

State of Michigan



Department of Community Health

Michigan Medicaid HEDIS® 2004 Results
STATEWIDE AGGREGATE REPORT

November 2004

HSAG
HEALTH SERVICES
ADVISORY GROUP

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ACKNOWLEDGMENTS AND COPYRIGHTS

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NCQA HEDIS Compliance Audit[™] is a trademark of the National Committee for Quality Assurance.

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Introduction

During the year 2003, Michigan Department of Community Health (MDCH) contracted with 17 health plans to provide managed care services to 833,791 Michigan Medicaid enrollees.¹⁻¹ To evaluate performance levels, MDCH implemented a system to provide objective, comparative review of health plan quality-of-care outcomes and performance measures. One component of the evaluation system is based on the Health Plan Employer Data and Information Set (HEDIS®). Developed and maintained by the National Committee for Quality Assurance (NCQA), HEDIS is a set of performance data broadly accepted in the managed care environment as an industry standard. MDCH selected 15 HEDIS measures from the standard Medicaid HEDIS reporting set as the Key Measures for evaluating performance of the Michigan Medicaid health plans (MHPs). These 15 measures are comprised of 34 distinct rates.

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

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

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

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

- ◆ A weighted average comparison presents the Michigan Medicaid 2004 results relative to the 2003 Michigan Medicaid weighted average and the national HEDIS 2003 Medicaid 50th percentiles.

¹⁻¹ Michigan Medicaid Managed Care. Medicaid Health Plan Enrollment Report. July 2004.

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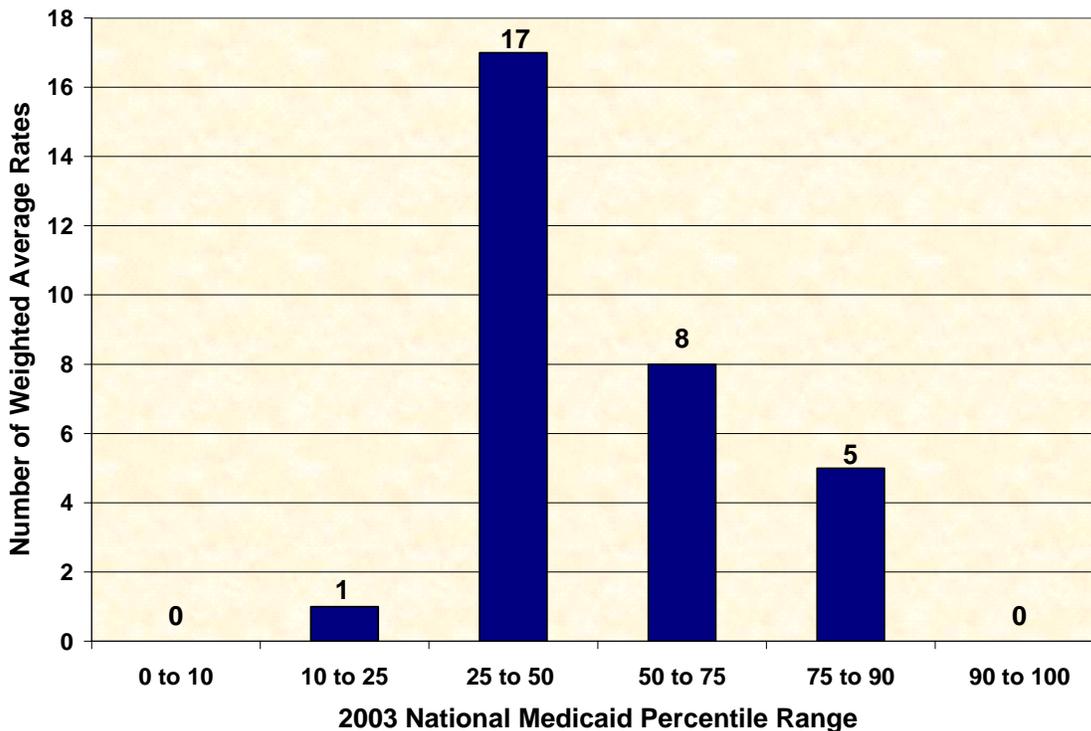
- ◆ A performance profile analysis discusses the overall Michigan Medicaid 2004 results and presents a summary of health plan performance relative to the Michigan Medicaid performance levels.
- ◆ A health plan ranking analysis provides a more detailed comparison, showing results relative to the Michigan Medicaid performance levels.
- ◆ A data collection analysis evaluates the potential impact of data collection methodology on reported rates.

In addition, Section 7 (“HEDIS Reporting Capabilities”) of the report provides a summary of the HEDIS data collection processes used by the Michigan Medicaid health plans and audit findings in relation to NCQA’s Information System (IS) standards.

Key Findings and Recommendations

This is the fourth year that HSAG has examined the MDCH HEDIS results, and continued generally favorable results are observed. Figure 1-1 below shows Michigan Medicaid health plan performance compared to national Medicaid benchmarks. The columns represent the number of Michigan Medicaid weighted averages falling into the percentile grouping listed on the horizontal axis. Forty-two percent (or 13 of 31) of the Michigan Medicaid weighted averages, where national benchmarking information was available, were above the 2003 national Medicaid 50th percentile.

**Figure 1-1—Michigan Medicaid HEDIS 2004:
Health Plan Performance Compared to National Medicaid Benchmarks**



There were only 4 of the 34 reported Michigan Medicaid weighted averages that showed a decline in performance: *Well-Child Visits in the First 15 Months of Life—Six or More Visits* was down 2.4 percentage points; *Breast Cancer Screening* declined by 1.6 percentage points; *Comprehensive Diabetes Care—Eye Exams* was down by 2.0 percentage points; and *Monitoring for Diabetic Nephropathy* declined by 6.9 percentage points. Eight measures had an increase of more than 5 percentage points. The largest increase was 13.8 percentage points, for *Adolescent Immunization Status—Combination #2*.

For some measures, the classic signs of a successful quality improvement project are seen. These include an increase in the average rate, as well as a decrease in the range of rates, indicating less variation in performance across the Michigan MHPs. Fifty-six percent (or 18 of 32 rates) showed a reduction in the range of reported rates. The reduction varied from 1.1 to 32.7 percentage points. Ten measures showed a reduction in the range of rates exceeding 10 percentage points. The largest reduction was 32.7 percentage points, for the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measure.

This report is organized in separate dimensions—Women’s Care, Children’s Care, Living With Illness, and Access to Care—to illustrate the complementary nature of these HEDIS measures. However, it is clear that the over-arching issue affecting all dimensions is that of members accessing care. The traditional direct-access measures (*Children’s and Adolescents’ Access to Primary Care Practitioners* and *Adults’ Access to Preventive/Ambulatory Health Services*) have weighted averages below the national Medicaid 50th percentile and show little improvement from last year for all numerators. Also, fewer plans are reporting rates above the HPL or the national median rate, indicating a general decline in performance.

Other measures that are direct indicators of members accessing care are the *Well-Child Visits in the First 15 Months of Life*, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, and *Adolescent Well-Care Visits*. The Michigan weighted averages for all these measures are below the national Medicaid 50th percentile. While there is some improvement in these measures over last year, fewer Michigan MHPs reported rates above the HPL or national Medicaid 50th percentile. Preventive care rates, such as *Breast Cancer Screening* and *Cervical Cancer Screening*, can also be considered indicators of members accessing care. The Michigan weighted average for both of these rates is within a percentage point or so of the national Medicaid 50th percentile. The *Breast Cancer Screening* measure shows little change from last year, while there is an overall slight improvement in the *Cervical Cancer Screening* measure.

The maternal care Key Measures (*Prenatal and Postpartum Care*) are also indicators of members accessing care and/or non-symptomatic utilization. The Michigan weighted average for the *Timeliness of Prenatal Care* measure is below the national Medicaid 50th percentile, and the *Postpartum Care* rate is below the 25th percentile. Access to maternal care in the Michigan Medicaid managed care population is below national benchmarks.

The single all-encompassing issue with members accessing care indicates that an overall approach will be most effective in improving Michigan MHP HEDIS results. In fact, MDCH has already started looking at this issue through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) research done by the Institute of Health Care Studies. Understanding the reasons for noncompliance with preventive care, from both the patient and physician perspectives, is an important first step. HSAG recommends that MDCH work with its MHP members to understand further the reasons for members not accessing care overall. After gaining additional insight and

understanding, Michigan MHPs might explore various interventions. Some thought should be given to overall interventions, not just to those targeting specific HEDIS measures. NCQA's *Quality Profiles™* Web site has an interesting case study showing the benefit of coordinated provider group reporting and member education activities.¹⁻² MDCH may want to consider a similar intervention.

This year, in addition to analyzing Michigan MHP HEDIS rates, HSAG sent a questionnaire to all the MDCH MHPs inquiring about member and provider interventions targeting HEDIS measures. The results of 14 completed questionnaires were examined along with the actual HEDIS rates to help provide additional insight as to what types of interventions were being undertaken. The effectiveness of the interventions was also analyzed. The relatively small number of observations submitted by Michigan MHPs did not permit analysis specific to a given HEDIS measure. Instead, the interventions were aggregated for all measures by intervention type and the effect on the measurement was analyzed. The presence of a case management program was shown to have a positive impact on Michigan MHP-reported rates. Provider-targeted interventions that had a positive impact on rates included the provision of lists of affected members, and giving providers their specific compliance rates as well as the compliance rates for their peer groups.

Weighted Average Comparisons for the Four Dimensions of Care

Figure 1-2 through Figure 1-5, on the following pages, present Michigan Medicaid HEDIS 2004 results for each dimension of care, comparing the current weighted average for each measure relative to the 2003 Michigan Medicaid weighted average and the national HEDIS 2003 Medicaid 50th percentile.

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

- ◆ The light-colored bars show the difference in percentage points between this year's Michigan results and last year's Michigan results, comparing the 2004 and 2003 Michigan Medicaid weighted averages.
- ◆ The dark-colored bars show the difference in percentage points between this year's Michigan results and the national results, comparing the 2004 Michigan Medicaid weighted average with the national HEDIS 2003 Medicaid 50th percentile.
- ◆ For all measures (except two), a bar to the **right** indicates an **improvement** in performance and a bar to the **left** indicates a **decline** in performance.

The two exceptions are:

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

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

¹⁻² http://www.qualityprofiles.org/quality_profiles/case_studies/Preventive_Care/2_16.asp

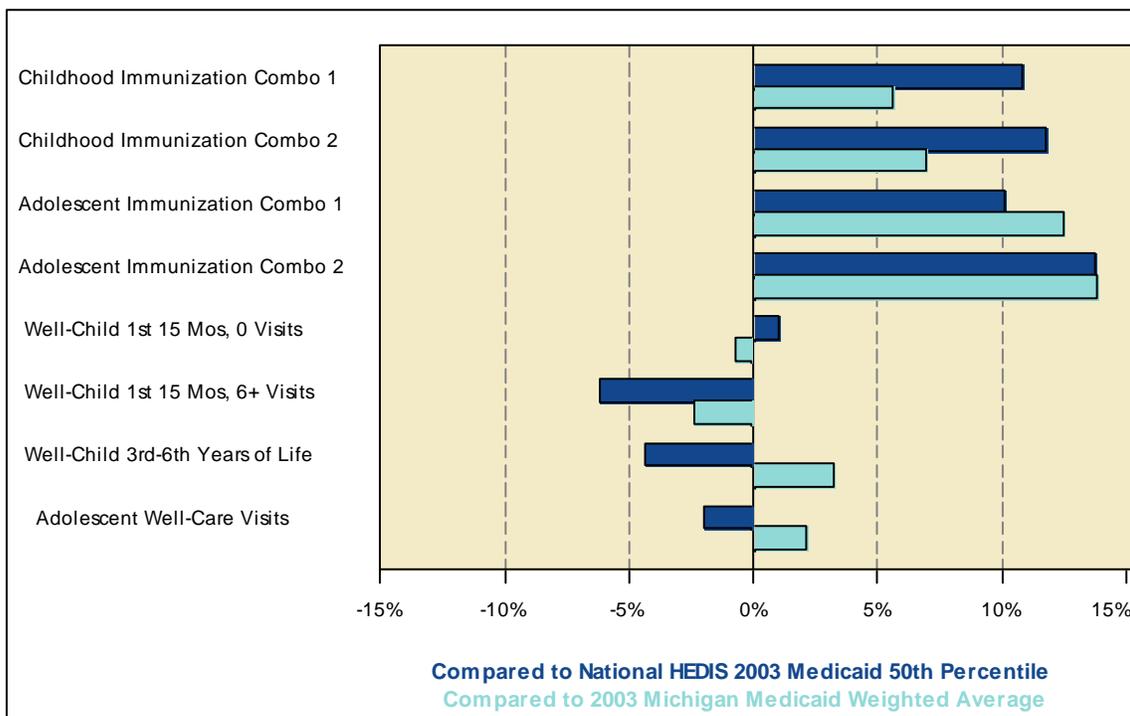
Summary of Results

Pediatric Care

The Michigan Medicaid managed care program continues to be one of the leaders in childhood immunization. For both *Childhood Immunization Status—Combination # 1* and *Combination # 2*, the Michigan Medicaid weighted average is above the national Medicaid 75th percentile, with only one health plan reporting a rate below the national median. Both the highest and lowest Michigan MHP reported rates increased substantially, leading to a more than 12 percentage-point reduction in the range of Michigan MHP rates. Adolescent immunization rates are also high and improving. The maximum rate for both combinations has improved by more than 13 percentage points, and the weighted average has shown similar improvement (above the 50th percentile, and approaching the 75th).

The area of children’s preventive care visits, as demonstrated by the applicable Key Measures, exhibits lesser performance. The Michigan Medicaid weighted average for *Well-Child Visits in the First 15 Months of Life—Zero Visits*; *Well-Child Visits in the First 15 Months of Life—Six or More Visits*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; and *Adolescent Well-Care Visits* are all below the national Medicaid 50th percentile. Only two health plans reported a single rate above the HPL. The number of Michigan MHPs reporting rates below the national median increased in all measures, with the most being an increase of four Michigan MHPs in the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measure.

Figure 1-2—Michigan Medicaid HEDIS 2004 Weighted Average Comparison: Pediatric Care



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

**Table 1-1—Michigan Medicaid HEDIS 2004 Performance Summary:
Pediatric Care**

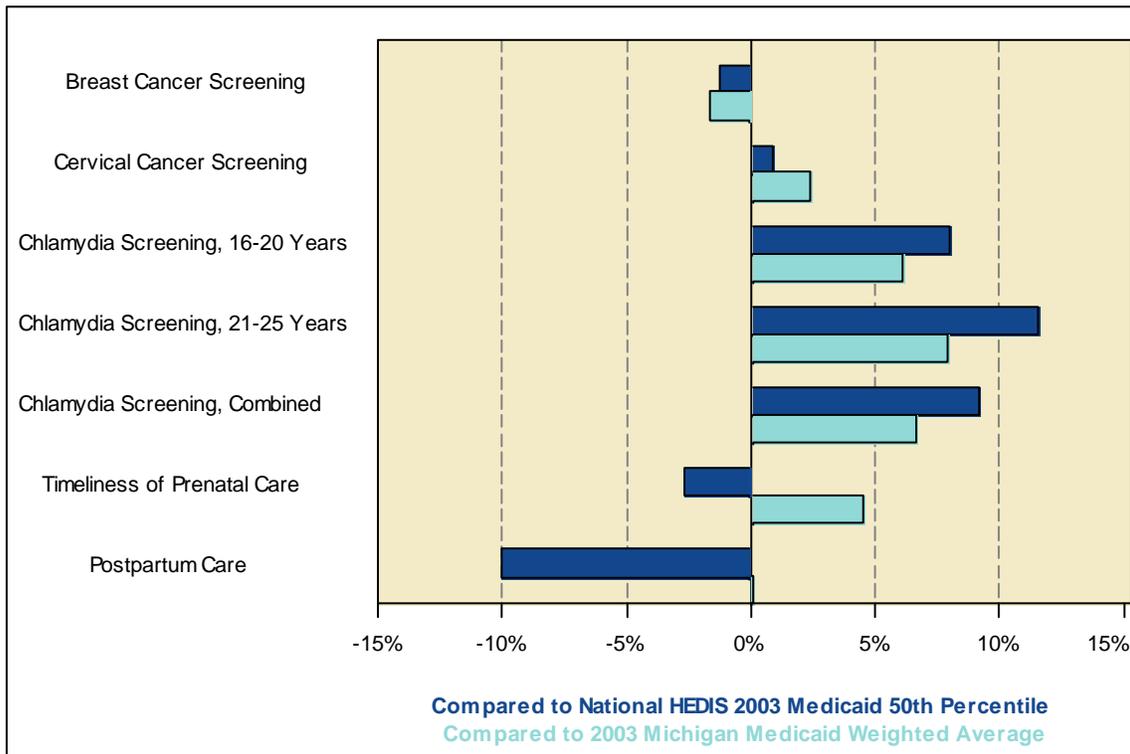
Health Plan Code	Childhood Immunization		Adolescent Immunization		Well-Child			Adolescent
	Combo 1	Combo 2	Combo 1	Combo 2	First 15 Months, 0 Visits	First 15 Months, 6+ Visits	3rd–6th Years of Life	Well-Care Visits
BOT	★★	★★	★★	★★	★★	★	★★	★★
CAP	★★	★★	★★	★★	★★	★★	★★	★★
CCM	★★	★★	★★	★★	★★	★	★★	★★
GLH	★★	★★	★★	★★	★★	★★	★★	★★
HPM	★★	★★	★★	★★	★★	★★★	★★	★★
HPP	★★★	★★★	★★	★★	★★	★★	★	★★
MCD	★★★	★★★	★★	★★	★★	★★	★★	★★
MCL	★★	★★	★★	★★	★★	★★	★★	★★
MID	★★	★★	★★	★★	★★	★★	★★	★★
MOL	★★	★★	★★	★★	★★	★★	★★	★★
OCH	★★	★★	★	★	★	★	★★	★★
PMD	★★	★★	★★	★★★	★★	★★	★★	★★
PRI	★★★	★★★	★★	★★★	★★★	★★	★★	★★
PSW	★★★	★★★	★★	★★	★★	★★	★★	★★
THC	★★	★★	★★	★★	★★	★	★★	★★
TWP	★★	★★	★★	★★	★★	★	★	★
UPP	★★★	★★	★★	★★	★★	★★	★★	★★
3-star count	5	4	0	2	1	1	0	0
2-star count	12	13	16	14	15	11	15	16
1-star count	0	0	1	1	1	5	2	1

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

Women’s Care

The Key Measures in the Women’s Care dimension illustrate a broad range in the provision of care. The Michigan Medicaid weighted average for all age bands in the *Chlamydia Screening in Women* rate has increased by more than 6 percentage points and is above the national Medicaid 75th percentile. Women 16 to 25 years of age who are sexually active are accessing care for their chlamydia tests. Unlike the chlamydia rates, maternal care rates are low. The *Timeliness of Prenatal Care* rate, although increasing, is below the national median rate; and the *Postpartum Care* rate is below the national Medicaid 25th percentile. Preventive care rates for women are similar to national Medicaid median rates, with the *Cervical Cancer Screening* rate less than 1 percentage point above the national Medicaid 50th percentile, and the *Breast Cancer Screening* rate a little more than 1 percentage point below the 50th percentile.

Figure 1-3—Michigan Medicaid HEDIS 2004 Weighted Average Comparison: Women’s Care



**Table 1-2—Michigan Medicaid HEDIS 2004 Performance Summary:
Women’s Care**

Health Plan Code	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening			Timeliness of Prenatal Care	Postpartum Care
			16–20 Years	21–25 Years	Combined		
BOT	★★	★★	★★	★★★	★★	★	★
CAP	★★	★★	★★	★★	★★	★★	★
CCM	★★	★★	★★	★★	★★	★★	★★
GLH	★	★	★★	★★	★★	★★	★
HPM	★★	★★	★★	★★	★★	★★	★★
HPP	★★★	★★	★★	★★	★★	★★	★★
MCD	★	★★	★★	★★	★★	★★	★★
MCL	★★	★★	★★	★★	★★	★★	★★
MID	★★	★	★	★★	★★	★	★
MOL	★★	★★	★★	★★	★★	★★	★★
OCH	★	★★	★★	★★	★★	★★	★
PMD	★★	★★	★★★	★★★	★★★	★★	★★
PRI	★★	★★★	★★	★★	★★	★★	★★
PSW	★★	★★	★★	★★	★★	★★	★★
THC	★	★★	★★	★★	★★	★★	★
TWP	★★	★★	★★★	★★★	★★★	★★	★
UPP	★★★	★★	★★	★★	★★	★★	★★
3-star count	2	1	2	3	2	0	0
2-star count	11	14	14	14	15	15	10
1-star count	4	2	1	0	0	2	7

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

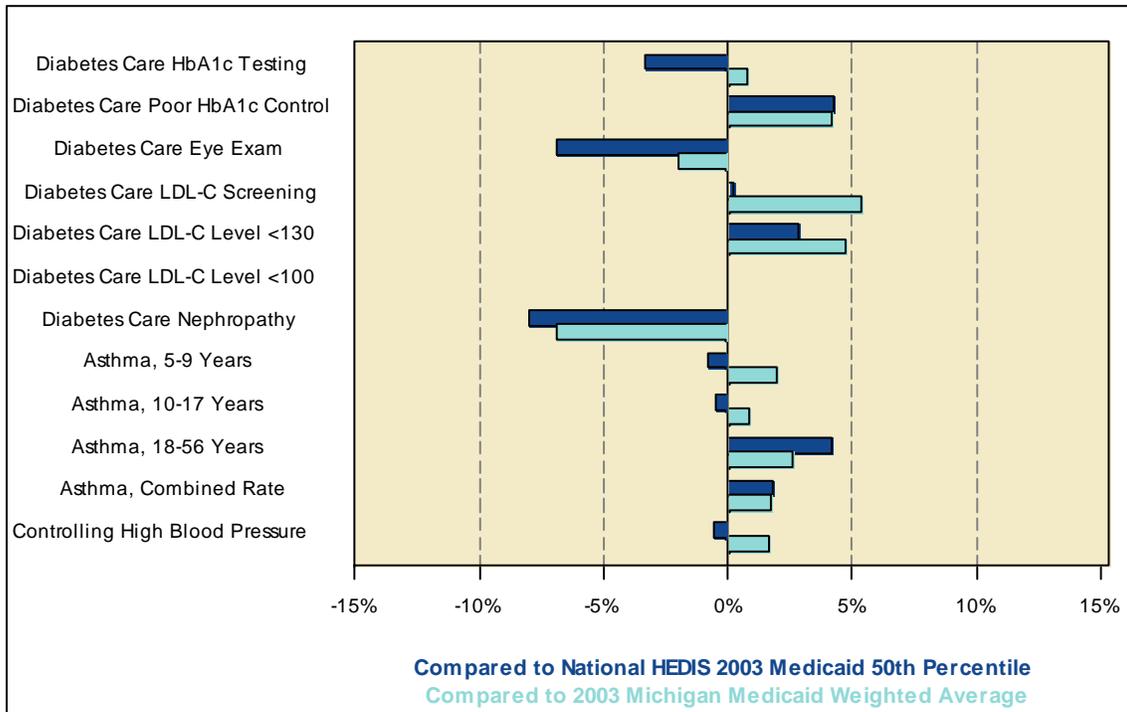
Living With Illness

Results for the Living With Illness dimension showed room for improvement in 2004. The Michigan weighted averages for *Comprehensive Diabetes Care* are near or below national Medicaid median rates. More health plans reported rates below the LPL compared to the previous year, and fewer reported rates above the HPL. The Michigan weighted averages for four of the six measures are below the national Medicaid median rate. The two rates that are above the national Medicaid 50th percentile show substantial improvement from the previous year: the *LDL-C Screening Rate* improved by 5.4 percentage points, and the *LDL-C Level <130* improved by 4.8 percentage points. The substantial decrease in the *Monitoring for Diabetic Nephropathy* rates is an area of concern.

Asthma results were more encouraging in 2004, though none of the weighted averages showed a statistically significant improvement from the previous year. In addition, the range of reported rates has increased with more health plans reporting rates above the HPL compared to last year, yet more health plans also reported rates below the LPL. For the *Use of Appropriate Medications for People with Asthma—Combined Rate* (all age groups), the 2004 Michigan Medicaid weighted average was 1.8 percentage points above the national HEDIS 2003 Medicaid 50th percentile. The rate for *Ages 18 to 56 Years* is just 0.4 percentage points below the national Medicaid 75th percentile.

Overall, the range of reported rates improved from 2003 to 2004 for *Controlling High Blood Pressure*. Although the 2004 Michigan Medicaid weighted average fell slightly below the national HEDIS 2003 Medicaid 50th percentile, fewer health plans fell below the national 50th percentile in 2004.

Figure 1-4—Michigan Medicaid HEDIS 2004 Weighted Average Comparison: Living With Illness



Notes: For *Comprehensive Diabetes Care—Poor HbA1c Control*, a bar to the left (lower rates) indicates better performance. *Comprehensive Diabetes Care—LDL-C Level<100* is a first-year HEDIS measure in 2004; therefore, no national performance data are available to establish the HPL, Median, and LPL. *Advising Smokers to Quit* is not included in this figure. National benchmarking data are not available nor could a weighted average be calculated.

**Table 1-3—Michigan Medicaid HEDIS 2004 Performance Summary:
Living With Illness (Part 1)**

Health Plan Code	Diabetes Care						
	HbA1c Testing	Poor HbA1c Control	Eye Exam	LDL-C Screening	LDL-C Level<130	LDL-C Level<100	Nephropathy
BOT	★★	★★	★★	★★	★★	NA	★★
CAP	★★	★★	★★	★★	★★	NA	★
CCM	★★	★	★	★	★	NA	★
GLH	★★	★★	★★	★★	★★	NA	★
HPM	★★	★★	★★	★★	★★	NA	★★
HPP	★★	★★	★★	★★	★★	NA	★★
MCD	★★★	★★	★★	★★★	★★★	NA	★★
MCL	★★	★★	★★	★★	★★	NA	★★
MID	★	★	★	★	★★	NA	★
MOL	★★	★★	★★	★	★★	NA	★
OCH	★	★	★	★★	★★	NA	★
PMD	★★	★★	★★	★★★	★★★	NA	★★
PRI	★★	★★	★★	★★★	★★★	NA	★★
PSW	★★	★★	★	★★	★★	NA	★★
THC	★★	★★	★	★★	★★	NA	★★
TWP	★★	★★	★	★★	★★	NA	★★
UPP	★★★	★★★	★★	★★★	★★	NA	★★
3-star count	2	1	0	4	3	0	0
2-star count	13	13	11	10	13	0	11
1-star count	2	3	6	3	1	0	6
NA count	0	0	0	0	0	17	0

Note: *Comprehensive Diabetes Care—LDL-C Level<100* is a first-year HEDIS measure in 2004; therefore, no national performance data are available to establish the HPL, Median, and LPL.

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

“NA” means “Not Applicable.”

**Table 1-4—Michigan Medicaid HEDIS 2004 Performance Summary:
Living With Illness (Part 2)**

Health Plan Code	Asthma				Controlling High Blood Pressure	Advising Smokers to Quit
	5–9 Years	10–17 Years	18–56 Years	Combined		
BOT	NA	★★	★★	★★	★★★	NA
CAP	★★	★	★★	★★	★★	NA
CCM	★★	★★	★★	★★	★★	NA
GLH	★	★★	★★	★★	★	NA
HPM	★★★	★★	★★	★★	★★★	NA
HPP	★★★	★★	★★	★★	★★	NA
MCD	★★	★★★	★★★	★★★	★★★	NA
MCL	★★	★★	★★	★★	★★★	NA
MID	★★	★	★★	★★	★★	NA
MOL	★★	★★	★★	★★	★★	NA
OCH	★	★	★★	★	★	NA
PMD	★★★	★★★	★★	★★★	★★	NA
PRI	★★★	★★★	★★	★★★	★★	NA
PSW	★★★	★★	★★	★★	★★	NA
THC	★★	★★	★	★	★★	NA
TWP	★★	★★	★★	★★	★★	NA
UPP	★★★	★★★	★★★	★★★	★★★	NA
3-star count	6	4	2	4	5	0
2-star count	8	10	14	11	10	0
1-star count	2	3	1	2	2	0
NA count	1	0	0	0	0	17

Note: There are no national performance data available to establish the HPL, Median, and LPL for the *Advising Smokers to Quit* measure.

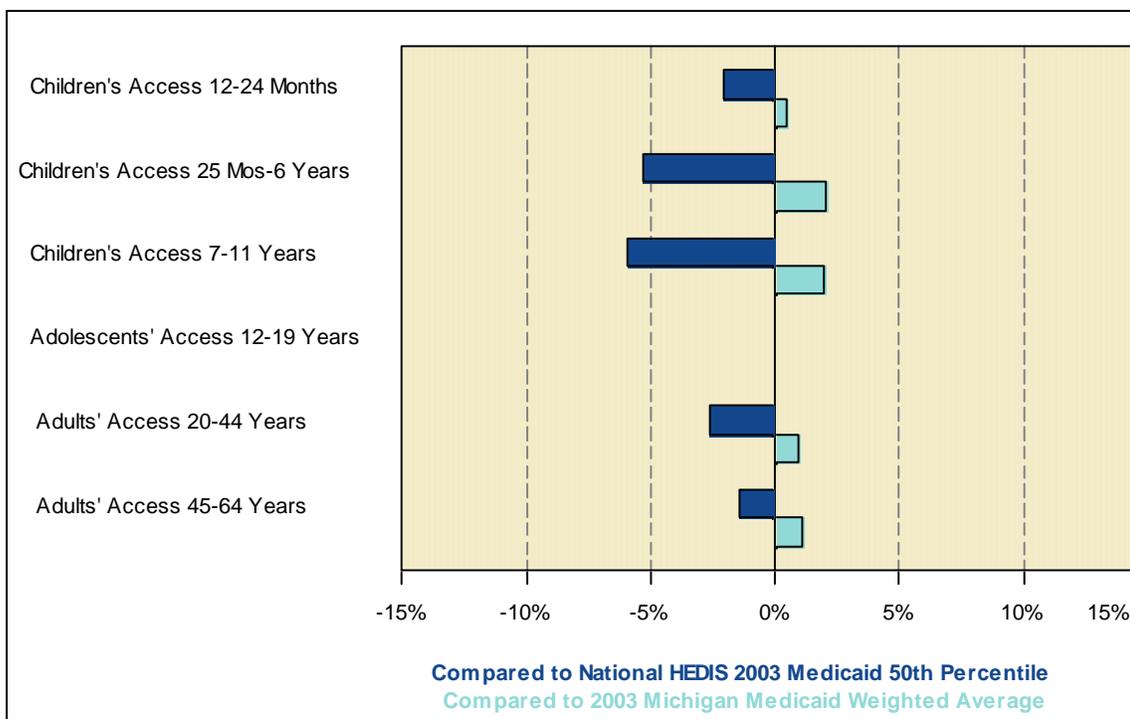
This symbol	shows this performance level
3 stars ★★★	≥ HPL
2 stars ★★	> LPL and < HPL
1 star ★	≤ LPL, or for <i>Not Report (NR)</i>

“NA” means “Not Applicable.”

Access to Care

It is clear that members in the Michigan Medicaid managed care program are not accessing care at the level seen in managed Medicaid programs across the country. Every numerator for the two measures in this section is below the national Medicaid 50th percentile, and in many cases very close to the 25th percentile. A slight improvement is seen in the Michigan weighted average rates and a reduction in the range of reported rates of 3.0 to 11.3 percentage points. However, these improvements are due to substantial increases in the lowest reported rate, not a general upward movement of all Michigan Medicaid health plans.

Figure 1-5—Michigan Medicaid HEDIS 2004 Weighted Average Comparison: Access to Care



Note: Adolescents' Access 12–19 Years is a first-year HEDIS measure in 2004; therefore, no national performance data are available to establish the HPL, Median, and LPL.

**Table 1-5—Michigan Medicaid HEDIS 2004 Performance Summary:
Access to Care**

Health Plan Code	Children's and Adolescents' Access				Adults' Access	
	Ages 12 to 24 Months	Ages 25 Months to 6 Years	Ages 7 to 11 Years	Ages 12 to 19 Years	Ages 20 to 44 Years	Ages 45 to 64 Years
BOT	★	★	★	NA	★	★
CAP	★★	★★	★★	NA	★★	★★
CCM	★★	★	★	NA	★★	★★
GLH	★★	★★	★★	NA	★★	★★
HPM	★★	★★	★★	NA	★★	★★
HPP	★★	★★	★★	NA	★★	★★★
MCD	★★	★★	★★	NA	★★	★★
MCL	★★	★★	★★	NA	★★	★★
MID	★	★★	★★	NA	★★	★★
MOL	★★	★★	★★	NA	★★	★★
OCH	★	★	★	NA	★★	★★
PMD	★★	★★	★★	NA	★★	★★
PRI	★★★	★★	★★	NA	★★	★★★
PSW	★★	★★	★★	NA	★★	★★★
THC	★	★	★	NA	★	★
TWP	★	★	★	NA	★★	★
UPP	★★★	★★	★★	NA	★★	★★★
3-star count	2	0	0	0	0	4
2-star count	10	12	12	0	15	10
1-star count	5	5	5	0	2	3
NA count	0	0	0	17	0	0

Note: *Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years* is a first-year HEDIS measure in 2004; therefore, no national performance data are available to establish the HPL, Median, and LPL.

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

"NA" means "Not Applicable."

2. How to Get the Most From This Report

Summary of Michigan Medicaid HEDIS 2004 Key Measures

HEDIS includes a standard set of measures that can be reported by Medicaid health plans nationwide. MDCH selected 15 HEDIS measures from the standard Medicaid set, and broke down these 15 measures into 34 distinct rates, shown in the table below. These 34 rates represent the 2004 MDCH Key Measures. Seventeen Michigan MHPs were required to report the Key Measures in 2004.

Table 2-1—Michigan Medicaid HEDIS 2004 Key Measures

Standard HEDIS 2004 Measures	2004 MDCH Key Measures
1. Childhood Immunization Status	1. Childhood Immunization Status—Combination #1 2. Childhood Immunization Status—Combination #2
2. Adolescent Immunization Status	3. Adolescent Immunization Status—Combination #1 4. Adolescent Immunization Status—Combination #2
3. Breast Cancer Screening	5. Breast Cancer Screening
4. Cervical Cancer Screening	6. Cervical Cancer Screening
5. Controlling High Blood Pressure	7. Controlling High Blood Pressure
6. Chlamydia Screening in Women	8. Chlamydia Screening in Women—Ages 16 to 20 Years 9. Chlamydia Screening in Women—Ages 21 to 25 Years 10. Chlamydia Screening in Women—Combined Rate
7. Comprehensive Diabetes Care	11. Comprehensive Diabetes Care—HbA1c Testing 12. Comprehensive Diabetes Care—Poor HbA1c Control 13. Comprehensive Diabetes Care—Eye Exam 14. Comprehensive Diabetes Care—LDL-C Screening 15. Comprehensive Diabetes Care—LDL-C Level <130 16. Comprehensive Diabetes Care—LDL-C Level <100 17. Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy
8. Use of Appropriate Medications for People With Asthma	18. Use of Appropriate Medications for People With Asthma—Ages 5 to 9 Years 19. Use of Appropriate Medications for People With Asthma—Ages 10 to 17 Years 20. Use of Appropriate Medications for People With Asthma—Ages 18 to 56 Years 21. Use of Appropriate Medications for People With Asthma—Combined Rate
9. Medical Assistance With Smoking Cessation	22. Medical Assistance With Smoking Cessation—Advising Smokers to Quit
10. Adults' Access to Preventive/ Ambulatory Health Services	23. Adults' Access to Preventive/Ambulatory Health Services—Ages 20–44 Years 24. Adults' Access to Preventive/Ambulatory Health Services—Ages 45–64 Years
11. Children's and Adolescents' Access to Primary Care Practitioners	25. Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months 26. Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years 27. Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years 28. Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years
12. Prenatal and Postpartum Care	29. Prenatal and Postpartum Care—Timeliness of Prenatal Care 30. Prenatal and Postpartum Care—Postpartum Care
13. Well-Child Visits in the First 15 Months of Life	31. Well-Child Visits in the First 15 Months of Life—Zero Visits 32. Well-Child Visits in the First 15 Months of Life—Six or More Visits
14. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	33. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
15. Adolescent Well-Care Visits	34. Adolescent Well-Care Visits

Key Measure Audit Designations

Through the audit process, each measure reported by a health plan is assigned an NCQA-defined audit designation. Measures can receive one of two predefined designations: *Report* or *Not Report*. An audit designation of *Report* indicates that the health plan complied with all HEDIS specifications to produce an unbiased, reportable rate or rates, which can be released for public reporting. An audit designation of *Not Report* indicates that the rate will not be publicly reported.

A subset of the *Report* designation is the *Not Applicable* assignment to a rate. Although a health plan may have complied with all applicable specifications, the denominator identified may be considered too small to report a rate (i.e., less than 30). The measure would have been assigned a *Report* designation with a *Not Applicable* rate.

In this report, only health plans with a reportable value for the Key Measure illustrated are shown on the graphs.

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

The health plans that met the HEDIS criteria for hybrid measure rotation could exercise that option if they chose to do so. Six health plans chose to rotate measures in 2004, and a total of 22 rates were rotated. Following NCQA methodology, rotated measures were assigned the same reported rate from 2003 and were included in the calculations for the Michigan Medicaid weighted averages.

Dimensions of Care

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

Changes to Measures

For HEDIS reporting year 2004, NCQA made several modifications to Key Measures included in this report, which may impact trending patterns:

Chlamydia Screening in Women

The upper age limit for chlamydia screening was lowered from 26 years to 25 years to reflect clinical guidelines. HSAG does not expect this change to have any significant impact on trending patterns from 2003 to 2004.

Children's and Adolescents' Access to Primary Care Practitioners

The adolescent age cohort of 12 years to 19 years was added to address access to care within this age group. Since this is a first year measure, no national performance data are available.

Comprehensive Diabetes Care

For the *Comprehensive Diabetes Care—Poor HbA1c Control* measure, the 9.5 percent threshold was lowered to 9.0 percent to more closely reflect the clinical definition for out of control diabetics. This change may impact the 2004 rates for this measure, showing less improvement in trending patterns.

One new numerator was added to the *Comprehensive Diabetes Care Key Measure: LDL-C Level <100*, to reflect more current clinical guidelines. Since this is a first year measure, no national performance data are available.

Medical Assistance with Smoking Cessation

In 2003, NCQA made changes to the *Advising Smokers to Quit* measure. The measure was renamed *Medical Assistance With Smoking Cessation* and was revised to include three separate rates, listed below:

- ◆ *Advising Smokers to Quit*
- ◆ *Discussing Smoking Cessation Medications*
- ◆ *Discussing Cessation Strategies*

The methodology to calculate the rate for *Advising Smokers to Quit* was changed to a rolling average. The rolling average represents the percentage of members 18 years of age and older who were continuously enrolled during the measurement year, who were either current smokers or recent quitters, who were seen by a Michigan MHP practitioner during the measurement year and who received advice to quit smoking. Rates are reported using data from the most recent two reporting years, with the rolling average of 2003 and 2004 included in this report. Trending data are also available by comparing the rolling average of 2002 and 2003. **Please note that all *Medical Assistance With Smoking Cessation—Advising Smokers to Quit* rates that appear in this report are two-year rolling averages.** A weighted average was not calculated for this measure since the eligible population data were not available.

Performance Levels

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

Comparative information in this report is based on the national NCQA Medicaid HEDIS 2003 results, which are the most recent percentiles available from NCQA. For most Key Measures included in this report, the 90th percentile indicates the HPL, the 25th percentile represents the LPL, and average performance falls between the LPL and the HPL. This means that Michigan MHPs with reported rates above the 90th percentile (HPL) rank in the top 10 percent of all Medicaid health plans nationally. Similarly, health plans reporting rates below the 25th percentile (LPL) rank in the bottom 25 percent nationally for that measure.

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

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

NCQA has not published national percentiles (90th, 50th, and 25th percentiles) for the *Medical Assistance With Smoking Cessation—Advising Smokers to Quit* since the 2002 reporting year. Given the 2003 change in the reporting methodology to a two-year rolling average and the lack of more recent performance data, no HPL or LPL have been established for this Key Measure. Instead, health plan results are ranked highest to lowest and compared with the 2004 Michigan Medicaid average.

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

Performance Star Ratings

For each dimension of care, a performance summary figure shows results for all Michigan MHPs. Results were calculated using a scoring algorithm based on individual health plan performance relative to the HPL, LPL, and national HEDIS 2003 Medicaid 50th percentile.

For each health plan, points were summed across all measures in the dimension and then averaged by the number of measures in that dimension. Fractions of 0.5 or greater were rounded up to the next whole number. *Not Applicable* (“NA”) designations were not included in the denominator.

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

- ◆ Three stars (★★★) for performance at or above the HPL.
- ◆ Two stars (★★) for performance above the LPL but below the HPL.
- ◆ One star (★) for performance at or below the LPL, or for *Not Report* (“NR”) designations.

Not Applicable designations are shown as “NA.”

Michigan Medicaid Averages

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

Interpreting and Using Reported Averages and Aggregate Results

The 2004 Michigan Medicaid weighted average was computed by HSAG based on the reported rates and weighted by the reported eligible population size for that measure. This is a better estimate of care for all of Michigan's Medicaid enrollees, rather than the average performance of Michigan MHPs.

The 2004 Michigan Medicaid aggregate results, which illustrate how much of the final rate is derived from administrative data and how much from medical record review, is not an average. It is the sum of all numerator events divided by the sum of all the denominators across all the reporting health plans for a given measure.

Example

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

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

Significance Testing

In this report, differences between the 2003 and 2004 Michigan Medicaid weighted averages have been analyzed using a t-test to determine if the change was statistically significant. The t-test evaluates the differences between mean values of two groups, relative to the variability of the distribution of the scores. The t-value generated is used to judge how likely it is that the difference is real and not the result of chance.

To determine the significance for this report, a risk level of 0.05 was selected. This risk level, or *alpha level*, means that 5 times out of 100 we may find a statistically significant difference between the mean values even if none actually existed (that is, it happened “by chance”). All comparisons between the 2003 and 2004 Michigan Medicaid weighted averages reported as statistically significant in this report are significant at the 0.05 level.

Calculation Methods: Administrative Versus Hybrid

Administrative Method

The administrative method requires health plans to identify the eligible population (i.e., the denominator) using administrative data, derived from claims and encounters (i.e., statistical claims). In addition, the numerator(s), or services provided to the members in the eligible population, are derived solely from administrative data. Medical records cannot be used to retrieve information. When using the administrative method, the entire eligible population becomes the denominator, and sampling is not allowed. In three of the four dimensions of care in this report—Women’s Care, Living with Illness, and Access to Care—there are measures where HEDIS methodology requires that the rates be derived using only the administrative method, and medical record review is not permitted. These are:

- ◆ *Chlamydia Screening in Women*
- ◆ *Use of Appropriate Medications for People With Asthma*
- ◆ *Children’s and Adolescents’ Access to Primary Care Practitioners*
- ◆ *Adults’ Access to Preventive/Ambulatory Health Services*

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

Hybrid Method

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

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

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

Interpreting Results

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

Four questions should be asked when examining these data:

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

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

1. How accurate are the results?

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

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

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

More information is provided in “Understanding Sampling Error” on page 2-10.

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

For each measure, a health plan ranking presents the reported rate in order from highest to lowest, with bars representing the established HPL, LPL, and the national HEDIS 2003 Medicaid 50th percentile. In addition, the 2004, 2003, and 2002 Michigan Medicaid weighted averages are presented for comparison purposes.

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

3. How are Michigan Medicaid health plans performing overall?

For each dimension, a performance profile analysis compares the 2004 Michigan Medicaid weighted average for each rate with the 2003 and 2002 Michigan Medicaid weighted averages and the national HEDIS 2003 Medicaid 50th percentile.

4. How do the Michigan Medicaid health plans calculate the measures?

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

The Michigan 2004 aggregate bar represents the sum of all administrative events and medical record review events for all members in the statewide denominator, regardless of the data collection methodology used.

In addition, Section 7 of this report discusses HEDIS reporting capabilities of the Michigan Medicaid health plans.

