optimal End Stage Renal Disease (ESRD) Starts	The Permanente Foundation	Nephrology	**Link to detail**
Pharmacotherapy Management of COPD Exacerbation (PCE) — Bronchodilators	NCQA	Pulmonology	**Link to detail**
Pharmacotherapy Management of COPD Exacerbation (PCE) — Systemic Corticosteroids	NCQA	Pulmonology	**Link to detail**

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MEASURE NAME	MEASURE SOURCE	APPLICABLE SPECIALTY	APPENDIX 4 LINK
Potentially Avoidable Complications Following Stroke	American Academy of Neurology	Neurology	**Link to detail**
Prenatal and Postpartum Care: Postpartum Care	NCQA	Obstetrics & Gynecology	**Link to detail**
Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA	Obstetrics & Gynecology	**Link to detail**
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	American Academy of Ophthalmology	Ophthalmology	**Link to detail**
Proportion of Days Covered — Diabetes All Class	Pharmacy Quality Alliance (Battelle)	Cardiology, Endocrinology	**Link to detail**
Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA)	CMS	Orthopedic Surgery	**Link to detail**
Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Knee Arthroplasty (TKA)	CMS	Orthopedic Surgery	**Link to detail**
Standardized Hospitalization Ratio (SHR)-ESRD Members Receiving Hemodialysis	CMS	Nephrology	**Link to detail**
Statin Therapy for Members with Cardiovascular Disease (SPC)	NCQA	Cardiology, Endocrinology, Nephrology	**Link to detail**
Statin Therapy for Members with Diabetes (SPD)	NCQA	Cardiology, Endocrinology, Nephrology	**Link to detail**
Surgical Site Infection (SSI)	American College of Surgeons (CDC)	General Surgery	**Link to detail**
Use of Pharmacotherapy for Opioid Use Disorder (OUD)	CMS	Psychiatry	**Link to detail**
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	NCQA	Pulmonology	**Link to detail**

AHRQ = Agency for Healthcare Research and Quality
CAB = Clinical Advisory Boards; measures developed with our Program's internal Clinical Advisory Boards based on published literature and/or specialty specific societies
CDC = Centers for Disease Control
CMS = Centers for Medicare and Medicaid Services
COPD = Chronic Obstructive Pulmonary Disease
ED = Emergency Department
ESRD = End Stage Renal Disease
NCQA = National Committee for Quality Assurance

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MINIMUM REQUIREMENTS

To be evaluated for Quality, a Specialist Group's attributed quality measurements must be derived from at least 20 unique members.

MEASUREMENT RISK ADJUSTMENT

Certain differences in the Specialist Group's mix of attributed members potentially affect the expected measurement results. Therefore, adjustments are applied to Quality evaluation within the Program methodology.

For each measure within a specialty type, an expected rate of non-compliance is calculated as the rate of non-compliance for measurements within a distinct quality adjustment cohort. Quality adjustment cohorts represent members in the same line of business (Medicaid or Medicare), in the same member burden of disease level, and with the same social determinants of health (SDoH) status level. Dual-eligible members who are covered by the health plan under both Medicare and Medicaid are grouped into the Medicare line of business. Any quality adjustment cohorts that do not have measurements from at least 20 unique members will not be evaluated within the Program.

MEMBER BURDEN OF DISEASE LEVEL

Member burden of disease level is based on either the CDPS algorithm (Medicaid) or the CMS-HCC algorithm (Medicare) which risk adjusts for member factors such as age, sex, and both behavioral and clinical comorbidities. For each measurement, the respective member's CDPS or CMS-HCC score is binned into one of five levels (very low, low, moderate, high, and very high). Members who have a score of very high have multiple chronic conditions that typically require more intensive management. Cut points for each bin are different for Medicare versus Medicaid and are based on the observed distribution of scores within each line of business.

SOCIAL DETERMINANTS OF HEALTH STATUS

The member is assessed for social determinants of health by identifying healthcare claims with specific Z-codes as detailed in Appendix 4). If the member has one or more SDoH codes within the relevant time frame of the quality measurement, the measurement will be categorized as "SDoH," otherwise the measurement will be categorized as "No SDoH."

CALCULATION OF EXPECTED RATE OF NON-COMPLIANCE

The observed non-compliant rate across all measurements for a given measure within a given specialty type for members of the same quality adjustment cohort is determined. Those non-compliant rates are the expected rates of non-compliance.

Table 5: Example Expected Rates of Non-Compliance

SPECIALTY	MEASURE	QUALITY ADJUSTMENT COHORT	EXPECTED RATE OF NON-COMPLIANCE
Orthopedic Surgery	TKA Complication Rate	MCD VERY LOW NO SDOH	0.0610
Orthopedic Surgery	TKA Complication Rate	MCD VERY LOW SDOH	0.0718
Orthopedic Surgery	TKA Complication Rate	MCD LOW NO SDOH	0.0826
Orthopedic Surgery	TKA Complication Rate	MCD LOW SDOH	0.0910
Orthopedic Surgery	TKA Complication Rate	MCD MOD NO SDOH	0.1037

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SPECIALTY	MEASURE	QUALITY ADJUSTMENT COHORT	EXPECTED RATE OF NON-COMPLIANCE
Orthopedic Surgery	TKA Complication Rate	MCD MOD SDOH	0.1159
Orthopedic Surgery	TKA Complication Rate	MCD HIGH NO SDOH	0.1210
Orthopedic Surgery	TKA Complication Rate	MCD HIGH SDOH	0.1726
Orthopedic Surgery	TKA Complication Rate	MCD VERY HIGH NO SDOH	0.1962
Orthopedic Surgery	TKA Complication Rate	MCD VERY HIGH SDOH	0.2037
Orthopedic Surgery	TKA Complication Rate	MCR VERY LOW NO SDOH	0.0317
Orthopedic Surgery	TKA Complication Rate	MCR VERY LOW SDOH	0.0392
Orthopedic Surgery	TKA Complication Rate	MCR LOW NO SDOH	0.0478
Orthopedic Surgery	TKA Complication Rate	MCR LOW SDOH	0.0515
Orthopedic Surgery	TKA Complication Rate	MCR MOD NO SDOH	0.0563
Orthopedic Surgery	TKA Complication Rate	MCR MOD SDOH	0.0594
Orthopedic Surgery	TKA Complication Rate	MCR HIGH NO SDOH	0.0640
Orthopedic Surgery	TKA Complication Rate	MCR HIGH SDOH	0.0898
Orthopedic Surgery	TKA Complication Rate	MCR VERY HIGH NO SDOH	0.1073
Orthopedic Surgery	TKA Complication Rate	MCR VERY HIGH SDOH	0.1810

MCD = Medicaid
MCR = Medicare
VERY LOW, LOW, MOD, HIGH, VERY HIGH = Member burden of disease level
NO SDOH = member without social determinant of health
SDOH = member with social determinant of health
TKA = total knee arthroscopy

Comparison of Actual to Expected

For each Specialist Group, the Quality Index (QI) is calculated by dividing total actual non-compliant measurements by the total of the expected non-compliant measurements. A lower QI score indicates better quality results.

$$\frac{\sum \textit{actual non-compliant}}{\sum \textit{expected non-compliant}} = \textit{Quality Index (QI)}$$

Example Quality Index Calculation
Specialist Group: ABC Orthopedic Surgery Group
Specialty: Orthopedic Surgery

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Table 6: Quality Index Calculation Example for Example Specialist Group

COHORT	MEASURE	QUALITY ADJUSTMENT COHORT	TOTAL MEASUREMENTS	EXPECTED RATE OF NON-COMPLIANCE	TOTAL EXPECTED NON-COMPLIANT OUTCOMES	TOTAL ACTUAL NON-COMPLIANT OUTCOMES
1	TKA Complications	MCD VERY LOW SDOH	1	0.0718	0.0718	0
2	TKA Complications	MCD LOW NO SDOH	6	0.0826	0.4956	0
3	TKA Complications	MCD MOD NO SDOH	2	0.1037	0.2074	0
4	TKA Complications	MCD HIGH SDOH	1	0.1726	0.1726	1
5	TKA Complications	MCR LOW NO SDOH	4	0.0478	0.1912	0
6	TKA Complications	MCR MOD NO SDOH	6	0.0563	0.3378	1
7	TKA Complications	MCR HIGH SDOH	1	0.0898	0.0898	0
8	TKA Complications	MCR HIGH NO SDOH	6	0.0640	0.3840	0
					1.9502	**2**

1 = non-compliant outcome occurred

0 = non-compliant outcome did not occur

MCD = Medicaid

MCR = Medicare

LOW, MOD, HIGH = Member burden of disease level

SDOH = member with social determinant of health

NO SDOH = member without social determinant of health

TKA = total knee arthroscopy

Note: This is only a simple example using one quality measure for purposes of illustration. A minimum of 20 measurements for 20 distinct members would be required for Specialist Group inclusion in Program Quality evaluation.

In this example, ABC Orthopedic Surgery Group's Quality Index score of 1.0255 would result by dividing the sum of actual non-compliant outcomes (2) by the expected sum of non-compliant outcomes (1.9502).

$$\frac{\sum \textit{actual non-compliant}}{\sum \textit{expected non-compliant}} = \frac{2}{1.9502} = 1.0255 = \textit{Quality Index (QI)}$$

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QUALITY DESIGNATION BENCHMARKS

Each Specialist Groups' QI score is compared to all other evaluable Specialist Groups of the same specialty type. QI scores are then converted to percentiles.

Within each specialty, a chi-square goodness of fit test is utilized to identify the highest percentile the Specialist Group could achieve statistically with 90% confidence. The highest percentile the Specialist Group can statistically receive is described as the adjusted percentile. Specialist Groups with an adjusted percentile at the 40th percentile or higher receive the Diamond Designation indication as shown in Table 2. Specialist Groups who are not evaluated on Quality are described as "not evaluated" in display results.

Efficiency

OVERVIEW

Specialist Groups are measured for Efficiency using industry-standard episodes of care evaluation. Episodes of care are built using the Merative Medical Episode Grouper (MEG).

The actual cost of attributed episodes is compared to the expected cost that generates a Cost Efficiency Index ("CEI") core for each Specialist Group. Expected costs are determined after adjustments for risk and case mix.

