

ANALYSIS OF MEDICAID HMO

(FY2010 Appropriation Bill - Public Act 131 of 2009)

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 MIHP and EPSDT programs. (5) The department shall assure the training and technical assistance are available for EPSDT and MIHP for Medicaid health plans, local health departments, and MIHP contractors.

*Michigan Department
of Community Health*



Jennifer M. Granholm, Governor
Janet Olszewski, Director

State of Michigan



Department of Community Health

**Michigan Medicaid HEDIS® 2009 Results
STATEWIDE AGGREGATE REPORT**

December 2009



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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 2008, the Michigan Department of Community Health (MDCH) contracted with 14 health plans to provide managed care services to Michigan Medicaid enrollees. 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 comprise 37 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 performance levels have been set at specific, attainable rates and are based on national percentiles. This standardization allows for comparison to the performance levels. Health plans meeting the high performance level (HPL) exhibit rates among the top in the nation. The low performance level (LPL) has been set to identify health plans in the greatest need of improvement. Details are shown in Section 2, "How to Get the Most From This Report."

HSAG has examined the key measures along four different dimensions of care: (1) Pediatric Care, (2) Women's Care, (3) Living With Illness, and (4) Access to Care. These dimensions reflect important groupings and expand on the dimensions model used by the Foundation for Accountability (FACCT). This approach to the analysis is designed to encourage consideration of the key measures as a whole rather than in isolation, and to think about the strategic and tactical changes required to improve overall performance.

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

- ◆ A weighted average comparison presents the Michigan Medicaid 2009 results relative to the 2008 Michigan Medicaid weighted averages and the national HEDIS 2008 Medicaid 50th percentiles.
- ◆ A performance profile analysis discusses the overall Michigan Medicaid 2009 results and presents a summary of health plan performance relative to the Michigan Medicaid performance levels.

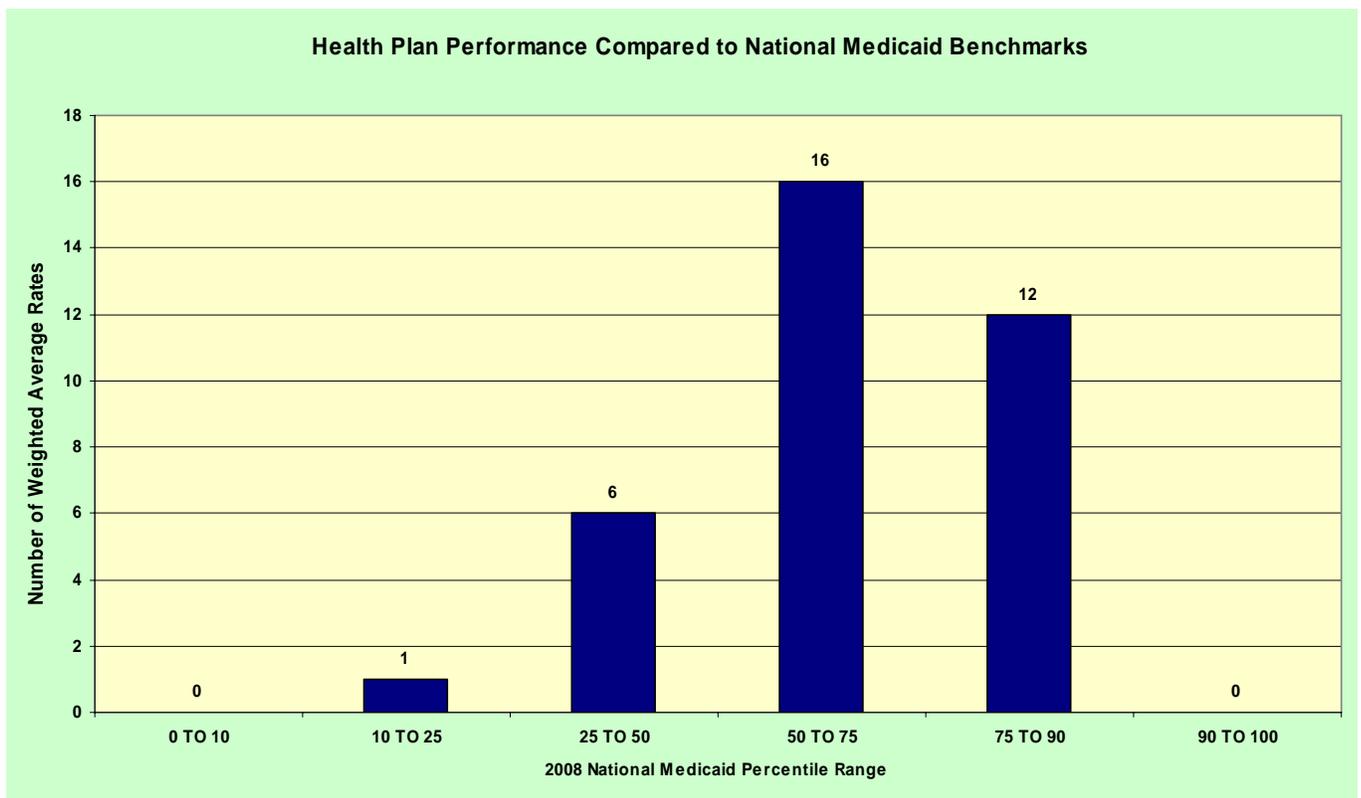
- ◆ A health plan ranking analysis provides a more detailed comparison, showing results relative to the Michigan Medicaid performance levels.
- ◆ A data collection analysis evaluates the potential impact of data collection methodology on reported rates.

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 National Committee for Quality Assurance’s (NCQA’s) information system (IS) standards.

Key Findings and Recommendations

This is the ninth 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 35 weighted averages for which national percentile data were available, 1 (or 3 percent) fell between the 10th and 25th percentiles, 6 (or 17 percent) fell between the 25th and 50th percentiles, 16 (or 46 percent) fell between the 50th and 75th percentiles, and 12 (or 34 percent) fell between the 75th and 90th percentiles. Eighty percent of results were at or above the 50th percentile. No measure results ranked below the 10th percentile or above the 90th percentile.

**Figure 1-1—Michigan Medicaid HEDIS 2009:
Health Plan Performance Compared With National Medicaid Percentiles**



Five of the 35 2009 Michigan Medicaid weighted averages declined compared to the 2008 rates, and none of the declines was statistically significant. The declines were very minor, ranging from 0.1 percentage point to 1.3 percentage points. The measures that had a decrease in rates were: *Childhood Immunization Status—Combination 2* and all four of the rates for the *Appropriate Medications for People With Asthma*. The remaining 30 measures showed improvement, with statistically significant improvement on 5 measures. Significant improvement was seen in the *Lead Screening in Children (LSC)* measure, the *Cervical Cancer Screening* measure, and the *Chlamydia Screening* rates.

Improvement was seen in all of the Pediatric Care measures except for *Childhood Immunization Status—Combination 2*, which had a decrease of only 0.1 percentage point from last year. The LSC measure had a statistically significant increase from 2008 of 4.8 percentage points, demonstrating the positive impact of the Michigan MHPs' focused improvement efforts on lead screening during the measurement year. Seven of the Pediatric Care measures ranked above the national 50th percentile, and four of those rates performed better than the 75th percentile, indicating that only 25 percent of the other health plans performed better than the Michigan weighted average. Two measures that continued to fall below the national average were *Appropriate Treatment for Children With Upper Respiratory Infections (URI)* and *Appropriate Testing for Children With Pharyngitis (CWP)*. These measures rely heavily on pharmacy data, and if pharmacy data are not complete for the health plans, lower rates would result. The MHPs should monitor pharmacy data submission from pharmacy vendors and educate providers on the appropriate treatment of patients diagnosed with these conditions. The use of medical record review continued to decrease in 2009, with more of the aggregate rates derived from administrative data than in previous years. More specific recommendations and best practices for each of the Pediatric Care measures can be found in Section 3—Pediatric Care of this report.

The weighted averages of all seven measures in the Women's Care dimension showed improvement compared to 2008 rates. Improvement ranged from 0.9 percentage points to 5.5 percentage points. Statistically significant improvement was seen for the *Cervical Cancer Screening* rate, as well as for all four rates of the *Chlamydia Screening* measure. The upper age limit for the *Chlamydia Screening* measure dropped from 25 years of age to 24 years of age, but this would not have significantly impacted the change in the rates. All of the weighted averages equaled or ranked higher than the national HEDIS 2008 50th percentile, and four of those rates exceeded the 75th percentile. The rates that exceeded the 75th percentile were the *Chlamydia Screening* rates and the *Prenatal and Postpartum Care—Postpartum Care* rate. Many of the Women's Care measures were affected by the barriers women have to seeking services. Section 4, Women's Care, provides specific examples of efforts by health plans across the country to improve performance on these measures.

Improvement was seen in 11 of the 15 rates reported in the Living With Illness section. All of the *Comprehensive Diabetes Care* measures showed improvement, with rates ranging from 0.1 to 2.4 percentage points. All of the diabetes rates, except for *Blood Pressure Control (<140/90 mm Hg)*, exceeded the national average, and three of the rates (*LDL-C Screening*, *LDL-C Level <100*, and *Medical Attention for Diabetic Nephropathy*) exceeded the 75th percentile. The portion of the aggregate rate derived from administrative data for these measures increased, indicating that the MHPs are not having to rely as much on medical record data to report diabetes care rates. All four

of the *Appropriate Medications for People With Asthma* rates declined. The declines, however, were small, ranging from 0.2 to 1.3 percentage points. Overall performance on the asthma measure was below average among the MHPs. *Controlling High Blood Pressure* saw a rate increase of 2.0 percentage points from 2008 and ranked above the national 50th percentile. Declines in the asthma rates could be associated with incomplete pharmacy data. Similar to the recommendation for the *URI* and *CWP* measures in the Pediatric Care dimension, the MHPs may consider reviewing and trending pharmacy data to ensure that they are receiving all data from the pharmacy vendors. More specific recommendations related to the Living With Illness measures can be found in Section 5 of this report.

While no national performance standards exist for the *Medical Assistance With Smoking Cessation* measures (*Advising Smokers to Quit* and *Smoking Cessation Strategies*), the rates showed improvement of 0.1 percentage point and 2.1 percentage points, respectively.

The weighted averages for the measures in the Access to Care dimension all showed improvement in 2009. While not statistically significant, improvement ranged from 0.7 percentage points to 2.5 percentage points. All of the measures except *Children's and Adolescents' Access to Primary Care Practitioners—7–11 Years* ranked above the national 50th percentile. The rate for this measure fell 1.6 percentage points below the national average. Improving rates on the Access to Care measures requires the MHPs evaluate why members are not seeking services and develop ways to overcome those barriers. Section 6—Access To Care addresses specific interventions and best practices that other health plans across the country have used to improve performance in these areas.

The use of supplemental data across all of the MHPs increased from previous years. Supplemental data allow the health plans to use other sources of data to supplement the administrative claims and encounter data typically used to report HEDIS rates. Supplemental data sources could include disease management databases, immunization registries, lead screening registries, electronic medical records, and lab data, among many others. The MHPs are encouraged to continue to use these data sources and investigate other sources of data to supplement standard sources of data.

All MHPs should continue to monitor data completeness. HSAG recommends that the MHPs evaluate the degree to which hybrid rates improved due to medical record review by comparing the initial administrative rate to the hybrid rate. Based on this difference in rates, the MHPs should determine why they did not receive medical record hits (other than lab values) as a claim or encounter.

As mentioned above, each section of the report contains domain-specific recommendations and best practices (if applicable) identified by HSAG. Please refer to the individual sections for this information.

Weighted Average Comparisons for the Four Dimensions of Care

Figure 1-2 through Figure 1-5 show Michigan Medicaid HEDIS 2009 results for each dimension of care, comparing the current weighted average for each measure relative to the 2008 Michigan Medicaid weighted average and the national HEDIS 2008 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 2009 and 2008 Michigan Medicaid weighted averages.
- ◆ The dark-colored bars show the difference in percentage points between this year's Michigan results and the national results, comparing the 2009 Michigan Medicaid weighted average with the national HEDIS 2008 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.

- ◆ National percentile data for *Advising Smokers to Quit* and *Discussing Smoking Cessation Strategies* measures are not available. Weighted averages could not be calculated.

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 national HEDIS 2008 Medicaid 50th percentile.

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

- ◆ Three stars (★★★) for performance at or above the HPL (90th percentile).
- ◆ Two stars (★★) for performance above the LPL but below the HPL (>25th percentile to <90th percentile).
- ◆ One star (★) for performance at or below the LPL (≤25th 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*.

The use of *Not Applicable* (NA) in graphs and tables 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.

The results of measures that did not have national percentiles available for comparison are presented as “- -” in the following tables.

Summary of Results

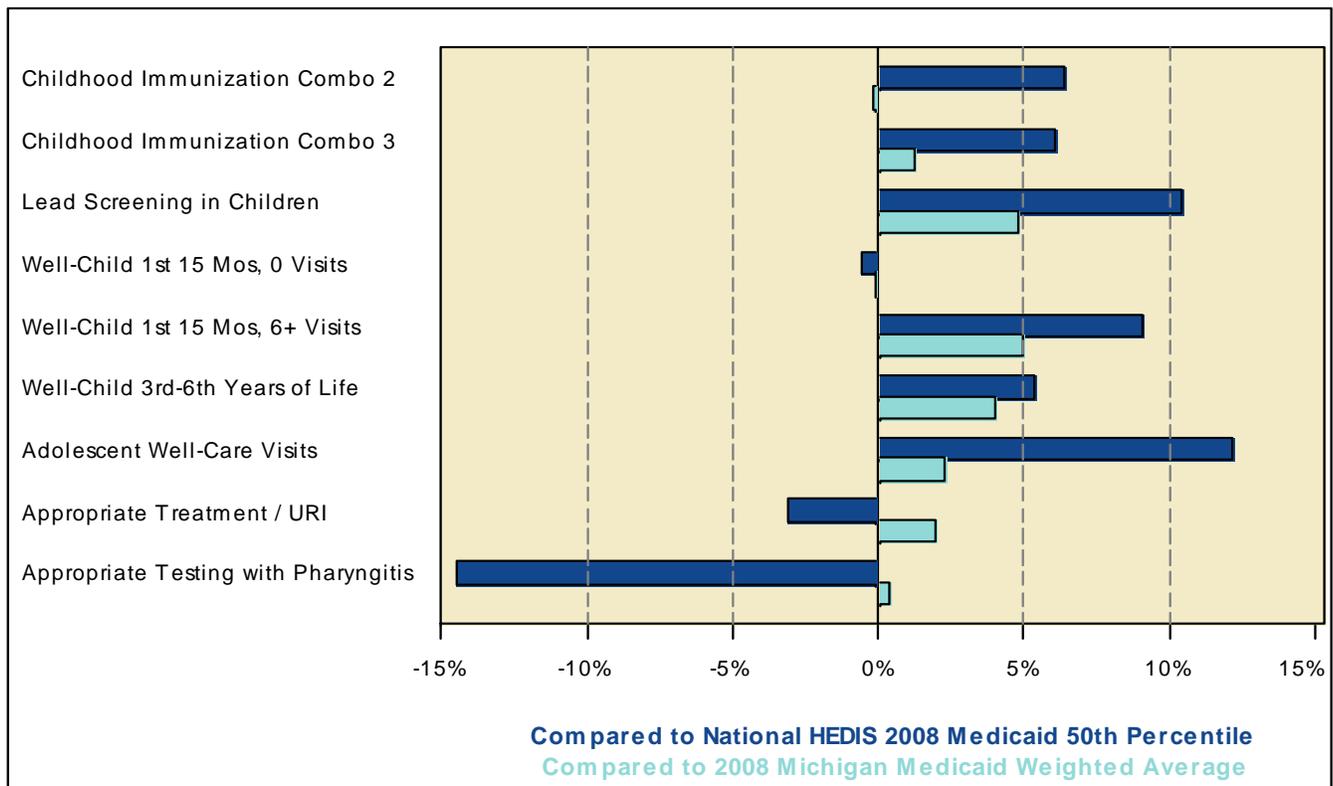
Pediatric Care

Eight out of the nine Pediatric Care measures' weighted averages showed improvement from 2008. *Lead Screening in Children* showed statistically significant improvement, with an increase of 4.8 percentage points compared to the 2008 Michigan Medicaid weighted average.

All of the weighted averages for the immunization, lead screening in children, and well-care measures performed better than the national HEDIS 2008 Medicaid 50th percentile. All of the MHPs' rates for these measures came primarily from administrative data, and the percentage of the rates derived from administrative data increased. This indicated 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 2008; however, more than half of the plans continued to perform below the national HEDIS 2008 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 2009 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 2009 Performance Summary: Pediatric Care

Health Plan Name	Childhood Immunization Combo 2	Childhood Immunization Combo 3	Lead Screening in Children	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	★★★	★★★	★★	★★	★★	★★	★★	★★	★★★
CSM	★★	★★	★★	★★	★★	★	★★	★	★★
GLH	★★	★★	★★	★★	★★★	★★	★★★	★★	★
HPM	★★★	★★★	★★	★★	★★	★★	★★★	★★	★★
HPP	★★	★★	★★	★★	★★	★★	★★	★	★
MCL	★★	★★	★★	★★★	★★	★★	★★	★	★★
MID	★★	★★	★★	★★	★★	★★	★★★	★★	★
MOL	★★	★★	★★	★★	★★	★★	★★	★★	★
OCH	★★	★★	★★	★★	★★	★★	★★	★★	★
PMD	★★	★★	★★★	★★	★★	★★	★★	★★	★★
PRI	★★★	★★★	★★	★★	★★	★★	★★	★★	★★
PRO	NA	NA	NA	NA	NA	NA	★	NA	NA
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>

Women’s Care

All of the Women’s Care measures’ weighted averages showed improvement compared to the 2008 weighted averages. The *Cervical Cancer Screening* and *Chlamydia Screening in Women—16 to 20 Years* showed statistically significant improvement, with an increase of 3.9 percentage points and 5.5 percentage points, respectively. In 2009, the upper age limits for *Chlamydia Screening in Women—21 to 25 Years* and *Chlamydia Screening in Women—Combined Rate* decreased from 25 years of age to 24 years of age. Please use caution when comparing the 2009 Michigan Medicaid weighted average with the national HEDIS 2008 Medicaid 50th percentile or the 2008 Michigan Medicaid weighted average.

All seven Women’s Care measures’ weighted averages exceeded the national HEDIS 2008 Medicaid 50th percentile.

Figure 1-3—Michigan Medicaid HEDIS 2009 Weighted Average Comparison: Women’s Care

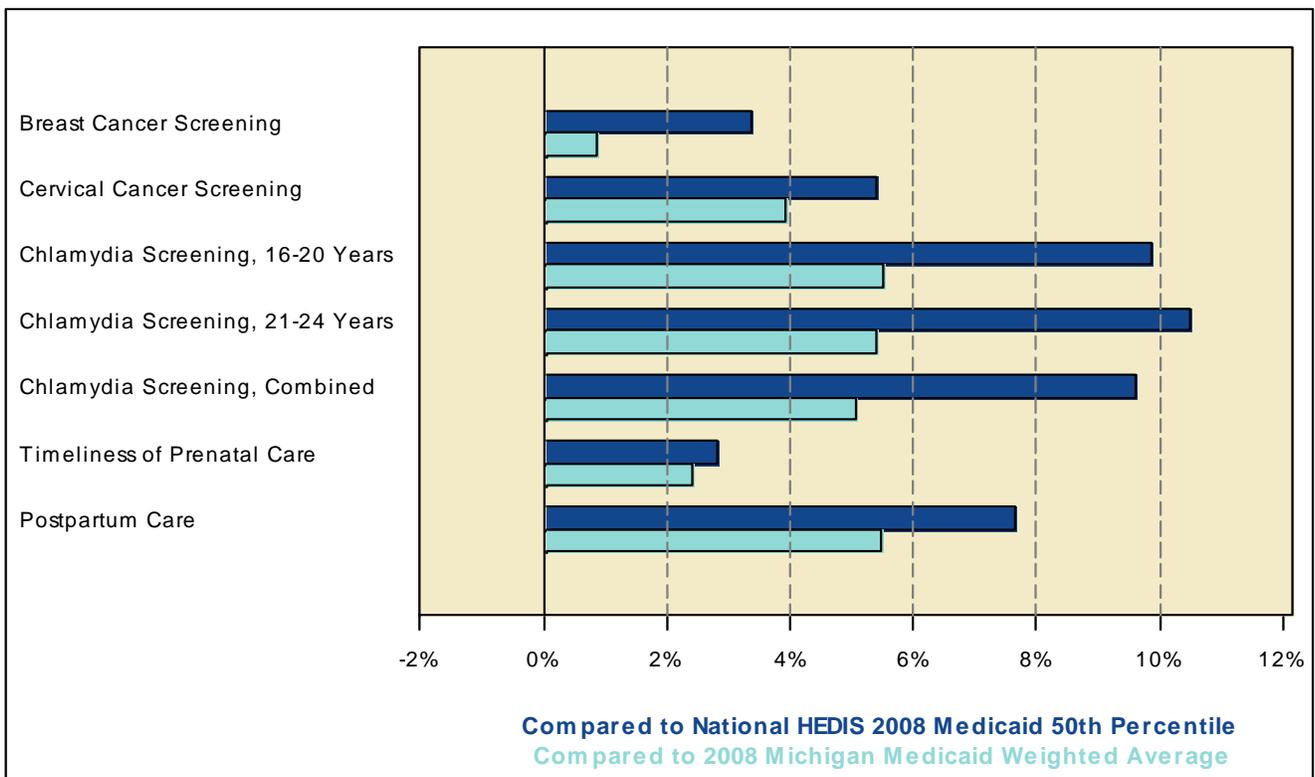


Table 1-2—Michigan Medicaid HEDIS 2009 Performance Summary: Women’s Care

Health Plan Name	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening 16–20 Yrs	Chlamydia Screening 21–24 Yrs	Chlamydia Screening Combined	Timeliness of Prenatal Care	Postpartum Care
BCD	★★	★★	★★	★★	★★	★★	★★
CSM	★★	★★	★★	★★	★★	★★	★★
GLH	★★	★★	★★	★★	★★	★★	★★
HPM	★★★	★★★	★★	★★	★★	★★	★★★
HPP	★★	★★	★★	★★	★★	★★	★★
MCL	★★	★★	★★	★★	★★	★★★	★★★
MID	★★	★★	★★	★★	★★	★★	★★
MOL	★★	★★	★★	★★	★★	★★	★★
OCH	★★	★★	★★★	★★★	★★★	★★	★★
PMD	★★	★★	★★	★★★	★★★	★★	★★
PRI	★★	★★★	★★★	★★★	★★★	★★	★★★
PRO	NA	NA	NA	NA	NA	NA	NA
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.

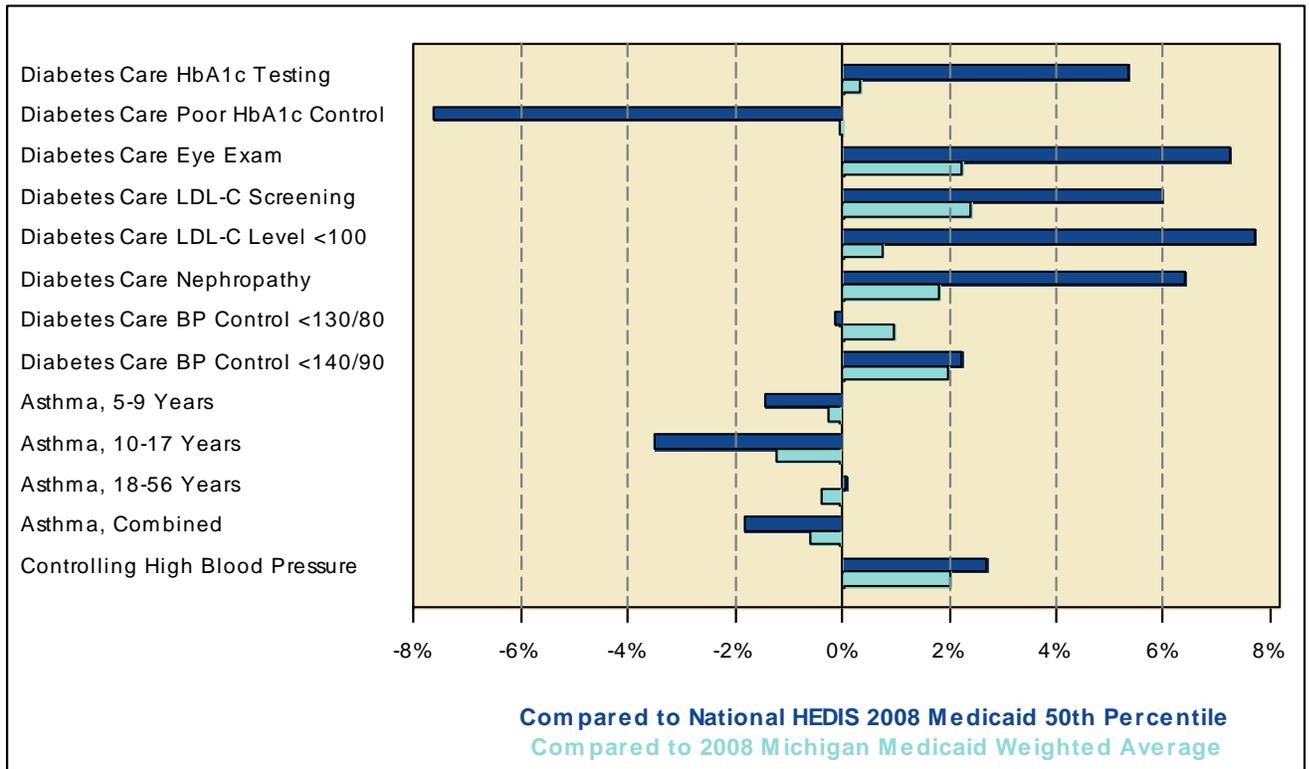
This symbol	shows this performance level
3 stars	★★★ ≥ HPL
2 stars	★★ > LPL and < HPL
1 star	★ ≤ LPL, or for <i>Not Report (NR)</i>

Living With Illness

Nine out of the 13 Living With Illness measures' weighted averages showed improvement compared to the 2008 results. None of the weighted averages for the *Use of Appropriate Medications for People With Asthma* measures showed improvement compared to the 2008 weighted averages.

Nine out of the 13 Living With Illness measures' weighted averages were above the national HEDIS 2008 Medicaid 50th percentile.

**Figure 1-4—Michigan Medicaid HEDIS 2009 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 *Smoking Cessation Strategies* are not included in this figure because national percentile data are not available and a weighted average could not be calculated.

**Table 1-3—Michigan Medicaid HEDIS 2009 Performance Summary:
Living With Illness (Part 1)**

Health Plan Name	Diabetes Care HbA1c Testing	Diabetes Care Poor 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	★★★	★★★	★★★	★★★	★★★	★★★	★★★	★★★
CSM	★★	★★★	★★	★★	★★	★★	★★	★★
GLH	★★	★★	★★	★★	★★	★★	★★	★★
HPM	★★★	★★★	★★★	★★★	★★★	★★★	★★	★★
HPP	★★	★★	★★★	★★	★★	★★★	★★	★★
MCL	★★	★★	★★★	★★	★★	★★★	★★	★★
MID	★★	★	★★	★★	★★	★★★	★★	★★
MOL	★★	★★	★★	★★	★★★	★★	★★	★★
OCH	★★	★★	★★	★★	★★	★★	★★	★★
PMD	★★	★★★	★★★	★★	★★★	★★	★★	★★
PRI	★★	★★★	★★★	★★	★★	★★	★★	★★
PRO	NA	NA	NA	NA	NA	NA	NA	NA
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>

**Table 1-3—Michigan Medicaid HEDIS 2009 Performance Summary:
Living With Illness (Part 2)**

Health Plan Name	Asthma 5–9 Yrs	Asthma 10–17 Yrs	Asthma 18–56 Yrs	Asthma Combined	Controlling High Blood Pressure	Advising Smokers to Quit*	Discussing Smoking Cessation Strategies*
BCD	★★	★★★	★★	★★	★★★	--	--
CSM	★★	★★	★★	★★	★★	--	--
GLH	★★	★	★★	★	★★	--	--
HPM	★★	★★	★★	★★	★★★	--	--
HPP	★★	★★	★★★	★★★	★★	--	--
MCL	★★	★★	★★	★★	★★★	--	--
MID	★	★	★★	★	★★	--	--
MOL	★	★	★★	★	★★	--	--
OCH	★	★	★★	★	★★	--	--
PMD	★★★	★★★	★★	★★★	★★	--	--
PRI	★★★	★★★	★★	★★★	★★	--	--
PRO	NA	NA	NA	NA	NA	--	--
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.

* -- 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 2008 Michigan Medicaid weighted averages.

All the Access to Care measures, except *Children’s and Adolescents’ Access to Primary Care Practitioners—7 to 11 Years*, performed better than the national HEDIS 2008 50th percentile.

Figure 1-5—Michigan Medicaid HEDIS 2009 Weighted Average Comparison: Access to Care

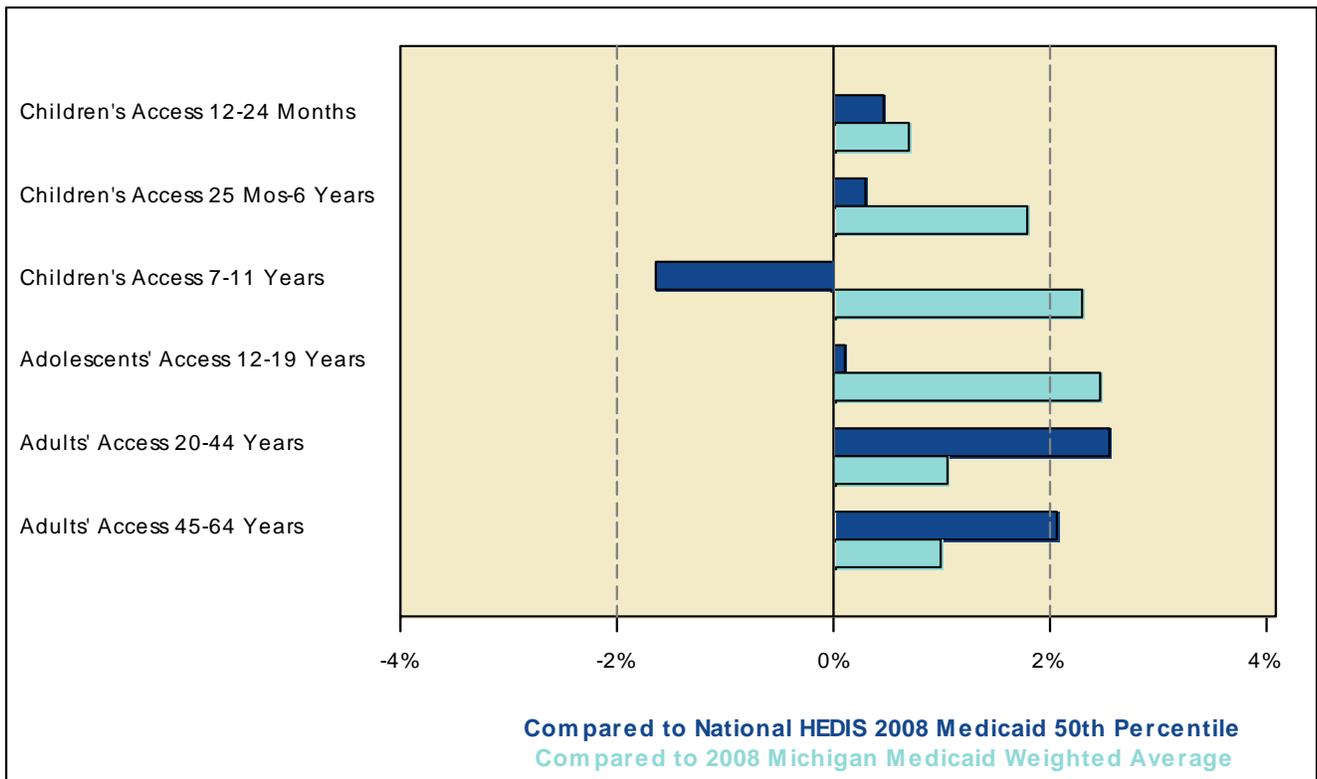


Table 1-4—Michigan Medicaid HEDIS 2009 Performance Summary: Access to Care

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	★★	★★	★★	★★	★★	★★
CSM	★★	★★	★★	★★	★★	★★
GLH	★★	★★	★★	★★	★★	★★
HPM	★★	★★	★★	★★	★★	★★★
HPP	★★	★★	★★	★★	★★	★★
MCL	★★	★★	★	★★	★★	★★
MID	★★	★★	★★	★★	★★	★★
MOL	★★	★★	★★	★★	★★	★★
OCH	★	★	★	★	★★	★★
PMD	★★	★★	★★	★★	★★	★★
PRI	★★	★★	★★	★★	★★	★★
PRO	NA	NA	NA	NA	NA	NA
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 2009 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 37 distinct rates, shown in Table 2-1. These 37 rates represent the 2009 MDCH key measures. Fourteen Michigan MHPs were required to report the key measures in 2009.

Table 2-1—Michigan Medicaid HEDIS 2009 Key Measures

Standard HEDIS 2007 Measures	2007 MDCH Key Measures
1. <i>Childhood Immunization Status</i>	1. <i>Childhood Immunization Status—Combination 2</i> 2. <i>Childhood Immunization Status—Combination 3</i>
2. <i>Lead Screening in Children</i>	3. <i>Lead Screening in Children</i>
3. <i>Well-Child Visits in the First 15 Months of Life</i>	4. <i>Well-Child Visits in the First 15 Months of Life—Zero Visits</i> 5. <i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>
4. <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	6. <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
5. <i>Adolescent Well-Care Visits</i>	7. <i>Adolescent Well-Care Visits</i>
6. <i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	8. <i>Appropriate Treatment for Children With Upper Respiratory Infection</i>
7. <i>Appropriate Testing for Children With Pharyngitis</i>	9. <i>Appropriate Testing for Children With Pharyngitis</i>
8. <i>Breast Cancer Screening</i>	10. <i>Breast Cancer Screening</i>
9. <i>Cervical Cancer Screening</i>	11. <i>Cervical Cancer Screening</i>
10. <i>Chlamydia Screening in Women</i>	12. <i>Chlamydia Screening in Women—16 to 20 Years</i> 13. <i>Chlamydia Screening in Women—21 to 24 Years</i> 14. <i>Chlamydia Screening in Women—Combined Rate</i>
11. <i>Prenatal and Postpartum Care</i>	15. <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> 16. <i>Prenatal and Postpartum Care—Postpartum Care</i>
12. <i>Comprehensive Diabetes Care</i>	17. <i>Comprehensive Diabetes Care—HbA1c Testing</i> 18. <i>Comprehensive Diabetes Care—Poor HbA1c Control</i> 19. <i>Comprehensive Diabetes Care—Eye Exam</i> 20. <i>Comprehensive Diabetes Care—LDL-C Screening</i> 21. <i>Comprehensive Diabetes Care—LDL-C Level <100</i> 22. <i>Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy</i> 23. <i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i> 24. <i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>
13. <i>Use of Appropriate Medications for People With Asthma</i>	25. <i>Use of Appropriate Medications for People With Asthma—5 to 9 Years</i> 26. <i>Use of Appropriate Medications for People With Asthma—10 to 17 Years</i> 27. <i>Use of Appropriate Medications for People With Asthma—18 to 56 Years</i> 28. <i>Use of Appropriate Medications for People With Asthma—Combined Rate</i>
14. <i>Controlling High Blood Pressure</i>	29. <i>Controlling High Blood Pressure</i>
15. <i>Medical Assistance With Smoking Cessation</i>	30. <i>Medical Assistance With Smoking Cessation—Advising Smokers to Quit</i> 31. <i>Medical Assistance With Smoking Cessation—Smoking Cessation Strategies</i>
16. <i>Children’s and Adolescents’ Access to Primary Care Practitioners</i>	32. <i>Children’s and Adolescents’ Access to Primary Care Practitioners—12 to 24 Months</i> 33. <i>Children’s and Adolescents’ Access to Primary Care Practitioners—25 Months to 6 Years</i> 34. <i>Children’s and Adolescents’ Access to Primary Care Practitioners—7 to 11 Years</i> 35. <i>Children’s and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years</i>
17. <i>Adults’ Access to Preventive/Ambulatory Health Services</i>	36. <i>Adults’ Access to Preventive/Ambulatory Health Services—20 to 44 Years</i> 37. <i>Adults’ Access to Preventive/Ambulatory Health Services—45 to 64 Years</i>

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. Six health plans chose to rotate measures in 2009. Following NCQA methodology, rotated measures were assigned the same reported rates from measurement year 2007 and were included in the calculations for the Michigan Medicaid weighted averages.

Dimensions of Care

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

Changes to Measures

For the 2009 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

- ◆ Revised the required number of doses for the Hib vaccine to defer the third Hib booster during vaccine shortage.

Breast Cancer Screening

- ◆ Removed age stratifications

Chlamydia Screening in Women

- ◆ Decreased upper age limit to 24 years

Use of Appropriate Medications for People with Asthma

- ◆ Clarified dispensing event and inhaler dispensing event criteria
- ◆ Clarified in step 2 that a member prescribed a leukotriene modifier needs at least one diagnosis of asthma in the same year as the leukotriene modifier dispensing event.

Controlling High Blood Pressure

- ◆ Clarified that BP reading taken during an acute inpatient state or emergency department (ED) visit should not be included

Comprehensive Diabetes Care

- ◆ NCQA added the *HbA1c Control <8.0 Percent* and *HbA1c Control <7.0 Percent* indicators this year. Reporting the *HbA1c Control <7.0 Percent* rate requires a larger sample size and additional exclusion criteria.

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 ultimately improve the Michigan Medicaid average for all of the key measures. The HPL represents current high performance in national Medicaid managed care, and the LPL represents below-average performance nationally. Health plans should focus their efforts on reaching and/or maintaining the HPL for each key measure, rather than comparing themselves to other Michigan MHPs.

Comparative information in this report is based on the national NCQA Medicaid HEDIS 2008 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 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 this key measure. Instead, health plan results are ranked highest to lowest and are compared with the 2009 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 “2008–2009 Health Plan Trend” shows, by key measure, the comparison between the 2008 results and the 2009 results for each health plan. Trends are shown graphically, using the key below:

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

Different symbols ( ) are used to indicate a 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 *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 2009 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 2009 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 2008 and 2009 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 2008 and 2009 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 2008 Medicaid 50th percentile. In addition, the 2009, 2008, and 2007 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 2009 Michigan Medicaid weighted average for each rate with the 2008 and 2007 Michigan Medicaid weighted averages and the national HEDIS 2008 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 2009 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.

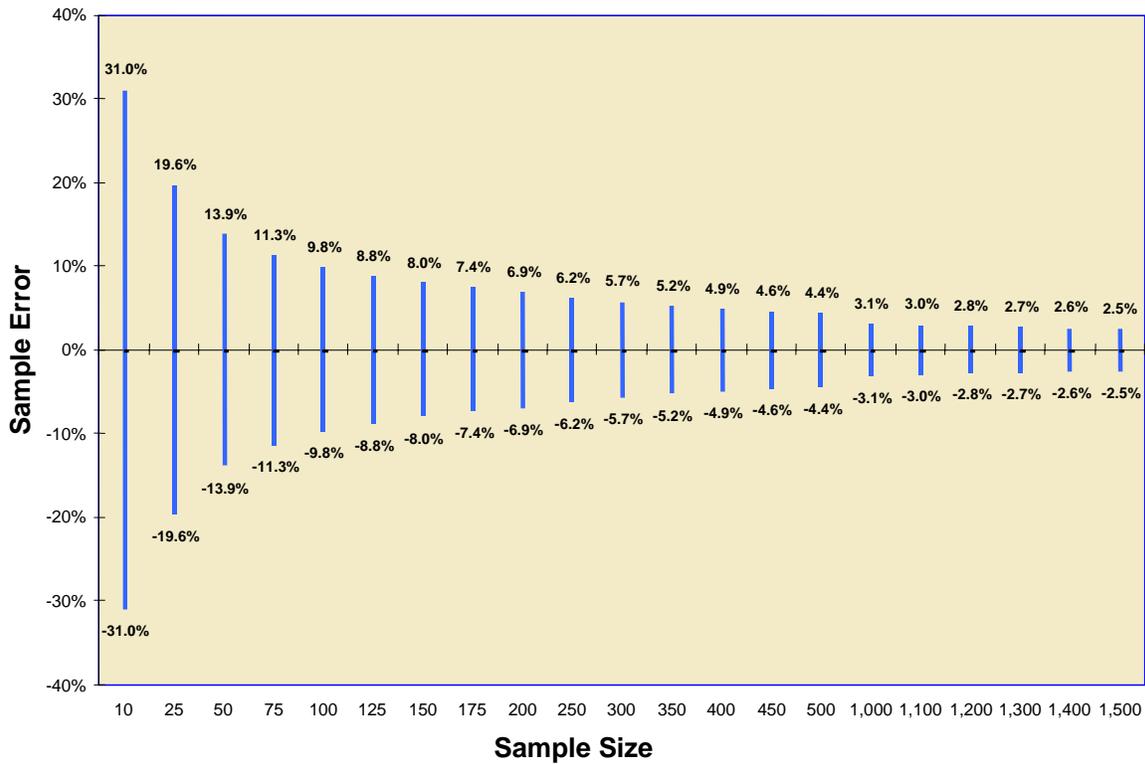
Understanding Sampling Error

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—2009 Michigan MHPs	
Code	Health Plan Name
BCD	BlueCaid of Michigan
CSM	CareSource of Michigan
GLH	Great Lakes Health Plan, Inc.
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, Inc.
PMD	Physicians Health Plan of Mid-Michigan
PRI	Priority Health Government Programs, Inc.
PRO	ProCare Health Plan
THC	Total Health Care
UPP	Upper Peninsula Health Plan

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 affect their 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 is a significant public health concern that continues to present clinical challenges. The Institute of Medicine (IOM) has cited antibiotic resistance as one of the key microbial threats to health in the United States. The IOM is focused on promoting appropriate use of antimicrobials as a primary means to address this threat. The Centers for Disease Control and Prevention (CDC) has also cited antimicrobial resistance as a major concern. The 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 (earache), sinusitis, pharyngitis (sore throat), 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 the CDC.

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

The Pediatric Care dimension encompasses the following MDCH key measures:

- ◆ **Childhood Immunization Status**
 - *Childhood Immunization Status—Combination 2*
 - *Childhood Immunization Status—Combination 3*
- ◆ **Lead Screening in Children**
 - *Lead Screening in Children*

³⁻¹ Michigan Care Improvement Registry. Available at: <http://www.mcir.org/accomplishments.html>. Accessed July 9, 2009.

³⁻² Centers for Disease Control and Prevention. Get Smart: Know When Antibiotics Work. Available at: <http://www.cdc.gov/getsmart/campaign-materials/about-campaign.html>. Accessed July 9, 2009.

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

Childhood Immunization Status

Over the last 50 years, childhood vaccination has led to dramatic declines in many life-threatening diseases such as polio, tetanus, whooping cough, mumps, measles, and meningitis. In unvaccinated children, these diseases can cause blindness, hearing loss, diminished motor functioning, liver damage, coma, and death. For example, discontinuing the Haemophilus influenzae type b (Hib) immunization would result in approximately 20,000 cases per year of invasive disease and 600 deaths.³⁻³ For children from birth to 6 years of age, the CDC suggests that they receive the following vaccinations: hepatitis B; rotavirus; diphtheria, tetanus, and pertussis (DTaP); Hib; pneumococcal; inactivated poliovirus (IPV); influenza; measles, mumps, and rubella (MMR); varicella (chicken pox or VZV); hepatitis A; and meningococcal.³⁻⁴

More than 4 million people are listed in the MCIR, including 182,145 children 19 to 35 months of age.³⁻⁵ Eighty-nine percent of children 6 years of age or younger have two or more vaccine doses recorded in the MCIR, while the national average for registries is 49 percent.³⁻⁶ According to National Immunization Survey data from January to December of 2007, 78.8 percent of children 2 years of age in Michigan were fully immunized using the 4:3:1:3:3:1 standard assessment.³⁻⁷ The United Health Foundation reported that Michigan ranked 21st in the United States in terms of immunization coverage in 2008 for children 19 to 35 months of age, with a rate of 80.6 percent.³⁻⁸

Key measures in this section include:

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

³⁻³ 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 July 8, 2009.

³⁻⁴ Centers for Disease Control and Prevention. 2009 Child & Adolescent Immunization Schedules. Available at: <http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm>. Accessed July 8, 2009.

³⁻⁵ Michigan Public Health Institute. Accomplishments. Michigan Care Improvement Registry. Available at: <http://www.mcir.org/accomplishments.html>. Accessed July 9, 2009.

³⁻⁶ Ibid.

³⁻⁷ Michigan Department of Community Health. Critical Health Indicators: Childhood Immunizations. Available at: http://www.mi.gov/documents/mdch/32_ChldImmUn_198933_7.pdf. Accessed July 9, 2009.

³⁻⁸ United Health Foundation. America's Health Rankings 2008. Available at: <http://www.americashealthrankings.org/2008/pdfs/mi.pdf>. Accessed July 9, 2009.

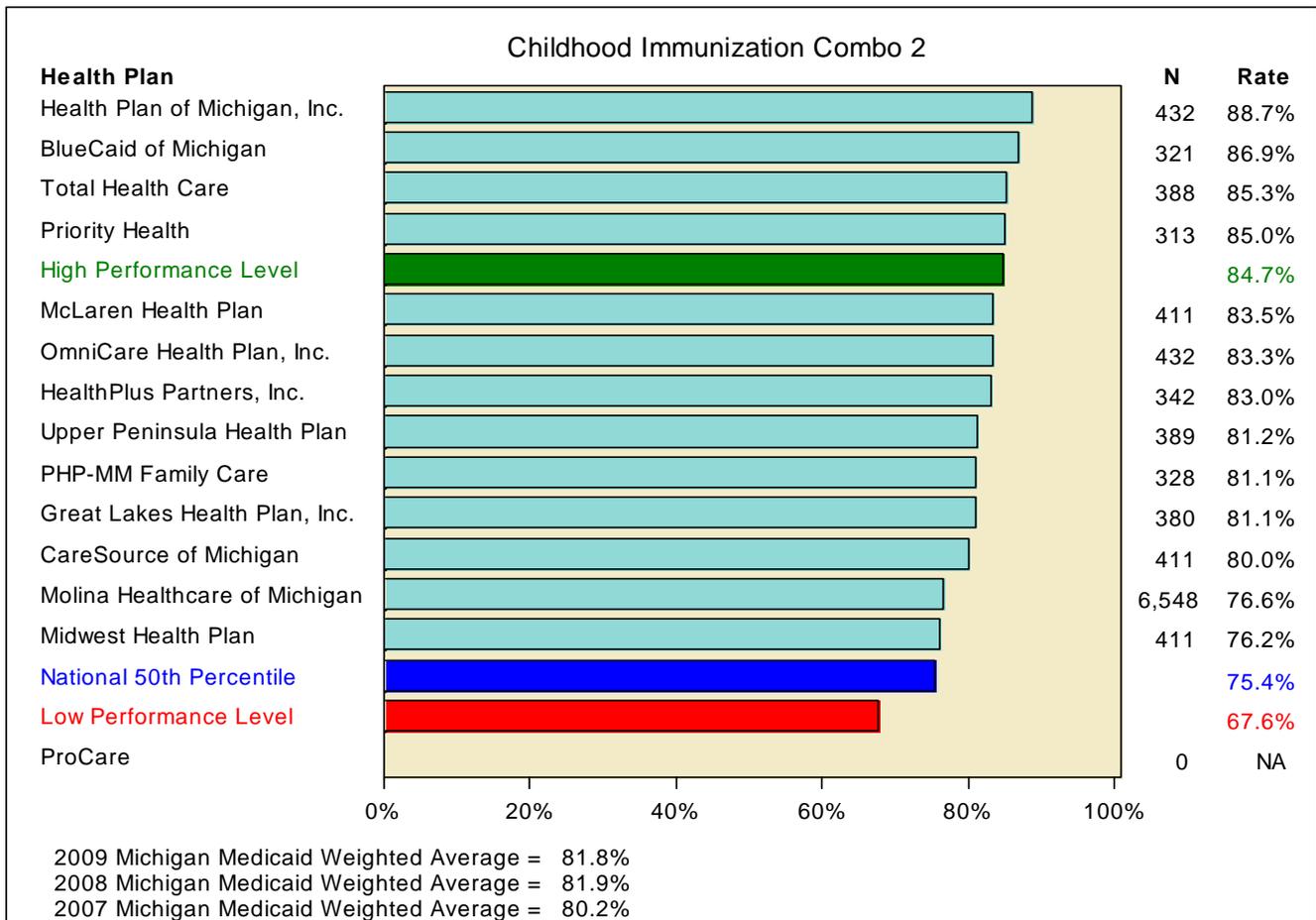
These key measures are commonly referred to as *Combo 2* and *Combo 3*.

HEDIS Specification: Childhood Immunization Status—Combination 2

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

Health Plan Ranking: Childhood Immunization Status—Combination 2

**Figure 3-1—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Childhood Immunization Status—Combination 2**



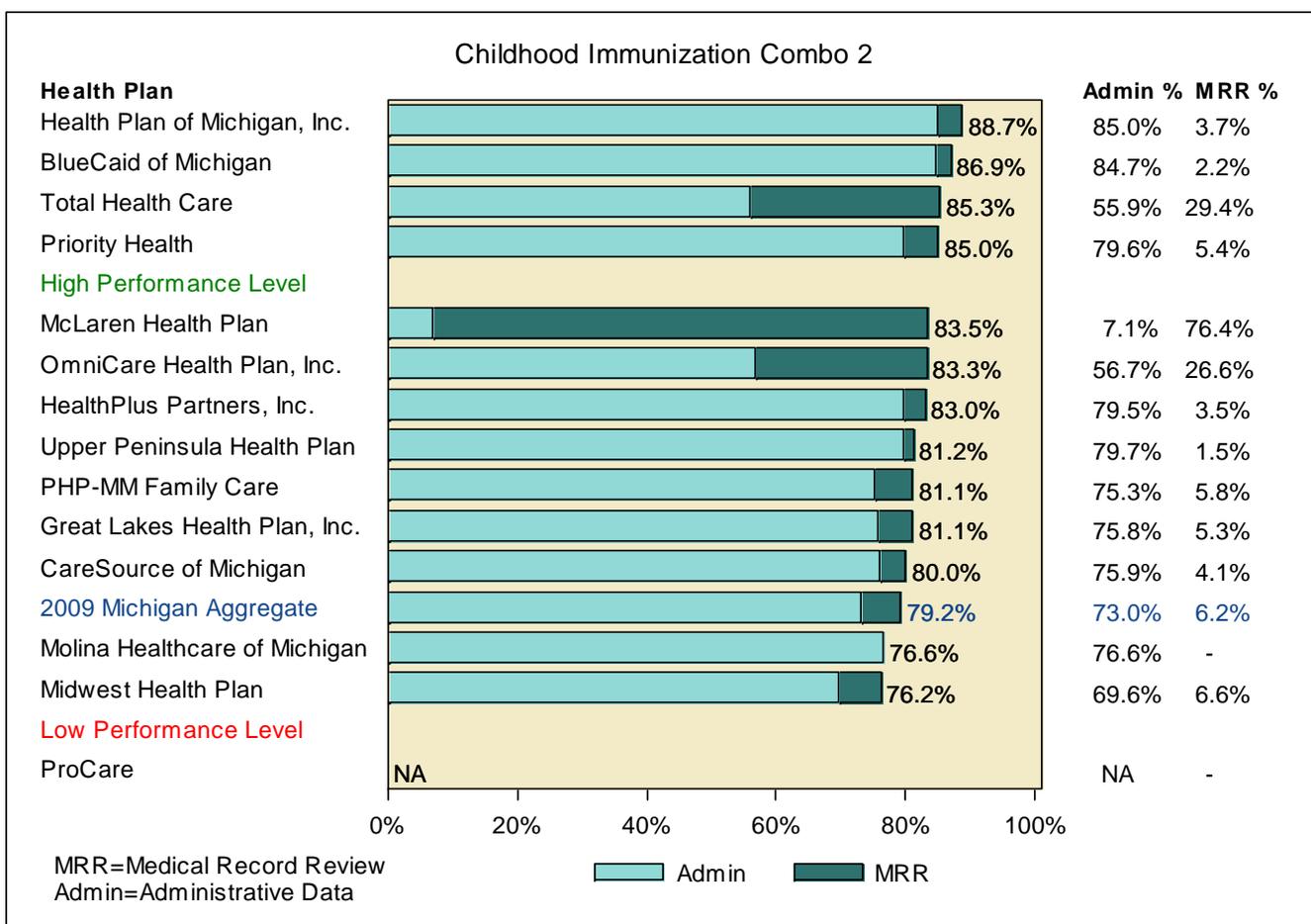
Four MHPs exceeded the HPL of 84.7 percent and none of the plans fell below the LPL of 67.6 percent. A total of 13 health plans reported rates above the national HEDIS 2008 Medicaid 50th percentile, and 7 of the MHPs ranked between the 75th and 90th percentile. One health plan was

unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

The 2009 Michigan Medicaid weighted average of 81.8 percent decreased by 0.1 percentage point compared to the 2008 Michigan Medicaid weighted average, but it still ranked 6.4 percentage points above the national HEDIS 2008 Medicaid 50th percentile.

Data Collection Analysis: Childhood Immunization Status—Combination 2

**Figure 3-2—Michigan Medicaid HEDIS 2009
Data Collection Analysis:
Childhood Immunization Status—Combination 2**



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

Twelve of the 14 health plans used the hybrid method to report this measure. The 2009 Michigan aggregate administrative rate was 73.0 percent and the aggregate medical record review rate was 6.2 percent.

The results show that 92.2 percent of the total aggregate rate (79.2 percent) was derived from administrative data and 7.8 percent from medical record review. In 2008, 87 percent of the

aggregate rate was derived from administrative data. This increase in the administrative data use rate shows that the MHPs are relying less on medical record review.

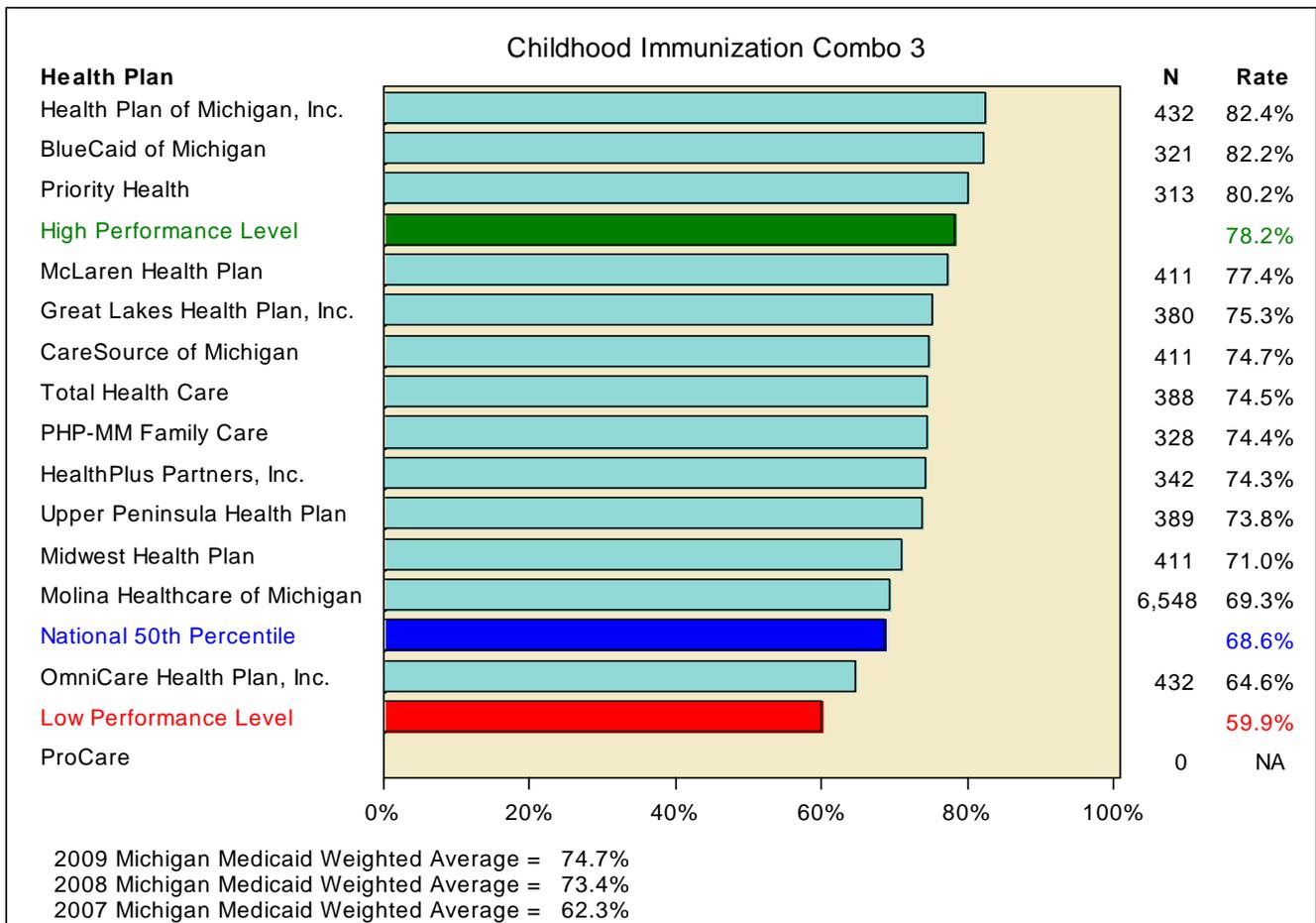
One health plan derived less than 10 percent of the rate from administrative data, while 11 of the other plans that used the hybrid method derived more than 60 percent of their rate from administrative data.

HEDIS Specification: Childhood Immunization Status—Combination 3

Childhood Immunization Status—Combination 3 calculates the percentage of enrolled children who turned two years old during the measurement year, who were continuously enrolled for 12 months immediately preceding their second birthdays, and who were identified as having four DTaP, three IPV, one MMR, two 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 2009
Health Plan Ranking:
Childhood Immunization Status—Combination 3**



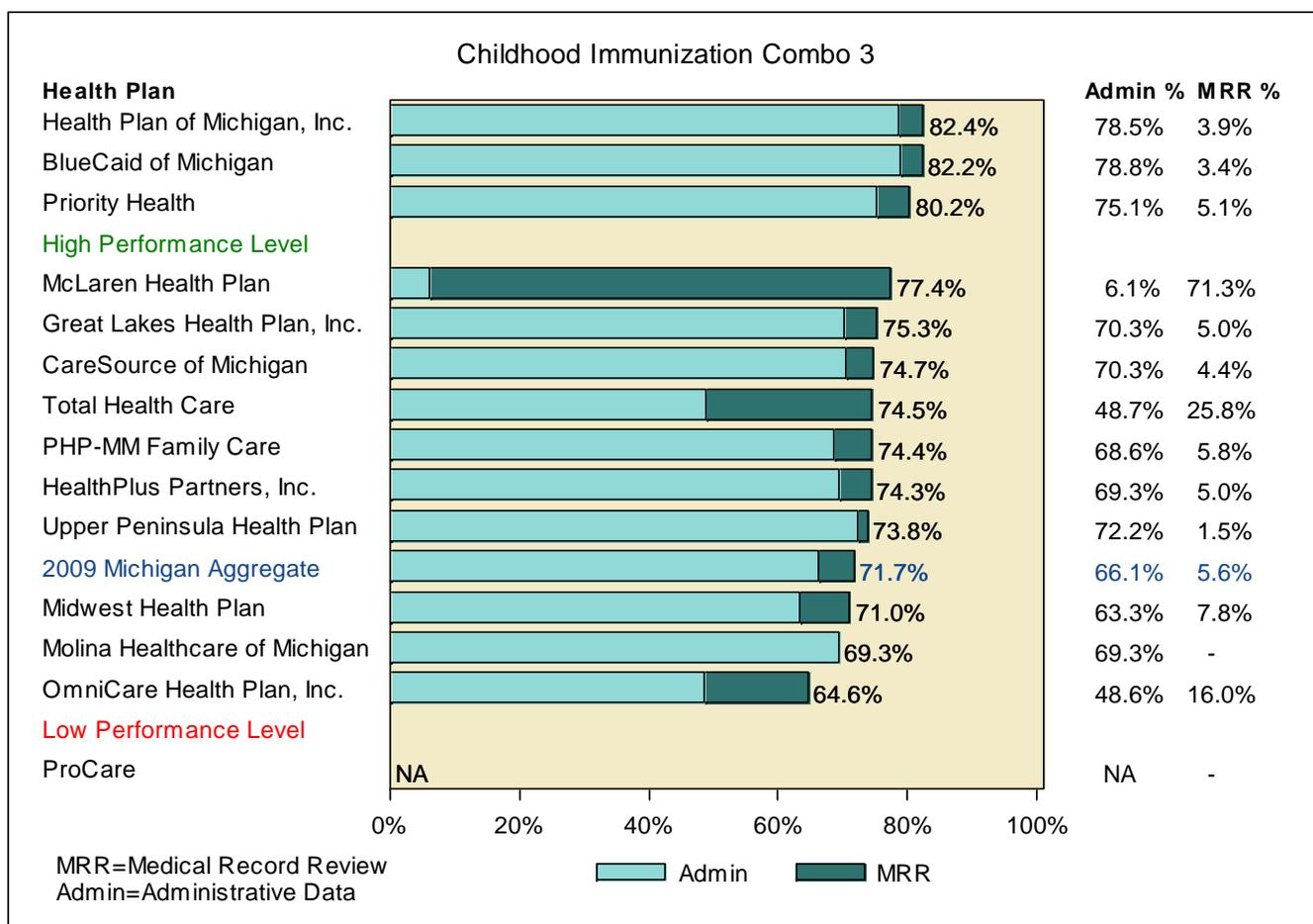
Twelve of the 14 MHPs reported rates above the national HEDIS 2008 Medicaid 50th percentile of 68.6 percent. Three health plans exceeded the HPL of 78.2 percent, and none of the MHPs reported a rate below the LPL of 59.9 percent. Five MHPs ranked above the 75th percentile of 74.3 percent and below the 90th percentile of 78.2 percent. One health plan was unable to report a rate for this

measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average increased by 1.3 percentage points over the average in 2008, and by 12.4 percentage points over the 2007 rate. The 2009 Michigan Medicaid weighted average was 6.1 percentage points above the national HEDIS 2008 Medicaid 50th percentile.

Data Collection Analysis: Childhood Immunization Status—Combination 3

**Figure 3-4—Michigan Medicaid HEDIS 2009
Data Collection Analysis:
Childhood Immunization Status—Combination 3**



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

All the MHPs except two used the hybrid methodology to report this measure. The 2009 Michigan aggregate administrative rate was 66.1 percent and the aggregate medical record review rate was 5.6 percent.

The results indicate that 92.2 percent of the total aggregate rate (71.7 percent) was derived from administrative data and 7.8 percent from medical record review. These percentages were consistent

with the *Childhood Immunization Status—Combination 2* findings. In 2008, 87.9 percent of the aggregate rate was derived from administrative data. This means that the health plans are now relying less on medical record review data.

One MHP derived less than 10 percent of its rate from administrative data. The other 11 MHPs that used the hybrid method derived more than 60 percent of their rates from administrative data.

Lead Screening in Children

Elevated blood lead levels (BLLs) are a significant and preventable health issue that can adversely impact children's physical and mental health. Children are more sensitive to lead poisoning than adults, and the effects of lead poisoning, which can include cognitive impairment and behavioral disorders, can be harder to reverse in children.³⁻⁹ BLLs as low as 10 micrograms/deciliter can have harmful effects on learning and behavior in children. The CDC recommends prevention of this level (or higher) in children.³⁻¹⁰ Today, approximately 310,000 U.S. children are at risk for exposure to harmful levels of lead.³⁻¹¹

In Michigan, the number of children tested for lead poisoning increased by almost 50 percent from 2003 to 2007. The number of Michigan children with confirmed elevated BLLs decreased by more than 35 percent during this time period.³⁻¹² In 2006, Michigan ranked seventh in the United States for number and percentage of children with lead poisoning.³⁻¹³

Key measures in this section include:

- ◆ *Lead Screening in Children*

HEDIS Specification: Lead Screening in Children

Lead Screening in Children calculates the percentage of enrolled children who turned two 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 one or more capillary or venous blood tests for lead poisoning by their second birthday.

³⁻⁹ 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 August 27, 2009.

³⁻¹⁰ Centers for Disease Control and Prevention. Facts on...Lead. Available at: <http://www.cdc.gov/nceh/lead/publications/1997/factlead.htm>. Accessed on August 27, 2009.

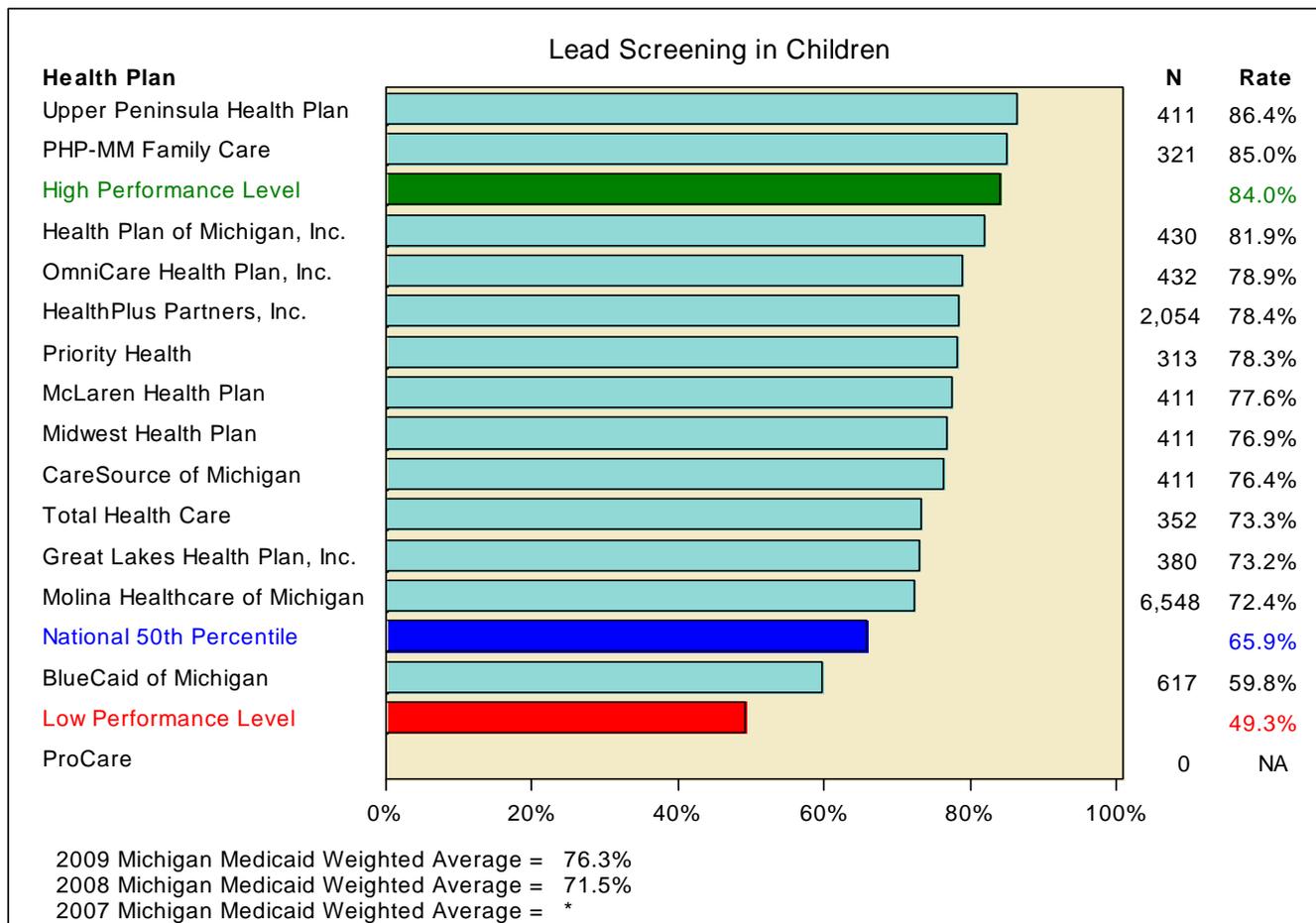
³⁻¹¹ National Committee for Quality Assurance. The State of Health Care Quality 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed on August 27, 2009.

³⁻¹² 2007 Annual Report on Blood Lead Levels on Adults and Children in Michigan. Available at: http://www.michigan.gov/documents/mdch/07Lead_all_287172_7.pdf. Accessed on August 27, 2009.

³⁻¹³ Ibid.

Health Plan Ranking: Lead Screening in Children

**Figure 3-5—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Lead Screening in Children**



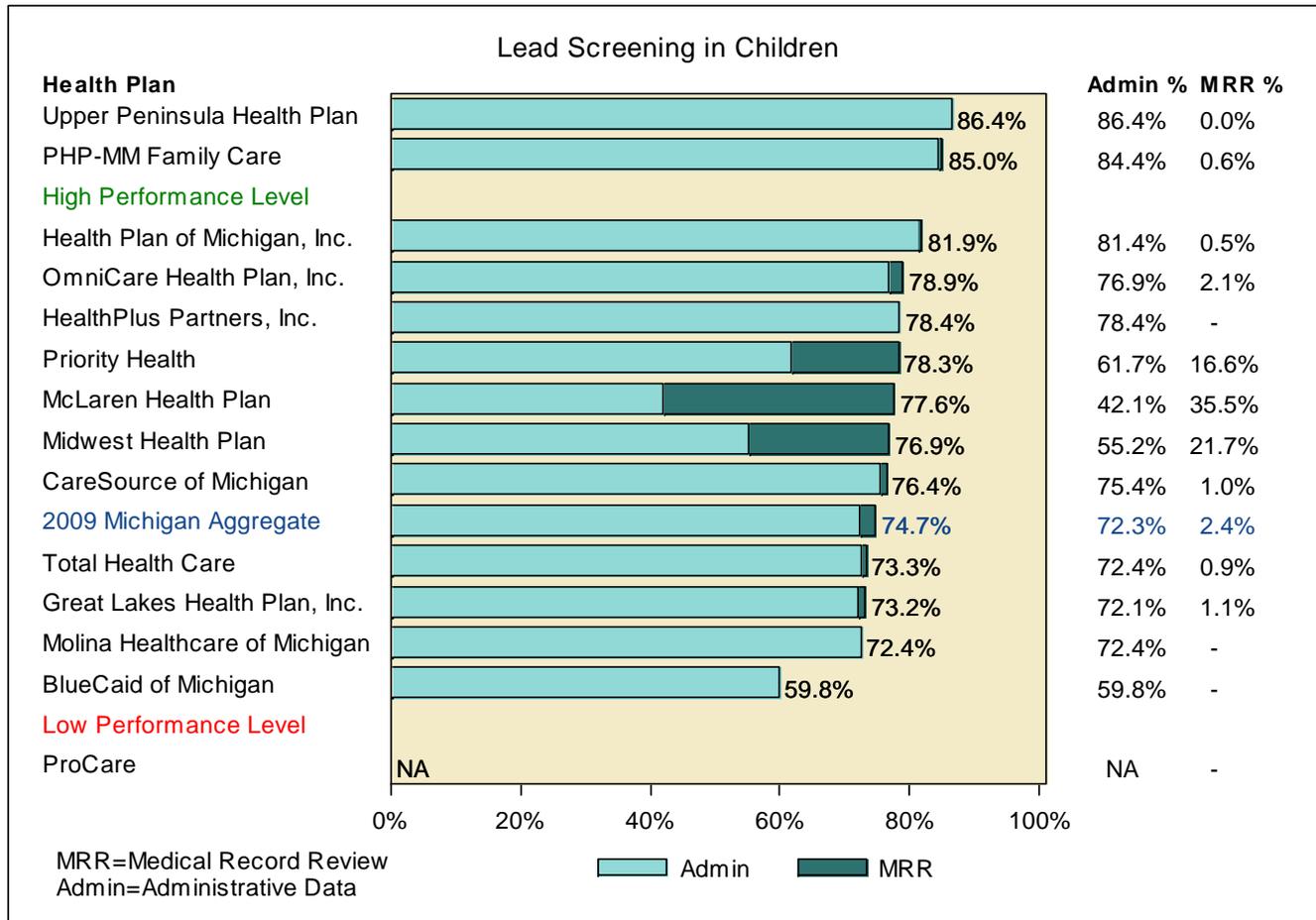
Lead Screening in Children was a new measure in 2008; therefore, this was the first year national performance data were available for comparison.

Twelve MHPs' rates ranked above the national HEDIS 2008 Medicaid 50th percentile of 65.9 percent. Two health plans exceeded the HPL of 84.0 percent, and none of the MHPs reported a rate below the LPL of 49.3 percent. Six MHPs ranked between the 75th and 90th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 76.3 percent had a statistically significant increase of 4.8 percentage points from the 2008 weighted average of 71.5 percent and was 10.4 percentage points above the national HEDIS 2008 Medicaid 50th percentile.

Data Collection Analysis: Lead Screening in Children

**Figure 3-6—Michigan Medicaid HEDIS 2009
Data Collection Analysis:
Lead Screening in Children**



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 medical record review (MRR). Note: Because of rounding differences, the sum of the Admin rate and the MRR rate may not always be exactly equal to the final rate.

Ten of the 14 health plans elected to use the hybrid method to report this measure. The 2009 Michigan aggregate administrative rate was 72.3 percent and the aggregate medical record review rate was 2.4 percent.

The results illustrated that 96.8 percent of the total aggregate rate (74.7 percent) was derived from administrative data and 3.2 percent from medical record review. The majority of plans relied very little on medical record data to report this measure.

All 10 health plans that used the hybrid method 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. 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 for avoidable hospitalizations for that group.³⁻¹⁴ According to the CDC, 17 percent of U.S. children have a behavioral or developmental disability, but fewer than 50 percent of these children are identified as having a problem before they start school.³⁻¹⁵

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, a complete physical exam, sensory screening (i.e., hearing and vision), a developmental assessment, health guidance/education, dental checks, and laboratory tests, including lead screenings.³⁻¹⁶ 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 through 15 months of age, and who received zero visits with a primary care practitioner (PCP) during their first 15 months of life.

It should be noted that 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

³⁻¹⁴ Hakim RB, Bye BV. Effectiveness of Compliance With Pediatric Preventive Care Guidelines Among Medicaid Beneficiaries. *Pediatrics*. 2001, 108 (1): 90–97.

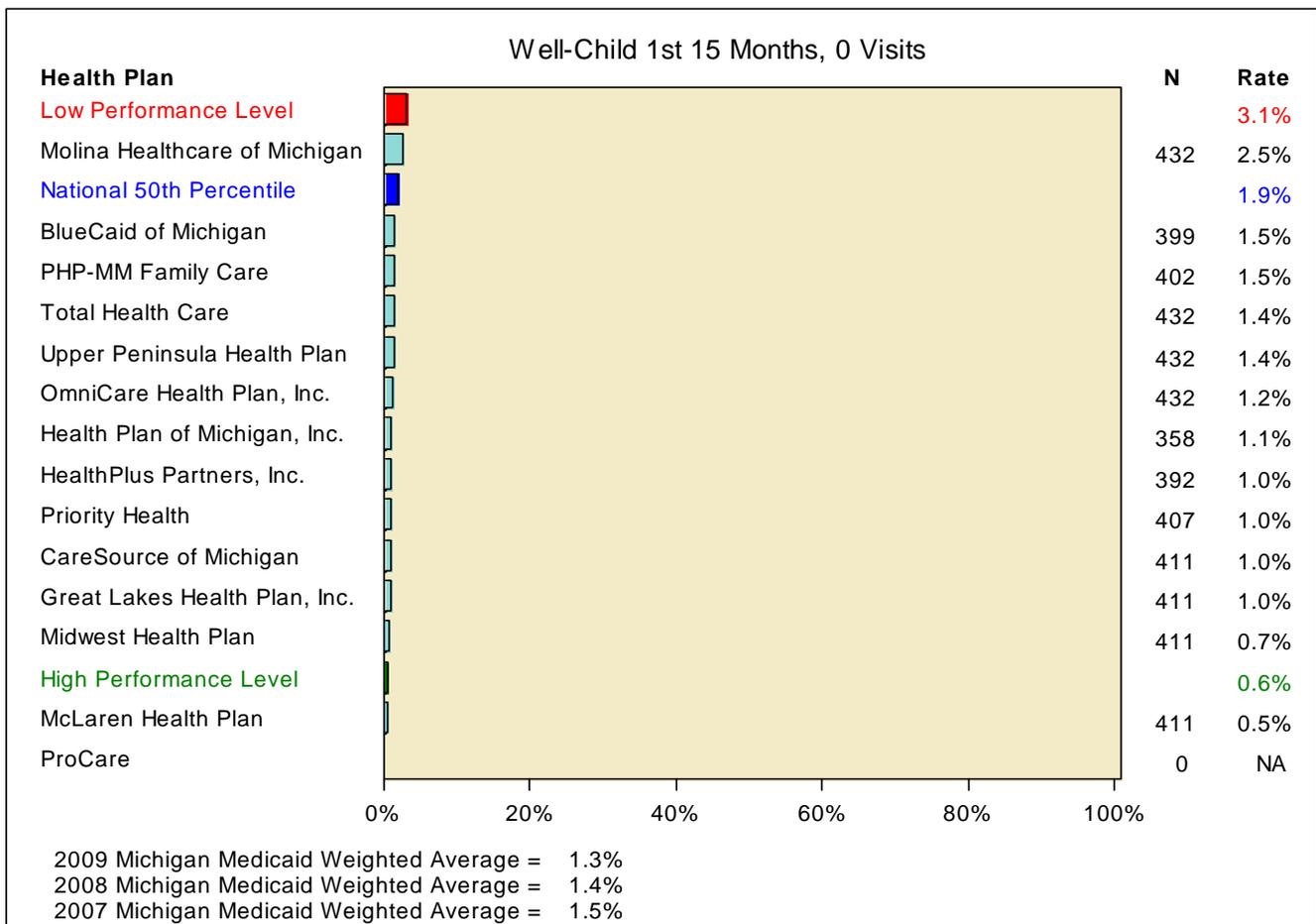
³⁻¹⁵ Centers for Disease Control and Prevention. Child Development: Developmental Screening. Available at: <http://www.cdc.gov/ncbddd/child/devtool.htm>. Accessed July 9, 2009.