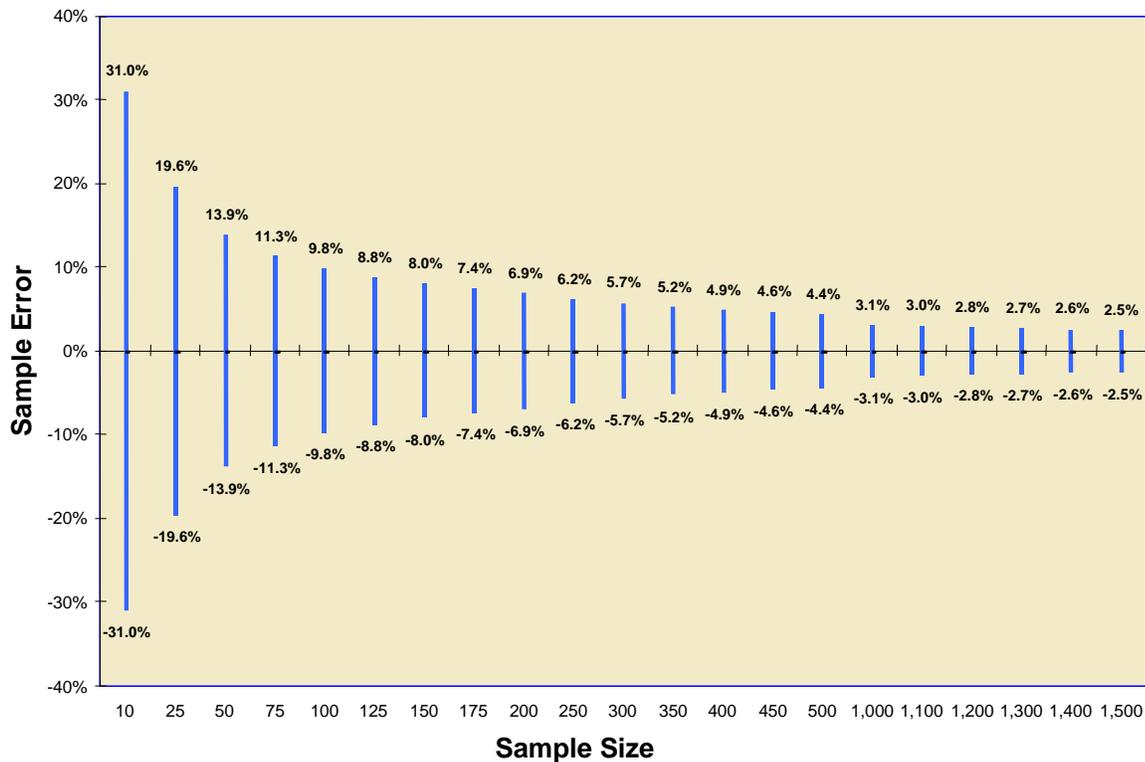
Understanding Sampling Error

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

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

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

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



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

Health Plan Name Key

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

Table 2-2—2004 Michigan MHPs

Code	Health Plan Name
BOT	Botsford Health Plan
CAP	Cape Health Plan
CCM	Community Choice Michigan
GLH	Great Lakes Health Plan
HPM	Health Plan of Michigan
HPP	HealthPlus Partners
MCD	M-CAID
MCL	McLaren Health Plan
MID	Midwest Health Plan
MOL	Molina Healthcare of Michigan
OCH	OmniCare Health Plan
PMD	Physician's Health Plan of Mid-Michigan Family Care
PRI	Priority Health Government Programs
PSW	Physician's Health Plan of Southwest Michigan
THC	Total Health Care
TWP	The Wellness Plan
UPP	Upper Peninsula Health Plan

Introduction

Pediatric primary health care is essential to prevention, recognition, and treatment of health conditions that could have significant developmental consequences for children and adolescents. The need for appropriate immunizations and health check-ups has even greater importance and significance at younger ages. For example, abnormalities in growth, hearing, and vision undetected in toddlers impact future learning opportunities and experiences. Early detection of developmental difficulties provides the greatest opportunity for intervention and resolution so that children continue to grow and learn free from any health-related limitations.

Healthy People 2010 set a national goal of enrolling 95 percent of children from birth through age 5 in an immunization registry.³⁻¹ The nationally recognized Michigan Childhood Immunization Registry (MCIR) provides health care providers with access to immunization records and allows them to more effectively identify children who are behind in their immunizations. All health care providers in the State of Michigan who provide immunization services to a child born after December 31, 1993, are required to report each immunization to the registry. Since 1996, the electronic database has grown to include more than 35 million vaccinations provided for 3 million Michigan children. The data are accessible only by authorized professionals to check which immunizations are due for children under their care. MCIR increased provider participation from 42 percent in 1998 to 75 percent in 2002.³⁻² As a result of increased provider participation, major barriers to infant and childhood immunizations have been identified, including missed opportunities to administer vaccines.

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

The Pediatric Care dimension encompasses the following MDCH Key Measures:

- ◆ **Childhood Immunization Status**
 - *Childhood Immunization Status—Combination #1*
 - *Childhood Immunization Status—Combination #2*
- ◆ **Adolescent Immunization Status**
 - *Adolescent Immunization Status—Combination #1*
 - *Adolescent Immunization Status—Combination #2*
- ◆ **Well-Care Visits**
 - *Well-Child Visits in the First 15 Months of Life—Zero Visits*
 - *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
 - *Adolescent Well-Care Visits*

³⁻¹ Healthy People 2010: Objectives for Improving Health. Available at: <http://www.healthypeople.gov/Document/HTML/Volume1/14Immunization.htm>. Accessed on August 11, 2004.

³⁻² Michigan Public Health Institute. 2001 Michigan Childhood Immunization Registry. Available at: http://www.mcir.org/pro_accomp.htm. Accessed on August 11, 2004.

Childhood Immunization Status

Over the last 50 years, childhood vaccination has led to dramatic declines in many life-threatening diseases such as polio, tetanus, whooping cough, mumps, measles, and meningitis. However, in the United States, approximately 300 children still die every year from these vaccine-preventable diseases and many more suffer from blindness, hearing loss, diminished motor functioning, liver damage, and coma because they have not been immunized.³⁻³

Overall, the State of Michigan has made notable progress in improving childhood immunization. Eighty-nine percent of children have two or more doses recorded in the MCIR, while the national average for registries is 24 percent.³⁻⁴

Key Measures in this section include:

- ◆ *Childhood Immunization Status—Combination #1*
- ◆ *Childhood Immunization Status—Combination #2*

These are commonly referred to as *Combo 1* and *Combo 2*.

HEDIS Specification: Childhood Immunization Status—Combination #1

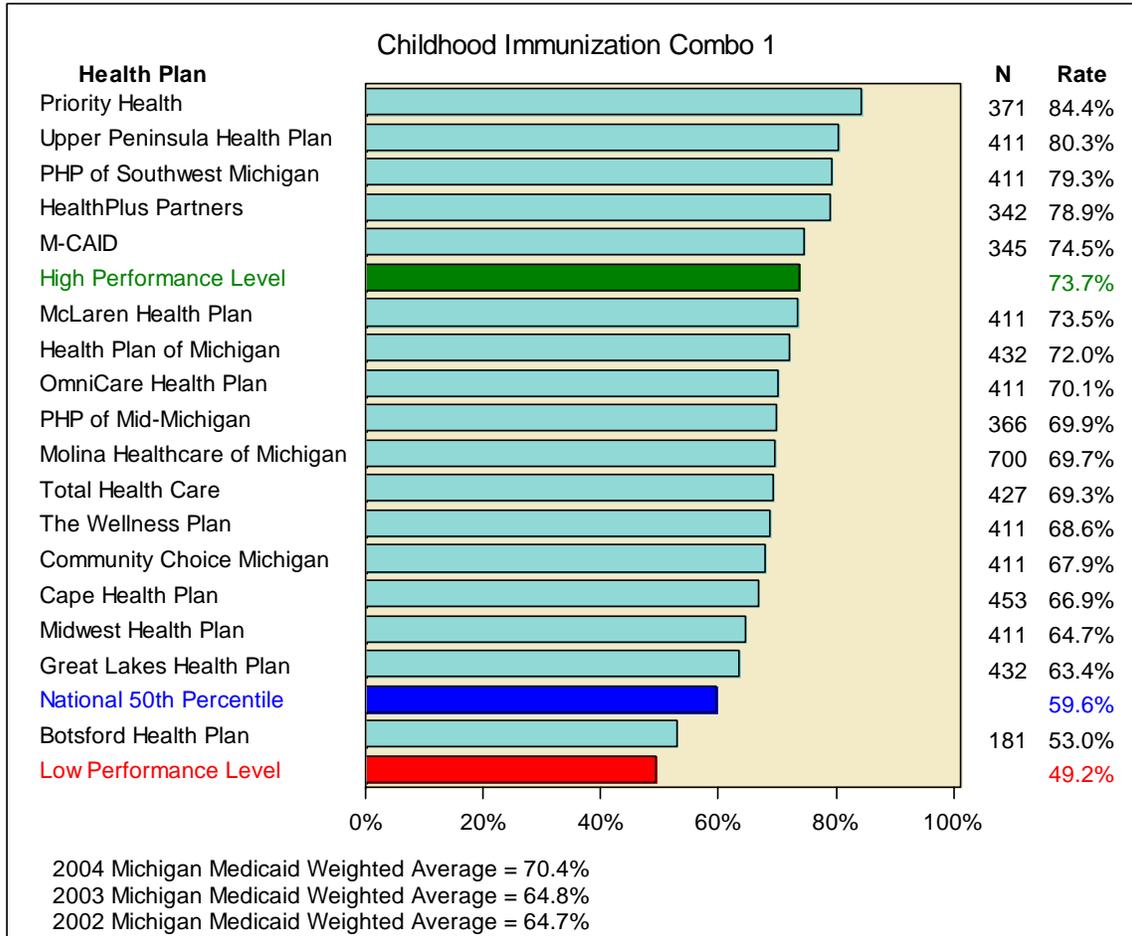
Childhood Immunization Status—Combination #1 calculates the percentage of enrolled children who turned two years old during the measurement year, who were continuously enrolled for 12 months immediately preceding their second birthdays, and who were identified as having four DtaP/DT, three IPV, one MMR, three H influenza type B, and three hepatitis B vaccinations each within the allowable time period and by the member's second birthday.

³⁻³ National Committee for Quality Assurance. *The State of Managed Care Quality, 2001*. Standard Version. Washington, DC: National Committee for Quality Assurance: 2001, p.39.

³⁻⁴ Michigan Public Health Institute. Information for Providers: Accomplishments. 2001 Michigan Childhood Immunization Registry. Available at: http://www.mcir.org/pro_accomp.htm. Accessed on August 11, 2004.

Health Plan Ranking: Childhood Immunization Status—Combination #1

**Figure 3-1—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Childhood Immunization Status—Combination #1**



Five health plans had rates above the HPL of 73.7 percent, while none of the health plans had rates below the LPL of 49.2 percent. Sixteen of the 17 health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

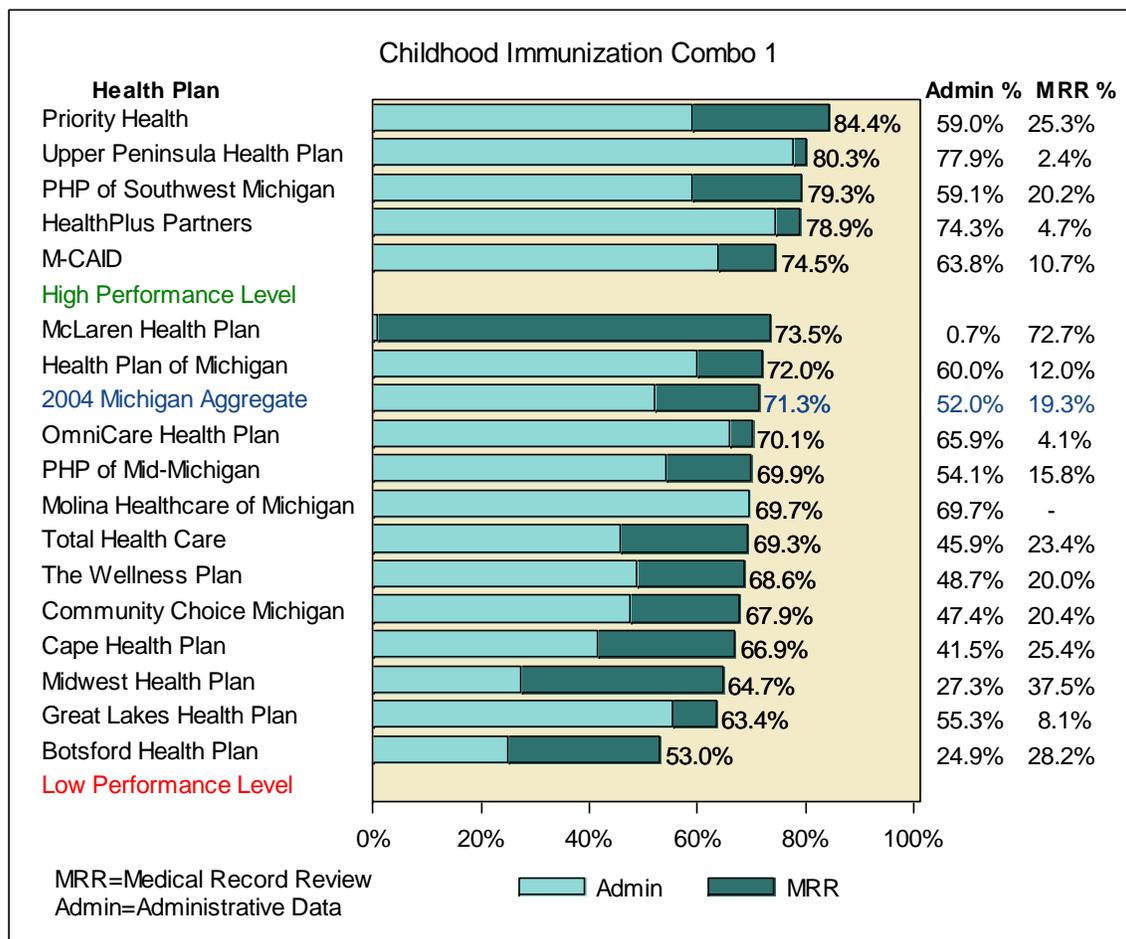
The 2004 Michigan Medicaid weighted average of 70.4 percent was 10.8 percentage points above the national HEDIS 2003 Medicaid 50th percentile of 59.6 percent. The reported rates ranged from a low of 53.0 percent to a high of 84.4 percent. Denominator sizes ranged from 181 to 700.

The 2004 Michigan Medicaid weighted average was higher than 2003, up 5.6 percentage points, and 5.7 percentage points above the 2002 Michigan Medicaid weighted average of 64.7 percent.

In 2003, five health plans reported rates above the HPL and two health plans had rates below the LPL. Overall, the range of reported rates improved from 2003 to 2004.

Data Collection Analysis: Childhood Immunization Status—Combination #1

**Figure 3-2—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Childhood Immunization Status—Combination #1**



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

All health plans with reported rates except Molina Healthcare of Michigan elected to use the hybrid methodology for calculation of this measure. The 2004 Michigan aggregate administrative rate was 52.0 percent, and the medical record review rate was 19.3 percent.

This result illustrates that, overall, 72.9 percent of the aggregate rate was derived from administrative data and 27.1 percent from medical record review. In 2003, 65.4 percent of the aggregate rate was derived from administrative data.

Fourteen health plans derived more than half of their rates from administrative data, while one health plan derived less than 5 percent of its rate from administrative data.

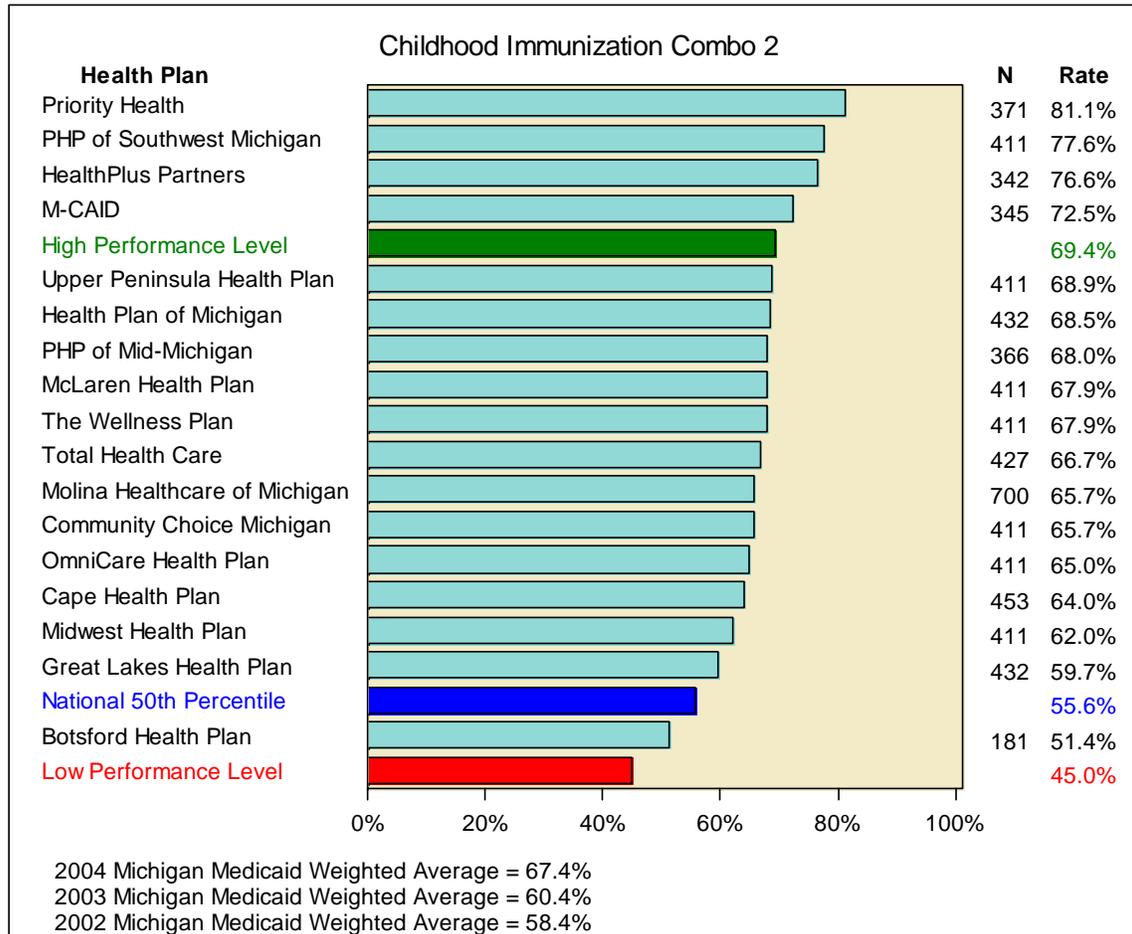
Administrative immunization data continue to improve with respect to the *Childhood Immunization Status* Key Measures. Notable are two health plans that exceeded the HPL and identified less than 5 percent of their compliant cases through medical record review.

HEDIS Specification: Childhood Immunization Status—Combination #2

Childhood Immunization Status—Combination #2 reports the percentage of enrolled children who turned two years old during the measurement year, who were continuously enrolled for 12 months immediately preceding their second birthdays, and who were identified as having all of the vaccines listed in Combination #1 and at least one varicella-zoster virus (chickenpox) vaccine (VZV) by the member's second birthday.

Health Plan Ranking: Childhood Immunization Status—Combination #2

**Figure 3-3—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Childhood Immunization Status—Combination #2**



Four health plans had rates above the HPL of 69.4 percent, while none of the health plans had rates below the LPL of 45.0 percent. Sixteen of the 17 health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

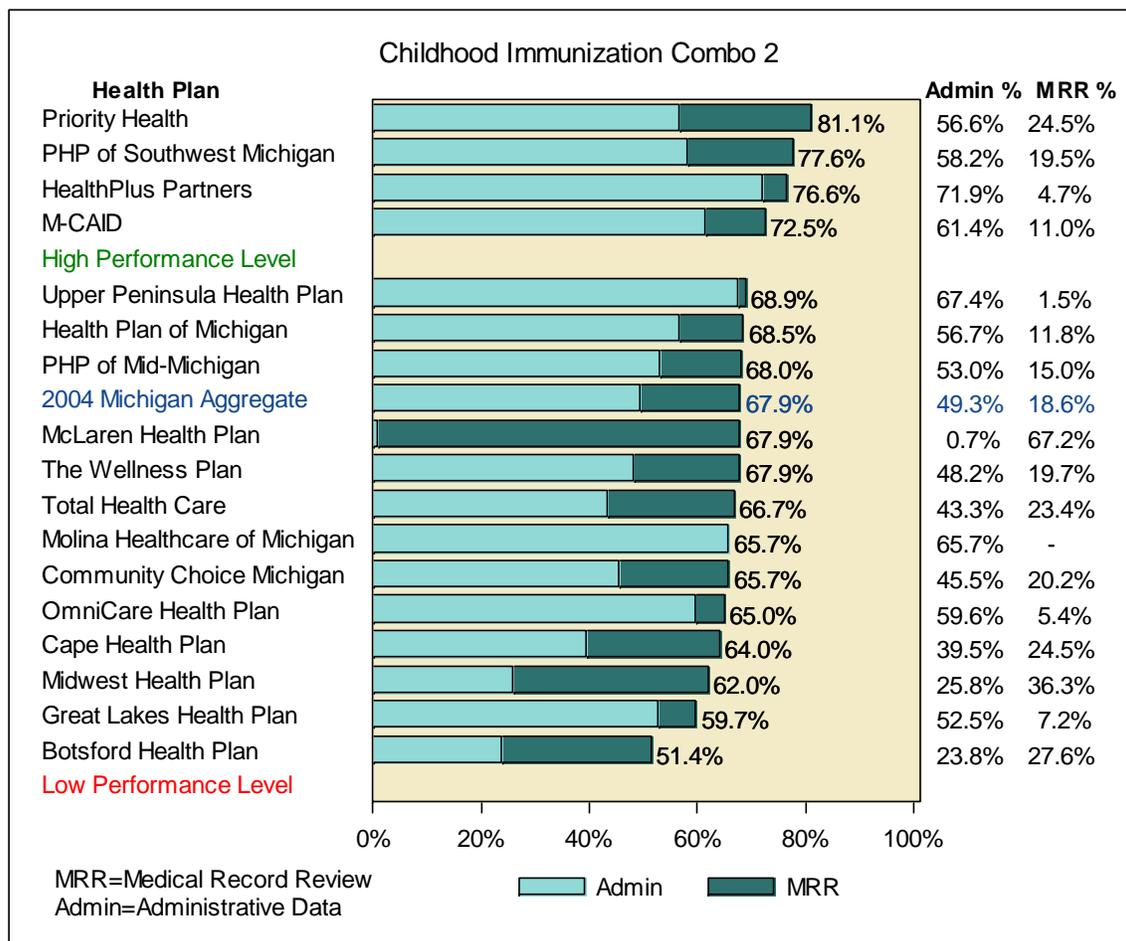
The 2004 Michigan Medicaid weighted average of 67.4 percent was 11.8 percentage points above the national HEDIS 2003 Medicaid 50th percentile of 55.6 percent. The reported rates ranged from a low of 51.4 percent to a high of 81.1 percent. Denominator sizes ranged from 181 to 700.

The 2004 Michigan Medicaid weighted average showed a statistically significant increase over 2003, up 7.0 percentage points. A gain of 9.0 percentage points was observed when compared to the 2002 Michigan Medicaid weighted average of 58.4 percent.

In 2003, four health plans reported rates above the HPL, and one health plan had a rate below the LPL. Overall, the range of reported rates showed a substantial increase from 2003 to 2004.

Data Collection Analysis: Childhood Immunization Status—Combination #2

**Figure 3-4—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Childhood Immunization Status—Combination #2**



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

With the exception of Molina Healthcare of Michigan, all health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2004 Michigan aggregate administrative rate was 49.3 percent, and the medical record review rate was 18.6 percent.

This result demonstrates that, overall, 72.6 percent of the aggregate rate was derived from administrative data and 27.4 percent from medical record review. In 2003, 64.8 percent of the aggregate rate was derived from administrative data.

Fourteen health plans derived more than half of their rates from administrative data, while one health plan derived less than 5 percent of its rate from administrative data.

Again, administrative immunization data appear complete, enhanced by consistent use of the MCIR. The addition of the varicella antigen (the difference between *Combo #1* and *Combo #2*) resulted in no impact to the administrative versus medical record breakout.

Adolescent Immunization Status

In the United States, immunization programs that focus on infants and children have decreased the occurrence of many vaccine-preventable diseases. However, adolescents and young adults continue to be adversely affected by vaccine-preventable diseases (e.g., varicella, hepatitis B, measles, and rubella), partly because many immunization programs have placed less emphasis on improving vaccination coverage among adolescents.

Each year, more than 70 percent of the estimated 125,000 new cases of hepatitis B affect adolescents and young adults.³⁻⁵ Immunizations effectively and efficiently reduce the occurrence of harmful and costly diseases. For every dollar spent, savings can range from \$2.20 for hepatitis B to as high as \$13 for the MMR vaccine.³⁻⁶

Key Measures in this section include:

- ◆ *Adolescent Immunization Status—Combination #1*
- ◆ *Adolescent Immunization Status—Combination #2*

These are commonly referred to as *Combo 1* and *Combo 2*.

HEDIS Specification: Adolescent Immunization Status—Combination #1

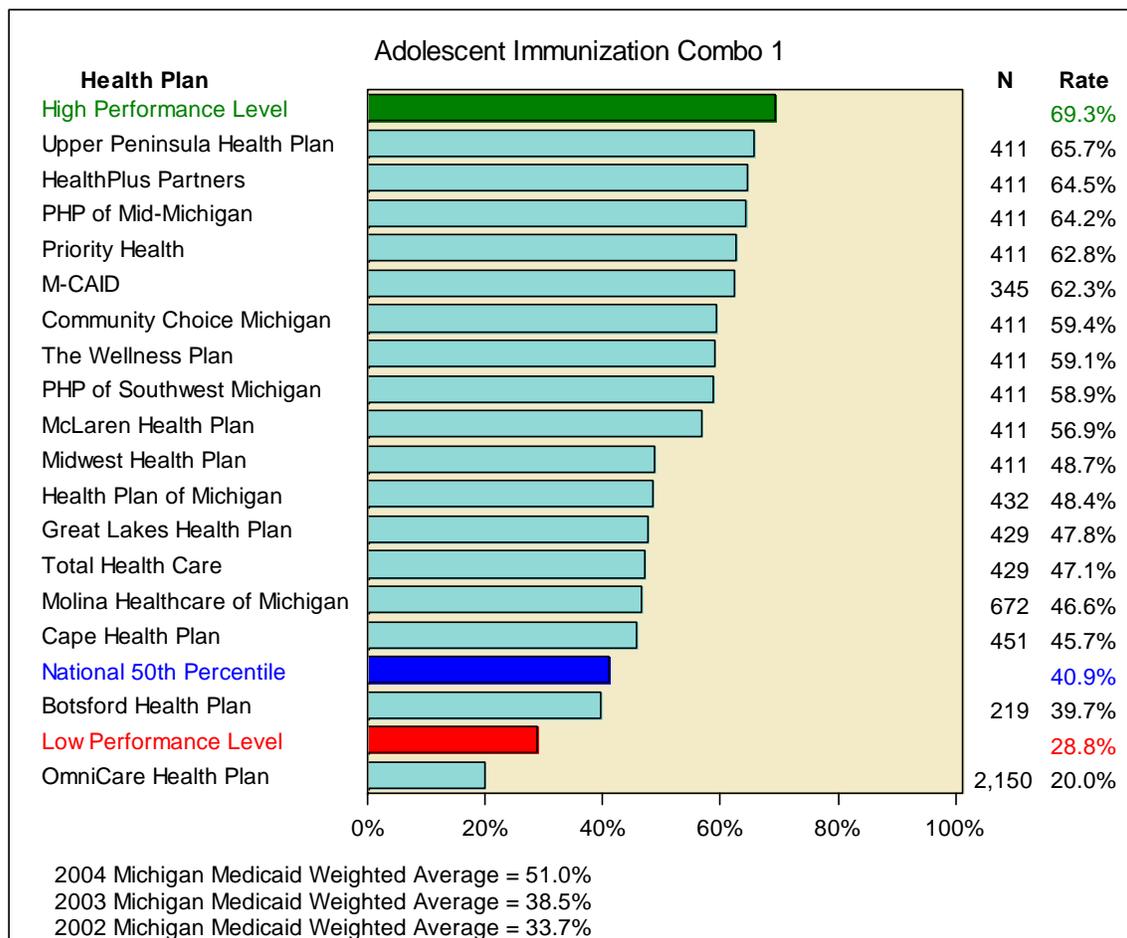
Adolescent Immunization Status—Combination #1 calculates the percentage of enrolled adolescents who turned 13 years old during the measurement year, who were continuously enrolled for 12 months immediately prior to their 13th birthdays, and who were identified as having had a second dose of MMR, and three hepatitis B vaccinations within the allowed time period and by the member's 13th birthday.

³⁻⁵ National Committee for Quality Assurance. *The State of Managed Care Quality. 2003* (Standard Version). Washington, DC: National Committee for Quality Assurance: 2003, p.23.

³⁻⁶ Iowa Department of Public Health. "Ch. 10: Immunization and Infectious Diseases," *Healthy Iowans 2010*.

Health Plan Ranking: Adolescent Immunization Status—Combination #1

**Figure 3-5—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Adolescent Immunization Status—Combination #1**



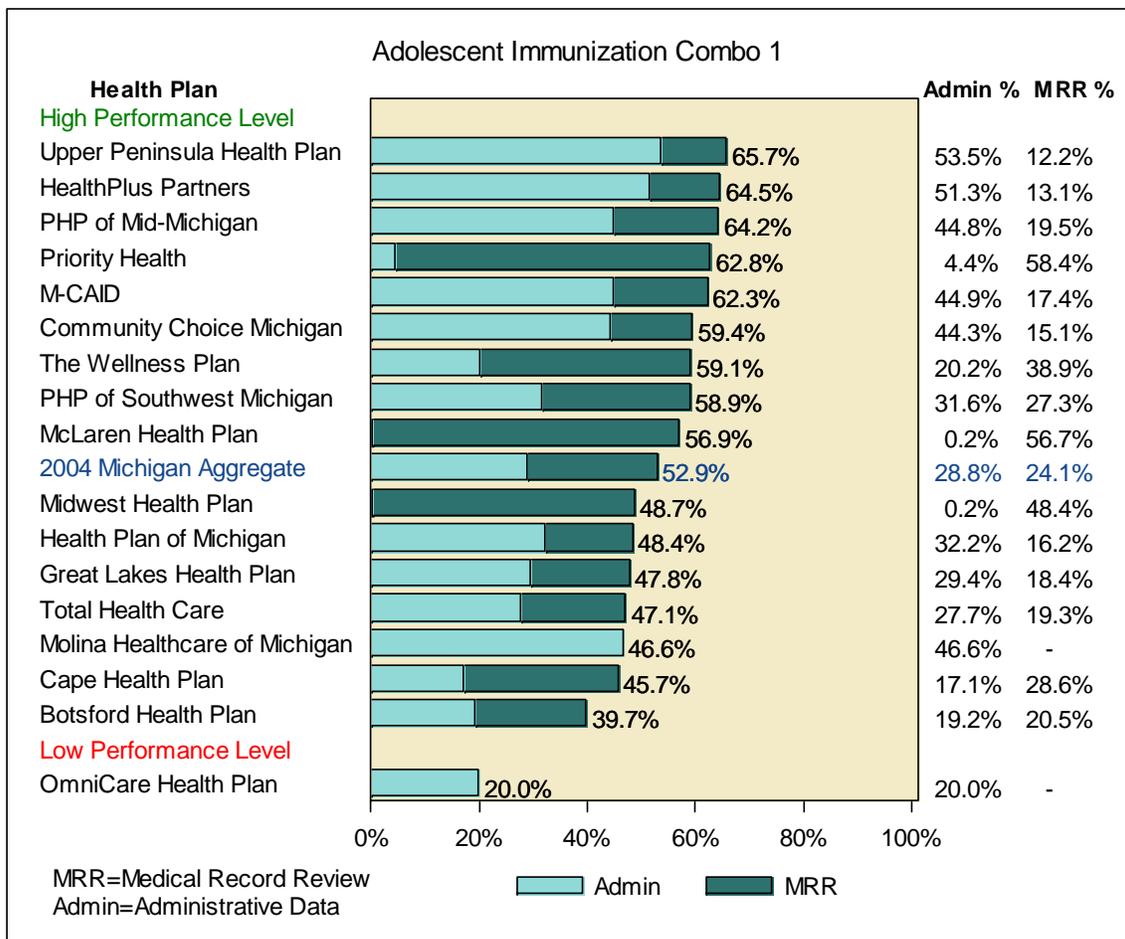
None of the health plans had rates above the HPL of 69.3 percent, while one health plan had a rate below the LPL of 28.8 percent. A total of 15 health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

The 2004 Michigan Medicaid weighted average of 51.0 percent was 10.1 percentage points above the national HEDIS 2003 Medicaid 50th percentile of 40.9 percent. The reported rates ranged from a low of 20.0 percent to a high of 65.7 percent. Denominator sizes ranged from 219 to 2,150.

The 2004 Michigan Medicaid weighted average showed a statistically significant increase over 2003, up 12.5 percentage points. A gain of 17.3 percentage points was observed when compared to the 2002 Michigan Medicaid weighted average of 33.7 percent.

In 2003, none of the health plans reported rates above the HPL, and one health plan had a rate below the LPL. The range of reported rates improved from 2003 to 2004, with three additional health plans exhibiting rates above the national HEDIS 2003 Medicaid 50th percentile.

Data Collection Analysis: Adolescent Immunization Status—Combination #1
Figure 3-6—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Adolescent Immunization Status—Combination #1



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

Fifteen of the 17 health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2004 Michigan aggregate administrative rate was 28.8 percent, and the medical record review rate was 24.1 percent.

This result illustrates that, overall, 54.4 percent of the aggregate rate was derived from administrative data and 45.6 percent from medical record review. In 2003, 46.4 percent of the aggregate rate was derived from administrative data.

Eleven health plans derived more than half of their rates from administrative data, while three health plans derived less than 5 percent of their rates from administrative data.

The completeness of administrative immunization data in Michigan Medicaid managed care has improved over the past year, accounting for more than half of the final reported rates. Nationally, health plans rely heavily on medical record review to report immunization measures. Michigan MHPs are an exception because their use of the MCIR greatly enhances the completeness of administrative data, reducing the volume of medical records that must be collected to report immunization rates accurately.

HEDIS Specification: Adolescent Immunization Status—Combination #2

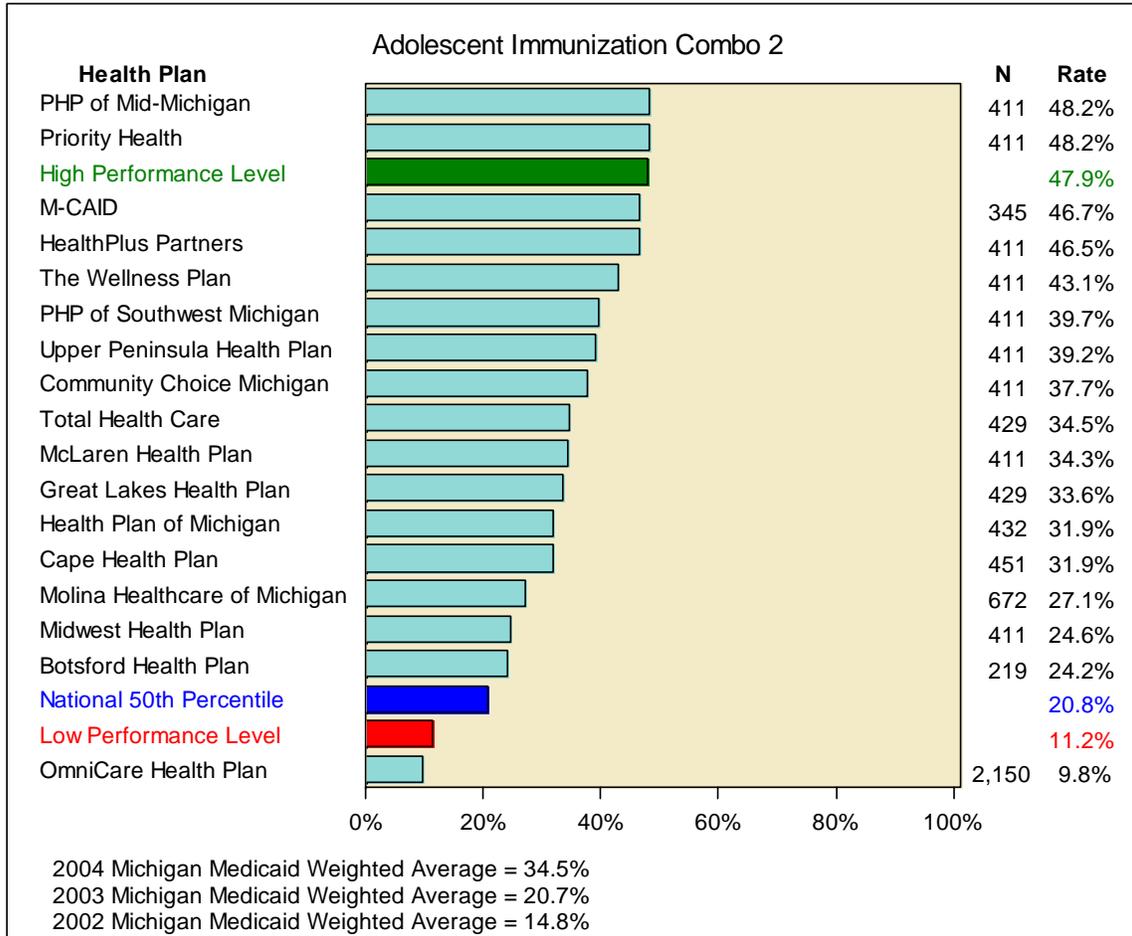
Adolescents are 10 times more likely than children to develop serious complications from varicella-zoster virus, commonly known as “chickenpox.” The rate of complications is greatest for those individuals aged 15 years or older, yet a significant number of teens still do not receive VZVs.³⁻⁷

The *Adolescent Immunization Status—Combination #2* measure calculates the percentage of enrolled adolescents who turned 13 years old during the measurement year, who were continuously enrolled for 12 months immediately prior to their 13th birthdays, and who were identified as having had all of the vaccinations listed in Combination #1 and at least one VZV within the allowed time period and by the member’s 13th birthday.

³⁻⁷ National Committee for Quality Assurance. *The State of Managed Care Quality, 2001*. Standard Version. Washington, DC: National Committee for Quality Assurance; 2001:26.

Health Plan Ranking: Adolescent Immunization Status—Combination #2

**Figure 3-7—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Adolescent Immunization Status—Combination #2**



Two health plans had rates above the HPL of 47.9 percent, whereas one health plan had a rate below the LPL of 11.2 percent. Sixteen of the 17 health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

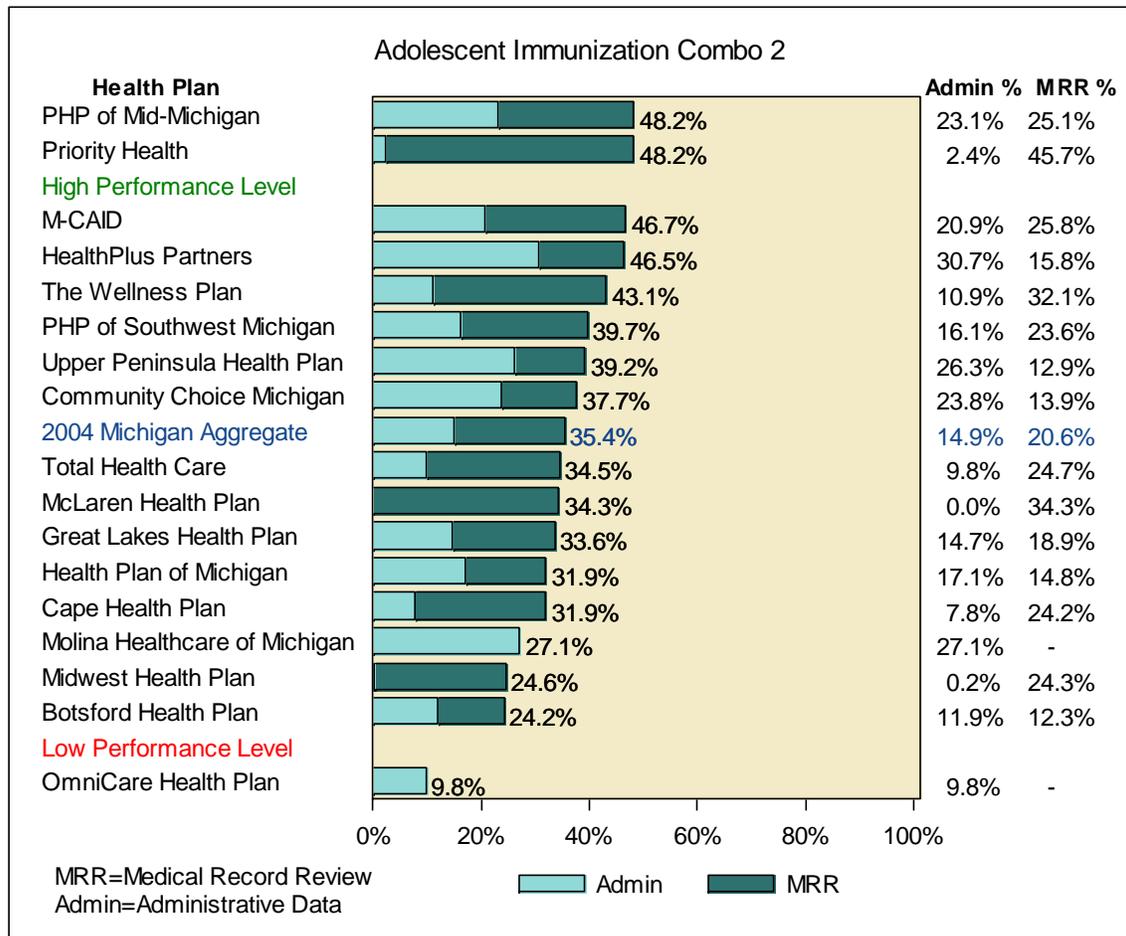
The 2004 Michigan Medicaid weighted average of 34.5 percent was 13.7 percentage points above the national HEDIS 2003 Medicaid 50th percentile of 20.8 percent. The reported rates ranged from a low of 9.8 percent to a high of 48.2 percent. Denominator sizes ranged from 219 to 2,150.

The 2004 Michigan Medicaid weighted average showed a statistically significant increase over 2003, up 13.8 percentage points. A gain of 19.7 percentage points was observed over the 2002 Michigan Medicaid weighted average of 14.8 percent.

In 2003, none of health plans reported rates above the HPL or below the LPL. Although one health plan fell below the LPL in 2004, the range of reported rates improved from 2003 to 2004.

Data Collection Analysis: Adolescent Immunization Status—Combination #2

**Figure 3-8—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Adolescent Immunization Status—Combination #2**



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

Fifteen of the 17 health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2004 Michigan aggregate administrative rate was 14.9 percent, and the medical record review rate was 20.6 percent.

This result indicates that approximately 42.0 percent of the aggregate rate was derived from administrative data and 58.2 percent from medical record review. In 2003, 30.8 percent of the aggregate rate was derived from administrative data.

Six health plans derived more than half of their rates from administrative data, while three health plans derived less than 5 percent of their rates from administrative data.

Improvement in the completeness of administrative immunization data is seen over the 2003 results. The addition of the varicella-zoster virus vaccine (the difference between *Combo #1* and *Combo #2*) resulted in more reliance on the medical record to identify fully compliant members—although, as seen in *Combo #1*, a good portion of the fully compliant cases were identified solely from administrative data.

Well-Child Visits in the First 15 Months of Life

The American Medical Association (AMA), the federal government's Bright Future program, and the American Academy of Pediatrics (AAP) all recommend comprehensive periodic well-child visits for children. These periodic checkups provide opportunities for addressing the physical, emotional, and social aspects of their health. These well-child visits provide opportunities for the primary care providers to detect physical, developmental, behavioral, and emotional problems and provide early interventions and treatment and appropriate referrals to specialists. It is also recommended that clinicians use these visits to offer counseling and guidance to parents.

Michigan EPSDT requirements specify the components of age-appropriate well-child visits. The required components include: review of the child's clinical history and immunization status, measuring height and weight, sensory screening, developmental assessment, anticipatory guidance, nutritional assessment, and testing for lead risk, tuberculosis, etc. Without these visits, children are at much greater risk of reaching their teenage years with developmental problems that have not been addressed. Although the HEDIS well-child visit measures do not directly collect performance data on individual EPSDT components rendered during a visit, the measures provide an indication of the amount of well-care visits delivered to children of various age groups.

