ANALYSIS OF MEDICAID HMO

(FY2011 Appropriation Bill - Public Act 187 of 2010)

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 require Medicaid HMOs to provide EPSDT utilization data through the encounter data system, and health employer data and information set well child health measures in accordance with the National Committee on Quality Assurance prescribed methodology. (3) 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. (4) 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 MIHP and EPSDT programs. (5) The department shall assure the training and technical assistance are available for EPSDT and MIHP for Medicaid health plans, local health departments, and MIHP contractors.

Michigan Department of Community Health

MDCH

Rick Snyder, Governor

Olga Dazzo, Director

Michigan Medicaid HEDIS 2011 Results Statewide Aggregate Report

January 2012

HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 300 ◆ Phoenix, AZ 85016

Phone 602.264.6382 ◆ Fax 602.241.0757

HSAG HEALTH SERVICES ADVISORY GROUP

CONTENTS

1. **Executive Summary 1-1**
   - Introduction 1-1
   - Summary of Performance 1-2
   - Recommendations 1-4
2. **How to Get the Most From This Report 2-1**
   - Summary of Michigan Medicaid HEDIS 2011 Key Measures 2-1
   - Key Measure Audit Results 2-2
   - Dimensions of Care 2-3
   - Changes to Measures 2-3
   - Percentile Ranking 2-5
   - Performance Levels 2-6
   - Performance Trend Analysis 2-7
   - Michigan Medicaid Overall Rates 2-7
   - Calculation Methods: Administrative Versus Hybrid 2-7
   - Interpreting Results 2-9
   - Understanding Sampling Error 2-10
   - Acronyms 2-11
3. **Pediatric and Adolescent Care 3-1**
   - Introduction 3-1
   - Childhood Immunization Status 3-2
   - Immunizations for Adolescents 3-10
   - Lead Screening in Children 3-14
   - Well-Child Visits 3-18
   - Adolescent Well-Care Visits 3-25
   - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents 3-29
   - Appropriate Treatment for Children With Upper Respiratory Infection 3-39
   - Appropriate Testing for Children With Pharyngitis 3-42
   - Pediatric Care Findings and Recommendations 3-45
4. **Women's and Adult Care 4-1**
   - Introduction 4-1
   - Breast Cancer Screening 4-2
   - Cervical Cancer Screening 4-5
   - Chlamydia Screening in Women 4-9
   - Prenatal and Postpartum Care—Timeliness of Prenatal Care 4-16
   - Prenatal and Postpartum Care—Postpartum Care 4-20
   - Adult BMI Assessment 4-24
   - Women's Care Findings and Recommendations 4-28
5. **Living With Illness 5-1**
   - Introduction 5-1
   - Comprehensive Diabetes Care 5-2
   - Comprehensive Diabetes Care—HbA1c Testing and Control 5-3
   - Comprehensive Diabetes Care—Eye Exam 5-10

Comprehensive Diabetes Care—LDL-C Screening 5-14
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy 5-21
Comprehensive Diabetes Care—Blood Pressure Control 5-25
Use of Appropriate Medications for People With Asthma 5-31
Controlling High Blood Pressure 5-38
Medical Assistance With Smoking and Tobacco Use Cessation 5-42
Living With Illness Findings and Recommendations 5-50

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 6-12
Ambulatory Care 6-21
Access to Care Findings and Recommendations 6-23

7. HEDIS Reporting Capabilities 7-1

Key Information Systems Findings 7-1

Appendix A: Tabular Results—Key Measures A-1

Appendix B: National HEDIS 2010 Medicaid Percentiles B-1

Appendix C: Trend Tables C-1

Appendix D: Glossary D-1

Introduction

During 2010, the Michigan Department of Community Health (MDCH) contracted with 14 health plans to provide managed care services to Michigan Medicaid enrollees. 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®).[1-1] MDCH selected 21 HEDIS measures from the standard Medicaid HEDIS reporting set as the key measures to evaluate performance of the Michigan Medicaid health plans (MHPs). These 21 measures comprise 45 distinct rates.

MDCH expects its contracted MHPs 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 but one of the key measures.[1-2] The performance levels have been set at specific, attainable rates and are based on national percentiles. MHPs meeting the high performance level (HPL) exhibit rates among the top in the nation. The low performance level (LPL) has been set to identify MHPs in the greatest need of improvement. Details describing these performance levels are presented 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 and Adolescent Care, (2) Women's and Adult Care, (3) Living With Illness, and (4) Access to Care. This approach to the analysis is designed to encourage consideration of the key measures as a whole rather than in isolation, and to consider the strategic and tactical changes required to improve overall performance.

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 the audit findings in relation to the National Committee for Quality Assurance's (NCQA's) information system (IS) standards.

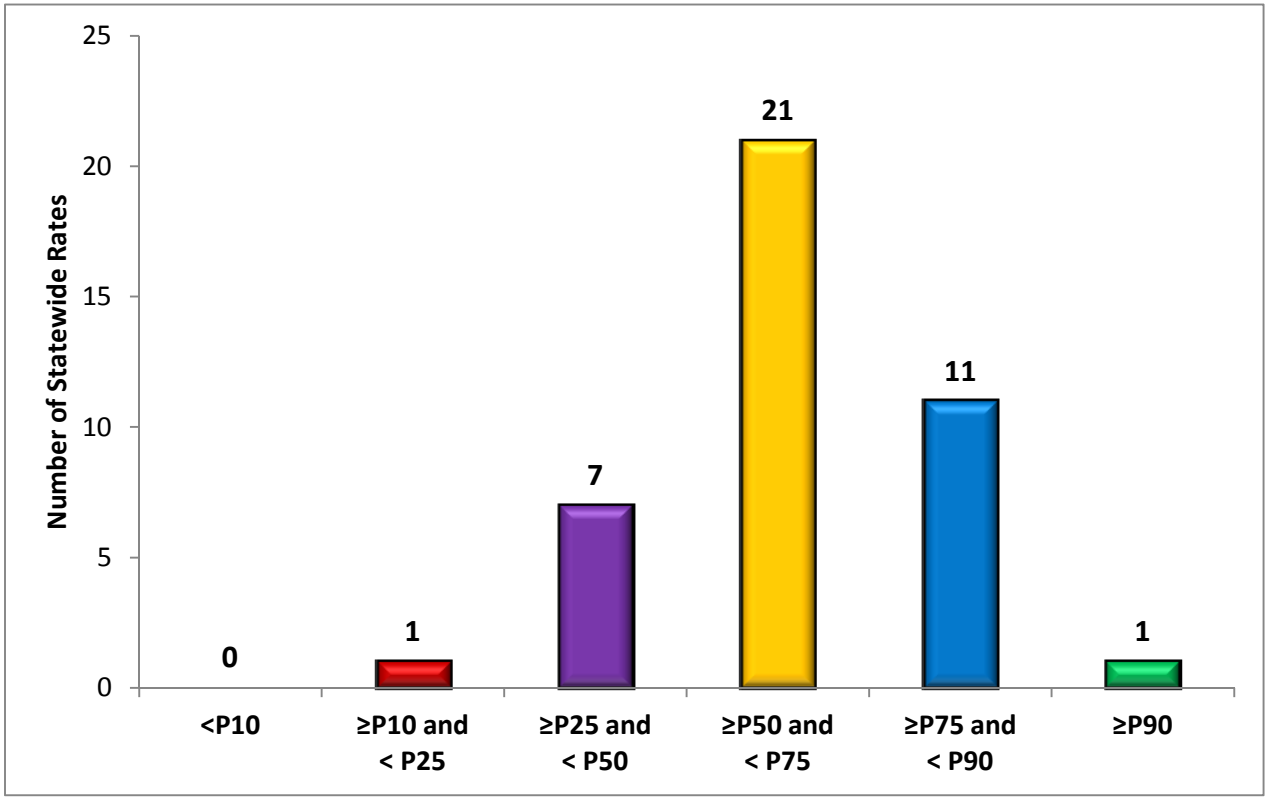
1.1 *HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).*

1-2 Performance levels were not developed for the *Ambulatory Care* measure since high/lower visit counts does not necessarily denote better/poorer performance.

Summary of Performance

Figure 1-1 compares the Michigan Medicaid program's overall rates with the national HEDIS 2010 Medicaid percentiles. The bars represent the number of Michigan Medicaid statewide rates falling into each HEDIS percentile range.

Figure 1-1—Michigan Medicaid Statewide Averages Compared to National Medicaid Percentiles



Of the 41 statewide rates [1-3] that were comparable to national percentile data:

- One (or 2.4 percent) was at or above the 10th percentile and below the 25th percentile (≥P10 and <P25)
- Seven (or 17.1 percent) were at or above the 25th percentile and below the 50th percentile (≥P25 and <P50)
- 21 (or 51.2 percent) were at or above the 50th percentile and below the 75th percentile (≥P50 and <P75)

[1-3] With the exception of the Ambulatory Care measures, all statewide rates were weighted averages. For *Ambulatory Care*, straight average was reported throughout this report. Figure 1-1 also included only 41 of the 45 measures because the three *Medical Assistance With Smoking and Tobacco Use Cessation* measures did not have national percentiles and the HEDIS 2011 rate for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/80 mm Hg)* measure could not be compared to the national HEDIS 2010 percentiles due to specification change. It is important to note that for *Comprehensive Diabetes Care—Poor HbA1c Control* rate, where a lower rate represents a higher performance, the percentiles were rotated to align with performance (e.g., if the *Comprehensive Diabetes Care—Poor HbA1c Control* rate was between the 10th and 25th percentiles, it would be inverted to be between the 75th and 90th percentiles to represent the level of performance).

- 11 (or 26.8 percent) were at or above the 75th percentile and below the 90th percentile (≥P75 and <P90)
- One (or 2.4 percent) was at or above the 90th percentile (≥P90)

Please note that although one measure ranked between the 10th and 25th percentile, this was one of the two *Ambulatory Care* measures where higher or lower visit counts do not necessarily denote better or poorer performance. Without taking these two *Utilization of Services* measures into account, the Michigan Medicaid program generally performed well when compared to the national percentiles: 82.1 percent of the weighted averages met or exceeded the 50th percentile. One measure was at or above the 90th percentile and no measure rate was below the 10th percentile.

A summary of statewide performance for each dimension is presented below:

- **Pediatric and Adolescent Care:** The Michigan Medicaid program performed fairly well for HEDIS 2011: six of the 12 weighted averages performed above the HEDIS 2010 Medicaid 75th percentile. Although two measures (*Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis*) ranked below the 50th percentile, this year's performance demonstrated significant improvement. When compared to last year's performance, all but one measure demonstrated a rate increase. Seven of these rates showed statistically significant improvement and four rates had an improvement of at least five percentage points. For 10 of the 12 measures under this dimension, the number of MHPs having significant improvement in HEDIS 2011 was larger than those exhibiting significant decline. One measure accomplished statistically significant improvement in 12 of the 14 health plans and another three measures had significant improvement in nine plans.

- **Women's and Adult Care:** The HEDIS 2011 Michigan Medicaid program performance was favorable compared to the national HEDIS 2010 Medicaid percentiles. All measures met or exceeded the national 50th percentile and one measure (*Adult BMI Assessment*) reported a statewide rate that met or exceeded the national 90th percentile. Although only four measures reported increases in their rates from HEDIS 2010, two (*Breast Cancer Screening* and *Adult BMI Assessment*) showed statistically significant improvement, and one measure in particular (*Adult BMI Assessment*) reported an increase of 15.3 percentage points. While most of the measures had only a few MHPs showing significant improvement, the *Adult BMI Assessment* measure had 12 of the 14 MHPs performing statistically significantly better from HEDIS 2010.

- **Living With Illness:** The Michigan Medicaid program performance in this dimension was comparable to the national average performance ranges but did not demonstrate significant improvements from last year. Of the 11 measures with comparable national Medicaid benchmarks, three (all under *Comprehensive Diabetes Care*) rates met or exceeded the 75th percentiles. Although three measures (all *Use of Appropriate Medications for People With Asthma* measures) were below the 50th percentile, this year's performance demonstrated a slight improvement compared to HEDIS 2010. Many measures showed improvement in performance from last year: however, none had an increase in performance of more than five percentage points and only one had statistically significant improvement (*Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg*). Only a few of the Living With Illness measures showed statistically significant improvement from HEDIS 2010 to HEDIS 2011, and this improvement appeared to only be supported by a small number of MHPs.

- **Access to Care:** The HEDIS 2011 statewide performance was fairly comparably with the national average performance ranges. Seven of the 10 statewide rates met or exceeded the national Medicaid 50th percentile. Although one measure (*Ambulatory Care—Outpatient Visits per 1,000 Member Months*) ranked below the 25th percentile, performance cannot be suggestive of a poorer performance level for Michigan. Two *Children's and Adolescents' Access to Primary Care Practitioners* measures performed below the 50th percentiles. When compared to last year's performance, six of the 10 measures demonstrated an increase in rate from last year, with three showing a statistically significant improvement. These three measures were all *Children's and Adolescents' Access to Primary Care Practitioners* measures, two of which had 10 MHPs reporting statistically significant improvement from HEDIS 2010.

Recommendations

MDCH and the MHPs should continue to focus efforts on improving performance for all low-performing measures, specifically in the area of Access to Care. Though improvements were observed across several measures, those in the Access to Care dimension performed the lowest among the four dimensions, with five of the eight measures under this dimension having at least seven of the MHPs with rates benchmarking below the national HEDIS Medicaid 50th percentile. Methods that may be used to help improve Access to Care include the following:

- **Improving Collaboration:** As a means of improving access to care, effective community strategies are being identified by various national organizations, local foundations, and academic centers, sharing the keys to their success and disseminating them as effective models and approaches. This collaboration has proven to be pivotal in helping state governments because many of them are facing significant budgetary issues. The state governments have taken note of the creative initiatives that are being pioneered in many communities, and some states have even joined efforts with these community stakeholders.[1-4] With input from the National Policy Consensus Center (NPCC), the community-based collaboratives from around the country developed these three key recommendations:

  1. Many more community-based collaboratives, of differing sizes and scales, should experiment with improving health care access.
  2. Policy leaders and funders should convene, support, and champion the efforts of those community-based collaboratives.
  3. Research on the outcomes and effectiveness of community-based collaboratives should be supported and disseminated.

- **Increasing the Utilization of Nurse Practitioners:** In an effort to reduce costs as well as increase accessibility, many plans are shifting more of the basic primary health care services from physicians to nurse practitioners, at the urging of the Affordable Care Act of 2010. Because of the shortage of primary care physicians in the United States compared to the growing need and rising costs, nurse practitioners are growing in number and charge much less for their services than their physician counterparts.[1-5]

[1-4] Improving HealthCare Access: Finding Solutions in a Time of Crisis. *Collaborative Problem Solving for States and Communities.* Available at http://www.policyconsensus.org/publications/reports/docs/Healthcare.pdf. Accessed on September 13, 2011.

[1-5] How Can Nurse Practitioners Help Improve Access to Health Care for the Uninsured and Underinsured? University of Phoenix. Available at https://www.phoenix.edu/colleges_divisions/nursing/articles/2011/08/how-can-nurse-practitioners-help-improve-access-to-health-care-for-the-uninsured-and-underinsured.html. Accessed on September 13, 2011.

Summary of Michigan Medicaid HEDIS 2011 Key Measures

HEDIS includes a standard set of measures that can be reported by health plans nationwide. MDCH selected 21 HEDIS measures from the standard Medicaid set and included 45 distinct rates, shown in Table 2-1. These 45 rates represent the HEDIS 2011 MDCH key measures.

Table 2-1—Michigan Medicaid HEDIS 2011 Key Measures

Standard HEDIS 2011 Measures	2011 MDCH Key Measures
1. *Childhood Immunization Status*	1. *Childhood Immunization Status—Combination 2* 2. *Childhood Immunization Status—Combination 3*
2. *Immunizations for Adolescents*	3. *Immunizations for Adolescents—Combination 1*
3. *Lead Screening in Children*	4. *Lead Screening in Children*
4. *Well-Child Visits in the First 15 Months of Life*	5. *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
5. *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	6. *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
6. *Adolescent Well-Care Visits*	7. *Adolescent Well-Care Visits*
7. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile*	8. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents —BMI Percentile—3 to11 Years* 9. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—12 to17 Years* 10. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
8. *Appropriate Treatment for Children With Upper Respiratory Infection*	11. *Appropriate Treatment for Children With Upper Respiratory Infection*
9. *Appropriate Testing for Children With Pharyngitis*	12. *Appropriate Testing for Children With Pharyngitis*
10. *Breast Cancer Screening*	13. *Breast Cancer Screening*
11. *Cervical Cancer Screening*	14. *Cervical Cancer Screening*
12. *Chlamydia Screening in Women*	15. *Chlamydia Screening in Women—16 to 20 Years* 16. *Chlamydia Screening in Women—21 to 24 Years* 17. *Chlamydia Screening in Women—Total*
13. *Prenatal and Postpartum Care*	18. *Prenatal and Postpartum Care—Timeliness of Prenatal Care* 19. *Prenatal and Postpartum Care—Postpartum Care*
14. *Adult BMI Assessment*	20. *Adult BMI Assessment*
15. *Comprehensive Diabetes Care*	21. *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* 22. *Comprehensive Diabetes Care—Poor HbA1c Control* 23. *Comprehensive Diabetes Care—Eye Exam* 24. *Comprehensive Diabetes Care—Low-Density Lipoprotein Cholesterol (LDL-C) Screening* 25. *Comprehensive Diabetes Care—LDL-C Level (<100 mg/dL)* 26. *Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy* 27. *Comprehensive Diabetes Care—Blood Pressure Control (<140/80 mm Hg)* 28. *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

Table 2-1—Michigan Medicaid HEDIS 2011 Key Measures	
Standard HEDIS 2011 Measures	**2011 MDCH Key Measures**
16. *Use of Appropriate Medications for People With Asthma*	29. *Use of Appropriate Medications for People With Asthma—5 to 11 Years* 30. *Use of Appropriate Medications for People With Asthma—12 to 50 Years* 31. *Use of Appropriate Medications for People With Asthma—Total*
17. *Controlling High Blood Pressure*	32. *Controlling High Blood Pressure*
18. *Medical Assistance With Smoking and Tobacco Use Cessation*	33. *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* 34. *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications* 35. *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies*
19. *Children's and Adolescents' Access to Primary Care Practitioners*	36. *Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* 37. *Children's and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* 38. *Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* 39. *Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
20. *Adults' Access to Preventive/Ambulatory Health Services*	40. *Adults' Access to Preventive/Ambulatory Health Services—20 to 44 Years* 41. *Adults' Access to Preventive/Ambulatory Health Services—45 to 64 Years* 42. *Adults' Access to Preventive/Ambulatory Health Services—65+ Years* 43. *Adults' Access to Preventive/Ambulatory Health Services—Total*
21. *Ambulatory Care*	44. *Ambulatory Care—Outpatient Visits per 1,000 Member Months* 45. *Ambulatory Care—ED Visits per 1,000 Member Months*

Key Measure Audit Results

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

It should be noted that NCQA allows health plans to "rotate" select HEDIS measures in some circumstances. A "rotation" schedule enables health plans to use the audited and reportable rate from the prior year. This strategy allows health plans with higher rates for some measures to focus resources on other measures' rates. 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 exercise that option if they chose to do so. Nine MHPs chose to rotate measures in 2011. Following NCQA methodology,

rotated measures were assigned the same reported rates from measurement year 2009 and were included in the calculations for the Michigan Medicaid weighted averages.[2-1]

Dimensions of Care

HSAG examined four different dimensions of care for Michigan Medicaid members: Pediatric and Adolescent Care, Women's and Adult Care, Living With Illness, and Access to Care. This approach to the analysis is designed to encourage MHPs to consider the key measures as a whole rather than in isolation, and to consider the strategic and tactical changes required to improve overall performance.

Changes to Measures

For the 2011 HEDIS reporting year, NCQA made modifications to some of the measures included in this report, which are outlined below.

Childhood Immunization Status

- Revised dosing requirements for HiB and Rotavirus vaccines.
- Clarified 6 months of age for influenza as "180 days."
- Clarified that the prior year's audited, product line-specific rate may be used for sample size reduction.

Well-Child Visits in the First 15 Months of Life

- Added ICD-9-CM Diagnosis code V20.3 to Table W15-A.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

- Added an anchor date to the eligible population criteria.
- Revised the age in the description to match the eligible population age criteria.
- Deleted UB Revenue code 077x from Table WCC-A.
- Clarified the use of member-reported BMIs in the *Note* section.

Appropriate Treatment for Children With Upper Respiratory Infection

- Deleted UB Revenue code 077x from Table URI-B.

Appropriate Testing for Children With Pharyngitis

- Deleted UB Revenue code 077x from Table CWP-B.

Breast Cancer Screening

- Deleted CPT codes 76090–76092 from Table BCS-A.

2-1 Key measures that were eligible for rotation in 2011 were *Childhood Immunization Status, Lead Screening in Children, Well-Child Visits in the First 15 Months of Life, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life , Adolescent Well-Care Visits,* and *Comprehensive Diabetes Care*.

Cervical Cancer Screening

- Added CPT codes 57540, 57545, 57550, 57555, 57556, 58548 to Table CCS-B.

Chlamydia Screening in Women

- Revised the age in the description to match the eligible population age criteria.
- Added LOINC codes 55869-2, 55870-0, 56497-1, 57032-5 to Table CHL-B.
- Deleted ICD-9-CM Diagnosis code 616 from Table CHL-B.
- Deleted CPT codes 87800, 87801 from Table CHL-B.
- Deleted HCPCS code S0180 from Table CHL-B
- Clarified that Tables CHL-D and CHL-E should be used to identify optional exclusions.
- Added LOINC codes 55869-2, 55870-0, 56497-1 to Table CHL-D.

Prenatal and Postpartum Care

- Clarified step 1 in the Administrative Specifications
- Added CPT code 99500 to Table PPC-C (Decision Rules 2, 3, and 4).
- Added LOINC codes 56990-5, 56991-3, 57321-2, 57743-7 to Table PPC-C (Decision Rules 2 and 3).
- Added CPT code 99500 to Table PPC-D.
- Added CPT code 99500 to Table PPC-E.
- Clarified that ultrasounds and lab results alone should not be considered a visit in the *Note* section.
- Added a practitioner type requirement to the *Postpartum Care* numerator.

Adult BMI Assessment

- Added an anchor date to the eligible population criteria.
- Deleted UB Revenue code 077x from Table ABA-A.

Comprehensive Diabetes Care

- Replaced *Blood Pressure Control (<130/80 mm Hg)* with *Blood Pressure Control (<140/80 mm Hg).*
- Deleted UB Revenue codes 022x, 077 from Table CDC-C.
- Deleted CPT code 67038 from Table CDC-G.
- Added LOINC codes 56553-1, 57369-1, 58448-2 to Table CDC-J.
- Added LOINC code 57735-3 to Table CDC-K.
- Revised the *Data Elements for Reporting* table.

Use of Appropriate Medications for People With Asthma

- Deleted UB Revenue codes 022x, 077 from Table ASM-B.
- Added ciclesonide to “Inhaled corticosteroids” description in Tables ASM-C and ASM-D.

Adults' Access to Preventive/Ambulatory Health Service

- Deleted UB Revenue codes 0524, 0525, 077x from Table AAP-A.

Ambulatory Care

- Removed "Ambulatory surgeries and procedures" and "Observation room stays" categories.
- Deleted UB Revenue codes 0524 and 0525 from Table AMB-A.
- Renamed Table AMB-C (formerly Table AMB-E).

Percentile Ranking

The Percentile Ranking tables presented depict each MHP's rank based on its rate as compared to the NCQA's national HEDIS 2010 Medicaid percentiles.

★★★★★ —indicates the MHP's rate is at or above the 90th percentile

★★★★ —indicates the MHP's rate is at or above the 75th percentiles but below the 90th percentiles

★★★ —indicates the MHP's rate is at or above the 50th percentiles but below the 75th percentiles

★★ —indicates the MHP's rate is at or above the 25th percentiles but below the 50th percentiles

★ —indicates the MHP's rate is below the 25th percentiles

NA —indicates Not Applicable (i.e., denominator size too small)

NR —indicates Not Report (i.e., biased, or MHP chose not to report)

NB —indicates No Benefit

NC —indicates Not Comparable (i.e., measure not comparable to national percentiles or national percentiles not available)

For the *Comprehensive Diabetes Care—Poor HbA1c Control* rates, where lower rates represent higher performance, the percentiles were rotated. For example, if the *Comprehensive Diabetes Care—Poor HbA1c Control* rate fell between the 10th and 25th percentiles, the percentiles would be inverted so that the rate would fall between the 75th and 90th percentiles.

For all measures except those under *Ambulatory Care*, MHP percentile ranking results are suggestive of their performance level. A MHP's rate that was at or above the 90th percentile would suggest better performance and a MHP's rate below the 25th percentile a poorer performance. For *Ambulatory Care* measures, since high/low visit counts reported in the interactive data submission system (IDSS) files did not take into account the demographic and clinical conditions of an eligible population, an MHP's percentile ranking does not denote better or worse performance.

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 statewide performance for the measures. Comparative information in this report is based on NCQA's national HEDIS 2010 Medicaid percentiles, which are the most recent data available from NCQA. For all key measures except those under *Ambulatory Care*, the statewide rates were compared to the High Performance Level (HPL) and Low Performance Level (LPL). The HPL represents current high performance in national Medicaid managed care, and the LPL represents low performance nationally.

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

For inverse measures such as *Comprehensive Diabetes Care—Poor HbA1c Control*, since lower rates indicate better performance, the 10th percentile (rather than the 90th percentile) represents excellent performance and the 75th percentile (rather than the 25th percentile) represents below average performance.

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.

MHPs should focus their efforts on reaching and/or maintaining the HPL for each key measure (except *Ambulatory Care*), rather than comparing themselves to other Michigan MHPs.

Performance Trend Analysis

Appendix C includes trend tables for each of the MHPs. Where applicable, each measure's HEDIS 2009, 2010, and 2011 rates are presented along with trend analysis results comparing the HEDIS 2010 and 2011 rates. Statistically significant differences using Pearson's Chi-square tests are displayed. The trends are shown in the following example with specific notations:

2010-2011 Health Plan Trend	Interpretation for measures other than *Ambulatory Care*
+2.5	The HEDIS 2011 rate is 2.5 percentage points ***higher*** than the HEDIS 2010 rate.
-2.5	The HEDIS 2011 rate is 2.5 percentage points ***lower*** than the HEDIS 2010 rate.
+2.5	The HEDIS 2011 rate is 2.5 percentage points ***statistically significantly higher*** than the HEDIS 2010 rate.
-2.5	The HEDIS 2011 rate is 2.5 percentage points ***statistically significantly lower*** than the HEDIS 2010 rate.

Please note that due to lack of variances reported in the IDSS file, statistical tests across years were not performed for utilization measures under *Ambulatory Care* that report rates per 1,000 member months. Nonetheless, difference in rates will still be reported without statistical test results.

Michigan Medicaid Overall Rates

For all measures except those under *Ambulatory Care*, the Michigan Medicaid weighted average rate (MWA) was used to represent Michigan Medicaid statewide performance. For *Ambulatory Care* measures, an unweighted average rate was calculated. Comparatively, the use of a weighted average, based on an MHP's eligible population for that measure, provides the most representative rate for the overall Michigan Medicaid population. Weighting the rate by an MHP's eligible population size ensures that a rate for an MHP with 125,000 members, for example, has a greater impact on the overall Michigan Medicaid rate than a rate for an MHP with only 10,000 members. Rates reported as *NA* was included in the calculations of these averages; rates reported as NR or NB were not included.

Calculation Methods: Administrative Versus Hybrid

Administrative Method

The administrative method requires MHPs 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, and 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's and Adolescents' Access to Primary Care Practitioners*
- *Adults' Access to Preventive/Ambulatory Health Services*
- *Ambulatory Care*

The administrative method is cost-efficient but can produce lower rates due to incomplete data submission by capitated providers. For example, an MHP has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure. The MHP 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 be 4,000/10,000, or 40 percent.

Hybrid Method

The hybrid method requires MHPs 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 rates because the completeness of documentation in the medical record exceeds what is typically captured in administrative data; however, the medical record review component of the hybrid method is considered more labor intensive. For example, an MHP has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure. The MHP chooses to use the hybrid method. After randomly selecting 411 eligible members, the MHP finds that 161 members had evidence of a postpartum visit using administrative data. The MHP 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. Therefore, the final rate for this measure, using the hybrid method, would be (161 + 54)/411, or 52 percent.

Interpreting Results

HEDIS results can differ among MHPs and even across measures for the same MHP.

The following 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?

1. How accurate are the results?

All Michigan MHPs are required by MDCH to have their HEDIS results confirmed through an NCQA HEDIS Compliance Audit™.[2-2] As a result, any rate included in this report has been verified as an unbiased estimate of the measure. NCQA's 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 an MHP 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, MHPs should understand and consider the issue of sampling error when evaluating HEDIS results.

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

For each measure, an MHP ranking presents the reported rate in order from highest to lowest, with bars representing the established HPL, LPL, and the national HEDIS 2010 Medicaid 50th percentile. In addition, the 2009, 2010, and 2011 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, MHPs 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 2011 Michigan Medicaid weighted average for each rate with the 2009 and 2010 Michigan Medicaid weighted averages and the HEDIS 2010 Medicaid 50th percentile.

[2-2] *NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).*

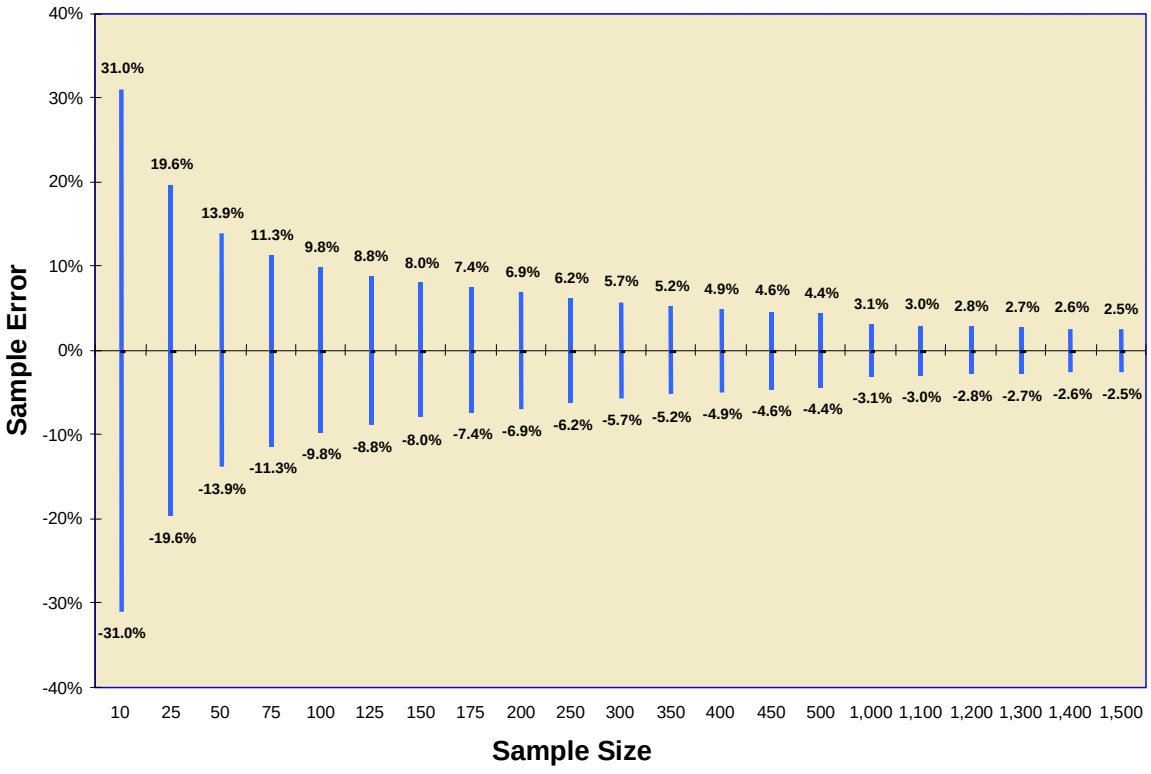
Understanding Sampling Error

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 perform 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 eligible 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 eligible 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 selecting at least 411 members of the eligible population. MHPs 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 MHP 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 sample 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.

Acronyms

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

Table 2-2—2011 Michigan MHPs

Acronym	Medicaid Health Plan Name
BCD	BlueCaid of Michigan
CSM	CareSource Michigan
GLH	UnitedHealthcare Great Lakes Health Plan, Inc.
HPM	Health Plan of Michigan, Inc.
HPP	HealthPlus Partners
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.
PRO	ProCare Health Plan
THC	Total Health Care, Inc.
UPP	Upper Peninsula Health Plan

In addition to the plans' acronyms, following are some additional abbreviations used in the tables or charts.

Table 2-3—Acronyms in Tables and Graphs

Acronym	Description
MWA	Michigan Medicaid Weighted Average
MA	Michigan Medicaid Average
P50	National HEDIS Medicaid 50th Percentile
HPL	High Performance Level
LPL	Low Performance Level

3. Pediatric and Adolescent Care

Introduction

The following section provides a detailed analysis of Michigan MHPs' performance for the Pediatric and Adolescent Care dimension.

The Pediatric and Adolescent Care dimension encompasses the following MDCH key measures:

- *Childhood Immunization Status—Combination 2*
- *Childhood Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1*
- *Lead Screening in Children*
- *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*
- *Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Percentile—3 to 11 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Percentile—12 to 17 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Percentile—Total*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Appropriate Testing for Children With Pharyngitis*

Childhood Immunization Status

Measure Definitions

Childhood Immunization Status—Combination 2 calculates the percentage of enrolled children who turned two years old during the measurement year, who were continuously enrolled for 12 months immediately preceding their second birthdays, and who were identified as having the following vaccinations: four diphtheria, tetanus, and acellular pertussis (DtaP); three inactivated polio (IPV); one measles, mumps, and rubella (MMR); two Haemophilus influenzae type b (HiB); three hepatitis B (HepB); and one varicella-zoster virus (chicken pox or VZV), on or before the child's second birthday.

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

Importance

Disease prevention is the key to public health, and one of the most basic methods of prevention is immunizations. Immunizations are the safest and most effective tools for protecting children from various potentially serious childhood diseases. Vaccines are proven to help children stay healthy and avoid the harmful effects of diseases such as diphtheria, tetanus, hepatitis, polio, measles, mumps, and rubella. While the rates of vaccine-preventable diseases are very low in the United States, the viruses and bacteria that cause these infectious diseases still exist. Without proper immunization, the potential to pass on vaccine-preventable diseases such as mumps to unprotected persons increases drastically. In fact, in 2009, the United States saw the largest outbreak of mumps since 2006.[3-1]

The social and direct economic costs of ensuring each child receives the CDC Advisory Committee for Immunization Practices' (ACIP's) recommended schedule of vaccines provide an impressive return on investment. Childhood vaccines prevent 10.5 million diseases among all children born in the United States in a given year and are a cost-effective preventive measure. It is estimated that for every $1 spent on immunizations, up to $29 can be saved in direct and indirect costs.[3-2]

Despite established guidelines and documented benefits and risks associated with childhood immunization, a gap in coverage still exists. Evidence has shown that the populations at greatest risk for under-immunization are minority children from low-income families or children who live in inner-cities or rural areas.[3-3] In the State of Michigan, in 2010, almost 94 percent of children from 19

[3-1] Centers for Disease Control and Prevention. *Mumps Outbreaks.* Available at: http://www.cdc.gov/mumps/outbreaks.html. Accessed on: August 8, 2011.

[3-2] National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on: August 22, 2011.

[3-3] American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine and Council on Community Pediatrics. Increasing Immunization Coverage. Available at: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;125/6/1295#B13. Accessed on: August 8, 2011.

to 35 months of age received their recommended vaccinations, an increase of more than 3 percent from the previous year.[3-4]

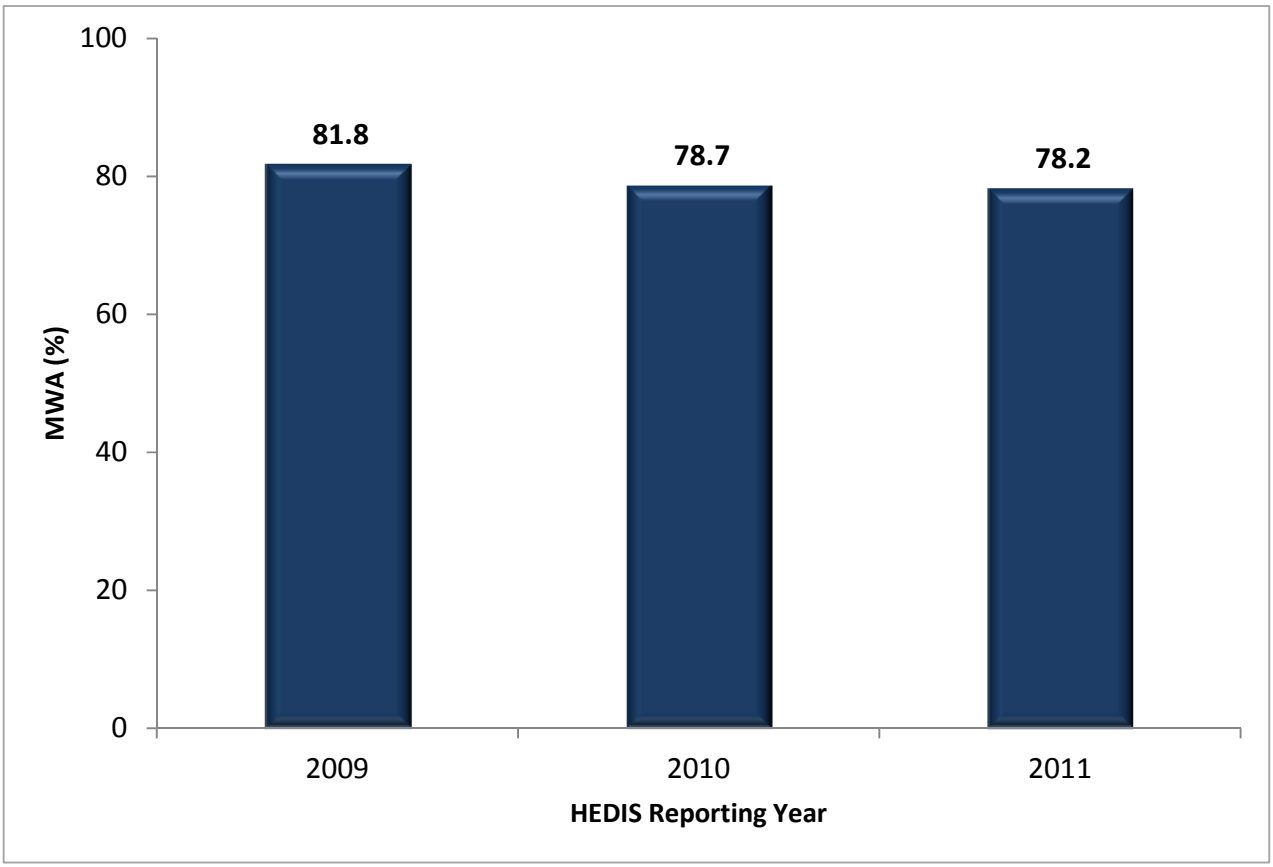
The Michigan Care Improvement Registry (MCIR), which was created in 1998 to collect immunization information, has grown to include more than 83 million vaccinations provided to 6.9 million people.[3-5] The MCIR allows providers to assess their patients' immunization levels, and gives local health departments the ability to perform targeted outreach to the areas most in need of increasing immunization rates.

[3-4] America's Health rankings. Michigan (2010). Available at http://www.americashealthrankings.org/yearcompare/2009/2010/MI.aspx. Accessed on August 22, 2011

[3-5] Michigan Care Improvement Registry. *Accomplishments*. Available at: http://www.mcir.org/accomplishments.html. Accessed on: August 22, 2011.

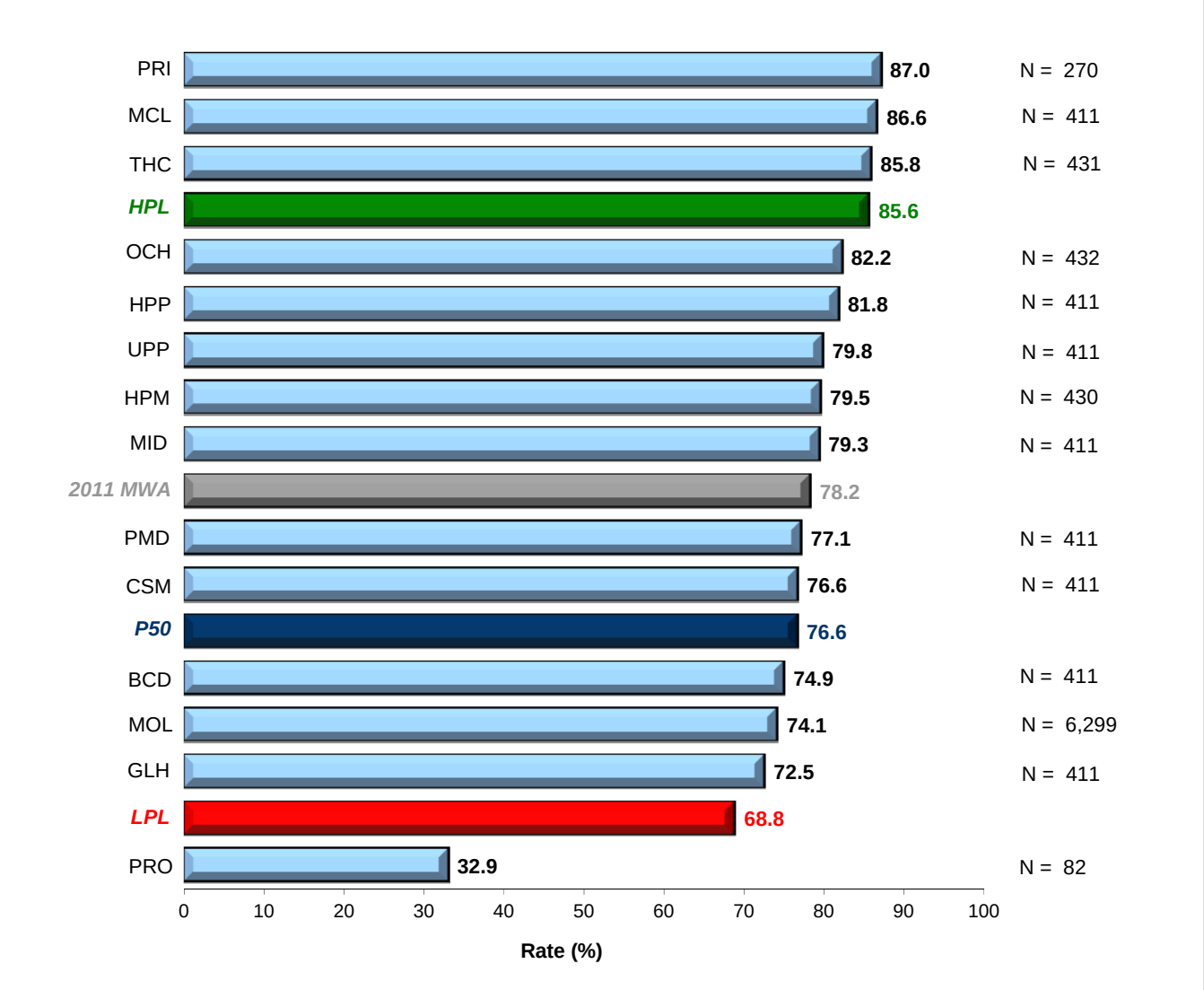
Performance Results

Figure 3-1—Childhood Immunization Status—Combination 2
Michigan Medicaid Weighted Averages



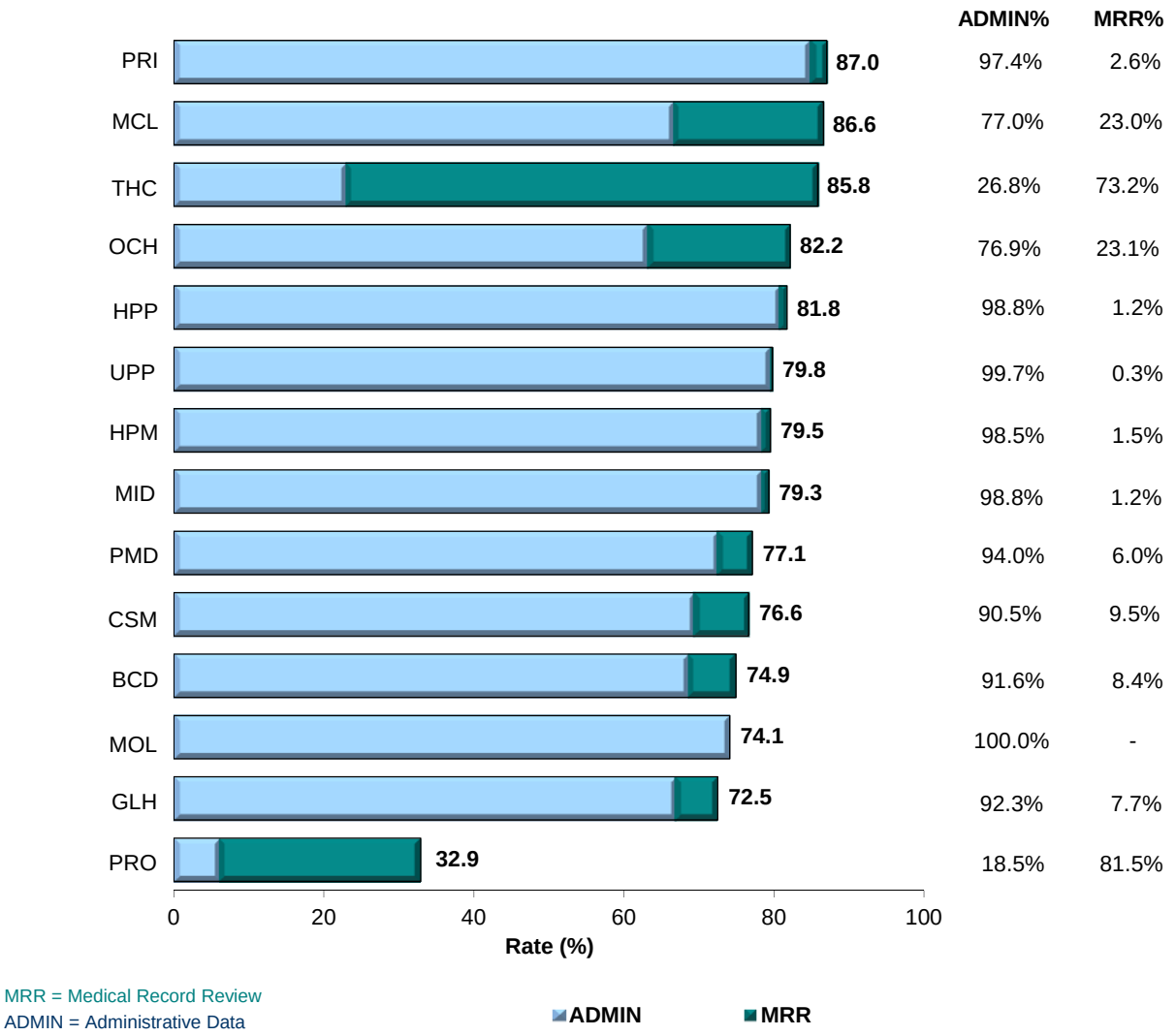
The HEDIS 2011 Michigan Medicaid weighted average for *Childhood Immunization Status—Combination 2* demonstrated a slight decline from previous years' results. The HEDIS 2011 weighted average decreased from the HEDIS 2009 and HEDIS 2010 weighted averages by 3.6 and 0.5 percentage points, respectively. Nonetheless, the decline from 2010 to 2011 was not statistically significant.

Figure 3-2—Childhood Immunization Status—Combination 2
Health Plan Ranking



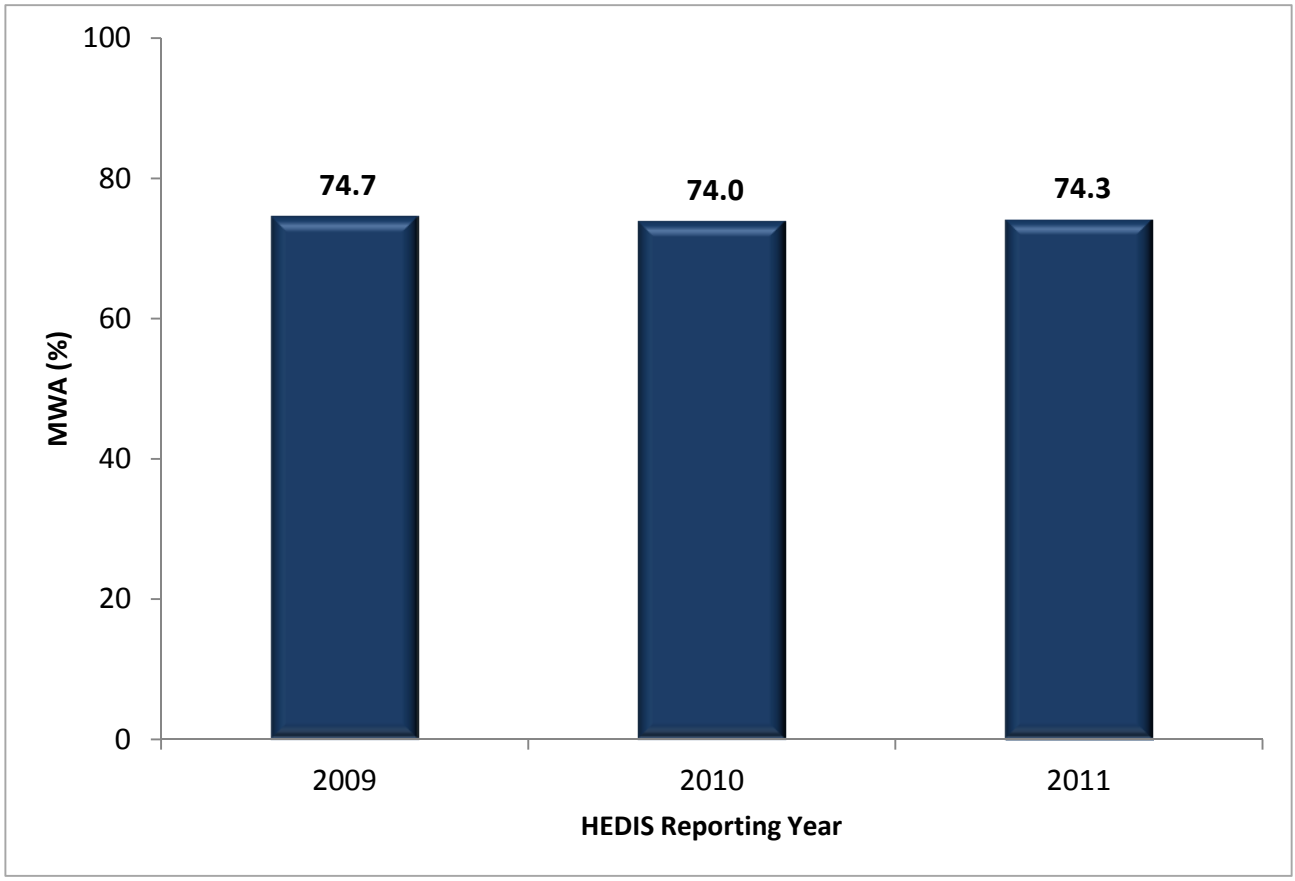
Three MHPs exceeded the HPL of 85.6 percent, and one MHP fell below the LPL of 68.8 percent. Ten MHPs, including the three that scored above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. The 2011 Michigan Medicaid weighted average of 78.2 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 1.6 percentage points.

Figure 3-3—Childhood Immunization Status—Combination 2
Data Collection Analysis



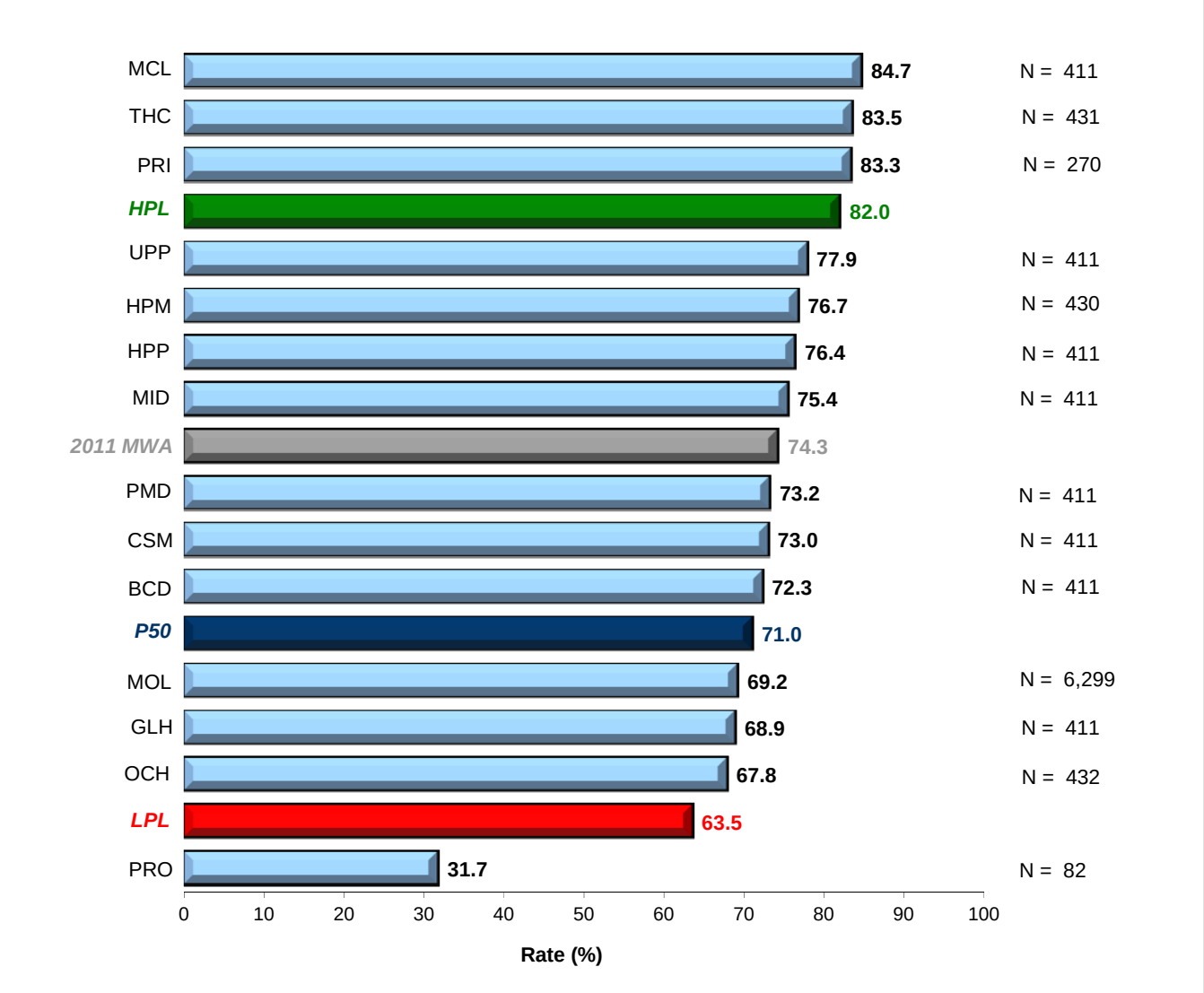
All but one MHP elected to use the hybrid method to report this measure. Of the thirteen plans using the hybrid method, five reported that at least 95 percent of the *Combo 2* rate was based on administrative data. For two MHPs, at least 70 percent of their reported rates were based on medical records.

Figure 3-4—Childhood Immunization Status—Combination 3
Michigan Medicaid Weighted Averages



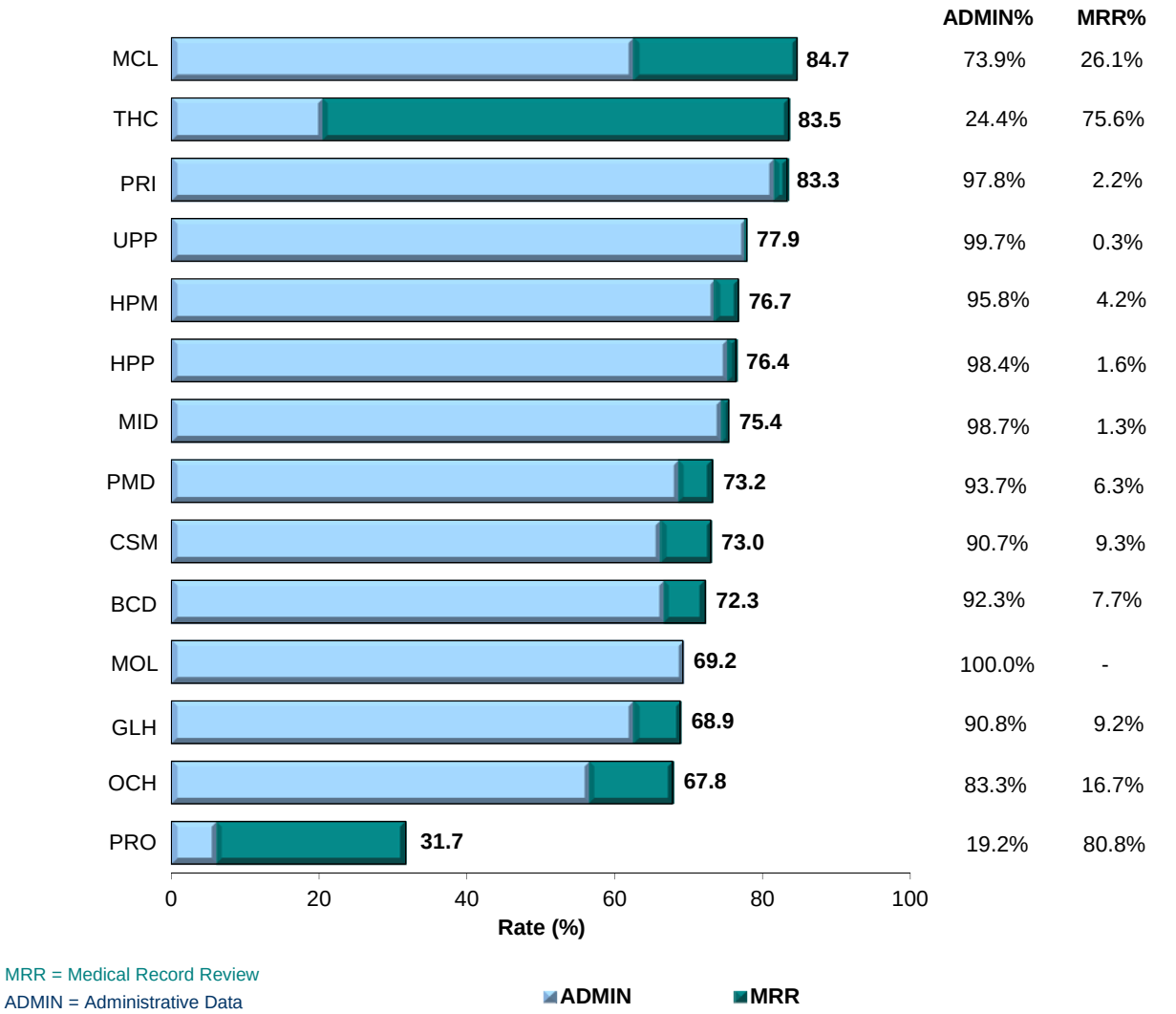
The HEDIS 2011 Michigan Medicaid weighted average for *Childhood Immunization Status—Combination 3* increased slightly from HEDIS 2010 (0.3 percentage point). This improvement, however, was not statistically significant. The current year's statewide rate was slightly below (0.4 percentage point) the HEDIS 2009 statewide rate.

Figure 3-5—Childhood Immunization Status—Combination 3
Health Plan Ranking



Three MHPs exceeded the HPL of 82.0 percent, and one fell below the LPL of 63.5 percent. Ten plans, including the three above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. The statewide weighted average was 3.3 percentage points above the national HEDIS 2010 Medicaid 50th percentile but 7.7 percentage points below the HPL.

Figure 3-6—Childhood Immunization Status—Combination 3
Data Collection Analysis



All but one MHP elected to use the hybrid method to report this measure. Of the thirteen plans using the hybrid method, five had at least 95 percent of their rates based on administrative data. Two MHPs had at least 70 percent of the reported rates based on medical records.

Immunizations for Adolescents

Measure Definition

Immunizations for Adolescents calculates the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their thirteenth birthday.

Importance

Immunization programs that focus on infants and children have been successful in combating vaccine-preventable diseases, but many adolescents and young adults continue to be adversely affected by several infectious diseases. For example, most of the estimated 43,000 new hepatitis B infections reported every year occur in adolescents and young adults.[3-6] Additionally, about 25–30 percent of reported pertussis cases occur in adolescents. Currently, CDC recommends that adolescents receive Tdap (for protection against tetanus, diphtheria, and pertussis); meningococcal conjugate; human papillomavirus (HPV); and influenza vaccines.[3-7] The CDC estimates that current U.S. vaccine coverage rates for adolescents are as follows:

- Forty-nine percent for one dose of HPV vaccine
- Sixty-three percent for meningococcal vaccine
- Sixty-nine percent for Tdap vaccine[3-8]

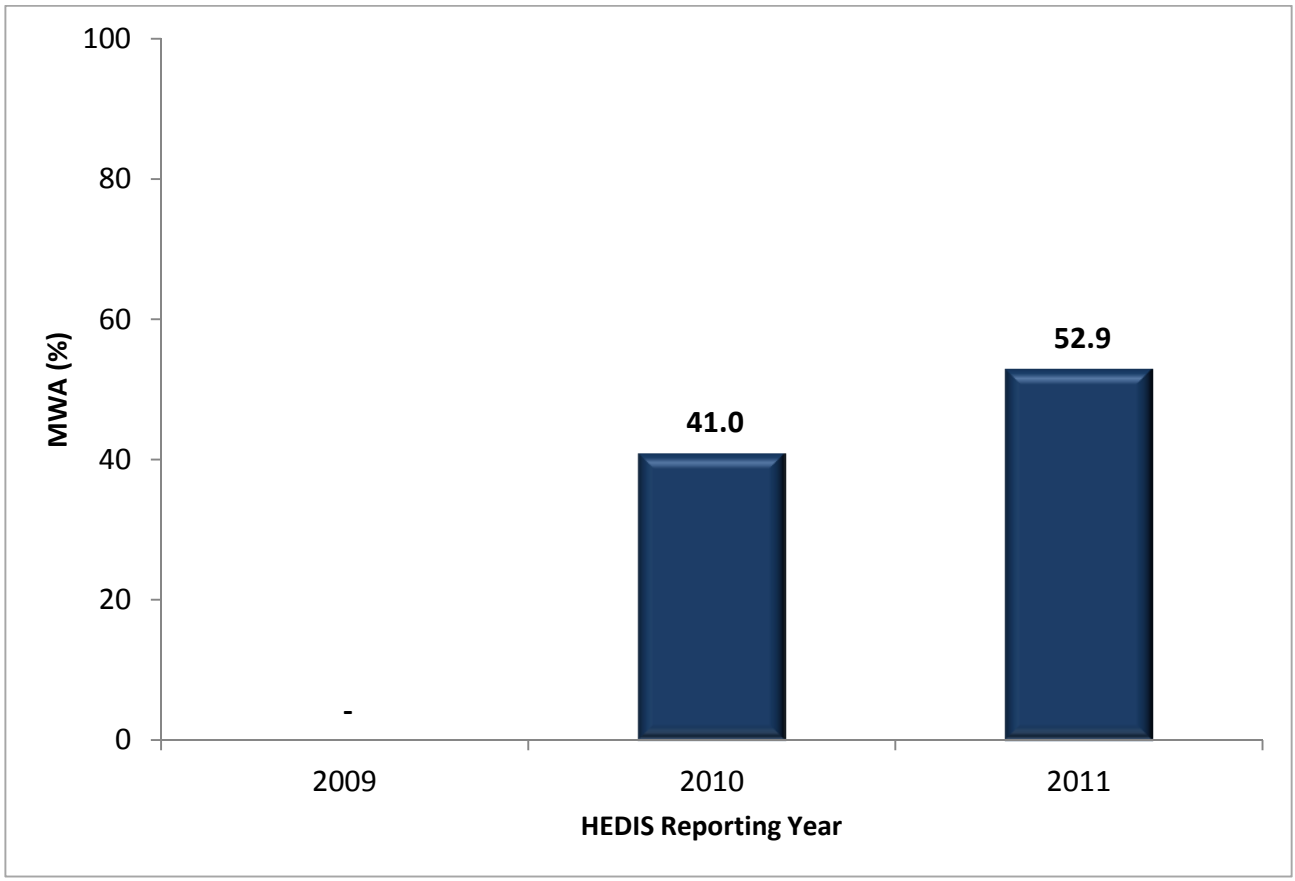
3-6 National Foundation for Infectious Diseases. Adolescent Immunization Questions & Answers. Available at: http://www.nfid.org/pdf/factsheets/adolescentqa.pdf. Accessed on September 19, 2011.

3-7 Centers for Disease Control and Prevention. Preteen and Teen Vaccines. Available at: http://www.cdc.gov/vaccines/who/teens/for-parents.html. Accessed on: September 19, 2011.

3-8 Centers for Disease Control and Prevention. Press release: National Survey Shows HPV Vaccine Rates Trail Other Teen Vaccines. Available at: http://www.cdc.gov/media/releases/2011/p0825_hpv_vaccine.html. Accessed on: September 19, 2011.

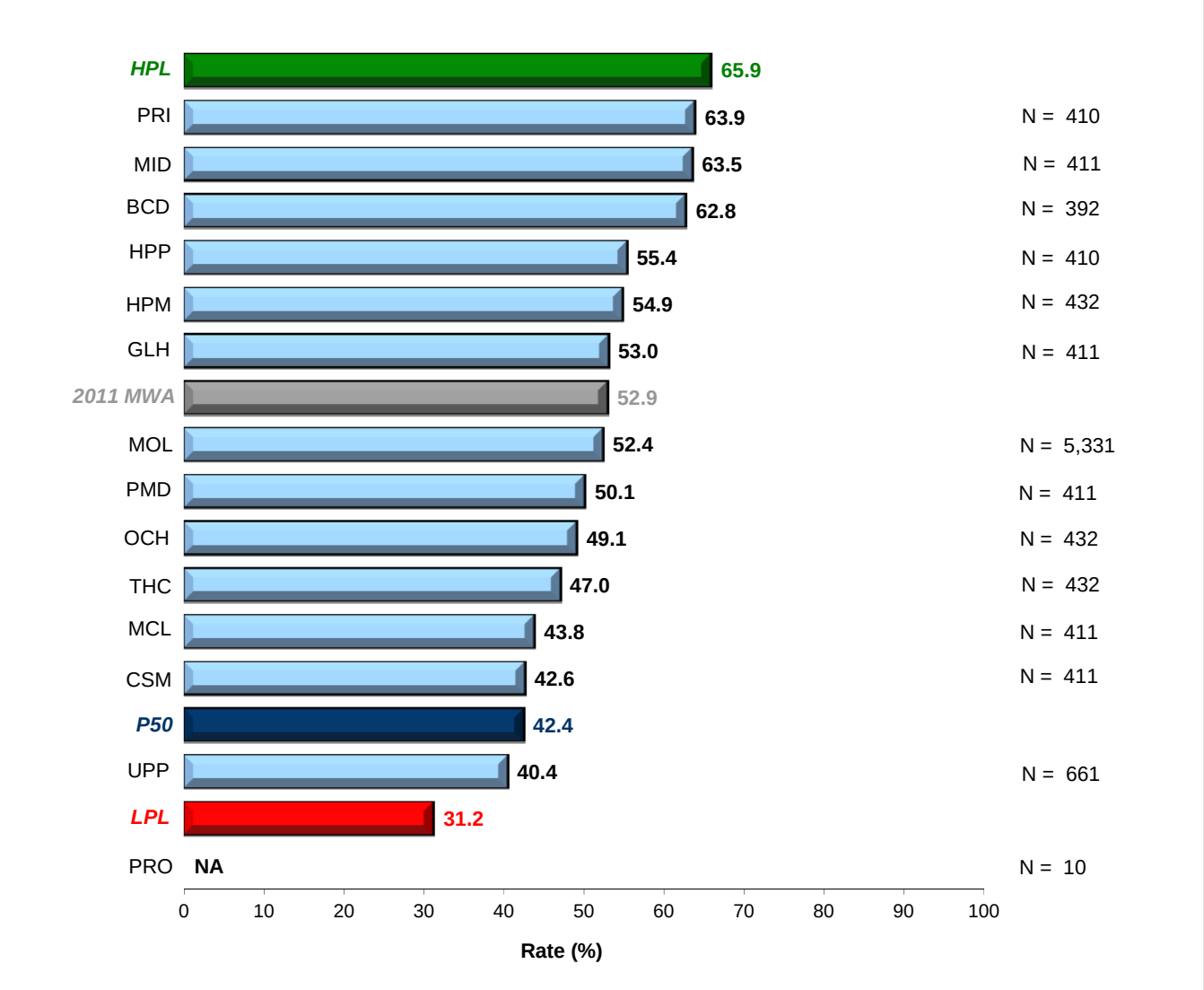
Performance Results

Figure 3-7—Immunizations for Adolescents—Combination 1
Michigan Medicaid Weighted Averages



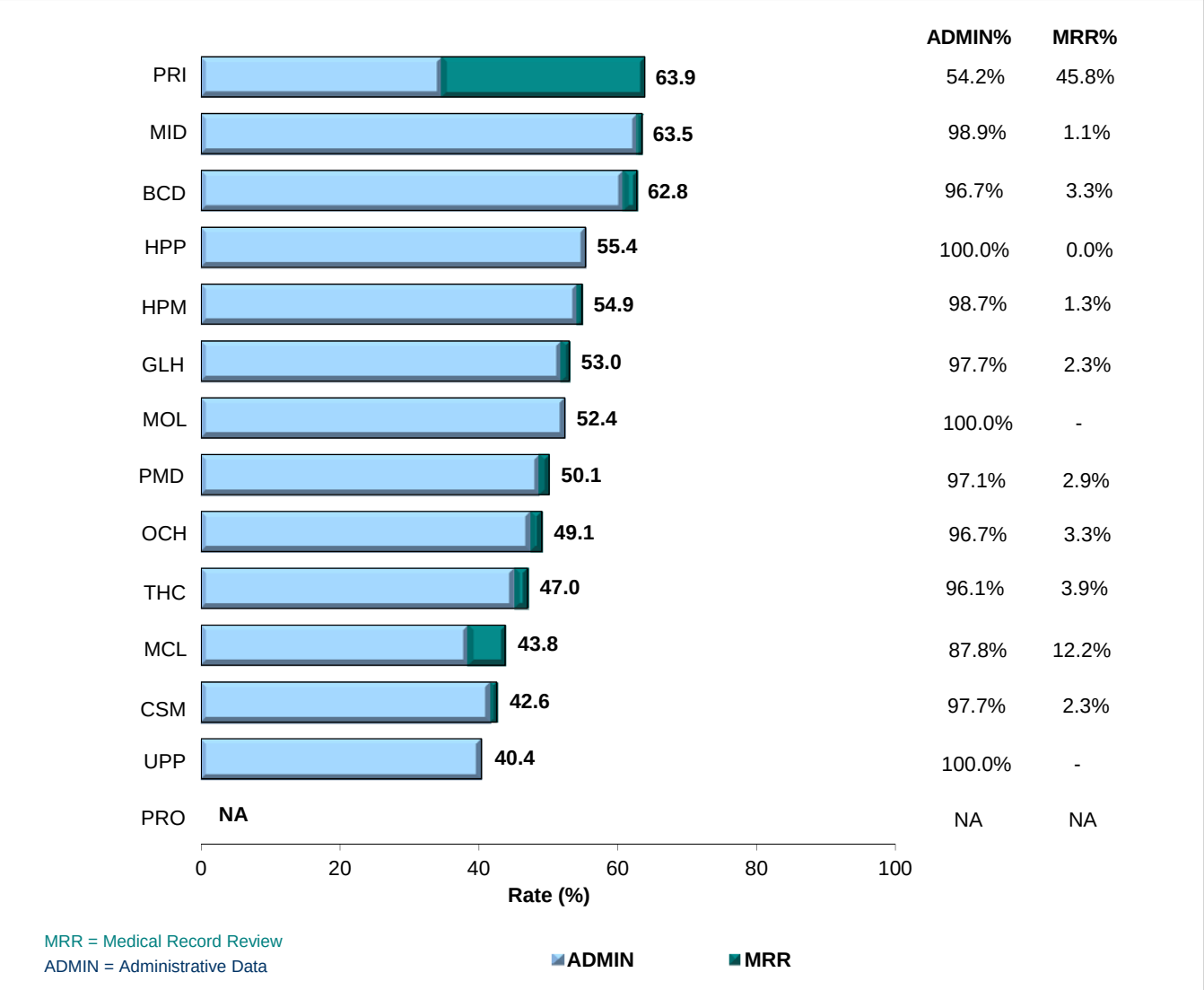
This measure was first reported for HEDIS 2010; therefore, a statewide weighted average for HEDIS 2009 was not available. Compared to HEDIS 2010, this year's statewide performance demonstrated a statistically significant improvement of more than 10 percentage points.

Figure 3-8—Immunizations for Adolescents—Combination 1
Health Plan Ranking



All but one MHP exceeded the national HEDIS 2010 Medicaid 50th percentile. The statewide weighted average (52.9 percent) exceeded the HEDIS 50th percentile by 10.5 percentage points. One MHP was unable to report a rate for this measure since the denominator was too small to report a valid rate (a denominator of less than 30).

Figure 3-9—Immunizations for Adolescents—Combination 1
Data Collection Analysis



All but two MHPs elected to use the hybrid method to report this measure. The majority of the plans relied primarily on administrative data to report this measure, with nine MHPs having at least 95 percent of their rates based on administrative data.

Lead Screening in Children

Measure Definition

Lead Screening in Children calculates the percentage of enrolled children who turned two 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 one or more capillary or venous blood tests for lead poisoning by their second birthday.

Importance

Elevated blood lead levels (BLLs) are a significant and preventable health issue that can adversely impact children's physical and mental health. Elevated BLLs can cause damage to a child's brain, kidneys, bone marrow, central nervous system, and other body systems. Today, there are approximately 24 million U.S. homes with deteriorating leaded paint and elevated levels of lead-containing dust.[3-9] Children younger than six years of age are most at risk for lead poisoning.[3-10]

While lead poisoning is on the decline, it is estimated that 250,000 U.S. children from 1 to 5 years of age have elevated blood lead levels (greater than 10 micrograms of lead per deciliter of blood).[3-11] Nationally, disparities still exist with regard to lead; children in low-income households, non-Hispanic African American children, and children living in housing built prior to 1950 have higher mean blood levels of lead.[3-12] However, despite these statistics, NCQA trending analysis estimates that only about six in 10 children are screened for lead poisoning.

It is estimated that environmental pollutants cost the United States approximately $55 billion per year; of this amount, more than $43 billion can be attributed to lead poisoning.[3-13] In addition, considering the damaging effects lead exposure can have on a young child's still-developing neurological system, it is plausible that childhood lead poisoning will affect social function, employment, and earnings in the long term.[3-14]

In Michigan, 1,403 children under six years of age had confirmed elevated BLLs in 2009.[3-15] This result represented 0.9 percent of children tested, and showed a decrease from the 2008 results of 1,686 children with elevated BLLs (1.1 percent of children tested).

3-9 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on: August 22, 2011.

3-10 Centers for Disease Control and Prevention. Lead: Prevention Tips. Available at: http://www.cdc.gov/nceh/lead/tips.htm. Accessed on: August 22, 2011.

3-11 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on: August 22, 2011.

3-12 Ibid.

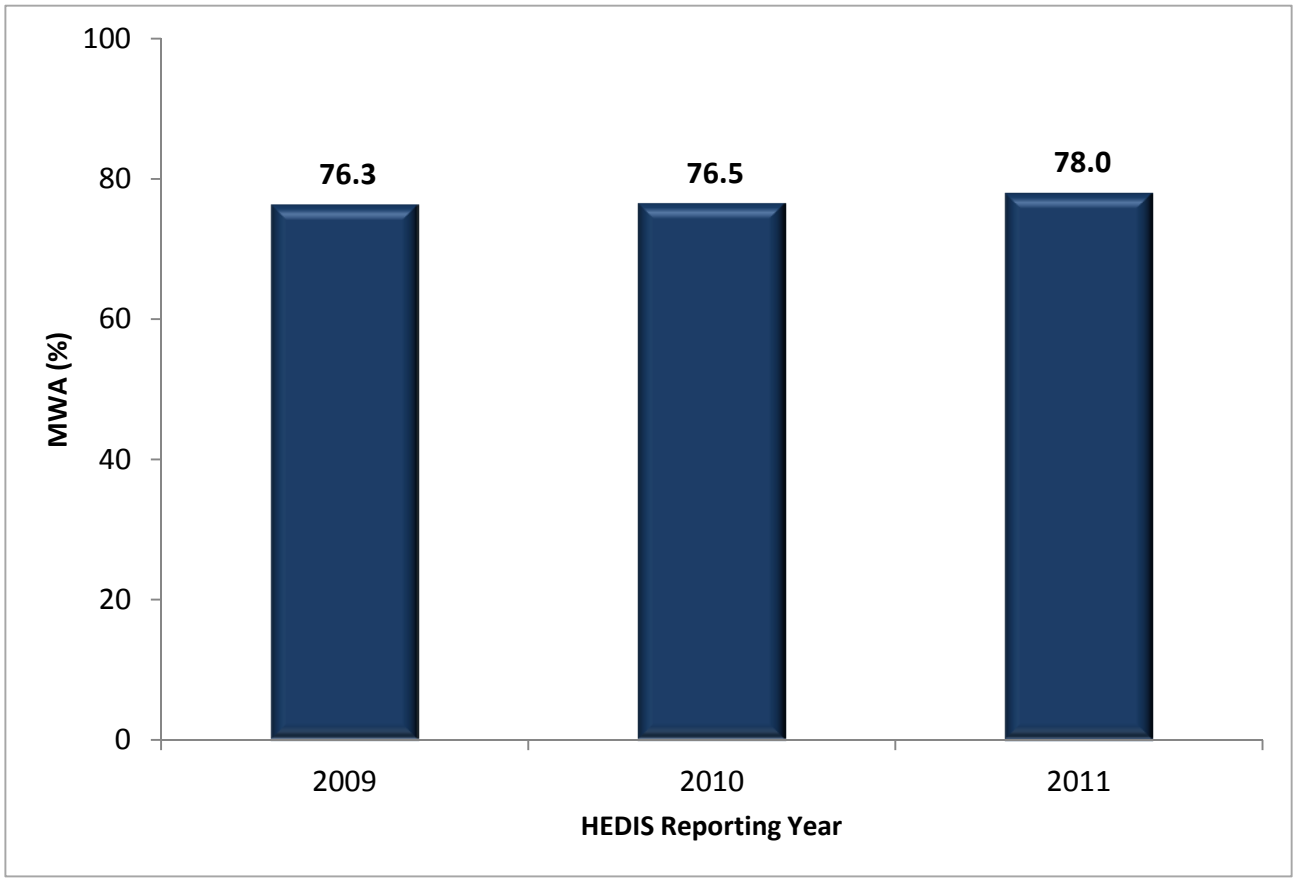
3-13 Ibid.

3-14 American Academy of Pediatrics. Committee on Environmental Health Lead Exposure in Children: Prevention, Detection, and Management. *Pediatrics*. 2005; 116(4): 1036–1046.

3-15 2009 Annual Report on Blood Lead Levels on Adults and Children in Michigan. Available at: http://www.oem.msu.edu/userfiles/file/Annual%20Reports/Lead/09ANNUALclpp-ablesCOMBINEDTimesR.pdf. Accessed on: August 22, 2011.