³⁻¹⁶ Human Services Research Institute. EPSDT: Supporting Children With Disabilities. Available at: <http://www.hsri.org/docs/792FinalEPSDTBooklet.PDF>. Accessed July 9, 2009.

collection for this measure. Health plans may choose to attribute the finding of zero visits solely to administrative data sources, solely to medical record review, or to a combination of these. Any one of these approaches is acceptable; therefore, a comparison of data collection methods for this measure is not relevant and has not been included in this report.

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

**Figure 3-7—Michigan Medicaid HEDIS 2009
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.

The figure above 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.

None of the MHPs’ rates performed worse than the LPL of 3.1 percent, and only one MHP’s rate performed worse than the national HEDIS 2008 Medicaid 50th percentile of 1.9 percent. Twelve plans performed better than the national average, including one plan that exceeded the HPL of 0.6 percent with a rate of 0.5 percent.

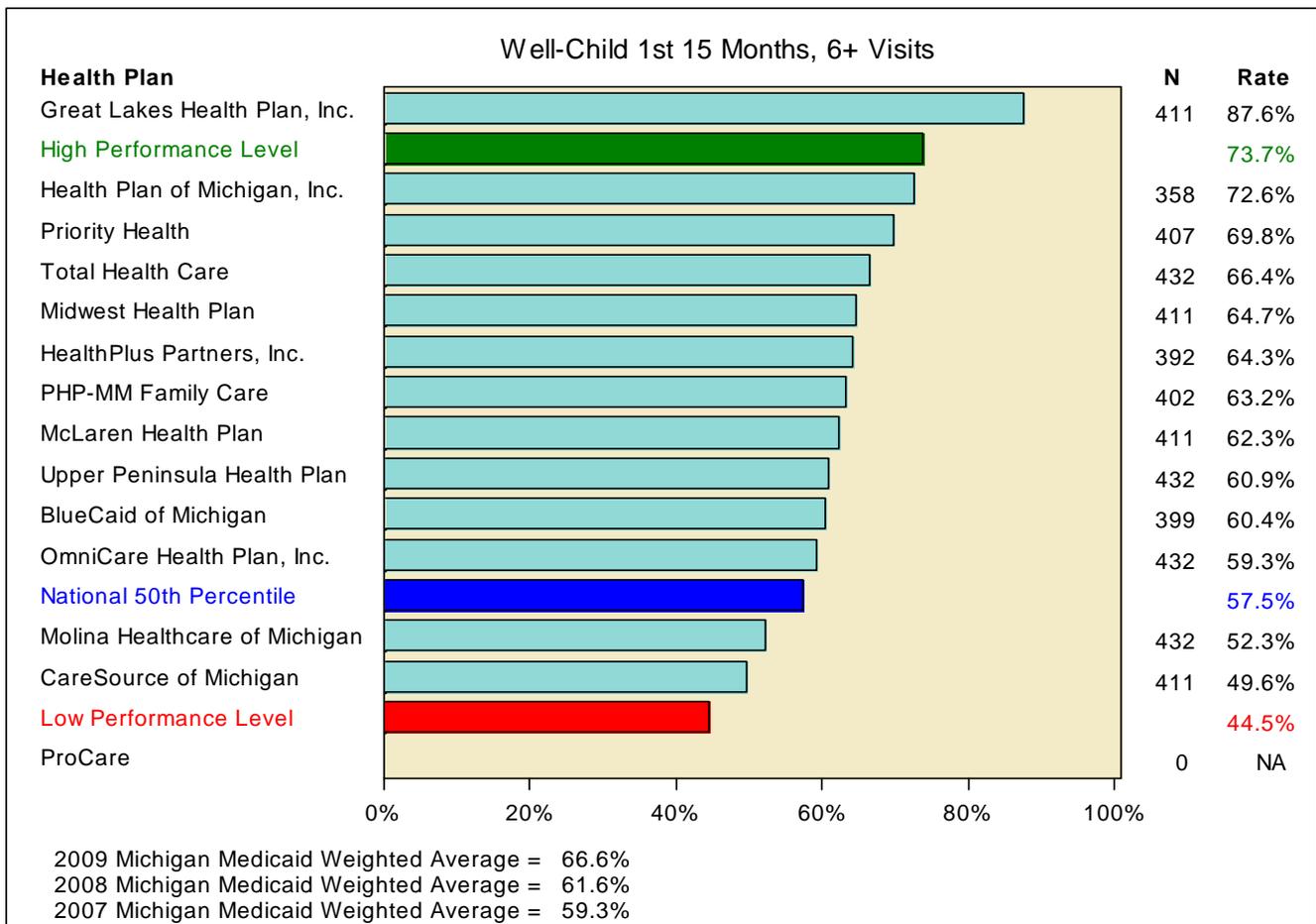
The 2009 Michigan Medicaid weighted average of 1.3 percent was 0.6 percentage points better than the national HEDIS 2008 Medicaid 50th percentile and showed a 0.1 percentage-point improvement over the 2008 weighted average of 1.4 percent.

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 old during the measurement year, who were continuously enrolled in the Michigan MHP from 31 days of age through 15 months of age, and who received six or more visits with a PCP during their first 15 months of life.

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

**Figure 3-8—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
*Well-Child Visits in the First 15 Months of Life—Six or More Visits***

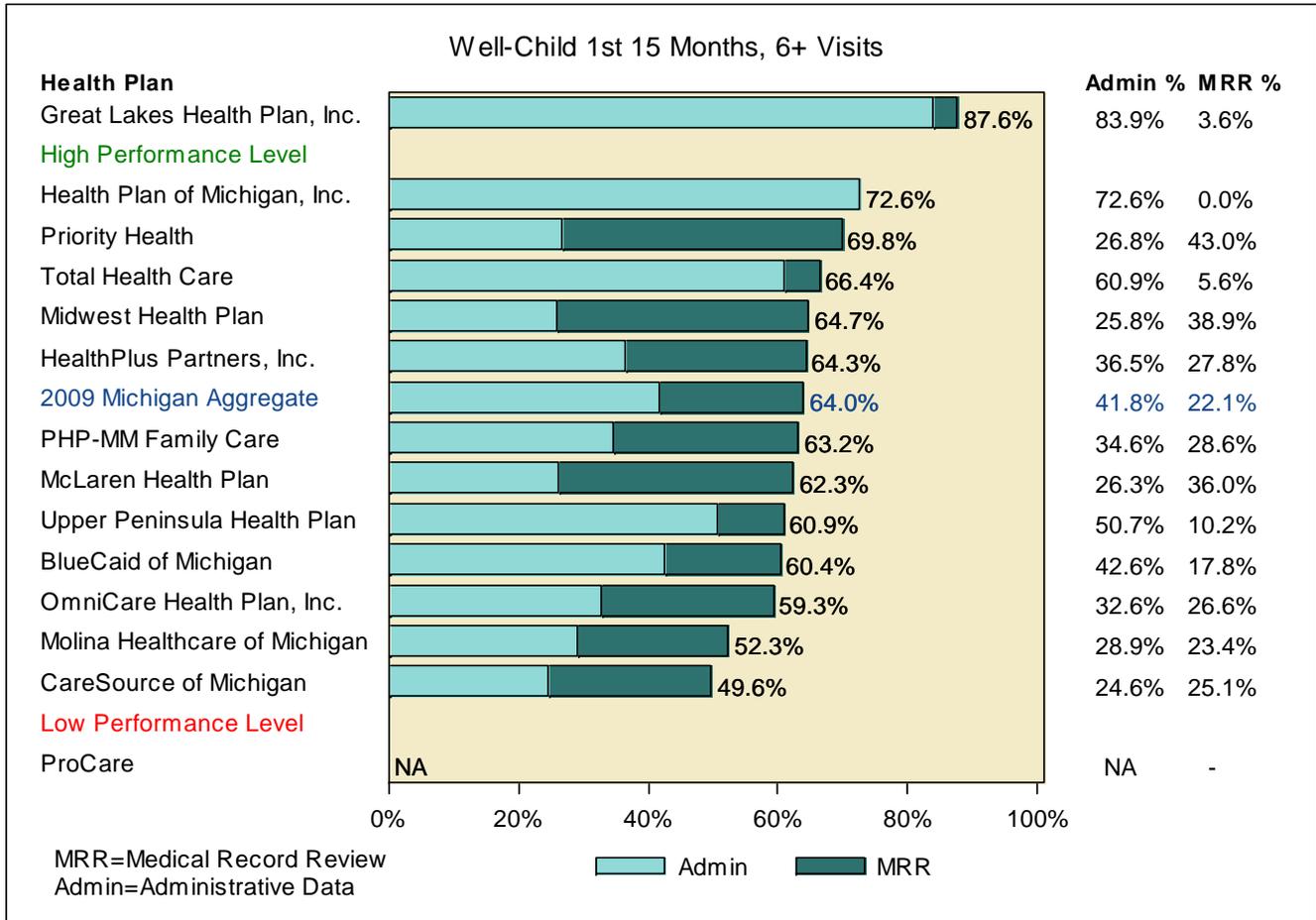


One health plan reported a rate above the HPL of 73.7 percent, and 11 MHPs (including the plan above the HPL) ranked above the national HEDIS 2008 Medicaid 50th percentile of 57.5 percent. None of the MHPs performed below the LPL of 44.5 percent. Three MHPs ranked between the 75th and 90th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan weighted average increased by 5.0 percentage points from 2008 and was 9.1 percentage points above the national HEDIS 2008 Medicaid 50th percentile.

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

**Figure 3-9—Michigan Medicaid HEDIS 2009
Data Collection Analysis:
Well-Child Visits in the First 15 Months of Life—Six or More Visits**



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

All of the MHPs except one reported this measure using the hybrid method. The 2009 Michigan aggregate administrative rate was 41.8 percent and the aggregate medical record review rate was 22.1 percent.

Results show that 65.3 percent of the total aggregate rate (64.0 percent) was derived from administrative data and 34.5 percent from medical record review. In 2008, 61.4 percent of the aggregate rate was derived from administrative data. The MHPs are continuing to increase their administrative data completeness and working to reduce the burden of medical record review. The

top two performing MHPs for this measure derived less than 5 percent of their rates from medical record review. Nine 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

The AAP recommends annual well-child visits for children between 3 and 6 years of age, provided that they are growing and developing normally and have no important health problems.³⁻¹⁷ 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 communications skills and reduce language and learning problems.

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

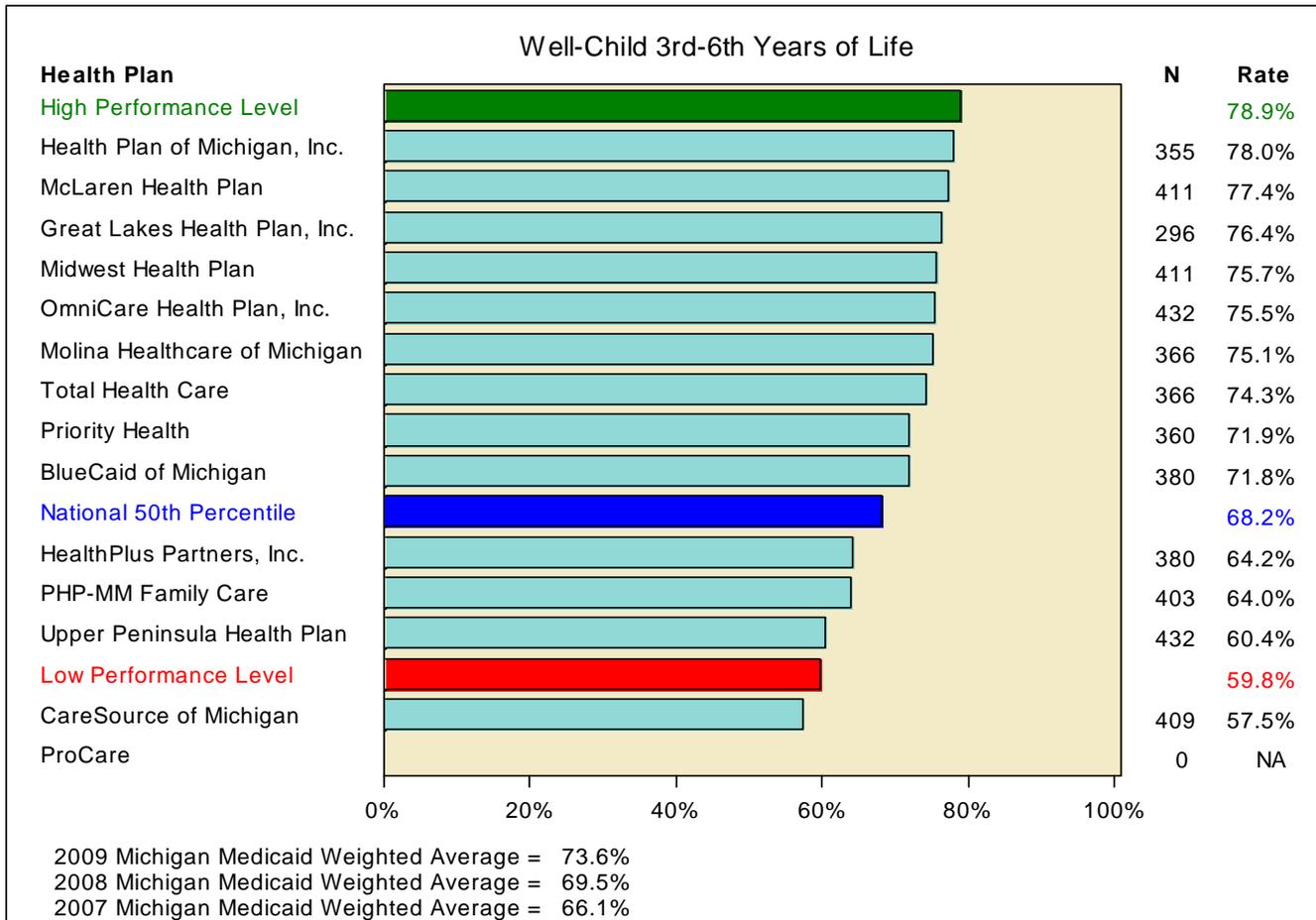
HEDIS Specification: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

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

³⁻¹⁷ American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care. Available at: <http://practice.aap.org/content.aspx?aid=1599>. Accessed July 9, 2009.

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

**Figure 3-10—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life**

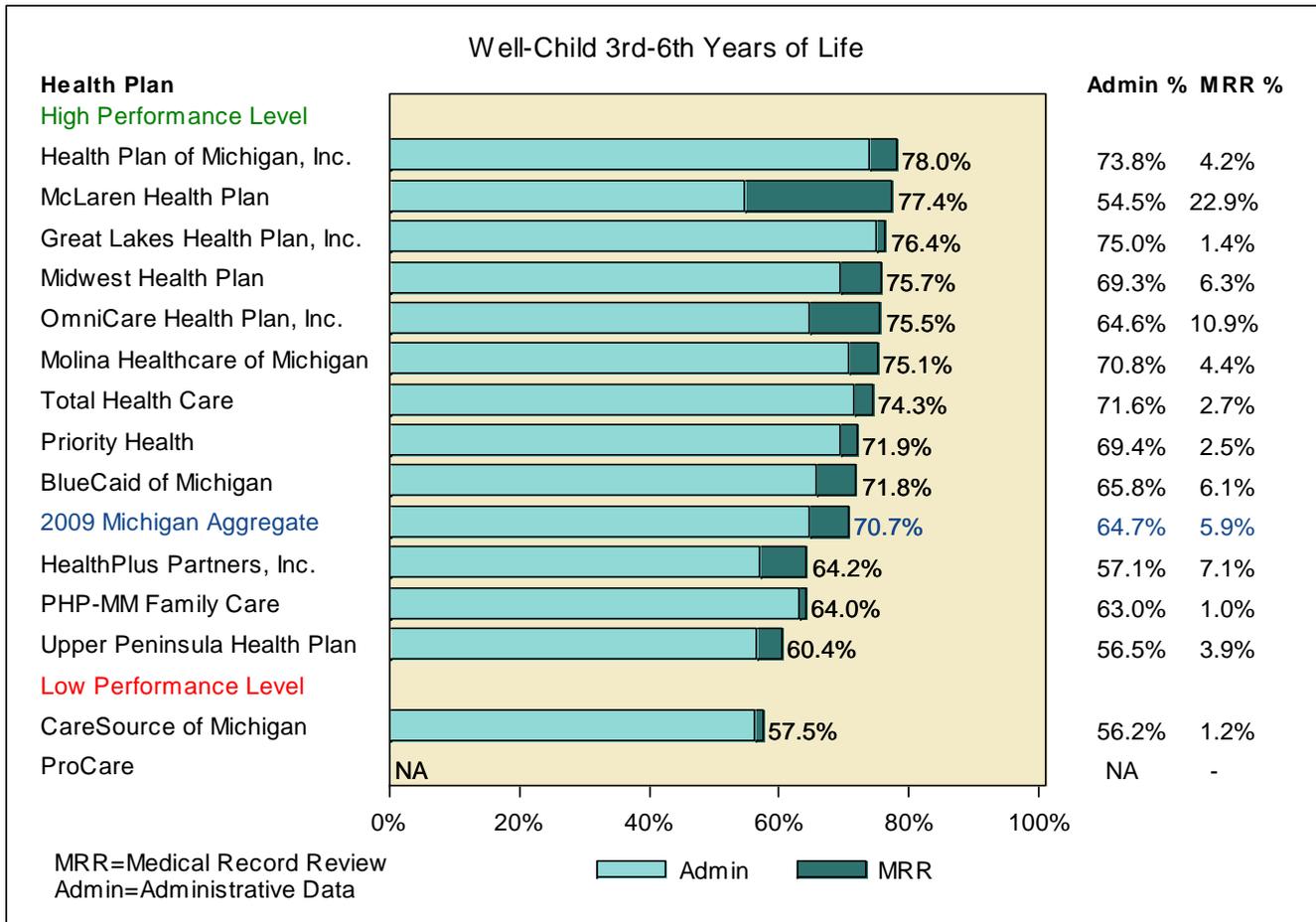


None of the MHPs reported rates above the HPL of 78.9 percent, and one health plan’s rate ranked below the LPL of 59.8 percent. Nine plans performed above the national HEDIS 2008 Medicaid 50th percentile of 68.2 percent and seven MHPs ranked between the 75th and 90th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

The 2009 Michigan Medicaid weighted average of 73.6 percent was 4.1 percentage points above the 2008 weighted average and 5.4 percentage points above the national HEDIS 2008 Medicaid 50th percentile.

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

**Figure 3-11—Michigan Medicaid HEDIS 2009
Data Collection Analysis:
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life**



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

Thirteen MHPs used the hybrid method to report this measure. The 2009 Michigan aggregate administrative rate was 64.7 percent and the aggregate medical record review rate was 5.9 percent.

The results showed that 91.5 percent of the total aggregate rate (70.7 percent) was derived from administrative data—up from 89.7 percent in 2008—and 8.3 percent of the rate this year was derived from medical record review.

All of the health plans using the hybrid method 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 2005, accounting for 48.3 percent of all deaths.³⁻¹⁸ Homicide and suicide were the next leading causes of death, accounting for 15.2 and 11.8 percent, respectively, of all adolescent deaths.³⁻¹⁹ 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 recommend that all adolescents 11 to 21 years of age have an annual preventive services visit that focuses on both the biomedical and psychosocial aspects of health.³⁻²⁰ However, adolescents can have difficulty obtaining appropriate health care services on their own due to developmental characteristics and lack of experience negotiating medical systems, and they often need specialized planning to respond to their needs for confidentiality, quality service, and coordination of care.³⁻²¹ The following information includes analyses of the performance profile, health plan rankings, and data collection methodology used by the Michigan MHPs for *Adolescent Well-Care Visits*.

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 PCP or an obstetrician/gynecologist (OB/GYN) during the measurement year.

³⁻¹⁸ U.S. Department of Health and Human Services. Child Health USA 2007. Available at: ftp://ftp.hrsa.gov/mchb/chusa_07/c07.pdf. Accessed July 9, 2009.

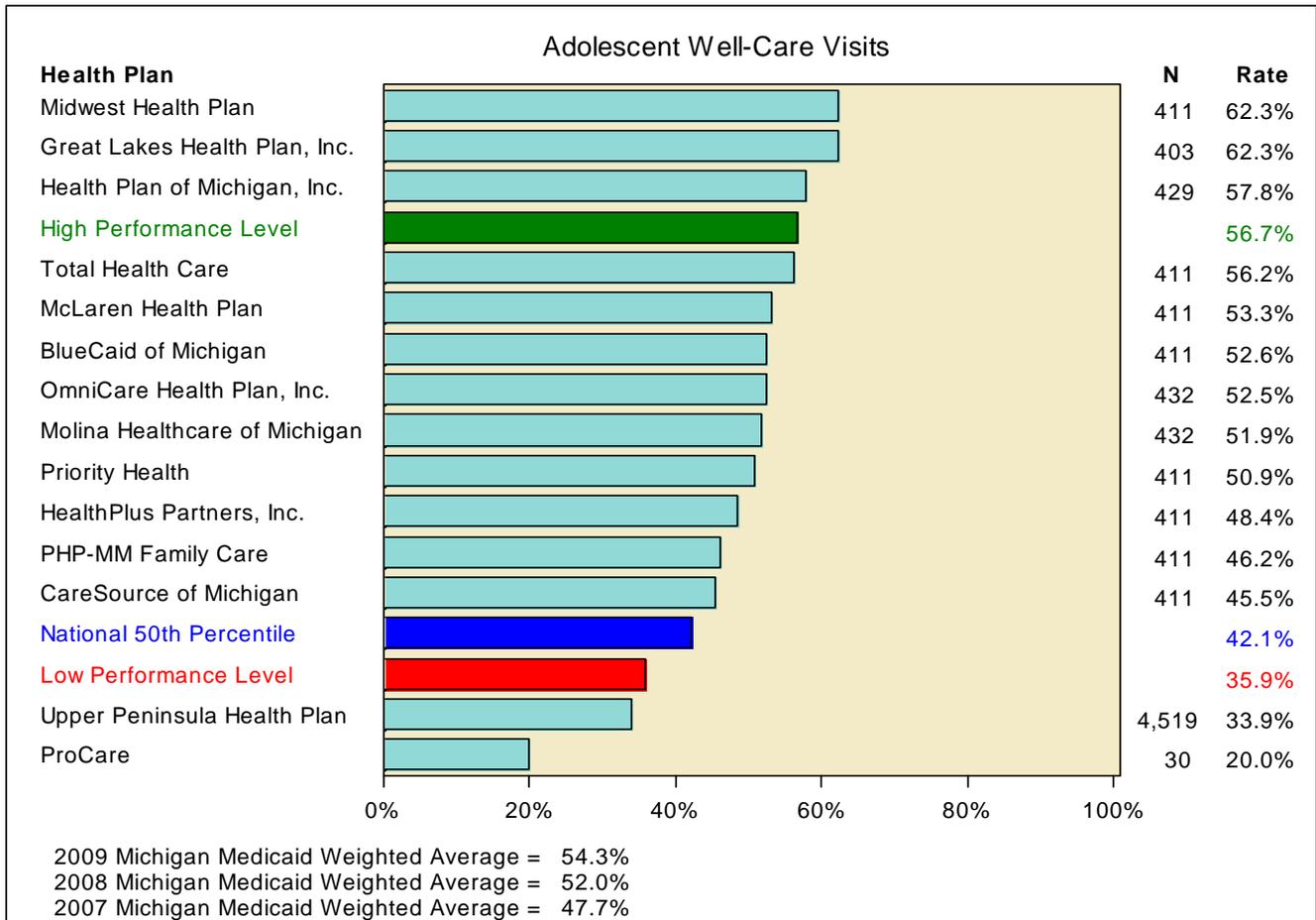
³⁻¹⁹ Ibid.

³⁻²⁰ American Medical Association. Guidelines for Adolescent Preventive Services (GAPS). Available at: <http://www.ama-assn.org/ama/upload/mm/39/gapsmono.pdf>. Accessed July 9, 2009.

³⁻²¹ 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 July 9, 2009.

Health Plan Ranking: Adolescent Well-Care Visits

**Figure 3-12—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Adolescent Well-Care Visits**

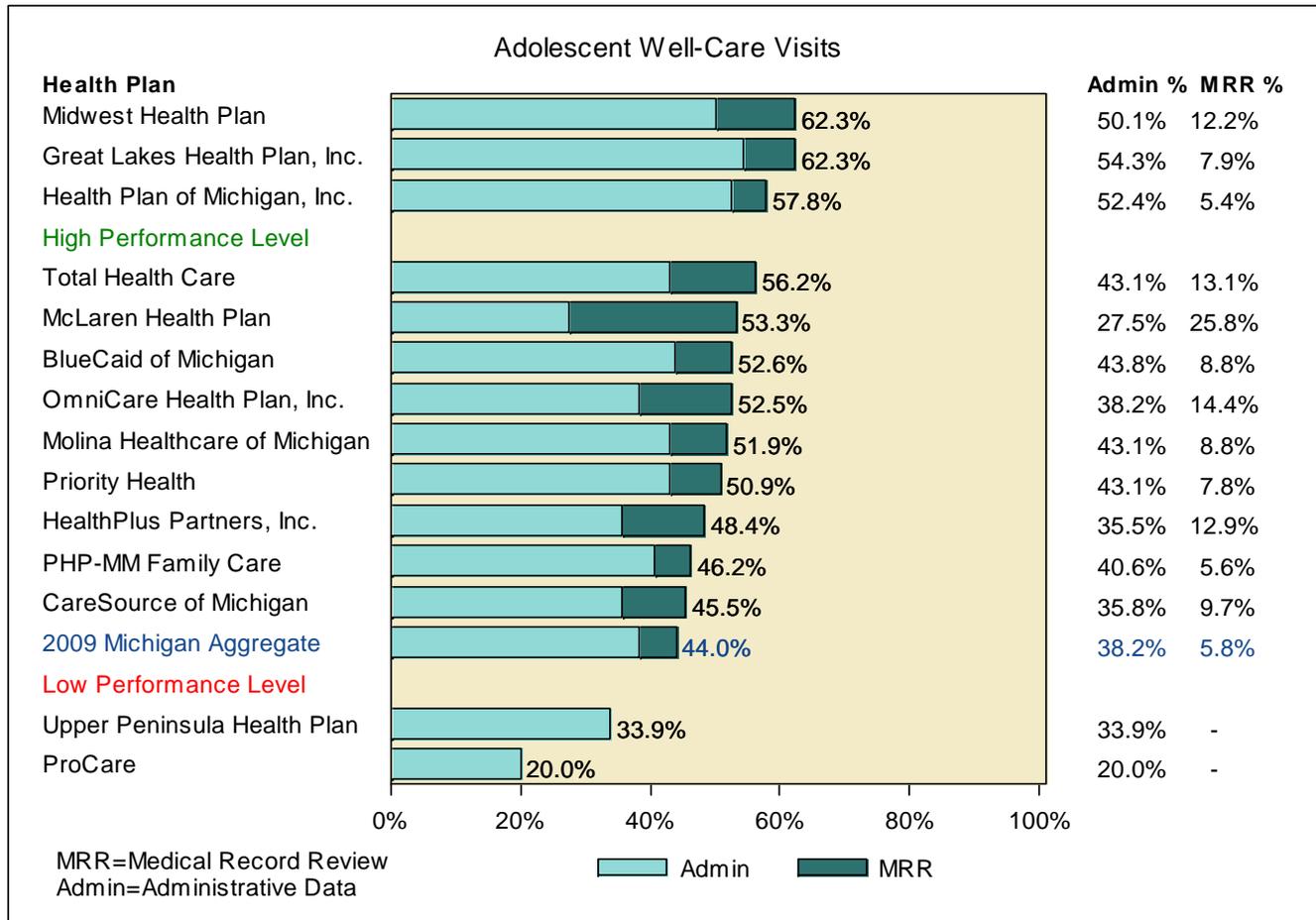


Three MHPs ranked above the HPL rate of 56.7 percent and two plans ranked below the national HEDIS 2008 Medicaid 50th percentile of 42.1 percent, as well as the LPL of 35.9 percent. Five MHPs ranked between the 75th percentile of 51.4 percent and the 90th percentile of 56.7 percent.

The 2009 Michigan Medicaid weighted average improved by 2.3 percentage points compared to the 2008 Michigan Medicaid weighted average of 52.0 percent and increased by 6.6 percentage points over the 2007 rate. In addition, the 2009 Michigan Medicaid weighted average scored 12.2 percentage points above the national average.

Data Collection Analysis: Adolescent Well-Care Visits

**Figure 3-13—Michigan Medicaid HEDIS 2009
Data Collection Analysis:
Adolescent Well-Care Visits**



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

Twelve MHPs used the hybrid method to report this measure. The 2009 Michigan aggregate administrative rate was 38.2 percent and the aggregate medical record rate was 5.8 percent.

In 2009, 86.8 percent of the total aggregate (44 percent) was derived from administrative data and 13.2 percent was derived from medical record review data, which was very similar to last year's percentages.

For the health plans that used the hybrid method, more than 70.0 percent of their rates were derived from administrative data, except for McLaren health plan.

Appropriate Treatment for Children With Upper Respiratory Infection

Americans suffer from an estimated 1 billion upper respiratory infections (URIs) annually. Children have about three to eight URIs per year due to lack of exposure to prior infections and high contact with other children.³⁻²² Although URIs are most often viral, antibiotics are frequently prescribed to children with this infection. When antibiotics are used inappropriately, an individual can develop a resistance to them over time, making the medication ineffective. Approximately \$227 million is spent annually on inappropriate and unnecessary treatment of URIs.³⁻²³

HEDIS Specification: Appropriate Treatment for Children With Upper Respiratory Infection

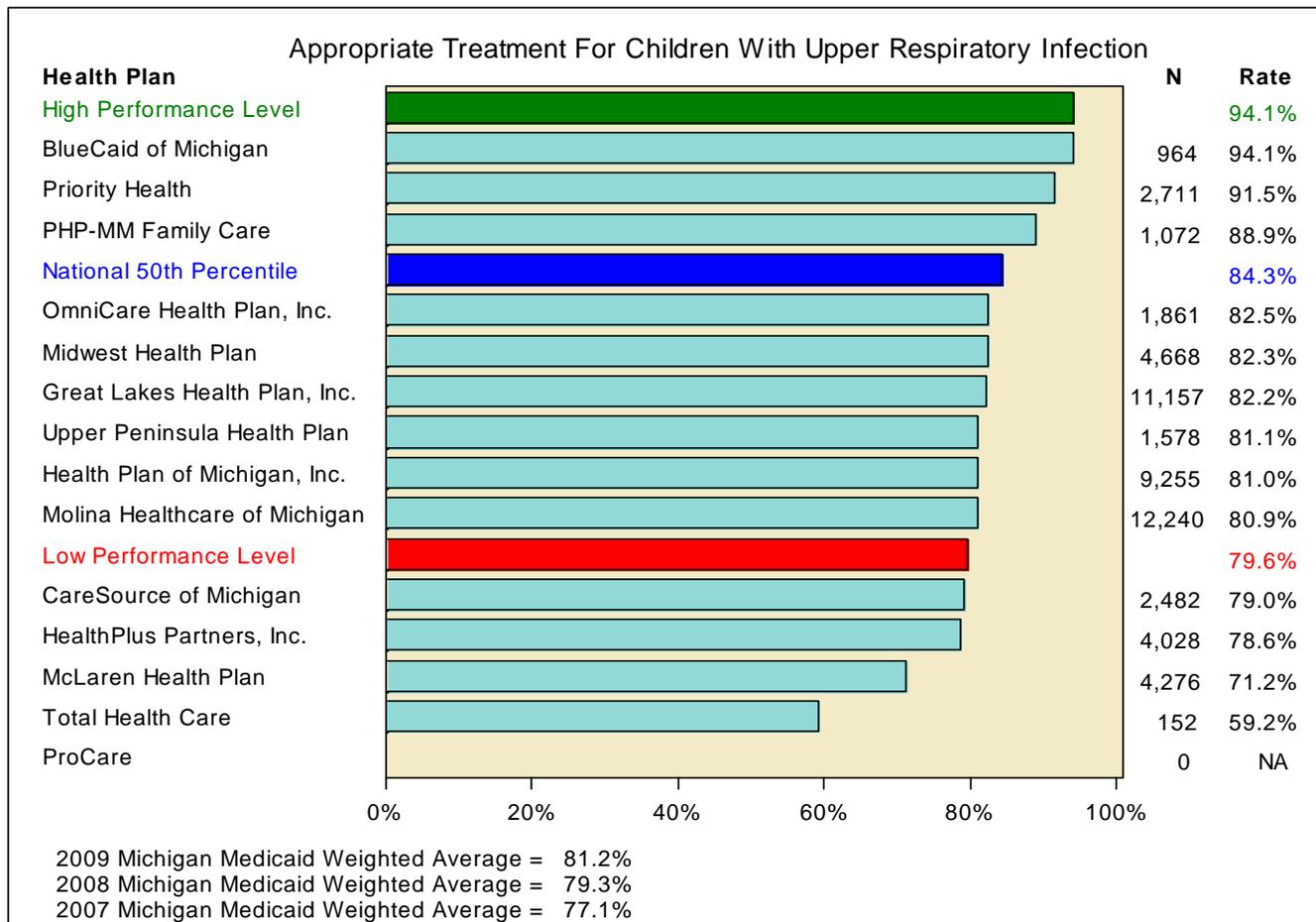
This key measure reports the percentage of enrolled members who were 3 months to 18 years of age during the measurement year, who were given a diagnosis of URI, and who were not dispensed an antibiotic prescription on or three days after the episode date.

³⁻²² 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 July 9, 2009.

³⁻²³ Ibid

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

**Figure 3-14—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Appropriate Treatment For Children With Upper Respiratory Infection**



None of the MHPs reported rates above the HPL of 94.1 percent, and four health plans ranked below the LPL of 79.6 percent. Three health plans reported rates above the national HEDIS 2008 Medicaid 50th percentile of 84.3 percent and two of those plans' rates ranked above the 75th percentile of 90.5 percent. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 81.2 percent was 1.9 percentage points above the 2008 Michigan Medicaid weighted average; however, the weighted average was below the national HEDIS 2008 Medicaid 50th percentile.

Appropriate Testing for Children With Pharyngitis

Pharyngitis (inflammation of the pharynx, or sore throat) occurs most commonly in children between 5 and 18 years of age.³⁻²⁴ Approximately 40 to 60 percent of pharyngitis cases are caused by a virus, and about 15 percent are associated with *Streptococcus* infection (strep throat).³⁻²⁵ In the United States, children usually average five sore throats per year, and a *Streptococcus* infection every four years. About 1 in 10 children who see a health care provider will be evaluated for pharyngitis.³⁻²⁶

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. In one study, 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.³⁻²⁷

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).

³⁻²⁴ Pulmonology Channel. Pharyngitis. Available at: <http://www.pulmonologychannel.com/pharyngitis/>. Accessed July 9, 2009.

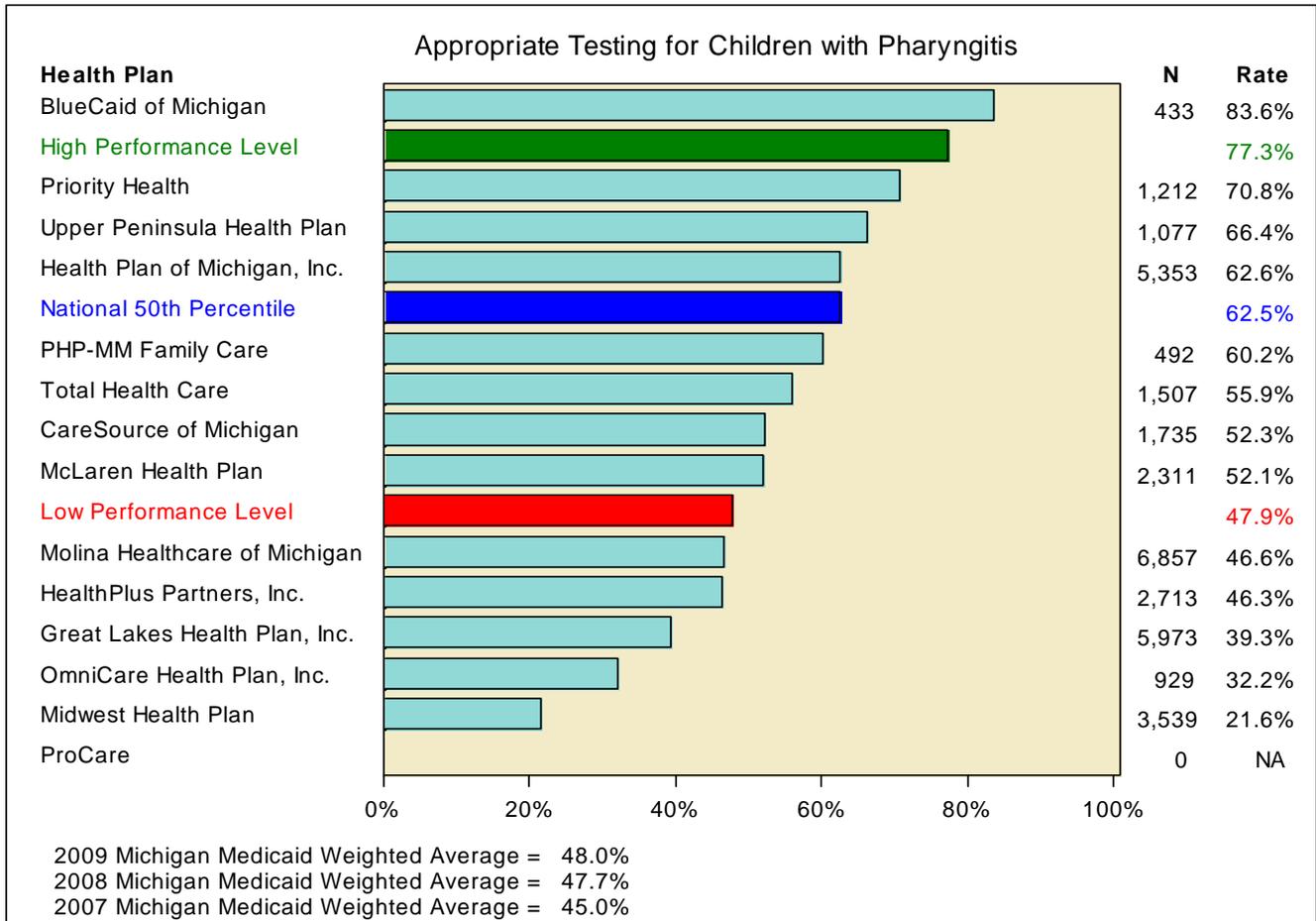
³⁻²⁵ Ibid.

³⁻²⁶ 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 July 9, 2009.

³⁻²⁷ Ibid.

Health Plan Ranking: Appropriate Testing for Children With Pharyngitis

**Figure 3-15—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Appropriate Testing for Children With Pharyngitis**



One MHP reported a rate above the HPL of 77.3 percent, and five health plans fell below the LPL of 47.9. Four health plans' rates, including the one health plan that exceeded the HPL, had rates above the national HEDIS 2008 Medicaid 50th percentile of 62.5 percent. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 48.0 percent showed slight improvement over the 2008 Michigan Medicaid weighted average; however, it was 14.5 percentage points below the national HEDIS 2008 Medicaid 50th percentile.

Pediatric Care Findings and Recommendations

Eight of the nine 2009 Michigan Medicaid weighted averages for the Pediatric Care dimension improved compared to the 2008 weighted averages. The one rate that showed a decline dropped by only 0.1 percentage point. Seven weighted averages performed above the national HEDIS 2008 Medicaid 50th percentile, and four of the rates ranked above the 75th percentile. There was an overall increase in the percentage of each rate that was derived from administrative data, indicating that the MHPs are relying less on medical record data to generate the hybrid rates.

Both of the *Childhood Immunization Status (CIS)* rates (*Combination 2* and *Combination 3*) ranked above the national HEDIS 2008 Medicaid 75th percentile. The MHPs increased the percentage of the aggregate rate they derived from administrative data by approximately 5.0 percentage points. The high percentage of administrative data shows that the Michigan MHPs are either receiving complete immunization data from their providers or providers are reporting immunization data to the Michigan immunization registry. The continued increase in administrative data completeness reduces the plans' burden to perform medical record review for these measures.

HSAG has researched and found numerous interventions implemented to increase immunization rates. In an article by Szilayi, a review of 41 studies was presented evaluating the effect of using patient reminder/recall interventions.³⁻²⁸ Overall, immunization rates were two times higher in study groups that used reminders compared to immunizations rates in the comparison groups. Telephone reminders were the most effective, increasing immunization rates fivefold. Tracking and outreach and the combination of patient and provider prompts were also effective, reporting immunization rates that were more than three times higher than those of the comparison groups.

Another review of the literature by Shefer documented that multicomponent interventions that included education were the most effective in increasing vaccination rates.³⁻²⁹ Of the 34 studies reviewed, 15 studies included a mix of patient and/or provider education with another intervention, which resulted in a median increase in immunization rates of 16 percentage points. The 24 studies that used reminder interventions alone resulted in a median difference in rates of eight percentage points. Combining patient reminders as part of a multicomponent intervention resulted in a median 16.0 percentage-point increase in immunization rates. These interventions were found to be effective across different ethnic and age groups. Provider reminders and provider feedback were both associated with median increases of 16 percentage points. Interestingly, provider interventions were also effective if used alone.

Hambridge found that stepped interventions improved well-child visits as well as immunization rates.³⁻³⁰ The steps included first mailing reminders to members, followed by phone calls to non-responders with several attempts to contact, followed by case management and/or visits to those that were still noncompliant.

³⁻²⁸ Szilayi, PG, Bordley, C, Vann, JC, et al. Effect of Patient Reminder/Recall Interventions on Immunization Rates: A Review. *JAMA*. 2000. 284(14):1820-1827.

³⁻²⁹ Shefer, A, Briss, P, Rodewald, L, et al. Improving Immunization Coverage Rates: An Evidence-based Review of the Literature. *Epidemiological Reviews*. 1999. 21(1):96-142.

³⁻³⁰ Hambridge, SJ, Phibbs, SL, et al. A Stepped Intervention Increases Well_Child Care and Immunization Rates in a Disadvantaged Population. *Pediatrics*. 2009. 124(2):455

Childhood Immunization Status is a HEDIS measure that is often the study topic for performance improvement projects (PIPs) and quality improvement projects (QIPS). The interventions documented by HSAG, excluding the interventions mentioned previously, included:

- ◆ Using immunization registries.
- ◆ Providing incentives to providers who report to an immunization registry.
- ◆ Providing electronic prompts to providers for needed immunizations.

Similar to the article findings, multicomponent interventions were most often associated with sustained increases in immunization rates.

This was the first year that national performance standards were available for the *Lead Screening in Children (LSC)* measure. The Michigan Medicaid weighted average of 76.3 percent ranked above the national average and fell just short of the 75th percentile of 76.5 percent. This rate showed a statistically significant increase of 4.8 percentage points over the 2008 rate. In combination with State requirements and internal goals, the MHPs made increasing lead screening rates a priority for 2008. Administrative data made up 96.8 percent of the aggregate rate for this measure, showing that providers submit fairly complete data to both the MHPs and the State.

HSAG has documented several successful interventions that have been implemented to increase lead screening rates in children corresponding to the *Lead Screening in Children* HEDIS measure. Successful in this context is defined as achieving sustained improvement over several years.³⁻³¹ The most effective method documented for improving the overall statewide rate for this HEDIS measure was the implementation of a state-mandated lead screening PIP. The State developed a lead screening database used by all plans. Additionally, the plans collaborated to sponsor a lead screening week. Each health plan performed its own barrier analysis and implemented interventions to address barriers specific to its population. While many of the interventions were the same type of intervention implemented to increase well-child visits, and in some cases were implemented in conjunction with other preventive services, there were also innovative initiatives. Interventions included:

- ◆ Collaborating with stakeholders to increase awareness.
- ◆ Implementing community interventions to promote education.
- ◆ Using automated phone reminders for lead screening.
- ◆ Providing in-office lead testing kits to clinicians.
- ◆ Working with laboratories to develop more convenient in-office blood collection processes.
- ◆ Sending referrals for screening directly to parents of children who have not been screened on behalf of their clinician.
- ◆ Implementing a patient registry for preventive services.
- ◆ Creating pre-populated fax forms to reduce the amount of information to be entered before submission to the lead screening registry.
- ◆ Establishing partnerships with outside entities to increase completeness of the data in the lead screening registry.

³⁻³¹ Health Services Advisory Group. Validation of Performance and Quality Improvement Projects. Studies validated between 2004 and 2009.

Recommendations for increasing blood lead screening from the CDC and best practices identified by the state of New York both mirror the interventions previously mentioned.^{3-32, 3-33}

All of the well-child measures saw improvement compared to the 2008 rates. *Well-Child Visits in the First 15 Months of Life—Six or More Visits* saw the largest increase of 5.0 percentage points. Both the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* and the *Adolescent Well Care Visits 2009* weighted averages ranked above the national HEDIS 2008 Medicaid 75th percentile. Similar to what was seen in the CIS and LSC measures, well-child rates also saw a decrease in the percentage of the aggregate rate derived from medical record data. The MHPs continue to improve administrative data completeness.

HSAG has documented several successful interventions that have been implemented to increase well-child visits and member visits. Successful in this context is defined as achieving sustained improvement over several years. The most effective interventions were those that targeted specific barriers. Assuming that culturally appropriate materials were available, member interventions such as reminders and newsletters were associated with real improvement. Newsletters should contain updated and timely information. The newsletter content with the highest frequency included articles, profiles of providers, and member tools. Most often, newsletters were distributed quarterly, but some plans had monthly newsletters. Reminders were usually sent in conjunction with birthdays or other milestones.

Another commonality among these interventions was that they were conducted in conjunction with provider interventions. Provider interventions included feedback to providers on their well-child visits rates and encounter/claims data review for missed opportunities such as performing well-child assessments during sick visits. Implementing electronic tracking tools and provider prompts were associated with greater provider satisfaction rates as well as increased well-child visit rates.

One of the most effective methods for improving the overall statewide rates has been the implementation of PIPs or QIPs, which use a state-mandated topic or a collaborative PIP conducted by all contracted health plans to improve these visit rates.³⁻³⁴

While the 2009 weighted averages for *Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis* improved (1.9 and 0.3 percentage points, respectively) they ranked below the national 50th percentile. These measures were reported using the administrative method only, and both rely on pharmacy data. The MHPs may be having difficulty receiving complete pharmacy data, or providers are not following guidelines for the treatment of these illnesses.

The HEDIS measures, *Appropriate Treatment for Children With Upper Respiratory Infection* and *Appropriate Testing for Children With Pharyngitis*, address antimicrobial overuse; therefore, many of the interventions could be implemented to improve the rates for either or both of these measures.

³⁻³² Centers for Disease Control. MMWR Recommendations and Reports. August 7, 2009. Recommendations for blood lead screening of Medicaid-eligible children aged 1-5 years: an updated approach to targeting a group at high risk. 58(RR09):1-11.

³⁻³³ State of New York. Health Care Bureau. 2005. An ounce of prevention: best practices for increasing childhood lead screening by New York's managed care plans.

³⁻³⁴ Health Services Advisory Group. Validation of Performance and Quality Improvement Projects. Studies validated between 2004 and 2009.

PIPs and QIPs focusing on antibiotic use have been effective in improving the HEDIS rate corresponding to the *Appropriate Treatment for Children With Upper Respiratory Infection* measure. HSAG has compiled information on interventions that were successfully implemented by health plans from PIPs/QIPs demonstrating sustained improvement for this HEDIS rate.³⁻³⁵ For an intervention to be successful it should address a specific barrier identified after conducting some type of barrier analysis.

Commonly identified barriers:

- ◆ Larger practices spending less time educating members
- ◆ Clinicians' lack of knowledge
- ◆ Inappropriate ICD-9 coding
- ◆ Parents' expectation of a prescription for antibiotics to treat a URI
- ◆ Parents taking children to the ER to receive an antibiotic prescription

Most of the interventions implemented were not unique and focused on educating members and providers through mailings and newsletters. However, frequently repeating information and emphasizing a common message was successful in addressing several barriers. Additionally, the education was reinforced by the following:

- ◆ Coders/billing, as well as the clinicians, were informed of proper coding for URIs
- ◆ Clinicians were sent reports on their antibiotic prescribing patterns for URIs
- ◆ Educational material was available for parents at the time of a visit

Providing an alternative to an antibiotic prescription for a child alleviates the frustration parents report when they feel a prescription is needed. One approach noted is to provide bags or kits of alternative treatments for URIs to parents instead of antibiotic prescriptions. An evidence-based review summarizes the seven Cochrane reviews of non-antibiotic treatment for upper respiratory tract infections that can aid discussions between clinician and parent.³⁻³⁶

In a recent *Med Care* article addressing efforts to reduce unnecessary antibiotic prescribing, the review of 43 studies determined that generally, active clinician interventions were more effective than passive interventions.³⁻³⁷ Additionally, interventions that targeted both clinicians and patients were more effective than those targeting clinicians or patients only.

This article, as well as another article in the *Journal of Antimicrobial Chemotherapy*, state that interventions that target antibiotic use for all respiratory infections/diseases are more effective than interventions that focus on one specific illness.³⁻³⁸ The JAC article compares the appropriate use of antibiotics before and after a single educational intervention. A one-day seminar on the diagnosis and judicious treatment of respiratory tract infections in children was provided to clinicians from

³⁻³⁵ Health Services Advisory Group. Validation of Performance and Quality Improvement Projects. Studies validated between 2004 and 2009.

³⁻³⁶ Arroll, B. Non-antibiotic treatments for upper-respiratory tract infections (common cold). *Respiratory Medicine*. 2005. 99:1477-1484.

³⁻³⁷ Ranji, SR, Steinman, MA, et al. Interventions to reduce unnecessary antibiotic prescribing: a systematic review and quantitative analysis. *Med Care*. 2008. Aug; 46(8):847-62.

³⁻³⁸ Razon, Y, Ashkenazi, et al. Effect of educational intervention on antibiotic prescription practices for upper respiratory infections in children: a multicentre study. *Journal of Antimicrobial Chemotherapy*. 2005. 56:937-940

multiple clinics. The study reported significant improvement in the appropriate treatment of upper respiratory infections as well as appropriate testing and treatment of pharyngitis.

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:

- ◆ **Cancer Screening**
 - *Breast Cancer Screening*
 - *Cervical Cancer Screening*
- ◆ **Chlamydia Screening**
 - *Chlamydia Screening in Women—16 to 20 Years*
 - *Chlamydia Screening in Women—21 to 24 Years*
 - *Chlamydia Screening in Women—Combined Rate*
- ◆ **Prenatal and Postpartum Care**
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
 - *Prenatal and Postpartum Care—Postpartum Care*

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

Breast Cancer Screening

Breast cancer is the second leading cause of cancer deaths among women nationally, as well as in Michigan.⁴⁻¹ The American Cancer Society estimates that there will be 192,370 new cases of breast cancer and 40,170 deaths from breast cancer in the United States during 2009.⁴⁻² The American Cancer Society also projects that 6,480 women will be newly diagnosed with breast cancer in Michigan during 2009, an increase of 360 cases from the previous year.⁴⁻³ While there has been a decline in the overall breast cancer death rate in recent years, there is a significant racial disparity. African-American women have a higher incidence of breast cancer before the age of 40 than white women, and African-American women have higher death rates from the disease at all ages.⁴⁻⁴

Today, nearly 90 percent of women diagnosed with breast cancer will survive for at least five years.⁴⁻⁵ A mammogram can detect breast cancer in its early stages, when treatment is more effective and a cure is more likely. Mammography can detect about 80 percent to 90 percent of breast cancers in women who do not have any symptoms.⁴⁻⁶ In 2006, approximately 70 percent of Michigan women 40 years of age and older reported having a mammogram and clinical breast exam in the past two years.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.

⁴⁻¹ American Cancer Society, Cancer Facts & Figures 2009. Available at: <http://www.cancer.org/downloads/STT/500809web.pdf>. Accessed July 9, 2009.

⁴⁻² Ibid.

⁴⁻³ Ibid.

⁴⁻⁴ Michigan Department of Community Health: Breast Cancer Deaths. Available at: http://www.michigan.gov/documents/mdch/12_BrstCanc_198882_7.pdf. Accessed July 9, 2009.

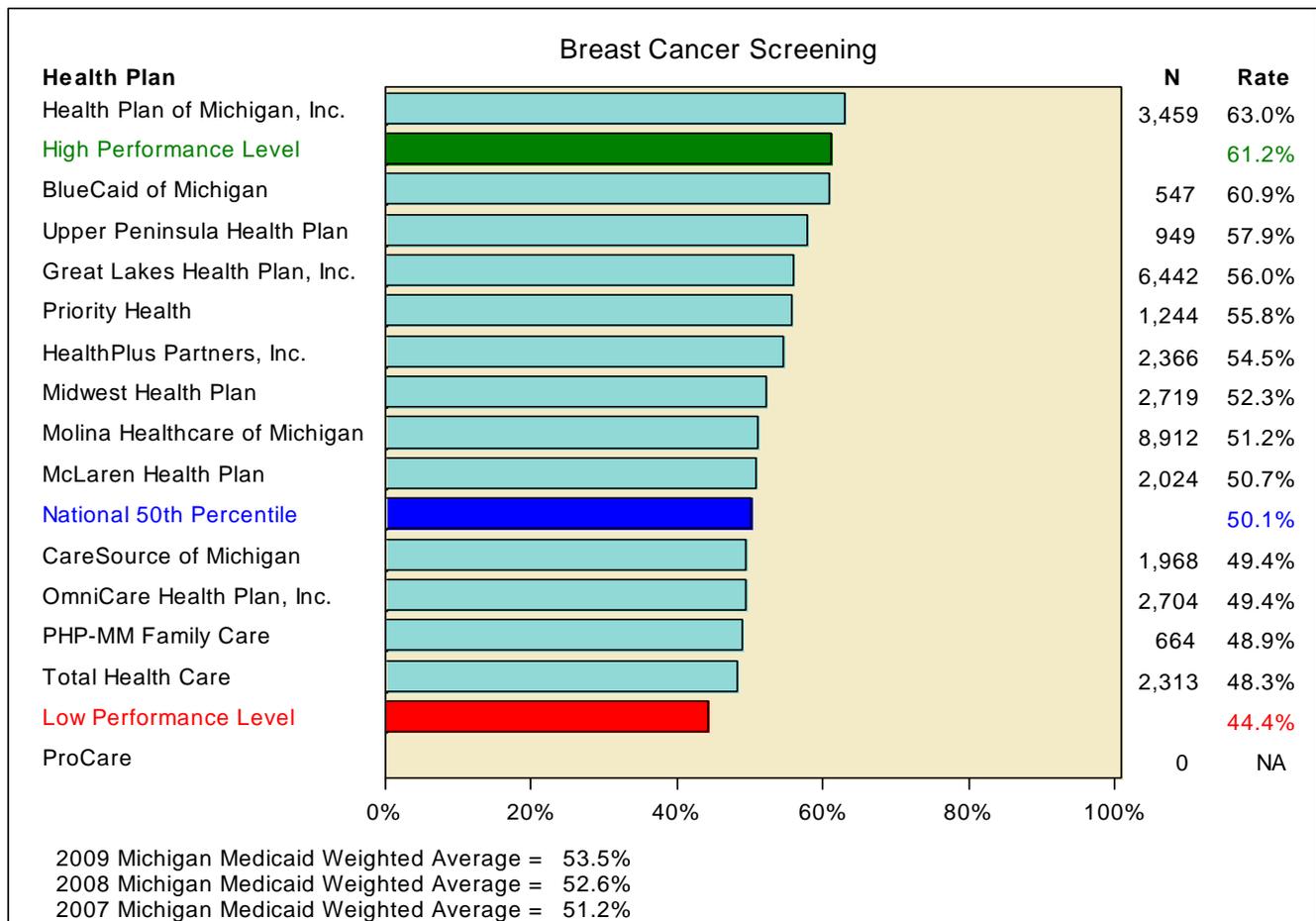
⁴⁻⁵ The American Cancer Society. Cancer Facts & Figures 2009. Available at: <http://www.cancer.org/downloads/STT/500809web.pdf>. Accessed July 10, 2009.

⁴⁻⁶ Ibid.

⁴⁻⁷ Michigan Cancer Consortium, Special Cancer Behavioral Risk Factor Survey 2006. Available at: <http://www.michigancancer.org/PDFs/MCCReports/MCCReports-SCBRFS-2006-121008.pdf>. Accessed July 9, 2009.

Health Plan Ranking: Breast Cancer Screening

**Figure 4-1—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Breast Cancer Screening**



One health plan exceeded the HPL of 61.2 percent, and no health plans ranked below the LPL of 44.4 percent. A total of nine MHPs, including the one above the HPL, reported rates above the national HEDIS 2008 Medicaid 50th percentile. Two MHPs ranked between the 75th percentile of 56.4 percent and 90th percentile of 61.2 percent. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 53.5 percent was 3.4 percentage points above the national HEDIS 2008 Medicaid 50th percentile of 50.1 percent and 0.9 percentage points higher than the 2008 Michigan Medicaid weighted average of 52.6 percent.

Cervical Cancer Screening

Early detection and appropriate treatment of cervical cancer result in a high treatment success rate. 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 2007, 399 new cases of cervical cancer were diagnosed in Michigan women, and 118 women died from the disease.⁴⁻⁸ Approximately 83 percent of Michigan women 18 years of age and older have received a Pap test within the past three years.⁴⁻⁹ In 2009, an estimated 320 new cases of cervical cancer will be diagnosed among women in Michigan, according to the American Cancer Society.⁴⁻¹⁰ Michigan reported a mortality rate of 1.8 deaths per 100,000 women for this disease in 2006.⁴⁻¹¹

HEDIS Specification: Cervical Cancer Screening

The *Cervical Cancer Screening* measure reports the percentage of women aged 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 Michigan Department of Community Health: Cervical Cancer Deaths and Screening. Available at: http://www.michigan.gov/documents/mdch/14_CervCanc_198884_7.pdf. Accessed July 10, 2009.

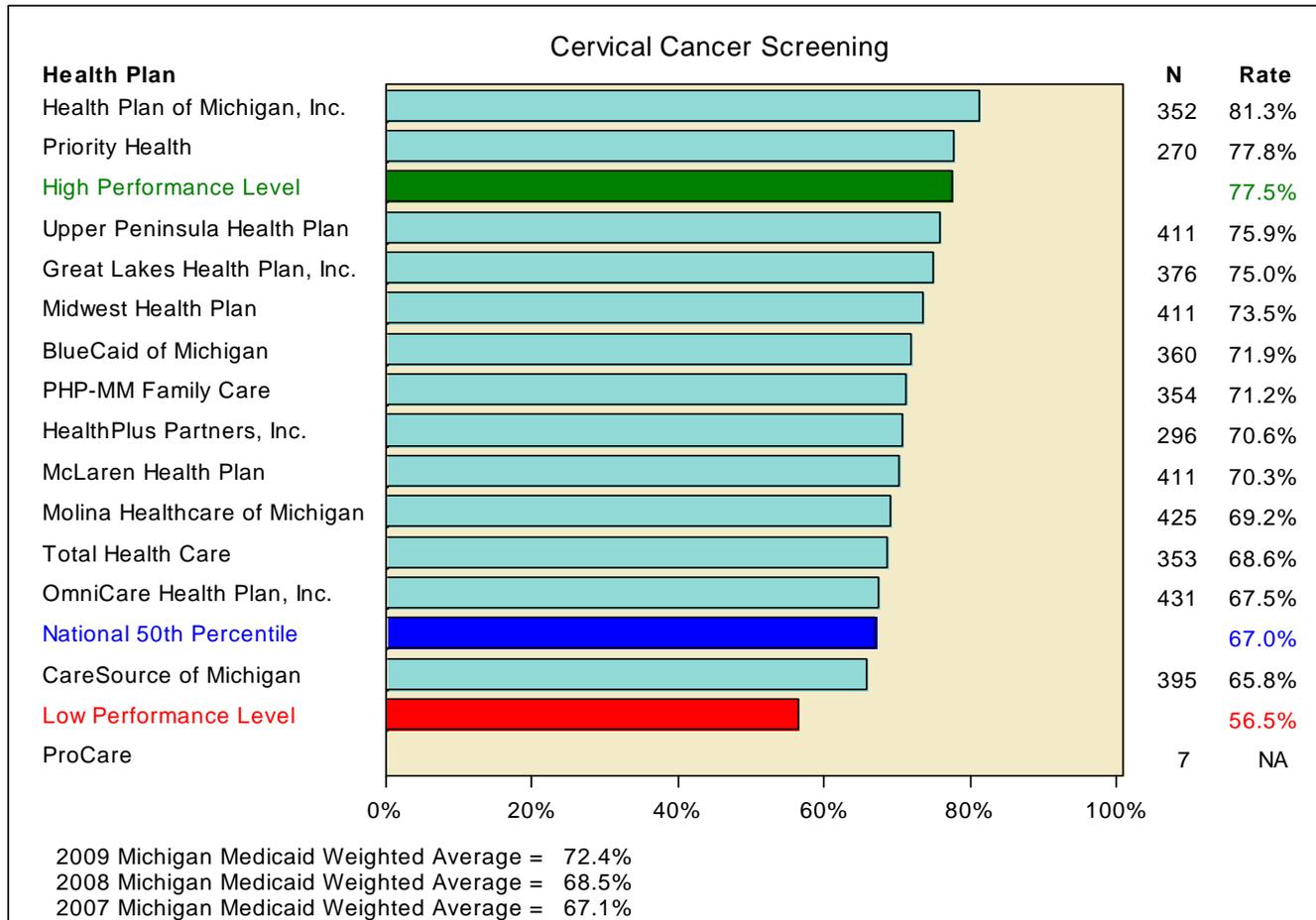
⁴⁻⁹ Michigan Department of Community Health: Facts about Cervical Cancer: February 2009. Available at: http://www.michigan.gov/documents/CervicalFacts_6648_7.pdf. Accessed July 10, 2009.

⁴⁻¹⁰ American Cancer Society, Cancer Facts & Figures 2009. Available at: <http://www.cancer.org/downloads/STT/500809web.pdf>. Accessed July 10, 2009.

⁴⁻¹¹ Michigan Department of Community Health: Facts about Cervical Cancer: February 2009. Available at: http://www.michigan.gov/documents/CervicalFacts_6648_7.pdf. Accessed July 10, 2009.

Health Plan Ranking: Cervical Cancer Screening

**Figure 4-2—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Cervical Cancer Screening**

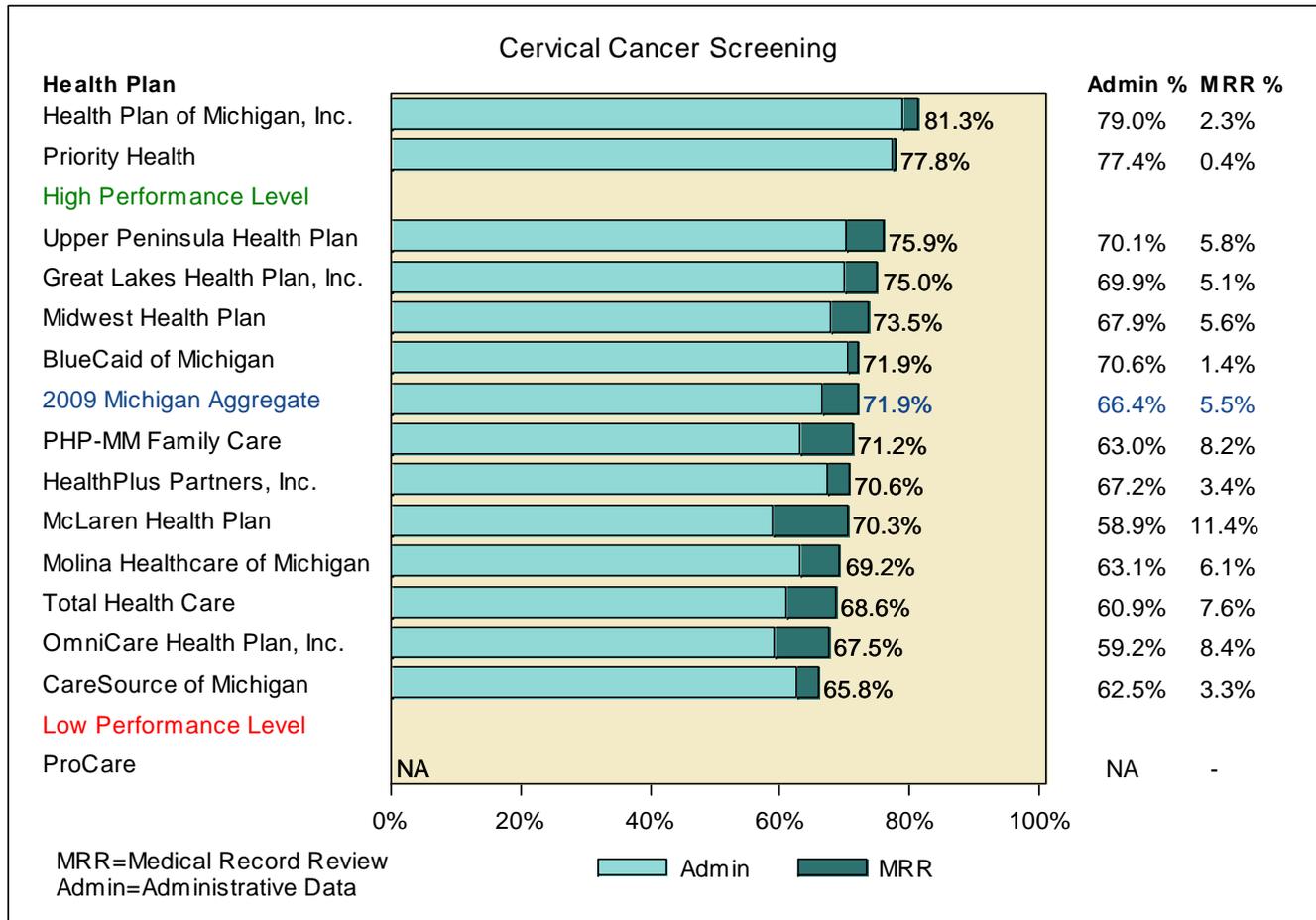


Two MHPs exceeded the HPL of 77.5 percent, and no health plans reported a rate below the LPL of 56.5 percent. A total of 12 health plans, including the two plans above the HPL, ranked above the national HEDIS 2008 Medicaid 50th percentile, and three MHPs ranked between the 75th and 90th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 72.4 percent showed a statistically significant increase of 3.9 percentage points over the 2008 Michigan Medicaid weighted average, and was 5.4 percentage points above the national HEDIS 2008 Medicaid 50th percentile of 67.0 percent.

Data Collection Analysis: Cervical Cancer Screening

**Figure 4-3—Michigan Medicaid HEDIS 2009
Data Collection Analysis:
Cervical Cancer Screening**



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

All of the MHPs except one reported this measure using the hybrid method. The 2009 Michigan aggregate administrative rate was 66.4 percent and the aggregate medical record review rate was 5.5 percent.

The results indicated that 92.4 percent of the total aggregate rate (71.9 percent) was derived from administrative data and 7.6 percent was from medical record review.

All of the health plans using the hybrid method derived more than 80 percent of their rates from administrative data. The health plans increased their overall rates anywhere from 0.4 to 11.4 percentage points through medical record review.

Chlamydia Screening in Women

Chlamydia is the most commonly reported STD in the United States, infecting approximately 2.3 million people between 14 and 39 years of age.⁴⁻¹² Chlamydia is sometimes referred to as a “silent” disease because the majority of those who are infected 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 potentially fatal ectopic pregnancy. Women with chlamydia are also up to five times more likely to become infected with HIV in the event of an exposure.⁴⁻¹³ Chlamydia can be treated with antibiotics. Untreated chlamydia costs an estimated \$3.1 billion per year.⁴⁻¹⁴

Michigan reported 41,291 cases of chlamydia in 2007, an 8 percent increase from 2006.⁴⁻¹⁵ The highest rates occur in the age groups of women 15–19 and 20–24 years of age.⁴⁻¹⁶

HEDIS Specification: Chlamydia Screening in Women

The *Chlamydia Screening in Women* measure is reported using the administrative method only. This measure reports the percentage of women 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. The measure is reported by three separate rates: *Chlamydia Screening in Women—16 to 20 Years*; *Chlamydia Screening in Women—21 to 24 Years*; and *Chlamydia Screening in Women—Combined Rate* (the total of both age groups, 16 to 24 years).

⁴⁻¹² Centers for Disease Control and Prevention. Chlamydia—CDC Fact Sheet. Available at: <http://www.cdc.gov/std/Chlamydia/STDFact-Chlamydia.htm#Common>. Accessed July 10, 2009.

⁴⁻¹³ Ibid.

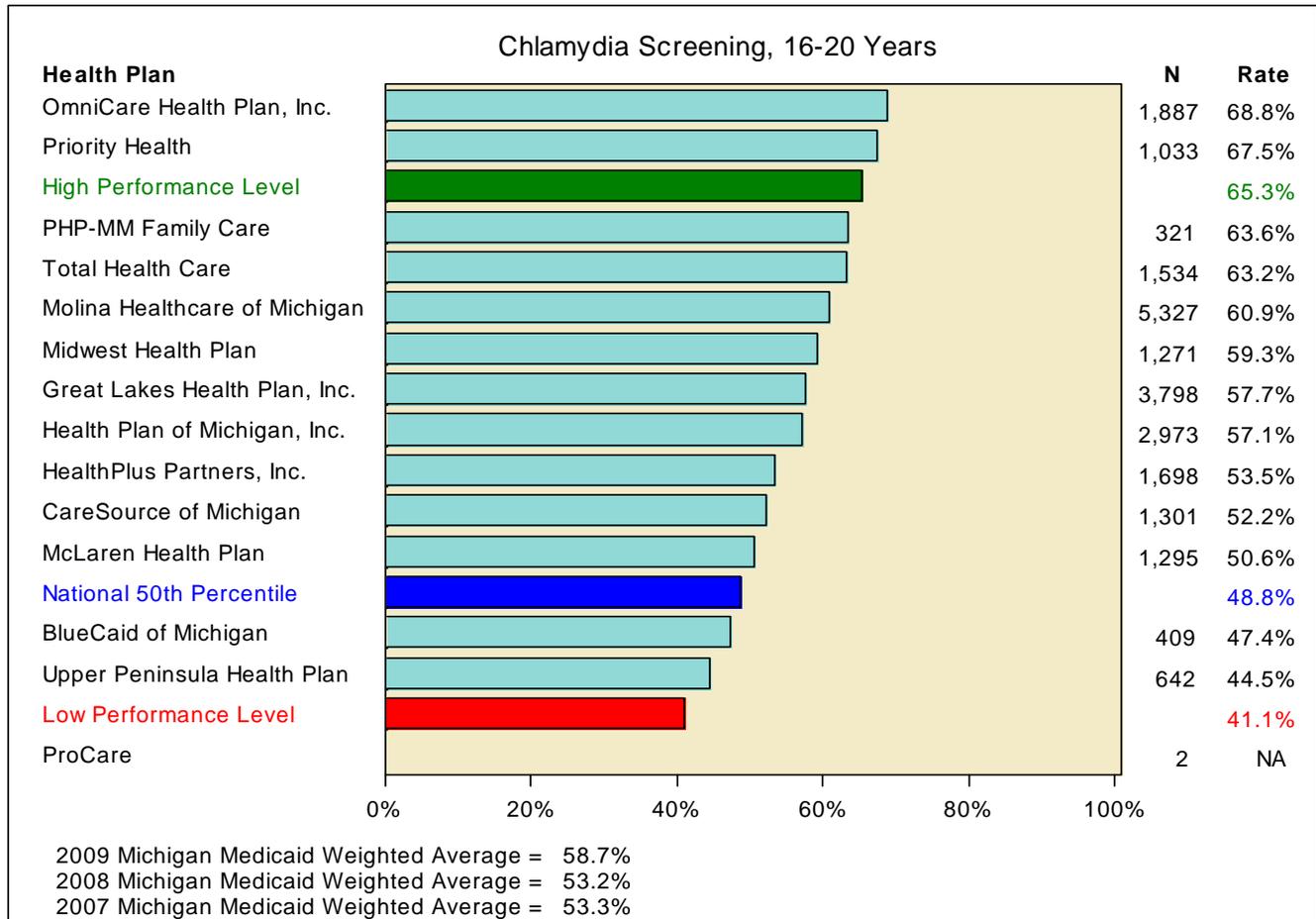
⁴⁻¹⁴ National Committee for Quality Assurance. The State of Health Care Quality 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed July 10, 2009.

⁴⁻¹⁵ Michigan Department of Community Health: Chlamydia. Available at: http://www.michigan.gov/documents/mdch/34_Chlamyd_198935_7.pdf. Accessed July 10, 2009.

⁴⁻¹⁶ Ibid.

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

**Figure 4-4—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Chlamydia Screening in Women—16 to 20 Years**

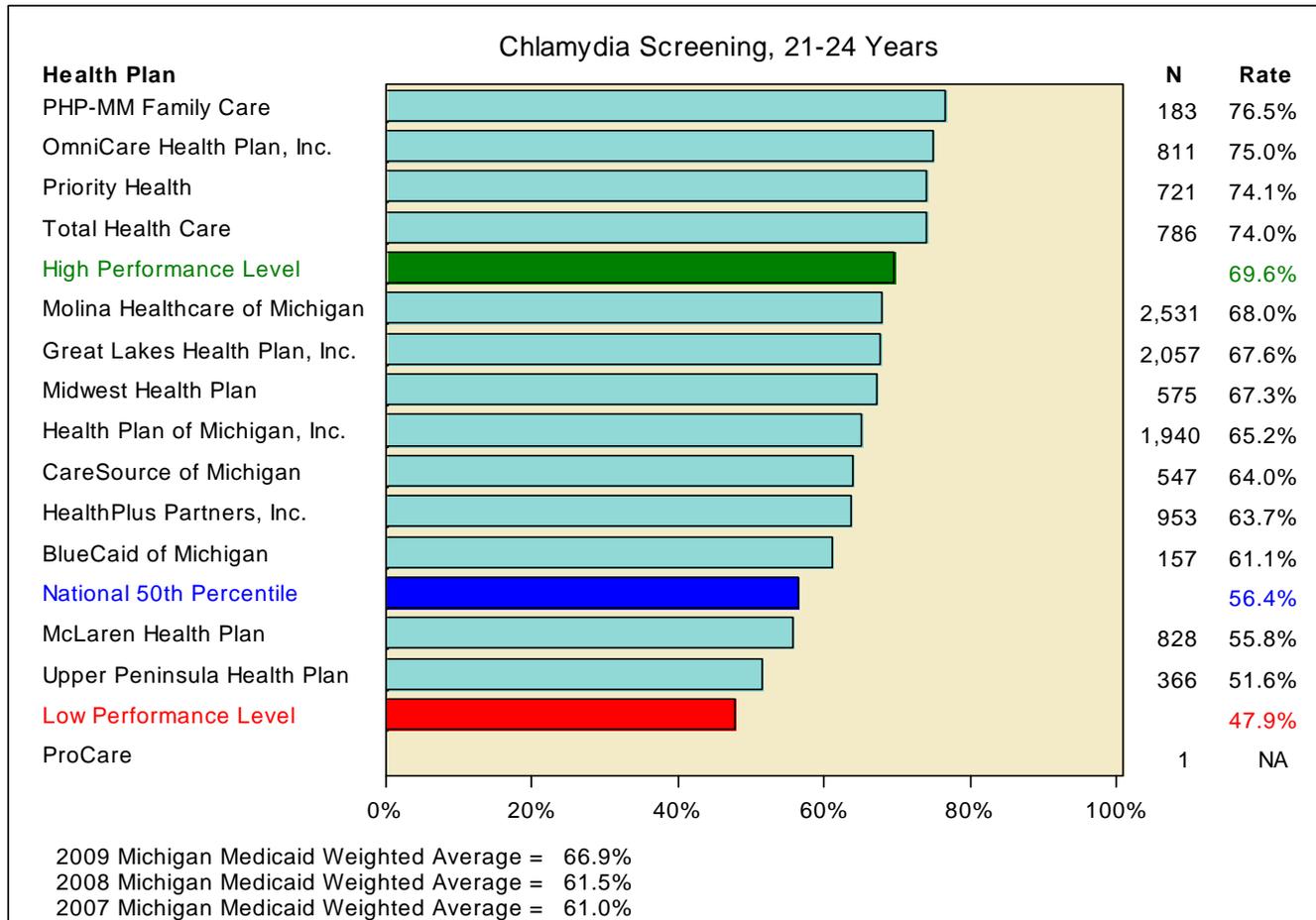


Two MHPs reported rates above the HPL of 65.3 percent, with no health plans ranking below the LPL of 41.1 percent. Eleven health plans, including the two plans with rates above the HPL, ranked above the national HEDIS 2008 Medicaid 50th percentile, and seven of these ranked above the 75th percentile of 57.2 percent. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 58.7 percent had a statistically significant increase of 5.5 percentage points over the 2008 Michigan Medicaid weighted average, and was 9.9 percentage points above the national HEDIS 2008 Medicaid 50th percentile of 48.8 percent.

