

*Michigan Department
of Community Health*



**Rick Snyder, Governor
James K. Haveman, Director**

**2011–2012 EXTERNAL QUALITY REVIEW
TECHNICAL REPORT**
for
Medicaid Health Plans

March 2013



3133 East Camelback Road, Suite 300 • Phoenix, AZ 85016
Phone 602.264.6382 • Fax 602.241.0757

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

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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:

- ◆ **Blue Cross Complete of Michigan (BCC)**¹⁻¹
- ◆ **CoventryCares of Michigan, Inc. (COV)**¹⁻²
- ◆ **CareSource Michigan (CSM)**
- ◆ **HealthPlus Partners (HPP)**
- ◆ **McLaren Health Plan (MCL)**
- ◆ **Meridian Health Plan of Michigan (MER)**¹⁻³
- ◆ **Midwest Health Plan (MID)**
- ◆ **Molina Healthcare of Michigan (MOL)**
- ◆ **Physicians Health Plan—FamilyCare (PHP)**
- ◆ **Priority Health Government Programs, Inc. (PRI)**
- ◆ **ProCare Health Plan (PRO)**
- ◆ **Total Health Care, Inc. (THC)**
- ◆ **UnitedHealthcare Community Plan (UNI)**¹⁻⁴
- ◆ **Upper Peninsula Health Plan (UPP)**

¹⁻¹ BlueCaid of Michigan became Blue Cross Complete of Michigan effective April 1, 2012.

¹⁻² OmniCare Health Plan became CoventryCares of Michigan effective June 1, 2012.

¹⁻³ Health Plan of Michigan became Meridian Health Plan of Michigan effective January 1, 2012.

¹⁻⁴ United Healthcare Great Lakes Health Plan became UnitedHealthcare Community Plan effective January 1, 2012.

Scope of External Quality Review (EQR) Activities Conducted

This EQR technical report analyzes and aggregates data from three mandatory EQR activities:

- ◆ **Compliance Monitoring:** MDCH evaluated the MHPs' compliance with federal Medicaid managed care regulations using a compliance review process. HSAG examined, compiled, and analyzed the results as presented in the MHP compliance review 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.

Summary of Findings

The following is a statewide summary of the conclusions drawn regarding the MHPs’ general performance in 2011–2012. Appendices A–N contain detailed, MHP-specific findings, while Section 3 presents detailed statewide findings with year-to-year comparisons.

Compliance Review

MDCH completed its review of the six standards shown in the table below over the course of the 2010–2011 and 2011–2012 annual compliance reviews. Table 1-1 shows the combined results of these two review cycles.

Table 1-1—Summary of Data From the Annual Compliance Reviews			
Standard	Combined Results		
	Range of MHP Scores	Number of MHPs With 100 Percent Compliance	Statewide Average Score
Standard 1: <i>Administrative</i>	75%–100%	10	93%
Standard 2: <i>Provider</i>	85%–100%	12	98%
Standard 3: <i>Member</i>	90%–100%	10	98%
Standard 4: <i>Quality/Utilization</i>	45%–100%	3	91%
Standard 5: <i>MIS/Data Reporting</i>	60%–100%	9	93%
Standard 6: <i>Fraud, Waste, and Abuse</i>	58%–100%	8	95%
Overall Score	69%–100%	1	96%

The statewide average across all standards and all 14 MHPs was 96 percent, reflecting continued strong performance. The *Member* and *Provider* standards showed the highest statewide average scores of 98 percent and had the highest number of MHPs meeting 100 percent of the contractual requirements (12 MHPs for the *Provider* standard, 10 MHPs for the *Member* standard). The *Administrative* standard represented another statewide strength with a statewide score of 93 percent and 10 MHPs demonstrating 100 percent compliance. Results for the *Fraud, Waste, and Abuse* and *MIS/Data Reporting* standards were also strong, with statewide average scores of 95 percent and 93 percent, respectively. The *Quality/Utilization* standard had the lowest statewide average of 91 percent as well as the lowest number of MHPs meeting 100 percent of the contractual requirements (three MHPs). These lower results did not reflect low levels of compliance across all criteria for the standard but were due to 11 of the 14 MHPs failing to demonstrate full compliance with one criterion related to meeting MDCH-specified standards for contractually defined performance measures. Overall, the compliance reviews continued to indicate strengths for the MHPs, with demonstrated compliance with all but a few contractual requirements.

Validation of Performance Measures

Table 1-2 displays the 2012 Michigan Medicaid weighted averages and performance levels. The performance levels are a comparison of the 2012 Michigan Medicaid weighted average and the NCQA national HEDIS 2011 Medicaid percentiles. For most measures, a display of ★★★★★ indicates performance at or above the 90th percentile. Performance levels displayed as ★★★★ represent performance at or above the 75th percentile but below the 90th percentile. A ★★★ performance level indicates performance at or above the 50th percentile but below the 75th percentile. Performance levels displayed as ★★ represent performance at or above the 25th percentile but below the 50th percentile. Finally, performance levels displayed as a ★ indicate that the weighted average performance was below the 25th percentile.

For inverse measures, such as *Comprehensive Diabetes Care—Poor HbA1c Control*, the 25th percentile (rather than the 90th percentile) represents excellent performance and the 90th percentile (rather than the 25th percentile) represents below-average performance. For *Ambulatory Care* measures, since high/low visit counts reported did not take into account the demographic and clinical conditions of an eligible population, performance levels do not necessarily denote better or worse performance.

For the purpose of the Technical Report, no benchmarks for the *Use of Appropriate Medications for People with Asthma (ASM)* are included due to the significant changes to this measure over the years. Most recently, the *ASM* measure increased the upper age limit to 64 years, added new age stratifications, and made exclusions that were formerly optional, required. These changes make benchmarking rates to national standards difficult. While not directly comparable, benchmarks for two indicators of the *ASM* measure (*5 to 11 Years* and *Total*) were presented in the HEDIS Aggregate report at a plan level only for informational purposes.

All 14 of the MHPs demonstrated the ability to calculate and report accurate performance measures specified by the State and were fully compliant with the information system (IS) standards related to the measures required to be reported by MDCH.

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

Performance Measure	2012 MI Medicaid	Performance Level for 2012
Child and Adolescent Care		
<i>Childhood Immunization—Combo 2</i>	79.3%	★★★
<i>Childhood Immunization—Combo 3</i>	75.7%	★★★
<i>Childhood Immunization—Combo 4</i>	35.9%	★★★
<i>Childhood Immunization—Combo 5</i>	54.8%	★★★
<i>Childhood Immunization—Combo 6</i>	36.4%	★★
<i>Childhood Immunization—Combo 7</i>	28.1%	★★
<i>Childhood Immunization—Combo 8</i>	20.5%	★★★
<i>Childhood Immunization—Combo 9</i>	28.9%	★★★
<i>Childhood Immunization—Combo 10</i>	17.1%	★★★
<i>Immunizations for Adolescents—Combo 1</i>	75.1%	★★★★
<i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>	75.3%	★★★★
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	78.6%	★★★★
<i>Adolescent Well-Care Visits</i>	61.7%	★★★★
<i>Lead Screening in Children</i>	78.1%	★★★
<i>Appropriate Treatment for Children With Upper Respiratory Infection (URI)</i>	83.9%	★★
<i>Appropriate Testing for Children With Pharyngitis</i>	61.2%	★
<i>Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase</i>	39.7%	★★★
<i>Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication—Continuation and Maintenance Phase</i>	49.5%	★★★
Women—Adult Care		
<i>Breast Cancer Screening</i>	57.0%	★★★
<i>Cervical Cancer Screening</i>	75.5%	★★★★
<i>Chlamydia Screening in Women—16 to 20 Years</i>	61.7%	★★★★
<i>Chlamydia Screening in Women—21 to 24 Years</i>	69.5%	★★★★
<i>Chlamydia Screening in Women—Total</i>	64.5%	★★★★
★★★★★ = 90th percentile and above ★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile		