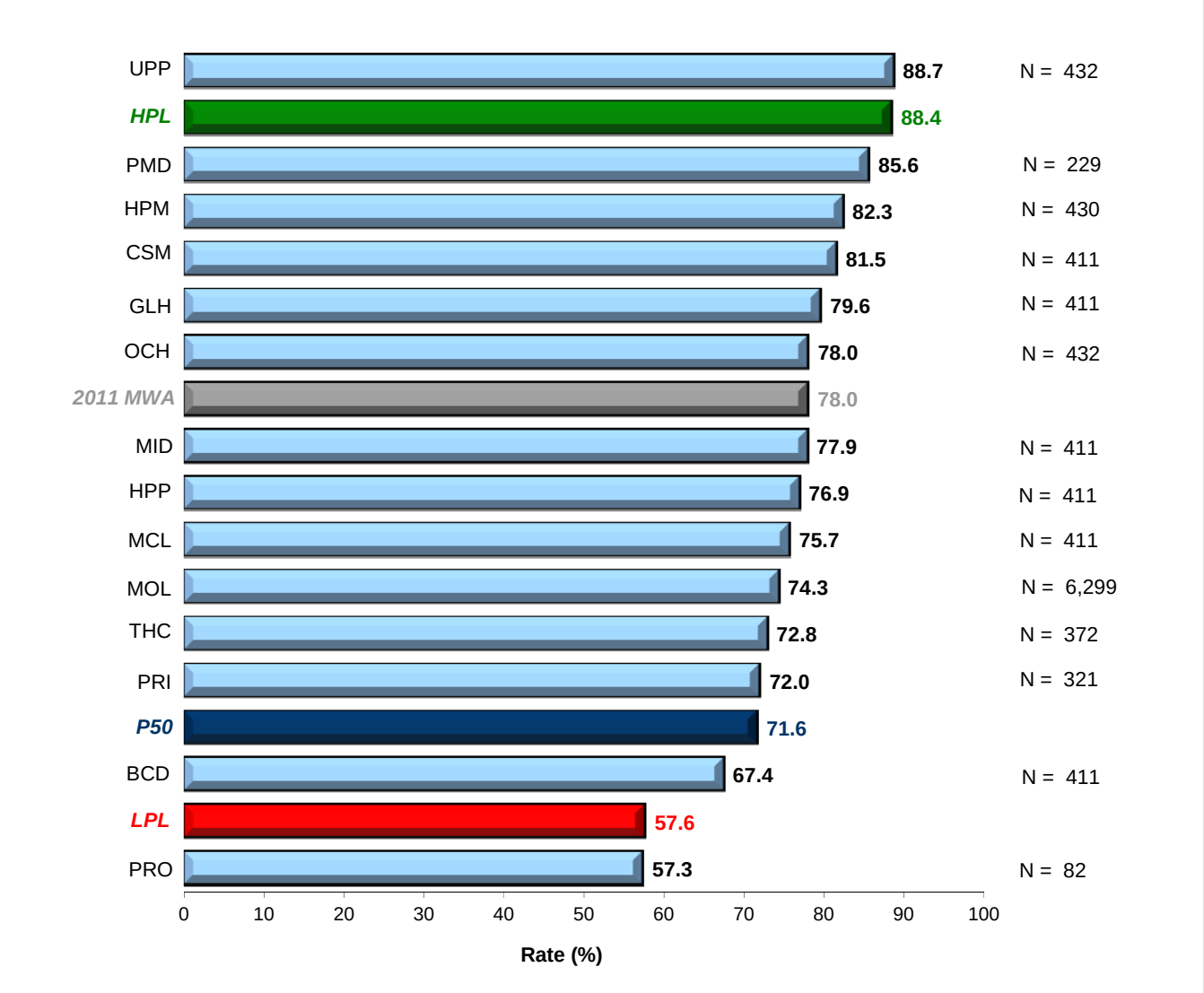
Performance Results

Figure 3-10—Lead Screening in Children
Michigan Medicaid Weighted Averages



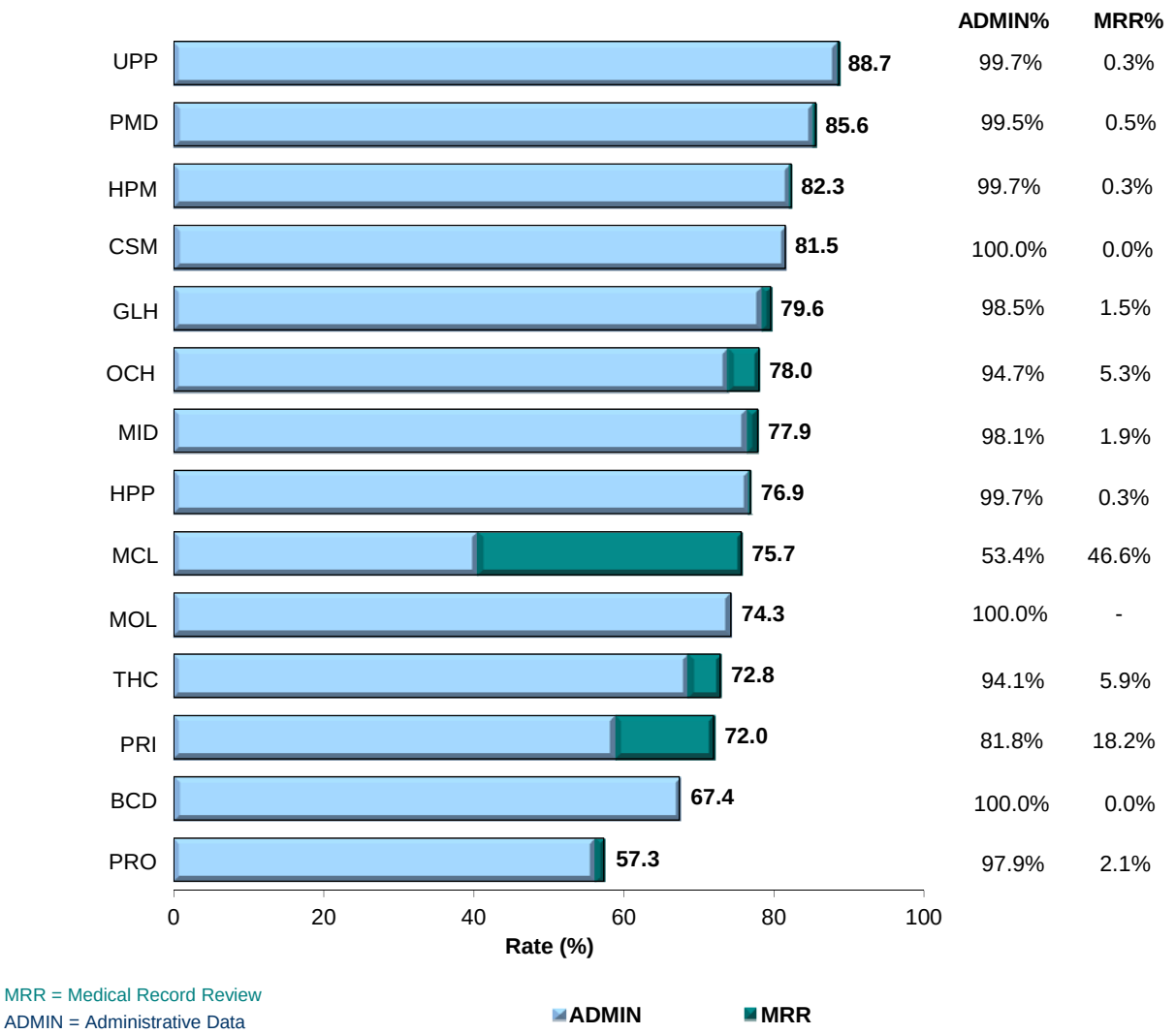
The Michigan Medicaid weighted averages for this measure demonstrated slight improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 1.7 and 1.5 percentage points, respectively. The observed improvement from last year was not statistically significant.

Figure 3-11—Lead Screening in Children
Health Plan Ranking



One MHP exceeded the HPL of 88.4 percent, and one fell below the LPL of 57.6 percent. All but two plans reported rates above the national HEDIS 2010 Medicaid 50th percentile. The 2011 Michigan Medicaid weighted average of 78.0 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 6.4 percentage points.

Figure 3-12—Lead Screening in Children
Data Collection Analysis



All but one MHP elected to use the hybrid method for this measure. Nine plans had at least 95 percent of their rates based on administrative data; only one plan had slightly over 50 percent of its rate derived from administrative data.

Well-Child Visits

Measure Definitions

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

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life calculates the percentage of members who were three, four, five, or six years old 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.

Importance

In order for practitioners to detect physical, developmental, behavioral, and emotional problems at an early stage, regular checkups are necessary. Well-child exams include many needed medical services important to the health and well-being of infants and children, such as vision, hearing, or lab services. Vaccinations are often performed as well, resulting in a reduction in disease and health costs over time. Timely preventive care in children has been shown to have a positive impact on overall health care utilization. Additionally, regular well-child visits result in fewer emergency room visits and avoidable hospitalizations.[3-16]

The American Medical Association (AMA) and the American Academy of Pediatrics (AAP) recommend timely, comprehensive well-child visits for children. These periodic checkups allow clinicians to assess a child's physical, behavioral, and developmental status and provide any necessary treatment, intervention, or referral to a specialist. There is evidence that timely preventive care in children has a positive impact on overall health care utilization. Researchers have found associations between increased well-child visits and reductions in avoidable hospitalizations, reductions in ED use, and improved child health.[3-17]

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, a complete physical exam, sensory screening (i.e., hearing and vision), a developmental assessment, health guidance/education, dental checks, and laboratory tests, including lead screenings.[3-18] These visits reduce a child's risk of reaching his or her teenage years with physical or 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.

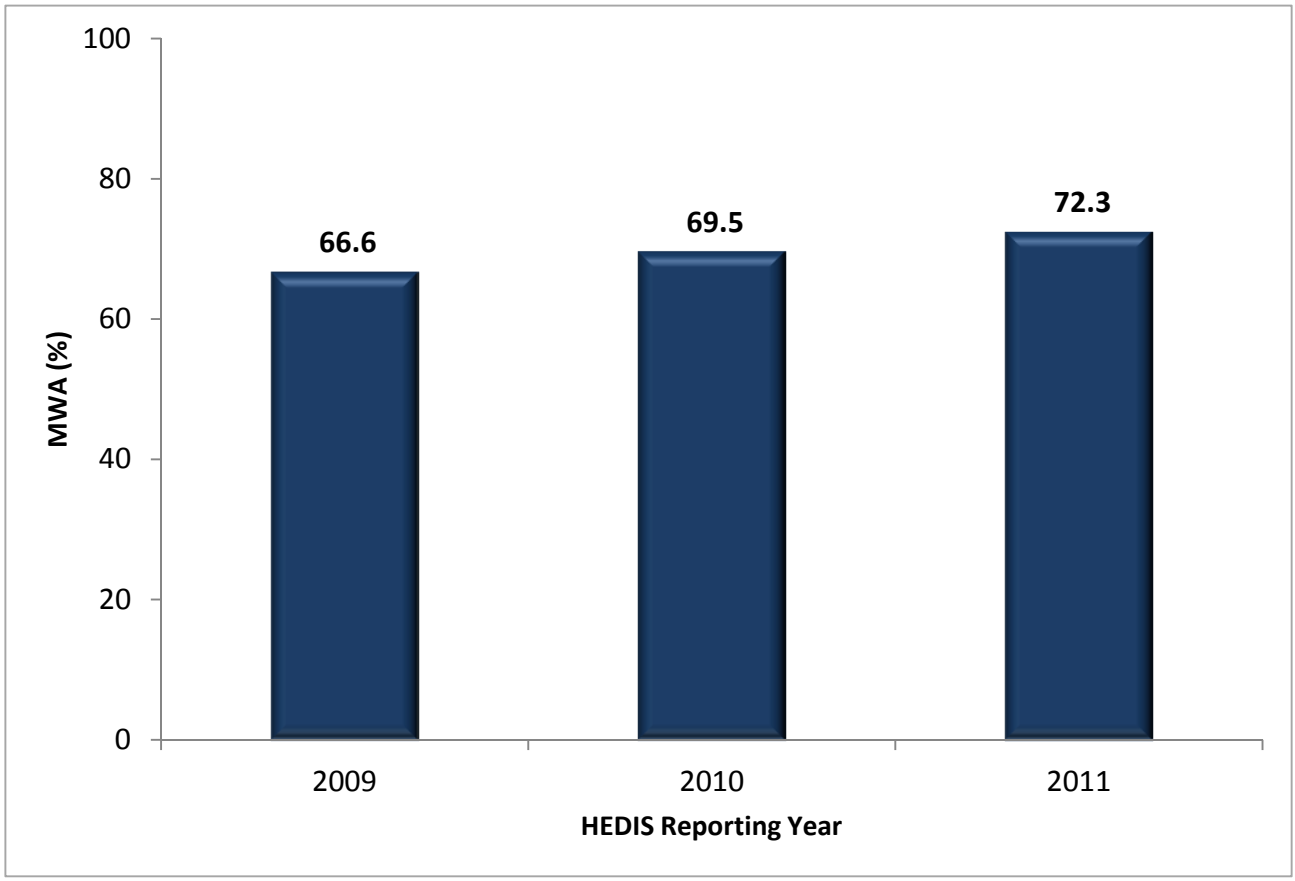
3-16 The Commonwealth Fund. Preventive Health and Dental Visits for Children and Adolescents. Available at: http://www.commonwealthfund.org/Performance-Snapshots/Preventive-Health-and-Dental-Care-Visits/Preventive-Health-and-Dental-Visits-for-Children-and-Adolescents.aspx. Accessed on: August 23, 2011.

3-17 Selden TM. Compliance with Well-Child Visit Recommendations: Evidence From the Medical Expenditure Panel Survey, 2000-2002. *Pediatrics.* 2006; 118(6): 1766–1778.

3-18 Human Services Research Institute. EPSDT: Supporting Children with Disabilities. Available at: http://www.spannj.org/cyshcn/core_outcome_4/EPSDT_Supporting_Children_with_Disabilities.pdf. Accessed on: September 7, 2011.

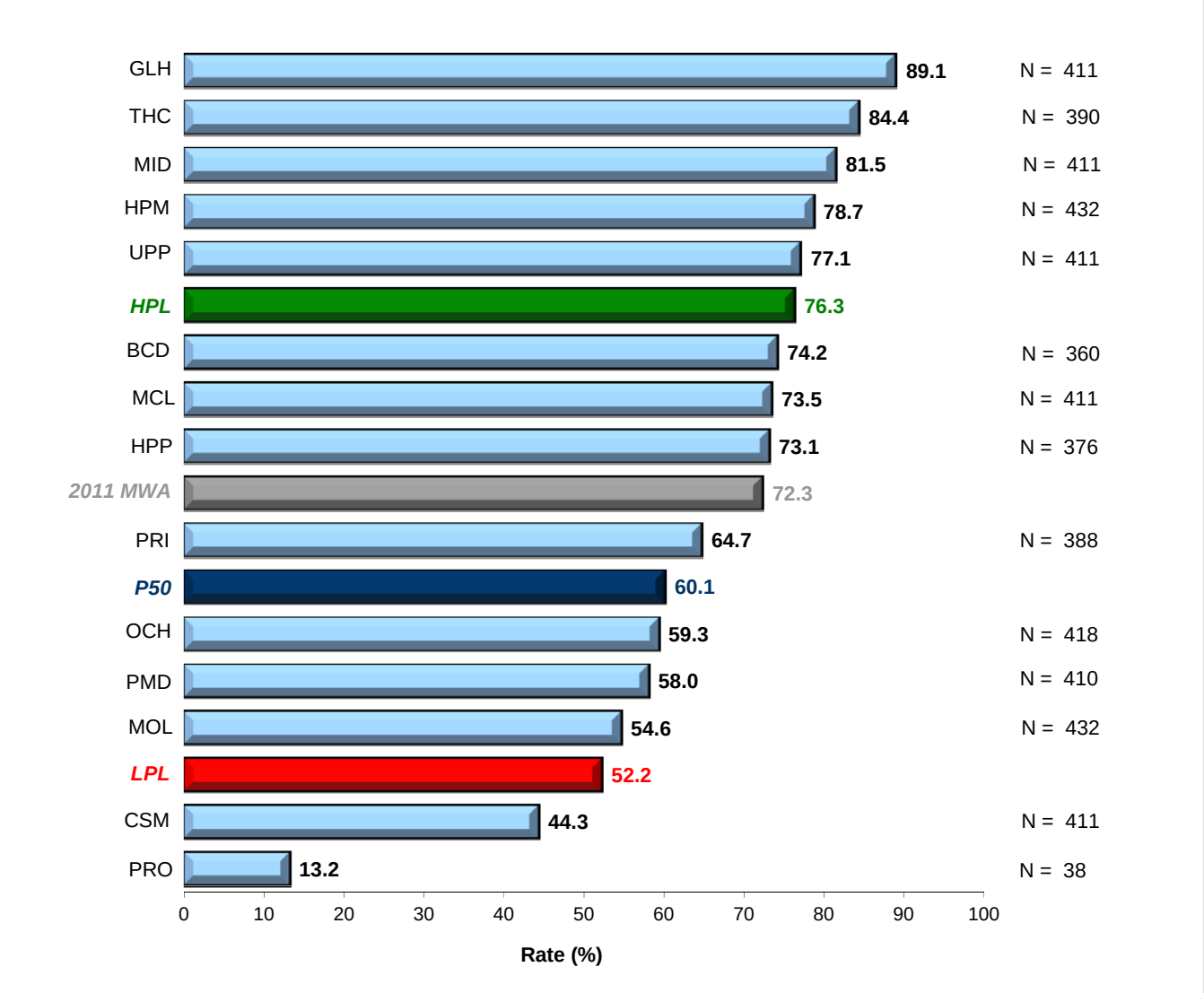
Performance Results

Figure 3-13—Well-Child Visits in the First 15 Months of Life—Six or More Visits
Michigan Medicaid Weighted Averages



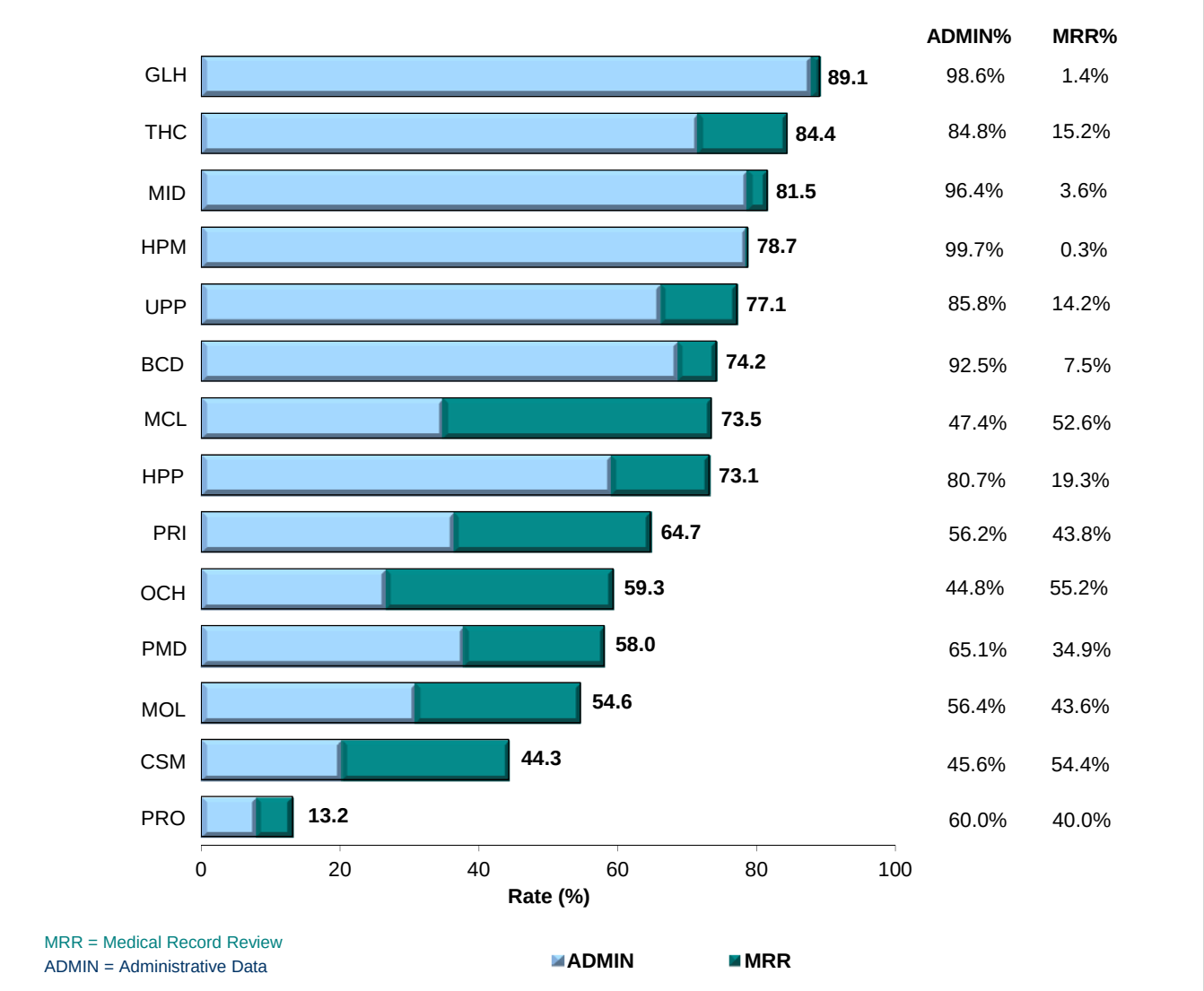
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated steady improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 5.7 and 2.8 percentage points, respectively. The observed improvement from last year was statistically significant.

Figure 3-14—Well-Child Visits in the First 15 Months of Life—Six or More Visits
Health Plan Ranking



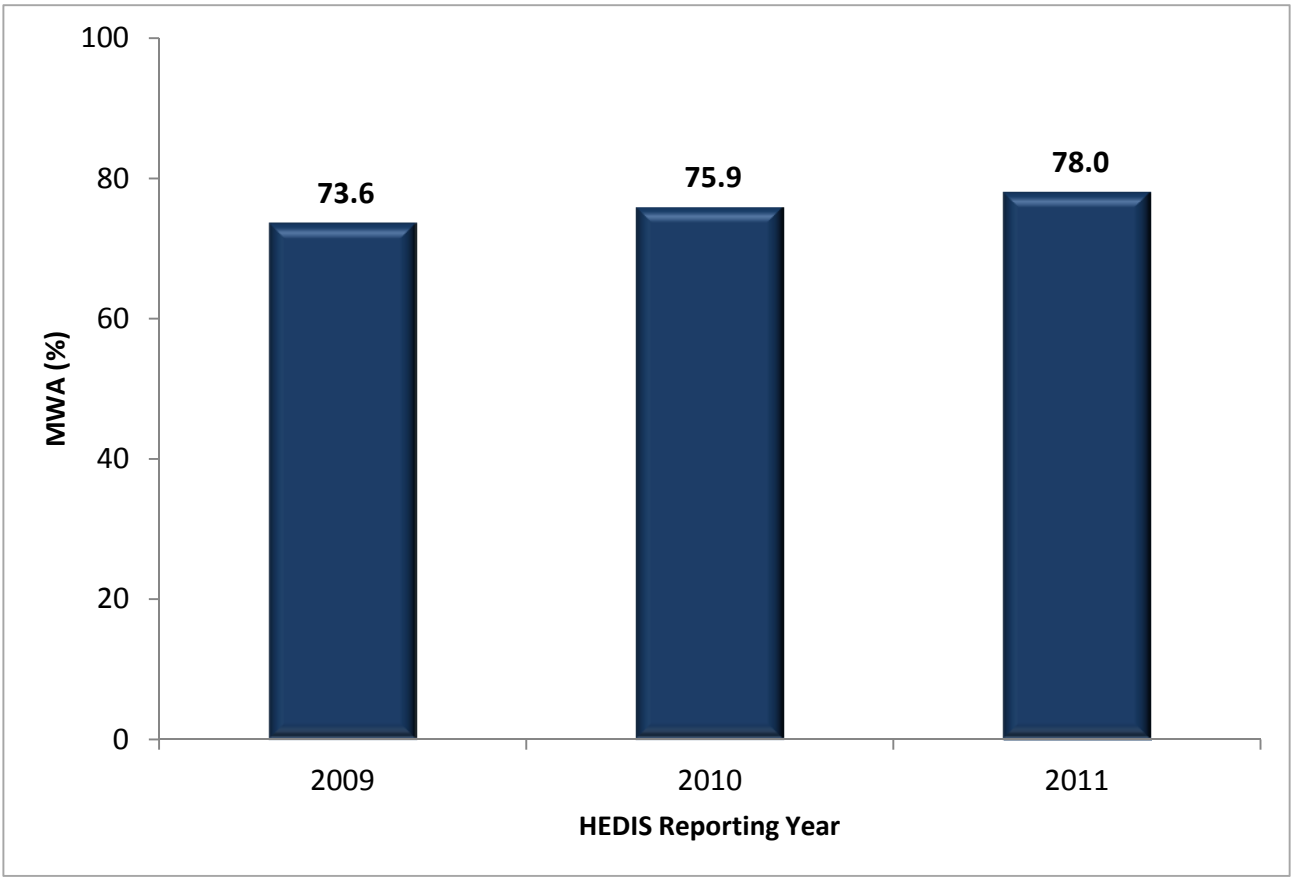
Five MHPs exceeded the HPL of 76.3 percent, and two fell below the LPL of 52.2 percent. Nine MHPs, including the five above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. The 2011 Michigan Medicaid weighted average of 72.3 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by more than 10 percentage points.

Figure 3-15—Well-Child Visits in the First 15 Months of Life—Six or More Visits Data Collection Analysis



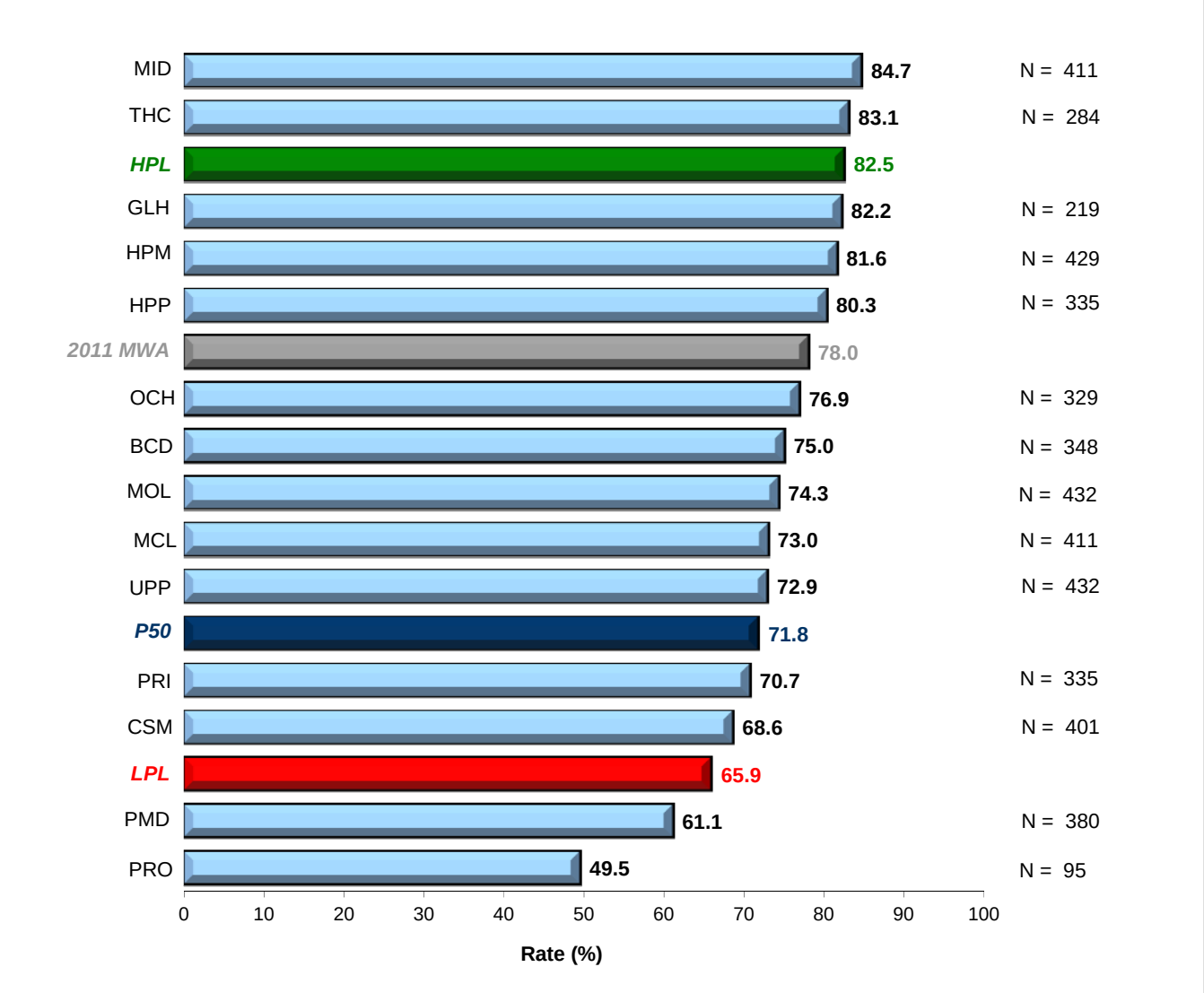
All MHPs elected to use the hybrid method for this measure, with only three reporting rates based on at least 95 percent of their administrative data. For three plans, at least 50 percent of their rates were based on medical record data. For this measure, plans reporting higher rates appeared to have more complete administrative data than those reporting lower rates.

Figure 3-16—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Michigan Medicaid Weighted Averages



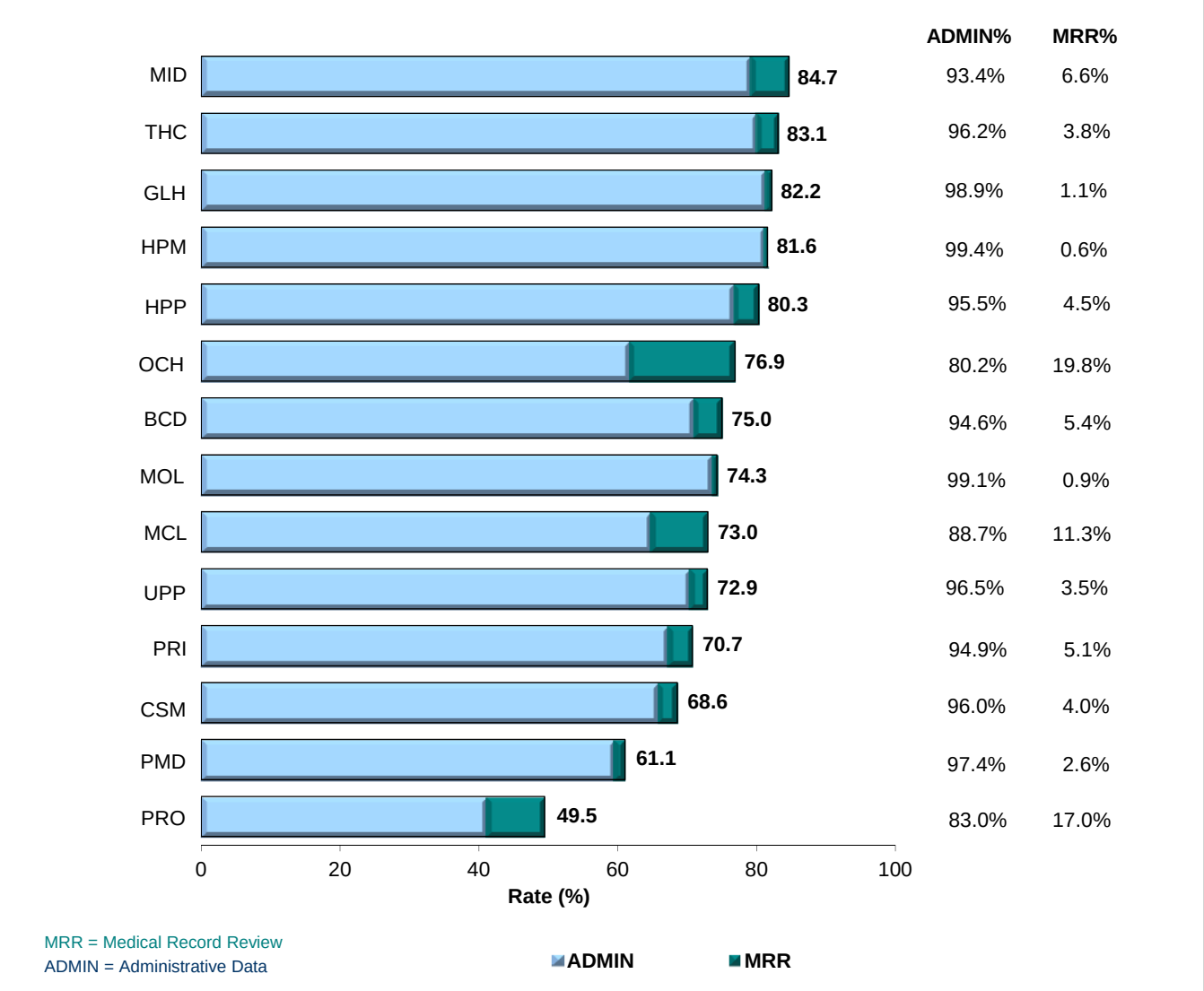
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated steady improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 4.4 and 2.1 percentage points, respectively. The observed improvement from last year was not statistically significant.

Figure 3-17—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Health Plan Ranking



Two MHPs exceeded the HPL of 82.5 percent, and two fell below the LPL of 65.9 percent. Ten MHPs, including the two above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 78.0 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 6.2 percentage points.

Figure 3-18—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life Data Collection Analysis



All MHPs elected to use the hybrid method for this measure. For eight of these plans, at least 95 percent of their rate was based on administrative data. For the remaining plans, less than 20 percent of the reported rate was based on medical record data.

Adolescent Well-Care Visits

Measure Definition

Adolescent Well-Care Visits 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 obstetrician/gynecologist (OB/GYN) during the measurement year.

Importance

The healthy transition from childhood to adolescence is critical to the well-being of children and the United States society. Understanding this transitional period is difficult and physicians can play a critical role in helping parents deal with physical, emotional, and social adolescent problems. Accidents, homicide, and suicide deaths increase dramatically between the first year of life and the thirteenth year of life and increase further in the 15–24 year age group.[3-19] While accidents are the largest cause of death for this age category, many of the other diseases or disorders including homicide and suicide are preventable. Physicians can help parents/guardians understand the root cause of many of these disorders including sexually transmitted diseases, substance abuse, pregnancy and antisocial behavior and work with the parents or other medical professionals to counsel young people about their behaviors and risks to their health.

Annual visits with a physician can reinforce health promotion messages, identify at-risk adolescents, and build relationships that foster open disclosure of future health information.[3-20] Furthermore, regular health care visits aid in the prevention, early diagnosis, and treatment of health care conditions so that the transition from youth to adulthood is a healthy one. The AMA's Guidelines for Adolescent Preventive Services recommend that all adolescents 11 to 21 years of age have an annual preventive services visit that focuses on both the biomedical and psychosocial aspects of health.[3-21] Adolescents, however, tend to have greater difficulty obtaining appropriate health care services on their own due to developmental characteristics and lack of experience negotiating medical systems. They often need specialized planning to respond to their needs for confidentiality, quality service, and coordination of care.[3-22]

3-19 U.S. Department of Health and Human Services. National Institutes of Health. MedlinePlus. *Death among children and adolescents*. Available at: http://www.nlm.nih/gov/medlineplus/ency/article/001915.htm. Accessed on: August 8, 2011.

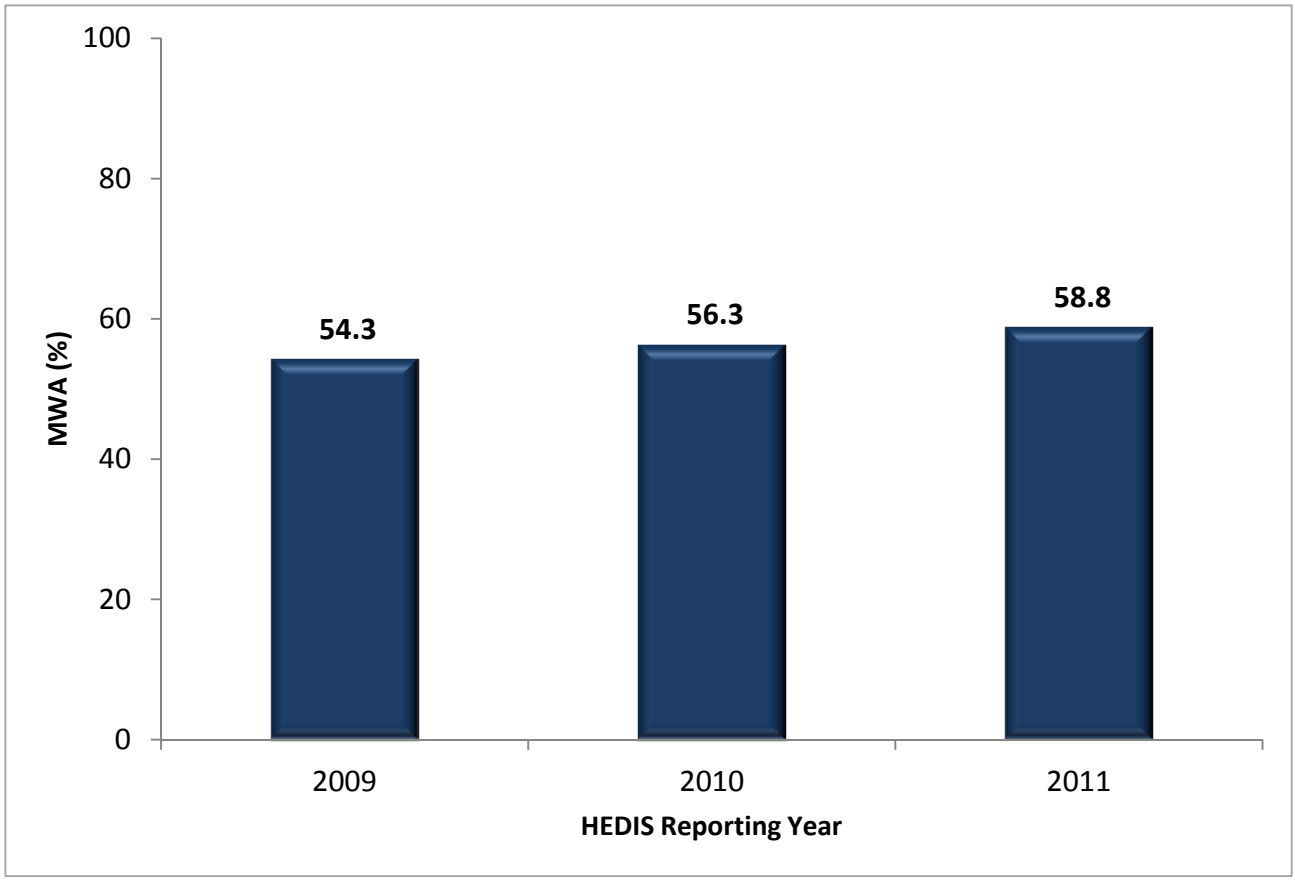
3-20 American Medical Association. Guidelines for Adolescent Preventive Services (GAPS). Available at: http://www.ama-assn.org/ama/upload/mm/39/gapsmono.pdf. Accessed on: August 3, 2011.

3-21 Ibid.

3-22 National Adolescent Health Information Center. Assuring the Health of Adolescents in Managed Care: A Quality Checklist for Planning and Evaluating Components of Adolescent Health Care. Available at: http://nahic.ucsf.edu/downloads/Assuring_Hlth_Checklist.pdf. Accessed on: August 3, 2011.

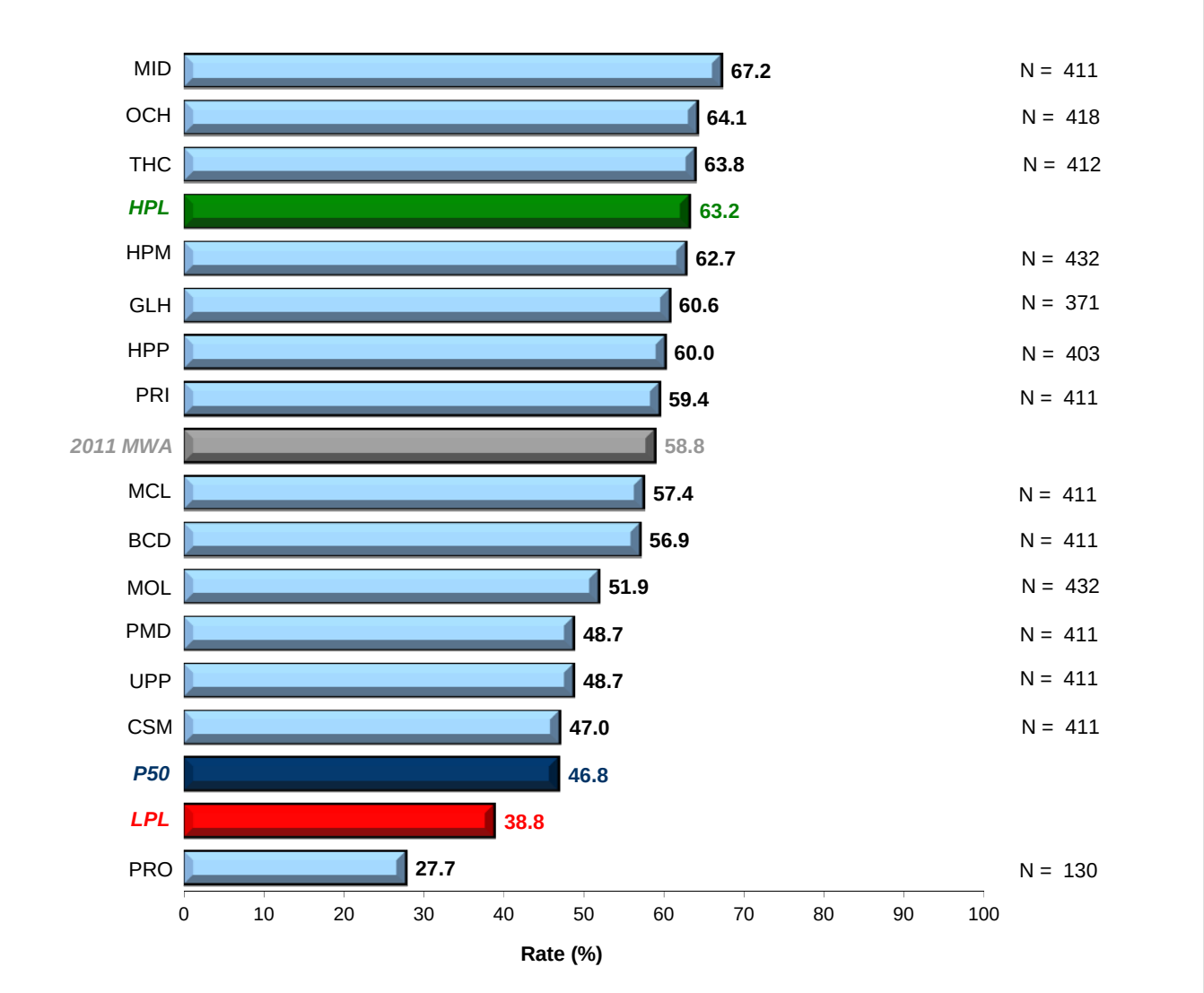
Performance Results

Figure 3-19—Adolescent Well-Care Visits
Michigan Medicaid Weighted Averages



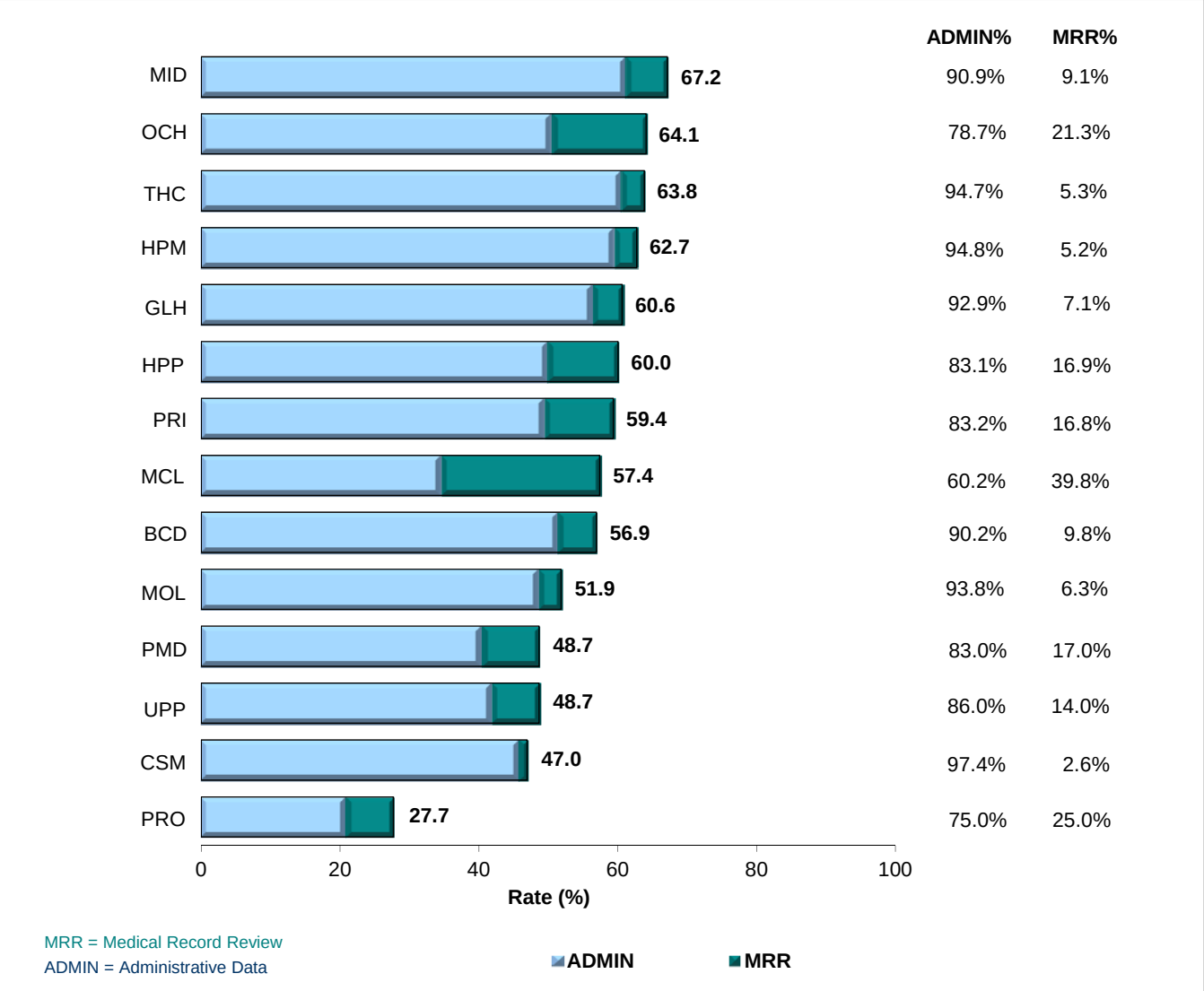
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated steady improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 4.5 and 2.5 percentage points, respectively. The observed improvement from last year was not statistically significant.

Figure 3-20—Adolescent Well-Care Visits
Health Plan Ranking



Three MHPs exceeded the HPL of 63.2 percent, and one fell below the LPL of 38.8 percent. With the exception of this one plan, all others reported rates above the national HEDIS 2010 Medicaid 50th percentile. The 2011 Michigan Medicaid weighted average of 58.8 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 12.0 percentage points.

Figure 3-21—Adolescent Well-Care Visits
Data Collection Analysis



All MHPs elected to use the hybrid method for this measure. All plans had at least 60 percent of the reported rate based on administrative data. One plan had at least 95 percent of its rate based on administrative data.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Measure Definition

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents reports the percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation during the measurement year.

Importance

Childhood obesity has many physical consequences including glucose intolerance and insulin resistance, type 2 diabetes, hypertension, sleep apnea, impaired balance and orthopedic problems.[3-23] In addition, childhood obesity has a social stigma and can cause emotional and social consequences including low self-esteem, negative body image, depression and discrimination.[3-24]

Daily participation in physical education classes dropped from 42 percent in 1991 to 33 percent in 2005, supporting research that approximately two thirds of young people in grades 9 through 12 do not engage in the recommended levels of physical activity. The following statistics show increases in childhood obesity for the last 30 years.[3-25]

- Children ages 2 to 5 years of age, an increase of 8.9 percentage points
- Children ages 6 to 11 years of age, an increase of 12.3 percentage points
- Children ages 12 to 19 years of age, an increase of 12.4 percentage points

For these reasons, it is essential that children and adolescents in the United States receive adequate weight assessment and counseling for nutrition and physical activity. The first step involves screening for overweight and obesity in physicians' offices with the calculation of a BMI. BMI is a useful screening tool for assessing and tracking the degree of obesity among children and adolescents. To address the lack of physical activity and nutritional education among children and adolescents in the United States, health care providers should promote regular physical activity and healthy eating, as well as assist parents to create an environment that supports these healthy habits.[3-26]

3-23 National Committee for Quality Assurance. *The State of Health Care Quality in 2010*. Washington, D.C.:NCQA; 2010

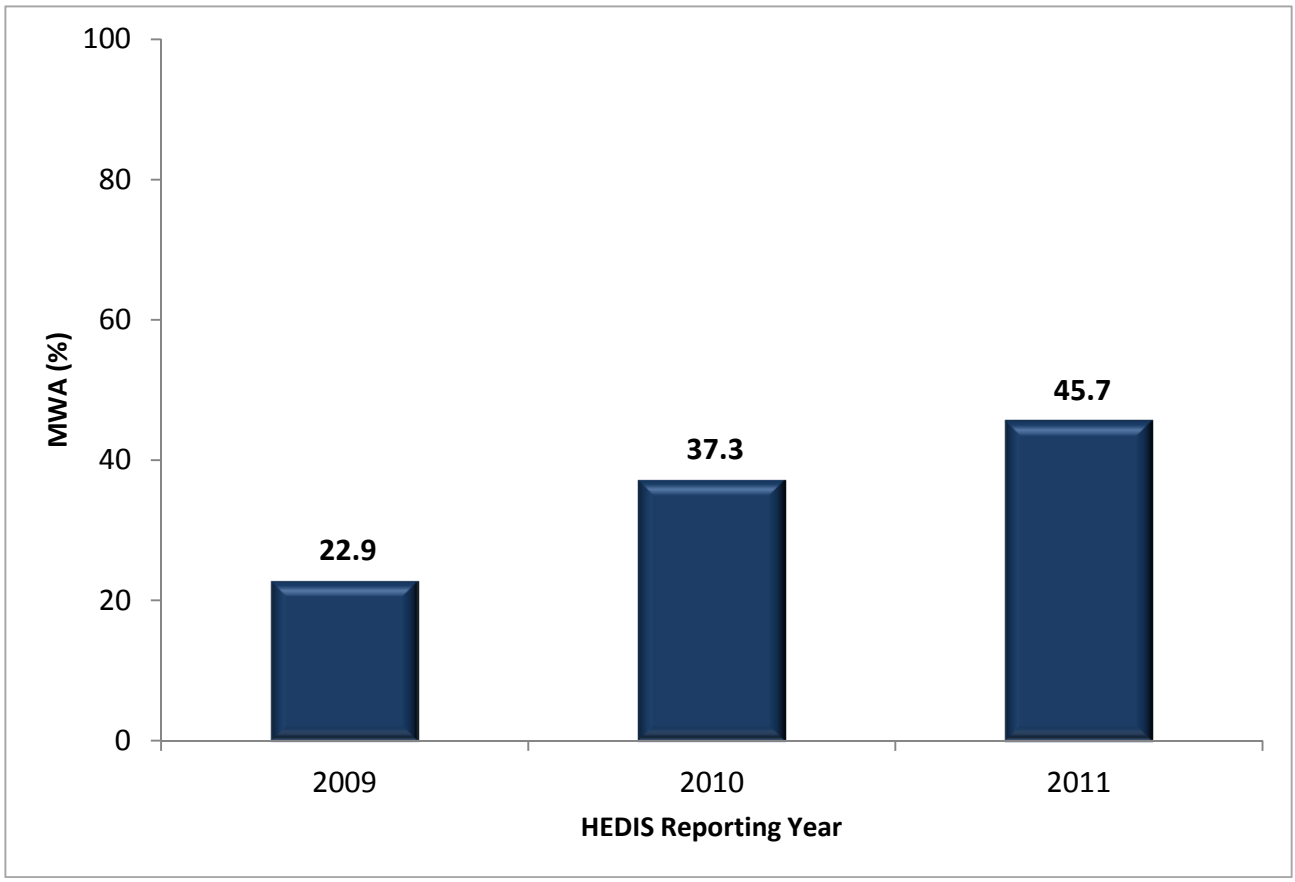
3-24 Ibid.

3-25 National Quality Measures Clearinghouse. Weight assessment and counseling for nutrition and physical activity for children and adolescent measure summary. Available at: http://www.qualitymeasures.ahrq.gov/content.aspx?id=32369&search=weight+assessment+and+counseling+for+nutrition+and+physical+activity+for+children. Accessed on: August 8, 2011.

3-26 U.S. Department of Health and Human Services. *Physical Activity and Health: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 1996.

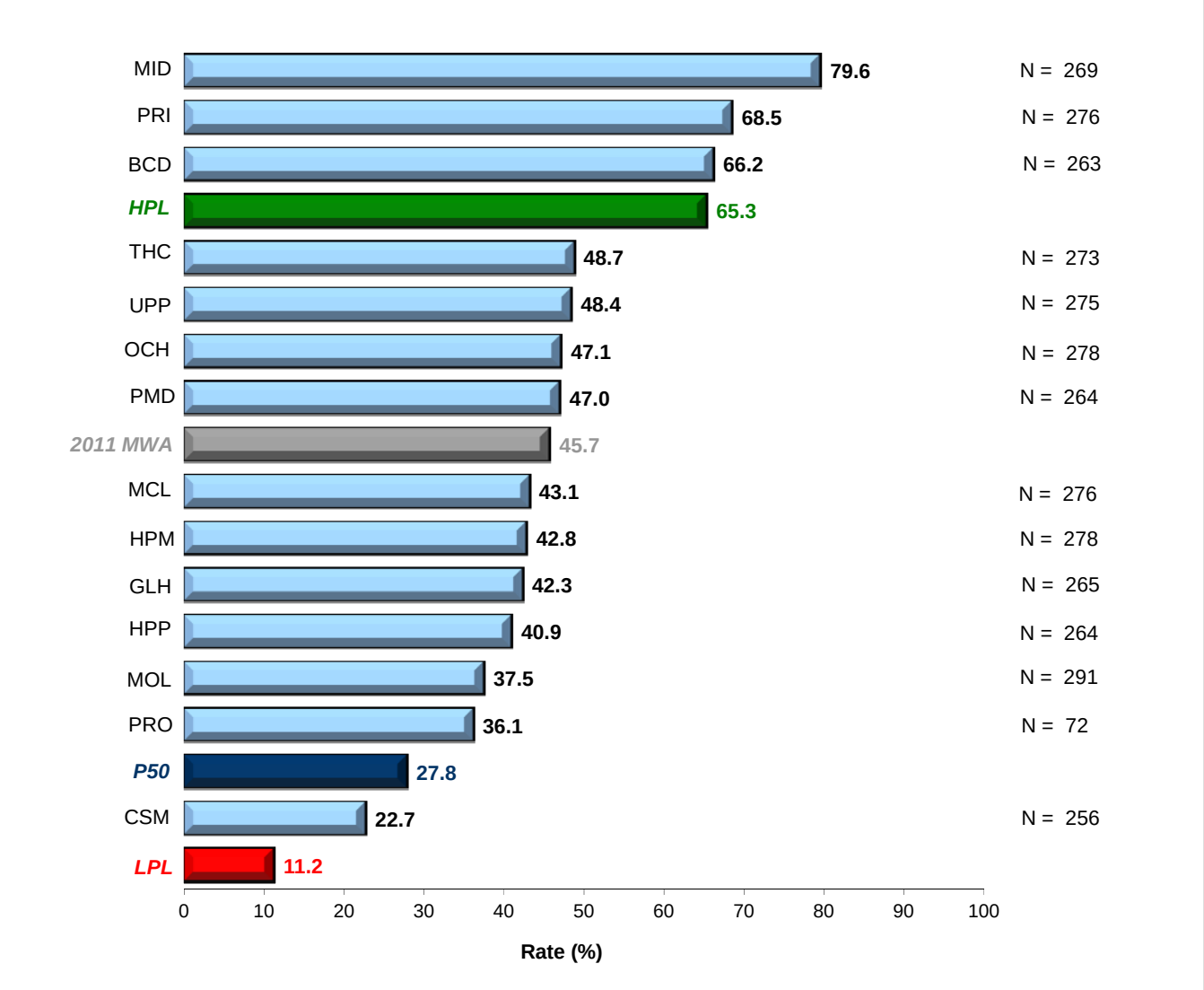
Performance Results

Figure 3-22—Weight Assessment for Children/Adolescents
BMI Percentile—3 to 11 Years
Michigan Medicaid Weighted Averages



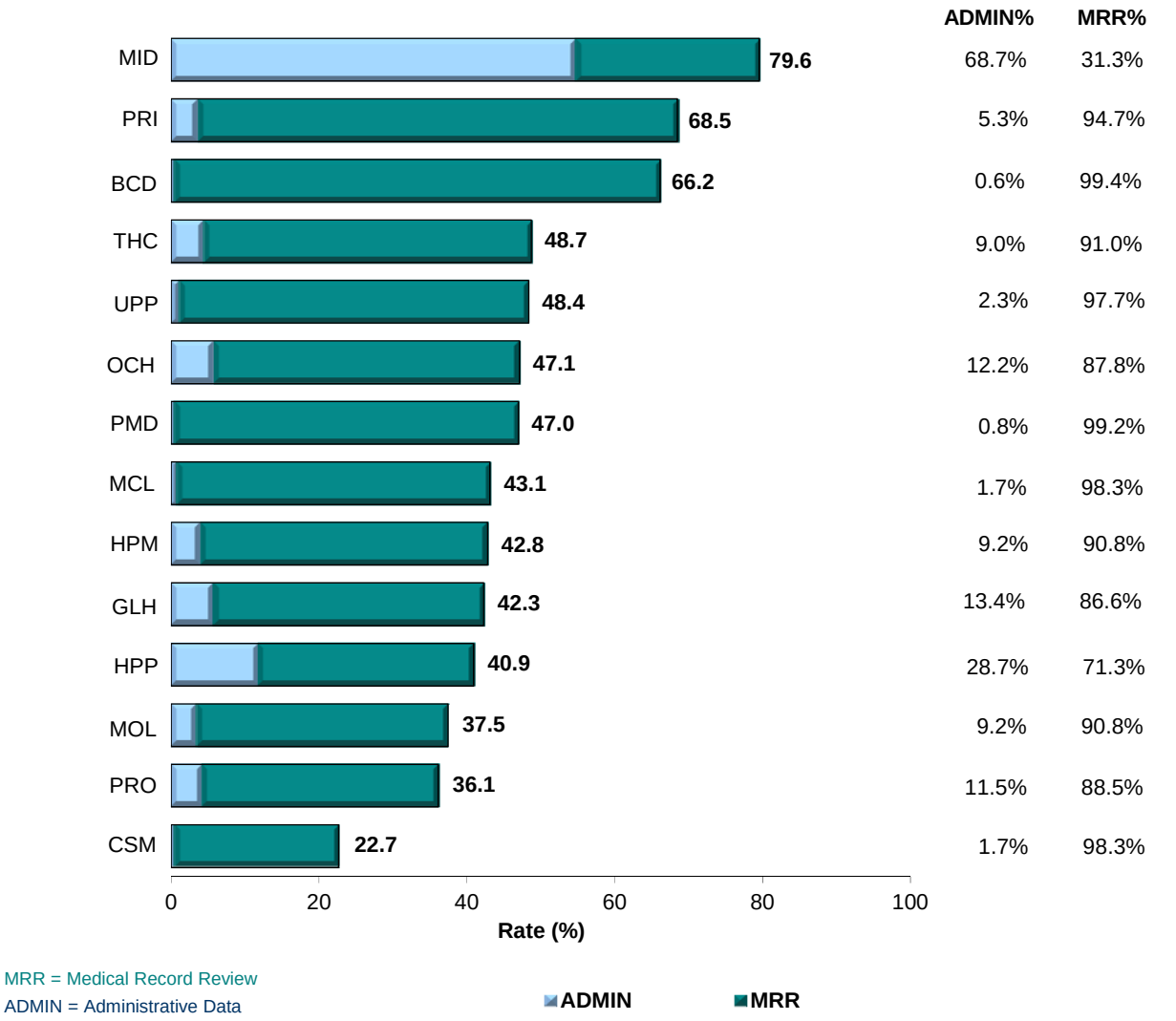
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated notable improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 22.8 and 8.4 percentage points, respectively. The observed improvement from last year was statistically significant.

Figure 3-23—Weight Assessment for Children/Adolescents
BMI Percentile—3 to 11 Years
Health Plan Ranking



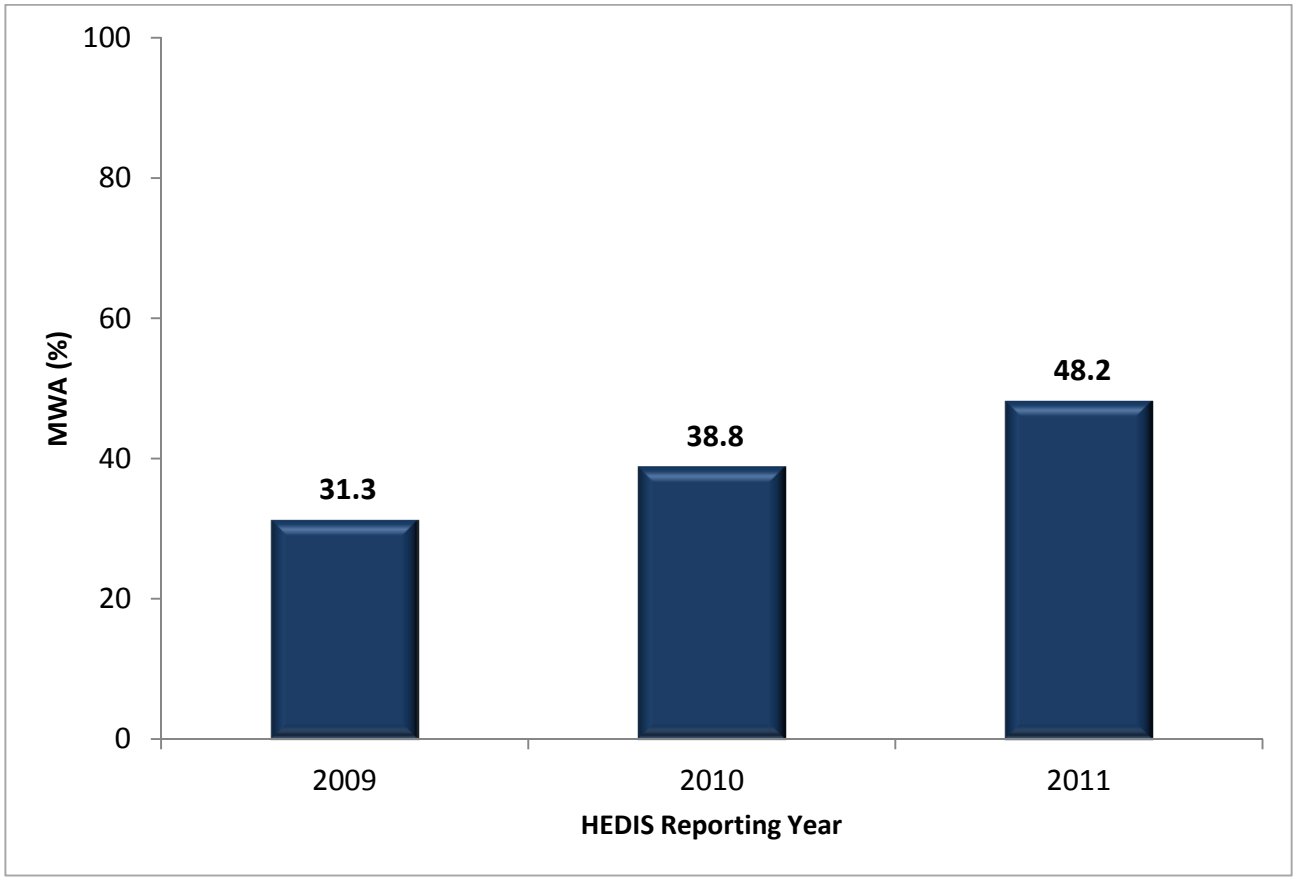
Three MHPs exceeded the HPL of 65.3 percent, and none of the MHPs performed below the LPL of 11.2 percent. All but one plan reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 45.7 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 17.9 percentage points.

Figure 3-24—Weight Assessment for Children/Adolescents
BMI Percentile—3 to 11 Years
Data Collection Analysis



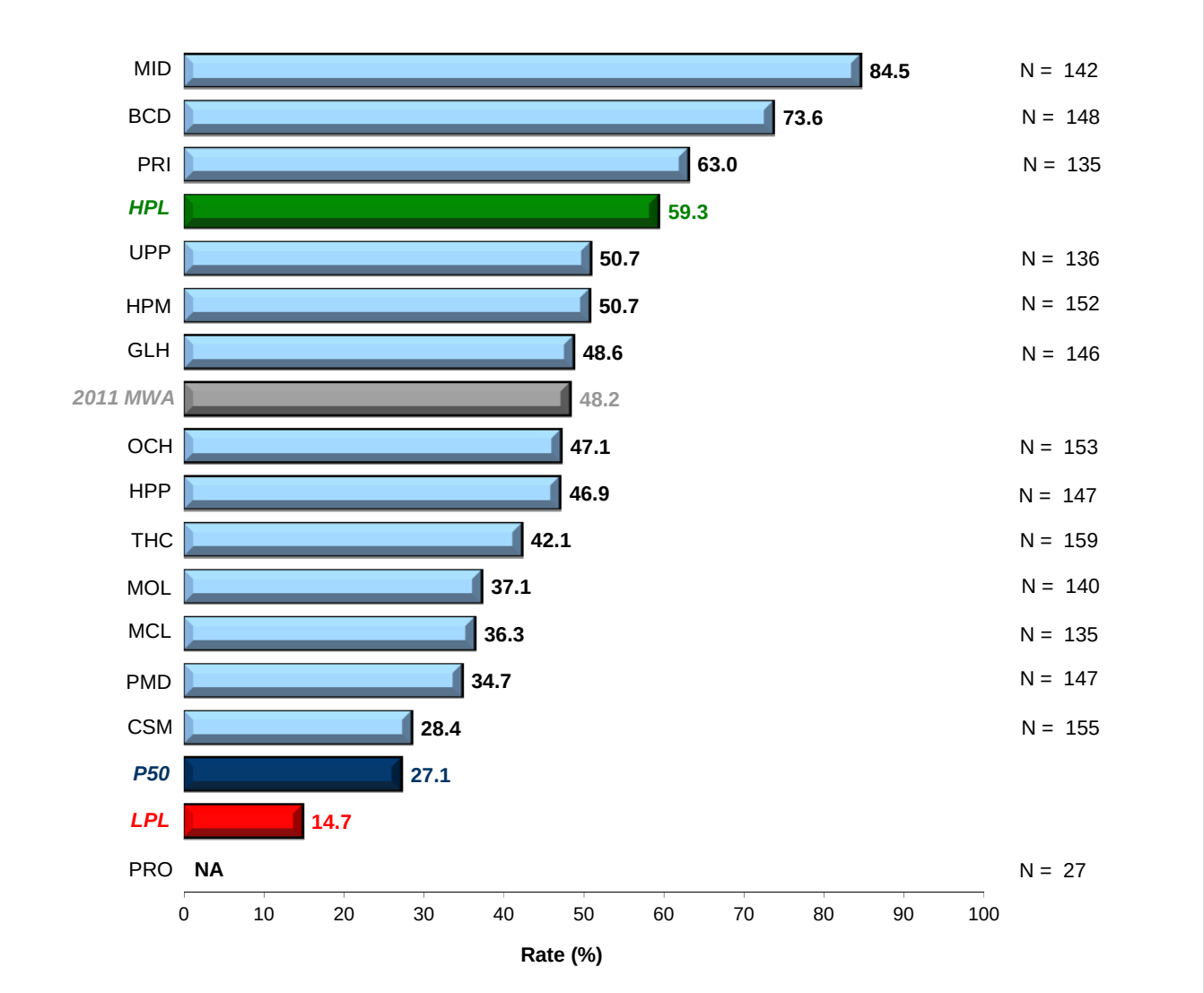
All MHPs elected to use the hybrid method for this measure. With the exception of one plan, all relied heavily on medical record data to report this rate (i.e., their medical record review rates exceeded 70 percent).

Figure 3-25—Weight Assessment for Children/Adolescents
BMI Percentile—12 to 17 Years
Michigan Medicaid Weighted Averages



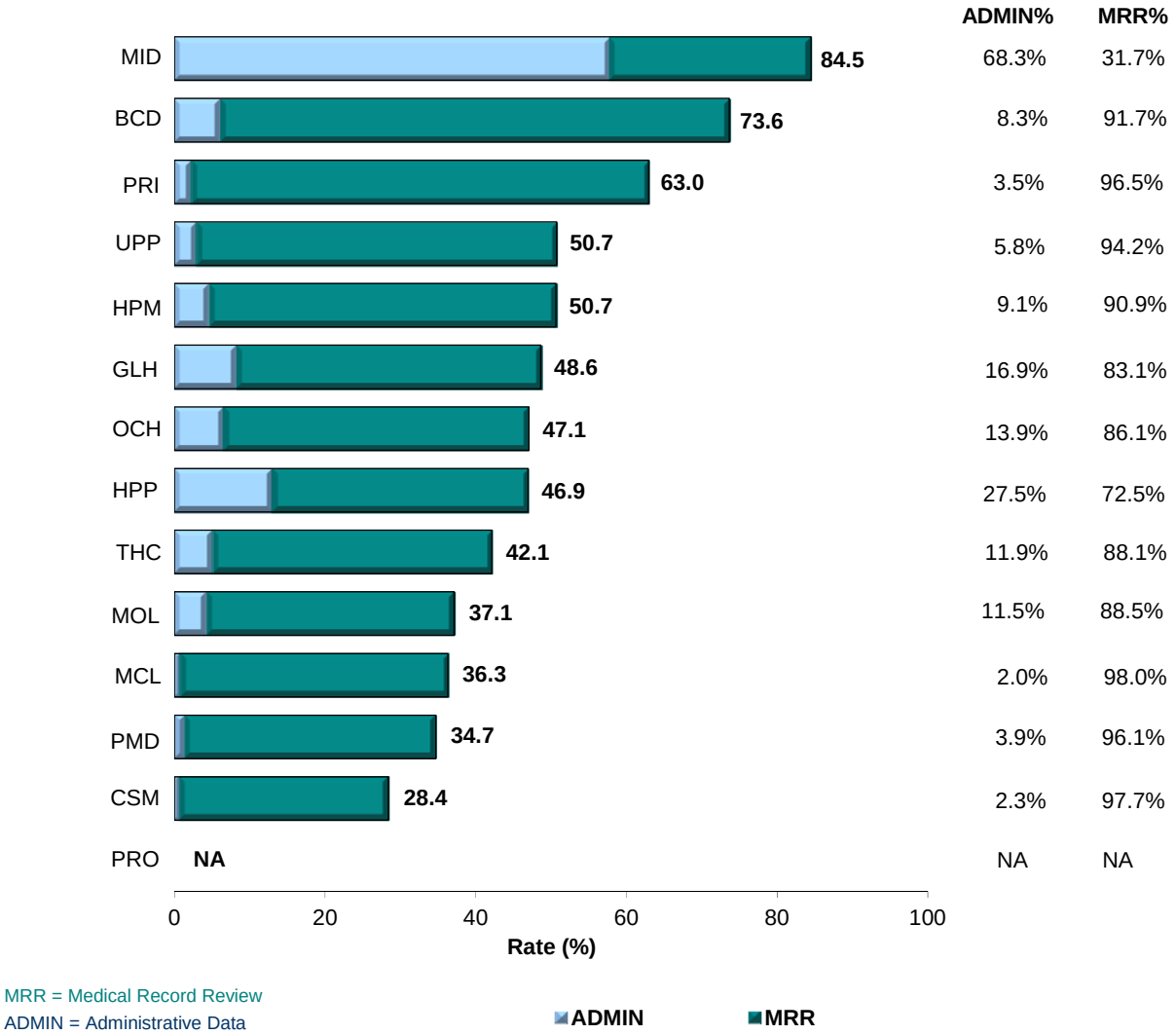
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated notable improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 16.9 and 9.4 percentage points, respectively. The observed improvement from last year was statistically significant.

Figure 3-26—Weight Assessment for Children/Adolescents
BMI Percentile—12 to 17 Years
Health Plan Ranking



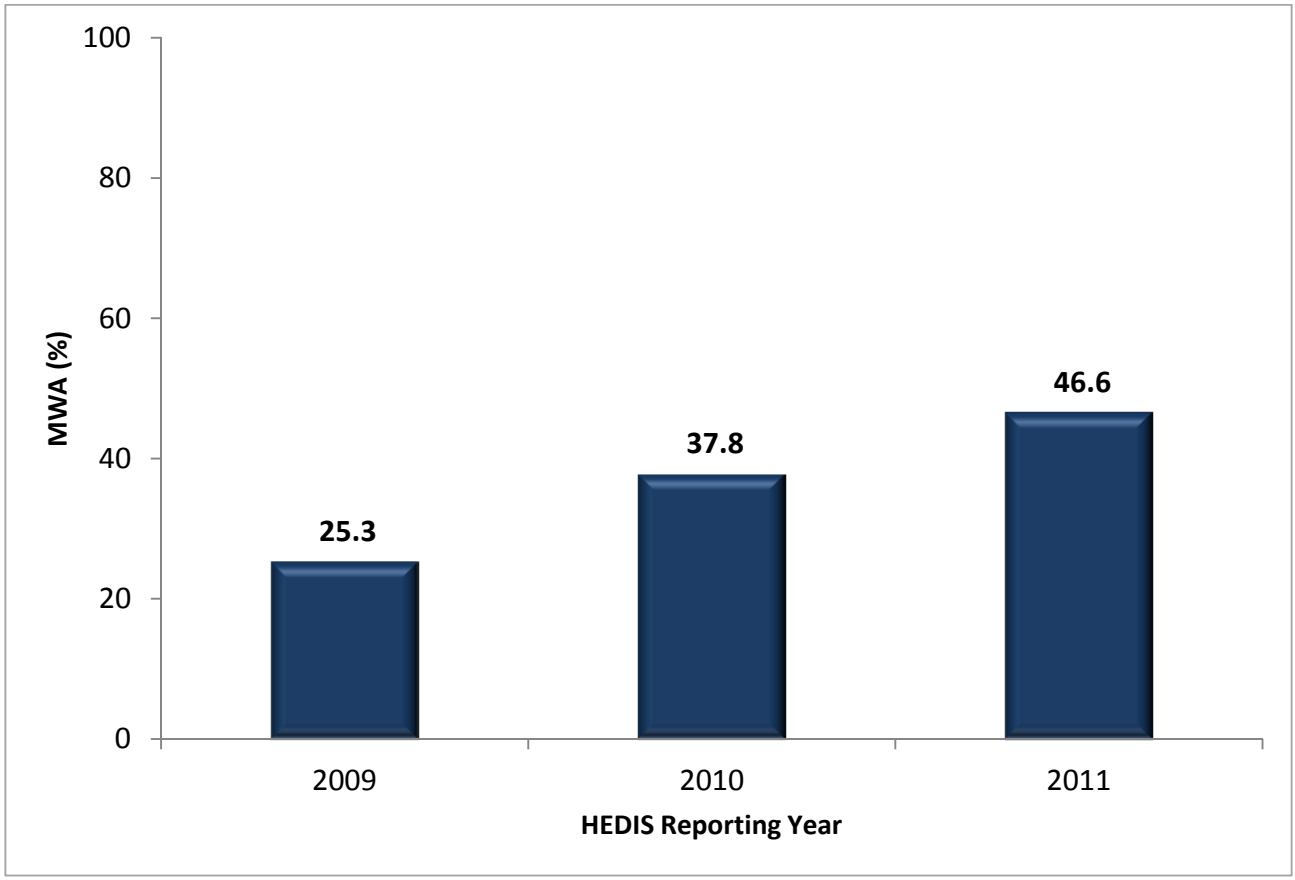
Three MHPs exceeded the HPL of 59.3 percent, and none of the MHPs performed below the LPL of 14.7 percent. All plans with reportable rates showed performance above the national HEDIS 2010 Medicaid 50th percentile. One MHP was unable to report a rate for this measure since the denominator was too small to report a valid rate (a denominator of less than 30). The HEDIS 2011 Michigan Medicaid weighted average of 48.2 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 21.1 percentage points.

Figure 3-27—Weight Assessment for Children/Adolescents
BMI Percentile—12 to 17 Years
Data Collection Analysis



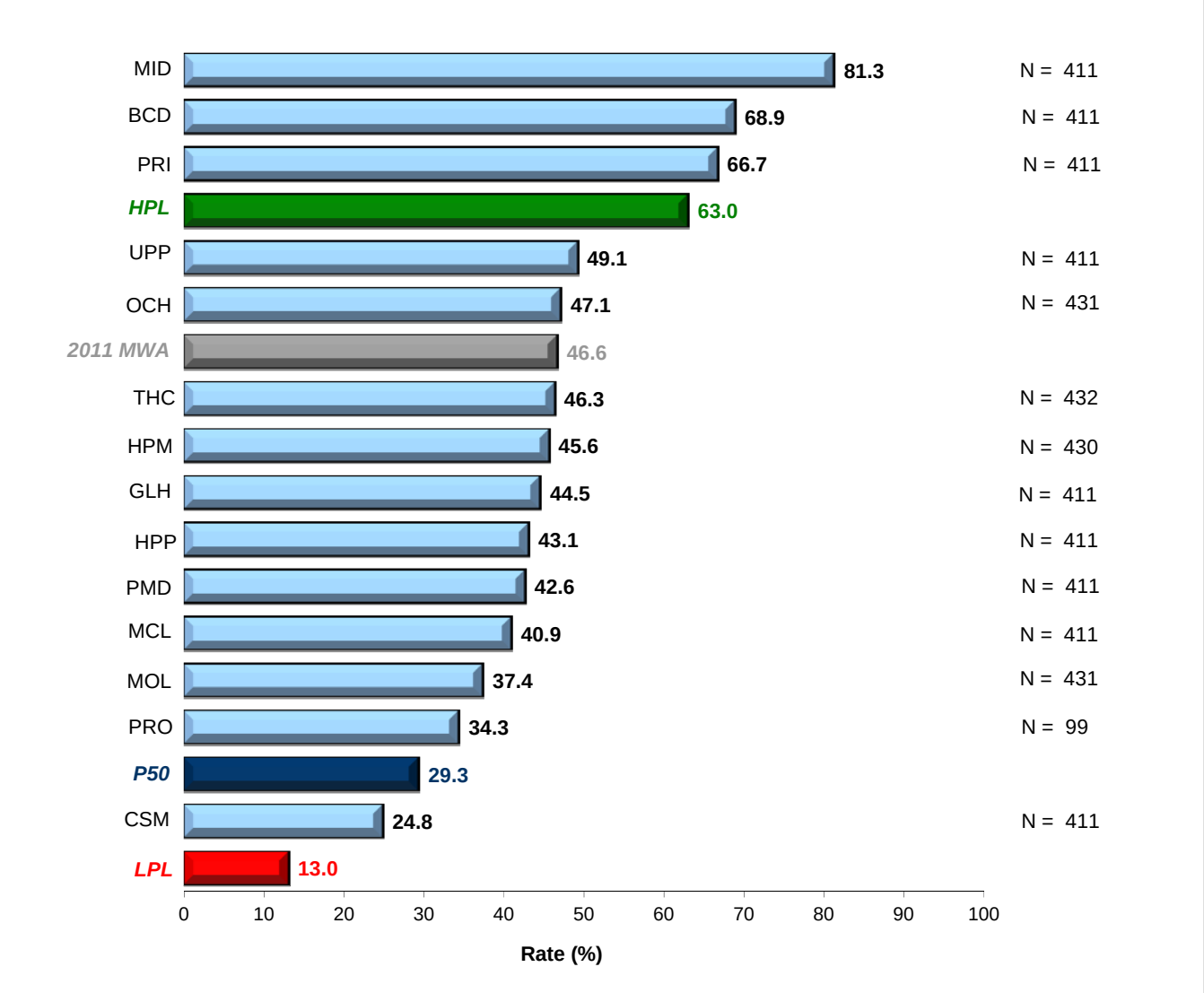
All MHPs with reportable rates elected to use the hybrid method for this measure. With the exception of one plan, all relied heavily on medical record data to report this rate (i.e., their medical record review rates exceeded 70 percent).

Figure 3-28—Weight Assessment for Children/Adolescents
BMI Percentile—Total
Michigan Medicaid Weighted Averages



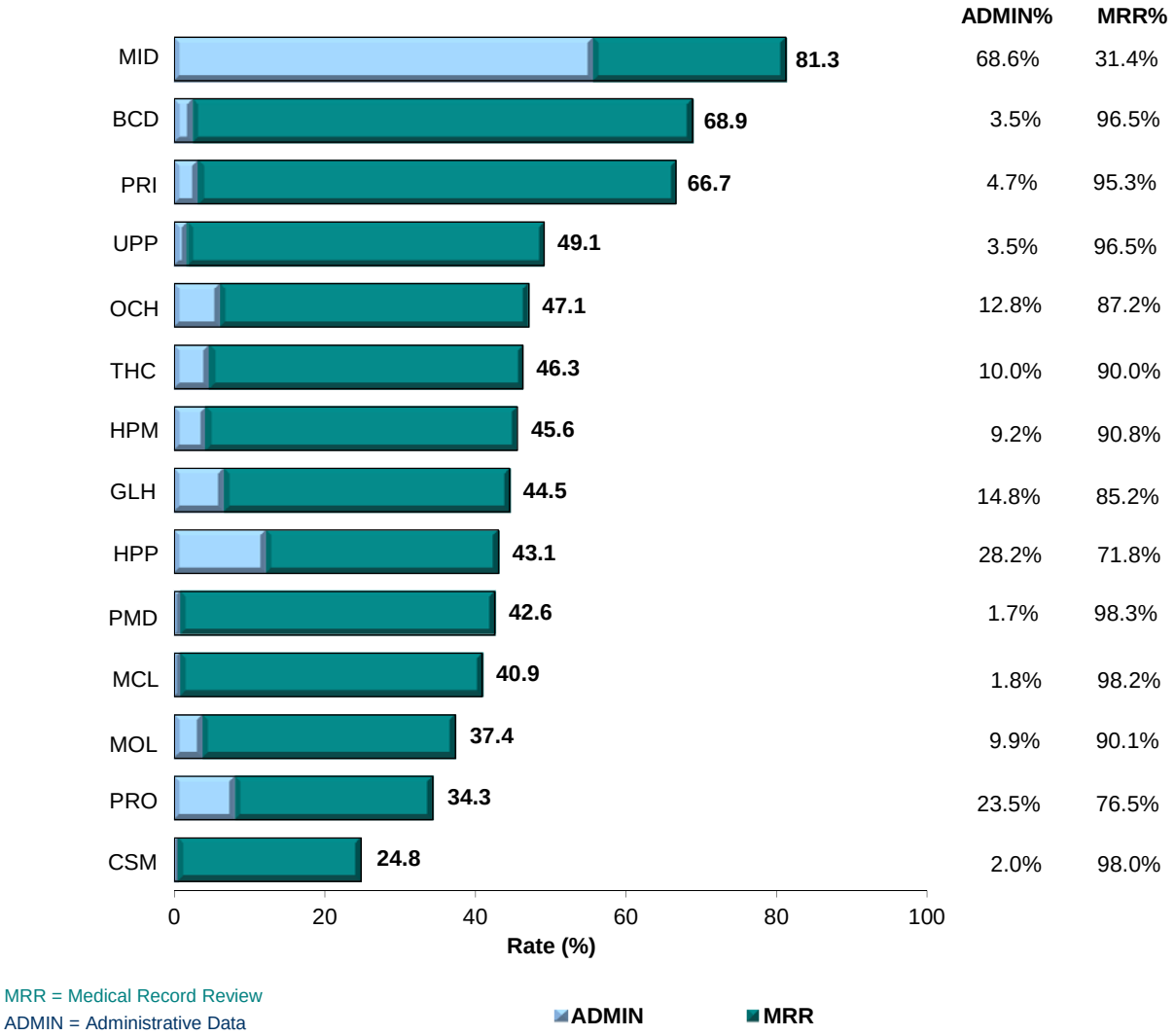
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated notable improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 21.3 and 8.8 percentage points, respectively. The observed improvement from last year was statistically significant.