Health Plan Ranking: Chlamydia Screening in Women—21 to 24 Years

**Figure 4-5—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Chlamydia Screening in Women—21 to 24 Years**



For 2009, the upper age limit for *Chlamydia Screening in Women—21 to 24 Years* decreased from 25 years of age to 24 years of age. Caution should be exercised when comparing 2009 health plans' rates with the national HEDIS 2008 Medicaid percentiles, or when comparing the 2009 Michigan Medicaid weighted average with previous Michigan Medicaid weighted averages.

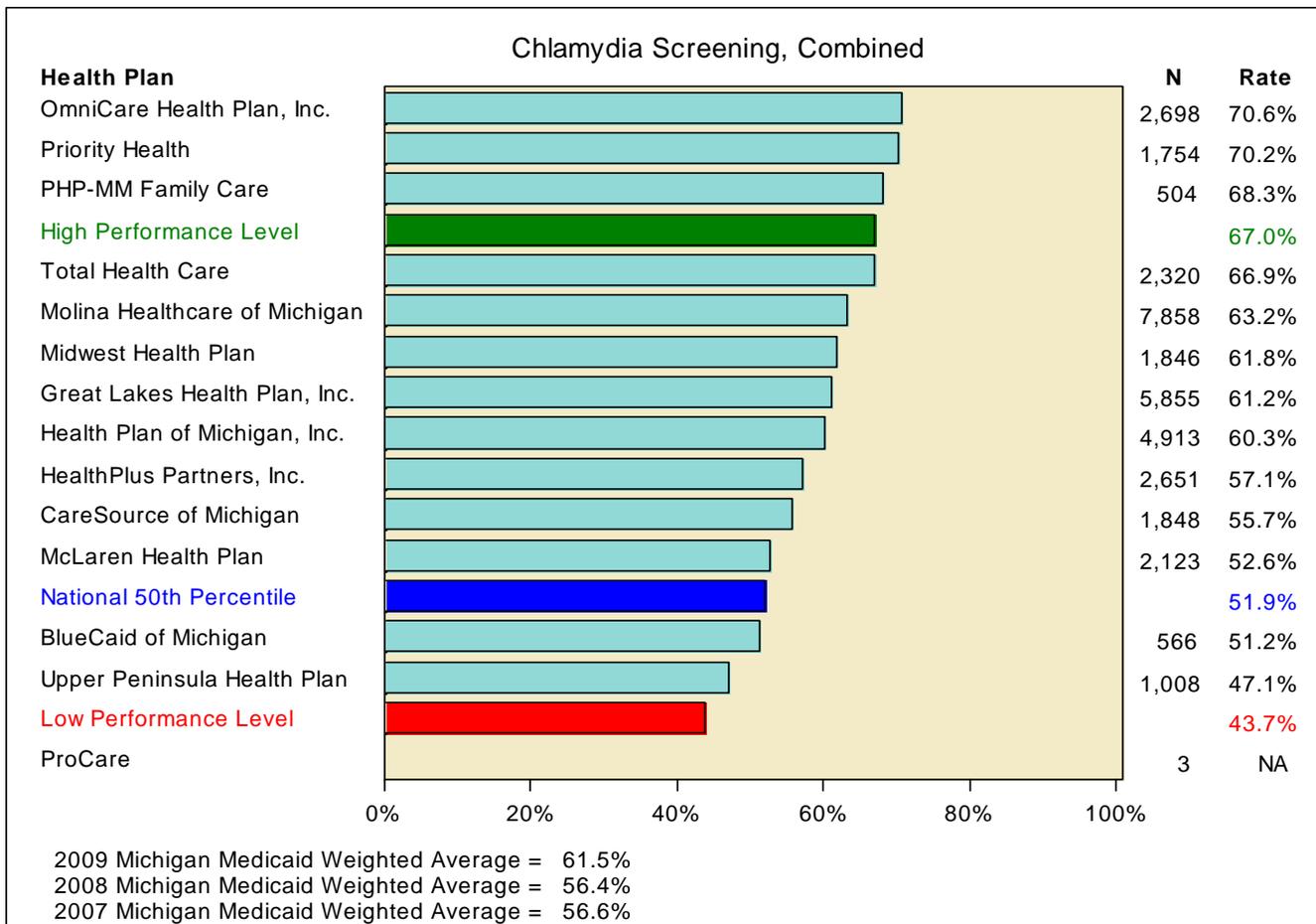
Four health plans ranked above the HPL of 69.6 percent, and none of the MHPs reported rates below the LPL of 47.9 percent. A total of 11 health plans, including the 4 above the HPL, reported rates above the national HEDIS 2008 Medicaid 50th percentile, and 8 of these plans ranked above the 75th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 66.9 percent showed statistically significant improvement compared to the 2008 weighted average, with an increase of 5.4 percentage points.

Also, the 2009 weighted average was 10.5 percentage points above the national HEDIS 2008 Medicaid 50th percentile.

Health Plan Ranking: Chlamydia Screening in Women—Combined Rate

**Figure 4-6—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Chlamydia Screening in Women—Combined Rate**



In 2009, the upper age limit for *Chlamydia Screening in Women—Combined Rate* decreased from 25 years of age to 24 years of age. Caution should be exercised when comparing 2009 health plans' rates with the national HEDIS 2008 Medicaid percentiles, or when comparing the 2009 Michigan Medicaid weighted average with previous Michigan Medicaid weighted averages.

Three health plans reported rates above the HPL of 67.0 percent, and no health plans had rates below the LPL of 43.7 percent. Eleven health plans, including the three above the HPL, had reported rates above the national HEDIS 2008 Medicaid 50th percentile, and eight of these were above the 75th percentile of 59.7 percent. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

There was statistically significant improvement seen between the 2009 Michigan Medicaid weighted average of 61.5 percent and the 2008 weighted average, with a 5.1 percentage-point increase between the years. Also, the weighted average this year was 9.6 percentage points above the national HEDIS 2008 Medicaid 50th percentile.

Prenatal and Postpartum Care

More than 4 million infants are born in the United States each year. Approximately 520,000 of these infants are born preterm, and another 338,000 are of low birth weight.⁴⁻¹⁷ Low birth weight increases the risk for neurodevelopmental 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 do not receive prenatal care are up to four times more likely to experience fatal complications related to pregnancy than those who receive prenatal care.⁴⁻¹⁸

More than 125,000 live births occurred in Michigan during 2007.⁴⁻¹⁹ Of these live births, 10,550 were of low weight.⁴⁻²⁰ In 2008, Michigan's infant mortality rate was 7.6 deaths per 1,000 live births, which ranked 35th in the United States.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 Additionally, women who receive timely, adequate prenatal care may be more likely to maintain a healthy weight and avoid extended hospitalization after giving birth.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 *Prenatal and Postpartum Care* measure consists of two numerators:

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

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

The *Timeliness of Prenatal Care* measure calculates the percentage of women who delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year, who were continuously enrolled at least 43 days prior to delivery through 56 days after delivery, and who received a prenatal care visit as a member of the MHP in the first trimester or within 42 days of enrollment in the MHP.

⁴⁻¹⁷ 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 July 10, 2009.

⁴⁻¹⁸ Ibid.

⁴⁻¹⁹ Michigan Department of Community Health. Live Births and Crude Birth Rates. Available at: <http://www.mdch.state.mi.us/PHA/OSR/natality/tab1.1.asp>. Accessed July 10, 2009.

⁴⁻²⁰ Michigan Department of Community Health. Low Weight Live Births by County of Residence. Available at: <http://www.mdch.state.mi.us/PHA/OSR/natality/LowWeightBirths.asp>. Accessed July 10, 2009.

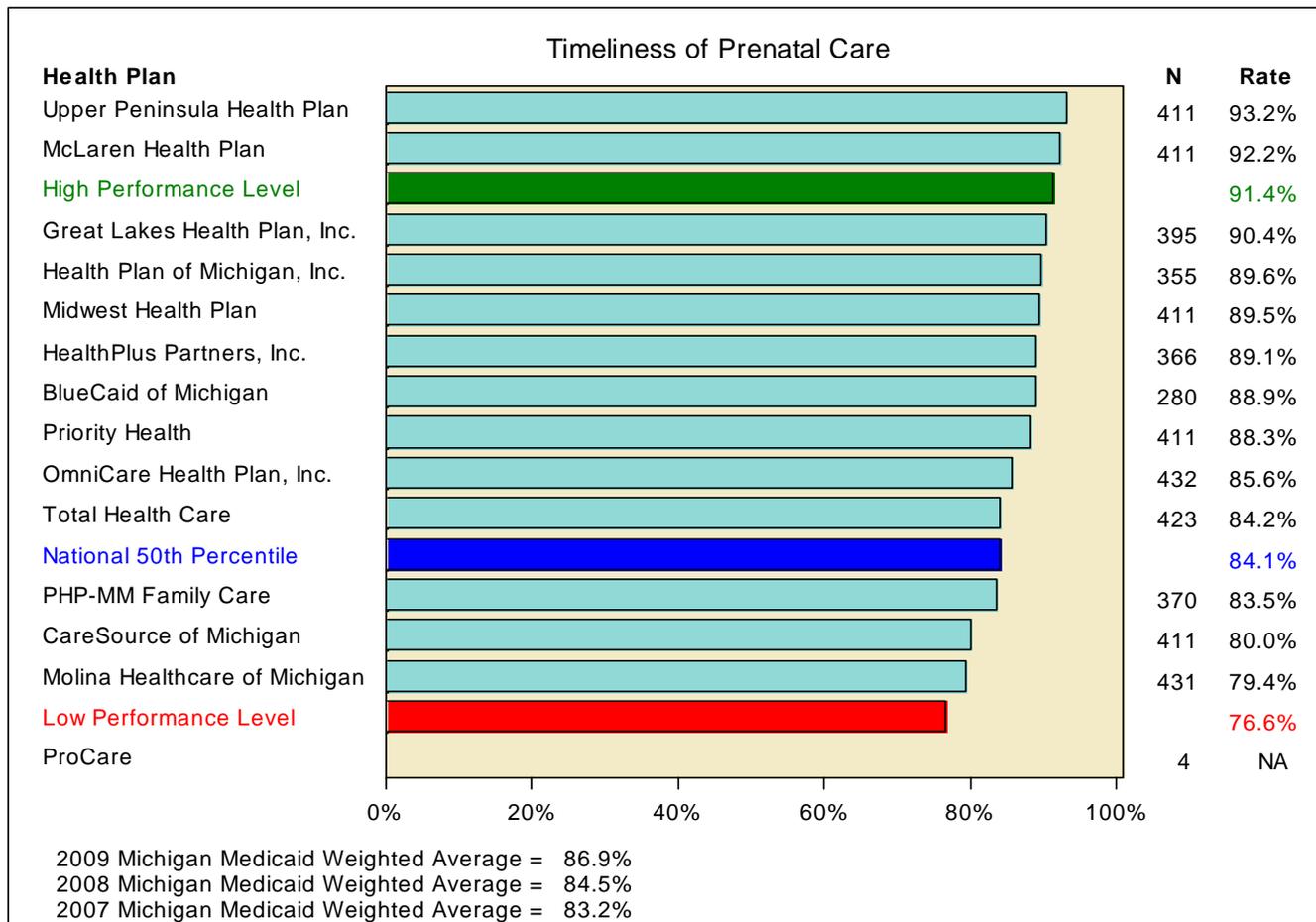
⁴⁻²¹ United Health Foundation. America's Health: State Health Rankings 2008. Available at: <http://www.americashealthrankings.org/2008/pdfs/mi.pdf>. Accessed July 10, 2009.

⁴⁻²² Family Health International. Better Postpartum Care Saves Lives. Available at: http://www.fhi.org/en/RH/Pubs/Network/v17_4/postpartum.htm. Accessed July 10, 2009.

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 July 10, 2009.

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

**Figure 4-7—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Prenatal and Postpartum Care—Timeliness of Prenatal Care**

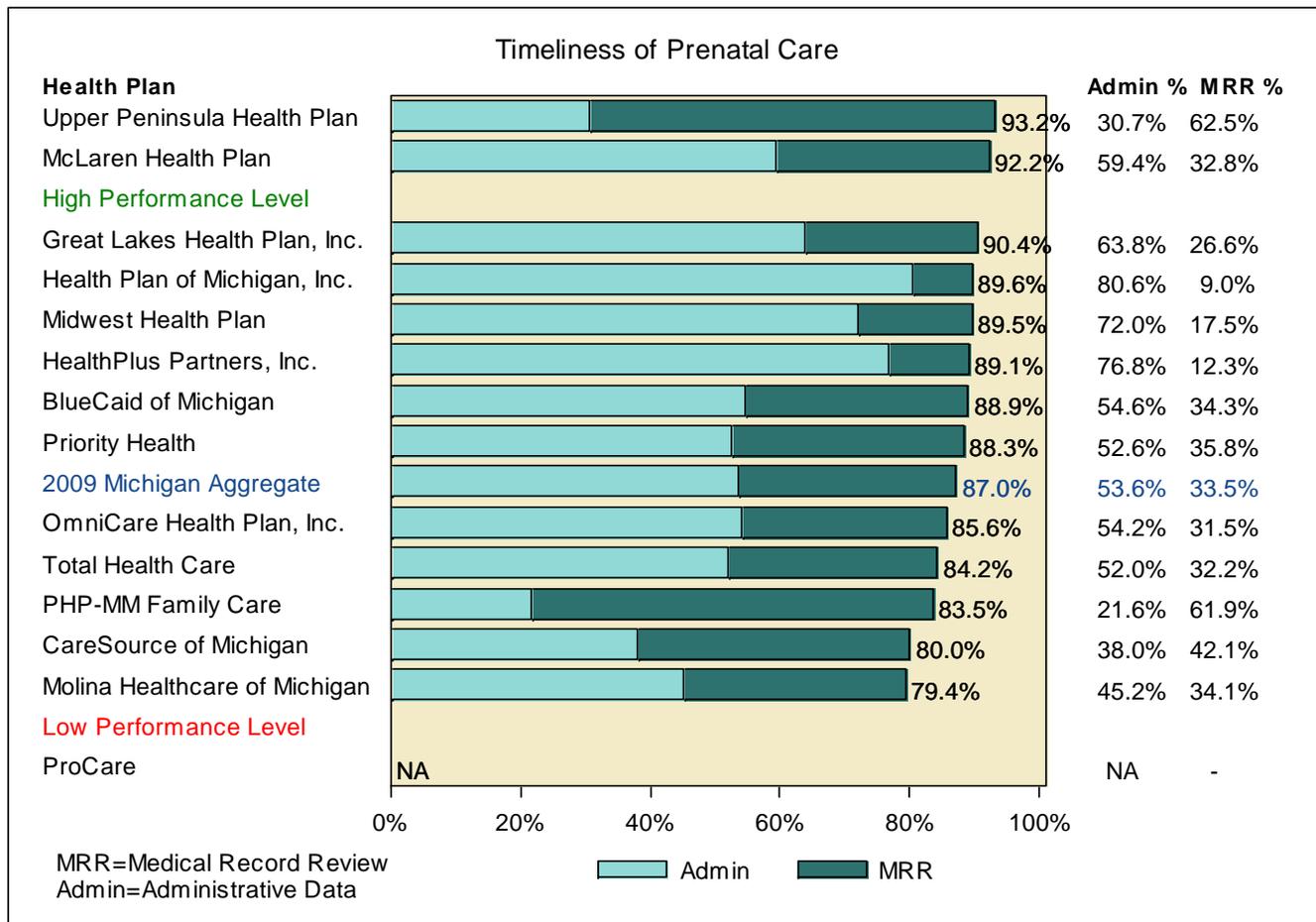


Two of the Michigan MHPs ranked above the HPL of 91.4 percent, and none of the plans fell below the LPL of 76.6 percent. Ten health plans, including the two above the HPL, had rates above the national HEDIS 2008 Medicaid 50th percentile, and seven of these were above the 75th percentile of 88.6 percent. One MHP was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 86.9 percent was 2.8 percentage points above the national HEDIS 2008 Medicaid 50th percentile of 84.1 percent and increased by 2.4 percentage points from last year's rate.

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

**Figure 4-8—Michigan Medicaid HEDIS 2009
Data Collection Analysis:
Prenatal and Postpartum Care—Timeliness of Prenatal Care**



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

All of the MHPs except one used the hybrid method to report this measure. The 2009 Michigan aggregate administrative rate was 53.6 percent and the aggregate medical record review rate was 33.5 percent.

Overall, 61.6 percent of the total aggregate rate (87.0 percent) was derived from administrative data and 38.5 percent was derived from medical record review data.

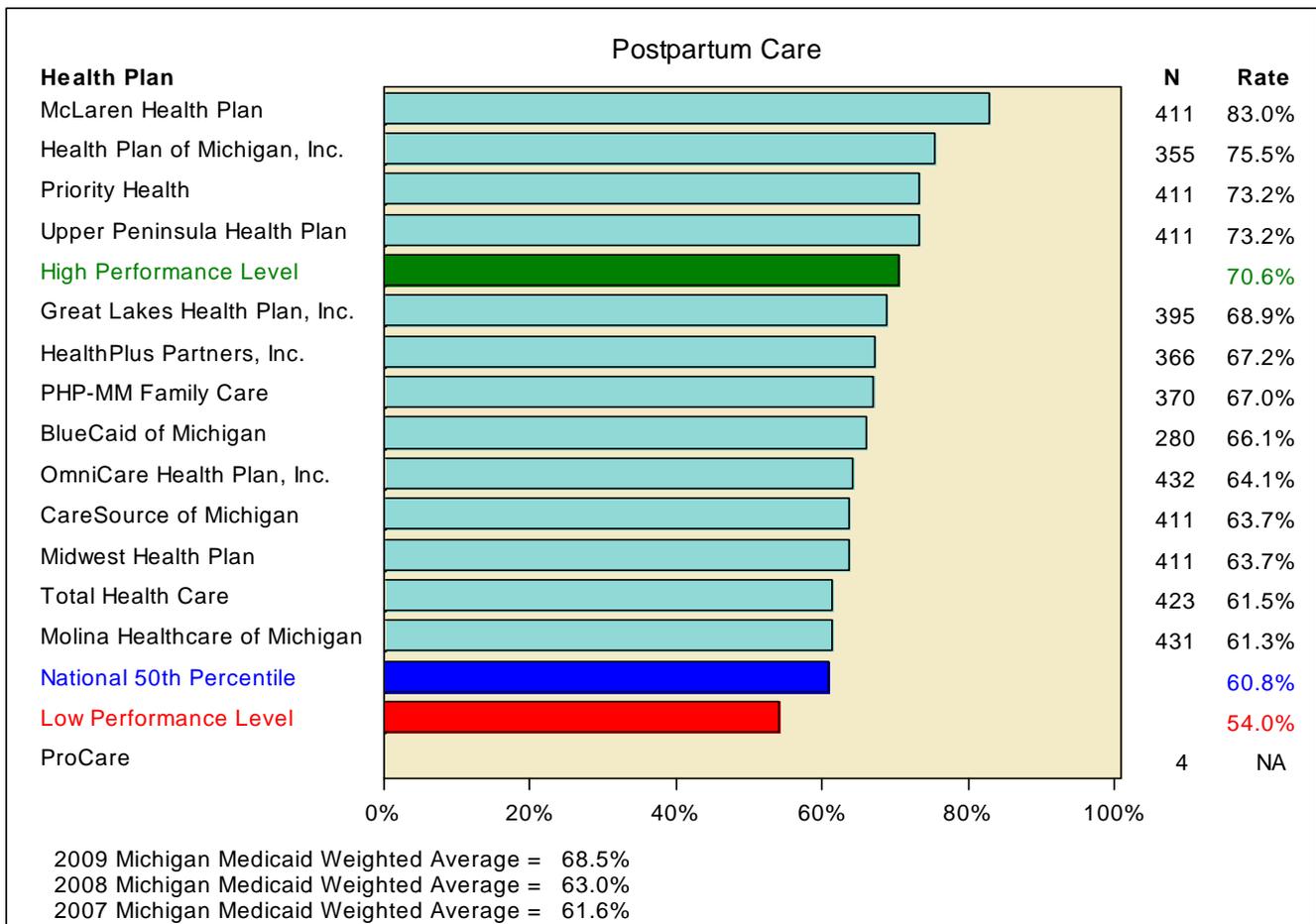
Ten health plans using hybrid method derived more than half of their rates from administrative data, and two health plans derived less than one third of their rate from administrative data.

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 43 days prior to delivery through 56 days after delivery, and who received a postpartum visit on or between 21 days and 56 days after delivery.

Health Plan Ranking: Prenatal and Postpartum Care—Postpartum Care

**Figure 4-9—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Prenatal and Postpartum Care—Postpartum Care**

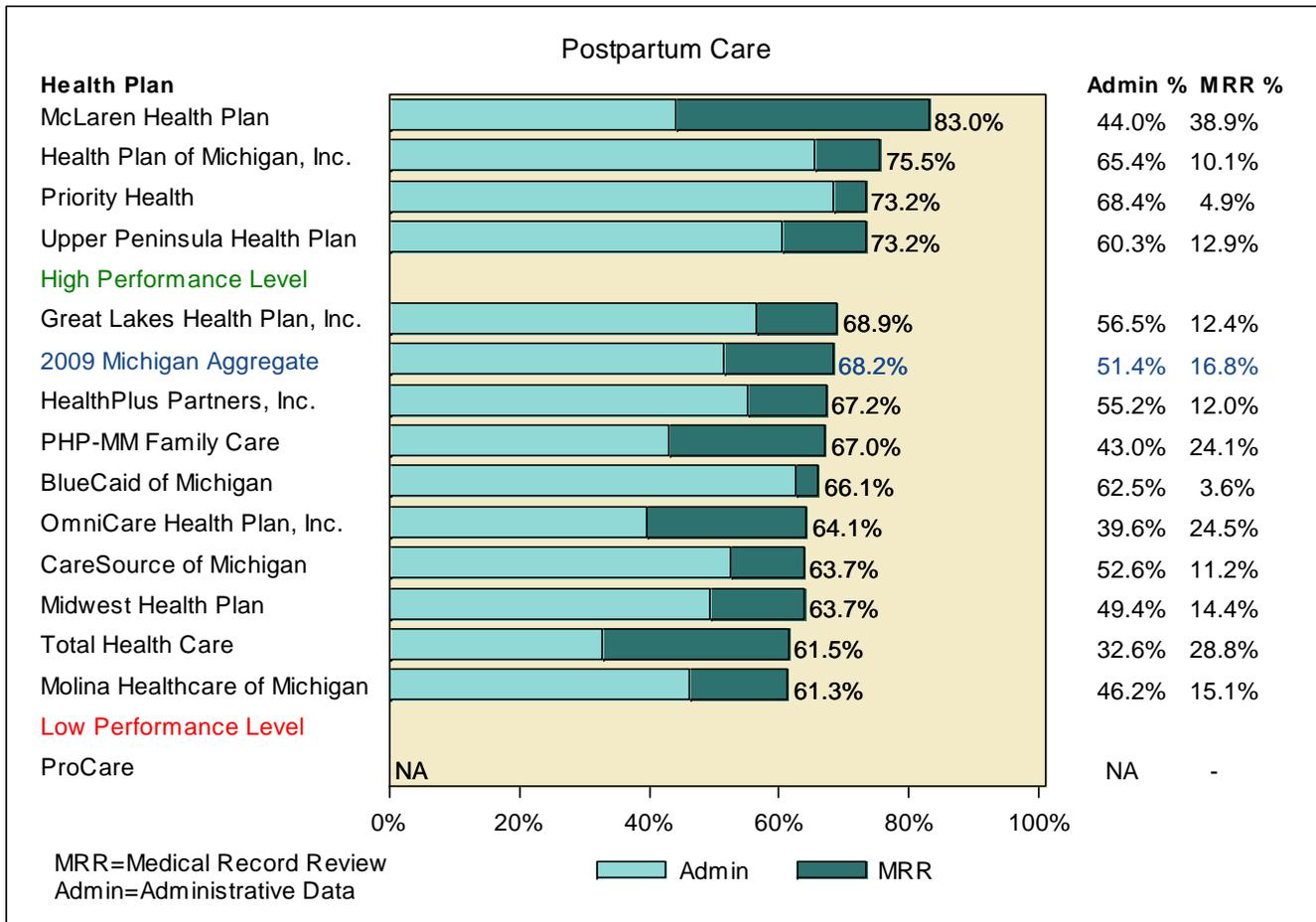


Four of the 14 MHPs reported rates above the HPL of 70.6 percent, and no health plans reported rates below the LPL of 54.0 percent. A total of 13 health plans' rates, including the 4 above the HPL, ranked above the national HEDIS 2008 Medicaid 50th percentile, and 8 of these plans ranked above the 75th percentile of 65.8 percent. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 68.5 percent outperformed the national HEDIS 2008 Medicaid 50th percentile by 7.7 percentage points and increased by 5.5 percentage points over the 2008 weighted average.

Data Collection Analysis: Prenatal and Postpartum Care—Postpartum Care

**Figure 4-10—Michigan Medicaid HEDIS 2009
Data Collection Analysis:
Prenatal and Postpartum Care—Postpartum Care**



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

All of the health plans except one reported this measure using the hybrid method. The 2009 Michigan aggregate administrative rate was 51.4 percent and the aggregate medical record review rate was 16.8 percent.

Overall, 75.4 percent of the total aggregate rate (68.2 percent) was derived from administrative data and 24.6 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 using hybrid method derived at least half of their rate from administrative data in 2009.

Women's Care Findings and Recommendations

All seven of the 2009 Michigan Medicaid weighted averages in this section improved compared to the 2008 weighted averages, and four of the rate increases were statistically significant. All of the 2009 weighted averages ranked above the national HEDIS 2008 Medicaid 50th percentile, and many of the rates performed between 5 and 10 percentage points greater than the national average. Performance on the Women's Care measures appeared to be an area where the MHPs have focused improvement efforts.

While both of the cancer screening rates improved compared to the 2008 rates, neither increase was statistically significant. The *Breast Cancer Screening* rate improved by almost 1 percentage point, and the *Cervical Cancer Screening* rate improved by almost 4 percentage points. Both weighted averages ranked above the national 50th percentile, and the weighted average for *Cervical Cancer Screening* equaled the 75th percentile of 72.4 percent. There has been little change in the range of rates reported by the MHPs for the cancer screening measures. For HEDIS 2008 the rates for *Breast Cancer Screening* ranged from 44.9 percent to 62.1 percent compared to 48.3 percent to 63.0 percent this year. For *Cervical Cancer Screening* the rates ranged from 64.2 percent to 79.7 percent in 2008 to 65.8 percent to 81.3 percent in 2009. These rates have remained fairly stable over the past few years and could be an area where the MHPs focus improvement efforts to stimulate increases in these rates.

PIPs focusing on breast cancer screening have been effective in improving the corresponding HEDIS measure. HSAG has compiled information on interventions that were successfully implemented by health plans from PIPs/QIPs demonstrating sustained improvement for this HEDIS rate.⁴⁻²⁴ These interventions primarily addressed barriers related to access and lack of awareness. The initial implementation of mobile mammography was unsuccessful, but was replaced with a successful intervention involving the plan ensuring access to mammography appointments within 30 days. Unlike the quality profiles provided below, the mobile units were placed in community settings and not work sites. Standard educational interventions were implemented in addition to both provider and member incentives.

The importance of barrier analyses was highlighted in following example taken from the quality profile, "Hitting the Road With Screening Programs."⁴⁻²⁵ A health plan determined that its current efforts to improve HEDIS results for *Breast Cancer Screening* were not sufficient. By using focus groups, surveys, and analyses of screening rates, the plan identified the need for education and awareness for PCPs and members, and the need for mobile mammography to address access barriers. Specifically, the plan determined that mobile mammography should be conducted at work sites and offices. The popularity of the mobile units program resulted in employers sharing the cost of mobile mammography.

⁴⁻²⁴ Health Services Advisory Group. Validation of Performance and Quality Improvement Projects. Studies validated between 2004 and 2009.

⁴⁻²⁵ National Committee for Quality Assurance. 2008. Quality Profiles. Available at http://www.qualityprofiles.org/quality_profiles/case_studies/Womens_Health/1_15.asp. Accessed September 8, 2009.

Another successful breast cancer screening case study was “Improving Access and Awareness.”⁴⁻²⁶ The plan used corporate resources to conduct barrier analyses. The results of these analyses identified access and education as primary barriers. Initially, to address access issues, the plan provided mobile mammography at work sites and expanded its network of mammography sites and gynecological practitioners. To further reduce this barrier, the plan offered direct access to OB/GYNs, eliminating the need for referrals. The plan implemented interventions to improve awareness and education for members and clinicians. For members, birthday cards were followed by phone calls and then letters from the medical director. For clinicians, reports were followed by letters from the medical director.

Specific to cervical cancer screening rate improvements, one program was able to increase cervical cancer screening rates by colocating gynecological services within an HIV clinic.⁴⁻²⁷ Cervical cancer screening rates increased from 10 percent to 61 percent. Gynecological visits were scheduled concurrently with HIV follow-up visits, and both transportation and child care were provided.

An example of a successful health plan improvement project was provided in the quality profile, “Intervention Improving High-Volume Screening in an Expanding Population.”⁴⁻²⁸ The goal of the project was to increase cervical cancer screening rates. Corporate resources were used to supply the study design and statistical analysis.

Initial barrier analysis demonstrated common barriers to screening. The plan initiated educational interventions in conjunction with reminders and member incentives. Further barrier analysis revealed that the majority of women 35 to 51 years of age were noncompliant with screening recommendations. The plan noted that these women were less likely to have regular visits for either birth control or hormone replacement. Women with partial hysterectomies also were less likely to be screened. The plan implemented focused interventions to reach this subset of women. The plan addressed the access barrier by extending clinic hours, expanding the provider network, and increasing the number of female physicians.

Health plans can successfully improve their cervical cancer screening rates by implementing standard interventions. Convening focus groups and/or conducting member surveys facilitate the health plan’s ability to identify subgroups within their populations with higher noncompliance rates. Modifying the standard interventions of health plans to reach these subgroups is an effective method for increasing screening rates.^{4-29, 4-30}

Chlamydia Screening in Women is presented in three rates, *16–20 Years*, *21–24 Years*, and *Combined*. All three of these rates showed statistically significant improvement compared to last

⁴⁻²⁶ National Committee for Quality Assurance. 2008. Quality Profiles. Available at http://www.qualityprofiles.org/quality_profiles/case_studies/Womens_Health/2_9.asp. Accessed September 8, 2009.

⁴⁻²⁷ AHRQ Health Care Innovations Exchange. Co-locating gynecological services within an HIV clinic increases cervical cancer screening rates, leading to identification and treatment of many cancer cases. Available at <http://www.innovations.ahrq.gov/content.aspx?id=2393>. Accessed September 22, 2009.

⁴⁻²⁸ National Committee for Quality Assurance. 2008. Quality Profiles. Available at http://www.qualityprofiles.org/quality_profiles/case_studies/Womens_Health/2_8.asp. Accessed September 22, 2009.

⁴⁻²⁹ National Committee for Quality Assurance. 2008. Quality Profiles: Sticking to the basics: outreach and self-referral. Available at http://www.qualityprofiles.org/quality_profiles/case_studies/Womens_Health/1_17.asp. Accessed September 22, 2009.

⁴⁻³⁰ National Committee for Quality Assurance. 2008. Quality Profiles: Turning plan awareness into action. Available at http://www.qualityprofiles.org/quality_profiles/case_studies/Womens_Health/1_18.asp. Accessed September 22, 2009.

year's rates. The upper age limit was decreased by one year, from 25 to 24 years of age. Similar to last year, the younger age group's weighted average was lower than the weighted average of the older age group by more than 8 percentage points. Outreach efforts should focus on the younger age group and could be tied in with efforts to increase *Adolescent Well-Care Visits*.

Increasing the rate of chlamydia screening presents unique challenges for health plans. Many of the same interventions used to increase cervical cancer screening rates can be applied to chlamydia screening. Interventions that increase gynecological visits have the potential to increase both of these screening rates. The differences in the effectiveness of standard interventions are two-fold. Distribution of materials for chlamydia screening occurs less frequently; the material is not as readily available, and the mailings combine many topics together. Additionally, there is often a stigma associated with sexually transmitted diseases that affects both the clinician's and woman's ability to discuss screening recommendations.

One documented successful approach was a system-level clinical practice intervention.⁴⁻³¹ To increase chlamydia screening rates, the policy change was made to collect urine samples at the beginning of all gynecological visits. If during the visit the clinician determined that the screening was indicated based on clinical guidelines, then the urine was sent to a laboratory for testing. If not, the urine was discarded. Additionally, educational materials were developed that included discussion points for practitioners.

NCQA released a report that documented strategies for improving chlamydia screening.⁴⁻³² All the interventions addressed three areas: physician behavior, patient behavior, and data collection. However, health plans varied in which area or areas they included in their improvement projects. Education was used to modify attitudes and subsequent behaviors. Clinicians were provided with tools to facilitate discussions with patients and to identify patients in need of screening. Additionally, chlamydia educational materials were developed and distributed separately from other preventive services. Plans also developed methods for the collection of screening data using either designated codes or laboratories, which sent the results directly to the plans as well as the clinicians. The interventions brought additional attention to chlamydia screening, and the concerted efforts were closely monitored and evaluated. Based on the results of the evaluations, interventions were continually modified to ensure sustained improvement.

The weighted averages for both *Prenatal and Postpartum Care* measures continued to show improvement compared to last year's weighted averages. The lowest-performing MHP on the *Timeliness of Prenatal Care* measure improved its rate by almost 7 percentage points compared to its 2008 rate. The range of rates narrowed for this measure from 20.3 percentage points separating the high-performing MHP from the low-performing MHP in 2008 to only 13.8 percentage points separating them in 2009. For the *Postpartum Care* measure, all of the MHPs performed above the national 2008 HEDIS 50th percentile compared to last year, when three MHPs ranked below the 50th percentile and two of those MHPs ranked below the LPL. The range of rates narrowed from 28.9 percentage points in 2008 to 21.7 in 2009. Both *Prenatal and Postpartum Care* measures were reported using the hybrid methodology, and the MHPs' reliance on the use of medical record data did not change from 2008. The MHPs should work with their providers to improve administrative

⁴⁻³¹ Shafer, MAB, Tebb, KP, Pantelli, RH, et al. 2002. Effect of a clinical practice improvement intervention on chlamydial screening among adolescent girls. *JAMA*. 288(22):2846-2852.

⁴⁻³² NCQA. 2007. Improving Chlamydia screening: strategies from top performing health plans.

data completeness for maternity services. These types of services are typically billed on a global bill that does not include individual dates of service for prenatal visits or the postpartum visit. This type of billing requires the plans to use medical record data to report these measures. The MHPs should investigate ways to obtain more complete data for these measures.

PIPs focusing on prenatal and postpartum care have been effective in improving the HEDIS rates corresponding to the *Timeliness of Prenatal Care* and *Postpartum Care* measures. For a PIP intervention to be successful, it should address a specific barrier identified after conducting some type of causal/barrier analysis. Identifying the reason for untimely and/or missed prenatal and postpartum appointments determines which intervention or intervention combination is applicable. HSAG has compiled information on the following interventions that health plans successfully implemented from PIPs demonstrating sustained improvement for these two HEDIS rates.⁴⁻³³

System/provider interventions:

- ◆ Implemented CPT Category II codes to facilitate the administrative capture of prenatal and postpartum visits.
- ◆ Distributed HEDIS results to medical directors.

Either prenatal or postpartum visits:

- ◆ Provided bus tokens or taxi vouchers for transportation.
- ◆ Offered incentives for timely prenatal and postpartum visits. Incentives ranged from baby books to car seats.
- ◆ Used multiple attempts to contact members regarding missed appointments.

Prenatal visits:

- ◆ Provided priority scheduling to late-entry prenatal patients.
- ◆ Conducted mailings to members of childbearing age with information on women's health, including prenatal care.
- ◆ Encouraged member contact with a provider when becoming pregnant by offering incentives for an early prenatal visit.

Postpartum visits:

- ◆ Scheduled postpartum appointments at 36 weeks gestation, with appointments falling within four to eight weeks after delivery.
- ◆ Used an obstetrical database to identify patients four to six weeks post-delivery who had not attended a postpartum visit and contacted them to facilitate an appointment.
- ◆ Notified the appointment scheduling supervisor to set up postpartum appointments at hospital discharge.

⁴⁻³³ Health Services Advisory Group. Validation of Performance and Quality Improvement Projects. Studies validated between 2004 and 2009.

Prenatal and postpartum care measures directly link to other HEDIS measures. Plans that coordinate care and validate practice guidelines between internists, family practitioners, and OB/GYNs can positively affect maternal health. Incorporating alternative types of providers such as nurses and midwives has been associated with increased member satisfaction. Interventions that incorporate member tools for well-child visits and immunization schedules as part of the postpartum visit increase the corresponding HEDIS rates. Additionally, providing members with schedules of future screening requirements for breast and cervical cancer positively affects members' compliance with the clinical guidelines.

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 By 2020, the aging U.S. population will push this number to an estimated 157 million.⁵⁻² Chronic diseases are responsible for 7 out of 10 deaths (for a total of 1.7 million people) in this country each year.⁵⁻³ 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.⁵⁻⁴

More than 30 million people in the United States will suffer from asthma at some time during their lives, including almost 9 million children.⁵⁻⁵ Among children, asthma tends to affect more boys than girls, although the incidence of the disease is higher in adult women than in adult men.⁵⁻⁶ The economic impact of asthma is considerable—the disease costs \$18 billion annually, including \$8 billion in indirect costs.⁵⁻⁷ In Michigan, approximately 724,000 adults and 233,000 children have asthma. The prevalence of adult asthma in Michigan is nearly the same as the nationwide rate.⁵⁻⁸ However, asthma hospitalization rates for all age groups are lower in Michigan compared to the rest of the country.

The American Diabetes Association estimates that 23.6 million people (8 percent of the population) have diabetes in the United States, although only about 17.9 million people have been diagnosed with the disease.⁵⁻⁹ 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 nationwide over the last decade. In Michigan, an estimated 648,000 adults had diabetes during 2005–2007, and an estimated 279,100 had undiagnosed diabetes.⁵⁻¹⁰ The total cost associated with diabetes among Michigan residents was

⁵⁻¹ Partnership for Solutions. Chronic Conditions: Making the Case for Ongoing Care. Available at: <http://www.partnershipforsolutions.org/DMS/files/chronicbook2004.pdf>. Accessed July 13, 2009.

⁵⁻² Ibid.

⁵⁻³ Centers for Disease Control and Prevention. Chronic Disease Overview. Available at: <http://www.cdc.gov/nccdphp/overview.htm>. Accessed July 13, 2009.

⁵⁻⁴ Ibid.

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 July 13, 2009.

⁵⁻⁶ National Heart, Lung, and Blood Institute. Diseases and Conditions Index: Asthma. Available at: http://www.nhlbi.nih.gov/health/dci/Diseases/Asthma/Asthma_WhoIsAtRisk.html. Accessed July 13, 2009.

⁵⁻⁷ 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 July 13, 2009.

⁵⁻⁸ Michigan Department of Community Health. Asthma and Preventable Asthma Hospitalizations. Available at: http://www.michigan.gov/documents/mdch/22_Asthma_198922_7.pdf. Accessed July 13, 2009.

⁵⁻⁹ American Diabetes Association. Diabetes Statistics. Available at: <http://www.diabetes.org/diabetes-statistics/prevalence.jsp>. Accessed July 13, 2009.

⁵⁻¹⁰ The Michigan Diabetes Prevention and Control Program. Diabetes in Michigan—2008. Available at: http://www.michigan.gov/documents/mdch/Diabetes_Fact_Page-2008_274978_7.pdf. Accessed July 13, 2009.

an estimated \$6.5 billion in 2007.⁵⁻¹¹ Of this number, indirect costs accounted for approximately \$2 billion.

Another chronic condition—high blood pressure—afflicts an estimated one in three adults in the United States, according to the American Heart Association, although almost one-third of these individuals are unaware of their condition.⁵⁻¹² 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 was responsible for 36.1 percent of all deaths in 2006.⁵⁻¹³

Cigarette smoking is responsible for about one in five deaths in the United States, and is the most preventable cause of morbidity and premature mortality.⁵⁻¹⁴ According to the American Lung Association, smoking kills 438,000 U.S. residents annually. Approximately 45.3 million U.S. adults were smokers in 2006.⁵⁻¹⁵ Smoking is the major cause of many cancers as well as other serious diseases, including heart disease, bronchitis, emphysema, and stroke. The CDC reports that about 70 percent of smokers want to quit, and about 44 percent try to quit each year. However, in 2005, only 4 to 7 percent were successful.⁵⁻¹⁶

Between 2000 and 2004, smoking accounted for more than \$196 billion in annual health-related economic costs.⁵⁻¹⁷ In Michigan, 5,816 residents died of lung cancer during 2006, and approximately 22.1 percent of Michigan adults are current smokers.⁵⁻¹⁸ Smoking cessation treatment, considered the gold standard of preventive interventions, is less costly than other routine medical interventions.⁵⁻¹⁹

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 Percent)*
- *Comprehensive Diabetes Care—Eye Exam*
- *Comprehensive Diabetes Care—LDL-C Screening*
- *Comprehensive Diabetes Care—LDL-C Level <100*

⁵⁻¹¹ The Michigan Diabetes Prevention and Control Program. Diabetes in Michigan—2008. Available at: http://www.michigan.gov/documents/mdch/Diabetes_Fact_Page-2008_274978_7.pdf. Accessed July 13, 2009.

⁵⁻¹² The American Heart Association. High Blood Pressure. Available at: <http://www.americanheart.org/presenter.jhtml?identifier=2114>. Accessed July 13, 2009.

⁵⁻¹³ 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 July 13, 2009.

⁵⁻¹⁴ 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 July 13, 2009.

⁵⁻¹⁵ Ibid.

⁵⁻¹⁶ 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 July 13, 2009.

⁵⁻¹⁷ 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. Accessed July 13, 2009.

⁵⁻¹⁸ Michigan Department of Community Health. Facts About Lung Cancer. Available at: <http://www.michigancancer.org/PDFs/MDCHFactSheets/LungCAFactSheet-Feb09.pdf>. Accessed July 13, 2009.

⁵⁻¹⁹ 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 July 13, 2009.

- *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)*
- ◆ **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*
- ◆ **Medical Assistance With Smoking Cessation**
 - *Advising Smokers to Quit*
 - *Smoking Cessation Strategies*

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

Comprehensive Diabetes Care

While diabetes can result in many serious complications such as heart disease and kidney disease, control of diabetes significantly reduces the rate of such complications and improves quality of life for diabetics. The annual cost of diabetes in the United States was an estimated \$174 billion in 2007. Of this total, \$116 billion was due to medical expenditures while \$58 billion was the result of lost productivity and other indirect costs.⁵⁻²⁰ The total cost has increased by \$42 billion since 2002.

In Michigan, 8.5 percent of adults had diabetes during 2005–2007.⁵⁻²¹ In 2006, the age-adjusted diabetes death rates (per 100,000 people) in Michigan were 29.0 for white males, 21.3 for white females, 47.8 for African-American males, and 36.5 for African-American females.⁵⁻²² Also in 2006, 20 percent of all hospital discharges in Michigan mentioned diabetes.⁵⁻²³ For a comprehensive assessment of diabetes care, multiple factors must be evaluated. 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 eight separate rates:

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

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

⁵⁻²⁰ 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 July 13, 2009.

⁵⁻²¹ The Michigan Diabetes Prevention and Control Program. Diabetes in Michigan—2008. Available at: http://www.michigan.gov/documents/mdch/Diabetes_Fact_Page-2008_274978_7.pdf. Accessed July 13, 2009.

⁵⁻²² Ibid.

⁵⁻²³ Ibid.

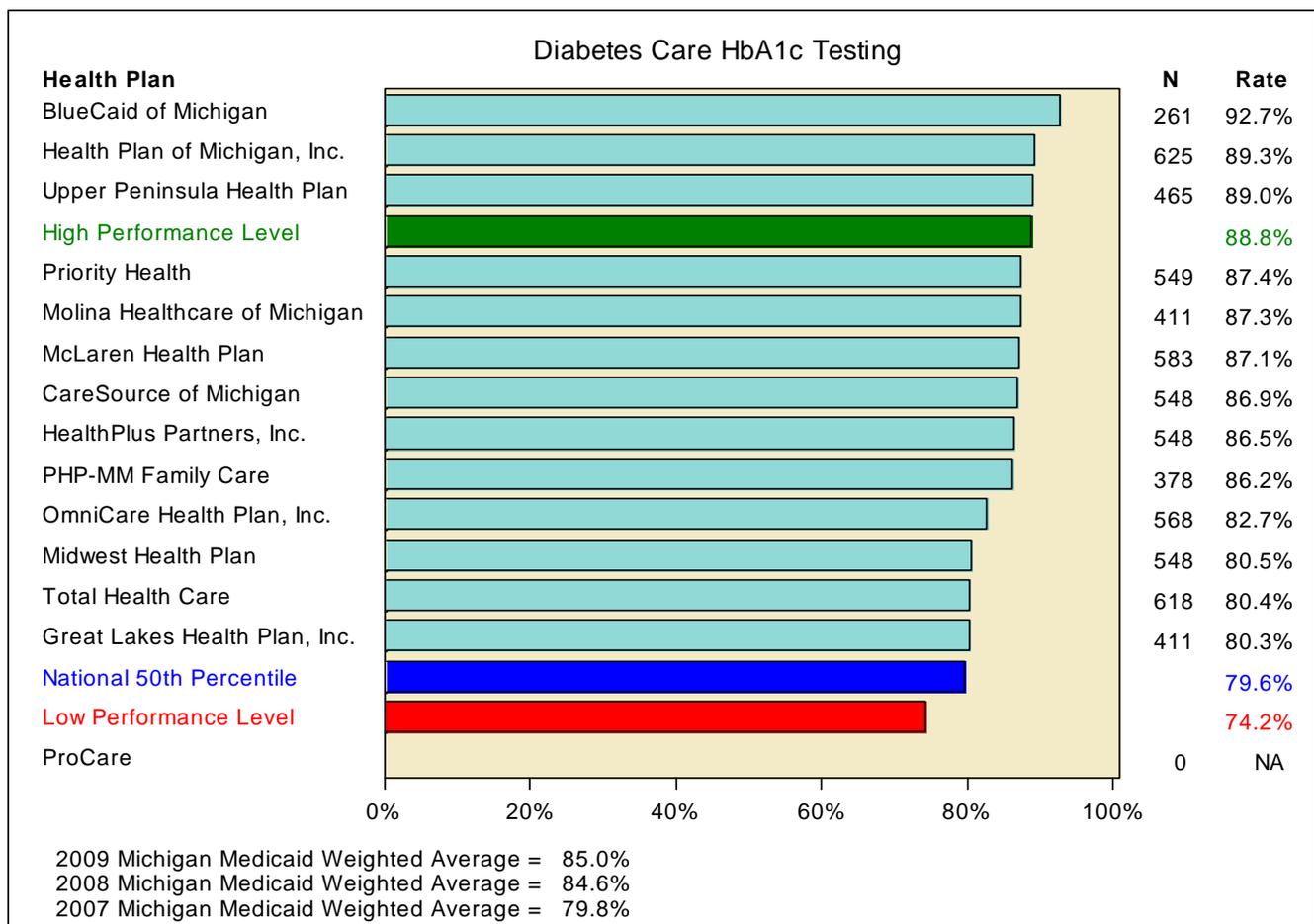
near-normal HbA1c levels can help diabetics gain an extra five years of life, eight years of eyesight, and six years of freedom from kidney disease, on average.⁵⁻²⁴

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.

Health Plan Ranking: Comprehensive Diabetes Care—HbA1c Testing

**Figure 5-1—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Comprehensive Diabetes Care—HbA1c Testing**



Three MHPs scored above the HPL of 88.8 percent, and none of the plans had a rate below the LPL of 74.2 percent. A total of 13 health plans, including the 3 above the HPL, had reported rates above

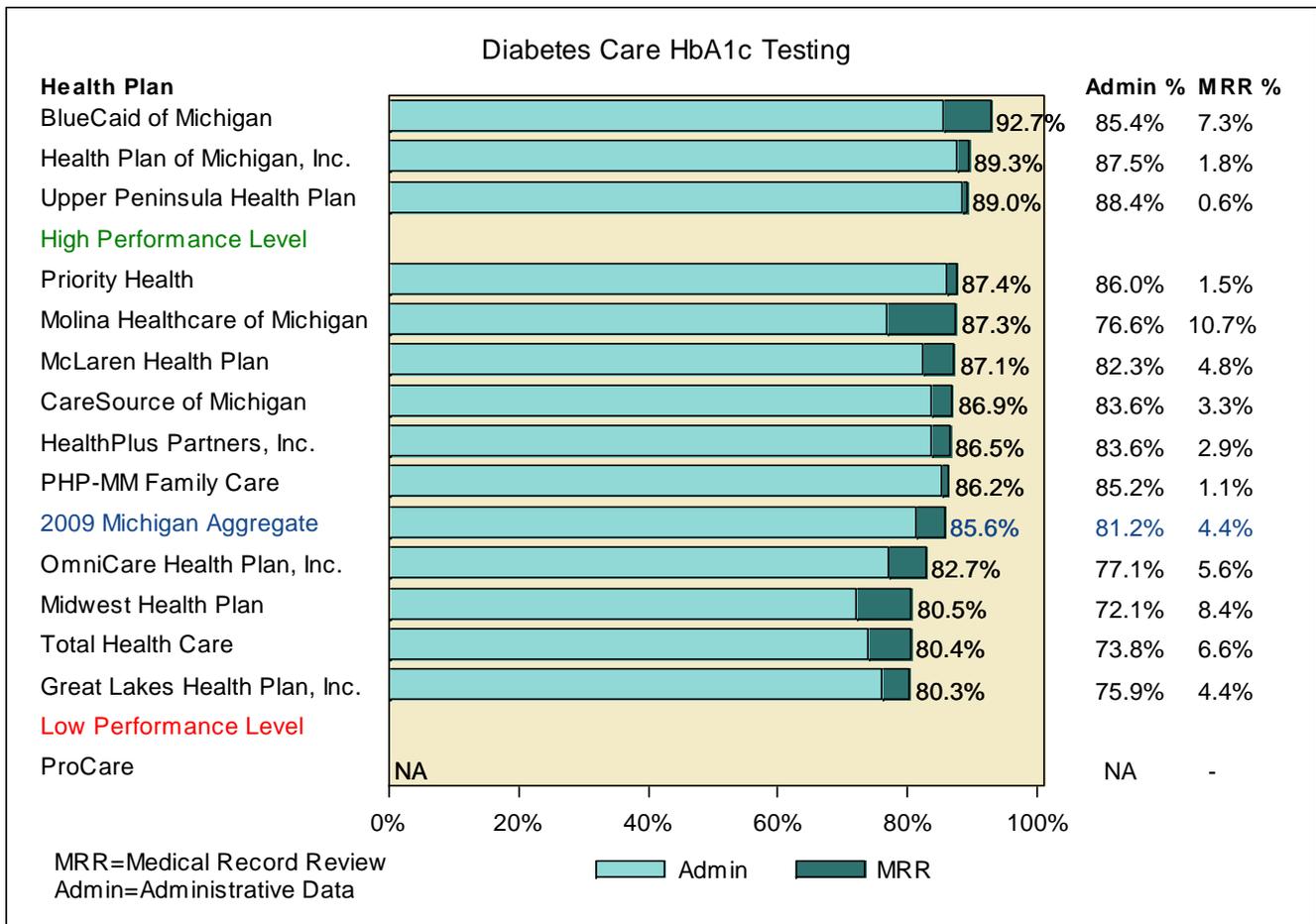
⁵⁻²⁴ National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed July 13, 2009.

the national HEDIS 2008 Medicaid 50th percentile, and 6 of those MHPs were between the 75th and 90th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 85.0 percent was 5.4 percentage points above the national HEDIS 2008 50th percentile of 79.6 percent and increased 0.4 percentage points over the 2008 rate.

Data Collection Analysis: Comprehensive Diabetes Care—HbA1c Testing

Figure 5-2—Michigan Medicaid HEDIS 2009 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 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 except one used the hybrid method to calculate the rate for this measure. The 2009 Michigan aggregate administrative rate was 81.2 percent and the aggregate medical record review rate was 4.4 percent.

In 2009, 94.9 percent of the total aggregate rate (85.6 percent) was derived from administrative data and 5.1 percent was from medical record review. All of the health plans derived more than 85 percent of their rates from administrative data. One health plan increased its overall rate by more than 10 percentage points from medical record review. Administrative data completeness did not appear to be an issue for many of the health plans, indicating that the MHPs are receiving complete claims and encounter data from their providers.

Comprehensive Diabetes Care—Poor HbA1c Control

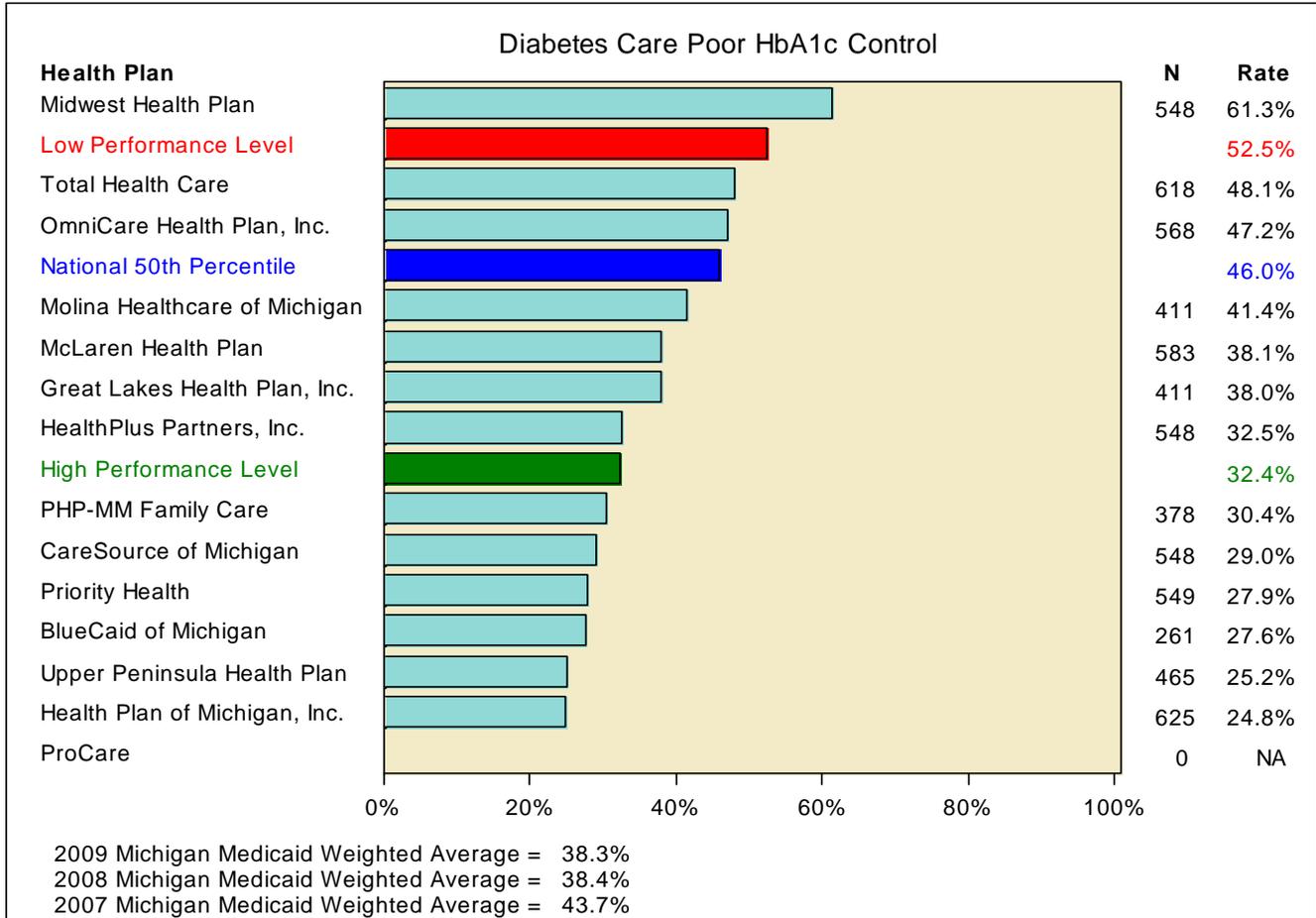
HbA1c control improves quality of life, increases work productivity, and decreases health care utilization. Decreasing the HbA1c level lowers the risk of diabetes-related death. Controlling blood glucose levels in people with diabetes significantly reduces the risk for blindness, end-stage renal disease, 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 2009
Health Plan Ranking: Comprehensive Diabetes Care—Poor HbA1c Control**



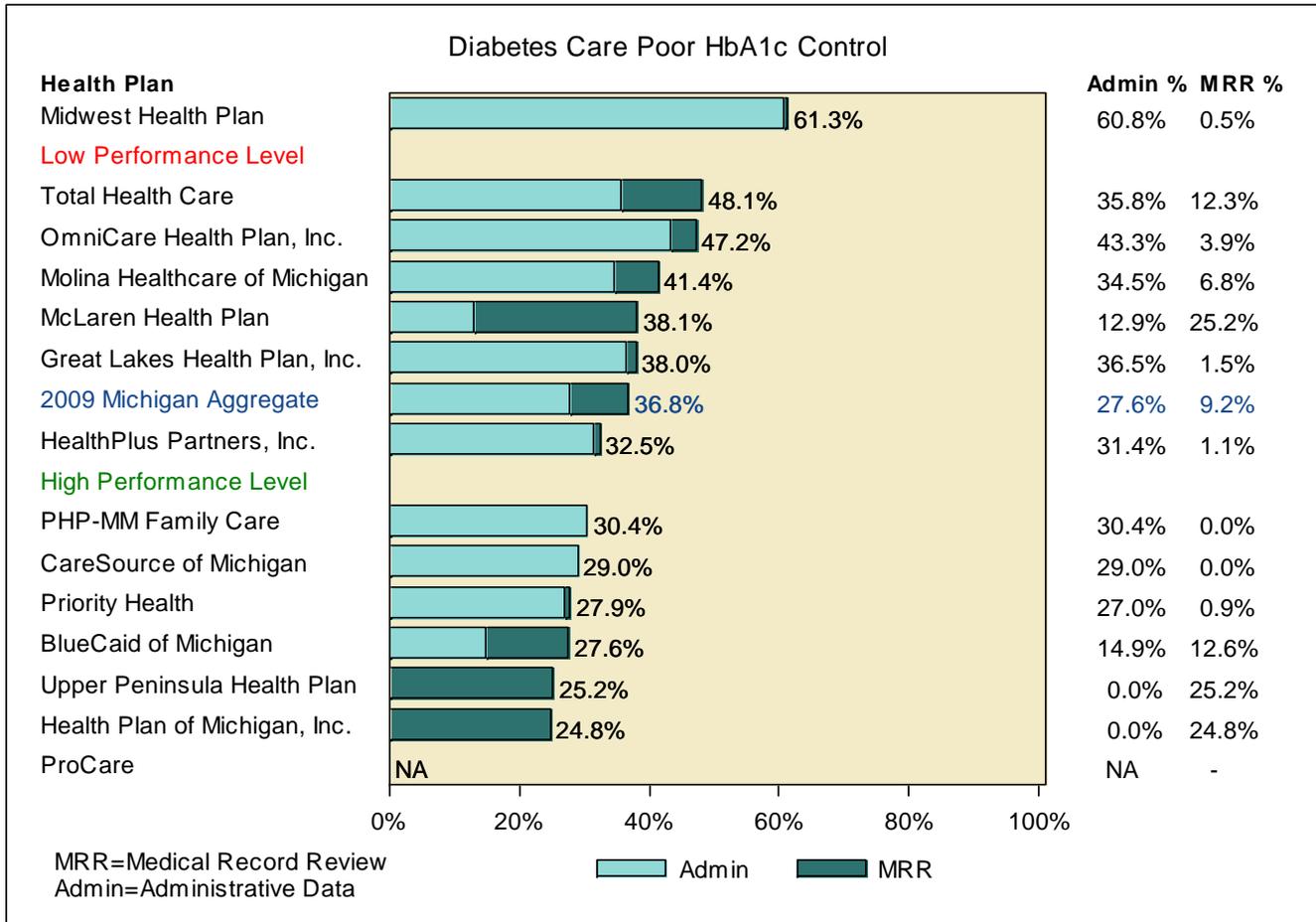
For this key measure, a *lower* rate indicates *better* performance, since low rates of *Poor HbA1c Control* indicate better care.

Six MHPs reported rates that performed better than the HPL of 32.4 percent, and one plan’s rate scored worse than the LPL of 52.5 percent. A total of 10 health plans performed better than the national HEDIS 2008 Medicaid 50th percentile, indicating better performance. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

The 2009 Michigan Medicaid weighted average of 38.3 percent was 7.7 percentage points below the national HEDIS 2008 Medicaid 50th percentile of 46.0 percent. This suggests that the MHPs performed better than health plans nationally for this measure.

Data Collection Analysis: Comprehensive Diabetes Care—Poor HbA1c Control

**Figure 5-4—Michigan Medicaid HEDIS 2009
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 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 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 except one used the hybrid method to calculate this measure. The 2009 Michigan aggregate administrative rate was 27.6 percent and the aggregate medical record review rate was 9.2 percent.

In 2009, 75.0 percent of the total aggregate rate (36.8 percent) was derived from administrative data and 25.0 percent was from medical record review. In 2008, 64.0 percent of the aggregate rate was derived from administrative data and 36.2 percent was from medical record review. The increase in

administrative data contributing to the rate indicated that the MHPs were not relying as much as they were on medical record review to report this measure.

Two health plans (HPM and UPP) derived all of their rates from medical record review data while 10 health plans derived at least half of their rates from administrative data. Six health plans derived more than 95 percent of their rates from administrative data. It appeared that while the *HbA1c Testing* measure captured the actual test data from submitted claims and encounters, the results of those tests were not captured administratively for some health plans.

Comprehensive Diabetes Care—Eye Exam

Diabetic retinopathy (abnormalities of the small blood vessels of the retina caused by diabetes) causes 12,000 to 24,000 new cases of blindness each year and is the leading cause of new cases of blindness in adults 20 to 74 years of age.⁵⁻²⁵ Up to 21 percent of Type 2 diabetics have retinopathy when they are first diagnosed with diabetes, and most will eventually develop some degree of retinopathy.⁵⁻²⁶ 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.⁵⁻²⁷

In 2007, 20.1 percent of Michigan adults with diabetes had been told by a doctor that they had retinopathy or that diabetes had affected their eyes.⁵⁻²⁸

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.

⁵⁻²⁵ American Diabetes Association. Diabetes and Retinopathy (Eye Complications). Available at: <http://www.diabetes.org/diabetes-statistics/eye-complications.jsp>. Accessed July 13, 2009.

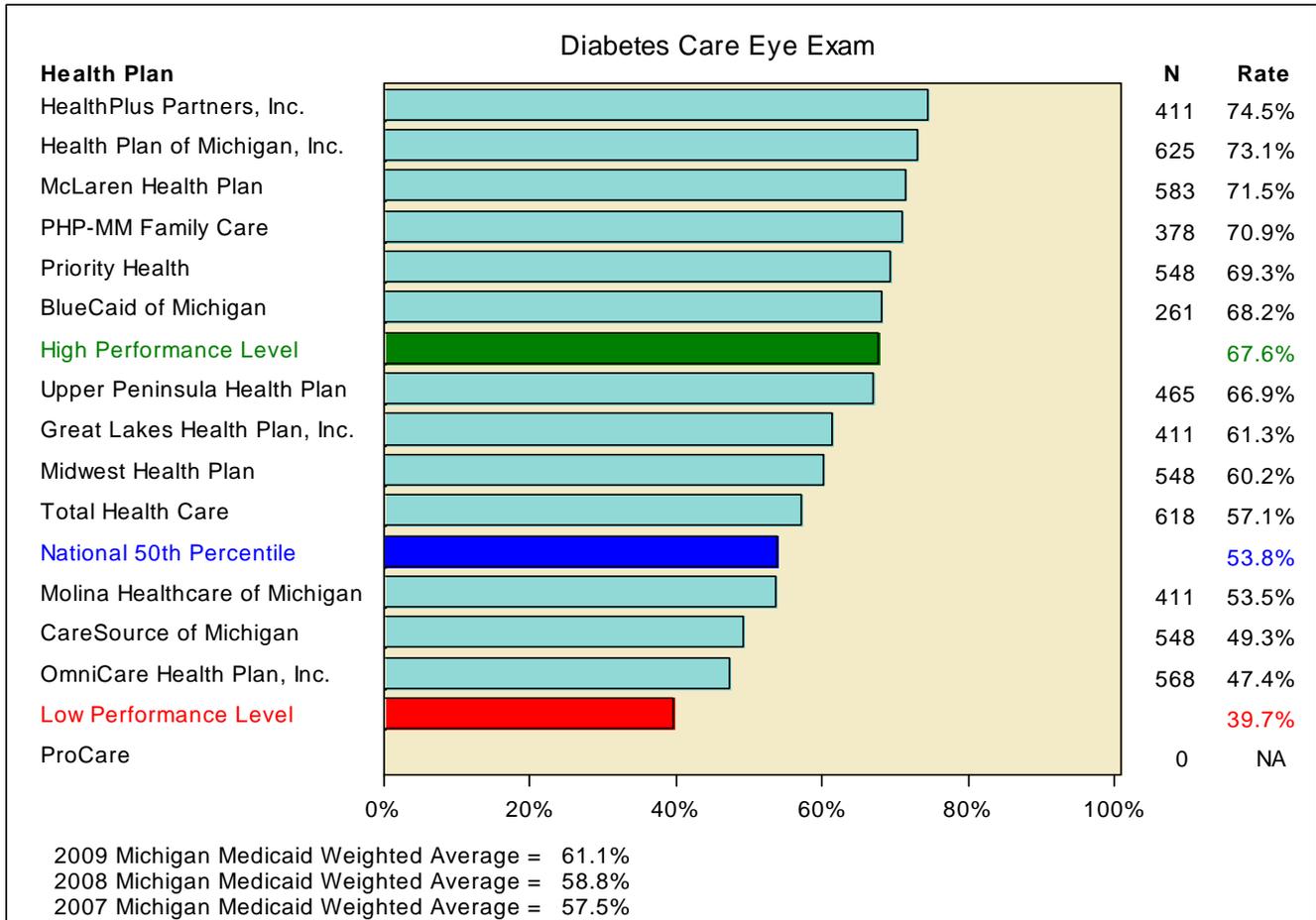
⁵⁻²⁶ Ibid.

⁵⁻²⁷ National Institutes of Health. Fact Sheet: Diabetic Retinopathy. Available at: <http://www.nih.gov/about/researchresultsforthepublic/DiabeticRetinopathy.pdf>. Accessed July 13, 2009.

⁵⁻²⁸ The Michigan Diabetes Prevention and Control Program. Diabetes in Michigan—2008. Available at: http://www.michigan.gov/documents/mdch/Diabetes_Fact_Page-2008_274978_7.pdf. Accessed July 13, 2009.

Health Plan Ranking: Comprehensive Diabetes Care—Eye Exam

**Figure 5-5—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Comprehensive Diabetes Care—Eye Exam**

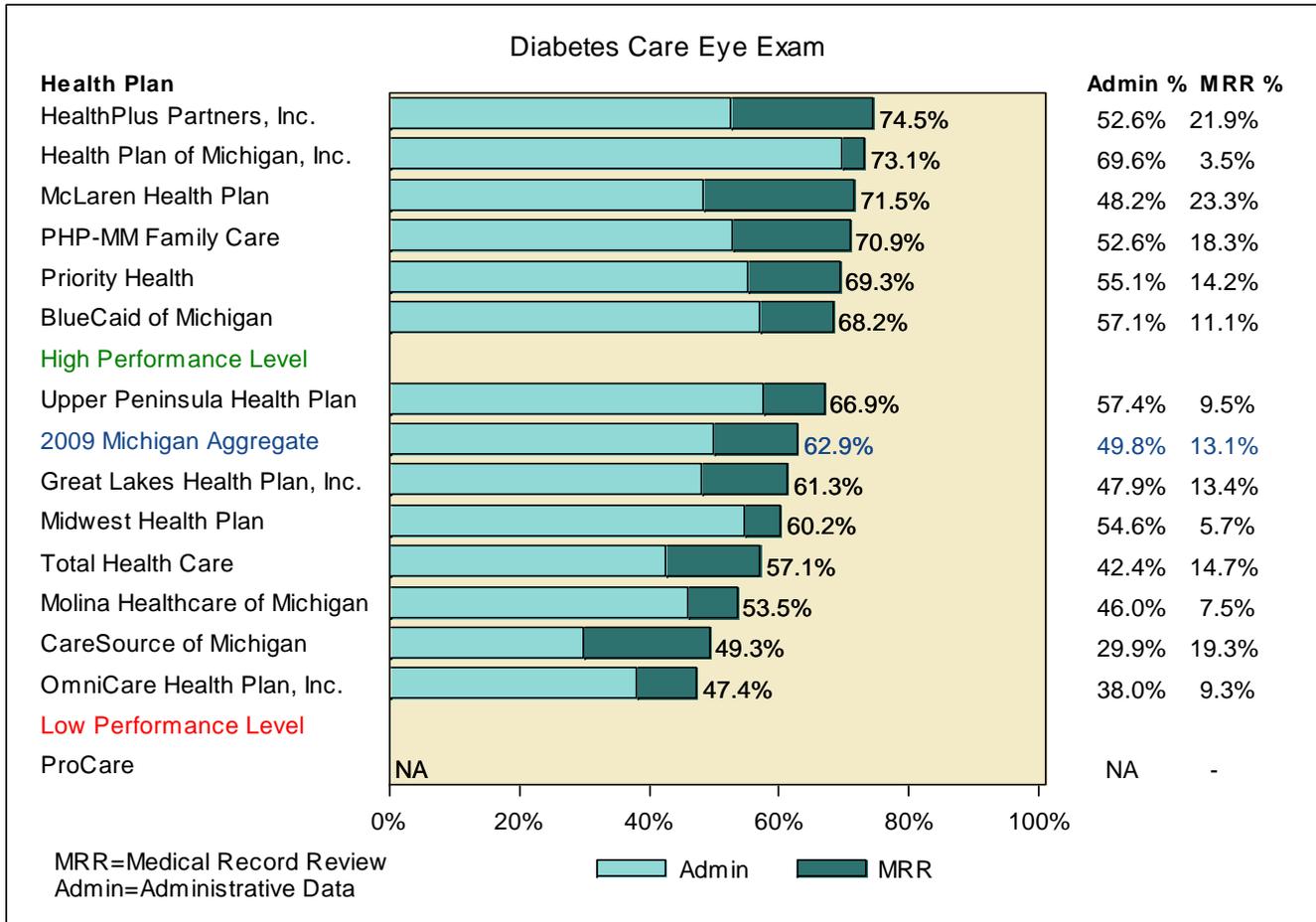


Six MHPs ranked above the HPL of 67.6 percent, and none of the health plans reported a rate below the LPL of 39.7 percent. Ten health plans, including the six above the HPL, had rates that exceeded the national HEDIS 2008 Medicaid 50th percentile, and one MHP ranked between the 75th and 90th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

The 2009 Michigan Medicaid weighted average of 61.1 percent was 7.3 percentage points above the national HEDIS 2008 Medicaid 50th percentile of 53.8 percent and improved by 2.3 percentage points over the 2008 weighted average.

Data Collection Analysis: Comprehensive Diabetes Care—Eye Exam

**Figure 5-6—Michigan Medicaid HEDIS 2009
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 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 except one used the hybrid method to calculate their rates for this measure. The 2009 Michigan aggregate administrative rate was 49.8 percent, and the aggregate medical record review rate was 13.1 percent.

In 2009, 79.2 percent of the total aggregate rate (62.9 percent) was derived from administrative data and 20.8 percent was derived from medical record review, consistent with last year’s percentages.

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

Comprehensive Diabetes Care—LDL-C Screening

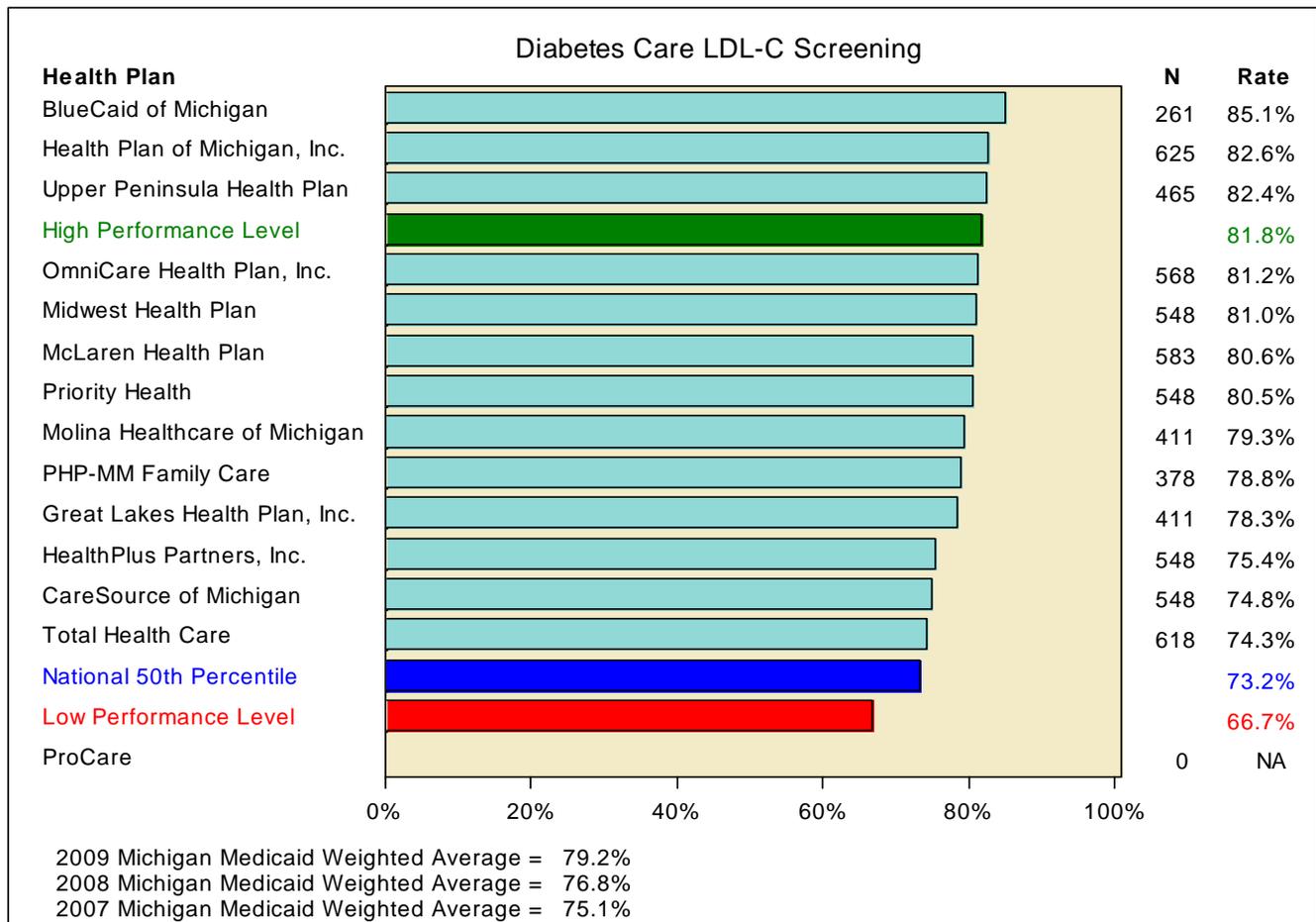
Low-density lipoprotein (LDL) is a type of lipoprotein that carries cholesterol in the blood. LDL is considered to be undesirable because it deposits excess cholesterol in the walls of blood vessels and contributes to atherosclerosis (hardening of the arteries) and heart disease. Therefore, LDL cholesterol 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 year prior to the measurement year, as determined by claims/encounters or automated laboratory data or medical record review.

