

ANALYSIS OF MEDICAID HMO

(FY2009 Appropriation Bill - Public Act 246 of 2008)

Within 30 days receipt of final report

Section 1662: (1) The department shall assure that an external quality review of each contracting HMO is performed that results in an analysis and evaluation of aggregated information on quality, timeliness, and access to health care services that the HMO or its contractors furnish to Medicaid beneficiaries. (2) The department shall require Medicaid HMOs to provide EPSDT utilization data through the encounter data system, and health employer data and information set well child health measures in accordance with the National Committee on Quality Assurance prescribed methodology. (3) The department shall provide a copy of the analysis of the Medicaid HMO annual audited health employer data and information set reports and the annual external quality review report to the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director, within 30 days of the department's receipt of the final reports from the contractors. (4) The department shall work with the Michigan association of health plans and the Michigan association for local public health to improve service delivery and coordination in the MSS/ISS and EPSDT programs. (5) The department shall assure the training and technical assistance are available for EPSDT and MSS/ISS for Medicaid health plans, local health departments, and MSS/ISS contractors.

*Michigan Department
of Community Health*



Jennifer M. Granholm, Governor
Janet Olszewski, Director

*Michigan Department
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Michigan Medicaid HEDIS® 2008 Results STATEWIDE AGGREGATE REPORT

December 2008



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HEDIS[®] refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

NCQA HEDIS Compliance Audit[™] is a trademark of the NCQA.

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

Introduction

During 2007, the Michigan Department of Community Health (MDCH) contracted with 13 health plans to provide managed care services to more than 993,000 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 was based on the Healthcare Effectiveness 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 consist of 39 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 MHP's current performance level relative to national Medicaid percentiles. MDCH uses HEDIS rates for the annual Medicaid consumer guide, as well as for the annual performance assessment.

Performance levels for Michigan MHPs have been established for all of the key measures. The National Committee for Quality Assurance (NCQA) publishes national percentiles based on the analysis of reportable data submitted by Medicaid health plans. 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. NCQA sets the low performance level (LPL) 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. This approach to the analysis is designed to encourage consideration of the related key measures as a category rather than in isolation, and to think about the strategic and tactical changes required to improve overall performance.

¹⁻¹ Medical Services Administration Bureau of Medicaid Program Operations and Quality Assurance. *Medicaid Managed Care Performance Monitoring Report, Composite—All Plans*. Michigan Department of Community Health, July 2008.

This report analyzes Michigan Medicaid HEDIS results in several ways. For each of the four dimensions of care:

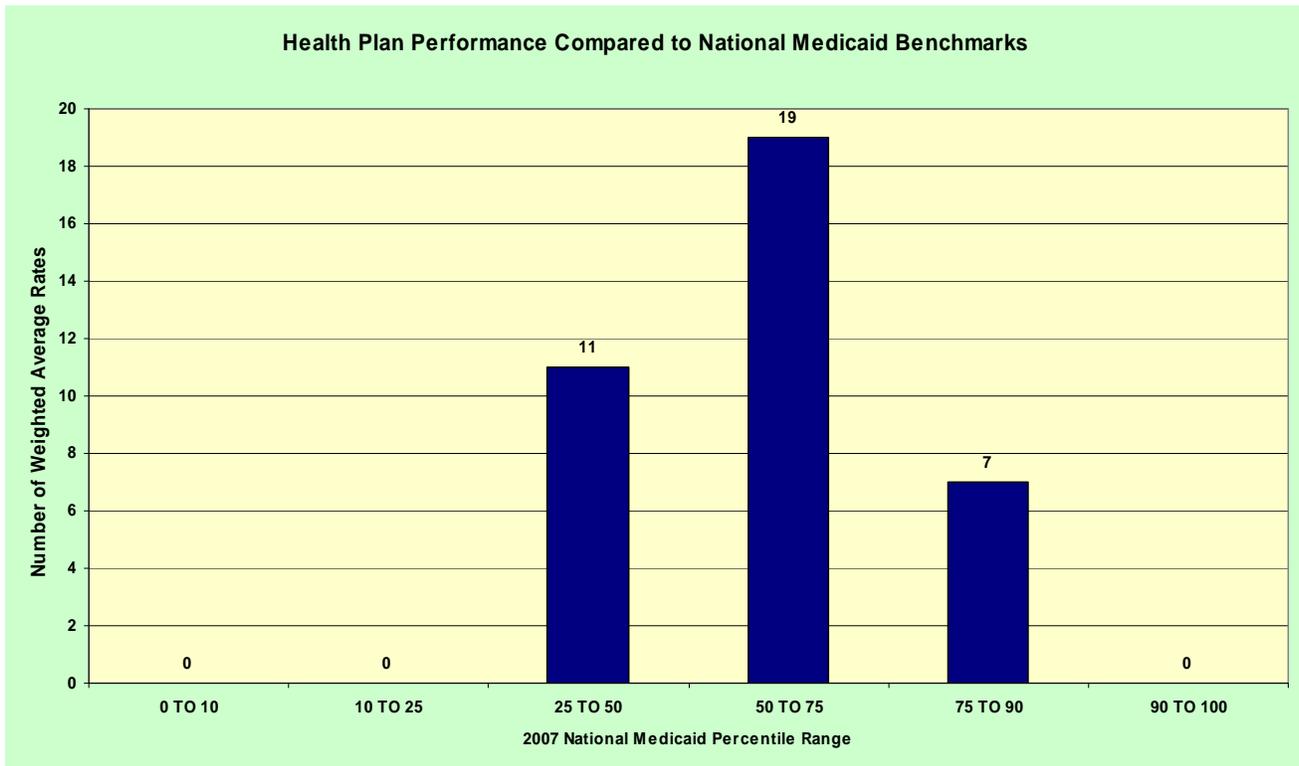
- ◆ A weighted average comparison presents the Michigan Medicaid 2008 results relative to the 2007 Michigan Medicaid weighted averages and the national HEDIS 2007 Medicaid 50th percentiles.
- ◆ A performance profile analysis discusses the overall Michigan Medicaid 2008 results and presents a summary 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 the NCQA's information system (IS) standards.

Key Findings and Recommendations

This is the eighth year that HSAG has examined the MDCH HEDIS results, and improvement continues. 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 37 weighted averages for which national percentile data were available, 11 (or 30 percent) fell between the 25th and 50th percentiles, 19 (or 51 percent) fell between the 50th and 75th percentiles, and 7 (or 19 percent) fell between the 75th and 90th percentiles. Approximately 70 percent of results are at or above the 50th percentile. No measure results ranked below the 25th percentile.

**Figure 1-1—Michigan Medicaid HEDIS 2008:
Health Plan Performance Compared With National Medicaid Percentiles**



Five of the 37 weighted averages declined from last year; however, none of these declines was statistically significant. The declines ranged from a decrease of 0.1 percentage point to 3.4 percentage points, with a majority of the declines being less than 1 percentage point. The measures that showed declines were: *Breast Cancer Screening—52 to 69 Years*, *Chlamydia Screening—16 to 20 Years*, *Chlamydia Screening—Combined*, *Comprehensive Diabetes Care—Blood Pressure Control <130/80*, and *Use of Appropriate Medications for People With Asthma—18-56 Years*.

The remaining 32 measures showed improvement, with statistically significant improvement for two of the measures. These measures were *Childhood Immunization Status—Combo 3* and *Comprehensive Diabetes Care—HbA1c Testing*.

All of the measures in the Pediatric Care dimension showed improvement from the previous year. The great improvement was seen in the *Childhood Immunization Status—Combo 3* measure's rate, with a statistically significant increase of 11.1 percentage points. Improvement in the remaining measures ranged from 0.1 percentage point to 4.3 percentage points. Three of the measures in this dimension of care ranked above the 75th percentile: *Childhood Immunization Status—Combo 2*, *Childhood Immunization Status—Combo 3*, and *Adolescent Well-Care Visits*. To continue improvement, MHPs could perform a root cause analysis for children who do not receive the recommended antigens to determine whether there are underlying problems that prohibit or deter children from receiving the recommended vaccines.

The well-child visit measures (*Zero Visits*, *Six or More Visits*, and *Third, Fourth, Fifth, and Sixth Years of Life*) all ranked at or above the national Medicaid HEDIS 2007 50th percentile but did not reach the 75th percentile. Recommendations for improving rates for this measure include developing and implementing interventions that target low-performing providers, performing educational visits with PCPs, sending Web notifications and/or written reminders to PCPs for children who need well-child services, and providing additional PCP incentives for well-child services that were billed.

The remaining measures in this section, *Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis* both ranked below the 50th percentile. Since these are pharmacy-driven measures, the MHPs should ensure the pharmacy data that they receive are complete and accurate. MHPs should monitor pharmacy submissions from vendors on a monthly or quarterly basis to ensure that there are no areas of data loss. A trending analysis could be performed to identify these gaps of data.

Six of the nine measures in the Women's Care dimension showed improvement compared to the 2007 rates. The improvements ranged from 0.5 percentage points to 2.6 percentage points; however, none of these improvements was statistically significant. Three measures had declines in their weighted averages compared to 2007, and none of the declines was statistically significant. These measures were: *Breast Cancer Screening—52–69 Years*, *Chlamydia Screening—16-20 Years*, and *Chlamydia Screening—Combined*. All of the measures ranked above the 50th percentile. It is evident the MHPs have room for improvement, especially with those measures that declined this past year. MHPs should identify barriers to accessing care and brainstorm possible ways to eliminate or minimize these barriers. In addition, the MHPs could provide patient reminder cards and telephone calls for enrollees who need screening services.

Fourteen of the 16 measures' rates in the Living With Illness dimension improved compared to the 2007 rates, with one measure, *Comprehensive Diabetes Care—HbA1c Testing*, showing statistically significant improvement. The improvement ranged from 0.7 to 5.3 percentage points. The two measures that had declining rates were *Comprehensive Diabetes Care—Blood Pressure Control <130/80* and *Use of Appropriate Medications for People With Asthma—18–56 Years*. None of the declines in rates was statistically significant. Based on the results for this dimension, it is clear that the MHPs are improving on the majority of rates. In order to continue this improvement, the MHPs should continue to focus efforts on improving administrative data completeness and consider creating a case management registry to access information such as laboratory screening and results data, most recent blood pressure results, and pharmacy data.

All of the measures' weighted averages in the Access to Care dimension improved compared to the 2007 weighted averages. The improvement ranged from 0.4 percentage points to 2.3 percentage points. All of the measures except *Adults' Access to Preventive/Ambulatory Health Services—20 to 44 Years* and *Adults' Access to Preventive/Ambulatory Health Services—45 to 64 Years* ranked below the national 50th percentile. This dimension of care is an area where the MHPs should continue to focus improvement efforts. It is recommended that the MHPs continue to work together to share best practices and determine the best ways to continue to improve these rates. In addition, convening focus groups could be useful to identify key barriers to access directly from members. The MHPs could then use these results to target the key barriers with specific interventions and provider education.

In reviewing the 2008 quality improvement (QI) work plans, it was evident that the Michigan MHPs continued to use disease management programs for asthma and diabetes, as well as other conditions such as hypertension and prenatal and postpartum care. The use of disease management programs assists the plans in tracking enrollees who need services and offers additional data to enhance the claims/encounter data the MHPs receive from providers. Improving HEDIS rates continues to be a goal of the MHPs, and the QI work plans outlined several methods the MHPs are using to do this. The MHPs are using newsletters and postcard/birthday cards as ways to reach members by mail and remind them of needed services. The MHPs are also using customer service lines to remind members of upcoming, needed services. One MHP indicated that it was producing clinical practice reports for its providers that identify members who do not have claims in the system but need services. This method of data mining is a good way to identify members who are not accessing care.

As mentioned in the previous year's report, all of the MHPs should evaluate data completeness. This is relevant to areas where the MHPs have services that are capitated or areas where providers may not bother to submit the claim if they perceive the reimbursement to be low. The MHPs should focus on expected claims or encounter volumes by provider type to help identify missing data. In addition, it is crucial that the MHPs also evaluate data completeness for their vendors (i.e., pharmacy vendor, lab vendor). Monitoring data submission and volume from vendors will help ensure that data are complete and accurate. The MHPs should ensure that formal reconciliation processes are in place to ensure the integrity of data transfer between the MHPs and their vendors.

Weighted Average Comparisons for the Four Dimensions of Care

Figure 1-2 through Figure 1-5 show Michigan Medicaid HEDIS 2008 results for each dimension of care, comparing the current weighted average for each measure relative to the 2007 Michigan Medicaid weighted average and the national HEDIS 2007 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 2008 and 2007 Michigan Medicaid weighted averages.
- ◆ The dark-colored bars show the difference in percentage points between this year's Michigan results and national results, comparing the 2008 Michigan Medicaid weighted average with the national HEDIS 2007 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 *Advising Smokers to Quit* and *Discussing Smoking Cessation Strategies* could not be calculated. National percentile data are not available for these measures.

Performance Level Analysis

Table 1-1 through Table 1-4 show the 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 the national HEDIS 2007 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 (≥ 90 th percentile).
- ◆ Two stars (★★) for performance above the LPL but below the HPL (>25 th percentile to <90 th percentile).
- ◆ One star (★) for performance at or below the LPL (≤ 25 th percentile) or for Not Report ("NR") designations.

There are two measures for which this differs—i.e., below the 10th percentile is three-star performance and above the 75th percentile is one-star performance—because for these two measures only, *lower* rates indicate better performance. The measures are *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Comprehensive Diabetes Care—Poor HbA1c Control*.

NA indicates that the health plan followed the specifications for producing a reportable denominator, but the denominator was too small to report a valid rate, resulting in an NA audit designation.

Measures that did not have national percentiles available for comparison will be presented as “- -” in the following tables.

Summary of Results

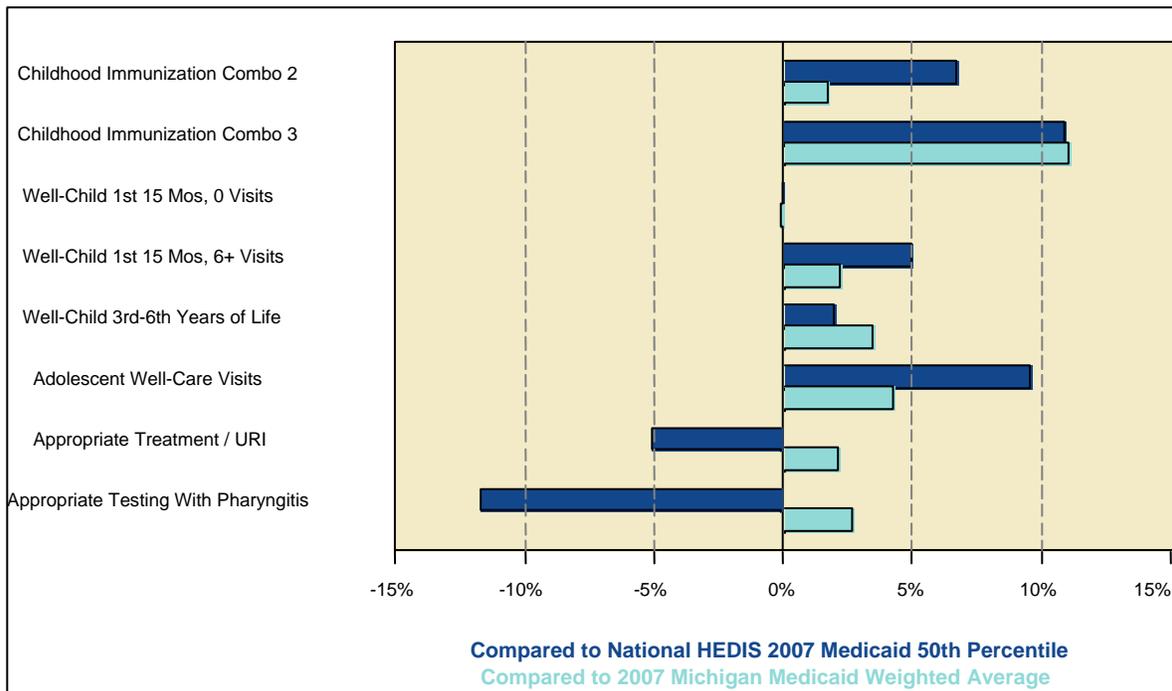
Pediatric Care

All of the 2008 Pediatric Care measures' weighted averages showed improvement from 2007. *Childhood Immunization Status—Combination 3* showed statistically significant improvement, with an increase of 11.1 percentage points compared to the 2007 Michigan Medicaid weighted average.

All of the weighted averages for the immunization and well-care measures performed better than the national HEDIS 2007 Medicaid 50th percentile. The *Adolescent Well-Care Visits* rate improved by 4.3 percentage points compared to the 2007 rate. All of the MHPs' rates for these measures came primarily from administrative data. For most of the immunization and well-care measures, the percentage of the rates derived from administrative data increased. This indicates that the health plans have fairly complete data and rely less on medical record review.

The rates for *Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis* improved from 2007; however, more than half of the plans continued to perform below the national HEDIS 2007 Medicaid 50th percentile for these measures. Opportunities still exist for the MHPs to improve their rates for these measures.

Figure 1-2—Michigan Medicaid HEDIS 2008 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 2008 Performance Summary: Pediatric Care

Health Plan Name	Childhood Immunization Combo 2	Childhood Immunization Combo 3	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
BCD	★★	★★★	★★	★★	★★	★★	★★	★★★
CCM	★★	★★	★	★★	★	★★	★★	★★
GLH	★★	★★	★★	★★★	★★	★★	★	★
HPM	★★★	★★★	★★	★★	★★	★★	★★	★★
HPP	★★	★★★	★★	★★	★★	★★	★	★
MCL	★★	★★	★★	★★	★★	★★	★	★★
MID	★★	★★	★★	★★	★★	★★★	★★	★
MOL	★★	★★	★★	★	★★	★★	★★	★★
OCH	★★	★★	★★	★★	★★	★★	★★	★
PMD	★★	★★★	★★	★★	★	★★	★★	★★
PRI	★★★	★★★	★★	★★	★★	★★	★★	★★
THC	★★★	★★★	★★	★	★★	★★	★	★
UPP	★★	★★	★★	★★	★	★★	★★	★★

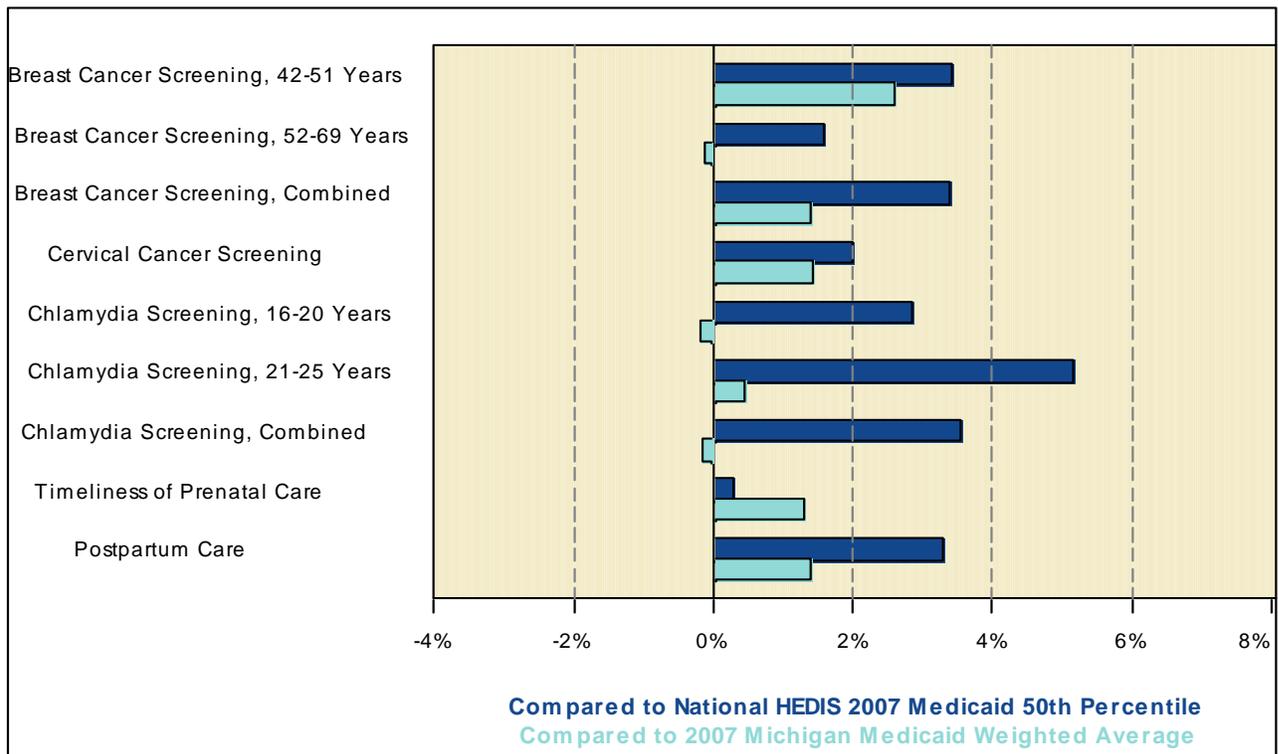
This symbol		shows this performance level
3 stars	★★★	≥ HPL
2 stars	★★	> LPL and < HPL
1 star	★	≤ LPL, or for <i>Not Report (NR)</i>

Women’s Care

Six out of the nine Women’s Care measures’ weighted averages showed improvement when compared to the 2007 weighted averages. The *Breast Cancer Screening—Ages 52 to 69 Years*, *Chlamydia Screening in Women—Ages 16 to 20 Years*, and *Chlamydia Screening in Women—Combined* measures did not improve; however, they each showed a decline of less than 0.3 percentage points.

All nine Women’s Care measures’ weighted averages exceed the national HEDIS 2007 Medicaid 50th percentile.

Figure 1-3—Michigan Medicaid HEDIS 2007 Weighted Average Comparison: Women’s Care



**Table 1-2—Michigan Medicaid HEDIS 2008 Performance Summary:
Women’s Care**

Health Plan Name	Breast Cancer Screening 42–51 Yrs	Breast Cancer Screening 52–69 Yrs	Breast Cancer Screening Combined	Cervical Cancer Screening	Chlamydia Screening 16–20 Yrs	Chlamydia Screening 21–25 Yrs	Chlamydia Screening Combined	Timeliness of Prenatal Care	Postpartum Care
BCD	★★	★	★★	★★	★★	★★	★★	★	★★
CCM	★★	★★	★★	★★	★★	★★	★★	★★	★★
GLH	★★	★★	★★	★★	★★	★★	★★	★★	★★
HPM	★★★	★★★	★★★	★★	★★	★★	★★	★★	★★★
HPP	★★	★★	★★	★★	★★	★★	★★	★★★	★★
MCL	★★	★★	★★	★★	★★	★★	★★	★★★	★★★
MID	★★	★★	★★	★★	★★	★★	★★	★★	★★
MOL	★★	★★	★★	★★	★★	★★	★★	★	★
OCH	★★	★★	★★	★★	★★	★★★	★★★	★★	★
PMD	★★	★★	★★	★★	★★★	★★	★★	★★	★★
PRI	★★	★★	★★	★★★	★★	★★	★★	★★	★★
THC	★★	★★	★★	★★	★★	★★★	★★★	★★	★★
UPP	★★	★★	★★	★★	★★	★★	★★	★★	★★

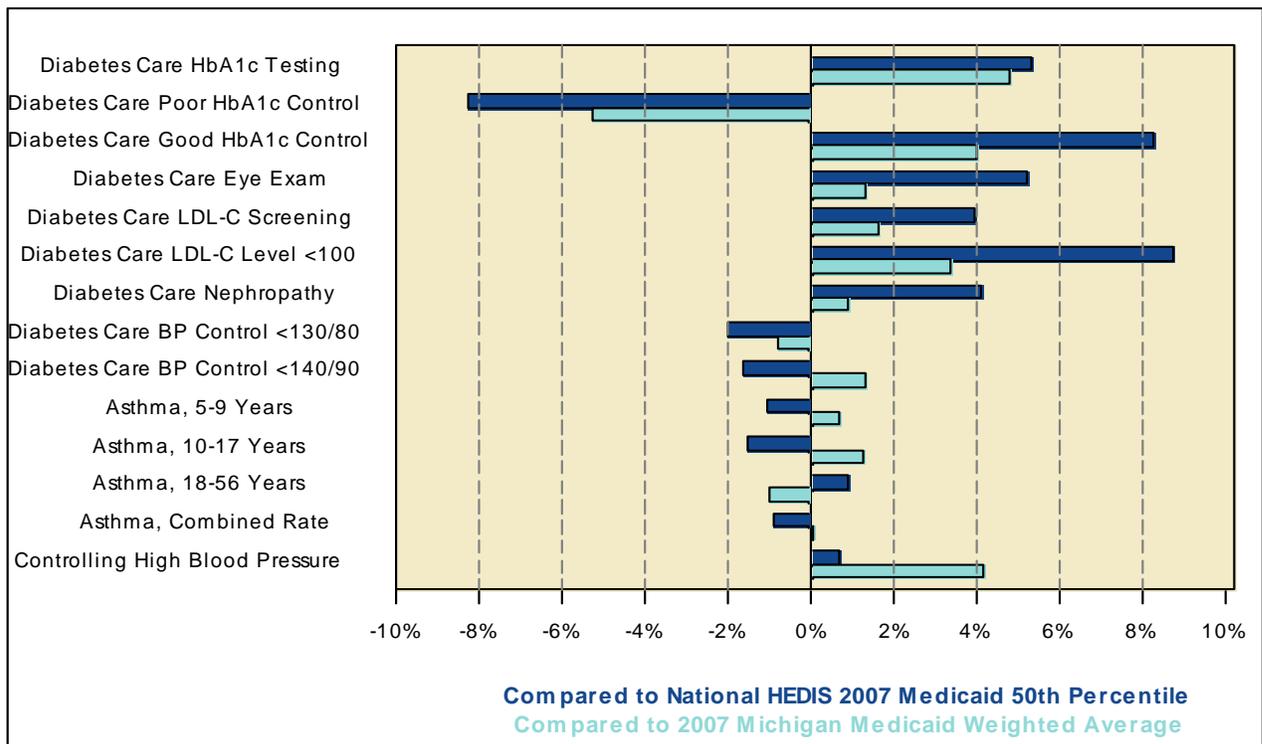
This symbol	shows this performance level
3 stars	★★★ ≥ HPL
2 stars	★★ > LPL and < HPL
1 star	★ ≤ LPL, or for <i>Not Report (NR)</i>

Living With Illness

Twelve out of the 14 Living With Illness measures' weighted averages showed improvement compared to the 2007 results. The *Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)* and *Use of Appropriate Medications for People With Asthma—Ages 18 to 56 Years* measures did not improve; however, the rates decreased by no more than 1 percentage point. *Comprehensive Diabetes Care—HbA1c Testing* showed statistically significant improvement, with an increase of 4.8 percentage points from the 2007 Michigan Medicaid weighted average.

Nine out of the 14 Living With Illness measures' weighted averages were above the national HEDIS 2007 Medicaid 50th percentile.

Figure 1-4—Michigan Medicaid HEDIS 2008 Weighted Average Comparison: Living With Illness



Notes: For *Comprehensive Diabetes Care—Poor HbA1c Control*, a bar to the left (a lower rate) indicates better performance. *Advising Smokers to Quit* and *Discussing Smoking Cessation Strategies* are not included in this figure because national percentile data are not available, nor could a weighted average be calculated.

**Table 1-3—Michigan Medicaid HEDIS 2008 Performance Summary:
Living With Illness (Part 1)**

Health Plan Name	Diabetes Care HbA1c Testing	Diabetes Care Poor HbA1c Control	Diabetes Care Good HbA1c Control	Diabetes Care Eye Exam	Diabetes Care LDL-C Screening	Diabetes Care LDL-C Level<100	Diabetes Care Nephropathy	Diabetes Care Blood Pressure Control <130/80	Diabetes Care Blood Pressure Control <140/90
BCD	★★★	★★	★★	★★★	★★	★★	★★★	★★★	★★★
CCM	★★	★★★	★★★	★★	★★	★★	★★	★★	★★
GLH	★★	★★	★★	★★	★★	★★	★★	★★	★★
HPM	★★★	★★★	★★★	★★★	★★★	★★	★★	★★	★★
HPP	★★	★★	★★★	★★★	★★	★★	★★	★★	★★
MCL	★★	★★	★★★	★★	★★	★★	★★★	★★	★★
MID	★★	★★	★★	★★	★★	★★	★★	★★	★★
MOL	★★	★★	★★	★★	★★	★★★	★★	★★	★★
OCH	★★	★★	★★	★★	★★	★★	★★	★	★
PMD	★★	★★	★★★	★★	★★	★★	★★	★★	★★
PRI	★★	★★	★★★	★★★	★★	★★	★★	★★	★★★
THC	★★	★★	★★	★★	★★	★★	★★	★	★
UPP	★★	★★★	★★★	★★	★★★	★★	★★	★★	★★★

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

**Table 1-3—Michigan Medicaid HEDIS 2008 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 Combined	Advising Smokers to Quit*	Discussing Smoking Cessation Strategies*
BCD	★★★	★★★	★★	★★★	★★★	--	--
CCM	★★	★★	★★	★★	★★	--	--
GLH	★	★	★★	★	★★	--	--
HPM	★★	★★	★★	★★	★★	--	--
HPP	★★	★★	★★	★★	★★	--	--
MCL	★★★	★★	★★	★★	★★★	--	--
MID	★	★	★	★	★★	--	--
MOL	★★	★	★★	★★	★★	--	--
OCH	★	★	★★	★	★★	--	--
PMD	★★	★★	★★	★★	★★	--	--
PRI	★★	★★★	★★	★★★	★★	--	--
THC	★	★	★	★	★★	--	--
UPP	★	★★	★★	★★	★★	--	--

* -- Means and percentiles are not available for the *Advising Smokers to Quit* and *Discussing Smoking Cessation Strategies* measures.

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

Access to Care

All six of the Access to Care measures showed improvement over the 2007 Michigan Medicaid weighted averages. Additionally, the *Adults' Access to Primary Care Practitioners* measures performed better than the national HEDIS 2007 50th percentile, while all of the other measures in this dimension did not meet the national average. These findings indicate opportunities for improvement.

Figure 1-5—Michigan Medicaid HEDIS 2008 Weighted Average Comparison: Access to Care

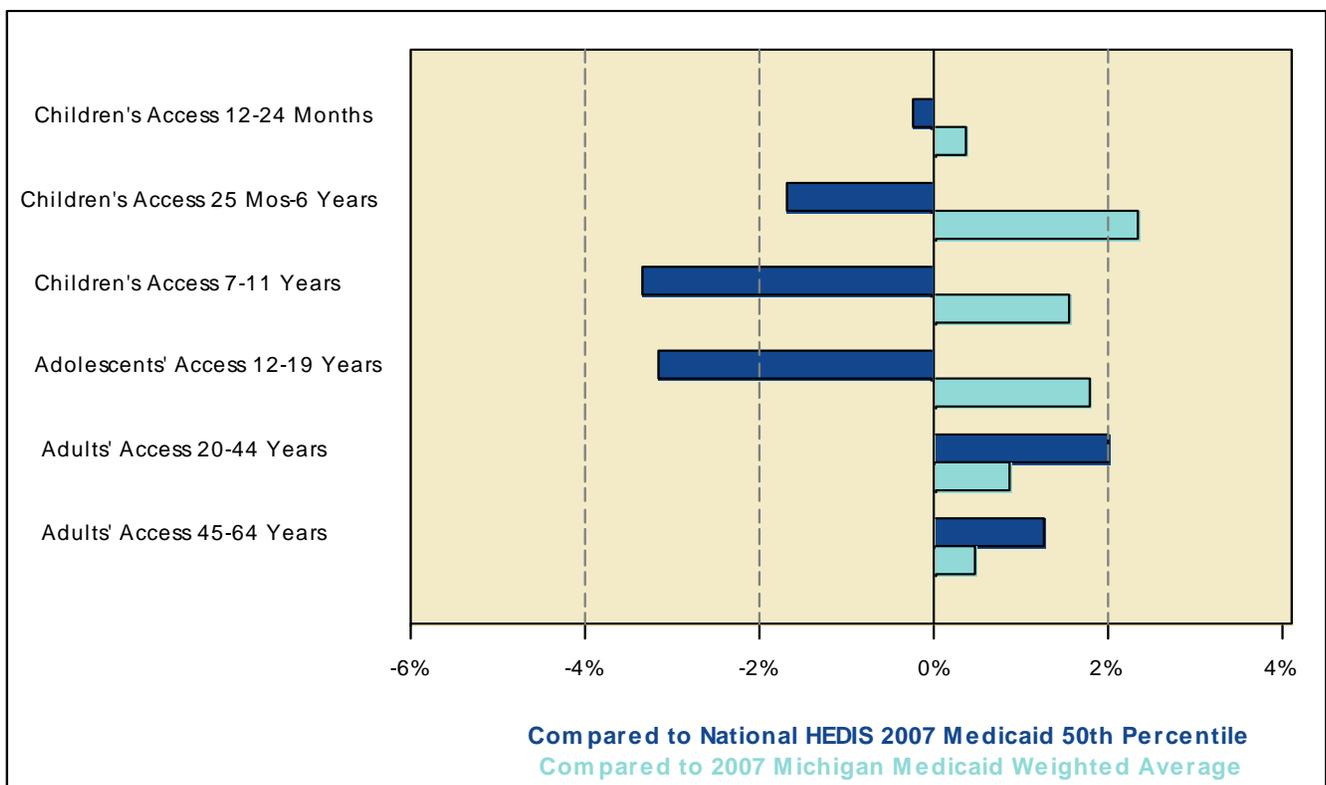


Table 1-4—Michigan Medicaid HEDIS 2008 Performance Summary: Access to Care						
Health Plan Name	Children's Access 12–24 Mos	Children's Access 25 Mos–6 Yrs	Children's Access 7–11 Yrs	Adolescents' Access 12–19 Yrs	Adults' Access 20–44 Yrs	Adults' Access 45–64 Yrs
BCD	★★	★★	★★	★★	★★	★★
CCM	★★	★	★	★★	★★	★★
GLH	★★	★★	★★	★★	★★	★★
HPM	★★	★★	★★	★★	★★	★★★
HPP	★★	★★	★★	★★	★★	★★
MCL	★★	★	★	★	★★	★★
MID	★★	★★	★	★	★★	★★
MOL	★★	★★	★	★	★★	★★
OCH	★	★	★	★	★★	★★
PMD	★★	★	★	★★	★★	★★
PRI	★★	★★	★★	★★	★★	★★★
THC	★	★	★	★	★★	★★
UPP	★★	★★	★★	★★	★★★	★★★

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

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

2. How to Get the Most From This Report

Summary of Michigan Medicaid HEDIS 2008 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 39 distinct rates, shown in Table 2-1. These 39 rates represent the 2008 MDCH key measures. Thirteen Michigan MHPs were required to report the key measures in 2008.

Table 2-1—Michigan Medicaid HEDIS 2008 Key Measures

Standard HEDIS 2008 Measures	2008 MDCH Key Measures
1. Childhood Immunization Status	1. Childhood Immunization Status—Combination #2 2. Childhood Immunization Status—Combination #3
3. Well-Child Visits in the First 15 Months of Life	3. Well-Child Visits in the First 15 Months of Life—Zero Visits 4. 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	5. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
5. Adolescent Well-Care Visits	6. Adolescent Well-Care Visits
6. Appropriate Treatment for Children With Upper Respiratory Infection	7. Appropriate Treatment for Children With Upper Respiratory Infection
7. Appropriate Testing for Children With Pharyngitis	8. Appropriate Testing for Children With Pharyngitis
8. Breast Cancer Screening	9. Breast Cancer Screening—42 to 51 Years 10. Breast Cancer Screening—52 to 69 Years 11. Breast Cancer Screening—Combined Rate
9. Cervical Cancer Screening	12. Cervical Cancer Screening
10. Chlamydia Screening in Women	13. Chlamydia Screening in Women—16 to 20 Years 14. Chlamydia Screening in Women—21 to 25 Years 15. Chlamydia Screening in Women—Combined Rate
11. Prenatal and Postpartum Care	16. Prenatal and Postpartum Care—Timeliness of Prenatal Care 17. Prenatal and Postpartum Care—Postpartum Care
12. Comprehensive Diabetes Care	18. Comprehensive Diabetes Care—HbA1c Testing 19. Comprehensive Diabetes Care—Poor HbA1c Control 20. Comprehensive Diabetes Care—Good HbA1c Control 21. Comprehensive Diabetes Care—Eye Exam 22. Comprehensive Diabetes Care—LDL-C Screening 23. Comprehensive Diabetes Care—LDL-C Level <100 24. Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy 25. Comprehensive Diabetes Care—Blood Pressure Control <130/80 26. Comprehensive Diabetes Care—Blood Pressure Control <140/90
13. Use of Appropriate Medications for People With Asthma	27. Use of Appropriate Medications for People With Asthma—5 to 9 Years 28. Use of Appropriate Medications for People With Asthma—10 to 17 Years 29. Use of Appropriate Medications for People With Asthma—18 to 56 Years 30. Use of Appropriate Medications for People With Asthma—Combined Rate
14. Controlling High Blood Pressure	31. Controlling High Blood Pressure—Combined
15. Medical Assistance With Smoking Cessation	32. Medical Assistance With Smoking Cessation—Advising Smokers to Quit 33. Medical Assistance With Smoking Cessation—Smoking Cessation Strategies
16. Children and Adolescents' Access to Primary Care Practitioners	34. Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months 35. Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years 36. Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years 37. Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years
17. Adults' Access to Preventive/Ambulatory Health Services	38. Adults' Access to Preventive/Ambulatory Health Services—20 to 44 Years 39. Adults' Access to Preventive/Ambulatory Health Services—45 to 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 four predefined audit findings: *Report*, *Not Applicable*, *Not Report*, and *No Benefit*. An audit finding 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. 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 *Not Applicable* audit finding. An audit finding of *Not Report* indicates that the rate could 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 *No Benefit* audit finding indicates that the MHP did not offer the benefit required by the measure.

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. Five health plans chose to rotate measures in 2007, and a total of 12 rates were rotated. Following NCQA methodology, rotated measures were assigned the same reported rates from 2006 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. 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 2008 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

- ◆ NCQA deleted “documented history of illness” and “seropositive test result” as numerator evidence for DTaP, IPV, HiB, and pneumococcal conjugate.
- ◆ The measure requires four acellular pertussis vaccines for the DTaP antigen.

Appropriate Testing for Children With Pharyngitis

- ◆ NCQA standardized the episode definitions. The first eligible episode is referred to as the *Index Episode Start Date (IESD)*.

Appropriate Treatment for Children With Upper Respiratory Infection

- ◆ NCQA added *Negative Competing Diagnosis* criteria.
- ◆ NCQA standardized the episode definitions. The first eligible episode is referred to as the *IESD*.

Chlamydia Screening in Women

- ◆ NCQA added Table CHL-A: Prescriptions to Identify Contraceptives.

Controlling High Blood Pressure

- ◆ NCQA removed the age stratifications.
- ◆ NCQA added anchor date criteria.
- ◆ NCQA added denominator terms for confirmation of hypertension.

Performance Levels

The purpose of identifying performance levels is to compare the quality of services provided to Michigan Medicaid managed care beneficiaries to national percentiles and to use as a reference point for improving 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 2007 percentiles, which are the most recent data 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 3-1 shows a rate that looks identical to the National 50th Percentile (72.4 percent). This health plan had an actual rate of 72.39 which is slightly lower than the 72.4 percent.

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* and *Smoking Cessation Strategies* since the 2002 reporting year. Given the lack of more recent performance data, no HPL or LPL has been established for these key measures. Instead, health plan results are ranked highest to lowest and are compared with the 2007 Michigan Medicaid 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 “2007–2008 Health Plan Trend” shows, by key measure, the comparison between the 2007 results and the 2008 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 Weighted 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 a health plan’s eligible population for that measure, provides the most representative rate for the overall Michigan Medicaid population. Weighting the rate by a 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 Weighted Averages and Aggregate Results

The 2008 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 2008 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 2007 and 2008 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 2007 and 2008 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 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 2007 Medicaid 50th percentile. In addition, the 2008, 2007, and 2006 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 2008 Michigan Medicaid weighted average for each rate with the 2007 and 2006 Michigan Medicaid weighted averages and the national HEDIS 2007 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 2008 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.

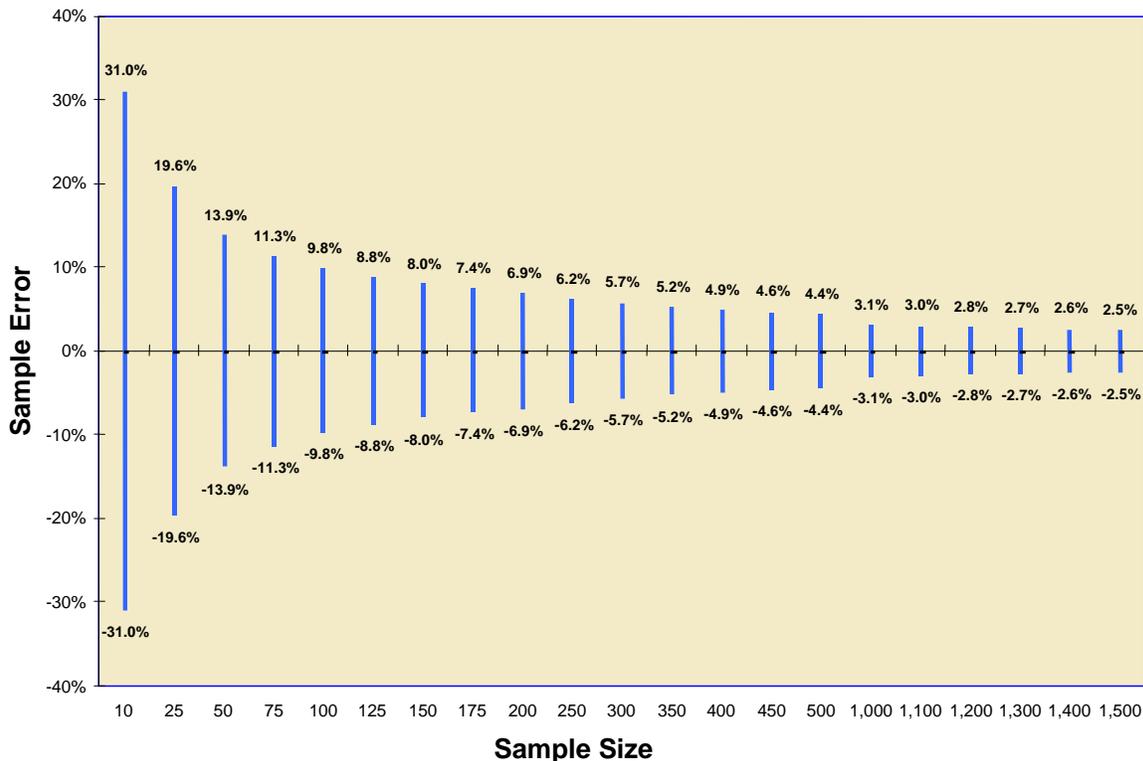
Understanding Sampling Error

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—2008 Michigan MHPs	
Code	Health Plan Name
BCD	BlueCaid of Michigan
CCM	Community Choice Michigan*
GLH	Great Lakes Health Plan
HPM	Health Plan of Michigan, Inc.
HPP	HealthPlus Partners, Inc.
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.
THC	Total Health Care, Inc.
UPP	Upper Peninsula Health Plan

*This report refers to CareSource of Michigan (CSM) as Community Choice Michigan (CCM) since this was the name under which it operated during the 2008 HEDIS validation process.

Introduction

Pediatric primary health care involves health promotion and disease prevention for children and adolescents. Immunizations and health checkups, when provided in a timely manner, are particularly important for young children. Failure to detect problems with growth, hearing, and vision in toddlers may adversely impact future abilities and experiences. When health care professionals can detect developmental issues early, they have the best opportunity to intervene and provide children with the chance to grow and learn without health-related limitations.

The Michigan Care Improvement Registry (MCIR) was created in 1998 to collect immunization information and make it accessible to authorized users online. MCIR was expanded to include adults in 2006. Through the careful tracking of immunizations provided by health care providers, the MCIR strives to reduce the occurrence of vaccine-preventable illness. The MCIR database has grown to include more than 50 million vaccinations provided to 4.2 million people.³⁻¹ Increased provider participation has helped identify major barriers to infant and childhood immunizations, including missed opportunities to administer vaccines.

Antimicrobial resistance continues to present clinical problems and is a significant public health concern. The Institute of Medicine has cited antibiotic resistance as one of the key microbial threats to health in the United States and is focused on promoting appropriate use of antimicrobials as a primary means to address this threat. Antimicrobial resistance is also a significant concern for the Centers for Disease Control and Prevention (CDC). CDC's Get Smart: Know When Antibiotics Work campaign seeks to reduce the rising rate of antibiotic resistance by targeting the five respiratory conditions that in 1992 accounted for more than 75 percent of all office-based prescribing for all ages combined: otitis media, sinusitis, pharyngitis, bronchitis, and the common cold.³⁻² Although antibiotic prescribing rates have decreased, patients of all ages are prescribed more than 10 million courses of antibiotics annually for viral conditions that do not benefit from antibiotics, according to CDC.

The following pages provide detailed analysis of the 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*
- ◆ **Well-Care Visits**
 - *Well-Child Visits in the First 15 Months of Life—Zero Visits*

³⁻¹ Michigan Care Improvement Registry. Available at: <http://www.mcir.org/accomplishments.html>. Accessed on October 17, 2008.

³⁻² Centers for Disease Control and Prevention. Get Smart: Know When Antibiotics Work. Available at: <http://www.cdc.gov/drugresistance/community/campaign-info.htm>. Accessed on October 2, 2008.

- *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*

Childhood Immunization Status

Childhood vaccination has led to dramatic declines in many life-threatening diseases such as polio, tetanus, whooping cough, mumps, measles, and meningitis over the last 50 years. These diseases can still be dangerous, however, and can cause blindness, hearing loss, diminished motor functioning, liver damage, coma, and death in unvaccinated children. For example, if the measles vaccine was discontinued, 3 to 4 million measles cases would occur every year, resulting in more than 1,800 deaths in the United States.³⁻³ For children 0–6 years of age, the CDC suggests that children receive the following vaccinations: hepatitis B; rotavirus; diphtheria, tetanus, and pertussis (DTaP); *Haemophilus influenzae* type b (Hib); pneumococcal; inactivated poliovirus (IPV); influenza; measles, mumps, and rubella (MMR); varicella (chicken pox or VZV); hepatitis A; and meningococcal.³⁻⁴

In Michigan, 182,145 children 19–35 months of age are listed in the MCIR, with an average of 14 immunizations per record.³⁻⁵ Eighty-nine percent of children 6 years of age or younger have two or more doses recorded in the MCIR, while the national average for registries is 49 percent. According to National Immunization Survey results, Michigan had the lowest immunization rates in the country in 1994, but had the ninth-highest rates in 2005.³⁻⁶ NCQA's The State of Health Care Quality 2007 report showed that Michigan was the top-performing state for the *Chicken Pox Vaccination* and *Combination 2 Rate* measures for its Medicaid population.³⁻⁷ 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 2 years of age during the measurement year, who were continuously enrolled for 12 months immediately preceding their second birthdays, and who were identified as having four DTaP, three IPV, one MMR, three Hib, three hepatitis B, and one VZV vaccination on or before the child's second birthday.

³⁻³ National Committee for Quality Assurance. The State of Health Care Quality 2007. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed on October 7, 2008.

³⁻⁴ Centers for Disease Control and Prevention. 2008 Child & Adolescent Immunization Schedules. Available at: <http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm>. Accessed on October 7, 2008.

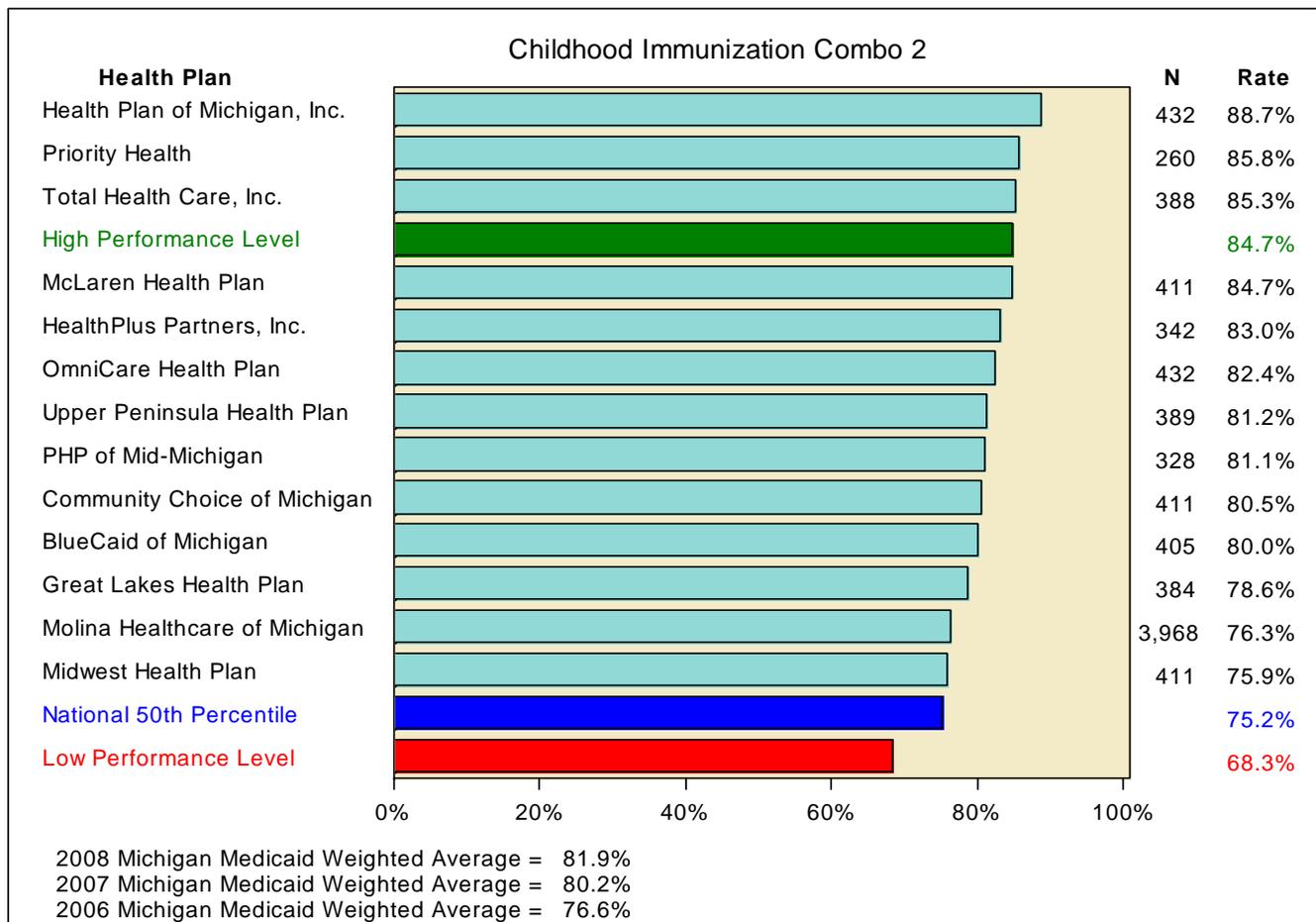
³⁻⁵ Michigan Public Health Institute. Accomplishments. Michigan Care Improvement Registry. Available at: <http://www.mcir.org/accomplishments.html>. Accessed on October 2, 2008.

³⁻⁶ Michigan Department of Community Health. Critical Health Indicators: Childhood Immunizations. Available at: http://www.michigan.gov/documents/mdch/32_ChldImmUn_198933_7.pdf. Accessed on October 2, 2008.

³⁻⁷ National Committee for Quality Assurance. The State of Health Care Quality 2007. Available at: http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_07.pdf. Accessed on October 7, 2008.

Health Plan Ranking: Childhood Immunization Status—Combination 2

**Figure 3-1—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Childhood Immunization Status—Combination 2**

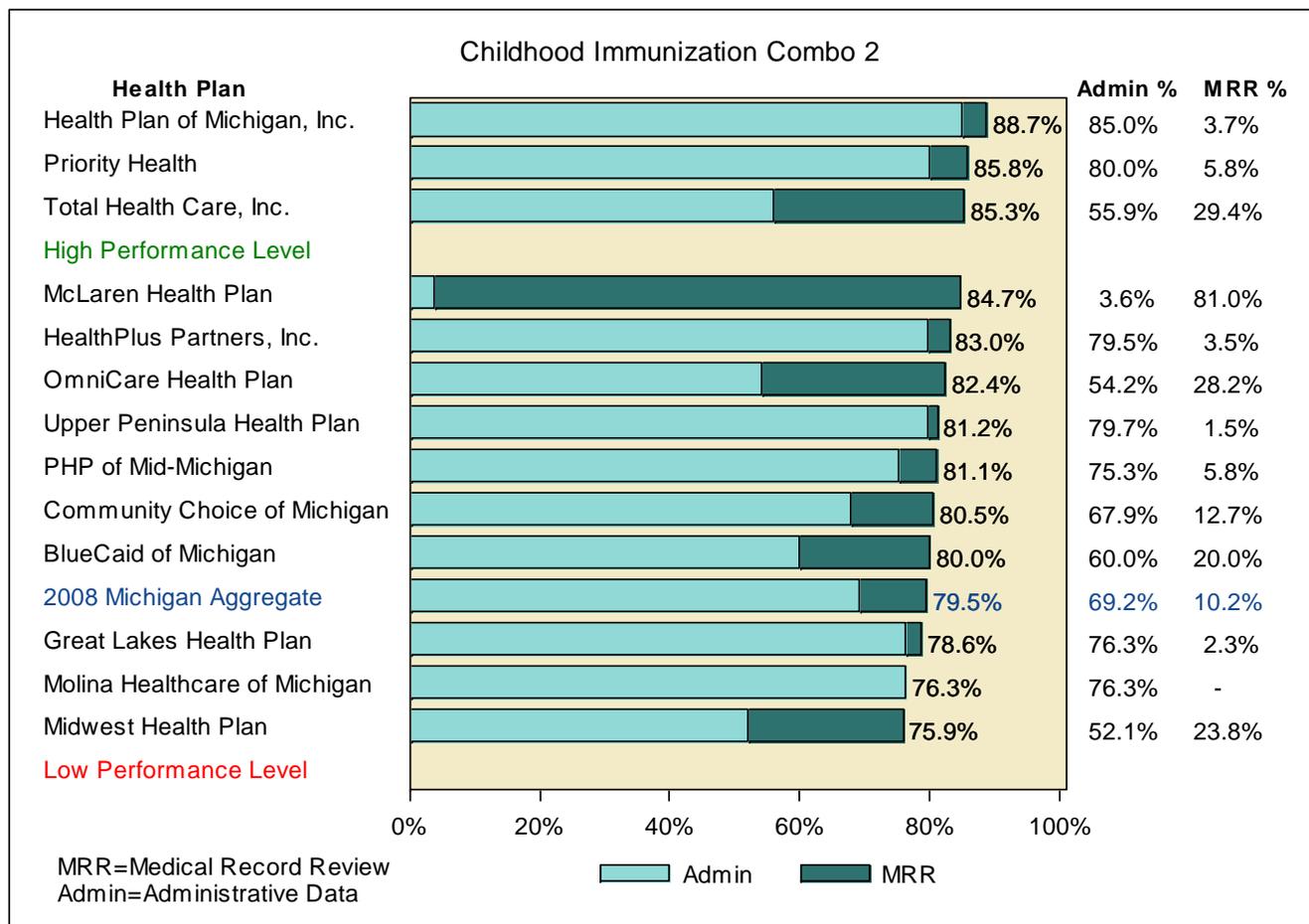


All 13 health plans reported rates above the national HEDIS 2007 Medicaid 50th percentile, and three health plans exceeded the HPL (or the national HEDIS 2007 Medicaid 90th percentile) of 84.7 percent. Six of the MHPs ranked between the 75th and 90th percentile.

