Optum

Optum Labs Qualified Entity (QE) Public Reports: 2024 Companion Guide

Optum Labs Public Report publication date: April 2024; Updated February 2025

Contents

Optum

This Companion Guide provides more detail on the Optum Labs QE Report, including our approach to reporting, data sources, measure selection and calculation methodologies, as well as limitations.

Reporting overview

The Optum Labs QE public report presents measures through two distinctive lenses. The first set of measures, *Comprehensive Care Process Measures*, focuses on measures of health care processes. The second set, *Transition to Medicare*, focuses on care quality for individuals making their first transition from private commercial (often employer-sponsored) health insurance to Medicare insurance. The Transition to Medicare theme is one that has not been examined before because it is only possible through the ability to link individuals longitudinally across commercial and Medicare plans.

Each set contains groupings of relevant measures to examine health care quality. The *Comprehensive Care Process Measures* are presented in the sub-domain of diabetes, an important disease area. The *Transition to Medicare* measures are presented in the sub-domains of diabetes and hospitalizations and harm, focusing on conditions requiring highly coordinated care.

Data sources

The Optum Labs Data Warehouse (OLDW) contains de-identified, longitudinal health information on enrollees and patients, representing a mixture of ages and geographical regions across the United States. The claims data in OLDW includes medical and pharmacy claims, laboratory results and enrollment records for commercial and Medicare Advantage enrollees. The EHR-derived data includes a subset of all EHR data that has been normalized and standardized into a single database and is used as supplemental data for the subset of insured individuals in our reports who have had encounters with these providers. These data assets have been combined with Medicare Parts A, B, and D claims data for the purposes of QE reporting.

All data used to create the Optum Labs QE public report are de-identified in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Claims data: The claims data in OLDW includes medical (inpatient, outpatient) and pharmacy claims, laboratory results and enrollment records for commercial and Medicare Advantage (MA) enrollees.

In the Optum Labs QE public report, we enable users to compare different coverage types, and as a result, users will see the terms “Commercial” and “MA” which refer, specifically, to the following:

> *Commercial*: This term refers to claims data representing employer-sponsored and individual health plans sold in the commercial health insurance markets. Generally, this includes populations who are not yet Medicare eligible (e.g., under 65 years old), but does also include individuals who continue to work past

age 65 and retain employer-sponsored insurance or have private health insurance through an employer's retirement (or pension) package.

Medicare Advantage (MA): This term refers to claims data representing Medicare health plans sold in commercial health insurance markets by companies that contract with Medicare. Plan types include preferred provider organizations (PPO), health maintenance organizations (HMO), and Special Needs Plans (SNP). These data include populations who are Medicare eligible and opted to purchase Medicare coverage in the commercial market from a private insurer, instead of traditional Medicare FFS offered directly by the federal government. Generally, MA-covered individuals are 65 years and older, and not receiving other health insurance. MA does cover a portion of individuals under 65 who are eligible for Medicare due to disability or end-stage renal disease (ESRD).

Medicare fee-for-service (FFS) claims data: Optum Labs received the Medicare FFS data as a result of its status as a national Qualified Entity. Medicare claims data, from Parts A, B, and D that were used to produce these public reports span the years 2015-2021. Generally, FFS-covered individuals are 65 years and older, and not receiving health coverage from an employer. Many individuals who become eligible for Medicare at age 65 continue to work and may maintain employer-sponsored commercial insurance as their primary coverage, with Medicare FFS as secondary coverage until retirement when Medicare FFS generally becomes the primary payer.

EHR-derived clinical encounters: The clinical data in OLDW is derived from electronic health record data representing a geographically diverse group of provider institutions (hospitals, clinics, laboratories, skilled nursing facilities, outpatient surgical centers) in the United States. The included institutions represent both Integrated Delivery Networks (IDN) and non-IDN affiliated providers and the patient population includes commercially insured, Medicare enrollees (both Medicare Advantage and traditional fee-for-service Medicare), Medicaid enrollees, and the uninsured. While the EHR-derived clinical data are substantial in volume overall, they do not capture all clinical encounters as they are limited to the health system departments that have agreed to provide data.