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

**Figure 5-7—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Comprehensive Diabetes Care—LDL-C Screening**

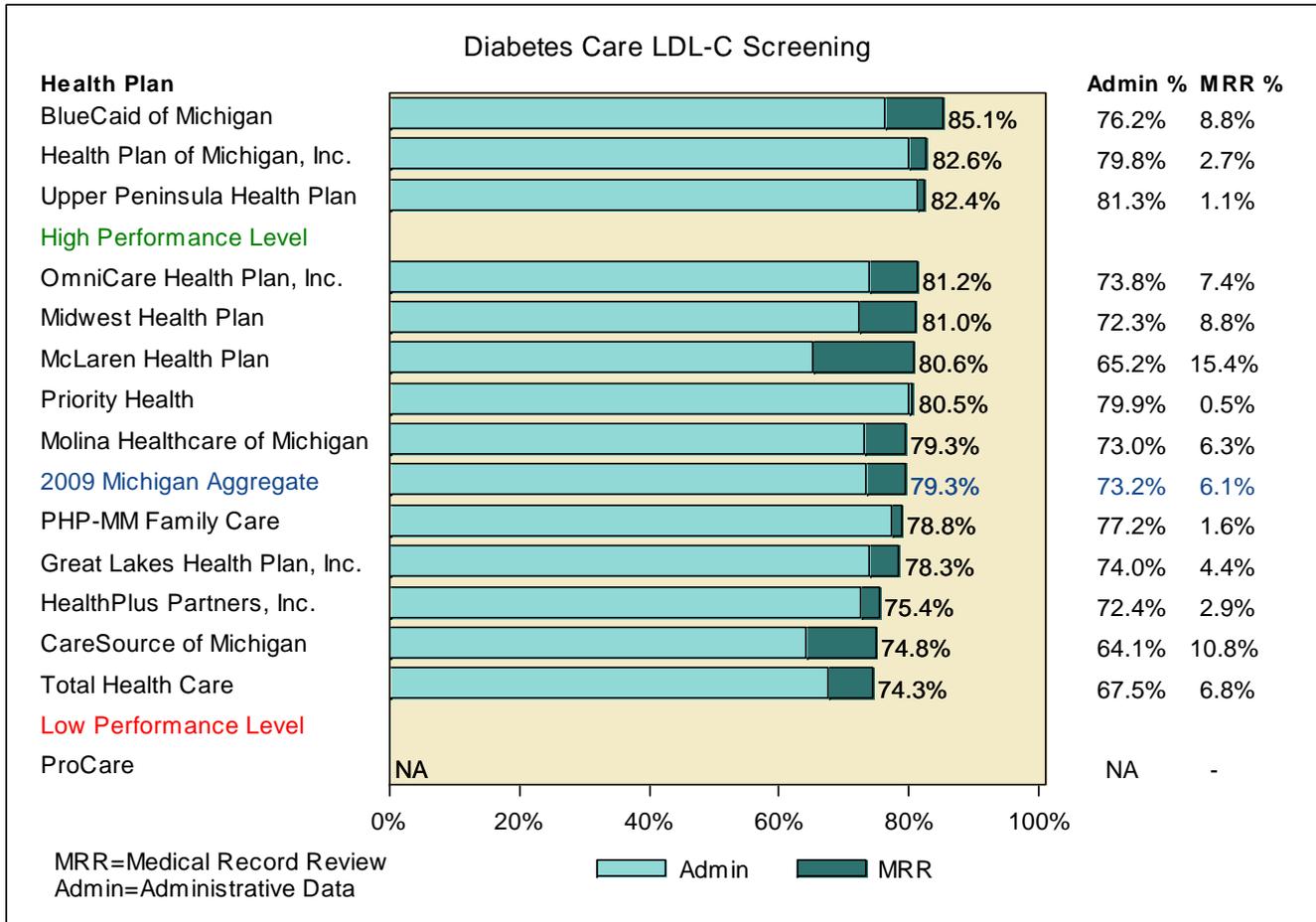


All of the MHPs reported rates above the national 2008 Medicaid 50th percentile of 73.2 percent, and three plans performed above the HPL of 81.8 percent. Six MHPs ranked between the 75th and 90th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 79.2 percent was 6.0 percentage points above the national HEDIS 2008 Medicaid 50th percentile and increased by 2.4 percentage points compared to the 2008 rate.

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

**Figure 5-8—Michigan Medicaid HEDIS 2009
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 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 except one elected to use the hybrid method to report this measure. The 2009 Michigan aggregate administrative rate was 73.2 percent and the aggregate medical record review rate was 6.1 percent.

In 2009, 92.3 percent of the total aggregate rate (79.3 percent) was derived from administrative data and 7.7 percent from medical record review.

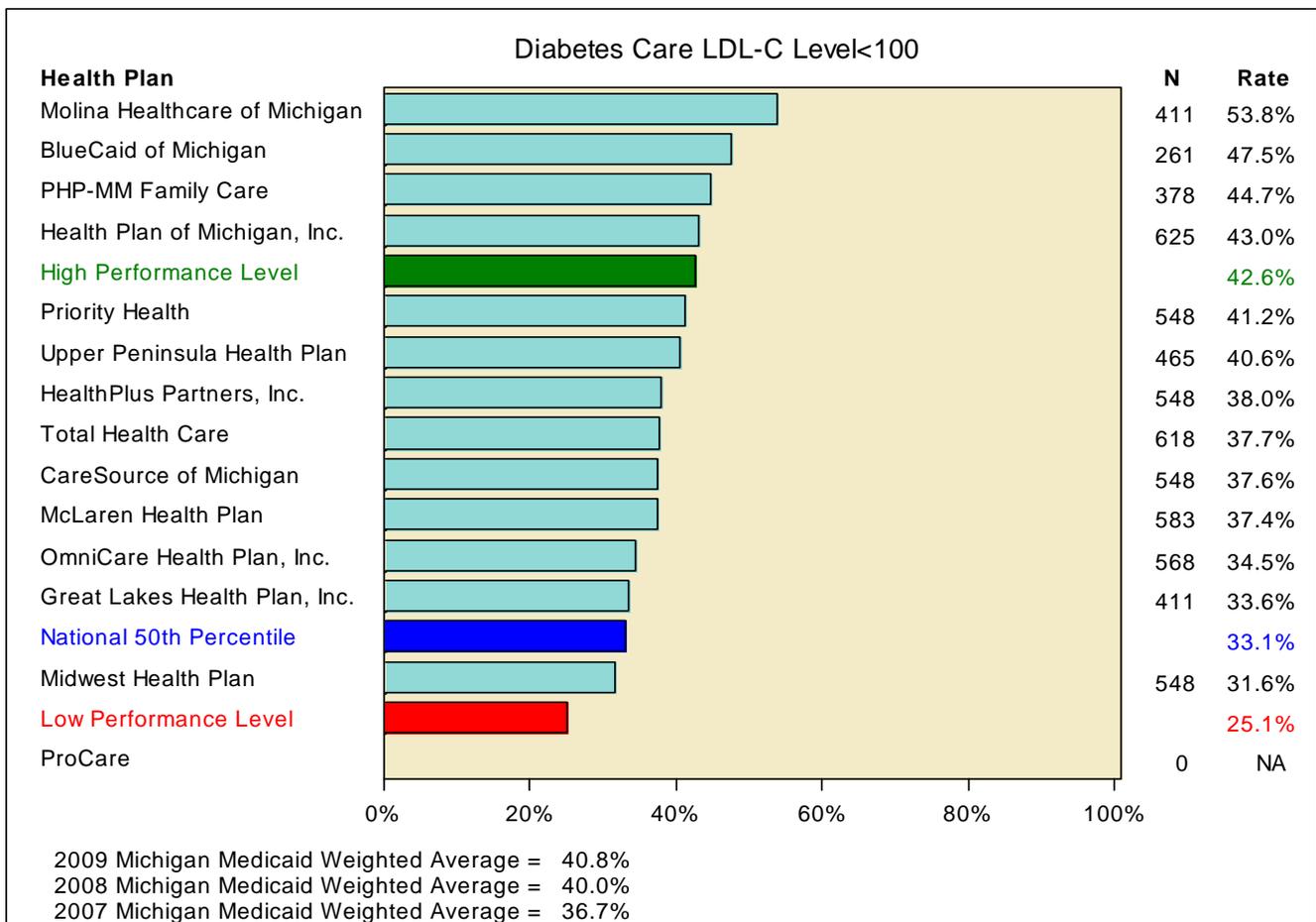
All 13 health plans using hybrid method derived more than 80 percent of their rates from administrative data.

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 5-9—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Comprehensive Diabetes Care—LDL-C Level <100**

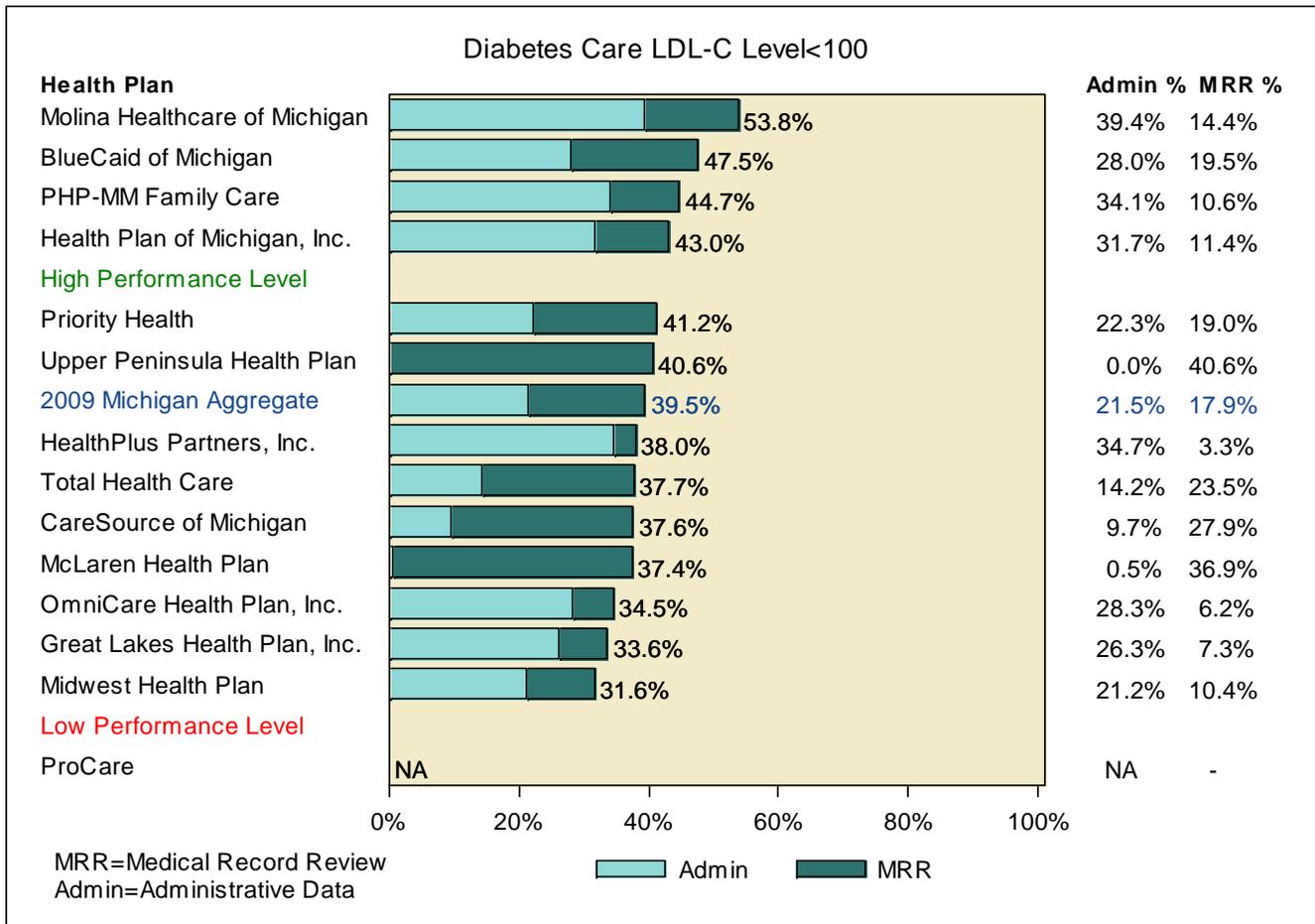


Four health plans reported a rate above the HPL of 42.6 percent, and none of the MHPs reported a rate below the LPL of 25.1 percent. Twelve health plans, including the four above the HPL, had rates that exceeded the national HEDIS 2008 Medicaid 50th percentile, and three MHPs ranked between the 75th and 90th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

The 2009 Michigan Medicaid weighted average of 40.8 percent was 7.7 percentage points above the national HEDIS 2008 Medicaid 50th percentile of 33.1 percent and showed an increase from the 2008 weighted average of 0.8 percentage points.

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

**Figure 5-10—Michigan Medicaid HEDIS 2009
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 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 except one used the hybrid method to report this measure. The 2009 Michigan Medicaid aggregate administrative rate was 21.5 percent and the aggregate medical record review rate was 17.9 percent.

Overall, 54.4 percent of the total aggregate rate (39.5 percent) was derived from administrative data and 45.3 percent was derived from medical record review. In 2008, 46.3 percent of the aggregate rate was derived from administrative data and 53.4 percent was derived from medical record

review. While the administrative rate is increasing, the rates for this measure still rely more on medical record review to get the actual LDL level compared to the *LDL-C Screening* measure.

Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy

Diabetes is the leading cause of end-stage renal disease (ESRD), a condition that can be treated only by dialysis or a kidney transplant. In the United States, almost 180,000 people live with kidney failure as a result of diabetes. In 2005, health care for patients with kidney failure cost the United States about \$32 billion.⁵⁻²⁹ 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. In 2006, 42 percent of the nearly 4,000 Michigan residents who had been newly diagnosed with ESRD had a primary diagnosis of diabetes.⁵⁻³⁰

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

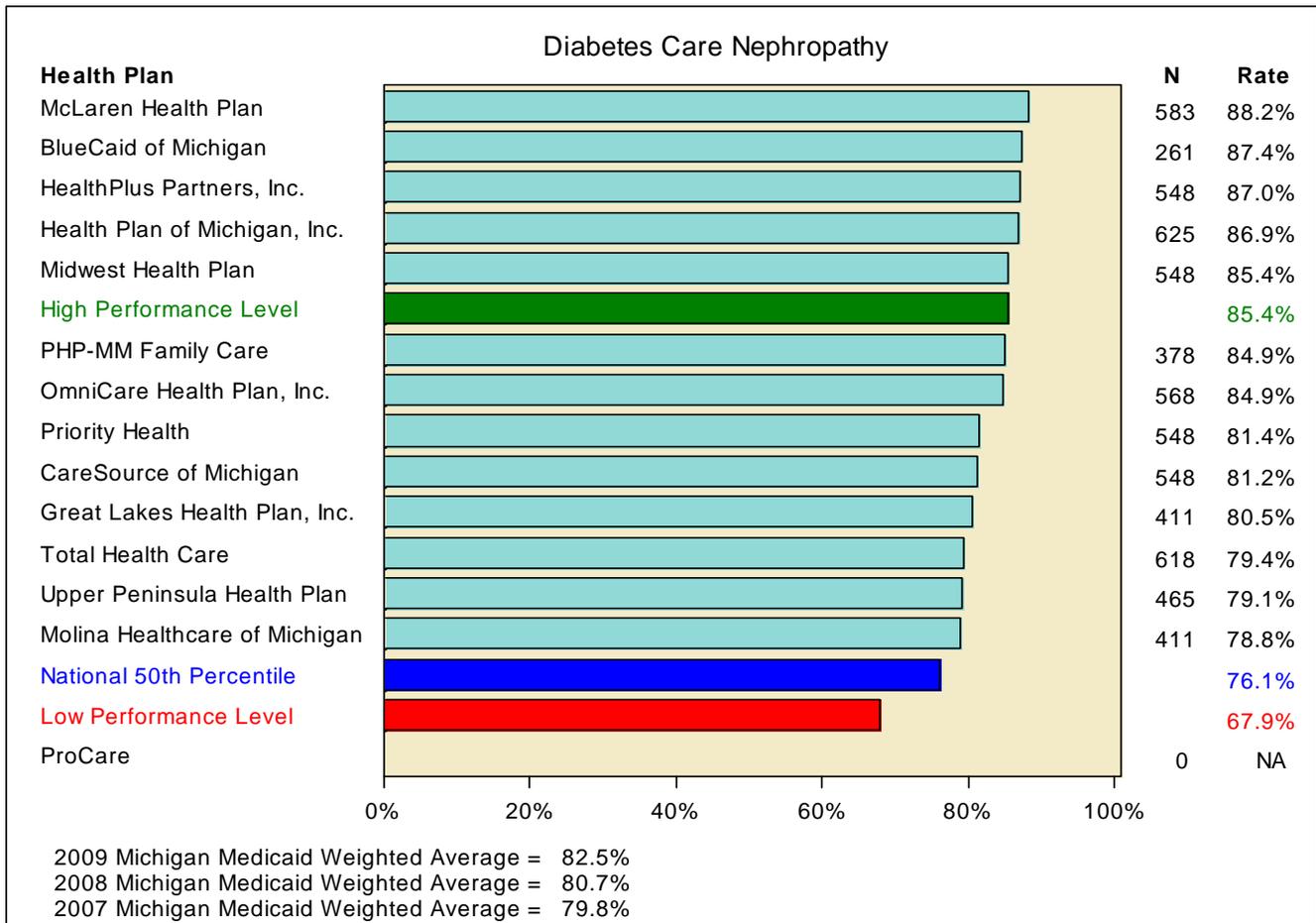
The *Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy* rate is intended to assess whether diabetic patients are being monitored for nephropathy. It reports the percentage of members with diabetes (Type 1 and Type 2) 18 through 75 years of age who were continuously enrolled during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

⁵⁻²⁹ National Kidney and Urologic Diseases Information Clearinghouse. Kidney Disease of Diabetes. Available at: <http://kidney.niddk.nih.gov/kudiseases/pubs/kdd/index.htm>. Accessed July 13, 2009.

⁵⁻³⁰ The Michigan Diabetes Prevention and Control Program. Diabetes in Michigan—2008. Available at: http://www.michigan.gov/documents/mdch/Diabetes_Fact_Page-2008_274978_7.pdf. Accessed July 13, 2009.

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

**Figure 5-11—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Comprehensive Diabetes Care—Medical Attention for Diabetic Nephropathy**

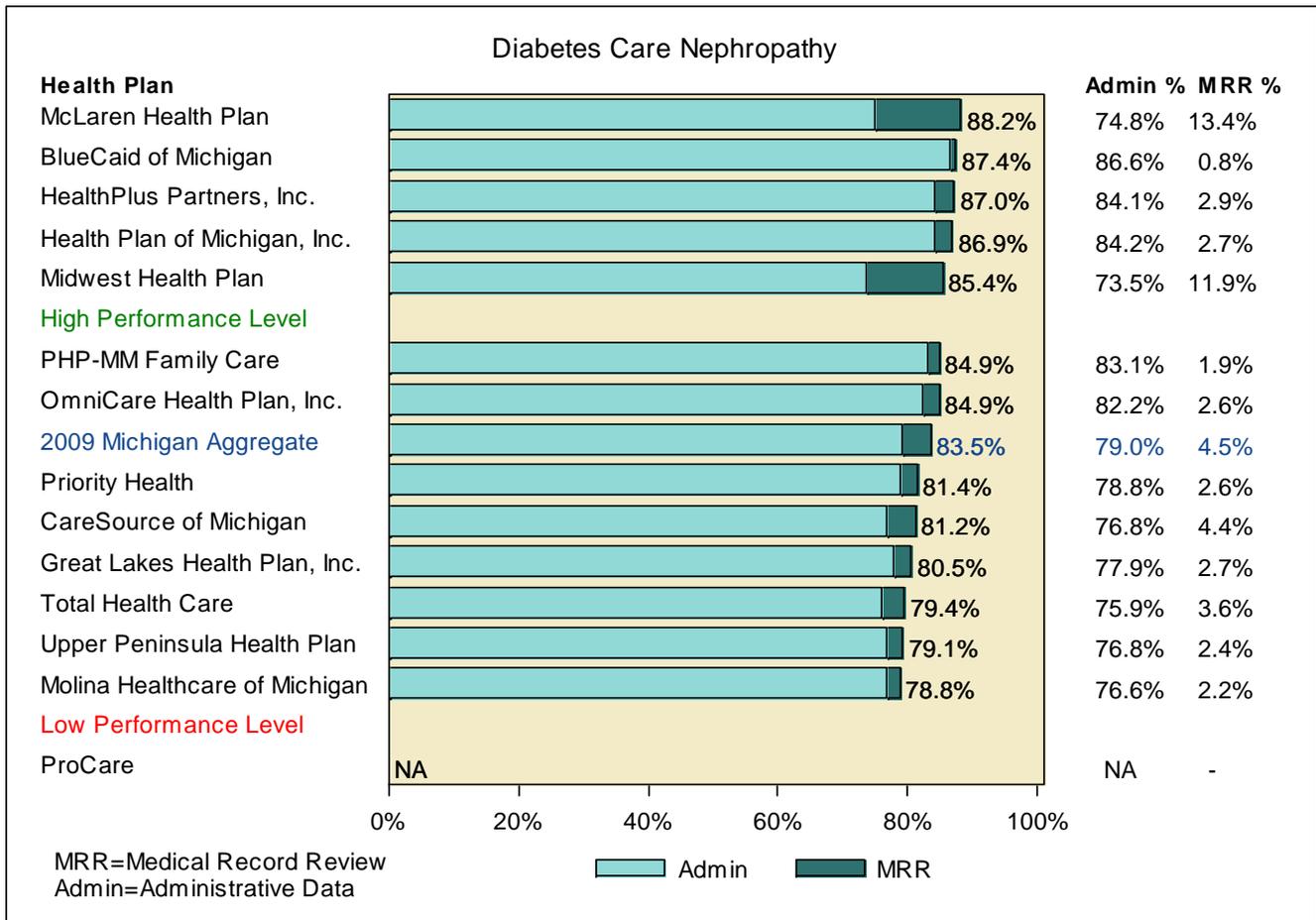


All 13 MHPs that reported a rate for this measure exceeded the national HEDIS 2008 Medicaid 50th percentile. Five plans ranked above the HPL of 85.4 percent and five MHPs ranked at or above the 75th percentile and below the 90th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

The 2009 Michigan Medicaid weighted average of 82.5 percent was 6.4 percentage points above the national HEDIS 2008 Medicaid 50th percentile of 76.1 percent and showed an increase from the 2008 weighted average of 1.8 percentage points.

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

Figure 5-12—Michigan Medicaid HEDIS 2009 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 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 except one elected to use the hybrid method for reporting this measure. The 2009 Michigan aggregate administrative rate was 79.0 percent and the aggregate medical record review rate was 4.5 percent.

Overall, 94.6 percent of the total aggregate rate (83.5 percent) was derived from administrative data and 5.4 percent was from medical record review.

All health plans using the hybrid method derived more than 80 percent of their rates from administrative data, indicating that administrative data for this measure were fairly complete.

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. The American Diabetes Association and the National Institutes of Health recommend that people with diabetes maintain a blood pressure of less than 130/80 mm Hg.⁵⁻³¹ From 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.⁵⁻³² 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 in diabetic complications of 12 percent.⁵⁻³³ According to the CDC, 67.1 percent of Michigan adults with diabetes also had hypertension in 2007.⁵⁻³⁴

Comprehensive Diabetes Care—Blood Pressure Control is 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 the blood pressure of diabetic patients is being monitored. It reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who were continuously enrolled during the measurement year and who had a blood pressure reading of <130/80 mm Hg. This measure can be reported either using the administrative or hybrid methodology.

⁵⁻³¹ American Diabetes Association. Treating High Blood Pressure in People With Diabetes. Available at: <http://www.diabetes.org/type-1-diabetes/well-being/treating-high-bp.jsp>. Accessed July 14, 2009.

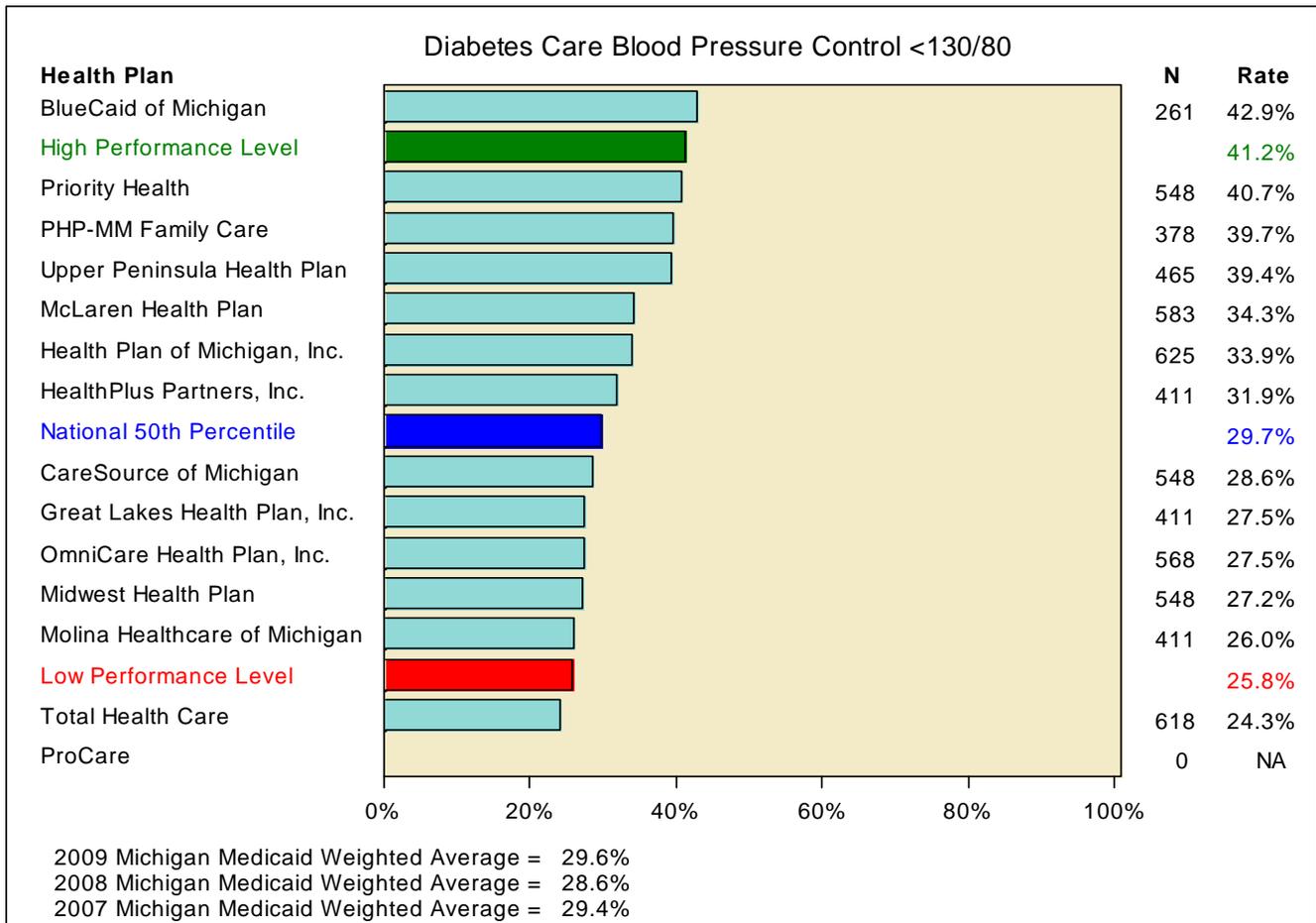
⁵⁻³² National Institute of Diabetes and Digestive and Kidney Diseases. National Diabetes Statistics, 2007 fact sheet. Available at: <http://diabetes.niddk.nih.gov/DM/PUBS/statistics/>. Accessed July 14, 2009.

⁵⁻³³ 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 July 14, 2009.

⁵⁻³⁴ Centers for Disease Control and Prevention. National Diabetes surveillance system Available at: <http://apps.nccd.cdc.gov/ddtstrs/Index.aspx?stateId=26&state=Michigan&cat=riskfactors&Data=data&view=TO&id=23&trend=hypertension>. Accessed July 14, 2009.

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

**Figure 5-13—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)**

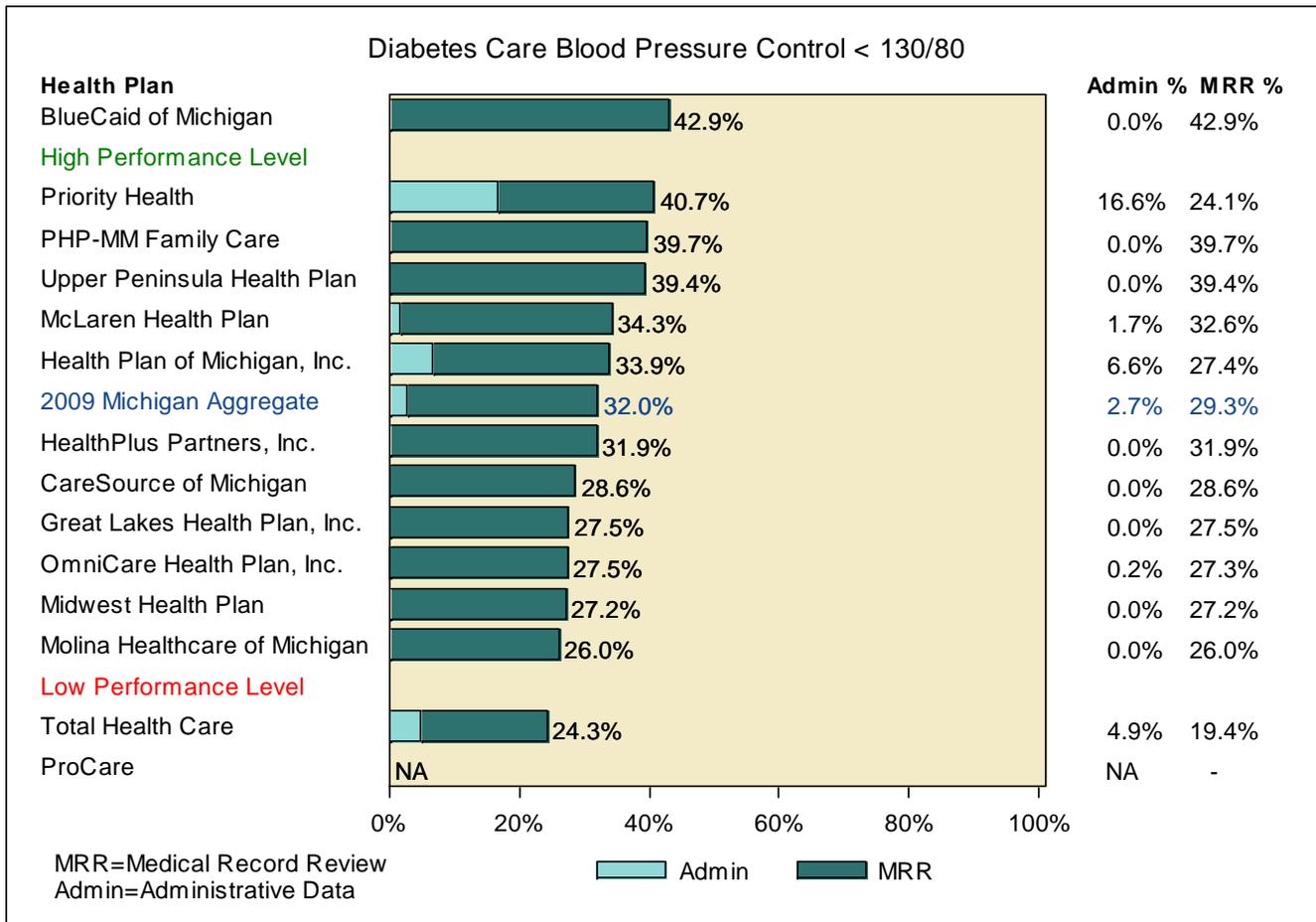


One health plan reported a rate above the HPL of 41.2 percent, and one health plan reported a rate below the LPL of 25.8 percent. Seven health plans, including the one above the HPL, had rates that exceeded the national HEDIS 2008 Medicaid 50th percentile, and three MHPs ranked between the 75th and 90th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

The 2009 Michigan Medicaid weighted average of 29.6 percent was 1.0 percentage point above the 2008 weighted average. However, the 2009 Michigan weighted average was 0.1 percentage point below the national HEDIS 2008 Medicaid 50th percentile of 29.7 percent.

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

**Figure 5-14—Michigan Medicaid HEDIS 2009
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 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 except one elected to use the hybrid method for reporting this measure. The 2009 Michigan aggregate administrative rate was 2.7 percent and the aggregate medical record review rate was 29.3 percent.

Overall, 8.4 percent of the total aggregate rate (32.0 percent) was derived from administrative data and 91.6 percent was from medical record review.

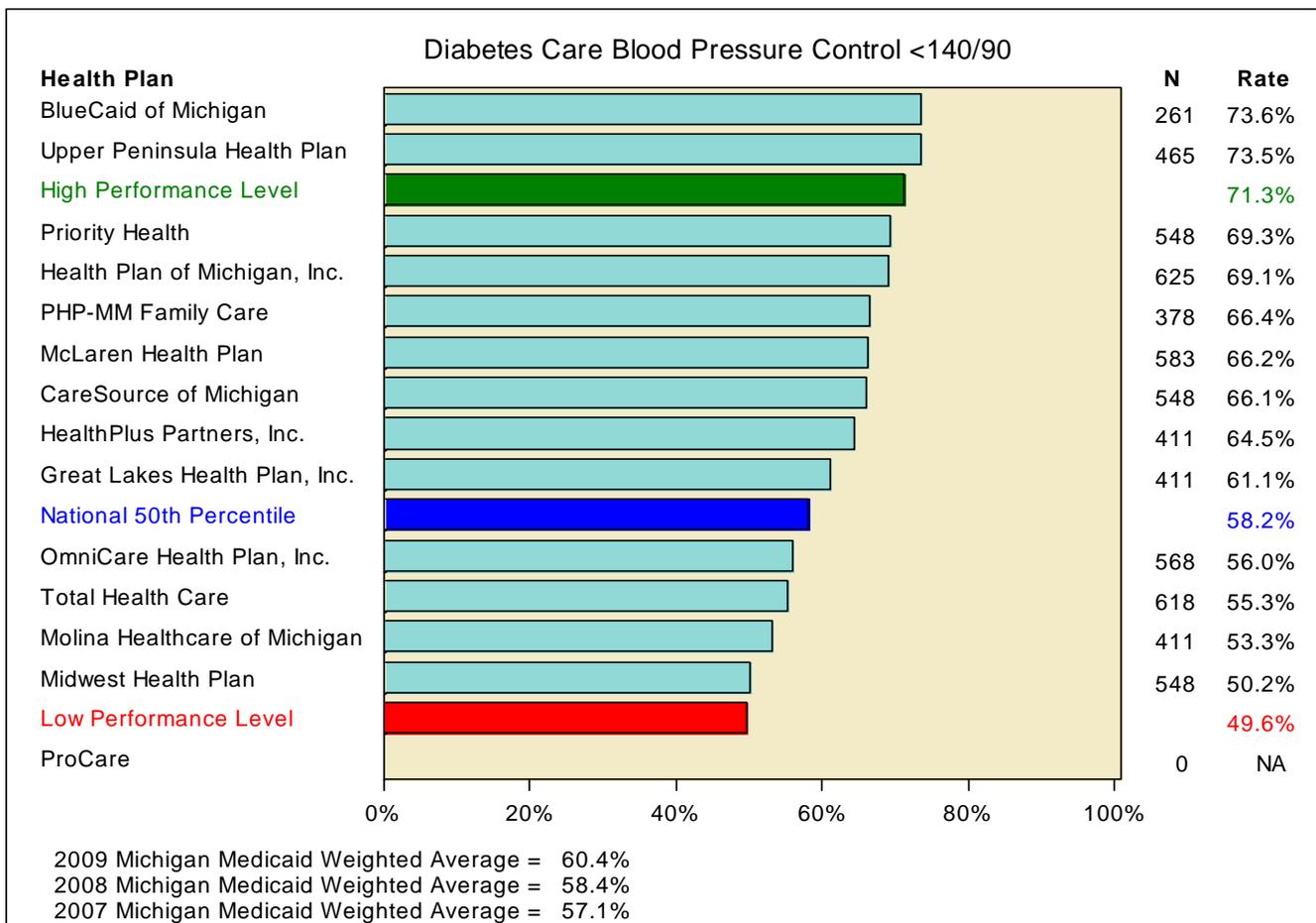
Ten health plans derived more than 95 percent of their rates from medical record review. This measure relied heavily on medical record review.

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 the blood pressure of diabetic patients is being monitored. It reports the percentage of members 18 through 75 years of age with diabetes (Type 1 and Type 2) who were continuously enrolled during the measurement year and who had a blood pressure reading of <140/90 mm Hg. This measure can be reported either using the administrative or hybrid methodology.

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

**Figure 5-15—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)**



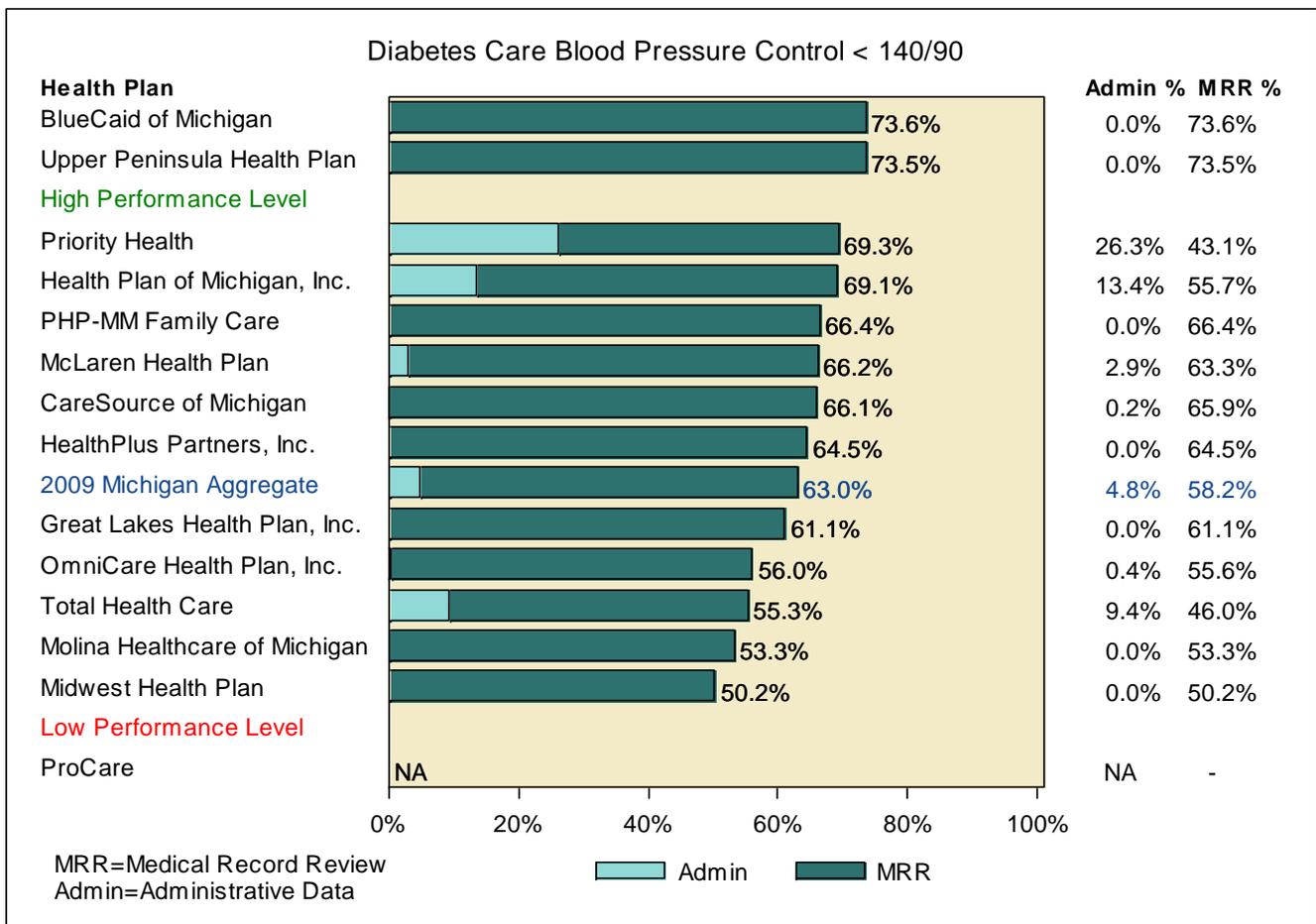
Two MHPs' rates ranked above the HPL of 71.3 percent, and no health plans reported rates below the LPL of 49.6 percent. Nine health plans, including the two above the HPL, had rates that exceeded the national HEDIS 2008 Medicaid 50th percentile, and five MHPs ranked between the 75th and 90th percentile. One health plan was unable to report a rate for this measure due to an

insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 60.4 percent was 2.0 percentage points above the 2008 weighted average and 2.2 percentage points above the national HEDIS 2008 Medicaid 50th percentile of 58.2 percent.

Data Collection Analysis: Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)

Figure 5-16—Michigan Medicaid HEDIS 2009 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 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 except one elected to use the hybrid method for reporting this measure. The 2009 Michigan aggregate administrative rate was 4.8 percent and the aggregate medical record review rate was 58.2 percent.

Overall, 7.6 percent of the total aggregate rate (63.0 percent) was derived from administrative data and 92.4 percent was from medical record review.

This measure relied heavily on medical record review, and 10 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 10.6 million visits to office-based physicians. Additionally, 444,000 hospital discharges occurred with asthma as the first-listed diagnosis.⁵⁻³⁵ Asthma is one of the most common chronic conditions in U.S. children and adults, affecting almost 7 million children and 16 million adults as of 2007.⁵⁻³⁶ The estimated lifetime asthma prevalence rate reported for adults in Michigan during 2005 was 13.9 percent, while the national rate was 12.6 percent.⁵⁻³⁷ 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.⁵⁻³⁸

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

⁵⁻³⁵ Centers for Disease Control and Prevention. FastStats: Asthma. Available at: <http://www.cdc.gov/nchs/FASTATS/asthma.htm>. Accessed July 14, 2009.

⁵⁻³⁶ Ibid.

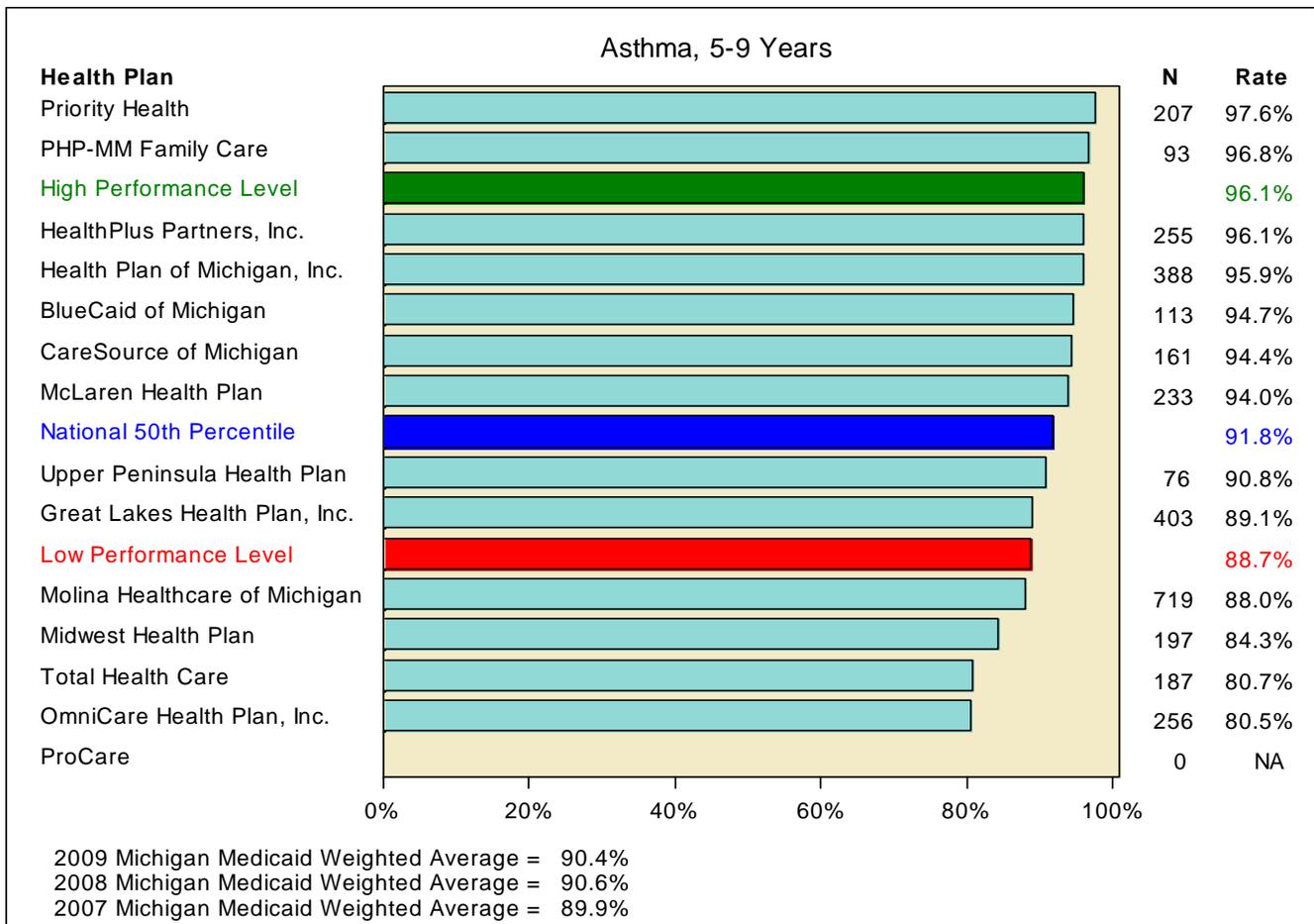
⁵⁻³⁷ American Lung Association Epidemiology & Statistics Unit. Trends in Asthma Morbidity and Mortality. Available at: <http://www.lungusa.org/atf/cf/%7B7A8D42C2-FCCA-4604-8ADE-7F5D5E762256%7D/ASTHMA06FINAL.PDF>. Accessed July 14, 2009.

⁵⁻³⁸ National Committee for Quality Assurance. *HEDIS 2007 Technical Specifications*. Volume 2. Washington, DC: National Committee for Quality Assurance; 2006.

The *Use of Appropriate Medications for People With Asthma* measure calculates the percentage of members 5 through 56 years of age who were 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 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 5-17—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—5 to 9 Years**

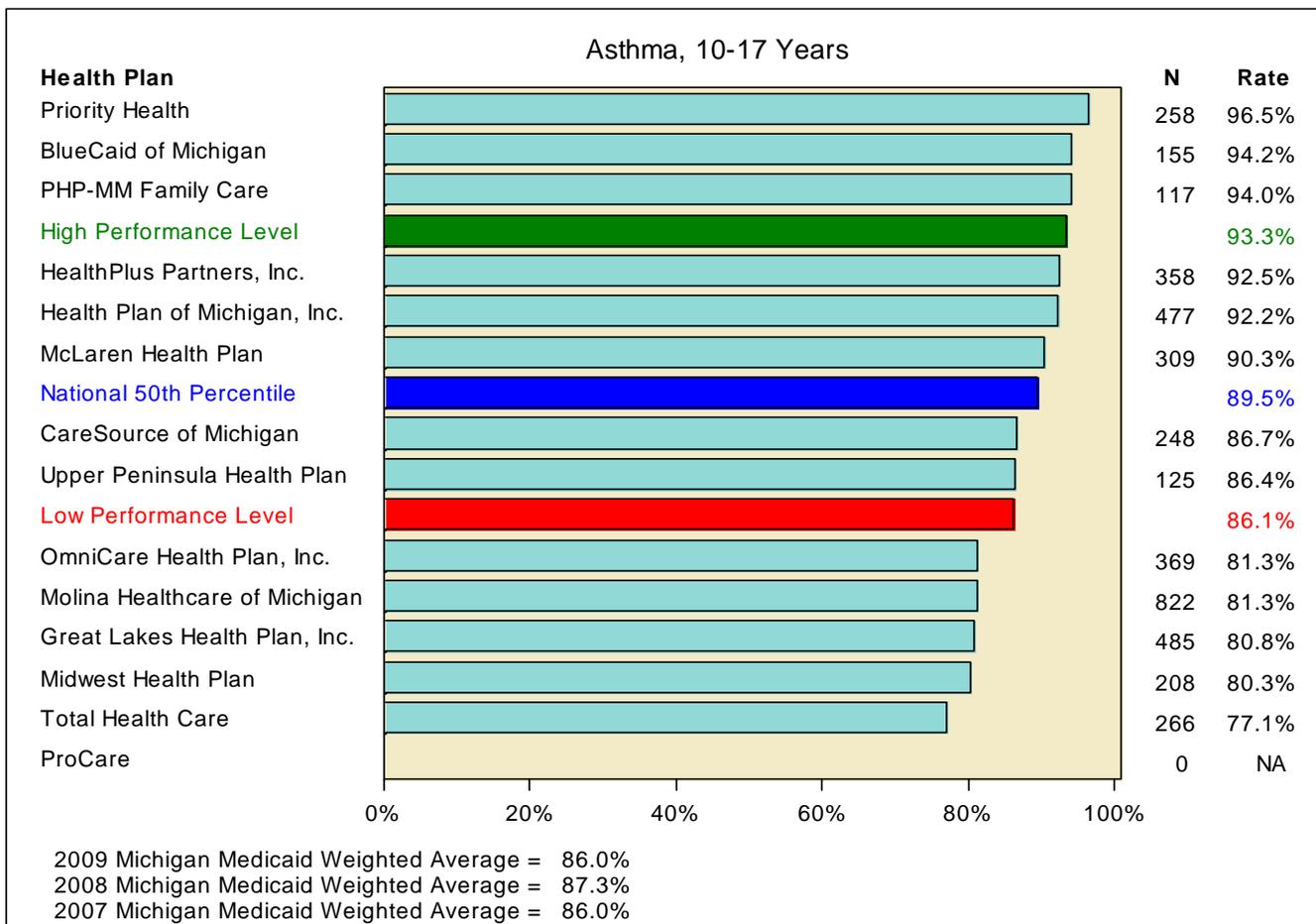


Two health plans reported rates above the HPL of 96.1 percent and four health plans had rates below the LPL of 88.7 percent. Seven health plans, including the two above the HPL, reported rates above the national HEDIS 2008 Medicaid 50th percentile, and three MHPs ranked between the 75th and 90th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 90.4 percent was 1.4 percentage points below the national HEDIS 2008 Medicaid 50th percentile of 91.8 percent and 0.2 percentage point below the 2008 weighted average of 90.6 percent.

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

**Figure 5-18—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—10 to 17 Years**

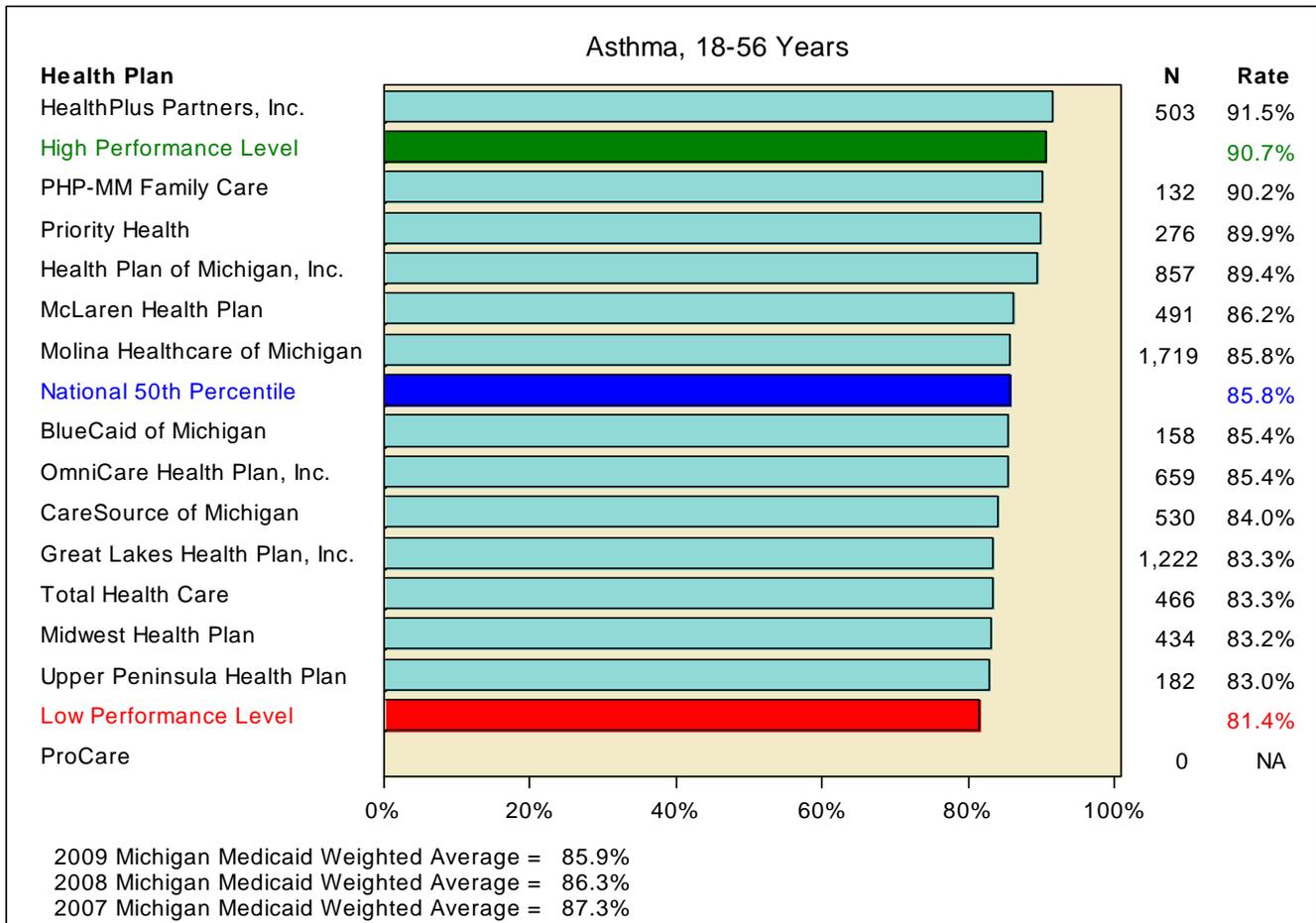


Three health plans reported rates above the HPL of 93.3 percent and five health plans had rates below the LPL of 86.1 percent. Six health plans, including the three above the HPL, reported rates above the national HEDIS 2008 Medicaid 50th percentile, and two MHPs ranked between the 75th and 90th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

The 2009 Michigan Medicaid weighted average of 86.0 percent was 3.5 percentage points below the national HEDIS 2008 Medicaid 50th percentile of 89.5 percent and 1.3 percentage points below the 2008 weighted average of 87.3 percent.

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

**Figure 5-19—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—18 to 56 Years**

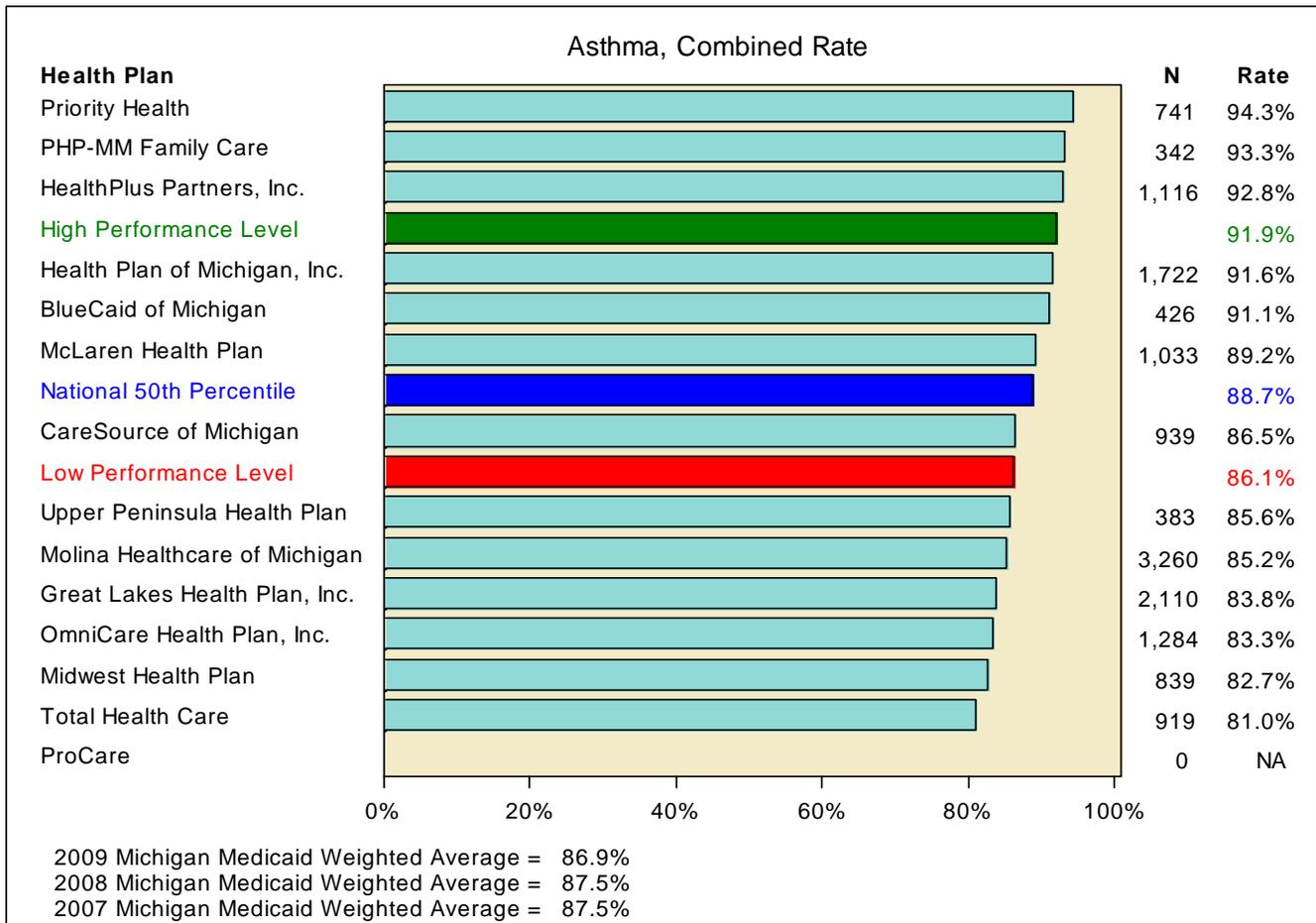


One MHP ranked above the HPL of 90.7 percent, and none of the plans fell below the LPL of 81.4 percent. Six health plans reported rates above the national HEDIS 2008 Medicaid 50th percentile, and three MHPs ranked between the 75th and 90th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

The 2009 Michigan Medicaid weighted average of 85.9 percent was 0.1 percentage point above the national HEDIS 2008 Medicaid 50th percentile of 85.8 percent. The 2009 Michigan Medicaid weighted average decreased by 0.4 percentage points below the 2008 weighted average of 86.3 percent.

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

**Figure 5-20—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Use of Appropriate Medications for People With Asthma—Combined Rate**



Three health plans reported rates above the HPL of 91.9 percent and six health plans scored below the LPL of 86.1 percent. Six health plans, including the three above the HPL, reported rates above the national HEDIS 2008 Medicaid 50th percentile and two MHPs ranked between the 75th and 90th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

The 2009 Michigan Medicaid weighted average of 86.9 percent was 1.8 percentage points below the national HEDIS 2008 Medicaid 50th percentile of 88.7 percent.

Controlling High Blood Pressure

About one of every three U.S. residents has high blood pressure, which is also referred to as hypertension.⁵⁻³⁹ Hypertension is a major risk factor for cardiovascular disease. Antihypertensive therapy can reduce the incidence of strokes by 35 to 40 percent, heart attacks by 20 to 25 percent, and heart failure by 50 percent.⁵⁻⁴⁰ In 2007, 29 percent of Michigan adults reported whether they had ever 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 2007.⁵⁻⁴¹

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.

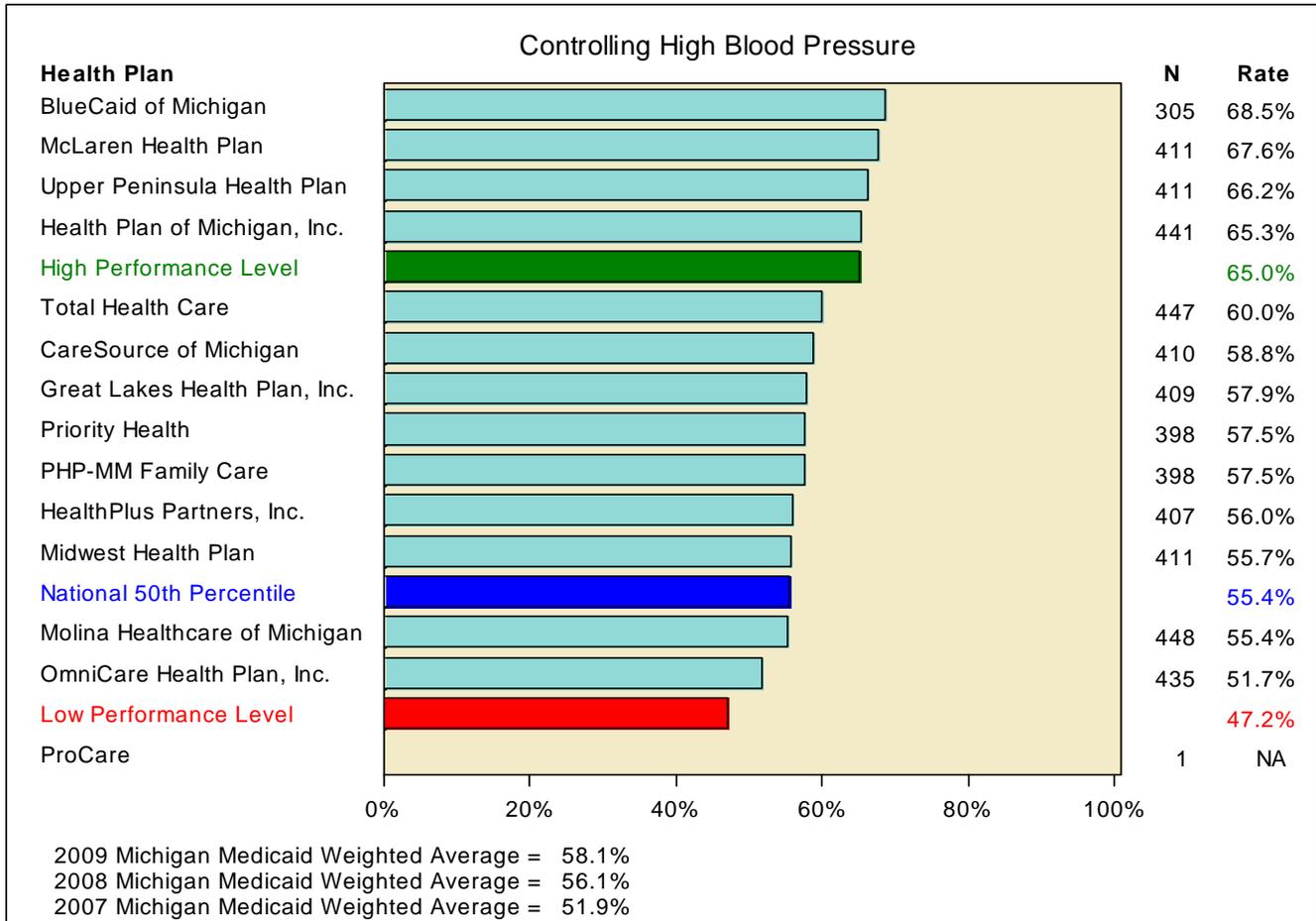
⁵⁻³⁹ National Committee for Quality Assurance. The State of Health Care Quality, 2008. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/SOHC_08.pdf. Accessed July 14, 2009.

⁵⁻⁴⁰ Ibid.

⁵⁻⁴¹ 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 July 14, 2009.

Health Plan Ranking: Controlling High Blood Pressure

**Figure 5-21—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Controlling High Blood Pressure**



Four MHPs reported rates that exceeded the HPL of 65.0 percent, and none of the plans' rates were below the LPL of 47.2 percent. Eleven health plans, including the four above the HPL, reported rates above the national HEDIS 2008 Medicaid 50th percentile. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 58.1 percent was 2.7 percentage points above the national HEDIS 2008 Medicaid 50th percentile of 55.4 percent and increased by 2.0 percentage points compared to the 2008 weighted average.

Medical Assistance With Smoking Cessation

Approximately 45.3 million adults in the United States were smokers in 2006.⁵⁻⁴² 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. In terms of the current generation of children, approximately 5 million of them will die prematurely of tobacco-related diseases if current smoking patterns continue.⁵⁻⁴³ Discontinuing the use of tobacco is the most cost-effective method of preventing disease in adults. Investing adequately in 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.⁵⁻⁴⁴

According to the CDC, 20.4 percent of Michigan adults were cigarette users in 2008 compared to 21.2 percent in 2007.⁵⁻⁴⁵ In 2008, the 25-to-44-year-old age group had the highest rate at 25.7 percent, followed by the 18-to-24-year-old age group at 23.7 percent. About 18 percent of all U.S. adults were smokers in 2008.⁵⁻⁴⁶

“Tobacco-Free Michigan” is a five-year strategic plan focused on preventing tobacco use in the state. The plan has established goals in four different areas:

- ◆ Identifying and eliminating tobacco-related health disparities
- ◆ Eliminating exposure to secondhand smoke
- ◆ Increasing cessation among adults and youth
- ◆ Increasing youth tobacco use prevention and decreasing initiation⁵⁻⁴⁷

Through the first four years of the plan, Michigan has achieved several goals such as the passage of smoke-free work site regulations and ordinances in 18 Michigan counties and four cities and the implementation of tobacco-free policies for buildings and campuses in more than 56.0 percent of Michigan’s public schools.⁵⁻⁴⁸

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

⁵⁻⁴² 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 July 14, 2009.

⁵⁻⁴³ 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 July 14, 2009.

⁵⁻⁴⁴ Ibid.

⁵⁻⁴⁵ 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=100&selectedMeasure=110&dir=epi_report&ucName=UCDetail&state=MI&year=2008&submitBk=y. Accessed July 14, 2009.

⁵⁻⁴⁶ Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System (BRFSS). Available at: <http://apps.nccd.cdc.gov/brfss/display.asp?cat=TU&yr=2008&qkey=4396&state=UB>. Accessed July 17, 2009.

⁵⁻⁴⁷ Tobacco-Free Michigan. A Five-Year Strategic Plan for Tobacco Use Prevention and Reduction. Available at: <http://www.tobaccofreemichigan.org/pdf/TobaccoFree5YrStrategicPlan.pdf>. Accessed July 17, 2009.

⁵⁻⁴⁸ Ibid.

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 clinicians use a combination of tobacco dependence counseling and medication treatment 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.⁵⁻⁴⁹

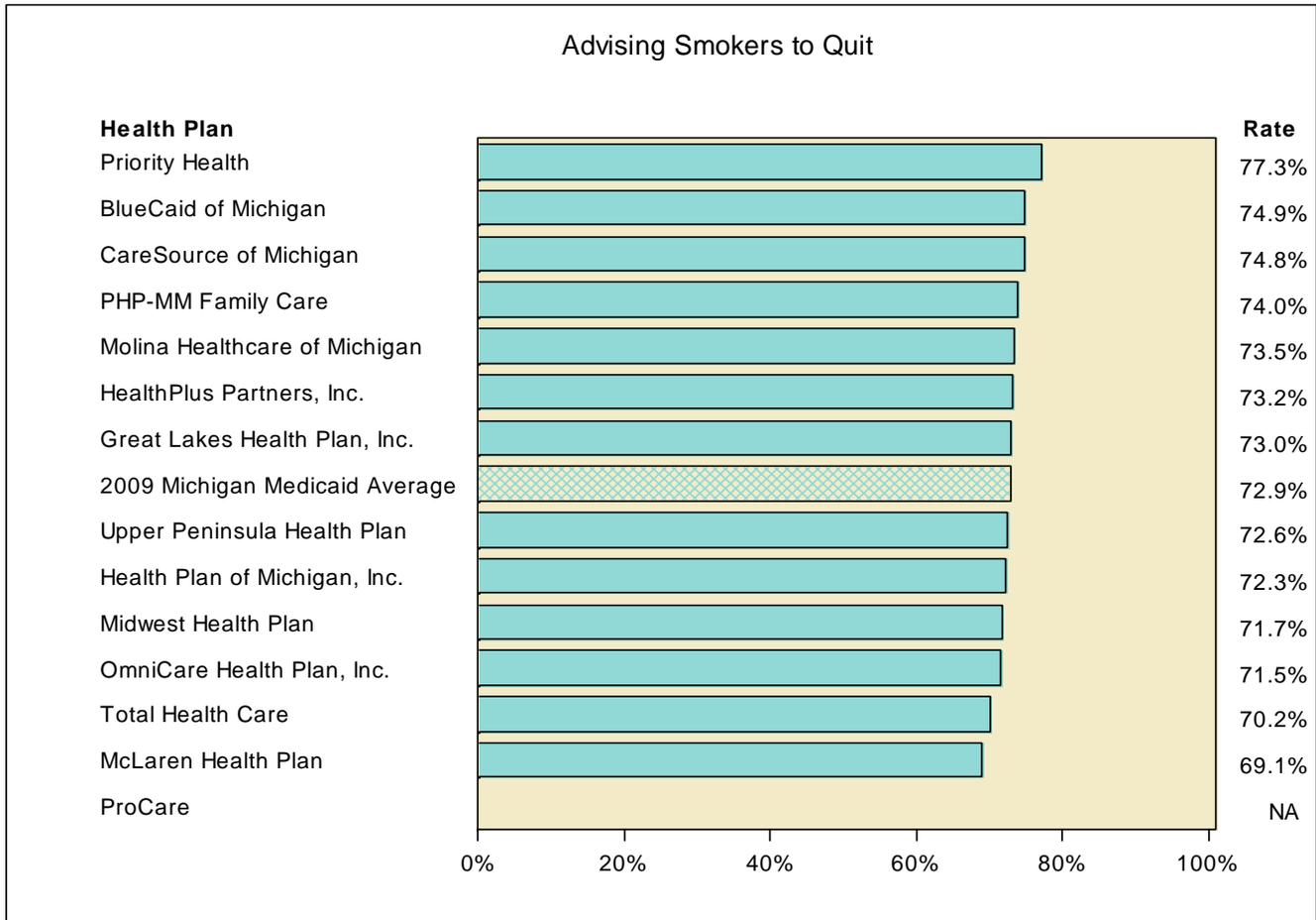
HEDIS Specification—Advising Smokers to Quit

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.

⁵⁻⁴⁹ 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 July 17, 2009.

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

**Figure 5-22—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Medical Assistance With Smoking Cessation—Advising Smokers to Quit**



Seven of the 14 MHPs reported rates above the 2009 Michigan Medicaid average of 72.9 percent. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

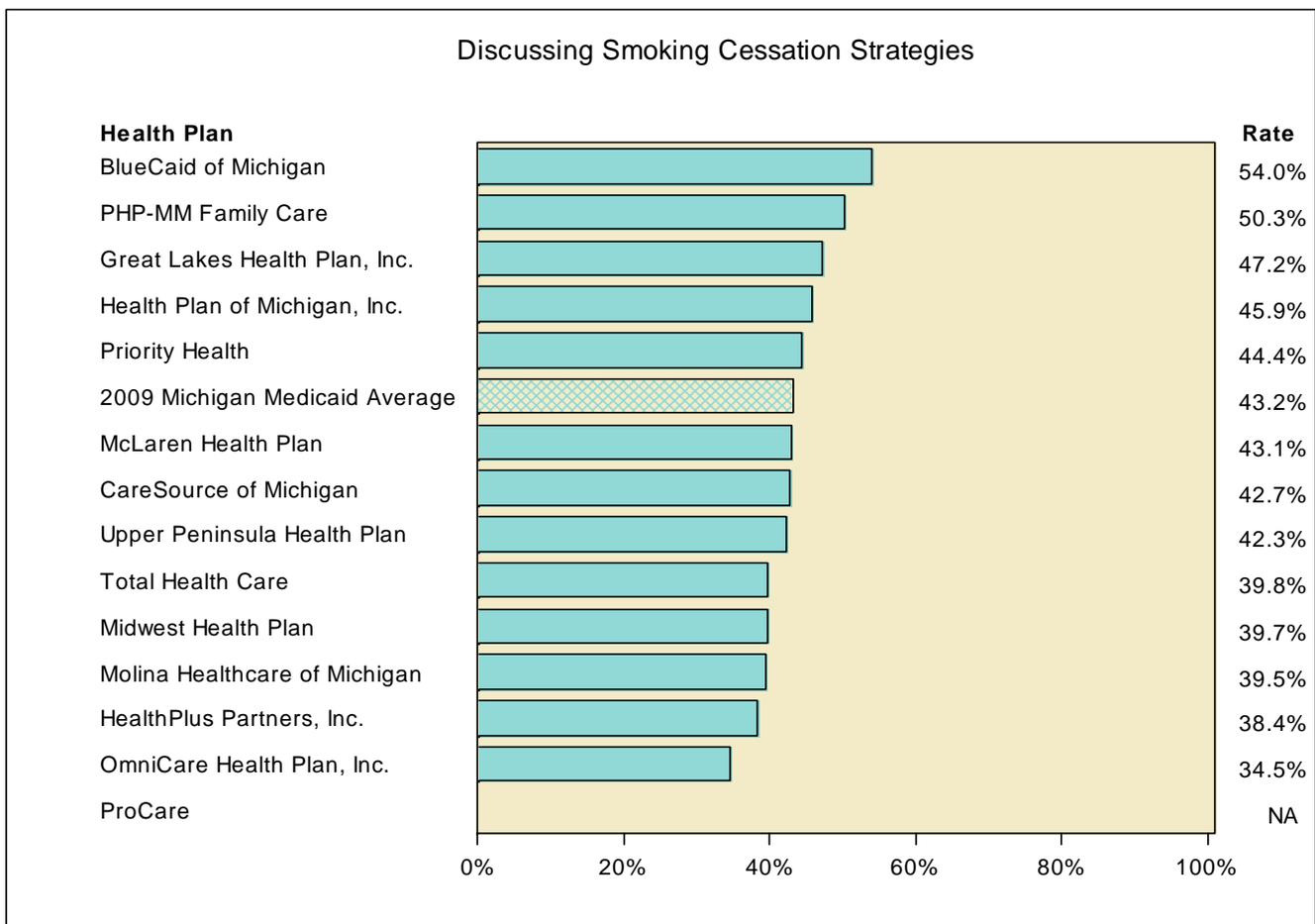
The 2009 Michigan Medicaid average increased 0.1 of a percentage point compared to the 2008 average of 72.8 percent. In 2008, five of the health plans reported rates above the 2008 Michigan Medicaid average. This year’s reported rates ranged from 69.1 percent to 77.3 percent, similar to last year, when the reported rates ranged from 69.1 percent to 77.8 percent.

HEDIS Specification—Smoking Cessation Strategies

The *Medical Assistance With Smoking Cessation* measure is collected using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. *Smoking Cessation Strategies* is another component (or rate) reported for the measure. *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, were smokers, were seen by an MHP practitioner in the six months prior to completing the CAHPS survey, and received recommendations for or discussion about smoking cessation medications.

Health Plan Ranking: Medical Assistance with Smoking Cessation—Smoking Cessation Strategies

**Figure 5-23—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Medical Assistance with Smoking Cessation—Smoking Cessation Strategies**



Five of the 14 MHPs’ rates ranked above the 2009 Michigan Medicaid average of 43.2 percent. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

The 2009 Michigan Medicaid average increased 2.1 percentage points compared to the 2008 average of 41.1 percent. In 2008, seven of the health plans reported rates above the 2008 Michigan Medicaid average. This year's range of rates spanned from 34.5 percent to 54.0 percent, similar to last year, when the rates ranged from 33.1 percent to 51.7 percent.

Living With Illness Findings and Recommendations

Nine of the 13 2009 Michigan Medicaid weighted averages in this dimension of care showed improvement compared to last year's rates. The smoking cessation measures' rates were not reported as weighted averages, but just as averages, and both of these rates improved over last year. Nine of the 13 weighted averages ranked above the national HEDIS 2008 Medicaid 50th percentile, and three of those rates ranked above the 75th percentile. Performance on four measures (*Appropriate Treatment for People With Asthma [ASM]—5–9 Years, 10–17 Years*, and *Total and Comprehensive Diabetes Care—Blood Pressure Control <130/80*) ranked below the 50th percentile, and the *ASM—10–17 Years* rate ranked below the 25th percentile. Administrative data completeness has improved for most of the Living With Illness measures, indicating less need for medical record review.

All rates for the *Comprehensive Diabetes Care (CDC)* measures showed improvement for 2009. The increase in weighted averages ranged from 0.1 percentage point to 2.4 percentage points. While none of these improvements was statistically significant, the Michigan MHPs continued to improve care to diabetic members. The rates for the *LDL-C Screening* and *LDL-C Level <100* measures, as well as the *Medical Attention for Diabetic Nephropathy* measure, performed above the national HEDIS 2009 Medicaid 75th percentile. Last year was the first year the Michigan MHPs reported that both of the *CDC—Blood Pressure* measures' performance ranked below the national average. This year, the *Blood Pressure Control <140/90* measure improved above the 50th percentile, and the *Blood Pressure Control <130/80* rate was only 0.1 percentage point below the national average. The MHPs improved the percentage of rates derived through administrative data for the diabetes measures, including the blood pressure measures, which improved by more than 7.0 percentage points. The improvement in the blood pressure administrative rates showed that the MHPs are receiving blood pressure results administratively. The MHPs should continue to work with providers to encourage the submission of CPT Level II codes that include blood pressure results to further reduce the burden of medical record review.