Figure 3-29—Weight Assessment for Children/Adolescents
BMI Percentile—Total
Health Plan Ranking



Three MHPs exceeded the HPL of 63.0 percent, and none of the MHPs performed below the LPL of 13.0 percent. All but one MHP reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 46.6 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 17.3 percentage points.

Figure 3-30—Weight Assessment for Children/Adolescents
BMI Percentile—Total
Data Collection Analysis



All MHPs elected to use the hybrid method for this measure. With the exception of one plan, all MHPS relied heavily on medical record data to report this rate (i.e., their medical record review rates exceeded 70 percent).

Appropriate Treatment for Children With Upper Respiratory Infection

Measure Definition

The *Appropriate Treatment for Children With Upper Respiratory Infection* 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 upper respiratory infection (URI), and who were not dispensed an antibiotic prescription on or three days after the episode date.

Importance

The inappropriate use of antibiotics in children with viral respiratory infections is common. This may be due in part to inadequate parental knowledge of the need for antibiotics, and pressuring clinicians for an antibiotic prescription.[3-27] As a result, many bacterial infections are becoming resistant to antibiotics, creating a lack of effective treatment for these infections and making it harder and harder to treat patients.

Antibiotics are still among the most commonly prescribed therapeutic agents for children, although the number of such prescriptions has decreased in recent years.[3-28] Since the origin of most upper respiratory infections (URIs) is viral, the prescribing of antibiotics for the treatment of a majority of URIs is inappropriate. The use of antibiotics is only appropriate for URIs of bacterial origin, such as acute otitis media, bacterial sinusitis, mucopurulent rhinitis with prolonged symptoms (i.e., at least 10 days of continual symptoms), and group A streptococcal (strep) pharyngitis (but only cases with a confirmatory test for group A strep).[3-29] Excessive and frequent use of unnecessary antibiotics, in addition to contributing to antibiotic resistance, can also lead to increased incidence of allergic drug reactions with significant associated morbidity and mortality.

It is estimated that $227 million is spent annually on 7.4 million patients for inappropriate treatment of URIs.[3-30] The total economic impact of URIs, estimated at around $40 billion in the United States, is more than that of hypertension, COPD, and asthma.

3-27 Barclay L. Perceived Parental Pressure May Result in Excessive Antibiotic Prescription. Medscape Medical News. Available at: http://www.medscape.com/viewarticle/711918. Accessed on: August 23, 2011.

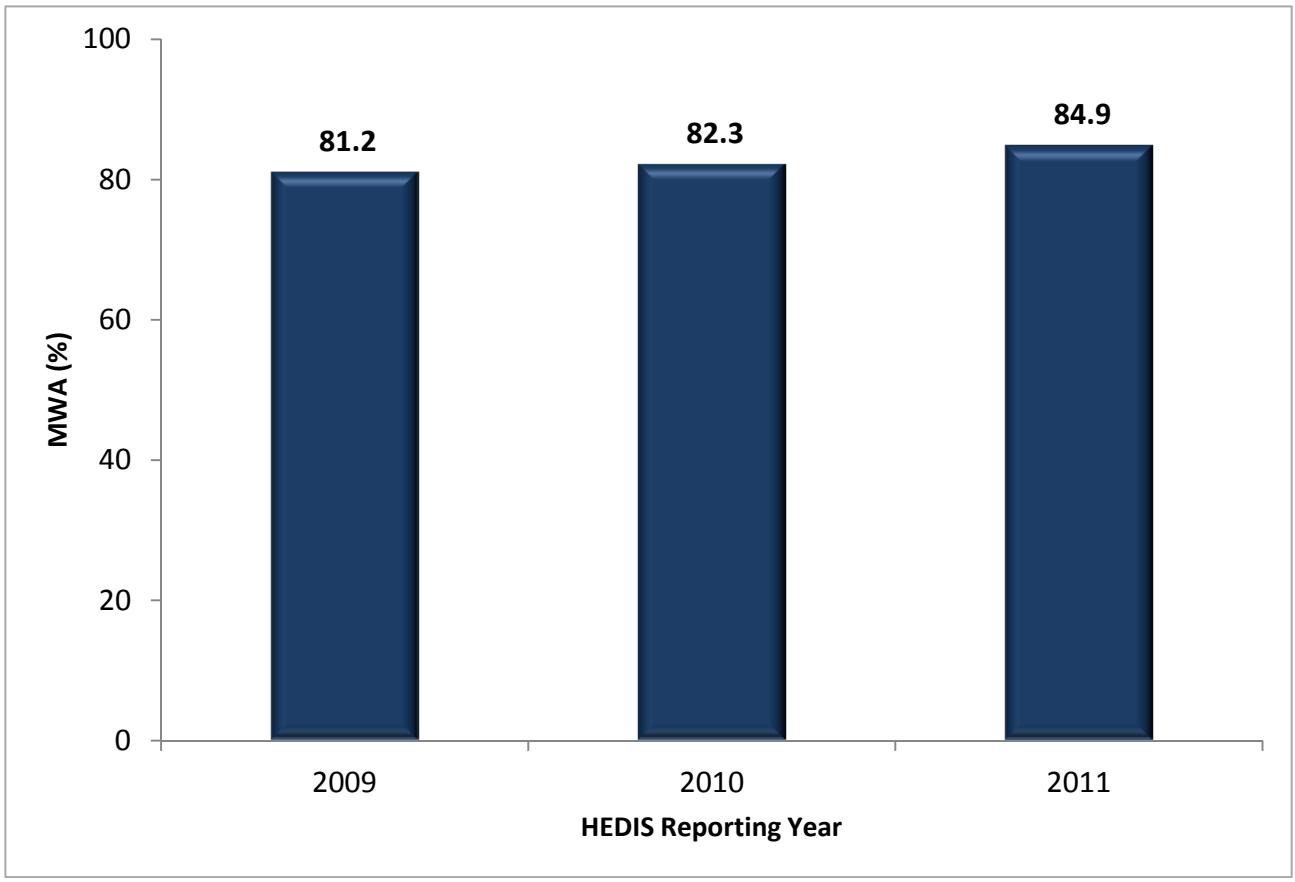
3-28 Bowlware KL, Stull T. Antibacterial Agents in Pediatrics. *Infectious Disease Clinics of North America.* 2004; 18(3):513–31.

3-29 The Centers for Medicare & Medicaid Services. *2010 Physician Quality Reporting Initiative Measure Specifications Manual for Claims and Registry Reporting of Individual Measures.* Version 4.1.

3-30 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on: August 22, 2011.

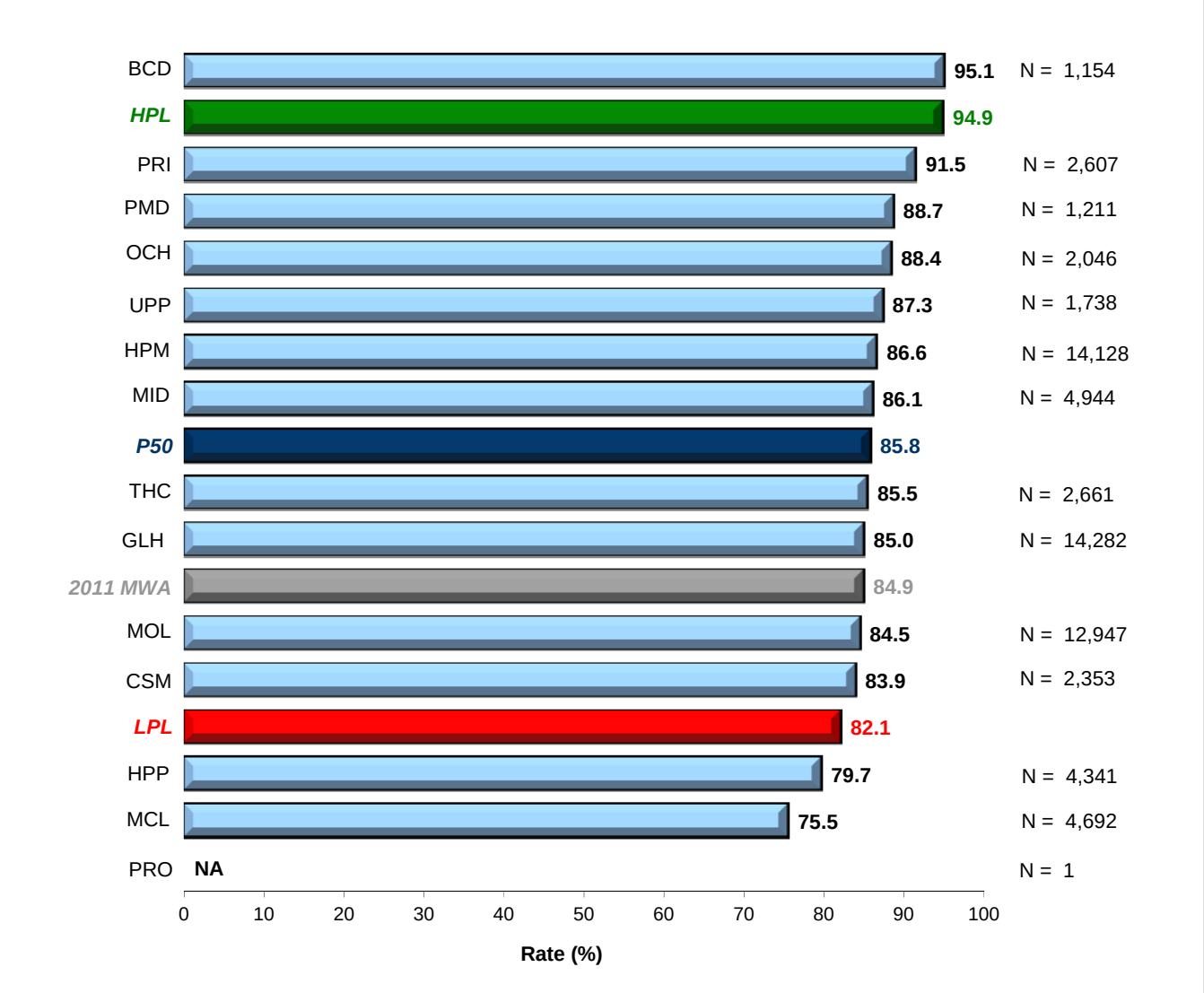
Performance Results

Figure 3-31—Appropriate Treatment for Children With Upper Respiratory Infection
Michigan Medicaid Weighted Averages



The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated slight improvement since HEDIS 2009. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 3.7 and 2.6 percentage points, respectively. The observed improvement from last year was statistically significant.

Figure 3-32—Appropriate Treatment for Children With Upper Respiratory Infection Health Plan Ranking



One MHP exceeded the HPL of 94.9 percent, and two fell below the LPL of 82.1 percent. A total of seven MHPs with reportable rates, including the one above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. One MHP was unable to report a rate for this measure since the denominator was too small to report a valid rate (a denominator of less than 30). The HEDIS 2011 Michigan Medicaid weighted average of 84.9 percent was 0.9 percentage point below the national HEDIS 2010 Medicaid 50th percentile.

Appropriate Testing for Children With Pharyngitis

Measure Definition

Appropriate Testing for Children With Pharyngitis 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 strep test for the episode.

Importance

Pharyngitis (i.e., sore throat) occurs most commonly in children between 5 and 18 years of age. Pharyngitis is caused primarily by one of two types of infections: (1) a viral upper respiratory tract infection, or (2) a group A strep bacterial infection (i.e., strep throat). Most cases that show clinical signs and symptoms of a *Streptococcus* infection are viral.[3-31] Determining the cause of pharyngitis is important since antibiotics are ineffective against viral infections. However, in the Medicaid population, the average strep testing rate for pharyngitis was only 62.3 percent in 2009, compared to the commercial population rate of 77.4 percent.[3-32]

There are other potential dangers involved in inappropriate antibiotic prescriptions as well—antibiotics are the most common cause of emergency room visits for adverse drug events among children.[3-33] Accurate, inexpensive tests for strep throat make testing for children easy and cost-effective, and offer an approach to avoid the overuse of antibiotics. These rapid diagnostic tests are widely available, and their use could reduce antibiotic consumption for pharyngitis in children by two-thirds.[3-34]

3-31 Centers for Disease Control and Prevention. Pharyngitis: Treat Only Proven GAS: Physician Information Sheet (Pediatrics). Available at: http://www.cdc.gov/getsmart/campaign-materials/info-sheets/child-pharyngitis.html Accessed on: August 23, 2011.

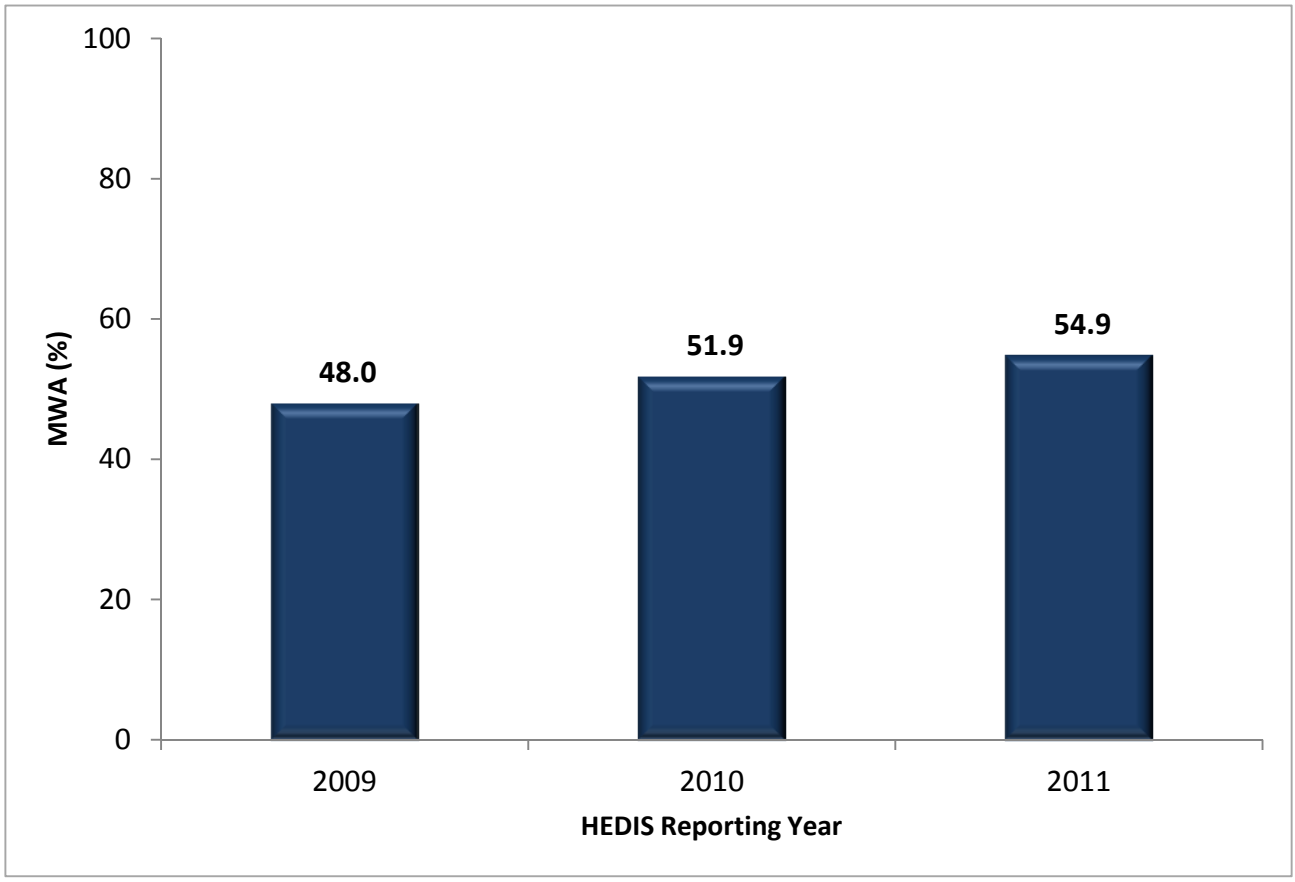
3-32 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf Accessed on: August 22, 2011.

3-33 Centers for Disease Control and Prevention. Get Smart: Know When Antibiotics Work. Available at: http://www.cdc.gov/features/getsmart/ Accessed on: August 23, 2011.

3-34 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf Accessed on" August 22, 2011.

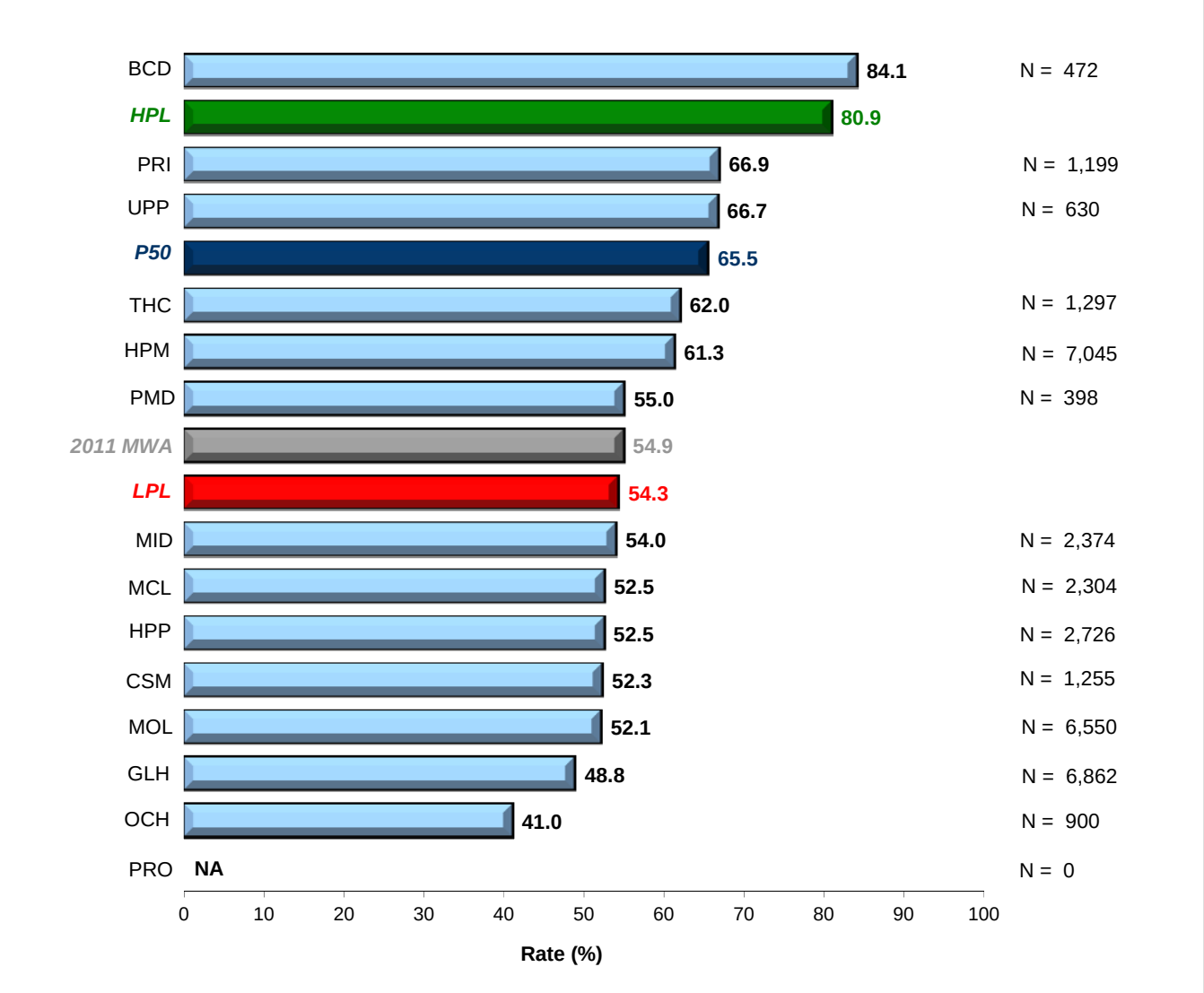
Performance Results

Figure 3-33—Appropriate Testing for Children With Pharyngitis
Michigan Medicaid Weighted Averages



The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated slight improvement since HEDIS 2009. The 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 6.9 and 3.0 percentage points, respectively. The observed improvement from last year was statistically significant.

Figure 3-34—Appropriate Testing for Children With Pharyngitis
Health Plan Ranking



One MHP exceeded the HPL of 80.9 percent, and seven fell below the LPL of 54.3 percent. Three MHPs with reportable rates, including the one above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. One MHP was unable to report a rate for this measure since the denominator was too small to report a valid rate (a denominator of less than 30). The HEDIS 2011 Michigan Medicaid weighted average of 54.9 percent was 10.6 percentage points below the national HEDIS 2010 Medicaid 50th percentile.

Pediatric Care Findings and Recommendations

Summary of Findings

Table 3-1 and Table 3-2 summarize MHP's rank relative to the national HEDIS 2010 Medicaid percentiles for each measure under the Pediatric and Adolescent Care dimension. Since the percentile rank is mostly associated with performance level, the tables also serve as high-level comparison of performance by measure across all plans. For the percentile range associated with each rank symbol, please refer to the Percentile Ranking section in Section 2 of this report.

Table 3-1—Pediatric and Adolescent Care Performance Summary

MHP Name	Childhood Immunization Combo 2	Childhood Immunization Combo 3	Immunizations for Adolescents Combo 1	Lead Screening in Children	Well-Child 1st 15 Months, 6+ Visits	Well-Child 3rd–6th Years of Life
BlueCaid of Michigan	★★	★★★	★★★★	★★	★★★★	★★★
CareSource Michigan	★★★	★★★	★★★	★★★★	★	★★
UnitedHealthcare Great Lakes Health Plan, Inc.	★★	★★	★★★	★★★	★★★★★	★★★★
Health Plan of Michigan, Inc.	★★★	★★★★	★★★★	★★★★	★★★★★	★★★★
HealthPlus Partners	★★★★	★★★	★★★★	★★★	★★★★	★★★★
McLaren Health Plan	★★★★★	★★★★★	★★★	★★★	★★★★	★★★
Midwest Health Plan	★★★	★★★	★★★★	★★★	★★★★★	★★★★★
Molina Healthcare of Michigan	★★	★★	★★★	★★★	★★	★★★
OmniCare Health Plan	★★★★	★★	★★★	★★★	★★	★★★
Physicians Health Plan of Mid-Michigan Family Care	★★★	★★★	★★★	★★★★	★★	★
Priority Health Government Programs, Inc.	★★★★★	★★★★★	★★★★	★★★	★★★	★★
ProCare Health Plan	★	★	NA	★	★	★
Total Health Care, Inc.	★★★★★	★★★★★	★★★	★★★	★★★★★	★★★★★
Upper Peninsula Health Plan	★★★	★★★★	★★	★★★★★	★★★★★	★★★

Table 3-2—Pediatric and Adolescent Care Performance Summary *Continued*						
MHP Name	Adolescent Well-Care Visits	Weight Assessment BMI Percentile 3–11 Years	Weight Assessment BMI Percentile 12–17 Years	Weight Assessment BMI Percentile Total	Appropriate Treatment URI	Children with Pharyngitis
BlueCaid of Michigan	★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
CareSource Michigan	★★★	★★	★★★	★★	★★	★
UnitedHealthcare Great Lakes Health Plan, Inc.	★★★★	★★★	★★★★	★★★	★★	★
Health Plan of Michigan, Inc.	★★★★	★★★	★★★★	★★★★	★★★	★★
HealthPlus Partners	★★★★	★★★	★★★★	★★★	★	★
McLaren Health Plan	★★★★	★★★	★★★	★★★	★	★
Midwest Health Plan	★★★★★	★★★★★	★★★★★	★★★★★	★★★	★
Molina Healthcare of Michigan	★★★	★★★	★★★	★★★	★★	★
OmniCare Health Plan	★★★★★	★★★★	★★★★	★★★★	★★★	★
Physicians Health Plan of Mid-Michigan Family Care	★★★	★★★★	★★★	★★★	★★★	★★
Priority Health Government Programs, Inc.	★★★★	★★★★★	★★★★★	★★★★★	★★★★	★★★
ProCare Health Plan	★	★★★	NA	★★★	NA	NA
Total Health Care, Inc.	★★★★★	★★★★	★★★	★★★★	★★	★★
Upper Peninsula Health Plan	★★★	★★★★	★★★★	★★★★	★★★	★★★

Among all the measures under this dimension, five had all but one plan performing at least at or above the national 50th percentile. These measures are *Immunizations for Adolescents—Combination 1*, *Adolescent Well-Care Visits* and the three *Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Percentile* measures. Comparatively, most MHPs performed relatively poorly on the *Appropriate Testing for Children With Pharyngitis* and *Appropriate Treatment for Children With Upper Respiratory Infection* measures. This is especially true for the

Appropriate Testing for Children With Pharyngitis measure where seven plans performed below the national 25th percentile.

Table 3-3 presents statewide performance at a glance for the measures under the Pediatric and Adolescent Care dimension. It lists the HEDIS 2011 weighted averages, the trended results, and a summary of the MHPs with rates showing significant changes from HEDIS 2010.

Table 3-3—Michigan Medicaid HEDIS 2011 Statewide Rate Trend
Pediatric and Adolescent Care

Measure	Statewide Rate		Number of MHPs	
	2011 Weighted Average	2010–2011 Trend	With Significant Improvement in 2011	With Significant Decline in 2011
Childhood Immunization Status—Combination 2	78.2%	-0.5	0	1
Childhood Immunization Status—Combination 3	74.3%	+0.3	0	0
Immunizations for Adolescents—Combination 1	52.9%	**+11.9**	12	0
Lead Screening in Children	78.0%	+1.5	2	1
Well-Child Visits in the First 15 Months of Life—Six or More Visits	72.3%	**+2.8**	3	1
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.0%	+2.1	2	0
Adolescent Well-Care Visits	58.8%	+2.5	3	0
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 3 to 11 Years	45.7%	**+8.4**	9	0
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 12 to 17 Years	48.2%	**+9.4**	9	0
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	46.6%	**+8.8**	9	1
Appropriate Treatment for Children With Upper Respiratory Infection	84.9%	**+2.6**	7	0
Appropriate Testing for Children With Pharyngitis	54.9%	**+3.0**	3	1

2010–2011 Trend note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decrease from the prior year.

Legend	<P10	≥P10 and < P25	≥P25 and < P50	≥P50 and < P75	≥P75 and < P90	≥P90

At the statewide level, the Michigan Medicaid Managed Care programs performed fairly well on the measures in the Pediatric and Adolescent Care dimension. Six of the 12 HEDIS 2011 weighted averages performed above the HEDIS 2010 Medicaid 75th percentile. Although two measures (*Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis*) ranked below the 50th percentile, this year's performance demonstrated

significant improvement. When compared to last year's performance, all but one measure demonstrated an increase in rate, with seven of these showing a statistically significant improvement (i.e., four had an improvement of at least five percentage points). For 10 of the 12 measures under this dimension, the number of MHPs having significant improvement in 2011 was larger than those exhibiting significant decline. One measure accomplished statistically significant improvement for 12 of the 14 health plans and another three measures demonstrated significant improvement for nine plans.

Best Practices

The American Academy of Pediatrics regularly releases recommendations that inform providers and parents of current recommendations on health screening guidelines, and treatment and prevention best practices. Implementing best practices or interventions can help to improve overall performance for pediatric and adolescent care measures.

4. Women's and Adult Care

Introduction

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

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—16 to 20 Years*
- *Chlamydia Screening in Women—21 to 24 Years*
- *Chlamydia Screening in Women—Total*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Adult BMI Assessment*

Breast Cancer Screening

Measure Definition

The *Breast Cancer Screening* measure is reported using only the administrative method. This measure calculates the percentage of women 40 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.

Importance

Breast cancer is one of the most prevalent forms of cancer among U.S. women; it accounts for one-fourth of all cancer diagnoses.[4-1] The American Cancer Society estimates that there will be 230,480 new cases of female breast cancer and 39,520 deaths from female breast cancer in the United States during 2011. The American Cancer Society also projects that 7,890 women will be newly diagnosed with breast cancer in Michigan during 2011, an increase of 550 cases from the previous year.[4-2]

Breast cancer is not thought to be preventable; therefore, early detection through screening tests is the preeminent method to reduce mortality.[4-3] In addition, when breast cancer is detected earlier, treatment has a better chance of being effective, and a cure is more likely.[4-4] For women 50 to 69 years of age, mammogram screenings decrease breast cancer mortality by up to 35 percent.[4-5]

In addition to personal loss, breast cancer accounts for substantial costs to the U.S. health care system. It is estimated that breast cancer costs the United States $7 billion per year; however, treatment for breast cancer detected in earlier stages costs significantly less than treatment for more advanced stages.[4-6]

4-1 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on: August 22, 2011.

4-2 American Cancer Society, Cancer Facts & Figures 2011. Available at: http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-029771.pdf. Accessed on: August 24, 2011.

4-3 United States Preventive Services Task Force. Screening for Breast Cancer: United States Preventive Services Task Force Recommendation Statement. *Annals of Internal Medicine*. 2009; 151(10): 716–726, W-236.

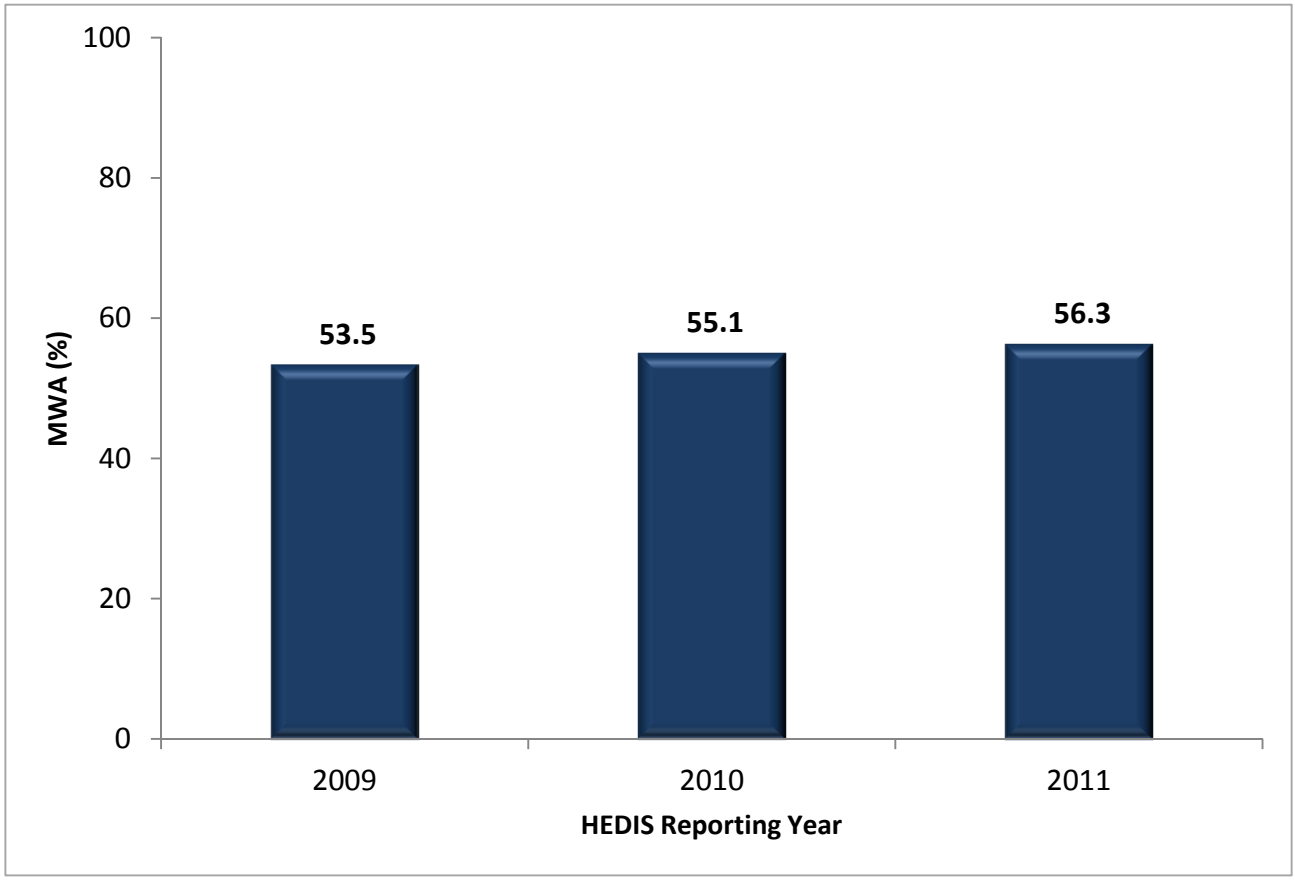
4-4 American Cancer Society. Cancer Facts & Figures 2011. http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-029771.pdf. Accessed on: August 24, 2011.

4-5 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on: August 24, 2011.

4-6 Ibid.

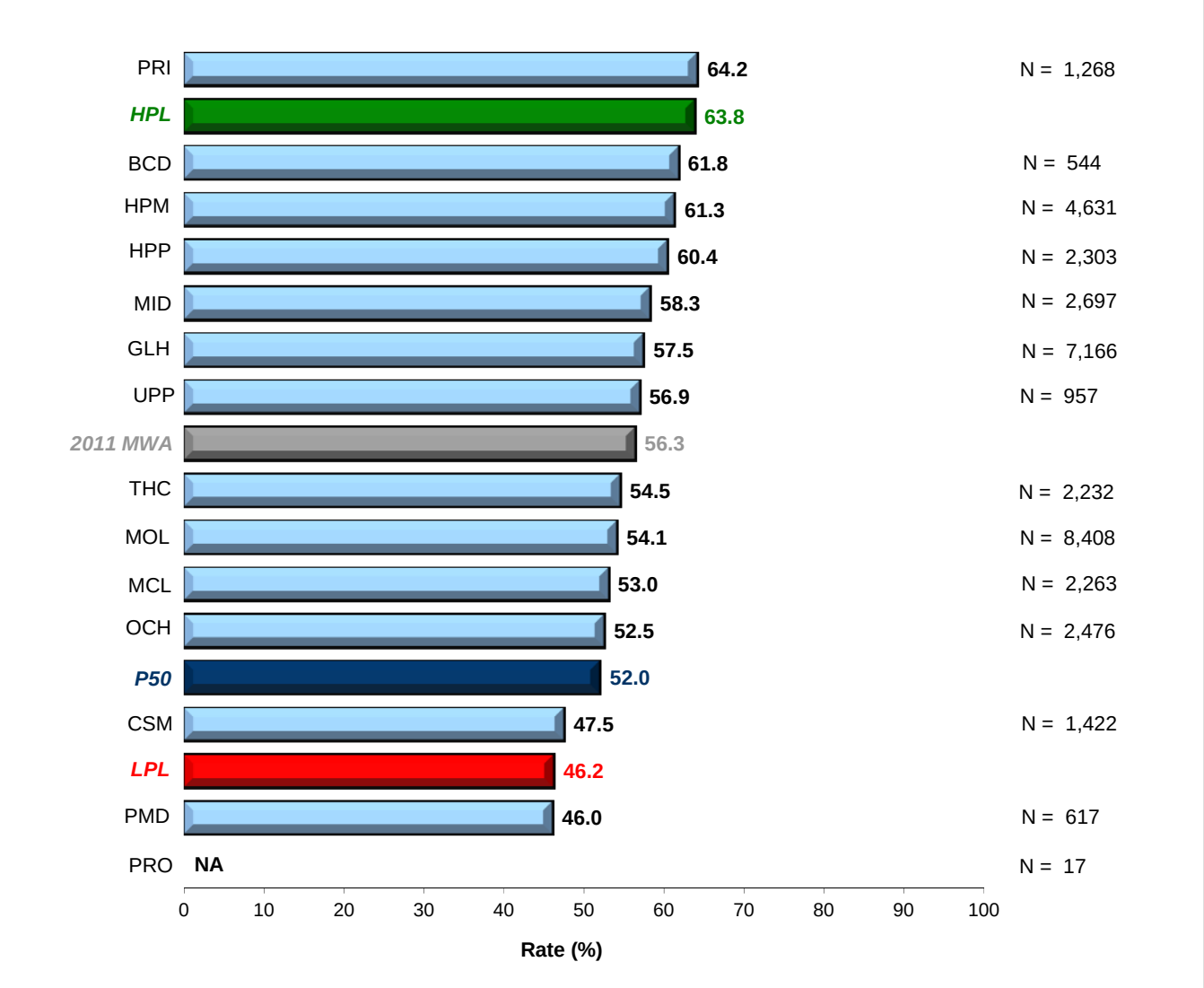
Performance Results

Figure 4-1—Breast Cancer Screening
Michigan Medicaid Weighted Averages



The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated slight improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 2.8 and 1.2 percentage points, respectively. The observed improvement from last year was statistically significant.

Figure 4-2—Breast Cancer Screening
Health Plan Ranking



One MHP exceeded the HPL of 63.8 percent, and one fell below the LPL of 46.2 percent. Eleven MHPs with reportable rates, including the one above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. One MHP was unable to report a rate for this measure since the denominator was too small to report a valid rate (a denominator of less than 30). The HEDIS 2011 Michigan Medicaid weighted average of 56.3 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 4.3 percentage points.

Cervical Cancer Screening

Measure Definition

The *Cervical Cancer Screening* measure reports the percentage of women ages 21 through 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.

Importance

When signs of cervical cancer are detected early, appropriate treatment can be started, which results in a high treatment success rate. Since the risk of developing cervical cancer increases with age, it is important that women continue to have screenings as they age, even with prior negative tests. The American Cancer Society estimates that 12,710 new cases and 4,290 deaths from cervical cancer will occur in 2011. In Michigan, an estimated 360 new cases of cervical cancer will be diagnosed in 2011.[4-7]

A proven method of cervical cancer prevention is testing (screening) to find pre-cancerous lesions before they can become invasive. The Pap test (or Pap smear) is the most common way to screen for cervical pre-cancers and cervical cancer. If a pre-cancer is found, it can be treated, preventing progression to invasive cervical cancer.[4-8] The five-year relative survival rate for localized stages of cervical cancer is 92 percent in the United States.[4-9] Approximately six out of every 10 cases of cervical cancer occur in women who have never received a Pap smear test or who have not been tested in five years.[4-10]

4-7 American Cancer Society, Cancer Facts & Figures 2011. Available at: http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-029771.pdf. Accessed on: August 24, 2011.

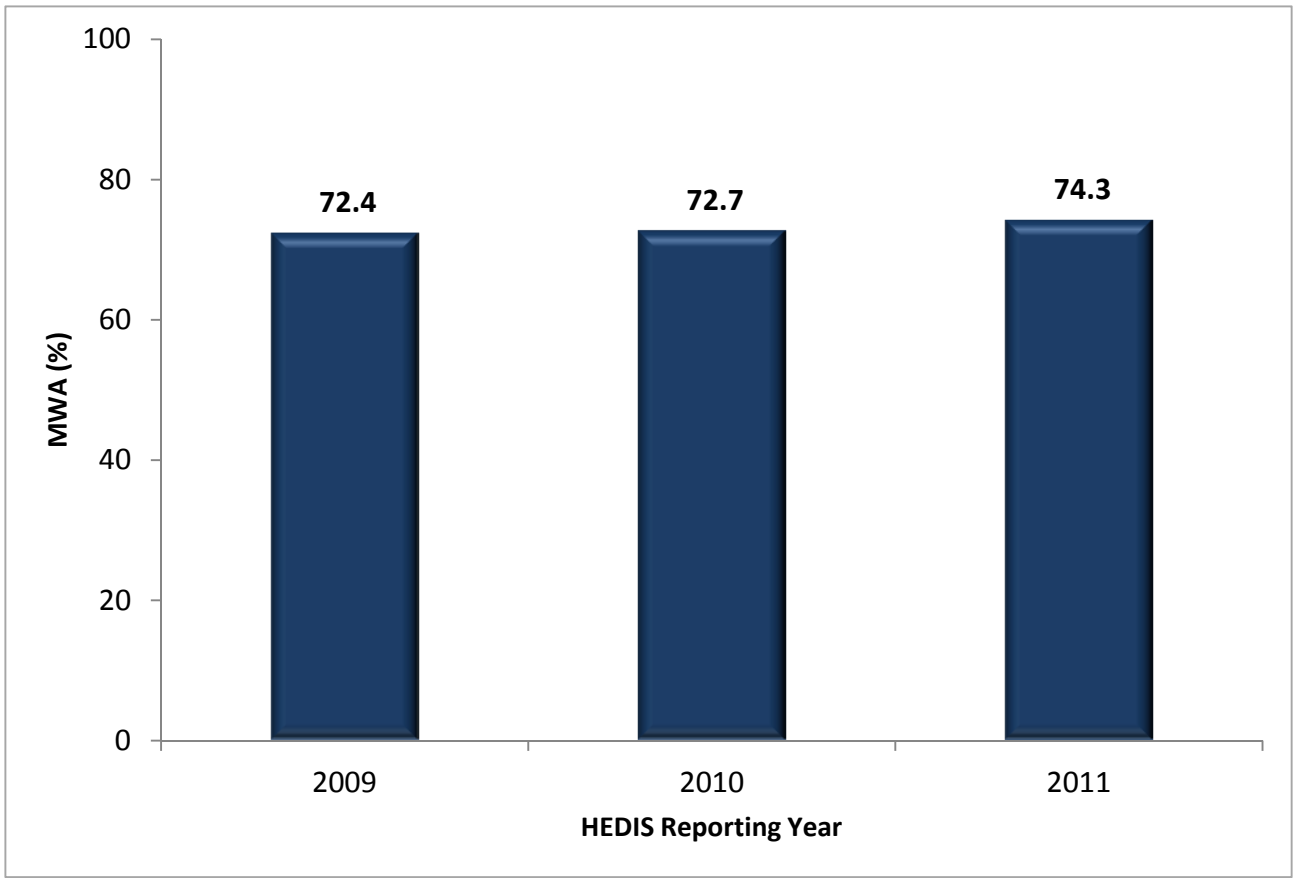
4-8 Ibid.

4-9 American Cancer Society. Cervical Cancer. Available at: http://www.cancer.org/acs/groups/content/@nho/documents/document/cervicalcancerpdf.pdf. Accessed on: August 24, 2011.

4-10 Centers for Disease Control and Prevention. Cervical Cancer. Available at: http://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf. Accessed on: August 24, 2011.

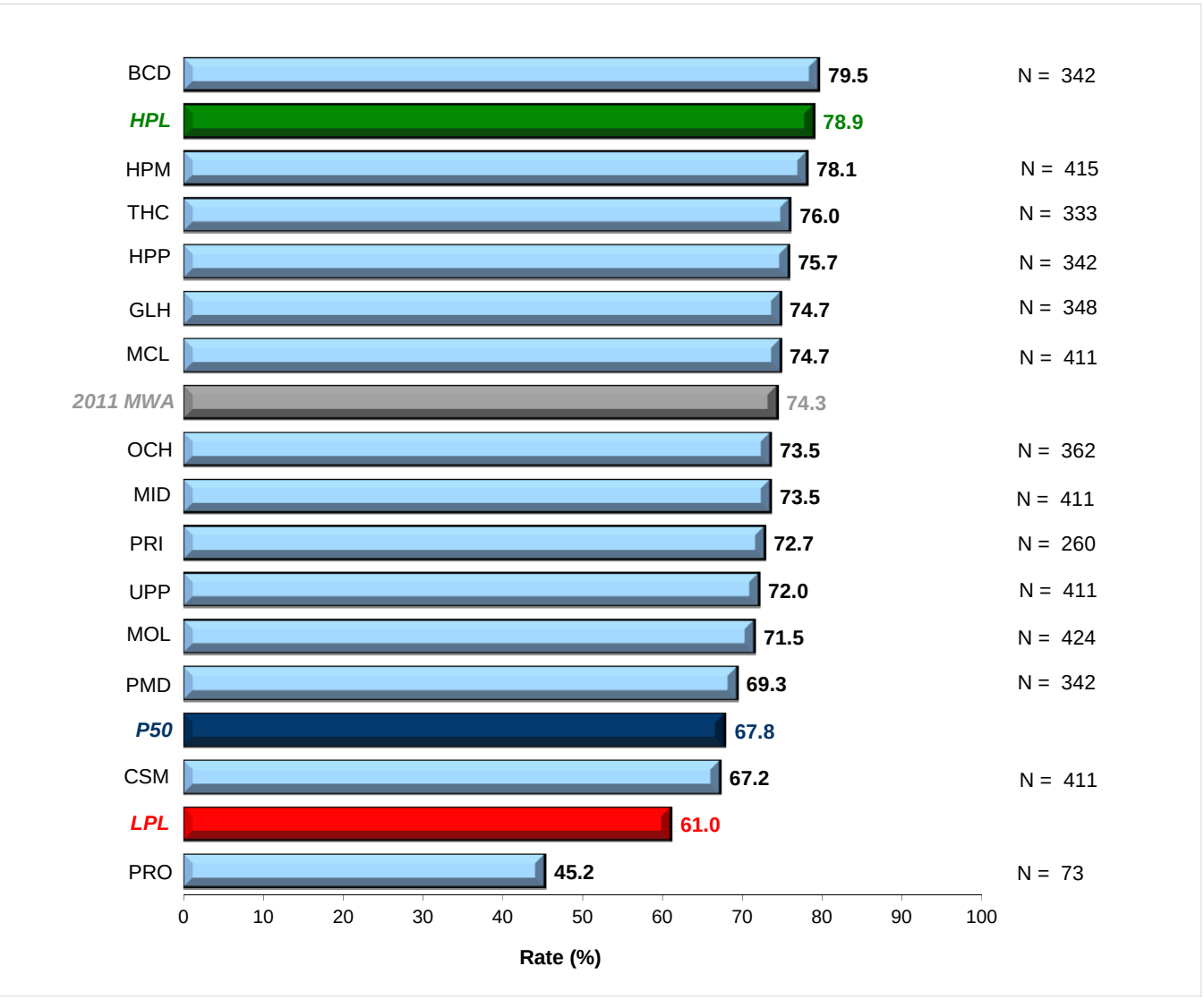
Performance Results

Figure 4-3—Cervical Cancer Screening
Michigan Medicaid Weighted Averages



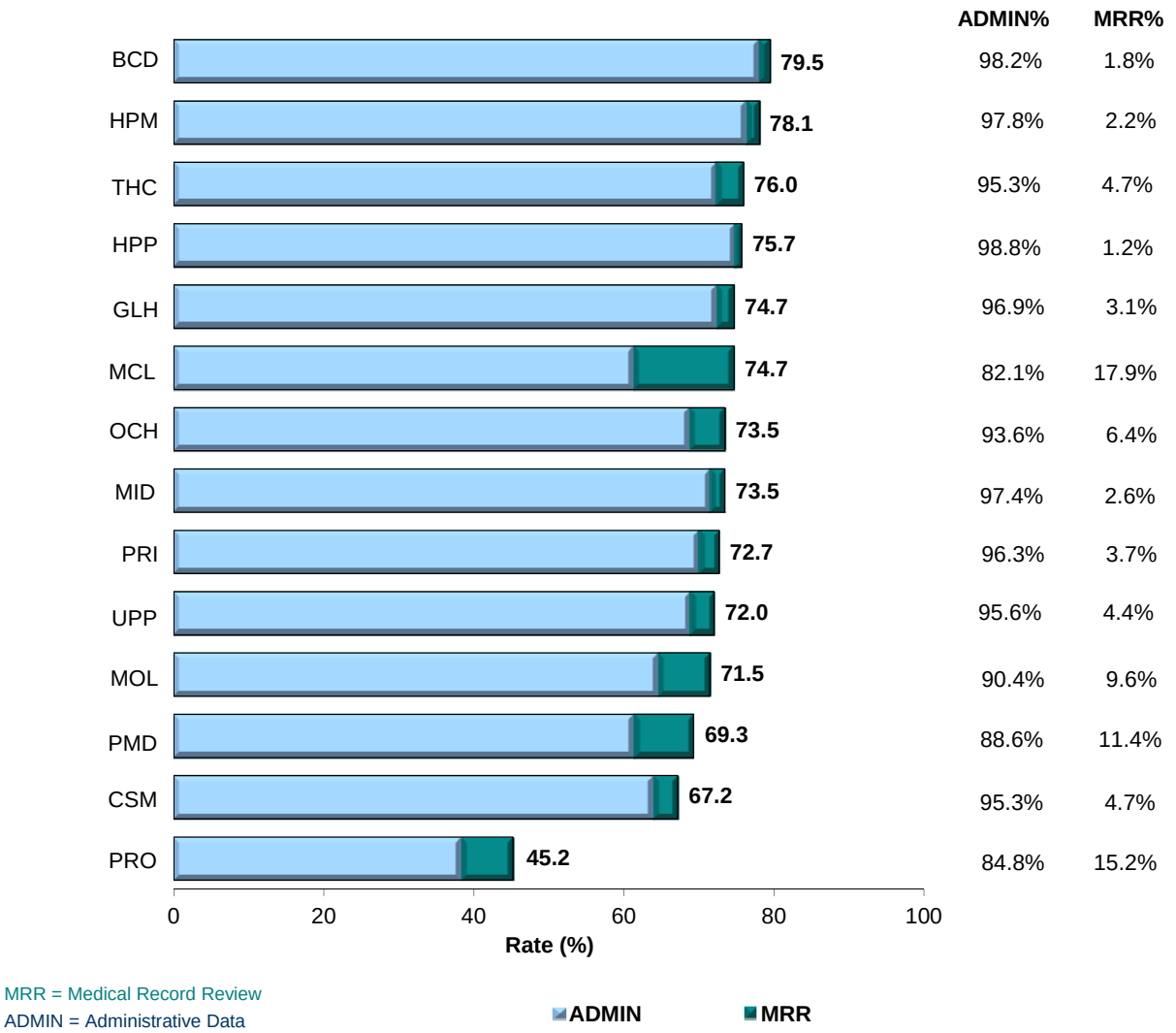
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated slight improvement from HEDIS 2009 and 2010. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 1.9 and 1.6 percentage points, respectively. The observed improvement from last year was not statistically significant.

Figure 4-4—Cervical Cancer Screening
Health Plan Ranking



One MHP exceeded the HPL of 78.9 percent, and one fell below the LPL of 61.0 percent. All but two MHPs reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 74.3 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 6.5 percentage points.

Figure 4-5—Cervical Cancer Screening Data Collection Analysis



All MHPs elected to use the hybrid method for this measure. All of the reported rates were derived from over 80 percent administrative data.

Chlamydia Screening in Women

Measure Definition

The *Chlamydia Screening in Women* measure is reported using the administrative method only. This measure reports the percentage of women 16 through 24 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. The measure is reported using three separate rates: *Chlamydia Screening in Women—16 to 20 Years; Chlamydia Screening in Women—21 to 24 Years;* and *Chlamydia Screening in Women—Total* (the total of both age groups, 16 to 24 years).

Importance

With approximately 1.2 million U.S. cases in 2009, chlamydia is the most frequently reported sexually transmitted disease (STD).[4-11] In Michigan, 457 cases of chlamydia cases per 100,000 population were reported in 2009, which was above the U.S. rate of 409.2.[4-12] Chlamydia is most prevalent in young women. About 5 to 14 percent of women from 16 to 20 years of age who are routinely screened for the disease are infected. Chlamydia is sometimes referred to as a "silent" disease since most infected women do not show any symptoms.[4-13]

Chlamydia can easily be cured with antibiotics; however, if left untreated, it can cause permanent damage to reproductive organs and even lead to infertility.[4-14] Chlamydia can also increase a woman's chances of contracting an HIV infection in the event of an exposire.[4-15] If all women under 25 years of age were screened for chlamydia, an annual cost savings of $45 per woman could be realized.[4-16] However, fewer than half of sexually active women under 25 years of age are screened for the disease.[4-17]

The number needed to screen (NNS) for chlamydia screening varies among different populations. For a low at-risk population, the NNS to prevent a case of pelvic inflammatory disease (PID) is 3,846; however, in a high-risk population, the NNS to prevent a case of PID is 38.3.[4-18, 4-19]

4-11 Centers for Disease Control and Prevention. Chlamydia—CDC Fact Sheet. Available at: http://www.cdc.gov/std/Chlamydia/STDFact-Chlamydia.htm#Common. Accessed on: August 9, 2011.

4-12 Kaiser Health Facts. Available at: http://www.statehealthfacts.org/profileind.jsp?rgn=24&cat=2&ind=100. Accessed on: August 24, 2011.

4-13 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on: August 9, 2011.

4-14 Ibid.

4-15 Centers for Disease Control and Prevention. Chlamydia—CDC Fact Sheet. Available at: http://www.cdc.gov/std/Chlamydia/STDFact-Chlamydia.htm#Common. Accessed on: August 9, 2011.

4-16 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on: August 9, 2011.

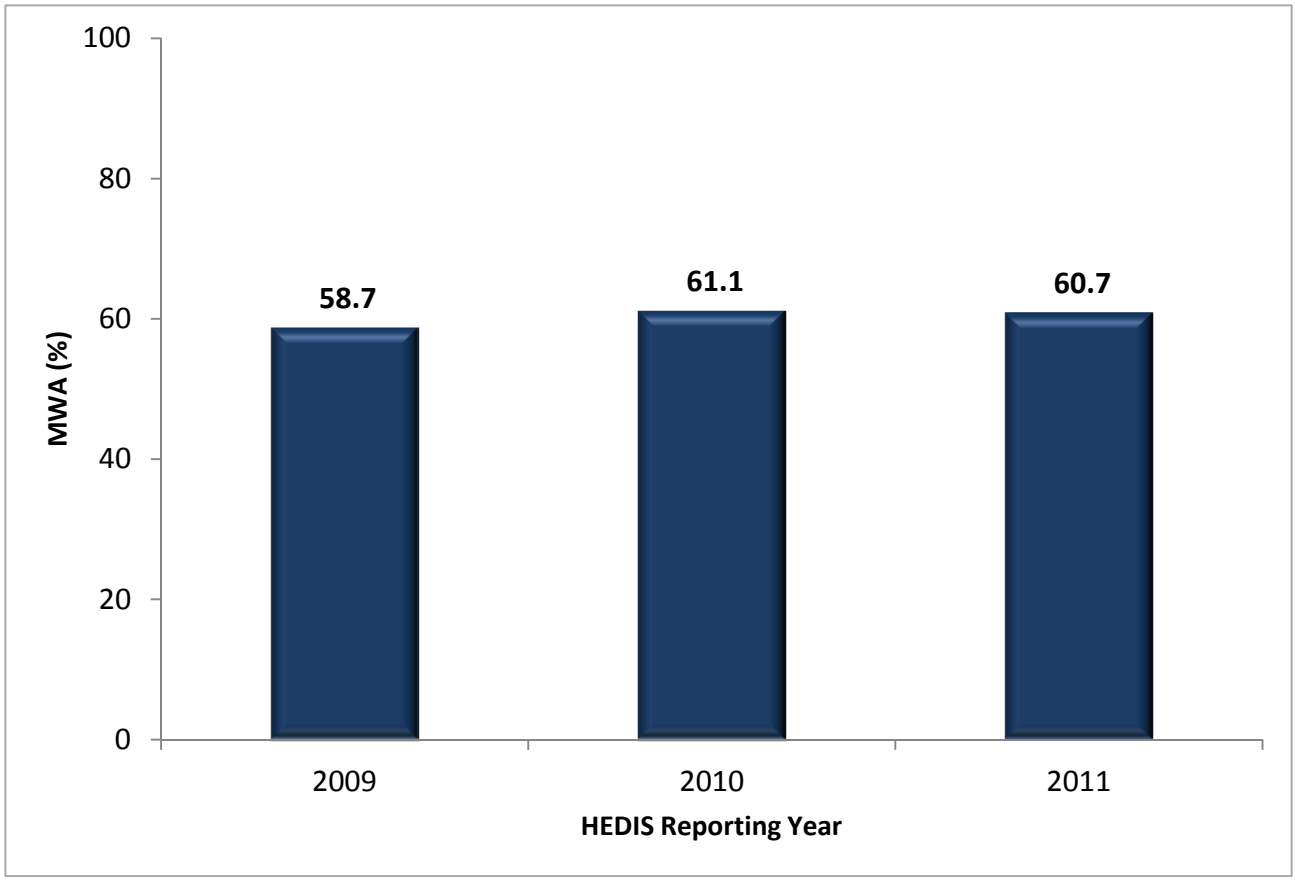
4-17 Ibid.

4-18 Meyers DS, Halvorson H, Luckhaupt S. Screening for Chlamydia Infection: A Focused Evidence Update for the United States Preventive Services Task Force. *Evidence Synthesis.* 2007. Available at: http://www.ahrq.gov/clinic/uspstf07/chlamydia/chlamydiasyn.pdf. Accessed on: August 9, 2011.

4-19 The NNS is used to determine how many screenings are necessary in order to prevent one bad outcome (or one case of PID, in this example).

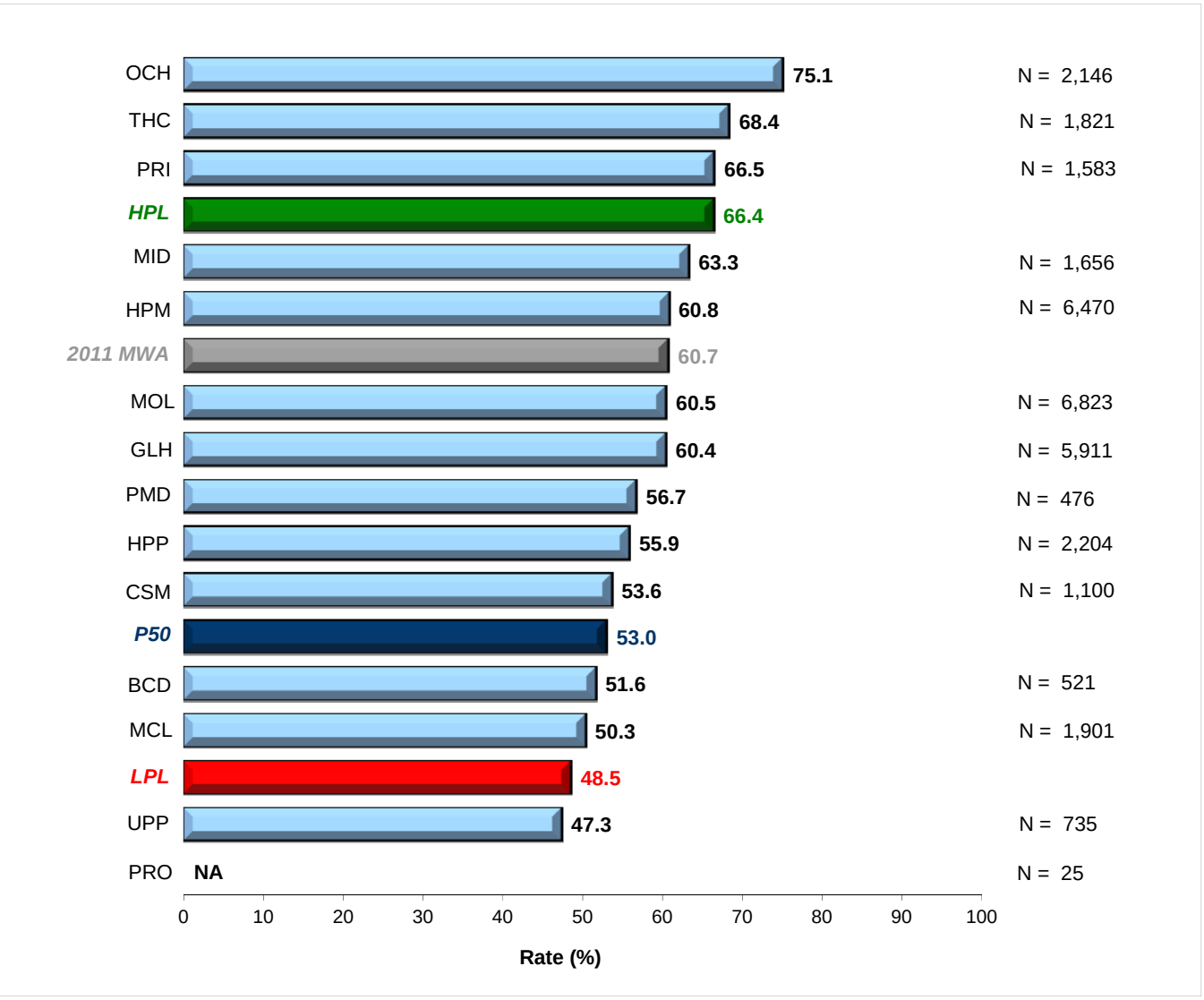
Performance Results

Figure 4-6—Chlamydia Screening in Women—16 to 20 Years
Michigan Medicaid Weighted Averages



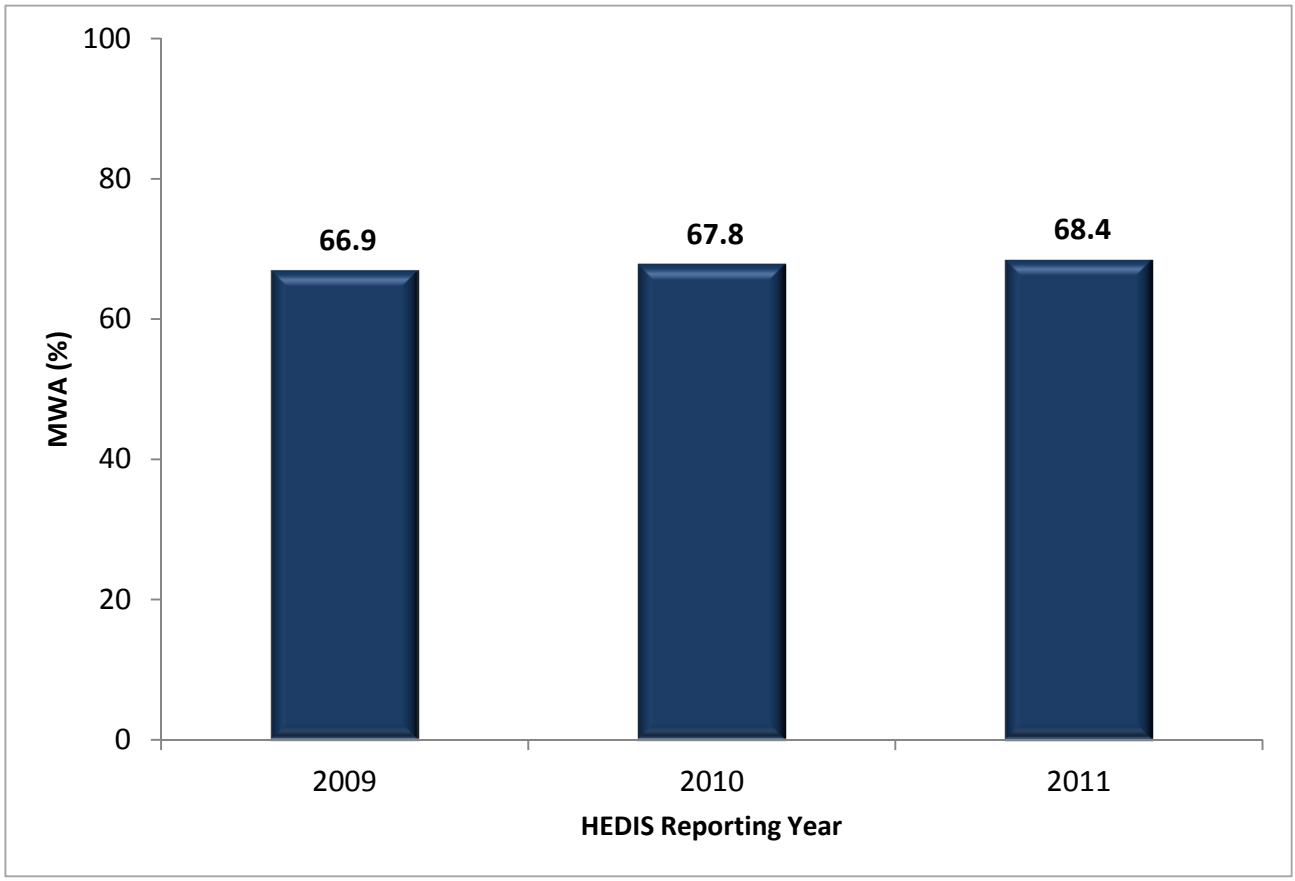
The HEDIS 2011 Michigan Medicaid weighted average for this measure was slightly lower than the HEDIS 2010 results (a 0.4 percentage point decline). The observed decline, however, was not statistically significant. Nonetheless, this year's result still demonstrated improvement from HEDIS 2009 by two percentage points.

Figure 4-7—Chlamydia Screening in Women—16 to 20 Years
Health Plan Ranking



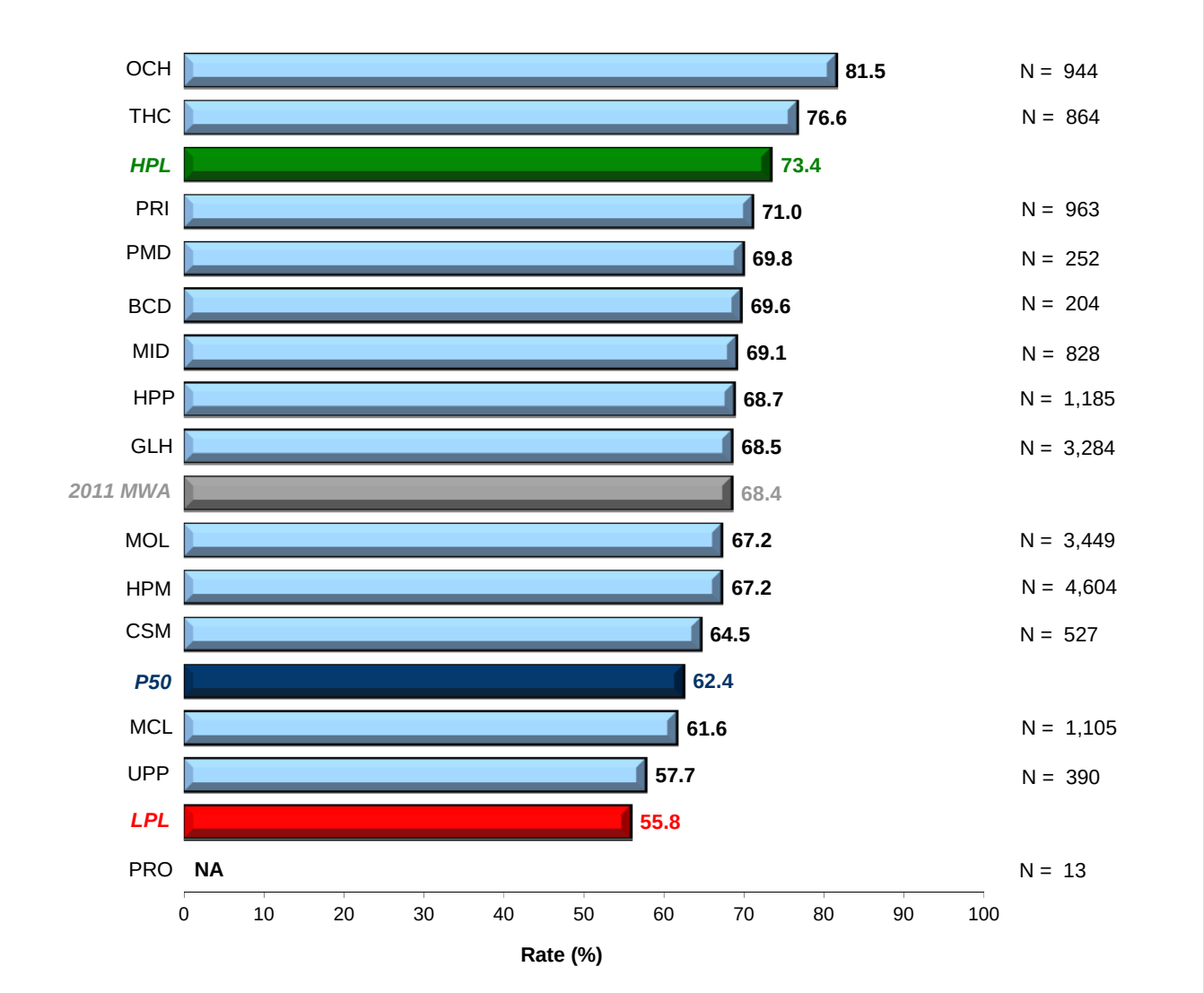
Three MHPs exceeded the HPL of 66.4 percent, and one fell below the LPL of 48.5 percent. Ten MHPs with reportable rates, including the three above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. One MHP was unable to report a rate for this measure since the denominator was too small to report a valid rate (a denominator of less than 30). The HEDIS 2011 Michigan Medicaid weighted average of 60.7 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 7.7 percentage points.

Figure 4-8—Chlamydia Screening in Women—21 to 24 Years
Michigan Medicaid Weighted Averages



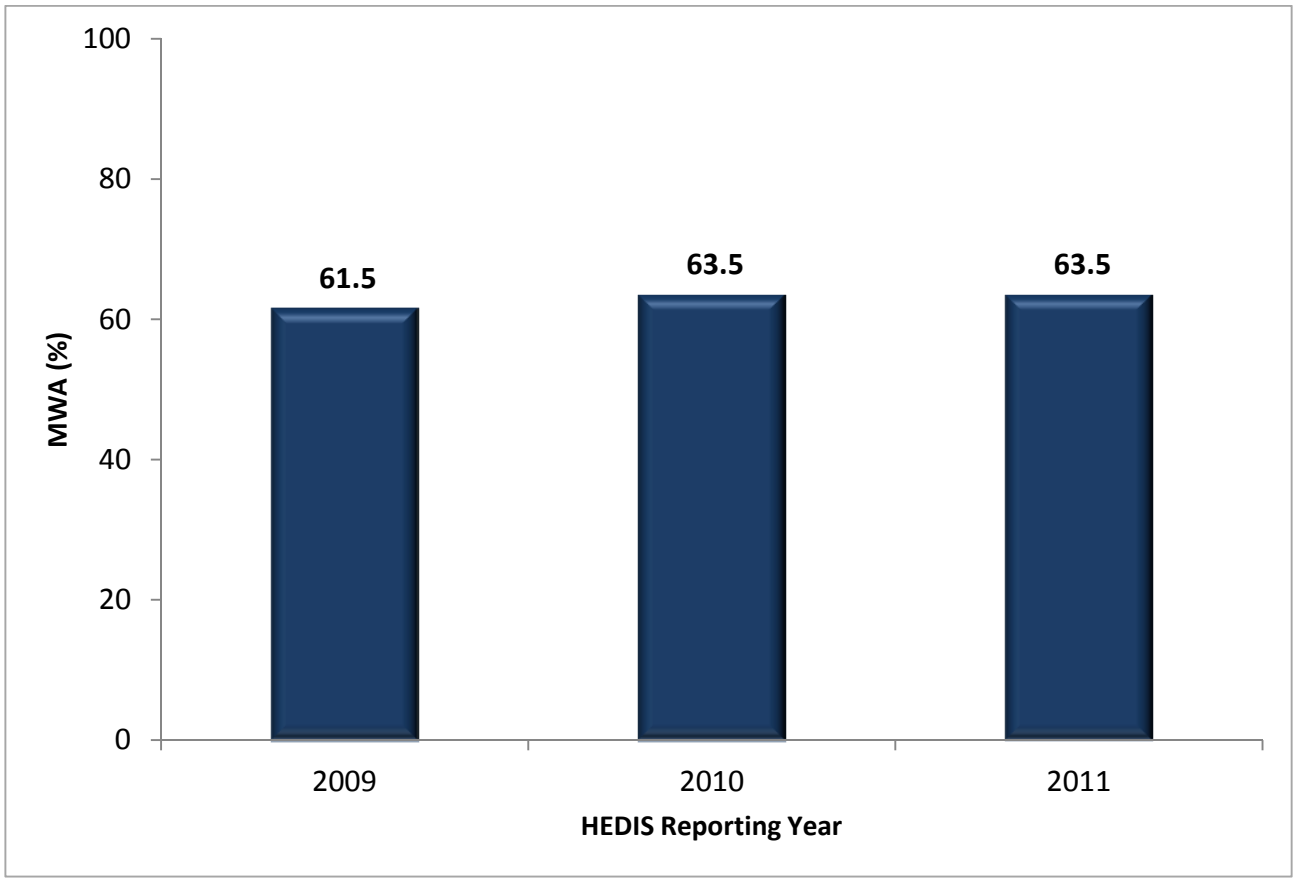
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated slight improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 1.5 percentage points and 0.6 percentage point, respectively. The observed improvement from last year was not statistically significant.

Figure 4-9—Chlamydia Screening in Women—21 to 24 Years
Health Plan Ranking



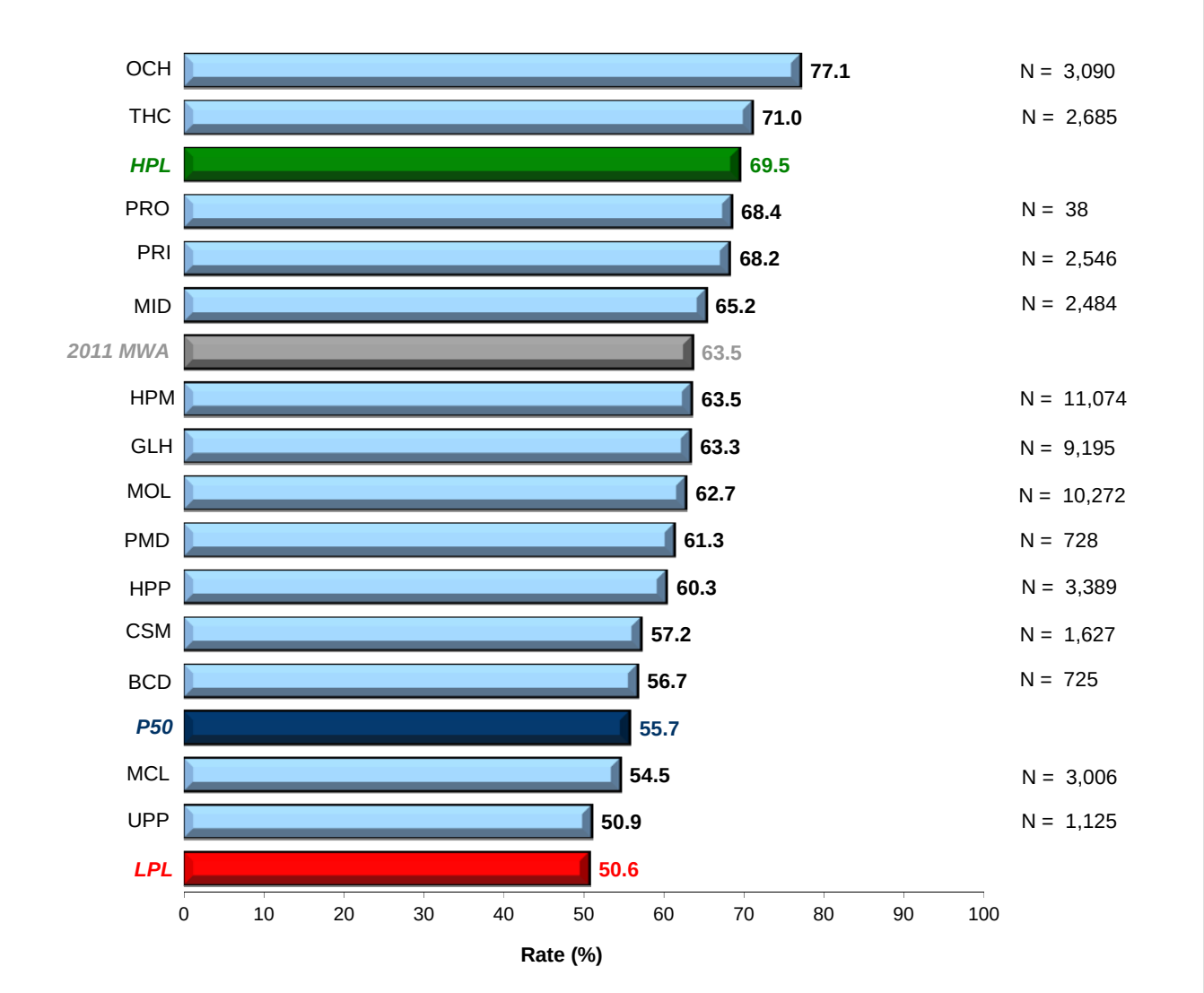
Two MHPs exceeded the HPL of 73.4 percent, and none of the MHPs were below the LPL of 55.8 percent. Eleven MHPs with reportable rates, including the two above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. One MHP was unable to report a rate for this measure since the denominator was too small to report a valid rate (a denominator of less than 30). The HEDIS 2011 Michigan Medicaid weighted average of 68.4 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 6 percentage points.

Figure 4-10—Chlamydia Screening in Women—Total
Michigan Medicaid Weighted Averages



The HEDIS 2011 Michigan Medicaid weighted average for this measure was the same as the HEDIS 2010 result. Compared to HEDIS 2009, the current year's rate showed improvement in performance by two percentage points.

Figure 4-11—Chlamydia Screening in Women—Total
Health Plan Ranking



Two MHPs exceeded the HPL of 69.5 percent, and none of the MHPs were below the LPL of 50.6 percent. Twelve MHPs with reportable rates, including the two above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 63.5 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 7.8 percentage points.

Prenatal and Postpartum Care—Timeliness of Prenatal Care

Measure Definition

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 43 days prior to delivery through 56 days after delivery, and who received a prenatal care visit as a member of the MHP in the first trimester or within 42 days of enrollment in the MHP.

Importance

More than four million infants are born in the United States each year. Approximately 12 percent of these infants are born preterm, and another 8.2 percent are of low birth weight.[4-20] Low birth weight increases the risk for neurodevelopmental handicaps, congenital abnormalities, and respiratory illnesses compared to infants of normal birth weight. More than 117,000 live births occurred in Michigan during 2009. Of these live births, 9,846 were of low birth weight.[4-21] In 2010, Michigan's infant mortality rate was 7.7 deaths per 1,000 live births, which ranked 37th in the United States.[4-22] With comprehensive prenatal care, the incidence of low birth weight and infant mortality can be reduced. Compared to women who received prenatal care, women who did not receive prenatal care were four times more likely to die from complications of pregnancy.[4-23]

Mothers are more likely to have babies with health problems when they begin receiving care late (defined as beginning in the third trimester of pregnancy) or receive no prenatal care at all. Infants are three times more likely to be low-weight when their mothers do not receive prenatal care. Additionally, those babies are five times more likely to die.[4-24] There are some researchers of health care data that have concerns about the effectiveness of prenatal care. It can be difficult to measure the unique effects of prenatal care, as research has shown that women who seek prenatal care are more likely to have higher incomes and intended pregnancies.[4-25] Prenatal care does not always address, and may not be as effective among, women with specific social and medical risks.[4-26] However, adequacy of care, as defined by the frequency and timing of visits, has been correlated with positive outcomes. Those visits may also play a part in the reduced likelihood of postpartum depression and infant injuries.

4-20 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on: August 9, 2011.

4-21 Michigan Department of Community Health. Low Weight Live Births by County of Residence. Available at: http://www.mdch.state.mi.us/pha/osr/Natality/LowWeightBirths.asp. Accessed on: August 24, 2011.

4.22 United Health Foundation. America's Health: State Health Rankings 2010. Available at: http://www.americashealthrankings.org/yearcompare/2009/2010/MI.aspx. Accessed on: August 24, 2011.

4-23 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on: August 24, 2011.

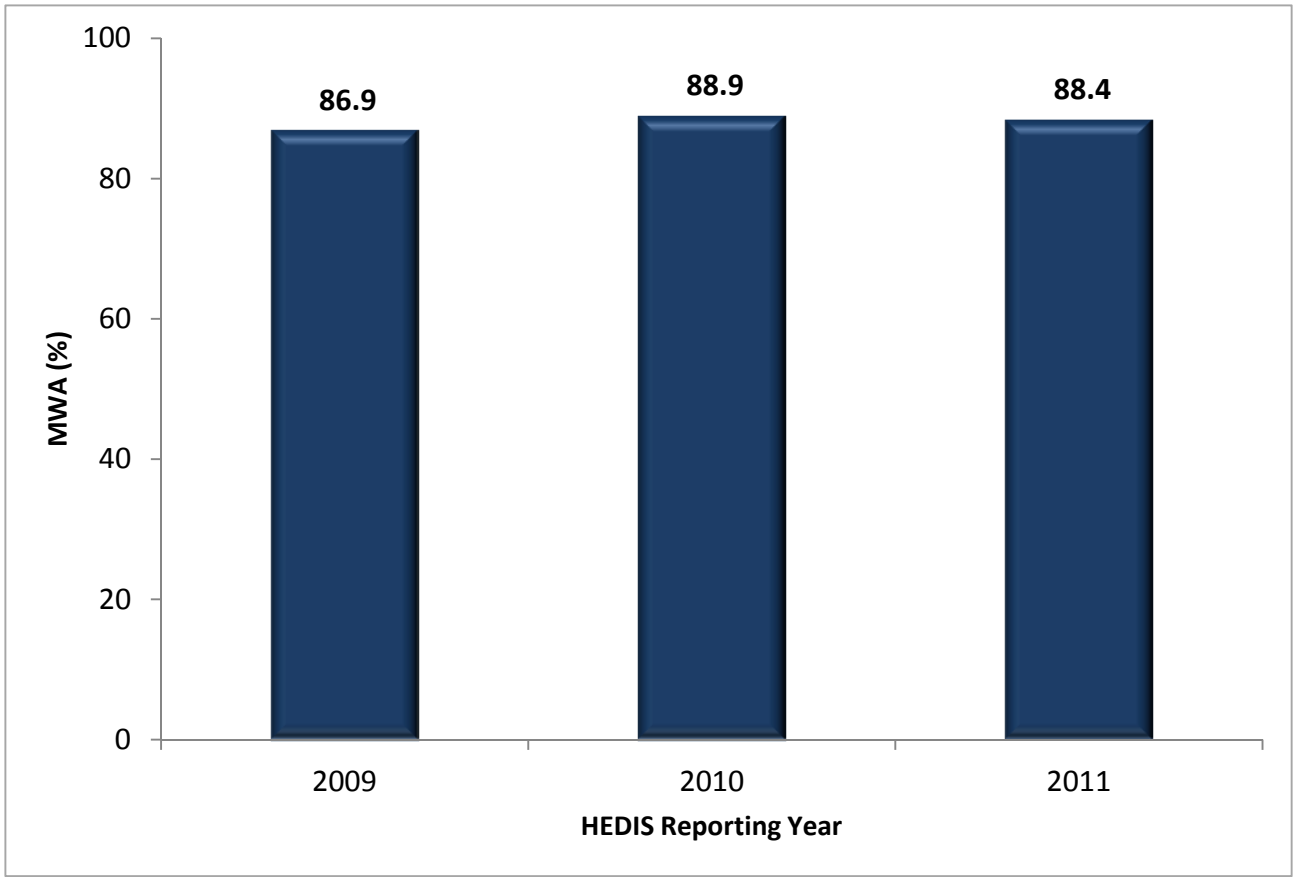
4-24 Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. "A Healthy Start: Begin Before Baby's Born." Available at: ftp://ftp.hrsa.gov/mchb/prenatal.pdf Accessed on: August 9,2011.

