

*Michigan Department  
of Community Health*



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**2008–2009 EXTERNAL QUALITY REVIEW  
TECHNICAL REPORT**  
*for*  
**Medicaid Health Plans**

March 2010



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## ACKNOWLEDGMENTS AND COPYRIGHTS

**CAHPS**<sup>®</sup> refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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## Purpose of Report

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with the Code of Federal Regulations (CFR), 42 CFR 438.358, were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the states' managed care organizations, called Medicaid Health Plans (MHPs) in Michigan. The report of results must also contain an assessment of the strengths and weaknesses of the plans regarding health care quality, timeliness, and access, and must make recommendations for improvement. Finally, the report must assess the degree to which the MHPs addressed any previous recommendations. To meet this requirement, the State of Michigan Department of Community Health (MDCH) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to aggregate and analyze MHP data and prepare the annual technical report.

The State of Michigan contracted with the following MHPs represented in this report:

- ◆ **BlueCaid of Michigan (BCD)**
- ◆ **CareSource Michigan (CSM)<sup>1-1</sup>**
- ◆ **Great Lakes Health Plan (GLH)**
- ◆ **Health Plan of Michigan, Inc. (HPM)**
- ◆ **HealthPlus Partners, Inc. (HPP)**
- ◆ **McLaren Health Plan (MCL)**
- ◆ **Midwest Health Plan (MID)**
- ◆ **Molina Healthcare of Michigan (MOL)**
- ◆ **OmniCare Health Plan (OCH)**
- ◆ **Physicians Health Plan of Mid-Michigan Family Care (PMD)**
- ◆ **Priority Health Government Programs, Inc. (PRI)**
- ◆ **ProCare Health Plan (PRO)<sup>1-2</sup>**
- ◆ **Total Health Care, Inc. (THC)**
- ◆ **Upper Peninsula Health Plan (UPP)**

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<sup>1-1</sup> Formerly Community Choice of Michigan (name change effective April 18, 2008).

<sup>1-2</sup> Included for the first time due to insufficient data in prior years.

## Scope of External Quality Review (EQR) Activities Conducted

This EQR technical report analyzes and aggregates data from three mandatory EQR activities and one optional activity (a consumer satisfaction survey), as listed below:

- ◆ **Compliance Monitoring:** MDCH evaluated the compliance of the MHPs with federal Medicaid managed care regulations using an on-site review process. HSAG reviewed the MHP site visit documentation provided by MDCH.
- ◆ **Validation of Performance Measures:** Each MHP underwent a National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audit™ conducted by an NCQA-licensed audit organization. HSAG performed an independent audit of the audit findings to determine the validity of each performance measure.
- ◆ **Validation of Performance Improvement Projects (PIPs):** HSAG reviewed one PIP for each MHP to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported improvements.
- ◆ **Consumer Assessment of Healthcare Providers and Systems (CAHPS):** For 2009, MDCH required the administration of the CAHPS 4.0H Adult Medicaid Health Plan Survey and the CAHPS 4.0H Child Medicaid Health Plan Survey. Adult and child members from each plan completed the surveys.

## Summary of Findings

The following is a statewide summary of the conclusions drawn regarding the MHPs’ general performance in 2008–2009. Appendices A–N contain detailed, MHP-specific findings, while Section 3 presents detailed statewide findings with year-to-year comparisons.

### Compliance Review

MDCH conducted its annual compliance site visits of all contracted MHPs over the course of the State fiscal year. For the 2008–2009 review cycle, MDCH chose to focus the site visits on areas in which the MHPs had failed to demonstrate full compliance with the requirement during the 2007–2008 site visit, reviewing all criteria for which an MHP had received a score of *Incomplete* or *Fail*. In addition to the follow-up on these criteria, which varied for each MHP, MDCH also selected a set of mandatory criteria for review for all MHPs, regardless of prior performance.

Findings from this annual site review cycle will be reported and analyzed together with the findings from the 2009–2010 compliance site visits, which will assess compliance with the remaining criteria that were not addressed this year.

Table 1-1 shows the focus of the 2008–2009 annual compliance review site visits.

Table 1-1—2008–2009 Compliance Site Visits		
Standard	Number of Criteria for Review	
	Follow-Up (Statewide)	Mandatory (Per MHP)
Standard 1: Administrative	1	2
Standard 2: Provider	40	2
Standard 3: Member	12	2
Standard 4: Quality/Utilization	15	3
Standard 5: MIS/Data Reporting/Claims Processing	11	3
Standard 6: Fraud and Abuse	18	3
<b>Total</b>	<b>97</b>	<b>15</b>
Note: Mandatory criteria may include criteria that received scores of <i>Incomplete</i> or <i>Fail</i> in the prior review. Therefore, the total number of criteria reviewed may be less than the sum of the two columns.		

### Validation of Performance Measures

All 14 of the MHPs demonstrated the ability to calculate and report accurate performance measures specified by the State. Table 1-2 displays the 2009 Michigan Medicaid weighted averages and performance levels compared to the NCQA HEDIS 2008 Medicaid percentiles. For most of the measures, the 90th percentile indicates above-average performance (★★★), the 25th percentile represents below-average performance (★), and average performance falls between these two percentiles (★★). Because lower rates indicate better performance for two measures (i.e., *Comprehensive Diabetes Care—Poor HbA1c Control* and *Well-Child Visits in the First 15 Months of Life—Zero Visits*), their performance levels are based on a different set of percentiles—i.e., the 10th percentile (rather than the 90th percentile) indicates above-average performance and the 75th percentile (rather than the 25th percentile) represents below-average performance.

**Table 1-2—Overall Statewide Weighted Averages for Performance Measures**

Performance Measure	2009 MI Medicaid	Performance Level for 2009
<b>Pediatric Care</b>		
<i>Childhood Immunization Status—Combo 2</i>	81.8%	★★
<i>Childhood Immunization Status—Combo 3</i>	74.7%	★★
<i>Lead Screening in Children</i>	76.3%	★★
<i>Well-Child Visits in the First 15 Months of Life—Zero Visits*</i>	1.3%	★★
<i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>	66.6%	★★
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	73.6%	★★
<i>Adolescent Well-Care Visits</i>	54.3%	★★
<i>Appropriate Treatment for Children With Upper Respiratory Infection (URI)</i>	81.2%	★★
<i>Appropriate Testing for Children With Pharyngitis</i>	48.0%	★★
<b>Women’s Care</b>		
<i>Breast Cancer Screening—Combined Rate</i>	53.5%	★★
<i>Cervical Cancer Screening</i>	72.4%	★★
<i>Chlamydia Screening in Women—16 to 20 Years</i>	58.7%	★★
<i>Chlamydia Screening in Women—21 to 24 Years**</i>	66.9%	★★
<i>Chlamydia Screening in Women—Combined Rate**</i>	61.5%	★★
<i>Timeliness of Prenatal Care</i>	86.9%	★★
<i>Postpartum Care</i>	68.5%	★★
* Lower rates indicate better performance for this measure.		
† National percentiles are not available for this analysis.		
** The upper age limit for this measure decreased from 25 years to 24 years for 2009. Please use caution when comparing the 2009 Michigan Medicaid weighted average with the national HEDIS 2008 percentiles.		
★ = Below-average performance relative to national Medicaid results.		
★★ = Average performance relative to national Medicaid results.		
★★★ = Above-average performance relative to national Medicaid results.		