Key Measures include the following rates:

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

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

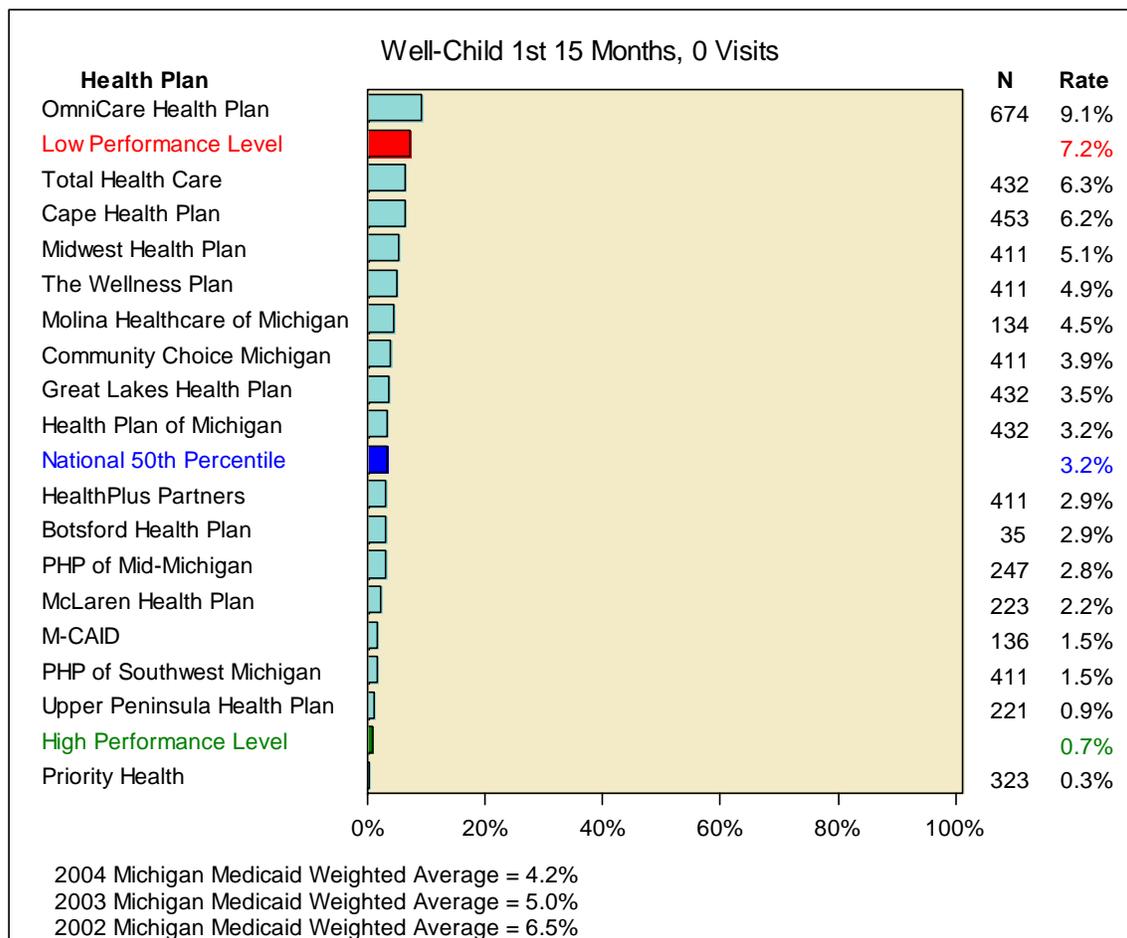
HEDIS Specification: Well-Child Visits in the First 15 Months of Life—Zero Visits

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

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

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

**Figure 3-9—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Well-Child Visits in the First 15 Months of Life—Zero Visits**



For this Key Measure, a *lower* rate indicates better performance, since low rates of Zero Visits indicate better care.

Figure 3-9 shows the percentage of children who received **no** well-child visits by age 15 months. For this measure, a *lower* rate indicates better performance.

One health plan had a rate above the HPL of 0.3 percent, while one health plan had a rate below the LPL of 7.2 percent. A total of eight health plans reported rates lower than the national HEDIS 2003 Medicaid 50th percentile, indicating better performance. The reported rates ranged from a low of 0.3 percent to a high of 9.1 percent. Denominator sizes ranged from 35 to 674.

The 2004 Michigan Medicaid weighted average showed improvement over 2003, down 0.8 percentage points, and improving by 2.3 percentage points from the 2002 Michigan Medicaid weighted average of 6.5 percent.

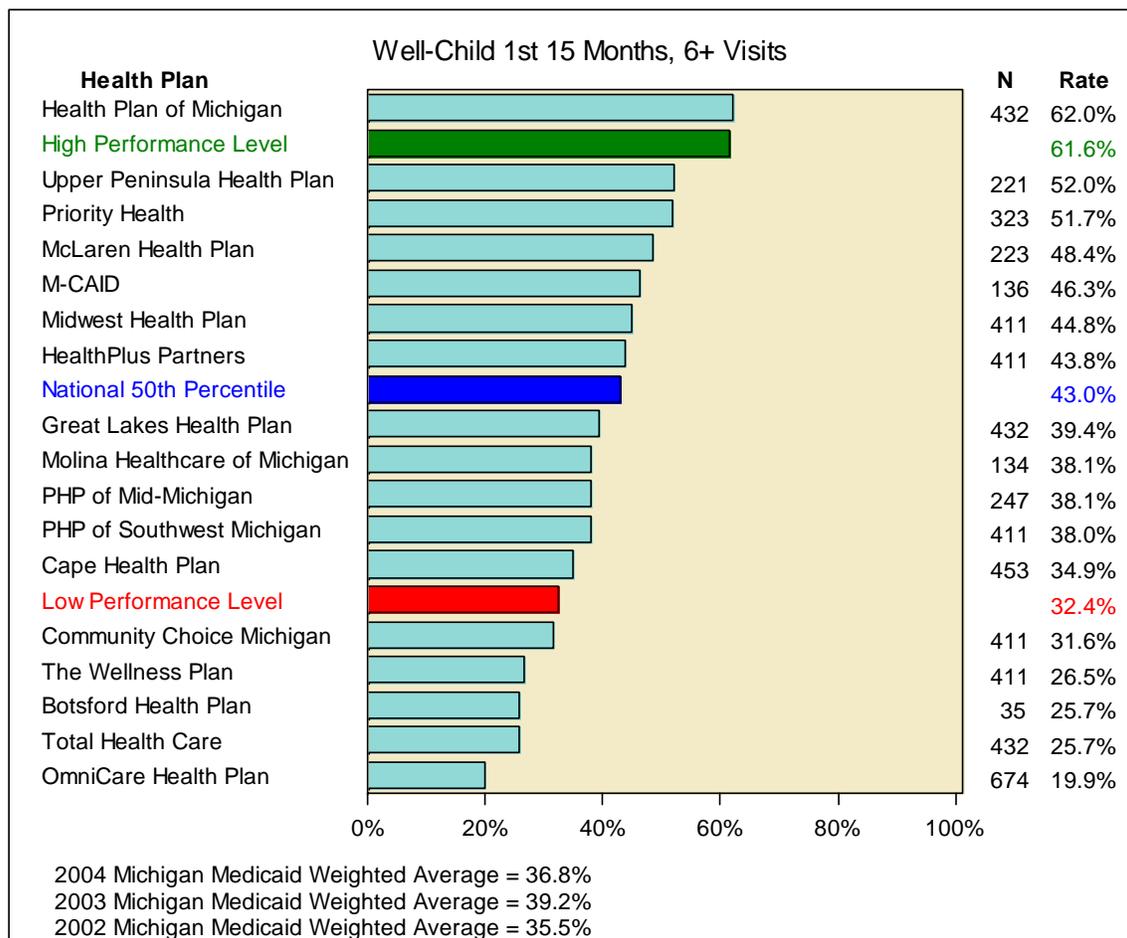
In 2003, two health plans reported rates above the HPL, and four health plans had rates below the LPL. Overall, the range of reported rates demonstrated improvement from 2003 to 2004.

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

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

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

**Figure 3-10—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Well-Child Visits in the First 15 Months of Life—Six or More Visits**



One health plan had a rate above the HPL of 61.6 percent, whereas five health plans had rates below the LPL of 32.4 percent. A total of seven health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

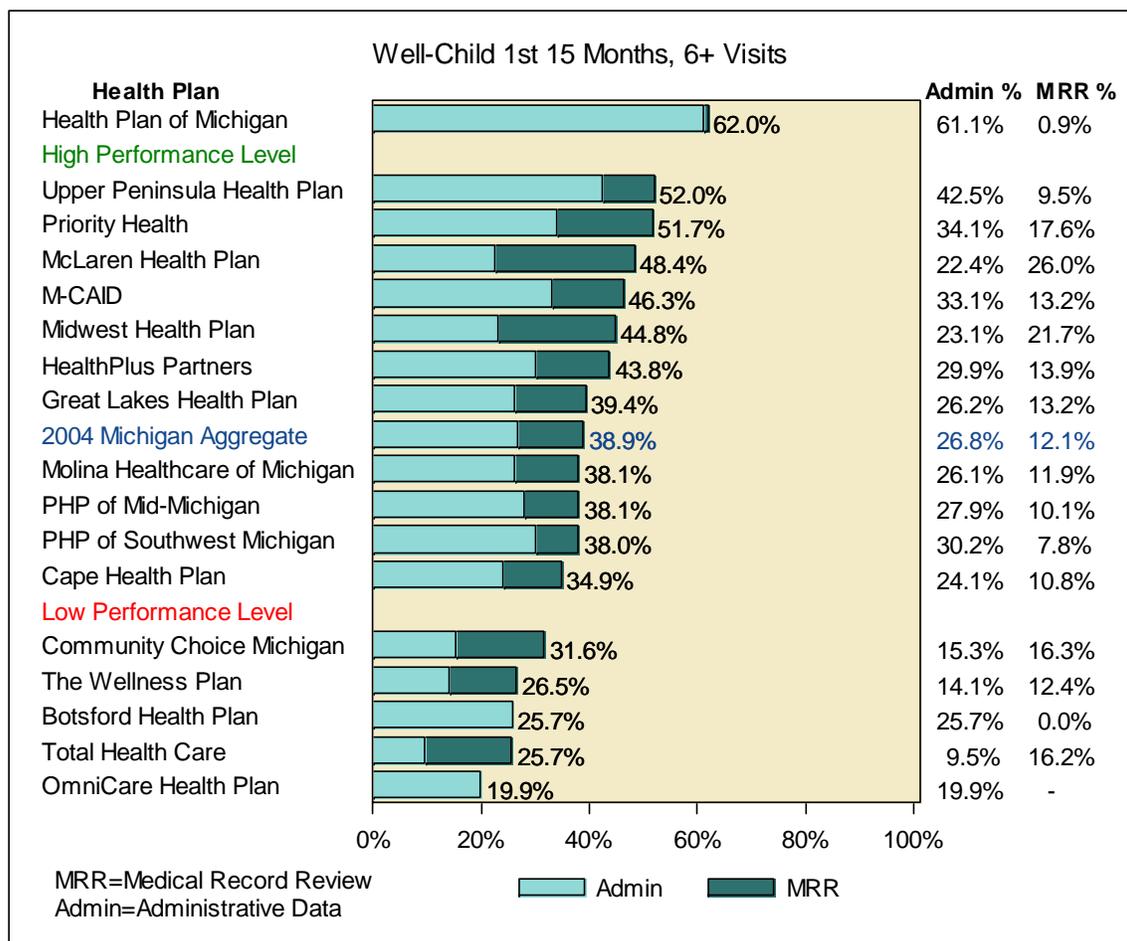
The 2004 Michigan Medicaid weighted average of 36.8 percent was 6.2 percentage points below the national HEDIS 2003 Medicaid 50th percentile of 43.0 percent. The reported rates ranged from a low of 19.9 percent to a high of 62.0 percent. Denominator sizes ranged from 35 to 674.

The 2004 Michigan Medicaid weighted average was lower than 2003, down 2.4 percentage points, while 1.3 percentage points above the 2002 Michigan Medicaid weighted average of 35.5 percent.

In 2003, one health plan reported a rate above the HPL, and three health plans had rates below the LPL. Overall, the range of reported rates showed no improvement from 2003 to 2004, with five health plans reporting rates below the LPL.

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

**Figure 3-11—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Well-Child Visits in the First 15 Months of Life—Six or More Visits**



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

Overall, 16 of the 17 Michigan MHPs reported this measure using the hybrid methodology. The 2004 Michigan aggregate administrative rate was 26.8 percent, and the medical record review rate was 12.1 percent.

This result illustrates that, overall, 68.9 percent of the aggregate rate was derived from administrative data and 31.1 percent from medical record review. In 2003, 59.8 percent of the aggregate rate was derived from administrative data.

Fourteen health plans derived more than half of their rates from administrative data, while none of the health plans derived less than 5 percent of their rates from administrative data.

Administrative data completeness for well-child care visits is strong and appears to be improving among the Michigan MHPs. The top performer, Health Plan of Michigan, derived over 98 percent of its reported rate from administrative data, indicating very complete administrative data.

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

The AAP recommends annual well-child visits for two- to six-year-olds. These check-up visits during the preschool and early school years allow clinicians to detect vision, speech, and language problems at the earliest opportunity. Early intervention in these areas can improve the child's communication skills and reduce language and learning problems.

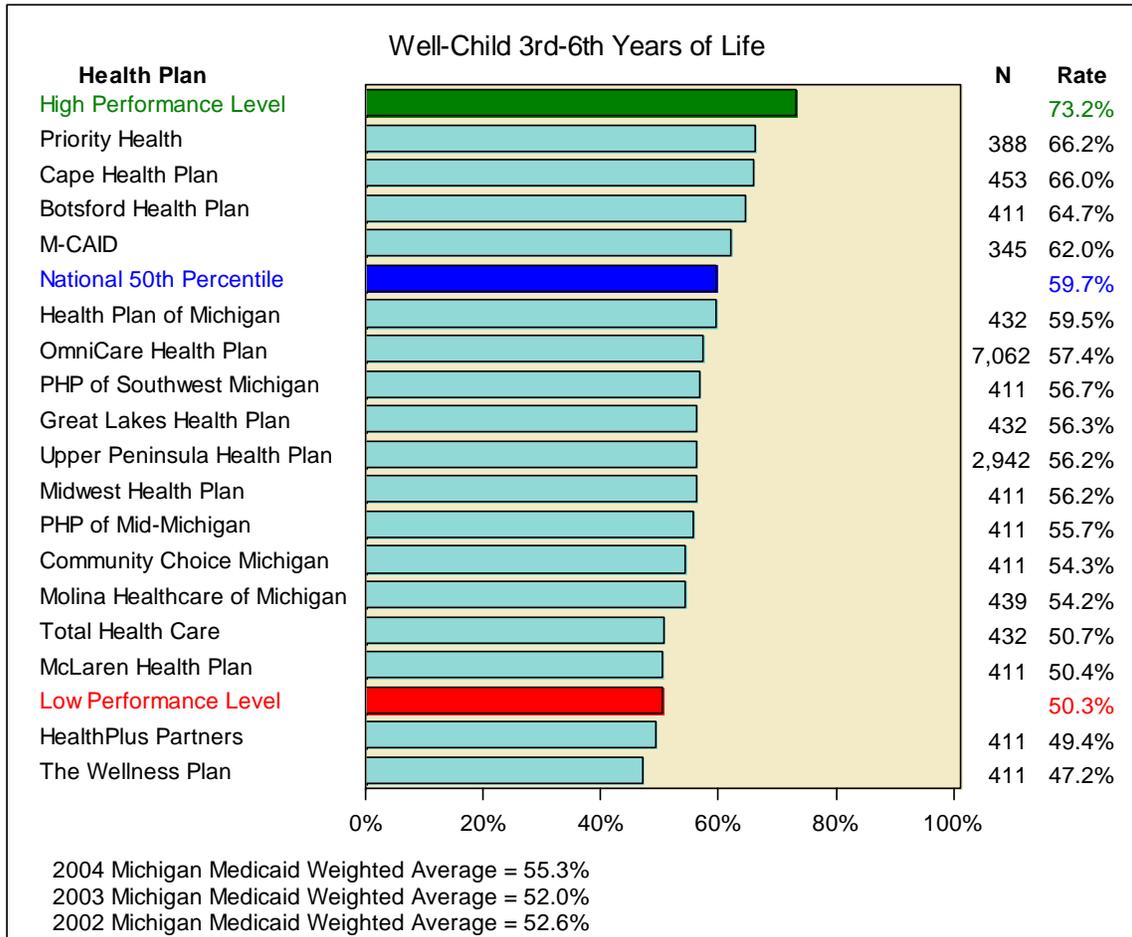
The following pages analyze in detail the performance profile, health plan rankings, and data collection methodology used by the Michigan MHPs for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

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

This Key Measure, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, reports the percentage of members who were three, four, five, or six years old during the measurement year; who were continuously enrolled during the measurement year; and who received one or more well-child visits with a primary care practitioner during the measurement year.

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

**Figure 3-12—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life**



None of the health plans had rates above the HPL of 73.2 percent, while two health plans had rates below the LPL of 50.3 percent. Four health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

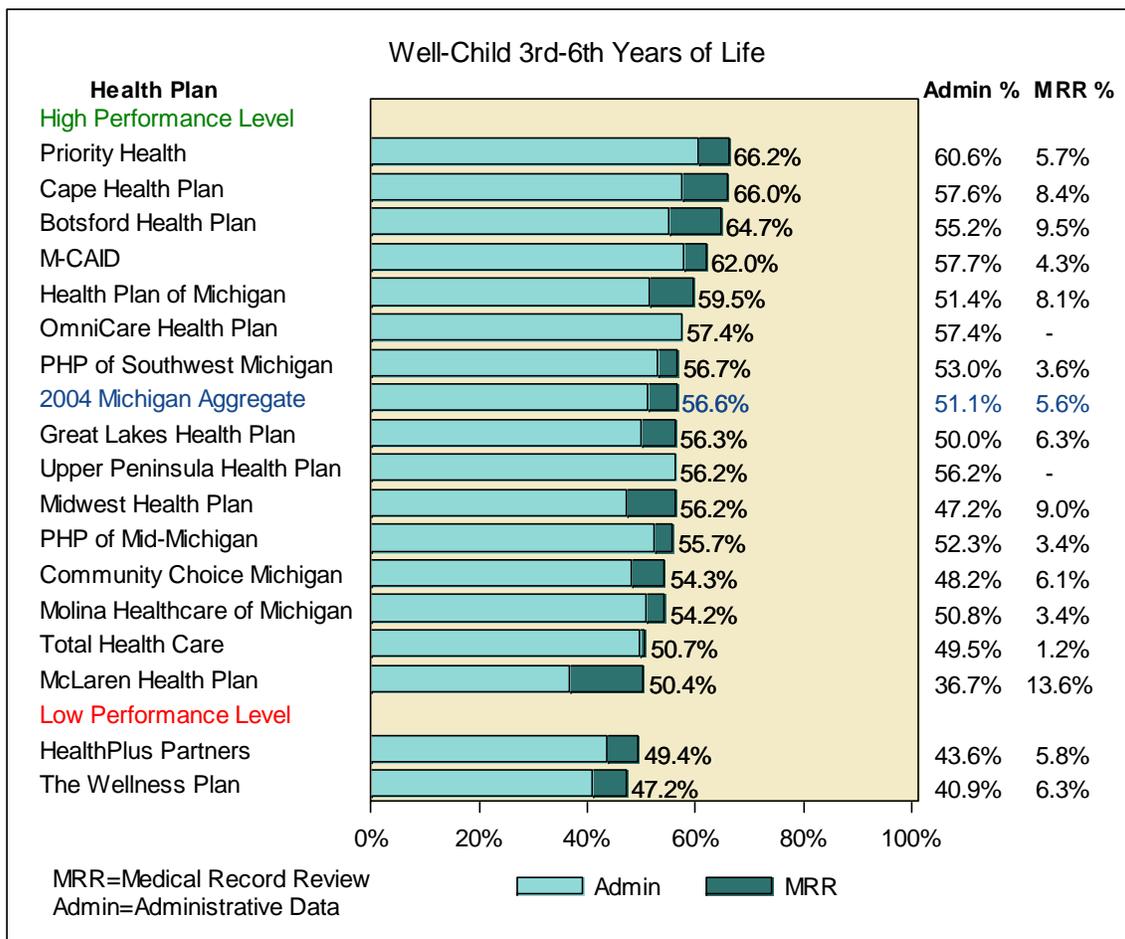
The 2004 Michigan Medicaid weighted average of 55.3 percent was 4.4 percentage points below the national HEDIS 2003 Medicaid 50th percentile of 59.7 percent. The reported rates ranged from a low of 47.2 percent to a high of 66.2 percent. Denominator sizes ranged from 345 to 7,062.

The 2004 Michigan Medicaid weighted average was higher than 2003, increasing by 3.3 percentage points, and 2.7 percentage points above the 2002 Michigan Medicaid weighted average of 52.6 percent.

In 2003, one health plan had a reported rate above the HPL, and four health plans had rates below the LPL. Although none of the health plans reached the HPL in 2004, the range of reported rates showed an improvement in 2004 when compared to 2003, with two fewer health plans falling below the LPL.

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

**Figure 3-13—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life**



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

Fifteen of the 17 health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2004 Michigan aggregate administrative rate was 51.1 percent, and the medical record review rate was 5.6 percent.

This result indicates that approximately 90.0 percent of the aggregate rate was derived from administrative data and 10.0 percent from medical record review. In 2003, 88.0 percent of the aggregate rate was derived from administrative data.

All health plans derived more than half of their rates from administrative data, indicating that Michigan Medicaid MHP administrative data for reporting well-child visits for children ages 3 to 6 years old are very complete.

Adolescent Well-Care Visits

Unintentional injuries, homicide, and suicide are the leading causes of adolescent death. Sexually transmitted diseases, substance abuse, pregnancy, and anti-social behavior are important causes of physical, emotional, and social problems among adolescents. The AMA Guidelines for Adolescent Preventive Services (GAPS), the federal government's Bright Futures programs, and the AAP guidelines all recommend comprehensive annual health care visits for adolescents.

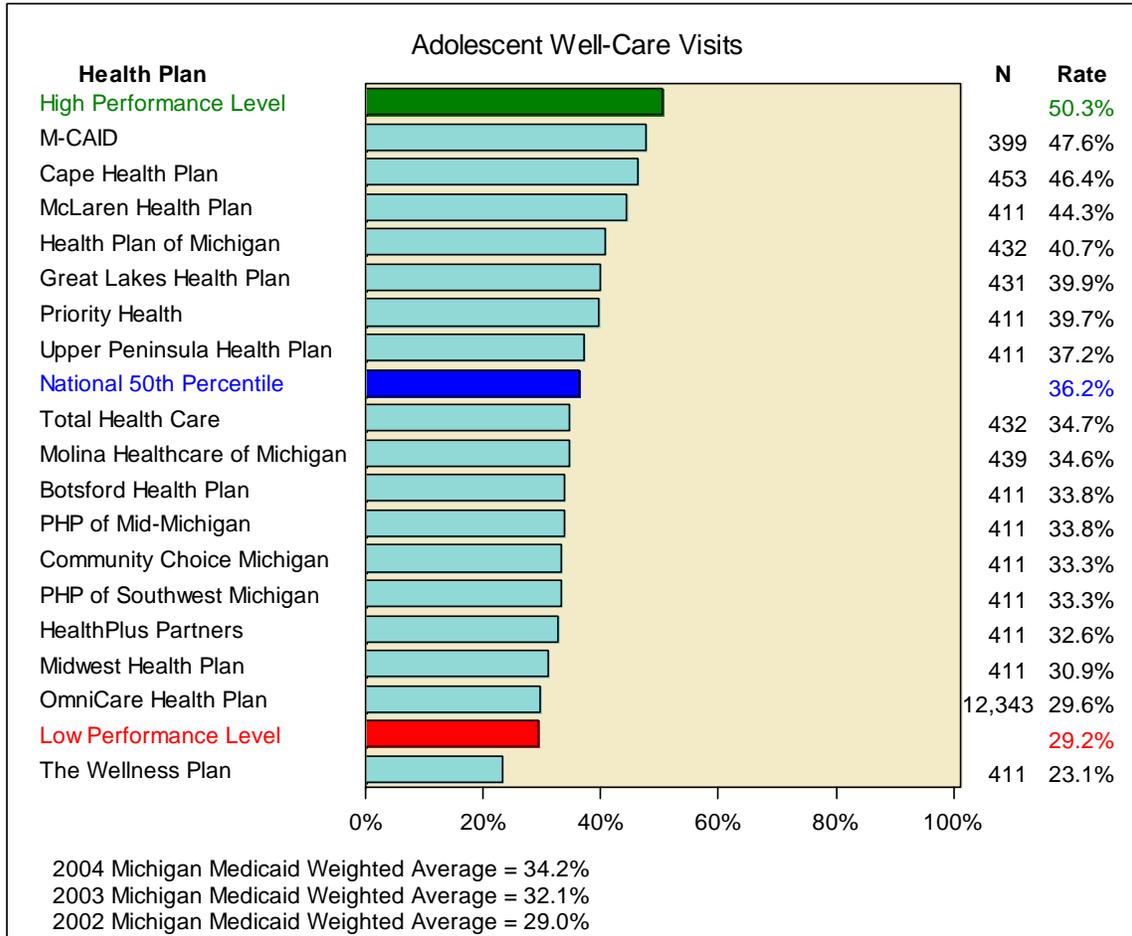
The following pages analyze in detail the performance profile, health plan rankings, and data collection methodology used by the Michigan MHPs for *Adolescent Well-Care Visits*.

HEDIS Specification: Adolescent Well-Care Visits

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

Health Plan Ranking: Adolescent Well-Care Visits

**Figure 3-14—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Adolescent Well-Care Visits**



None of the health plans had rates above the HPL of 50.3 percent, while one health plan had a rate below the LPL of 29.2 percent. A total of seven health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

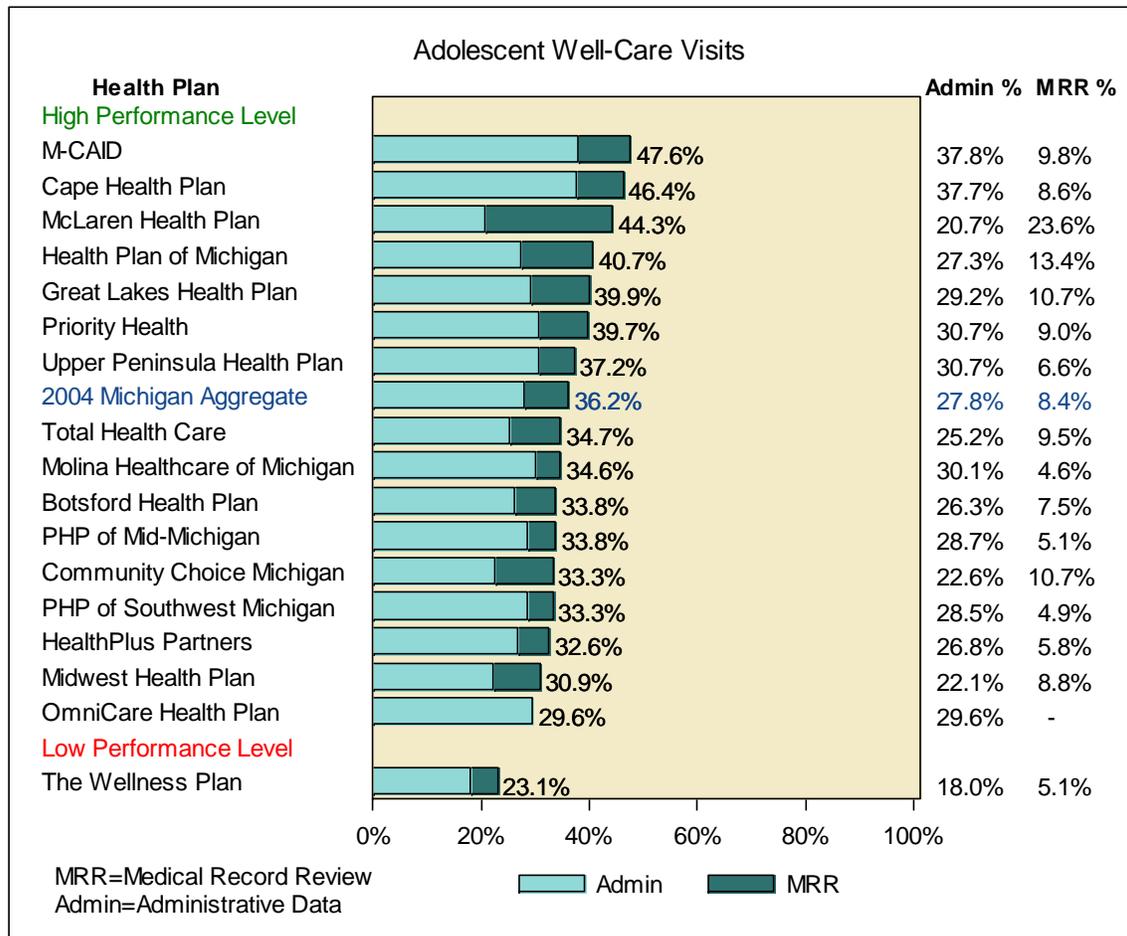
The 2004 Michigan Medicaid weighted average of 34.2 percent was 2.0 percentage points below the national HEDIS 2003 Medicaid 50th percentile of 36.2 percent. The reported rates ranged from a low of 23.1 percent to a high of 47.6 percent. Denominator sizes ranged from 399 to 12,343.

The 2004 Michigan Medicaid weighted average was higher than 2003, up 2.1 percentage points, and 5.2 percentage points above the 2002 Michigan Medicaid weighted average of 29.0 percent.

In 2003, one health plan reported a rate above the HPL and none below the LPL. In 2004, more health plans fell below the national 50th percentile than in 2003.

Data Collection Analysis: Adolescent Well-Care Visits

**Figure 3-15—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Adolescent Well-Care Visits**



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

With the exception of OmniCare Health Plan, all health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2004 Michigan aggregate administrative rate was 27.8 percent, and the medical record review rate was 8.4 percent.

This result illustrates that, overall, 76.8 percent of the aggregate rate was derived from administrative data and 23.2 percent from medical record review. In 2003, 76.2 percent of the aggregate rate was derived from administrative data.

Sixteen health plans derived more than half of their rates from administrative data, while none of the health plans derived less than 5 percent of their rates from administrative data.

Administrative encounter data completeness for well-care visits remained consistent from 2003 to 2004. Although a majority of the identified numerator events come from administrative data, there is an opportunity for improvement in the area of data completeness for well-child care services provided by the Michigan MHPs.

Pediatric Care Findings and Recommendations

The Michigan Medicaid managed care program continues to be one of the leaders in childhood immunizations. For *Childhood Immunization Status*, both *Combo # 1* and *Combo # 2*, the Michigan Medicaid weighted average is above the national Medicaid 75th percentile, with only one health plan reporting a rate below the national median. Both the highest and lowest Michigan MHP-reported rates increased substantially, leading to a reduction of more than 12 percentage points in the range of Michigan MHP rates. Adolescent immunization rates are also high and improving. The maximum rates for both combinations have improved by more than 13 percentage points, and the weighted average has shown similar improvement (above the 50th percentile, and approaching the 75th).

The area of children's preventive care visits, as demonstrated by the applicable HEDIS measures, exhibits lesser performance. The Michigan Medicaid weighted averages for *Well-Child Visits in the First 15 Months of Life* (both *Zero Visits* and *Six or More Visits*), *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, and *Adolescent Well-Care Visits* are all below the national Medicaid 50th percentile. Only two plans reported a single rate above the HPL. The number of Michigan MHPs reporting rates below the national median increased in all measures, with the majority being an increase of four Michigan MHPs in the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measure.

The dichotomy seen between the high immunization rates and low preventive visit rates is intriguing. All Key Measures in this dimension are measures of patients accessing preventive care. These are arguably not solely measures of Michigan MHP performance but also include patient behavior. When the low rates for preventive care in this dimension are considered along with other low preventive care visit rates seen in other dimensions of this report, it appears that these results are reflective of actual recipient behavior, not data anomalies. One possible explanation for the high performance in the area of immunizations is the improved data-gathering capability gained through the use of the MCIR. It can also be argued that efforts associated with the MCIR have increased attention to childhood immunizations in both the provider and recipient communities and have led to higher immunization rates. HSAG encourages MDCH to work collaboratively with its health plans to address the access issue and develop creative approaches to recipient and provider education efforts targeting preventive well-child care.

Introduction

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

The Women's Care dimension encompasses the following MDCH Key Measures:

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

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

Breast Cancer Screening

Breast cancer is one of the most common types of cancer among American women. In the United States, there will be an estimated 215,990 new cases of breast cancer and 40,200 deaths from breast cancer in 2004.⁴⁻¹ The American Cancer Society estimates that in 2004, 7,270 new cases of breast cancer will be diagnosed among women in Michigan.⁴⁻² While there has been a decline in the overall death rate in recent years, there is a significant racial disparity. Deaths among White women are declining, but deaths among African-American, Hispanic, Asian, and Native American women are not.⁴⁻³

If detected early, the five-year survival rate for localized breast cancer is 96 percent.⁴⁻⁴ Mammograms can detect breast cancer an average of 1.7 years before the patient can feel a breast lump, and are the most effective method for detecting breast cancer in the early stages, when it is most treatable. However, in 2002, more than 45 percent of Michigan women aged 40 and older did not receive appropriately timed breast cancer screening.⁴⁻⁵ Screening costs are low relative to the benefits of early detection. The average cost of treatment of early stage breast cancer is \$11,000, rising to \$140,000 for late stage treatment.⁴⁻⁶

HEDIS Specification: Breast Cancer Screening

The *Breast Cancer Screening* measure calculates the percentage of women aged 50 through 69 years who were continuously enrolled during the measurement year and the year prior to the measurement year, and who had a mammogram during the measurement year or the year prior to the measurement year.

⁴⁻¹ American Cancer Society, 2004. Available at: http://www.cancer.org/docroot/CRI/content/CRI_2_4_1X_What_are_the_key_statistics_for_breast_cancer_5.asp?sitearea. Accessed on August 11, 2004.

⁴⁻² Centers for Disease Control and Prevention, 2004 Cancer Burden Data Fact Sheets, Michigan. Available at: <http://www.cdc.gov/cancer/CancerBurden/mi.htm#breast>. Accessed on August 11, 2004.

⁴⁻³ National Committee for Quality Assurance. *The State of Managed Care Quality, 2001*. Standard Version. Washington, DC: National Committee for Quality Assurance; 2001:35.

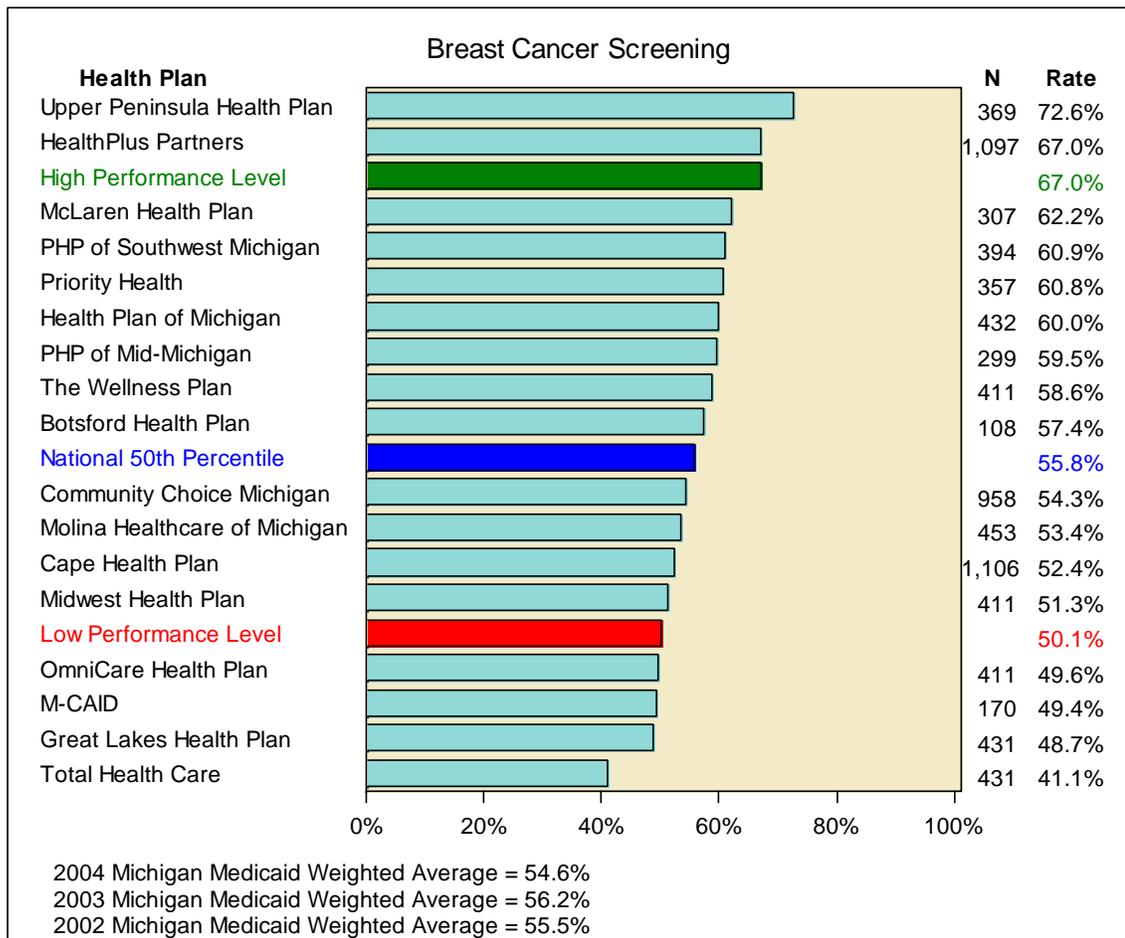
⁴⁻⁴ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. The National Breast and Cervical Cancer Early Detection Program, 2002 Program Fact Sheet August 2003. Available at: <http://www.cdc.gov/cancer/nbccedp/about.htm>. Accessed on August 11, 2004.

⁴⁻⁵ Surgeon General's Health Status Report, Healthy Michigan 2010. Available at: http://www.michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf. Accessed on August 11, 2004.

⁴⁻⁶ National Committee for Quality Assurance. *The State of Managed Care Quality, 2001*. Standard Version. Washington, DC: National Committee for Quality Assurance; 2001:35.

Health Plan Ranking: Breast Cancer Screening

**Figure 4-1—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Breast Cancer Screening**



Two health plans had rates at or above the HPL of 67.0 percent, while four health plans had rates below the LPL of 50.1 percent. A total of nine health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

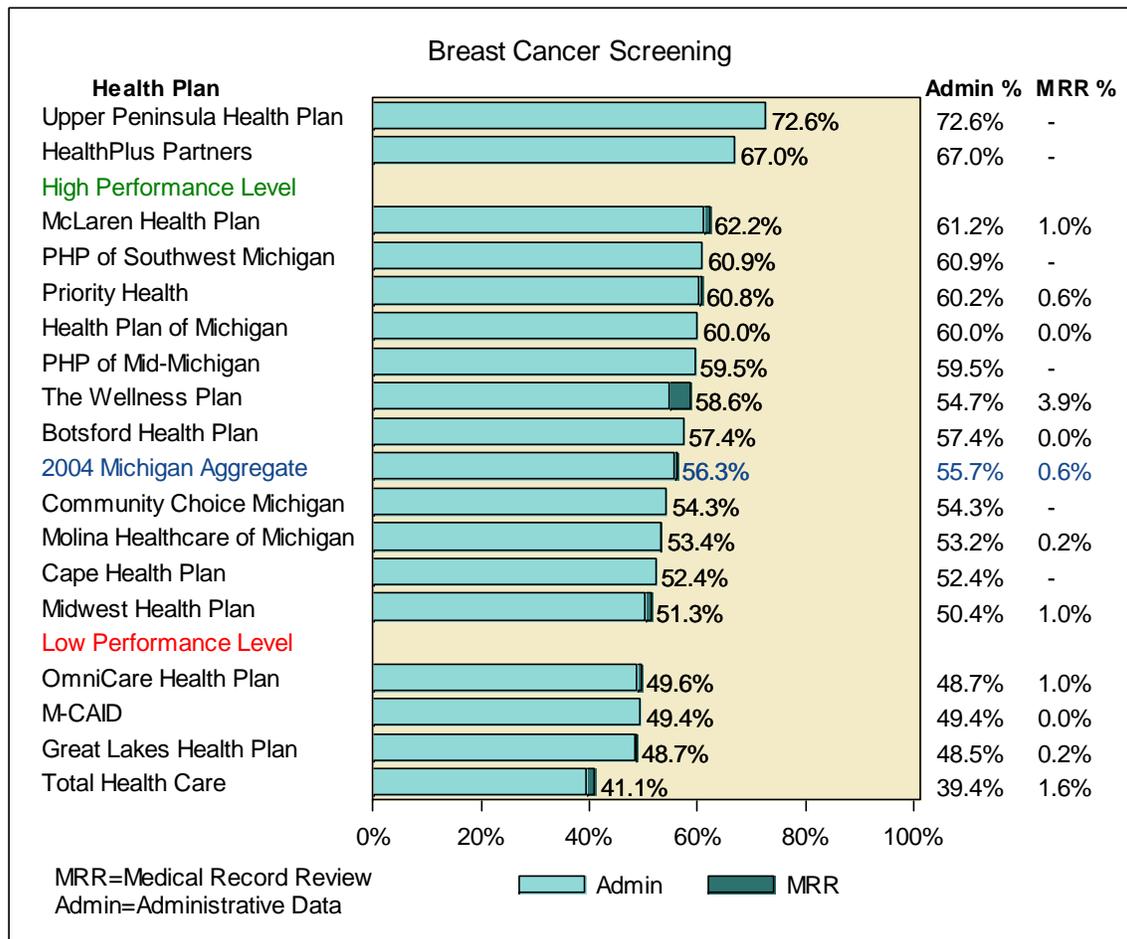
The 2004 Michigan Medicaid weighted average of 54.6 percent was 1.2 percentage points below the national HEDIS 2003 Medicaid 50th percentile of 55.8 percent. The reported rates ranged from a low of 41.1 percent to a high of 72.6 percent. Denominator sizes ranged from 108 to 1,106.

The 2004 Michigan Medicaid weighted average was lower than 2003, down 1.6 percentage points, and 0.9 percentage points below the 2002 Michigan Medicaid weighted average of 55.5 percent.

In 2003, three health plans reported rates above the HPL, and two had rates below the LPL. Overall, the range of reported rates showed a decline in 2004 when compared to 2003.

Data Collection Analysis: Breast Cancer Screening

**Figure 4-2—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Breast Cancer Screening**



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

The 2004 Michigan aggregate administrative rate for this measure was 55.7 percent. Six health plans elected to report this measure using the administrative methodology, while 11 health plans used the hybrid methodology.

Overall results demonstrate that 98.9 percent of the aggregate rate was derived from administrative data and 1.1 percent from medical record review. In 2003, 98.1 percent of the aggregate rate was derived from administrative data.

The 2004 Michigan aggregate rate shows that the total rate increased by only 0.6 percentage points through the use of medical record review. Administrative data for breast cancer screening services are complete, and little gain is seen from using the hybrid method for all Michigan MHPs.

Cervical Cancer Screening

Cervical cancer is one of the most successfully treatable cancers when detected early. Since the incidence of cervical cancer increases with age, it is important that women continue to have screenings even though earlier tests have been negative. Almost 95 percent of Michigan women 18 years and older have received at least one Pap smear during their lifetimes. Eighty-six percent of Michigan women 18 and older have received a Pap smear within the past three years.⁴⁻⁷ The American Cancer Society estimates that in 2004, 350 new cases of cervical cancer will be diagnosed among women in Michigan.⁴⁻⁸ With screening, a woman's lifetime risk of cervical cancer is estimated to be only 0.8 percent.⁴⁻⁹

HEDIS Specification: Cervical Cancer Screening

The *Cervical Cancer Screening* measure reports the percentage of women aged 18 through 64 years who were continuously enrolled during the measurement year and who received one or more Pap tests during the measurement year or the two years prior to the measurement year.