EPISODE QUALIFICATION REQUIREMENTS

- Episodes must be flagged as a qualified episode according to MEG qualification rules. Qualified episodes have enough claim sufficiency and encounter detail to be used for evaluation.
- The allowed amount for the episode must be greater than $50 and less than $1 million.
- Cancer-related episodes and those where death is known to have occurred during the episode are excluded from evaluation.
- There must be at least 100 occurrences of an episode within a given cost efficiency adjustment cohort, which is determined by the combination of: episode group, episode severity, member burden of disease level, member line of business (Medicare or Medicaid), and geographic area (state). When a cost efficiency adjustment cohort has at least 100 episodes, the episodes in that cohort are considered comparable episodes and can be utilized in evaluation of Efficiency.
- Episodes that include more than one administrative (non-claim) encounters are excluded because the service value of the encounter cannot be reliably determined with potential to artificially deflate the cost of the associated episode.
- Members must have either a Chronic Disease and Illness Payment System (CDPS) score or a CMS-Hierarchical Condition Category (HCC) score available to use relative to the episode timeframe in order for the episode to be included in evaluation.
- Any chronic episodes, which are assessed in annualized periods, with less than 10 months of member enrollment are excluded.
- Acute episodes are excluded when the member: 1.) was not enrolled from the episode start date to the episode end date; 2.) was not enrolled during the pre-episode clean period; or 3.) was not enrolled during the post-episode clean periods. Clean periods are windows of time around episodes that help ensure that the actual beginning and/ or end dates are accurately identified, often by establishing the absence of a condition.

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PROVIDER ATTRIBUTION

A Specialist Group is identified as the managing specialist group for the episode if all three of the following apply:

- ✓ The episode is clinically appropriate to assign to the specialty type of the Specialist Group. The Diamond Designation Program internal Clinical Advisory Boards determine the appropriate mapping of episode groups to the 14 evaluated specialty types.
- ✓ The Specialist Group provided more outpatient E&M services than any other Specialist Group in any specialty evaluated. Ties are broken by greatest number of unique encounters, then by the highest total allowed amount from services provided.
- ✓ The Specialist Group's total E&M encounters must make up at least 30% of the total E&M encounters within the episode across all providers and specialty types.

However, when a major surgery exists within an episode, the Specialty Group who performed that major surgery will be attributed to the episode. The AHRQ Healthcare Cost and Utilization Project (HCUP) surgical procedure code set is utilized to identify major surgeries. Additionally, whether a major surgery exists or not, the Specialty Group must be participating in the episode before the point where 50% of the total episode cost is incurred.

While the Program does not evaluate individual Specialists independently, an individual Specialist is identified as the managing specialist for the episode if such individual:

- ✓ Is a Specialist with a primary taxonomy included in evaluation (Appendix 1);
- ✓ Is a part of the managing specialist group; and either:
  - If a major surgery **did not occur** within the episode, provided more outpatient E&M services than any other Specialist within the managing specialist group, with ties broken by greatest number of unique encounters, then by highest total allowed amount from services provided.
  - If a major surgery **occurred** within the episode, was the rendering physician for the major surgery.

Mid-level provider (nurse practitioner, physician assistant, etc.) services are included as and assumed part of the specialty care provided by the Specialist Group if there is at least one Evaluation and Management (E & M) service from a physician Specialist in the same Taxpayer Identification Number (TIN) as the mid-level during the episode. The mid-level visits are included in determining the attribution of the managing Specialist Group described above. However, mid-level providers cannot be attributed to episodes directly as a managing Specialist.

MINIMUM REQUIREMENTS

In order to be included for Efficiency evaluation, a Specialist Group must be the managing specialist group for at least 20 comparable episodes after outliers have been removed.

EPISODE RISK ADJUSTMENT

The Program methodology provides adjustments for factors that can potentially affect expected episode cost in assessing provider Efficiency.

Each episode is grouped into a cost efficiency adjustment cohort of the same geography (state), member line of business (Medicare or Medicaid), member burden of disease level, episode group, and episode severity. Dual eligible members covered by the health plan under both Medicare and Medicaid are grouped into the Medicare line of business.

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MEMBER BURDEN OF DISEASE LEVEL

Member burden of disease level is based on either the CDPS algorithm (Medicaid) or the CMS-HCC algorithm (Medicare) which risk adjusts for member factors such as age, sex, and both behavioral and clinical comorbidities. Members are grouped into one of five bins based on the member's CDPS or CMS-HCC score at the start of the episode: very low, low, moderate, high, and very high. Members who have a score of very high have multiple chronic conditions that typically require more intensive management. Cut points for each bin are different for Medicare versus Medicaid and are based on the observed distribution of scores within each line of business.

EPISODE GROUP

The MEG software groups medical and pharmacy claim lines into distinct episodes that fall into any of over 580 different condition-based episode groups.

EPISODE SEVERITY

To address differing severity of episodes the Program leverages Merative Disease Staging that assigns severity level on a scale of zero to three (0–3) based on the progression or extent of the condition.

Table 7: Episode Severity Level Descriptions

SEVERITY LEVEL	DESCRIPTION
0	No active disease
1	Conditions with no complications or problems of minimal severity
2	Problems limited to an organ system; significantly increased risk of complications
3	Multiple site involvement; generalized systemic involvement, poor prognosis

OUTLIER METHODOLOGY AND COMPARISON OF ACTUAL TO EXPECTED

As previously noted, episodes with extremely low and extremely high allowed amounts are excluded. Before calculating expected costs, other outlier episodes are removed to improve reliability of Efficiency evaluation. Cost distributions within the cost efficiency adjustment cohorts are largely non-parametric. As such, a modified robust z test is utilized to determine high-cost outliers.

The robust z test is stronger at identifying outliers than the standard z test in non-normal distributions because it relies on the median for calculating the z score. It is less influenced by outliers when compared to the standard z score. The modified z score is calculated from the median absolute deviation. These values must be multiplied by a constant to approximate the standard deviation.

A robust z score is calculated for each episode within a cost efficiency adjustment cohort. Episodes with robust z scores greater than 5.00 (equivalent to standard deviations) are considered outliers. After these additional high-cost outliers are removed, the average of the remaining episodes within each cost efficiency adjustment cohort is determined. This average is assigned as the expected cost for each cost efficiency adjustment cohort.

(continued)

Table 8: Example Cost Efficiency Adjustment Cohort Actual and Expected Cost

EPISODE ID	COST EFFICIENCY ADJUSTMENT COHORT	ACTUAL EPISODE COST	EXPECTED EPISODE COST
ABC-3678	FL-MCR-306-3-LOW	$600	$750
ABC-3679	FL-MCR-306-3-LOW	$700	$750
ABC-3680	FL-MCR-306-3-LOW	$900	$750
ABC-3681	FL-MCR-306-3-LOW	$800	$750

In the example above, the FL-MCR-306-3-LOW cohort represents the cost efficiency adjustment cohort for episodes where the member is enrolled in the Florida (FL) Medicare (MCR) line of business with an episode group of hypertension (306), episode severity level of 3 (3), and a member burden of disease level of low (LOW).

The Cost Efficiency Index is determined from the sum of all actual episode costs for the Specialist Group divided by the sum of all corresponding expected episode costs. A lower CEI score indicates better Efficiency.

Table 9: CEI Calculation Example for Example Specialist Group

EPISODE ID	EPISODE COST ADJUSTMENT	ACTUAL EPISODE COST	EXPECTED EPISODE COST
ABC-3678	FL-MCR-306-3-LOW	$600	$750
ABC-3679	FL-MCR-249-1-MOD	$1,400	$1,200
ABC-3680	FL-MCR-306-3-LOW	$900	$750
ABC-3681	FL-MCR-299-2-LOW	$1,500	$1,800

Sum of Actual Episode Cost:	$4,400	
divided by		
Sum of Expected Episode Cost:		$4,500
Cost Efficiency Index:		**0.98**

FL= Florida
MCR = Medicare
306, 249, 299 = Episode group number
3, 1, 2 = Episode severity
LOW, MOD = Member burden of disease level

Note: This is only an example. A minimum of 20 comparable episodes for a Specialist Group would be required for inclusion in Program Efficiency evaluation.

(continued)

EFFICIENCY BENCHMARKS

Each Specialist Groups' CEI score is compared to all other evaluable Specialist Groups of the same specialty type. CEI scores are then converted to percentiles. Within each specialty, a chi-square goodness of fit test is utilized to identify the highest percentile the group could achieve statistically with 90% confidence. The highest percentile the Specialist Group can statistically receive is described as the adjusted percentile.

Specialist Groups with an adjusted percentile in the following ranges achieve the corresponding Efficiency star rating. However, the Efficiency rating **is only displayed** in Program reporting to primary care providers for Specialist Groups that receive the Diamond Designation for Quality. Specialist Groups that are not evaluated on Efficiency are described as "not evaluated" in associated display results.

Table 10. Efficiency Display Categories

EFFICIENCY DISPLAY*	ADJUSTED PERCENTILE
★☆☆☆☆	0 – 9
★★☆☆☆	10 – 19
★★★☆☆	20 – 44
★★★★☆	45 – 69
★★★★★	70 – 99
Not Evaluated	Not evaluated for one or more reasons including sample size limitations

*__Note:__ Specialist Groups who do not receive the Diamond Designation for Quality will not have an Efficiency star rating displayed in reporting to primary care providers or members. The Program emphasizes Quality results over Efficiency.

(continued)

IMPORTANT NOTES ABOUT THE DIAMOND DESIGNATION PROGRAM

The Diamond Designation Program makes quality and efficiency rating information available for potential use by primary care providers. Such information can help inform referral decisions for specialty care. Also, exclusive to Buckeye Health Plan Medicaid members in Ohio, a listing of Diamond Designation providers is made available online to potentially help inform specialty care provider selection. Quality is emphasized over efficiency in the evaluation process. Primary care providers and Buckeye Health Plan Medicaid members are advised that ratings from the Program should not serve as the sole basis for specialist provider selection. We evaluate specialty provider quality and efficiency for in-network providers at a practice group level based on tax identification number. The current Program evaluates 14 specialty types: Cardiology, Counseling, Endocrinology, Gastroenterology, General Surgery, Nephrology, Neurology, Obstetrics/Gynecology, Ophthalmology, Orthopedic Surgery, Podiatry, Psychiatry, Psychology, and Pulmonology.

