

ANALYSIS OF MEDICAID HMO

(FY2008 Appropriation Bill - Public Act 123 of 2007)

Within 30 days receipt of final report

Section 1662: (1) The department shall assure that an external quality review of each contracting HMO is performed that results in an analysis and evaluation of aggregated information on quality, timeliness, and access to health care services that the HMO or its contractors furnish to Medicaid beneficiaries. (2) The department shall provide a copy of the analysis of the Medicaid HMO annual audited health employer data and information set reports and the annual external quality review report to the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director, within 30 days of the department's receipt of the final reports from the contractors. (3) The department shall work with the Michigan association of health plans and the Michigan association for local public health to improve service delivery and coordination in the MSS/ISS and EPSDT programs. (4) The department shall assure that training and technical assistance are available for EPSDT and MSS/ISS for Medicaid health plans, local health departments, and MSS/ISS contractors.

*Michigan Department
of Community Health*



Jennifer M. Granholm, Governor
Janet Olszewski, Director

State of Michigan



Department of Community Health

**Michigan Medicaid HEDIS® 2007 Results
STATEWIDE AGGREGATE REPORT**

December 2007



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1. Executive Summary	1-1
Introduction	1-1
Key Findings and Recommendations	1-2
Summary of Results	1-7
2. How to Get the Most From This Report	2-1
Summary of Michigan Medicaid HEDIS 2007 Key Measures	2-1
Key Measure Audit Designations	2-2
Dimensions of Care	2-2
Changes to Measures	2-3
Performance Levels	2-4
Michigan Medicaid Weighted Averages	2-5
Interpreting and Using Reported Weighted Averages and Aggregate Results	2-5
Significance Testing	2-6
Calculation Methods: Administrative Versus Hybrid	2-7
Interpreting Results	2-8
Understanding Sampling Error	2-10
Health Plan Name Key	2-11
3. Pediatric Care	3-1
Introduction	3-1
Childhood Immunization Status	3-3
Adolescent Immunization Status	3-9
Well-Child Visits in the First 15 Months of Life	3-12
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	3-17
Adolescent Well-Care Visits	3-20
Appropriate Treatment for Children With Upper Respiratory Infection	3-23
Appropriate Testing for Children With Pharyngitis	3-25
Pediatric Care Findings and Recommendations	3-27
4. Women's Care	4-1
Introduction	4-1
Breast Cancer Screening	4-2
Cervical Cancer Screening	4-6
Chlamydia Screening in Women	4-9
Prenatal and Postpartum Care	4-13
Women's Care Findings and Recommendations	4-19
5. Living With Illness	5-1
Introduction	5-1
Comprehensive Diabetes Care	5-4
Use of Appropriate Medications for People With Asthma	5-24
Controlling High Blood Pressure	5-32
Medical Assistance With Smoking Cessation	5-36
Living With Illness Findings and Recommendations	5-40

6. Access to Care	6-1
Introduction	6-1
Children’s and Adolescents’ Access to Primary Care Practitioners	6-3
Adults’ Access to Preventive/Ambulatory Health Services	6-11
Access to Care Findings and Recommendations	6-15
7. HEDIS Reporting Capabilities	7-1
Key Findings	7-1
Conclusions and Recommendations	7-2
Appendix A: Tabular Results for Key Measures by Health Plan	A-1
Appendix B: National HEDIS 2006 Medicaid Percentiles	B-1
Appendix C: Trend Tables	C-1
Appendix D: Glossary	D-1

HEDIS[®] refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

NCQA HEDIS Compliance Audit[™] is a trademark of the NCQA.

CAHPS[®] refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Introduction

During 2006, the Michigan Department of Community Health (MDCH) contracted with 13 health plans to provide managed care services to 945,515 Michigan Medicaid enrollees.¹⁻¹ To evaluate performance levels, MDCH implemented a system to provide an objective, comparative review of health plan quality-of-care outcomes and performance measures. One component of the evaluation system was based on the Healthcare Effectiveness Data and Information Set (HEDIS). MDCH selected 17 HEDIS measures from the standard Medicaid HEDIS reporting set as the key measures by which to evaluate performance by the Michigan Medicaid health plans (MHPs). These 17 measures consist of 39 distinct rates.

MDCH expects its contracted health plans to support health care claims systems, membership and provider files, and hardware/software management tools that facilitate accurate and reliable reporting of HEDIS measures. MDCH has contracted with Health Services Advisory Group, Inc. (HSAG) to analyze Michigan MHP HEDIS results objectively and evaluate each MHP's current performance level relative to national Medicaid percentiles. MDCH uses HEDIS rates for the annual Medicaid consumer guide, as well as for the annual performance assessment.

Performance levels for Michigan MHPs have been established for all of the key measures. The performance levels have been set at specific, attainable rates and are based on national percentiles. This standardization allows for comparison to the performance levels. Health plans meeting the high performance level (HPL) exhibit rates among the top in the nation. The low performance level (LPL) has been set to identify health plans with the greatest need for improvement. Details are shown in Section 2, "How to Get the Most From This Report."

HSAG has examined the key measures along four different dimensions of care: (1) Pediatric Care, (2) Women's Care, (3) Living With Illness, and (4) Access to Care. These dimensions reflect important groupings and expand on the dimensions model used by the Foundation for Accountability (FACCT). This approach to the analysis is designed to encourage health plans to consider the key measures as a whole rather than in isolation, and to think about the strategic and tactical changes required to improve overall performance.

¹⁻¹ Michigan Medicaid Managed Care. *Medicaid Health Plan Enrollment Report*. July 2007.

Michigan Medicaid HEDIS results are analyzed in this report in several ways. For each of the four dimensions of care:

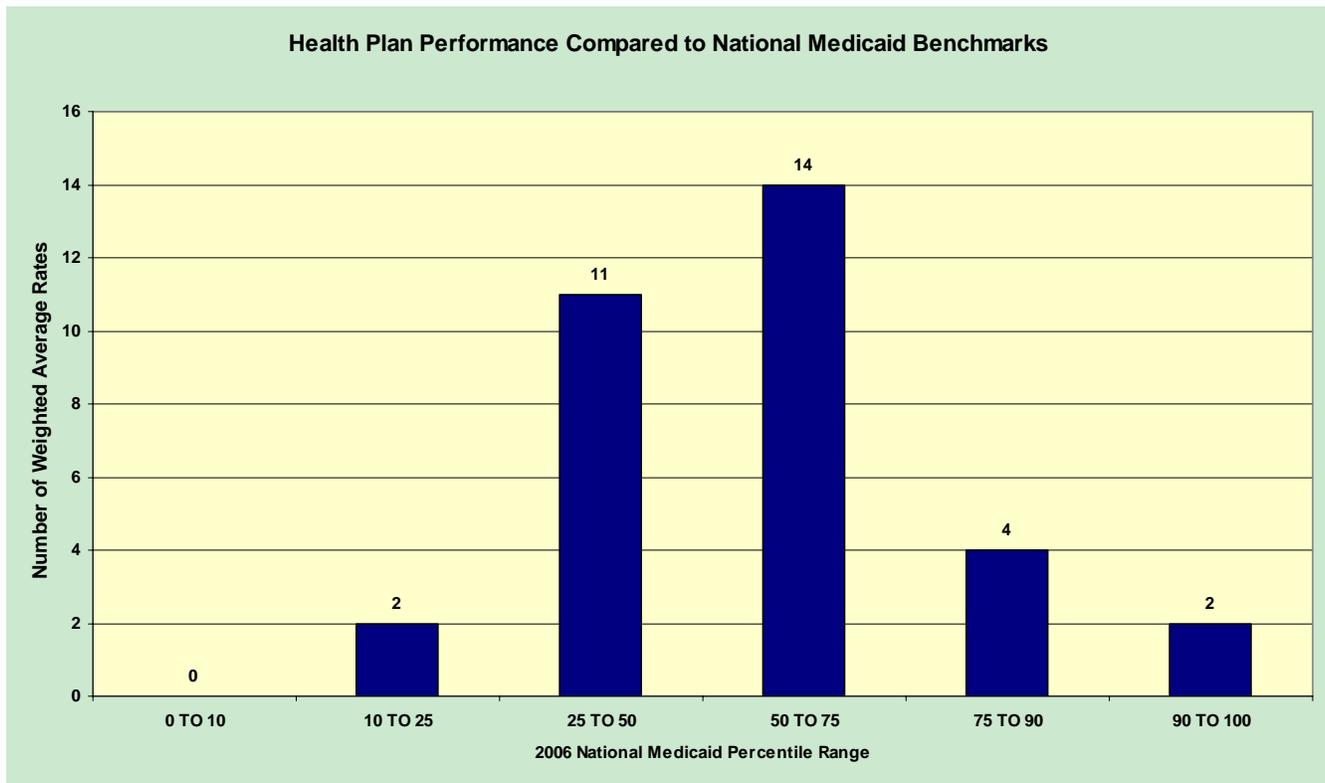
- ◆ A weighted average comparison presents the Michigan Medicaid 2007 results relative to the 2006 Michigan Medicaid weighted averages and the national HEDIS 2006 Medicaid 50th percentiles.
- ◆ A performance profile analysis discusses the overall Michigan Medicaid 2007 results and presents a summary of health plan performance relative to the Michigan Medicaid performance levels.
- ◆ A health plan ranking analysis provides a more detailed comparison, showing results relative to the Michigan Medicaid performance levels.
- ◆ A data collection analysis evaluates the potential impact of data collection methodology on reported rates.

In addition, Section 7 (“HEDIS Reporting Capabilities”) of the report provides a summary of the HEDIS data collection processes used by the Michigan MHPs and audit findings in relation to the National Committee for Quality Assurance’s (NCQA’s) information system (IS) standards.

Key Findings and Recommendations

This is the seventh year that HSAG has examined the MDCH HEDIS results, and improvement continues to be observed. Figure 1-1 shows Michigan MHP performance compared with national Medicaid percentiles. The columns represent the number of Michigan Medicaid weighted averages falling into the percentile grouping listed on the horizontal axis. Of the 33 weighted averages for which national percentile data were available, 2 (or 6 percent) fell between the national Medicaid 10th and 25th percentiles, 11 (or 33 percent) fell between the 25th and 50th percentiles, 14 (or 42 percent) fell between the 50th and 75th percentiles, four (or 12 percent) fell between the 75th and 90th percentiles, and 2 (or 6 percent) ranked above the 90th percentile. The 2007 weighted averages showed a slight downward shift in performance. In 2006, five of the rates exceeded the 90th percentile, whereas this year, only two weighted averages were in this range. It is important to note, though, that four of the five rates that exceeded the 90th percentile in 2006 were for indicators that made up the *Use of Appropriate Medication for People With Asthma* measure, which experienced significant specification changes in 2006. The rate increases, therefore, were likely not reflective of true improvement. However, a comparison between the 2007 weighted averages and the 2005 weighted averages, none of which ranked above the 90th percentile, indicates improvement. Two rates (*Comprehensive Diabetes Care—LDL-C Screening* and *Controlling High Blood Pressure—46 to 85 Years*) fell into the 10th to 25th percentile range. Changes to the 2007 HEDIS technical specifications for both of these measures may have contributed to a decline in these rates; however, changes to the *Controlling High Blood Pressure—46 to 85 Years* measure were minor and would not explain a significant drop in the rate.

**Figure 1-1—Michigan Medicaid HEDIS 2007:
Health Plan Performance Compared With National Medicaid Percentiles**



Four of the 33 weighted averages declined from last year, and two of these declines were statistically significant. The declines were seen in measures in the Living With Illness dimension: *Comprehensive Diabetes Care—LDL-C Screening* (statistically significant), *Comprehensive Diabetes Care—LDL-C Level <100*, *Use of Appropriate Medications for People With Asthma—Ages 10 to 17 Years*, and *Controlling High Blood Pressure—46 to 85 Years* (statistically significant). Both of the measures that showed statistically significant declines in their weighted averages had changes to the technical specifications in 2007 that could have contributed to the decline in rates.

Improvement was seen in the remaining 29 weighted averages, with three of these increases being statistically significant. The measures that showed statistically significant improvement were: *Childhood Immunization Status—Combination #3*, *Adolescent Immunization Status—Combination #2*, and *Comprehensive Diabetes Care—Medical Attention for Nephropathy*. There was a change to the 2007 HEDIS technical specification for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure, which may have led to an increase of 29.1 percentage points from the weighted average in 2006.

In the Pediatric Care dimension, all of the measures' rates showed improvement compared to the 2006 Michigan Medicaid weighted average, and seven of the nine measures' rates ranked better than the national HEDIS 2006 Medicaid 50th percentile. The weighted average for *Childhood Immunization Status—Combination #2* continued to perform above the HEDIS 2006 Medicaid 90th

percentile with an increase of four percentage points from 2006. While the rates for *Appropriate Treatment for Children With Upper Respiratory Infections* and *Appropriate Testing for Children With Pharyngitis* showed improvement in 2007, more than half of the health plans still performed below the national HEDIS 2006 Medicaid 50th percentile.

The performance of measures in the Women's Care dimension improved from 2006. All of the health plans showed improvement in their weighted averages; however, none of the improvements were statistically significant. The rate for *Timeliness of Prenatal Care* was slightly below the national HEDIS 2006 Medicaid 50th percentile, but only by 0.1 percentage point. The improvement efforts put forth by the MHPs in the area of Women's Care continued to show success.

The rates for measures in the Living With Illness dimension showed some declines when compared to last year. It is important to remember that the statistically significant improvement in 2006 in four of the indicators that make up the *Use of Appropriate Medications for People With Asthma* measure may have been the result of changes to the HEDIS technical specifications. Similar to last year, several of the measures in this dimension had changes to the technical specifications that may have contributed to the increases and decreases in rates. *Controlling High Blood Pressure—46 to 85 Years* saw a statistically significant decline in its rate from 2006 and should be further investigated to determine the reasons for the decline. One MHP saw a drop of nearly 20 percent in its reported rate for this measure.

All rates in the Access to Care dimension improved from 2006; however, there appears to be opportunities for improvement for children and adolescents accessing care between the ages of 25 months and 19 years of age. The MHPs should continue to work to improve access to care and investigate whether or not there are barriers related to members accessing care or if there are issues with providers submitting encounter data to the health plans for services rendered.

HSAG examined the quality improvement (QI) plans from each of the MHPs. The review found that all of the MHPs have disease management programs for diabetes and asthma, and many have programs for prenatal and postpartum care, smoking cessation, and cardiovascular disease. Several of the MHPs have or are considering adding depression and hypertension programs, as well. Overall, the MHPs focused on improving the rates of key HEDIS measures or plan to do this as part of their QI goals for 2007. The interventions included: reminder mailings or telephone calls to both providers and members for services due, incentives offered to both members and providers when services were rendered, and provider report cards and bonuses based on performance. Other interventions included: evaluation of missed opportunities, assessment of the adequacy of provider and provider specialty networks to meet the needs of their members, and identification of barriers to accessing care and barriers to members complying with appointments for preventive care.

Most of the MHPs provided educational services to members and providers, including: educational material sent to members and providers, Web-based educational information and programs, and documentation given to providers to enhance data capture of HEDIS-related codes for services provided to members.

Only a few MHPs mentioned that they evaluated assessment of data completeness. All of the MHPs should focus on this area because there may be missing service data due to capitation or claims that providers may not bother to submit if they perceive that reimbursement will be low. Any efforts to

improve the submission of encounter data could improve all of the HEDIS rates as well as reduce the burden of medical record review. The MHPs could use the hybrid rates as one method to assess missing administrative data. A comparison between the hybrid and administrative rates would identify missing encounter or claims data and would assist in identifying problem providers. The MHPs should also focus on expected claims or encounter volumes by provider type to help identify missing data.

Weighted Average Comparisons for the Four Dimensions of Care

Figure 1-2 through Figure 1-5 show Michigan Medicaid HEDIS 2007 results for each dimension of care, comparing the current weighted average for each measure relative to the 2006 Michigan Medicaid weighted average and the national HEDIS 2006 Medicaid 50th percentile.

In each figure, the following information will help the reader interpret these data:

- ◆ The light-colored bars show the difference in percentage points between this year’s Michigan results and last year’s Michigan results, comparing the 2007 and 2006 Michigan Medicaid weighted averages.
- ◆ The dark-colored bars show the difference in percentage points between this year’s Michigan results and the national results, comparing the 2007 Michigan Medicaid weighted average with the national HEDIS 2006 Medicaid 50th percentile.

For all measures (except two), a bar to the *right* indicates an *improvement* in performance and a bar to the *left* indicates a *decline* in performance.

The two exceptions are:

1. *Well-Child Visits in the First 15 Months of Life—Zero Visits*
2. *Comprehensive Diabetes Care—Poor HbA1c Control*

For these exceptions, *lower* rates (a bar to the left) indicate *better* performance.

- ◆ A weighted average for *Advising Smokers to Quit* and *Discussing Smoking Cessation Strategies* could not be calculated. National percentile data are not available for these measures.

Performance Level Analysis

Table 1-1 through Table 1-4 show performance summary results for all Michigan MHPs for each dimension of care. Results were calculated using a scoring algorithm based on individual health plan performance relative to the HPL, LPL, and the national HEDIS 2006 Medicaid 50th percentile.

For each health plan, points were summed across all measures in the dimension and then averaged by the number of measures in that dimension. Decimals of 0.5 or greater were rounded up to the next whole number. For measures that had an audit designation of *Report* with a rationale of *Not Applicable* (NA), rates were not included since the denominator was less than 30 cases.

Results are presented in this report using a star system assigned as follows:

- ◆ Three stars (★★★) for performance at or above the HPL (≥ 90 th percentile).
- ◆ Two stars (★★) for performance above the LPL but below the HPL (>25th percentile to <90th percentile).
- ◆ One star (★) for performance at or below the LPL (≤ 25 th percentile) or for *Not Report* (NR) designations.

Summary of Results

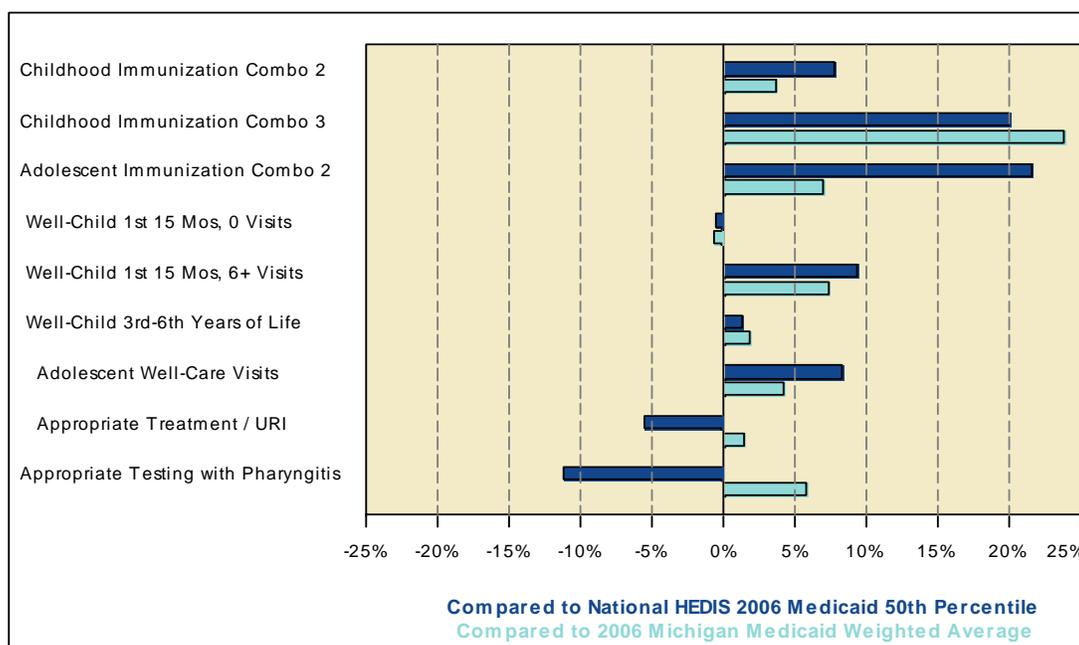
Pediatric Care

All of the Pediatric Care measures showed improvement from 2006. *Childhood Immunization Status—Combination #3* showed statistically significant improvement with an increase of 23.8 percentage points from the 2006 Michigan Medicaid weighted average. *Combo #3* was a new measure in 2006, so this was the first year that this measure was trended and compared to national performance standards. The *Adolescent Immunization Status—Combination #2* weighted average of 65.9 percent also showed statistically significant improvement over the 2006 rate. This improvement demonstrates an effort by the MHPs to capture and report complete data.

All of the well-care measures showed improvement in 2007 and all of the weighted averages performed better than the national HEDIS 2006 Medicaid 50th percentile. The *Well-Child Visits in the First 15 Months of Life—6 or More Visits* rate improved by 7.4 percentage points from 2006. All of the MHPs' rates for these measures came primarily from administrative data. The increase in administrative data rates means that the health plans have more complete data and are having to rely less on medical record review.

The rates for *Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis* improved from 2006; however, more than half of the plans continue to perform below the national HEDIS 2006 Medicaid 50th percentile for these measures. There are still many opportunities for the MHPs to improve their rates for these measures.

Figure 1-2—Michigan Medicaid HEDIS 2007 Weighted Average Comparison: Pediatric Care



Note: For *Well-Child Visits in the First 15 Months of Life—Zero Visits*, a bar to the left (lower rates) indicates better performance.

Table 1-1—Michigan Medicaid HEDIS 2007 Performance Summary: Pediatric Care

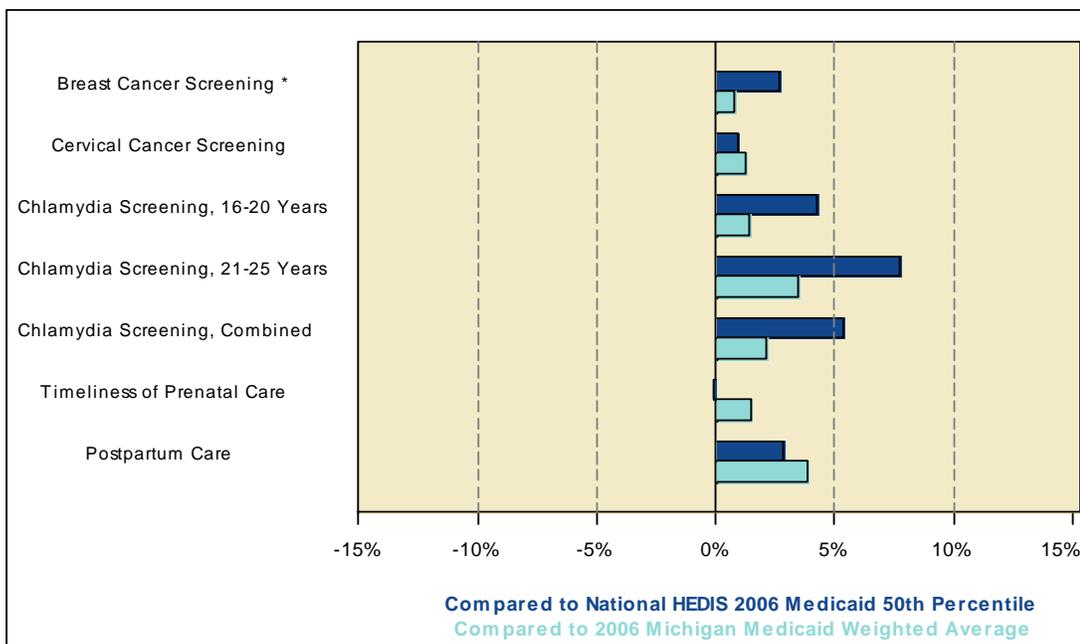
Health Plan Name	Childhood Immunization Combo 2	Childhood Immunization Combo 3	Adolescent Immunization Combo 2	Well-Child 1st 15 Mos, 0 Visits	Well-Child 1st 15 Mos, 6+ Visits	Well-Child 3rd–6th Yrs of Life	Adolescent Well-Care Visits	Appropriate Treatment URI	Children With Pharyngitis
CCM	★★	★★★	★★	★★	★	★★	★	★★	★★
GLH	★★	★★★	★★	★★★	★★★	★★	★★★	★	★★
HPM	★★★	★★★	★★★	★★	★★★	★★	★★★	★★	★★
HPP	★★★	★★★	★★★	★★	★★	★★	★★	★	★
MCD	★★	★★	★★	★★	★★	★★	★★	★★	★★★
MCL	★★	★★★	★★	★★	★★	★★	★★	★	★★
MID	★★	★★★	★★	★★	★★	★★	★★	★	★
MOL	★★	★★	★★	★★	★★	★★	★★	★★	★★
OCH	★★	★★	★★	★★	★★	★★	★★	★★	★
PMD	★★	★★★	★★★	★★	★★	★★	★★	★	★★
PRI	★★★	★★★	★★★	★★	★★	★★	★★	★★	★★
THC	★★	★★★	★★★	★★	★★	★★	★★	★	★
UPP	★★	★★★	★★★	★★	★★	★★	★★	★★	★★

This symbol		shows this performance level
3 stars	★★★	≥ HPL
2 stars	★★	> LPL and < HPL
1 star	★	≤ LPL, or for <i>Not Report (NR)</i>

Women’s Care

All seven of the Women’s Care measures’ weighted averages showed improvement compared to the 2006 results. *Timeliness of Prenatal Care* was the only measure that did not reach or exceed the national HEDIS 2006 Medicaid 50th percentile; however, it was only 0.1 percentage points shy. The administrative rates for the three hybrid measures continue to improve, minimizing the burden of medical record review.

Figure 1-3—Michigan Medicaid HEDIS 2007 Weighted Average Comparison: Women’s Care



*This measure represents the *Breast Cancer Screening—52 to 69 Years* rate.

Table 1-2—Michigan Medicaid HEDIS 2007 Performance Summary: Women’s Care

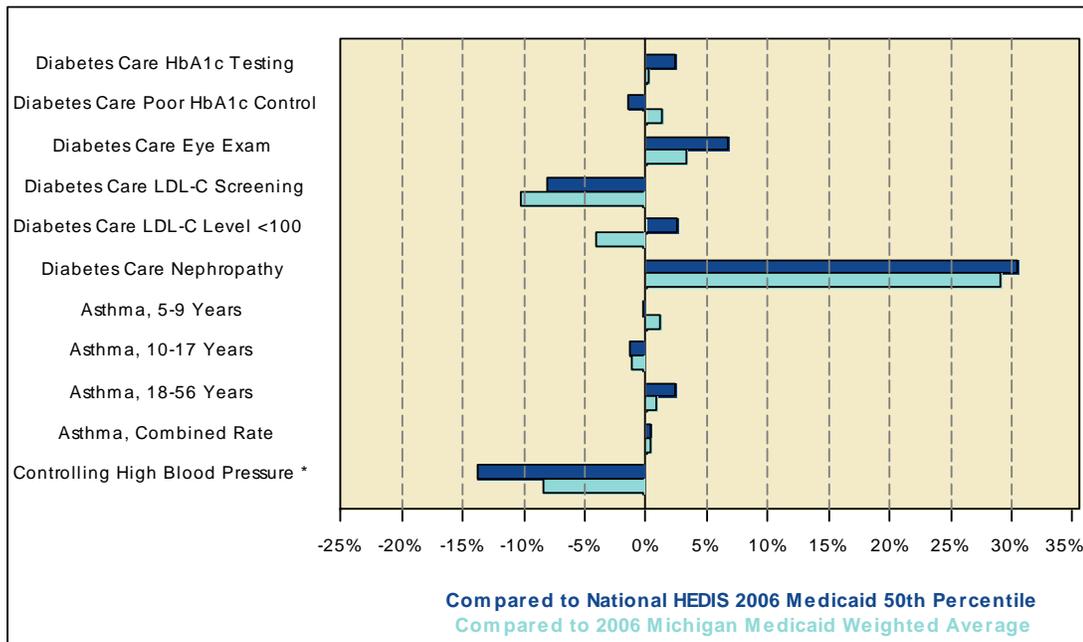
Health Plan Name	Breast Cancer Screening 52-69 Yrs	Cervical Cancer Screening	Chlamydia Screening 16-20 Yrs	Chlamydia Screening 21-25 Yrs	Chlamydia Screening Combined	Timeliness of Prenatal Care	Postpartum Care
CCM	★★	★★	★★	★★	★★	★★	★★
GLH	★★	★★	★★	★★	★★	★★	★★
HPM	★★	★★	★★	★★	★★	★★	★★
HPP	★★	★★★	★★	★★	★★	★★★	★★
MCD	★★	★★★	★★	★★	★★	★★	★★
MCL	★★	★★	★★	★★	★★	★★★	★★★
MID	★★	★★	★★	★★	★★	★★	★★
MOL	★★	★	★★	★★	★★	★	★
OCH	★★	★★	★★★	★★★	★★★	★★	★★
PMD	★★	★★	★★★	★★	★★★	★★	★★
PRI	★★	★★	★★	★★	★★	★★	★★
THC	★★	★★	★★	★★★	★★	★★	★★
UPP	★★★	★★★	★★	★★	★★	★★	★★

This symbol	shows this performance level
3 stars	★★★ ≥ HPL
2 stars	★★ > LPL and < HPL
1 star	★ ≤ LPL, or for <i>Not Report (NR)</i>

Living With Illness

Three of the measures in the Living With Illness dimension showed statistically significant changes in the 2007 weighted averages. *Comprehensive Diabetes Care—LDL-C Screening* and *Controlling High Blood Pressure—46 to 85 Years* showed significant declines, while *Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy* showed significant improvement. The significance of these changes should be considered with respect to changes made to the *HEDIS 2007 Technical Specifications* for each of these measures. Of the above mentioned measures, only *Controlling High Blood Pressure—46 to 85* had a rate that was directly comparable to the 2006 weighted average and the national performance standards, and should be looked at to determine reasons for the significant decline. Overall, performance in this area continues to offer opportunities for improvement.

Figure 1-4—Michigan Medicaid HEDIS 2007 Weighted Average Comparison: Living With Illness



Notes: For *Comprehensive Diabetes Care—Poor HbA1c Control*, a bar to the left (for lower rates) indicates better performance. *Advising Smokers to Quit* is not included in this figure. National percentile data are not available nor could a weighted average be calculated.

*This measure represents the *Controlling High Blood Pressure—46 to 85 Years* rate.

**Table 1-3—Michigan Medicaid HEDIS 2007 Performance Summary:
Living With Illness (Part 1)**

Health Plan Name	Diabetes Care HbA1c Testing	Diabetes Care Poor HbA1c Control	Diabetes Care Eye Exam	Diabetes Care LDL-C Screening	Diabetes Care LDL-C Level <100	Diabetes Care Nephropathy
CCM	★★	★★	★★	★	★★	★★★
GLH	★★	★★	★★	★★	★★	★★★
HPM	★★	★★	★★	★★	★★	★★★
HPP	★★	★★	★★★	★	★★	★★★
MCD	★★★	★★	★★	★★	★★	★★★
MCL	★★	★★	★★	★	★★	★★★
MID	★	★★	★★	★	★★	★★★
MOL	★★	★★	★★	★	★★★	★★★
OCH	★★	★★	★★	★	★★	★★★
PMD	★★	★★	★★	★★	★★	★★★
PRI	★★★	★★★	★★★	★★	★★	★★★
THC	★★	★★	★★	★	★★	★★★
UPP	★★★	★★★	★★★	★★	★★	★★★

This symbol		shows this performance level
3 stars	★★★	≥ HPL
2 stars	★★	> LPL and < HPL
1 star	★	≤ LPL, or for <i>Not Report (NR)</i>

**Table 1-3—Michigan Medicaid HEDIS 2007 Performance Summary:
Living With Illness (Part 2)**

Health Plan Name	Asthma 5-9 Yrs	Asthma 10-17 Yrs	Asthma 18-56 Yrs	Asthma Combined	Controlling High Blood Pressure 46-85 Yrs	Advising Smokers to Quit*	Discussing Smoking Cessation Strategies*
CCM	★★	★★	★★	★★	★★	NA	NA
GLH	★	★	★★	★★	★	NA	NA
HPM	★★★	★★★	★★★	★★★	★	NA	NA
HPP	★★	★★	★★	★★	★★	NA	NA
MCD	★★★	★★	★★	★★★	★★	NA	NA
MCL	★★★	★★	★★	★★	★★	NA	NA
MID	★★	★	★★	★	★	NA	NA
MOL	★	★	★★	★	★	NA	NA
OCH	★	★	★★	★	★	NA	NA
PMD	★★	★★	★★★	★★	★★	NA	NA
PRI	★★★	★★★	★★	★★★	★★	NA	NA
THC	★	★	★★	★	★	NA	NA
UPP	★★★	★★	★★	★★	★★	NA	NA

*Means and percentiles are not available for the *Advising Smokers to Quit* and *Discussing Smoking Cessation Strategies* measures.

This symbol	shows this performance level
3 stars ★★★	≥ HPL
2 stars ★★	> LPL and < HPL
1 star ★	≤ LPL, or for <i>Not Report (NR)</i>
"NA" means "Not Applicable."	

Access to Care

All of the measures in this dimension showed improvement over the 2006 Michigan Medicaid weighted averages; however, only three of the 2007 weighted averages, *Children's Access to Primary Care Practitioners—Ages 12 to 24 Months*, *Children's Access to Primary Care Practitioners—Ages 25 Months to 6 Years*, and *Adults' Access to Primary Care Practitioners—Ages 45 to 64 Years*, performed better than the national HEDIS 2006 50th percentile. There continued to be variations between the plans' performance on these measures and opportunities for improvement.

Figure 1-5—Michigan Medicaid HEDIS 2007 Weighted Average Comparison: Access to Care

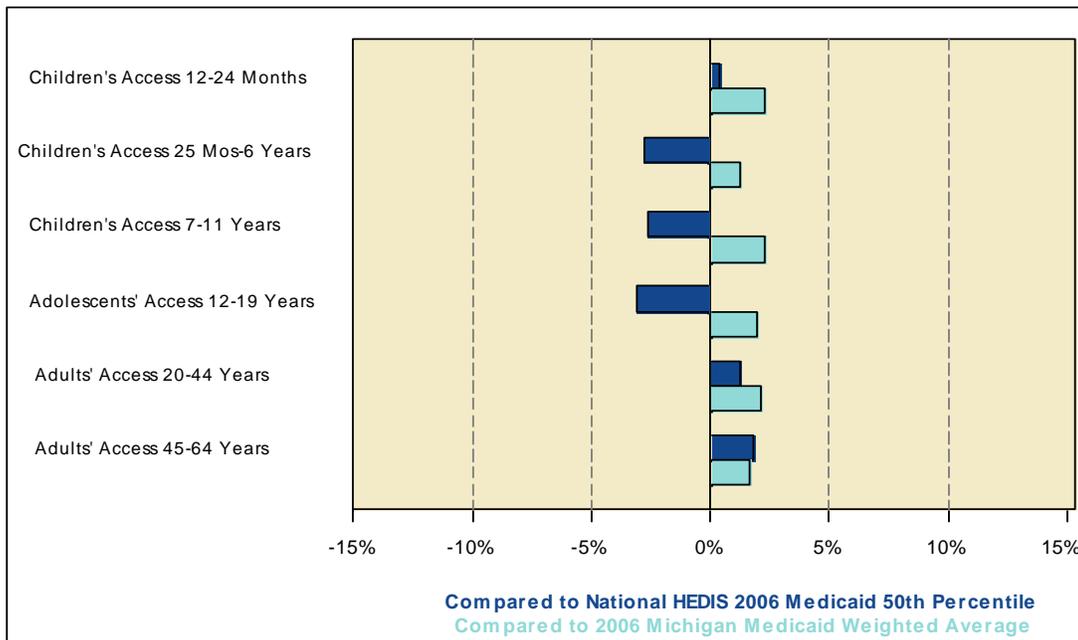


Table 1-4—Michigan Medicaid HEDIS 2007 Performance Summary: Access to Care

Health Plan Name	Children's Access 12–24 Mos	Children's Access 25 Mos–6 Yrs	Children's Access 7–11 Yrs	Adolescents' Access 12–19 Yrs	Adults' Access 20–44 Yrs	Adults' Access 45–64 Yrs
CCM	★★	★★	★★	★★	★★	★★
GLH	★★	★★	★★	★★	★★	★★
HPM	★★	★★	★★	★★	★★	★★★
HPP	★★	★★	★★	★★	★★	★★★
MCD	★★	★★	★★	★★	★★	★★
MCL	★★	★	★	★★	★★	★★
MID	★★	★★	★★	★★	★★	★★
MOL	★★	★★	★★	★★	★★	★★
OCH	★	★	★	★	★★	★★
PMD	★★	★★	★★	★★	★★	★★
PRI	★★	★★	★★	★★	★★	★★★
THC	★★	★	★	★★	★★	★★
UPP	★★	★★	★★	★★	★★★	★★★

This symbol	shows this performance level
3 stars ★★★	≥ HPL
2 stars ★★	> LPL and < HPL
1 star ★	≤ LPL, or for Not Report (NR)

2. How to Get the Most From This Report

Summary of Michigan Medicaid HEDIS 2007 Key Measures

HEDIS includes a standard set of measures that can be reported by MHPs nationwide. MDCH selected 17 HEDIS measures from the standard Medicaid set and divided them into 39 distinct rates, shown in Table 2-1. These 39 rates represent the 2007 MDCH key measures. Thirteen Michigan MHPs were required to report the key measures in 2007.

Table 2-1—Michigan Medicaid HEDIS 2007 Key Measures

Standard HEDIS 2007 Measures	2007 MDCH Key Measures
1. <i>Childhood Immunization Status</i>	1. <i>Childhood Immunization Status—Combination #2</i> 2. <i>Childhood Immunization Status—Combination #3</i>
2. <i>Adolescent Immunization Status</i>	3. <i>Adolescent Immunization Status—Combination #2</i>
3. <i>Well-Child Visits in the First 15 Months of Life</i>	4. <i>Well-Child Visits in the First 15 Months of Life—Zero Visits</i> 5. <i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>
4. <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	6. <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
5. <i>Adolescent Well-Care Visits</i>	7. <i>Adolescent Well-Care Visits</i>
6. <i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	8. <i>Appropriate Treatment for Children With Upper Respiratory Infection</i>
7. <i>Appropriate Testing for Children With Pharyngitis</i>	9. <i>Appropriate Testing for Children With Pharyngitis</i>
8. <i>Breast Cancer Screening</i>	10. <i>Breast Cancer Screening—Ages 42 to 51 Years</i> 11. <i>Breast Cancer Screening—Ages 52 to 69 Years</i> 12. <i>Breast Cancer Screening—Combined Rate</i>
9. <i>Cervical Cancer Screening</i>	13. <i>Cervical Cancer Screening</i>
10. <i>Chlamydia Screening in Women</i>	14. <i>Chlamydia Screening in Women—Ages 16 to 20 Years</i> 15. <i>Chlamydia Screening in Women—Ages 21 to 25 Years</i> 16. <i>Chlamydia Screening in Women—Combined Rate</i>
11. <i>Prenatal and Postpartum Care</i>	17. <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> 18. <i>Prenatal and Postpartum Care—Postpartum Care</i>
12. <i>Comprehensive Diabetes Care</i>	19. <i>Comprehensive Diabetes Care—HbA1c Testing</i> 20. <i>Comprehensive Diabetes Care—Poor HbA1c Control</i> 21. <i>Comprehensive Diabetes Care—Eye Exam</i> 22. <i>Comprehensive Diabetes Care—LDL-C Screening</i> 23. <i>Comprehensive Diabetes Care—LDL-C Level <100</i> 24. <i>Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy</i>
13. <i>Use of Appropriate Medications for People With Asthma</i>	25. <i>Use of Appropriate Medications for People With Asthma—Ages 5 to 9 Years</i> 26. <i>Use of Appropriate Medications for People With Asthma—Ages 10 to 17 Years</i> 27. <i>Use of Appropriate Medications for People With Asthma—Ages 18 to 56 Years</i> 28. <i>Use of Appropriate Medications for People With Asthma—Combined Rate</i>
14. <i>Controlling High Blood Pressure</i>	29. <i>Controlling High Blood Pressure—Ages 18 to 45 Years</i> 30. <i>Controlling High Blood Pressure—Ages 46 to 85 Years</i> 31. <i>Controlling High Blood Pressure—Combined</i>
15. <i>Medical Assistance With Smoking Cessation</i>	32. <i>Medical Assistance With Smoking Cessation—Advising Smokers to Quit</i> 33. <i>Medical Assistance With Smoking Cessation—Smoking Cessation Strategies</i>
16. <i>Children’s and Adolescents’ Access to Primary Care Practitioners</i>	34. <i>Children’s and Adolescents’ Access to Primary Care Practitioners—Ages 12 to 24 Months</i> 35. <i>Children’s and Adolescents’ Access to Primary Care Practitioners—Ages 25 Months to 6 Years</i> 36. <i>Children’s and Adolescents’ Access to Primary Care Practitioners—Ages 7 to 11 Years</i> 37. <i>Children’s and Adolescents’ Access to Primary Care Practitioners—Ages 12 to 19 Years</i>
17. <i>Adults’ Access to Preventive/Ambulatory Health Services</i>	38. <i>Adults’ Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years</i> 39. <i>Adults’ Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years</i>

Key Measure Audit Designations

Through the audit process, each measure reported by a health plan is assigned an NCQA-defined audit finding. Measures can receive one of four predefined audit findings: *Report*, *Not Applicable*, *Not Report*, and *No Benefit*. An audit finding of *Report* indicates that the health plan complied with all HEDIS specifications to produce an unbiased, reportable rate or rates, which can be released for public reporting. Although a health plan may have complied with all applicable specifications, the denominator identified may be considered too small to report a rate (i.e., less than 30). The measure would have been assigned a *Not Applicable* audit finding. An audit finding of *Not Report* indicates that the rate could not be publicly reported because the measure deviated from HEDIS specifications such that the reported rate was significantly biased or an MHP chose not to report the measure. A *No Benefit* audit finding indicates that the MHP did not offer the benefit required by the measure.

It should be noted that NCQA allows health plans to “rotate” HEDIS measures in some circumstances. A “rotation” schedule enables health plans to use the audited and reportable rates from the prior year. This strategy allows health plans with higher rates for some measures to expend resources toward improving rates for other measures. Rotated measures must have been audited in the prior year and must have received a *Report* audit designation. Only hybrid measures are eligible to be rotated.

The health plans that met the HEDIS criteria for hybrid measure rotation could choose to exercise that option. Five health plans chose to rotate measures in 2007, and a total of 12 rates were rotated. Following NCQA methodology, rotated measures were assigned the same reported rates from 2006 and were included in the calculations for the Michigan Medicaid weighted averages.

Dimensions of Care

HSAG has examined four different dimensions of care for Michigan Medicaid members: Pediatric Care, Women’s Care, Living With Illness, and Access to Care. These dimensions reflect important groupings similar to the dimensions model used by the FACCT. This approach to the analysis is designed to encourage health plans to consider the key measures as a whole rather than in isolation, and to think about the strategic and tactical changes required to improve overall performance.

Changes to Measures

For the 2007 HEDIS reporting year, NCQA made a few modifications to some of the measures included in this report, which may impact trending patterns.

Breast Cancer Screening

- ◆ Decreased the lower age limit to women 42 years of age.
- ◆ Reported the measure in three age bands (42 to 51 years of age, 52 to 69 years of age, and combined).

Cervical Cancer Screening

- ◆ Raised the lower age limit to 21 years of age.

Comprehensive Diabetes Care

- ◆ Retired the *LDL-C control <130 mg/dL* indicator.
- ◆ Added a new indicator, *HbA1c Good Control (<7.0 percent)*.
- ◆ Added two new indicators, *Blood Pressure Control <130/80 mm Hg* and *<140/90 mm Hg*.
- ◆ Restricted the LDL-C screening and control criteria to require testing during the measurement year.
- ◆ Added the use of angiotensin converting enzyme (ACE) inhibitors/angiotensin receptor blockers (ARBs) as numerator compliant for medical attention for nephropathy.

Controlling High Blood Pressure

- ◆ Decreased the lower age limit to 18 years of age.
- ◆ Reported the measure in three age bands (18 to 45 years of age, 46 to 85 years of age, and combined).
- ◆ Changed adequately controlled blood pressure from $\leq 140/90$ to $< 140/90$.
- ◆ Changed the methodology for determining representative blood pressure (BP). The lowest BP is used as the representative BP regardless of posture.
- ◆ Clarified that the lowest systolic and lowest diastolic values can be used to fulfill the numerator criteria for the representative BP.

Performance Levels

The purpose of identifying performance levels is to compare the quality of services provided to Michigan Medicaid managed care beneficiaries to national percentiles and ultimately improve the Michigan Medicaid average for all of the key measures. The HPL represents current high performance in national Medicaid managed care, and the LPL represents below-average performance nationally. Health plans should focus their efforts on reaching and/or maintaining the HPL for each key measure, rather than comparing themselves to other Michigan MHPs.

Comparative information in this report is based on the national NCQA Medicaid HEDIS 2006 percentiles, which are the most recent data available from NCQA. For this report, HEDIS rates were calculated to the sixth decimal place. The results displayed in this report were rounded to the first decimal place to be consistent with the display of national percentiles. There are some instances in which the rounded rate may appear the same; however, the more precise rates are not identical. In these instances, the hierarchy of the scores in the graphs is displayed in the correct order. For example, Figure 3-1 shows a rate that looks identical to the national 50th percentile (72.4 percent). This health plan had an actual rate of 72.39, which is slightly lower than the 72.4 percent.

For most key measures included in this report, the 90th percentile indicates the HPL, the 25th percentile represents the LPL, and average performance falls between the LPL and the HPL. This means that Michigan MHPs with reported rates above the 90th percentile (HPL) rank in the top 10 percent of all MHPs nationally. Similarly, health plans reporting rates below the 25th percentile (LPL) rank in the bottom 25 percent nationally for that measure.

There are two key measures for which this differs—i.e., the 10th percentile (rather than the 90th) shows excellent performance, and the 75th percentile (rather than the 25th) shows below-average performance—because for these two measures only, *lower* rates indicate better performance. The two measures are:

- ◆ *Well-Child Visits in the First 15 Months of Life—Zero Visits*, for which the *lower* rates of no visits indicate *better* care.
- ◆ *Comprehensive Diabetes Care—Poor HbA1c Control*, for which the *lower* rates of poor control indicate *better* care.

NCQA does not published national percentiles (90th, 50th, and 25th percentiles) for *Medical Assistance With Smoking Cessation—Advising Smokers to Quit* and *Medical Assistance With Smoking Cessation—Smoking Cessation Strategies*. Given the lack of performance data, no HPL or LPL has been established for these key measures. Instead, health plan results are ranked highest to lowest and are compared with the 2006 Michigan Medicaid weighted average.

This report identifies and specifies the number of Michigan MHPs with HPL, LPL, and average performance levels.

Performance Trend Analysis

In Appendix C, the column titled “2006–2007 Health Plan Trend” shows, by key measure, the comparison between the 2006 results and the 2007 results for each health plan. Trends are shown graphically, using the key below:

-  Denotes a significant improvement in performance (the rate has increased more than 10 percentage points)
-  Denotes no significant change in performance (the rate has not changed more than 10 percentage points, which is considered within the margin of error)
-  Denotes a significant decline in performance (the rate has decreased more than 10 percentage points)

Different symbols ( ) are used to indicate a significant performance change for two key measures. For only these two key measures (*Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Comprehensive Diabetes Care—Poor HbA1c Control*), a decrease in the rate indicates better performance. A downward-pointing triangle () denotes a significant *decline* in performance, as indicated by an *increase* in the rate of more than 10 percentage points. An upward-pointing triangle () denotes a significant *improvement* in performance, as indicated by a *decrease* in the rate of more than 10 percentage points.

Michigan Medicaid Weighted Averages

The principal measure of overall Michigan Medicaid managed care performance on a given key measure is the *weighted* average rate. The use of a weighted average, based on a health plan’s eligible population for that measure, provides the most representative rate for the overall Michigan Medicaid population. Weighting the rate by a health plan’s eligible population size ensures that rates for a health plan with 125,000 members, for example, have a greater impact on the overall Michigan Medicaid rate than do the rates for a health plan with only 10,000 members.

Interpreting and Using Reported Weighted Averages and Aggregate Results

The 2007 Michigan Medicaid weighted average was computed by HSAG based on the reported rates and weighted by the reported eligible population size for that measure. This is a better estimate of care for all of Michigan’s Medicaid enrollees, rather than the average performance of Michigan MHPs.

The 2007 Michigan Medicaid aggregate results, which illustrate how much of the final rate is derived from administrative data and how much from medical record review, is not an average. It is the sum of all numerator events divided by the sum of all the denominators across all the reporting health plans for a given measure.

Example

For example, three health plans in a given state reported the following for a particular measure:

- ◆ Health Plan A used the administrative method and had 6,000 numerator events out of 10,000 members in the denominator (60 percent).
- ◆ Health Plan B also used the administrative method and found 5,000 numerator events out of 15,000 members (33 percent).
- ◆ Health Plan C used the hybrid methodology and had 8,000 numerator events (1,000 of which came from medical record abstraction) and had 16,000 members in the denominator (50 percent).
- ◆ There are a total of 41,000 members across health plans.
- ◆ There are 19,000 numerator events across health plans, 18,000 from administrative data, and 1,000 from medical record abstraction.
- ◆ The rates are as follows:
 - The overall aggregate rate is 46 percent (or 19,000/41,000).
 - The administrative aggregate rate is 44 percent (or 18,000/41,000).
 - The medical review rate is 2 percent (or 1,000/41,000).

Significance Testing

In this report, differences between the 2006 and 2007 Michigan Medicaid weighted averages have been analyzed using a t-test to determine if the change was statistically significant. The t-test evaluates the differences between the mean values of two groups relative to the variability of the distribution of the scores. The t-value generated is used to judge how likely it is that the difference is real and not the result of chance.

To determine the significance for this report, a risk level of 0.05 was selected. This risk level, or alpha level, means that 5 times out of 100 we may find a statistically significant difference between the mean values, even if none actually existed (that is, it happened “by chance”). All comparisons between the 2006 and 2007 Michigan Medicaid weighted averages reported as statistically significant in this report are significant at the 0.05 level.

Calculation Methods: Administrative Versus Hybrid

Administrative Method

The administrative method requires health plans to identify the eligible population (i.e., the denominator) using administrative data derived from claims and encounters (i.e., statistical claims). In addition, the numerator(s), or services provided to the members in the eligible population, are derived solely from administrative data. Medical records cannot be used to retrieve information. When using the administrative method, the entire eligible population becomes the denominator, and sampling is not allowed. There are measures in each of the four dimensions of care in which HEDIS methodology requires that the rates be derived using only the administrative method. Medical record review is not permitted. These are:

- ◆ *Appropriate Treatment for Children With Upper Respiratory Infection*
- ◆ *Appropriate Testing for Children With Pharyngitis*
- ◆ *Breast Cancer Screening*
- ◆ *Chlamydia Screening in Women*
- ◆ *Use of Appropriate Medications for People With Asthma*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners*
- ◆ *Adults' Access to Preventive/Ambulatory Health Services*

The administrative method is cost-efficient, but it can produce lower rates due to incomplete data submission by capitated providers.

Hybrid Method

The hybrid method requires health plans to identify the eligible population using administrative data and then extract a systematic sample of members from the eligible population, which becomes the denominator. Administrative data are used to identify services provided to those members. Medical records must then be reviewed for those members who do not have evidence of a service being provided using administrative data.

The hybrid method generally produces higher results but is considerably more labor-intensive. For example, a health plan has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure. The health plan chooses to perform the hybrid method. After randomly selecting 411 eligible members, the health plan finds that 161 members had evidence of a postpartum visit using administrative data. The health plan then obtains and reviews medical records for the 250 members who did not have evidence of a postpartum visit using administrative data. Of those 250 members, 54 were found to have a postpartum visit recorded in the medical record. The final rate for this measure, using the hybrid method, would, therefore, be $(161 + 54)/411$, or 52 percent.

In contrast, using the administrative method, if the health plan finds that 4,000 members out of the 10,000 had evidence of a postpartum visit using only administrative data, the final rate for this measure would be $4,000/10,000$, or 40 percent.

Interpreting Results

As expected, HEDIS results can differ to a greater or lesser extent among health plans and even across measures for the same health plan.

Four questions should be asked when examining these data:

1. How accurate are the results?
2. How do Michigan Medicaid rates compare to national percentiles?
3. How are Michigan MHPs performing overall?
4. Can the health plans do a better job calculating the measures?

The following paragraphs address these questions and explain the methods used in this report to present the results for clear, easy, and accurate interpretation.

1. How accurate are the results?

All Michigan MHPs are required by MDCH to have their HEDIS results confirmed by an NCQA HEDIS Compliance Audit. As a result, any rate included in this report has been verified as an unbiased estimate of the measure. The NCQA HEDIS protocol is designed so that the hybrid method produces results with a sampling error of ± 5 percent at a 95 percent confidence level.

How sampling error affects the accuracy of results is best explained using an example. Suppose a health plan uses the hybrid method to derive a *Postpartum Care* rate of 52 percent. Because of sampling error, the true rate is actually ± 5 percent of this rate—somewhere between 47 percent and 57 percent at a 95 percent confidence level. If the target is a rate of 55 percent, it cannot be said with certainty whether the true rate between 47 percent and 57 percent meets or does not meet the target level.

To prevent such ambiguity, this report uses a standardized methodology that requires the reported rate to be at or above the threshold level to be considered as meeting the target. For internal purposes, health plans should understand and consider the issue of sampling error when implementing interventions.

2. How do Michigan Medicaid rates compare to national percentiles?

For each measure, a health plan ranking presents the reported rate in order from highest to lowest, with bars representing the established HPL, LPL, and the national HEDIS 2006 Medicaid 50th percentile. In addition, the 2007, 2006, and 2005 Michigan Medicaid weighted averages are presented for comparison purposes.

Michigan MHPs with reported rates above the 90th percentile (HPL) rank in the top 10 percent of all MHPs nationally. Similarly, health plans reporting rates below the 25th percentile (LPL) rank in the bottom 25 percent nationally for that measure.

3. How are Michigan MHPs performing overall?

For each dimension, a performance profile analysis compares the 2007 Michigan Medicaid weighted average for each rate with the 2006 and 2005 Michigan Medicaid weighted averages and the national HEDIS 2006 Medicaid 50th percentile.

4. Can the health plans do a better job calculating the measures?

For each rate, a data collection analysis shows the number of health plans using each methodology (hybrid or administrative). The proportion of each reported rate resulting from administrative data and the proportion resulting from medical record review are displayed in a stacked bar, except for measures reported administrative-only. Columns to the right of the stacked bar show precisely how much of the final rate was derived from the administrative method and how much from medical record review. Because of rounding differences, the sum of the administrative rate and the medical record review rate may not always be exactly equal to the final rate.

The Michigan 2007 aggregate bar represents the sum of all administrative events and medical record review events for all members in the statewide denominator, regardless of the data collection methodology used.

In addition, Section 7 of this report discusses HEDIS reporting capabilities of the Michigan MHPs.

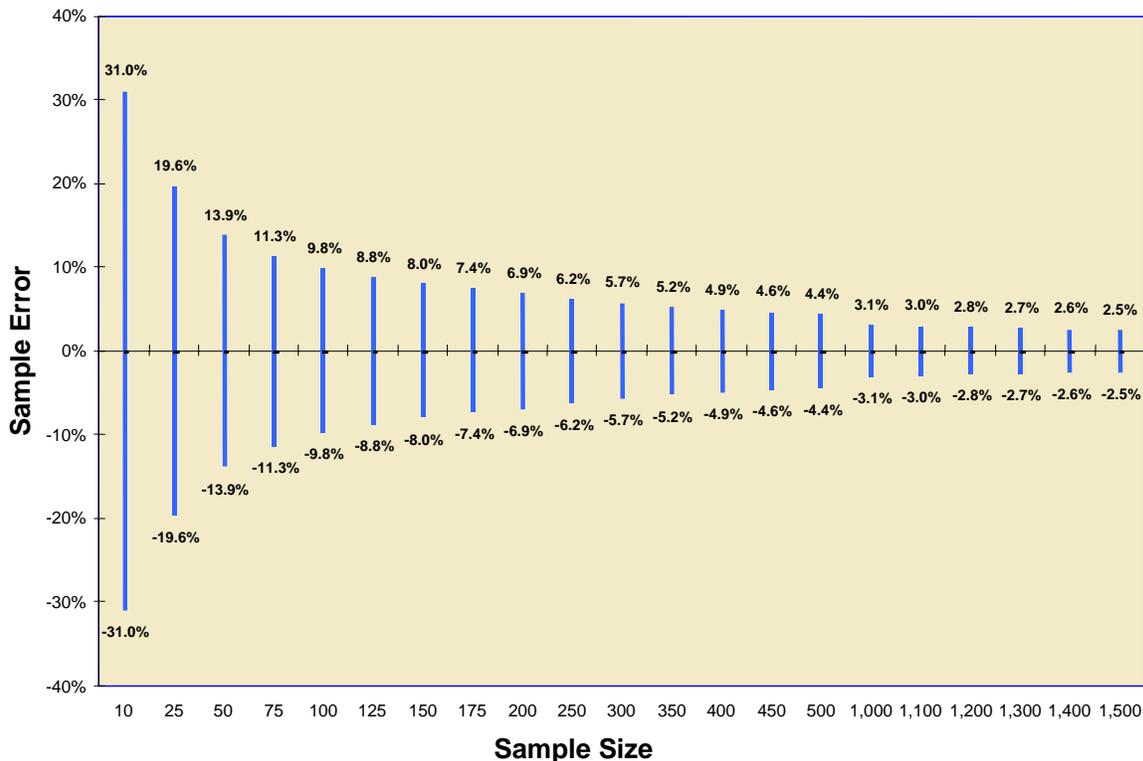
Understanding Sampling Error

Correct interpretation of results for measures collected using the HEDIS hybrid methodology requires an understanding of sampling error. It is rarely possible, logistically or financially, to do medical record review for the entire eligible population for a given measure. Measures collected using the HEDIS hybrid method include only a sample from the population, and statistical techniques are used to maximize the probability that the sample results reflect the experience of the entire eligible population.

For results to be generalized to the entire population, the process of sample selection must be such that everyone in the eligible population has an equal chance of being selected. The HEDIS hybrid method prescribes a systematic sampling process for selecting at least 411 members of the eligible population. Health plans may use a 5 percent, 10 percent, 15 percent, or 20 percent oversample to replace invalid cases (e.g., a male selected for *Postpartum Care*).

Figure 2-1 shows that if 411 health plan members are included in a measure, the margin of error is approximately ± 4.9 percentage points. Note that the data in this figure are based on the assumption that the size of the eligible population is greater than 2,000. The smaller the number included in the measure, the larger the sampling error.

Figure 2-1—Relationship of Sample Size to Sample Error



As Figure 2-1 shows, sample error gets smaller as the sample size gets larger. Consequently, when sample sizes are very large and sampling errors are very small, almost any difference is statistically significant. This does not mean that all such differences are important. On the other hand, the difference between two measured rates may not be statistically significant, but may, nevertheless, be important. The judgment of the reviewer is always a requisite for meaningful data interpretation.

Health Plan Name Key

Figures in the following sections of the report show overall health plan performance for each of the key measures. Below is the name key for each of the health plan abbreviations used in the figures.

Table 2-2—2007 Michigan MHPs	
Code	Health Plan Name
CCM	Community Choice Michigan
GLH	Great Lakes Health Plan
HPM	Health Plan of Michigan, Inc.
HPP	HealthPlus Partners, Inc.
MCD	M-CAID
MCL	McLaren Health Plan
MID	Midwest Health Plan
MOL	Molina Healthcare of Michigan
OCH	OmniCare Health Plan
PMD	Physicians Health Plan of Mid-Michigan Family Care
PRI	Priority Health Government Programs, Inc.
THC	Total Health Care, Inc.
UPP	Upper Peninsula Health Plan

Introduction

Pediatric primary health care is a vital part of the effort to prevent, recognize, and treat health conditions that can result in significant developmental consequences for children and adolescents. Timely immunizations and health checkups are particularly important for young children. Failure to detect problems with growth, hearing, and vision in toddlers may adversely impact future abilities and experiences. Early detection of developmental issues gives health care professionals the best opportunity to intervene and provide children with the chance to grow and learn without health-related limitations.