HSAG has documented several successful interventions implemented to improve *CDC* HEDIS rates. Successful in this context is defined as achieving sustained improvement over several years. PIPs and QIPs focusing on diabetes care have been effective in improving the HEDIS rates corresponding to the *CDC—Eye Exam, HbA1c Testing*, and *LDL-C Screening* measures. HSAG has compiled information from PIPs/QIPs demonstrating sustained improvement for these HEDIS rates.⁵⁻⁵⁰ After identifying specific barriers from causal/barrier analyses, health plans implemented the following interventions:

⁵⁻⁵⁰ Health Services Advisory Group. Validation of Performance and Quality Improvement Projects. Studies validated between 2004 and 2009.

For both members and providers:

- ◆ Instituted a Diabetic Health Management Program
- ◆ Changed health benefits to eliminate referral requirements for diabetic members' annual eye exam
- ◆ Created a dedicated diabetes health management committee to develop and implement interventions and program improvements and review guidelines

For members:

- ◆ Identified diabetic members in a new member welcome call assessment
- ◆ Distributed health report cards to members with their testing and results history
- ◆ Provided incentives to members if they were compliant with all screening requirements
- ◆ Distributed quarterly newsletters with diabetes articles and updates
- ◆ Contacted noncompliant members using reminder letters/calls

For providers:

- ◆ Informed providers of member incentives
- ◆ Sent report cards to providers documenting their care of diabetic members and included the identity of diabetic members, a summary of all diabetes services received, and a chart tool
- ◆ Recognized top-performing practitioners in diabetes care
- ◆ Mailed diabetes clinical care guidelines to practitioners, including an assessment tool
- ◆ Posted diabetes clinical care guidelines for practitioners on the Web site
- ◆ Distributed monthly newsletters to practitioners

Interventions related to education, either for the member or practitioner, were more successful if they were repeated numerous times and distributed using varied modalities.

The importance of barrier-specific interventions is highlighted in the following example taken from the Quality Lesson: Barrier-Based Diabetes Education Initiatives Improve HEDIS Results.⁵⁻⁵¹ A health plan determined that its efforts to improve HEDIS results for diabetes testing were not sufficient. Previously, efforts included newsletter mailings and case management of high-risk members. The plan decided to focus on diabetes education for members early in the course of their disease to prevent complications. The plan developed a database to track the tests and results of diabetic members and conducted a survey of its members with diabetes to determine the barriers to screening tests. Based on the survey results, the plan focused on specific areas that needed education efforts.

⁵⁻⁵¹ National Committee for Quality Assurance 2008. Quality Profiles: The Leadership Series. Focus on Diabetes. Available at http://www.qualityprofiles.org/leadership_series/diabetes/diabetes_prevention.asp#. Accessed September 8, 2009.

The health plan then implemented the following interventions:

- ◆ Mailing of the “Focus” eye care educational materials: Three mailings were sent during the year to members who had not received a retinal eye examination. These mailings included a reminder written partially in blurry text to encourage members to make an appointment, reinforcing the fact that eye exams are important.
- ◆ A glucose meter program: All members with diabetes received an expanded selection of equipment and accompanying education.

Evaluation of the HEDIS results demonstrated improvement for HbA1c and LDL-C screening, but the rates for retinal eye examinations decreased from baseline. Based on these results, the plan identified additional barriers through discussions with practitioners and members: referrals for eye exams created delays and members were unaware of the seriousness of their condition. From these findings, the health plan expanded educational efforts to more members using different teaching modalities.

Additional interventions included:

- ◆ Member educational seminars.
- ◆ “Eating for Health” and “Cooking With a Diabetic Chef” seminars conducted by a dietitian, which focused on proper meal planning and food selection. They included a healthy lunch to demonstrate the teaching content.
- ◆ A Christmas party for children with diabetes: The plan supplied gifts and entertainment while educating parents and children about diabetes and strategies for managing the disease. The children met other kids with diabetes, and the parents had the opportunity to form a support network.
- ◆ Web site education: Members could interact with a nurse via the Internet.
- ◆ A “Nurse Care Call” educational program. Members who were not obtaining screening tests according to HEDIS guidelines received calls from a nurse over an eight-week period. The nurse provided education and discussed issues or questions the member had about diabetes.
- ◆ Summer camp for children with diabetes. The health plan sponsored children’s attendance at a week-long camp offered by the American Diabetes Association. The children were selected through a coloring contest, and so far, the health plan has been able to sponsor all entrants.

Improved rates for HbA1c and LDL-C screening were statistically significant from baseline to final remeasurement. Diabetes eye examinations did not improve significantly but showed positive gains. The health plan improved HEDIS screening results for diabetes by tracking members throughout the year who were not receiving services and by providing continual reminders and education. Additionally, the personal contact by nurses permitted the health plan to tailor education to member-identified needs.

Performance on all four asthma measures declined in 2009. The decline in rates ranged from 0.2 percentage point to 1.3 percentage points. While one weighted average performed 0.1 percentage point above the national average, the remaining weighted averages ranked below the national 50th percentile, and one rate, *Appropriate Treatment for People With Asthma—10–17 Years* ranked below the 25th percentile. The decrease in asthma rates and average to below-average performance

indicated that the MHPs' pharmacy data might not be complete. The MHPs should work with their pharmacy vendors to ensure the submission of all pharmacy data.

A wide range of health care factors can affect the HEDIS measure, *Appropriate Medications for People With Asthma (ASM)*, including patient-provider relationships, medication compliance, chronic disease management, and disease self-management. Quality improvement projects address barriers associated with improving any combination of these factors. Successful improvement projects have implemented interventions applicable to the management of other chronic disease measures and/or interventions that employed unique methods and tools developed specifically for the asthma population. Examples of both approaches are included below.

The financial justification for the initiation of a quality improvement program can be determined by using a new tool, the Asthma Return on Investment Calculator, developed by the Agency for Healthcare Research and Quality (AHRQ).⁵⁻⁵² This is an online, evidence-based tool to estimate the potential health care cost savings and productivity gains of an asthma quality improvement program for a health plan's Medicaid or commercial members.

The Center for Healthcare Strategies, Inc. (CHCS), developed a toolkit for general asthma initiatives.⁵⁻⁵³ Approaches to improve asthma management include:

- ◆ Recognizing common barriers faced by Medicaid plans in achieving better care for members with asthma.
- ◆ Developing strategies to overcome these barriers.
- ◆ Reviewing clinical and administrative strategies that other health plans have implemented.
- ◆ Measuring incremental and long-term change.

Controlling High Blood Pressure is a hybrid measure that is only reported through medical record data. The 2009 rate improved by 2.0 percentage points and ranked above the national average. Performance among the MHPs ranked from above average to average. No MHPs reported rates below the LPL.

Research performed by HSAG identified that establishing a medical home and offering patient-centered care often are basic approaches to managing members with chronic illnesses. The medical home model allows for continuity of care and eases the navigation through the health care system with the assistance of case/care management. The patient-centered care model emphasizes the self-management of chronic disease. Many of the interventions used to improve the HEDIS rates associated with cardiovascular conditions and comprehensive diabetes care also apply to *Controlling High Blood Pressure (CBP)* measures, especially in populations with high rates of comorbidity for these diseases.

Successful approaches to improve the management of hypertension (HTN) recognize the multifaceted nature of the condition and the necessity of interventions that target multilevels within the health care system. Literature reviews by the Cochrane Collaboration focused on interventions

⁵⁻⁵² Agency for Healthcare Research and Quality. 2009. Available at <http://statesnapshots.ahrq.gov/asthma/>. Accessed September 3, 2009.

⁵⁻⁵³ Center for Healthcare Strategies, Inc. 2002. Achieving better care for asthma: a BCAP toolkit. Available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=585903. Accessed September 3, 2009.

to improve the control of blood pressure and the adherence to treatment for patients with HTN. After a review of 56 randomized controlled studies, the Cochrane Collaboration concluded that to control blood pressure an organized system of regular follow-up and review is necessary. Additionally, antihypertensive drug therapy should be implemented by means of a vigorous stepped care approach.⁵⁻⁵⁴ The second review of 38 studies concluded that reducing the number of daily doses should be a first-line strategy. The review also noted that patient education alone was unsuccessful.⁵⁻⁵⁵ Another review of 79 interventions to improve patient compliance with antihypertensive medications reported that of the 12 interventions recommended, “personalized, patient-focused programs that involved frequent contact with health professionals or a combination of interventions were most effective.” The review also noted that while strategies that simplify the medication regimen or include refill reminders achieved smaller improvements, they were potentially more cost-effective.⁵⁻⁵⁶

The *Medical Assistance With Smoking Cessation* measures were reported using CAHPS data. National means and percentile data were not available for benchmarking these rates. The 2009 Michigan Medicaid average of 72.9 percent for the *Advising Smokers to Quit* measure improved by 0.1 percentage point from 2008, and the rates for the MHPs ranged from 69.1 percent to 77.3 percent. Rates for the *Smoking Cessation Strategies* measure ranged from 34.5 percent to 54.0 percent, and the 2009 Michigan Medicaid average of 43.2 percent improved by 2.1 percentage points over the 2008 rate.

The MHPs should continue to drill down from the CAHPS results to identify key drivers of these measures. By identifying the key drivers of performance the MHPs can then focus on improving the reported rates.

⁵⁻⁵⁴ Fahey T, Schroeder K, Ebrahim S, et al. 2006. Interventions used to improve control of blood pressure in patients with hypertension. Cochrane Database of Systematic Reviews. Issue 4. Art. No.:CD005182. DOI: 10.1002/14651858.CD005182.pub3.

⁵⁻⁵⁵ Fahey T., Schroeder K., Ebrahim S. 2004. Interventions for improving adherence to treatment in patients with high blood pressure in ambulatory settings. Cochrane Database of Systematic Reviews. Issue 3. Art. No.:CD004804. DOI: 10.1002/14651858.CD004804.

⁵⁻⁵⁶ Petrilla, AA, Benner, JS, Battleman, DS, et al. 2005. Evidence-based interventions to improve patient compliance with antihypertensive and lipid-lowering medications. The International Journal of Clinical Practice. 59(12): 1441-1451.

Introduction

Access to appropriate and effective health 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 PCP 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 2006, approximately 902 million visits were made to office-based physicians in the United States.⁶⁻² The visit rate for whites was higher than the rate for African-American and Hispanic individuals (323.9 versus 235.4 and 271.0 visits per 100 individuals per year, respectively).⁶⁻³

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).⁶⁻⁴

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 was not permitted; therefore, a data collection analysis was 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 July 10, 2009.

⁶⁻² Centers for Disease Control and Prevention. National Ambulatory Medical Care Survey: 2006 Summary. Available at: <http://www.cdc.gov/nchs/data/nhsr/nhsr003.pdf>. Accessed July 10, 2009.

⁶⁻³ Ibid.

⁶⁻⁴ 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 July 10, 2009.

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

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

The *Children's and Adolescents' Access to Primary Care Practitioners* measure looks at visits to pediatricians, family physicians, and other PCPs 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 ranked third in the country in terms of the best access to care for children.⁶⁻⁵ One important component in this ranking was insurance coverage. The report ranked Michigan first nationwide for having the lowest rate of uninsured children: about 5 percent of Michigan children were uninsured in 2005–2006.

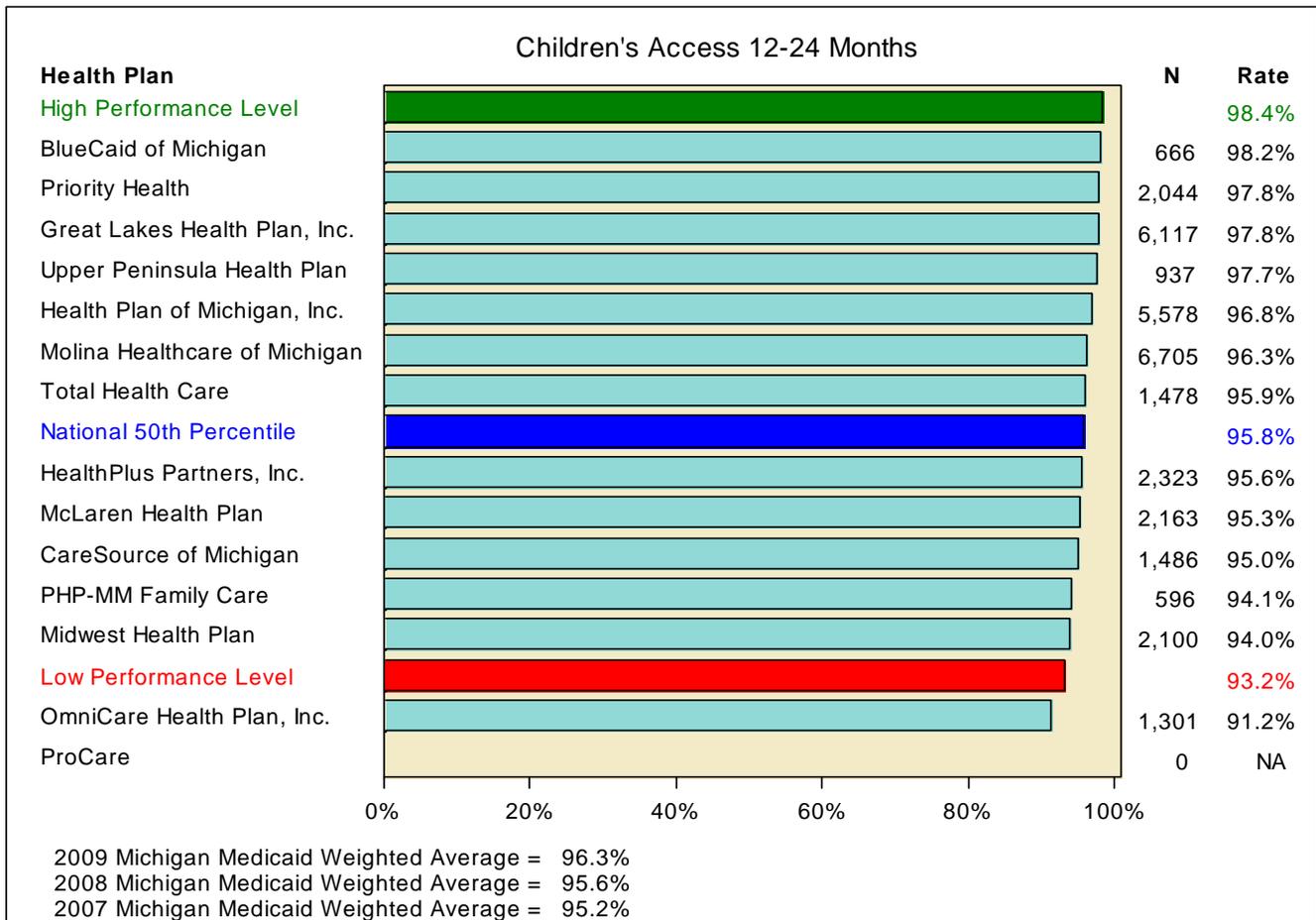
HEDIS Specification: Children's and Adolescents' Access to Primary Care Practitioners

Children's and Adolescents' Access to Primary Care Practitioners calculates the percentage of members 12 months to 19 years of age who were continuously enrolled during the measurement year and who had a visit with an MHP PCP during the measurement year. This measure is reported in four age groups: 12–24 months, 25 months–6 years, 7–11 years, and 12–19 years.

⁶⁻⁵ 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 July 10, 2009.

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

**Figure 6-1—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Children’s and Adolescents’ Access to Primary Care Practitioners—12 to 24 Months**

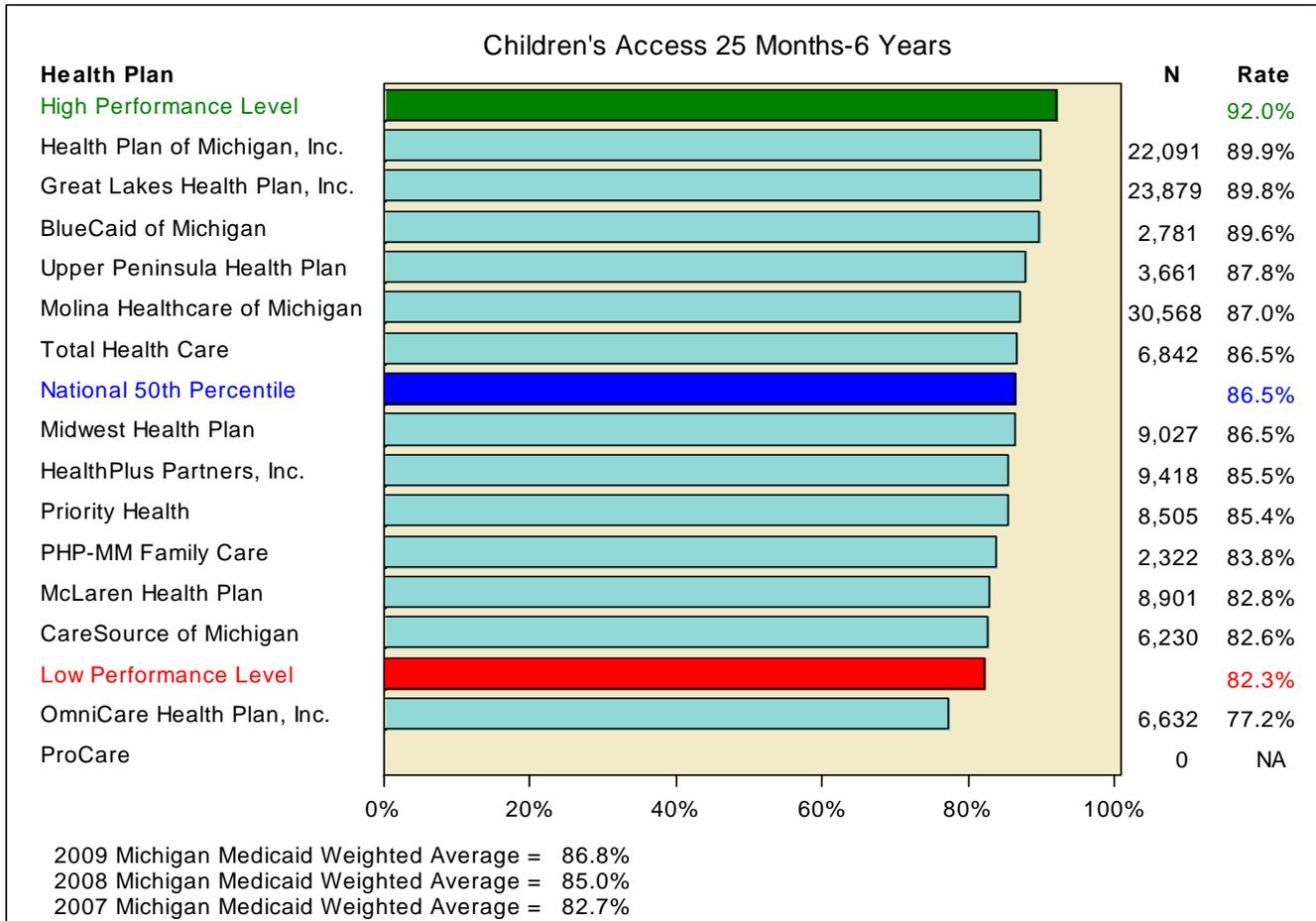


Although none of the plans reached the HPL of 98.4 percent, 7 of the 14 health plans reported rates above the national HEDIS 2008 Medicaid 50th percentile of 95.8 percent, and one health plan reported a rate below the LPL of 93.2 percent. Four of the MHPs ranked above the 75th percentile of 97.4 percent. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

The 2009 Michigan Medicaid weighted average of 96.3 percent improved by 0.7 percentage point compared to the 2008 weighted average and ranked above the national HEDIS 2008 Medicaid 50th percentile by 0.5 percentage point.

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

Figure 6-2—Michigan Medicaid HEDIS 2009 Health Plan Ranking: Children’s and Adolescents’ Access to Primary Care Practitioners—25 Months to 6 Years

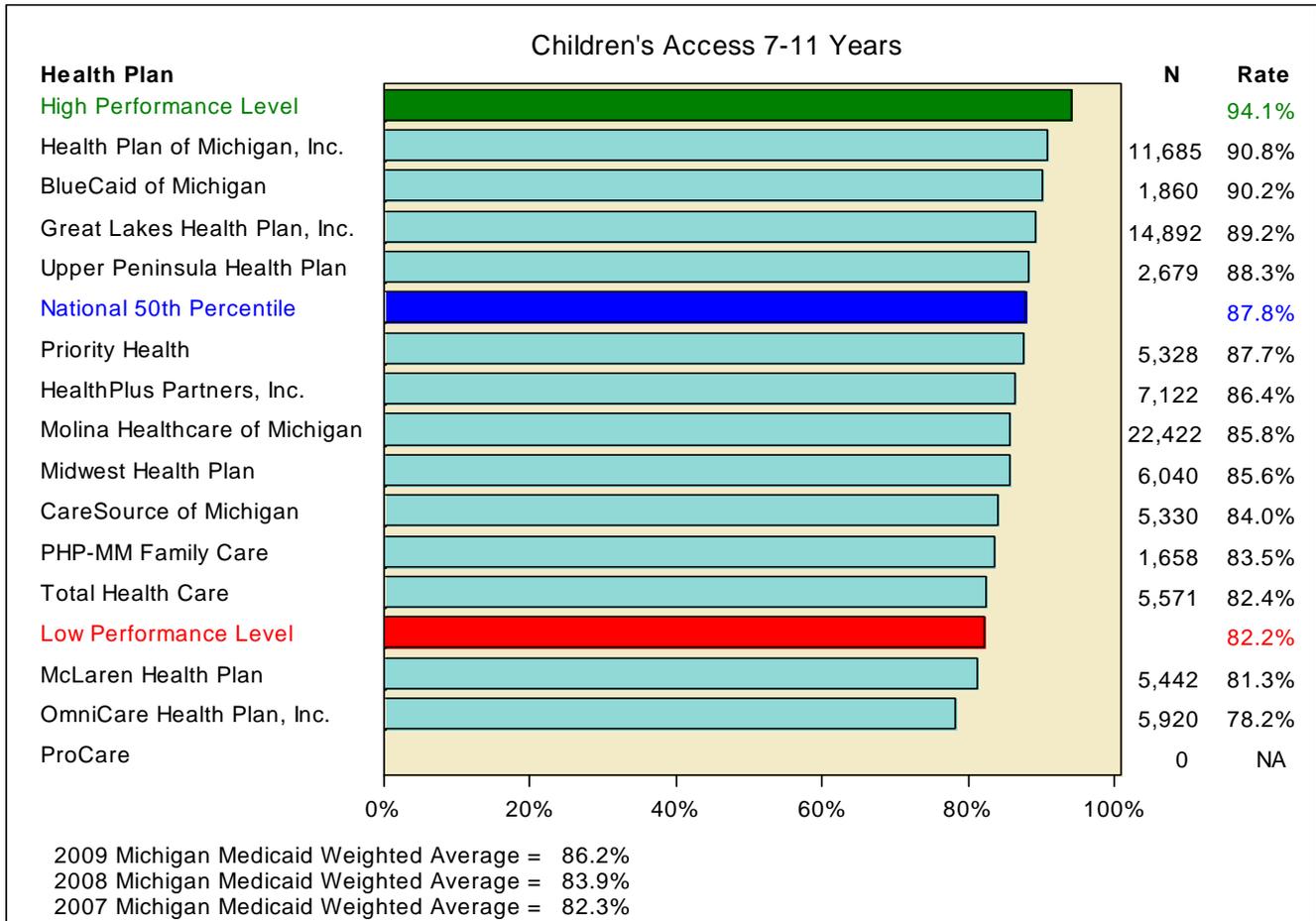


None of the MHPs exceeded the HPL of 92.0 percent; however, three MHPs ranked above the 75th percentile of 89.4 percent. One MHP reported a rate below the LPL of 82.3 percent, which was an improvement from last year, when five plans reported rates below the LPL. Six health plans exceeded the national HEDIS 2008 Medicaid 50th percentile of 86.5 percent. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

The 2009 Michigan Medicaid weighted average of 86.8 percent increased 1.8 percentage points compared to last year’s weighted average and ranked slightly above the HEDIS 2008 Medicaid 50th percentile. Compared to the 2007 weighted average, the 2009 weighted average increased by 4.1 percentage points.

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

**Figure 6-3—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Children’s and Adolescents’ Access to Primary Care Practitioners—7 to 11 Years**

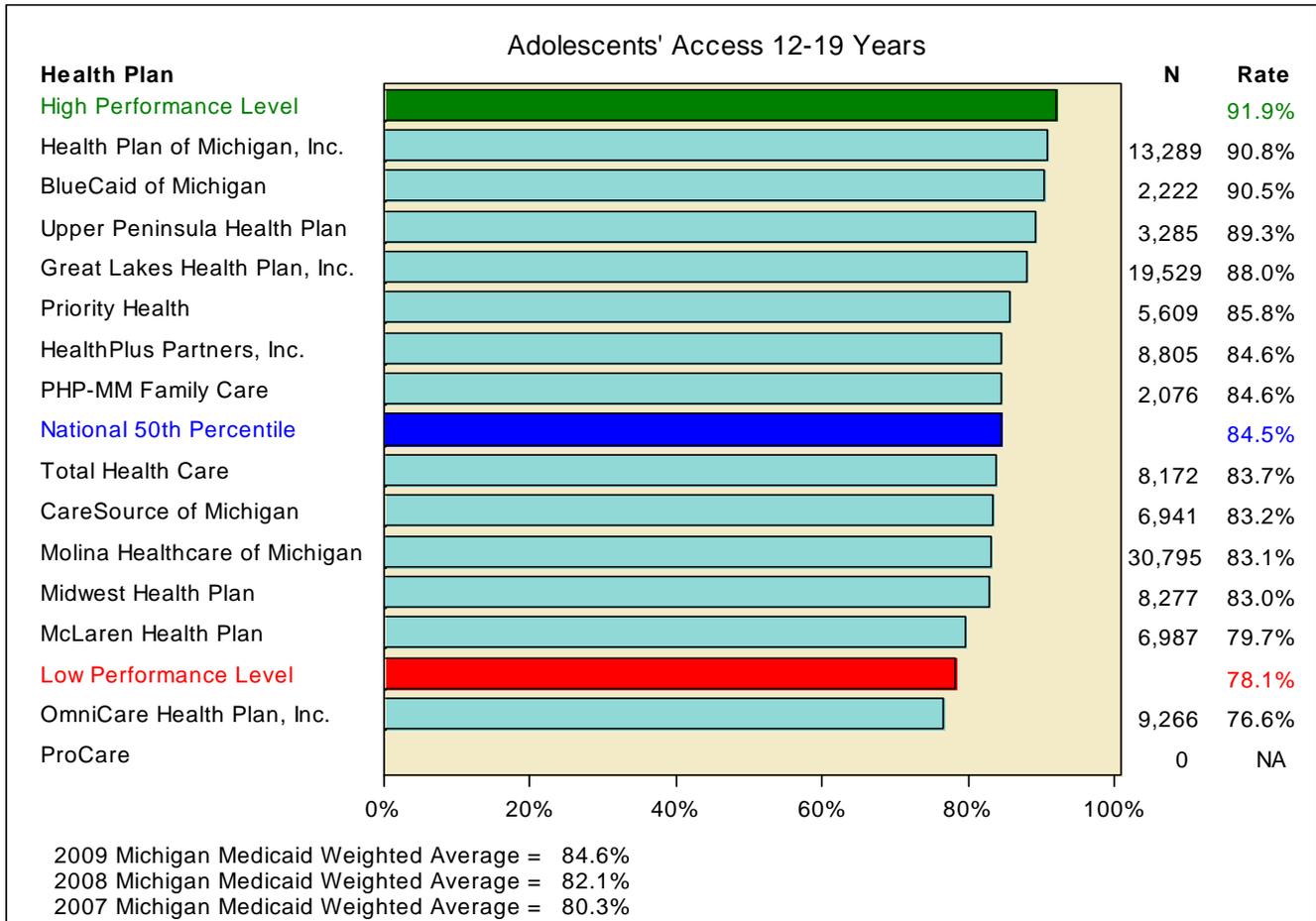


Four of the 14 health plans reported rates above the national HEDIS 2008 Medicaid 50th percentile of 87.8 percent. No MHPs ranked above the HPL of 94.1 percent, and two health plans performed below the LPL of 82.2 percent. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

The weighted average continued to improve for this measure. The 2009 Michigan Medicaid weighted average increased by 2.3 percentage points compared to the 2008 weighted average, and by 3.9 percentage points compared to the 2007 weighted average. Despite these increases, the 2009 weighted average ranked below the national HEDIS 2008 Medicaid 50th percentile.

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

Figure 6-4—Michigan Medicaid HEDIS 2009 Health Plan Ranking: Children’s and Adolescents’ Access to Primary Care Practitioners—12 to 19 Years



None of the MHPs reached the HPL rate of 91.9 percent, but two plans ranked above the 75th percentile of 90.0. Seven MHPs exceeded the national HEDIS 2008 Medicaid 50th percentile of 84.5 percent, and one health plan performed below the LPL of 78.1 percent. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan’s rate as NA.

The 2009 Michigan Medicaid weighted average of 84.6 percent was 0.1 percentage point above the national HEDIS 2008 Medicaid 50th percentile and 2.5 percentage points above the 2008 weighted average.

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 2005–2006, about 18 percent of U.S. adults 18–64 years of age did not have a usual source of health care.⁶⁻⁶ The cost of medical care can also be a barrier, particularly for those with lower incomes. Approximately 21 percent of interview respondents 45 to 64 years of age with incomes below 100 percent of the poverty level said that they did not get medical care due to cost in 2006.⁶⁻⁷ Lack of health insurance is also a barrier to access. Those who do not have insurance are more likely to delay or forego medical care than those with insurance.⁶⁻⁸

HEDIS Specification: Adults' Access to Preventive/Ambulatory Health Services

The *Adults' Access to Preventive/Ambulatory Health Services* measure calculates the percentage of adults 20 years and older who were continuously enrolled during the measurement year and who had an ambulatory or preventive care visit during the measurement year. For this report, this measure was reported in two rates: 20–44 years and 45–64 years.

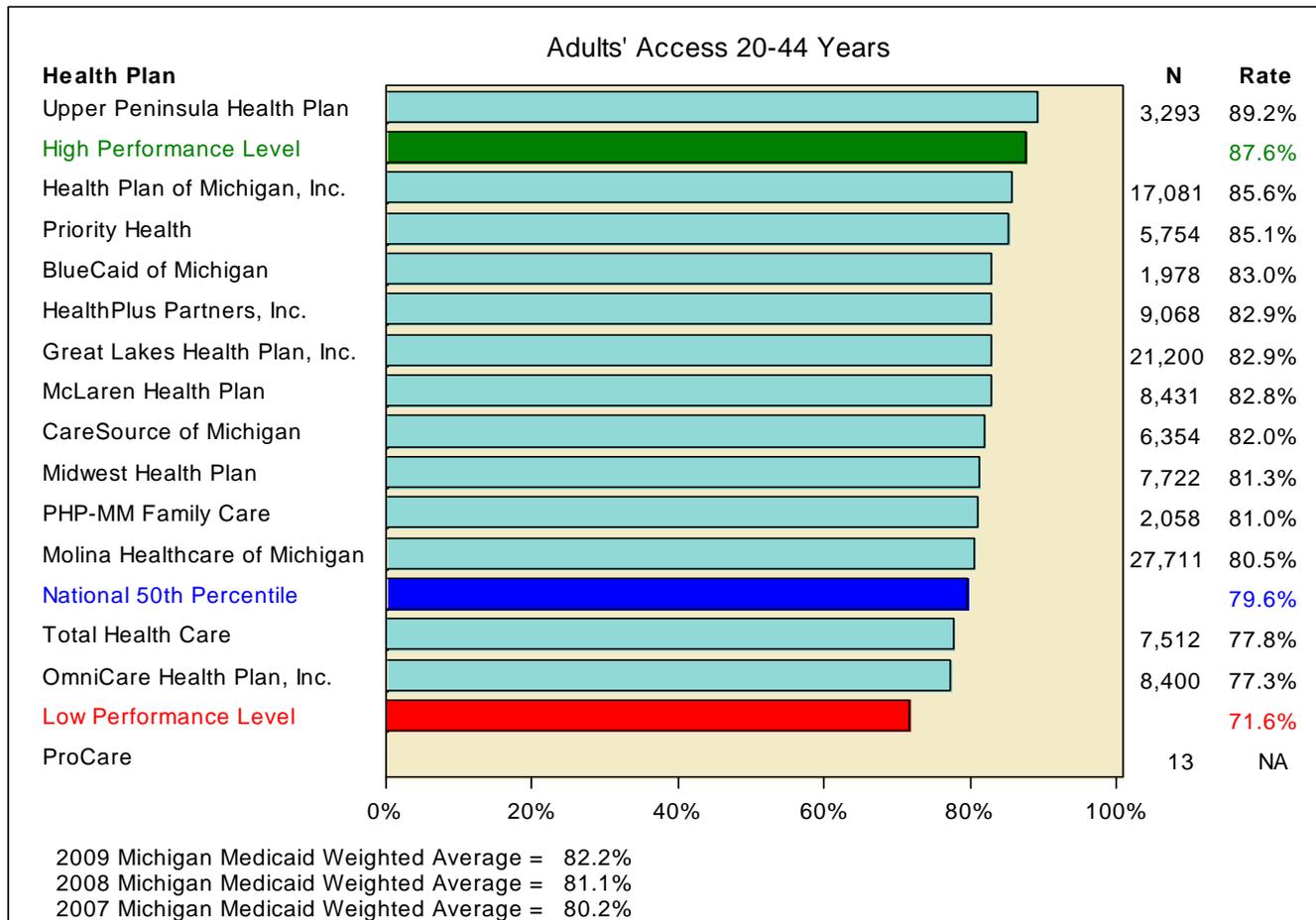
⁶⁻⁶ National Center for Health Statistics. Health, United States, 2008. Available at: <http://www.cdc.gov/nchs/data/hus/hus08.pdf>. Accessed July 10, 2009.

⁶⁻⁷ Ibid.

⁶⁻⁸ Ibid.

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

**Figure 6-5—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Adults' Access to Preventive/Ambulatory Health Services—20 to 44 Years**

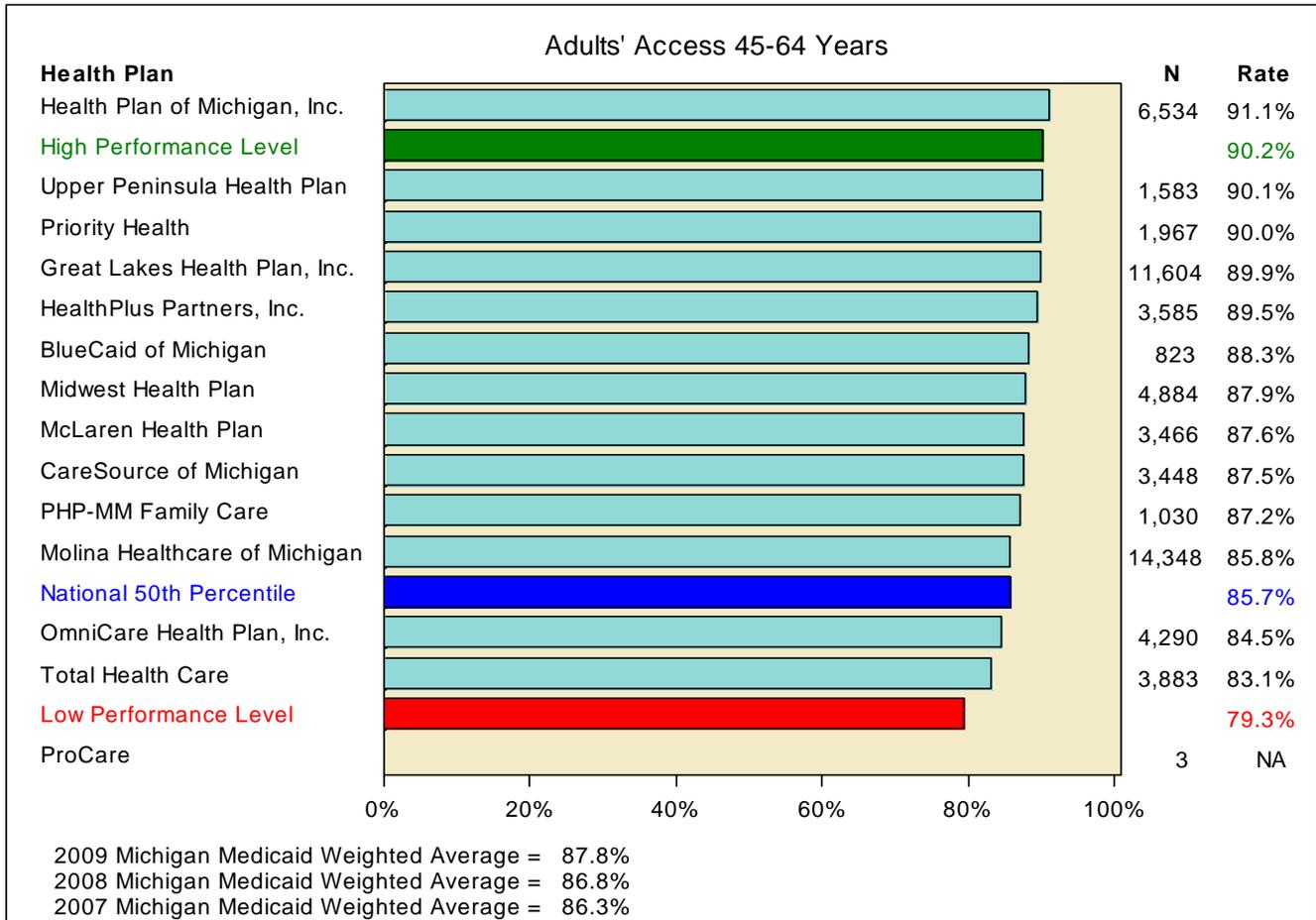


Similar to last year, one MHP exceeded the HPL of 87.6 percent, and no health plans fell below the LPL of 71.6 percent. The majority of the plans performed between the 50th and 75th percentile, with two MHPs ranking above the 75th percentile of 84.8 percent. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 82.2 percent increased by 1.1 percentage points from the 2008 weighted average and ranked 2.6 percentage points higher than national HEDIS 2008 Medicaid 50th percentile of 79.6 percent.

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

**Figure 6-6—Michigan Medicaid HEDIS 2009
Health Plan Ranking:
Adults' Access to Preventive/Ambulatory Health Services—45 to 64 Years**



One health plan exceeded the HPL of 90.2 percent, and none of the health plans had a rate below the LPL of 79.3 percent. Eleven MHPs exceeded the national HEDIS 2008 Medicaid 50th percentile of 85.7 percent. One health plan was unable to report a rate for this measure due to an insufficient sample size (a denominator of less than 30). The figure above designates this health plan's rate as NA.

The 2009 Michigan Medicaid weighted average of 87.8 percent was 2.1 percentage points above the national HEDIS 2008 Medicaid 50th percentile of 85.7 percent. In addition, the 2009 weighted average improved by 1.0 percentage point compared to the 2008 weighted average.

Access to Care Findings and Recommendations

Overall performance on the *Children's and Adolescents' Access to Primary Care Practitioners* measure improved compared to last year. Three of the four 2009 weighted averages ranked above the national HEDIS 2008 50th percentile. The *Children's and Adolescents' Access to Primary Care Practitioners—7–11 Years* weighted average of 86.2 percent was 1.6 percentage points lower than the national average. While the *Children's and Adolescents' Access to Primary Care Practitioners—12–19 Years* weighted average ranked above the national average, it was only by 0.1 percentage point. The adolescent age span tends to be a difficult age group to target for improving access to medical care. Education to providers and members and their parents is crucial to increase access-to-care rates among these age groups. Generally, the low-performing MHPs in previous years continued to be low performers in access to care for the 12 months to 19 years age span. These plans should continue to investigate ways to increase members' access to care and ensure that the plans receive all encounter data.

HSAG compiled information on interventions successfully implemented to improve *Children's and Adolescents' Access to Primary Care Practitioners*. Many of the interventions used to increase rates of well-child visits also apply to this HEDIS measure. Plans included specific information on the importance of ongoing annual visits and required services for this targeted age group as part of their other intervention initiatives.

Additional interventions included:

- ◆ Conducting provider/office personnel in-services.
- ◆ Implementing CPT Category II codes to facilitate the administrative capture of visits.
- ◆ Implementing new female/child health initiatives.
- ◆ Establishing a member awards program
- ◆ Coordinating transportation.
- ◆ Participating in health fairs.
- ◆ Providing follow-up reminder letters with phone calls

Plans also identified the need to coordinate with other entities, especially community centers that provide these services, to increase data completeness. Another successful practice documented was a provider reminder system that alerts the provider to needed assessments or other required services when a member presents with an injury or other sick visit.

The *Adults' Access to Preventive/Ambulatory Health Services* continued to perform above the national average for both age spans (*20–44 Years* and *45–64 Years*), with both weighted averages improving by about 1 percentage point compared to the previous year's rate. Performance among the health plans was consistent with last year in that the same few health plans performed at or around the HPL, and the same few health plans performed at or below the national average. Opportunities exist for the lower-performing plans to work with the higher-performing plans to investigate ways to improve access-to-care rates.

Many of the same interventions implemented to improve well visits and access to care for other age groups are used to improve the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS

measure results. The current literature points to a patient-centered care model to improve a patient's health outcomes and satisfaction. The Economic and Social Research Institute report outlines barriers and lessons learned in implementing this approach.⁶⁻⁹ While the Medicaid population is not uninsured, adults can find navigating through the health care system difficult.

Components related to access include:

- ◆ Providing a “medical home.”
- ◆ Keeping waiting times to a minimum.
- ◆ Providing convenient service hours.
- ◆ Promoting access and patient flow.
- ◆ Educating patients on how to navigate the health care system.

A method to operationalize this model includes developing a collaborative project such as a statewide PIP or a QIP.

HSAG has documented successful interventions for increasing member satisfaction with provider interactions and also for improving customer service and communication in the adult member population.

Interventions include:

- ◆ Keeping medical records for all family members in one folder.
- ◆ Providing Web-based clinical guidelines.
- ◆ Supplying a refrigerator magnet with plan contact information to members.
- ◆ Encouraging patient-provider joint decision making through a patient action plan.
- ◆ Providing a post-visit summary that includes the provider seen, location, diagnosis, medications being taken and/or prescribed, and referrals

The patient-centered care model and any related interventions can translate to other HEDIS measures related to screening and chronic disease management.

⁶⁻⁹ Silow-Carroll, S, Alteras, T, Stepnick, L. Patient-Centered Care for the Underserved Populations: Definition and Best Practices. Economic and Social Research Institute. 2006.

Key Findings and Recommendations

The information system (IS) standards are the foundation upon which certified HEDIS compliance auditors assess a health plan's ability to report HEDIS data accurately and reliably. For HEDIS 2009, health plans were assessed on seven IS standards. The following section summarizes the Michigan MHPs' performance on these standards for HEDIS 2009.

All 14 MHPs underwent HEDIS compliance audits. Ten MHPs contracted with the same licensed organization (LO) for their audit, while three other MHPs contracted with another LO and one plan contracted with a third LO for its audit. Health plans can select the LO they want to perform the HEDIS audit. Many health plans contract with HEDIS certified software vendors to produce their HEDIS measures. For HEDIS 2009, 13 of the 14 MHPs contracted with an NCQA-certified software vendor to generate HEDIS rates. One MHP generated its own source code for each measure and calculated its own rates. The use of a software vendor minimizes the burden on the plan to produce source code and calculate rates.

All 14 MHPs were fully compliant with *IS 1.0 Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry*. Compliance with this standard indicates that all of the MHPs required and captured industry standard codes, could distinguish between primary and secondary diagnosis codes, were able to map nonstandard codes (if used) to industry standard codes, captured data on standard submission forms, had timely and accurate data entry processes and had sufficient edits checks to ensure accurate entry of data, continually assessed data completeness, and monitored any contracted vendors involved in medical service data processing. The provider payment structure for each MHP varied. While a majority of providers were paid fee for service, a small number of MHPs had capitated payment arrangements that could lead to data completeness issues. While none of the MHPs had issues that impacted its ability to report HEDIS rates, all plans were encouraged to monitor capitated provider data submission to ensure data completeness. Several MHPs received recommendations from the auditors to increase the use of CPT Level II codes by their providers. These codes will enhance data completeness and accuracy and also minimize the burden of medical record review since the codes have results embedded in them.

All 14 MHPs were fully compliant with *IS 2.0 Enrollment Data—Data Capture, Transfer, and Entry*. This standard assesses that a health plan has procedures in place to ensure the accuracy of electronic transmission of membership data and that health plans have procedures for submitting HEDIS-relevant information for data entry, entry of enrollment data is timely and accurate and includes sufficient edit checks to ensure accurate entry, data completeness is continually assessed, and vendors (if used) are continually monitored. For a Medicaid audit, since the health plan typically receives enrollment and eligibility files from the state, minimal entry of enrollment data occurs as the applications are not processed at the health-plan level. The auditor assesses whether the MHPs processed the state files in a timely manner and that processes were in place to reconcile the data files and ensure that membership data were complete and accurate. No issues were identified and no recommendations were made to the MHPs on ways to improve enrollment file processing.

Each of the MHPs were fully compliant with all of the components of *IS 3.0 Practitioner Data—Data Capture, Transfer, and Entry*. This standard determines whether provider specialties were fully documented and mapped to HEDIS provider specialties, electronic practitioner data were checked for accuracy and procedures were in place for submitting the HEDIS-relevant data for data entry, data entry processes were timely and accurate and edit checks were in place to ensure accurate entry of provider data, data completeness was monitored, and vendors were monitored as applicable. The auditors had no concerns with the MHPs' methods for processing provider data and supplying evidence that the provider type could be identified in the data systems.

Thirteen of 14 MHPs were fully compliant with all components of *IS 4.0 Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight*. Review of this standard ensures that the MHPs had abstraction tools that captured all fields relevant for HEDIS reporting and that electronic transmission was according to industry standards and was accurate, that retrieval and abstraction of data from medical records was reliable and accurately performed, that data entry processes were timely and accurate and included sufficient edit checks, and that data completeness was continually monitored. Through a review of the final audit reports submitted it was evident that 13 of the MHPs used a medical record vendor to assist with the medical record abstraction process. Medical record vendors can be used in several ways. A health plan can contract with a vendor to perform the entire medical record process from tool development through data abstraction, or a health plan can contract with a vendor to use its abstraction tools and training services but use the health plan's internal staff to perform the medical record abstraction. The MHPs used both methods. Recommendations made by the auditors were that the MHPs should continue to monitor medical record vendors throughout the HEDIS process and assess the vendor's overall performance and the organization's satisfaction with the vendor, that the MHPs should conduct internal over-reads of medical record data, and that the MHPs should consider increasing hybrid measures for HEDIS 2010 and begin preparing accordingly.

IS 5.0 Supplemental Data—Capture, Transfer, and Entry considers the use of additional data outside of the standard claims/encounter data and medical record data that a health plan uses to produce HEDIS rates. Supplemental data include data received and collected from vendors (i.e., laboratories, pharmacies, state health registries), hospitals and providers, or internal data systems created by the health plan to supplement encounter data (i.e., a disease or case management database). These types of data require a more detailed review by the auditor to ensure that the data are being reported and captured appropriately and that they comply with NCQA specifications for inclusion in HEDIS rate reporting. Sources of supplemental data used by the Michigan MHPs included the MCIR State immunization registry, MDCH lead screening registry, MDCH Medicaid member history database, and laboratory and pharmacy data feeds. All of the MHPs were fully compliant with this standard and followed all NCQA requirements for including supplemental data in HEDIS reporting. The auditors recommended that some of the MHPs consider the use of more supplemental data sources to enhance administrative data completeness and minimize the burden of medical record review.

IS 6.0 Member Call Center Data—Capture, Transfer, and Entry was not applicable to the measures the Michigan Medicaid health plans were required report. This standard assesses the processes in place for monitoring member call center data used to report the *Call Abandonment* and *Call Answer Timeliness* measures.

All 14 MHPs were fully compliant with *IS 7.0 Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity*. The use of certified software greatly

ensures full compliance with this standard in that for a software vendor to receive full certification status it must be audited and approved by NCQA. A review of this standard ensures that physical security, data access authorization, and disaster recovery facilities and fire protection procedures were in place. There were no issues found during these reviews, and all MHPs were fully capable of reporting the required Medicaid measures for HEDIS 2009.

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 2007, 2008, and 2009 Michigan Medicaid weighted averages; and the national HEDIS 2008 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—*Lead Screening in Children*
- ◆ Table A-3—*Well-Child Visits in the First 15 Months of Life*
- ◆ Table A-4—*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life and Adolescent Well-Care Visits*
- ◆ Table A-5—*Appropriate Treatment for Children With Upper Respiratory Infection*
- ◆ Table A-6—*Appropriate Testing for Children With Pharyngitis*
- ◆ Table A-7—*Cancer Screening in Women*
- ◆ Table A-8—*Chlamydia Screening in Women*
- ◆ Table A-9—*Prenatal and Postpartum Care*
- ◆ Table A-10—*Comprehensive Diabetes Care*
- ◆ Table A-11—*Use of Appropriate Medications for People With Asthma*
- ◆ Table A-12—*Controlling High Blood Pressure*
- ◆ Table A-13—*Medical Assistance With Smoking Cessation—Numerator 1 and Numerator 3*
- ◆ Table A-14—*Children’s and Adolescents’ Access to Primary Care Practitioners*
- ◆ Table A-15—*Adults’ Access to Preventive/Ambulatory Health Services*

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	612	86.9%	82.2%
4265	CareSource of Michigan	CSM	1,215	80.0%	74.7%
4133	Great Lakes Health Plan, Inc.	GLH	5,140	81.1%	75.3%
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	1,838	83.5%	77.4%
4131	Midwest Health Plan	MID	1,887	76.2%	71.0%
4151	Molina Healthcare of Michigan	MOL	6,548	76.6%	69.3%
4055	OmniCare Health Plan, Inc.	OCH	1,228	83.3%	64.6%
4282	PHP-MM Family Care	PMD	466	81.1%	74.4%
4054	Priority Health Government Programs, Inc.	PRI	1,908	85.0%	80.2%
9106	ProCare	PRO	0	NA	NA
4268	Total Health Care	THC	1,350	85.3%	74.5%
4348	Upper Peninsula Health Plan	UPP	838	81.2%	73.8%
	2009 Michigan Medicaid Weighted Average		--	81.8%	74.7%
	2008 Michigan Medicaid Weighted Average		--	81.9%	73.4%
	2007 Michigan Medicaid Weighted Average		--	80.2%	62.3%
	National HEDIS 2008 Medicaid 50th Percentile		--	75.4%	68.6%

Note: The 2007 and 2008 Michigan Medicaid weighted averages included 13 health plans, and the 2009 Michigan Medicaid weighted average included 14 health plans.

Table A-2—Tabular Results for Key Measures by Health Plan: Lead Screening in Children				
IDSS	Plan Name	Code	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	617	59.8%
4265	CareSource of Michigan	CSM	1,214	76.4%
4133	Great Lakes Health Plan, Inc.	GLH	5,139	73.2%
4291	Health Plan of Michigan, Inc.	HPM	5,157	81.9%
4056	HealthPlus Partners, Inc.	HPP	2,054	78.4%
4312	McLaren Health Plan	MCL	1,838	77.6%
4131	Midwest Health Plan	MID	1,887	76.9%
4151	Molina Healthcare of Michigan	MOL	6,548	72.4%
4055	OmniCare Health Plan, Inc.	OCH	1,228	78.9%
4282	PHP-MM Family Care	PMD	526	85.0%
4054	Priority Health Government Programs, Inc.	PRI	1,908	78.3%
9106	ProCare	PRO	0	NA
4268	Total Health Care	THC	1,337	73.3%
4348	Upper Peninsula Health Plan	UPP	791	86.4%
	2009 Michigan Medicaid Weighted Average		--	76.3%
	2008 Michigan Medicaid Weighted Average		--	71.5%
	2007 Michigan Medicaid Weighted Average		--	--
	National HEDIS 2008 Medicaid 50th Percentile		--	65.9%

Note: The 2008 Michigan Medicaid weighted average included 13 health plans, and the 2009 Michigan Medicaid weighted average included 14 health plans.

Table A-3—Tabular Results for Key Measures by Health Plan: Well-Child Visits in the First 15 Months of Life					
IDSS	Plan Name	Code	Eligible Population	0 Visits Rate	6 or More Visits Rate
7836	BlueCaid of Michigan	BCD	399	1.5%	60.4%
4265	CareSource of Michigan	CSM	988	1.0%	49.6%
4133	Great Lakes Health Plan, Inc.	GLH	3,983	1.0%	87.6%
4291	Health Plan of Michigan, Inc.	HPM	3,181	1.1%	72.6%
4056	HealthPlus Partners, Inc.	HPP	1,725	1.0%	64.3%
4312	McLaren Health Plan	MCL	1,451	0.5%	62.3%
4131	Midwest Health Plan	MID	1,410	0.7%	64.7%
4151	Molina Healthcare of Michigan	MOL	4,464	2.5%	52.3%
4055	OmniCare Health Plan, Inc.	OCH	940	1.2%	59.3%
4282	PHP-MM Family Care	PMD	402	1.5%	63.2%
4054	Priority Health Government Programs, Inc.	PRI	1,679	1.0%	69.8%
9106	ProCare	PRO	0	NA	NA
4268	Total Health Care	THC	995	1.4%	66.4%
4348	Upper Peninsula Health Plan	UPP	786	1.4%	60.9%
	2009 Michigan Medicaid Weighted Average		--	1.3%	66.6%
	2008 Michigan Medicaid Weighted Average		--	1.4%	61.6%
	2007 Michigan Medicaid Weighted Average		--	1.5%	59.3%
	National HEDIS 2008 Medicaid 50th Percentile		--	1.9%	57.5%

Note: The 2007 and 2008 Michigan Medicaid weighted averages included 13 health plans, and the 2009 Michigan Medicaid weighted average included 14 health plans.

Table A-4—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	2,230	71.8%	3,174	52.6%
4265	CareSource of Michigan	CSM	5,106	57.5%	9,546	45.5%
4133	Great Lakes Health Plan, Inc.	GLH	19,007	76.4%	29,694	62.3%
4291	Health Plan of Michigan, Inc.	HPM	17,282	78.0%	22,234	57.8%
4056	HealthPlus Partners, Inc.	HPP	7,645	64.2%	11,756	48.4%
4312	McLaren Health Plan	MCL	7,150	77.4%	10,260	53.3%
4131	Midwest Health Plan	MID	7,302	75.7%	11,850	62.3%
4151	Molina Healthcare of Michigan	MOL	24,654	75.1%	42,659	51.9%
4055	OmniCare Health Plan, Inc.	OCH	5,469	75.5%	12,292	52.5%
4282	PHP-MM Family Care	PMD	1,860	64.0%	2,865	46.2%
4054	Priority Health Government Programs, Inc.	PRI	6,762	71.9%	8,335	50.9%
9106	ProCare	PRO	0	NA	30	20.0%
4268	Total Health Care	THC	5,595	74.3%	11,480	56.2%
4348	Upper Peninsula Health Plan	UPP	2,888	60.4%	4,519	33.9%
	2009 Michigan Medicaid Weighted Average		--	73.6%	--	54.3%
	2008 Michigan Medicaid Weighted Average		--	69.5%	--	52.0%
	2007 Michigan Medicaid Weighted Average		--	66.1%	--	47.7%
	National HEDIS 2008 Medicaid 50th Percentile		--	68.2%	--	42.1%

Note: The 2007 and 2008 Michigan Medicaid weighted averages included 13 health plans, and the 2009 Michigan Medicaid weighted average included 14 health plans.

Table A-5—Tabular Results for Key Measures by Health Plan: Appropriate Treatment for Children With Upper Respiratory Infection				
IDSS	Plan Name	Code	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	964	94.1%
4265	CareSource of Michigan	CSM	2,482	79.0%
4133	Great Lakes Health Plan, Inc.	GLH	11,157	82.2%
4291	Health Plan of Michigan, Inc.	HPM	9,255	81.0%
4056	HealthPlus Partners, Inc.	HPP	4,028	78.6%
4312	McLaren Health Plan	MCL	4,276	71.2%
4131	Midwest Health Plan	MID	4,668	82.3%
4151	Molina Healthcare of Michigan	MOL	12,240	80.9%
4055	OmniCare Health Plan, Inc.	OCH	1,861	82.5%
4282	PHP-MM Family Care	PMD	1,072	88.9%
4054	Priority Health Government Programs, Inc.	PRI	2,711	91.5%
9106	ProCare	PRO	0	NA
4268	Total Health Care	THC	152	59.2%
4348	Upper Peninsula Health Plan	UPP	1,578	81.1%
	2009 Michigan Medicaid Weighted Average		--	81.2%
	2008 Michigan Medicaid Weighted Average		--	79.3%
	2007 Michigan Medicaid Weighted Average		--	77.1%
	National HEDIS 2008 Medicaid 50th Percentile		--	84.3%

Note: The 2007 and 2008 Michigan Medicaid weighted averages included 13 health plans, and the 2009 Michigan Medicaid weighted average included 14 health plans.

Table A-6—Tabular Results for Key Measures by Health Plan: Appropriate Testing for Children With Pharyngitis				
IDSS	Plan Name	Code	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	433	83.6%
4265	CareSource of Michigan	CSM	1,735	52.3%
4133	Great Lakes Health Plan, Inc.	GLH	5,973	39.3%
4291	Health Plan of Michigan, Inc.	HPM	5,353	62.6%
4056	HealthPlus Partners, Inc.	HPP	2,713	46.3%
4312	McLaren Health Plan	MCL	2,311	52.1%
4131	Midwest Health Plan	MID	3,539	21.6%
4151	Molina Healthcare of Michigan	MOL	6,857	46.6%
4055	OmniCare Health Plan, Inc.	OCH	929	32.2%
4282	PHP-MM Family Care	PMD	492	60.2%
4054	Priority Health Government Programs, Inc.	PRI	1,212	70.8%
9106	ProCare	PRO	0	NA
4268	Total Health Care	THC	1,507	55.9%
4348	Upper Peninsula Health Plan	UPP	1,077	66.4%
	2009 Michigan Medicaid Weighted Average		--	48.0%
	2008 Michigan Medicaid Weighted Average		--	47.7%
	2007 Michigan Medicaid Weighted Average		--	45.0%
	National HEDIS 2008 Medicaid 50th Percentile		--	62.5%

Note: The 2007 and 2008 Michigan Medicaid weighted averages included 13 health plans, and the 2009 Michigan Medicaid weighted average included 14 health plans.

Table A-7—Tabular Results for Key Measures by Health Plan: <i>Cancer Screening in Women</i>						
			Breast Cancer Screening		Cervical Cancer Screening	
IDSS	Plan Name	Code	Eligible Population	Rate	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	547	60.9%	1,834	71.9%
4265	CareSource of Michigan	CSM	1,968	49.4%	5,985	65.8%
4133	Great Lakes Health Plan, Inc.	GLH	6,442	56.0%	20,620	75.0%
4291	Health Plan of Michigan, Inc.	HPM	3,459	63.0%	14,624	81.3%
4056	HealthPlus Partners, Inc.	HPP	2,366	54.5%	8,124	70.6%
4312	McLaren Health Plan	MCL	2,024	50.7%	7,400	70.3%
4131	Midwest Health Plan	MID	2,719	52.3%	7,784	73.5%
4151	Molina Healthcare of Michigan	MOL	8,912	51.2%	26,433	69.2%
4055	OmniCare Health Plan, Inc.	OCH	2,704	49.4%	8,254	67.5%
4282	PHP-MM Family Care	PMD	664	48.9%	1,985	71.2%
4054	Priority Health Government Programs, Inc.	PRI	1,244	55.8%	4,996	77.8%
9106	ProCare	PRO	0	NA	7	NA
4268	Total Health Care	THC	2,313	48.3%	7,243	68.6%
4348	Upper Peninsula Health Plan	UPP	949	57.9%	2,921	75.9%
	2009 Michigan Medicaid Weighted Average		--	53.5%	--	72.4%
	2008 Michigan Medicaid Weighted Average		--	52.6%	--	68.5%
	2007 Michigan Medicaid Weighted Average		--	51.2%	--	67.1%
	National HEDIS 2008 Medicaid 50th Percentile		--	50.1%	--	67.0%

Note: The 2007 and 2008 Michigan Medicaid weighted averages included 13 health plans, and the 2009 Michigan Medicaid weighted average included 14 health plans.

**Table A-8—Tabular Results for Key Measures by Health Plan:
*Chlamydia Screening in Women***

IDSS	Plan Name	Code	16 to 20 Years		21 to 24 Years		Combined Rate	
			Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	409	47.4%	157	61.1%	566	51.2%
4265	CareSource of Michigan	CSM	1,301	52.2%	547	64.0%	1,848	55.7%
4133	Great Lakes Health Plan, Inc.	GLH	3,798	57.7%	2,057	67.6%	5,855	61.2%
4291	Health Plan of Michigan, Inc.	HPM	2,973	57.1%	1,940	65.2%	4,913	60.3%
4056	HealthPlus Partners, Inc.	HPP	1,698	53.5%	953	63.7%	2,651	57.1%
4312	McLaren Health Plan	MCL	1,295	50.6%	828	55.8%	2,123	52.6%
4131	Midwest Health Plan	MID	1,271	59.3%	575	67.3%	1,846	61.8%
4151	Molina Healthcare of Michigan	MOL	5,327	60.9%	2,531	68.0%	7,858	63.2%
4055	OmniCare Health Plan, Inc.	OCH	1,887	68.8%	811	75.0%	2,698	70.6%
4282	PHP-MM Family Care	PMD	321	63.6%	183	76.5%	504	68.3%
4054	Priority Health Government Programs, Inc.	PRI	1,033	67.5%	721	74.1%	1,754	70.2%
9106	ProCare	PRO	2	NA	1	NA	3	NA
4268	Total Health Care	THC	1,534	63.2%	786	74.0%	2,320	66.9%
4348	Upper Peninsula Health Plan	UPP	642	44.5%	366	51.6%	1,008	47.1%
	2009 Michigan Medicaid Weighted Average		--	58.7%	--	66.9%	--	61.5%
	2008 Michigan Medicaid Weighted Average		--	53.2%	--	61.5%	--	56.4%
	2007 Michigan Medicaid Weighted Average		--	53.3%	--	61.0%	--	56.6%
	National HEDIS 2008 Medicaid 50th Percentile		--	48.8%	--	56.4%	--	51.9%

Note: The 2007 and 2008 Michigan Medicaid weighted averages included 13 health plans, and the 2009 Medicaid weighted average included 14 health plans.

For the *Chlamydia Screening in Women* measure, the upper age limit decreased from 25 to 24 years of age for the HEDIS 2009 rate. Please use caution when comparing plans' rates and the 2009 Michigan Medicaid weighted average with the 2008 or 2007 Michigan Medicaid weighted average or the national HEDIS 2008 Medicaid 50th percentile.

Table A-9—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	88.9%	281	66.1%
4265	CareSource of Michigan	CSM	824	80.0%	824	63.7%
4133	Great Lakes Health Plan, Inc.	GLH	3,293	90.4%	3,293	68.9%
4291	Health Plan of Michigan, Inc.	HPM	3,055	89.6%	3,055	75.5%
4056	HealthPlus Partners, Inc.	HPP	1,498	89.1%	1,498	67.2%
4312	McLaren Health Plan	MCL	1,271	92.2%	1,271	83.0%
4131	Midwest Health Plan	MID	1,088	89.5%	1,088	63.7%
4151	Molina Healthcare of Michigan	MOL	3,894	79.4%	3,894	61.3%
4055	OmniCare Health Plan, Inc.	OCH	1,049	85.6%	1,049	64.1%
4282	PHP-MM Family Care	PMD	373	83.5%	373	67.0%
4054	Priority Health Government Programs, Inc.	PRI	1,196	88.3%	1,196	73.2%
9106	ProCare	PRO	4	NA	4	NA
4268	Total Health Care	THC	965	84.2%	965	61.5%
4348	Upper Peninsula Health Plan	UPP	978	93.2%	978	73.2%
	2009 Michigan Medicaid Weighted Average		--	86.9%	--	68.5%
	2008 Michigan Medicaid Weighted Average		--	84.5%	--	63.0%
	2007 Michigan Medicaid Weighted Average		--	83.2%	--	61.6%
	National HEDIS 2008 Medicaid 50th Percentile		--	84.1%	--	60.8%

Note: The 2007 and 2008 Michigan Medicaid weighted averages included 13 health plans, and the 2009 Michigan Medicaid weighted average included 14 health plans.

**Table A-10—Tabular Results for Key Measures by Health Plan:
Comprehensive Diabetes Care**

IDSS	Plan Name	Code	HbA1C Testing		Poor HbA1C Control		Eye Exam		LDL-C Screening	
			Eligible Population	Rate						
7836	BlueCaid of Michigan	BCD	277	92.7%	277	27.6%	277	68.2%	277	85.1%
4265	CareSource of Michigan	CSM	1,478	86.9%	1,478	29.0%	1,478	49.3%	1,478	74.8%
4133	Great Lakes Health Plan, Inc.	GLH	4,666	80.3%	4,666	38.0%	4,666	61.3%	4,666	78.3%
4291	Health Plan of Michigan, Inc.	HPM	2,807	89.3%	2,807	24.8%	2,807	73.1%	2,807	82.6%
4056	HealthPlus Partners, Inc.	HPP	1,474	86.5%	1,474	32.5%	1,404	74.5%	1,474	75.4%
4312	McLaren Health Plan	MCL	1,374	87.1%	1,374	38.1%	1,374	71.5%	1,374	80.6%
4131	Midwest Health Plan	MID	1,848	80.5%	1,848	61.3%	1,848	60.2%	1,848	81.0%
4151	Molina Healthcare of Michigan	MOL	5,254	87.3%	5,254	41.4%	5,254	53.5%	5,254	79.3%
4055	OmniCare Health Plan, Inc.	OCH	1,519	82.7%	1,519	47.2%	1,519	47.4%	1,519	81.2%
4282	PHP-MM Family Care	PMD	406	86.2%	406	30.4%	406	70.9%	406	78.8%
4054	Priority Health Government Programs, Inc.	PRI	919	87.4%	919	27.9%	919	69.3%	919	80.5%
9106	ProCare	PRO	0	NA	0	NA	0	NA	0	NA
4268	Total Health Care	THC	1,413	80.4%	1,413	48.1%	1,413	57.1%	1,413	74.3%
4348	Upper Peninsula Health Plan	UPP	529	89.0%	529	25.2%	529	66.9%	529	82.4%
	2009 Michigan Medicaid Weighted Average		--	85.0%	--	38.3%	--	61.1%	--	79.2%
	2008 Michigan Medicaid Weighted Average		--	84.6%	--	38.4%	--	58.8%	--	76.8%
	2007 Michigan Medicaid Weighted Average		--	79.8%	--	43.7%	--	57.5%	--	75.1%
	National HEDIS 2008 Medicaid 50th Percentile		--	79.6%	--	46.0%	--	53.8%	--	73.2%

Note: The 2007 and 2008 Michigan Medicaid weighted averages included 13 health plans, and the 2009 Michigan Medicaid weighted average included 14 health plans.

**Table A-10—Tabular Results for Key Measures by Health Plan:
Comprehensive Diabetes Care (continued)**

IDSS	Plan Name	Code	LDL-C Level <100		Monitoring Nephropathy		Blood Pressure Control <130/80		Blood Pressure Control <140/90	
			Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	277	47.5%	277	87.4%	277	42.9%	277	73.6%
4265	CareSource of Michigan	CSM	1,478	37.6%	1,478	81.2%	1,478	28.6%	1,478	66.1%
4133	Great Lakes Health Plan, Inc.	GLH	4,666	33.6%	4,666	80.5%	4,666	27.5%	4,666	61.1%
4291	Health Plan of Michigan, Inc.	HPM	2,807	43.0%	2,807	86.9%	2,807	33.9%	2,807	69.1%
4056	HealthPlus Partners, Inc.	HPP	1,474	38.0%	1,474	87.0%	1,404	31.9%	1,404	64.5%
4312	McLaren Health Plan	MCL	1,374	37.4%	1,374	88.2%	1,374	34.3%	1,374	66.2%
4131	Midwest Health Plan	MID	1,848	31.6%	1,848	85.4%	1,848	27.2%	1,848	50.2%
4151	Molina Healthcare of Michigan	MOL	5,254	53.8%	5,254	78.8%	5,254	26.0%	5,254	53.3%
4055	OmniCare Health Plan, Inc.	OCH	1,519	34.5%	1,519	84.9%	1,519	27.5%	1,519	56.0%
4282	PHP-MM Family Care	PMD	406	44.7%	406	84.9%	406	39.7%	406	66.4%
4054	Priority Health Government Programs, Inc.	PRI	919	41.2%	919	81.4%	919	40.7%	919	69.3%
9106	ProCare	PRO	0	NA	0	NA	0	NA	0	NA
4268	Total Health Care	THC	1,413	37.7%	1,413	79.4%	1,413	24.3%	1,413	55.3%
4348	Upper Peninsula Health Plan	UPP	529	40.6%	529	79.1%	529	39.4%	529	73.5%
	2009 Michigan Medicaid Weighted Average		--	40.8%	--	82.5%	--	29.6%	--	60.4%
	2008 Michigan Medicaid Weighted Average		--	40.0%	--	80.7%	--	28.6%	--	58.4%
	2007 Michigan Medicaid Weighted Average		--	36.7%	--	79.8%	--	29.4%	--	57.1%
	National HEDIS 2008 Medicaid 50th Percentile		--	33.1%	--	76.1%	--	29.7%	--	58.2%

Note: The 2007 and 2008 Michigan Medicaid weighted averages included 13 health plans, and the 2009 Michigan Medicaid weighted average included 14 health plans.

**Table A-11—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	113	94.7%	155	94.2%	158	85.4%	426	91.1%
4265	CareSource of Michigan	CSM	161	94.4%	248	86.7%	530	84.0%	939	86.5%
4133	Great Lakes Health Plan, Inc.	GLH	403	89.1%	485	80.8%	1,222	83.3%	2,110	83.8%
4291	Health Plan of Michigan, Inc.	HPM	388	95.9%	477	92.2%	857	89.4%	1,722	91.6%
4056	HealthPlus Partners, Inc.	HPP	255	96.1%	358	92.5%	503	91.5%	1,116	92.8%
4312	McLaren Health Plan	MCL	233	94.0%	309	90.3%	491	86.2%	1,033	89.2%
4131	Midwest Health Plan	MID	197	84.3%	208	80.3%	434	83.2%	839	82.7%
4151	Molina Healthcare of Michigan	MOL	719	88.0%	822	81.3%	1,719	85.8%	3,260	85.2%
4055	OmniCare Health Plan, Inc.	OCH	256	80.5%	369	81.3%	659	85.4%	1,284	83.3%
4282	PHP-MM Family Care	PMD	93	96.8%	117	94.0%	132	90.2%	342	93.3%
4054	Priority Health Government Programs, Inc.	PRI	207	97.6%	258	96.5%	276	89.9%	741	94.3%
9106	ProCare	PRO	0	NA	0	NA	0	NA	0	NA
4268	Total Health Care	THC	187	80.7%	266	77.1%	466	83.3%	919	81.0%
4348	Upper Peninsula Health Plan	UPP	76	90.8%	125	86.4%	182	83.0%	383	85.6%
	2009 Michigan Medicaid Weighted Average		--	90.4%	--	86.0%	--	85.9%	--	86.9%
	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%
	National HEDIS 2008 Medicaid 50th Percentile		--	91.8%	--	89.5%	--	85.8%	--	88.7%

Note: The 2007 and 2008 Michigan Medicaid weighted averages included 13 health plans, and the 2009 Michigan Medicaid weighted average included 14 health plans.

Table A-12—Tabular Results for Key Measures by Health Plan: Controlling High Blood Pressure				
IDSS	Plan Name	Code	Eligible Population	Rate
7836	BlueCaid of Michigan	BCD	395	68.5%
4265	CareSource of Michigan	CSM	1,672	58.8%
4133	Great Lakes Health Plan, Inc.	GLH	6,389	57.9%
4291	Health Plan of Michigan, Inc.	HPM	2,861	65.3%
4056	HealthPlus Partners, Inc.	HPP	1,771	56.0%
4312	McLaren Health Plan	MCL	1,529	67.6%
4131	Midwest Health Plan	MID	2,436	55.7%
4151	Molina Healthcare of Michigan	MOL	7,462	55.4%
4055	OmniCare Health Plan, Inc.	OCH	2,595	51.7%
4282	PHP-MM Family Care	PMD	449	57.5%
4054	Priority Health Government Programs, Inc.	PRI	1,082	57.5%
9106	ProCare	PRO	1	NA
4268	Total Health Care	THC	2,076	60.0%
4348	Upper Peninsula Health Plan	UPP	533	66.2%
	2009 Michigan Medicaid Weighted Average		--	58.1%
	2008 Michigan Medicaid Weighted Average		--	56.1%
	2007 Michigan Medicaid Weighted Average		--	51.9%
	National HEDIS 2008 Medicaid 50th Percentile		--	55.4%

Note: The 2007 and 2008 Michigan Medicaid weighted averages included 13 health plans, and the 2009 Michigan Medicaid weighted average included 14 health plans.

Table A-13—Tabular Results for Key Measures by Health Plan: Medical Assistance With Smoking Cessation				
IDSS	Plan Name	Code	Advising Smokers to Quit Rate	Smoking Cessation Strategies Rate
7836	BlueCaid of Michigan	BCD	74.9%	54.0%
4265	CareSource of Michigan	CSM	74.8%	42.7%
4133	Great Lakes Health Plan, Inc.	GLH	73.0%	47.2%
4291	Health Plan of Michigan, Inc.	HPM	72.3%	45.9%
4056	HealthPlus Partners, Inc.	HPP	73.2%	38.4%
4312	McLaren Health Plan	MCL	69.1%	43.1%
4131	Midwest Health Plan	MID	71.7%	39.7%
4151	Molina Healthcare of Michigan	MOL	73.5%	39.5%
4055	OmniCare Health Plan, Inc.	OCH	71.5%	34.5%
4282	PHP-MM Family Care	PMD	74.0%	50.3%
4054	Priority Health Government Programs, Inc.	PRI	77.3%	44.4%
9106	ProCare	PRO	NA	NA
4268	Total Health Care	THC	70.2%	39.8%
4348	Upper Peninsula Health Plan	UPP	72.6%	42.3%
	2009 Michigan Medicaid Average		72.9%	43.2%
	2008 Michigan Medicaid Average		72.8%	41.1%
	2007 Michigan Medicaid Average		72.1%	38.1%

Note: The 2007 and 2008 Michigan Medicaid averages included 13 health plans, and the 2009 Michigan Medicaid average included 14 health plans.

The 2007, 2008, and 2009 Michigan Medicaid averages were not weighted.

**Table A-14—Tabular Results for Key Measures by Health Plan:
Children’s 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	666	98.2%	2,781	89.6%	1,860	90.2%	2,222	90.5%
4265	CareSource of Michigan	CSM	1,486	95.0%	6,230	82.6%	5,330	84.0%	6,941	83.2%
4133	Great Lakes Health Plan, Inc.	GLH	6,117	97.8%	23,879	89.8%	14,892	89.2%	19,529	88.0%
4291	Health Plan of Michigan, Inc.	HPM	5,578	96.8%	22,091	89.9%	11,685	90.8%	13,289	90.8%
4056	HealthPlus Partners, Inc.	HPP	2,323	95.6%	9,418	85.5%	7,122	86.4%	8,805	84.6%
4312	McLaren Health Plan	MCL	2,163	95.3%	8,901	82.8%	5,442	81.3%	6,987	79.7%
4131	Midwest Health Plan	MID	2,100	94.0%	9,027	86.5%	6,040	85.6%	8,277	83.0%
4151	Molina Healthcare of Michigan	MOL	6,705	96.3%	30,568	87.0%	22,422	85.8%	30,795	83.1%
4055	OmniCare Health Plan, Inc.	OCH	1,301	91.2%	6,632	77.2%	5,920	78.2%	9,266	76.6%
4282	PHP-MM Family Care	PMD	596	94.1%	2,322	83.8%	1,658	83.5%	2,076	84.6%
4054	Priority Health Government Programs, Inc.	PRI	2,044	97.8%	8,505	85.4%	5,328	87.7%	5,609	85.8%
9106	ProCare	PRO	0	NA	0	NA	0	NA	0	NA
4268	Total Health Care	THC	1,478	95.9%	6,842	86.5%	5,571	82.4%	8,172	83.7%
4348	Upper Peninsula Health Plan	UPP	937	97.7%	3,661	87.8%	2,679	88.3%	3,285	89.3%
	2009 Michigan Medicaid Weighted Average		--	96.3%	--	86.8%	--	86.2%	--	84.6%
	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%
	National HEDIS 2008 Medicaid 50th Percentile		--	95.8%	--	86.5%	--	87.8%	--	84.5%

Note: The 2007 and 2008 Michigan Medicaid weighted averages included 13 health plans, and the 2009 Michigan Medicaid weighted average included 14 health plans.