Physicians are solely responsible for evaluating the needs of members and directing them to the most appropriate healthcare services. The Diamond Designation Program does not, in any way, certify the quality or efficiency of care that members receive from providers who are included in Program evaluations, nor should information from the Program be considered, in any way, as an endorsement of a particular provider or such provider's delivery of care. Ratings from the Diamond Designation Program are only a partial evaluation of quality and efficiency and should not solely serve as the basis for specialist provider selection (as such ratings have a risk of error). Other factors may be important in the selection of a specialist. Neither participating specialists nor referring providers are agents of Wellcare. Providers are solely responsible for the treatment and outcomes of their patients. Physicians participating in Wellcare networks have met specific minimum credentialing requirements. Wellcare members have access to providers in the Wellcare network according to their benefit plan and are not limited to certain providers based on ratings from the Program. The Program and its results are not utilized to determine payment under Wellcare pay-for- performance programs.

The Program is based on national standards including the emphasis of quality over efficiency of care, and is developed with feedback from consumers, purchasers, physicians, and other clinicians. Specialty provider groups who are rated within the Program may, pursuant to Program policies, request a change or correction to information used to determine their quality or efficiency ratings. The absence of any quality or efficiency rating should not be construed to suggest that a provider does not provide quality or efficient healthcare services. Reasons a provider may not have a rating available for quality or efficiency include but are not limited to: 1) The provider practices in a specialty or geography that is not included in the Diamond Designation Program; or 2) There is insufficient data to meet minimum sample size requirements for statistical evaluation. The rating methodology of the Diamond Designation Program is subject to change from program year to program year. The information contained in this Methodology White Paper document is subject to change at the discretion of Wellcare.

Have questions or feedback for us?

Please contact **ContactUs@DiamondDesignation.com**.

For more information on methodology or other Program details, please visit **DiamondDesignation.com**.

(continued)

Appendix 1

Applicable Taxonomy Codes and Names

SPECIALTY	TAXONOMY CODE	TAXONOMY NAME
Cardiology	207RC0001X	Internal Medicine, Clinical Cardiac Electrophysiology
Cardiology	207RH0005X	Internal Medicine, Hypertension Specialist
Cardiology	207RI0011X	Internal Medicine, Interventional Cardiology
Cardiology	207RC0000X	Internal Medicine, Cardiovascular Disease
Counseling	101Y00000X	Counselor
Counseling	101YA0400X	Counselor, Addiction
Counseling	101YM0800X	Counselor, Mental Health
Counseling	102X00000X	Counselor, Poetry
Counseling	101YP2500X	Counselor, Professional
Counseling	102L00000X	Counselor, Psychoanalyst
Counseling	101YS0200X	Counselor, School
Counseling	222Q00000X	Developmental Therapist
Counseling	170300000X	Genetic Counselor, MS
Counseling	106H00000X	Marriage and Family Therapist
Counseling	225CA2500X	Rehab Counselor, Assistive Technology Supplier
Counseling	225CX0006X	Rehab Counselor, Orientation/Mobility Training
Counseling	225C00000X	Rehabilitation Counselor
Counseling	225CA2400X	Rehab Counselor, Assistive Technology Practitioner
Counseling	104100000X	Social Worker
Counseling	1041C0700X	Social Worker, Clinical
Counseling	1041S0200X	Social Worker, School
Endocrinology	207RE0101X	Internal Medicine, Endocrine, Diabetes, Metabolism
Gastroenterology	207RG0100X	Internal Medicine, Gastroenterology
Gastroenterology	207RI0008X	Internal Medicine, Hepatology
Surgery (General Surgery)	208600000X	Surgery
Nephrology	207RN0300X	Internal Medicine, Nephrology
Neurology	2084B0040X	Psychiatry/Neurology, Behavioral Neurology
Neurology	2084P0005X	Psychiatry/Neurology, Neurodevelopmental Disability
Neurology	2084P2900X	Psychiatry/Neurology, Pain Medicine
Neurology	2084S0010X	Psychiatry/Neurology, Sports Medicine
Neurology	2084S0012X	Psychiatry/Neurology, Sleep Medicine
Neurology	2084V0102X	Psychiatry/Neurology, Vascular Neurology
Neurology	2084N0400X	Allopath/Osteopath, Neurology
Neurology	2084N0600X	Psychiatry/Neurology, Clinical Neurophysiology

(continued)

SPECIALTY	TAXONOMY CODE	TAXONOMY NAME
Obstetrics & Gynecology	207V0000X	Obstetrics & Gynecology
Obstetrics & Gynecology	207VB0002X	Bariatric Medicine
Obstetrics & Gynecology	207VF0040X	Female Pelvic Medicine
Obstetrics & Gynecology	207VG0400X	Gynecology
Obstetrics & Gynecology	207VX0000X	Obstetrics
Ophthalmology	207W00000X	Ophthalmology
Orthopedic Surgery	207X00000X	Orthopedic Surgery
Orthopedic Surgery	207XX0005X	Orthopedic Surgery, Sports Medicine
Orthopedic Surgery	207XX0801X	Orthopedic Surgery, Orthopedic Trauma
Orthopedic Surgery	207XS0106X	Orthopedic Surgery, Hand Surgery
Orthopedic Surgery	207XS0114X	Orthopedic Surgery, Adult Reconstructive Surgery
Orthopedic Surgery	207XS0117X	Orthopedic Surgery, Orthopedic Surgery of Spine
Orthopedic Surgery	207XX0004X	Orthopedic Surgery, Foot/Ankle Orthopedics
Podiatry	213E00000X	Podiatrist
Podiatry	213EG0000X	Podiatrist, General Practice
Podiatry	213EP0504X	Podiatrist, Preventive Medicine, Public Health
Podiatry	213EP1101X	Podiatrist, Primary Podiatric Medicine
Podiatry	213ER0200X	Podiatrist, Radiology
Podiatry	213ES0000X	Podiatrist, Sports Medicine
Podiatry	213ES0103X	Podiatrist, Surgery, Foot/Ankle
Podiatry	213ES0131X	Podiatrist, Surgery, Foot
Psychiatry	2084B0002X	Psychiatry/Neurology, Bariatric Medicine
Psychiatry	2084D0003X	Psychiatry/Neurology, Diagnostic Neuroimaging
Psychiatry	2084P0015X	Psychiatry/Neurology, Psychosomatic Medicine
Psychiatry	2084P0800X	Psychiatry/Neurology, Psychiatry
Psychiatry	2084A0401X	Psychiatry/Neurology, Addiction Medicine
Psychiatry	2084P0802X	Psychiatry/Neurology, Addiction Psychiatry
Psychiatry	2084P0804X	Psychiatry/Neurology, Child/Adolescent Psychiatry
Psychiatry	2084P0805X	Psychiatry/Neurology, Geriatric Psychiatry
Psychiatry	2084F0202X	Psychiatry/Neurology, Forensic Psychiatry
Psychiatry	2084H0002X	Psychiatry/Neurology, Hospice/Palliative Medicine
Psychology	103TA0400X	Psychologist, Addiction
Psychology	103TA0700X	Psychologist, Adult Development and Aging
Psychology	103TB0200X	Psychologist, Cognitive and Behavioral
Psychology	103TC0700X	Psychologist, Clinical
Psychology	103TC1900X	Psychologist, Counseling

(continued)

SPECIALTY	TAXONOMY CODE	TAXONOMY NAME
Psychology	103TE1100X	Psychologist, Exercise and Sports
Psychology	103TH0100X	Psychologist, Health Service
Psychology	103TM1700X	Psychologist, Men and Masculinity
Psychology	103TM1800X	Psychologist, Mental Retardation and Development Disabilities
Psychology	103TP0016X	Psychologist, Prescribing (Medical)
Psychology	103TP0814X	Psychologist, Psychoanalysis
Psychology	103TP2700X	Psychologist, Psychotherapy
Psychology	103TP2701X	Psychologist, Psychotherapy, Group
Psychology	103TS0200X	Psychologist, School
Psychology	103G00000X	Neuropsychologist
Psychology	103GC0700X	Neuropsychologist, Clinical
Psychology	103K00000X	Behavioral Analyst
Psychology	103T00000X	Psychologist
Psychology	103TC2200X	Psychologist, Clinical Child and Adolescent
Psychology	103TE1000X	Psychologist, Educational
Psychology	103TF0000X	Psychologist, Family
Psychology	103TF0200X	Psychologist, Forensic
Psychology	103TH0004X	Psychologist, Health
Psychology	103TR0400X	Psychologist, Rehabilitation
Psychology	103TW0100X	Psychologist, Women
Pulmonology	207RP1001X	Internal Medicine, Pulmonary Disease

(continued)

Appendix 2

Availability of Diamond Designation Program

STATES	LINE OF BUSINESS	GEOGRAPHIC AVAILABILITY
Connecticut	Wellcare Medicare	Statewide
Florida	Wellcare Medicare*	Statewide
Georgia	Wellcare Medicare*	Limited to counties of Baldwin, Bartow, Bibb, Camden, Carroll, Chatham, Cherokee, Clarke, Clayton, Cobb, Columbia, Coweta, Dekalb, Douglas, Fayette, Floyd, Forsyth, Fulton, Glynn, Gwinnett, Hall, Henry, Houston, Jackson, Lowndes, Mcduffie, Murray, Muscogee, Newton, Oconee, Paulding, Pickens, Richmond, Rockdale, Spalding, Thomas, Tift, Troup, and Walton
Hawaii	ʻOhana Medicare and Medicaid	Statewide
Kentucky	Wellcare Medicare and Medicaid	Limited to counties of Anderson, Boone, Bourbon, Boyd, Boyle, Breckinridge, Bullitt, Campbell, Carroll, Clark, Daviess, Fayette, Fleming, Floyd, Franklin, Garrard, Grant, Graves, Grayson, Hardin, Harlan, Harrison, Henderson, Hopkins, Jefferson, Jessamine, Johnson, Kenton, Knox, Laurel, Lawrence, Lincoln, Madison, Marion, Mason, McCracken, Montgomery, Nelson, Oldham, Perry, Pike, Pulaski, Rowan, Scott, Shelby, Taylor, Warren, Wayne, Whitley, and Woodford
Maine	Wellcare Medicare	Statewide
Mississippi	Wellcare Medicare	Statewide
New Jersey	Wellcare Medicare and Medicaid	All counties except Hunterdon
New York	Wellcare Medicare	Statewide
Ohio	Buckeye Health Plan Medicaid and MyCare Ohio (Medicare-Medicaid Plan)	Limited to counties of Allen, Butler, Clark, Clermont, Cuyahoga, Delaware, Fairfield, Franklin, Fulton, Geauga, Greene, Hamilton, Lake, Licking, Lorain, Lucas, Mahoning, Medina, Miami, Montgomery, Pickaway, Portage, Stark, Summit, Trumbull, Warren, Wayne, and Wood
Tennessee	Wellcare Medicare	Statewide

*Evaluations may also include Medicaid member cases for Medicare providers who were also participating in Wellcare (or affiliated) Medicaid networks during the evaluation period.

