ANALYSIS OF MEDICAID HMO

(FY2006 Appropriation Bill - Public Act 154 of 2005)

Within 30 days receipt of final report

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Michigan Department of Community Health

MDCH

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Michigan Department of Community Health

MDCH

Jennifer M. Granholm, Governor

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State of Michigan

Department of Community Health

Michigan Medicaid HEDIS® 2006 Results
STATEWIDE AGGREGATE REPORT

December 2006

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HSAG HEALTH SERVICES ADVISORY GROUP

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ACKNOWLEDGMENTS AND COPYRIGHTS

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Introduction

During 2005, the Michigan Department of Community Health (MDCH) contracted with 15 health plans to provide managed care services to 921,569 Michigan Medicaid enrollees.[1-1] To evaluate performance levels, MDCH implemented a system to provide an objective, comparative review of health plan quality-of-care outcomes and performance measures. One component of the evaluation system is based on the Health Plan Employer Data and Information Set (HEDIS). MDCH selected 17 HEDIS measures from the standard Medicaid HEDIS reporting set as the key measures to evaluate performance by the Michigan Medicaid health plans (MHPs). These 17 measures comprise 35 distinct rates.

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

Performance levels for Michigan MHPs have been established for all of the key measures. The performance levels have been set at specific, attainable rates and are based on national percentiles. This standardization allows for comparison to the performance levels. Health plans meeting the high performance level (HPL) exhibit rates among the top in the nation. The low performance level (LPL) has been set to identify health plans 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: (1) Pediatric Care, (2) Women's Care, (3) Living With Illness, and (4) Access to Care. These dimensions reflect important groupings and expand on the dimensions model used by the Foundation for Accountability (FACCT). This approach to the analysis is designed to encourage 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.

[1-1] Michigan Medicaid Managed Care. *Medicaid Health Plan Enrollment Report.* January 2006.

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

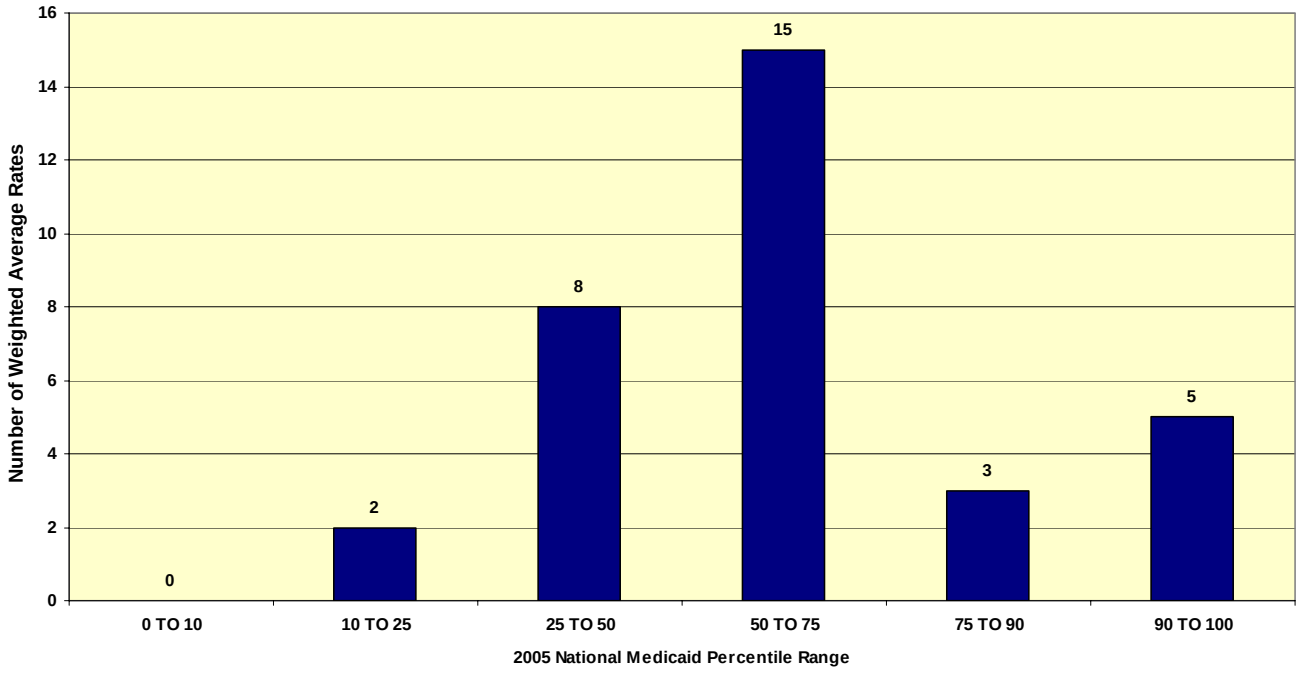
- A weighted average comparison presents the Michigan Medicaid 2006 results relative to the 2005 Michigan Medicaid weighted averages and the national HEDIS 2005 Medicaid 50th percentiles.
- A performance profile analysis discusses the overall Michigan Medicaid 2006 results and presents a summary of health plan performance relative to the Michigan Medicaid performance levels.
- A health plan ranking analysis provides a more detailed comparison, showing results relative to the Michigan Medicaid performance levels.
- A data collection analysis evaluates the potential impact of data collection methodology on reported rates.

In addition, Section 7 ("HEDIS Reporting Capabilities") of the report provides a summary of the HEDIS data collection processes used by the Michigan MHPs and audit findings in relation to NCQA's Information System (IS) standards.

Key Findings and Recommendations

This is the sixth year that HSAG has examined the MDCH HEDIS results, and improvement continues to be observed. Figure 1-1 shows Michigan MHP performance compared with national Medicaid percentiles. The columns represent the number of Michigan Medicaid weighted averages falling into the percentile grouping listed on the horizontal axis. Of the 33 weighted averages for which national percentile data were available, two (or 6 percent) fell between the national Medicaid 10th and 25th percentiles, eight (or 24 percent) fell between the 25th and 50th percentiles, 15 (or 45 percent) fell between the 50th and 75th percentiles, three (or 9 percent) fell between the 75th and 90th percentiles, and five (or 15 percent) ranked above the 90th percentile. Many rates demonstrated increases over the 2005 rates by moving into higher national percentile ranges. In 2005, none of the rates exceeded the 90th percentile, whereas this year, five weighted averages were in this range. It is important to note that of the five rates that exceeded the 90th percentile, four of them were indicators that make up the *Use of Appropriate Medication for People with Asthma* measure, which experienced significant changes to the measure specifications in 2006. The improvements seen in this measure are not likely to be true improvements in performance; rather, they reflect the specification changes, and are consistent with national trends. Two rates (*Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis*) fell into the 10th to 25th percentile range. None of the rates had been in this range in 2005. While this does not represent an actual decline in both rates, it does indicate that the Michigan MHPs have opportunity for improvement for these two measures.

Figure 1-1—Michigan Medicaid HEDIS 2006:
Health Plan Performance Compared With National Medicaid Percentiles



Only 1 of the 33 weighted averages showed a decline from 2005: Pediatric Care's *Appropriate Testing for Children With Pharyngitis*. The measure declined by 3.0 percentage points; however, it was not shown to be statistically significant. Improvement in the Michigan Medicaid weighted averages was seen in the remaining 32 key measures, with six showing statistically significant increases. The significant improvements were observed for *Childhood Immunization Status—Combination #2*; *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*; and *Comprehensive Diabetes Care—LDL-C Screening*.

Statewide, some notable improvements were made over last year's performance. Despite the already high performance in 2005, statistically significant improvement was observed in the *Childhood Immunization Status—Combination #2* measure. In addition, the weighted average for this measure exceeded the national Medicaid 90th percentile. However, emphasis will need to be placed on the new childhood immunization measure introduced this year, *Combination #3*, for rates to compare to the *Combination #2* measure. Michigan Medicaid performance for child and adolescent well-child visits showed exceptional improvement. All of the well-care measures' weighted averages increased significantly from 2005 to 2006. Finally, substantial improvement was seen in the *Comprehensive Diabetes Care—LDL-C Screening* measure, representing improved quality of care for *LDL-C Screening*.

In general, the Michigan MHPs performed well in the Pediatric Care dimension. Five measures demonstrated statistically significant improvement, and the range of rates improved, indicating positive movement by last year's lower performing MHPs. Most weighted averages were above the national Medicaid 50th percentile, and the weighted average for *Childhood Immunization Status—Combination #2* exceeded the national Medicaid 90th percentile. The exception to the high performance in the Pediatric Care dimension was in two measures: *Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis.* These measures assess misuse of antibiotics for common childhood illnesses. Lower performance indicates that clinicians are over or inappropriately prescribing antibiotics without performing the appropriate diagnostic testing for such conditions as the common cold and sore throats. These measures were more recent additions to Michigan's key measure set.

In the Women's Care dimension, Michigan MHP performance was generally flat for the screening measures. The weighted averages for *Breast Cancer Screening* and *Cervical Cancer Screening* were slightly above the national Medicaid 50th percentile, with only minimal improvement over the past few years. Performance for the *Chlamydia Screening in Women* measures was also average, although the weighted averages exceeded the national Medicaid 50th percentile by more than 5 percentage points for all indicators. For the *Prenatal and Postpartum Care* measures, an impressive two-year trend was observed, with the weighted average for each indicator gaining over 10 percentage points. MHP interventions and case management programs have made a positive impact on the quality of maternity care services provided by the Michigan MHPs.

Average performance was observed across the MHPs for the Living With Illness dimension. Modest gains were noted for most of the *Comprehensive Diabetes Care* indicators, with only one (*LDL-C Screening*) demonstrating statistically significant improvement in the weighted average representing improved quality of care in screening diabetics for hyperlipidemia. Two-year trends, however, for most indicators are encouraging. One Michigan MHP demonstrated superior performance in

diabetes care, exceeding the national Medicaid 90th percentile for five of the seven indicators. For the asthma indicators, improvement cannot be trended in 2006, due to significant changes in the measure specifications. For the two remaining measures within the Living with Illness dimension, average performance was also observed. The weighted average for the *Controlling High Blood Pressure* measure was below the national Medicaid 50th percentile, although some modest improvement over the 2005 rate was observed. Moderate improvement was also seen for the *Advising Smokers to Quit* statewide average.

Modest improvements were observed in the Access to Care dimension, although room for improvement still exists. The weighted averages for five of the six indicators fell between the national Medicaid 25th and 50th percentiles. The exception was the *Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years*, which exceeded the 50th percentile and also showed improvement in the range of rates across the MHPs.

A review of the Michigan Medicaid QI plans found that all MHPs have disease management programs for diabetes and asthma, and most have additional programs for prenatal and postpartum care and smoking cessation, along with an array of QI activities that target the various HEDIS measures within the key measure set. Renewed emphasis and focus should be placed on women's screening indicators, as these measures have not seen significant improvements over the past few years. Due to low statewide performance, MDCH may want to consider adding the *Appropriate Testing for Children With Pharyngitis* measure into its performance bonus program, along with relaying a message of strong emphasis on this measure and the *Appropriate Treatment for Children With Upper Respiratory Infection*. The measures within the Living with Illness dimension, particularly *Controlling High Blood Pressure* and *Advising Smokers to Quit* also could benefit from renewed attention and focus. Finally, improving access to care should continue to be emphasized as a key area of focus for the MHPs. A review of the QI plans showed that few plans focus their QI efforts on access to care, and the ones that do, direct their efforts towards provider education and intervention. The MHPs should explore seeking out members that never seek traditional primary care services, which will require a commitment of resources to an area that is not typically targeted. By reaching these "silent members," MHPs will not only improve their performance in the access to care measures, but will likely improve across all quality measures, which results in earlier identification of health care issues, better management of health conditions, and ultimately, improved outcomes of care.

Weighted Average Comparisons for the Four Dimensions of Care

Figure 1-2 through Figure 1-5 show Michigan Medicaid HEDIS 2006 results for each dimension of care, comparing the current weighted average for each measure relative to the 2005 Michigan Medicaid weighted average and the national HEDIS 2005 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 2006 and 2005 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 2006 Michigan Medicaid weighted average with the national HEDIS 2005 Medicaid 50th percentile.

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

  The two exceptions are:

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

  For these exceptions, *lower* rates (a bar to the left) indicate *better* performance.
- Weighted averages for *Childhood Immunization—Combination #3* and *Advising Smokers to Quit* could not be calculated. National percentile data are not available for these measures.

Performance Level Analysis

Table 1-1 through Table 1-4 show performance summary results for all Michigan MHPs for each dimension of care. Results were calculated using a scoring algorithm based on individual health plan performance relative to the HPL, LPL, and national HEDIS 2005 Medicaid 50th percentile.

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

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."

Summary of Results

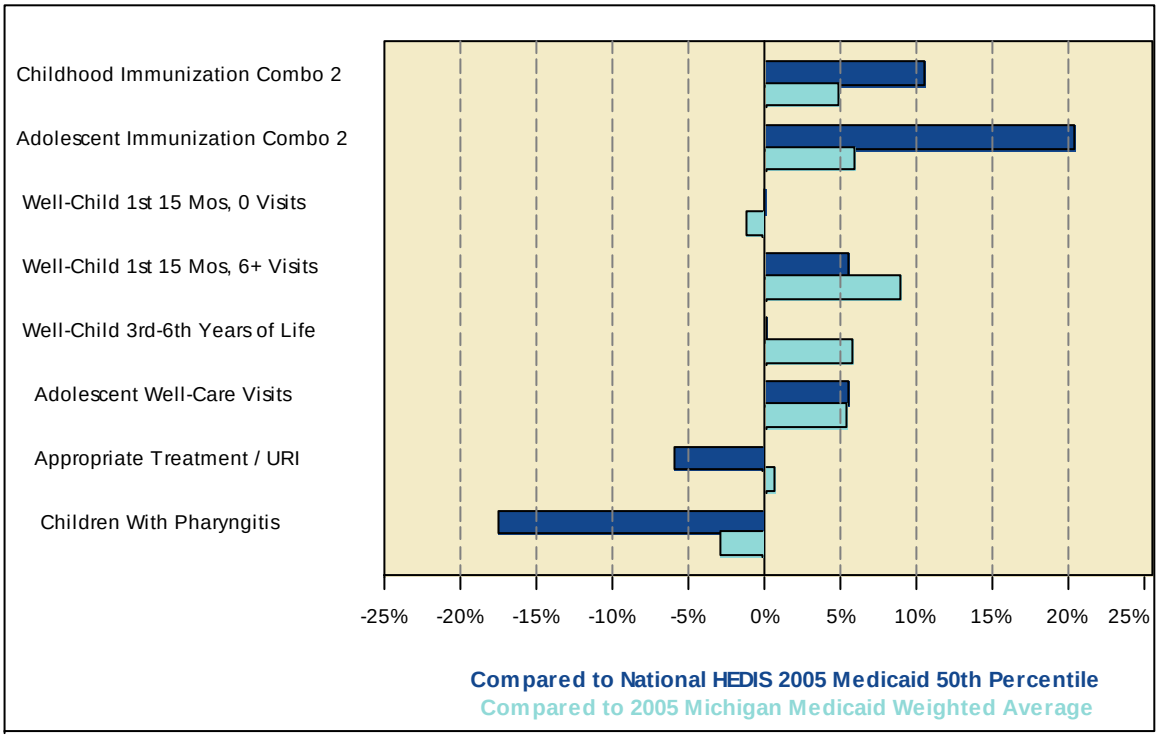
Pediatric Care

As observed in previous years, the Michigan Medicaid managed care program continued to demonstrate exceptional performance in the *Childhood Immunization Status—Combination #2* measure. The weighted average of 76.6 percent was above the HPL of 75.7 percent and showed a statistically significant improvement over the 2005 rate. The *Adolescent Immunization Status—Combination #2* weighted average also showed improvement from 2005, up 5.9 percentage points. All of the MHPs reported rates above the national HEDIS 2005 Medicaid 50th percentile of 38.5 percent for this measure. Given the high performance observed in previous years, these achievements are quite remarkable. Immunization results have been positively influenced by the nearly 100 percent provider participation in the Michigan Care Improvement Registry (MCIR), as well as quality improvement (QI) initiatives conducted by the MHPs.

For the well-care measures, statewide performance showed significant improvement. All of the well-care weighted averages had a statistically significant increase from 2005. Furthermore, all of the well-care Michigan Medicaid weighted averages exceeded the national HEDIS 2005 Medicaid 50th percentiles. This is a vast improvement for the child measures' weighted averages, which were below the national average in 2005. Quality improvement activities such as provider and member reminders and education seem to have had a positive affect on the MHPs' performance for these measures.

Both the *Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis* measures had weighted averages below the national HEDIS 2005 Medicaid 25th percentile. Although the statewide performance for the *Appropriate Treatment for Children With Upper Respiratory Infection* measure saw a small improvement from 2005 to 2006, the *Appropriate Testing for Children With Pharyngitis* measure declined by more than 3.0 percentage points. Added QI focus needs to be placed on these measures. QI activities and interventions need to be developed by both the State and the health plans to educate providers on the appropriate treatment of these conditions.

Figure 1-2—Michigan Medicaid HEDIS 2006 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 2006 Performance Summary: Pediatric Care

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

*Due to being a first year measure, means and percentiles are not available for the *Childhood Immunization Status—Combination #3* measure.

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

Women's Care

Michigan Medicaid performance showed improvement over 2005. All of the Women's Care measures showed an increase in their weighted averages when compared with last year's weighted averages, although the improvements were relatively small and not statistically significant. In 2005, only three measures exceeded the national average. Overall, statewide performance on all indicators was average. While modest improvements were seen, the measures within the Women's Care dimension offer several opportunities for improvement.

Figure 1-3—Michigan Medicaid HEDIS 2006 Weighted Average Comparison: Women's Care

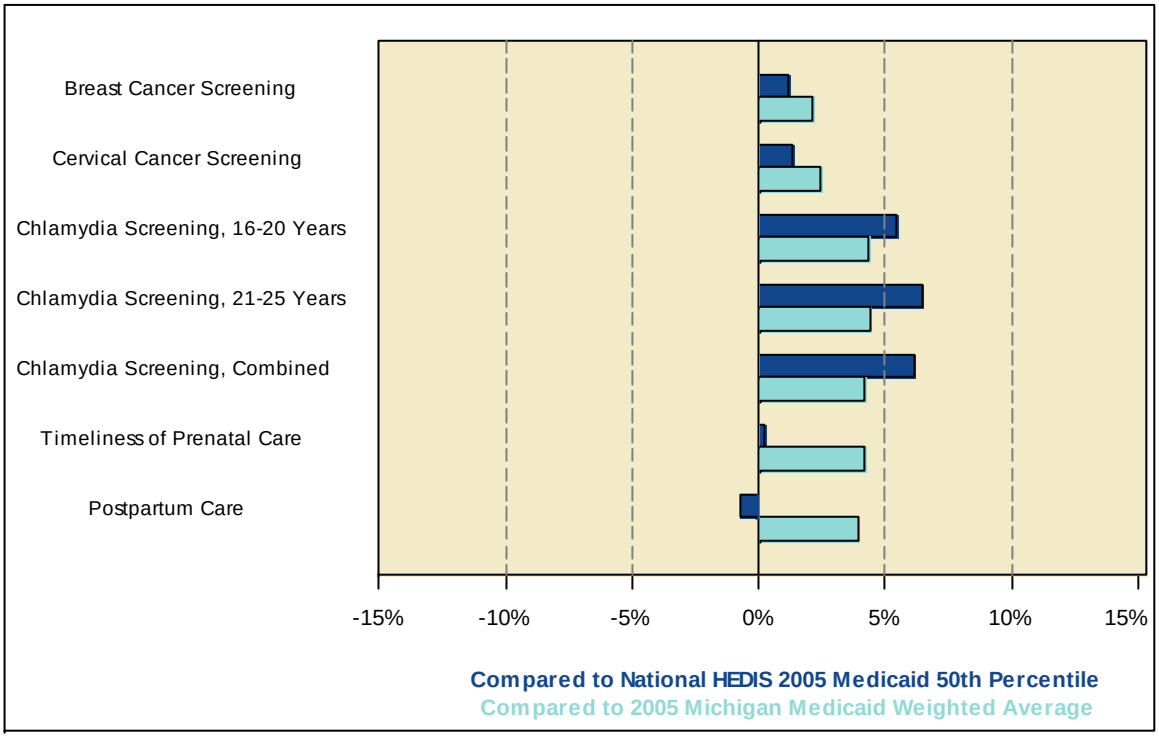


Table 1-2—Michigan Medicaid HEDIS 2006 Performance Summary: Women's Care

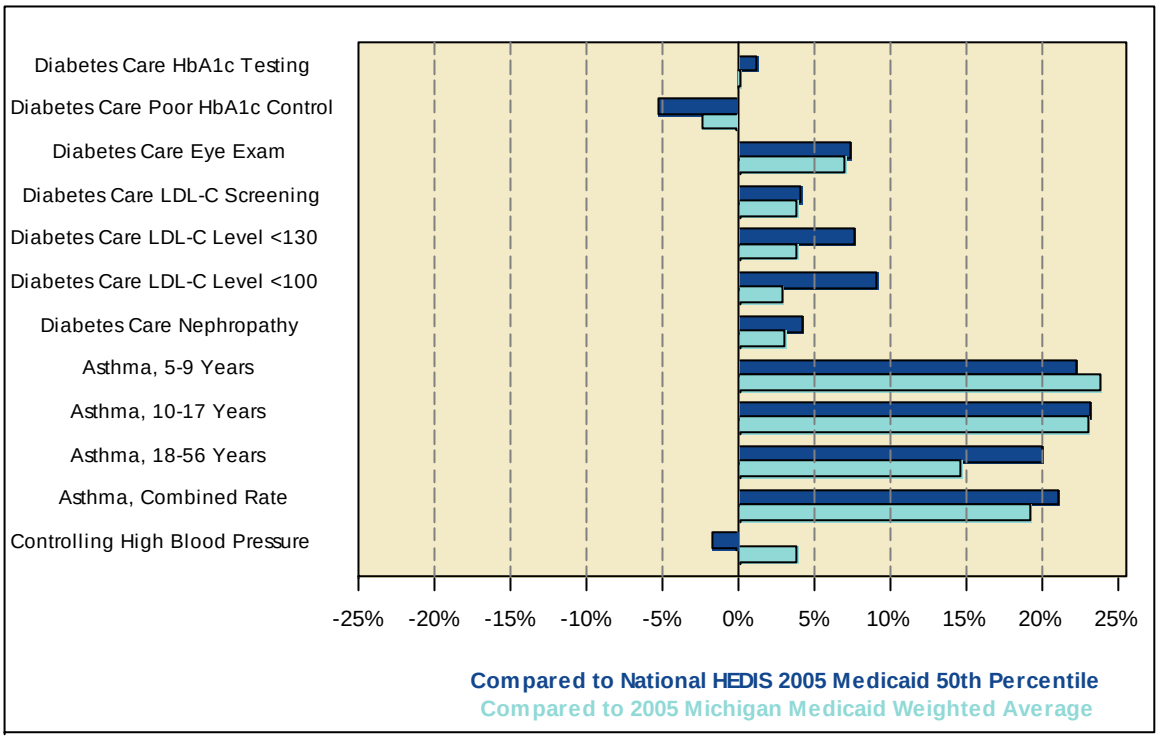
Health Plan Name	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening 16–20 Yrs	Chlamydia Screening 21–25 Yrs	Chlamydia Screening Combined	Timeliness of Prenatal Care	Postpartum Care
CAP	★★	★★	★★	★★	★★	★	★
CCM	★	★★	★★	★★	★★	★★	★★
GLH	★★	★★	★★	★★	★★	★★	★★
HPM	★★	★★	★★	★★	★★	★★	★★
HPP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

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

Living With Illness

In the Living With Illness dimension, only one *Comprehensive Diabetes Care* indicator showed significant improvement (*LDL-C Screening)*. All statewide weighted averages increased modestly (*Poor HbA1c Control* decreased, which indicates improved performance) from 2005 to 2006. All rates reported for *Comprehensive Diabetes Care* exceeded the national HEDIS 2005 Medicaid 50th percentile. Trending statewide performance for the asthma measures is not appropriate because the measure specifications changed significantly in 2006. An increase was observed in the *Controlling High Blood Pressure* weighted average of 3.9 percentage points. However, with a statewide weighted average still below the national HEDIS 2005 Medicaid 50th percentile, opportunities for improvement still exist for this measure. Finally, moderate improvement was seen in the *Advising Smokers to Quit* measure over the 2005 rate, although no national percentile data are available from NCQA.

Figure 1-4—Michigan Medicaid HEDIS 2006 Weighted Average Comparison: Living With Illness



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

Table 1-3—Michigan Medicaid HEDIS 2006 Performance Summary: Living With Illness (Part 1)

Health Plan Name	Diabetes Care HbA1c Testing	Diabetes Care HbA1c Control	Diabetes Care Eye Exam	Diabetes Care LDL-C Screening	Diabetes Care LDL-C Level <130	Diabetes Care LDL-C Level <100	Diabetes Care Nephropathy
CAP	★★	★★	★★	★★	★★	★★	★★
CCM	★★	★★	★★	★★	★★	★★	★★
GLH	★★	★★	★★	★★	★★★	★★★	★★
HPM	★★	★★	★★	★★	★★	★★	★★
HPP	★★	★★★	★★★	★★	★★	★★★	★★
MCD	★★	★★	★★	★★★	★★★	★★★	★★
MCL	★★	★★	★★★	★★	★★	★★	★★
MID	★★	★★	★★	★★	★★	★★	★★
MOL	★★	★★	★★	★★	★★	★★	★★
OCH	★★	★★	★	★★	★★	★★	★★
PMD	★★	★★	★★★	★★	★★★	★★★	★★★
PRI	★★	★★★	★★★	★★★	★★★	★★★	★★
PSW	★★	★★★	★★★	★★	★★	★★	★★
THC	★★	★★	★★	★★	★★	★★	★★★
UPP	★★★	★★★	★★★	★★★	★★	★★	★★★

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

Table 1-3—Michigan Medicaid HEDIS 2006 Performance Summary: Living With Illness (Part 2)						
Health Plan Name	Asthma 5–9 Yrs	Asthma 10–17 Yrs	Asthma 18–56 Yrs	Asthma Combined	Controlling High Blood Pressure	Advising Smokers to Quit*
CAP	★★★	★★★	★★★	★★★	★★	–
CCM	★★★	★★★	★★★	★★★	★★	–
GLH	★★★	★★★	★★★	★★★	★	–
HPM	★★★	★★★	★★★	★★★	★★	–
HPP	★★★	★★★	★★★	★★★	★★	–
MCD	★★★	★★★	★★★	★★★	★★★	–
MCL	★★★	★★★	★★★	★★★	★★	–
MID	★★★	★★★	★★★	★★★	★★	–
MOL	★★★	★★★	★★★	★★★	★★	–
OCH	★★★	★★★	★★★	★★★	★	–
PMD	★★★	★★★	★★★	★★★	★★	–
PRI	★★★	★★★	★★★	★★★	★★	–
PSW	★★★	★★★	★★★	★★★	★★	–
THC	★★★	★★★	★★★	★★★	★★	–
UPP	★★★	★★★	★★★	★★★	★★★	–

*Means and percentiles are not available 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 *Not Report (NR)*
"NA" means "Not Applicable."		

Access to Care

Performance in the Access to Care dimension continues to be a challenge for the Michigan MHPs. All rates showed some improvement from 2005 to 2006; however, only one of the measures had a statewide weighted average that exceeded the national HEDIS 2005 Medicaid 50th percentile. With the exception of the *Adult's Access to Preventive/Ambulatory Health Services—Ages 45-64 Years* measure, none of the rates exceeded the national average, suggesting a greater variation in performance across the Michigan health plans.

Figure 1-5—Michigan Medicaid HEDIS 2006 Weighted Average Comparison: Access to Care

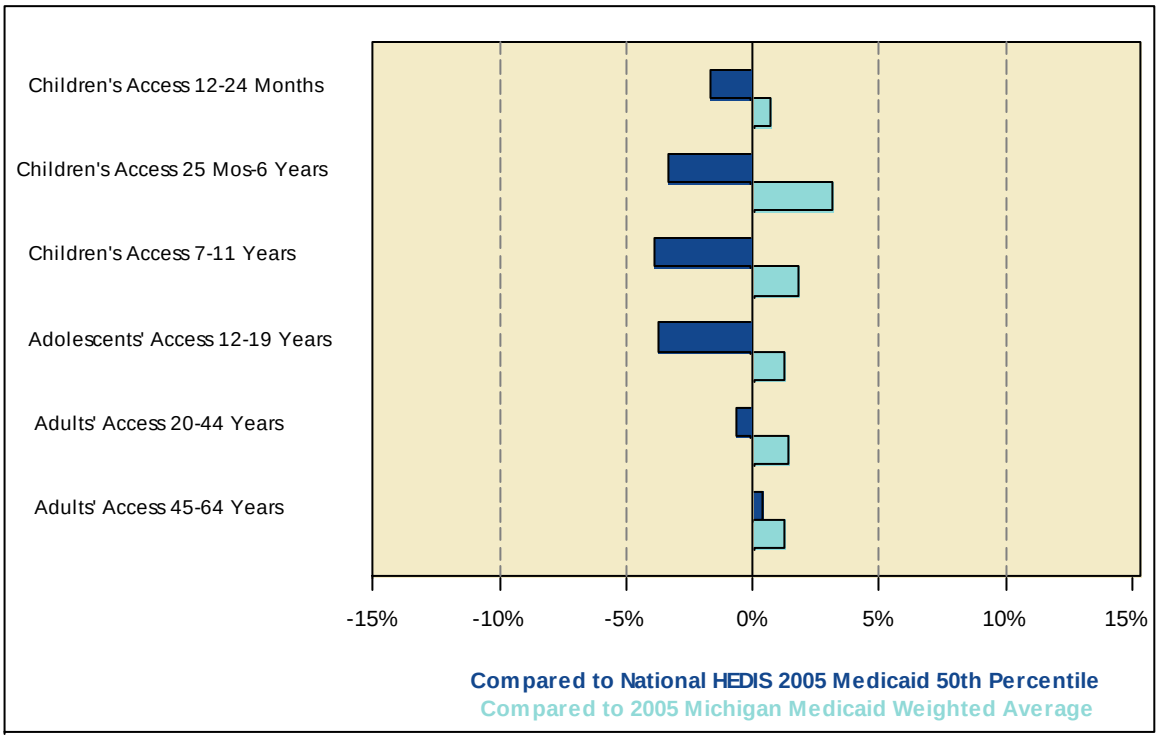


Table 1-4—Michigan Medicaid HEDIS 2006 Performance Summary: Access to Care

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

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

Summary of Michigan Medicaid HEDIS 2006 Key Measures

HEDIS includes a standard set of measures that can be reported by MHPs nationwide. MDCH selected 17 HEDIS measures from the standard Medicaid set and divided them into 35 distinct rates, shown in Table 2-1. These 35 rates represent the 2006 MDCH key measures. Fifteen Michigan MHPs were required to report the key measures in 2006.

Table 2-1—Michigan Medicaid HEDIS 2006 Key Measures

Standard HEDIS 2006 Measures	2006 MDCH Key Measures
1. Childhood Immunization Status	1. Childhood Immunization Status—Combination #2 2. Childhood Immunization Status—Combination #3
2. Adolescent Immunization Status	3. Adolescent Immunization Status—Combination #2
3. Well-Child Visits in the First 15 Months of Life	4. Well-Child Visits in the First 15 Months of Life—Zero Visits 5. Well-Child Visits in the First 15 Months of Life—Six or More Visits
4. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	6. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
5. Adolescent Well-Care Visits	7. Adolescent Well-Care Visits
6. Appropriate Treatment for Children With Upper Respiratory Infection	8. Appropriate Treatment for Children With Upper Respiratory Infection
7. Appropriate Testing for Children With Pharyngitis	9. Appropriate Testing for Children With Pharyngitis
8. Breast Cancer Screening	10. Breast Cancer Screening
9. Cervical Cancer Screening	11. Cervical Cancer Screening
10. Chlamydia Screening in Women	12. Chlamydia Screening in Women—Ages 16–20 Years 13. Chlamydia Screening in Women—Ages 21–25 Years 14. Chlamydia Screening in Women—Combined Rate
11. Prenatal and Postpartum Care	15. Prenatal and Postpartum Care—Timeliness of Prenatal Care 16. Prenatal and Postpartum Care—Postpartum Care
12. Comprehensive Diabetes Care	17. Comprehensive Diabetes Care—HbA1c Testing 18. Comprehensive Diabetes Care—Poor HbA1c Control 19. Comprehensive Diabetes Care—Eye Exam 20. Comprehensive Diabetes Care—LDL-C Screening 21. Comprehensive Diabetes Care—LDL-C Level <130 22. Comprehensive Diabetes Care—LDL-C Level <100 23. Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy
13. Use of Appropriate Medications for People With Asthma	24. Use of Appropriate Medications for People With Asthma—Ages 5–9 Years 25. Use of Appropriate Medications for People With Asthma—Ages 10–17 Years 26. Use of Appropriate Medications for People With Asthma—Ages 18–56 Years 27. Use of Appropriate Medications for People With Asthma—Combined Rate
14. Controlling High Blood Pressure	28. Controlling High Blood Pressure
15. Medical Assistance With Smoking Cessation	29. Medical Assistance With Smoking Cessation—Advising Smokers to Quit
16. Children's and Adolescents' Access to Primary Care Practitioners	30. Children's and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months 31. Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years 32. Children's and Adolescents' Access to Primary Care Practitioners—Ages 7–11 Years 33. Children's and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years
17. Adults' Access to Preventive/Ambulatory Health Services	34. Adults' Access to Preventive/Ambulatory Health Services—Ages 20–44 Years 35. Adults' Access to Preventive/Ambulatory Health Services—Ages 45–64 Years

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 because the measure deviated from HEDIS specifications such that the reported rate was significantly biased or an MHP chose not to report the measure.

A 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. For HEDIS 2006, there were no key measures reported by any of the health plans that had a *Not Applicable* rate.

It should be noted that NCQA allows health plans to "rotate" HEDIS measures in some circumstances. A "rotation" schedule enables health plans to use the audited and reportable 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. Eight health plans chose to rotate measures in 2006, and a total of 40 rates were rotated. Following NCQA methodology, rotated measures were assigned the same reported rates from 2005 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 Foundation for Accountability (FACCT). This approach to the analysis is designed to encourage health plans to consider the key measures as a whole rather than in isolation, and to think about the strategic and tactical changes required to improve overall performance.

Changes to Measures

For the 2006 HEDIS reporting year, NCQA made a few modifications to some of the measures included in this report, which may impact trending patterns.

Childhood Immunization Status

- The indicator for *Combination #1* was retired. A new indicator was added, *Combination #3*. This new indicator includes all of the antigens in *Combination #2* with the addition of the pneumococcal conjugate.

Adolescent Immunization Status

- The *Combination #1* indicator was retired.

Breast Cancer Screening

- The hybrid method was removed. This measure uses the administrative-only method. This may impact rates negatively for MCOs that previously reported this measure using the hybrid method. Since medical record review is no longer allowed to collect this measure, MCOs will have to rely on their administrative data to report the rate.

Use of Appropriate Medications for People With Asthma

- The definition of persistent asthma was changed. The denominator was refined to include members who had an asthma diagnosis in both the year prior to the measurement year and the measurement year. Previously, the criteria only needed to be present in one year. In general, the rates for this measure have gone up.

Medical Assistance With Smoking Cessation

- Members who recently quit smoking were removed from the denominator and two questions that identify members who recently quit smoking were deleted from the survey questions.

Comprehensive Diabetes Care

- The *Eye Exam* indicator was revised to allow a negative retinal exam by an eye care professional in the year prior to the measurement year. Previously, a negative retinal exam needed to also meet both of the following criteria:
  - The member was not prescribed or dispensed insulin during the measurement year.
  - The member's most recent HbA1c level (performed during the measurement year) was <8.0 percent.

Performance Levels

The purpose of identifying performance levels is to compare to national percentiles 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 2005 results, which are the most recent percentiles available from NCQA. For this report, HEDIS rates were calculated to the sixth decimal place. The results displayed in this report were rounded to the first decimal place to be consistent with the display of national percentiles. There are some instances in which the rounded rate may appear the same; however, the more precise rates are not identical. In these instances, the hierarchy of the scores in the graphs is displayed in the correct order. For example, Figure 3-7 shows a rate that looks identical to the HPL (0.5 percent). This health plan had an actual rate of 0.52 which is slightly higher than the 0.5 percent HPL.

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

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

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

NCQA 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 lack of more recent performance data, no HPL or LPL has been established for this key measure. Instead, health plan results are ranked highest to lowest and are compared with the 2005 Michigan Medicaid weighted average.

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

Performance Trend Analysis

In Appendix C, the column titled "2005–2006 Health Plan Trend" shows, by key measure, the comparison between the 2005 results and the 2006 results for each health plan. A conservative method was implemented to assess statistical significance (i.e., 95 percent confidence intervals that did not overlap were considered statistically significant). Trends are shown graphically, using the key below:

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

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

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's eligible population size ensures that rates for a health plan with 125,000 members, for example, have a greater impact on the overall Michigan Medicaid rate than do the rates for a health plan with only 10,000 members.

Interpreting and Using Reported Averages and Aggregate Results

The 2006 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 2006 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 2005 and 2006 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 2005 and 2006 Michigan Medicaid weighted averages reported as statistically significant in this report are significant at the 0.05 level.

Calculation Methods: Administrative Versus Hybrid

Administrative Method

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

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

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

Hybrid Method

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

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

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

Interpreting Results

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

Four questions should be asked when examining these data:

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

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

1. How accurate are the results?

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

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

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

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

For each measure, a health plan ranking presents the reported rate in order from highest to lowest, with bars representing the established HPL, LPL, and the national HEDIS 2005 Medicaid 50th percentile. In addition, the 2006, 2005, and 2004 Michigan Medicaid weighted averages are presented for comparison purposes.

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

3. How are Michigan MHPs performing overall?

For each dimension, a performance profile analysis compares the 2006 Michigan Medicaid weighted average for each rate with the 2005 and 2004 Michigan Medicaid weighted averages and the national HEDIS 2005 Medicaid 50th percentile.

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

For each rate, a data collection analysis shows the number of health plans using each methodology (hybrid or administrative). 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 2006 aggregate bar represents the sum of all administrative events and medical record review events for all members in the statewide denominator, regardless of the data collection methodology used.

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

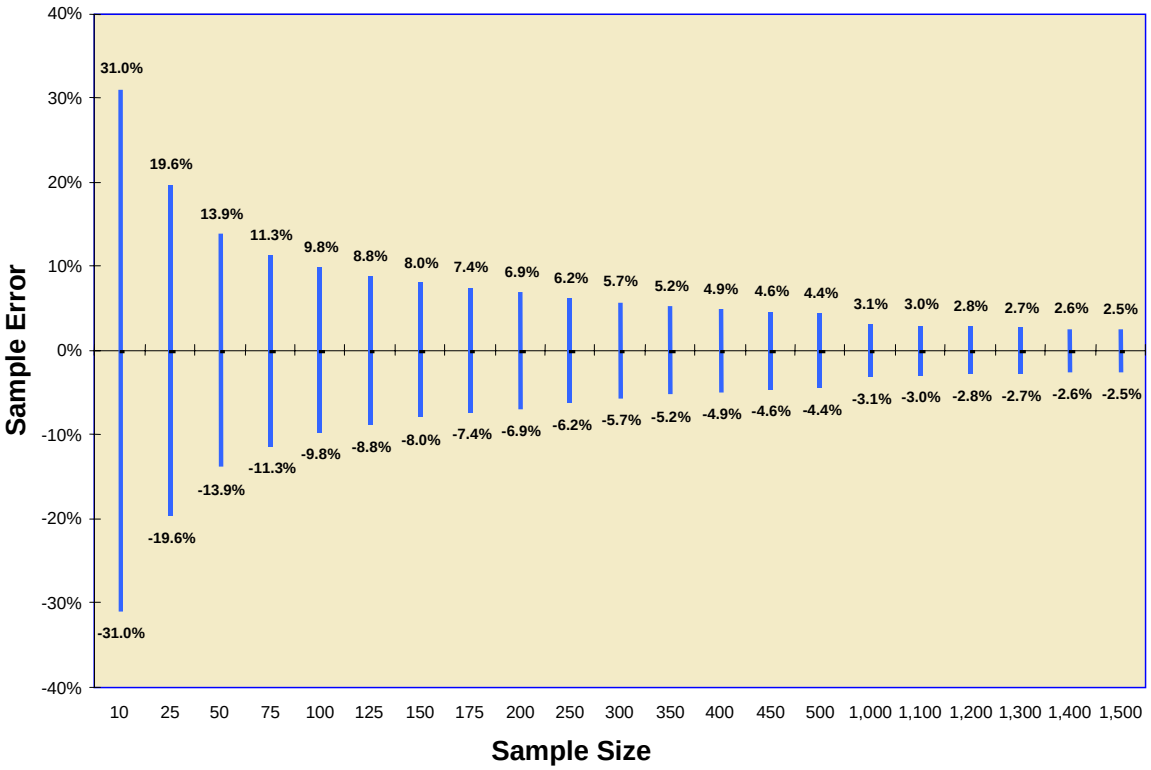
Understanding Sampling Error

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

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

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

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



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

Health Plan Name Key

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

Table 2-2—2006 Michigan MHPs

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

Introduction

Pediatric primary health care is essential to the prevention, recognition, and treatment of health conditions that could have significant developmental consequences for children and adolescents. The need for appropriate immunizations and health checkups has even greater importance and significance at younger ages. Abnormalities in growth, hearing, and vision undetected in toddlers may 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 under 6 years of age in an immunization registry and completing vaccine coverage for the 4:3:1:3:3:1 series for 90 percent of all 2-year-olds by June 2007.[3-1] During the baseline measurement year (1999), only 32 percent of children younger than 6 years of age participated in an immunization registry. The 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 40 million vaccinations provided to 3 million Michigan children. MCIR increased provider participation from 42 percent in 1998 to nearly 100 percent in 2005.[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. Also in 2005, MCIR began partnering with the Michigan Department of Education to document student immunizations and track compliance rates for 1.7 million children registered in Michigan public schools.

In the area of pediatric primary health care, there is also a continuing focus on the overuse of antibiotic therapies for viral conditions. Antimicrobial resistance among respiratory pathogens has become a common clinical problem. The Institute of Medicine has identified antibiotic resistance as one of the key microbial threats to health in the United States and has listed decreasing the inappropriate use of antimicrobials as a primary solution to address this threat. For this reason, antibiotic resistance is among the Centers for Disease Control and Prevention's (CDC's) top concerns. The CDC launched the National Campaign for Appropriate Antibiotic Use in the Community in 1995. In 2003, this program was renamed Get Smart: Know When Antibiotics Work. The campaign aims to reduce the rising rate of antibiotic resistance. Antibiotics are often used inappropriately, and although prescribing rates have decreased, current data suggest that for all ages

[3-1] Healthy People 2010: Objectives for Improving Health. Available at: http://www.healthypeople.gov/Document/HTML\Volume1\14Immunization.htm. Accessed on June 20, 2006.
[3-2] Michigan Public Health Institute. 2001 Michigan Childhood Immunization Registry. Available at: http://www.mcir.org/pro_accomp.htm. Accessed on June 20, 2006.

combined, more than 10 million courses of antibiotics are prescribed each year for viral conditions that do not benefit from antibiotics.[3-3]

In 2005, MDCH included the *Appropriate Treatment for Children With Upper Respiratory Infection* as a key measure and *Appropriate Testing for Children With Pharyngitis* as a tracking measure. In 2006, both measures were included in the key measure set. Both measures collect data on overuse of antibiotics for children diagnosed with either an upper respiratory infection or pharyngitis.

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

[3-3] Centers for Disease Control and Prevention, Department of Health and Human Services, GET SMART: Know When Antibiotics Work. Available at: http://www.cdc.gov/drugresistance/community/campaign_info.htm#3. Accessed on November 27, 2006.

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.[3-4] The CDC suggests that children receive the following: four doses of diphtheria, tetanus, and pertussis (DTP) vaccine, three or more doses of the polio vaccine, one or more doses of the measles-mumps-rubella (MMR) vaccine, three or more doses of the Haemophilus influenza type b (Hib) vaccine, the hepatitis B vaccine, and the varicella (chicken pox) vaccine.[3-5]

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 49 percent.[3-6]

Key measures in this section include:

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

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

HEDIS Specification: Childhood Immunization Status—Combination #2

Childhood Immunization Status—Combination #2 calculates the percentage of enrolled children who turned 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 Hib, three hepatitis B, and one varicella-zoster virus (chicken pox) vaccination (VZV), each within the allowable time period and by the member's second birthday.

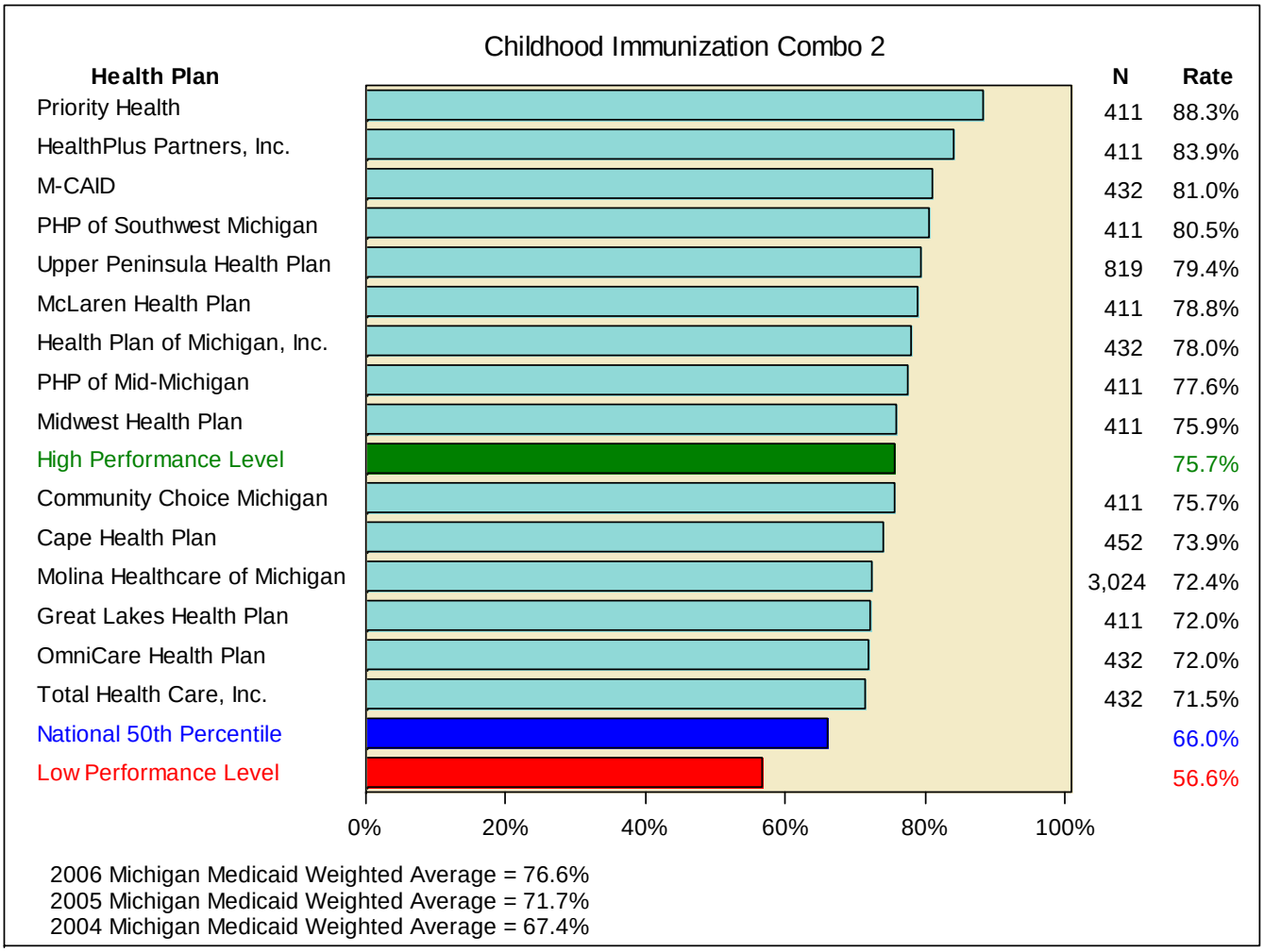
[3-4] National Committee for Quality Assurance. *The State of Managed Care Quality, 2001*. Standard Version. Washington, DC: National Committee for Quality Assurance: 2001, p.39.

[3-5] Child Trends DataBank. *Immunizations*. Available at: http://www.childtrendsdatabank.org/indicators/17Immunization.cfm. Accessed on July 6, 2006.

[3-6] Michigan Public Health Institute. Information for Providers: Accomplishments. 2001 Michigan Childhood Immunization Registry. Available at: http://www.mcir.org/accomplishments.html. Accessed on July 5, 2006.

Health Plan Ranking: Childhood Immunization Status—Combination #2

Figure 3-1—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Childhood Immunization Status—Combination #2



Nine health plans met or exceeded the HPL of 75.7 percent, and all health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

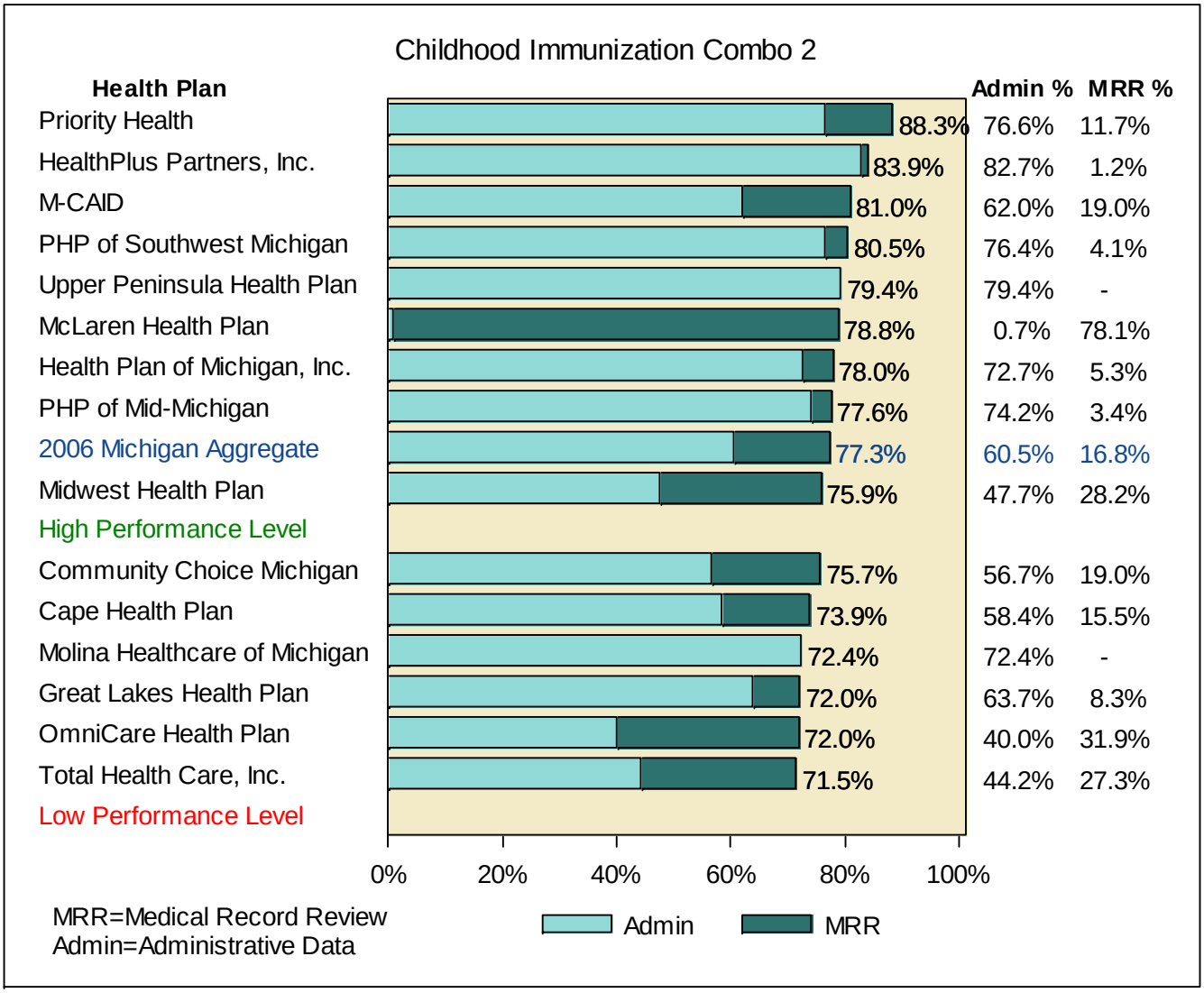
The 2006 Michigan Medicaid weighted average of 76.6 percent was 10.6 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 66.0 percent.