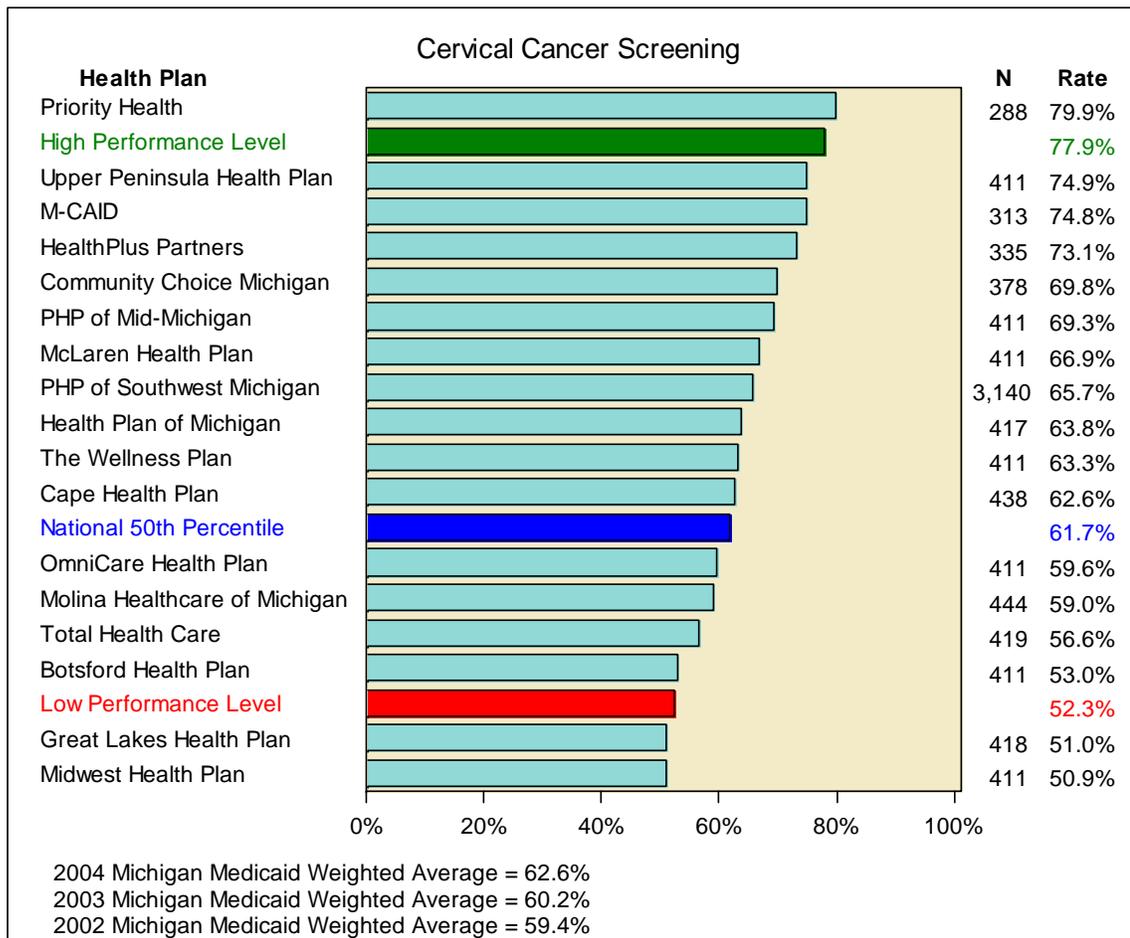
⁴⁻⁷ Michigan Department of Community Health: Facts about Cervical Cancer September 2002. Available at: http://www.michigan.gov/documents/CervicalFacts_6648_7.pdf. Accessed on August 11, 2004.

⁴⁻⁸ American Cancer Society, Facts and Figures 2004. Available at: <http://www.cancer.org/downloads/MED/Page5.pdf>.

⁴⁻⁹ National Committee for Quality Assurance. *The State of Health Care Quality. 2003* (Standard Version) Washington, DC: National Committee for Quality Assurance; 2003:29.

Health Plan Ranking: Cervical Cancer Screening

**Figure 4-3—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Cervical Cancer Screening**



One health plan had a rate above the HPL of 77.9 percent, while two health plans had rates below the LPL of 52.3 percent. A total of 11 health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

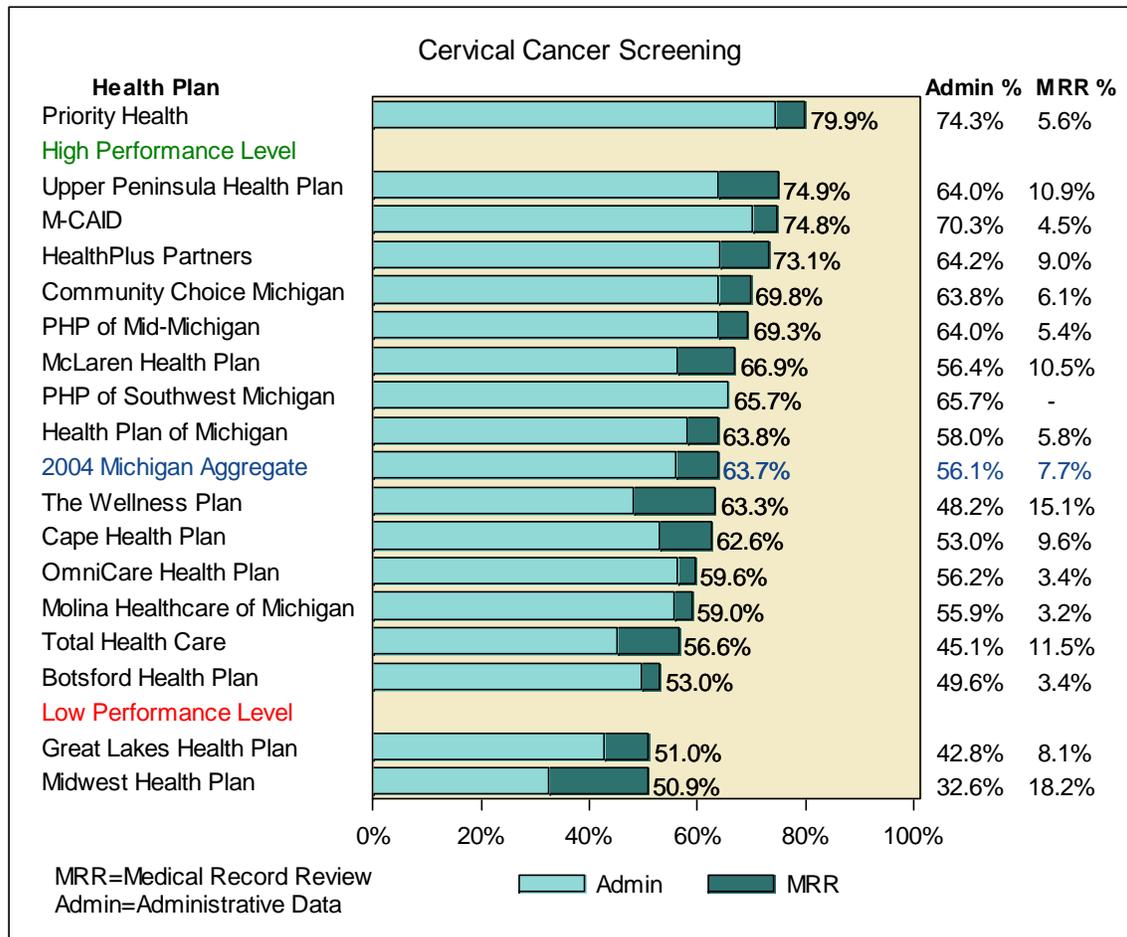
The 2004 Michigan Medicaid weighted average of 62.6 percent was 0.9 percentage points above the national HEDIS 2003 Medicaid 50th percentile of 61.7 percent. The reported rates ranged from a low of 50.9 percent to a high of 79.9 percent. Denominator sizes ranged from 288 to 3,140.

The 2004 Michigan Medicaid weighted average was higher than 2003, up 2.4 percentage points, and 3.2 percentage points above the 2002 Michigan Medicaid weighted average of 59.4 percent.

In 2003, one health plan reported rates above the HPL, and two had rates below the LPL. Overall, the range of reported rates showed an improvement in 2004 when compared to 2003.

Data Collection Analysis: Cervical Cancer Screening

**Figure 4-4—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Cervical Cancer Screening**



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

Sixteen of the 17 Michigan Medicaid health plans reported this measure using the hybrid methodology. The 2004 Michigan aggregate administrative rate was 56.1 percent, and the medical record review rate was 7.7 percent.

This result indicates that approximately 88.0 percent of the aggregate rate was derived from administrative data and 12.0 percent from medical record review. In 2003, 89.1 percent of the aggregate rate was derived from administrative data.

All of the health plans derived at least half of their rates from administrative data. Five health plans increased their overall rates by more than 10 percentage points through medical record review.

There is some variance in the completeness of administrative data for cervical cancer screening. Physician office coding practices may not include the level of detail necessary to identify a numerator event for this measure. Michigan MHPs should focus their efforts on improving the completeness of laboratory data to efficiently identify cervical cancer screening services that have occurred.

Chlamydia Screening in Women

There are approximately 3 million new cases of chlamydia annually, making it the most common STD in the United States.⁴⁻¹⁰ Chlamydia can be successfully treated with antibiotics. Untreated chlamydia increases the risk for pelvic inflammatory disease (PID), infertility, ectopic pregnancy, and HIV infection, yet women who are infected have no obvious symptoms. About 40 percent of infected women develop PID, with 20 percent of these women becoming infertile, 18 percent experiencing severe pelvic pain, and 9 percent having a life-threatening ectopic pregnancy. Nearly 80 percent of women infected are 24 years of age or younger.⁴⁻¹¹ In 2003, 9,488 cases were reported among Michigan women ages 20 to 24. This represents approximately 37 percent of the 25,918 reported cases of Michigan women with chlamydia in 2003.⁴⁻¹²

HEDIS Specification: Chlamydia Screening in Women

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

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

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

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

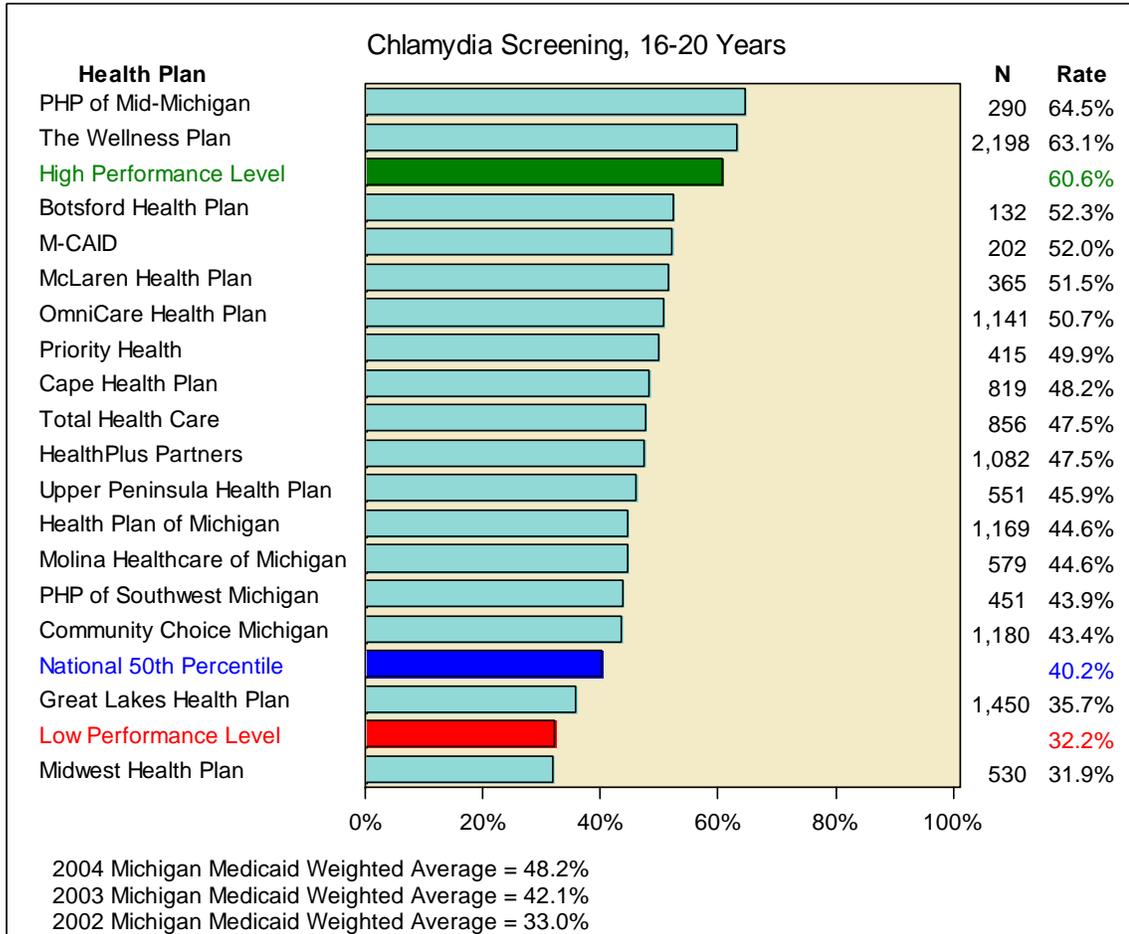
⁴⁻¹⁰ National Committee for Quality Assurance. *The State of Health Care Quality, 2003* (Standard Version). Washington, DC: National Committee for Quality Assurance; 2003:31.

⁴⁻¹¹ University of Michigan Health System. Women need testing and care for infection that can steal fertility expert says [press release]. University of Michigan; March 26, 2001.

⁴⁻¹² Michigan Sexually Transmitted Diseases Database, Sexually Transmitted Disease Section, Division of HIV/AIDS-STD, Michigan Department of Community Health. Available at: http://www.mdch.state.mi.us/pha/osr/CHI/STD_H/SD03ST4A.ASP. Accessed on August 11, 2004.

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

**Figure 4-5—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Chlamydia Screening in Women—Ages 16 to 20 Years**



Two health plans had rates above the HPL of 60.6 percent, while one health plan had a rate below the LPL of 32.2 percent. A total of 15 health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

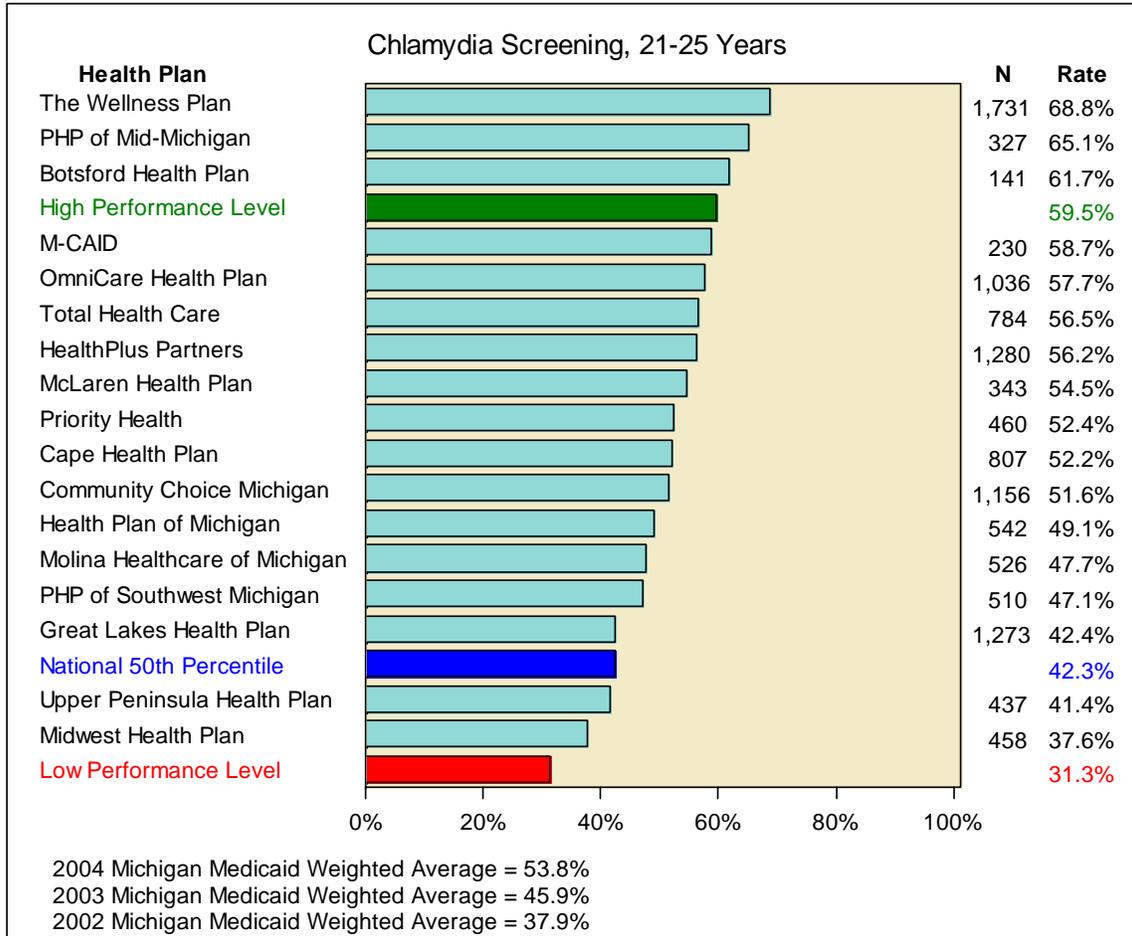
The 2004 Michigan Medicaid weighted average of 48.2 percent was 8.0 percentage points above the national HEDIS 2003 Medicaid 50th percentile of 40.2 percent. The reported rates ranged from a low of 31.9 percent to a high of 64.5 percent. Denominator sizes ranged from 132 to 2,198.

The 2004 Michigan Medicaid weighted average was higher than 2003, up 6.1 percentage points, and 15.2 percentage points above the 2002 Michigan Medicaid weighted average of 33.0 percent.

In 2003, one health plan reported a rate above the HPL, and one had a rate below the LPL. Overall, the range of reported rates improved from 2003 to 2004.

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

**Figure 4-6—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Chlamydia Screening in Women—Ages 21 to 25 Years**



Three health plans had rates above the HPL of 59.5 percent, while none of the health plans had rates below the LPL of 31.3 percent. A total of 15 health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

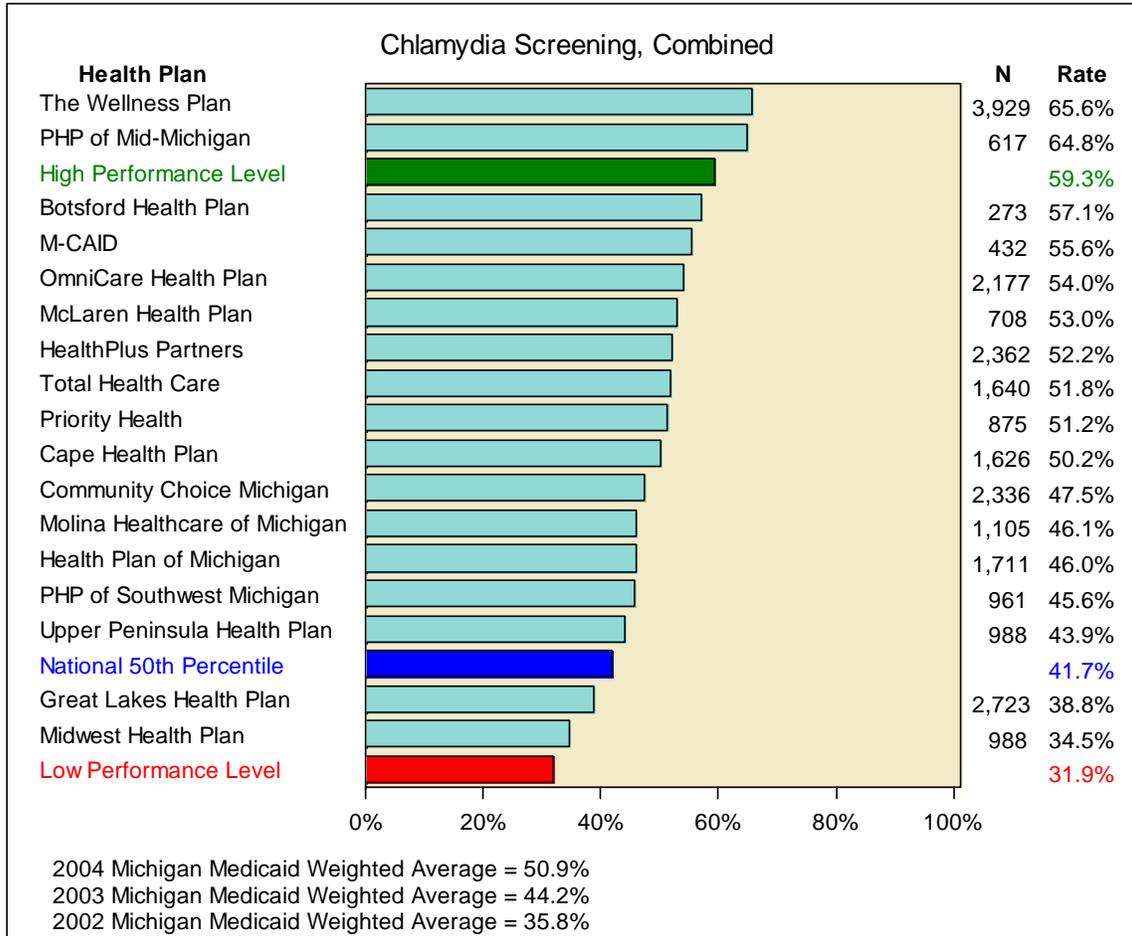
The 2004 Michigan Medicaid weighted average of 53.8 percent was 11.5 percentage points above the national HEDIS 2003 Medicaid 50th percentile of 42.3 percent. The reported rates ranged from a low of 37.6 percent to a high of 68.8 percent. Denominator sizes ranged from 141 to 1,731.

The 2004 Michigan Medicaid weighted average showed a statistically significant increase over 2003, up 7.9 percentage points. A gain of 15.9 percentage points was observed when compared to the 2002 Michigan Medicaid weighted average of 37.9 percent.

In 2003, two health plans reported rates above the HPL, and none had rates below the LPL. Overall, the range of reported rates showed a substantial improvement from 2003 to 2004.

Health Plan Ranking: Chlamydia Screening in Women—Combined Rate

**Figure 4-7—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Chlamydia Screening in Women—Combined Rate**



Two health plans had rates above the HPL of 59.3 percent, while none of the health plans had rates below the LPL of 31.9 percent. A total of 15 health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

The 2004 Michigan Medicaid weighted average of 50.9 percent was 9.2 percentage points above the national HEDIS 2003 Medicaid 50th percentile of 41.7 percent. The reported rates ranged from a low of 34.5 percent to a high of 65.6 percent. Denominator sizes ranged from 273 to 3,929.

The 2004 Michigan Medicaid weighted average demonstrated a statistically significant increase over 2003, up 6.7 percentage points. A gain of 15.1 percentage points was observed when compared to the 2002 Michigan Medicaid weighted average of 35.8 percent.

In 2003, two health plans reported rates above the HPL, and none of the health plans had rates below the LPL. Overall, the range of reported rates improved from 2003 to 2004.

Prenatal and Postpartum Care

There are nearly 4 million births annually in the United States. Over 6 percent of these infants are born weighing less than five pounds, and these babies are four times more likely to die prematurely than infants with a normal weight at birth.⁴⁻¹³ In 2002, 8 percent of Michigan infants were born with low birth weight.⁴⁻¹⁴ Several studies show a positive relationship between comprehensive prenatal care and reduction in low birth weight and infant mortality. HEDIS measures two important components of care: timeliness of prenatal care and health care for the mother and child up to 56 days after delivery.

Michigan ranks 39th nationally in infant mortality, and the disparity among rates for different racial groups are increasing.⁴⁻¹⁵ In 2002, the infant mortality rate for African-Americans was 18.4 per 1,000 live births, while for Whites it was 6.0 per 1,000 live births.⁴⁻¹⁶ African-American women in Michigan also have a higher rate of maternal mortality than White women, the largest racial gap in the nation. Michigan women under the age of 20 are least likely to receive adequate levels of prenatal care, and African-American women are two to three times more likely to experience inadequate levels of care when compared to women of other races.

This Key Measure examines whether or not care is available to members when needed and whether that care is provided in a timely manner. The measure consists of two numerators: Timeliness of Prenatal Care and Postpartum Care, giving rise to the MDCH Key Measure names:

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

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

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

⁴⁻¹³ National Committee for Quality Assurance. *The State of Managed Care Quality, 2001*. Standard Version. Washington, DC: National Committee for Quality Assurance; 2001:57.

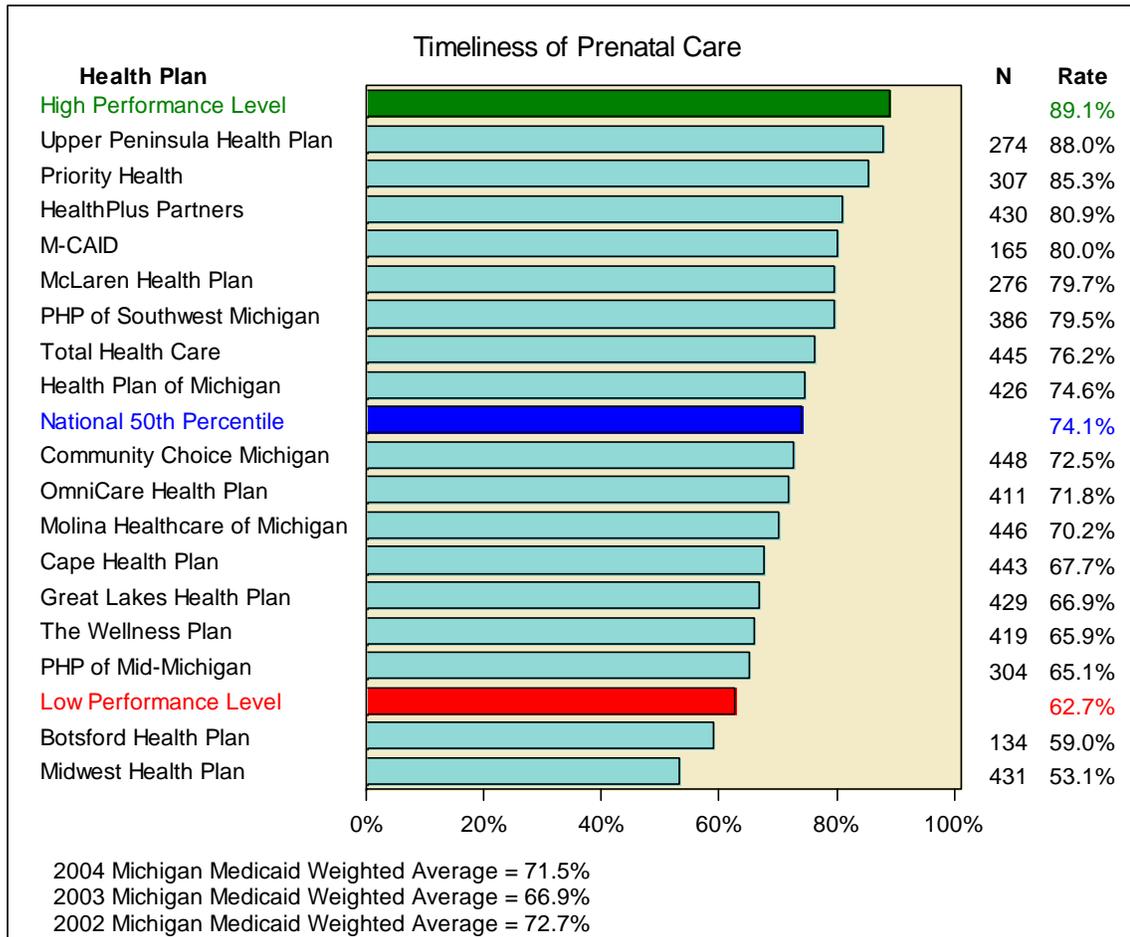
⁴⁻¹⁴ Michigan March of Dimes Birth Defects Foundation. Perinatal Profiles: Statistics for Monitoring State Maternal and Infant Health; 2003: 1. Available at: <http://www.marchofdimes.com/peristats/prematurity.aspx?reg=26&stop=60>.

⁴⁻¹⁵ United Health Foundation. America's Health: State Health Rankings, 2003 Edition. Available at: <http://www.unitedhealthfoundation.org/shr2003/components/infantmortality.html>. Accessed on August 11, 2004.

⁴⁻¹⁶ Michigan Department of Community Health, Michigan Resident Birth and Death Files, Vital Records & Health Data Development Section. Available at: <http://www.mdch.state.mi.us/pha/osr/InDxMain/Tab2.asp>. Accessed on August 11, 2004.

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

**Figure 4-8—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Prenatal and Postpartum Care—Timeliness of Prenatal Care**



None of the health plans had rates above the HPL of 89.1 percent, while two health plans had rates below the LPL of 62.7 percent. A total of eight health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

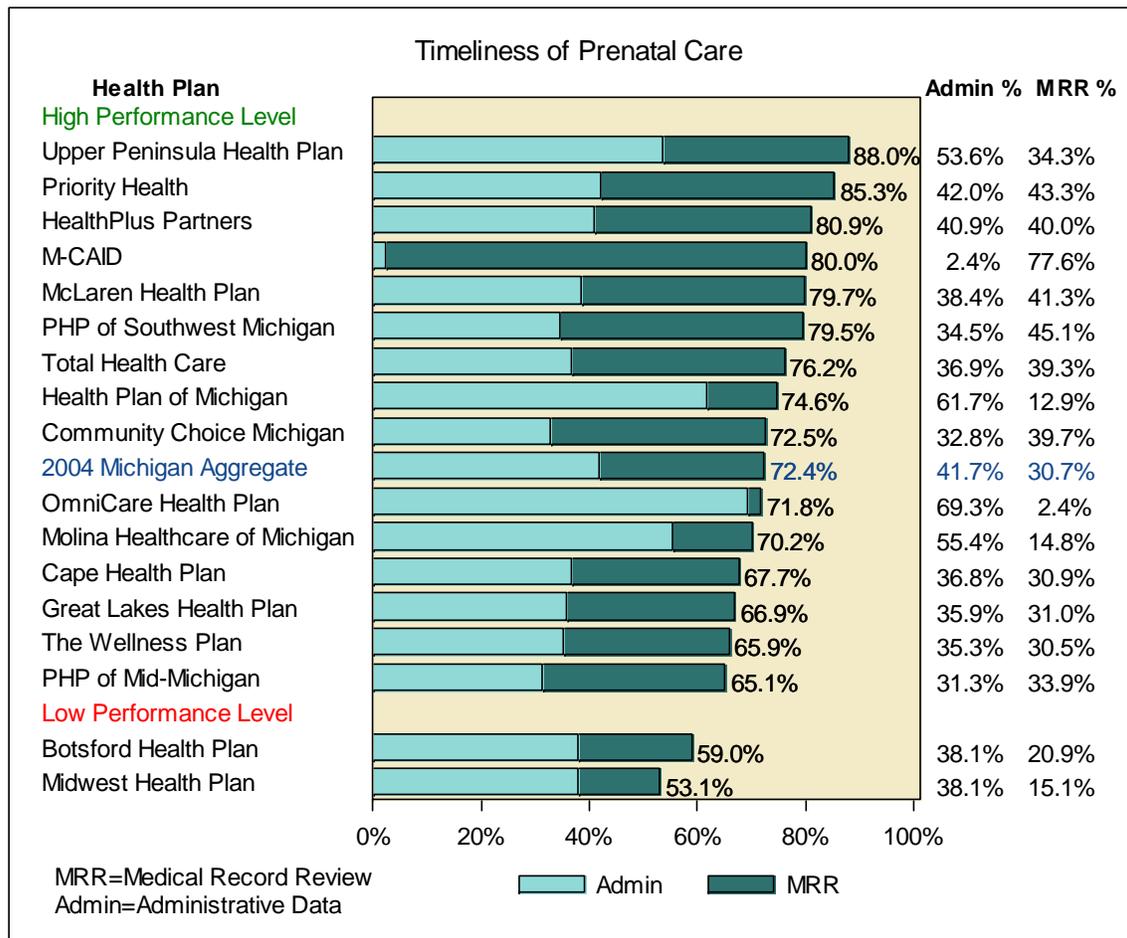
The 2004 Michigan Medicaid weighted average of 71.5 percent was 2.6 percentage points below the national HEDIS 2003 Medicaid 50th percentile of 74.1 percent. The reported rates ranged from a low of 53.1 percent to a high of 88.0 percent. Denominator sizes ranged from 134 to 448.

The 2004 Michigan Medicaid weighted average was 4.6 percentage points above the 2003 Michigan Medicaid weighted average, and 1.2 percentage points below the 2002 Michigan Medicaid weighted average of 72.7 percent.

In 2003, none of the health plans reported rates above the HPL, and four had rates below the LPL. The range for reported rates showed improvement in 2004 when compared to 2003, with fewer health plans falling below the LPL.

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

**Figure 4-9—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Prenatal and Postpartum Care—Timeliness of Prenatal Care**



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

All health plans elected to report this measure using the hybrid methodology. The 2004 Michigan aggregate administrative rate was 41.7 percent, and the medical record review rate was 30.7 percent.

Overall, 57.6 percent of the aggregate rate was derived from administrative data and 42.4 percent from medical record review. In 2003, 51.9 percent of the aggregate rate was derived from administrative data.

Ten health plans derived more than half of their rates from administrative data, while one health plan derived less than 5 percent of its rate from administrative data.

Considerable reliance on medical record review to identify numerator events for prenatal care visits is a common finding, due to global billing practices used by most health plans. Typically, a global

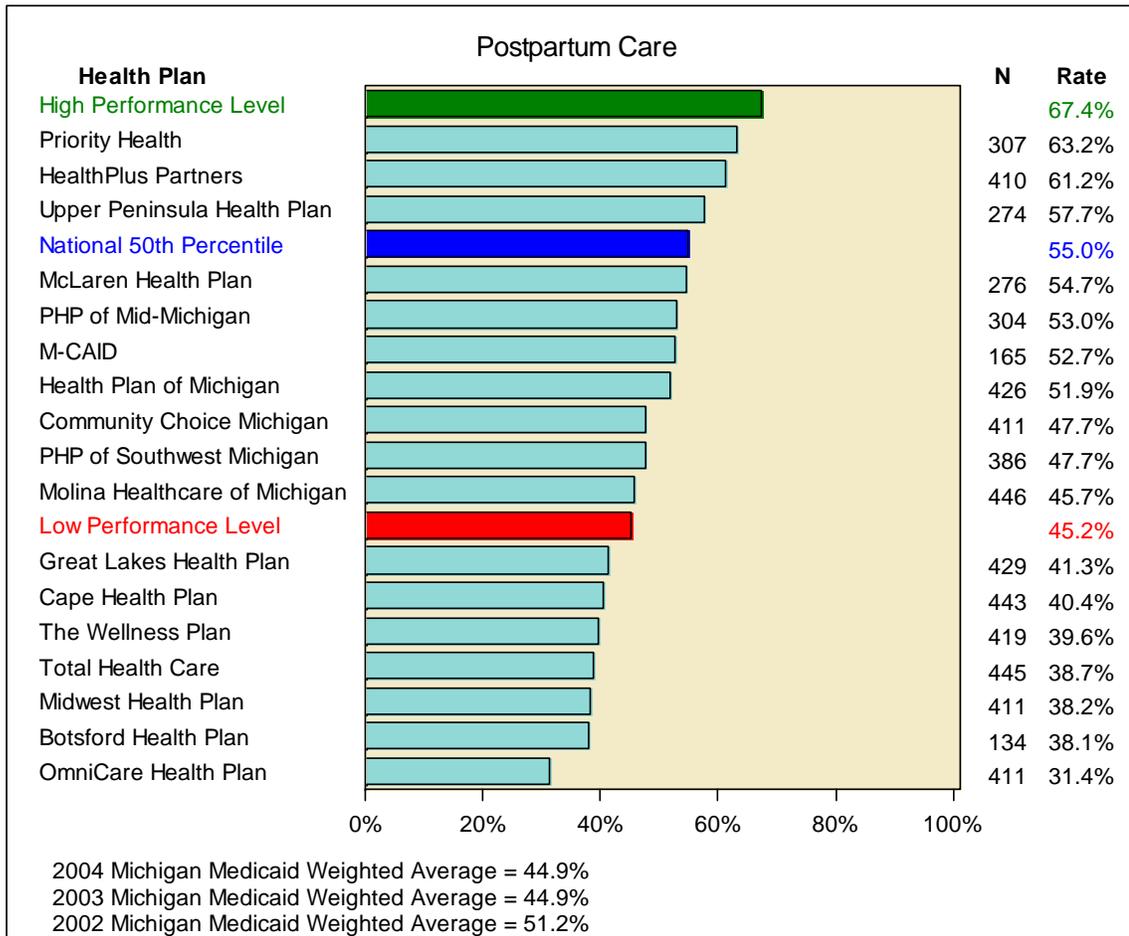
bill for obstetric (OB) services includes only the initial prenatal visit and the delivery date. The specifications for the *Timeliness of Prenatal Care* Key Measure identify a certain window of time during which the service must occur, which may not be consistently captured from a global bill. To lessen reliance on medical record review, Michigan MHPs should consider exploring ways to require providers to include each date of service on global bills. This could be included in the provider contracts and enforced through claims payment administration.

HEDIS Specification: Prenatal and Postpartum Care—Postpartum Care

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

Health Plan Ranking: Prenatal and Postpartum Care—Postpartum Care

**Figure 4-10—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Prenatal and Postpartum Care—Postpartum Care**



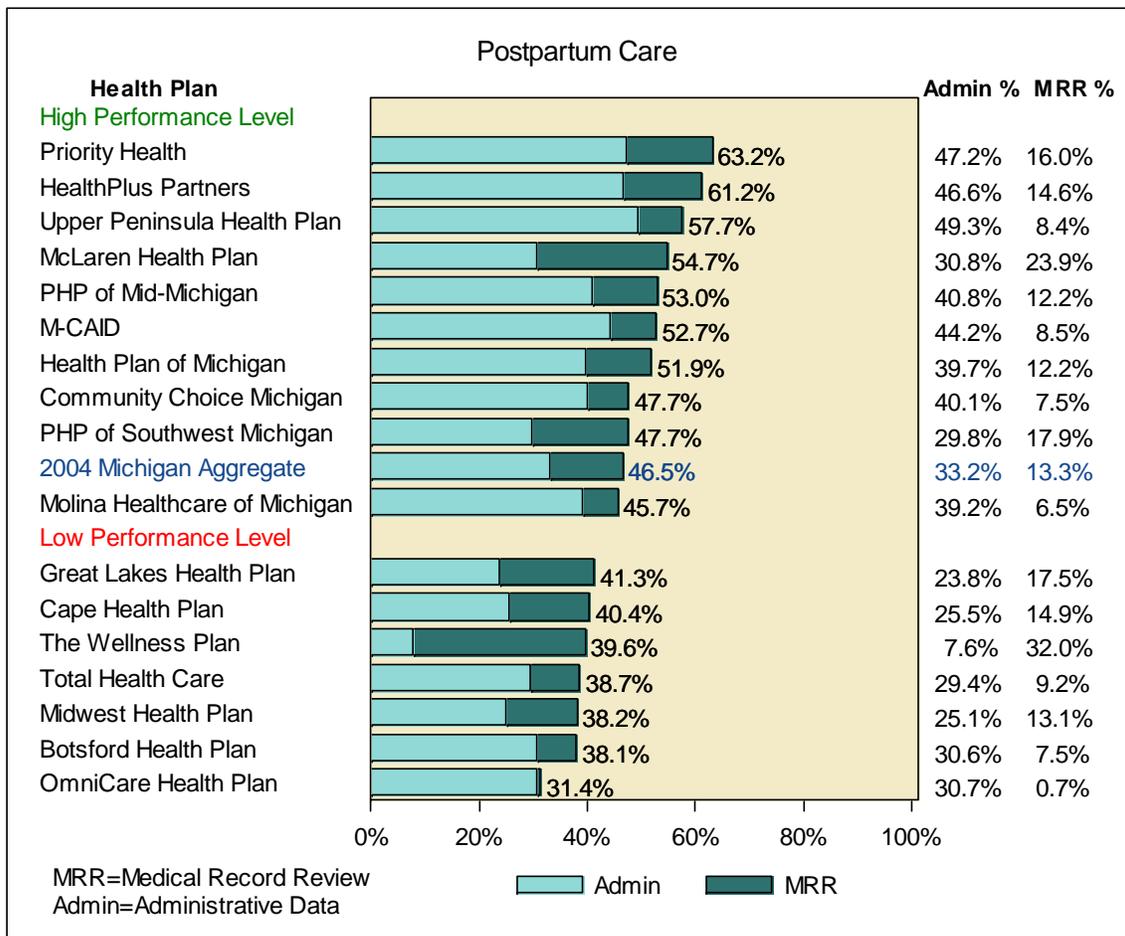
None of the health plans had rates above the HPL of 67.4 percent, while seven health plans had rates below the LPL of 45.2 percent. A total of three health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

The 2004 Michigan Medicaid weighted average of 44.9 percent was 10.1 percentage points below the national HEDIS 2003 Medicaid 50th percentile of 55.0 percent. The reported rates ranged from a low of 31.4 percent to a high of 63.2 percent. Denominator sizes ranged from 134 to 446.

The 2004 Michigan Medicaid weighted average equaled the 2003 Michigan Medicaid weighted average, and was 6.3 percentage points below the 2002 Michigan Medicaid weighted average of 51.2 percent.

In 2003, none of the health plans reported rates above the HPL, and seven had rates below the LPL. Overall, the range of reported rates showed minimal improvement in 2004 when compared to 2003.

Data Collection Analysis: Prenatal and Postpartum Care—Postpartum Care
Figure 4-11—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Prenatal and Postpartum Care—Postpartum Care



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

All health plans elected to report this measure using the hybrid methodology. The 2004 Michigan aggregate administrative rate was 33.2 percent, and the medical record review rate was 13.3 percent.

Overall, 71.4 percent of the aggregate rate was derived from administrative data and 28.6 percent from medical record review. In 2003, 69.1 percent of the aggregate rate was derived from administrative data.

Sixteen health plans derived more than half of their rates from administrative data, although some variance in the completeness of administrative data has been observed for this Key Measure. The completeness of administrative data is likely impacted by health plan global billing practices. Traditionally, the global bill includes the initial prenatal care visit and the date of delivery, missing the postpartum care visit. However, many health plans have required the postpartum care visit date on global bill submissions or have reimbursed separately for this service. Health plans that have focused efforts on improving administrative data for postpartum care visits can significantly reduce their reliance on medical record review.

Women's Care Findings and Recommendations

The Key Measures in the Women's Care dimension illustrate a broad range in the provision of care. The Michigan Medicaid weighted average for all age bands in the *Chlamydia Screening in Women* rate has increased by more than 6 percentage points and is above the national Medicaid 75th percentile. Women 16 to 25 years of age who are sexually active are accessing care for their chlamydia test. However, the access-to-care rates for these age bands are near the national Medicaid 25th percentile, although these rates include males as well as females. Converse to the chlamydia rates, maternal care rates are low. The *Timeliness of Prenatal Care* rate, though increasing, is below the national median rate; and the *Postpartum Care* rate is below the national Medicaid 25th percentile. An interesting finding is that children's well-care visit rates for 15-month-olds is also low, indicating that mothers and their children are not accessing care after birth at a rate consistent with national guidelines. Preventive care rates for women are also mediocre, with the *Cervical Cancer Screening* rate less than 1 percentage point above the national Medicaid 50th percentile, and the *Breast Cancer Screening* rate a little more than 1 percentage point below the 50th percentile.

The issue regarding the Women's Care dimension is not *why* most of the rates are low. Low rates continue to be associated with accessing the health care system for most of the measures in this dimension. The dilemma is why, at the same time, the chlamydia screening rates are so high; and how the Michigan MHPs are handling chlamydia screening differently from the other measures. How, as well, can the success of chlamydia screening be transferred to other areas of Women's Care? Unfortunately, HSAG is not in a position to answer these questions. HSAG analyzed how the rates correlate with each other and to MHP-reported quality improvement activities. These analyses indicated positive correlations between reminder cards and rates for some measures, and between provider incentives and rates for some measures. These correlations were small but statistically significant ($p < 0.05$). HSAG's analysis also found a positive correlation ($\sigma = 0.703$) between prenatal and postpartum rates, and a high correlation ($\sigma = 0.838$) between postpartum visits and cervical cancer screening rates.

Introduction

Chronic illness afflicts 100 million Americans and accounts for 70 percent of all health care spending. The measures in this section (asthma, diabetes, high blood pressure, and smoking) focus on how health plans ensure those with ongoing, chronic conditions take care of themselves, control symptoms, avoid complications, and maintain daily activities. Comprehensive programs implemented by health plans can help reduce the prevalence, impact, and economic costs associated with these chronic illnesses.

Asthma rates are increasing nationwide, and the impact on health and the economy is substantial. Recent analysis of the economic impact of asthma, commissioned by the American Lung Association to study asthma costs, cited annual estimated costs in 2002 of \$14 billion.⁵⁻¹ According to the most recent data available for the State of Michigan, more than 210,000 children and 650,000 adults currently have asthma in Michigan.⁵⁻² Prevalence of lifetime asthma for Michigan adults is slightly higher (12.8 percent) than that for the nation (11.8 percent).⁵⁻³ In addition, lifetime prevalence rates in Michigan rise to as high as 18.1 percent for adults with family incomes less than \$20,000.⁵⁻⁴

Diabetes prevalence, mortality, and complication rates associated with diabetes have also increased steadily in Michigan and in the nation over the last decade. Michigan average data (2001–2003) indicate that 590,000 adults and 8,700 persons under the age of 18 have been diagnosed with diabetes. Diabetes costs Michigan residents \$5.7 billion a year in lost productivity due to premature death, disability, and illness.⁵⁻⁵

High blood pressure affects approximately 50 million adults in the United States, roughly one quarter of the adult population. It can cause heart attacks, heart failure, stroke, kidney disease, and other serious problems. Only one-third of people with high blood pressure are even aware that they have the disease because they do not have the warning signs and have not been screened, according to the U.S. Preventive Services Task Force.⁵⁻⁶ The risk of developing high blood pressure increases with age. In fact, people with normal blood pressure at age 55 still have a 90 percent risk for developing high blood pressure in their lifetime.⁵⁻⁷ In Michigan, approximately 3 out of 4 premature deaths are due to high blood pressure, high blood cholesterol, and cigarette smoking.⁵⁻⁸

⁵⁻¹ American Lung Association. Epidemiology & Statistics Unit. *Trends in Asthma Morbidity and Mortality*. April 2004. Available at: <http://www.lungusa.org/>. Accessed on August 11, 2004.