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

Performance Measure	2012 MI Medicaid	Performance Level for 2012
Access to Care		
<i>Children’s Access to Primary Care Practitioners—12 to 24 Months</i>	97.1%	★★★★
<i>Children’s Access to Primary Care Practitioners—25 Months to 6 Years</i>	90.3%	★★★★
<i>Children’s Access to Primary Care Practitioners—7 to 11 Years</i>	91.8%	★★★★
<i>Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i>	90.6%	★★★★
<i>Adults’ Access to Preventive/Ambulatory Health Services—20 to 44 Years</i>	83.6%	★★★★
<i>Adults’ Access to Preventive/Ambulatory Health Services—45 to 64 Years</i>	89.7%	★★★★
<i>Adults’ Access to Preventive/Ambulatory Health Services—65+ Years</i>	92.5%	★★★★★
<i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i>	85.5%	★★★★
Obesity		
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, BMI Percentile—Ages 3 to 11 Years</i>	61.8%	★★★★★
<i>Weight Assessment and Counseling, BMI Percentile—Ages 12 to 17 Years</i>	61.4%	★★★★★
<i>Weight Assessment and Counseling, BMI Percentile—Total</i>	61.6%	★★★★★
<i>Weight Assessment and Counseling for Nutrition—Ages 3 to 11 Years</i>	58.6%	★★★★
<i>Weight Assessment and Counseling for Nutrition—Ages 12 to 17 Years</i>	57.1%	★★★★
<i>Weight Assessment and Counseling for Nutrition—Total</i>	58.0%	★★★★
<i>Weight Assessment and Counseling for Physical Activity—Ages 3 to 11 Years</i>	46.0%	★★★★
<i>Weight Assessment and Counseling for Physical Activity—Ages 12 to 17 Years</i>	49.7%	★★★★
<i>Weight Assessment and Counseling for Physical Activity—Total</i>	47.3%	★★★★
<i>Adult BMI Assessment</i>	72.5%	★★★★★
Pregnancy Care		
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	90.3%	★★★★★
<i>Prenatal and Postpartum Care—Postpartum Care</i>	70.3%	★★★★
<i>Weeks of Pregnancy at Time of Enrollment—≤ 0 Weeks</i>	27.9%	NC
<i>Weeks of Pregnancy at Time of Enrollment—1 to 12 Weeks</i>	9.2%	NC
<i>Weeks of Pregnancy at Time of Enrollment—13 to 27 Weeks</i>	40.8%	NC
<i>Weeks of Pregnancy at Time of Enrollment—28 or More Weeks</i>	18.5%	NC
<i>Weeks of Pregnancy at Time of Enrollment—Unknown</i>	3.5%	NC
NC = Not Comparable (i.e., measure not comparable to national HEDIS 2011 Medicaid percentiles or percentiles not available).		
★★★★★ = 90th percentile and above ★★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile		

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

Performance Measure	2012 MI Medicaid	Performance Level for 2012
Pregnancy Care (continued)		
<i>Frequency of Ongoing Prenatal Care—< 21 Percent*</i>	7.1%	☆☆
<i>Frequency of Ongoing Prenatal Care—21 to 40 Percent</i>	6.4%	NC
<i>Frequency of Ongoing Prenatal Care—41 to 60 Percent</i>	5.8%	NC
<i>Frequency of Ongoing Prenatal Care—61 to 80 Percent</i>	10.1%	NC
<i>Frequency of Ongoing Prenatal Care—≥ 81 Percent</i>	70.7%	★★★★
Living With Illness		
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	85.7%	★★★★
<i>Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)*</i>	35.8%	★★★★
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0%)</i>	55.0%	★★★★
<i>Comprehensive Diabetes Care—HbA1c Control (<7.0%)</i>	41.0%	★★★★
<i>Comprehensive Diabetes Care—Eye Exam</i>	56.6%	★★★★
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	80.1%	★★★★
<i>Comprehensive Diabetes Care—LDL-C Control <100mg/dL</i>	42.3%	★★★★
<i>Comprehensive Diabetes Care—Nephropathy</i>	83.0%	★★★★
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/80)</i>	43.7%	★★★★
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90)</i>	66.1%	★★★★
<i>Use of Appropriate Medications for People With Asthma—5 to 11 Years</i>	91.8%	^
<i>Use of Appropriate Medications for People With Asthma—12 to 18 Years</i>	84.9%	^
<i>Use of Appropriate Medications for People With Asthma—19 to 50 Years</i>	74.9%	^
<i>Use of Appropriate Medications for People With Asthma—51 to 64 Years</i>	66.4%	^
<i>Use of Appropriate Medications for People With Asthma—Total</i>	83.8%	^
<i>Controlling High Blood Pressure</i>	63.5%	★★★★
<i>Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers to Quit</i>	79.2%	NC
<i>Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications</i>	50.9%	NC
<i>Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies</i>	43.0%	NC
* For this measure, a lower rate indicates better performance.		
NC = Not Comparable (i.e., measure not comparable to national HEDIS 2011 Medicaid percentiles or percentiles not available).		
^ For HEDIS 2012, the upper age limit for the <i>Appropriate Medications for People With Asthma</i> measure was extended from 50 to 64 and the age band distribution was changed; therefore, HEDIS 2011 Medicaid percentiles for this measure are not presented.		
★★★★★ = 90th percentile and above ★★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile		

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

Performance Measure	2012 MI Medicaid	Performance Level for 2012
Health Plan Diversity		
<i>Race/Ethnicity Diversity of Membership—White</i>	54.7%	NC
<i>Race/Ethnicity Diversity of Membership —Black or African-American</i>	31.1%	NC
<i>Race/Ethnicity Diversity of Membership —American-Indian and Alaska Native</i>	0.2%	NC
<i>Race/Ethnicity Diversity of Membership —Asian</i>	0.6%	NC
<i>Race/Ethnicity Diversity of Membership —Native Hawaiian and Other Pacific Islanders</i>	< 0.1%	NC
<i>Race/Ethnicity Diversity of Membership —Some Other Race</i>	1.3%	NC
<i>Race/Ethnicity Diversity of Membership —Two or More Races</i>	0.0%	NC
<i>Race/Ethnicity Diversity of Membership —Unknown</i>	10.9%	NC
<i>Race/Ethnicity Diversity of Membership —Declined</i>	1.1%	NC
<i>Race/Ethnicity Diversity of Membership —Hispanic[£]</i>	5.4%	NC
<i>Language Diversity of Membership: Spoken Language—English</i>	91.0%	NC
<i>Language Diversity of Membership: Spoken Language—Non-English</i>	1.2%	NC
<i>Language Diversity of Membership: Spoken Language—Unknown</i>	7.8%	NC
<i>Language Diversity of Membership: Spoken Language—Declined</i>	< .0.1%	NC
<i>Language Diversity of Membership: Written Language—English</i>	60.5%	NC
<i>Language Diversity of Membership: Written Language—Non-English</i>	0.4%	NC
<i>Language Diversity of Membership: Written Language—Unknown</i>	39.1%	NC
<i>Language Diversity of Membership: Written Language—Declined</i>	0.0%	NC
<i>Language Diversity of Membership: Other Language Needs—English</i>	54.0%	NC
<i>Language Diversity of Membership: Other Language Needs—Non-English</i>	0.4%	NC
<i>Language Diversity of Membership: Other Language Needs—Unknown</i>	45.6%	NC
<i>Language Diversity of Membership: Other Language Needs—Declined</i>	0.0%	NC

NC = Not Comparable (i.e., measure not comparable to national HEDIS 2011 Medicaid percentiles or percentiles not available).