**Table 1-2—Overall Statewide Weighted Averages for Performance Measures**

Performance Measure	2009 MI Medicaid	Performance Level for 2009
<b>Living With Illness</b>		
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	85.0%	★★
<i>Comprehensive Diabetes Care—Poor HbA1c Control*</i>	38.3%	★★
<i>Comprehensive Diabetes Care—Eye Exam</i>	61.1%	★★
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	79.2%	★★
<i>Comprehensive Diabetes Care—LDL-C Level &lt;100</i>	40.8%	★★
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	82.5%	★★
<i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;130/80)</i>	29.6%	★★
<i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;140/90)</i>	60.4%	★★
<i>Use of Appropriate Medications for People With Asthma—5 to 9 Years</i>	90.4%	★★
<i>Use of Appropriate Medications for People With Asthma—10 to 17 Years</i>	86.0%	★
<i>Use of Appropriate Medications for People With Asthma—18 to 56 Years</i>	85.9%	★★
<i>Use of Appropriate Medications for People With Asthma—Combined Rate</i>	86.9%	★★
<i>Controlling High Blood Pressure</i>	58.1%	★★
<i>Medical Assistance With Smoking Cessation—Advising Smokers to Quit</i>	72.9%	†
<i>Medical Assistance With Smoking Cessation—Discussing Smoking Cessation Strategies</i>	43.2%	†
<b>Access to Care</b>		
<i>Children’s Access to Primary Care Practitioners—12 to 24 Months</i>	96.3%	★★
<i>Children’s Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.8%	★★
<i>Children’s Access to Primary Care Practitioners—7 to 11 Years</i>	86.2%	★★
<i>Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i>	84.6%	★★
<i>Adults’ Access to Preventive/Ambulatory Health Services—20 to 44 Years</i>	82.2%	★★
<i>Adults’ Access to Preventive/Ambulatory Health Services—45 to 64 Years</i>	87.8%	★★
* Lower rates indicate better performance for this measure.		
† National percentiles are not available for this analysis.		
★	=	Below-average performance relative to national Medicaid results.
★★	=	Average performance relative to national Medicaid results.
★★★	=	Above-average performance relative to national Medicaid results.

Of the 37 performance measures, 2 measures did not have national HEDIS 2008 percentiles available for comparison. The remaining 35 measures were compared to the HEDIS 2008 benchmarks. The statewide average rate for all but one of the comparable performance measures fell within its respective national Medicaid HEDIS 2008 average performance range. The *Use of Appropriate Medications for People With Asthma—10 to 17 Years* measure ranked below the 25th percentile of national Medicaid HEDIS 2008 performance.

### Performance Improvement Projects (PIPs)

In this report, HSAG refers to “steps” when discussing the PIP *validation process* and the Centers for Medicare & Medicaid Services (CMS) protocol for *validating* PIPs. HSAG refers to “activities” when discussing *conducting* a PIP and the CMS protocol for *conducting* PIPs based on the CMS publication, *Conducting Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002.

Thirteen of the MHPs submitted PIPs that were continued from the previous year, and one PIP was a first-year PIP submission. The MHPs chose between two disparity topics provided by MDCH. Eleven MHPs submitted PIPs on *Breast Cancer Screening Disparity*, while three MHPs chose the *Cervical Cancer Screening Disparity* PIP topic. Thirteen of the 14 MHPs received a validation status of *Met* for their PIPs, as shown in Table 1-3.

Validation Status	Number of MHPs
<i>Met</i>	13/14
<i>Partially Met</i>	1/14
<i>Not Met</i>	0/14

Table 1-4 presents a summary of the statewide 2008–2009 results of the validation of the ten steps of the protocol for validating PIPs. The MHPs differed in how far they had progressed in their study. Four MHPs completed all ten activities in the PIP Summary Form, eight MHPs progressed through Activity IX, and two MHPs completed Activities I through VIII. All MHPs demonstrated compliance with all applicable evaluation and critical elements for Steps I through V. Overall, the findings below indicate that for the activities completed, the MHPs had a good understanding of the requirements in the CMS protocol for conducting PIPs. The most significant area for improvement involved the MHPs achieving real and sustained improvement.

Review Steps		Number of PIPs Meeting all Evaluation Elements/ Number Reviewed	Number of PIPs Meeting all Critical Elements/ Number Reviewed
I.	Review the Selected Study Topic(s)	14/14	14/14
II.	Review the Study Question(s)	14/14	14/14
III.	Review the Selected Study Indicator(s)	14/14	14/14
IV.	Review the Identified Study Population	14/14	14/14
V.	Review Sampling Methods*	14/14	14/14
VI.	Review Data Collection Procedures	12/14	14/14
VII.	Assess Improvement Strategies	11/14	13/14
VIII.	Review Data Analysis and the Interpretation of Study Results	10/14	14/14
IX.	Assess for Real Improvement	1/12	No Critical Elements
X.	Assess for Sustained Improvement	2/4	No Critical Elements

\* This activity is assessed only for PIPs that conduct sampling.

### Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Table 1-5 presents the statewide 2009 CAHPS composite scores.

Table 1-5—2009 Statewide Average Results for CAHPS Child and Adult Composite Scores			
CAHPS Measure	Top-Box Percentage	Three-Point Mean Score	Performance Level
<b>Child</b>			
<i>Getting Needed Care</i>	57.6%	2.38	*
<i>Getting Care Quickly</i>	73.1%	2.61	*
<i>How Well Doctors Communicate</i>	74.1%	2.64	★★
<i>Customer Service</i>	65.7%	2.54	*
<i>Shared Decision Making</i>	66.6%	2.59	**
<b>Adult</b>			
<i>Getting Needed Care</i>	53.4%	2.32	★★★
<i>Getting Care Quickly</i>	58.1%	2.40	★★
<i>How Well Doctors Communicate</i>	67.8%	2.54	★★
<i>Customer Service</i>	58.6%	2.37	★★
<i>Shared Decision Making</i>	58.8%	2.48	—
<p>The top-box percentage indicates the percentage of responses of “Always” or “Definitely Yes.”</p> <p>Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p>* The results for these measures are not comparable to the distribution of NCQA national survey results due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p>			
<p>★ = Below-average performance (&lt;25th percentile) relative to national Medicaid results.</p> <p>★★ = Average performance (≥25th to &lt;75th percentile) relative to national Medicaid results.</p> <p>★★★ = Above-average performance (≥75th percentile) relative to national Medicaid results.</p>			

The MHPs showed average performance on the only comparable 2009 child CAHPS composite measure, *How Well Doctors Communicate*.

The MHPs showed above-average performance on one of the four comparable 2009 adult CAHPS composite measures, *Getting Needed Care*. The MHPs showed average performance on the remaining measures: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.

Table 1-6 presents the statewide 2009 CAHPS global ratings.