The Michigan Care Improvement Registry (MCIR) gives health care providers access to immunization records and allows them to more effectively identify children who are behind in their immunizations. All health care providers in the State of Michigan who provide immunization services to children born after December 31, 1993 are required to report each immunization to the registry. Since 1996, the electronic database has grown to include more than 50 million vaccinations provided to 4.2 million people. According to MCIR, 100 percent of the 45 local health departments and 80 percent of 2,500 registered private provider sites reported immunization data in 2004.³⁻¹ Increased provider participation has helped to identify major barriers to infant and childhood immunizations, including missed opportunities to administer vaccines. In 2005, MCIR began partnering with the Michigan Department of Education to document student immunizations and track compliance rates for children registered in Michigan public schools.

Inappropriate use of antibiotic therapies is another issue that continues to require attention in the area of pediatric primary health care. Antimicrobial resistance has become a common clinical problem, and a significant public health concern. The Institute of Medicine has identified antibiotic resistance as one of the key microbial threats to health in the United States, and has focused on promoting appropriate use of antimicrobials as a primary means to address this threat. The Centers for Disease Control and Prevention (CDC) has also cited antimicrobial resistance as one of its top concerns. The CDC's Get Smart: Know When Antibiotics Work campaign aims to reduce the rising rate of antibiotic resistance by targeting the five respiratory conditions that in 1992 accounted for more than 75 percent of all office-based prescribing for all ages combined: otitis media, sinusitis, pharyngitis, bronchitis, and the common cold. Although antibiotic prescribing rates have decreased, the CDC notes that patients of all ages are prescribed more than 10 million courses of antibiotics annually for viral conditions that do not benefit from antibiotics.³⁻²

The Appropriate Treatment for Children With Upper Respiratory Infection and Appropriate Testing for Children With Pharyngitis measures collect data on overuse of antibiotics for children diagnosed with either an upper respiratory infection or pharyngitis.

³⁻¹ Michigan Care Improvement Registry. Available at: <http://www.mcir.org/accomplishments.html>. Accessed on: July 17, 2007.

³⁻² Centers for Disease Control and Prevention, Department of Health and Human Services. *GET SMART: Know When Antibiotics Work*. Available at: http://www.cdc.gov/drugresistance/community/campaign_info.htm#3. Accessed on: July 25, 2007.

The following pages provide detailed analysis of the Michigan MHPs' performance, ranking, and the data collection methodology used for these measures.

The Pediatric Care dimension encompasses the following MDCH key measures:

- ◆ **Childhood Immunization Status**
 - *Childhood Immunization Status—Combination #2*
 - *Childhood Immunization Status—Combination #3*
- ◆ **Adolescent Immunization Status**
 - *Adolescent Immunization Status—Combination #2*
- ◆ **Well-Care Visits**
 - *Well-Child Visits in the First 15 Months of Life—Zero Visits*
 - *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
 - *Adolescent Well-Care Visits*
- ◆ **Appropriate Treatment for Children With Upper Respiratory Infection**
 - *Appropriate Treatment for Children With Upper Respiratory Infection*
- ◆ **Appropriate Testing for Children With Pharyngitis**
 - *Appropriate Testing for Children With Pharyngitis*

Childhood Immunization Status

Childhood vaccination has led to dramatic declines in many life-threatening diseases such as polio, tetanus, whooping cough, mumps, measles, and meningitis over the last 50 years. However, 20 percent of 2-year-olds in the United States have not received one or more of the recommended vaccinations. The importance of immunizations goes beyond decreasing the burden of disease. In addition to reducing disease incidence, immunizations also save on medical costs. Immunizations of DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine); Hib (Haemophilus influenzae type b vaccine); IPV (inactivated poliovirus vaccine); MMR (measles, mumps, and rubella vaccine); hepatitis B; and VZV (varicella-zoster virus [chicken pox] vaccine) save \$9.9 billion in direct medical costs and \$43.3 billion in indirect costs.³⁻³

In Michigan, 89 percent of children 6 years of age or younger have two or more doses recorded in the MCIR; the national average for registries is 49 percent.³⁻⁴ Michigan's progress in terms of increasing immunization rates has been significant over the past several years. According to National Immunization Survey results, the State of Michigan has gone from ranking lowest in the country in 1994 to having the ninth-highest rates.³⁻⁵ In addition, according to NCQA's *The State of Managed Care Quality, 2006* report, for its Medicaid population Michigan was the top-performing state on the *Childhood Immunization Status—Hepatitis B and Combination #2* measures.³⁻⁶

Key measures in this section include:

- ◆ *Childhood Immunization Status—Combination #2*
- ◆ *Childhood Immunization Status—Combination #3*

These key measures are also commonly referred to as *Combo #2* and *Combo #3*.

HEDIS Specification: Childhood Immunization Status—Combination #2

Childhood Immunization Status—Combination #2 calculates the percentage of enrolled children who turned 2 years of age during the measurement year, who were continuously enrolled for 12 months immediately preceding their second birthdays, and who were identified as having four DTaP/DT, three IPV, one MMR, three Hib, three hepatitis B, and one VZV vaccination on or before the child's second birthday.

³⁻³ National Committee for Quality Assurance. *The State of Managed Care Quality 2006*. Standard Version. Washington, DC: National Committee for Quality Assurance: 2006.

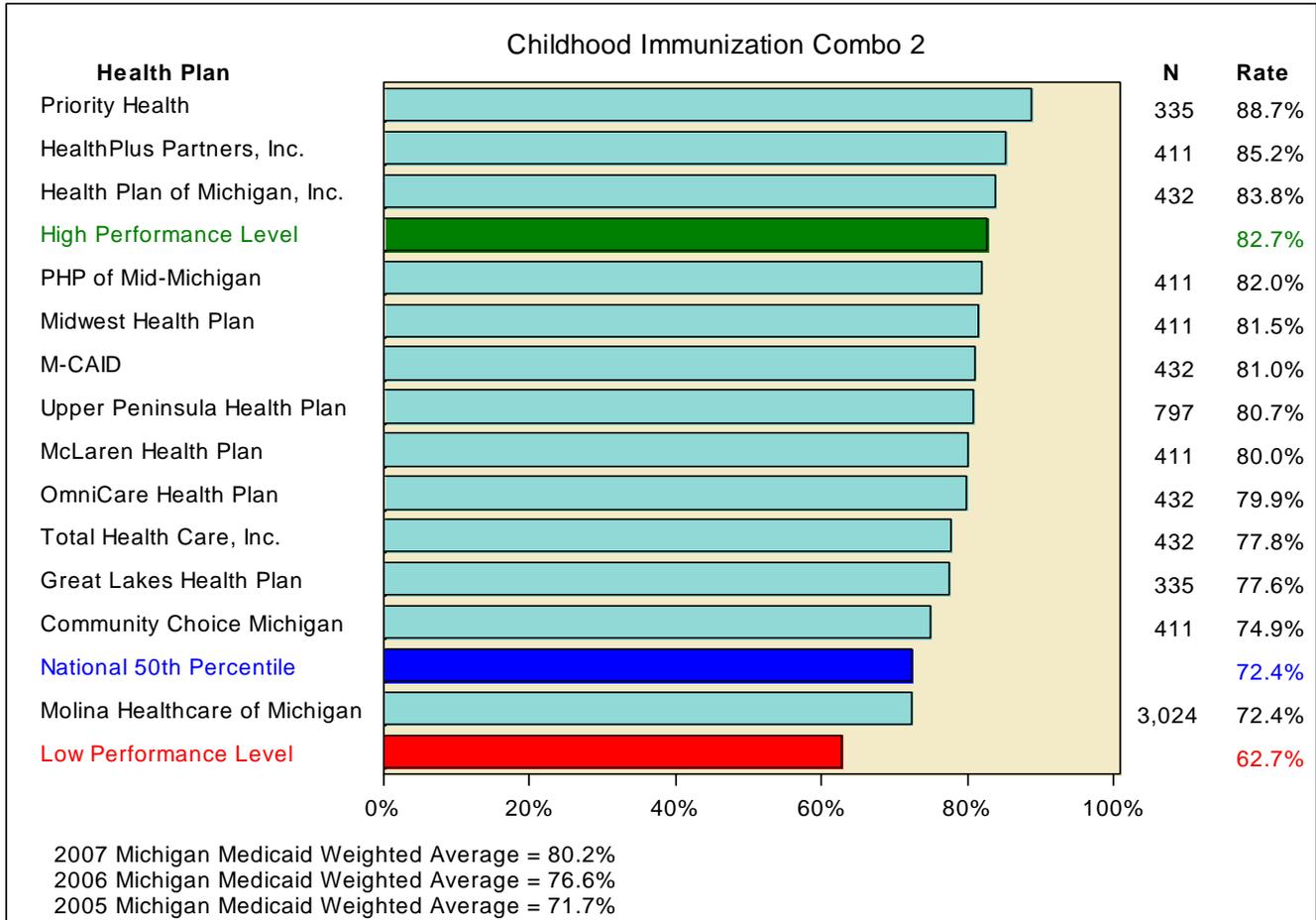
³⁻⁴ Michigan Public Health Institute. *Information for Providers: Accomplishments*. 2001 Michigan Childhood Immunization Registry. Available at: <http://www.mcir.org/accomplishments.html>. Accessed on: July 27, 2007.

³⁻⁵ Michigan Department of Community Health. *Critical Health Indicators: Childhood Immunizations*. Available at: http://www.michigan.gov/documents/mdch/32_ChldImmun_198933_7.pdf. Accessed on: July 27, 2007.

³⁻⁶ National Committee for Quality Assurance. *The State of Managed Care Quality 2006*. Standard Version. Washington, DC: National Committee for Quality Assurance: 2006.

Health Plan Ranking: Childhood Immunization Status—Combination #2

**Figure 3-1—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Childhood Immunization Status—Combination #2**

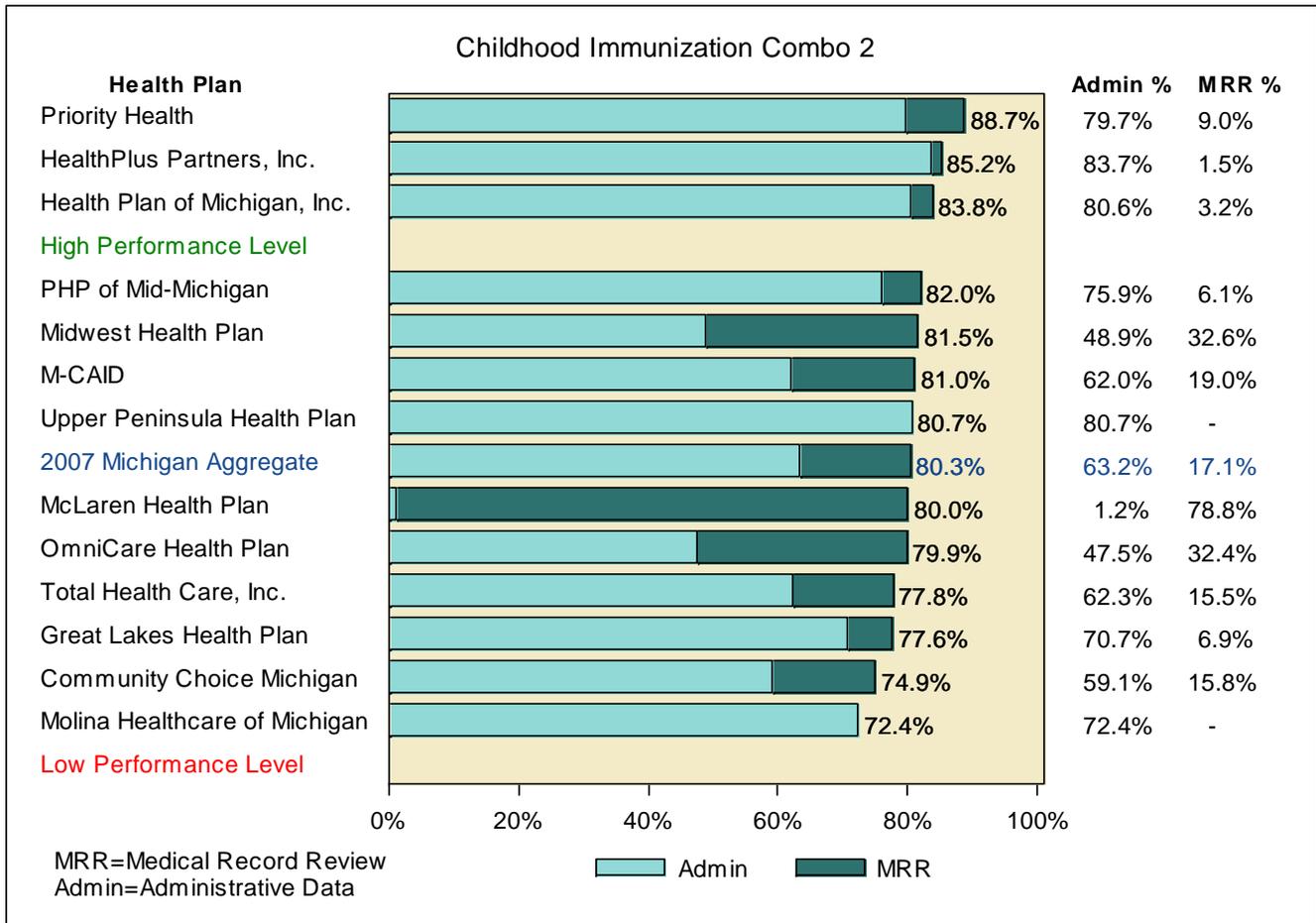


Twelve out of 13 health plans reported rates above the national HEDIS 2006 Medicaid 50th percentile. Three health plans exceeded the HPL of 82.7 percent and one health plan reported a rate nearly equal to the national HEDIS 2006 Medicaid 50th percentile rate of 72.4 percent.

The 2007 Michigan Medicaid weighted average increased by 3.6 percentage points over the 2006 Michigan Medicaid weighted average of 76.6 percent. The range of reported rates showed minimal improvement from 2006 to 2007.

Data Collection Analysis: Childhood Immunization Status—Combination #2

**Figure 3-2—Michigan Medicaid HEDIS 2007
Data Collection Analysis:
Childhood Immunization Status—Combination #2**



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much was from medical record review (MRR). Note: Because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

Eleven of the 13 health plans elected to use the hybrid method for this measure. The 2007 Michigan aggregate administrative rate was 63.2 percent and the medical record review rate was 17.1 percent.

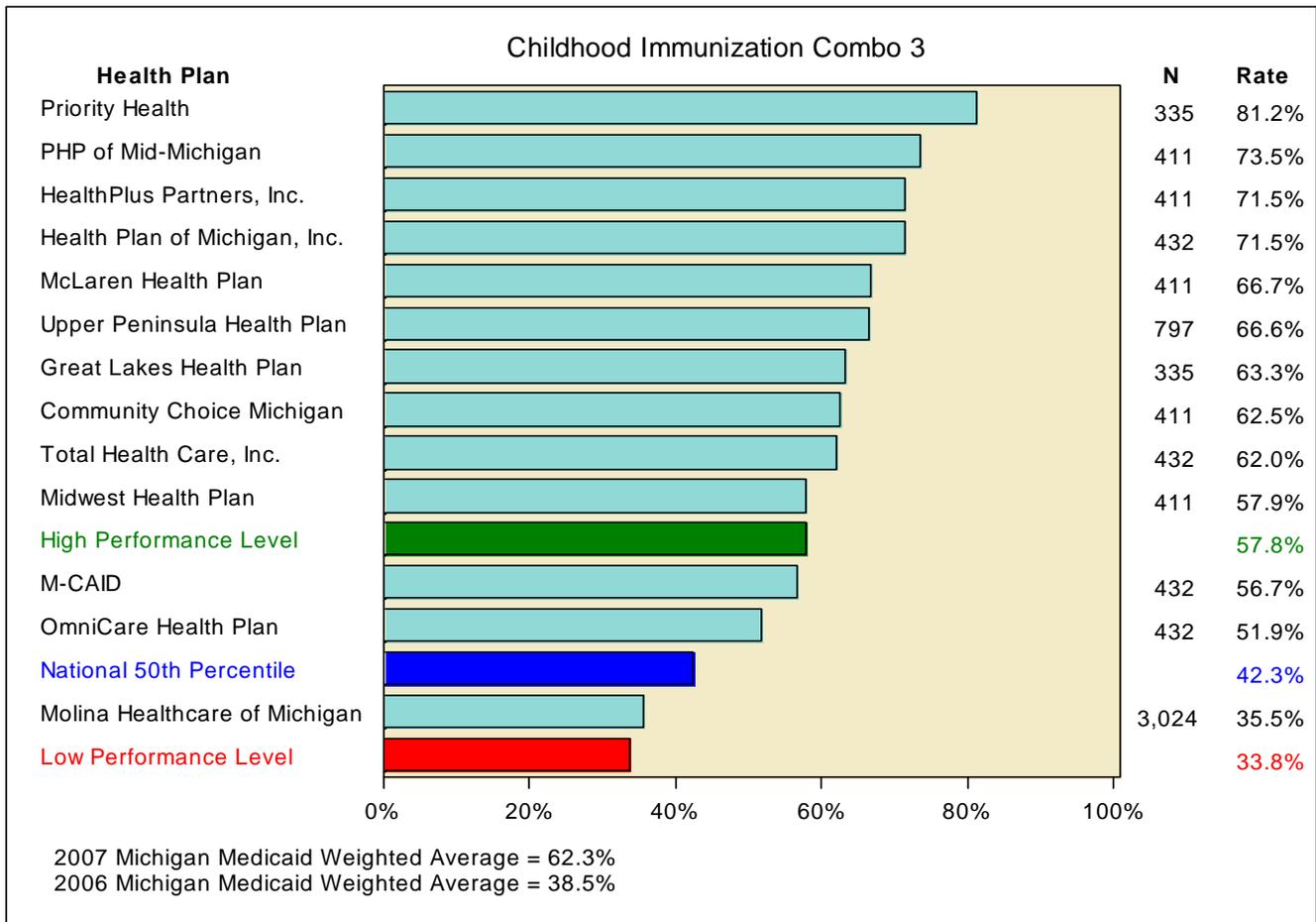
One health plan derived only 1.2 percent of the rate from administrative data, while 10 of the other plans derived more than half of their rates from administrative data.

HEDIS Specification: Childhood Immunization Status—Combination #3

Childhood Immunization Status—Combination #3 calculates the percentage of enrolled children who turned 2 years of age during the measurement year, who were continuously enrolled for 12 months immediately preceding their second birthdays, and who were identified as having four DTaP/DT, three IPV, one MMR, three Hib, three hepatitis B, one VZV, and four pneumococcal conjugate vaccinations, on or before the child's second birthday.

Health Plan Ranking: Childhood Immunization Status—Combination #3

**Figure 3-3—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Childhood Immunization Status—Combination #3**



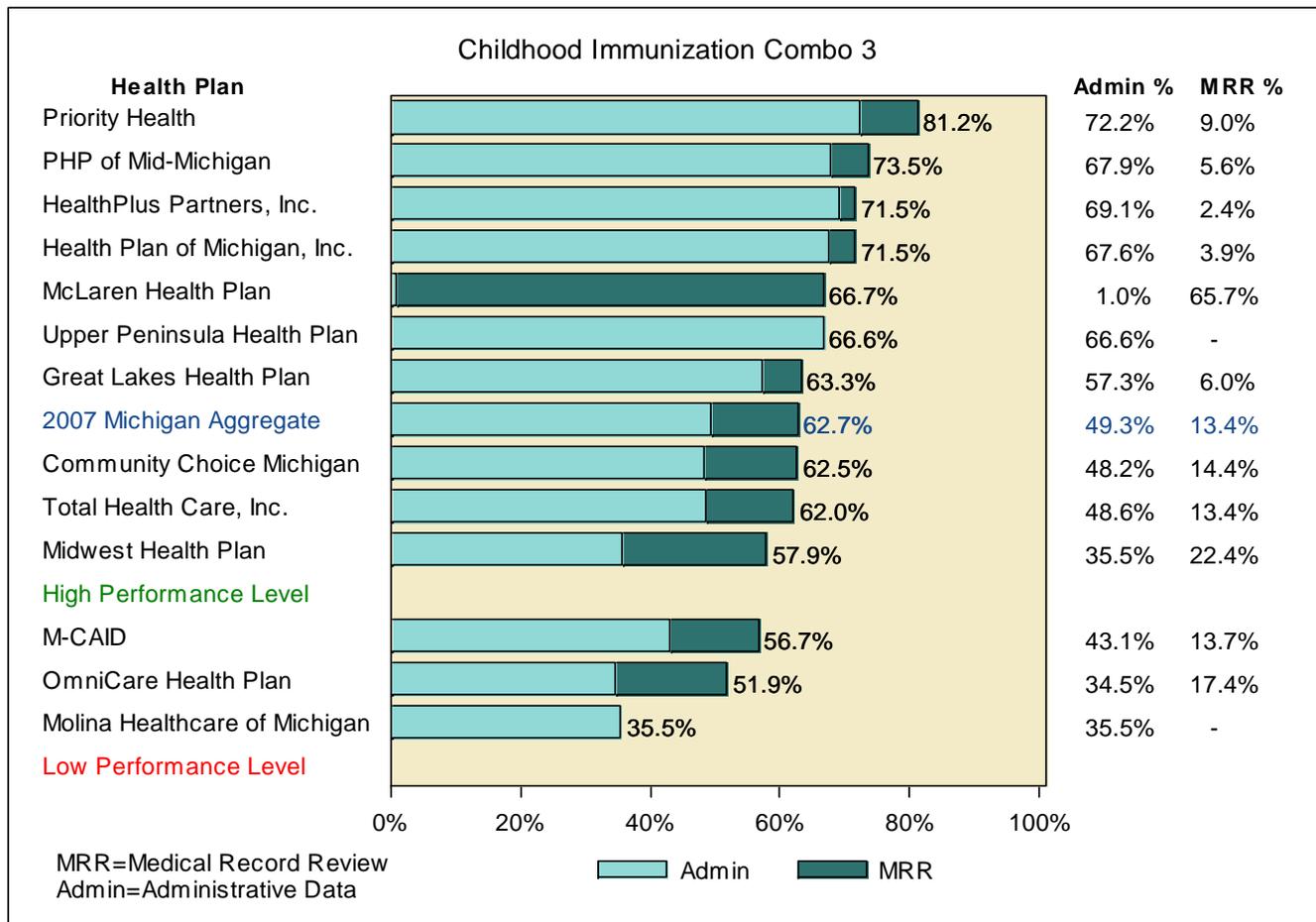
Childhood Immunization Status—Combination #3 was a new measure in 2006; therefore, 2007 was the first year that national performance data were available for comparison.

Ten health plans had rates above the HPL of 57.8 percent, and all 13 health plans' rates were above the LPL of 33.8 percent.

The 2007 Michigan Medicaid weighted average showed statistically significant improvement over the 2006 Michigan Medicaid weighted average, with an increase of 23.8 percentage points.

Data Collection Analysis: Childhood Immunization Status—Combination #3

**Figure 3-4—Michigan Medicaid HEDIS 2007
Data Collection Analysis:
Childhood Immunization Status—Combination #3**



The figure above shows the percent of the final rate for each health plan that was derived from the administrative method (Admin) and from medical record review (MRR). Note: Because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

Except for Upper Peninsula Health Plan, all the MHPs used the hybrid methodology for this measure. The 2007 Michigan aggregate administrative rate was 49.3 percent and the medical record review rate was 13.4 percent.

The results indicate that 78.6 percent of the aggregate rate was derived from administrative data and 21.4 percent from medical record review. These percentages were consistent with the *Childhood Immunization Status—Combination #2* findings.

All of the plans that used the hybrid methodology derived more than half of their rates from administrative data.

Adolescent Immunization Status

Although immunization programs that focus on infants and children have proven successful in combating vaccine-preventable diseases, adolescents and young adults continue to be adversely affected by varicella (chicken pox), hepatitis B, measles, rubella, and other infectious diseases. In fact, most of the approximately 60,000 new hepatitis B infections that occur each year are in adolescents and young adults, and of the 575 measles cases in 1996 in which the age of the person was known, one-third were 10 to 19 years of age.³⁻⁷ This may be due in part to the fact that some immunization programs have placed less emphasis on improving vaccination coverage among adolescents compared to young children. Prior to 2005, the only routinely recommended vaccination for adolescents was the tetanus and diphtheria toxoids (Td) booster. Currently, the CDC recommends that adolescents receive three vaccines: hepatitis B, VZV, and MMR.³⁻⁸ The State of Michigan has high performance in adolescent immunizations. Michigan was the top-performing state on the *Adolescent Immunization Status—VZV and Combination #2* measures for its Medicaid population, according to NCQA's *The State of Managed Care Quality 2006* report.³⁻⁹

The key measure in this section is:

◆ *Adolescent Immunization Status—Combination #2*

This is also commonly referred to as *Combo #2*.

HEDIS Specification: Adolescent Immunization Status—Combination #2

The *Adolescent Immunization Status—Combination #2* measure calculates the percentage of enrolled adolescents who turned 13 years of age during the measurement year, who were continuously enrolled for 12 months immediately prior to their 13th birthdays, and who were identified as having the following vaccinations: second dose of MMR, three hepatitis B vaccinations, and at least one VZV within the allowed time period and by the member's 13th birthday.

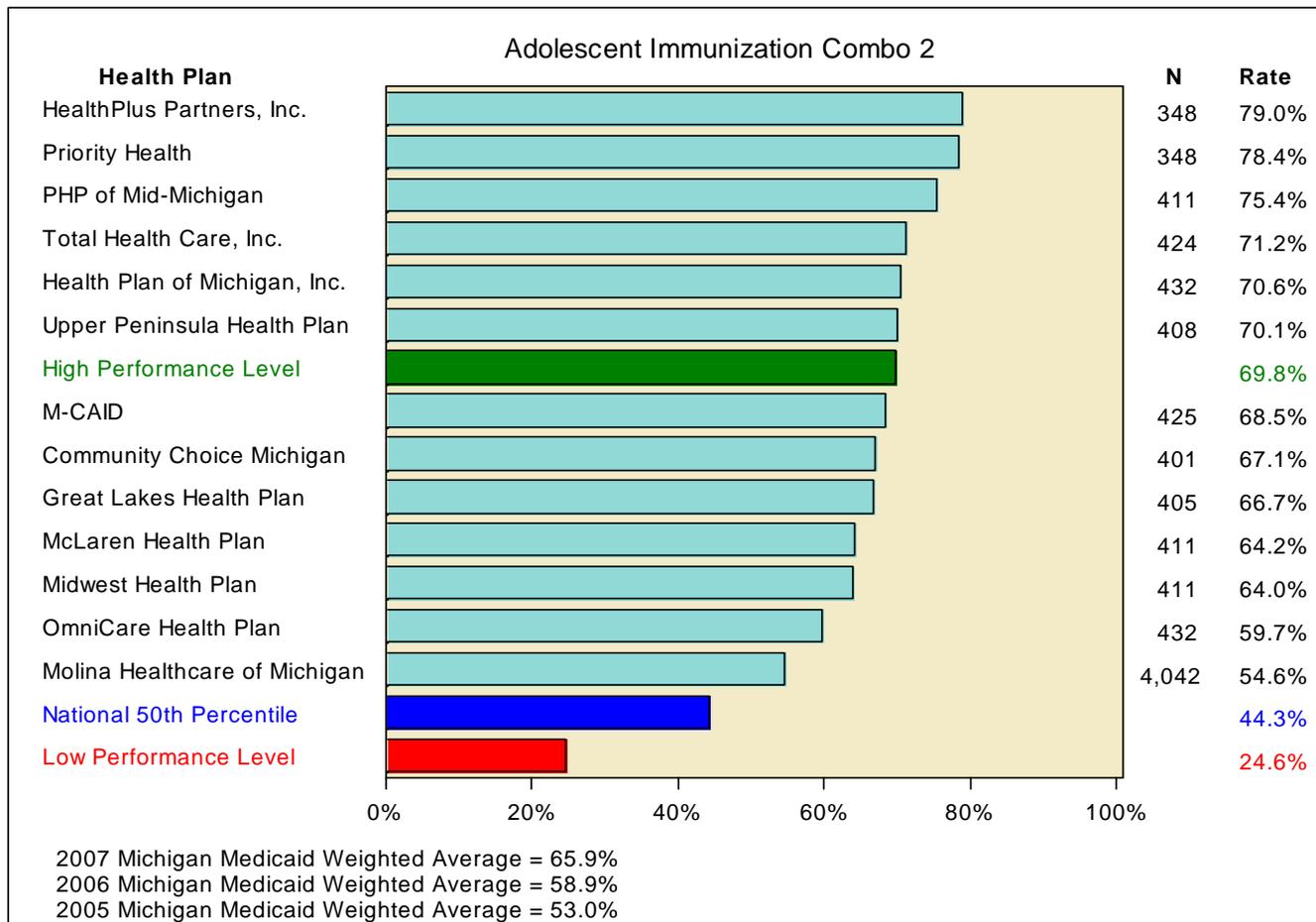
³⁻⁷ National Foundation for Infectious Diseases. *Adolescent Immunization Questions & Answers*. Available at: <http://www.nfid.org/pdf/factsheets/adolescentqa.pdf>. Accessed on: July 27, 2007.

³⁻⁸ National Committee for Quality Assurance. *The State of Managed Care Quality 2006*. Standard Version. Washington, DC: National Committee for Quality Assurance: 2006.

³⁻⁹ Ibid.

Health Plan Ranking: Adolescent Immunization Status—Combination #2

**Figure 3-5—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Adolescent Immunization Status—Combination #2**



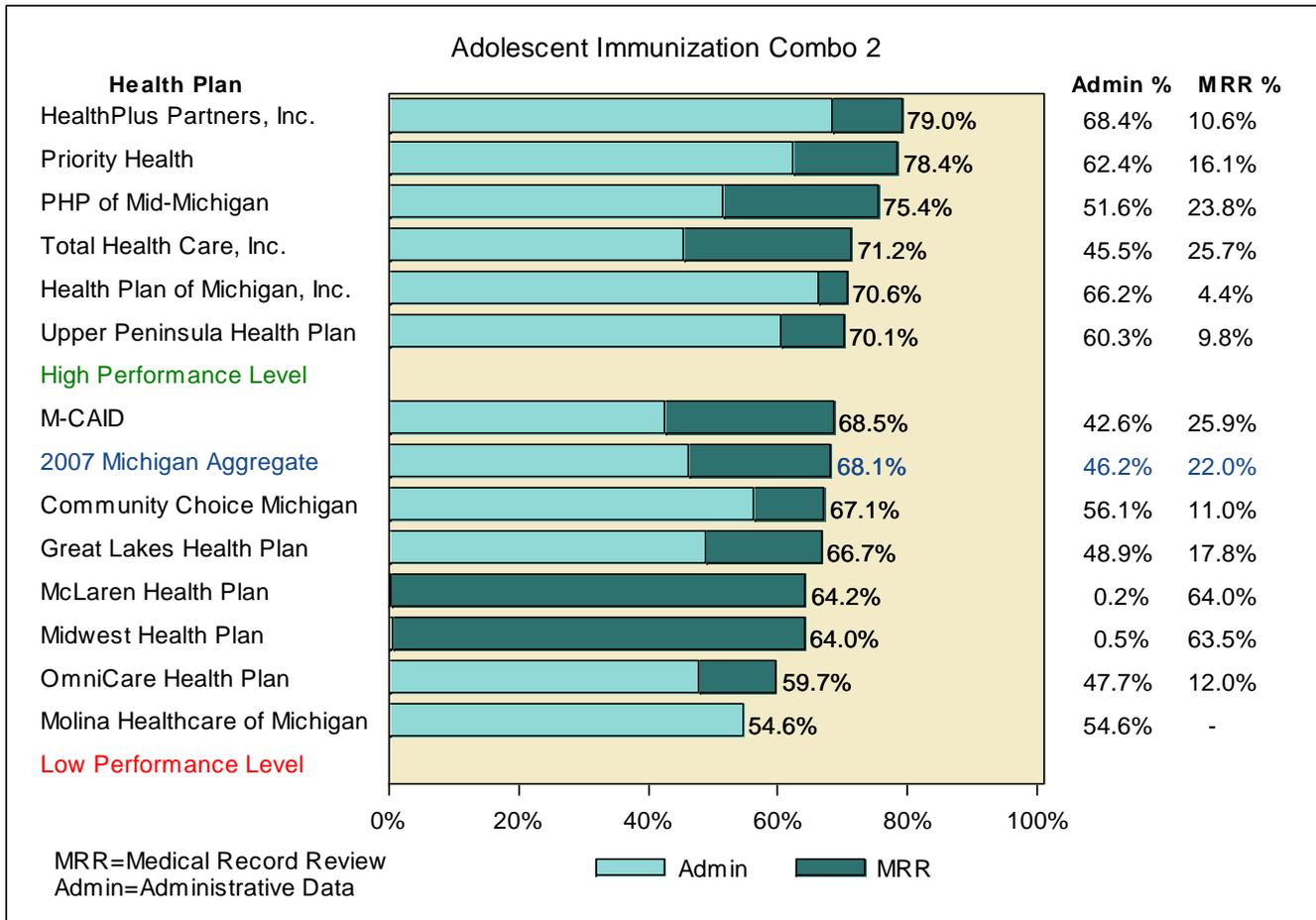
All of the 13 health plans ranked above both the LPL and the national HEDIS 2006 Medicaid 50th percentile, and six health plans ranked above the HPL of 69.8 percent.

The 2007 Michigan Medicaid weighted average of 65.9 percent increased by 7 percentage points over the 2006 weighted average and was 21.6 percentage points above the national HEDIS 2006 50th percentile. Nine of the MHPs had rates above the 2007 weighted average.

The range of reported rates showed considerable improvement from 2006 to 2007. The top-performing health plan increased its rate by more than 8 percentage points in 2007.

Data Collection Analysis: Adolescent Immunization Status—Combination #2

**Figure 3-6—Michigan Medicaid HEDIS 2007
Data Collection Analysis:
Adolescent Immunization Status—Combination #2**



The figure above shows the percent of the final rate for each health plan that was derived from the administrative method (Admin) and from medical record review (MRR). Note: Because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

Twelve out of the 13 MHPs used the hybrid method to report this measure. The 2007 Michigan aggregate administrative rate was 46.2 percent and the medical record review was 22.0 percent.

Two health plans, McLaren and Midwest, derived less than 1 percent of their data from administrative data.

The results for *Adolescent Immunization Status—Combination #2* illustrate that 67.8 percent of the aggregate rate was derived from administrative data and 32.3 percent from medical record review. The 2007 administrative rate increased by more than 7 percentage points from the 2006 administrative rate.

Well-Child Visits in the First 15 Months of Life

The American Medical Association (AMA) and the American Academy of Pediatrics (AAP) recommend timely, comprehensive well-child visits for children. In 2004, 85 percent of children younger than 6 years of age received a well-child checkup during the previous year.³⁻¹⁰ These periodic checkups allow clinicians to assess a child's physical, behavioral, and developmental status, and to provide any necessary treatment, intervention, or referral to a specialist. A study of Medicaid children who were up-to-date with the AAP's recommended well-child visit schedule showed a significant reduction in risk of avoidable hospitalizations for that group.³⁻¹¹

Michigan Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements specify the components of age-appropriate well-child visits. The required components include: review of the child's clinical history and immunization status, complete physical exam, sensory screening (i.e., hearing and vision), developmental assessment, health guidance/education, dental checks, and lab tests, including lead risk.³⁻¹² These visits reduce a child's risk of reaching his or her teenage years with developmental problems that have not been addressed. Although the HEDIS well-child visit measures do not directly collect performance data on individual EPSDT components rendered during a visit, the measures provide an indication of the number of well-care visits delivered to children of various age groups.

Key measures include the following rates:

- ◆ *Well-Child Visits in the First 15 Months of Life—Zero Visits*
- ◆ *Well-Child Visits in the First 15 Months of Life—Six or More Visits*

The following pages analyze in detail the performance profile, health plan rankings, and data collection methodology used by the Michigan MHPs for the two rates reported for this key measure: *Zero Visits* and *Six or More Visits*.

HEDIS Specification: Well-Child Visits in the First 15 Months of Life—Zero Visits

Well-Child Visits in the First 15 Months of Life—Zero Visits calculates the percentage of enrolled members who turned 15 months of age during the measurement year, who were continuously enrolled in the Michigan MHP from 31 days of age, and who received zero visits with a primary care practitioner (PCP) during their first 15 months of life.

It should be noted that limitations within the NCQA Interactive Data Submission System (IDSS), and differences in the way the health plans complete the IDSS, may potentially impact the findings for data collection for this measure. Health plans may choose to attribute the finding of zero visits solely to administrative data sources, solely to medical record review, or to a combination of these. Any one of these approaches is acceptable; therefore, a comparison of data collection methods for this measure is not relevant and has not been included in this report.

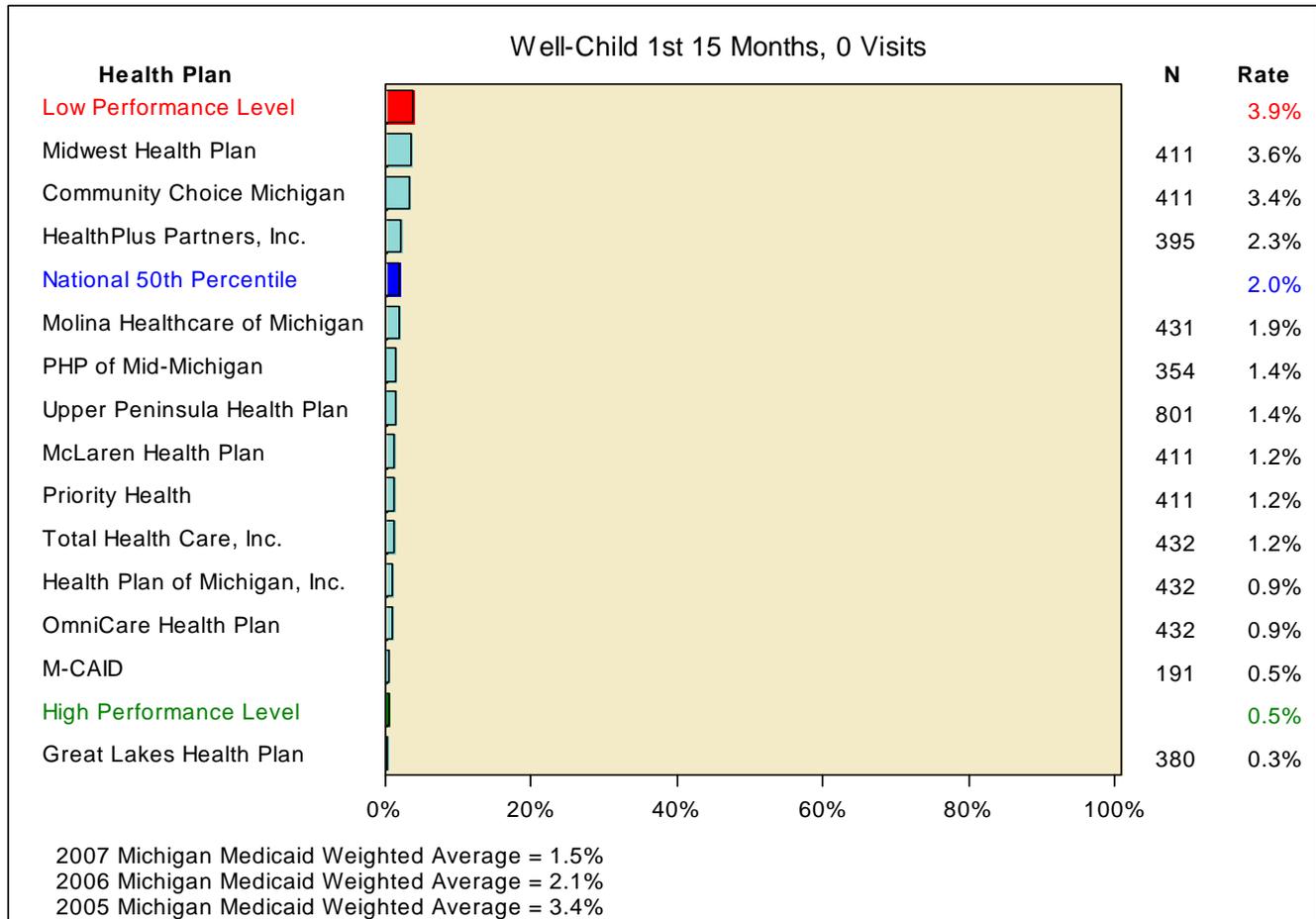
³⁻¹⁰ Child Trends Databank. *Well-child visits*. Available at: <http://www.childtrends.databank.org/indicators/93WellChildVisits.cfm>. Accessed on: July 7, 2006.

³⁻¹¹ Hakim RB, Bye BV. Effectiveness of Compliance With Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries. *Pediatrics*. 2001, 108 (1): 90-97.

³⁻¹² Human Services Research Institute. *EPSDT: Supporting Children with Disabilities*. September 2004.

Health Plan Ranking: Well-Child Visits in the First 15 Months of Life—Zero Visits

**Figure 3-7—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Well-Child Visits in the First 15 Months of Life—Zero Visits**



For this key measure, a *lower* rate indicates better performance, since low rates of zero visits indicate better care.

Figure 3-7 shows the percentage of children who received no well-child visits by 15 months of age. For this measure, a *lower* rate indicates better performance.

One health plan performed better than the HPL rate of 0.5 percent, and no plans performed worse than the LPL rate of 3.9 percent.

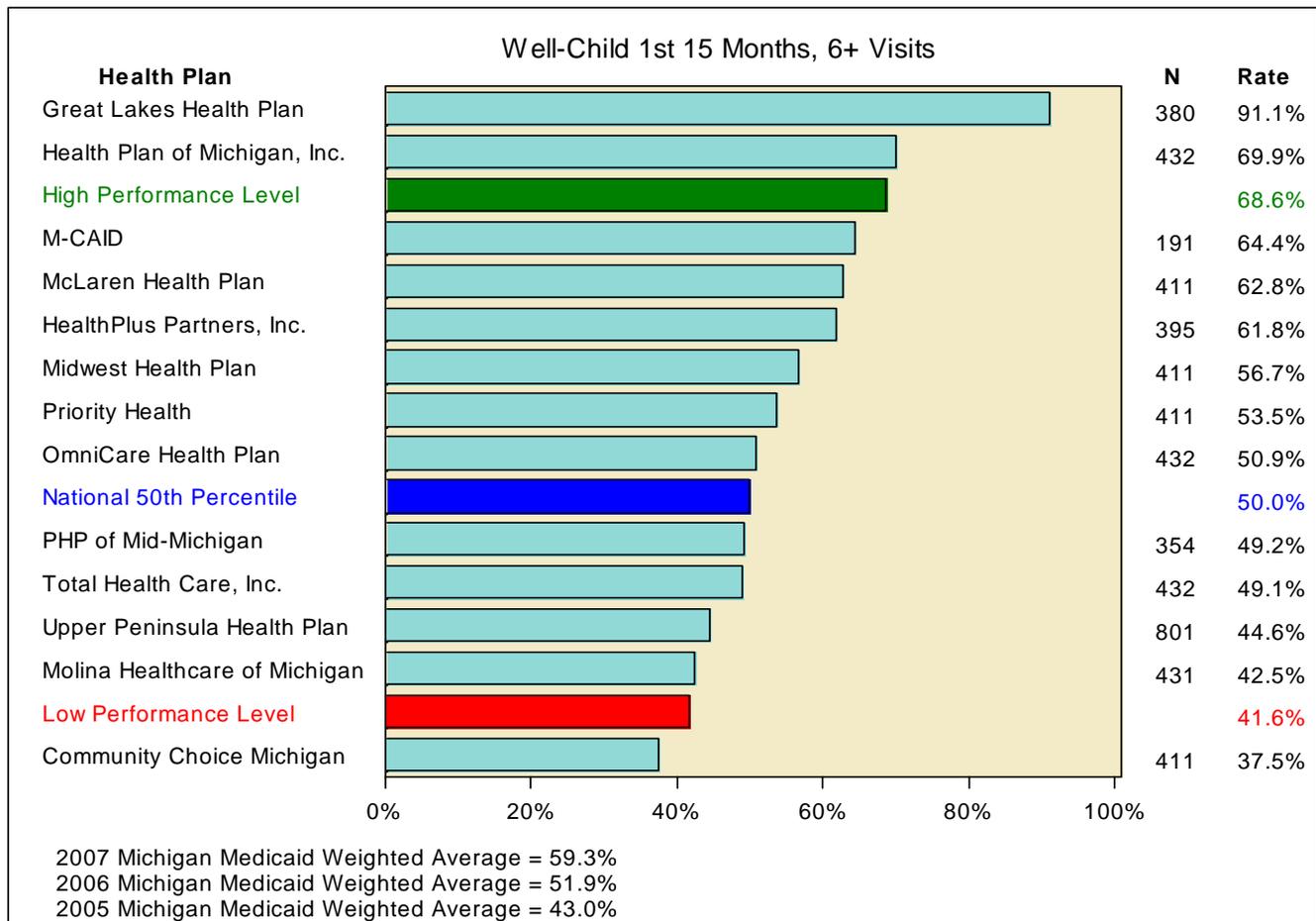
The 2007 Michigan Medicaid weighted average of 1.5 percent was better than the national HEDIS 2006 Medicaid 50th percentile rate of 2.0 percent and showed statistically significant improvement over the 2006 weighted average of 2.1 percent. The MHPs continue to show improvement in the number of children who received no well-child visits.

HEDIS Specification: Well-Child Visits in the First 15 Months of Life—Six or More Visits

Well-Child Visits in the First 15 Months of Life—Six or More Visits calculates the percentage of enrolled members who turned 15 months of age during the measurement year, who were continuously enrolled in the Michigan MHP from 31 days of age, and who received six or more visits with a PCP during their first 15 months of life.

Health Plan Ranking: Well-Child Visits in the First 15 Months of Life—Six or More Visits

**Figure 3-8—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Well-Child Visits in the First 15 Months of Life—Six or More Visits**



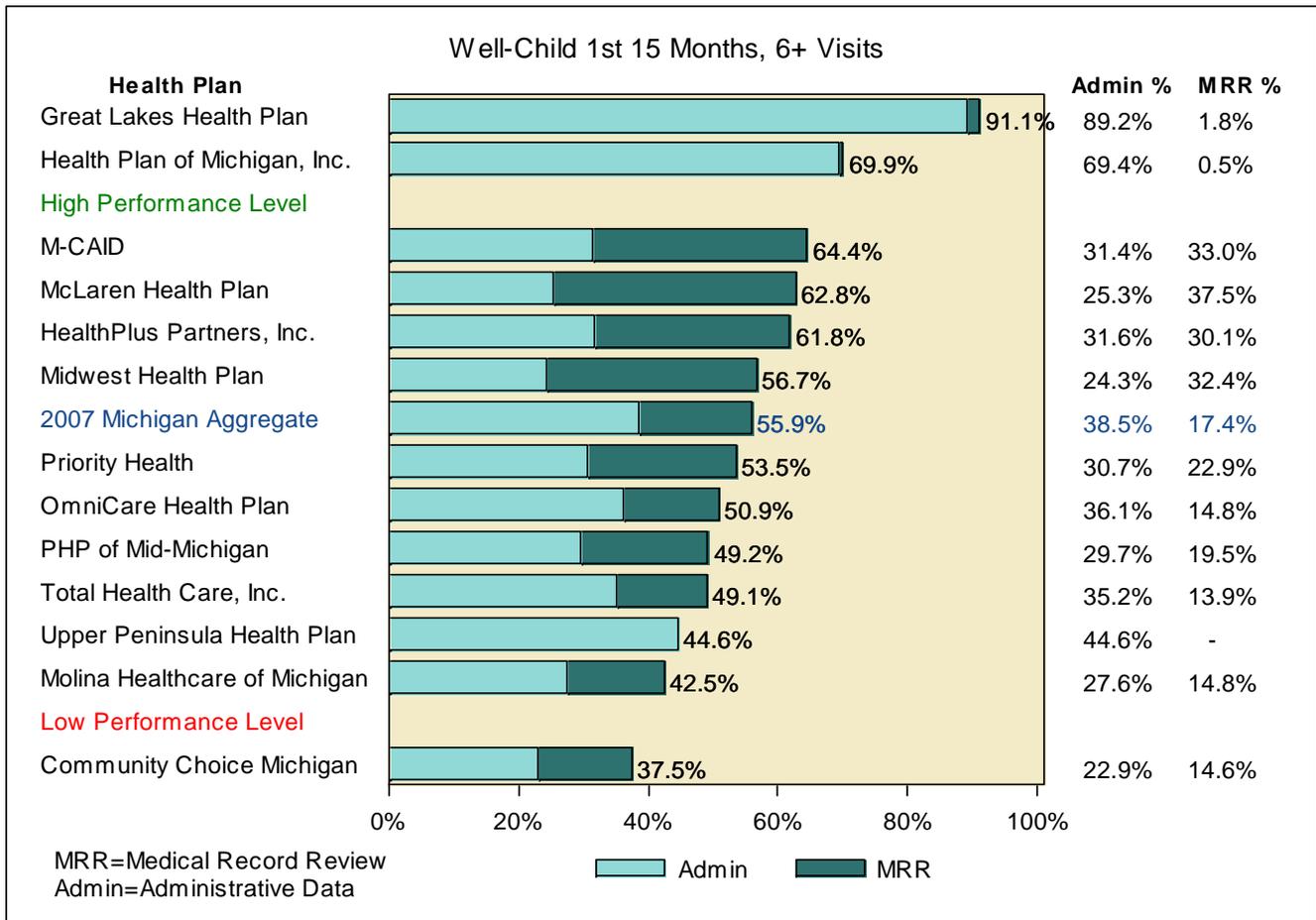
Two health plans reported rates above the HPL of 68.6 percent, and a total of eight health plans reported rates above the national HEDIS 2006 Medicaid 50th percentile of 50.0 percent. Five health plans had rates above the 2007 Michigan weighted average of 59.3 percent.

The 2007 Michigan weighted average increased by 7.4 percentage points from 2006 and by 16.3 percentage points since 2005. The health plans are showing improvement in the number of children receiving six or more well-child visits.

One health plan’s reported rate of 37.5 percent fell below the LPL of 41.6 percent.

Data Collection Analysis: Well-Child Visits in the First 15 Months of Life—Six or More Visits

**Figure 3-9—Michigan Medicaid HEDIS 2007
Data Collection Analysis:
Well-Child Visits in the First 15 Months of Life—Six or More Visits**



The figure above shows the percent of the final rate for each health plan that was derived from the administrative method (Admin) and from medical record review (MRR). Note: Because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All health plans except one elected to use the hybrid method for this measure. The 2007 Michigan aggregate administrative rate was 38.5 percent and the medical record review rate was 17.4 percent.

Results show that 68.9 percent of the aggregate rate was derived from administrative data and 31.1 percent from medical record review. The administrative rate increased by 5 percentage points from last year.

The top two performing MHPs for this measure derived less than 2 percent of their rates from medical record review. Ten of the health plans derived at least half of their rates from administrative data.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

AAP recommends annual well-child visits for children between 2 and 6 years of age.³⁻¹³ These checkups during the preschool and early school years help clinicians detect vision, speech, and language problems as early as possible. Early intervention in these areas can improve a child's communication skills and reduce language and learning problems.

The following pages analyze the performance profile, health plan rankings, and data collection methodology used by the Michigan MHPs for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

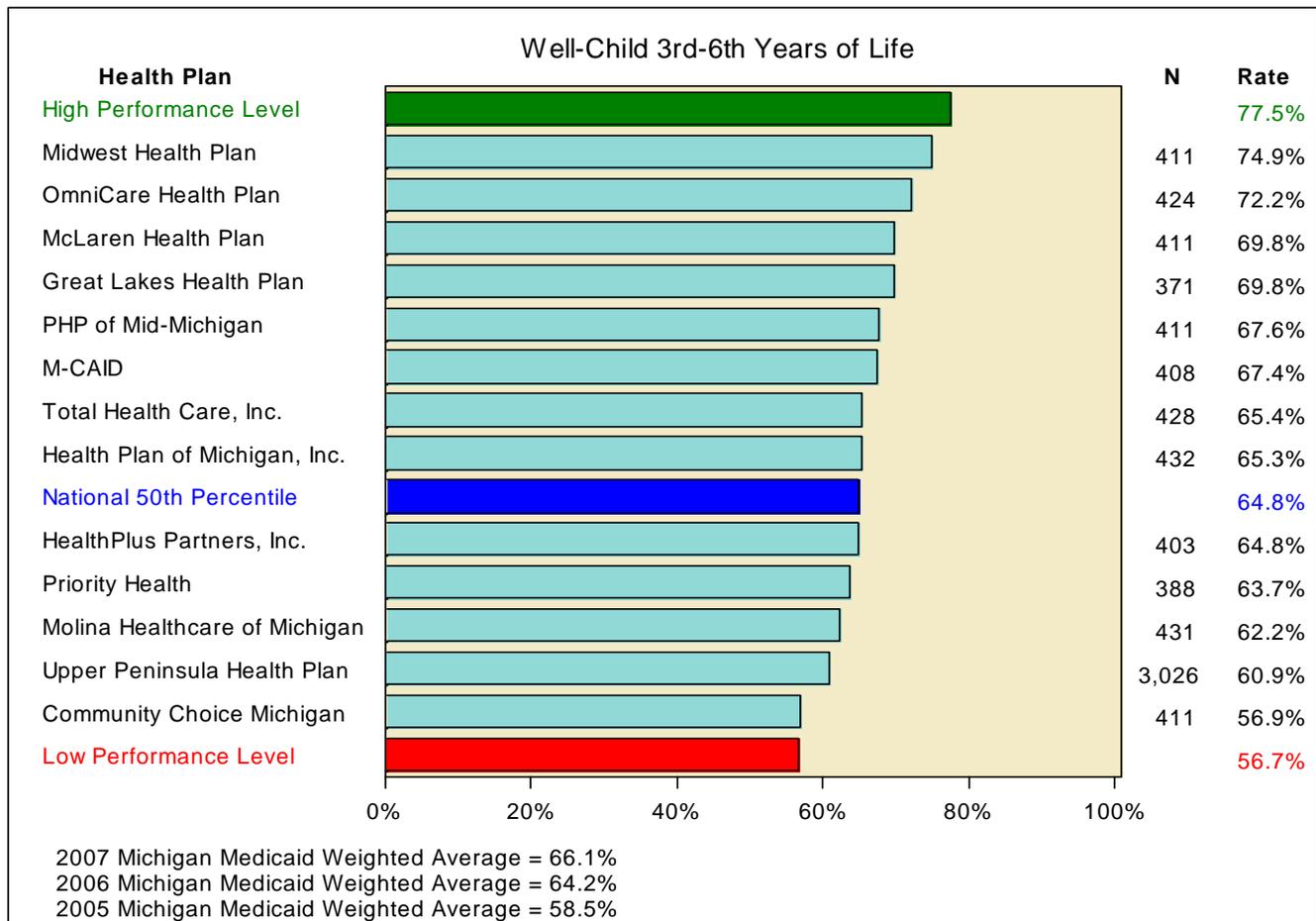
HEDIS Specification: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

This key measure, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, reports the percentage of members who were 3, 4, 5, or 6 years of age during the measurement year; who were continuously enrolled during the measurement year; and who received one or more well-child visits with a PCP during the measurement year.

³⁻¹³ American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: <http://practice.aap.org/content.aspx?aid=1599>. Accessed on: August 17, 2007.

Health Plan Ranking: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

**Figure 3-10—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life**

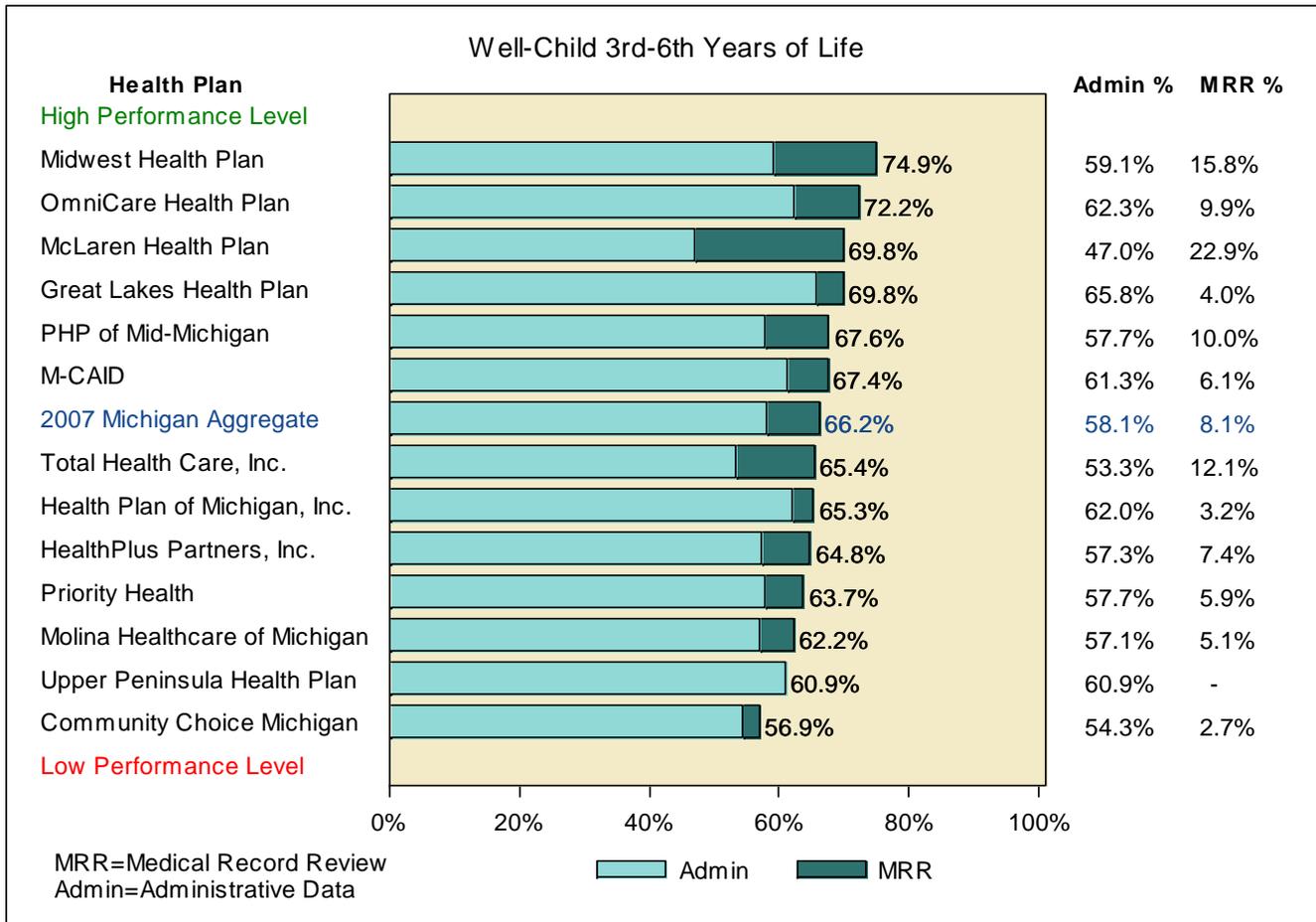


None of the health plans reported rates above the HPL of 77.5 percent, and no health plans reported rates below the LPL of 56.7 percent. Eight plans performed above the national HEDIS 2006 Medicaid 50th percentile of 64.8 percent.

The 2007 Michigan Medicaid weighted average of 66.1 percent was 1.9 percentage points above the 2006 weighted average and 1.3 percentage points above the national HEDIS 2006 Medicaid 50th percentile.

Data Collection Analysis: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

**Figure 3-11—Michigan Medicaid HEDIS 2007
Data Collection Analysis:
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life**



The figure above shows the percent of the final rate for each health plan that was derived from the administrative method (Admin) and from medical record review (MRR). Note: Because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

Twelve of the 13 health plans elected to use the hybrid method for this measure. The 2007 Michigan aggregate administrative rate was 58.1 percent and the medical record review rate was 8.1 percent.

For the health plans that used the hybrid method, more than half of their rates were derived from administrative data.

The results showed that 87.8 percent of the aggregate rate was derived from administrative data and 12.2 percent was derived from medical record review.