£ The rate was calculated by HSAG; national benchmarks are not comparable.

- ★★★★★ = 90th percentile and above
- ★★★★ = 75th to 89th percentile
- ★★★ = 50th to 74th percentile
- ★★ = 25th to 49th percentile
- ★ = Below 25th percentile

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

Performance Measure	2012 MI Medicaid	Performance Level for 2012
Utilization		
<i>Ambulatory Care—Total (Visits per 1,000 Member Months): Outpatient—Total</i>	323.5	★★
<i>Ambulatory Care—Total (Visits per 1,000 Member Months): ED—Total*</i>	72.6	★★★★
<i>Inpatient Utilization—General Hospital/Acute Care: Total (Visits per 1,000 Member Months): Total Inpatient—Total</i>	7.9	NC
<i>Inpatient Utilization—General Hospital/Acute Care: Discharges, Medicine—Total</i>	3.7	NC
<i>Inpatient Utilization—General Hospital/Acute Care: Discharges, Surgery—Total</i>	1.2	NC
<i>Inpatient Utilization—General Hospital/Acute Care: Discharges, Maternity—Total</i>	4.9	NC
<i>Inpatient Utilization—General Hospital/Acute Care: Total (Average Length of Stay), Total Inpatient—Total</i>	3.8	NC
<i>Inpatient Utilization—General Hospital/Acute Care: Total (Average Length of Stay), Medicine—Total</i>	3.9	NC
<i>Inpatient Utilization—General Hospital/Acute Care: Total (Average Length of Stay), Surgery—Total</i>	5.8	NC
<i>Inpatient Utilization—General Hospital/Acute Care: Total (Average Length of Stay), Maternity—Total</i>	2.6	NC
* For this measure, a lower rate indicates better performance.		
NC = Not Comparable (i.e., measure not comparable to national HEDIS 2011 Medicaid percentiles or percentiles not available).		
★★★★★ = 90th percentile and above ★★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile		

Of the 58 performance measures that had national results available and appropriate for comparison, two measures, *Adult BMI Assessment* and *Adults’ Access to Preventive/Ambulatory Health Services—65+ Years*, performed at or above the 90th percentile, while 17 measures (29.3 percent) showed statewide performance that fell between the 75th and 89th national HEDIS percentile. Thirty-three measures (56.9 percent) performed at or above the 50th percentile, but below the 75th percentile. A total of six measures (10.3 percent) performed below the national HEDIS 2011 Medicaid 50th percentile, which included one measure (*Appropriate Testing for Children With Pharyngitis*) performing below the 25th percentile.

Performance Improvement Projects (PIPs)

For the 2011–2012 validation cycle, the MHPs continued with the MDCH-mandated PIP topic, *Childhood Obesity*, which focused on the *Weight Assessment and Counseling for Nutrition and Physical Activity* HEDIS measure. All 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>	14
<i>Partially Met</i>	0
<i>Not Met</i>	0

Table 1-4 presents a summary of the statewide 2011–2012 results for the activities of the protocol for validating PIPs. HSAG validated all 14 PIPs for Activities I through IX. Six of the 14 PIPs demonstrated compliance with all evaluation elements, including critical elements, for the activities that were validated. The MHPs demonstrated strong performance related to the quality of their studies and a thorough application of the requirements for Activities I through IX of the CMS protocol for conducting PIPs.

Review Activities		Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	Number of PIPs Meeting All Critical Elements/ Number Reviewed
I.	Select the Study Topic(s)	14/14	14/14
II.	Define the Study Question(s)	14/14	14/14
III.	Select the Study Indicator(s)	14/14	14/14
IV.	Use a Representative and Generalizable Study Population	14/14	14/14
V.	Use Sound Sampling Techniques*	14/14	14/14
VI.	Use Valid and Reliable Data Collection Procedures	14/14	14/14
VII.	Data Analysis and Interpretation of Results	11/14	14/14
VIII.	Improvement Strategies (Interventions for Improvement as a Result of Analysis)	12/14	14/14
IX.	Assess for Real Improvement	8/14	No Critical Elements
X.	Assess for Sustained Improvement	0/0	No Critical Elements

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

The MHPs implemented interventions at the member-, provider-, and system-levels to address barriers to increasing rates for BMI percentile documentation for members 3–17 years of age. Several MHPs also targeted counseling for nutrition and counseling for physical activity as additional study indicators for this PIP on *Childhood Obesity*. Almost all MHPs demonstrated

improvement in their study indicators as a result of the planned interventions; however, only about half of them were able to achieve statistically significant—i.e., real—improvement. The MHPs should continue to evaluate the efficacy of their interventions and, as applicable, revise or implement new, targeted interventions to achieve the desired outcomes.

Quality, Timeliness, and Access

The annual compliance review of the MHPs showed strong performance across the domains of **quality, timeliness, and access**. The areas with the highest level of compliance—the *Provider* and *Member* standards—addressed the **quality** and **timeliness** of, as well as **access** to, services provided to beneficiaries. Opportunities for improvement identified in the compliance reviews addressed primarily the **quality** and **access** domains.

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

Fifty-six of the 104 performance indicators were compared with the available national Medicaid HEDIS percentiles. Overall, results of validated performance measures were average across the **quality, timeliness, and access** domains.

Table 1-5 shows HSAG’s assignment of the compliance review standards, performance measures, and PIPs into the domains of **quality**, **timeliness**, and **access**.

Table 1-5—Assignment of Activities to Performance Domains			
Compliance Review Standards	Quality	Timeliness	Access
Standard 1. <i>Administrative</i>	✓		
Standard 2. <i>Provider</i>	✓	✓	✓
Standard 3. <i>Member</i>	✓	✓	✓
Standard 4. <i>Quality/Utilization</i>	✓		✓
Standard 5. <i>MIS/Data Reporting</i>	✓	✓	
Standard 6. <i>Fraud, Waste, and Abuse</i>	✓	✓	✓
Performance Measures ¹⁻⁵	Quality	Timeliness	Access
<i>Childhood Immunization Status</i>	✓	✓	
<i>Immunizations for Adolescents</i>	✓	✓	
<i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>	✓		
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	✓		
<i>Adolescent Well-Care Visits</i>	✓		
<i>Lead Screening in Children</i>	✓	✓	
<i>Appropriate Treatment for Children With Upper Respiratory Infection (URI)</i>	✓		
<i>Appropriate Testing for Children With Pharyngitis</i>	✓		
<i>Follow-Up Care for Children Prescribed ADHD Medications</i>	✓	✓	✓
<i>Breast Cancer Screening</i>	✓		
<i>Cervical Cancer Screening</i>	✓		
<i>Chlamydia Screening in Women</i>	✓		
<i>Children’s and Adolescents’ Access to Primary Care Practitioners</i>			✓
<i>Adults’ Access to Preventive/Ambulatory Health Services</i>			✓
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i>	✓		
<i>Adult BMI Assessment</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 and Tobacco Use Cessation</i>	✓		
<i>Ambulatory Care</i>			✓
PIPs	Quality	Timeliness	Access
One PIP for each MHP, Childhood Obesity Topic	✓		

¹⁻⁵ *Race/Ethnicity Diversity of Membership, Language Diversity of Membership, Weeks of Pregnancy at Time of Enrollment, Frequency of Ongoing Prenatal Care, and Inpatient Utilization* were not included in Table 1-5 since they cannot be categorized into either domain. Please see Section 2 of this report for additional information.