The 2008 Michigan Medicaid weighted average of 81.9 percent increased by 1.7 percentage points over the 2007 Michigan Medicaid weighted average of 80.2 percent and was 6.7 percentage points above the national HEDIS 2007 Medicaid 50th percentile.

Data Collection Analysis: Childhood Immunization Status—Combination 2

**Figure 3-2—Michigan Medicaid HEDIS 2008
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 medical record review (MRR). Note: Because of rounding differences, the sum of the Admin and MRR rates may not always be exactly equal to the final rate.

Twelve of the 13 health plans elected to use the hybrid method for this measure. The 2008 Michigan aggregate administrative rate was 69.2 percent and the medical record review rate was 10.2 percent.

The results illustrate that 87 percent of the aggregate rate was derived from administrative data and 12.8 percent from medical record review.

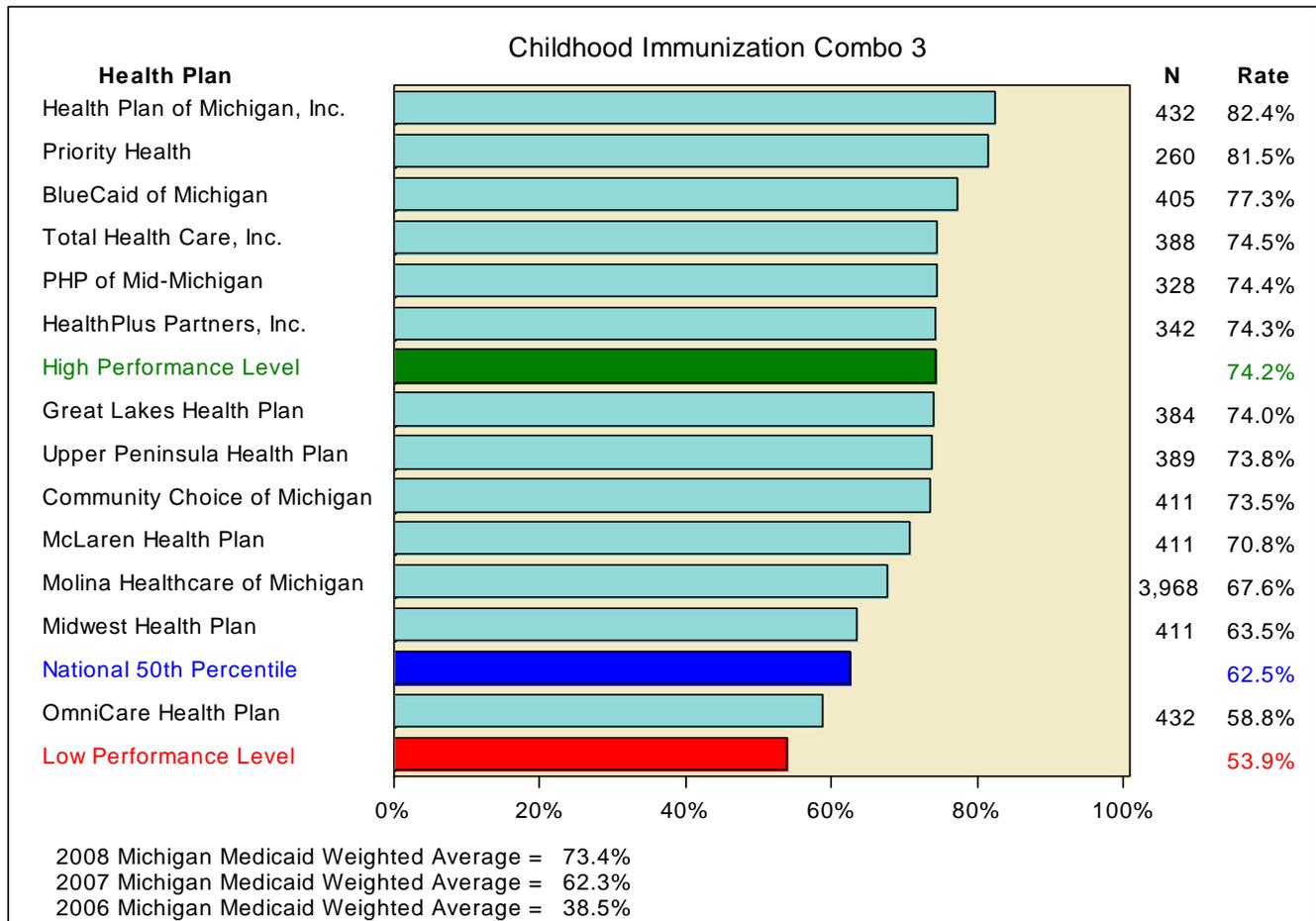
One health plan derived less than 5 percent of the rate from administrative data, while 11 of the other plans that used the hybrid methodology derived more than half of their rates from administrative data.

HEDIS Specification: Childhood Immunization Status—Combination 3

Childhood Immunization Status—Combination 3 calculates the percentage of enrolled children who turned 2 years of age during the measurement year, who were continuously enrolled for 12 months immediately preceding their second birthdays, and who were identified as having four DTaP, three IPV, one MMR, three Hib, three hepatitis B, one VZV, and four pneumococcal conjugate vaccinations on or before the child's second birthday.

Health Plan Ranking: Childhood Immunization Status—Combination 3

**Figure 3-3—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Childhood Immunization Status—Combination 3**

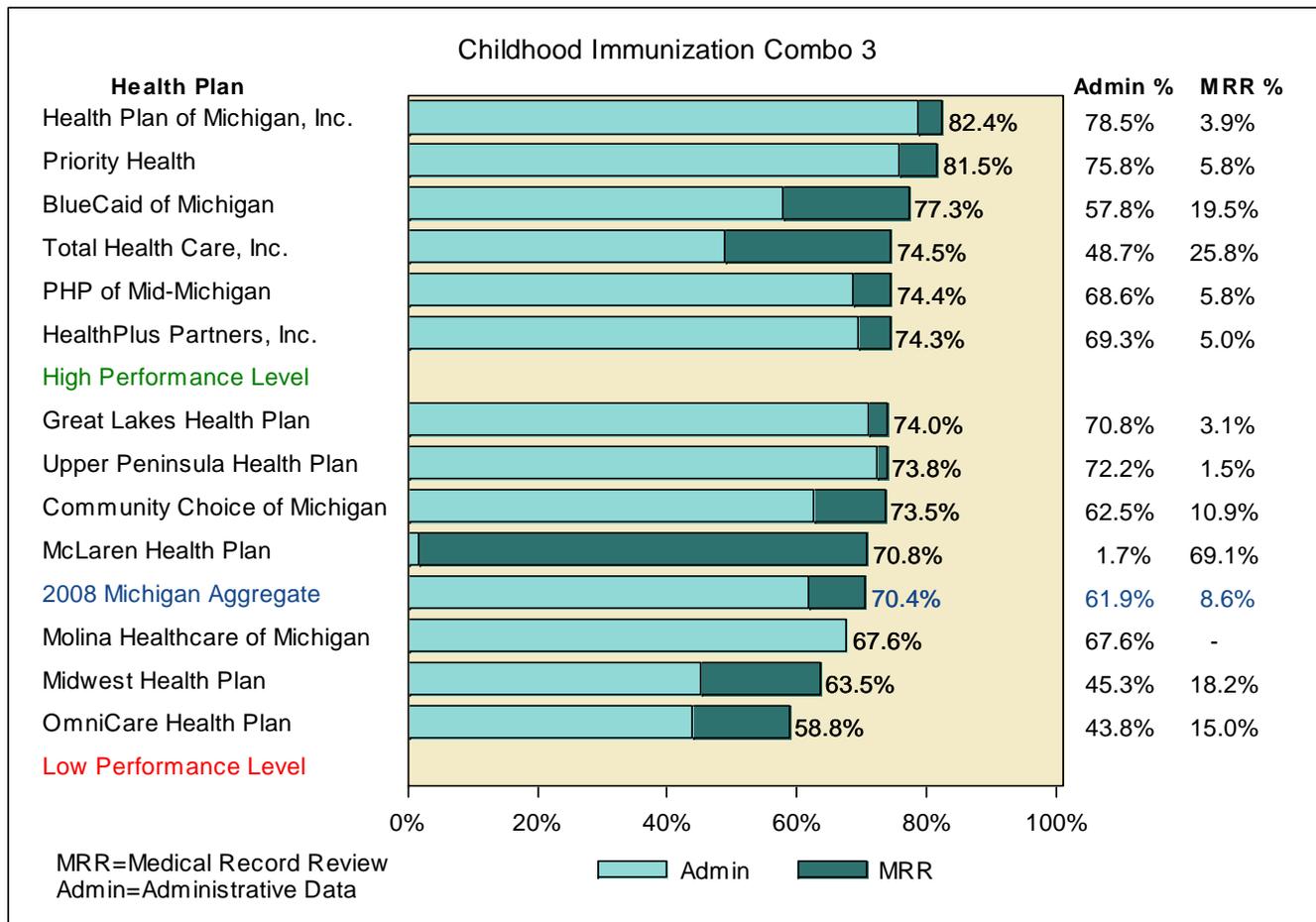


Twelve out of 13 health plans reported rates above the national HEDIS 2007 Medicaid 50th percentile. Six health plans exceeded the HPL (or the national HEDIS 2007 Medicaid 90th percentile) of 74.2 percent, and no health plans reported rates below the LPL of 53.9 percent. Four MHPs ranked between the 75th and 90th percentile.

The 2008 Michigan Medicaid weighted average increased significantly by 11.1 percentage points over the 2007 Michigan Medicaid weighted average and was 10.9 percentage points above the national HEDIS 2007 Medicaid 50th percentile.

Data Collection Analysis: Childhood Immunization Status—Combination 3

**Figure 3-4—Michigan Medicaid HEDIS 2008
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 medical record review (MRR). Note: Because of rounding differences, the sum of the Admin and MRR rates may not always be exactly equal to the final rate.

All the MHPs except one used the hybrid methodology for this measure. The 2008 Michigan aggregate administrative rate was 61.9 percent and the medical record review rate was 8.6 percent.

The results indicate that 87.9 percent of the aggregate rate was derived from administrative data and 12.2 percent from medical record review. These percentages were consistent with the *Childhood Immunization Status—Combination 2* findings. In 2007, 78.6 percent of the aggregate rate was derived from administrative data. This means that the health plans are relying less on medical record review data.

One health plan derived less than 3 percent of its rate from administrative data. The other 11 of the health plans that used the hybrid methodology derived more than half of their rates from administrative data.

Well-Child Visits in the First 15 Months of Life

The American Medical Association (AMA) and the American Academy of Pediatrics (AAP) recommend timely, comprehensive well-child visits for children. In 2004, 85 percent of children younger than 6 years of age received a well-child checkup during the previous year.³⁻⁸ These periodic checkups allow clinicians to assess a child's physical, behavioral, and developmental status and provide any necessary treatment, intervention, or referral to a specialist. A study of Medicaid children who were up to date for their age with AAP's recommended well-child visit schedule showed a significant reduction in risk of avoidable hospitalizations for that group.³⁻⁹

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, complete physical exam, sensory screening (i.e., hearing and vision), developmental assessment, health guidance/education, dental checks, and laboratory tests, including lead screenings.³⁻¹⁰ These visits reduce a child's risk of reaching his or her 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 number 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.

Limitations within the NCQA Interactive Data Submission System (IDSS) and differences in the way the health plans complete the IDSS will impact the 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.

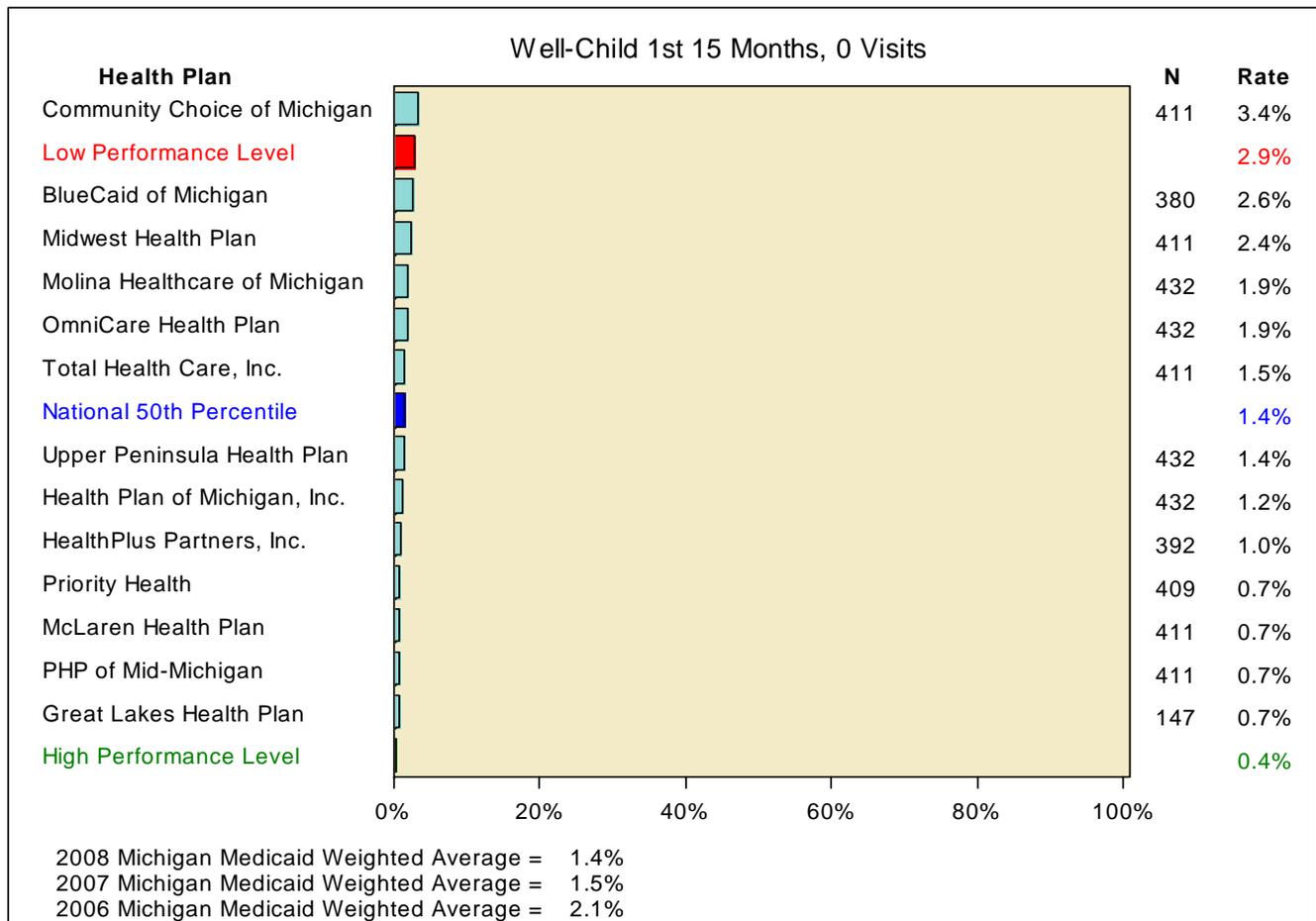
³⁻⁸ Child Trends Databank. Well-child visits. Available at: <http://www.childtrendsdatabank.org/indicators/93WellChildVisits.cfm>. Accessed on July 23, 2008.

³⁻⁹ Hakim RB, Bye BV. Effectiveness of Compliance With Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries. *Pediatrics*. 2001, 108 (1): 90–97.

³⁻¹⁰ Human Services Research Institute. EPSDT: Supporting Children With Disabilities. Available at: <http://www.hsri.org/docs/792FinalEPSDTBooklet.PDF>. Accessed on October 3, 2008.

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

**Figure 3-5—Michigan Medicaid HEDIS 2008
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 3-5 shows the percentage of children who received no well-child visits by 15 months of age. For this measure, a *lower* rate indicates better performance.

Seven health plans performed better than the national HEDIS 2007 Medicaid 50th percentile of 1.4 percent, and one plan performed worse than the LPL rate of 2.9 percent.

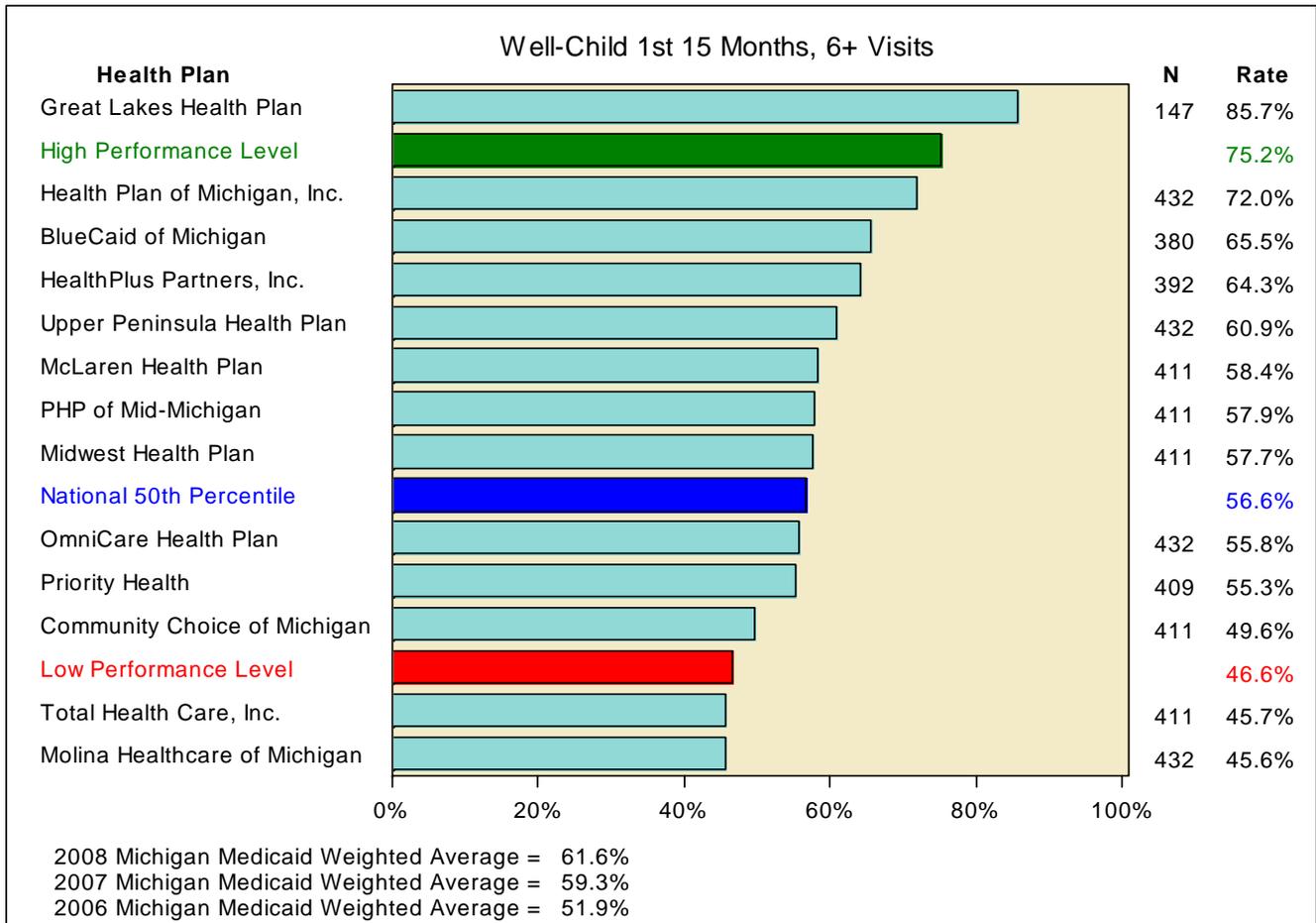
The 2008 Michigan Medicaid weighted average of 1.4 percent was the same as the national HEDIS 2007 Medicaid 50th percentile and showed 0.1 percent improvement over the 2007 weighted average of 1.5 percent.

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 of age 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 3-6—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Well-Child Visits in the First 15 Months of Life—Six or More Visits**

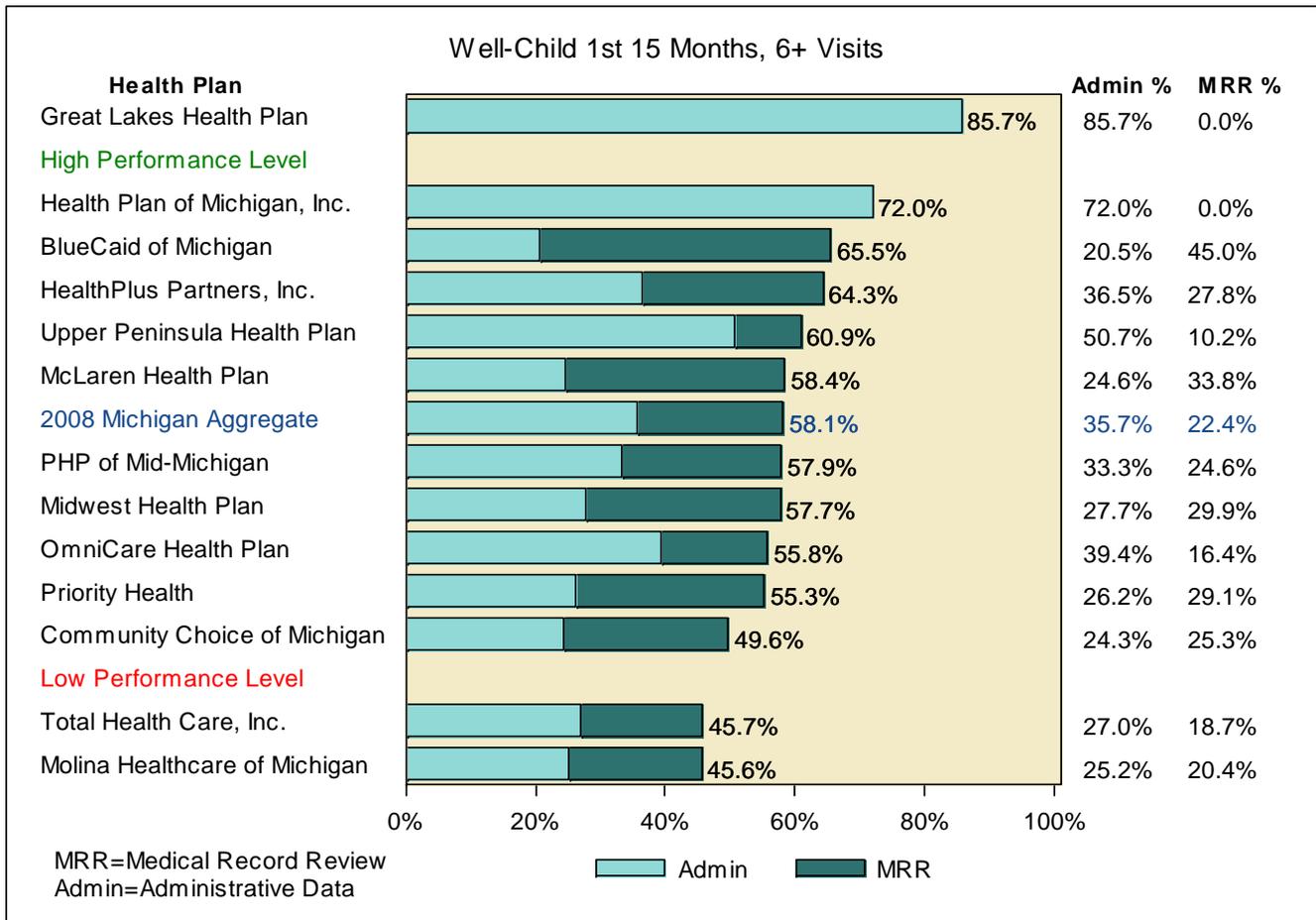


One health plan reported a rate above the HPL of 75.2 percent, and a total of eight health plans reported rates above the national HEDIS 2007 Medicaid 50th percentile of 56.6 percent. Two health plans ranked approximately 1 percentage point below the LPL of 46.6 percent.

The 2008 Michigan weighted average increased by 2.3 percentage points from 2007 and by almost 10 percentage points since 2006. The 2008 Michigan weighted average was 5.0 percentage points above the national HEDIS 2007 Medicaid 50th percentile.

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

**Figure 3-7—Michigan Medicaid HEDIS 2008
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 medical record review (MRR). Note: Because of rounding differences, the sum of the Admin and MRR rates may not always be exactly equal to the final rate.

All health plans elected to use the hybrid method for this measure. The 2008 Michigan aggregate administrative rate was 35.7 percent and the medical record review rate was 22.4 percent.

Results show that 61.4 percent of the aggregate rate was derived from administrative data and 38.6 percent from medical record review. In 2007, 68.9 percent of the aggregate rate was derived from administrative data. This means that the health plans are still relying on medical record review data for this measure.

The top two performing MHPs for this measure derived less than 1 percent of their rates from medical record review. Eight of the health plans derived at least half of their rates from administrative data.

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

AAP recommends annual well-child visits for children between 2 and 6 years of age.³⁻¹¹ These checkups during the preschool and early school years help clinicians detect vision, speech, and language problems as early as possible. 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*.

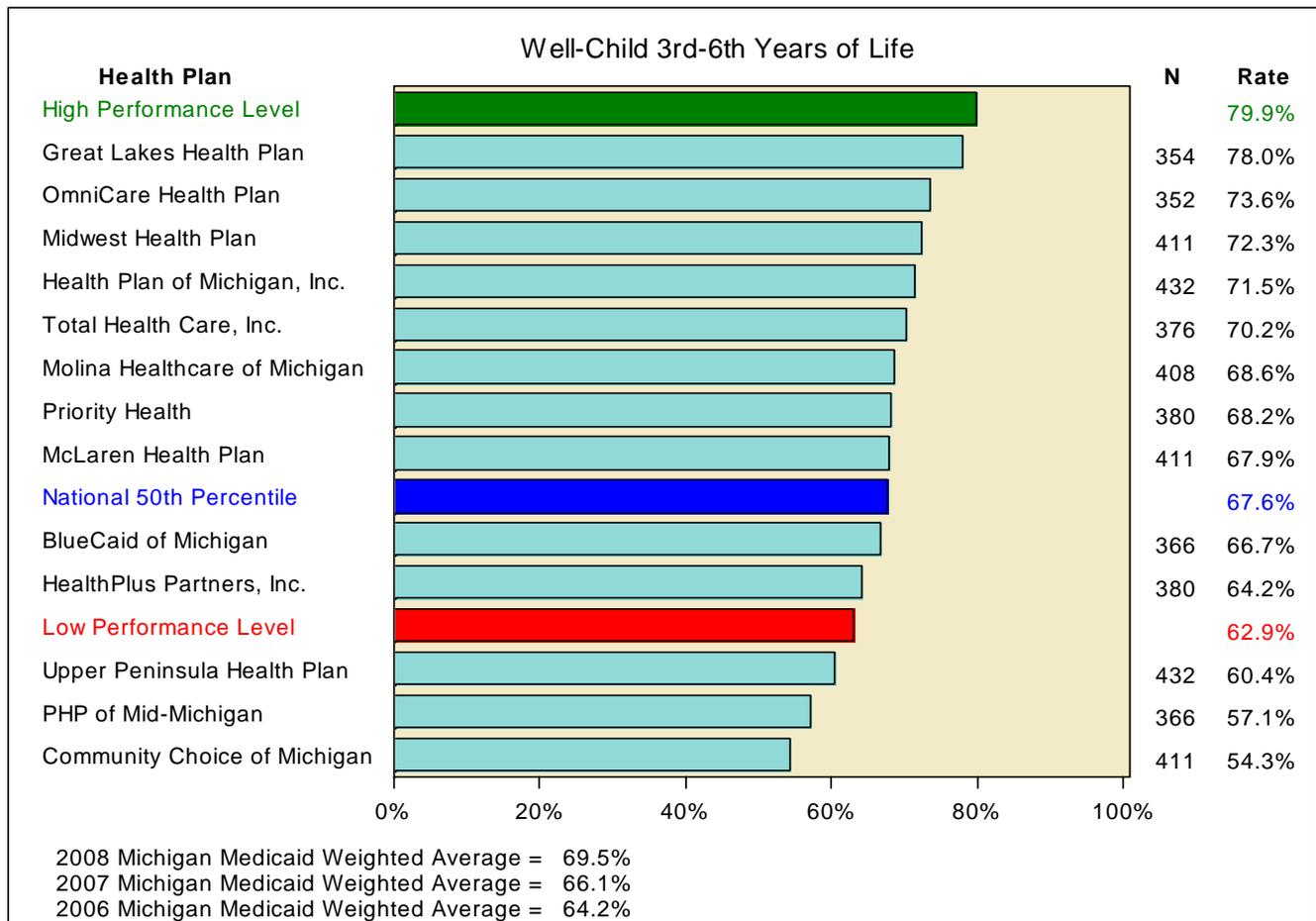
HEDIS Specification: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

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 of age 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.

³⁻¹¹ American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care. Available at: <http://practice.aap.org/content.aspx?aid=1599>. Accessed on October 7, 2008.

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

**Figure 3-8—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life**

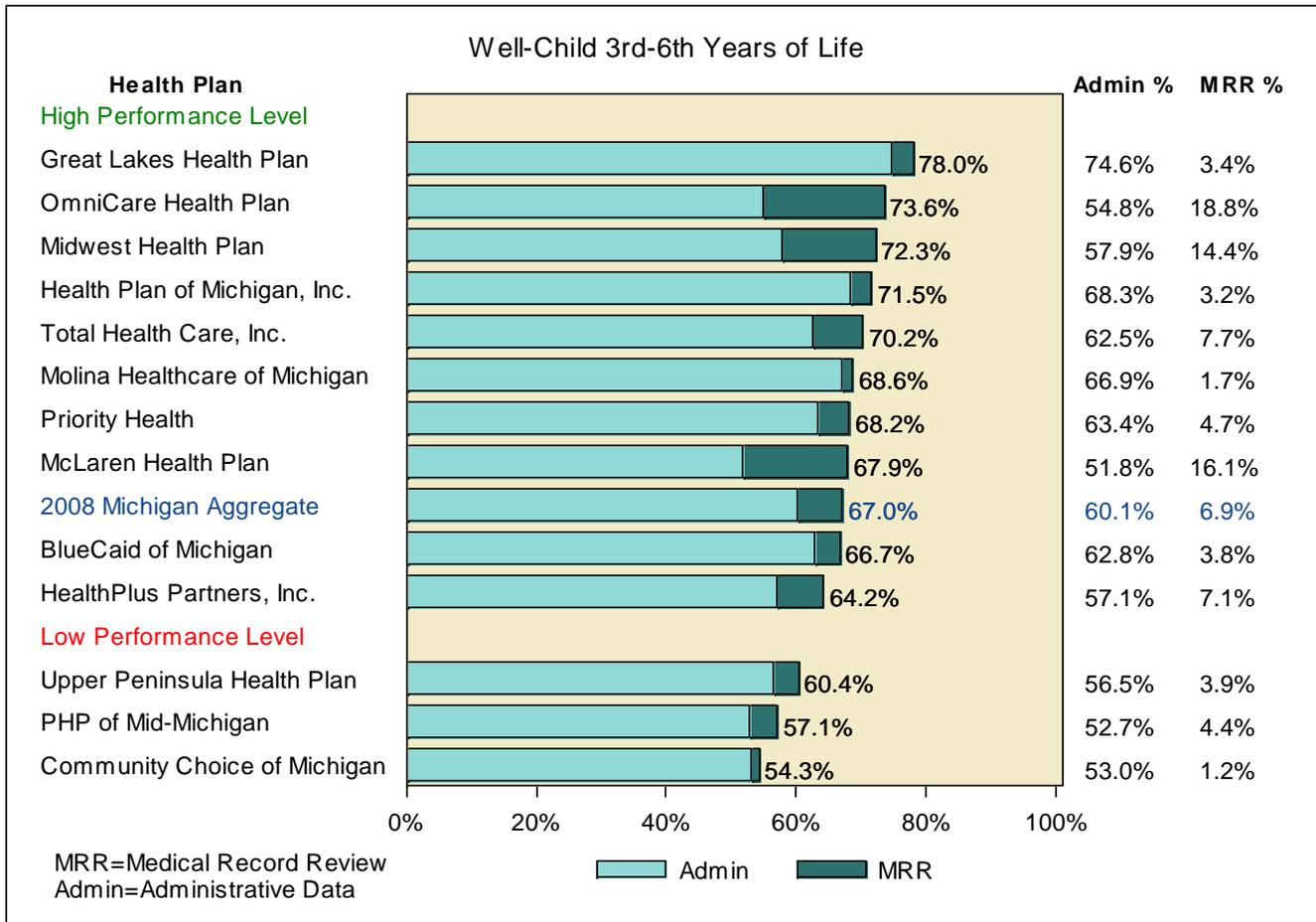


Eight plans performed above the national HEDIS 2007 Medicaid 50th percentile of 67.6 percent. None of the health plans reported rates above the HPL of 79.9 percent, and three health plans reported rates below the LPL of 62.9 percent. No MHPs fell below the LPL in 2007; therefore, this represents an opportunity for improvement.

The 2008 Michigan Medicaid weighted average of 69.5 percent was 3.4 percentage points above the 2007 weighted average and 1.9 percentage points above the national HEDIS 2007 Medicaid 50th percentile.

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

**Figure 3-9—Michigan Medicaid HEDIS 2008
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 medical record review (MRR). Note: Because of rounding differences, the sum of the Admin and MRR rates may not always be exactly equal to the final rate.

All the 13 health plans elected to use the hybrid method for this measure. The 2008 Michigan aggregate administrative rate was 60.1 percent and the medical record review rate was 6.9 percent.

The results showed that 89.7 percent of the aggregate rate was derived from administrative data and 10.3 percent was derived from medical record review.

All of the health plans derived more than 70 percent of their rates from administrative data.

Adolescent Well-Care Visits

Unintentional injury was the leading cause of death among the adolescent age group in 2004, accounting for 49.8 percent of all deaths.³⁻¹² Homicide and suicide were the next leading causes of death, accounting for 14.1 and 12.4 percent, respectively, of all adolescent deaths. Sexually transmitted diseases (STDs), substance abuse, pregnancy, and antisocial behavior are important causes of physical, emotional, and social problems in this age group. The AMA's Guidelines for Adolescent Preventive Services (GAPS) recommend that all adolescents 11–21 years of age should have an annual preventive services visit that focuses on both the biomedical and psychosocial aspects of health.³⁻¹³ However, adolescents tend to have barriers to care that must be addressed, such as access, cost, confidentiality, and participation in their own care. Additionally, the adolescent population often underutilizes health care services.³⁻¹⁴

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

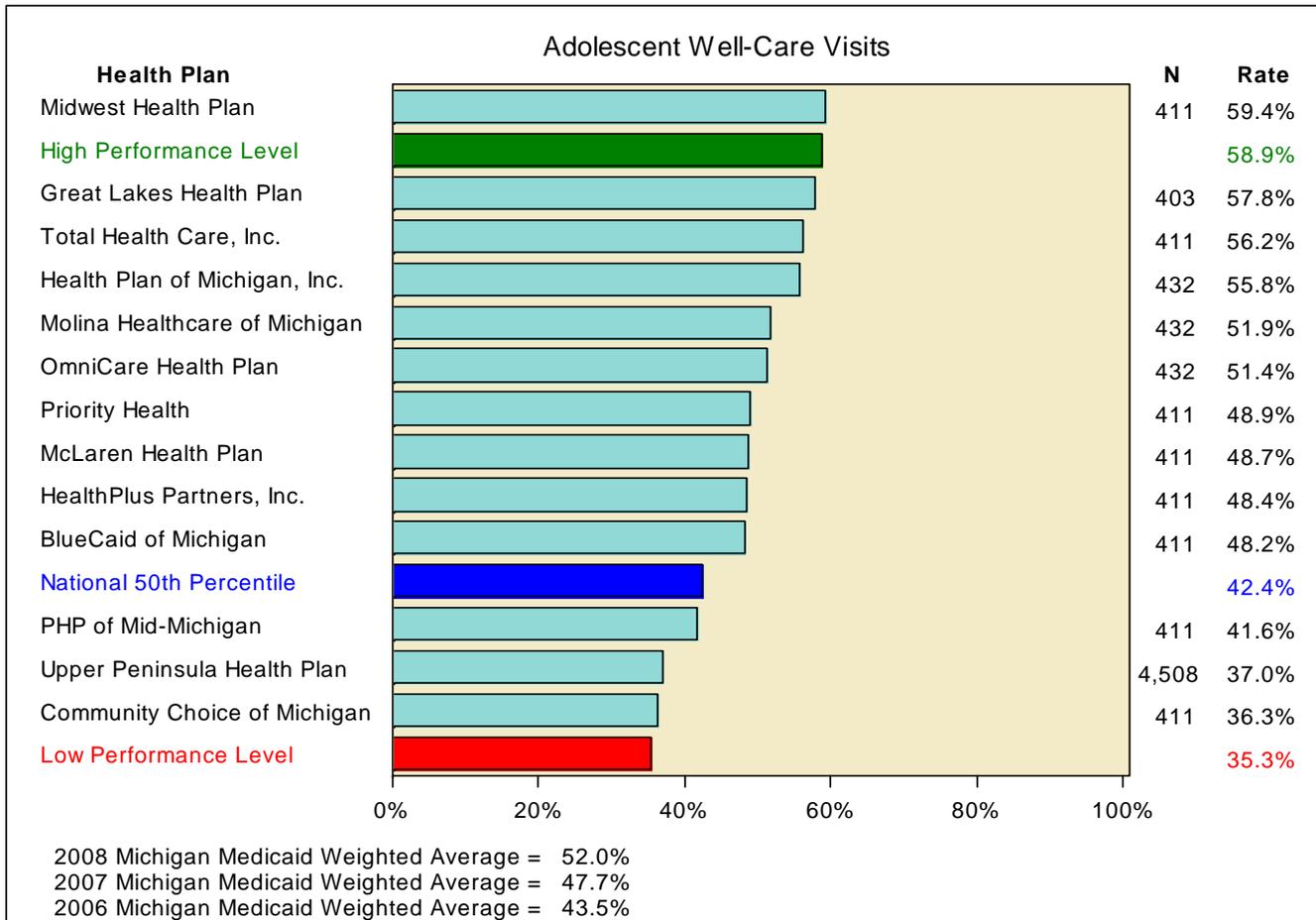
³⁻¹² U.S. Department of Health and Human Services. Child Health USA 2006. Available at: http://mchb.hrsa.gov/chusa_06/. Accessed on October 8, 2008.

³⁻¹³ American Medical Association. Guidelines for Adolescent Preventive Services (GAPS). Available at: <http://www.ama-assn.org/ama/upload/mm/39/gapsmono.pdf>. Accessed on October 2, 2008.

³⁻¹⁴ National Adolescent Health Information Center. Assuring the Health of Adolescents in Managed Care: A Quality Checklist for Planning and Evaluating Components of Adolescent Health Care. Available at: http://nahic.ucsf.edu/downloads/Assuring_Hlth_Checklist.pdf. Accessed on October 2, 2008.

Health Plan Ranking: Adolescent Well-Care Visits

**Figure 3-10—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Adolescent Well-Care Visits**

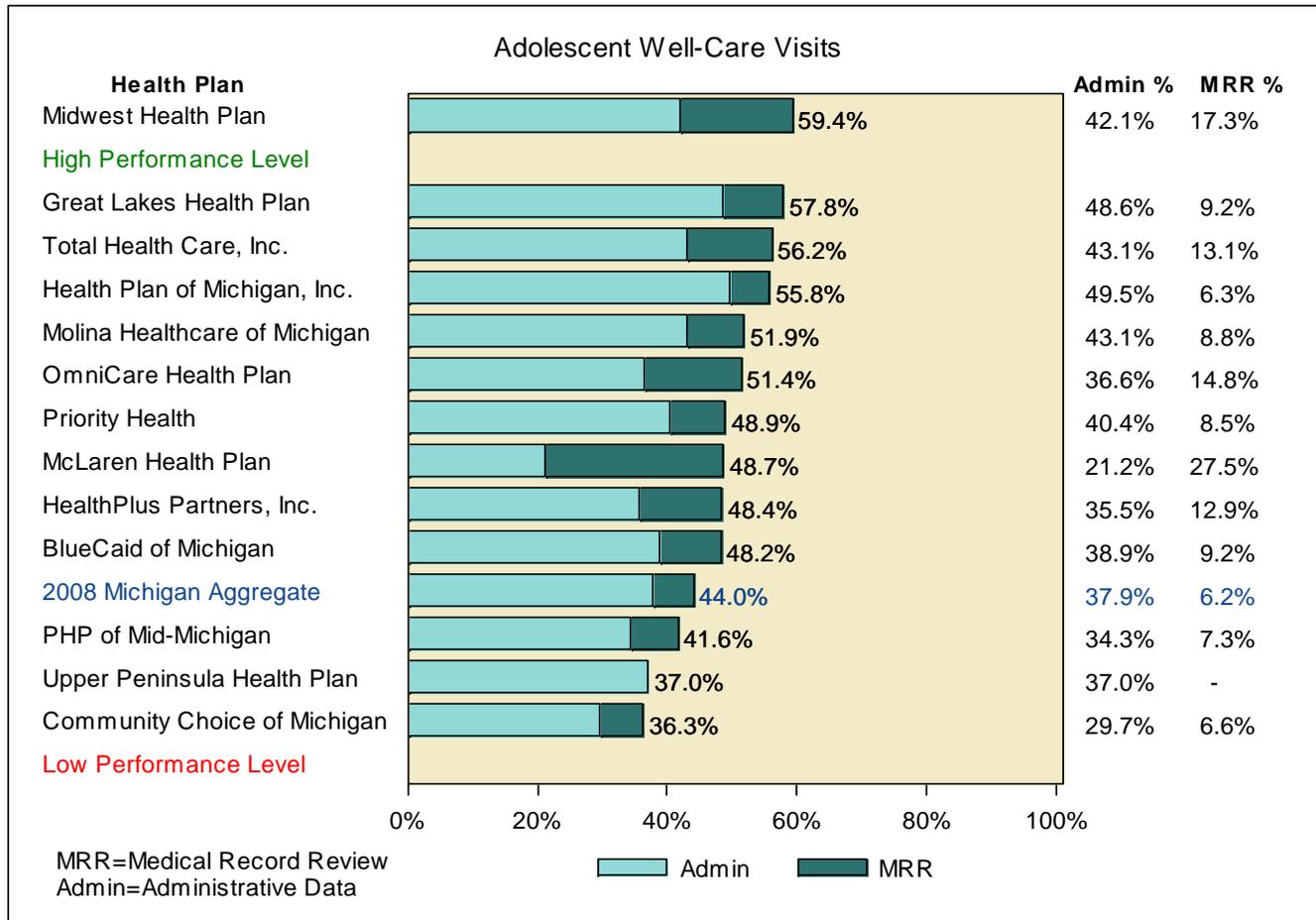


One health plan ranked above the HPL rate of 58.9 percent and three plans ranked below the national HEDIS 2007 Medicaid 50th percentile. None of the three plans below the national HEDIS 2007 Medicaid 50th percentile were below the LPL of 35.3 percent.

The 2008 Michigan Medicaid weighted average of 52.0 percent was 4.3 percentage points above the 2007 Michigan Medicaid weighted average of 47.7 percent and increased by 8.5 percentage points since 2006. In addition, the 2008 Michigan Medicaid weighted average was 9.6 percentage points above the national HEDIS 2007 Medicaid 50th percentile of 42.4 percent.

Data Collection Analysis: Adolescent Well-Care Visits

**Figure 3-11—Michigan Medicaid HEDIS 2008
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 medical record review (MRR). Note: Because of rounding differences, the sum of the Admin and MRR rates may not always be exactly equal to the final rate.

Twelve out of 13 health plans used the hybrid method for reporting this measure. The 2008 Michigan aggregate administrative rate was 37.9 percent and the medical record rate was 6.2 percent.

In 2008, 86.1 percent of the aggregate rate was derived from administrative data and 14.1 percent was derived from medical record review data. In 2007, 74.8 percent of the aggregate rate was derived from administrative data. This means that the health plans are relying less on medical record review data for this measure.

For the health plans that used the hybrid method, more than 70 percent of their rates were derived from administrative data, except for one health plan.

Appropriate Treatment for Children With Upper Respiratory Infection

Upper respiratory infection (URI), more commonly known as the common cold, accounts for the most missed school days of any childhood illness. Americans suffer an estimated 1 billion URIs annually, and children have about three to eight colds per year.³⁻¹⁵ Because URIs are caused by viruses, inappropriate use of antibiotics is a concern. If antibiotics are used inappropriately, a person will start to develop a resistance to them over time, making the medication ineffective if it is used appropriately. Despite the fact that antibiotics are not recommended for treating URIs, almost one quarter of children younger than 15 years of age who visit a doctor's office for a common cold receive antibiotics.³⁻¹⁶

HEDIS Specification: Appropriate Treatment for Children With Upper Respiratory Infection

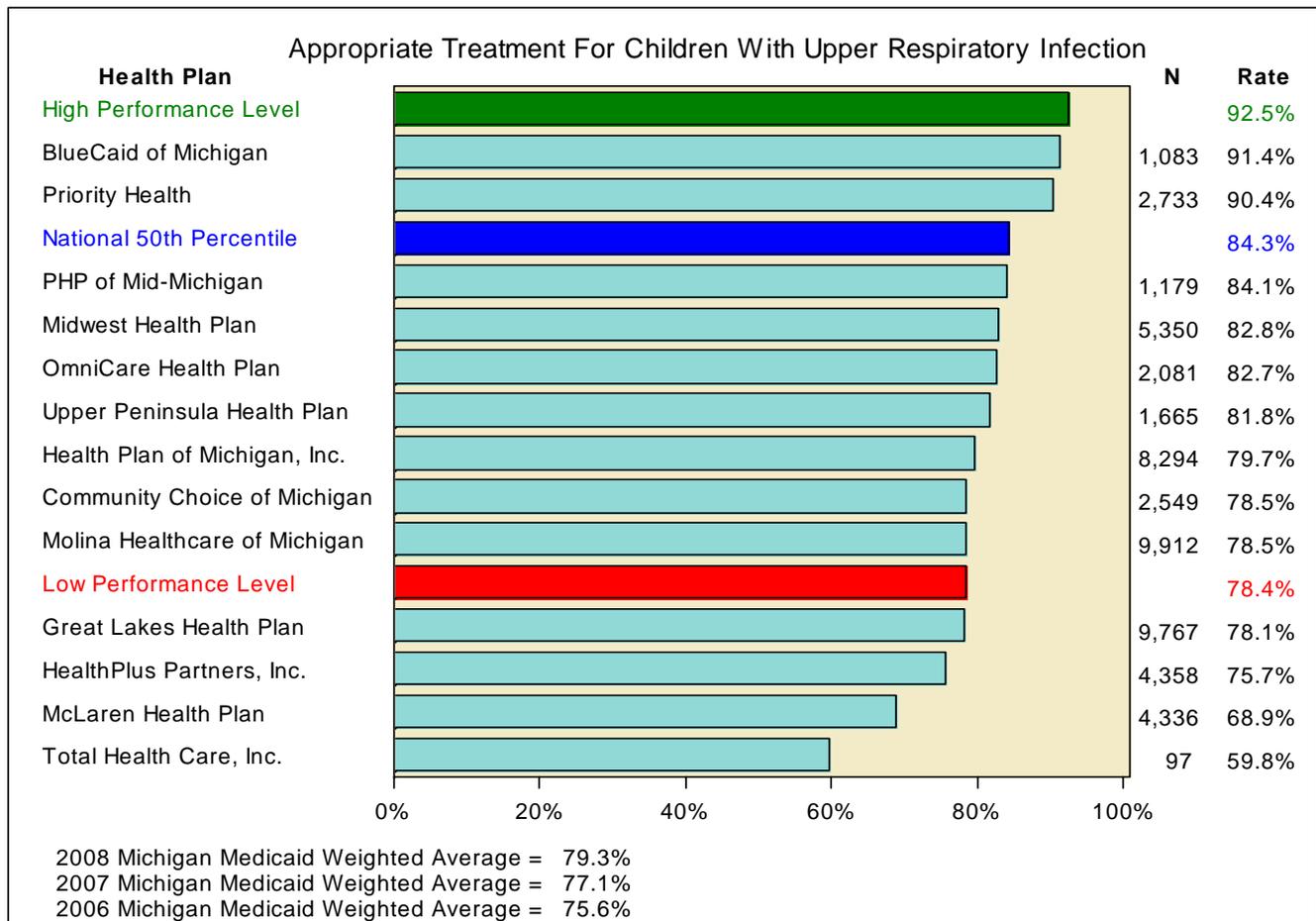
This key measure reports the percentage of enrolled members who were 3 months through 18 years of age during the measurement year, who were given a diagnosis of URI, and who were not dispensed an antibiotic prescription on or three days after the episode date.

³⁻¹⁵ National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed on October 2, 2008.

³⁻¹⁶ Ibid

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

**Figure 3-12—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Appropriate Treatment For Children With Upper Respiratory Infection**



No health plans reported rates above the HPL of 92.5 percent, and four health plans ranked below the LPL of 78.4 percent. Similar to last year, only two health plans reported rates above the national HEDIS 2007 Medicaid 50th percentile.

The 2008 Michigan Medicaid weighted average of 79.3 percent was 2.2 percentage points above the 2007 Michigan Medicaid weighted average; however, the weighted average continues to be below the national HEDIS Medicaid 50th percentile by 5 percentage points.

From 2007 to 2008, the number of health plans falling below the LPL decreased from six to four health plans.

Appropriate Testing for Children With Pharyngitis

Pharyngitis, an infection or irritation of the throat and/or tonsils (sore throat), occurs most commonly in children between 4 and 7 years of age.³⁻¹⁷ Children in the United States experience an average of five sore throats per year, and one streptococcal infection (strep throat) every four years.³⁻¹⁸ About 1 in 10 children who see a health care provider will be evaluated for pharyngitis.³⁻¹⁹

There are two types of pharyngitis: viral and bacterial. Determining the cause of pharyngitis is important to plan treatment since antibiotics are ineffective against viral infections. In fact, the overuse of antibiotics can increase the number of drug-resistant forms of bacteria, which can be very difficult to treat. One study showed that 4 in 10 physicians reported that they would begin antibiotic treatment for children with pharyngitis before knowing the results of a test for strep throat, and would continue with treatment even if the strep test was negative.³⁻²⁰ Strep throat can be treated with antibiotics, while treatments for viral pharyngitis may include throat lozenges, increased fluid intake, and acetaminophen.³⁻²¹

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).

³⁻¹⁷ eMedicine. Pharyngitis. Available at: <http://www.emedicine.com/emerg/topic419.htm>. Accessed on October 2, 2008.

³⁻¹⁸ Pulmonology Channel. Pharyngitis. Available at: <http://www.pulmonologychannel.com/pharyngitis/>. Accessed on October 2, 2008.

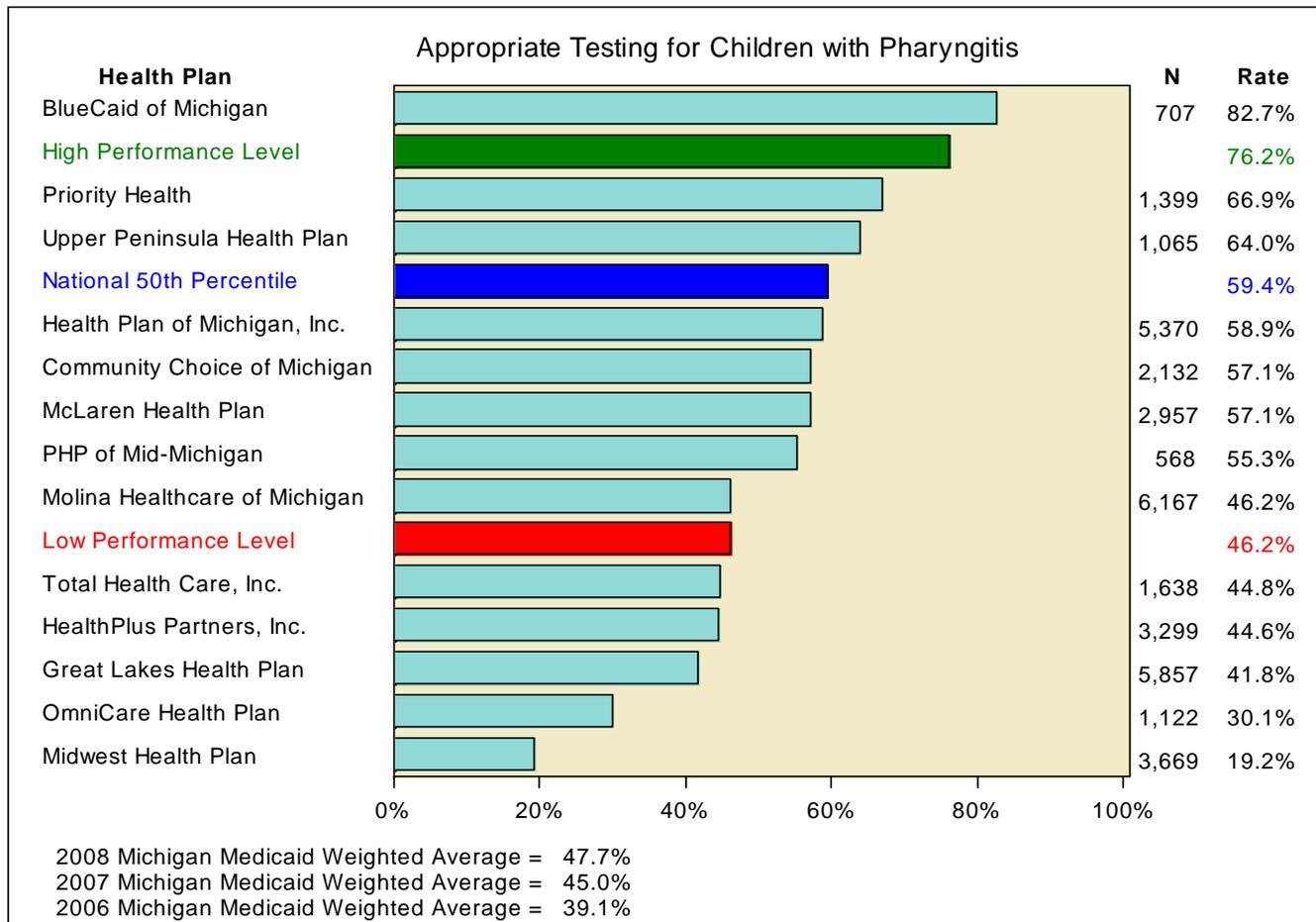
³⁻¹⁹ National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed on October 2, 2008.