Adolescent Well-Care Visits

Among adolescents, unintentional injuries, homicide, and suicide are the leading causes of death. Sexually transmitted diseases (STDs), substance abuse, pregnancy, and antisocial behavior are important causes of physical, emotional, and social problems in this age group. The AMA's Guidelines for Adolescent Preventive Services (GAPS) recommends comprehensive annual health care visits for adolescents.³⁻¹⁴ However, adolescents tend to have additional barriers to care that must be addressed, such as access, cost, confidentiality, and participation in their own care.³⁻¹⁵

The following pages analyze the performance profile, health plan rankings, and data collection methodology used by the Michigan MHPs for *Adolescent Well-Care Visits*.

HEDIS Specification: Adolescent Well-Care Visits

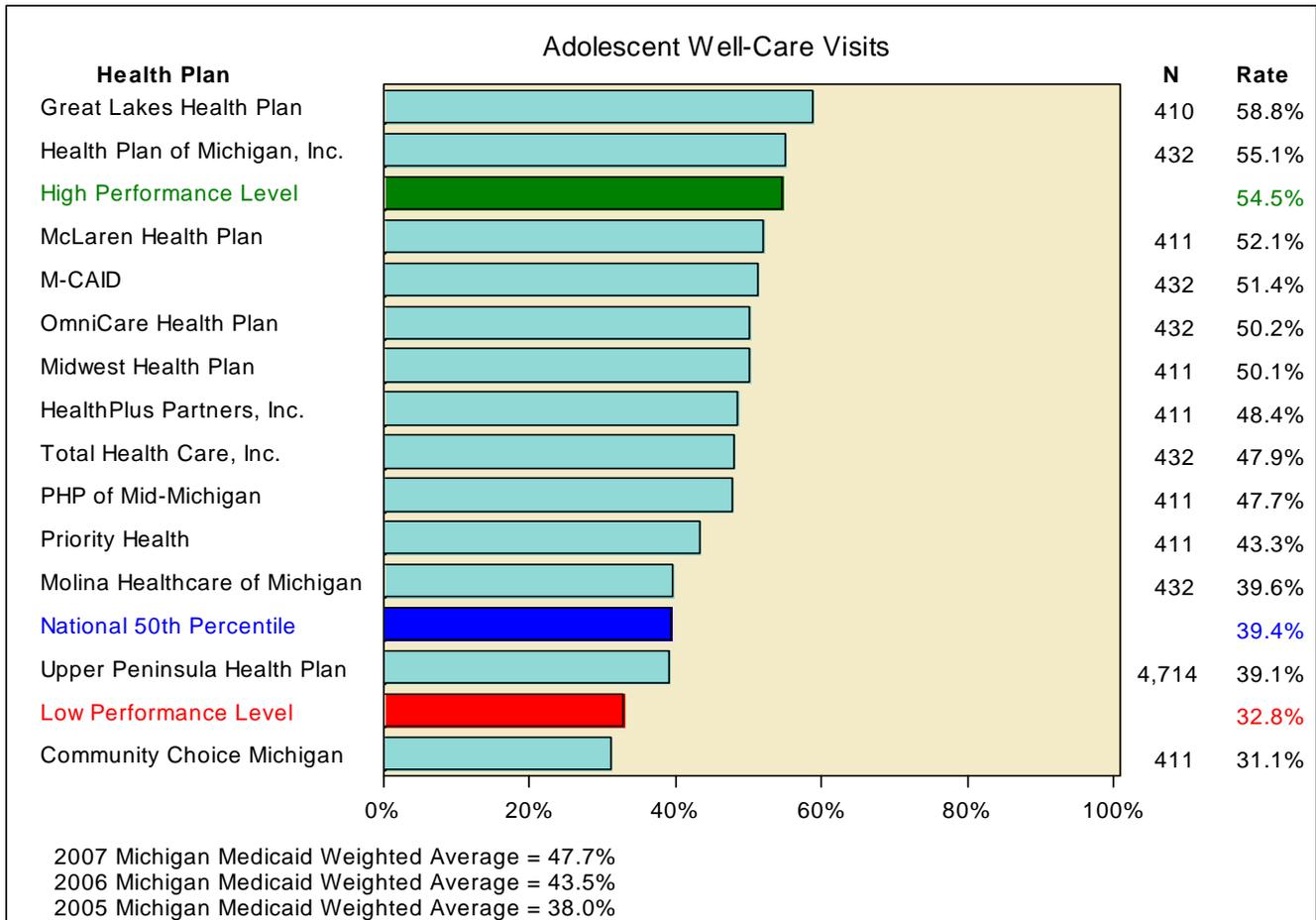
This key measure reports the percentage of enrolled members who were 12 to 21 years of age during the measurement year, who were continuously enrolled during the measurement year, and who had at least one comprehensive well-care visit with a PCP or an obstetrics/gynecology (OB/GYN) practitioner during the measurement year.

³⁻¹⁴ American Medical Association. *Guidelines for Adolescent Preventive Services (GAPS)*. 1997. Available at: <http://www.ama-assn.org/ama/upload/mm/39/gapsmono.pdf>. Accessed on: August 17, 2007.

³⁻¹⁵ National Adolescent Health Information Center. 1998. *Assuring the Health of Adolescents in Managed Care: A Quality Checklist for Planning and Evaluating Components of Adolescent Health Care*. San Francisco, CA: University of California, San Francisco, National Adolescent Health Information Center.

Health Plan Ranking: Adolescent Well-Care Visits

**Figure 3-12—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Adolescent Well-Care Visits**



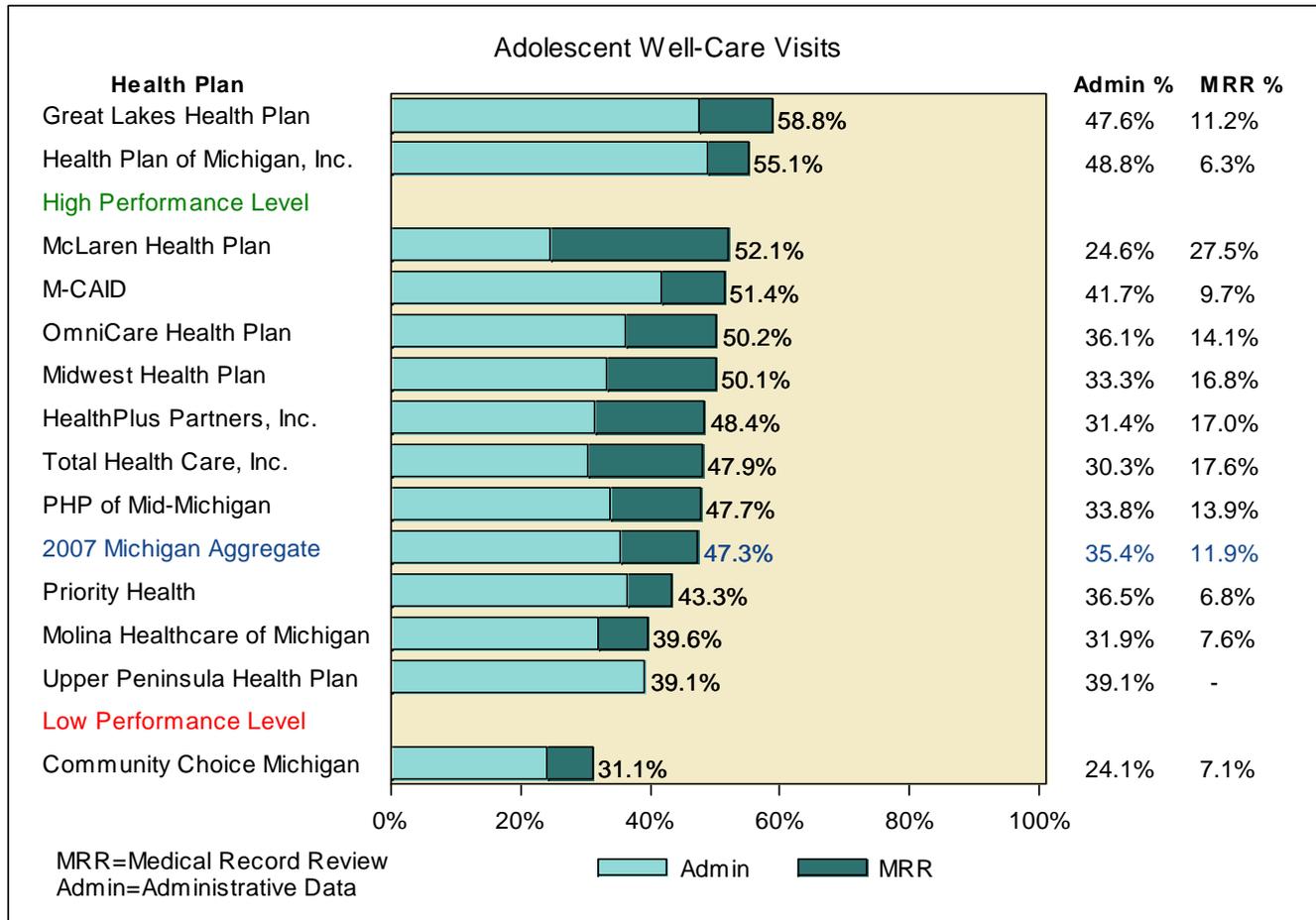
Two health plans ranked above the HPL rate of 54.5 percent and two plans ranked below the national HEDIS 2006 Medicaid 50th percentile. One of the two plans below the national HEDIS 2006 Medicaid 50th percentile was also below the LPL of 32.8 percent.

The 2007 Michigan Medicaid weighted average of 47.7 percent was 4.2 percentage points above the 2006 Michigan Medicaid weighted average of 43.5 percent and almost 10 percentage points above the 2005 weighted average.

Two health plans exceeded the HPL in 2007, while none reached the HPL in 2006. However, one health plan fell below the LPL in 2007 and none were below the LPL in 2006.

Data Collection Analysis: Adolescent Well-Care Visits

**Figure 3-13—Michigan Medicaid HEDIS 2007
Data Collection Analysis:
Adolescent Well-Care Visits**



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much was from medical record review (MRR). Note: Because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

Twelve out of 13 health plans used the hybrid method for reporting this measure. The 2007 Michigan aggregate administrative rate was 35.4 percent and the medical record rate was 11.9 percent.

In 2007, 74.8 percent of the aggregate rate was derived from administrative data and 25.2 percent was derived from medical record review data. The administrative data rate increased by 2.4 percentage points, which was fairly consistent with last year’s percentages (75.0 percent from administrative data and 24.8 percent from medical record review data).

Appropriate Treatment for Children With Upper Respiratory Infection

Upper respiratory infection (URI), more commonly known as the common cold, accounts for the most missed school days of any childhood illness, and according to the National Institutes of Health, URI is also the leading cause of doctor visits for children.³⁻¹⁶ Most children have six to eight colds per year, whereas adults average only two to four. Because URI is a viral infection, inappropriate use of antibiotics is a concern. The concern is that a person will start to develop a resistance to antibiotics over time if they are used inappropriately, making them ineffective when appropriately used. In spite of the fact that antibiotics are not recommended for treatment of the common cold, health care providers still prescribe more than 50 million antibiotics for this condition every year.³⁻¹⁷

HEDIS Specification: Appropriate Treatment for Children With Upper Respiratory Infection

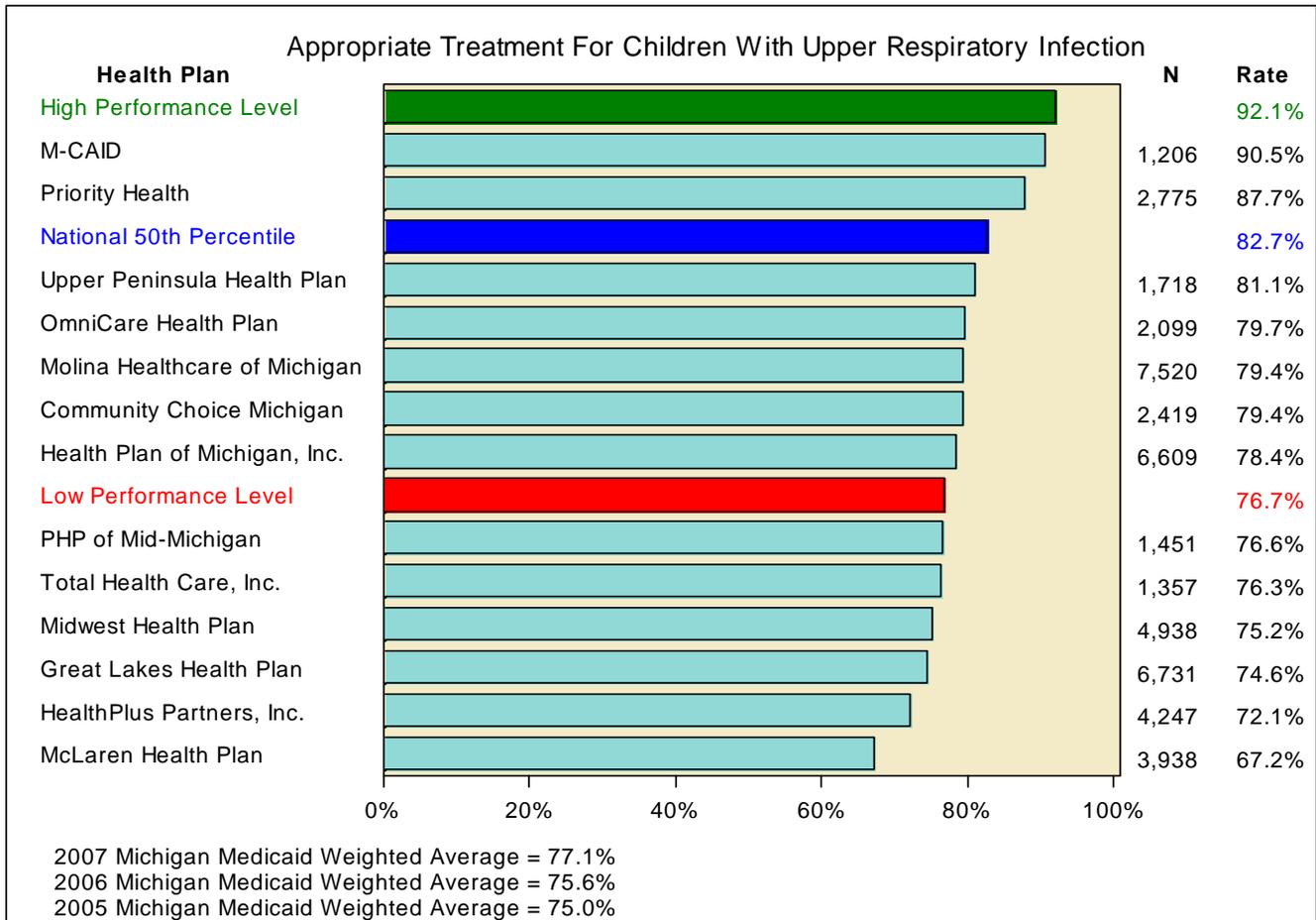
This key measure reports the percentage of enrolled members who were 3 months to 18 years of age during the measurement year, who were given a diagnosis of URI, and who were not dispensed an antibiotic prescription on or three days after the episode date.

³⁻¹⁶ Mayo Foundation for Medical Education and Research. *Children's Illness: Top 5 causes of missed school*. Available at: <http://www.mayoclinic.com/health/childrens-conditions/cc00059>. Accessed on: August 7, 2007.

³⁻¹⁷ Yale Health Education. *An Overview of the Cold and Flu*. Available at: http://www.yale.edu/yhp/med_services/health_ed/ColdOverview.htm. Accessed on: August 7, 2007.

Health Plan Ranking: Appropriate Treatment for Children With Upper Respiratory Infection

**Figure 3-14—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Appropriate Treatment For Children With Upper Respiratory Infection**



There were no health plans that reported rates above the HPL of 92.1 percent, and six health plans ranked below the LPL of 76.7 percent. Similar to last year, two health plans reported rates above the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 77.1 percent was 1.5 percentage points above the 2006 Michigan Medicaid weighted average; however, the weighted average continues to be below the national HEDIS Medicaid 50th percentile.

From 2006 to 2007, the number of health plans with rates above the HPL decreased, and the number of health plans falling below the LPL also decreased. In 2006, one health plan reported a rate above the HPL and eight health plans reported rates below the LPL. The range of reported rates showed improvement from 2006 to 2007.

Appropriate Testing for Children With Pharyngitis

Pharyngitis, an infection or irritation of the throat and/or tonsils (sore throat), occurs most commonly in children between 4 and 7 years of age.³⁻¹⁸ Children in the United States experience an average of five sore throats per year and one streptococcal infection (strep throat) every four years.³⁻¹⁹ An estimated 10 percent of all children who see a health care provider will be evaluated for pharyngitis.³⁻²⁰

There are two types of pharyngitis: viral and bacterial. Only 35 percent of pharyngitis cases in children are caused by bacteria. Determining the cause of the pharyngitis is vital for treatment since antibiotics are ineffective against viral infections. In fact, the overuse of antibiotics can instead increase the number of drug-resistant forms of bacteria, which can be very difficult to treat. To diagnose a bacterial virus such as Group A streptococcal pharyngitis (GABHS), appropriate laboratory tests should be used. Only 51 percent of physicians are performing the strep test on the pediatric population.³⁻²¹ Strep throat, which is caused by GABHS, can be treated with antibiotics. Treatments for viral pharyngitis may include throat lozenges, increased fluid intake, and acetaminophen.³⁻²²

HEDIS Specification: Appropriate Testing for Children With Pharyngitis

This key measure reports the percentage of enrolled members 2 to 18 years of age during the measurement year who were diagnosed with pharyngitis, prescribed an antibiotic, and received a Group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

³⁻¹⁸ eMedicine. *Pharyngitis*. Available at: <http://www.emedicine.com/emerg/topic419.htm>. Accessed on: August 8, 2007.

³⁻¹⁹ Pulmonology Channel. *Pharyngitis*. Available at: <http://www.pulmonologychannel.com/pharyngitis/>. Accessed on: August 8, 2007.

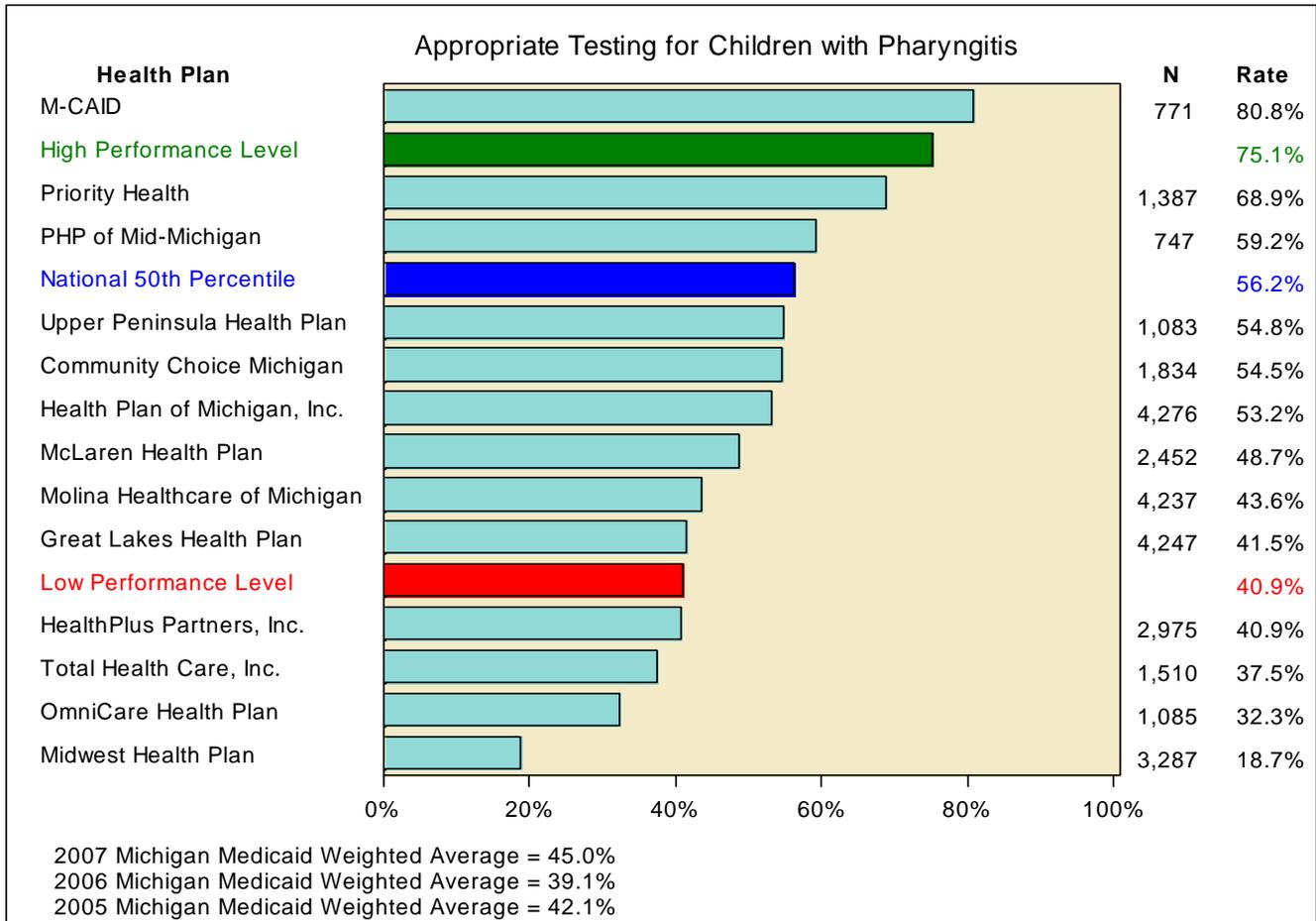
³⁻²⁰ National Committee for Quality Assurance. *The State of Managed Care Quality 2006*. Standard Version. Washington, DC: National Committee for Quality Assurance: 2006.

³⁻²¹ Ibid.

³⁻²² Children's Hospital of Michigan. *Pharyngitis and Tonsillitis*. Available at: <http://www.chmkids.org/healthlibrary/default.aspx?pageid=P02069&pt=Pharyngitis%20and%20Tonsillitis>. Accessed on: August 8, 2007.

Health Plan Ranking: Appropriate Testing for Children With Pharyngitis

**Figure 3-15—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Appropriate Testing for Children With Pharyngitis**



One health plan reported a rate above the HPL of 75.1 percent, and four health plans had rates below the LPL of 40.9. Three health plans' rates, including the one health plan that exceeded the HPL, had rates above the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 45.0 percent was 11.2 percentage points below the national HEDIS 2006 Medicaid 50th percentile. The 2007 Michigan Medicaid weighted average did, however, improve by 5.9 percentage points over the 2006 Michigan Medicaid weighted average.

Overall, the range of rates for this measure showed improvement from 2006 to 2007.

Pediatric Care Findings and Recommendations

All of the measures in the Pediatric Care dimension showed improvement from the previous year. Two measures, *Childhood Immunization Status—Combination #3* and *Adolescent Immunization Status—Combination #2*, showed statistically significant improvement in the 2007 Michigan Medicaid weighted averages when compared to the 2006 rates. The range of rates for the Pediatric Care measures continued to show improvement, indicating that the health plans are striving to increase performance among their providers. It was evident that the health plans focused efforts on administrative data completeness due to the improved administrative data rates for the hybrid measures. To eliminate the burden of medical record review, the health plans should continue their efforts to improve administrative data rates.

All three of the immunization measures (*Childhood Immunization Status—Combination #2* and *Combination #3*, and *Adolescent Immunization Status—Combination #2*) had improvement in the range of reported rates. The largest improvement was seen in *Childhood Immunization Status—Combination #3*, for which the range went from 24.1 to 56.7 percent in 2006 to 35.5 to 81.2 percent in 2007. The 23.8 percentage-point improvement in the weighted average for this measure from 2006 to 2007 was statistically significant. *Adolescent Immunization Status—Combo #2* also demonstrated statistically significant improvement in the weighted average from 2006 to 2007. This is commendable in light of the fact that the State of Michigan was the highest-ranking state nationwide for the *Adolescent Immunization Status—Combo #2* last year for its Medicaid population.

Next year, NCQA will be retiring *Adolescent Immunization Status* from the HEDIS measurement set; however, the MHPs should continue their quality improvement efforts toward improving adolescent immunizations because NCQA intends to bring back the measure for HEDIS 2009 with refocused specifications.

The weighted averages for all of the well-care visit measures increased compared to the 2006 weighted averages. None of the increases in the 2007 weighted averages were statistically significant. The rates for *Well-Child Visits in the First 15 Months of Life—Zero Visits* improved from 2006 with no health plans performing below the LPL and one plan performing better than the HPL by 0.2 percentage points. Two health plans performed above the HPL for *Well-Child Visits in the First 15-Months of Life—Six or More Visits*, and one of those plans performed 22.5 percentage points higher than the HPL of 68.6 percent. This MHP saw its rate increase by 26.9 percentage points this year over last year's rate. This health plan also derived more than 89 percent of its rate from administrative data. It was determined that this health plan had implemented several interventions, all of which contributed to its improved rate. Interventions included targeting low-performing providers, performing educational visits with PCPs, encouraging providers to perform well-child exams when children present for a sick visit, Web notifications and/or written reminders to PCPs for children who need well-child services, and additional PCP incentives for well-child services that were billed.

While the weighted averages for both the *Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis* measures improved this year, there is still room for improvement. The low end of the range for *Appropriate Testing for Children With Pharyngitis* improved from 9.1 percent in 2006 to 18.7 percent in 2007. One plan

performed above the HPL for this measure with a rate of 80.8 percent, which was 11.9 percentage points above the highest-performing MHP in 2006.

The MHPs' performance on the Pediatric Care measures continued to improve and demonstrate the commitment of the health plans to work with providers to further enhance the delivery of care to children. The efforts in place at the MHPs should be continued and the MHPs should work together to share best practices to further improve the rates.

Although the two measures that target the misuse of antibiotics showed improvement during the measurement year, they still have many opportunities for improvement, with more than half of the health plans performing below the national HEDIS 2006 Medicaid 50th percentile. The MHPs could focus interventions on provider education about the measure and the appropriate prescribing of antibiotics. The MHPs should also ensure that pharmacy data are complete for reporting these measures. If pharmacy data are missing, the rates for these measures could be misrepresented. Best practices seen in higher-performing health plans should be shared with other health plans.

Introduction

This section of the report addresses how well Michigan MHPs are performing to ensure that women 16 to 64 years of age are screened early for cancer and STDs, which are treatable if detected in the early stages. It also addresses how well Michigan MHPs are monitoring the appropriateness of prenatal and postpartum care.

The Women's Care dimension encompasses the following MDCH key measures:

- ◆ **Breast and Cervical Cancer Screening**
 - *Breast Cancer Screening—Ages 42 to 51 Years*
 - *Breast Cancer Screening—Ages 52 to 69 Years*
 - *Breast Cancer Screening—Combined Rate*
 - *Cervical Cancer Screening*
- ◆ **Chlamydia Screening**
 - *Chlamydia Screening in Women—Ages 16 to 20 Years*
 - *Chlamydia Screening in Women—Ages 21 to 25 Years*
 - *Chlamydia Screening in Women—Combined Rate*
- ◆ **Prenatal and Postpartum Care**
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
 - *Prenatal and Postpartum Care—Postpartum Care*

The following pages provide detailed analysis of the Michigan MHPs' performance and ranking, as well as the data collection methodology used by the Michigan MHPs for these measures.

Breast Cancer Screening

Breast cancer is the second-leading cause of cancer deaths among women nationally, as well as in Michigan.⁴⁻¹ In addition, it is the third most common diagnosis of cancer in the State of Michigan and the most common diagnosis for women in Michigan.⁴⁻² The American Cancer Society (ACS) estimates that in 2007 there will be 178,480 new cases of breast cancer and 40,460 deaths from breast cancer for women in the United States.⁴⁻³ The ACS also projects that 5,900 women will be newly diagnosed with breast cancer in Michigan during 2007, a decrease of 1,170 cases from the previous year.⁴⁻⁴ While there has been a decline in the overall breast cancer death rate in recent years, there is a significant racial disparity. African-American women are almost 47 percent more likely than Caucasian women to die from breast cancer, which can be partially attributed to diagnosis at a later stage of the disease.⁴⁻⁵

Today, nearly 90 percent of women diagnosed with breast cancer will survive for at least five years.⁴⁻⁶ A mammogram is the most effective method for detecting breast cancer in its early stages. Mammograms can detect approximately 85 percent of breast cancers and can reduce mortality from the disease by 30 percent in women 50 years of age and older.⁴⁻⁷ Michigan's Breast & Cervical Cancer Control Program helps in providing breast cancer screening services to low-income women; however, costs only allow for 15 percent of the eligible population to receive these services. And according to *Breast Cancer in Michigan: Early Detection Is the Key to Survival*, only 56 percent of Michigan women 40 years of age and older were obtaining appropriately timed mammograms.⁴⁻⁸

HEDIS Specification: Breast Cancer Screening

The *Breast Cancer Screening* measure is reported using only the administrative method. The *Breast Cancer Screening* measure calculates the percentage of women 42 through 69 years of age who were continuously enrolled during the measurement year and the year prior to the measurement year, and who had a mammogram during the measurement year or the year prior to the measurement year. Previously, this measure was calculated using women ages 52 to 69 years of age. This year the measure is reported using three age categories:

- ◆ Ages 42 to 51 Years
- ◆ Ages 52 to 69 Years
- ◆ Combined Rate

⁴⁻¹ Michigan Department of Community Health. *Breast Cancer Deaths*. Available at: http://www.michigan.gov/documents/mdch/12_BrstCanc_198882_7.pdf. Accessed on: July 17, 2007.

⁴⁻² Michigan Cancer Consortium. *Breast Cancer in Michigan: Early Detection Is the Key to Survival*. January 2007. Available at: <http://www.michigancancer.org/PDFs/MDCHFactSheets/BrCAInMichFactSheet-Jan07.pdf>. Accessed on: August 17, 2007.

⁴⁻³ American Cancer Society. *Cancer Facts & Figures 2007*. Available at: <http://www.cancer.org/downloads/STT/CAFF2007PWSecured.pdf>. Accessed on: July 17, 2007.

⁴⁻⁴ American Cancer Society. *Cancer Facts & Figures 2007*. Available at: <http://www.cancer.org/downloads/STT/CAFF2007PWSecured.pdf>. Accessed on: July 17, 2007.

⁴⁻⁵ Michigan Department of Community Health. *Breast Cancer Deaths*. April 2007. Available at: http://www.michigan.gov/documents/mdch/12_BrstCanc_198882_7.pdf. Accessed on: July 17, 2007.

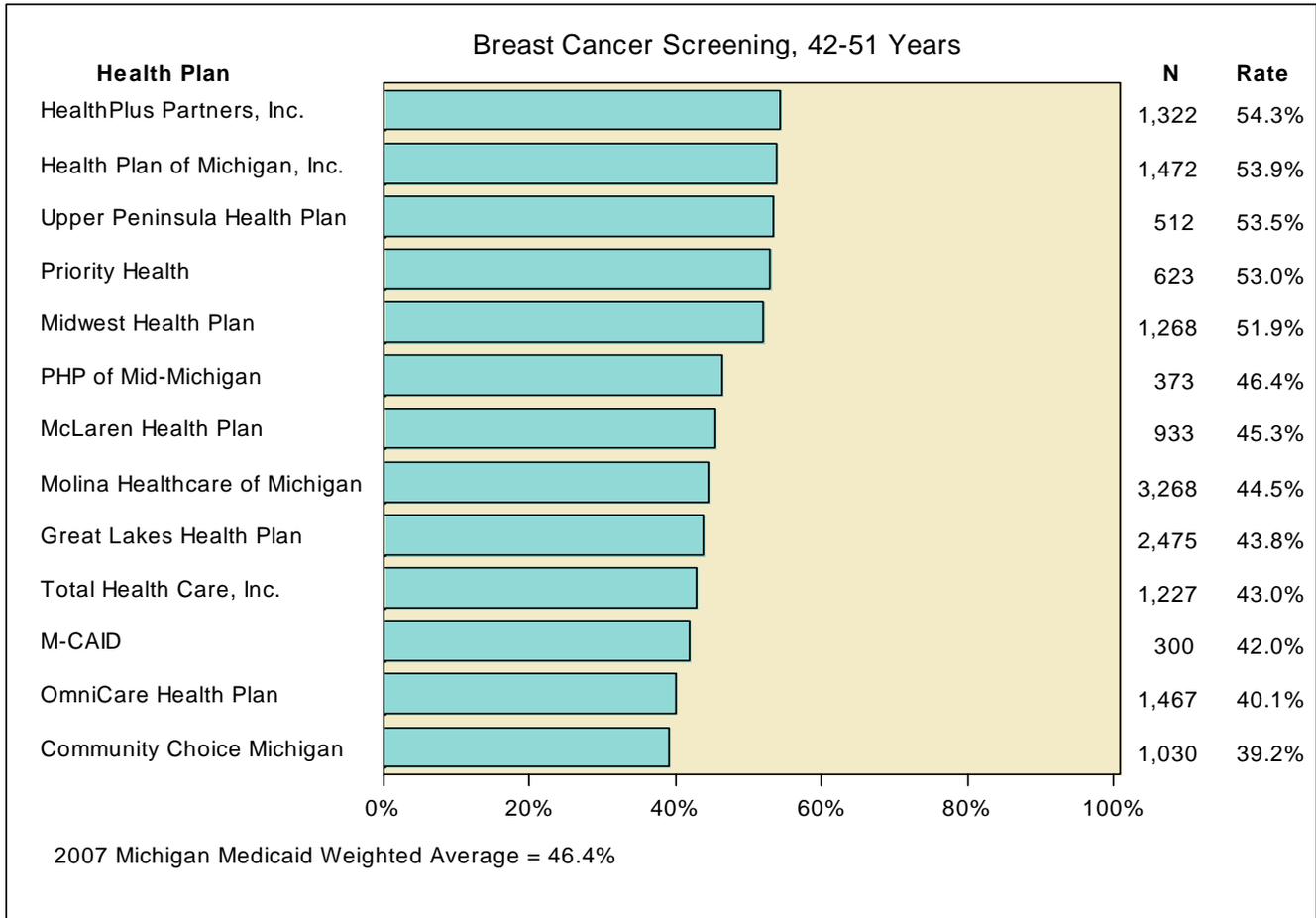
⁴⁻⁶ National Cancer Institute. *Cancer Advances in Focus: Breast Cancer*. Available at: <http://www.cancer.gov/aboutnci/cancer-advances-in-focus/breast>. Accessed on: July 17, 2007.

⁴⁻⁷ National Committee for Quality Assurance. *The State of Managed Care Quality 2006*. Standard Version. Washington, DC: National Committee for Quality Assurance: 2006.

⁴⁻⁸ Michigan Cancer Consortium. *Breast Cancer in Michigan: Early Detection Is the Key to Survival*. January 2007. Available at: <http://www.michigancancer.org/PDFs/MDCHFactSheets/BrCAInMichFactSheet-Jan07.pdf>. Accessed on: August 17, 2007.

Health Plan Ranking: Breast Cancer Screening—Ages 42 to 51 Years

**Figure 4-1—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Breast Cancer Screening—Ages 42 to 51 Years**

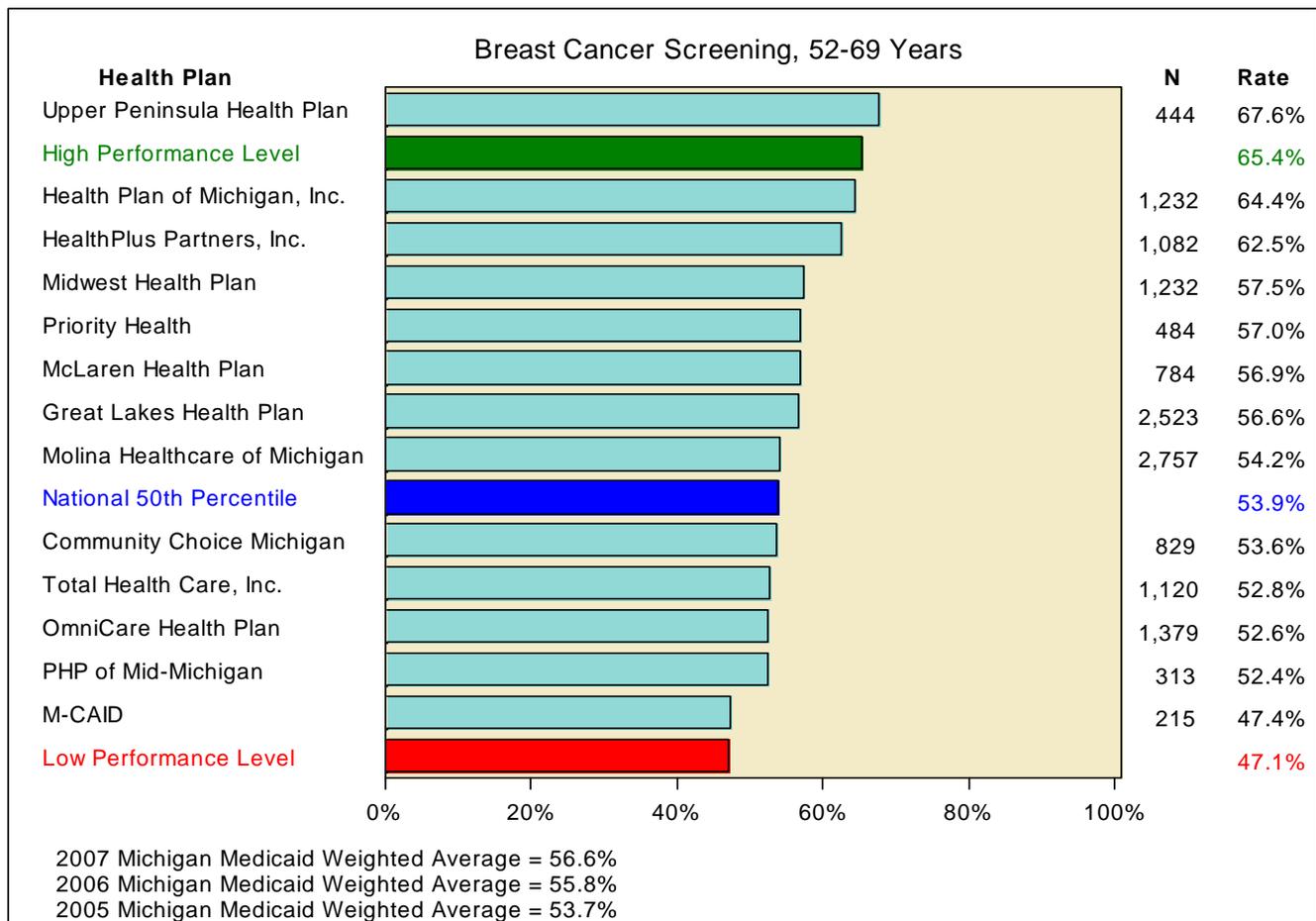


Breast Cancer Screening—Ages 42 to 51 Years was a new measure for 2007; therefore, national performance data are not available for comparison.

The 2007 Michigan Medicaid weighted average was 46.4 percent. Six plans reported rates equal to or above the weighted average.

Health Plan Ranking: Breast Cancer Screening—Ages 52 to 69 Years

**Figure 4-2—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Breast Cancer Screening—Ages 52 to 69 Years**



The 2007 *Breast Cancer Screening—Ages 52 to 69 Years* measure is directly comparable to the *Breast Cancer Screening* rates from 2006 and 2005, as well as to the 2006 national performance standards.

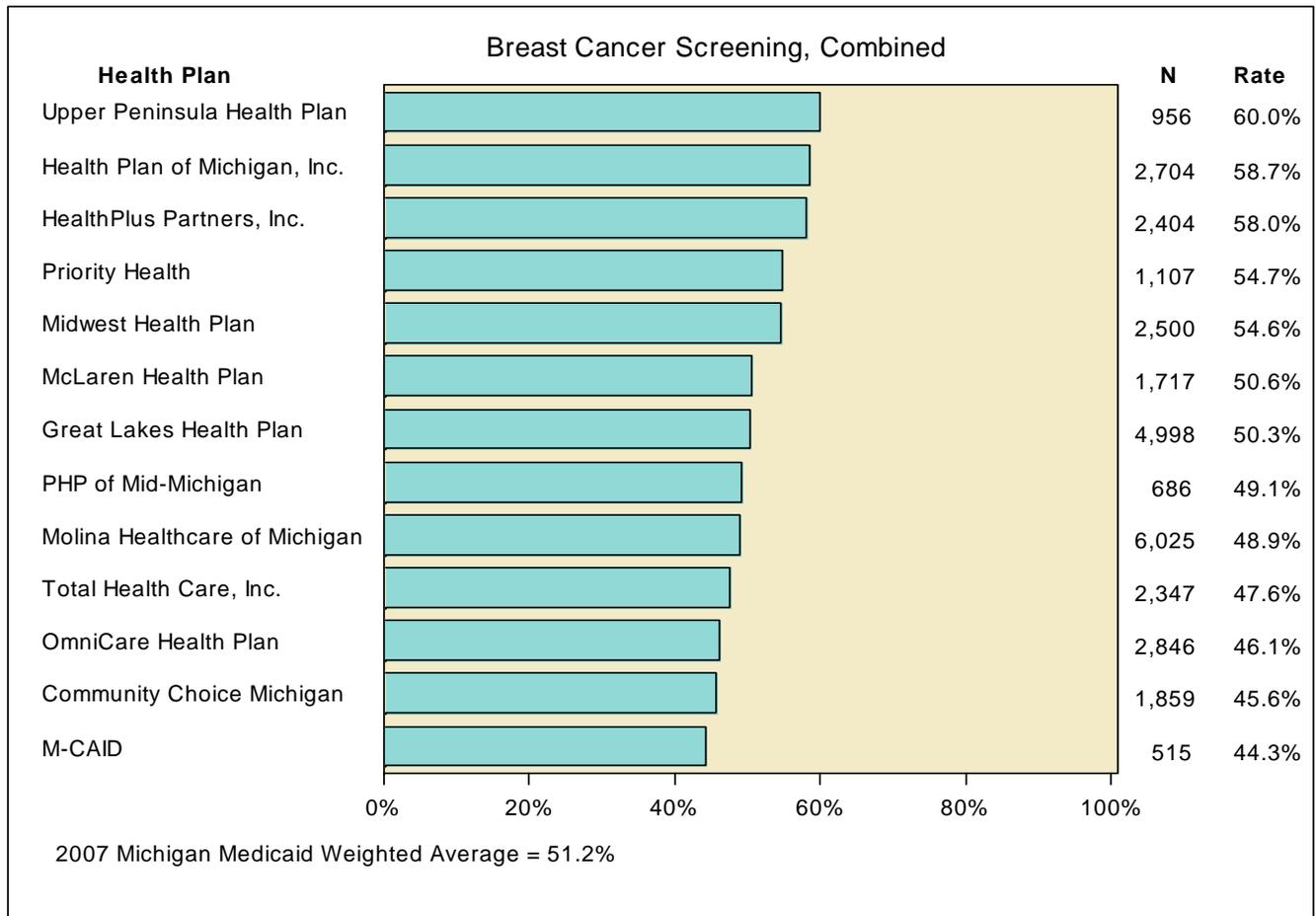
One health plan exceeded the HPL of 65.4 percent, and no health plans ranked below the LPL of 47.1 percent. A total of eight health plans, including the one above the HPL, reported rates above the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 56.6 percent was 2.7 percentage points above the national HEDIS 2006 Medicaid 50th percentile of 53.9 percent.

The 2007 Michigan Medicaid weighted average was 0.8 percentage points higher than the 2006 Michigan Medicaid weighted average and 2.9 percentage points above the 2005 weighted average of 53.7 percent.

Health Plan Ranking: Breast Cancer Screening—Combined Rate

**Figure 4-3—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Breast Cancer Screening—Combined Rate**



The *Breast Cancer Screening—Combined Rate* is considered a new measure for 2007 since it contains a wider age span of women; therefore, national performance data are not available for comparison.

The 2007 Michigan Medicaid weighted average was 51.2 percent. Five health plans reported rates above the weighted average.

Cervical Cancer Screening

Early detection and appropriate treatment of cervical cancer have been shown to have high treatment success rates. In fact, it is estimated that screening reduces cervical cancer by 80 percent.⁴⁻⁹ Older women are more likely to develop cervical cancer; therefore it is important that women continue to have screenings as they age, even with prior negative tests. In Michigan, 93.6 percent of cervical cancer cases are diagnosed in the early stages of the disease.⁴⁻¹⁰ Approximately 83 percent of Michigan women 18 years of age and older have received a Pap test within the past three years, which is the most effective way to detect cervical cancer.⁴⁻¹¹ In 2007, an estimated 370 new cases of cervical cancer will be diagnosed among women in Michigan, according to the ACS.⁴⁻¹²

HEDIS Specification: Cervical Cancer Screening

The *Cervical Cancer Screening* measure reports the percentage of women 21 to 64 years of age who were continuously enrolled during the measurement year and who received one or more Pap tests during the measurement year or the two years prior to the measurement year. There was a minor change to this measure in 2007. The lower age range was raised from 18 to 21 years of age.

⁴⁻⁹ National Committee for Quality Assurance. *The State of Managed Care Quality 2006*. Standard Version. Washington, DC: National Committee for Quality Assurance: 2006.

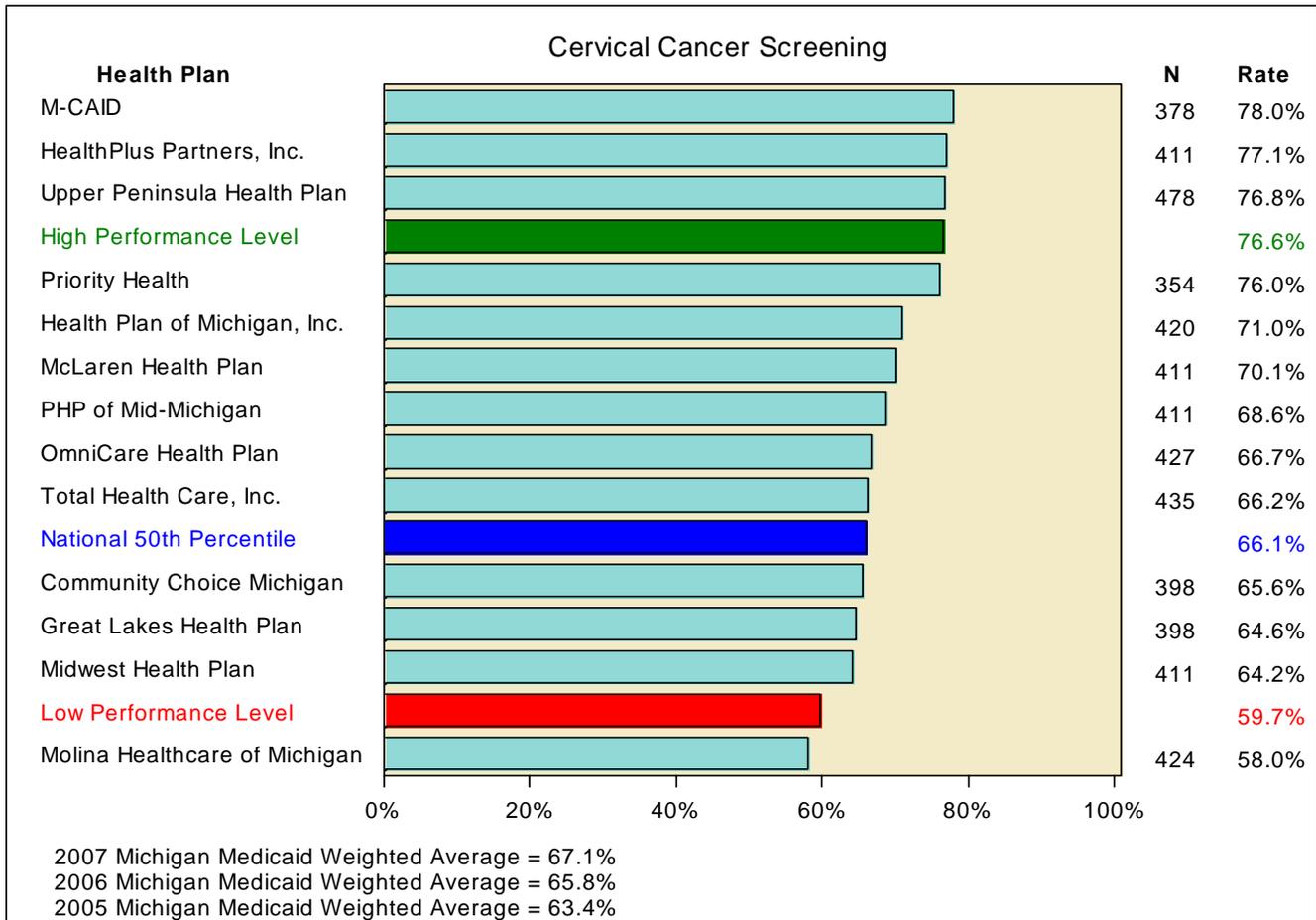
⁴⁻¹⁰ Michigan Department of Community Health. *Cervical Cancer Deaths and Screening*. April 2007. Available at: http://www.michigan.gov/documents/mdch/14_CervCanc_198884_7.pdf. Accessed on: July 18, 2007.

⁴⁻¹¹ Michigan Department of Community Health. *Facts about Cervical Cancer*. February 2007. Available at: http://www.michigan.gov/documents/CervicalFacts_6648_7.pdf. Accessed on: July 18, 2007.

⁴⁻¹² American Cancer Society. *Cancer Facts & Figures 2007*. Available at: <http://www.cancer.org/downloads/STT/CAFF2007PWSecured.pdf>. Accessed on: July 17, 2007.

Health Plan Ranking: Cervical Cancer Screening

**Figure 4-4—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Cervical Cancer Screening**



The revision of the *Cervical Cancer Screening* measure in 2007 should be considered when comparing previously reported rates and national performance data. The lower age range was raised from 18 to 21 years of age.

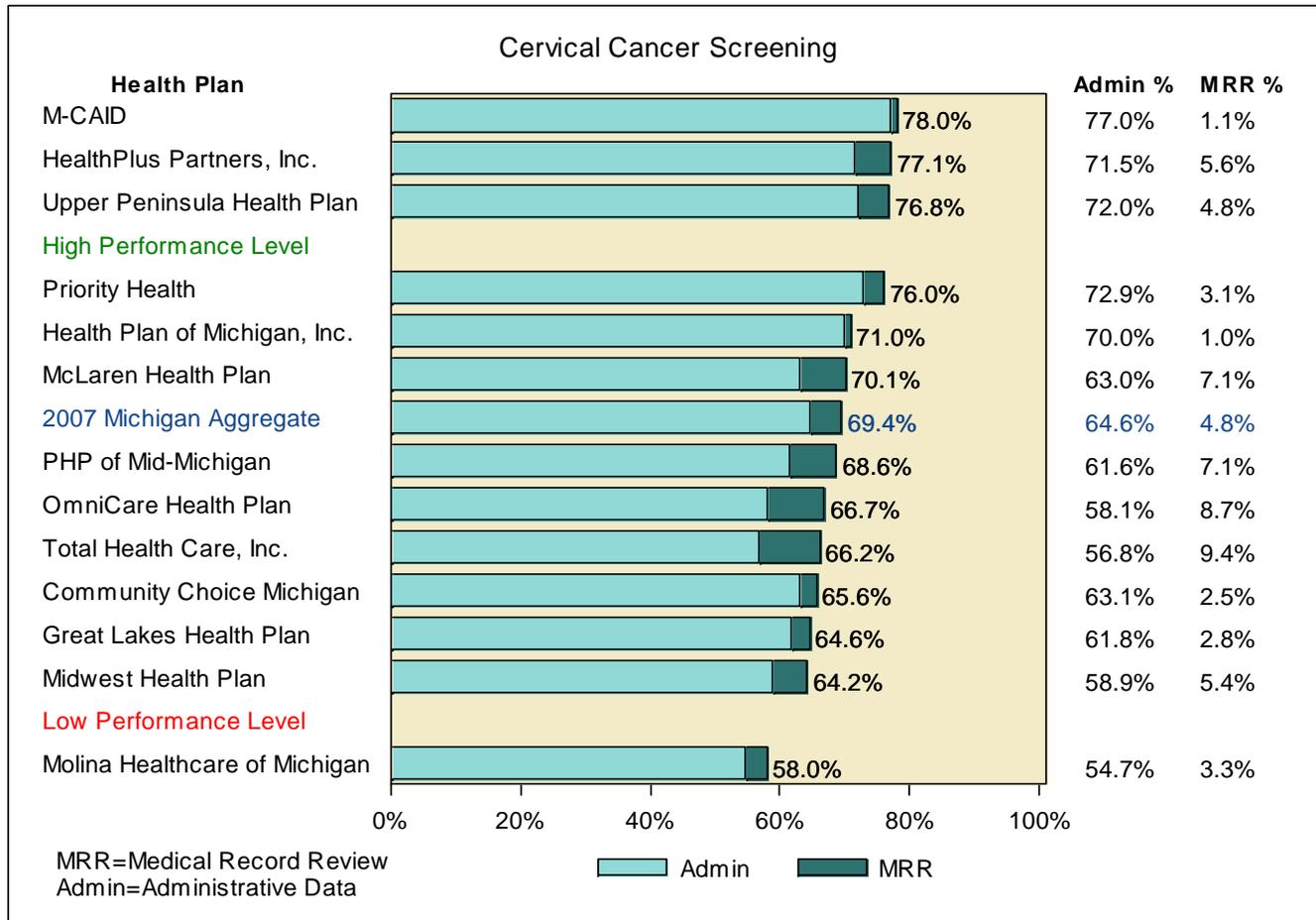
Three health plans exceeded the HPL of 76.6 percent and one health plan reported a rate below the LPL of 59.7 percent. A total of nine health plans, including the three above the HPL, ranked above the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 67.1 percent was 1.0 percentage point above the national HEDIS 2006 Medicaid 50th percentile of 66.1 percent.

The 2007 Michigan Medicaid weighted average was 1.3 percentage points higher than the 2006 Michigan Medicaid weighted average and 3.7 percentage points above the 2005 weighted average of 63.4 percent.

Data Collection Analysis: Cervical Cancer Screening

**Figure 4-5—Michigan Medicaid HEDIS 2007
Data Collection Analysis:
Cervical Cancer Screening**



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much was from medical record review (MRR). Note: Because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All 13 health plans reported this measure using the hybrid method. The 2007 Michigan aggregate administrative rate was 64.6 percent and the medical record review rate was 4.8 percent.

The results indicate that 93.1 percent of the aggregate rate was derived from administrative data and 6.9 percent was from medical record review. The 2007 administrative rate showed an increase of 3.4 percentage points over the 2006 administrative rate.

All of the health plans derived more than 85 percent of their rates from administrative data. The health plans increased their overall rates by anywhere from 1.0 to 9.4 percentage points through medical record review.

Analyses of the findings indicate that health plans' administrative data for the *Cervical Cancer Screening* measure was relatively complete.

Chlamydia Screening in Women

Chlamydia is the most commonly reported STD in the United States, infecting approximately 2.8 million Americans each year.⁴⁻¹³ Chlamydia is sometimes referred to as a “silent” disease because the majority of those who are infected have no symptoms. If left untreated, however, chlamydia can spread into the uterus or fallopian tubes of women and cause pelvic inflammatory disease (PID). Damage resulting from PID can cause chronic pelvic pain, infertility, and potentially fatal ectopic pregnancy. In addition, women with chlamydia are up to five times more likely to become infected with HIV in the event of an exposure.⁴⁻¹⁴ Screening all sexually active women 18 to 24 years of age for chlamydia could potentially prevent 140,000 cases of PID annually and save \$45 per woman screened.⁴⁻¹⁵

Michigan reported 36,746 cases of chlamydia in 2006, with the highest rates occurring in women 15 to 19 years of age and 20 to 24 years of age.⁴⁻¹⁶ To improve detection of chlamydia, Michigan works with the National Infertility Prevention Project, which targets young adults and adolescents. Michigan’s efforts can be seen in the State’s performance in NCQA’s *The State of Health Care Quality, 2006* report. The State of Michigan was the highest-performing State (for its Medicaid population) for the *Chlamydia Screening in Women—Ages 21 to 25 Years* measure.

HEDIS Specification: Chlamydia Screening in Women

The *Chlamydia Screening in Women* measure is reported using the administrative method only. The measure is reported by three separate rates: *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Chlamydia Screening in Women—Ages 21 to 25 Years*, and *Chlamydia Screening in Women—Combined Rate* (the total of both age groups, ages 16 to 25 years).

The *Chlamydia Screening in Women—Ages 16 to 20 Years* rate calculates the percentage of women 16 to 20 years of age who were identified as sexually active, who were continuously enrolled during the measurement year, and who had at least one test for chlamydia during the measurement year.

Chlamydia Screening in Women—Ages 21 to 25 Years reports the percentage of women 21 to 25 years of age who were identified as sexually active, who were continuously enrolled during the measurement year, and who had at least one test for chlamydia during the measurement year.

Chlamydia Screening in Women—Combined Rate reports the sum of both groups, i.e., the two numerators divided by the sum of the denominators. Therefore, *Chlamydia Screening in Women—Combined Rate* reports the percentage of women 16 to 25 years of age who were sexually active, who were continuously enrolled during the measurement year, and who had at least one test for chlamydia during the measurement year.

⁴⁻¹³ Centers for Disease Control and Prevention. *Chlamydia—CDC Fact Sheet*. April 2006. Available at: <http://www.cdc.gov/std/Chlamydia/STDFact-Chlamydia.htm>. Accessed on: July 18, 2007.

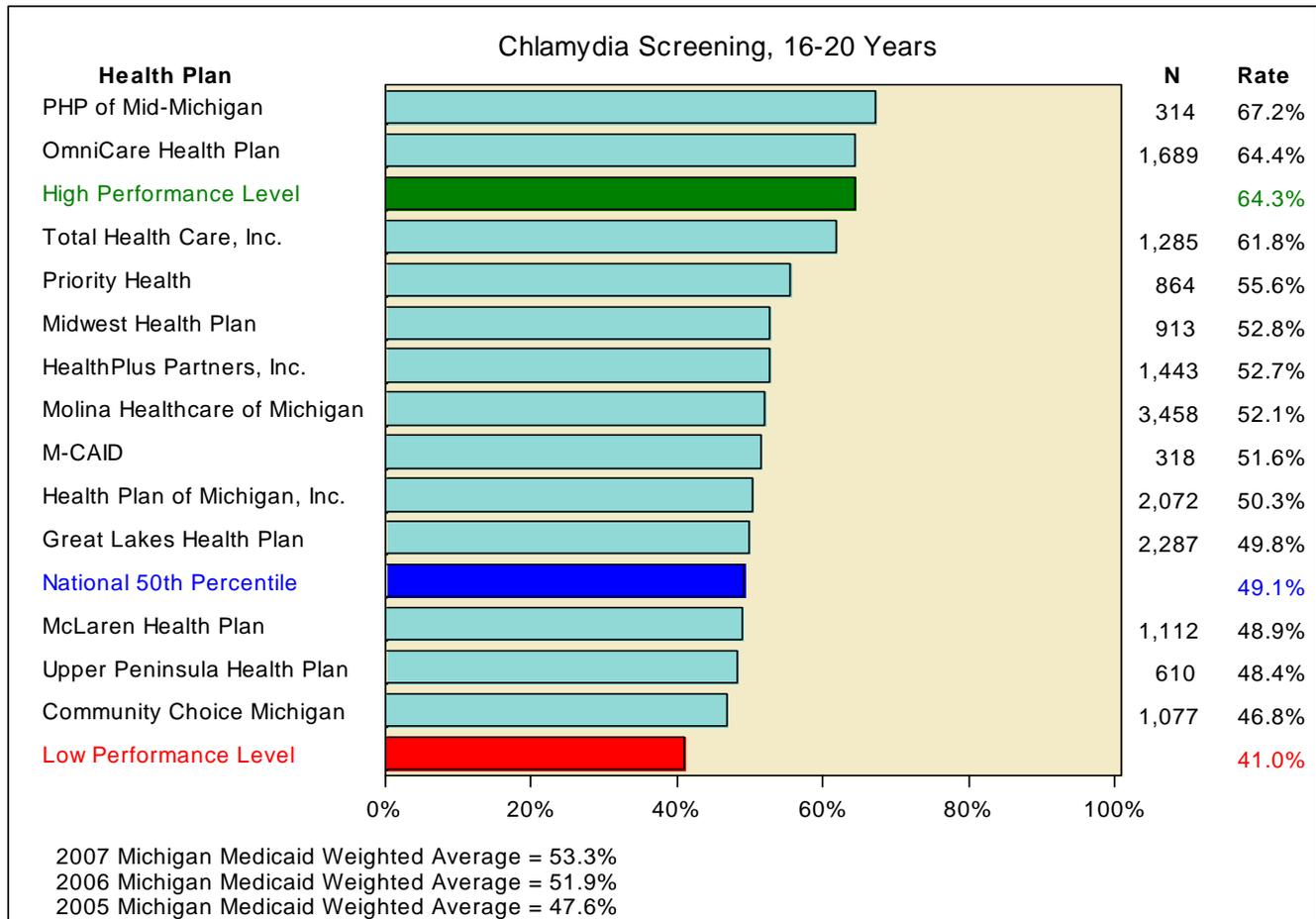
⁴⁻¹⁴ Ibid.