Note: Not all specialty types are evaluated in each state for reasons including but not limited to: the relative size of the specialty care network; the adequacy of claims volume; the distinguishability of specialty care performance; and the extent of interest by primary care providers.

(continued)

Appendix 3

E&M Codes Excluded from Identification of Qualified Encounters for Quality Measurement Longitudinal Attribution

CPT CODE	CPT CODE NAME
90785	Psytx Complex Interactive
90865	Narcosynthesis
90867	Tcranial Magn Stim Tx Plan
90868	Tcranial Magn Stim Tx Deli
90869	Tcran Magn Stim Redetemine
90870	Electroconvulsive Therapy
90882	Environmental Manipulation
90885	Psy Evaluation of Records
90887	Consultation With Family
90889	Preparation of Report
90899	Psychiatric Service/Therapy
96160	Pt-Focused Hlth Risk Assmt
96161	Caregiver Health Risk Assmt

Appendix 4

Z Codes Used for SDoH Status

Z CODE	Z CODE NAME
Z59.4	Lack of Adequate Food and Safe Drinking Water
Z59.41	Food Insecurity
Z59.48	Other Specified Lack of Adequate Food
Z59.5	Extreme Poverty
Z59.6	Low Income
Z59.7	Insufficient Social Insurance and Welfare Support
Z59.89	Other Problems Related to Housing And Economic Circumstances
Z74.0	Reduced Mobility
Z74.01	Bed Confinement Status
Z74.09	Other Reduced Mobility
Z74.1	Need for Assistance with Personal Care
Z74.2	Need for Assistance at Home and No Other Household Member Able to Render Care
Z74.3	Need for Continuous Supervision
Z74.8	Other Problems Related to Care Provider Dependency

(continued)

Z CODE	Z CODE NAME
Z74.9	Problem Related to Care Provider Dependency, Unspecified
Z59.0	Homelessness
Z59.00	Homelessness Unspecified
Z59.01	Sheltered Homelessness
Z59.02	Unsheltered Homelessness
Z59.1	Inadequate Housing
Z59.2	Discord with Neighbors, Lodgers and Landlord
Z59.3	Problems Related to Living in Residential Institution
Z59.811	Housing Instability, Housed, with Risk of Homelessness
Z59.812	Housing Instability, Housed, Homelessness in Past 12 Months
Z59.819	Housing Instability, Housed Unspecified

Appendix 5

Quality Measure Descriptions*

*All measure specifications including numerators, denominators, exclusions, diagnostic and procedure codes, data sources, and other details are available upon request by emailing **ContactUs@DiamondDesignation.com**.

(continued)

14-Day C-Section Complications

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Obstetrics & Gynecology	12 to 51

Description

Measures the rate of c-sections that result in a complication within 14 days of the procedure.

Rationale

Cesarean delivery (CD) is one of the most common procedures performed in the United States accounting for 32% of all deliveries. Postpartum complications, wound infection, and endometritis are some of the major causes of prolonged hospital stay and readmissions and poses a burden to the healthcare system. The goal of this measure is to focus on the provider's performance and subsequent care in comparison with standards throughout the field. Tracking clinical outcomes post procedure can provide significant insights into the effectiveness of current treatments, and important issues regarding follow-up care and patient satisfaction with the care provided.

(continued)

14-Day Total Hysterectomy Complications

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Obstetrics & Gynecology	18 to 75

Description

Measures the rate of laparoscopic total hysterectomies that result in a complication within 14 days of the procedure.

Rationale

Hysterectomies are one of the most common surgical procedures in the United States. Post procedure complications can cause prolonged hospital stays and readmissions posing a burden to the healthcare system. The goal of this measure is to focus on the provider's performance and subsequent care in comparison with standards throughout the field. Tracking clinical outcomes post procedure can provide significant insights into the effectiveness of current treatments, and important issues regarding follow-up care and patient satisfaction with the care provided.

(continued)

7-Day Hospital Visit Rate After Appendectomy

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	General Surgery	5+

Description

Measures 7-day all cause unplanned hospital visit (inpatient or ED) rate following an appendectomy.

Rationale

Patients presenting with acute appendicitis are usually hospitalized for a few days for appendectomy and postoperative recovery. Hospital utilization following surgery is an important and accepted patient-centered outcome reported in healthcare. National estimates of hospital visit rates following surgery vary based on the type of surgery, outcome measured (admissions alone or admissions and emergency department visits), and timeframe for measurement after surgery. However, surgeons are often unaware of their patients' hospital visits after surgery since patients often present to the ED or to different hospitals. The quality measure tracking hospital visits following appendectomy can improve transparency, inform patients and providers, and foster quality improvement.

(continued)

7-Day Hospital Visit Rate After Endoscopic Retrograde Cholangiopancreatography (ERCP)

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Gastroenterology	18+

Description

Measures 7-day all cause hospital visit (inpatient and emergency department) rate following an ERCP procedure.

Rationale

Endoscopic retrograde cholangiopancreatography (ERCP) is the main therapeutic modality for bile duct disease in modern practice. ERCP is a complex procedure associated with the potential for significant adverse events including pancreatitis, perforation, hemorrhage, and infection; despite these risks, ERCP is widely practiced in both tertiary-care as well as in smaller community settings. A post ERCP hospital visit is defined as an unplanned hospital admission or an emergency department visit and has been used as a surrogate for adverse events and measure of provider performance, following endoscopic procedures.

(continued)

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid (National Committee for Quality Assurance)	Psychiatry	18+

Description

The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Rationale

Schizophrenia is a chronic and disabling psychiatric disorder that requires ongoing treatment and monitoring. Symptoms include hallucinations, illogical thinking, memory impairment, and incoherent speech. Medication non-adherence is common and a major concern in the treatment of schizophrenia. Using antipsychotic medications as prescribed reduces the risk of relapse or hospitalization. Managing providers can assess their own performance in comparison to benchmarks and identify areas for targeted improvements.

(continued)

Adult Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
American Academy of Ophthalmology	Ophthalmology	18+

Description

Rate of members aged 18 years or older who had surgery for primary hematogenous retinal detachment and required to return to the operating room within 90 days of surgery.

Rationale

The goal of this quality measure is to enhance the quality of retinal detachment surgery, minimize complications, and improve patient outcomes. By ensuring that patients achieve successful retinal reattachment with minimal need for additional surgical interventions, healthcare providers can support visual recovery and preserve or improve patients' quality of life.

(continued)

All-Cause Unplanned Readmission Following Hospitalization in an Inpatient Psychiatric Facility (31 to 90-Day Post-Discharge)

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid	Psychiatry, Psychology, Counseling	18+

Description

Rate of unplanned, 31 to 90-day, readmissions for members aged 18 years or older with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease from an inpatient psychiatric facility (IPF).

Rationale

This measure aims to assess the effectiveness of the psychiatric facility's care transition and post-discharge support, as well as identify potential gaps in care that may contribute to readmissions. The goal of this quality measure is to improve the continuity of care for individuals discharged from inpatient psychiatric facilities, minimize unplanned readmissions, and support long-term mental health stability.

(continued)

Antidepressant Medication Management (AMM)

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
National Committee for Quality Assurance	Psychiatry	18+

Description

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

Two rates are reported.

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

Rationale

Major 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 United States each year. 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. 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. Managing providers can assess their own performance in comparison to benchmarks and identify areas for targeted improvements.

(continued)

Asthma in Younger Adults Admission Rate

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Agency for Healthcare Research & Quality	Pulmonology	18 to 39

Description

Rate of asthma related inpatient admissions during the measure period for members with asthma diagnosis from prior years.

Rationale

This measure gauges how well asthma, a chronic condition, is managed. If managed well, asthma should not lead to frequent hospitalizations. High admission rates might hint at less effective asthma management, including potential gaps in patient education and engagement in their own care. It also reflects on broader aspects of care, such as timely access, communication, and coordination among healthcare professionals. Additionally, it allows for comparison and benchmarking across different healthcare providers, promoting quality improvement. Importantly, this measure also informs resource allocation, as high admission rates imply substantial healthcare costs.

(continued)

Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
American College of Cardiology	Cardiology	18+

Description

Measures adherence to anticoagulant medications for members previously diagnosed with atrial fibrillation and who filled at least one anticoagulant prescription in the year prior to the measurement year; adherence is defined as at least 80% proportion of days covered (PDC) of the measure year.

Rationale

Atrial fibrillation (AF) is associated with a 5-fold increase in stroke risk and is the most common cause of ischemic stroke in the elderly. Oral anticoagulation (OAC) reduces the risk of stroke associated with AF by 60%, yet only half of AF patients recommended for OAC receive these medications, and less than half of them adhere to OAC over time.

Successful attempts to improve patient adherence depend upon a set of key factors. These include realistic assessment of patients' knowledge and understanding of the regimen with clear and effective communication between provider and their patients. Physician–patient partnerships are essential when choosing amongst various therapeutic options to maximize adherence. Mutual collaboration fosters greater patient satisfaction, reduces the risks of nonadherence, and improves patients' healthcare outcomes. Engaging in this quality improvement activity allows providers to assess their own performance and identify areas for targeted interventions.

(continued)

Bloodstream Infection in Hemodialysis Members

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Disease Control	Nephrology	18+

Description

Measures the rate of members having a bloodstream infection among members receiving hemodialysis.

Rationale

Bloodstream infections are an important cause of hospitalizations, morbidity, and mortality in patients receiving hemodialysis. Eliminating bloodstream infections in the hemodialysis setting has been the focus of the Centers for Disease Control and Prevention. Though, infection-related hospitalizations have increased dramatically over the last 10 years in patients receiving in-center hemodialysis. It is vitally important for treating providers to play a key role in developing and implementing infection control measures in the dialysis facilities, because physician leadership is essential in preventing health care–associated infections. Providers can frequently review infection preventing policies in facilities they work with and make preventative and screening recommendations. The goal of this measure is to reinforce the importance of proper infection control procedures for physicians, nurses, dialysis technicians, and all healthcare workers involved in hemodialysis treatments.