4-25 Logan, C., Moore, K., Manlove, J., Mincieli, L., Cottingham, S. "Conceptualizing a 'Strong Start': Antecedents of Positive Child Outcomes at Birth and Into Early Childhood". Child Trends Research Brief. Child Trends: Washington, D.C. http://www.childtrends.org/files/Child_Trends-2007_02_12_RB_StrongStart.pdf. Accessed on: August 9, 2011.

4-26 Alexander, G.R., Kotelchuck, M. 2001. "Assessing the role and effectiveness of prenatal care: history, challenges, and directions for future research." Public Health Reports. Vol. 116 (4). pp. 306-16. http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1497343&blobtype=pdf. Accessed on: August 9, 2011.

Performance Results

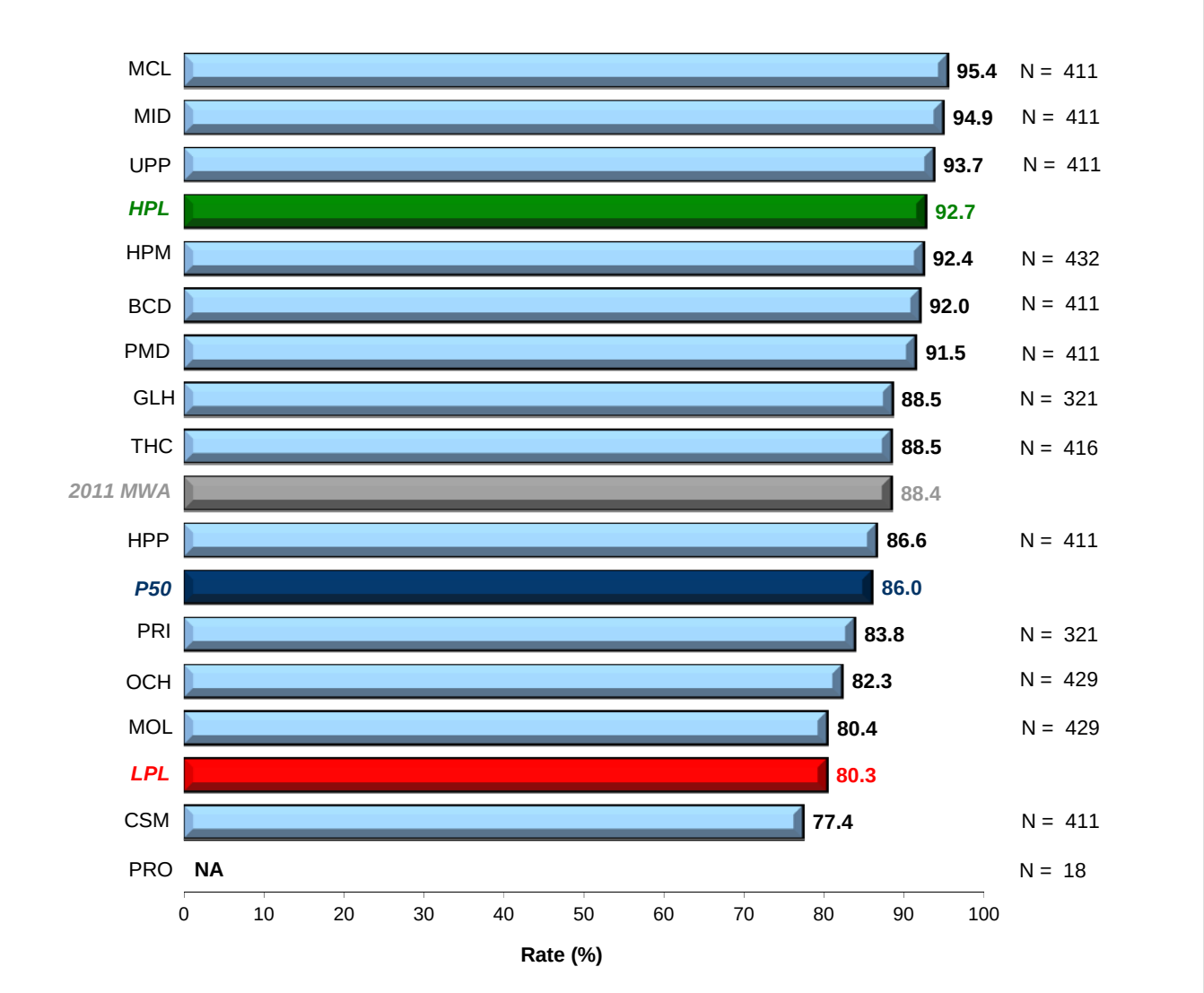
Figure 4-12—Prenatal and Postpartum Care—Timeliness of Prenatal Care
Michigan Medicaid Weighted Averages



The HEDIS 2011 Michigan Medicaid weighted average for this measure showed a slight decline from HEDIS 2010, but the decline was not statistically significant.

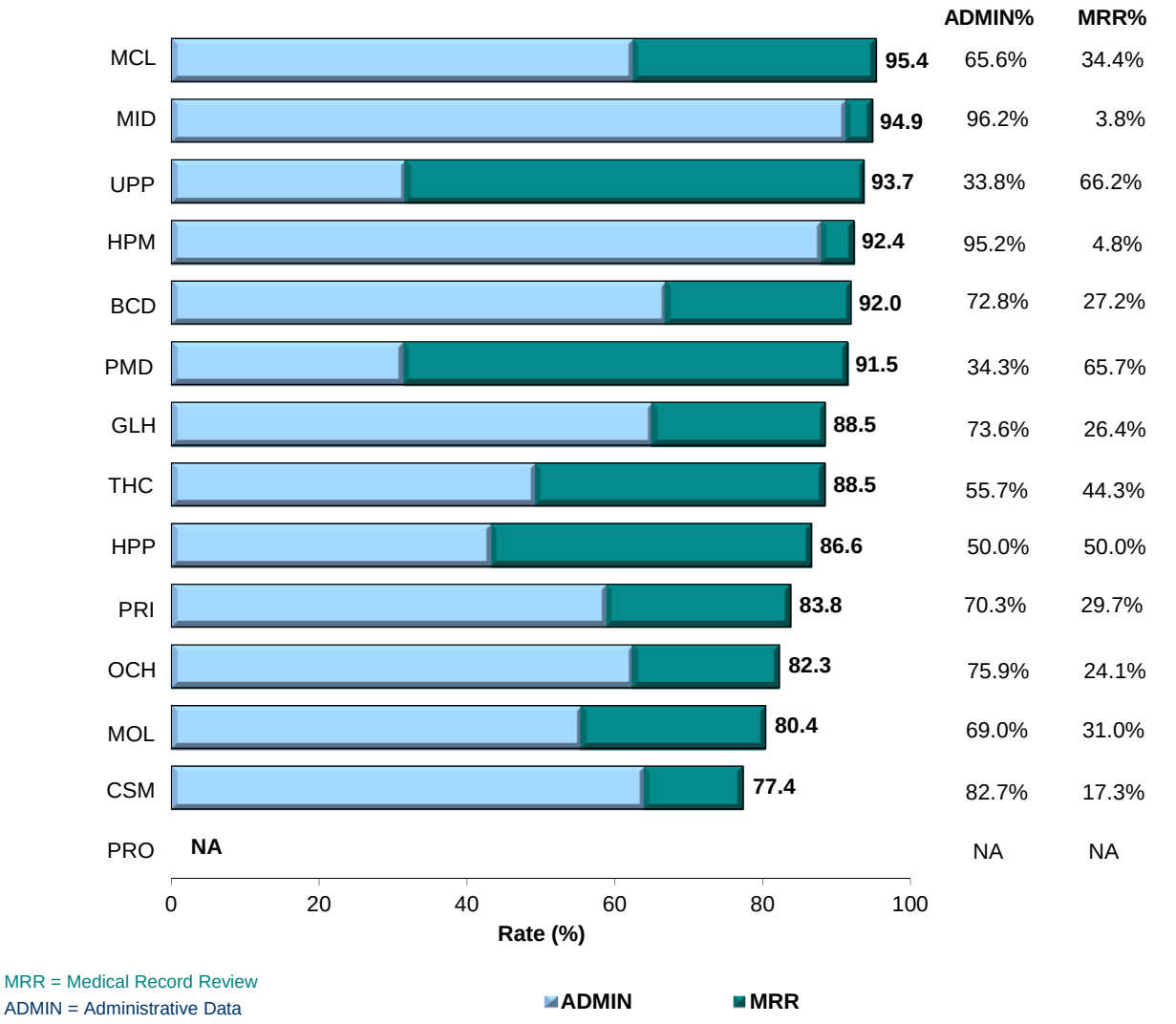
Compared to HEDIS 2009, the current year's rate demonstrated a slight improvement by 1.5 percentage points.

Figure 4-13—Prenatal and Postpartum Care—Timeliness of Prenatal Care
Health Plan Ranking



Three MHPs exceeded the HPL of 92.7 percent, and one fell below the LPL of 80.3 percent. Nine MHPs with reportable rates, including the three above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. One MHP was unable to report a rate for this measure since the denominator was too small to report a valid rate (a denominator of less than 30). The HEDIS 2011 Michigan Medicaid weighted average of 88.4 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 2.4 percentage points.

Figure 4-14—Prenatal and Postpartum Care—Timeliness of Prenatal Care Data Collection Analysis



All MHPs reporting valid rates elected to use the hybrid method for this measure. Of these thirteen plans, only two relied on their administrative data for more than 90 percent of the reported rate.

Prenatal and Postpartum Care—Postpartum Care

Measure Definition

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 43 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.

Importance

While care strategies tend to emphasize the prenatal period, appropriate care during the postpartum period is also important. Socioeconomic factors that present barriers to consistent care are common in the Medicaid population. In 2009, 83.6 percent of commercial health plan members received timely postpartum care; however, only 64.1 percent of Medicaid members received timely postpartum care.[4-27]

Postpartum care is an important determinant of health outcomes for women giving birth. Since medical complications and death can occur after a woman has given birth, postpartum visits can address any adverse effects, such as persistent bleeding, inadequate iron levels, elevated blood pressure, pain, emotional changes, and infections.

Postpartum depression is one of the most prevalent complications that can occur after delivery. Data show that 10 to 15 percent of mothers are affected by postpartum depression within a year of giving birth.[4-28] Possible risk factors for postpartum depression include low infant birth weight; admission to a neonatal intensive-care unit; tobacco use during the last three months of pregnancy; and emotional, financial, partner-related, or traumatic stress during the 12 months prior to delivery. Receiving appropriate postpartum care can help to address postpartum depressive symptoms.

There are also physical issues associated with pregnancy that should be closely monitored during the postpartum period. For example, 1 to 3 percent of vaginal deliveries result in postpartum endometriosis. Additionally, up to 23 percent of women experience urinary incontinence after the first year of delivery. Thyroid disorders are also relatively common after delivery; 4 to 7 percent of women experience hypothyroidism or hyperthyroidism in the first year postpartum. Women at risk for any of these complications should be tested and treated during the postpartum period.[4-29]

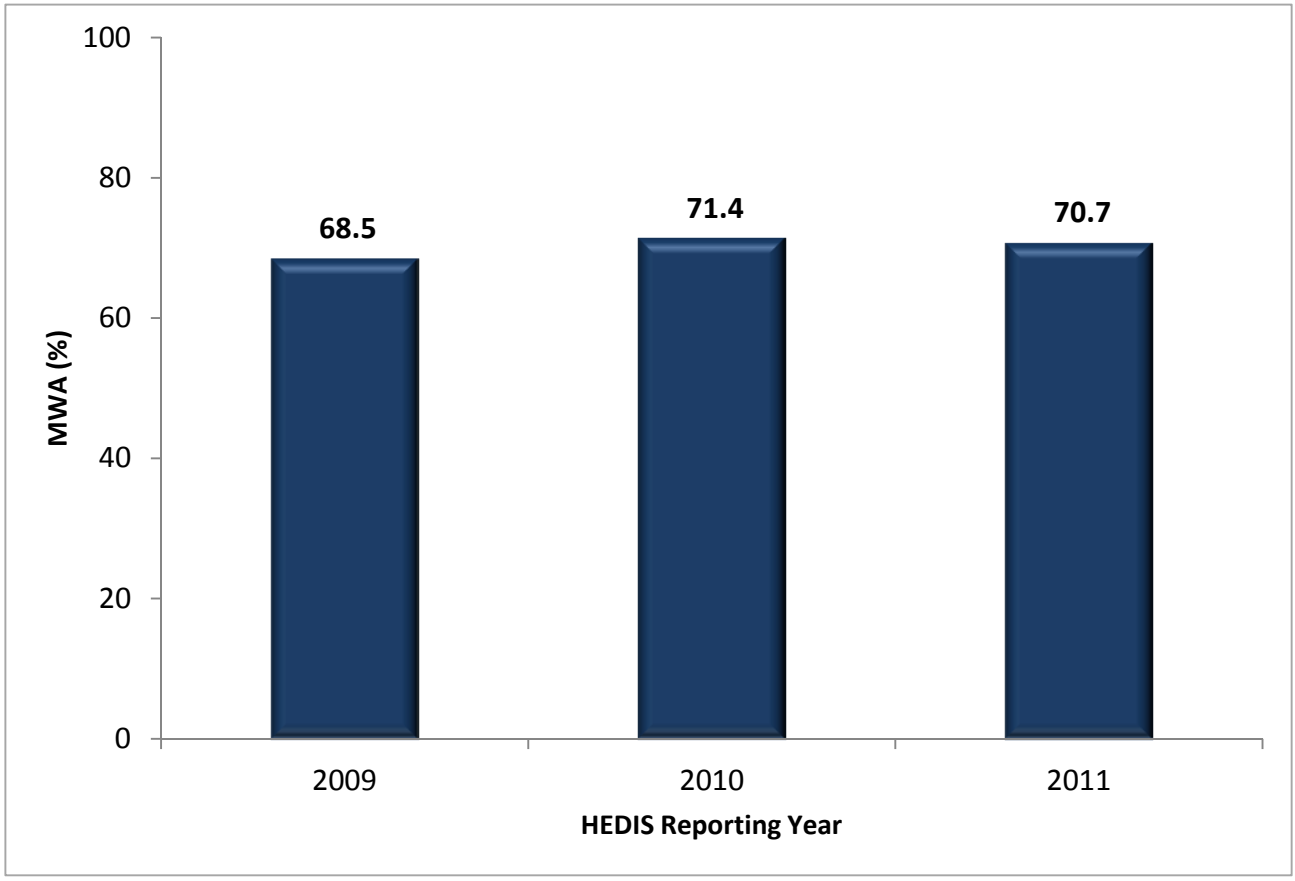
4-27 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on: August 24, 2011.

4-28 Centers for Disease Control and Prevention. Prevalence of Self-Reported Postpartum Depressive Symptoms—17 States, 2004–2005. *Morbidity and Mortality Weekly Report*. April 11, 2008. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5714a1.htm. Accessed on: September 7, 2011.

4-29 Blenning C, Paladine H. An Approach to the Postpartum Office Visit. *American Family Physician.* 2005; 72(12): 2491–2496.

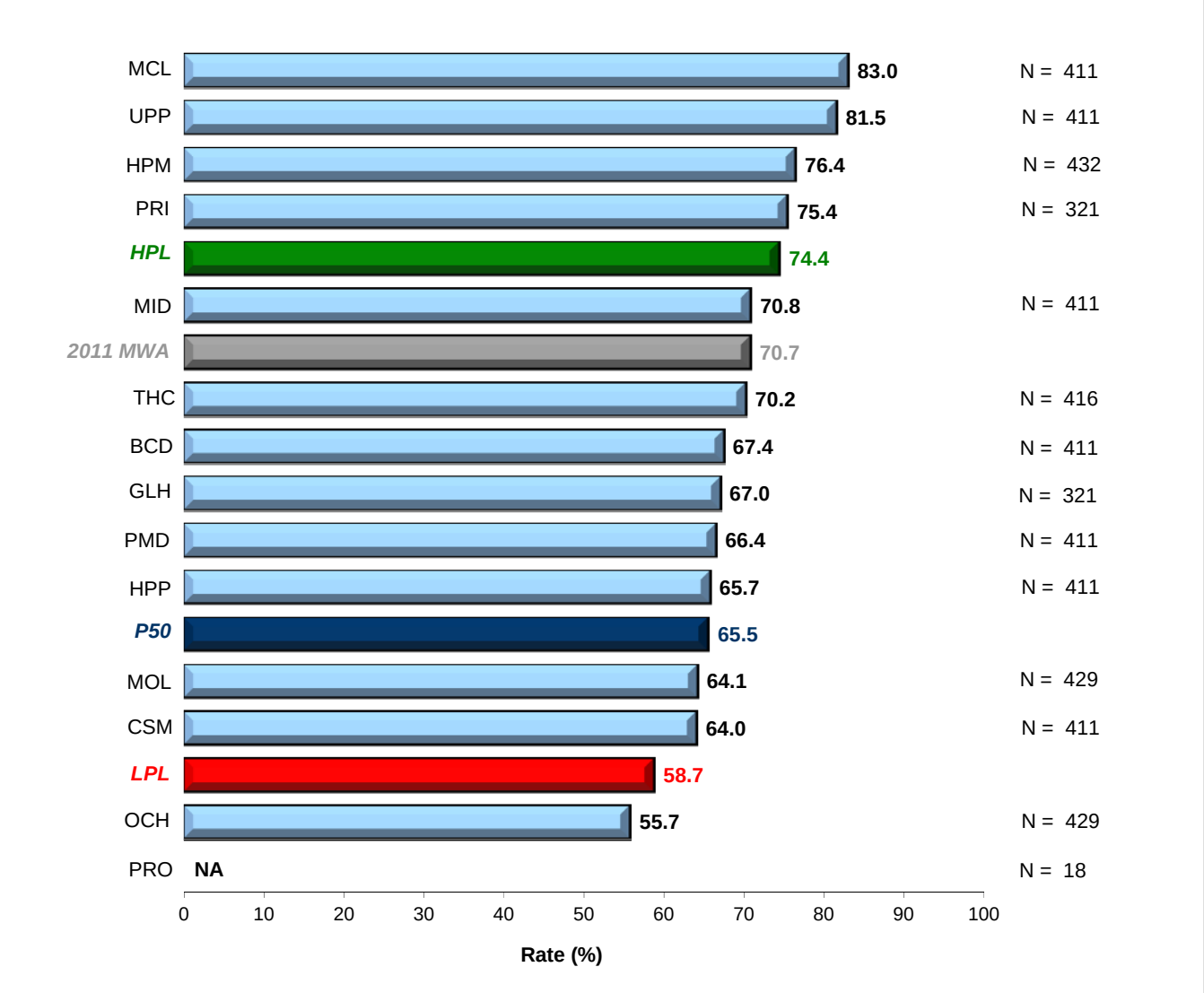
Performance Results

Figure 4-15—Prenatal and Postpartum Care—Postpartum Care
Michigan Medicaid Weighted Averages



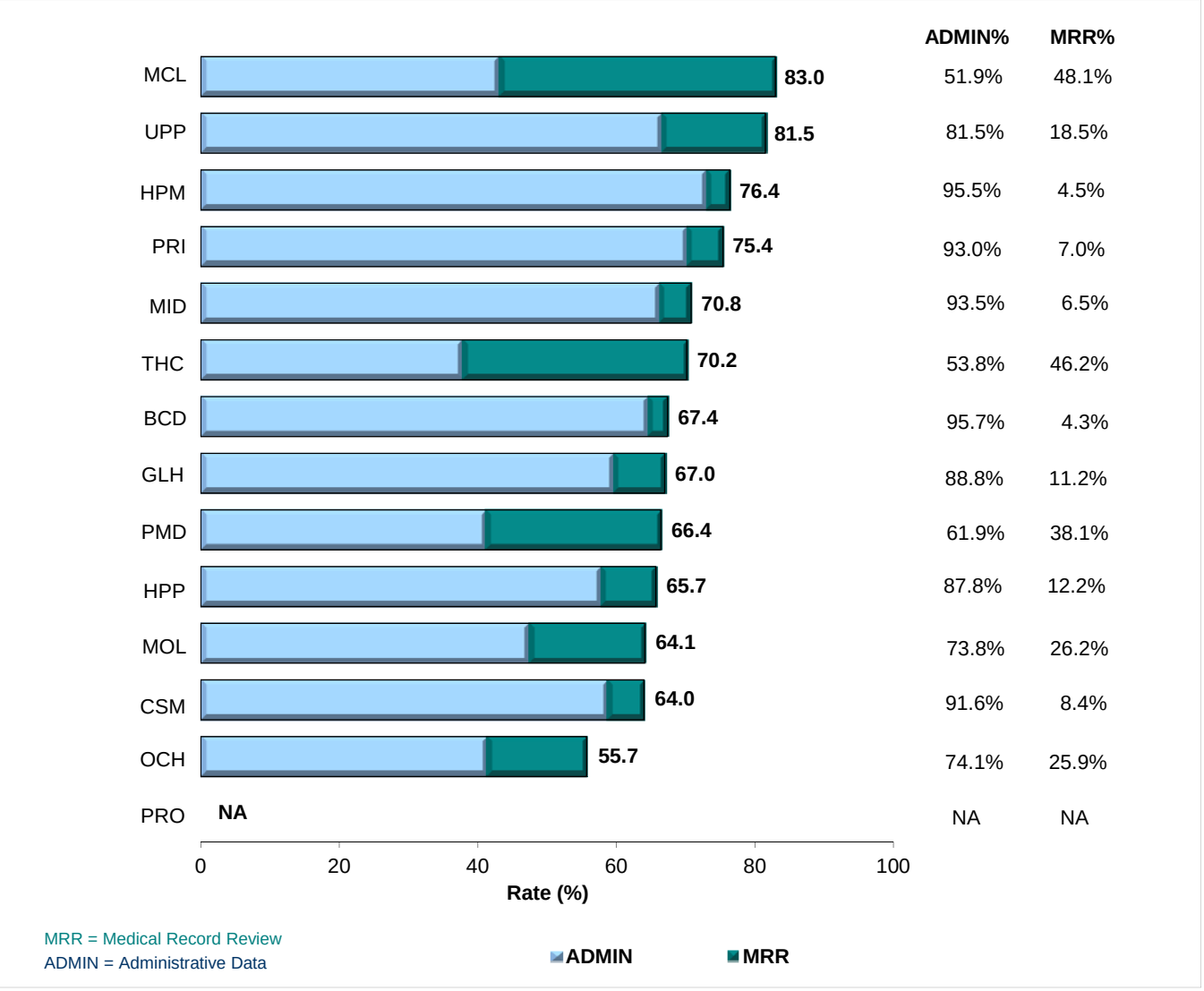
The HEDIS 2011 Michigan Medicaid weighted average for this measure showed a slight decline from HEDIS 2010, but the decline was not statistically significant. Compared to HEDIS 2009, the current year's rate demonstrated a slight improvement by 2.2 percentage points.

Figure 4-16—Prenatal and Postpartum Care—Postpartum Care
Health Plan Ranking



Four MHPs exceeded the HPL of 74.4 percent, and one fell below the LPL of 58.7 percent. Ten MHPs with reportable rates, including the four above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. One MHP was unable to report a rate for this measure since the denominator was too small to report a valid rate (a denominator of less than 30). The HEDIS 2011 Michigan Medicaid weighted average of 70.7 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 5.2 percentage points.

Figure 4-17—Prenatal and Postpartum Care—Postpartum Care Data Collection Analysis



All MHPs reporting valid rates elected to use the hybrid method to report this measure. Of these thirteen plans, five had more than 90 percent of their rates derived from administrative data.

Adult BMI Assessment

Measure Definition

Adult BMI Assessment reports the percentage of members 18–74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year.

Importance

The current epidemic of obesity in the United States continues to pose a major public health challenge. The number of obese Americans has increased dramatically in recent years, and today almost 34 percent of U.S. adults are obese.[4-30] In 2010, no U.S. state had an obesity prevalence less than 20 percent. Michigan ranked 44 of 51 states that have obese populations, reporting over 30 percent of all Michigan adults were obese in 2010.[4-31]

The rapid growth of obesity in the United States has resulted in an increasing impact on individual overall health. Obesity, defined as a BMI of 30 or higher, is correlated with excess mortality. Those who have grade 2+ obesity (BMI of 35 or higher) are at significantly higher risk of death. Obesity also increases the risk of heart disease, stroke, some cancers, osteoarthritis, and disability, and is the most important risk factor for Type 2 diabetes.[4-32] Obesity is the second leading cause of preventable death behind smoking, and affects every ethnic group, socioeconomic class, and geographic region in the United States.[4-33]

Obesity and its related health problems also have substantial economic consequences for the U.S. health care system. According to one study, medical spending across all payers (i.e., Medicare, Medicaid, and private insurers) for someone who is obese was $1,429 greater per year, or approximately 42 percent higher, than for someone of normal weight.[4-34] In terms of overall spending in the United States, obesity costs around $92 billion per year in medical care and disability.[4-35]

Determining a patient's BMI is usually the first step in weight management and treatment. Studies have shown that for the majority of patients, BMI provides an acceptable approximation of total body fat. In epidemiological studies, BMI is also the favored measure of excess body weight to estimate relative risk of disease.[4-36]

4-30 Centers for Disease Control and Prevention. U.S. Obesity Trends. Available at: http://www.cdc.gov/obesity/data/trends.html. Accessed on: August 10, 2011.

4-31 Ibid.

4-32 U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. *Health, United States, 2010*. Atlanta, GA: DHHS; 2011.

4-33 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on August 10, 2011.

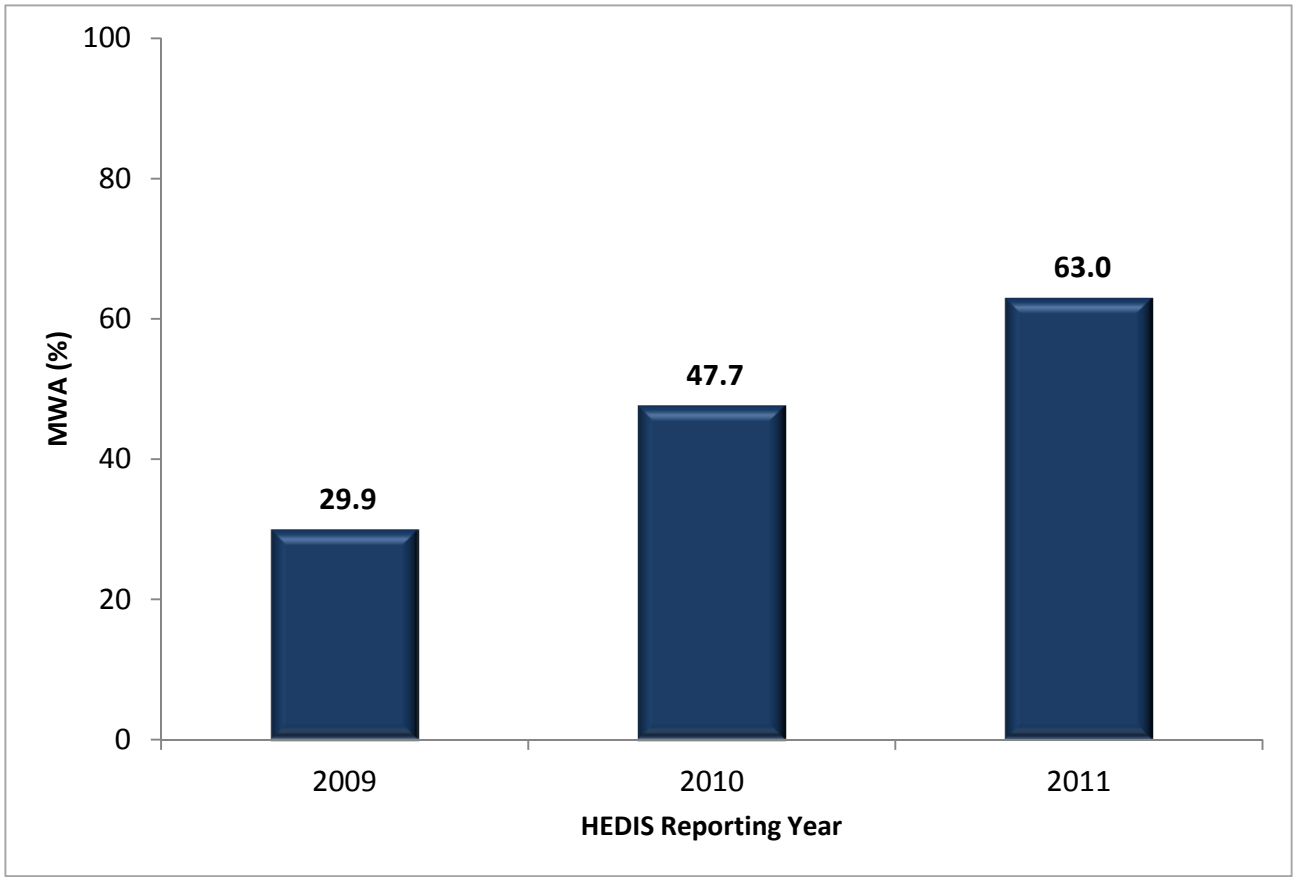
4-34 Finkelstein EA, Trogdon JG, Cohen JW, et al. Annual Medical Spending Attributable to Obesity: Payer-and Service-Specific Estimates. *Health Affairs*. 2009; 28: w822-w831. Available at http://www.npr.org/blogs/thetwo-way/obesity%20costs%20study.pdf. Accessed on: August 10, 2011.

4-35 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on August 10, 2011.

4-36 National Institutes of Health. Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. Available at: http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf. Accessed on August 16, 2011.

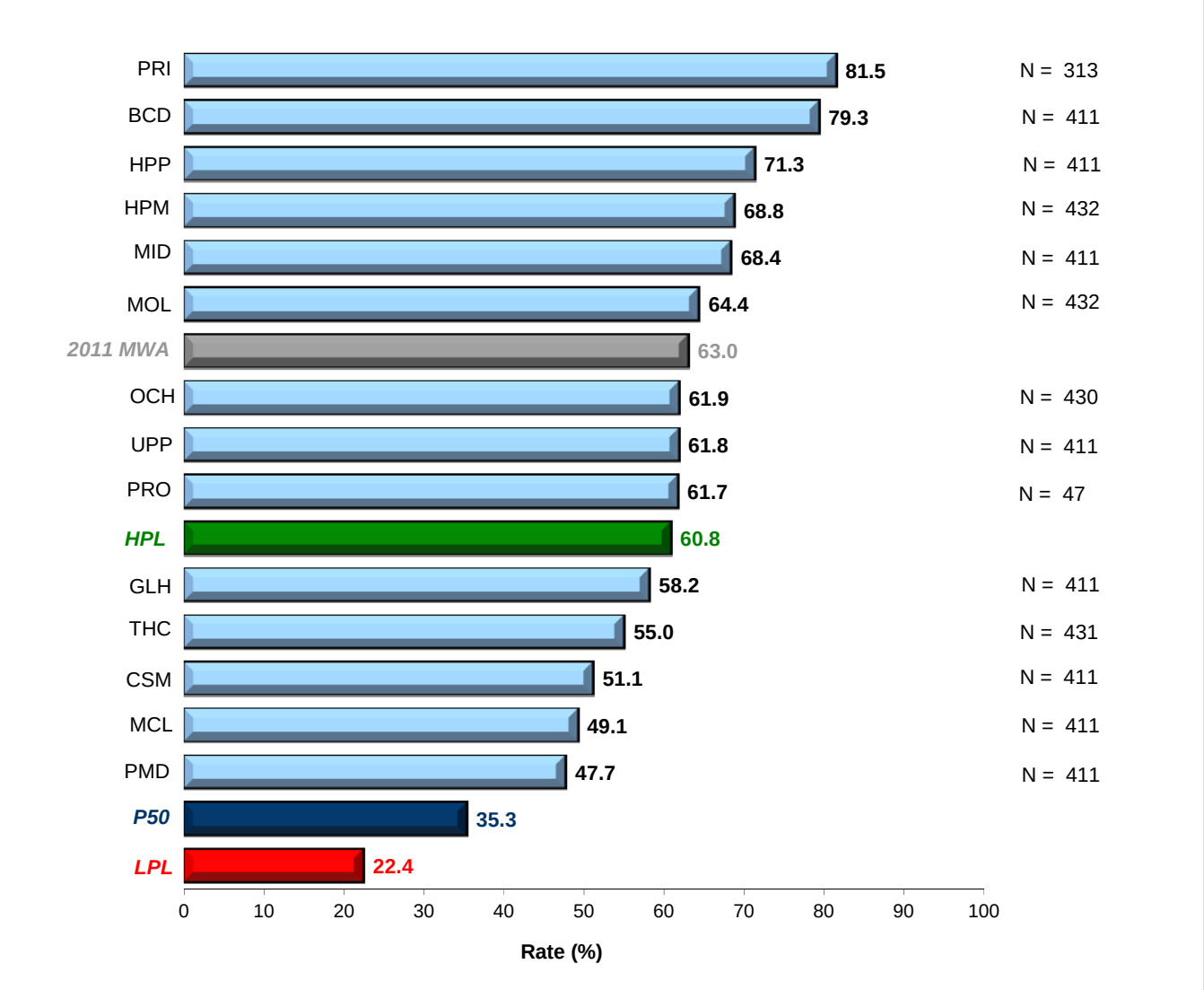
Performance Results

Figure 4-18—Adult BMI Assessment
Michigan Medicaid Weighted Averages



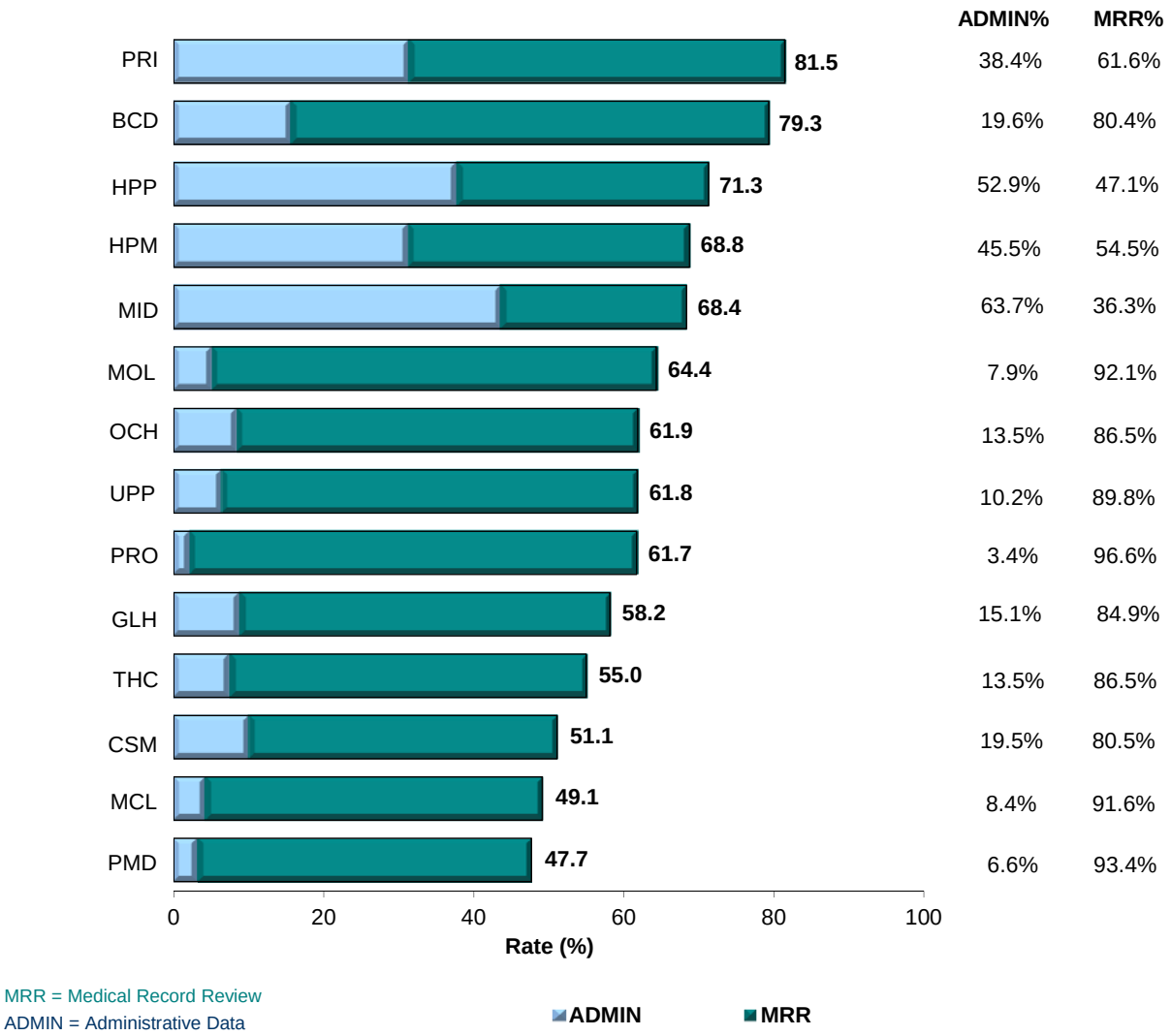
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated notable and statistically significant improvement since HEDIS 2009. The HEDIS 2011 weighted average increased from the HEDIS 2010 rate by 15.3 percentage points. Since HEDIS 2009, this measure had improved by 33.1 percentage points.

Figure 4-19—Adult BMI Assessment
Health Plan Ranking



Nine MHPs and the HEDIS 2011 Michigan Medicaid weighted average exceeded the HPL of 60.8 percent; none of the MHPs fell below the LPL of 22.4 percent. While all MHPs with reportable rates reported rates above the national HEDIS 2010 Medicaid 50th percentile, plans exhibited wide variation in their performance. Rate variation ranged from 47.7 percent to 81.5 percent, a difference of 33.8 percentage points.

Figure 4-20—Adult BMI Assessment
Data Collection Analysis



All MHPs elected to use the hybrid method to report this measure. With the exception of two plans, all relied on medical record data for at least 50 percent of the rate.

Women's Care Findings and Recommendations

Summary of Findings

Table 4-1 summarizes MHP's rank relative to the national HEDIS 2010 Medicaid percentiles for each measure under the Women's and Adult Care dimension. Since the percentile rank is mostly associated with performance level, the tables also serve as high-level comparison of performance by measure across all plans. For percentile range associated with each rank symbol, please refer to the Percentile Ranking section in Section 2 of this report.

Table 4-1—Women's and Adult Care Performance Summary

MHP Name	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening 16–20 Years	Chlamydia Screening 21–24 Years	Chlamydia Screening Total	Timeliness of Prenatal Care	Post-partum Care	Adult BMI Assessment
BlueCaid of Michigan	★★★★	★★★★★	★★	★★★★	★★★	★★★★	★★★	★★★★★
CareSource Michigan	★★	★★	★★★	★★★	★★★	★	★★	★★★★
United-Healthcare Great Lakes Health Plan, Inc.	★★★	★★★★	★★★	★★★	★★★	★★★	★★★	★★★★
Health Plan of Michigan, Inc.	★★★★	★★★★	★★★	★★★	★★★	★★★★	★★★★★	★★★★★
HealthPlus Partners	★★★★	★★★★	★★★	★★★	★★★	★★★	★★★	★★★★★
McLaren Health Plan	★★★	★★★★	★★	★★	★★	★★★★★	★★★★★	★★★★
Midwest Health Plan	★★★	★★★★	★★★★	★★★	★★★★	★★★★★	★★★★	★★★★★
Molina Healthcare of Michigan	★★★	★★★	★★★	★★★	★★★	★★	★★	★★★★★
OmniCare Health Plan	★★★	★★★★	★★★★★	★★★★★	★★★★★	★★	★	★★★★★
Physicians Health Plan of Mid-Michigan Family Care	★	★★★	★★★	★★★★	★★★	★★★★	★★★	★★★

Table 4-1—Women's and Adult Care Performance Summary								
MHP Name	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening 16–20 Years	Chlamydia Screening 21–24 Years	Chlamydia Screening Total	Timeliness of Prenatal Care	Post-partum Care	Adult BMI Assessment
Priority Health Government Programs, Inc.	★★★★★	★★★	★★★★★	★★★★	★★★★	★★	★★★★★	★★★★★
ProCare Health Plan	NA	★	NA	NA	★★★★	NA	NA	★★★★★
Total Health Care, Inc.	★★★	★★★★	★★★★★	★★★★★	★★★★★	★★★	★★★	★★★★
Upper Peninsula Health Plan	★★★	★★★	★	★★	★★	★★★★★	★★★★★	★★★★★

Among all the measures under this dimension, only the *Adult BMI Assessment* measure had all plans performing at or above the national HEDIS 2010 Medicaid 50th percentile. In addition, nine of the 14 MHPs reported *Adult BMI Assessment rates* meeting or exceeding the national HEDIS 2010 Medicaid 90th percentile. The *Cervical Cancer Screening* measure also demonstrated fairly good performance across most of the plans; eight plans reported rates meeting or exceeding the national HEDIS 2010 Medicaid 75th percentile. Comparatively, the two *Prenatal and Postpartum Care* measures reported relatively poor performance among the plans. For both of these measures, at least three plans fell below the national HEDIS 2010 Medicaid 50th percentile.

Table 4-2 presents statewide performance at a glance for the measures under the Women's and Adult Care dimension. It lists the HEDIS 2011 weighted averages, the trended results, and a summary of the MHPs with rates showing significant changes from HEDIS 2010.

Table 4-2—Michigan Medicaid HEDIS 2011 Statewide Rate Trend
Women's and Adult Care

Measure	Statewide Rate		Number of MHPs	
	2011 Weighted Average	2010–2011 Trend	With Significant Improvement in 2011	With Significant Decline in 2011
Breast Cancer Screening	56.3%	**+1.2**	3	0
Cervical Cancer Screening	74.3%	+1.6	0	1
Chlamydia Screening in Women—Ages 16 to 20 Years	60.7%	-0.4	1	2
Chlamydia Screening in Women—Ages 21 to 24 Years	68.4%	+0.6	2	0
Chlamydia Screening in Women—Total	63.5%	0.0	1	2
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.4%	-0.5	1	1
Prenatal and Postpartum Care—Postpartum Care	70.7%	-0.7	1	2
Adult BMI Assessment	63.0%	**+15.3**	12	0

2010–2011 Trend note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decrease from the prior year.

Legend	<P10	≥P10 and < P25	≥P25 and < P50	≥P50 and < P75	≥P75 and < P90	≥P90

At the statewide level, the HEDIS 2011 Michigan Medicaid program performance in the Women's and Adult Care dimension was favorably comparable to the national HEDIS 2010 Medicaid percentiles. All measures met or exceeded the national 50th percentile and one (*Adult BMI Assessment*) reported a statewide rate that met the national 90th percentile. Although only four measures reported increases in their rates from HEDIS 2010, two (*Breast Cancer Screening* and *Adult BMI Assessment*) showed statistical significant improvement, and one in particular (*Adult BMI Assessment*) reported an increase of 15.3 percentage points. While most of the measures had only a few MHPs showing significant improvement, the *Adult BMI Assessment* measure had 12 of the 14 MHPs performing statistically significantly better from HEDIS 2010.

Best Practices

There are many health care factors that can be attributed to the results of the Women's and Adult Care measures. Some of those factors include the coordination of care between providers and outreach programs to educate members of the importance and availability of services. Other factors include methods of removing barriers to receiving screening and preventive services, such as providing transportation and/or making user-friendly resource directories available. Quality improvement projects should aim at eliminating barriers associated with improving these health care factors.

Introduction

Chronic diseases affect 133 million people in the United States—nearly half of all Americans—and account for seven out of 10 deaths per year, as well as the vast majority of health care spending.[5-1] The aging U.S. population will increase this population to an estimated 157 million people by the year 2020.[5-2] Chronic diseases are also the leading causes of disability in the United States. Additionally, about one-fourth of those with chronic conditions experience at least one daily activity limitation.

The following section provides a detailed analysis of the Michigan MHPs' performance for the Living With Illness dimension. The Living With Illness dimension encompasses the following MDCH key measures:

- *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 mg/dL*
- *Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy*
- *Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Use of Appropriate Medications for People With Asthma—5 to 11 Years*
- *Use of Appropriate Medications for People With Asthma—12 to 50 Years*
- *Use of Appropriate Medications for People With Asthma—Combined Rate*
- *Controlling High Blood Pressure*
- *Medical Assistance with Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*
- *Medical Assistance with Smoking and Tobacco Use Cessation—Discussing Cessation Medications*
- *Medical Assistance with Smoking and Tobacco Use Cessation—Discussing Cessation Strategies*

5-1 Centers for Disease Control and Prevention. Chronic Diseases and Health Promotion. Available at: http://www.cdc.gov/chronicdisease/overview/index.htm. Accessed on: August 4, 2011.

5-2 Partnership for Solutions. Chronic Conditions: Making the Case for Ongoing Care. Available at: http://www.partnershipforsolutions.org/DMS/files/chronicbook2004.pdf. Accessed on: August 4, 2011.

Comprehensive Diabetes Care

The annual cost of diabetes in the United States was an estimated $174 billion in 2007. Of this total, $116 billion was due to medical expenditures, while $58 billion was the result of lost productivity and other indirect costs.[5-3] The total costs associated Michigan residents who have been diagnosed with diabetes is an estimated $7 billion, while another $1 billion in costs is associated with Michigan residents with undiagnosed diabetes.[5-4] While diabetes can result in many serious complications such as heart disease and kidney disease, control of diabetes significantly reduces the rate of such complications and improves quality of life.

In Michigan, just over 9 percent of adults have been diagnosed with diabetes, which ranks the State 15th in the United States for diabetes prevalence. African Americans and Native Americans in Michigan have double the prevalence of diagnosed diabetes as non-Hispanic, White adults, while Hispanics have 75 percent more cases of diagnosed diabetes compared to Whites.[5-5] For a comprehensive assessment of diabetes care, multiple factors must be evaluated. 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.

5-3 American Diabetes Association. Direct and Indirect Costs of Diabetes in the United States. Available at: http://www.diabetes.org/diabetes-basics/diabetes-statistics/. Accessed on: August 25, 2011.

5-4 Michigan Department of Community Health. Diabetes in Michigan 2010—The Facts. Available at: http://www.michigan.gov/documents/mdch/Diabetes_in_Michigan2010_331597_7.pdf. Accessed on: August 25, 2011.

5-5 Ibid.

Comprehensive Diabetes Care—HbA1c Testing and Control

Measure Definition

The *Comprehensive Diabetes Care—HbA1c Testing* rate reports the percentage of members with diabetes (Type 1 and Type 2) 18 through 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.

The *Comprehensive Diabetes Care—Poor HbA1c Control* rate reports the percentage of members with diabetes (Type 1 and Type 2) 18 through 75 years of age who were continuously enrolled during the measurement year and whose most recent HbA1c test conducted during the measurement year showed a greater than 9 percent HbA1c level, as documented through automated laboratory data and/or medical record review. If no HbA1c level test occurred during the measurement year, the level is considered to be greater than 9 percent (i.e., no test is counted as poor HbA1c control).

Importance

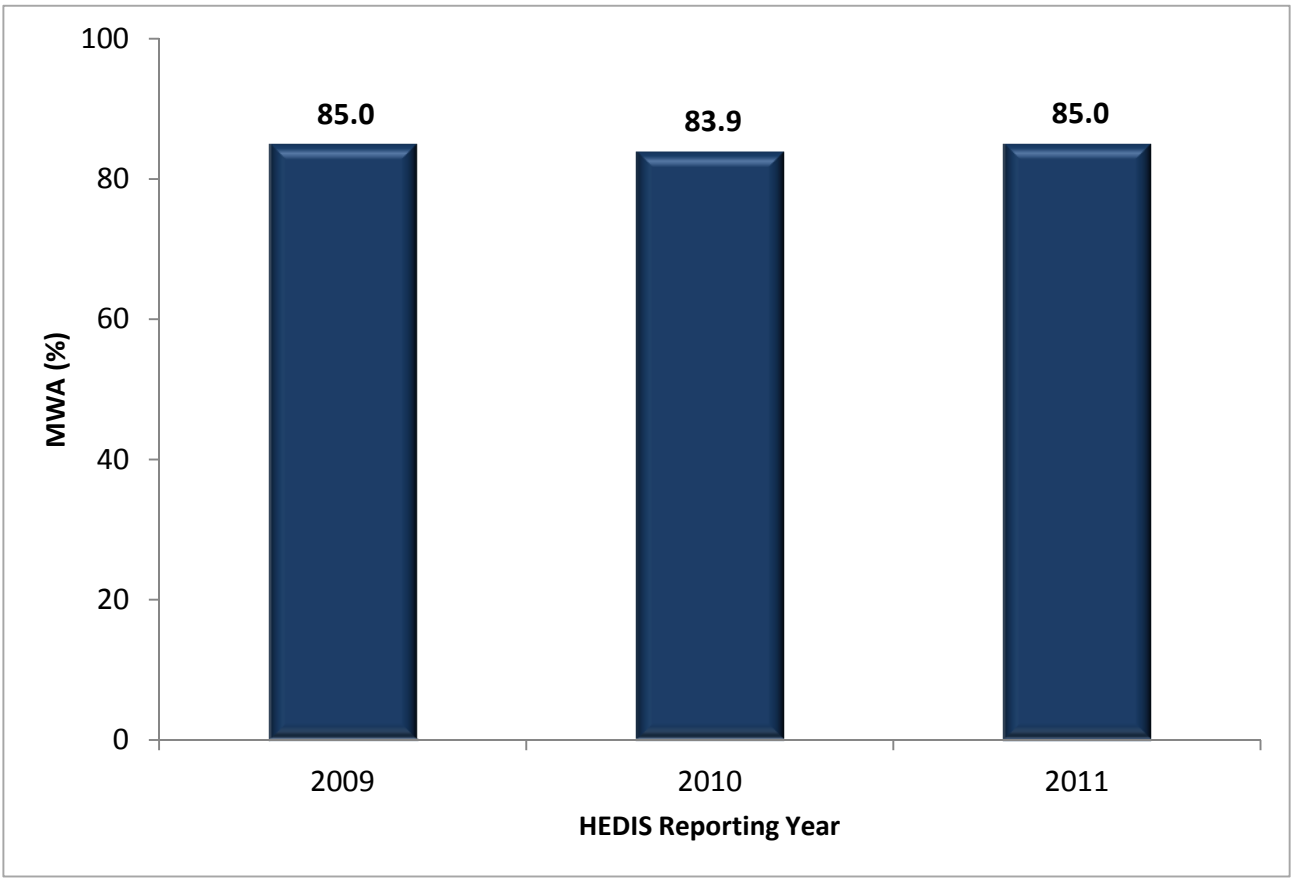
The HbA1c test (hemoglobin A1c test or glycosylated hemoglobin test) provides the average blood glucose level over a period of two to three months. Specifically, the test measures the percentage of hemoglobin in red blood cells that is glycosylated (or glycated).

HbA1c control improves quality of life, increases work productivity, and decreases health care utilization. Diabetic patients who maintain HbA1c levels close to normal levels gain, on average, an extra five years of life, eight years of sight, and six years of freedom from kidney disease.[5-6]

[5-6] National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on: August 24, 2011.

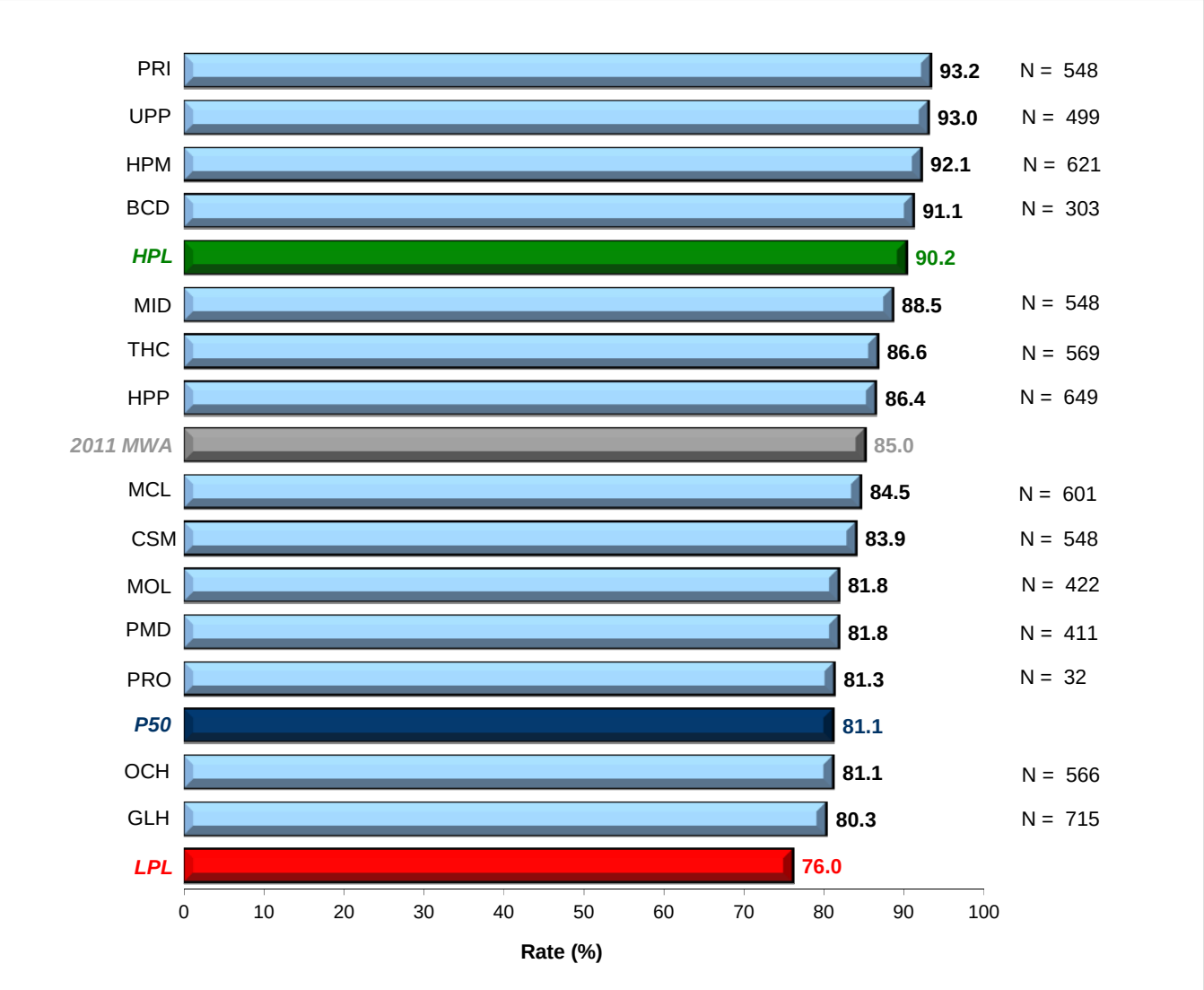
Performance Results

Figure 5-1—Comprehensive Diabetes Care—HbA1c Testing
Michigan Medicaid Weighted Averages



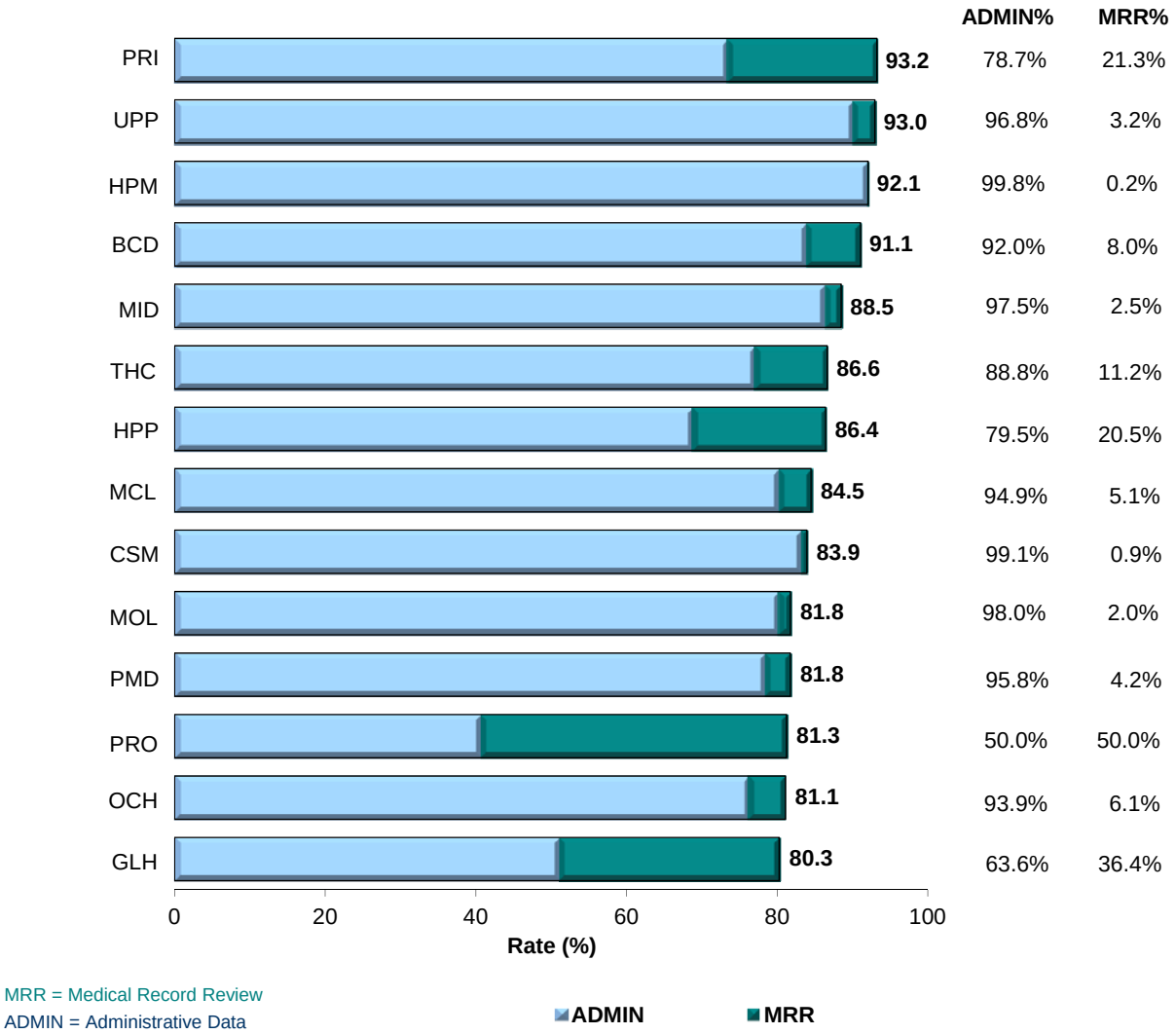
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated slight and statistically insignificant improvement from HEDIS 2010 (1.1 percentage points increase) and was the same as the HEDIS 2009 rate.

Figure 5-2—Comprehensive Diabetes Care—HbA1c Testing
Health Plan Ranking



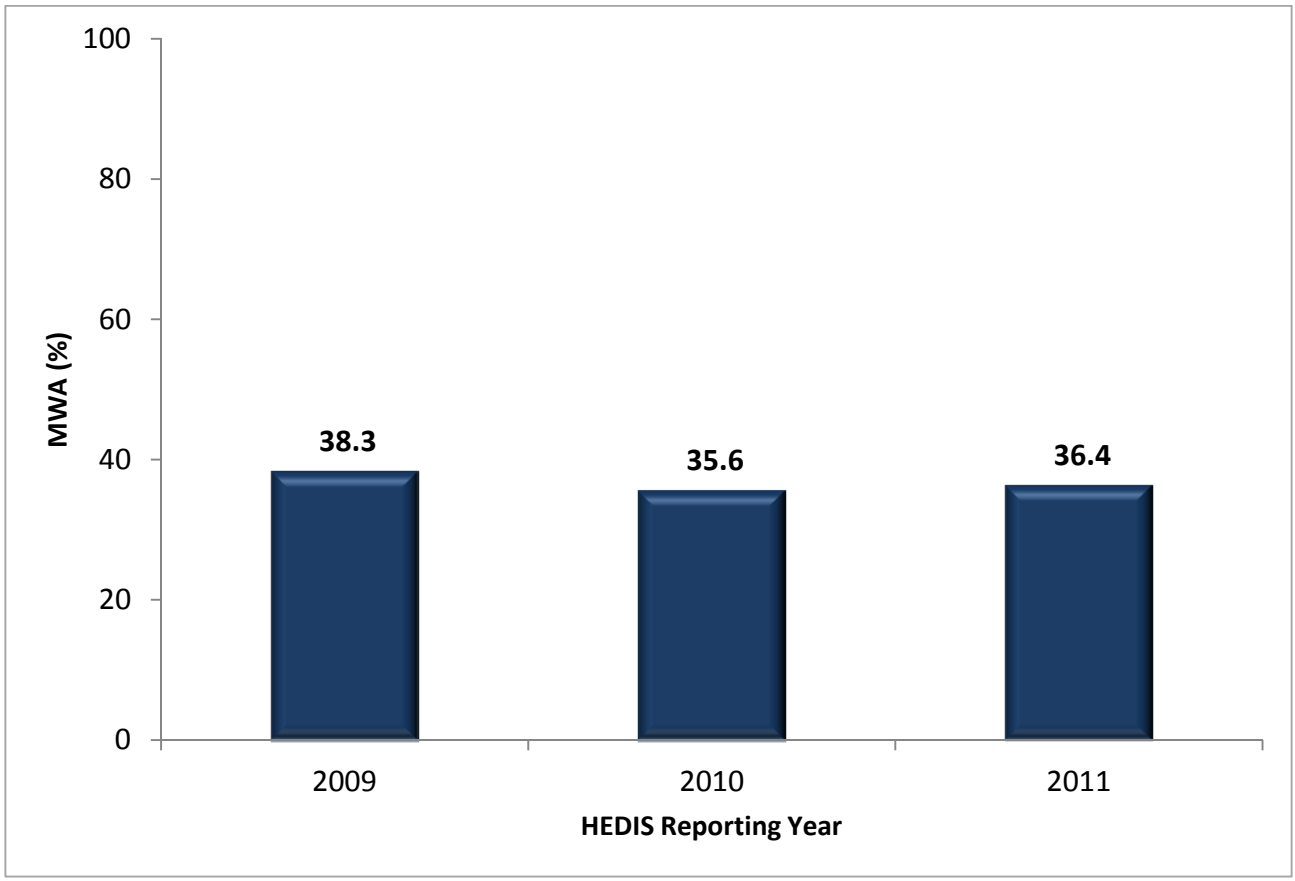
Four MHPs exceeded the HPL of 90.2 percent, and none of the MHPs fell below the LPL of 76.0 percent. All but two MHPs reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 85.0 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 3.9 percentage points.

Figure 5-3—Comprehensive Diabetes Care—HbA1c Testing
Data Collection Analysis



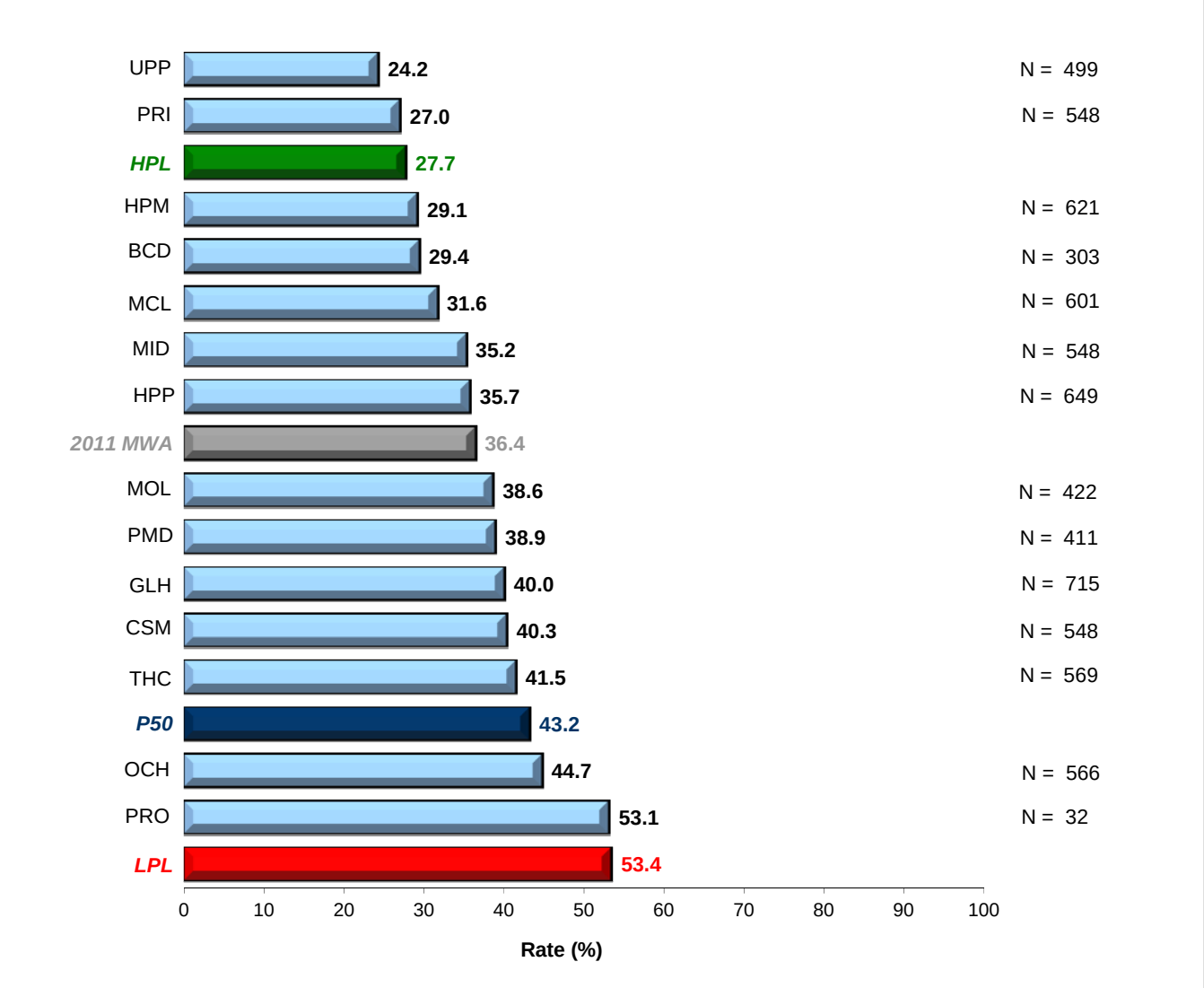
All MHPs elected to use the hybrid method for this measure. Six plans had at least 95 percent of their rates derived from administrative data. One plan had 50 percent of its rate derived from medical record review data.

Figure 5-4—Comprehensive Diabetes Care—Poor HbA1c Control
Michigan Medicaid Weighted Averages



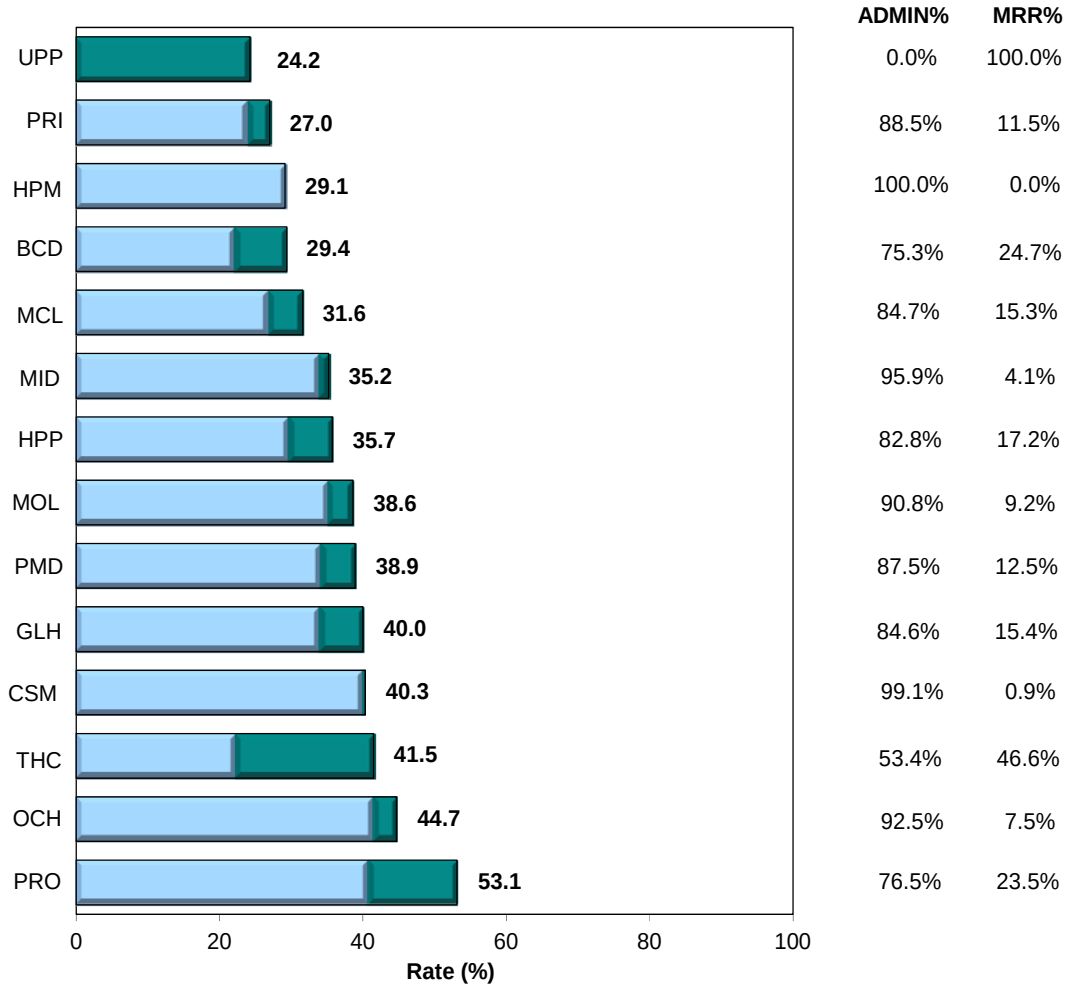
For this measure a lower rate indicates better performance. The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated a slight, though statistically insignificant increase from HEDIS 2010 (0.8 percentage point increase). However, the current year's rate showed improvement from HEDIS 2009 by 1.9 percentage points.

Figure 5-5—Comprehensive Diabetes Care—Poor HbA1c Control
Health Plan Ranking



Since a lower rate indicates better performance for this measure, two MHPs exceeded the HPL of 27.7 percent, and none of the MHPs were below the LPL of 53.4 percent. Twelve MHPs with reportable rates, including the two above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 36.4 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 6.8 percentage points.

Figure 5-6—Comprehensive Diabetes Care—Poor HbA1c Control
Data Collection Analysis



All MHPs elected to use the hybrid method for this measure. One plan relied completely on medical record data to derive its rate. Three plans had at least 95 percent of their rates based on administrative data.

Comprehensive Diabetes Care—Eye Exam

Measure Definition

The *Comprehensive Diabetes Care—Eye Exam* rate reports the percentage of members with diabetes (Type 1 and Type 2) 18 through 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) or a negative retinal exam in the year prior to the measurement year, as documented through either administrative data or medical record review.

Importance

The three most common eye complications in diabetics are retinopathy, cataracts, and glaucoma.[5-7] From 2005 to 2008, 4.2 million diabetics 40 years of age or older had retinopathy, and of these people, 655,000 had advanced retinopathy with the potential for severe vision loss.[5-8] From 2007 to 2009, the rate of eye disease in Michigan adults with diabetes was 279 per 1,000 people, compared to a rate of 88 per 1,000 for the general population.[5-9] 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.[5-10]

5-7 WebMD. Eye Problems and Diabetes. Available at: http://diabetes.webmd.com/eye-problems. Accessed on: August 25, 2011.

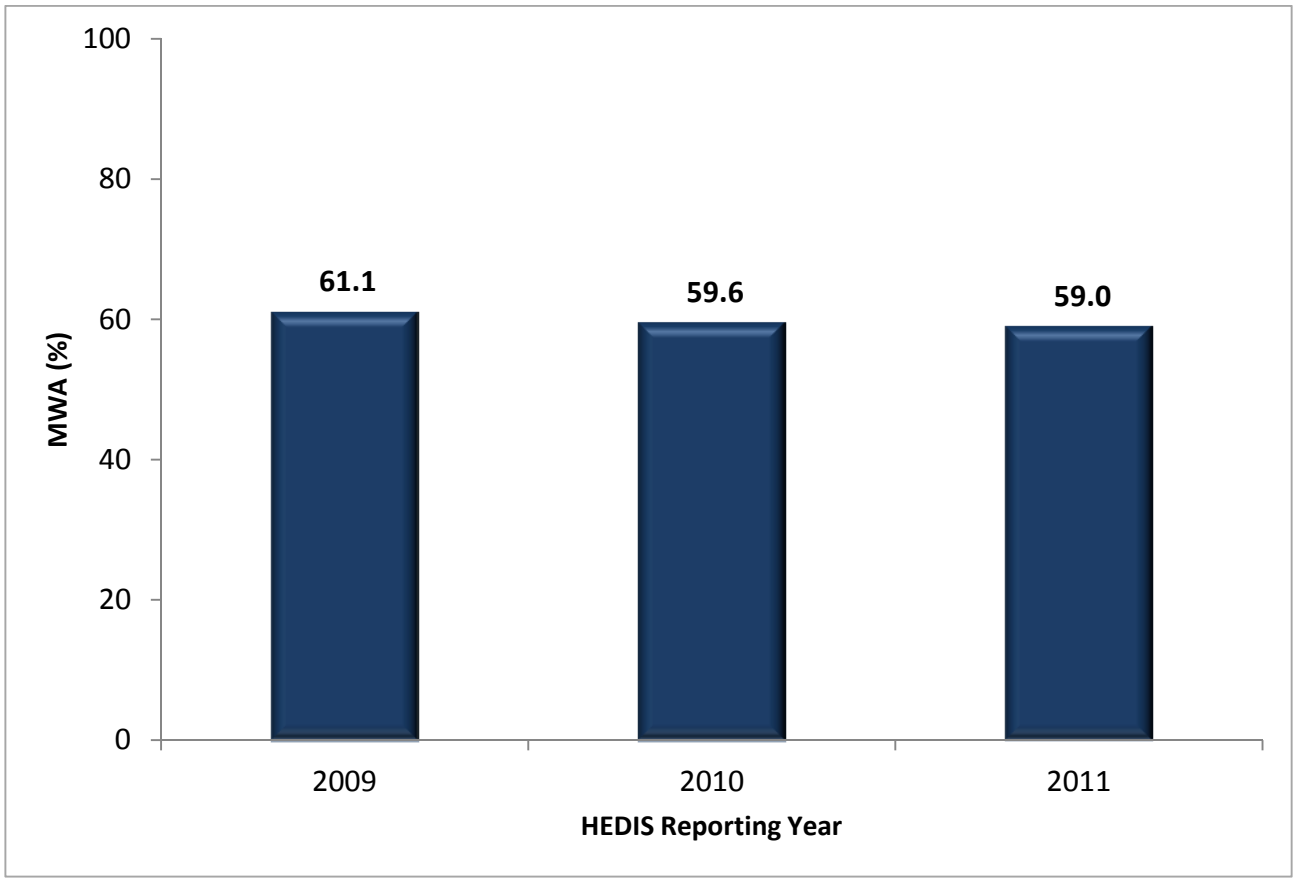
5-8 National Diabetes Information Clearinghouse (NDIC). National Diabetes Statistics, 2011. Available at: http://diabetes.niddk.nih.gov/dm/pubs/statistics/#Blindness. Accessed on: August 25, 2011.

5-9 Michigan Department of Community Health. Diabetes in Michigan 2010—The Facts. Available at: http://www.michigan.gov/documents/mdch/Diabetes_in_Michigan2010_331597_7.pdf. Accessed on: August 25, 2011.

5-10 National Institutes of Health. Fact Sheet: Diabetic Retinopathy. Available at: http://report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=86&key=D#D. Accessed on: August 25, 2011.

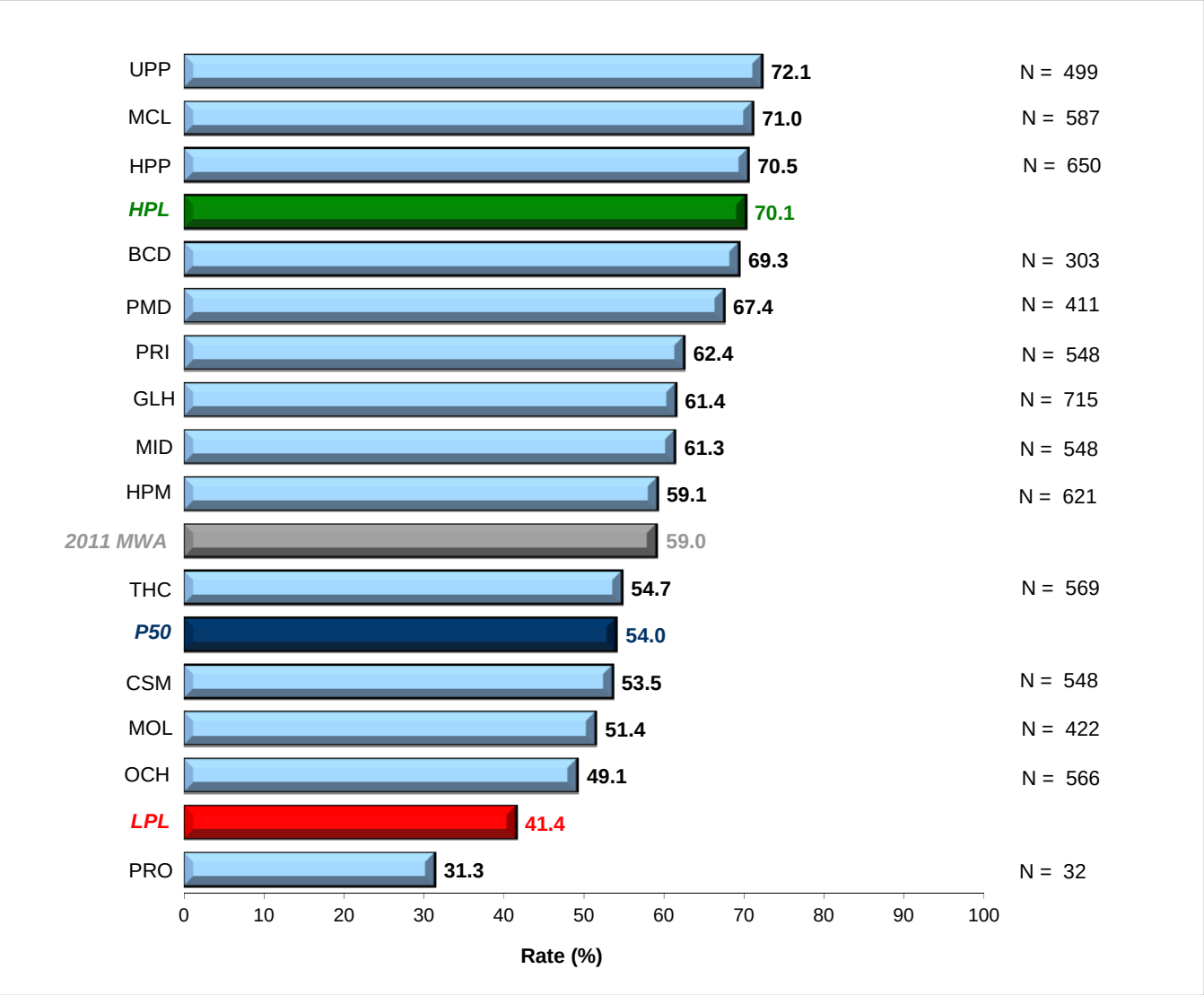
Performance Results

Figure 5-7—Comprehensive Diabetes Care—Eye Exam
Michigan Medicaid Weighted Averages



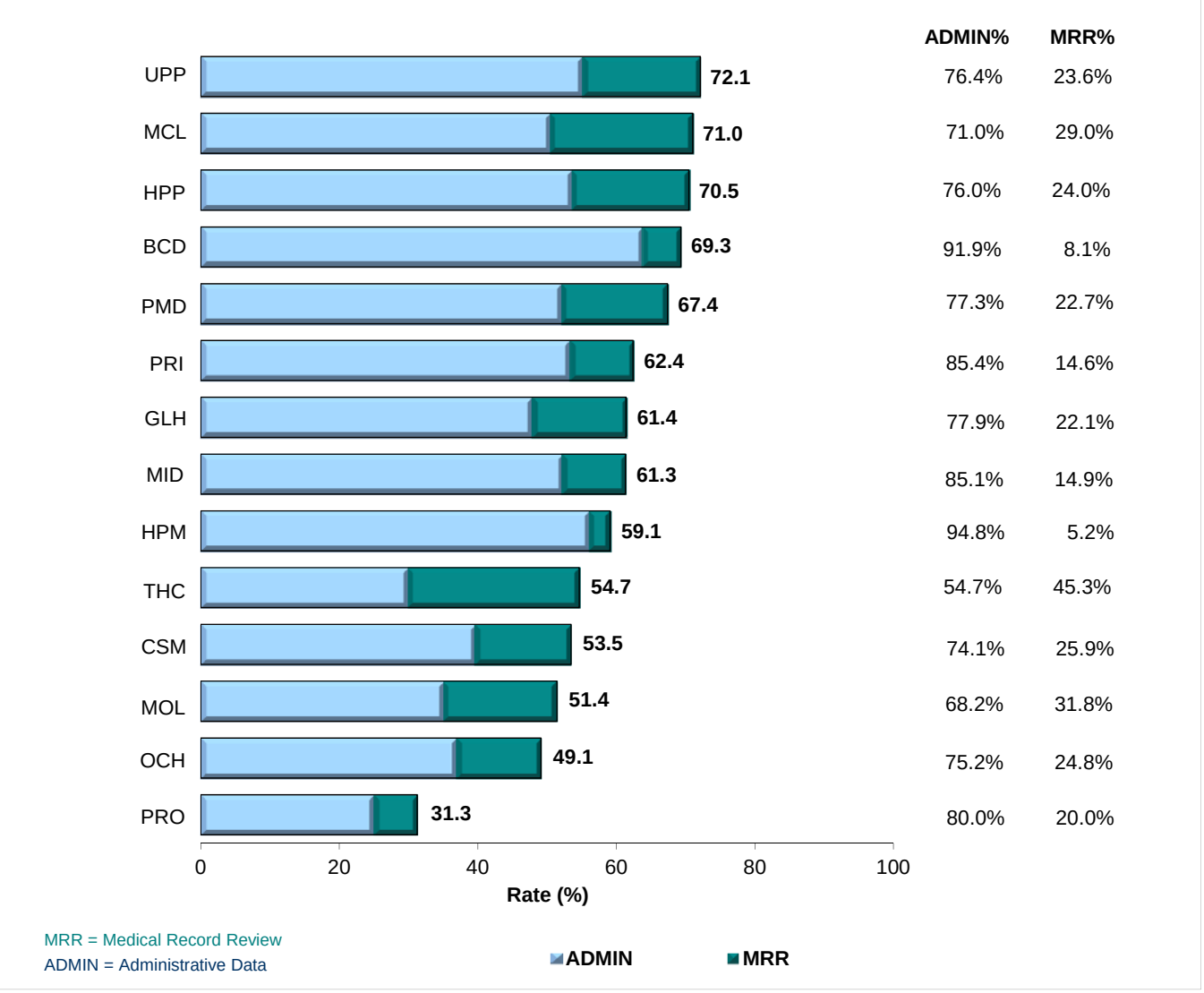
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated a slight decline from previous years' results. The HEDIS 2011 weighted average decreased from the HEDIS 2009 and HEDIS 2010 weighted averages by 2.1 percentage points and 0.6 percentage point, respectively.