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 compliance 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. This technical report presents the combined results of the 2010–2011 and 2011–2012 compliance reviews. Over the course of these two review cycles, MDCH completed a review of all criteria in the six standards listed below:

1. *Administrative* (2 criteria)
2. *Provider* (13 criteria)
3. *Member* (11 criteria)
4. *Quality/Utilization* (10 criteria)
5. *MIS/Data Reporting* (5 criteria)
6. *Fraud, Waste, and Abuse* (14 criteria)

In addition to assessing the MHPs' compliance with a subset of the criteria—including some that had been designated as mandatory for review in every review cycle—MDCH also evaluated compliance with any criteria that had received a score of less than *Met* during the previous review.

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 quality assessment and performance improvement (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, waste, and abuse logs; fraud, waste, 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 2011–2012 compliance reviews, MDCH continued to use its automated tool in an Access database application. Prior to the scheduled compliance review, 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 compliance review, MDCH completed the section for State findings and assigned a score for each criterion. The tool was also used for the MHP to describe, after the compliance review, any required corrective action plan and to document MDCH's action plan assessment. MDCH summarized each of the MHPs' focus studies in a focus study report.

Data Aggregation, Analysis, and How Conclusions Were Drawn

MDCH reviewers used the compliance review 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).
- ◆ *Not Applicable (N/A)*—The requirement was not applicable to the MHP

HSAG calculated a total compliance score for each standard, reflecting the degree of compliance with contractual requirements related to that area, and an overall score for each MHP across all six standards. The total compliance scores were obtained by adding the weighted number of criteria that received a score of *Pass* (value: 1 point) to the weighted number of criteria that received a score of *Incomplete* (0.5 points), *Fail* (0 points), or *N/A* (0 points), then dividing this total by the total number of applicable criteria reviewed. The number of criteria scored *Pass* included scores from the 2010–2011 compliance reviews for criteria not addressed in 2011–2012, as well as all scores from the 2011–2012 compliance reviews. Statewide averages were calculated by summing the individual MHP scores, then dividing that sum by the total number of applicable criteria reviewed across all MHPs.

Some sections of this report present comparisons to prior-year performance. Results of the 2010–2011 and 2011–2012 compliance reviews are not comparable since each of the two review cycles addressed a different set of requirements. Therefore, the comparisons evaluate the combined 2010–2011 and 2011–2012 results against the combined results of the 2008–2009 and 2009–2010 compliance reviews, as these represent the most recent complete set of scores available.

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 1-5 (page 1-12) 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 2012 *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.

Each HEDIS Compliance Audit, conducted by a licensed audit organization, 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 one to two day(s), 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 teams 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 teams 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) 2011 (HEDIS 2012)
Performance measure reports, submitted by the MHPs using NCQA’s Interactive Data Submission System (IDSS), were analyzed and subsequently validated by the HSAG validation team.	CY 2011 (HEDIS 2012)
Previous performance measure reports were reviewed to assess trending patterns and the reasonability of rates.	CY 2010 (HEDIS 2011)

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.

While national benchmarks were available for the following measures, they were not included in the report, as it was not appropriate to use them for benchmarking the MHPs' performance: *Frequency of Ongoing Prenatal Care* (for the 21–40 percent, 41–60 percent, and 61–80 percent indicators), *Race/Ethnicity Diversity of Membership*, *Language Diversity of Membership*, and *Inpatient Utilization*. The *Diversity* indicators are demographic descriptors only and do not reflect health plan performance. For *Frequency of Ongoing Prenatal Care*, benchmarking is appropriate only for the highest and lowest categories (≥ 81 Percent and <21 Percent), which denote better or worse performance. The *Inpatient Utilization* measures without the context of the MHP's population characteristics are not reflective of the quality of the health plan's performance. HEDIS benchmarks were not available for the *Medical Assistance With Smoking and Tobacco Use Cessation* and *Weeks of Pregnancy at Time of Enrollment* measures.

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, measures were categorized to evaluate one or more of the three domains. Table 1-5 (page 1-12) shows HSAG's assignment of performance measures to these domains of performance.

Several measures do not fit into these domains since they are collected and reported as health plan descriptive measures or because the measure results cannot be tied to any of the domains. These measures include: *Race/Ethnicity Diversity of Membership*, *Language Diversity of Membership*, *Weeks of Pregnancy at Time of Enrollment*, *Frequency of Ongoing Prenatal Care*, and *Inpatient Utilization*. The first three measures are considered health plan descriptive measures. These measures do not have associated benchmarks and performance cannot be directly impacted by improvement efforts. The other two measures do not fit into the domains due to the inability to directly correlate performance to **quality**, **timeliness**, or **access** to care. For these reasons, these measures were not included in Table 1-5.

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. For the 2011–2012 validation cycle, the MHPs provided their second-year submissions of the State-mandated PIP topic, *Childhood Obesity*.

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 PIPs was based on guidelines 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.

HSAG, with MDCH's input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS protocols. The CMS protocols identify ten activities that should be validated for each PIP, although in some cases the PIP may not have progressed to the point at which all of the activities can be validated.

These activities are:

- ◆ Activity I. Select the Study Topic(s)
- ◆ Activity II. Define the Study Question(s)
- ◆ Activity III. Select the Study Indicator(s)
- ◆ Activity IV. Use a Representative and Generalizable Study Population
- ◆ Activity V. Use Sound Sampling Techniques
- ◆ Activity VI. Reliably Collect Data
- ◆ Activity VII. Analyze Data and Interpret Study Results
- ◆ Activity VIII. Implement Intervention and Improvement Strategies
- ◆ Activity IX. Assess for Real Improvement
- ◆ Activity 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 activities reviewed and evaluated for the 2011–2012 validation cycle.

Data Aggregation, Analysis, and How Conclusions Were Drawn

HSAG used the following methodology to evaluate PIPs conducted by the MHPs to determine if a PIP is valid and to rate the percentage of compliance with CMS' protocol for conducting PIPs.

Each PIP activity consisted of critical and noncritical evaluation elements necessary for successful completion of a valid PIP. Each evaluation element was scored as *Met (M)*, *Partially Met (PM)*, *Not Met (NM)*, *Not Applicable (NA)*, or *Not Assessed*.