³⁻²⁰ Ibid.

³⁻²¹ 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 October 6, 2008.

Health Plan Ranking: Appropriate Testing for Children With Pharyngitis

**Figure 3-13—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Appropriate Testing for Children With Pharyngitis**



One health plan reported a rate above the HPL of 76.2 percent, and five health plans had rates below the LPL of 46.2. Three health plans' rates, including the one health plan that exceeded the HPL, had rates above the national HEDIS 2007 Medicaid 50th percentile.

The 2008 Michigan Medicaid weighted average of 47.7 percent was 11.7 percentage points below the national HEDIS 2007 Medicaid 50th percentile of 59.4 percent. The 2008 Michigan Medicaid weighted average did, however, improve by 2.7 percentage points over the 2007 Michigan Medicaid weighted average.

Pediatric Care Findings and Recommendations

All of the measures in the Pediatric Care dimension showed improvement compared to the 2007 rates. One measure, *Childhood Immunization Status—Combo 3* showed statistically significant improvement, with an increase of 11.1 percentage points from the previous year. The Pediatric Care measures' weighted averages ranged from as small as 0.1 percentage point to 11.1 percentage points. The MHPs continue to demonstrate improvement in these measures, and it appears that the burden of medical record data collection for these measures is declining slightly.

The *Childhood Immunization Status (CIS)* measures both improved compared to the 2007 rates. Both of these rates ranked above the 75th percentile and, as mentioned previously, the *Combo 3* rate had statistically significant improvement. The administrative data rate for both of the measures for *CIS* improved from 2007, indicating that the MHPs' administrative data for immunizations were more complete. For *Combo 2*, 11 of the MHPs that used the hybrid methodology derived more than half of their rates from administrative data, and for *Combo 3*, almost 88 percent of the aggregate rate was derived from administrative data. Improving administrative data completeness minimizes the burden on the MHP to perform medical record review and frees up resources for other activities.

The weighted averages for the *Well-Child Visits in the First Fifteen Months of Life—Zero Visits* and *Well-Child Visits in the First Fifteen Months of Life—Six or More Visits* both improved from 2007. While both of these measures saw improvement in the weighted averages, the individual MHPs' performance varied, with the upper and lower range for each measure decreasing. In 2007 none of the MHPs performed worse than the LPL for the *Zero Visits* measure, and in 2008, one MHP fell below this rate. In 2007, two MHPs performed better than the HPL and only one plan fell below the LPL for the *Six or More Visits* measure, and this year, only one MHP outperformed the HPL and two plans were below the LPL. While the 2008 weighted average for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* improved from 2007, individual MHP performance varied, with one MHP's rate dropping by 10 percentage points and another MHP's rate improving by almost 8 percentage points. This variation in individual plan rates represents opportunities for improvement. The 2008 weighted average for *Adolescent Well-Care Visits* improved by 4.3 percentage points from 2007 and ranked above the national HEDIS 2007 Medicaid 75th percentile. No MHPs ranked below the LPL in 2008. There was a slight improvement in the administrative rate for this measure, which continued to demonstrate the MHPs' efforts to improve administrative data completeness.

The weighted averages for both *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* and *Appropriate Testing for Children With Pharyngitis (CWP)* both continued to improve in 2008. Both of these rates ranked below the national HEDIS 2007 50th percentile. None of the MHPs ranked above the HPL for the *URI* measure, and only four MHPs ranked below the LPL compared to six MHPs in 2007. For the *CWP* measure, one MHP ranked above the HPL and five MHPs ranked below the LPL. These two measures are still areas where the MHPs should focus improvement efforts. The lower-performing MHPs should look to the higher performers for best practices.

Although the weighted averages for the measures in the Pediatric Care dimension showed improvement compared to the 2007 rates, there are still opportunities for the MHPs to continue to improve their rates.

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 Cancer Screening**
 - *Breast Cancer Screening—42 to 51 Years*
 - *Breast Cancer Screening—52 to 69 Years*
 - *Breast Cancer Screening—Combined Rate*
- ◆ **Cervical Cancer Screening**
 - *Cervical Cancer Screening*
- ◆ **Chlamydia Screening**
 - *Chlamydia Screening in Women—16 to 20 Years*
 - *Chlamydia Screening in Women—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 the Michigan MHPs' performance and ranking, as well as the data collection methodology used by Michigan MHPs for these measures.

Breast Cancer Screening

An estimated 182,460 women will be diagnosed with, and 40,480 women will die from, breast cancer in 2008.⁴⁻¹ Breast cancer is the third-most-common cancer diagnosis in the State of Michigan, and the most common diagnosis for women in Michigan.⁴⁻² ACS projects that 6,120 women will be newly diagnosed with breast cancer in Michigan during 2008, a slight increase from the previous year.⁴⁻³ There is a significant racial disparity in regard to breast cancer mortality in Michigan: African-American women are more likely than Caucasian women to die from breast cancer, even though breast cancer incidence is higher among Caucasian women.⁴⁻⁴

Today, nearly 90 percent of women diagnosed with breast cancer will survive for at least five years, compared to only 75 percent 35 years ago.⁴⁻⁵ A mammogram is the most effective method for detecting breast cancer in its early stages. Mammograms can detect breast cancer one to four years before a woman can feel a lump, and can reduce mortality by as much as 35 percent through early detection.⁴⁻⁶ Michigan's Breast & Cervical Cancer Control Program provides life-saving cancer screening services and follow-up care to low-income women, including cancer treatment if needed. As of January 2007, only 56 percent of Michigan women 40 years of age and older were getting mammograms at the appropriate time.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 40 through 69 years of age who were continuously enrolled during the measurement year and the year prior to the measurement year, and who had a mammogram during the measurement year or the year prior to the measurement year. This year the measure is reported using three age categories:

- ◆ 42 through 51 years of age
- ◆ 52 through 69 years of age
- ◆ Combined rate

⁴⁻¹ National Cancer Institute. Surveillance Epidemiology and End Results. Available at: <http://seer.cancer.gov/statfacts/html/breast.html>. Accessed on October 2, 2008.

⁴⁻² Michigan Cancer Consortium. Breast Cancer in Michigan: Early Detection Is the Key to Survival. Available at: <http://www.michigancancer.org/PDFs/MDCHFactSheets/BrCAInMichFactSheet-Jan07.pdf>. Accessed on October 3, 2008.

⁴⁻³ American Cancer Society. Cancer Facts & Figures 2008. Available at: <http://www.cancer.org/downloads/STT/2008CAFFfinalsecured.pdf>. Accessed on October 2, 2008.

⁴⁻⁴ Michigan Department of Community Health. Facts About Breast Cancer. Available at: <http://www.michigancancer.org/PDFs/MDCHFactSheets/BrCAFactSheet-Feb08.pdf>. Accessed on October 2, 2008.

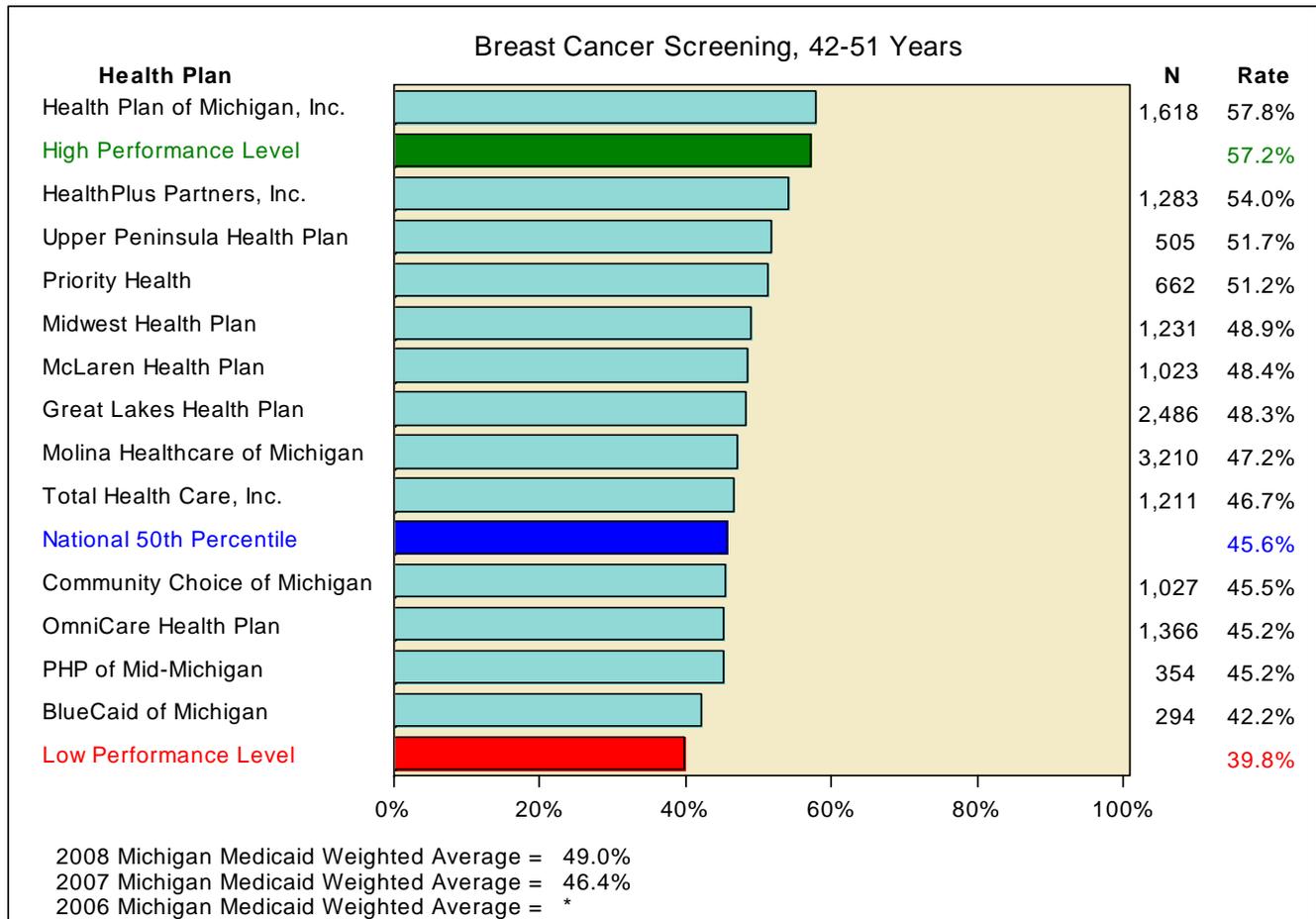
⁴⁻⁵ National Cancer Institute. Cancer Advances in Focus: Breast Cancer. Available at: <http://www.cancer.gov/aboutnci/cancer-advances-in-focus/breast>. Accessed on October 2, 2008.

⁴⁻⁶ National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed on October 2, 2008.

⁴⁻⁷ Michigan Cancer Consortium. Breast Cancer in Michigan: Early Detection Is the Key to Survival. Available at: <http://www.michigancancer.org/PDFs/MDCHFactSheets/BrCAInMichFactSheet-Jan07.pdf>. Accessed on October 2, 2008.

Health Plan Ranking: Breast Cancer Screening—42 to 51 Years

**Figure 4-1—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Breast Cancer Screening—42 to 51 Years**



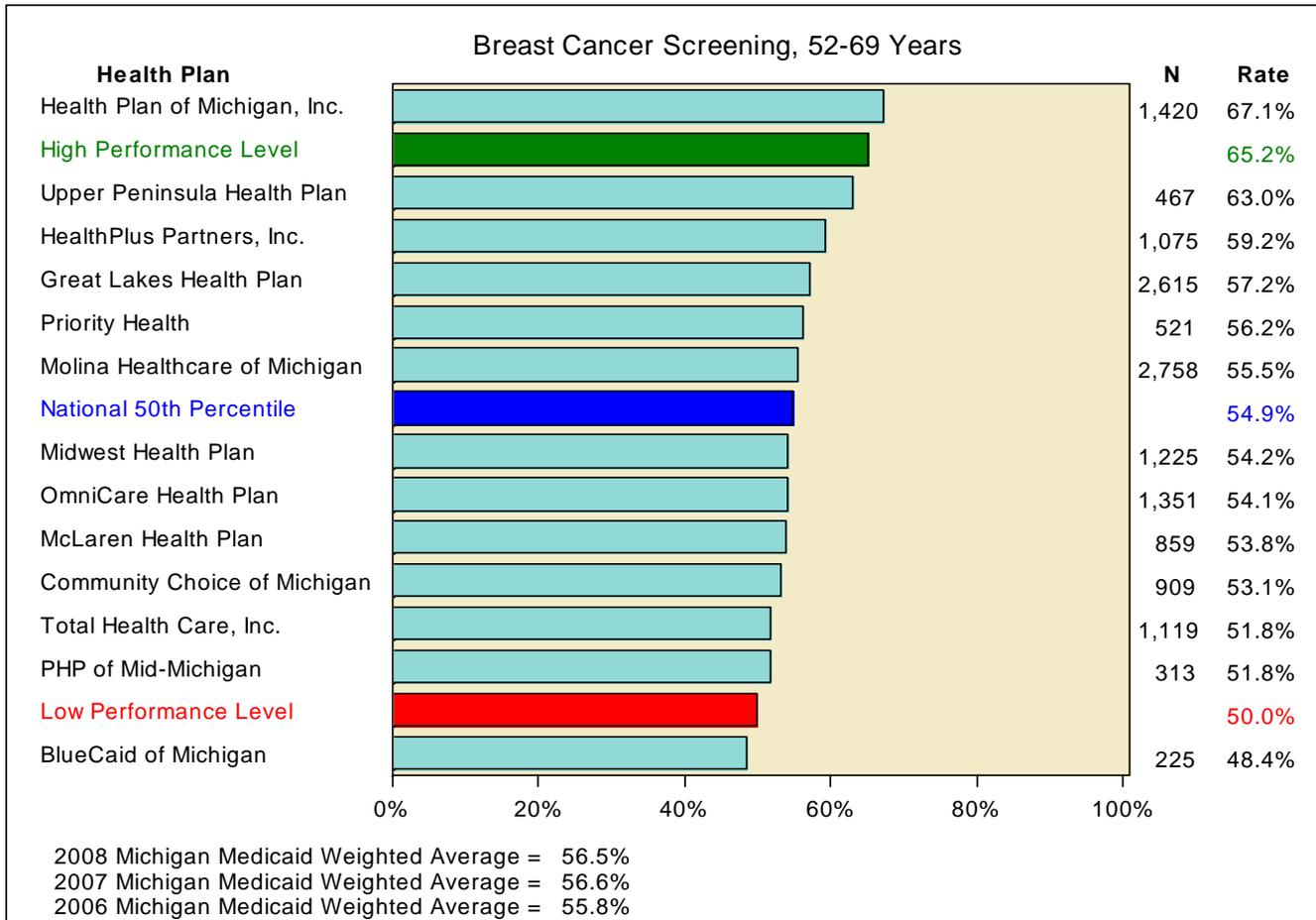
Breast Cancer Screening—42 to 51 Years was a new measure for 2007; therefore, 2008 was the first year that national performance data were available for comparison.

One health plan exceeded the HPL of 57.2 percent, and no health plans ranked below the LPL of 39.8 percent. A total of nine health plans, including the one above the HPL, reported rates above the national HEDIS 2007 Medicaid 50th percentile.

The 2008 Michigan Medicaid weighted average of 49.0 percent was 3.4 percentage points above the national HEDIS 2007 Medicaid 50th percentile of 45.6 percent and 2.6 percentage points higher than the 2007 Michigan Medicaid weighted average of 46.4 percent.

Health Plan Ranking: Breast Cancer Screening—52 to 69 Years

**Figure 4-2—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Breast Cancer Screening—52 to 69 Years**

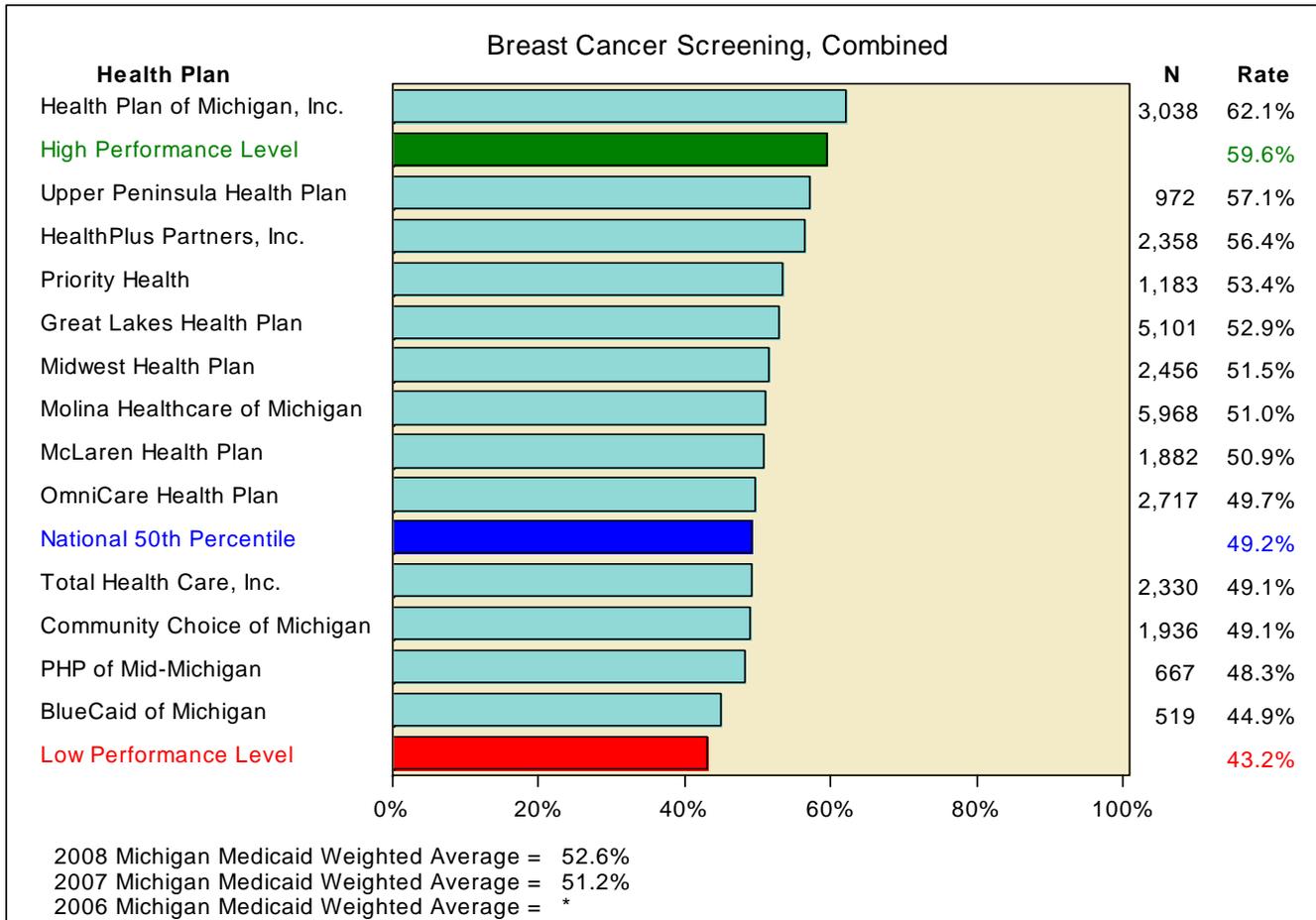


One health plan exceeded the HPL of 65.2 percent, and one health plan ranked below the LPL of 50.0 percent. A total of six health plans, including the one above the HPL, reported rates above the national HEDIS 2007 Medicaid 50th percentile.

The 2008 Michigan Medicaid weighted average of 56.5 percent was 1.6 percentage points above the national HEDIS 2007 Medicaid 50th percentile of 54.9 percent and almost the same as the 2007 Michigan Medicaid weighted average.

Health Plan Ranking: Breast Cancer Screening—Combined Rate

**Figure 4-3—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Breast Cancer Screening—Combined Rate**



Breast Cancer Screening—Combined Rate was a new measure for 2007; therefore, 2008 was the first year that national performance data were available for comparison.

Nine out of 13 health plans reported rates above the national HEDIS 2007 Medicaid 50th percentile of 49.2 percent. One health plan exceeded the HPL of 59.6 percent, and no health plans reported a rate below the LPL of 43.2 percent.

The 2008 Michigan Medicaid weighted average of 52.6 percent increased by 1.4 percentage points over the 2007 Michigan Medicaid weighted average, and was 3.4 percentage points above the national HEDIS 2007 Medicaid 50th percentile.

Cervical Cancer Screening

Cervical cancer is the second-most-common cancer throughout the world, and the third-leading cause of cancer-related deaths.⁴⁻⁸ Most of these deaths are preventable through early detection and appropriate treatment. Older women are more likely to develop cervical cancer; therefore, it is important that women continue to have screenings as they age, even with prior negative tests. In Michigan, 93.6 percent of cervical cancer cases are diagnosed in the early stages of the disease.⁴⁻⁹ Approximately 83 percent of Michigan women 18 years of age and older received a Pap smear in the past three years.⁴⁻¹⁰ Women less likely to receive cervical cancer screening during this time include those with low incomes, those with less than a high-school-level education, and/or those between 18 and 29 years of age and older than 70 years of age.⁴⁻¹¹ In 2008, an estimated 330 new cases of cervical cancer will be diagnosed among women in Michigan, according to the ACS, which is a slight decrease from the previous year.⁴⁻¹²

HEDIS Specification: Cervical Cancer Screening

The *Cervical Cancer Screening* measure reports the percentage of women 21 through 64 years of age who were continuously enrolled during the measurement year and who received one or more Pap tests during the measurement year or the two years prior to the measurement year.

⁴⁻⁸ National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed on October 2, 2008.

⁴⁻⁹ Michigan Department of Community Health. Cervical Cancer Deaths and Screening. Available at: http://www.michigan.gov/documents/mdch/14_CervCanc_198884_7.pdf. Accessed on October 2, 2008.

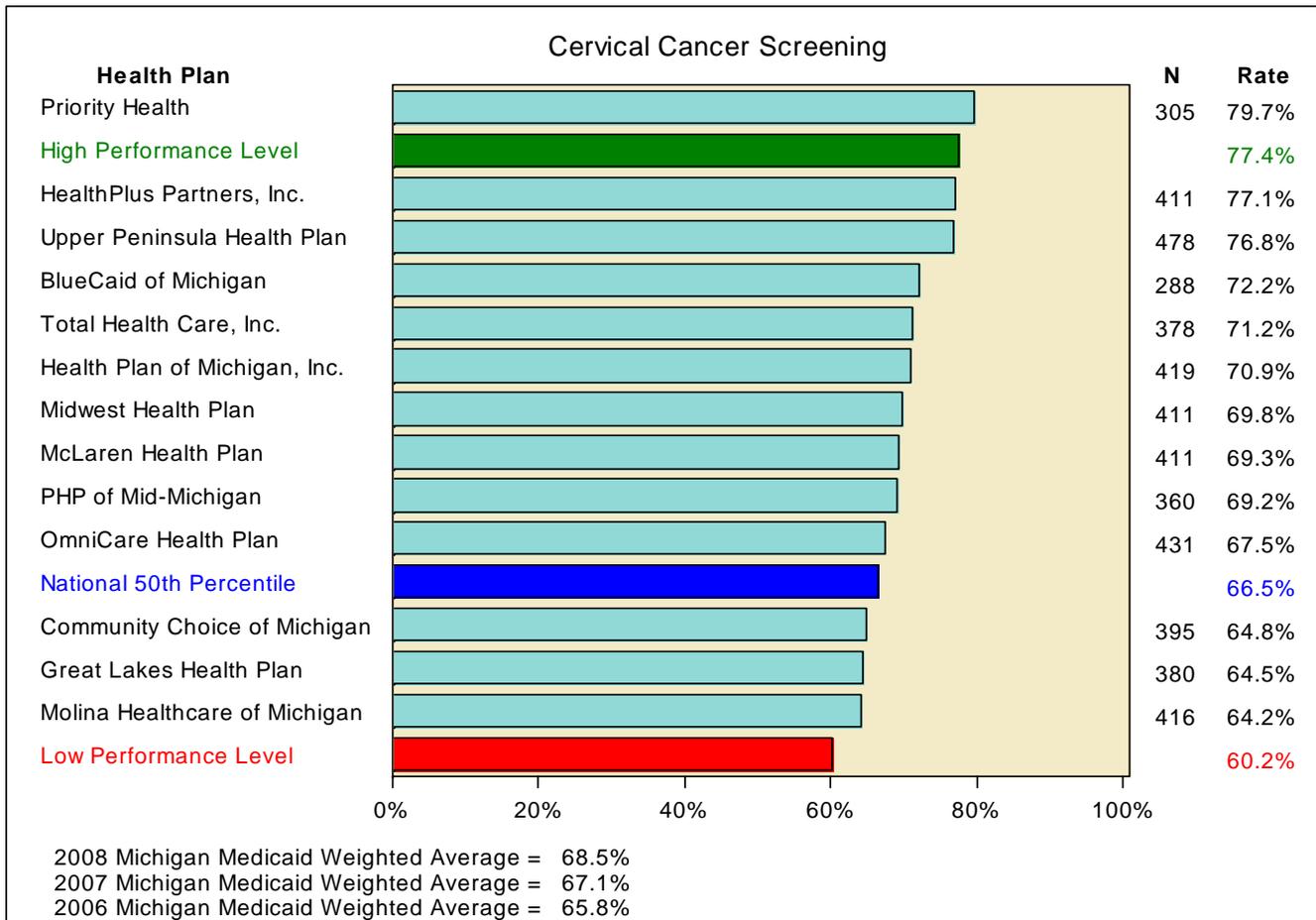
⁴⁻¹⁰ Michigan Department of Community Health. Facts about Cervical Cancer. Available at: http://www.michigan.gov/documents/CervicalFacts_6648_7.pdf. Accessed on October 2, 2008.

⁴⁻¹¹ Ibid.

⁴⁻¹² American Cancer Society. Cancer Facts & Figures 2008. Available at: <http://www.cancer.org/downloads/STT/2008CAFFfinalsecured.pdf>. Accessed on October 2, 2008.

Health Plan Ranking: Cervical Cancer Screening

**Figure 4-4—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Cervical Cancer Screening**

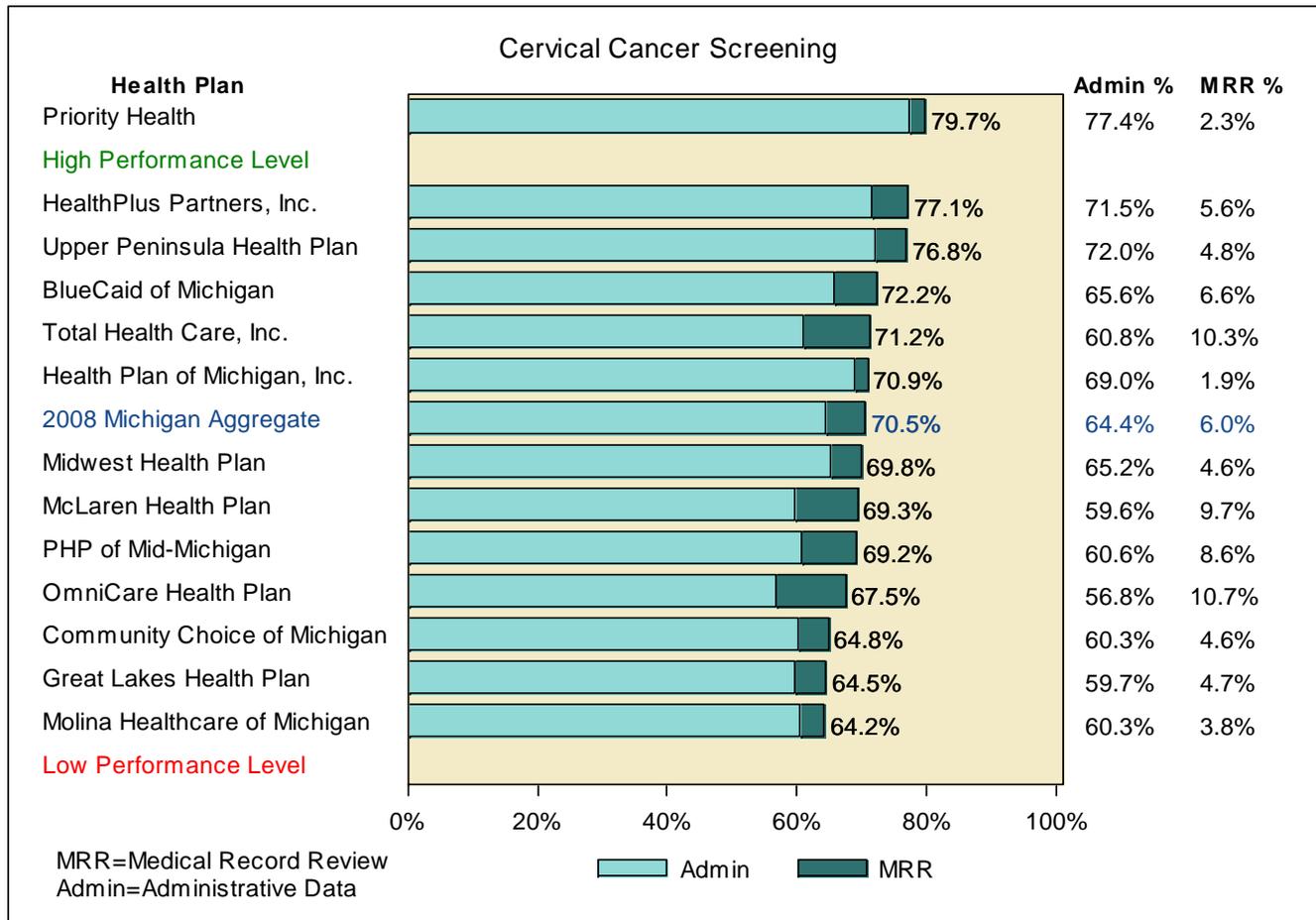


One health plan exceeded the HPL of 77.4 percent, and no health plans reported a rate below the LPL of 60.2 percent. A total of 10 health plans, including the one above the HPL, ranked above the national HEDIS 2007 Medicaid 50th percentile, and three MHPs ranked between the 75th and 90th percentile.

The 2008 Michigan Medicaid weighted average of 68.5 percent was 2 percentage points above the national HEDIS 2007 Medicaid 50th percentile of 66.5 percent and 1.4 percentage points higher than the 2007 Michigan Medicaid weighted average.

Data Collection Analysis: Cervical Cancer Screening

Figure 4-5—Michigan Medicaid HEDIS 2008 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 medical record review (MRR). Note: Because of rounding differences, the sum of the Admin and MRR rates may not always be exactly equal to the final rate.

All 13 health plans reported this measure using the hybrid method. The 2008 Michigan aggregate administrative rate was 64.4 percent and the medical record review rate was 6.0 percent.

The results indicated that 91.3 percent of the aggregate rate was derived from administrative data and 8.5 percent was from medical record review.

All of the health plans derived more than 80 percent of their rates from administrative data. The health plans increased their overall rates anywhere from 1.9 to 10.7 percentage points through medical record review.

Chlamydia Screening in Women

Chlamydia is the most commonly reported STD in the United States, infecting approximately 2.29 million Americans between 14 and 39 years of age each year.⁴⁻¹³ The majority of those who are infected with chlamydia have no symptoms. If left untreated, however, chlamydia can spread into the uterus or fallopian tubes of women and cause pelvic inflammatory disease (PID). Damage resulting from PID can cause chronic pelvic pain, infertility, and a potentially fatal ectopic pregnancy. In addition, women with chlamydia are up to five times more likely to become infected with HIV in the event of an exposure.⁴⁻¹⁴ Universal chlamydia screening could prevent up to 60,000 cases of PID and 8,000 cases of chronic pelvic pain each year.⁴⁻¹⁵ Michigan reported 36,746 cases of chlamydia in 2006; the highest rates generally occur in women 15 to 19 years of age and 20 to 24 years of age.⁴⁻¹⁶

HEDIS Specification: Chlamydia Screening in Women

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

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

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

The *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 16 through 25 years of age 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.

⁴⁻¹³ Centers for Disease Control and Prevention. Chlamydia—CDC Fact Sheet. Available at: <http://www.cdc.gov/std/Chlamydia/STDFact-Chlamydia.htm>. Accessed on October 3, 2008.

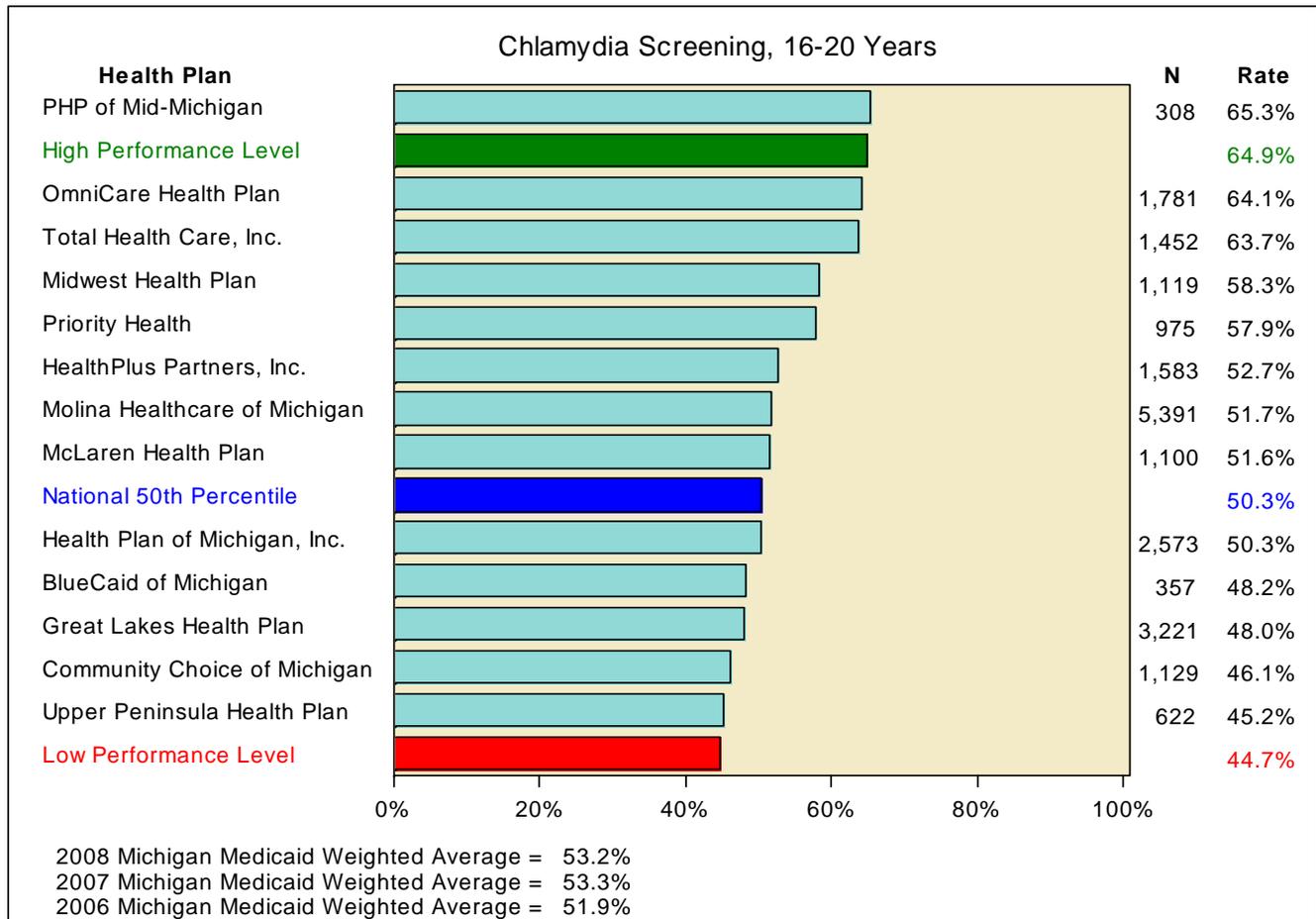
⁴⁻¹⁴ Ibid.

⁴⁻¹⁵ National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed on October 3, 2008.

⁴⁻¹⁶ Michigan Department of Community Health. Chlamydia. Available at: http://www.michigan.gov/documents/mdch/34_Chlamyd_198935_7.pdf. Accessed on October 3, 2008.

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

**Figure 4-6—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Chlamydia Screening in Women—16 to 20 Years**



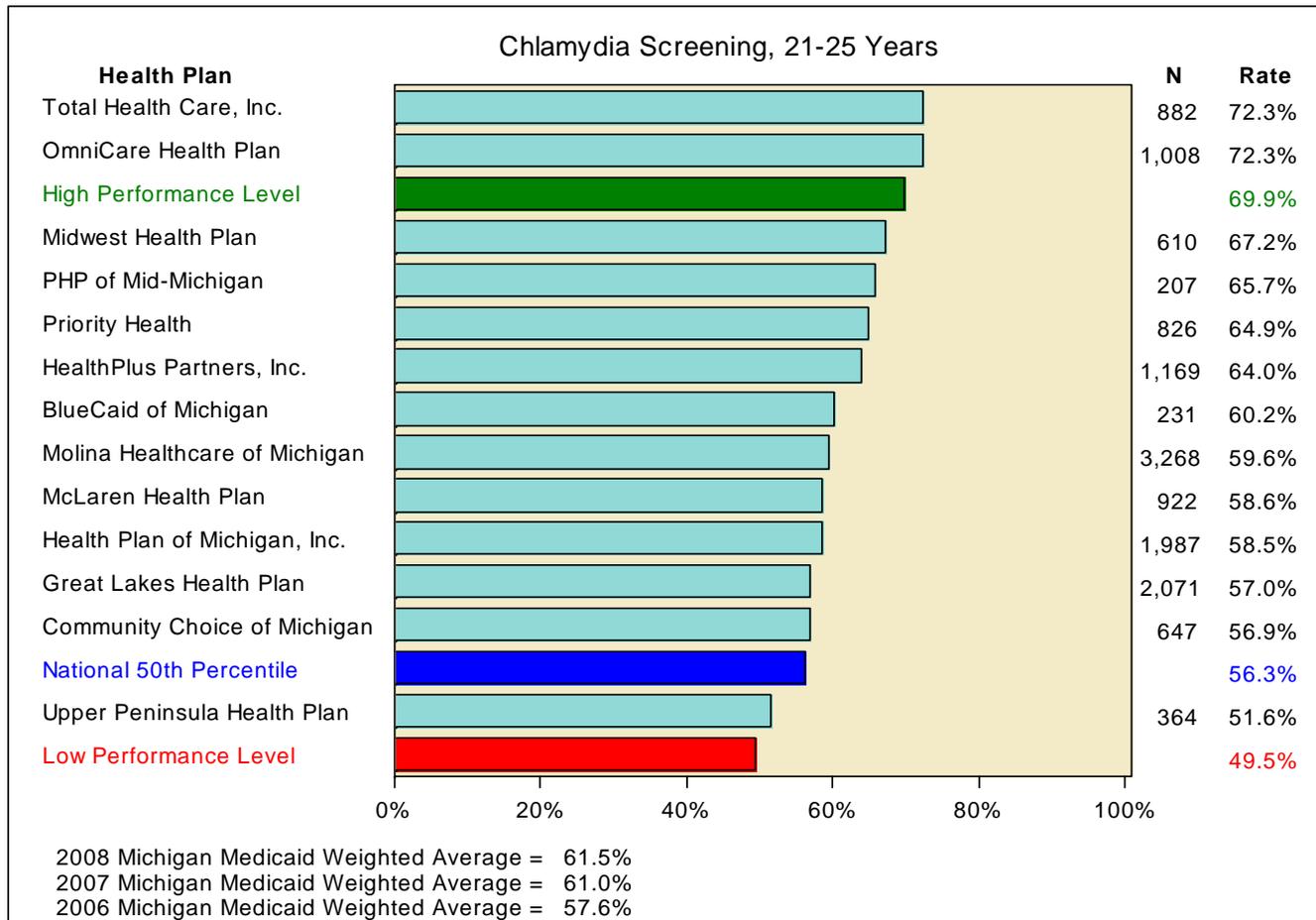
One health plan had a rate above the HPL of 64.9 percent, and none of the health plans had rates below the LPL of 44.7 percent. Eight health plans, including the one with rates above the HPL, ranked above the national HEDIS 2007 Medicaid 50th percentile, and three of these ranked above the 75th percentile.

The 2008 Michigan Medicaid weighted average of 53.2 percent was 2.9 percentage points above the national HEDIS 2007 Medicaid 50th percentile of 50.3 percent.

The 2008 Michigan Medicaid weighted average of 53.2 percent was 0.1 percentage points below the 2007 Michigan Medicaid weighted average and 1.3 percentage points above the 2006 weighted average.

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

**Figure 4-7—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Chlamydia Screening in Women—21 to 25 Years**



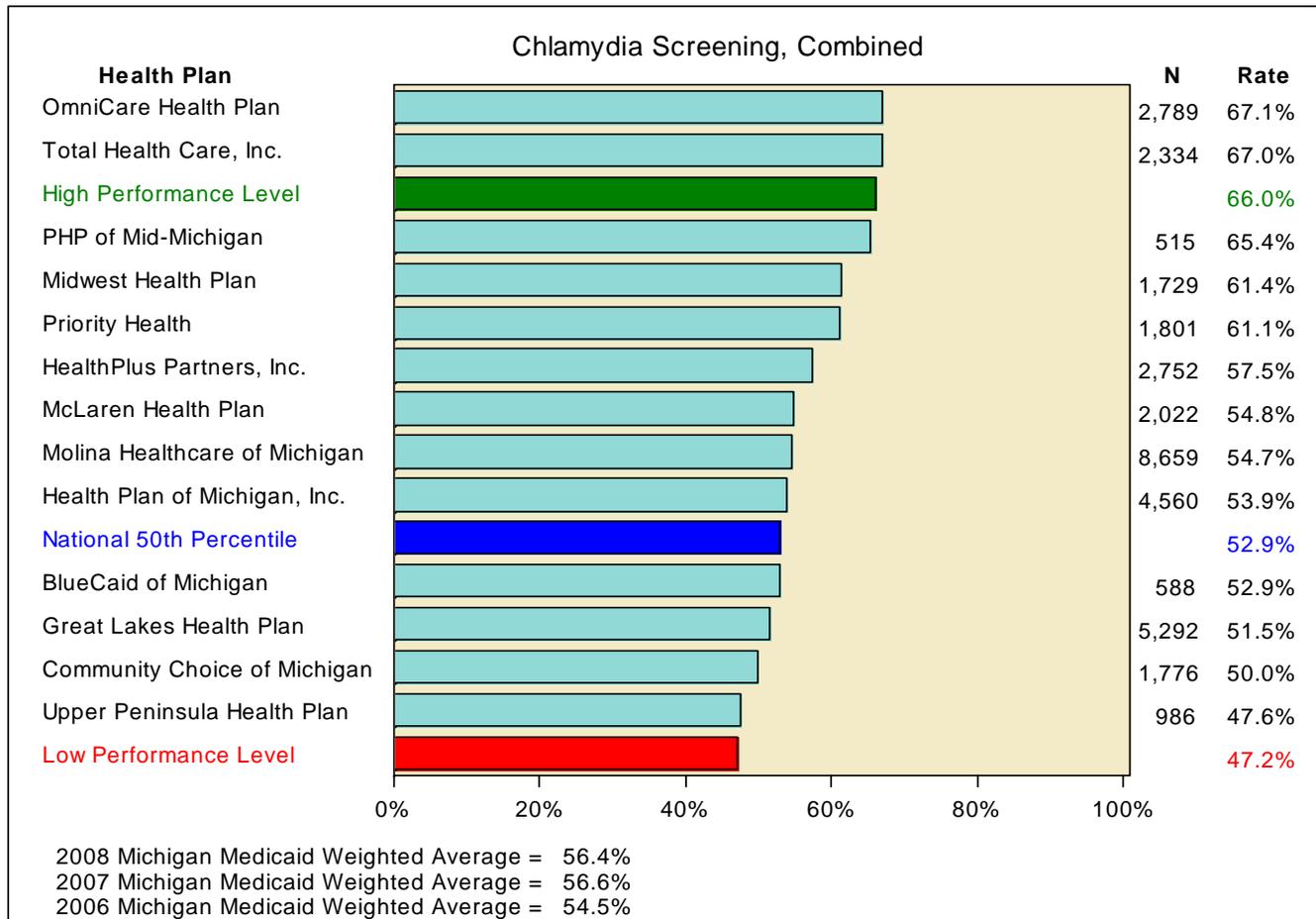
Two health plans had rates above the HPL of 69.9 percent, and none of the health plans reported rates below the LPL of 49.5 percent. A total of 12 health plans, including the two above the HPL, reported rates above the national HEDIS 2007 Medicaid 50th percentile, and six of these plans ranked above the 75th percentile.

The 2008 Michigan Medicaid weighted average of 61.5 percent was 5.2 percentage points above the national HEDIS 2007 Medicaid 50th percentile of 56.3 percent.

The 2008 Michigan Medicaid weighted average increased from 2007, up 0.5 percentage points. The rate improved by 3.9 percentage points when compared to the 2006 Michigan Medicaid weighted average of 57.6 percent.

Health Plan Ranking: Chlamydia Screening in Women—Combined Rate

**Figure 4-8—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Chlamydia Screening in Women—Combined Rate**



Two health plans reported rates above the HPL of 66.0 percent, and no health plans had rates below the LPL of 47.2 percent. Nine health plans, including the two above the HPL, had reported rates above the national HEDIS 2007 Medicaid 50th percentile, and five of these were above the 75th percentile.

The 2008 Michigan Medicaid weighted average of 56.4 percent was 3.5 percentage points above the national HEDIS 2007 Medicaid 50th percentile of 52.9 percent.

The 2008 Michigan Medicaid weighted average of 56.4 percent showed a small decrease of 0.2 percentage points over the 2007 weighted average and was 1.9 percentage points more than the 2006 weighted average.

Prenatal and Postpartum Care

More than 4 million infants are born in the United States each year. Approximately 10,000 premature infants and 6,500 infants of low birth weight are born every week.⁴⁻¹⁷ Low birth weight increases the risk for neuron developmental handicaps, congenital abnormalities, and respiratory illness compared to infants with a normal birth weight. With comprehensive prenatal care, the incidence of low birth weight and infant mortality can be reduced. Additionally, mothers who receive prenatal care are up to four times less likely to experience fatal complications related to pregnancy than those who do not receive prenatal care.⁴⁻¹⁸

More than 127,000 live births occurred in Michigan during 2006. Of this number, 8.4 percent resulted in low-birth-weight infants.⁴⁻¹⁹ In 2007, Michigan's infant mortality rate was 7.8 deaths per 1,000 live births, which ranked 36th nationwide.⁴⁻²⁰ Race continues to have a significant impact on infant mortality rates in Michigan. Among African Americans the rate was 14.8 per 1,000 live births, while for Caucasians it was 5.4 per 1,000 live births in 2006.⁴⁻²¹

While care strategies tend to emphasize the prenatal period, appropriate care during the postpartum period can also prevent complications and deaths. For example, more than 60 percent of maternal deaths occur during the postpartum period.⁴⁻²² Some women experience emotional lability during the postpartum period, which warrants a follow-up visit with their health care provider. Women can also benefit from personalized care during this time to enhance the development of a healthy mother-infant relationship.⁴⁻²³

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 for the following MDCH key measures:

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

⁴⁻¹⁷ National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed on October 3, 2008.

⁴⁻¹⁸ National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed on October 3, 2008..

⁴⁻¹⁹ Michigan Department of Community Health. Numbers and Percents of Low Birthweight Live Births by Prenatal Care Index, by Race and Ancestry of Mother Michigan Residents, 2005. Available at: <http://www.mdch.state.mi.us/pha/osr/natality/tab1.10.asp>. Accessed on October 3, 2008.

⁴⁻²⁰ United Health Foundation. America's Health. State Health Rankings. 2007 Edition. Available at: <http://www.unitedhealthfoundation.org/media2007/shrmediakit/ahr2007.pdf>. Accessed on October 3, 2008.

⁴⁻²¹ 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 October 3, 2008.

⁴⁻²² Family Health International. Better Postpartum Care Saves Lives. Network. Available at: http://www.fhi.org/en/RH/Pubs/Network/v17_4/postpartum.htm. Accessed on October 3, 2008.

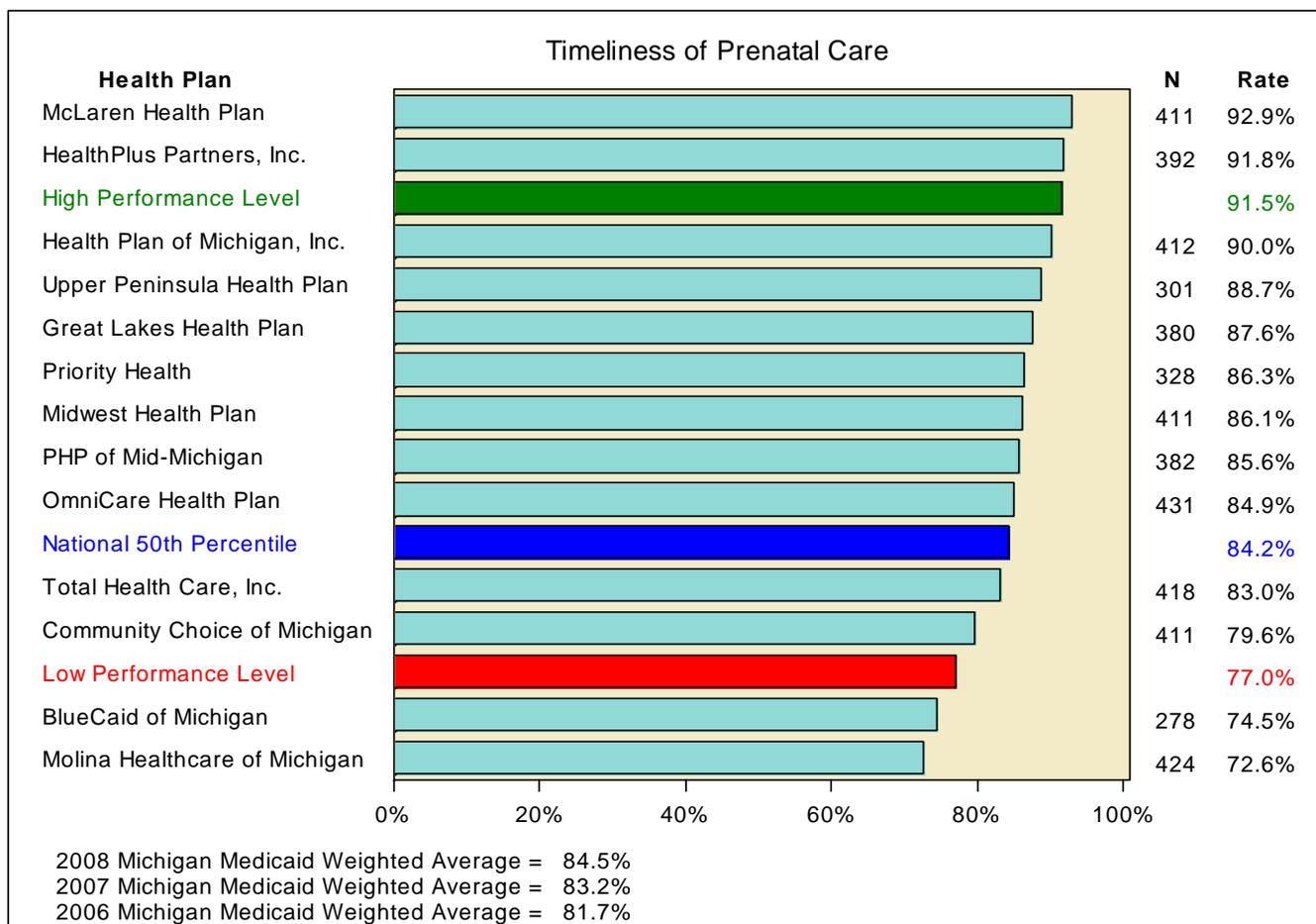
⁴⁻²³ National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed on October 3, 2008.

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.

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

**Figure 4-9—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Prenatal and Postpartum Care—Timeliness of Prenatal Care**



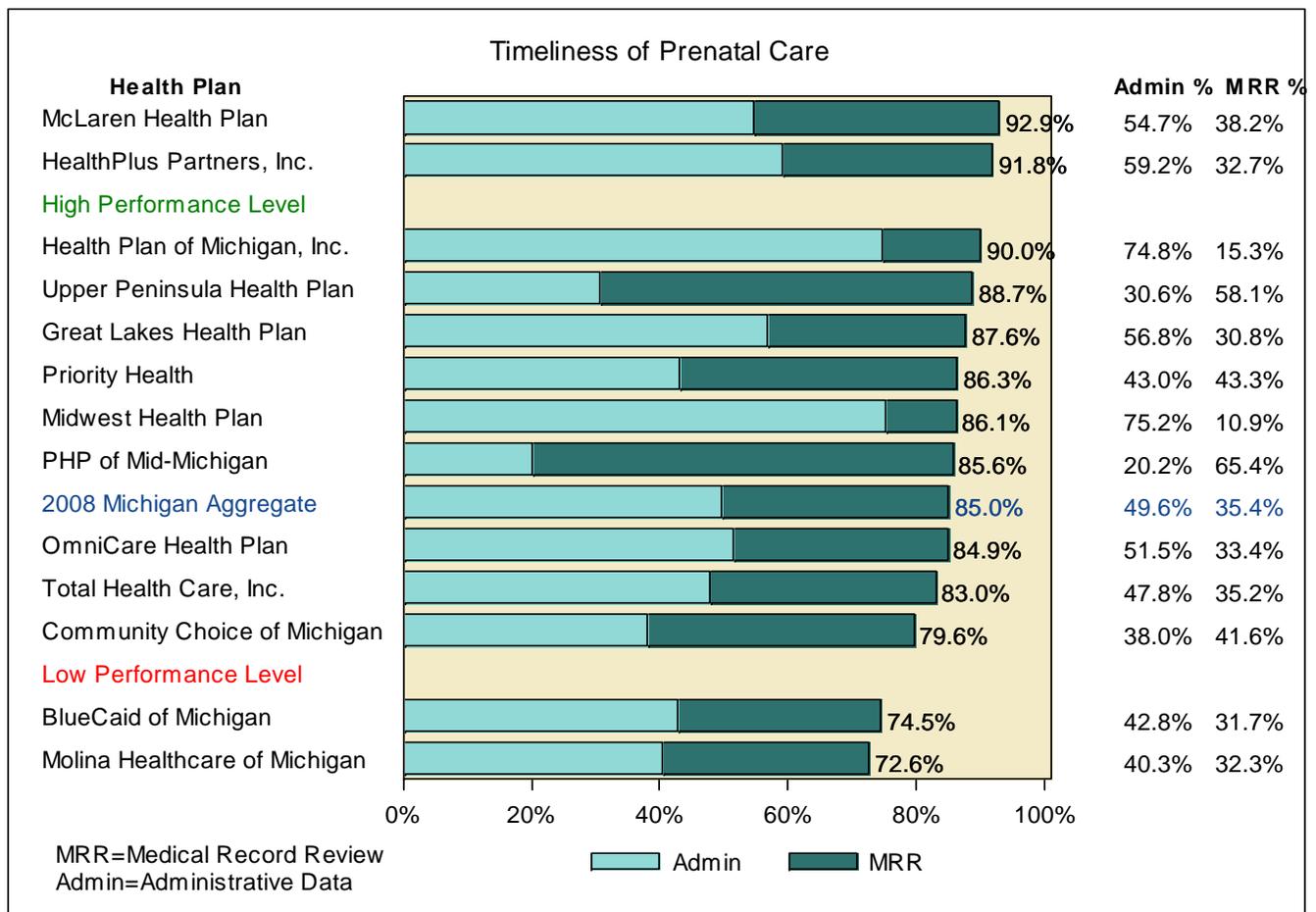
Two health plans had rates above the HPL of 91.5 percent, and two health plans had a reported rate below the LPL of 77.0 percent. Nine health plans, including the two above the HPL, had rates above the national HEDIS 2007 Medicaid 50th percentile.