⁵⁻² Michigan Department of Community Health. *Epidemiology of Asthma in Michigan, 2004 Surveillance Report*.

Available at: http://www.michigan.gov/documents/MI_Asthma_Surveillance_2004_96083_7.pdf. Accessed on August 11, 2004.

⁵⁻³ Centers for Disease Control and Prevention. *Asthma Prevalence and Control Characteristics by Race/Ethnicity, 2002*. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5307a1.htm>. Accessed on August 11, 2004.

⁵⁻⁴ Michigan Department of Community Health. *Epidemiology of Asthma in Michigan, 2004 Surveillance Report*.

Available at: http://www.michigan.gov/documents/MI_Asthma_Surveillance_2004_96083_7.pdf. Accessed on August 11, 2004.

⁵⁻⁵ Michigan Department of Community Health. *Diabetes in Michigan, 2004*. Available at:

http://www.michigan.gov/documents/mifact_6829_7.pdf. Accessed on August 11, 2004.

⁵⁻⁶ Agency for Healthcare Quality and Research (AHRQ). *Prevention Experts Urge High Blood Pressure Screening for All Adults Age 18 and Older* [press release]; July 14, 2003. Available at: <http://www.ahrq.gov/news/press/pr2003/highbpr.htm>. Accessed on August 11, 2004.

Cigarette smoking kills about half of all continuing smokers, and is the most preventable cause of premature death in the United States. According to the American Cancer Society, about 430,000 deaths from smoking are expected in any given year.⁵⁻⁹ Yet, about 25 percent of all American adults smoke, and the prevalence of smoking among adolescents has risen dramatically over the past decade. Smoking is the major cause of many cancers, as well as other serious diseases, including heart disease, bronchitis, emphysema, and strokes. Most smokers make several attempts to quit, and, according to the U.S. Surgeon General, 46 percent of smokers try to quit each year.⁵⁻¹⁰

Assistance with smoking cessation is extremely cost effective compared to the estimated \$50 billion of annual medical care costs related to smoking or smoking-related diseases. The U.S. Public Health Service issued a clinical practice guideline for treating tobacco use and dependence (June 2000), estimating that it would cost \$6.3 billion each year to provide 75 percent of smokers over age 18 with a counseling and/or medication intervention for smoking cessation. This would result in an estimated 1.7 million new quitters at an average cost of \$3,779 per quitter.⁵⁻¹¹ Furthermore, the Michigan Cancer Consortium estimates that if overall adult smoking prevalence in Michigan were reduced by 42 percent and adult per capita consumption in the State were reduced by 25 percent, there would be 1,100 fewer lung cancer deaths each year.⁵⁻¹²

The Living With Illness dimension encompasses the following MDCH Key Measures:

- ◆ **Comprehensive Diabetes Care**
 - *Comprehensive Diabetes Care—HbA1c Testing*
 - *Comprehensive Diabetes Care—Poor HbA1c Control*
 - *Comprehensive Diabetes Care—Eye Exam*
 - *Comprehensive Diabetes Care—LDL-C Screening*
 - *Comprehensive Diabetes Care—LDL-C Level<130*
 - *Comprehensive Diabetes Care—LDL-C Level<100*
 - *Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy*
- ◆ **Use of Appropriate Medications for People With Asthma**
 - *Use of Appropriate Medications for People With Asthma—Ages 5 to 9 Years*
 - *Use of Appropriate Medications for People With Asthma—Ages 10 to 17 Years*
 - *Use of Appropriate Medications for People With Asthma—Ages 18 to 56 Years*
 - *Use of Appropriate Medications for People With Asthma—Combined Rate*
- ◆ **Controlling High Blood Pressure**
- ◆ **Medical Assistance With Smoking Cessation—Advising Smokers to Quit**

⁵⁻⁷ National Institutes of Health Web site. Available at: http://hin.nhlbi.nih.gov/nhbpep_slds/jnc/slides/part1/img006.gif. Accessed on August 11, 2004.

⁵⁻⁸ Michigan Department of Community Health. 2004 CVD Fact Sheet. Available at: http://www.michigan.gov/documents/cvdfact03_78179_7.pdf. Accessed on August 11, 2004.

⁵⁻⁹ American Cancer Society. Health Information Seekers – Cigarette Smoking Tobacco-related Diseases Kill Half of All Smokers; 2003. Available at: http://www.cancer.org/docroot/PED/content/PED_10_2X_Cigarette_Smoking_and_Cancer.asp?sitearea=PED. Accessed on August 11, 2004.

⁵⁻¹⁰ U.S. Public Health Service. Treating Tobacco Use and Dependence. Fact Sheet; June 2000. Available at: <http://www.surgeongeneral.gov/tobacco/smokfact.htm>. Accessed on August 11, 2004.

⁵⁻¹¹ U.S. Public Health Service. Treating Tobacco Use and Dependence—A Systems Approach. A Guide for Health Care Administrators, Insurers, Managed Care Organizations, and Purchasers; November 2000. Available at: <http://www.surgeongeneral.gov/tobacco/systems.htm>. Accessed on August 11, 2004.

⁵⁻¹² Michigan Department of Community Health. Facts About Lung Cancer, October 2003. Available at: <http://www.michiganancer.org/PDFS/MDCHFactSheets/LungCAFactSheet-Oct03.pdf>. Accessed on August 11, 2004.

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

Comprehensive Diabetes Care

Approximately 13 million Americans were diagnosed with diabetes in 2002, the sixth leading cause of death in the United States.⁵⁻¹³ In Michigan, 560,000 people were newly diagnosed with diabetes in 2002.⁵⁻¹⁴ Control of diabetes significantly reduces the rate of complications and improves quality of life for diabetics. The World Health Organization (WHO) estimates that the total health care costs of a person with diabetes in the United States are three times those for people without the condition. The estimated direct and indirect costs of diabetes in Michigan were nearly \$6 billion in 2002.⁵⁻¹⁵

Diabetes is the leading cause of blindness and kidney failure in Michigan and a major factor in hypertension, cardiovascular disease, and lower-extremity amputations.⁵⁻¹⁶ Control of diabetes significantly reduces the rate of complications and improves quality of life for diabetics. It is estimated that, for every 1 percent reduction in blood glucose levels, the risk of developing diabetic retinal (eye) disease or kidney end stage renal disease, and for requiring lower-extremity amputation, drops by 40 percent.⁵⁻¹⁷ Therefore, a comprehensive assessment of diabetes care necessitates examination of multiple factors. This measure contains a variety of indicators, each of which provides a critical element of information. These indicators are consistent with the Diabetes Quality Improvement Project (DQIP) set of measures (excluding hypertension and foot care). The DQIP is a national quality of care project sponsored by the Centers for Medicare & Medicaid Services (CMS), the American Diabetic Association (ADA), FACCT, and NCQA. When taken together, the components build a comprehensive picture that permits a better understanding of the quality of diabetes care.

The *Comprehensive Diabetes Care* measure is reported using seven separate rates:

1. *Comprehensive Diabetes Care—HbA1c Testing*
2. *Comprehensive Diabetes Care—Poor HbA1c Control*
3. *Comprehensive Diabetes Care—Eye Exam*
4. *Comprehensive Diabetes Care—LDL-C Screening*
5. *Comprehensive Diabetes Care—LDL-C Level <100*
6. *Comprehensive Diabetes Care—LDL-C Level <130*
7. *Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy*

⁵⁻¹³ National Institutes of Health. National Diabetes Statistics, 2004. Available at: <http://diabetes.niddk.nih.gov/dm/pubs/statistics/index.htm#11>. Accessed on August 11, 2004.

⁵⁻¹⁴ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adult and Community Health, data from the Behavioral Risk Factor Surveillance System. Available at: <http://www.cdc.gov/diabetes/statistics/prev/state/table15.htm>. Accessed on August 11, 2004.

⁵⁻¹⁵ Ibid.

⁵⁻¹⁶ Michigan Department of Community Health. Michigan Diabetes Strategic Plan, October 2003. Available at: http://www.michigan.gov/documents/DM_StrategicPlan_82795_7.pdf. Accessed on August 11, 2004.

⁵⁻¹⁷ National Committee for Quality Assurance. *The State of Health Care Quality 2003*. (Standard Version). Washington, DC: National Committee for Quality Assurance; 2003: p. 34.

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

Comprehensive Diabetes Care—HbA1c Testing

The HbA1c test (hemoglobin A1c test or glycosylated hemoglobin test) is a laboratory test that reveals average blood glucose over a period of two to three months. Specifically, it measures the number of glucose molecules attached to hemoglobin in red blood cells. The test takes advantage of the lifecycle of red blood cells. Although constantly replaced, individual cells live for about four months. By measuring attached glucose in a current blood sample, average blood sugar levels over the previous two to three months can be determined. HbA1c test results are expressed as a percentage, with

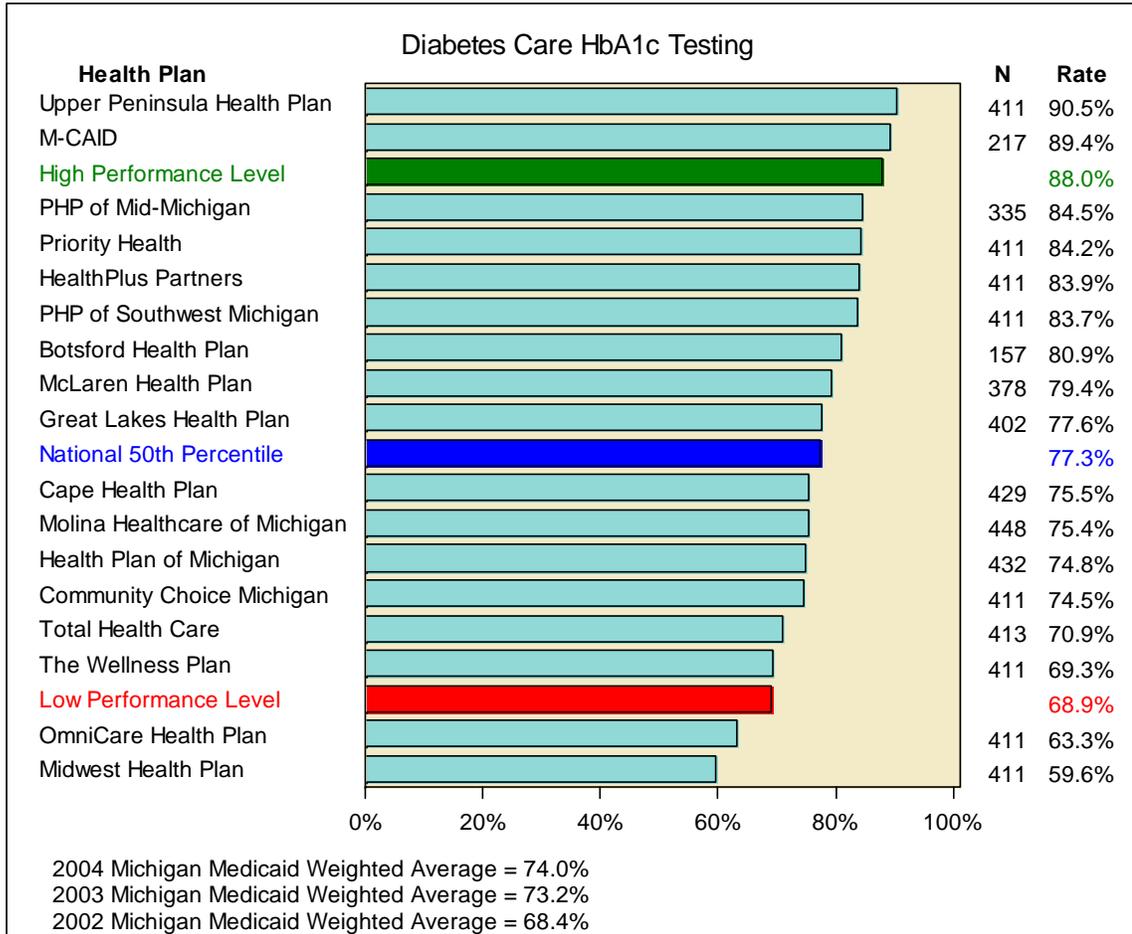
4 percent to 6 percent considered normal. The HbA1c tests the "big picture" and complements the day-to-day "snapshots" obtained from the self-monitoring of blood glucose (mg/dL).

HEDIS Specification: Comprehensive Diabetes Care—HbA1c Testing

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

Health Plan Ranking: Comprehensive Diabetes Care—HbA1c Testing

**Figure 5-1—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Comprehensive Diabetes Care—HbA1c Testing**



Two health plans had rates above the HPL of 88.0 percent, while two health plans had rates below the LPL of 68.9 percent. A total of nine health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

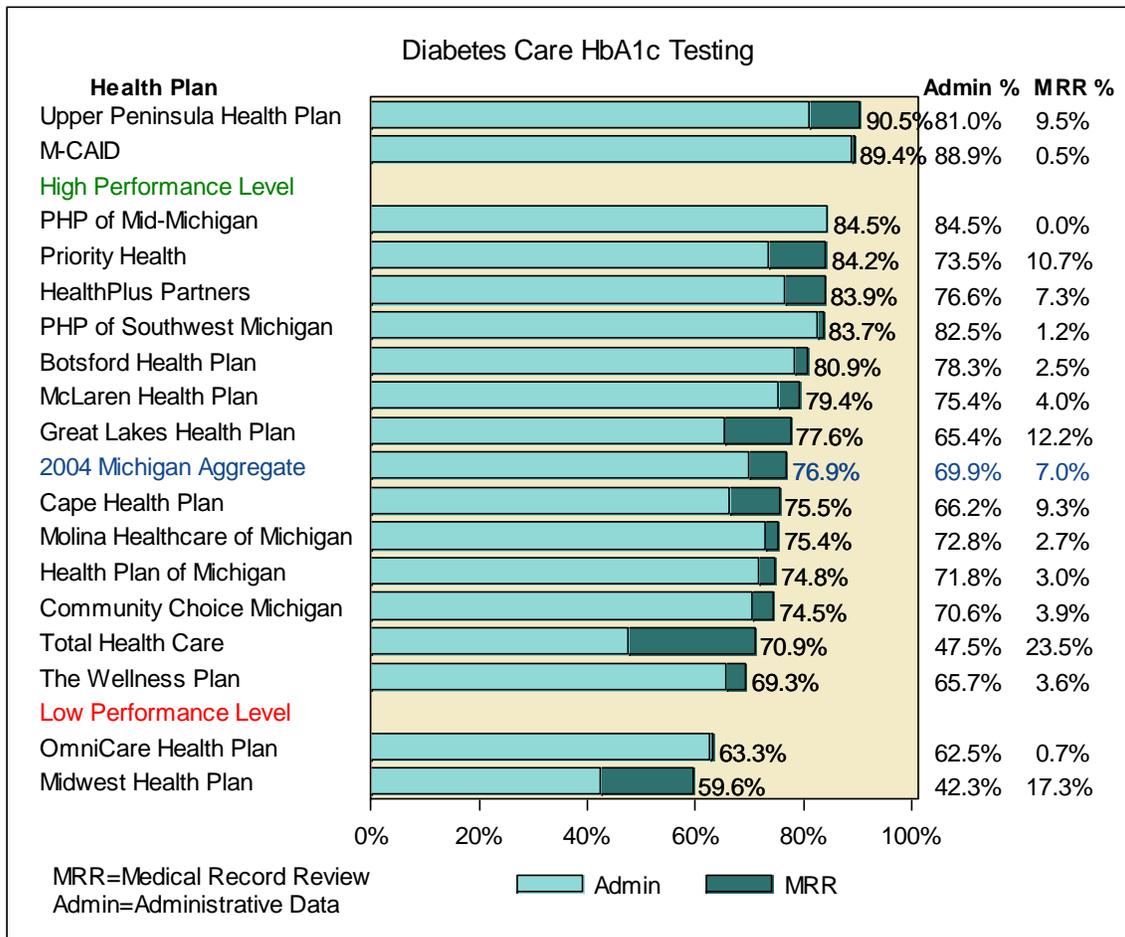
The 2004 Michigan Medicaid weighted average of 74.0 percent was 3.3 percentage points below the national HEDIS 2003 Medicaid 50th percentile of 77.3 percent. The reported rates ranged from a low of 59.6 percent to a high of 90.5 percent. Denominator sizes ranged from 157 to 448.

The 2004 Michigan Medicaid weighted average was higher than 2003, up 0.8 percentage points, and 5.6 percentage points above the 2002 Michigan Medicaid weighted average of 68.4 percent.

In 2003, four health plans reported rates above the HPL, and three health plans had rates below the LPL. Overall, the range of reported rates showed minimal improvement from 2003 to 2004, since fewer health plans met the HPL.

Data Collection Analysis: Comprehensive Diabetes Care—HbA1c Testing

**Figure 5-2—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Comprehensive Diabetes Care—HbA1c Testing**



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

All of the 17 health plans elected to use the hybrid methodology for calculation of this measure. The 2004 Michigan aggregate administrative rate for this measure was 69.9 percent.

In 2004, 90.9 percent of the aggregate rate was derived from administrative data and 9.1 percent from medical record review. In 2003, 89.1 percent of the aggregate rate was derived from administrative data.

The use of medical record review increased the 2004 Michigan aggregate rate by 7.0 percentage points. Four health plans increased their overall rates by 10 percentage points or more from medical record review.

Administratively, laboratory encounter data appear stable and generally complete among the Michigan MHPs. Although several of the health plans received only minimal gain from medical record review, the practice should continue, since other *Comprehensive Diabetes Care* numerators require chart review in most circumstances.

Comprehensive Diabetes Care—Poor HbA1c Control

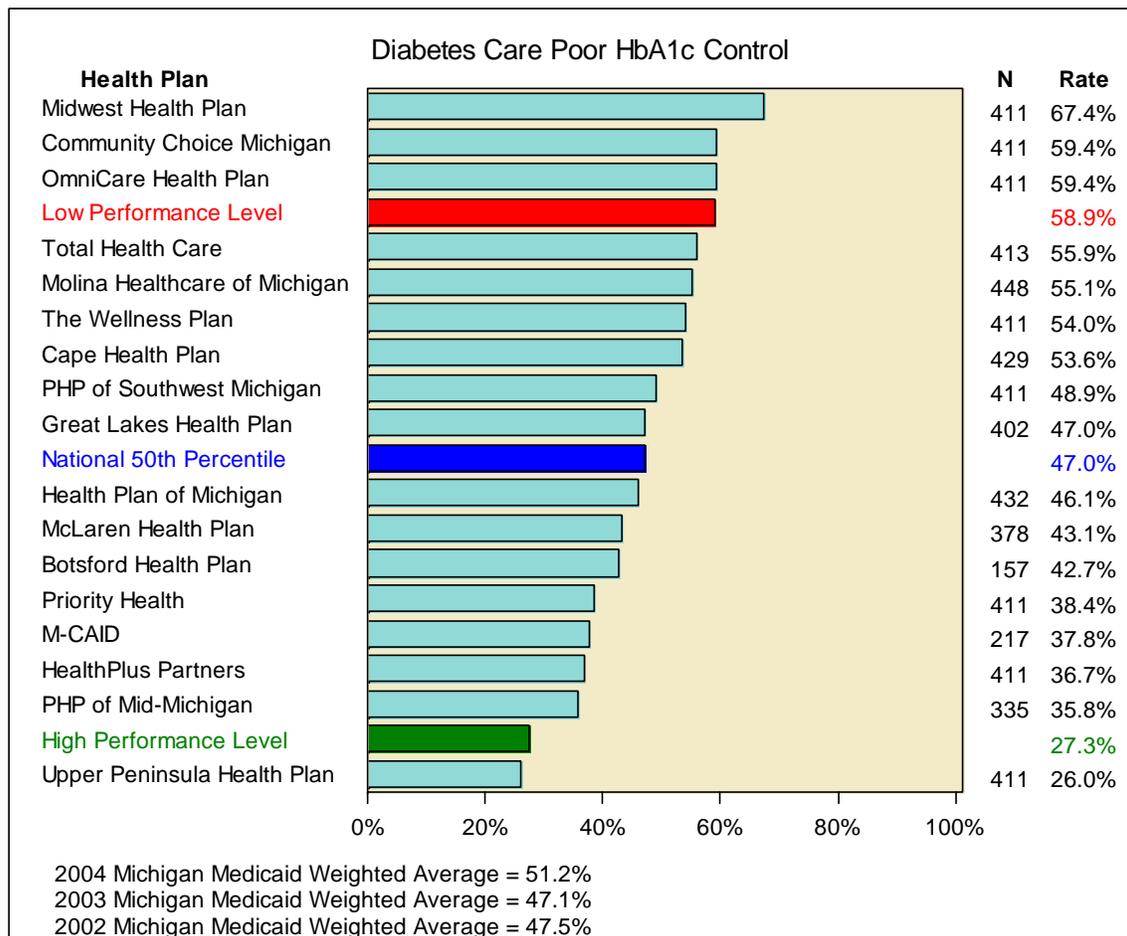
HbA1c control improves quality of life, increases work productivity, and decreases health care utilization. Decreasing the HbA1c level lowers the risk of diabetes related death. Controlling blood glucose levels in people with diabetes significantly reduces the risk for blindness, end-stage renal disease,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

HEDIS Specification: Comprehensive Diabetes Care—Poor HbA1c Control

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

Health Plan Ranking: Comprehensive Diabetes Care—Poor HbA1c Control

**Figure 5-3—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Comprehensive Diabetes Care—Poor HbA1c Control**



For this Key Measure, a lower rate indicates better performance, since low rates of Poor HbA1c Control indicate better care.

One health plan had a rate above the HPL of 27.3 percent, while three health plans had rates below the LPL of 58.9 percent. A total of eight health plans reported rates lower than the national HEDIS 2003 Medicaid 50th percentile, signifying better performance.

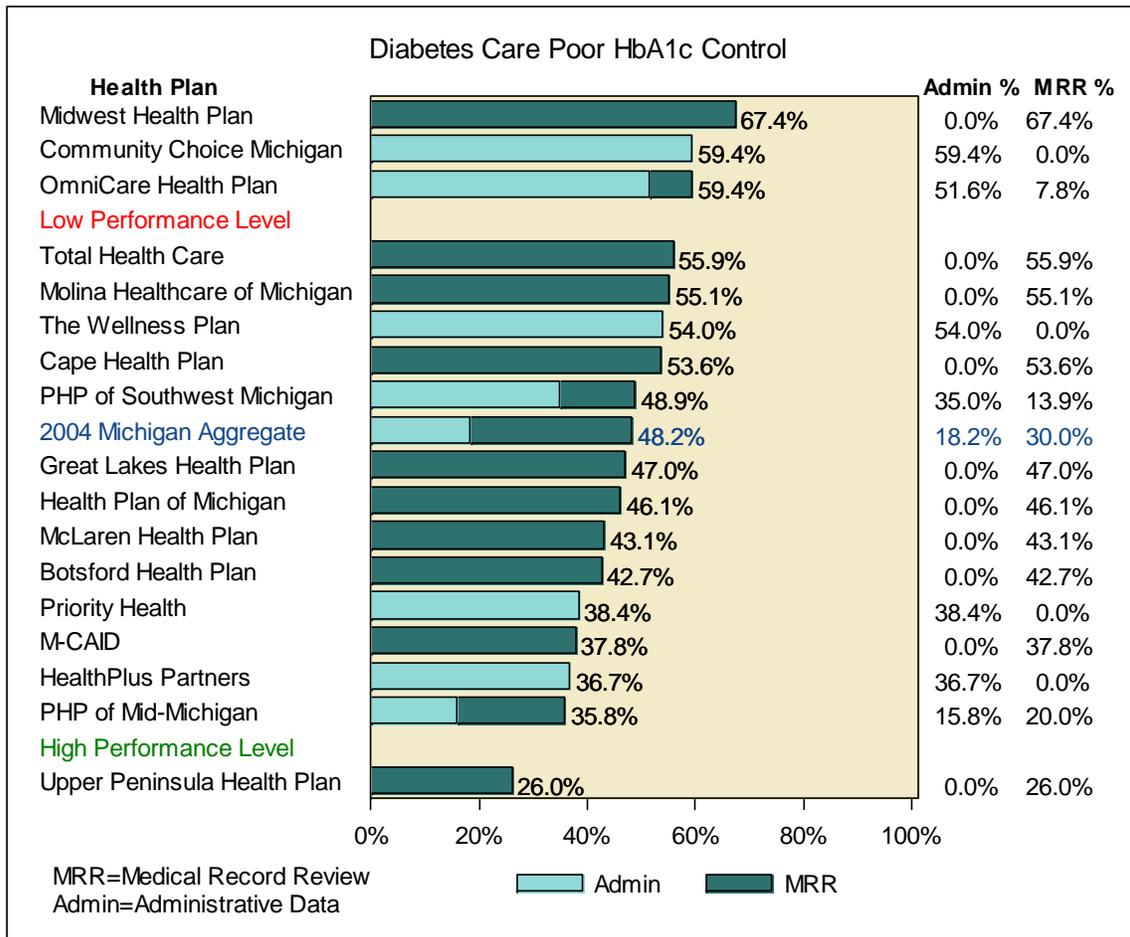
The 2004 Michigan Medicaid weighted average of 51.2 percent was 4.2 percentage points above the national HEDIS 2003 Medicaid 50th percentile of 47.0 percent. The reported rates ranged from a low of 26.0 percent to a high of 67.4 percent. Denominator sizes ranged from 157 to 448.

The 2004 Michigan Medicaid weighted average was 4.1 percentage points higher than in 2003, representing negative progress.

In 2003, three health plans reported rates above the HPL, and two health plans had rates below the LPL. Overall, the range of reported rates showed no improvement from 2003 to 2004.

Data Collection Analysis: Comprehensive Diabetes Care—Poor HbA1c Control

**Figure 5-4—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Comprehensive Diabetes Care—Poor HbA1c Control**



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

For this Key Measure, a lower rate indicates better performance, since low rates of Poor HbA1c Control indicate better care.

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

All health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2004 Michigan aggregate administrative rate for this measure was 18.2 percent and 30.0 percent for medical record review.

Results indicate that 37.8 percent of the aggregate rate was derived from administrative data, while 62.2 percent was derived from medical record review. In 2003, 23.6 percent of the aggregate rate was derived from administrative data.

For this measure, the results illustrate that few health plans have the ability to capture laboratory values administratively with their claims systems, or that laboratory vendors do not regularly provide this level of detailed information.

An examination of the breakout of administrative and medical record data sources for this numerator must be made with extreme caution. Members who had no HbA1c screening are automatically included as compliant for this indicator; and there is little consistency as to which data source, administrative or medical record, the Michigan MHPs will attribute these numerator events.

Comprehensive Diabetes Care—Eye Exam

Diabetic retinopathy causes up to 24,000 new cases of blindness every year. Blindness in diabetics under the age of 65 costs the federal government more than \$14,000 annually for each affected person, while screening for diabetic retinopathy has been estimated to cost about \$31 per patient.⁵⁻¹⁸

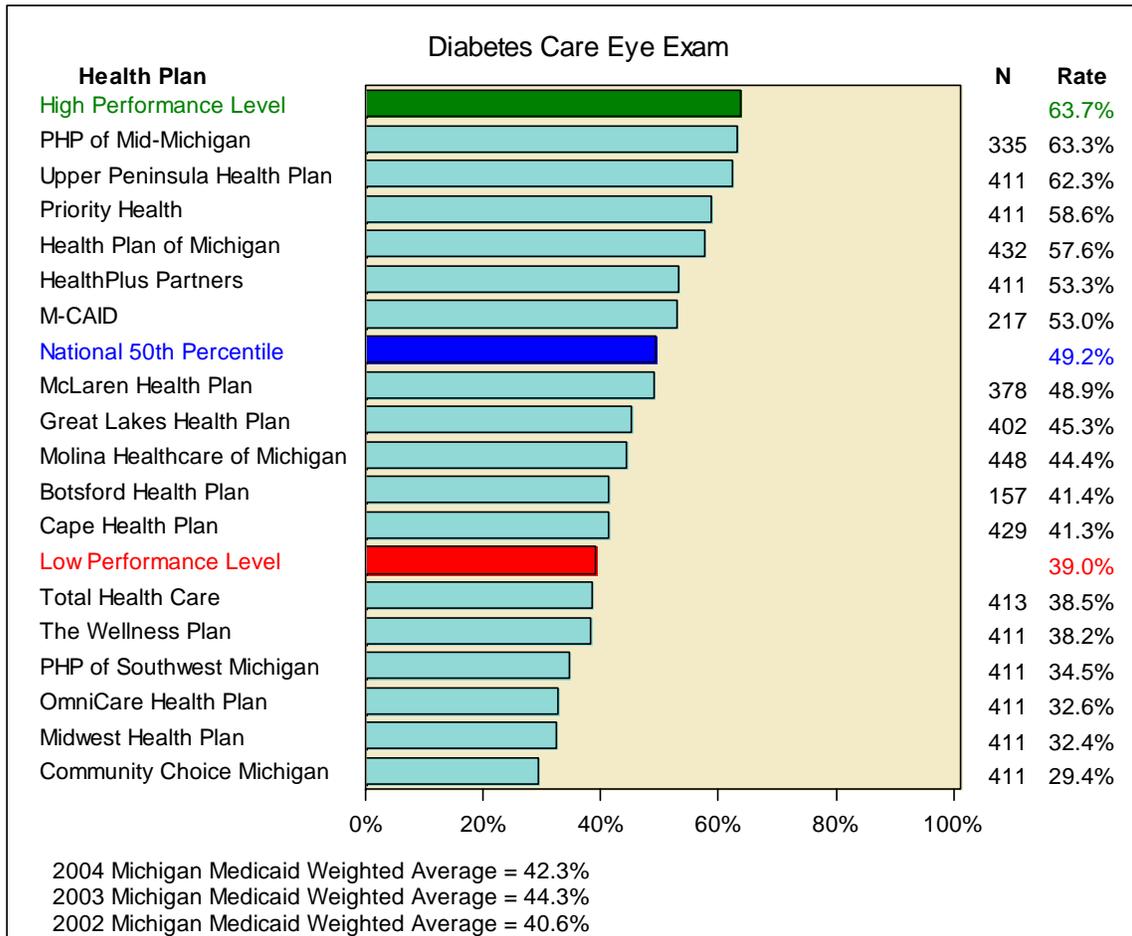
HEDIS Specification: Comprehensive Diabetes Care—Eye Exam

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

⁵⁻¹⁸ National Committee for Quality Assurance. *The State of Managed Care Quality*. 2001. Standard Version. Washington, DC: National Committee for Quality Assurance; 2001:47-8.

Health Plan Ranking: Comprehensive Diabetes Care—Eye Exam

**Figure 5-5—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Comprehensive Diabetes Care—Eye Exam**



None of the health plans had rates above the HPL of 63.7 percent, while six health plans had rates below the LPL of 39.0 percent. A total of six health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

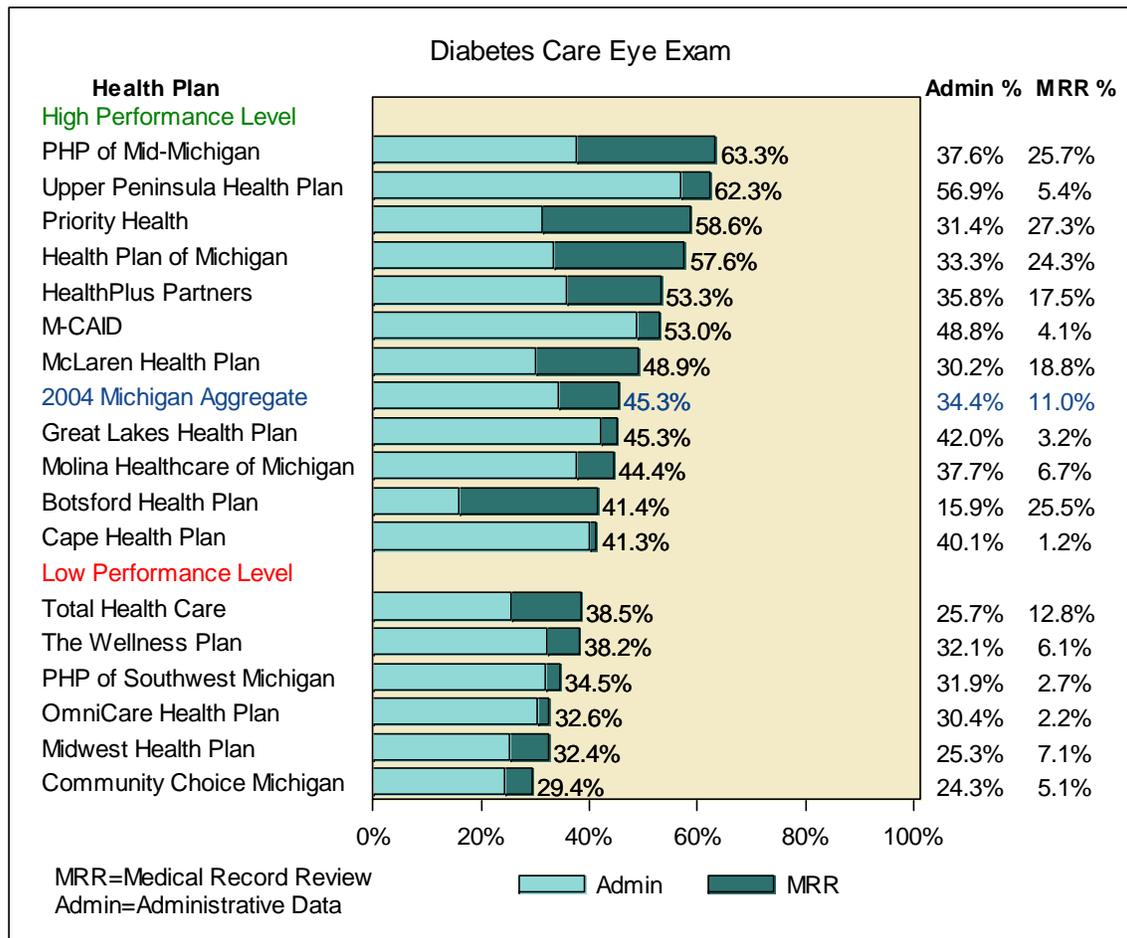
The 2004 Michigan Medicaid weighted average of 42.3 percent was 6.9 percentage points below the national HEDIS 2003 Medicaid 50th percentile of 49.2 percent. The reported rates ranged from a low of 29.4 percent to a high of 63.3 percent. Denominator sizes ranged from 157 to 448.

The 2004 Michigan Medicaid weighted average was lower than in 2003, down 2.0 percentage points, while 1.7 percentage points above the 2002 Michigan Medicaid weighted average of 40.6 percent.

In 2003, none of the health plans reported rates above the HPL, and two health plans had rates below the LPL. Overall, the range of reported rates showed no improvement from 2003 to 2004.

Data Collection Analysis: Comprehensive Diabetes Care—Eye Exam

**Figure 5-6—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Comprehensive Diabetes Care—Eye Exam**



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

All of the 17 health plans elected to use the hybrid methodology for calculation of this measure. The 2004 Michigan aggregate administrative rate for this measure was 34.4 percent.

Overall, approximately 76.0 percent of the aggregate rate was derived from administrative data and 24.0 percent from medical record review. In 2003, 73.2 percent of the aggregate rate was derived from administrative data.

The use of medical record review increased the 2004 Michigan aggregate rate by 11.0 percentage points. Four health plans showed substantial improvement in their overall rates from medical record review, increasing by more than 20 percentage points.

There is a high degree of variance among the Michigan MHPs in terms of administrative data completeness for eye exams. This is likely due to the variety of contracting arrangements between the vision providers and the respective health plans. Michigan MHPs that rely on medical record review for identifying a considerable volume of eye exams should re-evaluate their contracting arrangements with vision care providers. At a minimum, routinely tracking the volume of vision data submitted by external vendors is recommended.

Comprehensive Diabetes Care—LDL-C Screening

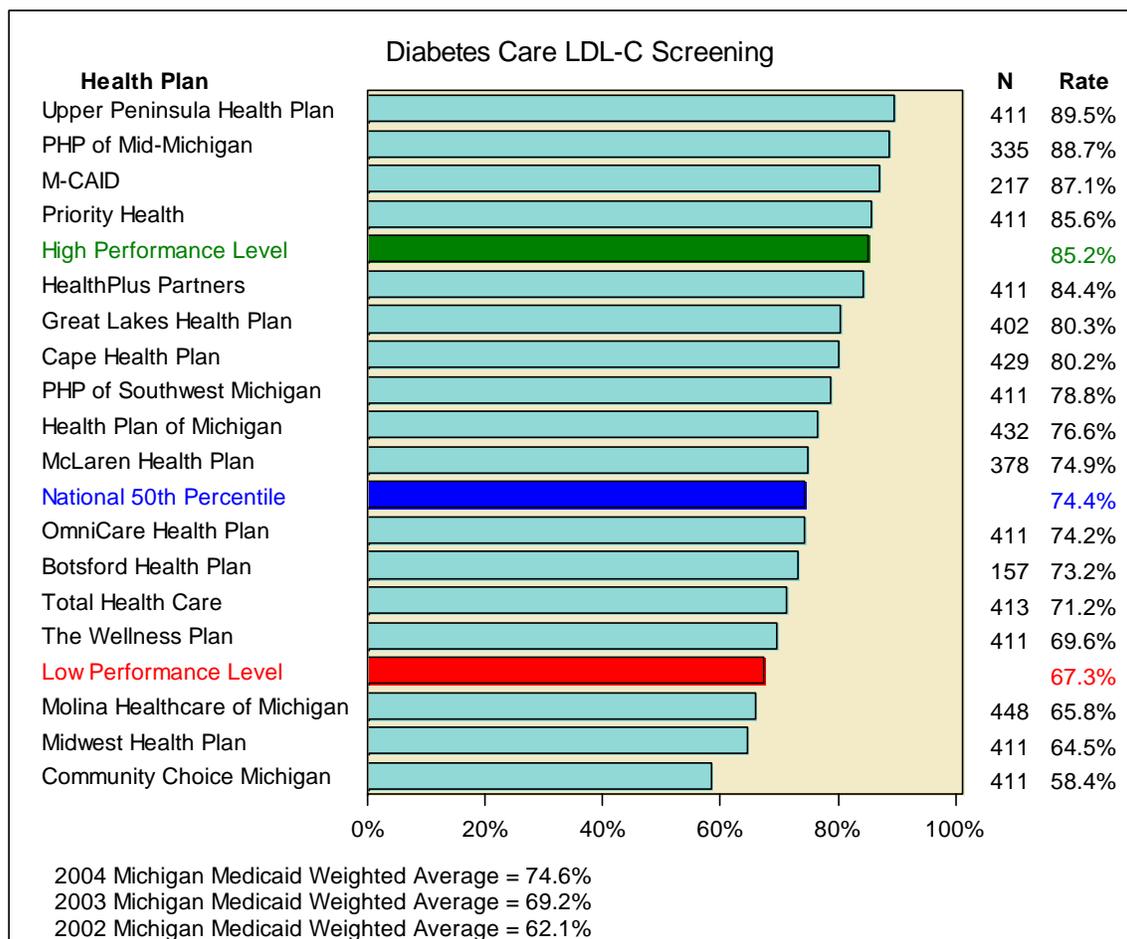
LDL is a type of lipoprotein that carries cholesterol in the blood. LDL is considered to be undesirable because it deposits excess cholesterol in walls of blood vessels and contributes to “hardening of the arteries” and heart disease. Hence, LDL cholesterol is often termed “bad” cholesterol. The test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

HEDIS Specification: Comprehensive Diabetes Care—LDL-C Screening

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

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

**Figure 5-7—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Comprehensive Diabetes Care—LDL-C Screening**



Four health plans had rates above the HPL of 85.2 percent, while three health plans had rates below the LPL of 67.3 percent. A total of 10 health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

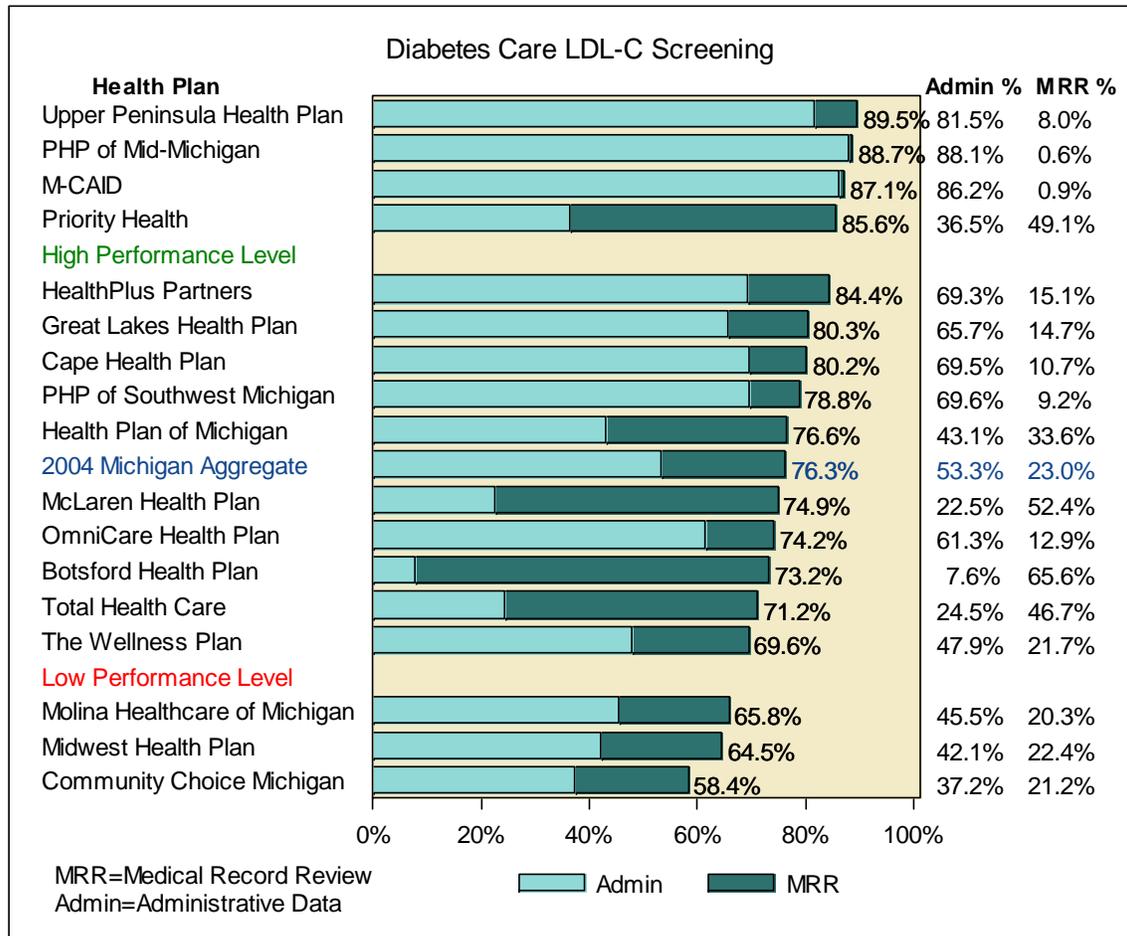
The 2004 Michigan Medicaid weighted average of 74.6 percent was 0.2 percentage points above the national HEDIS 2003 Medicaid 50th percentile of 74.4 percent. The reported rates ranged from a low of 58.4 percent to a high of 89.5 percent. Denominator sizes ranged from 157 to 448.

The 2004 Michigan Medicaid weighted average was higher than 2003, up 5.4 percentage points, and 12.5 percentage points above the 2002 Michigan Medicaid weighted average of 62.1 percent.

In 2003, four health plans reported rates above the HPL, and one health plan had a rate below the LPL. Although three health plans demonstrated rates below the LPL in 2004, the overall range of reported rates showed a slight increase from 2003 to 2004.

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

**Figure 5-8—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Comprehensive Diabetes Care—LDL-C Screening**



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

All health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2004 Michigan aggregate administrative rate was 53.3 percent and the medical record review rate was 23.0 percent.

In 2004, nearly 70 percent of the aggregate rate was derived from administrative data and 30 percent from medical record review. In 2003, 65.6 percent of the aggregate rate was derived from administrative data.

Nine health plans increased their overall rates by 20 percentage points or more from medical record review.