(continued)

Bunionectomy Redos

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Podiatry	18+

Description

Measures the percentage of bunionectomies that result in a redo procedure within 365 days following the index procedure.

Rationale

A variety of surgical procedures is available to treat bunions. The procedures are designed to correct the changes in the bony structure of the foot, and correct soft tissue changes that may also have occurred. The goal of surgery is the reduction of pain and deformity. It goes without saying that a failed bunionectomy can take a significant toll on patients' quality of life by compromising the function and appearance of the foot, limiting your ability to tolerate shoe wear, and causing chronic foot pain. Tracking post-procedure outcomes remain a top priority because it can provide significant insights into the effectiveness of initial treatments, and important issues regarding follow-up care and patient satisfaction with the care provided.

(continued)

Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Heart Rhythm Society	Cardiology	18+

Description

Rate of cardiac tamponade and/or pericardiocentesis following atrial fibrillation ablation.

Rationale

By measuring the occurrence of cardiac tamponade and the need for pericardiocentesis following AF ablation, healthcare providers can assess the safety and effectiveness of their procedures and identify areas for improvement. This measure helps healthcare professionals identify potential risk factors, refine procedural techniques, and enhance patient selection and monitoring to reduce the occurrence of complications.

(continued)

Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
American Academy of Ophthalmology	Ophthalmology	18+

Description

Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence.

Rationale

Cataract surgery is one of the most frequently performed and successful surgical procedures worldwide, with high rates of visual improvement and patient satisfaction. However, complications can occasionally occur, some of which may require unplanned additional surgical intervention. These complications — such as endophthalmitis, retinal detachment, or significant posterior capsular rupture — can significantly impact visual outcomes, increase healthcare costs, and decrease patient quality of life. Tracking the rate of complications within 30 days that necessitate further surgical procedures serves as a critical indicator of surgical quality, patient safety, and adherence to evidence-based clinical protocols. A low rate of such events suggests effective preoperative evaluation, surgical technique, and postoperative care. Conversely, a higher rate may signal potential issues with surgical processes, patient selection, or follow-up management.

(continued)

Cervical Spine Procedure Complication: Unplanned Return to OR

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
The Joint Commission	Orthopedic Surgery	18+

Description

Rate of unplanned returns to the operating room within 90 days of initial procedure for members aged 18 years or older that underwent an elective cervical spine procedure.

Rationale

By measuring unplanned returns to the OR after cervical spine procedures, healthcare providers can assess their surgical outcomes, identify areas for improvement, and implement strategies to optimize patient care. This may involve enhancing surgical techniques, infection control measures, patient selection criteria, or postoperative monitoring protocols.

(continued)

Chlamydia Screening in Women (CHL)

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
National Committee for Quality Assurance	Obstetrics & Gynecology	16 to 24

Description

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

Rationale

Chlamydia is the most commonly reported bacterial sexually-transmitted disease in the United States. It occurs most often among adolescent and young adult females.

Untreated chlamydia infections can lead to serious and irreversible complications. This includes pelvic inflammatory disease, infertility, and increased risk of becoming infected with HIV. Screening is important, as approximately 75% of chlamydia infections in women and 95% of infections in men are asymptomatic. This results in delayed medical care and treatment. Managing providers can assess their own performance in comparison to benchmarks and identify areas for targeted improvements.

(continued)

Chronic Kidney Disease (CKD) Related ED Visits in Members with CKD

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Nephrology	18+

Description

Measures the rate of members having a CKD-related emergency department (ED) visit during the measure year in members previously diagnosed with CKD.

Rationale

Emergency department use is high among patients with CKD, although only a small proportion of these encounters is for potentially preventable CKD-related care. The goal of this measure is to improve CKD management by providing patients, physicians, and health plans with information about specialty provider-level chronic disease outcomes. Additionally, engaging in this preventive care quality improvement activity allows managing providers to assess their own performance and identify areas for targeted process improvements.

(continued)

Continuity of Pharmacotherapy for Opioid Use Disorder

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
University of Southern California (Battelle)	Psychiatry	18+

Description

Measures the proportion of members previously diagnosed with opioid use disorder (OUD) and taking OUD therapy medication who maintain 93% proportion of days covered with their OUD medications for the first 6 months of the measure year.

Rationale

Recent patient outcome studies suggests that pharmacotherapy can improve outcomes for individuals with OUD and that continuity of pharmacotherapy is critical to prevent relapse and overdose. However, despite the evidence and recommendations of clinical practice guidelines, pharmacotherapy is an underutilized treatment option for individuals with OUD. This measure's goal is to address this gap in care. This care process measure allows managing providers to assess their own performance and identify areas for targeted process improvements.

(continued)

Diabetes Long-Term Complications Admission Rate

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Agency for Healthcare Research & Quality	Endocrinology	18+

Description

Measures the rate of members admitted to the hospital with a principal diagnosis of diabetes with long term complications (renal, eye, neurological, circulatory, or complications not otherwise specified) during the measure year in members previously diagnosed with diabetes prior to the measure year.

Rationale

Without access to high quality outpatient diabetes care, certain diabetes conditions can become life-threatening. Long-term diabetes complications arise from sustained long- term poor control of diabetes. These complications may result in costly and avoidable inpatient hospital admissions. Inpatient hospital admissions for these complications can be an indicator that diabetes is not being properly prevented or managed. Additionally, engaging in this quality improvement activity allows diabetes managing providers to assess their own performance and identify areas for targeted interventions.

(continued)

Diabetes Short-Term Complications ED Visit Rate

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Agency for Healthcare Research & Quality	Endocrinology	18+

Description

Measures the rate of members admitted to the hospital with a principal diagnosis of diabetes short term complications (ketoacidosis, hyperosmolarity) during the measure year in members previously diagnosed with diabetes prior to the measure year.

Rationale

Without access to high quality outpatient diabetes care, certain diabetes conditions can become life-threatening. Short-term diabetes complications are thought to arise from short-term and long-term poor control of diabetes. These complications may result in costly and avoidable emergency department visits or inpatient hospital admissions.

Emergency department visits for these complications can be an indicator that diabetes is not being properly prevented or managed. The goal of this measure is to fully understand how patient demographics, physician practice patterns, social determinants, and clinical characteristics are related to the long-term outcome of diabetes treatment. Additionally, engaging in this quality improvement activity allows diabetes managing providers to assess their own performance and identify areas for targeted interventions.

(continued)

Diabetic Members Having a Diabetic Foot-Related Inpatient Admission or ED Visit

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Podiatry	18+

Description

Measures the rate of members having a diabetic foot-related inpatient admission during the measure year in members previously diagnosed with diabetes.

Rationale

Diabetic foot complications take a substantial clinical and economic toll in acute care settings. Clear opportunities exist to reduce costs and improve outcomes for this systematically neglected condition by establishing effective practice paradigms for screening, prevention, and coordinated care. Acute hospital visits for diabetic foot can be an indicator that diabetes screenings are not being properly managed. This measure's goal is to identify members with suboptimal Podiatry related preventative care.

(continued)

Discharge on Statin Medication Post Ischemic Stroke

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
The Joint Commission	Neurology	18+

Description

Rate of members aged 18 years or older with an ischemic stroke diagnosis who were prescribed or are continuing to take statin medication post hospital discharge.

Rationale

The goal of this quality measure is to enhance the quality of care for individuals post ischemic stroke, optimize secondary stroke prevention, and reduce the risk of future cardiovascular events. By measuring statin medication prescription and adherence post ischemic stroke, healthcare providers can assess their adherence to evidence-based guidelines and identify potential gaps in care. This measure promotes the appropriate use of statins, facilitates secondary stroke prevention, and improves long-term outcomes for individuals who have experienced an ischemic stroke.

(continued)

Epileptic Members Having an Epilepsy-Related Inpatient Admission

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Neurology	18+

Description

Measures the rate of members having an epilepsy-related inpatient admission during the measure year in members previously diagnosed with epilepsy.

Rationale

Seizures are listed as an Ambulatory Care Sensitive Condition (ACSC), but in some cases, hospitalization is required. Patient education, counselling and seizure management support that targets medication compliance and lifestyle management reduce avoidable hospitalizations.

(continued)

Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid	Gastroenterology	65+

Description

Measures the rate of an all-cause unplanned hospital visit (inpatient and emergency department) occurring within 7 days of an outpatient colonoscopy.

Rationale

This measure will reduce adverse patient outcomes associated with preparation for colonoscopy, the procedure itself, and follow-up care by capturing and making more visible to providers and patients all unplanned hospital visits following the procedure. Engaging in this procedure-based outcome measure allows performing providers to assess their own performance and identify areas for targeted improvement.

(continued)

Functional Status Assessment for Total Hip Replacement

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid	Orthopedic Surgery	18+

Description

Measures the percentage of patients 18 years of age and older who received an elective primary total hip arthroplasty (THA) and completed a functional status assessment within 90 days prior to the surgery and in the 270 to 365 days after the surgery.

Rationale

The goal of this quality measure is to enhance the quality of care for individuals who have undergone total hip replacement, optimize functional recovery, and improve patient satisfaction and overall well-being. By assessing functional status, healthcare providers can monitor progress, identify areas for intervention, and provide comprehensive support to help patients achieve their functional goals after total hip replacement surgery.

(continued)

Functional Status Assessment for Total Knee Replacement

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid	Orthopedic Surgery	18+

Description

Measures the percentage of patients 18 years of age and older who received an elective primary total knee arthroplasty (TKA) and completed a functional status assessment within 90 days prior to the surgery and in the 270 to 365 days after the surgery.

Rationale

The goal of this quality measure is to enhance the quality of care for individuals who have undergone total knee replacement, optimize functional recovery, and improve patient satisfaction and overall well-being. By assessing functional status, healthcare providers can monitor progress, identify areas for intervention, and provide comprehensive support to help patients achieve their functional goals after total knee replacement surgery.

(continued)

Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Members with Cirrhosis

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
American Gastroenterological Association	Gastroenterology	18+

Description

Measures the rate of members who underwent imaging with either ultrasound, contrast enhanced CT or MRI for hepatocellular carcinoma (HCC) in members aged 18 years or older previously diagnosed with chronic hepatitis C and cirrhosis.

Rationale

HCC (hepatocellular carcinoma) is the fourth most common cancer in the world and is the fastest rising cause of cancer-related deaths in the United States. Hepatitis C (HCV) is the leading cause of HCC and the risk of developing HCC is highest in patients with established HCV cirrhosis. Patients at high risk for developing HCC, including patients with HCV cirrhosis, should be entered into surveillance programs. Engaging in this preventive care quality improvement activity allows managing providers to assess their own performance and identify areas for targeted process improvements.