Table 1-6—2009 Statewide Average Results for CAHPS Child and Adult Global Ratings			
CAHPS Measure	Top-Box Percentage	Three-Point Mean Score	Performance Level
<b>Child</b>			
<i>Rating of All Health Care</i>	59.0%	2.45	★
<i>Rating of Personal Doctor</i>	67.5%	2.55	★★
<i>Rating of Specialist Seen Most Often</i>	62.8%	2.50	★★
<i>Rating of Health Plan</i>	61.2%	2.57	★★
<b>Adult</b>			
<i>Rating of All Health Care</i>	47.9%	2.27	★★
<i>Rating of Personal Doctor</i>	60.0%	2.43	★★
<i>Rating of Specialist Seen Most Often</i>	61.5%	2.48	★★
<i>Rating of Health Plan</i>	56.2%	2.39	★★
The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.			
★ = Below-average performance (<25th percentile) relative to national Medicaid results.			
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.			
★★★ = Above-average performance (≥75th percentile) relative to national Medicaid results.			

The MHPs showed average performance on three of the four child CAHPS global ratings: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often* and *Rating of Health Plan*. However, *Rating of All Health Care* showed below-average performance compared to NCQA national survey results. This area of below-average performance may be a potential target for quality improvement activities aimed at improving member satisfaction.

The MHPs showed average performance on all four of the adult CAHPS global ratings: *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.

### **Quality, Timeliness, and Access**

The validation of the MHPs' PIPs reflected strong performance in the **quality** domain. The projects were designed, conducted, and reported in a methodologically sound manner, giving confidence in the reported results.

Thirty-five of the 37 performance measures were compared with the available national Medicaid HEDIS percentiles. Overall, results of validated performance measures were average across the **quality, timeliness, and access** domains.

The MHPs showed above-average performance in the **access** domain and average performance in the **timeliness** domain for CAHPS. The **quality** domain, on the other hand, exhibited mixed results. Most of the measures had average performance; however, one measure had below-average performance and one measure exhibited above-average performance.

Table 1-7 shows HSAG's assignment of the compliance review standards, performance measures, PIPs, and CAHPS topics into the domains of **quality, timeliness, and access**.

**Table 1-7—Assignment of Activities to Performance Domains**

<b>Compliance Review Standards</b>	<b>Quality</b>	<b>Timeliness</b>	<b>Access</b>
Standard 1. Administrative	✓		
Standard 2. Provider	✓	✓	✓
Standard 3. Member	✓	✓	✓
Standard 4. Quality/Utilization	✓		✓
Standard 5. MIS/Data Reporting/Claims Processing	✓	✓	
Standard 6. Fraud and Abuse	✓	✓	✓
<b>Performance Measures</b>	<b>Quality</b>	<b>Timeliness</b>	<b>Access</b>
<i>Childhood Immunization Status</i>	✓	✓	
<i>Lead Screening in Children</i>	✓	✓	
<i>Well-Child Visits in the First 15 Months of Life</i>	✓	✓	
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	✓	✓	
<i>Adolescent Well-Care Visits</i>	✓	✓	
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	✓		
<i>Appropriate Testing for Children With Pharyngitis</i>	✓		
<i>Breast Cancer Screening</i>	✓		
<i>Cervical Cancer Screening</i>	✓		
<i>Chlamydia Screening in Women</i>	✓		
<i>Prenatal and Postpartum Care</i>	✓	✓	✓
<i>Comprehensive Diabetes Care</i>	✓		
<i>Use of Appropriate Medications for People With Asthma</i>	✓		
<i>Controlling High Blood Pressure</i>	✓		
<i>Medical Assistance With Smoking Cessation</i>	✓		
<i>Children’s and Adolescents’ Access to Primary Care Practitioners</i>	✓		✓
<i>Adults’ Access to Preventive/Ambulatory Health Services</i>	✓		✓
<b>PIPs</b>	<b>Quality</b>	<b>Timeliness</b>	<b>Access</b>
One PIP for each MHP	✓		
<b>CAHPS Topics</b>	<b>Quality</b>	<b>Timeliness</b>	<b>Access</b>
<i>Getting Needed Care</i>	✓		✓
<i>Getting Care Quickly</i>	✓	✓	
<i>Customer Service</i>	✓		
<i>How Well Doctors Communicate</i>	✓		
<i>Shared Decision Making</i>	✓		
<i>Rating of Health Plan</i>	✓		
<i>Rating of All Health Care</i>	✓		
<i>Rating of Personal Doctor</i>	✓		
<i>Rating of Specialist Seen Most Often</i>	✓		

### Introduction

This section of the report describes the manner in which data from the activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed.

### Compliance Monitoring

#### Objectives

According to 42 CFR 438.358, a state or its EQRO must conduct a review within a three-year period to determine the Medicaid managed care organizations' compliance with standards established by the state for access to care, structure and operations, and quality measurement and improvement. To meet this requirement, MDCH performed on-site reviews of its MHPs.

The objectives of evaluating contractual compliance with federal Medicaid managed care regulations were to identify any areas of noncompliance and to assist the MHPs in developing corrective actions to achieve compliance with the contractual requirements.

#### Technical Methods of Data Collection

MDCH was responsible for the activities that assessed MHP compliance with federal Medicaid managed care regulations. For the 2008–2009 site visits, MDCH chose to focus the review on only those criteria for which the MHPs had received scores of *Incomplete* or *Fail* during the previous site visit.

Due to timeline delays, MDCH decided to combine the 2008–2009 and 2009–2010 compliance review cycles for reporting in the 2009–2010 technical report.

#### Description of Data Obtained

To assess the MHPs' compliance with federal and State requirements, MDCH obtained information from a wide range of written documents produced by the MHPs, including the following:

- ◆ Policies and procedures
- ◆ Current QAPI programs
- ◆ Minutes of meetings of the governing body, quality improvement (QI) committee, compliance committee, utilization management (UM) committee, credentialing committee, and peer review committee
- ◆ QI work plans, utilization reports, provider and member profiling reports, QI effectiveness reports

- ◆ Internal auditing/monitoring plans, auditing/monitoring findings
- ◆ Claims review reports, prior authorization reports, complaint logs, grievance logs, telephone contact logs, disenrollment logs, MDCH hearing requests, medical record review reports
- ◆ Provider service and delegation agreements and contracts
- ◆ Provider files, disclosure statements, current sanctioned/suspended provider lists
- ◆ Organizational charts
- ◆ Fraud and abuse logs, fraud and abuse reports
- ◆ Employee handbooks, fliers, employee newsletters, provider manuals, provider newsletters, Web sites, educational/training materials, and sign-in sheets
- ◆ Member materials, including welcome letters, member handbooks, member newsletters, provider directories, and certificates of coverage
- ◆ Provider manuals

For the 2008–2009 compliance site visits, MDCH continued to use its automated site visit tool in an Access database application. Prior to the scheduled site visit, each MHP received the tool with instructions for entering the required information. For each criterion, the Access application specified which supporting documents were required for submission, stated the previous score, and provided a space for the MHP’s response. Following the site visit, MDCH completed the section for State findings and assigned a score for each criterion. The site visit tool was also used for the MHP to describe, after the site review, any required corrective action plan and to document MDCH’s action plan assessment.

MDCH summarized each of the MHPs’ focus studies presented at the site visit in a focus study report.

### ***Data Aggregation, Analysis, and How Conclusions Were Drawn***

MDCH reviewers used the site visit tool for each MHP to document their findings and to identify, when applicable, specific action(s) required of the plan to address any areas of noncompliance with contractual requirements.