The 2008 Michigan Medicaid weighted average of 84.5 percent was 0.3 percentage points above the national HEDIS 2007 Medicaid 50th percentile of 84.2 percent.

The 2008 Michigan Medicaid weighted average showed an increase from 2007, up 1.3 percentage points. The 2008 weighted average improved by 2.8 percentage points compared to the 2006 Michigan Medicaid weighted average of 81.7 percent.

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

**Figure 4-10—Michigan Medicaid HEDIS 2008
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 medical record review (MRR). Note: Because of rounding differences, the sum of the Admin and MRR rates may not always be exactly equal to the final rate.

All of the health plans used the hybrid method to report this measure. The 2008 Michigan aggregate administrative rate was 49.6 percent and the medical record review rate was 35.4 percent.

Overall, 58.4 percent of the aggregate rate was derived from administrative data and 41.6 percent was derived from medical record review data.

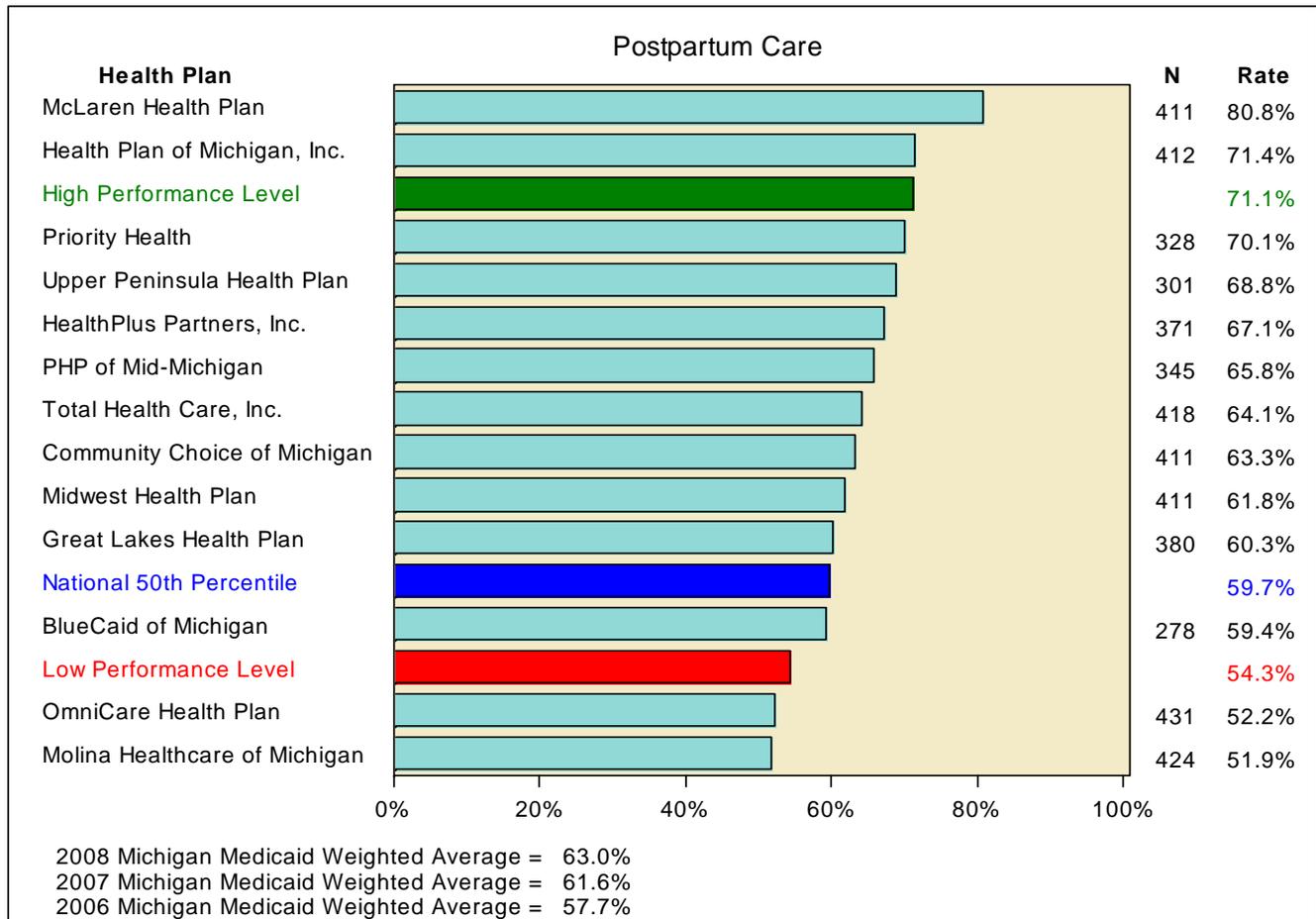
Nine health plans derived more than half of their rates from administrative data, and one health plan derived less than one quarter of its rate from administrative data.

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 4-11—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Prenatal and Postpartum Care—Postpartum Care**



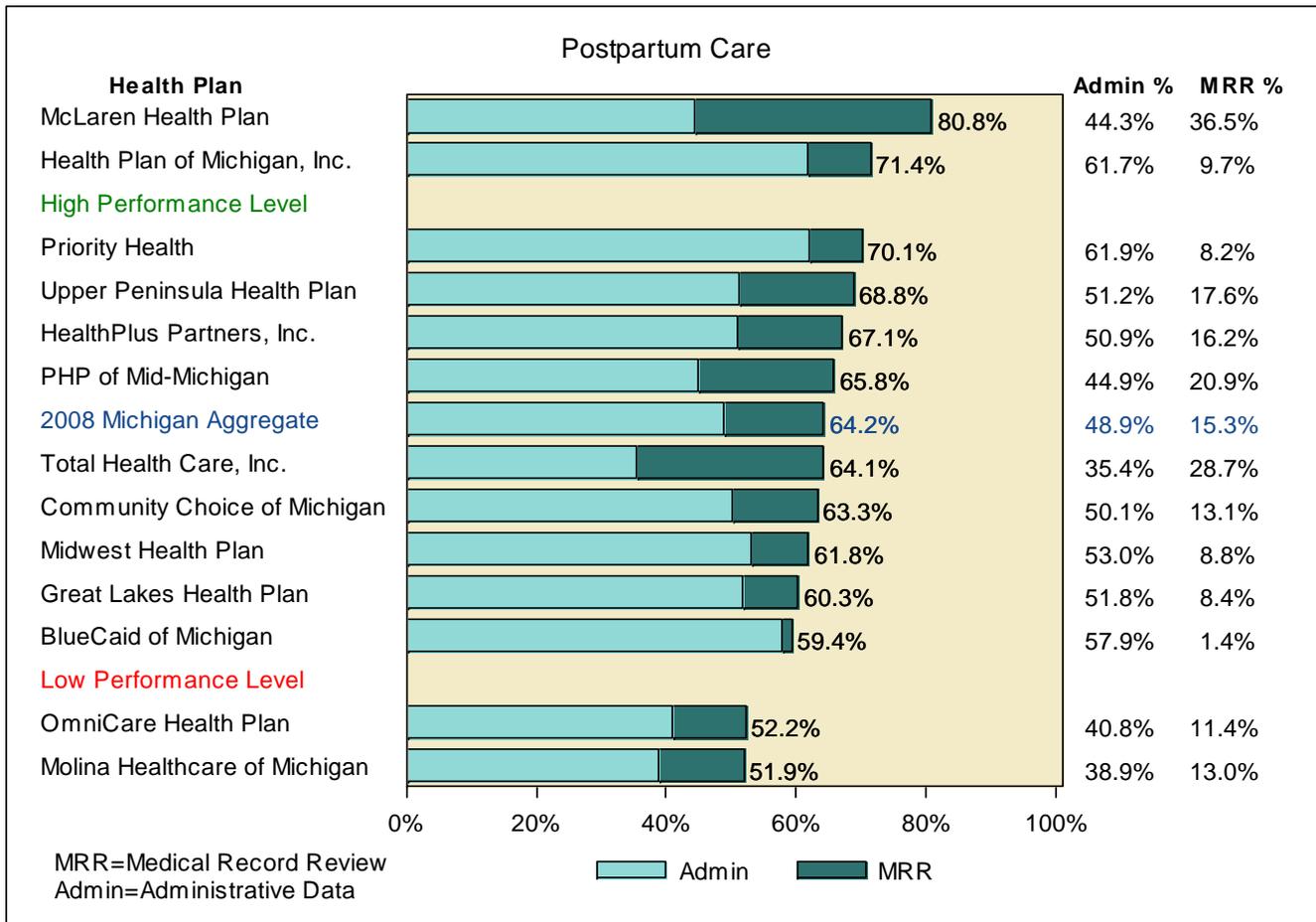
Two of the health plans reported rates above the HPL of 71.1 percent, and two health plans reported rates below the LPL of 54.3 percent. A total of 10 health plans' rates, including the two above the HPL, were above the national HEDIS 2007 Medicaid 50th percentile, and six of these plans were above the 75th percentile.

The 2008 Michigan Medicaid weighted average of 63.0 percent was 3.3 percentage points above the national HEDIS 2007 Medicaid 50th percentile of 59.7 percent.

The 2008 Michigan Medicaid weighted average continued to show improvement with an increase of 1.4 percentage points over the 2007 weighted average and 5.3 percentage points over the 2006 weighted average.

Data Collection Analysis: Prenatal and Postpartum Care—Postpartum Care

**Figure 4-12—Michigan Medicaid HEDIS 2008
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 medical record review (MRR). Note: Because of rounding differences, the sum of the Admin and MRR rates 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 2008 Michigan aggregate administrative rate was 48.9 percent and the medical record review rate was 15.3 percent.

Overall, 76.2 percent of the aggregate rate was derived from administrative data and 23.8 percent from medical record review. Compared with *Timeliness of Prenatal Care*, the percentage of the rate derived from administrative data was higher for *Postpartum Care*.

All health plans derived at least half of their rate from administrative data in 2008.

Women's Care Findings and Recommendations

All of the measures' weighted averages in the Women's Care dimension ranked above the national HEDIS 2007 Medicaid 50th percentile; however, none of the rates had statistically significant improvement from 2007, and rates for three measures declined slightly from the previous year.

Compared to last year, the *Breast Cancer Screening—42 to 51 Years* rate improved by 2.6 percentage points and the *Breast Cancer Screening—42 to 51 Years* rate decreased by 0.1 percentage points, leading to an overall increase in the weighted average for the *Combined* rate of 1.4 percentage points. All three of these rates ranked above the national 50th percentile, but there continues to be room for improvement. Next year, this measure will not be reported by age span. It will be reported only as a *Combined* rate.

The *Cervical Cancer Screening* weighted average improved by 1.4 percentage points over last year's rate and continued to rank above the national HEDIS 2007 50th percentile. The rates for this measure ranged from 64.2 percent to 79.7 percent, with no plans ranking below the LPL and one plan ranking above the HPL. Three of the same MHPs continued to rank below the 50th percentile, as they did in previous years. HSAG recommends that these MHPs investigate why their rates for this measure have not changed.

Two of the three weighted averages for the *Chlamydia Screening in Women* measures dropped slightly from 2007; however, all of the weighted averages continued to rank above the national 50th percentile. Although the difference in rates between the younger and older age groups was smaller this year compared to last year, the gap in performance continued. The younger age group's weighted average was 8.3 percentage points lower than the older age group's. The MHPs should continue to focus screening efforts toward this younger age group.

Both of the *Prenatal and Postpartum Care* measures improved from 2007. The *Timeliness of Prenatal Care* measure's weighted average improved by 1.3 percentage points and the *Postpartum Care* measure's rate improved by 1.4 percentage points. Both of these rates ranked above the national HEDIS 2007 50th percentile. The range in performance for the prenatal measure spanned 20 percentage points, and the range spanned almost 30 percentage points for the postpartum measure. These large ranges indicate varied performance among the MHPs. The *Prenatal and Postpartum Care* measure is susceptible to global billing payment arrangements, so 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. It appears that a majority of the MHPs derive at least half of their rates for these measures from medical record review.

Introduction

Chronic illness afflicts 133 million people in the United States—nearly half of all Americans—and accounts for the vast majority of health care spending.⁵⁻¹ Chronic diseases are responsible for seven out of 10 deaths (for a total of 1.7 million people) in this country each year.⁵⁻² Chronic conditions also contribute to disability and decreased quality of life for many Americans, and more than 25 million people experience limitations in activity due to these conditions.⁵⁻³

According to the National Heart, Lung, and Blood Institute, approximately 22 million people in the United States suffer from asthma, including nearly 6 million children.⁵⁻⁴ Asthma usually begins during childhood and tends to affect more boys than girls, although the incidence is higher in adult women than in adult men. The economic impact of asthma is considerable—the disease costs \$18 billion annually, including \$8 billion in indirect costs.⁵⁻⁵ In Michigan, approximately 863,000 people have asthma; the prevalence of adult asthma in Michigan is nearly the same as in the United States as a whole.⁵⁻⁶ However, asthma hospitalization rates for all age groups are lower in Michigan compared to the rest of the country.

As for diabetes, the American Diabetes Association estimates that 23.6 million people have the disease in the United States, although only 17.9 million have been diagnosed with it.⁵⁻⁷ Another 57 million have “pre-diabetes,” which refers to blood glucose levels above normal but not high enough for a formal diabetes diagnosis. Diabetes prevalence, mortality, and complication rates have increased steadily in Michigan and in the nation over the last decade. In Michigan, an estimated 593,200 adults have been diagnosed with diabetes, and an estimated 292,000 have undiagnosed diabetes.⁵⁻⁸ Additionally, more than 1.5 million Michigan adults have pre-diabetes. The estimated direct medical costs associated with diabetes among Michigan residents was \$4.5 billion in 2004.⁵⁻⁹ Indirect costs related to lost work days, restricted activity days, mortality, and disability totaled approximately \$2 billion.

⁵⁻¹ Partnership for Solutions. Chronic Conditions: Making the Case for Ongoing Care. Available at: <http://www.partnershipforsolutions.org/DMS/files/chronicbook2004.pdf>. Accessed on August 11, 2008.

⁵⁻² Centers for Disease Control and Prevention. Chronic Disease Overview. Available at: <http://www.cdc.gov/nccdphp/overview.htm>. Accessed on August 11, 2008.

⁵⁻³ Ibid.

⁵⁻⁴ National Heart, Lung, and Blood Institute. Who is at risk for Asthma? Available at: http://www.nhlbi.nih.gov/health/dci/Diseases/Asthma/Asthma_WhoIsAtRisk.html. Accessed on October 3, 2008.

⁵⁻⁵ National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed on October 3, 2008.

⁵⁻⁶ Michigan Department of Community Health. Asthma and Preventable Asthma Hospitalizations. Available at: http://www.michigan.gov/documents/mdch/22_Asthma_198922_7.pdf. Accessed on October 3, 2008.

⁵⁻⁷ American Diabetes Association. Diabetes Statistics. Available at: <http://www.diabetes.org/diabetes-statistics/prevalence.jsp>. Accessed on October 3, 2008.

⁵⁻⁸ Michigan Department of Community Health. Diabetes in Michigan. Available at: http://michigan.gov/documents/mdch/FactPageMichigan-Darline_2_172250_7.pdf. Accessed on October 3, 2008.

⁵⁻⁹ Michigan Department of Community Health. Diabetes in Michigan. Available at: http://michigan.gov/documents/mdch/FactPageMichigan-Darline_2_172250_7.pdf. Accessed on October 3, 2008.

Another chronic condition—high blood pressure—afflicts an estimated one in three adults in the United States, according to the American Heart Association, although one-third of these people are unaware of it.⁵⁻¹⁰ Failure to control high blood pressure can lead to stroke, heart attack, heart failure, or kidney failure, and the risk of developing high blood pressure increases with age. In Michigan, cardiovascular disease is the leading cause of mortality, causing approximately one of every three deaths.⁵⁻¹¹

Cigarette smoking is responsible for about one in five deaths in the United States, and is the most preventable cause of preventable morbidity and premature mortality worldwide.⁵⁻¹² According to the American Lung Association, smoking kills almost 440,000 U.S. residents annually and approximately 20.6 percent of U.S. adults were smokers in 2006. Smoking is the major cause of many cancers as well as other serious diseases, including heart disease, bronchitis, emphysema, and stroke. The Centers for Disease Control (CDC) estimates that about 44 percent of smokers try to quit each year; in 2005, 19 million adult smokers made the attempt to quit, but only 4 to 7 percent were successful.⁵⁻¹³

Smoking is responsible for more than \$167 billion in health care-related economic costs annually.⁵⁻¹⁴ Smoking cessation interventions are less costly than other routine medical interventions; smoking cessation treatment has been referred to as the “gold standard” of preventive interventions.⁵⁻¹⁵ If the overall prevalence of adult smoking in Michigan were reduced by 42 percent, and if adult per capita consumption in the state were reduced by 25 percent, the Michigan Cancer Consortium estimates that there would be 1,100 fewer lung cancer deaths each year among Michigan adults.⁵⁻¹⁶

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 (>9.0%)*
- *Comprehensive Diabetes Care—Good HbA1c Control (<7.0%)*
- *Comprehensive Diabetes Care—Eye Exam*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—LDL-C Level <100*
- *Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy*
- *Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

⁵⁻¹⁰ The American Heart Association. High Blood Pressure. Available at: <http://www.americanheart.org/presenter.jhtml?identifier=2114>. Accessed on October 3, 2008.

⁵⁻¹¹ Michigan Department of Community Health. 2007 CVD Fact Sheet. Available at: http://michigan.gov/documents/mdch/CVDFactsheet2007bcol_202765_7.pdf. Accessed on October 3, 2008.

⁵⁻¹² American Lung Association. Trends in Tobacco Use. Available at: http://www.lungusa.org/atf/cf/%7B7a8d42c2-fcca-4604-8ade-7f5d5e762256%7D/TREND_TOBACCO_JULY_08.PDF. Accessed on October 6, 2008.

⁵⁻¹³ Centers for Disease Control and Prevention. Treating Tobacco Use and Dependence: 2008 Update. Available at: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf. Accessed on October 3, 2008.

⁵⁻¹⁴ American Cancer Society. Tobacco-Related Cancers Fact Sheet. Available at: http://www.cancer.org/docroot/PED/content/PED_10_2x_Tobacco-Related_Cancers_Fact_Sheet.asp?sitearea=PED. Accessed on October 3, 2008.

⁵⁻¹⁵ 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. Available at: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf. Accessed on October 3, 2008.

⁵⁻¹⁶ Michigan Department of Community Health. Facts About Lung Cancer. Available at: <http://www.michigancancer.org/PDFs/MDCHFactSheets/LungCAFactSheet-Feb08.pdf>. Accessed on October 3, 2008.

- ◆ **Use of Appropriate Medications for People With Asthma**
 - *Use of Appropriate Medications for People With Asthma—5 to 9 Years*
 - *Use of Appropriate Medications for People With Asthma—10 to 17 Years*
 - *Use of Appropriate Medications for People With Asthma—18 to 56 Years*
 - *Use of Appropriate Medications for People With Asthma—Combined Rate*
- ◆ **Controlling High Blood Pressure**
 - *Controlling High Blood Pressure—Combined Rate*
- ◆ **Medical Assistance With Smoking Cessation**
 - *Advising Smokers to Quit*
 - *Smoking Cessation Strategies*

The following pages provide a detailed analysis of Michigan Medicaid health plan (MHP) performance and ranking, as well as data collection methodology for these measures.

Comprehensive Diabetes Care

As of 2007, 17.9 million Americans had been diagnosed with diabetes while an additional 5.7 million were estimated to have undiagnosed diabetes.⁵⁻¹⁷ Control of diabetes significantly reduces the rate of complications and improves quality of life for diabetics. The annual cost of diabetes in the United States was an estimated \$174 billion in 2007; \$116 billion of this total was due to medical expenditures, while \$58 billion was the result of lost productivity and other indirect costs.⁵⁻¹⁸

In 2006, 9 percent of Michigan adults had diabetes. An estimated 85 percent of these adults were 45 years of age or older.⁵⁻¹⁹ In 2004, diabetes was the leading cause of death for 2,954 people in Michigan and contributed to an additional 5,462 deaths.⁵⁻²⁰ Additionally, diabetes is the leading cause of blindness and kidney failure in Michigan and a major factor in hypertension, cardiovascular disease, and lower-extremity amputations.⁵⁻²¹ Control of blood glucose levels, however, can significantly reduce the rate of these complications and improve quality of life for diabetics. 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. When viewed simultaneously, the components build a comprehensive picture of the quality of diabetes care.

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

1. *Comprehensive Diabetes Care—HbA1c Testing*
2. *Comprehensive Diabetes Care—Poor HbA1c Control (>9.0%)*
3. *Comprehensive Diabetes Care—Good HbA1c Control (<7.0%)*
4. *Comprehensive Diabetes Care—Eye Exam*
5. *Comprehensive Diabetes Care—LDL-C Screening*
6. *Comprehensive Diabetes Care—LDL-C Level <100*
7. *Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy*
8. *Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)*
9. *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

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

⁵⁻¹⁷ National Institutes of Health. National Diabetes Statistics. Available at: <http://diabetes.niddk.nih.gov/dm/pubs/statistics/index.htm>. Accessed on July 31, 2008.

⁵⁻¹⁸ American Diabetes Association. Direct and Indirect Costs of Diabetes in the United States. Available at: <http://www.diabetes.org/diabetes-statistics/cost-of-diabetes-in-us.jsp>. Accessed on August 1, 2008.

⁵⁻¹⁹ Michigan Department of Community Health. Diabetes Prevalence and Management. Available at: http://www.michigan.gov/documents/mdch/MIBRFSS_Surveillance_Brief_December2007_Vol1No2_Dec10_2007_FINAL_221887_7.pdf. Accessed on October 3, 2008.

⁵⁻²⁰ Michigan Department of Community Health. Diabetes in Michigan. Available at: http://www.michigan.gov/documents/mdch/FactPageMichigan-Darline_2_172250_7.pdf. Accessed on October 3, 2008.

⁵⁻²¹ 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 October 3, 2008.

Comprehensive Diabetes Care—HbA1c Testing

The HbA1c test (hemoglobin A1c test or glycosylated hemoglobin test) shows the average blood glucose level over a period of two to three months. Specifically, the test measures the number of glucose molecules attached to hemoglobin in red blood cells. Although constantly replaced, individual cells live for about four months. Measuring attached glucose in a current blood sample can determine the average blood sugar levels from the previous two to three months. HbA1c test results are expressed as a percentage, with 4 percent to 6 percent considered normal. Maintaining near-normal HbA1c levels can help diabetics gain an extra five years of life, eight years of eyesight, and six years of freedom from kidney disease, on average.⁵⁻²²

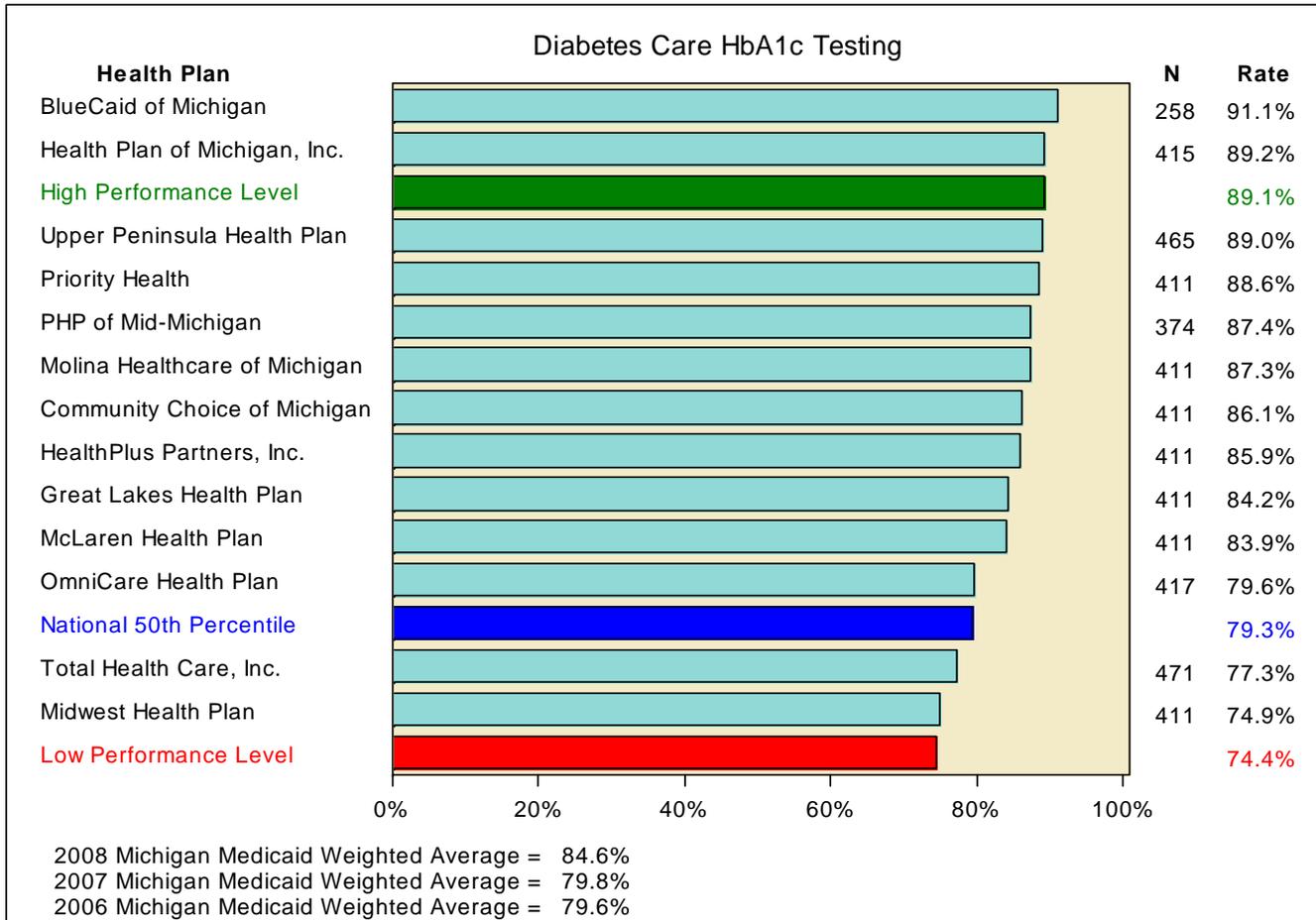
HEDIS Specification: Comprehensive Diabetes Care—HbA1c Testing

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

⁵⁻²² National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed on October 6, 2008.

Health Plan Ranking: Comprehensive Diabetes Care—HbA1c Testing

**Figure 5-1—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Comprehensive Diabetes Care—HbA1c Testing**



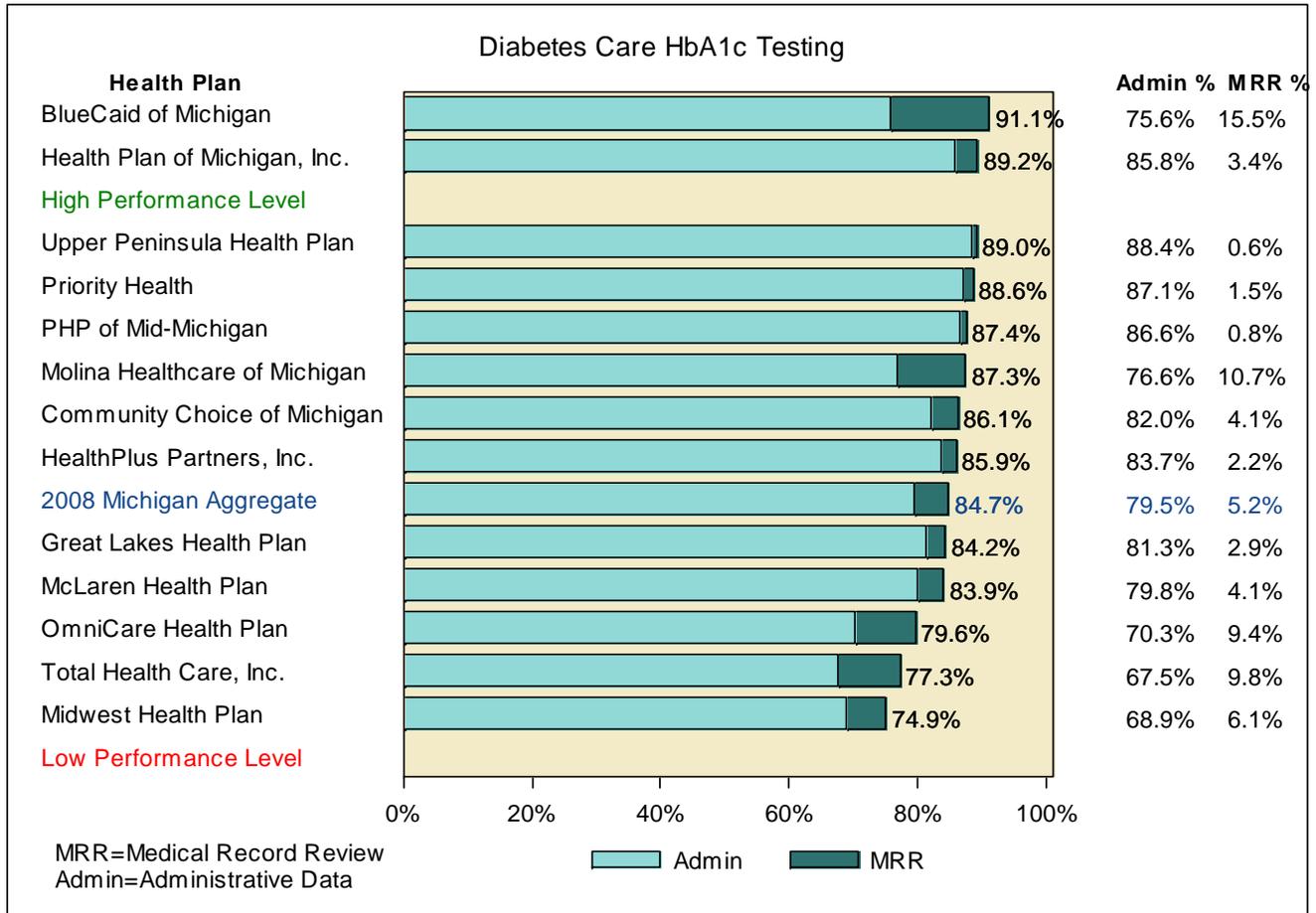
Two health plans reported rates above the HPL of 89.1 percent, and no health plan had a rate below the LPL of 74.4 percent. A total of 11 health plans, including the two above the HPL, had reported rates higher than the national HEDIS 2007 Medicaid 50th percentile, and six of those MHPs were between the 75th and 90th percentile.

The 2008 Michigan Medicaid weighted average of 84.6 percent was 5.3 percentage points above the national HEDIS 2007 50th percentile of 79.3 percent.

The Michigan Medicaid weighted average did not show much change between 2006 and 2007. However, the 2008 weighted average of 84.6 percent increased 4.8 percentage points over the 2007 weighted average, which was a statistically significant improvement.

Data Collection Analysis: Comprehensive Diabetes Care—HbA1c Testing

**Figure 5-2—Michigan Medicaid HEDIS 2008
Data Collection Analysis:
Comprehensive Diabetes Care—HbA1c Testing**



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

All of the health plans used the hybrid method to calculate this measure. The 2008 Michigan aggregate administrative rate was 79.5 percent and the medical record review rate was 5.2 percent.

In 2008, 93.9 percent of the aggregate rate was derived from administrative data and 6.1 percent was from medical record review.

All of the health plans derived more than three-quarters of their rates from administrative data. One health plan increased its overall rate by more than 15 percentage points from medical record review.

As seen in 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

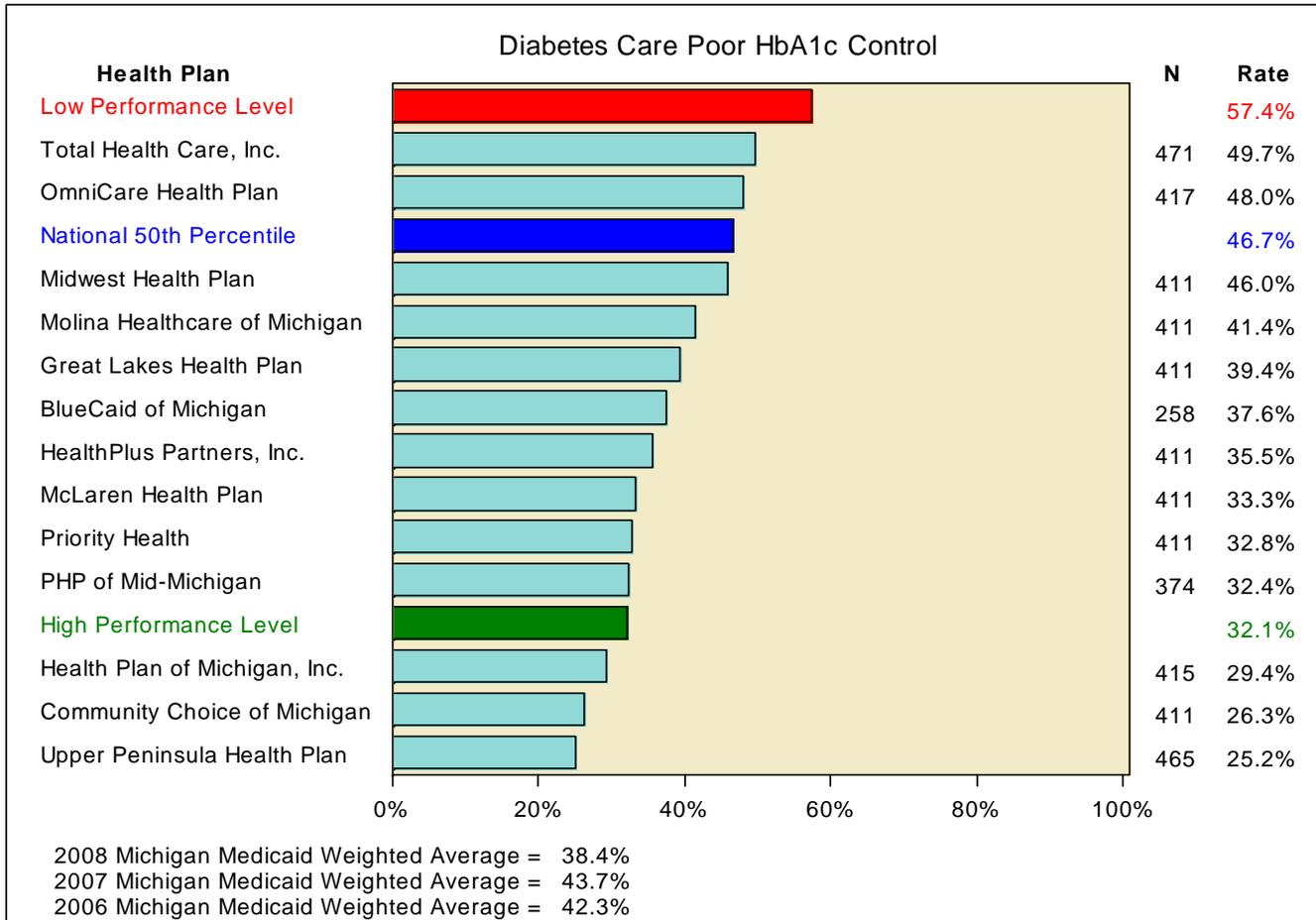
HbA1c control improves quality of life, increases work productivity, and decreases health care utilization. Decreasing the HbA1c level lowers the risk of diabetes-related death. Controlling blood glucose levels in people with diabetes significantly reduces the risk for blindness, end-stage renal disease, 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) 18 through 75 years of age who were continuously enrolled during the measurement year and whose most recent HbA1c test conducted during the measurement year showed a greater than 9 percent HbA1c level, as documented through automated laboratory data and/or medical record review. If 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 2008
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.

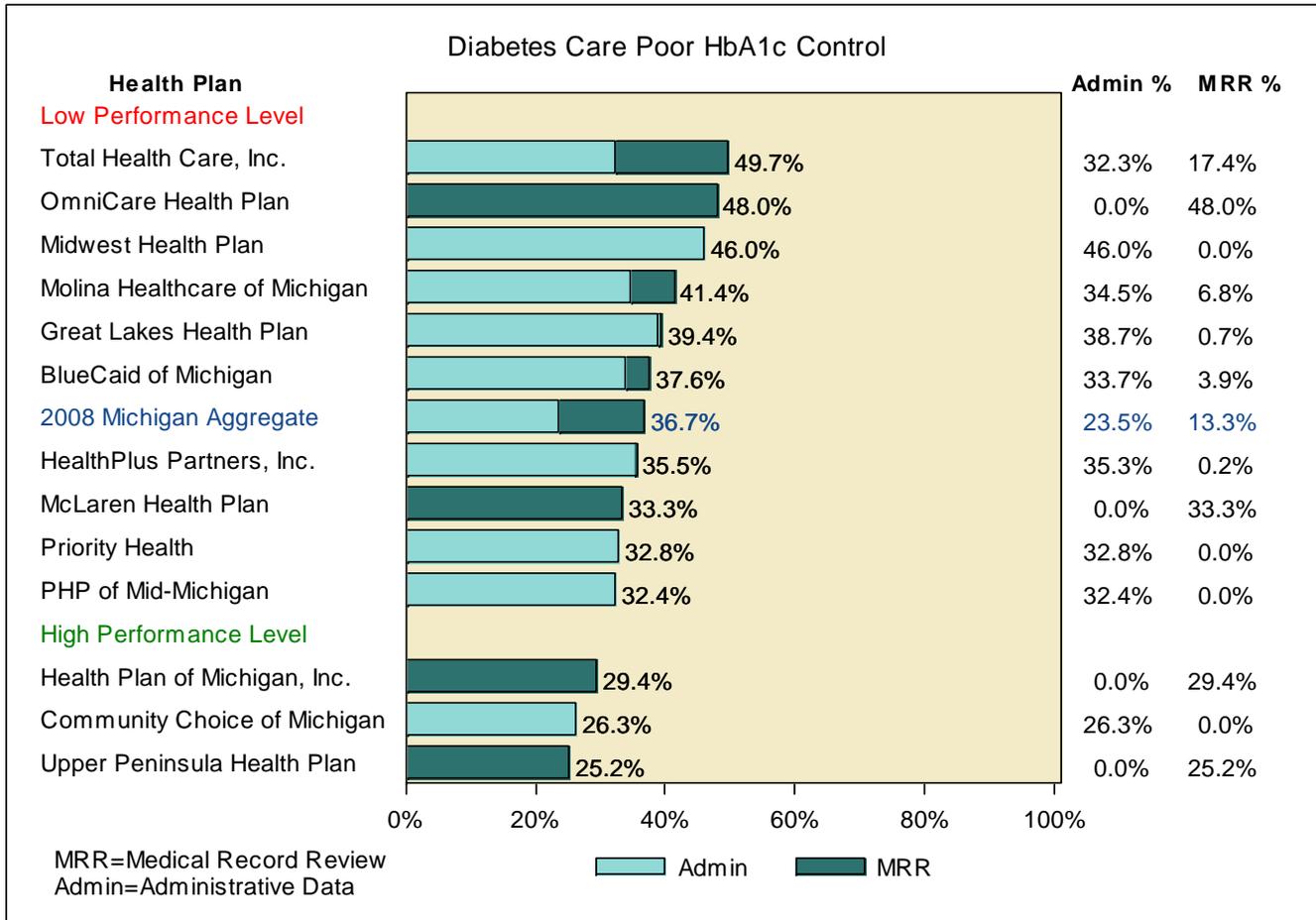
Three health plans reported rates that outperformed the HPL of 32.1 percent and no health plans had rates above the LPL of 57.4 percent. A total of 11 health plans performed lower than the national HEDIS 2007 Medicaid 50th percentile, indicating better performance.

The 2008 Michigan Medicaid weighted average of 38.4 percent was 8.3 percentage points below the national HEDIS 2007 Medicaid 50th percentile of 46.7 percent. This suggests that the MHPs performed better than health plans nationally for this measure.

The 2008 Michigan Medicaid weighted average decreased by 5.3 percentage points over the 2007 weighted average. This decrease demonstrates an improvement in performance from the previous year.

Data Collection Analysis: Comprehensive Diabetes Care—Poor HbA1c Control

**Figure 5-4—Michigan Medicaid HEDIS 2008
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 rates derived from administrative data and medical record review for *Comprehensive Diabetes Care—Poor HbA1c Control*. For this measure, a *lower* rate indicates better performance.

All of the health plans used the hybrid method to calculate this measure. The 2008 Michigan aggregate administrative rate was 23.5 percent and the medical record review rate was 13.3 percent.

In 2008, 64.0 percent of the aggregate rate was derived from administrative data and 36.2 percent was from medical record review data. In 2007, 33.3 percent of the aggregate rate was derived from

administrative data and 66.7 percent was from medical record review data. This indicated that the health plans were not relying on medical record review to report this measure as much as before.

Four health plans (OCH, MCL, HPM, UPP) derived all their rates from medical review data while the other nine health plans derived at least half of their rates from administrative data. Five health plans derived over 99 percent of their rates from administrative data. It appears that while the *HbA1c Testing* measure captures the actual test data from submitted claims and encounters, the results of those tests are not captured administratively for some health plans.

Comprehensive Diabetes Care—Good HbA1c Control

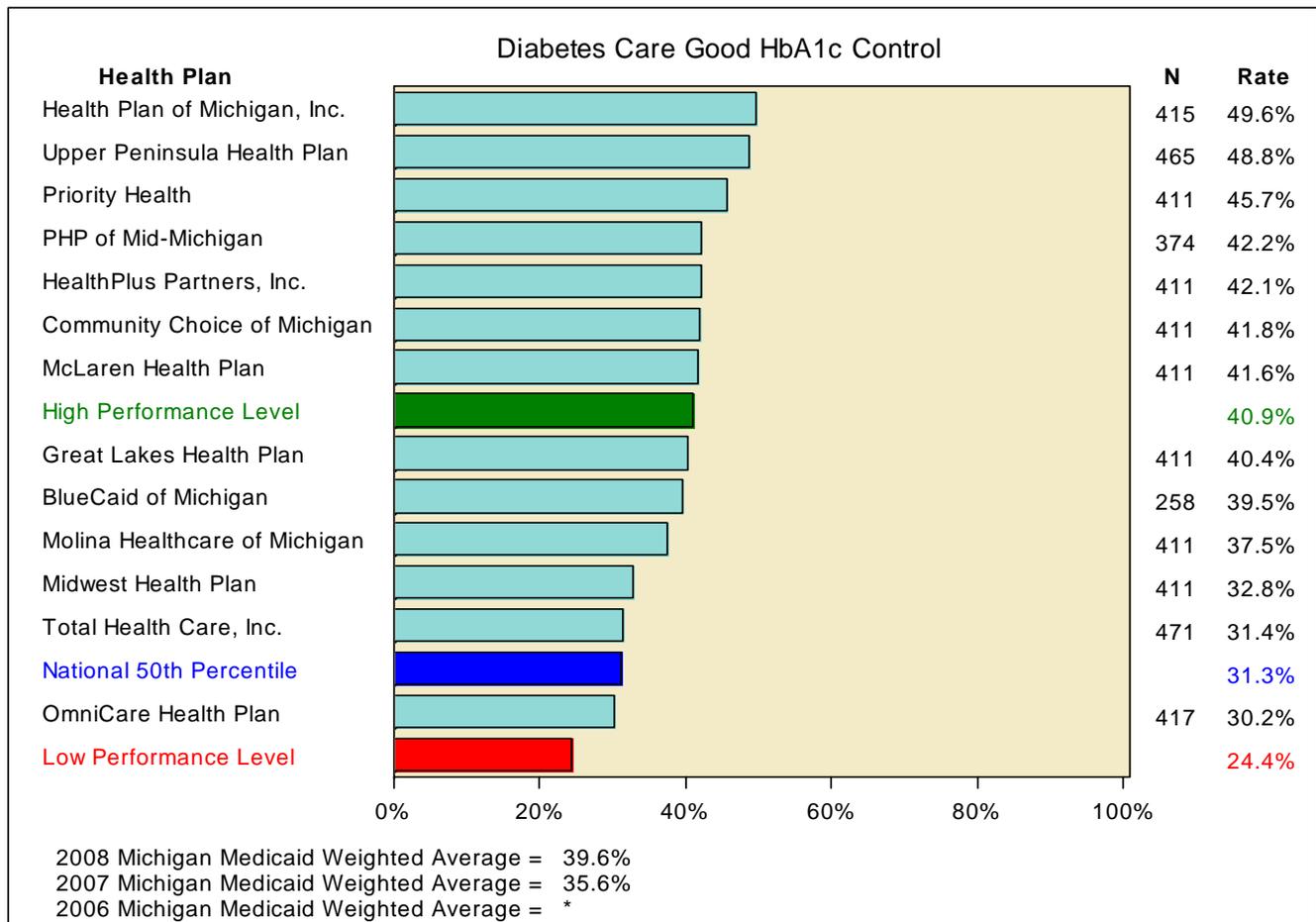
HbA1c control improves quality of life, increases work productivity, and decreases health care utilization. Decreasing the HbA1c level lowers the risk of diabetes-related death. Controlling blood glucose levels in people with diabetes significantly reduces the risk for blindness, end-stage renal disease,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

HEDIS Specification: Comprehensive Diabetes Care—Good HbA1c Control

The *Comprehensive Diabetes Care—Good HbA1c Control* rate reports the percentage of members with diabetes (Type 1 and Type 2) 18 through 75 years of age who were continuously enrolled during the measurement year and whose most recent HbA1c test conducted during the measurement year showed an HbA1c level of less than 7 percent, as documented through automated laboratory data and/or medical record review.

Health Plan Ranking: Comprehensive Diabetes Care—Good HbA1c Control

**Figure 5-5—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Comprehensive Diabetes Care—Good HbA1c Control**



Comprehensive Diabetes Care—Good HbA1c Control was a new measure in 2007; therefore, 2008 was the first year that national performance data are available for comparison.

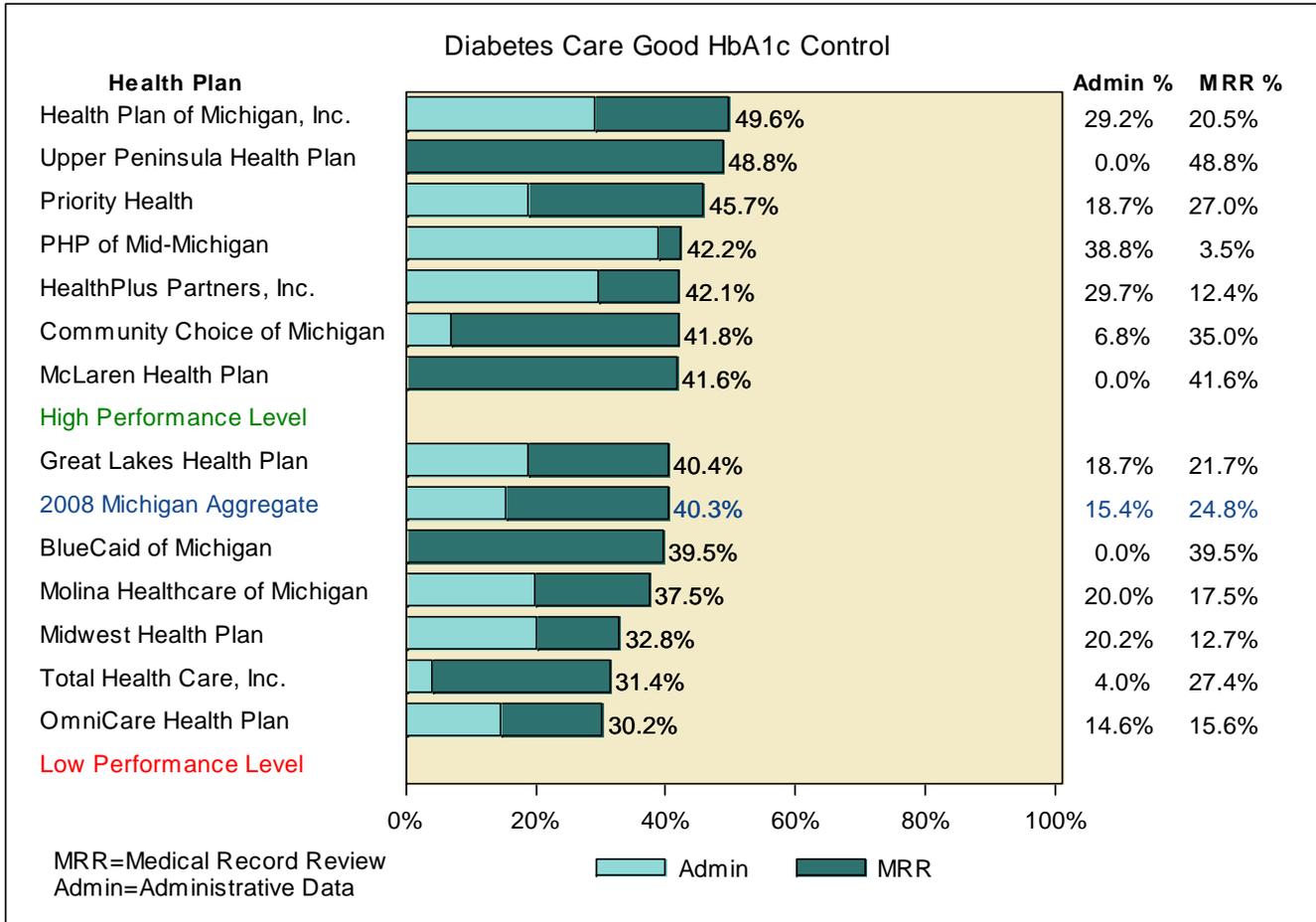
Seven health plans reported rates above the HPL of 40.9 percent, and no health plan had a rate below the LPL of 24.4 percent. A total of 12 health plans, including the seven above the HPL, had reported rates higher than the national HEDIS 2007 Medicaid 50th percentile.

The 2008 Michigan Medicaid weighted average of 39.6 percent was 8.3 percentage points above the national HEDIS 2007 50th percentile of 31.3 percent and was just 1.3 percentage points below the HPL of 40.9 percent. This suggests that the MHPs performed much better than health plans nationally for this measure.

The 2008 Michigan Medicaid weighted average of 39.6 percent increased 4.0 percentage points over the 2007 Michigan Medicaid weighted average.

Data Collection Analysis: Comprehensive Diabetes Care—Good HbA1c Control

**Figure 5-6—Michigan Medicaid HEDIS 2008
Data Collection Analysis:
Comprehensive Diabetes Care—Good 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.

All of the health plans used the hybrid method to calculate this measure. The 2008 Michigan aggregate administrative rate was 15.4 percent and the medical record review rate was 24.8 percent.

In 2008, 38.2 percent of the aggregate rate was derived from administrative data and 61.5 percent was from medical record review data. Compared with *Comprehensive Diabetes Care—Poor HbA1c Control*, the percentage of rate derived from administrative data was lower for this measure, *Comprehensive Diabetes Care—Good HbA1c Control*. It appears that while the *HbA1c Testing* measure captured the actual test data from submitted claims and encounters, the results of the test were not captured administratively.

Eight health plans derived more than half of their rates from medical record review data.

Comprehensive Diabetes Care—Eye Exam

Diabetic retinopathy causes 12,000 to 24,000 new cases of blindness each year, and it is the leading cause of new cases of blindness in adults 20 to 74 years of age.⁵⁻²³ However, with timely and appropriate intervention, which may include laser treatment and vitrectomy, blindness can be reduced by up to 90 percent in patients with severe diabetic retinopathy.⁵⁻²⁴

According to the National Eye Institute, approximately 184,589 Michigan residents have diabetic retinopathy. This equates to approximately 36 percent of all Michigan diabetics.⁵⁻²⁵

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) 18 through 75 years of age who were continuously enrolled during the measurement year and who had an eye screening for diabetic retinal diseases (i.e., a retinal exam by an eye care professional), as documented through either administrative data or medical record review.