The 2006 Michigan Medicaid weighted average showed a statistically significant gain over 2005, up 4.9 percentage points. An increase of 9.2 percentage points was observed when compared with the 2004 Michigan Medicaid weighted average of 67.4 percent.

Five health plans reached the HPL in 2005, while none of the health plans had rates below the LPL. Overall, the range of reported rates demonstrated substantial improvement from 2005 to 2006.

Data Collection Analysis: Childhood Immunization Status—Combination #2

Figure 3-2—Michigan Medicaid HEDIS 2006
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: 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 exceptions of Molina Healthcare of Michigan and Upper Peninsula Health Plan, all health plans elected to use the hybrid method. The 2006 Michigan aggregate administrative rate was 60.5 percent and the medical record review rate was 16.8 percent.

Results from 2005 to 2006 showed no change, with 78.3 percent of the aggregate rate being derived from administrative data and 21.7 percent from medical record review.

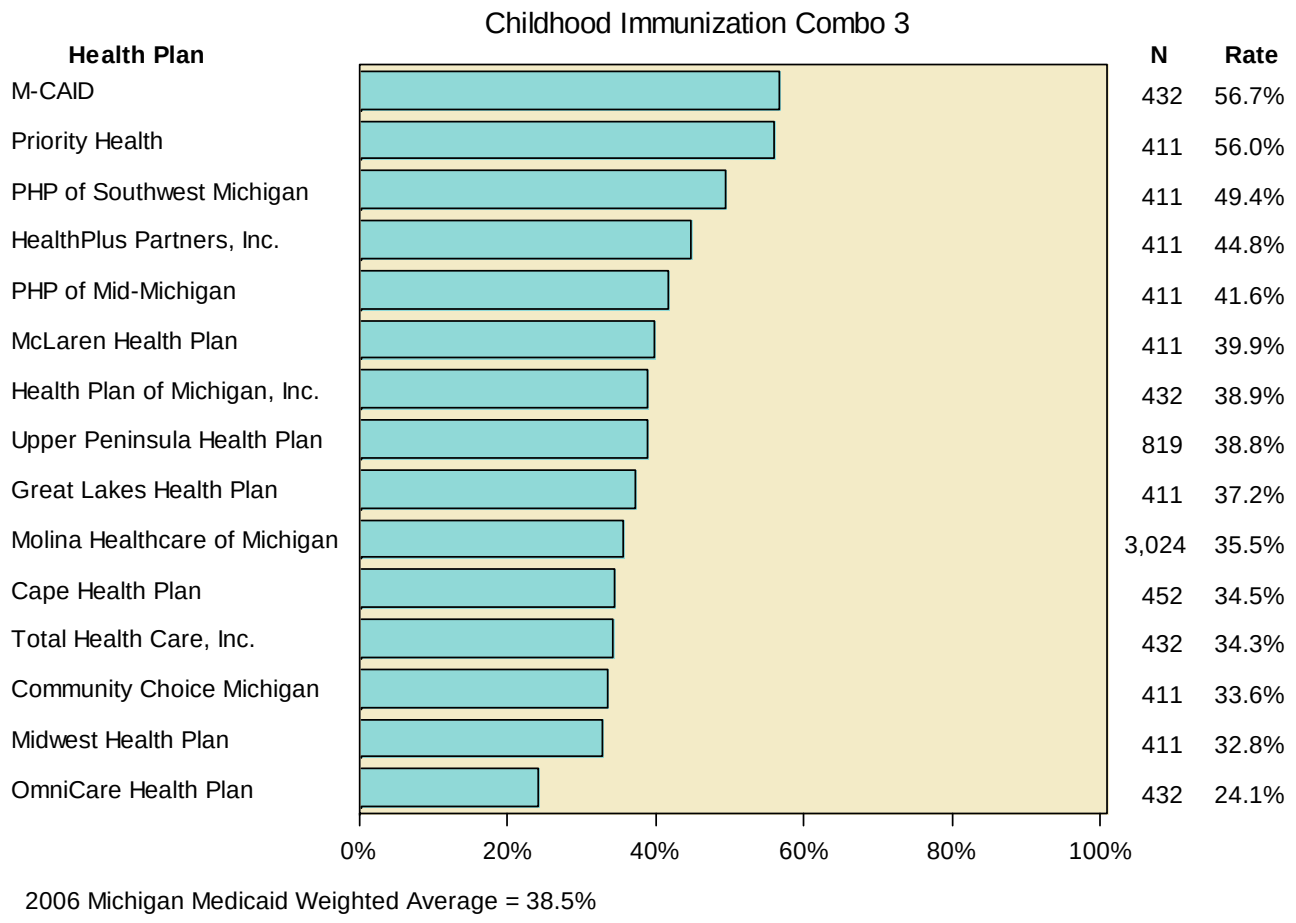
Twelve health plans that used the hybrid method derived more than half of their rates from administrative data, while one health plan derived less than one percent from administrative data. Of particular note is Upper Peninsula Health Plan with a reported rate that exceeded the national Medicaid 90th percentile using only administrative data.

HEDIS Specification: Childhood Immunization Status—Combination #3

Childhood Immunization Status—Combination #3 calculates the percentage of enrolled children who turned two years old during the measurement year, who were continuously enrolled for 12 months immediately preceding their second birthdays, and who were identified as having four DTaP/DT, three IPV, one MMR, three Hib, three hepatitis B, one VZV, and four pneumococcal conjugate vaccinations, each within the allowable time period and by the member's second birthday.

Health Plan Ranking: Childhood Immunization Status—Combination #3

Figure 3-3—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Childhood Immunization Status—Combination #3

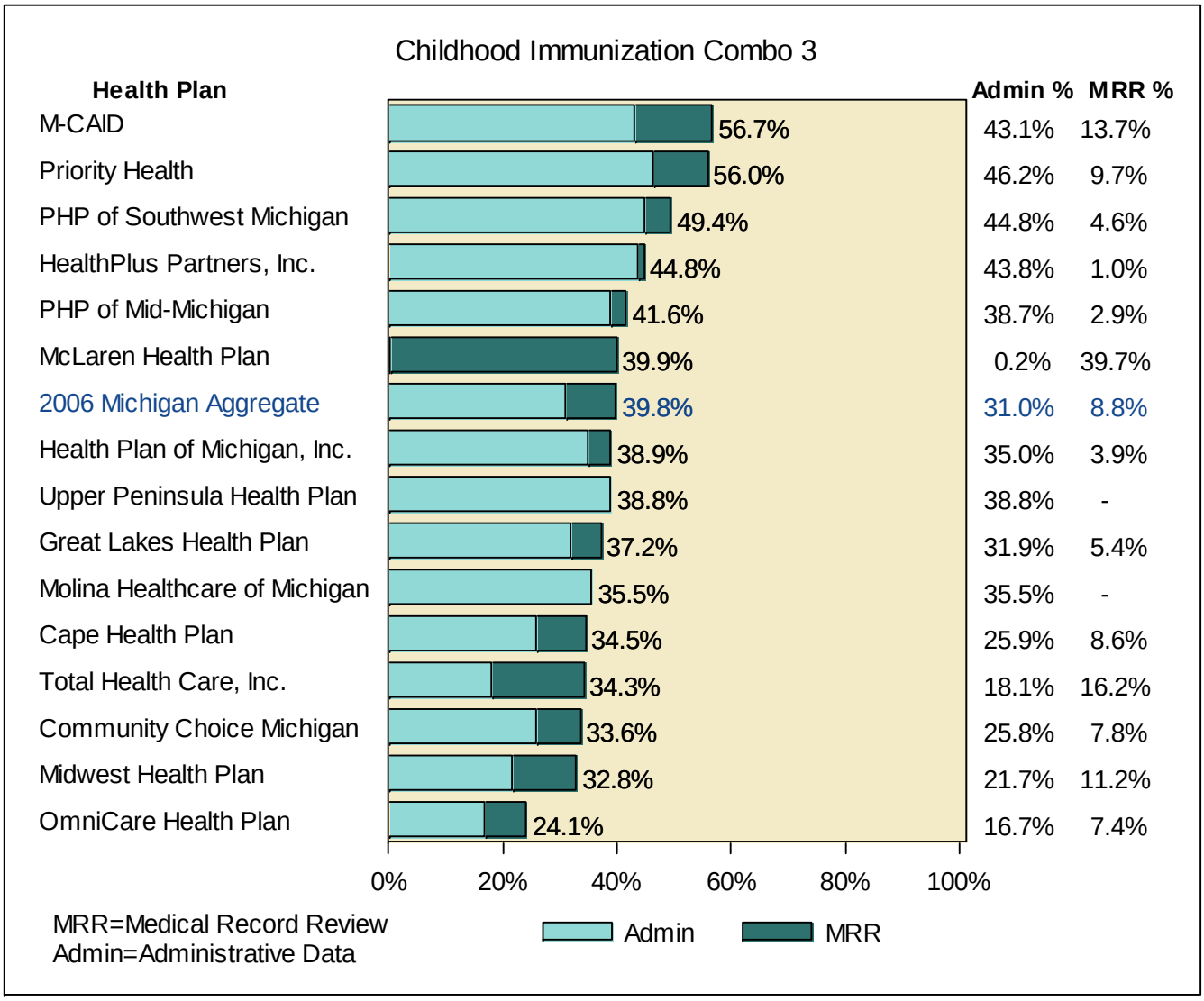


Childhood Immunization Status—Combination #3 is a new measure for 2006; therefore, national performance data are not available for comparison.

The rates for the health plans ranged from 24.1 percent to 56.7 percent, a relatively wide range. The 2006 Michigan Medicaid weighted average was 38.5 percent. Eight health plans reported rates above the weighted average.

Data Collection Analysis: Childhood Immunization Status—Combination #3

Figure 3-4—Michigan Medicaid HEDIS 2006
Data Collection Analysis:
Childhood Immunization Status—Combination #3



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: 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 exceptions of Molina Healthcare of Michigan and Upper Peninsula Health Plan, all health plans elected to use the hybrid methodology. The 2006 Michigan aggregate administrative rate was 31.0 percent and the medical record review rate was 8.8 percent.

The results indicate that 77.9 percent of the aggregate rate was derived from administrative data and 22.1 percent from medical record review, which is very similar to the *Childhood Immunization Status—Combination #2* measure findings.

Twelve health plans that used the hybrid methodology derived more than half of their rates from administrative data, while one health plan derived less than 1 percent of its rate from administrative data.

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. Adolescents are 10 times more likely than children to develop serious complications from the varicella-zoster virus (VZV), commonly known as chicken pox. The rate of complications is greatest for individuals 15 years of age or older, yet a significant number of teens still do not receive the VZV vaccine.[3-7] Prior to 2005, the only routinely recommended vaccines for adolescents were the tetanus and diphtheria toxoids (Td) booster. However, as additional vaccines have been released for administration to the adolescent population, and as new vaccines are being developed, it will be important for providers to focus immunization efforts on the adolescent population.[3-8]

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, saving society more than $5 for each dollar spent.[3-9]

The key measure in this section is:

- *Adolescent Immunization Status—Combination #2* (The *Combination #1* indicator was retired by NCQA in HEDIS 2006 and, therefore, is no longer a key measure.)

This is commonly referred to as *Combo 2*.

HEDIS Specification: Adolescent Immunization Status—Combination #2

The *Adolescent Immunization Status—Combination #2* measure calculates the percentage of enrolled adolescents who turned 13 years old during the measurement year, who were continuously enrolled for 12 months immediately prior to their 13th birthdays, and who were identified as having the following vaccinations: second dose of MMR, 3 hepatitis B vaccinations, and at least one VZV within the allowed time period and by the member's 13th birthday.

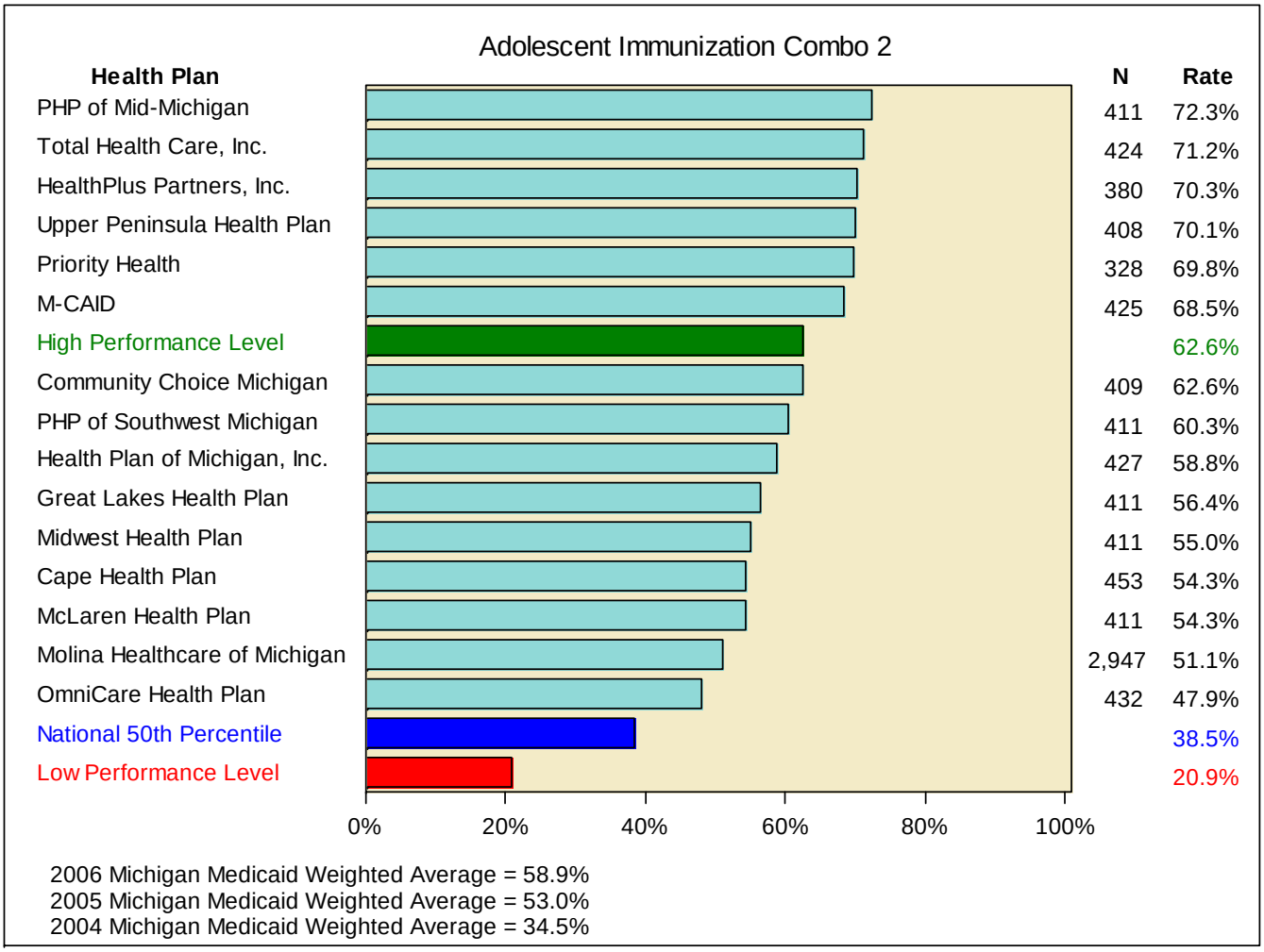
[3-7] Vaccine Place Web site. Varicella. Available at: http://www.vaccineplace.com/?fa=explore/frame&frame=http://www.vaccineprotection.com/professional/diseases/varicella.cfm&CFID=2848194&CFTOKEN=96567328. Accessed on July 5, 2006.

[3-8] Iowa Department of Public Health. "Chapter 10: Immunization and Infectious Diseases," *Healthy Iowans 2010.* Available at: http://www.cdc.gov/drugresistance/community/files/Snort-Sniffle-Sneeze_No_Antibiotics%20Please.pdf. Accessed on July 5, 2006.

[3-9] Iowa Department of Public Health. "Chapter 10: Immunization and Infectious Diseases," *Healthy Iowans 2010.* Available at: http://www.cdc.gov/drugresistance/community/files/Snort-Sniffle-Sneeze_No_Antibiotics%20Please.pdf. Accessed on July 5, 2006.

Health Plan Ranking: Adolescent Immunization Status—Combination #2

Figure 3-5—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Adolescent Immunization Status—Combination #2



Six of the 15 health plans had rates above the HPL of 62.6 percent and all health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

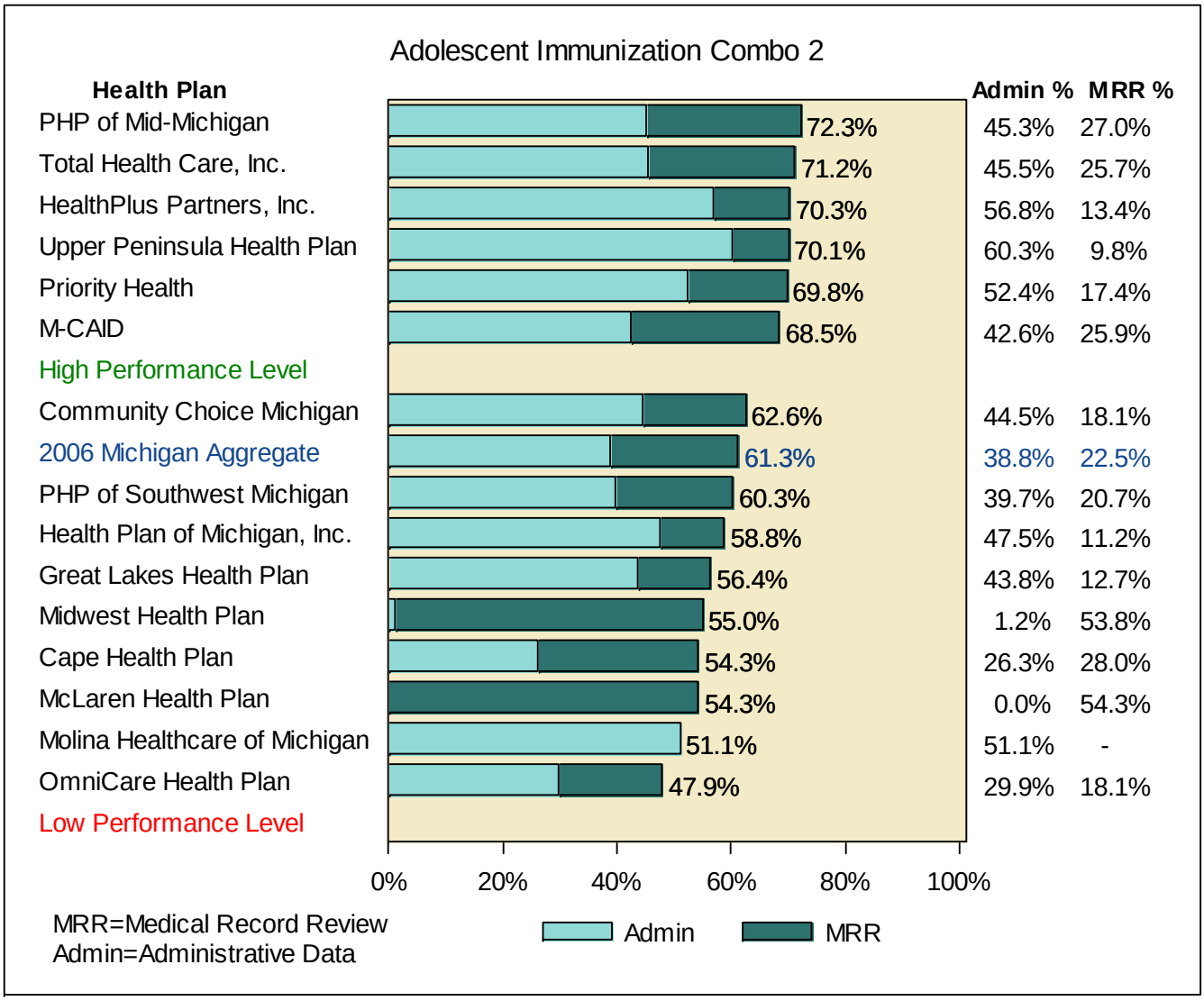
The 2006 Michigan Medicaid weighted average of 58.9 percent was 20.4 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 38.5 percent.

The 2006 Michigan Medicaid weighted average showed an increase from 2005, up 5.9 percentage points. A gain of 24.4 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 34.5 percent.

In 2005, eight health plans reported rates above the HPL and none of the health plans had rates below the LPL. The reported range of rates showed minimal improvement from 2005 to 2006.

Data Collection Analysis: Adolescent Immunization Status—Combination #2

Figure 3-6—Michigan Medicaid HEDIS 2006
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: 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 elected to use the hybrid method. The 2006 Michigan aggregate administrative rate was 38.8 percent and the medical record review was 22.5 percent.

The results illustrate that 63.3 percent of the aggregate rate was derived from administrative data and 36.7 percent from medical record review. In 2005, 57.5 percent of the aggregate rate was derived from administrative data. As with other immunization measures, Michigan Medicaid administrative immunization data appear to be increasingly complete.

Eleven of the health plans that used the hybrid method derived at least half of their rates from administrative data, while two health plans relied primarily on medical record review.

Well-Child Visits in the First 15 Months of Life

The American Medical Association (AMA), the federal government's Bright Futures program, and the American Academy of Pediatrics (AAP) all recommend comprehensive, periodic well-child visits for children. In 2004, 85 percent of children younger than 6 years of age received a well-child checkup in the past year.[3-10] These periodic checkups provide opportunities for addressing the physical, emotional, and social aspects of their health. These well-child visits provide opportunities for primary care providers to detect physical, developmental, behavioral, and emotional problems and provide early interventions, treatment, and appropriate referrals to specialists. It is also recommended that clinicians use these visits to offer counseling and guidance to parents. According to one study of Medicaid children, those who were up-to-date for their age with the AAP's recommended number of well-child visits were associated with a statistically significant reduction in risk of avoidable hospitalizations.[3-11]

Michigan Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements specify the components of age-appropriate well-child visits. The required components include: review of the child's clinical history and immunization status, 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.

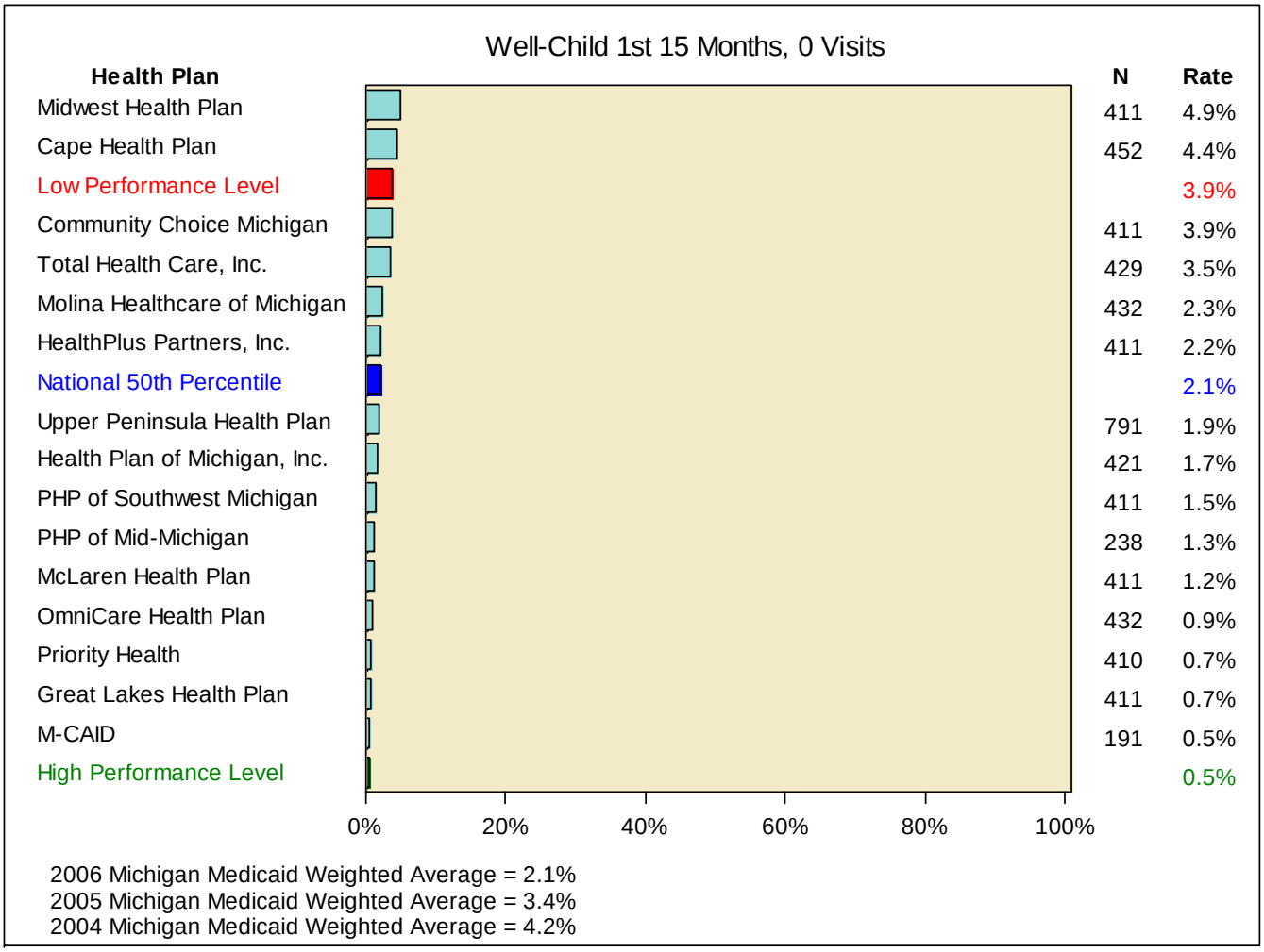
It should be noted that limitations within the NCQA Data Submission Tool (DST), and differences in the way the health plans complete the DST, will impact any findings for data collection for this measure. Health plans may choose to attribute the finding of zero visits solely to administrative data sources, 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.

[3-10] Child Trends Databank. *Well-child visits*. Available at: http://www.childtrendsdatabank.org/indicators/93WellChildVisits.cfm. Accessed on July 7, 2006.

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

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

Figure 3-7—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Well-Child Visits in the First 15 Months of Life—Zero Visits



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

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

One health plan nearly met the HPL of 0.5 percent, while two health plans had rates above the LPL of 3.9 percent. A total of nine health plans reported rates lower than the national HEDIS 2005 Medicaid 50th percentile, indicating better performance.

The 2006 Michigan Medicaid weighted average demonstrated a statistically significant improvement over 2005, down 1.3 percentage points and improving by 2.1 percentage points from the 2004 Michigan Medicaid weighted average of 4.2 percent.

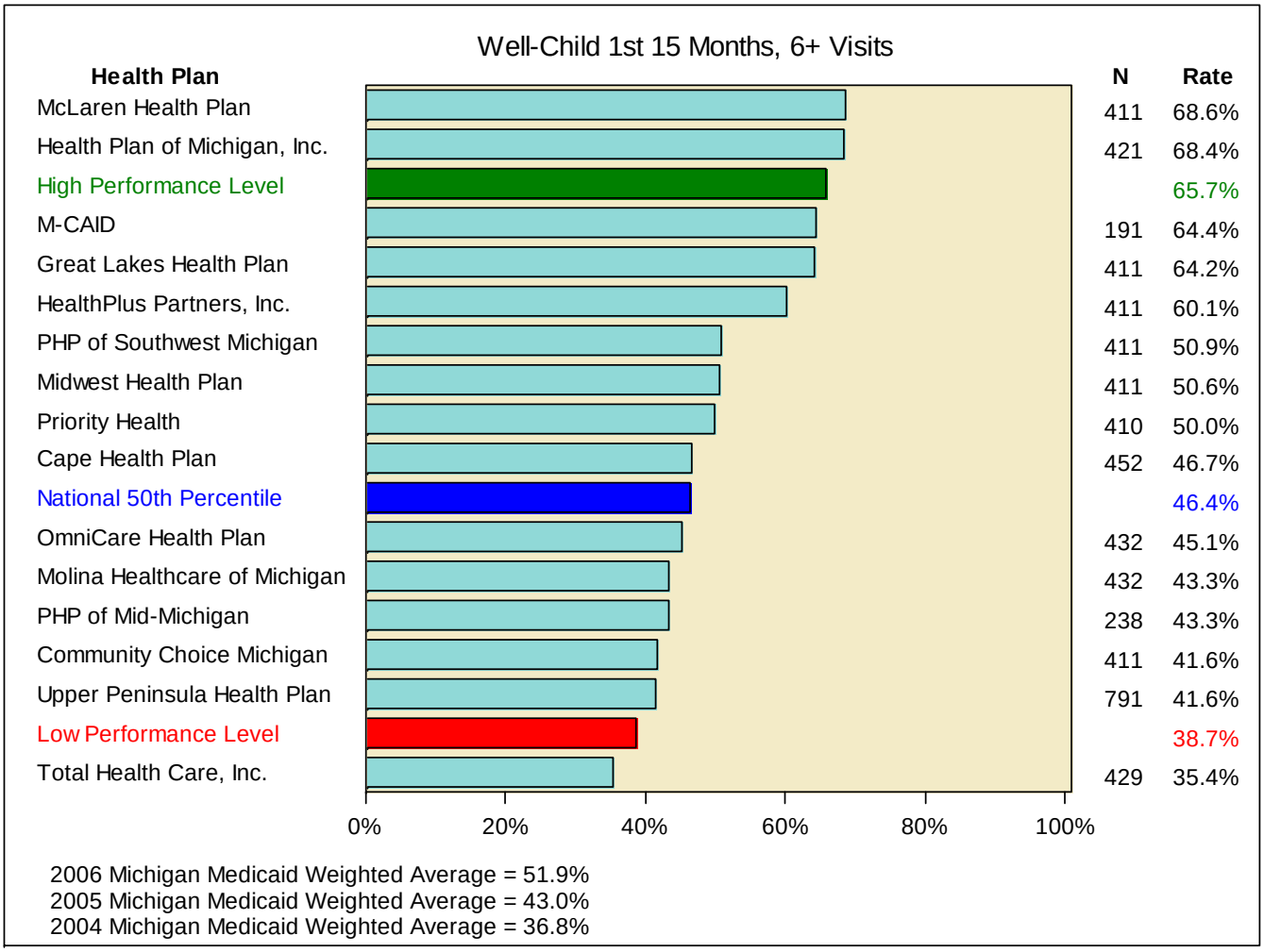
None of the health plans reported a rate that exceeded the HPL in 2005, and five health plans' rates were above the LPL. Overall, the range of reported rates showed considerable improvement from 2005 to 2006.

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 3-8—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Well-Child Visits in the First 15 Months of Life—Six or More Visits



Two health plans reported rates above the HPL of 65.7 percent, while one health plan had a rate below the LPL of 38.7 percent. A total of nine health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

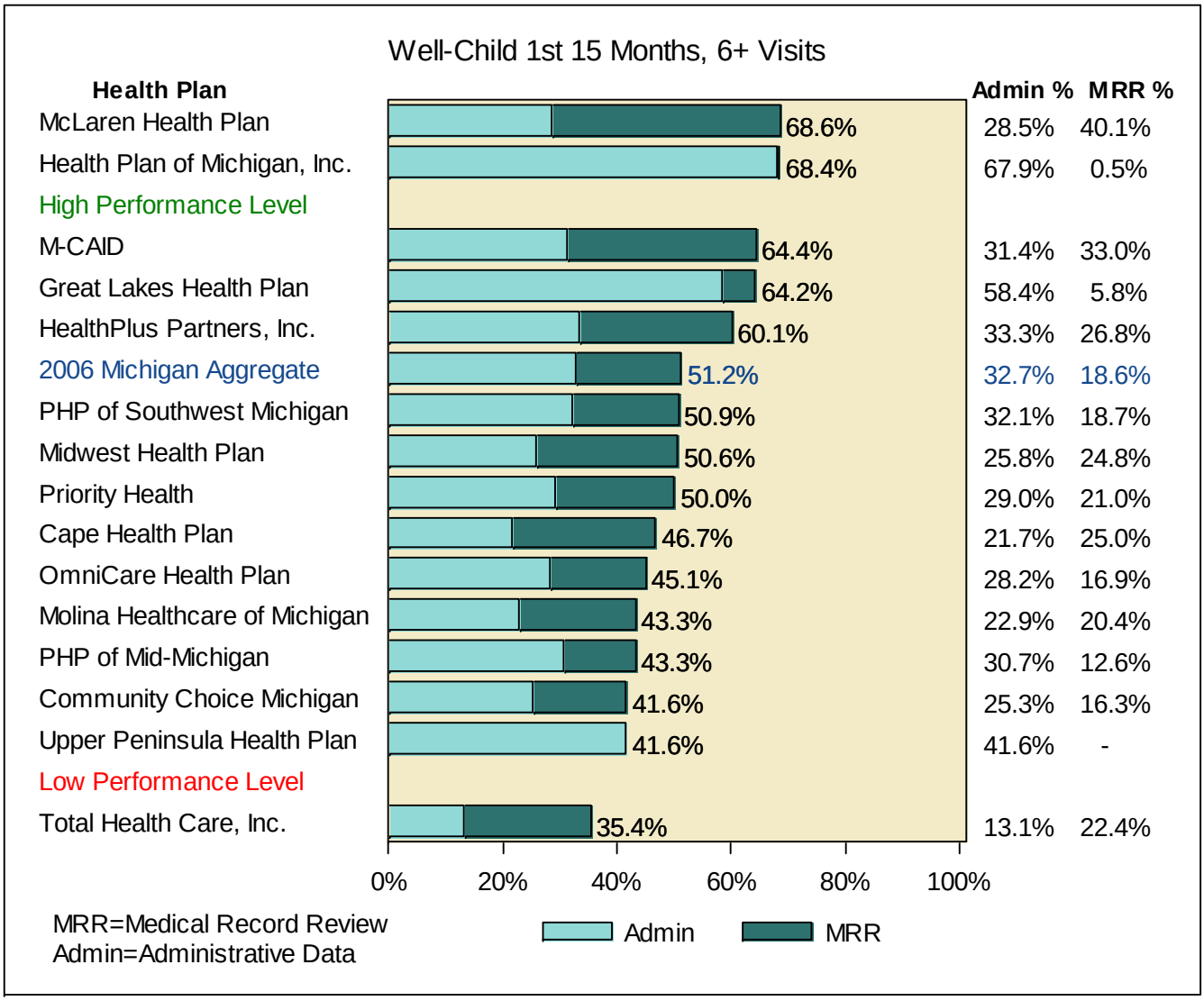
The 2006 Michigan Medicaid weighted average of 51.9 percent was 5.5 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 46.4 percent.

The 2006 Michigan Medicaid weighted average showed a statistically significant increase over 2005, up 8.9 percentage points. A gain of 15.1 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 36.8 percent.

In 2005, none of the health plans reported a rate above the HPL and three health plans had rates below the LPL. Overall, the range of reported rates showed substantial improvement from 2005 to 2006.

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

Figure 3-9—Michigan Medicaid HEDIS 2006
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: 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 Upper Peninsula Health Plan, all health plans elected to use the hybrid method. The 2006 Michigan aggregate administrative rate was 32.7 percent and the medical record review rate was 18.6 percent.

Overall results show that 63.9 percent of the aggregate rate was derived from administrative data and 36.3 percent from medical record review. In 2005, 63.3 percent of the aggregate rate was derived from administrative data.

Ten of the health plans that used the hybrid method derived at least half of their rates from administrative data.

Of note is Health Plan of Michigan's high performance based almost exclusively on administrative data. This measure is challenging when data collection uses only administrative sources due to the need to identify six separate numerator events to determine compliance.

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

AAP recommends annual well-child visits for 2- to 6-year-olds. These checkups 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 a child's communication skills and reduce language and learning problems.

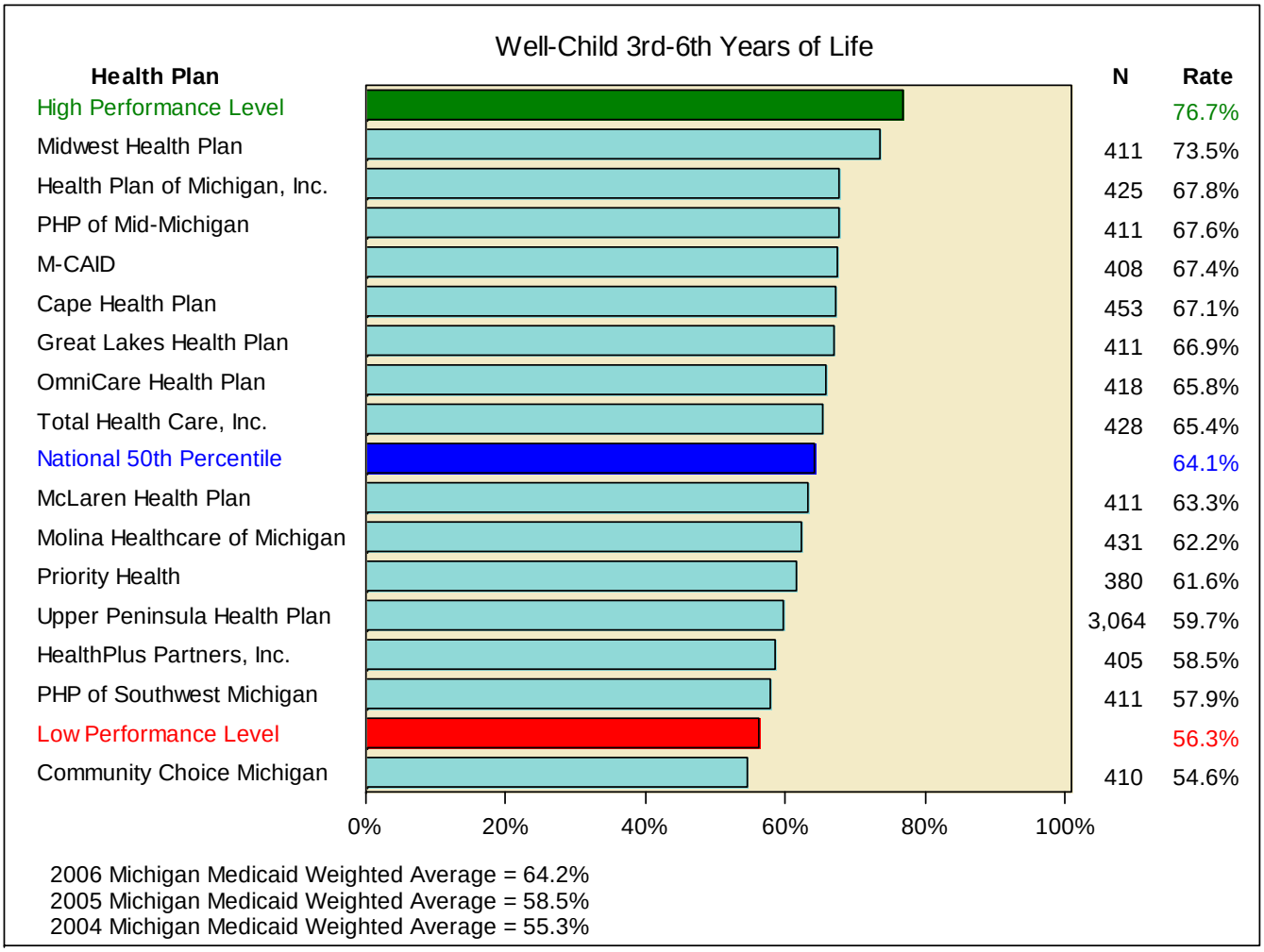
The following pages analyze the performance profile, health plan rankings, and data collection methodology used by the Michigan MHPs for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

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

This key measure, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, reports the percentage of members who were 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 3-10—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life



None of the health plans met the HPL of 76.7 percent, while one health plan reported a rate below the LPL of 56.3 percent. Eight of the health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

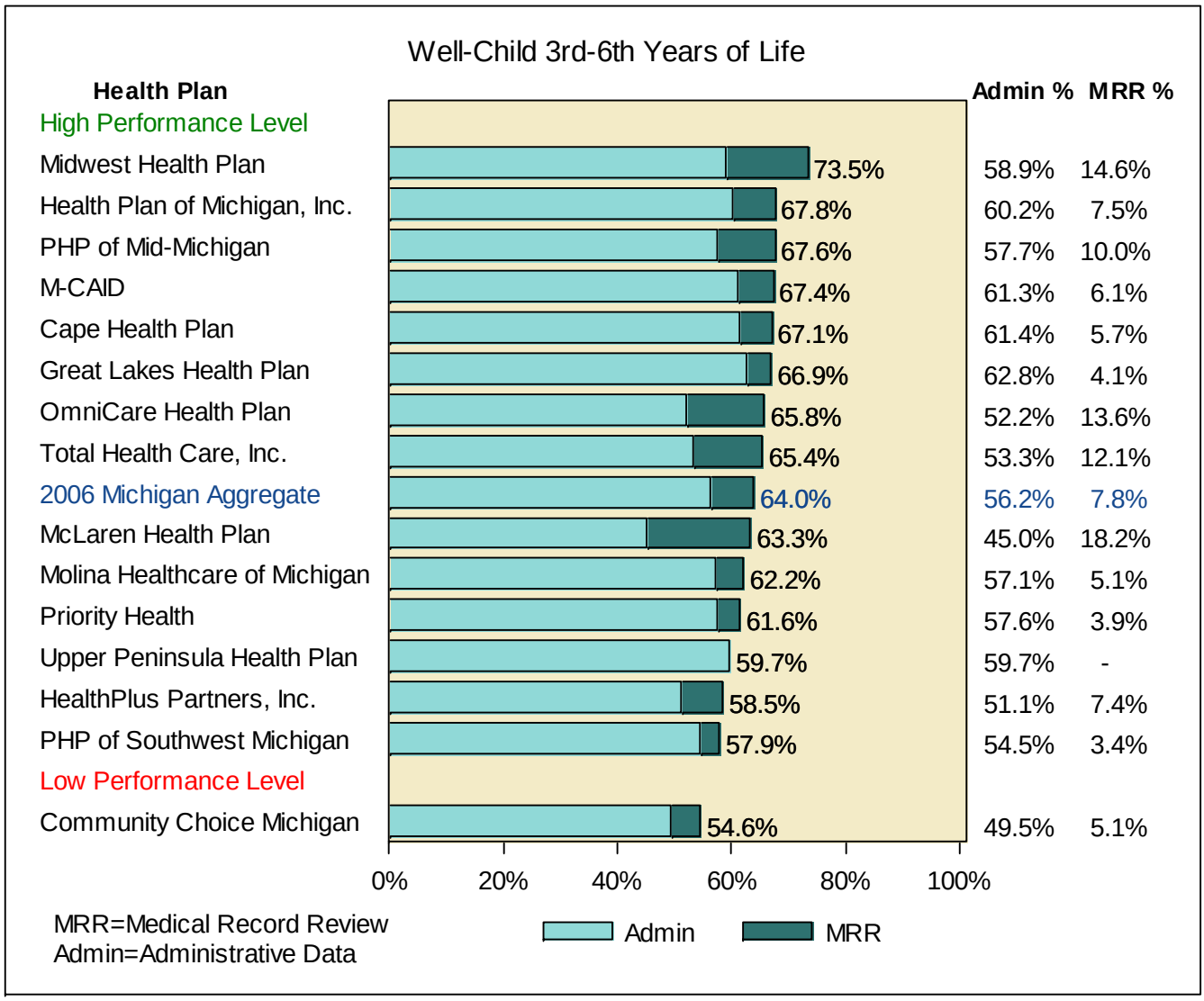
The 2006 Michigan Medicaid weighted average of 64.2 percent was 0.1 of a percentage point above the national HEDIS 2005 Medicaid 50th percentile of 64.1 percent.

The 2006 Michigan Medicaid weighted average showed a statistically significant increase over 2005, up 5.7 percentage points. A gain of 8.9 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 55.3 percent.

None of the health plans reached the HPL in 2005, while three health plans had rates below the LPL. Overall, the range of reported rates showed considerable improvement from 2005 to 2006.

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

Figure 3-11—Michigan Medicaid HEDIS 2006
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: 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 Upper Peninsula Health Plan, all health plans elected to use the hybrid method. The 2006 Michigan aggregate administrative rate was 56.2 percent and the medical record review rate was 7.8 percent.

The results show that 87.8 percent of the aggregate rate was derived from administrative data and 12.2 percent from medical record review. In 2005, 89.2 percent of the aggregate rate was derived from administrative data.

All of the health plans that used the hybrid method derived at least half of their rates from administrative data. Five plans increased their rates by 10 percentage points or more through medical record review.

Administrative data for this measure appeared to be relatively complete. This is likely due to the requirement for only one well-child visit per year for this age group. This may also be due to a focus by the health plans on more complete administrative data to decrease the need for medical record review, which is more costly and includes more stringent specifications for numerator compliance.

Adolescent Well-Care Visits

Unintentional injuries, homicide, and suicide are the leading causes of adolescent death. Sexually transmitted diseases (STDs), substance abuse, pregnancy, and antisocial behavior are important causes of physical, emotional, and social problems among adolescents. Promoting healthy adolescent development and behavioral choices has the potential to improve the health of adults as well as adolescents. The AMA Guidelines for Adolescent Preventive Services (GAPS), the federal government's Bright Futures program, and the AAP guidelines all recommend comprehensive annual health care visits for adolescents.

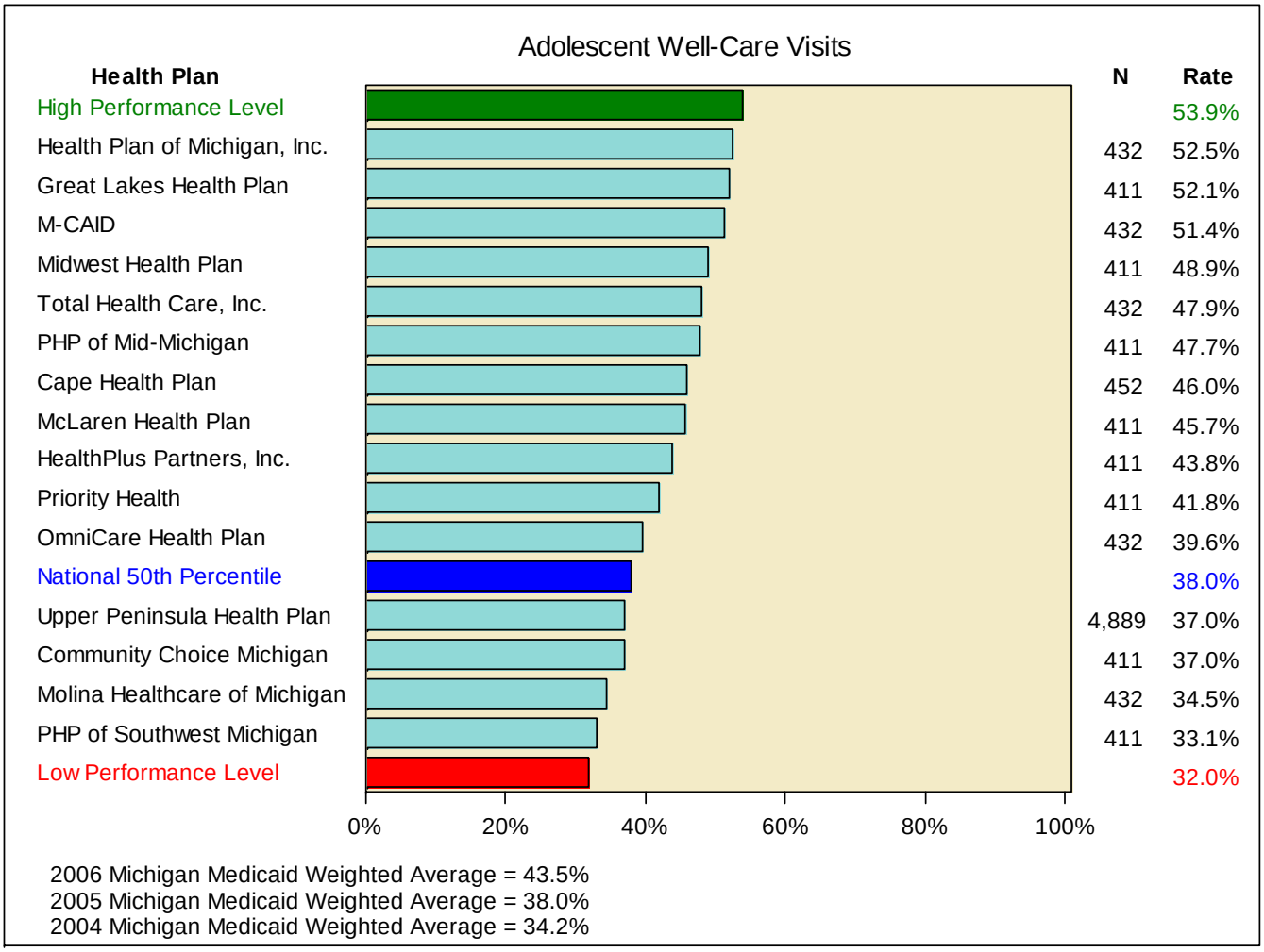
The following pages analyze the performance profile, health plan rankings, and data collection methodology used by the Michigan MHPs for *Adolescent Well-Care Visits*.