Table A-15—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	1,978	83.0%	823	88.3%
4265	CareSource of Michigan	CSM	6,354	82.0%	3,448	87.5%
4133	Great Lakes Health Plan, Inc.	GLH	21,200	82.9%	11,604	89.9%
4291	Health Plan of Michigan, Inc.	HPM	17,081	85.6%	6,534	91.1%
4056	HealthPlus Partners, Inc.	HPP	9,068	82.9%	3,585	89.5%
4312	McLaren Health Plan	MCL	8,431	82.8%	3,466	87.6%
4131	Midwest Health Plan	MID	7,722	81.3%	4,884	87.9%
4151	Molina Healthcare of Michigan	MOL	27,711	80.5%	14,348	85.8%
4055	OmniCare Health Plan, Inc.	OCH	8,400	77.3%	4,290	84.5%
4282	PHP-MM Family Care	PMD	2,058	81.0%	1,030	87.2%
4054	Priority Health Government Programs, Inc.	PRI	5,754	85.1%	1,967	90.0%
9106	ProCare	PRO	13	NA	3	NA
4268	Total Health Care	THC	7,512	77.8%	3,883	83.1%
4348	Upper Peninsula Health Plan	UPP	3,293	89.2%	1,583	90.1%
	2009 Michigan Medicaid Weighted Average		--	82.2%	--	87.8%
	2008 Michigan Medicaid Weighted Average		--	81.1%	--	86.8%
	2007 Michigan Medicaid Weighted Average		--	80.2%	--	86.3%
	National HEDIS 2008 Medicaid 50th Percentile		--	79.6%	--	85.7%

Note: The 2007 and 2008 Michigan Medicaid weighted averages included 13 health plans, and the 2009 Michigan Medicaid weighted average included 14 health plans.

Appendix B. National HEDIS 2008 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 2008 Medicaid Percentiles—Pediatric Care

Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
<i>Childhood Immunization Status—Combination 2</i>	57.2	67.6	75.4	80.0	84.7
<i>Childhood Immunization Status—Combination 3</i>	50.1	59.9	68.6	74.3	78.2
<i>Lead Screening in Children</i>	32.3	49.3	65.9	76.5	84.0
<i>Well-Child Visits in the First 15 Months—Zero Visits*</i>	0.6	1.0	1.9	3.1	6.8
<i>Well-Child Visits in the First 15 Months—Six or More Visits</i>	29.0	44.5	57.5	65.4	73.7
<i>Well-Child in the Third, Fourth, Fifth, and Sixth Years of Life</i>	52.3	59.8	68.2	74.0	78.9
<i>Adolescent Well-Care Visits</i>	27.2	35.9	42.1	51.4	56.7
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	75.5	79.6	84.3	90.5	94.1
<i>Appropriate Testing for Children With Pharyngitis</i>	30.1	47.9	62.5	71.7	77.3

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

Table B-2—National HEDIS 2008 Medicaid Percentiles—Women’s Care					
Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
<i>Breast Cancer Screening—Combined Rate</i>	38.8	44.4	50.1	56.4	61.2
<i>Cervical Cancer Screening</i>	50.5	56.5	67.0	72.4	77.5
<i>Chlamydia Screening in Women—16–20 Years</i>	32.7	41.1	48.8	57.2	65.3
<i>Chlamydia Screening in Women—21–25 Years</i>	33.4	47.9	56.4	64.7	69.6
<i>Chlamydia Screening in Women—Combined Rate</i>	32.6	43.7	51.9	59.7	67.0
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	68.4	76.6	84.1	88.6	91.4
<i>Prenatal and Postpartum Care—Postpartum Care</i>	47.0	54.0	60.8	65.8	70.6

Table B-3—National HEDIS 2008 Medicaid Percentiles—Living With Illness

Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	65.7	74.2	79.6	85.6	88.8
<i>Comprehensive Diabetes Care—Poor HbA1c Control*</i>	32.4	37.7	46.0	52.5	69.8
<i>Comprehensive Diabetes Care—Eye Exam</i>	24.2	39.7	53.8	62.5	67.6
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	58.6	66.7	73.2	78.6	81.8
<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	16.5	25.1	33.1	37.9	42.6
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	59.7	67.9	76.1	80.5	85.4
<i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i>	16.3	25.8	29.7	36.5	41.2
<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	37.0	49.6	58.2	65.7	71.3
<i>Use of Appropriate Medications for People With Asthma—5–9 Years</i>	82.8	88.7	91.8	94.5	96.1
<i>Use of Appropriate Medications for People With Asthma—10–17 Years</i>	81.0	86.1	89.5	91.5	93.3
<i>Use of Appropriate Medications for People With Asthma—18–56 Years</i>	77.6	81.4	85.8	88.9	90.7
<i>Use of Appropriate Medications for People With Asthma—Combined Rate</i>	80.4	86.1	88.7	90.6	91.9
<i>Controlling High Blood Pressure (Total)</i>	39.0	47.2	55.4	61.6	65.0

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

Table B-4—National HEDIS 2008 Medicaid Percentiles—Access to Care					
Measure	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
<i>Children’s and Adolescents’ Access to Primary Care Practitioners—12–24 Months</i>	87.7	93.2	95.8	97.4	98.4
<i>Children’s and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years</i>	74.2	82.3	86.5	89.4	92.0
<i>Children’s and Adolescents’ Access to Primary Care Practitioners—7–11 Years</i>	75.5	82.2	87.8	91.2	94.1
<i>Children’s and Adolescents’ Access to Primary Care Practitioners—12–19 Years</i>	70.6	78.1	84.5	90.0	91.9
<i>Adults’ Access to Preventive/Ambulatory Services—20–44 Years</i>	60.7	71.6	79.6	84.8	87.6
<i>Adults’ Access to Preventive/Ambulatory Services—45–64 Years</i>	71.2	79.3	85.7	88.3	90.2

Appendix C includes trend tables for each of the MHPs. Where applicable, each measure's rate for 2007, 2008, and 2009 is presented along with a trend analysis that compares a measure's 2008 rate to its 2009 rate to assess whether there was any significant change in the rate.

Rates that were significantly higher in 2009 than in 2008 (improved by more than 10 percent) are noted with upward arrows (↑). Rates that were significantly lower in 2009 than in 2008 (decreased by more than 10 percent) are noted with downward arrows (↓). Rates in 2009 that were not significantly different than in 2008 (did not change more than 10 percent) are noted with parallel arrows (↔). For two measures, *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Comprehensive Diabetes Care—Poor HbA1c Control*, for which a lower rate indicates better performance, an upward triangle (▲) indicates performance improvement (a rate that decreased by more than 10 percent) and a downward triangle (▼) indicates a decline in performance (a rate that increased by more than 10 percent).

The MHP trend tables are presented as follows:

- ◆ Table C-1—BCD
- ◆ Table C-2—CSM
- ◆ 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—PRO
- ◆ Table C-13—THC
- ◆ Table C-14—UPP

Table C-1—Michigan Medicaid HEDIS 2009 Trend Table: BCD					
Dimension of Care	Measure	2007	2008	2009	2008–2009 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Status—Combo 2</i>	81.0%	80.0%	86.9%	↔↔
	<i>Childhood Immunization Status—Combo 3</i>	56.7%	77.3%	82.2%	↔↔
	<i>Lead Screening in Children</i>	--	59.6%	59.8%	↔↔
	<i>Well-Child Visits 1st 15 Mos—0 Visits</i>	0.5%	2.6%	1.5%	↔↔
	<i>Well-Child Visits 1st 15 Mos—6+ Visits</i>	64.4%	65.5%	60.4%	↔↔
	<i>Well-Child Visits 3rd-6th Years of Life</i>	67.4%	66.7%	71.8%	↔↔
	<i>Adolescent Well-Care Visits</i>	51.4%	48.2%	52.6%	↔↔
	<i>Appropriate Treatment of URI</i>	90.5%	91.4%	94.1%	↔↔
	<i>Children With Pharyngitis</i>	80.8%	82.7%	83.6%	↔↔
Women's Care	<i>Breast Cancer Screening</i>	44.3%	44.9%	60.9%	↑
	<i>Cervical Cancer Screening</i>	78.0%	72.2%	71.9%	↔↔
	<i>Chlamydia Screening—16–20 Years</i>	51.6%	48.2%	47.4%	↔↔
	<i>Chlamydia Screening—21–24 Years</i>	61.4%	60.2%	61.1%	↔↔
	<i>Chlamydia Screening—Combined</i>	55.8%	52.9%	51.2%	↔↔
	<i>Timeliness of Prenatal Care</i>	85.4%	74.5%	88.9%	↑
	<i>Postpartum Care</i>	66.0%	59.4%	66.1%	↔↔
Living With Illness	<i>Comprehensive Diabetes Car—HbA1c Testing</i>	89.1%	91.1%	92.7%	↔↔
	<i>Comprehensive Diabetes Care—Poor HbA1c Control</i>	34.0%	37.6%	27.6%	▲
	<i>Comprehensive Diabetes Care—Eye Exam</i>	62.5%	70.2%	68.2%	↔↔
	<i>Comprehensive Diabetes Care—LDL-C Screening</i>	80.9%	79.8%	85.1%	↔↔
	<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	45.7%	39.1%	47.5%	↔↔
	<i>Comprehensive Diabetes Care—Nephropathy</i>	84.8%	87.2%	87.4%	↔↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i>	42.6%	43.8%	42.9%	↔↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	75.0%	70.2%	73.6%	↔↔
	<i>Asthma—5–9 Years</i>	99.0%	96.5%	94.7%	↔↔
	<i>Asthma—10–17 Years</i>	91.2%	94.0%	94.2%	↔↔
	<i>Asthma—18–56 Years</i>	90.0%	89.2%	85.4%	↔↔
	<i>Asthma—Combined Rate</i>	93.0%	93.1%	91.1%	↔↔
	<i>Controlling High Blood Pressure</i>	66.2%	69.9%	68.5%	↔↔
	<i>Advising Smokers to Quit</i>	76.4%	77.4%	74.9%	↔↔
<i>Smoking Cessation Strategies</i>	47.9%	51.7%	54.0%	↔↔	
Access to Care	<i>Children's Access—12–24 Months</i>	97.3%	97.6%	98.2%	↔↔
	<i>Children's Access—25 Mos–6 Years</i>	89.5%	88.9%	89.6%	↔↔
	<i>Children's Access—7–11 Years</i>	89.8%	89.6%	90.2%	↔↔
	<i>Adolescents' Access—12–19 Years</i>	87.8%	90.2%	90.5%	↔↔
	<i>Adults' Access—20–44 Years</i>	83.9%	84.6%	83.0%	↔↔
	<i>Adults' Access—45–64 Years</i>	88.6%	87.1%	88.3%	↔↔

Table C-2—Michigan Medicaid HEDIS 2009 Trend Table: CSM					
Dimension of Care	Measure	2007	2008	2009	2008–2009 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Status—Combo 2</i>	74.9%	80.5%	80.0%	↔
	<i>Childhood Immunization Status—Combo 3</i>	62.5%	73.5%	74.7%	↔
	<i>Lead Screening in Children</i>	--	68.6%	76.4%	↔
	<i>Well-Child Visits 1st 15 Mos—0 Visits</i>	3.4%	3.4%	1.0%	↔
	<i>Well-Child Visits 1st 15 Mos—6+ Visits</i>	37.5%	49.6%	49.6%	↔
	<i>Well-Child Visits 3rd-6th Years of Life</i>	56.9%	54.3%	57.5%	↔
	<i>Adolescent Well-Care Visits</i>	31.1%	36.3%	45.5%	↔
	<i>Appropriate Treatment of URI</i>	79.4%	78.5%	79.0%	↔
	<i>Children With Pharyngitis</i>	54.5%	57.1%	52.3%	↔
Women's Care	<i>Breast Cancer Screening</i>	45.6%	49.1%	49.4%	↔
	<i>Cervical Cancer Screening</i>	65.6%	64.8%	65.8%	↔
	<i>Chlamydia Screening—16–20 Years</i>	46.8%	46.1%	52.2%	↔
	<i>Chlamydia Screening—21–24 Years</i>	56.5%	56.9%	64.0%	↔
	<i>Chlamydia Screening—Combined</i>	50.7%	50.0%	55.7%	↔
	<i>Timeliness of Prenatal Care</i>	81.3%	79.6%	80.0%	↔
	<i>Postpartum Care</i>	62.8%	63.3%	63.7%	↔
Living With Illness	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	83.7%	86.1%	86.9%	↔
	<i>Comprehensive Diabetes Care—Poor HbA1c Control</i>	43.1%	26.3%	29.0%	↔
	<i>Comprehensive Diabetes Care—Eye Exam</i>	43.8%	51.1%	49.3%	↔
	<i>Comprehensive Diabetes Care—LDL-C Screening</i>	66.9%	71.3%	74.8%	↔
	<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	29.2%	31.4%	37.6%	↔
	<i>Comprehensive Diabetes Care—Nephropathy</i>	76.6%	80.3%	81.2%	↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i>	33.8%	34.5%	28.6%	↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	65.5%	60.3%	66.1%	↔
	<i>Asthma—5–9 Years</i>	95.7%	94.2%	94.4%	↔
	<i>Asthma—10–17 Years</i>	91.8%	91.6%	86.7%	↔
	<i>Asthma—18–56 Years</i>	89.0%	88.5%	84.0%	↔
	<i>Asthma—Combined Rate</i>	91.0%	90.4%	86.5%	↔
	<i>Controlling High Blood Pressure</i>	58.6%	52.8%	58.8%	↔
	<i>Advising Smokers to Quit</i>	77.1%	76.9%	74.8%	↔
	<i>Smoking Cessation Strategies</i>	36.1%	42.9%	42.7%	↔
Access to Care	<i>Children's Access—12–24 Months</i>	93.2%	94.8%	95.0%	↔
	<i>Children's Access—25 Mos–6 Years</i>	80.0%	82.3%	82.6%	↔
	<i>Children's Access—7–11 Years</i>	81.6%	83.3%	84.0%	↔
	<i>Adolescents' Access—12–19 Years</i>	78.4%	81.5%	83.2%	↔
	<i>Adults' Access—20–44 Years</i>	78.5%	80.0%	82.0%	↔
	<i>Adults' Access—45–64 Years</i>	85.8%	86.6%	87.5%	↔

Table C-3—Michigan Medicaid HEDIS 2009 Trend Table: GLH					
Dimension of Care	Measure	2007	2008	2009	2008–2009 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Status—Combo 2</i>	77.6%	78.6%	81.1%	↔↔
	<i>Childhood Immunization Status—Combo 3</i>	63.3%	74.0%	75.3%	↔↔
	<i>Lead Screening in Children</i>	--	64.1%	73.2%	↔↔
	<i>Well-Child Visits 1st 15 Mos—0 Visits</i>	0.3%	0.7%	1.0%	↔↔
	<i>Well-Child Visits 1st 15 Mos—6+ Visits</i>	91.1%	85.7%	87.6%	↔↔
	<i>Well-Child Visits 3rd-6th Years of Life</i>	69.8%	78.0%	76.4%	↔↔
	<i>Adolescent Well-Care Visits</i>	58.8%	57.8%	62.3%	↔↔
	<i>Appropriate Treatment of URI</i>	74.6%	78.1%	82.2%	↔↔
	<i>Children With Pharyngitis</i>	41.5%	41.8%	39.3%	↔↔
Women's Care	<i>Breast Cancer Screening</i>	50.3%	52.9%	56.0%	↔↔
	<i>Cervical Cancer Screening</i>	64.6%	64.5%	75.0%	↑
	<i>Chlamydia Screening—16–20 Years</i>	49.8%	48.0%	57.7%	↔↔
	<i>Chlamydia Screening—21–24 Years</i>	57.5%	57.0%	67.6%	↑
	<i>Chlamydia Screening—Combined</i>	52.9%	51.5%	61.2%	↔↔
	<i>Timeliness of Prenatal Care</i>	78.3%	87.6%	90.4%	↔↔
	<i>Postpartum Care</i>	58.6%	60.3%	68.9%	↔↔
Living With Illness	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	77.1%	84.2%	80.3%	↔↔
	<i>Comprehensive Diabetes Care—Poor HbA1c Control</i>	50.6%	39.4%	38.0%	↔↔
	<i>Comprehensive Diabetes Care—Eye Exam</i>	53.3%	54.3%	61.3%	↔↔
	<i>Comprehensive Diabetes Care—LDL-C Screening</i>	76.9%	77.9%	78.3%	↔↔
	<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	30.9%	37.5%	33.6%	↔↔
	<i>Comprehensive Diabetes Care—Nephropathy</i>	77.9%	80.5%	80.5%	↔↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i>	25.1%	26.5%	27.5%	↔↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	52.1%	58.6%	61.1%	↔↔
	<i>Asthma—5–9 Years</i>	84.7%	85.7%	89.1%	↔↔
	<i>Asthma—10–17 Years</i>	80.8%	79.3%	80.8%	↔↔
	<i>Asthma—18–56 Years</i>	89.9%	85.5%	83.3%	↔↔
	<i>Asthma—Combined Rate</i>	86.8%	84.0%	83.8%	↔↔
	<i>Controlling High Blood Pressure</i>	50.6%	54.3%	57.9%	↔↔
	<i>Advising Smokers to Quit</i>	68.9%	71.1%	73.0%	↔↔
	<i>Smoking Cessation Strategies</i>	31.9%	42.4%	47.2%	↔↔
Access to Care	<i>Children's Access—12–24 Months</i>	97.6%	97.5%	97.8%	↔↔
	<i>Children's Access—25 Mos–6 Years</i>	86.5%	89.3%	89.8%	↔↔
	<i>Children's Access—7–11 Years</i>	84.7%	86.8%	89.2%	↔↔
	<i>Adolescents' Access—12–19 Years</i>	84.7%	86.3%	88.0%	↔↔
	<i>Adults' Access—20–44 Years</i>	80.6%	81.8%	82.9%	↔↔
	<i>Adults' Access—45–64 Years</i>	88.1%	89.1%	89.9%	↔↔

Table C-4—Michigan Medicaid HEDIS 2009 Trend Table: HPM

Dimension of Care	Measure	2007	2008	2009	2008–2009 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Status—Combo 2</i>	83.8%	88.7%	88.7%	Rotated Measure
	<i>Childhood Immunization Status—Combo 3</i>	71.5%	82.4%	82.4%	Rotated Measure
	<i>Lead Screening in Children</i>	--	77.5%	81.9%	↔↔
	<i>Well-Child Visits 1st 15 Mos—0 Visits</i>	0.9%	1.2%	1.1%	↔↔
	<i>Well-Child Visits 1st 15 Mos—6+ Visits</i>	69.9%	72.0%	72.6%	↔↔
	<i>Well-Child Visits 3rd-6th Years of Life</i>	65.3%	71.5%	78.0%	↔↔
	<i>Adolescent Well-Care Visits</i>	55.1%	55.8%	57.8%	↔↔
	<i>Appropriate Treatment of URI</i>	78.4%	79.7%	81.0%	↔↔
	<i>Children With Pharyngitis</i>	53.2%	58.9%	62.6%	↔↔
Women's Care	<i>Breast Cancer Screening</i>	58.7%	62.1%	63.0%	↔↔
	<i>Cervical Cancer Screening</i>	71.0%	70.9%	81.3%	↑
	<i>Chlamydia Screening—16–20 Years</i>	50.3%	50.3%	57.1%	↔↔
	<i>Chlamydia Screening—21–24 Years</i>	60.2%	58.5%	65.2%	↔↔
	<i>Chlamydia Screening—Combined</i>	54.8%	53.9%	60.3%	↔↔
	<i>Timeliness of Prenatal Care</i>	90.0%	90.0%	89.6%	↔↔
	<i>Postpartum Care</i>	67.0%	71.4%	75.5%	↔↔
Living With Illness	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	86.4%	89.2%	89.3%	↔↔
	<i>Comprehensive Diabetes Care—Poor HbA1c Control</i>	33.0%	29.4%	24.8%	↔↔
	<i>Comprehensive Diabetes Care—Eye Exam</i>	67.0%	68.9%	73.1%	↔↔
	<i>Comprehensive Diabetes Care—LDL-C Screening</i>	82.5%	82.7%	82.6%	↔↔
	<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	35.2%	38.1%	43.0%	↔↔
	<i>Comprehensive Diabetes Care—Nephropathy</i>	78.0%	82.9%	86.9%	↔↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i>	33.0%	30.6%	33.9%	↔↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	58.4%	67.5%	69.1%	↔↔
	<i>Asthma—5–9 Years</i>	98.2%	95.6%	95.9%	↔↔
	<i>Asthma—10–17 Years</i>	97.3%	90.4%	92.2%	↔↔
	<i>Asthma—18–56 Years</i>	94.5%	88.9%	89.4%	↔↔
	<i>Asthma—Combined Rate</i>	96.1%	90.8%	91.6%	↔↔
	<i>Controlling High Blood Pressure</i>	56.5%	57.8%	65.3%	↔↔
	<i>Advising Smokers to Quit</i>	75.4%	75.8%	72.3%	↔↔
	<i>Smoking Cessation Strategies</i>	40.0%	41.9%	45.9%	↔↔
Access to Care	<i>Children's Access—12–24 Months</i>	96.8%	97.0%	96.8%	↔↔
	<i>Children's Access—25 Mos–6 Years</i>	87.6%	89.0%	89.9%	↔↔
	<i>Children's Access—7–11 Years</i>	87.7%	89.3%	90.8%	↔↔
	<i>Adolescents' Access—12–19 Years</i>	87.9%	89.3%	90.8%	↔↔
	<i>Adults' Access—20–44 Years</i>	85.1%	85.4%	85.6%	↔↔
	<i>Adults' Access—45–64 Years</i>	90.6%	90.6%	91.1%	↔↔

Table C-5—Michigan Medicaid HEDIS 2009 Trend Table: HPP

Dimension of Care	Measure	2007	2008	2009	2008–2009 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Status—Combo 2</i>	85.2%	83.0%	83.0%	Rotated Measure
	<i>Childhood Immunization Status—Combo 3</i>	71.5%	74.3%	74.3%	Rotated Measure
	<i>Lead Screening in Children</i>	--	78.4%	78.4%	↔
	<i>Well-Child Visits 1st 15 Mos—0 Visits</i>	2.3%	1.0%	1.0%	Rotated Measure
	<i>Well-Child Visits 1st 15 Mos—6+ Visits</i>	61.8%	64.3%	64.3%	Rotated Measure
	<i>Well-Child Visits 3rd-6th Years of Life</i>	64.8%	64.2%	64.2%	Rotated Measure
	<i>Adolescent Well-Care Visits</i>	48.4%	48.4%	48.4%	Rotated Measure
	<i>Appropriate Treatment of URI</i>	72.1%	75.7%	78.6%	↔
	<i>Children With Pharyngitis</i>	40.9%	44.6%	46.3%	↔
Women's Care	<i>Breast Cancer Screening</i>	58.0%	56.4%	54.5%	↔
	<i>Cervical Cancer Screening</i>	77.1%	77.1%	70.6%	↔
	<i>Chlamydia Screening—16–20 Years</i>	52.7%	52.7%	53.5%	↔
	<i>Chlamydia Screening—21–24 Years</i>	61.2%	64.0%	63.7%	↔
	<i>Chlamydia Screening—Combined</i>	56.6%	57.5%	57.1%	↔
	<i>Timeliness of Prenatal Care</i>	91.8%	91.8%	89.1%	↔
	<i>Postpartum Care</i>	66.1%	67.1%	67.2%	↔
Living With Illness	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	86.6%	85.9%	86.5%	↔
	<i>Comprehensive Diabetes Care—Poor HbA1c Control</i>	32.8%	35.5%	32.5%	↔
	<i>Comprehensive Diabetes Care—Eye Exam</i>	74.0%	74.5%	74.5%	Rotated Measure
	<i>Comprehensive Diabetes Care—LDL-C Screening</i>	75.4%	75.2%	75.4%	↔
	<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	36.5%	39.2%	38.0%	↔
	<i>Comprehensive Diabetes Care—Nephropathy</i>	85.4%	82.7%	87.0%	↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i>	31.4%	31.9%	31.9%	Rotated Measure
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	61.6%	64.5%	64.5%	Rotated Measure
	<i>Asthma—5–9 Years</i>	93.8%	94.9%	96.1%	↔
	<i>Asthma—10–17 Years</i>	91.7%	92.0%	92.5%	↔
	<i>Asthma—18–56 Years</i>	88.6%	90.2%	91.5%	↔
	<i>Asthma—Combined Rate</i>	90.9%	91.9%	92.8%	↔
	<i>Controlling High Blood Pressure</i>	56.0%	56.0%	56.0%	↔
	<i>Advising Smokers to Quit</i>	70.9%	71.1%	73.2%	↔
<i>Smoking Cessation Strategies</i>	33.1%	36.8%	38.4%	↔	
Access to Care	<i>Children's Access—12–24 Months</i>	95.3%	96.5%	95.6%	↔
	<i>Children's Access—25 Mos–6 Years</i>	84.2%	85.9%	85.5%	↔
	<i>Children's Access—7–11 Years</i>	84.5%	86.1%	86.4%	↔
	<i>Adolescents' Access—12–19 Years</i>	82.2%	83.7%	84.6%	↔
	<i>Adults' Access—20–44 Years</i>	84.0%	83.7%	82.9%	↔
	<i>Adults' Access—45–64 Years</i>	90.0%	89.7%	89.5%	↔

Table C-6—Michigan Medicaid HEDIS 2009 Trend Table: MCL					
Dimension of Care	Measure	2007	2008	2009	2008–2009 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Status—Combo 2</i>	80.0%	84.7%	83.5%	↔
	<i>Childhood Immunization Status—Combo 3</i>	66.7%	70.8%	77.4%	↔
	<i>Lead Screening in Children</i>	--	65.0%	77.6%	↑
	<i>Well-Child Visits 1st 15 Mos—0 Visits</i>	1.2%	0.7%	0.5%	↔
	<i>Well-Child Visits 1st 15 Mos—6+ Visits</i>	62.8%	58.4%	62.3%	↔
	<i>Well-Child Visits 3rd-6th Years of Life</i>	69.8%	67.9%	77.4%	↔
	<i>Adolescent Well-Care Visits</i>	52.1%	48.7%	53.3%	↔
	<i>Appropriate Treatment of URI</i>	67.2%	68.9%	71.2%	↔
	<i>Children With Pharyngitis</i>	48.7%	57.1%	52.1%	↔
Women's Care	<i>Breast Cancer Screening</i>	50.6%	50.9%	50.7%	↔
	<i>Cervical Cancer Screening</i>	70.1%	69.3%	70.3%	↔
	<i>Chlamydia Screening—16–20 Years</i>	48.9%	51.6%	50.6%	↔
	<i>Chlamydia Screening—21–24 Years</i>	58.8%	58.6%	55.8%	↔
	<i>Chlamydia Screening—Combined</i>	53.4%	54.8%	52.6%	↔
	<i>Timeliness of Prenatal Care</i>	93.4%	92.9%	92.2%	↔
	<i>Postpartum Care</i>	85.6%	80.8%	83.0%	↔
Living With Illness	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	84.4%	83.9%	87.1%	↔
	<i>Comprehensive Diabetes Care—Poor HbA1c Control</i>	41.8%	33.3%	38.1%	↔
	<i>Comprehensive Diabetes Care—Eye Exam</i>	67.4%	65.9%	71.5%	↔
	<i>Comprehensive Diabetes Care—LDL-C Screening</i>	71.5%	74.9%	80.6%	↔
	<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	33.1%	35.8%	37.4%	↔
	<i>Comprehensive Diabetes Care—Nephropathy</i>	91.2%	86.9%	88.2%	↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i>	32.1%	32.6%	34.3%	↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	60.6%	64.2%	66.2%	↔
	<i>Asthma—5–9 Years</i>	96.7%	96.5%	94.0%	↔
	<i>Asthma—10–17 Years</i>	90.6%	90.6%	90.3%	↔
	<i>Asthma—18–56 Years</i>	85.2%	90.2%	86.2%	↔
	<i>Asthma—Combined Rate</i>	89.1%	91.7%	89.2%	↔
	<i>Controlling High Blood Pressure</i>	69.1%	67.6%	67.6%	↔
	<i>Advising Smokers to Quit</i>	69.6%	69.4%	69.1%	↔
<i>Smoking Cessation Strategies</i>	37.2%	40.8%	43.1%	↔	
Access to Care	<i>Children's Access—12–24 Months</i>	94.9%	93.1%	95.3%	↔
	<i>Children's Access—25 Mos–6 Years</i>	78.1%	80.2%	82.8%	↔
	<i>Children's Access—7–11 Years</i>	77.0%	78.1%	81.3%	↔
	<i>Adolescents' Access—12–19 Years</i>	76.5%	77.0%	79.7%	↔
	<i>Adults' Access—20–44 Years</i>	81.0%	82.6%	82.8%	↔
	<i>Adults' Access—45–64 Years</i>	87.0%	87.0%	87.6%	↔

Table C-7—Michigan Medicaid HEDIS 2009 Trend Table: MID

Dimension of Care	Measure	2007	2008	2009	2008–2009 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Status—Combo 2</i>	81.5%	75.9%	76.2%	↔↔
	<i>Childhood Immunization Status—Combo 3</i>	57.9%	63.5%	71.0%	↔↔
	<i>Lead Screening in Children</i>	--	69.8%	76.9%	↔↔
	<i>Well-Child Visits 1st 15 Mos—0 Visits</i>	3.6%	2.4%	0.7%	↔↔
	<i>Well-Child Visits 1st 15 Mos—6+ Visits</i>	56.7%	57.7%	64.7%	↔↔
	<i>Well-Child Visits 3rd-6th Years of Life</i>	74.9%	72.3%	75.7%	↔↔
	<i>Adolescent Well-Care Visits</i>	50.1%	59.4%	62.3%	↔↔
	<i>Appropriate Treatment of URI</i>	75.2%	82.8%	82.3%	↔↔
	<i>Children With Pharyngitis</i>	18.7%	19.2%	21.6%	↔↔
Women's Care	<i>Breast Cancer Screening</i>	54.6%	51.5%	52.3%	↔↔
	<i>Cervical Cancer Screening</i>	64.2%	69.8%	73.5%	↔↔
	<i>Chlamydia Screening—16–20 Years</i>	52.8%	58.3%	59.3%	↔↔
	<i>Chlamydia Screening—21–24 Years</i>	60.3%	67.2%	67.3%	↔↔
	<i>Chlamydia Screening—Combined</i>	55.9%	61.4%	61.8%	↔↔
	<i>Timeliness of Prenatal Care</i>	76.4%	86.1%	89.5%	↔↔
	<i>Postpartum Care</i>	50.9%	61.8%	63.7%	↔↔
Living With Illness	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	70.1%	74.9%	80.5%	↔↔
	<i>Comprehensive Diabetes Care—Poor HbA1c Control</i>	48.2%	46.0%	61.3%	▼
	<i>Comprehensive Diabetes Care—Eye Exam</i>	53.5%	58.2%	60.2%	↔↔
	<i>Comprehensive Diabetes Care—LDL-C Screening</i>	70.1%	72.0%	81.0%	↔↔
	<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	29.7%	27.5%	31.6%	↔↔
	<i>Comprehensive Diabetes Care—Nephropathy</i>	77.9%	80.0%	85.4%	↔↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i>	27.0%	28.5%	27.2%	↔↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	56.9%	52.6%	50.2%	↔↔
	<i>Asthma—5–9 Years</i>	86.7%	86.5%	84.3%	↔↔
	<i>Asthma—10–17 Years</i>	81.8%	76.9%	80.3%	↔↔
	<i>Asthma—18–56 Years</i>	83.4%	79.8%	83.2%	↔↔
	<i>Asthma—Combined Rate</i>	83.7%	80.6%	82.7%	↔↔
	<i>Controlling High Blood Pressure</i>	52.6%	49.6%	55.7%	↔↔
	<i>Advising Smokers to Quit</i>	68.3%	70.5%	71.7%	↔↔
<i>Smoking Cessation Strategies</i>	37.1%	41.6%	39.7%	↔↔	
Access to Care	<i>Children's Access—12–24 Months</i>	92.1%	93.2%	94.0%	↔↔
	<i>Children's Access—25 Mos–6 Years</i>	81.4%	82.9%	86.5%	↔↔
	<i>Children's Access—7–11 Years</i>	81.2%	83.0%	85.6%	↔↔
	<i>Adolescents' Access—12–19 Years</i>	76.8%	79.0%	83.0%	↔↔
	<i>Adults' Access—20–44 Years</i>	78.2%	80.2%	81.3%	↔↔
	<i>Adults' Access—45–64 Years</i>	85.5%	86.7%	87.9%	↔↔

Table C-8—Michigan Medicaid HEDIS 2009 Trend Table: MOL

Dimension of Care	Measure	2007	2008	2009	2008–2009 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Status—Combo 2</i>	72.4%	76.3%	76.6%	↔↔
	<i>Childhood Immunization Status—Combo 3</i>	35.5%	67.6%	69.3%	↔↔
	<i>Lead Screening in Children</i>	--	69.8%	72.4%	↔↔
	<i>Well-Child Visits 1st 15 Mos—0 Visits</i>	1.9%	1.9%	2.5%	↔↔
	<i>Well-Child Visits 1st 15 Mos—6+ Visits</i>	42.5%	45.6%	52.3%	↔↔
	<i>Well-Child Visits 3rd-6th Years of Life</i>	62.2%	68.6%	75.1%	↔↔
	<i>Adolescent Well-Care Visits</i>	39.6%	51.9%	51.9%	Rotated Measure
	<i>Appropriate Treatment of URI</i>	79.4%	78.5%	80.9%	↔↔
	<i>Children With Pharyngitis</i>	43.6%	46.2%	46.6%	↔↔
Women's Care	<i>Breast Cancer Screening</i>	48.9%	51.0%	51.2%	↔↔
	<i>Cervical Cancer Screening</i>	58.0%	64.2%	69.2%	↔↔
	<i>Chlamydia Screening—16–20 Years</i>	52.1%	51.7%	60.9%	↔↔
	<i>Chlamydia Screening—21–24 Years</i>	58.4%	59.6%	68.0%	↔↔
	<i>Chlamydia Screening—Combined</i>	54.5%	54.7%	63.2%	↔↔
	<i>Timeliness of Prenatal Care</i>	67.4%	72.6%	79.4%	↔↔
	<i>Postpartum Care</i>	49.7%	51.9%	61.3%	↔↔
Living With Illness	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	74.1%	87.3%	87.3%	Rotated Measure
	<i>Comprehensive Diabetes Care—Poor HbA1c Control</i>	50.1%	41.4%	41.4%	Rotated Measure
	<i>Comprehensive Diabetes Care—Eye Exam</i>	50.6%	53.5%	53.5%	Rotated Measure
	<i>Comprehensive Diabetes Care—LDL-C Screening</i>	73.4%	79.3%	79.3%	Rotated Measure
	<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	51.3%	53.8%	53.8%	Rotated Measure
	<i>Comprehensive Diabetes Care—Nephropathy</i>	76.9%	78.8%	78.8%	Rotated Measure
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i>	29.6%	26.0%	26.0%	Rotated Measure
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	54.3%	53.3%	53.3%	Rotated Measure
	<i>Asthma—5–9 Years</i>	83.1%	89.8%	88.0%	↔↔
	<i>Asthma—10–17 Years</i>	82.0%	86.1%	81.3%	↔↔
	<i>Asthma—18–56 Years</i>	84.4%	84.7%	85.8%	↔↔
	<i>Asthma—Combined Rate</i>	83.5%	86.1%	85.2%	↔↔
	<i>Controlling High Blood Pressure</i>	45.2%	55.7%	55.4%	↔↔
	<i>Advising Smokers to Quit</i>	69.1%	70.4%	73.5%	↔↔
	<i>Smoking Cessation Strategies</i>	36.2%	35.6%	39.5%	↔↔
Access to Care	<i>Children's Access—12–24 Months</i>	94.4%	95.5%	96.3%	↔↔
	<i>Children's Access—25 Mos–6 Years</i>	82.0%	84.9%	87.0%	↔↔
	<i>Children's Access—7–11 Years</i>	80.5%	81.8%	85.8%	↔↔
	<i>Adolescents' Access—12–19 Years</i>	78.0%	79.6%	83.1%	↔↔
	<i>Adults' Access—20–44 Years</i>	77.2%	78.7%	80.5%	↔↔
	<i>Adults' Access—45–64 Years</i>	83.8%	84.3%	85.8%	↔↔

Table C-9—Michigan Medicaid HEDIS 2009 Trend Table: OCH

Dimension of Care	Measure	2007	2008	2009	2008–2009 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Status—Combo 2</i>	79.9%	82.4%	83.3%	↔↔
	<i>Childhood Immunization Status—Combo 3</i>	51.9%	58.8%	64.6%	↔↔
	<i>Lead Screening in Children</i>	--	74.1%	78.9%	↔↔
	<i>Well-Child Visits 1st 15 Mos—0 Visits</i>	0.9%	1.9%	1.2%	↔↔
	<i>Well-Child Visits 1st 15 Mos—6+ Visits</i>	50.9%	55.8%	59.3%	↔↔
	<i>Well-Child Visits 3rd-6th Years of Life</i>	72.2%	73.6%	75.5%	↔↔
	<i>Adolescent Well-Care Visits</i>	50.2%	51.4%	52.5%	↔↔
	<i>Appropriate Treatment of URI</i>	79.7%	82.7%	82.5%	↔↔
	<i>Children With Pharyngitis</i>	32.3%	30.1%	32.2%	↔↔
Women's Care	<i>Breast Cancer Screening</i>	46.1%	49.7%	49.4%	↔↔
	<i>Cervical Cancer Screening</i>	66.7%	67.5%	67.5%	↔↔
	<i>Chlamydia Screening—16–20 Years</i>	64.4%	64.1%	68.8%	↔↔
	<i>Chlamydia Screening—21–24 Years</i>	72.4%	72.3%	75.0%	↔↔
	<i>Chlamydia Screening—Combined</i>	67.7%	67.1%	70.6%	↔↔
	<i>Timeliness of Prenatal Care</i>	84.1%	84.9%	85.6%	↔↔
	<i>Postpartum Care</i>	50.7%	52.2%	64.1%	↑
Living With Illness	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	78.8%	79.6%	82.7%	↔↔
	<i>Comprehensive Diabetes Care—Poor HbA1c Control</i>	49.9%	48.0%	47.2%	↔↔
	<i>Comprehensive Diabetes Care—Eye Exam</i>	47.8%	54.4%	47.4%	↔↔
	<i>Comprehensive Diabetes Care—LDL-C Screening</i>	74.8%	71.5%	81.2%	↔↔
	<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	34.9%	34.3%	34.5%	↔↔
	<i>Comprehensive Diabetes Care—Nephropathy</i>	83.4%	80.3%	84.9%	↔↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i>	20.1%	20.9%	27.5%	↔↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	46.4%	47.7%	56.0%	↔↔
	<i>Asthma—5–9 Years</i>	77.9%	82.8%	80.5%	↔↔
	<i>Asthma—10–17 Years</i>	75.1%	82.5%	81.3%	↔↔
	<i>Asthma—18–56 Years</i>	86.0%	85.3%	85.4%	↔↔
	<i>Asthma—Combined Rate</i>	81.2%	83.9%	83.3%	↔↔
	<i>Controlling High Blood Pressure</i>	44.0%	52.2%	51.7%	↔↔
	<i>Advising Smokers to Quit</i>	69.9%	70.5%	71.5%	↔↔
<i>Smoking Cessation Strategies</i>	34.6%	34.3%	34.5%	↔↔	
Access to Care	<i>Children's Access—12–24 Months</i>	90.2%	89.2%	91.2%	↔↔
	<i>Children's Access—25 Mos–6 Years</i>	73.7%	74.2%	77.2%	↔↔
	<i>Children's Access—7–11 Years</i>	73.8%	76.8%	78.2%	↔↔
	<i>Adolescents' Access—12–19 Years</i>	70.8%	73.9%	76.6%	↔↔
	<i>Adults' Access—20–44 Years</i>	74.5%	75.9%	77.3%	↔↔
	<i>Adults' Access—45–64 Years</i>	81.7%	83.1%	84.5%	↔↔

Table C-10—Michigan Medicaid HEDIS 2009 Trend Table: PMD					
Dimension of Care	Measure	2007	2008	2009	2008–2009 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Status—Combo 2</i>	82.0%	81.1%	81.1%	Rotated Measure
	<i>Childhood Immunization Status—Combo 3</i>	73.5%	74.4%	74.4%	Rotated Measure
	<i>Lead Screening in Children</i>	--	75.9%	85.0%	↔
	<i>Well-Child Visits 1st 15 Mos—0 Visits</i>	1.4%	0.7%	1.5%	↔
	<i>Well-Child Visits 1st 15 Mos—6+ Visits</i>	49.2%	57.9%	63.2%	↔
	<i>Well-Child Visits 3rd-6th Years of Life</i>	67.6%	57.1%	64.0%	↔
	<i>Adolescent Well-Care Visits</i>	47.7%	41.6%	46.2%	↔
	<i>Appropriate Treatment of URI</i>	76.6%	84.1%	88.9%	↔
	<i>Children With Pharyngitis</i>	59.2%	55.3%	60.2%	↔
Women's Care	<i>Breast Cancer Screening</i>	49.1%	48.3%	48.9%	↔
	<i>Cervical Cancer Screening</i>	68.6%	69.2%	71.2%	↔
	<i>Chlamydia Screening—16–20 Years</i>	67.2%	65.3%	63.6%	↔
	<i>Chlamydia Screening—21–24 Years</i>	65.7%	65.7%	76.5%	↑
	<i>Chlamydia Screening—Combined</i>	66.5%	65.4%	68.3%	↔
	<i>Timeliness of Prenatal Care</i>	85.6%	85.6%	83.5%	↔
	<i>Postpartum Care</i>	62.6%	65.8%	67.0%	↔
Living With Illness	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	83.0%	87.4%	86.2%	↔
	<i>Comprehensive Diabetes Care—Poor HbA1c Control</i>	38.0%	32.4%	30.4%	↔
	<i>Comprehensive Diabetes Care—Eye Exam</i>	67.8%	63.4%	70.9%	↔
	<i>Comprehensive Diabetes Care—LDL-C Screening</i>	77.1%	77.5%	78.8%	↔
	<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	46.0%	43.3%	44.7%	↔
	<i>Comprehensive Diabetes Care—Nephropathy</i>	78.2%	82.4%	84.9%	↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i>	32.2%	34.0%	39.7%	↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	65.2%	62.8%	66.4%	↔
	<i>Asthma—5–9 Years</i>	90.4%	91.8%	96.8%	↔
	<i>Asthma—10–17 Years</i>	89.3%	91.5%	94.0%	↔
	<i>Asthma—18–56 Years</i>	94.5%	89.5%	90.2%	↔
	<i>Asthma—Combined Rate</i>	91.8%	90.7%	93.3%	↔
	<i>Controlling High Blood Pressure</i>	59.4%	59.9%	57.5%	↔
	<i>Advising Smokers to Quit</i>	77.5%	74.3%	74.0%	↔
	<i>Smoking Cessation Strategies</i>	48.8%	48.2%	50.3%	↔
Access to Care	<i>Children's Access—12–24 Months</i>	95.0%	94.5%	94.1%	↔
	<i>Children's Access—25 Mos–6 Years</i>	81.2%	77.7%	83.8%	↔
	<i>Children's Access—7–11 Years</i>	84.5%	82.2%	83.5%	↔
	<i>Adolescents' Access—12–19 Years</i>	81.8%	81.0%	84.6%	↔
	<i>Adults' Access—20–44 Years</i>	80.5%	78.7%	81.0%	↔
	<i>Adults' Access—45–64 Years</i>	86.1%	85.7%	87.2%	↔

Table C-11—Michigan Medicaid HEDIS 2009 Trend Table: PRI					
Dimension of Care	Measure	2007	2008	2009	2008–2009 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Status—Combo 2</i>	88.7%	85.8%	85.0%	↔↔
	<i>Childhood Immunization Status—Combo 3</i>	81.2%	81.5%	80.2%	↔↔
	<i>Lead Screening in Children</i>	--	75.0%	78.3%	↔↔
	<i>Well-Child Visits 1st 15 Mos—0 Visits</i>	1.2%	0.7%	1.0%	↔↔
	<i>Well-Child Visits 1st 15 Mos—6+ Visits</i>	53.5%	55.3%	69.8%	↑
	<i>Well-Child Visits 3rd-6th Years of Life</i>	63.7%	68.2%	71.9%	↔↔
	<i>Adolescent Well-Care Visits</i>	43.3%	48.9%	50.9%	↔↔
	<i>Appropriate Treatment of URI</i>	87.7%	90.4%	91.5%	↔↔
	<i>Children With Pharyngitis</i>	68.9%	66.9%	70.8%	↔↔
Women's Care	<i>Breast Cancer Screening</i>	54.7%	53.4%	55.8%	↔↔
	<i>Cervical Cancer Screening</i>	76.0%	79.7%	77.8%	↔↔
	<i>Chlamydia Screening—16–20 Years</i>	55.6%	57.9%	67.5%	↔↔
	<i>Chlamydia Screening—21–24 Years</i>	62.4%	64.9%	74.1%	↔↔
	<i>Chlamydia Screening—Combined</i>	59.1%	61.1%	70.2%	↔↔
	<i>Timeliness of Prenatal Care</i>	86.8%	86.3%	88.3%	↔↔
	<i>Postpartum Care</i>	66.3%	70.1%	73.2%	↔↔
Living With Illness	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	89.3%	88.6%	87.4%	↔↔
	<i>Comprehensive Diabetes Care—Poor HbA1c Control</i>	27.3%	32.8%	27.9%	↔↔
	<i>Comprehensive Diabetes Care—Eye Exam</i>	70.6%	71.3%	69.3%	↔↔
	<i>Comprehensive Diabetes Care—LDL-C Screening</i>	81.0%	79.8%	80.5%	↔↔
	<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	39.4%	41.8%	41.2%	↔↔
	<i>Comprehensive Diabetes Care—Nephropathy</i>	82.5%	80.3%	81.4%	↔↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i>	40.9%	38.7%	40.7%	↔↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	70.8%	70.6%	69.3%	↔↔
	<i>Asthma—5–9 Years</i>	98.3%	94.4%	97.6%	↔↔
	<i>Asthma—10–17 Years</i>	95.4%	95.1%	96.5%	↔↔
	<i>Asthma—18–56 Years</i>	88.5%	90.7%	89.9%	↔↔
	<i>Asthma—Combined Rate</i>	93.6%	93.2%	94.3%	↔↔
	<i>Controlling High Blood Pressure</i>	58.9%	58.8%	57.5%	↔↔
	<i>Advising Smokers to Quit</i>	76.1%	77.8%	77.3%	↔↔
<i>Smoking Cessation Strategies</i>	43.3%	44.8%	44.4%	↔↔	
Access to Care	<i>Children's Access—12–24 Months</i>	96.9%	96.6%	97.8%	↔↔
	<i>Children's Access—25 Mos–6 Years</i>	83.7%	85.3%	85.4%	↔↔
	<i>Children's Access—7–11 Years</i>	87.4%	86.1%	87.7%	↔↔
	<i>Adolescents' Access—12–19 Years</i>	85.5%	84.5%	85.8%	↔↔
	<i>Adults' Access—20–44 Years</i>	86.5%	86.8%	85.1%	↔↔
	<i>Adults' Access—45–64 Years</i>	93.1%	91.7%	90.0%	↔↔

Table C-12—Michigan Medicaid HEDIS 2009 Trend Table: PRO					
Dimension of Care	Measure	2007	2008	2009	2008–2009 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Status—Combo 2</i>	--	--	NA	--
	<i>Childhood Immunization Status—Combo 3</i>	--	--	NA	--
	<i>Lead Screening in Children</i>	--	--	NA	--
	<i>Well-Child Visits 1st 15 Mos—0 Visits</i>	--	--	NA	--
	<i>Well-Child Visits 1st 15 Mos—6+ Visits</i>	--	--	NA	--
	<i>Well-Child Visits 3rd-6th Years of Life</i>	--	--	NA	--
	<i>Adolescent Well-Care Visits</i>	--	--	20.0%	--
	<i>Appropriate Treatment of URI</i>	--	--	NA	--
	<i>Children With Pharyngitis</i>	--	--	NA	--
Women’s Care	<i>Breast Cancer Screening</i>	--	--	NA	--
	<i>Cervical Cancer Screening</i>	--	--	NA	--
	<i>Chlamydia Screening—16–20 Years</i>	--	--	NA	--
	<i>Chlamydia Screening—21–24 Years</i>	--	--	NA	--
	<i>Chlamydia Screening—Combined</i>	--	--	NA	--
	<i>Timeliness of Prenatal Care</i>	--	--	NA	--
	<i>Postpartum Care</i>	--	--	NA	--
Living With Illness	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	--	--	NA	--
	<i>Comprehensive Diabetes Care—Poor HbA1c Control</i>	--	--	NA	--
	<i>Comprehensive Diabetes Care—Eye Exam</i>	--	--	NA	--
	<i>Comprehensive Diabetes Care—LDL-C Screening</i>	--	--	NA	--
	<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	--	--	NA	--
	<i>Comprehensive Diabetes Care—Nephropathy</i>	--	--	NA	--
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i>	--	--	NA	--
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	--	--	NA	--
	<i>Asthma—5–9 Years</i>	--	--	NA	--
	<i>Asthma—10–17 Years</i>	--	--	NA	--
	<i>Asthma—18–56 Years</i>	--	--	NA	--
	<i>Asthma—Combined Rate</i>	--	--	NA	--
	<i>Controlling High Blood Pressure</i>	--	--	NA	--
	<i>Advising Smokers to Quit</i>	--	--	NA	--
<i>Smoking Cessation Strategies</i>	--	--	NA	--	
Access to Care	<i>Children’s Access—12–24 Months</i>	--	--	NA	--
	<i>Children’s Access—25 Mos–6 Years</i>	--	--	NA	--
	<i>Children’s Access—7–11 Years</i>	--	--	NA	--
	<i>Adolescents’ Access—12–19 Years</i>	--	--	NA	--
	<i>Adults’ Access—20–44 Years</i>	--	--	NA	--
	<i>Adults’ Access—45–64 Years</i>	--	--	NA	--

Table C-13—Michigan Medicaid HEDIS 2009 Trend Table: THC					
Dimension of Care	Measure	2007	2008	2009	2008–2009 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Status—Combo 2</i>	77.8%	85.3%	85.3%	Rotated Measure
	<i>Childhood Immunization Status—Combo 3</i>	62.0%	74.5%	74.5%	Rotated Measure
	<i>Lead Screening in Children</i>	--	72.0%	73.3%	↔
	<i>Well-Child Visits 1st 15 Mos—0 Visits</i>	1.2%	1.5%	1.4%	↔
	<i>Well-Child Visits 1st 15 Mos—6+ Visits</i>	49.1%	45.7%	66.4%	↑
	<i>Well-Child Visits 3rd-6th Years of Life</i>	65.4%	70.2%	74.3%	↔
	<i>Adolescent Well-Care Visits</i>	47.9%	56.2%	56.2%	Rotated Measure
	<i>Appropriate Treatment of URI</i>	76.3%	59.8%	59.2%	↔
	<i>Children With Pharyngitis</i>	37.5%	44.8%	55.9%	↑
Women's Care	<i>Breast Cancer Screening</i>	47.6%	49.1%	48.3%	↔
	<i>Cervical Cancer Screening</i>	66.2%	71.2%	68.6%	↔
	<i>Chlamydia Screening—16–20 Years</i>	61.8%	63.7%	63.2%	↔
	<i>Chlamydia Screening—21–24 Years</i>	68.7%	72.3%	74.0%	↔
	<i>Chlamydia Screening—Combined</i>	64.6%	67.0%	66.9%	↔
	<i>Timeliness of Prenatal Care</i>	84.2%	83.0%	84.2%	↔
	<i>Postpartum Care</i>	57.9%	64.1%	61.5%	↔
Living With Illness	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	76.7%	77.3%	80.4%	↔
	<i>Comprehensive Diabetes Care—Poor HbA1c Control</i>	47.0%	49.7%	48.1%	↔
	<i>Comprehensive Diabetes Care—Eye Exam</i>	57.3%	52.0%	57.1%	↔
	<i>Comprehensive Diabetes Care—LDL-C Screening</i>	72.8%	68.8%	74.3%	↔
	<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	28.2%	32.7%	37.7%	↔
	<i>Comprehensive Diabetes Care—Nephropathy</i>	77.6%	77.5%	79.4%	↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i>	24.1%	22.3%	24.3%	↔
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	52.6%	50.3%	55.3%	↔
	<i>Asthma—5–9 Years</i>	86.6%	84.6%	80.7%	↔
	<i>Asthma—10–17 Years</i>	80.2%	81.4%	77.1%	↔
	<i>Asthma—18–56 Years</i>	82.9%	80.6%	83.3%	↔
	<i>Asthma—Combined Rate</i>	82.8%	81.7%	81.0%	↔
	<i>Controlling High Blood Pressure</i>	41.6%	59.3%	60.0%	↔
	<i>Advising Smokers to Quit</i>	65.6%	69.1%	70.2%	↔
	<i>Smoking Cessation Strategies</i>	30.9%	33.1%	39.8%	↔
Access to Care	<i>Children's Access—12–24 Months</i>	91.8%	91.9%	95.9%	↔
	<i>Children's Access—25 Mos–6 Years</i>	75.0%	80.7%	86.5%	↔
	<i>Children's Access—7–11 Years</i>	78.3%	80.0%	82.4%	↔
	<i>Adolescents' Access—12–19 Years</i>	77.4%	79.9%	83.7%	↔
	<i>Adults' Access—20–44 Years</i>	74.9%	75.2%	77.8%	↔
	<i>Adults' Access—45–64 Years</i>	80.4%	81.4%	83.1%	↔

Table C-14—Michigan Medicaid HEDIS 2009 Trend Table: UPP					
Dimension of Care	Measure	2007	2008	2009	2008–2009 Health Plan Trend
Pediatric Care	<i>Childhood Immunization Status—Combo 2</i>	80.7%	81.2%	81.2%	Rotated Measure
	<i>Childhood Immunization Status—Combo 3</i>	66.6%	73.8%	73.8%	Rotated Measure
	<i>Lead Screening in Children</i>	--	82.8%	86.4%	↔
	<i>Well-Child Visits 1st 15 Mos—0 Visits</i>	1.4%	1.4%	1.4%	Rotated Measure
	<i>Well-Child Visits 1st 15 Mos—6+ Visits</i>	44.6%	60.9%	60.9%	Rotated Measure
	<i>Well-Child Visits 3rd-6th Years of Life</i>	60.9%	60.4%	60.4%	Rotated Measure
	<i>Adolescent Well-Care Visits</i>	39.1%	37.0%	33.9%	↔
	<i>Appropriate Treatment of URI</i>	81.1%	81.8%	81.1%	↔
	<i>Children With Pharyngitis</i>	54.8%	64.0%	66.4%	↔
Women's Care	<i>Breast Cancer Screening</i>	60.0%	57.1%	57.9%	↔
	<i>Cervical Cancer Screening</i>	76.8%	76.8%	75.9%	↔
	<i>Chlamydia Screening—16–20 Years</i>	48.4%	45.2%	44.5%	↔
	<i>Chlamydia Screening—21–24 Years</i>	49.4%	51.6%	51.6%	↔
	<i>Chlamydia Screening—Combined</i>	48.8%	47.6%	47.1%	↔
	<i>Timeliness of Prenatal Care</i>	88.7%	88.7%	93.2%	↔
	<i>Postpartum Care</i>	68.8%	68.8%	73.2%	↔
Living With Illness	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	89.7%	89.0%	89.0%	Rotated Measure
	<i>Comprehensive Diabetes Care—Poor HbA1c Control</i>	27.8%	25.2%	25.2%	Rotated Measure
	<i>Comprehensive Diabetes Care—Eye Exam</i>	70.6%	66.9%	66.9%	Rotated Measure
	<i>Comprehensive Diabetes Care—LDL-C Screening</i>	81.7%	82.4%	82.4%	Rotated Measure
	<i>Comprehensive Diabetes Care—LDL-C Level <100</i>	37.4%	40.6%	40.6%	Rotated Measure
	<i>Comprehensive Diabetes Care—Nephropathy</i>	81.4%	79.1%	79.1%	Rotated Measure
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)</i>	39.9%	39.4%	39.4%	Rotated Measure
	<i>Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)</i>	69.0%	73.5%	73.5%	Rotated Measure
	<i>Asthma—5–9 Years</i>	97.8%	88.0%	90.8%	↔
	<i>Asthma—10–17 Years</i>	92.5%	89.3%	86.4%	↔
	<i>Asthma—18–56 Years</i>	87.2%	86.4%	83.0%	↔
	<i>Asthma—Combined Rate</i>	91.3%	87.7%	85.6%	↔
	<i>Controlling High Blood Pressure</i>	64.8%	65.3%	66.2%	↔
	<i>Advising Smokers to Quit</i>	72.9%	71.7%	72.6%	↔
	<i>Smoking Cessation Strategies</i>	38.5%	40.7%	42.3%	↔
Access to Care	<i>Children's Access—12–24 Months</i>	97.7%	97.7%	97.7%	↔
	<i>Children's Access—25 Mos–6 Years</i>	88.1%	88.1%	87.8%	↔
	<i>Children's Access—7–11 Years</i>	87.2%	87.9%	88.3%	↔
	<i>Adolescents' Access—12–19 Years</i>	90.0%	90.4%	89.3%	↔
	<i>Adults' Access—20–44 Years</i>	89.5%	88.7%	89.2%	↔
	<i>Adults' Access—45–64 Years</i>	91.2%	91.3%	90.1%	↔

Appendix D includes terms, acronyms, and abbreviations commonly used in HEDIS and NCQA literature and text. This glossary can be used as a reference and guide 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 be 4,000/10,000, or 40 percent.

Audit Designation

The auditor's final determination, based on audit findings, of the appropriateness of the health plan publicly reporting its HEDIS measure rates. Each measure included in the HEDIS audit receives a *Report*, *Not Applicable*, *No Benefit*, or *Not Report* audit finding.

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 the 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 is provided services or not. Therefore, there is little incentive for providers to submit individual encounters, knowing that payment is not dependent upon such submission.

Certified HEDIS Software Vendor

A third party, with source code 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 percentage 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 that 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 U.S. 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.

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.

EDI

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

Electronic Data

Data 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 encounter, submission of 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.

FFS

Fee for service: A reimbursement mechanism in which the provider is paid for services billed.

Final Audit Report

Following the health plan's completion of any corrective actions, the final audit report is completed by the auditor and documents 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 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

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 rates 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 have evidence of a postpartum visit using administrative data. The health plan then obtains and reviews medical records for the 250 members who do not have evidence of a postpartum visit using administrative data. Of those 250 members, 54 are 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, Ninth Revision, Clinical Modification, is the classification of diseases and injuries into groups according to established criteria 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

Interrater 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.

IS Standards

Information system (IS) standards: An NCQA-defined set of standards that measure how an organization collects, stores, analyzes, and reports medical, customer service, member, practitioner, and vendor 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 report HEDIS measures.

Key Measures

The HEDIS measures selected by MDCH that health plans are 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. The LPL for these measures is the 75th percentile rather than the 25th percentile.

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 a health plan's medical record abstraction meets industry standards and that 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: If a 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 will 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.

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 a health plan as part of its medical record review process, and auditors over-read a sample of a 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 that have to be mapped to industry standard codes for HEDIS reporting.

Provider Data

Electronic files containing information about physicians, such as the 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.

Record of Administration, Data Management and Processes (Roadmap)

The Roadmap, completed by each MCP undergoing the HEDIS audit process, provides information to auditors regarding an MCP's systems for collecting and processing data for HEDIS reporting. Auditors review the Roadmap prior to the scheduled on-site 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.

Previously the Baseline Assessment Tool (BAT).

Sample Frame

The eligible population that meets 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.

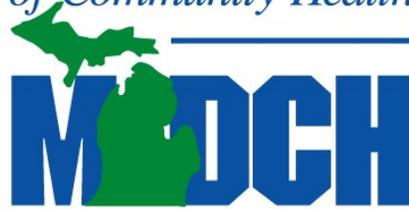
Vendor

Any third party that contracts with a health plan to perform services. The most common types of vendors used by health plans are pharmacy, vision care, laboratory, claims processing, HEDIS software, and provider credentialing vendors.

VZV

Varicella-zoster virus (chicken pox) vaccine.

*Michigan Department
of Community Health*



**Jennifer M. Granholm, Governor
Janet Olszewski, Director**

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

March 2010



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ACKNOWLEDGMENTS AND COPYRIGHTS

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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.

Purpose of Report

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

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

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

¹⁻¹ Formerly Community Choice of Michigan (name change effective April 18, 2008).

¹⁻² Included for the first time due to insufficient data in prior years.

Scope of External Quality Review (EQR) Activities Conducted

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

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

Summary of Findings

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

Compliance Review

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

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

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

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

Validation of Performance Measures

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

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

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

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

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

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

Performance Improvement Projects (PIPs)

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

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

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

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

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

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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

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

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

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

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

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

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

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

Quality, Timeliness, and Access

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

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

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

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

Table 1-7—Assignment of Activities to Performance Domains

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

Introduction

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

Compliance Monitoring

Objectives

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

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

Technical Methods of Data Collection

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

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

Description of Data Obtained

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

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

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

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

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

Data Aggregation, Analysis, and How Conclusions Were Drawn

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

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

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

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

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

Validation of Performance Measures

Objectives

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

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

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

Technical Methods of Data Collection and Analysis

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

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

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

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

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

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

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

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

Description of Data Obtained

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

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

Data Aggregation, Analysis, and How Conclusions Were Drawn

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

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

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

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

Validation of Performance Improvement Projects (PIPs)

Objectives

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

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

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

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

Technical Methods of Data Collection and Analysis

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

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

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

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

Description of Data Obtained

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

Data Aggregation, Analysis, and How Conclusions Were Drawn

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

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

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

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

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

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

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Objectives

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

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

Technical Methods of Data Collection and Analysis

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

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

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

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

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

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

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

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

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

Description of Data Obtained

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

Data Aggregation, Analysis, and How Conclusions Were Drawn

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

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

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

Annual Compliance Review

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

Performance Measures

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

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

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

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

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

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

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

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

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

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

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

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

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

Performance Improvement Projects (PIPs)

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

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

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

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

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

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

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

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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

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

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

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

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

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

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

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

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

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

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

Conclusions/Summary

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

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

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

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

4. Appendices Introduction

Overview

This Appendices Introduction section of the report summarizes MHP-specific key findings and an assessment of MHP follow-up on prior recommendations for the three mandatory EQR-related activities: validation of performance measures, validation of PIPs, and compliance monitoring. Information about the compliance site visits is limited pending the completion of the 2009–2010 compliance monitoring cycle. In addition, CAHPS results are presented. For a more detailed description of the results of the mandatory EQR-related activities, refer to the aggregate and MHP-specific reports, including:

- ◆ Reports of site visit findings for each MHP
- ◆ Michigan Medicaid HEDIS 2009 results reports
- ◆ 2009 PIP validation reports

Michigan Medicaid Health Plan Names

MDCH uses a three-letter acronym for each MHP. The acronyms are illustrated in Table 4-1 and are used throughout this report.

Table 4-1—Michigan MHP Formal Names, Abbreviations, and Appendix Letter Assignment		
MHP Name	Acronym	Appendix Letter Assignment
BlueCaid of Michigan	BCD	A
CareSource Michigan	CSM	B
Great Lakes Health Plan	GLH	C
Health Plan of Michigan, Inc.	HPM	D
HealthPlus Partners, Inc.	HPP	E
McLaren Health Plan	MCL	F
Midwest Health Plan	MID	G
Molina Healthcare of Michigan	MOL	H
OmniCare Health Plan	OCH	I
Physicians Health Plan of Mid-Michigan Family Care	PMD	J
Priority Health Government Programs, Inc.	PRI	K
ProCare Health Plan	PRO	L
Total Health Care, Inc.	THC	M
Upper Peninsula Health Plan	UPP	N

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement.

MDCH conducted a compliance site visit to evaluate **BCD**'s implementation of corrective actions identified in the 2007–2008 site visit. MDCH also assessed **BCD**'s compliance with a set of mandatory criteria included in the review for all MHPs, regardless of prior performance.

The next technical report will present an analysis of the combined findings from the 2008–2009 and 2009–2010 site visits.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess the ability of each MHP’s support system to report accurate HEDIS measures. The results of this assessment are presented in Table A-1. The table shows each of the performance measures, the rate for each measure for 2009, and the categorized performance for 2009 relative to national HEDIS 2008 Medicaid results.

Table A-1—2009 Scores for Performance Measures for BCD			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Pediatric Care	<i>Childhood Immunization—Combo 2</i>	86.9%	★★★
	<i>Childhood Immunization—Combo 3</i>	82.2%	★★★
	<i>Lead Screening in Children</i>	59.8%	★★
	<i>Well-Child 1st 15 Months—0 Visits*</i>	1.5%	★★
	<i>Well-Child 1st 15 Months—6+ Visits</i>	60.4%	★★
	<i>Well-Child 3rd–6th Years of Life</i>	71.8%	★★
	<i>Adolescent Well-Care Visits</i>	52.6%	★★
	<i>Appropriate Treatment of URI</i>	94.1%	★★
	<i>Children With Pharyngitis</i>	83.6%	★★★
Women’s Care	<i>Breast Cancer Screening—Combined Rate</i>	60.9%	★★
	<i>Cervical Cancer Screening</i>	71.9%	★★
	<i>Chlamydia Screening—16 to 20 Years</i>	47.4%	★★
	<i>Chlamydia Screening—21 to 24 Years</i>	61.1%	★★
	<i>Chlamydia Screening—Combined</i>	51.2%	★★
	<i>Timeliness of Prenatal Care</i>	88.9%	★★
	<i>Postpartum Care</i>	66.1%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table A-1—2009 Scores for Performance Measures for BCD			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Living With Illness	<i>Diabetes Care—HbA1c Testing</i>	92.7%	★★★
	<i>Diabetes Care—Poor HbA1c Control*</i>	27.6%	★★★
	<i>Diabetes Care—Eye Exam</i>	68.2%	★★★
	<i>Diabetes Care—LDL-C Screening</i>	85.1%	★★★
	<i>Diabetes Care—LDL-C Level <100</i>	47.5%	★★★
	<i>Diabetes Care—Nephropathy</i>	87.4%	★★★
	<i>Diabetes Care—Blood Pressure Control (<130/80)</i>	42.9%	★★★
	<i>Diabetes Care—Blood Pressure Control (<140/90)</i>	73.6%	★★★
	<i>Asthma—5 to 9 Years</i>	94.7%	★★
	<i>Asthma—10 to 17 Years</i>	94.2%	★★★
	<i>Asthma—18 to 56 Years</i>	85.4%	★★
	<i>Asthma—Combined Rate</i>	91.1%	★★
	<i>Controlling High Blood Pressure</i>	68.5%	★★★
	<i>Advising Smokers to Quit</i>	74.9%	†
	<i>Discussing Smoking Cessation Strategies</i>	54.0%	†
Access to Care	<i>Children’s Access—12 to 24 Months</i>	98.2%	★★
	<i>Children’s Access—25 Months to 6 Years</i>	89.6%	★★
	<i>Children’s Access—7 to 11 Years</i>	90.2%	★★
	<i>Adolescents’ Access—12 to 19 Years</i>	90.5%	★★
	<i>Adults’ Access—20 to 44 Years</i>	83.0%	★★
	<i>Adults’ Access—45 to 64 Years</i>	88.3%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table A-1 shows that **BCD**’s rates for 13 of the performance measures were above average compared to the national Medicaid HEDIS 2008 results: *Childhood Immunization Status—Combo 2 and Combo 3, Appropriate Testing for Children With Pharyngitis*, all eight measures of *Comprehensive Diabetes Care*, *Use of Appropriate Medications for People With Asthma 10 to 17 Years*, and *Controlling High Blood Pressure*. These measures presented areas of relative strength for **BCD**.

The table also shows that rates for 22 of the performance measures ranked within their respective national Medicaid HEDIS 2008 average performance ranges. These measures represented neither areas of relative strength nor high-priority opportunities for improvement.

None of the rates fell below the national Medicaid HEDIS 2008 average performance range, indicating that in general, **BCD** achieved at least average performance for all its performance measures.

Validation of Performance Improvement Projects (PIPs)

Table A-2 presents the scoring for each of the steps in the CMS PIP protocol. The table shows the number of elements within each step and, of those, the number that were scored *Met*, *Partially Met*, *Not Met*, or *NA*; the total percentage scores for evaluation and critical elements *Met*; and the validation status for the PIP.

Table A-2—2008–2009 PIP Validation Results for BCD						
Step		Number of Elements				
		Total	Met	Partially Met	Not Met	NA
I.	Review the Selected Study Topic(s)	6	6	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	7	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0
V.	Review Sampling Methods (if sampling was used)	6	0	0	0	6
VI.	Review Data Collection Procedures	11	9	1	0	1
VII.	Assess Improvement Strategies	4	1	1	0	2
VIII.	Review Data Analysis and the Interpretation of Study Results	9	5	0	0	4
IX.	Assess for Real Improvement	4	Not Assessed			
X.	Assess for Sustained Improvement	1	Not Assessed			
Totals for all Steps		53	33	2	0	13
Percentage Score of Evaluation Elements Met		94%				
Percentage Score of Critical Elements Met		92%				
Validation Status		Partially Met				

The 2008–2009 validation of **BCD**'s PIP on *Breast Cancer Screening Disparity* resulted in a validation status of *Partially Met* with an overall score of 94 percent and a score of 92 percent for critical elements. While **BCD** demonstrated compliance with all applicable requirements for Steps I through V and Step VIII of the CMS protocol for validating PIPs, HSAG identified opportunities for improvement in Steps VI and VII that **BCD** will need to address prior to the next annual submission for the scores and the overall validation status to improve.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **BCD**'s composite CAHPS scores are shown in Table A-3. The table presents each of the CAHPS measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table A-3—2009 CAHPS Child and Adult Composite Scores for BCD			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Getting Needed Care</i>	62.4%	2.45	*
<i>Getting Care Quickly</i>	73.2%	2.61	*
<i>How Well Doctors Communicate</i>	79.9%	2.74	★★★
<i>Customer Service</i>	64.5%	2.48	*
<i>Shared Decision Making</i>	72.8%	2.68	**
Adult			
<i>Getting Needed Care</i>	51.9%	2.32	★★★
<i>Getting Care Quickly</i>	55.7%	2.39	★★
<i>How Well Doctors Communicate</i>	67.5%	2.56	★★
<i>Customer Service</i>	61.5%	2.42	★★
<i>Shared Decision Making</i>	61.9%	2.53	—
<p>The top-box percentage indicates the percentage of responses of “Always,” “Definitely Yes,” or “Not a Problem.” Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p>* The results for these measures are not comparable to the distribution of NCQA national survey results due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results. ★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results. ★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

BCD showed above-average performance on the only comparable 2009 child CAHPS composite measure, *How Well Doctors Communicate*.

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

BCD did not have any CAHPS measures that showed below-average performance.

BCD’s detailed scores for the global ratings are presented in Table A-4. The table presents each of the CAHPS global measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table A-4—2009 CAHPS Child and Adult Global Ratings for BCD			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Rating of All Health Care</i>	71.6%	2.65	★★★
<i>Rating of Personal Doctor</i>	77.3%	2.70	★★★
<i>Rating of Specialist Seen Most Often</i>	65.9%	2.54	★★
<i>Rating of Health Plan</i>	67.2%	2.60	★★★
Adult			
<i>Rating of All Health Care</i>	50.5%	2.34	★★★
<i>Rating of Personal Doctor</i>	60.9%	2.46	★★
<i>Rating of Specialist Seen Most Often</i>	56.4%	2.44	★★
<i>Rating of Health Plan</i>	57.6%	2.43	★★★
The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.			
★ = Below-average performance (<25th percentile) relative to national Medicaid results.			
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.			
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.			

BCD showed above-average performance on three of the four child CAHPS global ratings in 2009: *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Furthermore, *Rating of Specialist Seen Most Often* showed average performance. BCD did not have any 2009 child CAHPS global ratings that performed below average.

BCD showed above-average performance on two of the four adult CAHPS global ratings for 2009: *Rating of All Health Care* and *Rating of Health Plan*. Furthermore, *Rating of Specialist Seen Most Often* and *Rating of Personal Doctor* showed average performance. BCD did not have any 2009 adult CAHPS global ratings that performed below average.

Assessment of Follow-up on Prior Recommendations

Annual Compliance Reviews

During the 2007–2008 compliance site visit, MDCH identified recommendations for **BCD** for the following standards:

- ◆ Provider
- ◆ Member
- ◆ Quality/Utilization
- ◆ Fraud and Abuse

MDCH evaluated **BCD**'s progress in implementing corrective actions to address these recommendations. Results will be included in the next technical report.

Performance Measures

Two measures (*Breast Cancer Screening—52 to 69 Years* and *Timeliness of Prenatal Care*) had below-average rates in last year's report. During 2008, **BCD** identified barriers associated with the MHP's performance on these measures and implemented several interventions to improve the rates. For the *Breast Cancer Screening* measure, interventions included reminder cards and calls to noncompliant members, as well as gift cards for members who completed their screening by the end of the year. The plan also provided transportation to a mammogram facility and information on breast cancer awareness on the plan's Web site and in member and provider newsletters, handbooks, and manuals. To improve the rate for the *Timeliness of Prenatal Care* measure, **BCD** provided prevention guidelines for adult females, with prenatal care recommendations, on multiple media, including the Web site, member and provider newsletters, handbooks, and manuals, and at community health fairs. **BCD** also offered a pregnancy program and encouraged members to call the health education line to request information on pregnancy and infant care. The 2009 rate and its relative ranking based on HEDIS 2008 percentiles indicated that both measures were ranked within the national average performance levels, suggesting the effectiveness of the interventions implemented by **BCD**.

Performance Improvement Projects (PIPs)

BCD received scores of *Met* for all applicable evaluation and critical elements in the 2007–2008 validation of its PIP. Therefore, there was no need for **BCD** to follow-up on any prior recommendations.

Recommendations and Summary Assessment Related to Quality, Timeliness, and Access

The current review of **BCD** showed both strengths and opportunities for improvement.

The 2007–2008 compliance site visit resulted in recommendations across the three domains of **quality** and **timeliness** of, and **access** to, services provided by **BCD**. While MDCH evaluated **BCD**'s progress in addressing these recommendations as well as performance related to a set of mandatory criteria, results from the 2008–2009 compliance site visits will be included in the next technical report.

Compared to the national HEDIS 2008 performance, **BCD** demonstrated at least average performance for the measures in the **quality**, **timeliness**, and **access** domains. For performance measures in the **quality** domain, 13 of the 35 comparable measures showed above-average performance, with 8 related to *Comprehensive Diabetes Care* and 2 related to *Childhood Immunization Status*. The remaining 22 measures ranked within their respective national HEDIS 2008 average performance ranges. For the **timeliness** domain, 2 measures (both under *Childhood Immunization Status*) showed above-average performance and the remaining 7 measures ranked within their national respective average performance ranges. For the **access** domain, all measures showed average performance compared to the national Medicaid percentiles. Nonetheless, several measures had exhibited a decline of at least a 2 percentage points from their 2008 rates and presented opportunities for improvement. These measures included the following: *Well-Child Visits In the First 15 Months of Life—Six or More Visits* (a decline of 5.1 percentage points), *Comprehensive Diabetes Care—Eye Exam* (a decline of 2 percentage points), *Use of Appropriate Medications for People With Asthma—18 to 56 Years* (a decline of 3.8 percentage points), *Use of Appropriate Medications for People With Asthma—Combined Rate* (a decline of 2 percentage points), and *Medical Assistance With Smoking Cessation—Advising Smokers to Quit* (a decline of 2.5 percentage points). **BCD** implemented several member and practitioner-focused interventions for the *Well-Child Visits—Six or More Visits*, *Comprehensive Diabetes Care—Eye Exams*, *Use of Appropriate Medications for People With Asthma*, and *Medical Assistance With Smoking Cessation—Advising Smokers to Quit* measures. **BCD** should consider conducting further investigation to examine if the decline in performance was restricted to certain subgroups of members and target interventions to improve the rates.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the MHP's processes for conducting valid PIPs. Therefore, all PIPs were assigned to the **quality** domain. **BCD** demonstrated strong performance related to the quality of its PIP and a thorough understanding of the requirements for Activities I through V and Activity VIII of the CMS protocol for conducting PIPs. To strengthen the study, **BCD** should address the *Point of Clarification* for Step VI and address the *Partially Met* scores in Step VI and VII. **BCD** should ensure that all documentation requirements for critical elements have been addressed. As **BCD** progresses in its study, future validations will evaluate **BCD**'s compliance with the requirements of the remaining PIP activities.

In the CAHPS domain of **quality**, **BCD** had average or above-average performance on 13 of the 13 comparable measures. **BCD** demonstrated above-average performance for the **access** domain and

average performance for the **timeliness** domain. Measures that showed below-average performance represent the greatest opportunities for quality improvement. **BCD** had no measures for which the child and/or adult Medicaid populations had below-average performance.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement.

MDCH conducted a compliance site visit to evaluate **CSM**'s implementation of corrective actions identified in the 2007–2008 site visit. MDCH also assessed **CSM**'s compliance with a set of mandatory criteria included in the review for all MHPs, regardless of prior performance.

The next technical report will present an analysis of the combined findings from the 2008–2009 and 2009–2010 site visits.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess the ability of each MHP’s support system to report accurate HEDIS measures. The results of this assessment are presented in Table B-1. The table shows each of the performance measures, the rate for each measure for 2009, and the categorized performance for 2009 relative to national Medicaid results.