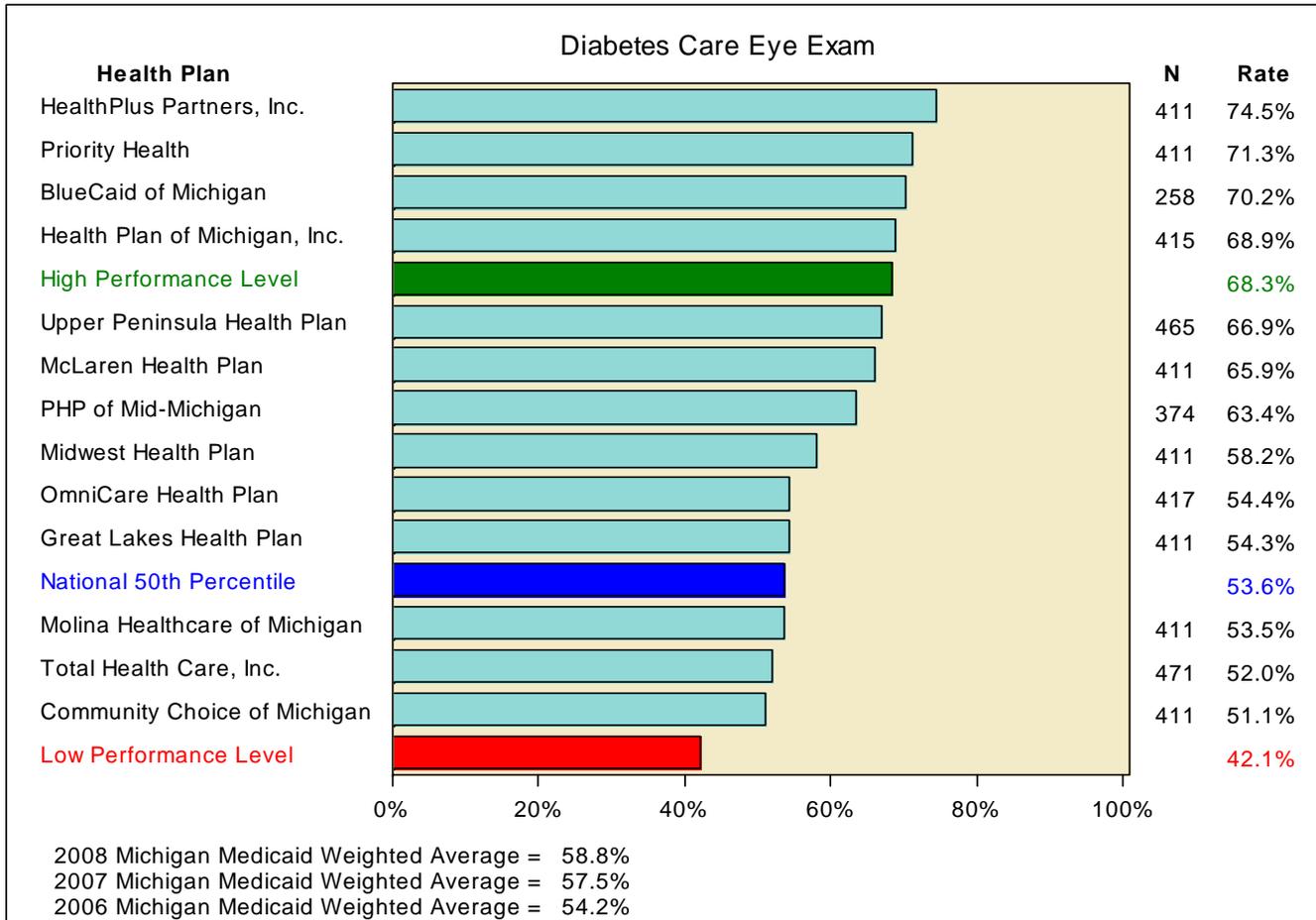
⁵⁻²³ National Diabetes Education Program. Eye Health and Diabetes. Available at: <http://ndep.nih.gov/diabetes/WTMD/eye.htm>. Accessed on October 6, 2008.

⁵⁻²⁴ National Institutes of Health. Fact Sheet: Diabetic Retinopathy. Available at: <http://www.nih.gov/about/researchresultsforthepublic/DiabeticRetinopathy.pdf>. Accessed on October 6, 2008.

⁵⁻²⁵ Michigan Department of Community Health. Michigan Diabetes Strategic Plan. Available at: http://michigan.gov/documents/DM_StrategicPlan_82795_7.pdf. Accessed on October 6, 2008.

Health Plan Ranking: Comprehensive Diabetes Care—Eye Exam

**Figure 5-7—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Comprehensive Diabetes Care—Eye Exam**



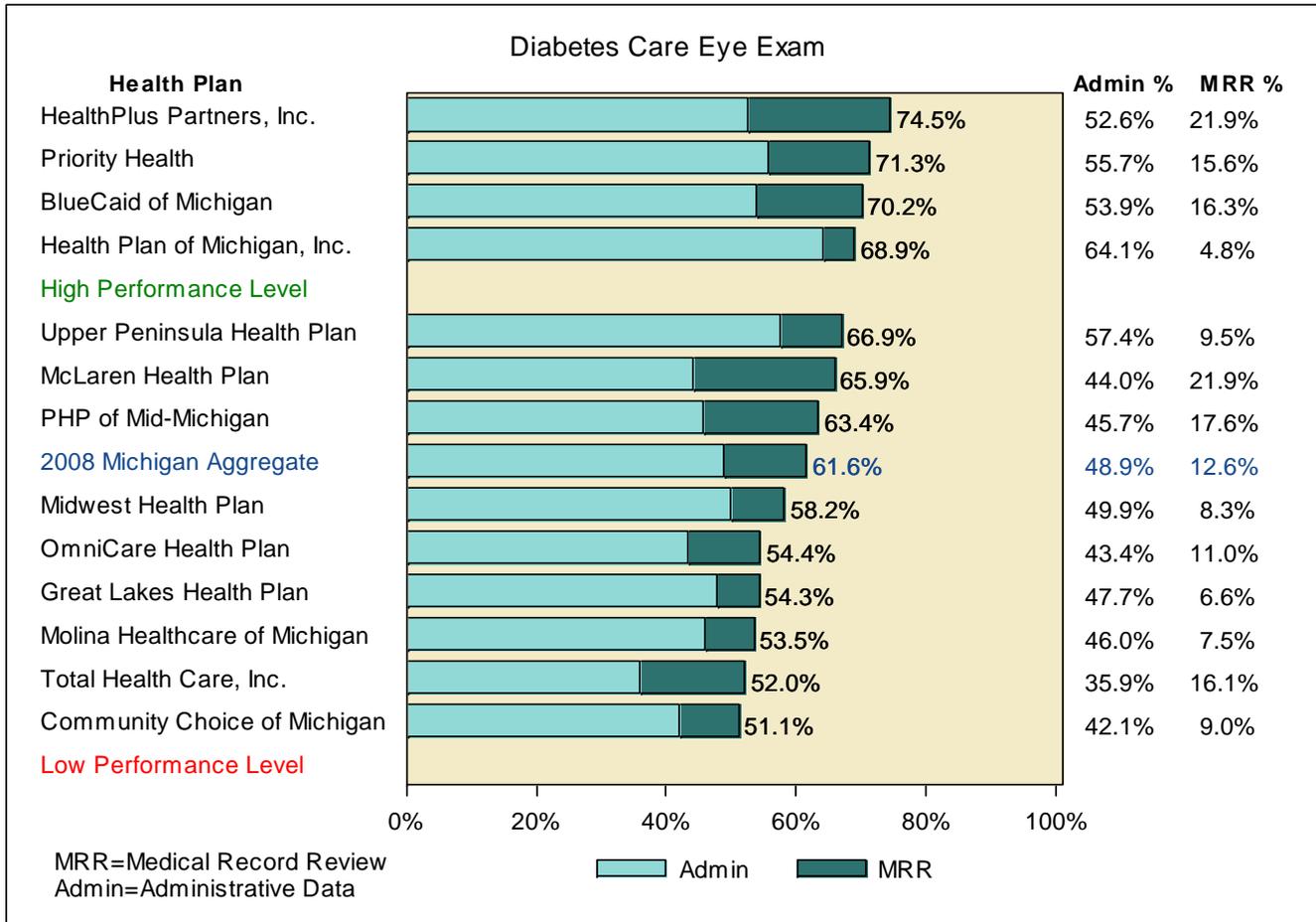
Four health plans reported rates above the HPL of 68.3 percent, and none of the health plans reported rates below the LPL of 42.1 percent. Ten health plans, including the four above the HPL, had rates that exceeded the national HEDIS 2007 Medicaid 50th percentile.

The 2008 Michigan Medicaid weighted average of 58.8 percent was 5.2 percentage points above the national HEDIS 2007 Medicaid 50th percentile of 53.6 percent.

The 2008 Michigan Medicaid weighted average increased by 1.3 percentage points over the 2007 weighted average and by 4.6 percentage points over the 2006 weighted average.

Data Collection Analysis: Comprehensive Diabetes Care—Eye Exam

**Figure 5-8—Michigan Medicaid HEDIS 2008
Data Collection Analysis:
Comprehensive Diabetes Care—Eye Exam**



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

All of the health plans used the hybrid method to calculate their rates for this measure. The 2008 Michigan aggregate administrative rate was 48.9 percent and the medical record review rate was 12.6 percent.

In 2008, 79.4 percent of the aggregate rate was derived from administrative data and 20.5 percent was derived from medical record review. These rates have remained fairly consistent for the past two years.

All 13 health plans derived more than two-thirds of their rates from administrative data.

Comprehensive Diabetes Care—LDL-C Screening

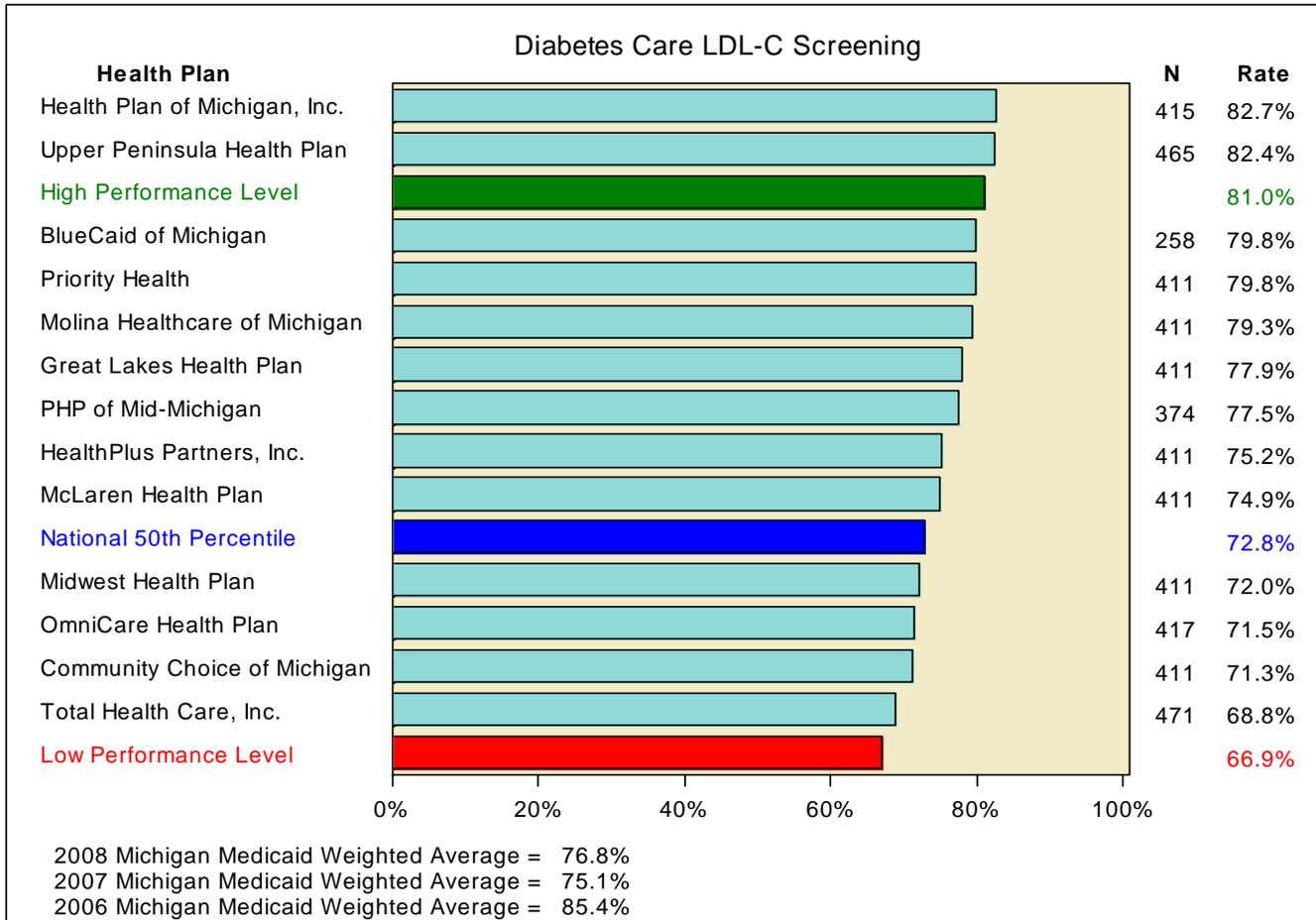
Low-density lipoprotein (LDL) is a type of lipoprotein that carries cholesterol in the blood. LDL is considered to be undesirable because it deposits excess cholesterol in the walls of blood vessels and contributes to atherosclerosis (hardening of the arteries) and heart disease. Therefore, LDL cholesterol 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) 18 through 75 years of age who were continuously enrolled during the measurement year and who had an LDL-C test during the measurement year or the 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 5-9—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Comprehensive Diabetes Care—LDL-C Screening**

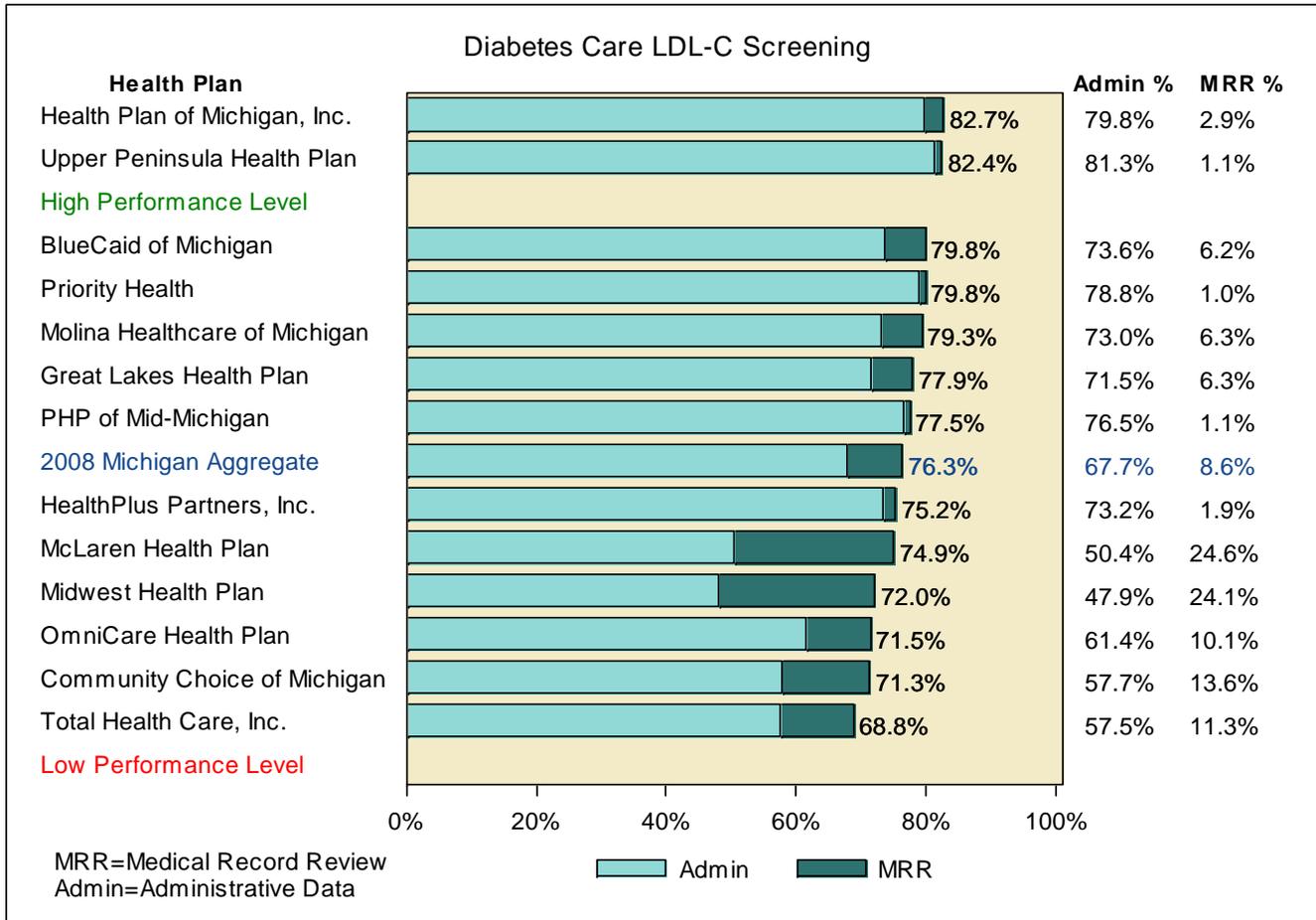


Two health plans reported rates above the HPL of 81.0 percent, and none of the health plans reported rates below the LPL of 66.9 percent. Nine health plans, including the two above the HPL, had rates that exceeded the national HEDIS 2007 Medicaid 50th percentile.

The 2008 Michigan Medicaid weighted average of 76.8 percent is 4.0 percentage points above the national HEDIS 2007 Medicaid 50th percentile and showed an increase of 1.7 percentage points from the 2007 weighted average. The 2006 Michigan Medicaid weighted average was not comparable to the 2007 and 2008 weighted averages because of measure specification changes in 2007.

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

**Figure 5-10—Michigan Medicaid HEDIS 2008
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 of the health plans elected to use the hybrid method to report this measure. The 2008 Michigan aggregate administrative rate was 67.7 percent and the medical record review rate was 8.6 percent.

In 2008, 88.7 percent of the aggregate rate was derived from administrative data and 11.3 percent from medical record review.

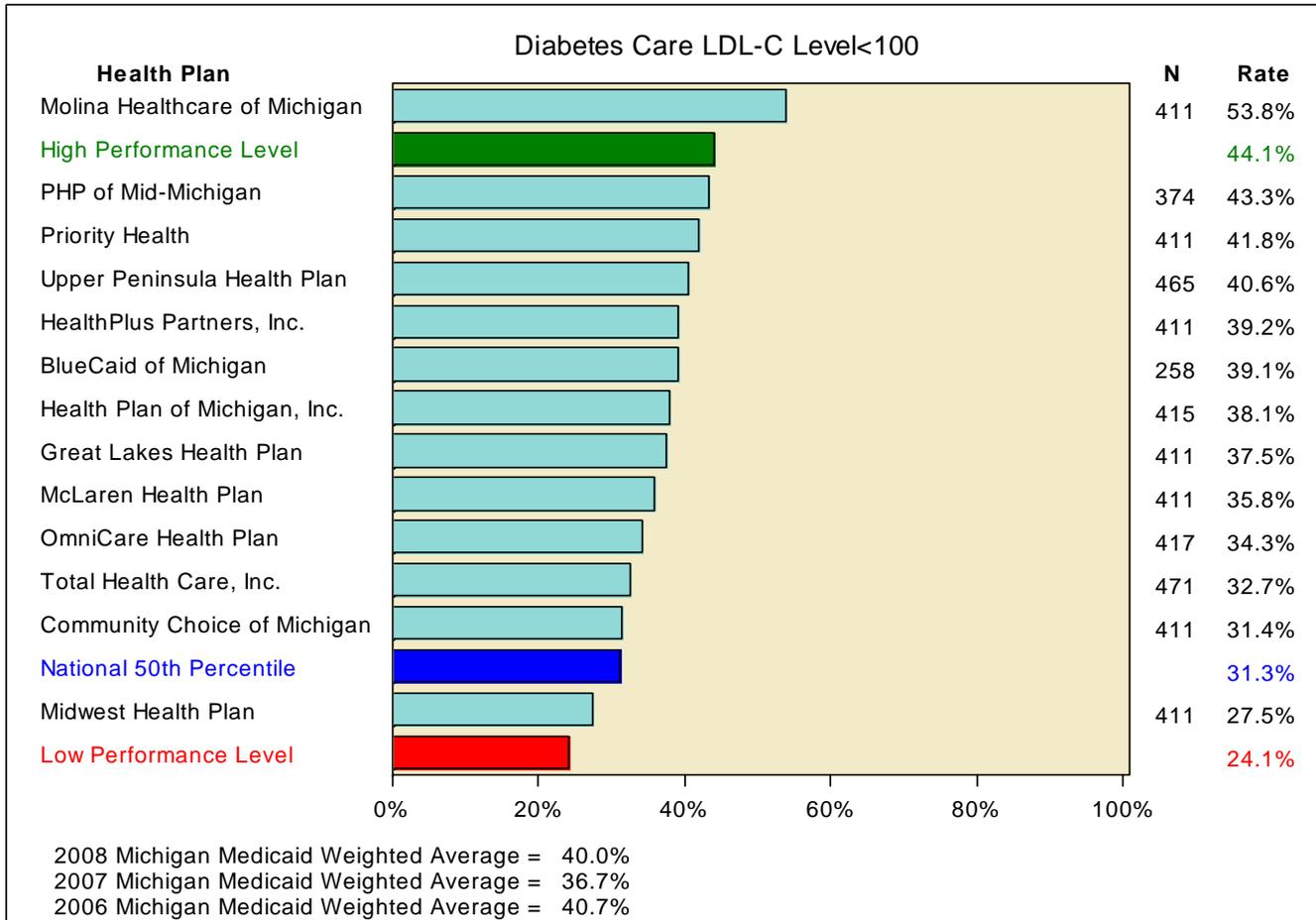
All 13 health plans derived more than 60 percent of their rates from administrative data.

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) 18 through 75 years of age who were continuously enrolled during the measurement year and whose most recent LDL-C test (performed during the measurement year 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 2008
Health Plan Ranking:
Comprehensive Diabetes Care—LDL-C Level <100**

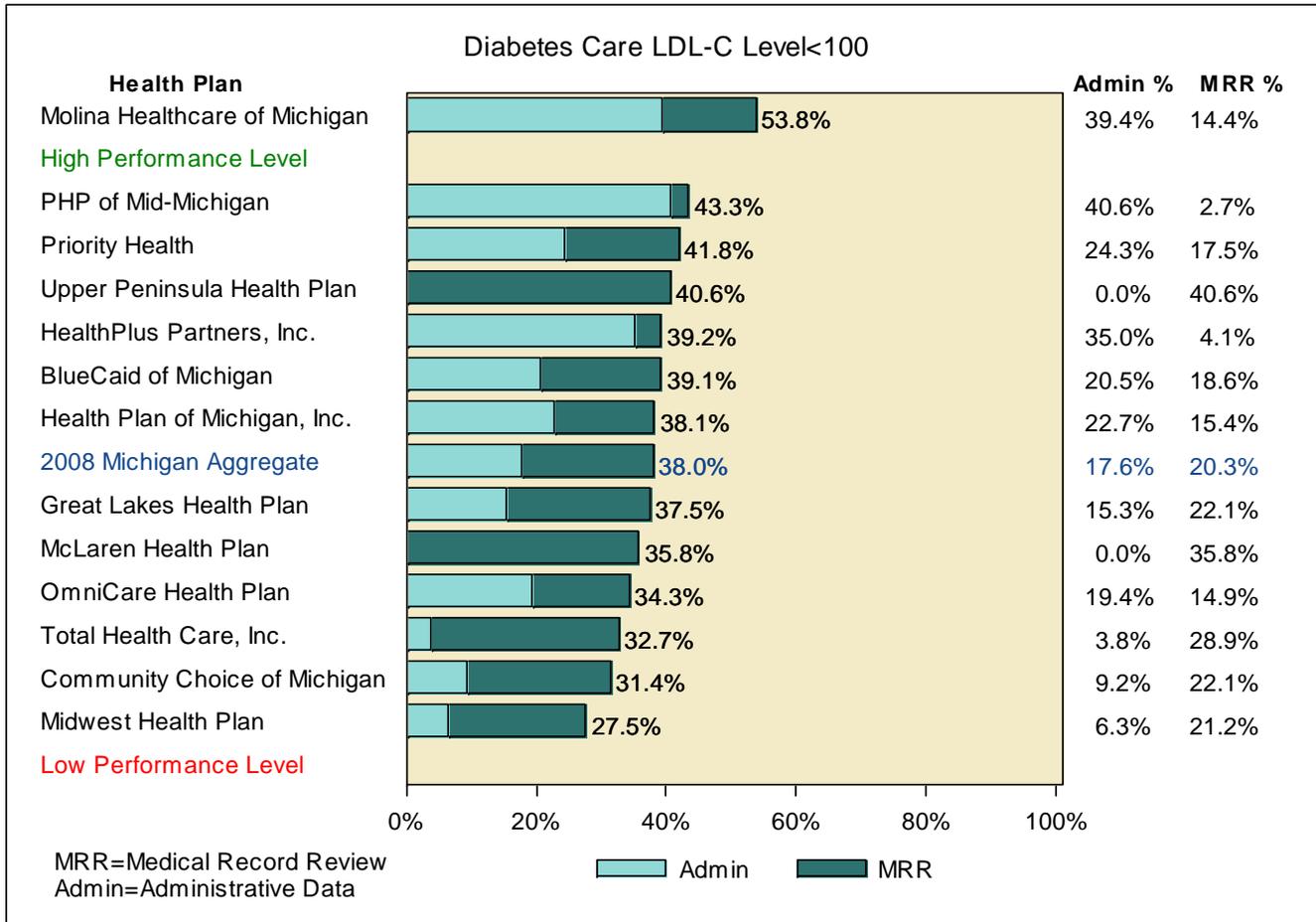


One health plan reported a rate above the HPL of 44.1 percent, and none of the health plans reported rates below the LPL of 24.1 percent. Twelve health plans, including the one above the HPL, had rates that exceeded the national HEDIS 2007 Medicaid 50th percentile and seven MHPs ranked between the 75th and 90th percentile.

The 2008 Michigan Medicaid weighted average of 40.0 percent is 8.7 percentage points above the national HEDIS 2007 Medicaid 50th percentile of 31.3 percent and showed an increase from 2007 of 3.3 percentage points. The 2006 Michigan Medicaid weighted average was not comparable with the 2007 and 2008 weighted averages because of measure specification changes in 2007.

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

**Figure 5-12—Michigan Medicaid HEDIS 2008
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 of the health plans used the hybrid method to report this measure. The 2008 Michigan Medicaid aggregate administrative rate was 17.6 percent and the medical record review rate was 20.3 percent.

Overall, 46.3 percent of the aggregate rate was derived from administrative data and 53.4 percent was derived from medical record review.

While seven of the 13 health plans derived more than half of their rates from administrative data this year, the rates for this measure still rely heavily on medical record review to get the actual LDL levels.

Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy

Diabetes is the leading cause of end-stage renal disease (ESRD), a condition that must be treated by dialysis or a kidney transplant. In the United States, diabetes causes more than 180,000 cases of kidney failure; health care for patients with kidney failure cost the United States almost \$32 billion.⁵⁻²⁶ Diabetic nephropathy is a progressive kidney disease that takes years to develop and progress; usually 15 to 25 years will pass after the onset of diabetes before kidney failure occurs. Approximately 20 to 30 percent of patients with diabetes develop evidence of nephropathy, although those with Type 2 diabetes are less likely to develop ESRD.⁵⁻²⁷ As of December 31, 2004, 42.4 percent (4,672) of the 11,002 living dialysis patients in Michigan had a primary diagnosis of diabetes.⁵⁻²⁸

HEDIS Specification: Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy

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

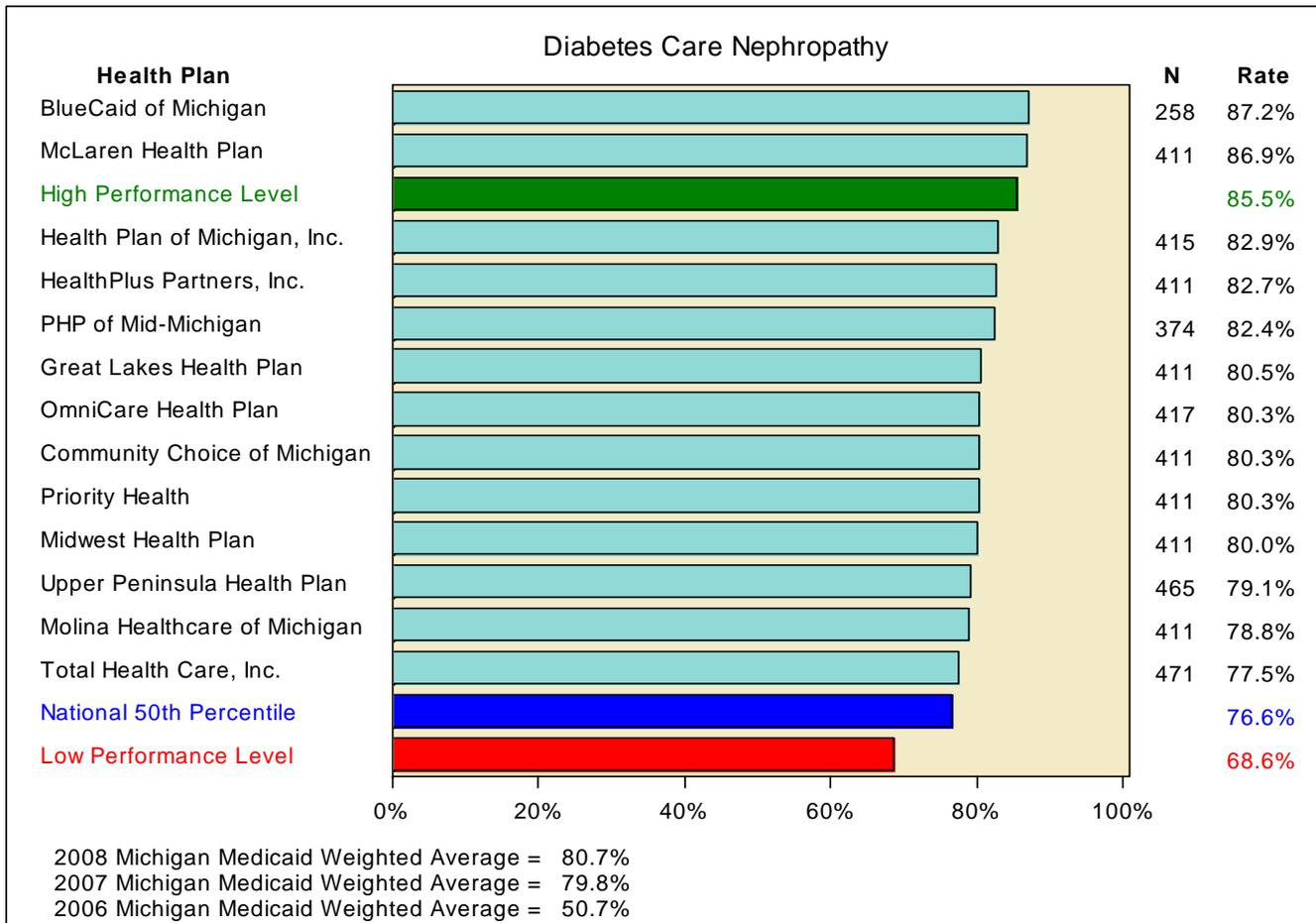
⁵⁻²⁶ National Kidney and Urologic Diseases Information Clearinghouse. Kidney Disease of Diabetes. Available at: <http://kidney.niddk.nih.gov/kudiseases/pubs/kdd/index.htm>. Accessed on October 6, 2008.

⁵⁻²⁷ Nephropathy in Diabetes. Diabetes Care, 2004. Available at: http://care.diabetesjournals.org/cgi/content/full/27/suppl_1/s79. Accessed on October 6, 2008.

⁵⁻²⁸ Michigan Department of Community Health. Diabetes in Michigan. Available at: http://www.michigan.gov/documents/mdch/FactPageMichigan-Darline_2_172250_7.pdf. Accessed on October 6, 2008.

Health Plan Ranking: Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy

**Figure 5-13—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy**

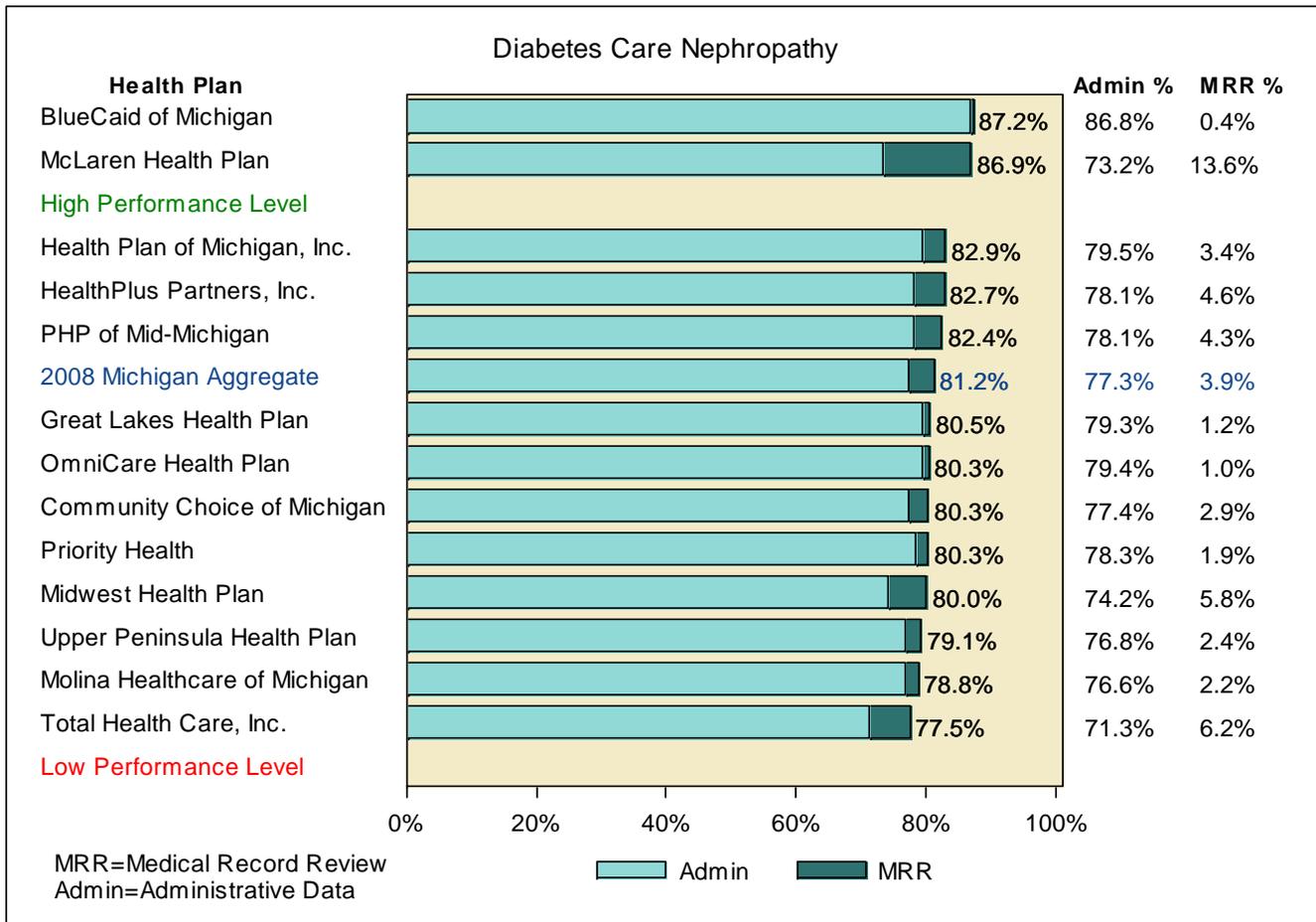


All 13 health plans had rates that exceeded the national HEDIS 2007 Medicaid 50th percentile. Two health plans reported rates above the HPL of 85.5 percent.

The 2008 Michigan Medicaid weighted average of 80.7 percent is 4.1 percentage points above the national HEDIS 2007 Medicaid 50th percentile of 76.6 percent and showed an increase from 2007 of 0.9 of a percentage point. The 2006 Michigan Medicaid weighted average was not comparable with the weighted averages in 2007 and 2008 due to the revisions to the measure specifications in 2007.

Data Collection Analysis: Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy

**Figure 5-14—Michigan Medicaid HEDIS 2008
Data Collection Analysis:
Comprehensive Diabetes Care—Medical Attention 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 of the health plans elected to use the hybrid method for reporting this measure. The 2008 Michigan aggregate administrative rate was 77.3 percent and the medical record review rate was 3.9 percent.

Overall, 95.2 percent of the aggregate rate was derived from administrative data and 4.8 percent was from medical record review.

All health plans derived more than 80 percent of their rates from administrative data.

Comprehensive Diabetes Care—Blood Pressure Control

High blood pressure is a significant risk factor for the development and worsening of many complications of diabetes, such as nephropathy and retinopathy. ADA and the National Institutes of Health recommend that people with diabetes maintain a blood pressure of less than 130/80mm Hg. In 2003 to 2004, 75 percent of adults with diabetes had blood pressure greater than or equal to this level, or took prescription medication for hypertension.⁵⁻²⁹ When blood pressure is under control, those with diabetes benefit greatly; for every 10 millimeters of mercury reduction in systolic blood pressure, there is a subsequent reduction of diabetic complications of 12 percent.⁵⁻³⁰ According to the CDC, 66.4 percent of Michigan adults with diabetes also had hypertension in 2003.⁵⁻³¹

Presented in two rates:

- ◆ Blood Pressure Control <130/80 mm Hg
- ◆ Blood Pressure Control <140/90 mm Hg

HEDIS Specification: Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)

The *Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)* rate is intended to assess whether diabetic patients' blood pressure is being monitored. It reports the percentage of members with diabetes (Type 1 and Type 2) 18 through 75 years of age who were continuously enrolled during the measurement year and who had a blood pressure reading of <130/80 mm Hg.

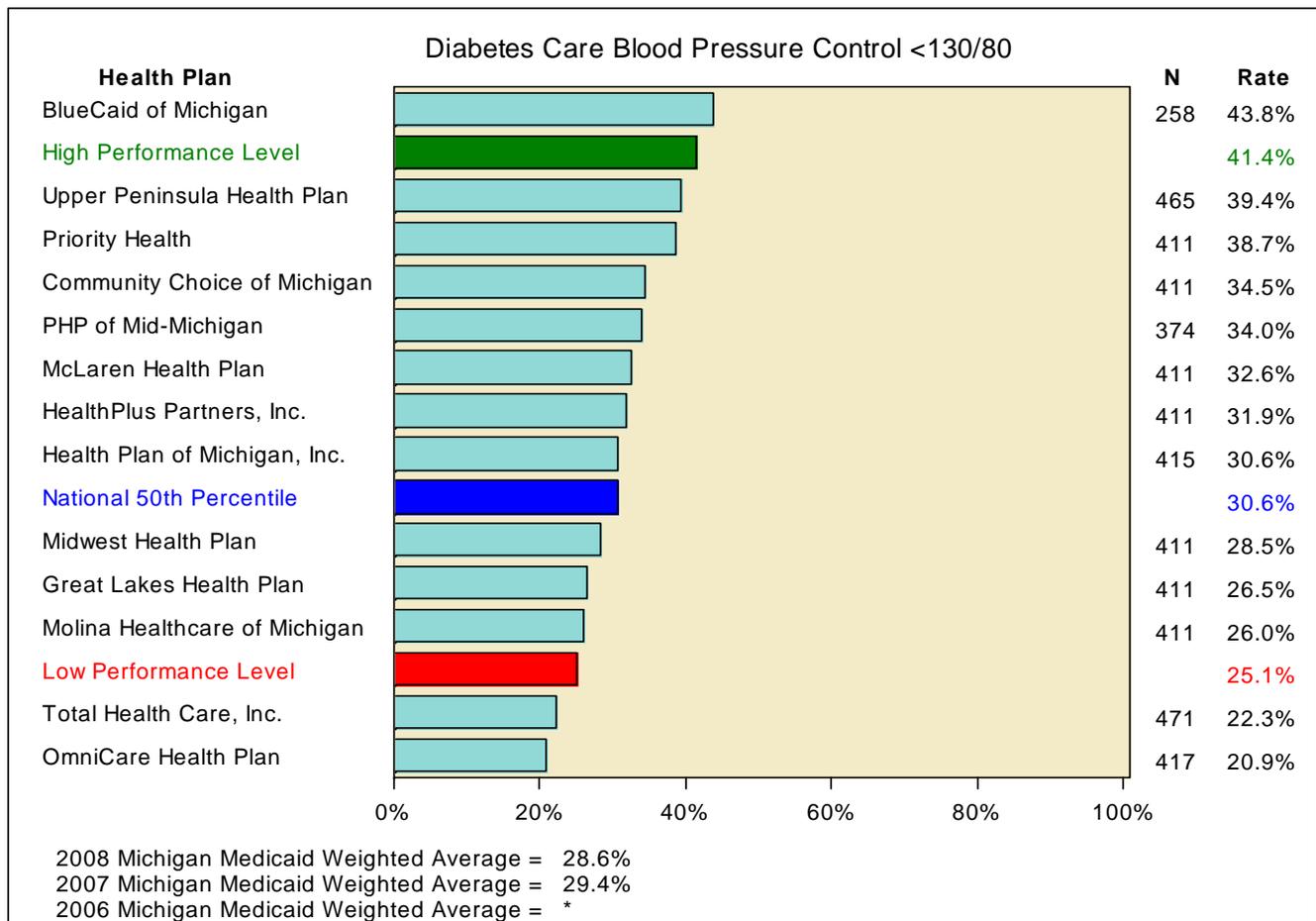
⁵⁻²⁹ National Institute of Diabetes and Digestive and Kidney Diseases. National Diabetes Statistics, 2007 fact sheet. Available at: <http://diabetes.niddk.nih.gov/dm/pubs/statistics/>. Accessed on October 30, 2008.

⁵⁻³⁰ National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed on October 30, 2008.

⁵⁻³¹ Centers for Disease Control and Prevention. National Diabetes surveillance system Available at: www.cdc.gov/diabetes/statistics/index.htm. Accessed on October 30, 2008.

Health Plan Ranking: Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)

**Figure 5-15—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)**



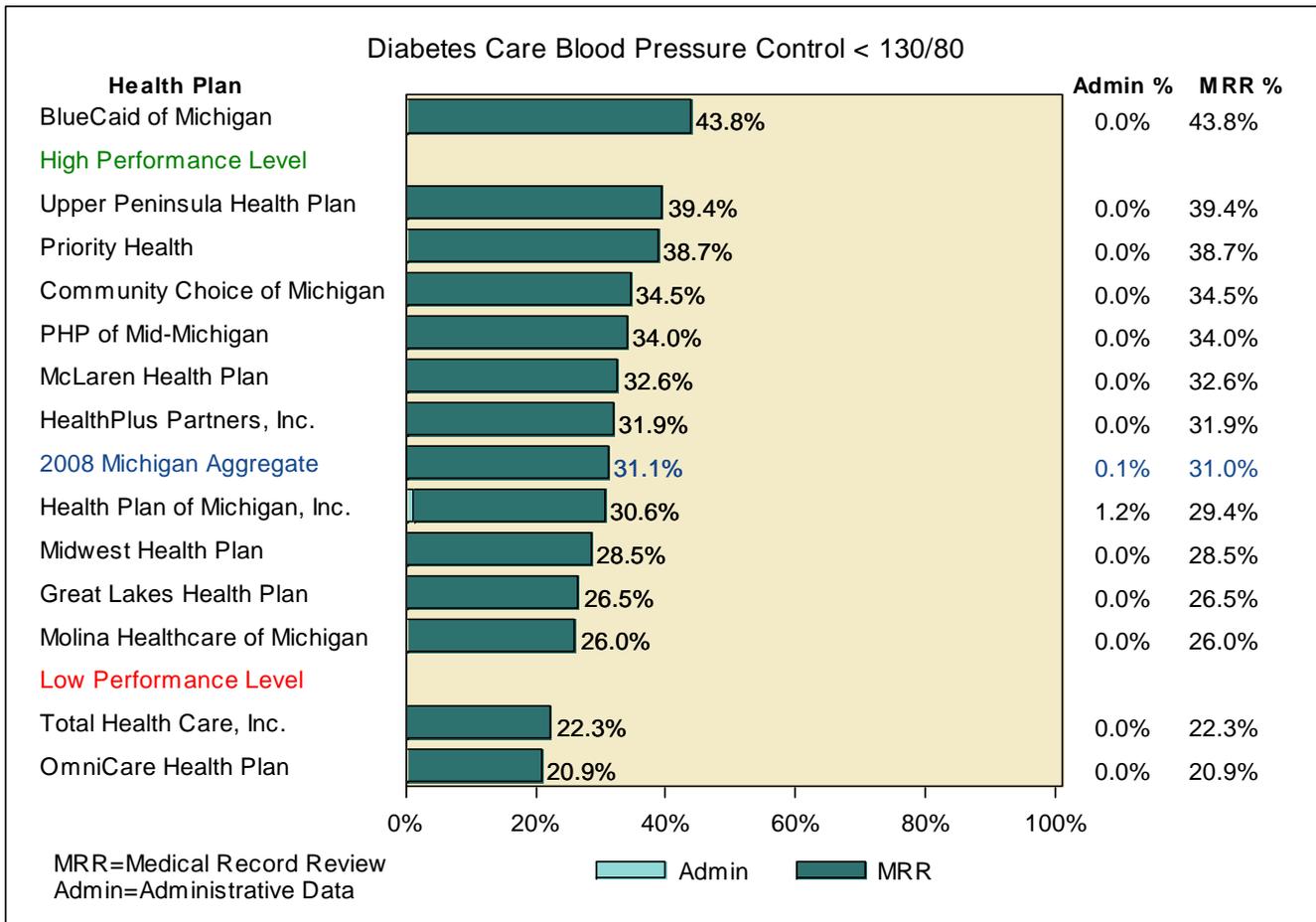
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg) was a new measure in 2007; therefore, 2008 was the first year that national performance data were available for comparison.

One health plan reported a rate above the HPL of 41.4 percent and two of the health plans reported rates below the LPL of 25.1 percent. Eight health plans, including the one above the HPL, had rates that exceeded the national HEDIS 2007 Medicaid 50th percentile.

The 2008 Michigan Medicaid weighted average of 28.6 percent was 0.8 of a percentage point below the 2007 weighted average and 2.0 percentage points below the national HEDIS 2007 Medicaid 50th percentile. This indicates an opportunity for improvement.

Data Collection Analysis: Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)

**Figure 5-16—Michigan Medicaid HEDIS 2008
Data Collection Analysis:
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)**



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

All of the health plans elected to use the hybrid method for reporting this measure. The 2008 Michigan aggregate administrative rate was 0.1 percent and the medical record review rate was 31.0 percent.

Overall for the aggregate rate, 0.3 of a percentage point was derived from administrative data and 99.7 percent was from medical record review.

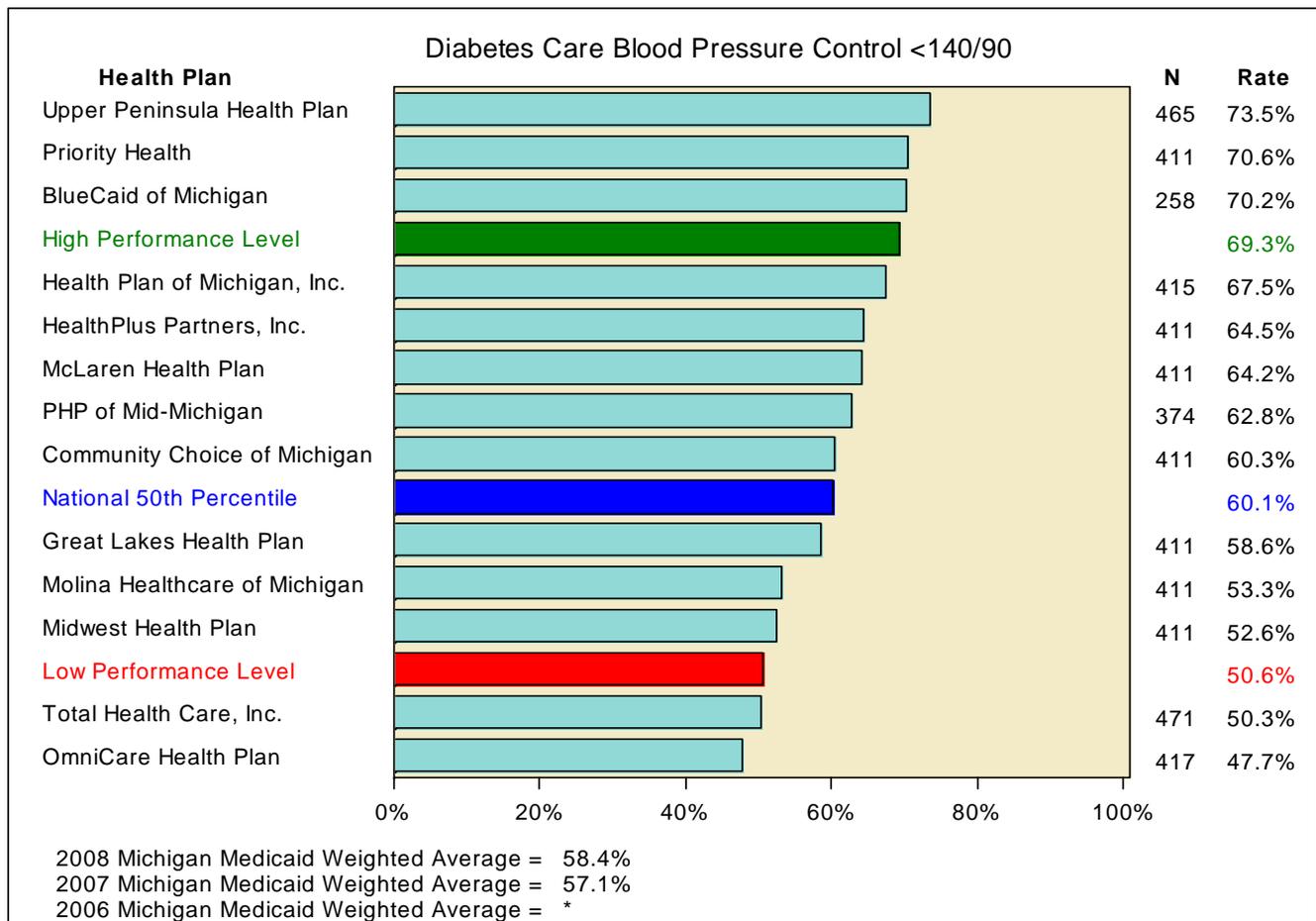
All health plans derived more than 95 percent of their rates from medical record review data. This measure relied heavily on medical record review.

HEDIS Specification: Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)

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

Health Plan Ranking: Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)

**Figure 5-17—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)**



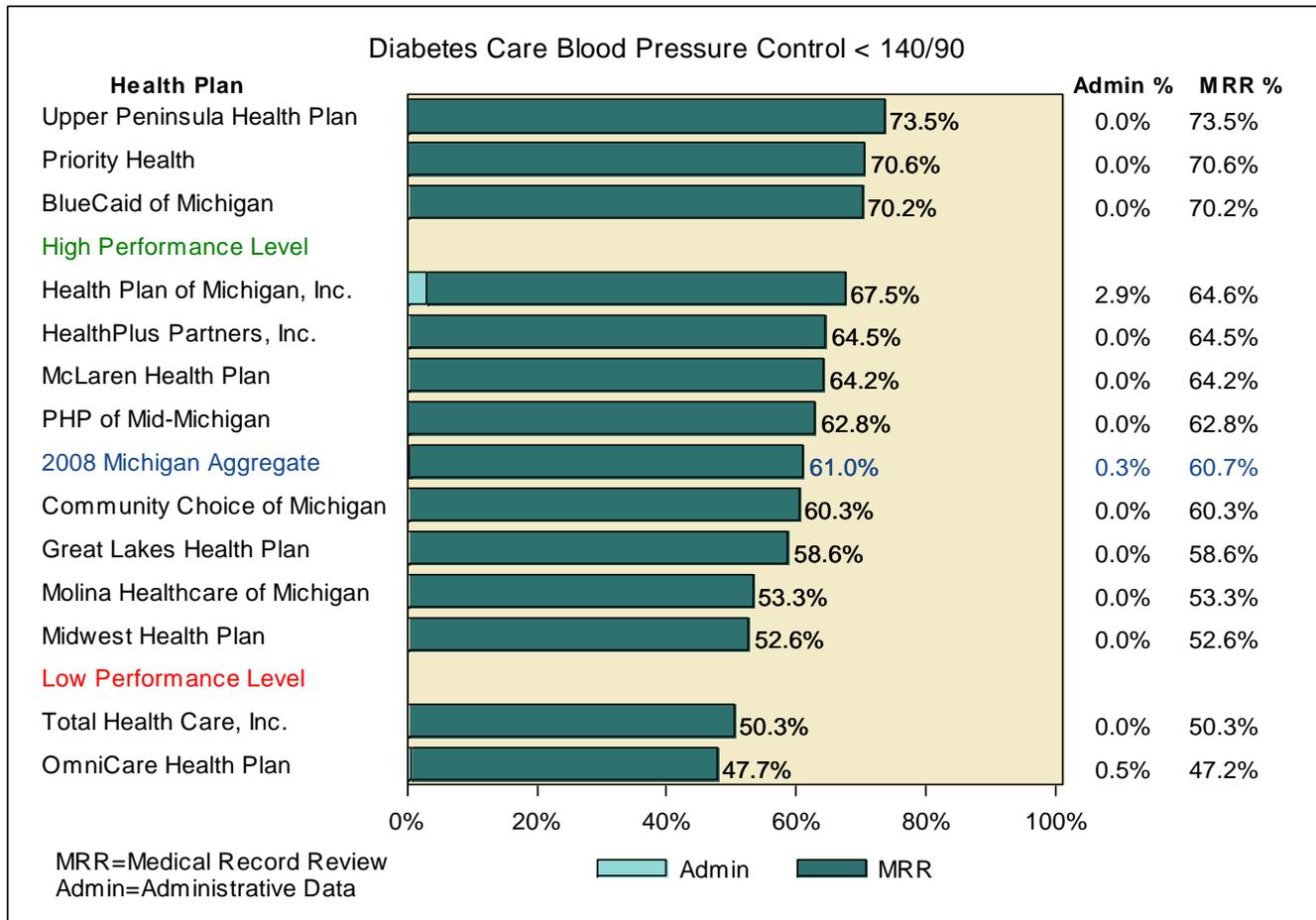
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) was a new measure in 2007; therefore, 2008 was the first year that national performance data were available for comparison.

Three health plans reported rates above the HPL of 69.3 percent, and two health plans reported rates below the LPL of 50.6 percent. Eight health plans, including the three above the HPL, had rates that exceeded the national HEDIS 2007 Medicaid 50th percentile.

The 2008 Michigan Medicaid weighted average of 58.4 percent was 1.3 percentage points above the 2007 weighted average and 1.7 percentage points below the national HEDIS 2007 Medicaid 50th percentile. This indicates an opportunity for improvement.

Data Collection Analysis: Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)

**Figure 5-18—Michigan Medicaid HEDIS 2008
Data Collection Analysis:
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)**



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

All of the health plans elected to use the hybrid method for reporting this measure. The 2008 Michigan aggregate administrative rate was 0.3 percent and the medical record review rate was 60.7 percent.

Overall, 0.5 percent of the aggregate rate was derived from administrative data and 99.5 percent was from medical record review.

This measure relied heavily on medical record review, and all health plans derived more than 95 percent of their rates from medical record review data.