HEDIS Specification: Adolescent Well-Care Visits

This key measure reports the percentage of enrolled members who were 12 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 3-12—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Adolescent Well-Care Visits



None of the health plans met the HPL of 53.9 percent, and none of the health plans reported a rate below the LPL of 32.0 percent. Eleven of the health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

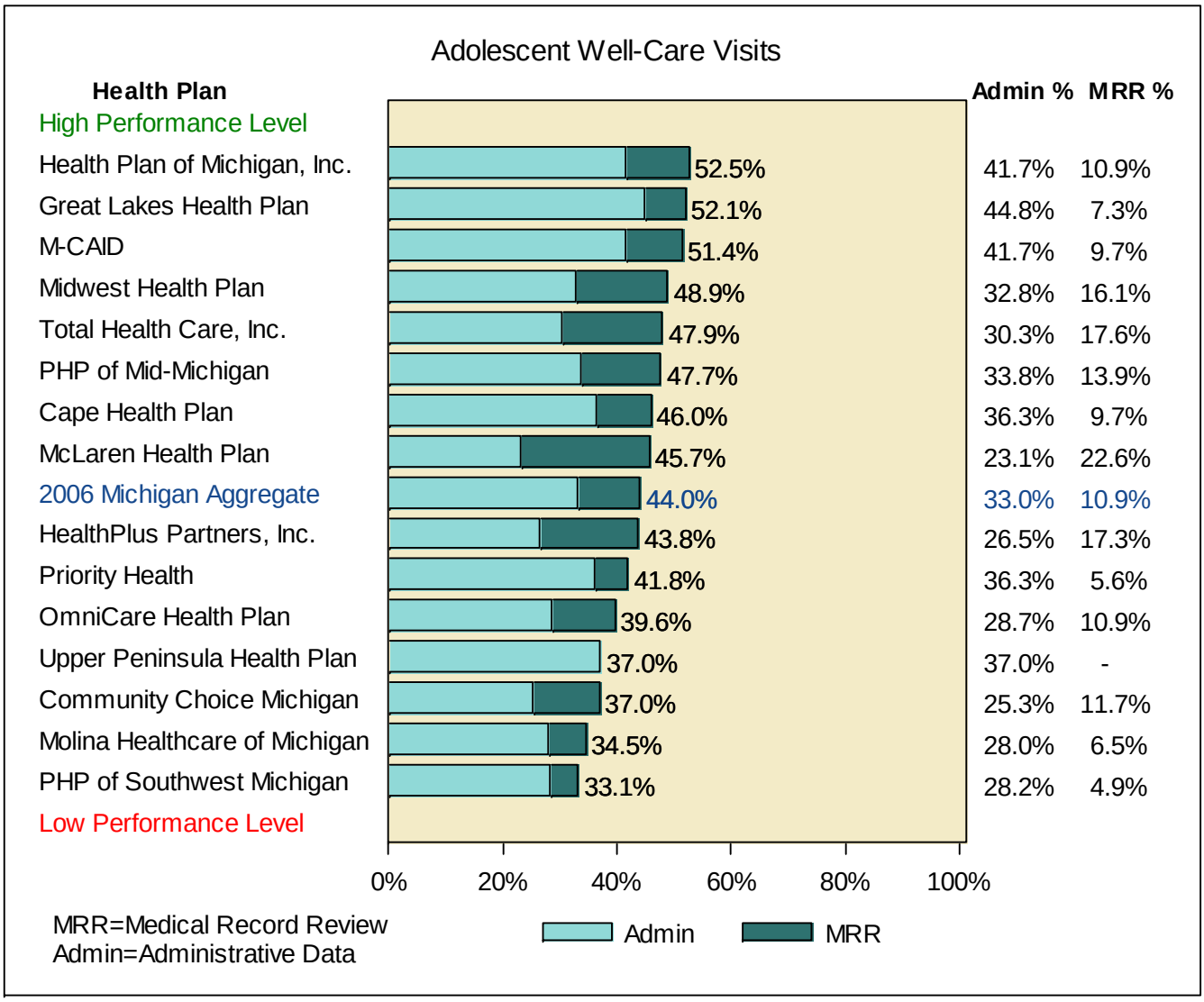
The 2006 Michigan Medicaid weighted average of 43.5 percent was 5.5 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 38.0 percent.

The 2006 Michigan Medicaid weighted average showed a statistically significant increase over 2005, up 5.5 percentage points. A gain of 9.3 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 34.2 percent.

None of the health plans reached the HPL in 2005, and none of the health plans had rates below the LPL. Overall, the range of reported rates showed notable improvement from 2005 to 2006.

Data Collection Analysis: Adolescent Well-Care Visits

Figure 3-13—Michigan Medicaid HEDIS 2006
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: Because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All health plans except Upper Peninsula Health Plan reported this measure using the hybrid method. The 2006 Michigan aggregate administrative rate was 33.0 percent and the medical record review rate was 10.9 percent.

The results demonstrate that 75.0 percent of the aggregate rate was derived from administrative data and 24.8 percent from medical record review. In 2005, 76.4 percent of the aggregate rate was derived from administrative data.

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

Again, administrative data appeared to be the most significant form of data collection, although there was still a need for more complete data.

Appropriate Treatment for Children With Upper Respiratory Infection

Overuse of antibiotics to treat viral infections continues to be a common concern across the health care industry today. The common cold (upper respiratory infection, or URI) is one of the top causes of school absenteeism, with most children having 6 to 10 colds per year.[3-12] The common cold is also the leading cause of doctors' visits for children, according to the National Institutes for Health. Antibiotics are not the recommended standard of practice for the treatment of the common cold; however, more than 50 million antibiotics are inappropriately prescribed for this condition.[3-13]

HEDIS Specification: Appropriate Treatment for Children With Upper Respiratory Infection

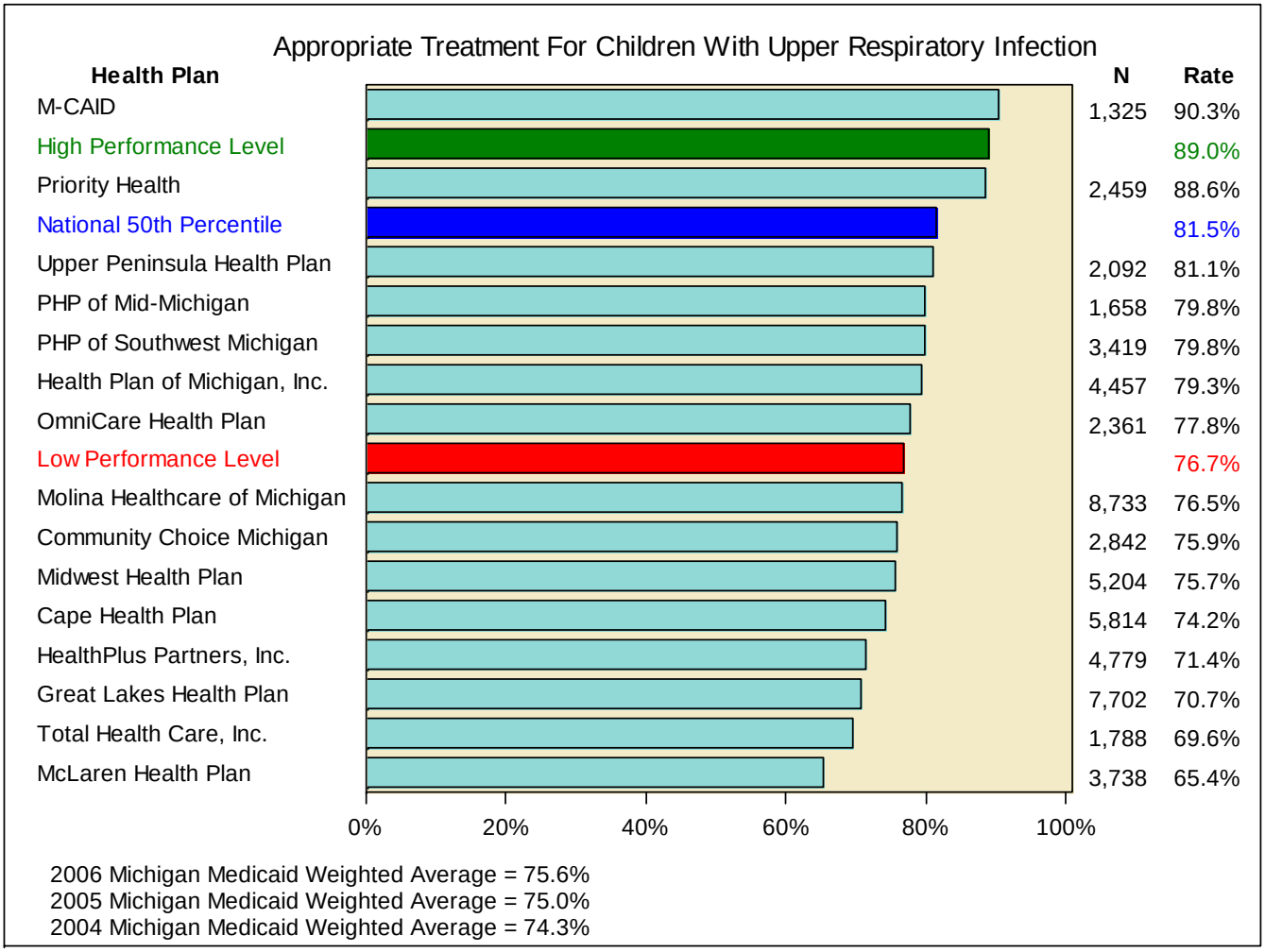
This key measure reports the percentage of enrolled members who were 3 months through 18 years of age during the measurement year, who were given a diagnosis of URI, and who were not dispensed an antibiotic prescription on or three days after the episode date.

[3-12] Mayo Foundation for Medical Education and Research. Children's Illness: Top 5 causes of missed school. Available at: http://www.mayoclinic.com/health/childrens-conditions/cc00059. Accessed on November 27, 2006.

[3-13] Yale Health Education. An Overview of the Cold and Flu. Available at: http://www.yau.edu/yhp/departments/health_ed/Coldoverview.htm. Accessed on October 17, 2006.

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

Figure 3-14—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Appropriate Treatment For Children With Upper Respiratory Infection



One of the health plans reported a rate that was above the HPL of 89.0 percent, while eight health plans had rates below the LPL of 76.7 percent. Two health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

The 2006 Michigan Medicaid weighted average of 75.6 percent was 5.9 percentage points below the national HEDIS 2005 Medicaid 50th percentile of 81.5 percent.

The 2006 Michigan Medicaid weighted average was slightly higher than in 2005, up 0.6 of a percentage point. A gain of 1.3 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 74.3 percent.

In 2005, none of the health plans reported rates above the HPL and four health plans had rates below the LPL. Although the number of health plans with rates below the LPL increased in 2006, overall, the range of reported rates showed moderate improvement from 2005 to 2006.

Appropriate Testing for Children With Pharyngitis

Pharyngitis, also known as a sore throat, occurs with a greater frequency in the pediatric population, most commonly between 4 and 7 years of age.[3-14] It has been estimated that children in the United States experience an average of five sore throats per year and one streptococcal infection every four years.[3-15] It has further been reported that pharyngitis accounts for 1.1 percent of visits in the primary care setting and is ranked in the top 20 reported primary diagnoses resulting in office visits.[3-16]

There are two types of pharyngitis: viral and bacterial. In children, 60 to 75 percent of pharyngitis cases are viral.[3-17] Because antibiotics do not cure viral infections, a proper viral or bacterial diagnosis is important to treating the condition. The overuse of antibiotics can instead increase the number of drug-resistant forms of bacteria, which can later be difficult to treat. To make a proper diagnosis of a bacterial virus such as Group A streptococcal pharyngitis (GABHS), appropriate laboratory tests should be used. Strep throat, which is caused by GABHS, can be treated with antibiotics. Treatment for viral pharyngitis include throat lozenges, increased fluid intake, and acetaminophen (for pain).[3-18]

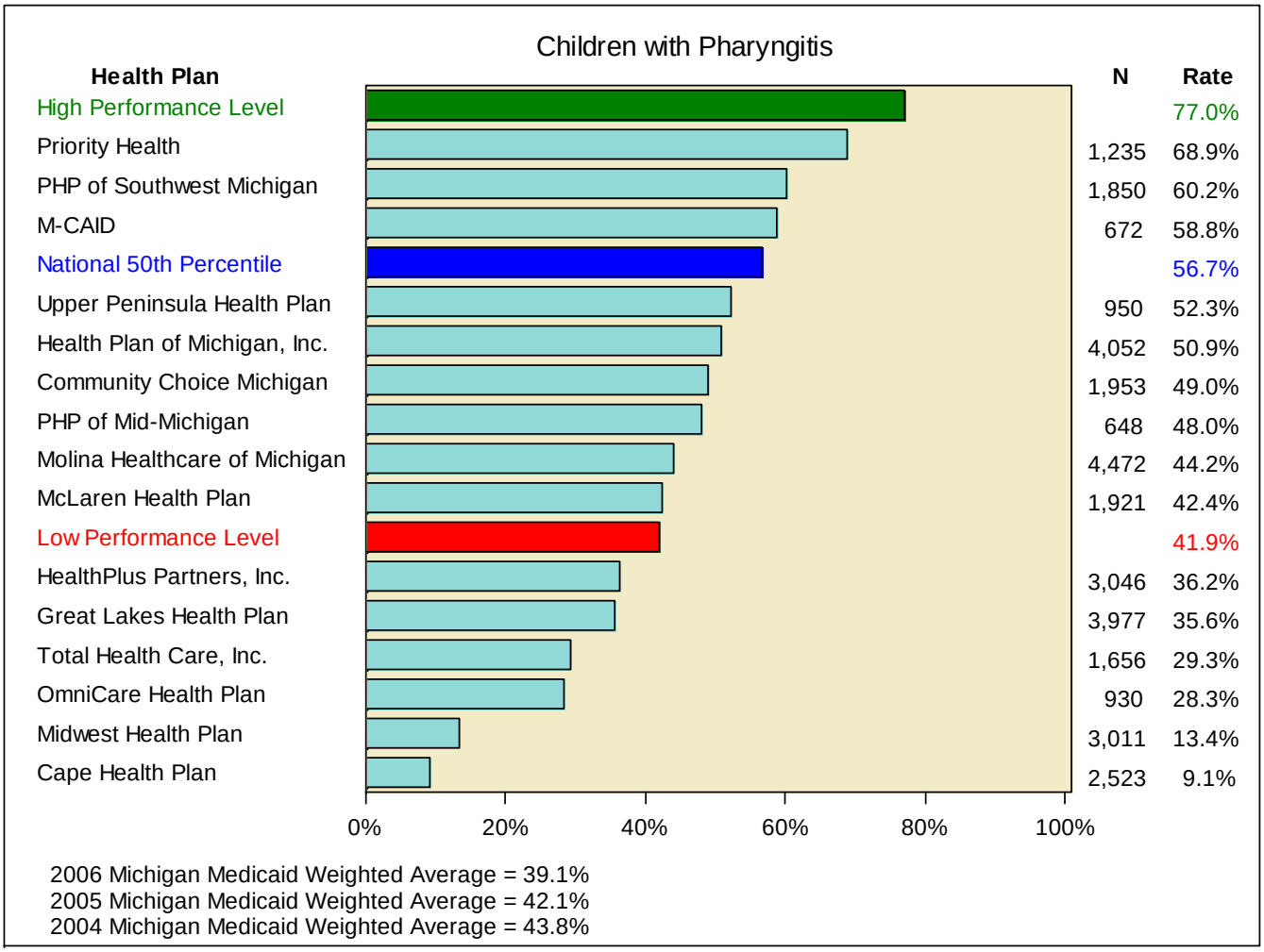
HEDIS Specification: Appropriate Testing for Children With Pharyngitis

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

[3-14] emedicine. Pharyngitis. Available at: http://www.emedicine.com/emerg/topic419.htm. Accessed on August 9, 2006.
[3-15] Pulmonology Channel. Pharyngitis. Available at: http://www.pulmonologychannel.com/pharyngitis/. Accessed on August 9, 2006.
[3-16] Cherry DK, Woodwell DA. National Ambulatory Medical Care Survey: 2000 summary. Adv Data 2002;328:1-32.
[3-17] Michigan Quality Improvement Consortium. Acute pharyngitis in children. Southfield (MI): Michigan Quality Improvement Consortium; 2004 Apr. 1 p.
[3-18] Children's Hospital of Michigan. Pharyngitis and Tonsillitis. Available at: http://www.chmkids.org/healthlibrary/default.aspx?pageid=P02069&pt=Pharyngitis%20and%20Tonsillitis. Accessed on August 9, 2006.

Health Plan Ranking: Appropriate Testing for Children With Pharyngitis

Figure 3-15—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Appropriate Testing for Children With Pharyngitis



None of the health plans reported a rate that was above the HPL of 77.0 percent, while six health plans had rates below the LPL of 41.9 percent. Three health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

The 2006 Michigan Medicaid weighted average of 39.1 percent was 17.6 percentage points below the national HEDIS 2005 Medicaid 50th percentile of 56.7 percent.

The 2006 Michigan Medicaid weighted average was lower than in 2005, down 3.0 percentage points. A decrease of 4.7 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 43.8 percent.

Pediatric Care Findings and Recommendations

In the Pediatric Care dimension, notable improvements and strong performance were observed for a majority of the pediatric-related measures. Of the nine individual measures within this dimension, five showed statistically significant improvement in the 2006 Michigan Medicaid weighted averages when compared with the 2005 results. The range of rates (the variance in performance across the MHPs) also improved, indicating that the lower-performing MHPs are decreasing the gap between the high and low performers. Although some stagnant performance was observed in one specific area of pediatric care, these measures present very actionable opportunities to improve results and outcomes.

Continued improvement was seen across the Michigan MHPs in the area of immunizations, specifically in the immunization status of 2-year-old children. The *Childhood Immunization Status—Combination #2* weighted average demonstrated a statistically significant improvement despite already strong performance in 2005. More MHPs exceeded the national Medicaid 90th percentile, and the lowest reported rate was more than 5 percentage points above the national Medicaid 50th percentile.

The weighted average for *Childhood Immunization Status—Combination #3,* a new indicator in 2006, was established as a baseline result of 38.5 percent for the Michigan MHPs, with a wide range of rates noted. National performance data will not be available until 2007 for this measure.

Improvement was also seen in the *Adolescent Immunization Status—Combination #2* measure, although the improvement was not statistically significant. An area of concern with this measure is the reduction in the number of MHPs that exceeded the HPL when compared with the 2005 results.

In the area of well-care visits, all of the weighted averages for the four reported measures demonstrated statistically significant improvement. Positive movement was seen across the measures, with more MHPs exceeding the HPL and less performing below the LPL. In addition, the range of rates improved, indicating that the State as a whole is focusing efforts on high performance.

Misuse of antibiotics is an area that offers an opportunity for improvement for the Michigan MHPs. The weighted average for the two measures that assess this area (*Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis*) either remained stagnant or declined. For the *Appropriate Treatment for Children With Upper Respiratory Infection* measure, eight MHPs reported a rate below the LPL and the weighted average fell below the national Medicaid 25th percentile. For the *Appropriate Testing for Children With Pharyngitis* measure, the weighted average also fell below the 25th percentile, declined by 3 percentage points, and a very wide range of rates was noted.

Given the strong and continually improving MHP performance in the immunization- and well-child-related measures, HSAG recommends that the MHPs continue existing improvement efforts, which have proven to be effective. Improvement efforts and interventions should be made for the *Adolescent Immunization Status—Combination #2,* which did not show statistically significant improvement. Emphasis on ensuring that all providers submit their data to the MCIR should be

maintained. MDCH's performance bonus program, which supports and encourages high performance and innovation, should be routinely evaluated and adjusted as performance levels rise.

Collective focus should be made toward improving performance in the *Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis* measures. Improvement efforts for these two measures can be clearly defined and easily actionable. Provider education on the measures' components and appropriate prescribing practices should be implemented by the MHPs. In addition, each MHP should perform additional analysis of the noncompliant cases stratified by provider group or individual providers. Furnishing poor-performing providers with their specific data at the member level can be a powerful tool to improve performance. In addition, comparing providers to their peers can also be very effective. Finally, arranging for the high-performing MHPs to share their best practices and discuss lessons learned in an open forum should be considered.

Introduction

This section of the report addresses how well Michigan MHPs are performing to ensure that women 16 to 64 years of age are screened early for cancer and 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 MHPs' 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 212,920 new cases of breast cancer and 40,970 deaths from breast cancer in 2006.[4-1] The American Cancer Society estimates that in 2006, 7,070 new cases of breast cancer will be diagnosed among women in Michigan, 140 cases less than the previous year.[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 97 percent.[4-4] A mammogram is the most effective method for detecting breast cancer in the early stages, when it is most treatable and can detect breast cancer an average of 1.7 years before the patient can feel a breast lump. Timely mammogram screening can reduce the mortality rate among women 40 years and older by 16 percent compared with those who are not screened.[4-5] In 2004, approximately 64 percent of Michigan women 40 years of age and older reported having a mammogram in the past year.[4-6] Screening costs are low relative to the benefits of early detection. Direct medical costs associated with treating breast cancer exceed $6 billion annually. It costs $10,000 to $15,000 to treat breast cancer when detected early compared with $60,000 to $145,000 when it is detected in more advanced stages.[4-7]

HEDIS Specification: Breast Cancer Screening

The *Breast Cancer Screening* measure is reported using only the administrative method. The *Breast Cancer Screening* measure calculates the percentage of women 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, Cancer Facts & Figures 2006. Available at: http://www.cancer.org/downloads/STT/CAFF2006PWSecured.pdf. Accessed on June 20, 2006.

[4-2] Ibid.

[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, 2003 Program Fact Sheet May 2004. Available at: http://www.cdc.gov/cancer/nbccedp/about.htm#facts. Accessed on June 20, 2006.

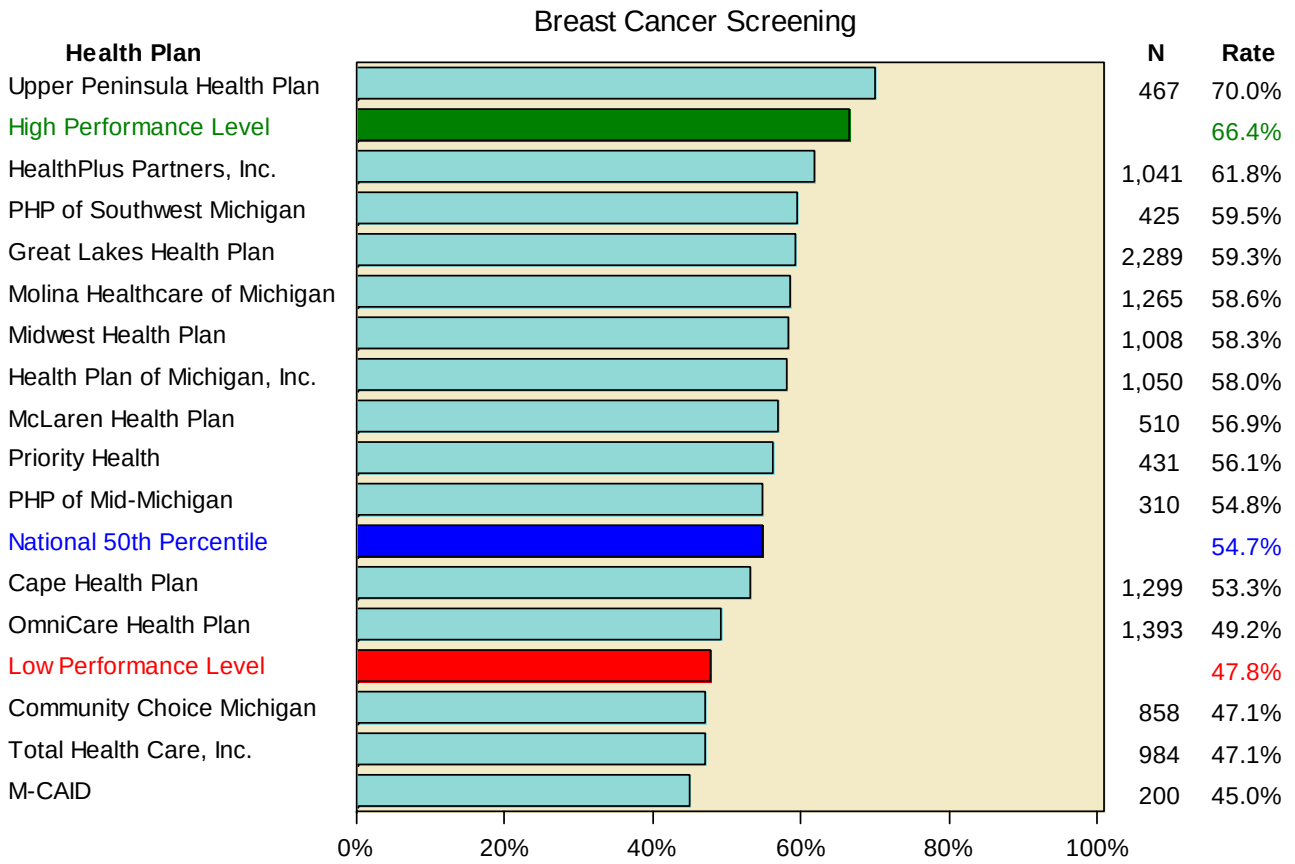
[4-5] Ibid.

[4-6] Michigan Cancer Consortium, Special Cancer Risk Factor Survey 2004. Available at: http://www.michigancancer.org/PDFs/MCCReports/MCCReports-SCBRFS-2004-012606.pdf. Accessed on June 27, 2006.

[4-7] Medical Technology Web site. Breast Cancer Medical Technologies for Detection & Treatment. Available at: http://www.advamed.org/VOT/savinglives/breastcancer.shtml. Accessed on July 5, 2006.

Health Plan Ranking: Breast Cancer Screening

Figure 4-1—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Breast Cancer Screening



One health plan reported a rate above the HPL of 66.4 percent, while three health plans had rates below the LPL of 47.8 percent. A total of 10 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

The 2006 Michigan Medicaid weighted average of 55.8 percent was 1.1 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 54.7 percent.

The 2006 Michigan Medicaid weighted average showed an increase in 2006 over 2005, up 2.1 percentage points. A gain of 1.2 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 54.6 percent.

In 2005, one health plan reported a rate that met the HPL and five had rates below the LPL. While fewer health plans reported rates below the LPL in 2006, overall, the range of reported rates showed little improvement in 2006.

Cervical Cancer Screening

When detected early, cervical cancer has a high treatment success rate. Since the incidence of cervical cancer increases with age, it is important that women continue to have screenings even when earlier tests have been negative. Almost 95 percent of Michigan women 18 years of age and older have received at least one Pap smear during their lifetimes. Approximately 83 percent of Michigan women 18 years of age and older have received a Pap smear within the past three years.[4-8] The American Cancer Society estimates that in 2006, 260 new cases of cervical cancer will be diagnosed among women in Michigan.[4-9] With screening, a woman's lifetime risk of cervical cancer is estimated to be only 0.7 of a percentage point.[4-10]

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.

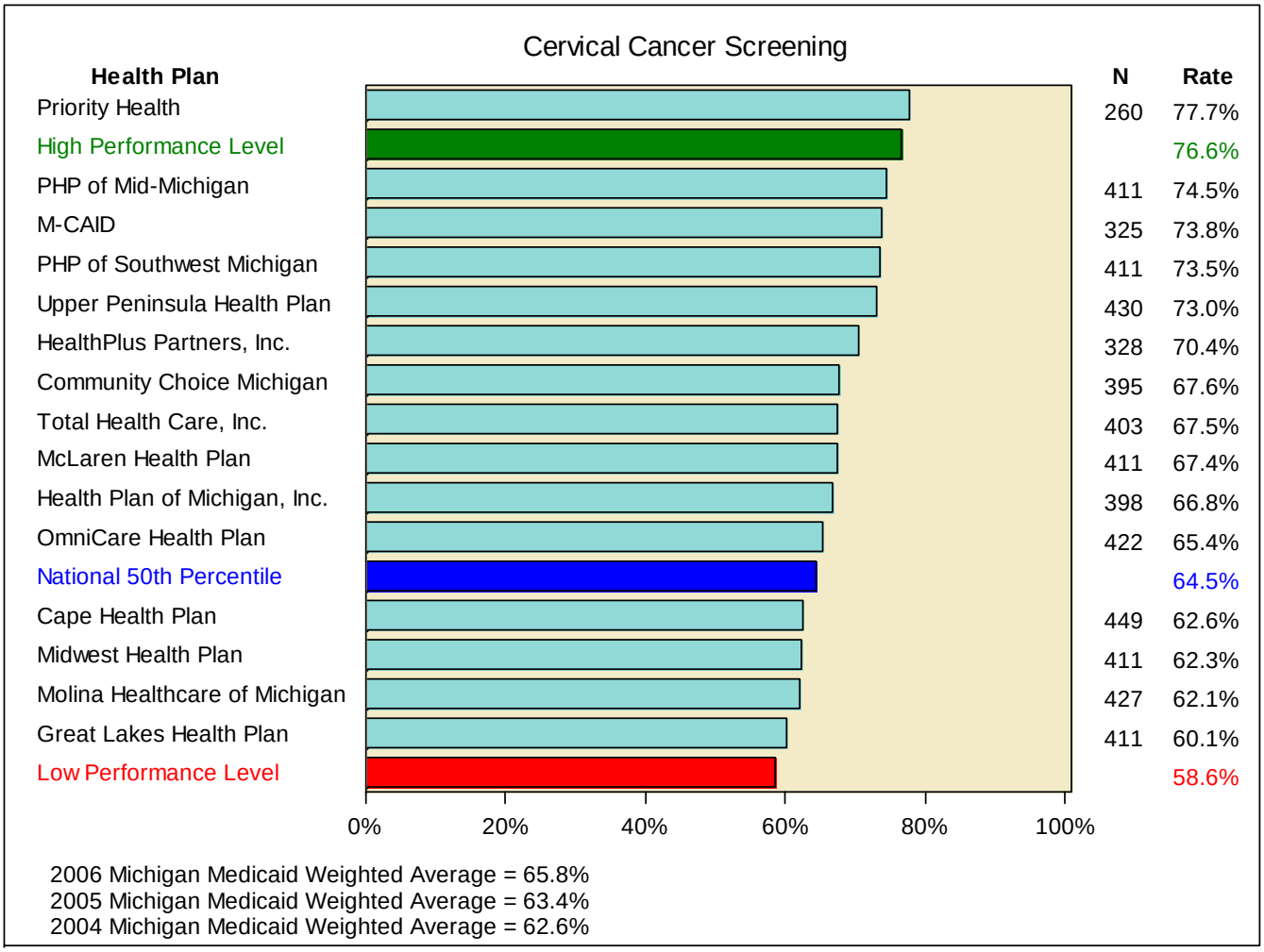
[4-8] Michigan Department of Community Health: Facts about Cervical Cancer December 2005. Available at: http://www.michigan.gov/documents/CervicalFacts_6648_7.pdf. Accessed on June 20, 2006.

[4-9] American Cancer Society, Cancer Facts & Figures 2006. Available at: http://www.cancer.org/downloads/STT/CAFF2006f4PWSecured.pdf. Accessed on June 20, 2006

[4-10] National Committee for Quality Assurance. *The State of Health Care Quality*. 2004 (Standard Version) Washington, DC: National Committee for Quality Assurance; 2004:28.

Health Plan Ranking: Cervical Cancer Screening

Figure 4-2—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Cervical Cancer Screening



One health plan exceeded the HPL of 76.6 percent, while none of the health plans reported rates below the LPL of 58.6 percent. Eleven of the 15 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

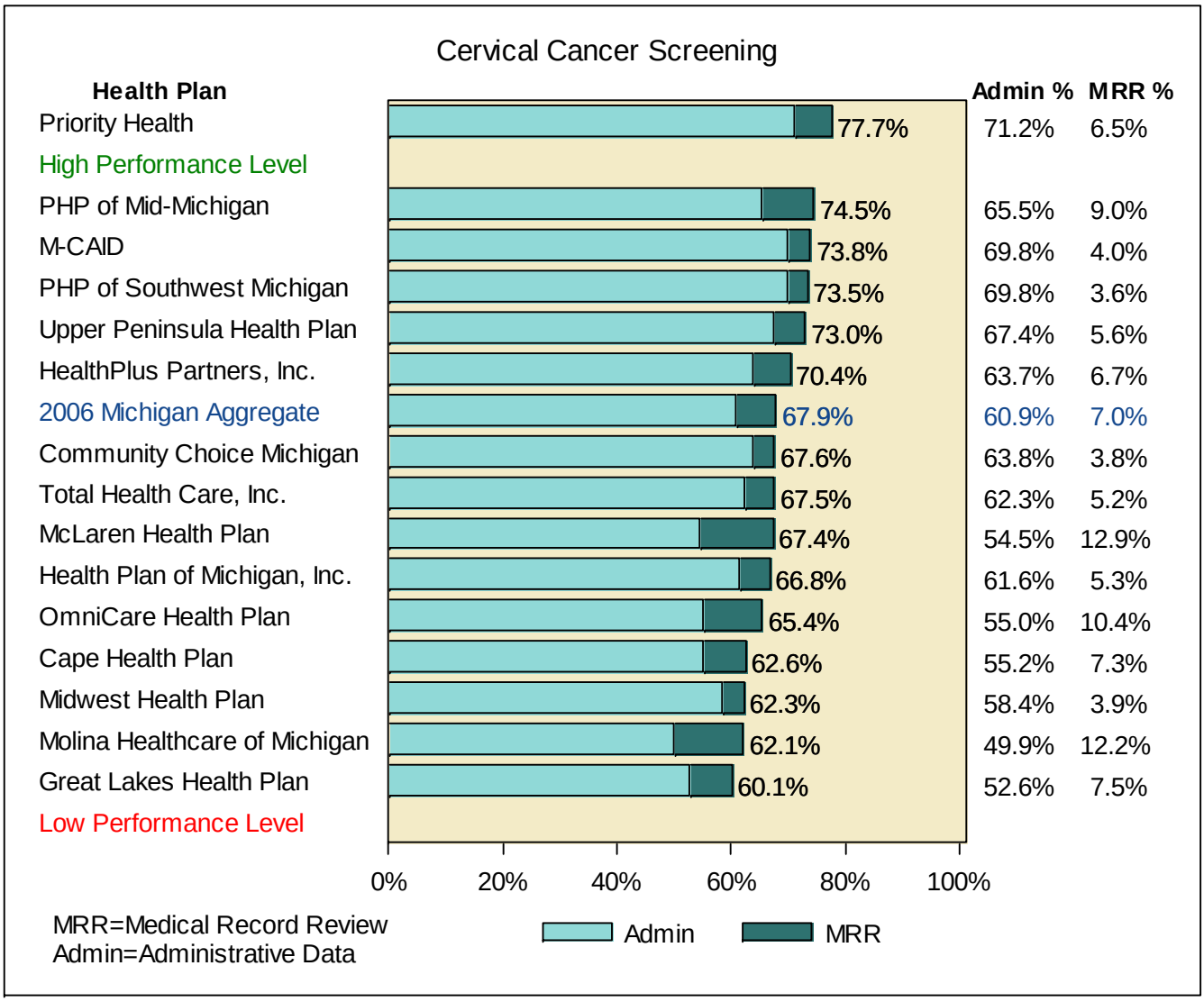
The 2006 Michigan Medicaid weighted average of 65.8 percent was 1.3 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 64.5 percent.

The 2006 Michigan Medicaid weighted average showed improvement from 2005, up 2.4 percentage points. A gain of 3.2 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 62.6 percent.

One health plan reached the HPL in 2005, while none of the health plans had rates below the LPL. Overall, the range of reported rates did not show notable improvement in 2006.

Data Collection Analysis: Cervical Cancer Screening

Figure 4-3—Michigan Medicaid HEDIS 2006
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: 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 15 Michigan MHPs reported this measure using the hybrid method. The 2006 Michigan aggregate administrative rate was 60.9 percent and the medical record review rate was 7.0 percent.

The results indicate that 89.7 percent of the aggregate rate was derived from administrative data and 10.3 percent from medical record review. In 2005, 90.4 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. Three health plans increased their overall rates by more than 10 percentage points through medical record review.

Analysis of the findings indicates that the health plans' administrative data for the *Cervical Cancer Screening* measure was relatively complete. However, health plans that derived more than 10 percent of their numerator events from medical record review should focus efforts on improving administrative data completeness.

Chlamydia Screening in Women

There are approximately 3 million new cases of chlamydia annually, making it the most common STD in the United States. Chlamydia can be successfully treated with antibiotics; however, when untreated, chlamydia increases the risk for pelvic inflammatory disease (PID), infertility, ectopic pregnancy, and HIV infection. Because most women who are infected have no obvious symptoms, screening is important for early detection. Chlamydia screening programs have successfully decreased the incidence of chlamydia and PID in young women by 60 percent.[4-11]

In 2004, 12,171 cases were reported among Michigan women 20 to 24 years of age, an increase of 2,683 new cases since 2003. In addition, this represents approximately 37 percent of the 32,625 reported cases of Michigan women with chlamydia in 2004.[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.

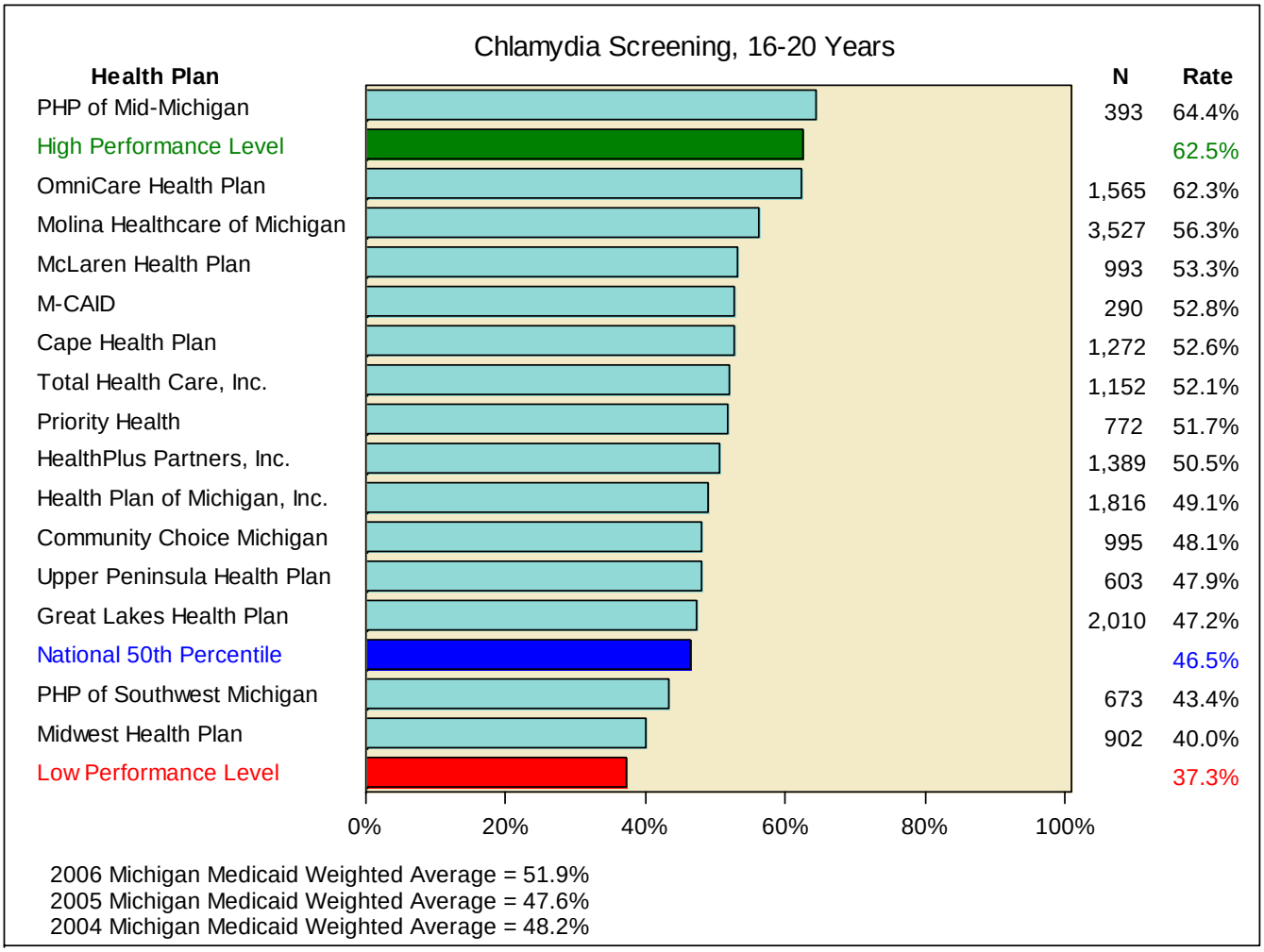
The *Chlamydia Screening in Women—Combined Rate* reports the sum of both groups, i.e., the two numerators divided by the sum of the denominators. Therefore, the *Chlamydia Screening in Women—Combined Rate* reports the percentage of women aged 16 through 25 years who were sexually active, who were continuously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

[4-11] National Committee for Quality Assurance. *The State of Health Care Quality, 2004* (Standard Version). Washington, DC: National Committee for Quality Assurance; 2004:30.

[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/SD04ST4A.ASP. Accessed on September 13, 2005.

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

Figure 4-4—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Chlamydia Screening in Women—Ages 16 to 20 Years



One health plan had a rate above the HPL of 62.5 percent, while none of the health plans reported a rate below the LPL of 37.3 percent. A total of 13 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

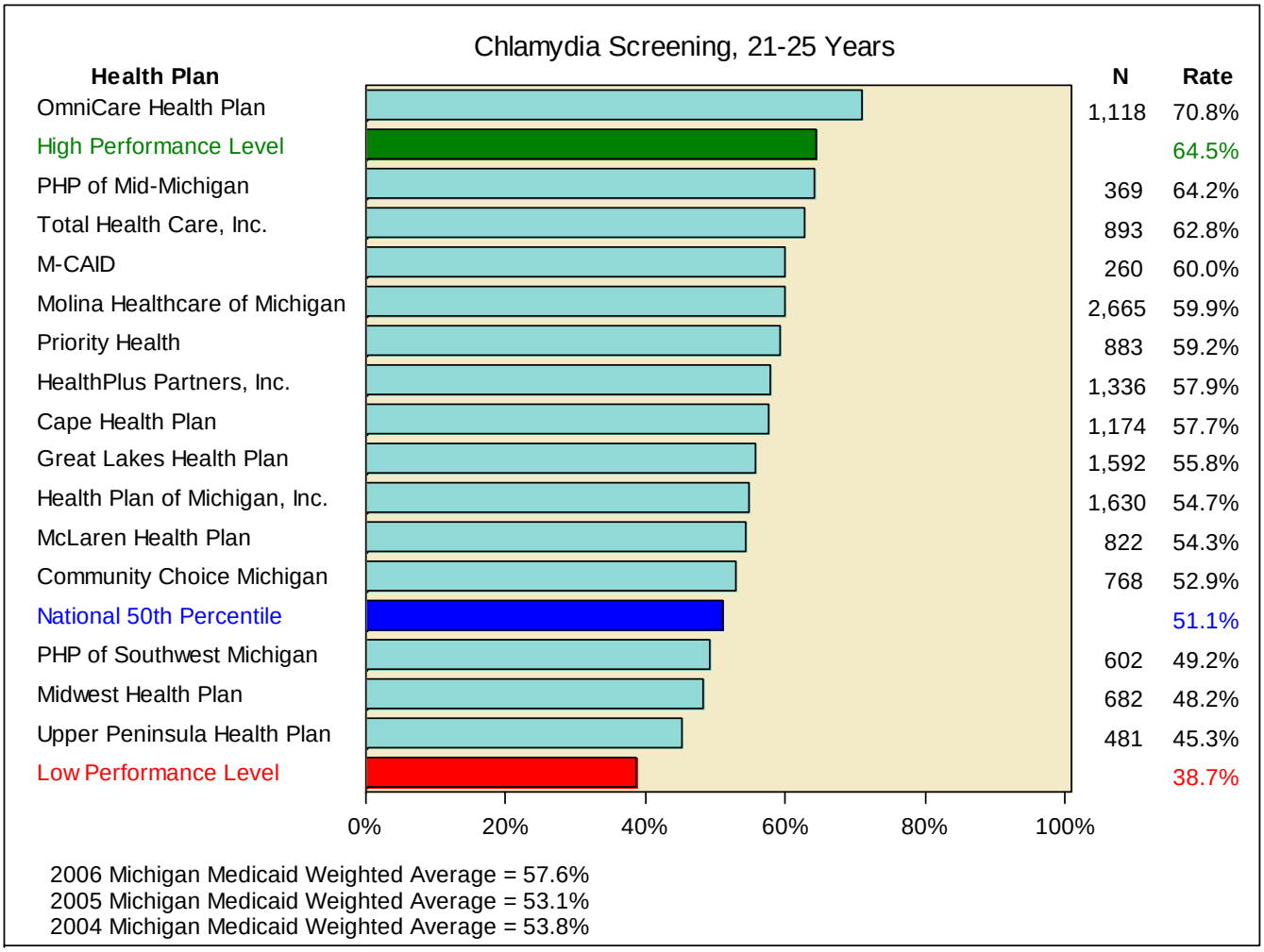
The 2006 Michigan Medicaid weighted average of 51.9 percent was 5.4 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 46.5 percent.

The 2006 Michigan Medicaid weighted average showed an improvement from 2005, up by 4.3 percentage points. A gain of 3.7 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 48.2 percent.

In 2005, one health plan reported a rate above the HPL and one health plan had a rate below the LPL. Overall, the range of reported rates showed minimal improvement in 2006 compared with 2005.

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

Figure 4-5—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Chlamydia Screening in Women—Ages 21 to 25 Years



One health plan had a rate above the HPL of 64.5 percent, while none of the health plans had reported rates below the LPL of 38.7 percent. A total of 12 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

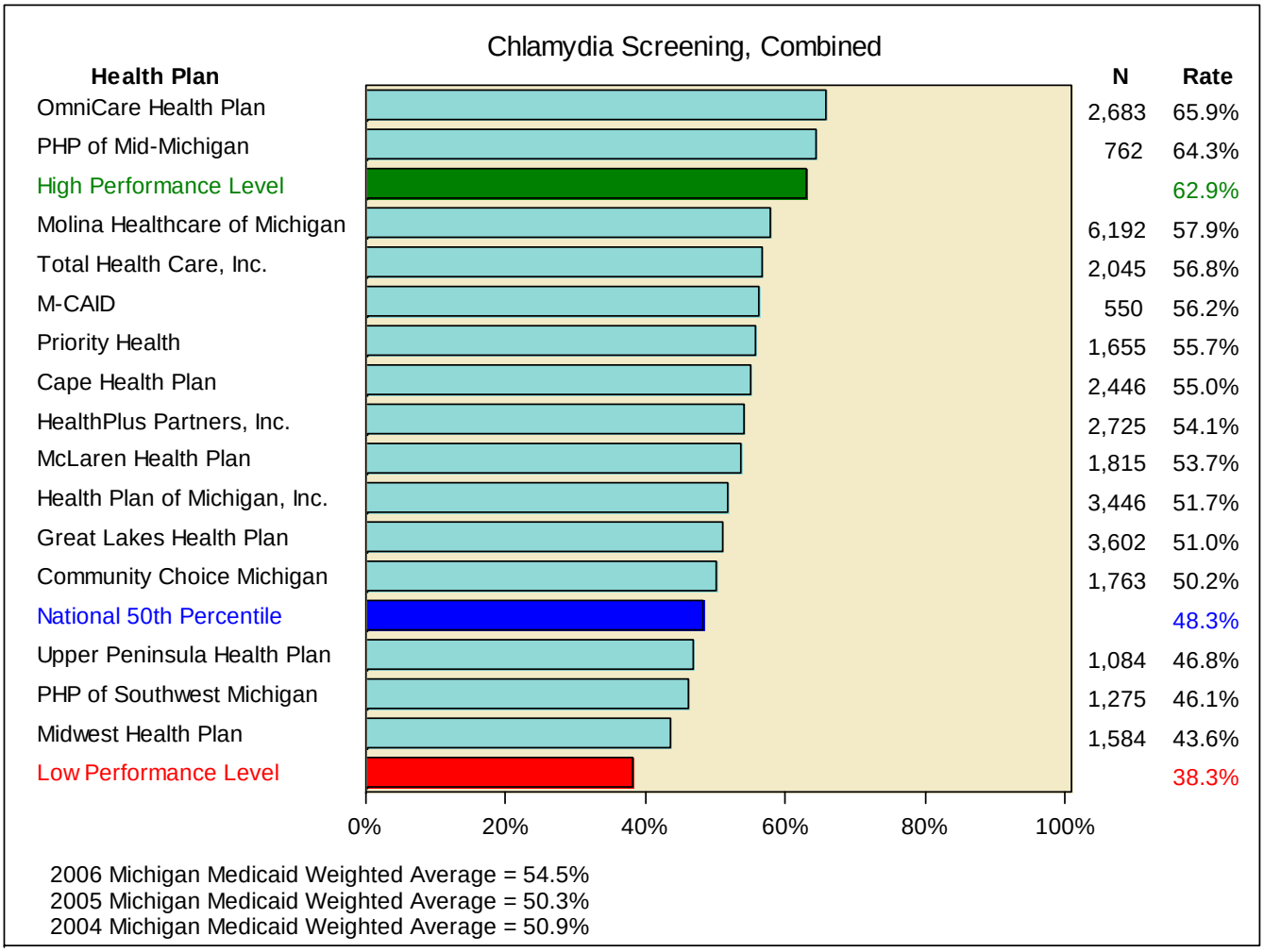
The 2006 Michigan Medicaid weighted average of 57.6 percent was 6.5 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 51.1 percent.

The 2006 Michigan Medicaid weighted average showed an increase from 2005, up 4.5 percentage points. A gain of 3.8 percentage points was observed when compared with the 2004 Michigan Medicaid weighted average of 53.8 percent.

Three health plans reported rates above the HPL in 2005, and none of the health plans had rates below the LPL. Overall, the range of reported rates demonstrated notable improvement in 2006 compared with 2005.

Health Plan Ranking: Chlamydia Screening in Women—Combined Rate

Figure 4-6—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Chlamydia Screening in Women—Combined Rate



Two health plans had rates above the HPL of 62.9 percent, while none of the health plans reported rates below the LPL of 38.3 percent. A total of 12 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

The 2006 Michigan Medicaid weighted average of 54.5 percent was 6.2 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 48.3 percent.

The 2006 Michigan Medicaid weighted average showed an increase from 2005, up 4.2 percentage points. A gain of 3.6 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 50.9 percent.

One health plan reported a rate above the HPL in 2005 and one of the health plans had a rate below the LPL. Overall, there was moderate improvement in the range of reported rates from 2005 to 2006.

Prenatal and Postpartum Care

There are nearly 4 million births annually in the United States. Three hundred thousand of these infants (nearly 6 percent) are born weighing less than five pounds. Infants born with a low birth weight are at an increased risk for neuron developmental handicaps, congenital abnormalities, and respiratory illness compared with infants with a normal birth weight.[4-13] However, studies suggest that adequate prenatal care, including initiating care in the first trimester and receiving regular care until delivery, can result in fewer birth complications and healthier babies (i.e., a reduction in low birth weight and infant mortality). In fact, it was found that women who did not receive adequate prenatal care experienced infant mortality rates nearly three times as high as women receiving adequate prenatal care.

In 2004, 8.4 percent of Michigan infants were born with a low birth weight, and for every 1,000 Michigan live births, approximately eight infants died before 1 year of age.[4-14] In 2004, the infant mortality rate was 7.6 per 1,000, and the disparity between different racial groups continues to be observed.[4-15] In 2004, the infant mortality rate for African Americans was 17.3 per 1,000 live births, while for whites it was 5.2 per 1,000 live births.[4-16]

Although care strategies tend to focus on prenatal care, the postpartum period can be a critical time for preventing complications and death after pregnancy. In fact, more than 60 percent of maternal deaths occur during the postpartum period.[4-17] Observational studies have shown that women with more post delivery visits have lower maternal, fetal, and neonatal illness and mortality.[4-18]

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 giving rise to the MDCH key measures:

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

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

The *Timeliness of Prenatal Care* measure calculates the percentage of women who delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year, who were continuously enrolled at least 45 days prior to delivery through 56 days after delivery, and who received a prenatal care visit as 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 Health Care Quality, 2005*. Standard Version. Washington, DC: National Committee for Quality Assurance; 2005:49.