How data sources were used

Optum Labs seeks to produce QE public reports that characterize quality, leveraging all facets of the distinctive data assets in OLDW to calculate measures whose specifications (both logical and technical methodologies) are maintained by measure stewards, subject to the adjustments discussed below. The reports utilize the scope of the linked multi-payer claims (Commercial, Medicare Advantage, Medicare FFS) and EHR-derived clinical data available in the OLDW.

This combined data source is comprised of the three individual claims sources described above (i.e., Commercial, Medicare Advantage, and Medicare FFS), along with the EHR-derived clinical data, de-identified and linked at the patient level. Combining the claims and clinical data creates a set that includes individuals who both had coverage and at least one encounter with the providers represented in the EHR-derived data. It is important to note that because the combined claims and clinical data represent only a subset of the individual data sources,

sample sizes using these combined data may become too small for reliable or reportable results in some cases. In these cases, results are represented by an asterisk (“*”) and noted as “Insufficient data.”

Identifying the Transition to Medicare eligible population

With our capability to link together patient level claims across multiple payers and health plans, Optum Labs developed the *Transition to Medicare* analysis to compare trends in quality of care in the first transition from commercial to Medicare coverage. To do this, Optum Labs developed a methodology to longitudinally follow beneficiaries who transitioned from commercial coverage to Medicare during the reporting period. The beneficiary’s transition year (e.g., when a person transitioned to Medicare coverage) and the type of Medicare coverage (e.g., MA or Medicare FFS) were determined for each individual in this population.

Two methodologies were used to define transition to Medicare, depending on the type of Medicare coverage into which the individual first transitioned. In both the MA and FFS cases, the transition year used in the public reports is defined as the year of initial transition to Medicare. These methods are described below.

1) Commercial to MA transition population: Due to the capitated nature of MA, coverage rules are relatively clear that once a member enrolls in a MA plan, that MA plan is the primary payer responsible for the member. As a result, other insurance coverage held by the member either becomes secondary to MA or is dropped. Individuals were defined as having transitioned to MA if:

    - The earliest MA enrollment start date was either before or within 45 days of their commercial end date (e.g., overlapping coverage or a gap less than or equal to 45 days, respectively). Members meeting these criteria had an initial Medicare transition date set to the MA enrollment start date.

2) Commercial to Medicare FFS transition population: Coverage rules for Medicare FFS are more complex, such that enrollment alone cannot be used to determine transition to FFS. For example, Medicare beneficiaries may enroll in Part A coverage at age 65, but keep working and maintain commercial insurance as the primary payer. Many additional rules apply, so defining transition was based on an algorithm developed for this report and based on claim-level evidence of the primary payer for each member. Individuals were defined as having transitioned to FFS if:

    - There was a gap of less than 45 days between Commercial coverage and Medicare FFS coverage and no evidence of secondary coverage exists, or
    - The Medicare transition date was before the Commercial end date (e.g., overlapping coverage) AND Medicare FFS was determined to be the primary payer. For members with overlapping coverage, the following logic was used to determine the start date for Medicare FFS as primary payer:

- If the member had no commercial claims during the overlapping period and the first claim after the start of Medicare FFS enrollment indicates Medicare FFS was the primary payer, then the Medicare transition date was set to the start of Medicare FFS enrollment.
- If the member had claims evidence of commercial primary coverage after the start of FFS enrollment, then the first claim date where Medicare FFS is the primary payer was used as the initial Medicare transition date.