For each criterion reviewed, MDCH assigned one of the following scores:

- ◆ *Pass*—The MHP demonstrated full compliance with the requirement(s).
- ◆ *Incomplete*—The MHP demonstrated partial compliance with the requirement(s).
- ◆ *Fail*—The MHP failed to demonstrate compliance with the requirement(s).

For the 2009–2010 compliance reviews, MDCH will assess the MHPs’ compliance with all criteria not included in the 2008–2009 review. The next technical report will present the combined results from the two review cycles.

To draw conclusions and make overall assessments about the **quality** and **timeliness** of, and **access** to, care provided by the MHPs using findings from the compliance reviews, the standards were categorized to evaluate each of these three domains. Using this framework, Table 1-7 (page 1-10) shows HSAG’s assignment of standards to the three domains of performance.

## Validation of Performance Measures

### Objectives

As set forth in 42 CFR 438.358, validation of performance measures is one of the mandatory EQR activities. The primary objectives of the performance measure validation process are to:

- ◆ Evaluate the accuracy of the performance measure data collected by the MHP.
- ◆ Determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure.

To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess each MHP's support system available to report accurate HEDIS measures.

### Technical Methods of Data Collection and Analysis

MDCH required each MHP to collect and report a set of Medicaid HEDIS measures. Developed and maintained by NCQA, HEDIS is a set of performance measures broadly accepted in the managed care environment as an industry standard.

Each MHP underwent an NCQA HEDIS Compliance Audit™ conducted by an NCQA-licensed audit organization. The NCQA HEDIS Compliance Audit followed NCQA audit methodology as set out in NCQA's 2009 *HEDIS Compliance Audit: Standards, Policies, and Procedures*. The NCQA HEDIS Compliance Audit encompasses an in-depth examination of the health plans' processes consistent with CMS' protocols for validation of performance measures. To complete the validation of performance measures process according to the CMS protocols, HSAG performed an independent evaluation of the audit results and findings to determine the validity of each performance measure.

The HEDIS Compliance Audits, conducted by the licensed audit organizations, included the following activities:

**Pre-review Activities:** Each MHP was required to complete the NCQA Record of Administration, Data Management, and Processes (Roadmap), which is comparable to the Information Systems Capabilities Assessment Tool, Appendix Z, of the CMS protocols. Pre-on-site conference calls were held to follow up on any outstanding questions. The audit team conducted a thorough review of the Roadmap and supporting documentation, including an evaluation of processes used for collecting, storing, validating, and reporting the performance measure data.

**On-site Review:** The on-site reviews, which typically lasted two days, included:

- ◆ An evaluation of system compliance, focusing on the processing of claims and encounters.
- ◆ An overview of data integration and control procedures, including discussion and observation.

- ◆ A review of how all data sources were combined and the method used to produce the performance measures.
- ◆ Interviews with MHP staff members involved with any aspect of performance measure reporting.
- ◆ A closing conference at which the audit team summarized preliminary findings and recommendations.

**Post-on-site Review Activities:** For each performance measure calculated and reported by the MHPs, the audit team aggregated the findings from the pre-on-site and on-site activities to determine whether the reported measures were valid, based on an allowable bias. The audit team assigned each measure one of four audit findings: (1) *Report* (the rate was valid and below the allowable threshold for bias), (2) *Not Applicable* (the MHP followed the specifications but the denominator was too small to report a valid rate), (3) *No Benefit* (the MHP did not offer the health benefits required by the measure), or (4) *Not Report* (the measure was significantly biased or the plan chose not to report the measure).

### Description of Data Obtained

As identified in the CMS protocol, the following key types of data were obtained and reviewed as part of the validation of performance measures. Table 2-1 shows the data sources used in the validation of performance measures and the time period to which the data applied.

Table 2-1—Description of Data Sources	
Data Obtained	Time Period to Which the Data Applied
HEDIS Compliance Audit reports were obtained for each MHP, which included a description of the audit process, the results of the information systems findings, and the final audit designations for each performance measure.	Calendar Year (CY) 2008 (HEDIS 2009)
Performance measure reports, submitted by the MHPs using NCQA’s Information Data Submission System (IDSS), were analyzed and subsequently validated by the HSAG validation team.	CY 2008 (HEDIS 2009)
Previous performance measure reports were reviewed to assess trending patterns and the reasonability of rates.	CY 2007 (HEDIS 2008)

### ***Data Aggregation, Analysis, and How Conclusions Were Drawn***

HSAG performed a comprehensive review and analysis of the MHPs' IDSS results, data submission tools, and MHP-specific HEDIS Compliance Audit reports and performance measure reports.

HSAG ensured that the following criteria were met prior to accepting any validation results:

- ◆ An NCQA-licensed audit organization completed the audit.
- ◆ An NCQA-certified HEDIS compliance auditor led the audit.
- ◆ The audit scope included all MDCH-selected HEDIS measures.
- ◆ The audit scope focused on the Medicaid product line.
- ◆ Data were submitted via an auditor-locked NCQA IDSS.
- ◆ A final Audit Opinion, signed by the lead auditor and responsible officer within the licensed organization, was produced.

To draw conclusions and make overall assessments about the quality and timeliness of, and access to, care provided by the MHPs using findings from the validation of performance measures, each measure was categorized to evaluate one or more of the three domains. Table 1-7 (page 1-10) shows HSAG's assignment of performance measures to these domains of performance.

## Validation of Performance Improvement Projects (PIPs)

### Objectives

As part of its QAPI program, each MHP is required by MDCH to conduct PIPs in accordance with 42 CFR 438.240. The purpose of the PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. As one of the mandatory EQR activities under the BBA, a state is required to validate the PIPs conducted by its contracted Medicaid managed care organizations. To meet this validation requirement for the MHPs, MDCH contracted with HSAG.

The primary objective of PIP validation was to determine each MHP's compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

- ◆ Measurement of performance using objective quality indicators.
- ◆ Implementation of systematic interventions to achieve improvement in quality.
- ◆ Evaluation of the effectiveness of the interventions.
- ◆ Planning and initiation of activities for increasing or sustaining improvement.

MDCH required that each MHP conduct one PIP subject to validation by HSAG. In 2007–2008, MDCH allowed the MHPs to select either *Breast Cancer Screening Disparity* or *Cervical Cancer Screening Disparity* as a PIP topic for validation. Eleven MHPs submitted a PIP on *Breast Cancer Screening Disparity*, while three MHPs submitted a PIP on *Cervical Cancer Screening Disparity*. The PIPs were continued from 2007–2008, except for one first-year submission on *Breast Cancer Screening Disparity*.

### Technical Methods of Data Collection and Analysis

The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design, and a clinician with expertise in performance improvement processes. The methodology used to validate the PIPs was based on guidelines as outlined in the CMS publication, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002. Using this protocol, HSAG, in collaboration with MDCH, developed the PIP Summary Form. Each MHP completed this form and submitted it to HSAG for review. The PIP Summary Form standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

In this report, HSAG refers to “steps” when discussing the PIP *validation process* and CMS' protocol for *validating* PIPs. HSAG refers to “activities” when discussing *conducting* a PIP and CMS' protocol for *conducting* PIPs, based on the CMS publication, *Conducting Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002.