The percentage score for all evaluation elements was calculated by dividing the number of elements (including critical elements) *Met* by the sum of evaluation elements *Met*, *Partially Met*, and *Not Met*. The percentage score for critical elements *Met* was calculated by dividing the number of critical elements *Met* by the sum of critical elements *Met*, *Partially Met*, and *Not Met*. The scoring methodology also included the *Not Applicable* designation for situations in which the evaluation element did not apply to the PIP. For example, in Activity V, if the PIP did not use sampling techniques, HSAG would score the evaluation elements in Activity V as *Not Applicable*. HSAG used the *Not Assessed* scoring designation when the PIP had not progressed to the remaining activities in the CMS protocol. HSAG used a *Point of Clarification* when documentation for an evaluation element included the basic components to meet requirements for the evaluation element (as described in the narrative of the PIP), but enhanced documentation would demonstrate a stronger understanding of CMS protocols.

The validation status score was based on the percentage score and whether or not critical elements were *Met*, *Partially Met*, or *Not Met*. Due to the importance of critical elements, any critical element scored as *Not Met* would invalidate a PIP. Critical elements that were *Partially Met* and noncritical

elements that were *Partially Met* or *Not Met* would not invalidate the PIP, but they would affect the overall percentage score (which indicates the percentage of the PIP's compliance with CMS' protocol for conducting PIPs).

HSAG assessed the implications of the study's findings on the likely validity and reliability of the results as follows:

- ◆ *Met*: Confidence/high confidence in the reported PIP results.
- ◆ *Partially Met*: Low confidence in the reported PIP results.
- ◆ *Not Met*: Reported PIP results that were not credible.

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. Five of the 14 MHPs requested and received technical assistance from HSAG. HSAG conducted conference calls or responded to e-mails to answer questions regarding the plans' PIPs or to discuss areas of deficiency. HSAG encouraged the MHPs to use the PIP Summary Form Completion Instructions as they completed their PIPs. These instructions outlined each evaluation element 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.

The EQR activities related to PIPs were designed to evaluate the validity and reliability of the MHP's processes in conducting the PIPs and to draw conclusions about the MHP's performance in the domains of quality, timeliness, and access to care and services. The *Childhood Obesity* PIP addressed CMS' requirements related to quality outcomes—specifically, quality of care and services. The goal of the PIPs was to improve the quality of care and services by increasing the rate of body mass index (BMI) documentation for members 3–17 years of age, increasing the percentage of members 3–17 years of age referred for nutritional counseling, and/or increasing the percentage of members 3–17 years of age referred for physical activity; therefore, HSAG assigned the PIPs to the **quality** domain, as shown in Table 1-5.

The following section presents findings from the annual compliance reviews and the EQR activities of validation of performance measures and validation of PIPs for the two reporting periods of 2010–2011 and 2011–2012. Appendices A–N present additional details about the plan-specific results of the activities.

Annual Compliance Review

MDCH conducted annual compliance reviews of the MHPs, assessing the MHPs’ compliance with contractual requirements on six standards: *Administrative*; *Provider*; *Member*; *Quality/Utilization*; *MIS/Data Reporting*; and *Fraud, Waste, and Abuse*. MDCH completed the current review of all standards over the course of the 2010–2011 and 2011–2012 compliance review cycles. Therefore, this section presents a comparison of the combined 2010–2012 results with the results of the combined 2008–2010 reviews as these represent the most recent complete set of scores available. In addition to the range of compliance scores and the statewide averages for each of the six standards and overall, Table 3-1 presents the number of corrective actions required and the number and percentage of MHPs that achieved 100 percent compliance for each standard, including a total across all standards.

**Table 3-1—Comparison of Results From the Compliance Reviews:
Previous Results for 2008–2010 (P) and Current Results for 2010–2012 (C)**

		Compliance Scores				Number of Corrective Actions Required		MHPs in Full Compliance (Number/Percent)	
		Range		Statewide Average					
		P	C	P	C	P	C	P	C
1	<i>Administrative</i>	75%–100%	75%–100%	98%	93%	1	4	13/93%	10/71%
2	<i>Provider</i>	94%–100%	85%–100%	97%	98%	11	4	7/50%	12/86%
3	<i>Member</i>	95%–100%	90%–100%	99%	98%	2	4	12/86%	10/71%
4	<i>Quality/Utilization</i>	95%–100%	45%–100%	97%	91%	10	18	4/29%	3/21%
5	<i>MIS/Data Reporting</i>	80%–100%	60%–100%	91%	93%	13	7	3/21%	9/64%
6	<i>Fraud, Waste, and Abuse</i>	46%–100%	58%–100%	91%	95%	30	14	1/7%	8/57%
Overall Score/Total		86%–98%	69%–100%	95%	96%	67	51	40/48%	52/62%

Overall, the MHPs demonstrated continued strong performance related to their compliance with contractual requirements assessed in the compliance reviews. The current compliance review cycle resulted in a higher statewide overall compliance score and fewer recommendations for corrective actions. Across all standards, MHPs with a compliance score of 100 percent increased from fewer than half of the plans in the previous cycles to about two-thirds in the combined 2010–2011 and 2011–2012 cycles.

The statewide score across all standards and MHPs increased from 95 percent in 2010–2011 to 96 percent for the current review cycle. One MHP achieved an overall score of 100 percent. Statewide,

seven of the 14 MHPs had an increase in their overall scores, four overall scores decreased, and three MHPs had no change in the overall score. The range of scores across the MHPs for the *Administrative* standard remained unchanged. For the remaining standards, the low end of the range decreased, while the high score for all standards remained at 100 percent.

The *Provider* and *Member* standards continued to represent statewide strengths, with an average score of 98 percent. For the *Provider* standard, the number of MHPs in full compliance with all requirements increased from seven to 12, while the statewide score had a slight decline. The statewide average score for the *Member* standard also decreased by one percentage point. For 12 of the 14 MHPs, there was no change in their compliance score for this standard.

Performance on the *Administrative* standard decreased slightly, with a statewide average score of 93 percent (98 percent was the previous score), and four MHPs had lower scores on this standard for the current review cycle.

The *Fraud, Waste, and Abuse* standard showed the largest number of MHPs with an improved compliance score. Statewide, eight MHPs increased their scores, while two MHPs had a decrease and four MHPs maintained their previous score. The statewide average for this standard improved more than any of the other standards, from 91 percent to 95 percent. The number of MHPs that achieved full compliance on this standard increased from one to eight. While there were no areas of statewide low performance, the most frequent recommendations addressed requirements for the compliance officer and committee (for four plans) and the use of data sources to detect fraud, waste, and abuse by providers (three plans).

The *MIS/Data Reporting* standard showed improvement in the statewide score from 91 percent to 93 percent for the current review cycle, and had more MHPs with 100 percent compliance in this area (three of 14 MHPs in the previous review cycles, and nine for the current review cycles). Statewide, most of the corrective actions continued to address the timeliness of report submissions (four MHPs) and the claims payment process (two MHPs).

The statewide average for the *Quality/Utilization* standard decreased from 97 percent to 91 percent, and six of the MHPs had a lower score for this standard. One MHP increased its score, and seven MHPs saw no change in their score for this standard. The number of MHPs that achieved 100 percent compliance on this standard remained the lowest among all standards (three MHPs). The criterion for which most MHPs failed to demonstrate full compliance addressed performance monitoring measures, with 11 of the 14 MHPs receiving a score of *Incomplete* for this criterion. Compliance with MDCH-specified minimum performance standards remains the only statewide opportunity for improvement.

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 suggested that the information systems for reporting HEDIS measures were a statewide strength.