[4-14] Vital Records & Health Data Development Section, Michigan Department of Community Health 2004. Available at: http://www.mdch.state.mi.us/pha/osr/natality/tab1.10.asp. Accessed on June 22, 2006.

[4-15] United Health Foundation. America's Health: State Health Rankings, 2004 Edition. Available at: http://www.unitedhealthfoundation.org/shr2004/components/infantmortality.html. Accessed on November 27, 2006.

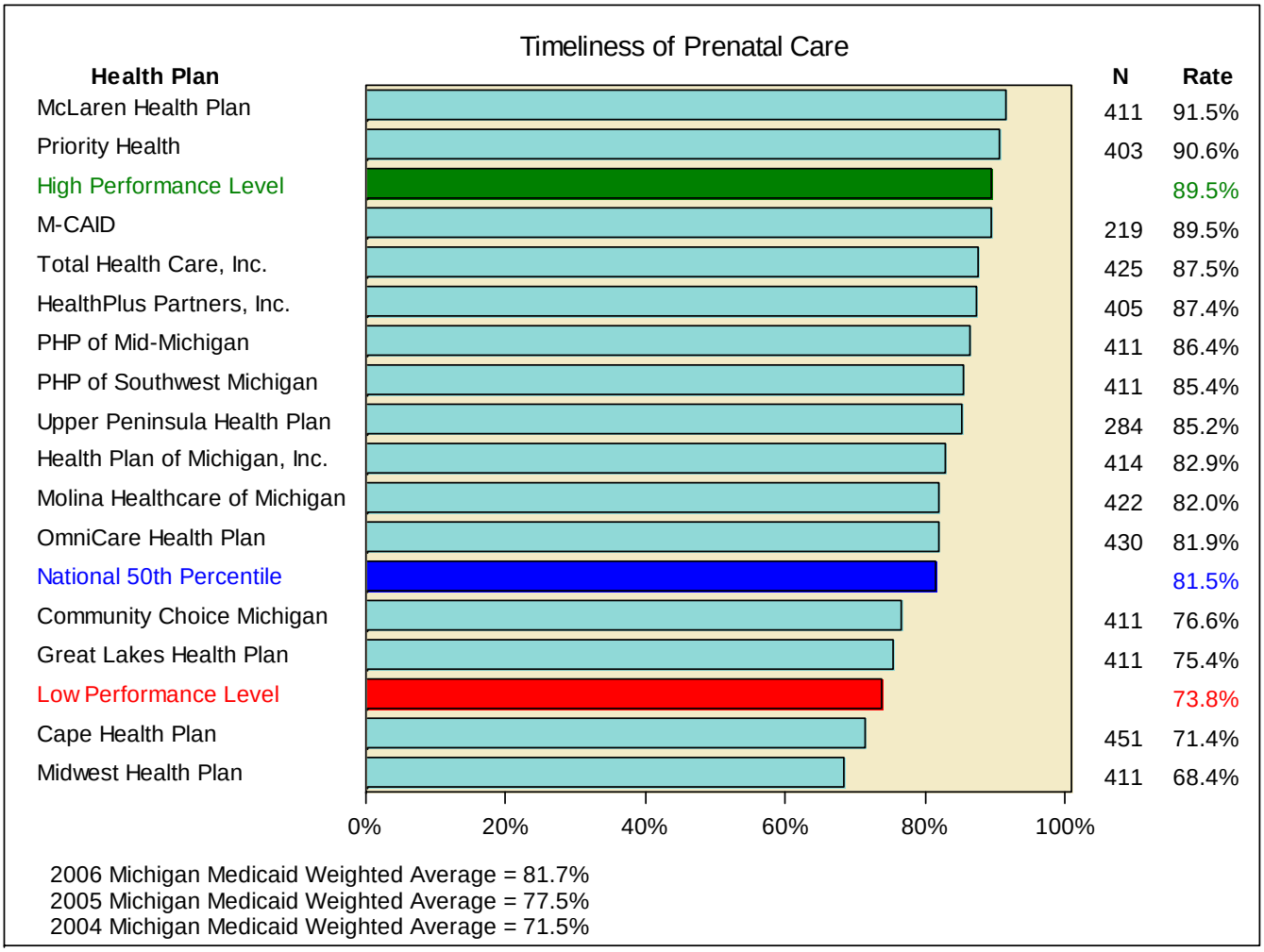
[4-16] Michigan Department of Community Health, Michigan Resident Birth and Death Files, Vital Records & Health Data Development Section. Available at: http://www.mdch.state.mi.us/pha/osr/InDxMain/Tab2.asp. Accessed on November 27, 2006.

[4-17] Family Health International. *Better Postpartum Care Saves Lives.* Available at: http://www.fhi.org/NR/Shared/enFHI/PrinterFriendly.asp. Accessed on July 6, 2006.

[4-18] National Committee for Quality Assurance. *The State of Health Care Quality, 2003.* Available at: http://www.ncqa.org/sohc2003/prenatal_and_postpartum_care.htm. Accessed on July 7, 2006.

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

Figure 4-7—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Prenatal and Postpartum Care—Timeliness of Prenatal Care



Two health plans had rates above the HPL of 89.5 percent, while two health plans had rates below the LPL of 73.8 percent. A total of 11 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

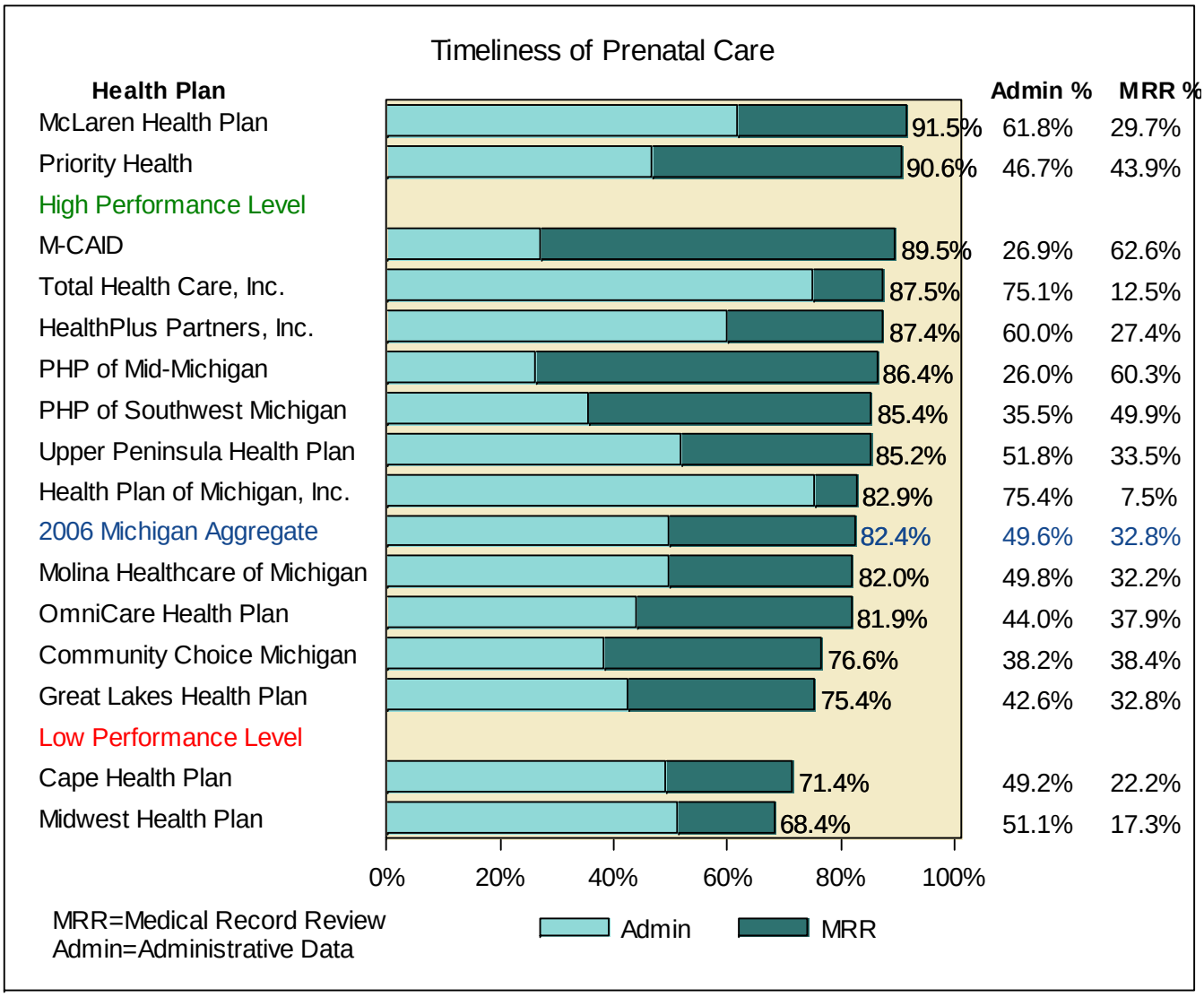
The 2006 Michigan Medicaid weighted average of 81.7 percent was 0.2 of a percentage point above the national HEDIS 2005 Medicaid 50th percentile of 81.5 percent.

The 2006 Michigan Medicaid weighted average showed an increase from 2005, up 4.2 percentage points. A gain of 10.2 percentage points was observed when 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 71.5 percent.

In 2005, none of the health plans reported rates above the HPL and three health plans had rates below the LPL. Overall, the range of reported rates shifted upward, indicating improvement from 2005 to 2006.

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

Figure 4-8—Michigan Medicaid HEDIS 2006
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: 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 method. The 2006 Michigan aggregate administrative rate was 49.6 percent and the medical record review rate was 32.8 percent.

Overall, 60.2 percent of the aggregate rate was derived from administrative data and 39.8 percent from medical record review. In 2005, 60.3 percent was derived from administrative data.

Eleven health plans derived more than half of their rates from administrative data, while two health plans derived less than one-third of their rates from administrative data.

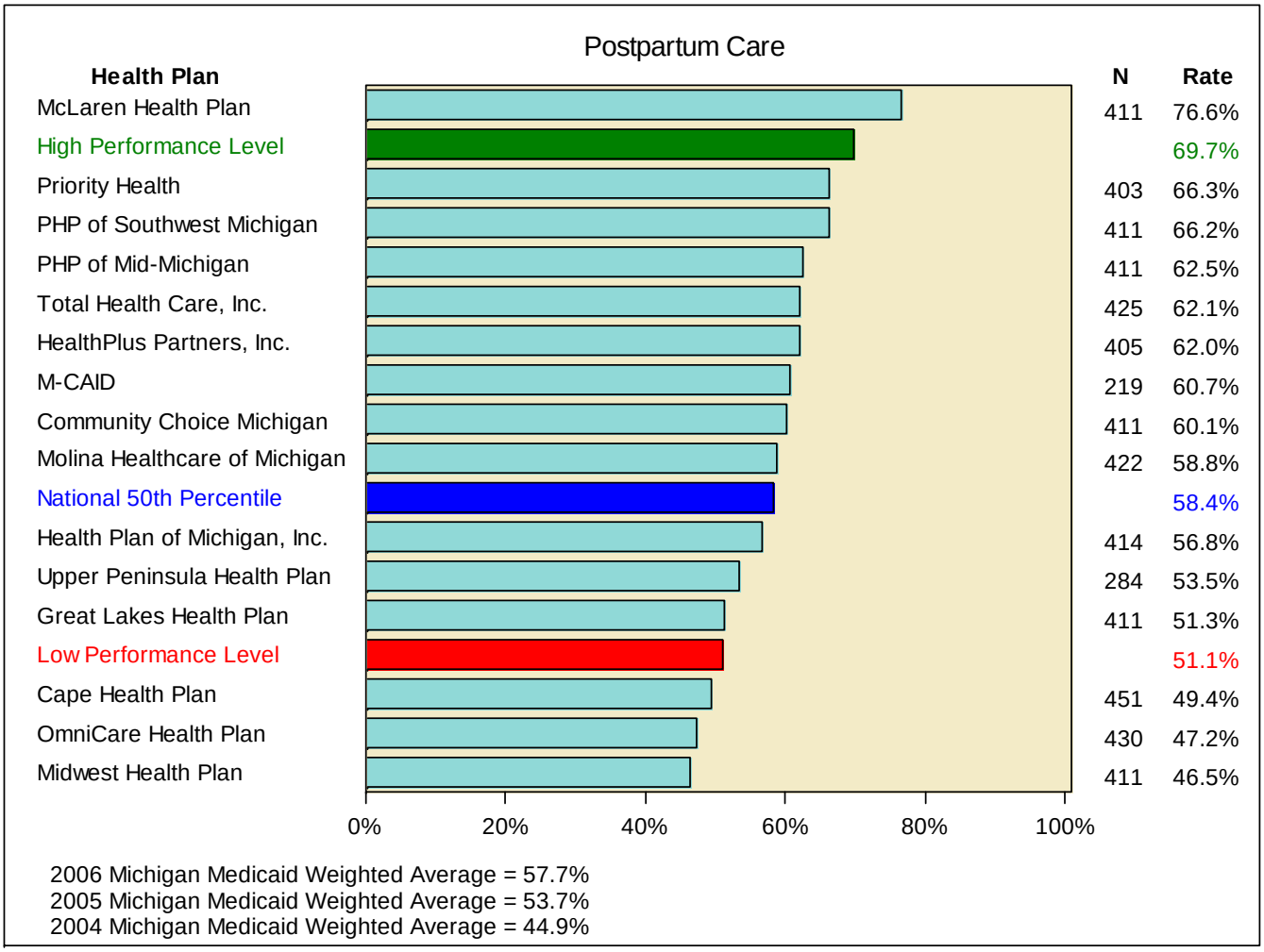
Historically, administrative data used to identify individual prenatal care visits has been negatively impacted by the use of global billing practices by most health plans. Health plans that do not use global billing payment mechanisms to reimburse providers for prenatal care services typically have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

HEDIS Specification: Prenatal and Postpartum Care—Postpartum Care

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

Health Plan Ranking: Prenatal and Postpartum Care—Postpartum Care

Figure 4-9—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Prenatal and Postpartum Care—Postpartum Care



One of the health plans reported a rate above the HPL of 69.7 percent, while three health plans had rates below the LPL of 51.1 percent. A total of nine health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

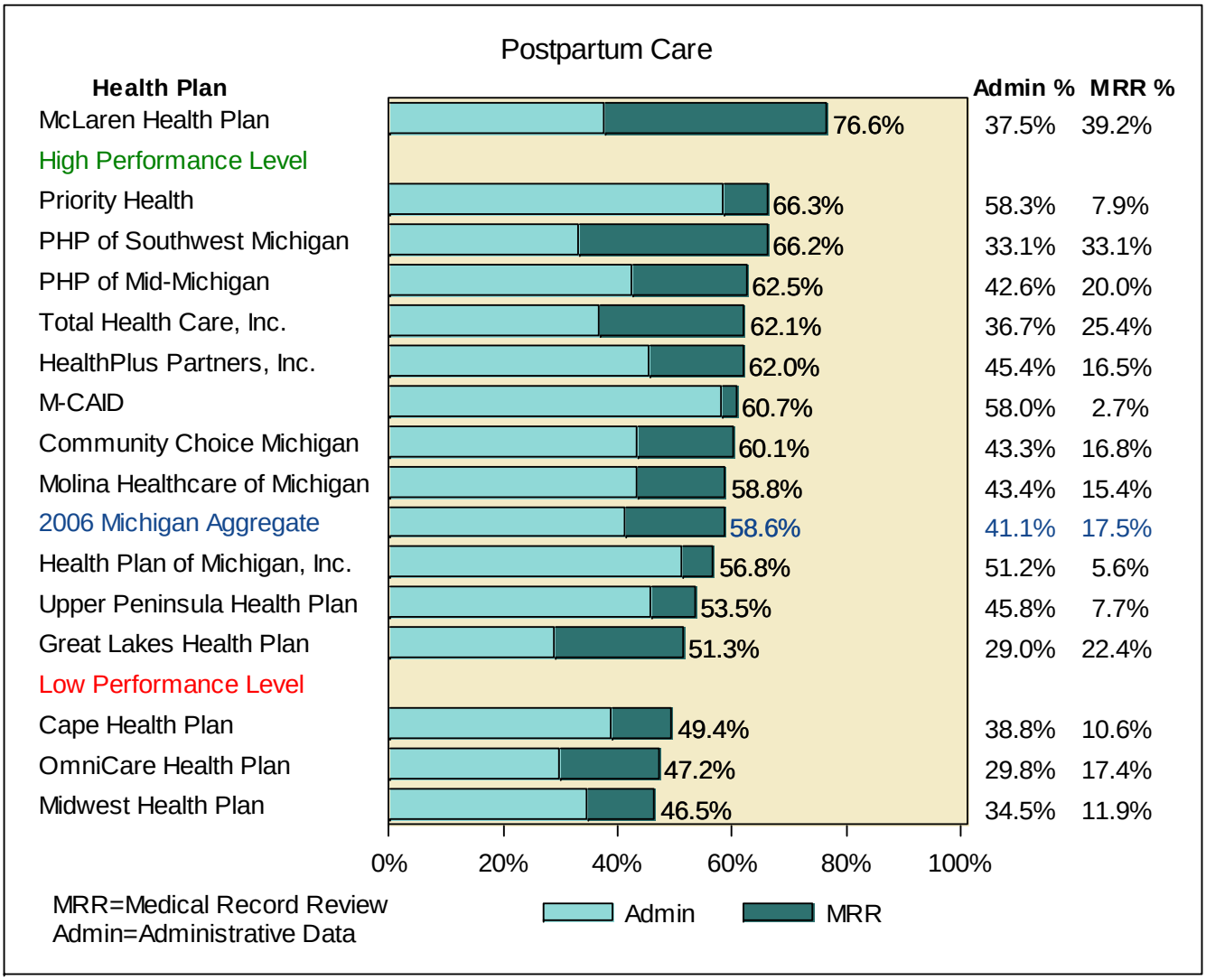
The 2006 Michigan Medicaid weighted average of 57.7 percent was 0.7 of a percentage point below the national HEDIS 2005 Medicaid 50th percentile of 58.4 percent.

The 2006 Michigan Medicaid weighted average showed an increase over 2005, up 4.0 percentage points. A gain of 12.8 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 44.9 percent.

None of the health plans reported rates above the HPL in 2005 and four health plans had rates below the LPL. Overall, the range of reported rates demonstrated improvement in 2006 compared with 2005.

Data Collection Analysis: Prenatal and Postpartum Care—Postpartum Care

Figure 4-10—Michigan Medicaid HEDIS 2006
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: Because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

All of the health plans elected to report this measure using the hybrid method. The 2006 Michigan aggregate administrative rate was 41.1 percent and the medical record review rate was 17.5 percent.

Overall, 70.1 percent of the aggregate rate was derived from administrative data and 29.9 percent from medical record review. In 2005, 72.4 percent was derived from administrative data.

In 2006, all but one health plan derived at least half of their rates from administrative data.

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

Women's Care Findings and Recommendations

Michigan MHPs' performance in the area of Women's Care was average. Across the Women's Care-related measures, performance was generally flat, except for some improvement trends observed within the *Prenatal and Postpartum Care* measures.

Performance on the cancer screening measures was stagnant across the Michigan MHPs. For the *Breast Cancer Screening* measure, the statewide weighted average was slightly above the national Medicaid 50th percentile, with a relatively wide range of rates. The weighted average increased by 2.1 percentage points, which was not statistically significant. Improvement may have been hampered in 2006 because the hybrid method was retired for this specific measure. Health plans that relied on medical record review for the *Breast Cancer Screening* measure likely observed a reduction in their performance. For the *Cervical Cancer Screening* measure, the performance trend was similar. The weighted average was just above the national Medicaid 50th percentile, with an increase of 2.4 percentage points from the 2005 weighted average.

Statewide performance within all age groups on the *Chlamydia Screening in Women* measure was also average. Minimal gains were observed compared with the 2005 weighted averages, although the 2006 weighted averages were all 5 percentage points more than the national Medicaid 50th percentile. Of note is the performance of two health plans (PHP of Mid-Michigan and OmniCare Health Plan), which were consistently the top two performing plans and exceeded the HPL for two of the three age groups. Although no quality improvement (QI) initiatives were identified within these health plans' annual QI evaluations, health plan operations that support this measure could be shared with the other Michigan MHPs.

Within the maternity measures, some improvements were observed. Moderate increases in the weighted averages were seen for both the *Timeliness of Prenatal Care* indicator and the *Postpartum Care* indicator compared with the 2005 performance. An impressive trend was observed, compared with the 2004 performance, with a gain of 10.2 percentage points for the *Timeliness of Prenatal Care* indicator and 12.8 percentage points for the *Postpartum Care* indicator. The range of rates also showed a positive shift toward improved performance for both indicators. Relatively heavy reliance on medical record review was seen for both indicators, a common finding nationwide due to the widespread use of global billing payment arrangements by health plans for maternity care services.

To improve MHP performance within the cancer screening measures, an emerging approach has been identified as a best practice for some health plans. The use of a barrier analysis survey mailed to women who have not received the recommended screenings can provide very specific areas for intervention. In addition, improving access for mammography by either expanding the hours of operation or providing a mobile mammography unit have resulted in statistically significant gains for many health plans. For the *Chlamydia Screening in Women* measure, a targeted analysis of physician and laboratory coding practices should be considered by the health plans. Frequently, these screens are not specifically or appropriately coded, even though the service was provided. Physician education and heightened awareness are frequently the keys for success in bringing about improvements for this measure. Given the sensitive issues related to this screening, member-targeted interventions are not recommended.

For the maternity-related measures, health plans that can identify their pregnant members as early as possible have the best opportunity for success. Creative practices such as contacting new members to welcome them to the health plan and inquire about their health care needs (including prenatal care needs) and using pharmacy data to identify new prescriptions for prenatal vitamins can improve the early identification of pregnant members. Member incentives, including the provision of car seats, diapers, or other infant needs to mothers who complete the recommended prenatal care visits are frequently successful. These activities, coupled with a strong and focused prenatal care case management program, are among the most powerful tools available to health plans for recognizing improvement in maternity care.

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.

The National Heart, Lung, and Blood Institute estimates that about 20 million people in the United States suffer from asthma, nearly 9 million of whom are children. Asthma affects all races; however, African Americans are more likely than whites to be hospitalized and to die from asthma.[5-1] Recent analysis of the economic impact of asthma cited annual estimated costs of $14 billion, including $4.6 billion in lost productivity.[5-2] As of 2003, approximately 253,579 of Michigan children had asthma. Estimates for 2005 show that approximately 691,289 adults had asthma in Michigan. Prevalence of lifetime asthma for Michigan adults is slightly higher (13.9 percent) than that for the nation (12.6 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]

The American Diabetes Association estimates that 20.8 million people in the United States, 7.0 percent of the population, suffer from diabetes, but only 14.6 million have been formally diagnosed with the disease. The prevalence of diabetes is higher in Hispanics, African Americans, Asian Americans, Native Americans, and Pacific Islanders than in whites.[5-5] Diabetes prevalence, mortality, and complication rates 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 people younger than 18 years of age have been diagnosed with diabetes. Diabetes costs Michigan residents $5.7 billion a year in lost productivity due to premature death, disability, and illness.[5-6]

Estimates reported by the American Heart Association indicate that nearly one in three adults in the United States has high blood pressure, but because there are no symptoms, nearly one-third of these people are undiagnosed. Uncontrolled high blood pressure can lead to stroke, heart attack, heart

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[5-1] National Heart, Lung, and Blood Institute. Diseases and Conditions Index: Asthma. Available at: http://www.nhlbi.nih.gov/health/dci/Diseases/Asthma_WhoIsAtRisk.html/. Accessed on June 27, 2006.

[5-2] National Committee for Quality Assurance. *The State of Health Care Quality, 2005.* Washington DC: National Committee for Quality Assurance; 2005: 50. Available at: http://www.ncqa.org/Docs/SOHCQ_2005.pdf. Accessed on June 22, 2006.

[5-3] American Lung Association. Epidemiology & Statistics Unit. *Trends in Asthma Morbidity and Mortality.* July 2006. Available at: http;//www.kintera.org/atf/cf/%7B7A8D42C2-FCCA-4604-8ADE-7F5D5E762256%7D/ASTHMA1.PDF. Accessed on August 3, 2006.

[5-4] Michigan Department of Community Health. Epidemiology of Asthma in Michigan, 2004 Surveillance Report. Available at: http://www.michigan.gov/documents/MIAsthmaSurveillance_2004_96083_7.pdf. Accessed on June 20,2006.

[5-5] American Diabetes Association. Diabetes Statistics. Available at: http://www.diabetes.org/diabetes-statistics/prevalence.jsp. Accessed on June 27, 2006.

[5-6] Michigan Department of Community Health. Diabetes in Michigan, 2004. Available at: http://www.michigan.gov/documents/mifact_6829_7.pdf. Accessed on June 20, 2006.

failure, or kidney failure. The risk of developing high blood pressure increases with age. In fact, people with normal blood pressure at 55 years of age still have a 90 percent risk for developing high blood pressure in their lifetime.[5-7] In Michigan, approximately 4 out of every 10 deaths are due to cardiovascular disease.[5-8]

Cigarette smoking kills about half of all continuing smokers and is the most preventable cause of premature death in the United States. According to the American Cancer Society, about 440,000 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]

The societal costs of tobacco death and disease approach $100 billion. Americans spend an estimated $50 billion annually on direct medical care for smoking-related illnesses. Lost productivity and forfeited earnings due to smoking-related disability account for another $47 billion per year. Smoking cessation interventions are less costly than other routine medical interventions. In fact, the average cost per smoker for effective cessation treatment is $165.61.[5-11] 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*

[5-7] National Institutes of Health Web site. Available at: http://hin.nhlbi.nih.gov/nhbpep_slds/jnc/slides/part1/img006.gif. Accessed on June 20, 2006.

[5-8] Michigan Department of Community Health. 2006 CVD Fact Sheet. Available at: http://www.michigan.gov/documents/CVDFactsheet2006col_154795_7.pdf. Accessed on June 20, 2006.

[5-9] American Cancer Society. Health Information Seekers – Cigarette Smoking Tobacco-related Diseases Kill Half of All Smokers; 2006. Available at: http://www.cancer.org/docroot/PED/content/PED_10_2X_Cigarette_Smoking_and_Cancer.asp?sitearea=PED. Accessed on June 20, 2006.

[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 July 5, 2006.

[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 June 20, 2006.

[5-12] Michigan Department of Community Health. Facts About Lung Cancer, December 2005. Available at: http://www.michigancancer.org/PDFs/MDCHFactSheets/LungCAFactSheet-Dec05.pdf. Accessed on June 22, 2006.

- **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**

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 15 million Americans were diagnosed with diabetes in 2005.[5-13] In Michigan, the most recent statistics show that 587,000 people were newly diagnosed with diabetes in 2004.[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 two to three times those for people without the condition.[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] In 2004, diabetes was the leading cause of death for 2,954 people in Michigan and a contributory cause for an additional 5,462 deaths.[5-17] 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 the risk of lower-extremity amputation, drops by 40 percent.[5-18] 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.[5-19] When viewed simultaneously, 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 <130*
6. *Comprehensive Diabetes Care—LDL-C Level <100*
7. *Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy*

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

[5-13] National Institutes of Health. National Diabetes Statistics, 2004. Available at: http://diabetes.niddk.nih.gov/dm/pubs/statistics/index.htm#11. Accessed on June 22, 2006.

[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/tNumberTotal.htm. Accessed on June 22, 2006.

[5-15] World Health Organization. The Cost of Diabetes Fact Sheet. Available at: http://www.who.int/mediacentre/factsheets/fs236/en/. Accessed on June 27, 2006.

[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 June 22, 2006.

[5-17] Michigan Department of Community Health. Diabetes in Michigan, September 2006. Available at: http://www.michigan.gov/documents/mdch/FactPageMichigan-Darline_2_172250_7.pdf. Accessed on November 15, 2006.

[5-18] National Committee for Quality Assurance. *The State of Health Care Quality, 2005.* Washington DC: National Committee for Quality Assurance; 2005: 38. Available at: http://www.ncqa.org/Doc/SOHCQ_2005.pdf. Accessed on June 22, 2006.

[5-19] National Committee for Quality Assurance. Diabetes Quality Improvement Project Initial Measure Set (Final Version). Available at: http://www.ncqa.org/dprp/dqip2.htm#. Access on November 15, 2006.

Comprehensive Diabetes Care—HbA1c Testing

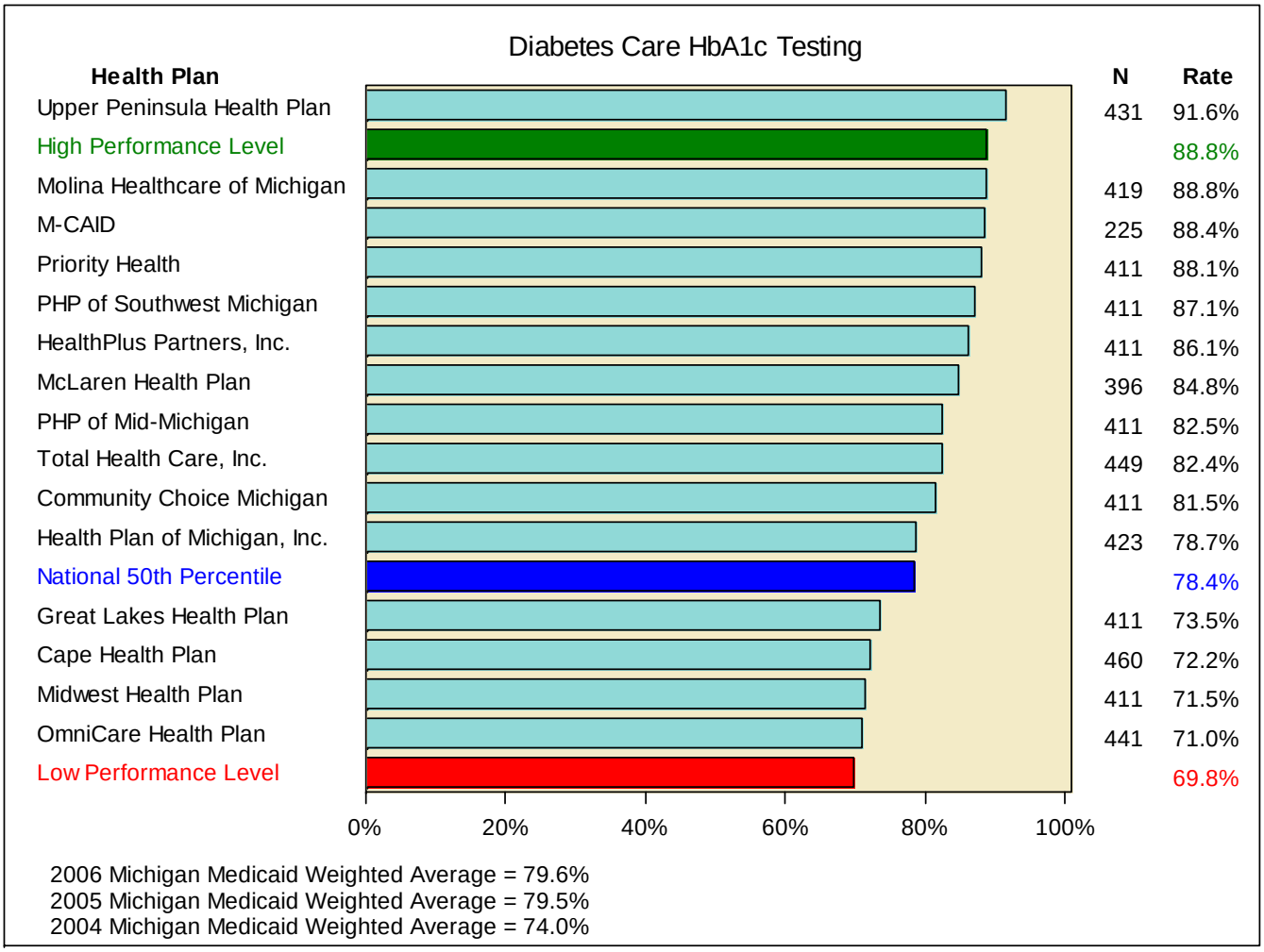
The HbA1c test (hemoglobin A1c test or glycosylated hemoglobin test) is a laboratory test that reveals average blood glucose over a period of two to three months. Specifically, it measures the number of glucose molecules attached to hemoglobin in red blood cells. The test takes advantage of the lifecycle 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 from the previous two to three months can be determined. HbA1c test results are expressed as a percentage, with 4 percent to 6 percent considered normal. The HbA1c 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 2006
Health Plan Ranking:
Comprehensive Diabetes Care—HbA1c Testing



One health plan reported a rated above the HPL of 88.8 percent, while none of the health plans had rates below the LPL of 69.8 percent. A total of 11 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

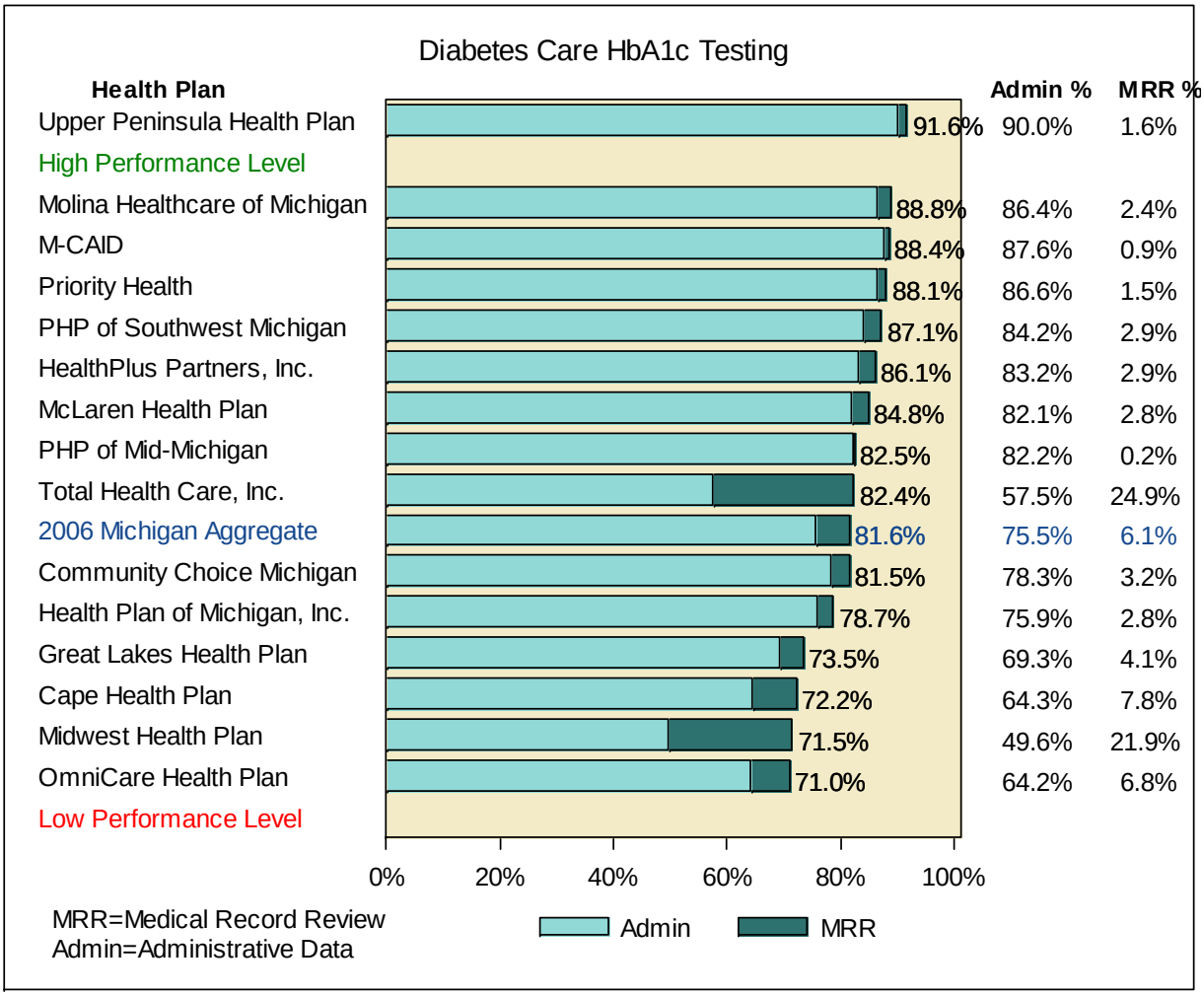
The 2006 Michigan Medicaid weighted average of 79.6 percent was 1.2 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 78.4 percent.

The 2006 Michigan weighted average showed an increase over 2005 by 0.1 of a percentage point. An increase of 5.6 percentage points was observed over the 2004 Michigan Medicaid weighted average of 74.0 percent.

In 2005, four health plans reached the HPL and one health plan had a rate below the LPL. Overall, the range of reported rates did not show notable improvement from 2005 to 2006.

Data Collection Analysis: Comprehensive Diabetes Care—HbA1c Testing

Figure 5-2—Michigan Medicaid HEDIS 2006
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 health plans elected to use the hybrid method to calculate this measure. The 2006 Michigan aggregate administrative rate was 75.5 percent and the medical record review rate was 6.1 percent.

In 2006, 92.5 percent of the aggregate rate was derived from administrative data and 7.5 percent from medical record review. In 2005, 91.2 percent of the aggregate rate was derived from administrative data.

Most of the health plans derived a majority of their rate from administrative data. Two health plans, however, increased their overall rates by more than 20 percentage points from medical record review.

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

Comprehensive Diabetes Care—Poor HbA1c Control

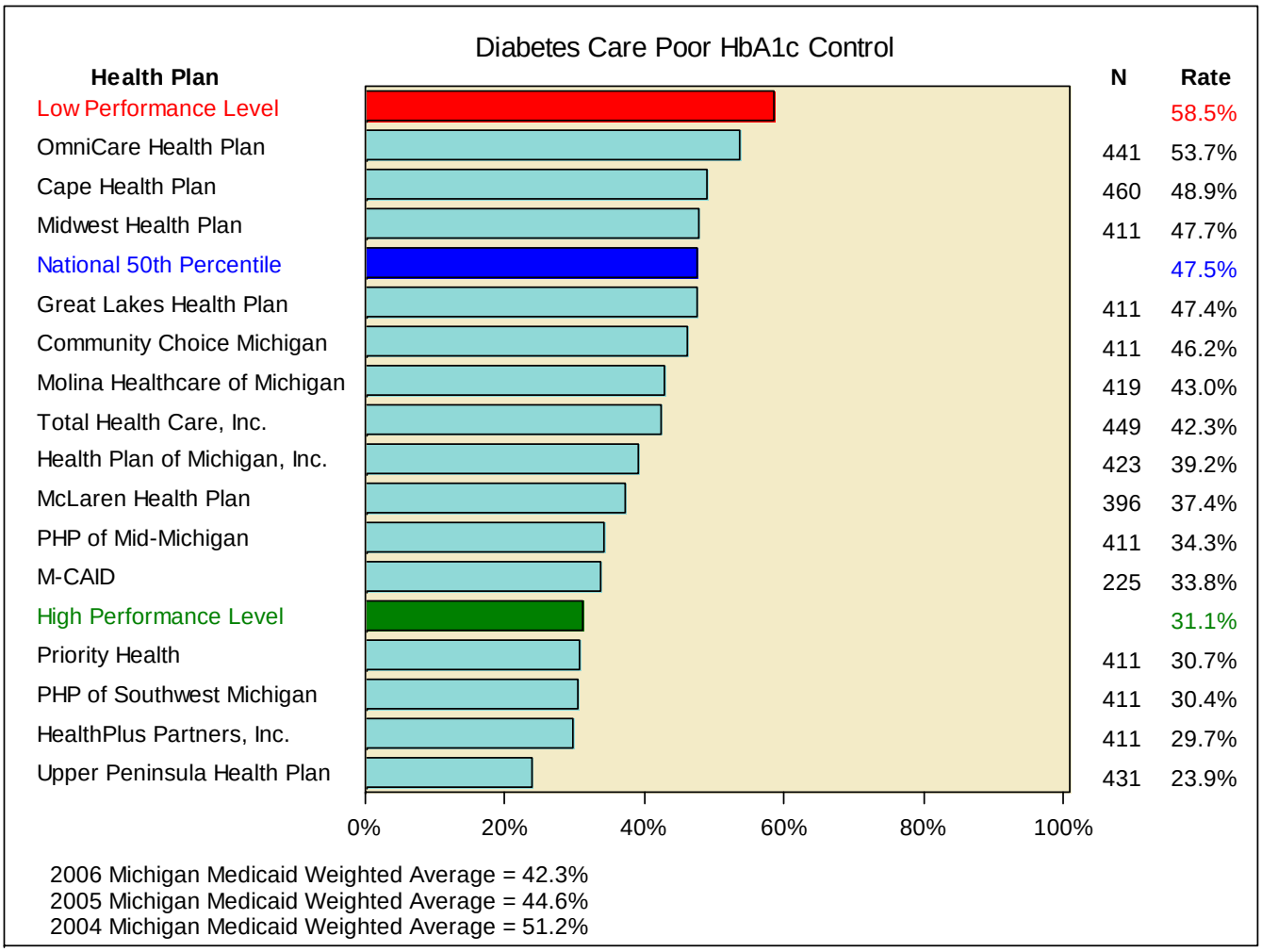
HbA1c control improves quality of life, increases work productivity, and decreases health care utilization. Decreasing the HbA1c level lowers the risk of diabetes-related death. Controlling blood glucose levels in people with diabetes significantly reduces the risk for blindness, end-stage renal disease,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

HEDIS Specification: Comprehensive Diabetes Care—Poor HbA1c Control

The *Comprehensive Diabetes Care—Poor HbA1c Control* rate reports the percentage of members with diabetes (Type 1 and Type 2) 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 2006
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.

Four health plans exceeded the HPL of 31.1 percent, while none had a rate above the LPL of 58.5 percent. A total of 12 health plans reported rates lower than the national HEDIS 2005 Medicaid 50th percentile, signifying better performance.

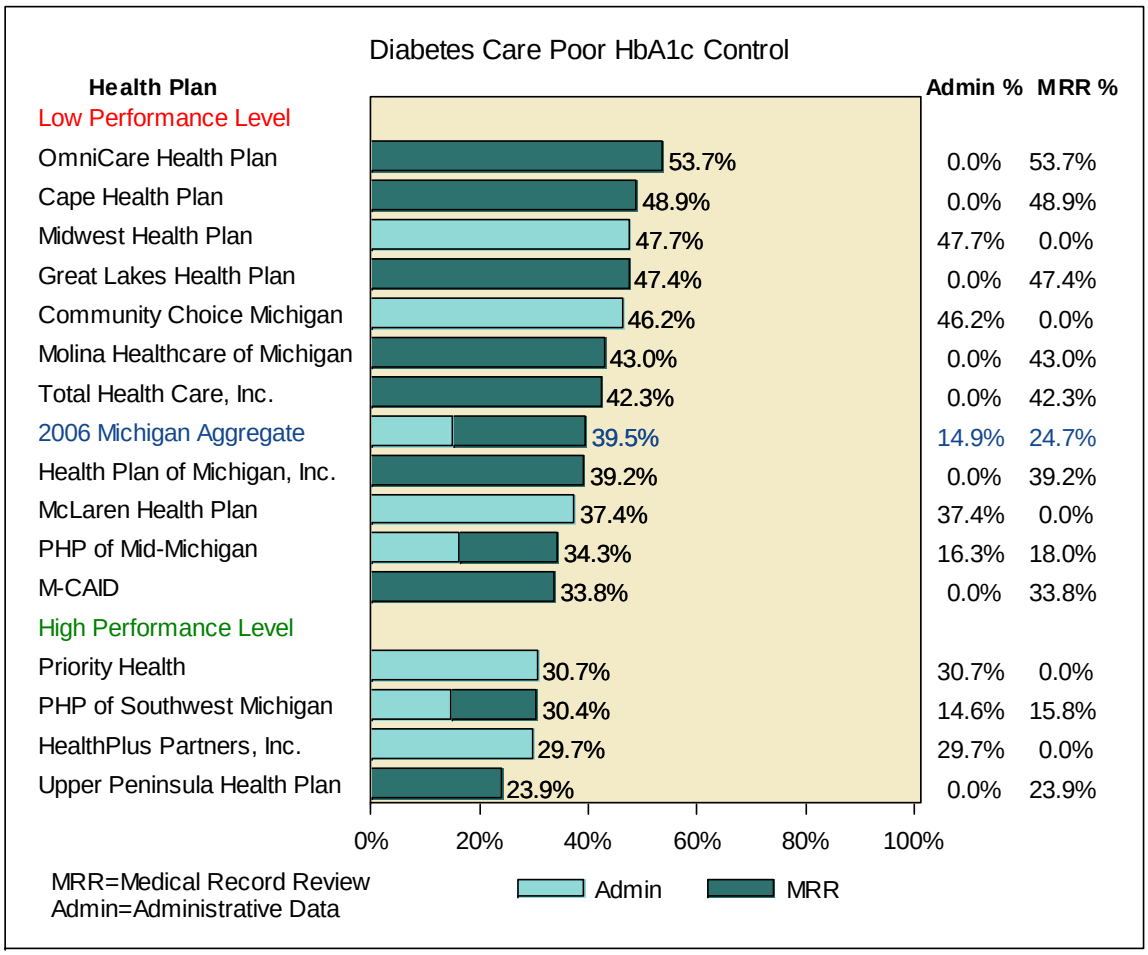
The 2006 Michigan Medicaid weighted average of 42.3 percent was 5.2 percentage points below the national HEDIS 2005 Medicaid 50th percentile of 47.5 percent.

The 2006 Michigan Medicaid weighted average showed a decrease from 2005 of 2.3 percentage points, demonstrating a positive gain. A decrease of 8.9 percentage points was observed when compared with the 2004 Michigan Medicaid weighted average.

In 2005, one health plan met the HPL and one health plan had a rate below the LPL. Overall, the range of reported rates demonstrated moderate improvement from 2005 to 2006.

Data Collection Analysis: Comprehensive Diabetes Care—Poor HbA1c Control

Figure 5-4—Michigan Medicaid HEDIS 2006
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 *Poor HbA1c Control*. For this measure, a lower rate indicates better performance.

All health plans elected to use the hybrid method to calculate this measure. The 2006 Michigan aggregate administrative rate for this measure was 14.9 percent and the medical record review rate was 24.7 percent.

Results indicate that 37.7 percent of the aggregate rate was derived from administrative data, while 62.5 percent was derived from medical record review. In 2005, 30.7 percent of the aggregate rate was derived from administrative data.

Although administrative data completeness has shown some improvement for this measure, the rates were still dependent on medical record review. In conjunction with the *HbA1c Testing* measure, the results imply that a claim or encounter was typically submitted for the actual test, but the results of the test (i.e., the HbA1c level) was not captured administratively. This is a challenge for health plans nationwide.

Comprehensive Diabetes Care—Eye Exam

Diabetic retinopathy causes 12,000 to 24,000 new cases of blindness every year. According to the American Academy of Ophthalmology, people with diabetes are 25 times more likely to lose their vision than those who do not have diabetes.[5-20] Blindness in diabetics younger than 65 years of age costs the federal government more than $14,000 annually for each affected person, while screening for diabetic retinopathy has been estimated to cost about $31 per patient.[5-21]

According to the National Institutes of Health, approximately 197,500 people older than 40 years of age have diabetic retinopathy in Michigan. This equates to 40.3 percent of this age group with diabetes.[5-22]

HEDIS Specification: Comprehensive Diabetes Care—Eye Exam

The *Comprehensive Diabetes Care—Eye Exam* rate reports the percentage of members with diabetes (Type 1 and Type 2) 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.

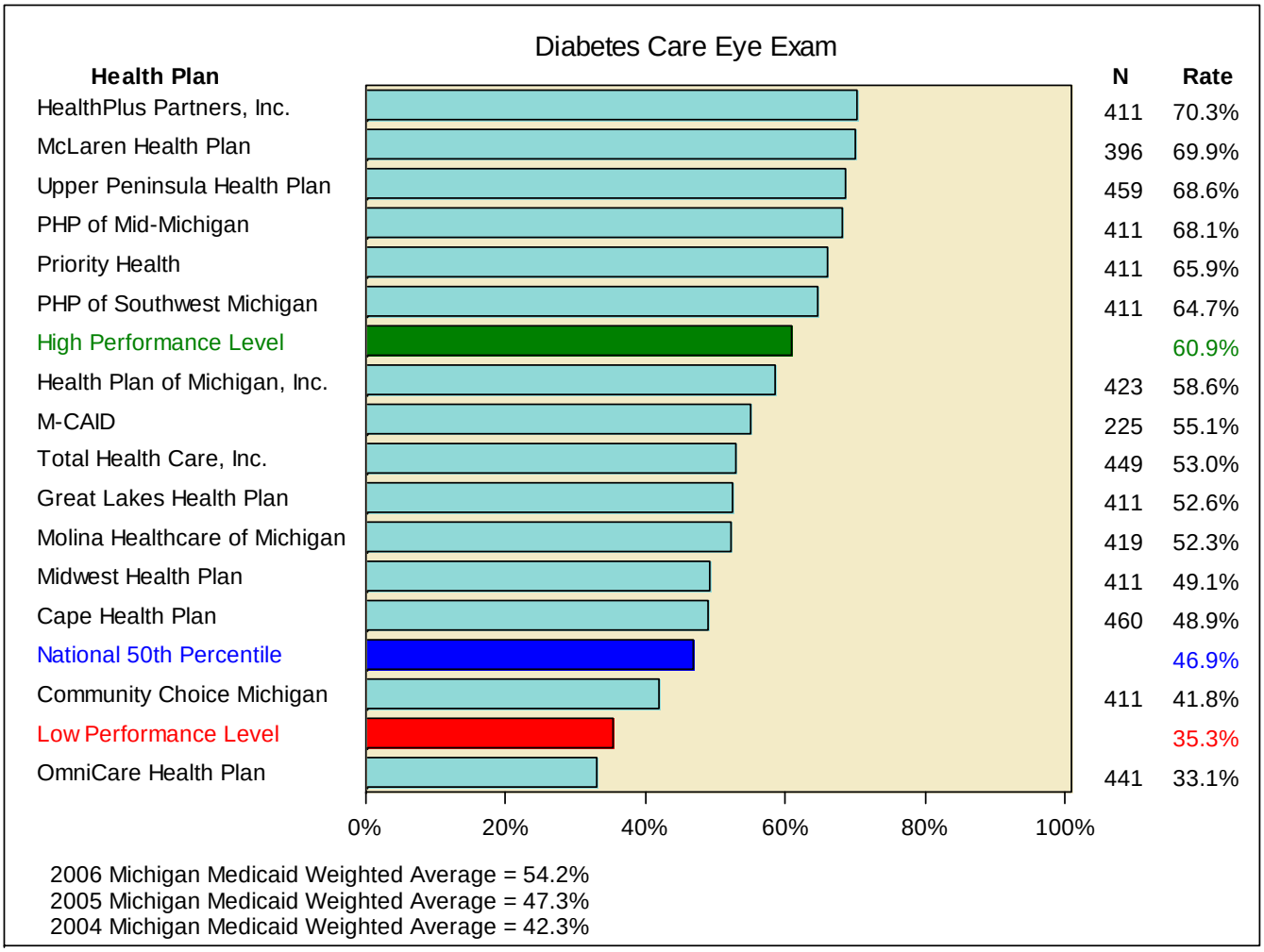
[5-20] National Committee for Quality Assurance. *The State of Managed Care Quality. 2001*. Standard Version. Washington, DC: National Committee for Quality Assurance; 2001:47-8.