With MDCH input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. Using this tool, HSAG reviewed each of the PIPs for the following ten CMS PIP protocol steps:

- ◆ Step I. Review the Selected Study Topic(s)
- ◆ Step II. Review the Study Question(s)
- ◆ Step III. Review the Selected Study Indicator(s)
- ◆ Step IV. Review the Identified Study Population
- ◆ Step V. Review Sampling Methods (if sampling was used)
- ◆ Step VI. Review Data Collection Procedures
- ◆ Step VII. Assess Improvement Strategies
- ◆ Step VIII. Review Data Analysis and the Interpretation of Study Results
- ◆ Step IX. Assess for Real Improvement
- ◆ Step X. Assess for Sustained Improvement

### **Description of Data Obtained**

HSAG obtained the data needed to conduct the PIP validations from the MHPs' PIP Summary Form. This form provided detailed information about each MHP's PIP as it related to the ten steps reviewed and evaluated for the 2008–2009 validation cycle.

### **Data Aggregation, Analysis, and How Conclusions Were Drawn**

Each of the ten protocol steps consisted of evaluation elements necessary for the successful completion of a valid PIP. The HSAG PIP Review Team scored the elements within each step as *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. The scoring methodology included a *Not Applicable* designation for evaluation elements (including critical elements) that did not apply to the PIP (e.g., a PIP that did not use any sampling techniques would have all elements in Step V scored *Not Applicable*). HSAG used the *Not Assessed* designation when a PIP had not progressed to the remaining steps in the CMS PIP protocol. Elements designated as *Not Applicable* and *Not Assessed* were removed from all scoring.

HSAG identified a *Point of Clarification* when the documentation for an evaluation element included the basic components needed to meet the requirements of the evaluation element (as described in the narrative of the PIP), but enhanced documentation would demonstrate a stronger understanding of the CMS PIP protocol.

To ensure a valid and reliable review, HSAG designated some of the evaluation elements as “critical” elements. HSAG determined that these elements had to be *Met* for the MHP to produce an accurate and reliable PIP. Given the importance of critical elements to this scoring methodology, any critical element that received a *Not Met* status resulted in an overall validation rating for the PIP of *Not Met*. An MHP received a *Partially Met* score if 60 percent to 79 percent of all elements were *Met* across all steps, or one or more critical elements were *Partially Met*.

The MHPs had an opportunity to resubmit revised PIP Summary Forms and additional information in response to any *Partially Met* or *Not Met* evaluation scores, regardless of whether the evaluation element was critical or noncritical. HSAG re-reviewed the resubmitted documents and rescored the PIPs before determining a final score. With MDCH's approval, HSAG offered technical guidance to any MHP that requested an opportunity to review the scoring of the evaluation elements prior to a resubmission. Eight of the 14 MHPs requested technical guidance from HSAG. HSAG conducted conference calls to provide an opportunity for the MHPs to discuss areas of deficiency. HSAG reviewed and discussed each *Point of Clarification* and *Partially Met* or *Not Met* evaluation element. As a result of the technical guidance conference calls, HSAG provided each MHP with PIP Summary Form Completion Instructions. The instructions outlined the evaluation elements and provided documentation resources to support CMS PIP protocol requirements.

HSAG followed the above methodology for validating the PIPs for all MHPs to assess the degree to which the MHPs designed, conducted, and reported their projects in a methodologically sound manner.

After completing the validation review, HSAG prepared a report of its findings and recommendations for each validated PIP. These reports, which complied with 42 CFR 438.364, were forwarded to MDCH and the appropriate MHP.

Although an MHP's purpose for conducting a PIP may have been to improve performance in an area related to any of the domains of **quality**, **timeliness**, and/or **access**, the purpose of the EQR activities related to PIPs was to evaluate the validity and quality of the MHP's processes in conducting PIPs. Therefore, to draw conclusions and make overall assessments about each MHP's performance in conducting valid PIPs, HSAG assigned all PIPs to the **quality** domain.

## Consumer Assessment of Healthcare Providers and Systems (CAHPS)

### Objectives

The CAHPS survey was designed to assess key satisfaction drivers throughout the continuum of care, including health plan performance and the member's experience in the physician's office.

The objective of the CAHPS survey was to provide performance feedback to help improve overall member satisfaction.

### Technical Methods of Data Collection and Analysis

The technical method of data collection was through the administration of the CAHPS 4.0H Adult Medicaid Health Plan Survey and the CAHPS 4.0H Child Medicaid Health Plan Survey (without the children with chronic conditions measurement set). The survey encompassed a set of standardized items that assessed patient perspectives on care (or, for the child survey, the parent's or caretaker's perspective). To achieve reliable and valid findings, the selection of members and the distribution of surveys followed the *HEDIS Volume 3: Specifications for Survey Measures* sampling and data collection procedures. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from the multiple waves of mailings and response-gathering activities were aggregated into a database for analysis.

The survey questions were categorized into measures of satisfaction. These included **four global ratings** and **five composite measures** for the adult and child surveys. The global ratings reflected respondents' overall satisfaction with their or their child's personal doctor, specialist, and health plan, and with all health care. The composite scores were derived from sets of questions to address different aspects of care. The adult and child survey's composites addressed the following topics: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*. When a minimum of 100 responses for a measure was not received, the results of the measure were not applicable for reporting, resulting in a *Not Applicable (NA)* designation.

For each of the global ratings, the percentage of respondents who chose the top-box satisfaction rating (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This was referred to as the question summary rate. In addition, a three-point mean score was calculated. Response values of 0 to 6 were given a score of 1, response values of 7 and 8 were given a score of 2, and response values of 9 and 10 were given a score of 3. The three-point mean score was determined by calculating the sum of the response scores (1, 2, or 3) and dividing the sum by the total number of responses to the global rating question.

For each of the composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS questions used in composites were scaled in one of two ways:

- ◆ *Never/Sometimes/Usually/Always*
- ◆ *Definitely No/Somewhat No/Somewhat Yes/Definitely Yes*

NCQA defined a top-box response for these composites as a response of *Always* or *Definitely Yes*. This is referred to as a global proportion for the composite scores.

In addition, a three-point mean score was calculated for each of the composite measures. Scoring was based on a three-point scale. Responses of *Always* and *Definitely Yes* were given a score of 3, responses of *Usually* and *Somewhat Yes* were given a score of 2, and all other responses were given a score of 1. The three-point mean score is the average of the mean scores for each question included in the composite (i.e., the mean of the means).

As part of the data analysis, three-point mean scores for each measure were compared to national benchmarks. However, due to changes made from the CAHPS 3.0H Child Medicaid Health Plan Survey to the CAHPS 4.0H Child Medicaid Health Plan Survey, the *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service* composites were not comparable to NCQA national data. In addition, the *Shared Decision Making* composite was added as a first-year measure; therefore, national data do not exist.

CAHPS reports prepared for each MHP by its vendor contain details on the global ratings and composite scores.

### **Description of Data Obtained**

For the CAHPS 2009 reporting year, which represents an evaluation of the 2008 measurement year (MY), the CAHPS 4.0H Adult Medicaid Health Plan Survey was used to obtain adult member satisfaction ratings for members meeting enrollment criteria in 2008. The CAHPS 4.0H Child Medicaid Health Plan Survey was used to obtain child member satisfaction ratings for members meeting enrollment criteria in 2008.