Figure 5-8—Comprehensive Diabetes Care—Eye Exam
Health Plan Ranking



Three MHPs exceeded the HPL of 70.1 percent, and one fell below the LPL of 41.4 percent. Ten MHPs reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 59.0 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 5.0 percentage points.

Figure 5-9—Comprehensive Diabetes Care—Eye Exam
Data Collection Analysis



All MHPs elected to use the hybrid method for this measure. While all plans had at least 50 percent of their rates derived from administrative data, only two relied on administrative data for over 90 percent of their rates.

Comprehensive Diabetes Care—LDL-C Screening

Measure Definitions

The *Comprehensive Diabetes Care—LDL-C Screening* rate reports the percentage of members with diabetes (Type 1 and Type 2) 18 through 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, automated laboratory data, or medical record review.

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

Importance

Low-density lipoprotein (LDL) is considered to be undesirable because it can build up in the inner walls of blood vessels and contribute to atherosclerosis and heart disease.[5-11] LDL-C screening is important for diabetics because high LDL-C levels are associated with increased risk for cardiovascular mortality, heart disease, heart attack, and stroke.

Patients with diabetes are at two-to-three times greater risk of cardiovascular mortality compared to non-diabetic patients.[5-12] However, reducing cholesterol levels can have a major impact; a 30 percent reduction in LDL-C levels has been shown to reduce major vascular events by approximately 25 percent, regardless of the baseline LDL.[5-13]

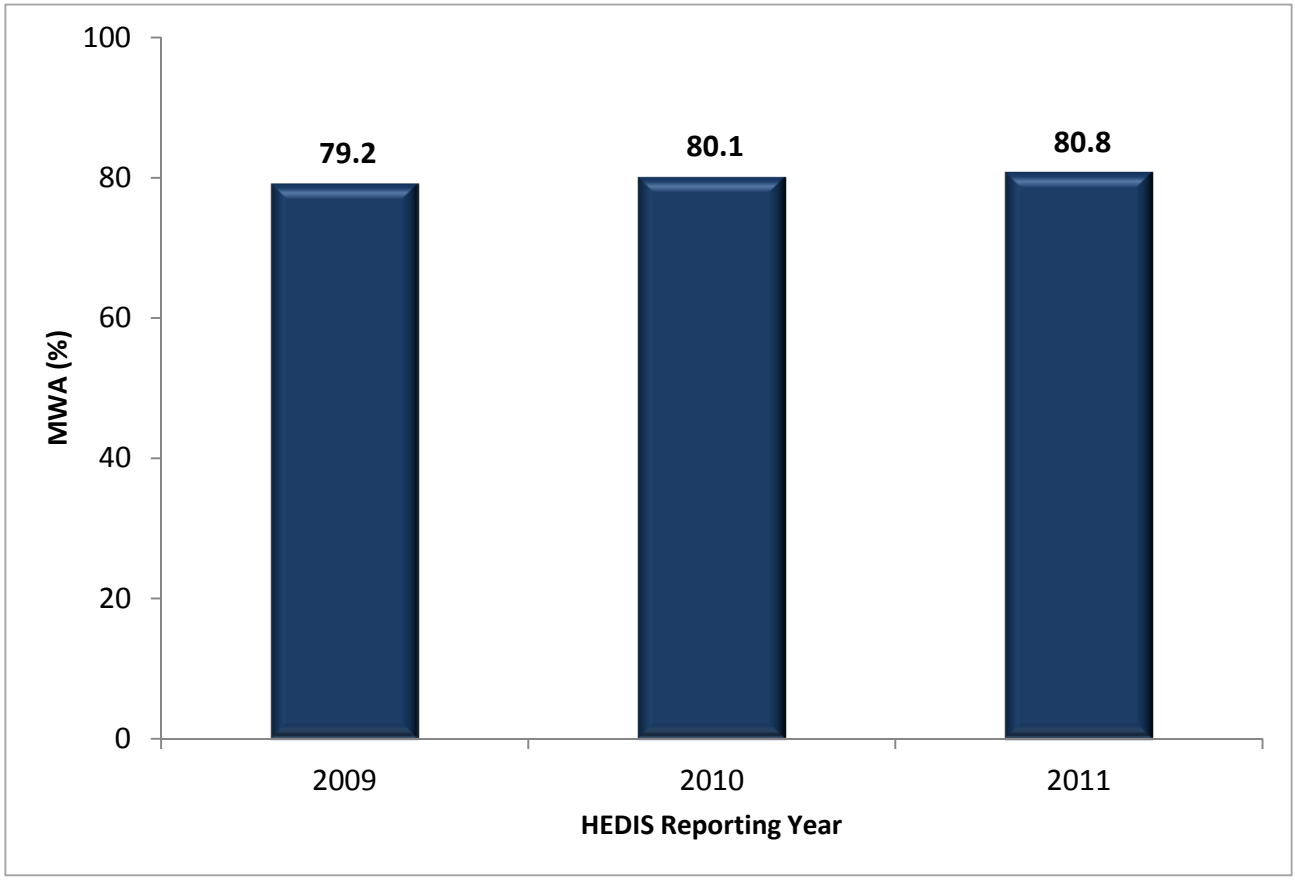
[5-11] American Heart Association. Good vs. Bad Cholesterol. Available at: http://www.heart.org/HEARTORG/Conditions/Cholesterol/AboutCholesterol/Good-vs-Bad-Cholesterol_UCM_305561_Article.jsp. Accessed on: August 25, 2011.

[5-12] Tovar JM, Bazaldua OV, Poursani RS. LDL Levels in Diabetes: How Low Should They Go? *The Journal of Family Practice*. 2007;56(8):634–40.

[5-13] Ibid.

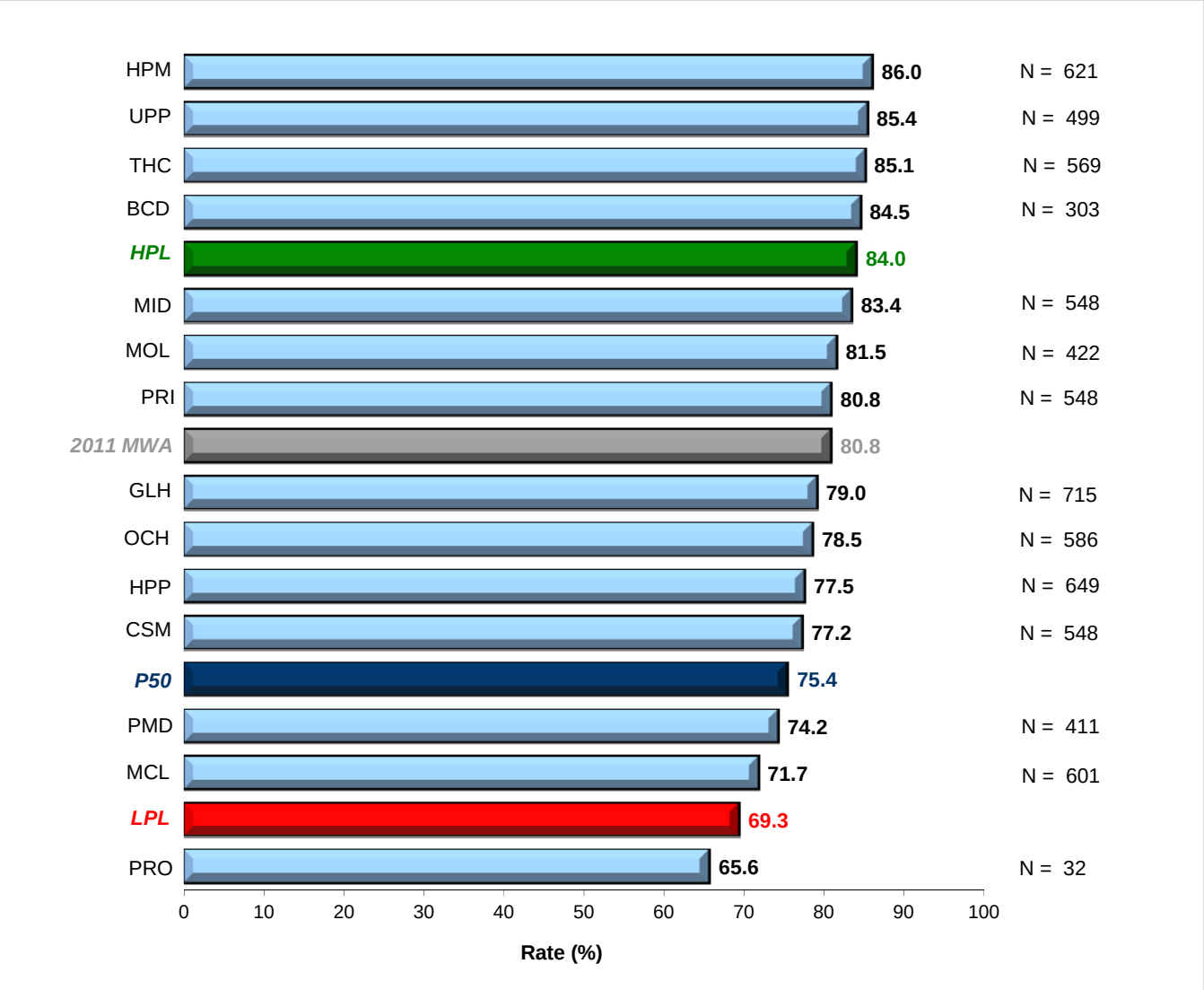
Performance Results

Figure 5-10—Comprehensive Diabetes Care—LDL-C Screening
Michigan Medicaid Weighted Averages



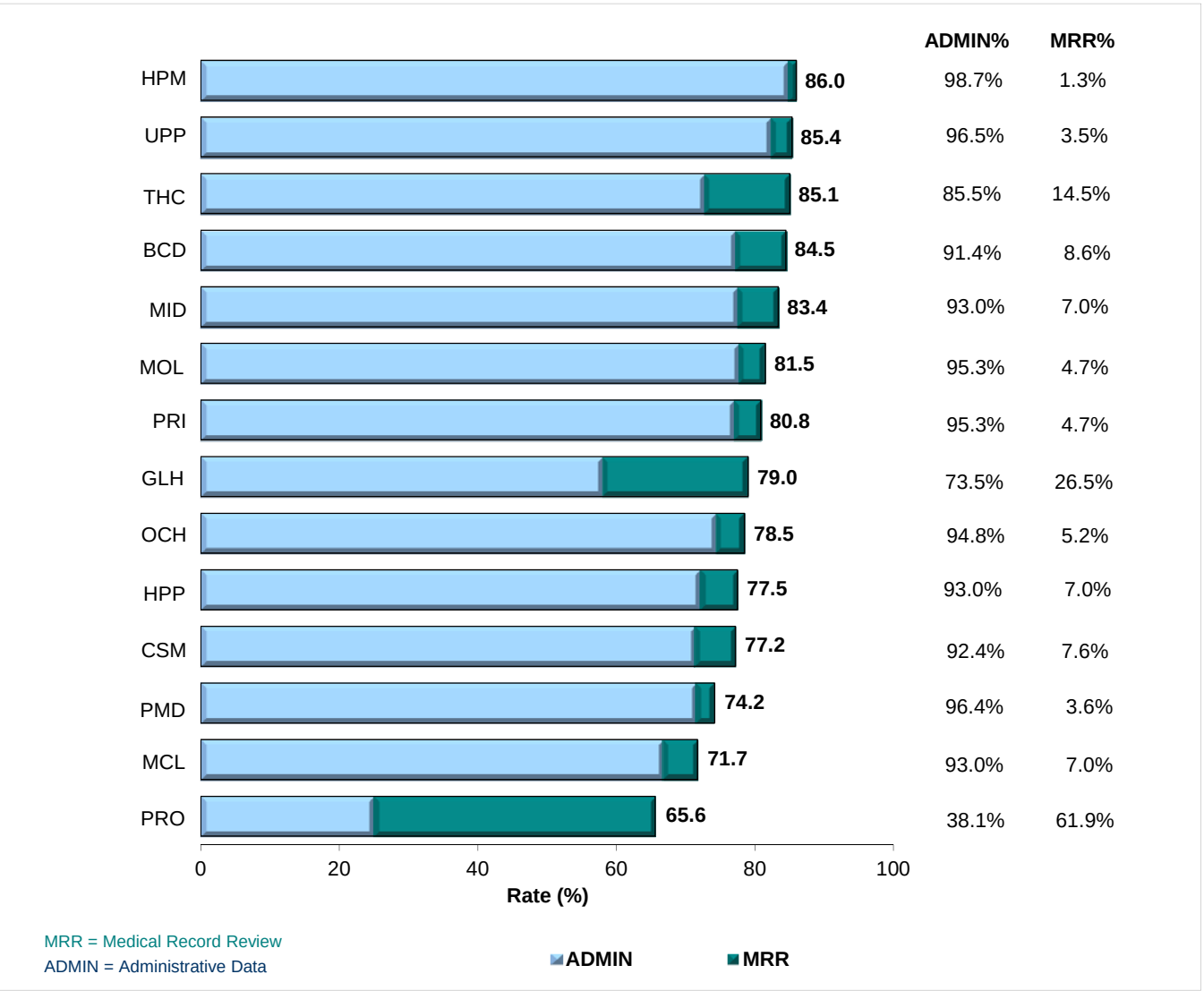
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated slight improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 1.6 percentage points and 0.7 percentage point, respectively. The observed improvement from last year was not statistically significant.

Figure 5-11—Comprehensive Diabetes Care—LDL-C Screening
Health Plan Ranking



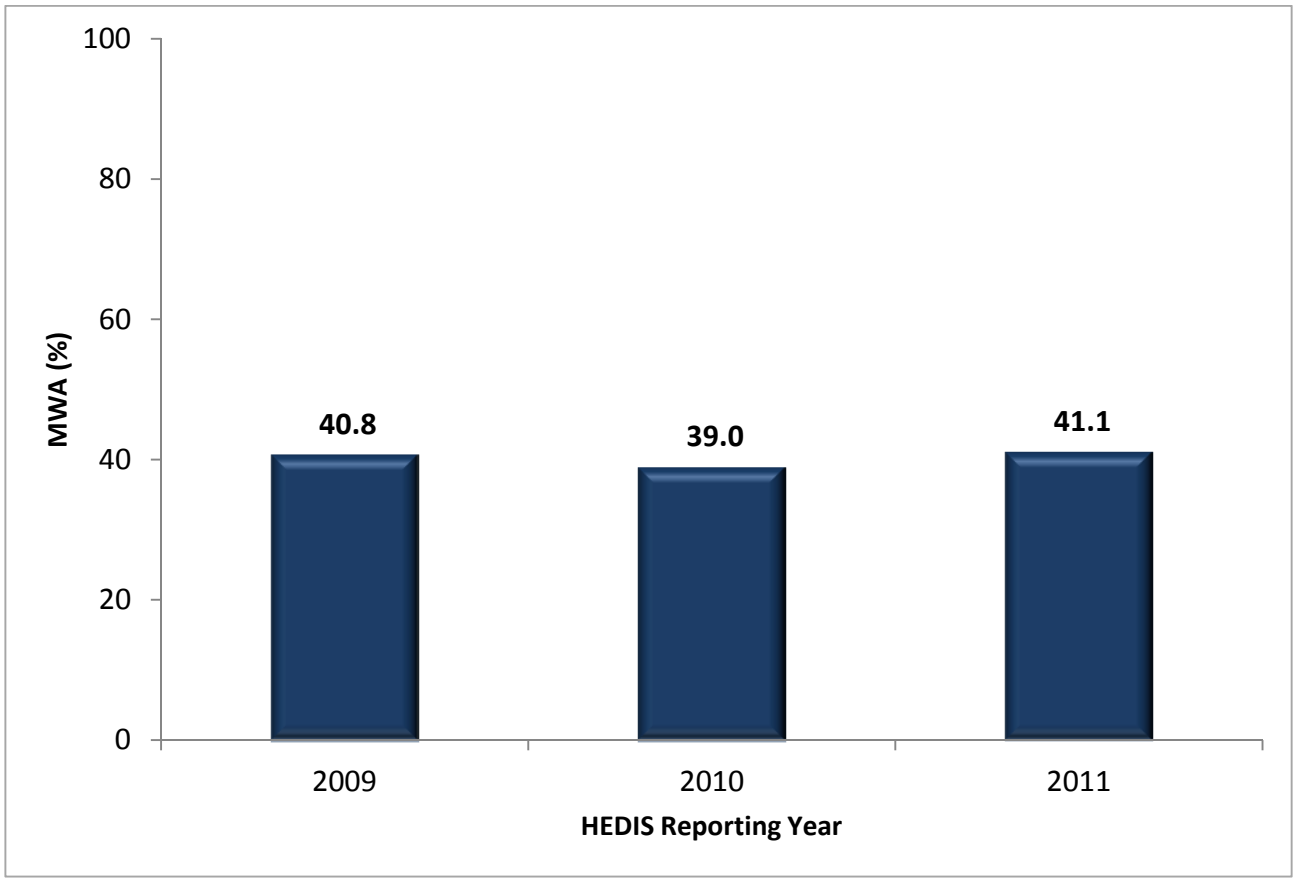
Four MHPs exceeded the HPL of 84.0 percent, and one fell below the LPL of 69.3 percent. Eleven MHPs reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 80.8 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 5.4 percentage points.

Figure 5-12—Comprehensive Diabetes Care—LDL-C Screening Data Collection Analysis



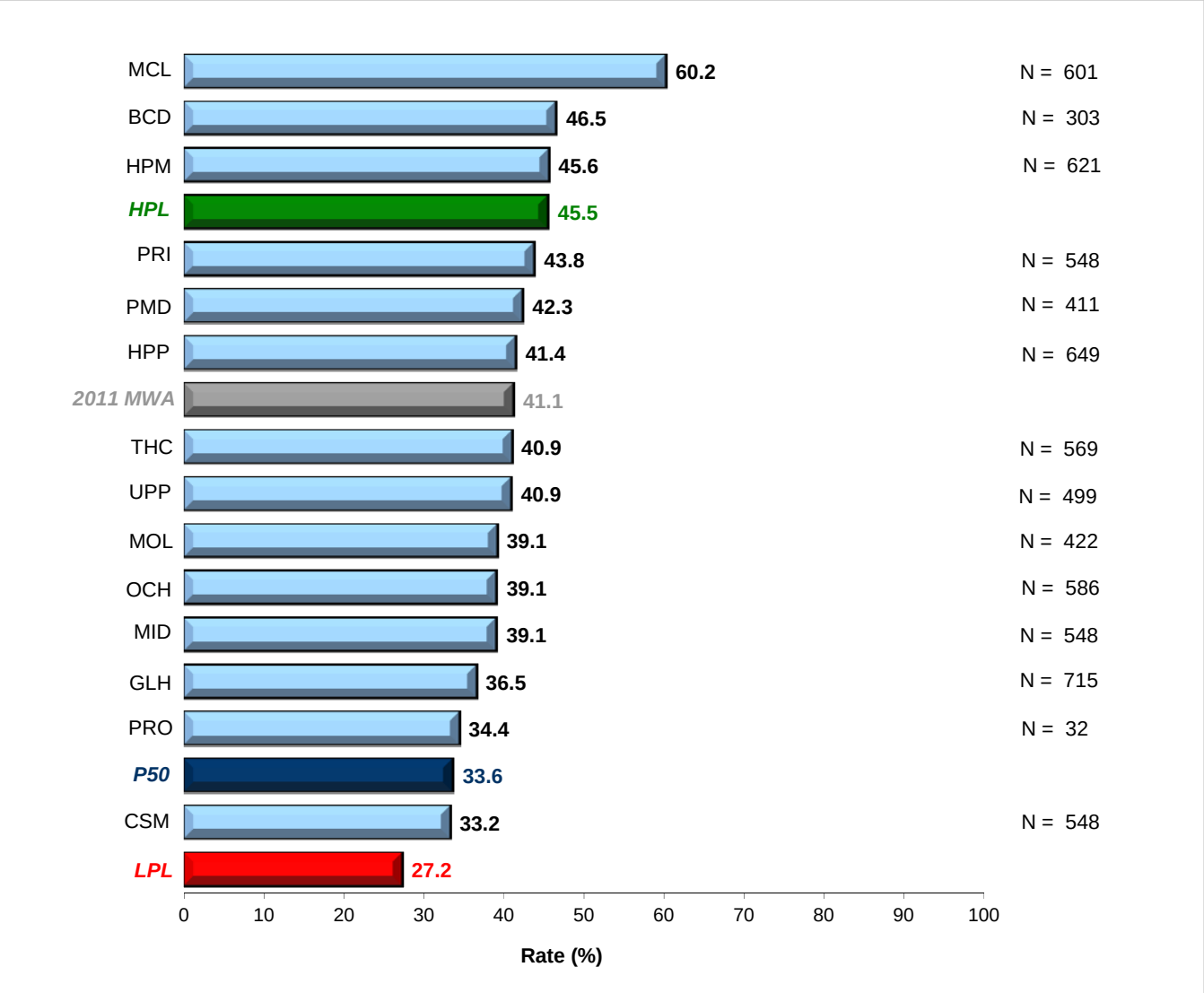
All MHPs elected to use the hybrid method for this measure. With the exception of one plan, all plans had at least 50 percent of their rates derived from administrative data; and five plans had at least 95 percent of their rates derived from administrative data.

Figure 5-13—Comprehensive Diabetes Care—LDL-C Level (<100 mg/dL)
Michigan Medicaid Weighted Averages



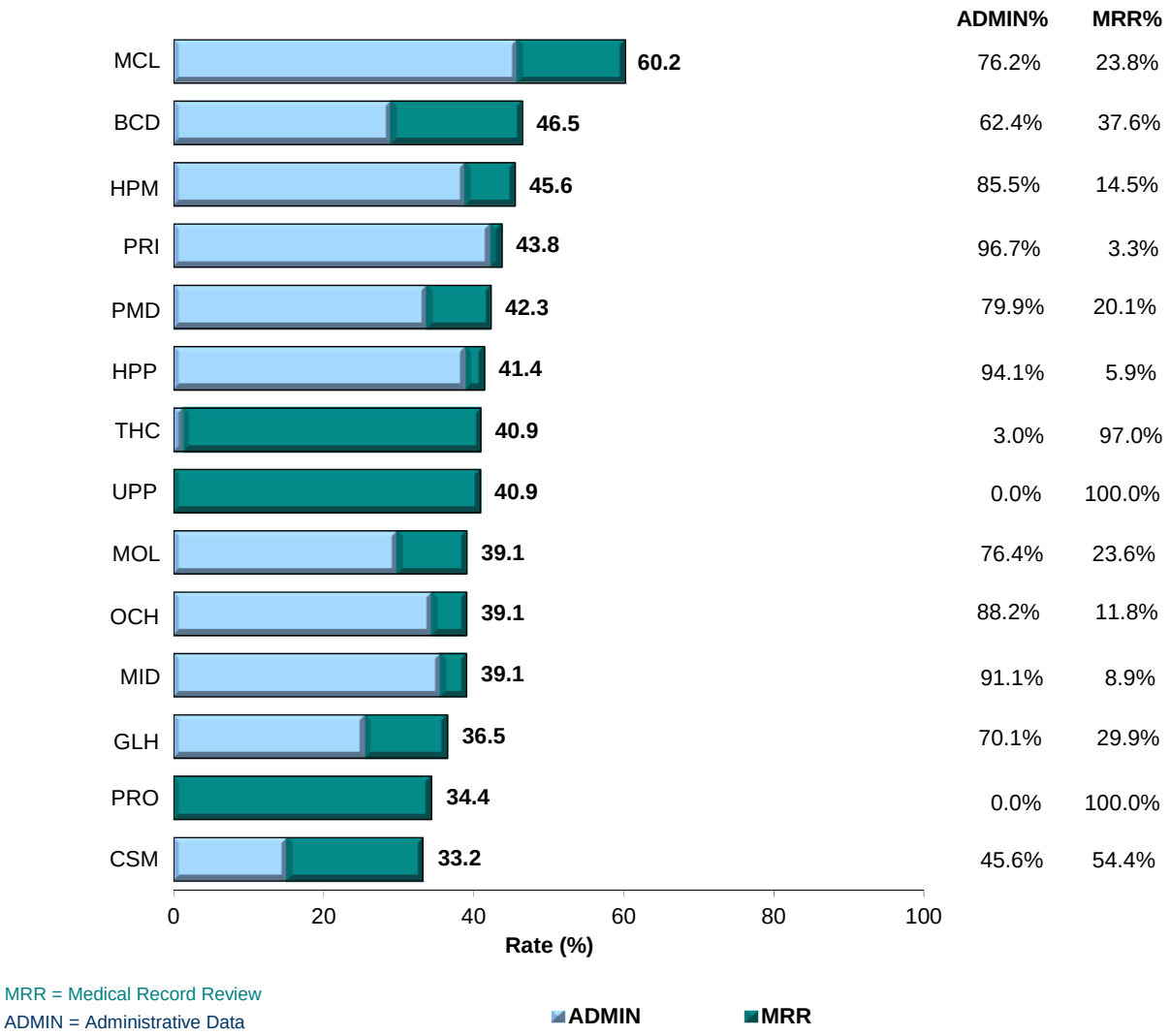
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated slight improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 0.3 percentage point and 2.1 percentage points, respectively. The observed improvement was not statistically significant.

Figure 5-14—Comprehensive Diabetes Care—LDL-C Level (<100 mg/dL)
Health Plan Ranking



Three MHPs exceeded the HPL of 45.5 percent, and none of the MHPs fell below the LPL of 27.2 percent. All but one plan reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 41.1 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 7.5 percentage points.

Figure 5-15—Comprehensive Diabetes Care—LDL-C Level (<100 mg/dL)
Data Collection Analysis



All MHPs elected to use the hybrid method to report this measure. There was wide variation among plans on how much of their rates were derived from medical record review data. Three plans had at least 95 percent of their rates based on medical records, but five plans had at least 80 percent of their rates derived from administrative data.

Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy

Measure Definition

The *Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropath*y 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 through 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 or a positive microalbuminuria test, or evidence of ACE inhibitor/ARB therapy.

Importance

In the United States, diabetes is the leading cause of kidney failure—the disease accounted for 44 percent of new kidney failure cases in 2008.[5-14] Approximately 20 to 30 percent of those with type 1 or type 2 diabetes develop nephropathy.[5-15] However, a smaller percentage of those with type 2 diabetes progress to end-stage renal disease (ESRD). For patients with type 2 diabetes, Native Americans, Hispanics, and African Americans are at a greater risk of developing ESRD compared to non-Hispanic Whites. In 2008, 202,290 patients with ESRD due to diabetes were on chronic dialysis or had a kidney transplant.[5-16]

In 2007, ESRD cost the United States over $35 billion in public and private spending.[5-17] Diabetic nephropathy is a progressive kidney disease that takes years to develop. Kidney failure usually occurs 15 to 25 years after the onset of diabetes. In 2008, more than 3,800 new cases of ESRD were diagnosed in Michigan, and more than 18,000 Michigan residents were receiving treatment for ESRD.[5-18]

Blood sugar control reduces the risk of microalbuminuria (having small amounts of protein in the urine) by one-third and reduces the risk of microalbuminuria progressing by 50 percent. It has also been shown that tight control of blood sugar may even reverse microalbuminuria.[5-19]

5-14 American Diabetes Association. Diabetes Statistics. Available at: http://www.diabetes.org/diabetes-basics/diabetes-statistics/ Accessed on: August 25, 2011.

5-15 American Diabetes Association. Nephropathy in Diabetes. Available at: http://care.diabetesjournals.org/content/27/suppl_1/s79.full. Accessed on: August 25, 2011.

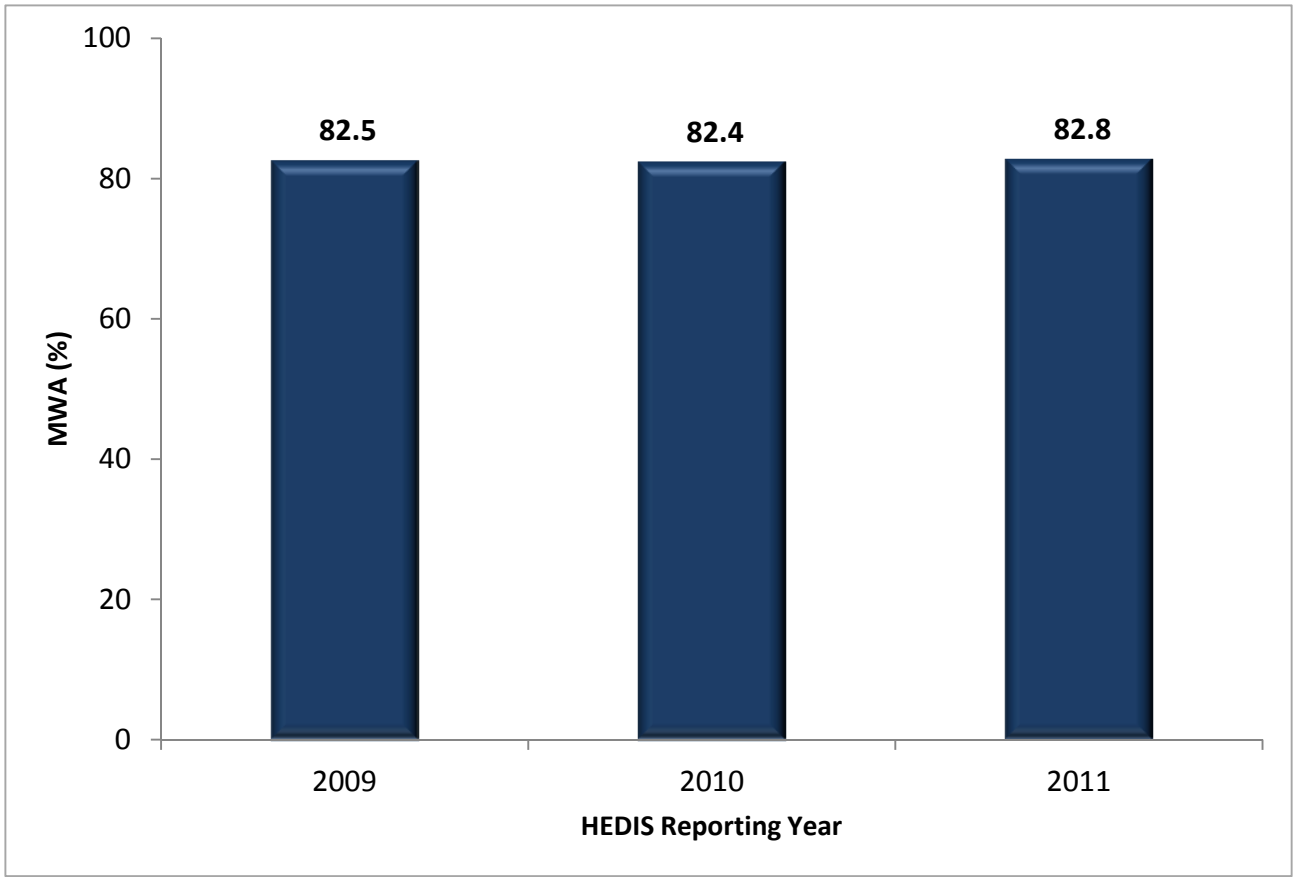
5-16 National Diabetes Information Clearinghouse (NDIC). National Diabetes Statistics, 2011. Available at: http://diabetes.niddk.nih.gov/dm/pubs/statistics/#Kidney. Accessed on: August 25, 2011.

5-17 National Kidney and Urologic Diseases Information Clearinghouse. Kidney and Urologic Diseases Statistics for the United States. Available at: http://kidney.niddk.nih.gov/kudiseases/pubs/kustats/. Accessed on: August 25, 2011.

5-18 Michigan Department of Community Health. Critical Health Indicators: Diabetes and Kidney Disease. Available at: http://www.michigan.gov/documents/mdch/20_Kidney_198920_7.pdf. Accessed on: August 25, 2011.

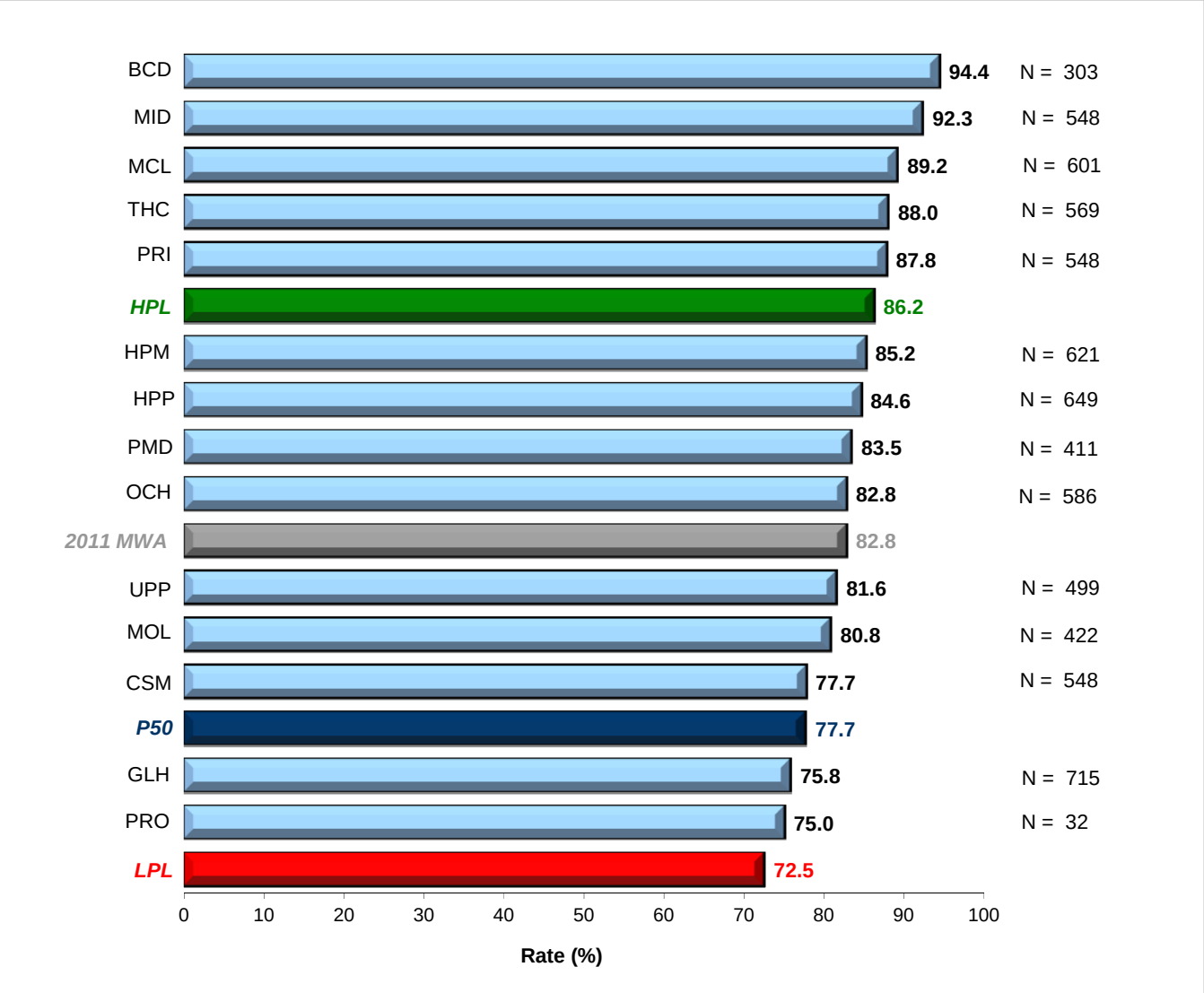
5-19 American Diabetes Association. Kidney Disease (Nephropathy). Available at: http://www.diabetes.org/living-with-diabetes/complications/kidney-disease-nephropathy.html. Accessed on: August 25, 2011.

Figure 5-16—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy
Michigan Medicaid Weighted Averages



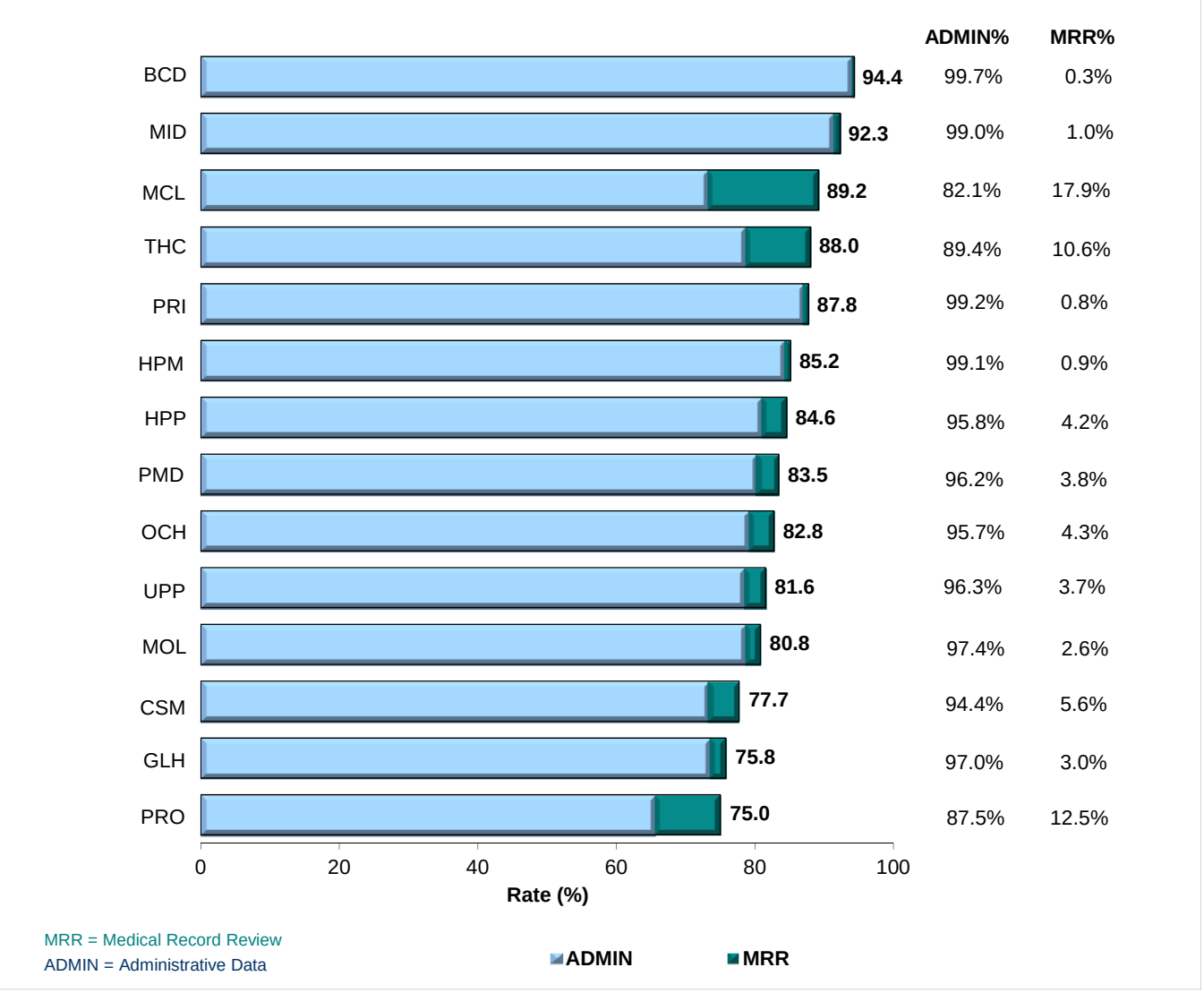
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated slight improvement from HEDIS 2010. The HEDIS 2011 weighted average increased from both the HEDIS 2009 and HEDIS 2010 weighted averages by less than 0.5 percentage point. The observed improvement was not statistically significant.

Figure 5-17—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy Health Plan Ranking



Five MHPs exceeded the HPL of 86.2 percent, and none of the MHPs were below the LPL of 72.5 percent. All but two plans reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 82.8 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 5.1 percentage points.

Figure 5-18—Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy Data Collection Analysis



All MHPs elected to use the hybrid method to report this measure. All plans relied heavily (>82 percent) on administrative data to report rates. None of the plans reported having more than 20 percent of their rates from medical record data.

Comprehensive Diabetes Care—Blood Pressure Control

Measure Definitions

The *Comprehensive Diabetes Care—Blood Pressure Control (<140/80 mm Hg*) rate is intended to assess whether the blood pressure of diabetic patients is being monitored. It reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who were continuously enrolled during the measurement year and who had a blood pressure reading of <140/80 mm Hg. This measure can be reported either using the administrative or hybrid methodology.

The *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* rate is intended to assess whether the blood pressure of diabetic patients is being monitored. It reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who were continuously enrolled during the measurement year and who had a blood pressure reading of <140/90 mm Hg. This measure can be reported either using the administrative or hybrid methodology.

Importance

High blood pressure (i.e., hypertension) is one of the most common complications of diabetes; as many as two out of three diabetic adults have the condition.[5-20] According to the CDC, 65.5 percent of Michigan adults with diabetes also had hypertension in 2009.[5-21] Diabetics are at an increased risk for developing hypertension due to the effect diabetes has on a person's arteries, which can increase the risk of heart attack and stroke.[5-22] A person who has a combination of diabetes and hypertension is at increased risk of heart attack, stroke, and eye and kidney disease.[5-23]

Blood pressure control in diabetics reduces the risk of heart disease and stroke by 33 percent and 50 percent, respectively. Additionally, blood pressure control reduces the risk of eye, kidney, and nerve diseases by approximately 33 percent. For diabetics, a small reduction in diastolic blood pressure (from 90 mmHg to 80 mmHg) can halve the risk of major cardiovascular events. Furthermore, for every 10 mm Hg reduction in systolic blood pressure, the risk for any complication related to diabetes is decreased by 12 percent.[5-24]

5-20 American Diabetes Association. High Blood Pressure (Hypertension). Available at: http://www.diabetes.org/living-with-diabetes/complications/high-blood-pressure-hypertension.html. Accessed on: August 25, 2011.

5-21 Centers for Disease Control and Prevention. National Diabetes surveillance system. Available at: http://apps.nccd.cdc.gov/ddtstrs/Index.aspx?stateId=26&state=Michigan&cat=riskfactors&Data=data&view=TO&id=23&trend=hypertenxion. Accessed on: August 25, 2011.

5-22 WebMD. Diabetes and High Blood Pressure. Available at: http://www.webmd.com/hypertension-high-blood-pressure/guide/high-blood-pressure Accessed on: August 25, 2011.

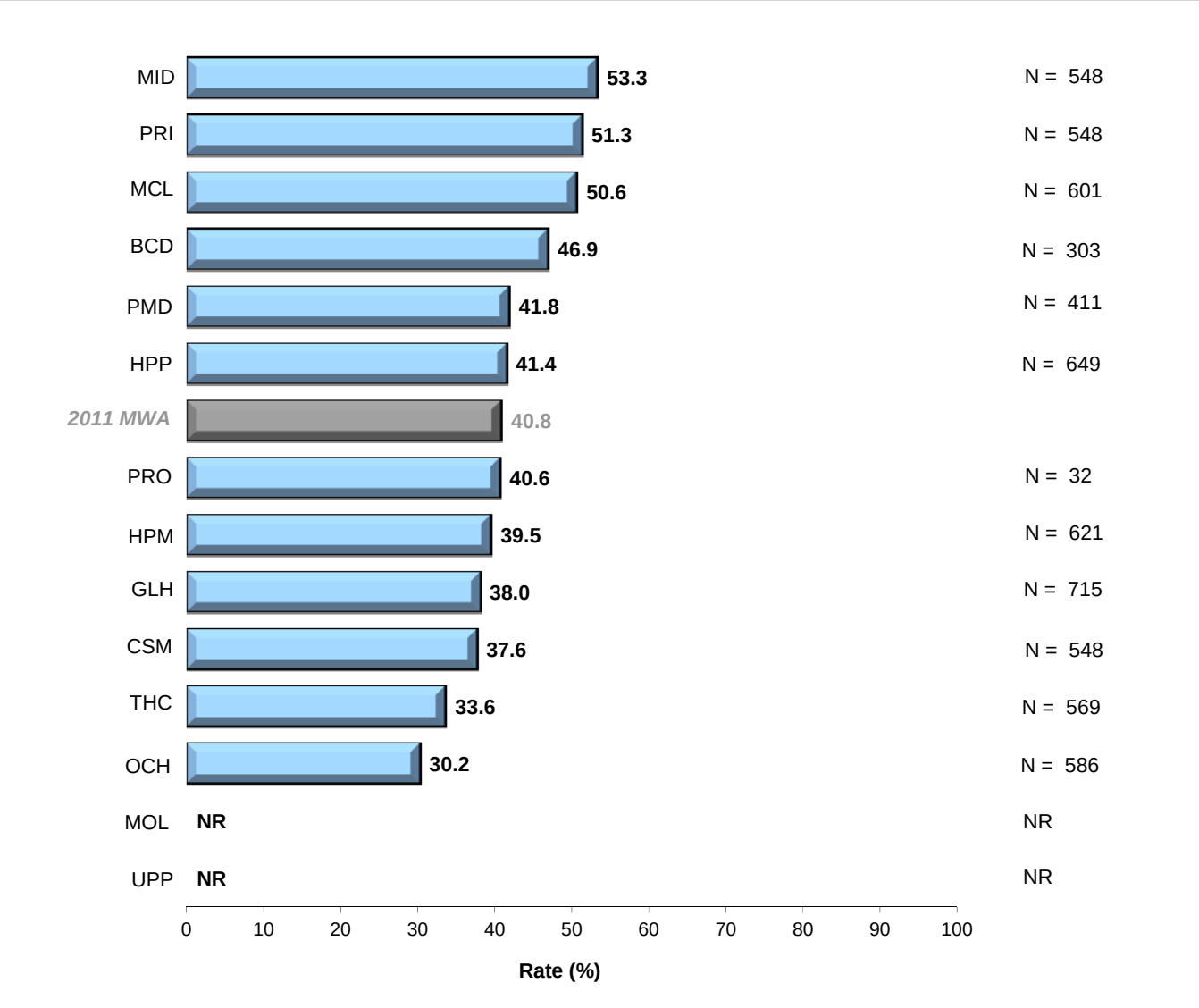
5-23 American Diabetes Association. High Blood Pressure (Hypertension). Available at: http://www.diabetes.org/living-with-diabetes/complications/high-blood-pressure-hypertension.html Accessed on: August 25, 2011.

5-24 National Diabetes Information Clearinghouse (NDIC). National Diabetes Statistics, 2011. Available at: http://diabetes.niddk.nih.gov/dm/pubs/statistics/#bpc. Accessed on: August 25, 2011.

Performance Results

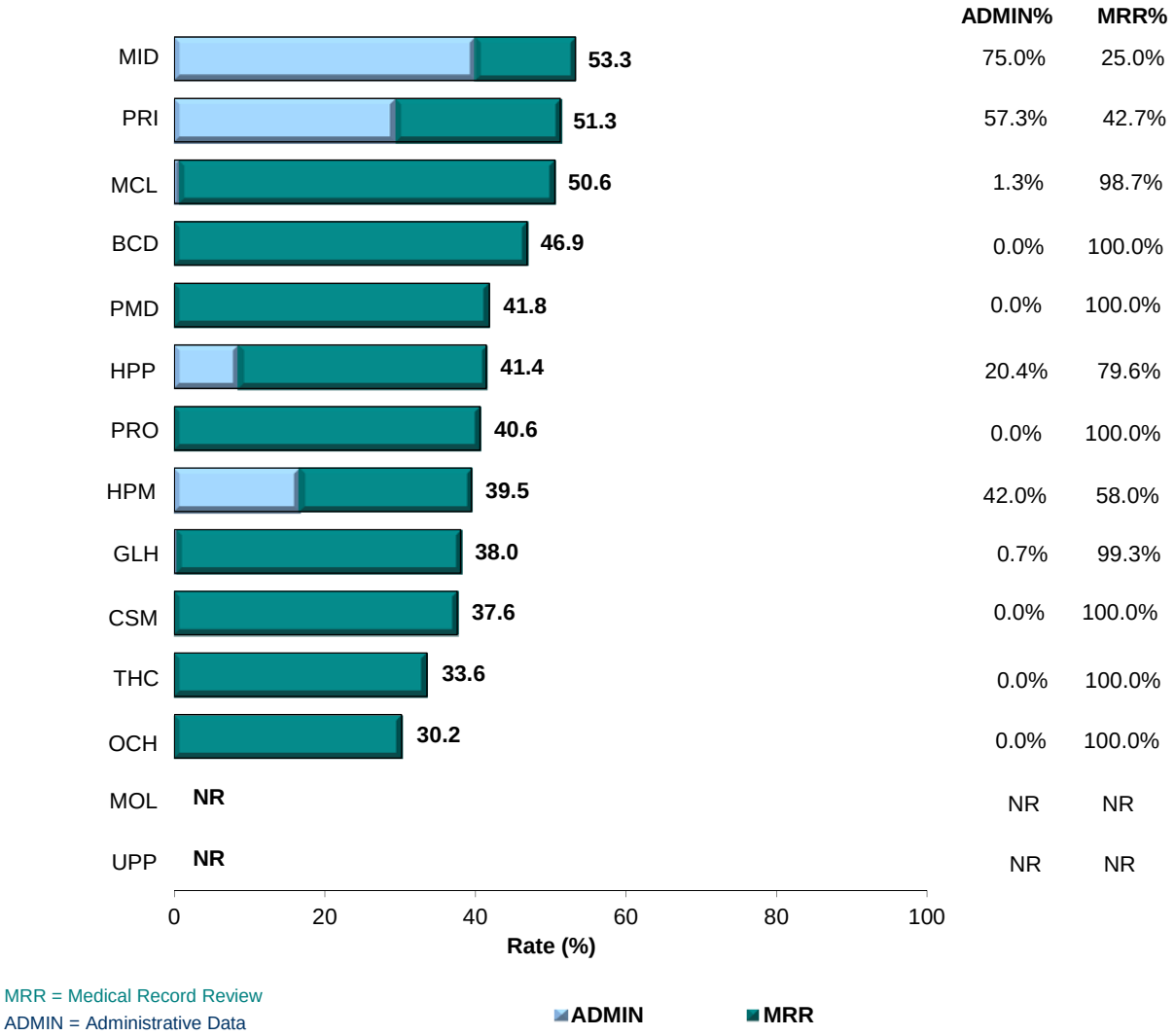
Due to changes for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/80 mm Hg)* measure in HEDIS 2011, the HEDIS 2011 Michigan Medicaid weighted average was not comparable to results from previous years or the national HEDIS 2010 Medicaid percentiles. Therefore, a three-year weighted average trend chart was not presented for this measure. Additionally, Figure 5-19 contains only plan rates without the HEDIS 2010 HPL, P50, and LPL.

Figure 5-19—Comprehensive Diabetes Care—Blood Pressure Control (<140/80 mm Hg)
Health Plan Ranking



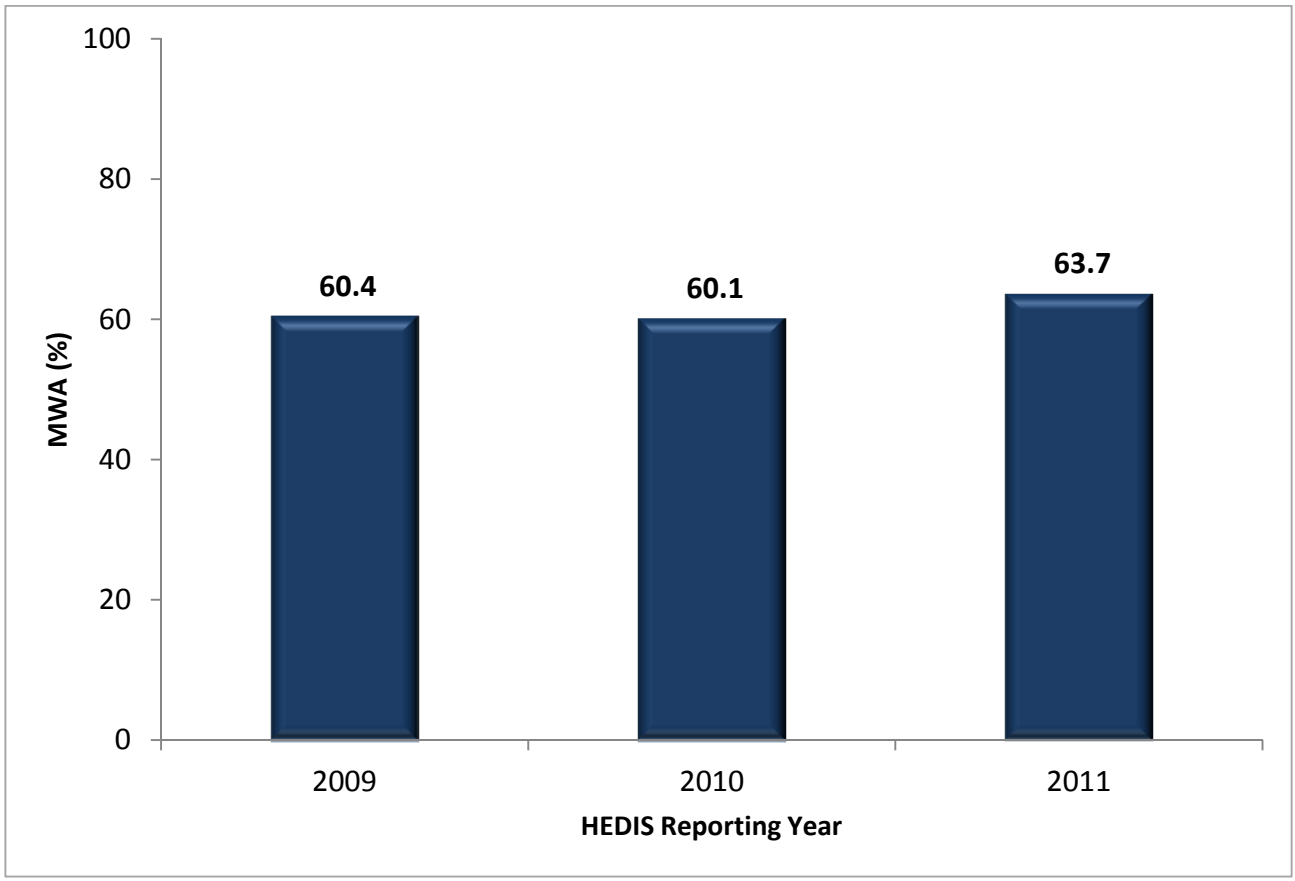
For HEDIS 2011, twelve of the fourteen MHPs reported valid rates for this measure. The HEDIS 2011 Michigan Medicaid weighted average was 40.8 percent, with individual plan rates ranging from 30.2 percent to 53.3 percent, a difference of 23.1 percentage points.

Figure 5-20—Comprehensive Diabetes Care—Blood Pressure Control (<140/80 mm Hg) Data Collection Analysis



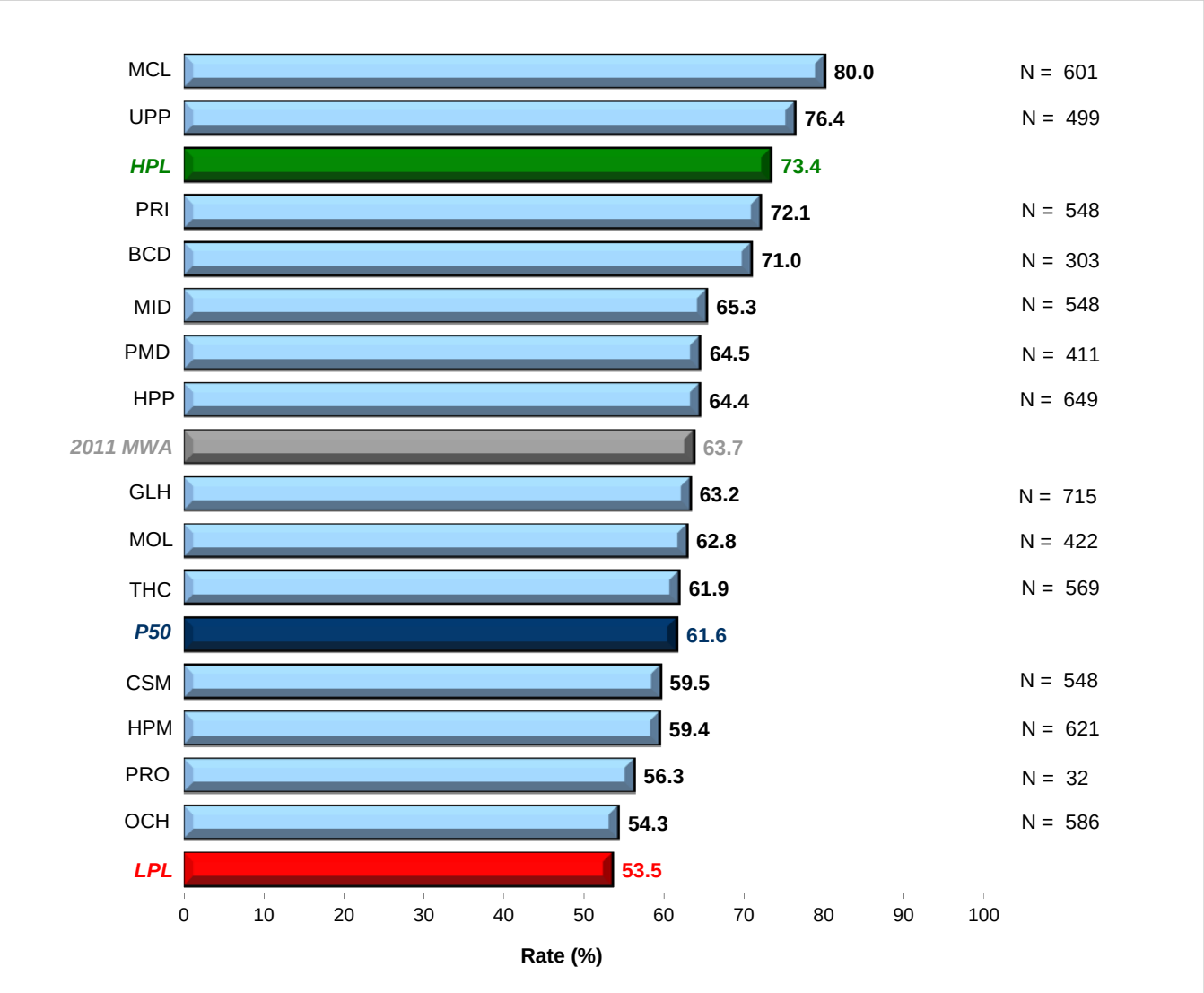
All MHPs reporting valid rates elected to use the hybrid method for this measure. Six plans relied on medical record data entirely to report their rates. Only one plan indicated that 75 percent of its rate was derived from administrative data.

Figure 5-21—Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)
Michigan Medicaid Weighted Averages



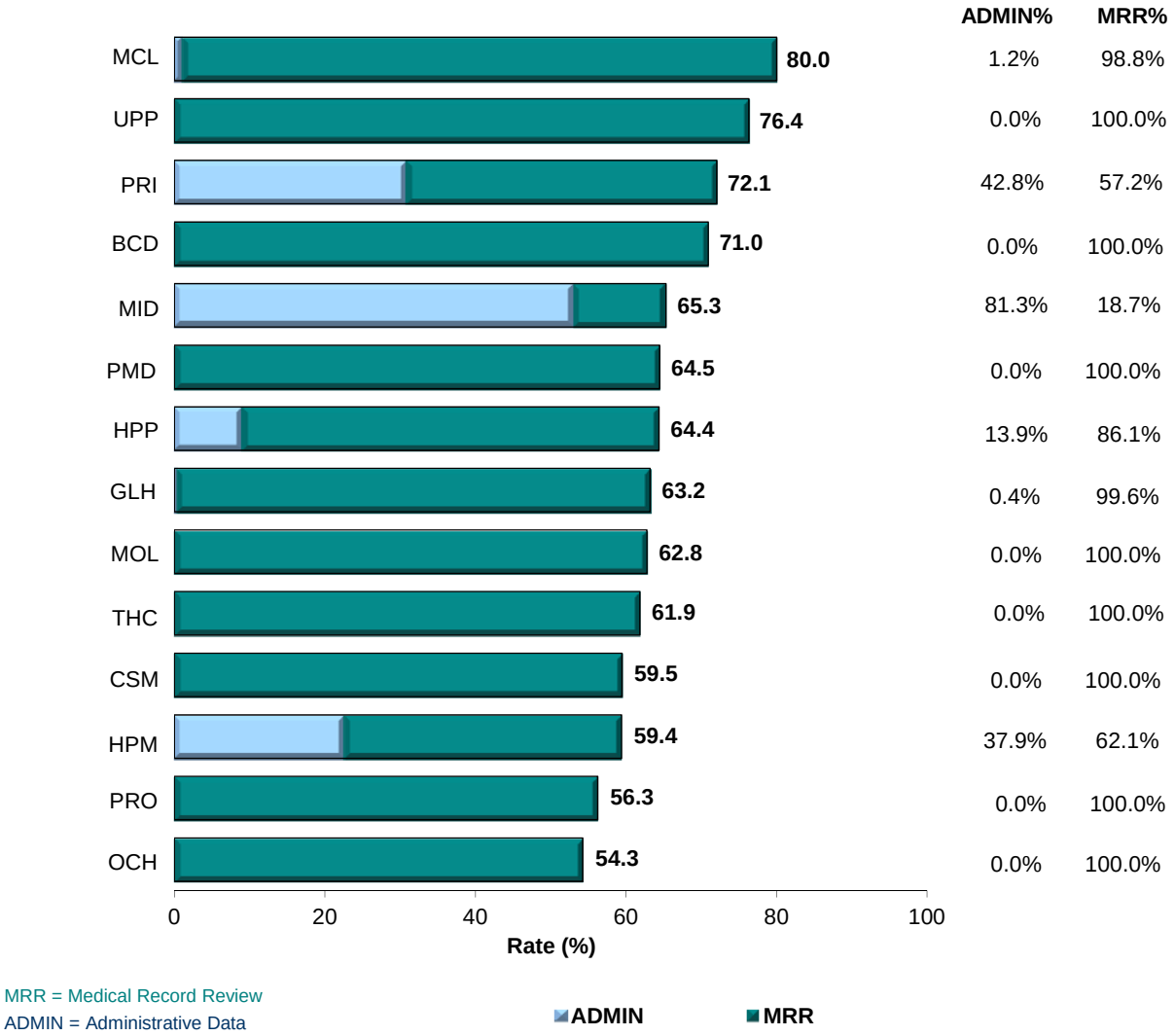
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 3.3 and 3.6 percentage points, respectively. The observed improvement from last year was statistically significant.

Figure 5-22—Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)
Health Plan Ranking



Two MHPs exceeded the HPL of 73.4 percent, and none of the MHPs fell below the LPL of 53.5 percent. Ten MHPs reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 63.7 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 2.1 percentage points.

Figure 5-23—Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) Data Collection Analysis



All MHPs elected to use the hybrid method for this measure. The majority of plans relied on medical record review data heavily to derive their rates, of which eight relied on medical records entirely. Only one plan relied on administrative data for more than 80 percent of its rate.

Use of Appropriate Medications for People With Asthma

Measure Definition

The *Use of Appropriate Medications for People With Asthma* measures the percentage of members (ages 5 to 50) who were identified as persistent asthmatics and who were prescribed appropriate asthma medication during the measurement year. This measure contains three distinct rates, one for each of the following groups: 5–11 Years, 12–50 Years, and Total.

Importance

Asthma is one of the most common diseases in the nation. It was estimated in 2009 that 39.9 million people in the United States had been diagnosed with asthma by a health professional in their lifetime, including 8.5 million children between 5 and 17 years of age.[5-25] The prevalence of asthma is expected to reach more than 100 million by 2025.[5-26] In Michigan, approximately 724,000 adults and 232,500 children had asthma in 2007.[5-27]

A lack of proper asthma management frequently results in hospitalizations, ED visits, and missed work and school days. Asthma was the cause of 1.7 million ED visits in 2006, as well as 14 million missed school days and 14.2 million missed work days. In 2009, the overall asthma treatment rate for Medicaid HMOs was 88.6 percent, compared to a rate of 92.7 percent for commercial plans.[5-28]

Asthma is also one of the most costly diseases financially. Approximately $20.7 billion per year can be attributed to asthma, which includes $5.1 billion in lost productivity.[5-29] In Michigan, asthma costs more than $394 million annually, including approximately $170 million in indirect costs.[5-30]

The appropriate management of asthma medication is important to help decrease the effects of asthma and can reduce the number of asthma-related hospitalizations and missed school and work days. For example, one study showed that patients who used an inhaled corticosteroid treatment had a 45 percent reduction in ED visits when compared to patients who did not use an inhaled corticosteroid.[5-31]

5-25 American Lung Association, Epidemiology and Statistics Unit, Research and Program Services Division. Trends in Asthma Morbidity and Mortality. July 2011. Available at: http://www.lungusa.org/finding-cures/our-research/trend-reports/asthma-trend-report.pdf. Accessed on : September 7, 2011.

5-26 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on: September 7, 2011.

5-27 Michigan Department of Community Health's Bureau of Epidemiology. Epidemiology of Asthma in Michigan. 2009. Available at: http://www.michigan.gov/documents/mdch/04_Ch2_Asthma_Prevalence_276543_7.pdf. Accessed on: September 7, 2011.

5-28 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on: September 7, 2011.

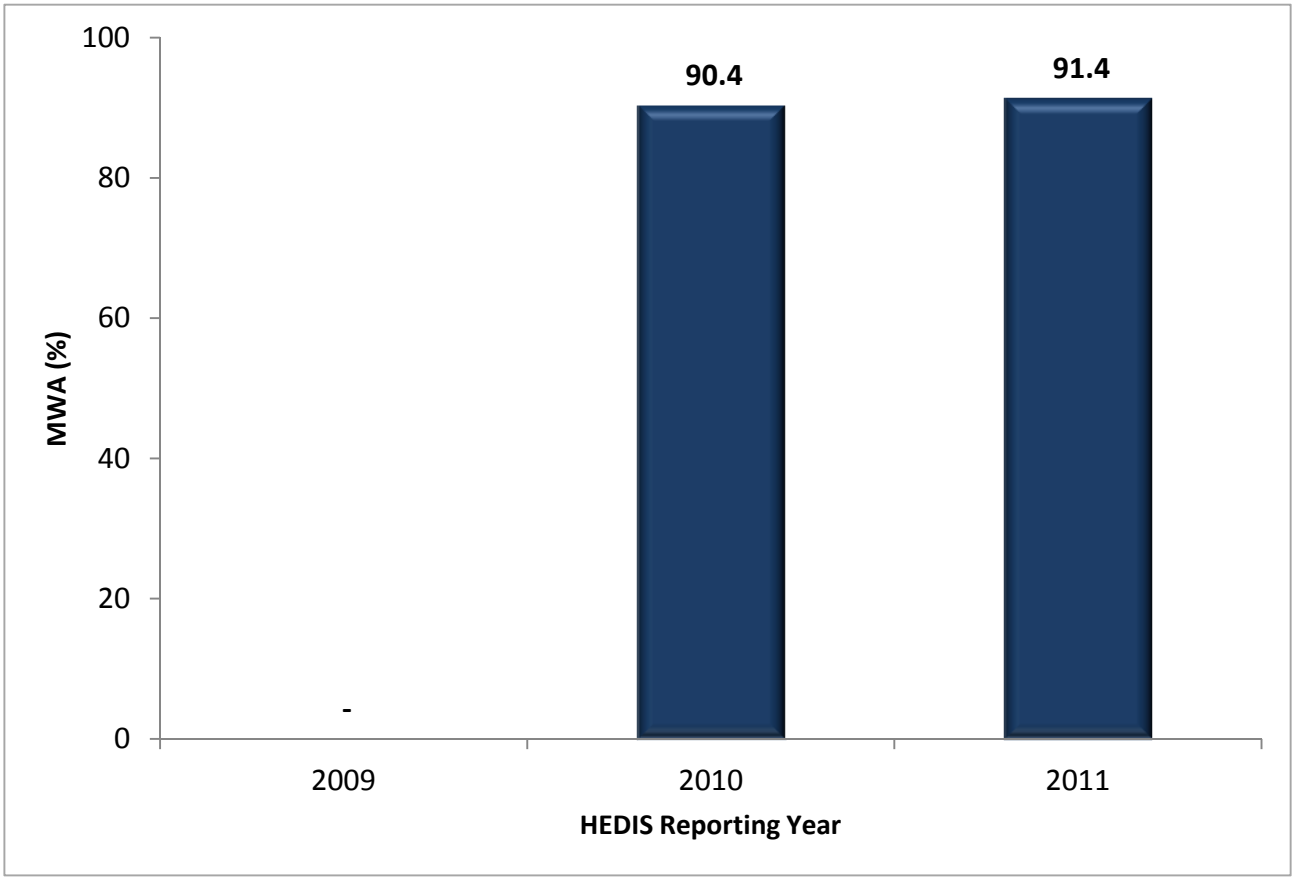
5-29 Ibid.

5-30 Asthma Initiative of Michigan. Asthma Cost. Available at: http://www.getasthmahelp.org/michigan-asthma-statistics-cost.aspx. Accessed on: September 7, 2011.

5-31 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on: September 7, 2011.

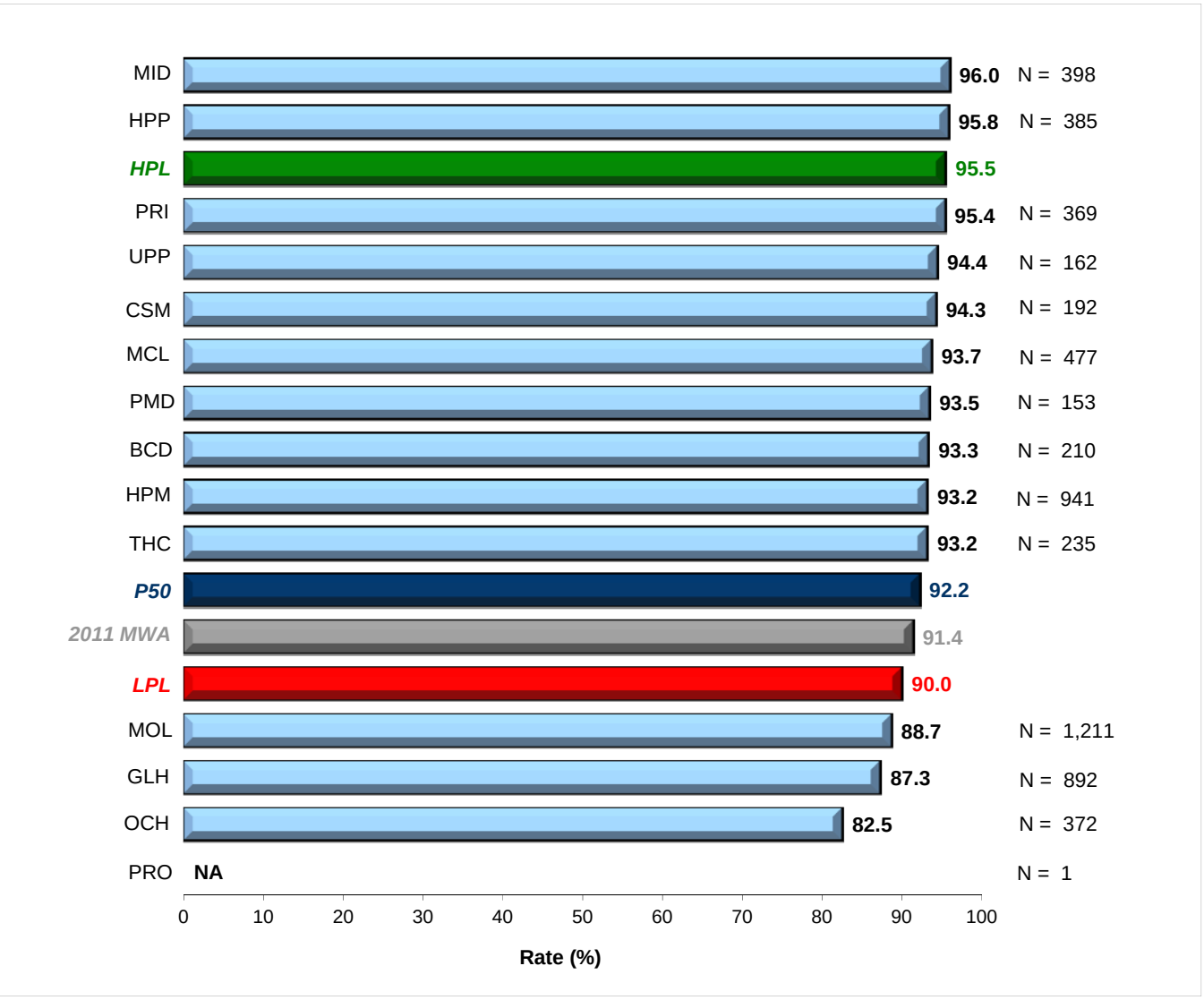
Performance Results

Figure 5-24—Use of Appropriate Medications for People With Asthma—5 to 11 Years
Michigan Medicaid Weighted Averages



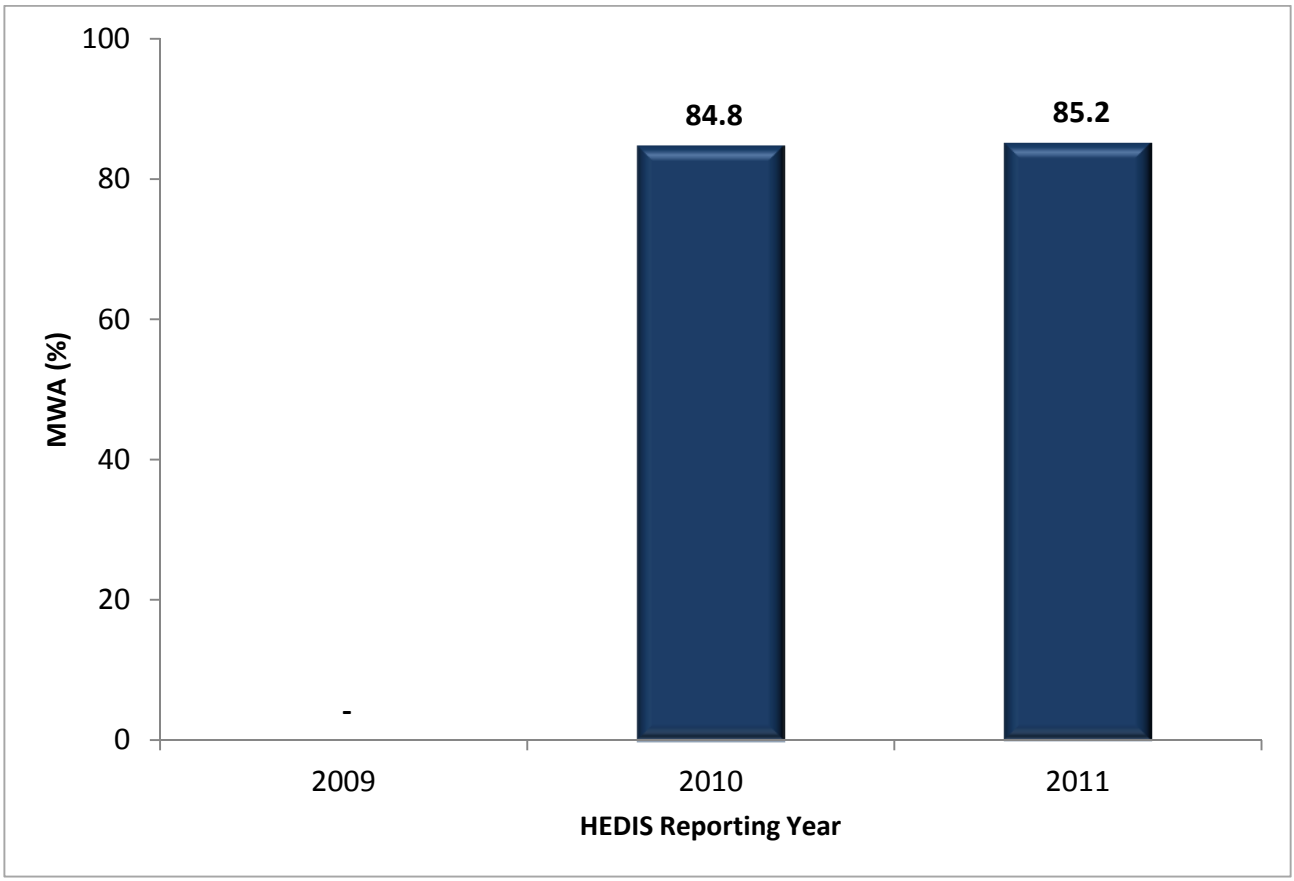
Due to measure specification changes from HEDIS 2009 to 2010, the HEDIS 2009 weighted average was not comparable to HEDIS 2010 or HEDIS 2011 and therefore was not presented in the chart. The HEDIS 2011 Michigan Medicaid weighted average showed slight improvement, but not statistically significant from last year's result. Compared to HEDIS 2010, this year's rate increased by 1.0 percentage point.

Figure 5-25—Use of Appropriate Medications for People With Asthma—5 to 11 Years
Health Plan Ranking



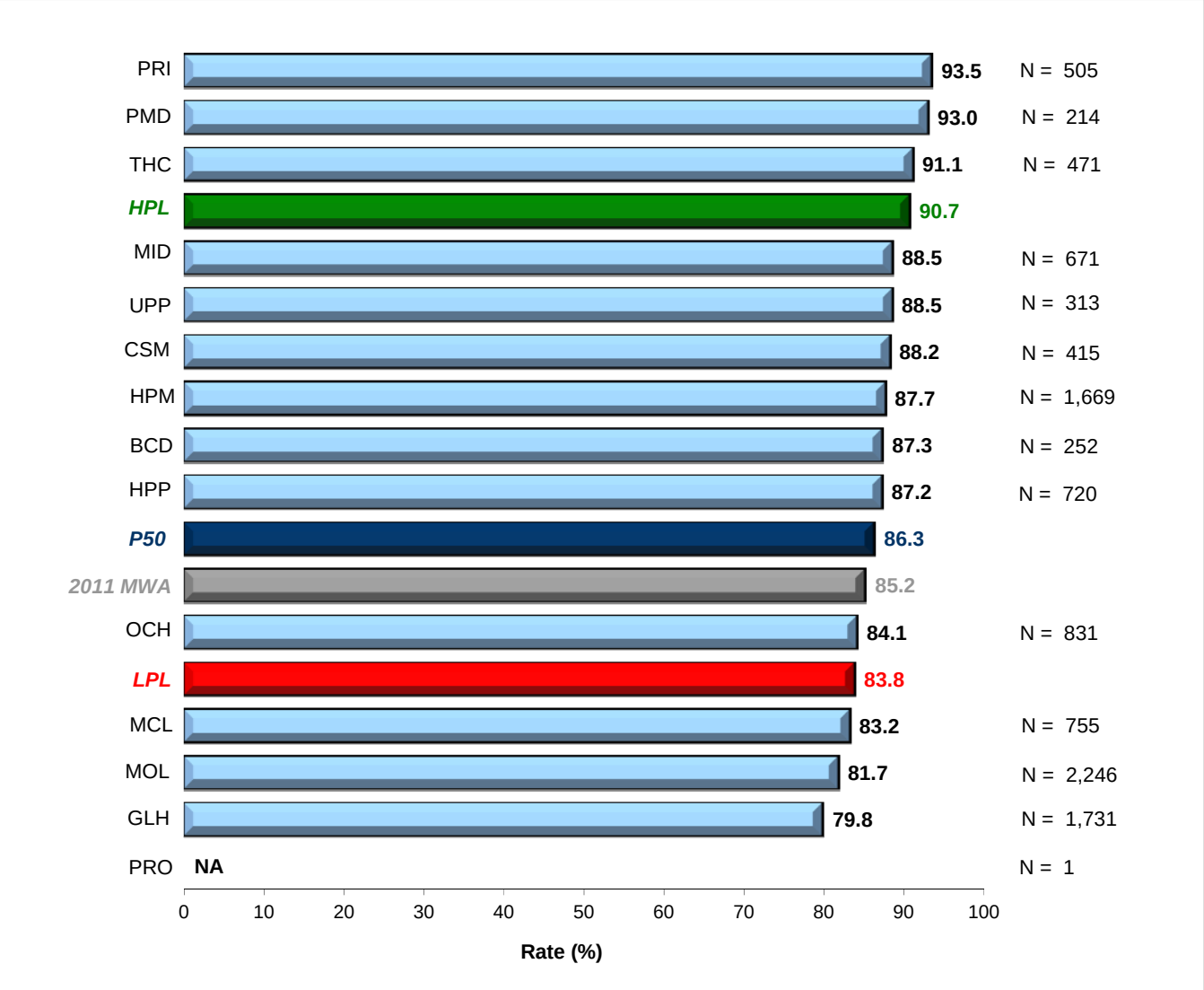
Two MHPs exceeded the HPL of 95.5 percent, and three MHPs fell below the LPL of 90.0 percent. Ten MHPs with reportable rates, including the two above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. One MHP was unable to report a rate for this measure since the denominator was too small to report a valid rate (a denominator of less than 30). The HEDIS 2011 Michigan Medicaid weighted average of 91.4 percent was 0.8 percentage points below the national HEDIS 2010 Medicaid 50th percentile.