Use of Appropriate Medications for People With Asthma

In 2006, asthma accounted for more than 10.5 million visits to office-based physicians, 6.3 million visits to hospital outpatient departments, and 217,000 million visits to emergency departments (EDs) in the United States.⁵⁻³² Asthma is one of the most common chronic conditions in both children and adults, affecting approximately 6 million children and 16 million adults.⁵⁻³³ The asthma prevalence rate reported for adults in Michigan during 2005 was 9.1 percent, while the national rate was 8.0 percent.⁵⁻³⁴ Lack of asthma management frequently results in hospitalizations, ED 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). This measure also requires that members be identified as having persistent asthma, 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 acute inpatient discharge 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 in this numerator.⁵⁻³⁵

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

⁵⁻³² Centers for Disease Control and Prevention. National Center for Health Statistics: Asthma. Available at: <http://www.cdc.gov/nchs/FASTATS/asthma.htm>. Accessed on October 6, 2008.

⁵⁻³³ National Heart, Lung, and Blood Institute. Who Is At Risk for Asthma? Available at: http://www.nhlbi.nih.gov/health/dci/Diseases/Asthma/Asthma_WhoIsAtRisk.html. Accessed on October 6, 2008.

⁵⁻³⁴ American Lung Association Epidemiology & Statistics Unit. Trends in Asthma Morbidity and Mortality. Available at: <http://www.lungusa.org/atf/cf/%7B7A8D42C2-FCCA-4604-8ADE-7F5D5E762256%7D/ASTHMA06FINAL.PDF>. Accessed on October 6, 2008.

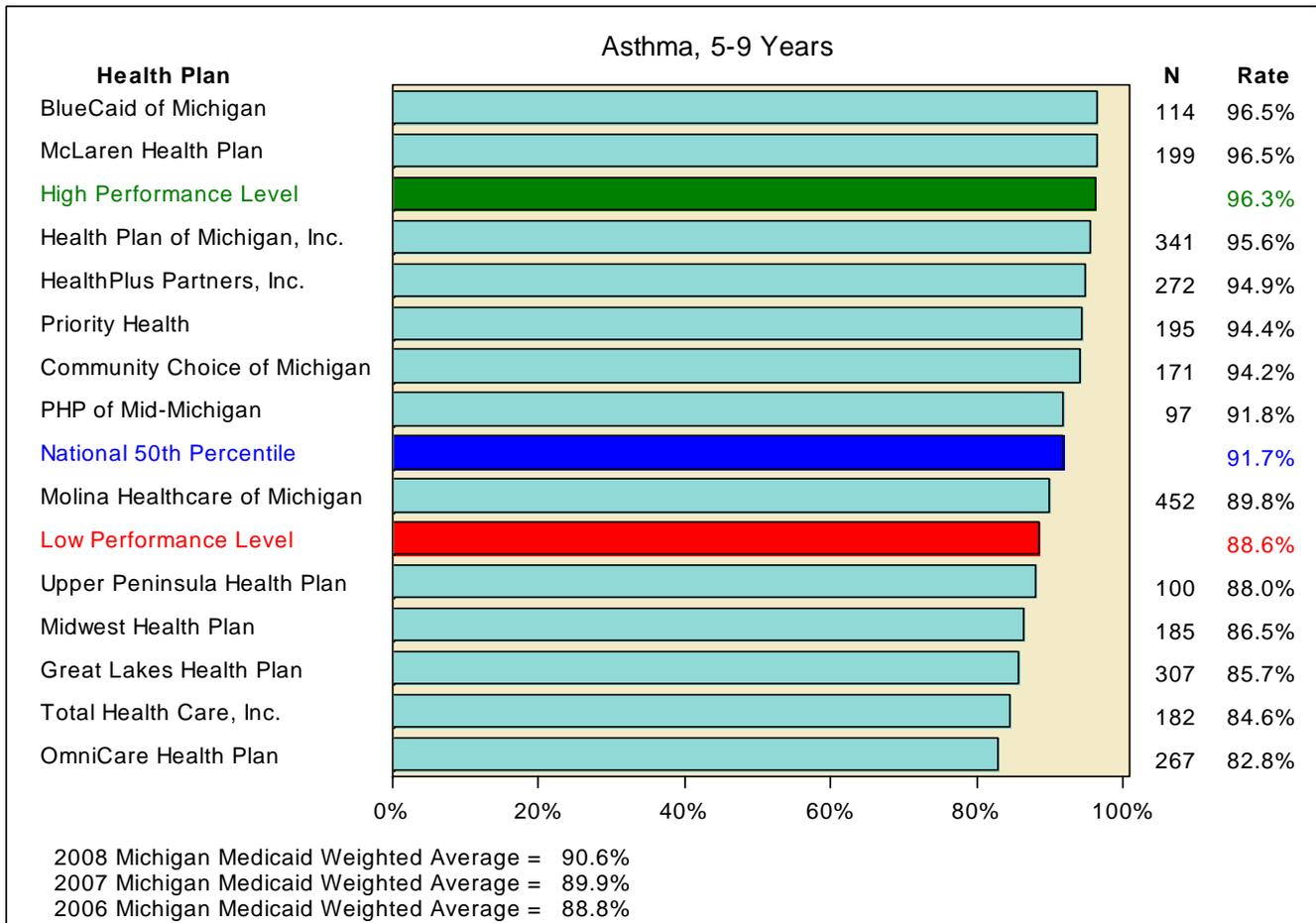
⁵⁻³⁵ National Committee for Quality Assurance. *HEDIS 2007 Technical Specifications*. Volume 2. Washington, DC: National Committee for Quality Assurance; 2006.

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

The *Use of Appropriate Medications for People With Asthma—5 to 9 Years* rate calculates the percentage of members 5 through 9 years of age 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 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—5 to 9 Years

**Figure 5-19—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—5 to 9 Years**



Two health plans reported rates above the HPL of 96.3 percent and five health plans had rates below the LPL of 88.6 percent. Seven health plans, including the two above the HPL, reported rates above the national HEDIS 2007 Medicaid 50th percentile.

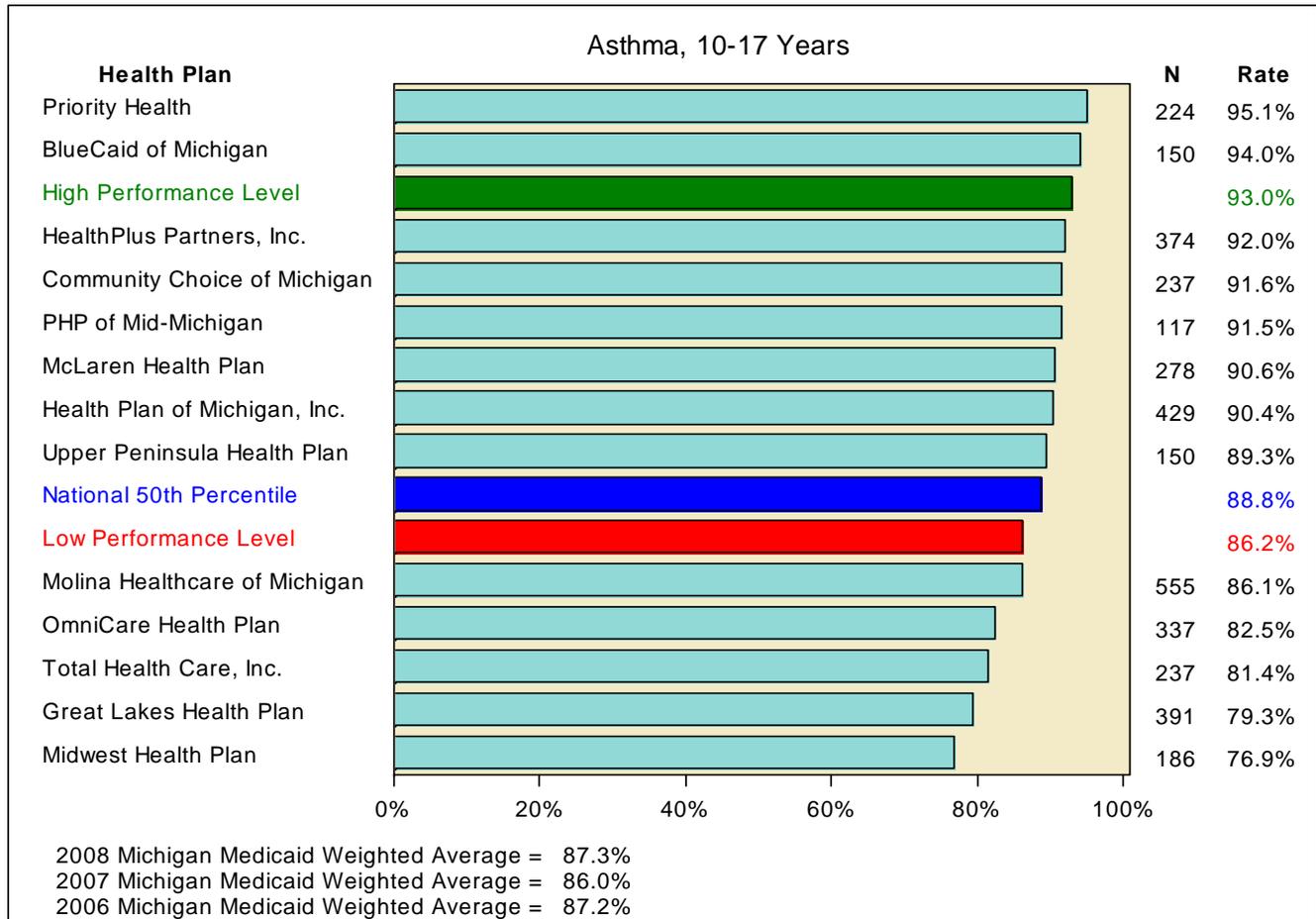
The 2008 Michigan Medicaid weighted average of 90.6 percent was 1.1 percentage points below the national HEDIS 2007 Medicaid 50th percentile of 91.7 percent. However, the 2008 Michigan Medicaid weighted average did increase by 0.7 of a percentage point above the 2007 weighted average of 89.9 percent.

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

The rate for *Use of Appropriate Medications for People With Asthma—10 to 17 Years* calculates the percentage of members 10 through 17 years of age 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—10 to 17 Years

**Figure 5-20—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—10 to 17 Years**



Two health plans reported rates above the HPL of 93.0 percent and five health plans had rates below the LPL of 86.2 percent. Eight health plans, including the two above the HPL, reported rates above the national HEDIS 2007 Medicaid 50th percentile.

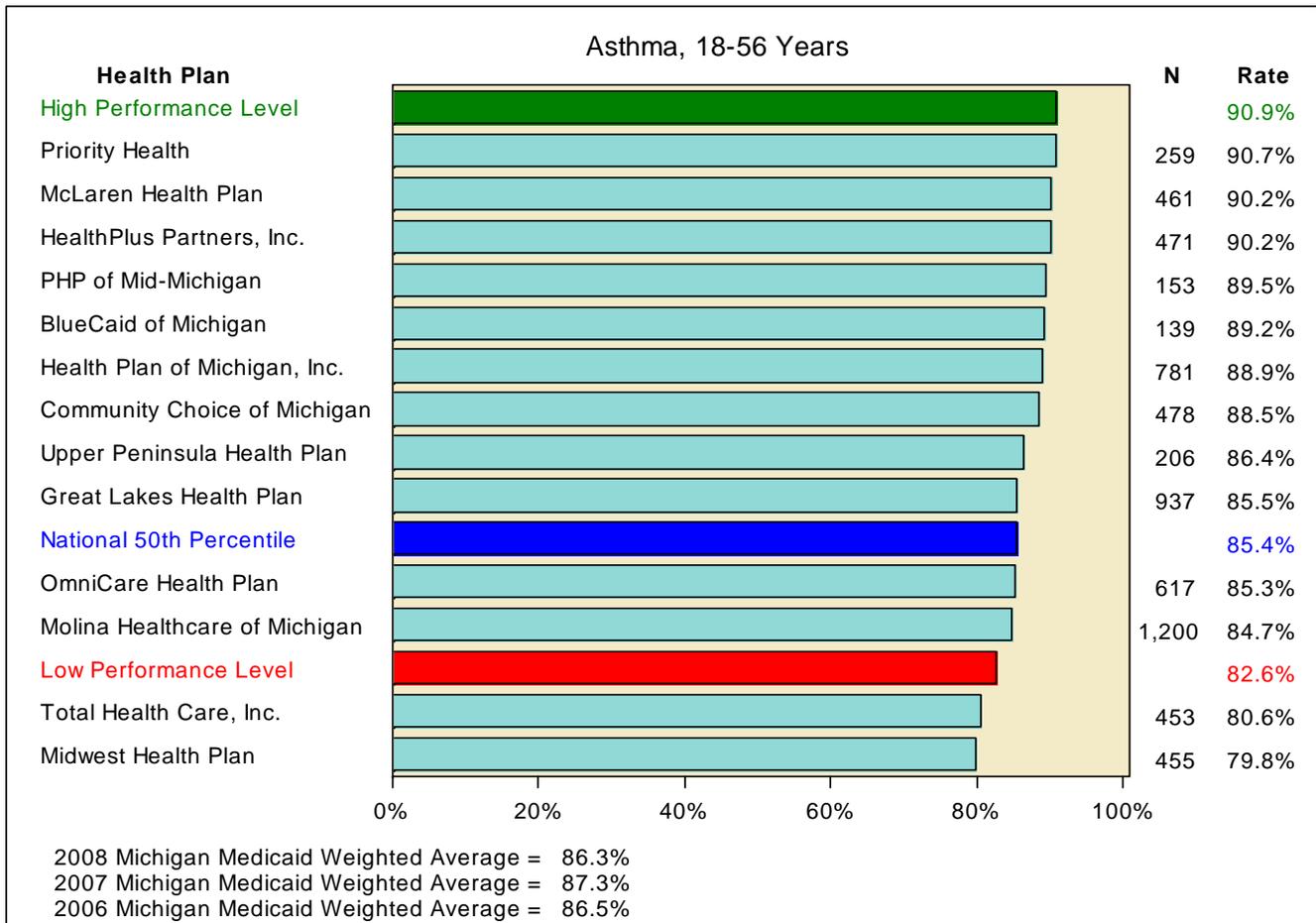
The 2008 Michigan Medicaid weighted average of 87.3 percent was 1.5 percentage points below the national HEDIS 2007 Medicaid 50th percentile of 88.8 percent; however, it was 1.3 percentage points above the 2007 weighted average of 86.0 percent.

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

Use of Appropriate Medications for People With Asthma—18 to 56 Years measures the percentage of members 18 through 56 years of age 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—18 to 56 Years

**Figure 5-21—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—18 to 56 Years**



No health plans reported rates above the HPL of 90.9 percent and two health plans had rates below the LPL of 82.6 percent. Nine health plans reported rates above the national HEDIS 2007 Medicaid 50th percentile.

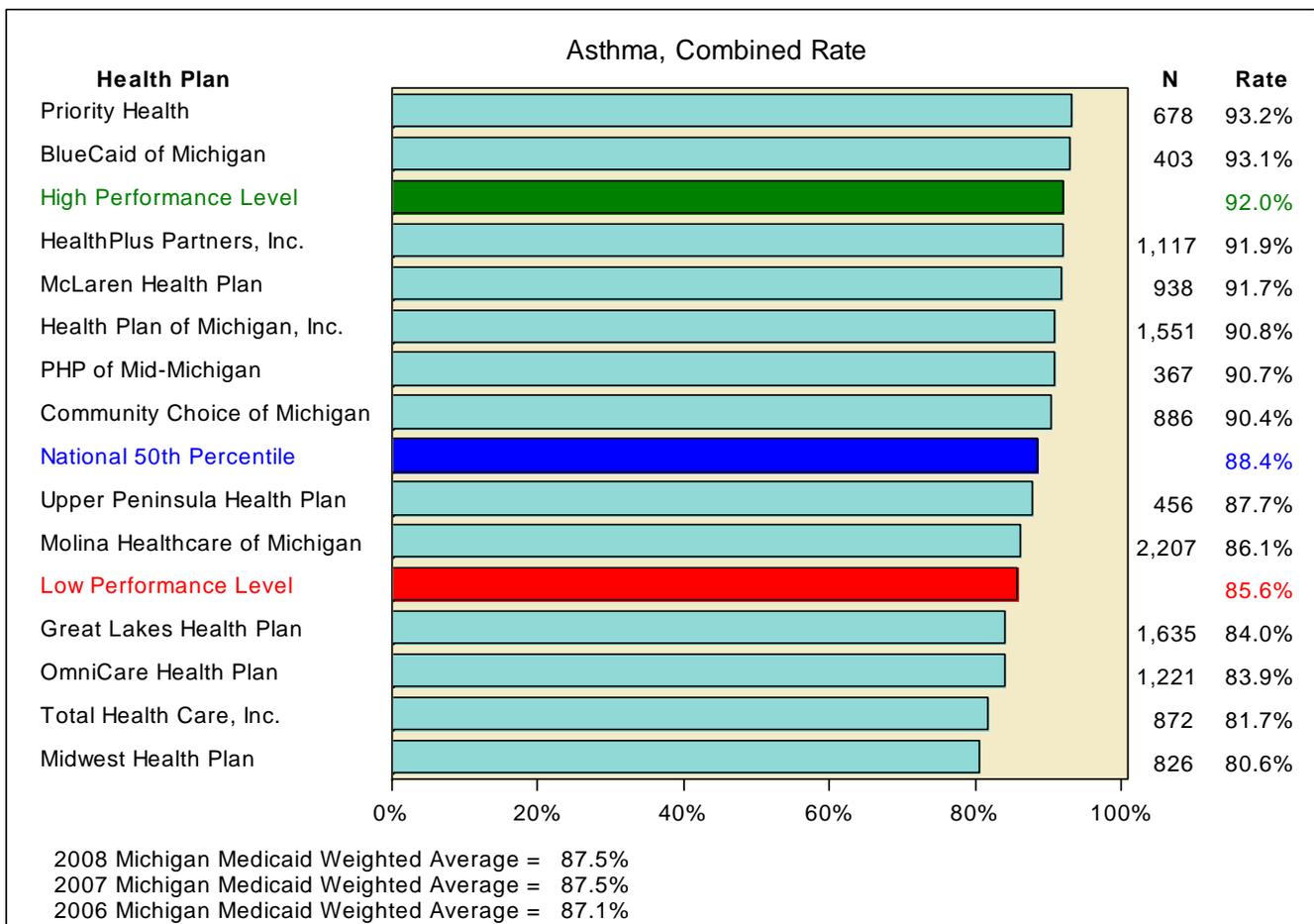
The 2008 Michigan Medicaid weighted average of 86.3 percent was 0.9 percentage points above the national HEDIS 2007 Medicaid 50th percentile of 85.4 percent. The 2008 Michigan Medicaid weighted average decreased by 1.0 percentage point below the 2007 weighted average of 87.3 percent.

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 5-22—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—Combined Rate**



Two health plans reported rates above the HPL of 92.0 percent, and four health plans had rates below the LPL of 85.6 percent. Seven health plans, including the two above the HPL, reported rates above the national HEDIS 2007 Medicaid 50th percentile.

While the Michigan Medicaid weighted averages in 2007 and 2008 were the same, the 2008 weighted average of 87.5 percent was 0.9 of a percentage point below the national HEDIS 2007 Medicaid 50th percentile of 88.4 percent.

Controlling High Blood Pressure

About one of every three U.S. residents has high blood pressure, which is also referred to as hypertension.⁵⁻³⁶ Although effective treatment options are available, 65 percent of Americans with the condition are untreated or undertreated. Antihypertensive therapy can reduce the incidence of strokes by 35 to 40 percent, and can reduce heart attacks by 20 to 25 percent.⁵⁻³⁷ In 2007, 29 percent of Michigan adults reported ever having been told by a physician that they had high blood pressure; Michigan ranked 17th worst in the country in terms of high blood pressure prevalence in 2007.⁵⁻³⁸

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

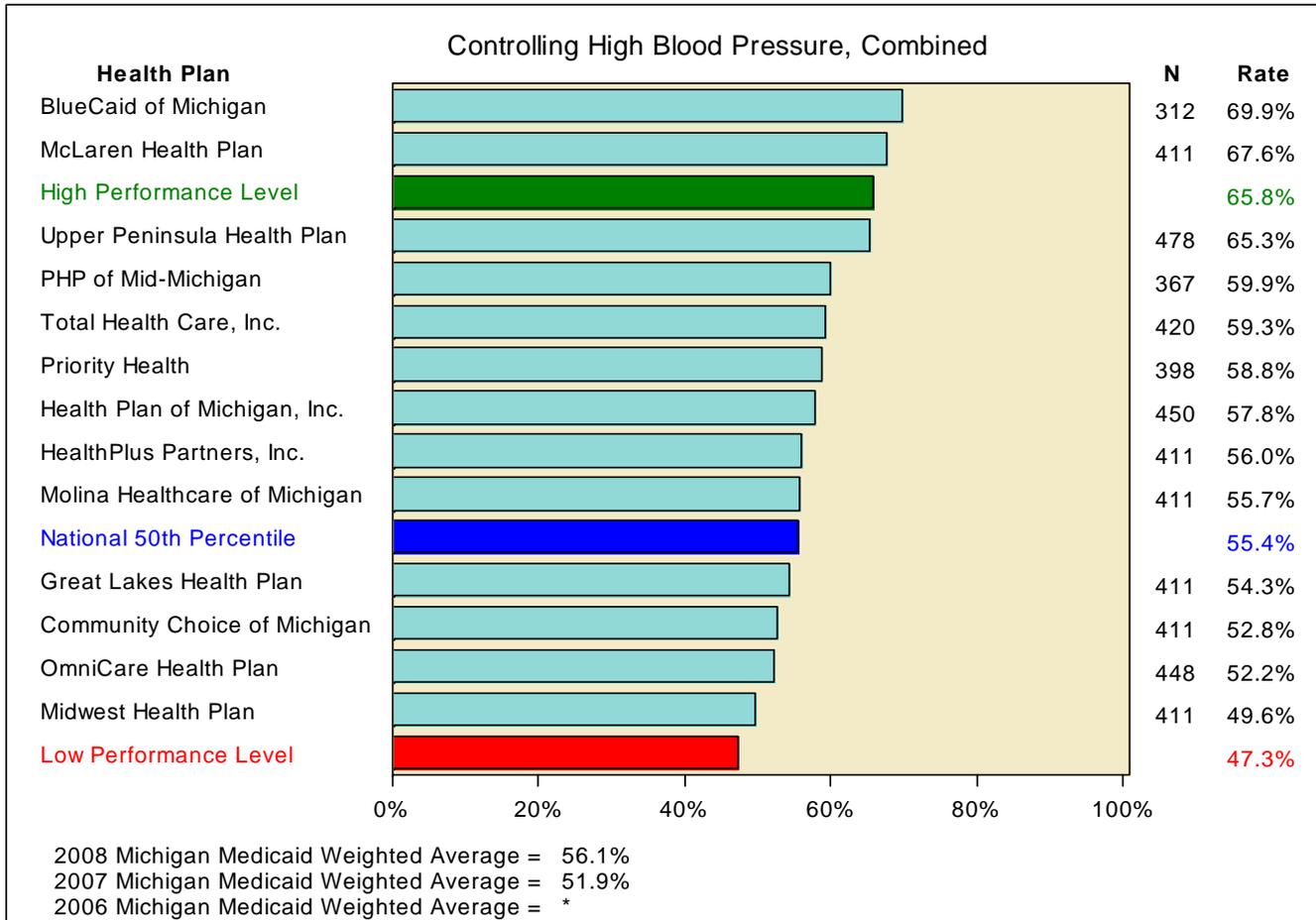
⁵⁻³⁶ National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed on October 6, 2008.

⁵⁻³⁷ Ibid.

⁵⁻³⁸ Michigan Department of Community Health. Impact of Heart Disease and Stroke in Michigan: 2008 Report on Surveillance. Available at: http://www.michigan.gov/documents/mdch/Impact_complete_report_245958_7.pdf. Accessed on October 6, 2008.

Health Plan Ranking: Controlling High Blood Pressure

**Figure 5-23—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Controlling High Blood Pressure—Combined Rate**



Controlling High Blood Pressure was considered a new measure for 2007 because the lower age span decreased; therefore, 2008 was the first year that national performance data are available for comparison.

Two health plans reported rates above the HPL of 65.8 percent and no health plans had rates below the LPL of 47.3 percent. Nine health plans, including the two above the HPL, reported rates above the national HEDIS 2007 Medicaid 50th percentile.

The 2008 Michigan Medicaid weighted average of 56.1 percent was 0.7 of a percentage point above the national HEDIS 2007 Medicaid 50th percentile of 55.4 percent. The 2008 Michigan Medicaid weighted average increased by 4.2 percentage points over the 2007 weighted average of 51.9 percent.

Medical Assistance With Smoking Cessation

Approximately 45.3 million adults in the United States were smokers in 2006.⁵⁻³⁹ Excluding adult deaths due to secondhand smoke, males and females lost an average of 13.2 and 14.5 years of life, respectively, from smoking. Discontinuing the use of tobacco is the most cost-effective method of preventing disease in adults. Investing adequately on comprehensive tobacco control programs would result in proportionately greater reductions in smoking among the various states. In fact, if states were to sustain their individual levels of investment for five years as recommended by the CDC, there would be an estimated 5 million fewer smokers nationwide and hundreds of thousands of premature tobacco-related deaths might be prevented.⁵⁻⁴⁰

Michigan's smoking rate has shown a slight decrease recently; data show that 21.2 percent of adults were cigarette users in 2007, compared to 22.4 percent in 2006.⁵⁻⁴¹ In 2007, the 18-to-24-year-old age group had the highest rate at 29.0 percent, followed by the 25-to-34-year-old age group at 28.5 percent. The smoking rate for all U.S. adults was 19.7 percent in 2006.⁵⁻⁴²

“Tobacco-Free Michigan” is a five-year strategic plan that is focused on preventing tobacco use in the state. The plan has established goals in four different areas: identify and eliminate disparities in tobacco use, eliminate exposure to secondhand smoke, increase cessation among adults and youth, and prevent youth tobacco-use initiation.⁵⁻⁴³ Through the first four years of the plan, several goals have been achieved, such as the passage of smoke-free worksite regulations and ordinances in 18 Michigan counties and four cities, and the implementation of tobacco-free policies for buildings and campuses in more than 56 percent of Michigan's public schools.⁵⁻⁴⁴

Many smokers are unable to quit, even when they are educated about the negative health effects of smoking and informed that eliminating tobacco is the most important step they can take to improve their health. However, advising a patient to quit smoking is a cost-effective intervention that does increase the chances that the patient will quit. It is now recommended that a combination of tobacco dependence counseling and medication treatment be used by clinicians to assist smokers in their efforts to quit smoking. These new guidelines can be found in the *Treating Tobacco Use and Dependence: 2008 Update*, a Public Health Service-sponsored Clinical Practice Guideline.⁵⁻⁴⁵

⁵⁻³⁹ American Lung Association. Trends in Tobacco Use. Available at: http://www.lungusa.org/atf/cf/%7B7a8d42c2-fcca-4604-8ade-7f5d5e762256%7D/TREND_TOBACCO_JULY_08.PDF. Accessed on October 6, 2008.

⁵⁻⁴⁰ Centers for Disease Control and Prevention. Preventing Tobacco Use. August 2005. Available at: <http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/pdf/tobacco.pdf>. Accessed on October 6, 2008.

⁵⁻⁴¹ Centers for Disease Control and Prevention. State Tobacco Activities Tracking and Evaluation (STATE) System. Available at: http://apps.nccd.cdc.gov/statesystem/statesystem.aspx?selectedTopic=999&selectedMeasure=999&dir=epi_report&ucName=UCSummary. Accessed on October 6, 2008.

⁵⁻⁴² Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System (BRFSS). Available at: <http://www.cdc.gov/brfss/>. Accessed on October 6, 2008.

⁵⁻⁴³ Tobacco-Free Michigan. A Five-Year Strategic Plan for Tobacco Use Prevention and Reduction. Available at: <http://www.tobaccofreemichigan.org/pdf/TobaccoFree5YrStrategicPlan.pdf>. Accessed on October 7, 2008.

⁵⁻⁴⁴ Ibid.

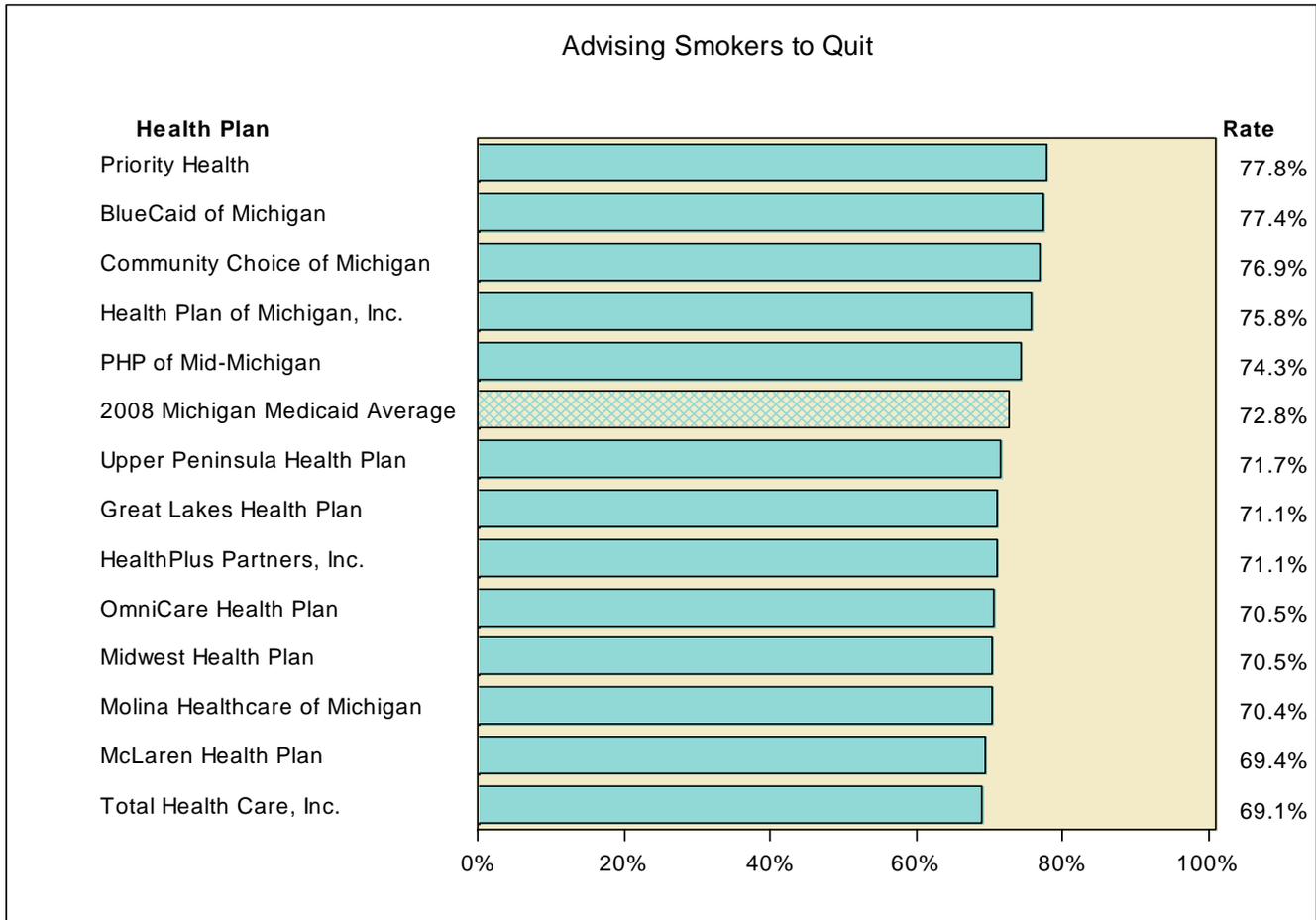
⁵⁻⁴⁵ National Library of Medicine. AHCPR Supported Clinical Practice Guidelines: Treating Tobacco Use and Dependence: 2008 Update. Available at: <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.section.28165>. Accessed on December 17, 2008.

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 18 years of age or older who were continuously enrolled during the last six months of the measurement year, who were smokers, who were seen by an MHP practitioner in the six months prior to completing the CAHPS survey, and who received advice to quit smoking in the six months prior to completing the CAHPS survey.

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

**Figure 5-24—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Medical Assistance with Smoking Cessation—Advising Smokers to Quit**



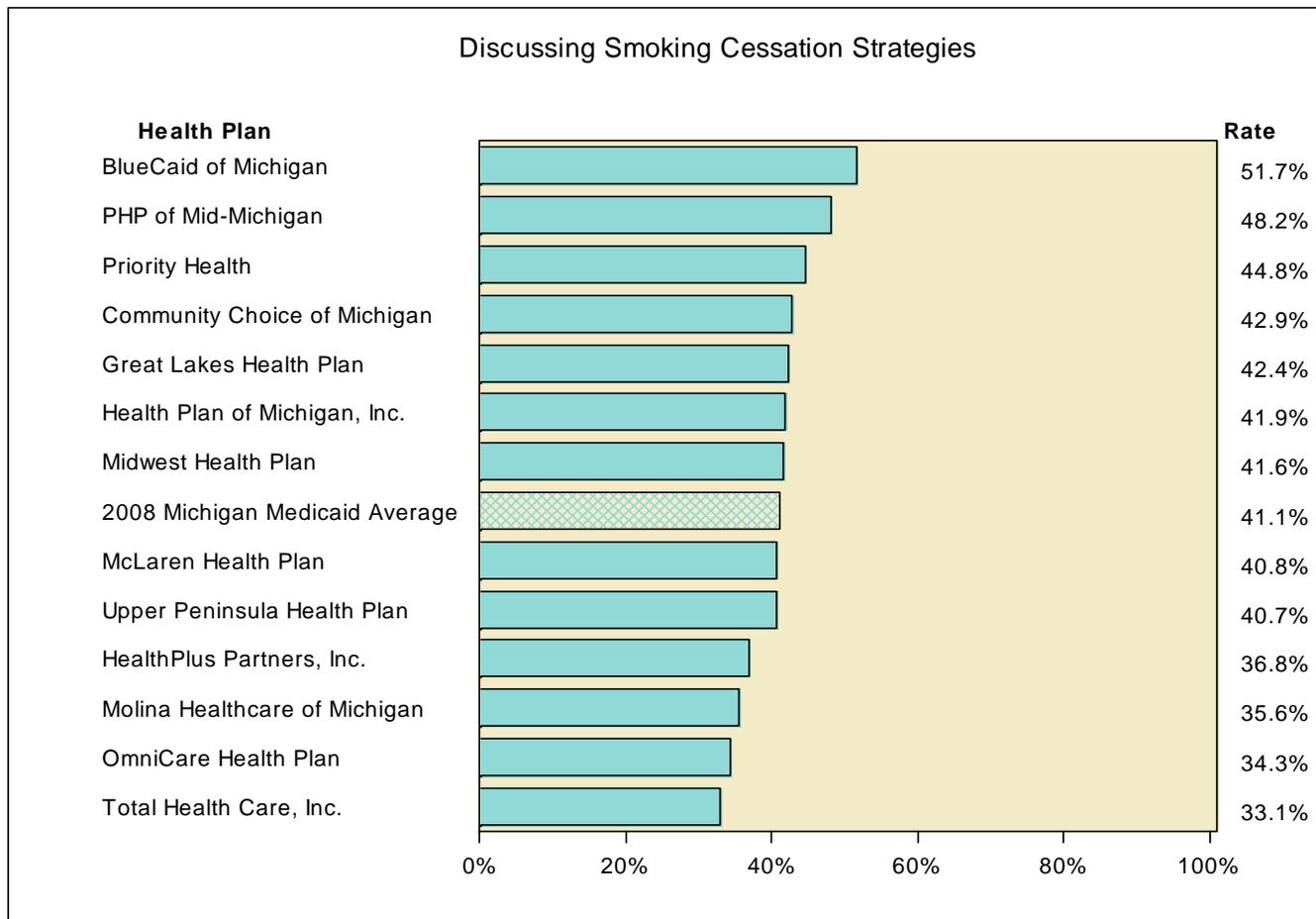
For this measure, five of the 13 health plans had rates above the 2008 Michigan Medicaid average of 72.8 percent. The 2008 Michigan Medicaid average increased 0.7 of a percentage point when compared to the 2007 average of 72.1 percent. In 2007, six of the health plans reported rates above the 2007 Michigan Medicaid average.

The rates reported by the 13 health plans ranged from 69.1 percent to 77.8 percent. The range of reported rates showed some improvement from 2007 to 2008.

HEDIS Specification—Discussing Smoking Cessation Strategies

The *Medical Assistance With Smoking Cessation* measure is collected using the CAHPS survey. *Discussing Smoking Cessation Strategies* is another component (or rate) reported for the measure. *Discussing Smoking Cessation Strategies* calculates the percentage of members 18 years of age or older who were continuously enrolled during the last six months of the measurement year, who were smokers, who were seen by an MHP practitioner in the six months prior to completing the CAHPS survey, and for whom smoking cessation medications were recommended or discussed.

**Figure 5-25—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Medical Assistance with Smoking Cessation—Discussing Smoking Cessation Strategies**



For this measure, seven of the 13 health plans had rates above the 2008 Michigan Medicaid average of 41.1 percent. The 2008 Michigan Medicaid average increased 3.0 percentage points when compared to the 2007 average of 38.1 percent. In 2007, five of the health plans reported rates above the 2007 Michigan Medicaid average.

In 2008 the rates reported by the 13 health plans ranged from 33.1 percent to 51.7 percent, while the range was from 30.9 percent to 48.8 percent in 2007.

Living With Illness Findings and Recommendations

All of the 2008 weighted averages in the Living With Illness dimension of care showed improvement compared to the 2007 rates, with the exception of the rates for *Comprehensive Diabetes Care—Blood Pressure Control <130/80* and *Use of Appropriate Medications for People with Asthma—18 to 56 Years*. While these two rates dropped, the decline was only 1 percent or less for both measures. One measure, *Comprehensive Diabetes Care—HbA1c Testing*, showed statistically significant improvement from 2007. While performance improved for the most part across all of these measures, improvement opportunities still exist.

Performance among the *Comprehensive Diabetes Care* measures showed improvement for all measures except one, with increases in the weighted averages ranging from 0.9 of a percentage point to 5.3 percentage points. Significant improvement was seen in the *HbA1c Testing* measure, and both this measure and the *Good Control* measure ranked above the 75th percentile. The *HbA1c Poor Control* measure rate decreased by 5.3 percentage points, which is good since a lower rate for this measure indicates better performance. *Eye Exams* and *Medical Attention for Diabetic Nephropathy* both ranked above the 50th percentile. The *LDL-C Screening* and *LDL-C Control* measures' rates both improved when compared to the 2007 rates, and these rates ranked above the 50th and 75th percentiles, respectively. The year 2008 was the first year the MHPs reported the *Blood Pressure Control* measures, and both of these weighted averages ranked below the 50th percentile. Similar to what was seen for the Pediatric and Women's Care measures, the MHPs have been relying less on medical record review for reporting the measures for *Comprehensive Diabetes Care*, with the exception of the *Blood Pressure Control* measures, which are reported only through medical record review.

The rates for the *Use of Appropriate Medications for People With Asthma* all ranked below the national HEDIS 2007 Medicaid 50th percentile except in the age span of 18 to 56 years. The MHP specific rates for the *Combined* measure ranged from 80.6 percent to 93.2 percent. Four MHPs ranked below the LPL and two MHPs ranked above the HPL.

The *Controlling High Blood Pressure* measure was reported only as a *Combined* rate for 2008. The weighted average for this measure improved by 4.2 percentage points when compared to last year's rate. No MHP ranked below the LPL and two MHPs ranked above the HPL.

National means and percentile data are not available for benchmarking the *Medical Assistance to Smoking Cessation* measures. The 2008 Michigan Medicaid average of 72.8 percent for the *Advising Smokers to Quit* measure improved by 0.7 of a percentage point from 2007 and the rates for the MHPs ranged from 69.1 percent to 77.8 percent. The rates for the *Discussing Smoking Cessation Strategies* measure ranged from 33.1 percent to 51.7 percent and the 2008 Michigan Medicaid average of 41.1 percent improved by 3.0 percentage points over the 2007 rate.

Areas to focus improvement efforts for the Living With Illness measures include:

- ◆ Working with vendors (i.e. laboratory and pharmacy) to ensure that data are complete. Several of the measures in this dimension of care rely on data from vendors. If the MHPs can work to ensure these data are complete and accurate, this will only enhance their rates.

- ◆ Continue to focus efforts on improving administrative data completeness. The more data that can be obtained administratively reduces the burden of medical record review and frees up resources to be redirected at other activities.
- ◆ Consider creating case management registry to access information such as laboratory screening and results data, most recent blood pressure results, and pharmacy data.
- ◆ Provide incentives to providers who meet performance thresholds on HEDIS measures.

Introduction

Access to care is an essential component of the effort to diagnose and treat health problems, and to increase the quality and duration of healthy life. Establishing a relationship with a primary care practitioner is necessary to improve access to care for both adults and children. To increase access to quality care, the public health system, health plans, and health care researchers focus on identifying barriers to existing health services and eliminating disparities. Through this process, health plans can increase preventive care and successful disease management.

The Center for Studying Health System Change (HSC) reported an increase in access to needed medical care from 2001 to 2003 among Americans.⁶⁻¹ Statistics regarding access to care often vary considerably by race. The CDC reports that during 2005, visits to office-based physicians were higher for white persons compared with black and Hispanic persons (355.3 versus 243.4 and 234.5 per 100 persons, respectively).⁶⁻² The visit rate for Asians was 263.6 visits per 100 persons.

The type of insurance coverage (or lack of insurance) has a significant impact on the ability to obtain timely access to care. Individuals with Medicaid coverage were less likely to receive an appointment than those with private coverage (34.2 percent for Medicaid compared with 63.3 percent for private insurance).⁶⁻³

The following pages provide detailed analysis of the Michigan MHPs' 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.

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, 2008.

⁶⁻² Centers for Disease Control and Prevention. National Ambulatory Medical Care Survey: 2005 Summary. Available at: <http://www.cdc.gov/nchs/data/ad/ad387.pdf>. Accessed on October 7, 2008.

⁶⁻³ 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, 2008.

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

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

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

Children and Adolescents' Access to Primary Care Practitioners

The *Children 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 of age.

According to a report from The Commonwealth Fund, Michigan ranks third in the country in terms of best access to care for children.⁶⁻⁴ One important component in this ranking is insurance coverage, and the report found that only 5 percent of Michigan children were uninsured.

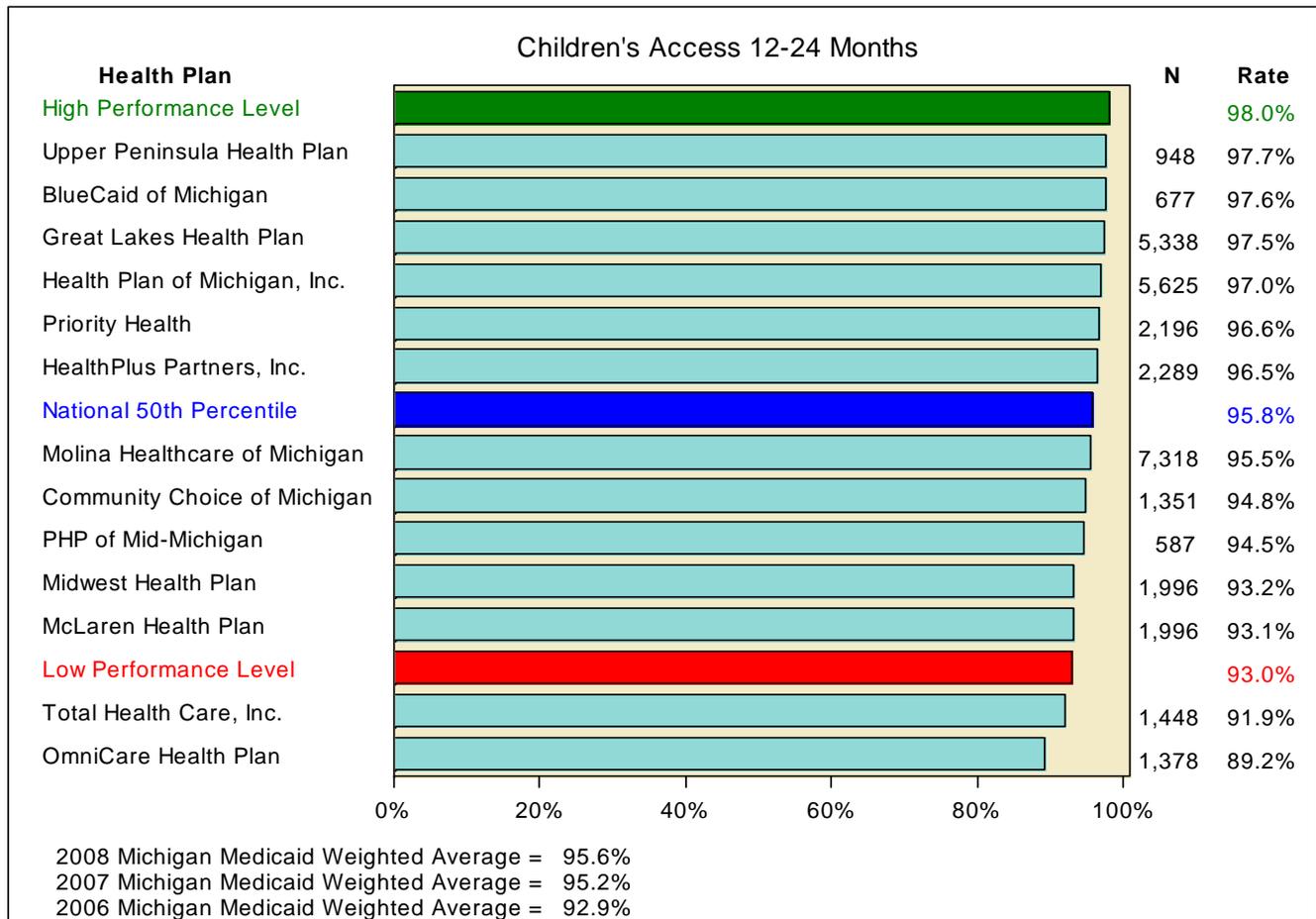
HEDIS Specification: Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months

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

⁶⁻⁴ The Commonwealth Fund. U.S. Variations in Child Health System Performance: A State Scorecard. Available at: http://www.commonwealthfund.org/usr_doc/Shea_Child_Health_rev_6-6-08_optimized.pdf?section=4039. Accessed on October 7, 2008.

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

**Figure 6-1—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months**



Six of the 13 health plans reported rates above the national HEDIS 2007 Medicaid 50th percentile of 95.8 percent and two of the health plans reported rates below the LPL of 93.0 percent.

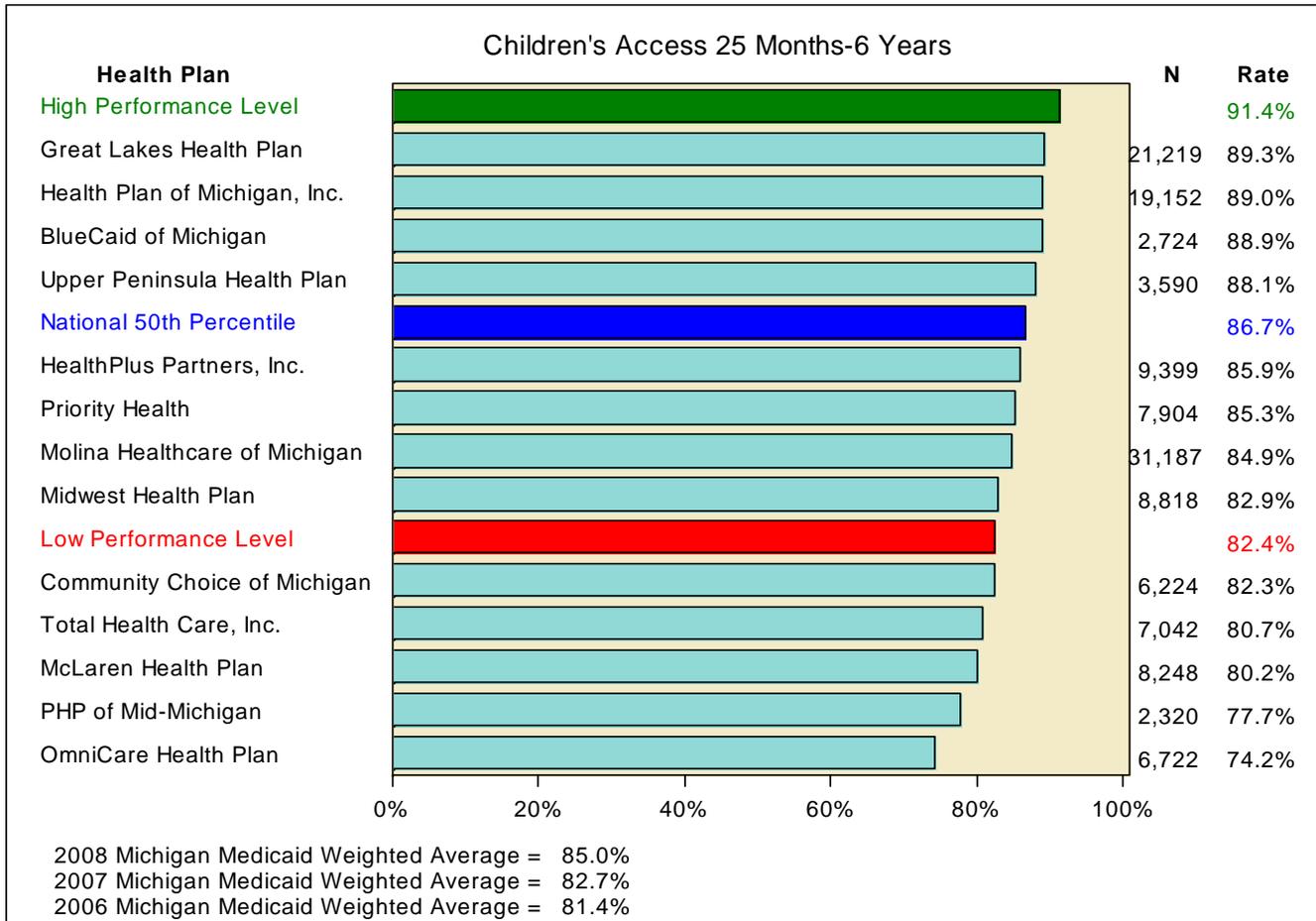
The 2008 Michigan Medicaid weighted average of 95.6 percent improved by 0.4 percentage points compared to 2007. However, unlike last year, the rate fell below the national HEDIS 2007 Medicaid 50th percentile by 0.2 percentage points due to the increase in the national HEDIS Medicaid 50th percentile.

HEDIS Specification: Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years

Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years reports the percentage of members 25 months to 6 years of age 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 and Adolescents' Access to Primary Care Practitioners
—25 Months to 6 Years**

**Figure 6-2—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years**



None of the health plans exceeded the HPL of 91.4 percent, while five health plans reported rates below the LPL of 82.4 percent. Four health plans did, however, exceed the national HEDIS 2007 Medicaid 50th percentile of 86.7 percent.

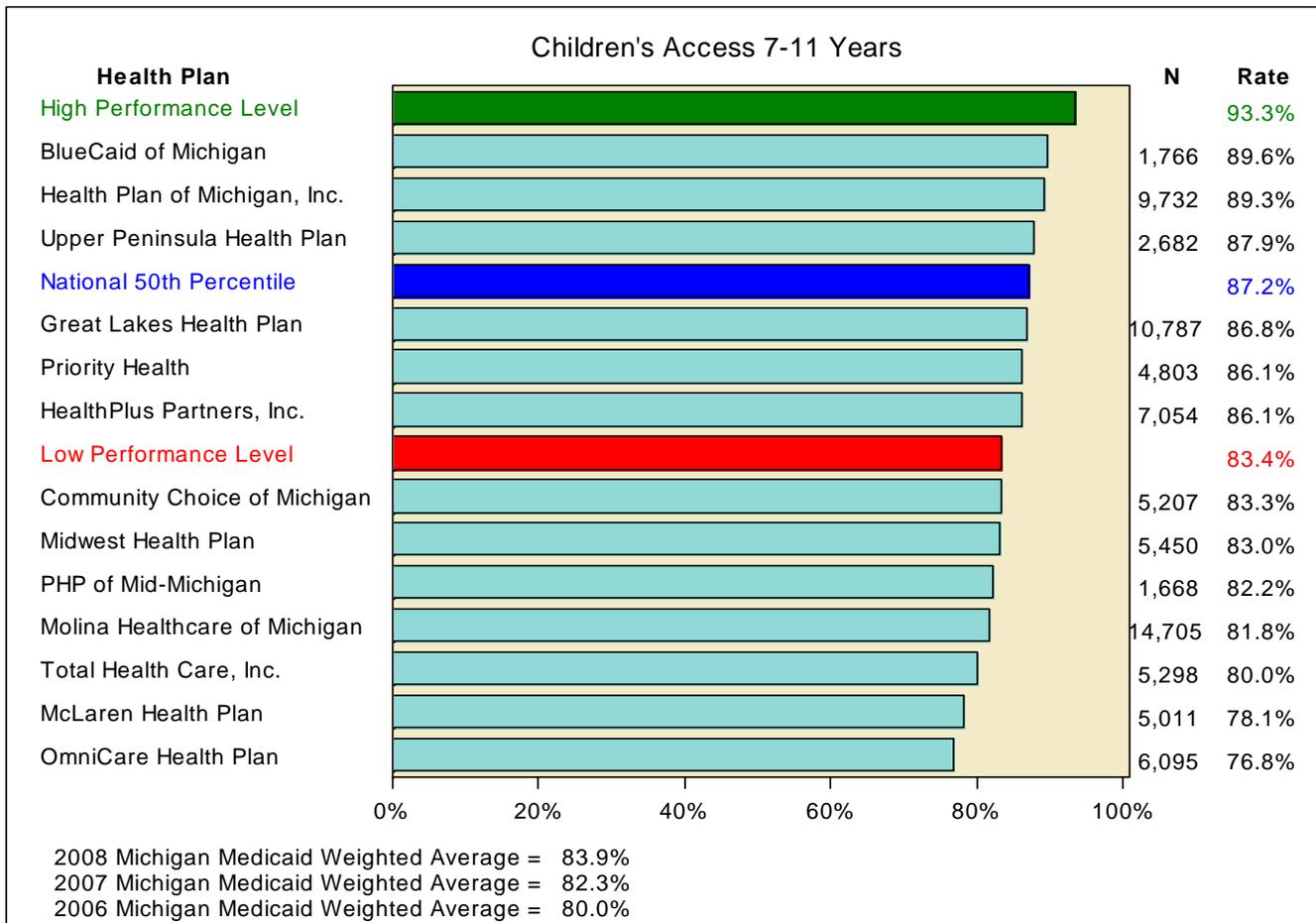
The 2008 Michigan Medicaid weighted average of 85 percent fell below the national HEDIS 2007 Medicaid 50th percentile by 1.7 percentage points. However, the Michigan Medicaid weighted average increased by 2.3 percentage points from 2007 to 2008. A gain of 3.6 percentage points was observed when the 2008 weighted average was compared with the 2006 weighted average.