### **Data Aggregation, Analysis, and How Conclusions Were Drawn**

The CAHPS questions for both surveys were summarized by the CAHPS measures of satisfaction. These measures were calculated as described above and assigned to the domains of **quality**, **timeliness**, and **access**, as shown in Table 1-7 (page 1-10).

The following section presents details for the 2008–2009 annual compliance reviews and findings for the EQR activities of validation of performance measures, validation of PIPs, and CAHPS for the two reporting periods of 2007–2008 and 2008–2009.

Appendices A–N present additional details about the results of the plan-specific EQR activities.

### Annual Compliance Review

MDCH conducted its annual compliance site visits of all contracted MHPs over the course of the State fiscal year. For the 2008–2009 review cycle, MDCH chose to focus the site visits on areas in which the MHPs had failed to demonstrate full compliance with the requirement during the previous site visit, reviewing all criteria for which an MHP had received a score of *Incomplete* or *Fail*. In addition to the follow-up on these criteria, which varied for each MHP, MDCH also selected a set of mandatory criteria for review for all MHPs, regardless of prior performance. The 2009–2010 technical report will present the combined results and analysis of findings from this annual site review cycle and the 2009–2010 compliance site visits, which will assess compliance with the remaining criteria that were not addressed this year.

## Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process were to evaluate the accuracy of the performance measure data collected by the MHPs and determine the extent to which the specific performance measures calculated by the MHPs (or on behalf of the MHPs) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a thorough information system evaluation was performed to assess the ability of each MHP's support system to report accurate HEDIS measures, as well as a measure-specific review of all reported measures.

Results from the validation of performance measures activities showed that all 14 MHPs received a finding of *Report* (i.e., appropriate processes, procedures, and corresponding documentation) for all assessed performance measures. The performance measure data were collected accurately from a wide variety of sources statewide. All of the MHPs demonstrated the ability to calculate and accurately report performance measures that complied with HEDIS specifications. This finding suggests that the information systems for reporting HEDIS measures are a statewide strength.

Table 3-1 shows each of the performance measures, the 2008 and 2009 rates for each measure, and the categorized performance for 2009 relative to national 2008 Medicaid results. For most of the measures, the 90th percentile indicates above-average performance (★★★), the 25th percentile represents below-average performance (★), and average performance falls between these two percentiles (★★). Because lower rates indicate better performance for two measures (i.e., *Comprehensive Diabetes Care—Poor HbA1c Control* and *Well-Child Visits in the First 15 Months of Life—Zero Visits*), their performance levels are based on a different set of percentiles—i.e., the 10th percentile (rather than the 90th percentile) indicates above-average performance and the 75th percentile (rather than the 25th percentile) represents below-average performance.

Table 3-1—Overall Statewide Weighted Averages for Performance Measures			
Performance Measure	2008 MI Medicaid	2009 MI Medicaid	Performance Level for 2009
<b>Pediatric Care</b>			
<i>Childhood Immunization Status—Combo 2</i>	81.9%	81.8%	★★
<i>Childhood Immunization Status—Combo 3</i>	73.4%	74.7%	★★
<i>Lead Screening for Children</i>	71.5%	76.3%	★★
<i>Well-Child Visits in the First 15 Months of Life—Zero Visits*</i>	1.4%	1.3%	★★
<i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>	61.6%	66.6%	★★
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	69.5%	73.6%	★★
<i>Adolescent Well-Care Visits</i>	52.0%	54.3%	★★
<i>Appropriate Treatment for Children With URI</i>	79.3%	81.2%	★★
<i>Appropriate Testing for Children With Pharyngitis</i>	47.7%	48.0%	★★
<b>Women’s Care</b>			
<i>Breast Cancer Screening—Combined Rate</i>	52.6%	53.5%	★★
<i>Cervical Cancer Screening</i>	68.5%	72.4%	★★
<i>Chlamydia Screening in Women—16 to 20 Years</i>	53.2%	58.7%	★★
<i>Chlamydia Screening in Women—21 to 24 Years**</i>	61.5%	66.9%	★★
<i>Chlamydia Screening in Women—Combined Rate**</i>	56.4%	61.5%	★★
<i>Timeliness of Prenatal Care</i>	84.5%	86.9%	★★
<i>Postpartum Care</i>	63.0%	68.5%	★★
<b>Living With Illness</b>			
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	84.6%	85.0%	★★
<i>Comprehensive Diabetes Care—Poor HbA1c Control*</i>	38.4%	38.3%	★★
<i>Comprehensive Diabetes Care—Eye Exam</i>	58.8%	61.1%	★★
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	76.8%	79.2%	★★
<i>Comprehensive Diabetes Care—LDL-C Level &lt;100</i>	40.0%	40.8%	★★
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	80.7%	82.5%	★★
<i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;130/80)</i>	28.6%	29.6%	★★
<i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;140/90)</i>	58.4%	60.4%	★★
<i>Use of Appropriate Medications for People With Asthma—5 to 9 Years</i>	90.6%	90.4%	★★
<i>Use of Appropriate Medications for People With Asthma—10 to 17 Years</i>	87.3%	86.0%	★
<i>Use of Appropriate Medications for People With Asthma—18 to 56 Years</i>	86.3%	85.9%	★★
<i>Use of Appropriate Medications for People With Asthma—Combined Rate</i>	87.5%	86.9%	★★
<i>Controlling High Blood Pressure</i>	56.1%	58.1%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
** The upper age limit for this measure decreased from 25 years to 24 years for 2009. Please use caution when comparing the 2009 Michigan Medicaid weighted average with the national HEDIS 2008 percentiles.			
★ = Below-average performance relative to national Medicaid results.			
★★ = Average performance relative to national Medicaid results.			
★★★ = Above-average performance relative to national Medicaid results.			

Table 3-1—Overall Statewide Weighted Averages for Performance Measures			
Performance Measure	2008 MI Medicaid	2009 MI Medicaid	Performance Level for 2009
<b>Living With Illness (continued)</b>			
<i>Medical Assistance With Smoking Cessation—Advising Smokers to Quit</i>	72.8%	72.9%	†
<i>Medical Assistance With Smoking Cessation—Discussing Smoking Cessation Strategies</i>	41.1%	43.2%	†
<b>Access to Care</b>			
<i>Children’s Access to Primary Care Practitioners—12 to 24 Months</i>	95.6%	96.3%	★★
<i>Children’s Access to Primary Care Practitioners—25 Months to 6 Years</i>	85.0%	86.8%	★★
<i>Children’s Access to Primary Care Practitioners—7 to 11 Years</i>	83.9%	86.2%	★★
<i>Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i>	82.1%	84.6%	★★
<i>Adults’ Access to Preventive/Ambulatory Health Services—20 to 44 Years</i>	81.1%	82.2%	★★
<i>Adults’ Access to Preventive/Ambulatory Health Services—45 to 64 Years</i>	86.8%	87.8%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★ = Below-average performance relative to national Medicaid results.			
★★ = Average performance relative to national Medicaid results.			
★★★ = Above-average performance relative to national Medicaid results.			

Table 3-1 shows that the statewide average rates for all but one of the 35 comparable performance measures were about average, falling between the national Medicaid HEDIS 2008 25th and 90th percentiles. The *Use of Appropriate Medications for People With Asthma—10 to 17 Years* measure fell below the 25th percentile.