⁴⁻¹⁵ National Committee for Quality Assurance. *The State of Health Care Quality 2006*. Available at: http://www.ncqa.org/communications/sohc2006/sohc_2006.pdf. Accessed on: July 18, 2007.

⁴⁻¹⁶ Michigan Department of Community Health. *Chlamydia*. April 2007. Available at: http://www.michigan.gov/documents/mdch/34_Chlamydia_198935_7.pdf. Accessed on: July 18, 2007.

Health Plan Ranking: Chlamydia Screening in Women—Ages 16 to 20 Years

**Figure 4-6—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Chlamydia Screening in Women—Ages 16 to 20 Years**



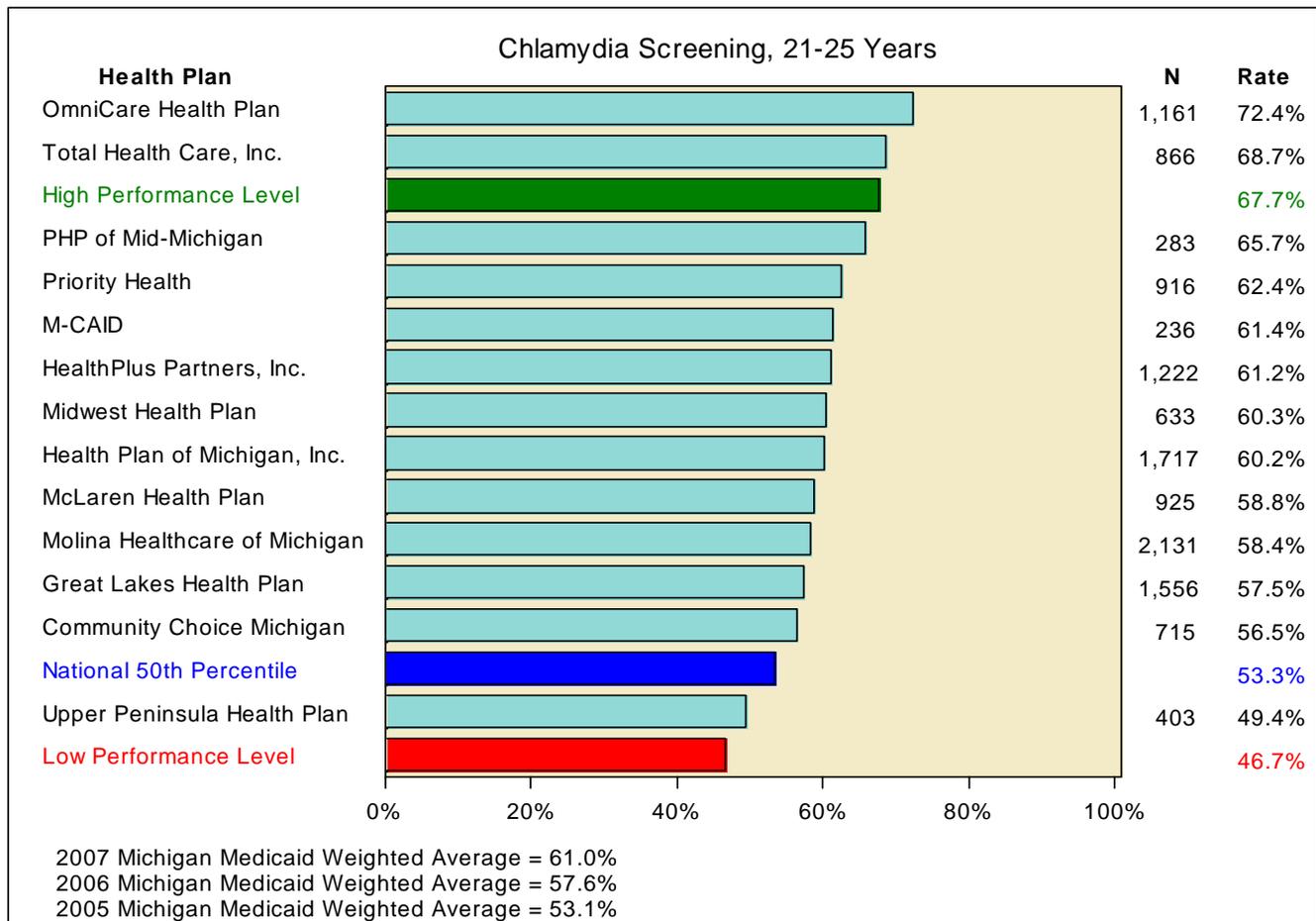
Two health plans had rates above the HPL of 64.3 percent, and none of the health plans had rates below the LPL of 41.0 percent. Ten health plans, including the two with rates above the HPL, ranked above the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 53.3 percent was 4.2 percentage points above the national HEDIS 2006 Medicaid 50th percentile of 49.1 percent.

The 2007 Michigan Medicaid weighted average of 53.3 percent was 1.4 percentage points above the 2006 Michigan Medicaid weighted average and 5.7 percentage points above the 2005 weighted average.

Health Plan Ranking: Chlamydia Screening in Women—Ages 21 to 25 Years

**Figure 4-7—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Chlamydia Screening in Women—Ages 21 to 25 Years**



Two health plans had rates above the HPL of 67.7 percent, and none of the health plans had reported rates below the LPL of 46.7 percent. A total of 12 health plans, including the two above the HPL, reported rates above the national HEDIS 2006 Medicaid 50th percentile.

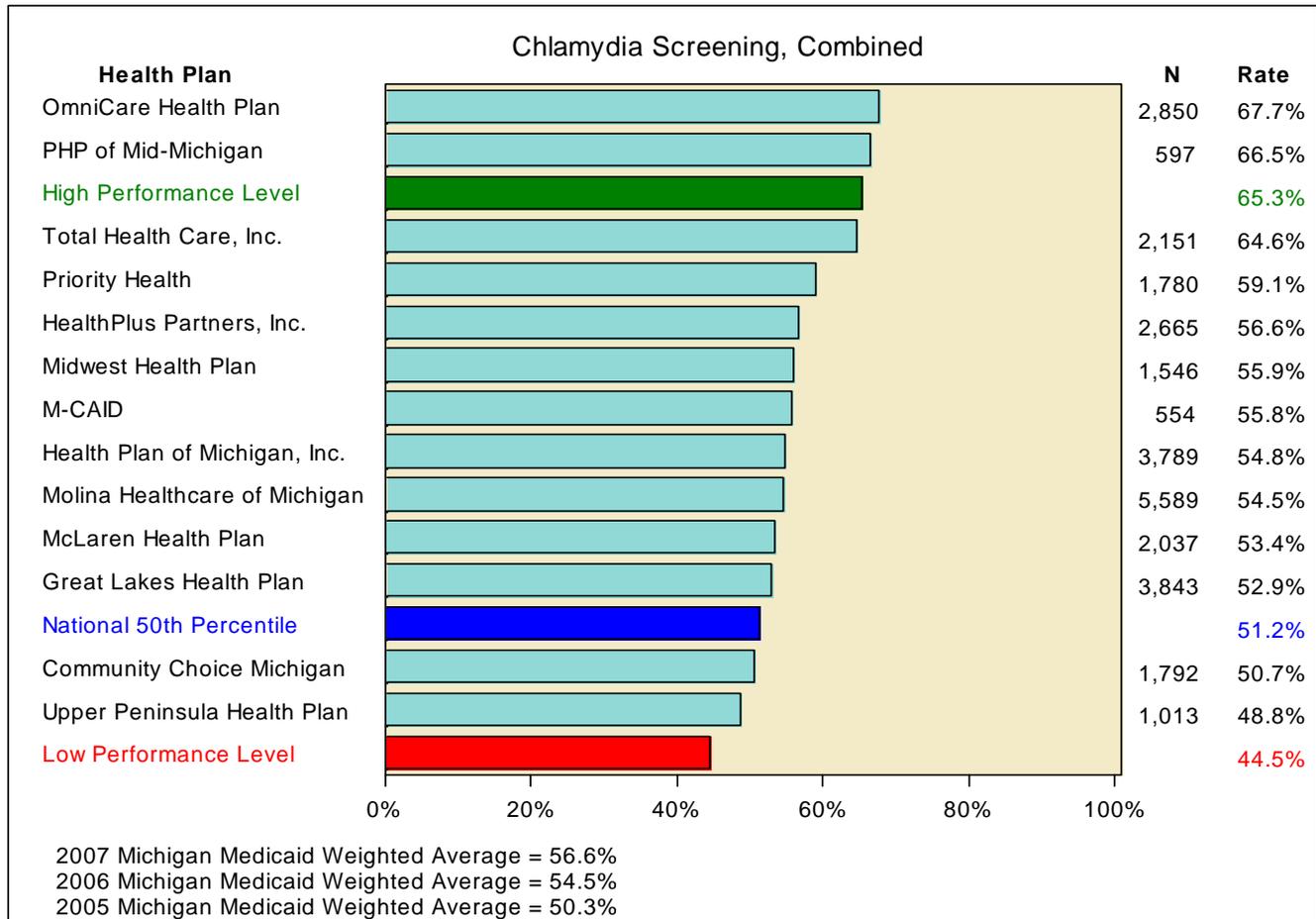
The 2007 Michigan Medicaid weighted average of 61.0 percent was 7.7 percentage points above the national HEDIS 2006 Medicaid 50th percentile of 53.3 percent.

The 2007 Michigan Medicaid weighted average showed an increase from 2006, up 3.4 percentage points. The rate improved by 7.9 percentage points when compared to the 2005 Michigan Medicaid weighted average of 53.1 percent.

The range of reported rates showed improvement from the previous year's rates.

Health Plan Ranking: Chlamydia Screening in Women—Combined Rate

**Figure 4-8—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Chlamydia Screening in Women—Combined Rate**



Two health plans reported rates above the HPL of 65.3 percent, and no health plans had rates below the LPL. Eleven health plans, including the two above the HPL, had reported rates above the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 56.6 percent was 5.4 percentage points above the national HEDIS 2006 Medicaid 50th percentile of 51.2 percent.

The 2007 Michigan Medicaid weighted average of 56.6 percent continued to show improvement with an increase of 2.1 percentage points over the 2006 weighted average and 6.3 percentage points over the 2005 weighted average.

Prenatal and Postpartum Care

More than 4 million infants are born in the United States each year. Approximately 490,000 of these infants are born preterm, and another 322,000 are of low birth weight each year. Low birth weight increases the risk for neuron developmental handicaps, congenital abnormalities, and respiratory illness compared to infants with a normal birth weight. With comprehensive prenatal care, the incidence of low birth weight and infant mortality can be reduced. Additionally, mothers who do not receive prenatal care are three to four times more likely to experience fatal complications related to pregnancy than those who receive prenatal care.⁴⁻¹⁷

More than 127,000 live births occurred in Michigan during 2005. Of this number, 8.4 percent resulted in low-birth-weight infants.⁴⁻¹⁸ In 2005, Michigan's infant mortality rate was 8.2 deaths per 1,000 live births, which ranked 41st nationwide.⁴⁻¹⁹ Race continues to have a significant impact on infant mortality rates in Michigan. Among African Americans the rate was 17.9 per 1,000 live births, while for Caucasians it was 5.5 per 1,000 live births in 2005.⁴⁻²⁰

While care strategies tend to emphasize the prenatal period, appropriate care during the postpartum period can also prevent complications and deaths. For example, more than 60 percent of maternal deaths occur during the postpartum period.⁴⁻²¹ Studies have also shown that women who receive more postdelivery care have lower maternal, fetal, and neonatal illness and mortality.⁴⁻²²

This measure examines whether or not care is available to members when needed and whether that care is provided in a timely manner. The measure consists of the following two numerators:

- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- ◆ *Prenatal and Postpartum Care—Postpartum Care*

HEDIS Specification: Prenatal and Postpartum Care—Timeliness of Prenatal Care

The *Timeliness of Prenatal Care* measure calculates the percentage of women who delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year, who were continuously enrolled at least 45 days prior to delivery through 56 days after delivery, and who received a prenatal care visit as an MHP member in the first trimester or within 42 days of enrollment in the MHP.

⁴⁻¹⁷ National Committee for Quality Assurance. *The State of Health Care Quality 2006*. Available at: http://www.ncqa.org/communications/sohc2006/sohc_2006.pdf. Accessed on: July 18, 2007.

⁴⁻¹⁸ Michigan Department of Community Health. *Numbers and Percents of Low Birthweight Live Births by Prenatal Care Index, by Race and Ancestry of Mother Michigan Residents, 2005*. Available at: <http://www.mdch.state.mi.us/pha/osr/natality/tab1.10.asp>. Accessed on: July 25, 2007.

⁴⁻¹⁹ United Health Foundation. *America's Health. State Health Rankings*. 2005 Edition. Available at: <http://www.unitedhealthfoundation.org/shr2005/components/infantmortality.html>. Accessed on: July 25, 2007.

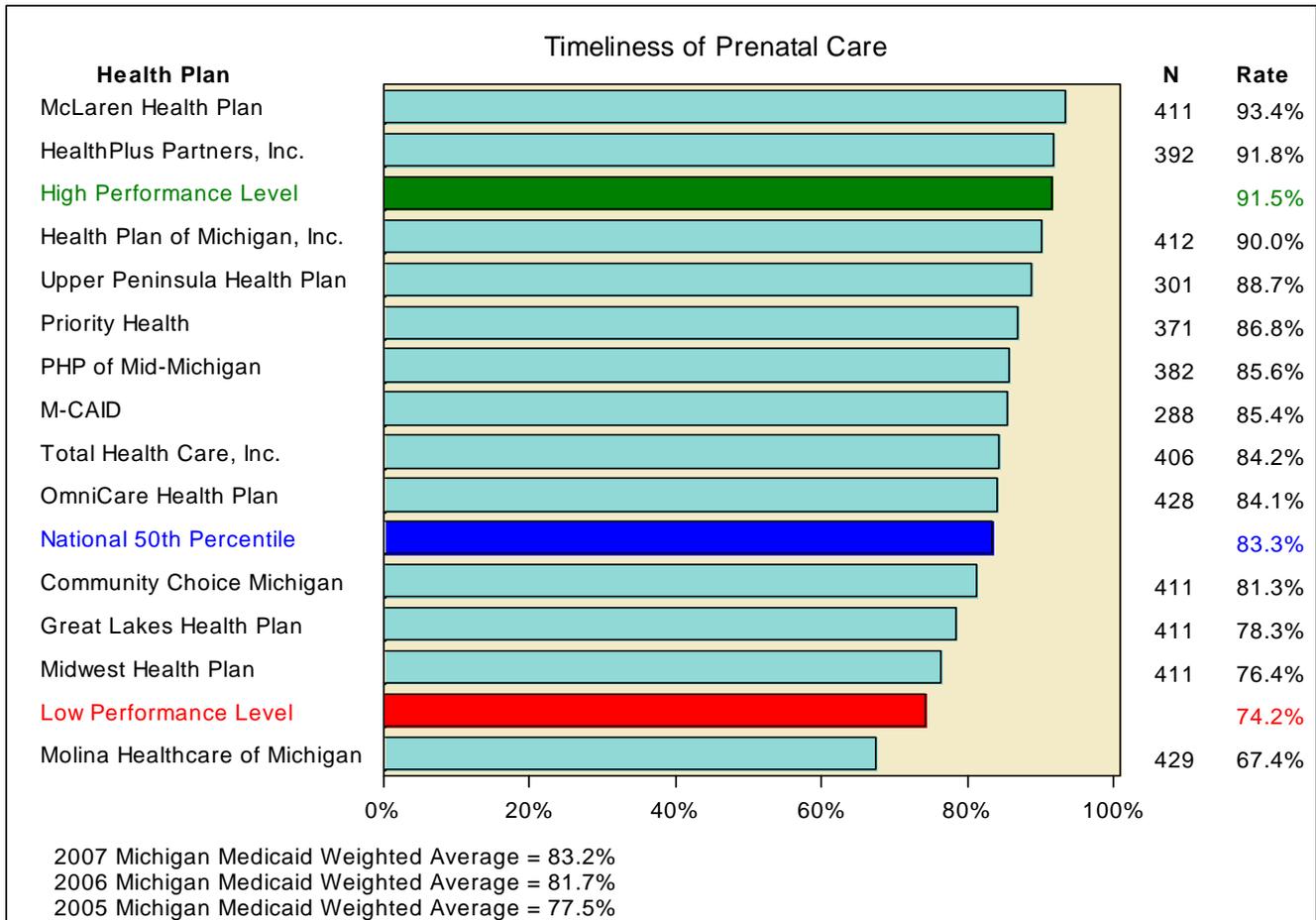
⁴⁻²⁰ Michigan Department of Community Health. Michigan Resident Birth and Death Files, Vital Records & Health Data Development Section. Available at: <http://www.mdch.state.mi.us/pha/osr/InDxMain/Tab2.asp>. Accessed on: July 25, 2007.

⁴⁻²¹ Family Health International. Better Postpartum Care Saves Lives. *Network*. Summer 1997, 17(4). Available at: http://www.fhi.org/en/RH/Pubs/Network/v17_4/postpartum.htm. Accessed on: July 26, 2007.

⁴⁻²² National Committee for Quality Assurance. *The State of Health Care Quality 2003*. Available at: http://www.ncqa.org/sohc2003/prenatal_and_postpartum_care.htm. Accessed on: July 26, 2007.

Health Plan Ranking: Prenatal and Postpartum Care—Timeliness of Prenatal Care

**Figure 4-9—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Prenatal and Postpartum Care—Timeliness of Prenatal Care**



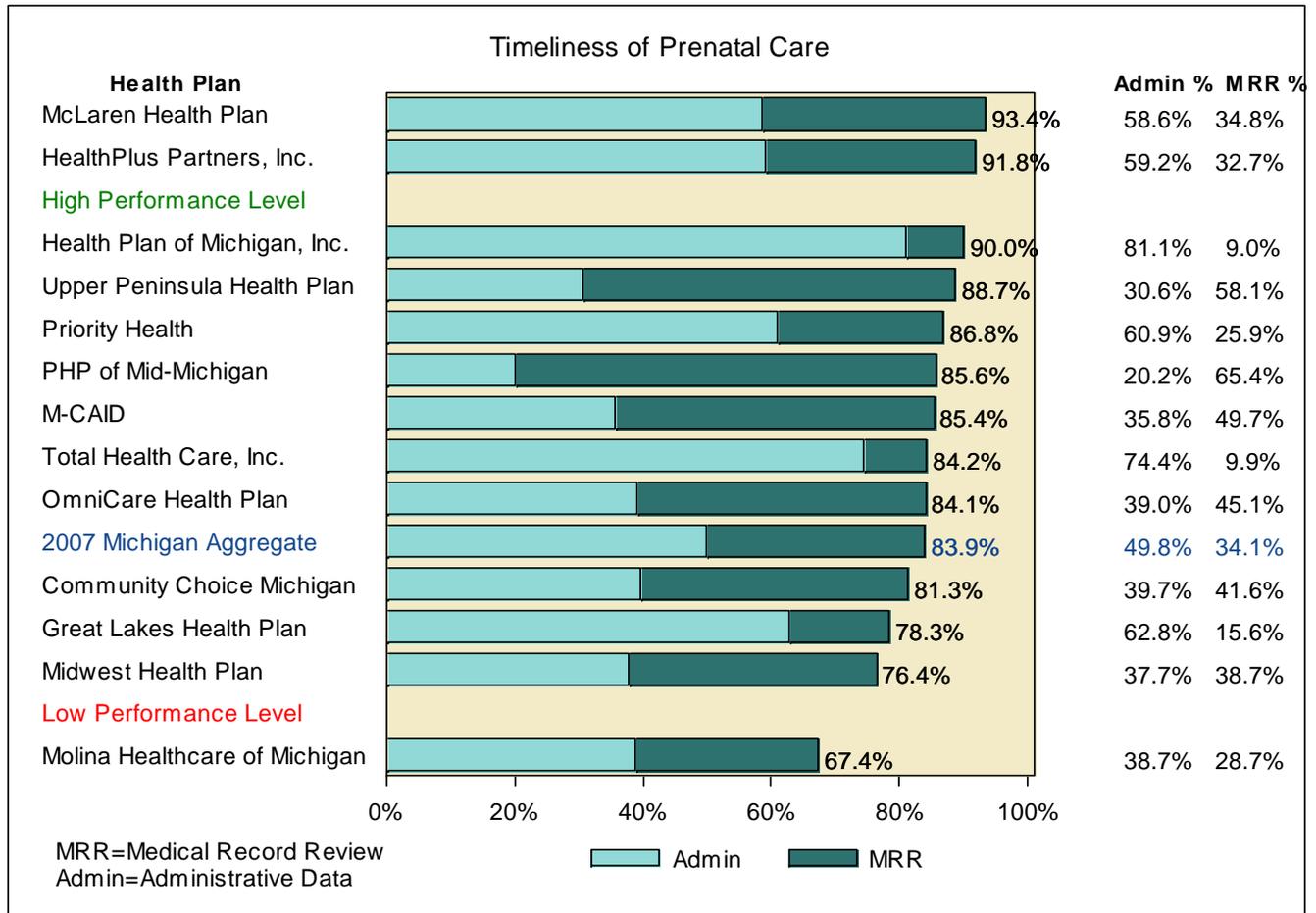
Two health plans had rates above the HPL of 91.5 percent and one health plan had a reported rate below the LPL of 74.2 percent. Nine health plans, including the two above the HPL, had rates above the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 83.2 percent was 0.1 percentage points below the national HEDIS 2006 Medicaid 50th percentile of 83.3 percent.

The 2007 Michigan Medicaid weighted average showed an increase from 2006, up 1.5 percentage points. A gain of 5.7 percentage points was observed when the 2007 weighted average was compared to the 2005 Michigan Medicaid weighted average of 77.5 percent.

Data Collection Analysis: Prenatal and Postpartum Care—Timeliness of Prenatal Care

**Figure 4-10—Michigan Medicaid HEDIS 2007
Data Collection Analysis:
Prenatal and Postpartum Care—Timeliness of Prenatal Care**



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much was from medical record review (MRR). Note: Because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All of the health plans used the hybrid method to report this measure. The 2007 Michigan aggregate administrative rate was 49.8 percent and the medical record review rate was 34.1 percent.

Overall, 59.4 percent of the aggregate rate was derived from administrative data and 40.6 percent was derived from medical record review data. The administrative rate decreased by 0.8 percentage points when compared to the 2006 rate.

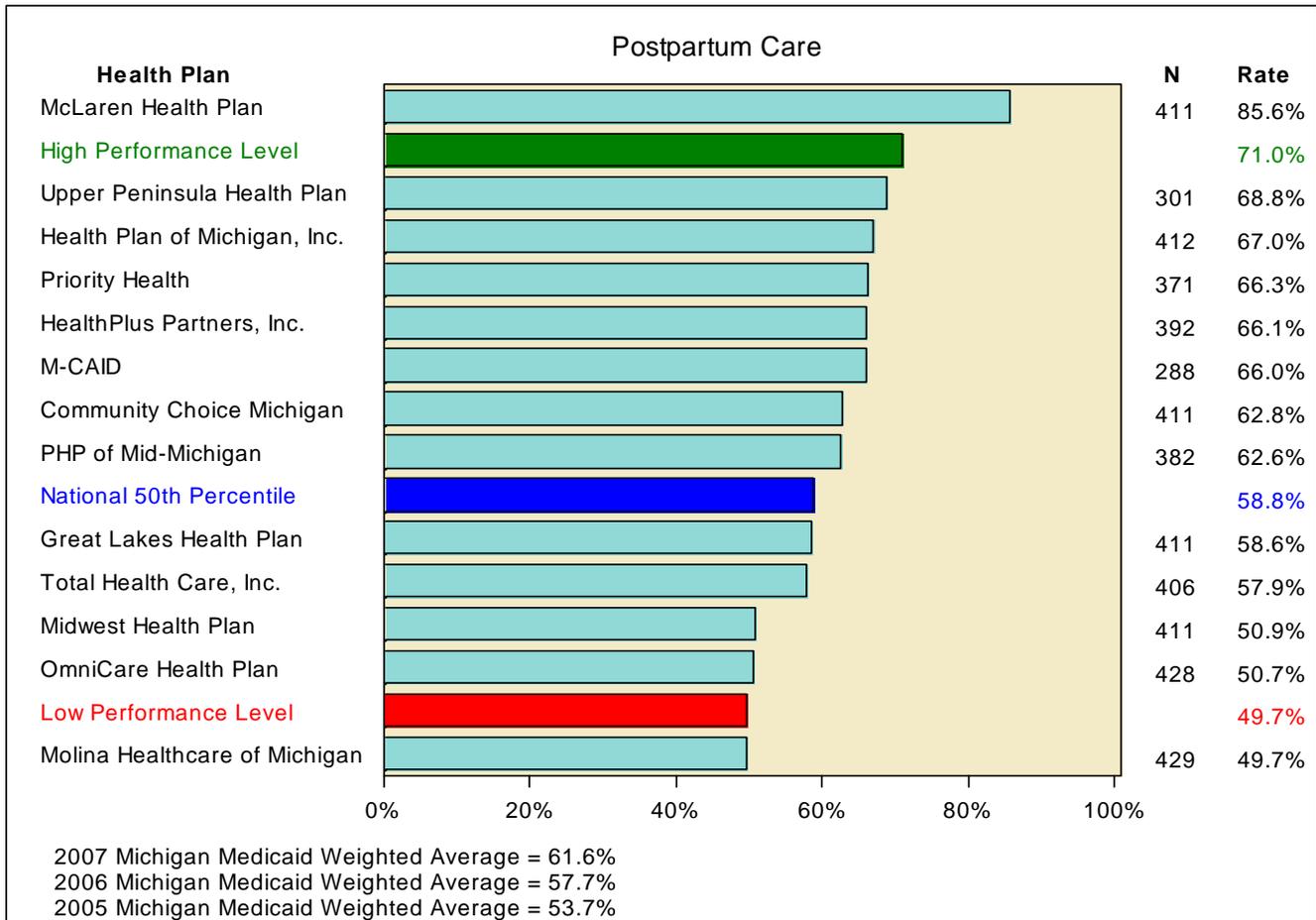
Seven health plans derived more than half of their rates from administrative data, and one health plan derived less than one-quarter of its rate from administrative data.

HEDIS Specification: Prenatal and Postpartum Care—Postpartum Care

The *Postpartum Care* measure reports the percentage of women who delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year, who were continuously enrolled at least 45 days prior to delivery through 56 days after delivery, and who received a postpartum visit on or between 21 days and 56 days after delivery.

Health Plan Ranking: Prenatal and Postpartum Care—Postpartum Care

**Figure 4-11—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Prenatal and Postpartum Care—Postpartum Care**



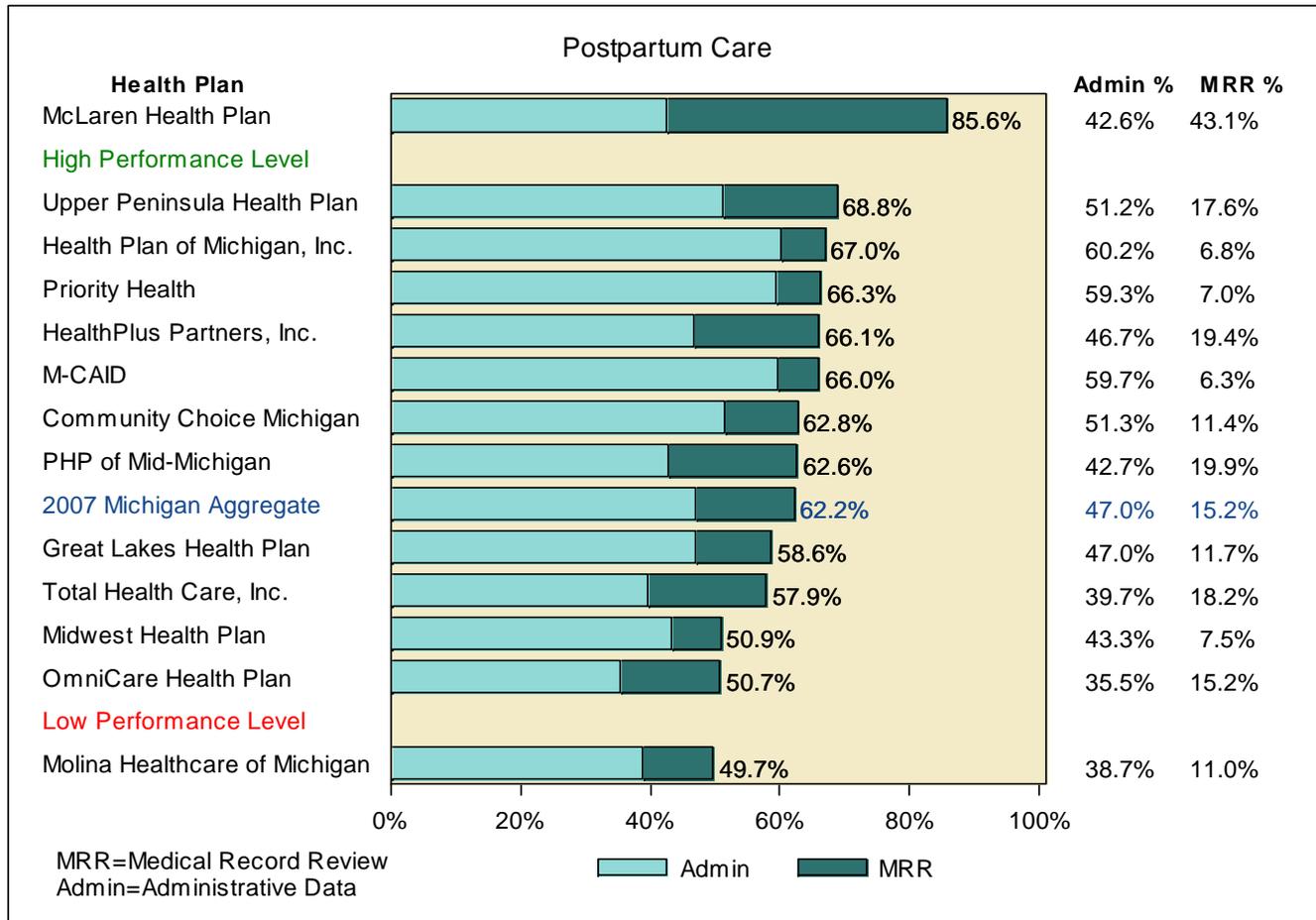
One of the health plans reported a rate above the HPL of 71.0 percent, and one health plan reported a rate equal to the LPL of 49.7 percent. A total of eight health plans' rates, including the one above the HPL, were above the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 61.6 percent was 2.8 percentage points above the national HEDIS 2006 Medicaid 50th percentile of 58.8 percent.

The 2007 Michigan Medicaid weighted average showed an increase over 2006, up 3.9 percentage points. A gain of 7.9 percentage points was observed when the 2007 weighted average was compared to the 2005 weighted average.

Data Collection Analysis: Prenatal and Postpartum Care—Postpartum Care

**Figure 4-12—Michigan Medicaid HEDIS 2007
Data Collection Analysis:
Prenatal and Postpartum Care—Postpartum Care**



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much was from medical record review (MRR). Note: Because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All of the health plans elected to report this measure using the hybrid method. The 2007 Michigan aggregate administrative rate was 47.0 percent and the medical record review rate was 15.2 percent.

Overall, 75.6 percent of the aggregate rate was derived from administrative data and 24.4 percent from medical record review. The 2007 administrative rate showed an increase of 5.5 percentage points over the 2006 administrative rate. As seen in 2006, all but one health plan derived at least half of its rate from administrative data in 2007.

This key measure is also susceptible to global billing payment arrangements. Unless an MHP requires provider submission of postpartum care visit data, the health plan will need to rely more heavily on labor-intensive medical record review.

Women's Care Findings and Recommendations

Performance in the Women's Care dimension continues to be an area in which the MHPs should focus more of their quality improvement efforts. Although all of the measures' weighted averages saw some improvement, none of the increases were statistically significant.

The technical specifications for the *Breast Cancer Screening* measure changed in 2007, shifting the lower age range to 42 years of age instead of 52 years of age; therefore, there were no national comparison data for the lower age cohort (42 to 51 years) and for the combined rate. A review of the weighted averages for the *Breast Cancer Screening* age stratifications, 42 to 51 years of age and 52 to 69 years of age, showed where additional improvement efforts might need to be focused. The weighted average for the younger age group was more than 10 percentage points less than the older age group. This suggests that greater attention needs to be paid to the younger cohort to ensure that its members are receiving the necessary screening.

The *Cervical Cancer Screening* measure exhibited a moderate increase in performance from 2006 to 2007. While only one health plan outperformed the HPL in 2006, three plans exceeded this rate in 2007. Of particular concern, however, was that the same four health plans continued to perform below the national HEDIS 2006 Medicaid 50th percentile. In fact, one health plan dropped below the LPL. Therefore, these health plans' interventions should be examined in order to determine areas for improvement, and best practices from higher-performing MHPs should be shared.

Statewide performance for *Chlamydia Screening in Women* continued to improve and all of the weighted averages for the measure remained above the national HEDIS Medicaid 50th percentile. However, there were differences in rates for the younger and older age ranges that were similar to the *Breast Cancer Screening* measures. The weighted average for the 16-to-20-year-old age group was almost 8 percentage points lower than the weighted average of the 21-to-25-year-old age group.

Modest improvements were observed for the *Prenatal and Postpartum Care* measures. Of note was the performance of McLaren Health Plan, which exceeded the HPL for both measures. Molina's performance, on the other hand, fell below the LPL for both of the measures. In fact, Molina's rate for *Timeliness of Prenatal Care* significantly decreased from 2006 to 2007 by 14.6 percentage points, and its *Postpartum Care* rate decreased by 9.1 percentage points.

Historically, administrative data used to identify individual prenatal care visits has been negatively impacted by the use of global billing practices by most health plans. Health plans that do not use global billing payment mechanisms to reimburse providers for prenatal care services typically have more complete administrative data, although this is not always linked to better performance. Health plans that establish a mechanism to collect individual prenatal care dates of service, either through global billing documentation requirements or the use of a prenatal care monitoring program, have been successful not only in decreasing their reliance on medical record review but in actually improving performance.

The following quality improvement activities have shown to be effective in improving Women's Care measures:

- ◆ Early identification of members requiring care
- ◆ Identification of any racial or cultural barriers to accessing care
- ◆ Patient education through brochures, newsletters, and health plan Web sites
- ◆ Reminder postcards and telephone calls to members who have not received screening/care
- ◆ Physician education on standards of care and appropriate methods for submitting claims/encounter data
- ◆ Physician-level reports that indicate a physician's performance on HEDIS measures
- ◆ Improvements to accessibility of care (e.g., providing transportation to appointments, providing additional locations of service through a mobile unit)
- ◆ Member and physician incentives for compliance with standards
- ◆ A forum for MHPs to share best practices

Introduction

Chronic illness afflicts 133 million people—nearly half of all Americans—and accounts for the vast majority of health care spending.⁵⁻¹ The measures in this section (asthma, diabetes, high blood pressure, and smoking) focus on how health plans can help those with ongoing, chronic conditions take care of themselves, control symptoms, avoid complications, and maintain daily activities. Comprehensive programs implemented by health plans can help reduce the prevalence, impact, and economic costs associated with these chronic illnesses.

According to the National Heart, Lung, and Blood Institute, approximately 20 million people in the United States suffer from asthma, including nearly 9 million children. Asthma usually begins during childhood and tends to affect more boys than girls, although the incidence of asthma is higher in adult women than in adult men.⁵⁻² The economic impact of asthma is considerable—the disease costs \$14 billion annually, including \$4.6 billion in lost productivity.⁵⁻³ In Michigan, 654,100 adults and 213,600 children have asthma; the prevalence of adult asthma in Michigan is nearly the same as in the U.S. as a whole. However, asthma hospitalization rates for all age groups are lower in Michigan compared to the rest of the country.⁵⁻⁴

The American Diabetes Association estimates that 7.0 percent of all U.S. citizens (20.8 million people) suffer from diabetes, although only 14.6 million have been diagnosed with the disease. Another 54 million have “pre-diabetes,” which refers to blood glucose levels above normal, but not high enough for a formal diabetes diagnosis.⁵⁻⁵ Diabetes prevalence, mortality, and complication rates have increased steadily in Michigan and in the nation over the last decade. In Michigan, an estimated 593,200 adults have been diagnosed with diabetes, and another 292,000 have undiagnosed diabetes. Additionally, more than 1.5 million Michigan adults have pre-diabetes. The estimated direct medical costs associated with diabetes in Michigan residents was \$4.5 billion in 2004. Indirect costs related to lost work days, restricted activity days, mortality, and disability totaled \$2.0 billion.⁵⁻⁶

The American Heart Association estimates that 72 million adults in the United States have high blood pressure, although only 71 percent of those people are aware of their condition. Failure to

⁵⁻¹ Partnership for Solutions. *Chronic Conditions: Making the Case for Ongoing Care*. Available at: <http://www.partnershipforsolutions.org/DMS/files/chronicbook2004.pdf>. Accessed on: July 27, 2007.

⁵⁻² National Heart, Lung, and Blood Institute. *Who is at risk for Asthma?* Available at: http://www.nhlbi.nih.gov/health/dci/Diseases/Asthma/Asthma_WhoIsAtRisk.html. Accessed on: July 27, 2007.

⁵⁻³ National Committee for Quality Assurance. *The State of Health Care Quality 2006*. Washington DC: National Committee for Quality Assurance; 2006. Available at: http://www.ncqa.org/communications/sohc2006/sohc_2006.pdf. Accessed on: July 27, 2007.

⁵⁻⁴ Michigan Department of Community Health. *Asthma and Preventable Asthma Hospitalizations*. April 2007. Available at: http://www.michigan.gov/documents/mdch/22_Asthma_198922_7.pdf. Accessed on: July 27, 2007.

⁵⁻⁵ American Diabetes Association. *Diabetes Statistics*. Available at: <http://www.diabetes.org/diabetes-statistics/prevalence.jsp>. Accessed on: July 27, 2007.

⁵⁻⁶ Michigan Department of Community Health. *Diabetes in Michigan*. September 2006. Available at: http://michigan.gov/documents/mdch/FactPageMichigan-Darline_2_172250_7.pdf. Accessed on: July 27, 2007.

control high blood pressure can lead to stroke, heart attack, heart failure, or kidney failure. The risk of developing high blood pressure increases with age.⁵⁻⁷ In Michigan, cardiovascular disease is the leading cause of death, causing approximately one of every three deaths.⁵⁻⁸

Cigarette smoking kills about half of all continuing smokers and is the most preventable cause of premature death in the United States. According to the American Lung Association, smoking kills almost 440,000 U.S. residents each year.⁵⁻⁹ Approximately 20 percent of U.S. adults were smokers in 2005. Smoking is the major cause of many cancers, as well as other serious diseases, including heart disease, bronchitis, emphysema, and strokes. The CDC estimates that in 2005, approximately 70 percent of smokers wanted to quit and approximately 19 million adult smokers had stopped smoking for at least one day in the prior 12 months because they were trying to quit.⁵⁻¹⁰

In terms of health-related economic costs, smoking is responsible for more than \$167 billion annually.⁵⁻¹¹ Smoking cessation interventions are less costly than other routine medical interventions; the average cost per smoker for effective cessation treatment is \$165.61.⁵⁻¹² If the overall prevalence of adult smoking in Michigan was reduced by 42 percent, and adult per-capita consumption in the State was reduced by 25 percent, the Michigan Cancer Consortium estimates that there would be 1,100 fewer lung cancer deaths each year among Michigan adults.⁵⁻¹³

The Living With Illness dimension encompasses the following MDCH key measures:

◆ **Comprehensive Diabetes Care**

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—Poor HbA1c Control*
- *Comprehensive Diabetes Care—Eye Exam*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—LDL-C Level <100*
- *Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy*

◆ **Use of Appropriate Medications for People With Asthma**

- *Use of Appropriate Medications for People With Asthma—Ages 5 to 9 Years*
- *Use of Appropriate Medications for People With Asthma—Ages 10 to 17 Years*
- *Use of Appropriate Medications for People With Asthma—Ages 18 to 56 Years*
- *Use of Appropriate Medications for People With Asthma—Combined Rate*

⁵⁻⁷ National Committee for Quality Assurance. *The State of Health Care Quality, 2006*. Washington DC: National Committee for Quality Assurance; 2006. Available at: http://www.ncqa.org/communications/sohc2006/sohc_2006.pdf. Accessed on: July 27, 2007.

⁵⁻⁸ Michigan Department of Community Health. *2007 CVD Fact Sheet*. Available at: http://michigan.gov/documents/mdch/CVDFactsheet2007bcol_202765_7.pdf. Accessed on: July 30, 2007.

⁵⁻⁹ American Lung Association. *Trends in Tobacco Use*. June 2007. Available at: http://www.lungusa.org/atf/cf/%7B7A8D42C2-FCCA-4604-8ADE-7F5D5E762256%7D/TREND_TOBACCO_JUNE07.PDF. Accessed on: July 30, 2007.

⁵⁻¹⁰ Centers for Disease Control and Prevention. *Smoking & Tobacco Use Cessation*. March 2007. Available at: http://www.cdc.gov/tobacco/data_statistics/Factsheets/cessation2.htm#. Accessed on: July 30, 2007.

⁵⁻¹¹ American Cancer Society. *Tobacco-Related Cancers Fact Sheet*. Available at: http://www.cancer.org/docroot/PED/content/PED_10_2x_Tobacco-Related_Cancers_Fact_Sheet.asp?sitearea=PED. Accessed on: July 30, 2007.

⁵⁻¹² U.S. Public Health Service. *Treating Tobacco Use and Dependence—A Systems Approach. A Guide for Health Care Administrators, Insurers, Managed Care Organizations, and Purchasers*. November 2000. Available at: <http://www.surgeongeneral.gov/tobacco/systems.htm>. Accessed on: July 30, 2007.

⁵⁻¹³ Michigan Department of Community Health. *Facts About Lung Cancer*. February 2007. Available at: <http://www.michigancancer.org/PDFs/MDCHFactSheets/LungCAFactSheet-Feb07.pdf>. Accessed on: July 30, 2007.

- ◆ **Controlling High Blood Pressure**
 - *Controlling High Blood Pressure—Ages 18 to 45 Years*
 - *Controlling High Blood Pressure—Ages 46 to 85 Years*
 - *Controlling High Blood Pressure—Combined Rate*
- ◆ **Medical Assistance With Smoking Cessation**
 - *Advising Smokers to Quit*
 - *Smoking Cessation Strategies*

The following pages provide detailed analysis of Michigan MHP performance and rankings, as well as the data collection methodology used for these measures.

Comprehensive Diabetes Care

Nearly 1.5 million Americans (20 years of age and older) were newly diagnosed with diabetes in 2005, contributing to a total prevalence of nearly 15 million people with diabetes. The annual per-capita costs of health care for diabetics increased from \$10,071 in 1997 to \$13,243 in 2002. Overall, one of every 10 dollars spent on health care in the U.S. is spent on diabetes and its complications.⁵⁻¹⁴

In 2004, diabetes was the leading cause of death for 2,954 people in Michigan and contributed to an additional 5,462 deaths.⁵⁻¹⁵ In addition, diabetes is the leading cause of blindness and kidney failure in Michigan and a major factor in hypertension, cardiovascular disease, and lower-extremity amputations.⁵⁻¹⁶ However, control of blood glucose levels can significantly reduce the rate of these complications and improve quality of life for diabetics. It is estimated that for every 1 percent reduction in blood glucose levels, the risk of developing diabetic retinal (eye) disease, kidney/end-stage renal disease, and nerve disease drops by 40 percent.⁵⁻¹⁷ Therefore, a comprehensive assessment of diabetes care necessitates examination of multiple factors. This measure contains a variety of indicators, each of which provides a critical element of information. When viewed simultaneously, the components build a comprehensive picture of the quality of diabetes care.

The *Comprehensive Diabetes Care* measure is reported using nine separate rates; however, only six were included in this report. The six rates listed below are considered key measures for reporting purposes.

1. *Comprehensive Diabetes Care—HbA1c Testing*
2. *Comprehensive Diabetes Care—Poor HbA1c Control*
3. *Comprehensive Diabetes Care—Eye Exam*
4. *Comprehensive Diabetes Care—LDL-C Screening*
5. *Comprehensive Diabetes Care—LDL-C Level <100*
6. *Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy*

The following pages show in detail the performance profile, health plan rankings, and analysis of data collection methodology used by the Michigan MHPs for each of these measures.

⁵⁻¹⁴ American Diabetes Association. *Direct and Indirect Costs of Diabetes in the United States*. Available at: <http://www.diabetes.org/diabetes-statistics/cost-of-diabetes-in-us.jsp>. Accessed on: July 30, 2007.

⁵⁻¹⁵ Michigan Department of Community Health. *Diabetes in Michigan*. September 2006. Available at: http://www.michigan.gov/documents/mdch/FactPageMichigan-Darline_2_172250_7.pdf. Accessed on: July 30, 2007.

⁵⁻¹⁶ Michigan Department of Community Health. *Michigan Diabetes Strategic Plan*. October 2003. Available at: http://www.michigan.gov/documents/DM_StrategicPlan_82795_7.pdf. Accessed on: July 30, 2007.

⁵⁻¹⁷ National Committee for Quality Assurance. *The State of Health Care Quality 2006*. Washington DC: National Committee for Quality Assurance; 2005. Available at: http://www.ncqa.org/communications/sohc2006/sohc_2006.pdf. Accessed on: July 30, 2007.

Comprehensive Diabetes Care—HbA1c Testing

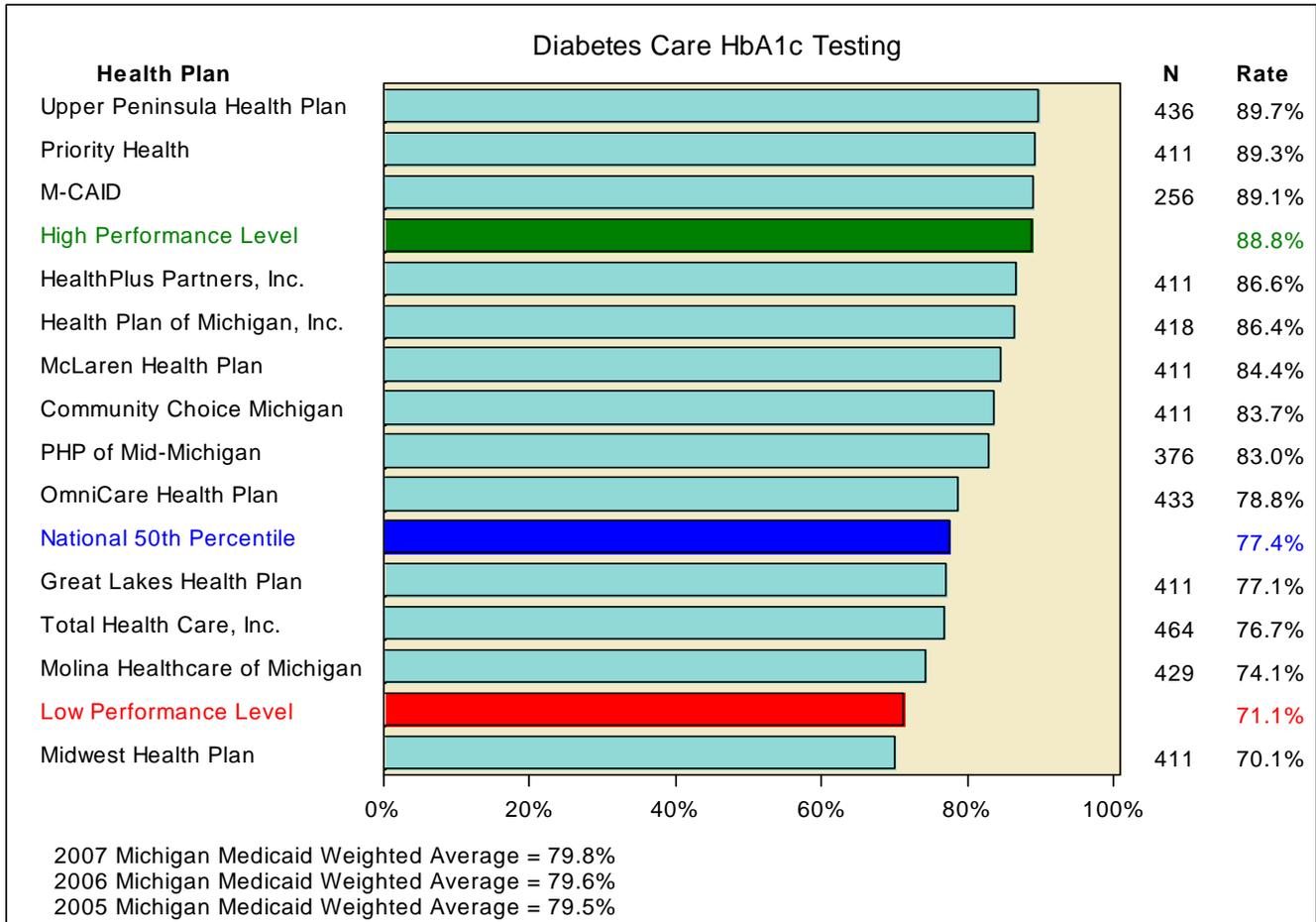
The HbA1c test (hemoglobin A1c test or glycosylated hemoglobin test) shows the average blood glucose level over a period of two to three months. Specifically, the test measures the number of glucose molecules attached to hemoglobin in red blood cells. Although constantly replaced, individual cells live for about four months. By measuring attached glucose in a current blood sample, average blood sugar levels from the previous two to three months can be determined. HbA1c test results are expressed as a percentage, with 4 percent to 6 percent considered normal. The HbA1c test complements the day-to-day snapshots obtained from the self-monitoring of blood glucose levels (mg/dL).

HEDIS Specification: Comprehensive Diabetes Care—HbA1c Testing

The *Comprehensive Diabetes Care—HbA1c Testing* rate reports the percentage of members with diabetes (Type 1 and Type 2) 18 to 75 years of age who were continuously enrolled during the measurement year and who had one or more HbA1c test(s) conducted during the measurement year identified through either administrative data or medical record review.

Health Plan Ranking: Comprehensive Diabetes Care—HbA1c Testing

**Figure 5-1—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Comprehensive Diabetes Care—HbA1c Testing**



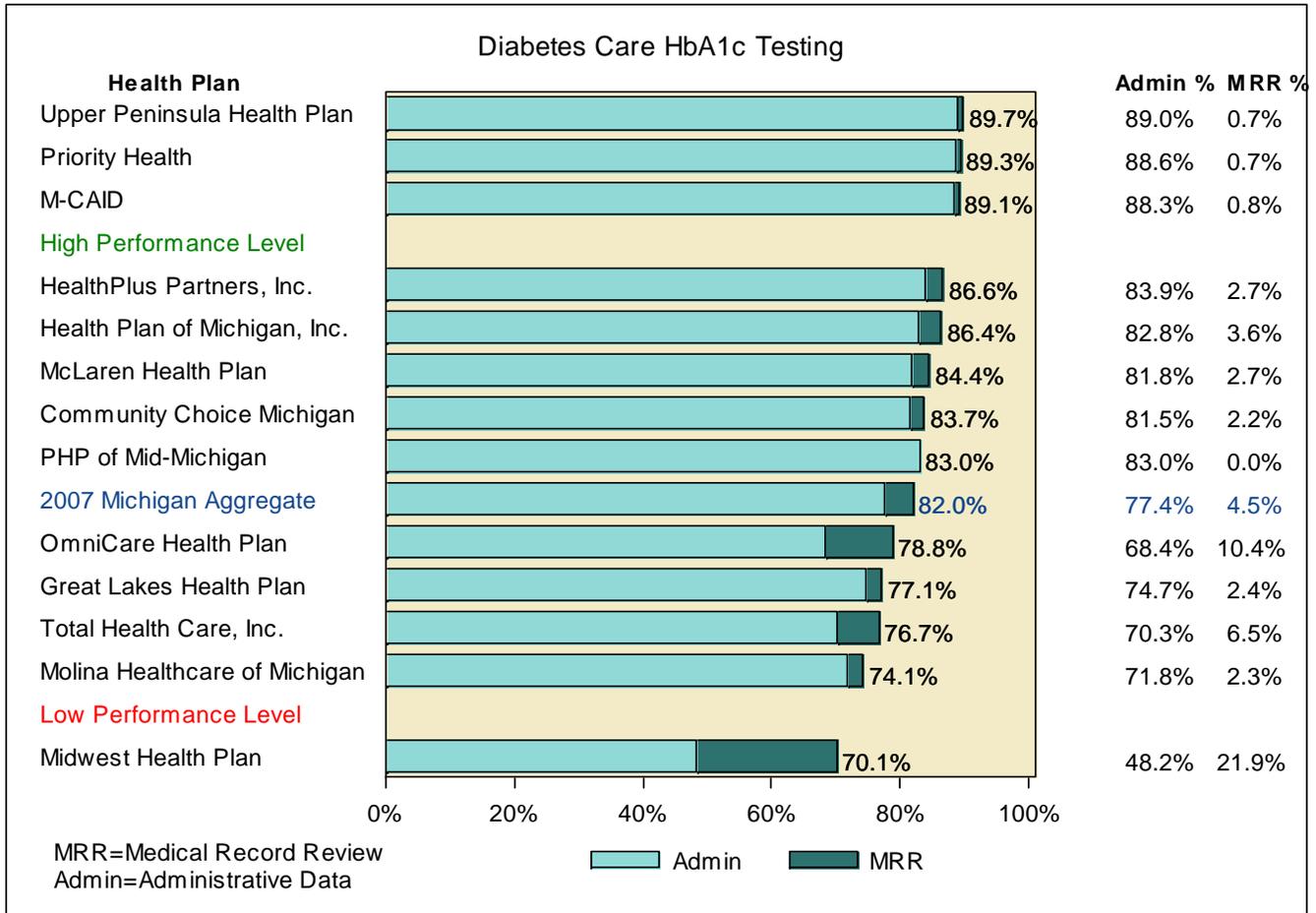
Three health plans reported rates above the HPL of 88.8 percent, and one health plan had a rate below the LPL of 71.1 percent. A total of nine health plans, including the three above the HPL, had reported rates higher than the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 79.8 percent was 2.4 percentage points above the national HEDIS 2006 50th percentile of 77.4 percent.

The weighted average has not shown much change in the past three years. The 2007 Michigan Medicaid weighted average of 79.8 percent is only 0.3 percentage points higher than the 2005 Michigan Medicaid weighted average.

Data Collection Analysis: Comprehensive Diabetes Care—HbA1c Testing

**Figure 5-2—Michigan Medicaid HEDIS 2007
Data Collection Analysis:
Comprehensive Diabetes Care—HbA1c Testing**



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much was from medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All of the health plans used the hybrid method to calculate this measure. The 2007 Michigan aggregate administrative rate was 77.4 percent and the medical record review rate was 4.5 percent.

In 2007, 94.4 percent of the aggregate rate was derived from administrative data and 5.5 percent was from medical record review. The administrative rate increased by 1.9 percentage points from 2006 to 2007.

All of the health plans derived more than two-thirds of their rates from administrative data. One health plan increased its overall rate by more than 20 percentage points from medical record review.

As seen in the figure above, administrative data completeness (i.e., claims and encounter data submission) was not an issue for a majority of health plans for this measure. This implies that providers and/or laboratories routinely submitted claims and encounter data for diabetic members who received HbA1c testing.

Comprehensive Diabetes Care—Poor HbA1c Control

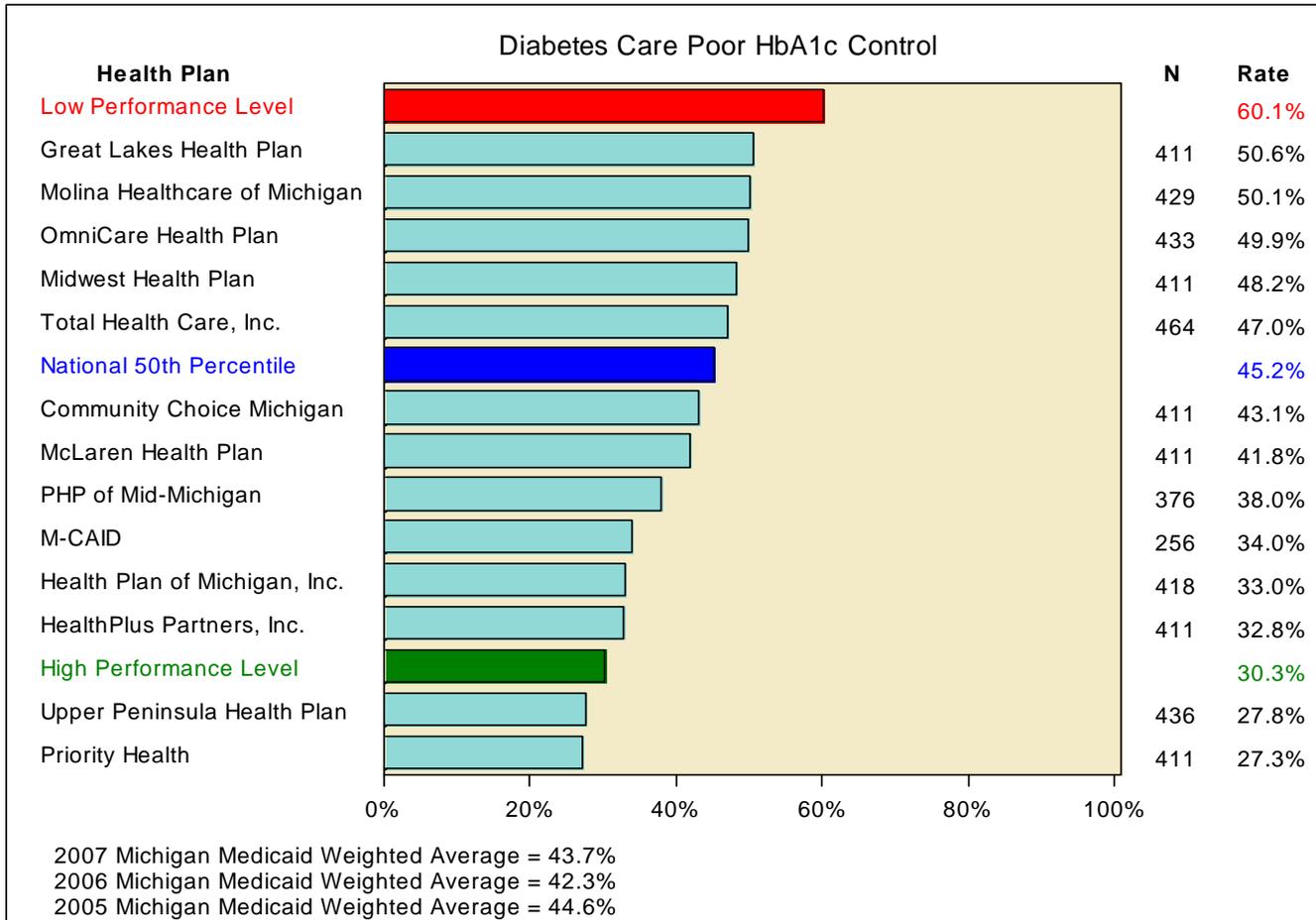
HbA1c control improves quality of life, increases work productivity, and decreases health care utilization. Decreasing the HbA1c level lowers the risk of diabetes-related death. Controlling blood glucose levels in people with diabetes significantly reduces the risk for blindness, end-stage renal disease, and lower extremity amputation.