Table B-1—2009 Scores for Performance Measures for CSM			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Pediatric Care	<i>Childhood Immunization—Combo 2</i>	80.0%	★★
	<i>Childhood Immunization—Combo 3</i>	74.7%	★★
	<i>Lead Screening in Children</i>	76.4%	★★
	<i>Well-Child 1st 15 Months—0 Visits*</i>	1.0%	★★
	<i>Well-Child 1st 15 Months—6+ Visits</i>	49.6%	★★
	<i>Well-Child 3rd–6th Years of Life</i>	57.5%	★
	<i>Adolescent Well-Care Visits</i>	45.5%	★★
	<i>Appropriate Treatment of URI</i>	79.0%	★
	<i>Children With Pharyngitis</i>	52.3%	★★
Women’s Care	<i>Breast Cancer Screening—Combined Rate</i>	49.4%	★★
	<i>Cervical Cancer Screening</i>	65.8%	★★
	<i>Chlamydia Screening—16 to 20 Years</i>	52.2%	★★
	<i>Chlamydia Screening—21 to 24 Years</i>	64.0%	★★
	<i>Chlamydia Screening—Combined</i>	55.7%	★★
	<i>Timeliness of Prenatal Care</i>	80.0%	★★
	<i>Postpartum Care</i>	63.7%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★ = Below-average performance relative to national Medicaid results.			
★★ = Average performance relative to national Medicaid results.			
★★★ = Above-average performance relative to national Medicaid results.			

Table B-1—2009 Scores for Performance Measures for CSM			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Living With Illness	Diabetes Care—HbA1c Testing	86.9%	★★
	Diabetes Care—Poor HbA1c Control*	29.0%	★★★
	Diabetes Care—Eye Exam	49.3%	★★
	Diabetes Care—LDL-C Screening	74.8%	★★
	Diabetes Care—LDL-C Level <100	37.6%	★★
	Diabetes Care—Nephropathy	81.2%	★★
	Diabetes Care—Blood Pressure Control (<130/80)	28.6%	★★
	Diabetes Care—Blood Pressure Control (<140/90)	66.1%	★★
	Asthma—5 to 9 Years	94.4%	★★
	Asthma—10 to 17 Years	86.7%	★★
	Asthma—18 to 56 Years	84.0%	★★
	Asthma—Combined Rate	86.5%	★★
	Controlling High Blood Pressure	58.8%	★★
	Advising Smokers to Quit	74.8%	†
	Discussing Smoking Cessation Strategies	42.7%	†
Access to Care	Children’s Access—12 to 24 Months	95.0%	★★
	Children’s Access—25 Months to 6 Years	82.6%	★★
	Children’s Access—7 to 11 Years	84.0%	★★
	Adolescents’ Access—12 to 19 Years	83.2%	★★
	Adults’ Access—20 to 44 Years	82.0%	★★
	Adults’ Access—45 to 64 Years	87.5%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table B-1 shows that **CSM**’s rate for the *Comprehensive Diabetes Care—Poor HbA1c Control* measure was above average compared to the national Medicaid HEDIS 2008 results. This measure represented an area of relative strength for **CSM**.

The table also shows that rates for 32 of the performance measures ranked within their respective national Medicaid HEDIS 2008 average performance ranges. These measures represented neither areas of relative strength nor high-priority opportunities for improvement.

Two measures, including *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Appropriate Treatment of URI*, reported rates that were below the national Medicaid HEDIS 2008 average performance levels. These measures represented opportunities for improvement for **CSM** compared to national results.

Validation of Performance Improvement Projects (PIPs)

Table B-2 presents the scoring for each of the steps in the CMS PIP protocol. The table shows the number of elements within each step and, of those, the number that were scored as *Met*, *Partially Met*, *Not Met*, or *NA*; the total percentage scores for evaluation and critical elements *Met*; and the validation status for the PIP.

Table B-2—2008–2009 PIP Validation Results for CSM						
Step		Number of Elements				
		Total	Met	Partially Met	Not Met	NA
I.	Review the Selected Study Topic(s)	6	6	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	6	0	0	1
IV.	Review the Identified Study Population	3	3	0	0	0
V.	Review Sampling Methods (if sampling was used)	6	0	0	0	6
VI.	Review Data Collection Procedures	11	6	0	0	5
VII.	Assess Improvement Strategies	4	3	0	0	1
VIII.	Review Data Analysis and the Interpretation of Study Results	9	7	1	0	1
IX.	Assess for Real Improvement	4	3	1	0	0
X.	Assess for Sustained Improvement	1	Not Assessed			
Totals for all Steps		53	36	2	0	14
Percentage Score of Evaluation Elements Met		95%				
Percentage Score of Critical Elements Met		100%				
Validation Status		Met				

The 2008–2009 validation of **CSM**'s PIP on *Breast Cancer Screening Disparity* resulted in a validation status of *Met* with an overall score of 95 percent and a score of 100 percent for critical elements. While **CSM** demonstrated compliance with all applicable requirements for Steps I through VII of the CMS protocol for validating PIPs, HSAG identified opportunities for improvement in Steps VIII and IX that **CSM** will need to address prior to the next annual submission.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **CSM**'s composite CAHPS scores are shown in Table B-3. The table presents each of the CAHPS measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table B-3—2009 CAHPS Child and Adult Composite Scores for CSM			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Getting Needed Care</i>	48.5%	2.21	*
<i>Getting Care Quickly</i>	71.9%	2.60	*
<i>How Well Doctors Communicate</i>	72.5%	2.64	★★
<i>Customer Service</i>	NA	NA	*
<i>Shared Decision Making</i>	65.3%	2.56	**
Adult			
<i>Getting Needed Care</i>	52.6%	2.30	★★
<i>Getting Care Quickly</i>	56.8%	2.37	★★
<i>How Well Doctors Communicate</i>	67.1%	2.54	★★
<i>Customer Service</i>	57.4%	2.36	★★
<i>Shared Decision Making</i>	59.8%	2.51	—
<p>The top-box percentage indicates the percentage of responses of “Always” or “Definitely Yes.”</p> <p>Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p>* The results for these measures are not comparable to the distribution of NCQA national survey results due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p> <p>NA = Composites that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results.</p> <p>★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.</p> <p>★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

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

CSM showed average performance on all four of the comparable 2009 adult CAHPS composite measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. **CSM** did not show below- or above-average performance on any of the measures.

CSM’s detailed scores for the global ratings are presented in Table B-4. The table shows each of the four CAHPS global measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table B-4—2009 CAHPS Child and Adult Global Ratings for CSM			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Rating of All Health Care</i>	54.1%	2.38	★
<i>Rating of Personal Doctor</i>	60.7%	2.48	★
<i>Rating of Specialist Seen Most Often</i>	NA	NA	NA
<i>Rating of Health Plan</i>	51.8%	2.33	★
Adult			
<i>Rating of All Health Care</i>	49.0%	2.28	★★
<i>Rating of Personal Doctor</i>	58.1%	2.41	★★
<i>Rating of Specialist Seen Most Often</i>	62.4%	2.49	★★★
<i>Rating of Health Plan</i>	54.2%	2.33	★★
<p>The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population. NA = Global ratings that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results. ★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results. ★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

CSM scored below average on all three of the comparable 2009 child CAHPS global ratings: *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Therefore, these areas of below-average performance could be targeted for quality improvement activities aimed at improving member satisfaction. CSM did not show average or above-average performance on any of the child CAHPS global ratings.

CSM showed above-average performance on one of the four 2009 adult CAHPS global ratings, *Rating of Specialist Seen Most Often*. This indicates an area of strength for CSM. CSM showed average performance on the remaining three measures: *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

Assessment of Follow-up on Prior Recommendations

Annual Compliance Reviews

During the 2007–2008 compliance site visit, MDCH identified recommendations for **CSM** for the following standards:

- ◆ Provider
- ◆ Quality/Utilization
- ◆ Fraud and Abuse

MDCH evaluated **CSM**'s progress in implementing corrective actions to address these recommendations. Results will be included in the next technical report.

Performance Measures

CSM's 2008 rates for four measures (*Well-Child Visits in the First 15 Months of Life—Zero Visits*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Children's Access to Primary Care Practitioners—25 Months to 6 Years*; and *Children's Access to Primary Care Practitioners—7 to 11 Years*) fell below their respective national Medicaid HEDIS 2007 average performance ranges. During 2008, **CSM** implemented several interventions to improve its performance. For the well-child measures, major interventions included continuation of a coupon incentive program and an outbound call reminder program to encourage members to keep well-child visits. The MHP also offered incentives to compensate providers for both a well-child and a sick visit during the same appointment and introduced its Enhanced Physician Quality Enhancement Program to encourage providers to perform EPSDT visits. The 2009 rates for these measures improved from last year's rates. Rates for all but one measure (*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) increased to rank within the national HEDIS 2008 average performance ranges, suggesting that the interventions implemented by **CSM** were effective.

Performance Improvement Projects (PIPs)

CSM received scores of *Met* for all applicable evaluation and critical elements in the 2007–2008 validation of its PIP. Therefore, there was no need for **CSM** to follow-up on any prior recommendations.

Recommendations and Summary Assessment Related to Quality, Timeliness, and Access

The 2007–2008 compliance site visit resulted in recommendations across the three domains of **quality** and **timeliness** of, and **access** to, services provided by **CSM**. While MDCH evaluated **CSM**'s progress in addressing these recommendations as well as performance related to a set of mandatory criteria, results from the 2008–2009 compliance site visits will be included in the next technical report.

Compared to the national HEDIS 2008 percentiles, **CSM** demonstrated mixed performance on measures in the **quality** and **timeliness** domains, but showed average performance across measures in the **access** domain. In the **quality** domain, one *Comprehensive Diabetes Care* measure showed above-average performance (*Poor HbA1c Control*). Thirty-two measures ranked within their respective national HEDIS 2008 average performance ranges. Only two measures (*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Appropriate Treatment of URI*) fell below their corresponding national HEDIS 2008 average performance levels. However, **CSM** increased its rate on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure by 3.2 percentage points over last year's rate. Although eight of the nine **timeliness** measures ranked within the respective national HEDIS 2008 average performance ranges, the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure performed below the national average range. All measures in the **access** domain ranked within their respective national average performance ranges. Opportunities for improvement were present not only in measures that ranked below the national HEDIS 2008 average performance levels but also in those that exhibited a decline from the 2008 rate. Measures with a decrease of at least 2 percentage points in their rate included *Appropriate Testing for Children With Pharyngitis* (a decline of 4.8 percentage points); *Comprehensive Diabetes Care—Blood Pressure Control <130/80* (a decline of 5.9 percentage points); *Poor HbA1c Control* (a decline of 2.7 percentage points); *Medical Assistance With Smoking Cessation—Advising Smokers to Quit* (a decline of 2.1 percentage points); and *Use of Appropriate Medications for People With Asthma* (with a decline of 4.9 percentage points for the *10 to 17 Years* measure, a decline of 4.5 percentage points for the *18 to 56 Years* measure, and a decline of 3.9 percentage points for the *Combined Rate*). **CSM** implemented several interventions to address the *Comprehensive Diabetes Care—Blood Pressure >130/80*, *Poor HbA1c Control*, *Use of Appropriate Medications for People With Asthma*, and *Medical Assistance With Smoking Cessation—Advising Smokers to Quit* measures. However, **CSM** did not report any interventions related to the *Appropriate Testing for Children With Pharyngitis* measure. **CSM** could consider multi-pronged strategies that target members and providers to improve performance. The MHP should consider continuing the interventions for the other measures.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the MHP's processes for conducting valid PIPs. Therefore, all PIPs were assigned to the **quality** domain. **CSM** demonstrated strong performance related to the quality of its PIP and a thorough understanding of the requirements for Activities I through VII of the CMS protocol for conducting PIPs. To strengthen the study, **CSM** should address all *Points of Clarification* and *Partially Met* scores in the PIP Validation Tool by removing the result of 45.6 reported at the end of the statement, "We will compare this data trend in the remeasurement year for improvement which will

help to answer study question 1. 45.6,” and performing statistical testing between black non-Hispanic and white non-Hispanic females. As **CSM** progresses in its study, future validations will evaluate **CSM**’s compliance with the requirements of the remaining PIP activities.

In the CAHPS domain of **quality**, **CSM** had average or above-average performance on 9 of the 12 comparable measures. **CSM** demonstrated average performance across both the **access** and **timeliness** domains. Measures that showed below-average performance represented the greatest opportunities for quality improvement. **CSM** had no measures for which both the child and adult Medicaid populations had below-average performance. However, three child measures—*Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*—had below-average performance and could be targeted for quality improvement activities aimed at improving member satisfaction. To improve the overall *Rating of All Health Care* measure, quality improvement activities could target member satisfaction with physicians, member perception of access to care, experience with care, and experience with the health plan. To improve the *Rating of Personal Doctor* measure, quality improvement activities could target increasing levels of communication between physicians and patients. The activities could also aim to decrease the time between the point when patients need care and when patients receive care by eliminating barriers that may prohibit patients from receiving prompt, adequate care. To improve the overall *Rating of Health Plan* measure, quality improvement activities could target changing health plan operations to improve existing activities (e.g., customer service) and improving operations at individual physician offices (e.g., efficiency and ease of scheduling appointments).

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement.

MDCH conducted a compliance site visit to evaluate **GLH**'s implementation of corrective actions identified in the 2007–2008 site visit. MDCH also assessed **GLH**'s compliance with a set of mandatory criteria included in the review for all MHPs, regardless of prior performance.

The next technical report will present an analysis of the combined findings from the 2008–2009 and 2009–2010 site visits.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and to determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess the ability of each MHP’s support system to report accurate HEDIS measures. The results of this assessment are presented in Table C-1. The table shows each of the performance measures, the rates for each measure for 2009, and the categorized performance for 2009 relative to national Medicaid results.

Table C-1—2009 Scores for Performance Measures for GLH			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Pediatric Care	<i>Childhood Immunization—Combo 2</i>	81.1%	★★
	<i>Childhood Immunization—Combo 3</i>	75.3%	★★
	<i>Lead Screening in Children</i>	73.2%	★★
	<i>Well-Child 1st 15 Months—0 Visits*</i>	1.0%	★★
	<i>Well-Child 1st 15 Months—6+ Visits</i>	87.6%	★★★
	<i>Well-Child 3rd–6th Years of Life</i>	76.4%	★★
	<i>Adolescent Well-Care Visits</i>	62.3%	★★★
	<i>Appropriate Treatment of URI</i>	82.2%	★★
	<i>Children With Pharyngitis</i>	39.3%	★
Women’s Care	<i>Breast Cancer Screening—Combined Rate</i>	56.0%	★★
	<i>Cervical Cancer Screening</i>	75.0%	★★
	<i>Chlamydia Screening—16 to 20 Years</i>	57.7%	★★
	<i>Chlamydia Screening—21 to 24 Years</i>	67.6%	★★
	<i>Chlamydia Screening—Combined</i>	61.2%	★★
	<i>Timeliness of Prenatal Care</i>	90.4%	★★
	<i>Postpartum Care</i>	68.9%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table C-1—2009 Scores for Performance Measures for GLH			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Living With Illness	Diabetes Care—HbA1c Testing	80.3%	★★
	Diabetes Care—Poor HbA1c Control*	38.0%	★★
	Diabetes Care—Eye Exam	61.3%	★★
	Diabetes Care—LDL-C Screening	78.3%	★★
	Diabetes Care—LDL-C Level <100	33.6%	★★
	Diabetes Care—Nephropathy	80.5%	★★
	Diabetes Care—Blood Pressure Control (<130/80)	27.5%	★★
	Diabetes Care—Blood Pressure Control (<140/90)	61.1%	★★
	Asthma—5 to 9 Years	89.1%	★★
	Asthma—10 to 17 Years	80.8%	★
	Asthma—18 to 56 Years	83.3%	★★
	Asthma—Combined Rate	83.8%	★
	Controlling High Blood Pressure	57.9%	★★
	Advising Smokers to Quit	73.0%	†
	Discussing Smoking Cessation Strategies	47.2%	†
Access to Care	Children’s Access—12 to 24 Months	97.8%	★★
	Children’s Access—25 Months to 6 Years	89.8%	★★
	Children’s Access—7 to 11 Years	89.2%	★★
	Adolescents’ Access—12 to 19 Years	88.0%	★★
	Adults’ Access—20 to 44 Years	82.9%	★★
	Adults’ Access—45 to 64 Years	89.9%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table C-1 shows that **GLH**’s rate for two performance measures, *Well-Child Visits in the First 15 Months of Life—Six or More Visits* and *Adolescent Well-Care Visits*, were above average compared to the national Medicaid HEDIS 2008 results. These measures represented an area of relative strength for **GLH**.

The table also shows that the rates for 30 of the performance measures ranked within their respective national Medicaid HEDIS 2008 average performance ranges. These measures represented neither areas of relative strength nor high-priority opportunities for improvement.

Three measures reported rates that were below the national Medicaid HEDIS 2008 average performance ranges, with two of the below-average measures related to the use of appropriate asthma medications. The measures were *Appropriate Testing for Children With Pharyngitis*, *Use of*

Appropriate Medications for People With Asthma—10 to 17 Years, and Use of Appropriate Medications for People With Asthma—Combined. These measures, compared with national results, represented opportunities for improvement for **GLH**.

Validation of Performance Improvement Projects (PIPs)

Table C-2 presents the scoring for each of the steps in the CMS PIP protocol. The table shows the number of elements within each step and, of those, the number that were scored as *Met*, *Partially Met*, *Not Met*, or *NA*; the total percentage scores for evaluation and critical elements *Met*; and the validation status for the PIP.

Table C-2—2008–2009 PIP Validation Results <i>for</i> GLH						
Step		Number of Elements				
		Total	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
I.	Review the Selected Study Topic(s)	6	6	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	6	0	0	1
IV.	Review the Identified Study Population	3	3	0	0	0
V.	Review Sampling Methods (if sampling was used)	6	0	0	0	6
VI.	Review Data Collection Procedures	11	6	0	0	5
VII.	Assess Improvement Strategies	4	3	0	0	1
VIII.	Review Data Analysis and the Interpretation of Study Results	9	6	2	0	1
IX.	Assess for Real Improvement	4	1	0	3	0
X.	Assess for Sustained Improvement	1	0	0	1	0
Totals for all Steps		53	33	2	4	14
Percentage Score of Evaluation Elements <i>Met</i>		85%				
Percentage Score of Critical Elements <i>Met</i>		100%				
Validation Status		<i>Met</i>				

The 2008–2009 validation of **GLH**'s PIP on *Breast Cancer Screening Disparity* resulted in a validation status of *Met* with an overall score of 85 percent and a score of 100 percent for critical elements. **GLH** demonstrated compliance with all applicable requirements of the CMS protocol for validating PIPs for Steps I through VII. HSAG identified opportunities for improvement in Steps VIII, IX, and X that **GLH** will need to address prior to the next annual submission.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **GLH**'s composite CAHPS scores are shown in Table C-3. The table presents each of the CAHPS measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table C-3—2009 CAHPS Child and Adult Composite Scores for GLH			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Getting Needed Care</i>	63.9%	2.48	*
<i>Getting Care Quickly</i>	72.5%	2.61	*
<i>How Well Doctors Communicate</i>	75.6%	2.68	★★★
<i>Customer Service</i>	NA	NA	*
<i>Shared Decision Making</i>	64.4%	2.53	**
Adult			
<i>Getting Needed Care</i>	56.2%	2.35	★★★
<i>Getting Care Quickly</i>	56.8%	2.39	★★
<i>How Well Doctors Communicate</i>	70.0%	2.57	★★
<i>Customer Service</i>	64.9%	2.46	★★★
<i>Shared Decision Making</i>	59.9%	2.50	—
<p>The top-box percentage indicates the percentage of responses of “Always” or “Definitely Yes.”</p> <p>Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p>* The results for these measures are not comparable to the distribution of NCQA national survey results due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p> <p>NA = Composites that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results.</p> <p>★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.</p> <p>★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

GLH showed above-average performance on the only comparable 2009 child CAHPS composite measure, *How Well Doctors Communicate*.

GLH showed above-average performance on two of the four comparable 2009 adult CAHPS composite measures: *Getting Needed Care* and *Customer Service*. These measures indicate areas of strength for **GLH**. Furthermore, **GLH** showed average performance on the remaining two measures: *Getting Care Quickly* and *How Well Doctors Communicate*.

GLH’s detailed scores for the global ratings are presented in Table C-4. The table shows each of the four CAHPS global measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table C-4—2009 CAHPS Child and Adult Global Ratings for GLH			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Rating of All Health Care</i>	64.9%	2.55	★★
<i>Rating of Personal Doctor</i>	67.4%	2.59	★★★
<i>Rating of Specialist Seen Most Often</i>	NA	NA	NA
<i>Rating of Health Plan</i>	69.9%	2.63	★★★
Adult			
<i>Rating of All Health Care</i>	49.8%	2.31	★★★
<i>Rating of Personal Doctor</i>	62.1%	2.46	★★
<i>Rating of Specialist Seen Most Often</i>	58.1%	2.42	★★
<i>Rating of Health Plan</i>	60.6%	2.50	★★★
The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population. NA = Global ratings that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).			
★ = Below-average performance (<25th percentile) relative to national Medicaid results. ★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results. ★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.			

GLH showed above-average performance on two of the three 2009 child CAHPS global ratings: *Rating of Personal Doctor* and *Rating of Health Plan*. These indicate areas of strength for GLH. Furthermore, GLH showed average performance for one measure, *Rating of All Health Care*. GLH did not show below-average performance on any of the child CAHPS global ratings.

GLH showed above-average performance on two of the four 2009 adult CAHPS global ratings: *Rating of All Health Care* and *Rating of Health Plan*. These indicate areas of strength for GLH. Furthermore, GLH showed average performance on the remaining two measures: *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*. GLH did not show below-average performance on any of the adult CAHPS global ratings.

Assessment of Follow-up on Prior Recommendations

Annual Compliance Reviews

During the 2007–2008 compliance site visit, MDCH identified recommendations for **GLH** for the following standards:

- ◆ Provider
- ◆ Quality/Utilization
- ◆ MIS/Data Reporting/Claims Processing
- ◆ Fraud and Abuse

MDCH evaluated **GLH**'s progress in implementing corrective actions to address these recommendations. Results will be included in the next technical report.

Performance Measures

GLH implemented improvement strategies to target the measures that were below the national Medicaid HEDIS 2007 average performance standards—*Appropriate Treatment for Children With URI*, *Appropriate Testing for Children With Pharyngitis*, and *Use of Appropriate Medications for People With Asthma*. **GLH** reviewed and updated the Michigan Quality Improvement Consortium (MQIC) guidelines for asthma and developed the 2009 guideline development agenda for upper respiratory infection in children. The health plan also identified potential tools for acute pharyngitis guidelines. In September 2008, **GLH** implemented a disease management program for members with asthma. **GLH** determined that the HEDIS software identified false positives for the asthma measures, which was a barrier to better performance. The health plan started to identify members who did not have a diagnosis of asthma and remove them from the denominator of the asthma measures. The improvement strategies resulted in increases in the targeted rates, except for the *Appropriate Testing for Children With Pharyngitis* and *Use of Appropriate Medications for People With Asthma—Combined Rate* measures. In addition, the 2009 rates for the *Appropriate Treatment for Children With URI* measure and the *Use of Appropriate Medications for People With Asthma—5 to 9 Years* measure fell within the respective national HEDIS 2008 average performance ranges.

Performance Improvement Projects (PIPs)

Based on the 2007–2008 validation, HSAG recommended that **GLH** revise existing or implement new interventions to achieve statistically significant improvement for the study indicator. The 2008–2009 validation determined that there was no improvement in the outcomes of care from the first to the second remeasurement period. **GLH** should continue to consider alternative interventions for the study population.

Recommendations and Summary Assessment Related to Quality, Timeliness, and Access

The current review of **GLH** showed both strengths and opportunities for improvement.

The 2007–2008 compliance site visit resulted in recommendations across the three domains of **quality** and **timeliness** of, and **access** to, services provided by **GLH**. While MDCH evaluated **GLH**'s progress in addressing these recommendations as well as performance related to a set of mandatory criteria, results from the 2008–2009 compliance site visits will be included in the next technical report.

GLH demonstrated mixed performance for measures in the **quality** domain, but showed at least average performance across measures in the **timeliness** and **access** domains. In the **quality** domain, two measures showed above-average performance (*Well-Child Visits in the First 15 Months of Life—Six or More Visits* and *Adolescent Well-Care Visits*). Thirty measures ranked within their respective national HEDIS 2008 average performance ranges. Three measures (*Appropriate Testing for Children With Pharyngitis* and two asthma measures—*10 to 17 Years* and *Combined Rate*) ranked below their corresponding national HEDIS 2008 average performance levels. Despite implementing several interventions in 2008, **GLH** continued to show low performance on the *Appropriate Testing for Children With Pharyngitis* and *Use of Appropriate Medications for People With Asthma* measures. Two of the nine **timeliness** measures (*Well-Child Visits in the First 15 Months of Life—Six or More Visits* and *Adolescent Well-Care Visits*) showed above-average performance. The remaining seven measures ranked within their respective national HEDIS 2008 average performance ranges. All **access** measures showed average performance compared to the national Medicaid percentiles. Additionally, four measures had a decline of at least 2 percentage points from their 2008 rates. These measures were *Appropriate Testing for Children With Pharyngitis* (a decline of 2.5 percentage points), *Comprehensive Diabetes Care—HbA1c Testing* and *LDL-C Level <100* (each had a decline of 3.9 percentage points), and *Use of Appropriate Medications for People With Asthma—18–56 Years* (a decline of 2.2 percentage points). **GLH** implemented several interventions focused on members and practitioners to address the following measures: *Appropriate Testing for Children With Pharyngitis*, *Comprehensive Diabetes Care—HbA1c Testing* and *LDL-C Level <100*, and *Use of Appropriate Medications for People With Asthma*. **GLH** should consider continuing all interventions to improve the rates for these measures.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the MHP's processes for conducting valid PIPs. Therefore, all PIPs were assigned to the **quality** domain. **GLH** demonstrated improved performance related to the quality of its PIP and a thorough understanding of the requirements for Activities I through VII of the CMS protocol for conducting PIPs. After three annual remeasurement periods, the PIP has not demonstrated sustained improvement. The results were essentially unchanged from baseline to the second remeasurement period. **GLH** should continue to monitor the rates for the study indicator and determine if any additional improvement strategies could be implemented for the MHP to reach its desired goal and benchmark. HSAG also recommended that **GLH** conduct statistical testing between the screening rates of the study group and the overall plan rate to evaluate any change in disparity between the two groups.

In the CAHPS domain of **quality**, **GLH** had average or above-average performance on all 12 of the comparable measures. **GLH** demonstrated above-average performance in the **access** domain and average performance in the **timeliness** domain. Measures with below-average performance represent the greatest opportunities for quality improvement. However, none of the adult or child Medicaid measures showed below-average performance.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement.

MDCH conducted a compliance site visit to evaluate **HPM**'s implementation of corrective actions identified in the 2007–2008 site visit. MDCH also assessed **HPM**'s compliance with a set of mandatory criteria included in the review for all MHPs, regardless of prior performance.

The next technical report will present an analysis of the combined findings from the 2008–2009 and 2009–2010 site visits.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess the ability of each MHP’s support system to report accurate HEDIS measures. The results of this assessment are presented in Table D-1. The table shows each of the performance measures, the rates for each measure for 2009, and the categorized performance for 2009 relative to national Medicaid results.

Table D-1—2009 Scores for Performance Measures for HPM			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Pediatric Care	<i>Childhood Immunization—Combo 2</i>	88.7%	★★★
	<i>Childhood Immunization—Combo 3</i>	82.4%	★★★
	<i>Lead Screening in Children</i>	81.9%	★★
	<i>Well-Child 1st 15 Months—0 Visits*</i>	1.1%	★★
	<i>Well-Child 1st 15 Months—6+ Visits</i>	72.6%	★★
	<i>Well-Child 3rd–6th Years of Life</i>	78.0%	★★
	<i>Adolescent Well-Care Visits</i>	57.8%	★★★
	<i>Appropriate Treatment of URI</i>	81.0%	★★
	<i>Children With Pharyngitis</i>	62.6%	★★
Women’s Care	<i>Breast Cancer Screening—Combined Rate</i>	63.0%	★★★
	<i>Cervical Cancer Screening</i>	81.3%	★★★
	<i>Chlamydia Screening—16 to 20 Years</i>	57.1%	★★
	<i>Chlamydia Screening—21 to 24 Years</i>	65.2%	★★
	<i>Chlamydia Screening—Combined</i>	60.3%	★★
	<i>Timeliness of Prenatal Care</i>	89.6%	★★
	<i>Postpartum Care</i>	75.5%	★★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★ = Below-average performance relative to national Medicaid results.			
★★ = Average performance relative to national Medicaid results.			
★★★ = Above-average performance relative to national Medicaid results.			

Table D-1—2009 Scores for Performance Measures for HPM			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Living With Illness	Diabetes Care—HbA1c Testing	89.3%	★★★
	Diabetes Care—Poor HbA1c Control*	24.8%	★★★
	Diabetes Care—Eye Exam	73.1%	★★★
	Diabetes Care—LDL-C Screening	82.6%	★★★
	Diabetes Care—LDL-C Level <100	43.0%	★★★
	Diabetes Care—Nephropathy	86.9%	★★★
	Diabetes Care—Blood Pressure Control (<130/80)	33.9%	★★
	Diabetes Care—Blood Pressure Control (<140/90)	69.1%	★★
	Asthma—5 to 9 Years	95.9%	★★
	Asthma—10 to 17 Years	92.2%	★★
	Asthma—18 to 56 Years	89.4%	★★
	Asthma—Combined Rate	91.6%	★★
	Controlling High Blood Pressure	65.3%	★★★
	Advising Smokers to Quit	72.3%	†
Discussing Smoking Cessation Strategies	45.9%	†	
Access to Care	Children’s Access—12 to 24 Months	96.8%	★★
	Children’s Access—25 Months to 6 Years	89.9%	★★
	Children’s Access—7 to 11 Years	90.8%	★★
	Adolescents’ Access—12 to 19 Years	90.8%	★★
	Adults’ Access—20 to 44 Years	85.6%	★★
	Adults’ Access—45 to 64 Years	91.1%	★★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table D-1 shows that **HPM**’s rates for 14 of the performance measures were above average compared to the national Medicaid HEDIS 2008 results. These measures were: both *Childhood Immunization* measures, *Adolescent Well-Care Visits*, *Breast Cancer Screening—Combined Rate*, *Cervical Cancer Screening*, *Postpartum Care*, 6 of the 8 *Comprehensive Diabetes Care* measures, *Controlling High Blood Pressure*, and *Adults’ Access to Preventive/Ambulatory Health Services—45 to 64 Years*. These measures represented areas of relative strength for **HPM**.

The table also shows that rates for 21 of the performance measures ranked within their respective national Medicaid HEDIS 2008 average performance ranges. These measures represented neither areas of relative strength nor high-priority opportunities for improvement.

None of the rates was below the national Medicaid HEDIS 2008 average performance, indicating that in general, **HPM** achieved at least average performance for all of its performance measures.

Validation of Performance Improvement Projects (PIPs)

Table D-2 presents the scoring for each of the steps in the CMS PIP protocol. The table shows the number of elements within each step and, of those, the number that were scored as *Met*, *Partially Met*, *Not Met*, or *NA*; the total percentage scores for evaluation and critical elements *Met*; and the validation status for the PIP.

Table D-2—2008–2009 PIP Validation Results for HPM						
Step		Number of Elements				
		Total	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
I.	Review the Selected Study Topic(s)	6	6	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	7	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0
V.	Review Sampling Methods (if sampling was used)	6	0	0	0	6
VI.	Review Data Collection Procedures	11	6	0	0	5
VII.	Assess Improvement Strategies	4	3	0	0	1
VIII.	Review Data Analysis and the Interpretation of Study Results	9	8	0	0	1
IX.	Assess for Real Improvement	4	4	0	0	0
X.	Assess for Sustained Improvement	1	1	0	0	0
Totals for all Steps		53	40	0	0	13
Percentage Score of Evaluation Elements <i>Met</i>		100%				
Percentage Score of Critical Elements <i>Met</i>		100%				
Validation Status		<i>Met</i>				

The 2008–2009 validation of **HPM**'s PIP on *Cervical Cancer Screening Disparity* resulted in a validation status of *Met* with an overall score of 100 percent and a score of 100 percent for critical elements. **HPM** demonstrated compliance with all applicable requirements of the CMS protocol for validating PIPs. There were no opportunities for improvement identified for **HPM**. Based on the results of the 2008–2009 validation, there was high confidence that the PIP produced valid results.

HPM has demonstrated improvement for both study indicators from baseline through the third remeasurement period. **HPM**'s data showed no significant disparity, a result that reflects the success of the improvement strategies.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **HPM**'s composite CAHPS scores are shown in Table D-3. The table presents each of the CAHPS measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table D-3—2009 CAHPS Child and Adult Composite Scores for HPM			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Getting Needed Care</i>	59.9%	2.43	*
<i>Getting Care Quickly</i>	76.3%	2.68	*
<i>How Well Doctors Communicate</i>	72.9%	2.65	★★★
<i>Customer Service</i>	66.9%	2.54	*
<i>Shared Decision Making</i>	68.3%	2.61	**
Adult			
<i>Getting Needed Care</i>	54.2%	2.33	★★★
<i>Getting Care Quickly</i>	59.3%	2.42	★★★
<i>How Well Doctors Communicate</i>	66.9%	2.51	★★
<i>Customer Service</i>	58.4%	2.39	★★
<i>Shared Decision Making</i>	58.9%	2.47	—
<p>The top-box percentage indicates the percentage of responses of “Always” or “Definitely Yes.”</p> <p>Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p>* The results for these measures are not comparable to the distribution of NCQA national survey results due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results. ★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results. ★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

HPM showed above-average performance for the only comparable 2009 child CAHPS composite measure, *How Well Doctors Communicate*, indicating an area of strength.

HPM showed above-average performance for two of the four comparable 2009 adult CAHPS composite measures: *Getting Needed Care* and *Getting Care Quickly*. These results indicate areas of strength for **HPM**. **HPM** showed average performance on the remaining two measures: *How Well Doctors Communicate* and *Customer Service*. **HPM** did not show below-average performance on any of the adult CAHPS composite scores.

HPM’s detailed scores for the global ratings are presented in Table D-4. The table shows each of the four CAHPS global measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table D-4—2009 CAHPS Child and Adult Global Ratings for HPM			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Rating of All Health Care</i>	61.5%	2.53	★★
<i>Rating of Personal Doctor</i>	67.9%	2.59	★★★
<i>Rating of Specialist Seen Most Often</i>	69.4%	2.57	★★★
<i>Rating of Health Plan</i>	67.8%	2.60	★★★
Adult			
<i>Rating of All Health Care</i>	51.3%	2.31	★★★
<i>Rating of Personal Doctor</i>	61.8%	2.44	★★
<i>Rating of Specialist Seen Most Often</i>	62.5%	2.47	★★
<i>Rating of Health Plan</i>	61.1%	2.47	★★★
The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.			
<ul style="list-style-type: none"> ★ = Below-average performance (<25th percentile) relative to national Medicaid results. ★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results. ★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results. 			

HPM showed above-average performance for three of the four 2009 child CAHPS global ratings: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. HPM showed average performance for the remaining measure, *Rating of All Health Care*. HPM did not show below-average performance for any of the child global ratings.

HPM showed above-average performance for two of the four 2009 adult CAHPS global ratings: *Rating of All Health Care* and *Rating of Health Plan*. Furthermore, HPM showed average performance for the remaining two measures: *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*. HPM did not show below-average performance for any of the adult global ratings.

Assessment of Follow-up on Prior Recommendations

Annual Compliance Reviews

During the 2007–2008 compliance site visit, MDCH identified recommendations for **HPM** for the following standards:

- ◆ Provider
- ◆ Quality/Utilization

MDCH evaluated **HPM**'s progress in implementing corrective actions to address these recommendations. Results will be included in the next technical report.

Performance Measures

Although **HPM** did not have any measures with rates below the national Medicaid HEDIS 2007 average performance standards, its 2008 rate for the *Use of Appropriate Medications for People With Asthma* measures had declined from the previous year. During 2008, **HPM** implemented several improvement strategies. These strategies included early identification of adult members for the asthma disease management program, notification to primary care providers of members with asthma, and initial contact and semi-annual follow-up with the identified members by phone. **HPM** also strengthened its outreach to members via the TouchStar autodial phone system, HEDIS and health risk assessment (HRA) calls, and a targeted approach to mailing educational materials. The 2009 rates for all the *Use of Appropriate Medications for People With Asthma* measures demonstrated improvement, suggesting the effectiveness of these strategies.

Performance Improvement Projects (PIPs)

HPM received scores of *Met* for all applicable evaluation and critical elements in the 2007–2008 validation of its PIP. Therefore, there was no need for **HPM** to follow-up on any prior recommendations.

Recommendations and Summary Assessment Related to Quality, Timeliness, and Access

The current review of **HPM** showed both strengths and opportunities for improvement.

The 2007–2008 compliance site visit resulted in recommendations across the three domains of **quality** and **timeliness** of, and **access** to, services provided by **HPM**. While MDCH evaluated **HPM**'s progress in addressing these recommendations as well as performance related to a set of mandatory criteria, results from the 2008–2009 compliance site visits will be included in the next technical report.

HPM demonstrated at least average performance across measures in the **quality**, **timeliness**, and **access** domains. In the **quality** domain, the following 14 measures showed above-average performance: both *Childhood Immunization* measures, *Adolescent Well-Care Visits*, *Breast Cancer Screening—Combined Rate*, *Cervical Cancer Screening*, *Postpartum Care*, 6 of the 8 *Comprehensive Diabetes Care* measures, *Controlling High Blood Pressure—Combined*, and *Adults' Access to Preventive/Ambulatory Health Services—45 to 64 Years*. The remaining 21 measures ranked within their respective national HEDIS 2008 average performance ranges. For the **timeliness** domain, 4 measures (both *Childhood Immunization* measures, *Adolescent Well-Care Visits*, and *Postpartum Care*) had above-average rates, and the remaining 5 measures ranked within their respective national average performance ranges. For the **access** domain, 2 measures (*Postpartum Care* and *Adults' Access to Preventive/Ambulatory Health Services—45 to 64 Years*) ranked above average compared to the national Medicaid percentiles. The remaining 6 measures ranked within their respective national average performance ranges. Although none of the measures performed below the national Medicaid HEDIS 2008 average performance level, the 2009 rate for the *Medical Assistance With Smoking Cessation—Advising Smokers to Quit* measure was 3.5 percentage points lower than the 2008 rate, reflecting an opportunity for improvement. **HPM** implemented interventions focused on members and practitioners to address the *Medical Assistance With Smoking Cessation—Advising Smokers to Quit* measure. The plan should continue these interventions to improve the rate for this measure.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the MHP's processes for conducting valid PIPs. Therefore, all PIPs were assigned to the **quality** domain. **HPM** demonstrated strong performance related to the quality of its PIP and a thorough understanding of the requirements of the CMS protocol for conducting PIPs. Because **HPM** has completed all 10 activities, received a *Met* validation status, and demonstrated improvement in outcomes of care, this PIP could be considered for retirement.

In the CAHPS domain of **quality**, **HPM** had average or above-average performance on all 13 comparable measures. **HPM** demonstrated above-average performance across both the **access** and **timeliness** domains. Measures that showed below-average performance represent the greatest opportunities for quality improvement. However, **HPM** had no measures for which the child and/or adult Medicaid populations had below-average performance.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement.

MDCH conducted a compliance site visit to evaluate **HPP's** implementation of corrective actions identified in the 2007–2008 site visit. MDCH also assessed **HPP's** compliance with a set of mandatory criteria included in the review for all MHPs, regardless of prior performance.

The next technical report will present an analysis of the combined findings from the 2008–2009 and 2009–2010 site visits.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess the ability of each MHP’s support system to report accurate HEDIS measures. The results of this assessment are presented in Table E-1. The table shows each of the performance measures, the rates for each measure for 2009, and the categorized performance for 2009 relative to national Medicaid results.

Table E-1—2009 Scores for Performance Measures for HPP			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Pediatric Care	<i>Childhood Immunization—Combo 2</i>	83.0%	★★
	<i>Childhood Immunization—Combo 3</i>	74.3%	★★
	<i>Lead Screening in Children</i>	78.4%	★★
	<i>Well-Child 1st 15 Months—0 Visits*</i>	1.0%	★★
	<i>Well-Child 1st 15 Months—6+ Visits</i>	64.3%	★★
	<i>Well-Child 3rd–6th Years of Life</i>	64.2%	★★
	<i>Adolescent Well-Care Visits</i>	48.4%	★★
	<i>Appropriate Treatment of URI</i>	78.6%	★
	<i>Children With Pharyngitis</i>	46.3%	★
Women’s Care	<i>Breast Cancer Screening—Combined Rate</i>	54.5%	★★
	<i>Cervical Cancer Screening</i>	70.6%	★★
	<i>Chlamydia Screening—16 to 20 Years</i>	53.5%	★★
	<i>Chlamydia Screening—21 to 24 Years</i>	63.7%	★★
	<i>Chlamydia Screening—Combined</i>	57.1%	★★
	<i>Timeliness of Prenatal Care</i>	89.1%	★★
	<i>Postpartum Care</i>	67.2%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table E-1—2009 Scores for Performance Measures for HPP			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Living With Illness	Diabetes Care—HbA1c Testing	86.5%	★★
	Diabetes Care—Poor HbA1c Control*	32.5%	★★
	Diabetes Care—Eye Exam	74.5%	★★★
	Diabetes Care—LDL-C Screening	75.4%	★★
	Diabetes Care—LDL-C Level <100	38.0%	★★
	Diabetes Care—Nephropathy	87.0%	★★★
	Diabetes Care—Blood Pressure Control (<130/80)	31.9%	★★
	Diabetes Care—Blood Pressure Control (<140/90)	64.5%	★★
	Asthma—5 to 9 Years	96.1%	★★
	Asthma—10 to 17 Years	92.5%	★★
	Asthma—18 to 56 Years	91.5%	★★★
	Asthma—Combined Rate	92.8%	★★★
	Controlling High Blood Pressure	56.0%	★★
	Advising Smokers to Quit	73.2%	†
	Discussing Smoking Cessation Strategies	38.4%	†
Access to Care	Children’s Access—12 to 24 Months	95.6%	★★
	Children’s Access—25 Months to 6 Years	85.5%	★★
	Children’s Access—7 to 11 Years	86.4%	★★
	Adolescents’ Access—12 to 19 Years	84.6%	★★
	Adults’ Access—20 to 44 Years	82.9%	★★
	Adults’ Access—45 to 64 Years	89.5%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table E-1 shows that HPP’s rates for four of the performance measures, *Comprehensive Diabetes Care—Eye Exam*, *Comprehensive Diabetes Care—Nephropathy*, and two *Use of Appropriate Medications for People With Asthma* measures (*18 to 56 Years* and *Combined Rate*), were above average compared to the national Medicaid HEDIS 2008 results. These measures represented areas of relative strength for HPP.

The table also shows that the rates for 29 of the performance measures ranked within their respective national Medicaid HEDIS 2008 average performance ranges. These measures represented neither areas of relative strength nor high-priority opportunities for improvement.

Two measures reported rates that were below the national Medicaid HEDIS 2008 average performance. These measures were *Appropriate Treatment for Children With URI* and *Appropriate*

Testing for Children With Pharyngitis. These findings suggested opportunities for improvement for **HPP**.

Validation of Performance Improvement Projects (PIPs)

Table E-2 presents the scoring for each of the steps in the CMS PIP protocol. The table shows the number of elements within each step and, of those, the number that were scored as *Met*, *Partially Met*, *Not Met*, or *NA*; the total percentage scores for evaluation and critical elements *Met*; and the validation status for the PIP.

Table E-2—2008–2009 PIP Validation Results for HPP						
Step		Number of Elements				
		Total	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
I.	Review the Selected Study Topic(s)	6	6	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	6	0	0	1
IV.	Review the Identified Study Population	3	3	0	0	0
V.	Review Sampling Methods (if sampling was used)	6	0	0	0	6
VI.	Review Data Collection Procedures	11	5	1	0	5
VII.	Assess Improvement Strategies	4	3	0	0	1
VIII.	Review Data Analysis and the Interpretation of Study Results	9	8	0	0	1
IX.	Assess for Real Improvement	4	1	0	3	0
X.	Assess for Sustained Improvement	1	Not Assessed			
Totals for all Steps		53	34	1	3	14
Percentage Score of Evaluation Elements <i>Met</i>		89%				
Percentage Score of Critical Elements <i>Met</i>		100%				
Validation Status		<i>Met</i>				

The 2008–2009 validation of HPP’s PIP on *Breast Cancer Screening Disparity* resulted in a validation status of *Met* with an overall score of 89 percent and a score of 100 percent for critical elements. HPP demonstrated compliance with all applicable requirements of the CMS protocol for validating PIPs for Steps I through V, VII, and VIII. HSAG identified opportunities for improvement in Steps VI and IX that HPP will need to address prior to the next annual submission.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **HPP**'s composite CAHPS scores are shown in Table E-3. The table presents each of the CAHPS measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table E-3—2009 CAHPS Child and Adult Composite Scores for HPP			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Getting Needed Care</i>	62.5%	2.46	*
<i>Getting Care Quickly</i>	77.1%	2.67	*
<i>How Well Doctors Communicate</i>	71.9%	2.63	★★
<i>Customer Service</i>	NA	NA	*
<i>Shared Decision Making</i>	59.8%	2.51	**
Adult			
<i>Getting Needed Care</i>	54.9%	2.34	★★★
<i>Getting Care Quickly</i>	57.9%	2.39	★★
<i>How Well Doctors Communicate</i>	66.7%	2.52	★★
<i>Customer Service</i>	NA	NA	NA
<i>Shared Decision Making</i>	59.7%	2.48	—
<p>The top-box percentage indicates the percentage of responses of “Always” or “Definitely Yes.”</p> <p>Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p>* The results for these measures are not comparable to the distribution of NCQA national survey results due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p> <p>NA = Composites that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results.</p> <p>★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.</p> <p>★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

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

HPP showed above-average performance for one of the three comparable 2009 adult CAHPS composite measures, *Getting Needed Care*. This indicates an area of strength for **HPP**. **HPP** showed average performance on the remaining two measures: *Getting Care Quickly* and *How Well Doctors Communicate*.

HPP’s detailed scores for the global ratings are presented in Table E-4. The table shows each of the four CAHPS global measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table E-4—2009 CAHPS Child and Adult Global Ratings for HPP			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Rating of All Health Care</i>	57.9%	2.46	★
<i>Rating of Personal Doctor</i>	65.4%	2.52	★★
<i>Rating of Specialist Seen Most Often</i>	NA	NA	NA
<i>Rating of Health Plan</i>	62.1%	2.51	★★
Adult			
<i>Rating of All Health Care</i>	45.3%	2.24	★★
<i>Rating of Personal Doctor</i>	57.9%	2.38	★★
<i>Rating of Specialist Seen Most Often</i>	61.6%	2.49	★★★
<i>Rating of Health Plan</i>	59.0%	2.43	★★★
<p>The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population. NA = Global ratings that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results. ★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results. ★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

HPP showed average performance on two of the three comparable 2009 child CAHPS global ratings: *Rating of Personal Doctor* and *Rating of Health Plan*. However, HPP showed below-average performance for one measure, *Rating of All Health Care*. This area of below-average performance indicates that opportunities exist to improve member satisfaction. HPP did not show above-average performance for any of the child measures.

HPP showed average performance on two of the four 2009 adult CAHPS global ratings: *Rating of All Health Care* and *Rating of Personal Doctor*. Furthermore, HPP showed above-average performance for the remaining two measures, indicating areas of strength: *Rating of Specialist Seen Most Often* and *Rating of Health Plan*.

Assessment of Follow-up on Prior Recommendations

Annual Compliance Reviews

During the 2007–2008 compliance site visit, MDCH identified recommendations for **HPP** for the following standards:

- ◆ Administrative
- ◆ Provider
- ◆ Member
- ◆ Quality/Utilization
- ◆ MIS/Data Reporting/Claims Processing
- ◆ Fraud and Abuse

MDCH evaluated **HPP**'s progress in implementing corrective actions to address these recommendations. Results will be included in the next technical report.

Performance Measures

HPP's 2008 rates for the *Appropriate Treatment for Children With URI* and *Appropriate Testing for Children With Pharyngitis* measures showed below-average performance compared to the national HEDIS 2007 performance standards. **HPP** implemented strategies to improve performance on these measures. These strategies included educating and alerting physicians to their patients who did not receive recommended services. **HPP** also provided automated phone calls to remind eligible members who were missing preventive health services. Although the 2009 rates for these measures improved from 2008, both measures still performed below the national HEDIS 2008 average performance levels. **HPP** continued to focus on these measures for its 2009 quality improvement program priorities.

Performance Improvement Projects (PIPs)

HPP received scores of *Met* for all applicable evaluation and critical elements in the 2007–2008 validation of its PIP. Therefore, there was no need for **HPP** to follow-up on any prior recommendations.

Recommendations and Summary Assessment Related to Quality, Timeliness, and Access

The current review of **HPP** showed both strengths and opportunities for improvement.

The 2007–2008 compliance site visit resulted in recommendations across the three domains of **quality** and **timeliness** of, and **access** to, services provided by **HPP**. While MDCH evaluated **HPP**'s progress in addressing these recommendations as well as performance related to a set of mandatory criteria, results from the 2008–2009 compliance site visits will be included in the next technical report.

HPP demonstrated mixed performance for measures in the **quality** domain, but showed average performance across all measures in the **timeliness** and **access** domains. In the **quality** domain, four measures showed above-average performance: two *Use of Appropriate Medications for People With Asthma* measures (*18 to 56 Years* and *Combined Rate*) and two *Comprehensive Diabetes Care* measures (*Eye Exam* and *Nephropathy*). Twenty-nine measures ranked within their respective national HEDIS 2008 average performance ranges. Two measures—*Appropriate Treatment for Children With URI* and *Appropriate Testing for Children With Pharyngitis*—ranked below their respective national HEDIS 2008 average performance levels. Despite last year's improvement efforts, **HPP**'s performance on the *Appropriate Treatment for Children With URI* and *Appropriate Testing for Children With Pharyngitis* measures remained below the national average. All **timeliness** and **access** measures ranked within their respective national average performance ranges. Compared to last year's rates, two measures showed a decline of at least 2 percentage points: *Cervical Cancer Screening* (a decline of 6.5 percentage points) and *Timeliness of Prenatal Care* (a decline of 2.7 percentage points). Together with the two measures below the national average performance, these measures presented opportunities for improvement. **HPP** implemented interventions focused on members and practitioners designed to improve rates for the *Cervical Cancer Screening* and *Timeliness of Prenatal Care* measures. **HPP** should continue these interventions to improve performance.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the MHP's processes for conducting valid PIPs. Therefore, all PIPs were assigned to the **quality** domain. **HPP** demonstrated strong performance related to the quality of its PIP and a thorough understanding of the requirements for Activities I through V, VII, and VIII of the CMS protocol for conducting PIPs. To strengthen the study, **HPP** should address the *Point of Clarification* and the *Partially Met* and *Not Met* scores in Steps III, VI, and IX, respectively. As **HPP** progresses in its study, future validations will evaluate **HPP**'s compliance with the requirements of the remaining PIP activities.

In the CAHPS domain of **quality**, **HPP** had average or above-average performance on 10 of the 11 comparable measures. **HPP** demonstrated above-average performance for the **access** domain and average performance for the **timeliness** domain. Measures that showed below-average performance represented the greatest opportunities for quality improvement. The *Rating of All Health Care* measure showed below-average performance for the child population. To improve the *Rating of All Health Care* measure, quality improvement activities could target member satisfaction with

physicians, member perception of access to care, experience with care, and experience with the health plan.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement.

MDCH conducted a compliance site visit to evaluate **MCL**'s implementation of corrective actions identified in the 2007–2008 site visit. MDCH also assessed **MCL**'s compliance with a set of mandatory criteria included in the review for all MHPs, regardless of prior performance.

The next technical report will present an analysis of the combined findings from the 2008–2009 and 2009–2010 site visits.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess the ability of each MHP’s support system to report accurate HEDIS measures. The results of this assessment are presented in Table F-1. The table shows each of the performance measures, the rates for each measure for 2009, and the categorized performance for 2009 relative to national Medicaid results.

Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Pediatric Care	<i>Childhood Immunization—Combo 2</i>	83.5%	★★
	<i>Childhood Immunization—Combo 3</i>	77.4%	★★
	<i>Lead Screening in Children</i>	77.6%	★★
	<i>Well-Child 1st 15 Months—0 Visits*</i>	0.5%	★★★
	<i>Well-Child 1st 15 Months—6+ Visits</i>	62.3%	★★
	<i>Well-Child 3rd–6th Years of Life</i>	77.4%	★★
	<i>Adolescent Well-Care Visits</i>	53.3%	★★
	<i>Appropriate Treatment of URI</i>	71.2%	★
	<i>Children With Pharyngitis</i>	52.1%	★★
Women’s Care	<i>Breast Cancer Screening—Combined Rate</i>	50.7%	★★
	<i>Cervical Cancer Screening</i>	70.3%	★★
	<i>Chlamydia Screening—16 to 20 Years</i>	50.6%	★★
	<i>Chlamydia Screening—21 to 24 Years</i>	55.8%	★★
	<i>Chlamydia Screening—Combined</i>	52.6%	★★
	<i>Timeliness of Prenatal Care</i>	92.2%	★★★
	<i>Postpartum Care</i>	83.0%	★★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★ = Below-average performance relative to national Medicaid results.			
★★ = Average performance relative to national Medicaid results.			
★★★ = Above-average performance relative to national Medicaid results.			

Table F-1—2009 Scores for Performance Measures for MCL			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Living With Illness	Diabetes Care—HbA1c Testing	87.1%	★★
	Diabetes Care—Poor HbA1c Control*	38.1%	★★
	Diabetes Care—Eye Exam	71.5%	★★★
	Diabetes Care—LDL-C Screening	80.6%	★★
	Diabetes Care—LDL-C Level <100	37.4%	★★
	Diabetes Care—Nephropathy	88.2%	★★★
	Diabetes Care—Blood Pressure Control (<130/80)	34.3%	★★
	Diabetes Care—Blood Pressure Control (<140/90)	66.2%	★★
	Asthma—5 to 9 Years	94.0%	★★
	Asthma—10 to 17 Years	90.3%	★★
	Asthma—18 to 56 Years	86.2%	★★
	Asthma—Combined Rate	89.2%	★★
	Controlling High Blood Pressure	67.6%	★★★
	Advising Smokers to Quit	69.1%	†
	Discussing Smoking Cessation Strategies	43.1%	†
Access to Care	Children’s Access—12 to 24 Months	95.3%	★★
	Children’s Access—25 Months to 6 Years	82.8%	★★
	Children’s Access—7 to 11 Years	81.3%	★
	Adolescents’ Access—12 to 19 Years	79.7%	★★
	Adults’ Access—20 to 44 Years	82.8%	★★
	Adults’ Access—45 to 64 Years	87.6%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table F-1 shows that MCL’s rates for the following six performance measures were above average compared to the national Medicaid HEDIS 2008 results: *Well-Child Visits in the First 15 Months of Life—Zero Visits*, *Timeliness of Prenatal Care*, *Postpartum Care*, *Comprehensive Diabetes Care—Eye Exam*, *Comprehensive Diabetes Care—Nephropathy*, and *Controlling High Blood Pressure*. These measures represented areas of relative strength for MCL.

The table also shows that the rates for 27 of the performance measures ranked within their respective national Medicaid HEDIS 2008 average performance ranges. These measures represented neither areas of relative strength nor high-priority opportunities for improvement.

Two measures, including *Appropriate Treatment for Children With URI* and *Children’s Access to Primary Care Practitioners—7 to 11 Years* reported rates that were below average compared to the

national Medicaid HEDIS 2008 results. The findings suggested that these performance measures represent opportunities for improvement for **MCL**.

Validation of Performance Improvement Projects (PIPs)

Table F-2 presents the scoring for each of the steps in the CMS PIP protocol. The table shows the number of elements within each step and, of those, the number that were scored as *Met*, *Partially Met*, *Not Met*, or *NA*; the total percentage scores for evaluation and critical elements *Met*; and the validation status for the PIP.

Table F-2—2008–2009 PIP Validation Results for MCL						
Step		Number of Elements				
		Total	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
I.	Review the Selected Study Topic(s)	6	6	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	6	0	0	1
IV.	Review the Identified Study Population	3	3	0	0	0
V.	Review Sampling Methods (if sampling was used)	6	0	0	0	6
VI.	Review Data Collection Procedures	11	6	0	0	5
VII.	Assess Improvement Strategies	4	3	0	0	1
VIII.	Review Data Analysis and the Interpretation of Study Results	9	6	2	0	1
IX.	Assess for Real Improvement	4	1	2	1	0
X.	Assess for Sustained Improvement	1	Not Assessed			
Totals for all Steps		53	33	4	1	14
Percentage Score of Evaluation Elements <i>Met</i>		87%				
Percentage Score of Critical Elements <i>Met</i>		100%				
Validation Status		<i>Met</i>				

The 2008–2009 validation of **MCL**'s PIP on *Breast Cancer Screening Disparity* resulted in a validation status of *Met* with an overall score of 87 percent and a score of 100 percent for critical elements. **MCL** demonstrated compliance with all applicable requirements for Steps I through VII of the CMS protocol for validating PIPs. HSAG identified opportunities for improvement in Steps III, IV, VI, VIII, and IX that **MCL** will need to address prior to the next annual submission.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **MCL**'s composite CAHPS scores are shown in Table F-3. The table presents each of the CAHPS measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table F-3—2009 CAHPS Child and Adult Composite Scores for MCL			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Getting Needed Care</i>	55.0%	2.35	*
<i>Getting Care Quickly</i>	72.7%	2.62	*
<i>How Well Doctors Communicate</i>	71.1%	2.60	★★
<i>Customer Service</i>	NA	NA	*
<i>Shared Decision Making</i>	63.7%	2.52	**
Adult			
<i>Getting Needed Care</i>	52.1%	2.35	★★★
<i>Getting Care Quickly</i>	55.1%	2.35	★★
<i>How Well Doctors Communicate</i>	65.3%	2.50	★★
<i>Customer Service</i>	NA	NA	NA
<i>Shared Decision Making</i>	55.8%	2.45	—
<p>The top-box percentage indicates the percentage of responses of “Always” or “Definitely Yes.”</p> <p>Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p>* The results for these measures are not comparable to the distribution of NCQA national survey results due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p> <p>NA = Composites that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results.</p> <p>★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.</p> <p>★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

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

MCL showed average performance for two of the three comparable 2009 adult CAHPS composite measures: *Getting Care Quickly* and *How Well Doctors Communicate*. Furthermore, **MCL** showed above-average performance for the remaining measure, *Getting Needed Care*, indicating an area of strength.

MCL’s detailed scores for the global ratings are presented in Table F-4. The table shows each of the four CAHPS global measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table F-4—2009 CAHPS Child and Adult Global Ratings for MCL			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Rating of All Health Care</i>	53.8%	2.40	★
<i>Rating of Personal Doctor</i>	63.2%	2.49	★
<i>Rating of Specialist Seen Most Often</i>	55.9%	2.46	★
<i>Rating of Health Plan</i>	55.9%	2.43	★
Adult			
<i>Rating of All Health Care</i>	46.0%	2.27	★★
<i>Rating of Personal Doctor</i>	63.8%	2.47	★★
<i>Rating of Specialist Seen Most Often</i>	61.3%	2.50	★★★
<i>Rating of Health Plan</i>	58.5%	2.42	★★★
The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.			
★ = Below-average performance (<25th percentile) relative to national Medicaid results. ★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results. ★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.			

MCL showed below-average performance for all four comparable 2009 child CAHPS global ratings: *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. These areas of below-average performance indicate that opportunities exist for quality improvement activities aimed at improving member satisfaction. MCL did not show average or above-average performance for any of the child global ratings.

MCL showed above-average performance on two of the four 2009 adult CAHPS global ratings: *Rating of Specialist Seen Most Often* and *Rating of Health Plan*. MCL showed average performance on the remaining two measures: *Rating of All Health Care* and *Rating of Personal Doctor*.

Assessment of Follow-up on Prior Recommendations

Annual Compliance Reviews

During the 2007–2008 compliance site visit, MDCH identified recommendations for **MCL** for the following standards:

- ◆ Provider
- ◆ Member
- ◆ Quality/Utilization
- ◆ Fraud and Abuse

MDCH evaluated **MCL**'s progress in implementing corrective actions to address these recommendations. Results will be included in the next technical report.

Performance Measures

MCL's 2008 performance on four measures (*Appropriate Treatment for Children With URI*, *Children's Access to Primary Care Practitioners—25 Months to 6 Years*, *Children's Access to Primary Care Practitioners—7 to 11 Years*, and *Adolescent's Access to Primary Care Practitioners—12 to 19 Years*) were below average compared to the national Medicaid HEDIS 2007 performance standards. During 2008, **MCL** informed the primary care provider network of the below-average performance on the URI measure and distributed updated guidelines. The health plan also conducted specific improvement strategies, such as monitoring member complaints for access problems and educating providers on noncompliance. **MCL** also researched the possibility of moving all primary care providers to a fee-for-service model to increase access to services. Although the 2009 rates were higher than the 2008 rates, **MCL**'s 2009 performance on two of the targeted measures (*Appropriate Treatment for Children With URI* and *Children's Access to Primary Care Practitioners—7 to 11 Years*) remained below the national HEDIS 2008 average performance levels.

Performance Improvement Projects (PIPs)

MCL received scores of *Met* for all applicable evaluation and critical elements in the 2007–2008 validation of its PIP. Therefore, there was no need for **MCL** to follow-up on any recommendations.

Recommendations and Summary Assessment Related to Quality, Timeliness, and Access

The current review of **MCL** showed both strengths and opportunities for improvement.

The 2007–2008 compliance site visit resulted in recommendations across the three domains of **quality** and **timeliness** of, and **access** to, services provided by **MCL**. While MDCH evaluated **MCL**'s progress in addressing these recommendations as well as performance related to a set of mandatory criteria, results from the 2008–2009 compliance site visits will be included in the next technical report.

MCL demonstrated mixed performance for measures in the **quality** and **access** domains, but showed at least average performance across measures in the **timeliness** domain. In the **quality** domain, six measures showed above-average performance. These measures were: *Well-Child Visits in the First 15 Months of Life—Zero Visits*, *Timeliness of Prenatal Care*, *Postpartum Care*, *Comprehensive Diabetes Care—Eye Exam*, *Comprehensive Diabetes Care—Nephropathy*, and *Controlling High Blood Pressure*. Twenty-seven measures ranked within their respective national HEDIS 2008 average performance ranges. Two measures (*Appropriate Treatment for Children With URI* and *Children's Access to Primary Care Practitioners—7 to 11 Years*) ranked below average. Three of the nine **timeliness** measures (*Well-Child Visits in the First 15 Months of Life—Zero Visits*, *Timeliness of Prenatal Care*, and *Postpartum Care*) showed above-average performance, while the remaining six ranked within their respective national average performance ranges. In the **access** domain, the prenatal and postpartum care measures showed above-average performance. Despite last year's intervention efforts, one access measure (*Children's Access to Primary Care Practitioners—7 to 11 Years*) still ranked below its respective national HEDIS 2008 average performance level. The *Appropriate Treatment for Children With URI* and *Children's Access to Primary Care Practitioners—7 to 11 Years* measures remained the two areas for improvement for **MCL**. Additionally, compared with last year's rates, seven measures exhibited a decline by more than 2 percentage points. These measures included *Appropriate Testing for Children With Pharyngitis* (a decline of 5.0 percentage points), *Chlamydia Screening for Women* (a decline of 2.8 percentage points for the *21 to 24 Years* measure and a decline of 2.2 percentage points for the *Combined Rate*), and *Comprehensive Diabetes Care—Poor HbA1c Control* (a decline of 4.8 percentage points). Three measures for *Use of Appropriate Medications for People With Asthma* also had lower rates. The rate for the *5 to 9 Years* group declined by 2.5 percentage points, the *18 to 56 Years* group declined by 4.0 percentage points, and the *Combined Rate* declined by 2.5 percentage points. **MCL** implemented interventions targeted at members and providers to address these lower rates. The plan should continue these interventions to improve performance.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the MHP's processes for conducting valid PIPs. Therefore, all PIPs were assigned to the **quality** domain. **MCL** demonstrated strong performance related to the quality of its PIP and a thorough understanding of the requirements for Activities I through VII of the CMS protocol for conducting PIPs. Results for Study Indicator 1 were essentially unchanged, and Study Indicator 2 demonstrated an increase that was not statistically significant. Study Indicator 3, however, demonstrated a decline. The Quality Improvement Committee, which was composed of senior management, held companywide sessions to review causes and barriers. The committee determined that the primary

barriers were focused on enrollees. As a result, **MCL** recognized the need to enhance existing interventions. For example, the MHP expanded the enrollee contact process. In addition to contacting women older than 40 years of age, **MCL** included women who had not received a screening. As **MCL** progresses in its study, future validation will evaluate **MCL**'s compliance with the requirements of the remaining PIP activities and any impact of the enhanced interventions on the results of the study indicators.

In the CAHPS domain of **quality**, **MCL** had average or above-average performance on 8 of the 12 comparable measures. **MCL** demonstrated above-average performance for the **access** domain and average performance for the **timeliness** domain. Measures that showed below-average performance represented the greatest opportunities for quality improvement. **MCL** had no measures for which both the child and adult Medicaid populations had below-average performance. However, four child measures—*Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*—had below-average performance and could be targeted for quality improvement activities aimed at improving member satisfaction. To improve the *Rating of All Health Care* measure, quality improvement activities could target member satisfaction with physicians, member perception of access to care, experience with care, and experience with the health plan. Quality improvement activities aimed at increasing the *Rating of Personal Doctor* measure include: 1) increasing levels of communication between physicians and patients and 2) decreasing the time between the point when patients need care and when patients receive care by eliminating barriers that may prohibit patients from receiving prompt, adequate care. To improve the overall *Rating of Specialist Seen Most Often* measure, quality improvement activities should focus on increasing the availability of specialists and streamlining the referral process. To improve the overall *Rating of Health Plan* measure, quality improvement activities could target changing health plan operations to improve existing activities (e.g., customer service) and improving operations at individual physician offices (e.g., efficiency and ease of scheduling appointments).

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement.

MDCH conducted a compliance site visit to evaluate **MID**'s implementation of corrective actions identified in the 2007–2008 site visit. MDCH also assessed **MID**'s compliance with a set of mandatory criteria included in the review for all MHPs, regardless of prior performance.

The next technical report will present an analysis of the combined findings from the 2008–2009 and 2009–2010 site visits.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and to determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess the ability of each MHP’s support system to report accurate HEDIS measures. The results of this assessment are presented in Table G-1. The table shows each of the performance measures, the rates for each measure for 2009, and the categorized performance for 2009 relative to national Medicaid results.

Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Pediatric Care	<i>Childhood Immunization—Combo 2</i>	76.2%	★★
	<i>Childhood Immunization—Combo 3</i>	71.0%	★★
	<i>Lead Screening in Children</i>	76.9%	★★
	<i>Well-Child 1st 15 Months—0 Visits*</i>	0.7%	★★
	<i>Well-Child 1st 15 Months—6+ Visits</i>	64.7%	★★
	<i>Well-Child 3rd–6th Years of Life</i>	75.7%	★★
	<i>Adolescent Well-Care Visits</i>	62.3%	★★★
	<i>Appropriate Treatment of URI</i>	82.3%	★★
	<i>Children With Pharyngitis</i>	21.6%	★
Women’s Care	<i>Breast Cancer Screening</i>	52.3%	★★
	<i>Cervical Cancer Screening</i>	73.5%	★★
	<i>Chlamydia Screening—16 to 20 Years</i>	59.3%	★★
	<i>Chlamydia Screening—21 to 24 Years</i>	67.3%	★★
	<i>Chlamydia Screening—Combined</i>	61.8%	★★
	<i>Timeliness of Prenatal Care</i>	89.5%	★★
	<i>Postpartum Care</i>	63.7%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table G-1—2009 Scores for Performance Measures for MID			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Living With Illness	Diabetes Care—HbA1c Testing	80.5%	★★
	Diabetes Care—Poor HbA1c Control*	61.3%	★
	Diabetes Care—Eye Exam	60.2%	★★
	Diabetes Care—LDL-C Screening	81.0%	★★
	Diabetes Care—LDL-C Level <100	31.6%	★★
	Diabetes Care—Nephropathy	85.4%	★★★
	Diabetes Care—Blood Pressure Control (<130/80)	27.2%	★★
	Diabetes Care—Blood Pressure Control (<140/90)	50.2%	★★
	Asthma—5 to 9 Years	84.3%	★
	Asthma—10 to 17 Years	80.3%	★
	Asthma—18 to 56 Years	83.2%	★★
	Asthma—Combined Rate	82.7%	★
	Controlling High Blood Pressure	55.7%	★★
	Advising Smokers to Quit	71.7%	†
	Discussing Smoking Cessation Strategies	39.7%	†
Access to Care	Children’s Access—12 to 24 Months	94.0%	★★
	Children’s Access—25 Months to 6 Years	86.5%	★★
	Children’s Access—7 to 11 Years	85.6%	★★
	Adolescents’ Access—12 to 19 Years	83.0%	★★
	Adults’ Access—20 to 44 Years	81.3%	★★
	Adults’ Access—45 to 64 Years	87.9%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table G-1 shows that **MID**’s rate for two of the performance measures, *Adolescent Well-Care Visits* and *Comprehensive Diabetes Care—Nephropathy*, were above average compared to the national Medicaid HEDIS 2008 results. These measures represented an area of relative strength for **MID**.

The table also shows that the rates for 28 of the performance measures ranked within their respective national Medicaid HEDIS 2008 average performance ranges. These measures represented neither areas of relative strength nor high-priority opportunities for improvement.

Five measures reported rates that were below average compared to the national Medicaid HEDIS 2008 results: *Appropriate Testing for Children With Pharyngitis*, *Comprehensive Diabetes Care—Poor HbA1c Control*, and three measures for *Use of Appropriate Medications for People With*

Asthma (5 to 9 Years, 10 to 17 Years, and Combined Rate). These findings presented opportunities for improvement for **MID**.

Validation of Performance Improvement Projects (PIPs)

Table G-2 presents the scoring for each of the steps in the CMS PIP protocol. The table shows the number of elements within each step and, of those, the number that were scored as *Met*, *Partially Met*, *Not Met*, or *NA*; the total percentage scores for evaluation and critical elements *Met*; and the validation status for the PIP.

Table G-2—2008–2009 PIP Validation Results for MID						
Step		Number of Elements				
		Total	Met	Partially Met	Not Met	NA
I.	Review the Selected Study Topic(s)	6	6	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	7	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0
V.	Review Sampling Methods (if sampling was used)	6	6	0	0	0
VI.	Review Data Collection Procedures	11	10	0	0	1
VII.	Assess Improvement Strategies	4	3	0	0	1
VIII.	Review Data Analysis and the Interpretation of Study Results	9	9	0	0	0
IX.	Assess for Real Improvement	4	3	1	0	0
X.	Assess for Sustained Improvement	1	Not Assessed			
Totals for all Steps		53	49	1	0	2
Percentage Score of Evaluation Elements Met		98%				
Percentage Score of Critical Elements Met		100%				
Validation Status		Met				

The 2008–2009 validation of MID’s PIP on *Cervical Cancer Screening Disparity* resulted in a validation status of *Met* with an overall score of 98 percent and a score of 100 percent for critical elements. MID demonstrated compliance with all but one of the applicable requirements for Steps I through IX of the CMS protocol for validating PIPs. HSAG identified opportunities for improvement in Steps VIII and IX related to identifying factors that affect the ability to compare measurement periods and achieving statistically significant improvement across all study indicators. MID should address these recommendations prior to the next PIP submission.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **MID**'s composite CAHPS scores are shown in Table G-3. The table presents each of the CAHPS measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table G-3—2009 CAHPS Child and Adult Composite Scores for MID			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Getting Needed Care</i>	50.8%	2.29	*
<i>Getting Care Quickly</i>	68.0%	2.51	*
<i>How Well Doctors Communicate</i>	71.8%	2.60	★★
<i>Customer Service</i>	NA	NA	*
<i>Shared Decision Making</i>	61.0%	2.49	**
Adult			
<i>Getting Needed Care</i>	52.3%	2.27	★★
<i>Getting Care Quickly</i>	64.1%	2.47	★★★
<i>How Well Doctors Communicate</i>	68.1%	2.55	★★
<i>Customer Service</i>	47.4%	2.16	★
<i>Shared Decision Making</i>	60.6%	2.51	—
<p>The top-box percentage indicates the percentage of responses of “Always” or “Definitely Yes.”</p> <p>Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p>* The results for these measures are not comparable to the distribution of NCQA national survey results due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p> <p>NA = Composites that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results.</p> <p>★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.</p> <p>★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

MID showed average performance for the only comparable 2009 child CAHPS composite measure, *How Well Doctors Communicate*.

MID showed above-average performance for one of the four comparable 2009 adult CAHPS composite measures, *Getting Care Quickly*. Furthermore, **MID** showed average performance for two measures: *Getting Needed Care* and *How Well Doctors Communicate*. **MID** showed below-average performance on the remaining composite measure, *Customer Service*, indicating an area for improvement for **MID**.

MID’s detailed scores for the global ratings are presented in Table G-4. The table shows each of the four CAHPS global measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table G-4—2009 CAHPS Child and Adult Global Ratings for MID			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Rating of All Health Care</i>	55.1%	2.40	★
<i>Rating of Personal Doctor</i>	65.4%	2.55	★★
<i>Rating of Specialist Seen Most Often</i>	57.8%	2.45	★
<i>Rating of Health Plan</i>	54.9%	2.41	★
Adult			
<i>Rating of All Health Care</i>	45.3%	2.19	★★
<i>Rating of Personal Doctor</i>	58.1%	2.38	★★
<i>Rating of Specialist Seen Most Often</i>	60.6%	2.47	★★
<i>Rating of Health Plan</i>	53.1%	2.31	★★
The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.			
★ = Below-average performance (<25th percentile) relative to national Medicaid results. ★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results. ★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.			

MID showed below-average performance for three of the four comparable 2009 child CAHPS global ratings: *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. MID showed average performance on one measure, *Rating of Personal Doctor*. The areas of below-average performance indicate that opportunities exist for quality improvement activities aimed at improving member satisfaction. MID did not show above-average performance for any of the child global ratings.

MID showed average performance on all four 2009 adult CAHPS global ratings: *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. MID did not show above-average or below-average performance for any of the adult global ratings.

Assessment of Follow-up on Prior Recommendations

Annual Compliance Reviews

During the 2007–2008 compliance site visit, MDCH identified recommendations for **MID** for the following standards:

- ◆ Provider
- ◆ Quality/Utilization
- ◆ MIS/Data Reporting/Claims Processing
- ◆ Fraud and Abuse

MDCH evaluated **MID**'s progress in implementing corrective actions to address these recommendations. Results will be included in the next technical report.

Performance Measures

Last year, **MID** had seven measures with below-average performance compared to the national Medicaid HEDIS 2007 performance standards: *Appropriate Testing for Children With Pharyngitis*, all four measures for *Use of Appropriate Medications for People With Asthma*, and two measures for *Children's and Adolescents' Access to Primary Care Practitioners*. To improve its asthma measures, **MID** implemented several improvement strategies, including the McKesson Disease Monitor software system, physician guidelines and management updates, use of asthma-related emergency room service data to follow up with primary care physicians, and identification of and additional interventions for high-risk members. To improve performance on access-to-care measures, **MID** continued the Practice Size Exploratory Project and implemented practice changes at a number of low-performing practice sites. In addition, the health plan also simplified members' process to change primary care physicians and created new pay-for-performance incentive systems for providers to perform well visits. Comparison of the 2009 rates for the *Use of Appropriate Medications for People With Asthma* measures with the 2008 rates showed that three of the rates were improved. Similarly, the rates for the *Children's and Adolescents' Access to Primary Care Practitioners* measures also improved in 2009. Despite these increases, **MID**'s performance on all but one of the asthma measures continued to fall below the national HEDIS 2008 average performance levels. Although **MID** did not appear to implement any additional interventions, the *Appropriate Testing for Children With Pharyngitis* measure was identified as one of the targeted preventive health care topics for 2009.

Performance Improvement Projects (PIPs)

Based on the prior validation in 2007–2008, HSAG recommended that **MID** include an overview of the study in the manual data collection tool. **MID** addressed this recommendation by providing an overview of the study as part of the training on completing the data collection tool.

Recommendations and Summary Assessment Related to Quality, Timeliness, and Access

The current review of **MID** showed both strengths and opportunities for improvement.

The 2007–2008 compliance site visit resulted in recommendations across the three domains of **quality** and **timeliness** of, and **access** to, services provided by **MID**. While MDCH evaluated **MID**'s progress in addressing these recommendations as well as performance related to a set of mandatory criteria, results from the 2008–2009 compliance site visits will be included in the next technical report.

MID demonstrated mixed performance for measures in the **quality** domain, but showed at least average performance across measures in the **timeliness** and **access** domains. In the **quality** domain, two measures, *Adolescent Well-Care Visits* and *Comprehensive Diabetes Care—Nephropathy*, showed above-average performance. Twenty-eight measures ranked within their respective national HEDIS 2008 average performance ranges. Five measures (*Appropriate Testing for Children With Pharyngitis*, *Comprehensive Diabetes Care—Poor HbA1c Control*, and three measures for *Use of Appropriate Medications for People With Asthma (5 to 9 Years, 10 to 17 Years, and Combined Rate)*) ranked below their respective national HEDIS 2008 average performance level. Additionally, three measures had a decline of more than 2 percentage points from their 2008 rates. These measures were: two *Comprehensive Diabetes Care* measures (*Poor HbA1c Control*, with a decline of 15.3 percentage points, and *Blood Pressure Control <140/90*, with a decline of 2.4 percentage points) and the *Use of Appropriate Medications for People With Asthma—5 to 9 Years* measure, with a decline of 2.2 percentage points. **MID** implemented disease management programs for members with diabetes or asthma. The plan should continue these interventions to improve rates for asthma and diabetes measures. One measure in the **timeliness** domain (*Adolescent Well-Care Visits*) had above-average performance compared to the national HEDIS 2008 results; the remaining eight measures ranked within their respective average performance levels. All **access** measures had average performance compared to the national Medicaid percentiles.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the MHP's processes for conducting valid PIPs. Therefore, all PIPs were assigned to the **quality** domain. **MID** demonstrated strong performance related to the quality of its PIP and a thorough understanding of all requirements for Activities I through VIII of the CMS protocol for conducting PIPs. HSAG recommended that **MID** perform statistical testing between rates for the study population and rates for any subgroup of the study population to evaluate disparities in screening rates.