Table 3-2 displays the 2012 Michigan Medicaid weighted averages and performance levels. The performance levels are a comparison of the 2012 Michigan Medicaid weighted average and the NCQA national HEDIS 2011 Medicaid percentiles. For most measures, a display of ★★★★★ indicates performance at or above the 90th percentile. Performance levels displayed as ★★★★ represent performance at or above the 75th percentile but below the 90th percentile. A ★★★ performance level indicates performance at or above the 50th percentile but below the 75th percentile. Performance levels displayed as ★★ represent performance at or above the 25th percentile but below the 50th percentile. Finally, performance levels displayed as a ★ indicate that the weighted average performance was below the 25th percentile.

For inverse measures, such as *Comprehensive Diabetes Care—Poor HbA1c Control*, the 25th percentile (rather than the 90th percentile) represents excellent performance and the 90th percentile (rather than the 25th percentile) represents below-average performance.

For *Ambulatory Care* measures, since high/low visit counts reported did not take into account the demographic and clinical conditions of an eligible population, performance levels do not necessarily denote better or worse performance.

Table 3-2—Overall Statewide Weighted Averages for Performance Measures

Performance Measure	2011 MI Medicaid	2012 MI Medicaid	Performance Level for 2012	2011–2012 Comparison
Child and Adolescent Care				
<i>Childhood Immunization—Combo 2</i>	78.2%	79.3%	★★★	+1.1
<i>Childhood Immunization—Combo 3</i>	74.3%	75.7%	★★★	+1.4
<i>Childhood Immunization—Combo 4</i>	30.9%	35.9%	★★★	+5.0
<i>Childhood Immunization—Combo 5</i>	46.8%	54.8%	★★★	+8.0
<i>Childhood Immunization—Combo 6</i>	33.2%	36.4%	★★	+3.2
<i>Childhood Immunization—Combo 7</i>	21.6%	28.1%	★★	+6.5
<i>Childhood Immunization—Combo 8</i>	16.8%	20.5%	★★★	+3.7
<i>Childhood Immunization—Combo 9</i>	23.6%	28.9%	★★★	+5.3
<i>Childhood Immunization—Combo 10</i>	12.6%	17.1%	★★★	+4.5
<i>Immunizations for Adolescents—Combo 1</i>	52.9%	75.1%	★★★★	+22.2
<i>Well-Child Visits, First 15 Months—6 or More Visits</i>	72.3%	75.3%	★★★★	+3.0
<i>Well-Child Visits, Third Through Sixth Years of Life</i>	78.0%	78.6%	★★★★	+0.6
<i>Adolescent Well-Care Visits</i>	58.8%	61.7%	★★★★	+2.9
<i>Lead Screening in Children</i>	78.0%	78.1%	★★★	+0.1
<i>Appropriate Treatment for Children With URI</i>	84.9%	83.9%	★★	-1.0
<i>Appropriate Testing for Children With Pharyngitis</i>	54.9%	61.2%	★	+6.3
<i>Follow-Up Care for Children Prescribed ADHD Meds—Initiation Phase</i>	36.7%	39.7%	★★★	+3.0
<i>Follow-Up Care for Children Prescribed ADHD Meds—Continuation and Maintenance Phase</i>	41.9%	49.5%	★★★	+7.6
Women—Adult Care				
<i>Breast Cancer Screening</i>	56.3%	57.0%	★★★	+0.7
<i>Cervical Cancer Screening</i>	74.3%	75.5%	★★★★	+1.2
<i>Chlamydia Screening in Women—16 to 20 Years</i>	60.7%	61.7%	★★★★	+1.0
<i>Chlamydia Screening in Women—21 to 24 Years</i>	68.4%	69.5%	★★★★	+1.1
<i>Chlamydia Screening in Women—Total</i>	63.5%	64.5%	★★★★	+1.0
2011–2012 comparison 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.				
★★★★★ = 90th percentile and above ★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile				

Table 3-2—Overall Statewide Weighted Averages for Performance Measures

Performance Measure	2011 MI Medicaid	2012 MI Medicaid	Performance Level for 2012	2011–2012 Comparison
Access to Care				
<i>Children’s Access to Primary Care Practitioners—12 to 24 Months</i>	96.7%	97.1%	★★★	+0.4
<i>Children’s Access to Primary Care Practitioners—25 Months to 6 Years</i>	89.8%	90.3%	★★★	+0.5
<i>Children’s Access to Primary Care Practitioners—7 to 11 Years</i>	91.1%	91.8%	★★★	+0.7
<i>Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i>	89.5%	90.6%	★★★	+1.1
<i>Adults’ Access to Preventive/Ambulatory Health Services—20 to 44 Years</i>	83.2%	83.6%	★★★	+0.4
<i>Adults’ Access to Preventive/Ambulatory Health Services—45 to 64 Years</i>	89.1%	89.7%	★★★	+0.6
<i>Adults’ Access to Preventive/Ambulatory Health Services—65+ Years</i>	89.1%	92.5%	★★★★★	+3.4
<i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i>	85.0%	85.5%	★★★	+0.5
Obesity				
<i>Children/Adolescents—BMI Assessment—Total</i>	46.6%	61.6%	★★★★	+15.0
<i>Children/Adolescents—Counseling for Nutrition—Total</i>	54.0%	58.0%	★★★	+4.0
<i>Children/Adolescents—Counseling for Physical Activity—Total</i>	44.9%	47.3%	★★★	+2.4
<i>Adult BMI Assessment</i>	63.0%	72.5%	★★★★★	+9.5
Pregnancy Care				
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	88.4%	90.3%	★★★★	+1.9
<i>Prenatal and Postpartum Care—Postpartum Care</i>	70.7%	70.3%	★★★	-0.4
Living With Illness				
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	85.0%	85.7%	★★★	+0.7
<i>Comprehensive Diabetes Care—Poor HbA1c Control*</i>	36.4%	35.8%	★★★★	-0.6
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0%)</i>	53.7%	55.0%	★★★★	+1.3
<i>Comprehensive Diabetes Care—HbA1c Control (<7.0%)</i>	42.9%	41.0%	★★★	-1.9
<i>Comprehensive Diabetes Care—Eye Exam</i>	59.0%	56.6%	★★★	-2.4
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	80.8%	80.1%	★★★	-0.7
<i>Comprehensive Diabetes Care—LDL-C Control <100mg/dL</i>	41.1%	42.3%	★★★★	+1.2
<i>Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy</i>	82.8%	83.0%	★★★★	+0.2
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/80 mm Hg)</i>	40.8%	43.7%	★★★	+2.9
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	63.7%	66.1%	★★★	+2.4
* For this measure, a lower rate indicates better performance.				
2011–2012 comparison 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.				
★★★★★	=	90th percentile and above		
★★★★	=	75th to 89th percentile		
★★★	=	50th to 74th percentile		
★★	=	25th to 49th percentile		
★	=	Below 25th percentile		