Figure 5-26—Use of Appropriate Medications for People With Asthma—12 to 50 Years
Michigan Medicaid Weighted Averages



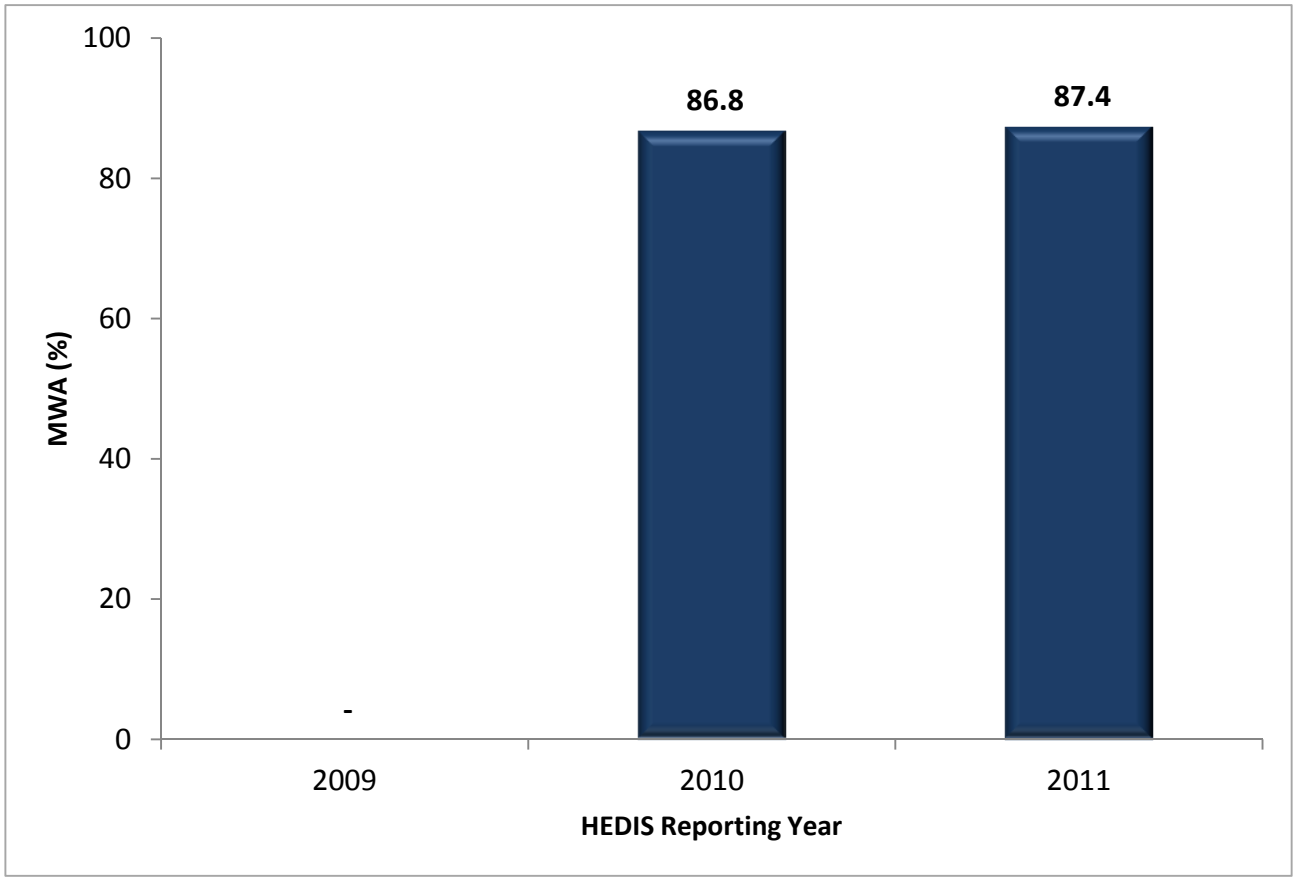
Due to measure specification changes from HEDIS 2009 to HEDIS 2010, the HEDIS 2009 weighted average was not comparable to HEDIS 2010 or HEDIS 2011 and therefore was not presented in the chart. The HEDIS 2011 Michigan Medicaid weighted average showed slight improvement, but not statistically significant from last year's result. Compared to HEDIS 2010, this year's rate increased by 0.4 percentage point.

Figure 5-27—Use of Appropriate Medications for People With Asthma—12 to 50 Years
Health Plan Ranking



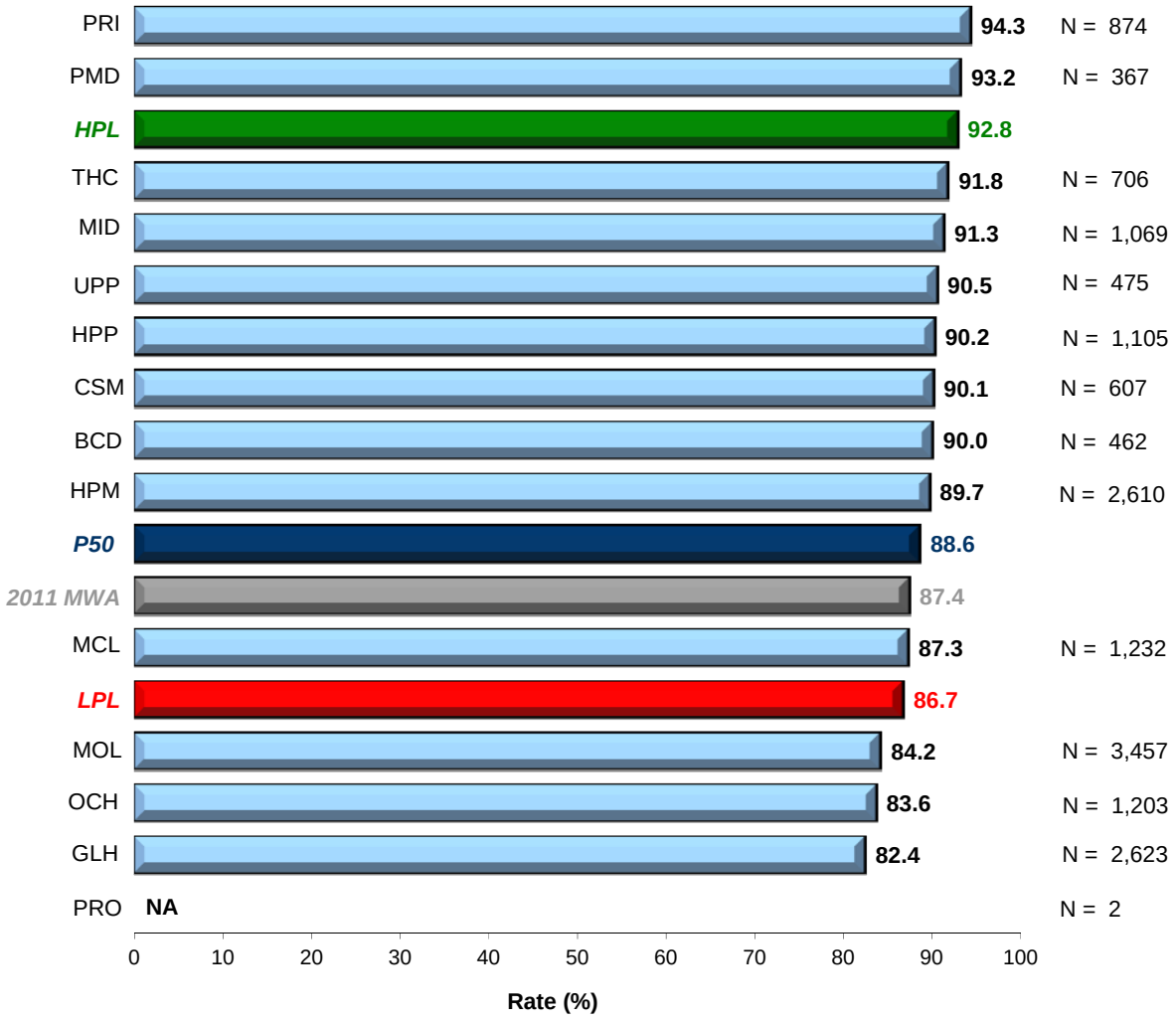
Three MHPs exceeded the HPL of 90.7 percent, and three MHPs fell below the LPL of 83.8 percent. Nine MHPs with reportable rates, including the three above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. One MHP was unable to report a rate for this measure since the denominator was too small to report a valid rate (a denominator of less than 30). The HEDIS 2011 Michigan Medicaid weighted average of 85.2 percent was 1.1 percentage points below the national HEDIS 2010 Medicaid 50th percentile.

Figure 5-28—Use of Appropriate Medications for People With Asthma—Total Michigan Medicaid Weighted Averages



Due to measure specification changes from HEDIS 2009 to HEDIS 2010, the HEDIS 2009 weighted average was not comparable to HEDIS 2010 or HEDIS 2011 and therefore was not presented in the chart. The HEDIS 2011 Michigan Medicaid weighted average showed slight improvement, but not statistically significant from last year's result. Compared to HEDIS 2010, this year's rate increased by 0.6 percentage point.

Figure 5-29—Use of Appropriate Medications for People With Asthma—Total Health Plan Ranking



Two MHPs exceeded the HPL of 92.8 percent, and three MHPs were below the LPL of 86.7 percent. Nine MHPs with reportable rates, including the two above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. One MHP was unable to report a rate for this measure since the denominator was too small to report a valid rate (a denominator of less than 30). The HEDIS 2011 Michigan Medicaid weighted average of 87.4 percent was 1.2 percentage points below the national HEDIS 2010 Medicaid 50th percentile.

Controlling High Blood Pressure

Measure Definition

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 through 85 years of age who were continuously enrolled for the measurement year, who had an ambulatory claim or encounter with a diagnosis of hypertension or a diagnosis confirmed within the medical record, and whose blood pressure was controlled below 140/90 mm Hg.

Importance

In 2008, approximately one in three U.S. adults (76.4 million people) over the age of 20 has high blood pressure (i.e., hypertension) in the United States.[5-32] Hypertension was the primary cause of 57,732 deaths in the United States in 2007, and the condition is a major risk factor for cardiovascular disease. About 77 percent of those who have a stroke, 69 percent of those who have a heart attack, and 74 percent of those with heart failure have high blood pressure.[5-33]

The projected 2010 direct and indirect costs associated with hypertension in the United States are almost $77 billion.[5-34] The prevalence of high blood pressure has increased over the past decade for both Michigan and the United States. In 2009, an estimated 29.7 percent of Michigan adults reported being diagnosed with high blood pressure compared to 28.6 percent for the United States as a whole.[5-35]

Fortunately, high blood pressure is easily detected and usually controllable. More than two-thirds of U.S. residents who have been diagnosed with the condition use medication, and about 70 percent of people who take medication are able to control their hypertension.[5-36]

Uncontrolled high blood pressure can lead to many further complications, including:

- Enlargement of the heart, which may lead to heart failure.
- Formation of aneurysms in blood vessels throughout the body (e.g., heart, brain, legs, intestines, and spleen).
- Narrowing of the blood vessels in the kidney, which may lead to kidney failure.
- Hardening of the arteries throughout the body (e.g., heart, brain, kidneys, and legs) which may lead to heart attack, stroke, kidney failure, or amputation.
- Bursting or bleeding of blood vessels in the eyes, which may cause vision changes and can ultimately result in blindness.

5-32 American Heart Association. Statistical Fact Sheet – Risk Factors, 2011 Update. High Blood Pressure Statistics. Available at: http://www.heart.org/idc/groups/heart-public/@wcm/@sop/@smd/documents/downloadable/ucm_319587.pdf. Accessed on: August 5, 2011.

5-33 National Committee for Quality Assurance. *The State of Health Care Quality 2010*. Washington, D.C.: NCQA; 2010. Available at: http://www.ncqa.org/portals/0/state%20of%20health%20care/2010/sohc%202010%20-%20full2.pdf. Accessed on August 5, 2011.

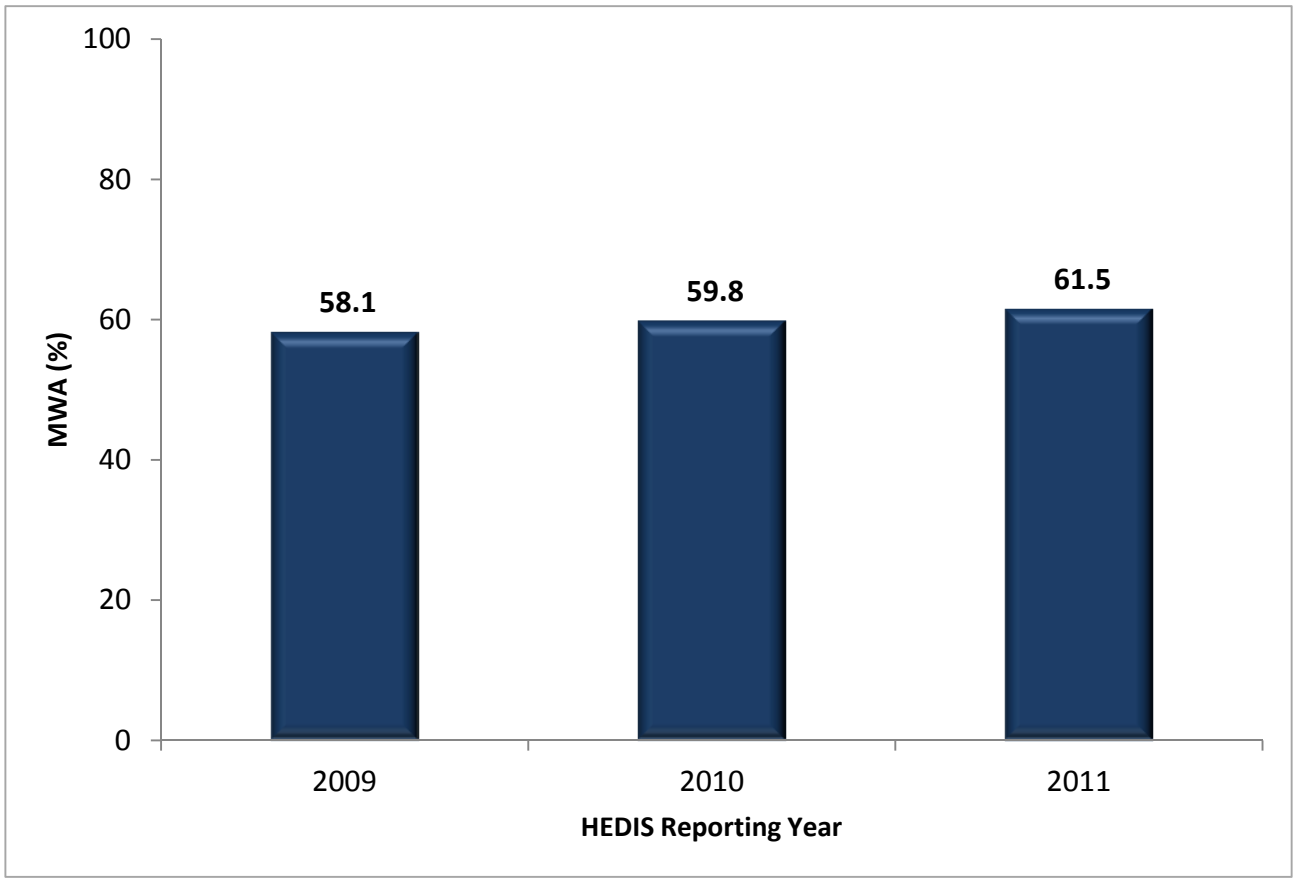
5-34 Ibid.

5-35 Michigan Department of Community Health. Michigan BRFSS Surveillance Brief. Available at: http://www.michigan.gov/documents/mdch/MIBRFSS_Surveillance_Brief_August_2010_Vol4No4_FINAL_329768_7.pdf. Accessed on: August 5, 2011.

5-36 Centers for Disease Control and Prevention. High Blood Pressure Facts. Available at: http://www.cdc.gov/bloodpressure/facts.htm. Accessed on August 5, 2011.

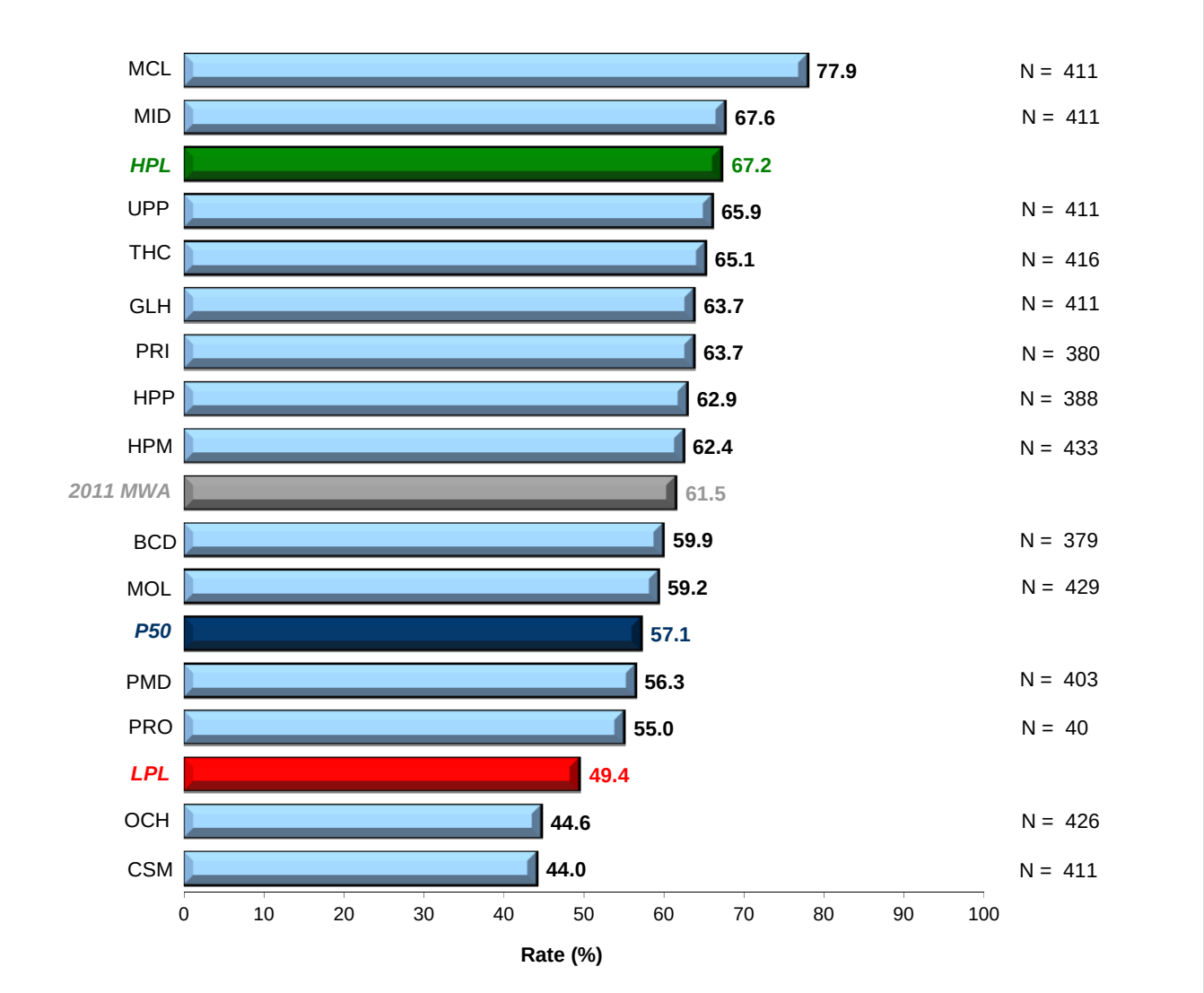
Performance Results

Figure 5-30—Controlling High Blood Pressure
Michigan Medicaid Weighted Averages



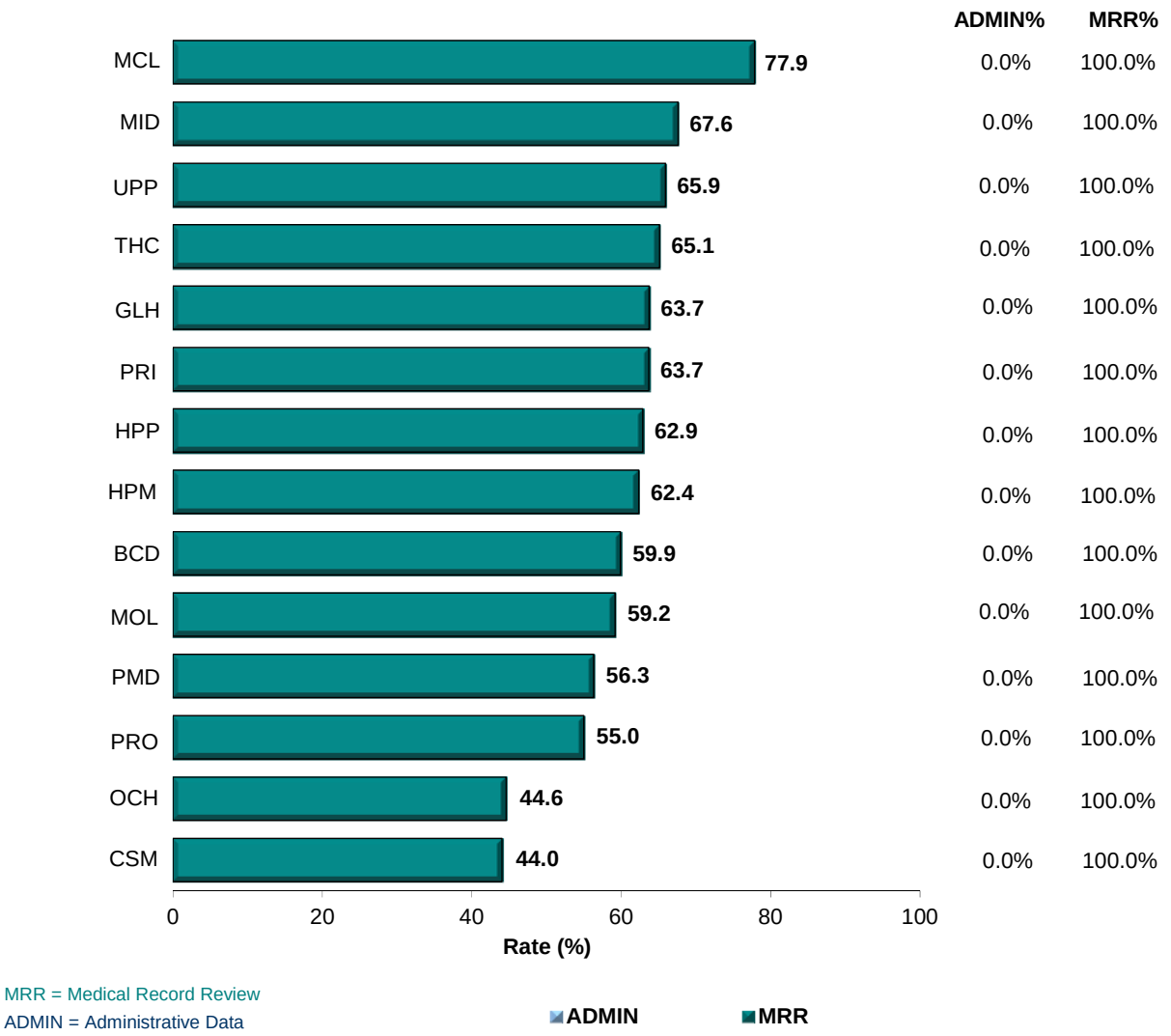
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated steady improvement from previous years' results. The 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 3.4 and 1.7 percentage points, respectively. The observed improvement from last year was not statistically significant.

Figure 5-31—Controlling High Blood Pressure
Health Plan Ranking



Two MHPs exceeded the HPL of 67.2 percent, and two MHPs fell below the LPL of 49.4 percent. Ten MHPs, including the two above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 61.5 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 4.4 percentage points.

Figure 5-32—Controlling High Blood Pressure Data Collection Analysis



HEDIS requires this measure to be reported using the hybrid data collection methodology. All results were derived from medical record data.

Medical Assistance With Smoking and Tobacco Use Cessation

Measure Definition

The *Medical Assistance With Smoking and Tobacco Use Cessation* measure is collected using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.[5-37] *Advising Smokers and Tobacco Users to Quit* is one component (or rate) reported for the measure. *Advising Smokers and Tobacco Users 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, who were smokers or tobacco users, who were seen by an MHP practitioner in the six months prior to completing the CAHPS survey, and who received advice to quit smoking or using tobacco in the six months prior to completing the CAHPS survey.

Discussing Cessation Medications is another component (or rate) reported for the measure. A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.

Discussing Cessation Strategies is another component (or rate) reported for the measure. *Discussing 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 or tobacco users, were seen by an MHP practitioner in the six months prior to completing the CAHPS survey, and received recommendations for or discussion about smoking or tobacco use cessation strategies in the six months prior to completing the CAHPS survey.

For the 2010 HEDIS reporting year, NCQA made substantial changes to the *Medical Assistance with Smoking and Tobacco Use Cessation* measure. These modifications included expanding the scope to include smokeless tobacco use, revising the denominator to include smokers and tobacco users who were not seen by a health practitioner during the measurement year, and a revision of the CAHPS survey question response choices. Due to these changes, results cannot be compared to national standards and previous years' weighted averages. The measure was changed due to an update to the U.S. Department of Health and Human Services, Public Health Service Clinical Practice Guideline on tobacco use, *Treating Tobacco Use and Dependence: 2008 Update*.[5-38]

Importance

Smoking is the leading cause of preventable morbidity and mortality in the United States. Approximately 46.6 million U.S. adults were smokers in 2009.[5-39] 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. If current trends of tobacco use continue, smoking-related diseases will be

---

5-37 *CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).*

5-38 Agency for Healthcare Research and Quality. Treating Tobacco Use And Dependence: 2008 Update. *National Guideline Clearinghouse.* Available at: http://www.guideline.gov/content.aspx?id=12520. Accessed on: November 5, 2010.

5-39 American Lung Association. Trends in Tobacco Use. Available at: http://www.lungusa.org/finding-cures/our-research/trend-reports/Tobacco-Trend-Report.pdf. Accessed on: September 7, 2011.

responsible for the eventual premature deaths of approximately 6.4 million children. Discontinuing the use of tobacco is the most cost-effective method of preventing disease in adults. Investing adequately in comprehensive tobacco control programs would result in proportionately greater reductions in smoking among the various states.

In fact, if states were to sustain their individual levels of investment for five years, as recommended by the CDC, there would be an estimated 5 million fewer smokers nationwide, and hundreds of thousands of premature tobacco-related deaths might be prevented.[5-40] Investments for longer periods of time could have an even greater impact.

According to the CDC, 18.9 percent of Michigan adults were cigarette users in 2010.[5-41] The 25-to-44-year-old age group had the highest rate at 23.5 percent, followed by the 45-to-64-year-old age group at 19.9 percent.

"Tobacco-Free Michigan" is a five-year strategic plan focused on preventing tobacco use in the State. The plan has established goals in five different areas:

- Identifying and eliminating disparities in tobacco use.
- Eliminating exposure to secondhand smoke.
- Increasing cessation treatment among adults and youth.
- Preventing tobacco use initiation among youth.
- Expanding and stabilizing tobacco infrastructure.[5-42]

Through 2008, the program has achieved a number of significant accomplishments. For example, 21 counties and four cities have passed smoke-free worksite regulations, protecting more than 47 percent of Michigan residents from second-hand smoke exposure at work. Michigan's Tobacco QuitLine has also helped more than 42,000 residents attempt to quit smoking.[5-43]

5-40 Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs—2007. Fact Sheet. Available at: http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/BestPracticesFactSheet.pdf. Accessed on: September 7, 2011.

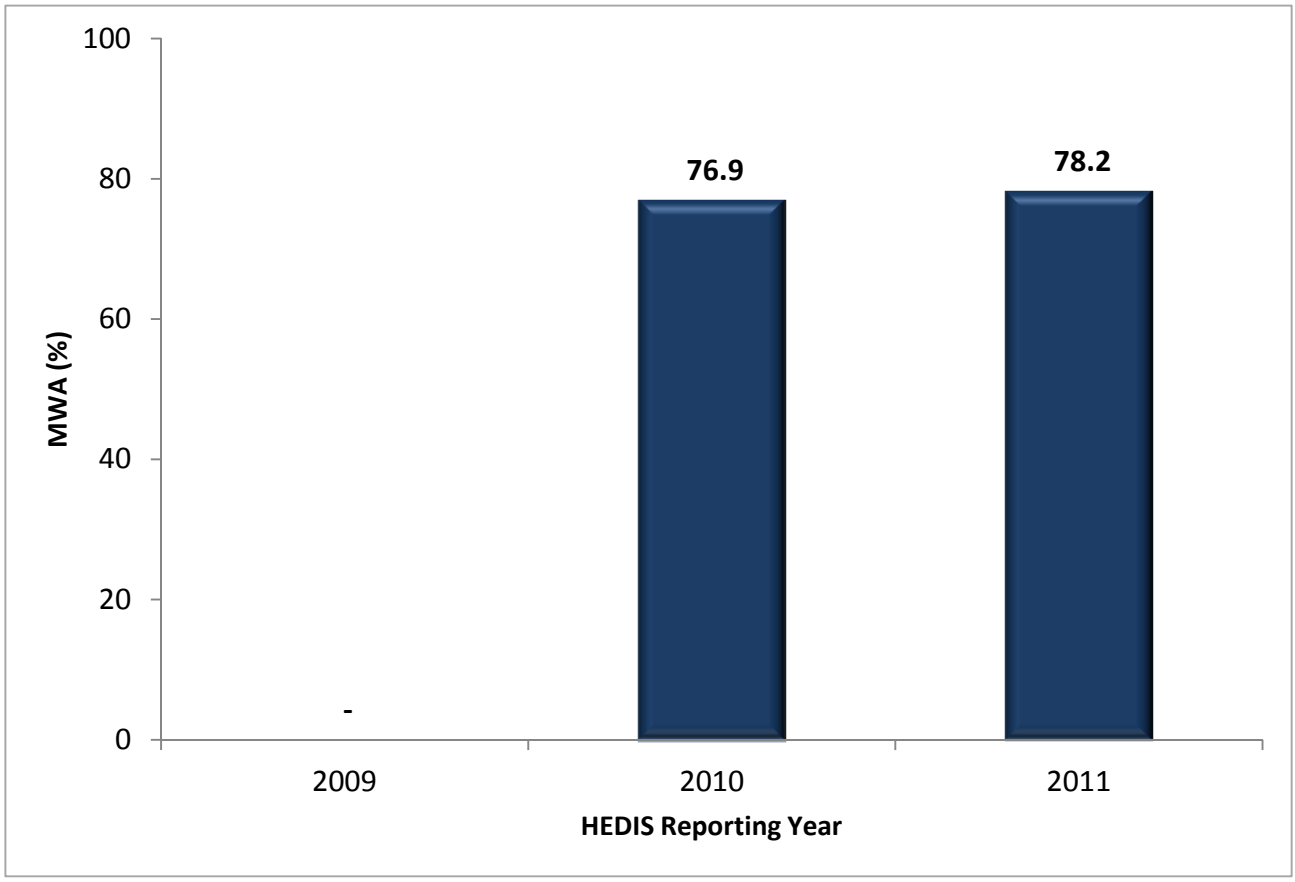
5-41 Centers for Disease Control and Prevention. State Tobacco Activities Tracking and Evaluation (STATE) System. Available at: http://apps.nccd.cdc.gov/statesystem/HighlightReport/HighlightReport.aspx?FromHomePage=Y&StateName=Michigan&StateId=MI#ReportDetail. Accessed on: September 7, 2011.

5-42 Tobacco-Free Michigan. A Five-Year Strategic MHP for Tobacco Use Prevention and Reduction 2008–2013. Available at: http://www.michigan.gov/documents/DCH_Strategic_Plan-single_113971_7.pdf. Accessed on: September 7, 2011.

5-43 Ibid.

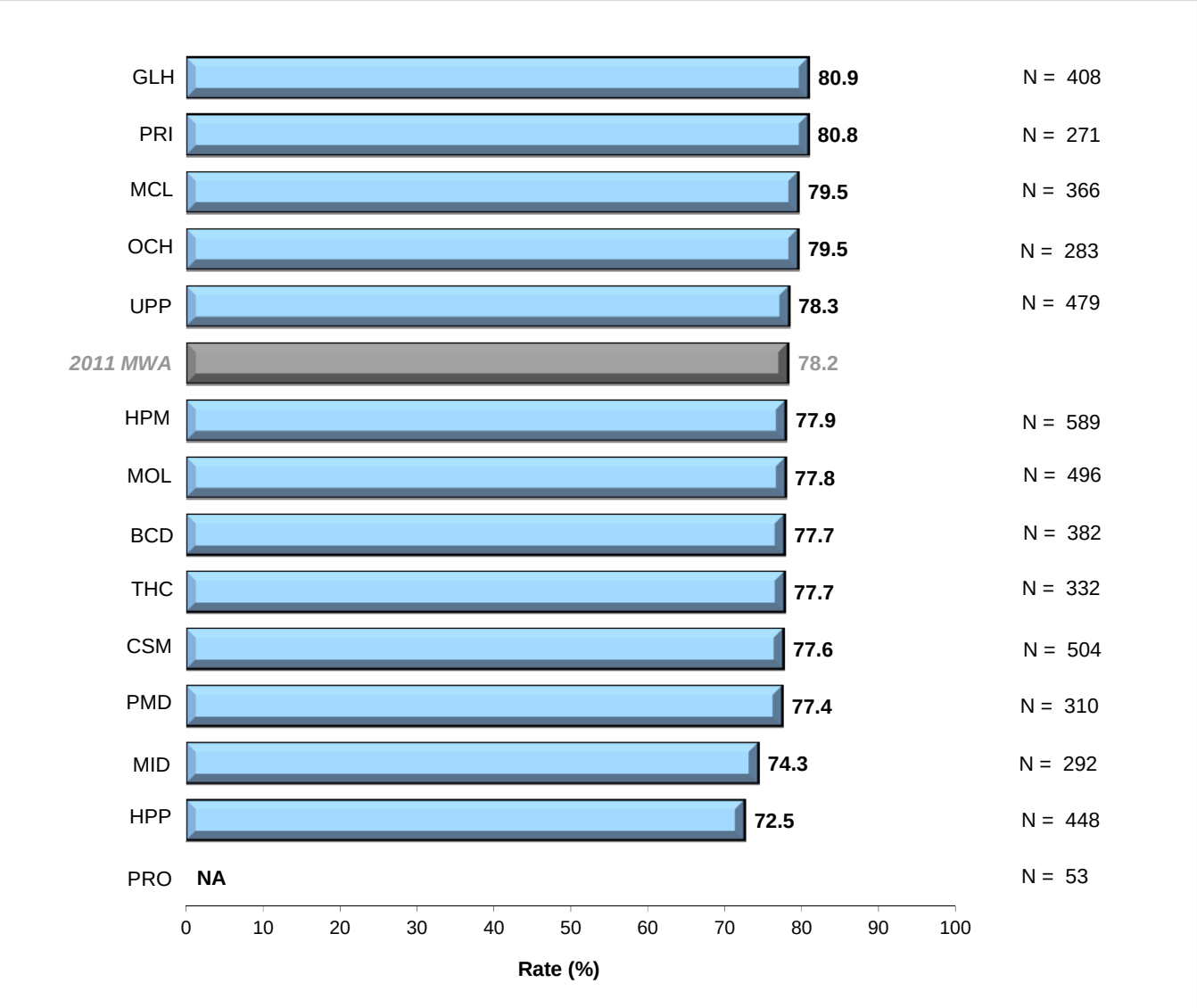
Performance Results

Figure 5-33—Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit Michigan Medicaid Weighted Averages



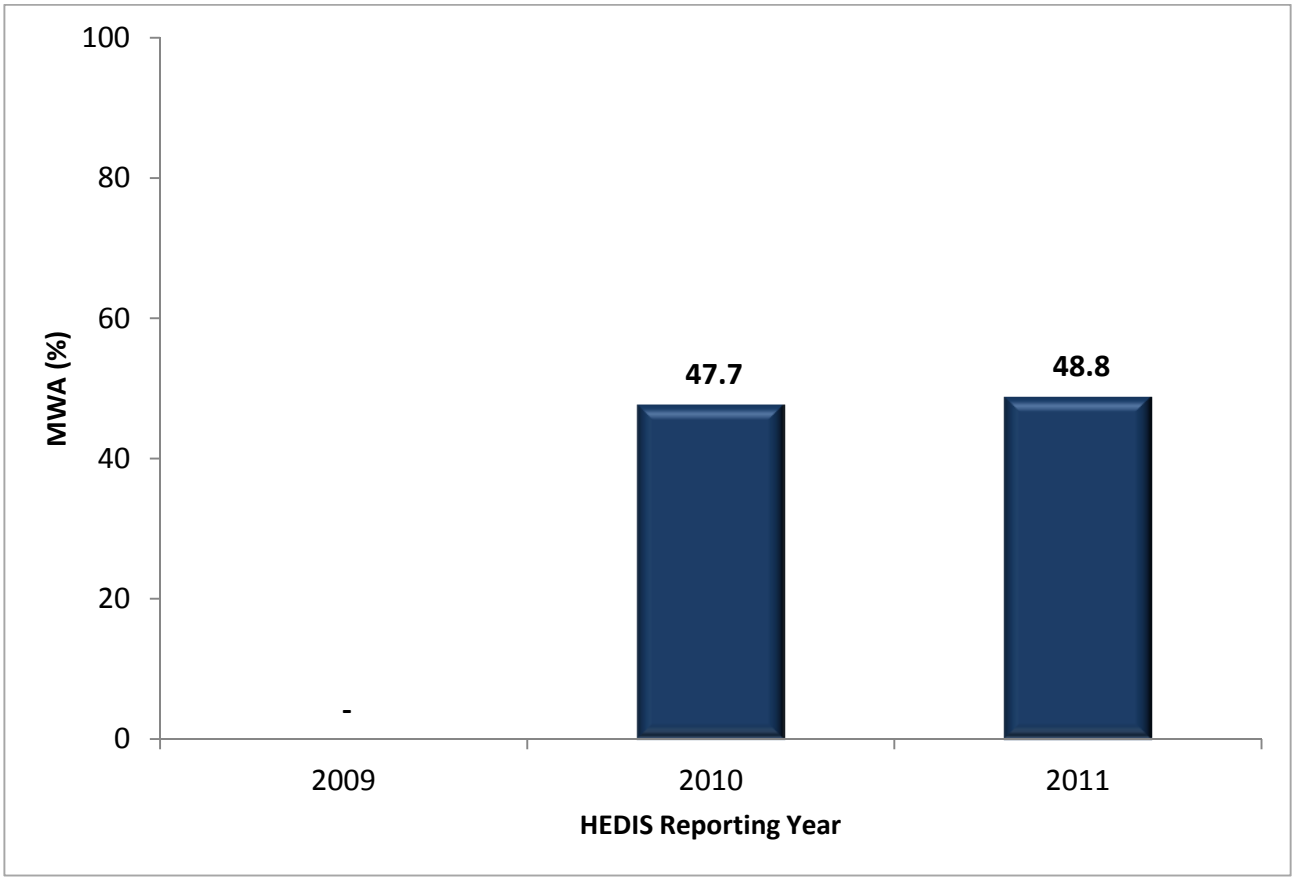
Due to specification changes in HEDIS 2010, the HEDIS 2009 result was not presented in Figure 5-33. The HEDIS 2011 Michigan Medicaid weighted average showed a slight improvement from last year's result. Compared to HEDIS 2010, this year's rate increased by 1.3 percentage points. The observed improvement from last year was not statistically significant.

Figure 5-34—Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit Health Plan Ranking



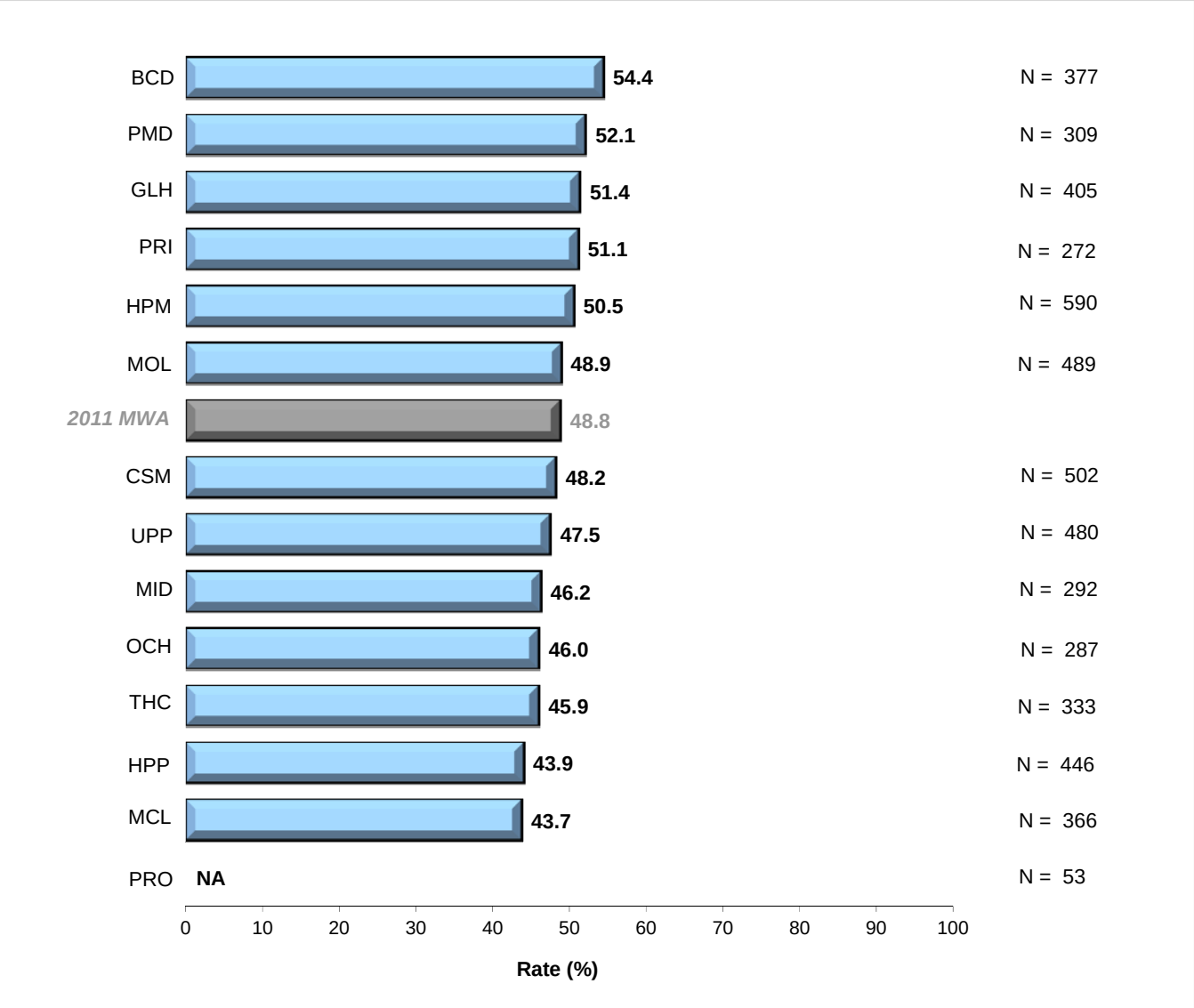
All but one MHP reported a valid rate for this measure. One MHP was unable to report a rate for this measure since the health plan did not meet the minimum number of responses to report a valid rate (i.e., a denominator of less than 100). The HEDIS 2011 Michigan Medicaid weighted average was 78.2 percent. Individual plan performance demonstrated very little variance across plans, with rates ranging from 72.5 percent to 80.9 percent.

Figure 5-35—Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medication Michigan Medicaid Weighted Averages



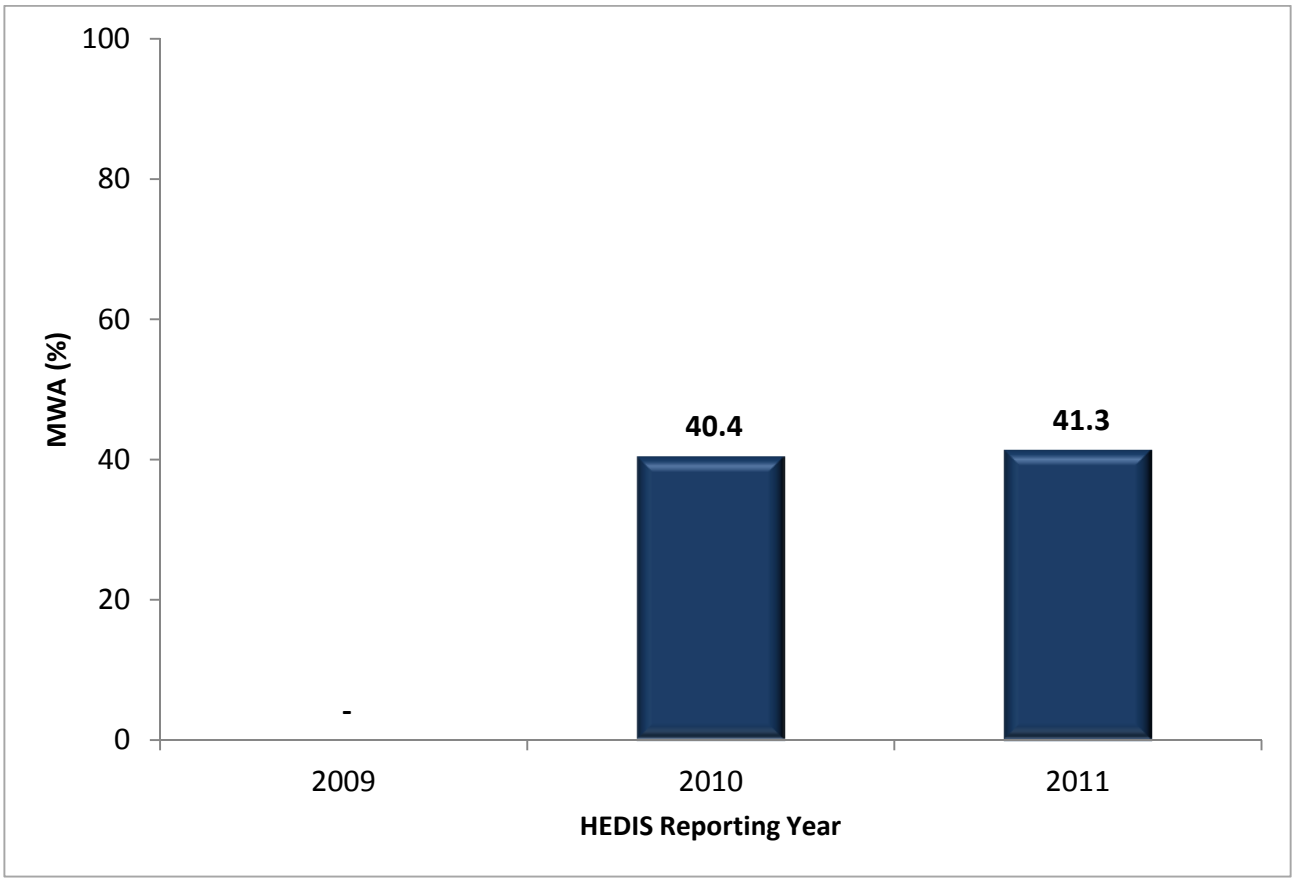
Due to specification changes in HEDIS 2010, the HEDIS 2009 result is not presented in Figure 5-35. The HEDIS 2011 Michigan Medicaid weighted average showed a slight improvement from last year's result. Compared to HEDIS 2010, this year's rate increased by 1.1 percentage points. The observed improvement was not statistically significant.

Figure 5-36—Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medication Health Plan Ranking



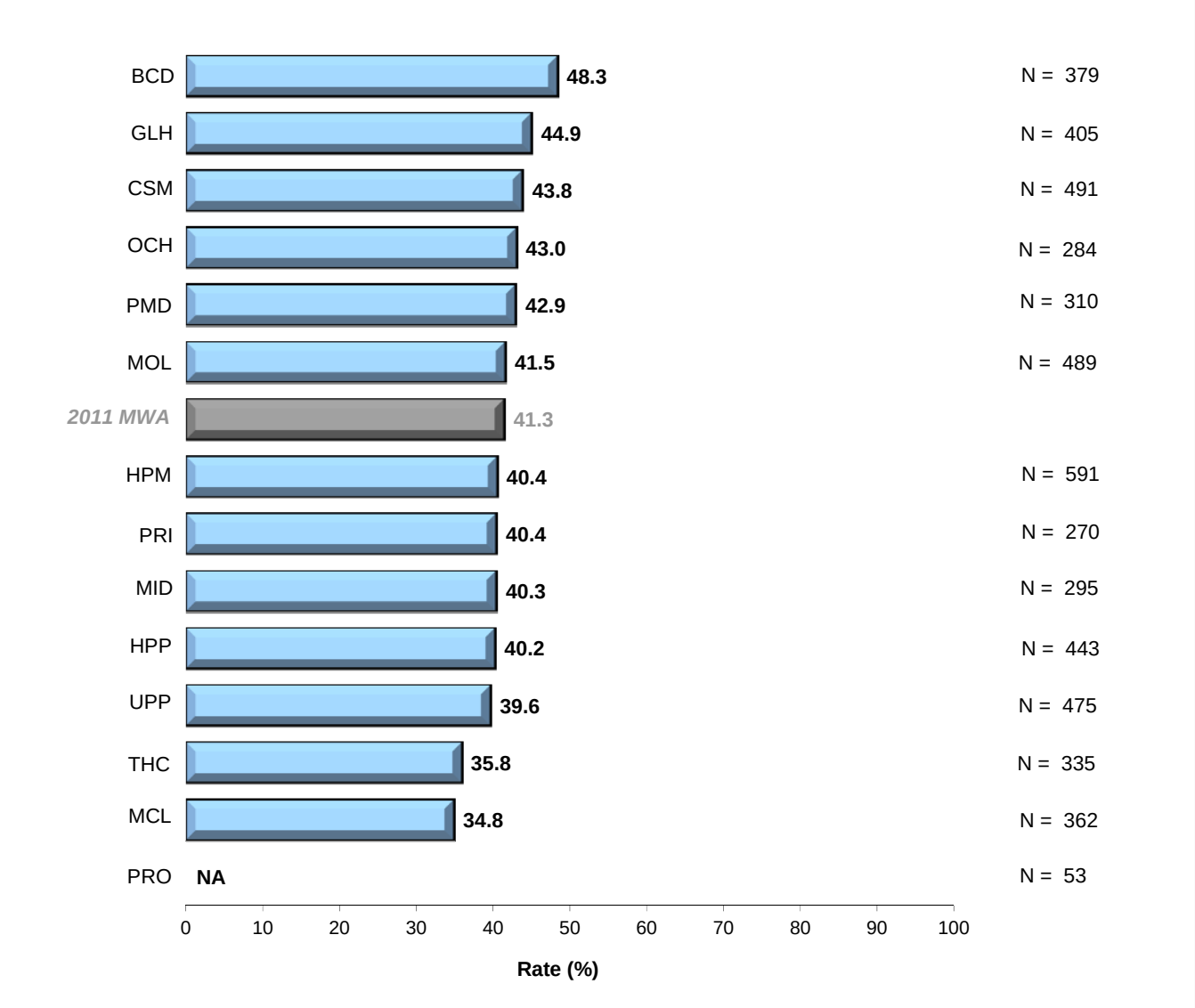
All but one MHP reported a valid rate for this measure. One MHP was unable to report a rate for this measure since the health plan did not meet the minimum number of responses to report a valid rate (i.e., a denominator of less than 100). The HEDIS 2011 Michigan Medicaid weighted average was 48.8 percent. Individual plan performance ranged from 43.7 percent to 54.4 percent, a difference of 10.7 percentage points.

Figure 5-37—Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies Michigan Medicaid Weighted Averages



Due to specification changes in HEDIS 2010, the HEDIS 2009 result is not presented in Figure 5-37. The HEDIS 2011 Michigan Medicaid weighted average showed a slight improvement from last year's result. Compared to HEDIS 2010, this year's rate increased by 0.9 percentage point. The observed improvement was not statistically significant.

Figure 5-38—Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies Health Plan Ranking



All but one MHP reported a valid rate for this measure. One MHP was unable to report a rate for this measure since the health plan did not meet the minimum number of responses to report a valid rate (i.e., a denominator of less than 100). The HEDIS 2011 Michigan Medicaid weighted average was 41.3 percent. Individual plan performance ranged from 34.8 percent to 48.3 percent, a difference of 13.5 percentage points.

Living With Illness Findings and Recommendations

Summary of Findings

Table 5-1 and Table 5-2 summarize the MHP's rank relative to the national HEDIS 2010 Medicaid percentiles for each measure under the Living With Illness dimension. Since the percentile rank is mostly associated with performance level, the tables also serve as a high-level comparison of performance by measure across all plans. For percentile range associated with each rank symbol, please refer to the Percentile Ranking segment in Section 2 of this report.

Table 5-1—Living With Illness Performance Summary

MHP 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	Diabetes Care Blood Pressure Control <140/80	Diabetes Care Blood Pressure Control <140/90
BlueCaid of Michigan	★★★★★	★★★★	★★★★	★★★★★	★★★★★	★★★★★	NC	★★★★
CareSource Michigan	★★★	★★★	★★	★★★	★★	★★★	NC	★★
UnitedHealthcare Great Lakes Health Plan, Inc.	★★	★★★	★★★	★★★	★★★	★★	NC	★★★
Health Plan of Michigan, Inc.	★★★★★	★★★★	★★★	★★★★★	★★★★★	★★★★	NC	★★
HealthPlus Partners	★★★★	★★★	★★★★★	★★★	★★★★	★★★★	NC	★★★
McLaren Health Plan	★★★	★★★★	★★★★★	★★	★★★★★	★★★★★	NC	★★★★★
Midwest Health Plan	★★★★	★★★	★★★	★★★★	★★★	★★★★★	NC	★★★
Molina Healthcare of Michigan	★★★	★★★	★★	★★★★	★★★	★★★	NC	★★★
OmniCare Health Plan	★★	★★	★★	★★★	★★★	★★★★	NC	★★
Physicians Health Plan of Mid-Michigan Family Care	★★★	★★★	★★★★	★★	★★★★	★★★★	NC	★★★

Table 5-1—Living With Illness Performance Summary								
MHP 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	Diabetes Care Blood Pressure Control <140/80	Diabetes Care Blood Pressure Control <140/90
Priority Health Government Programs, Inc.	★★★★★	★★★★★	★★★	★★★★	★★★★	★★★★★	NC	★★★★
ProCare Health Plan	★★★	★★	★	★	★★★	★★	NC	★★
Total Health Care, Inc.	★★★★	★★★	★★★	★★★★★	★★★★	★★★★★	NC	★★★
Upper Peninsula Health Plan	★★★★★	★★★★★	★★★★★	★★★★★	★★★	★★★	NC	★★★★★

Table 5-2—Living With Illness Performance Summary *Continued*							
MHP Name	Asthma 5–11 Years	Asthma 12–50 Years	Asthma Total	Controlling High Blood Pressure	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies
BlueCaid of Michigan	★★★	★★★	★★★	★★★	NC	NC	NC
CareSource Michigan	★★★★	★★★	★★★	★	NC	NC	NC
UnitedHealthcare Great Lakes Health Plan, Inc.	★	★	★	★★★★	NC	NC	NC
Health Plan of Michigan, Inc.	★★★	★★★	★★★	★★★	NC	NC	NC
HealthPlus Partners	★★★★★	★★★	★★★	★★★	NC	NC	NC
McLaren Health Plan	★★★	★	★★	★★★★★	NC	NC	NC
Midwest Health Plan	★★★★★	★★★	★★★★	★★★★★	NC	NC	NC
Molina Healthcare of Michigan	★	★	★	★★★	NC	NC	NC
OmniCare Health Plan	★	★★	★	★	NC	NC	NC
Physicians Health Plan of Mid-Michigan Family Care	★★★	★★★★★	★★★★★	★★	NC	NC	NC
Priority Health Government Programs, Inc.	★★★★	★★★★★	★★★★★	★★★★	NC	NC	NC
ProCare Health Plan	NA	NA	NA	★★	NC	NC	NC
Total Health Care, Inc.	★★★	★★★★★	★★★★	★★★★	NC	NC	NC
Upper Peninsula Health Plan	★★★★	★★★	★★★	★★★★	NC	NC	NC

Among all the measures under this dimension, only one measure (*Comprehensive Diabetes Care—LDL-C Level <100 mg/dL*) had all but one plan performing at least at or above the national 50th percentile. *Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy* showed nine of the 14 MHPs reporting their performance at least at or above the 75th percentile. Comparing the three main chronic illnesses (diabetes, asthma, and high blood pressure), MHPs performed relatively poorly on the asthma measures. Two MHPs reported rates below the 25th percentile for all of the *Use of Appropriate Medications for People With Asthma* indicators.

Table 5-3 presents statewide performance at a glance for the measures under the Living With Illness dimension. It lists the HEDIS 2011 weighted averages, the trended results, and a summary of the MHPs with rates showing significant changes from HEDIS 2010.

Table 5-3—Michigan Medicaid HEDIS 2011 Statewide Rate Trend
Living With Illness

Measure	Statewide Rate		Number of MHPs	
	2011 Weighted Average	2010–2011 Trend	With Significant Improvement in 2011	With Significant Decline in 2011
Comprehensive Diabetes Care—HbA1c Testing	85.0%	+1.1	2	0
*Comprehensive Diabetes Care—Poor HbA1c Control**	36.4%	+0.8	0	2
Comprehensive Diabetes Care—Eye Exam	59.0%	-0.6	0	1
Comprehensive Diabetes Care—LDL-C Screening	80.8%	+0.7	1	0
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	41.1%	+2.1	2	0
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	82.8%	+0.4	3	1
*Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg***	40.8%	—	—	—
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	63.7%	**+3.6**	3	0
Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years	91.4%	+1.0	2	1
Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years	85.2%	+0.4	1	0
Use of Appropriate Medications for People With Asthma—Total	87.4%	+0.6	1	0
Controlling High Blood Pressure	61.5%	+1.7	1	4
*Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit***	78.2%	+1.3	0	0
*Medical Assistance With Smoking and Tobacco Use Cessation—Discuss Cessation Medications***	48.8%	+1.1	0	0
*Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies***	41.3%	+0.9	0	0

2010–2011 Trend note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decrease from the prior year.
* For this measure, a lower rate indicates better performance.
**These measures are CAHPS measures and have no benchmark information available.

Legend	<P10	≥P10 and < P25	≥P25 and < P50	≥P50 and < P75	≥P75 nd < P90	≥P90

At the statewide level, the HEDIS 2011 Michigan Medicaid program performance in this dimension was comparable to the national average performance ranges but did not demonstrate significant improvements from last year. Of the 11 measures with comparable national percentiles, three (all under *Comprehensive Diabetes Care*) showed performance that met or exceeded the 75th percentiles. Although three measures (all *Use of Appropriate Medications for People With Asthma* measures) were below the 50th percentiles, this year's performance demonstrated slight improvement from last year's. Although many measures showed improvement in performance from last year, none had an increase in rate for more than five percentage points; and only one had a statistically significant improvement (*Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg*). The few number of measures with significant improvements appeared to be supported by the relatively small number of MHPs exhibiting significant improvement in HEDIS 2011.

Best Practices

There are many health care factors that can be attributed to the results of the Living With Illness measures, such as patient-provider relationships, medication compliance, chronic disease management, and disease self-management. Quality improvement projects should aim at eliminating barriers associated with improving any combination of these health care factors. Successful improvement projects have implemented interventions that manage other chronic disease measures and/or employed unique methods and tools developed specifically for a particular population of chronically ill members.

Introduction

As federal, state and local programs that provide and support primary care services are required to demonstrate that they in fact maintain or increase access to primary care, measures of access to care will become increasingly important, particularly to plans already reporting. Measures that capture both the perception and the "reality" of access to primary care services at a population or community level will be important for this measurement process.[6-1]

Accessibility to primary care, health care specialists and emergency treatment are the focal point of Access to Care type measures. Access to primary health care specialists and emergency treatment can be restricted at times due to constraints, such as distance between the patient and physician, lack of transportation, a disability prohibiting the patient from traveling to see the physician, the cost of receiving services, limited office hours and long waits to get an appointment.[6-2]

According to a research study analyzing National Health Interview Survey data, people with one or more barriers to primary care are more likely to visit the emergency department. The likelihood of an emergency department visit over a primary care health care specialist has significantly increased, as the research also found that the barriers to primary care have doubled over the past decade.[6-3]

Statistics regarding access to care often vary considerably by race. The CDC reports that during 2006, approximately 902 million visits were made to office-based physicians in the United States. The visit rate for Whites was higher than the rate for African-American and Hispanic individuals (323.9 versus 235.4 and 271.0 visits per 100 individuals per year, respectively).[6-4] Furthermore, the type or lack of insurance coverage has a significant impact on the ability to obtain timely access to care. Individuals with Medicaid coverage were less likely to receive an appointment than those with private coverage (34.2 percent for Medicaid compared with 63.3 percent for private insurance).[6-5]

Better primary care improves equity in health.[6-6] Areas with inequality larger disparity of household income have a one-third higher rate of reporting poor or fair health only if coincident with a poor supply of PCPs. Several studies have compared patients at community health centers (CHCs),

---

6-1 NLM Gateway. Measures of Access to Primary Health Care: Perceptions and Reality. Available at http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102194440.html. Accessed on August 9, 2011.

6-2 [1] Hall A, Harris Lemak C, Steingraber H, *et al.* Expanding the definition of access: It isn't just about health insurance. *J Health Care Poor Underserved.* 2008;19:625–638.

6-3 PR Newswire. Barriers to Primary Care Doubled in a Decade Leading to Continued Rise in Emergency Department Visits. Available at http://www.prnewswire.com/news-releases/barriers-to-primary-care-doubled-in-a-decade-leading-to-continued-rise-in-emergency-department-visits-127266898.html. Accessed on August 9, 2011.

6-4 Centers for Disease Control and Prevention. National Ambulatory Medical Care Survey: 2006 Summary. Available at: http://www.cdc.gov/nchs/data/nhsr/nhsr003.pdf. Accessed on: August3, 2011.

6-5 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.

6-6 Murray M, Swanson JA, Margolis PA. Behind Schedule: Improving Access to Care for Children One Practice at a Time. *Pediatrics.* 2004; 113(3): e230–237.

which provide high quality primary care services, to the general population and found health disparities are significantly decreased in these settings.[6-7]

There is a correlation between higher continuity of and improved utilization in primary care settings. Evidence shows that with increased access to primary care comes better treatment compliance, lower ED usage, and lower hospitalization rates.[6-8] Having a regular source of care was found to be the single most important factor associated with receiving preventive care services, even after considering the effect of demographic characteristics, financial status, and need for ongoing care.

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

- *Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- *Children's and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—20 to 44 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—45 to 64 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—65+ Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Ambulatory Care—Outpatient Visits per 1,000 Member Months*
- *Ambulatory Care—ED Visits per 1,000 Member Months*

6-7 Starfield B, Shi L. The Medical Home, Access to Care, and Insurance: A Review of Evidence. *Pediatrics.* 2004; 113(5): 1493–1498.

6-8 Murray M, Swanson JA, Margolis PA. Behind Schedule: Improving Access to Care for Children One Practice at a Time. *Pediatrics.* 2004; 113(3): e230–237.

Children's and Adolescents' Access to Primary Care Practitioners

Measure Definition

Children's and Adolescents' Access to Primary Care Practitioners calculates the percentage of:

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

This measure is reported in four age groups: 12 to 24 months, 25 months to 6 years, 7 to 11 years, and 12 to 19 years.

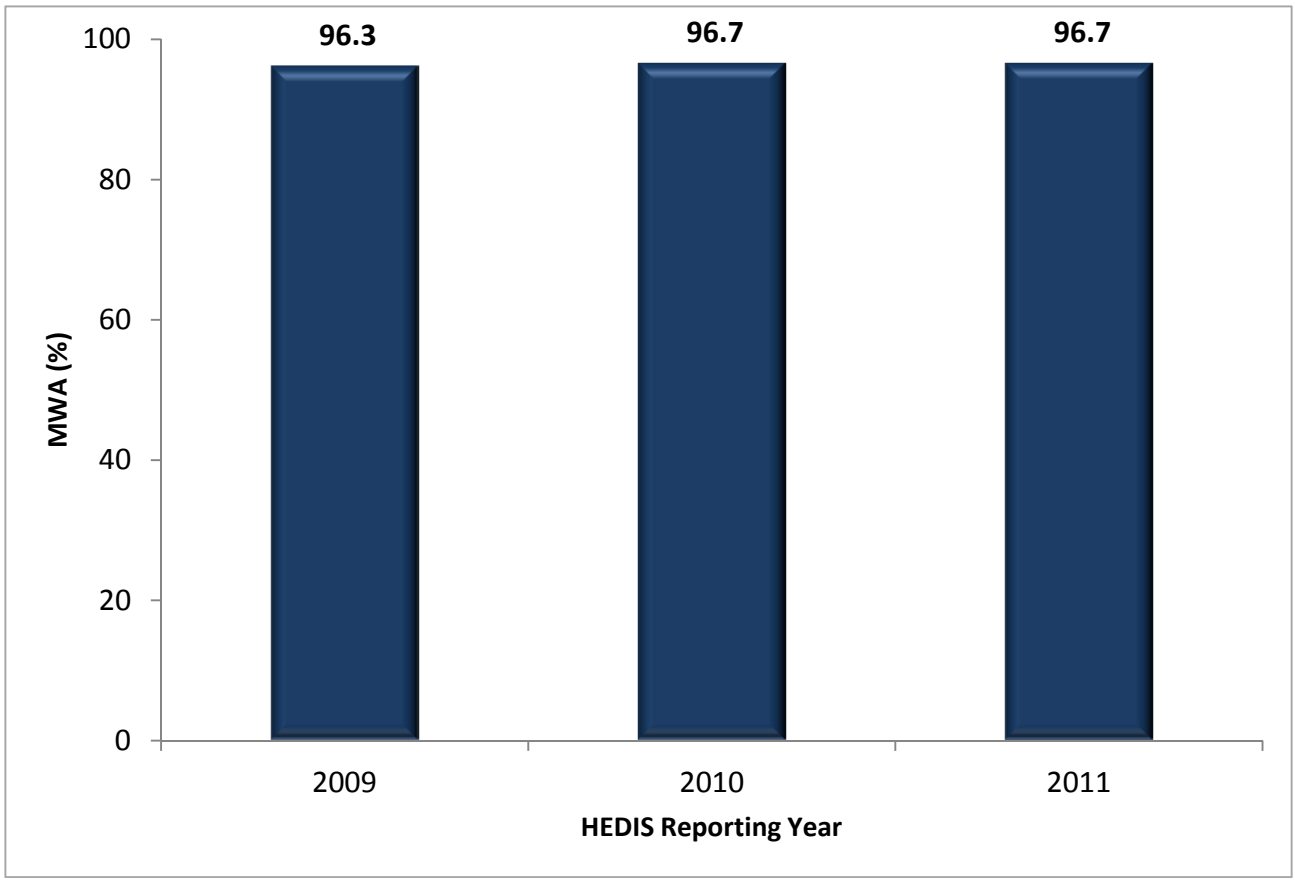
Importance

The *Children's and Adolescents' Access to Primary Care Practitioners* measure looks at visits to pediatricians, family physicians, and other PCPs as a way to assess general access to care for children. Regular access to primary care assures continuity of care and provides essential preventative and acute care services to children and adolescents. Michigan ranked 14th in the country in terms of the access and affordability of care for children, according to a report from The Commonwealth Fund.[6-9] One important component in this ranking was insurance coverage. The report ranked Michigan 7th nationwide for having the lowest rate of uninsured children. In addition, Michigan ranked 19th in the United States for percentage of children with a preventive medical care visit in the past year.

[6-9] The Commonwealth Fund. United States Variations in Child Health System Performance: A State Scorecard. Available at: http://www.commonwealthfund.org/Maps-and-Data/State-Data-Center/Child-Health/DataByState/State.aspx?state=MI. Accessed on: September 7, 2011.

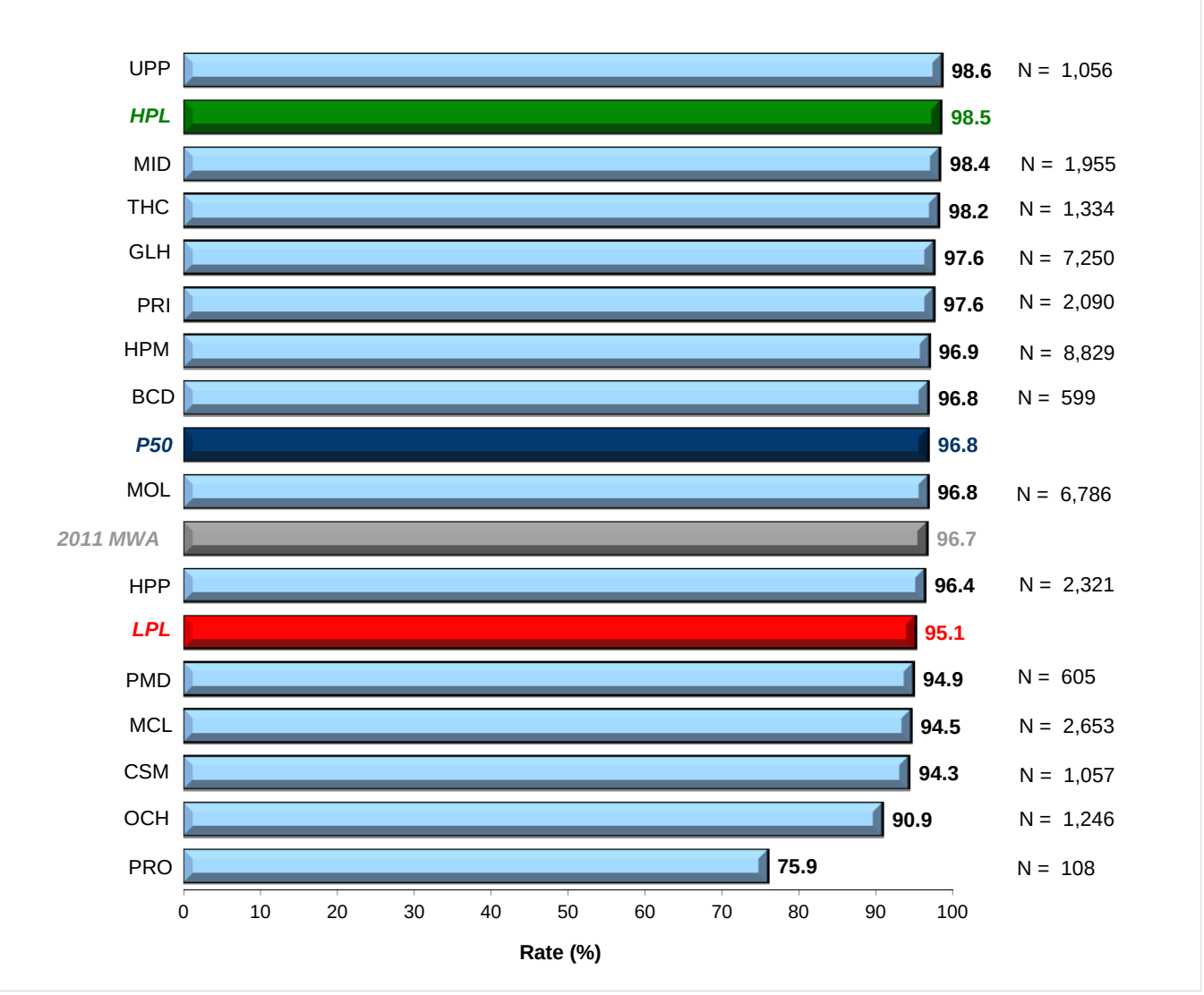
Performance Results

Figure 6-1—Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 Months
Michigan Medicaid Weighted Averages



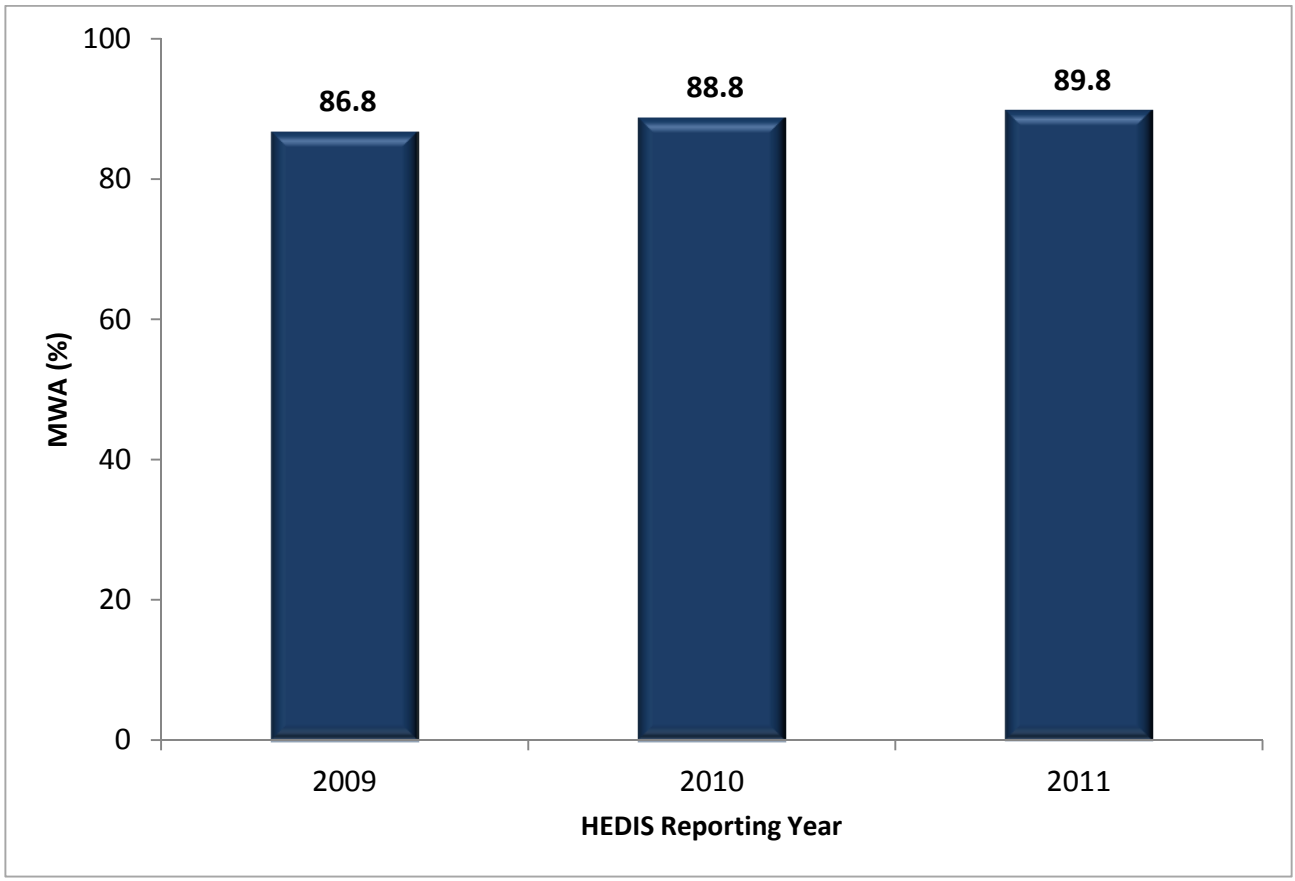
The HEDIS 2011 Michigan Medicaid weighted average maintained the same performance level as HEDIS 2010. Compared to HEDIS 2009, the current year's rate increased by 0.4 percentage point.

Figure 6-2—Children's and Adolescents' Access to Primary Care Practitioners—12 to 24 Months Health Plan Ranking



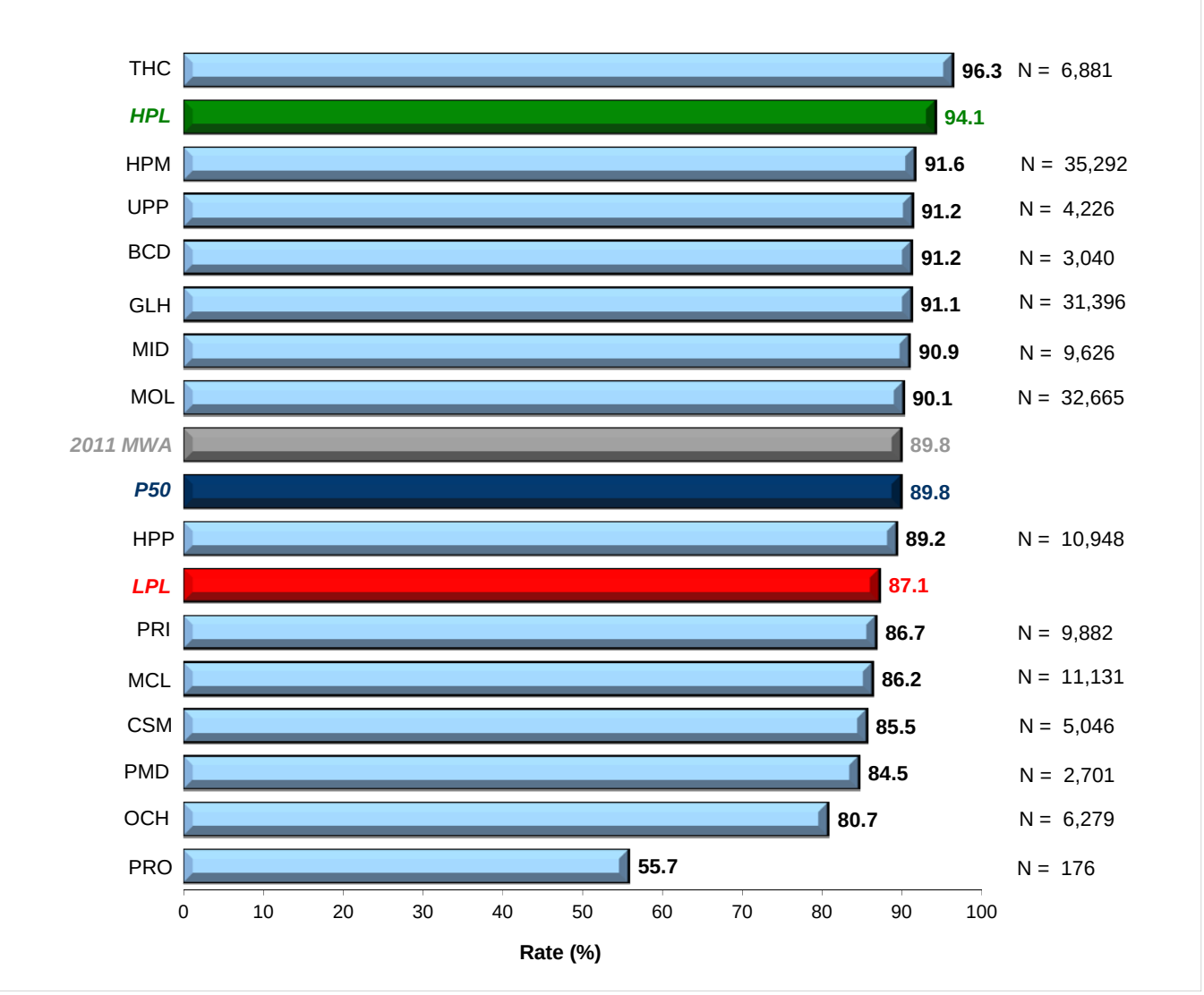
One MHP exceeded the HPL of 98.5 percent, and five fell below the LPL of 95.1 percent. Seven MHPs, including the one above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 96.7 percent was only 0.1 percentage point below the national HEDIS 2010 Medicaid 50th percentile.