From a quality improvement perspective, the 2009 average rates for 32 measures improved or remained the same compared to the MHPs’ 2008 performance. Six measures (*Lead Screening for Children*, *Well-Child Visits in the First 15 Months of Life—Six or More Visits*, *Postpartum Care*, and all three *Chlamydia Screening* measures) reported an increase in performance by about 5 percentage points from last year.

The statewide performance for five of the measures declined between 2008 and 2009: *Childhood Immunization Status—Combo 2* and all four *Use of Appropriate Medications for People With Asthma* measures. However, each of the five measures differed from last year’s rate by only 1.3 percentage points or less.

Table 3-2 presents the number of MHPs with performance measure rates of below-average, average, and above-average performance for 2009. Except for the *Adolescent Well-Care Visits* measure, results were calculated based on 13 rather than 14 plans because one MHP did not have sufficient sample sizes to report the rates.

Table 3-2—Distribution of MHP Performance Compared to National Medicaid Benchmarks			
Performance Measure	Number of Stars		
	★	★★	★★★
<b>Pediatric Care</b>			
<i>Childhood Immunization Status—Combo 2</i>	0	9	4
<i>Childhood Immunization Status—Combo 3</i>	0	10	3
<i>Lead Screening in Children</i>	0	11	2
<i>Well-Child Visits in the First 15 Months of Life—Zero Visits*</i>	0	12	1
<i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>	0	12	1
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	1	12	0
<i>Adolescent Well-Care Visits</i>	2	9	3
<i>Appropriate Treatment for Children With URI</i>	4	9	0
<i>Appropriate Testing for Children With Pharyngitis</i>	5	7	1
<b>Women’s Care</b>			
<i>Breast Cancer Screening—Combined Rate</i>	0	12	1
<i>Cervical Cancer Screening</i>	0	11	2
<i>Chlamydia Screening in Women—16 to 20 Years</i>	0	11	2
<i>Chlamydia Screening in Women—21 to 24 Years</i>	0	9	4
<i>Chlamydia Screening in Women—Combined Rate</i>	0	10	3
<i>Timeliness of Prenatal Care</i>	0	11	2
<i>Postpartum Care</i>	0	9	4
<b>Living With Illness</b>			
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	0	10	3
<i>Comprehensive Diabetes Care—Poor HbA1c Control*</i>	1	6	6
<i>Comprehensive Diabetes Care—Eye Exam</i>	0	7	6
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	0	10	3
<i>Comprehensive Diabetes Care—LDL-C Level &lt;100</i>	0	9	4
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	0	8	5
<i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;130/80)</i>	1	11	1
<i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;140/90)</i>	0	11	2
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table 3-2—Distribution of MHP Performance Compared to National Medicaid Benchmarks			
Performance Measure	Number of Stars		
	★	★★	★★★
<b>Living With Illness (continued)</b>			
<i>Use of Appropriate Medications for People With Asthma—5 to 9 Years</i>	4	7	2
<i>Use of Appropriate Medications for People With Asthma—10 to 17 Years</i>	5	5	3
<i>Use of Appropriate Medications for People With Asthma—18 to 56 Years</i>	0	12	1
<i>Use of Appropriate Medications for People With Asthma—Combined Rate</i>	6	4	3
<i>Controlling High Blood Pressure</i>	0	9	4
<i>Medical Assistance With Smoking Cessation—Advising Smokers to Quit</i>	†	†	†
<i>Medical Assistance With Smoking Cessation—Discussing Smoking Cessation Strategies</i>	†	†	†
<b>Access to Care</b>			
<i>Children’s Access to Primary Care Practitioners—12 to 24 Months</i>	1	12	0
<i>Children’s Access to Primary Care Practitioners—25 Months to 6 Years</i>	1	12	0
<i>Children’s Access to Primary Care Practitioners—7 to 11 Years</i>	2	11	0
<i>Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i>	1	12	0
<i>Adults’ Access to Preventive/Ambulatory Health Services—20 to 44 Years</i>	0	12	1
<i>Adults’ Access to Preventive/Ambulatory Health Services—45 to 64 Years</i>	0	12	1
<b>Total</b>	34	344	78
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table 3-2 shows that 75.4 percent of all rates (344 out of 456) for the performance measures fell into the average range relative to national Medicaid results. While 17.1 percent of the rates indicated above-average performance, 7.5 percent of the rates fell below the national average. The above-average rates were more often in the Women’s Care and Living With Illness dimensions, whereas the below-average rates were mostly in the Pediatric Care and Living With Illness dimensions.

Together with the findings from Table 3-2, the results of the current validation of performance measures show continuous statewide improvement that reflects overall average performance, from a national perspective.

## Performance Improvement Projects (PIPs)

Table 3-3 presents a summary of the MHPs’ PIP validation status results. The PIPs submitted for validation addressed disparity in breast cancer or cervical cancer screening. For the 2008–2009 validation, 13 of the 14 PIPs (93 percent) received a validation status of *Met*, essentially the same percentage as in 2007–2008. None of the PIPs received a validation status of *Not Met*.

Table 3-3—MHP’s PIP Validation Status		
Validation Status	Percentage of PIPs	
	2007–2008	2008–2009
<i>Met</i>	92%	93%
<i>Partially Met</i>	8%	7%
<i>Not Met</i>	0%	0%

The following presents a summary of the validation results for the MHPs for each of the ten steps from the CMS PIP protocol. The MHPs were in different stages of implementation of their PIPs. Therefore, the number of MHPs evaluated for the steps varied. All 14 MHPs completed Activities I through VIII, 12 MHPs progressed through Activity IX, and 4 MHPs completed all ten activities.

Table 3-4 shows the percentage of MHPs having completed the activity that met all of the evaluation or critical elements within each of the ten steps.

Table 3-4—Summary of Data From Validation of Performance Improvement Projects			
Review Steps		Percentage Meeting all Elements/ Percentage Meeting all Critical Elements	
		2007–2008	2008–2009
I.	Review the Selected Study Topic(s)	100%/100%	100%/100%
II.	Review the Study Question(s)	92%/92%	100%/100%
III.	Review the Selected Study Indicator(s)	92%/92%	100%/100%
IV.	Review the Identified Study Population	100%/100%	100%/100%
V.	Review Sampling Methods*	100%/100%	100%/100%
VI.	Review Data Collection Procedures	92%/92%	86%/100%
VII.	Assess Improvement Strategies	100%/100%	79%/93%
VIII.	Review Data Analysis and the Interpretation of Study Results	92%/92%	71%/100%
IX.	Assess for Real Improvement	25%/NCE	8%/NCE
X.	Assess for Sustained Improvement	50%/NCE	50%/NCE

NCE = No Critical Elements  
 \* This activity is assessed only for PIPs that conduct sampling.