HEDIS Specification: Comprehensive Diabetes Care—Poor HbA1c Control

The *Comprehensive Diabetes Care—Poor HbA1c Control* rate reports the percentage of members with diabetes (Type 1 and Type 2) 18 to 75 years of age who were continuously enrolled during the measurement year and whose most recent HbA1c test conducted during the measurement year showed an HbA1c level of more than 9 percent, as documented through automated laboratory data and/or medical record review. If there was not an HbA1c level during the measurement year, the level is considered to be greater than 9 percent (i.e., no test is counted as poor HbA1c control).

Health Plan Ranking: Comprehensive Diabetes Care—Poor HbA1c Control

**Figure 5-3—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Comprehensive Diabetes Care—Poor HbA1c Control**



For this key measure, a *lower* rate indicates *better* performance since low rates of *Poor HbA1c Control* indicate better care.

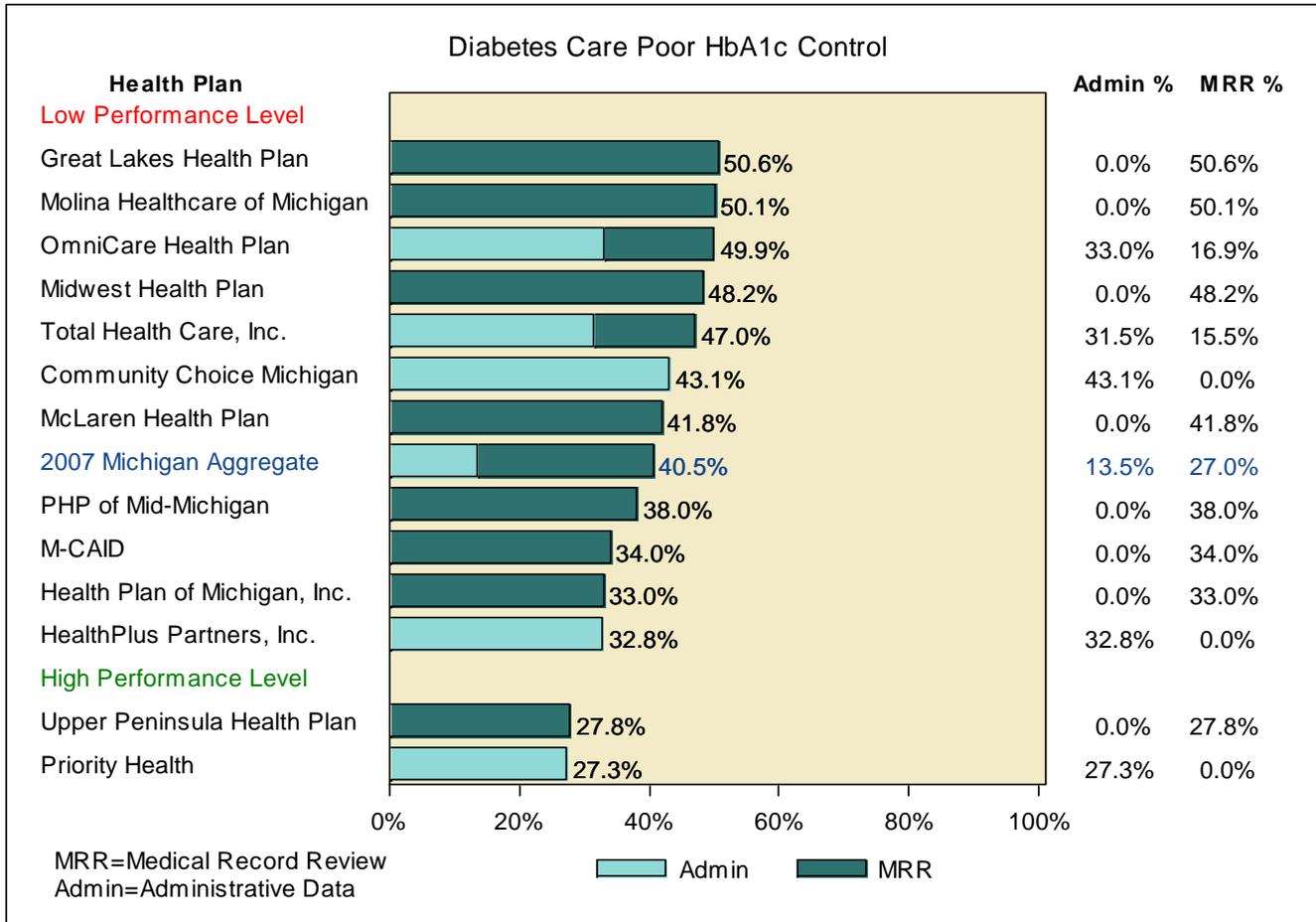
Two health plans’ reported rates that outperformed the HPL of 30.3 percent, and no health plans had rates above the LPL of 60.1 percent. A total of eight health plans performed better than the national HEDIS 2006 Medicaid 50th percentile, indicating better performance.

The 2007 Michigan Medicaid weighted average of 43.7 percent was 1.5 percentage points below the national HEDIS 2006 Medicaid 50th percentile of 45.2 percent. This suggests that the MHPs performed slightly better than health plans nationally for this measure.

The 2007 Michigan Medicaid weighted average increased by 1.4 percentage points over the 2006 weighted average. This slight increase demonstrates a decline in performance from the previous year.

Data Collection Analysis: Comprehensive Diabetes Care—Poor HbA1c Control

**Figure 5-4—Michigan Medicaid HEDIS 2007
Data Collection Analysis:
Comprehensive Diabetes Care—Poor HbA1c Control**



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much was from medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

For this key measure, a *lower* rate indicates *better* performance since low rates of *Poor HbA1c Control* indicate better care.

Figure 5-4 presents the breakout rates that were derived from administrative data and medical record review for *Poor HbA1c Control*. For this measure, a *lower* rate indicates better performance.

All of the health plans used the hybrid method to calculate this measure. The 2007 Michigan aggregate administrative rate was 13.5 percent and the medical record review rate was 27.0 percent.

The aggregate rate for this measure was derived from 33.3 percent administrative data and 66.7 percent medical record review data. The administrative rate decreased by 4.4 percent from 2006, indicating that the health plans were relying more on medical record review to report this measure. It appears that while the *HbA1c Testing* measure captured the actual test data from submitted claims and encounters, the results of the test were not captured administratively. This continues to be a challenge for health plans across the country.

Comprehensive Diabetes Care—Eye Exam

Diabetic retinopathy causes 12,000 to 24,000 new cases of blindness each year, and it is the leading cause of new cases of blindness in adults 20 to 74 years of age.⁵⁻¹⁸ According to the American Academy of Ophthalmology, people with diabetes are 25 times more likely to lose their vision than those who do not have diabetes.⁵⁻¹⁹ Blindness in diabetics younger than 65 years of age costs the federal government more than \$14,000 annually for each affected person, while screening for diabetic retinopathy has been estimated to cost only \$31 per patient.⁵⁻²⁰ However, with timely and appropriate intervention, which may include laser treatment and vitrectomy, blindness can be reduced by up to 90 percent in patients with severe diabetic retinopathy.⁵⁻²¹

According to the National Eye Institute, approximately 184,589 Michigan residents have diabetic retinopathy. This equates to approximately 36 percent of all Michigan diabetics.⁵⁻²²

HEDIS Specification: Comprehensive Diabetes Care—Eye Exam

The *Comprehensive Diabetes Care—Eye Exam* rate reports the percentage of members with diabetes (Type 1 and Type 2) 18 to 75 years of age who were continuously enrolled during the measurement year and who had an eye screening for diabetic retinal diseases (i.e., a retinal exam by an eye care professional), as documented through either administrative data or medical record review.

⁵⁻¹⁸ National Diabetes Education Program. *Eye Health and Diabetes*. Available at: <http://ndep.nih.gov/diabetes/WTMD/eye.htm>. Accessed on: July 30, 2007.

⁵⁻¹⁹ Centers for Disease Control and Prevention. *National Diabetes Fact Sheet, 2003*. Available at: http://www.cdc.gov/DIABETES/pubs/pdf/ndfs_2003.pdf. Accessed on: June 22, 2006.

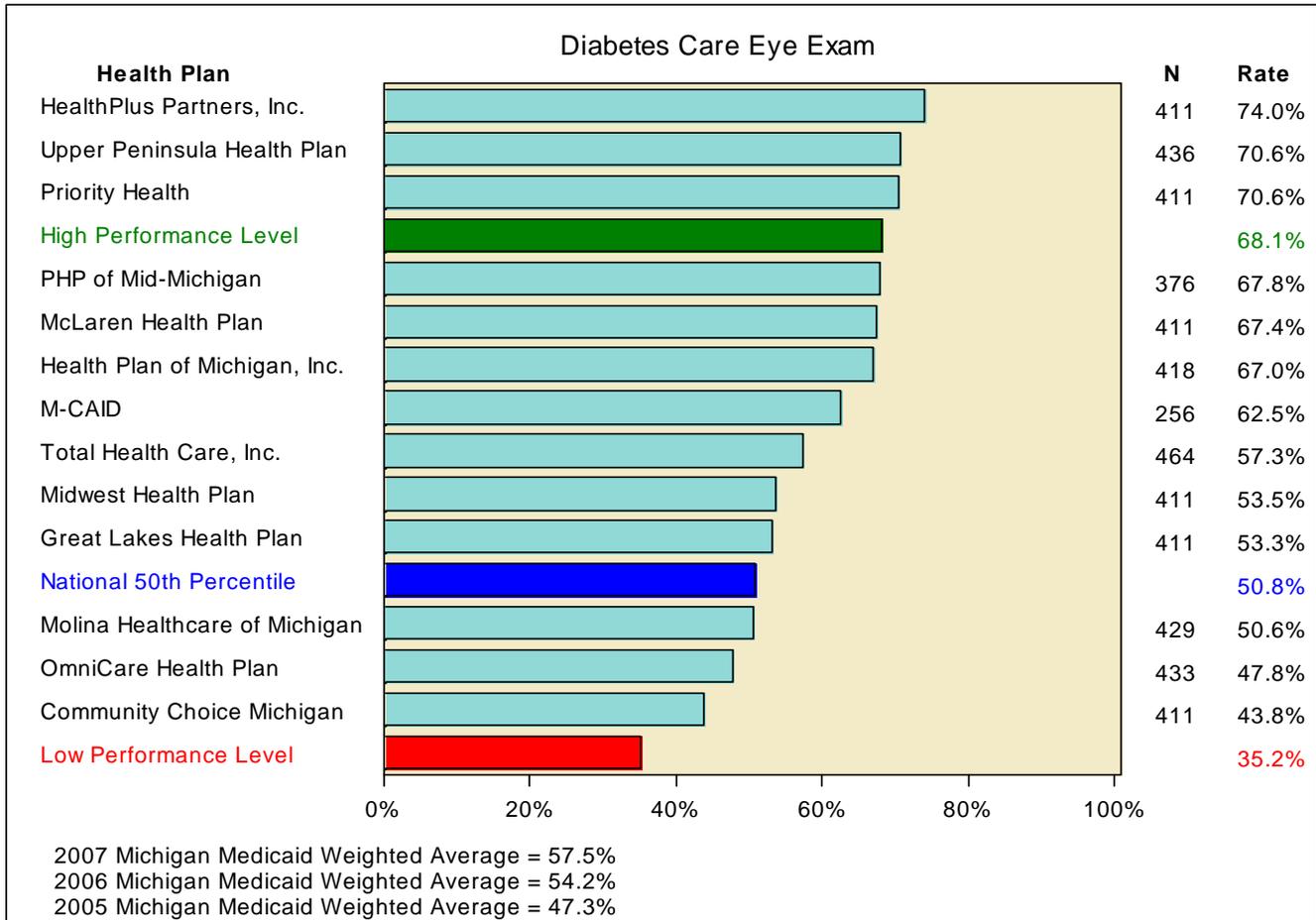
⁵⁻²⁰ National Committee for Quality Assurance. *The State of Managed Care Quality 2001*. Standard Version. Washington, DC: National Committee for Quality Assurance; 2001.

⁵⁻²¹ National Institutes of Health. *Fact Sheet: Diabetic Retinopathy*. Available at: <http://www.nih.gov/about/researchresultsforthepublic/DiabeticRetinopathy.pdf>. Accessed on: July 30, 2007.

⁵⁻²² Michigan Department of Community Health. *Michigan Diabetes Strategic Plan*. Available at: http://michigan.gov/documents/DM_StrategicPlan_82795_7.pdf. Accessed on: July 30, 2007.

Health Plan Ranking: Comprehensive Diabetes Care—Eye Exam

**Figure 5-5—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Comprehensive Diabetes Care—Eye Exam**



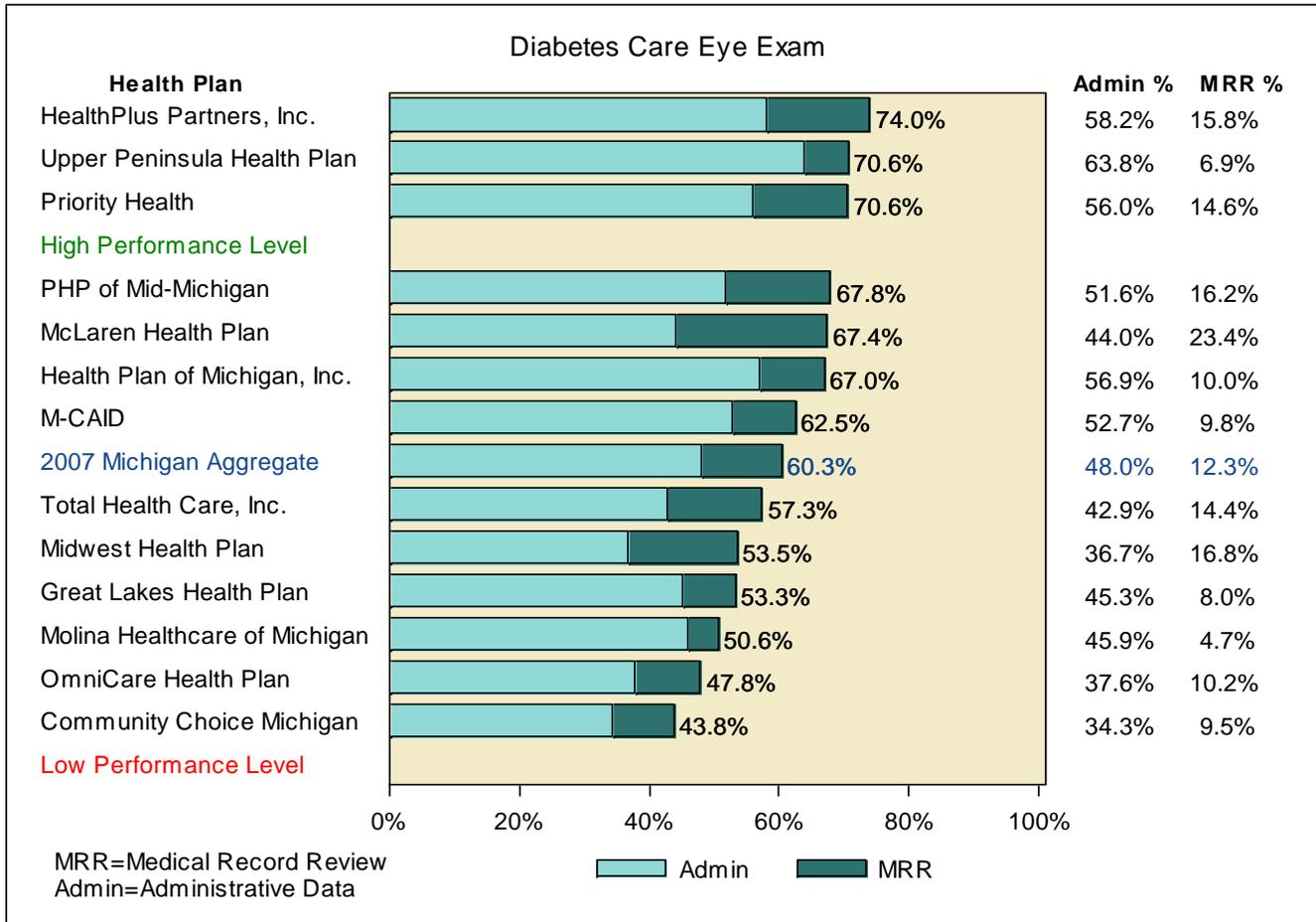
Three health plans reported rates above the HPL of 68.1 percent, and none of the health plans reported rates below the LPL of 35.2 percent. Ten health plans, including the three above the HPL, had rates that exceeded the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 57.5 percent was 6.7 percent above the national HEDIS 2006 Medicaid 50th percentile of 50.8 percent.

The 2007 Michigan Medicaid weighted average increased by 3.3 percentage points over the 2006 weighted average and by 10.2 percentage points over the 2005 weighted average. The range of reported rates showed improvement from 2006 to 2007.

Data Collection Analysis: Comprehensive Diabetes Care—Eye Exam

Figure 5-6—Michigan Medicaid HEDIS 2007 Data Collection Analysis: Comprehensive Diabetes Care—Eye Exam



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much was from medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All of the health plans used the hybrid method to calculate their rates for this measure. The 2007 Michigan aggregate administrative rate was 48.0 percent and the medical record review rate was 12.3 percent.

In 2007, 79.6 percent of the aggregate rate was derived from administrative data and 20.4 percent was derived from medical record review. These rates have remained fairly consistent for the past two years.

Comprehensive Diabetes Care—LDL-C Screening

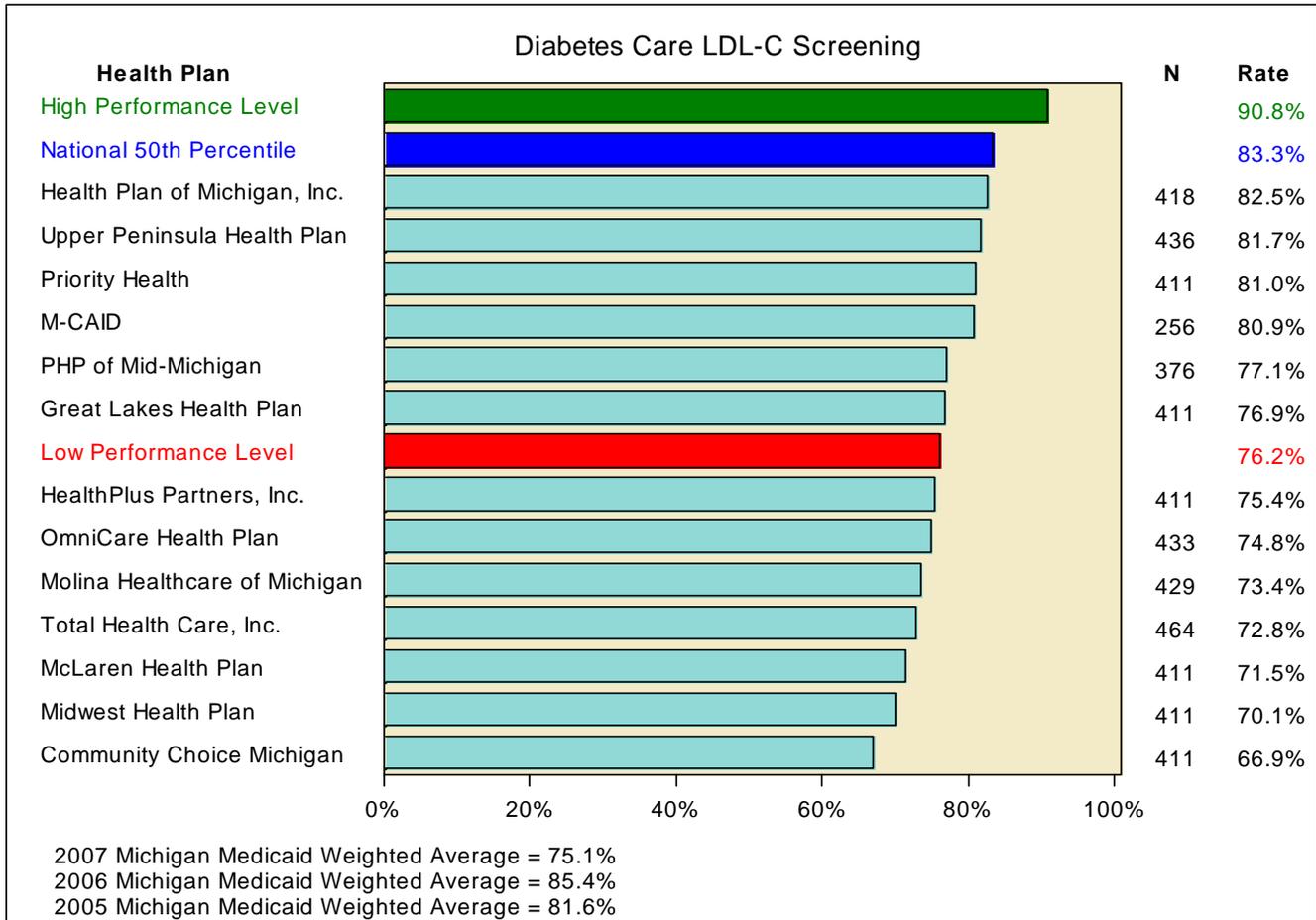
Low-density lipoprotein (LDL) is a type of lipoprotein that carries cholesterol in the blood. LDL is considered to be undesirable because it deposits excess cholesterol in the walls of blood vessels and contributes to atherosclerosis (hardening of the arteries) and heart disease. Therefore, LDL cholesterol is often termed “bad” cholesterol. The test for LDL measures the amount of LDL cholesterol in the blood.

HEDIS Specification: Comprehensive Diabetes Care—LDL-C Screening

The *Comprehensive Diabetes Care—LDL-C Screening* rate reports the percentage of members with diabetes (Type 1 and Type 2) 18 to 75 years of age who were continuously enrolled during the measurement year and who had an LDL-C test during the measurement year, as determined by claims/encounters or automated laboratory data or medical record review.

Health Plan Ranking: Comprehensive Diabetes Care—LDL-C Screening

**Figure 5-7—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Comprehensive Diabetes Care—LDL-C Screening**



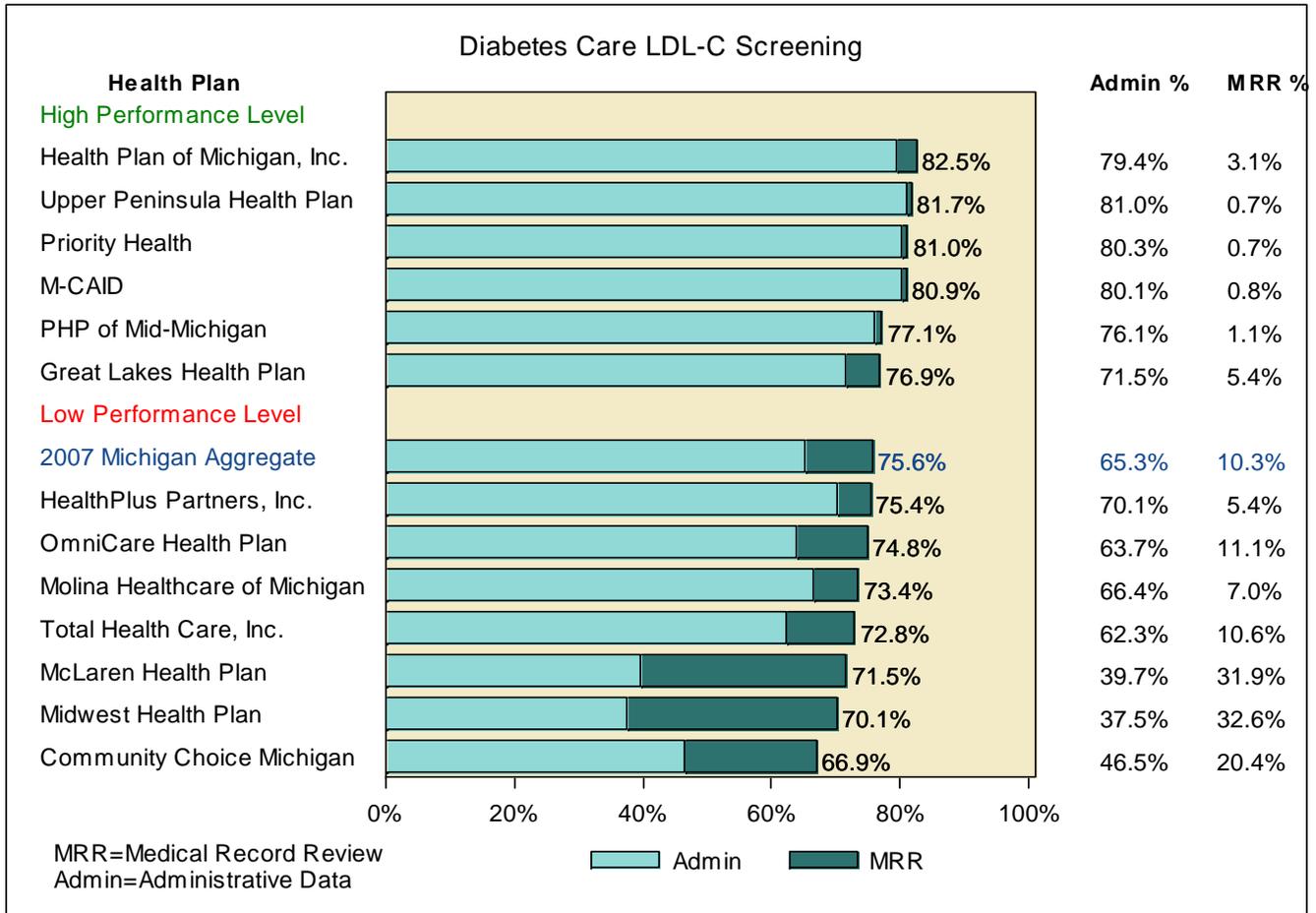
It should be noted that changes were made to this indicator’s specifications that would result in lower rates. In previous years, the specifications allowed for the LDL-C screening to occur in either the measurement year or the year prior to the measurement year. In 2007, however, the specifications were changed to require that the screening take place during the measurement year. Therefore, these rates may not be directly comparable to previous years’ rates or national benchmarks and are presented for informational purposes only.

There were no health plans that met or exceeded either the national HEDIS 2006 Medicaid 50th percentile or the HPL. Seven health plans reported rates below the LPL of 76.2 percent.

The 2007 Michigan Medicaid weighted average showed a statistically significant decline from 2006, down 10.3 percentage points. This decline may be associated with the measure specification changes.

Data Collection Analysis: Comprehensive Diabetes Care—LDL-C Screening

**Figure 5-8—Michigan Medicaid HEDIS 2007
Data Collection Analysis:
Comprehensive Diabetes Care—LDL-C Screening**



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much was from medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All of the health plans elected to use the hybrid method to report this measure. The 2007 Michigan aggregate administrative rate was 65.3 percent and the medical record review rate was 10.3 percent.

In 2007, 86.4 percent of the aggregate rate was derived from administrative data and 13.6 percent from medical record review. The 2007 administrative rate increased by 8.8 percentage points compared to the 2006 rate, indicating that administrative data completeness is improving.

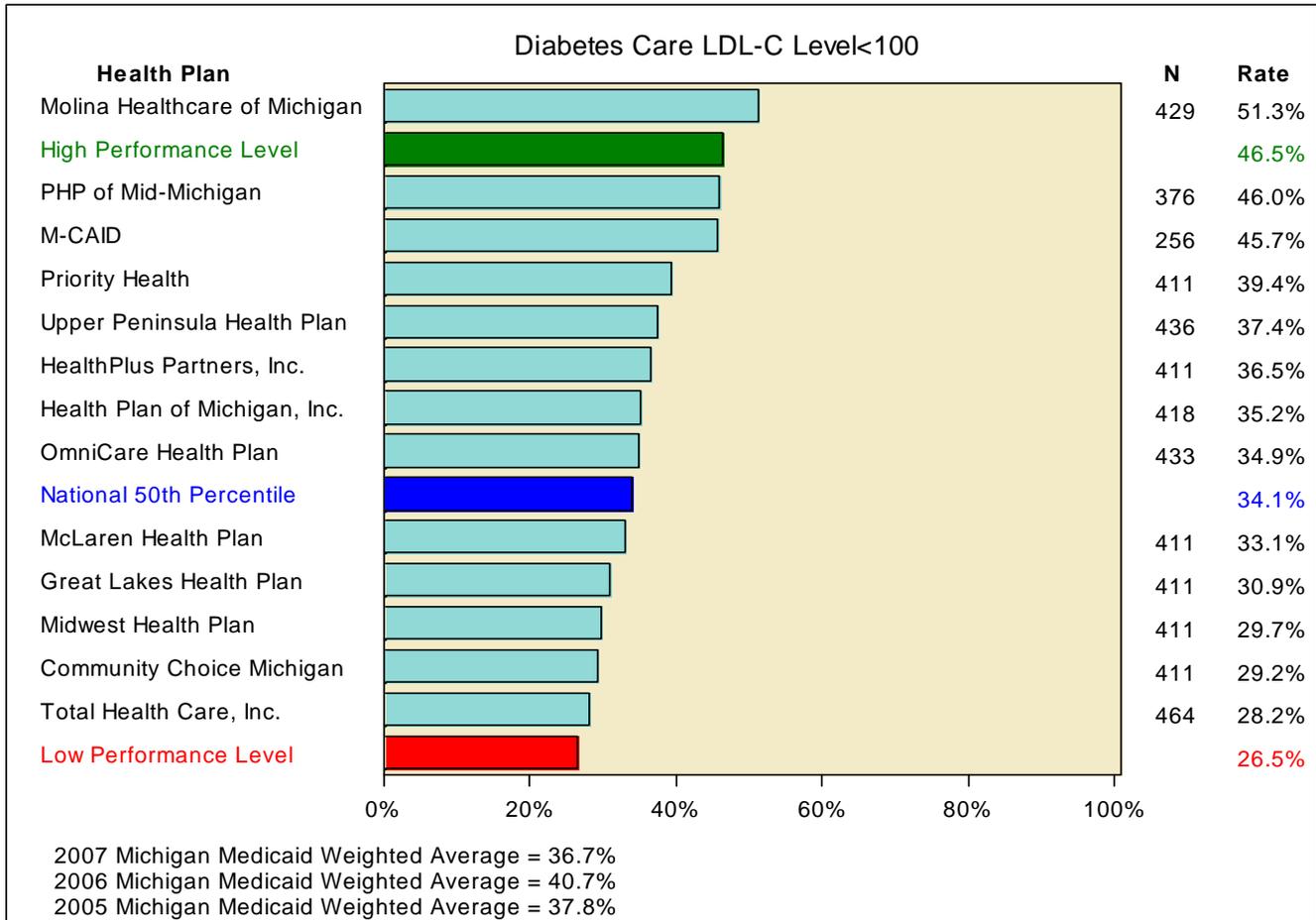
All 13 health plans derived more than half of their rates from administrative data.

HEDIS Specification:- Comprehensive Diabetes Care—LDL-C Level <100

The rate for *Comprehensive Diabetes Care—LDL-C Level <100* calculates the percentage of members with diabetes (Type 1 and Type 2) 18 to 75 years of age who were continuously enrolled during the measurement year and whose most recent LDL-C test (performed during the measurement) indicated an LDL-C level less than 100 mg/dL, as documented through automated laboratory data and/or medical record review.

Health Plan Ranking: Comprehensive Diabetes Care—LDL-C Level <100

**Figure 5-9—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Comprehensive Diabetes Care—LDL-C Level <100**



It should be noted that changes were made to this indicator’s specifications that would result in lower rates. In previous years, the specifications allowed for the LDL-C screening to occur in either the measurement year or the year prior to the measurement year. In 2007, however, the specifications were changed to require that the screening take place during the measurement year. Therefore, these rates may not be directly comparable to previous years’ rates or national benchmarks and are presented for informational purposes only.

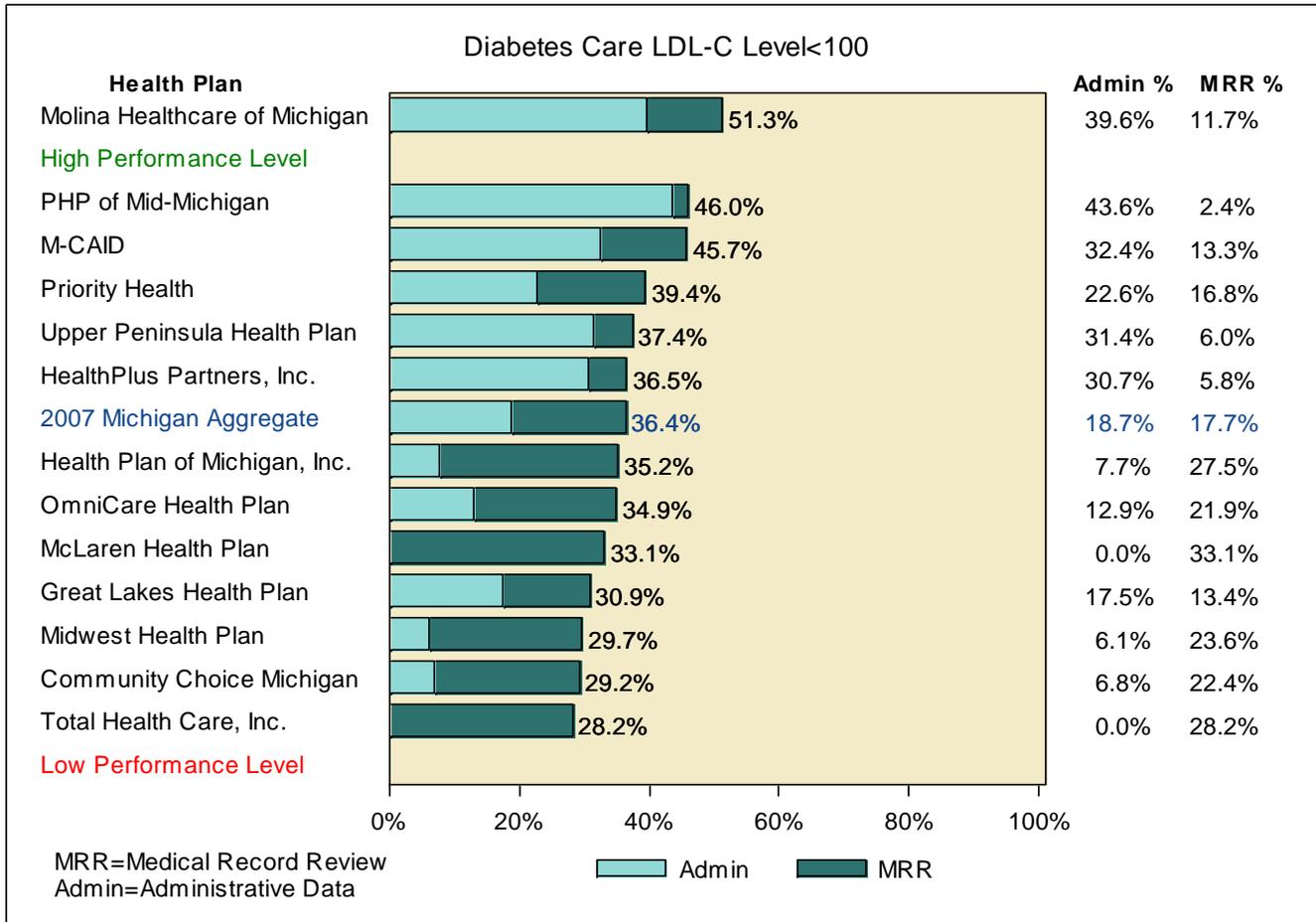
One health plan reported a rate above the HPL of 46.5 percent, and no health plans reported rates below the LPL of 26.5 percent. Eight health plans, including the one above the HPL, reported rates above the national HEDIS 2006 50th percentile.

The 2007 Michigan Medicaid weighted average of 36.7 percent was 2.6 percentage points above the national HEDIS 2006 50th percentile of 34.1 percent.

The 2007 Michigan Medicaid weighted average decreased below both the 2006 weighted average and the 2005 weighted average by 4.0 and 1.1 percentage points, respectively. This decline was not statistically significant and may be associated with the measure specification changes requiring testing to occur within the measurement year.

Data Collection Analysis: Comprehensive Diabetes Care—LDL-C Level <100

**Figure 5-10—Michigan Medicaid HEDIS 2007
Data Collection Analysis:
Comprehensive Diabetes Care—LDL-C Level <100**



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much was from medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All of the health plans used the hybrid method to report this measure. The 2007 Michigan Medicaid aggregate administrative rate was 18.7 percent and the medical record review rate was 17.7 percent.

Overall, 51.4 percent of the aggregate rate was derived from administrative data and 48.6 percent was derived from medical record review. The administrative rate increased by 9.3 percentage points over the 2006 rate.

While administrative data submission continued to show improvement this year, the rates for this measure still rely heavily on medical record review.

Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy

Diabetes is the leading cause of end-stage renal disease (ESRD), a condition that must be treated by dialysis or a kidney transplant. In the United States, diabetes causes more than 150,000 cases of kidney failure. In 2003, health care for patients with kidney failure cost the United States more than \$27 billion.⁵⁻²³ Diabetic nephropathy is a progressive kidney disease that takes years to develop and progress; usually 15 to 25 years will pass after the onset of diabetes before kidney failure occurs. Approximately 20 to 30 percent of patients with diabetes develop evidence of nephropathy, although those with Type 2 diabetes are less likely to develop ESRD.⁵⁻²⁴ In Michigan, 43.8 percent of people newly diagnosed with ESRD in 2004 also had a primary diagnosis of diabetes.⁵⁻²⁵

HEDIS Specification: Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy

The *Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy* rate is intended to assess whether diabetic patients are being monitored for nephropathy. It reports the percentage of members with diabetes (Type 1 and Type 2) 18 to 75 years of age who were continuously enrolled during the measurement year and who were screened for nephropathy, or who received treatment for nephropathy, as documented through either administrative data or medical record review. The rate includes patients who have been screened for nephropathy or who already have evidence of nephropathy as demonstrated by medical attention for nephropathy, a positive microalbuminuria test, or evidence of ACE inhibitor/ARB therapy.

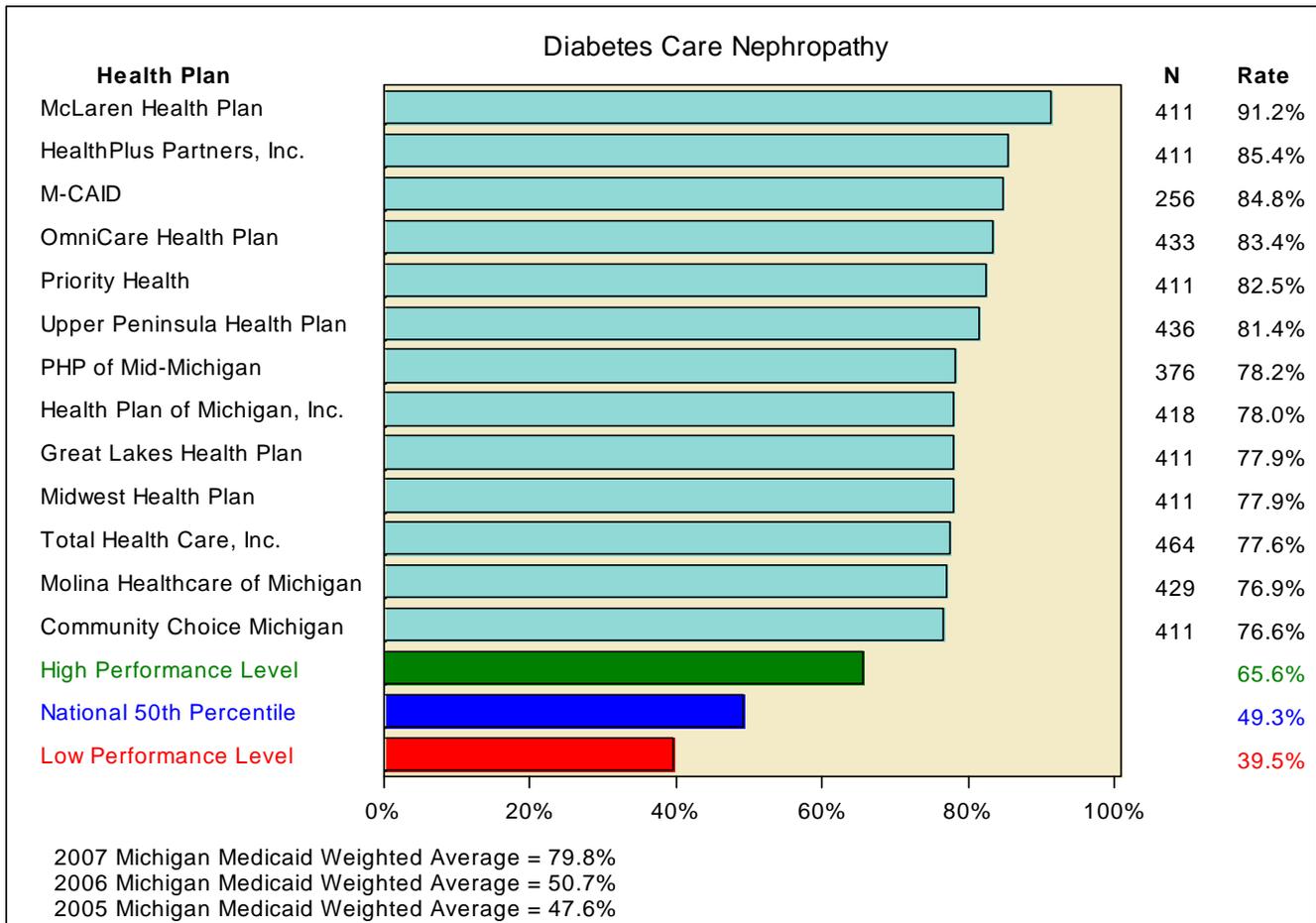
⁵⁻²³ National Kidney and Urologic Diseases Information Clearinghouse. *Kidney Disease of Diabetes*. Available at: <http://kidney.niddk.nih.gov/kudiseases/pubs/kdd/index.htm>. Accessed on: July 31, 2007.

⁵⁻²⁴ Nephropathy in Diabetes. *Diabetes Care*, 2004. Available at: http://care.diabetesjournals.org/cgi/content/full/27/suppl_1/s79. Accessed on: July 31, 2007.

⁵⁻²⁵ Michigan Department of Community Health. *Diabetes in Michigan*. September 2006. Available at: http://www.michigan.gov/documents/mdch/FactPageMichigan-Darline_2_172250_7.pdf. Accessed on: July 30, 2007.

Health Plan Ranking: Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy

**Figure 5-11—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy**

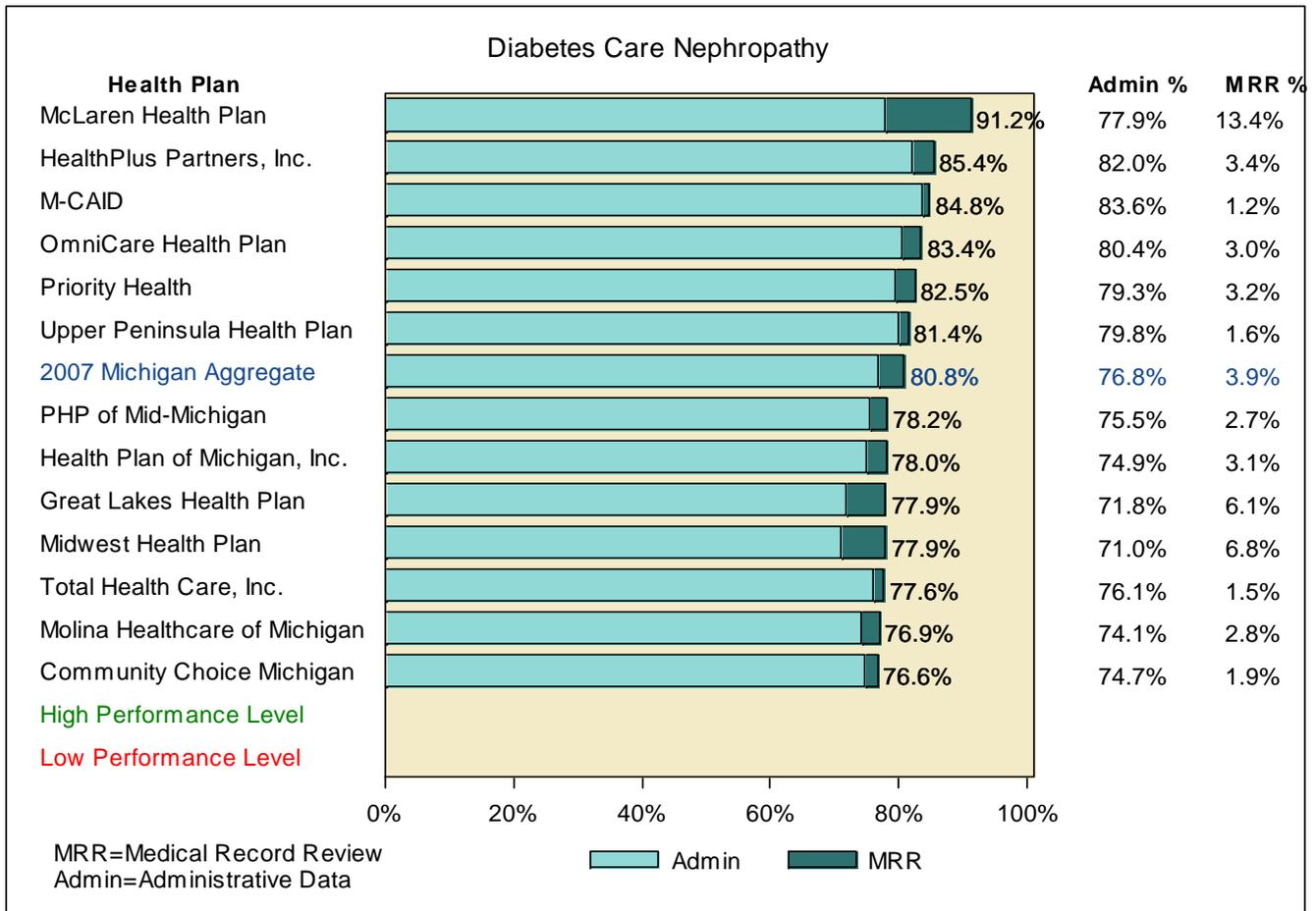


There was a revision to the technical specifications for this indicator this year, which may have resulted in higher rates. The use of ACE inhibitor/ARB therapy for numerator compliance was added for compliance with medical attention to nephropathy. Therefore, direct comparisons with previous years' rates and national benchmarks are displayed for informational purposes only and for future trending.

The 2007 Michigan Medicaid weighted average of 79.8 percent showed statistically significant improvement with an increase of 29.1 percentage points above the 2006 weighted average. Revisions to the measure specifications should be considered with respect to this increase.

Data Collection Analysis: Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy

**Figure 5-12—Michigan Medicaid HEDIS 2007
Data Collection Analysis:
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy**



The figure above shows how much of the final rate for each health plan was derived from the administrative method (Admin) and how much was from medical record review (MRR). Note that, because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All of the health plans elected to use the hybrid method for reporting this measure. The 2007 Michigan aggregate administrative rate was 76.8 percent and the medical record review rate was 3.9 percent.

Overall, 95.0 percent of the aggregate rate was derived from administrative data and 4.8 percent was from medical record review. In 2006, 83.8 percent of the aggregate rate was derived from administrative data. Health plans have greatly improved their administrative data completeness from 2006 to 2007. This could be due in part to the addition of the ACE inhibitor/ARBs that are obtained through pharmacy data, which are potentially more complete than lab data or capitated service claims.

Use of Appropriate Medications for People With Asthma

In 2004, asthma accounted for more than 13.6 million physician visits, 1 million hospital outpatient department visits, and 1.8 million emergency room (ER) visits in the United States.⁵⁻²⁶ Asthma is one of the most common chronic conditions in both children and adults, affecting approximately 9 million children and 11 million adults.⁵⁻²⁷ The asthma prevalence rate reported for adults in Michigan during 2005 was 9.1 percent, while the national rate was 9.0 percent.⁵⁻²⁸ Management of asthma is critical, and neglect of the condition frequently results in hospitalizations, ER visits, and missed work and school days.

HEDIS Specification: Use of Appropriate Medications for People With Asthma

This measure is reported using the administrative method only. Rates are reported for three age groups: 5 to 9 years of age, 10 to 17 years of age, and 18 to 56 years of age, as well as a combined rate.

In addition to enrollment data, claims are used to identify the denominator. Members are identified for each denominator based on age and a two-year continuous enrollment criterion (the measurement year and the year prior to the measurement year). In addition, this measure requires that members be identified as having persistent asthma. Persistent asthma is defined by the HEDIS specifications as having any of the following events within the current and prior measurement year:

1. At least four asthma medication dispensing events
2. At least one ER visit with a principal diagnosis of asthma
3. At least one acute inpatient discharge with a principal diagnosis of asthma
4. At least four outpatient visits with a corresponding diagnosis of asthma and at least two asthma medication dispensing events.

This measure evaluates whether members with persistent asthma are being prescribed medications acceptable as primary therapy for long-term control of asthma during the measurement year. There are a number of acceptable therapies for people with persistent asthma, although the best available evidence demonstrates that inhaled corticosteroids are the preferred primary therapy. For people with moderate to severe asthma, inhaled corticosteroids are the only recommended primary therapy. While long-acting beta-agonists are a preferred adjunct therapy for long-term control of moderate to severe asthma, their use is recommended as an add-on therapy to inhaled corticosteroids. Therefore, they should not be included in this numerator.⁵⁻²⁹

For this particular measure, NCQA requires that rates be calculated using the administrative method; therefore, a data collection analysis is not presented.

⁵⁻²⁶ American Lung Association Epidemiology & Statistics Unit. *Trends in Asthma Morbidity and Mortality*. July 2006. Available at: <http://www.lungusa.org>. Accessed on: July 31, 2007.

⁵⁻²⁷ National Heart, Lung, and Blood Institute. *Who Is At Risk for Asthma?* Available at: http://www.nhlbi.nih.gov/health/dci/Diseases/Asthma/Asthma_WhoIsAtRisk.html. Accessed on: July 31, 2007.

⁵⁻²⁸ American Lung Association Epidemiology & Statistics Unit. *Trends in Asthma Morbidity and Mortality*. July 2006. Available at: <http://www.lungusa.org>. Accessed on: July 31, 2007.

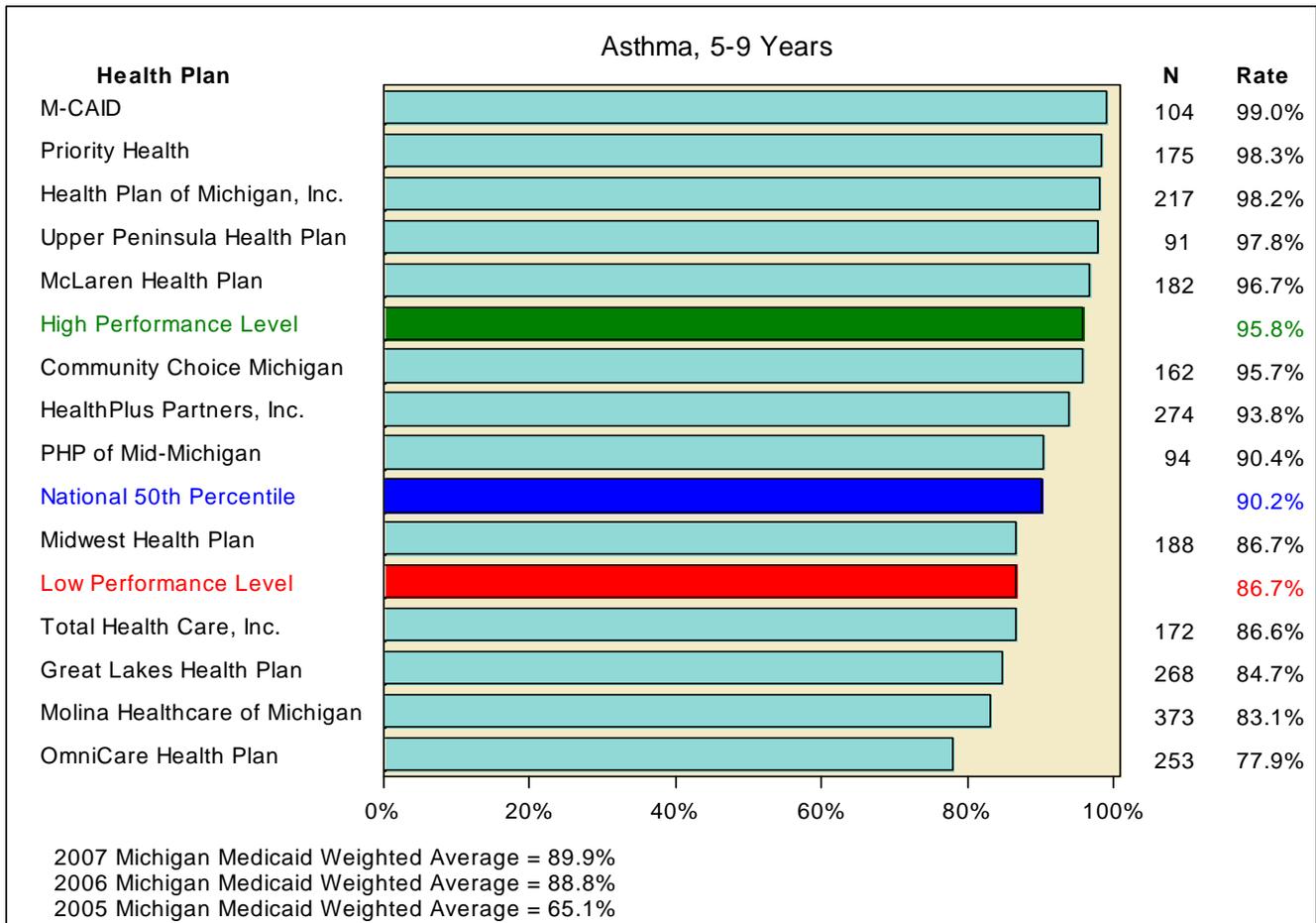
⁵⁻²⁹ National Committee for Quality Assurance. *HEDIS 2007 Technical Specifications*. Volume 2. Washington, DC: National Committee for Quality Assurance; 2006.

Use of Appropriate Medications for People With Asthma—Ages 5 to 9 Years

The *Use of Appropriate Medications for People With Asthma—Ages 5 to 9 Years* rate calculates the percentage of members 5 to 9 years of age who had been continuously enrolled for the measurement year and the year prior to the measurement year, were identified as having persistent asthma as a result of any one of four specified events during the measurement year and the year prior to the measurement year, and were prescribed medications that were acceptable as primary therapy for long-term asthma control.

Health Plan Ranking: Use of Appropriate Medications for People With Asthma—Ages 5 to 9 Years

**Figure 5-13—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—Ages 5 to 9 Years**



Five health plans reported rates above the HPL of 95.8 percent and four health plans had rates below the LPL of 86.7 percent. Eight health plans, including the five above the HPL, reported rates above the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 89.9 percent was 0.3 percentage points below the national HEDIS 2006 Medicaid 50th percentile of 90.2 percent.

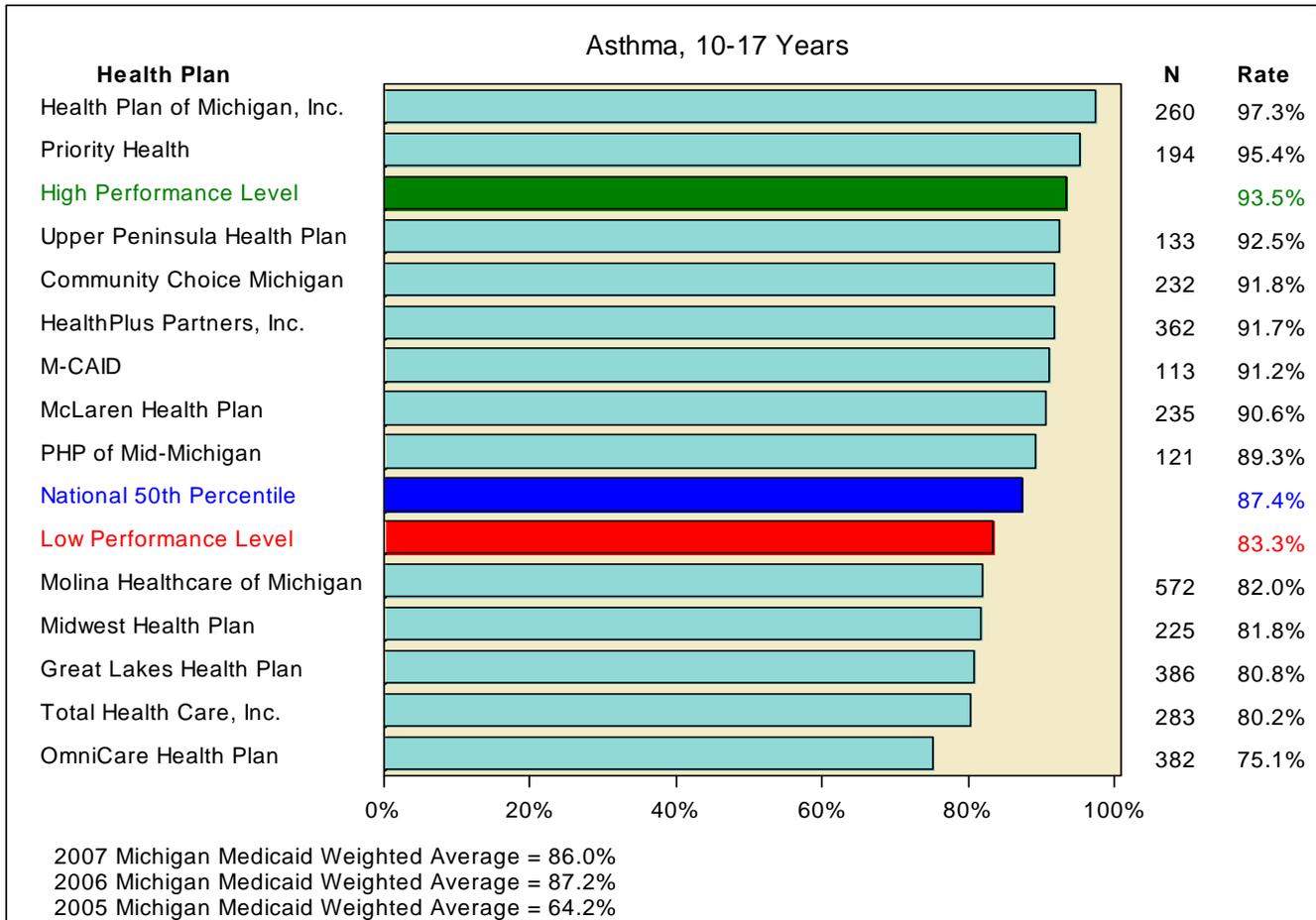
The 2007 Michigan Medicaid weighted average increased by 1.1 percentage points above the 2006 weighted average of 88.8 percent.

Use of Appropriate Medications for People With Asthma—Ages 10 to 17 Years

The rate for *Use of Appropriate Medications for People With Asthma—Ages 10 to 17 Years* calculates the percentage of members 10 to 17 years of age who had been continuously enrolled for the measurement year and the year prior to the measurement year, were identified as having persistent asthma as a result of any one of four specified events during the measurement year and the year prior to the measurement year, and were prescribed medications that were acceptable as primary therapy for long-term asthma control.

Health Plan Ranking: Use of Appropriate Medications for People With Asthma—Ages 10 to 17 Years

**Figure 5-14—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—Ages 10 to 17 Years**



Two health plans reported rates above the HPL of 93.5 percent and five health plans had rates below the LPL of 83.3 percent. Eight health plans, including the two above the HPL, reported rates above the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 86.0 percent was 1.4 percentage points below the national HEDIS 2006 Medicaid 50th percentile of 87.4 percent. The 2007 Michigan Medicaid weighted average was also 1.2 percentage points below the 2006 weighted average of 87.2 percent.