All individuals meeting our specified criteria for the "initial transition to Medicare" are included in the eligible population for the *Transition to Medicare* analysis. Individuals in the eligible population must then also meet the measure specifications to be included in the report for a given measure. The two years before and two years after the transition are each handled as independent measurement years, so while an individual might meet measure criteria in the transition year, they may not meet the criteria in all preceding or following years. For example, a newly diagnosed diabetic in the denominator for diabetes measures in the transition year ("0"), might not be included in the diabetes denominator in prior measurement years ("-2" and "-1").

Identifying hospitalization stays and discharges

Measure steward specifications were followed for the *Hospitalizations per 1000* measures (NQF 2503 and 2504)[1] to define the eligible population, denominator/numerator, index hospitalization time period, and hospital transfer methodology for the rate calculation. The Hospitalization and Harms measures used in our report did not provide a code list to identify hospitalization, so Optum Labs analyzed the claims data and relevant literature and determined that "type of bill" values that indicated an inpatient hospital stay (11x, 41x)[2] could be used to determine hospital stay records for both measures.

For the Acute Admission Rates measures, "type of bill" values in the claims data indicating an inpatient hospital stay (11x, 41x) were used to determine hospital stay records for both measures. These measures also specify a denominator exclusion for members who die during the measurement year. Due to HIPAA de-identification requirements, date of death data were not available. Instead, members who dis-enrolled were excluded from the denominator because they did not meet continuous enrollment criteria and may have been disenrolled due to death during the year.

Risk adjustment exceptions

The specifications of the CMS Risk Standardized Acute Admission Rate measures (CQF 2886, NQF 2887, NQF 2888) included in the *Transition to Medicare* analysis, call for risk adjustment using two-level hierarchical statistical models.

For this report, however, Optum Labs determined that risk adjustment was not necessary as the same cohorts of beneficiaries are followed over a five-year period. While there is some upward

[1] See Measures Specifications in the Appendix for more information
[2] Values defined by the National Uniform Billing Committee (NUBC)

drift in risk over time as the beneficiaries age, these cohorts should be relatively stable from year to year in their risk profile. In aggregate, the only difference among groups will be one additional year of age. Using the raw (unadjusted) acute admission rates is most appropriate for the *Transition to Medicare* analysis.

Also in the *Transition to Medicare* analysis, the measure steward for NQF 0709 (Potentially Avoidable Complication Measure), recommends risk adjustment of cost of care for treatment episodes. Optum Labs calculated this measure on members who transition into Medicare and focused on examining the Potential Avoidable Complication (PAC) events (not episode cost) and therefore did not risk adjust this measure.

Ages in calculations exceptions

Included in the *Transition to Medicare* analysis, the Acute Admission Rates (NQF 2886, NQF 2887, NQF 2888) and the Potentially Harmful Drug Disease Interactions (NQF 2993) measures, target a population of ambulatory Medicare FFS beneficiaries for ages 65 years or older. The age requirement was removed to include all individuals who transition into Medicare, regardless of age, so that these measures may be applied to the transition to Medicare concept.

Confidence intervals

The Qualified Entity Certification Program (QECP) requires that public reports include either the number of individuals represented by a measure result, or a confidence interval for the reported result. Optum Labs chose to do the latter and used the following methodology. Note that a denominator of less than 30 individuals resulting from a measure calculation is considered too small to be reliable. In such cases, instead of displaying the result, we represent the measures result with an asterisk "*", meaning there was "Insufficient data" to reliably report the measure.

Confidence intervals were used to determine the statistical validity for the measure results. Calculations of 90% confidence intervals were done for the upper and lower bound results.

The following categories were calculated using percentage measures: Comprehensive Diabetes Care Measures

$$p \pm \left(t\,dist_{90\%} \times \sqrt{\frac{p \times (1-p)}{n}} \right)$$

where p is the rate (adherent members/total members) and n is the number of members.

The following categories were calculated using Per Member Year Measures: Hospitalizations per 1000, Acute Admissions Rates, Potentially Avoidable Complications and Potentially Harmful Drug Disease Interactions,

$$x \pm \left(t\,dist_{90\%} \times \frac{s}{\sqrt{n}} \right)$$

where x is the rate (sum of first admission days / total member years), n is the total member years and s is the standard deviation of first admission days.