Figure 6-3—Children's and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years Michigan Medicaid Weighted Averages



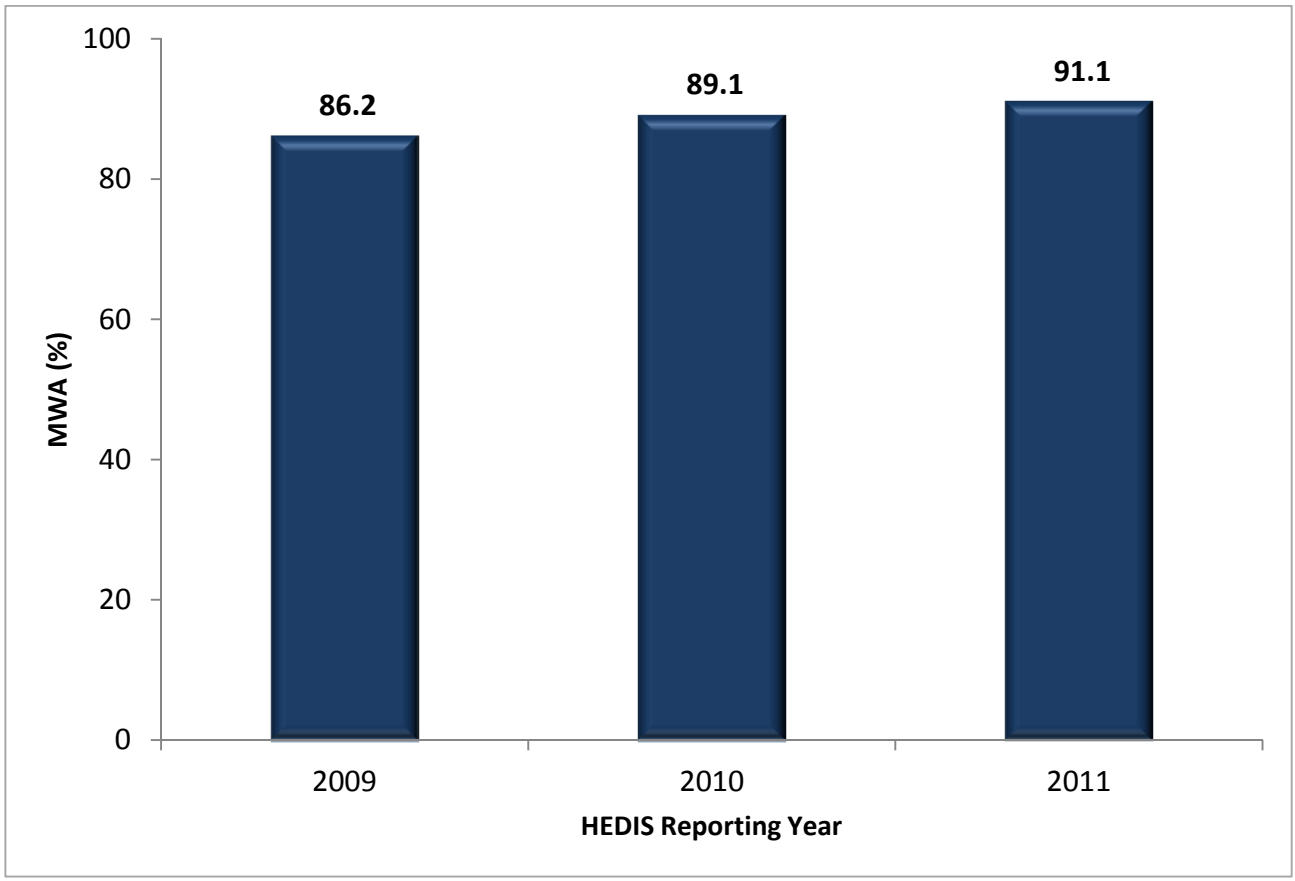
The HEDIS 2011 Michigan Medicaid weighted average showed steady improvement from previous year's results. The current year's rate increased 1.0 percentage point from HEDIS 2010. The HEDIS 2011 rate was three percentage points higher than HEDIS 2009 rate. The observed improvement from last year was statistically significant.

Figure 6-4—Children's and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years Health Plan Ranking



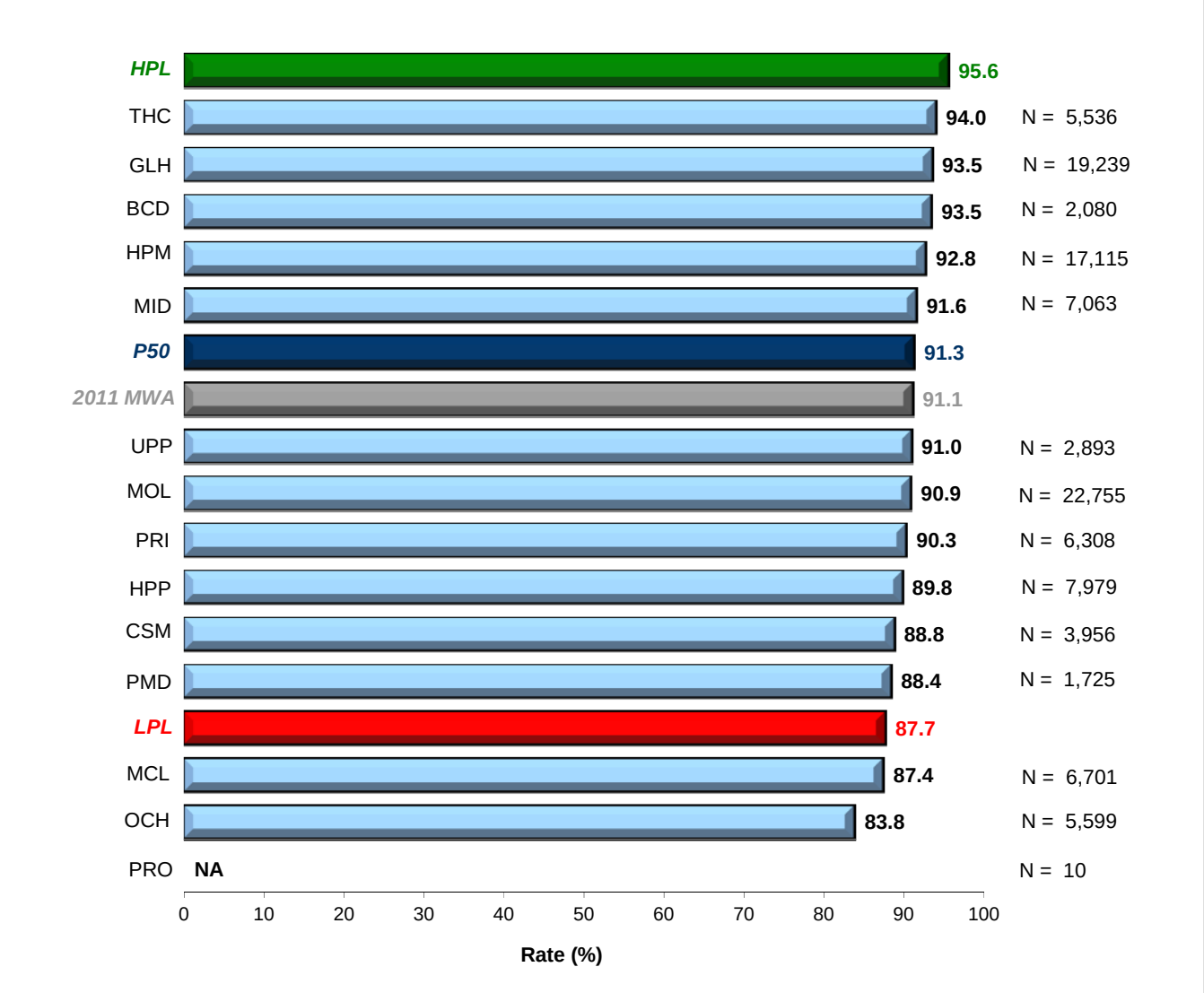
One MHP exceeded the HPL of 94.1 percent, and six MHPs fell below the LPL of 87.1 percent. Seven MHPs, including the one above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 89.8 percent was at the national HEDIS 2010 Medicaid 50th percentile.

Figure 6-5—Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 Years
Michigan Medicaid Weighted Averages



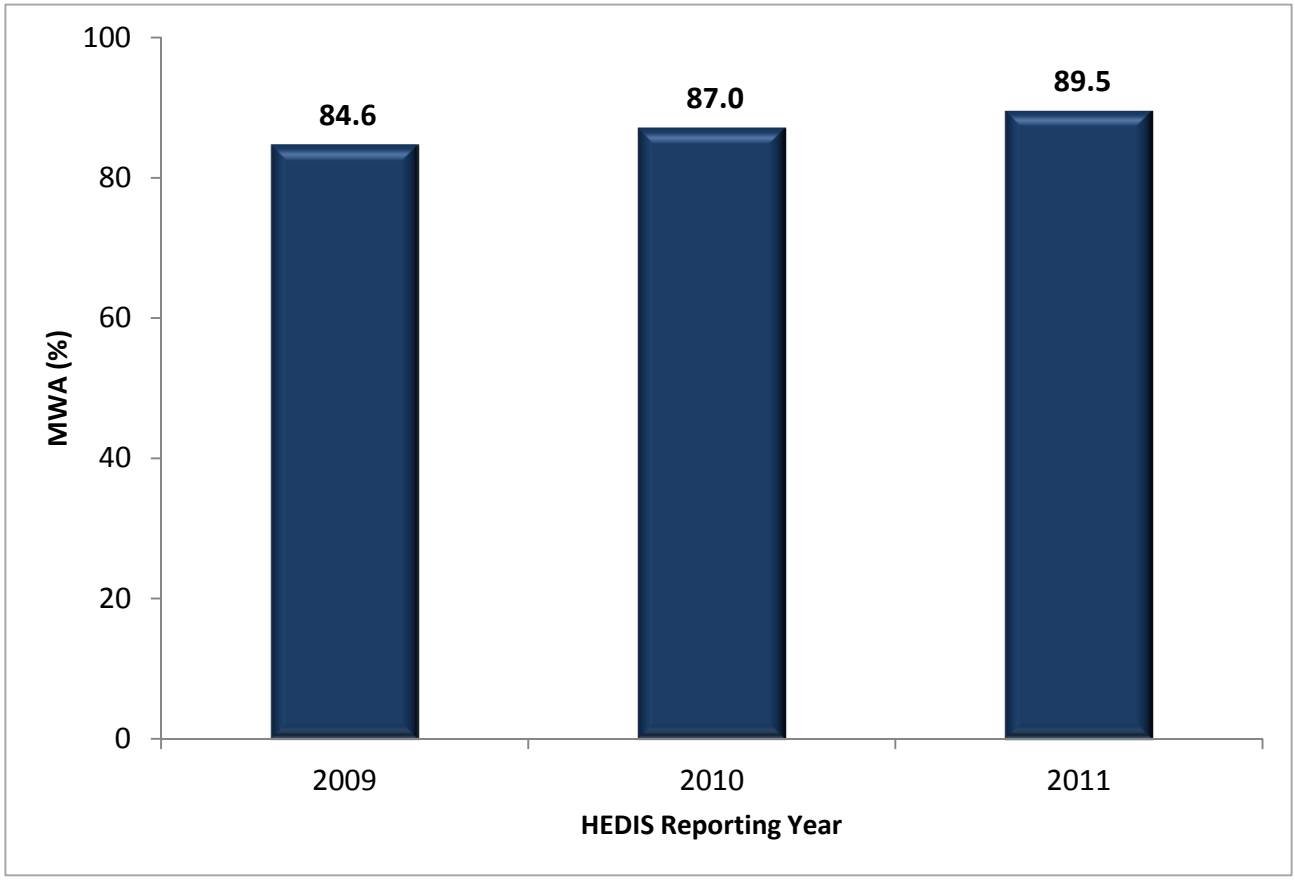
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated steady improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 4.9 and 2.0 percentage points, respectively. The observed improvement from last year was statistically significant.

Figure 6-6—Children's and Adolescents' Access to Primary Care Practitioners—7 to 11 Years
Health Plan Ranking



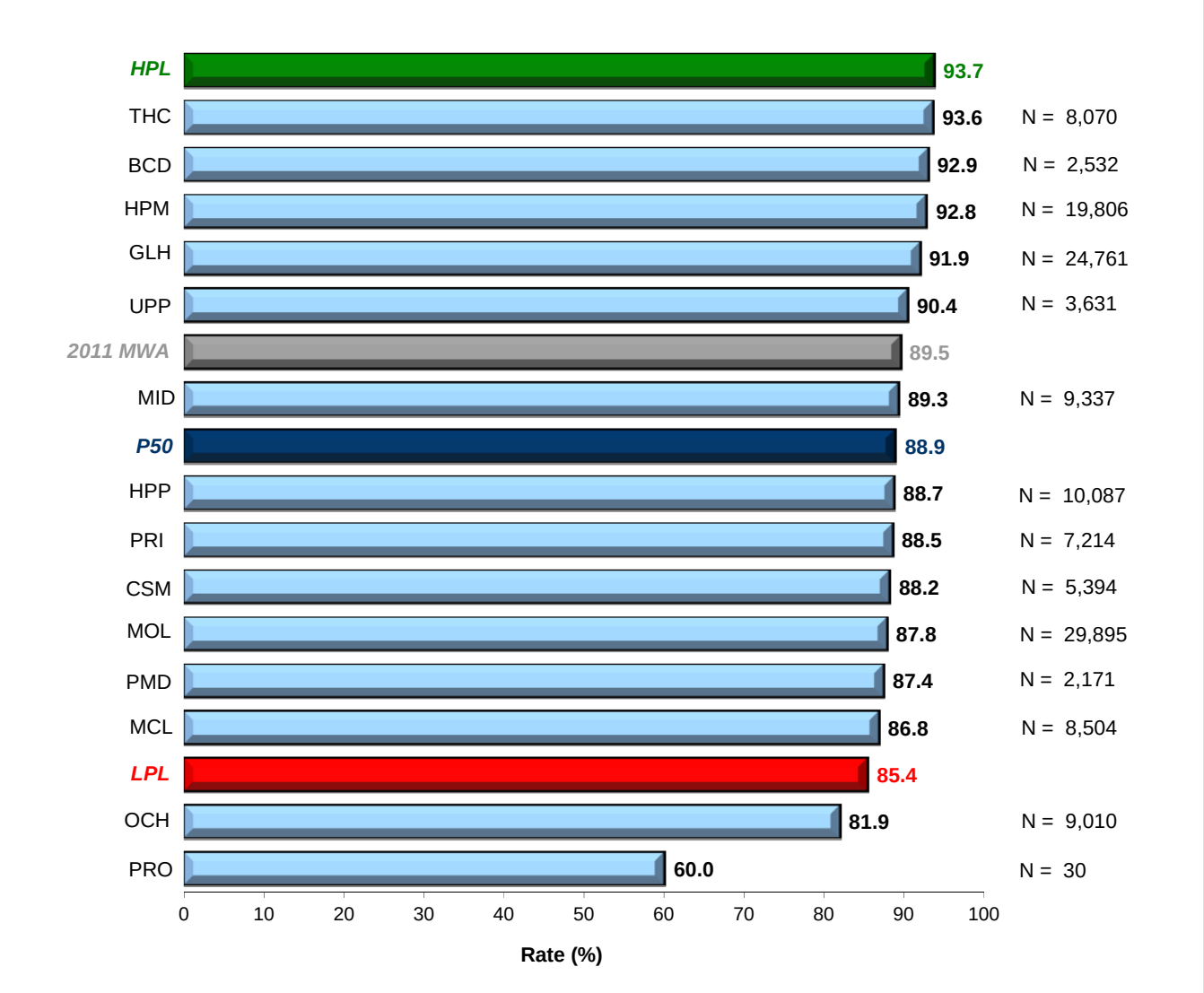
Though none of the MHPs exceeded the HPL of 95.6 percent, five MHPs were above the national HEDIS 2010 Medicaid 50th percentile. Two plans reported rates below the LPL of 87.7 percent. One MHP was unable to report a rate for this measure since the denominator was too small to report a valid rate (a denominator of less than 30). The HEDIS 2011 Michigan Medicaid weighted average of 91.1 percent was just 0.2 percentage point below the national HEDIS 2010 Medicaid 50th percentile.

Figure 6-7—Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 Years Michigan Medicaid Weighted Averages



The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated steady improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 4.9 and 2.5 percentage points, respectively. The observed improvement from last year was statistically significant.

Figure 6-8—Children's and Adolescents' Access to Primary Care Practitioners—12 to 19 Years
Health Plan Ranking



Although none of the MHPs exceeded the HPL of 93.7 percent, six MHPs performed above the national HEDIS 2010 Medicaid 50th percentile. Two plans reported rates below the LPL of 85.4 percent. The HEDIS 2011 Michigan Medicaid weighted average of 89.5 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 0.6 percentage point.

Adults' Access to Preventive/Ambulatory Health Services

Measure Definition

The *Adults' Access to Preventive/Ambulatory Health Services* measure calculates the percentage of adults 20 years and older who were continuously enrolled during the measurement year and who had an ambulatory or preventive care visit during the measurement year. For this report, four rates are reported for this measure: 20 to 44 years, 45 to 64 years, 65 years and older, and Total.

Importance

Access to health care can help people achieve the best health outcomes possible. Access can positively impact many facets of life, including preventable death, life expectancy, quality of life, and disease prevention.[6-10] A shortage of health care providers or facilities is a basic limitation that may impact access, but other factors such as lack of adequate health insurance, cultural and language differences, and lack of knowledge or education can also limit access. Lack of a usual source of care can also be a barrier to accessing health care. Additionally, the U.S. health care system faces a significant challenge in terms of access and capacity in 2014, when 32 million U.S. residents will get health insurance for the first time.[6-11] In 2008–2009, about 19 percent of U.S. adults 18 to 64 years of age did not have a usual source of health care.[6-12]

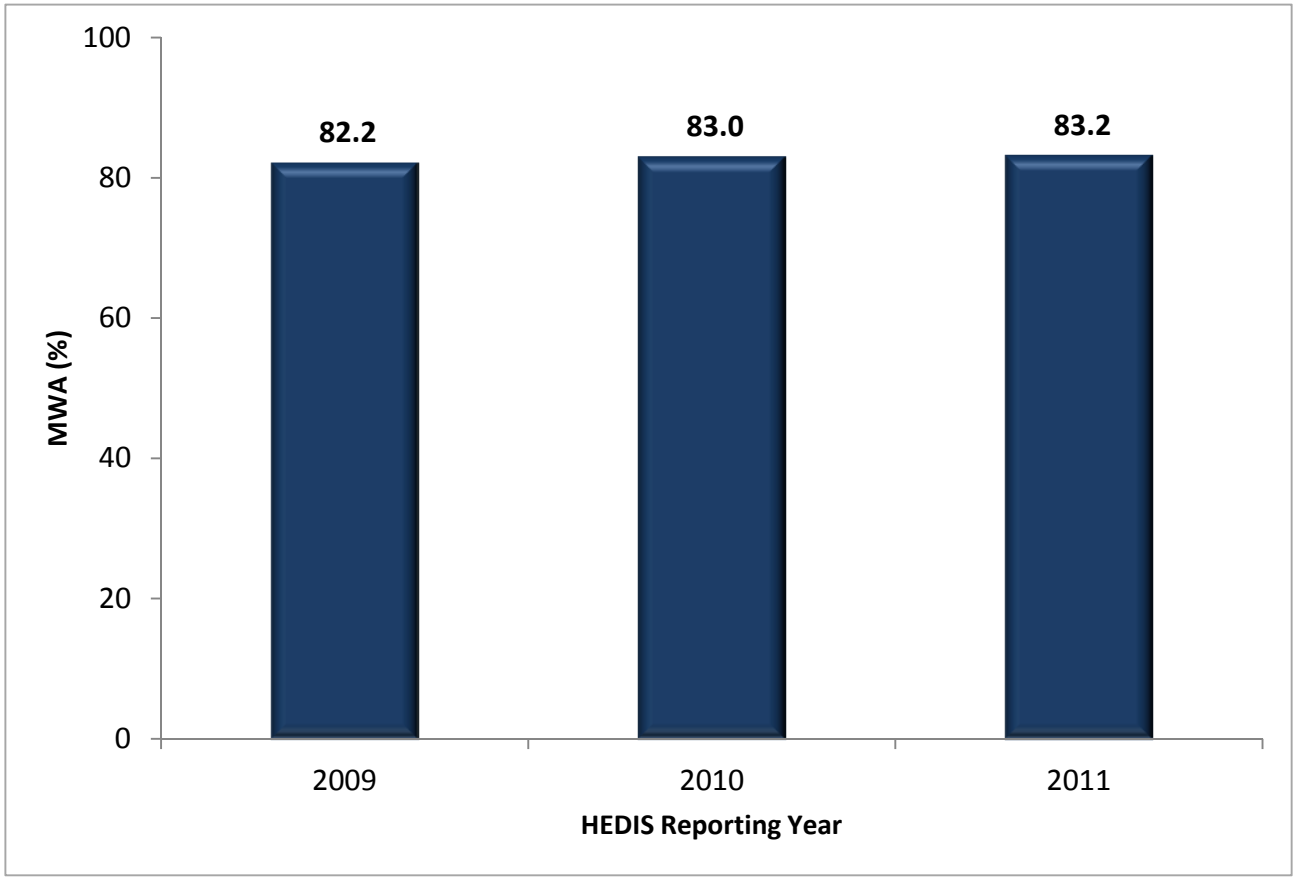
6-10 U.S. Department of Health and Human Services. Healthy People 2020. Access to Health Services. Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=1. Accessed on August 11, 2011.

6-11 Ibid.

6-12 U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. *Health, United States, 2010*. Atlanta, GA: DHHS; 2010.Available at: http://www.cdc.gov/nchs/data/hus/hus10.pdf. Accessed on: August 4, 2011.

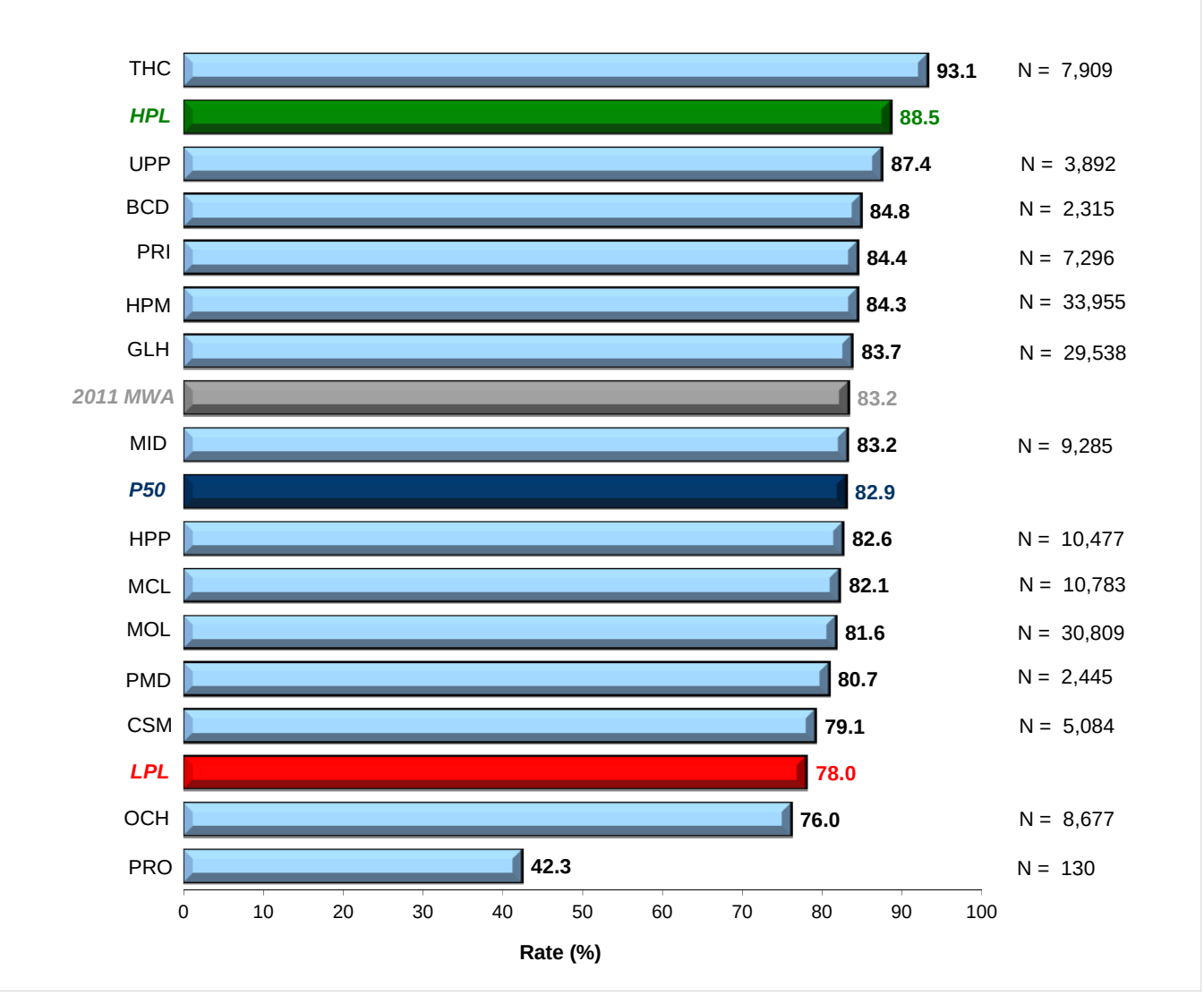
Performance Results

Figure 6-9—Adults' Access to Preventive/Ambulatory Health Services—20 to 44 Years
Michigan Medicaid Weighted Averages



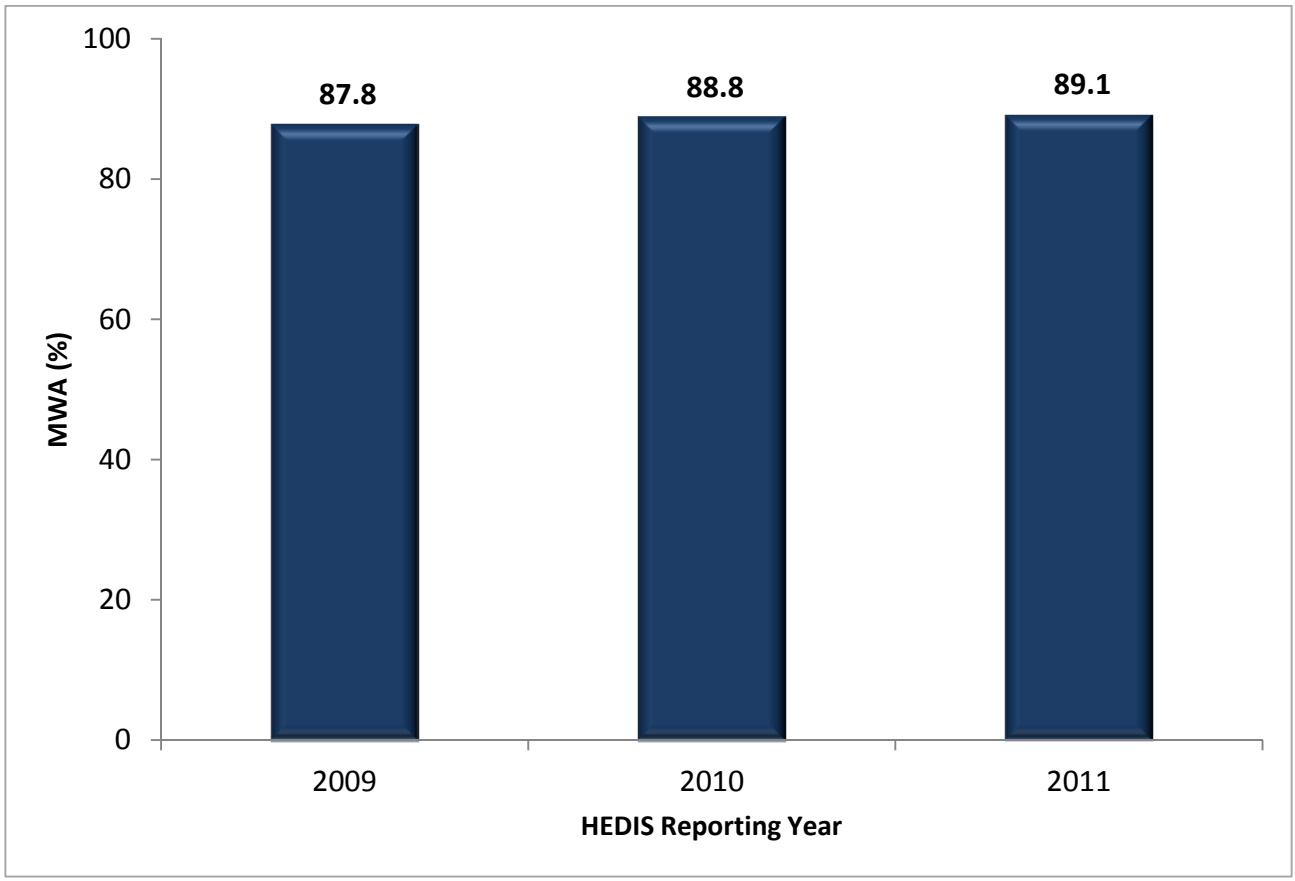
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated slight improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 1.0 percentage point and 0.2 percentage point, respectively. The observed improvement from last year was not statistically significant.

Figure 6-10—Adults' Access to Preventive/Ambulatory Health Services—20 to 44 Years
Health Plan Ranking



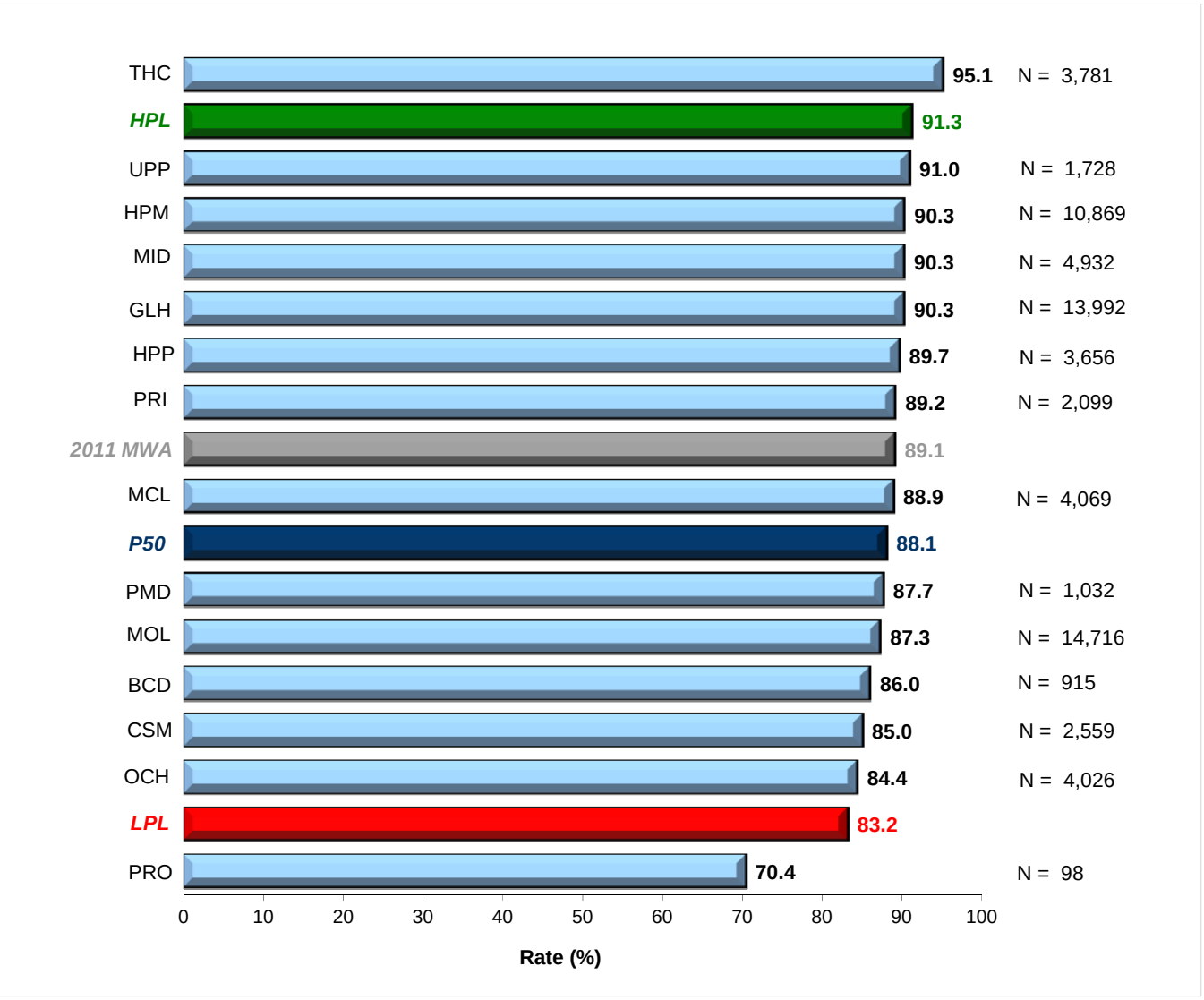
One MHP exceeded the HPL of 88.5 percent, and two were below the LPL of 78.0 percent. Seven MHPs, including the one above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 83.2 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 0.3 percentage point.

Figure 6-11—Adults' Access to Preventive/Ambulatory Health Services—45 to 64 Years
Michigan Medicaid Weighted Averages



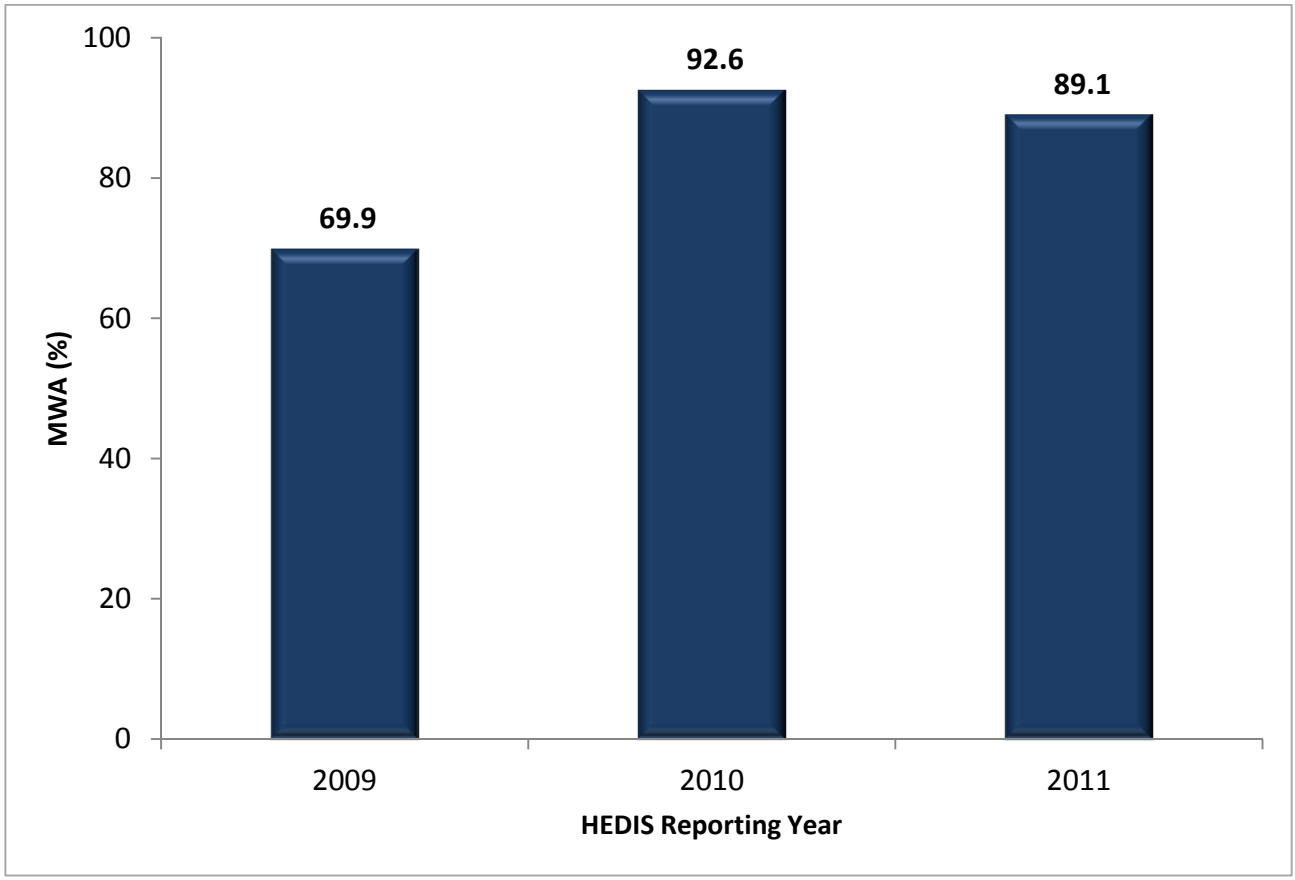
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated slight improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by 1.3 percentage points and 0.3 percentage point, respectively. The observed improvement from last year was not statistically significant.

Figure 6-12—Adults' Access to Preventive/Ambulatory Health Services—45 to 64 Years
Health Plan Ranking



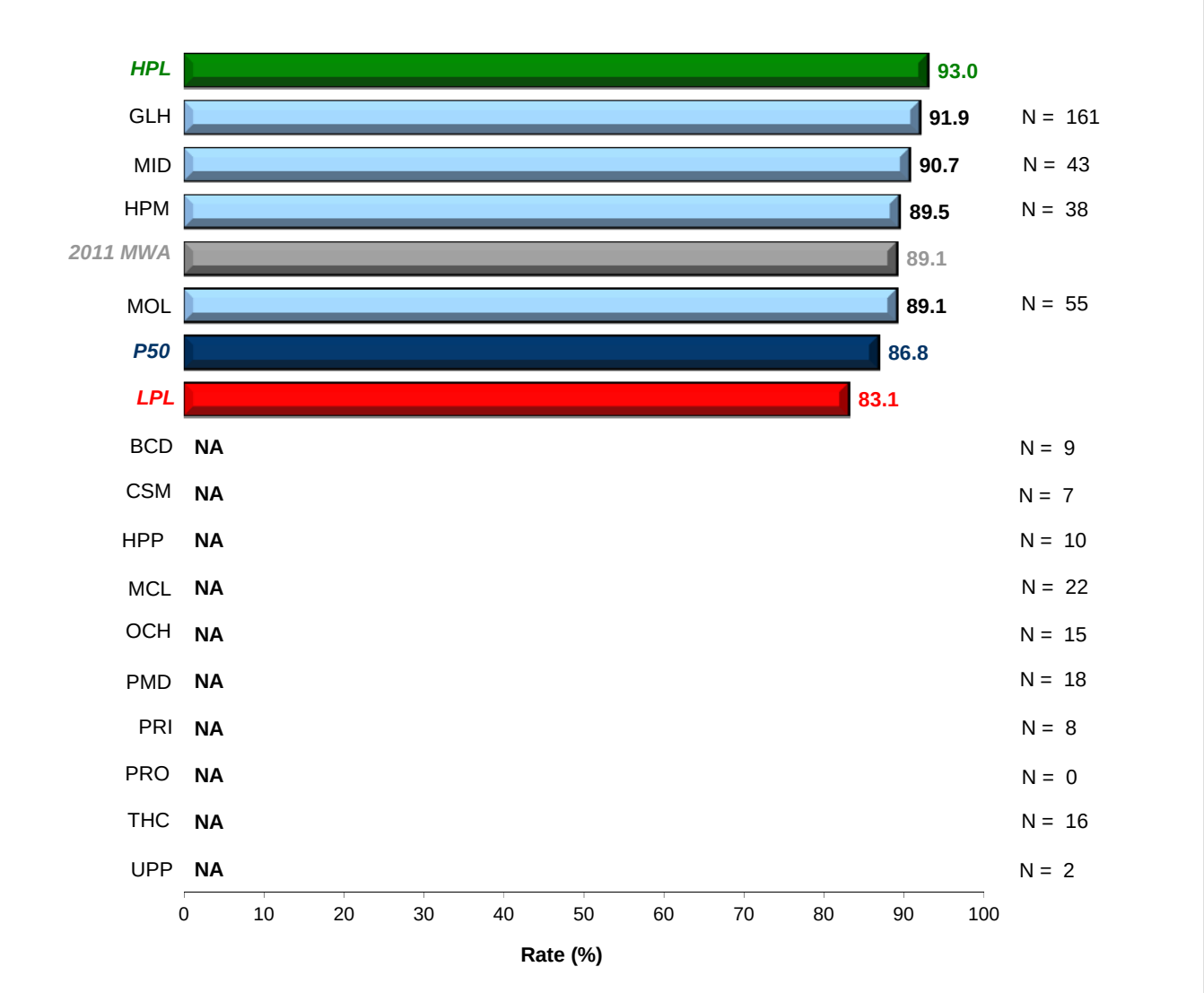
One MHP exceeded the HPL of 91.3 percent, and one was below the LPL of 83.2 percent. Eight MHPs, including the one above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 89.1 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 1.0 percentage point.

Figure 6-13—Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years
Michigan Medicaid Weighted Averages



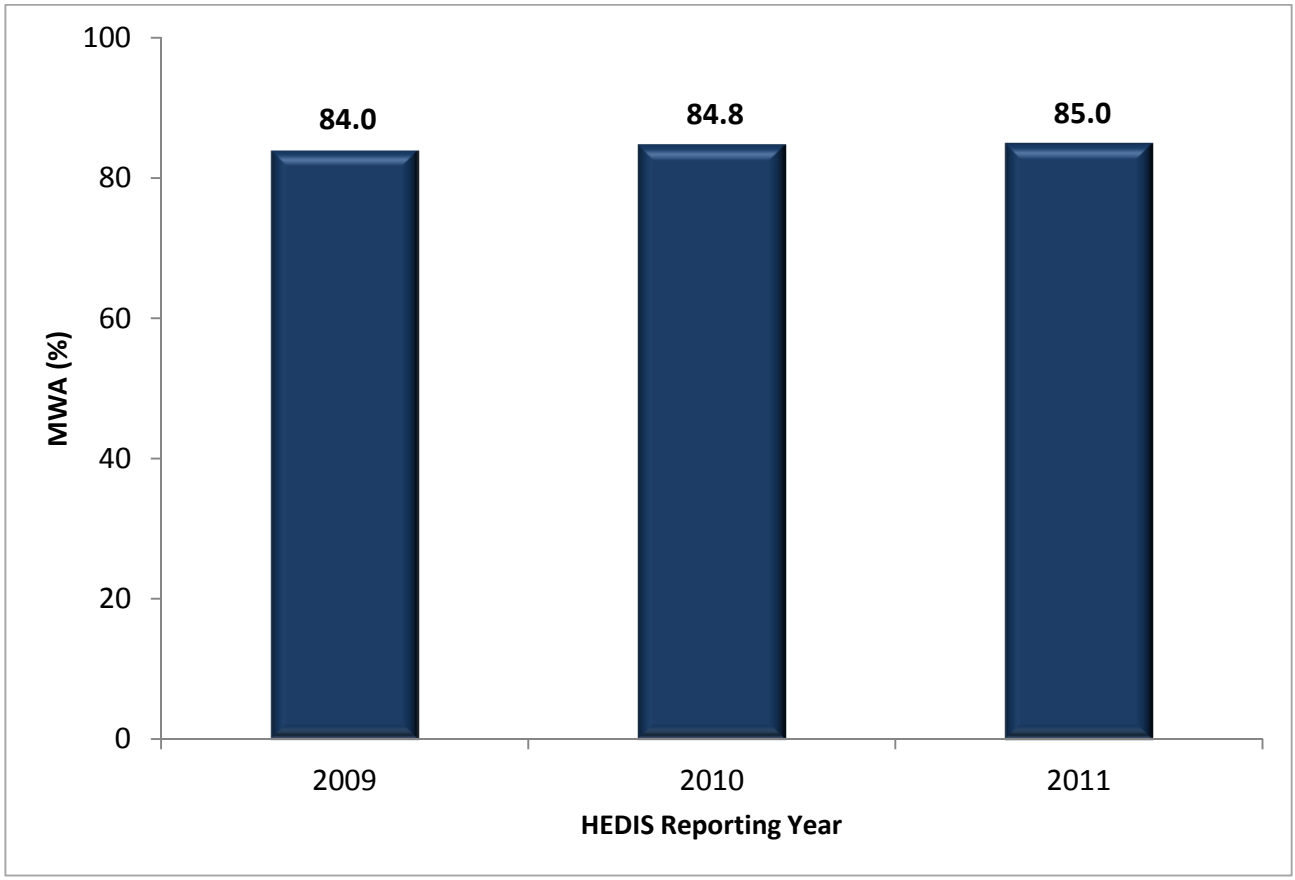
The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated a slight decline from HEDIS 2010 (3.5 percentage point decrease). Nonetheless, this year's performance was notably improved from HEDIS 2009 (a 19.2 percentage point increase). The observed decline from last year was not statistically significant.

Figure 6-14—Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years
Health Plan Ranking



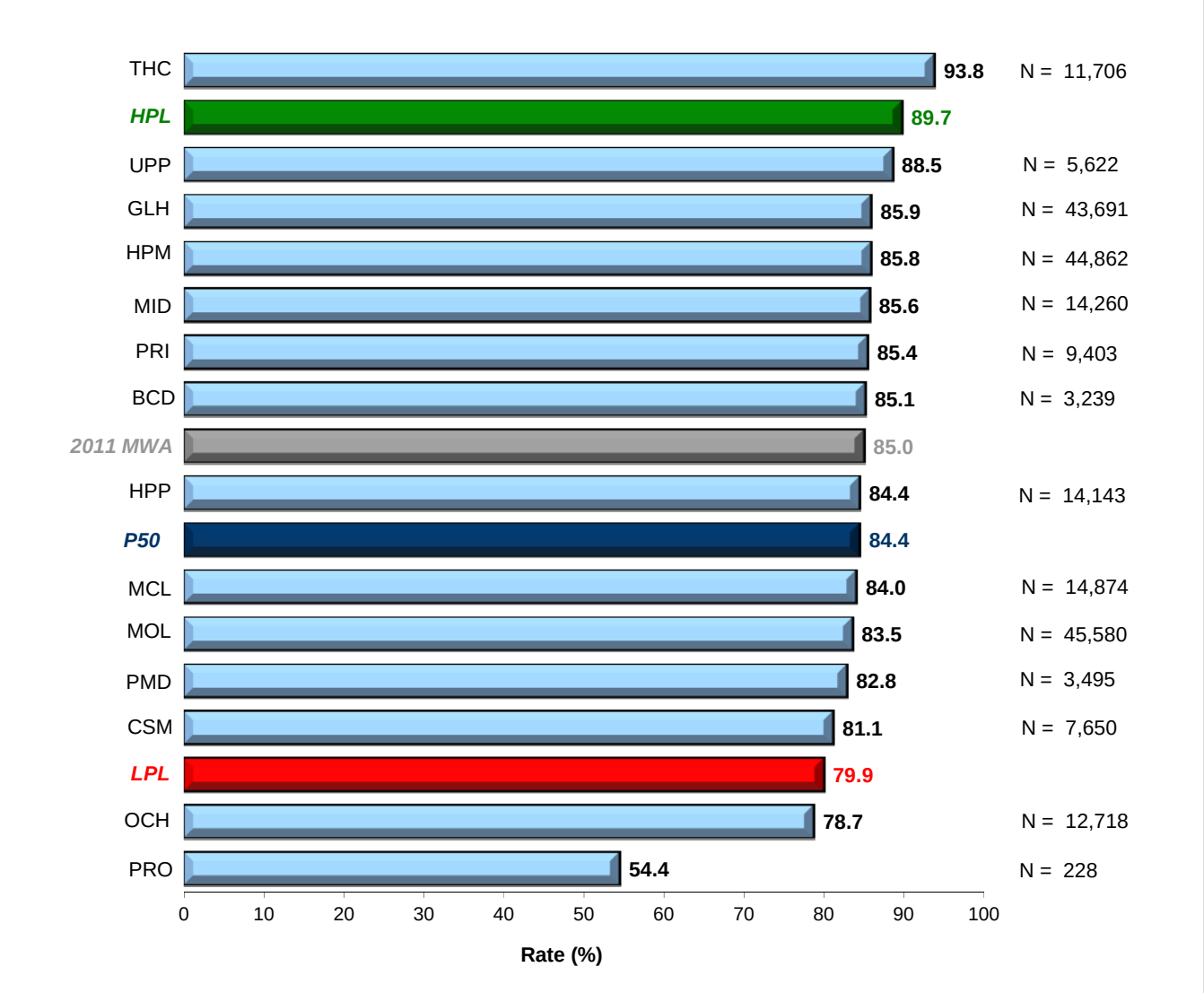
For this measure, only four plans reported valid rates. Though none exceeded the HPL of 93.0 percent, all were above the national HEDIS 2010 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 89.1 percent exceeded the national HEDIS 2010 50th percentile by 2.3 percentage points.

Figure 6-15—Adults' Access to Preventive/Ambulatory Health Services—Total Michigan Medicaid Weighted Averages



The HEDIS 2011 Michigan Medicaid weighted average for this measure demonstrated slight improvement from previous years' results. The HEDIS 2011 weighted average increased from the HEDIS 2009 and HEDIS 2010 weighted averages by no more than one percentage point, respectively. The observed improvement from last year was not statistically significant.

Figure 6-16—Adults' Access to Preventive/Ambulatory Health Services—Total Health Plan Ranking



One MHP exceeded the HPL of 89.7 percent, and two were below the LPL of 79.9 percent. Eight MHPs, including the one above the HPL, reported rates above the national HEDIS 2010 Medicaid 50th percentile. The HEDIS 2011 Michigan Medicaid weighted average of 85.0 percent exceeded the national HEDIS 2010 Medicaid 50th percentile by 0.6 percentage point.

Ambulatory Care

Measure Definition

The *Ambulatory Care* measure summarizes the utilization of ambulatory care in the Outpatient Visits and Emergency Department Visits categories.

Importance

A Centers for Disease Control and Prevention (CDC) survey revealed that during 2009, 19 percent of U.S. adults did not have an office visit to a doctor or other health professional in the previous 12 months. Of those who had an office visit, 17 percent reported 1 office visit, 26 percent reported 2 to 3 visits, 24 percent reported 4 to 9 visits, and 14 percent reported 10 or more visits.[6-13] The survey also showed that women were more likely than men to have had a recent office visit with a doctor or other health professional (within the past 12 months) and that office visits to a doctor or other health professional in the past 12 months were inversely related to patients' level of education.

Americans made approximately 109.9 million visits to hospital outpatient departments (OPDs) in 2008. Based on demographics, OPD visit rates were higher for females than males and were higher for Whites than African Americans. About 51 percent of all OPD visits were made by patients with one or more comorbid chronic conditions, and hypertension was the leading primary diagnosis.[6-14]

For all measures in this dimension, HEDIS methodology requires that the rates be derived using only the administrative method. While the national HEDIS 50th percentiles are provided for reference, it is important to assess utilization based on the characteristics of each health plan's population.

6-13 Centers for Disease Control and Prevention. Summary Health Statistics for United States Adults: National Health Interview Survey, 2008 (Provisional Report). National Center for Health Statistics. Available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_249.pdf: Accessed on: September 20, 2011.

6-14 Centers for Disease Control and Prevention. National Hospital Ambulatory Medical Care Survey: 2006 Outpatient Department Summary. Available at: http://www.cdc.gov/nchs/data/ahcd/nhamcs_outpatient/nhamcs0utpat2008.pdf. Accessed on: September 20, 2011.

Results

Table 6-1—Ambulatory Care			
MHP	Member Months	Outpatient Visits Per 1,000 MM	Emergency Department Visits Per 1,000 MM
BlueCaid of Michigan	230,191	308.5	60.5
CareSource Michigan	465,033	304.2	72.3
UnitedHealthcare Great Lakes Health Plan, Inc.	2,697,884	366.4	72.0
Health Plan of Michigan, Inc.	3,005,876	364.1	75.7
HealthPlus Partners	851,195	318.2	65.2
McLaren Health Plan	939,315	331.5	70.5
Midwest Health Plan	847,371	377.3	59.1
Molina Healthcare of Michigan	2,639,121	357.7	72.9
OmniCare Health Plan	628,315	269.8	81.9
Physicians Health Plan of Mid-Michigan Family Care	222,269	322.2	67.0
Priority Health Government Programs, Inc.	736,647	327.1	73.6
ProCare Health Plan	20,212	196.0	71.2
Total Health Care, Inc.	642,047	228.6	68.0
Upper Peninsula Health Plan	347,755	364.7	64.0
2011 MA	—	**316.9**	**69.6**
2010 MA	—	**319.3**	**72.2**
2009 MA	—	**320.7**	**67.4**
2010 P50	—	**365.9**	**67.7**

The statewide rates for both outpatient visits and emergency department visits demonstrated a slight decline from HEDIS 2010 (2.4 visits and 2.6 visits per 1,000 MM, respectively). Plan variations in the number of outpatient visits were greater than those for emergency department visits. For example, the number of outpatient visits ranged from 196 visits to 377.3 visits (a difference of 181.3 visits), whereas the number of emergency department visits ranged from 59.1 visits to 81.9 visits (a difference of 22.8 visits). Variations in visit rates among plans could be related to plan-specific demographic composition, clinical profiles of the eligible population and interventions provided by individual MHPs. Therefore, without further investigation and adjusting these rates with proper risk factors, higher/lower rates do not necessarily denote better or poorer performance.

Access to Care Findings and Recommendations

Summary of Findings

Table 6-2 summarizes MHP's rank relative to the national HEDIS 2010 Medicaid percentiles for each measure under the Access to Care dimension. Since the percentile rank is mostly associated with performance level, the table also serves as a high-level comparison of performance by measure across all plans. For the *Ambulatory Care* measures, since higher/lower rates do not necessarily denote better or poorer performance, caution needs to be applied when interpreting these results. For percentile range associated with each rank symbol, please refer to the Percentile Ranking section in Section 2 of this report.

Table 6-2—Access to Care Performance Summary

MHP Name	Children's Access 12 to 24 mos	Children's Access 25 mos to 6 yrs	Children's Access 7 to 11 yrs	Adolescents' Access 12–19 yrs	Adults' Access 20–44 yrs	Adults' Access 45–64 yrs	Adults' Access 65+ yrs	Adults' Access Total	Ambulatory Care Outpatient Visits Total	Ambulatory Care ED Visits Total
BlueCaid of Michigan	★★★	★★★	★★★★	★★★★	★★★	★★	NA	★★★	★	★★
CareSource Michigan	★	★	★★	★★	★★	★★	NA	★★	★	★★★
UnitedHealthcare Great Lakes Health Plan, Inc.	★★★	★★★	★★★★	★★★★	★★★	★★★★	★★★★	★★★	★★★	★★★
Health Plan of Michigan, Inc.	★★★	★★★	★★★	★★★★	★★★	★★★★	★★★	★★★	★★	★★★
HealthPlus Partners	★★	★★	★★	★★	★★	★★★	NA	★★★	★★	★★
McLaren Health Plan	★	★	★	★★	★★	★★★	NA	★★	★★	★★★
Midwest Health Plan	★★★★	★★★	★★★	★★★	★★★	★★★★	★★★★	★★★	★★★	★★
Molina Healthcare of Michigan	★★	★★★	★★	★★	★★	★★	★★★	★★	★★	★★★
OmniCare Health Plan	★	★	★	★	★	★★	NA	★	★	★★★★
Physicians Health Plan of Mid-Michigan Family Care	★	★	★★	★★	★★	★★	NA	★★	★★	★★
Priority Health Government Programs, Inc.	★★★	★	★★	★★	★★★	★★★	NA	★★★	★★	★★★
ProCare Health Plan	★	★	NA	★	★	★	NA	★	★	★★★
Total Health Care, Inc.	★★★★	★★★★★	★★★★	★★★★	★★★★★	★★★★★	NA	★★★★★	★	★★★
Upper Peninsula Health Plan	★★★★★	★★★	★★	★★★	★★★★	★★★★	NA	★★★★	★★	★★

Without considering the two *Ambulatory Care* measures, five of the eight measures under this dimension had at least seven of 14 MHPs with rates below the 50th percentiles. Most plans performed relatively poorly for the *Children's Access to Primary Care Practitioners* measures, especially for the younger age groups (i.e., 12–24 Months and 25 Months–6 Years). Comparatively, the *Adolescent's Access to Primary Care Practitioners—Ages 12 to 19 Years* and *Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years* measures showed that at least four plans reported performance above the 75th percentiles.

For the *Ambulatory Care* utilization measures, all but two plans reported outpatient visits below the 50th percentile. Nine plans showed that their emergency room visit rates were meeting or exceeding the national median (50th percentile) utilization.

Table 6-3 presents statewide performance at a glance for the measures under the Access to Care dimension. It lists the HEDIS 2011 weighted averages, the trended results, and a summary of the MHPs with rates showing significant changes from HEDIS 2010.

Table 6-3—Michigan Medicaid HEDIS 2011 Statewide Rate Trend
Access to Care

Measure	Statewide Rate		Number of MHPs	
	2011 Weighted Average	2010–2011 Trend	With Significant Improvement in 2011	With Significant Decline in 2011
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	96.7%	0.0	2	0
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	89.8%	**+1.0**	6	1
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	91.1%	**+2.0**	10	0
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	89.5%	**+2.5**	10	0
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	83.2%	+0.2	1	3
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	89.1%	+0.3	1	1
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	89.1%	-3.5	0	0
Adults' Access to Preventive/Ambulatory Health Services—Total	85.0%	+0.2	1	4
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	316.9	-2.4	—	—
Ambulatory Care—ED Visits per 1,000 Member Months*	69.6	-2.6	—	—

2010–2011 Trend note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decrease from the prior year.
* For the Ambulatory Care measures, the statewide rates were straight averages, not weighted averages. In addition, due to lack of variance reported in the IDSS file for these measures, the differences in rates were reported without statistical testing results.

Legend	<P10	≥P10 and < P25	≥P25 and < P50	≥P50 and < P75	≥P75 and < P90	≥P90

At the statewide level, the HEDIS 2011 Michigan Medicaid program performed fairly comparably with the national average performance ranges. Seven of the ten statewide rates were meeting the national 50th percentile. Although one measure (*Ambulatory Care—Outpatient Visits per 1,000 Member Months*) ranked below the 25th percentile, the rank cannot be suggestive of a poorer performance level for Michigan. Two *Children's and Adolescents' Access to Primary Care Practitioners* measures performed below the 50th percentiles. When compared to last year's performance, six of the ten measures demonstrated an increase in rate from last year, with three

showing a statistically significant improvement. These three measures were all *Children's and Adolescents' Access to Primary Care Practitioners* measures, two of which had 10 MHPs reporting significant improvement form HEDIS 2010.

Best Practices

There are many factors that can be attributed to the results of the Access to Care measures, such as availability of appointments and access to clinics and providers. Access to clinics and providers could be related to transportation or geographical limitations. The MHPs should evaluate the needs of their members and determine how best to improve performance in the area of access to care.

Key Information Systems Findings

NCQA's IS standards are the guidelines used by certified HEDIS compliance auditors to assess a health plan's ability to report HEDIS data accurately and reliably. Compliance with the guidelines also helps an auditor to understand a health plan's HEDIS reporting capabilities. For HEDIS 2011, health plans were assessed on seven IS standards. To assess an MHP's adherence to the IS standards, HSAG reviewed several documents for the Michigan MHPs. These included the MHPs': final audit reports, IS compliance tools, and the MHPs' interactive data submission system (IDSS) files generated and approved by an NCQA-licensed audit organization.

Each of the Michigan MHPs contracted with an NCQA-licensed audit organization (LO) to perform the NCQA HEDIS Compliance Audit. Health plans can select the LO they want to perform the HEDIS audit. Overall, the Michigan MHPs have consistently maintained the same LOs across reporting years.

All but one MHP contracted with an NCQA-Certified software vendor to produce the HEDIS measures. Most MHPs purchase the certified software and manage it internally to generate the HEDIS measures. Others provide all data to the certified software vendors to generate the HEDIS measures for them. Either way, certified software reduces a health plan's burden to report HEDIS measures and also helps to ensure the validity of the rates.

HSAG found that overall the MHPs were fully compliant with all of the IS standards as they related to the key Michigan Medicaid measures for HEDIS 2011. Since the MHPs have been collecting and reporting HEDIS measures for over 10 years, this finding was expected. MHPs should have resolved any systems issues in the first several years of reporting.

IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture

This standard assesses whether:

- Industry standard codes are required and captured.
- Primary and secondary diagnosis codes are identified.
- Nonstandard codes (if used) are mapped to industry standard codes.
- Standard submission forms are used.
- Timely and accurate data entry processes and sufficient edit checks are used.
- Data completeness is continually assessed and all contracted vendors involved in medical claims processing are monitored.

HSAG found that all MHPs were fully compliant with IS 1.0. All plans required the use of only industry standard codes and forms. Data were submitted on time and processed accurately. The MHPs all had mechanisms in place to monitor and track data completeness. There were no issues or concerns noted by the auditors.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

This standard assesses whether:

- All HEDIS-relevant information for data entry or electronic transmissions of enrollment data were accurate and complete.
- Manual entry of enrollment data is timely and accurate and sufficient edit checks are in place.
- The health plans continually assess data completeness and take steps to improve performance.
- The health plans effectively monitor the quality and accuracy of electronic submissions.
- The health plans have effective control processes for the transmission of enrollment data.

HSAG found that all MHPs were fully compliant with IS 2.0. All MHPs received and processed enrollment data in an accurate and timely manner. There were no issues or concerns noted by the auditors.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

This standard assesses whether:

- Provider specialties are fully documented and mapped to HEDIS provider specialties.
- Effective procedures for submitting HEDIS-relevant information are in place.
- Electronic transmissions of practitioner data are checked to ensure accuracy.
- Processes and edit checks ensure accurate and timely entry of data into the transaction files.
- Data completeness is assessed and steps are taken to improve performance.
- Vendors are regularly monitored against expected performance standards.

HSAG found that 13 of 14 MHPs were fully compliant with IS 3.0. One MHP had issues with updating board certification expiration dates due to resource and staffing limitations and maintained the credentialing information in a Microsoft Excel spreadsheet which had no system edit checks in place. The auditors recommended that this MHP consider purchasing an automated system to upload data to its credentialing system. Implementing an automated system may be more cost effective than hiring additional staff. For those MHPs that utilized a credentialing database with no system edit checks, the auditor agreed with the MHPs intention of adding a data link between the credentialing database and the transactional system. These findings did not impact the measures reported in the HEDIS Aggregate report.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight

This standard assesses whether:

- Forms or tools used for medical record review captured all fields relevant to HEDIS reporting.
- Checking procedures are in place to ensure data integrity for electronic transmission of information.
- Retrieval and abstraction of data from medical records is accurately performed.

- Data entry processes including edit checks are timely and accurate.
- Data completeness is assessed including steps to improve performance.
- Vendor performance is monitored against expected performance standards.

HSAG found that all MHPs were fully compliant with IS 4.0 All of the MHPs used medical record data to report hybrid measures. Whether through a vendor, or by internal staff, all medical record data collection processes were sufficient. There were no issues or concerns noted by the auditors.

IS 5.0—Supplemental Data—Capture, Transfer, and Entry

This standard assesses whether:

- Nonstandard coding schemes are fully documented and mapped to industry standard codes.
- Effective procedures for submitting HEDIS-relevant information are in place.
- Electronic transmissions of supplemental data are checked to ensure accuracy.
- Data entry processes including edit checks are timely and accurate.
- Data completeness is assessed including steps to improve performance.
- Vendor performance is monitored against expected performance standards.

HSAG found that all MHPs were fully compliant with IS 5.0. Some MHPs used supplemental data to enhance the completeness of claims and encounter data. All supplemental data sources were reviewed and determined to be compliant with supplemental data requirements. There were no issues or concerns noted by the auditors. The auditors made recommendations to the MHPs to increase the use of supplemental data where applicable.

IS 6.0—Member Call Center Data—Capture, Transfer, and Entry

This standard assesses whether member call center data are reliably and accurately captured. However, since the Michigan MHPs were not required to report member call center measures, this standard is not applicable.

IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

This standard assesses whether:

- Nonstandard coding schemes are fully documented and mapped to industry standard codes.
- Data transfers to the HEDIS repository from transaction files are accurate.
- File consolidations, extracts, and derivations are accurate.
- Repository structure and formatting are suitable for HEDIS measures and enable required programming efforts.
- Report production is managed effectively and operators perform appropriately.
- HEDIS reporting software is managed properly.
- Physical control procedures ensure HEDIS data integrity.

HSAG found that all MHPs were fully compliant with IS 7.0. All but one MHP contracted with an NCQA certified software vendor to calculate the HEDIS rates. All data consolidation and transfers were tracked and monitored to ensure no data were lost. The MHP had sufficient data security and control procedures in place. There were no issues or concerns noted by the auditors.

Appendix A. Tabular Results—Key Measures

Appendix A presents tables showing results for the key measures by MHP. Where applicable, the results provided for each measure include the eligible population and rate for each MHP; the 2009, 2010, and 2011 Michigan Medicaid weighted averages; and the national HEDIS 2010 Medicaid 50th percentile. The following is a list of the tables and the key measures presented for each health plan.

- Table A-1—Childhood Immunization Status—Combination 2 and Combination 3
- Table A-2—Immunizations for Adolescents—Combination 1
- Table A-3—Lead Screening in Children
- Table A-4—Well-Child Visits in the First 15 Months of Life—Six or More Visits
- Table A-5—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life and Adolescent Well-Care Visits
- Table A-6—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile
- Table A-7—Appropriate Treatment for Children With Upper Respiratory Infection
- Table A-8—Appropriate Testing for Children With Pharyngitis
- Table A-9—Breast and Cervical Cancer Screening in Women
- Table A-10—Chlamydia Screening in Women
- Table A-11—Prenatal and Postpartum Care
- Table A-12—Adult BMI Assessment
- Table A-13—Comprehensive Diabetes Care—all numerators except HbA1c Control (<8.0%) or HbA1c Control (<7.0%)
- Table A-14—Use of Appropriate Medications for People With Asthma
- Table A-15—Controlling High Blood Pressure
- Table A-16—Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medication, and Discussing Cessation Strategies
- Table A-17—Children's and Adolescents' Access to Primary Care Practitioners
- Table A-18—Adults' Access to Preventive/Ambulatory Health Services
- Table A-19—Ambulatory Care

Table A-1 Childhood Immunization Status			
Plan	**Eligible Population**	**Combination 2 Rate**	**Combination 3 Rate**
BlueCaid of Michigan	593	74.9%	72.3%
CareSource Michigan	1,275	76.6%†	73.0%†
UnitedHealthcare Great Lakes Health Plan, Inc.	6,401	72.5%	68.9%
Health Plan of Michigan, Inc.	7,135	79.5%	76.7%
HealthPlus Partners	2,169	81.8%†	76.4%†
McLaren Health Plan	2,290	86.6%	84.7%
Midwest Health Plan	1,847	79.3%	75.4%
Molina Healthcare of Michigan	6,299	74.1%	69.2%
OmniCare Health Plan	1,245	82.2%†	67.8%†
Physicians Health Plan of Mid-Michigan Family Care	548	77.1%†	73.2%†
Priority Health Government Programs, Inc.	1,894	87.0%†	83.3%†
ProCare Health Plan	82	32.9%	31.7%
Total Health Care, Inc.	1,338	85.8%†	83.5%†
Upper Peninsula Health Plan	888	79.8%	77.9%
2011 MWA	—	**78.2%**	**74.3%**
2010 MWA	—	**78.7%**	**74.0%**
2009 MWA	—	**81.8%**	**74.7%**
2010 P50	—	**76.6%**	**71.0%**

† Plan chose to rotate the measure. Measure rotation allows the health plan to use the audited and reportable rate from the previous year as specified by NCQA in the *2011 HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*.

Table A-2 Immunizations for Adolescents				
Plan	**Eligible Population**	**Meningococcal Rate**	**Tdap/Td Rate**	**Combination 1 Rate**
BlueCaid of Michigan	493	66.1%	74.0%	62.8%
CareSource Michigan	1,043	50.9%	54.7%	42.6%
UnitedHealthcare Great Lakes Health Plan, Inc.	4,839	60.6%	62.8%	53.0%
Health Plan of Michigan, Inc.	4,537	63.9%	63.4%	54.9%
HealthPlus Partners	1,880	60.2%	67.1%	55.4%
McLaren Health Plan	1,692	47.4%	58.2%	43.8%
Midwest Health Plan	1,695	69.1%	72.5%	63.5%
Molina Healthcare of Michigan	5,331	60.5%	61.7%	52.4%
OmniCare Health Plan	1,483	56.3%	61.6%	49.1%
Physicians Health Plan of Mid-Michigan Family Care	439	55.5%	62.8%	50.1%
Priority Health Government Programs, Inc.	1,497	70.7%	70.2%	63.9%
ProCare Health Plan	10	**NA**	**NA**	**NA**
Total Health Care, Inc.	1,346	54.6%	58.6%	47.0%
Upper Peninsula Health Plan	661	50.2%	50.8%	40.4%
2011 MWA	—	**60.2%**	**63.0%**	**52.9%**
2010 MWA	—	**48.7%**	**57.0%**	**41.0%**
2010 P50	—	**46.7%**	**60.8%**	**42.4%**

Note: This measure was a new measure in 2010; therefore, a 2009 MWA was not available.

NA indicates that the health plan followed the specifications but the denominator was too small to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Table A-3 Lead Screening in Children		
Plan	**Eligible Population**	**Rate**
BlueCaid of Michigan	593	67.4%
CareSource Michigan	1,275	81.5%†
UnitedHealthcare Great Lakes Health Plan, Inc.	6,401	79.6%
Health Plan of Michigan, Inc.	7,135	82.3%
HealthPlus Partners	2,173	76.9%
McLaren Health Plan	2,290	75.7%
Midwest Health Plan	1,847	77.9%
Molina Healthcare of Michigan	6,299	74.3%
OmniCare Health Plan	1,245	78.0%†
Physicians Health Plan of Mid-Michigan Family Care	473	85.6%
Priority Health Government Programs, Inc.	1,959	72.0%
ProCare Health Plan	82	57.3%
Total Health Care, Inc.	1,311	72.8%
Upper Peninsula Health Plan	827	88.7%†
2011 MWA	—	**78.0%**
2010 MWA	—	**76.5%**
2009 MWA	—	**76.3%**
2010 P50	—	**71.6%**

† Plan chose to rotate the measure. Measure rotation allows the health plan to use the audited and reportable rate from the previous year as specified by NCQA in the *2011 HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*.

Table A-4 Well-Child Visits in the First 15 Months of Life		
Plan	**Eligible Population**	**6 or More Visits Rate**
BlueCaid of Michigan	400	74.2%
CareSource Michigan	857	44.3%†
UnitedHealthcare Great Lakes Health Plan, Inc.	4,731	89.1%
Health Plan of Michigan, Inc.	3,439	78.7%
HealthPlus Partners	1,633	73.1%
McLaren Health Plan	1,779	73.5%
Midwest Health Plan	1,225	81.5%
Molina Healthcare of Michigan	4,243	54.6%†
OmniCare Health Plan	863	59.3%†
Physicians Health Plan of Mid-Michigan Family Care	424	58.0%
Priority Health Government Programs, Inc.	1,586	64.7%
ProCare Health Plan	38	13.2%
Total Health Care, Inc.	884	84.4%†
Upper Peninsula Health Plan	853	77.1%
2011 MWA	—	**72.3%**
2010 MWA	—	**69.5%**
2009 MWA	—	**66.6%**
2010 P50	—	**60.1%**

† Plan chose to rotate the measure. Measure rotation allows the health plan to use the audited and reportable rate from the previous year as specified by NCQA in the *2011 HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*.

Table A-5 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, and Adolescent Well-Care Visits				
	3rd–6th Years of Life		Adolescent	
Plan	Eligible Population	Rate	Eligible Population	Rate
BlueCaid of Michigan	2,482	75.0%	3,790	56.9%
CareSource Michigan	3,980	68.6%†	7,823	47.0%
UnitedHealthcare Great Lakes Health Plan, Inc.	25,216	82.2%	40,592	60.6%
Health Plan of Michigan, Inc.	28,524	81.6%	40,731	62.7%
HealthPlus Partners	8,903	80.3%	14,785	60.0%
McLaren Health Plan	8,915	73.0%	13,758	57.4%
Midwest Health Plan	7,909	84.7%	13,846	67.2%
Molina Healthcare of Michigan	26,625	74.3%	41,011	51.9%†
OmniCare Health Plan	5,446	76.9%†	12,447	64.1%
Physicians Health Plan of Mid-Michigan Family Care	2,019	61.1%†	3,359	48.7%
Priority Health Government Programs, Inc.	8,082	70.7%	11,337	59.4%
ProCare Health Plan	95	49.5%	130	27.7%
Total Health Care, Inc.	5,664	83.1%	11,789	63.8%
Upper Peninsula Health Plan	3,106	72.9%†	5,267	48.7%
2011 MWA	—	**78.0%**	—	**58.8%**
2010 MWA	—	**75.9%**	—	**56.3%**
2009 MWA	—	**73.6%**	—	**54.3%**
2010 P50	—	**71.8%**	—	**46.8%**

† Plan chose to rotate the measure. Measure rotation allows the health plan to use the audited and reportable rate from the previous year as specified by NCQA in the *2011 HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*.

Table A-6
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile

Plan	3–11 Years		12–17 Years		Total	
	Eligible Population	BMI Rate	Eligible Population	BMI Rate	Eligible Population	BMI Rate
BlueCaid of Michigan	4,595	66.2%	2,432	73.6%	7,027	68.9%
CareSource Michigan	7,479	22.7%	4,415	28.4%	11,894	24.8%
UnitedHealthcare Great Lakes Health Plan, Inc.	45,787	42.3%	23,826	48.6%	69,613	44.5%
Health Plan of Michigan, Inc.	49,284	42.8%	24,300	50.7%	73,584	45.6%
HealthPlus Partners	15,514	40.9%	8,360	46.9%	23,874	43.1%
McLaren Health Plan	12,480	43.1%	6,161	36.3%	18,641	40.9%
Midwest Health Plan	14,598	79.6%	7,676	84.5%	22,274	81.3%
Molina Healthcare of Michigan	48,080	37.5%	24,623	37.1%	72,703	37.4%
OmniCare Health Plan	8,313	47.1%	5,307	47.1%	13,620	47.1%
Physicians Health Plan of Mid-Michigan Family Care	3,589	47.0%	1,879	34.7%	5,468	42.6%
Priority Health Government Programs, Inc.	14,082	68.5%	6,815	63.0%	20,897	66.7%
ProCare Health Plan	72	36.1%	28	**NA**	100	34.3%
Total Health Care, Inc.	10,709	48.7%	6,485	42.1%	17,194	46.3%
Upper Peninsula Health Plan	6,027	48.4%	3,237	50.7%	9,264	49.1%
2011 MWA	—	**45.7%**	—	**48.2%**	—	**46.6%**
2010 MWA	—	**37.3%**	—	**38.8%**	—	**37.8%**
2009 MWA	—	**22.9%**	—	**31.3%**	—	**25.3%**
2010 P50	—	**27.8%**	—	**27.1%**	—	**29.3%**

NA indicates that the health plan followed the specifications but the denominator was too small to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Table A-7 Appropriate Treatment for Children With Upper Respiratory Infection		
Plan	**Eligible Population**	**Rate**
BlueCaid of Michigan	1,154	95.1%
CareSource Michigan	2,353	83.9%
UnitedHealthcare Great Lakes Health Plan, Inc.	14,282	85.0%
Health Plan of Michigan, Inc.	14,128	86.6%
HealthPlus Partners	4,341	79.7%
McLaren Health Plan	4,692	75.5%
Midwest Health Plan	4,944	86.1%
Molina Healthcare of Michigan	12,947	84.5%
OmniCare Health Plan	2,046	88.4%
Physicians Health Plan of Mid-Michigan Family Care	1,211	88.7%
Priority Health Government Programs, Inc.	2,607	91.5%
ProCare Health Plan	1	**NA**
Total Health Care, Inc.	2,661	85.5%
Upper Peninsula Health Plan	1,738	87.3%
2011 MWA	—	**84.9%**
2010 MWA	—	**82.3%**
2009 MWA	—	**81.2%**
2010 P50	—	**85.8%**

NA indicates that the health plan followed the specifications but the denominator was too small to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Table A-8 Appropriate Testing for Children With Pharyngitis		
Plan	**Eligible Population**	**Rate**
BlueCaid of Michigan	472	84.1%
CareSource Michigan	1,255	52.3%
UnitedHealthcare Great Lakes Health Plan, Inc.	6,862	48.8%
Health Plan of Michigan, Inc.	7,045	61.3%
HealthPlus Partners	2,726	52.5%
McLaren Health Plan	2,304	52.5%
Midwest Health Plan	2,374	54.0%
Molina Healthcare of Michigan	6,550	52.1%
OmniCare Health Plan	900	41.0%
Physicians Health Plan of Mid-Michigan Family Care	398	55.0%
Priority Health Government Programs, Inc.	1,199	66.9%
ProCare Health Plan	0	**NA**
Total Health Care, Inc.	1,297	62.0%
Upper Peninsula Health Plan	630	66.7%
2011 MWA	—	**54.9%**
2010 MWA	—	**51.9%**
2009 MWA	—	**48.0%**
2010 P50	—	**65.5%**

NA indicates that the health plan followed the specifications but the denominator was too small to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Table A-9 Breast and Cervical Cancer Screening in Women				
	Breast Cancer Screening		Cervical Cancer Screening	
Plan	Eligible Population	Rate	Eligible Population	Rate
BlueCaid of Michigan	544	61.8%	2,014	79.5%
CareSource Michigan	1,422	47.5%	4,290	67.2%
UnitedHealthcare Great Lakes Health Plan, Inc.	7,166	57.5%	25,577	74.7%
Health Plan of Michigan, Inc.	4,631	61.3%	25,978	78.1%
HealthPlus Partners	2,303	60.4%	8,573	75.7%
McLaren Health Plan	2,263	53.0%	8,530	74.7%
Midwest Health Plan	2,697	58.3%	8,241	73.5%
Molina Healthcare of Michigan	8,408	54.1%	27,102	71.5%
OmniCare Health Plan	2,476	52.5%	7,760	73.5%
Physicians Health Plan of Mid-Michigan Family Care	617	46.0%	2,082	69.3%
Priority Health Government Programs, Inc.	1,268	64.2%	5,661	72.7%
ProCare Health Plan	17	**NA**	79	45.2%
Total Health Care, Inc.	2,232	54.5%	6,906	76.0%
Upper Peninsula Health Plan	957	56.9%	3,263	72.0%
2011 MWA	—	**56.3%**	—	**74.3%**
2010 MWA	—	**55.1%**	—	**72.7%**
2009 MWA	—	**53.5%**	—	**72.4%**
2010 P50	—	**52.0%**	—	**67.8%**

NA indicates that the health plan followed the specifications but the denominator was too small to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Table A-10 Chlamydia Screening in Women						
	Ages 16 to 20 Years		Ages 21 to 24 Years		Total	
Plan	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
BlueCaid of Michigan	521	51.6%	204	69.6%	725	56.7%
CareSource Michigan	1,100	53.6%	527	64.5%	1,627	57.2%
UnitedHealthcare Great Lakes Health Plan, Inc.	5,911	60.4%	3,284	68.5%	9,195	63.3%
Health Plan of Michigan, Inc.	6,470	60.8%	4,604	67.2%	11,074	63.5%
HealthPlus Partners	2,204	55.9%	1,185	68.7%	3,389	60.3%
McLaren Health Plan	1,901	50.3%	1,105	61.6%	3,006	54.5%
Midwest Health Plan	1,656	63.3%	828	69.1%	2,484	65.2%
Molina Healthcare of Michigan	6,823	60.5%	3,449	67.2%	10,272	62.7%
OmniCare Health Plan	2,146	75.1%	944	81.5%	3,090	77.1%
Physicians Health Plan of Mid-Michigan Family Care	476	56.7%	252	69.8%	728	61.3%
Priority Health Government Programs, Inc.	1,583	66.5%	963	71.0%	2,546	68.2%
ProCare Health Plan	25	**NA**	13	**NA**	38	68.4%
Total Health Care, Inc.	1,821	68.4%	864	76.6%	2,685	71.0%
Upper Peninsula Health Plan	735	47.3%	390	57.7%	1,125	50.9%
2011 MWA	—	**60.7%**	—	**68.4%**	—	**63.5%**
2010 MWA	—	**61.1%**	—	**67.8%**	—	**63.5%**
2009 MWA	—	**58.7%**	—	**66.9%**	—	**61.5%**
2010 P50	—	**53.0%**	—	**62.4%**	—	**55.7%**

NA indicates that the health plan followed the specifications but the denominator was too small to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Table A-11 Prenatal and Postpartum Care				
	Timeliness of Prenatal Care		Postpartum Care	
Plan	Eligible Population	Rate	Eligible Population	Rate
BlueCaid of Michigan	419	92.0%	419	67.4%
CareSource Michigan	995	77.4%	995	64.0%
UnitedHealthcare Great Lakes Health Plan, Inc.	7,564	88.5%	7,564	67.0%
Health Plan of Michigan, Inc.	10,602	92.4%	10,602	76.4%
HealthPlus Partners	2,095	86.6%	2,095	65.7%
McLaren Health Plan	2,690	95.4%	2,690	83.0%
Midwest Health Plan	2,112	94.9%	2,112	70.8%
Molina Healthcare of Michigan	6,469	80.4%	6,469	64.1%
OmniCare Health Plan	1,390	82.3%	1,390	55.7%
Physicians Health Plan of Mid-Michigan Family Care	606	91.5%	606	66.4%
Priority Health Government Programs, Inc.	2,062	83.8%	2,062	75.4%
ProCare Health Plan	19	**NA**	19	**NA**
Total Health Care, Inc.	1,279	88.5%	1,279	70.2%
Upper Peninsula Health Plan	1,086	93.7%	1,086	81.5%
2011 MWA	—	**88.4%**	—	**70.7%**
2010 MWA	—	**88.9%**	—	**71.4%**
2009 MWA	—	**86.9%**	—	**68.5%**
2010 P50	—	**86.0%**	—	**65.5%**

NA indicates that the health plan followed the specifications but the denominator was too small to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Table A-12 Adult BMI Assessment		
Plan	**Eligible Population**	**Rate**
BlueCaid of Michigan	1,980	79.3%
CareSource Michigan	4,777	51.1%
UnitedHealthcare Great Lakes Health Plan, Inc.	24,848	58.2%
Health Plan of Michigan, Inc.	16,896	68.8%
HealthPlus Partners	9,081	71.3%
McLaren Health Plan	7,433	49.1%
Midwest Health Plan	8,832	68.4%
Molina Healthcare of Michigan	28,355	64.4%
OmniCare Health Plan	8,556	61.9%
Physicians Health Plan of Mid-Michigan Family Care	2,068	47.7%
Priority Health Government Programs, Inc.	5,554	81.5%
ProCare Health Plan	53	61.7%
Total Health Care, Inc.	8,362	55.0%
Upper Peninsula Health Plan	3,447	61.8%
2011 MWA	—	**63.0%**
2010 MWA	—	**47.7%**
2009 MWA	—	**29.9%**
2010 P50	—	**35.3%**

Table A-13a Comprehensive Diabetes Care								
	HbA1c Testing		Poor HbA1c Control*		Eye Exam		LDL-C Screening	
Plan	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
BlueCaid of Michigan	322	91.1%	322	29.4%	322	69.3%	322	84.5%
CareSource Michigan	1,088	83.9%†	1,088	40.3%†	1,059	53.5%	1,088	77.2%†
UnitedHealthcare Great Lakes Health Plan, Inc.	6,380	80.3%	6,380	40.0%	6,380	61.4%	6,380	79.0%
Health Plan of Michigan, Inc.	4,616	92.1%	4,616	29.1%	4,616	59.1%	4,616	86.0%
HealthPlus Partners	1,640	86.4%	1,640	35.7%	1,619	70.5%†	1,640	77.5%
McLaren Health Plan	1,706	84.5%	1,706	31.6%	1,492	71.0%†	1,706	71.7%
Midwest Health Plan	2,040	88.5%	2,040	35.2%	2,040	61.3%	2,040	83.4%
Molina Healthcare of Michigan	5,800	81.8%†	5,800	38.6%†	5,800	51.4%†	5,800	81.5%†
OmniCare Health Plan	1,630	81.1%†	1,630	44.7%†	1,630	49.1%†	1,669	78.5%
Physicians Health Plan of Mid-Michigan Family Care	431	81.8%	431	38.9%	434	67.4%†	434	74.2%†
Priority Health Government Programs, Inc.	1,047	93.2%	1,047	27.0%	1,047	62.4%	1,047	80.8%
ProCare Health Plan	32	81.3%	32	53.1%	32	31.3%	32	65.6%
Total Health Care, Inc.	1,508	86.6%	1,508	41.5%	1,508	54.7%	1,508	85.1%
Upper Peninsula Health Plan	529	93.0%†	529	24.2%†	529	72.1%†	529	85.4%†
2011 MWA	—	**85.0%**	—	**36.4%**	—	**59.0%**	—	**80.8%**
2010 MWA	—	**83.9%**	—	**35.6%**	—	**59.6%**	—	**80.1%**
2009 MWA	—	**85.0%**	—	**38.3%**	—	**61.1%**	—	**79.2%**
2010 P50	—	**81.1%**	—	**43.2%**	—	**54.0%**	—	**75.4%**

* For this measure, a lower rate indicates better performance (i.e., low rates of poor HbA1c control indicate better care).