Table 3-2—Overall Statewide Weighted Averages for Performance Measures

Performance Measure	2011 MI Medicaid	2012 MI Medicaid	Performance Level for 2012	2011–2012 Comparison
Living With Illness (continued)				
<i>Use of Appropriate Medications for People With Asthma—5 to 11 Years</i>	91.4%	£	^	£
<i>Use of Appropriate Medications for People With Asthma—12 to 50 Years</i>	85.2%	£	^	£
<i>Use of Appropriate Medications for People With Asthma—Combined Rate</i>	87.4%	£	^	£
<i>Controlling High Blood Pressure</i>	61.5%	63.5%	★★★★	+2.0
<i>Smoking and Tobacco Use Cessation—Advising Smokers to Quit</i>	78.2%	79.2%	NC	+1.0
<i>Smoking and Tobacco Use Cessation—Discussing Cessation Medications</i>	48.8%	50.9%	NC	+2.1
<i>Smoking and Tobacco Use Cessation—Discussing Cessation Strategies</i>	41.3%	43.0%	NC	+1.7
Utilization				
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months</i>	316.9	323.5	★★	+6.6
<i>Ambulatory Care—ED Visits per 1,000 Member Months*</i>	69.6	72.6	★★★★	+3.0
* For this measure, a lower rate indicates better performance.				
£ Rates were not presented due to changes to the measure specifications and age bands for the measure. Not comparable to the HEDIS 2011 rates.				
^ For HEDIS 2012, the upper age limit for the <i>Appropriate Medications for People With Asthma</i> measure was extended from 50 to 64 and the age band distribution was changed; therefore, HEDIS 2011 Medicaid percentiles for this measure are not presented.				
NC = Not Comparable (i.e., measure not comparable to national HEDIS 2011 Medicaid percentiles or percentiles not available).				
★★★★★	=	90th percentile and above		
★★★★	=	75th to 89th percentile		
★★★	=	50th to 74th percentile		
★★	=	25th to 49th percentile		
★	=	Below 25th percentile		

The HEDIS 2012, average rates for 48 of the 53 measures that could be compared to prior-year performance showed an increase, with 25 of these increases reaching statistical significance. Rates for five measures declined from the 2011 results. Increases in rates ranged from less than 1 percentage point to over 22 percentage points, while most decreases were less than 2.4 percentage points.

The Child and Adolescent Care dimension showed more improvement than the other dimensions, with all but one of the 18 measures showing an increase in the rate and 14 measures noting statistically significant increases from the prior year. The *Immunizations for Adolescents—Combo 1* measure improved the most in this dimension, showing a 22.2 percentage point increase from the prior year. Measures in the Living With Illness dimension showed small increases in almost all measures, but none of the measures had statistically significant improvement. The measure with the second largest improvement was found within the Obesity dimension, where the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Total* measure improved by 15.0 percentage points from the prior year.

One measure, *Appropriate Treatment for Children With Upper Respiratory Infection*, showed a statistically significant decrease compared to 2011. The Living With Illness dimension had the most measures with decreases in performance, including the *Comprehensive Diabetes Care* measures for *HbA1c Control <7.0*, *Eye Exam*, and *LDL-C Screening*. The declines ranged from 0.7 to 2.4 percentage points. None of the declines were statistically significant.

Table 3-3 presents by measure the number of MHPs that performed at each performance level. The counts include only measures with a valid, reportable rate that could be benchmarked to national standards. This excludes any measure reported as an *NA* or *NR* since these cannot be benchmarked.

Table 3-3—Overall Statewide Weighted Averages for Performance Measures

Performance Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Child and Adolescent Care					
<i>Childhood Immunization—Combo 2</i>	1	1	6	5	1
<i>Childhood Immunization—Combo 3</i>	1	2	5	2	4
<i>Childhood Immunization—Combo 4</i>	3	1	5	2	3
<i>Childhood Immunization—Combo 5</i>	1	1	5	5	2
<i>Childhood Immunization—Combo 6</i>	4	3	4	1	2
<i>Childhood Immunization—Combo 7</i>	1	5	2	3	3
<i>Childhood Immunization—Combo 8</i>	4	3	2	2	3
<i>Childhood Immunization—Combo 9</i>	4	3	3	1	3
<i>Childhood Immunization—Combo 10</i>	4	3	3	1	3
<i>Immunizations for Adolescents—Combo 1</i>	0	0	0	7	6
<i>Well-Child Visits, First 15 Months—6 or More Visits</i>	1	2	1	5	4
<i>Well-Child Visits, Third Through Sixth Years of Life</i>	3	1	2	6	2
<i>Adolescent Well-Care Visits</i>	1	1	3	5	4
<i>Lead Screening in Children</i>	0	3	7	3	1
<i>Appropriate Treatment for Children With URI</i>	5	6	1	2	0
<i>Appropriate Testing for Children With Pharyngitis</i>	4	5	3	0	1
<i>Follow-Up Care for Children Prescribed ADHD Meds—Initiation Phase</i>	1	4	6	2	0
<i>Follow-Up Care for Children Prescribed ADHD Meds—Continuation and Maintenance Phase</i>	1	1	7	2	0
Women—Adult Care					
<i>Breast Cancer Screening</i>	1	2	3	7	0
<i>Cervical Cancer Screening</i>	1	2	4	5	2
<i>Chlamydia Screening in Women—16 to 20 Years</i>	1	1	4	4	3
<i>Chlamydia Screening in Women—21 to 24 Years</i>	1	0	5	4	3
<i>Chlamydia Screening in Women—Total</i>	1	1	5	4	3
★★★★★★ = 90th percentile and above ★★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile					

Table 3-3—Overall Statewide Weighted Averages for Performance Measures

Performance Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Access to Care					
<i>Children’s Access—12 to 24 Months</i>	4	2	5	2	1
<i>Children’s Access—25 Months to 6 Years</i>	4	3	3	3	1
<i>Children’s Access—7 to 11 Years</i>	2	4	3	4	0
<i>Adolescents’ Access—12 to 19 Years</i>	2	3	2	5	1
<i>Adults’ Access—20 to 44 Years</i>	3	3	6	1	1
<i>Adults’ Access—45 to 64 Years</i>	2	3	4	2	3
<i>Adults’ Access—65+ Years</i>	0	0	3	1	7
<i>Adults’ Access—Total</i>	3	3	6	1	1
Obesity					
<i>Children/Adolescents—BMI Percentile, 3 to 11 years</i>	0	1	5	6	2
<i>Children/Adolescents—BMI Percentile, 12 to 17 years</i>	0	1	4	5	4
<i>Children/Adolescents—BMI Percentile, Total</i>	0	1	5	4	4
<i>Children/Adolescents—Nutrition, 3 to 11 years</i>	0	2	6	5	1
<i>Children/Adolescents—Nutrition, 12 to 17 years</i>	0	2	6	5	1
<i>Children/Adolescents—Nutrition, Total</i>	0	2	6	5	1
<i>Children/Adolescents—Physical Activity, 3 to 11 years</i>	1	1	5	4	3
<i>Children/Adolescents—Physical Activity, 12 to 17 years</i>	1	3	5	3	2
<i>Children/Adolescents—Physical Activity, Total</i>	1	1	5	6	1
<i>Adult BMI Assessment</i>	0	0	1	4	8
Pregnancy Care					
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	1	1	3	4	4
<i>Prenatal and Postpartum Care—Postpartum Care</i>	1	1	2	7	2
<i>Frequency of Ongoing Prenatal Care—< 21 Percent*</i>	1	4	5	1	1
<i>Frequency of Ongoing Prenatal Care—≥ 81 Percent</i>	3	2	4	1	2
Living With Illness					
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	1	3	5	2	3
<i>Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)</i>	1	2	5	5	1
<i>Comprehensive Diabetes Care—HbA1c Control (<8.0%)</i>	1	0	7	4	2
<i>Comprehensive Diabetes Care—HbA1c Control (<7.0%)</i>	1	2	6	3	1
* For this measure, a lower rate indicates better performance.					
★★★★★ = 90th percentile and above ★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile					