Percent change

The public reports illustrate percentage changes in measures. In each report, the percent change is calculated against the mean actual performance for each measure in the reference year. The basic calculation for a given mean rate in year i , with a reference mean rate (ref) is:

$$Percent\ change\ (i) = \frac{Mean\ rate\ (i) - Mean\ rate\ (ref)}{Mean\ rate\ (ref)}$$

For the *Comprehensive Care Process Measures*, percent change in mean performance for each of the years (i), 2015 through 2021, is calculated against mean performance in the reference year, 2015. As such, the percent change values in this report indicate the degree to which actual performance in a given year for a measure is higher (positive %), the same (0%), or lower (negative %), as compared to the mean measure performance in 2015, the baseline year for trends is this report.

For the *Transition to Medicare* analysis, percent change in mean performance for years (i), two years before transition (Year -2) through two years after transition (Year +2), is calculated against mean performance in the reference year, which is the year a member first transitions from commercial to Medicare primary insurance (Year 0). As such, the percent change values in this report indicate the degree to which actual performance in a given year before or after first transition to Medicare as primary insurance for a measure is higher (positive %), the same (0%), or lower (negative %), as compared to the mean measure performance during the year of first transition to Medicare as primary insurance, the baseline year for trends is this report.

Points of note on measure use (limitations)

When using administrative data sources to replicate existing measure specifications, there will always be some limitations. The most significant of these are described below.

- **Variability in the capture of measure criteria**:
  - **Billing variation**: While Optum Labs followed measure specifications for all measures in the report, it is important to understand that not all specifications (e.g., services and diagnoses) are captured equally across the different claims and clinical data sources. Some services may not be billed through medical claims or may be billed through non-medical coverage (e.g., eye exams billed through separate vision coverage which may not be visible in our data). As a result, there will be some variations in measure results that may be subject to poor capture of specifications in the real-world data sources used for these reports and which may result in the appearance of sub-optimal performance on these measures.
  - **Changes in enrollment**: Some measures specify that diagnostic services provided years before the measure year count toward performance on the

measure. As a result, these measures as calculated in our data may not fully capture actual performance.

- **Capture of supplemental data**: The specifications for most of the process measures in these public reports allow for the additional collection of supplemental data beyond the administrative claims alone (e.g., EHR and other provider data) to attempt to fully capture adherence on performance measures. The supplemental EHR data in OLDW represent only a subset of all patient encounters captured for the individuals who are represented in the claim sources, and so cannot completely fill in the data gaps found in the claims like a full medical record review.

- Specific measures in the report that may be impacted by any or all the limitations above include the following:
  - Comprehensive Diabetes Care measures
    - Eye Exam
    - HbA1c Control
    - HbA1c Poor Control
    - Blood Pressure Control

- Specific known measure limitations:
  - **Eye Exam (Diabetes)**: Eye exams may be billed under either medical or optical insurance coverage. This results in the inability to fully capture the exam using medical claims alone and will likely under-capture the true exam rate.
  - **Transition to Medicare Hospitalization and Harm** measures are unadjusted outcomes that may be impacted by population differences. Population differences may include demographic differences (i.e., different proportions of gender, race, or age), as well as different comorbidities and disease severity that indicate one group is sicker before enrolling in Medicare.
  - **Transition to Medicare** – All measures may also be subject to selection bias, since individuals have the option to select the type of Medicare coverage (i.e., Medicare Advantage or traditional fee-for-service) that best suits their particular needs.

- **Small sample size**: Optum Labs has suppressed all measure results that represent a denominator of fewer than 30 individuals, because these results are statistically unreliable. These results are masked and represented in the report by an asterisk (“*”) that indicates “Insufficient data” for the measure. While measures with a denominator larger than 30 individuals are statistically reliable, these results may still vary in accuracy and be subject to substantial variation and large confidence intervals.