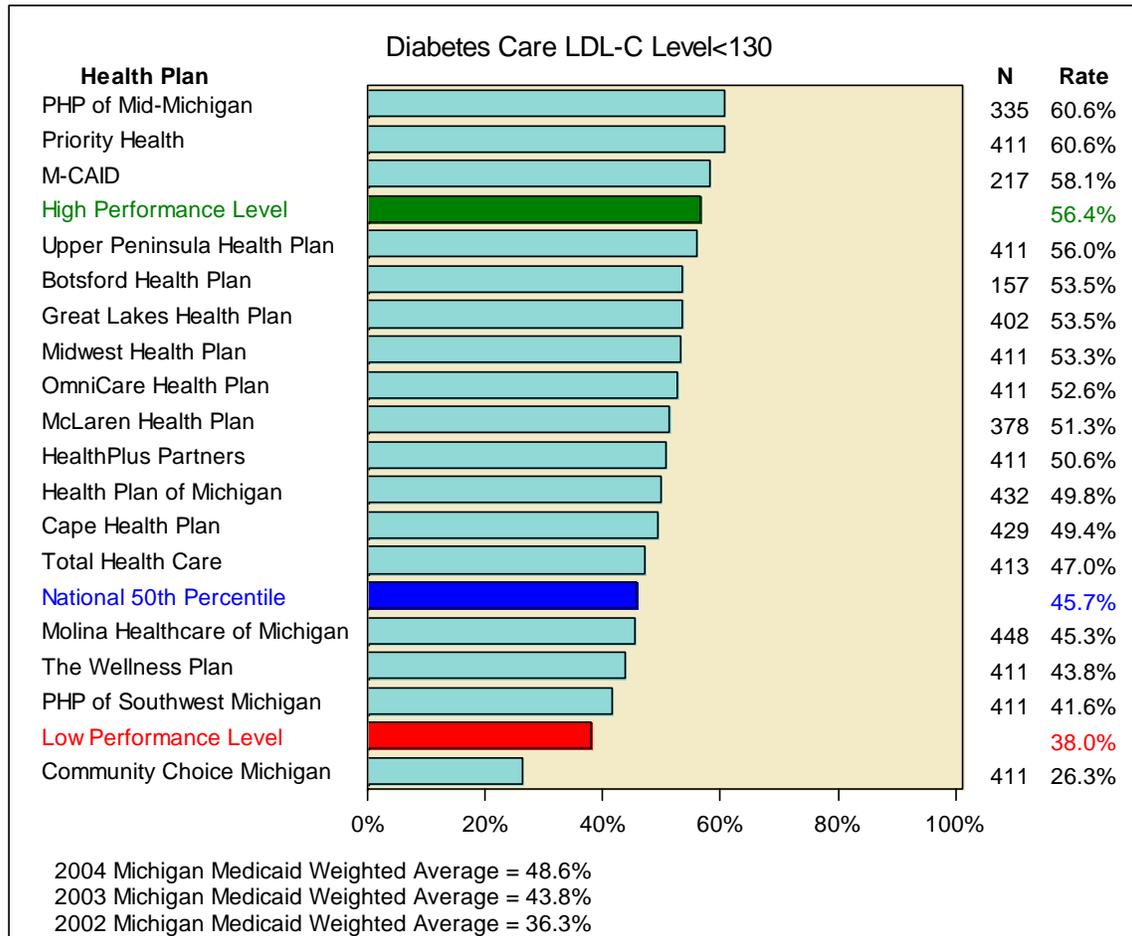
Generally, administrative laboratory encounter data are complete among the Michigan MHPs, although some variance is seen among them. Michigan MHPs that acquired a significant gain in their rate from medical record review should consider implementing a method to routinely monitor the submission of laboratory encounter data to ensure sufficient volumes are submitted over time.

HEDIS Specification: Comprehensive Diabetes Care—LDL-C Level <130

The rate for *Comprehensive Diabetes Care—LDL-C Level <130* calculates the percentage of members with diabetes (Type 1 and Type 2) aged 18 through 75 years who were continuously enrolled during the measurement year and whose most recent LDL-C test (performed during the measurement year or the year prior to the measurement year) indicated an LDL-C level less than 130 mg/dL, as documented through automated laboratory data and/or medical record review.

Health Plan Ranking: Comprehensive Diabetes Care—LDL-C Level<130

**Figure 5-9—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Comprehensive Diabetes Care—LDL-C Level<130**



Three health plans had rates above the HPL of 56.4 percent, while one health plan had a rate below the LPL of 38.0 percent. A total of 13 health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

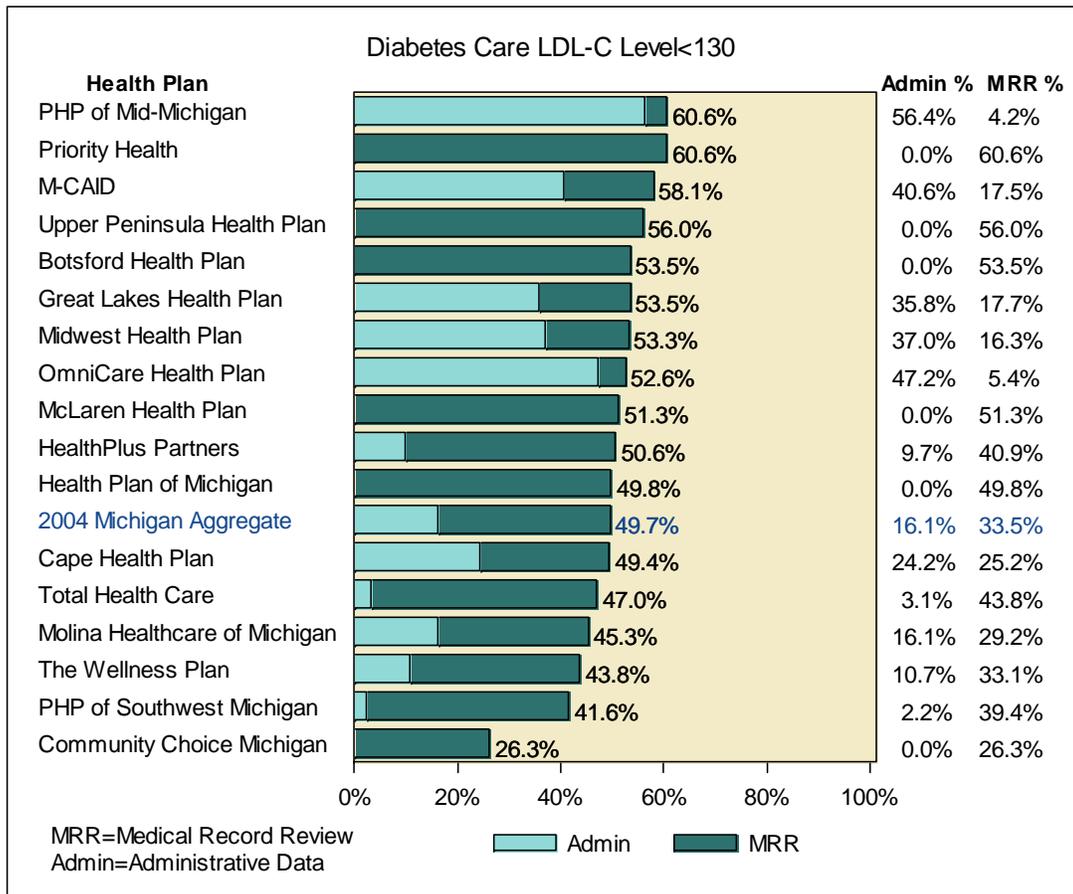
The 2004 Michigan Medicaid weighted average of 48.6 percent was 2.9 percentage points above the national HEDIS 2003 Medicaid 50th percentile of 45.7 percent. The reported rates ranged from a low of 26.3 percent to a high of 60.6 percent. Denominator sizes ranged from 157 to 448.

The 2004 Michigan Medicaid weighted average was higher than 2003, up 4.8 percentage points, and 12.3 percentage points above the 2002 Michigan Medicaid weighted average of 36.3 percent.

In 2003, five health plans reported rates above the HPL, and none of the health plans had rates below the LPL. Overall, the range of reported rates showed little improvement from 2003 to 2004, given fewer health plans reaching the HPL.

Data Collection Analysis: Comprehensive Diabetes Care—LDL-C Level<130

**Figure 5-10—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Comprehensive Diabetes Care—LDL-C Level<130**



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

All health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2004 Michigan aggregate administrative rate was 16.1 percent, and the medical record review rate was 33.5 percent. Only five health plans derived more than half of their rates from administrative data, while six health plans derived their rates entirely from medical record review.

Overall, approximately 32.0 percent of the aggregate rate was derived from administrative data and 68.0 percent from medical record review. In 2003, 24.9 percent was derived from administrative data.

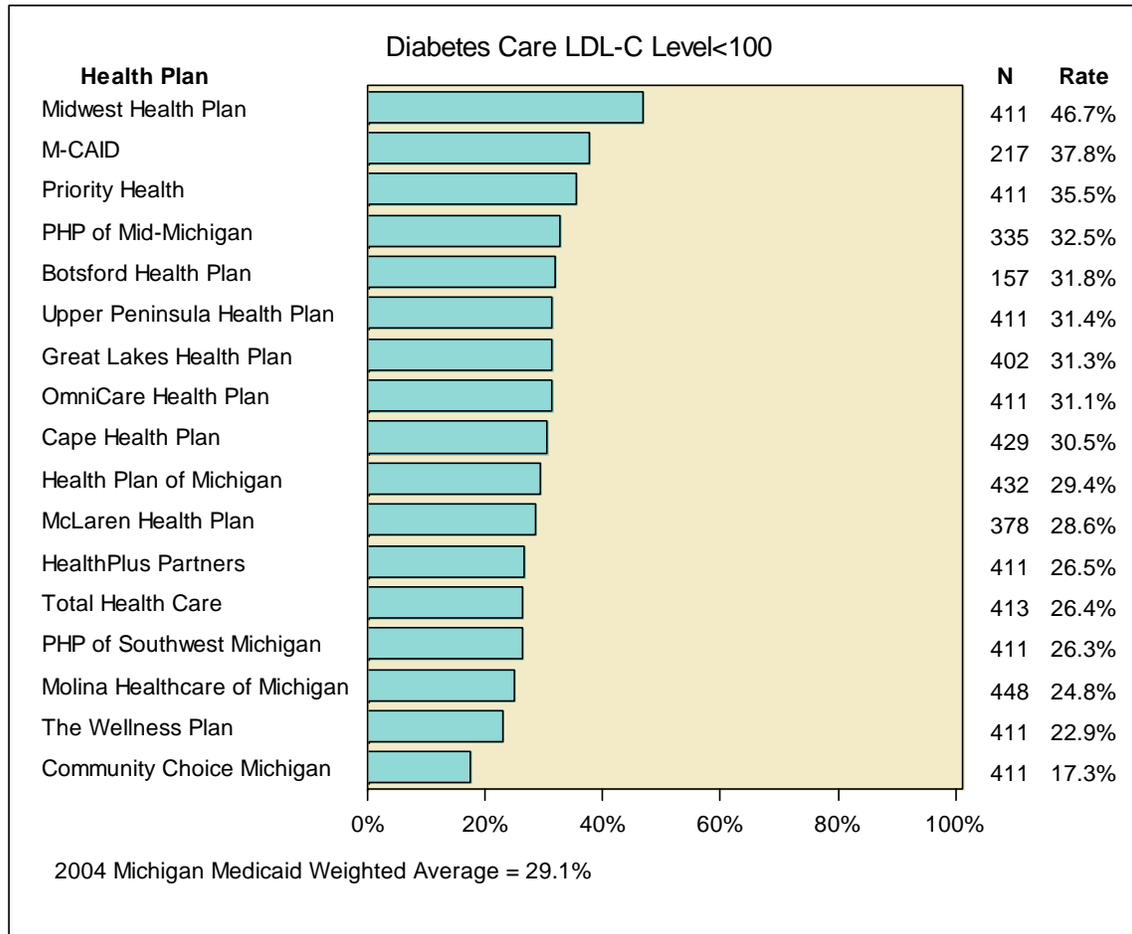
As expected, medical record review was the main source for identification of numerator events, since laboratory values are not typically provided with encounter data by contracted laboratory vendors.

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

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

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

**Figure 5-11—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Comprehensive Diabetes Care—LDL-C Level<100**

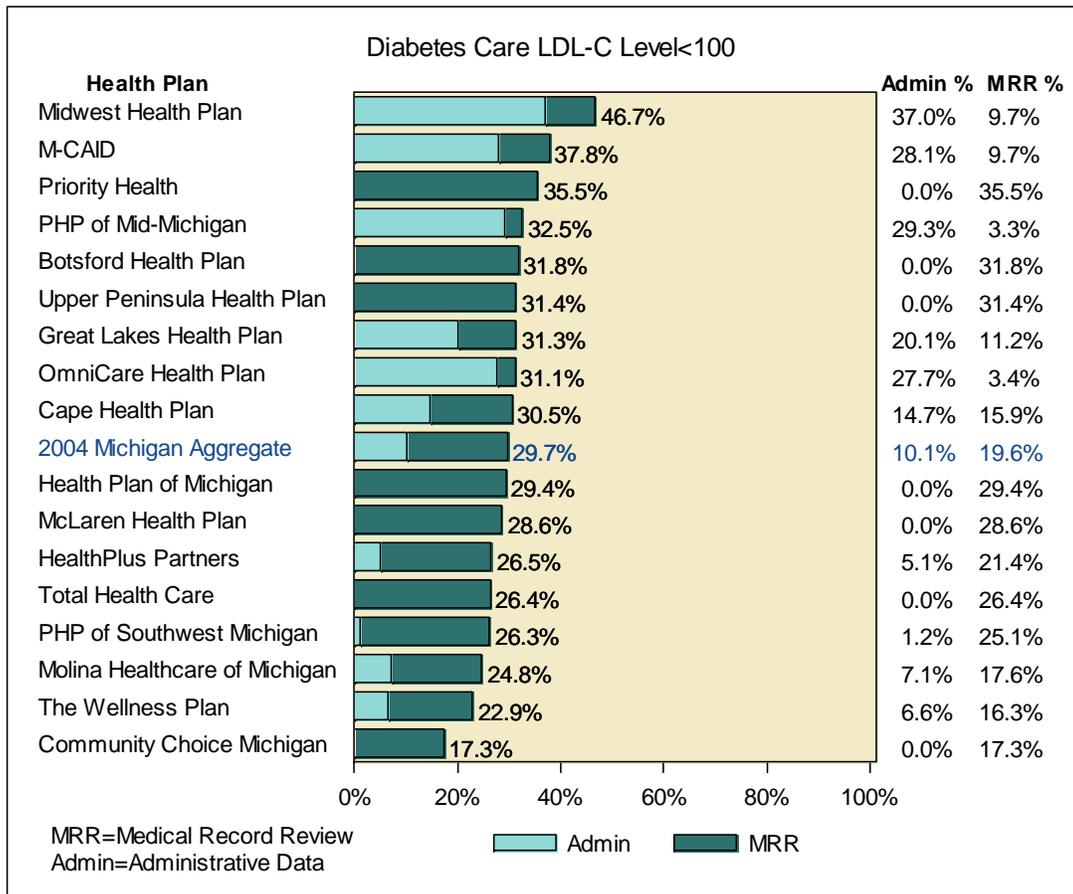


Note: This Key Measure is a first-year HEDIS measure in 2004; therefore, no national performance data are available to establish the HPL, Median, and LPL.

Reported rates for 10 health plans exceeded the 2004 Michigan weighted average of 29.1 percent in 2004. The 17 reported rates ranged from a low of 17.3 percent to a high of 46.7 percent. Denominator sizes ranged from 157 to 448.

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

**Figure 5-12—Michigan Medicaid HEDIS 2004
Data Collection Analysis:
Comprehensive Diabetes Care—LDL-C Level<100**



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

All health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2004 Michigan aggregate administrative rate was 10.1 percent, and the medical record review rate was 19.6 percent. Only five health plans derived more than half of their rates from administrative data, while seven health plans derived their rates entirely from medical record review.

Overall, 34.0 percent of the aggregate rate was derived from administrative data and 66.0 percent from medical record review.

As expected, medical record review was the main source for identification of numerator events, since laboratory values are not typically provided with encounter data by contracted laboratory vendors. It is interesting to note that some of the top-performing plans for this Key Measure also demonstrated relatively complete administrative laboratory values. Health plans are encouraged to work with their laboratory vendors to acquire laboratory value data.

Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy

Diabetes is the leading cause of end stage renal disease (ESRD). About 100,000 Americans have kidney failure as a result of uncontrolled diabetes.⁵⁻¹⁹

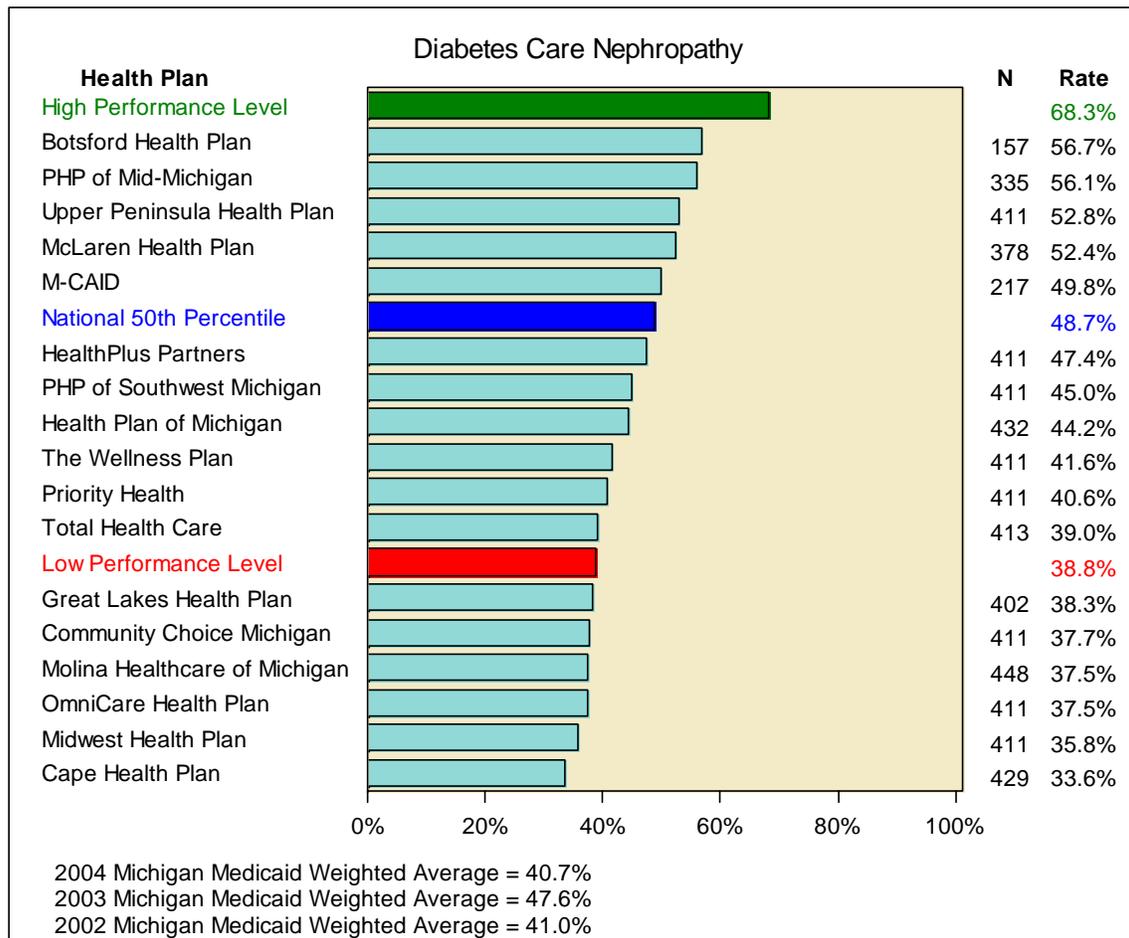
HEDIS Specification: Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy

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

⁵⁻¹⁹ National Committee for Quality Assurance. *The State of Managed Care Quality*. 2001. Standard Version. Washington, DC: National Committee for Quality Assurance; 2001:47.

Health Plan Ranking: Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy

**Figure 5-13—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy**



None of the health plans had rates above the HPL of 68.3 percent, while six health plans had rates below the LPL of 38.8 percent. A total of five health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

The 2004 Michigan Medicaid weighted average of 40.7 percent was 8.0 percentage points below the national HEDIS 2003 Medicaid 50th percentile of 48.7 percent. The reported rates ranged from a low of 33.6 percent to a high of 56.7 percent. Denominator sizes ranged from 157 to 448.

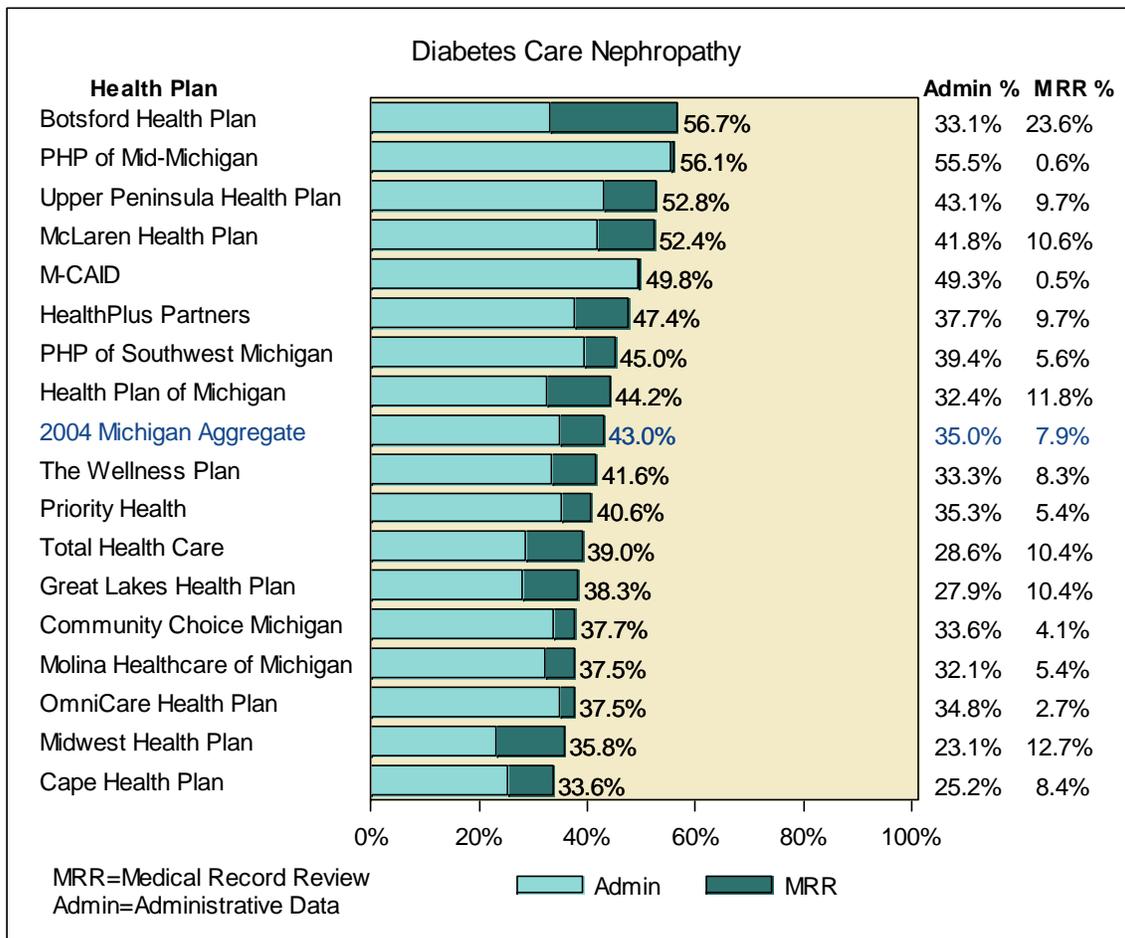
The 2004 Michigan Medicaid weighted average showed a statistically significant decline from 2003, down 6.9 percentage points. Meanwhile, a gain of 0.3 percentage points was observed when compared to the 2002 Michigan Medicaid weighted average of 41.0 percent.

In 2003, five health plans reported rates above the HPL, and one health plan had a rate below the LPL. Overall, the range of reported rates showed no improvement from 2003 to 2004.

Data Collection Analysis: Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy

Figure 5-14—Michigan Medicaid HEDIS 2004

**Data Collection Analysis:
Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy**



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

All health plans with reported rates elected to use the hybrid methodology for calculation of this measure. The 2004 Michigan aggregate administrative rate was 35.0 percent, and the medical record review rate was 7.9 percent.

Results indicate that approximately 82.0 percent of the aggregate rate was derived from administrative data and 18.0 percent from medical record review. In 2003, 73.6 percent of the aggregate rate was derived from administrative data.

Six health plans increased their overall rates by 10 percentage points or more from medical record review.

Identifying numerator events from administrative data for the *Monitoring for Diabetic Nephropathy* Key Measure is somewhat difficult. The level of detail necessary within the laboratory encounter data may not consistently be present. In addition, CPT codes indicating treatment for nephropathy may not be present during the measurement year. Therefore, some reliance on the medical record for this indicator is expected.

Use of Appropriate Medications for People With Asthma

Asthma accounts for more than 11.3 million physician visits, 454,000 hospitalizations, 1.7 million ER visits, and approximately 10 million missed school days annually.⁵⁻²⁰ It is the most common chronic condition in children and the sixth most common chronic condition overall in the U.S., with 5 million children and 12 million adults affected.⁵⁻²¹ In 2002, the current asthma prevalence rate reported for adults in Michigan was 8.8 percent of the population, higher than the United States rate of 7.5 percent.⁵⁻²² Management of asthma is critical, and neglect of the condition frequently results in hospitalization, ER visits, and missed work and school days.

HEDIS Specification: Use of Appropriate Medications for People With Asthma

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

In addition to enrollment data, claims are used to identify the denominator. Members are identified for each denominator based on age and a two-year continuous enrollment criterion (the measurement year and the year prior to the measurement year). In addition, this measure requires that members be identified as having “persistent asthma.” Persistent asthma is defined by the HEDIS specifications as having any of the following events within the year prior to the measurement year (in this case, 2002):

1. At least four asthma medication dispensing events, or
2. At least one Emergency Department visit with a principal diagnosis of asthma, or
3. At least one hospitalization with a principal diagnosis of asthma, or
4. At least four outpatient visits with a corresponding diagnosis of asthma and at least two asthma medication dispensing events.

This measure evaluates whether members with persistent asthma are being prescribed medications acceptable as primary therapy for long-term control of asthma. There are a number of acceptable therapies for people with persistent asthma, although the best available evidence demonstrates that inhaled corticosteroids are the preferred primary therapy. For people with moderate to severe asthma, inhaled corticosteroids are the only recommended primary therapy. While long acting beta-agonists are a preferred adjunct therapy for long-term control of moderate to severe asthma, their recommended use is as add-on therapy with inhaled corticosteroids. Therefore, they should not be included as counting by themselves in this numerator.⁵⁻²³

For this particular measure, NCQA requires that rates be computed using the administrative methodology, so a data collection analysis is not relevant.

⁵⁻²⁰ American Lung Association Epidemiology & Statistics Unit. *Trends in Asthma Morbidity and Mortality*, Table 16. April 2004. Available at <http://www.lungusa.org>. Accessed on: August 11, 2004.

⁵⁻²¹ National Committee of Quality Assurance. *The State of Managed Care Quality, 2001*. Standard Version. Washington, DC: National Committee for Quality Assurance; 2001:29.

⁵⁻²² American Lung Association Epidemiology & Statistics Unit. *Trends in Asthma Morbidity and Mortality*, Table 12. April 2004. Available at: <http://www.lungusa.org>. Accessed on August 11, 2004.

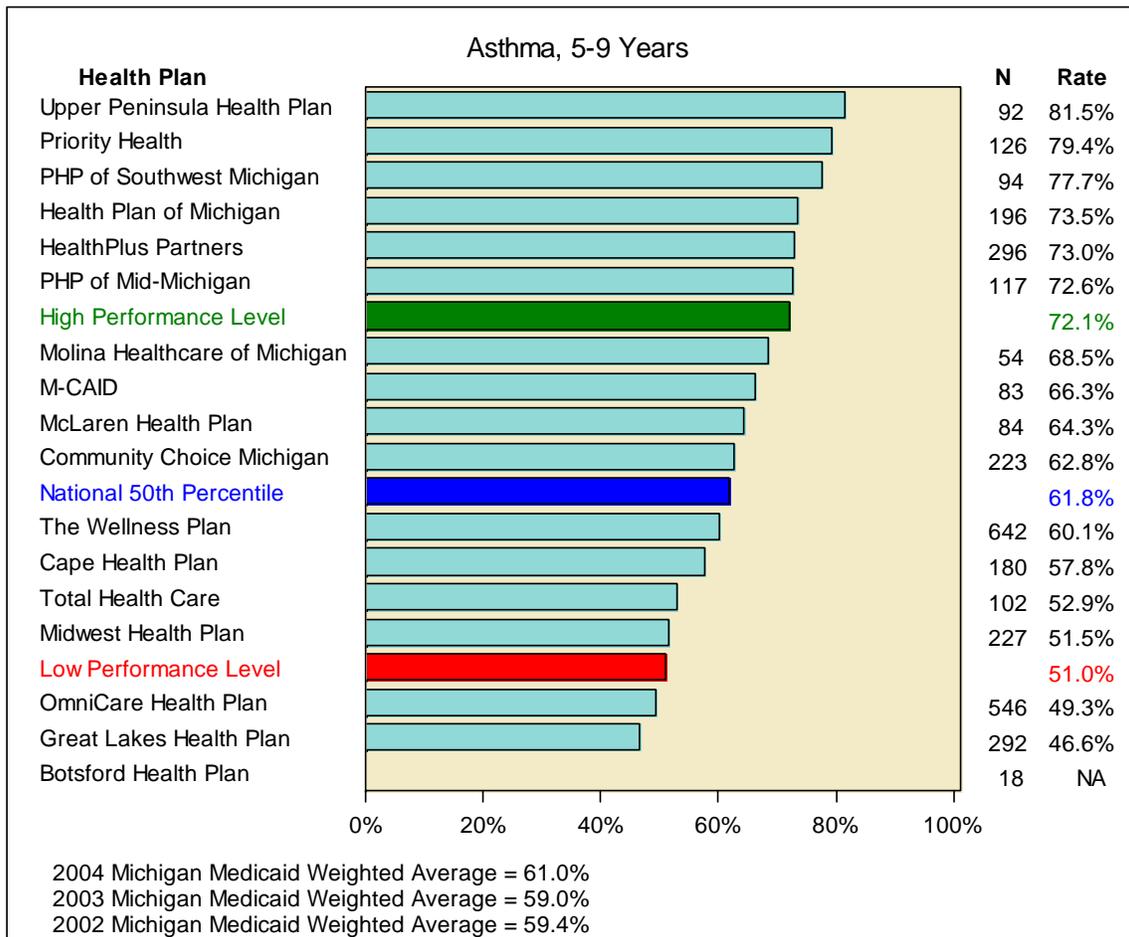
⁵⁻²³ National Committee for Quality Assurance. *HEDIS 2002 Technical Specifications*. Volume 2. Washington, DC: National Committee for Quality Assurance; 2001:96.

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

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

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

**Figure 5-15—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—Ages 5 to 9 Years**



Six of the health plans had rates above the HPL of 72.1 percent, while two health plans had rates below the LPL of 51.0 percent. The reported rates ranged from a low of 46.6 percent to a high of 81.5 percent. The rate for Botsford Health Plan was designated *Not Applicable* by HEDIS auditors because the sample size was less than 30. Denominator sizes ranged from 18 to 642.

A total of 10 health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile. The 2004 Michigan Medicaid weighted average of 61.0 percent was 0.8 percentage points below the national HEDIS 2003 Medicaid 50th percentile of 61.8 percent.

The 2004 Michigan Medicaid weighted average was higher than 2003, up 2.0 percentage points, and 1.6 percentage points above the 2002 Michigan Medicaid weighted average of 59.4 percent.

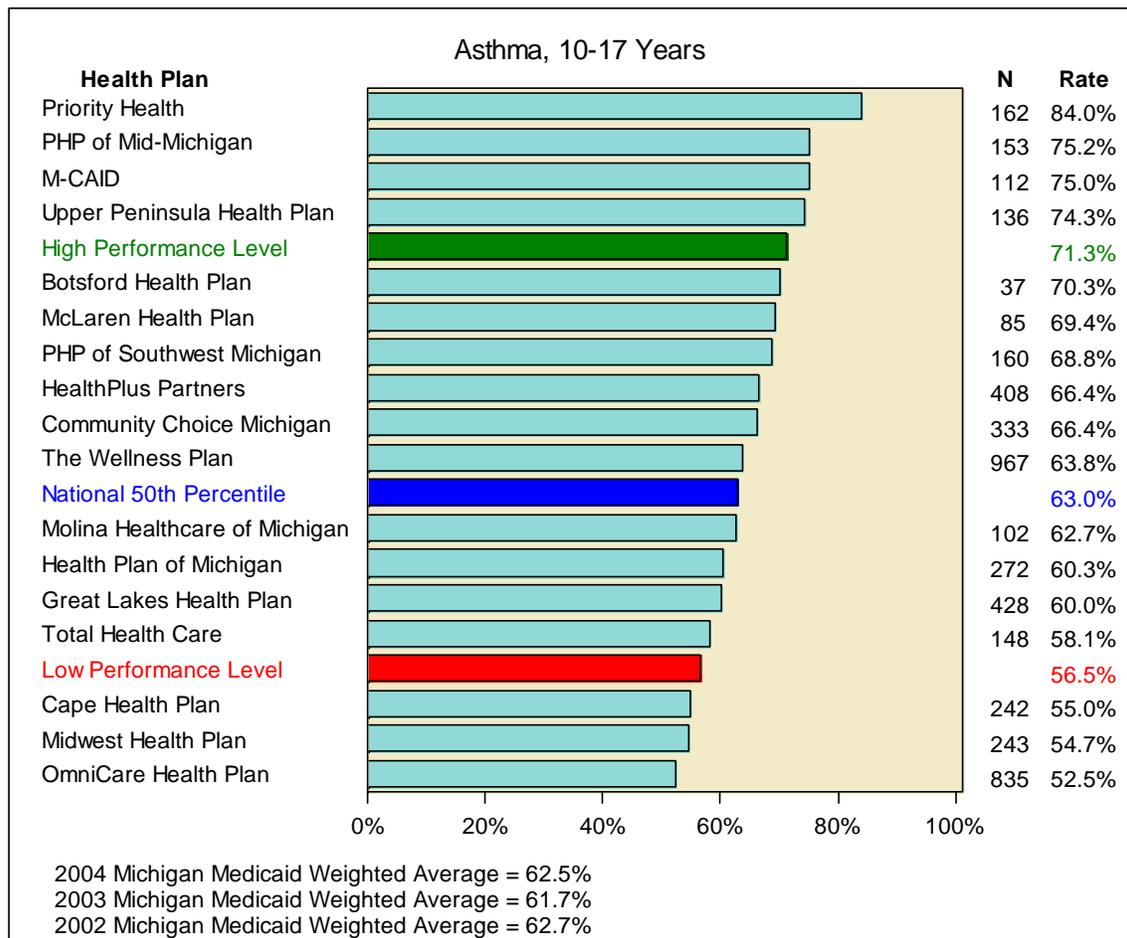
In 2003, four health plans reported rates above the HPL, and three had rates below the LPL. Overall, the range of reported rates showed improvement from 2003 to 2004.

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

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

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

**Figure 5-16—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—Ages 10 to 17 Years**



Four of the health plans had rates above the HPL of 71.3 percent, whereas three health plans had rates below the LPL of 56.5 percent. A total of 10 health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

The 2004 Michigan Medicaid weighted average of 62.5 percent was 0.5 percentage points below the national HEDIS 2003 Medicaid 50th percentile of 63.0 percent. The reported rates ranged from a low of 52.5 percent to a high of 84.0 percent. Denominator sizes ranged from 37 to 967.

The 2004 Michigan Medicaid weighted average was slightly higher than 2003, up 0.8 percentage points, while 0.2 percentage points below the 2002 Michigan Medicaid weighted average of 62.7 percent.

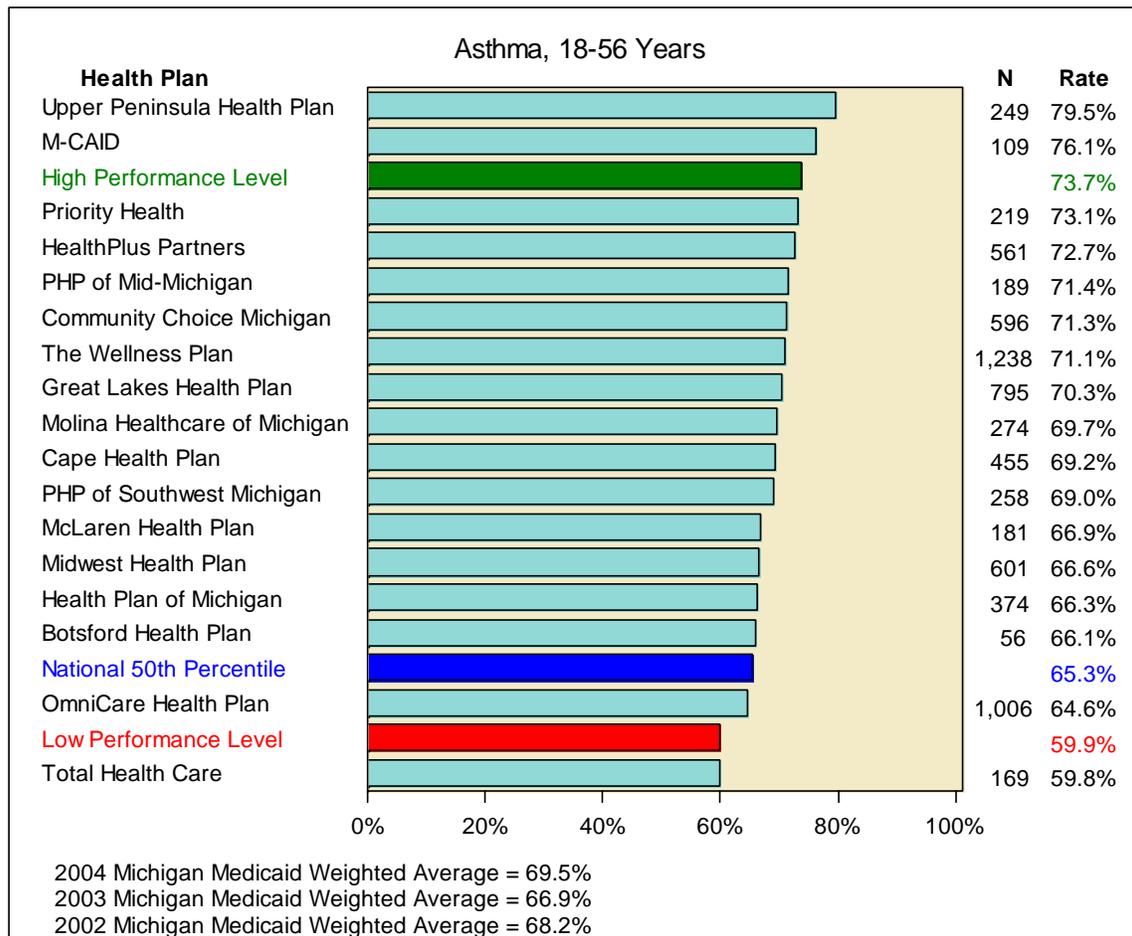
In 2003, four health plans reported rates above the HPL, and one had a rate below the LPL. Overall, the range of reported rates improved from 2003 to 2004.

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

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

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

**Figure 5-17—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—Ages 18 to 56 Years**



Two of the health plans had rates above the HPL of 73.7 percent, while one health plan had a rate below the LPL of 59.9 percent. Fifteen of the 17 health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

The 2004 Michigan Medicaid weighted average of 69.5 percent was 4.2 percentage points above the national HEDIS 2003 Medicaid 50th percentile of 65.3 percent. The reported rates ranged from a low of 59.8 percent to a high of 79.5 percent. Denominator sizes ranged from 56 to 1,238.

The 2004 Michigan Medicaid weighted average showed a statistically significant increase over 2003, up 2.6 percentage points. A gain of 1.3 percentage points was observed over the 2002 Michigan Medicaid weighted average of 68.2 percent.

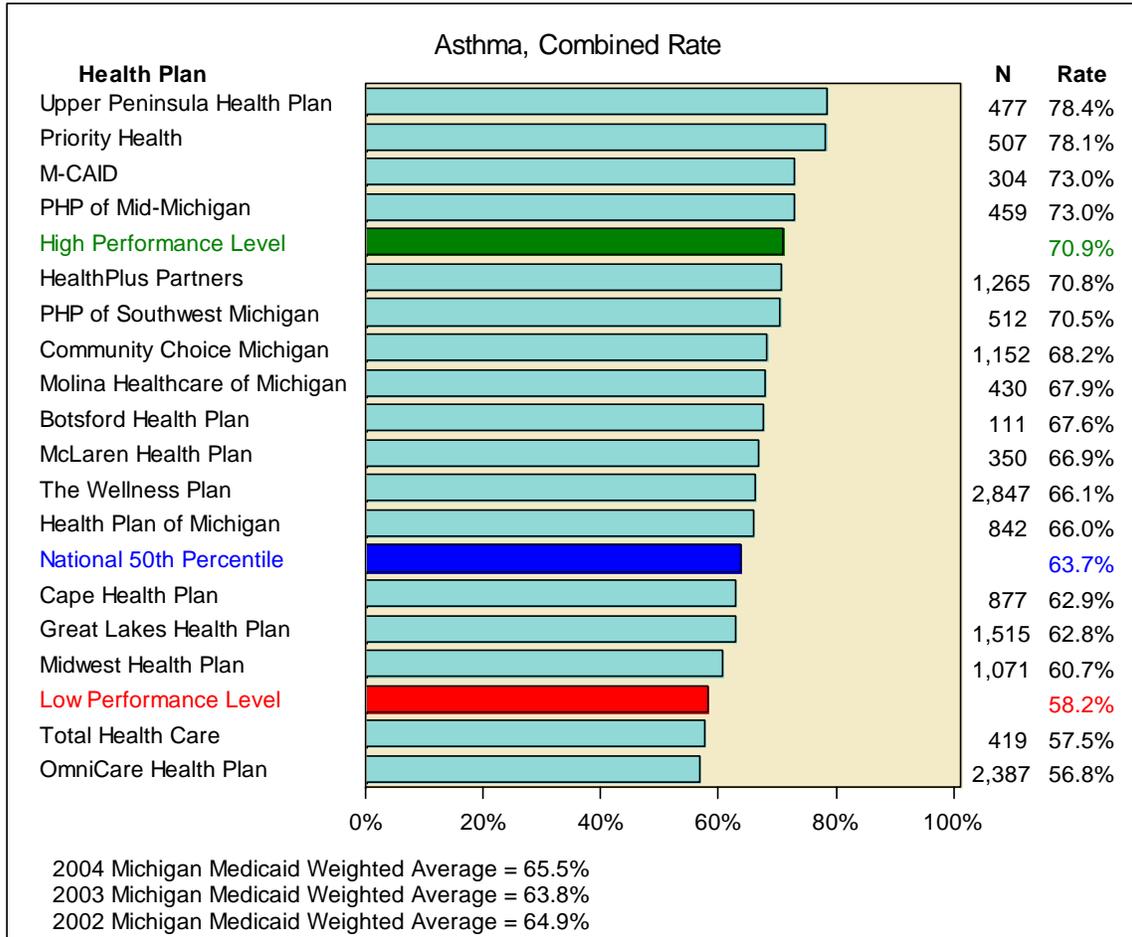
In 2003, one health plan reported a rate above the HPL, and none of the health plans had rates below the LPL. Overall, the range of reported rates improved slightly from 2003 to 2004.

Use of Appropriate Medications for People With Asthma—Combined Rate

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

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

**Figure 5-18—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—Combined Rate**



Four health plans had rates above the HPL of 70.9 percent, while two health plans had rates below the LPL of 58.2 percent. A total of 12 health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

The 2004 Michigan Medicaid weighted average of 65.5 percent was 1.8 percentage points above the national HEDIS 2003 Medicaid 50th percentile of 63.7 percent. The reported rates ranged from a low of 56.8 percent to a high of 78.4 percent. Denominator sizes ranged from 111 to 2,847.

The 2004 Michigan Medicaid weighted average was higher than 2003, up 1.7 percentage points, and 0.6 percentage points above the 2002 Michigan Medicaid weighted average of 64.9 percent.

In 2003, five health plans reported rates above the HPL, and none of the health plans had rates below the LPL. Although two health plans fell below the LPL in 2004, the range of reported rates improved slightly from 2003 to 2004.