[5-21] All About Vision Web site. Diabetic Retinopathy. Available at: http://www.allaboutvision.com/conditions/diabetic.htm. Accessed on July 5, 2006.

[5-22] Michigan Department of Community Health: Diabetes, Kidney, and Other Chronic Diseases Section: June 2004. Available at: http://www.michigan.gov/documents/mifact_6829_7.pdf. Accessed on July 5, 2006.

Health Plan Ranking: Comprehensive Diabetes Care—Eye Exam

Figure 5-5—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Comprehensive Diabetes Care—Eye Exam



Six health plans reported rates above the HPL of 60.9 percent, while one health plan had a rate below the LPL of 35.3 percent. A total of 13 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

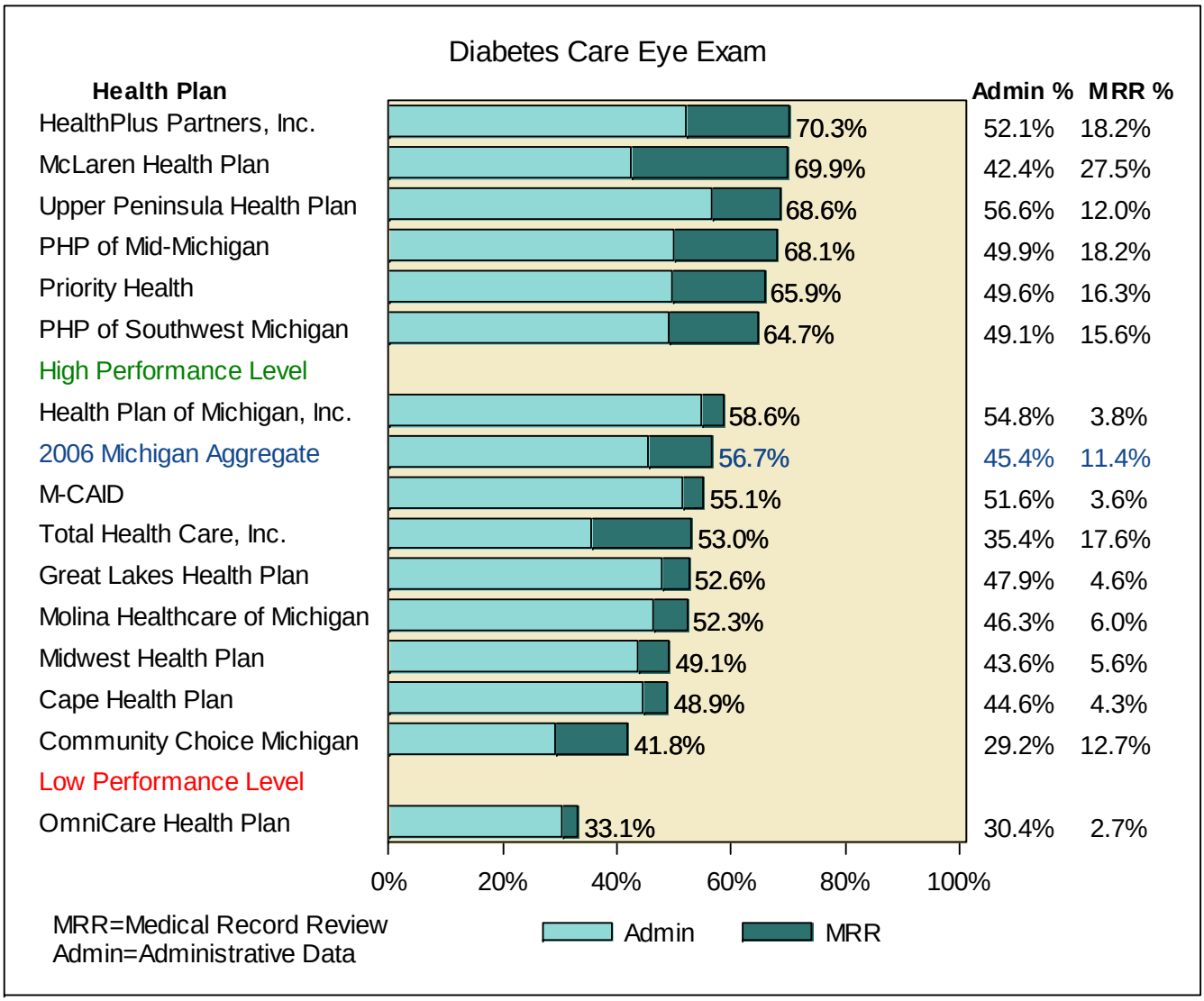
The 2006 Michigan Medicaid weighted average of 54.2 percent was 7.3 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 46.9 percent.

The 2006 Michigan Medicaid weighted average increased by 6.9 percentage points over 2005 and 11.9 percentage points above the 2004 Michigan Medicaid weighted average of 42.3 percent.

Two health plans reached the HPL in 2005 and one health plan had a rate below the LPL. Overall, improvement was observed from 2005 to 2006, with more health plans reaching the HPL.

Data Collection Analysis: Comprehensive Diabetes Care—Eye Exam

Figure 5-6—Michigan Medicaid HEDIS 2006
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 health plans elected to use the hybrid method to calculate this measure. The 2006 Michigan aggregate administrative rate was 45.4 percent and the medical record rate was 11.4 percent.

In 2006, 80.0 percent of the aggregate rate was derived from administrative data and 20.0 from medical record review. In 2005, 78.8 percent of the aggregate rate was derived from administrative data.

Six health plans showed substantial improvement in their overall rates from medical record review, increasing by more than 15 percentage points.

The completeness of administrative data was moderate. Success in identifying numerator events using administrative data is highly dependent upon the contractual arrangement with the provider and whether the provider contract requires the submission of complete and accurate claims or encounter data. Success is also dependent upon monitoring and oversight functions by the health plan of its eye care providers.

Comprehensive Diabetes Care—LDL-C Screening

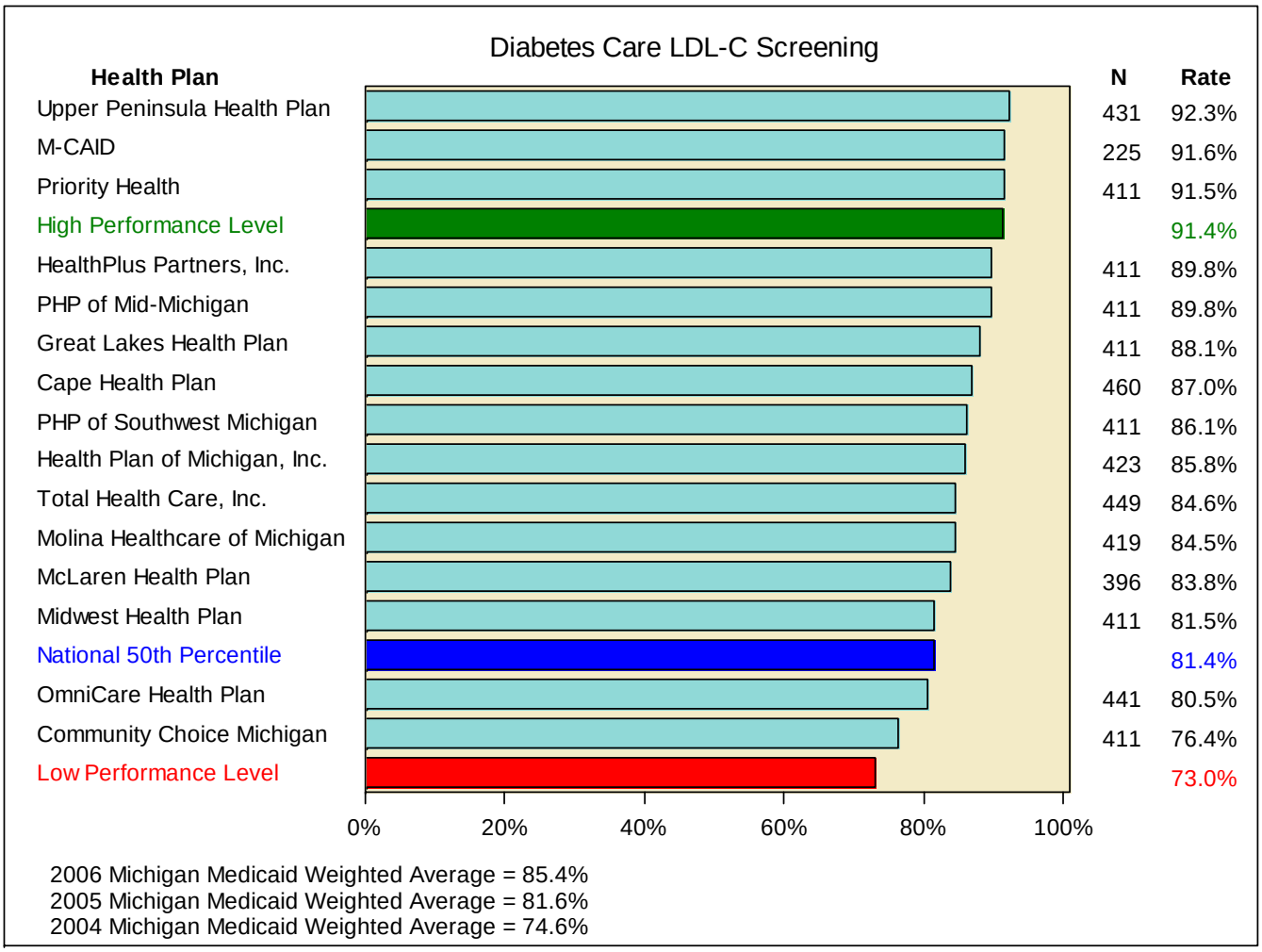
Low-density lipoprotein (LDL) is a type of lipoprotein that carries cholesterol in the blood. LDL is considered to be undesirable because it deposits excess cholesterol in the walls of blood vessels and contributes to atherosclerosis (hardening of the arteries) and heart disease. Hence, LDL cholesterol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

HEDIS Specification: Comprehensive Diabetes Care—LDL-C Screening

The *Comprehensive Diabetes Care—LDL-C Screening* rate reports the percentage of members with diabetes (Type 1 and Type 2) 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 2006
Health Plan Ranking:
Comprehensive Diabetes Care—LDL-C Screening



Three health plans reported rates above the HPL of 91.4 percent, while none of the health plans had rates below the LPL of 73.0 percent. A total of 13 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

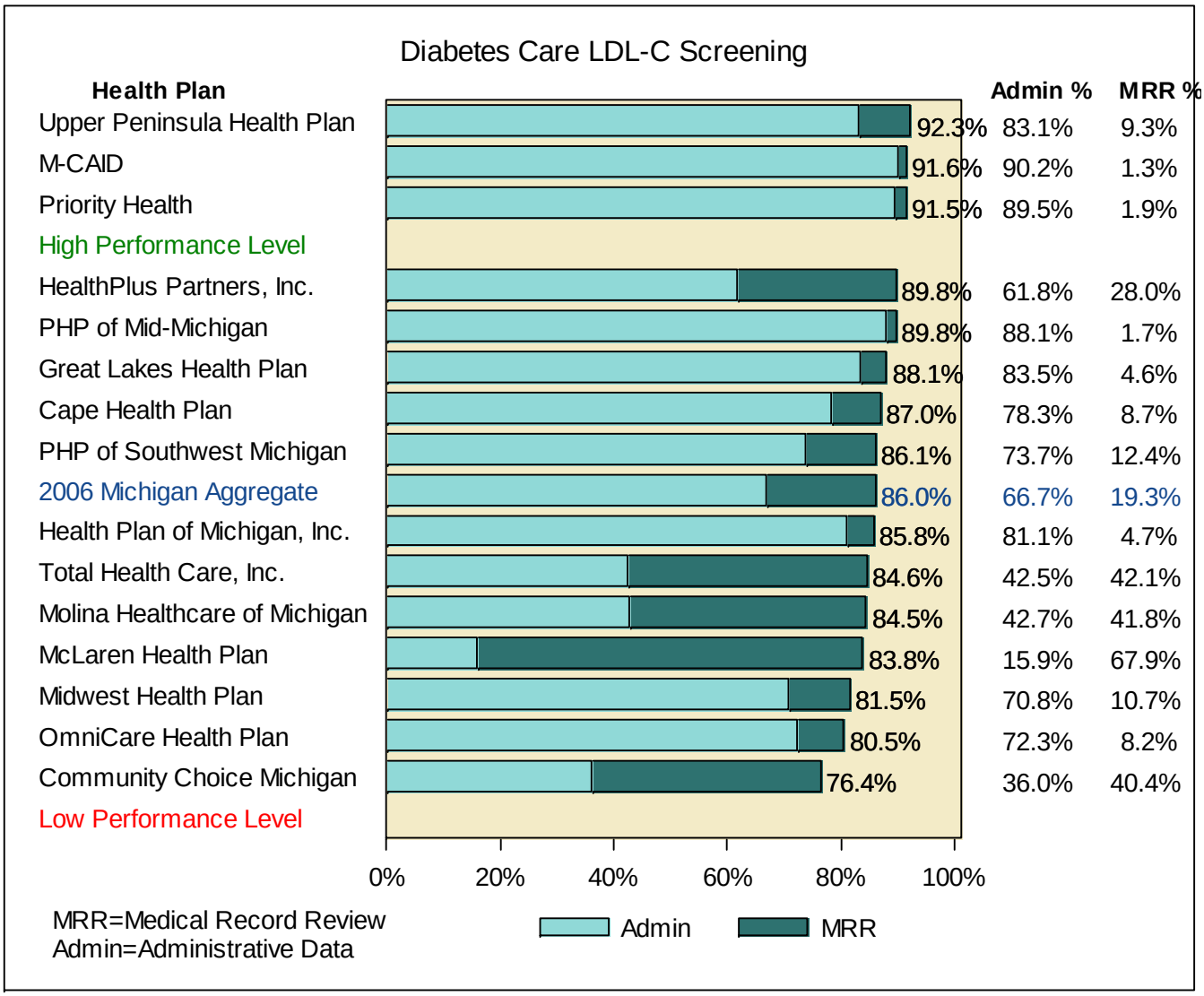
The 2006 Michigan Medicaid weighted average of 85.4 percent was 4.0 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 81.4 percent.

The 2006 Michigan Medicaid weighted average showed a statistically significant increase over 2005, up 3.8 percentage points. A gain of 10.8 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 74.6 percent.

In 2005, three health plans reached the HPL and none of the health plans had rates below the LPL. Overall, the range of reported rates showed improvement from 2005 to 2006.

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

Figure 5-8—Michigan Medicaid HEDIS 2006
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 elected to report this measure using the hybrid method. The 2005 Michigan aggregate administrative rate was 66.7 percent and the medical record review rate was 19.3 percent.

Overall, 77.6 percent of the aggregate rate was derived from administrative data and 22.4 percent from medical record review. In 2005, 76.1 percent was derived from administrative data.

Thirteen of the 15 health plans derived more than half of their rates from administrative data, while one health plan derived less than 20 percent from administrative data.

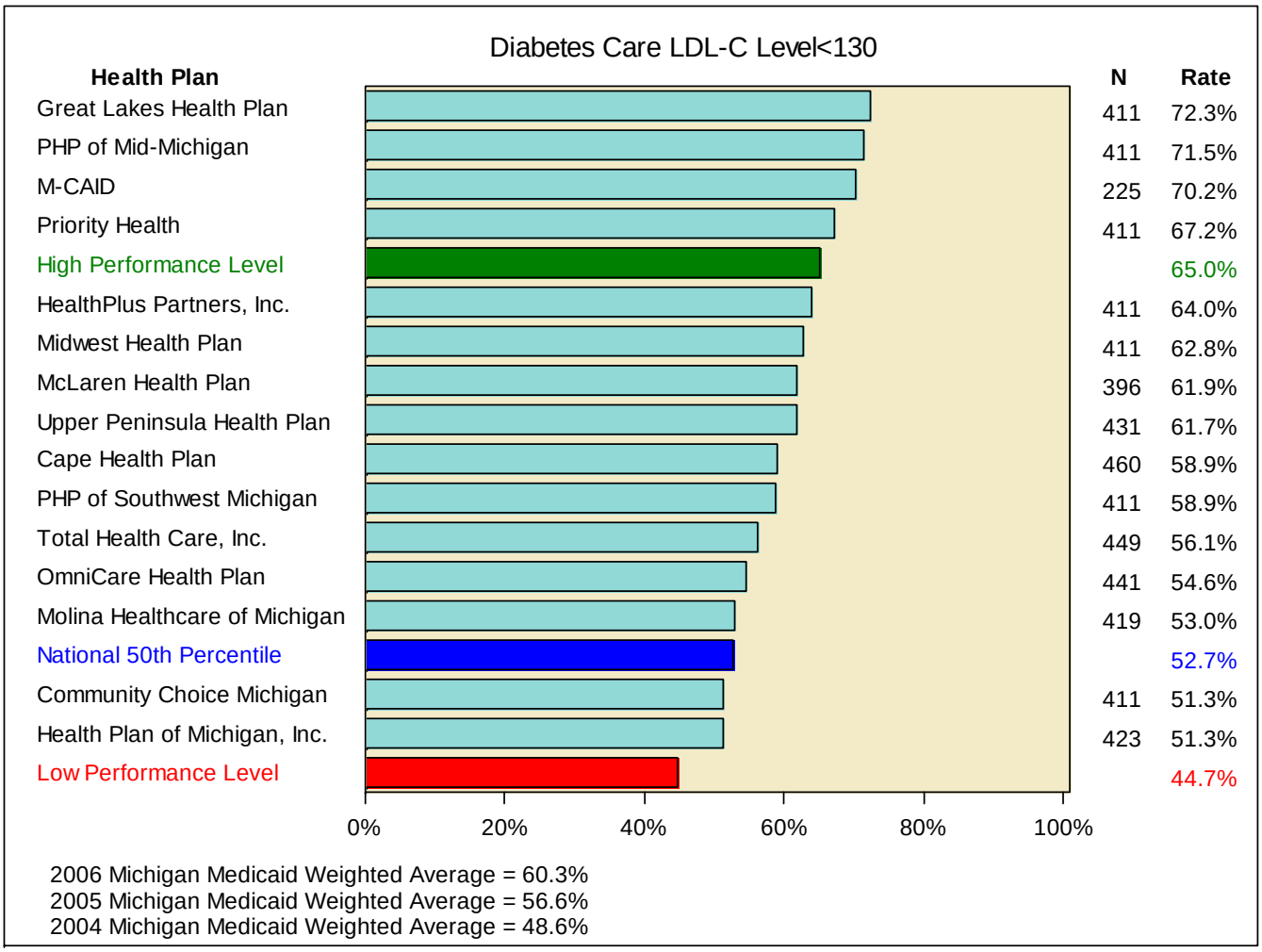
The administrative rate showed minimal improvement from 2005 to 2006, and the health plans still rely heavily upon medical record review to report this rate. This implies that the health plans do not receive complete billing data from providers and/or laboratories for this measure, yet the health plans do receive data for HbA1c testing (see Figure 5-2). Lack of specific billing data may be due to contractual and/or billing policies among the health plans and their contracted providers. The health plans should further explore the possible reasons for substantially lower administrative data submission for LDL-C screening compared with HbA1c testing.

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 2006
Health Plan Ranking:
Comprehensive Diabetes Care—LDL-C Level <130



Four health plans reported rates above the HPL of 65.0 percent, while none of the health plans had rates below the LPL of 44.7 percent. A total of 13 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

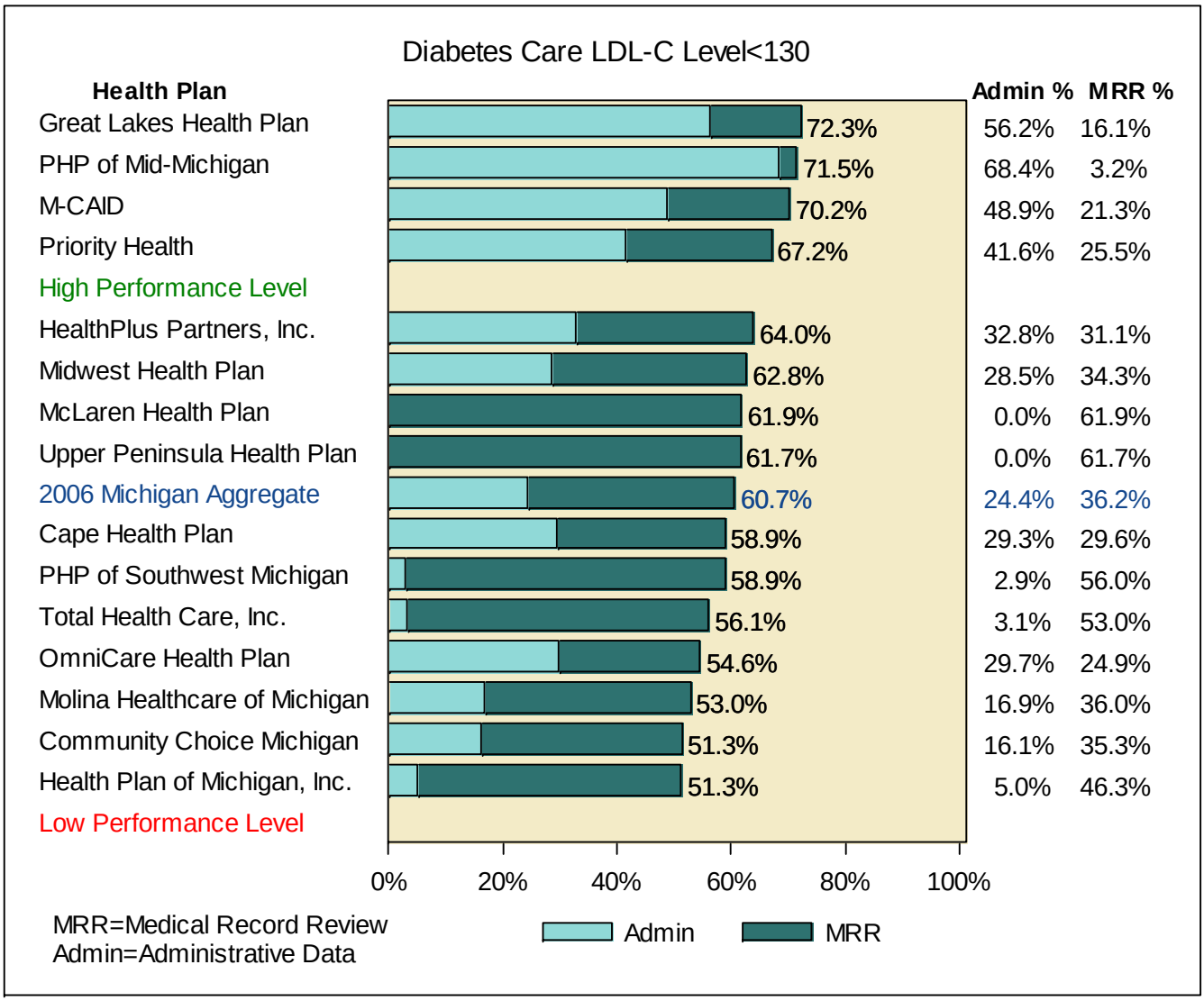
The 2006 Michigan Medicaid weighted average of 60.3 percent was 7.6 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 52.7 percent.

The 2006 Michigan Medicaid weighted average showed an increase from 2005, up 3.7 percentage points. An increase of 11.7 percentage points was identified when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 48.6 percent.

In 2005, six health plans reached the HPL and none of the health plans had rates below the LPL. Overall, the range of reported rates demonstrated improvement from 2005 to 2006.

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

Figure 5-10—Michigan Medicaid HEDIS 2006
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 method to calculate this measure. The 2006 Michigan aggregate administrative rate was 24.4 percent and the medical record review rate was 36.2 percent.

Overall, 40.2 percent of the aggregate rate was derived from administrative data and 59.6 percent from medical record review. In 2005, 36.3 percent was derived from administrative data.

Six health plans derived more than half of their rates from administrative data, while two derived their rates entirely from medical record review.

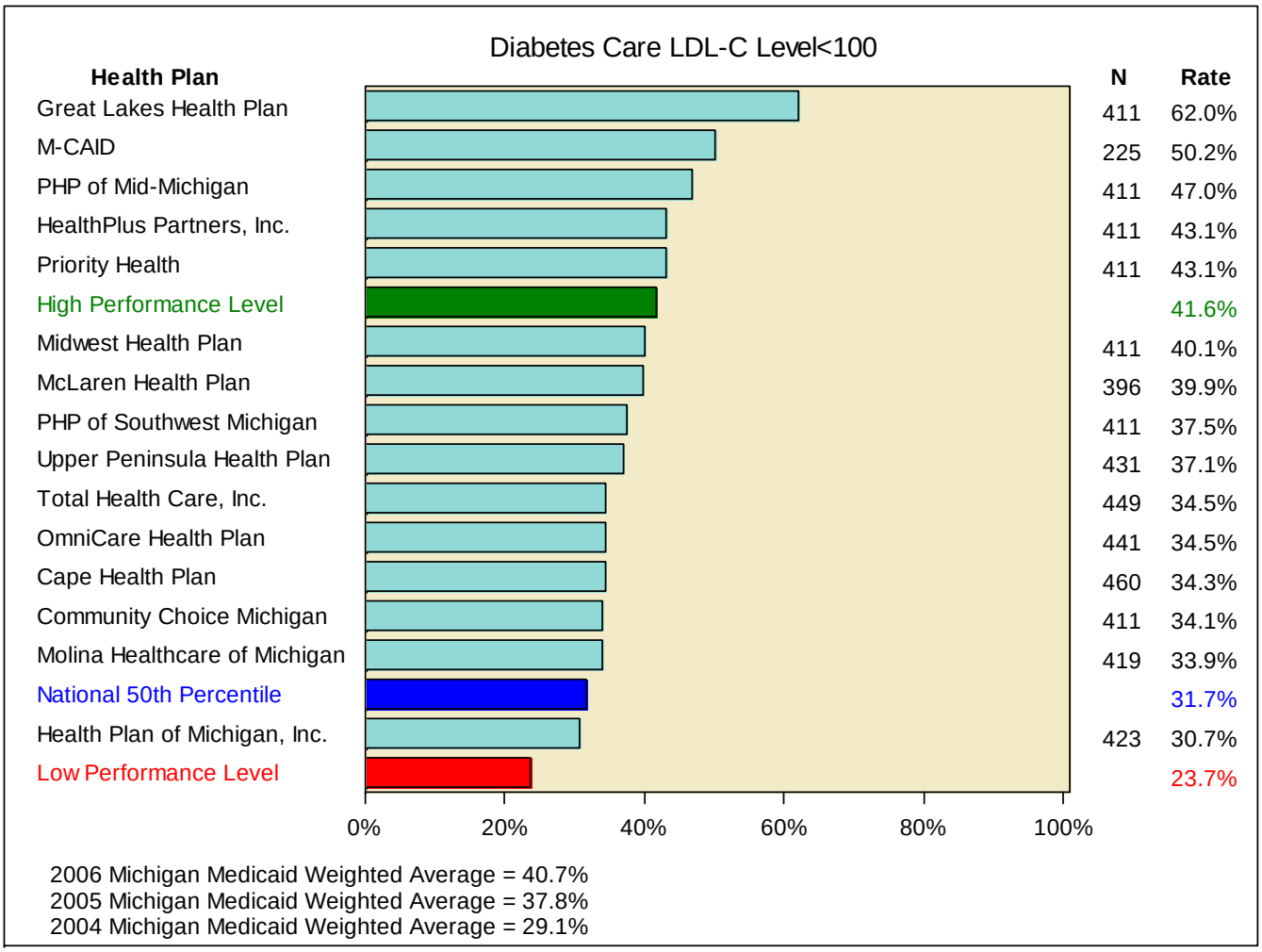
Although administrative data submission has shown improvement for this measure, the rates were still dependent on medical record review. In conjunction with the LDL-C screening measure (see Figure 5-8), the results imply that administrative data was usually submitted for the screening, but the LDL-C screening level was not captured administratively.

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 2006
Health Plan Ranking:
Comprehensive Diabetes Care—LDL-C Level <100



Five health plans reported rates above the HPL of 41.6 percent, while none of the health plans had rates below the LPL of 23.7 percent. Fourteen of the 15 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

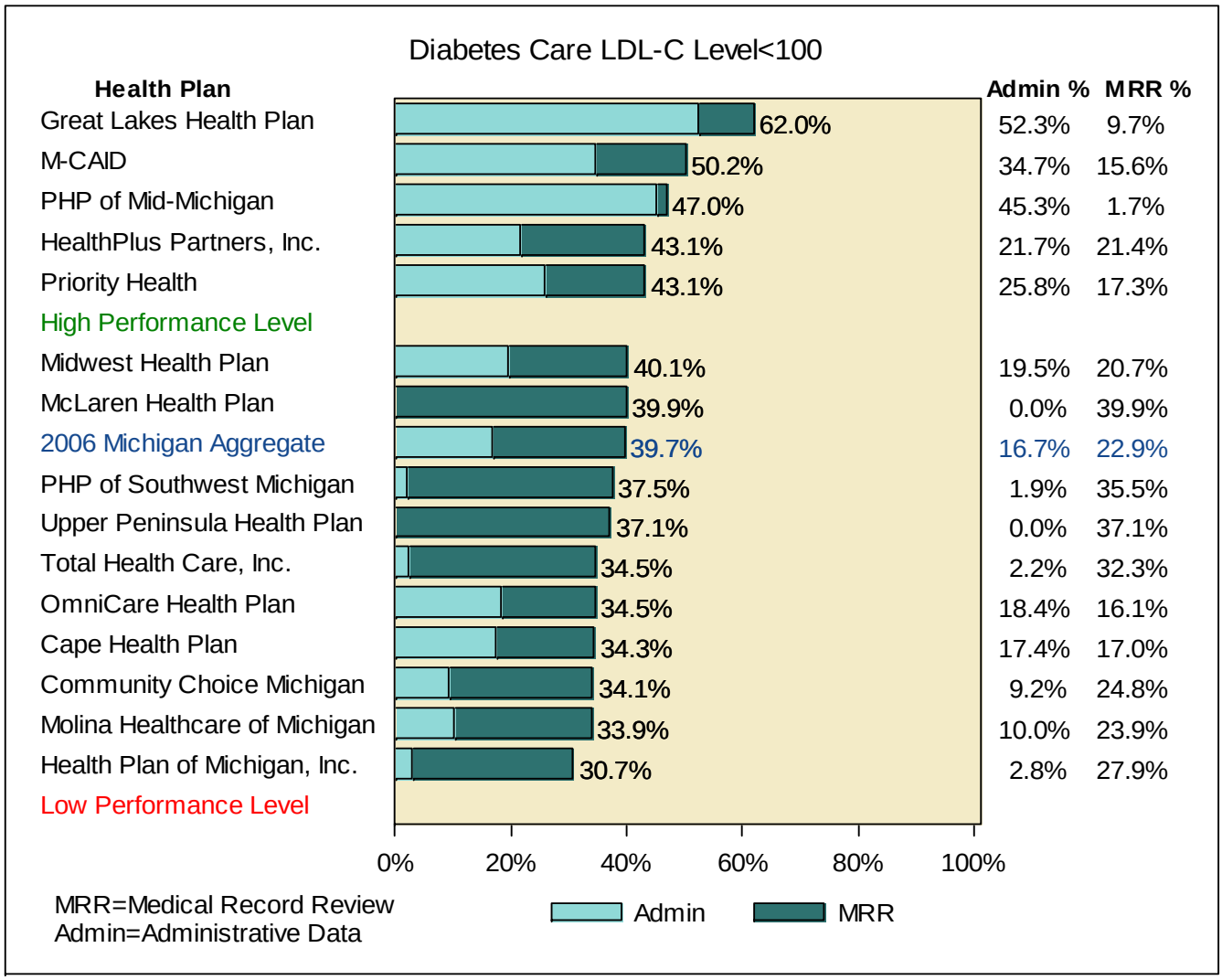
The 2006 Michigan Medicaid weighted average of 40.7 percent was 9.0 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 31.7 percent.

The 2006 Michigan Medicaid weighted average showed an increase from 2005, up 2.9 percentage points. An increase of 11.6 percentage points was identified when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 29.1 percent.

In 2005, five health plans reported rates above the HPL and none of the health plans had rates below the LPL. Overall, the reported rates showed notable improvement from 2005 to 2006.

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

Figure 5-12—Michigan Medicaid HEDIS 2006
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 method for calculation of this measure. The 2006 Michigan aggregate administrative rate was 16.7 percent and the medical record review rate was 22.9 percent.

Overall, 42.1 percent of the aggregate rate was derived from administrative data and 57.7 percent from medical record review. In 2005, 38.7 percent was derived from administrative data.

Seven health plans derived more than half of their rates from administrative data, while two derived their rates entirely from medical record review.

Although administrative data submission has shown improvement for this measure, the rates were still dependent on medical record review, a finding that mirrors the *LDL-C Level <130* indicator.

Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy

Diabetes is the leading cause of end-stage renal disease (ESRD). In the United States, more than 150,000 people are living with kidney failure as a result of diabetes. In 2003, care for patients with kidney failure cost the United States more than $27 billion.[5-23] Diabetic nephropathy is a progressive disease that takes years to develop. Ten to 21 percent of diabetics have nephropathy. ESRD is a condition that requires patients to receive dialysis or a kidney transplant to live.[5-24]

HEDIS Specification: Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy

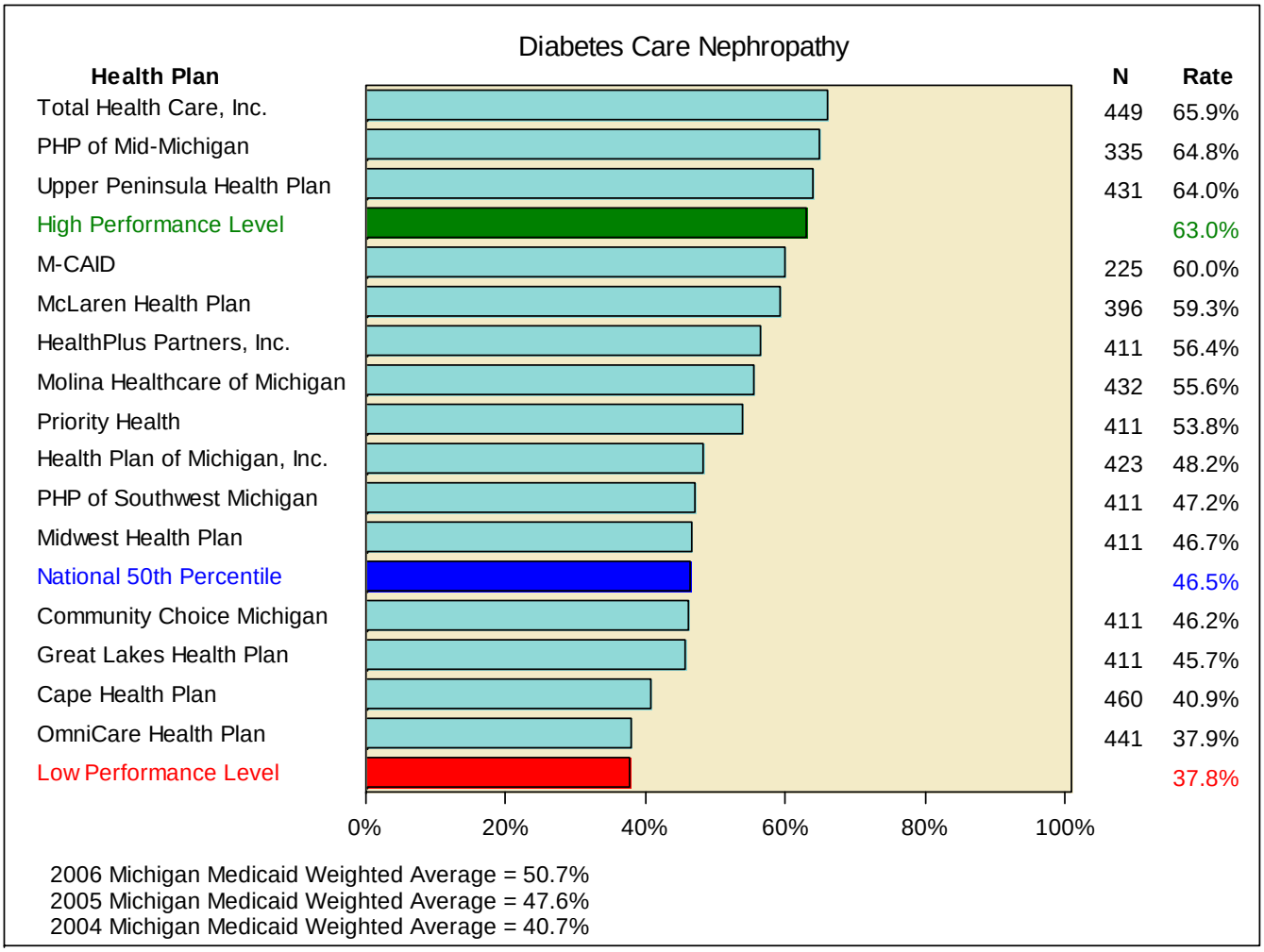
The *Comprehensive Diabetes Care—Monitoring for Diabetic Nephropath*y rate is intended to assess whether diabetic patients are being monitored for nephropathy. It reports the percentage of members with diabetes (Type 1 and Type 2) aged 18 through 75 years old who were continuously enrolled during the 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.

[5-23] National Kidney and Urologic Diseases Information Clearinghouse. Kidney Disease of Diabetes. Available at: http://kidney.niddk.nih.gov/kudiseases/pubs/kdd/index.htm. Accessed on July 5, 2006.

[5-24] Florida Department of Health. Diabetes and Nephropathy. Available at: http://www.doh.state.fl.us/family/dcp/whatis/nephropathy.html. Accessed on June 20, 2006.

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

Figure 5-13—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy



Three health plans reported rates above the HPL of 63.0 percent, while none of the health plans had rates below the LPL of 37.8 percent. A total of 11 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

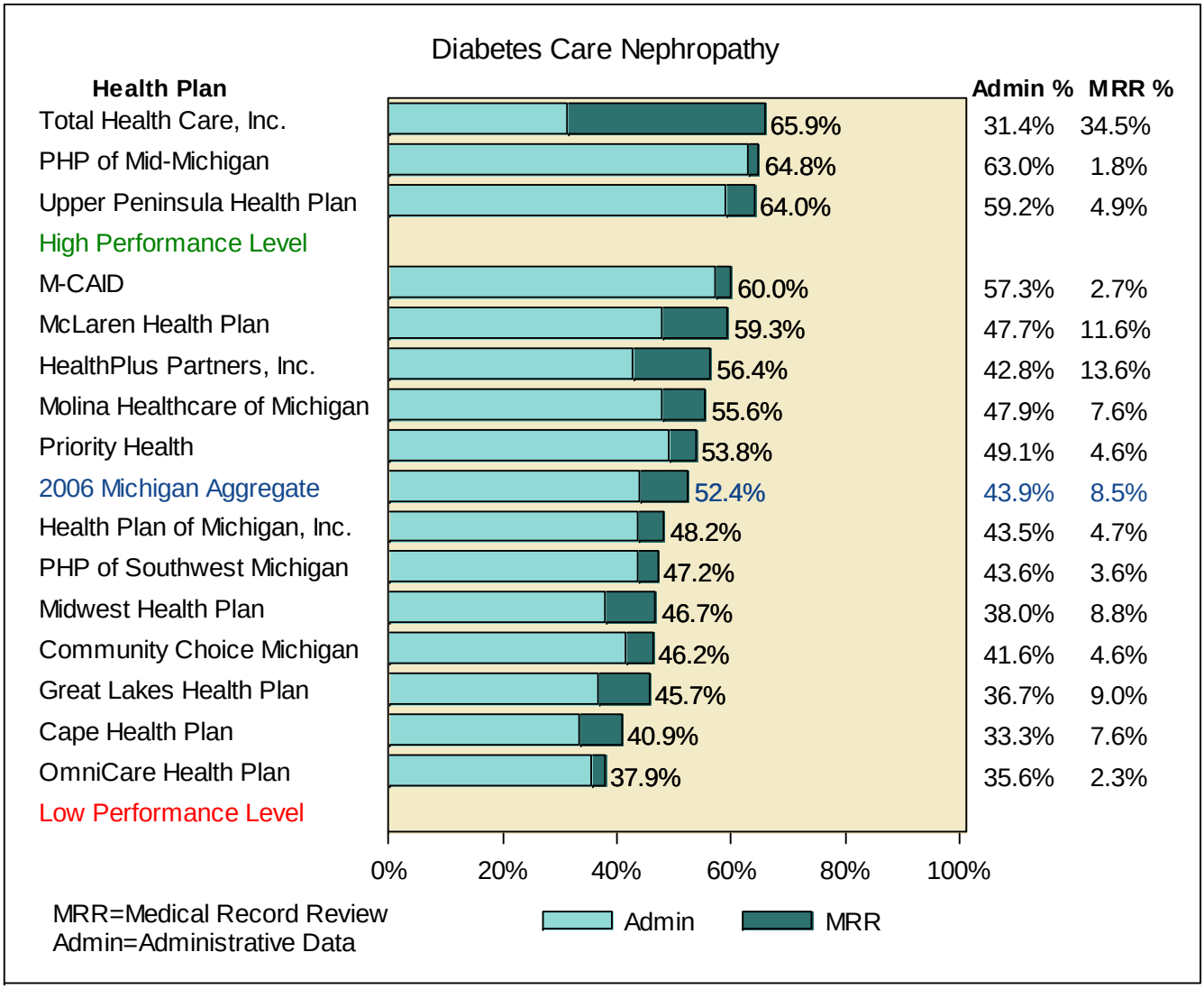
The 2006 Michigan Medicaid weighted average of 50.7 percent was 4.2 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 46.5 percent.

The 2006 Michigan Medicaid weighted average showed an increase from 2005, up 3.1 percentage points. An increase of 10.0 percentage points was identified when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 40.7 percent.

In 2005, three health plans reported rates above the HPL and none of the health plans had rates below the LPL. Overall, the reported rates showed modest improvement from 2005 to 2006.

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

Figure 5-14—Michigan Medicaid HEDIS 2006
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 method for calculation of this measure. The 2006 Michigan aggregate administrative rate was 43.9 percent and the medical record review rate was 8.5 percent.

Overall, 83.8 percent of the aggregate rate was derived from administrative data and 16.2 percent from medical record review. In 2005, 82.6 percent was derived from administrative data.

Administrative data completeness was not an issue with the majority of the health plans for this measure. This implies that providers and/or laboratories routinely submitted claims or encounter data for diabetic members who received monitoring for nephropathy.

Use of Appropriate Medications for People With Asthma

In 2004, asthma accounted for more than 13.6 million physician visits, 497,000 hospitalizations, and approximately 1.9 million emergency room (ER) visits in the United States.[5-25] It is one of the most common chronic conditions in both children and adults. The most current statistics show that approximately 9 million children and 11 million adults are affected.[5-26] In 2005, 15.3 percent of high school students in Michigan reported having asthma in a youth risk behavior survey.[5-27] In 2002, the asthma prevalence rate reported for adults in Michigan was 13.9 percent of the population, higher than the United States rate of 12.6 percent.[5-28] 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 current and prior measurement year:

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

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

[5-25] American Lung Association Epidemiology & Statistics Unit. *Trends in Asthma Morbidity and Mortality*, Table 18 & 19. July 2006. Available at: http://www.lungusa.org. Accessed on August 3, 2006.

[5-26] National Heart, Lung, and Blood Institute. Diseases and Conditions Index: Asthma. Available at: http://www.nhlbi.nih.gov/health/dci/Diseases/Asthma/Asthma_WhoIsAtRisk.html. Accessed on June 27, 2006.

[5-27] Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report. *Youth Risk Behavior Surveillance – United States, 2005*. June 9, 2006; 55(No. SS-5): 103.

[5-28] American Lung Association Epidemiology & Statistics Unit. *Trends in Asthma Morbidity and Mortality*, July 2006. Available at: http://www.lungusa.org. Accessed on August 3, 2006.

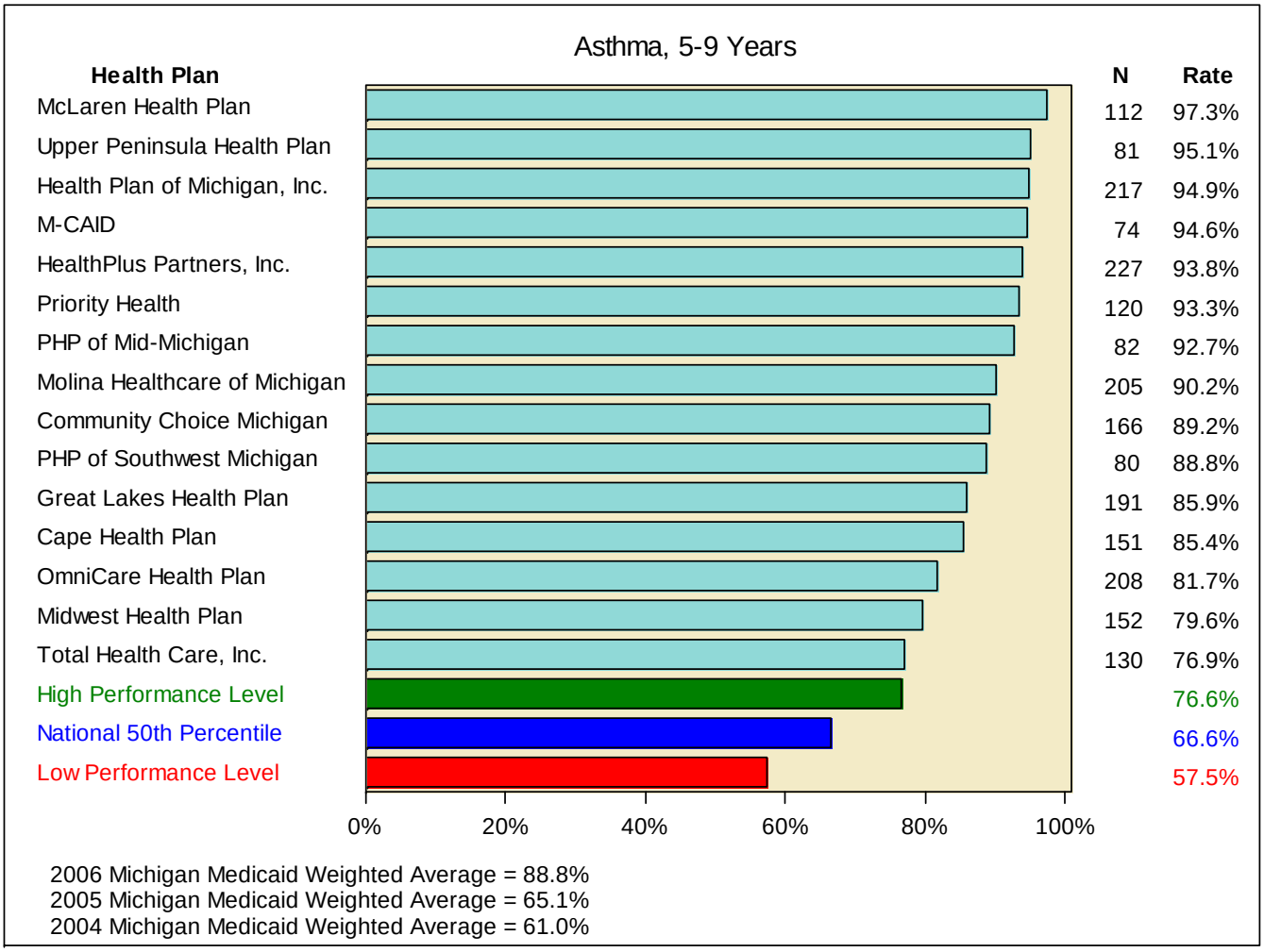
[5-29] National Committee for Quality Assurance. *HEDIS 2002 Technical Specifications.* Volume 2. Washington, DC: National Committee for Quality Assurance; 2001:96.

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 2006
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—Ages 5 to 9 Years



All of the health plans had rates above the HPL of 76.6 percent.

The 2006 Michigan Medicaid weighted average of 88.8 percent was 22.2 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 66.6 percent.

The 2006 Michigan Medicaid weighted average was higher than in 2005, up 23.7 percentage points. An increase of 27.8 percentage points was identified when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 61.0 percent.

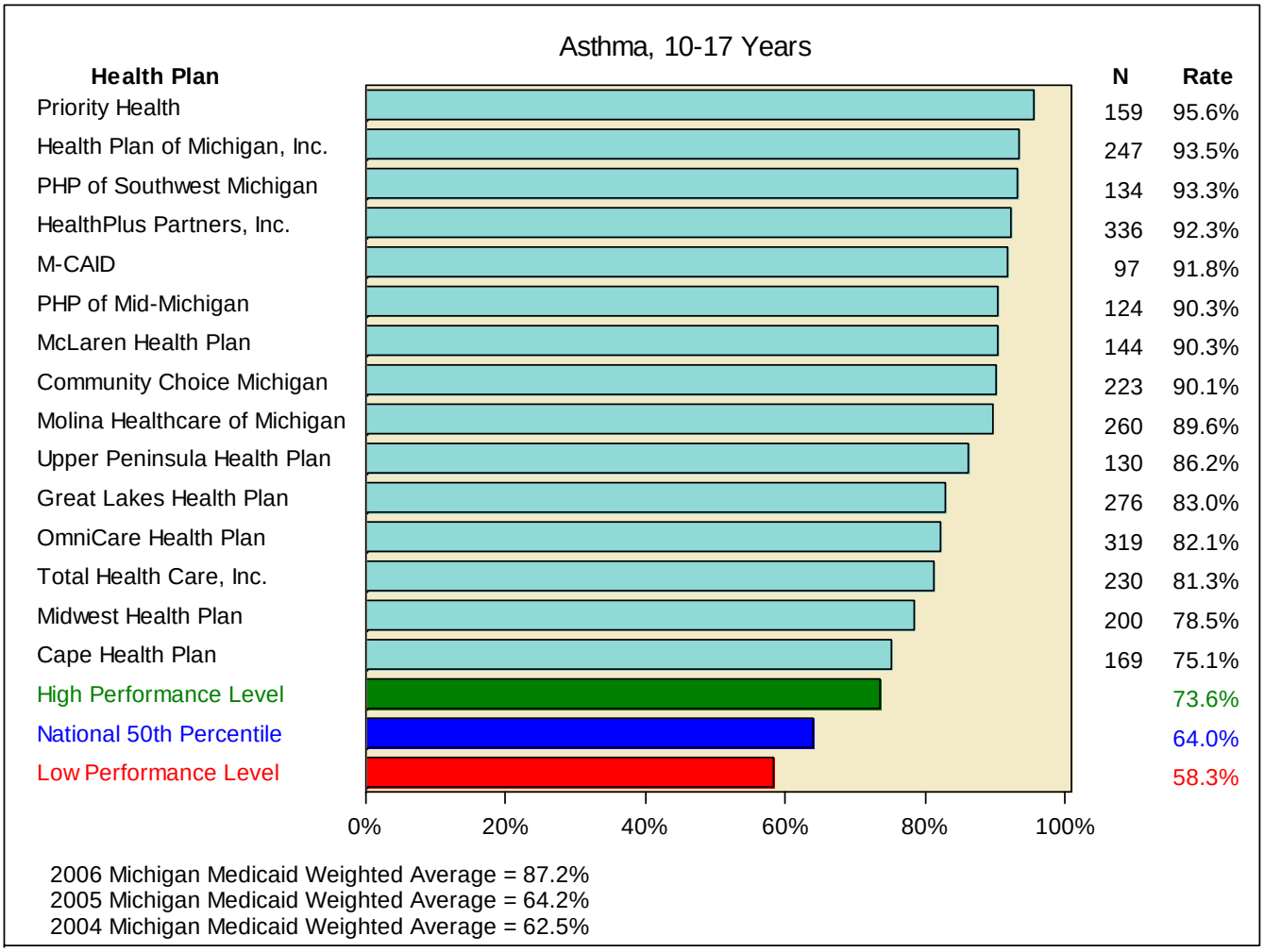
In 2005, six health plans reported rates above the HPL, and three health plans had rates below the LPL.