Optum

Measure specifications

The tables below provide basic detailed measure information for the standard and QECP alternative measures presented in the Optum Labs QE public reports. We provide the measure description, numerator, denominator, exclusions, and more. More detailed information on these measures can be found on the measure steward's website.

Measure	Title	Description	Numerator Statement	Denominator Statement	Exclusions	Steward
55	Comprehensive Diabetes Care: Eye Exam	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.	Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. • Bilaterial eye enucleation anytime during the member's history through December 31 of the measurement year.	Members 18-75 years of age as of December 31 of the measurement year who were identified with diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.	Exclude from the eligible population members who begin using hospice services during the measurement year. Optional Exclusions: Identify members who do not have a diagnosis of diabetes, in any setting, during the measurement year or year prior to the measurement year and who had: • A diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.	NCQA
59	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had an HbA1c level >9.0% (poor control) during the measurement year.	Most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.	Members 18-75 years of age as of December 31 of the measurement year who were identified with diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.	Exclude from the eligible population members who begin using hospice services during the measurement year.	NCQA
61	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had a blood pressure (BP) level <140/90 mm Hg.	Most recent BP reading is <140/90 mm Hg during the measurement year.	Members 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.	Exclude from the eligible population members who begin using hospice services during the measurement year.	NCQA
575	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	The percentage of members 18 - 75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is <8.0% during the measurement year.	Members whose HbA1c level is <8.0% during the measurement year.	Members 18-75 years of age as of December 31 of the measurement year who were identified with diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.	Exclude from the eligible population members who begin using hospice services during the measurement year.	NCQA

Optum

Measure	Title	Description	Numerator Statement	Denominator Statement	Exclusions	Steward	Original Steward
Not Applicable	Comprehensive Diabetes Care: Eye Exam	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.	Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. • Bilaterial eye enucleation anytime during the member's history through December 31 of the measurement year.	Members 18-75 years of age as of December 31 of the measurement year who were identified with diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.	Exclude from the eligible population members who begin using hospice services during the measurement year. Optional Exclusions: Identify members who do not have a diagnosis of diabetes, in any setting, during the measurement year or year prior to the measurement year and who had: • A diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.	Optum Labs	NCQA
Not Applicable	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had an HbA1c level >9.0% (poor control) during the measurement year.	Most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.	Members 18-75 years of age as of December 31 of the measurement year who were identified with diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.	Exclude from the eligible population members who begin using hospice services during the measurement year.	Optum Labs	NCQA
Not Applicable	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had a blood pressure (BP) level <140/90 mm Hg.	Most recent BP reading is <140/90 mm Hg during the measurement year.	Members 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.	Exclude from the eligible population members who begin using hospice services during the measurement year.	Optum Labs	NCQA
Not Applicable	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	The percentage of members 18 - 75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is <8.0% during the measurement year.	Members whose HbA1c level is <8.0% during the measurement year.	Members 18-75 years of age as of December 31 of the measurement year who were identified with diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.	Exclude from the eligible population members who begin using hospice services during the measurement year.	Optum Labs	NCQA

Measure	Title	Description	Numerator Statement	Denominator Statement	Exclusions	Steward	Original Steward
Not Applicable	Hospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries	Number of hospital discharges from an acute care hospital (PPS or CAH) per 1000 FFS Medicare beneficiaries at the state and community level by quarter and year.	Number of hospital discharges from an acute care hospital (PPS or CAH)	Medicare FFS beneficiaries, prorated based on the number of days of FFS eligibility in the time period (quarter or year).	None	Optum Labs	CMS