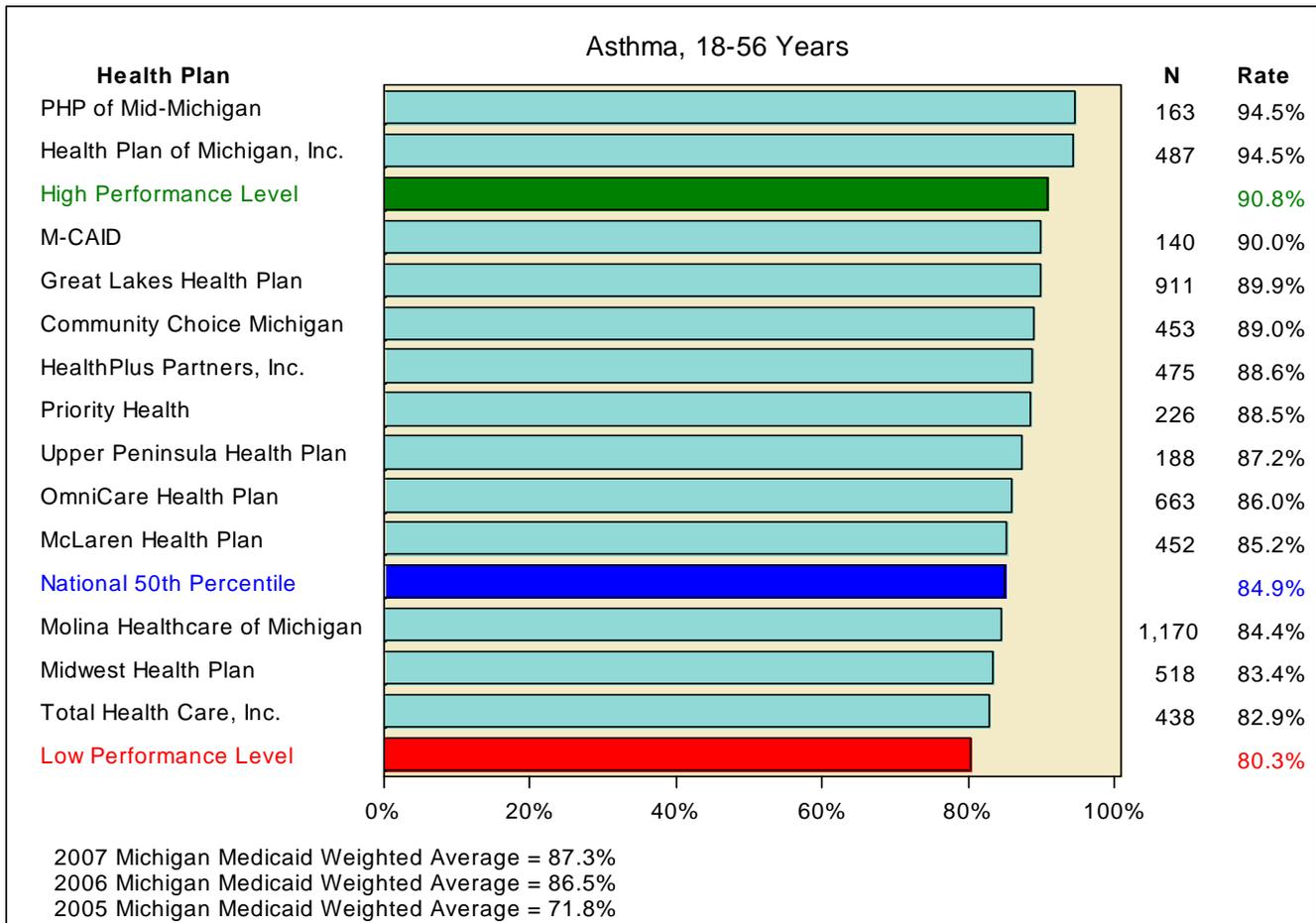
In 2006, all of the health plans reported rates above all of the national standards due to changes in the specifications for this measure during that measurement year.

Use of Appropriate Medications for People With Asthma—Ages 18 to 56 Years

Use of Appropriate Medications for People With Asthma—Ages 18 to 56 Years measures the percentage of members 18 to 56 years of age who had been continuously enrolled for the measurement year and the year prior to the measurement year, were identified as having persistent asthma as a result of any one of four specified events during the measurement year and the year prior to the measurement year, and were prescribed medications that were acceptable as primary therapy for long-term asthma control.

Health Plan Ranking: Use of Appropriate Medications for People With Asthma—Ages 18 to 56 Years

**Figure 5-15—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—Ages 18 to 56 Years**



Two health plans reported rates above the HPL of 90.8 percent and no health plans had rates below the LPL of 80.3 percent. Ten health plans, including the two above the HPL, reported rates above the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 87.3 percent was 2.4 percentage points above the national HEDIS 2006 Medicaid 50th percentile of 84.9 percent. The 2007 Michigan Medicaid weighted average increased by 0.8 percentage points above the 2006 weighted average of 86.5 percent.

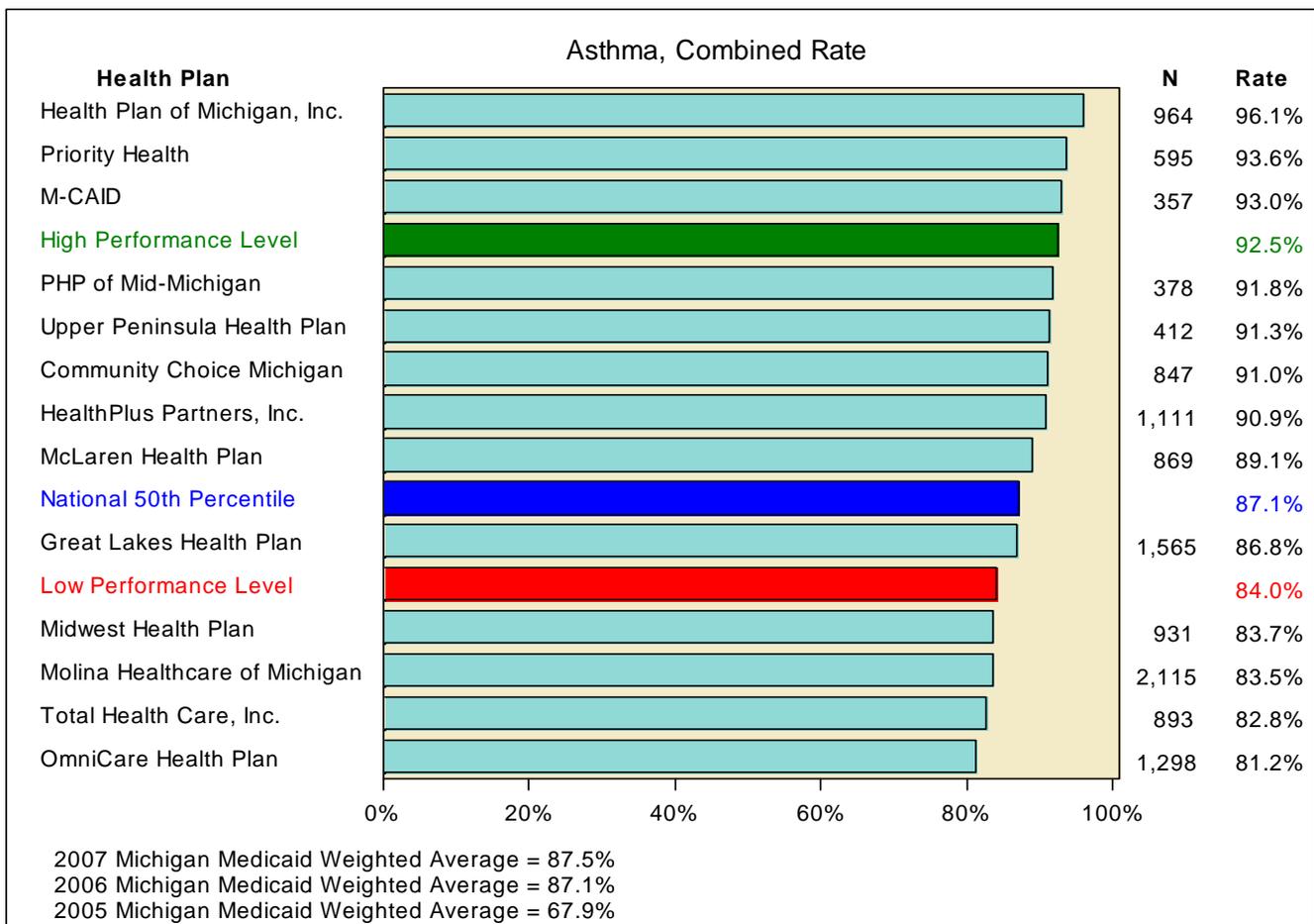
In 2006, all of the health plans reported rates above all of the national standards due to changes in the specifications for this measure during that measurement year.

Use of Appropriate Medications for People With Asthma—Combined Rate

The *Use of Appropriate Medications for People With Asthma—Combined Rate* calculates the sum of the numerators from the three age groups divided by the sum of the three denominators.

Health Plan Ranking: Use of Appropriate Medications for People With Asthma—Combined Rate

**Figure 5-16—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—Combined Rate**



Three health plans reported rates above the HPL of 92.5 percent, and four health plans had rates below the LPL of 84.0 percent. Eight health plans, including the three above the HPL, reported rates above the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 87.5 percent was 0.4 percentage points above the national HEDIS 2006 Medicaid 50th percentile of 87.1 percent.

In 2006, all of the health plans reported rates above all of the national standards due to changes in the specifications for this measure during that measurement year.

Controlling High Blood Pressure

Approximately 30 percent of those with high blood pressure do not know they have it, which accounts for its reputation as a “silent killer.” Furthermore, 65 percent of people with high blood pressure do not have it under control.⁵⁻³⁰ High blood pressure is a major risk factor for developing cardiovascular disease, kidney failure, stroke, and heart failure, although improvements in the detection and treatment of this condition have led to decreasing death rates from cardiovascular disease and stroke in recent years.⁵⁻³¹ A healthy blood pressure level is a critical factor in preserving kidney function and can reduce the risk of stroke by up to 40 percent. In 2005, 27.8 percent of Michigan adults reported having high blood pressure, and heart disease and stroke were responsible for 30,147 deaths.⁵⁻³²

HEDIS Specification: Controlling High Blood Pressure

The *Controlling High Blood Pressure* measure assesses if blood pressure was controlled for adults with diagnosed hypertension. This measure calculates the percentage of members 18 to 85 years of age who were continuously enrolled for the measurement year, who had an ambulatory claim or encounter with a diagnosis of hypertension that was confirmed within the medical record, and whose blood pressure was controlled below 140/90 mm Hg.

The age range of 18 to 45 years of age was added this year, lowering the age span from 46 to 18 years of age. This year the measure was reported in the following age bands:

- ◆ 18 to 45 years of age
- ◆ 46 to 85 years of age (comparable to 2005, 2006, and the 2006 national performance standards)
- ◆ Total

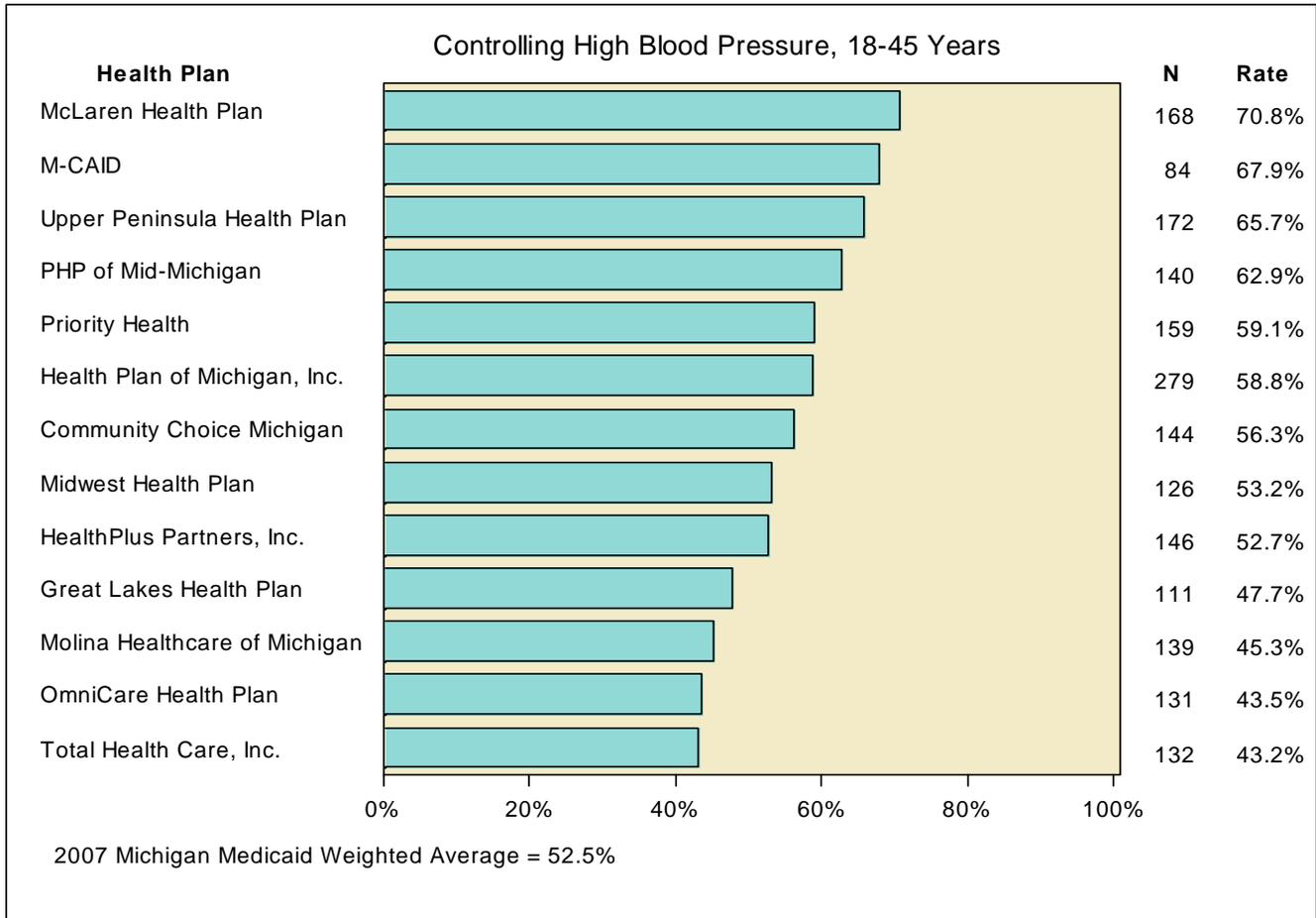
⁵⁻³⁰ American Heart Association. World Hypertension Day Highlights Risk of “Silent Killer”. *Journal Report*. April 10, 2007. Available at: <http://www.americanheart.org/presenter.jhtml?identifier=3046938>. Accessed on: August 20, 2007.

⁵⁻³¹ Healthy People 2010. *Information Access Project Report on Heart Disease and Stroke*. Available at: <http://www.healthypeople.gov/document/html/volume1/12heart.htm>. Accessed on: August 1, 2007.

⁵⁻³² Michigan Department of Community Health. *2007 CVD Fact Sheet*. Available at: http://michigan.gov/documents/mdch/CVDFactsheet2007bcol_202765_7.pdf. Accessed on: August 1, 2007.

Health Plan Ranking: Controlling High Blood Pressure

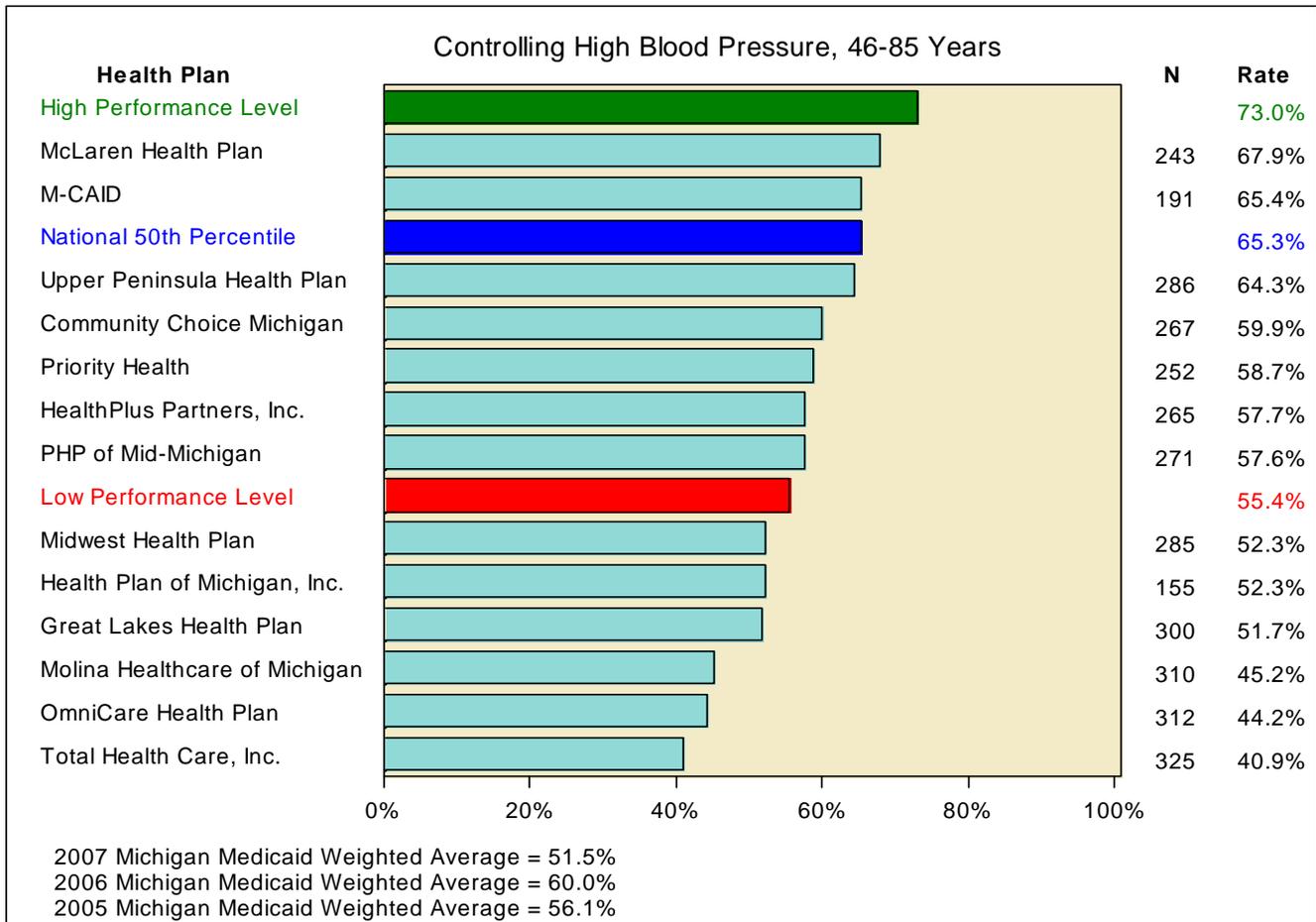
**Figure 5-17—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Controlling High Blood Pressure—Ages 18 to 45 Years**



Controlling High Blood Pressure—Ages 18 to 45 Years was a new measure for 2007; therefore, national performance data were not available for comparison.

The 2007 Michigan Medicaid weighted average was 52.5 percent. Nine health plans reported rates above the weighted average.

**Figure 5-18—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Controlling High Blood Pressure—Ages 46 to 85 Years**

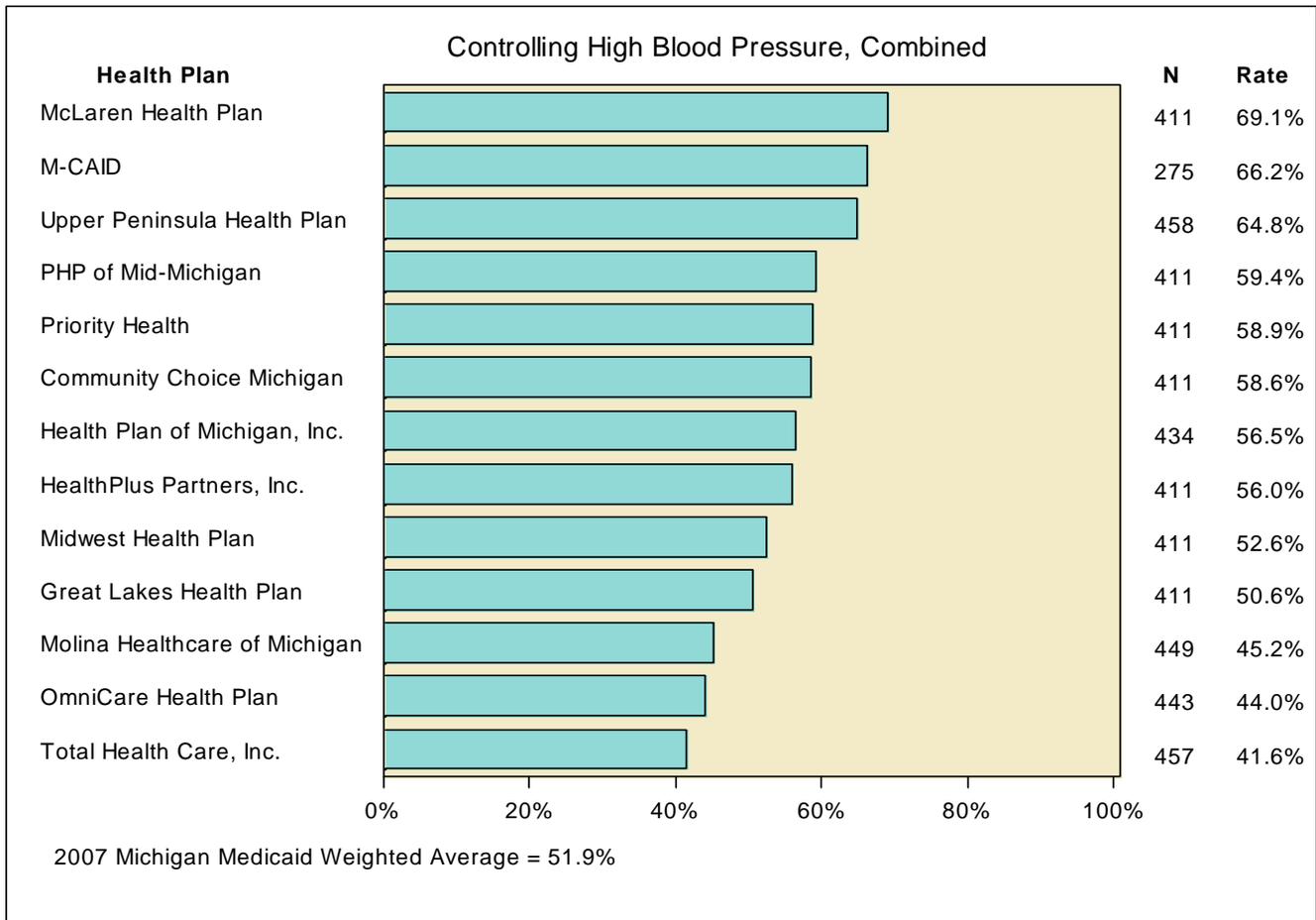


None of the health plans reported rates above the HPL of 73.0 percent, and six health plans reported rates below the LPL of 55.4 percent. Two plans reported rates above the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 51.5 percent was 13.8 percentage points below the national HEDIS 2006 Medicaid 50th percentile of 65.3 percent. Although there were changes to the specification for the *Controlling High Blood Pressure* measure, this rate can be compared to the 2006 Michigan Medicaid weighted average and the 2006 national performance standards.

The 2007 Michigan Medicaid weighted average showed a statistically significant decline of 8.5 percentage points from the 2006 Michigan Medicaid weighed average of 60.0 percent. The 2007 weighted average was 4.6 percentage points below the 2005 weighed average. Eleven of the 13 health plans saw a decrease in their 2007 rates, with four of the declines being greater than 10 percentage points.

**Figure 5-19—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Controlling High Blood Pressure—Combined Rate**



Controlling High Blood Pressure—Combined Rate was considered a new measure for 2007 because the lower age span decreased; therefore, national performance data were not available for comparison.

The 2007 Michigan Medicaid weighted average was 51.9 percent. Nine health plans reported rates that exceeded the weighted average.

Medical Assistance With Smoking Cessation

Approximately 45.1 million adults in the United States were smokers in 2005. Excluding adult deaths due to secondhand smoke, males and females lost an average of 13.2 and 14.5 years of life, respectively, from smoking.⁵⁻³³ Discontinuing the use of tobacco is the most cost-effective method of preventing disease in adults. An economic assessment found that a health plan's annual cost of covering treatment to help people quit smoking ranged from \$0.89 to \$4.92 per smoker, while the annual cost of treating smoking-related illnesses ranged from \$6 to \$33 per smoker.⁵⁻³⁴

Michigan's smoking rate has shown a slight increase recently; data show that 22.4 percent of adults were current smokers in 2006 compared to 22.0 percent in 2005. African Americans accounted for the highest rate among ethnic groups at 32.3 percent, and the 25-to-34-year-old age group was the highest at 30.2 percent. The smoking rate for all U.S. adults was 20.1 percent in 2006.⁵⁻³⁵

MDCH has many initiatives designed to decrease tobacco use, including free self-help smoking cessation kits and a statewide task force to assist with regulations and ordinances aimed at clean indoor air. Ongoing efforts also include smoking cessation programs for pregnant women, counseling for Michigan's Women, Infants & Children program enrollees on the dangers of smoking and secondhand smoke, college initiatives, community education programs, and the support of activities related to the Youth Tobacco Act. In fact, according to NCQA's *The State of Health Care Quality 2006* report, Michigan ranked as the top-performing state for its Medicaid population for this measure.⁵⁻³⁶

Many smokers are unable to quit, even when they are educated about the negative health effects of smoking and informed that eliminating tobacco is the most important step they can take to improve their health. Studies have shown that when physicians advise smokers to quit it can have positive results.⁵⁻³⁷

HEDIS Specification—Advising Smokers to Quit

The *Medical Assistance With Smoking Cessation* measure is collected using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. *Advising Smokers to Quit* is one component (or rate) reported for the measure. *Advising Smokers to Quit* calculates the percentage of members 18 years of age or older who were continuously enrolled during the last six months of the measurement year, were smokers, were seen by an MHP practitioner in the six months prior to completing the CAHPS survey, and received advice to quit smoking in the six months prior to completing the CAHPS survey.

⁵⁻³³ American Lung Association. *Trends in Tobacco Use*. June 2007. Available at: http://www.lungusa.org/atf/cf/%7B7A8D42C2-FCCA-4604-8ADE-7F5D5E762256%7D/TREND_TOBACCO_JUNE07.PDF. Accessed on: July 30, 2007.

⁵⁻³⁴ Centers for Disease Control and Prevention. *Preventing Tobacco Use*. August 2005. Available at: <http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/pdf/tobacco.pdf>. Accessed on: August 1, 2007.

⁵⁻³⁵ Centers for Disease Control and Prevention. *Behavioral Risk Factor Surveillance System (BRFSS)*. Available at: <http://www.cdc.gov/brfss/>. Accessed on: August 1, 2007.

⁵⁻³⁶ National Committee for Quality Assurance. *The State of Health Care Quality 2006*. Washington DC: National Committee for Quality Assurance; 2005. Available at: http://www.ncqa.org/communications/sohc2006/sohc_2006.pdf. Accessed on: July 30, 2007.

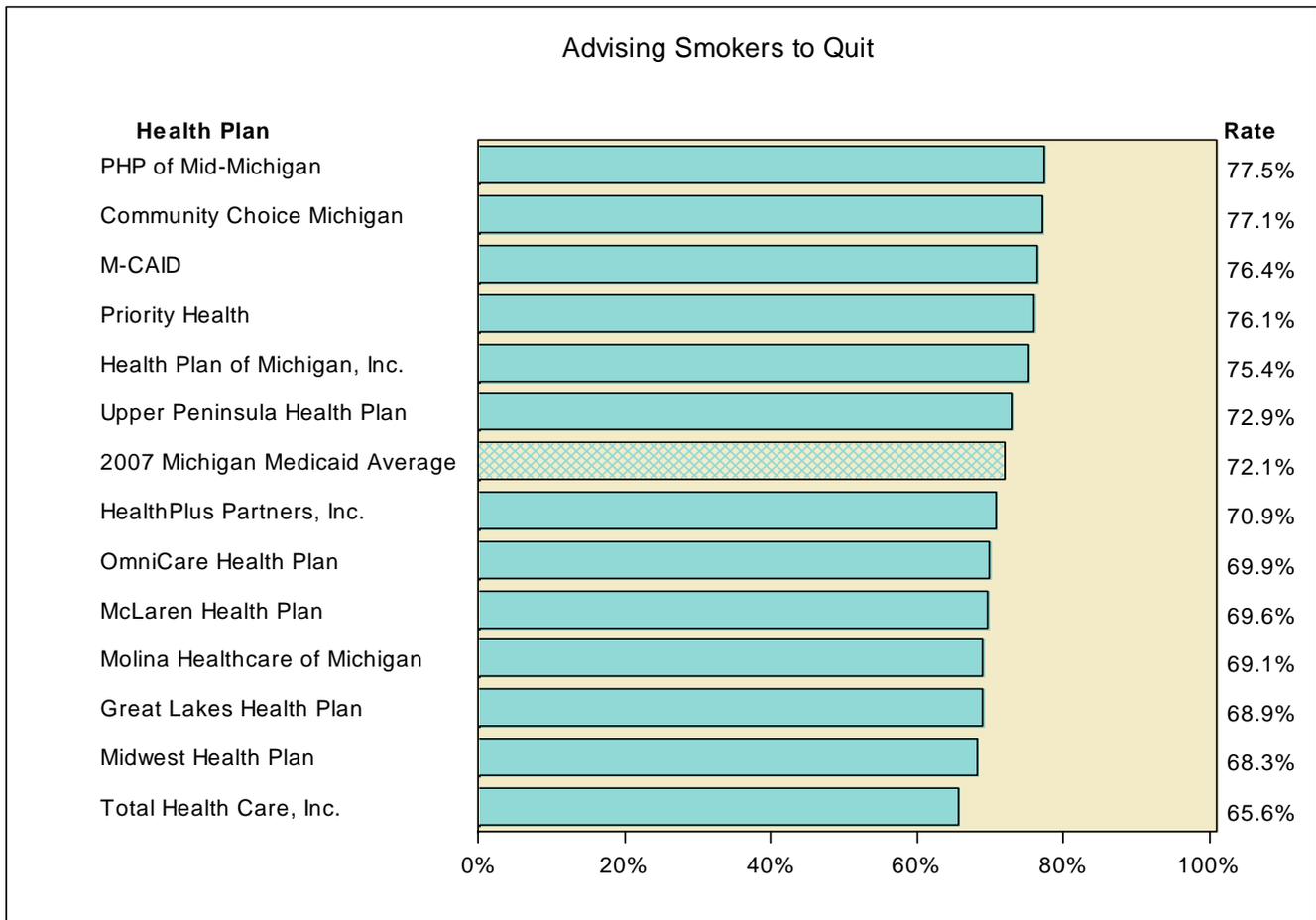
⁵⁻³⁷ Ibid.

HEDIS Specification—Discussing Smoking Cessation Strategies

The *Medical Assistance With Smoking Cessation* measure is collected using the CAHPS survey. *Discussing Smoking Cessation Strategies* is another component (or rate) reported for the measure. *Discussing Smoking Cessation Strategies* calculates the percentage of members 18 years of age or older who were continuously enrolled during the last six months of the measurement year, were smokers, were seen by an MHP practitioner in the six months prior to completing the CAHPS survey, and for whom smoking cessation medications were recommended or discussed.

Health Plan Ranking: Medical Assistance With Smoking Cessation—Advising Smokers to Quit

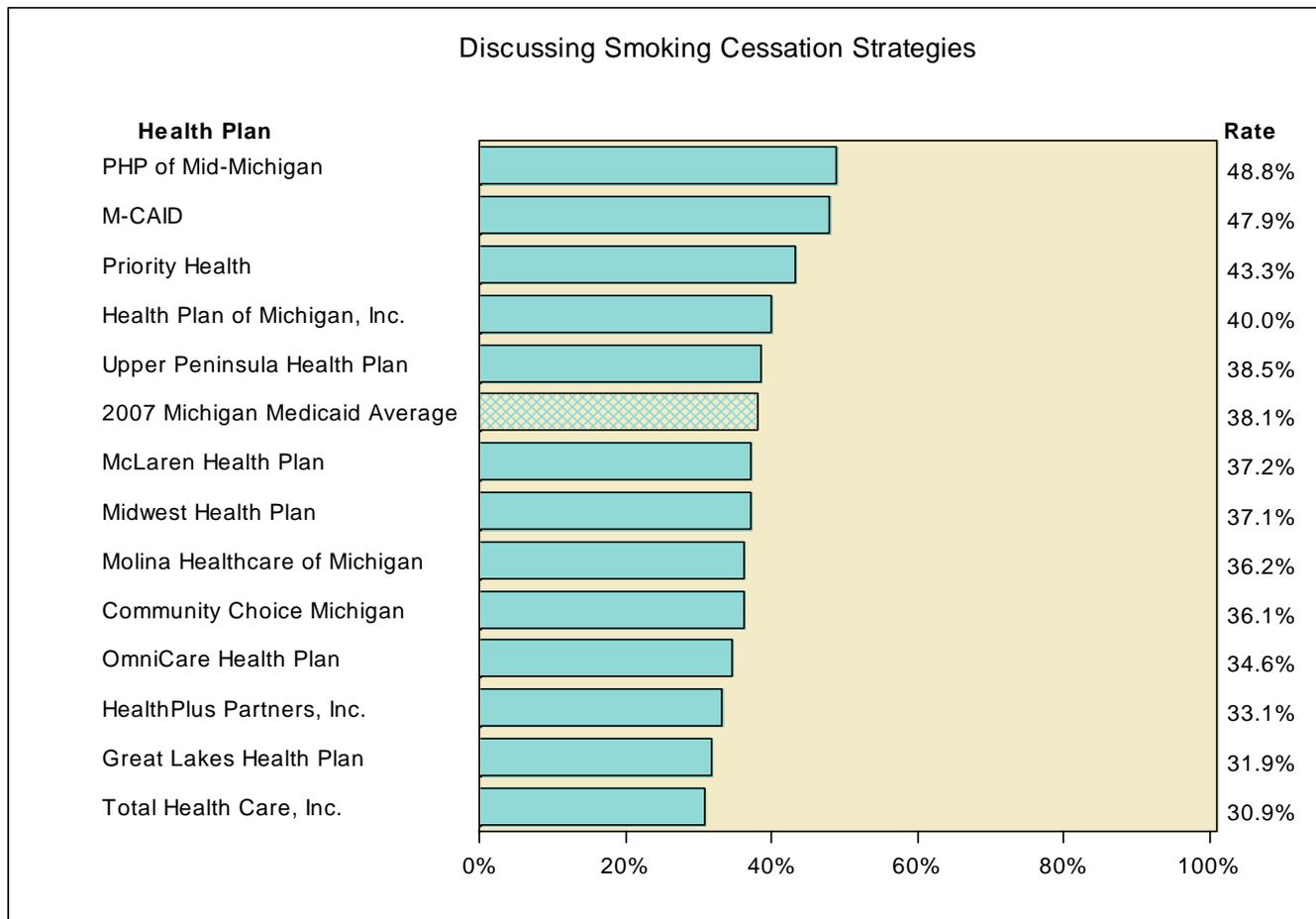
**Figure 5-20—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Medical Assistance With Smoking Cessation—Advising Smokers to Quit**



For this measure, 6 of the 13 health plans had rates above the 2007 Michigan Medicaid average of 72.1 percent. The 2007 Michigan Medicaid average increased 2.4 percentage points when compared to the 2006 average of 69.7 percent. In 2006, four of the health plans reported rates above the 2006 Michigan Medicaid average.

The rates reported by the 13 health plans ranged from 65.6 percent to 77.5 percent. The range of reported rates showed little improvement from 2006 to 2007.

**Figure 5-21—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Medical Assistance With Smoking Cessation—Discussing Smoking Cessation Strategies**



For this measure, 5 of the 13 health plans had rates above the 2007 Michigan Medicaid average of 38.1 percent. The rates reported by the 13 health plans ranged from 30.9 percent to 48.8 percent.

Living With Illness Findings and Recommendations

The measures in the Living With Illness dimension showed relatively flat improvement compared to 2006 rates, except for *Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy*, which showed improvement from 2006. A decline of 10.3 percentage points was seen in the *Comprehensive Diabetes Care—LDL-C Screening* measure. There were significant changes made to the *HEDIS 2007 Technical Specifications* for both the *Nephropathy* and *LDL-C Screening* measures, which may have contributed to the dramatic changes in those rates; therefore, caution should be exercised when interpreting these results. Other *Comprehensive Diabetes Care* measures that reported a decline in their weighted averages were *Poor HbA1c Control* and *LDL-C Level <100*. The administrative rates for data collection improved for all measure except *Poor HbA1c Control*. While the actual test data can be collected administratively for this measure, the health plans are still relying on medical record review to capture the test result.

There were increases in all of the *Use of Appropriate Medications for People With Asthma* indicators except the *Ages 10 to 17 Years* age band. This specific indicator saw a decline in its weighted average by 1.2 percentage points. This was the first year of reporting for this measure since the specifications changed in 2006.

The *Controlling High Blood Pressure* measure was split into three indicators for 2007 reporting. Two of the indicators were considered new for this year (*Controlling High Blood Pressure—Ages 18 to 45 Years* and *Controlling High Blood Pressure—Combined Rate*); therefore, there were no national standards for comparison. The 2007 *Controlling High Blood Pressure—Ages 46 to 85 Years* rate showed a statistically significant decline compared to the 2006 *Controlling High Blood Pressure* measure. While there were changes to the *HEDIS 2007 Technical Specifications* for this measure, the changes should not have contributed to the decline of 8.5 percentage points. The rate for one health plan fell nearly 20 percentage points, which would cause a decline in the overall weighted average. The MHPs should further investigate possible reasons for this decline. This measure relies solely on medical record review for reporting purposes. The health plans should ensure that all specification changes for this measure were implemented.

The MHPs' performance on the *Medical Assistance With Smoking Cessation* measures do not have national means and percentiles for benchmarking purposes; therefore, comparing rates between health plans is not possible. The 2007 Michigan Medicaid average for the *Advising Smokers to Quit* measure increased by 2.4 percentage points compared to the 2006 average. This was the first year that *Discussing Smoking Cessation Strategies* was reported. Five MHPs reported rates higher than the Michigan Medicaid average of 38.1 percent.

Several of the measures in the Living With Illness section rely on data that are typically received from outside sources or vendors, such as pharmacy and lab. The MHPs should continue to work with their vendors to enhance the completeness of these data. Improving administrative data rates will minimize the burden of medical record review.

The MHPs should ensure that their providers are current on all changes to the technical specifications for the reported measures. NCQA annually updates the specifications for measures; therefore, providers should continually be aware of these updates and changes.

The MHPs should consider implementing established quality improvement interventions to improve diabetes rates. The following list contains examples of some interventions:

- ◆ Provide reminders for diabetes services to providers and members through newsletters, postcards, birthday cards, phone calls, and management tools.
- ◆ Educate providers on diabetes health guidelines and publish guidelines in multiple places such as an MHP's Web site.
- ◆ Create a diabetes and/or case management registry to access information such as laboratory screening and results data, most recent blood pressure results, etc.
- ◆ Provide incentives to providers with diabetic members who receive required labs, exams, and screenings.
- ◆ Provide incentives to providers who meet performance thresholds on HEDIS measures.
- ◆ Educate/alert physicians with patients who are not receiving recommended services.
- ◆ Secure contracts with lab vendors for enhanced lab data.
- ◆ Provide member incentives for obtaining necessary diabetic services.
- ◆ Conduct a medical record review to identify members who are in need of services.

In the future, MDCH may want to consider using the cost-of-care HEDIS indicators that are pertinent to diabetes. The *Relative Resource Use for People With Diabetes* measure provides more information about the efficiency or value of services rendered by a health plan. This measure uses standard costs to evaluate the cost of care for patients in the *Comprehensive Diabetes Care* denominator. The relative resource measures focus on high-cost conditions, differentiate between unit price and utilization variation, and rely on a transparent risk-adjustment methodology.

Introduction

Access to care is an essential component in the effort to diagnose and treat health problems and to increase the quality and duration of healthy life. Establishing a relationship with a primary care practitioner is necessary to improve access to care for both adults and children. In order to increase access to quality care, the public health system, health plans, and health care researchers focus on identifying barriers to existing health services and eliminating disparities. Through this process, health plans can increase preventive care and implement successful disease management programs.

The Center for Studying Health System Change (HSC) reported an increase in access to needed medical care from 2001 to 2003 among Americans.⁶⁻¹ Statistics related to access to care often vary considerably by race. The CDC reports that during 2004, Whites had significantly more office-based visits to physicians than Blacks and Hispanics (333.6 versus 271.3 and 226.4 per 100 persons, respectively).⁶⁻²

An article in the *Journal of the American Medical Association* (JAMA) noted that the type of insurance coverage (or lack of insurance) had a significant impact on the ability to obtain timely access to care. Individuals with Medicaid coverage were found to be less likely to receive an appointment than those with private coverage (34.2 percent for Medicaid compared with 63.3 percent for private insurance).⁶⁻³

Although this is a vitally important issue, there are relatively few examples of effective improvement strategies that target access-to-care issues. Few health plans identify access to care as a specific quality improvement topic, and even a literature search yielded minimal sources of information on improvement efforts.

The following pages provide detailed analysis of Michigan MHP performance and ranking. For all measures in this dimension, HEDIS methodology requires that the rates be derived using only the administrative method. Medical record review is not permitted; therefore, a data collection analysis is not relevant.

⁶⁻¹ Strunk BC, Cunningham PJ. *Trends in Americans' Access to Needed Medical Care, 2001–2003*. Center for Studying Health System Change: Tracking Report No. 10. August 2004. Available at: <http://hschange.org/CONTENT/701/?topic=topic02>. Accessed on: July 31, 2007.

⁶⁻² Centers for Disease Control and Prevention. National Center for Health Statistics. NCHS Data on Health Insurance and Access to Care. October 2006. Available at: <http://www.cdc.gov/nchs/data/factsheets/healthinsurance.pdf>. Accessed on: August 1, 2007.

⁶⁻³ Asplin BR, Rhodes KV, Levy H, et al. Insurance Status and Access to Urgent Ambulatory Care Follow-up Appointments. *Journal of the American Medical Association*. 2005; 294:1248–1254.

The Access to Care dimension encompasses the following MDCH key measures:

◆ **Children's and Adolescents' Access to Primary Care Practitioners**

- *Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*
- *Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years*
- *Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years*
- *Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years*

◆ **Adults' Access to Preventive/Ambulatory Health Services**

- *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years*

Children's and Adolescents' Access to Primary Care Practitioners

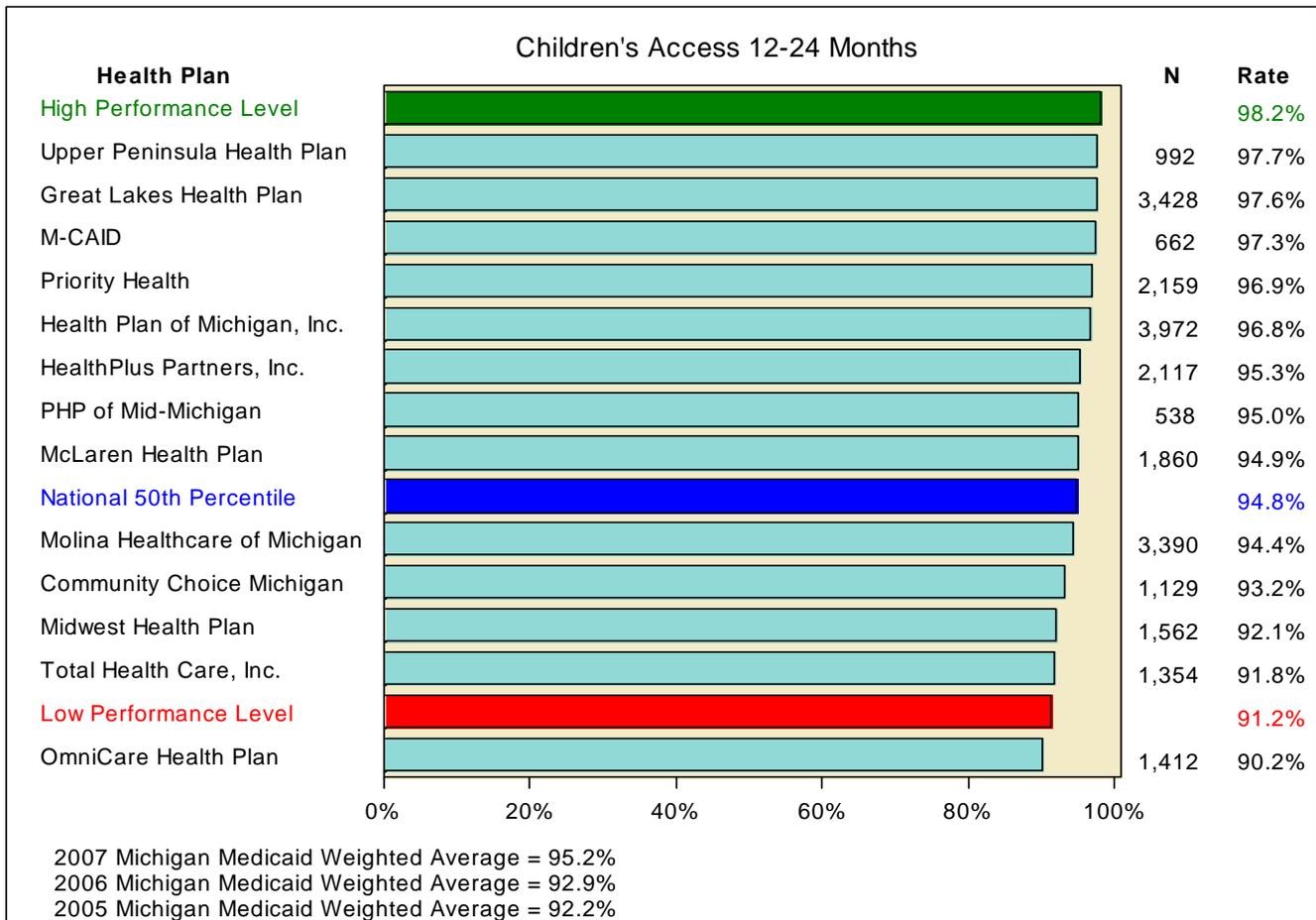
The *Children's and Adolescents' Access to Primary Care Practitioners* measure looks at visits to pediatricians, family physicians, and other primary care providers as a way to assess general access to care for children. Rates for four age groups are provided: 12 to 24 months, 25 months to 6 years, 7 to 11 years, and 12 to 19 years.

HEDIS Specification: Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months

Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months calculates the percentage of members 12 to 24 months of age who were continuously enrolled during the measurement year and who had a visit with an MHP PCP during the measurement year.

**Health Plan Ranking: Children's and Adolescents' Access to Primary Care Practitioners
—Ages 12 to 24 Months**

**Figure 6-1—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months**



Eight of the 13 health plans reported rates above the national HEDIS 2006 Medicaid 50th percentile of 94.8 percent. Furthermore, one of the health plans reported a rate below the LPL of 91.2 percent.

The 2007 Michigan Medicaid weighted average of 95.2 percent improved by 2.3 percentage points compared to 2006. In addition, the rate exceeded the national HEDIS 2006 Medicaid 50th percentile by 0.4 percentage points. The range of reported rates also showed improvement. In 2006, the difference between the highest and lowest rates was 15.1 percentage points. In 2007, the range narrowed by 7.5 percentage points, suggesting that the lower-performing health plans are improving their rates.

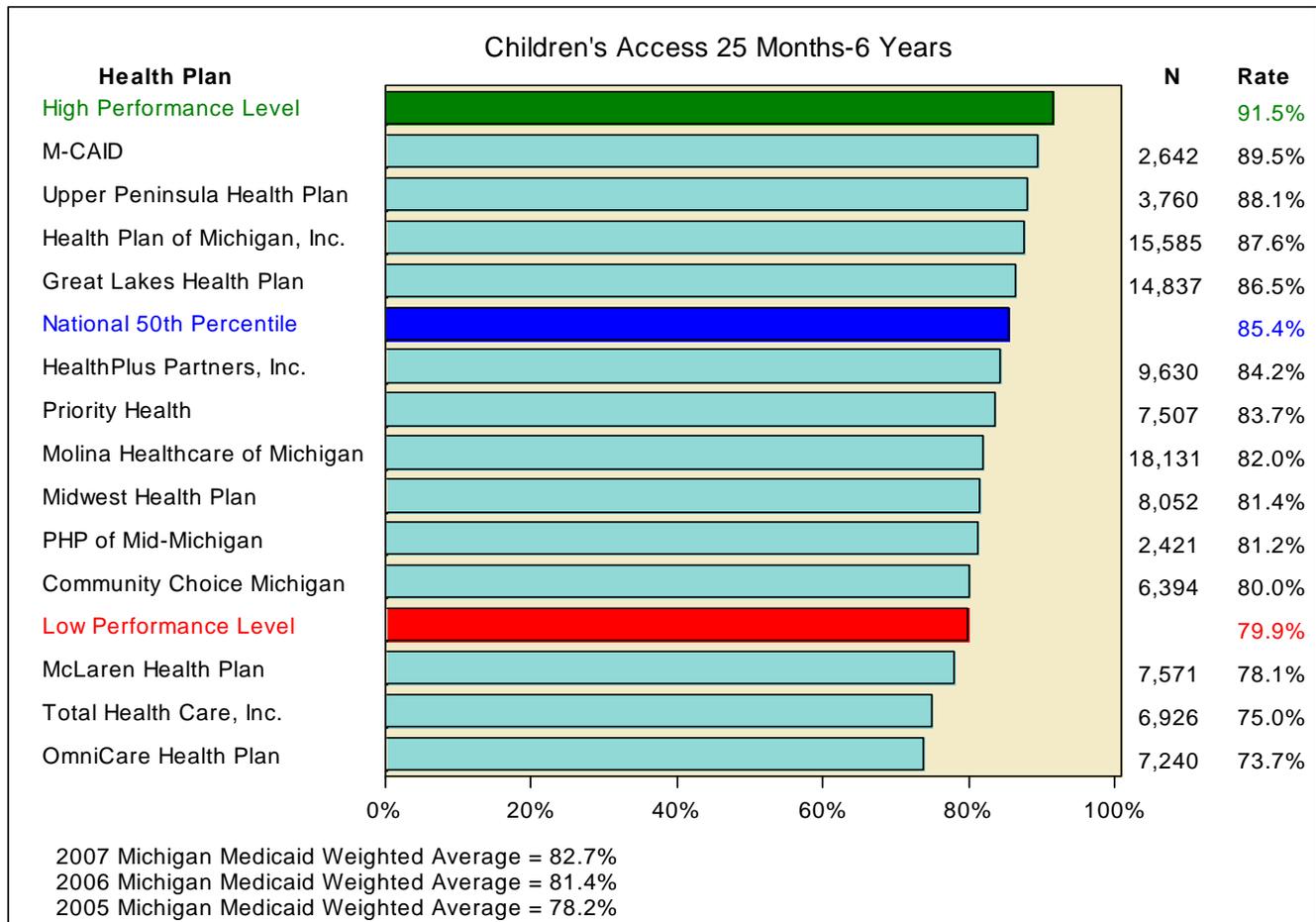
Last year one of the health plans exceeded the HPL and four of the health plans performed below the LPL. This year, however, none of the health plans exceeded the HPL of 98.2 percent and only one fell below the LPL.

***HEDIS Specification: Children's and Adolescents' Access to Primary Care Practitioners
—Ages 25 Months to 6 Years***

Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years reports the percentage of members 25 months to 6 years of age who were continuously enrolled during the measurement year and who had a visit with an MHP PCP during the measurement year.

**Health Plan Ranking: Children's and Adolescents' Access to Primary Care Practitioners
—Ages 25 Months to 6 Years**

**Figure 6-2—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years**



None of the health plans exceeded the HPL of 91.5 percent, while three health plans reported rates below the LPL of 79.9 percent. Four health plans did, however, exceed the national HEDIS 2006 Medicaid 50th percentile of 85.4 percent.

The 2007 Michigan Medicaid weighted average of 82.7 percent fell below the national HEDIS 2006 Medicaid 50th percentile by 2.7 percentage points. The Michigan Medicaid weighted average increased by 1.3 percentage points from 2006 to 2007. A gain of 4.5 percentage points was observed when the 2007 weighted average was compared with the 2005 weighted average.

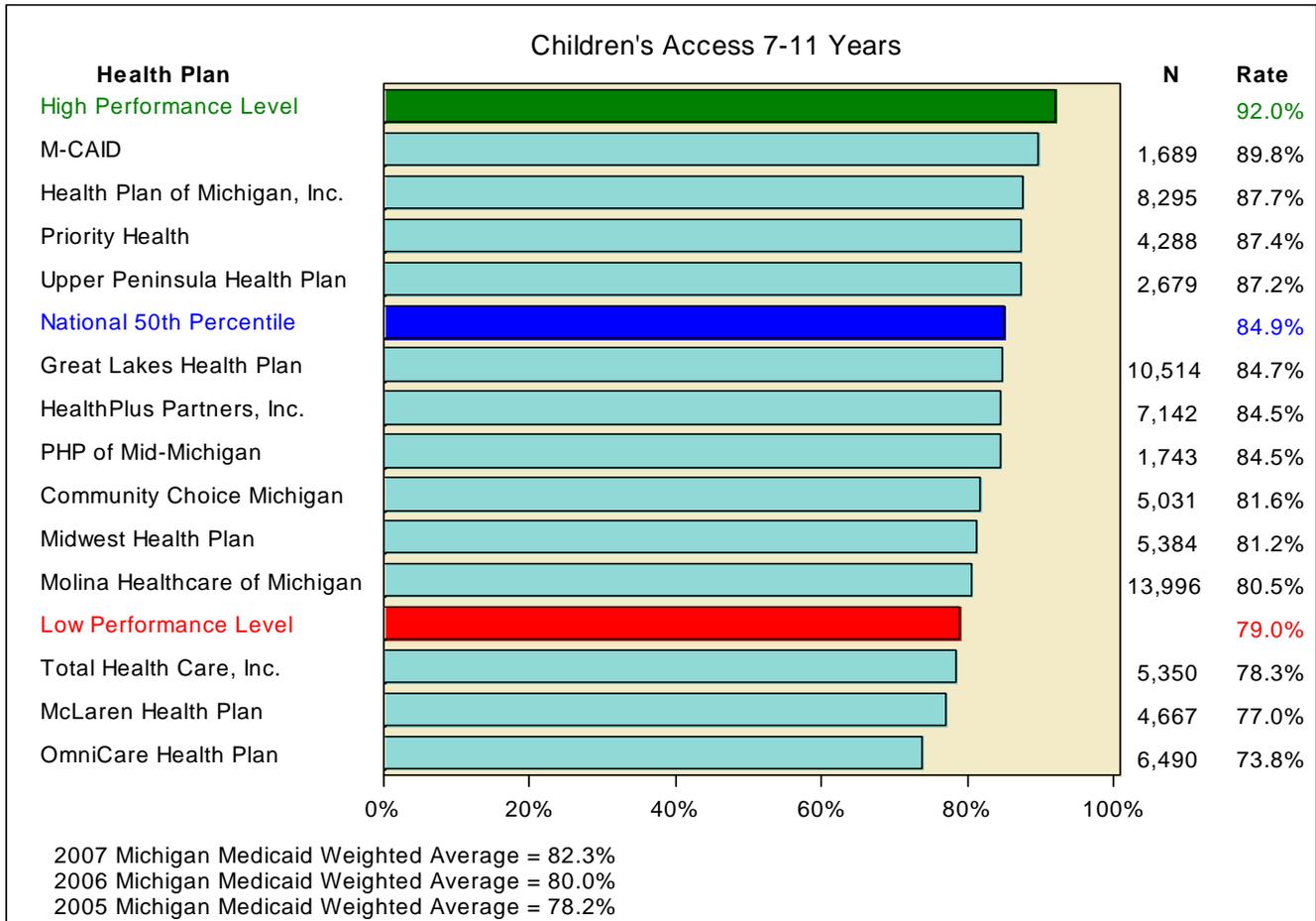
In 2006, four health plans fell below the LPL. Three of those four plans were still below the LPL in 2007. Furthermore in 2006, five health plans exceeded the national 50th percentile; however, only four of those five health plans exceeded the national 50th percentile in 2007.

HEDIS Specification: Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years

Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years reports the percentage of members 7 to 11 years of age who were continuously enrolled during the measurement year and the year prior to the measurement year, and who had a visit with an MHP PCP during the measurement year or the year prior to the measurement year.

**Health Plan Ranking: Children's and Adolescents' Access to Primary Care Practitioners
—Ages 7 to 11 Years**

**Figure 6-3—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years**



None of the health plans met the HPL of 92.0 percent, while 4 of the 13 health plans had rates that exceeded the national HEDIS 2006 Medicaid 50th percentile of 84.9 percent. Three health plans performed below the LPL of 79.0 percent.

The 2007 Michigan Medicaid weighted average of 82.3 percent was below the national HEDIS 2006 Medicaid 50th percentile. The 2007 weighted average did, however, show improvement from 2006 to 2007 with an increase of 2.3 percentage points.

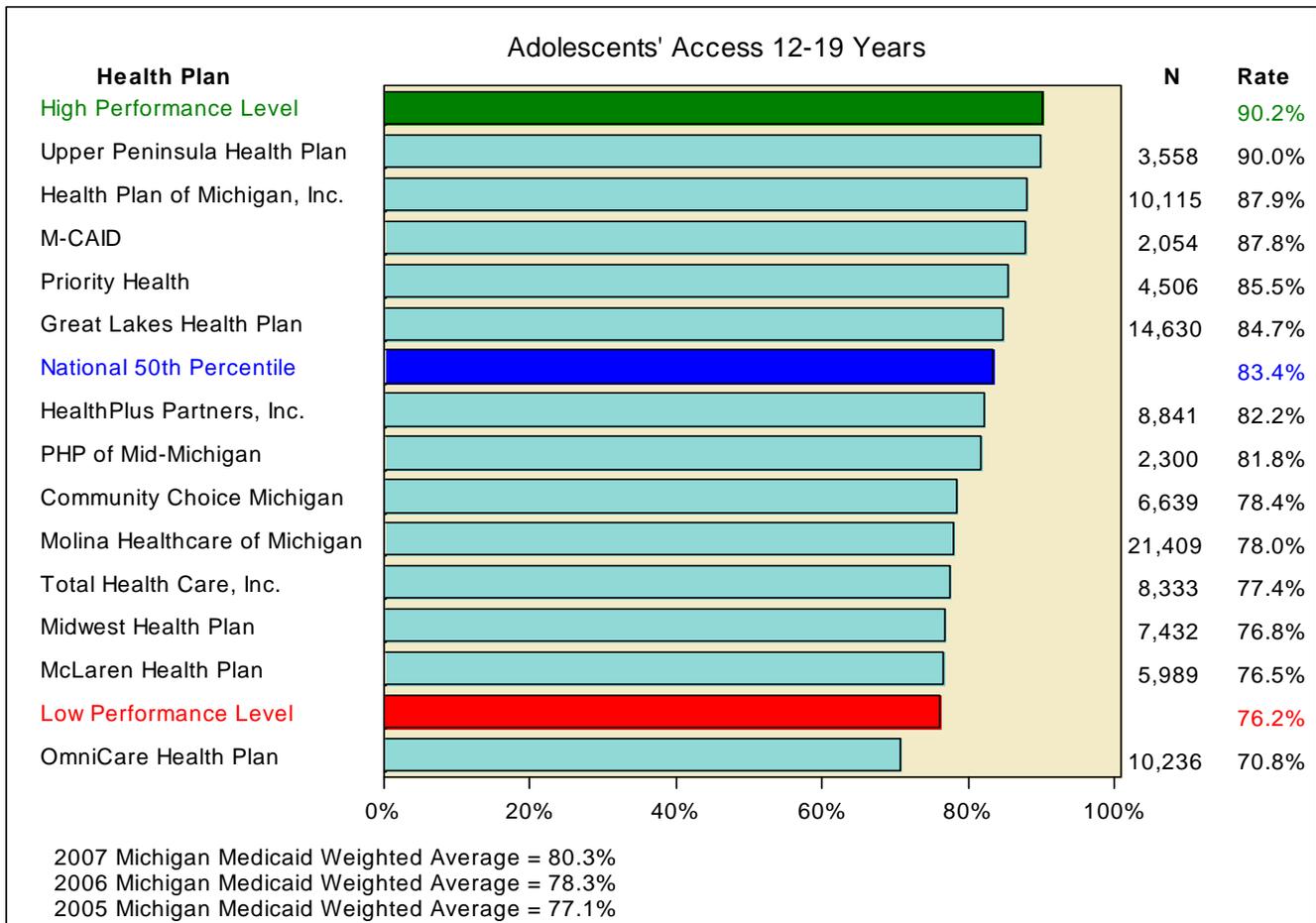
Three health plans fell below the LPL in 2007, while only two health plans had rates below the LPL in 2006. The range of reported rates showed a slight improvement in 2007 compared to 2006.