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, 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 who 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 2006
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—Ages 10 to 17 Years



All of the health plans had rates above the HPL of 73.6 percent.

The 2006 Michigan Medicaid weighted average of 87.2 percent was 23.2 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 64.0 percent.

The 2006 Michigan Medicaid weighted average was higher than in 2005, up 23.0 percentage points. An increase of 24.7 percentage points was identified when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 62.5 percent.

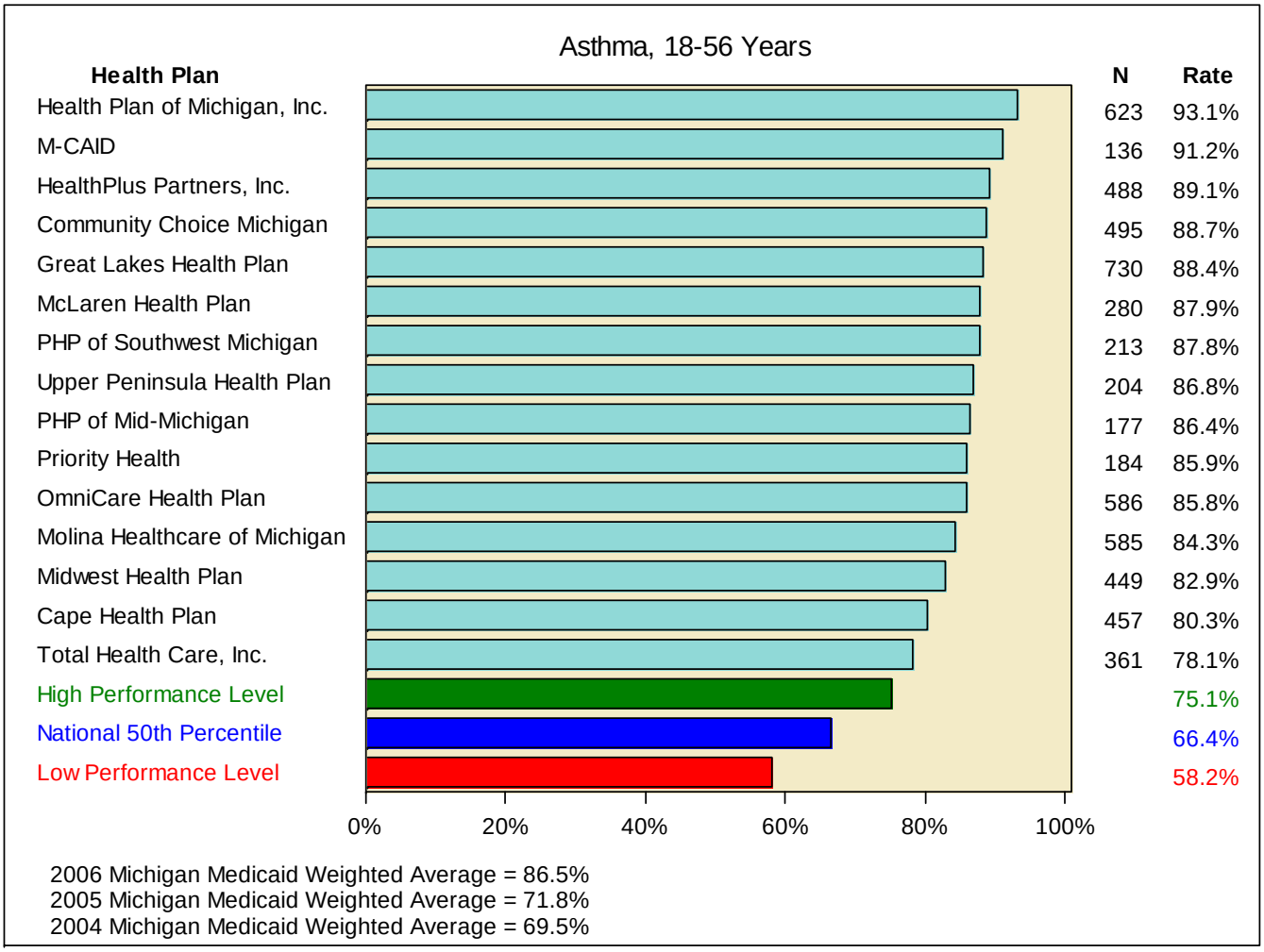
In 2005, two health plans reported rates above the HPL and three health plans had rates below the LPL.

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, who were identified as having persistent asthma as a result of any one of four specified events during the measurement year and the year prior to the measurement year, and who 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 2006
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—Ages 18 to 56 Years



All of the health plans had rates above the HPL of 75.1 percent.

The 2006 Michigan Medicaid weighted average of 86.5 percent was 20.1 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 66.4 percent.

The 2006 Michigan Medicaid weighted average was higher than in 2005, up 14.7 percentage points. An increase of 17.0 percentage points was identified when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 69.5 percent.

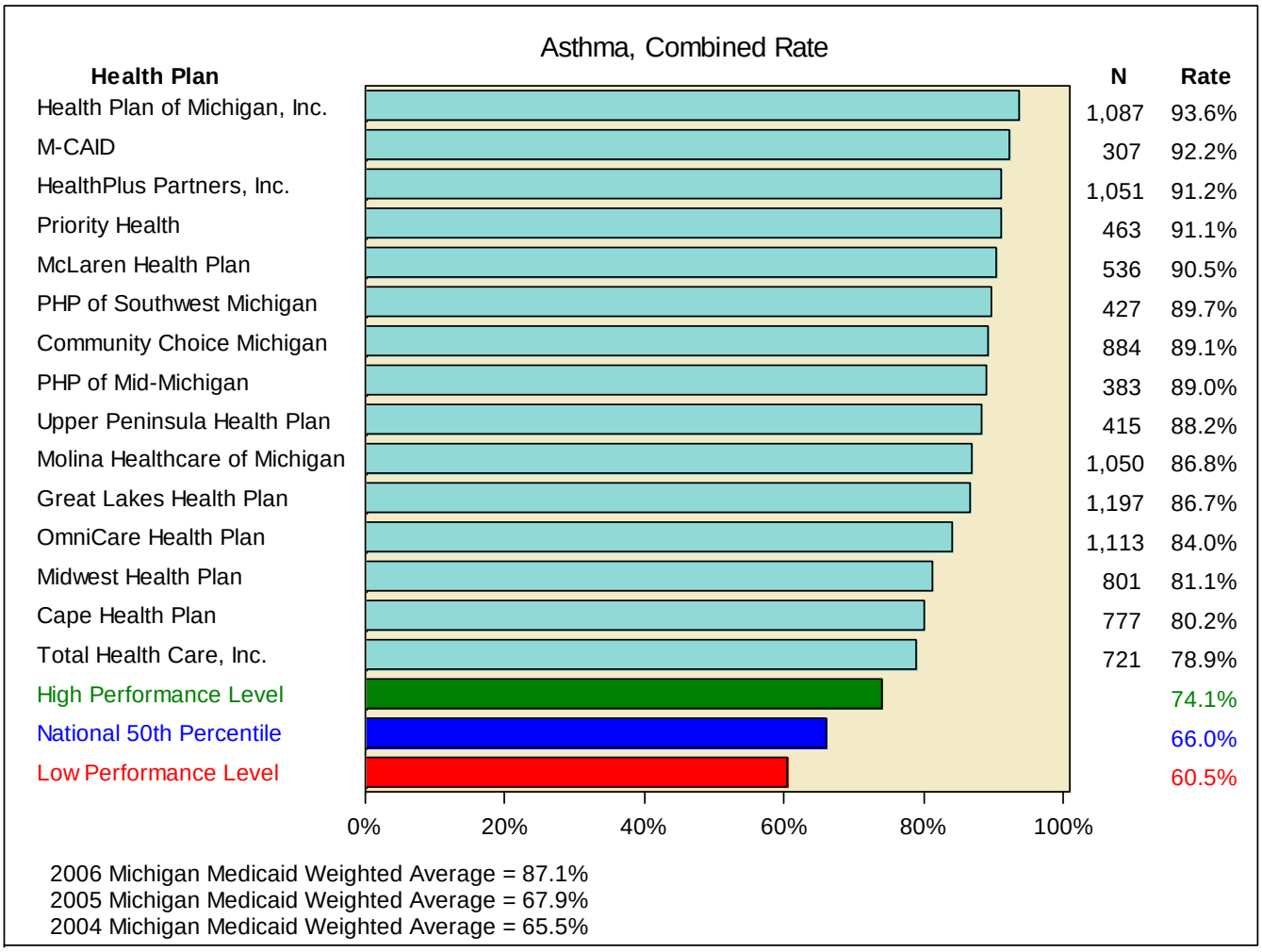
In 2005, two health plans reported rates above the HPL and none of the health plans had rates below the LPL.

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 2006
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—Combined Rate



All of the health plans had rates above the HPL of 74.1 percent.

The 2006 Michigan Medicaid weighted average of 87.1 percent was 21.1 percentage points above the national HEDIS 2005 Medicaid 50th percentile of 66.0 percent.

The 2006 Michigan Medicaid weighted average was higher than in 2005, up 19.2 percentage points. An increase of 21.6 percentage points was identified when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 65.5 percent.

In 2005, five health plans reported rates above the HPL and one health plan had a rate below the LPL.

Controlling High Blood Pressure

High blood pressure has long been referred to as the silent killer in the medical community. In fact, 70 percent of people with high blood pressure do not have it under control.[5-30] High blood pressure is a major risk factor for developing cardiovascular disease, kidney failure, stroke, and heart failure. 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.[5-31] Behavioral Risk Factor Surveillance System data indicate that 27.3 percent of adults in Michigan had high blood pressure in 2002.[5-32] Blood pressure is the most important factor in preserving kidney function and is critical in reducing the risk of stroke up to 40 percent.[5-33] 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.[5-34]

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 that was confirmed within the medical record, and whose blood pressure was controlled at 140/90 mm hg or less.

[5-30] 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 June 28, 2006.

[5-31] Healthy People 2010 Information Access Project Report on Heart Disease and Stroke. Available at: http://www.healthypeople.gov/document/html/volume1/12heart.htm. Accessed on November 27, 2006.

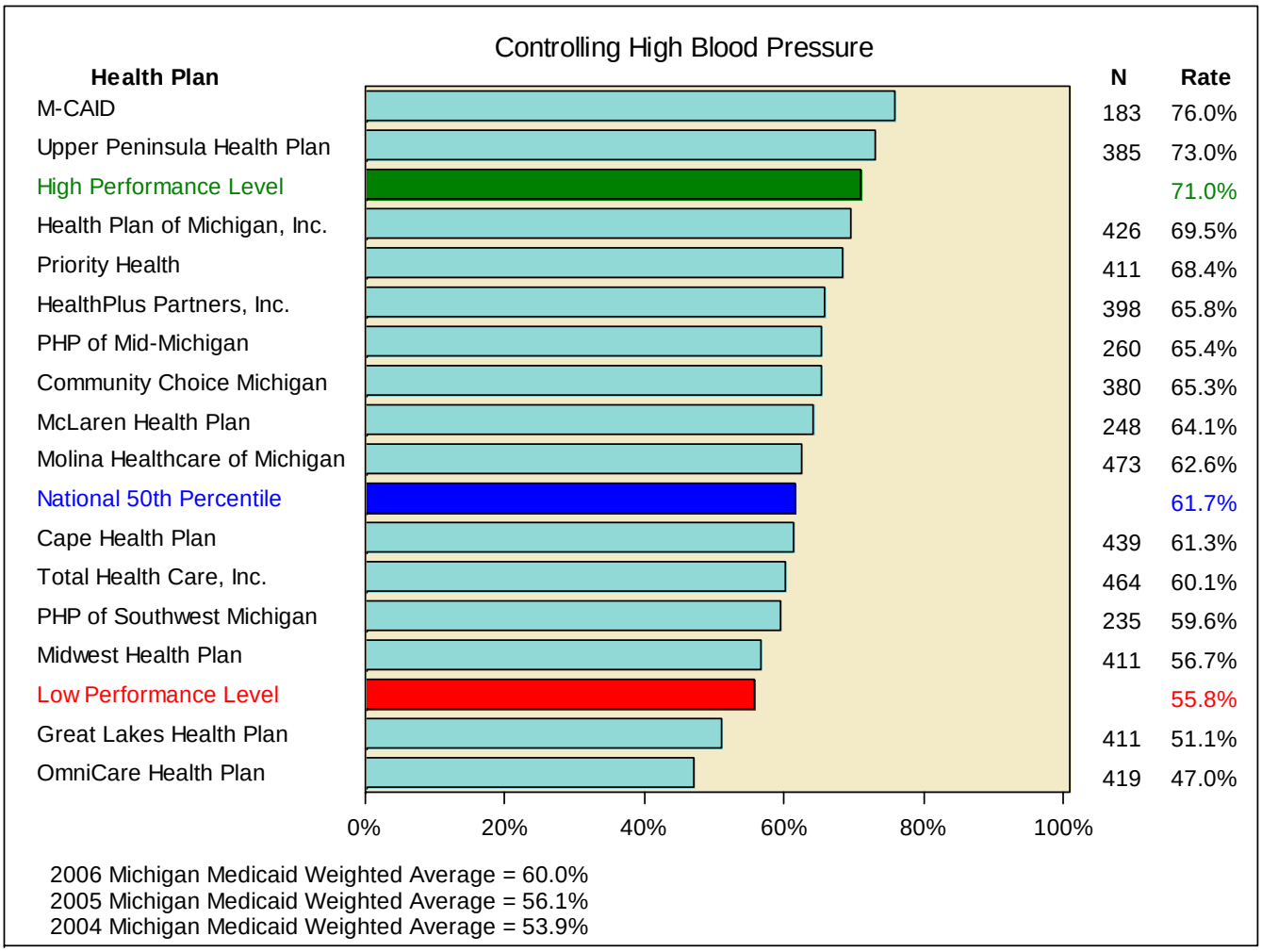
[5-32] Centers for Disease Control and Prevention. The Burden of Chronic Diseases and Their Risk Factors, 2004. Available at: http://www.cdc.gov/nccdphp/burdenbook2004/Section03/bloodpres.htm. Accessed on June 22, 2006.

[5-33] Michigan Department of Community Health. 2006 CVD Fact Sheet. Available at: http://www.michigan.gov/documents/cvdfact03_78179_7.pdf. Accessed on June 22, 2006.

[5-34] 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 June 22, 2006.

Health Plan Ranking: Controlling High Blood Pressure

Figure 5-19—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Controlling High Blood Pressure



Two of the health plans had rates above the HPL of 71.0 percent, while two health plans reported rates below the LPL of 55.8 percent. A total of nine health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

The 2006 Michigan Medicaid weighted average of 60.0 percent was 1.7 percentage points below the national HEDIS 2005 Medicaid 50th percentile of 61.7 percent.

The 2006 Michigan Medicaid weighted average was higher than in 2005, up 3.9 percentage points. An increase of 6.1 percentage points was identified when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 53.9 percent.

In 2005, two health plans reported rates above the HPL and three health plans had rates below the LPL. Overall, the range of reported rates showed improvement from 2005 to 2006.

Medical Assistance With Smoking Cessation—Advising Smokers to Quit

Approximately 44.5 million adults in the United States smoke cigarettes. Tobacco use is the leading cause of death in the United States, resulting in approximately 440,000 deaths each year. Discontinued use of tobacco is the most cost-effective method of preventing disease in adults. An economic assessment found that a health plan's annual cost of covering treatment to help people quit smoking ranged from $0.89 to $4.92 per smoker, whereas the annual cost of treating smoking-related illnesses ranged from $6 to $33 per smoker.[5-35]

Michigan currently has the 18th-highest rate of adult smokers in the nation. Michigan's smoking rate has shown a slight decline, with the most recent data showing 22 percent of adults smoking in 2005 compared with 23.4 percent in 2004.[5-36] In 2001, rates were high for some vulnerable populations: 43 percent of women enrolled in the Michigan Women, Infants, and Children (WIC) program smoked prior to pregnancy and 30 percent smoked during pregnancy.[5-37] Smoking during pregnancy increases the risk of infant mortality and low birth weight. Furthermore, children of smokers experience higher rates of asthma than children of nonsmokers.

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 secondhand 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 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.[5-38] This shows that even a brief message that is clear, strong, and personalized can have a positive affect on future smoking behavior.

HEDIS Specification—Advising Smokers to Quit

The *Medical Assistance With Smoking Cessation* measure is collected using the 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.

[5-35] Centers for Disease Control and Prevention. Office on Smoking and Health. Available at: http://www.cdc.gov/StateSytem/index.aspx. Accessed on July 5, 2006.

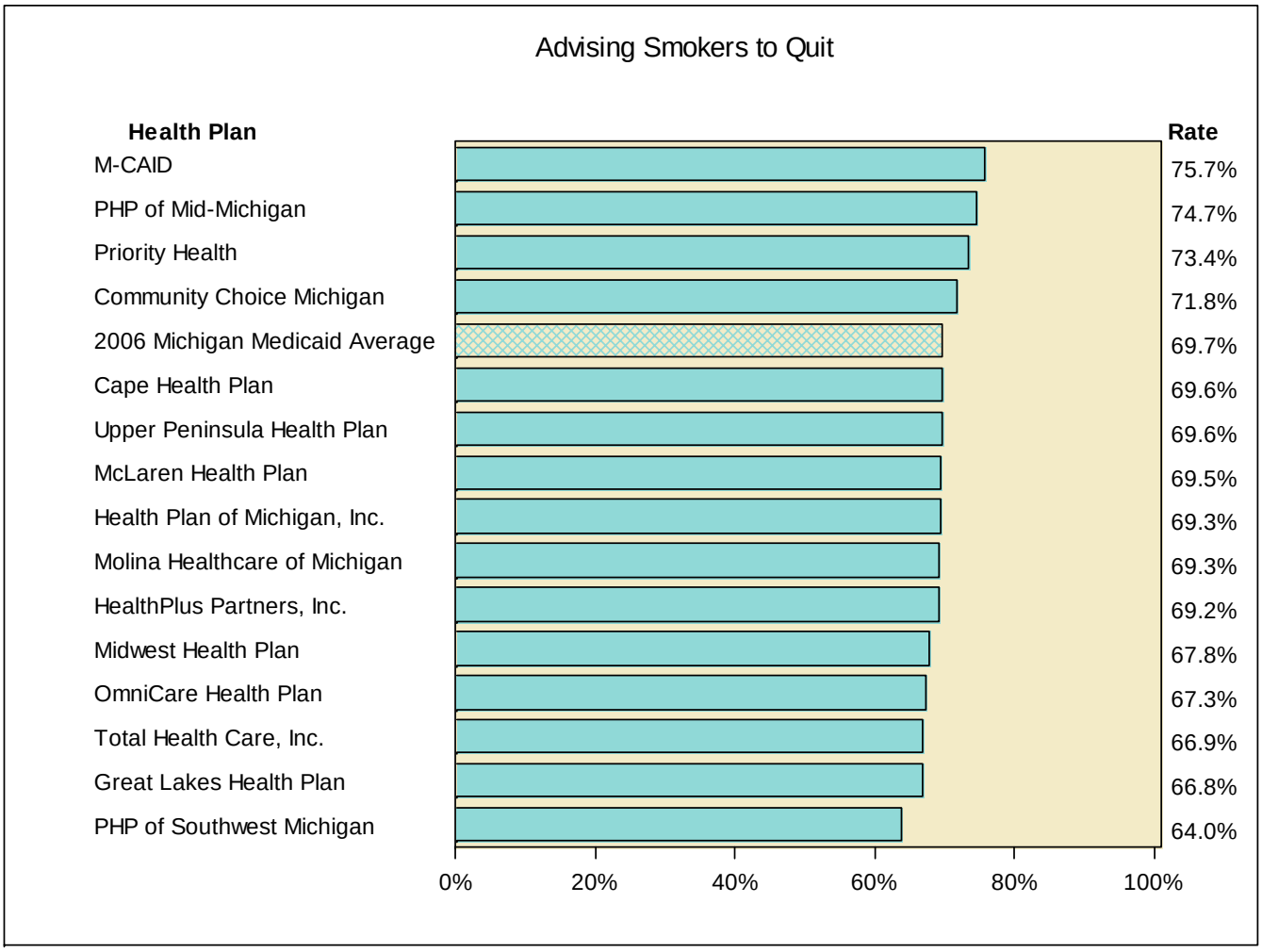
[5-36] Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System (BRFSS). Available at: http://www.cdc.gov/brfss/. Accessed on July 5, 2006.

[5-37] 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 June 22, 2006.

[5-38] 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.

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

Figure 5-20—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Medical Assistance with Smoking Cessation—Advising Smokers to Quit



For this measure, four of the 15 health plans had rates above the 2006 Michigan Medicaid average of 69.7 percent. The 2006 Michigan Medicaid average increased by 1.2 percentage points over the 2005 rate of 68.5 percent. The rates reported by the 15 health plans ranged from 64.0 percent to 75.7 percent. In 2005, seven of the health plans reported rates above the 2005 Michigan Medicaid average.

Living With Illness Findings and Recommendations

Within the Living With Illness dimension, some moderate improvements mixed with flat performance were observed. For the *Comprehensive Diabetes Care* indicators, all of the weighted averages showed an increase over the 2005 rates, but only one was statistically significant (*LDL-C Screening*). Modest gains were observed in the other diabetes indicators. Strong two-year trends in improvement were seen in the *HbA1c Poor Control, LDL-C Screening, LDL-C Level <130, LDL-C Level <100,* and *Monitoring for Diabetic Nephropathy.* Health plans continue to rely on the hybrid method for data collection for this measure, a common finding. An interesting observation was noted, however, when comparing what portion of the rate was obtained from medical record review for the *HbA1c Testing* and *LDL-C Screening* indicators. Administrative data for the *HbA1c Testing* indicator was relatively complete; however, for the *LDL-C Screening* indicator, heavier reliance on medical record review was observed. Given that these two indicators are collected from the same data sources, health plans should explore this phenomenon to determine if potential improvements can be made.

Of particular note in the area of diabetes care is the performance of Upper Peninsula Health Plan and Priority Health (UPP and PRI), both of which exceeded the HPL on five of the seven diabetes care indicators. These health plans have an existing disease management program for diabetes, as well as diabetic-focused improvement activities and goals. MDCH should consider allowing UPP and/or PRI to present some of its successful interventions and best practices to other MHPs.

Performance trending for the asthma indicators was not appropriate in 2006 due to significant changes to the HEDIS specifications for the measure. The changes resulted in a more refined process to identify asthmatics and, subsequently, smaller eligible populations, as well as significantly improved performance across the nation. These results were also observed in the Michigan MHP performance. The 2007 specifications will not change significantly, allowing again for trending of performance.

Michigan MHP performance for the remaining two measures within the Living With Illness dimension was average. Some modest improvement was seen in the weighted average for the *Controlling High Blood Pressure* measure; however, the rate was below the national Medicaid 50th percentile. The 2006 Michigan Medicaid average for the *Advising Smokers to Quit* measure demonstrated modest improvement over the 2005 rate, indicating a positive trend. The lack of a national percentile for this measure eliminated any ability to compare the State's performance to other MHPs.

The Living With Illness dimension offers the Michigan MHPs some opportunities for improvement. To realize improvement in the diabetes, asthma, and blood pressure measures, strong, focused case management programs are essential. The use of an internal registry that contains current, member-level data, such as claims/encounters and lab tests with results that are shared with the managing physicians, are very effective. Disease management programs must have the support and commitment of health plan senior management, with a dedicated individual to run the program. Additional best practices targeting the improvement of the diabetes care indicators include integrating the scheduling of health education appointments with the primary care physician's

(PCP's) appointment system, the use of standing orders that allow appropriate staff (a diabetic nurse educator or nutritionist) to order diabetic lab tests or modify diabetic medications according to established protocols, provision of current lists of diabetic members who are missing necessary screenings to physicians on a routine basis, and distribution of lists of diabetic members with high HbA1c values to their physicians. A survey targeted toward diabetics who are not receiving the appropriate services is recommended for further, more specific barrier analysis.

Hypertensive patients can also benefit from case management programs and the use of registry data. Routine monitoring and tracking of blood pressure results can provide physicians with the necessary data to keep their patients in better control. Members who have prescriptions for blood pressure medications who have not seen their provider for an extended period of time should have targeted outreach efforts.

Pharmacy data is also a powerful tool for the management of asthmatics. Providing PCPs with current information on their patients who are identified as asthmatics, coupled with a focused awareness on appropriate clinical management, can result in significant improvements.

The role of the medical director within the health plan can bring about positive change. Providing leadership and heightened awareness of improvement efforts, along with support from senior management, can result in the achievement of health plan goals, and subsequently, improvements in the outcomes of care.

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 existing health services and eliminating disparities 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 Center for Studying Health System Change (HSC) noted an increase in Americans' access to needed medical care from 2001 to 2003.[6-1] An HSC study published in 2004 used survey data to identify trends in increased access and potential delays in seeking needed care. Although access to care increased even among uninsured and low-income Americans, disparities still existed. A recent article in the *Journal of the American Medical Association (JAMA)* noted that the type of insurance coverage (or lack of insurance) had a significant impact on the ability to obtain timely access to care. Individuals with Medicaid coverage were found to be less likely to receive an appointment than those with private coverage (34.2 percent for Medicaid compared with 63.3 percent for private insurance).[6-2]

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

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

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

- **Children's and Adolescents' Access to Primary Care Practitioners**
  - *Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*
  - *Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years*
  - *Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years*
  - *Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years*
- **Adults' Access to Preventive/Ambulatory Health Services**
  - *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*
  - *Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years*

[6-1] Strunk BC, Cunningham PJ. *Trends in Americans' Access to Needed Medical Care, 2001–2003.* Center for Studying Health System Change: Tracking Report No. 10. August 2004. Available at: http://hschange.org/CONTENT/701/?topic=topic02. Accessed on October 7, 2005.

[6-2] Asplin BR, Rhodes KV, Levy H, et al. Insurance Status and Access to Urgent Ambulatory Care Follow-up Appointments. *Journal of the American Medical Association*. 2005; 294:1248–1254. Available at: http://jama.ama-assn.org/cgi/content/abstract/294/10/1248?maxtoshow=&HITS=10&hits. Accessed on October 7, 2005.

Children's and Adolescents' Access to Primary Care Practitioners

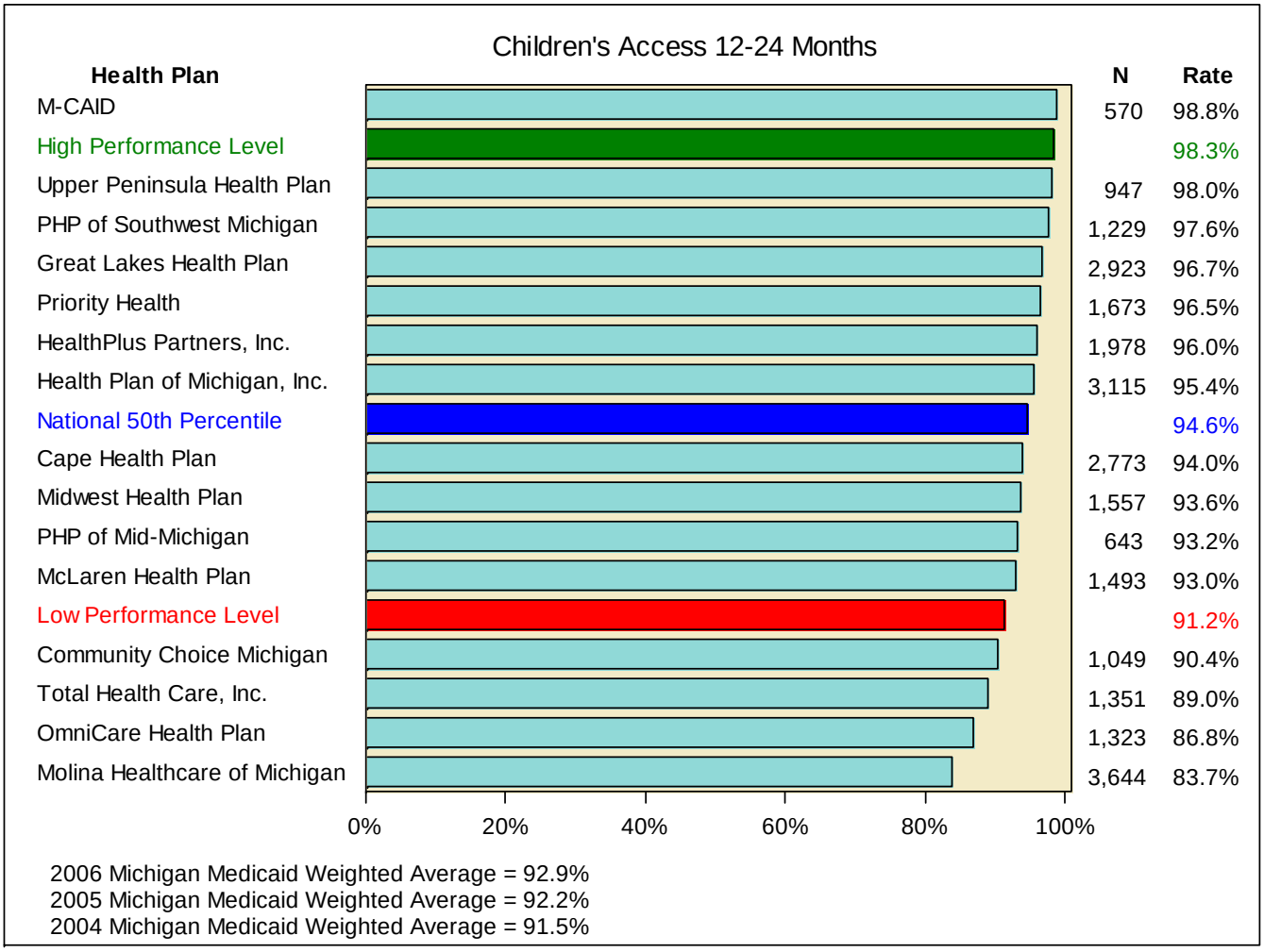
The *Children's and Adolescents' Access to Primary Care Practitioners* measure looks at visits to pediatricians, family physicians, and other primary care providers as a way to assess general access to care for children. Rates for four age groups are provided: 12 to 24 months, 25 months to 6 years, 7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

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

Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months calculates the percentage of members 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 2006
Health Plan Ranking:
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months



One of the health plans exceeded the HPL of 98.3 percent, while four health plans reported rates below the LPL of 91.2 percent. Seven of the 15 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

The 2006 Michigan Medicaid weighted average of 92.9 percent was 1.7 percentage points below the national HEDIS 2005 Medicaid 50th percentile of 94.6 percent.

The 2006 Michigan Medicaid weighted average was slightly higher than in 2005, up 0.7 of a percentage point. A gain of 1.4 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 91.5 percent.

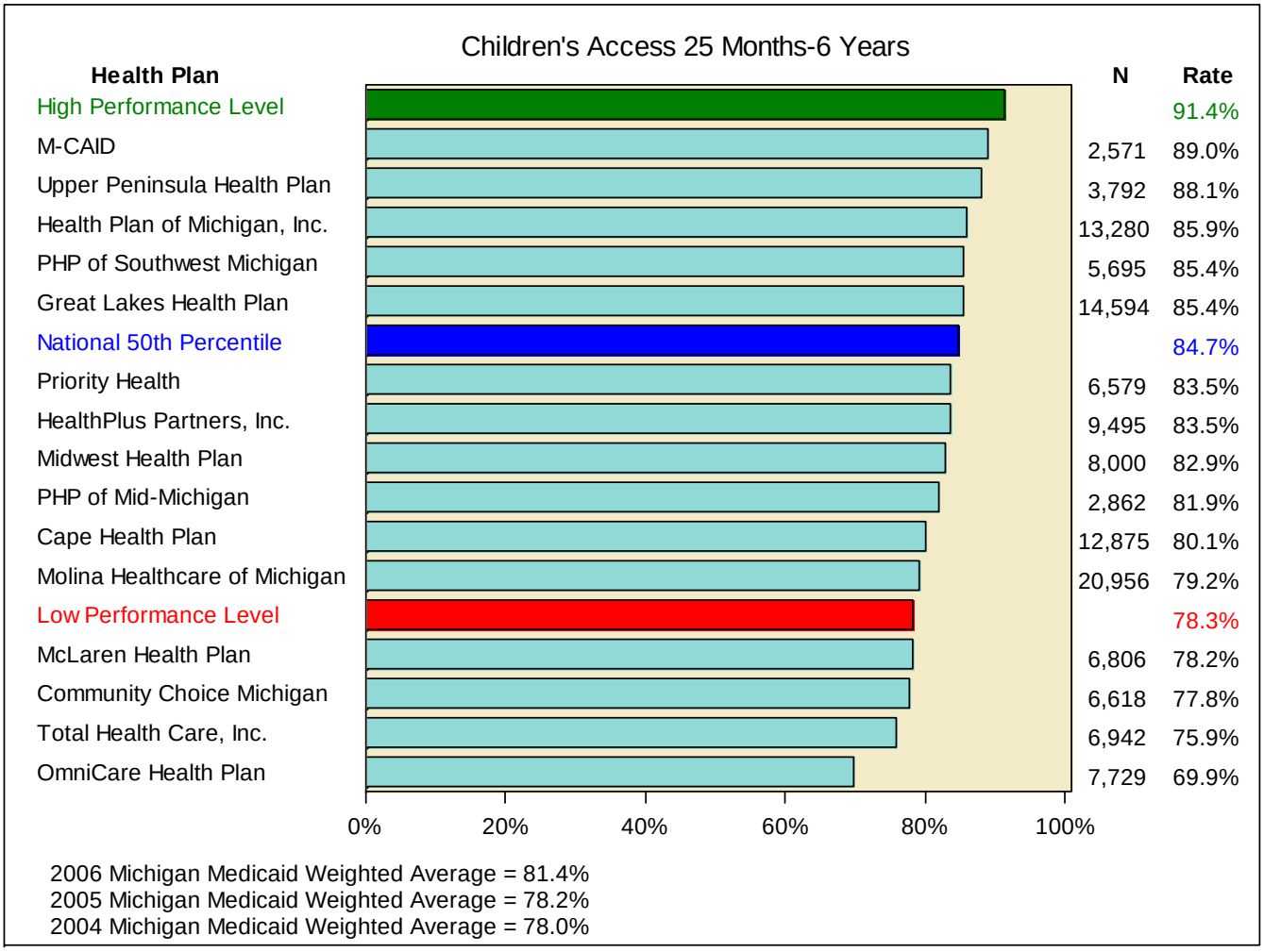
None of the health plans reached the HPL in 2005, while three health plans had rates below the LPL. Overall, the range of reported rates showed little improvement in 2006 when compared with 2005.

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 2006
Health Plan Ranking:
Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years



None of the health plans met the HPL of 91.4 percent, while four health plans reported rates below the LPL of 78.3 percent. Five of the 15 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

The 2006 Michigan Medicaid weighted average of 81.4 percent was 3.3 percentage points below the national HEDIS 2005 Medicaid 50th percentile of 84.7 percent.

The 2006 Michigan Medicaid weighted average was higher than in 2005, up 3.2 percentage points. A gain of 3.4 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 78.0 percent.

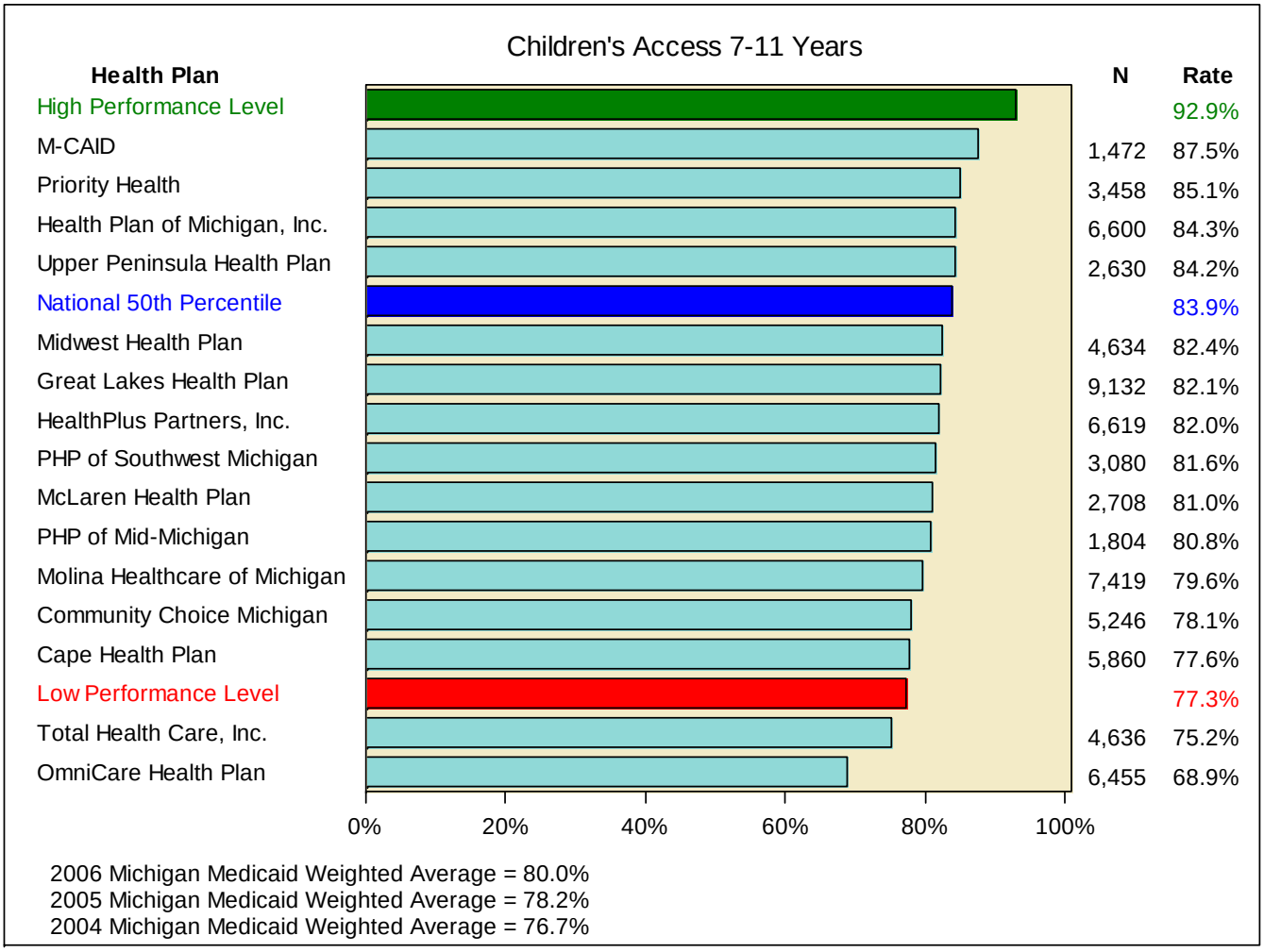
None of the health plans reached the HPL in 2005, while five health plans had rates below the LPL. Overall, the range of reported rates showed moderate improvement in 2006 when compared with 2005.

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 2006
Health Plan Ranking:
Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years



None of the health plans met the HPL of 92.9 percent, while two health plans reported rates below the LPL of 77.3 percent. Four of the 15 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

The 2006 Michigan Medicaid weighted average of 80.0 percent was 3.9 percentage points below the national HEDIS 2005 Medicaid 50th percentile of 83.9 percent.

The 2006 Michigan Medicaid weighted average was higher than in 2005, up 1.8 percentage points. A gain of 3.3 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 76.7 percent.

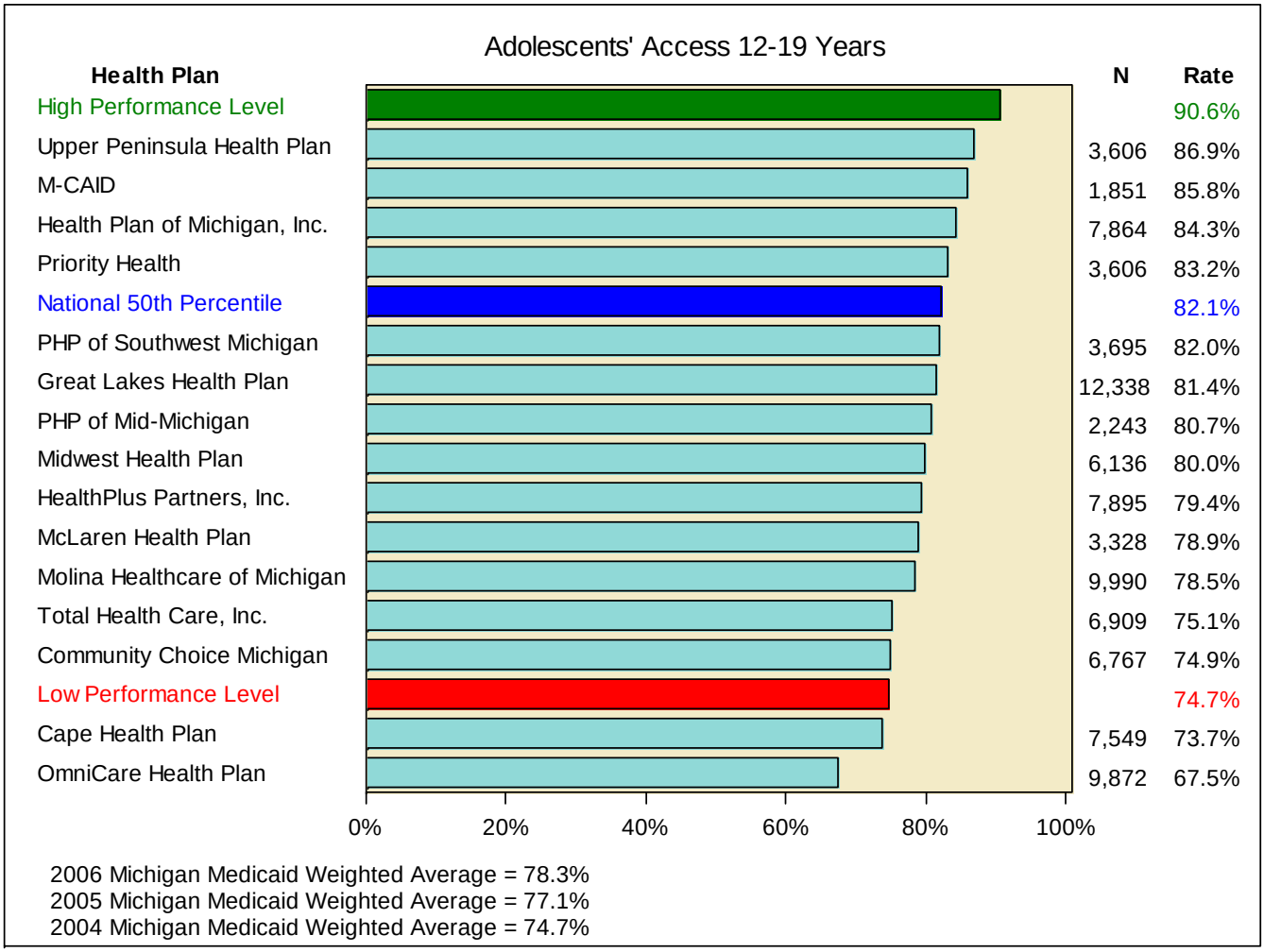
None of the health plans reached the HPL in 2005, while five health plans had rates below the LPL. Overall, the range of reported rates showed improvement in 2006 when compared with 2005.

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 2006
Health Plan Ranking:
Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years



None of the health plans met the HPL of 90.6 percent, while two health plans reported rates below the LPL of 74.7 percent. Four of the 15 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

The 2006 Michigan Medicaid weighted average of 78.3 percent was 3.8 percentage points below the national HEDIS 2005 Medicaid 50th percentile of 82.1 percent.

The 2006 Michigan Medicaid weighted average was higher than in 2005, up 1.2 percentage points. A gain of 3.6 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 74.7 percent.

None of the health plans reached the HPL in 2005, while three health plans had rates below the LPL. Overall, the range of reported rates showed a modest gain in 2006 when compared with 2005.

Adults' Access to Preventive/Ambulatory Health Services

The majority of adults have relatively frequent contact with their health care provider. According to the NCQA, 85 percent of Americans reported at least one visit with their health care provider within the last year and 13.5 percent reported 10 or more visits.[6-3]

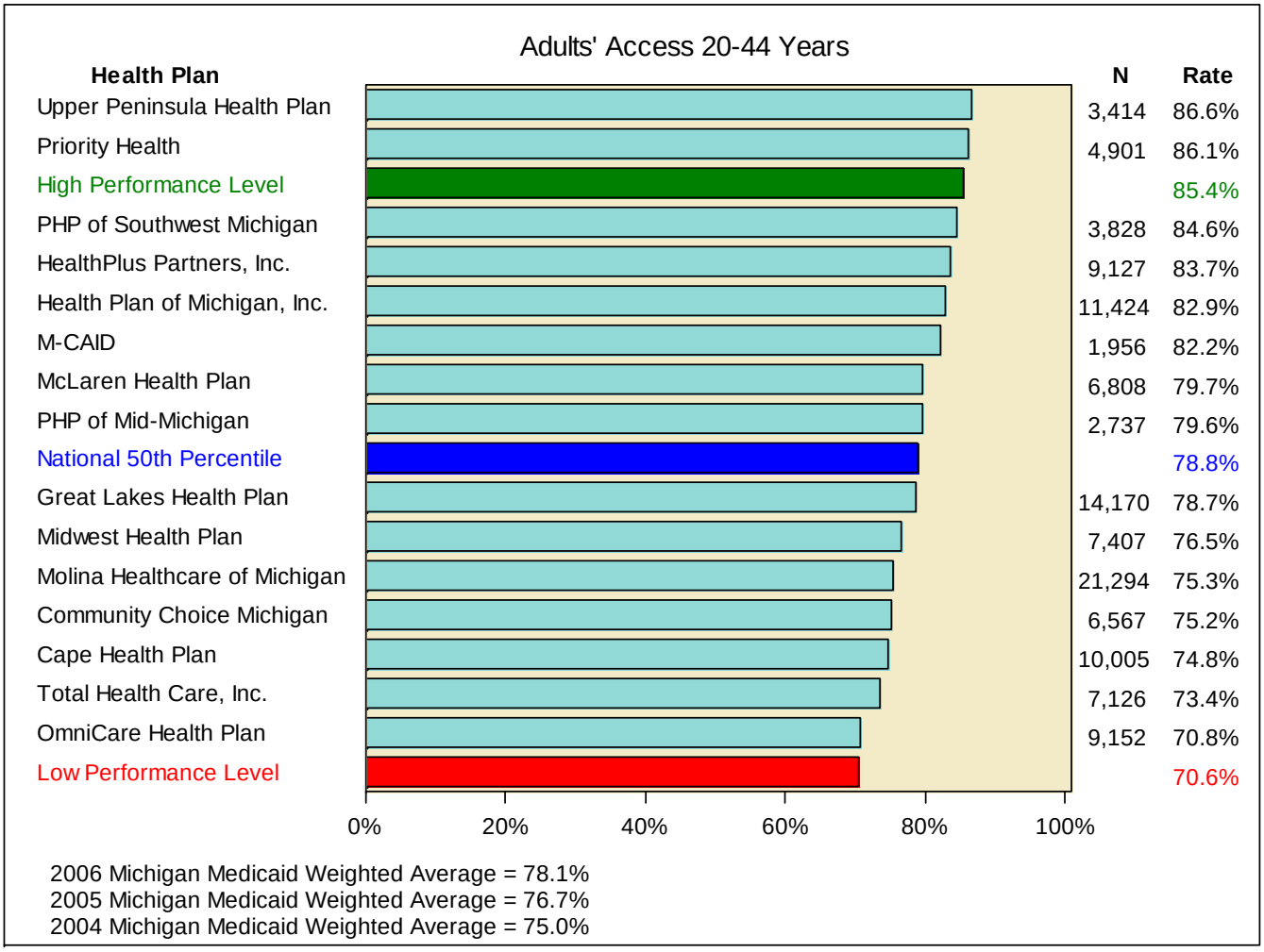
HEDIS Specification: Adults' Access to Preventive/Ambulatory Health Services —Ages 20 to 44 Years

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.

[6-3] 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 November 27, 2006.

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

Figure 6-5—Michigan Medicaid HEDIS 2006
Health Plan Ranking:
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years



Two of the health plans exceeded the HPL of 85.4 percent, while none of the health plans reported rates below the LPL of 70.6 percent. Eight of the 15 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

The 2006 Michigan Medicaid weighted average of 78.1 percent was 0.7 of a percentage point below the national HEDIS 2005 Medicaid 50th percentile of 78.8 percent.

The 2006 Michigan Medicaid weighted average was higher than in 2005, up 1.4 percentage points. A gain of 3.1 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 75.0 percent.