(continued)

Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid	Cardiology	65+

Description

Measures 30-day cardiovascular-related readmission rate for members discharged from the hospital with a principal diagnosis of acute myocardial infarction (AMI) on the index admission.

Rationale

Readmission for Acute Myocardial Infarction (AMI) significantly contributes to preventable morbidity and healthcare costs. The goal of this measure is to improve patient outcomes by providing patients, physicians, and health plans with information about specialty provider-level readmission rates following hospitalization for AMI. Measurement of patient outcomes allows for a broad view of quality of care that encompasses more than what can be captured by individual process-of-care measures. Hospital readmissions for AMI depend more on compound relations between patient and provider rather than on clinical severity of illness alone.

(continued)

Hospital 30-Day Risk-Standardized Readmission Rates following Percutaneous Coronary Intervention (PCI)

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
American College of Cardiology	Cardiology	65+

Description

This measure estimates a hospital-level risk-standardized readmission rate (RSRR) following PCI for Medicare Fee-for-Service (FFS) patients who are 65 years of age or older. The outcome is defined as unplanned readmission for any cause within 30 days following hospital stays. The measure includes both patients who are admitted to the hospital (inpatients) for their PCI and patients who undergo PCI without being admitted (outpatient or observation stay). A specified set of planned readmissions do not count as readmissions. The measure uses clinical data available in the National Cardiovascular Disease Registry (NCDR) CathPCI Registry for risk adjustment and Medicare claims to identify readmissions. Additionally, the measure uses direct patient identifiers including Social Security Number (SSN) and date of birth to link the datasets.

Rationale

The 30-day cardiac catheterization all-cause readmission measure helps assess whether patients who undergo this procedure experience a need for subsequent hospitalization within 30 days for any reason. This measure reflects the overall quality of care provided during the initial procedure and the effectiveness of post-procedure management and follow-up. Reducing readmissions after cardiac catheterization is essential in improving patient experiences, optimizing resource utilization, and minimizing healthcare costs.

(continued)

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid	Pulmonology	65+

Description

Measures the 30-day COPD-related readmission rate for members discharged from the hospital with principal diagnosis of COPD on the index discharge.

Rationale

Chronic obstructive pulmonary disease (COPD) is a major cause of morbidity and mortality. One of the main characteristics of this disease phenotypes is acute exacerbations. Admissions for exacerbations account for large portion of costs associated with COPD. Hospital admission or readmission is an important outcome for patients, as it is disruptive to patients and caregivers, costly to the healthcare system, and puts patients at additional risk of hospital-acquired infections and complications. Research has shown that readmission rates are influenced by the quality of inpatient and outpatient care and adherence to treatment plans. Despite the need to provide prompt patient follow-up during the transition from hospital to home, gaps within the health care system create barriers to providing timely post discharge care. These gaps include breakdowns in practitioner and patient communication, lengthy time to follow-up, and incomplete medication reconciliation. The purpose of this measure is to examine outpatient care of adults with COPD. This outcome quality measure allows managing providers to assess their own performance and identify areas for targeted process improvements.

(continued)

Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid	Cardiology	65+

Description

Measures 30-day cardiovascular-related readmission rate for members discharged from the hospital with principal diagnosis of Heart Failure (HF) on the index admission.

Rationale

Heart Failure (HF) is the most common cause of hospitalization in the US for people older than 65 years of age. It has the highest 30-day re-hospitalization rate among medical and surgical conditions, accounting for up one third of the total readmission rates. Readmission for Heart Failure significantly contributes to preventable morbidity and healthcare costs. The goal of this measure is to improve patient outcomes by providing patients, physicians, and health plans with information about specialty provider-level readmission rates following hospitalization for HF. Measurement of patient outcomes allows for a broad view of quality of care that encompasses more than what can be captured by individual process-of-care measures.

(continued)

Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate Following Pneumonia Hospitalization

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid	Pulmonology	18+

Description

This measure estimates a hospital-level, 30-day risk-standardized readmission rate (RSRR) for patients who are 65 years or older and are discharged from the hospital with diagnosis coding that meets one of the two following requirements: 1. Principal discharge diagnosis of pneumonia; or, 2. a. Principal discharge diagnosis of sepsis (that is not severe); and b. A secondary diagnosis of pneumonia coded as present on admission (POA); and c. No secondary diagnosis of sepsis that is both severe and coded as POA. Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm.

Rationale

The goal of this quality measure is to reduce readmissions and improve patient outcomes following pneumonia hospitalization. By ensuring effective transitions of care, enhancing post-discharge support, and implementing evidence-based practices, healthcare providers can optimize recovery, reduce complications, and enhance the overall quality of care for individuals with pneumonia.

(continued)

Hospital Visits After Hospital Outpatient Surgery

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid	General Surgery	18+

Description

Rate of unplanned 7-day post op hospital visits for members aged 18 years and older who underwent outpatient General Surgery procedures at an ambulatory surgical center.

Rationale

This measure serves as an indicator of the effectiveness and success of the outpatient surgical procedures performed. A high rate of hospital visits post-surgery could suggest complications, ineffective procedures, or inadequate preoperative or postoperative care. Secondly, it provides insights into the quality of patient education and discharge planning. Successful outpatient surgery relies heavily on patient understanding and adherence to postoperative care instructions. High rates of hospital visits may suggest a need for improved patient education and discharge planning. This measure also provides a basis for comparison and benchmarking between healthcare providers or institutions, fostering an environment that encourages quality improvement.

(continued)

Hospital Visits After Ophthalmology Outpatient Surgery

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid	Ophthalmology	18+

Description

Rate of members aged 18 years or older that underwent an outpatient ophthalmology surgery procedure at an ambulatory surgical center (ASC) that had an unplanned hospital visit occurring within seven days following the index procedure.

Rationale

The aim of this quality measure is to enhance the safety and effectiveness of ophthalmology outpatient surgery, reduce complications, and improve patient outcomes. By minimizing the need for hospital visits or readmissions, healthcare providers can ensure that patients receive optimal care in the outpatient setting, leading to better patient experiences and efficient resource utilization.

(continued)

Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid	Orthopedic Surgery	18+

Description

Rate of members aged 18 years or older that underwent an outpatient orthopedic surgery procedure at an ambulatory surgical center (ASC) that had an unplanned hospital visit occurring within seven days following the index procedure.

Rationale

The goal of this quality measure is to enhance the safety and effectiveness of orthopedic outpatient surgery, minimize complications, and improve patient outcomes. By measuring hospital visits or readmissions after orthopedic outpatient surgery, healthcare providers can assess their surgical outcomes, identify areas for improvement, and implement strategies to optimize patient care.

(continued)

Hospital Visits After Podiatry Outpatient Surgery

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Podiatry	18+

Description

Rate of members aged 18 years or older that underwent an outpatient podiatry surgery procedure at an ambulatory surgical center (ASC) that had an unplanned hospital visit occurring within seven days following the index procedure.

Rationale

This measure aims to assess the quality of care provided during podiatry procedures performed on an outpatient basis and identify potential complications or issues that may require additional hospital-based interventions. By minimizing the need for hospital visits or readmissions, healthcare providers can ensure that patients receive optimal care, reduce the risk of complications, and improve the overall surgical experience and recovery for individuals undergoing podiatry outpatient procedures.

(continued)

Inflammatory Bowel Disease: Postoperative Monitoring for Recurrence of Crohn's Disease at 6 to 12 Months After Surgical Resection in Patients with Crohn's Disease

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
American Gastroenterological Association	Gastroenterology	18+

Description

Rate of members aged 18 years or older that received a surgical resection for Crohn's disease that were monitored for recurrence of Crohn's disease by colonoscopy between 6 and 12 months after surgical resection.

Rationale

Crohn's Disease is a chronic condition with potential for recurrence even after surgical intervention. Regular postoperative monitoring helps detect early signs of recurrence, leading to timely intervention and improved patient outcomes. This measure reflects the quality of ongoing care, indicating that healthcare providers are proactive in their follow-up post-surgery. Measurement facilitates standardized comparison between healthcare providers, promoting adherence to best practices and continuous care improvement.

(continued)

Initiation and Engagement of Substance Use Disorder Treatment (IET) — Engagement

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
National Committee for Quality Assurance	Psychiatry	13+

Description

The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement.

Two rates are reported:

1. **Initiation of SUD Treatment.** The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.
2. **Engagement of SUD Treatment.** The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Rationale

In 2016, 20.1 million Americans over 12 years of age (about 7.5% of the population) were classified as having a substance use disorder involving AOD. Treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce AOD-associated morbidity and mortality, improve health, productivity and social outcomes and reduce health care spending. Despite strong evidence, less than 20% of individuals with substance use disorders receive treatment. Managing providers can assess their own performance in comparison to benchmarks and identify areas for targeted improvements.

(continued)

Initiation and Engagement of Substance Use Disorder Treatment (IET) — Initiation

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
National Committee for Quality Assurance	Psychiatry	13+

Description

The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement.

Two rates are reported:

1. **Initiation of SUD Treatment.** The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.
2. **Engagement of SUD Treatment.** The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Rationale

In 2016, 20.1 million Americans over 12 years of age (about 7.5% of the population) were classified as having a substance use disorder involving AOD. Treatment, including MAT, in conjunction with counseling or other behavioral therapies, has been shown to reduce AOD-associated morbidity and mortality, improve health, productivity and social outcomes and reduce health care spending. Despite strong evidence, less than 20% of individuals with substance use disorders receive treatment. Managing providers can assess their own performance in comparison to benchmarks and identify areas for targeted improvements.

(continued)

Initiation of Medication Therapy for Patient with New Bipolar Diagnosis

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Psychiatry	18+

Description

Rate of members aged 18 years or older with a new diagnosis of bipolar disorder who had guideline-recommended medication therapy initiated within 14 days of index diagnosis.

Rationale

This measure aims to ensure that patients receive prompt pharmacological treatment following a new bipolar diagnosis, as medication plays a crucial role in managing symptoms and promoting stability. By initiating medication therapy promptly and ensuring ongoing treatment, healthcare providers can support patients in achieving stability, minimizing the impact of mood episodes, and enhancing their overall well-being.