HEDIS Specification: Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years

Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years reports the percentage of members 12 to 19 years of age who were continuously enrolled during the measurement year and the year prior to the measurement year, and who had a visit with an MHP PCP during the measurement year or the year prior to the measurement year.

**Health Plan Ranking: Children's and Adolescents' Access to Primary Care Practitioners
—Ages 12 to 19 Years**

**Figure 6-4—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years**



None of the health plans reached the HPL rate of 90.2 percent, while five health plans exceeded the national HEDIS 2006 Medicaid 50th percentile of 83.4 percent. One of the health plans performed below the LPL of 76.2 percent.

The 2007 Michigan Medicaid weighted average of 80.3 percent was 3.1 percentage points below the national HEDIS 2006 Medicaid 50th percentile and 2.0 percentage points above the 2006 weighted average. Almost no difference was observed for the range of reported rates between 2006 and 2007.

Four health plans exceeded the national HEDIS Medicaid 50th percentile in 2006, and in 2007, all four continued to exceed the 50th percentile. In 2006, two health plans fell below the LPL. One of the health plans continued to be below the LPL in 2007.

Adults' Access to Preventive/Ambulatory Health Services

The majority of adults have relatively frequent contact with their health care providers. In 2004, approximately 910 million visits were made to physician offices in the United States.⁶⁻⁴ Of these, about 16 percent were for preventive care. Females had a visit rate of 67.6 visits per 100 people for preventive care, which was significantly higher than the rate for males (33.6 visits per 100 people).

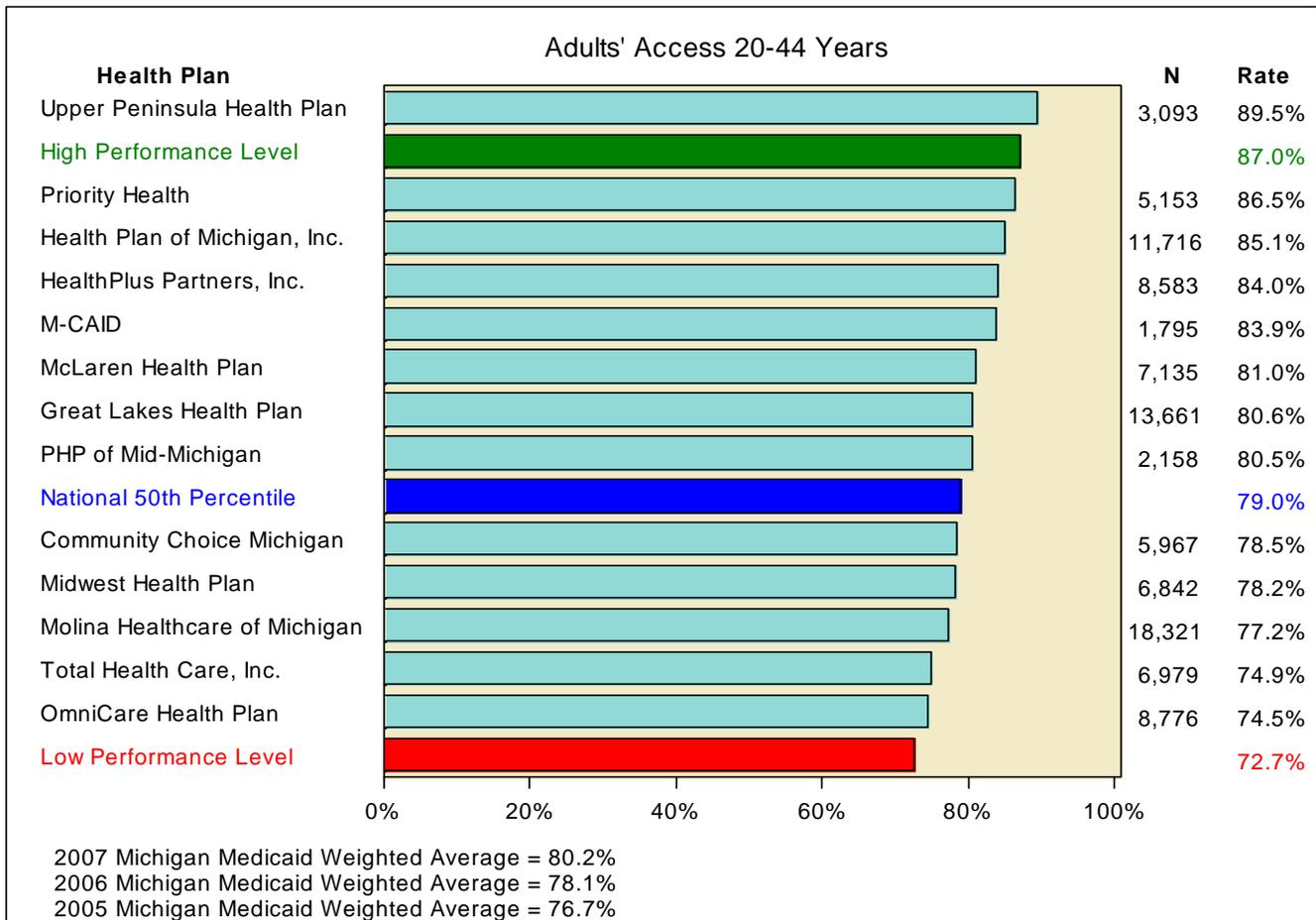
HEDIS Specification: Adults' Access to Preventive/Ambulatory Health Services —Ages 20 to 44 Years

The *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years* measure calculates the percentage of adults 20 to 44 years of age who were continuously enrolled during the measurement year and who had an ambulatory or preventive care visit during the measurement year.

⁶⁻⁴ Hing E, Cherry D, and Woodwell, D. National Ambulatory Medical Care Survey: 2004 Summary. *Advance Data*. Centers for Disease Control and Prevention. June 23, 2006. Number 374. Available at: <http://www.cdc.gov/nchs/data/ad/ad374.pdf>. Accessed on: August 2, 2007.

**Health Plan Ranking: Adults' Access to Preventive/Ambulatory Health Services
—Ages 20 to 44 Years**

**Figure 6-5—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years**



One health plan exceeded the HPL of 87.0 percent, while none of the health plans fell below the LPL of 72.7 percent. Eight of the 13 health plans reported rates above the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 80.2 percent was 1.2 percentage points above the national HEDIS 2006 Medicaid 50th percentile of 79.0 percent. In addition, the Michigan Medicaid weighted average increased by 2.1 percentage points from 2006 to 2007.

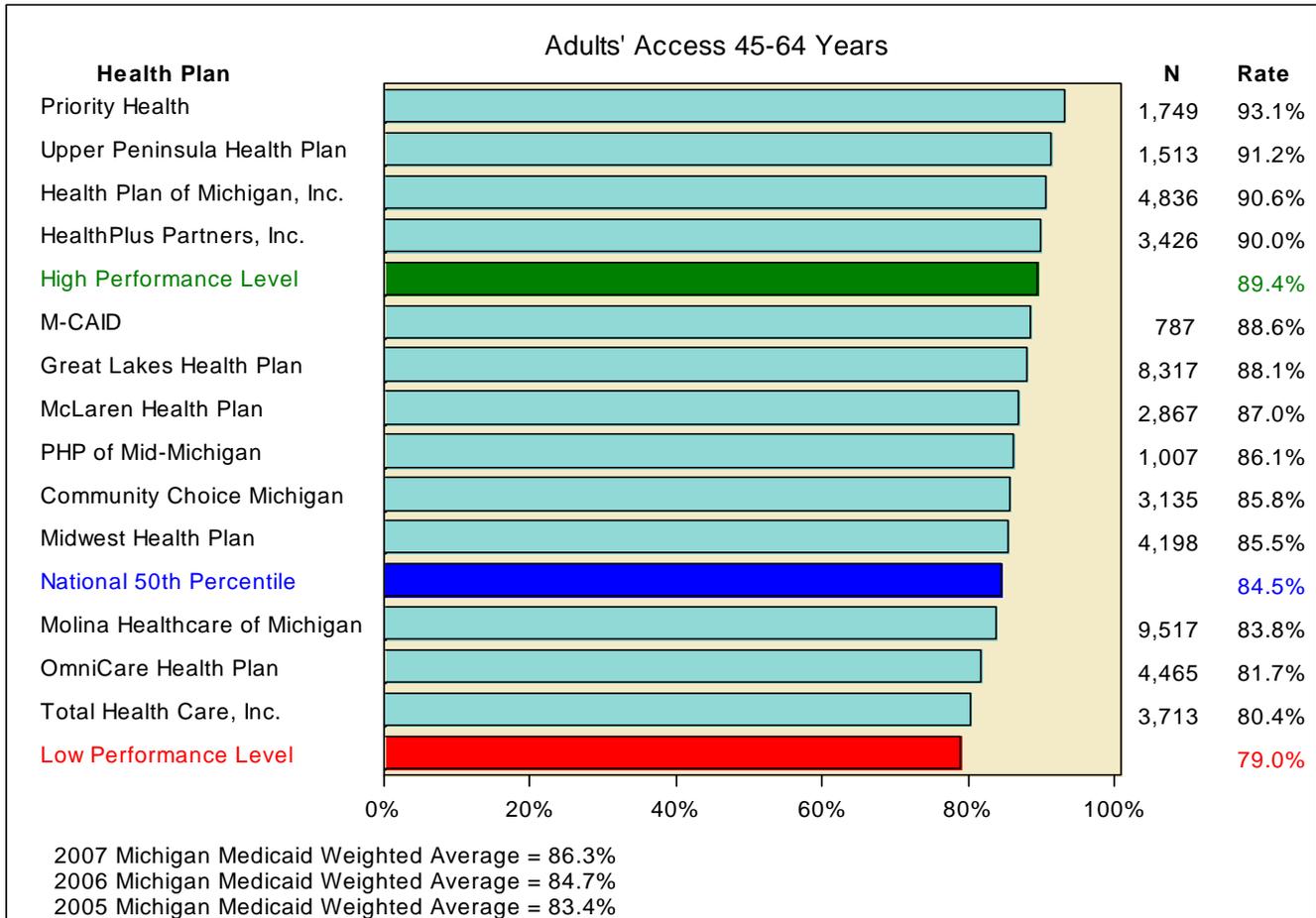
Similar to this year's results, in 2006, none of the health plans had a rate below the LPL. However, in 2006, two health plans exceeded the HPL. Only one of the two health plans outperformed the HPL in 2007.

HEDIS Specification: Adults' Access to Preventive/Ambulatory Health Services —Ages 45 to 64 Years

The *Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years* measure calculates the percentage of adults 45 to 64 years of age who were continuously enrolled during the measurement year and who had an ambulatory or preventive care visit during the measurement year.

**Health Plan Ranking: Adults' Access to Preventive/Ambulatory Health Services
—Ages 45 to 64 Years**

**Figure 6-6—Michigan Medicaid HEDIS 2007
Health Plan Ranking:
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years**



Four health plans exceeded the HPL of 89.4 percent, and none of the health plans had a rate below the LPL of 79.0 percent. In addition, a majority of the health plans (10 out of 13) exceeded the national HEDIS 2006 Medicaid 50th percentile.

The 2007 Michigan Medicaid weighted average of 86.3 percent was 1.8 percentage points above the national HEDIS 2006 Medicaid 50th percentile of 84.5 percent. In addition, the 2007 weighted average improved by 1.6 percentage points when compared to the 2006 weighted average. The range of reported rates showed a slight improvement in 2007 compared to 2006.

In 2006, five health plans exceeded the HPL; however, only four of those health plans continued to have performance above the HPL in 2007. Three health plans had rates below the national HEDIS 2006 Medicaid 50th percentile in 2007, while five health plans fell below the 50th percentile in 2006.

Access to Care Findings and Recommendations

Although increases from 2006 to 2007 were observed for all of the Access to Care measures' weighted averages, none of the measures showed statistically significant improvement. It appeared that the greatest challenge for the health plans was the younger population. While both of the *Adults' Access to Preventive/Ambulatory Health Services* measures' weighted averages were above the national HEDIS 2006 Medicaid 50th percentile, only one out of the four weighted averages for the *Children's and Adolescent's Access to Primary Care Physicians* indicators (*Children's Access 12–24 Months*) exceeded the 50th percentile. In addition, most of the ranges of rates only moderately improved across the measures. Furthermore, many of the health plans that were low performers in 2006 remained low-performing health plans in 2007, suggesting that these health plans need to focus more improvement efforts on access to care.

The MHPs should investigate whether or not their rates for access to care reflect that members are not accessing their PCPs or that the MHPs are not receiving all of the encounter data from providers for members who receive capitated services. This will help the MHPs focus on areas for improvement specific to the where problems exist.

The health plans should work together to brainstorm and share other opportunities for improvement for these measures. Sharing best practices between MHPs would help lower-performing health plans implement interventions that are showing success in the higher-performing plans.

Key Findings

No major issues with HEDIS reporting were identified after a review of each health plan's Final Audit Report and Interactive Data Submission Systems results. Similar to previous years' findings, HSAG determined that the MHPs had no major issues that impacted HEDIS reporting and all of the health plans achieved *Report* status for all measures presented in this report.

Twelve of the 13 MHPs used an NCQA-certified software vendor to produce rates for the key measures they reported. All of the software vendors used by the MHPs achieved full certification for the HEDIS measures. One MHP produced its own measures with internally developed source code and programming logic.

The HEDIS audits were performed by three NCQA-licensed audit organizations (LOs). Ten MHPs used the same LO as last year. Nine of the 13 audits were performed by one LO, another LO performed three of the audits, and a third organization performed one audit. Since a majority of the audits were performed by one LO, the reports were very consistent. The audit reports provided sufficient detail to allow HSAG to evaluate the MHPs' information systems (IS) capabilities.

IS Standards 3.0, 5.0, and 6.0 were determined to be fully compliant for all 13 MHPs. The auditors did not find any issues with membership data processing, the integration of data for HEDIS reporting, or the control procedures to ensure HEDIS data integrity.

Ten of the MHPs were fully compliant with IS Standard 1.0 and three MHPs were considered substantially compliant with IS Standard 1.0. The issues that were noted for these three MHPs were minor and did not result in a bias to any of the HEDIS rates. In addition, some auditors suggested that the MHPs modify their systems to accommodate Current Procedural Terminology (CPT) Category II codes.

Twelve of the 13 MHPs were fully compliant with IS Standard 2.0, and one was considered substantially compliant with this standard, specifically IS 2.5. There were issues with this MHP receiving encounter data from one of its contracted providers. The MHP continues to move toward more fee-for-service contracts, and it was also noted that the MHP initiated a provider pay-for-performance program in 2005.

One MHP was not fully compliant with IS Standard 4.2. Issues were identified with procedures for updating board certification status.

A similar recommendation made across all of the MHPs was to continue to work to get lab results and match them to lab claims and encounter data. This will further enhance the completeness of measures that rely on lab data for reporting.

Conclusions and Recommendations

The Michigan MHPs' IS capabilities pertaining to accurate and valid HEDIS reporting have continued to improve over the past seven years. The MHPs should continue to explore ways to improve their rates. One way is to assess whether or not providers are submitting claims or encounter data for services rendered to their patients. This is particularly important for capitated providers. Although this was an area where all of the MHPs focused, there is room for improvement. The MHPs should also investigate other possible missing capitated service data or service data for which there is a low fee-for-service reimbursement. Along these lines, the MHPs should work with their contracted labs to obtain lab values, thereby decreasing the need for medical record review for measures that require a lab value. The MHPs should ensure that their data systems are able to capture the CPT Category II codes that were recently added to several of the HEDIS measures and should work to educate their providers on the use of them.

Several best-practice were noted in the MHPs' final audit reports by their HEDIS compliance auditor. It would be beneficial for the MHPs that were identified as having best practices to share these activities with the other MHPs. Some of the best practices identified were:

- ◆ One MHP was noted for two best practices by its HEDIS compliance auditor. The MHP's data completeness program was noted as a best practice since it linked data submission with quality improvement activities and physician bonus payments. The MHP had a very active and productive pay-for-performance program that rewarded submission of claims and encounter data.⁷⁻¹ The MHP also received a best practice for its provider data system since the provider credentialing module electronically linked to all tables within the system, eliminating the need for dual data entry.⁷⁻²
- ◆ One MHP received a best-practice commendation from its HEDIS compliance auditor related to its claims preprocessing edits, which were designed to maximize auto-adjudication of the claims in order to reduce processing time.⁷⁻³
- ◆ Another MHP received a best-practice commendation for setting up an internal audit office that randomly samples and reviews all claims and encounters it processes. The office provided results of the analysis to managers for any necessary corrective actions. The audit team noted that this process allowed for early identification of coding and submission problems.⁷⁻⁴

Although not all the MHPs received best-practice commendations in a particular area, there were many positive notations and feedback provided to the MHPs. Several MHPs were starting or already participating in pay-for-performance programs, and some MHPs are developing various administrative databases that could be used to supplement claims and encounter data. NCQA has outlined updated processes and standards for building, maintaining, and validating both internal and external administrative databases and the MHPs should be directed to the latest version of NCQA's technical specifications.

⁷⁻¹ Health Plan of Michigan, Inc. NCQA HEDIS Compliance Audit, Final Audit Report. July 2007, p. 7

⁷⁻² Health Plan of Michigan, Inc. NCQA HEDIS Compliance Audit, Final Audit Report. July 2007, p. 9

⁷⁻³ OmniCare Health Plan, Inc., NCQA HEDIS Compliance Audit, Final Audit Report. July 2007, p. 9

⁷⁻⁴ Total Health Care, Inc. NCQA HEDIS Compliance Audit, Final Audit Report. July 2007, p.5

Appendix A. Tabular Results for Key Measures by Health Plan

Appendix A presents tables showing results for the key measures by health plan. Where applicable, the results provided for each measure include the eligible population and rate for each MHP; the 2005, 2006, and 2007 Michigan Medicaid weighted averages; and the national HEDIS 2006 Medicaid 50th percentile. The following is a list of the tables and the key measures presented for each health plan.

- ◆ Table A-1—*Immunization Status*
- ◆ Table A-2—*Well-Child Visits in the First 15 Months of Life*
- ◆ Table A-3—*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life and Adolescent Well-Care Visits*
- ◆ Table A-4—*Appropriate Treatment for Children With Upper Respiratory Infection*
- ◆ Table A-5—*Appropriate Testing for Children With Pharyngitis*
- ◆ Table A-6—*Cancer Screening in Women*
- ◆ Table A-7—*Chlamydia Screening in Women*
- ◆ Table A-8—*Prenatal and Postpartum Care*
- ◆ Table A-9—*Comprehensive Diabetes Care*
- ◆ Table A-10—*Use of Appropriate Medications for People With Asthma*
- ◆ Table A-11—*Controlling High Blood Pressure*
- ◆ Table A-12—*Children’s and Adolescents’ Access to Primary Care Practitioners*
- ◆ Table A-13—*Adults’ Access to Preventive/Ambulatory Health Services*
- ◆ Table A-14—*Medical Assistance With Smoking Cessation—Numerator 1 and Numerator 3*

Table A-1—Tabular Results for Key Measures by Health Plan: <i>Immunization Status</i>							
IDSS	Plan Name	Code	Childhood Immunization Status			Adolescent Immunization Status	
			Eligible Population	Combo 2 Rate	Combo 3 Rate	Eligible Population	Combo 2 Rate
4265	Community Choice Michigan	CCM	1,032	74.9%	62.5%	1,292	67.1%
4133	Great Lakes Health Plan	GLH	3,116	77.6%	63.3%	2,794	66.7%
4291	Health Plan of Michigan, Inc.	HPM	3,442	83.8%	71.5%	2,122	70.6%
4056	HealthPlus Partners, Inc.	HPP	1,992	85.2%	71.5%	1,665	79.0%
4243	M-CAID	MCD	485	81.0%	56.7%	425	68.5%
4312	McLaren Health Plan	MCL	1,602	80.0%	66.7%	1,279	64.2%
4131	Midwest Health Plan	MID	1,602	81.5%	57.9%	1,470	64.0%
4151	Molina Healthcare of Michigan	MOL	3,024	72.4%	35.5%	4,042	54.6%
4055	OmniCare Health Plan	OCH	1,343	79.9%	51.9%	1,904	59.7%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	550	82.0%	73.5%	451	75.4%
4054	Priority Health Government Programs, Inc.	PRI	1,828	88.7%	81.2%	957	78.4%
4268	Total Health Care, Inc.	THC	1,359	77.8%	62.0%	1,385	71.2%
4348	Upper Peninsula Health Plan	UPP	797	80.7%	66.6%	686	70.1%
	2007 Michigan Medicaid Weighted Average		--	80.2%	62.3%	--	65.9%
	2006 Michigan Medicaid Weighted Average		--	76.6%	38.5%	--	58.9%
	2005 Michigan Medicaid Weighted Average		--	71.7%	--	--	53.0%
	National HEDIS 2006 Medicaid 50th Percentile		--	72.4%	42.3%	--	44.3%

Notes: The 2005 and 2006 Michigan Medicaid weighted averages included 15 health plans, and the 2007 Medicaid weighted average included 13 health plans.

Table A-2—Tabular Results for Key Measures by Health Plan: <i>Well-Child Visits in the First 15 Months of Life</i>					
IDSS	Plan Name	Code	Eligible Population	0 Visits Rate	6 or More Visits Rate
4265	Community Choice Michigan	CCM	665	3.4%	37.5%
4133	Great Lakes Health Plan	GLH	1,876	0.3%	91.1%
4291	Health Plan of Michigan, Inc.	HPM	1,665	0.9%	69.9%
4056	HealthPlus Partners, Inc.	HPP	1,302	2.3%	61.8%
4243	M-CAID	MCD	191	0.5%	64.4%
4312	McLaren Health Plan	MCL	1,023	1.2%	62.8%
4131	Midwest Health Plan	MID	874	3.6%	56.7%
4151	Molina Healthcare of Michigan	MOL	1,708	1.9%	42.5%
4055	OmniCare Health Plan	OCH	907	0.9%	50.9%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	354	1.4%	49.2%
4054	Priority Health Government Programs, Inc.	PRI	1,296	1.2%	53.5%
4268	Total Health Care, Inc.	THC	812	1.2%	49.1%
4348	Upper Peninsula Health Plan	UPP	801	1.4%	44.6%
	2007 Michigan Medicaid Weighted Average		--	1.5%	59.3%
	2006 Michigan Medicaid Weighted Average		--	2.1%	51.9%
	2005 Michigan Medicaid Weighted Average		--	3.4%	43.0%
	National HEDIS 2006 Medicaid 50th Percentile		--	2.0%	50.0%

Note: The 2005 and 2006 Michigan Medicaid weighted averages included 15 health plans, and the 2007 Medicaid weighted average included 13 health plans.

Table A-3—Tabular Results for Key Measures by Health Plan: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, and Adolescent Well-Care Visits						
IDSS	Plan Name	Code	3rd–6th Years of Life		Adolescent	
			Eligible Population	Rate	Eligible Population	Rate
4265	Community Choice Michigan	CCM	5,372	56.9%	9,265	31.1%
4133	Great Lakes Health Plan	GLH	11,956	69.8%	20,330	58.8%
4291	Health Plan of Michigan, Inc.	HPM	12,281	65.3%	16,515	55.1%
4056	HealthPlus Partners, Inc.	HPP	7,767	64.8%	11,614	48.4%
4243	M-CAID	MCD	2,129	67.4%	2,776	51.4%
4312	McLaren Health Plan	MCL	6,046	69.8%	9,119	52.1%
4131	Midwest Health Plan	MID	6,558	74.9%	10,251	50.1%
4151	Molina Healthcare of Michigan	MOL	17,282	62.2%	29,023	39.6%
4055	OmniCare Health Plan	OCH	6,004	72.2%	13,336	50.2%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	2,288	67.6%	3,445	47.7%
4054	Priority Health Government Programs, Inc.	PRI	5,824	63.7%	7,055	43.3%
4268	Total Health Care, Inc.	THC	5,691	65.4%	10,884	47.9%
4348	Upper Peninsula Health Plan	UPP	3,026	60.9%	4,714	39.1%
	2007 Michigan Medicaid Weighted Average		--	66.1%	--	47.7%
	2006 Michigan Medicaid Weighted Average		--	64.2%	--	43.5%
	2005 Michigan Medicaid Weighted Average		--	58.5%	--	38.0%
	National HEDIS 2006 Medicaid 50th Percentile		--	64.8%	--	39.4%

Note: The 2005 and 2006 Michigan Medicaid weighted averages included 15 health plans, and the 2007 Medicaid weighted average included 13 health plans.

Table A-4—Tabular Results for Key Measures by Health Plan: Appropriate Treatment for Children With Upper Respiratory Infection				
IDSS	Plan Name	Code	Eligible Population	Rate
4265	Community Choice Michigan	CCM	2,419	79.4%
4133	Great Lakes Health Plan	GLH	6,731	74.6%
4291	Health Plan of Michigan, Inc.	HPM	6,609	78.4%
4056	HealthPlus Partners, Inc.	HPP	4,247	72.1%
4243	M-CAID	MCD	1,206	90.5%
4312	McLaren Health Plan	MCL	3,938	67.2%
4131	Midwest Health Plan	MID	4,938	75.2%
4151	Molina Healthcare of Michigan	MOL	7,520	79.4%
4055	OmniCare Health Plan	OCH	2,099	79.7%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	1,451	76.6%
4054	Priority Health Government Programs, Inc.	PRI	2,775	87.7%
4268	Total Health Care, Inc.	THC	1,357	76.3%
4348	Upper Peninsula Health Plan	UPP	1,718	81.1%
	2007 Michigan Medicaid Weighted Average		--	77.1%
	2006 Michigan Medicaid Weighted Average		--	75.6%
	2005 Michigan Medicaid Weighted Average		--	75.0%
	National HEDIS 2006 Medicaid 50th Percentile		--	82.7%

Note: The 2005 and 2006 Michigan Medicaid weighted averages included 15 health plans, and the 2007 Medicaid weighted average included 13 health plans.

Table A-5—Tabular Results for Key Measures by Health Plan: Appropriate Testing for Children With Pharyngitis				
IDSS	Plan Name	Code	Eligible Population	Rate
4265	Community Choice Michigan	CCM	1,834	54.5%
4133	Great Lakes Health Plan	GLH	4,247	41.5%
4291	Health Plan of Michigan, Inc.	HPM	4,276	53.2%
4056	HealthPlus Partners, Inc.	HPP	2,975	40.9%
4243	M-CAID	MCD	771	80.8%
4312	McLaren Health Plan	MCL	2,452	48.7%
4131	Midwest Health Plan	MID	3,287	18.7%
4151	Molina Healthcare of Michigan	MOL	4,237	43.6%
4055	OmniCare Health Plan	OCH	1,085	32.3%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	747	59.2%
4054	Priority Health Government Programs, Inc.	PRI	1,387	68.9%
4268	Total Health Care, Inc.	THC	1,510	37.5%
4348	Upper Peninsula Health Plan	UPP	1,083	54.8%
	2007 Michigan Medicaid Weighted Average		--	45.0%
	2006 Michigan Medicaid Weighted Average		--	39.1%
	2005 Michigan Medicaid Weighted Average		--	42.1%
	National HEDIS 2006 Medicaid 50th Percentile		--	56.2%

Note: The 2005 and 2006 Michigan Medicaid weighted averages included 15 health plans, and the 2007 Medicaid weighted average included 13 health plans.

Table A-6—Tabular Results for Key Measures by Health Plan: Cancer Screening in Women										
			Breast Cancer Screening						Cervical Cancer Screening	
			Ages 42–51 Years		Ages 52–69 Years		Combined			
IDSS	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
4265	Community Choice Michigan	CCM	1,030	39.2%	829	53.6%	1,859	45.6%	5,608	65.6%
4133	Great Lakes Health Plan	GLH	2,475	43.8%	2,523	56.6%	4,998	50.3%	13,937	64.6%
4291	Health Plan of Michigan, Inc.	HPM	1,472	53.9%	1,232	64.4%	2,704	58.7%	10,300	71.0%
4056	HealthPlus Partners, Inc.	HPP	1,322	54.3%	1,082	62.5%	2,404	58.0%	7,913	77.1%
4243	M-CAID	MCD	300	42.0%	215	47.4%	515	44.3%	1,713	78.0%
4312	McLaren Health Plan	MCL	933	45.3%	784	56.9%	1,717	50.6%	6,281	70.1%
4131	Midwest Health Plan	MID	1,268	51.9%	1,232	57.5%	2,500	54.6%	6,928	64.2%
4151	Molina Healthcare of Michigan	MOL	3,268	44.5%	2,757	54.2%	6,025	48.9%	17,374	58.0%
4055	OmniCare Health Plan	OCH	1,467	40.1%	1,379	52.6%	2,846	46.1%	8,698	66.7%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	373	46.4%	313	52.4%	686	49.1%	2,018	68.6%
4054	Priority Health Government Programs, Inc.	PRI	623	53.0%	484	57.0%	1,107	54.7%	4,586	76.0%
4268	Total Health Care, Inc.	THC	1,227	43.0%	1,120	52.8%	2,347	47.6%	6,852	66.2%
4348	Upper Peninsula Health Plan	UPP	512	53.5%	444	67.6%	956	60.0%	2,727	76.8%
	2007 Michigan Medicaid Weighted Average		--	46.4%	--	56.6%	--	51.2%	--	67.1%
	2006 Michigan Medicaid Weighted Average		--	--	--	55.8%	--	--	--	65.8%
	2005 Michigan Medicaid Weighted Average		--	--	--	53.7%	--	--	--	63.4%
	National HEDIS 2006 Medicaid 50th Percentile		--	--	--	53.9%	--	--	--	66.1%

Note: The 2005 and 2006 Michigan Medicaid weighted averages included 15 health plans, and the 2007 Medicaid weighted averages included 13 health plans.

Table A-7—Tabular Results for Key Measures by Health Plan: <i>Chlamydia Screening in Women</i>								
IDSS	Plan Name	Code	Ages 16 to 20 Years		Ages 21 to 25 Years		Combined Rate	
			Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
4265	Community Choice Michigan	CCM	1,077	46.8%	715	56.5%	1,792	50.7%
4133	Great Lakes Health Plan	GLH	2,287	49.8%	1,556	57.5%	3,843	52.9%
4291	Health Plan of Michigan, Inc.	HPM	2,072	50.3%	1,717	60.2%	3,789	54.8%
4056	HealthPlus Partners, Inc.	HPP	1,443	52.7%	1,222	61.2%	2,665	56.6%
4243	M-CAID	MCD	318	51.6%	236	61.4%	554	55.8%
4312	McLaren Health Plan	MCL	1,112	48.9%	925	58.8%	2,037	53.4%
4131	Midwest Health Plan	MID	913	52.8%	633	60.3%	1,546	55.9%
4151	Molina Healthcare of Michigan	MOL	3,458	52.1%	2,131	58.4%	5,589	54.5%
4055	OmniCare Health Plan	OCH	1,689	64.4%	1,161	72.4%	2,850	67.7%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	314	67.2%	283	65.7%	597	66.5%
4054	Priority Health Government Programs, Inc.	PRI	864	55.6%	916	62.4%	1,780	59.1%
4268	Total Health Care, Inc.	THC	1,285	61.8%	866	68.7%	2,151	64.6%
4348	Upper Peninsula Health Plan	UPP	610	48.4%	403	49.4%	1,013	48.8%
	2007 Michigan Medicaid Weighted Average		--	53.3%	--	61.0%	--	56.6%
	2006 Michigan Medicaid Weighted Average		--	51.9%	--	57.6%	--	54.5%
	2005 Michigan Medicaid Weighted Average		--	47.6%	--	53.1%	--	50.3%
	National HEDIS 2006 Medicaid 50th Percentile		--	49.1%	--	53.3%	--	51.2%

Note: The 2005 and 2006 Michigan Medicaid weighted averages included 15 health plans, and the 2007 Medicaid weighted average included 13 health plans.

Table A-8—Tabular Results for Key Measures by Health Plan: Prenatal and Postpartum Care					
IDSS	Plan Name	Code	Eligible Population	Timeliness of Prenatal Care Rate	Postpartum Care Rate
4265	Community Choice Michigan	CCM	860	81.3%	62.8%
4133	Great Lakes Health Plan	GLH	2,207	78.3%	58.6%
4291	Health Plan of Michigan, Inc.	HPM	2,275	90.0%	67.0%
4056	HealthPlus Partners, Inc.	HPP	1,430	91.8%	66.1%
4243	M-CAID	MCD	292	85.4%	66.0%
4312	McLaren Health Plan	MCL	1,200	93.4%	85.6%
4131	Midwest Health Plan	MID	997	76.4%	50.9%
4151	Molina Healthcare of Michigan	MOL	1,970	67.4%	49.7%
4055	OmniCare Health Plan	OCH	1,247	84.1%	50.7%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	382	85.6%	62.6%
4054	Priority Health Government Programs, Inc.	PRI	1,269	86.8%	66.3%
4268	Total Health Care, Inc.	THC	1,005	84.2%	57.9%
4348	Upper Peninsula Health Plan	UPP	309	88.7%	68.8%
	2007 Michigan Medicaid Weighted Average		--	83.2%	61.6%
	2006 Michigan Medicaid Weighted Average		--	81.7%	57.7%
	2005 Michigan Medicaid Weighted Average		--	77.5%	53.7%
	National HEDIS 2006 Medicaid 50th Percentile		--	83.3%	58.8%

Note: The 2005 and 2006 Michigan Medicaid weighted averages included 15 health plans, and the 2007 Medicaid weighted average included 13 health plans.

Table A-9—Tabular Results for Key Measures by Health Plan: Comprehensive Diabetes Care						
IDSS	Plan Name	Code	Eligible Population	HbA1c Testing Rate	Poor HbA1c Control Rate	Eye Exam Rate
4265	Community Choice Michigan	CCM	1,263	83.7%	43.1%	43.8%
4133	Great Lakes Health Plan	GLH	3,264	77.1%	50.6%	53.3%
4291	Health Plan of Michigan, Inc.	HPM	2,035	86.4%	33.0%	67.0%
4056	HealthPlus Partners, Inc.	HPP	1,400	86.6%	32.8%	74.0%
4243	M-CAID	MCD	279	89.1%	34.0%	62.5%
4312	McLaren Health Plan	MCL	1,119	84.4%	41.8%	67.4%
4131	Midwest Health Plan	MID	1,503	70.1%	48.2%	53.5%
4151	Molina Healthcare of Michigan	MOL	3,496	74.1%	50.1%	50.6%
4055	OmniCare Health Plan	OCH	1,505	78.8%	49.9%	47.8%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	384	83.0%	38.0%	67.8%
4054	Priority Health Government Programs, Inc.	PRI	805	89.3%	27.3%	70.6%
4268	Total Health Care, Inc.	THC	1,308	76.7%	47.0%	57.3%
4348	Upper Peninsula Health Plan	UPP	508	89.7%	27.8%	70.6%
	2007 Michigan Medicaid Weighted Average		--	79.8%	43.7%	57.5%
	2006 Michigan Medicaid Weighted Average		--	79.6%	42.3%	54.2%
	2005 Michigan Medicaid Weighted Average		--	79.5%	44.6%	47.3%
	National HEDIS 2006 Medicaid 50th Percentile		--	77.4%	45.2%	50.8%

Notes: The 2005 and 2006 Michigan Medicaid weighted averages included 15 health plans, and the 2007 Medicaid weighted average included 13 health plans.

Table A-9—Tabular Results for Key Measures by Health Plan: <i>Comprehensive Diabetes Care (continued)</i>						
IDSS	Plan Name	Code	Eligible Population	LDL-C Screening Rate	LDL-C Level <100 Rate	Medical Attention for Nephropathy Rate
4265	Community Choice Michigan	CCM	1,263	66.9%	29.2%	76.6%
4133	Great Lakes Health Plan	GLH	3,264	76.9%	30.9%	77.9%
4291	Health Plan of Michigan, Inc.	HPM	2,035	82.5%	35.2%	78.0%
4056	HealthPlus Partners, Inc.	HPP	1,400	75.4%	36.5%	85.4%
4243	M-CAID	MCD	279	80.9%	45.7%	84.8%
4312	McLaren Health Plan	MCL	1,119	71.5%	33.1%	91.2%
4131	Midwest Health Plan	MID	1,503	70.1%	29.7%	77.9%
4151	Molina Healthcare of Michigan	MOL	3,496	73.4%	51.3%	76.9%
4055	OmniCare Health Plan	OCH	1,505	74.8%	34.9%	83.4%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	384	77.1%	46.0%	78.2%
4054	Priority Health Government Programs, Inc.	PRI	805	81.0%	39.4%	82.5%
4268	Total Health Care, Inc.	THC	1,308	72.8%	28.2%	77.6%
4348	Upper Peninsula Health Plan	UPP	508	81.7%	37.4%	81.4%
	2007 Michigan Medicaid Weighted Average		--	75.1%	36.7%	79.8%
	2006 Michigan Medicaid Weighted Average		--	85.4%	40.7%	50.7%
	2005 Michigan Medicaid Weighted Average		--	81.6%	37.8%	47.6%
	National HEDIS 2006 Medicaid 50th Percentile		--	83.3%	34.1%	49.3%

Notes: The 2005 and 2006 Michigan Medicaid weighted averages included 15 health plans, and the 2007 Medicaid weighted average included 13 health plans.

**Table A-10—Tabular Results for Key Measures by Health Plan:
Use of Appropriate Medications for People With Asthma**

IDSS	Plan Name	Code	Ages 5 to 9 Years		Ages 10 to 17 Years		Ages 18 to 56 Years		Combined Rate	
			Eligible Population	Rate						
4265	Community Choice Michigan	CCM	162	95.7%	232	91.8%	453	89.0%	847	91.0%
4133	Great Lakes Health Plan	GLH	268	84.7%	386	80.8%	911	89.9%	1,565	86.8%
4291	Health Plan of Michigan, Inc.	HPM	217	98.2%	260	97.3%	487	94.5%	964	96.1%
4056	HealthPlus Partners, Inc.	HPP	274	93.8%	362	91.7%	475	88.6%	1,111	90.9%
4243	M-CAID	MCD	104	99.0%	113	91.2%	140	90.0%	357	93.0%
4312	McLaren Health Plan	MCL	182	96.7%	235	90.6%	452	85.2%	869	89.1%
4131	Midwest Health Plan	MID	188	86.7%	225	81.8%	518	83.4%	931	83.7%
4151	Molina Healthcare of Michigan	MOL	373	83.1%	572	82.0%	1,170	84.4%	2,115	83.5%
4055	OmniCare Health Plan	OCH	253	77.9%	382	75.1%	663	86.0%	1,298	81.2%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	94	90.4%	121	89.3%	163	94.5%	378	91.8%
4054	Priority Health Government Programs, Inc.	PRI	175	98.3%	194	95.4%	226	88.5%	595	93.6%
4268	Total Health Care, Inc.	THC	172	86.6%	283	80.2%	438	82.9%	893	82.8%
4348	Upper Peninsula Health Plan	UPP	91	97.8%	133	92.5%	188	87.2%	412	91.3%
	2007 Michigan Medicaid Weighted Average		--	89.9%	--	86.0%	--	87.3%	--	87.5%
	2006 Michigan Medicaid Weighted Average		--	88.8%	--	87.2%	--	86.5%	--	87.1%
	2005 Michigan Medicaid Weighted Average		--	65.1%	--	64.2%	--	71.8%	--	67.9%
	National HEDIS 2006 Medicaid 50th Percentile		--	90.2%	--	87.4%	--	84.9%	--	87.1%

Note: The 2005 and 2006 Michigan Medicaid weighted averages included 15 health plans, and the 2007 Medicaid weighted average included 13 health plans.

Table A-11—Tabular Results for Key Measures by Health Plan: Controlling High Blood Pressure								
			Ages 18–45 Years		Ages 46–85 Years		Combined	
IDSS	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
4265	Community Choice Michigan	CCM	538	56.3%	956	59.9%	1,494	58.6%
4133	Great Lakes Health Plan	GLH	1,290	47.7%	2,992	51.7%	4,282	50.6%
4291	Health Plan of Michigan, Inc.	HPM	1,332	58.8%	691	52.3%	2,023	56.5%
4056	HealthPlus Partners, Inc.	HPP	762	52.7%	1,104	57.7%	1,866	56.0%
4243	M-CAID	MCD	96	67.9%	210	65.4%	306	66.2%
4312	McLaren Health Plan	MCL	564	70.8%	847	67.9%	1,411	69.1%
4131	Midwest Health Plan	MID	474	53.2%	1,173	52.3%	1,647	52.6%
4151	Molina Healthcare of Michigan	MOL	1,312	45.3%	2,682	45.2%	3,994	45.2%
4055	OmniCare Health Plan	OCH	853	43.5%	1,725	44.2%	2,578	44.0%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	158	62.9%	307	57.6%	465	59.4%
4054	Priority Health Government Programs, Inc.	PRI	355	59.1%	559	58.7%	914	58.9%
4268	Total Health Care, Inc.	THC	608	43.2%	1,263	40.9%	1,871	41.6%
4348	Upper Peninsula Health Plan	UPP	182	65.7%	291	64.3%	473	64.8%
	2007 Michigan Medicaid Weighted Average		--	52.5%	--	51.5%	--	51.9%
	2006 Michigan Medicaid Weighted Average		--	--	--	60.0%	--	--
	2005 Michigan Medicaid Weighted Average		--	--	--	56.1%	--	--
	National HEDIS 2006 Medicaid 50th Percentile		--	--	--	65.3%	--	--

Note: The 2005 and 2006 Michigan Medicaid weighted averages included 15 health plans, and the 2007 Medicaid weighted average included 13 health plans.

**Table A-12—Tabular Results for Key Measures by Health Plan:
Children’s and Adolescents’ Access to Primary Care Practitioners**

IDSS	Plan Name	Code	Ages 12 to 24 Months		Ages 25 Months to 6 Years		Ages 7 to 11 Years		Ages 12 to 19 Years	
			Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
4265	Community Choice Michigan	CCM	1,129	93.2%	6,394	80.0%	5,031	81.6%	6,639	78.4%
4133	Great Lakes Health Plan	GLH	3,428	97.6%	14,837	86.5%	10,514	84.7%	14,630	84.7%
4291	Health Plan of Michigan, Inc.	HPM	3,972	96.8%	15,585	87.6%	8,295	87.7%	10,115	87.9%
4056	HealthPlus Partners, Inc.	HPP	2,117	95.3%	9,630	84.2%	7,142	84.5%	8,841	82.2%
4243	M-CAID	MCD	662	97.3%	2,642	89.5%	1,689	89.8%	2,054	87.8%
4312	McLaren Health Plan	MCL	1,860	94.9%	7,571	78.1%	4,667	77.0%	5,989	76.5%
4131	Midwest Health Plan	MID	1,562	92.1%	8,052	81.4%	5,384	81.2%	7,432	76.8%
4151	Molina Healthcare of Michigan	MOL	3,390	94.4%	18,131	82.0%	13,996	80.5%	21,409	78.0%
4055	OmniCare Health Plan	OCH	1,412	90.2%	7,240	73.7%	6,490	73.8%	10,236	70.8%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	538	95.0%	2,421	81.2%	1,743	84.5%	2,300	81.8%
4054	Priority Health Government Programs, Inc.	PRI	2,159	96.9%	7,507	83.7%	4,288	87.4%	4,506	85.5%
4268	Total Health Care, Inc.	THC	1,354	91.8%	6,926	75.0%	5,350	78.3%	8,333	77.4%
4348	Upper Peninsula Health Plan	UPP	992	97.7%	3,760	88.1%	2,679	87.2%	3,558	90.0%
	2007 Michigan Medicaid Weighted Average		--	95.2%	--	82.7%	--	82.3%	--	80.3%
	2006 Michigan Medicaid Weighted Average		--	92.9%	--	81.4%	--	80.0%	--	78.3%
	2005 Michigan Medicaid Weighted Average		--	92.2%	--	78.2%	--	78.2%	--	77.1%
	National HEDIS 2006 Medicaid 50th Percentile		--	94.8%	--	85.4%	--	84.9%	--	83.4%

Note: The 2005 and 2006 Michigan Medicaid weighted averages included 15 health plans, and the 2007 Medicaid weighted average included 13 health plans.

Table A-13—Tabular Results for Key Measures by Health Plan: Adults' Access to Preventive/Ambulatory Health Services						
IDSS	Plan Name	Code	Ages 20 to 44 Years		Ages 45 to 64 Years	
			Eligible Population	Rate	Eligible Population	Rate
4265	Community Choice Michigan	CCM	5,967	78.5%	3,135	85.8%
4133	Great Lakes Health Plan	GLH	13,661	80.6%	8,317	88.1%
4291	Health Plan of Michigan, Inc.	HPM	11,716	85.1%	4,836	90.6%
4056	HealthPlus Partners, Inc.	HPP	8,583	84.0%	3,426	90.0%
4243	M-CAID	MCD	1,795	83.9%	787	88.6%
4312	McLaren Health Plan	MCL	7,135	81.0%	2,867	87.0%
4131	Midwest Health Plan	MID	6,842	78.2%	4,198	85.5%
4151	Molina Healthcare of Michigan	MOL	18,321	77.2%	9,517	83.8%
4055	OmniCare Health Plan	OCH	8,776	74.5%	4,465	81.7%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	2,158	80.5%	1,007	86.1%
4054	Priority Health Government Programs, Inc.	PRI	5,153	86.5%	1,749	93.1%
4268	Total Health Care, Inc.	THC	6,979	74.9%	3,713	80.4%
4348	Upper Peninsula Health Plan	UPP	3,093	89.5%	1,513	91.2%
	2007 Michigan Medicaid Weighted Average		--	80.2%	--	86.3%
	2006 Michigan Medicaid Weighted Average		--	78.1%	--	84.7%
	2005 Michigan Medicaid Weighted Average		--	76.7%	--	83.4%
	National HEDIS 2006 Medicaid 50th Percentile		--	79.0%	--	84.5%

Note: The 2005 and 2006 Michigan Medicaid weighted averages included 15 health plans, and the 2007 Medicaid weighted average included 13 health plans.

**Table A-14—Tabular Results for Key Measures by Health Plan:
Medical Assistance With Smoking Cessation**

IDSS	Plan Name	Code	Advising Smokers to Quit Rate	Discussing Smoking Cessation Strategies Rate
4265	Community Choice Michigan	CCM	77.1%	36.1%
4133	Great Lakes Health Plan	GLH	68.9%	31.9%
4291	Health Plan of Michigan, Inc.	HPM	75.4%	40.0%
4056	HealthPlus Partners, Inc.	HPP	70.9%	33.1%
4243	M-CAID	MCD	76.4%	47.9%
4312	McLaren Health Plan	MCL	69.6%	37.2%
4131	Midwest Health Plan	MID	68.3%	37.1%
4151	Molina Healthcare of Michigan	MOL	69.1%	36.2%
4055	OmniCare Health Plan	OCH	69.9%	34.6%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	77.5%	48.8%
4054	Priority Health Government Programs, Inc.	PRI	76.1%	43.3%
4268	Total Health Care, Inc.	THC	65.6%	30.9%
4348	Upper Peninsula Health Plan	UPP	72.9%	38.5%
	2007 Michigan Medicaid Average		72.1%	38.1%
	2006 Michigan Medicaid Average		69.7%	36.2%
	2005 Michigan Medicaid Average		68.5%	34.0%

Note: The 2005 and 2006 Michigan Medicaid weighted averages included 15 health plans, and the 2007 Medicaid weighted average included 13 health plans.

Appendix B. National HEDIS 2006 Medicaid Percentiles

Appendix B provides the national HEDIS Medicaid percentiles published by NCQA using prior-year's rates. This information is helpful to evaluate the current rates of the MHPs. The rates are presented for the 10th, 25th, 50th, 75th, and 90th percentiles. Rates in red represent below-average performance, rates in blue represent average performance, and rates in green represent above-average performance. The rates are presented in tables by dimension.

- ◆ Table B-1—Pediatric Care
- ◆ Table B-2—Women's Care
- ◆ Table B-3—Living With Illness
- ◆ Table B-4—Access to Care

Table B-1—National HEDIS 2006 Medicaid Percentiles—Pediatric Care

Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
<i>Childhood Immunization Status—Combination #2</i>	53.8%	62.7%	72.4%	78.5%	82.7%
<i>Childhood Immunization Status—Combination #3</i>	25.1%	33.8%	42.3%	49.8%	57.8%
<i>Adolescent Immunization Status—Combination #2</i>	13.7%	24.6%	44.3%	58.2%	69.8%
<i>Well-Child Visits in the First 15 Months—Zero Visits*</i>	0.5%	1.1%	2.0%	3.9%	10.0%
<i>Well-Child Visits in the First 15 Months—Six or More Visits</i>	22.4%	41.6%	50.0%	59.2%	68.6%
<i>Well-Child in the Third, Fourth, Fifth, and Sixth Years of Life</i>	50.1%	56.7%	64.8%	70.8%	77.5%
<i>Adolescent Well-Care Visits</i>	28.0%	32.8%	39.4%	47.9%	54.5%
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	71.3%	76.7%	82.7%	89.6%	92.1%
<i>Appropriate Testing for Children With Pharyngitis</i>	20.3%	40.9%	56.2%	64.3%	75.1%

* For this key measure, a lower rate indicates better performance.

Table B-2—National HEDIS 2006 Medicaid Percentiles—Women’s Care					
Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
<i>Breast Cancer Screening (52–69 years)</i>	42.9%	47.1%	53.9%	59.2%	65.4%
<i>Cervical Cancer Screening</i>	49.9%	59.7%	66.1%	73.0%	76.6%
<i>Chlamydia Screening in Women—Ages 16–20 Years</i>	35.3%	41.0%	49.1%	57.3%	64.3%
<i>Chlamydia Screening in Women—Ages 21–25 Years</i>	36.1%	46.7%	53.3%	60.3%	67.7%
<i>Chlamydia Screening in Women—Combined Rate</i>	36.5%	44.5%	51.2%	59.0%	65.3%
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	61.1%	74.2%	83.3%	88.1%	91.5%
<i>Prenatal and Postpartum Care—Postpartum Care</i>	41.8%	49.7%	58.8%	65.9%	71.0%

Table B-3—National HEDIS 2006 Medicaid Percentiles—Living With Illness

Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	64.0%	71.1%	77.4%	84.9%	88.8%
<i>Comprehensive Diabetes Care—Poor HbA1c Control*</i>	30.3%	37.3%	45.2%	60.1%	74.3%
<i>Comprehensive Diabetes Care—Eye Exam</i>	25.5%	35.2%	50.8%	61.5%	68.1%
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	66.3%	76.2%	83.3%	88.1%	90.8%
<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	14.4%	26.5%	34.1%	41.0%	46.5%
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	30.2%	39.5%	49.3%	59.7%	65.6%
<i>Use of Appropriate Medications for People With Asthma—Ages 5–9 Years</i>	80.2%	86.7%	90.2%	93.4%	95.8%
<i>Use of Appropriate Medications for People With Asthma—Ages 10–17 Years</i>	75.3%	83.3%	87.4%	91.1%	93.5%
<i>Use of Appropriate Medications for People With Asthma—Ages 18–56 Years</i>	74.0%	80.3%	84.9%	88.0%	90.8%
<i>Use of Appropriate Medications for People With Asthma—Combined Rate</i>	78.4%	84.0%	87.1%	89.7%	92.5%
<i>Controlling High Blood Pressure (46–85 years)</i>	43.1%	55.4%	65.3%	68.5%	73.0%

* For this key measure, a lower rate indicates better performance.

Table B-4—National HEDIS 2006 Medicaid Percentiles—Access to Care					
Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
<i>Children's Access to Primary Care Practitioners—Ages 12–24 Months</i>	84.9%	91.2%	94.8%	97.5%	98.2%
<i>Children's Access to Primary Care Practitioners—Ages 25 Months–6 Years</i>	71.6%	79.9%	85.4%	88.6%	91.5%
<i>Children's Access to Primary Care Practitioners—Ages 7–11 Years</i>	72.9%	79.0%	84.9%	89.3%	92.0%
<i>Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years</i>	69.2%	76.2%	83.4%	87.7%	90.2%
<i>Adults' Access to Preventive/Ambulatory Services—Ages 20–44 Years</i>	59.3%	72.7%	79.0%	83.7%	87.0%
<i>Adults' Access to Preventive/Ambulatory Services—Ages 45–64 Years</i>	66.7%	79.0%	84.5%	87.4%	89.4%

Appendix C includes trend tables for each of the MHPs. Where applicable, each measure's rate for 2005, 2006, and 2007 is presented along with a trend analysis that compares a measure's 2006 rate to its 2007 rate in order to assess whether there was any significant change in the rate.

Rates that were significantly higher in 2007 than in 2006 (improved by more than 10 percent) are noted with upward arrows (↑). Rates that were significantly lower in 2007 than in 2006 (decreased by more than 10 percent) are noted with downward arrows (↓). Rates in 2007 that were not significantly different than in 2006 (did not change more than 10 percent) are noted with parallel arrows (↔). For two measures, *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Comprehensive Diabetes Care—Poor HbA1c Control*, where a lower rate indicates better performance, an upward triangle (▲) indicates performance improvement (the rate decreased by more than 10 percent) and a downward triangle (▼) indicates a decline in performance (the rate increased by more than 10 percent).