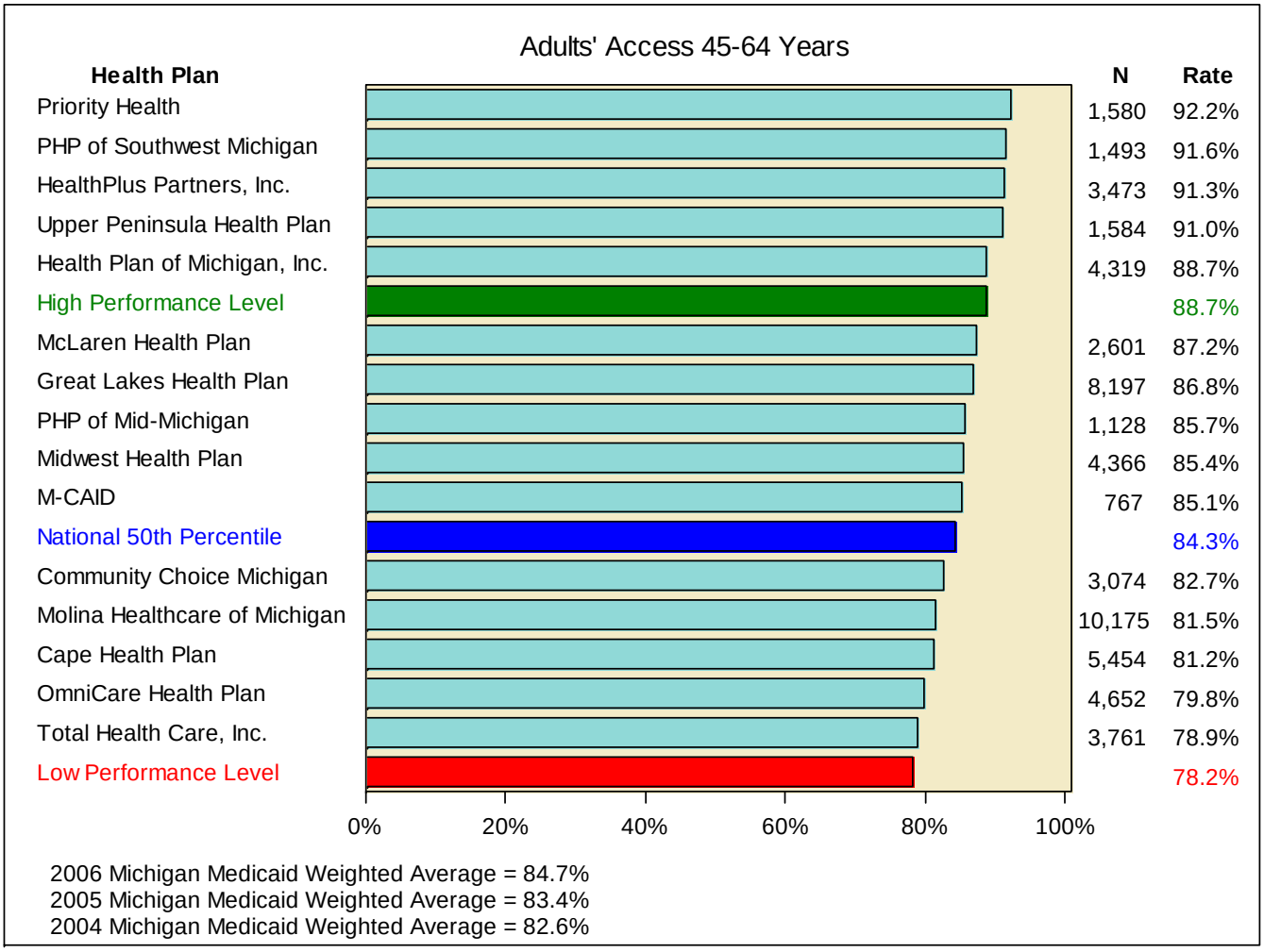
None of the health plans reached the HPL in 2005, while one of the health plans had a rate below the LPL. Overall, the range of reported rates showed improvement in 2006 when compared with 2005.

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 2006
Health Plan Ranking:
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years



Five of the health plans exceeded the HPL of 88.7 percent, while none of the health plans reported rates below the LPL of 78.2 percent. Ten of the 15 health plans reported rates above the national HEDIS 2005 Medicaid 50th percentile.

The 2006 Michigan Medicaid weighted average of 84.7 percent was 0.4 of a percentage point above the national HEDIS 2005 Medicaid 50th percentile of 84.3 percent.

The 2006 Michigan Medicaid weighted average was higher than in 2005, up 1.3 percentage points. A gain of 2.1 percentage points was observed when the 2006 Michigan Medicaid weighted average was compared with the 2004 Michigan Medicaid weighted average of 82.6 percent.

One health plan reached the HPL in 2005, while three health plans had rates below the LPL. Overall, the range of reported rates showed notable improvement in 2006 when compared with 2005.

Access to Care Findings and Recommendations

Average performance was observed within the Access to Care dimension for all indicators. As with previous years, improving access-to-care rates was a challenge. A modest improvement in all indicators was noted, which was encouraging, although none were statistically significant. Five out of the six weighted averages for the indicators within the dimension were below the national Medicaid 50th percentile. The exception was the *Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years* measure, which slightly exceeded the national Medicaid 50th percentile. The range of rates was moderately improved in the adult age groups, indicating less variation in performance across the Michigan MHPs.

Traditional quality improvement (QI) efforts such as case management programs, member education, and member incentives are not likely to have any positive impact on the Access to Care measures. These measures assess whether members have at least one ambulatory care visit with a health plan provider (with a primary care practitioner [PCP] for the children's and adolescents' measures). Intervention efforts must be targeted toward members who have not sought care in a physician's office (often called "silent members"). The MHPs must commit resources toward these silent, often forgotten, members (and possibly away from other successful QI initiatives) to make any significant changes. This will require a longer-term focus and commitment from MHP senior management, efforts that should be incorporated into the MHPs' QI plans.

Key Findings

HSAG staff reviewed each of the health plan's Final Audit Reports and Data Submission Tools (DSTs). Consistent with the findings last year, HSAG determined that, overall, the MHPs had no major issues that impacted HEDIS reporting. Again, none of the health plans had issues related to information systems capabilities that severely impacted the HEDIS results leading to a *Not Report*.

Fourteen of the 15 MHPs contracted with a certified software vendor to produce the rates for the key measures they reported. All of the five certified software vendors contracted by the MHPs achieved full certification for the HEDIS measures. One of the 15 MHPs developed and maintained its own programming logic to produce the measures.

The HEDIS audits were performed by four separate NCQA-Licensed Audit Organizations. One of the audit organizations conducted audits for the same 10 MHPs it audited last year. Another audit organization performed three of the four audits it conducted last year. Again this year, with one firm performing the majority of the audits, there was consistency in the audit reports information. In general, the audit reports provided sufficient detail to enable HSAG to evaluate the MHPs' IS capabilities.

Overall, the MHPs continued to improve again this year. For the most part, MHP auditors noted an increase in the number of claims/encounter data that are received electronically. Electronic transmission generally ensures the validity of the claims and encounter data. This is accomplished through automated edit and data completeness checks. Timeliness of the receipt, processing, and adjudication of the data are also generally improved with electronic submission. MHP auditors also noted, in many instances, that many MHPs were beginning to focus on data completeness. Some examples of the focus made by some of the MHPs were:

- Requiring providers to submit individual dates of service for prenatal care visits when submitting a global bill for maternity-related services. This was an attempt to further reduce the reliance on medical record review and helped to minimize the costs associated with it.
- Matching lab results data to lab claims or encounter data by: date of service, lab test code, and member ID number. Lab data sent to health plans by the lab generally do not include lab results. Some MHPs have worked with labs to secure lab results data. Matching the lab results data to the claims and encounter data helped to ensure the reliability of the data.
- Searching for additional sources of administrative data to further identify missing claims or encounter data for numerator compliance.

MHP auditors also noted the following for a few of the health plans:

- Several of the health plans were not reducing the sample size of the measures that they were reporting using the hybrid methodology. NCQA allows for the reduction in the sample size of certain hybrid measures based upon specific guidelines in the HEDIS® 2006 Technical

Specifications.[7-1] The guidelines for reducing are contingent upon specific administrative rates in the current year or reported rates in the year prior to the current year. Although NCQA does not require that a health plan reduce its sample size, the reduction would help to relieve the financial burden associated with the costs of medical record review for the hybrid measures.

- Some of the MHPs did not effectively track changes in eligibility status when transitioning from a dependent to a subscriber or vice-versa. Although this did not result in a significant bias for any of the measures reported by the MHPs, effectively tracking these changes helps to more accurately reflect continuous enrollment for members.

Conclusions and Recommendations

For the past six years, Michigan MHP information system capabilities pertaining to accurate and valid HEDIS reporting have been steadily improving. Overall audit issues continue to decrease and have become for the most part minimal. Many of the MHPs have begun to focus on alternate administrative data sources to help augment their administrative data, which was a recommendation made in last year's report. This should continue to be a focus for the MHPs. It was not noted by any of the MHP auditors that the MHPs were implementing targeted interventions to help improve rates or data completeness. This does not mean that none of the health plans implemented a targeted intervention(s); however, the evidence for this was not noted in the final reports. This continues to be an area health plans should focus on to improve both data completeness and their rates.

MDCH should continue to focus on maintaining a relatively consistent set of required measures as it has in the past years in order to utilize trending information advantageously. However, the approach could be balanced by adding one or two newer HEDIS measures to the key measures reporting set. Wherever possible, administrative measures that are less labor-intensive and costly to produce should be considered. HSAG recommends that MDCH continue to consult with the health plans regarding the capability to collect the necessary data and to determine collectively whether the measures add value to the State's overall quality improvement strategy.

[7-1] National Committee for Quality Assurance. *HEDIS 2006 Technical Specifications*, Volume 2. Washington, D.C.; National Committee for Quality Assurance; 2005.

Appendix A. Tabular Results for Key Measures by Health Plan

Appendix A presents tables showing results for the key measures by health plan. Where applicable, the results provided for each measure include the eligible population and rate for each MHP; the 2004, 2005, and 2006 Michigan Medicaid weighted averages; and the national HEDIS 2005 Medicaid 50th percentile. The following is a list of the tables and the key measures presented in each.

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

Table A-1—Tabular Results for Key Measures by Health Plan: Immunization Status

			Childhood Immunization Status			Adolescent Immunization Status	
DST	Plan Name	Code	Eligible Population	Combo 2 Rate	Combo 3 Rate	Eligible Population	Combo 2 Rate
4333	Cape Health Plan	CAP	2,500	73.9%	34.5%	1,809	54.3%
4265	Community Choice Michigan	CCM	1,074	75.7%	33.6%	1,403	62.6%
4133	Great Lakes Health Plan	GLH	2,717	72.0%	37.2%	2,582	56.4%
4291	Health Plan of Michigan, Inc.	HPM	2,860	78.0%	38.9%	1,765	58.8%
4056	HealthPlus Partners, Inc.	HPP	1,783	83.9%	44.8%	1,631	70.3%
4243	M-CAID	MCD	485	81.0%	56.7%	425	68.5%
4312	McLaren Health Plan	MCL	1,303	78.8%	39.9%	875	54.3%
4131	Midwest Health Plan	MID	1,644	75.9%	32.8%	1,269	55.0%
4151	Molina Healthcare of Michigan	MOL	3,024	72.4%	35.5%	2,947	51.1%
4055	OmniCare Health Plan	OCH	1,444	72.0%	24.1%	1,941	47.9%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	572	77.6%	41.6%	465	72.3%
4054	Priority Health Government Programs, Inc.	PRI	1,383	88.3%	56.0%	808	69.8%
4283	Physicians Health Plan of Southwest Michigan	PSW	1,265	80.5%	49.4%	785	60.3%
4268	Total Health Care, Inc.	THC	1,259	71.5%	34.3%	1,385	71.2%
4348	Upper Peninsula Health Plan	UPP	819	79.4%	38.8%	686	70.1%
	2006 Michigan Medicaid Weighted Average		- -	76.6%	38.5%	- -	58.9%
	2005 Michigan Medicaid Weighted Average		- -	71.7%	- -	- -	53.0%
	2004 Michigan Medicaid Weighted Average		- -	67.4%	- -	- -	34.5%
	National HEDIS 2005 Medicaid 50th Percentile		- -	66.0%	- -	- -	38.5%

Notes: The 2004 Michigan Medicaid Weighted Average included 17 health plans, and the 2005 and 2006 Michigan Medicaid Weighted Averages included 15 health plans.

Childhood Immunization Status—Combo 3 was a new measure for HEDIS 2006. Therefore, no percentile data were available.

Table A-2—Tabular Results for Key Measures by Health Plan: Well-Child Visits in the First 15 Months of Life

DST	Plan Name	Code	Eligible Population	0 Visits Rate	6 or More Visits Rate
4333	Cape Health Plan	CAP	875	4.4%	46.7%
4265	Community Choice Michigan	CCM	507	3.9%	41.6%
4133	Great Lakes Health Plan	GLH	1,053	0.7%	64.2%
4291	Health Plan of Michigan, Inc.	HPM	812	1.7%	68.4%
4056	HealthPlus Partners, Inc.	HPP	889	2.2%	60.1%
4243	M-CAID	MCD	191	0.5%	64.4%
4312	McLaren Health Plan	MCL	466	1.2%	68.6%
4131	Midwest Health Plan	MID	475	4.9%	50.6%
4151	Molina Healthcare of Michigan	MOL	898	2.3%	43.3%
4055	OmniCare Health Plan	OCH	633	0.9%	45.1%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	238	1.3%	43.3%
4054	Priority Health Government Programs, Inc.	PRI	657	0.7%	50.0%
4283	Physicians Health Plan of Southwest Michigan	PSW	497	1.5%	50.9%
4268	Total Health Care, Inc.	THC	553	3.5%	35.4%
4348	Upper Peninsula Health Plan	UPP	791	1.9%	41.6%
	2006 Michigan Medicaid Weighted Average		- -	2.1%	51.9%
	2005 Michigan Medicaid Weighted Average		- -	3.4%	43.0%
	2004 Michigan Medicaid Weighted Average		- -	4.2%	36.8%
	National HEDIS 2005 Medicaid 50th Percentile		- -	2.1%	46.4%

Note: The 2004 Michigan Medicaid Weighted Average included 17 health plans, and the 2005 and 2006 Michigan Medicaid Weighted Averages included 15 health plans.

Table A-3—Tabular Results for Key Measures by Health Plan: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, and Adolescent Well-Care Visits

			3rd–6th Years of Life		Adolescent	
DST	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate
4333	Cape Health Plan	CAP	10,317	67.1%	13,885	46.0%
4265	Community Choice Michigan	CCM	5,364	54.6%	8,764	37.0%
4133	Great Lakes Health Plan	GLH	11,940	66.9%	19,671	52.1%
4291	Health Plan of Michigan, Inc.	HPM	10,489	67.8%	14,402	52.5%
4056	HealthPlus Partners, Inc.	HPP	7,825	58.5%	11,261	43.8%
4243	M-CAID	MCD	2,129	67.4%	2,776	51.4%
4312	McLaren Health Plan	MCL	5,419	63.3%	8,327	45.7%
4131	Midwest Health Plan	MID	6,339	73.5%	10,051	48.9%
4151	Molina Healthcare of Michigan	MOL	17,282	62.2%	31,814	34.5%
4055	OmniCare Health Plan	OCH	6,326	65.8%	13,645	39.6%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	2,288	67.6%	3,445	47.7%
4054	Priority Health Government Programs, Inc.	PRI	5,203	61.6%	6,195	41.8%
4283	Physicians Health Plan of Southwest Michigan	PSW	4,510	57.9%	5,559	33.1%
4268	Total Health Care, Inc.	THC	5,691	65.4%	10,884	47.9%
4348	Upper Peninsula Health Plan	UPP	3,064	59.7%	4,889	37.0%
	2006 Michigan Medicaid Weighted Average		- -	64.2%	- -	43.5%
	2005 Michigan Medicaid Weighted Average		- -	58.5%	- -	38.0%
	2004 Michigan Medicaid Weighted Average		- -	55.3%	- -	34.2%
	National HEDIS 2005 Medicaid 50th Percentile		- -	64.1%	- -	38.0%

Note: The 2004 Michigan Medicaid Weighted Average included 17 health plans, and the 2005 and 2006 Michigan Medicaid Weighted Averages included 15 health plans.

Table A-4—Tabular Results for Key Measures by Health Plan: Appropriate Treatment for Children With Upper Respiratory Infection				
DST	Plan Name	Code	Eligible Population	Rate
4333	Cape Health Plan	CAP	5,814	74.2%
4265	Community Choice Michigan	CCM	2,842	75.9%
4133	Great Lakes Health Plan	GLH	7,702	70.7%
4291	Health Plan of Michigan, Inc.	HPM	4,457	79.3%
4056	HealthPlus Partners, Inc.	HPP	4,779	71.4%
4243	M-CAID	MCD	1,325	90.3%
4312	McLaren Health Plan	MCL	3,738	65.4%
4131	Midwest Health Plan	MID	5,204	75.7%
4151	Molina Healthcare of Michigan	MOL	8,733	76.5%
4055	OmniCare Health Plan	OCH	2,361	77.8%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	1,658	79.8%
4054	Priority Health Government Programs, Inc.	PRI	2,459	88.6%
4283	Physicians Health Plan of Southwest Michigan	PSW	3,419	79.8%
4268	Total Health Care, Inc.	THC	1,788	69.6%
4348	Upper Peninsula Health Plan	UPP	2,092	81.1%
	2006 Michigan Medicaid Weighted Average		- -	75.6%
	2005 Michigan Medicaid Weighted Average		- -	75.0%
	2004 Michigan Medicaid Weighted Average		- -	74.3%
	National HEDIS 2005 Medicaid 50th Percentile		- -	81.5%

Note: The 2004 Michigan Medicaid Weighted Average included 17 health plans, and the 2005 and 2006 Michigan Medicaid Weighted Averages included 15 health plans.

Table A-5—Tabular Results for Key Measures by Health Plan: Appropriate Testing for Children With Pharyngitis				
DST	Plan Name	Code	Eligible Population	Rate
4333	Cape Health Plan	CAP	2,523	9.1%
4265	Community Choice Michigan	CCM	1,953	49.0%
4133	Great Lakes Health Plan	GLH	3,977	35.6%
4291	Health Plan of Michigan, Inc.	HPM	4,052	50.9%
4056	HealthPlus Partners, Inc.	HPP	3,046	36.2%
4243	M-CAID	MCD	672	58.8%
4312	McLaren Health Plan	MCL	1,921	42.4%
4131	Midwest Health Plan	MID	3,011	13.4%
4151	Molina Healthcare of Michigan	MOL	4,472	44.2%
4055	OmniCare Health Plan	OCH	930	28.3%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	648	48.0%
4054	Priority Health Government Programs, Inc.	PRI	1,235	68.9%
4283	Physicians Health Plan of Southwest Michigan	PSW	1,850	60.2%
4268	Total Health Care, Inc.	THC	1,656	29.3%
4348	Upper Peninsula Health Plan	UPP	950	52.3%
	2006 Michigan Medicaid Weighted Average		- -	39.1%
	2005 Michigan Medicaid Weighted Average		- -	42.1%
	2004 Michigan Medicaid Weighted Average		- -	43.8%
	National HEDIS 2005 Medicaid 50th Percentile		- -	56.7%

Note: The 2004 Michigan Medicaid Weighted Average included 17 health plans, and the 2005 and 2006 Michigan Medicaid Weighted Averages included 15 health plans.

Table A-6—Tabular Results for Key Measures by Health Plan: Cancer Screening in Women

			Breast Cancer Screening		Cervical Cancer Screening	
DST	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate
4333	Cape Health Plan	CAP	1,299	53.3%	10,685	62.6%
4265	Community Choice Michigan	CCM	858	47.1%	7,596	67.6%
4133	Great Lakes Health Plan	GLH	2,289	59.3%	15,304	60.1%
4291	Health Plan of Michigan, Inc.	HPM	1,050	58.0%	10,877	66.8%
4056	HealthPlus Partners, Inc.	HPP	1,041	61.8%	8,713	70.4%
4243	M-CAID	MCD	200	45.0%	1,774	73.8%
4312	McLaren Health Plan	MCL	510	56.9%	6,548	67.4%
4131	Midwest Health Plan	MID	1,008	58.3%	7,828	62.3%
4151	Molina Healthcare of Michigan	MOL	1,265	58.6%	21,466	62.1%
4055	OmniCare Health Plan	OCH	1,393	49.2%	9,877	65.4%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	310	54.8%	2,720	74.5%
4054	Priority Health Government Programs, Inc.	PRI	431	56.1%	4,892	77.7%
4283	Physicians Health Plan of Southwest Michigan	PSW	425	59.5%	3,758	73.5%
4268	Total Health Care, Inc.	THC	984	47.1%	7,622	67.5%
4348	Upper Peninsula Health Plan	UPP	467	70.0%	3,235	73.0%
	2006 Michigan Medicaid Weighted Average		- -	55.8%	- -	65.8%
	2005 Michigan Medicaid Weighted Average		- -	53.7%	- -	63.4%
	2004 Michigan Medicaid Weighted Average		- -	54.6%	- -	62.6%
	National HEDIS 2005 Medicaid 50th Percentile		- -	54.7%	- -	64.5%

Note: The 2004 Michigan Medicaid Weighted Average included 17 health plans, and the 2005 and 2006 Michigan Medicaid Weighted Averages included 15 health plans.

Table A-7—Tabular Results for Key Measures by Health Plan: Chlamydia Screening in Women

			Ages 16 to 20 Years		Ages 21 to 25 Years		Combined Rate	
DST	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
4333	Cape Health Plan	CAP	1,272	52.6%	1,174	57.7%	2,446	55.0%
4265	Community Choice Michigan	CCM	995	48.1%	768	52.9%	1,763	50.2%
4133	Great Lakes Health Plan	GLH	2,010	47.2%	1,592	55.8%	3,602	51.0%
4291	Health Plan of Michigan, Inc.	HPM	1,816	49.1%	1,630	54.7%	3,446	51.7%
4056	HealthPlus Partners, Inc.	HPP	1,389	50.5%	1,336	57.9%	2,725	54.1%
4243	M-CAID	MCD	290	52.8%	260	60.0%	550	56.2%
4312	McLaren Health Plan	MCL	993	53.3%	822	54.3%	1,815	53.7%
4131	Midwest Health Plan	MID	902	40.0%	682	48.2%	1,584	43.6%
4151	Molina Healthcare of Michigan	MOL	3,527	56.3%	2,665	59.9%	6,192	57.9%
4055	OmniCare Health Plan	OCH	1,565	62.3%	1,118	70.8%	2,683	65.9%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	393	64.4%	369	64.2%	762	64.3%
4054	Priority Health Government Programs, Inc.	PRI	772	51.7%	883	59.2%	1,655	55.7%
4283	Physicians Health Plan of Southwest Michigan	PSW	673	43.4%	602	49.2%	1,275	46.1%
4268	Total Health Care, Inc.	THC	1,152	52.1%	893	62.8%	2,045	56.8%
4348	Upper Peninsula Health Plan	UPP	603	47.9%	481	45.3%	1,084	46.8%
	2006 Michigan Medicaid Weighted Average		- -	51.9%	- -	57.6%	- -	54.5%
	2005 Michigan Medicaid Weighted Average		- -	47.6%	- -	53.1%	- -	50.3%
	2004 Michigan Medicaid Weighted Average		- -	48.2%	- -	53.8%	- -	50.9%
	National HEDIS 2005 Medicaid 50th Percentile		- -	46.5%	- -	51.1%	- -	48.3%

Note: The 2004 Michigan Medicaid Weighted Average included 17 health plans, and the 2005 and 2006 Michigan Medicaid Weighted Averages included 15 health plans.

Table A-8—Tabular Results for Key Measures by Health Plan: Prenatal and Postpartum Care					
DST	Plan Name	Code	Eligible Population	Timeliness of Prenatal Care Rate	Postpartum Care Rate
4333	Cape Health Plan	CAP	1,500	71.4%	49.4%
4265	Community Choice Michigan	CCM	801	76.6%	60.1%
4133	Great Lakes Health Plan	GLH	1,955	75.4%	51.3%
4291	Health Plan of Michigan, Inc.	HPM	2,032	82.9%	56.8%
4056	HealthPlus Partners, Inc.	HPP	1,346	87.4%	62.0%
4243	M-CAID	MCD	220	89.5%	60.7%
4312	McLaren Health Plan	MCL	1,051	91.5%	76.6%
4131	Midwest Health Plan	MID	886	68.4%	46.5%
4151	Molina Healthcare of Michigan	MOL	1,295	82.0%	58.8%
4055	OmniCare Health Plan	OCH	1,231	81.9%	47.2%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	458	86.4%	62.5%
4054	Priority Health Government Programs, Inc.	PRI	1,094	90.6%	66.3%
4283	Physicians Health Plan of Southwest Michigan	PSW	656	85.4%	66.2%
4268	Total Health Care, Inc.	THC	954	87.5%	62.1%
4348	Upper Peninsula Health Plan	UPP	291	85.2%	53.5%
	2006 Michigan Medicaid Weighted Average		- -	81.7%	57.7%
	2005 Michigan Medicaid Weighted Average		- -	77.5%	53.7%
	2004 Michigan Medicaid Weighted Average		- -	71.5%	44.9%
	National HEDIS 2005 Medicaid 50th Percentile		- -	81.5%	58.4%

Note: The 2004 Michigan Medicaid Weighted Average included 17 health plans, and the 2005 and 2006 Michigan Medicaid Weighted Averages included 15 health plans.

Table A-9—Tabular Results for Key Measures by Health Plan: Comprehensive Diabetes Care

DST	Plan Name	Code	Eligible Population	HbA1c Testing Rate	Poor HbA1c Control Rate	Eye Exam Rate
4333	Cape Health Plan	CAP	1,781	72.2%	48.9%	48.9%
4265	Community Choice Michigan	CCM	1,191	81.5%	46.2%	41.8%
4133	Great Lakes Health Plan	GLH	2,918	73.5%	47.4%	52.6%
4291	Health Plan of Michigan, Inc.	HPM	1,808	78.7%	39.2%	58.6%
4056	HealthPlus Partners, Inc.	HPP	1,401	86.1%	29.7%	70.3%
4243	M-CAID	MCD	244	88.4%	33.8%	55.1%
4312	McLaren Health Plan	MCL	1,018	84.8%	37.4%	69.9%
4131	Midwest Health Plan	MID	1,574	71.5%	47.7%	49.1%
4151	Molina Healthcare of Michigan	MOL	3,620	88.8%	43.0%	52.3%
4055	OmniCare Health Plan	OCH	1,523	71.0%	53.7%	33.1%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	426	82.5%	34.3%	68.1%
4054	Priority Health Government Programs, Inc.	PRI	698	88.1%	30.7%	65.9%
4283	Physicians Health Plan of Southwest Michigan	PSW	600	87.1%	30.4%	64.7%
4268	Total Health Care, Inc.	THC	1,291	82.4%	42.3%	53.0%
4348	Upper Peninsula Health Plan	UPP	470	91.6%	23.9%	68.6%
	2006 Michigan Medicaid Weighted Average		- -	79.6%	42.3%	54.2%
	2005 Michigan Medicaid Weighted Average		- -	79.5%	44.6%	47.3%
	2004 Michigan Medicaid Weighted Average		- -	74.0%	51.2%	42.3%
	National HEDIS 2005 Medicaid 50th Percentile		- -	78.4%	47.5%	46.9%

Notes: The 2004 Michigan Medicaid Weighted Average included 17 health plans, and the 2005 and 2006 Michigan Medicaid Weighted Averages included 15 health plans.

HPP, MID, MOL, PMD, and UPP chose to rotate some (but not all) of the diabetes indicators. Measure rotation allows the MCO to use the audited and reportable rate from the previous year as specified by NCQA in the *HEDIS® 2006 HEDIS Compliance Audit™ : Standards, Policies, and Procedures*. HSAG chose to display the eligible population for the measurement year (MY) 2005 unless all indicators were rotated by the MCO (i.e., MCD chose to rotate all indicators and the eligible population displayed is from MY 2004).

Table A-9—Tabular Results for Key Measures by Health Plan: 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
4333	Cape Health Plan	CAP	1,781	87.0%	58.9%	34.3%	40.9%
4265	Community Choice Michigan	CCM	1,191	76.4%	51.3%	34.1%	46.2%
4133	Great Lakes Health Plan	GLH	2,918	88.1%	72.3%	62.0%	45.7%
4291	Health Plan of Michigan, Inc.	HPM	1,808	85.8%	51.3%	30.7%	48.2%
4056	HealthPlus Partners, Inc.	HPP	1,401	89.8%	64.0%	43.1%	56.4%
4243	M-CAID	MCD	244	91.6%	70.2%	50.2%	60.0%
4312	McLaren Health Plan	MCL	1,018	83.8%	61.9%	39.9%	59.3%
4131	Midwest Health Plan	MID	1,574	81.5%	62.8%	40.1%	46.7%
4151	Molina Healthcare of Michigan	MOL	3,620	84.5%	53.0%	33.9%	55.6%
4055	OmniCare Health Plan	OCH	1,523	80.5%	54.6%	34.5%	37.9%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	426	89.8%	71.5%	47.0%	64.8%
4054	Priority Health Government Programs, Inc.	PRI	698	91.5%	67.2%	43.1%	53.8%
4283	Physicians Health Plan of Southwest Michigan	PSW	600	86.1%	58.9%	37.5%	47.2%
4268	Total Health Care, Inc.	THC	1,291	84.6%	56.1%	34.5%	65.9%
4348	Upper Peninsula Health Plan	UPP	470	92.3%	61.7%	37.1%	64.0%
	2006 Michigan Medicaid Weighted Average		- -	85.4%	60.3%	40.7%	50.7%
	2005 Michigan Medicaid Weighted Average		- -	81.6%	56.6%	37.8%	47.6%
	2004 Michigan Medicaid Weighted Average		- -	74.6%	48.6%	29.1%	40.7%
	National HEDIS 2005 Medicaid 50th Percentile		- -	81.4%	52.7%	31.7%	46.5%

Notes: The 2004 Michigan Medicaid Weighted Average included 17 health plans, and the 2005 and 2006 Michigan Medicaid Weighted Averages included 15 health plans.

HPP, MID, MOL, PMD, and UPP chose to rotate some (but not all) of the diabetes indicators. Measure rotation allows the MCO to use the audited and reportable rate from the previous year as specified by NCQA in the *HEDIS® 2006 HEDIS Compliance Audit™ : Standards, Policies and Procedures*. HSAG chose to display the eligible population for the measurement year (MY) 2005 unless all indicators were rotated by the MCO (i.e., MCD chose to rotate all indicators and the eligible population displayed is from MY 2004).

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

			Ages 5 to 9 Years		Ages 10 to 17 Years		Ages 18 to 56 Years		Combined Rate	
DST	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
4333	Cape Health Plan	CAP	151	85.4%	169	75.1%	457	80.3%	777	80.2%
4265	Community Choice Michigan	CCM	166	89.2%	223	90.1%	495	88.7%	884	89.1%
4133	Great Lakes Health Plan	GLH	191	85.9%	276	83.0%	730	88.4%	1,197	86.7%
4291	Health Plan of Michigan, Inc.	HPM	217	94.9%	247	93.5%	623	93.1%	1,087	93.6%
4056	HealthPlus Partners, Inc.	HPP	227	93.8%	336	92.3%	488	89.1%	1,051	91.2%
4243	M-CAID	MCD	74	94.6%	97	91.8%	136	91.2%	307	92.2%
4312	McLaren Health Plan	MCL	112	97.3%	144	90.3%	280	87.9%	536	90.5%
4131	Midwest Health Plan	MID	152	79.6%	200	78.5%	449	82.9%	801	81.1%
4151	Molina Healthcare of Michigan	MOL	205	90.2%	260	89.6%	585	84.3%	1,050	86.8%
4055	OmniCare Health Plan	OCH	208	81.7%	319	82.1%	586	85.8%	1,113	84.0%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	82	92.7%	124	90.3%	177	86.4%	383	89.0%
4054	Priority Health Government Programs, Inc.	PRI	120	93.3%	159	95.6%	184	85.9%	463	91.1%
4283	Physicians Health Plan of Southwest Michigan	PSW	80	88.8%	134	93.3%	213	87.8%	427	89.7%
4268	Total Health Care, Inc.	THC	130	76.9%	230	81.3%	361	78.1%	721	78.9%
4348	Upper Peninsula Health Plan	UPP	81	95.1%	130	86.2%	204	86.8%	415	88.2%
	2006 Michigan Medicaid Weighted Average		- -	88.8%	- -	87.2%	- -	86.5%	- -	87.1%
	2005 Michigan Medicaid Weighted Average		- -	65.1%	- -	64.2%	- -	71.8%	- -	67.9%
	2004 Michigan Medicaid Weighted Average		- -	61.0%	- -	62.5%	- -	69.5%	- -	65.5%
	National HEDIS 2005 Medicaid 50th Percentile		- -	66.6%	- -	64.0%	- -	66.4%	- -	66.0%

Note: The 2004 Michigan Medicaid Weighted Average included 17 health plans, and the 2005 and 2006 Michigan Medicaid Weighted Averages included 15 health plans.

Table A-11—Tabular Results for Key Measures by Health Plan: Controlling High Blood Pressure				
DST	Plan Name	Code	Eligible Population	Rate
4333	Cape Health Plan	CAP	1,575	61.3%
4265	Community Choice Michigan	CCM	881	65.3%
4133	Great Lakes Health Plan	GLH	2,545	51.1%
4291	Health Plan of Michigan, Inc.	HPM	1,146	69.5%
4056	HealthPlus Partners, Inc.	HPP	1,013	65.8%
4243	M-CAID	MCD	194	76.0%
4312	McLaren Health Plan	MCL	255	64.1%
4131	Midwest Health Plan	MID	691	56.7%
4151	Molina Healthcare of Michigan	MOL	2,918	62.6%
4055	OmniCare Health Plan	OCH	1,617	47.0%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	272	65.4%
4054	Priority Health Government Programs, Inc.	PRI	502	68.4%
4283	Physicians Health Plan of Southwest Michigan	PSW	250	59.6%
4268	Total Health Care, Inc.	THC	1,206	60.1%
4348	Upper Peninsula Health Plan	UPP	405	73.0%
	2006 Michigan Medicaid Weighted Average		- -	60.0%
	2005 Michigan Medicaid Weighted Average		- -	56.1%
	2004 Michigan Medicaid Weighted Average		- -	53.9%
	National HEDIS 2005 Medicaid 50th Percentile		- -	61.7%

Note: The 2004 Michigan Medicaid Weighted Average included 17 health plans, and the 2005 and 2006 Michigan Medicaid Weighted Averages included 15 health plans.

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

			Ages 12 to 24 Months		Ages 25 Months to 6 Years		Ages 7 to 11 Years		Ages 12 to 19 Years	
DST	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
4333	Cape Health Plan	CAP	2,773	94.0%	12,875	80.1%	5,860	77.6%	7,549	73.7%
4265	Community Choice Michigan	CCM	1,049	90.4%	6,618	77.8%	5,246	78.1%	6,767	74.9%
4133	Great Lakes Health Plan	GLH	2,923	96.7%	14,594	85.4%	9,132	82.1%	12,338	81.4%
4291	Health Plan of Michigan, Inc.	HPM	3,115	95.4%	13,280	85.9%	6,600	84.3%	7,864	84.3%
4056	HealthPlus Partners, Inc.	HPP	1,978	96.0%	9,495	83.5%	6,619	82.0%	7,895	79.4%
4243	M-CAID	MCD	570	98.8%	2,571	89.0%	1,472	87.5%	1,851	85.8%
4312	McLaren Health Plan	MCL	1,493	93.0%	6,806	78.2%	2,708	81.0%	3,328	78.9%
4131	Midwest Health Plan	MID	1,557	93.6%	8,000	82.9%	4,634	82.4%	6,136	80.0%
4151	Molina Healthcare of Michigan	MOL	3,644	83.7%	20,956	79.2%	7,419	79.6%	9,990	78.5%
4055	OmniCare Health Plan	OCH	1,323	86.8%	7,729	69.9%	6,455	68.9%	9,872	67.5%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	643	93.2%	2,862	81.9%	1,804	80.8%	2,243	80.7%
4054	Priority Health Government Programs, Inc.	PRI	1,673	96.5%	6,579	83.5%	3,458	85.1%	3,606	83.2%
4283	Physicians Health Plan of Southwest Michigan	PSW	1,229	97.6%	5,695	85.4%	3,080	81.6%	3,695	82.0%
4268	Total Health Care, Inc.	THC	1,351	89.0%	6,942	75.9%	4,636	75.2%	6,909	75.1%
4348	Upper Peninsula Health Plan	UPP	947	98.0%	3,792	88.1%	2,630	84.2%	3,606	86.9%
	2006 Michigan Medicaid Weighted Average		- -	92.9%	- -	81.4%	- -	80.0%	- -	78.3%
	2005 Michigan Medicaid Weighted Average		- -	92.2%	- -	78.2%	- -	78.2%	- -	77.1%
	2004 Michigan Medicaid Weighted Average		- -	91.5%	- -	78.0%	- -	76.7%	- -	74.7%
	National HEDIS 2005 Medicaid 50th Percentile		- -	94.6%	- -	84.7%	- -	83.9%	- -	82.1%

Note: The 2004 Michigan Medicaid Weighted Average included 17 health plans, and the 2005 and 2006 Michigan Medicaid Weighted Averages included 15 health plans.

Table A-13—Tabular Results for Key Measures by Health Plan: Adults' Access to Preventive/Ambulatory Health Services						
			Ages 20 to 44 Years		Ages 45 to 64 Years	
DST	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate
4333	Cape Health Plan	CAP	10,005	74.8%	5,454	81.2%
4265	Community Choice Michigan	CCM	6,567	75.2%	3,074	82.7%
4133	Great Lakes Health Plan	GLH	14,170	78.7%	8,197	86.8%
4291	Health Plan of Michigan, Inc.	HPM	11,424	82.9%	4,319	88.7%
4056	HealthPlus Partners, Inc.	HPP	9,127	83.7%	3,473	91.3%
4243	M-CAID	MCD	1,956	82.2%	767	85.1%
4312	McLaren Health Plan	MCL	6,808	79.7%	2,601	87.2%
4131	Midwest Health Plan	MID	7,407	76.5%	4,366	85.4%
4151	Molina Healthcare of Michigan	MOL	21,294	75.3%	10,175	81.5%
4055	OmniCare Health Plan	OCH	9,152	70.8%	4,652	79.8%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	2,737	79.6%	1,128	85.7%
4054	Priority Health Government Programs, Inc.	PRI	4,901	86.1%	1,580	92.2%
4283	Physicians Health Plan of Southwest Michigan	PSW	3,828	84.6%	1,493	91.6%
4268	Total Health Care, Inc.	THC	7,126	73.4%	3,761	78.9%
4348	Upper Peninsula Health Plan	UPP	3,414	86.6%	1,584	91.0%
	2006 Michigan Medicaid Weighted Average		- -	78.1%	- -	84.7%
	2005 Michigan Medicaid Weighted Average		- -	76.7%	- -	83.4%
	2004 Michigan Medicaid Weighted Average		- -	75.0%	- -	82.6%
	National HEDIS 2005 Medicaid 50th Percentile		- -	78.8%	- -	84.3%

Note: The 2004 Michigan Medicaid Weighted Average included 17 health plans, and the 2005 and 2006 Michigan Medicaid Weighted Averages included 15 health plans.

Table A-14—Tabular Results for Key Measures by Health Plan: Medical Assistance With Smoking Cessation—Numerator 1			
DST	Plan Name	Code	Advising Smokers to Quit Rate
4333	Cape Health Plan	CAP	69.6%
4265	Community Choice Michigan	CCM	71.8%
4133	Great Lakes Health Plan	GLH	66.8%
4291	Health Plan of Michigan, Inc.	HPM	69.3%
4056	HealthPlus Partners, Inc.	HPP	69.2%
4243	M-CAID	MCD	75.7%
4312	McLaren Health Plan	MCL	69.5%
4131	Midwest Health Plan	MID	67.8%
4151	Molina Healthcare of Michigan	MOL	69.3%
4055	OmniCare Health Plan	OCH	67.3%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	74.7%
4054	Priority Health Government Programs, Inc.	PRI	73.4%
4283	Physicians Health Plan of Southwest Michigan	PSW	64.0%
4268	Total Health Care, Inc.	THC	66.9%
4348	Upper Peninsula Health Plan	UPP	69.6%
	2006 Michigan Medicaid Average		69.7%
	2005 Michigan Medicaid Average		68.5%
	2004 Michigan Medicaid Average		66.7%

Note: The 2004, 2005, and 2006 Michigan Medicaid Averages were not weighted.

Appendix B. National HEDIS 2005 Medicaid Percentiles

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

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

Table B-1—National HEDIS 2005 Medicaid Percentiles—Pediatric Care					
Measure	**10th Percentile**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**90th Percentile**
Childhood Immunization Status—Combination #2	47.8%	56.6%	66.0%	71.4%	75.7%
Adolescent Immunization Status—Combination #2	9.5%	20.9%	38.5%	53.8%	62.6%
Well-Child Visits in the First 15 Months—Zero Visits*	0.5%	1.0%	2.1%	3.9%	13.1%
Well-Child Visits in the First 15 Months—Six or More Visits	15.2%	38.7%	46.4%	56.3%	65.7%
Well-Child in the Third, Fourth, Fifth, and Sixth Years of Life	48.6%	56.3%	64.1%	70.8%	76.7%
Adolescent Well-Care Visits	27.1%	32.0%	38.0%	46.3%	53.9%
Appropriate Treatment for Children With Upper Respiratory Infection	71.3%	76.7%	81.5%	85.5%	89.0%
Children With Pharyngitis	24.6%	41.9%	56.7%	67.5%	77.0%

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

Table B-2—National HEDIS 2005 Medicaid Percentiles—Women's Care					
Measure	**10th Percentile**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**90th Percentile**
Breast Cancer Screening	39.2%	47.8%	54.7%	59.4%	66.4%
Cervical Cancer Screening	51.1%	58.6%	64.5%	71.8%	76.6%
Chlamydia Screening in Women—Ages 16–20 Years	28.9%	37.3%	46.5%	54.0%	62.5%
Chlamydia Screening in Women—Ages 21–25 Years	28.6%	38.7%	51.1%	58.3%	64.5%
Chlamydia Screening in Women—Combined Rate	28.8%	38.3%	48.3%	55.8%	62.9%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	63.7%	73.8%	81.5%	86.7%	89.5%
Prenatal and Postpartum Care—Postpartum Care	40.9%	51.1%	58.4%	64.5%	69.7%

Table B-3—National HEDIS 2005 Medicaid Percentiles—Living With Illness					
Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Comprehensive Diabetes Care—HbA1c Testing	56.9%	69.8%	78.4%	84.1%	88.8%
Comprehensive Diabetes Care—Poor HbA1c Control*	31.1%	37.8%	47.5%	58.5%	76.6%
Comprehensive Diabetes Care—Eye Exam	18.5%	35.3%	46.9%	54.9%	60.9%
Comprehensive Diabetes Care—LDL-C Screening	61.8%	73.0%	81.4%	86.6%	91.4%
Comprehensive Diabetes Care—LDL-C Level <130	26.6%	44.7%	52.7%	59.4%	65.0%
Comprehensive Diabetes Care—LDL-C Level <100	14.4%	23.7%	31.7%	36.4%	41.6%
Comprehensive Diabetes Care—Monitoring for Diabetic Nephropathy	26.0%	37.8%	46.5%	54.7%	63.0%
Use of Appropriate Medications for People With Asthma—Ages 5–9 Years	45.1%	57.5%	66.6%	72.3%	76.6%
Use of Appropriate Medications for People With Asthma—Ages 10–17 Years	52.0%	58.3%	64.0%	69.5%	73.6%
Use of Appropriate Medications for People With Asthma—Ages 18–56 Years	52.1%	58.2%	66.4%	71.6%	75.1%
Use of Appropriate Medications for People With Asthma—Combined Rate	55.1%	60.5%	66.0%	70.7%	74.1%
Controlling High Blood Pressure	48.2%	55.8%	61.7%	68.4%	71.0%

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

Table B-4—National HEDIS 2005 Medicaid Percentiles—Access to Care					
Measure	**10th Percentile**	**25th Percentile**	**50th Percentile**	**75th Percentile**	**90th Percentile**
Children's Access to Primary Care Practitioners—Ages 12–24 Months	**79.7%**	**91.2%**	**94.6%**	**97.2%**	**98.3%**
Children's Access to Primary Care Practitioners—Ages 25 Months–6 Years	**68.7%**	**78.3%**	**84.7%**	**88.2%**	**91.4%**
Children's Access to Primary Care Practitioners—Ages 7–11 Years	**70.5%**	**77.3%**	**83.9%**	**89.7%**	**92.9%**
Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years	**63.2%**	**74.7%**	**82.1%**	**88.2%**	**90.6%**
Adults' Access to Preventive/Ambulatory Services—Ages 20–44 Years	**62.2%**	**70.6%**	**78.8%**	**83.5%**	**85.4%**
Adults' Access to Preventive/ Ambulatory Services—Ages 45–64 Years	**66.0%**	**78.2%**	**84.3%**	**87.1%**	**88.7%**

Appendix C. Trend Tables

Appendix C includes trend tables for each of the MHPs. Where applicable, the rates for 2004, 2005, and 2006 for each measure are presented along with a trend analysis that compares a measure's 2005 rate to its 2006 rate in order to assess whether there was any significant change in the rate.

Rates that are significantly higher in 2006 than in 2005 (improved by more than 10 percent) are noted with upward arrows (⬆). Rates that are significantly lower in 2006 than in 2005 (decreased by more than 10 percent) are noted with downward arrows (⬇). Rates in 2006 that are not significantly different than in 2005 (did not change more than 10 percent) are noted with parallel arrows (⬅➡). For two measures, *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Comprehensive Diabetes Care—Poor HbA1c Control*, where a lower rate indicates better performance, an upward triangle (▲) indicates performance improvement (rate decreased by more than 10 percent) and a downward triangle (▼) indicates a decline in performance (rate increased by more than 10 percent).