(continued)

Knee Arthroscopy Complications

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Orthopedic Surgery	18+

Description

Measures the rate of 14-day post knee arthroscopy complications (septic arthritis, and other arthroscopy-related complications).

Rationale

Knee arthroscopy is one of the most common surgical procedures worldwide and the number of arthroscopies has substantially increased in the last 30 years. Knee arthroscopy is widely acknowledged to be a safe procedure. Still, there are known serious complications such as joint infections, thrombosis, embolism and other arthroscopy related complications. Tracking clinical outcomes post procedure can provide significant insights into the effectiveness of surgical treatment, and important issues regarding follow-up care and patient satisfaction with the care provided.

(continued)

Laparoscopic Cholecystectomy Complications

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	General Surgery	18+

Description

Measures 30-day all cause inpatient admission rate following laparoscopic cholecystectomy procedures.

Rationale

Gallstone disease is one of the commonest digestive pathologies and, as a result, cholecystectomy is one of the most frequently performed surgical procedures. Laparoscopic cholecystectomy (LC), one of the most performed cholecystectomy procedures, remains associated with significant major complications including bile leak and bile duct injury (BDI). Unplanned hospital admission or emergency department (ED) visit after this surgery is used as a surrogate for adverse events and measure of provider performance. This outcome measure allows managing providers to assess their own performance and identify areas for targeted process improvements.

(continued)

Lumbar Spine Fusion Complications

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Orthopedic Surgery	18+

Description

Measures the rate of lumbar spine fusion procedures that result in a lumbar spine fusion complication (device displacement, DVT, or other intraoperative or postprocedural complication).

Rationale

Surgical treatment of adult lumbar spinal disorders is associated with a substantial risk of intraoperative and perioperative complications. The improvement in perioperative management and the development of new techniques in anesthetics and surgical sciences have led to substantial reduction of complications related to lumbar spine surgery. Measuring and reporting complication rates will inform healthcare providers and facilities about opportunities to improve care. In addition, it has the potential to lower healthcare costs associated with complications.

(continued)

Management of Mild-to-Moderate Ulcerative Colitis

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
American Gastroenterological Association	Gastroenterology	18+

Description

Rate of members aged 18 years or older diagnosed with extensive mild-moderate ulcerative colitis (UC), that receive a high-dose (> 3 g/d) or standard-dose mesalamine (2-3 g/d) or diazo-bonded 5-ASA.

Rationale

This measure focuses on evaluating whether individuals with UC receive appropriate and timely prescriptions and medication refills for mesalamine or diazo-bonded 5-aminosalicylates (5-ASA), during the specified measurement period. Ultimately, the goal of this quality measure is to enhance the quality of care for individuals with mild-to-moderate UC, optimize treatment outcomes, and improve the overall management and well-being of patients living with this chronic condition.

(continued)

Members Ages 18 to 65 Previously Diagnosed with Asthma Having an Asthma-Related ED Visit

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Pulmonology	18 to 65

Description

Measures the rate of members having an asthma-related ED visit during the measure year in 18 to 65 year-old members previously diagnosed with asthma.

Rationale

Asthma is one of the most common chronic diseases in younger adults. Patients with asthma often present to the emergency department for treatment for acute exacerbations. Evidence shows that consistency of ambulatory asthma care can decrease asthma-specific emergency department (ED) utilization risk and providers and should reinforce the use of follow-up care and education for high-risk groups to improve their quality of life. This outcome quality measure allows managing providers to assess their own performance and identify areas for targeted process improvements.

(continued)

Members Previously Diagnosed with a Mental Health Disorder Having a Mental Health or Substance Abuse-Related ED Visit

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Psychiatry, Psychology, Counseling	18+

Description

Measures the rate of members having a behavioral or substance abuse-related emergency department (ED) visit during the measure year in members previously diagnosed with a mental health disorder.

Rationale

Visits to EDs for substance use pose significant problems for public health and emergency care. Mental illness can affect people of all ages. In the United States, 18% of adults and 13%–20% of children under 18 years of age experience mental illness. Evidence shows that outpatient engagement and timely follow-up care post discharge for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function and increased treatment compliance. This care process measure allows managing providers to assess their own performance and identify areas for targeted process improvements.

(continued)

Members Previously Diagnosed with Chronic Headaches Having Multiple Headache-Related ED Visits

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Neurology	18+

Description

Measures the rate of members having 2 or more headache-related emergency department (ED) visits during the measure year in members previously diagnosed with chronic headaches.

Rationale

Headache is noted as one of most common reasons for ED visits. Chronic headache patients may repeatedly use ED services for headache care. Identifying patients who are at high risk of using the ED is important so that providers can reduce ED use for nonurgent care. Headaches can be extremely disabling. Correct diagnosis and effective treatment makes a huge difference in quality of patient life.

(continued)

Members Previously Diagnosed with Major Depressive Disorder Having a Depression-Related Acute Hospital Admission

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Psychiatry, Psychology, Counseling	18+

Description

Measures the rate of members having a depression-related inpatient admission during the measure year in members previously diagnosed with major depressive disorder.

Rationale

Evidence shows that depressive symptoms are associated with higher general hospital admissions, longer hospital stays and increased risk of re-admission posing a high cost on the healthcare system. Additionally, depression is a primary cause of disability and functional limitations, reduced quality of life, and mortality. In order to close treatment gaps and ensure that people achieve long-lasting recovery, providers need to educate patients and family members on the importance of their diagnosis, treatment adherence, plus proper and timely follow ups. Providers can also recommend alternative options during crisis such as virtual and acute care clinics. The purpose of this measure is to examine outpatient care of older adults with major depressive disorder. This outcome quality measure allows managing providers to assess their own performance and identify areas for targeted process improvements.

(continued)

Members Previously Diagnosed with Self Harm or Suicide Attempt Having a Mental Health or Substance Abuse-Related ED Visit

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centene Clinical Advisory Board	Psychiatry, Psychology, Counseling	18+

Description

Measures the rate of members having a behavioral or substance abuse-related emergency department (ED) visit during the measure year in members previously diagnosed with a self-harm or suicide attempt.

Rationale

ED visits for self-harm and suicidal ideation have increased for older adults in the United States. While there are effective ED-based interventions in place for patients at high risk of suicide, these interventions are not widely used in community practice. The purpose of this outcome measure is to examine outpatient care of older adults treated in emergency departments for suicide attempt (SA), suicidal ideation (SI), or deliberate self-harm (DSH). In order to close treatment gaps and ensure that people achieve long-lasting recovery, providers need to educate patients and family members on the importance of their diagnosis, treatment adherence, plus proper and timely follow ups. Providers can also recommend alternative options during crisis such as, virtual and acute care clinics. This outcome quality measure allows managing providers to assess their own performance and identify areas for targeted process improvements.

(continued)

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
National Committee for Quality Assurance	Psychiatry	1 to 17

Description

The percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

Three rates are reported:

1. The percentage of children and adolescents on antipsychotics who received blood glucose testing.
2. The percentage of children and adolescents on antipsychotics who received cholesterol testing.
3. The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

Rationale

Antipsychotic prescribing for children and adolescents has increased rapidly in recent decades. These medications can elevate a child's risk for developing serious metabolic health complications associated with poor cardiometabolic outcomes in adulthood. Given these risks and the potential lifelong consequences, metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications. Managing providers can assess their own performance in comparison to benchmarks and identify areas for targeted improvements.

(continued)

Non-Invasive Arterial Assessment of Patients with Lower Extremity Wounds or Ulcers for Determination of Healing Potential at the Initial Visit

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
US Wound Registry	Podiatry	18+

Description

Rate of members aged 18 years or older with a nonhealing lower extremity wound or ulcer that undergo a non-invasive arterial assessment at the initial visit for the would or ulcer, once in a 12-month period.

Rationale

The goal of this quality measure is to enhance the quality of care for patients with lower extremity wounds or ulcers, improve wound healing outcomes, and reduce the risk of complications. By ensuring that patients receive timely and appropriate non-invasive arterial assessments, healthcare providers can accurately diagnose and address underlying arterial insufficiency, optimize treatment plans, and maximize the chances of successful wound-healing.

(continued)

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

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
National Committee for Quality Assurance	Obstetrics & Gynecology	16 to 20

Description

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

Rationale

Cervical cancer screening can result in more harm than benefits for adolescent females. Adolescent females tend to have high rates of transient HPV infection and regressive cervical abnormalities. This may produce false-positive results and lead to unnecessary and potentially detrimental follow-up tests and treatment. With proper specialty-provider attribution, managing providers can assess their own performance in comparison to benchmarks and identify areas for targeted improvements.

(continued)

Obstetric Trauma Rate — Vaginal Delivery with Instrument

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Agency for Healthcare Research & Quality	Obstetrics & Gynecology	18+

Description

Rate of obstetric traumas reported on the same day or up to two days post instrument-assisted vaginal deliveries.

Rationale

The goal of this measure is to assess and monitor the incidence of obstetric trauma occurring during vaginal deliveries that involve the use of instruments, such as forceps or vacuum extractors. This measure aims to evaluate the safety and effectiveness of instrumental vaginal deliveries and identify areas for improvement in obstetric care.

(continued)

Optimal End Stage Renal Disease (ESRD) Starts

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
The Permanente Foundation	Nephrology	18+

Description

Rate of new ESRD members aged 18 years or older during the measurement period who experience a planned start of renal replacement therapy by receiving a preemptive kidney transplant, by initiating home dialysis (peritoneal dialysis or home hemodialysis), or by initiating outpatient in-center hemodialysis via arteriovenous fistula or arteriovenous graft.

Rationale

Optimal ESRD Starts measure focuses on assessing the ability of a provider to prepare patients for ESRD by identifying high-risk patients, educating them and their families about the need for dialysis or kidney transplant, helping them to make appropriate and informed choices, and then successfully transitioning to dialysis or kidney transplantation as kidney function declines to the level of ESRD. The measure aims to evaluate whether patients with ESRD receive timely and appropriate care, leading to optimal outcomes and improved quality of life.

(continued)

Pharmacotherapy Management of COPD Exacerbation (PCE) — Bronchodilators

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
National Committee for Quality Assurance	Pulmonology	40+

Description

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or emergency department (ED) visit on or between Jan. 1 and Nov. 30 of the measurement year and who were dispensed appropriate medications.

Two rates are reported:

1. **Dispensed a Systemic Corticosteroid** (or there was evidence of an active prescription) within 14 days of the event.
2. **Dispensed a Bronchodilator** (or there was evidence of an active prescription) within 30 days of the event.