Optum

Measure	Title	Description	Numerator Statement	Denominator Statement	Exclusions	Steward	Original Steward
Not Applicable	Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year.	Percent of adult population aged 18+ years who were identified as having at least one of the following six chronic conditions: Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Heart Failure (HF), Hypertension (HTN), or Diabetes Mellitus (DM), were followed for at least one-year, and had one or more potentially avoidable complications (PACs) during the most recent 12 months. Please reference attached document labeled NQF_Chronic_Care_PACs_01_24_17.xls, in the tabs labeled PACs I-9 & I-10 for a list of code definitions of PACs relevant to each of the above chronic conditions.	Outcome: Number of patients with at least one of the following six chronic conditions: Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Heart Failure (HF), Hypertension (HTN), or Diabetes Mellitus (DM), and had one or more potentially avoidable complications (PACs), during the most recent 12 months.	Adult patients aged 18+ years who were identified as having at least one of the following six chronic conditions: Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Heart Failure (HF), Hypertension (HTN), or Diabetes Mellitus (DM), and were followed for at least 12 months.	Patients are excluded from the measure if they are less than 18 years of age, have an incomplete episode of care (less than 18 months of claims), have an enrollment gap of more than 30 days, or have outlier costs for the most recent 12 months of claim costs. Claims are excluded from the episode if they are for services that are not relevant to the chronic condition.	Optum Labs	Altarum Institute
Not Applicable	30-day Re-hospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries	Number of re-hospitalizations occurring within 30 days of discharge from an acute care hospital (prospective payment system (PPS) or critical access hospital (CAH)) per 1000 FFS Medicare beneficiaries at the state and community level by quarter and year.	Number of re-hospitalizations within 30 days of discharge from an acute care hospital (PPS or CAH).	Medicare FFS beneficiaries, prorated based on the number of days of FFS eligibility in the time period (quarter or year).	None	Optum Labs	CMS
Not Applicable	Risk-Standardized Acute Admission Rates for Patients with Heart Failure	Rate of risk-standardized acute, unplanned hospital admissions among Medicare Fee-for-Service (FFS) patients 65 years and older with heart failure	The outcome measured for each patient is the number of acute, unplanned admissions per 100 person-years at risk for admission. Persons are considered at risk for admission if they are alive, enrolled in FFS Medicare, and not currently admitted.	The target population is ambulatory Medicare FFS patients aged 65 years and older with a diagnosis of heart failure.	The measure excludes: 1. Patients without continuous enrollment in Medicare Part A for the duration of the measurement period (or until death). Rationale: We exclude these patients to ensure full data availability for outcome assessment. 2. Patients with left ventricular assist devices (LVADs). Rationale: We exclude these patients because while they have a high risk of admission, they are low in prevalence and are clustered among a few ACOs.	Optum Labs	CMS
Not Applicable	Risk-Standardized Acute Admission	Rate of risk-standardized acute, unplanned hospital admissions	The outcome measured for each patient is the number of acute,	The target population is ambulatory Medicare FFS	The measure excludes: 1. Patients without	Optum Labs	CMS

Measure	Title	Description	Numerator Statement	Denominator Statement	Exclusions	Steward	Original Steward
	Rates for Patients with Diabetes	among Medicare fee-for-service (FFS) patients 65 years and older with diabetes	unplanned admissions per 100 person-years at risk for admission. Persons are considered at risk for admission if they are alive, enrolled in FFS Medicare, and not currently admitted.	patients aged 65 years and older with a diagnosis of diabetes.	continuous enrollment in Medicare Part A for the duration of the measurement period (or until death). Rationale: We exclude these patients to ensure full data availability for outcome assessment (Part A during the measurement year).		
Not Applicable	Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions	Rate of risk-standardized acute, unplanned hospital admissions among Medicare fee-for-service (FFS) patients 65 years and older with multiple chronic conditions (MCCs)	The outcome measured for each patient is the number of acute, unplanned admissions per 100 person-years at risk for admission. Persons are considered at risk for admission if they are alive, enrolled in FFS Medicare, and not currently admitted.	Our target population is Medicare FFS patients aged 65+ whose combinations of chronic conditions put them at high risk of admission and whose admission rates could be lowered through better care. The NQF's "Multiple Chronic Conditions Measurement Framework," defines patients with multiple chronic conditions as people "having two or more concurrent chronic conditions that…. act together to significantly increase the complexity of management, and affect functional roles and health outcomes, compromise life expectancy, or hinder self-management [1]." Operationally, the measure cohort includes patients with diagnoses in two or more of eight chronic disease groups: 1. Acute myocardial infarction (AMI), Alzheimer's disease and related disorders or senile dementia, Atrial fibrillation, Chronic kidney disease (CKD), Chronic obstructive pulmonary disease (COPD) and asthma, Depression, Heart failure, Stroke and transient ischemic attack (TIA) This approach captures ~ 25% of Medicare FFS beneficiaries 65+ with at least 1 chronic condition.	The measure excludes: 1. Patients without continuous enrollment in Medicare Part A for the duration of the measurement period (or until death). Rationale: We exclude these patients to ensure full data availability for outcome assessment (Part A during the measurement year).	Optum Labs	CMS