The MHPs demonstrated high levels of compliance with the requirements of the CMS PIP protocol for activities related to the study topic, study question, study indicator, study population, sampling techniques, and data collection. For Steps I through V, all PIPs scored 100 percent for both evaluation and critical elements. Validation findings for 2008–2009 reflect strong performance in Steps I through VI. For Step VI, 12 of the 14 PIPs met all applicable evaluation elements and all PIPs scored 100 percent for critical elements. For Steps VII and VIII addressing improvement strategies and data analysis, the MHPs' performance was good, with 79 percent and 71 percent, respectively, of all evaluation elements *Met*. For Step VIII, the MHPs improved the score for critical elements *Met*; however, the percentage for overall evaluation elements *Met* declined. The MHPs should improve their documentation related to analysis and interpretation of study results as well as *p* value calculations. Steps IX and X, which assess for real and sustained improvement, reflected the greatest need for improvement. Although the MHPs had difficulty achieving statistically significant improvement—i.e., real improvement—50 percent of the plans that progressed to Step IX demonstrated improvement in the outcomes of care. Of the four plans that completed all ten activities, one MHP achieved real and sustained improvement. HSAG recommended that the MHPs conduct causal/barrier analyses to determine what barriers are preventing real and sustained improvement and revise existing or implement new improvement strategies to assist them in achieving the desired outcomes.

Across all MHPs, the 2008–2009 validation identified two PIPs that met all applicable evaluation and critical elements, one PIP that failed to demonstrate compliance with one of the elements, four PIPs that did not meet the requirements for two elements across multiple steps, and seven PIPs that failed to meet three or more evaluation elements across the completed activities. HSAG identified *Points of Clarification* in many of the PIPs. These *Points of Clarification* will assist the MHPs in strengthening their studies.

## Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Table 3-5 presents the detailed, statewide 2008 and 2009 CAHPS composite scores. While MHPs conduct the adult CAHPS survey every year, the child CAHPS survey is administered every other year. Therefore, the 2008 child CAHPS results for comparison to prior-year performance reflect data from 2007.

Table 3-5—Detailed State Average Results for CAHPS Child and Adult Composite Scores					
CAHPS Measure	Top-Box Percentage		Three-Point Mean Score		Performance Level for 2009
	2008	2009	2008	2009	
<b>Child<sup>†</sup></b>					
<i>Getting Needed Care</i>	79.3%	57.6%	2.72	2.38	*
<i>Getting Care Quickly</i>	54.4%	73.1%	2.33	2.61	*
<i>How Well Doctors Communicate</i>	68.9%	74.1%	2.59	2.64	★★
<i>Customer Service</i>	72.1%	65.7%	2.65	2.54	*
<i>Shared Decision Making</i>	**	66.6%	**	2.59	**
<b>Adult</b>					
<i>Getting Needed Care</i>	51.4%	53.4%	2.29	2.32	★★★
<i>Getting Care Quickly</i>	56.2%	58.1%	2.38	2.40	★★
<i>How Well Doctors Communicate</i>	66.3%	67.8%	2.51	2.54	★★
<i>Customer Service</i>	59.3%	58.6%	2.39	2.37	★★
<i>Shared Decision Making</i>	58.7%	58.8%	2.48	2.48	—
<p>The top-box percentage indicates the percentage of responses of “Always” or “Definitely Yes.”</p> <p>Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p><sup>†</sup> Child results for 2008 reflect 2007 data.</p> <p>* Due to changes from the CAHPS Child 3.0H to the CAHPS Child 4.0H Health Plan Survey, these composites are not comparable to the previous year’s results or national benchmarks.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Survey; therefore, prior-year scores do not exist. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p>					
<p>★ = Below-average performance (&lt;25th percentile) relative to national Medicaid results</p> <p>★★ = Average performance (≥25th to &lt;75th percentile) relative to national Medicaid results</p> <p>★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results</p>					

The only comparable child CAHPS composite measure, *How Well Doctors Communicate*, showed average performance from a national perspective.

The top-box percentages showed improvement for four of the five adult composite measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision*

*Making*. However, the one composite measure that did not show improvement, *Customer Service*, had a top-box percentage that decreased by less than 1 percentage point.

From a quality perspective, the statewide results showed average performance. Four of the five comparable composite measures scored between the 25th and 74th percentiles. None of the composite measures had a rate below the national 25th percentile, and one adult composite measure, *Getting Needed Care*, scored at or above the national 75th percentile.

Table 3-6 presents the detailed, statewide 2008 and 2009 CAHPS global ratings. While MHPs conduct the adult CAHPS survey every year, the child CAHPS survey is administered every other year. Therefore, the 2008 child CAHPS results for comparison to prior-year performance reflect data from 2007.

Table 3-6—Detailed State Average Scores for CAHPS Child and Adult Global Ratings					
CAHPS Measure	Top-Box Percentage		Three-Point Mean Score		Performance Level for 2009
	2008	2009	2008	2009	
<b>Child<sup>†</sup></b>					
<i>Rating of All Health Care</i>	61.9%	59.0%	2.50	2.45	★
<i>Rating of Personal Doctor</i>	59.7%	67.5%	2.48	2.55	★★
<i>Rating of Specialist Seen Most Often</i>	60.3%	62.8%	2.47	2.50	★★
<i>Rating of Health Plan</i>	57.9%	61.2%	2.45	2.57	★★
<b>Adult</b>					
<i>Rating of All Health Care</i>	45.9%	47.9%	2.22	2.27	★★
<i>Rating of Personal Doctor</i>	59.0%	60.0%	2.40	2.43	★★
<i>Rating of Specialist Seen Most Often</i>	60.4%	61.5%	2.44	2.48	★★
<i>Rating of Health Plan</i>	52.9%	56.2%	2.33	2.39	★★
The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population. † Child results for 2008 reflect 2007 data.					
★ = Below-average performance (<25th percentile) relative to national Medicaid results. ★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results. ★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.					

Three of the four child CAHPS global ratings showed average performance from a national perspective: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. *Rating of All Health Care* showed below-average performance, which suggests a statewide opportunity for improvement for this measure.

For the adult population, all four top-box percentages increased: *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. All four of the adult global ratings showed average performance from a national perspective.

From a quality perspective, the statewide results for the global ratings showed average performance. Seven of the eight global ratings scored between the 25th and 74th percentiles. One of the global ratings had a rate below the national 25th percentile; however, none of the measures scored at or above the 75th percentile.

## Conclusions/Summary

The review of the MHPs showed both strengths and opportunities for improvement statewide.

Overall, the MHPs demonstrated average performance across the performance measures compared with national Medicaid HEDIS 2008 results. Compared with the 2008 Michigan statewide rates, 32 measures improved over last year's results or remained at the same level of performance. Six measures improved by about 5 percentage points, demonstrating a statewide strength.

The 2008–2009 validation of the PIPs reflected high levels of compliance with the requirements of the CMS PIP protocol. Four of the PIPs validated this year completed all ten activities. HSAG recommended that two of these PIPs be retired and the other two PIPs continue for another year to evaluate whether or not new, specific interventions will impact the study results. Thirteen PIPs received a validation status of *Met* and one PIP was rated *Partially Met*, indicating that the PIPs were designed in a methodologically sound manner, giving confidence that the PIPs produced valid and reliable results.

CAHPS survey results showed average performance across the composite and global rating measures. Only one measure, *Getting Needed Care* for the adult population, showed above-average performance. Only one measure, *Rating of All Health Care* for the child population, fell below the national average range. Strategies to improve the *Rating of All Health Care* could focus on identifying potential barriers for having access to care, eliminating any challenges that members may encounter when receiving health care, or other quality initiatives to improve the overall experience with a health plan.