† Plan chose to rotate the measure. Measure rotation allows the health plan to use the audited and reportable rate from the previous year as specified by NCQA in the *2011 HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*.

Table A-13b Comprehensive Diabetes Care (continued)								
Plan	LDL-C Level <100 mg/dL		Medical Attention for Nephropathy		Blood Pressure Control <140/80 mm Hg*		Blood Pressure Control <140/90 mm Hg	
	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
BlueCaid of Michigan	322	46.5%	322	94.4%	322	46.9%	322	71.0%
CareSource Michigan	1,088	33.2%†	1,059	77.7%	1,059	37.6%	1,059	59.5%
UnitedHealthcare Great Lakes Health Plan, Inc.	6,380	36.5%	6,380	75.8%	6,380	38.0%	6,380	63.2%
Health Plan of Michigan, Inc.	4,616	45.6%	4,616	85.2%	4,616	39.5%	4,616	59.4%
HealthPlus Partners	1,640	41.4%	1,640	84.6%	1,640	41.4%	1,640	64.4%
McLaren Health Plan	1,706	60.2%	1,706	89.2%	1,706	50.6%	1,706	80.0%
Midwest Health Plan	2,040	39.1%	2,040	92.3%	2,040	53.3%	2,040	65.3%
Molina Healthcare of Michigan	5,800	39.1%†	5,800	80.8%†	**NR**	**NR**	5,800	62.8%†
OmniCare Health Plan	1,669	39.1%	1,669	82.8%	1,669	30.2%	1,669	54.3%
Physicians Health Plan of Mid-Michigan Family Care	434	42.3%†	431	83.5%	431	41.8%	431	64.5%
Priority Health Government Programs, Inc.	1,047	43.8%	1,047	87.8%	1,047	51.3%	1,047	72.1%
ProCare Health Plan	32	34.4%	32	75.0%	32	40.6%	32	56.3%
Total Health Care, Inc.	1,508	40.9%	1,508	88.0%	1,508	33.6%	1,508	61.9%
Upper Peninsula Health Plan	529	40.9%†	529	81.6%†	**NR**	**NR**	529	76.4%†
2011 MWA	—	**41.1%**	—	**82.8%**	—	**40.8%**	—	**63.7%**
2010 MWA	—	**39.0%**	—	**82.4%**	—	—	—	**60.1%**
2009 MWA	—	**40.8%**	—	**82.5%**	—	—	—	**60.4%**
2010 P50	—	**33.6%**	—	**77.7%**	—	—	—	**61.6%**

NR denotes a Not Report audit designation, indicating that either the health plan calculated the measure but the rate was materially biased or the health plan chose not to report the measure.

† Plan chose to rotate the measure. Measure rotation allows the health plan to use the audited and reportable rate from the previous year as specified by NCQA in the *2011 HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*.

* Due to changes made to the *Blood Pressure Control <140/80 mm Hg* measure in 2011, results were not comparable to the national HEDIS 2010 Medicaid 50th Percentile or results from previous years. Therefore, the 2009 and 2010 MWA as well as the 2010 P50 were not listed for this measure in the table.

Table A-14 Use of Appropriate Medications for People With Asthma						
	Ages 5 to 11 Years		Ages 12 to 50 Years		Total	
Plan	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
BlueCaid of Michigan	210	93.3%	252	87.3%	462	90.0%
CareSource Michigan	192	94.3%	415	88.2%	607	90.1%
UnitedHealthcare Great Lakes Health Plan, Inc.	892	87.3%	1,731	79.8%	2,623	82.4%
Health Plan of Michigan, Inc.	941	93.2%	1,669	87.7%	2,610	89.7%
HealthPlus Partners	385	95.8%	720	87.2%	1,105	90.2%
McLaren Health Plan	477	93.7%	755	83.2%	1,232	87.3%
Midwest Health Plan	398	96.0%	671	88.5%	1,069	91.3%
Molina Healthcare of Michigan	1,211	88.7%	2,246	81.7%	3,457	84.2%
OmniCare Health Plan	372	82.5%	831	84.1%	1,203	83.6%
Physicians Health Plan of Mid-Michigan Family Care	153	93.5%	214	93.0%	367	93.2%
Priority Health Government Programs, Inc.	369	95.4%	505	93.5%	874	94.3%
ProCare Health Plan	1	**NA**	1	**NA**	2	**NA**
Total Health Care, Inc.	235	93.2%	471	91.1%	706	91.8%
Upper Peninsula Health Plan	162	94.4%	313	88.5%	475	90.5%
2011 MWA	—	**91.4%**	—	**85.2%**	—	**87.4%**
2010 MWA	—	**90.4%**	—	**84.8%**	—	**86.8%**
2010 P50	—	**92.2%**	—	**86.3%**	—	**88.6%**

Note: Due to measure specification changes from HEDIS 2009 to 2010, the 2009 results were not comparable to 2010 or 2011 and therefore were not listed in the table.

NA indicates that the health plan followed the specifications but the denominator was too small to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Table A-15 Controlling High Blood Pressure		
Plan	**Eligible Population**	**Rate**
BlueCaid of Michigan	415	59.9%
CareSource Michigan	1,172	44.0%
UnitedHealthcare Great Lakes Health Plan, Inc.	8,640	63.7%
Health Plan of Michigan, Inc.	5,980	62.4%
HealthPlus Partners	1,958	62.9%
McLaren Health Plan	1,994	77.9%
Midwest Health Plan	2,837	67.6%
Molina Healthcare of Michigan	8,599	59.2%
OmniCare Health Plan	2,903	44.6%
Physicians Health Plan of Mid-Michigan Family Care	470	56.3%
Priority Health Government Programs, Inc.	1,325	63.7%
ProCare Health Plan	42	55.0%
Total Health Care, Inc.	2,232	65.1%
Upper Peninsula Health Plan	680	65.9%
2011 MWA	—	**61.5%**
2010 MWA	—	**59.8%**
2009 MWA	—	**58.1%**
2010 P50	—	**57.1%**

Table A-16 Medical Assistance With Smoking and Tobacco Use Cessation				
Plan	**Eligible Population***	**Advising Smokers and Tobacco Users to Quit Rate**	**Discussing Cessation Medications Rate**	**Discussing Cessation Strategies Rate**
BlueCaid of Michigan	10,242	77.7%	54.4%	48.3%
CareSource Michigan	21,695	77.6%	48.2%	43.8%
UnitedHealthcare Great Lakes Health Plan, Inc.	127,804	80.9%	51.4%	44.9%
Health Plan of Michigan, Inc.	134,487	77.9%	50.5%	40.4%
HealthPlus Partners	39,280	72.5%	43.9%	40.2%
McLaren Health Plan	43,942	79.5%	43.7%	34.8%
Midwest Health Plan	41,274	74.3%	46.2%	40.3%
Molina Healthcare of Michigan	125,500	77.8%	48.9%	41.5%
OmniCare Health Plan	36,427	79.5%	46.0%	43.0%
Physicians Health Plan of Mid-Michigan Family Care	10,749	77.4%	52.1%	42.9%
Priority Health Government Programs, Inc.	30,105	80.8%	51.1%	40.4%
ProCare Health Plan	747	**NA**	**NA**	**NA**
Total Health Care, Inc.	24,543	77.7%	45.9%	35.8%
Upper Peninsula Health Plan	12,694	78.3%	47.5%	39.6%
2011 MWA	—	**78.2%**	**48.8%**	**41.3%**
2010 MWA	—	**76.9%**	**47.7%**	**40.4%**

Note: Due to measure specification changes from 2009 to 2010, the 2009 results were not comparable to 2010 or 2011 and therefore were not listed in the table. National percentiles were also not available for this measure.

NA indicates that the health plan followed the specifications but the denominator was too small to report a valid rate, resulting in a Not Applicable (NA) audit designation.

*The eligible population for each health plan reported here was the sum of the CAHPS sample frame sizes from 2010 and 2011 and did not represent the exact eligible population (i.e., smokers) for this measure. However, assuming the proportion of smokers for all plans were the same, the sample frame size was used to derive an approximate weight when calculating the Michigan Medicaid weighted average (MWA).

Table A-17 Children's and Adolescents' Access to Primary Care Practitioners								
	Ages 12 to 24 Months		Ages 25 Months to 6 Years		Ages 7 to 11 Years		Ages 12 to 19 Years	
Plan	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
BlueCaid of Michigan	599	96.8%	3,040	91.2%	2,080	93.5%	2,532	92.9%
CareSource Michigan	1,057	94.3%	5,046	85.5%	3,956	88.8%	5,394	88.2%
UnitedHealthcare Great Lakes Health Plan, Inc.	7,250	97.6%	31,396	91.1%	19,239	93.5%	24,761	91.9%
Health Plan of Michigan, Inc.	8,829	96.9%	35,292	91.6%	17,115	92.8%	19,806	92.8%
HealthPlus Partners	2,321	96.4%	10,948	89.2%	7,979	89.8%	10,087	88.7%
McLaren Health Plan	2,653	94.5%	11,131	86.2%	6,701	87.4%	8,504	86.8%
Midwest Health Plan	1,955	98.4%	9,626	90.9%	7,063	91.6%	9,337	89.3%
Molina Healthcare of Michigan	6,786	96.8%	32,665	90.1%	22,755	90.9%	29,895	87.8%
OmniCare Health Plan	1,246	90.9%	6,279	80.7%	5,599	83.8%	9,010	81.9%
Physicians Health Plan of Mid-Michigan Family Care	605	94.9%	2,701	84.5%	1,725	88.4%	2,171	87.4%
Priority Health Government Programs, Inc.	2,090	97.6%	9,882	86.7%	6,308	90.3%	7,214	88.5%
ProCare Health Plan	108	75.9%	176	55.7%	10	**NA**	30	60.0%
Total Health Care, Inc.	1,334	98.2%	6,881	96.3%	5,536	94.0%	8,070	93.6%
Upper Peninsula Health Plan	1,056	98.6%	4,226	91.2%	2,893	91.0%	3,631	90.4%
2011 MWA	—	**96.7%**	—	**89.8%**	—	**91.1%**	—	**89.5%**
2010 MWA	—	**96.7%**	—	**88.8%**	—	**89.1%**	—	**87.0%**
2009 MWA	—	**96.3%**	—	**86.8%**	—	**86.2%**	—	**84.6%**
2010 P50	—	**96.8%**	—	**89.8%**	—	**91.3%**	—	**88.9%**

NA indicates that the health plan followed the specifications but the denominator was too small to report a valid rate, resulting in a *Not Applicable (NA)* audit designation.

Table A-18 Adults' Access to Preventive/Ambulatory Health Services								
	Ages 20 to 44 Years		Ages 45 to 64 Years		Ages 65+ Years		Total	
Plan	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
BlueCaid of Michigan	2,315	84.8%	915	86.0%	9	**NA**	3,239	85.1%
CareSource Michigan	5,084	79.1%	2,559	85.0%	7	**NA**	7,650	81.1%
UnitedHealthcare Great Lakes Health Plan, Inc.	29,538	83.7%	13,992	90.3%	161	91.9%	43,691	85.9%
Health Plan of Michigan, Inc.	33,955	84.3%	10,869	90.3%	38	89.5%	44,862	85.8%
HealthPlus Partners	10,477	82.6%	3,656	89.7%	10	**NA**	14,143	84.4%
McLaren Health Plan	10,783	82.1%	4,069	88.9%	22	**NA**	14,874	84.0%
Midwest Health Plan	9,285	83.2%	4,932	90.3%	43	90.7%	14,260	85.6%
Molina Healthcare of Michigan	30,809	81.6%	14,716	87.3%	55	89.1%	45,580	83.5%
OmniCare Health Plan	8,677	76.0%	4,026	84.4%	15	**NA**	12,718	78.7%
Physicians Health Plan of Mid-Michigan Family Care	2,445	80.7%	1,032	87.7%	18	**NA**	3,495	82.8%
Priority Health Government Programs, Inc.	7,296	84.4%	2,099	89.2%	8	**NA**	9,403	85.4%
ProCare Health Plan	130	42.3%	98	70.4%	0	**NA**	228	54.4%
Total Health Care, Inc.	7,909	93.1%	3,781	95.1%	16	**NA**	11,706	93.8%
Upper Peninsula Health Plan	3,892	87.4%	1,728	91.0%	2	**NA**	5,622	88.5%
2011 MWA	—	**83.2%**	—	**89.1%**	—	**89.1%**	—	**85.0%**
2010 MWA	—	**83.0%**	—	**88.8%**	—	**92.6%**	—	**84.8%**
2009 MWA	—	**82.2%**	—	**87.8%**	—	**69.9%**	—	**84.0%**†
2010 P50	—	**82.9%**	—	**88.1%**	—	**86.8%**	—	**84.4%**

NA indicates that the health plan followed the specifications but the denominator was too small to report a valid rate, resulting in a *Not Applicable (NA)* audit designation.
† The 'Total' age group was not a reported age group in HEDIS 2009; it was calculated based on the three reported age groups.

Table A-19 Ambulatory Care			
Plan	**Member Months**	**Outpatient Visits Per 1,000 MM**	**Emergency Department Visits Per 1,000 MM**
BlueCaid of Michigan	230,191	308.5	60.5
CareSource Michigan	465,033	304.2	72.3
UnitedHealthcare Great Lakes Health Plan, Inc.	2,697,884	366.4	72.0
Health Plan of Michigan, Inc.	3,005,876	364.1	75.7
HealthPlus Partners	851,195	318.2	65.2
McLaren Health Plan	939,315	331.5	70.5
Midwest Health Plan	847,371	377.3	59.1
Molina Healthcare of Michigan	2,639,121	357.7	72.9
OmniCare Health Plan	628,315	269.8	81.9
Physicians Health Plan of Mid-Michigan Family Care	222,269	322.2	67.0
Priority Health Government Programs, Inc.	736,647	327.1	73.6
ProCare Health Plan	20,212	196.0	71.2
Total Health Care, Inc.	642,047	228.6	68.0
Upper Peninsula Health Plan	347,755	364.7	64.0
2011 MA	—	**316.9**	**69.6**
2010 MA	—	**319.3**	**72.2**
2009 MA	—	**320.7**	**67.4**
2010 P50	—	**365.9**	**67.7**

MM = Member Months

Appendix B. National HEDIS 2010 Medicaid Percentiles

Appendix B provides the national HEDIS Medicaid percentiles published by NCQA using prior-year 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. The rates are presented in tables by dimension.

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

Table B-1—National HEDIS 2010 Medicaid Percentiles Pediatric and Adolescent Care					
Measure	**10th Percentile**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**90th Percentile**
Childhood Immunization Status—Combination 2	61.8	68.8	76.6	81.6	85.6
Childhood Immunization Status—Combination 3	56.0	63.5	71.0	76.6	82.0
Immunizations for Adolescents—Combination 1	21.9	31.2	42.4	53.9	65.9
Lead Screening in Children	42.3	57.6	71.6	81.0	88.4
Well-Child Visits in the first 15 Months of Life – 6+ Visits	40.9	52.2	60.1	69.7	76.3
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	59.9	65.9	71.8	77.3	82.5
Adolescent Well-Care Visits	34.4	38.8	46.8	56.0	63.2
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	0.3	13.0	29.3	45.2	63.0
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile–3–11 Years	0.3	11.2	27.8	45.1	65.3
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile–12–17 Years	0.4	14.7	27.1	44.2	59.3
Appropriate Treatment for Children With Upper Respiratory Infection	77.7	82.1	85.8	90.6	94.9
Appropriate Testing for Children With Pharyngitis	40.2	54.3	65.5	73.5	80.9

Table B-2—National HEDIS 2010 Medicaid Percentiles Women's and Adult Care					
Measure	**10th Percentile**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**90th Percentile**
Breast Cancer Screening	39.8	46.2	52.0	59.6	63.8
Cervical Cancer Screening	50.4	61.0	67.8	72.9	78.9
Chlamydia Screening in Women—Ages 16 to 20 Years	43.8	48.5	53.0	61.1	66.4
Chlamydia Screening in Women—Ages 21 to 24 Years	49.5	55.8	62.4	69.1	73.4
Chlamydia Screening in Women—Combined	44.2	50.6	55.7	63.7	69.5
Prenatal and Postpartum Care—Timeliness of Prenatal Care	70.6	80.3	86.0	90.0	92.7
Prenatal and Postpartum Care—Postpartum Care	53.0	58.7	65.5	70.3	74.4
Adult BMI Assessment	2.6	22.4	35.3	48.7	60.8

Table B-3—National HEDIS 2010 Medicaid Percentiles Living With Illness					
Measure	**10th Percentile**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**90th Percentile**
Comprehensive Diabetes Care—HbA1c Testing	69.4	76.0	81.1	86.4	90.2
*Comprehensive Diabetes Care—Poor HbA1c Control**	27.7	33.8	43.2	53.4	63.5
Comprehensive Diabetes Care—Eye Exam	32.1	41.4	54.0	63.7	70.1
Comprehensive Diabetes Care—LDL-C Screening	62.6	69.3	75.4	80.1	84.0
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	19.5	27.2	33.6	40.9	45.5
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	65.7	72.5	77.7	82.7	86.2
Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg ^	-	-	-	-	-
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	43.8	53.5	61.6	68.2	73.4
*Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years***	88.2	90.0	92.2	93.9	95.5
*Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years***	79.9	83.8	86.3	89.1	90.7
*Use of Appropriate Medications for People With Asthma—Combined Rate***	84.6	86.7	88.6	90.8	92.8
Controlling High Blood Pressure	41.9	49.4	57.1	63.3	67.2

* For this measure, a lower rate indicates better performance; therefore, the 10th percentile is a better performing level than the 90th percentile.

^ During HEDIS 2011, this indicator was changed from blood pressure control <130/80 to blood pressure control <140/80. No benchmarks are available.

** Due to changes for these measures, results are not comparable to national percentiles.

Table B-4—National HEDIS 2010 Medicaid Percentiles Access to Care					
Measure	**10th Percentile**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**90th Percentile**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	90.6	95.1	96.8	97.9	98.5
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	81.0	87.1	89.8	92.2	94.1
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	85.0	87.7	91.3	93.4	95.6
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	80.6	85.4	88.9	91.8	93.7
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	67.4	78.0	82.9	86.7	88.5
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	73.2	83.2	88.1	90.1	91.3
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	72.9	83.1	86.8	89.5	93.0
Adults' Access to Preventive/Ambulatory Health Services—Total	68.4	79.9	84.4	87.5	89.7
Ambulatory Care—Outpatient Visits per 1,000 Member Months	248.7	317.6	365.9	416.7	470.5
Ambulatory Care—ED Visits per 1,000 Member Months	48.3	58.5	67.7	77.2	84.7

Appendix C. Trend Tables

Appendix C includes trend tables for each of the MHPs. Where applicable, each measure's HEDIS 2009, 2010, and 2011 rates are presented along with trend analysis results. Statistically significant differences using Pearson's Chi-square tests are presented where appropriate. The trends are shown in the following example with specific notations:

2010–2011 Health Plan Trend	Interpretations for measures other than *Ambulatory Care*
+2.5	The HEDIS 2011 rate is 2.5 percentage points ***higher*** than the HEDIS 2010 rate.
- 2.5	The HEDIS 2011 rate is 2.5 percentage points ***lower*** than the HEDIS 2010 rate.
+2.5	The HEDIS 2011 rate is 2.5 percentage points ***statistically significantly higher*** than the HEDIS 2010 rate.
- 2.5	The HEDIS 2011 rate is 2.5 percentage points ***statistically significantly lower*** than the HEDIS 2010 rate.

Please note that due to lack of variances reported in the IDSS file**,** statistical tests across years were not performed for utilization measures under *Ambulatory Care* that report rates per 1,000 member months. Nonetheless, difference in rates (i.e., visit counts per 1,000 MM) will still be reported without statistical test results.

The MHP trend tables are presented as follows:

- Table C-1—BlueCaid of Michigan
- Table C-2—CareSource Michigan
- Table C-3—UnitedHealthcare Great Lakes Health Plan, Inc.
- Table C-4—Health Plan of Michigan, Inc.
- Table C-5—HealthPlus Partners
- Table C-6—McLaren Health Plan
- Table C-7—Midwest Health Plan
- Table C-8—Molina Healthcare of Michigan
- Table C-9—OmniCare Health Plan
- Table C-10—Physicians Health Plan of Mid-Michigan Family Care
- Table C-11—Priority Health Government Programs, Inc.
- Table C-12—ProCare Health Plan
- Table C-13—Total Health Care, Inc.
- Table C-14—Upper Peninsula Health Plan

Table C-1 BlueCaid of Michigan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Pediatric and Adolescent Care				
Childhood Immunization Status—Combination 2	86.9%	82.5%	74.9%	**-7.6**
Childhood Immunization Status—Combination 3	82.2%	76.6%	72.3%	-4.3
Immunizations for Adolescents—Combination 1	—	55.0%	62.8%	**+7.8**
Lead Screening in Children	59.8%	55.7%	67.4%	**+11.7**
Well-Child Visits in the First 15 Months of Life—6 or More Visits	60.4%	63.3%	74.2%	**+10.9**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.8%	70.5%	75.0%	+4.5
Adolescent Well-Care Visits	52.6%	53.5%	56.9%	+3.4
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 3 to 11 Years	NR	68.9%	66.2%	-2.7
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 12 to 17 Years	NR	80.9%	73.6%	-7.3
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	NR	72.7%	68.9%	-3.8
Appropriate Treatment for Children With Upper Respiratory Infection	94.1%	95.7%	95.1%	-0.6
Appropriate Testing for Children With Pharyngitis	83.6%	80.2%	84.1%	+3.9
Women's and Adult Care				
Breast Cancer Screening	60.9%	62.1%	61.8%	-0.3
Cervical Cancer Screening	71.9%	73.9%	79.5%	+5.6
Chlamydia Screening in Women—Ages 16 to 20 Years	47.4%	53.1%	51.6%	-1.5
Chlamydia Screening in Women—Ages 21 to 24 Years	61.1%	72.2%	69.6%	-2.6
Chlamydia Screening in Women—Total	51.2%	59.1%	56.7%	-2.4
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.9%	92.2%	92.0%	-0.2
Prenatal and Postpartum Care—Postpartum Care	66.1%	66.9%	67.4%	+0.5
Adult BMI Assessment	59.1%	70.8%	79.3%	**+8.5**
Living With Illness				
Comprehensive Diabetes Care—HbA1c Testing	92.7%	92.2%	91.1%	-1.1
*Comprehensive Diabetes Care—Poor HbA1c Control**	27.6%	21.7%	29.4%	**+7.7**
Comprehensive Diabetes Care—Eye Exam	68.2%	69.5%	69.3%	-0.2
Comprehensive Diabetes Care—LDL-C Screening	85.1%	84.1%	84.5%	+0.4
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	47.5%	46.8%	46.5%	-0.3
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	87.4%	92.5%	94.4%	+1.9
Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg	—	—	46.9%	—
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	73.6%	71.2%	71.0%	-0.2
Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years	—	92.7%	93.3%	+0.6
Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years	—	88.1%	87.3%	-0.8
Use of Appropriate Medications for People With Asthma—Total	—	90.2%	90.0%	-0.2

Table C-1 BlueCaid of Michigan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Controlling High Blood Pressure	68.5%	68.5%	59.9%	**-8.6**
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	—	76.4%	77.7%	+1.3
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications	—	56.7%	54.4%	-2.3
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	—	48.1%	48.3%	+0.2
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	98.2%	96.8%	96.8%	0.0
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	89.6%	90.5%	91.2%	+0.7
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	90.2%	93.1%	93.5%	+0.4
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	90.5%	91.3%	92.9%	**+1.6**
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	83.0%	84.0%	84.8%	+0.8
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	88.3%	88.5%	86.0%	-2.5
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	NA	NA	NA	—
Adults' Access to Preventive/Ambulatory Health Services—Total	84.5%†	85.3%	85.1%	-0.2
*Ambulatory Care—Outpatient Visits per 1,000 Member Months***	303.5	321.5	308.5	-13.0
*Ambulatory Care—ED Visits per 1,000 Member Months***	61.3	66.8	60.5	-6.3

* For the *Comprehensive Diabetes Care—Poor HbA1c Control* measure, a lower rate indicates better performance.
**For the *Ambulatory Care* measures, statistical tests across years were not performed due to lack of variances reported in the IDSS file; differences in rates were reported without statistical test results.
† The 'Total' age group was not a reported age group in HEDIS 2009; it was calculated based on the three reported age groups.

Table C-2 CareSource Michigan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Pediatric and Adolescent Care				
Childhood Immunization Status—Combination 2	80.0%	76.6%	76.6%	Rotated
Childhood Immunization Status—Combination 3	74.7%	73.0%	73.0%	Rotated
Immunizations for Adolescents—Combination 1	—	29.0%	42.6%	**+13.6**
Lead Screening in Children	76.4%	81.5%	81.5%	Rotated
Well-Child Visits in the First 15 Months of Life—6 or More Visits	49.6%	44.3%	44.3%	Rotated
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	57.5%	68.6%	68.6%	Rotated
Adolescent Well-Care Visits	45.5%	31.9%	47.0%	**+15.1**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 3 to 11 Years	12.0%	9.7%	22.7%	**+13.0**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 12 to 17 Years	17.4%	12.6%	28.4%	**+15.8**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	14.1%	10.7%	24.8%	**+14.1**
Appropriate Treatment for Children With Upper Respiratory Infection	79.0%	81.4%	83.9%	**+2.5**
Appropriate Testing for Children With Pharyngitis	52.3%	49.7%	52.3%	+2.6
Women's and Adult Care				
Breast Cancer Screening	49.4%	49.5%	47.5%	-2.0
Cervical Cancer Screening	65.8%	65.8%	67.2%	+1.4
Chlamydia Screening in Women—Ages 16 to 20 Years	52.2%	54.2%	53.6%	-0.6
Chlamydia Screening in Women—Ages 21 to 24 Years	64.0%	65.2%	64.5%	-0.7
Chlamydia Screening in Women—Total	55.7%	57.7%	57.2%	-0.5
Prenatal and Postpartum Care—Timeliness of Prenatal Care	80.0%	80.0%	77.4%	-2.6
Prenatal and Postpartum Care—Postpartum Care	63.7%	66.9%	64.0%	-2.9
Adult BMI Assessment	37.2%	34.8%	51.1%	**+16.3**
Living With Illness				
Comprehensive Diabetes Care—HbA1c Testing	86.9%	83.9%	83.9%	Rotated
*Comprehensive Diabetes Care—Poor HbA1c Control**	29.0%	40.3%	40.3%	Rotated
Comprehensive Diabetes Care—Eye Exam	49.3%	53.1%	53.5%	+0.4
Comprehensive Diabetes Care—LDL-C Screening	74.8%	77.2%	77.2%	Rotated
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	37.6%	33.2%	33.2%	Rotated
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	81.2%	77.4%	77.7%	+0.3
Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg	—	—	37.6%	—
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	66.1%	62.8%	59.5%	-3.3
Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years	—	93.9%	94.3%	+0.4
Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years	—	84.7%	88.2%	+3.5
Use of Appropriate Medications for People With Asthma—Total	—	87.6%	90.1%	+2.5
Controlling High Blood Pressure	58.8%	58.8%	44.0%	**-14.8**

Table C-2 CareSource Michigan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	—	79.5%	77.6%	-1.9
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications	—	51.0%	48.2%	-2.8
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	—	46.8%	43.8%	-3.0
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	95.0%	94.9%	94.3%	-0.6
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	82.6%	84.7%	85.5%	+0.8
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	84.0%	85.5%	88.8%	**+3.3**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	83.2%	84.9%	88.2%	**+3.3**
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	82.0%	80.6%	79.1%	-1.5
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	87.5%	86.2%	85.0%	-1.2
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	NA	NA	NA	—
Adults' Access to Preventive/Ambulatory Health Services—Total	83.9%†	82.5%	81.1%	**-1.4**
*Ambulatory Care—Outpatient Visits per 1,000 Member Months***	291.6	305.2	304.2	-1.0
*Ambulatory Care—ED Visits per 1,000 Member Months***	69.8	78.6	72.3	-6.3

* For the *Comprehensive Diabetes Care—Poor HbA1c Control* measure, a lower rate indicates better performance.
**For the *Ambulatory Care* measures, statistical tests across years were not performed due to lack of variances reported in the IDSS file; differences in rates were reported without statistical test results.
† The 'Total' age group was not a reported age group in HEDIS 2009; it was calculated based on the three reported age groups.

Table C-3 UnitedHealthcare Great Lakes Health Plan, Inc. Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Pediatric and Adolescent Care				
Childhood Immunization Status—Combination 2	81.1%	73.2%	72.5%	-0.7
Childhood Immunization Status—Combination 3	75.3%	68.9%	68.9%	0.0
Immunizations for Adolescents—Combination 1	—	41.1%	53.0%	**+11.9**
Lead Screening in Children	73.2%	78.6%	79.6%	+1.0
Well-Child Visits in the First 15 Months of Life—6 or More Visits	87.6%	90.5%	89.1%	-1.4
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.4%	85.1%	82.2%	-2.9
Adolescent Well-Care Visits	62.3%	66.0%	60.6%	-5.4
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 3 to 11 Years	26.4%	39.3%	42.3%	+3.0
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 12 to 17 Years	28.4%	35.3%	48.6%	**+13.3**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	27.0%	38.0%	44.5%	+6.5
Appropriate Treatment for Children With Upper Respiratory Infection	82.2%	81.3%	85.0%	**+3.7**
Appropriate Testing for Children With Pharyngitis	39.3%	43.2%	48.8%	**+5.6**
Women's and Adult Care				
Breast Cancer Screening	56.0%	57.6%	57.5%	-0.1
Cervical Cancer Screening	75.0%	70.3%	74.7%	+4.4
Chlamydia Screening in Women—Ages 16 to 20 Years	57.7%	61.3%	60.4%	-0.9
Chlamydia Screening in Women—Ages 21 to 24 Years	67.6%	67.7%	68.5%	+0.8
Chlamydia Screening in Women—Total	61.2%	63.6%	63.3%	-0.3
Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.4%	94.4%	88.5%	**-5.9**
Prenatal and Postpartum Care—Postpartum Care	68.9%	74.4%	67.0%	**-7.4**
Adult BMI Assessment	25.5%	42.8%	58.2%	**+15.4**
Living With Illness				
Comprehensive Diabetes Care—HbA1c Testing	80.3%	81.0%	80.3%	-0.7
*Comprehensive Diabetes Care—Poor HbA1c Control**	38.0%	42.4%	40.0%	-2.4
Comprehensive Diabetes Care—Eye Exam	61.3%	59.9%	61.4%	+1.5
Comprehensive Diabetes Care—LDL-C Screening	78.3%	81.5%	79.0%	-2.5
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	33.6%	37.2%	36.5%	-0.7
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	80.5%	80.7%	75.8%	**-4.9**
Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg	—	—	38.0%	—
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	61.1%	61.6%	63.2%	+1.6
Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years	—	85.2%	87.3%	+2.1
Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years	—	80.8%	79.8%	-1.0
Use of Appropriate Medications for People With Asthma—Total	—	82.2%	82.4%	+0.2
Controlling High Blood Pressure	57.9%	52.4%	63.7%	**+11.3**

Table C-3 UnitedHealthcare Great Lakes Health Plan, Inc. Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	—	81.1%	80.9%	-0.2
Medical Assistance With Smoking and Tobacco Use Cessation—Discuss Cessation Medications	—	49.8%	51.4%	+1.6
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	—	43.1%	44.9%	+1.8
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	97.8%	97.9%	97.6%	-0.3
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	89.8%	91.8%	91.1%	**-0.7**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	89.2%	92.0%	93.5%	**+1.5**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	88.0%	89.8%	91.9%	**+2.1**
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	82.9%	84.3%	83.7%	**-0.6**
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	89.9%	90.8%	90.3%	-0.5
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	76.2%	93.7%	91.9%	-1.8
Adults' Access to Preventive/Ambulatory Health Services—Total	85.4%†	86.5%	85.9%	**-0.6**
*Ambulatory Care—Outpatient Visits per 1,000 Member Months***	366.3	392.3	366.4	-25.9
*Ambulatory Care—ED Visits per 1,000 Member Months***	71.0	80.1	72.0	-8.1

* For the *Comprehensive Diabetes Care—Poor HbA1c Control* measure, a lower rate indicates better performance.
**For the *Ambulatory Care* measures, statistical tests across years were not performed due to lack of variances reported in the IDSS file; differences in rates were reported without statistical test results.
† The 'Total' age group was not a reported age group in HEDIS 2009; it was calculated based on the three reported age groups.

Table C-4 Health Plan of Michigan, Inc. Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Pediatric and Adolescent Care				
Childhood Immunization Status—Combination 2	88.7%	80.1%	79.5%	-0.6
Childhood Immunization Status—Combination 3	82.4%	75.2%	76.7%	+1.5
Immunizations for Adolescents—Combination 1	—	44.4%	54.9%	**+10.5**
Lead Screening in Children	81.9%	78.2%	82.3%	+4.1
Well-Child Visits in the First 15 Months of Life—6 or More Visits	72.6%	69.0%	78.7%	**+9.7**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.0%	79.1%	81.6%	+2.5
Adolescent Well-Care Visits	57.8%	56.9%	62.7%	+5.8
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 3 to 11 Years	36.1%	32.2%	42.8%	**+10.6**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 12 to 17 Years	86.5%	39.0%	50.7%	**+11.7**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	49.3%	34.5%	45.6%	**+11.1**
Appropriate Treatment for Children With Upper Respiratory Infection	81.0%	82.6%	86.6%	**+4.0**
Appropriate Testing for Children With Pharyngitis	62.6%	60.4%	61.3%	+0.9
Women's and Adult Care				
Breast Cancer Screening	63.0%	62.3%	61.3%	-1.0
Cervical Cancer Screening	81.3%	80.7%	78.1%	-2.6
Chlamydia Screening in Women—Ages 16 to 20 Years	57.1%	61.4%	60.8%	-0.6
Chlamydia Screening in Women—Ages 21 to 24 Years	65.2%	67.2%	67.2%	0.0
Chlamydia Screening in Women—Total	60.3%	63.8%	63.5%	-0.3
Prenatal and Postpartum Care—Timeliness of Prenatal Care	89.6%	89.6%	92.4%	+2.8
Prenatal and Postpartum Care—Postpartum Care	75.5%	75.5%	76.4%	+0.9
Adult BMI Assessment	37.0%	63.0%	68.8%	+5.8
Living With Illness				
Comprehensive Diabetes Care—HbA1c Testing	89.3%	88.7%	92.1%	**+3.4**
*Comprehensive Diabetes Care—Poor HbA1c Control**	24.8%	24.9%	29.1%	+4.2
Comprehensive Diabetes Care—Eye Exam	73.1%	62.8%	59.1%	-3.7
Comprehensive Diabetes Care—LDL-C Screening	82.6%	81.0%	86.0%	**+5.0**
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	43.0%	36.8%	45.6%	**+8.8**
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	86.9%	80.3%	85.2%	**+4.9**
Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg	—	—	39.5%	—
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	69.1%	55.3%	59.4%	+4.1
Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years	—	93.6%	93.2%	-0.4
Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years	—	88.2%	87.7%	-0.5
Use of Appropriate Medications for People With Asthma—Total	—	90.2%	89.7%	-0.5
Controlling High Blood Pressure	65.3%	65.3%	62.4%	-2.9

Table C-4 Health Plan of Michigan, Inc. Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	—	76.3%	77.9%	+1.6
Medical Assistance With Smoking and Tobacco Use Cessation—Discuss Cessation Medications	—	47.4%	50.5%	+3.1
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	—	40.6%	40.4%	-0.2
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	96.8%	96.9%	96.9%	0.0
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	89.9%	91.4%	91.6%	+0.2
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	90.8%	92.3%	92.8%	+0.5
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	90.8%	92.3%	92.8%	+0.5
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	85.6%	84.4%	84.3%	-0.1
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	91.1%	90.1%	90.3%	+0.2
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	NA	NA	89.5%	—
Adults' Access to Preventive/Ambulatory Health Services—Total	87.1%†	85.8%	85.8%	0.0
*Ambulatory Care—Outpatient Visits per 1,000 Member Months***	363.3	372.8	364.1	-8.7
*Ambulatory Care—ED Visits per 1,000 Member Months***	74.8	78.5	75.7	-2.8

* For the *Comprehensive Diabetes Care—Poor HbA1c Control* measure, a lower rate indicates better performance.
**For the *Ambulatory Care* measures, statistical tests across years were not performed due to lack of variances reported in the IDSS file; differences in rates were reported without statistical test results.
† The 'Total' age group was not a reported age group in HEDIS 2009; it was calculated based on the three reported age groups.

Table C-5 HealthPlus Partners Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Pediatric and Adolescent Care				
Childhood Immunization Status—Combination 2	83.0%	81.8%	81.8%	Rotated
Childhood Immunization Status—Combination 3	74.3%	76.4%	76.4%	Rotated
Immunizations for Adolescents—Combination 1	—	40.1%	55.4%	**+15.3**
Lead Screening in Children	78.4%	72.8%	76.9%	+4.1
Well-Child Visits in the First 15 Months of Life—6 or More Visits	64.3%	65.3%	73.1%	**+7.8**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.2%	71.7%	80.3%	**+8.6**
Adolescent Well-Care Visits	48.4%	57.9%	60.0%	+2.1
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 3 to 11 Years	0.1%	24.4%	40.9%	**+16.5**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 12 to 17 Years	0.4%	26.5%	46.9%	**+20.4**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	0.2%	25.1%	43.1%	**+18.0**
Appropriate Treatment for Children With Upper Respiratory Infection	78.6%	79.6%	79.7%	+0.1
Appropriate Testing for Children With Pharyngitis	46.3%	48.2%	52.5%	**+4.3**
Women's and Adult Care				
Breast Cancer Screening	54.5%	57.1%	60.4%	**+3.3**
Cervical Cancer Screening	70.6%	71.7%	75.7%	+4.0
Chlamydia Screening in Women—Ages 16 to 20 Years	53.5%	60.5%	55.9%	**-4.6**
Chlamydia Screening in Women—Ages 21 to 24 Years	63.7%	69.0%	68.7%	-0.3
Chlamydia Screening in Women—Total	57.1%	63.6%	60.3%	**-3.3**
Prenatal and Postpartum Care—Timeliness of Prenatal Care	89.1%	89.1%	86.6%	-2.5
Prenatal and Postpartum Care—Postpartum Care	67.2%	69.8%	65.7%	-4.1
Adult BMI Assessment	2.6%	23.5%	71.3%	**+47.8**
Living With Illness				
Comprehensive Diabetes Care—HbA1c Testing	86.5%	83.4%	86.4%	+3.0
*Comprehensive Diabetes Care—Poor HbA1c Control**	32.5%	33.7%	35.7%	+2.0
Comprehensive Diabetes Care—Eye Exam	74.5%	70.5%	70.5%	Rotated
Comprehensive Diabetes Care—LDL-C Screening	75.4%	73.2%	77.5%	+4.3
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	38.0%	37.1%	41.4%	+4.3
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	87.0%	82.9%	84.6%	+1.7
Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg	—	—	41.4%	—
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	64.5%	64.5%	64.4%	-0.1
Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years	—	95.0%	95.8%	+0.8
Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years	—	87.6%	87.2%	-0.4
Use of Appropriate Medications for People With Asthma—Total	—	90.3%	90.2%	-0.1
Controlling High Blood Pressure	56.0%	62.7%	62.9%	+0.2

Table C-5 HealthPlus Partners Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	—	72.7%	72.5%	-0.2
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications	—	44.0%	43.9%	-0.1
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	—	37.4%	40.2%	+2.8
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	95.6%	96.8%	96.4%	-0.4
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	85.5%	88.1%	89.2%	**+1.1**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	86.4%	87.8%	89.8%	**+2.0**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	84.6%	85.8%	88.7%	**+2.9**
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	82.9%	82.8%	82.6%	-0.2
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	89.5%	89.3%	89.7%	+0.4
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	NA	NA	NA	—
Adults' Access to Preventive/Ambulatory Health Services—Total	84.8%†	84.5%	84.4%	-0.1
*Ambulatory Care—Outpatient Visits per 1,000 Member Months***	334.7	347.5	318.2	-29.3
*Ambulatory Care—ED Visits per 1,000 Member Months***	66.3	70.3	65.2	-5.1

* For the *Comprehensive Diabetes Care—Poor HbA1c Control* measure, a lower rate indicates better performance.
**For the *Ambulatory Care* measures, statistical tests across years were not performed due to lack of variances reported in the IDSS file; differences in rates were reported without statistical test results.
† The 'Total' age group was not a reported age group in HEDIS 2009; it was calculated based on the three reported age groups.

Table C-6 McLaren Health Plan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Pediatric and Adolescent Care				
Childhood Immunization Status—Combination 2	83.5%	83.2%	86.6%	+3.4
Childhood Immunization Status—Combination 3	77.4%	83.2%	84.7%	+1.5
Immunizations for Adolescents—Combination 1	—	28.0%	43.8%	**+15.8**
Lead Screening in Children	77.6%	82.7%	75.7%	**-7.0**
Well-Child Visits in the First 15 Months of Life—6 or More Visits	62.3%	67.4%	73.5%	+6.1
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.4%	67.2%	73.0%	+5.8
Adolescent Well-Care Visits	53.3%	54.3%	57.4%	+3.1
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 3 to 11 Years	19.9%	28.7%	43.1%	**+14.4**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 12 to 17 Years	22.4%	32.9%	36.3%	+3.4
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	20.7%	30.2%	40.9%	**+10.7**
Appropriate Treatment for Children With Upper Respiratory Infection	71.2%	70.0%	75.5%	**+5.5**
Appropriate Testing for Children With Pharyngitis	52.1%	52.1%	52.5%	+0.4
Women's and Adult Care				
Breast Cancer Screening	50.7%	52.5%	53.0%	+0.5
Cervical Cancer Screening	70.3%	71.3%	74.7%	+3.4
Chlamydia Screening in Women—Ages 16 to 20 Years	50.6%	50.1%	50.3%	+0.2
Chlamydia Screening in Women—Ages 21 to 24 Years	55.8%	55.8%	61.6%	**+5.8**
Chlamydia Screening in Women—Total	52.6%	52.3%	54.5%	+2.2
Prenatal and Postpartum Care—Timeliness of Prenatal Care	92.2%	96.8%	95.4%	-1.4
Prenatal and Postpartum Care—Postpartum Care	83.0%	85.2%	83.0%	-2.2
Adult BMI Assessment	24.1%	38.7%	49.1%	**+10.4**
Living With Illness				
Comprehensive Diabetes Care—HbA1c Testing	87.1%	85.3%	84.5%	-0.8
*Comprehensive Diabetes Care—Poor HbA1c Control**	38.1%	32.2%	31.6%	-0.6
Comprehensive Diabetes Care—Eye Exam	71.5%	71.0%	71.0%	Rotated
Comprehensive Diabetes Care—LDL-C Screening	80.6%	76.5%	71.7%	-4.8
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	37.4%	55.7%	60.2%	+4.5
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	88.2%	91.8%	89.2%	-2.6
Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg	—	—	50.6%	—
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	66.2%	73.3%	80.0%	**+6.7**
Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years	—	93.7%	93.7%	0.0
Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years	—	85.0%	83.2%	-1.8
Use of Appropriate Medications for People With Asthma—Total	—	88.5%	87.3%	-1.2
Controlling High Blood Pressure	67.6%	73.5%	77.9%	+4.4

Table C-6 McLaren Health Plan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	—	76.7%	79.5%	+2.8
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications	—	42.6%	43.7%	+1.1
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	—	34.0%	34.8%	+0.8
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	95.3%	95.6%	94.5%	-1.1
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	82.8%	85.8%	86.2%	+0.4
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	81.3%	85.0%	87.4%	**+2.4**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	79.7%	84.3%	86.8%	**+2.5**
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	82.8%	82.5%	82.1%	-0.4
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	87.6%	88.4%	88.9%	+0.5
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	NA	NA	NA	—
Adults' Access to Preventive/Ambulatory Health Services—Total	84.2%†	84.2%	84.0%	-0.2
*Ambulatory Care—Outpatient Visits per 1,000 Member Months***	340.9	173.2	331.5	+158.3
*Ambulatory Care—ED Visits per 1,000 Member Months***	67.5	70.4	70.5	+0.1

* For the *Comprehensive Diabetes Care—Poor HbA1c Control* measure, a lower rate indicates better performance.

**For the *Ambulatory Care* measures, statistical tests across years were not performed due to lack of variances reported in the IDSS file; differences in rates were reported without statistical test results.

† The 'Total' age group was not a reported age group in HEDIS 2009; it was calculated based on the three reported age groups.

Table C-7 Midwest Health Plan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Pediatric and Adolescent Care				
Childhood Immunization Status—Combination 2	76.2%	81.8%	79.3%	-2.5
Childhood Immunization Status—Combination 3	71.0%	76.4%	75.4%	-1.0
Immunizations for Adolescents—Combination 1	—	47.2%	63.5%	**+16.3**
Lead Screening in Children	76.9%	80.5%	77.9%	-2.6
Well-Child Visits in the First 15 Months of Life—6 or More Visits	64.7%	89.1%	81.5%	**-7.6**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.7%	75.9%	84.7%	**+8.8**
Adolescent Well-Care Visits	62.3%	65.0%	67.2%	+2.2
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 3 to 11 Years	43.3%	82.7%	79.6%	-3.1
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 12 to 17 Years	46.7%	75.2%	84.5%	**+9.3**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	44.5%	80.0%	81.3%	+1.3
Appropriate Treatment for Children With Upper Respiratory Infection	82.3%	85.7%	86.1%	+0.4
Appropriate Testing for Children With Pharyngitis	21.6%	41.4%	54.0%	**+12.6**
Women's and Adult Care				
Breast Cancer Screening	52.3%	55.0%	58.3%	**+3.3**
Cervical Cancer Screening	73.5%	74.2%	73.5%	-0.7
Chlamydia Screening in Women—Ages 16 to 20 Years	59.3%	64.0%	63.3%	-0.7
Chlamydia Screening in Women—Ages 21 to 24 Years	67.3%	70.7%	69.1%	-1.6
Chlamydia Screening in Women—Total	61.8%	66.1%	65.2%	-0.9
Prenatal and Postpartum Care—Timeliness of Prenatal Care	89.5%	94.4%	94.9%	+0.5
Prenatal and Postpartum Care—Postpartum Care	63.7%	73.7%	70.8%	-2.9
Adult BMI Assessment	51.3%	61.3%	68.4%	**+7.1**
Living With Illness				
Comprehensive Diabetes Care—HbA1c Testing	80.5%	82.1%	88.5%	**+6.4**
*Comprehensive Diabetes Care—Poor HbA1c Control**	61.3%	25.5%	35.2%	**+9.7**
Comprehensive Diabetes Care—Eye Exam	60.2%	59.7%	61.3%	+1.6
Comprehensive Diabetes Care—LDL-C Screening	81.0%	79.2%	83.4%	+4.2
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	31.6%	32.3%	39.1%	**+6.8**
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	85.4%	86.5%	92.3%	**+5.8**
Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg	—	—	53.3%	—
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	50.2%	59.9%	65.3%	+5.4
Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years	—	90.1%	96.0%	**+5.9**
Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years	—	89.6%	88.5%	-1.1
Use of Appropriate Medications for People With Asthma—Total	—	89.8%	91.3%	+1.5
Controlling High Blood Pressure	55.7%	67.9%	67.6%	-0.3

Table C-7 Midwest Health Plan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	—	70.1%	74.3%	+4.2
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications	—	47.7%	46.2%	-1.5
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	—	38.7%	40.3%	+1.6
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	94.0%	98.4%	98.4%	0.0
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	86.5%	89.6%	90.9%	**+1.3**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	85.6%	89.8%	91.6%	**+1.8**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	83.0%	87.4%	89.3%	**+1.9**
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	81.3%	84.6%	83.2%	**-1.4**
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	87.9%	90.6%	90.3%	-0.3
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	70.3%	87.9%	90.7%	+2.8
Adults' Access to Preventive/Ambulatory Health Services—Total	83.8%†	86.8%	85.6%	**-1.2**
*Ambulatory Care—Outpatient Visits per 1,000 Member Months***	370.1	411.7	377.3	-34.4
*Ambulatory Care—ED Visits per 1,000 Member Months***	58.7	63.7	59.1	-4.6

* For the *Comprehensive Diabetes Care—Poor HbA1c Control* measure, a lower rate indicates better performance.

**For the *Ambulatory Care* measures, statistical tests across years were not performed due to lack of variances reported in the IDSS file; differences in rates were reported without statistical test results.

† The 'Total' age group was not a reported age group in HEDIS 2009; it was calculated based on the three reported age groups.

Table C-8 Molina Healthcare of Michigan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Pediatric and Adolescent Care				
Childhood Immunization Status—Combination 2	76.6%	74.4%	74.1%	-0.3
Childhood Immunization Status—Combination 3	69.3%	68.9%	69.2%	+0.3
Immunizations for Adolescents—Combination 1	—	42.9%	52.4%	**+9.5**
Lead Screening in Children	72.4%	71.6%	74.3%	**+2.7**
Well-Child Visits in the First 15 Months of Life—6 or More Visits	52.3%	54.6%	54.6%	Rotated
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.1%	72.7%	74.3%	+1.6
Adolescent Well-Care Visits	51.9%	51.9%	51.9%	Rotated
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 3 to 11 Years	19.4%	44.1%	37.5%	-6.6
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 12 to 17 Years	18.8%	47.5%	37.1%	-10.4
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	19.2%	45.2%	37.4%	**-7.8**
Appropriate Treatment for Children With Upper Respiratory Infection	80.9%	83.0%	84.5%	**+1.5**
Appropriate Testing for Children With Pharyngitis	46.6%	52.0%	52.1%	+0.1
Women's and Adult Care				
Breast Cancer Screening	51.2%	51.9%	54.1%	**+2.2**
Cervical Cancer Screening	69.2%	70.9%	71.5%	+0.6
Chlamydia Screening in Women—Ages 16 to 20 Years	60.9%	60.7%	60.5%	-0.2
Chlamydia Screening in Women—Ages 21 to 24 Years	68.0%	66.7%	67.2%	+0.5
Chlamydia Screening in Women—Total	63.2%	62.7%	62.7%	0.0
Prenatal and Postpartum Care—Timeliness of Prenatal Care	79.4%	79.4%	80.4%	+1.0
Prenatal and Postpartum Care—Postpartum Care	61.3%	61.3%	64.1%	+2.8
Adult BMI Assessment	32.2%	53.5%	64.4%	**+10.9**
Living With Illness				
Comprehensive Diabetes Care—HbA1c Testing	87.3%	81.8%	81.8%	Rotated
*Comprehensive Diabetes Care—Poor HbA1c Control**	41.4%	38.6%	38.6%	Rotated
Comprehensive Diabetes Care—Eye Exam	53.5%	51.4%	51.4%	Rotated
Comprehensive Diabetes Care—LDL-C Screening	79.3%	81.5%	81.5%	Rotated
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	53.8%	39.1%	39.1%	Rotated
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	78.8%	80.8%	80.8%	Rotated
Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg	—	—	NR	—
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	53.3%	62.8%	62.8%	Rotated
Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years	—	89.0%	88.7%	-0.3
Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years	—	82.9%	81.7%	-1.2
Use of Appropriate Medications for People With Asthma—Total	—	85.0%	84.2%	-0.8
Controlling High Blood Pressure	55.4%	59.0%	59.2%	+0.2
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	—	73.8%	77.8%	+4.0

Table C-8 Molina Healthcare of Michigan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications	—	45.8%	48.9%	+3.1
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	—	39.4%	41.5%	+2.1
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	96.3%	96.6%	96.8%	+0.2
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	87.0%	88.5%	90.1%	**+1.6**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	85.8%	88.7%	90.9%	**+2.2**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	83.1%	85.4%	87.8%	**+2.4**
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	80.5%	82.0%	81.6%	-0.4
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	85.8%	86.9%	87.3%	+0.4
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	61.8%	93.3%	89.1%	-4.2
Adults' Access to Preventive/Ambulatory Health Services—Total	82.3%†	83.6%	83.5%	-0.1
*Ambulatory Care—Outpatient Visits per 1,000 Member Months***	327.7	355.4	357.7	+2.3
*Ambulatory Care—ED Visits per 1,000 Member Months***	70.3	75.6	72.9	-2.7

* For the *Comprehensive Diabetes Care—Poor HbA1c Control* measure, a lower rate indicates better performance.

**For the *Ambulatory Care* measures, statistical tests across years were not performed due to lack of variances reported in the IDSS file; differences in rates were reported without statistical test results.

† The 'Total' age group was not a reported age group in HEDIS 2009; it was calculated based on the three reported age groups.

Table C-9 OmniCare Health Plan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Pediatric and Adolescent Care				
Childhood Immunization Status—Combination 2	83.3%	82.2%	82.2%	Rotated
Childhood Immunization Status—Combination 3	64.6%	67.8%	67.8%	Rotated
Immunizations for Adolescents—Combination 1	—	37.0%	49.1%	**+12.1**
Lead Screening in Children	78.9%	78.0%	78.0%	Rotated
Well-Child Visits in the First 15 Months of Life—6 or More Visits	59.3%	59.3%	59.3%	Rotated
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.5%	76.9%	76.9%	Rotated
Adolescent Well-Care Visits	52.5%	59.2%	64.1%	+4.9
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 3 to 11 Years	2.7%	12.1%	47.1%	**+35.0**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 12 to 17 Years	14.9%	22.9%	47.1%	**+24.2**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	7.4%	16.2%	47.1%	**+30.9**
Appropriate Treatment for Children With Upper Respiratory Infection	82.5%	86.9%	88.4%	+1.5
Appropriate Testing for Children With Pharyngitis	32.2%	40.2%	41.0%	+0.8
Women's and Adult Care				
Breast Cancer Screening	49.4%	49.8%	52.5%	+2.7
Cervical Cancer Screening	67.5%	69.8%	73.5%	+3.7
Chlamydia Screening in Women—Ages 16 to 20 Years	68.8%	67.8%	75.1%	**+7.3**
Chlamydia Screening in Women—Ages 21 to 24 Years	75.0%	73.7%	81.5%	**+7.8**
Chlamydia Screening in Women—Total	70.6%	69.7%	77.1%	**+7.4**
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.6%	85.6%	82.3%	-3.3
Prenatal and Postpartum Care—Postpartum Care	64.1%	64.1%	55.7%	**-8.4**
Adult BMI Assessment	13.7%	40.5%	61.9%	**+21.4**
Living With Illness				
Comprehensive Diabetes Care—HbA1c Testing	82.7%	81.1%	81.1%	Rotated
*Comprehensive Diabetes Care—Poor HbA1c Control**	47.2%	44.7%	44.7%	Rotated
Comprehensive Diabetes Care—Eye Exam	47.4%	49.1%	49.1%	Rotated
Comprehensive Diabetes Care—LDL-C Screening	81.2%	77.4%	78.5%	+1.1
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	34.5%	37.5%	39.1%	+1.6
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	84.9%	82.0%	82.8%	+0.8
Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg	—	—	30.2%	—
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	56.0%	41.3%	54.3%	**+13.0**
Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years	—	82.6%	82.5%	-0.1
Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years	—	81.6%	84.1%	+2.5
Use of Appropriate Medications for People With Asthma—Total	—	81.9%	83.6%	+1.7
Controlling High Blood Pressure	51.7%	51.7%	44.6%	**-7.1**

Table C-9 OmniCare Health Plan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	—	81.4%	79.5%	-1.9
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications	—	48.5%	46.0%	-2.5
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	—	43.5%	43.0%	-0.5
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	91.2%	92.4%	90.9%	-1.5
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	77.2%	77.0%	80.7%	**+3.7**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	78.2%	79.3%	83.8%	**+4.5**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	76.6%	77.6%	81.9%	**+4.3**
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	77.3%	78.0%	76.0%	**-2.0**
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	84.5%	86.2%	84.4%	**-1.8**
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	NA	NA	NA	—
Adults' Access to Preventive/Ambulatory Health Services—Total	79.7%†	80.7%	78.7%	**-2.0**
*Ambulatory Care—Outpatient Visits per 1,000 Member Months***	245.1	271.5	269.8	-1.7
*Ambulatory Care—ED Visits per 1,000 Member Months***	77.4	83.6	81.9	-1.7

* For the *Comprehensive Diabetes Care—Poor HbA1c Control* measure, a lower rate indicates better performance.

**For the *Ambulatory Care* measures, statistical tests across years were not performed due to lack of variances reported in the IDSS file; differences in rates were reported without statistical test results.

† The 'Total' age group was not a reported age group in HEDIS 2009; it was calculated based on the three reported age groups.

Table C-10 Physicians Health Plan of Mid-Michigan Family Care Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Pediatric and Adolescent Care				
Childhood Immunization Status—Combination 2	81.1%	77.1%	77.1%	Rotated
Childhood Immunization Status—Combination 3	74.4%	73.2%	73.2%	Rotated
Immunizations for Adolescents—Combination 1	—	41.6%	50.1%	**+8.5**
Lead Screening in Children	85.0%	84.0%	85.6%	+1.6
Well-Child Visits in the First 15 Months of Life—6 or More Visits	63.2%	52.1%	58.0%	+5.9
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.0%	61.1%	61.1%	Rotated
Adolescent Well-Care Visits	46.2%	46.0%	48.7%	+2.7
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 3 to 11 Years	27.9%	34.6%	47.0%	**+12.4**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 12 to 17 Years	31.9%	33.8%	34.7%	+0.9
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	29.2%	34.3%	42.6%	**+8.3**
Appropriate Treatment for Children With Upper Respiratory Infection	88.9%	86.7%	88.7%	+2.0
Appropriate Testing for Children With Pharyngitis	60.2%	62.1%	55.0%	**-7.1**
Women's and Adult Care				
Breast Cancer Screening	48.9%	50.4%	46.0%	-4.4
Cervical Cancer Screening	71.2%	71.2%	69.3%	-1.9
Chlamydia Screening in Women—Ages 16 to 20 Years	63.6%	63.5%	56.7%	**-6.8**
Chlamydia Screening in Women—Ages 21 to 24 Years	76.5%	75.6%	69.8%	-5.8
Chlamydia Screening in Women—Total	68.3%	68.2%	61.3%	**-6.9**
Prenatal and Postpartum Care—Timeliness of Prenatal Care	83.5%	85.4%	91.5%	**+6.1**
Prenatal and Postpartum Care—Postpartum Care	67.0%	68.6%	66.4%	-2.2
Adult BMI Assessment	23.4%	31.4%	47.7%	**+16.3**
Living With Illness				
Comprehensive Diabetes Care—HbA1c Testing	86.2%	81.8%	81.8%	0.0
*Comprehensive Diabetes Care—Poor HbA1c Control**	30.4%	38.7%	38.9%	+0.2
Comprehensive Diabetes Care—Eye Exam	70.9%	67.4%	67.4%	Rotated
Comprehensive Diabetes Care—LDL-C Screening	78.8%	74.2%	74.2%	Rotated
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	44.7%	42.3%	42.3%	Rotated
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	84.9%	80.8%	83.5%	+2.7
Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg	—	—	41.8%	—
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	66.4%	64.5%	64.5%	0.0
Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years	—	99.2%	93.5%	**-5.7**
Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years	—	92.1%	93.0%	+0.9
Use of Appropriate Medications for People With Asthma—Total	—	95.0%	93.2%	-1.8
Controlling High Blood Pressure	57.5%	57.5%	56.3%	-1.2

Table C-10 Physicians Health Plan of Mid-Michigan Family Care Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	—	76.8%	77.4%	+0.6
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications	—	52.1%	52.1%	0.0
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	—	44.2%	42.9%	-1.3
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	94.1%	93.7%	94.9%	+1.2
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	83.8%	85.0%	84.5%	-0.5
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	83.5%	87.9%	88.4%	+0.5
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	84.6%	86.6%	87.4%	+0.8
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	81.0%	80.5%	80.7%	+0.2
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	87.2%	88.3%	87.7%	-0.6
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	NA	NA	NA	—
Adults' Access to Preventive/Ambulatory Health Services—Total	83.1%†	82.8%	82.8%	0.0
*Ambulatory Care—Outpatient Visits per 1,000 Member Months***	332.0	337.3	322.2	-15.1
*Ambulatory Care—ED Visits per 1,000 Member Months***	63.5	72.0	67.0	-5.0

* For the *Comprehensive Diabetes Care—Poor HbA1c Control* measure, a lower rate indicates better performance.

**For the *Ambulatory Care* measures, statistical tests across years were not performed due to lack of variances reported in the IDSS file; differences in rates were reported without statistical test results.

† The 'Total' age group was not a reported age group in HEDIS 2009; it was calculated based on the three reported age groups.

Table C-11 Priority Health Government Programs, Inc. Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Pediatric and Adolescent Care				
Childhood Immunization Status—Combination 2	85.0%	87.0%	87.0%	Rotated
Childhood Immunization Status—Combination 3	80.2%	83.3%	83.3%	Rotated
Immunizations for Adolescents—Combination 1	—	51.8%	63.9%	**+12.1**
Lead Screening in Children	78.3%	73.6%	72.0%	-1.6
Well-Child Visits in the First 15 Months of Life—6 or More Visits	69.8%	62.4%	64.7%	+2.3
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.9%	71.6%	70.7%	-0.9
Adolescent Well-Care Visits	50.9%	51.3%	59.4%	**+8.1**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 3 to 11 Years	40.6%	50.2%	68.5%	**+18.3**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 12 to 17 Years	40.8%	50.7%	63.0%	**+12.3**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	40.6%	50.4%	66.7%	**+16.3**
Appropriate Treatment for Children With Upper Respiratory Infection	91.5%	91.1%	91.5%	+0.4
Appropriate Testing for Children With Pharyngitis	70.8%	67.5%	66.9%	-0.6
Women's and Adult Care				
Breast Cancer Screening	55.8%	63.2%	64.2%	+1.0
Cervical Cancer Screening	77.8%	80.6%	72.7%	**-7.9**
Chlamydia Screening in Women—Ages 16 to 20 Years	67.5%	67.2%	66.5%	-0.7
Chlamydia Screening in Women—Ages 21 to 24 Years	74.1%	73.0%	71.0%	-2.0
Chlamydia Screening in Women—Total	70.2%	69.5%	68.2%	-1.3
Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.3%	87.1%	83.8%	-3.3
Prenatal and Postpartum Care—Postpartum Care	73.2%	74.4%	75.4%	+1.0
Adult BMI Assessment	65.7%	74.9%	81.5%	**+6.6**
Living With Illness				
Comprehensive Diabetes Care—HbA1c Testing	87.4%	93.2%	93.2%	0.0
*Comprehensive Diabetes Care—Poor HbA1c Control**	27.9%	27.6%	27.0%	-0.6
Comprehensive Diabetes Care—Eye Exam	69.3%	63.5%	62.4%	-1.1
Comprehensive Diabetes Care—LDL-C Screening	80.5%	82.7%	80.8%	-1.9
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	41.2%	44.7%	43.8%	-0.9
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	81.4%	87.0%	87.8%	+0.8
Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg	—	—	51.3%	—
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	69.3%	73.4%	72.1%	-1.3
Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years	—	97.4%	95.4%	-2.0
Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years	—	92.8%	93.5%	+0.7
Use of Appropriate Medications for People With Asthma—Total	—	94.8%	94.3%	-0.5
Controlling High Blood Pressure	57.5%	64.0%	63.7%	-0.3

Table C-11 Priority Health Government Programs, Inc. Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	—	80.1%	80.8%	+0.7
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications	—	53.2%	51.1%	-2.1
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	—	41.8%	40.4%	-1.4
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	97.8%	97.3%	97.6%	+0.3
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	85.4%	86.5%	86.7%	+0.2
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	87.7%	88.9%	90.3%	**+1.4**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	85.8%	86.9%	88.5%	**+1.6**
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	85.1%	84.5%	84.4%	-0.1
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	90.0%	90.7%	89.2%	-1.5
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	NA	NA	NA	—
Adults' Access to Preventive/Ambulatory Health Services—Total	86.4%†	85.9%	85.4%	-0.5
*Ambulatory Care—Outpatient Visits per 1,000 Member Months***	343.4	337.5	327.1	-10.4
*Ambulatory Care—ED Visits per 1,000 Member Months***	72.9	75.6	73.6	-2.0

* For the *Comprehensive Diabetes Care—Poor HbA1c Control* measure, a lower rate indicates better performance.

**For the *Ambulatory Care* measures, statistical tests across years were not performed due to lack of variances reported in the IDSS file; differences in rates were reported without statistical test results.

† The 'Total' age group was not a reported age group in HEDIS 2009; it was calculated based on the three reported age groups.

Table C-12 ProCare Health Plan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Pediatric and Adolescent Care				
Childhood Immunization Status—Combination 2	NA	NA	32.9%	—
Childhood Immunization Status—Combination 3	NA	NA	31.7%	—
Immunizations for Adolescents—Combination 1	—	NA	NA	—
Lead Screening in Children	NA	NA	57.3%	—
Well-Child Visits in the First 15 Months of Life—6 or More Visits	NA	NA	13.2%	—
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NA	56.5%	49.5%	-7.0
Adolescent Well-Care Visits	20.0%	30.4%	27.7%	-2.7
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 3 to 11 Years	NA	21.9%	36.1%	+14.2
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 12 to 17 Years	NA	NA	NA	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	NA	21.8%	34.3%	+12.5
Appropriate Treatment for Children With Upper Respiratory Infection	NA	NA	NA	—
Appropriate Testing for Children With Pharyngitis	NA	NA	NA	—
Women's and Adult Care				
Breast Cancer Screening	NA	NA	NA	—
Cervical Cancer Screening	NA	37.1%	45.2%	+8.1
Chlamydia Screening in Women—Ages 16 to 20 Years	NA	NA	NA	—
Chlamydia Screening in Women—Ages 21 to 24 Years	NA	NA	NA	—
Chlamydia Screening in Women—Total	NA	NA	68.4%	—
Prenatal and Postpartum Care—Timeliness of Prenatal Care	NA	NA	NA	—
Prenatal and Postpartum Care—Postpartum Care	NA	NA	NA	—
Adult BMI Assessment	NA	NA	61.7%	—
Living With Illness				
Comprehensive Diabetes Care—HbA1c Testing	NA	NA	81.3%	—
*Comprehensive Diabetes Care—Poor HbA1c Control**	NA	NA	53.1%	—
Comprehensive Diabetes Care—Eye Exam	NA	NA	31.3%	—
Comprehensive Diabetes Care—LDL-C Screening	NA	NA	65.6%	—
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	NA	NA	34.4%	—
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	NA	NA	75.0%	—
Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg	—	—	40.6%	—
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	NA	NA	56.3%	—
Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years	—	NA	NA	—
Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years	—	NA	NA	—
Use of Appropriate Medications for People With Asthma—Total	—	NA	NA	—
Controlling High Blood Pressure	NA	NA	55.0%	—

Table C-12 ProCare Health Plan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	—	NA	NA	—
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications	—	NA	NA	—
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	—	NA	NA	—
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	NA	50.0%	75.9%	**+25.9**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	NA	45.2%	55.7%	+10.5
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	NA	NA	NA	—
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	NA	NA	60.0%	—
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	NA	39.6%	42.3%	+2.7
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	NA	71.2%	70.4%	-0.8
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	NA	NA	NA	—
Adults' Access to Preventive/Ambulatory Health Services—Total	NA†	50.3%	54.4%	+4.1
*Ambulatory Care—Outpatient Visits per 1,000 Member Months***	130.0	158.0	196.0	+38.0
*Ambulatory Care—ED Visits per 1,000 Member Months***	56.1	61.8	71.2	+9.4

* For the *Comprehensive Diabetes Care—Poor HbA1c Control* measure, a lower rate indicates better performance.

**For the *Ambulatory Care* measures, statistical tests across years were not performed due to lack of variances reported in the IDSS file; differences in rates were reported without statistical test results.

† The 'Total' age group was not a reported age group in HEDIS 2009; it was calculated based on the three reported age groups.

Table C-13 Total Health Care, Inc. Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010-2011 Health Plan Trend**
Pediatric and Adolescent Care				
Childhood Immunization Status—Combination 2	85.3%	85.8%	85.8%	Rotated
Childhood Immunization Status—Combination 3	74.5%	83.5%	83.5%	Rotated
Immunizations for Adolescents—Combination 1	—	40.5%	47.0%	+6.5
Lead Screening in Children	73.3%	69.9%	72.8%	+2.9
Well-Child Visits in the First 15 Months of Life—6 or More Visits	66.4%	84.4%	84.4%	Rotated
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.3%	80.5%	83.1%	+2.6
Adolescent Well-Care Visits	56.2%	62.0%	63.8%	+1.8
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 3 to 11 Years	9.2%	14.1%	48.7%	**+34.6**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 12 to 17 Years	15.6%	14.7%	42.1%	**+27.4**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	11.6%	14.4%	46.3%	**+31.9**
Appropriate Treatment for Children With Upper Respiratory Infection	59.2%	82.9%	85.5%	**+2.6**
Appropriate Testing for Children With Pharyngitis	55.9%	60.5%	62.0%	+1.5
Women's and Adult Care				
Breast Cancer Screening	48.3%	51.6%	54.5%	+2.9
Cervical Cancer Screening	68.6%	74.1%	76.0%	+1.9
Chlamydia Screening in Women—Ages 16 to 20 Years	63.2%	67.8%	68.4%	+0.6
Chlamydia Screening in Women—Ages 21 to 24 Years	74.0%	76.7%	76.6%	-0.1
Chlamydia Screening in Women—Total	66.9%	70.6%	71.0%	+0.4
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.2%	86.2%	88.5%	+2.3
Prenatal and Postpartum Care—Postpartum Care	61.5%	64.4%	70.2%	+5.8
Adult BMI Assessment	26.9%	46.5%	55.0%	**+8.5**
Living With Illness				
Comprehensive Diabetes Care—HbA1c Testing	80.4%	85.2%	86.6%	+1.4
*Comprehensive Diabetes Care—Poor HbA1c Control**	48.1%	40.9%	41.5%	+0.6
Comprehensive Diabetes Care—Eye Exam	57.1%	64.0%	54.7%	**-9.3**
Comprehensive Diabetes Care—LDL-C Screening	74.3%	83.2%	85.1%	+1.9
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	37.7%	42.6%	40.9%	-1.7
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	79.4%	83.2%	88.0%	**+4.8**
Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg	—	—	33.6%	—
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	55.3%	38.5%	61.9%	**+23.4**
Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years	—	80.4%	93.2%	**+12.8**
Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years	—	79.9%	91.1%	**+11.2**
Use of Appropriate Medications for People With Asthma—Total	—	80.0%	91.8%	**+11.8**
Controlling High Blood Pressure	60.0%	60.0%	65.1%	+5.1

Table C-13 Total Health Care, Inc. Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010-2011 Health Plan Trend**
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	—	78.6%	77.7%	-0.9
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications	—	44.4%	45.9%	+1.5
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	—	31.9%	35.8%	+3.9
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	95.9%	96.9%	98.2%	**+1.3**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	86.5%	89.7%	96.3%	**+6.6**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	82.4%	91.3%	94.0%	**+2.7**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	83.7%	87.8%	93.6%	**+5.8**
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	77.8%	81.6%	93.1%	**+11.5**
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	83.1%	87.8%	95.1%	**+7.3**
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	NA	NA	NA	—
Adults' Access to Preventive/Ambulatory Health Services—Total	79.6%†	83.6%	93.8%	**+10.2**
*Ambulatory Care—Outpatient Visits per 1,000 Member Months***	334.8	323.6	228.6	-95.0
*Ambulatory Care—ED Visits per 1,000 Member Months***	67.1	70.4	68.0	-2.4

* For the *Comprehensive Diabetes Care—Poor HbA1c Control* measure, a lower rate indicates better performance.

**For the *Ambulatory Care* measures, statistical tests across years were not performed due to lack of variances reported in the IDSS file; differences in rates were reported without statistical test results.

† The 'Total' age group was not a reported age group in HEDIS 2009; it was calculated based on the three reported age groups.

Table C-14 Upper Peninsula Health Plan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Pediatric and Adolescent Care				
Childhood Immunization Status—Combination 2	81.2%	79.3%	79.8%	+0.5
Childhood Immunization Status—Combination 3	73.8%	76.4%	77.9%	+1.5
Immunizations for Adolescents—Combination 1	—	23.2%	40.4%	**+17.2**
Lead Screening in Children	86.4%	88.7%	88.7%	Rotated
Well-Child Visits in the First 15 Months of Life—6 or More Visits	60.9%	72.2%	77.1%	+4.9
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.4%	72.9%	72.9%	Rotated
Adolescent Well-Care Visits	33.9%	36.6%	48.7%	**+12.1**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 3 to 11 Years	0.1%	0.1%	48.4%	**+48.3**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Ages 12 to 17 Years	0.1%	0.1%	50.7%	**+50.6**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	0.1%	0.1%	49.1%	**+49.0**
Appropriate Treatment for Children With Upper Respiratory Infection	81.1%	83.3%	87.3%	**+4.0**
Appropriate Testing for Children With Pharyngitis	66.4%	65.0%	66.7%	+1.7
Women's and Adult Care				
Breast Cancer Screening	57.9%	59.5%	56.9%	-2.6
Cervical Cancer Screening	75.9%	75.9%	72.0%	-3.9
Chlamydia Screening in Women—Ages 16 to 20 Years	44.5%	48.6%	47.3%	-1.3
Chlamydia Screening in Women—Ages 21 to 24 Years	51.6%	53.4%	57.7%	+4.3
Chlamydia Screening in Women—Total	47.1%	50.3%	50.9%	+0.6
Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.2%	93.2%	93.7%	+0.5
Prenatal and Postpartum Care—Postpartum Care	73.2%	73.2%	81.5%	**+8.3**
Adult BMI Assessment	1.6%	2.6%	61.8%	**+59.2**
Living With Illness				
Comprehensive Diabetes Care—HbA1c Testing	89.0%	93.0%	93.0%	Rotated
*Comprehensive Diabetes Care—Poor HbA1c Control**	25.2%	24.2%	24.2%	Rotated
Comprehensive Diabetes Care—Eye Exam	66.9%	72.1%	72.1%	Rotated
Comprehensive Diabetes Care—LDL-C Screening	82.4%	85.4%	85.4%	Rotated
Comprehensive Diabetes Care—LDL-C Level <100 mg/dL	40.6%	40.9%	40.9%	Rotated
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy	79.1%	81.6%	81.6%	Rotated
Comprehensive Diabetes Care—Blood Pressure Control <140/80 mm Hg	—	—	NR	—
Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg	73.5%	76.4%	76.4%	Rotated
Use of Appropriate Medications for People With Asthma—Ages 5 to 11 Years	—	91.7%	94.4%	+2.7
Use of Appropriate Medications for People With Asthma—Ages 12 to 50 Years	—	84.4%	88.5%	+4.1
Use of Appropriate Medications for People With Asthma—Total	—	86.8%	90.5%	+3.7
Controlling High Blood Pressure	66.2%	73.6%	65.9%	**-7.7**

Table C-14 Upper Peninsula Health Plan Trend Table				
Measure	**HEDIS 2009**	**HEDIS 2010**	**HEDIS 2011**	**2010–2011 Health Plan Trend**
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	—	80.7%	78.3%	-2.4
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications	—	50.4%	47.5%	-2.9
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	—	41.2%	39.6%	-1.6
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	97.7%	97.9%	98.6%	+0.7
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	87.8%	89.8%	91.2%	**+1.4**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	88.3%	89.3%	91.0%	**+1.7**
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	89.3%	89.8%	90.4%	+0.6
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years	89.2%	87.3%	87.4%	+0.1
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years	90.1%	90.8%	91.0%	+0.2
Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years	NA	NA	NA	—
Adults' Access to Preventive/Ambulatory Health Services—Total	89.5%†	88.4%	88.5%	+0.1
*Ambulatory Care—Outpatient Visits per 1,000 Member Months***	407.0	362.7	364.7	+2.0
*Ambulatory Care—ED Visits per 1,000 Member Months***	NR	63.1	64.0	+0.9

* For the *Comprehensive Diabetes Care—Poor HbA1c Control* measure, a lower rate indicates better performance.

**For the *Ambulatory Care* measures, statistical tests across years were not performed due to lack of variances reported in the IDSS file; differences in rates were reported without statistical test results.

† The 'Total' age group was not a reported age group in HEDIS 2009; it was calculated based on the three reported age groups.

Appendix D. Glossary

Appendix D includes terms, acronyms, and abbreviations commonly used in HEDIS and NCQA literature and text. This glossary can be used as a reference and guide to identify 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 MHP 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 be 4,000/10,000, or 40 percent.

Audit Designation

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 a *Report*, *Not Applicable*, *No Benefit*, or *Not Report* audit designation.

BMI

Body mass index.

CAHPS

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

Capitation

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

Certified HEDIS Software Vendor

A third party, with source code 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 percentage of the measures must receive a "Pass" or "Pass with Qualifications" designation.

Claims-Based Denominator

The eligible population for a measure is obtained from claims data. For hybrid measures with claims-based denominators, health plans may not identify their eligible population and draw their sample earlier than January of the year following the measurement year to ensure that 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 & 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 to 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 to 11 years of age as of December 31 of the measurement year; and Cohort 4, adolescents 12 to 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.

CPT

Current Procedural Terminology (CPT®) is a listing of billing codes generated by the American Medical Association (AMA) to report the provision of medical services and procedures.[D-1]

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

Diagnostic-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.

EDI

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

Electronic Data

Data 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 encounter, submission of encounter data to the health plan allows the health plan to collect the data for future HEDIS reporting.

[D-1] American Medical Association. *CPT-Current Procedural Terminology*. Available at: http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.shtml. Accessed on: September 13, 2010.

Exclusions

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

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 final audit report is completed by the auditor and documents 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 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.

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

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 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 members from the eligible population, which becomes the denominator. Administrative data are then used to identify services provided to the sampled 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 rates but is considerably more labor intensive. For example, a MHP 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 have evidence of a postpartum visit using administrative data. The health plan then obtains and reviews medical records for the 250 members who do not have evidence of a postpartum visit using administrative data. Of those 250 members, 54 are found to have a postpartum visit recorded in the medical record. The final rate for this measure, using the hybrid method, would be (161 + 54) /411, or 52 percent.

ICD-9-CM

ICD-9-CM, the acronym for the International Classification of Diseases, Ninth Revision, Clinical Modification, is the classification of diseases and injuries into groups according to established criteria 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.

IPV

Inactivated polio vaccine.

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.

IS Standards

Information system (IS) standards: An NCQA-defined set of standards that measure how an organization collects, stores, analyzes, and reports medical, customer service, member, practitioner, and vendor data.

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 report HEDIS measures.

Key Measures

The HEDIS measures selected by MDCH that health plans are required to report for HEDIS.

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. The LPL for these measures is the 75th percentile rather than the 25th percentile.

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 *Medical Assistance with Smoking and Tobacco Use Cessation*), 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 *Medical Assistance with Smoking and Tobacco Use Cessation* measure), 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.

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.

Medical Record Validation

The process that auditors follow to verify that a health plan's medical record abstraction meets industry standards and that abstracted data are accurate.

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: If a health plan's denominator for a measure was too small to report a valid rate, the result/rate is NA.

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 designation.

A measure will have an NR audit designation for one of three reasons:

1. The health plan chose not to report the measure.
2. The health plan calculated the measure but the result was materially biased.
3. The health plan was not required to report.

Numerator

The number of members in the denominator who received all the services as specified in the measure.

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 a health plan as part of its medical record review process, and auditors over-read a sample of a 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.

Record of Administration, Data Management and Processes (Roadmap)

The Roadmap, completed by each MCP undergoing the HEDIS audit process, provides information to auditors regarding an MCP's systems for collecting and processing data for HEDIS reporting. Auditors review the Roadmap prior to the scheduled on-site 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 review 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.

Previously the Baseline Assessment Tool (BAT).

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-04 Claims

A type of claim form used to bill hospital-based inpatient, outpatient, emergency room and clinic drugs, supplies, and/or services. UB-04 codes are primarily Type of Bill and Revenue codes. The UB-04 replaced the UB-92.

Vendor

Any third party that contracts with a health plan to perform services. The most common delegated services from vendors are pharmacy services, vision care services, laboratory services, claims processing, HEDIS software services, and provider credentialing.

VZV

Varicella-zoster virus (chicken pox) vaccine.