Optum

Measure	Title	Description	Numerator Statement	Denominator Statement	Exclusions	Steward	Original Steward
Not Applicable	Potentially Harmful Drug-Disease Interactions in the Elderly	The percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis. Report each of the three rates separately and as a total rate. • A history of falls and a prescription for anticonvulsants, nonbenzodiazepine hypnotics, SSRIs, antipsychotics, benzodiazepines or tricyclic antidepressants. • Dementia and a prescription for antipsychotics, benzodiazepines, tricyclic antidepressants, H2 Receptor Antagonists, nonbenzodiazepine hypnotics or anticholinergic agents. • Chronic kidney disease and prescription for Cox-2 Selective NSAIDs or nonaspirin NSAIDs. • Total rate (the sum of the three numerators divided by the sum of the three denominators). Members with more than one disease or condition may appear in the measure multiple times (i.e., in each indicator for which they qualify). A lower rate represents better performance for all three rates.	Rate 1: Drug-Disease Interactions (DDI)—History of Falls and Anticonvulsants, Nonbenzodiazepine Hypnotics, SSRIs, Antipsychotics, Benzodiazepines or Tricyclic Antidepressants -Dispensed an ambulatory prescription for an anticonvulsant, nonbenzodiazepine hypnotic, SSRI, antipsychotic, benzodiazepine or tricyclic antidepressant on or between the IESD and December 31 of measurement year. Rate 2: DDI—Dementia and Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine Hypnotics or Anticholinergic Agents - Dispensed an ambulatory prescription for an antipsychotic, benzodiazepine or tricyclic antidepressant or H2 receptor antagonist, nonbenzodiazepine hypnotic or anticholinergic agent on or between the IESD and December 31 of the measurement year. Rate 3: DDI-Chronic Kidney Disease and Cox-2 Selective NSAIDs or Nonaspirin NSAIDS - Dispensed an ambulatory prescription for a Cox-2 selective NSAID or nonaspirin NSAID on or between the IESD and December 31 of the measurement year.	Members 67 years or older as of December 31 of the measurement year who had at least one disease, condition or procedure in the measurement year or the year prior to the measurement year. Refer to Additional Eligible Population Criteria for each rate. Rate 1: An accidental fall or hip fracture* on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Rate 2: Identify members with a diagnosis of dementia (Dementia Value Set) or a dispensed dementia medication on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Rate 3: Chronic kidney disease as identified by a diagnosis of ESRD, stage 4 chronic kidney disease or kidney transplant on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.	Exclude from the eligible population members who begin using hospice services during the measurement year. Exclude denied claims from the numerator. Rate 1: Exclude members with a diagnosis of psychosis, schizophrenia, bipolar disorder or seizure disorder on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Rate 2: Exclude members with a diagnosis of psychosis, schizophrenia or bipolar disorder on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.	Optum Labs	NCQA