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

Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years reports the percentage of members 7 to 11 years of age 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 and Adolescents' Access to Primary Care Practitioners
—7 to 11 Years**

**Figure 6-3—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years**



None of the health plans met the HPL of 93.3 percent while 3 of the 13 health plans had rates that exceeded the national HEDIS 2007 Medicaid 50th percentile of 87.2 percent. Seven health plans performed below the LPL of 83.4 percent.

The 2008 Michigan Medicaid weighted average of 83.9 percent was below the national HEDIS 2007 Medicaid 50th percentile. The 2008 weighted average did, however, show improvement from 2007 to 2008 with an increase of 1.6 percentage points.

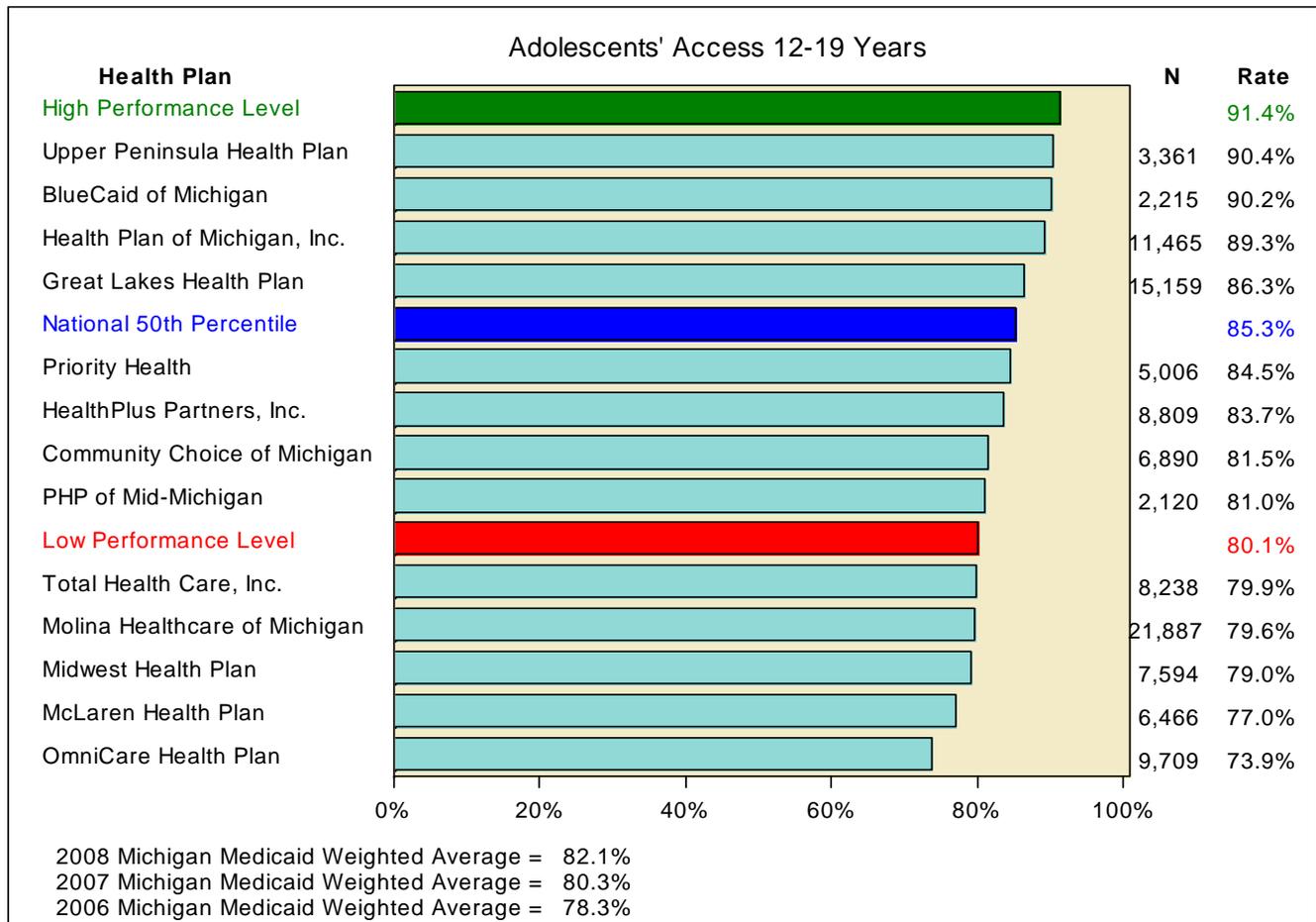
Seven health plans fell below the LPL in 2008 while only three health plans had rates below the LPL in 2007. The increase in the LPL from 79.0 percent in 2007 to 83.4 percent could have contributed to this ranking change.

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

Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years reports the percentage of members 12 to 19 years of age 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 and Adolescents' Access to Primary Care Practitioners
—12 to 19 Years**

**Figure 6-4—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years**



None of the health plans reached the HPL rate of 91.4 percent, while four health plans exceeded the national HEDIS 2007 Medicaid 50th percentile of 85.3 percent. Five of the health plans performed below the LPL of 80.1 percent.

The 2008 Michigan Medicaid weighted average of 82.1 percent was 3.2 percentage points below the national HEDIS 2007 Medicaid 50th percentile and 1.8 percentage points above the 2007 weighted average.

Five health plans fell below the LPL in 2008, while only one health plan had rates below the LPL in 2007. The increase in the LPL from 76.2 percent in 2007 to 80.1 percent in 2008 could have contributed to this ranking change.

Adults' Access to Preventive/Ambulatory Health Services

Preventive care can significantly and positively affect many causes of disease and death, but to realize these benefits, people must have access to effective services. A shortage of health care providers or facilities is a basic limitation that may impact access, but other factors such as lack of adequate health insurance, cultural and language differences, and lack of knowledge or education can also limit access.

Lack of a usual source of medical care can be a barrier to accessing health care. In 2004–2005, about 10 percent of U.S. adults 45–64 years of age did not have a usual source of health care.⁶⁻⁵ Transportation can be an issue, particularly for those with lower incomes. Families with incomes below 100 percent of the poverty level cited lack of transportation as the reason for delaying health care at 10 times the rate of families with incomes of 200 percent or more of the poverty level.⁶⁻⁶ Lack of health insurance is also a barrier to access. Those who do not have insurance are less likely to have a source of medical care or a recent health care visit than those with insurance.

⁶⁻⁵ National Center for Health Statistics. Health, United States, 2007. Available at: [http://www.cdc.gov/nchs/data/07.pdf](http://www.cdc.gov/nchs/data/hus/07.pdf). Accessed on October 7, 2008.

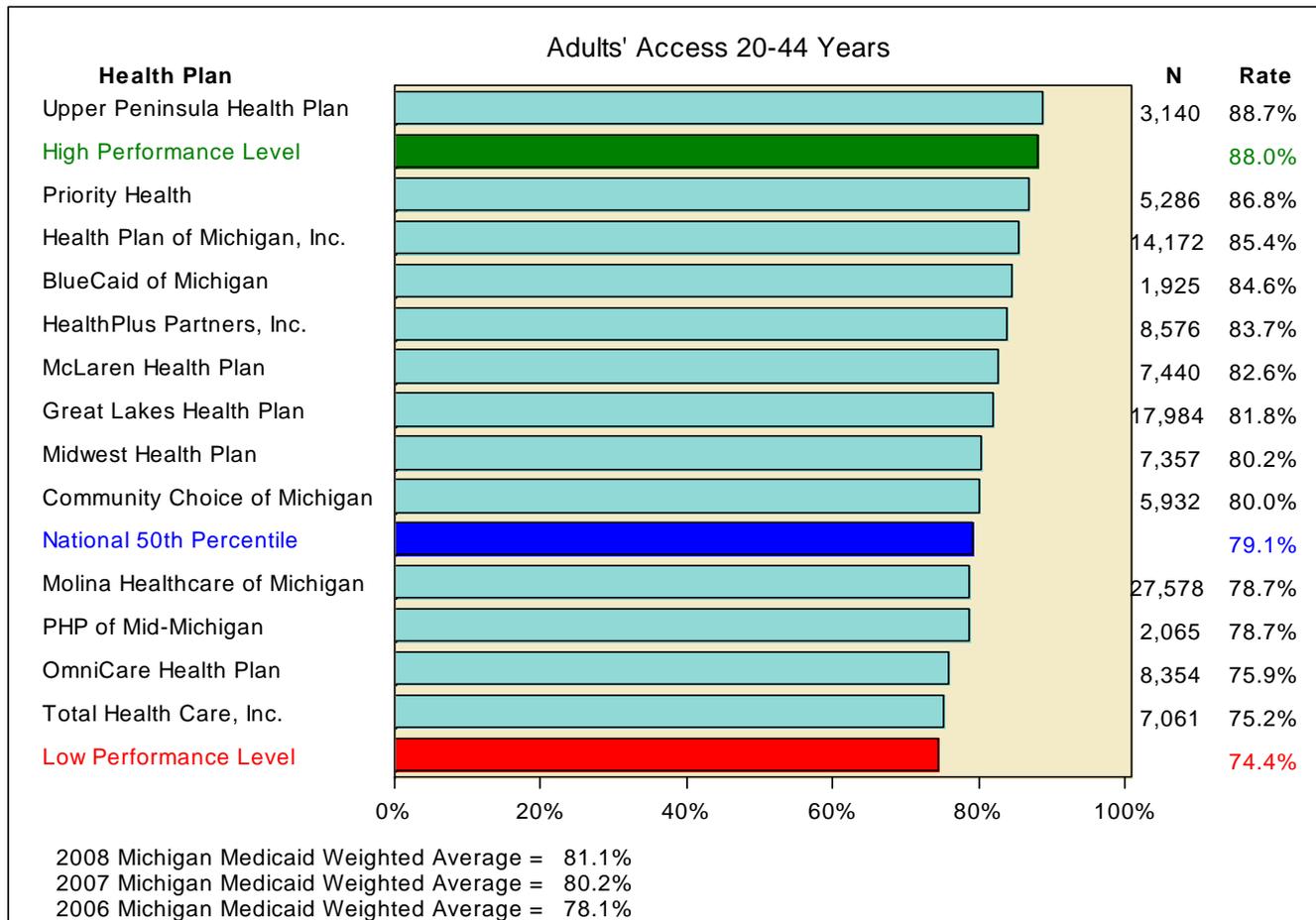
⁶⁻⁶ Ibid.

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

The *Adults' Access to Preventive/Ambulatory Health Services—20 to 44 Years* measure calculates the percentage of adults 20 to 44 years of age 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
—20 to 44 Years**

**Figure 6-5—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Adults' Access to Preventive/Ambulatory Health Services—20 to 44 Years**



One health plan exceeded the HPL of 88 percent while none of the health plans fell below the LPL of 74.4 percent. Nine of the 13 health plans reported rates above the national HEDIS 2007 Medicaid 50th percentile.

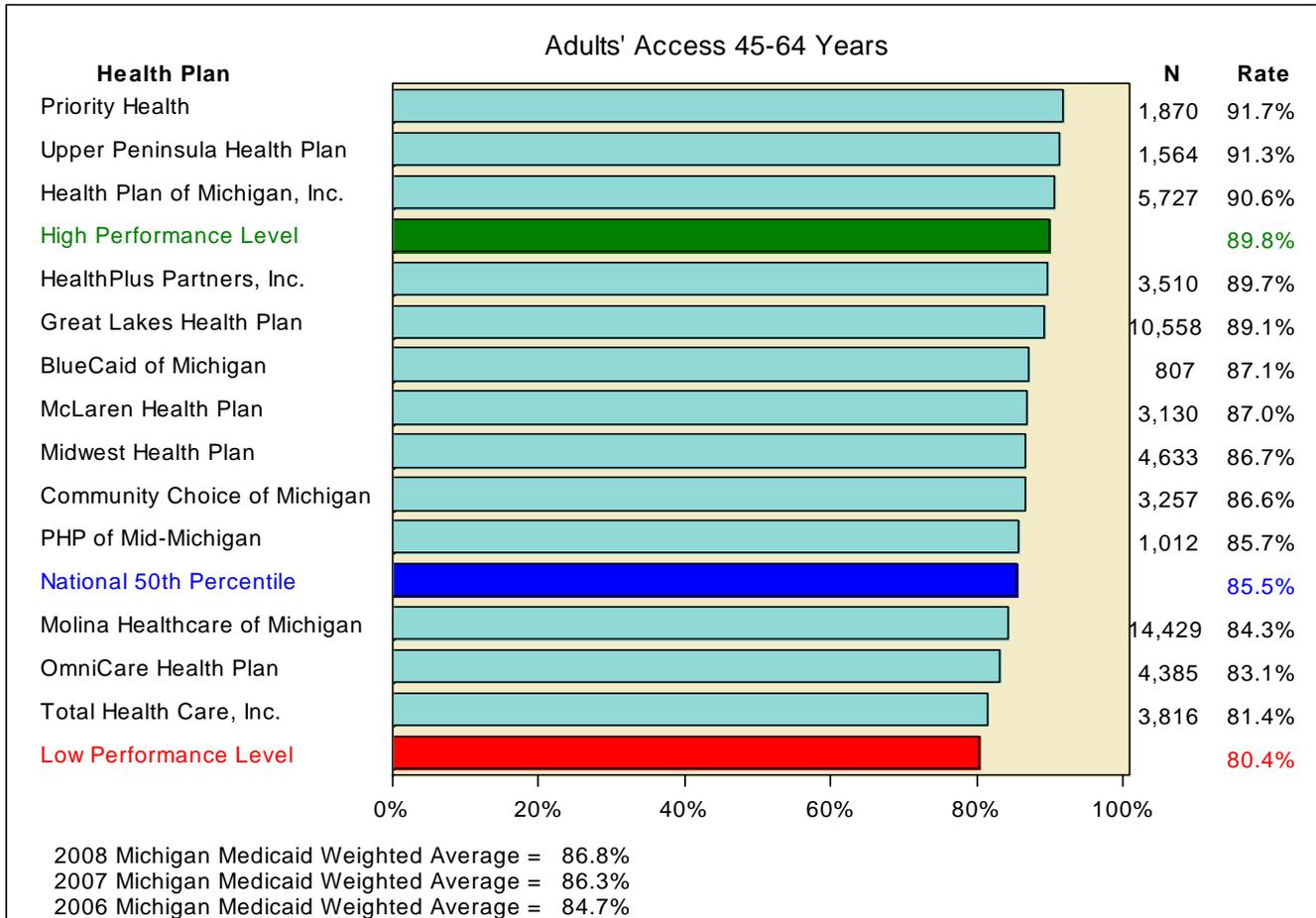
The 2008 Michigan Medicaid weighted average of 81.1 percent was 2.0 percentage points above the national HEDIS 2007 Medicaid 50th percentile of 79.1 percent. In addition, the Michigan Medicaid weighted average increased by 0.9 percentage points from 2007 to 2008.

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

The *Adults' Access to Preventive/Ambulatory Health Services—45 to 64 Years* measure calculates the percentage of adults 45 to 64 years of age 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
—45 to 64 Years**

**Figure 6-6—Michigan Medicaid HEDIS 2008
Health Plan Ranking:
Adults' Access to Preventive/Ambulatory Health Services—45 to 64 Years**



Three health plans exceeded the HPL of 89.8 percent, and none of the health plans had a rate below the LPL of 80.4 percent. In addition, a majority of the health plans (10 out of 13) exceeded the national HEDIS 2007 Medicaid 50th percentile.

The 2008 Michigan Medicaid weighted average of 86.8 percent was 1.3 percentage points above the national HEDIS 2007 Medicaid 50th percentile of 85.5 percent. In addition, the 2008 weighted average improved by 0.5 percentage points compared to the 2007 weighted average.

In 2007, four health plans exceeded the HPL; however, only three of those health plans continued to have performance above the HPL in 2008.

Access to Care Findings and Recommendations

All of the measures in this dimension of care have improved over the past two years. While the *Children and Adolescents' Access to Primary Care Practitioners* weighted averages have improved over the years, they still rank below the national HEDIS 2007 Medicaid 50th percentile. Two measures in this dimension of care ranked above the 50th percentile: *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years* and *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years*. The low-performing MHPs in previous years continued to be low performers for these indicators and should consider working with the higher-performing MHPs to investigate ways to improve their rates.

The ranges for the MHPs' rates for the Access to Care measures were fairly narrow, indicating that only a few percentage points separate the low-performing MHPs from the high-performing MHPs. The MHPs should ensure that all providers are submitting service data for all of their members regardless of their payment arrangement. The MHPs may want to focus on identifying barriers to children's and adolescents' access to primary care practitioners. A focus group consisting of youth and their parents could be convened to assess why there are access issues. After the barriers are identified, the MHPs also could identify the key drivers of these barriers with the focus group. As in previous years, HSAG recommends that the MHPs continue to work together to share best practices and determine the best ways to continue to improve these rates.

Key Findings

HEDIS-certified compliance auditors from HSAG reviewed the findings from each MHP's Final Audit Report and rates submitted in the IDSS, which were audited by other licensed NCQA auditors. As in previous reporting years, auditors identified no major issues that impacted the reporting of any of the HEDIS rates for any of the MHPs. All of the MHPs received a "Report" designation for all of the measures required by MDCH. Some rates that received a "Report" designation had a denominator that was too small, resulting in a *Not Applicable* rate.

Twelve of the 13 MHPs used an NCQA-certified software vendor to produce rates for the key measures they reported. All of the software vendors used by the MHPs achieved full certification status for the HEDIS measures. One MHP produced internally-developed source code and programming logic to produce the HEDIS measures. The source code/programming logic was reviewed and approved by the MHP's auditor.

Consistent with the past few years, the HEDIS audits were performed by three NCQA-licensed audit organizations (LOs). There was one new MHP this year (BlueCaid of Michigan), which acquired a previously reporting MHP (M-CAID). Nine of the 13 audits were performed by one LO, another LO performed three of the audits, and a third organization performed one audit. Each of the MHPs continued to use the same LO they used last year. Each of the LOs provided sufficient detail in the final audit reports, allowing HSAG auditors to evaluate the MHPs' compliance with the information systems standards as defined by NCQA.

All of the MHPs were compliant with IS Standard 1.0, indicating that the MHPs were using industry standard codes, collecting all characters, and identifying and capturing principal and secondary codes. If nonstandard codes were allowed, nonstandard coding schemes were fully documented and mapped to industry standard codes. Plans still face challenges with data capture due to the industry's use of global billing. One organization (Community Choice Michigan) "created a task force that will investigate methods to improve data capture and administrative rates for the prenatal and postpartum care measures."⁷⁻¹ For Great Lakes Health Plan and HealthPlus Partners, the auditor recommended disaggregating the postpartum visit from the global bill since similar efforts at other organizations have resulted in a large increase in administrative rates for the postpartum component of the Prenatal and Postpartum Care measure.⁷⁻²

Twelve of the 13 MHPs were fully compliant with IS Standards 2.1 and 2.2, which indicates that standard submission forms were used routinely and all fields relevant to HEDIS reporting were captured, and any proprietary forms captured equivalent data. Processes to receive and enter medical and service data were efficient, accurate, timely and complete. Total Health Care, Inc., used a local encounter form for capitated providers. The local forms were data-entered by a vendor, but

⁷⁻¹ HEDIS Compliance Audit, Final Audit Report, Community Choice Michigan, July 2008

⁷⁻² HEDIS Compliance Audit, Final Audit Report, Great Lakes Health Plan, July 2008

no oversight and review of the vendor was performed. Total Health Care's vendor for processing claims experienced a backlog during the measurement year due to a change in processing locations. The auditors determined that these issues did not result in a bias to the HEDIS rates.⁷⁻³

All 13 MHPs were fully compliant with IS Standard 2.3, where applicable, indicating that any electronic transmission procedures conformed to industry standards and had the necessary validation procedures to ensure data accuracy.

Twelve of the 13 MHPs were fully compliant with IS Standard 2.4. These MHPs had processes in place to reliably and accurately abstract data from medical records. One organization, Molina Healthcare, faced a challenge with its medical record vendor. The problems were with the vendor's scoring, timeliness, and data integrity, which caused the organization to expand oversight and re-work computations. The errors were corrected before the final report was generated and did not result in a bias to any of the hybrid rates.⁷⁻⁴

One of the 13 MHPs was found to be substantially compliant with IS Standard 2.5. Great Lakes Health Plan did not receive all expected lab results data from its lab vendor after contract terminations.⁷⁻⁵ This challenge did not impact any of the HEDIS rates included in this report. The other 12 MHPs were fully compliant with this standard, indicating that the MHPs assessed data completeness continually and took steps to improve its performance.

All 13 MHPs were compliant with IS Standard 3.0. The MHPs had procedures in place to capture accurate, complete, and timely membership data. Any errors in enrollment processing noted by auditors did not impact any of the HEDIS rates.

The 13 MHPs were fully compliant with IS Standard 4.0, indicating that the capture, transfer, and entry of practitioner data was accurate.

Community Choice Michigan (CCM) was substantially compliant with IS Standard 5.1. The auditor recommended that CCM integrate all vendor data through its transactional system and, where appropriate, its data warehouse to subject the data to additional validations, including matchings between laboratory encounter data and laboratory results based on accession codes.⁷⁻⁶ The other 12 MHPs were fully compliant with IS 5.1, indicating that data transfers to the HEDIS repository from the transactional files were accurate. All 13 MHPs were fully compliant with IS Standards 5.2 and 5.3. File consolidations, extracts, repository structure and formatting were accurate.

In addition, all of the MHPs were fully compliant with IS Standard 6.0. Report production, HEDIS reporting software, and physical control procedures were managed effectively and ensured the integrity of the HEDIS data.

⁷⁻³ HEDIS Compliance Audit, Final Audit Report, Total Health Care, Inc., July 2008

⁷⁻⁴ HEDIS Compliance Audit, Final Audit Report, Molina Healthcare, July 2008

⁷⁻⁵ HEDIS Compliance Audit, Final Audit Report, Great Lakes Health Plan, July 2008

⁷⁻⁶ HEDIS Compliance Audit, Final Audit Report, Community Choice Michigan, July 2008

Conclusions and Recommendations

Overall, the Michigan MHPs' compliance with the IS NCQA audit standards continues to improve, resulting in more complete and accurate data. MHPs continue to struggle with issues that arise from staffing turnover and changes in addition to problems with vendors. The MHPs were able to meet these challenges this year to the extent that none of the issues noted in any of the final audit reports resulted in the inability of an MHP to report a rate due to bias.

Another area that continues to improve is the auto-adjudication of claims and encounter processing, which helps to ensure that claims and encounters that are received contain accurate data and are processed in a timely manner. Many of the MHPs continue to see increases in the numbers of claims and encounters that are received electronically, which also facilitates the timeliness of claims adjudication. MHPs that serve or expand into large rural areas may find it challenging to improve upon the electronic submission of industry standard files and auto-adjudication.⁷⁻⁷

Several best practices or commendations were noted by the MHP auditors in the final audit reports. The best practices included the following:

- ◆ McLaren Health Plan retains its commitment to meeting the special needs of its Medicaid membership in both creative and inventive ways. The MHP stands out among its peers in terms of its ranking, understanding and concern for its membership, and willingness to extend itself to improve the care provided to its members.⁷⁻⁸
- ◆ Health Plan of Michigan (HPM) had an excellent practice for monitoring claims, identifying coding issues, tracking vendor data, identifying noncompliant members, and engaging new members. Also, a separate audit division performs all internal audits and provides feedback to managers and supervisors. All staff members are audited based on a weighted formula that uses total workload.⁷⁻⁹
- ◆ HealthPlus of Michigan, Inc., conducted ongoing validations and matches of laboratory claims data to laboratory results data, producing notable increases in the administrative rates of the laboratory-based HEDIS measures.⁷⁻¹⁰

This year NCQA introduced a new standard to verify in further detail the use of supplemental data to augment the HEDIS rates. Since plans are using other data sources to supplement their claims and encounter systems (administrative systems) NCQA developed specific standards to validate these supplemental data systems. Although not mentioned in every Michigan MHP final report, it was assumed that all MHPs used the MCIR immunization and lead screening data from the State. In addition, many MHPs used additional sources to obtain relevant HEDIS data. Supplemental data collected included diabetes and asthma disease management data, prenatal and postpartum care data, and beta blocker contraindications data. As the MHPs use this type of data to augment their rates, they should continue to monitor updates posted or published by NCQA to ensure compliance with the current requirements. In addition, the MHPs need to document formal policies and procedures that identify the process by which the data are collected, validated, and maintained.

⁷⁻⁷ HEDIS Compliance Audit, Final Audit Report, McClaren Health Plan, July 2008

⁷⁻⁸ HEDIS Compliance Audit, Final Audit Report, McLaren Health Plan, July 2008

⁷⁻⁹ HEDIS Compliance Audit, Final Audit Report, Health Plan of Michigan, Inc., July 2008

⁷⁻¹⁰ HEDIS Compliance Audit, Final Audit Report, HealthPlus of Michigan, Inc., July 2008

These data sources can be valuable tools to identify exclusions and numerator compliance for many of the HEDIS measures.

The assessment and monitoring of data completeness continues to be an opportunity for improvement. In the MHP final reports, auditors noted progress in the organizations' initiation or continuation of provider pay-for-performance programs or various other ways to encourage submission of encounter data. CCM initiated a provider pay-for-performance program. The program reimbursed providers with a bill-above payment for delivery of immunizations, lead screenings, and well-child visits.⁷⁻¹¹ HPP also maintained a physician pay-for-performance program, which included annual bonuses for meeting benchmarks on designated metrics. HPP also generated HEDIS compliance member exception reports, which identified members lacking HEDIS procedures, and provided the reports to physicians to improve compliance.⁷⁻¹² These interventions have improved submission of encounter data nationally to varying degrees. The MHPs should consider which interventions may work best for them.

A few of the audit reports noted challenges that the MHPs had with vendors. Health plans are facing these challenges nationwide. The MHPs should consider processes to monitor vendors on an ongoing basis to help identify problems as they arise and avoid problems that the MHP cannot correct. Ongoing communication and oversight can help alleviate these types of issues or identify them early in the process.

⁷⁻¹¹ HEDIS Compliance Audit, Final Audit Report, Community Choice Michigan, July 2008

⁷⁻¹² HEDIS Compliance Audit, Final Audit Report, HealthPlus of Michigan, Inc., July 2008

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 2006, 2007, and 2008 Michigan Medicaid weighted averages; and the national HEDIS 2007 Medicaid 50th percentile. The following is a list of the tables and the key measures presented for each health plan.

- ◆ Table A-1—*Childhood Immunization Status*
- ◆ 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 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 and Numerator 3*

Table A-1—Tabular Results for Key Measures by Health Plan: Childhood Immunization Status					
IDSS	Plan Name	Code	Childhood Immunization Status		
			Eligible Population	Combo 2 Rate	Combo 3 Rate
7836	BlueCaid of Michigan	BCD	628	80.0%	77.3%
4265	Community Choice of Michigan	CCM	1,187	80.5%	73.5%
4133	Great Lakes Health Plan	GLH	3,983	78.6%	74.0%
4291	Health Plan of Michigan, Inc.	HPM	4,280	88.7%	82.4%
4056	HealthPlus Partners, Inc.	HPP	1,956	83.0%	74.3%
4312	McLaren Health Plan	MCL	1,921	84.7%	70.8%
4131	Midwest Health Plan	MID	1,647	75.9%	63.5%
4151	Molina Healthcare of Michigan	MOL	3,968	76.3%	67.6%
4055	OmniCare Health Plan	OCH	1,340	82.4%	58.8%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	466	81.1%	74.4%
4054	Priority Health Government Programs, Inc.	PRI	1,936	85.8%	81.5%
4268	Total Health Care, Inc.	THC	1,350	85.3%	74.5%
4348	Upper Peninsula Health Plan	UPP	838	81.2%	73.8%
	2008 Michigan Medicaid Weighted Average		--	81.9%	73.4%
	2007 Michigan Medicaid Weighted Average		--	80.2%	62.3%
	2006 Michigan Medicaid Weighted Average		--	76.6%	38.5%
	National HEDIS 2007 Medicaid 50th Percentile		--	75.2%	62.5%

Notes: The 2006 Michigan Medicaid weighted averages include 15 health plans, and the 2007 and 2008 Medicaid weighted averages include 13 health plans.

Table A-2—Tabular Results for Key Measures by Health Plan: <i>Well-Child Visits in the First 15 Months of Life</i>					
IDSS	Plan Name	Code	Eligible Population	0 Visits Rate	6 or More Visits Rate
7836	BlueCaid of Michigan	BCD	485	2.6%	65.5%
4265	Community Choice of Michigan	CCM	882	3.4%	49.6%
4133	Great Lakes Health Plan	GLH	3,002	0.7%	85.7%
4291	Health Plan of Michigan, Inc.	HPM	2,730	1.2%	72.0%
4056	HealthPlus Partners, Inc.	HPP	1,725	1.0%	64.3%
4312	McLaren Health Plan	MCL	1,433	0.7%	58.4%
4131	Midwest Health Plan	MID	1,185	2.4%	57.7%
4151	Molina Healthcare of Michigan	MOL	3,284	1.9%	45.6%
4055	OmniCare Health Plan	OCH	984	1.9%	55.8%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	436	0.7%	57.9%
4054	Priority Health Government Programs, Inc.	PRI	1,763	0.7%	55.3%
4268	Total Health Care, Inc.	THC	1,054	1.5%	45.7%
4348	Upper Peninsula Health Plan	UPP	786	1.4%	60.9%
	2008 Michigan Medicaid Weighted Average		--	1.4%	61.6%
	2007 Michigan Medicaid Weighted Average		--	1.5%	59.3%
	2006 Michigan Medicaid Weighted Average		--	2.1%	51.9%
	National HEDIS 2007 Medicaid 50th Percentile		--	1.4%	56.6%

Note: The 2006 Michigan Medicaid weighted averages include 15 health plans, and the 2007 and 2008 Medicaid weighted averages include 13 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						
IDSS	Plan Name	Code	3rd–6th Years of Life		Adolescent	
			Eligible Population	Rate	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	2,172	66.7%	3,091	48.2%
4265	Community Choice of Michigan	CCM	5,111	54.3%	9,336	36.3%
4133	Great Lakes Health Plan	GLH	16,901	78.0%	26,961	57.8%
4291	Health Plan of Michigan, Inc.	HPM	15,092	71.5%	19,675	55.8%
4056	HealthPlus Partners, Inc.	HPP	7,645	64.2%	11,756	48.4%
4312	McLaren Health Plan	MCL	6,538	67.9%	9,656	48.7%
4131	Midwest Health Plan	MID	7,219	72.3%	11,532	59.4%
4151	Molina Healthcare of Michigan	MOL	25,332	68.6%	42,659	51.9%
4055	OmniCare Health Plan	OCH	5,527	73.6%	12,830	51.4%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	1,902	57.1%	2,864	41.6%
4054	Priority Health Government Programs, Inc.	PRI	6,189	68.2%	7,613	48.9%
4268	Total Health Care, Inc.	THC	5,784	70.2%	11,480	56.2%
4348	Upper Peninsula Health Plan	UPP	2,888	60.4%	4,508	37.0%
	2008 Michigan Medicaid Weighted Average		--	69.5%	--	52.0%
	2007 Michigan Medicaid Weighted Average		--	66.1%	--	47.7%
	2006 Michigan Medicaid Weighted Average		--	64.2%	--	43.5%
	National HEDIS 2007 Medicaid 50th Percentile		--	67.6%	--	42.4%

Note: The 2006 Michigan Medicaid weighted averages include 15 health plans, and the 2007 and 2008 Medicaid weighted averages include 13 health plans.

Table A-4—Tabular Results for Key Measures by Health Plan: <i>Appropriate Treatment for Children With Upper Respiratory Infection</i>				
IDSS	Plan Name	Code	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	1,083	91.4%
4265	Community Choice of Michigan	CCM	2,549	78.5%
4133	Great Lakes Health Plan	GLH	9,767	78.1%
4291	Health Plan of Michigan, Inc.	HPM	8,294	79.7%
4056	HealthPlus Partners, Inc.	HPP	4,358	75.7%
4312	McLaren Health Plan	MCL	4,336	68.9%
4131	Midwest Health Plan	MID	5,350	82.8%
4151	Molina Healthcare of Michigan	MOL	9,912	78.5%
4055	OmniCare Health Plan	OCH	2,081	82.7%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	1,179	84.1%
4054	Priority Health Government Programs, Inc.	PRI	2,733	90.4%
4268	Total Health Care, Inc.	THC	97	59.8%
4348	Upper Peninsula Health Plan	UPP	1,665	81.8%
	2008 Michigan Medicaid Weighted Average		--	79.3%
	2007 Michigan Medicaid Weighted Average		--	77.1%
	2006 Michigan Medicaid Weighted Average		--	75.6%
	National HEDIS 2007 Medicaid 50th Percentile		--	84.3%

Note: The 2006 Michigan Medicaid weighted averages include 15 health plans, and the 2007 and 2008 Medicaid weighted averages include 13 health plans.

Table A-5—Tabular Results for Key Measures by Health Plan: <i>Appropriate Testing for Children With Pharyngitis</i>				
IDSS	Plan Name	Code	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	707	82.7%
4265	Community Choice of Michigan	CCM	2,132	57.1%
4133	Great Lakes Health Plan	GLH	5,857	41.8%
4291	Health Plan of Michigan, Inc.	HPM	5,370	58.9%
4056	HealthPlus Partners, Inc.	HPP	3,299	44.6%
4312	McLaren Health Plan	MCL	2,957	57.1%
4131	Midwest Health Plan	MID	3,669	19.2%
4151	Molina Healthcare of Michigan	MOL	6,167	46.2%
4055	OmniCare Health Plan	OCH	1,122	30.1%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	568	55.3%
4054	Priority Health Government Programs, Inc.	PRI	1,399	66.9%
4268	Total Health Care, Inc.	THC	1,638	44.8%
4348	Upper Peninsula Health Plan	UPP	1,065	64.0%
	2008 Michigan Medicaid Weighted Average		--	47.7%
	2007 Michigan Medicaid Weighted Average		--	45.0%
	2006 Michigan Medicaid Weighted Average		--	39.1%
	National HEDIS 2007 Medicaid 50th Percentile		--	59.4%

Note: The 2006 Michigan Medicaid weighted averages include 15 health plans, and the 2007 and 2008 Medicaid weighted averages include 13 health plans.

Table A-6—Tabular Results for Key Measures by Health Plan: Cancer Screening in Women										
			Breast Cancer Screening						Cervical Cancer Screening	
			42–51 Years		52–69 Years		Combined			
IDSS	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	294	42.2%	225	48.4%	519	44.9%	1,797	72.2%
4265	Community Choice of Michigan	CCM	1,027	45.5%	909	53.1%	1,936	49.1%	5,592	64.8%
4133	Great Lakes Health Plan	GLH	2,486	48.3%	2,615	57.2%	5,101	52.9%	17,944	64.5%
4291	Health Plan of Michigan, Inc.	HPM	1,618	57.8%	1,420	67.1%	3,038	62.1%	12,214	70.9%
4056	HealthPlus Partners, Inc.	HPP	1,283	54.0%	1,075	59.2%	2,358	56.4%	7,913	77.1%
4312	McLaren Health Plan	MCL	1,023	48.4%	859	53.8%	1,882	50.9%	6,586	69.3%
4131	Midwest Health Plan	MID	1,231	48.9%	1,225	54.2%	2,456	51.5%	7,527	69.8%
4151	Molina Healthcare of Michigan	MOL	3,210	47.2%	2,758	55.5%	5,968	51.0%	26,285	64.2%
4055	OmniCare Health Plan	OCH	1,366	45.2%	1,351	54.1%	2,717	49.7%	8,290	67.5%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	354	45.2%	313	51.8%	667	48.3%	1,962	69.2%
4054	Priority Health Government Programs, Inc.	PRI	662	51.2%	521	56.2%	1,183	53.4%	4,700	79.7%
4268	Total Health Care, Inc.	THC	1,211	46.7%	1,119	51.8%	2,330	49.1%	6,918	71.2%
4348	Upper Peninsula Health Plan	UPP	505	51.7%	467	63.0%	972	57.1%	2,727	76.8%
	2008 Michigan Medicaid Weighted Average		--	49.0%	--	56.5%	--	52.6%	--	68.5%
	2007 Michigan Medicaid Weighted Average		--	46.4%	--	56.6%	--	51.2%	--	67.1%
	2006 Michigan Medicaid Weighted Average		--	--	--	55.8%	--	--	--	65.8%
	National HEDIS 2007 Medicaid 50th Percentile		--	45.6%	--	54.9%	--	49.2%	--	66.5%

Note: The 2006 Michigan Medicaid weighted averages include 15 health plans, and the 2007 and 2008 Medicaid weighted averages include 13 health plans.

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

IDSS	Plan Name	Code	16 to 20 Years		21 to 25 Years		Combined Rate	
			Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	357	48.2%	231	60.2%	588	52.9%
4265	Community Choice of Michigan	CCM	1,129	46.1%	647	56.9%	1,776	50.0%
4133	Great Lakes Health Plan	GLH	3,221	48.0%	2,071	57.0%	5,292	51.5%
4291	Health Plan of Michigan, Inc.	HPM	2,573	50.3%	1,987	58.5%	4,560	53.9%
4056	HealthPlus Partners, Inc.	HPP	1,583	52.7%	1,169	64.0%	2,752	57.5%
4312	McLaren Health Plan	MCL	1,100	51.6%	922	58.6%	2,022	54.8%
4131	Midwest Health Plan	MID	1,119	58.3%	610	67.2%	1,729	61.4%
4151	Molina Healthcare of Michigan	MOL	5,391	51.7%	3,268	59.6%	8,659	54.7%
4055	OmniCare Health Plan	OCH	1,781	64.1%	1,008	72.3%	2,789	67.1%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	308	65.3%	207	65.7%	515	65.4%
4054	Priority Health Government Programs, Inc.	PRI	975	57.9%	826	64.9%	1,801	61.1%
4268	Total Health Care, Inc.	THC	1,452	63.7%	882	72.3%	2,334	67.0%
4348	Upper Peninsula Health Plan	UPP	622	45.2%	364	51.6%	986	47.6%
	2008 Michigan Medicaid Weighted Average		--	53.2%	--	61.5%	--	56.4%
	2007 Michigan Medicaid Weighted Average		--	53.3%	--	61.0%	--	56.6%
	2006 Michigan Medicaid Weighted Average		--	51.9%	--	57.6%	--	54.5%
	National HEDIS 2007 Medicaid 50th Percentile		--	50.3%	--	56.3%	--	52.9%

Note: The 2006 Michigan Medicaid weighted averages include 15 health plans, and the 2007 and 2008 Medicaid weighted averages include 13 health plans.

Table A-8—Tabular Results for Key Measures by Health Plan: <i>Prenatal and Postpartum Care</i>						
IDSS	Plan Name	Code	Timeliness of Prenatal Care		Postpartum Care	
			Eligible Population	Rate	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	281	74.5%	281	59.4%
4265	Community Choice of Michigan	CCM	950	79.6%	950	63.3%
4133	Great Lakes Health Plan	GLH	2,902	87.6%	2,902	60.3%
4291	Health Plan of Michigan, Inc.	HPM	2,723	90.0%	2,723	71.4%
4056	HealthPlus Partners, Inc.	HPP	1,430	91.8%	1,425	67.1%
4312	McLaren Health Plan	MCL	1,104	92.9%	1,104	80.8%
4131	Midwest Health Plan	MID	1,053	86.1%	1,053	61.8%
4151	Molina Healthcare of Michigan	MOL	3,475	72.6%	3,475	51.9%
4055	OmniCare Health Plan	OCH	1,141	84.9%	1,141	52.2%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	382	85.6%	347	65.8%
4054	Priority Health Government Programs, Inc.	PRI	1,222	86.3%	1,222	70.1%
4268	Total Health Care, Inc.	THC	1,042	83.0%	1,042	64.1%
4348	Upper Peninsula Health Plan	UPP	309	88.7%	309	68.8%
	2008 Michigan Medicaid Weighted Average		--	84.5%	--	63.0%
	2007 Michigan Medicaid Weighted Average		--	83.2%	--	61.6%
	2006 Michigan Medicaid Weighted Average		--	81.7%	--	57.7%
	National HEDIS 2007 Medicaid 50th Percentile		--	84.2%	--	59.7%

Note: The 2006 Michigan Medicaid weighted averages include 15 health plans, and the 2007 and 2008 Medicaid weighted averages include 13 health plans.

Table A-9—Tabular Results for Key Measures by Health Plan: Comprehensive Diabetes Care							
IDSS	Plan Name	Code	Eligible Population	HbA1C Testing Rate	Poor HbA1C Control Rate	Good HbA1C Control Rate	Eye Exam Rate
7836	BlueCaid of Michigan	BCD	274	91.1%	37.6%	39.5%	70.2%
4265	Community Choice of Michigan	CCM	1,367	86.1%	26.3%	41.8%	51.1%
4133	Great Lakes Health Plan	GLH	4,351	84.2%	39.4%	40.4%	54.3%
4291	Health Plan of Michigan, Inc.	HPM	2,446	89.2%	29.4%	49.6%	68.9%
4056	HealthPlus Partners, Inc.	HPP	1,404	85.9%	35.5%	42.1%	74.5%
4312	McLaren Health Plan	MCL	1,246	83.9%	33.3%	41.6%	65.9%
4131	Midwest Health Plan	MID	1,750	74.9%	46.0%	32.8%	58.2%
4151	Molina Healthcare of Michigan	MOL	5,254	87.3%	41.4%	37.5%	53.5%
4055	OmniCare Health Plan	OCH	1,507	79.6%	48.0%	30.2%	54.4%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	391	87.4%	32.4%	42.2%	63.4%
4054	Priority Health Government Programs, Inc.	PRI	874	88.6%	32.8%	45.7%	71.3%
4268	Total Health Care, Inc.	THC	1,387	77.3%	49.7%	31.4%	52.0%
4348	Upper Peninsula Health Plan	UPP	529	89.0%	25.2%	48.8%	66.9%
	2008 Michigan Medicaid Weighted Average		--	84.6%	38.4%	39.6%	58.8%
	2007 Michigan Medicaid Weighted Average		--	79.8%	43.7%	35.6%	57.5%
	2006 Michigan Medicaid Weighted Average		--	79.6%	42.3%	--	54.2%
	National HEDIS 2007 Medicaid 50th Percentile		--	79.3%	46.7%	31.3%	53.6%

Notes: The 2006 Michigan Medicaid weighted averages include 15 health plans, and the 2007 and 2008 Medicaid weighted averages include 13 health plans.

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

IDSS	Plan Name	Code	Eligible Population	LDL-C Screening Rate	LDL-C Level <100 Rate	Medical Attention for Nephropathy Rate	Blood Pressure Control <130/80 Rate	Blood Pressure Control <140/90 Rate
7836	BlueCaid of Michigan	BCD	274	79.8%	39.1%	87.2%	43.8%	70.2%
4265	Community Choice of Michigan	CCM	1,367	71.3%	31.4%	80.3%	34.5%	60.3%
4133	Great Lakes Health Plan	GLH	4,351	77.9%	37.5%	80.5%	26.5%	58.6%
4291	Health Plan of Michigan, Inc.	HPM	2,446	82.7%	38.1%	82.9%	30.6%	67.5%
4056	HealthPlus Partners, Inc.	HPP	1,404	75.2%	39.2%	82.7%	31.9%	64.5%
4312	McLaren Health Plan	MCL	1,246	74.9%	35.8%	86.9%	32.6%	64.2%
4131	Midwest Health Plan	MID	1,750	72.0%	27.5%	80.0%	28.5%	52.6%
4151	Molina Healthcare of Michigan	MOL	5,254	79.3%	53.8%	78.8%	26.0%	53.3%
4055	OmniCare Health Plan	OCH	1,507	71.5%	34.3%	80.3%	20.9%	47.7%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	391	77.5%	43.3%	82.4%	34.0%	62.8%
4054	Priority Health Government Programs, Inc.	PRI	874	79.8%	41.8%	80.3%	38.7%	70.6%
4268	Total Health Care, Inc.	THC	1,387	68.8%	32.7%	77.5%	22.3%	50.3%
4348	Upper Peninsula Health Plan	UPP	529	82.4%	40.6%	79.1%	39.4%	73.5%
	2008 Michigan Medicaid Weighted Average		--	76.8%	40.0%	80.7%	28.6%	58.4%
	2007 Michigan Medicaid Weighted Average		--	75.1%	36.7%	79.8%	29.4%	57.1%
	2006 Michigan Medicaid Weighted Average		--	85.4%	40.7%	50.7%	--	--
	National HEDIS 2007 Medicaid 50th Percentile		--	72.8%	31.3%	76.6%	30.6%	60.1%

Notes: The 2006 Michigan Medicaid weighted averages include 15 health plans, and the 2007 and 2008 Medicaid weighted averages include 13 health plans.

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

IDSS	Plan Name	Code	5 to 9 Years		10 to 17 Years		18 to 56 Years		Combined Rate	
			Eligible Population	Rate						
7836	BlueCaid of Michigan	BCD	114	96.5%	150	94.0%	139	89.2%	403	93.1%
4265	Community Choice of Michigan	CCM	171	94.2%	237	91.6%	478	88.5%	886	90.4%
4133	Great Lakes Health Plan	GLH	307	85.7%	391	79.3%	937	85.5%	1,635	84.0%
4291	Health Plan of Michigan, Inc.	HPM	341	95.6%	429	90.4%	781	88.9%	1,551	90.8%
4056	HealthPlus Partners, Inc.	HPP	272	94.9%	374	92.0%	471	90.2%	1,117	91.9%
4312	McLaren Health Plan	MCL	199	96.5%	278	90.6%	461	90.2%	938	91.7%
4131	Midwest Health Plan	MID	185	86.5%	186	76.9%	455	79.8%	826	80.6%
4151	Molina Healthcare of Michigan	MOL	452	89.8%	555	86.1%	1,200	84.7%	2,207	86.1%
4055	OmniCare Health Plan	OCH	267	82.8%	337	82.5%	617	85.3%	1,221	83.9%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	97	91.8%	117	91.5%	153	89.5%	367	90.7%
4054	Priority Health Government Programs, Inc.	PRI	195	94.4%	224	95.1%	259	90.7%	678	93.2%
4268	Total Health Care, Inc.	THC	182	84.6%	237	81.4%	453	80.6%	872	81.7%
4348	Upper Peninsula Health Plan	UPP	100	88.0%	150	89.3%	206	86.4%	456	87.7%
	2008 Michigan Medicaid Weighted Average		--	90.6%	--	87.3%	--	86.3%	--	87.5%
	2007 Michigan Medicaid Weighted Average		--	89.9%	--	86.0%	--	87.3%	--	87.5%
	2006 Michigan Medicaid Weighted Average		--	88.8%	--	87.2%	--	86.5%	--	87.1%
	National HEDIS 2007 Medicaid 50th Percentile		--	91.7%	--	88.8%	--	85.4%	--	88.4%

Note: The 2006 Michigan Medicaid weighted averages include 15 health plans, and the 2007 and 2008 Medicaid weighted averages include 13 health plans.

**Table A-11—Tabular Results for Key Measures by Health Plan:
Controlling High Blood Pressure**

IDSS	Plan Name	Code	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	336	69.9%
4265	Community Choice of Michigan	CCM	1,519	52.8%
4133	Great Lakes Health Plan	GLH	5,489	54.3%
4291	Health Plan of Michigan, Inc.	HPM	2,308	57.8%
4056	HealthPlus Partners, Inc.	HPP	1,866	56.0%
4312	McLaren Health Plan	MCL	1,497	67.6%
4131	Midwest Health Plan	MID	2,220	49.6%
4151	Molina Healthcare of Michigan	MOL	7,187	55.7%
4055	OmniCare Health Plan	OCH	2,573	52.2%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	401	59.9%
4054	Priority Health Government Programs, Inc.	PRI	1,020	58.8%
4268	Total Health Care, Inc.	THC	2,015	59.3%
4348	Upper Peninsula Health Plan	UPP	626	65.3%
	2008 Michigan Medicaid Weighted Average		--	56.1%
	2007 Michigan Medicaid Weighted Average		--	51.9%
	2006 Michigan Medicaid Weighted Average		--	--
	National HEDIS 2007 Medicaid 50th Percentile		--	55.4%

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

IDSS	Plan Name	Code	12 to 24 Months		25 Months to 6 Years		7 to 11 Years		12 to 19 Years	
			Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	677	97.6%	2,724	88.9%	1,766	89.6%	2,215	90.2%
4265	Community Choice of Michigan	CCM	1,351	94.8%	6,224	82.3%	5,207	83.3%	6,890	81.5%
4133	Great Lakes Health Plan	GLH	5,338	97.5%	21,219	89.3%	10,787	86.8%	15,159	86.3%
4291	Health Plan of Michigan, Inc.	HPM	5,625	97.0%	19,152	89.0%	9,732	89.3%	11,465	89.3%
4056	HealthPlus Partners, Inc.	HPP	2,289	96.5%	9,399	85.9%	7,054	86.1%	8,809	83.7%
4312	McLaren Health Plan	MCL	1,996	93.1%	8,248	80.2%	5,011	78.1%	6,466	77.0%
4131	Midwest Health Plan	MID	1,996	93.2%	8,818	82.9%	5,450	83.0%	7,594	79.0%
4151	Molina Healthcare of Michigan	MOL	7,318	95.5%	31,187	84.9%	14,705	81.8%	21,887	79.6%
4055	OmniCare Health Plan	OCH	1,378	89.2%	6,722	74.2%	6,095	76.8%	9,709	73.9%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	587	94.5%	2,320	77.7%	1,668	82.2%	2,120	81.0%
4054	Priority Health Government Programs, Inc.	PRI	2,196	96.6%	7,904	85.3%	4,803	86.1%	5,006	84.5%
4268	Total Health Care, Inc.	THC	1,448	91.9%	7,042	80.7%	5,298	80.0%	8,238	79.9%
4348	Upper Peninsula Health Plan	UPP	948	97.7%	3,590	88.1%	2,682	87.9%	3,361	90.4%
	2008 Michigan Medicaid Weighted Average		--	95.6%	--	85.0%	--	83.9%	--	82.1%
	2007 Michigan Medicaid Weighted Average		--	95.2%	--	82.7%	--	82.3%	--	80.3%
	2006 Michigan Medicaid Weighted Average		--	92.9%	--	81.4%	--	80.0%	--	78.3%
	National HEDIS 2007 Medicaid 50th Percentile		--	95.8%	--	86.7%	--	87.2%	--	85.3%

Note: The 2006 Michigan Medicaid weighted averages include 15 health plans, and the 2007 and 2008 Medicaid weighted averages include 13 health plans.

**Table A-13—Tabular Results for Key Measures by Health Plan:
Adults’ Access to Preventive/Ambulatory Health Services**

IDSS	Plan Name	Code	20 to 44 Years		45 to 64 Years	
			Eligible Population	Rate	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	1,925	84.6%	807	87.1%
4265	Community Choice of Michigan	CCM	5,932	80.0%	3,257	86.6%
4133	Great Lakes Health Plan	GLH	17,984	81.8%	10,558	89.1%
4291	Health Plan of Michigan, Inc.	HPM	14,172	85.4%	5,727	90.6%
4056	HealthPlus Partners, Inc.	HPP	8,576	83.7%	3,510	89.7%
4312	McLaren Health Plan	MCL	7,440	82.6%	3,130	87.0%
4131	Midwest Health Plan	MID	7,357	80.2%	4,633	86.7%
4151	Molina Healthcare of Michigan	MOL	27,578	78.7%	14,429	84.3%
4055	OmniCare Health Plan	OCH	8,354	75.9%	4,385	83.1%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	2,065	78.7%	1,012	85.7%
4054	Priority Health Government Programs, Inc.	PRI	5,286	86.8%	1,870	91.7%
4268	Total Health Care, Inc.	THC	7,061	75.2%	3,816	81.4%
4348	Upper Peninsula Health Plan	UPP	3,140	88.7%	1,564	91.3%
	2008 Michigan Medicaid Weighted Average		--	81.1%	--	86.8%
	2007 Michigan Medicaid Weighted Average		--	80.2%	--	86.3%
	2006 Michigan Medicaid Weighted Average		--	78.1%	--	84.7%
	National HEDIS 2007 Medicaid 50th Percentile		--	79.1%	--	85.5%

Notes: The 2006 Michigan Medicaid weighted averages include 15 health plans, and the 2007 and 2008 Medicaid weighted averages include 13 health plans.

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

**Table A-14—Tabular Results for Key Measures by Health Plan:
Medical Assistance With Smoking Cessation**

IDSS	Plan Name	Code	Advising Smokers to Quit Rate	Discussing Smoking Cessation Strategies Rate
7836	BlueCaid of Michigan	BCD	77.4%	51.7%
4265	Community Choice of Michigan	CCM	76.9%	42.9%
4133	Great Lakes Health Plan	GLH	71.1%	42.4%
4291	Health Plan of Michigan, Inc.	HPM	75.8%	41.9%
4056	HealthPlus Partners, Inc.	HPP	71.1%	36.8%
4312	McLaren Health Plan	MCL	69.4%	40.8%
4131	Midwest Health Plan	MID	70.5%	41.6%
4151	Molina Healthcare of Michigan	MOL	70.4%	35.6%
4055	OmniCare Health Plan	OCH	70.5%	34.3%
4282	Physicians Health Plan of Mid-Michigan Family Care	PMD	74.3%	48.2%
4054	Priority Health Government Programs, Inc.	PRI	77.8%	44.8%
4268	Total Health Care, Inc.	THC	69.1%	33.1%
4348	Upper Peninsula Health Plan	UPP	71.7%	40.7%
	2008 Michigan Medicaid Average		72.8%	41.1%
	2007 Michigan Medicaid Average		72.1%	38.1%
	2006 Michigan Medicaid Average		69.7%	36.2%

Note: The 2006 Michigan Medicaid weighted averages include 15 health plans, and the 2007 and 2008 Medicaid weighted averages include 13 health plans.

The 2006, 2007, and 2008 Michigan Medicaid averages were not weighted.