Rationale

Approximately 15 million adults in the United States have COPD, an irreversible disease that limits airflow to the lungs. COPD exacerbations or "flare-ups" make up a significant portion of the costs associated with the disease. However, symptoms can be controlled with appropriate medication. Appropriate prescribing of medication following exacerbation can prevent future flare-ups and drastically reduce the costs of COPD. Managing providers can assess their own performance in comparison to benchmarks and identify areas for targeted improvements.

(continued)

Pharmacotherapy Management of COPD Exacerbation (PCE) — Systemic Corticosteroids

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
National Committee for Quality Assurance	Pulmonology	40+

Description

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or emergency department (ED) visit on or between Jan. 1 and Nov. 30 of the measurement year and who were dispensed appropriate medications.

Two rates are reported:

1. **Dispensed a Systemic Corticosteroid** (or there was evidence of an active prescription) within 14 days of the event.
2. **Dispensed a Bronchodilator** (or there was evidence of an active prescription) within 30 days of the event.

Rationale

Approximately 15 million adults in the United States have COPD, an irreversible disease that limits airflow to the lungs. COPD exacerbations or "flare-ups" make up a significant portion of the costs associated with the disease. However, symptoms can be controlled with appropriate medication. Appropriate prescribing of medication following exacerbation can prevent future flare-ups and drastically reduce the costs of COPD. Managing providers can assess their own performance in comparison to benchmarks and identify areas for targeted improvements.

(continued)

Potentially Avoidable Complications Following Stroke

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
American Academy of Neurology	Neurology	18+

Description

Rate of potentially avoidable complications for members at least 18 years of age with a new diagnosis of ischemic stroke or intracranial hemorrhage.

Rationale

The aim of this measure is to assess the occurrence of complications that could have been prevented or mitigated with appropriate care and interventions after a stroke. It focuses on evaluating the quality of post-stroke care to identify areas for improvement and reduce avoidable complications. By measuring potentially avoidable complications following stroke, healthcare providers and healthcare systems can assess the effectiveness of their stroke care protocols, identify gaps or variations in practice, and implement strategies to improve patient outcomes.

(continued)

Prenatal and Postpartum Care: Postpartum Care

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
National Committee for Quality Assurance	Obstetrics & Gynecology	All Ages

Description

The percentage of deliveries of live births on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year. For these members, 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 in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization.
- ✓ **Postpartum Care.** The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Rationale

The rational for this measure is to ensure that women receive appropriate and comprehensive care following childbirth. Postpartum care is a critical component of maternity care that focuses on the health and well-being of the mother after delivery. By measuring the quality of postpartum care, healthcare providers and systems can assess the extent to which women receive recommended services and interventions during this crucial period. This measure helps identify gaps and variations in postpartum care practices, enabling healthcare professionals to implement interventions and policies that enhance the quality and consistency of care.

(continued)

Prenatal and Postpartum Care: Timeliness of Prenatal Care

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
National Committee for Quality Assurance	Obstetrics & Gynecology	All Ages

Description

The percentage of deliveries of live births on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year. For these members, 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 in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization.
- ✓ **Postpartum Care.** The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Rationale

The goal of this measure is to ensure that pregnant women receive early and timely access to prenatal care services. Prenatal care plays a vital role in promoting the health and well-being of both the mother and the unborn child. The recommended timeframe for initiating prenatal care varies, but generally, it is advised that women receive their first prenatal visit in the first trimester, ideally within the first 12 weeks of pregnancy. Early initiation of prenatal care allows for comprehensive assessment, including medical history, physical examinations, laboratory tests, and the establishment of a care plan tailored to the individual needs of the mother and the baby.

(continued)

Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
American Academy of Ophthalmology	Ophthalmology	18+

Description

Rate of members aged 18 years or older with a diagnosis of primary open-angle glaucoma (POAG) who have any eye exam.

Rationale

This measure focuses on assessing the adherence to guidelines and best practices in the evaluation of the optic nerve in individuals with primary open-angle glaucoma (POAG). This measure aims to ensure that patients with POAG receive appropriate and regular assessments of their optic nerve, which is essential for the diagnosis, monitoring, and management of the condition.

(continued)

Proportion of Days Covered — Diabetes All Class

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Pharmacy Quality Alliance (Battelle)	Cardiology, Endocrinology	18+

Description

Rate of members aged 18 years or older who maintain at least 80% adherence to their diabetes medications during the measurement period.

Rationale

This measure is a metric used to assess the adherence and persistence of patients with diabetes in taking their prescribed medications. It focuses on evaluating the proportion of days in a specific time period that patients have medication coverage for all classes of diabetes medications. Improving medication adherence and persistence in diabetes management can lead to better glycemic control, reduced risk of complications, and improved overall health outcomes for patients. By implementing interventions to enhance medication adherence, healthcare providers can support patients in achieving optimal diabetes management and reduce the burden of the disease.

(continued)

Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA)

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid	Orthopedic Surgery	65+

Description

Measures the rate of THA procedures that result in a THA complication (joint implant complication, deep vein thrombosis (DVT), pulmonary embolism, surgical site infection, bone fracture following joint implant, or other intraoperative or postprocedural complication).

Rationale

The goal of this measure is to improve patient outcomes by providing patients, physicians, hospitals, and policy makers with information about provider-level outcomes following a primary elective THA. A THA complication is an outcome that is likely attributable to care processes and is an important outcome for patients. Measuring and reporting complication rates will inform healthcare providers and facilities about opportunities to improve care.

(continued)

Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Knee Arthroplasty (TKA)

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid	Orthopedic Surgery	65+

Description

Measures the rate of TKA procedures that result in a TKA complication (joint implant complication, deep vein thrombosis (DVT), pulmonary embolism, surgical site infection, bone fracture following joint implant, or other intraoperative or postprocedural complication).

Rationale

The goal of this measure is to improve patient outcomes by providing patients, physicians, hospitals, and policy makers with information about provider-level, risk-standardized complication rates (RSCRs) following a primary elective TKA. A TKA complication is an outcome that is likely attributable to care processes and is an important outcome for patients. Measuring and reporting complication rates will inform healthcare providers and facilities about opportunities to improve care. In addition, it has the potential to lower health care costs associated with complications.

(continued)

Standardized Hospitalization Ratio (SHR)-ESRD Members Receiving Hemodialysis

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid	Nephrology	65+

Description

Measures the rate of all-cause inpatient admission among members receiving hemodialysis.

Rationale

Hospitalization among hemodialysis patients remains a significant healthcare burden and detractor of quality of life. Inpatient admissions of patient on hemodialysis are concerning in that they may represent premature discharge, suboptimal care during a period of patient vulnerability, and diminished capacity for enacting self-care. The goal of this measure is to decrease avoidable hospitalization which will lead to improved patient outcomes, including reduction of avoidable medical costs, patient morbidity, and mortality.

(continued)

Statin Therapy for Members with Cardiovascular Disease (SPC)

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
National Committee for Quality Assurance	Cardiology, Endocrinology, Nephrology	Males: 21 to 75 Females: 40 to 75

Description

The percentage of males 21 to 75 years of age and females 40 to 75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria.

The following rates are reported:

1. **Received Statin Therapy.** Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
2. **Statin Adherence 80%.** Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Rationale

Cardiovascular disease is the leading cause of death in the United States. It is estimated that 92.1 million American adults have one or more types of cardiovascular disease.

People with diabetes also have elevated cardiovascular risk, thought to be due in part to elevations in unhealthy cholesterol levels. Having unhealthy cholesterol levels places people at significant risk for developing ASCVD1. Statins are a class of drugs that lower blood cholesterol. American College of Cardiology and American Heart Association (ACC/AHA) guidelines state that statins of moderate or high intensity are recommended for adults with established clinical ASCVD.

(continued)

Statin Therapy for Members with Diabetes (SPD)

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
National Committee for Quality Assurance	Cardiology, Endocrinology, Nephrology	40 to 75

Description

The percentage of members 40 to 75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria.

Two rates are reported:

1. **Received Statin Therapy.** Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. **Statin Adherence 80%.** Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Rationale

According to guidelines from the American College of Cardiology (ACC) and the American Heart Association (AHS), lowering LDL-C levels in patients with diabetes helps manage risk factors for atherosclerotic cardiovascular disease (ASCVD). Statins are a class of drugs that lower blood cholesterol. The American Diabetes Association and ACC/AHA guidelines also recommend statins for primary prevention of cardiovascular disease in patients with diabetes, based on age and other risk factors. Guidelines also state that adherence to statins will aid in ASCVD risk reduction in both populations.

(continued)

Surgical Site Infection (SSI)

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
American College of Surgeons (Centers for Disease Control)	General Surgery	18+

Description

Measures the rate of 30-day post operative surgical site infections following operations where at least one incision is made through the skin or mucous membrane, or reoperation via an incision that was left open during a prior operative procedure.

Rationale

While advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical technique, and availability of antimicrobial prophylaxis, SSIs remain a substantial cause of morbidity, hospitalization, and death. The goal of this measure is to promote SSI-prevention activities which will lead to improved patient outcomes, including reduction of avoidable medical costs, patient morbidity, and mortality.

(continued)

Use of Pharmacotherapy for Opioid Use Disorder (OUD)

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
Centers for Medicare & Medicaid	Psychiatry	18+

Description

Measures the proportion of patients diagnosed for the first time in a 90-day lookback period with opioid use disorder who filled a prescription for an OUD therapy medication within seven days of the index diagnosis.

Rationale

Patient outcome studies suggests that pharmacotherapy can improve outcomes for individuals with OUD and that continuity of pharmacotherapy is critical to prevent relapse and overdose. However, despite the evidence and recommendations of clinical practice guidelines, pharmacotherapy is an underutilized treatment option for individuals with OUD. This measure's goal is to address this gap in care. This care process measure allows managing providers to assess their own performance and identify areas for targeted process improvements.

(continued)

Use of Spirometry Testing in the Assessment and Diagnosis of COPD

MEASURE STEWARD	APPLICABLE SPECIALTIES	MEMBER AGE RANGE
National Committee for Quality Assurance	Pulmonology	40+

Description

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

Rationale

The goal of this quality measure is to enhance the accuracy of COPD diagnosis, optimize treatment decisions, and improve patient outcomes. By ensuring the appropriate utilization of spirometry testing, healthcare providers can provide timely and accurate diagnoses, tailor treatment plans to individual needs, and improve the overall management of COPD.