The MHP trend tables are presented as follows:

- Table C-1—CAP
- Table C-2—CCM
- Table C-3—GLH
- Table C-4—HPM
- Table C-5—HPP
- Table C-6—MCD
- Table C-7—MCL
- Table C-8—MID
- Table C-9—MOL
- Table C-10—OCH
- Table C-11—PMD
- Table C-12—PRI
- Table C-13—PSW
- Table C-14—THC
- Table C-15—UPP

Table C-1—Michigan Medicaid HEDIS 2006 Trend Table: CAP					
Dimension of Care	**Measure**	**2004**	**2005**	**2006**	**2005–2006 Health Plan Trend**
Pediatric Care	Childhood Immunization Combo 2	64.0%	71.7%	73.9%	⬅➡
	Childhood Immunization Combo 3	- -	- -	34.5%	- -
	Adolescent Immunization Combo 2	31.9%	51.9%	54.3%	⬅➡
	Well-Child 1st 15 Mos, 0 Visits	6.2%	6.0%	4.4%	⬅➡
	Well-Child 1st 15 Mos, 6+ Visits	34.9%	37.2%	46.7%	⬅➡
	Well-Child 3rd-6th Years of Life	66.0%	66.3%	67.1%	⬅➡
	Adolescent Well-Care Visits	46.4%	46.4%	46.0%	⬅➡
	Appropriate Treatment of URI	75.5%	75.5%	74.2%	⬅➡
	Children with Pharyngitis	NR	NR	9.1%	- -
Women's Care	Breast Cancer Screening	52.4%	54.7%	53.3%	⬅➡
	Cervical Cancer Screening	62.6%	60.7%	62.6%	⬅➡
	Chlamydia Screening, 16-20 Years	48.2%	41.8%	52.6%	⬆
	Chlamydia Screening, 21-25 Years	52.2%	45.9%	57.7%	⬆
	Chlamydia Screening, Combined	50.2%	43.8%	55.0%	⬆
	Timeliness of Prenatal Care	67.7%	68.5%	71.4%	⬅➡
	Postpartum Care	40.4%	46.3%	49.4%	⬅➡
Living With Illness	Diabetes Care HbA1c Testing	75.5%	71.4%	72.2%	⬅➡
	Diabetes Care Poor HbA1c Control	53.6%	48.3%	48.9%	⬅➡
	Diabetes Care Eye Exam	41.3%	44.0%	48.9%	⬅➡
	Diabetes Care LDL-C Screening	80.2%	84.1%	87.0%	⬅➡
	Diabetes Care LDL-C Level <130	49.4%	54.9%	58.9%	⬅➡
	Diabetes Care LDL-C Level <100	30.5%	31.7%	34.3%	⬅➡
	Diabetes Care Nephropathy	33.6%	37.9%	40.9%	⬅➡
	Asthma 5-9 Years	57.8%	58.4%	85.4%	⬆
	Asthma 10-17 Years	55.0%	49.8%	75.1%	⬆
	Asthma 18-56 Years	69.2%	66.1%	80.3%	⬆
	Asthma Combined Rate	62.9%	59.9%	80.2%	⬆
	Controlling High Blood Pressure	58.9%	60.1%	61.3%	⬅➡
	Advising Smokers to Quit	63.6%	66.6%	69.6%	⬅➡
Access to Care	Children's Access 12-24 Months	93.3%	91.2%	94.0%	⬅➡
	Children's Access 25 Mos-6 Years	81.0%	75.7%	80.1%	⬅➡
	Children's Access 7-11 Years	78.9%	78.3%	77.6%	⬅➡
	Adolescents' Access 12-19 Years	77.8%	75.9%	73.7%	⬅➡
	Adults' Access 20-44 Years	71.0%	71.2%	74.8%	⬅➡
	Adults' Access 45-64 Years	79.5%	78.8%	81.2%	⬅➡

Notes

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

⬆ = Performance improvement (rate increase >10%)*
⬅➡ = No significant performance change (rate change ≤10%)
⬇ = Performance decline (rate decrease >10%)*
- - = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control:*
▼ = Performance *decline* (rate *increase* >10%)
▲ = Performance *improvement* (rate *decrease* >10%)

Table C-2—Michigan Medicaid HEDIS 2006 Trend Table: CCM					
Dimension of Care	**Measure**	**2004**	**2005**	**2006**	**2005–2006 Health Plan Trend**
Pediatric Care	**Childhood Immunization Combo 2**	**65.7%**	**69.3%**	**75.7%**	⬅➡
	Childhood Immunization Combo 3	**- -**	**- -**	**33.6%**	**- -**
	Adolescent Immunization Combo 2	**37.7%**	**54.0%**	**62.6%**	⬅➡
	Well-Child 1st 15 Mos, 0 Visits	**3.9%**	**5.4%**	**3.9%**	⬅➡
	Well-Child 1st 15 Mos, 6+ Visits	**31.6%**	**41.4%**	**41.6%**	⬅➡
	Well-Child 3rd-6th Years of Life	**54.3%**	**54.3%**	**54.6%**	⬅➡
	Adolescent Well-Care Visits	**33.3%**	**33.3%**	**37.0%**	⬅➡
	Appropriate Treatment of URI	**75.9%**	**77.5%**	**75.9%**	⬅➡
	Children with Pharyngitis	**46.1%**	**41.1%**	**49.0%**	⬅➡
Women's Care	**Breast Cancer Screening**	**54.3%**	**49.9%**	**47.1%**	⬅➡
	Cervical Cancer Screening	**69.8%**	**67.6%**	**67.6%**	**Rotated Measure**
	Chlamydia Screening, 16-20 Years	**43.4%**	**48.7%**	**48.1%**	⬅➡
	Chlamydia Screening, 21-25 Years	**51.6%**	**55.6%**	**52.9%**	⬅➡
	Chlamydia Screening, Combined	**47.5%**	**52.0%**	**50.2%**	⬅➡
	Timeliness of Prenatal Care	**72.5%**	**75.7%**	**76.6%**	⬅➡
	Postpartum Care	**47.7%**	**58.9%**	**60.1%**	⬅➡
Living With Illness	**Diabetes Care HbA1c Testing**	**74.5%**	**83.7%**	**81.5%**	⬅➡
	Diabetes Care Poor HbA1c Control	**59.4%**	**41.6%**	**46.2%**	⬅➡
	Diabetes Care Eye Exam	**29.4%**	**38.4%**	**41.8%**	⬅➡
	Diabetes Care LDL-C Screening	**58.4%**	**71.8%**	**76.4%**	⬅➡
	Diabetes Care LDL-C Level <130	**26.3%**	**47.9%**	**51.3%**	⬅➡
	Diabetes Care LDL-C Level <100	**17.3%**	**32.6%**	**34.1%**	⬅➡
	Diabetes Care Nephropathy	**37.7%**	**43.1%**	**46.2%**	⬅➡
	Asthma 5-9 Years	**62.8%**	**70.0%**	**89.2%**	⬆
	Asthma 10-17 Years	**66.4%**	**65.4%**	**90.1%**	⬆
	Asthma 18-56 Years	**71.3%**	**74.0%**	**88.7%**	⬆
	Asthma Combined Rate	**68.2%**	**70.9%**	**89.1%**	⬆
	Controlling High Blood Pressure	**59.3%**	**65.0%**	**65.3%**	⬅➡
	Advising Smokers to Quit	**64.8%**	**69.1%**	**71.8%**	⬅➡
Access to Care	**Children's Access 12-24 Months**	**90.5%**	**84.8%**	**90.4%**	⬅➡
	Children's Access 25 Mos-6 Years	**74.9%**	**77.1%**	**77.8%**	⬅➡
	Children's Access 7-11 Years	**75.7%**	**77.1%**	**78.1%**	⬅➡
	Adolescents' Access 12-19 Years	**73.9%**	**75.4%**	**74.9%**	⬅➡
	Adults' Access 20-44 Years	**74.4%**	**76.2%**	**75.2%**	⬅➡
	Adults' Access 45-64 Years	**83.5%**	**83.2%**	**82.7%**	⬅➡

Notes

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⬆ = Performance improvement (rate increase >10%)*
⬅➡ = No significant performance change (rate change ≤10%)
⬇ = Performance decline (rate decrease >10%)*
- - = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control:*
▼ = Performance *decline* (rate *increase* >10%)
▲ = Performance *improvement* (rate *decrease* >10%)

Table C-3—Michigan Medicaid HEDIS 2006 Trend Table: GLH					
Dimension of Care	**Measure**	**2004**	**2005**	**2006**	**2005–2006 Health Plan Trend**
Pediatric Care	Childhood Immunization Combo 2	59.7%	68.3%	72.0%	⬅➡
	Childhood Immunization Combo 3	- -	- -	37.2%	- -
	Adolescent Immunization Combo 2	33.6%	51.8%	56.4%	⬅➡
	Well-Child 1st 15 Mos, 0 Visits	3.5%	3.5%	0.7%	⬅➡
	Well-Child 1st 15 Mos, 6+ Visits	39.4%	39.4%	64.2%	⬆
	Well-Child 3rd-6th Years of Life	56.3%	60.8%	66.9%	⬅➡
	Adolescent Well-Care Visits	39.9%	40.4%	52.1%	⬆
	Appropriate Treatment of URI	68.4%	70.6%	70.7%	⬅➡
	Children with Pharyngitis	39.2%	37.6%	35.6%	⬅➡
Women's Care	Breast Cancer Screening	48.7%	54.3%	59.3%	⬅➡
	Cervical Cancer Screening	51.0%	59.6%	60.1%	⬅➡
	Chlamydia Screening, 16-20 Years	35.7%	47.2%	47.2%	⬅➡
	Chlamydia Screening, 21-25 Years	42.4%	52.1%	55.8%	⬅➡
	Chlamydia Screening, Combined	38.8%	49.4%	51.0%	⬅➡
	Timeliness of Prenatal Care	66.9%	72.0%	75.4%	⬅➡
	Postpartum Care	41.3%	51.1%	51.3%	⬅➡
Living With Illness	Diabetes Care HbA1c Testing	77.6%	79.0%	73.5%	⬅➡
	Diabetes Care Poor HbA1c Control	47.0%	46.3%	47.4%	⬅➡
	Diabetes Care Eye Exam	45.3%	45.0%	52.6%	⬅➡
	Diabetes Care LDL-C Screening	80.3%	81.4%	88.1%	⬅➡
	Diabetes Care LDL-C Level <130	53.5%	67.1%	72.3%	⬅➡
	Diabetes Care LDL-C Level <100	31.3%	60.1%	62.0%	⬅➡
	Diabetes Care Nephropathy	38.3%	47.0%	45.7%	⬅➡
	Asthma 5-9 Years	46.6%	57.0%	85.9%	⬆
	Asthma 10-17 Years	60.0%	57.9%	83.0%	⬆
	Asthma 18-56 Years	70.3%	73.7%	88.4%	⬆
	Asthma Combined Rate	62.8%	65.9%	86.7%	⬆
	Controlling High Blood Pressure	44.7%	47.4%	51.1%	⬅➡
	Advising Smokers to Quit	59.6%	64.5%	66.8%	⬅➡
Access to Care	Children's Access 12-24 Months	90.7%	91.4%	96.7%	⬅➡
	Children's Access 25 Mos-6 Years	77.8%	79.5%	85.4%	⬅➡
	Children's Access 7-11 Years	79.1%	78.5%	82.1%	⬅➡
	Adolescents' Access 12-19 Years	75.7%	77.5%	81.4%	⬅➡
	Adults' Access 20-44 Years	75.0%	74.7%	78.7%	⬅➡
	Adults' Access 45-64 Years	84.0%	83.2%	86.8%	⬅➡

Notes

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⬆ = Performance improvement (rate increase >10%)*
⬅➡ = No significant performance change (rate change ≤10%)
⬇ = Performance decline (rate decrease >10%)*
- - = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control:*
▼ = Performance *decline* (rate *increase* >10%)
▲ = Performance *improvement* (rate *decrease* >10%)

Table C-4—Michigan Medicaid HEDIS 2006 Trend Table: HPM					
Dimension of Care	**Measure**	**2004**	**2005**	**2006**	**2005–2006 Health Plan Trend**
Pediatric Care	Childhood Immunization Combo 2	68.5%	68.5%	78.0%	⬅➡
	Childhood Immunization Combo 3	- -	- -	38.9%	- -
	Adolescent Immunization Combo 2	31.9%	54.9%	58.8%	⬅➡
	Well-Child 1st 15 Mos, 0 Visits	3.2%	2.0%	1.7%	⬅➡
	Well-Child 1st 15 Mos, 6+ Visits	62.0%	59.0%	68.4%	⬅➡
	Well-Child 3rd-6th Years of Life	59.5%	56.9%	67.8%	⬆
	Adolescent Well-Care Visits	40.7%	41.2%	52.5%	⬆
	Appropriate Treatment of URI	79.8%	74.4%	79.3%	⬅➡
	Children with Pharyngitis	59.0%	58.9%	50.9%	⬅➡
Women's Care	Breast Cancer Screening	60.0%	56.9%	58.0%	⬅➡
	Cervical Cancer Screening	63.8%	61.6%	66.8%	⬅➡
	Chlamydia Screening, 16-20 Years	44.6%	47.6%	49.1%	⬅➡
	Chlamydia Screening, 21-25 Years	49.1%	52.2%	54.7%	⬅➡
	Chlamydia Screening, Combined	46.0%	49.9%	51.7%	⬅➡
	Timeliness of Prenatal Care	74.6%	78.3%	82.9%	⬅➡
	Postpartum Care	51.9%	57.4%	56.8%	⬅➡
Living With Illness	Diabetes Care HbA1c Testing	74.8%	79.2%	78.7%	⬅➡
	Diabetes Care Poor HbA1c Control	46.1%	47.5%	39.2%	⬅➡
	Diabetes Care Eye Exam	57.6%	54.9%	58.6%	⬅➡
	Diabetes Care LDL-C Screening	76.6%	85.4%	85.8%	⬅➡
	Diabetes Care LDL-C Level <130	49.8%	47.7%	51.3%	⬅➡
	Diabetes Care LDL-C Level <100	29.4%	27.8%	30.7%	⬅➡
	Diabetes Care Nephropathy	44.2%	49.8%	48.2%	⬅➡
	Asthma 5-9 Years	73.5%	67.7%	94.9%	⬆
	Asthma 10-17 Years	60.3%	66.1%	93.5%	⬆
	Asthma 18-56 Years	66.3%	70.7%	93.1%	⬆
	Asthma Combined Rate	66.0%	68.5%	93.6%	⬆
	Controlling High Blood Pressure	66.4%	61.2%	69.5%	⬅➡
	Advising Smokers to Quit	65.4%	65.6%	69.3%	⬅➡
Access to Care	Children's Access 12-24 Months	92.2%	93.9%	95.4%	⬅➡
	Children's Access 25 Mos-6 Years	82.2%	81.5%	85.9%	⬅➡
	Children's Access 7-11 Years	82.5%	82.5%	84.3%	⬅➡
	Adolescents' Access 12-19 Years	81.0%	82.4%	84.3%	⬅➡
	Adults' Access 20-44 Years	79.5%	80.0%	82.9%	⬅➡
	Adults' Access 45-64 Years	88.6%	88.0%	88.7%	⬅➡

Notes

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

⬆ = Performance improvement (rate increase >10%)*
⬅➡ = No significant performance change (rate change ≤10%)
⬇ = Performance decline (rate decrease >10%)*
- - = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control:*
▼ = Performance *decline* (rate *increase* >10%)
▲ = Performance *improvement* (rate *decrease* >10%)

Table C-5—Michigan Medicaid HEDIS 2006 Trend Table: HPP					
Dimension of Care	**Measure**	**2004**	**2005**	**2006**	**2005–2006 Health Plan Trend**
Pediatric Care	Childhood Immunization Combo 2	76.6%	76.7%	83.9%	⬅➡
	Childhood Immunization Combo 3	- -	- -	44.8%	- -
	Adolescent Immunization Combo 2	46.5%	64.0%	70.3%	⬅➡
	Well-Child 1st 15 Mos, 0 Visits	2.9%	2.9%	2.2%	⬅➡
	Well-Child 1st 15 Mos, 6+ Visits	43.8%	43.8%	60.1%	⬆
	Well-Child 3rd-6th Years of Life	49.4%	57.2%	58.5%	⬅➡
	Adolescent Well-Care Visits	32.6%	37.5%	43.8%	⬅➡
	Appropriate Treatment of URI	65.7%	71.3%	71.4%	⬅➡
	Children with Pharyngitis	36.0%	33.7%	36.2%	⬅➡
Women's Care	Breast Cancer Screening	67.0%	59.6%	61.8%	⬅➡
	Cervical Cancer Screening	73.1%	70.4%	70.4%	Rotated Measure
	Chlamydia Screening, 16-20 Years	47.5%	45.6%	50.5%	⬅➡
	Chlamydia Screening, 21-25 Years	56.2%	52.9%	57.9%	⬅➡
	Chlamydia Screening, Combined	52.2%	49.4%	54.1%	⬅➡
	Timeliness of Prenatal Care	80.9%	82.9%	87.4%	⬅➡
	Postpartum Care	61.2%	57.4%	62.0%	⬅➡
Living With Illness	Diabetes Care HbA1c Testing	83.9%	83.9%	86.1%	⬅➡
	Diabetes Care Poor HbA1c Control	36.7%	33.6%	29.7%	⬅➡
	Diabetes Care Eye Exam	53.3%	57.4%	70.3%	⬆
	Diabetes Care LDL-C Screening	84.4%	86.6%	89.8%	⬅➡
	Diabetes Care LDL-C Level <130	50.6%	59.1%	64.0%	⬅➡
	Diabetes Care LDL-C Level <100	26.5%	34.1%	43.1%	⬅➡
	Diabetes Care Nephropathy	47.4%	56.4%	56.4%	Rotated Measure
	Asthma 5-9 Years	73.0%	75.0%	93.8%	⬆
	Asthma 10-17 Years	66.4%	69.3%	92.3%	⬆
	Asthma 18-56 Years	72.7%	75.3%	89.1%	⬆
	Asthma Combined Rate	70.8%	73.3%	91.2%	⬆
	Controlling High Blood Pressure	61.0%	65.8%	65.8%	Rotated Measure
	Advising Smokers to Quit	72.6%	73.1%	69.2%	⬅➡
Access to Care	Children's Access 12-24 Months	94.2%	94.7%	96.0%	⬅➡
	Children's Access 25 Mos-6 Years	81.4%	80.8%	83.5%	⬅➡
	Children's Access 7-11 Years	81.7%	81.8%	82.0%	⬅➡
	Adolescents' Access 12-19 Years	82.2%	79.4%	79.4%	⬅➡
	Adults' Access 20-44 Years	80.5%	82.0%	83.7%	⬅➡
	Adults' Access 45-64 Years	89.7%	89.6%	91.3%	⬅➡

Notes

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

⬆ = Performance improvement (rate increase >10%)*
⬅➡ = No significant performance change (rate change ≤10%)
⬇ = Performance decline (rate decrease >10%)*
- - = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control:*
▼ = Performance *decline* (rate *increase* >10%)
▲ = Performance *improvement* (rate *decrease* >10%)

Table C-6—Michigan Medicaid HEDIS 2006 Trend Table: MCD					
Dimension of Care	**Measure**	**2004**	**2005**	**2006**	**2005–2006 Health Plan Trend**
Pediatric Care	Childhood Immunization Combo 2	72.5%	72.5%	81.0%	⬅➡
	Childhood Immunization Combo 3	- -	- -	56.7%	- -
	Adolescent Immunization Combo 2	46.7%	46.7%	68.5%	⬆
	Well-Child 1st 15 Mos, 0 Visits	1.5%	1.5%	0.5%	⬅➡
	Well-Child 1st 15 Mos, 6+ Visits	46.3%	46.3%	64.4%	⬆
	Well-Child 3rd-6th Years of Life	62.0%	62.0%	67.4%	⬅➡
	Adolescent Well-Care Visits	47.6%	47.6%	51.4%	⬅➡
	Appropriate Treatment of URI	90.4%	88.5%	90.3%	⬅➡
	Children with Pharyngitis	76.0%	74.8%	58.8%	⬇
Women's Care	Breast Cancer Screening	49.4%	47.2%	45.0%	⬅➡
	Cervical Cancer Screening	74.8%	73.8%	73.8%	Rotated Measure
	Chlamydia Screening, 16-20 Years	52.0%	56.9%	52.8%	⬅➡
	Chlamydia Screening, 21-25 Years	58.7%	56.9%	60.0%	⬅➡
	Chlamydia Screening, Combined	55.6%	56.9%	56.2%	⬅➡
	Timeliness of Prenatal Care	80.0%	89.5%	89.5%	Rotated Measure
	Postpartum Care	52.7%	60.7%	60.7%	Rotated Measure
Living With Illness	Diabetes Care HbA1c Testing	89.4%	88.4%	88.4%	Rotated Measure
	Diabetes Care Poor HbA1c Control	37.8%	33.8%	33.8%	Rotated Measure
	Diabetes Care Eye Exam	53.0%	55.1%	55.1%	Rotated Measure
	Diabetes Care LDL-C Screening	87.1%	91.6%	91.6%	Rotated Measure
	Diabetes Care LDL-C Level <130	58.1%	70.2%	70.2%	Rotated Measure
	Diabetes Care LDL-C Level <100	37.8%	50.2%	50.2%	Rotated Measure
	Diabetes Care Nephropathy	49.8%	60.0%	60.0%	Rotated Measure
	Asthma 5-9 Years	66.3%	77.6%	94.6%	⬆
	Asthma 10-17 Years	75.0%	75.0%	91.8%	⬆
	Asthma 18-56 Years	76.1%	69.6%	91.2%	⬆
	Asthma Combined Rate	73.0%	73.6%	92.2%	⬆
	Controlling High Blood Pressure	71.1%	76.0%	76.0%	Rotated Measure
	Advising Smokers to Quit	70.8%	74.3%	75.7%	⬅➡
Access to Care	Children's Access 12-24 Months	97.3%	96.8%	98.8%	⬅➡
	Children's Access 25 Mos-6 Years	86.2%	86.3%	89.0%	⬅➡
	Children's Access 7-11 Years	86.8%	83.7%	87.5%	⬅➡
	Adolescents' Access 12-19 Years	84.6%	81.5%	85.8%	⬅➡
	Adults' Access 20-44 Years	80.2%	82.0%	82.2%	⬅➡
	Adults' Access 45-64 Years	84.1%	85.5%	85.1%	⬅➡

Notes

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

⬆ = Performance improvement (rate increase >10%)*
⬅➡ = No significant performance change (rate change ≤10%)
⬇ = Performance decline (rate decrease >10%)*
- - = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control:*
▼ = Performance *decline* (rate *increase* >10%)
▲ = Performance *improvement* (rate *decrease* >10%)

Table C-7—Michigan Medicaid HEDIS 2006 Trend Table: MCL					
Dimension of Care	**Measure**	**2004**	**2005**	**2006**	**2005–2006 Health Plan Trend**
Pediatric Care	Childhood Immunization Combo 2	67.9%	73.7%	78.8%	⬅➡
	Childhood Immunization Combo 3	- -	- -	39.9%	- -
	Adolescent Immunization Combo 2	34.3%	46.7%	54.3%	⬅➡
	Well-Child 1st 15 Mos, 0 Visits	2.2%	2.2%	1.2%	⬅➡
	Well-Child 1st 15 Mos, 6+ Visits	48.4%	45.4%	68.6%	⬆
	Well-Child 3rd-6th Years of Life	50.4%	51.6%	63.3%	⬆
	Adolescent Well-Care Visits	44.3%	36.7%	45.7%	⬅➡
	Appropriate Treatment of URI	67.8%	64.8%	65.4%	⬅➡
	Children with Pharyngitis	48.2%	45.8%	42.4%	⬅➡
Women's Care	Breast Cancer Screening	62.2%	57.8%	56.9%	⬅➡
	Cervical Cancer Screening	66.9%	67.9%	67.4%	⬅➡
	Chlamydia Screening, 16-20 Years	51.5%	48.4%	53.3%	⬅➡
	Chlamydia Screening, 21-25 Years	54.5%	52.3%	54.3%	⬅➡
	Chlamydia Screening, Combined	53.0%	50.4%	53.7%	⬅➡
	Timeliness of Prenatal Care	79.7%	88.1%	91.5%	⬅➡
	Postpartum Care	54.7%	65.5%	76.6%	⬆
Living With Illness	Diabetes Care HbA1c Testing	79.4%	79.3%	84.8%	⬅➡
	Diabetes Care Poor HbA1c Control	43.1%	41.1%	37.4%	⬅➡
	Diabetes Care Eye Exam	48.9%	51.6%	69.9%	⬆
	Diabetes Care LDL-C Screening	74.9%	75.4%	83.8%	⬅➡
	Diabetes Care LDL-C Level <130	51.3%	53.5%	61.9%	⬅➡
	Diabetes Care LDL-C Level <100	28.6%	31.1%	39.9%	⬅➡
	Diabetes Care Nephropathy	52.4%	52.8%	59.3%	⬅➡
	Asthma 5-9 Years	64.3%	82.9%	97.3%	⬆
	Asthma 10-17 Years	69.4%	71.9%	90.3%	⬆
	Asthma 18-56 Years	66.9%	75.7%	87.9%	⬆
	Asthma Combined Rate	66.9%	76.5%	90.5%	⬆
	Controlling High Blood Pressure	72.5%	59.6%	64.1%	⬅➡
	Advising Smokers to Quit	66.7%	69.4%	69.5%	⬅➡
Access to Care	Children's Access 12-24 Months	91.7%	93.9%	93.0%	⬅➡
	Children's Access 25 Mos-6 Years	78.5%	79.2%	78.2%	⬅➡
	Children's Access 7-11 Years	79.4%	80.0%	81.0%	⬅➡
	Adolescents' Access 12-19 Years	75.5%	76.5%	78.9%	⬅➡
	Adults' Access 20-44 Years	79.7%	80.4%	79.7%	⬅➡
	Adults' Access 45-64 Years	87.8%	88.0%	87.2%	⬅➡

Notes

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⬆ = Performance improvement (rate increase >10%)*
⬅➡ = No significant performance change (rate change ≤10%)
⬇ = Performance decline (rate decrease >10%)*
- - = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control:*
▼ = Performance *decline* (rate *increase* >10%)
▲ = Performance *improvement* (rate *decrease* >10%)

Table C-8—Michigan Medicaid HEDIS 2006 Trend Table: MID					
Dimension of Care	**Measure**	**2004**	**2005**	**2006**	**2005–2006 Health Plan Trend**
Pediatric Care	Childhood Immunization Combo 2	62.0%	72.0%	75.9%	⬅➡
	Childhood Immunization Combo 3	- -	- -	32.8%	- -
	Adolescent Immunization Combo 2	24.6%	51.8%	55.0%	⬅➡
	Well-Child 1st 15 Mos, 0 Visits	5.1%	5.0%	4.9%	⬅➡
	Well-Child 1st 15 Mos, 6+ Visits	44.8%	46.1%	50.6%	⬅➡
	Well-Child 3rd-6th Years of Life	56.2%	65.9%	73.5%	⬅➡
	Adolescent Well-Care Visits	30.9%	48.4%	48.9%	⬅➡
	Appropriate Treatment of URI	75.5%	75.7%	75.7%	⬅➡
	Children with Pharyngitis	5.8%	7.6%	13.4%	⬅➡
Women's Care	Breast Cancer Screening	51.3%	49.6%	58.3%	⬅➡
	Cervical Cancer Screening	50.9%	58.9%	62.3%	⬅➡
	Chlamydia Screening, 16-20 Years	31.9%	32.1%	40.0%	⬅➡
	Chlamydia Screening, 21-25 Years	37.6%	37.8%	48.2%	⬆
	Chlamydia Screening, Combined	34.5%	34.8%	43.6%	⬅➡
	Timeliness of Prenatal Care	53.1%	66.7%	68.4%	⬅➡
	Postpartum Care	38.2%	41.8%	46.5%	⬅➡
Living With Illness	Diabetes Care HbA1c Testing	59.6%	71.5%	71.5%	Rotated Measure
	Diabetes Care Poor HbA1c Control	67.4%	47.7%	47.7%	Rotated Measure
	Diabetes Care Eye Exam	32.4%	44.3%	49.1%	⬅➡
	Diabetes Care LDL-C Screening	64.5%	79.8%	81.5%	⬅➡
	Diabetes Care LDL-C Level <130	53.3%	62.8%	62.8%	Rotated Measure
	Diabetes Care LDL-C Level <100	46.7%	40.1%	40.1%	Rotated Measure
	Diabetes Care Nephropathy	35.8%	43.6%	46.7%	⬅➡
	Asthma 5-9 Years	51.5%	52.9%	79.6%	⬆
	Asthma 10-17 Years	54.7%	56.3%	78.5%	⬆
	Asthma 18-56 Years	66.6%	67.0%	82.9%	⬆
	Asthma Combined Rate	60.7%	61.3%	81.1%	⬆
	Controlling High Blood Pressure	54.8%	56.7%	56.7%	Rotated Measure
	Advising Smokers to Quit	60.4%	63.3%	67.8%	⬅➡
Access to Care	Children's Access 12-24 Months	89.5%	91.2%	93.6%	⬅➡
	Children's Access 25 Mos-6 Years	76.5%	79.2%	82.9%	⬅➡
	Children's Access 7-11 Years	79.7%	80.9%	82.4%	⬅➡
	Adolescents' Access 12-19 Years	75.0%	78.4%	80.0%	⬅➡
	Adults' Access 20-44 Years	74.2%	72.6%	76.5%	⬅➡
	Adults' Access 45-64 Years	82.5%	82.6%	85.4%	⬅➡

Notes

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⬅➡ = No significant performance change (rate change ≤10%)
⬇ = Performance decline (rate decrease >10%)*
- - = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control:*
▼ = Performance *decline* (rate *increase* >10%)
▲ = Performance *improvement* (rate *decrease* >10%)

Table C-9—Michigan Medicaid HEDIS 2006 Trend Table: MOL					
Dimension of Care	**Measure**	**2004**	**2005**	**2006**	**2005–2006 Health Plan Trend**
Pediatric Care	Childhood Immunization Combo 2	65.7%	69.9%	72.4%	⬅➡
	Childhood Immunization Combo 3	- -	- -	35.5%	- -
	Adolescent Immunization Combo 2	27.1%	46.6%	51.1%	⬅➡
	Well-Child 1st 15 Mos, 0 Visits	4.5%	5.4%	2.3%	⬅➡
	Well-Child 1st 15 Mos, 6+ Visits	38.1%	35.2%	43.3%	⬅➡
	Well-Child 3rd-6th Years of Life	54.2%	55.3%	62.2%	⬅➡
	Adolescent Well-Care Visits	34.6%	33.6%	34.5%	⬅➡
	Appropriate Treatment of URI	71.4%	76.5%	76.5%	⬅➡
	Children with Pharyngitis	43.2%	52.0%	44.2%	⬅➡
Women's Care	Breast Cancer Screening	53.4%	57.0%	58.6%	⬅➡
	Cervical Cancer Screening	59.0%	59.0%	62.1%	⬅➡
	Chlamydia Screening, 16-20 Years	44.6%	44.1%	56.3%	⬆
	Chlamydia Screening, 21-25 Years	47.7%	51.1%	59.9%	⬅➡
	Chlamydia Screening, Combined	46.1%	47.5%	57.9%	⬆
	Timeliness of Prenatal Care	70.2%	82.0%	82.0%	Rotated Measure
	Postpartum Care	45.7%	58.8%	58.8%	Rotated Measure
Living With Illness	Diabetes Care HbA1c Testing	75.4%	88.8%	88.8%	Rotated Measure
	Diabetes Care Poor HbA1c Control	55.1%	43.0%	43.0%	Rotated Measure
	Diabetes Care Eye Exam	44.4%	52.3%	52.3%	Rotated Measure
	Diabetes Care LDL-C Screening	65.8%	84.5%	84.5%	Rotated Measure
	Diabetes Care LDL-C Level <130	45.3%	53.0%	53.0%	Rotated Measure
	Diabetes Care LDL-C Level <100	24.8%	33.9%	33.9%	Rotated Measure
	Diabetes Care Nephropathy	37.5%	49.6%	55.6%	⬅➡
	Asthma 5-9 Years	68.5%	65.3%	90.2%	⬆
	Asthma 10-17 Years	62.7%	63.5%	89.6%	⬆
	Asthma 18-56 Years	69.7%	70.9%	84.3%	⬆
	Asthma Combined Rate	67.9%	67.9%	86.8%	⬆
	Controlling High Blood Pressure	55.0%	62.1%	62.6%	⬅➡
	Advising Smokers to Quit	68.8%	67.9%	69.3%	⬅➡
Access to Care	Children's Access 12-24 Months	90.6%	91.4%	83.7%	⬅➡
	Children's Access 25 Mos-6 Years	78.5%	77.1%	79.2%	⬅➡
	Children's Access 7-11 Years	77.6%	72.9%	79.6%	⬅➡
	Adolescents' Access 12-19 Years	78.4%	73.4%	78.5%	⬅➡
	Adults' Access 20-44 Years	74.4%	78.8%	75.3%	⬅➡
	Adults' Access 45-64 Years	81.8%	84.6%	81.5%	⬅➡

Notes

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⬆ = Performance improvement (rate increase >10%)*
⬅➡ = No significant performance change (rate change ≤10%)
⬇ = Performance decline (rate decrease >10%)*
- - = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control:*
▼ = Performance *decline* (rate *increase* >10%)
▲ = Performance *improvement* (rate *decrease* >10%)

Table C-10—Michigan Medicaid HEDIS 2006 Trend Table: OCH					
Dimension of Care	**Measure**	**2004**	**2005**	**2006**	**2005–2006 Health Plan Trend**
Pediatric Care	Childhood Immunization Combo 2	65.0%	65.0%	72.0%	⬅➡
	Childhood Immunization Combo 3	- -	- -	24.1%	- -
	Adolescent Immunization Combo 2	9.8%	35.7%	47.9%	⬆
	Well-Child 1st 15 Mos, 0 Visits	9.1%	1.6%	0.9%	⬅➡
	Well-Child 1st 15 Mos, 6+ Visits	19.9%	48.5%	45.1%	⬅➡
	Well-Child 3rd-6th Years of Life	57.4%	59.3%	65.8%	⬅➡
	Adolescent Well-Care Visits	29.6%	30.1%	39.6%	⬅➡
	Appropriate Treatment of URI	56.9%	74.7%	77.8%	⬅➡
	Children with Pharyngitis	55.6%	25.8%	28.3%	⬅➡
Women's Care	Breast Cancer Screening	49.6%	47.4%	49.2%	⬅➡
	Cervical Cancer Screening	59.6%	58.4%	65.4%	⬅➡
	Chlamydia Screening, 16-20 Years	50.7%	56.7%	62.3%	⬅➡
	Chlamydia Screening, 21-25 Years	57.7%	63.9%	70.8%	⬅➡
	Chlamydia Screening, Combined	54.0%	60.0%	65.9%	⬅➡
	Timeliness of Prenatal Care	71.8%	64.7%	81.9%	⬆
	Postpartum Care	31.4%	40.5%	47.2%	⬅➡
Living With Illness	Diabetes Care HbA1c Testing	63.3%	69.1%	71.0%	⬅➡
	Diabetes Care Poor HbA1c Control	59.4%	62.9%	53.7%	⬅➡
	Diabetes Care Eye Exam	32.6%	27.9%	33.1%	⬅➡
	Diabetes Care LDL-C Screening	74.2%	72.1%	80.5%	⬅➡
	Diabetes Care LDL-C Level <130	52.6%	46.7%	54.6%	⬅➡
	Diabetes Care LDL-C Level <100	31.1%	31.1%	34.5%	⬅➡
	Diabetes Care Nephropathy	37.5%	37.1%	37.9%	⬅➡
	Asthma 5-9 Years	49.3%	55.1%	81.7%	⬆
	Asthma 10-17 Years	52.5%	61.0%	82.1%	⬆
	Asthma 18-56 Years	64.6%	70.9%	85.8%	⬆
	Asthma Combined Rate	56.8%	64.3%	84.0%	⬆
	Controlling High Blood Pressure	39.7%	39.2%	47.0%	⬅➡
	Advising Smokers to Quit	70.3%	67.0%	67.3%	⬅➡
Access to Care	Children's Access 12-24 Months	86.3%	89.0%	86.8%	⬅➡
	Children's Access 25 Mos-6 Years	74.5%	68.1%	69.9%	⬅➡
	Children's Access 7-11 Years	69.7%	70.2%	68.9%	⬅➡
	Adolescents' Access 12-19 Years	68.2%	70.8%	67.5%	⬅➡
	Adults' Access 20-44 Years	72.3%	70.3%	70.8%	⬅➡
	Adults' Access 45-64 Years	80.7%	78.2%	79.8%	⬅➡

Notes

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

⬆ = Performance improvement (rate increase >10%)*
⬅➡ = No significant performance change (rate change ≤10%)
⬇ = Performance decline (rate decrease >10%)*
- - = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control:*
▼ = Performance *decline* (rate *increase* >10%)
▲ = Performance *improvement* (rate *decrease* >10%)

Table C-11—Michigan Medicaid HEDIS 2006 Trend Table: PMD					
Dimension of Care	**Measure**	**2004**	**2005**	**2006**	**2005–2006 Health Plan Trend**
Pediatric Care	Childhood Immunization Combo 2	68.0%	73.0%	77.6%	⬅➡
	Childhood Immunization Combo 3	- -	- -	41.6%	- -
	Adolescent Immunization Combo 2	48.2%	64.7%	72.3%	⬅➡
	Well-Child 1st 15 Mos, 0 Visits	2.8%	2.8%	1.3%	⬅➡
	Well-Child 1st 15 Mos, 6+ Visits	38.1%	38.1%	43.3%	⬅➡
	Well-Child 3rd-6th Years of Life	55.7%	57.4%	67.6%	⬆
	Adolescent Well-Care Visits	33.8%	37.7%	47.7%	⬅➡
	Appropriate Treatment of URI	73.7%	78.5%	79.8%	⬅➡
	Children with Pharyngitis	49.8%	49.3%	48.0%	⬅➡
Women's Care	Breast Cancer Screening	59.5%	57.5%	54.8%	⬅➡
	Cervical Cancer Screening	69.3%	66.2%	74.5%	⬅➡
	Chlamydia Screening, 16-20 Years	64.5%	66.6%	64.4%	⬅➡
	Chlamydia Screening, 21-25 Years	65.1%	64.5%	64.2%	⬅➡
	Chlamydia Screening, Combined	64.8%	65.5%	64.3%	⬅➡
	Timeliness of Prenatal Care	65.1%	79.6%	86.4%	⬅➡
	Postpartum Care	53.0%	63.3%	62.5%	⬅➡
Living With Illness	Diabetes Care HbA1c Testing	84.5%	84.8%	82.5%	⬅➡
	Diabetes Care Poor HbA1c Control	35.8%	36.1%	34.3%	⬅➡
	Diabetes Care Eye Exam	63.3%	63.3%	68.1%	⬅➡
	Diabetes Care LDL-C Screening	88.7%	91.6%	89.8%	⬅➡
	Diabetes Care LDL-C Level <130	60.6%	70.4%	71.5%	⬅➡
	Diabetes Care LDL-C Level <100	32.5%	42.4%	47.0%	⬅➡
	Diabetes Care Nephropathy	56.1%	64.8%	64.8%	Rotated Measure
	Asthma 5-9 Years	72.6%	76.5%	92.7%	⬆
	Asthma 10-17 Years	75.2%	70.1%	90.3%	⬆
	Asthma 18-56 Years	71.4%	74.4%	86.4%	⬆
	Asthma Combined Rate	73.0%	73.4%	89.0%	⬆
	Controlling High Blood Pressure	55.3%	64.2%	65.4%	⬅➡
	Advising Smokers to Quit	68.9%	69.0%	74.7%	⬅➡
Access to Care	Children's Access 12-24 Months	90.9%	91.7%	93.2%	⬅➡
	Children's Access 25 Mos-6 Years	77.4%	78.8%	81.9%	⬅➡
	Children's Access 7-11 Years	77.1%	77.4%	80.8%	⬅➡
	Adolescents' Access 12-19 Years	79.1%	79.1%	80.7%	⬅➡
	Adults' Access 20-44 Years	74.7%	76.3%	79.6%	⬅➡
	Adults' Access 45-64 Years	85.2%	84.3%	85.7%	⬅➡

Notes

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

⬆ = Performance improvement (rate increase >10%)*
⬅➡ = No significant performance change (rate change ≤10%)
⬇ = Performance decline (rate decrease >10%)*
- - = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control:*
▼ = Performance *decline* (rate *increase* >10%)
▲ = Performance *improvement* (rate *decrease* >10%)

Table C-12—Michigan Medicaid HEDIS 2006 Trend Table: PRI					
Dimension of Care	**Measure**	**2004**	**2005**	**2006**	**2005–2006 Health Plan Trend**
Pediatric Care	Childhood Immunization Combo 2	81.1%	88.8%	88.3%	⬅➡
	Childhood Immunization Combo 3	- -	- -	56.0%	- -
	Adolescent Immunization Combo 2	48.2%	73.2%	69.8%	⬅➡
	Well-Child 1st 15 Mos, 0 Visits	0.3%	0.6%	0.7%	⬅➡
	Well-Child 1st 15 Mos, 6+ Visits	51.7%	52.1%	50.0%	⬅➡
	Well-Child 3rd-6th Years of Life	66.2%	64.2%	61.6%	⬅➡
	Adolescent Well-Care Visits	39.7%	36.7%	41.8%	⬅➡
	Appropriate Treatment of URI	87.5%	87.8%	88.6%	⬅➡
	Children with Pharyngitis	73.3%	76.2%	68.9%	⬅➡
Women's Care	Breast Cancer Screening	60.8%	57.4%	56.1%	⬅➡
	Cervical Cancer Screening	79.9%	81.1%	77.7%	⬅➡
	Chlamydia Screening, 16-20 Years	49.9%	54.8%	51.7%	⬅➡
	Chlamydia Screening, 21-25 Years	52.4%	58.7%	59.2%	⬅➡
	Chlamydia Screening, Combined	51.2%	56.9%	55.7%	⬅➡
	Timeliness of Prenatal Care	85.3%	86.9%	90.6%	⬅➡
	Postpartum Care	63.2%	58.4%	66.3%	⬅➡
Living With Illness	Diabetes Care HbA1c Testing	84.2%	88.8%	88.1%	⬅➡
	Diabetes Care Poor HbA1c Control	38.4%	31.6%	30.7%	⬅➡
	Diabetes Care Eye Exam	58.6%	58.4%	65.9%	⬅➡
	Diabetes Care LDL-C Screening	85.6%	87.8%	91.5%	⬅➡
	Diabetes Care LDL-C Level <130	60.6%	64.5%	67.2%	⬅➡
	Diabetes Care LDL-C Level <100	35.5%	39.4%	43.1%	⬅➡
	Diabetes Care Nephropathy	40.6%	47.0%	53.8%	⬅➡
	Asthma 5-9 Years	79.4%	75.9%	93.3%	⬆
	Asthma 10-17 Years	84.0%	80.4%	95.6%	⬆
	Asthma 18-56 Years	73.1%	77.2%	85.9%	⬅➡
	Asthma Combined Rate	78.1%	78.1%	91.1%	⬆
	Controlling High Blood Pressure	59.9%	63.8%	68.4%	⬅➡
	Advising Smokers to Quit	71.3%	73.0%	73.4%	⬅➡
Access to Care	Children's Access 12-24 Months	97.5%	97.2%	96.5%	⬅➡
	Children's Access 25 Mos-6 Years	84.3%	83.4%	83.5%	⬅➡
	Children's Access 7-11 Years	84.5%	83.5%	85.1%	⬅➡
	Adolescents' Access 12-19 Years	80.5%	82.0%	83.2%	⬅➡
	Adults' Access 20-44 Years	84.1%	84.3%	86.1%	⬅➡
	Adults' Access 45-64 Years	90.8%	91.7%	92.2%	⬅➡

Notes

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

⬆ = Performance improvement (rate increase >10%)*
⬅➡ = No significant performance change (rate change ≤10%)
⬇ = Performance decline (rate decrease >10%)*
- - = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control:*
▼ = Performance *decline* (rate *increase* >10%)
▲ = Performance *improvement* (rate *decrease* >10%)

Table C-13—Michigan Medicaid HEDIS 2006 Trend Table: PSW					
Dimension of Care	**Measure**	**2004**	**2005**	**2006**	**2005–2006 Health Plan Trend**
Pediatric Care	Childhood Immunization Combo 2	77.6%	78.3%	80.5%	⬅➡
	Childhood Immunization Combo 3	- -	- -	49.4%	- -
	Adolescent Immunization Combo 2	39.7%	58.6%	60.3%	⬅➡
	Well-Child 1st 15 Mos, 0 Visits	1.5%	1.3%	1.5%	⬅➡
	Well-Child 1st 15 Mos, 6+ Visits	38.0%	44.3%	50.9%	⬅➡
	Well-Child 3rd-6th Years of Life	56.7%	49.1%	57.9%	⬅➡
	Adolescent Well-Care Visits	33.3%	32.1%	33.1%	⬅➡
	Appropriate Treatment of URI	74.0%	76.7%	79.8%	⬅➡
	Children with Pharyngitis	62.6%	63.1%	60.2%	⬅➡
Women's Care	Breast Cancer Screening	60.9%	56.5%	59.5%	⬅➡
	Cervical Cancer Screening	65.7%	64.5%	73.5%	⬅➡
	Chlamydia Screening, 16-20 Years	43.9%	46.1%	43.4%	⬅➡
	Chlamydia Screening, 21-25 Years	47.1%	48.2%	49.2%	⬅➡
	Chlamydia Screening, Combined	45.6%	47.2%	46.1%	⬅➡
	Timeliness of Prenatal Care	79.5%	81.0%	85.4%	⬅➡
	Postpartum Care	47.7%	61.6%	66.2%	⬅➡
Living With Illness	Diabetes Care HbA1c Testing	83.7%	82.0%	87.1%	⬅➡
	Diabetes Care Poor HbA1c Control	48.9%	36.5%	30.4%	⬅➡
	Diabetes Care Eye Exam	34.5%	49.9%	64.7%	⬆
	Diabetes Care LDL-C Screening	78.8%	85.4%	86.1%	⬅➡
	Diabetes Care LDL-C Level <130	41.6%	54.5%	58.9%	⬅➡
	Diabetes Care LDL-C Level <100	26.3%	35.0%	37.5%	⬅➡
	Diabetes Care Nephropathy	45.0%	41.1%	47.2%	⬅➡
	Asthma 5-9 Years	77.7%	76.4%	88.8%	⬆
	Asthma 10-17 Years	68.8%	69.2%	93.3%	⬆
	Asthma 18-56 Years	69.0%	73.0%	87.8%	⬆
	Asthma Combined Rate	70.5%	72.6%	89.7%	⬆
	Controlling High Blood Pressure	48.2%	59.6%	59.6%	Rotated Measure
	Advising Smokers to Quit	68.5%	67.0%	64.0%	⬅➡
Access to Care	Children's Access 12-24 Months	96.6%	94.3%	97.6%	⬅➡
	Children's Access 25 Mos-6 Years	84.5%	77.8%	85.4%	⬅➡
	Children's Access 7-11 Years	83.1%	81.3%	81.6%	⬅➡
	Adolescents' Access 12-19 Years	82.4%	81.6%	82.0%	⬅➡
	Adults' Access 20-44 Years	81.9%	81.2%	84.6%	⬅➡
	Adults' Access 45-64 Years	91.1%	87.7%	91.6%	⬅➡

Notes

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

⬆ = Performance improvement (rate increase >10%)*
⬅➡ = No significant performance change (rate change ≤10%)
⬇ = Performance decline (rate decrease >10%)*
- - = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control:*
▼ = Performance *decline* (rate *increase* >10%)
▲ = Performance *improvement* (rate *decrease* >10%)

Table C-14—Michigan Medicaid HEDIS 2006 Trend Table: THC					
Dimension of Care	**Measure**	**2004**	**2005**	**2006**	**2005–2006 Health Plan Trend**
Pediatric Care	**Childhood Immunization Combo 2**	**66.7%**	**70.0%**	**71.5%**	⬅➡
	Childhood Immunization Combo 3	**- -**	**- -**	**34.3%**	**- -**
	Adolescent Immunization Combo 2	**34.5%**	**57.9%**	**71.2%**	⬆
	Well-Child 1st 15 Mos, 0 Visits	**6.3%**	**6.7%**	**3.5%**	⬅➡
	Well-Child 1st 15 Mos, 6+ Visits	**25.7%**	**24.0%**	**35.4%**	⬆
	Well-Child 3rd-6th Years of Life	**50.7%**	**55.6%**	**65.4%**	⬅➡
	Adolescent Well-Care Visits	**34.7%**	**39.1%**	**47.9%**	⬅➡
	Appropriate Treatment of URI	**83.3%**	**73.3%**	**69.6%**	⬅➡
	Children with Pharyngitis	**31.6%**	**29.0%**	**29.3%**	⬅➡
Women's Care	**Breast Cancer Screening**	**41.1%**	**46.5%**	**47.1%**	⬅➡
	Cervical Cancer Screening	**56.6%**	**59.8%**	**67.5%**	⬅➡
	Chlamydia Screening, 16-20 Years	**47.5%**	**50.1%**	**52.1%**	⬅➡
	Chlamydia Screening, 21-25 Years	**56.5%**	**63.5%**	**62.8%**	⬅➡
	Chlamydia Screening, Combined	**51.8%**	**56.2%**	**56.8%**	⬅➡
	Timeliness of Prenatal Care	**76.2%**	**86.3%**	**87.5%**	⬅➡
	Postpartum Care	**38.7%**	**46.9%**	**62.1%**	⬆
Living With Illness	**Diabetes Care HbA1c Testing**	**70.9%**	**76.4%**	**82.4%**	⬅➡
	Diabetes Care Poor HbA1c Control	**55.9%**	**47.7%**	**42.3%**	⬅➡
	Diabetes Care Eye Exam	**38.5%**	**47.9%**	**53.0%**	⬅➡
	Diabetes Care LDL-C Screening	**71.2%**	**79.6%**	**84.6%**	⬅➡
	Diabetes Care LDL-C Level <130	**47.0%**	**56.0%**	**56.1%**	⬅➡
	Diabetes Care LDL-C Level <100	**26.4%**	**32.6%**	**34.5%**	⬅➡
	Diabetes Care Nephropathy	**39.0%**	**56.7%**	**65.9%**	⬅➡
	Asthma 5-9 Years	**52.9%**	**56.3%**	**76.9%**	⬆
	Asthma 10-17 Years	**58.1%**	**62.9%**	**81.3%**	⬆
	Asthma 18-56 Years	**59.8%**	**72.7%**	**78.1%**	⬅➡
	Asthma Combined Rate	**57.5%**	**65.6%**	**78.9%**	⬆
	Controlling High Blood Pressure	**52.8%**	**52.1%**	**60.1%**	⬅➡
	Advising Smokers to Quit	**72.6%**	**71.7%**	**66.9%**	⬅➡
Access to Care	**Children's Access 12-24 Months**	**87.5%**	**88.2%**	**89.0%**	⬅➡
	Children's Access 25 Mos-6 Years	**71.5%**	**72.5%**	**75.9%**	⬅➡
	Children's Access 7-11 Years	**68.0%**	**71.5%**	**75.2%**	⬅➡
	Adolescents' Access 12-19 Years	**68.1%**	**72.5%**	**75.1%**	⬅➡
	Adults' Access 20-44 Years	**65.9%**	**70.6%**	**73.4%**	⬅➡
	Adults' Access 45-64 Years	**74.1%**	**76.1%**	**78.9%**	⬅➡

Notes

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

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⬅➡ = No significant performance change (rate change ≤10%)
⬇ = Performance decline (rate decrease >10%)*
- - = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control:*
▼ = Performance *decline* (rate *increase* >10%)
▲ = Performance *improvement* (rate *decrease* >10%)

Table C-15—Michigan Medicaid HEDIS 2006 Trend Table: UPP					
Dimension of Care	**Measure**	**2004**	**2005**	**2006**	**2005–2006 Health Plan Trend**
Pediatric Care	Childhood Immunization Combo 2	68.9%	72.1%	79.4%	⬅➡
	Childhood Immunization Combo 3	- -	- -	38.8%	- -
	Adolescent Immunization Combo 2	39.2%	62.7%	70.1%	⬅➡
	Well-Child 1st 15 Mos, 0 Visits	0.9%	0.9%	1.9%	⬅➡
	Well-Child 1st 15 Mos, 6+ Visits	52.0%	52.0%	41.6%	⬇
	Well-Child 3rd-6th Years of Life	56.2%	58.6%	59.7%	⬅➡
	Adolescent Well-Care Visits	37.2%	37.2%	37.0%	⬅➡
	Appropriate Treatment of URI	79.0%	82.1%	81.1%	⬅➡
	Children with Pharyngitis	55.1%	53.3%	52.3%	⬅➡
Women's Care	Breast Cancer Screening	72.6%	67.8%	70.0%	⬅➡
	Cervical Cancer Screening	74.9%	73.0%	73.0%	Rotated Measure
	Chlamydia Screening, 16-20 Years	45.9%	43.2%	47.9%	⬅➡
	Chlamydia Screening, 21-25 Years	41.4%	42.0%	45.3%	⬅➡
	Chlamydia Screening, Combined	43.9%	42.7%	46.8%	⬅➡
	Timeliness of Prenatal Care	88.0%	85.2%	85.2%	Rotated Measure
	Postpartum Care	57.7%	53.5%	53.5%	Rotated Measure
Living With Illness	Diabetes Care HbA1c Testing	90.5%	91.6%	91.6%	Rotated Measure
	Diabetes Care Poor HbA1c Control	26.0%	23.9%	23.9%	Rotated Measure
	Diabetes Care Eye Exam	62.3%	60.3%	68.6%	⬅➡
	Diabetes Care LDL-C Screening	89.5%	92.3%	92.3%	Rotated Measure
	Diabetes Care LDL-C Level <130	56.0%	61.7%	61.7%	Rotated Measure
	Diabetes Care LDL-C Level <100	31.4%	37.1%	37.1%	Rotated Measure
	Diabetes Care Nephropathy	52.8%	64.0%	64.0%	Rotated Measure
	Asthma 5-9 Years	81.5%	66.0%	95.1%	⬆
	Asthma 10-17 Years	74.3%	70.6%	86.2%	⬆
	Asthma 18-56 Years	79.5%	69.1%	86.8%	⬆
	Asthma Combined Rate	78.4%	68.8%	88.2%	⬆
	Controlling High Blood Pressure	65.1%	73.0%	73.0%	Rotated Measure
	Advising Smokers to Quit	65.8%	66.2%	69.6%	⬅➡
Access to Care	Children's Access 12-24 Months	97.4%	97.7%	98.0%	⬅➡
	Children's Access 25 Mos-6 Years	88.0%	85.2%	88.1%	⬅➡
	Children's Access 7-11 Years	84.2%	84.0%	84.2%	⬅➡
	Adolescents' Access 12-19 Years	87.2%	85.0%	86.9%	⬅➡
	Adults' Access 20-44 Years	86.3%	83.7%	86.6%	⬅➡
	Adults' Access 45-64 Years	90.7%	88.4%	91.0%	⬅➡

Notes

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

⬆ = Performance improvement (rate increase >10%)*
⬅➡ = No significant performance change (rate change ≤10%)
⬇ = Performance decline (rate decrease >10%)*
- - = No data available

*For two measures—*Well-Child 1st 15 Mos., 0 Visits* and *Diabetes Care, Poor HbA1c Control:*
▼ = Performance *decline* (rate *increase* >10%)
▲ = Performance *improvement* (rate *decrease* >10%)

Appendix D. Glossary

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

Terms, Acronyms, and Abbreviations

Administrative Data

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

Administrative Method

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

The administrative method is cost-efficient but can produce lower rates due to incomplete data submission by capitated providers. For example, a 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 Healthcare Providers and Systems* is a set of standardized surveys that assess patient satisfaction with experience of care.

**Formerly the Consumer Assessment of Health Plans Study.*

Capitation

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

Certified HEDIS Software Vendor

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

Claims-Based Denominator

When the eligible population for a measure is obtained from claims data. For 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

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

CMS 1500

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

Cohorts

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

Computer Logic

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

Continuous Enrollment Requirement

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

Core Set

For a full HEDIS audit, the process auditors 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 represent 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 occurring services/diagnoses appear in the health plan's administrative data systems.

Data Completeness Study

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

Denominator

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

DRG Coding

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

DST

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

DTaP

Diphtheria and tetanus toxoids and acellular pertussis vaccine.

DT

Diphtheria and tetanus toxoids vaccine.

EDI

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

Electronic Data

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

Encounter Data

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

Exclusions

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

FACCT

Foundation for Accountability.

FFS

Fee-for-service: A reimbursement mechanism 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 represents 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 Billing Practices

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

HbA1c

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

HCFA 1500

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

HCPCS

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

HEDIS

The 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 Vaccine

Haemophilus influenzae type b vaccine.

HPL

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

HSAG

Health Services Advisory Group, Inc.

Hybrid Measures

Measures that can be reported using the hybrid method.

Hybrid Method

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

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

ICD-9-CM

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

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 poliovirus vaccine.

IT

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

Key Data Elements

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

Key Measures

The HEDIS measures selected by MDCH that health plans 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 most measures reported as a rate (which includes all of the key measures except *Advising Smokers to Quit*), any error that causes a ± 5 percent difference in the reported rate is considered materially biased. For non-rate measures or measures collected via the CAHPS survey, (such as the key measure *Advising Smokers to Quit*), any error that causes a ± 10 percent difference in the reported rate or calculation.

MCIR

Michigan Care Improvement Registry.

MCO

Managed care organization.

MDCH

Michigan Department of Community Health.

Medical Record Validation

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

Milligrams per deciliter.

MHP

Medicaid health plan.

Modifier Codes

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

MMR

Measles, mumps, and rubella vaccine.

MUPC Codes

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

NA

Not Applicable: The health plan 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

The *Not Report* HEDIS audit designation.

A measure may be designated NR for any of three reasons:

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.
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.

PCV

Pneumococcal conjugate vaccine

Pharmacy Data

Data derived from the provision of pharmacy services.

Primary Source Verification

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

Proprietary Codes

Unique billing codes developed by a health plan, 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 the denominators/numerators for calculating the rate for each measure.

Standard Codes

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

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 (chicken pox) vaccine.