Controlling High Blood Pressure

High blood pressure has long been referred to as the “silent killer” in the medical community. It is a major risk factor for developing cardiovascular disease, stroke, and heart failure. According to the Healthy People 2010 *Information Access Project Report on Heart Disease and Stroke*, death rates due to cardiovascular disease and stroke have declined over the past 30 years, mainly due to improvements in detection and treatment of high blood pressure.⁵⁻²⁴ The Behavioral Risk Factor Surveillance System data indicate that 27.3 percent of adults in Michigan had high blood pressure in 2002.⁵⁻²⁵ Blood pressure is the most important factor in preserving kidney function and is critical in reducing the risk of stroke up to 50 percent.⁵⁻²⁶ In Michigan, diseases of the heart, including high blood pressure, were the most common causes of death in 2001, responsible for 26,896 deaths, or 31 percent of all deaths.⁵⁻²⁷

HEDIS Specification: Controlling High Blood Pressure

The *Controlling High Blood Pressure* measure assesses if blood pressure was controlled for adults with diagnosed hypertension. This measure calculates the percentage of members aged 46 through 85 years who were continuously enrolled for the measurement year, who had an ambulatory claim or encounter with a diagnosis of hypertension which was confirmed within the medical record, and whose blood pressure was controlled at 140/90 mm hg or less.

⁵⁻²⁴ Healthy People 2010 Information Access Project Report on Heart Disease and Stroke. Available at: <http://www.healthypeople.gov/document/html/volume1/12heart.htm>. Accessed on August 11, 2004.

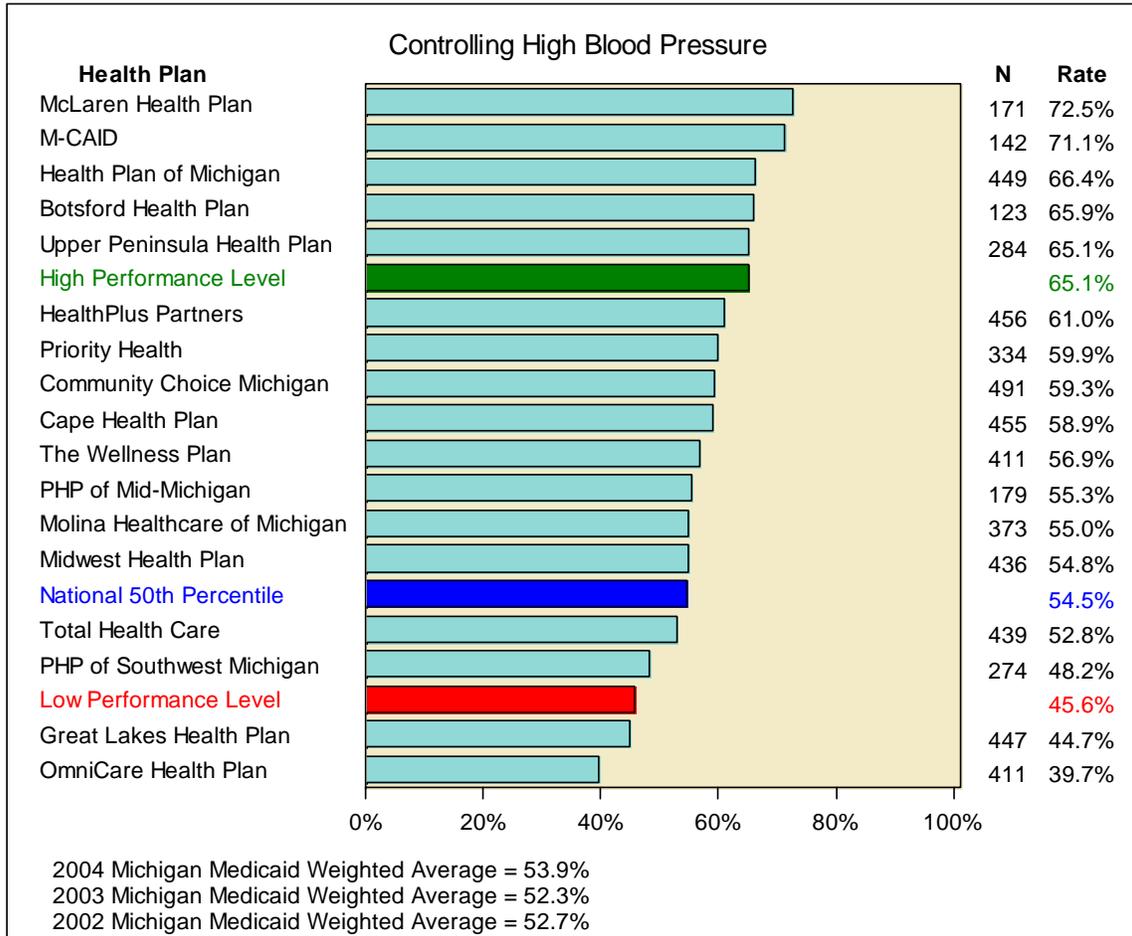
⁵⁻²⁵ Centers for Disease Control and Prevention. The Burden of Chronic Diseases and Their Risk Factors, 2004. Available at: <http://www.cdc.gov/nccdphp/burdenbook2004/Section03/bloodpres.htm>. Accessed on August 11, 2004.

⁵⁻²⁶ Michigan Department of Community Health. 2004 CVD Fact Sheet. Available at: http://www.michigan.gov/documents/cvdfact03_78179_7.pdf. Accessed on August 11, 2004.

⁵⁻²⁷ Centers for Disease Control and Prevention. The Burden of Chronic Diseases and Their Risk Factors, 2004. Available at: http://www.cdc.gov/nccdphp/burdenbook2004/pdf/burden_book2004.pdf. Accessed on August 11, 2004.

Health Plan Ranking: Controlling High Blood Pressure

**Figure 5-19—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Controlling High Blood Pressure**



Five health plans had rates above the HPL of 65.1 percent, while two health plans had rates below the LPL of 45.6 percent. A total of 13 health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

The 2004 Michigan Medicaid weighted average of 53.9 percent was 0.6 percentage points below the national HEDIS 2003 Medicaid 50th percentile of 54.5 percent. The reported rates ranged from a low of 39.7 percent to a high of 72.5 percent. Denominator sizes ranged from 123 to 491.

The 2004 Michigan Medicaid weighted average was higher than 2003, up 1.6 percentage points, and 1.2 percentage points above the 2002 Michigan Medicaid weighted average of 52.7 percent.

In 2003, three health plans reported rates above the HPL, and three health plans had rates below the LPL. Overall, the range of reported rates improved from 2003 to 2004.

Medical Assistance With Smoking Cessation—Advising Smokers to Quit

Michigan currently has the sixth highest rate of adult smokers in the nation. State rates have shown a slight decline since 1998, with the most recent data showing 24.2 percent of adults smoking in 2002 compared to 27.5 percent in 1998.⁵⁻²⁸ In 2001, rates were high for some vulnerable populations: 43 percent of women enrolled in the Michigan Women, Infants, and Children's (WIC) program smoked prior to pregnancy and 30 percent smoked during pregnancy.⁵⁻²⁹ Smoking during pregnancy increases the risk of infant mortality and low birth weight. Children of smokers experience higher rates of asthma than children of non-smokers.

The MDCH has many ongoing efforts to decrease the use of tobacco, including offering free self-help smoking cessation kits and implementing a statewide task force to assist with regulations and ordinances aimed at clean indoor air and smoke free businesses. Ongoing efforts also include smoking cessation programs for pregnant women, counseling for WIC enrollees on the dangers of smoking and second hand smoke, college initiatives, community education programs, and support of activities related to the Youth Tobacco Act.

Many smokers have been unable to quit, even when they know the negative health effects, and know that eliminating tobacco is the single most important step they can take to improve their health. Seven different studies involving brief physician advice to quit (less than three minutes) were analyzed, with results showing that 2.3 percent more patients quit after this minimal intervention than patients with no intervention.⁵⁻³⁰ This shows that even a brief message that is clear, strong, and personalized can have a positive effect on future smoking behavior.

HEDIS Specification—Advising Smokers to Quit

The *Medical Assistance With Smoking Cessation* measure is collected using the Consumer Assessment of Health Plans (CAHPS®) survey. *Advising Smokers to Quit* is one component (or rate) reported for the measure. *Advising Smokers to Quit* calculates the percentage of members aged 18 years or older who were continuously enrolled during the measurement year, who were either smokers or recent quitters, who were seen by an MHP practitioner during the measurement year, and who received advice to quit smoking.

⁵⁻²⁸ Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System (BRFSS). Available at: <http://www.cdc.gov/brfss/>. Accessed on August 11, 2004.

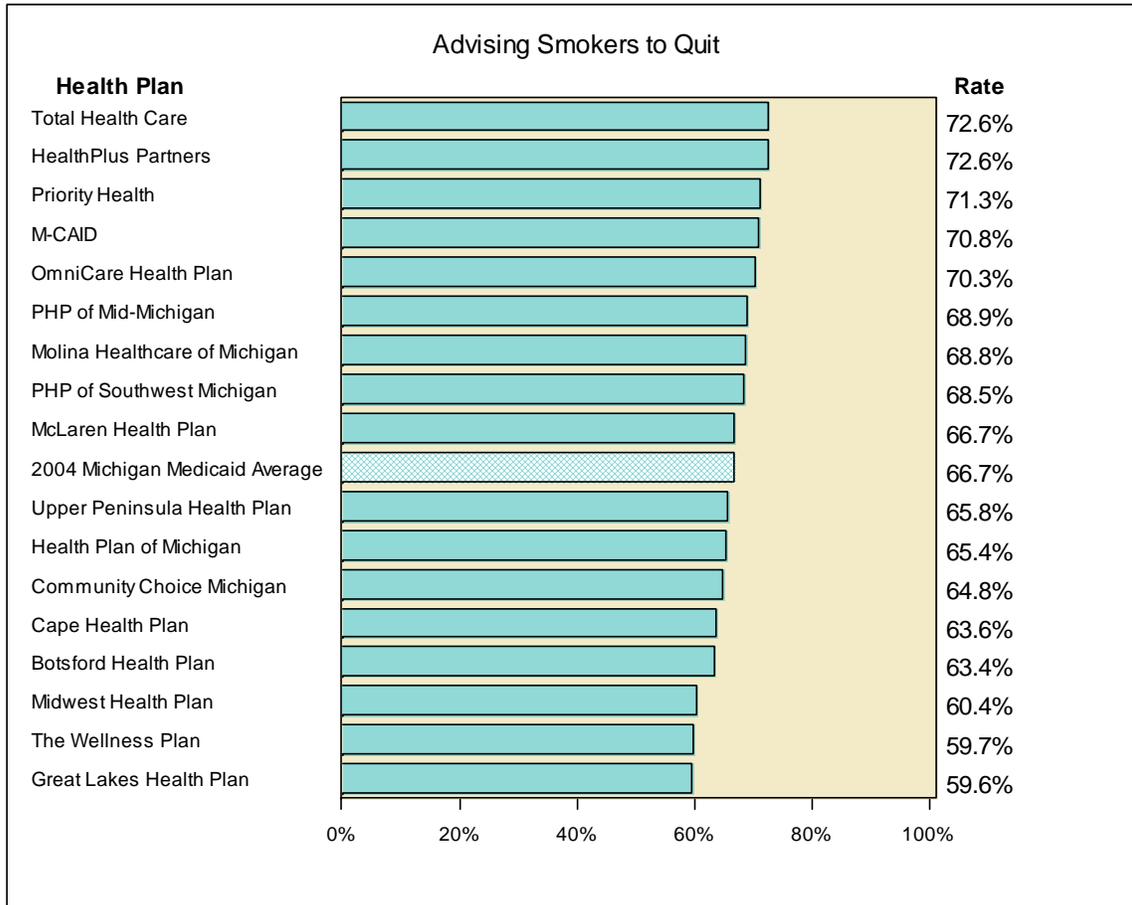
⁵⁻²⁹ Michigan Department of Community Health. Critical Health Indicators 2003. Available at: http://www.michigan.gov/documents/Cigarette_Smoking_April_02_23534_7.pdf. Accessed on August 11, 2004.

⁵⁻³⁰ Smith SS, Fiore MC. The Epidemiology of Tobacco Use, Dependence, and Cessation in the United States. *Primary Care, Clinics in Office Practice*; September 1999; 26(3):433-61.

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

**Figure 5-20—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Medical Assistance with Smoking Cessation—Advising Smokers to Quit**



The cross-hatch bar shows the 2004 Michigan Medicaid Average. This is not a weighted average. Since eligible population data were not available, a weighted average could not be calculated for this measure.

For this measure, 9 of the 17 health plans had rates above the 2004 Michigan Medicaid Average of 66.7 percent. The rates reported by the 17 health plans ranged from 59.6 percent to 72.6 percent.

Living With Illness Findings and Recommendations

Results for the Living with Illness dimension showed room for improvement in 2004. The Michigan weighted averages for *Comprehensive Diabetes Care* are near or below national Medicaid median rates. More Michigan MHPs reported rates below the LPL compared to the previous year, and fewer reported rates above the HPL. The Michigan Medicaid weighted average for four of the six measures that have benchmarking information are below the national Medicaid median rate. The two rates that are above the national Medicaid 50th percentile show substantial improvement from the previous year: *LDL-C Screening* rate improved by 5.4 percentage points, and the *LDL-C Level <130* improved by 4.8 percentage points.

Asthma results were more encouraging in 2004, although no weighted average showed a statistically significant improvement from the previous year. The range of reported rates has increased, with more Michigan MHPs reporting rates above the HPL compared to last year (indicating improvement); however, more Michigan MHPs also reported rates below the LPL. For *Use of Appropriate Medications for People With Asthma—Combined Rate* (which covers all age groups), the 2004 Michigan Medicaid weighted average was 1.8 percentage points above the national HEDIS 2003 Medicaid 50th percentile. The *Ages 18 to 56 Years* rate is just 0.4 percentage points below the national Medicaid 75th percentile.

Overall, the range of reported rates improved from 2003 to 2004 for *Controlling High Blood Pressure*. Although the 2004 Michigan Medicaid weighted average fell slightly below the national HEDIS 2003 Medicaid 50th percentile, fewer health plans individually fell below the national 50th percentile in 2004.

Improving the rates for the HEDIS measures in this dimension may require more intense case management at the health plan level, along with provider incentives and education. Medicaid health plans in other states have shown significant improvement by using case management in conjunction with automated reports. In addition, financial incentives were given to providers for completing tests on diabetic members and for showing improvement in outcomes, such as lower HbA1c levels, in these members. Using these strategies may allow health plans to improve rates and reach the HPL.

HSAG analyzed the Michigan Medicaid HEDIS rates along with intervention information submitted by the Michigan MHPs. Analysis in this dimension showed a positive correlation for the *Use of Appropriate Medications for People With Asthma* Key Measure, between giving providers feedback on their panel's prescription compliance, and the overall asthma pharmacy compliance rate.

Health plans that work directly with their laboratory vendors to receive laboratory data have also seen improvement in their rates for the *Comprehensive Diabetes Care—Poor Control* and *LDL-C Level* measures. An added benefit of decreasing the reliance on medical record review allows the health plans to focus resources on other areas, such as provider education or focused case management activities.

Introduction

Access to care is the foundation for diagnosing and treating health problems and for increasing the quality and years of healthy life. Establishing a relationship with a primary care practitioner is essential to improving access to care for both adults and children. The public health system, health plans, and health care researchers focus on identifying barriers to the use of existing health services and eliminating disparities in order to increase access to quality care. By breaking down barriers to care and improving access, health plans can increase preventive care and successful management of disease processes.

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

The Access to Care dimension encompasses the following MDCH Key Measures:

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

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

Children's and Adolescents' Access to Primary Care Practitioners

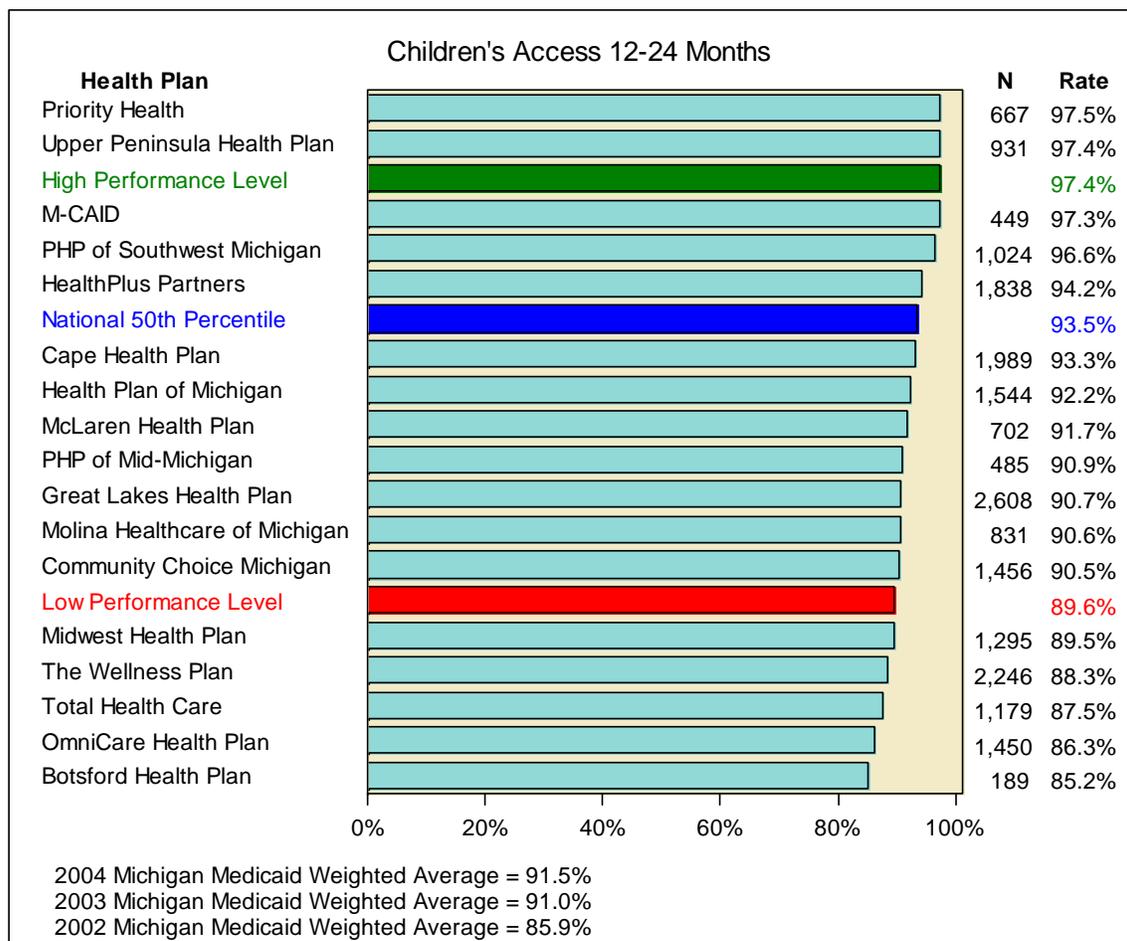
The *Children's and Adolescents' Access to Primary Care Practitioners* measure looks at visits to pediatricians, family physicians, and other primary care providers as a way to assess general access to care for children. Rates for four age groups are provided: Ages 12 to 24 months, 25 months to 6 years,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

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

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

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

**Figure 6-1—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months**



Two health plans reported rates above the HPL of 97.4 percent, while five health plans had rates below the LPL of 89.6 percent. A total of five health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

The 2004 Michigan Medicaid weighted average of 91.5 percent was 2.0 percentage points below the national HEDIS 2003 Medicaid 50th percentile rate of 93.5 percent. The reported rates ranged from a low of 85.2 percent to a high of 97.5 percent. Denominator sizes ranged from 189 to 2,608.

The 2004 Michigan Medicaid weighted average was slightly higher than in 2003, up 0.5 percentage points and 5.6 percentage points higher than in 2002.

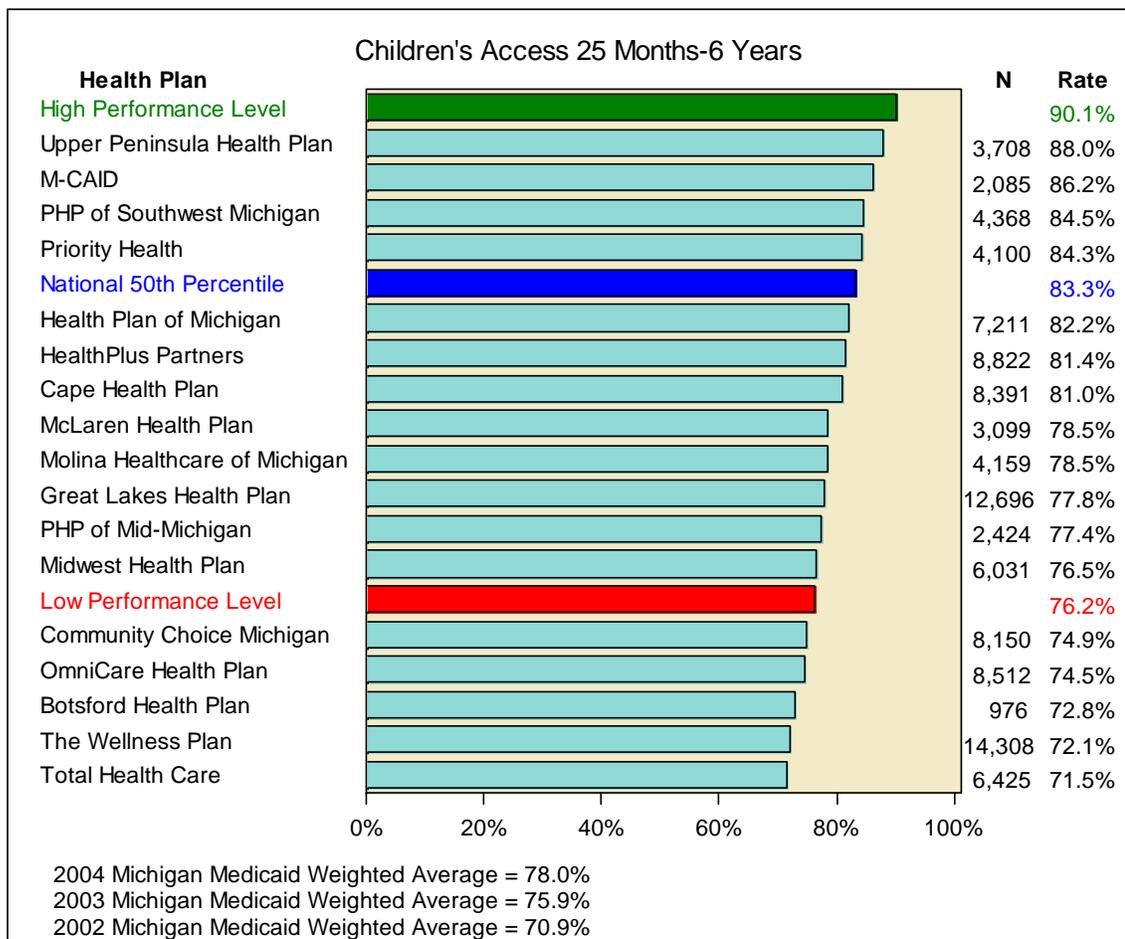
In 2003, one health plan reported a rate above the HPL and five had rates below the LPL. Overall, the range of reported rates improved from 2003 to 2004.

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

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

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

**Figure 6-2—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years**



None of the health plans reported a rate above the HPL of 90.1 percent, while five health plans had rates below the LPL of 76.2 percent. A total of four health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

The 2004 Michigan Medicaid weighted average of 78.0 percent was 5.3 percentage points below the national HEDIS 2003 Medicaid 50th percentile of 83.3 percent and 1.8 percentage points above the LPL. The reported rates ranged from 71.5 percent to 88.0 percent. Denominator sizes ranged from 976 to 14,308.

The 2004 Michigan Medicaid weighted average was 2.1 percentage points higher than in 2003, and 7.1 percentage points above the 2002 Michigan Medicaid weighted average of 70.9 percent.

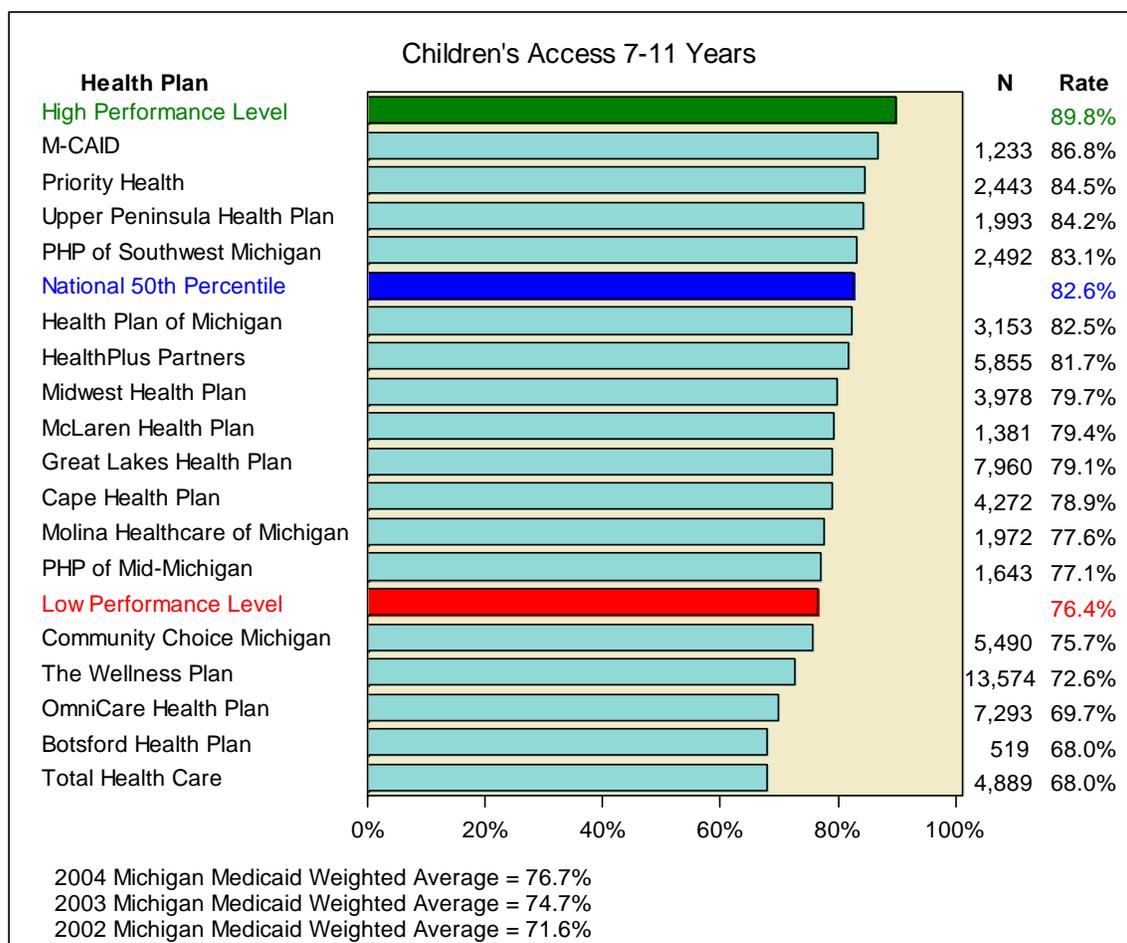
In 2003, none of the health plans reported rates above the HPL, and five had rates below the LPL. Overall, the range of reported rates improved in 2004 when compared to 2003.

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

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

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

**Figure 6-3—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years**



None of the health plans reported a rate above the HPL of 89.8 percent, while five health plans had rates below the LPL of 76.4 percent. A total of four health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

The 2003 Michigan Medicaid weighted average of 76.7 percent was 5.9 percentage points below the national HEDIS 2003 Medicaid 50th percentile of 82.6 percent. The reported rates ranged from a low of 68.0 percent to a high of 86.8 percent. Denominator sizes ranged from 519 to 13,574.

The 2004 Michigan Medicaid weighted average was 2.0 percentage points higher than in 2003, and 5.1 percentage points higher than the 2002 Michigan Medicaid weighted average of 71.6 percent.

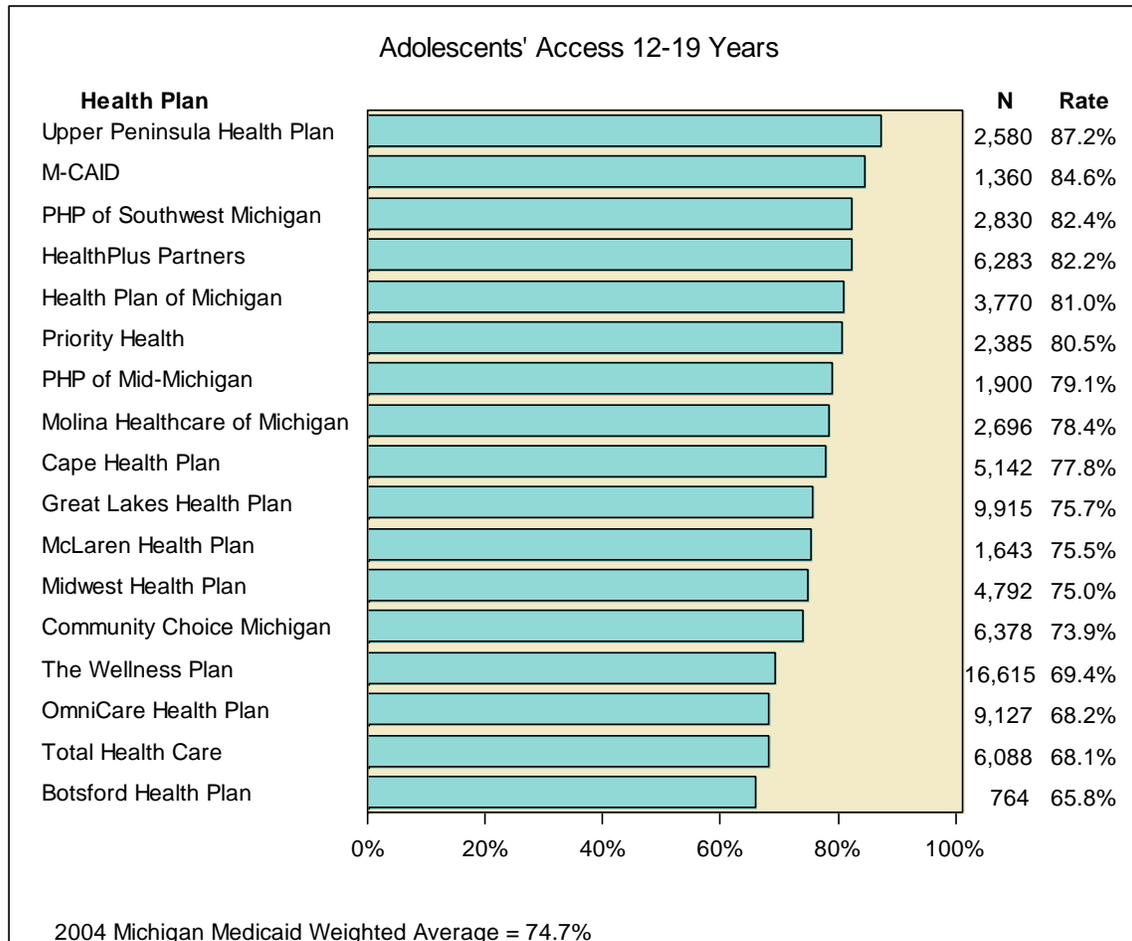
In 2003, one health plan reached the HPL and four health plans were below the LPL. Although none of the health plans reached the HPL in 2004, the range of rates in 2004 showed improvement when compared to 2003.

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

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

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

**Figure 6-4—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years**



Note: This Key Measure is a first-year HEDIS measure in 2004; therefore, no national performance data are available to establish the HPL, Median, and LPL.

Reported rates for 12 health plans exceeded the 2004 Michigan weighted average of 74.7 percent in 2004. The 17 reported rates ranged from a low of 65.8 percent to a high of 87.2 percent. Denominator sizes ranged from 764 to 16,615.

Adults' Access to Preventive/Ambulatory Health Services

The majority of adults have relatively frequent contact with their health care providers. According to the NCQA, 85 percent of Americans reported at least 1 visit with their health care provider within the last year and 13.5 percent reported 10 or more visits.⁶⁻¹

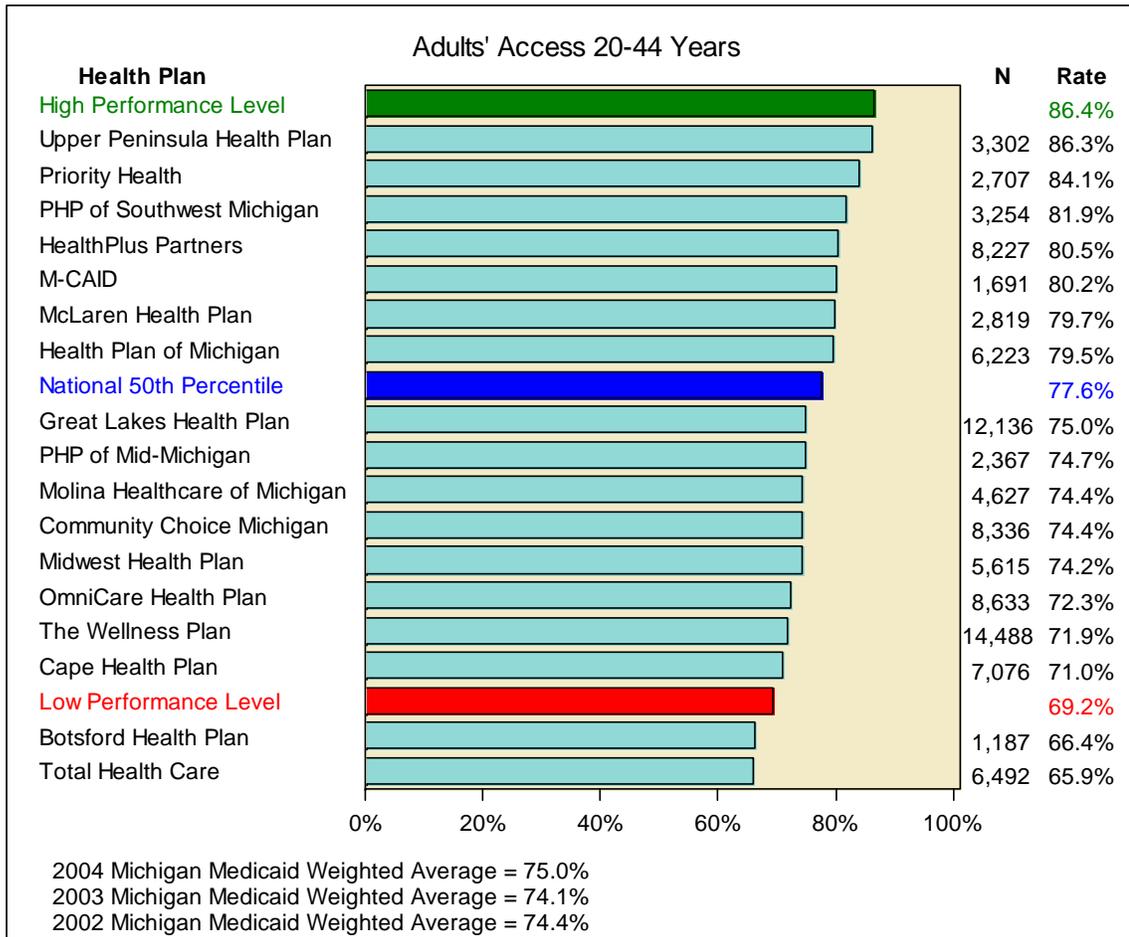
HEDIS Specification: Adults' Access to Preventive/Ambulatory Health Services —Ages 20 to 44 Years

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

⁶⁻¹ National Committee for Quality Assurance. *The State of Managed Care Quality, 2001*. Available at: www.ncqa.org/somc2001/intro/somc_2001_industry.htm. Accessed on August 11, 2004.

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

**Figure 6-5—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years**



None of the health plans reported a rate above the HPL of 86.4 percent, while two health plans had rates below the LPL of 69.2 percent. A total of seven health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

The 2004 Michigan Medicaid weighted average of 75.0 percent was 2.6 percentage points below the national HEDIS 2003 Medicaid 50th percentile. The reported rates ranged from 65.9 percent to 86.3 percent. Denominator sizes ranged from 1,187 to 14,488.

The 2004 Michigan Medicaid weighted average was slightly higher than 2003, up 0.9 percentage points, and 0.6 percentage points above the 2002 Michigan Medicaid weighted average of 74.4 percent.

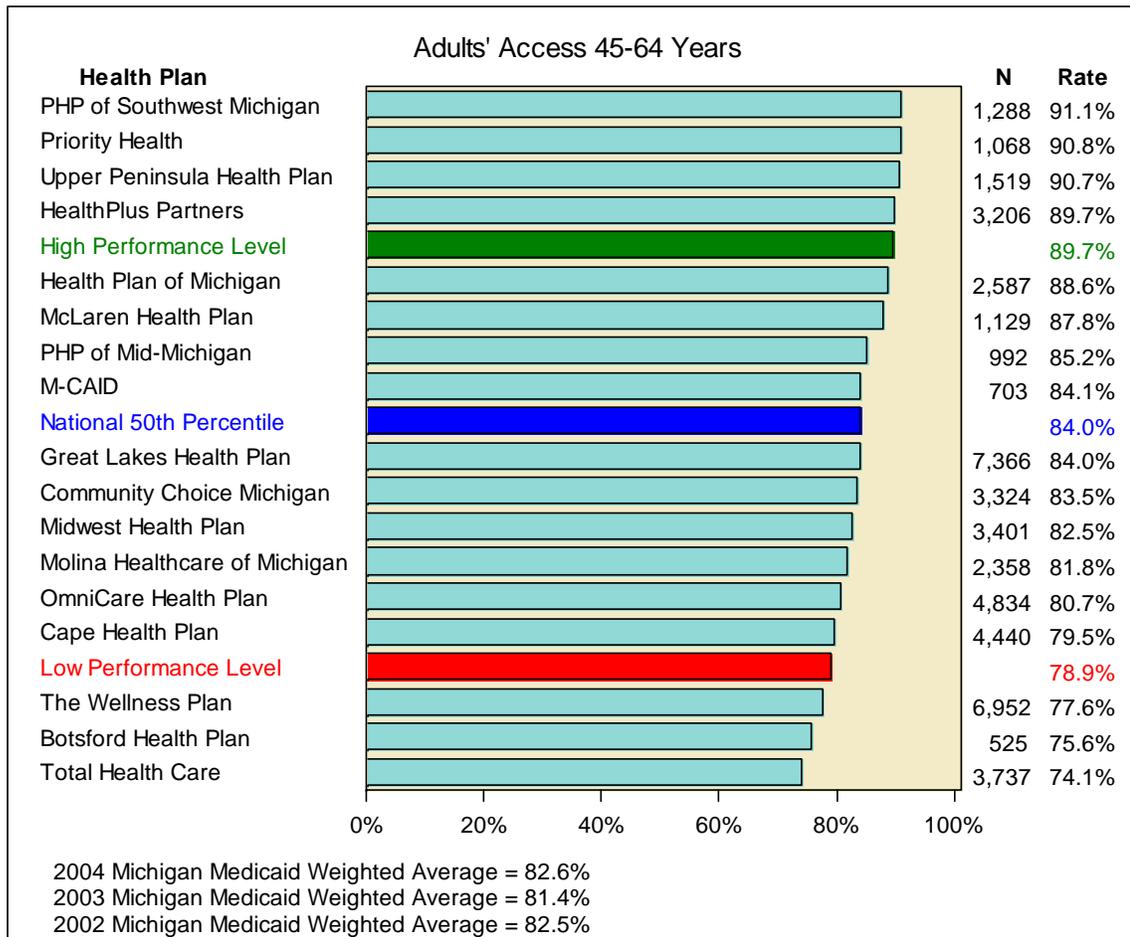
In 2003, two health plans reported rates above the HPL, and four had rates below the LPL. Although none of the health plans reached the HPL in 2004, the range of reported rates showed a slight improvement when compared to 2003.

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

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

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

**Figure 6-6—Michigan Medicaid HEDIS 2004
Health Plan Ranking:
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years**



Four health plans reported rates above the HPL of 89.7 percent, while three health plans had rates below the LPL of 78.9 percent. A total of eight health plans reported rates above the national HEDIS 2003 Medicaid 50th percentile.

The 2004 Michigan Medicaid weighted average of 82.6 percent was 1.4 percentage points below the national HEDIS 2003 Medicaid 50th percentile of 84.0 percent. The reported rates ranged from a low of 74.1 percent to a high of 91.1 percent. Denominator sizes ranged from 525 to 7,366.

The 2004 Michigan Medicaid weighted average was 1.2 percentage points higher than in 2003, and only 0.1 percentage points above the 2002 Michigan Medicaid weighted average.

In 2003, six health plans reported rates above the HPL, and five had rates below the LPL. The range for reported rates demonstrated a modest upward shift in 2004 compared to 2003, with fewer health plans reaching the HPL and falling below the LPL.

Access-to-Care Findings and Recommendations

Traditionally, access to care is monitored through the examination of provider networks or appointment availability. The HEDIS measures that make up this dimension address whether or not members are accessing routine care. Consequently, some may consider the title of this dimension misleading. This dimension may also be considered to be more of an indication of member behavior than MHP compliance. It is much easier to score high on traditional access-to-care measures than to achieve high rates for members accessing care.

It is clear that members in the Michigan Medicaid program are not accessing care at the level seen in managed Medicaid programs across the country. Every numerator for the two Key Measures in this section where benchmarking information is available is below the national Medicaid 50th percentile, and in many cases very close to the 25th percentile. A slight improvement is seen in the Michigan weighted average rates, and in a reduction in the range of reported rates of 3.0 to 11.3 percentage points. However, these improvements are due to substantial increases in the lowest reported rate, not a general upward movement of all Michigan Medicaid health plans.

Interventions targeted to increase member utilization of preventive care services are among the most difficult for MHPs. However, the EPSDT research MDCH has done with Michigan State University's Institute of Health Care Studies has pointed out gaps in understanding by members, parents, and practitioners regarding the importance and need for appropriate preventive care. MDCH may want to consider sponsoring multidisciplinary teams to examine member messaging and/or provider messaging regarding the importance of preventive care visits.

7. HEDIS Reporting Capabilities

Key Findings

From the review of each health plan's Final Audit Reports and Data Submission Tools (DSTs), HSAG determined whether or not there were significant audit issues that commonly occurred among Michigan MHPs. A comprehensive systemic review of the 2004 Michigan Medicaid HEDIS audit reports indicated that, overall, the MHPs had no major process issues that impacted HEDIS reporting. None of the health plans had issues related to information systems capabilities that severely impacted the HEDIS results leading to a *Not Report*. These findings are not surprising for the Michigan MHPs, which have been improving information system capabilities over the past several years in order to report HEDIS data more accurately.

Michigan MHPs improved overall on the issues pertaining to the 2003 HEDIS Audits. Inaccurate claims/encounter data capture was identified as an issue for some of the health plans in 2003. In 2004, however, none of the health plans encountered issues, according to the auditors. More accurate coding of ER visits or urgent care visits at the provider level attributed to positive findings. In 2003, encounter data completeness and provider data were also noted as areas of concern for some of the health plans. This did not hold true in 2004, as the auditors indicated that data completeness and provider-related IS standards met NCQA HEDIS specifications. More complete claims/encounter data typically result in higher HEDIS rates and also decrease reliance on medical record review.

Conclusions and Recommendations

Over the past four years, Michigan MHP information system capabilities pertaining to accurate and valid HEDIS reporting have been steadily improving. Performing HEDIS data collection and reporting has been an invaluable experience for both the health plans and MDCH, as identified by decreasing audit issues and overall increasing rates across the years. Since the Michigan MHPs have demonstrated the capability to report HEDIS data by having the necessary information systems and data collection processes in place, the primary focus should be on improvement of measure results, either through targeted interventions or pursuit of external administrative data that have not been previously available.

For upcoming HEDIS reporting years, MDCH should continue to focus on maintaining a relatively consistent set of required measures in order to utilize trending information advantageously. However, the approach could be balanced with a consideration of adding one or two newer HEDIS measures to the Key Measures reporting set. Several new Effectiveness of Care measures released in 2004 are now stabilizing, and benchmark data will be available in the spring of 2005. HSAG recommends that the MDCH continue to consult with the health plans regarding the capability to collect the necessary data and determine collectively whether the measure adds value to the State's overall quality improvement strategy.

Introduction

This section contains these appendices:

- Appendix A: Tabular Results for Key Measures by Health Plan
- Appendix B: National HEDIS 2003 Medicaid Percentiles
- Appendix C: Quality Improvement Interventions Questionnaire
- Appendix D: Glossary

Appendix A. Tabular Results for Key Measures by Health Plan

This section presents tables showing results for Key Measures by health plan.