Table 3-3—Overall Statewide Weighted Averages for Performance Measures

Performance Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Living With Illness (continued)					
<i>Comprehensive Diabetes Care—Eye Exam</i>	1	3	6	3	1
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	2	1	4	5	2
<i>Comprehensive Diabetes Care—LDL-C Control <100mg/dL</i>	1	1	6	4	2
<i>Comprehensive Diabetes Care—Nephropathy</i>	1	2	4	1	6
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/80)</i>	1	3	4	5	1
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90)</i>	2	1	7	3	1
<i>Controlling High Blood Pressure</i>	2	1	5	2	4
Utilization					
<i>Ambulatory Care—Total (Visits per 1,000 Member Months): Outpatient—Total</i>	4	6	4	0	0
<i>Ambulatory Care—Total (Visits per 1,000 Member Months): ED—Total</i>	10	4	0	0	0
Total	101	123	243	194	128
★★★★★★ = 90th percentile and above ★★★★★ = 75th to 89th percentile ★★★ = 50th to 74th percentile ★★ = 25th to 49th percentile ★ = Below 25th percentile					

Table 3-3 shows that 30.8 percent of all performance measure rates (243 of 789) fell into the average (★★★) range relative to national Medicaid results. While 16.2 percent of all performance measure rates ranked in the 90th percentile and above (★★★★★), 28.4 percent of all performance measure rates fell below the national Medicaid HEDIS 2011 50th percentile, providing opportunities for improvement.

Performance Improvement Projects (PIPs)

Table 3-4 presents a summary of the MHPs’ PIP validation status results. All PIPs submitted for the 2011–2012 validation continued with the State-mandated topic, *Childhood Obesity*. For the 2011–2012 validation, all PIPs received a validation status of *Met*, reflecting continued strong performance.

Table 3-4—MHPs’ PIP Validation Status		
Validation Status	Percentage of PIPs	
	2010–2011	2011–2012
<i>Met</i>	100%	100%
<i>Partially Met</i>	0%	0%
<i>Not Met</i>	0%	0%

The following presents a summary of the validation results for the MHPs for the activities from the CMS PIP protocol. For the 2011–2012 cycle, HSAG validated all second-year PIP submissions for Activity I—Select the Study Topic(s), through Activity IX—Assess for Real Improvement.

Table 3-5 shows the percentage of MHPs that met all of the applicable evaluation or critical elements within each of the ten activities.

Table 3-5—Summary of Data From Validation of Performance Improvement Projects			
Review Activities		Percentage Meeting All Elements/ Percentage Meeting All Critical Elements	
		2010–2011	2011–2012
I.	Select the Study Topic(s)	100%/100%	100%/100%
II.	Define the Study Question(s)	100%/100%	100%/100%
III.	Select the Study Indicator(s)	100%/100%	100%/100%
IV.	Use a Representative and Generalizable Study Population	100%/100%	100%/100%
V.	Use Sound Sampling Techniques*	92%/100%	100%/100%
VI.	Use Valid and Reliable Data Collection Procedures	93%/100%	100%/100%
VII.	Data Analysis and Interpretation of Results	93%/100%	79%/100%
VIII.	Improvement Strategies (Interventions for Improvement as a Result of Analysis)	100%/100%	86%/100%
IX.	Assess for Real Improvement	Not Assessed	57%/NCE
X.	Assess for Sustained Improvement	Not Assessed	Not Assessed

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

The results from the 2011–2012 validation continued to reflect strong performance. All 14 MHPs received scores of *Fully Compliant* for each applicable evaluation element in Activities I through VI, as well as for each applicable critical element across all activities. Six of the MHPs met all

applicable evaluation and critical elements. Four MHPs failed to demonstrate full compliance with one element, and the remaining four MHPs received scores of less than *Met* for two or more elements.

The MHPs demonstrated full compliance with the requirements of the CMS PIP protocol for activities related to the study topic, study question, study indicator, and study population. Performance on the activities related to sampling techniques and data collection procedures improved, resulting in all MHPs demonstrating full compliance with all applicable evaluation elements in Activities V and VI. The percentages of MHPs meeting all evaluation elements remained high for the activities related to data analysis and interpretation and improvement strategies. Opportunities for improvement identified for these two activities addressed interpretation of findings, identification of differences between the initial measurement and remeasurement, discussion of factors that affect the ability to compare results across measurement periods, and standardization and monitoring of successful interventions. These recommendations applied to only one or two MHPs each, while the remaining MHPs were in full compliance with the requirements. About two-thirds of the recommendations from the 2011–2012 validation cycle addressed Activity IX—Real Improvement Achieved. While eight of the MHPs achieved statistically significant improvement in the study indicators, the remaining six MHPs did not reach statistically significant increases over the baseline rates.

During the first remeasurement period, the MHPs continued interventions implemented during the baseline period, standardized those that were successful, and revised or replaced others that did not achieve the desired outcomes for the study indicators. Interventions to increase the rates of documentation of BMI percentiles, counseling for nutrition, or counseling for physical activity occurred at the provider, member, and system level. Examples of such interventions included educational efforts through member and provider newsletters, MHP Web sites, provider visits, and targeted mailings. MHPs also sponsored community wellness events, such as health fairs, to promote healthy lifestyles and increased resources available to members by developing in-house programs or increasing the number of providers available for weight management or exercise programs.

HSAG identified *Points of Clarification* in many of the PIPs, which will assist the MHPs in strengthening their studies.

Conclusions/Summary

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

Results of the annual compliance reviews reflected continued strong performance by the MHPs, demonstrating high levels of compliance with contractual requirements in all areas assessed. Statewide average scores increased for three of the six standards as well as for the overall compliance score. Across all MHPs, performance on the standards remained at the same level for about half of the scores, while about one-third of scores reflected improvement. The *Provider, MIS/Data Reporting*, and *Fraud, Waste, and Abuse* standards had the largest number of MHPs with improved scores, representing statewide strengths. Compliance with MDCH-specified minimum performance standards—assessed in the *Quality/Utilization* standard—remained a statewide opportunity for improvement.

The MHPs demonstrated mostly average to above-average performance across the performance measures compared with national Medicaid HEDIS 2011 results, with 72.0 percent of rates performing above the national HEDIS Medicaid 50th percentile, and 16.3 percent performing above the 90th percentile. Compared with the prior-year Michigan statewide rates, 48 of the 53 comparable measures reflected improved performance. Only five measures showed a decline from 2011, and the declines were not statistically significant. Overall, the MHPs continued to show improvement across all measures in all of the dimensions of care. Efforts should continue to improve on the 28.0 percent of rates that fell below the national average.

The 2011–2012 validation of the PIPs reflected high levels of compliance with the requirements of the CMS PIP protocol for the first nine activities. All 14 PIPs received a validation status of *Met* for their second-year submission of the PIP on *Childhood Obesity*. The studies demonstrated a thorough application of the PIP design stage, which created the foundation for the MHPs to progress to subsequent PIP stages—implementing improvement strategies and accurately assessing study outcomes. The MHP demonstrated strong performance in the PIP implementation stage, properly defining and collecting the data to produce accurate study indicator rates. As the studies progress to the second remeasurement, the MHPs should evaluate the efficacy of their interventions and revise or implement new, targeted interventions to achieve the desired outcomes; ensure accurate reporting and interpretation of the data; and work to achieve statistically significant improvement in the study indicators.