Appendix B. National HEDIS 2007 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 2007 Medicaid Percentiles—Pediatric Care

Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
<i>Childhood Immunization Status—Combination 2</i>	58.7	68.3	75.2	80.0	84.7
<i>Childhood Immunization Status—Combination 3</i>	41.7	53.9	62.5	70.6	74.2
<i>Well-Child Visits in the First 15 Months—Zero Visits*</i>	0.4	0.7	1.4	2.9	6.8
<i>Well-Child Visits in the First 15 Months—Six or More Visits</i>	38.0	46.6	56.6	64.4	75.2
<i>Well-Child in the Third, Fourth, Fifth, and Sixth Years of Life</i>	55.7	62.9	67.6	74.9	79.9
<i>Adolescent Well-Care Visits</i>	31.3	35.3	42.4	51.4	58.9
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	73.0	78.4	84.3	89.3	92.5
<i>Appropriate Testing for Children With Pharyngitis</i>	26.4	46.2	59.4	69.0	76.2

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

Table B-2—National HEDIS 2007 Medicaid Percentiles—Women’s Care					
Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
<i>Breast Cancer Screening—42–51 Years</i>	34.8	39.8	45.6	52.0	57.2
<i>Breast Cancer Screening—52–69 Years</i>	43.9	50.0	54.9	59.2	65.2
<i>Breast Cancer Screening— Combined Rate</i>	39.5	43.2	49.2	55.1	59.6
<i>Cervical Cancer Screening</i>	53.7	60.2	66.5	72.0	77.4
<i>Chlamydia Screening in Women— 16–20 Years</i>	35.7	44.7	50.3	58.6	64.9
<i>Chlamydia Screening in Women— 21–25 Years</i>	37.5	49.5	56.3	63.0	69.9
<i>Chlamydia Screening in Women— Combined Rate</i>	37.7	47.2	52.9	60.6	66.0
<i>Prenatal and Postpartum Care— Timeliness of Prenatal Care</i>	70.3	77.0	84.2	88.7	91.5
<i>Prenatal and Postpartum Care— Postpartum Care</i>	47.4	54.3	59.7	65.5	71.1

Table B-3—National HEDIS 2007 Medicaid Percentiles—Living With Illness

Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	67.6	74.4	79.3	84.3	89.1
<i>Comprehensive Diabetes Care—Poor HbA1c Control*</i>	32.1	39.7	46.7	57.4	69.6
<i>Comprehensive Diabetes Care—Good HbA1c Control</i>	14.9	24.4	31.3	36.6	40.9
<i>Comprehensive Diabetes Care—Eye Exam</i>	30.6	42.1	53.6	62.7	68.3
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	58.7	66.9	72.8	77.9	81.0
<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	15.2	24.1	31.3	37.2	44.1
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	60.3	68.6	76.6	81.8	85.5
<i>Comprehensive Diabetes Care—Blood Pressure Control <130/80</i>	19.2	25.1	30.6	35.5	41.4
<i>Comprehensive Diabetes Care—Blood Pressure Control <140/90</i>	41.1	50.6	60.1	65.5	69.3
<i>Use of Appropriate Medications for People With Asthma—5–9 Years</i>	83.1	88.6	91.7	94.6	96.3
<i>Use of Appropriate Medications for People With Asthma—10–17 Years</i>	80.2	86.2	88.8	91.4	93.0
<i>Use of Appropriate Medications for People With Asthma—18–56 Years</i>	76.4	82.6	85.4	88.2	90.9
<i>Use of Appropriate Medications for People With Asthma—Combined Rate</i>	81.5	85.6	88.4	90.3	92.0
<i>Controlling High Blood Pressure (Total)</i>	40.1	47.3	55.4	59.9	65.8

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

Table B-4—National HEDIS 2007 Medicaid Percentiles—Access to Care					
Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
<i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months</i>	90.2	93.0	95.8	97.4	98.0
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>	77.9	82.4	86.7	89.4	91.4
<i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>	77.0	83.4	87.2	90.5	93.3
<i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>	73.9	80.1	85.3	89.2	91.4
<i>Adults' Access to Preventive/Ambulatory Services—20–44 Years</i>	66.3	74.4	79.1	85.1	88.0
<i>Adults' Access to Preventive/Ambulatory Services—45–64 Years</i>	74.1	80.4	85.5	88.6	89.8

Appendix C includes trend tables for each of the MHPs. Where applicable, each measure's rate for 2006, 2007, and 2008 is presented along with a trend analysis that compares a measure's 2007 rate to its 2008 rate to assess whether there was any significant change in the rate.

Rates that are significantly higher in 2008 than in 2007 (an improvement of more than 10 percent) are noted with upward arrows (↑). Rates that are significantly lower in 2008 than in 2007 (a decrease of more than 10 percent) are noted with downward arrows (↓). Rates in 2008 that are not significantly different than in 2007 (a change of no 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 (a rate decrease by more than 10 percent) and a downward triangle (▼) indicates a decline in performance (a rate increase by more than 10 percent).

The MHP trend tables are presented as follows:

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

Table C-1—Michigan Medicaid HEDIS 2008 Trend Table: BCD					
Dimension of Care	Measure	2006	2007	2008	2007–2008 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	81.0%	81.0%	80.0%	↔
	<i>Childhood Immunization Combo 3</i>	56.7%	56.7%	77.3%	↑
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	0.5%	0.5%	2.6%	↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	64.4%	64.4%	65.5%	↔
	<i>Well-Child 3rd–6th Years of Life</i>	67.4%	67.4%	66.7%	↔
	<i>Adolescent Well-Care Visits</i>	51.4%	51.4%	48.2%	↔
	<i>Appropriate Treatment of URI</i>	90.3%	90.5%	91.4%	↔
	<i>Children with Pharyngitis</i>	58.8%	80.8%	82.7%	↔
Women's Care	<i>Breast Cancer Screening, 42–51 Years</i>	--	42.0%	42.2%	↔
	<i>Breast Cancer Screening, 52–69 Years</i>	45.0%	47.4%	48.4%	↔
	<i>Breast Cancer Screening, Combined</i>	--	44.3%	44.9%	↔
	<i>Cervical Cancer Screening</i>	73.8%	78.0%	72.2%	↔
	<i>Chlamydia Screening, 16–20 Years</i>	52.8%	51.6%	48.2%	↔
	<i>Chlamydia Screening, 21–25 Years</i>	60.0%	61.4%	60.2%	↔
	<i>Chlamydia Screening, Combined</i>	56.2%	55.8%	52.9%	↔
	<i>Timeliness of Prenatal Care</i>	89.5%	85.4%	74.5%	↓
	<i>Postpartum Care</i>	60.7%	66.0%	59.4%	↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	88.4%	89.1%	91.1%	↔
	<i>Diabetes Care Poor HbA1c Control</i>	33.8%	34.0%	37.6%	↔
	<i>Diabetes Care Good HbA1c Control</i>	--	40.6%	39.5%	↔
	<i>Diabetes Care Eye Exam</i>	55.1%	62.5%	70.2%	↔
	<i>Diabetes Care LDL-C Screening</i>	91.6%	80.9%	79.8%	↔
	<i>Diabetes Care LDL-C Level <100</i>	50.2%	45.7%	39.1%	↔
	<i>Diabetes Care Nephropathy</i>	60.0%	84.8%	87.2%	↔
	<i>Diabetes Care Blood Pressure Control <130/80</i>	--	42.6%	43.8%	↔
	<i>Diabetes Care Blood Pressure Control <140/90</i>	--	75.0%	70.2%	↔
	<i>Asthma 5–9 Years</i>	94.6%	99.0%	96.5%	↔
	<i>Asthma 10–17 Years</i>	91.8%	91.2%	94.0%	↔
	<i>Asthma 18–56 Years</i>	91.2%	90.0%	89.2%	↔
	<i>Asthma Combined Rate</i>	92.2%	93.0%	93.1%	↔
	<i>Controlling High Blood Pressure, Combined</i>	--	66.2%	69.9%	↔
	<i>Advising Smokers to Quit</i>	75.7%	76.4%	77.4%	↔
<i>Discussing Smoking Cessation Strategies</i>	50.2%	47.9%	51.7%	↔	
Access to Care	<i>Children's Access 12–24 Months</i>	98.8%	97.3%	97.6%	↔
	<i>Children's Access 25 Mos–6 Years</i>	89.0%	89.5%	88.9%	↔
	<i>Children's Access 7–11 Years</i>	87.5%	89.8%	89.6%	↔
	<i>Adolescents' Access 12–19 Years</i>	85.8%	87.8%	90.2%	↔
	<i>Adults' Access 20–44 Years</i>	82.2%	83.9%	84.6%	↔
	<i>Adults' Access 45–64 Years</i>	85.1%	88.6%	87.1%	↔

Table C-2—Michigan Medicaid HEDIS 2008 Trend Table: CCM					
Dimension of Care	Measure	2006	2007	2008	2007–2008 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	75.7%	74.9%	80.5%	↔↔
	<i>Childhood Immunization Combo 3</i>	33.6%	62.5%	73.5%	↑
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	3.9%	3.4%	3.4%	↔↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	41.6%	37.5%	49.6%	↑
	<i>Well-Child 3rd–6th Years of Life</i>	54.6%	56.9%	54.3%	↔↔
	<i>Adolescent Well-Care Visits</i>	37.0%	31.1%	36.3%	↔↔
	<i>Appropriate Treatment of URI</i>	75.9%	79.4%	78.5%	↔↔
	<i>Children with Pharyngitis</i>	49.0%	54.5%	57.1%	↔↔
Women's Care	<i>Breast Cancer Screening, 42–51 Years</i>	--	39.2%	45.5%	↔↔
	<i>Breast Cancer Screening, 52–69 Years</i>	47.1%	53.6%	53.1%	↔↔
	<i>Breast Cancer Screening, Combined</i>	--	45.6%	49.1%	↔↔
	<i>Cervical Cancer Screening</i>	67.6%	65.6%	64.8%	↔↔
	<i>Chlamydia Screening, 16–20 Years</i>	48.1%	46.8%	46.1%	↔↔
	<i>Chlamydia Screening, 21–25 Years</i>	52.9%	56.5%	56.9%	↔↔
	<i>Chlamydia Screening, Combined</i>	50.2%	50.7%	50.0%	↔↔
	<i>Timeliness of Prenatal Care</i>	76.6%	81.3%	79.6%	↔↔
	<i>Postpartum Care</i>	60.1%	62.8%	63.3%	↔↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	81.5%	83.7%	86.1%	↔↔
	<i>Diabetes Care Poor HbA1c Control</i>	46.2%	43.1%	26.3%	▲
	<i>Diabetes Care Good HbA1c Control</i>	--	38.0%	41.8%	↔↔
	<i>Diabetes Care Eye Exam</i>	41.8%	43.8%	51.1%	↔↔
	<i>Diabetes Care LDL-C Screening</i>	76.4%	66.9%	71.3%	↔↔
	<i>Diabetes Care LDL-C Level <100</i>	34.1%	29.2%	31.4%	↔↔
	<i>Diabetes Care Nephropathy</i>	46.2%	76.6%	80.3%	↔↔
	<i>Diabetes Care Blood Pressure Control <130/80</i>	--	33.8%	34.5%	↔↔
	<i>Diabetes Care Blood Pressure Control <140/90</i>	--	65.5%	60.3%	↔↔
	<i>Asthma 5–9 Years</i>	89.2%	95.7%	94.2%	↔↔
	<i>Asthma 10–17 Years</i>	90.1%	91.8%	91.6%	↔↔
	<i>Asthma 18–56 Years</i>	88.7%	89.0%	88.5%	↔↔
	<i>Asthma Combined Rate</i>	89.1%	91.0%	90.4%	↔↔
	<i>Controlling High Blood Pressure, Combined</i>	--	58.6%	52.8%	↔↔
	<i>Advising Smokers to Quit</i>	71.8%	77.1%	76.9%	↔↔
	<i>Discussing Smoking Cessation Strategies</i>	29.3%	36.1%	42.9%	↔↔
Access to Care	<i>Children's Access 12–24 Months</i>	90.4%	93.2%	94.8%	↔↔
	<i>Children's Access 25 Mos–6 Years</i>	77.8%	80.0%	82.3%	↔↔
	<i>Children's Access 7–11 Years</i>	78.1%	81.6%	83.3%	↔↔
	<i>Adolescents' Access 12–19 Years</i>	74.9%	78.4%	81.5%	↔↔
	<i>Adults' Access 20–44 Years</i>	75.2%	78.5%	80.0%	↔↔
	<i>Adults' Access 45–64 Years</i>	82.7%	85.8%	86.6%	↔↔

Table C-3—Michigan Medicaid HEDIS 2008 Trend Table: GLH					
Dimension of Care	Measure	2006	2007	2008	2007–2008 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	72.0%	77.6%	78.6%	↔↔
	<i>Childhood Immunization Combo 3</i>	37.2%	63.3%	74.0%	↑
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	0.7%	0.3%	0.7%	↔↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	64.2%	91.1%	85.7%	↔↔
	<i>Well-Child 3rd–6th Years of Life</i>	66.9%	69.8%	78.0%	↔↔
	<i>Adolescent Well-Care Visits</i>	52.1%	58.8%	57.8%	↔↔
	<i>Appropriate Treatment of URI</i>	70.7%	74.6%	78.1%	↔↔
	<i>Children with Pharyngitis</i>	35.6%	41.5%	41.8%	↔↔
Women's Care	<i>Breast Cancer Screening, 42–51 Years</i>	--	43.8%	48.3%	↔↔
	<i>Breast Cancer Screening, 52–69 Years</i>	59.3%	56.6%	57.2%	↔↔
	<i>Breast Cancer Screening, Combined</i>	--	50.3%	52.9%	↔↔
	<i>Cervical Cancer Screening</i>	60.1%	64.6%	64.5%	↔↔
	<i>Chlamydia Screening, 16–20 Years</i>	47.2%	49.8%	48.0%	↔↔
	<i>Chlamydia Screening, 21–25 Years</i>	55.8%	57.5%	57.0%	↔↔
	<i>Chlamydia Screening, Combined</i>	51.0%	52.9%	51.5%	↔↔
	<i>Timeliness of Prenatal Care</i>	75.4%	78.3%	87.6%	↔↔
	<i>Postpartum Care</i>	51.3%	58.6%	60.3%	↔↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	73.5%	77.1%	84.2%	↔↔
	<i>Diabetes Care Poor HbA1c Control</i>	47.4%	50.6%	39.4%	▲
	<i>Diabetes Care Good HbA1c Control</i>	--	32.4%	40.4%	↔↔
	<i>Diabetes Care Eye Exam</i>	52.6%	53.3%	54.3%	↔↔
	<i>Diabetes Care LDL-C Screening</i>	88.1%	76.9%	77.9%	↔↔
	<i>Diabetes Care LDL-C Level <100</i>	62.0%	30.9%	37.5%	↔↔
	<i>Diabetes Care Nephropathy</i>	45.7%	77.9%	80.5%	↔↔
	<i>Diabetes Care Blood Pressure Control <130/80</i>	--	25.1%	26.5%	↔↔
	<i>Diabetes Care Blood Pressure Control <140/90</i>	--	52.1%	58.6%	↔↔
	<i>Asthma 5–9 Years</i>	85.9%	84.7%	85.7%	↔↔
	<i>Asthma 10–17 Years</i>	83.0%	80.8%	79.3%	↔↔
	<i>Asthma 18–56 Years</i>	88.4%	89.9%	85.5%	↔↔
	<i>Asthma Combined Rate</i>	86.7%	86.8%	84.0%	↔↔
	<i>Controlling High Blood Pressure, Combined</i>	--	50.6%	54.3%	↔↔
	<i>Advising Smokers to Quit</i>	66.8%	68.9%	71.1%	↔↔
	<i>Discussing Smoking Cessation Strategies</i>	28.7%	31.9%	42.4%	↑
Access to Care	<i>Children's Access 12–24 Months</i>	96.7%	97.6%	97.5%	↔↔
	<i>Children's Access 25 Mos–6 Years</i>	85.4%	86.5%	89.3%	↔↔
	<i>Children's Access 7–11 Years</i>	82.1%	84.7%	86.8%	↔↔
	<i>Adolescents' Access 12–19 Years</i>	81.4%	84.7%	86.3%	↔↔
	<i>Adults' Access 20–44 Years</i>	78.7%	80.6%	81.8%	↔↔
	<i>Adults' Access 45–64 Years</i>	86.8%	88.1%	89.1%	↔↔

Table C-4—Michigan Medicaid HEDIS 2008 Trend Table: HPM					
Dimension of Care	Measure	2006	2007	2008	2007–2008 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	78.0%	83.8%	88.7%	↔↔
	<i>Childhood Immunization Combo 3</i>	38.9%	71.5%	82.4%	↑
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	1.7%	0.9%	1.2%	↔↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	68.4%	69.9%	72.0%	↔↔
	<i>Well-Child 3rd–6th Years of Life</i>	67.8%	65.3%	71.5%	↔↔
	<i>Adolescent Well-Care Visits</i>	52.5%	55.1%	55.8%	↔↔
	<i>Appropriate Treatment of URI</i>	79.3%	78.4%	79.7%	↔↔
	<i>Children with Pharyngitis</i>	50.9%	53.2%	58.9%	↔↔
Women's Care	<i>Breast Cancer Screening, 42–51 Years</i>	--	53.9%	57.8%	↔↔
	<i>Breast Cancer Screening, 52–69 Years</i>	58.0%	64.4%	67.1%	↔↔
	<i>Breast Cancer Screening, Combined</i>	--	58.7%	62.1%	↔↔
	<i>Cervical Cancer Screening</i>	66.8%	71.0%	70.9%	↔↔
	<i>Chlamydia Screening, 16–20 Years</i>	49.1%	50.3%	50.3%	↔↔
	<i>Chlamydia Screening, 21–25 Years</i>	54.7%	60.2%	58.5%	↔↔
	<i>Chlamydia Screening, Combined</i>	51.7%	54.8%	53.9%	↔↔
	<i>Timeliness of Prenatal Care</i>	82.9%	90.0%	90.0%	↔↔
Living With Illness	<i>Postpartum Care</i>	56.8%	67.0%	71.4%	↔↔
	<i>Diabetes Care HbA1c Testing</i>	78.7%	86.4%	89.2%	↔↔
	<i>Diabetes Care Poor HbA1c Control</i>	39.2%	33.0%	29.4%	↔↔
	<i>Diabetes Care Good HbA1c Control</i>	--	44.3%	49.6%	↔↔
	<i>Diabetes Care Eye Exam</i>	58.6%	67.0%	68.9%	↔↔
	<i>Diabetes Care LDL-C Screening</i>	85.8%	82.5%	82.7%	↔↔
	<i>Diabetes Care LDL-C Level <100</i>	30.7%	35.2%	38.1%	↔↔
	<i>Diabetes Care Nephropathy</i>	48.2%	78.0%	82.9%	↔↔
	<i>Diabetes Care Blood Pressure Control <130/80</i>	--	33.0%	30.6%	↔↔
	<i>Diabetes Care Blood Pressure Control <140/90</i>	--	58.4%	67.5%	↔↔
	<i>Asthma 5–9 Years</i>	94.9%	98.2%	95.6%	↔↔
	<i>Asthma 10–17 Years</i>	93.5%	97.3%	90.4%	↔↔
	<i>Asthma 18–56 Years</i>	93.1%	94.5%	88.9%	↔↔
	<i>Asthma Combined Rate</i>	93.6%	96.1%	90.8%	↔↔
	<i>Controlling High Blood Pressure, Combined</i>	--	56.5%	57.8%	↔↔
	<i>Advising Smokers to Quit</i>	69.3%	75.4%	75.8%	↔↔
<i>Discussing Smoking Cessation Strategies</i>	33.0%	40.0%	41.9%	↔↔	
Access to Care	<i>Children's Access 12–24 Months</i>	95.4%	96.8%	97.0%	↔↔
	<i>Children's Access 25 Mos–6 Years</i>	85.9%	87.6%	89.0%	↔↔
	<i>Children's Access 7–11 Years</i>	84.3%	87.7%	89.3%	↔↔
	<i>Adolescents' Access 12–19 Years</i>	84.3%	87.9%	89.3%	↔↔
	<i>Adults' Access 20–44 Years</i>	82.9%	85.1%	85.4%	↔↔
	<i>Adults' Access 45–64 Years</i>	88.7%	90.6%	90.6%	↔↔

Table C-5—Michigan Medicaid HEDIS 2008 Trend Table: HPP

Dimension of Care	Measure	2006	2007	2008	2007–2008 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	83.9%	85.2%	83.0%	↔↔
	<i>Childhood Immunization Combo 3</i>	44.8%	71.5%	74.3%	↔↔
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	2.2%	2.3%	1.0%	↔↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	60.1%	61.8%	64.3%	↔↔
	<i>Well-Child 3rd–6th Years of Life</i>	58.5%	64.8%	64.2%	↔↔
	<i>Adolescent Well-Care Visits</i>	43.8%	48.4%	48.4%	↔↔
	<i>Appropriate Treatment of URI</i>	71.4%	72.1%	75.7%	↔↔
	<i>Children with Pharyngitis</i>	36.2%	40.9%	44.6%	↔↔
Women's Care	<i>Breast Cancer Screening, 42–51 Years</i>	--	54.3%	54.0%	↔↔
	<i>Breast Cancer Screening, 52–69 Years</i>	61.8%	62.5%	59.2%	↔↔
	<i>Breast Cancer Screening, Combined</i>	--	58.0%	56.4%	↔↔
	<i>Cervical Cancer Screening</i>	70.4%	77.1%	77.1%	Rotated Measure
	<i>Chlamydia Screening, 16–20 Years</i>	50.5%	52.7%	52.7%	↔↔
	<i>Chlamydia Screening, 21–25 Years</i>	57.9%	61.2%	64.0%	↔↔
	<i>Chlamydia Screening, Combined</i>	54.1%	56.6%	57.5%	↔↔
	<i>Timeliness of Prenatal Care</i>	87.4%	91.8%	91.8%	Rotated Measure
	<i>Postpartum Care</i>	62.0%	66.1%	67.1%	↔↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	86.1%	86.6%	85.9%	↔↔
	<i>Diabetes Care Poor HbA1c Control</i>	29.7%	32.8%	35.5%	↔↔
	<i>Diabetes Care Good HbA1c Control</i>	--	45.3%	42.1%	↔↔
	<i>Diabetes Care Eye Exam</i>	70.3%	74.0%	74.5%	↔↔
	<i>Diabetes Care LDL-C Screening</i>	89.8%	75.4%	75.2%	↔↔
	<i>Diabetes Care LDL-C Level <100</i>	43.1%	36.5%	39.2%	↔↔
	<i>Diabetes Care Nephropathy</i>	56.4%	85.4%	82.7%	↔↔
	<i>Diabetes Care Blood Pressure Control <130/80</i>	--	31.4%	31.9%	↔↔
	<i>Diabetes Care Blood Pressure Control <140/90</i>	--	61.6%	64.5%	↔↔
	<i>Asthma 5–9 Years</i>	93.8%	93.8%	94.9%	↔↔
	<i>Asthma 10–17 Years</i>	92.3%	91.7%	92.0%	↔↔
	<i>Asthma 18–56 Years</i>	89.1%	88.6%	90.2%	↔↔
	<i>Asthma Combined Rate</i>	91.2%	90.9%	91.9%	↔↔
	<i>Controlling High Blood Pressure, Combined</i>	--	56.0%	56.0%	Rotated Measure
	<i>Advising Smokers to Quit</i>	69.2%	70.9%	71.1%	↔↔
	<i>Discussing Smoking Cessation Strategies</i>	32.8%	33.1%	36.8%	↔↔
Access to Care	<i>Children's Access 12–24 Months</i>	96.0%	95.3%	96.5%	↔↔
	<i>Children's Access 25 Mos–6 Years</i>	83.5%	84.2%	85.9%	↔↔
	<i>Children's Access 7–11 Years</i>	82.0%	84.5%	86.1%	↔↔
	<i>Adolescents' Access 12–19 Years</i>	79.4%	82.2%	83.7%	↔↔
	<i>Adults' Access 20–44 Years</i>	83.7%	84.0%	83.7%	↔↔
	<i>Adults' Access 45–64 Years</i>	91.3%	90.0%	89.7%	↔↔

Table C-6—Michigan Medicaid HEDIS 2008 Trend Table: MCL					
Dimension of Care	Measure	2006	2007	2008	2007–2008 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	78.8%	80.0%	84.7%	↔↔
	<i>Childhood Immunization Combo 3</i>	39.9%	66.7%	70.8%	↔↔
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	1.2%	1.2%	0.7%	↔↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	68.6%	62.8%	58.4%	↔↔
	<i>Well-Child 3rd–6th Years of Life</i>	63.3%	69.8%	67.9%	↔↔
	<i>Adolescent Well-Care Visits</i>	45.7%	52.1%	48.7%	↔↔
	<i>Appropriate Treatment of URI</i>	65.4%	67.2%	68.9%	↔↔
	<i>Children with Pharyngitis</i>	42.4%	48.7%	57.1%	↔↔
Women's Care	<i>Breast Cancer Screening, 42–51 Years</i>	--	45.3%	48.4%	↔↔
	<i>Breast Cancer Screening, 52–69 Years</i>	56.9%	56.9%	53.8%	↔↔
	<i>Breast Cancer Screening, Combined</i>	--	50.6%	50.9%	↔↔
	<i>Cervical Cancer Screening</i>	67.4%	70.1%	69.3%	↔↔
	<i>Chlamydia Screening, 16–20 Years</i>	53.3%	48.9%	51.6%	↔↔
	<i>Chlamydia Screening, 21–25 Years</i>	54.3%	58.8%	58.6%	↔↔
	<i>Chlamydia Screening, Combined</i>	53.7%	53.4%	54.8%	↔↔
	<i>Timeliness of Prenatal Care</i>	91.5%	93.4%	92.9%	↔↔
	<i>Postpartum Care</i>	76.6%	85.6%	80.8%	↔↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	84.8%	84.4%	83.9%	↔↔
	<i>Diabetes Care Poor HbA1c Control</i>	37.4%	41.8%	33.3%	↔↔
	<i>Diabetes Care Good HbA1c Control</i>	--	32.8%	41.6%	↔↔
	<i>Diabetes Care Eye Exam</i>	69.9%	67.4%	65.9%	↔↔
	<i>Diabetes Care LDL-C Screening</i>	83.8%	71.5%	74.9%	↔↔
	<i>Diabetes Care LDL-C Level <100</i>	39.9%	33.1%	35.8%	↔↔
	<i>Diabetes Care Nephropathy</i>	59.3%	91.2%	86.9%	↔↔
	<i>Diabetes Care Blood Pressure Control <130/80</i>	--	32.1%	32.6%	↔↔
	<i>Diabetes Care Blood Pressure Control <140/90</i>	--	60.6%	64.2%	↔↔
	<i>Asthma 5–9 Years</i>	97.3%	96.7%	96.5%	↔↔
	<i>Asthma 10–17 Years</i>	90.3%	90.6%	90.6%	↔↔
	<i>Asthma 18–56 Years</i>	87.9%	85.2%	90.2%	↔↔
	<i>Asthma Combined Rate</i>	90.5%	89.1%	91.7%	↔↔
	<i>Controlling High Blood Pressure, Combined</i>	--	69.1%	67.6%	↔↔
	<i>Advising Smokers to Quit</i>	69.5%	69.6%	69.4%	↔↔
	<i>Discussing Smoking Cessation Strategies</i>	32.4%	37.2%	40.8%	↔↔
Access to Care	<i>Children's Access 12–24 Months</i>	93.0%	94.9%	93.1%	↔↔
	<i>Children's Access 25 Mos–6 Years</i>	78.2%	78.1%	80.2%	↔↔
	<i>Children's Access 7–11 Years</i>	81.0%	77.0%	78.1%	↔↔
	<i>Adolescents' Access 12–19 Years</i>	78.9%	76.5%	77.0%	↔↔
	<i>Adults' Access 20–44 Years</i>	79.7%	81.0%	82.6%	↔↔
	<i>Adults' Access 45–64 Years</i>	87.2%	87.0%	87.0%	↔↔

Table C-7—Michigan Medicaid HEDIS 2008 Trend Table: MID

Dimension of Care	Measure	2006	2007	2008	2007–2008 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	75.9%	81.5%	75.9%	↔↔
	<i>Childhood Immunization Combo 3</i>	32.8%	57.9%	63.5%	↔↔
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	4.9%	3.6%	2.4%	↔↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	50.6%	56.7%	57.7%	↔↔
	<i>Well-Child 3rd–6th Years of Life</i>	73.5%	74.9%	72.3%	↔↔
	<i>Adolescent Well-Care Visits</i>	48.9%	50.1%	59.4%	↔↔
	<i>Appropriate Treatment of URI</i>	75.7%	75.2%	82.8%	↔↔
	<i>Children with Pharyngitis</i>	13.4%	18.7%	19.2%	↔↔
Women's Care	<i>Breast Cancer Screening, 42–51 Years</i>	--	51.9%	48.9%	↔↔
	<i>Breast Cancer Screening, 52–69 Years</i>	58.3%	57.5%	54.2%	↔↔
	<i>Breast Cancer Screening, Combined</i>	--	54.6%	51.5%	↔↔
	<i>Cervical Cancer Screening</i>	62.3%	64.2%	69.8%	↔↔
	<i>Chlamydia Screening, 16–20 Years</i>	40.0%	52.8%	58.3%	↔↔
	<i>Chlamydia Screening, 21–25 Years</i>	48.2%	60.3%	67.2%	↔↔
	<i>Chlamydia Screening, Combined</i>	43.6%	55.9%	61.4%	↔↔
	<i>Timeliness of Prenatal Care</i>	68.4%	76.4%	86.1%	↔↔
	<i>Postpartum Care</i>	46.5%	50.9%	61.8%	↑
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	71.5%	70.1%	74.9%	↔↔
	<i>Diabetes Care Poor HbA1c Control</i>	47.7%	48.2%	46.0%	↔↔
	<i>Diabetes Care Good HbA1c Control</i>	--	32.4%	32.8%	↔↔
	<i>Diabetes Care Eye Exam</i>	49.1%	53.5%	58.2%	↔↔
	<i>Diabetes Care LDL-C Screening</i>	81.5%	70.1%	72.0%	↔↔
	<i>Diabetes Care LDL-C Level <100</i>	40.1%	29.7%	27.5%	↔↔
	<i>Diabetes Care Nephropathy</i>	46.7%	77.9%	80.0%	↔↔
	<i>Diabetes Care Blood Pressure Control <130/80</i>	--	27.0%	28.5%	↔↔
	<i>Diabetes Care Blood Pressure Control <140/90</i>	--	56.9%	52.6%	↔↔
	<i>Asthma 5–9 Years</i>	79.6%	86.7%	86.5%	↔↔
	<i>Asthma 10–17 Years</i>	78.5%	81.8%	76.9%	↔↔
	<i>Asthma 18–56 Years</i>	82.9%	83.4%	79.8%	↔↔
	<i>Asthma Combined Rate</i>	81.1%	83.7%	80.6%	↔↔
	<i>Controlling High Blood Pressure, Combined</i>	--	52.6%	49.6%	↔↔
	<i>Advising Smokers to Quit</i>	67.8%	68.3%	70.5%	↔↔
	<i>Discussing Smoking Cessation Strategies</i>	34.9%	37.1%	41.6%	↔↔
Access to Care	<i>Children's Access 12–24 Months</i>	93.6%	92.1%	93.2%	↔↔
	<i>Children's Access 25 Mos–6 Years</i>	82.9%	81.4%	82.9%	↔↔
	<i>Children's Access 7–11 Years</i>	82.4%	81.2%	83.0%	↔↔
	<i>Adolescents' Access 12–19 Years</i>	80.0%	76.8%	79.0%	↔↔
	<i>Adults' Access 20–44 Years</i>	76.5%	78.2%	80.2%	↔↔
	<i>Adults' Access 45–64 Years</i>	85.4%	85.5%	86.7%	↔↔

Table C-8—Michigan Medicaid HEDIS 2008 Trend Table: MOL					
Dimension of Care	Measure	2006	2007	2008	2007–2008 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	72.4%	72.4%	76.3%	↔
	<i>Childhood Immunization Combo 3</i>	35.5%	35.5%	67.6%	↑
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	2.3%	1.9%	1.9%	↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	43.3%	42.5%	45.6%	↔
	<i>Well-Child 3rd–6th Years of Life</i>	62.2%	62.2%	68.6%	↔
	<i>Adolescent Well-Care Visits</i>	34.5%	39.6%	51.9%	↑
	<i>Appropriate Treatment of URI</i>	76.5%	79.4%	78.5%	↔
	<i>Children with Pharyngitis</i>	44.2%	43.6%	46.2%	↔
Women's Care	<i>Breast Cancer Screening, 42–51 Years</i>	--	44.5%	47.2%	↔
	<i>Breast Cancer Screening, 52–69 Years</i>	58.6%	54.2%	55.5%	↔
	<i>Breast Cancer Screening, Combined</i>	--	48.9%	51.0%	↔
	<i>Cervical Cancer Screening</i>	62.1%	58.0%	64.2%	↔
	<i>Chlamydia Screening, 16–20 Years</i>	56.3%	52.1%	51.7%	↔
	<i>Chlamydia Screening, 21–25 Years</i>	59.9%	58.4%	59.6%	↔
	<i>Chlamydia Screening, Combined</i>	57.9%	54.5%	54.7%	↔
	<i>Timeliness of Prenatal Care</i>	82.0%	67.4%	72.6%	↔
	<i>Postpartum Care</i>	58.8%	49.7%	51.9%	↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	88.8%	74.1%	87.3%	↑
	<i>Diabetes Care Poor HbA1c Control</i>	43.0%	50.1%	41.4%	↔
	<i>Diabetes Care Good HbA1c Control</i>	--	31.0%	37.5%	↔
	<i>Diabetes Care Eye Exam</i>	52.3%	50.6%	53.5%	↔
	<i>Diabetes Care LDL-C Screening</i>	84.5%	73.4%	79.3%	↔
	<i>Diabetes Care LDL-C Level <100</i>	33.9%	51.3%	53.8%	↔
	<i>Diabetes Care Nephropathy</i>	55.6%	76.9%	78.8%	↔
	<i>Diabetes Care Blood Pressure Control <130/80</i>	--	29.6%	26.0%	↔
	<i>Diabetes Care Blood Pressure Control <140/90</i>	--	54.3%	53.3%	↔
	<i>Asthma 5–9 Years</i>	90.2%	83.1%	89.8%	↔
	<i>Asthma 10–17 Years</i>	89.6%	82.0%	86.1%	↔
	<i>Asthma 18–56 Years</i>	84.3%	84.4%	84.7%	↔
	<i>Asthma Combined Rate</i>	86.8%	83.5%	86.1%	↔
	<i>Controlling High Blood Pressure, Combined</i>	--	45.2%	55.7%	↑
	<i>Advising Smokers to Quit</i>	69.3%	69.1%	70.4%	↔
	<i>Discussing Smoking Cessation Strategies</i>	41.7%	36.2%	35.6%	↔
Access to Care	<i>Children's Access 12–24 Months</i>	83.7%	94.4%	95.5%	↔
	<i>Children's Access 25 Mos–6 Years</i>	79.2%	82.0%	84.9%	↔
	<i>Children's Access 7–11 Years</i>	79.6%	80.5%	81.8%	↔
	<i>Adolescents' Access 12–19 Years</i>	78.5%	78.0%	79.6%	↔
	<i>Adults' Access 20–44 Years</i>	75.3%	77.2%	78.7%	↔
	<i>Adults' Access 45–64 Years</i>	81.5%	83.8%	84.3%	↔

Table C-9—Michigan Medicaid HEDIS 2008 Trend Table: OCH					
Dimension of Care	Measure	2006	2007	2008	2007–2008 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	72.0%	79.9%	82.4%	↔↔
	<i>Childhood Immunization Combo 3</i>	24.1%	51.9%	58.8%	↔↔
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	0.9%	0.9%	1.9%	↔↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	45.1%	50.9%	55.8%	↔↔
	<i>Well-Child 3rd–6th Years of Life</i>	65.8%	72.2%	73.6%	↔↔
	<i>Adolescent Well-Care Visits</i>	39.6%	50.2%	51.4%	↔↔
	<i>Appropriate Treatment of URI</i>	77.8%	79.7%	82.7%	↔↔
	<i>Children with Pharyngitis</i>	28.3%	32.3%	30.1%	↔↔
Women's Care	<i>Breast Cancer Screening, 42–51 Years</i>	--	40.1%	45.2%	↔↔
	<i>Breast Cancer Screening, 52–69 Years</i>	49.2%	52.6%	54.1%	↔↔
	<i>Breast Cancer Screening, Combined</i>	--	46.1%	49.7%	↔↔
	<i>Cervical Cancer Screening</i>	65.4%	66.7%	67.5%	↔↔
	<i>Chlamydia Screening, 16–20 Years</i>	62.3%	64.4%	64.1%	↔↔
	<i>Chlamydia Screening, 21–25 Years</i>	70.8%	72.4%	72.3%	↔↔
	<i>Chlamydia Screening, Combined</i>	65.9%	67.7%	67.1%	↔↔
	<i>Timeliness of Prenatal Care</i>	81.9%	84.1%	84.9%	↔↔
	<i>Postpartum Care</i>	47.2%	50.7%	52.2%	↔↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	71.0%	78.8%	79.6%	↔↔
	<i>Diabetes Care Poor HbA1c Control</i>	53.7%	49.9%	48.0%	↔↔
	<i>Diabetes Care Good HbA1c Control</i>	--	30.3%	30.2%	↔↔
	<i>Diabetes Care Eye Exam</i>	33.1%	47.8%	54.4%	↔↔
	<i>Diabetes Care LDL-C Screening</i>	80.5%	74.8%	71.5%	↔↔
	<i>Diabetes Care LDL-C Level <100</i>	34.5%	34.9%	34.3%	↔↔
	<i>Diabetes Care Nephropathy</i>	37.9%	83.4%	80.3%	↔↔
	<i>Diabetes Care Blood Pressure Control <130/80</i>	--	20.1%	20.9%	↔↔
	<i>Diabetes Care Blood Pressure Control <140/90</i>	--	46.4%	47.7%	↔↔
	<i>Asthma 5–9 Years</i>	81.7%	77.9%	82.8%	↔↔
	<i>Asthma 10–17 Years</i>	82.1%	75.1%	82.5%	↔↔
	<i>Asthma 18–56 Years</i>	85.8%	86.0%	85.3%	↔↔
	<i>Asthma Combined Rate</i>	84.0%	81.2%	83.9%	↔↔
	<i>Controlling High Blood Pressure, Combined</i>	--	44.0%	52.2%	↔↔
	<i>Advising Smokers to Quit</i>	67.3%	69.9%	70.5%	↔↔
	<i>Discussing Smoking Cessation Strategies</i>	32.9%	34.6%	34.3%	↔↔
Access to Care	<i>Children's Access 12–24 Months</i>	86.8%	90.2%	89.2%	↔↔
	<i>Children's Access 25 Mos–6 Years</i>	69.9%	73.7%	74.2%	↔↔
	<i>Children's Access 7–11 Years</i>	68.9%	73.8%	76.8%	↔↔
	<i>Adolescents' Access 12–19 Years</i>	67.5%	70.8%	73.9%	↔↔
	<i>Adults' Access 20–44 Years</i>	70.8%	74.5%	75.9%	↔↔
	<i>Adults' Access 45–64 Years</i>	79.8%	81.7%	83.1%	↔↔

Table C-10—Michigan Medicaid HEDIS 2008 Trend Table: PMD

Dimension of Care	Measure	2006	2007	2008	2007–2008 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	77.6%	82.0%	81.1%	↔↔
	<i>Childhood Immunization Combo 3</i>	41.6%	73.5%	74.4%	↔↔
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	1.3%	1.4%	0.7%	↔↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	43.3%	49.2%	57.9%	↔↔
	<i>Well-Child 3rd–6th Years of Life</i>	67.6%	67.6%	57.1%	↓
	<i>Adolescent Well-Care Visits</i>	47.7%	47.7%	41.6%	↔↔
	<i>Appropriate Treatment of URI</i>	79.8%	76.6%	84.1%	↔↔
	<i>Children with Pharyngitis</i>	48.0%	59.2%	55.3%	↔↔
Women's Care	<i>Breast Cancer Screening, 42–51 Years</i>	--	46.4%	45.2%	↔↔
	<i>Breast Cancer Screening, 52–69 Years</i>	54.8%	52.4%	51.8%	↔↔
	<i>Breast Cancer Screening, Combined</i>	--	49.1%	48.3%	↔↔
	<i>Cervical Cancer Screening</i>	74.5%	68.6%	69.2%	↔↔
	<i>Chlamydia Screening, 16–20 Years</i>	64.4%	67.2%	65.3%	↔↔
	<i>Chlamydia Screening, 21–25 Years</i>	64.2%	65.7%	65.7%	↔↔
	<i>Chlamydia Screening, Combined</i>	64.3%	66.5%	65.4%	↔↔
	<i>Timeliness of Prenatal Care</i>	86.4%	85.6%	85.6%	Rotated Measure
	<i>Postpartum Care</i>	62.5%	62.6%	65.8%	↔↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	82.5%	83.0%	87.4%	↔↔
	<i>Diabetes Care Poor HbA1c Control</i>	34.3%	38.0%	32.4%	↔↔
	<i>Diabetes Care Good HbA1c Control</i>	--	37.2%	42.2%	↔↔
	<i>Diabetes Care Eye Exam</i>	68.1%	67.8%	63.4%	↔↔
	<i>Diabetes Care LDL-C Screening</i>	89.8%	77.1%	77.5%	↔↔
	<i>Diabetes Care LDL-C Level <100</i>	47.0%	46.0%	43.3%	↔↔
	<i>Diabetes Care Nephropathy</i>	64.8%	78.2%	82.4%	↔↔
	<i>Diabetes Care Blood Pressure Control <130/80</i>	--	32.2%	34.0%	↔↔
	<i>Diabetes Care Blood Pressure Control <140/90</i>	--	65.2%	62.8%	↔↔
	<i>Asthma 5–9 Years</i>	92.7%	90.4%	91.8%	↔↔
	<i>Asthma 10–17 Years</i>	90.3%	89.3%	91.5%	↔↔
	<i>Asthma 18–56 Years</i>	86.4%	94.5%	89.5%	↔↔
	<i>Asthma Combined Rate</i>	89.0%	91.8%	90.7%	↔↔
	<i>Controlling High Blood Pressure, Combined</i>	--	59.4%	59.9%	↔↔
	<i>Advising Smokers to Quit</i>	74.7%	77.5%	74.3%	↔↔
	<i>Discussing Smoking Cessation Strategies</i>	49.4%	48.8%	48.2%	↔↔
	Access to Care	<i>Children's Access 12–24 Months</i>	93.2%	95.0%	94.5%
<i>Children's Access 25 Mos–6 Years</i>		81.9%	81.2%	77.7%	↔↔
<i>Children's Access 7–11 Years</i>		80.8%	84.5%	82.2%	↔↔
<i>Adolescents' Access 12–19 Years</i>		80.7%	81.8%	81.0%	↔↔
<i>Adults' Access 20–44 Years</i>		79.6%	80.5%	78.7%	↔↔
<i>Adults' Access 45–64 Years</i>		85.7%	86.1%	85.7%	↔↔

Table C-11—Michigan Medicaid HEDIS 2008 Trend Table: PRI					
Dimension of Care	Measure	2006	2007	2008	2007–2008 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	88.3%	88.7%	85.8%	↔
	<i>Childhood Immunization Combo 3</i>	56.0%	81.2%	81.5%	↔
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	0.7%	1.2%	0.7%	↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	50.0%	53.5%	55.3%	↔
	<i>Well-Child 3rd–6th Years of Life</i>	61.6%	63.7%	68.2%	↔
	<i>Adolescent Well-Care Visits</i>	41.8%	43.3%	48.9%	↔
	<i>Appropriate Treatment of URI</i>	88.6%	87.7%	90.4%	↔
	<i>Children with Pharyngitis</i>	68.9%	68.9%	66.9%	↔
Women's Care	<i>Breast Cancer Screening, 42–51 Years</i>	--	53.0%	51.2%	↔
	<i>Breast Cancer Screening, 52–69 Years</i>	56.1%	57.0%	56.2%	↔
	<i>Breast Cancer Screening, Combined</i>	--	54.7%	53.4%	↔
	<i>Cervical Cancer Screening</i>	77.7%	76.0%	79.7%	↔
	<i>Chlamydia Screening, 16–20 Years</i>	51.7%	55.6%	57.9%	↔
	<i>Chlamydia Screening, 21–25 Years</i>	59.2%	62.4%	64.9%	↔
	<i>Chlamydia Screening, Combined</i>	55.7%	59.1%	61.1%	↔
	<i>Timeliness of Prenatal Care</i>	90.6%	86.8%	86.3%	↔
	<i>Postpartum Care</i>	66.3%	66.3%	70.1%	↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	88.1%	89.3%	88.6%	↔
	<i>Diabetes Care Poor HbA1c Control</i>	30.7%	27.3%	32.8%	↔
	<i>Diabetes Care Good HbA1c Control</i>	--	48.7%	45.7%	↔
	<i>Diabetes Care Eye Exam</i>	65.9%	70.6%	71.3%	↔
	<i>Diabetes Care LDL-C Screening</i>	91.5%	81.0%	79.8%	↔
	<i>Diabetes Care LDL-C Level <100</i>	43.1%	39.4%	41.8%	↔
	<i>Diabetes Care Nephropathy</i>	53.8%	82.5%	80.3%	↔
	<i>Diabetes Care Blood Pressure Control <130/80</i>	--	40.9%	38.7%	↔
	<i>Diabetes Care Blood Pressure Control <140/90</i>	--	70.8%	70.6%	↔
	<i>Asthma 5–9 Years</i>	93.3%	98.3%	94.4%	↔
	<i>Asthma 10–17 Years</i>	95.6%	95.4%	95.1%	↔
	<i>Asthma 18–56 Years</i>	85.9%	88.5%	90.7%	↔
	<i>Asthma Combined Rate</i>	91.1%	93.6%	93.2%	↔
	<i>Controlling High Blood Pressure, Combined</i>	--	58.9%	58.8%	↔
	<i>Advising Smokers to Quit</i>	73.4%	76.1%	77.8%	↔
	<i>Discussing Smoking Cessation Strategies</i>	39.3%	43.3%	44.8%	↔
Access to Care	<i>Children's Access 12–24 Months</i>	96.5%	96.9%	96.6%	↔
	<i>Children's Access 25 Mos–6 Years</i>	83.5%	83.7%	85.3%	↔
	<i>Children's Access 7–11 Years</i>	85.1%	87.4%	86.1%	↔
	<i>Adolescents' Access 12–19 Years</i>	83.2%	85.5%	84.5%	↔
	<i>Adults' Access 20–44 Years</i>	86.1%	86.5%	86.8%	↔
	<i>Adults' Access 45–64 Years</i>	92.2%	93.1%	91.7%	↔

Table C-12—Michigan Medicaid HEDIS 2008 Trend Table: THC					
Dimension of Care	Measure	2006	2007	2008	2007–2008 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	71.5%	77.8%	85.3%	↔↔
	<i>Childhood Immunization Combo 3</i>	34.3%	62.0%	74.5%	↑
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	3.5%	1.2%	1.5%	↔↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	35.4%	49.1%	45.7%	↔↔
	<i>Well-Child 3rd–6th Years of Life</i>	65.4%	65.4%	70.2%	↔↔
	<i>Adolescent Well-Care Visits</i>	47.9%	47.9%	56.2%	↔↔
	<i>Appropriate Treatment of URI</i>	69.6%	76.3%	59.8%	↓
	<i>Children with Pharyngitis</i>	29.3%	37.5%	44.8%	↔↔
Women's Care	<i>Breast Cancer Screening, 42–51 Years</i>	--	43.0%	46.7%	↔↔
	<i>Breast Cancer Screening, 52–69 Years</i>	47.1%	52.8%	51.8%	↔↔
	<i>Breast Cancer Screening, Combined</i>	--	47.6%	49.1%	↔↔
	<i>Cervical Cancer Screening</i>	67.5%	66.2%	71.2%	↔↔
	<i>Chlamydia Screening, 16–20 Years</i>	52.1%	61.8%	63.7%	↔↔
	<i>Chlamydia Screening, 21–25 Years</i>	62.8%	68.7%	72.3%	↔↔
	<i>Chlamydia Screening, Combined</i>	56.8%	64.6%	67.0%	↔↔
	<i>Timeliness of Prenatal Care</i>	87.5%	84.2%	83.0%	↔↔
	<i>Postpartum Care</i>	62.1%	57.9%	64.1%	↔↔
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	82.4%	76.7%	77.3%	↔↔
	<i>Diabetes Care Poor HbA1c Control</i>	42.3%	47.0%	49.7%	↔↔
	<i>Diabetes Care Good HbA1c Control</i>	--	29.3%	31.4%	↔↔
	<i>Diabetes Care Eye Exam</i>	53.0%	57.3%	52.0%	↔↔
	<i>Diabetes Care LDL-C Screening</i>	84.6%	72.8%	68.8%	↔↔
	<i>Diabetes Care LDL-C Level <100</i>	34.5%	28.2%	32.7%	↔↔
	<i>Diabetes Care Nephropathy</i>	65.9%	77.6%	77.5%	↔↔
	<i>Diabetes Care Blood Pressure Control <130/80</i>	--	24.1%	22.3%	↔↔
	<i>Diabetes Care Blood Pressure Control <140/90</i>	--	52.6%	50.3%	↔↔
	<i>Asthma 5–9 Years</i>	76.9%	86.6%	84.6%	↔↔
	<i>Asthma 10–17 Years</i>	81.3%	80.2%	81.4%	↔↔
	<i>Asthma 18–56 Years</i>	78.1%	82.9%	80.6%	↔↔
	<i>Asthma Combined Rate</i>	78.9%	82.8%	81.7%	↔↔
	<i>Controlling High Blood Pressure, Combined</i>	--	41.6%	59.3%	↑
	<i>Advising Smokers to Quit</i>	66.9%	65.6%	69.1%	↔↔
	<i>Discussing Smoking Cessation Strategies</i>	32.4%	30.9%	33.1%	↔↔
	Access to Care	<i>Children's Access 12–24 Months</i>	89.0%	91.8%	91.9%
<i>Children's Access 25 Mos–6 Years</i>		75.9%	75.0%	80.7%	↔↔
<i>Children's Access 7–11 Years</i>		75.2%	78.3%	80.0%	↔↔
<i>Adolescents' Access 12–19 Years</i>		75.1%	77.4%	79.9%	↔↔
<i>Adults' Access 20–44 Years</i>		73.4%	74.9%	75.2%	↔↔
<i>Adults' Access 45–64 Years</i>		78.9%	80.4%	81.4%	↔↔

Table C-13—Michigan Medicaid HEDIS 2008 Trend Table: UPP

Dimension of Care	Measure	2006	2007	2008	2007–2008 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Combo 2</i>	79.4%	80.7%	81.2%	↔↔
	<i>Childhood Immunization Combo 3</i>	38.8%	66.6%	73.8%	↔↔
	<i>Well-Child 1st 15 Mos, 0 Visit</i>	1.9%	1.4%	1.4%	↔↔
	<i>Well-Child 1st 15 Mos, 6+ Visits</i>	41.6%	44.6%	60.9%	↑
	<i>Well-Child 3rd–6th Years of Life</i>	59.7%	60.9%	60.4%	↔↔
	<i>Adolescent Well-Care Visits</i>	37.0%	39.1%	37.0%	↔↔
	<i>Appropriate Treatment of URI</i>	81.1%	81.1%	81.8%	↔↔
	<i>Children with Pharyngitis</i>	52.3%	54.8%	64.0%	↔↔
Women's Care	<i>Breast Cancer Screening, 42–51 Years</i>	--	53.5%	51.7%	↔↔
	<i>Breast Cancer Screening, 52–69 Years</i>	70.0%	67.6%	63.0%	↔↔
	<i>Breast Cancer Screening, Combined</i>	--	60.0%	57.1%	↔↔
	<i>Cervical Cancer Screening</i>	73.0%	76.8%	76.8%	Rotated Measure
	<i>Chlamydia Screening, 16–20 Years</i>	47.9%	48.4%	45.2%	↔↔
	<i>Chlamydia Screening, 21–25 Years</i>	45.3%	49.4%	51.6%	↔↔
	<i>Chlamydia Screening, Combined</i>	46.8%	48.8%	47.6%	↔↔
	<i>Timeliness of Prenatal Care</i>	85.2%	88.7%	88.7%	Rotated Measure
	<i>Postpartum Care</i>	53.5%	68.8%	68.8%	Rotated Measure
Living With Illness	<i>Diabetes Care HbA1c Testing</i>	91.6%	89.7%	89.0%	↔↔
	<i>Diabetes Care Poor HbA1c Control</i>	23.9%	27.8%	25.2%	↔↔
	<i>Diabetes Care Good HbA1c Control</i>	--	44.3%	48.8%	↔↔
	<i>Diabetes Care Eye Exam</i>	68.6%	70.6%	66.9%	↔↔
	<i>Diabetes Care LDL-C Screening</i>	92.3%	81.7%	82.4%	↔↔
	<i>Diabetes Care LDL-C Level <100</i>	37.1%	37.4%	40.6%	↔↔
	<i>Diabetes Care Nephropathy</i>	64.0%	81.4%	79.1%	↔↔
	<i>Diabetes Care Blood Pressure Control <130/80</i>	--	39.9%	39.4%	↔↔
	<i>Diabetes Care Blood Pressure Control <140/90</i>	--	69.0%	73.5%	↔↔
	<i>Asthma 5–9 Years</i>	95.1%	97.8%	88.0%	↔↔
	<i>Asthma 10–17 Years</i>	86.2%	92.5%	89.3%	↔↔
	<i>Asthma 18–56 Years</i>	86.8%	87.2%	86.4%	↔↔
	<i>Asthma Combined Rate</i>	88.2%	91.3%	87.7%	↔↔
	<i>Controlling High Blood Pressure, Combined</i>	--	64.8%	65.3%	↔↔
	<i>Advising Smokers to Quit</i>	69.6%	72.9%	71.7%	↔↔
	<i>Discussing Smoking Cessation Strategies</i>	34.7%	38.5%	40.7%	↔↔
Access to Care	<i>Children's Access 12–24 Months</i>	98.0%	97.7%	97.7%	↔↔
	<i>Children's Access 25 Mos–6 Years</i>	88.1%	88.1%	88.1%	↔↔
	<i>Children's Access 7–11 Years</i>	84.2%	87.2%	87.9%	↔↔
	<i>Adolescents' Access 12–19 Years</i>	86.9%	90.0%	90.4%	↔↔
	<i>Adults' Access 20–44 Years</i>	86.6%	89.5%	88.7%	↔↔
	<i>Adults' Access 45–64 Years</i>	91.0%	91.2%	91.3%	↔↔

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 Finding

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*, *Not Applicable*, *No Benefit*, or *Not Report* audit finding.

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

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

Capitation

A method of payment for providers. Under a capitated payment arrangement, providers are reimbursed on a per-member/per-month basis. The provider receives payment each month, regardless of whether the member 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 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

Because of the large number of measures and the required level of assessment, a selection of a core set of measures allows for the findings of the review to be projected to the remaining measures. The core set of measures must include 15 measures, plus the Adult and Child Surveys, when applicable. 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 15 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.

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 Audit 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).

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

**Formerly the Health Plan Employer Data and Information Set.*

HEDIS Measure Determination Standards (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.

IDSS

Interactive Data Submission System—a tool used to submit data to NCQA.

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

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's denominator for a measure 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 finding.

A measure have an NR audit finding for one of two reasons:

1. The health plan chose not to report the measure;
2. 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.

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

The eligible population who meet all criteria specified in the measure from which a systematic sample is drawn.

Source Code

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

Standard Codes

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

T-test Validation

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

UB-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.