**Table A-1—Michigan Medicaid HEDIS 2004 Tabular Results for Key Measures:
Immunization Status**

DST	Plan Name	Code	Childhood Immunization Status			Adolescent Immunization Status		
			Eligible Population	Combo 1 Rate	Combo 2 Rate	Eligible Population	Combo 1 Rate	Combo 2 Rate
4136	Botsford Health Plan	BOT	181	53.0%	51.4%	219	39.7%	24.2%
4333	Cape Health Plan	CAP	1,920	66.9%	64.0%	1,402	45.7%	31.9%
4265	Community Choice Michigan	CCM	1,897	67.9%	65.7%	1,613	59.4%	37.7%
4133	Great Lakes Health Plan	GLH	2,694	63.4%	59.7%	2,444	47.8%	33.6%
4291	Health Plan of Michigan	HPM	1,366	72.0%	68.5%	962	48.4%	31.9%
4056	HealthPlus Partners	HPP	1,852	78.9%	76.6%	1,435	64.5%	46.5%
4243	M-CAID	MCD	530	74.5%	72.5%	345	62.3%	46.7%
4312	McLaren Health Plan	MCL	647	73.5%	67.9%	483	56.9%	34.3%
4131	Midwest Health Plan	MID	1,281	64.7%	62.0%	1,088	48.7%	24.6%
4151	Molina Healthcare of Michigan	MOL	700	69.7%	65.7%	673	46.6%	27.1%
4055	OmniCare Health Plan	OCH	1,584	70.1%	65.0%	2,150	20.0%	9.8%
4282	Physician's Health Plan of Mid-Michigan Family Care	PMD	597	69.9%	68.0%	491	64.2%	48.2%
4054	Priority Health Government Programs	PRI	824	84.4%	81.1%	567	62.8%	48.2%
4283	Physician's Health Plan of Southwest Michigan	PSW	980	79.3%	77.6%	642	58.9%	39.7%
4268	Total Health Care	THC	1,267	69.3%	66.7%	1,465	47.1%	34.5%
4218	The Wellness Plan	TWP	2,696	68.6%	67.9%	3,876	59.1%	43.1%
4348	Upper Peninsula Health Plan	UPP	620	80.3%	68.9%	586	65.7%	39.2%
	2004 Michigan Medicaid Weighted Average		--	70.4%	67.4%	--	51.0%	34.5%
	2003 Michigan Medicaid Weighted Average		--	64.8%	60.4%	--	38.5%	20.7%
	2002 Michigan Medicaid Weighted Average		--	64.7%	58.4%	--	33.7%	14.8%
	National HEDIS 2003 Medicaid 50th Percentile		--	59.6%	55.6%	--	40.9%	20.8%

Note: The 2002 Michigan Medicaid Weighted Average included 19 health plans; the 2003 Michigan Medicaid Weighted Averages included 18 health plans; and the 2004 Michigan Medicaid Weighted Average includes 17 health plans.

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**Table A-2—Michigan Medicaid HEDIS 2004 Tabular Results for Key Measures:
Well-Child Visits in the First 15 Months of Life**

DST	Plan Name	Code	Eligible Population	0 Visits Rate	6 or More Visits Rate
4136	Botsford Health Plan	BOT	35	2.9%	25.7%
4333	Cape Health Plan	CAP	552	6.2%	34.9%
4265	Community Choice Michigan	CCM	781	3.9%	31.6%
4133	Great Lakes Health Plan	GLH	870	3.5%	39.4%
4291	Health Plan of Michigan	HPM	435	3.2%	62.0%
4056	HealthPlus Partners	HPP	889	2.9%	43.8%
4243	M-CAID	MCD	136	1.5%	46.3%
4312	McLaren Health Plan	MCL	223	2.2%	48.4%
4131	Midwest Health Plan	MID	464	5.1%	44.8%
4151	Molina Healthcare of Michigan	MOL	139	4.5%	38.1%
4055	OmniCare Health Plan	OCH	674	9.1%	19.9%
4282	Physician's Health Plan of Mid-Michigan Family Care	PMD	247	2.8%	38.1%
4054	Priority Health Government Programs	PRI	323	0.3%	51.7%
4283	Physician's Health Plan of Southwest Michigan	PSW	412	1.5%	38.0%
4268	Total Health Care	THC	506	6.3%	25.7%
4218	The Wellness Plan	TWP	1,330	4.9%	26.5%
4348	Upper Peninsula Health Plan	UPP	221	0.9%	52.0%
	2004 Michigan Medicaid Weighted Average		--	4.2%	36.8%
	2003 Michigan Medicaid Weighted Average		--	5.0%	39.2%
	2002 Michigan Medicaid Weighted Average		--	6.5%	35.5%
	National HEDIS 2003 Medicaid 50th Percentile		--	3.2%	43.0%

Note: The 2002 Michigan Medicaid Weighted Average included 19 health plans; the 2003 Michigan Medicaid Weighted Averages included 18 health plans; and the 2004 Michigan Medicaid Weighted Average includes 17 health plans.

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**Table A-3—Michigan Medicaid HEDIS 2004 Tabular Results for Key Measures:
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life and Adolescent Well-Care Visits**

DST	Plan Name	Code	3rd–6th Years of Life		Adolescent	
			Eligible Population	Rate	Eligible Population	Rate
4136	Botsford Health Plan	BOT	804	64.7%	1,597	33.8%
4333	Cape Health Plan	CAP	6,505	66.0%	8,901	46.4%
4265	Community Choice Michigan	CCM	6,586	54.3%	9,733	33.3%
4133	Great Lakes Health Plan	GLH	10,200	56.3%	15,957	39.9%
4291	Health Plan of Michigan	HPM	5,754	59.5%	7,673	40.7%
4056	HealthPlus Partners	HPP	7,038	49.4%	9,281	32.6%
4243	M-CAID	MCD	1,615	62.0%	2,198	47.6%
4312	McLaren Health Plan	MCL	2,438	50.4%	3,283	44.3%
4131	Midwest Health Plan	MID	4,793	56.2%	7,256	30.9%
4151	Molina Healthcare of Michigan	MOL	3,308	54.2%	5,575	34.6%
4055	OmniCare Health Plan	OCH	7,062	57.4%	12,343	29.6%
4282	Physician's Health Plan of Mid-Michigan Family Care	PMD	1,934	55.7%	2,736	33.8%
4054	Priority Health Government Programs	PRI	3,328	66.2%	3,446	39.7%
4283	Physician's Health Plan of Southwest Michigan	PSW	3,442	56.7%	4,376	33.3%
4268	Total Health Care	THC	5,188	50.7%	8,994	34.7%
4218	The Wellness Plan	TWP	11,883	47.2%	21,891	23.1%
4348	Upper Peninsula Health Plan	UPP	2,942	56.2%	4,736	37.2%
	2004 Michigan Medicaid Weighted Average		--	55.3%	--	34.2%
	2003 Michigan Medicaid Weighted Average		--	52.0%	--	32.1%
	2002 Michigan Medicaid Weighted Average		--	52.6%	--	29.0%
	National HEDIS 2003 Medicaid 50th Percentile		--	59.7%	--	36.2%

Note: The 2002 Michigan Medicaid Weighted Average included 19 health plans; the 2003 Michigan Medicaid Weighted Averages included 18 health plans; and the 2004 Michigan Medicaid Weighted Average includes 17 health plans.

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**Table A-4—Michigan Medicaid HEDIS 2004 Tabular Results for Key Measures:
Cancer Screening in Women**

DST	Plan Name	Code	Breast Cancer Screening		Cervical Cancer Screening	
			Eligible Population	Rate	Eligible Population	Rate
4136	Botsford Health Plan	BOT	110	57.4%	1,195	53.0%
4333	Cape Health Plan	CAP	1,106	52.4%	7,758	62.6%
4265	Community Choice Michigan	CCM	958	54.3%	9,174	69.8%
4133	Great Lakes Health Plan	GLH	2,151	48.7%	12,997	51.0%
4291	Health Plan of Michigan	HPM	627	60.0%	6,140	63.8%
4056	HealthPlus Partners	HPP	1,097	67.0%	8,243	73.1%
4243	M-CAID	MCD	172	49.4%	1,377	74.8%
4312	McLaren Health Plan	MCL	311	62.2%	2,726	66.9%
4131	Midwest Health Plan	MID	905	51.3%	5,748	50.9%
4151	Molina Healthcare of Michigan	MOL	500	53.4%	4,526	59.0%
4055	OmniCare Health Plan	OCH	1,500	49.6%	9,426	59.6%
4282	Physician's Health Plan of Mid-Michigan Family Care	PMD	299	59.5%	2,343	69.3%
4054	Priority Health Government Programs	PRI	359	60.8%	2,889	79.9%
4283	Physician's Health Plan of Southwest Michigan	PSW	394	60.9%	3,156	65.7%
4268	Total Health Care	THC	992	41.1%	6,908	56.6%
4218	The Wellness Plan	TWP	1,929	58.6%	15,855	63.3%
4348	Upper Peninsula Health Plan	UPP	369	72.6%	3,113	74.9%
	2004 Michigan Medicaid Weighted Average		--	54.6%	--	62.6%
	2003 Michigan Medicaid Weighted Average		--	56.2%	--	60.2%
	2002 Michigan Medicaid Weighted Average		--	55.5%	--	59.4%
	National HEDIS 2003 Medicaid 50th Percentile		--	55.8%	--	61.7%

Note: The 2002 Michigan Medicaid Weighted Average included 19 health plans; the 2003 Michigan Medicaid Weighted Averages included 18 health plans; and the 2004 Michigan Medicaid Weighted Average includes 17 health plans.

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**Table A-5—Michigan Medicaid HEDIS 2004 Tabular Results for Key Measures:
Chlamydia Screening in Women**

DST	Plan Name	Code	Ages 16 to 20 Years		Ages 21 to 25 Years		Combined Rate	
			Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
4136	Botsford Health Plan	BOT	141	52.3%	145	61.7%	286	57.1%
4333	Cape Health Plan	CAP	850	48.2%	826	52.2%	1,676	50.2%
4265	Community Choice Michigan	CCM	1,220	43.4%	1,167	51.6%	2,387	47.5%
4133	Great Lakes Health Plan	GLH	1,505	35.7%	1,291	42.4%	2,796	38.8%
4291	Health Plan of Michigan	HPM	1,198	44.6%	551	49.1%	1,749	46.0%
4056	HealthPlus Partners	HPP	1,107	47.5%	1,294	56.2%	2,401	52.2%
4243	M-CAID	MCD	208	52.0%	232	58.7%	440	55.6%
4312	McLaren Health Plan	MCL	365	51.5%	343	54.5%	708	53.0%
4131	Midwest Health Plan	MID	530	31.9%	458	37.6%	988	34.5%
4151	Molina Healthcare of Michigan	MOL	599	44.6%	536	47.7%	1,135	46.1%
4055	OmniCare Health Plan	OCH	1,141	50.7%	1,036	57.7%	2,177	54.0%
4282	Physician's Health Plan of Mid-Michigan Family Care	PMD	295	64.5%	328	65.1%	623	64.8%
4054	Priority Health Government Programs	PRI	422	49.9%	465	52.4%	887	51.2%
4283	Physician's Health Plan of Southwest Michigan	PSW	464	43.9%	515	47.1%	979	45.6%
4268	Total Health Care	THC	886	47.5%	796	56.5%	1,682	51.8%
4218	The Wellness Plan	TWP	2,265	63.1%	1,758	68.8%	4,023	65.6%
4348	Upper Peninsula Health Plan	UPP	551	45.9%	437	41.4%	988	43.9%
	2004 Michigan Medicaid Weighted Average		--	48.2%	--	53.8%	--	50.9%
	2003 Michigan Medicaid Weighted Average		--	42.1%	--	45.9%	--	44.2%
	2002 Michigan Medicaid Weighted Average		--	33.0%	--	37.9%	--	35.8%
	National HEDIS 2003 Medicaid 50th Percentile		--	40.2%	--	42.3%	--	41.7%

Note: The 2002 Michigan Medicaid Weighted Average included 19 health plans; the 2003 Michigan Medicaid Weighted Averages included 18 health plans; and the 2004 Michigan Medicaid Weighted Average includes 17 health plans.

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**Table A-6—Michigan Medicaid HEDIS 2004 Tabular Results for Key Measures:
Prenatal and Postpartum Care**

DST	Plan Name	Code	Timeliness of Prenatal Care		Postpartum Care	
			Eligible Population	Rate	Eligible Population	Rate
4136	Botsford Health Plan	BOT	135	59.0%	135	38.1%
4333	Cape Health Plan	CAP	718	67.7%	718	40.4%
4265	Community Choice Michigan	CCM	1,316	72.5%	1,003	47.7%
4133	Great Lakes Health Plan	GLH	1,131	66.9%	1,131	41.3%
4291	Health Plan of Michigan	HPM	680	74.6%	680	51.9%
4056	HealthPlus Partners	HPP	1,064	80.9%	888	61.2%
4243	M-CAID	MCD	167	80.0%	167	52.7%
4312	McLaren Health Plan	MCL	278	79.7%	278	54.7%
4131	Midwest Health Plan	MID	546	53.1%	534	38.2%
4151	Molina Healthcare of Michigan	MOL	455	70.2%	455	45.7%
4055	OmniCare Health Plan	OCH	940	71.8%	940	31.4%
4282	Physician's Health Plan of Mid-Michigan Family Care	PMD	308	65.1%	308	53.0%
4054	Priority Health Government Programs	PRI	307	85.3%	307	63.2%
4283	Physician's Health Plan of Southwest Michigan	PSW	387	79.5%	387	47.7%
4268	Total Health Care	THC	646	76.2%	646	38.7%
4218	The Wellness Plan	TWP	1,916	65.9%	1,916	39.6%
4348	Upper Peninsula Health Plan	UPP	281	88.0%	281	57.7%
	2004 Michigan Medicaid Weighted Average		--	71.5%	--	44.9%
	2003 Michigan Medicaid Weighted Average		--	66.9%	--	44.9%
	2002 Michigan Medicaid Weighted Average		--	72.7%	--	51.2%
	National HEDIS 2003 Medicaid 50th Percentile		--	74.1%	--	55.0%

Note: The 2002 Michigan Medicaid Weighted Average included 19 health plans; the 2003 Michigan Medicaid Weighted Averages included 18 health plans; and the 2004 Michigan Medicaid Weighted Average includes 17 health plans.

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**Table A-7—Michigan Medicaid HEDIS 2004 Tabular Results for Key Measures:
Comprehensive Diabetes Care**

DST	Plan Name	Code	Eligible Population	HbA1c Testing Rate	Poor HbA1c Control Rate	Eye Exam Rate
4136	Botsford Health Plan	BOT	166	80.9%	42.7%	41.4%
4333	Cape Health Plan	CAP	1,442	75.5%	53.6%	41.3%
4265	Community Choice Michigan	CCM	1,311	74.5%	59.4%	29.4%
4133	Great Lakes Health Plan	GLH	2,336	77.6%	47.0%	45.3%
4291	Health Plan of Michigan	HPM	1,090	74.8%	46.1%	57.6%
4056	HealthPlus Partners	HPP	1,166	83.9%	36.7%	53.3%
4243	M-CAID	MCD	242	89.4%	37.8%	53.0%
4312	McLaren Health Plan	MCL	430	79.4%	43.1%	48.9%
4131	Midwest Health Plan	MID	1,243	59.6%	67.4%	32.4%
4151	Molina Healthcare of Michigan	MOL	815	75.4%	55.1%	44.4%
4055	OmniCare Health Plan	OCH	1,989	63.3%	59.4%	32.6%
4282	Physician's Health Plan of Mid-Michigan Family Care	PMD	355	84.5%	35.8%	63.3%
4054	Priority Health Government Programs	PRI	485	84.2%	38.4%	58.6%
4283	Physician's Health Plan of Southwest Michigan	PSW	537	83.7%	48.9%	34.5%
4268	Total Health Care	THC	1,204	70.9%	55.9%	38.5%
4218	The Wellness Plan	TWP	2,263	69.3%	54.0%	38.2%
4348	Upper Peninsula Health Plan	UPP	467	90.5%	26.0%	62.3%
	2004 Michigan Medicaid Weighted Average		--	74.0%	51.2%	42.3%
	2003 Michigan Medicaid Weighted Average		--	73.2%	47.1%	44.3%
	2002 Michigan Medicaid Weighted Average		--	68.4%	47.5%	40.6%
	National HEDIS 2003 Medicaid 50th Percentile		--	77.3%	47.0%	49.2%

Note: The 2002 Michigan Medicaid Weighted Average included 19 health plans; the 2003 Michigan Medicaid Weighted Averages included 18 health plans; and the 2004 Michigan Medicaid Weighted Average includes 17 health plans.

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**Table A-8—Michigan Medicaid HEDIS 2004 Tabular Results for Key Measures:
Comprehensive Diabetes Care (continued)**

DST	Plan Name	Code	Eligible Population	LDL-C Screening Rate	LDL-C Level <130 Rate	LDL-C Level <100 Rate	Monitoring Nephropathy Rate
4136	Botsford Health Plan	BOT	166	73.2%	53.5%	31.8%	56.7%
4333	Cape Health Plan	CAP	1,442	80.2%	49.4%	30.5%	33.6%
4265	Community Choice Michigan	CCM	1,311	58.4%	26.3%	17.3%	37.7%
4133	Great Lakes Health Plan	GLH	2,336	80.3%	53.5%	31.3%	38.3%
4291	Health Plan of Michigan	HPM	1,090	76.6%	49.8%	29.4%	44.2%
4056	HealthPlus Partners	HPP	1,166	84.4%	50.6%	26.5%	47.4%
4243	M-CAID	MCD	242	87.1%	58.1%	37.8%	49.8%
4312	McLaren Health Plan	MCL	430	74.9%	51.3%	28.6%	52.4%
4131	Midwest Health Plan	MID	1,243	64.5%	53.3%	46.7%	35.8%
4151	Molina Healthcare of Michigan	MOL	815	65.8%	45.3%	24.8%	37.5%
4055	OmniCare Health Plan	OCH	1,989	74.2%	52.6%	31.1%	37.5%
4282	Physician's Health Plan of Mid-Michigan Family Care	PMD	355	88.7%	60.6%	32.5%	56.1%
4054	Priority Health Government Programs	PRI	485	85.6%	60.6%	35.5%	40.6%
4283	Physician's Health Plan of Southwest Michigan	PSW	537	78.8%	41.6%	26.3%	45.0%
4268	Total Health Care	THC	1,204	71.2%	47.0%	26.4%	39.0%
4218	The Wellness Plan	TWP	2,263	69.6%	43.8%	22.9%	41.6%
4348	Upper Peninsula Health Plan	UPP	467	89.5%	56.0%	31.4%	52.8%
	2004 Michigan Medicaid Weighted Average		--	74.6%	48.6%	29.1%	40.7%
	2003 Michigan Medicaid Weighted Average		--	69.2%	43.8%	--	47.6%
	2002 Michigan Medicaid Weighted Average		--	62.1%	36.3%	--	41.0%
	National HEDIS 2003 Medicaid 50th Percentile		--	74.4%	45.7%	--	48.7%

Note: The 2002 Michigan Medicaid Weighted Average included 19 health plans; the 2003 Michigan Medicaid Weighted Averages included 18 health plans; and the 2004 Michigan Medicaid Weighted Average includes 17 health plans.

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**Table A-9—Michigan Medicaid HEDIS 2004 Tabular Results for Key Measures:
Use of Appropriate Medications for People With Asthma**

DST	Plan Name	Code	Ages 5 to 9 Years		Ages 10 to 17 Years		Ages 18 to 56 Years		Combined Rate	
			Eligible Population	Rate						
4136	Botsford Health Plan	BOT	18	NA	37	70.3%	65	66.1%	120	67.6%
4333	Cape Health Plan	CAP	183	57.8%	245	55.0%	554	69.2%	982	62.9%
4265	Community Choice Michigan	CCM	225	62.8%	335	66.4%	676	71.3%	1,236	68.2%
4133	Great Lakes Health Plan	GLH	301	46.6%	437	60.0%	935	70.3%	1,673	62.8%
4291	Health Plan of Michigan	HPM	196	73.5%	276	60.3%	411	66.3%	883	66.0%
4056	HealthPlus Partners	HPP	303	73.0%	418	66.4%	688	72.7%	1,409	70.8%
4243	M-CAID	MCD	83	66.3%	114	75.0%	122	76.1%	319	73.0%
4312	McLaren Health Plan	MCL	84	64.3%	85	69.4%	181	66.9%	350	66.9%
4131	Midwest Health Plan	MID	227	51.5%	243	54.7%	601	66.6%	1,071	60.7%
4151	Molina Healthcare of Michigan	MOL	57	68.5%	103	62.7%	332	69.7%	492	67.9%
4055	OmniCare Health Plan	OCH	546	49.3%	835	52.5%	1,006	64.6%	2,387	56.8%
4282	Physician's Health Plan of Mid-Michigan Family Care	PMD	120	72.6%	156	75.2%	205	71.4%	481	73.0%
4054	Priority Health Government Programs	PRI	128	79.4%	162	84.0%	245	73.1%	535	78.1%
4283	Physician's Health Plan of Southwest Michigan	PSW	94	77.7%	161	68.8%	291	69.0%	546	70.5%
4268	Total Health Care	THC	104	52.9%	152	58.1%	188	59.8%	444	57.5%
4218	The Wellness Plan	TWP	646	60.1%	977	63.8%	1,324	71.1%	2,947	66.1%
4348	Upper Peninsula Health Plan	UPP	92	81.5%	136	74.3%	249	79.5%	477	78.4%
	2004 Michigan Medicaid Weighted Average		--	61.0%	--	62.5%	--	69.5%	--	65.5%
	2003 Michigan Medicaid Weighted Average		--	59.0%	--	61.7%	--	66.9%	--	63.8%
	2002 Michigan Medicaid Weighted Average		--	59.4%	--	62.7%	--	68.2%	--	64.9%
	National HEDIS 2003 Medicaid 50th Percentile		--	61.8%	--	63.0%	--	65.3%	--	63.7%

Note: The 2002 Michigan Medicaid Weighted Average included 19 health plans; the 2003 Michigan Medicaid Weighted Averages included 18 health plans; and the 2004 Michigan Medicaid Weighted Average includes 17 health plans.

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**Table A-10—Michigan Medicaid HEDIS 2004 Tabular Results for Key Measures:
Controlling High Blood Pressure**

DST	Plan Name	Code	Eligible Population	Rate
4136	Botsford Health Plan	BOT	142	65.9%
4333	Cape Health Plan	CAP	1,186	58.9%
4265	Community Choice Michigan	CCM	968	59.3%
4133	Great Lakes Health Plan	GLH	1,824	44.7%
4291	Health Plan of Michigan	HPM	616	66.4%
4056	HealthPlus Partners	HPP	1,007	61.0%
4243	M-CAID	MCD	148	71.1%
4312	McLaren Health Plan	MCL	183	72.5%
4131	Midwest Health Plan	MID	627	54.8%
4151	Molina Healthcare of Michigan	MOL	428	55.0%
4055	OmniCare Health Plan	OCH	1,835	39.7%
4282	Physician's Health Plan of Mid-Michigan Family Care	PMD	183	55.3%
4054	Priority Health Government Programs	PRI	341	59.9%
4283	Physician's Health Plan of Southwest Michigan	PSW	281	48.2%
4268	Total Health Care	THC	913	52.8%
4218	The Wellness Plan	TWP	1,805	56.9%
4348	Upper Peninsula Health Plan	UPP	301	65.1%
	2004 Michigan Medicaid Weighted Average		--	53.9%
	2003 Michigan Medicaid Weighted Average		--	52.3%
	2002 Michigan Medicaid Weighted Average		--	52.7%
	National HEDIS 2003 Medicaid 50th Percentile		--	54.5%

Note: The 2002 Michigan Medicaid Weighted Average included 19 health plans; the 2003 Michigan Medicaid Weighted Averages included 18 health plans; and the 2004 Michigan Medicaid Weighted Average includes 17 health plans.

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**Table A-11—Michigan Medicaid HEDIS 2004 Tabular Results for Key Measures:
Children’s and Adolescents’ Access to Primary Care Practitioners**

DST	Plan Name	Code	Ages 12 to 24 Months		Ages 25 Months to 6 Years		Ages 7 to 11 Years		Ages 12 to 19 Years	
			Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
4136	Botsford Health Plan	BOT	189	85.2%	976	72.8%	519	68.0%	764	65.8%
4333	Cape Health Plan	CAP	1,989	93.3%	8,391	81.0%	4,272	78.9%	5,142	77.8%
4265	Community Choice Michigan	CCM	1,456	90.5%	8,150	74.9%	5,490	75.7%	6,378	73.9%
4133	Great Lakes Health Plan	GLH	2,608	90.7%	12,696	77.8%	7,960	79.1%	9,915	75.7%
4291	Health Plan of Michigan	HPM	1,544	92.2%	7,211	82.2%	3,153	82.5%	3,770	81.0%
4056	HealthPlus Partners	HPP	1,838	94.2%	8,822	81.4%	5,855	81.7%	6,283	82.2%
4243	M-CAID	MCD	449	97.3%	2,085	86.2%	1,233	86.8%	1,360	84.6%
4312	McLaren Health Plan	MCL	702	91.7%	3,099	78.5%	1,381	79.4%	1,643	75.5%
4131	Midwest Health Plan	MID	1,295	89.5%	6,031	76.5%	3,978	79.7%	4,792	75.0%
4151	Molina Healthcare of Michigan	MOL	831	90.6%	4,159	78.5%	1,972	77.6%	2,696	78.4%
4055	OmniCare Health Plan	OCH	1,450	86.3%	8,512	74.5%	7,293	69.7%	9,127	68.2%
4282	Physician's Health Plan of Mid-Michigan Family Care	PMD	485	90.9%	2,424	77.4%	1,643	77.1%	1,900	79.1%
4054	Priority Health Government Programs	PRI	667	97.5%	4,100	84.3%	2,443	84.5%	2,385	80.5%
4283	Physician's Health Plan of Southwest Michigan	PSW	1,024	96.6%	4,368	84.5%	2,492	83.1%	2,830	82.4%
4268	Total Health Care	THC	1,179	87.5%	6,425	71.5%	4,889	68.0%	6,088	68.1%
4218	The Wellness Plan	TWP	2,246	88.3%	14,308	72.1%	13,574	72.6%	16,615	69.4%
4348	Upper Peninsula Health Plan	UPP	931	97.4%	3,708	88.0%	1,993	84.2%	2,580	87.2%
	2004 Michigan Medicaid Weighted Average		--	91.5%	--	78.0%	--	76.7%	--	74.7%
	2003 Michigan Medicaid Weighted Average		--	91.0%	--	75.9%	--	74.7%	--	--
	2002 Michigan Medicaid Weighted Average		--	85.9%	--	70.9%	--	71.6%	--	--
	National HEDIS 2003 Medicaid 50th Percentile		--	93.5%	--	83.3%	--	82.6%	--	--

Note: The 2002 Michigan Medicaid Weighted Average included 19 health plans; the 2003 Michigan Medicaid Weighted Averages included 18 health plans; and the 2004 Michigan Medicaid Weighted Average includes 17 health plans.

R denotes a Report audit designation.

NR denotes a Not Report audit designation.

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

**Table A-12—Michigan Medicaid HEDIS 2004 Tabular Results for Key Measures:
Adults' Access to Preventive/Ambulatory Health Services**

DST	Plan Name	Code	Ages 20 to 44 Years		Ages 45 to 64 Years	
			Eligible Population	Rate	Eligible Population	Rate
4136	Botsford Health Plan	BOT	1,187	66.4%	525	75.6%
4333	Cape Health Plan	CAP	7,076	71.0%	4,440	79.5%
4265	Community Choice Michigan	CCM	8,336	74.4%	3,324	83.5%
4133	Great Lakes Health Plan	GLH	12,136	75.0%	7,366	84.0%
4291	Health Plan of Michigan	HPM	6,223	79.5%	2,587	88.6%
4056	HealthPlus Partners	HPP	8,227	80.5%	3,206	89.7%
4243	M-CAID	MCD	1,691	80.2%	703	84.1%
4312	McLaren Health Plan	MCL	2,819	79.7%	1,129	87.8%
4131	Midwest Health Plan	MID	5,615	74.2%	3,401	82.5%
4151	Molina Healthcare of Michigan	MOL	4,627	74.4%	2,358	81.8%
4055	OmniCare Health Plan	OCH	8,633	72.3%	4,834	80.7%
4282	Physician's Health Plan of Mid-Michigan Family Care	PMD	2,367	74.7%	992	85.2%
4054	Priority Health Government Programs	PRI	2,707	84.1%	1,068	90.8%
4283	Physician's Health Plan of Southwest Michigan	PSW	3,254	81.9%	1,288	91.1%
4268	Total Health Care	THC	6,492	65.9%	3,737	74.1%
4218	The Wellness Plan	TWP	14,488	71.9%	6,952	77.6%
4348	Upper Peninsula Health Plan	UPP	3,302	86.3%	1,519	90.7%
	2004 Michigan Medicaid Weighted Average		--	75.0%	--	82.6%
	2003 Michigan Medicaid Weighted Average		--	74.1%	--	81.4%
	2002 Michigan Medicaid Weighted Average		--	74.4%	--	82.5%
	National HEDIS 2003 Medicaid 50th Percentile		--	77.6%	--	84.0%

Note: The 2002 Michigan Medicaid Weighted Average included 19 health plans; the 2003 Michigan Medicaid Weighted Averages included 18 health plans; and the 2004 Michigan Medicaid Weighted Average includes 17 health plans.

R denotes a Report audit designation.

NR denotes a Not Report audit designation.

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

**Table A-13—Michigan Medicaid HEDIS 2004 Tabular Results for Key Measures:
Medical Assistance With Smoking Cessation**

DST	Plan Name	Code	Advising Smokers to Quit Rate
4136	Botsford Health Plan	BOT	63.4%
4333	Cape Health Plan	CAP	63.6%
4265	Community Choice Michigan	CCM	64.8%
4133	Great Lakes Health Plan	GLH	59.6%
4291	Health Plan of Michigan	HPM	65.4%
4056	HealthPlus Partners	HPP	72.6%
4243	M-CAID	MCD	70.8%
4312	McLaren Health Plan	MCL	66.7%
4131	Midwest Health Plan	MID	60.4%
4151	Molina Healthcare of Michigan	MOL	68.8%
4055	OmniCare Health Plan	OCH	70.3%
4282	Physician's Health Plan of Mid-Michigan Family Care	PMD	68.9%
4054	Priority Health Government Programs	PRI	71.3%
4283	Physician's Health Plan of Southwest Michigan	PSW	68.5%
4268	Total Health Care	THC	72.6%
4218	The Wellness Plan	TWP	59.7%
4348	Upper Peninsula Health Plan	UPP	65.8%
	2004 Michigan Medicaid Average		66.7%
	2003 Michigan Medicaid Average		66.2%

Note: The 2003 and 2004 Michigan Medicaid Averages are not weighted.

R denotes a Report audit designation.

NR denotes a Not Report audit designation.

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

Appendix B. National HEDIS 2003 Medicaid Percentiles

Table B-1—National HEDIS 2003 Medicaid Percentiles—Pediatric Care

Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Childhood Immunization Status—Combination #1	35.2%	49.2%	59.6%	68.4%	73.7%
Childhood Immunization Status—Combination #2	32.5%	45.0%	55.6%	63.1%	69.4%
Adolescent Immunization Status—Combination #1	17.3%	28.8%	40.9%	55.5%	69.3%
Adolescent Immunization Status—Combination #2	4.5%	11.2%	20.8%	35.0%	47.9%
Well-Child Visits in the First 15 Months—Zero Visits*	0.7%	1.8%	3.2%	7.2%	16.0%
Well-Child Visits in the First 15 Months—Six or More Visits	20.2%	32.4%	43.0%	53.4%	61.6%
Well-Child in the Third, Fourth, Fifth, and Sixth Years of Life	39.4%	50.3%	59.7%	67.4%	73.2%
Adolescent Well-Care Visits	23.6%	29.2%	36.2%	44.0%	50.3%

* For this Key Measure, a lower rate indicates better performance.

Table B-2—National HEDIS 2003 Medicaid Percentiles—Women’s Care

Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Cervical Cancer Screening	45.9%	52.3%	61.7%	73.0%	77.9%
Breast Cancer Screening	46.2%	50.1%	55.8%	62.1%	67.0%
Chlamydia Screening in Women—Ages 16 to 20 Years	17.3%	32.2%	40.2%	47.7%	60.6%
Chlamydia Screening in Women—Ages 21 to 26 Years	18.9%	31.3%	42.3%	50.0%	59.5%
Chlamydia Screening in Women—Combined Rate	18.0%	31.9%	41.7%	48.6%	59.3%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	47.2%	62.7%	74.1%	85.1%	89.1%
Prenatal and Postpartum Care—Postpartum Care	32.2%	45.2%	55.0%	61.7%	67.4%

Table B-3—National HEDIS 2003 Medicaid Percentiles—Living With Illness

Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Comprehensive Diabetes Care—Eye Exam	19.1%	39.0%	49.2%	58.2%	63.7%
Comprehensive Diabetes Care—HbA1c Testing	44.3%	68.9%	77.3%	84.2%	88.0%
Comprehensive Diabetes Care—Poor HbA1c Control*	27.3%	34.7%	47.0%	58.9%	83.5%
Comprehensive Diabetes Care—LDL-C Screening	46.3%	67.3%	74.4%	80.5%	85.2%
Comprehensive Diabetes Care—LDL-C Level <130	23.4%	38.0%	45.7%	51.1%	56.4%
Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy	22.1%	38.8%	48.7%	56.5%	68.3%
Use of Appropriate Medications for People With Asthma—Ages 5 to 9 Years	41.0%	51.0%	61.8%	66.4%	72.1%
Use of Appropriate Medications for People With Asthma—Ages 10 to 17 Years	50.0%	56.5%	63.0%	66.3%	71.3%
Use of Appropriate Medications for People With Asthma—Ages 18 to 56 Years	54.7%	59.9%	65.3%	69.9%	73.7%
Use of Appropriate Medications for People With Asthma—Combined Rate	53.3%	58.2%	63.7%	67.9%	70.9%
Controlling High Blood Pressure	39.4%	45.6%	54.5%	60.7%	65.1%

* For this Key Measure, a lower rate indicates better performance.

Note: No Medicaid percentiles are available this year for the new measure, *Comprehensive Diabetes Care—LDL-C Level <100*.

Table B-4—National HEDIS 2003 Medicaid Percentiles—Access to Care

Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Children's Access to Primary Care Practitioners—Ages 12 to 24 Months	77.2%	89.6%	93.5%	96.3%	97.4%
Children's Access to Primary Care Practitioners—Ages 25 Months to 6 Years	69.0%	76.2%	83.3%	86.7%	90.1%
Children's Access to Primary Care Practitioners—Ages 7 to 11 Years	70.0%	76.4%	82.6%	87.1%	89.8%
Adults' Access to Preventive/Ambulatory Services—Ages 20 to 44 Years	62.7%	69.2%	77.6%	82.7%	86.4%
Adults' Access to Preventive/Ambulatory Services—Ages 45 to 64 Years	71.0%	78.9%	84.0%	87.8%	89.7%

Note: No Medicaid percentiles are available this year for the new measure, *Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years*.

Quality Improvement Interventions Questionnaire

MEMBER Targeted Interventions

In each box, please indicate the number of years you have been doing listed interventions for these conditions. If you are not doing a given intervention for a condition, just leave the box empty.

Member-Targeted	Women's and Maternal Care						Chronic Care			Children's Care			Other	
	Breast Cancer Screens	Cervical Cancer Screens	Chlamydia Screening	High Risk Pregnancy	Prenatal Care	Postpartum Care	Asthma Care	Diabetes Care	CVD	Child Immun.	Adol. Immun.	Well Child Visits		Adol. Well Care
Information in member newsletter/website														
Distribution of education material														
Non-specific reminder cards														
Targeted reminder cards														
Reminder calls														
Visit/Service incentives														
Case Management														
Referral to third party Disease management														
Less restrictive authorization process														
Improve access to services														
Other														

Plan Name: _____

Comments: _____

Quality Improvement Interventions Questionnaire

PROVIDER Targeted Interventions

Provider-Targeted	Women's and Maternal Care						Chronic Care			Children's Care				Other
	Breast Cancer Screens	Cervical Cancer Screens	Chlamydia Screening	High Risk Pregnancy	Prenatal Care	Postpartum Care	Asthma Care	Diabetes Care	CVD	Child Immun.	Adol. Immun.	Well Child Visits	Adol. Well Care	
Information in member newsletter/website														
Distribution of education material														
List of patients with chronic condition														
List of patients needing screening														
Distribution of compliance figures, ind, & peer														
Compliance figure incentives														
Bonus pool based on compliance figures														
Carve-out from Cap to FFS														
Referral to third party DX mgmt.														
Other														

Plan Name: _____

Comments: _____

Terms, Acronyms, and Abbreviations

Administrative Data

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

Administrative Method

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

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

Audit Designation

The auditor's final determination, based on audit findings, of the appropriateness of the health plan publicly reporting its HEDIS measure rates. Each measure included in the HEDIS audit receives either a "Report" designation or a "Not Report" designation, along with the rationale for why the measure received that particular designation.

Baseline Assessment Tool (BAT) Review

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

BRFSS

Behavioral Risk Factor Surveillance System

CAHPS® 3.0H

Consumer Assessment of Health Plans Survey is a set of standardized surveys that assess patient satisfaction with experience of care.

Capitation

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

Certified HEDIS Software Vendor

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

Claims-Based Denominator

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

CMS (formerly known as HCFA)

The Centers for Medicare & Medicaid Services (CMS) provides health insurance to individuals through Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). In addition, CMS also regulates laboratory testing through Clinical Laboratory Improvement Amendments (CLIA), develops coverage policies, and initiates quality of care improvement activities. CMS also maintains oversight of nursing homes and continuing care providers. This includes home health agencies, intermediate care facilities for the mentally retarded, and hospitals.

Cohorts

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

Computer Logic

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

Continuous Enrollment Requirement

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

Core Set

For a full HEDIS audit, the process auditors follow to select the core set of measures to be reviewed in detail during the audit process. The core set of measures must include 13 measures across all domains of care, and represents all data sources, all product lines/products, and all intricacies of health plan data collection and reporting. In addition, the core set must focus on any health plan weaknesses identified during the BAT review. The core set can be expanded to more than 13 measures, but cannot be less than 13 measures. Rotated measures are not included in the core set.

CPT

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

CVO

Credentials Verification Organization

Data Completeness

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

Data Completeness Study

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

Denominator

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

DRG Coding

Diagnostic-Related Group (DRG) coding sorts diagnoses and procedures for inpatient encounters by groups under major diagnostic categories with defined reimbursement limits.

DST

Data Submission Tool: The tool used to report HEDIS data to NCQA.

DtaP

Diphtheria, tetanus, and acellular pertussis vaccine

DT

Diphtheria and tetanus vaccine

EDI

Electronic Data Interchange (EDI) is the direct computer-to-computer transfer of data.

Electronic Data

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

Encounter Data

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

Exclusions

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

FACCT

Foundation for Accountability

FFS

Fee-for-service: A reimbursement mechanism where the provider is paid for services billed.

Final Report

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

Full HEDIS Audit

A full audit occurs when the HEDIS auditor selects a sample of measures (core set) that represent all HEDIS domains of care and extrapolates the findings on that sample to the entire set of HEDIS measures. Health plans that undergo a full audit can use the NCQA seal in marketing materials.

Global Bill Practices

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

HbA1c

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

HCFA 1500

A type of claim form used to bill professional services.

HCPCS

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

HEDIS

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

HEDIS Measure Determination Standards (HD)

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

HEDIS Repository

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

HEDIS Warehouse

See HEDIS repository.

HiB

H influenza type b vaccine

HPL

High performance level. MDCH has defined the HPL as the most recent national HEDIS Medicaid 90th percentile, except for two Key Measures (*Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Comprehensive Diabetes Care—Poor HbA1c Control*) for which lower rates indicate better performance. For these two measures, the 10th percentile (rather than the 90th) shows excellent performance.

Hybrid Measures

Measures that can be reported using the hybrid method.

Hybrid Method

The hybrid method requires health plans to identify the eligible population using administrative data, and then extract a systematic sample of 411 members from the eligible population, which becomes the denominator. Administrative data are then used to identify services provided to those 411 members. Medical records must then be reviewed for those members who do not have evidence of a service being provided using administrative data.

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

ICD-9-CM

ICD-9-CM, the acronym for the International Classification of Diseases, 9th Revision, Clinical Modification, is the classification of diseases and injuries into groups according to established criteria that is used for reporting morbidity, mortality, and utilization rates as well as for billing purposes.

Inpatient Data

Data derived from an inpatient hospital stay.

IRR

Inter-rater reliability: The degree of agreement exhibited when a measurement is repeated under the same conditions by different raters.

IS

Information System: An automated system for collecting, processing and transmitting data.

IPV

Inactivated Polio vaccine

IT

Information Technology: The technology used to create, store, exchange, and use information in its various forms.

Key Data Elements

The data elements that must be captured to be able to report HEDIS measures.

Key Measures

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

LDL-C

Low-Density Lipoprotein Cholesterol

Logic Checks

Evaluations of programming logic to determine its accuracy.

LPL

Low performance level. For most Key Measures, MDCH has defined the LPL as the most recent national HEDIS Medicaid 25th percentile. For two Key Measures (*Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Comprehensive Diabetes Care—Poor HbA1c Control*) lower rates indicate better performance, and the LPLs for these measures are the 75th percentile rather than the 25th.

Manual Data Collection

Collection of data through a paper versus an automated process.

Mapping Codes

The process of translating a health plan's propriety or nonstandard billing codes to industry standard codes specified in HEDIS measures. Mapping documentation should include a crosswalk of relevant codes, descriptions, and clinical information, as well as the policies and procedures for implementing the codes.

Material Bias

For measures reported as a rate (which includes all of the Key Measures except *Advising Smokers to Quit*), any error that causes a \pm five percent difference in the reported rate. For measures not reported as a rate (such as the key measure *Advising Smokers to Quit*), any error that causes a \pm 10 percent difference in the reported rate.

MCIR

Michigan Childhood Immunization Registry

MCO

Managed Care Organization

MDCH

Michigan Department of Community Health

Medical Record Validation

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

Medicaid Percentiles

The NCQA national average for each HEDIS measure for the Medicaid product line, used to compare health plan performance and assess the reliability of a health plan's HEDIS rates.

Membership Data

Electronic health plan files containing information about members, such as name, date of birth, gender, current address, and enrollment (i.e., when the member joined the health plan).

Mg/dL

Micrograms per deciliter

MHP

Medicaid Health Plan

Modifier Codes

Two- or five-digit extensions added to CPT[®] codes to provide additional information about services/procedures.

MMR

Measles, mumps, rubella vaccine

MUPC Codes

Michigan Uniform Procedure Codes: Procedure codes developed by the State of Michigan for billing services performed.

NA

Not applicable: The health plan did not offer the benefit or the denominator was too small (i.e., less than 30) to report a valid rate; the result/rate is NA.

NCQA

The National Committee for Quality Assurance (NCQA) is a not-for-profit organization that assesses, through accreditation reviews and standardized measures, the quality of care provided by managed health care delivery systems; reports results of those assessments to employers, consumers, public purchasers, and regulators; and ultimately seeks to improve the health care provided within the managed care industry.

NDC

National Drug Codes used for billing pharmacy services.

NR

Not Report HEDIS audit designation. There are three reasons a measure may be designated NR: (1) the health plan did not calculate the measure and a population existed for which the measure could have been calculated; (2) the health plan calculated the measure but chose not to report the result; or (3) the health plan calculated the measure but the result was materially biased.

Numerator

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

OPV

Oral polio vaccine

Over-Read Process

The process of re-reviewing a sample of medical records by a different abstractor to assess the degree of agreement between two different abstractors and ensure the accuracy of abstracted data. The over-read process should be conducted by the health plan as part of their medical record review process, and auditors over-read a sample of the health plan's medical records as part of the audit process.

Partial HEDIS Audit

A partial audit occurs when the health plan, state regulator, or purchaser selects the HEDIS measures for audit. There may be any number of measures selected, but, unlike a full audit, findings are not extrapolated to the entire set of HEDIS measures. In addition, the health plan cannot use the NCQA seal in marketing materials.

Pharmacy Data

Data derived from the provision of pharmacy services.

Primary Source Verification

The practice of reviewing the processes and procedures to input, transmit, and track data from its originating source to the HEDIS repository to verify that the originating information matches the output information for HEDIS reporting.

Proprietary Codes

Unique billing codes developed by a health plan, which have to be mapped to industry standard codes for HEDIS reporting.

Provider Data

Electronic files containing information about physicians, such as type of physician, specialty, reimbursement arrangement, and office location.

Retroactive Enrollment

The effective date of a member's enrollment in a health plan occurs prior to the date that the health plan is notified of that member's enrollment. Medicaid members who are retroactively enrolled in a health plan must be excluded from a HEDIS measure denominator if the time period from the date of enrollment to the date of notification exceeds the measure's allowable gap specifications.

Revenue Codes

Cost codes for facilities to bill by category; services, procedures, supplies, and materials.

Sample Frame

In the hybrid method, the eligible population who meet all criteria specified in the measure from which the systematic sample is drawn.

Source Code

The written computer programming logic for determining the eligible population and denominators/numerators and for calculating the rate for each measure.

Standard Codes

Industry standard billing codes such as ICD-9-CM, CPT[®], DRG, Revenue, and UB-92 codes used for billing inpatient and outpatient health care services.

Studies on Data Completeness

Studies that health plans conduct to assess data completeness.

T-test Validation

A statistical validation of a health plan's positive medical record numerator events.

UB-92 Claims

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

Vendor

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

VZV

Varicella-zoster virus (chickenpox) vaccine