The MHP trend tables are presented as follows:

- ◆ Table C-1—CCM
- ◆ Table C-2—GLH
- ◆ Table C-3—HPM
- ◆ Table C-4—HPP
- ◆ Table C-5—MCD
- ◆ Table C-6—MCL
- ◆ Table C-7—MID
- ◆ Table C-8—MOL
- ◆ Table C-9—OCH
- ◆ Table C-10—PMD
- ◆ Table C-11—PRI
- ◆ Table C-12—THC
- ◆ Table C-13—UPP

Table C-1—Michigan Medicaid HEDIS 2007 Trend Table: CCM

Dimension of Care	Measure	2005	2006	2007	2006–2007 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	69.3%	75.7%	74.9%	↔
	<i>Childhood Immunization Combo 3</i>	--	33.6%	62.5%	↑
	<i>Adolescent Immunization Combo 2</i>	54.0%	62.6%	67.1%	↔
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	5.4%	3.9%	3.4%	↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	41.4%	41.6%	37.5%	↔
	<i>Well-Child 3rd-6th Years of Life</i>	54.3%	54.6%	56.9%	↔
	<i>Adolescent Well-Care Visits</i>	33.3%	37.0%	31.1%	↔
	<i>Appropriate Treatment of URI</i>	77.5%	75.9%	79.4%	↔
	<i>Children with Pharyngitis</i>	41.1%	49.0%	54.5%	↔
Women's Care	<i>Breast Cancer Screening, 42-51 Years</i>	--	--	39.2%	--
	<i>Breast Cancer Screening, 52-69 Years</i>	49.9%	47.1%	53.6%	↔
	<i>Breast Cancer Screening, Combined</i>	--	--	45.6%	--
	<i>Cervical Cancer Screening</i>	67.6%	67.6%	65.6%	↔
	<i>Chlamydia Screening, 16-20 Years</i>	48.7%	48.1%	46.8%	↔
	<i>Chlamydia Screening, 21-25 Years</i>	55.6%	52.9%	56.5%	↔
	<i>Chlamydia Screening, Combined</i>	52.0%	50.2%	50.7%	↔
	<i>Timeliness of Prenatal Care</i>	75.7%	76.6%	81.3%	↔
	<i>Postpartum Care</i>	58.9%	60.1%	62.8%	↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	83.7%	81.5%	83.7%	↔
	<i>Diabetes Care Poor HbA1c Control</i>	41.6%	46.2%	43.1%	↔
	<i>Diabetes Care Eye Exam</i>	38.4%	41.8%	43.8%	↔
	<i>Diabetes Care LDL-C Screening</i>	71.8%	76.4%	66.9%	↔
	<i>Diabetes Care LDL-C Level <100</i>	32.6%	34.1%	29.2%	↔
	<i>Diabetes Care Nephropathy</i>	43.1%	46.2%	76.6%	↑
	<i>Asthma 5-9 Years</i>	70.0%	89.2%	95.7%	↔
	<i>Asthma 10-17 Years</i>	65.4%	90.1%	91.8%	↔
	<i>Asthma 18-56 Years</i>	74.0%	88.7%	89.0%	↔
	<i>Asthma Combined Rate</i>	70.9%	89.1%	91.0%	↔
	<i>Controlling High Blood Pressure, 18-45 Years</i>	--	--	56.3%	--
	<i>Controlling High Blood Pressure, 46-85 Years</i>	65.0%	65.3%	59.9%	↔
	<i>Controlling High Blood Pressure, Combined</i>	--	--	58.6%	--
	<i>Advising Smokers to Quit</i>	69.1%	71.8%	77.1%	↔
<i>Discussing Smoking Cessation Strategies</i>	30.1%	29.3%	36.1%	↔	
Access to Care	<i>Children's Access 12-24 Months</i>	84.8%	90.4%	93.2%	↔
	<i>Children's Access 25 Mos-6 Years</i>	77.1%	77.8%	80.0%	↔
	<i>Children's Access 7-11 Years</i>	77.1%	78.1%	81.6%	↔
	<i>Adolescents' Access 12-19 Years</i>	75.4%	74.9%	78.4%	↔
	<i>Adults' Access 20-44 Years</i>	76.2%	75.2%	78.5%	↔
	<i>Adults' Access 45-64 Years</i>	83.2%	82.7%	85.8%	↔

Notes

A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

- ↑ = Performance improvement (rate increase >10%)*
- ↔ = No significant performance change (rate change ≤10%)
- ↓ = Performance decline (rate decrease >10%)*
- = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control*:

- ▼ = Performance decline (rate increase >10%)
- ▲ = Performance improvement (rate decrease >10%)

Table C-2—Michigan Medicaid HEDIS 2007 Trend Table: GLH					
Dimension of Care	Measure	2005	2006	2007	2006–2007 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	68.3%	72.0%	77.6%	↔
	<i>Childhood Immunization Combo 3</i>	--	37.2%	63.3%	↑
	<i>Adolescent Immunization Combo 2</i>	51.8%	56.4%	66.7%	↑
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	3.5%	0.7%	0.3%	↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	39.4%	64.2%	91.1%	↑
	<i>Well-Child 3rd-6th Years of Life</i>	60.8%	66.9%	69.8%	↔
	<i>Adolescent Well-Care Visits</i>	40.4%	52.1%	58.8%	↔
	<i>Appropriate Treatment of URI</i>	70.6%	70.7%	74.6%	↔
	<i>Children with Pharyngitis</i>	37.6%	35.6%	41.5%	↔
Women's Care	<i>Breast Cancer Screening, 42-51 Years</i>	--	--	43.8%	--
	<i>Breast Cancer Screening, 52-69 Years</i>	54.3%	59.3%	56.6%	↔
	<i>Breast Cancer Screening, Combined</i>	--	--	50.3%	--
	<i>Cervical Cancer Screening</i>	59.6%	60.1%	64.6%	↔
	<i>Chlamydia Screening, 16-20 Years</i>	47.2%	47.2%	49.8%	↔
	<i>Chlamydia Screening, 21-25 Years</i>	52.1%	55.8%	57.5%	↔
	<i>Chlamydia Screening, Combined</i>	49.4%	51.0%	52.9%	↔
	<i>Timeliness of Prenatal Care</i>	72.0%	75.4%	78.3%	↔
	<i>Postpartum Care</i>	51.1%	51.3%	58.6%	↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	79.0%	73.5%	77.1%	↔
	<i>Diabetes Care Poor HbA1c Control</i>	46.3%	47.4%	50.6%	↔
	<i>Diabetes Care Eye Exam</i>	45.0%	52.6%	53.3%	↔
	<i>Diabetes Care LDL-C Screening</i>	81.4%	88.1%	76.9%	↓
	<i>Diabetes Care LDL-C Level <100</i>	60.1%	62.0%	30.9%	↓
	<i>Diabetes Care Nephropathy</i>	47.0%	45.7%	77.9%	↑
	<i>Asthma 5-9 Years</i>	57.0%	85.9%	84.7%	↔
	<i>Asthma 10-17 Years</i>	57.9%	83.0%	80.8%	↔
	<i>Asthma 18-56 Years</i>	73.7%	88.4%	89.9%	↔
	<i>Asthma Combined Rate</i>	65.9%	86.7%	86.8%	↔
	<i>Controlling High Blood Pressure, 18-45 Years</i>	--	--	47.7%	--
	<i>Controlling High Blood Pressure, 46-85 Years</i>	47.4%	51.1%	51.7%	↔
	<i>Controlling High Blood Pressure, Combined</i>	--	--	50.6%	--
	<i>Advising Smokers to Quit</i>	64.5%	66.8%	68.9%	↔
<i>Discussing Smoking Cessation Strategies</i>	28.7%	28.7%	31.9%	↔	
Access to Care	<i>Children's Access 12-24 Months</i>	91.4%	96.7%	97.6%	↔
	<i>Children's Access 25 Mos-6 Years</i>	79.5%	85.4%	86.5%	↔
	<i>Children's Access 7-11 Years</i>	78.5%	82.1%	84.7%	↔
	<i>Adolescents' Access 12-19 Years</i>	77.5%	81.4%	84.7%	↔
	<i>Adults' Access 20-44 Years</i>	74.7%	78.7%	80.6%	↔
	<i>Adults' Access 45-64 Years</i>	83.2%	86.8%	88.1%	↔

Notes

A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

- ↑ = Performance improvement (rate increase >10%)*
- ↔ = No significant performance change (rate change ≤10%)
- ↓ = Performance decline (rate decrease >10%)*
- = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control*:

- ▼ = Performance decline (rate increase >10%)
- ▲ = Performance improvement (rate decrease >10%)

Table C-3—Michigan Medicaid HEDIS 2007 Trend Table: HPM

Dimension of Care	Measure	2005	2006	2007	2006–2007 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	68.5%	78.0%	83.8%	↔↔
	<i>Childhood Immunization Combo 3</i>	--	38.9%	71.5%	↑
	<i>Adolescent Immunization Combo 2</i>	54.9%	58.8%	70.6%	↑
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	2.0%	1.7%	0.9%	↔↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	59.0%	68.4%	69.9%	↔↔
	<i>Well-Child 3rd-6th Years of Life</i>	56.9%	67.8%	65.3%	↔↔
	<i>Adolescent Well-Care Visits</i>	41.2%	52.5%	55.1%	↔↔
	<i>Appropriate Treatment of URI</i>	74.4%	79.3%	78.4%	↔↔
	<i>Children with Pharyngitis</i>	58.9%	50.9%	53.2%	↔↔
Women's Care	<i>Breast Cancer Screening, 42-51 Years</i>	--	--	53.9%	--
	<i>Breast Cancer Screening, 52-69 Years</i>	56.9%	58.0%	64.4%	↔↔
	<i>Breast Cancer Screening, Combined</i>	--	--	58.7%	--
	<i>Cervical Cancer Screening</i>	61.6%	66.8%	71.0%	↔↔
	<i>Chlamydia Screening, 16-20 Years</i>	47.6%	49.1%	50.3%	↔↔
	<i>Chlamydia Screening, 21-25 Years</i>	52.2%	54.7%	60.2%	↔↔
	<i>Chlamydia Screening, Combined</i>	49.9%	51.7%	54.8%	↔↔
	<i>Timeliness of Prenatal Care</i>	78.3%	82.9%	90.0%	↔↔
	<i>Postpartum Care</i>	57.4%	56.8%	67.0%	↑
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	79.2%	78.7%	86.4%	↔↔
	<i>Diabetes Care Poor HbA1c Control</i>	47.5%	39.2%	33.0%	↔↔
	<i>Diabetes Care Eye Exam</i>	54.9%	58.6%	67.0%	↔↔
	<i>Diabetes Care LDL-C Screening</i>	85.4%	85.8%	82.5%	↔↔
	<i>Diabetes Care LDL-C Level <100</i>	27.8%	30.7%	35.2%	↔↔
	<i>Diabetes Care Nephropathy</i>	49.8%	48.2%	78.0%	↑
	<i>Asthma 5-9 Years</i>	67.7%	94.9%	98.2%	↔↔
	<i>Asthma 10-17 Years</i>	66.1%	93.5%	97.3%	↔↔
	<i>Asthma 18-56 Years</i>	70.7%	93.1%	94.5%	↔↔
	<i>Asthma Combined Rate</i>	68.5%	93.6%	96.1%	↔↔
	<i>Controlling High Blood Pressure, 18-45 Years</i>	--	--	58.8%	--
	<i>Controlling High Blood Pressure, 46-85 Years</i>	61.2%	69.5%	52.3%	↓
	<i>Controlling High Blood Pressure, Combined</i>	--	--	56.5%	--
	<i>Advising Smokers to Quit</i>	65.6%	69.3%	75.4%	↔↔
<i>Discussing Smoking Cessation Strategies</i>	30.5%	33.0%	40.0%	↔↔	
Access to Care	<i>Children's Access 12-24 Months</i>	93.9%	95.4%	96.8%	↔↔
	<i>Children's Access 25 Mos-6 Years</i>	81.5%	85.9%	87.6%	↔↔
	<i>Children's Access 7-11 Years</i>	82.5%	84.3%	87.7%	↔↔
	<i>Adolescents' Access 12-19 Years</i>	82.4%	84.3%	87.9%	↔↔
	<i>Adults' Access 20-44 Years</i>	80.0%	82.9%	85.1%	↔↔
	<i>Adults' Access 45-64 Years</i>	88.0%	88.7%	90.6%	↔↔

Notes

A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

- ↑ = Performance improvement (rate increase >10%)*
- ↔↔ = No significant performance change (rate change ≤10%)
- ↓ = Performance decline (rate decrease >10%)*
- = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control*:

- ↓ = Performance decline (rate increase >10%)
- ▲ = Performance improvement (rate decrease >10%)

Table C-4—Michigan Medicaid HEDIS 2007 Trend Table: HPP

Dimension of Care	Measure	2005	2006	2007	2006–2007 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	76.7%	83.9%	85.2%	↔↔
	<i>Childhood Immunization Combo 3</i>	--	44.8%	71.5%	↑
	<i>Adolescent Immunization Combo 2</i>	64.0%	70.3%	79.0%	↔↔
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	2.9%	2.2%	2.3%	↔↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	43.8%	60.1%	61.8%	↔↔
	<i>Well-Child 3rd-6th Years of Life</i>	57.2%	58.5%	64.8%	↔↔
	<i>Adolescent Well-Care Visits</i>	37.5%	43.8%	48.4%	↔↔
	<i>Appropriate Treatment of URI</i>	71.3%	71.4%	72.1%	↔↔
	<i>Children with Pharyngitis</i>	33.7%	36.2%	40.9%	↔↔
Women's Care	<i>Breast Cancer Screening, 42-51 Years</i>	--	--	54.3%	--
	<i>Breast Cancer Screening, 52-69 Years</i>	59.6%	61.8%	62.5%	↔↔
	<i>Breast Cancer Screening, Combined</i>	--	--	58.0%	--
	<i>Cervical Cancer Screening</i>	70.4%	70.4%	77.1%	↔↔
	<i>Chlamydia Screening, 16-20 Years</i>	45.6%	50.5%	52.7%	↔↔
	<i>Chlamydia Screening, 21-25 Years</i>	52.9%	57.9%	61.2%	↔↔
	<i>Chlamydia Screening, Combined</i>	49.4%	54.1%	56.6%	↔↔
	<i>Timeliness of Prenatal Care</i>	82.9%	87.4%	91.8%	↔↔
	<i>Postpartum Care</i>	57.4%	62.0%	66.1%	↔↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	83.9%	86.1%	86.6%	↔↔
	<i>Diabetes Care Poor HbA1c Control</i>	33.6%	29.7%	32.8%	↔↔
	<i>Diabetes Care Eye Exam</i>	57.4%	70.3%	74.0%	↔↔
	<i>Diabetes Care LDL-C Screening</i>	86.6%	89.8%	75.4%	↓
	<i>Diabetes Care LDL-C Level <100</i>	34.1%	43.1%	36.5%	↔↔
	<i>Diabetes Care Nephropathy</i>	56.4%	56.4%	85.4%	↑
	<i>Asthma 5-9 Years</i>	75.0%	93.8%	93.8%	↔↔
	<i>Asthma 10-17 Years</i>	69.3%	92.3%	91.7%	↔↔
	<i>Asthma 18-56 Years</i>	75.3%	89.1%	88.6%	↔↔
	<i>Asthma Combined Rate</i>	73.3%	91.2%	90.9%	↔↔
	<i>Controlling High Blood Pressure, 18-45 Years</i>	--	--	52.7%	--
	<i>Controlling High Blood Pressure, 46-85 Years</i>	65.8%	65.8%	57.7%	↔↔
	<i>Controlling High Blood Pressure, Combined</i>	--	--	56.0%	--
	<i>Advising Smokers to Quit</i>	73.1%	69.2%	70.9%	↔↔
<i>Discussing Smoking Cessation Strategies</i>	31.2%	32.8%	33.1%	↔↔	
Access to Care	<i>Children's Access 12-24 Months</i>	94.7%	96.0%	95.3%	↔↔
	<i>Children's Access 25 Mos-6 Years</i>	80.8%	83.5%	84.2%	↔↔
	<i>Children's Access 7-11 Years</i>	81.8%	82.0%	84.5%	↔↔
	<i>Adolescents' Access 12-19 Years</i>	79.4%	79.4%	82.2%	↔↔
	<i>Adults' Access 20-44 Years</i>	82.0%	83.7%	84.0%	↔↔
	<i>Adults' Access 45-64 Years</i>	89.6%	91.3%	90.0%	↔↔

Notes

A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

- ↑ = Performance improvement (rate increase >10%)*
- ↔↔ = No significant performance change (rate change ≤10%)
- ↓ = Performance decline (rate decrease >10%)*
- = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control*:

- ↓ = Performance decline (rate increase >10%)
- ↑ = Performance improvement (rate decrease >10%)

Table C-5—Michigan Medicaid HEDIS 2007 Trend Table: MCD

Dimension of Care	Measure	2005	2006	2007	2006–2007 Health Plan Trend
Pediatric Care	Childhood Immunization Combo 2	72.5%	81.0%	81.0%	↔
	Childhood Immunization Combo 3	--	56.7%	56.7%	↔
	Adolescent Immunization Combo 2	46.7%	68.5%	68.5%	Rotated Measure
	Well-Child 1st 15 Mos, 0 Visit	1.5%	0.5%	0.5%	Rotated Measure
	Well-Child 1st 15 Mos, 6+ Visits	46.3%	64.4%	64.4%	Rotated Measure
	Well-Child 3rd-6th Years of Life	62.0%	67.4%	67.4%	Rotated Measure
	Adolescent Well-Care Visits	47.6%	51.4%	51.4%	Rotated Measure
	Appropriate Treatment of URI	88.5%	90.3%	90.5%	↔
	Children with Pharyngitis	74.8%	58.8%	80.8%	↑
Women's Care	Breast Cancer Screening, 42-51 Years	--	--	42.0%	--
	Breast Cancer Screening, 52-69 Years	47.2%	45.0%	47.4%	↔
	Breast Cancer Screening, Combined	--	--	44.3%	--
	Cervical Cancer Screening	73.8%	73.8%	78.0%	↔
	Chlamydia Screening, 16-20 Years	56.9%	52.8%	51.6%	↔
	Chlamydia Screening, 21-25 Years	56.9%	60.0%	61.4%	↔
	Chlamydia Screening, Combined	56.9%	56.2%	55.8%	↔
	Timeliness of Prenatal Care	89.5%	89.5%	85.4%	↔
	Postpartum Care	60.7%	60.7%	66.0%	↔
Living With Illness	Diabetes Care HbA1c Testing	88.4%	88.4%	89.1%	↔
	Diabetes Care Poor HbA1c Control	33.8%	33.8%	34.0%	↔
	Diabetes Care Eye Exam	55.1%	55.1%	62.5%	↔
	Diabetes Care LDL-C Screening	91.6%	91.6%	80.9%	↓
	Diabetes Care LDL-C Level <100	50.2%	50.2%	45.7%	↔
	Diabetes Care Nephropathy	60.0%	60.0%	84.8%	↑
	Asthma 5-9 Years	77.6%	94.6%	99.0%	↔
	Asthma 10-17 Years	75.0%	91.8%	91.2%	↔
	Asthma 18-56 Years	69.6%	91.2%	90.0%	↔
	Asthma Combined Rate	73.6%	92.2%	93.0%	↔
	Controlling High Blood Pressure, 18-45 Years	--	--	67.9%	--
	Controlling High Blood Pressure, 46-85 Years	76.0%	76.0%	65.4%	↓
	Controlling High Blood Pressure, Combined	--	--	66.2%	--
	Advising Smokers to Quit	74.3%	75.7%	76.4%	↔
	Discussing Smoking Cessation Strategies	46.7%	50.2%	47.9%	↔
Access to Care	Children's Access 12-24 Months	96.8%	98.8%	97.3%	↔
	Children's Access 25 Mos-6 Years	86.3%	89.0%	89.5%	↔
	Children's Access 7-11 Years	83.7%	87.5%	89.8%	↔
	Adolescents' Access 12-19 Years	81.5%	85.8%	87.8%	↔
	Adults' Access 20-44 Years	82.0%	82.2%	83.9%	↔
	Adults' Access 45-64 Years	85.5%	85.1%	88.6%	↔

Notes

A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

- ↑ = Performance improvement (rate increase >10%)*
- ↔ = No significant performance change (rate change ≤10%)
- ↓ = Performance decline (rate decrease >10%)*
- = No data available

*For two measures—Well-Child 1st 15 Mos., 0 Visits and Diabetes Care, Poor HbA1c Control:

- ↓ = Performance decline (rate increase >10%)
- ▲ = Performance improvement (rate decrease >10%)

Table C-6—Michigan Medicaid HEDIS 2007 Trend Table: MCL

Dimension of Care	Measure	2005	2006	2007	2006–2007 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	73.7%	78.8%	80.0%	↔↔
	<i>Childhood Immunization Combo 3</i>	--	39.9%	66.7%	↑
	<i>Adolescent Immunization Combo 2</i>	46.7%	54.3%	64.2%	↔↔
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	2.2%	1.2%	1.2%	↔↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	45.4%	68.6%	62.8%	↔↔
	<i>Well-Child 3rd-6th Years of Life</i>	51.6%	63.3%	69.8%	↔↔
	<i>Adolescent Well-Care Visits</i>	36.7%	45.7%	52.1%	↔↔
	<i>Appropriate Treatment of URI</i>	64.8%	65.4%	67.2%	↔↔
	<i>Children with Pharyngitis</i>	45.8%	42.4%	48.7%	↔↔
Women's Care	<i>Breast Cancer Screening, 42-51 Years</i>	--	--	45.3%	--
	<i>Breast Cancer Screening, 52-69 Years</i>	57.8%	56.9%	56.9%	↔↔
	<i>Breast Cancer Screening, Combined</i>	--	--	50.6%	--
	<i>Cervical Cancer Screening</i>	67.9%	67.4%	70.1%	↔↔
	<i>Chlamydia Screening, 16-20 Years</i>	48.4%	53.3%	48.9%	↔↔
	<i>Chlamydia Screening, 21-25 Years</i>	52.3%	54.3%	58.8%	↔↔
	<i>Chlamydia Screening, Combined</i>	50.4%	53.7%	53.4%	↔↔
	<i>Timeliness of Prenatal Care</i>	88.1%	91.5%	93.4%	↔↔
	<i>Postpartum Care</i>	65.5%	76.6%	85.6%	↔↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	79.3%	84.8%	84.4%	↔↔
	<i>Diabetes Care Poor HbA1c Control</i>	41.1%	37.4%	41.8%	↔↔
	<i>Diabetes Care Eye Exam</i>	51.6%	69.9%	67.4%	↔↔
	<i>Diabetes Care LDL-C Screening</i>	75.4%	83.8%	71.5%	↓
	<i>Diabetes Care LDL-C Level <100</i>	31.1%	39.9%	33.1%	↔↔
	<i>Diabetes Care Nephropathy</i>	52.8%	59.3%	91.2%	↑
	<i>Asthma 5-9 Years</i>	82.9%	97.3%	96.7%	↔↔
	<i>Asthma 10-17 Years</i>	71.9%	90.3%	90.6%	↔↔
	<i>Asthma 18-56 Years</i>	75.7%	87.9%	85.2%	↔↔
	<i>Asthma Combined Rate</i>	76.5%	90.5%	89.1%	↔↔
	<i>Controlling High Blood Pressure, 18-45 Years</i>	--	--	70.8%	--
	<i>Controlling High Blood Pressure, 46-85 Years</i>	59.6%	64.1%	67.9%	↔↔
	<i>Controlling High Blood Pressure, Combined</i>	--	--	69.1%	--
	<i>Advising Smokers to Quit</i>	69.4%	69.5%	69.6%	↔↔
<i>Discussing Smoking Cessation Strategies</i>	32.4%	32.4%	37.2%	↔↔	
Access to Care	<i>Children's Access 12-24 Months</i>	93.9%	93.0%	94.9%	↔↔
	<i>Children's Access 25 Mos-6 Years</i>	79.2%	78.2%	78.1%	↔↔
	<i>Children's Access 7-11 Years</i>	80.0%	81.0%	77.0%	↔↔
	<i>Adolescents' Access 12-19 Years</i>	76.5%	78.9%	76.5%	↔↔
	<i>Adults' Access 20-44 Years</i>	80.4%	79.7%	81.0%	↔↔
	<i>Adults' Access 45-64 Years</i>	88.0%	87.2%	87.0%	↔↔

Notes

A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

- ↑ = Performance improvement (rate increase >10%)*
- ↔↔ = No significant performance change (rate change ≤10%)
- ↓ = Performance decline (rate decrease >10%)*
- = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control*:

- ▼ = Performance decline (rate increase >10%)
- ▲ = Performance improvement (rate decrease >10%)

Table C-7—Michigan Medicaid HEDIS 2007 Trend Table: MID

Dimension of Care	Measure	2005	2006	2007	2006–2007 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	72.0%	75.9%	81.5%	↔
	<i>Childhood Immunization Combo 3</i>	--	32.8%	57.9%	↑
	<i>Adolescent Immunization Combo 2</i>	51.8%	55.0%	64.0%	↔
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	5.0%	4.9%	3.6%	↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	46.1%	50.6%	56.7%	↔
	<i>Well-Child 3rd-6th Years of Life</i>	65.9%	73.5%	74.9%	↔
	<i>Adolescent Well-Care Visits</i>	48.4%	48.9%	50.1%	↔
	<i>Appropriate Treatment of URI</i>	75.7%	75.7%	75.2%	↔
	<i>Children with Pharyngitis</i>	7.6%	13.4%	18.7%	↔
Women's Care	<i>Breast Cancer Screening, 42-51 Years</i>	--	--	51.9%	--
	<i>Breast Cancer Screening, 52-69 Years</i>	49.6%	58.3%	57.5%	↔
	<i>Breast Cancer Screening, Combined</i>	--	--	54.6%	--
	<i>Cervical Cancer Screening</i>	58.9%	62.3%	64.2%	↔
	<i>Chlamydia Screening, 16-20 Years</i>	32.1%	40.0%	52.8%	↑
	<i>Chlamydia Screening, 21-25 Years</i>	37.8%	48.2%	60.3%	↑
	<i>Chlamydia Screening, Combined</i>	34.8%	43.6%	55.9%	↑
	<i>Timeliness of Prenatal Care</i>	66.7%	68.4%	76.4%	↔
	<i>Postpartum Care</i>	41.8%	46.5%	50.9%	↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	71.5%	71.5%	70.1%	↔
	<i>Diabetes Care Poor HbA1c Control</i>	47.7%	47.7%	48.2%	↔
	<i>Diabetes Care Eye Exam</i>	44.3%	49.1%	53.5%	↔
	<i>Diabetes Care LDL-C Screening</i>	79.8%	81.5%	70.1%	↓
	<i>Diabetes Care LDL-C Level <100</i>	40.1%	40.1%	29.7%	↓
	<i>Diabetes Care Nephropathy</i>	43.6%	46.7%	77.9%	↑
	<i>Asthma 5-9 Years</i>	52.9%	79.6%	86.7%	↔
	<i>Asthma 10-17 Years</i>	56.3%	78.5%	81.8%	↔
	<i>Asthma 18-56 Years</i>	67.0%	82.9%	83.4%	↔
	<i>Asthma Combined Rate</i>	61.3%	81.1%	83.7%	↔
	<i>Controlling High Blood Pressure, 18-45 Years</i>	--	--	53.2%	--
	<i>Controlling High Blood Pressure, 46-85 Years</i>	56.7%	56.7%	52.3%	↔
	<i>Controlling High Blood Pressure, Combined</i>	--	--	52.6%	--
	<i>Advising Smokers to Quit</i>	63.3%	67.8%	68.3%	↔
<i>Discussing Smoking Cessation Strategies</i>	30.0%	34.9%	37.1%	↔	
Access to Care	<i>Children's Access 12-24 Months</i>	91.2%	93.6%	92.1%	↔
	<i>Children's Access 25 Mos-6 Years</i>	79.2%	82.9%	81.4%	↔
	<i>Children's Access 7-11 Years</i>	80.9%	82.4%	81.2%	↔
	<i>Adolescents' Access 12-19 Years</i>	78.4%	80.0%	76.8%	↔
	<i>Adults' Access 20-44 Years</i>	72.6%	76.5%	78.2%	↔
	<i>Adults' Access 45-64 Years</i>	82.6%	85.4%	85.5%	↔

Notes

A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

- ↑ = Performance improvement (rate increase >10%)*
- ↔ = No significant performance change (rate change ≤10%)
- ↓ = Performance decline (rate decrease >10%)*
- = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control*:

- ▼ = Performance decline (rate increase >10%)
- ▲ = Performance improvement (rate decrease >10%)

Table C-8—Michigan Medicaid HEDIS 2007 Trend Table: MOL

Dimension of Care	Measure	2005	2006	2007	2006–2007 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	69.9%	72.4%	72.4%	Rotated Measure
	<i>Childhood Immunization Combo 3</i>	--	35.5%	35.5%	Rotated Measure
	<i>Adolescent Immunization Combo 2</i>	46.6%	51.1%	54.6%	↔
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	5.4%	2.3%	1.9%	↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	35.2%	43.3%	42.5%	↔
	<i>Well-Child 3rd-6th Years of Life</i>	55.3%	62.2%	62.2%	Rotated Measure
	<i>Adolescent Well-Care Visits</i>	33.6%	34.5%	39.6%	↔
	<i>Appropriate Treatment of URI</i>	76.5%	76.5%	79.4%	↔
	<i>Children with Pharyngitis</i>	52.0%	44.2%	43.6%	↔
Women's Care	<i>Breast Cancer Screening, 42-51 Years</i>	--	--	44.5%	--
	<i>Breast Cancer Screening, 52-69 Years</i>	57.0%	58.6%	54.2%	↔
	<i>Breast Cancer Screening, Combined</i>	--	--	48.9%	--
	<i>Cervical Cancer Screening</i>	59.0%	62.1%	58.0%	↔
	<i>Chlamydia Screening, 16-20 Years</i>	44.1%	56.3%	52.1%	↔
	<i>Chlamydia Screening, 21-25 Years</i>	51.1%	59.9%	58.4%	↔
	<i>Chlamydia Screening, Combined</i>	47.5%	57.9%	54.5%	↔
	<i>Timeliness of Prenatal Care</i>	82.0%	82.0%	67.4%	↓
	<i>Postpartum Care</i>	58.8%	58.8%	49.7%	↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	88.8%	88.8%	74.1%	↓
	<i>Diabetes Care Poor HbA1c Control</i>	43.0%	43.0%	50.1%	↔
	<i>Diabetes Care Eye Exam</i>	52.3%	52.3%	50.6%	↔
	<i>Diabetes Care LDL-C Screening</i>	84.5%	84.5%	73.4%	↓
	<i>Diabetes Care LDL-C Level <100</i>	33.9%	33.9%	51.3%	↑
	<i>Diabetes Care Nephropathy</i>	49.6%	55.6%	76.9%	↑
	<i>Asthma 5-9 Years</i>	65.3%	90.2%	83.1%	↔
	<i>Asthma 10-17 Years</i>	63.5%	89.6%	82.0%	↔
	<i>Asthma 18-56 Years</i>	70.9%	84.3%	84.4%	↔
	<i>Asthma Combined Rate</i>	67.9%	86.8%	83.5%	↔
	<i>Controlling High Blood Pressure, 18-45 Years</i>	--	--	45.3%	--
	<i>Controlling High Blood Pressure, 46-85 Years</i>	62.1%	62.6%	45.2%	↓
	<i>Controlling High Blood Pressure, Combined</i>	--	--	45.2%	--
	<i>Advising Smokers to Quit</i>	67.9%	69.3%	69.1%	↔
<i>Discussing Smoking Cessation Strategies</i>	36.1%	41.7%	36.2%	↔	
Access to Care	<i>Children's Access 12-24 Months</i>	91.4%	83.7%	94.4%	↑
	<i>Children's Access 25 Mos-6 Years</i>	77.1%	79.2%	82.0%	↔
	<i>Children's Access 7-11 Years</i>	72.9%	79.6%	80.5%	↔
	<i>Adolescents' Access 12-19 Years</i>	73.4%	78.5%	78.0%	↔
	<i>Adults' Access 20-44 Years</i>	78.8%	75.3%	77.2%	↔
	<i>Adults' Access 45-64 Years</i>	84.6%	81.5%	83.8%	↔

Notes

A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

- ↑ = Performance improvement (rate increase >10%)*
- ↔ = No significant performance change (rate change ≤10%)
- ↓ = Performance decline (rate decrease >10%)*
- = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control*:

- ▼ = Performance decline (rate increase >10%)
- ▲ = Performance improvement (rate decrease >10%)

Table C-9—Michigan Medicaid HEDIS 2007 Trend Table: OCH

Dimension of Care	Measure	2005	2006	2007	2006–2007 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	65.0%	72.0%	79.9%	↔
	<i>Childhood Immunization Combo 3</i>	--	24.1%	51.9%	↑
	<i>Adolescent Immunization Combo 2</i>	35.7%	47.9%	59.7%	↑
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	1.6%	0.9%	0.9%	↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	48.5%	45.1%	50.9%	↔
	<i>Well-Child 3rd-6th Years of Life</i>	59.3%	65.8%	72.2%	↔
	<i>Adolescent Well-Care Visits</i>	30.1%	39.6%	50.2%	↑
	<i>Appropriate Treatment of URI</i>	74.7%	77.8%	79.7%	↔
	<i>Children with Pharyngitis</i>	25.8%	28.3%	32.3%	↔
Women's Care	<i>Breast Cancer Screening, 42-51 Years</i>	--	--	40.1%	--
	<i>Breast Cancer Screening, 52-69 Years</i>	47.4%	49.2%	52.6%	↔
	<i>Breast Cancer Screening, Combined</i>	--	--	46.1%	--
	<i>Cervical Cancer Screening</i>	58.4%	65.4%	66.7%	↔
	<i>Chlamydia Screening, 16-20 Years</i>	56.7%	62.3%	64.4%	↔
	<i>Chlamydia Screening, 21-25 Years</i>	63.9%	70.8%	72.4%	↔
	<i>Chlamydia Screening, Combined</i>	60.0%	65.9%	67.7%	↔
	<i>Timeliness of Prenatal Care</i>	64.7%	81.9%	84.1%	↔
	<i>Postpartum Care</i>	40.5%	47.2%	50.7%	↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	69.1%	71.0%	78.8%	↔
	<i>Diabetes Care Poor HbA1c Control</i>	62.9%	53.7%	49.9%	↔
	<i>Diabetes Care Eye Exam</i>	27.9%	33.1%	47.8%	↑
	<i>Diabetes Care LDL-C Screening</i>	72.1%	80.5%	74.8%	↔
	<i>Diabetes Care LDL-C Level <100</i>	31.1%	34.5%	34.9%	↔
	<i>Diabetes Care Nephropathy</i>	37.1%	37.9%	83.4%	↑
	<i>Asthma 5-9 Years</i>	55.1%	81.7%	77.9%	↔
	<i>Asthma 10-17 Years</i>	61.0%	82.1%	75.1%	↔
	<i>Asthma 18-56 Years</i>	70.9%	85.8%	86.0%	↔
	<i>Asthma Combined Rate</i>	64.3%	84.0%	81.2%	↔
	<i>Controlling High Blood Pressure, 18-45 Years</i>	--	--	43.5%	--
	<i>Controlling High Blood Pressure, 46-85 Years</i>	39.2%	47.0%	44.2%	↔
	<i>Controlling High Blood Pressure, Combined</i>	--	--	44.0%	--
	<i>Advising Smokers to Quit</i>	67.0%	67.3%	69.9%	↔
	<i>Discussing Smoking Cessation Strategies</i>	29.5%	32.9%	34.6%	↔
Access to Care	<i>Children's Access 12-24 Months</i>	89.0%	86.8%	90.2%	↔
	<i>Children's Access 25 Mos-6 Years</i>	68.1%	69.9%	73.7%	↔
	<i>Children's Access 7-11 Years</i>	70.2%	68.9%	73.8%	↔
	<i>Adolescents' Access 12-19 Years</i>	70.8%	67.5%	70.8%	↔
	<i>Adults' Access 20-44 Years</i>	70.3%	70.8%	74.5%	↔
	<i>Adults' Access 45-64 Years</i>	78.2%	79.8%	81.7%	↔

Notes

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- ↓ = Performance decline (rate decrease >10%)*
- = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control*:

- ▼ = Performance decline (rate increase >10%)
- ▲ = Performance improvement (rate decrease >10%)

Table C-10—Michigan Medicaid HEDIS 2007 Trend Table: PMD					
Dimension of Care	Measure	2005	2006	2007	2006–2007 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	73.0%	77.6%	82.0%	↔
	<i>Childhood Immunization Combo 3</i>	--	41.6%	73.5%	↑
	<i>Adolescent Immunization Combo 2</i>	64.7%	72.3%	75.4%	↔
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	2.8%	1.3%	1.4%	↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	38.1%	43.3%	49.2%	↔
	<i>Well-Child 3rd-6th Years of Life</i>	57.4%	67.6%	67.6%	Rotated Measure
	<i>Adolescent Well-Care Visits</i>	37.7%	47.7%	47.7%	Rotated Measure
	<i>Appropriate Treatment of URI</i>	78.5%	79.8%	76.6%	↔
	<i>Children with Pharyngitis</i>	49.3%	48.0%	59.2%	↑
Women's Care	<i>Breast Cancer Screening, 42-51 Years</i>	--	--	46.4%	--
	<i>Breast Cancer Screening, 52-69 Years</i>	57.5%	54.8%	52.4%	↔
	<i>Breast Cancer Screening, Combined</i>	--	--	49.1%	--
	<i>Cervical Cancer Screening</i>	66.2%	74.5%	68.6%	↔
	<i>Chlamydia Screening, 16-20 Years</i>	66.6%	64.4%	67.2%	↔
	<i>Chlamydia Screening, 21-25 Years</i>	64.5%	64.2%	65.7%	↔
	<i>Chlamydia Screening, Combined</i>	65.5%	64.3%	66.5%	↔
	<i>Timeliness of Prenatal Care</i>	79.6%	86.4%	85.6%	↔
Living With Illness	<i>Postpartum Care</i>	63.3%	62.5%	62.6%	↔
	<i>Diabetes Care HbA1c Testing</i>	84.8%	82.5%	83.0%	↔
	<i>Diabetes Care Poor HbA1c Control</i>	36.1%	34.3%	38.0%	↔
	<i>Diabetes Care Eye Exam</i>	63.3%	68.1%	67.8%	↔
	<i>Diabetes Care LDL-C Screening</i>	91.6%	89.8%	77.1%	↓
	<i>Diabetes Care LDL-C Level <100</i>	42.4%	47.0%	46.0%	↔
	<i>Diabetes Care Nephropathy</i>	64.8%	64.8%	78.2%	↑
	<i>Asthma 5-9 Years</i>	76.5%	92.7%	90.4%	↔
	<i>Asthma 10-17 Years</i>	70.1%	90.3%	89.3%	↔
	<i>Asthma 18-56 Years</i>	74.4%	86.4%	94.5%	↔
	<i>Asthma Combined Rate</i>	73.4%	89.0%	91.8%	↔
	<i>Controlling High Blood Pressure, 18-45 Years</i>	--	--	62.9%	--
	<i>Controlling High Blood Pressure, 46-85 Years</i>	64.2%	65.4%	57.6%	↔
	<i>Controlling High Blood Pressure, Combined</i>	--	--	59.4%	--
	<i>Advising Smokers to Quit</i>	69.0%	74.7%	77.5%	↔
<i>Discussing Smoking Cessation Strategies</i>	42.8%	49.4%	48.8%	↔	
Access to Care	<i>Children's Access 12-24 Months</i>	91.7%	93.2%	95.0%	↔
	<i>Children's Access 25 Mos-6 Years</i>	78.8%	81.9%	81.2%	↔
	<i>Children's Access 7-11 Years</i>	77.4%	80.8%	84.5%	↔
	<i>Adolescents' Access 12-19 Years</i>	79.1%	80.7%	81.8%	↔
	<i>Adults' Access 20-44 Years</i>	76.3%	79.6%	80.5%	↔
	<i>Adults' Access 45-64 Years</i>	84.3%	85.7%	86.1%	↔

Notes

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- ↔ = No significant performance change (rate change ≤10%)
- ↓ = Performance decline (rate decrease >10%)*
- = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control*:

- ▼ = Performance decline (rate increase >10%)
- ▲ = Performance improvement (rate decrease >10%)

Table C-11—Michigan Medicaid HEDIS 2007 Trend Table: PRI						
Dimension of Care	Measure	2005	2006	2007	2006–2007 Health Plan Trend	
Pediatric Care	<i>Childhood Immunization Combo 2</i>	88.8%	88.3%	88.7%	↔	
	<i>Childhood Immunization Combo 3</i>	--	56.0%	81.2%	↑	
	<i>Adolescent Immunization Combo 2</i>	73.2%	69.8%	78.4%	↔	
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	0.6%	0.7%	1.2%	↔	
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	52.1%	50.0%	53.5%	↔	
	<i>Well-Child 3rd-6th Years of Life</i>	64.2%	61.6%	63.7%	↔	
	<i>Adolescent Well-Care Visits</i>	36.7%	41.8%	43.3%	↔	
	<i>Appropriate Treatment of URI</i>	87.8%	88.6%	87.7%	↔	
	<i>Children with Pharyngitis</i>	76.2%	68.9%	68.9%	↔	
Women's Care	<i>Breast Cancer Screening, 42-51 Years</i>	--	--	53.0%	--	
	<i>Breast Cancer Screening, 52-69 Years</i>	57.4%	56.1%	57.0%	↔	
	<i>Breast Cancer Screening, Combined</i>	--	--	54.7%	--	
	<i>Cervical Cancer Screening</i>	81.1%	77.7%	76.0%	↔	
	<i>Chlamydia Screening, 16-20 Years</i>	54.8%	51.7%	55.6%	↔	
	<i>Chlamydia Screening, 21-25 Years</i>	58.7%	59.2%	62.4%	↔	
	<i>Chlamydia Screening, Combined</i>	56.9%	55.7%	59.1%	↔	
	<i>Timeliness of Prenatal Care</i>	86.9%	90.6%	86.8%	↔	
	<i>Postpartum Care</i>	58.4%	66.3%	66.3%	↔	
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	88.8%	88.1%	89.3%	↔	
	<i>Diabetes Care Poor HbA1c Control</i>	31.6%	30.7%	27.3%	↔	
	<i>Diabetes Care Eye Exam</i>	58.4%	65.9%	70.6%	↔	
	<i>Diabetes Care LDL-C Screening</i>	87.8%	91.5%	81.0%	↓	
	<i>Diabetes Care LDL-C Level <100</i>	39.4%	43.1%	39.4%	↔	
	<i>Diabetes Care Nephropathy</i>	47.0%	53.8%	82.5%	↑	
	<i>Asthma 5-9 Years</i>	75.9%	93.3%	98.3%	↔	
	<i>Asthma 10-17 Years</i>	80.4%	95.6%	95.4%	↔	
	<i>Asthma 18-56 Years</i>	77.2%	85.9%	88.5%	↔	
	<i>Asthma Combined Rate</i>	78.1%	91.1%	93.6%	↔	
	<i>Controlling High Blood Pressure, 18-45 Years</i>	--	--	59.1%	--	
	<i>Controlling High Blood Pressure, 46-85 Years</i>	63.8%	68.4%	58.7%	↔	
	<i>Controlling High Blood Pressure, Combined</i>	--	--	58.9%	--	
	<i>Advising Smokers to Quit</i>	73.0%	73.4%	76.1%	↔	
<i>Discussing Smoking Cessation Strategies</i>	35.5%	39.3%	43.3%	↔		
Access to Care	<i>Children's Access 12-24 Months</i>	97.2%	96.5%	96.9%	↔	
	<i>Children's Access 25 Mos-6 Years</i>	83.4%	83.5%	83.7%	↔	
	<i>Children's Access 7-11 Years</i>	83.5%	85.1%	87.4%	↔	
	<i>Adolescents' Access 12-19 Years</i>	82.0%	83.2%	85.5%	↔	
	<i>Adults' Access 20-44 Years</i>	84.3%	86.1%	86.5%	↔	
	<i>Adults' Access 45-64 Years</i>	91.7%	92.2%	93.1%	↔	

Notes
 A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

- ↑ = Performance improvement (rate increase >10%)*
- ↔ = No significant performance change (rate change ≤10%)
- ↓ = Performance decline (rate decrease >10%)*
- = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control*:

- ▼ = Performance decline (rate increase >10%)
- ▲ = Performance improvement (rate decrease >10%)

Table C-12—Michigan Medicaid HEDIS 2007 Trend Table: THC

Dimension of Care	Measure	2005	2006	2007	2006–2007 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	70.0%	71.5%	77.8%	↔↔
	<i>Childhood Immunization Combo 3</i>	--	34.3%	62.0%	↑
	<i>Adolescent Immunization Combo 2</i>	57.9%	71.2%	71.2%	Rotated Measure
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	6.7%	3.5%	1.2%	↔↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	24.0%	35.4%	49.1%	↑
	<i>Well-Child 3rd-6th Years of Life</i>	55.6%	65.4%	65.4%	Rotated Measure
	<i>Adolescent Well-Care Visits</i>	39.1%	47.9%	47.9%	Rotated Measure
	<i>Appropriate Treatment of URI</i>	73.3%	69.6%	76.3%	↔↔
Women's Care	<i>Children with Pharyngitis</i>	29.0%	29.3%	37.5%	↔↔
	<i>Breast Cancer Screening, 42-51 Years</i>	--	--	43.0%	--
	<i>Breast Cancer Screening, 52-69 Years</i>	46.5%	47.1%	52.8%	↔↔
	<i>Breast Cancer Screening, Combined</i>	--	--	47.6%	--
	<i>Cervical Cancer Screening</i>	59.8%	67.5%	66.2%	↔↔
	<i>Chlamydia Screening, 16-20 Years</i>	50.1%	52.1%	61.8%	↔↔
	<i>Chlamydia Screening, 21-25 Years</i>	63.5%	62.8%	68.7%	↔↔
	<i>Chlamydia Screening, Combined</i>	56.2%	56.8%	64.6%	↔↔
Living With Illness	<i>Timeliness of Prenatal Care</i>	86.3%	87.5%	84.2%	↔↔
	<i>Postpartum Care</i>	46.9%	62.1%	57.9%	↔↔
	<i>Diabetes Care HbA1c Testing</i>	76.4%	82.4%	76.7%	↔↔
	<i>Diabetes Care Poor HbA1c Control</i>	47.7%	42.3%	47.0%	↔↔
	<i>Diabetes Care Eye Exam</i>	47.9%	53.0%	57.3%	↔↔
	<i>Diabetes Care LDL-C Screening</i>	79.6%	84.6%	72.8%	↓
	<i>Diabetes Care LDL-C Level <100</i>	32.6%	34.5%	28.2%	↔↔
	<i>Diabetes Care Nephropathy</i>	56.7%	65.9%	77.6%	↑
	<i>Asthma 5-9 Years</i>	56.3%	76.9%	86.6%	↔↔
	<i>Asthma 10-17 Years</i>	62.9%	81.3%	80.2%	↔↔
	<i>Asthma 18-56 Years</i>	72.7%	78.1%	82.9%	↔↔
	<i>Asthma Combined Rate</i>	65.6%	78.9%	82.8%	↔↔
	<i>Controlling High Blood Pressure, 18-45 Years</i>	--	--	43.2%	--
	<i>Controlling High Blood Pressure, 46-85 Years</i>	52.1%	60.1%	40.9%	↓
<i>Controlling High Blood Pressure, Combined</i>	--	--	41.6%	--	
Access to Care	<i>Advising Smokers to Quit</i>	71.7%	66.9%	65.6%	↔↔
	<i>Discussing Smoking Cessation Strategies</i>	33.0%	32.4%	30.9%	↔↔
	<i>Children's Access 12-24 Months</i>	88.2%	89.0%	91.8%	↔↔
	<i>Children's Access 25 Mos-6 Years</i>	72.5%	75.9%	75.0%	↔↔
	<i>Children's Access 7-11 Years</i>	71.5%	75.2%	78.3%	↔↔
	<i>Adolescents' Access 12-19 Years</i>	72.5%	75.1%	77.4%	↔↔
	<i>Adults' Access 20-44 Years</i>	70.6%	73.4%	74.9%	↔↔
	<i>Adults' Access 45-64 Years</i>	76.1%	78.9%	80.4%	↔↔

Notes

A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

- ↑ = Performance improvement (rate increase >10%)*
- ↔↔ = No significant performance change (rate change ≤10%)
- ↓ = Performance decline (rate decrease >10%)*
- = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control*:

- ▼ = Performance decline (rate increase >10%)
- ▲ = Performance improvement (rate decrease >10%)

Table C-13—Michigan Medicaid HEDIS 2007 Trend Table: UPP

Dimension of Care	Measure	2005	2006	2007	2006–2007 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	72.1%	79.4%	80.7%	↔
	<i>Childhood Immunization Combo 3</i>	--	38.8%	66.6%	↑
	<i>Adolescent Immunization Combo 2</i>	62.7%	70.1%	70.1%	Rotated Measure
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	0.9%	1.9%	1.4%	↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	52.0%	41.6%	44.6%	↔
	<i>Well-Child 3rd-6th Years of Life</i>	58.6%	59.7%	60.9%	↔
	<i>Adolescent Well-Care Visits</i>	37.2%	37.0%	39.1%	↔
	<i>Appropriate Treatment of URI</i>	82.1%	81.1%	81.1%	↔
	<i>Children with Pharyngitis</i>	53.3%	52.3%	54.8%	↔
Women's Care	<i>Breast Cancer Screening, 42-51 Years</i>	--	--	53.5%	--
	<i>Breast Cancer Screening, 52-69 Years</i>	67.8%	70.0%	67.6%	↔
	<i>Breast Cancer Screening, Combined</i>	--	--	60.0%	--
	<i>Cervical Cancer Screening</i>	73.0%	73.0%	76.8%	↔
	<i>Chlamydia Screening, 16-20 Years</i>	43.2%	47.9%	48.4%	↔
	<i>Chlamydia Screening, 21-25 Years</i>	42.0%	45.3%	49.4%	↔
	<i>Chlamydia Screening, Combined</i>	42.7%	46.8%	48.8%	↔
	<i>Timeliness of Prenatal Care</i>	85.2%	85.2%	88.7%	↔
	<i>Postpartum Care</i>	53.5%	53.5%	68.8%	↑
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	91.6%	91.6%	89.7%	↔
	<i>Diabetes Care Poor HbA1c Control</i>	23.9%	23.9%	27.8%	↔
	<i>Diabetes Care Eye Exam</i>	60.3%	68.6%	70.6%	↔
	<i>Diabetes Care LDL-C Screening</i>	92.3%	92.3%	81.7%	↓
	<i>Diabetes Care LDL-C Level <100</i>	37.1%	37.1%	37.4%	↔
	<i>Diabetes Care Nephropathy</i>	64.0%	64.0%	81.4%	↑
	<i>Asthma 5-9 Years</i>	66.0%	95.1%	97.8%	↔
	<i>Asthma 10-17 Years</i>	70.6%	86.2%	92.5%	↔
	<i>Asthma 18-56 Years</i>	69.1%	86.8%	87.2%	↔
	<i>Asthma Combined Rate</i>	68.8%	88.2%	91.3%	↔
	<i>Controlling High Blood Pressure, 18-45 Years</i>	--	--	65.7%	--
	<i>Controlling High Blood Pressure, 46-85 Years</i>	73.0%	73.0%	64.3%	↔
	<i>Controlling High Blood Pressure, Combined</i>	--	--	64.8%	--
	<i>Advising Smokers to Quit</i>	66.2%	69.6%	72.9%	↔
<i>Discussing Smoking Cessation Strategies</i>	33.3%	34.7%	38.5%	↔	
Access to Care	<i>Children's Access 12-24 Months</i>	97.7%	98.0%	97.7%	↔
	<i>Children's Access 25 Mos-6 Years</i>	85.2%	88.1%	88.1%	↔
	<i>Children's Access 7-11 Years</i>	84.0%	84.2%	87.2%	↔
	<i>Adolescents' Access 12-19 Years</i>	85.0%	86.9%	90.0%	↔
	<i>Adults' Access 20-44 Years</i>	83.7%	86.6%	89.5%	↔
	<i>Adults' Access 45-64 Years</i>	88.4%	91.0%	91.2%	↔

Notes

A rotated measure is one for which the MHP exercised the NCQA-approved option to use the audited and reportable rate from the prior year.

- ↑ = Performance improvement (rate increase >10%)*
- ↔ = No significant performance change (rate change ≤10%)
- ↓ = Performance decline (rate decrease >10%)*
- = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control*:

- ↓ = Performance decline (rate increase >10%)
- ↑ = Performance improvement (rate decrease >10%)

Appendix D includes terms, acronyms, and abbreviations that are commonly used in HEDIS and NCQA literature and text. This glossary can be used as a reference and guide to explain common HEDIS language used throughout the report.

Terms, Acronyms, and Abbreviations

Administrative Data

Any automated data within a health plan (e.g., claims/encounter data, member data, provider data, hospital billing data, pharmacy data, and laboratory data).

Administrative Method

The administrative method requires health plans to identify the eligible population (i.e., the denominator) using administrative data. In addition, the numerator(s), or services provided to the members who are in the eligible population, are solely derived from administrative data. Medical records cannot be used to retrieve information. When using the administrative method, the entire eligible population becomes the denominator, and sampling is not allowed.

The administrative method is cost-efficient but can produce lower rates due to incomplete data submission by capitated providers. For example, a health plan has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure. The health plan chooses to perform the administrative method and finds that 4,000 members out of the 10,000 had evidence of a postpartum visit using administrative data. The final rate for this measure, using the administrative method, would therefore be 4,000/10,000, or 40 percent.

Audit Finding

The auditor's final determination, based on audit findings, of the appropriateness of the health plan publicly reporting its HEDIS measure rates. Each measure included in the HEDIS audit receives either a *Report*, *Not Applicable*, *No Benefit*, or *Not Report* audit finding.

Baseline Assessment Tool (BAT) Review

The BAT, completed by each health plan undergoing the HEDIS audit process, provides information to auditors regarding the health plan's systems for collecting and processing data for HEDIS reporting. Auditors review the BAT prior to the scheduled on-site health plan visit to gather preliminary information for planning/targeting on-site visit assessment activities; determining the core set of measures to be reviewed; determining which hybrid measures will be included in medical record validation; requesting core measures source code, as needed; identifying areas that require additional clarification during the on-site visit; and determining whether the core set of measures needs to be expanded.

BRFSS

Behavioral Risk Factor Surveillance System.

CAHPS

Consumer Assessment of Healthcare Providers and Systems is a set of standardized surveys that assess patient satisfaction with experience of care.

Capitation

A method of payment for providers. Under a capitated payment arrangement, providers are reimbursed on a per-member/per-month basis. The provider receives payment each month, regardless of whether the member needs services or not. Therefore, there is little incentive for providers to submit individual encounters, knowing that payment is not dependent on such submission.

Certified HEDIS Software Vendor

A third party, whose source code has been certified by NCQA, that contracts with a health plan to write source code for HEDIS measures. For a vendor's software to be certified by NCQA, all of the vendor's programmed HEDIS measures must be submitted to NCQA for automated testing of program logic, and a minimum of 70 percent of the measures must receive a "Pass" or "Pass with Qualifications" designation.

Claims-Based Denominator

When the eligible population for a measure is obtained from claims data. For hybrid measures with a claims-based denominator, health plans must identify their eligible population and draw their sample no earlier than January of the year following the measurement year to ensure all claims incurred through December 31 of the measurement year are captured in their systems.

CMS

The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services (DHHS) that regulates requirements and procedures for external quality review of managed care organizations. CMS provides health insurance to individuals through Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). In addition, CMS regulates laboratory testing through Clinical Laboratory Improvement Amendments (CLIA), develops coverage policies, and initiates quality-of-care improvement activities. CMS also maintains oversight of nursing homes and continuing care providers. This includes home health agencies, intermediate care facilities for the mentally retarded, and hospitals.

CMS 1500

A type of health insurance claim form used to bill professional services (formerly HCFA 1500).

Cohorts

Population components of a measure based on the age of the member at a particular point in time. A separate HEDIS rate is calculated for each cohort in a measure. For example, the *Children's and Adolescents' Access to Primary Care Practitioners* measure has four cohorts: Cohort 1, children 12–24 months of age as of December 31 of the measurement year; Cohort 2, children 25 months to 6 years of age as of December 31 of the measurement year; Cohort 3, children 7–11 years of age as of December 31 of the measurement year; and Cohort 4, adolescents 12–19 years of age as of December 31 of the measurement year.

Computer Logic

A programmed, step-by-step sequence of instructions to perform a given task.

Continuous Enrollment Requirement

The minimum amount of time that a member must be enrolled in a health plan to be eligible for inclusion in a measure to ensure that the health plan has a sufficient amount of time to be held accountable for providing services to that member.

Core Set

Because of the large number of measures and the required level of assessment, the selection of a core set of measures allows for the findings of the review to be projected to the remaining measures. The core set of measures must include 15 measures, plus the adult and child surveys, when applicable. In addition, the core set must focus on any health plan weaknesses identified during the BAT review. The core set can be expanded to more than 15 measures, but cannot be less than 13 measures. Rotated measures are not included in the core set.

CPT

Current Procedural Terminology (CPT[®]) is a listing of billing codes generated by the American Medical Association used to report the provision of medical services and procedures.

CVO

Credentials verification organization.

Data Completeness

The degree to which occurring services/diagnoses appear in the health plan's administrative data systems.

Data Completeness Study

An internal assessment developed and performed by a health plan, using a statistically sound methodology, to quantify the degree to which occurring services/diagnoses appear or do not appear in the health plan's administrative data systems.

Denominator

The number of members who meet all criteria specified in the measure for inclusion in the eligible population. When using the administrative method, the entire eligible population becomes the denominator. When using the hybrid method, a sample of the eligible population becomes the denominator.

DRG Coding

Diagnosis-related group coding sorts diagnoses and procedures for inpatient encounters by groups under major diagnostic categories with defined reimbursement limits.

DTaP

Diphtheria and tetanus toxoids and acellular pertussis vaccine.

DT

Diphtheria and tetanus toxoids vaccine.

EDI

Electronic data interchange is the direct, computer-to-computer transfer of data.

Electronic Data

Data that are maintained in a computer environment versus a paper environment.

Encounter Data

Billing data received from a capitated provider. Although the health plan does not reimburse the provider for each individual encounter, submission of the encounter data to the health plan allows the health plan to collect the data for future HEDIS reporting.

Exclusions

Conditions outlined in HEDIS measure specifications that describe when a member should not be included in the denominator.

FACCT

Foundation for Accountability.

FFS

Fee for service: A reimbursement mechanism in which the provider is paid for services billed.

Final Audit Report

Following the health plan's completion of any corrective actions, the written report that is completed by the auditor documenting all final findings and results of the HEDIS audit. The final report includes the Summary Report, IS Capabilities Assessment, Medical Record Review Validation Findings, Measure Designations, and Audit Opinion (Final Audit Statement).

Global Billing Practices

The practice of billing multiple services provided over a period of time in one inclusive bill, commonly used by obstetrics (OB) providers to bill prenatal and postpartum care.

HbA1c

The HbA1c test (hemoglobin A1c test or glycosylated hemoglobin test) is a lab test that reveals average blood glucose over a period of two to three months.

HCFA 1500

A type of claim form that was used to bill professional services. The claim form has been changed to the CMS 1500.

HCPCS

Healthcare Common Procedure Coding System: A standardized alphanumeric coding system that maps to certain CPT codes (see also CPT).

HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS),* developed and maintained by NCQA, is a set of performance measures used to assess the quality of care provided by managed health care organizations.

**Formerly the Health Plan Employer Data and Information Set.*

HEDIS Measure Determination Standards (HD)

The standards that auditors use during the audit process to assess a health plan's adherence to HEDIS measure specifications.

HEDIS Repository

The data warehouse where all data used for HEDIS reporting are stored.

HEDIS Warehouse

See HEDIS repository.

Hib Vaccine

Haemophilus influenzae type b vaccine.

HPL

High performance level: MDCH has defined the HPL as the most recent national HEDIS Medicaid 90th percentile, except for two key measures (*Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Comprehensive Diabetes Care—Poor HbA1c Control*) for which lower rates indicate better performance. For these two measures, the 10th percentile (rather than the 90th) shows excellent performance.

HSAG

Health Services Advisory Group, Inc.

Hybrid Measures

Measures that can be reported using the hybrid method.

Hybrid Method

The hybrid method requires health plans to identify the eligible population using administrative data, and then extract a systematic sample of 411 members from the eligible population, which becomes the denominator. Administrative data are then used to identify services provided to those 411 members. Medical records must then be reviewed for those members who do not have evidence of a service being provided using administrative data.

The hybrid method generally produces higher results but is considerably more labor intensive. For example, a health plan has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure. The health plan chooses to perform the hybrid method. After randomly selecting 411 eligible members, the health plan finds that 161 members had evidence of a postpartum visit using administrative data. The health plan then obtains and reviews medical records for the 250 members who did not have evidence of a postpartum visit using administrative data. Of those 250 members, 54 were found to have a postpartum visit recorded in the medical record. The final rate for this measure, using the hybrid method, would therefore be $(161 + 54) / 411$, or 52 percent.

ICD-9-CM

ICD-9-CM, the acronym for the International Classification of Diseases, 9th Revision, Clinical Modification, is the classification of diseases and injuries into groups according to established criteria that is used for reporting morbidity, mortality, and utilization rates as well as for billing purposes.

IDSS

Interactive Data Submission System—a tool used to submit data to NCQA.

Inpatient Data

Data derived from an inpatient hospital stay.

IRR

Interrater reliability: The degree of agreement exhibited when a measurement is repeated under the same conditions by different raters.

IS

Information system: An automated system for collecting, processing, and transmitting data.

IPV

Inactivated poliovirus vaccine.

IT

Information technology: The technology used to create, store, exchange, and use information in its various forms.

Key Data Elements

The data elements that must be captured to be able to report HEDIS measures.

Key Measures

The HEDIS measures selected by MDCH that health plans use for HEDIS reporting.

LDL-C

Low-density lipoprotein cholesterol.

Logic Checks

Evaluations of programming logic to determine its accuracy.

LPL

Low performance level: For most key measures, MDCH has defined the LPL as the most recent national HEDIS Medicaid 25th percentile. For two key measures (*Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Comprehensive Diabetes Care—Poor HbA1c Control*) lower rates indicate better performance, and the LPL for these measures is the 75th percentile rather than the 25th.

Manual Data Collection

Collection of data through a paper versus an automated process.

Mapping Codes

The process of translating a health plan's propriety or nonstandard billing codes to industry standard codes specified in HEDIS measures. Mapping documentation should include a crosswalk of relevant codes, descriptions, and clinical information, as well as the policies and procedures for implementing the codes.

Material Bias

For most measures reported as a rate (which includes all of the key measures except *Advising Smokers to Quit*), any error that causes a ± 5 percent difference in the reported rate is considered materially biased. For non-rate measures or measures collected via the CAHPS survey, (such as the key measure *Advising Smokers to Quit*), any error that causes a ± 10 percent difference in the reported rate or calculation.

MCIR

Michigan Care Improvement Registry.

MCO

Managed care organization.

MDCH

Michigan Department of Community Health.

Medical Record Validation

The process that auditors follow to verify that the health plan's medical record abstraction meets industry standards and that abstracted data are accurate.

Medicaid Percentiles

The NCQA national percentiles for each HEDIS measure for the Medicaid product line, used to compare health plan performance and assess the reliability of a health plan's HEDIS rates.

Membership Data

Electronic health plan files containing information about members, such as name, date of birth, gender, current address, and enrollment (i.e., when the member joined the health plan).

Mg/dL

Milligrams per deciliter.

MHP

Medicaid health plan.

Modifier Codes

Two- or five-digit extensions added to CPT[®] codes to provide additional information about services/procedures.

MMR

Measles, mumps, and rubella vaccine.

MUPC Codes

Michigan Uniform Procedure Codes: procedure codes developed by the State of Michigan for billing services performed.

NA

Not applicable: The health plan's denominator for a measure was too small (i.e., less than 30) to report a valid rate; the result/rate is NA.

NB

No benefit: The health plan did not offer the health benefits required by the measure.

NCQA

The National Committee for Quality Assurance (NCQA) is a not-for-profit organization that assesses, through accreditation reviews and standardized measures, the quality of care provided by managed health care delivery systems; reports results of those assessments to employers, consumers, public purchasers, and regulators; and ultimately seeks to improve the health care provided within the managed care industry.

NDC

National Drug Codes used for billing pharmacy services.

NR

The *Not Report* HEDIS audit finding.

A measure has an NR audit finding for one of two reasons:

1. The health plan chose not to report the measure
2. The health plan calculated the measure but the result was materially biased

Numerator

The number of members in the denominator who received all the services as specified in the measure.

OPV

Oral polio vaccine.

Over-Read Process

The process of re-reviewing a sample of medical records by a different abstractor to assess the degree of agreement between two different abstractors and ensure the accuracy of abstracted data. The over-read process should be conducted by the health plan as part of its medical record review process. Auditors overread a sample of the health plan's medical records as part of the audit process.

PCV

Pneumococcal conjugate vaccine

Pharmacy Data

Data derived from the provision of pharmacy services.

Primary Source Verification

The practice of reviewing the processes and procedures to input, transmit, and track data from its originating source to the HEDIS repository to verify that the originating information matches the output information for HEDIS reporting.

Proprietary Codes

Unique billing codes developed by a health plan that have to be mapped to industry standard codes for HEDIS reporting.

Provider Data

Electronic files containing information about physicians, such as the type of physician, specialty, reimbursement arrangement, and office location.

Retroactive Enrollment

The effective date of a member's enrollment in a health plan occurs prior to the date that the health plan is notified of that member's enrollment. Medicaid members who are retroactively enrolled in a health plan must be excluded from a HEDIS measure denominator if the time period from the date of enrollment to the date of notification exceeds the measure's allowable gap specifications.

Revenue Codes

Cost codes for facilities to bill by category, services, procedures, supplies, and materials.

Sample Frame

The eligible population that meets all criteria specified in the measure from which a systematic sample is drawn.

Source Code

The written computer programming logic for determining the eligible population and the denominators/numerators for calculating the rate for each measure.

Standard Codes

Industry standard billing codes such as ICD-9-CM, CPT[®], DRG, Revenue, and UB-92 codes used for billing inpatient and outpatient health care services.

T-test Validation

A statistical validation of a health plan's positive medical record numerator events.

UB-92 Claims

A type of claim form used to bill facility-based services (inpatient, outpatient, emergency room) as well as drugs and supplies. UB-92 codes are primarily Type of Bill and revenue codes.

Vendor

Any third party that contracts with a health plan to perform services. The most common delegated services are pharmacy vendors, vision care services, laboratory services, claims processing, HEDIS software vendors, and provider credentialing.

VZV

Varicella-zoster virus (chicken pox) vaccine.