In the CAHPS domain of **quality**, **MID** had average or above-average performance on 9 of the 13 comparable measures. **MID** demonstrated average performance in the **access** domain and average and above-average performance in the **timeliness** domain. Measures that showed below-average performance represented the greatest opportunities for quality improvement. **MID** had no measures for which both the child and adult Medicaid populations had below-average performance. However, the adult *Customer Service* measure and three child measures—*Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*—had below-average performance and could be targeted for quality improvement activities aimed at improving member satisfaction. To improve

the *Customer Service* measure, quality improvement activities could include developing a complaint and recovery program to effectively organize grievances and ensure that each complaint is appropriately addressed. To improve the overall *Rating of Specialist Seen Most Often* measure, quality improvement activities should focus on increasing the availability of specialists and streamlining the referral process. To improve the *Rating of All Health Care* measure, quality improvement activities could target member satisfaction with physicians, member perception of access to care, experience with care, and experience with the health plan. To improve the overall *Rating of Health Plan* measure, quality improvement activities could target changing health plan operations to improve existing activities (e.g., customer service) and improving operations at individual physician offices (e.g., efficiency and ease of scheduling appointments).

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement.

MDCH conducted a compliance site visit to evaluate **MOL**'s implementation of corrective actions identified in the 2007–2008 site visit. MDCH also assessed **MOL**'s compliance with a set of mandatory criteria included in the review for all MHPs, regardless of prior performance.

The next technical report will present an analysis of the combined findings from the 2008–2009 and 2009–2010 site visits.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess the ability of each MHP’s support system to report accurate HEDIS measures. The results of this assessment are presented in Table H-1. The table shows each of the performance measures, the rates for each measure for 2009, and the categorized performance for 2009 relative to national Medicaid results.

Table H-1—2009 Scores for Performance Measures for MOL			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Pediatric Care	<i>Childhood Immunization—Combo 2</i>	76.6%	★★
	<i>Childhood Immunization—Combo 3</i>	69.3%	★★
	<i>Lead Screening in Children</i>	72.4%	★★
	<i>Well-Child 1st 15 Months—0 Visits*</i>	2.5%	★★
	<i>Well-Child 1st 15 Months—6+ Visits</i>	52.3%	★★
	<i>Well-Child 3rd–6th Years of Life</i>	75.1%	★★
	<i>Adolescent Well-Care Visits</i>	51.9%	★★
	<i>Appropriate Treatment of URI</i>	80.9%	★★
	<i>Children With Pharyngitis</i>	46.6%	★
Women’s Care	<i>Breast Cancer Screening—Combined</i>	51.2%	★★
	<i>Cervical Cancer Screening</i>	69.2%	★★
	<i>Chlamydia Screening—16 to 20 Years</i>	60.9%	★★
	<i>Chlamydia Screening—21 to 24 Years</i>	68.0%	★★
	<i>Chlamydia Screening—Combined</i>	63.2%	★★
	<i>Timeliness of Prenatal Care</i>	79.4%	★★
	<i>Postpartum Care</i>	61.3%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table H-1—2009 Scores for Performance Measures for MOL			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Living With Illness	Diabetes Care—HbA1c Testing	87.3%	★★
	Diabetes Care—Poor HbA1c Control*	41.4%	★★
	Diabetes Care—Eye Exam	53.5%	★★
	Diabetes Care—LDL-C Screening	79.3%	★★
	Diabetes Care—LDL-C Level <100	53.8%	★★★
	Diabetes Care—Nephropathy	78.8%	★★
	Diabetes Care—Blood Pressure Control (<130/80)	26.0%	★★
	Diabetes Care—Blood Pressure Control (<140/90)	53.3%	★★
	Asthma—5 to 9 Years	88.0%	★
	Asthma—10 to 17 Years	81.3%	★
	Asthma—18 to 56 Years	85.8%	★★
	Asthma—Combined Rate	85.2%	★
	Controlling High Blood Pressure	55.4%	★★
	Advising Smokers to Quit	73.5%	†
	Discussing Smoking Cessation Strategies	39.5%	†
Access to Care	Children’s Access—12 to 24 Months	96.3%	★★
	Children’s Access—25 Months to 6 Years	87.0%	★★
	Children’s Access—7 to 11 Years	85.8%	★★
	Adolescents’ Access—12 to 19 Years	83.1%	★★
	Adults’ Access—20 to 44 Years	80.5%	★★
	Adults’ Access—45 to 64 Years	85.8%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table H-1 shows that **MOL**’s rate for one of the performance measures, *Comprehensive Diabetes Care—LDL-C Level <100*, was above average compared to the national Medicaid HEDIS 2008 results. This measure represented an area of relative strength for **MOL**.

The table also shows that the rates for 30 of the performance measures ranked within their respective national Medicaid HEDIS 2008 average performance ranges. These measures represented neither areas of relative strength nor high-priority opportunities for improvement.

Four measures reported rates that were below average compared to the national Medicaid HEDIS 2008 results. These measures were: *Appropriate Testing for Children With Pharyngitis* and *Use of Appropriate Medications for People With Asthma (5 to 9 Years, 10 to 17 Years, and Combined Rate)*. These performance measures represent opportunities for improvement for **MOL**.

Validation of Performance Improvement Projects (PIPs)

Table H-2 presents the scoring for each of the steps in the CMS PIP protocol. The table shows the number of elements within each step and, of those, the number that were scored as *Met*, *Partially Met*, *Not Met*, or *NA*; the total percentage scores for evaluation and critical elements *Met*; and the validation status for the PIP.

Table H-2—2008–2009 PIP Validation Results for MOL						
Step		Number of Elements				
		Total	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
I.	Review the Selected Study Topic(s)	6	6	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	7	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0
V.	Review Sampling Methods (if sampling was used)	6	0	0	0	6
VI.	Review Data Collection Procedures	11	6	0	0	5
VII.	Assess Improvement Strategies	4	3	0	0	1
VIII.	Review Data Analysis and the Interpretation of Study Results	9	6	2	0	1
IX.	Assess for Real Improvement	4	3	1	0	0
X.	Assess for Sustained Improvement	1	0	0	1	0
Totals for all Steps		53	36	3	1	13
Percentage Score of Evaluation Elements <i>Met</i>		90%				
Percentage Score of Critical Elements <i>Met</i>		100%				
Validation Status		<i>Met</i>				

The 2008–2009 validation of **MOL**'s PIP on *Breast Cancer Screening Disparity* resulted in a validation status of *Met* with an overall score of 90 percent and a score of 100 percent for critical elements. While **MOL** demonstrated compliance with all applicable requirements of the CMS protocol for validating PIPs for Steps I through VII, HSAG identified opportunities for improvement in Steps III, VIII, IX, and X. **MOL** should address these opportunities for improvement prior to the next annual submission.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **MOL**'s composite CAHPS scores are shown in Table H-3. The table presents each of the CAHPS measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table H-3—2009 CAHPS Child and Adult Composite Scores for MOL			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Getting Needed Care</i>	60.8%	2.39	*
<i>Getting Care Quickly</i>	71.6%	2.58	*
<i>How Well Doctors Communicate</i>	76.1%	2.68	★★★
<i>Customer Service</i>	NA	NA	*
<i>Shared Decision Making</i>	70.8%	2.64	**
Adult			
<i>Getting Needed Care</i>	53.6%	2.32	★★★
<i>Getting Care Quickly</i>	61.4%	2.45	★★★
<i>How Well Doctors Communicate</i>	68.3%	2.55	★★
<i>Customer Service</i>	60.9%	2.41	★★
<i>Shared Decision Making</i>	56.1%	2.45	—
<p>The top-box percentage indicates the percentage of responses of “Always” or “Definitely Yes.”</p> <p>Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p>* The results for these measures are not comparable to the distribution of NCQA national survey results due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p> <p>NA = Composites that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results.</p> <p>★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.</p> <p>★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

MOL showed above-average performance on the only comparable 2009 child CAHPS composite measure, *How Well Doctors Communicate*.

MOL showed above-average performance for two of the four 2009 comparable adult CAHPS composite measures: *Getting Needed Care* and *Getting Care Quickly*. These represented areas of strength for **MOL**. **MOL** showed average performance on the remaining measures: *How Well Doctors Communicate* and *Customer Service*.

MOL’s detailed scores for the global ratings are presented in Table H-4. The table shows each of the four CAHPS global measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table H-4—2009 CAHPS Child and Adult Global Ratings for MOL			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Rating of All Health Care</i>	60.3%	2.49	★
<i>Rating of Personal Doctor</i>	68.0%	2.58	★★★
<i>Rating of Specialist Seen Most Often</i>	NA	NA	NA
<i>Rating of Health Plan</i>	59.7%	2.44	★
Adult			
<i>Rating of All Health Care</i>	48.0%	2.24	★★
<i>Rating of Personal Doctor</i>	60.0%	2.44	★★
<i>Rating of Specialist Seen Most Often</i>	59.1%	2.42	★★
<i>Rating of Health Plan</i>	53.8%	2.34	★★
The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population. NA = Global ratings that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).			
★ = Below-average performance (<25th percentile) relative to national Medicaid results. ★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results. ★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.			

MOL showed above-average performance for one of the three comparable 2009 child CAHPS global ratings, *Rating of Personal Doctor*. MOL showed below-average performance for the remaining two global ratings: *Rating of All Health Care* and *Rating of Health Plan*. These areas of below-average performance indicate that opportunities exist for quality improvement activities aimed at improving member satisfaction.

MOL showed average performance on all four 2009 adult CAHPS global ratings: *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.

Assessment of Follow-up on Prior Recommendations

Annual Compliance Reviews

During the 2007–2008 compliance site visit, MDCH identified recommendations for **MOL** for the following standards:

- ◆ Provider
- ◆ Member
- ◆ Quality/Utilization
- ◆ MIS/Data Reporting/Claims Processing
- ◆ Fraud and Abuse

MDCH evaluated **MOL**'s progress in implementing corrective actions to address these recommendations. Results will be included in the next technical report.

Performance Measures

Last year, **MOL** had six measures with below-average performance compared to the national Medicaid HEDIS 2007 results. These measures were: *Prenatal and Postpartum Care*, two *Children's and Adolescents' Access to Primary Care Practitioners* measures, *Well-Child Visits in the First 15 Months of Life—Six or More Visits*, and *Use of Appropriate Medications for People With Asthma—10 to 17 Years*. To improve its performance related to *Prenatal and Postpartum Care*, **MOL** implemented several improvement strategies. These strategies included identifying pregnant members early in their pregnancy and educating them on the importance of regular prenatal visits. **MOL** also coordinated with high-volume obstetrics offices to encourage members to seek early care and facilitate regular visits, and offered postpartum gifts to encourage members to obtain recommended care. To improve the rate for the *Use of Appropriate Medications for People With Asthma* measure, **MOL** encouraged members to schedule appointments with providers to develop an asthma action plan and conducted educational sessions with members at high-volume primary care physician offices. The health plan also collaborated with the Asthma Allergy Clinic at Children's Hospital and contracted with the Asthma Alliance of West Michigan to provide asthma education. To improve its well-child visit performance, **MOL** also implemented several improvement strategies, which included using a database to identify noncompliant members, sending reminder letters to parents, reporting to providers on a monthly basis to assist in identifying outstanding examinations, educating providers on using appropriate codes, and organizing health fairs in the community. With these efforts, performance on the targeted measures improved in 2009, except for *Use of Appropriate Medications for People With Asthma—10 to 17 Years*.

Performance Improvement Projects (PIPs)

MOL successfully addressed several opportunities for improvement from the 2007–2008 validation. **MOL** made the recommended changes to the study question and study indicators, resulting in improved overall scores and an improved validation status. **MOL** revised its interventions and implemented new improvement strategies. Prior to the next PIP submission, **MOL** should address the remaining recommendations related to the study data, use of statistical testing, and achieving real and sustained improvement.

Recommendations and Summary Assessment Related to Quality, Timeliness, and Access

The current review of **MOL** showed both strengths and opportunities for improvement.

The 2007–2008 compliance site visit resulted in recommendations across the three domains of **quality** and **timeliness** of, and **access** to, services provided by **MOL**. While MDCH evaluated **MOL**'s progress in addressing these recommendations as well as performance related to a set of mandatory criteria, results from the 2008–2009 compliance site visits will be included in the next technical report.

MOL demonstrated mixed performance in the **quality** domain, but showed average performance across the measures in the **timeliness** and **access** domains. In the **quality** domain, one measure (*Diabetes Care—LDL-C Level <100*) showed above-average performance. Thirty measures ranked within their respective national HEDIS 2008 average performance ranges. Four measures (i.e., *Appropriate Testing for Children With Pharyngitis* and 3 measures for *Use of Appropriate Medications for People With Asthma*) fell below their respective national HEDIS 2008 average performance level. Despite last year's effort to improve performance, the rate for *Use of Appropriate Medications for People With Asthma—10 to 17 Years* declined by 4.8 percentage points. **MOL**'s quality improvement documents indicated that the plan implemented interventions to address the below-average performance. The plan should continue these interventions to improve the asthma rates. For the **timeliness** and **access** domains, all measures ranked within their respective national average performance ranges.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the MHP's processes for conducting valid PIPs. Therefore, all PIPs were assigned to the **quality** domain. **MOL** demonstrated strong performance related to the quality of its PIP and a thorough understanding of the requirements for Activities I through VII of the CMS protocol for conducting PIPs. This PIP has been validated through Step X for both validation years. The PIP's three study indicators demonstrated improvement during some measurement periods; however, the improvement has not been sustained over the four annual remeasurement periods. Study indicator results from baseline to the final remeasurement period have not achieved the set benchmark. During the second remeasurement period, the population doubled in size for the Caucasian study group, and the African-American population increased in size tenfold. Due to these findings, HSAG recommended that the PIP continue for another measurement period to assess whether or not the revised and new improvement strategies will have an impact on the results and produce sustained improvement. HSAG also recommended that **MOL** perform statistical testing between the screening rates of the Caucasian study group and the African-American group to evaluate any change in disparity between the two groups.

In the CAHPS domain of **quality**, **MOL** had average or above-average performance on 10 of the 12 comparable measures. **MOL** demonstrated above-average performance for both the **access** and **timeliness** domains. Measures that showed below-average performance represented the greatest opportunities for quality improvement. None of the adult Medicaid measures showed below-average performance. However, the child *Rating of All Health Care* and *Rating of Health Plan* measures showed below-average performance. To improve performance on the *Rating of All Health*

Care measure, quality improvement activities should target improving overall satisfaction with patient health care and program experiences. To improve the overall *Rating of Health Plan* measure, quality improvement activities could target changing health plan operations to improve existing activities (e.g., customer service) and improving operations at individual physician offices (e.g., efficiency and ease of scheduling appointments).

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement.

MDCH conducted a compliance site visit to evaluate **OCH**'s implementation of corrective actions identified in the 2007–2008 site visit. MDCH also assessed **OCH**'s compliance with a set of mandatory criteria included in the review for all MHPs, regardless of prior performance.

The next technical report will present an analysis of the combined findings from the 2008–2009 and 2009–2010 site visits.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess the ability of each MHP’s support system to report accurate HEDIS measures. The results of this assessment are presented in Table I-1. The table shows each of the performance measures, the rates for each measure for 2009, and the categorized performance for 2009 relative to national Medicaid results.

Table I-1—2009 Scores for Performance Measures for OCH			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Pediatric Care	<i>Childhood Immunization—Combo 2</i>	83.3%	★★
	<i>Childhood Immunization—Combo 3</i>	64.6%	★★
	<i>Lead Screening in Children</i>	78.9%	★★
	<i>Well-Child 1st 15 Months—0 Visits*</i>	1.2%	★★
	<i>Well-Child 1st 15 Months—6+ Visits</i>	59.3%	★★
	<i>Well-Child 3rd–6th Years of Life</i>	75.5%	★★
	<i>Adolescent Well-Care Visits</i>	52.5%	★★
	<i>Appropriate Treatment of URI</i>	82.5%	★★
	<i>Children With Pharyngitis</i>	32.2%	★
Women’s Care	<i>Breast Cancer Screening</i>	49.4%	★★
	<i>Cervical Cancer Screening</i>	67.5%	★★
	<i>Chlamydia Screening—16 to 20 Years</i>	68.8%	★★★
	<i>Chlamydia Screening—21 to 24 Years</i>	75.0%	★★★
	<i>Chlamydia Screening—Combined</i>	70.6%	★★★
	<i>Timeliness of Prenatal Care</i>	85.6%	★★
	<i>Postpartum Care</i>	64.1%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table I-1—2009 Scores for Performance Measures for OCH			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Living With Illness	Diabetes Care—HbA1c Testing	82.7%	★★
	Diabetes Care—Poor HbA1c Control*	47.2%	★★
	Diabetes Care—Eye Exam	47.4%	★★
	Diabetes Care—LDL-C Screening	81.2%	★★
	Diabetes Care—LDL-C Level <100	34.5%	★★
	Diabetes Care—Nephropathy	84.9%	★★
	Diabetes Care—Blood Pressure Control (<130/80)	27.5%	★★
	Diabetes Care—Blood Pressure Control (<140/90)	56.0%	★★
	Asthma—5 to 9 Years	80.5%	★
	Asthma—10 to 17 Years	81.3%	★
	Asthma—18 to 56 Years	85.4%	★★
	Asthma—Combined Rate	83.3%	★
	Controlling High Blood Pressure	51.7%	★★
	Advising Smokers to Quit	71.5%	†
	Discussing Smoking Cessation Strategies	34.5%	†
Access to Care	Children’s Access—12 to 24 Months	91.2%	★
	Children’s Access—25 Months to 6 Years	77.2%	★
	Children’s Access—7 to 11 Years	78.2%	★
	Adolescents’ Access—12 to 19 Years	76.6%	★
	Adults’ Access—20 to 44 Years	77.3%	★★
	Adults’ Access—45 to 64 Years	84.5%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table I-1 shows that **OCH**’s rates for the performance measures for *Chlamydia Screening in Women* were above average compared to the national Medicaid HEDIS 2008 results. These measures represented areas of relative strength for **OCH**.

The table also shows that the rates for 24 of the performance measures ranked within their respective national Medicaid HEDIS 2008 average performance ranges. These measures represented neither areas of relative strength nor high-priority opportunities for improvement.

Eight measures reported rates that were below national Medicaid HEDIS 2008 average performance. These rates were for the following measures: *Appropriate Testing for Children With Pharyngitis*, three measures for *Use of Appropriate Medications for People With Asthma*, and all

four measures for *Children's and Adolescents' Access to Primary Care Practitioners*. The findings suggest opportunities for improvement for **OCH**.

Validation of Performance Improvement Projects (PIPs)

Table I-2 presents the scoring for each of the steps in the CMS PIP protocol. The table shows the number of elements within each step and, of those, the number that were scored as *Met*, *Partially Met*, *Not Met*, or *NA*; the total percentage scores for evaluation and critical elements *Met*; and the validation status for the PIP.

Table I-2—2008–2009 PIP Validation Results for OCH						
Step		Number of Elements				
		Total	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
I.	Review the Selected Study Topic(s)	6	6	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	6	0	0	1
IV.	Review the Identified Study Population	3	3	0	0	0
V.	Review Sampling Methods (if sampling was used)	6	0	0	0	6
VI.	Review Data Collection Procedures	11	6	0	0	5
VII.	Assess Improvement Strategies	4	2	1	0	1
VIII.	Review Data Analysis and the Interpretation of Study Results	9	8	0	0	1
IX.	Assess for Real Improvement	4	3	1	0	0
X.	Assess for Sustained Improvement	1	Not Assessed			
Totals for all Steps		53	36	2	0	14
Percentage Score of Evaluation Elements <i>Met</i>		95%				
Percentage Score of Critical Elements <i>Met</i>		100%				
Validation Status		<i>Met</i>				

The 2008–2009 validation of **OCH**'s PIP on *Breast Cancer Screening Disparity* resulted in a validation status of *Met* with an overall score of 95 percent and a score of 100 percent for critical elements. While **OCH** demonstrated compliance with all applicable requirements of the CMS protocol for validating PIPs for Steps I through VI and Step VIII, HSAG identified opportunities for improvement in Steps I, VII, and IX. **OCH** should address these recommendations prior to the next annual submission.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **OCH**'s composite CAHPS scores are shown in Table I-3. The table presents each of the CAHPS measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table I-3—2009 CAHPS Child and Adult Composite Scores for OCH			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Getting Needed Care</i>	NA	NA	*
<i>Getting Care Quickly</i>	70.5%	2.54	*
<i>How Well Doctors Communicate</i>	73.3%	2.61	★★
<i>Customer Service</i>	NA	NA	*
<i>Shared Decision Making</i>	63.2%	2.55	**
Adult			
<i>Getting Needed Care</i>	49.8%	2.21	★★
<i>Getting Care Quickly</i>	61.0%	2.41	★★★
<i>How Well Doctors Communicate</i>	64.8%	2.47	★
<i>Customer Service</i>	64.9%	2.47	★★★
<i>Shared Decision Making</i>	52.1%	2.37	—
<p>The top-box percentage indicates the percentage of responses of “Always” or “Definitely Yes.”</p> <p>Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p>* The results for these measures are not comparable to the distribution of NCQA national survey results due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p> <p>NA = Composites that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results.</p> <p>★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.</p> <p>★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

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

OCH showed average performance on one of the four comparable 2009 adult CAHPS composite measures, *Getting Needed Care*. Furthermore, **OCH** showed above-average performance for two measures: *Getting Care Quickly* and *Customer Service*. High levels of performance for these measures indicate areas of strength for **OCH**. However, for *How Well Doctors Communicate*, **OCH**

showed below-average performance, indicating that opportunities exist to improve member satisfaction.

OCH’s detailed scores for the global ratings are presented in Table I-4. The table shows each of the four CAHPS global measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table I-4—2009 CAHPS Child and Adult Global Ratings for OCH			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Rating of All Health Care</i>	55.3%	2.37	★
<i>Rating of Personal Doctor</i>	66.6%	2.52	★★
<i>Rating of Specialist Seen Most Often</i>	NA	NA	NA
<i>Rating of Health Plan</i>	59.3%	2.42	★
Adult			
<i>Rating of All Health Care</i>	45.1%	2.19	★★
<i>Rating of Personal Doctor</i>	53.1%	2.31	★
<i>Rating of Specialist Seen Most Often</i>	61.0%	2.46	★★
<i>Rating of Health Plan</i>	57.7%	2.39	★★
The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population. NA = Global ratings that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).			
★ = Below-average performance (<25th percentile) relative to national Medicaid results. ★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results. ★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.			

OCH showed average performance on one of the three comparable 2009 child CAHPS global ratings, *Rating of Personal Doctor*. *Rating of All Health Care* and *Rating of Health Plan*, however, showed below-average performance. These areas of below-average performance indicate that opportunities exist for quality improvement activities aimed at improving member satisfaction.

OCH showed average performance on three of the four 2009 adult CAHPS global ratings: *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. Below-average performance on the remaining measure, *Rating of Personal Doctor*, indicates that opportunities still exist to improve member satisfaction.

Assessment of Follow-up on Prior Recommendations

Annual Compliance Reviews

During the 2007–2008 compliance site visit, MDCH identified recommendations for **OCH** for the following standards:

- ◆ Provider
- ◆ Member
- ◆ Quality/Utilization
- ◆ MIS/Data Reporting/Claims Processing
- ◆ Fraud and Abuse

MDCH evaluated **OCH**'s progress in implementing corrective actions to address these recommendations. Results will be included in the next technical report.

Performance Measures

Last year, **OCH** had several measures that performed below the national Medicaid HEDIS 2007 average performance standards. These measures included *Appropriate Testing for Children With Pharyngitis*, *Postpartum Care*, two *Comprehensive Diabetes Care—Blood Pressure Control* measures, three *Use of Appropriate Medications for People With Asthma* measures, and four *Children's and Adolescents' Access to Primary Care Practitioners* measures. To improve its performance for *Postpartum Care*, **OCH** implemented a variety of improvement strategies. Examples of these approaches included an on-site outreach program at two hospitals, allowing pregnant members to access prenatal care without authorization, and provider office incentives for high-volume obstetricians.

To improve performance on the *Comprehensive Diabetes Care* measures, **OCH** mailed incentives to all members in the disease management program for diabetes and followed up with outreach calls to assist with scheduling of appointments and transportation. The health plan also held a diabetes health fair with vendors conducting on-site screenings and used HEDIS rates to measure provider compliance with clinical practice guidelines for diabetes care.

To target performance on the asthma measures, **OCH** implemented several improvement strategies, which included creating an asthma educator position to reinforce regular contact with physicians and long-term controller medication use, partnering with University Pediatricians to hold weekly asthma “tune-up” clinics in December, and providing member and provider education about use of controller medication.

For the *Children's and Adolescents' Access to Primary Care Practitioners* measures, **OCH** continued its PCP Access to Care incentive program to reward medical practices demonstrating compliance with access-to-care standards and provided outreach to chronically noncompliant

members. **OCH** generated quarterly reports of members with more than six emergency room visits per quarter to identify members for possible enrollment in case management.

Although these efforts resulted in improved rates for some measures, only three of the measures (*Postpartum Care* and the two *Comprehensive Diabetes Care—Blood Pressure Control* measures) ranked within the national HEDIS 2008 average performance levels for their 2009 rates.

Performance Improvement Projects (PIPs)

OCH received scores of *Met* for all applicable evaluation and critical elements in the 2007–2008 validation of its PIP. Therefore, there was no need for **OCH** to follow-up on any prior recommendations.

Recommendations and Summary Assessment Related to Quality, Timeliness, and Access

The current review of **OCH** showed both strengths and opportunities for improvement.

The 2007–2008 compliance site visit resulted in recommendations across the three domains of **quality** and **timeliness** of, and **access** to, services provided by **OCH**. While MDCH evaluated **OCH**'s progress in addressing these recommendations as well as performance related to a set of mandatory criteria, results from the 2008–2009 compliance site visits will be included in the next technical report.

OCH demonstrated mixed performance in the **quality** and **access** domains, but had average performance for all measures in the **timeliness** domain. In the **quality** domain, all three measures for *Chlamydia Screening* showed above-average performance. Twenty-four measures ranked within their respective national HEDIS 2008 average performance ranges. Eight measures had below-average rates: *Appropriate Testing for Children With Pharyngitis*, three measures for *Use of Appropriate Medications for People With Asthma*, and all four measures of *Children's and Adolescents' Access to Primary Care Practitioners*. For several of these measures, last year's rates were also below average. In addition, the rates for two measures declined by more than 2 percentage points. These measures were *Comprehensive Diabetes Care—Eye Exam* (a decline of 7 percentage points) and *Use of Appropriate Medications for People With Asthma—5 to 9 Years* (a decline of 2.3 percentage points). The plan implemented interventions to address diabetes and asthma care. **OCH** should continue these interventions to improve the rates for these measures. All measures related to the **timeliness** domain ranked within their respective national average performance ranges. For the **access** domain, the two *Adults' Access to Preventive/Ambulatory Health Services* measures and the two *Prenatal and Postpartum Care* measures showed average performance compared to the national Medicaid percentiles. The measures for *Children's and Adolescents' Access to Primary Care Practitioners* ranked below their respective national HEDIS 2008 average performance levels.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the MHP's processes for conducting valid PIPs. Therefore, all PIPs were assigned to the **quality** domain. **OCH** demonstrated strong performance related to the quality of its PIP and a thorough understanding of the requirements for Activities I through VI and for Activity VIII of the CMS protocol for conducting PIPs. **OCH**'s PIP demonstrated improvement for both study indicators. The gap between the two age groups has narrowed, showing a decrease in the disparity. **OCH** plans to focus its interventions on the younger age group (42 to 51 years of age) to improve breast cancer screening rates. **OCH** should address all *Points of Clarification* and *Partially Met* scores prior to the next annual submission. As the study progresses, HSAG will evaluate **OCH**'s compliance with the requirements of the remaining PIP activities.

In the CAHPS domain of **quality**, **OCH** had average or above-average performance on 8 of the 12 comparable measures. **OCH** demonstrated average performance for the **access** domain and above-average performance for the **timeliness** domain. Measures that showed below-average performance represented the greatest opportunity for quality improvement. **OCH** had no measures for which

both the child and adult Medicaid populations showed below-average performance. However, the adult *How Well Doctors Communicate* and *Rating of Personal Doctor* measures and the child *Rating of All Health Care* and *Rating of Health Plan* measures showed below-average performance and could be targeted for quality improvement activities aimed at improving member satisfaction. Strategies for improving satisfaction levels with *How Well Doctors Communicate* could include providing specialized workshops for clinicians, supplying patients with a structured question list that will help them communicate with their physicians, and developing a system that will customarily send out routine and preventive care reminders to patients. Interventions for improving satisfaction levels for the *Rating of Personal Doctor* measure could include increasing levels of communication between patients and their physicians and decreasing wait times by eliminating barriers that may prohibit patients from receiving prompt, adequate care. To improve performance for the *Rating of All Health Care* measure, quality improvement activities should target improving overall satisfaction with patient health care and program experiences. To improve the overall *Rating of Health Plan* measure, quality improvement activities could target changing health plan operations to improve existing activities (e.g., customer service) and improving operations at individual physician offices (e.g., efficiency and ease of scheduling appointments).

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement.

MDCH conducted a compliance site visit to evaluate **PMD**'s implementation of corrective actions identified in the 2007–2008 site visit. MDCH also assessed **PMD**'s compliance with a set of mandatory criteria included in the review for all MHPs, regardless of prior performance.

The next technical report will present an analysis of the combined findings from the 2008–2009 and 2009–2010 site visits.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess the ability of each MHP’s support system to report accurate HEDIS measures. The results of this assessment are presented in Table J-1. The table shows each of the performance measures, the rates for each measure for 2009, and the categorized performance for 2009 relative to national Medicaid results.

Table J-1—2009 Scores for Performance Measures for PMD			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Pediatric Care	<i>Childhood Immunization—Combo 2</i>	81.1%	★★
	<i>Childhood Immunization—Combo 3</i>	74.4%	★★
	<i>Lead Screening in Children</i>	85.0%	★★★
	<i>Well-Child 1st 15 Months—0 Visits*</i>	1.5%	★★
	<i>Well-Child 1st 15 Months—6+ Visits</i>	63.2%	★★
	<i>Well-Child 3rd–6th Years of Life</i>	64.0%	★★
	<i>Adolescent Well-Care Visits</i>	46.2%	★★
	<i>Appropriate Treatment of URI</i>	88.9%	★★
	<i>Children With Pharyngitis</i>	60.2%	★★
Women’s Care	<i>Breast Cancer Screening</i>	48.9%	★★
	<i>Cervical Cancer Screening</i>	71.2%	★★
	<i>Chlamydia Screening—16 to 20 Years</i>	63.6%	★★
	<i>Chlamydia Screening—21 to 24 Years</i>	76.5%	★★★
	<i>Chlamydia Screening—Combined</i>	68.3%	★★★
	<i>Timeliness of Prenatal Care</i>	83.5%	★★
	<i>Postpartum Care</i>	67.0%	★★

* Lower rates indicate better performance for this measure.

† National percentiles are not available for this analysis.

- ★ = Below-average performance relative to national Medicaid results.
- ★★ = Average performance relative to national Medicaid results.
- ★★★ = Above-average performance relative to national Medicaid results.

Table J-1—2009 Scores for Performance Measures for PMD			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Living With Illness	Diabetes Care—HbA1c Testing	86.2%	★★
	Diabetes Care—Poor HbA1c Control*	30.4%	★★★
	Diabetes Care—Eye Exam	70.9%	★★★
	Diabetes Care—LDL-C Screening	78.8%	★★
	Diabetes Care—LDL-C Level <100	44.7%	★★★
	Diabetes Care—Nephropathy	84.9%	★★
	Diabetes Care—Blood Pressure Control (<130/80)	39.7%	★★
	Diabetes Care—Blood Pressure Control (<140/90)	66.4%	★★
	Asthma—5 to 9 Years	96.8%	★★★
	Asthma—10 to 17 Years	94.0%	★★★
	Asthma—18 to 56 Years	90.2%	★★
	Asthma—Combined Rate	93.3%	★★★
	Controlling High Blood Pressure	57.5%	★★
	Advising Smokers to Quit	74.0%	†
	Discussing Smoking Cessation Strategies	50.3%	†
Access to Care	Children’s Access—12 to 24 Months	94.1%	★★
	Children’s Access—25 Months to 6 Years	83.8%	★★
	Children’s Access—7 to 11 Years	83.5%	★★
	Adolescents’ Access—12 to 19 Years	84.6%	★★
	Adults’ Access—20 to 44 Years	81.0%	★★
	Adults’ Access—45 to 64 Years	87.2%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table J-1 shows that **PMD**’s rates for nine performance measures were above average compared to the national Medicaid HEDIS 2008 results. The above-average rates were for *Lead Screening in Children*, two of the *Chlamydia Screening* measures (*21 to 24 Years* and *Combined Rate*), three measures for *Comprehensive Diabetes Care* (*Poor HbA1c Control*, *Eye Exam*, and *LDL-C Level < 100*), and three measures for *Use of Appropriate Medications for People With Asthma* (*5 to 9 Years*, *10 to 17 Years*, and *Combined Rate*). These measures represented areas of relative strength for **PMD**.

The table also shows that rates for 26 performance measures ranked within their respective national Medicaid HEDIS 2008 average performance ranges. These measures represented neither areas of relative strength nor high-priority opportunities for improvement.

None of the rates was below the national Medicaid HEDIS 2008 average performance, indicating that in general, **PMD** achieved at least average performance for all HEDIS measures.

Validation of Performance Improvement Projects (PIPs)

Table J-2 presents the scoring for each of the steps in the CMS PIP protocol. The table shows the number of elements within each step and, of those, the number that were scored as *Met*, *Partially Met*, *Not Met*, or *NA*; the total percentage scores for evaluation and critical elements *Met*; and the validation status for the PIP.

Table J-2—2008–2009 PIP Validation Results for PMD						
Step		Number of Elements				
		Total	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
I.	Review the Selected Study Topic(s)	6	6	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	7	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0
V.	Review Sampling Methods (if sampling was used)	6	0	0	0	6
VI.	Review Data Collection Procedures	11	6	0	0	5
VII.	Assess Improvement Strategies	4	3	0	0	1
VIII.	Review Data Analysis and the Interpretation of Study Results	9	8	0	0	1
IX.	Assess for Real Improvement	4	1	3	0	0
X.	Assess for Sustained Improvement	1	Not Assessed			
Totals for all Steps		53	36	3	0	13
Percentage Score of Evaluation Elements <i>Met</i>		92%				
Percentage Score of Critical Elements <i>Met</i>		100%				
Validation Status		<i>Met</i>				

The 2008–2009 validation of **PMD**'s PIP on *Cervical Cancer Screening Disparity* resulted in a validation status of *Met* with an overall score of 92 percent and a score of 100 percent for critical elements. **PMD** demonstrated compliance with all applicable requirements for Steps I through VIII of the CMS protocol for validating PIPs. HSAG identified opportunities for improvement in Steps VI and IX that will need to be addressed prior to the next annual submission.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **PMD**'s composite CAHPS scores are shown in Table J-3. The table presents each of the CAHPS measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table J-3—2009 CAHPS Child and Adult Composite Scores for PMD			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Getting Needed Care</i>	54.8%	2.38	*
<i>Getting Care Quickly</i>	77.2%	2.68	*
<i>How Well Doctors Communicate</i>	76.9%	2.70	★★★
<i>Customer Service</i>	NA	NA	*
<i>Shared Decision Making</i>	69.6%	2.63	**
Adult			
<i>Getting Needed Care</i>	53.6%	2.32	★★★
<i>Getting Care Quickly</i>	57.4%	2.38	★★
<i>How Well Doctors Communicate</i>	71.9%	2.58	★★★
<i>Customer Service</i>	54.5%	2.33	★★
<i>Shared Decision Making</i>	55.9%	2.43	—
<p>The top-box percentage indicates the percentage of responses of “Always” or “Definitely Yes.”</p> <p>Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p>* The results for these measures are not comparable to the distribution of NCQA national survey results due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p> <p>NA = Composites that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results.</p> <p>★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.</p> <p>★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

PMD showed above-average performance on the only comparable 2009 child CAHPS composite measure, *How Well Doctors Communicate*.

PMD showed above-average performance on two of the four comparable 2009 adult CAHPS composite measures, *Getting Needed Care* and *How Well Doctors Communicate*, indicating areas of strength for **PMD**. For the remaining composite measures, *Getting Care Quickly* and *Customer Service*, **PMD** showed average performance.

PMD's detailed scores for the global ratings are presented in Table J-4. The table shows each of the four CAHPS global measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table J-4—2009 CAHPS Child and Adult Global Ratings for PMD			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Rating of All Health Care</i>	56.5%	2.47	★
<i>Rating of Personal Doctor</i>	69.8%	2.60	★★★
<i>Rating of Specialist Seen Most Often</i>	63.6%	2.49	★★
<i>Rating of Health Plan</i>	64.3%	2.55	★★
Adult			
<i>Rating of All Health Care</i>	48.2%	2.26	★★
<i>Rating of Personal Doctor</i>	64.4%	2.49	★★★
<i>Rating of Specialist Seen Most Often</i>	61.6%	2.49	★★★
<i>Rating of Health Plan</i>	55.1%	2.39	★★
The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.			
★ = Below-average performance (<25th percentile) relative to national Medicaid results.			
★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.			
★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.			

PMD showed above-average performance on one of the four 2009 comparable child CAHPS global ratings, *Rating of Personal Doctor*. **PMD** showed average performance on two measures: *Rating of Specialist Seen Most Often* and *Rating of Health Plan*. The remaining measure, *Rating of All Health Care*, showed below-average performance. This area of below-average performance indicates that opportunities exist for quality improvement activities aimed at improving member satisfaction.

PMD showed average performance on two of the four 2009 adult CAHPS global ratings: *Rating of All Health Care* and *Rating of Health Plan*. **PMD** showed above-average performance for *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*, indicating areas of strength for **PMD**.

Assessment of Follow-up on Prior Recommendations

Annual Compliance Reviews

During the 2007–2008 compliance site visit, MDCH identified recommendations for **PMD** for the following standards:

- ◆ Provider
- ◆ Member
- ◆ Quality/Utilization
- ◆ MIS/Data Reporting/Claims Processing

MDCH evaluated **PMD**'s progress in implementing corrective actions to address these recommendations. Results will be included in the next technical report.

Performance Measures

In 2008, **PMD**'s rates for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and two *Children's Access to Primary Care Practitioners* measures showed below-average performance compared to the national Medicaid HEDIS 2007 performance standards. To improve the rate for well-child visits, **PMD** continued to provide member and provider education and incentives, implement missed service reminders, and develop or update clinical guidelines. To improve performance on access-to-care measures, **PMD** focused on reducing the disparity in practice patterns by encouraging practitioners to adopt patient-centered medical home concepts and processes. The 2009 rates for these measures improved from the 2008 rates and were within the average performance ranges compared to the national HEDIS 2008 results.

Performance Improvement Projects (PIPs)

PMD received scores of *Met* for all applicable evaluation and critical elements in the 2007–2008 validation of its PIP. Therefore, there was no need for **PMD** to follow-up on any prior recommendations.

Recommendations and Summary Assessment Related to Quality, Timeliness, and Access

The current review of **PMD** showed both strengths and opportunities for improvement.

The 2007–2008 compliance site visit resulted in recommendations across the three domains of **quality** and **timeliness** of, and **access** to, services provided by **PMD**. While MDCH evaluated **PMD**'s progress in addressing these recommendations as well as performance related to a set of mandatory criteria, results from the 2008–2009 compliance site visits will be included in the next technical report.

PMD demonstrated at least average performance for measures across the **quality**, **timeliness**, and **access** domains. In the **quality** domain, nine performance measures were above average compared to the national Medicaid HEDIS 2008 results: *Lead Screening in Children*, two of the *Chlamydia Screening* measures, three measures for *Comprehensive Diabetes Care (Poor HbA1c Control, Eye Exam, and LDL-C Level < 100)*, and three measures for *Use of Appropriate Medications for People With Asthma (5 to 9 Years, 10 to 17 Years, and Combined Rate)*. Twenty-six measures ranked within their respective national HEDIS 2008 average performance ranges. One measure in the timeliness domain—*Lead Screening in Children*—ranked above the average performance level, while the remaining eight ranked within their respective average performance ranges. All measures related to the **access** domain ranked within their respective national average performance ranges. Compared to last year's rates, some measures reported a decline of more than 2 percentage points. These measures included *Timeliness of Prenatal Care* (a decline of 2.1 percentage points) and *Controlling High Blood Pressure—Combined Rate* (a decline of 2.4 percentage points), representing opportunities for improvement for **PMD**. The plan implemented interventions to improve prenatal care for members. **PMD** should continue the interventions to address prenatal care and develop interventions for controlling high blood pressure.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the MHP's processes for conducting valid PIPs. Therefore, all PIPs were assigned to the **quality** domain. **PMD** demonstrated strong performance related to the quality of its PIP and a thorough understanding of the requirements for Activities I through VIII of the CMS protocol for conducting PIPs. **PMD** demonstrated improvement for three of the four study indicators. **PMD** reported that lab data had not been captured and that the data included only claims/encounters from administrative data. This could have affected the results. **PMD** requested that the 2010 administrative data include all lab data. **PMD** also increased financial incentives, included educational materials in its mailers, and added the phone number for the physician referral line to all postcard reminders. **PMD** expects that these changes will have an impact on all study indicators. HSAG recommends that **PMD** address all *Points of Clarification* and *Partially Met* scores as the study progresses. In future validations, HSAG will evaluate **PMD**'s compliance with the requirements of the remaining PIP activities.

In the CAHPS domain of **quality**, **PMD** had average or above-average performance on 12 of the 13 comparable measures. **PMD** demonstrated above-average performance for the **access** domain and average performance for the **timeliness** domain. Measures that showed below-average performance represented the greatest opportunities for quality improvement. **PMD** had no measures for which

both the child and adult Medicaid populations showed below-average performance. However, the child *Rating of All Health Care* measure showed below-average performance and could be targeted for quality improvement activities aimed at improving member satisfaction. To improve performance for the *Rating of All Health Care* measure, quality improvement activities should target improving overall satisfaction with patient health care and program experiences.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement.

MDCH conducted a compliance site visit to evaluate **PRI**'s implementation of corrective actions identified in the 2007–2008 site visit. MDCH also assessed **PRI**'s compliance with a set of mandatory criteria included in the review for all MHPs, regardless of prior performance.

The next technical report will present an analysis of the combined findings from the 2008–2009 and 2009–2010 site visits.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess the ability of each MHP’s support system to report accurate HEDIS measures. The results of this assessment are presented in Table K-1. The table shows each of the performance measures, the rates for each measure for 2009, and the categorized performance for 2009 relative to national Medicaid results.

Table K-1—2009 Scores for Performance Measures for PRI			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Pediatric Care	<i>Childhood Immunization—Combo 2</i>	85.0%	★★★
	<i>Childhood Immunization—Combo 3</i>	80.2%	★★★
	<i>Lead Screening in Children</i>	78.3%	★★
	<i>Well-Child 1st 15 Months—0 Visits*</i>	1.0%	★★
	<i>Well-Child 1st 15 Months—6+ Visits</i>	69.8%	★★
	<i>Well-Child 3rd–6th Years of Life</i>	71.9%	★★
	<i>Adolescent Well-Care Visits</i>	50.9%	★★
	<i>Appropriate Treatment of URI</i>	91.5%	★★
	<i>Children With Pharyngitis</i>	70.8%	★★
Women’s Care	<i>Breast Cancer Screening</i>	55.8%	★★
	<i>Cervical Cancer Screening</i>	77.8%	★★★
	<i>Chlamydia Screening—16 to 20 Years</i>	67.5%	★★★
	<i>Chlamydia Screening—21 to 24 Years</i>	74.1%	★★★
	<i>Chlamydia Screening—Combined</i>	70.2%	★★★
	<i>Timeliness of Prenatal Care</i>	88.3%	★★
	<i>Postpartum Care</i>	73.2%	★★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table K-1—2009 Scores for Performance Measures for PRI			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Living With Illness	Diabetes Care—HbA1c Testing	87.4%	★★
	Diabetes Care—Poor HbA1c Control*	27.9%	★★★
	Diabetes Care—Eye Exam	69.3%	★★★
	Diabetes Care—LDL-C Screening	80.5%	★★
	Diabetes Care—LDL-C Level <100	41.2%	★★
	Diabetes Care—Nephropathy	81.4%	★★
	Diabetes Care—Blood Pressure Control (<130/80)	40.7%	★★
	Diabetes Care—Blood Pressure Control (<140/90)	69.3%	★★
	Asthma—5 to 9 Years	97.6%	★★★
	Asthma—10 to 17 Years	96.5%	★★★
	Asthma—18 to 56 Years	89.9%	★★
	Asthma—Combined Rate	94.3%	★★★
	Controlling High Blood Pressure	57.5%	★★
	Advising Smokers to Quit	77.3%	†
	Discussing Smoking Cessation Strategies	44.4%	†
Access to Care	Children’s Access—12 to 24 Months	97.8%	★★
	Children’s Access—25 Months to 6 Years	85.4%	★★
	Children’s Access—7 to 11 Years	87.7%	★★
	Adolescents’ Access—12 to 19 Years	85.8%	★★
	Adults’ Access—20 to 44 Years	85.1%	★★
	Adults’ Access—45 to 64 Years	90.0%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table K-1 shows that **PRI**’s rates for 12 performance measures were above average compared to the national Medicaid HEDIS 2008 results. The above-average rates were for both measures of *Childhood Immunization Status*, 3 measures of *Chlamydia Screening*, 2 measures of *Comprehensive Diabetes Care*, 3 measures of *Use of Appropriate Medications for People With Asthma*, *Cervical Cancer Screening*, and *Postpartum Care*. These measures represented areas of relative strength for **PRI**.

The table also shows that rates for 23 of the performance measures ranked within their respective national Medicaid HEDIS 2008 average performance ranges. These measures represented neither areas of relative strength nor high-priority opportunities for improvement.

None of the rates fell below the national Medicaid HEDIS 2008 average performance, indicating that in general, **PRI** achieved at least average rates for the performance measures.

Validation of Performance Improvement Projects (PIPs)

Table K-2 presents the scoring for each of the steps in the CMS PIP protocol. The table shows the number of elements within each step and, of those, the number that were scored as *Met*, *Partially Met*, *Not Met*, or *NA*; the total percentage scores for evaluation and critical elements *Met*; and the validation status for the PIP.

Table K-2—2008–2009 PIP Validation Results for PRI						
Step		Number of Elements				
		Total	Met	Partially Met	Not Met	NA
I.	Review the Selected Study Topic(s)	6	6	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	6	0	0	1
IV.	Review the Identified Study Population	3	3	0	0	0
V.	Review Sampling Methods (if sampling was used)	6	0	0	0	6
VI.	Review Data Collection Procedures	11	6	0	0	5
VII.	Assess Improvement Strategies	4	3	0	0	1
VIII.	Review Data Analysis and the Interpretation of Study Results	9	8	0	0	1
IX.	Assess for Real Improvement	4	1	0	3	0
X.	Assess for Sustained Improvement	1	Not Assessed			
Totals for all Steps		53	35	0	3	14
Percentage Score of Evaluation Elements Met		92%				
Percentage Score of Critical Elements Met		100%				
Validation Status		Met				

The 2008–2009 validation of **PRI**'s PIP on *Breast Cancer Screening Disparity* resulted in a validation status of *Met* with an overall score of 92 percent and a score of 100 percent for critical elements. While **PRI** demonstrated compliance with all applicable requirements for Steps I through VIII of the CMS protocol for validating PIPs, HSAG identified opportunities for improvement in Step IX, Assessing for Real Improvement. **PRI** should address these opportunities for improvement prior to the next annual submission.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **PRI**'s composite CAHPS scores are shown in Table K-3. The table presents each of the CAHPS measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table K-3—2009 CAHPS Child and Adult Composite Scores for PRI			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Getting Needed Care</i>	57.4%	2.40	*
<i>Getting Care Quickly</i>	73.4%	2.63	*
<i>How Well Doctors Communicate</i>	74.8%	2.68	★★★
<i>Customer Service</i>	NA	NA	*
<i>Shared Decision Making</i>	69.9%	2.64	**
Adult			
<i>Getting Needed Care</i>	51.3%	2.29	★★
<i>Getting Care Quickly</i>	52.9%	2.38	★★
<i>How Well Doctors Communicate</i>	69.8%	2.59	★★★
<i>Customer Service</i>	NA	NA	NA
<i>Shared Decision Making</i>	62.2%	2.52	—
<p>The top-box percentage indicates the percentage of responses of “Always” or “Definitely Yes.”</p> <p>Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p>* The results for these measures are not comparable to the distribution of NCQA national survey results due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p> <p>NA = Composites that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results.</p> <p>★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.</p> <p>★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

PRI showed above-average performance on the only comparable 2009 child CAHPS composite measure, *How Well Doctors Communicate*, indicating an area of strength for **PRI**.

PRI showed above-average performance for one of the three 2009 comparable adult CAHPS composite measures, *How Well Doctors Communicate*. Furthermore, **PRI** showed average performance for the remaining two measures: *Getting Needed Care* and *Getting Care Quickly*. **PRI** did not show below-average performance on any of the adult CAHPS composite measures.

PRI’s detailed scores for the global ratings are presented in Table K-4. The table shows each of the four CAHPS global measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table K-4—2009 CAHPS Child and Adult Global Ratings for PRI			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Rating of All Health Care</i>	63.8%	2.52	★★
<i>Rating of Personal Doctor</i>	71.7%	2.63	★★★
<i>Rating of Specialist Seen Most Often</i>	NA	NA	NA
<i>Rating of Health Plan</i>	64.8%	2.54	★★
Adult			
<i>Rating of All Health Care</i>	49.0%	2.32	★★★
<i>Rating of Personal Doctor</i>	60.0%	2.47	★★
<i>Rating of Specialist Seen Most Often</i>	69.5%	2.60	★★★
<i>Rating of Health Plan</i>	56.7%	2.40	★★
<p>The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population. NA = Global ratings that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results. ★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results. ★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

PRI showed above-average performance for one of the three 2009 child CAHPS global ratings, *Rating of Personal Doctor*. Two global ratings for PRI showed average performance: *Rating of All Health Care* and *Rating of Health Plan*.

PRI showed above-average performance for two of the four 2009 adult CAHPS global ratings: *Rating of All Health Care* and *Rating of Specialist Seen Most Often*. For *Rating of Personal Doctor* and *Rating of Health Plan*, PRI showed average performance.

Assessment of Follow-up on Prior Recommendations

Annual Compliance Reviews

During the 2007–2008 compliance site visit, MDCH identified recommendations for **PRI** for the following standards:

- ◆ Provider
- ◆ Quality/Utilization

MDCH evaluated **PRI**'s progress in implementing corrective actions to address these recommendations. Results will be included in the next technical report.

Performance Measures

Although none of the 2008 rates for **PRI** fell below the national Medicaid HEDIS 2007 average performance, the rates for several measures declined. These measures included *Well-Child Visits in the First 15 Months of Life—Zero Visits*, *Appropriate Testing for Children With Pharyngitis*, and several measures for *Comprehensive Diabetes Care (Poor HbA1c Control, LDL-C Screening, and Nephropathy)*. **PRI** implemented a variety of improvement strategies to increase its rates for these measures. For well-child visits, these strategies included mailing of postcards to remind members of appointments and including information on well-child visits and physical exams in newsletters and/or mailing packets. The plan also added well-child visits for children to the 2009 Partners in Performance financial incentive program and investigated possible best practices. Strategies for improving the *Comprehensive Diabetes Care* measures included interventions such as health management programs for diabetes, educational mailings, and automated reminder calls for missed appointments. Provider-level strategies included automating online forms sent to physicians for care coordination and providing physicians member-specific diabetes data on patient profiles. These efforts resulted in improvement in the targeted measures except for the *Well-Child Visits in the First 15 Months of Life—Zero Visits* measure.

Performance Improvement Projects (PIPs)

PRI received scores of *Met* for all applicable evaluation and critical elements in the 2007–2008 validation of its PIP. Therefore, there was no need for **PRI** to follow-up on any prior recommendations.

Recommendations and Summary Assessment Related to Quality, Timeliness, and Access

The current review of **PRI** showed both strengths and opportunities for improvement.

The 2007–2008 compliance site visit resulted in recommendations across the three domains of **quality** and **timeliness** of, and **access** to, services provided by **PRI**. While MDCH evaluated **PRI**'s progress in addressing these recommendations as well as performance related to a set of mandatory criteria, results from the 2008–2009 compliance site visits will be included in the next technical report.

PRI demonstrated at least average performance across the **quality**, **timeliness**, and **access** domains. In the **quality** domain, 12 measures showed above-average performance. These measures included both measures of *Childhood Immunization Status*, 3 measures of *Chlamydia Screening*, 2 measures of *Comprehensive Diabetes Care*, 3 measures of *Use of Appropriate Medications for People With Asthma*, *Cervical Cancer Screening*, and *Postpartum Care*. Twenty-three measures in the **quality** domain ranked within their respective national HEDIS 2008 average performance ranges. In addition, compared to last year's rates, the *Comprehensive Diabetes Care—Eye Exam* measure was the only measure to show a decline of 2 or more percentage points. **PRI** implemented several interventions to address diabetes care. The plan should continue with these interventions to improve the rates for the diabetes measure. Three of the 9 measures in the **timeliness** domain (*Childhood Immunization Status—Combo 2* and *Combo 3* and *Postpartum Care*) performed above the national HEDIS 2008 average performance levels, and the remaining 6 measures ranked within their average performance ranges. For the **access** domain, the *Postpartum Care* measure showed above-average performance and the remaining 5 measures had average performance compared to the national HEDIS 2008 performance levels.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the MHP's processes for conducting valid PIPs. Therefore, all PIPs were assigned to the **quality** domain. **PRI** demonstrated strong performance related to the quality of its PIP and a thorough understanding of the requirements for Activities I through VIII of the CMS protocol for conducting PIPs. **PRI** reported an increase in its enrollee population of 20 percent during the last measurement period. **PRI** reported that this could have affected the study results. To strengthen the study, **PRI** should implement interventions targeting enrollee education for its new members.

In the CAHPS domain of **quality**, **PRI** had average or above-average performance on all 11 of the comparable measures. **PRI** demonstrated average performance for the **access** and **timeliness** domains. Measures that showed below-average performance represent the greatest opportunities for quality improvement. However, **PRI** had no measures for which the child and/or adult Medicaid populations had below-average performance.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement.

MDCH conducted its first compliance site visit of **PRO** to evaluate its readiness to perform as an MHP. The review assessed **PRO**'s compliance with all criteria in Standards 1–5.

The next technical report will present an analysis of the combined findings from the 2008–2009 and 2009–2010 site visits.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess the ability of each MHP’s support system to report accurate HEDIS measures. The results of this assessment are presented in Table L-1. The table shows each of the performance measures, the rates for each measure for 2009, and the categorized performance for 2009 relative to national Medicaid results.

Table L-1—2009 Scores for Performance Measures for PRO			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Pediatric Care	<i>Childhood Immunization—Combo 2</i>	NA	NA
	<i>Childhood Immunization—Combo 3</i>	NA	NA
	<i>Lead Screening in Children</i>	NA	NA
	<i>Well-Child 1st 15 Months—0 Visits*</i>	NA	NA
	<i>Well-Child 1st 15 Months—6+ Visits</i>	NA	NA
	<i>Well-Child 3rd–6th Years of Life</i>	NA	NA
	<i>Adolescent Well-Care Visits</i>	20.0%	★
	<i>Appropriate Treatment of URI</i>	NA	NA
	<i>Children With Pharyngitis</i>	NA	NA
Women’s Care	<i>Breast Cancer Screening</i>	NA	NA
	<i>Cervical Cancer Screening</i>	NA	NA
	<i>Chlamydia Screening—16 to 20 Years</i>	NA	NA
	<i>Chlamydia Screening—21 to 24 Years</i>	NA	NA
	<i>Chlamydia Screening—Combined</i>	NA	NA
	<i>Timeliness of Prenatal Care</i>	NA	NA
	<i>Postpartum Care</i>	NA	NA
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
NA indicates that the health plan followed the specifications for producing a reportable denominator, but the denominator was too small to report a valid rate, resulting in a <i>Not Applicable</i> (NA) audit designation.			
★ = Below-average performance relative to national Medicaid results.			
★★ = Average performance relative to national Medicaid results.			
★★★ = Above-average performance relative to national Medicaid results.			

Table L-1—2009 Scores for Performance Measures for PRO			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Living With Illness	Diabetes Care—HbA1c Testing	NA	NA
	Diabetes Care—Poor HbA1c Control*	NA	NA
	Diabetes Care—Eye Exam	NA	NA
	Diabetes Care—LDL-C Screening	NA	NA
	Diabetes Care—LDL-C Level <100	NA	NA
	Diabetes Care—Nephropathy	NA	NA
	Diabetes Care—Blood Pressure Control (<130/80)	NA	NA
	Diabetes Care—Blood Pressure Control (<140/90)	NA	NA
	Asthma—5 to 9 Years	NA	NA
	Asthma—10 to 17 Years	NA	NA
	Asthma—18 to 56 Years	NA	NA
	Asthma—Combined Rate	NA	NA
	Controlling High Blood Pressure	NA	NA
	Advising Smokers to Quit	NA	†
	Discussing Smoking Cessation Strategies	NA	†
Access to Care	Children’s Access—12 to 24 Months	NA	NA
	Children’s Access—25 Months to 6 Years	NA	NA
	Children’s Access—7 to 11 Years	NA	NA
	Adolescents’ Access—12 to 19 Years	NA	NA
	Adults’ Access—20 to 44 Years	NA	NA
	Adults’ Access—45 to 64 Years	NA	NA
<p>* Lower rates indicate better performance for this measure.</p> <p>† National percentiles are not available for this analysis.</p> <p>NA indicates that the health plan followed the specifications for producing a reportable denominator, but the denominator was too small to report a valid rate, resulting in a <i>Not Applicable</i> (NA) audit designation.</p> <p>★ = Below-average performance relative to national Medicaid results.</p> <p>★★ = Average performance relative to national Medicaid results.</p> <p>★★★ = Above-average performance relative to national Medicaid results.</p>			

Table L-1 shows that **PRO** was unable to report rates for all but one measure (*Adolescent Well-Care Visits*) due to insufficient sample sizes (a denominator of less than 30). The table above designates this health plan’s rates as NA.

For the one measure with a sufficient sample size to report a rate, **PRO**’s performance was below the average performance level of the national Medicaid HEDIS 2008 rates. This measure represented an opportunity for improvement.

Validation of Performance Improvement Projects (PIPs)

Table L-2 presents the scoring for each of the steps in the CMS PIP protocol. The table shows the number of elements within each step and, of those, the number that were scored as *Met*, *Partially Met*, *Not Met*, or *NA*; the total percentage scores for evaluation and critical elements *Met*; and the validation status for the PIP.

Table L-2—2008–2009 PIP Validation Results for PRO						
Step		Number of Elements				
		Total	Met	Partially Met	Not Met	NA
I.	Review the Selected Study Topic(s)	6	6	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	6	0	0	1
IV.	Review the Identified Study Population	3	3	0	0	0
V.	Review Sampling Methods (if sampling was used)	6	0	0	0	6
VI.	Review Data Collection Procedures	11	6	0	0	5
VII.	Assess Improvement Strategies	4	2	0	0	2
VIII.	Review Data Analysis and the Interpretation of Study Results	9	4	0	0	5
IX.	Assess for Real Improvement	4	Not Assessed			
X.	Assess for Sustained Improvement	1	Not Assessed			
Totals for all Steps		53	29	0	0	19
Percentage Score of Evaluation Elements Met		100%				
Percentage Score of Critical Elements Met		100%				
Validation Status		Met				

The 2008–2009 validation of **PRO**'s PIP on *Breast Cancer Screening Disparity* resulted in a validation status of *Met* with an overall score of 100 percent and a score of 100 percent for critical elements. While **PRO** demonstrated compliance with all applicable requirements for Steps I through VIII of the CMS protocol for validating PIPs, HSAG identified opportunities for improvement in Steps II, III, IV, VI, VII and VIII. **PRO** should address these *Points of Clarification* prior to the next annual PIP submission.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **PRO**'s composite CAHPS scores are shown in Table L-3. The table presents each of the CAHPS measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table L-3—2009 CAHPS Child and Adult Composite Scores for PRO			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Getting Needed Care</i>	NA	NA	*
<i>Getting Care Quickly</i>	NA	NA	*
<i>How Well Doctors Communicate</i>	NA	NA	NA
<i>Customer Service</i>	NA	NA	*
<i>Shared Decision Making</i>	NA	NA	**
Adult			
<i>Getting Needed Care</i>	NA	NA	NA
<i>Getting Care Quickly</i>	NA	NA	NA
<i>How Well Doctors Communicate</i>	NA	NA	NA
<i>Customer Service</i>	NA	NA	NA
<i>Shared Decision Making</i>	NA	NA	—
<p>The top-box percentage indicates the percentage of responses of “Always” or “Definitely Yes.”</p> <p>Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p>* The results for these measures are not comparable to the distribution of NCQA national survey results due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p> <p>NA = Composites that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results.</p> <p>★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.</p> <p>★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

PRO did not meet the minimum number of responses for any of the 2009 child or adult CAHPS composite measures.

PRO's detailed scores for the global ratings are presented in Table L-4. The table shows each of the four CAHPS global measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table L-4—2009 CAHPS Child and Adult Global Ratings <i>for</i> PRO			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Rating of All Health Care</i>	NA	NA	NA
<i>Rating of Personal Doctor</i>	NA	NA	NA
<i>Rating of Specialist Seen Most Often</i>	NA	NA	NA
<i>Rating of Health Plan</i>	NA	NA	NA
Adult			
<i>Rating of All Health Care</i>	NA	NA	NA
<i>Rating of Personal Doctor</i>	NA	NA	NA
<i>Rating of Specialist Seen Most Often</i>	NA	NA	NA
<i>Rating of Health Plan</i>	NA	NA	NA
<p>The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population. NA = Global ratings that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p>			
<p>★ = Below-average performance (<25th percentile) relative to national Medicaid results. ★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results. ★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

PRO did not meet the minimum number of responses for any of the 2009 child or adult CAHPS global ratings.

Assessment of Follow-up on Prior Recommendations

Annual Compliance Reviews

The 2008–2009 site visit was the first compliance review for **PRO**. The next technical report will include an assessment of **PRO**'s follow-up on recommendations from this compliance review.

Performance Measures

PRO did not report on the 2008 HEDIS measures due to insufficient data.

Performance Improvement Projects (PIPs)

The *Breast Cancer Screening Disparity* PIP was a first-year submission for **PRO**. There were no prior recommendations for this PIP.

Recommendations and Summary Assessment Related to Quality, Timeliness, and Access

The current review of **PRO** showed both strengths and opportunities for improvement.

The 2008–2009 site visit was the first compliance review of **PRO**. Recommendations based on the findings from the 2008–2009 compliance site visit and a summary assessment related to the **quality** and **timeliness** of, and **access** to, services provided by **PRO** will be included in the next technical report.

PRO reported a rate for one measure—*Adolescent Well-Care Visits*. The rate for this measure fell below the national Medicaid HEDIS 2008 performance level, reflecting an opportunity for improvement. **PRO** did not report rates for any of the remaining measures due to insufficient sample sizes. Therefore, overall conclusions could not be drawn for **PRO**'s performance in the **quality**, **timeliness**, and **access** domains. The plan implemented member-focused interventions to address adolescent well-care visits. The plan should continue with these interventions to improve the rate for this measure.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the MHP's processes for conducting valid PIPs. Therefore, all PIPs were assigned to the **quality** domain. **PRO** demonstrated strong performance related to the quality of its PIP and a thorough understanding of the requirements for Activities I through VIII of the CMS protocol for conducting PIPs. This was a first-year PIP submission with **PRO** reporting baseline data. Based on the reported results, the disparity initially identified by the plan does not appear to exist. HSAG recommends that **PRO** select a different disparity and revise the study question and study indicator(s) based on the new study focus.

The CAHPS domains of **quality**, **timeliness**, and **access** for **PRO** were not assessed since **PRO** did not meet the minimum number of 100 responses in the survey.

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement.

MDCH conducted a compliance site visit to evaluate **THC**'s implementation of corrective actions identified in the 2007–2008 site visit. MDCH also assessed **THC**'s compliance with a set of mandatory criteria included in the review for all MHPs, regardless of prior performance.

The next technical report will present an analysis of the combined findings from the 2008–2009 and 2009–2010 site visits.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess the ability of each MHP’s support system to report accurate HEDIS measures. The results of this assessment are presented in Table M-1. The table shows each of the performance measures, the rates for each measure for 2009, and the categorized performance for 2009 relative to national Medicaid results.

Table M-1—2009 Scores for Performance Measures for THC			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Pediatric Care	<i>Childhood Immunization—Combo 2</i>	85.3%	★★★
	<i>Childhood Immunization—Combo 3</i>	74.5%	★★
	<i>Lead Screening in Children</i>	73.3%	★★
	<i>Well-Child 1st 15 Months—0 Visits*</i>	1.4%	★★
	<i>Well-Child 1st 15 Months—6+ Visits</i>	66.4%	★★
	<i>Well-Child 3rd–6th Years of Life</i>	74.3%	★★
	<i>Adolescent Well-Care Visits</i>	56.2%	★★
	<i>Appropriate Treatment of URI</i>	59.2%	★
	<i>Children With Pharyngitis</i>	55.9%	★★
Women’s Care	<i>Breast Cancer Screening</i>	48.3%	★★
	<i>Cervical Cancer Screening</i>	68.6%	★★
	<i>Chlamydia Screening—16 to 20 Years</i>	63.2%	★★
	<i>Chlamydia Screening—21 to 24 Years</i>	74.0%	★★★
	<i>Chlamydia Screening—Combined</i>	66.9%	★★
	<i>Timeliness of Prenatal Care</i>	84.2%	★★
	<i>Postpartum Care</i>	61.5%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table M-1—2009 Scores for Performance Measures for THC			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Living With Illness	Diabetes Care—HbA1c Testing	80.4%	★★
	Diabetes Care—Poor HbA1c Control*	48.1%	★★
	Diabetes Care—Eye Exam	57.1%	★★
	Diabetes Care—LDL-C Screening	74.3%	★★
	Diabetes Care—LDL-C Level <100	37.7%	★★
	Diabetes Care—Nephropathy	79.4%	★★
	Diabetes Care—Blood Pressure Control (<130/80)	24.3%	★
	Diabetes Care—Blood Pressure Control (<140/90)	55.3%	★★
	Asthma—5 to 9 Years	80.7%	★
	Asthma—10 to 17 Years	77.1%	★
	Asthma—18 to 56 Years	83.3%	★★
	Asthma—Combined Rate	81.0%	★
	Controlling High Blood Pressure	60.0%	★★
	Advising Smokers to Quit	70.2%	†
	Discussing Smoking Cessation Strategies	39.8%	†
Access to Care	Children’s Access—12 to 24 Months	95.9%	★★
	Children’s Access—25 Months to 6 Years	86.5%	★★
	Children’s Access—7 to 11 Years	82.4%	★★
	Adolescents’ Access—12 to 19 Years	83.7%	★★
	Adults’ Access—20 to 44 Years	77.8%	★★
	Adults’ Access—45 to 64 Years	83.1%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table M-1 shows that **THC**’s rates for two of the performance measures were above average compared to the national Medicaid HEDIS 2008 results. The above-average rates were for *Childhood Immunization Status—Combo 2* and *Chlamydia Screening in Women—21 to 24 Years*. These above-average measures represented areas of relative strength for **THC**.

The table also shows that the rates for 28 of the performance measures ranked within their respective national Medicaid HEDIS 2008 average performance ranges. These measures represented neither areas of relative strength nor high-priority opportunities for improvement.

Five measures reported rates that were below average compared to the national Medicaid HEDIS 2008 results: *Appropriate Treatment for Children With URI*, *Comprehensive Diabetes Care—Blood Pressure Control <130/80*, and three measures for *Use of Appropriate Medications for People With*

Asthma (5 to 9 Years, 10 to 17 Years, and Combined Rate). These findings suggest opportunities for improvement for **THC**.

Validation of Performance Improvement Projects (PIPs)

Table M-2 presents the scoring for each of the steps in the CMS PIP protocol. The table shows the number of elements within each step and, of those, the number that were scored as *Met*, *Partially Met*, *Not Met*, or *NA*; the total percentage scores for evaluation and critical elements *Met*; and the validation status for the PIP.

Table M-2—2008–2009 PIP Validation Results for THC						
Step		Number of Elements				
		Total	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
I.	Review the Selected Study Topic(s)	6	6	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	7	0	0	0
IV.	Review the Identified Study Population	3	3	0	0	0
V.	Review Sampling Methods (if sampling was used)	6	0	0	0	6
VI.	Review Data Collection Procedures	11	6	0	0	5
VII.	Assess Improvement Strategies	4	2	1	0	1
VIII.	Review Data Analysis and the Interpretation of Study Results	9	8	0	0	1
IX.	Assess for Real Improvement	4	3	0	1	0
X.	Assess for Sustained Improvement	1	1	0	0	0
Totals for all Steps		53	38	1	1	13
Percentage Score of Evaluation Elements <i>Met</i>		95%				
Percentage Score of Critical Elements <i>Met</i>		100%				
Validation Status		<i>Met</i>				

The 2008–2009 validation of **THC**'s PIP on *Breast Cancer Screening Disparity* resulted in a validation status of *Met* with an overall score of 95 percent and a score of 100 percent for critical elements. **THC** demonstrated compliance with all applicable requirements for Steps I through VI and Step VIII of the CMS protocol. HSAG identified opportunities for improvement in Steps I, VII, and IX that **THC** will need to address prior to the next annual submission if **THC** continues with this PIP.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **THC**'s composite CAHPS scores are shown in Table M-3. The table presents each of the CAHPS measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table M-3—2009 CAHPS Child and Adult Composite Scores for THC			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Getting Needed Care</i>	48.7%	2.20	*
<i>Getting Care Quickly</i>	70.0%	2.54	*
<i>How Well Doctors Communicate</i>	69.0%	2.56	★★
<i>Customer Service</i>	NA	NA	*
<i>Shared Decision Making</i>	NA	NA	**
Adult			
<i>Getting Needed Care</i>	55.7%	2.33	★★★
<i>Getting Care Quickly</i>	60.0%	2.37	★★
<i>How Well Doctors Communicate</i>	69.0%	2.51	★★
<i>Customer Service</i>	60.1%	2.39	★★
<i>Shared Decision Making</i>	61.4%	2.49	—
<p>The top-box percentage indicates the percentage of responses of “Always” or “Definitely Yes.”</p> <p>Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p>* The results for these measures are not comparable to the distribution of NCQA national survey results due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p> <p>NA = Composites that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results.</p> <p>★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.</p> <p>★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

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

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

THC’s detailed scores for the global ratings are presented in Table M-4. The table shows each of the four CAHPS global measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table M-4—2009 CAHPS Child and Adult Global Ratings for THC			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Rating of All Health Care</i>	53.7%	2.38	★
<i>Rating of Personal Doctor</i>	64.9%	2.48	★
<i>Rating of Specialist Seen Most Often</i>	NA	NA	NA
<i>Rating of Health Plan</i>	55.8%	2.35	★
Adult			
<i>Rating of All Health Care</i>	47.2%	2.25	★★
<i>Rating of Personal Doctor</i>	58.8%	2.37	★
<i>Rating of Specialist Seen Most Often</i>	66.4%	2.53	★★★
<i>Rating of Health Plan</i>	51.8%	2.31	★★
The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population. NA = Global ratings that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).			
★ = Below-average performance (<25th percentile) relative to national Medicaid results. ★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results. ★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.			

All three of THC’s comparable 2009 child CAHPS global ratings, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*, showed below-average performance. These areas of below-average performance indicate that opportunities exist for quality improvement activities aimed at improving member satisfaction.

THC showed above-average performance on one of the four 2009 adult CAHPS global ratings, *Rating of Specialist Seen Most Often*. THC showed average performance on two of the measures: *Rating of All Health Care* and *Rating of Health Plan*. Below-average performance on the remaining measure, *Rating of Personal Doctor*, indicates that opportunities exist to improve member satisfaction.

Assessment of Follow-up on Prior Recommendations

Annual Compliance Reviews

During the 2007–2008 compliance site visit, MDCH identified recommendations for **THC** for the following standards:

- ◆ Provider
- ◆ Member
- ◆ Quality/Utilization
- ◆ MIS/Data Reporting/Claims Processing
- ◆ Fraud and Abuse

MDCH evaluated **THC**'s progress in implementing corrective actions to address these recommendations. Results will be included in the next technical report.

Performance Measures

THC had 13 measures with below-average performance compared to the national Medicaid HEDIS 2007 performance standards. These measures were: *Well-Child Visits in the First 15 Months of Life—Six or More Visits*, *Appropriate Treatment for Children With URI*, *Appropriate Testing for Children With Pharyngitis*, *2 Comprehensive Diabetes Care—Blood Pressure Control* measures, all 4 measures for *Use of Appropriate Medications for People With Asthma*, and all 4 measures for *Children's and Adolescents' Access to Primary Care Practitioners*. During 2008, **THC** implemented a variety of improvement strategies to improve performance on these measures. For well-child visits, member-level improvement strategies included reminder cards; personalized letters; member newsletters; and incentives such as gift cards and drawings for \$500 or game systems. Provider-level strategies included education of physician office staff on coding requirements for encounters or claims and incentive programs for providers. **THC** also implemented a pilot project with St. John's Pediatrics to improve well-child screening rates. The health plan continued to implement its diabetes disease management program.

To improve performance on the asthma measures, **THC** distributed several resources to providers, including the asthma clinical practice guidelines and the "Michigan Asthma Resource Kit" flyer. The health plan also notified primary care physicians of any members enrolled in the disease management program for asthma. For member-level strategies, **THC** provided member education regarding asthma control management through educational mailings and newsletters and contracted with Parrish Home Healthcare to provide home visits to members discharged from the hospital with a diagnosis of asthma. The health plan also adopted Schering Plough's NCQA-accredited Disease Management Education Program.

To improve on the access-to-care measures, **THC** generated HEDIS report results by practice location and distributed them to providers, conducted medical record reviews for noncompliant members, organized provider education programs with an emphasis on access-to-care standards,

and offered incentives to providers to perform well-child visits. These strategies resulted in improved rates for some of the targeted measures.

Performance Improvement Projects (PIPs)

Based on the prior validation in 2007–2008, HSAG determined that the improvement from baseline to the first remeasurement period was not significant for either of the two study indicators. **THC**'s study results submitted for the current validation reflected that the improvement from baseline to the second remeasurement failed to reach statistical significance. However, the results were at or above the baseline level.

Recommendations and Summary Assessment Related to Quality, Timeliness, and Access

The current review of **THC** showed both strengths and opportunities for improvement.

The 2007–2008 compliance site visit resulted in recommendations across the three domains of **quality** and **timeliness** of, and **access** to, services provided by **THC**. While MDCH evaluated **THC**'s progress in addressing these recommendations as well as performance related to a set of mandatory criteria, results from the 2008–2009 compliance site visits will be included in the next technical report.

THC demonstrated mixed performance on measures in the **quality** domain, but showed at least average performance on measures in the **timeliness** and **access** domains. In the **quality** domain, two measures (*Childhood Immunization Status—Combo 2* and *Chlamydia Screening in Women—21 to 24 Years*) showed above-average performance. Twenty-eight measures ranked within their respective national HEDIS 2008 average performance ranges. Five **quality** measures had below-average rates. These measures were: *Appropriate Treatment for Children With URI*, *Comprehensive Diabetes Care—Blood Pressure Control <130/80*, and three measures of *Use of Appropriate Medications for People With Asthma (5 to 9 Years, 10 to 17 Years, and Combined Rate)*. Additionally, four measures had rates that showed a decline of at least 2 percentage points from the 2008 rates. These measures were: *Cervical Cancer Screening* and *Postpartum Care* (both with a decline of 2.6 percentage points) and two measures of *Use of Appropriate Medications for People With Asthma (5 to 9 Years* showed a decline of 3.9 percentage points and *10 to 17 Years* had a decline of 4.3 percentage points). **THC** implemented interventions to address asthma, cervical cancer screening, and prenatal and postpartum care. The plan should continue with these interventions to improve the rates for these measures. One **timeliness** measure (*Childhood Immunization Status—Combo 2*) performed above the national HEDIS 2008 average performance. The remaining eight **timeliness** measures and all the measures in the **access** domain ranked at least within their respective national average performance ranges.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the MHP's processes for conducting valid PIPs. Therefore, all PIPs were assigned to the **quality** domain. **THC** demonstrated strong performance related to the quality of its PIP and a thorough understanding of the requirements for conducting PIPs according to the CMS protocol. **THC** completed all ten activities for this PIP. **THC**'s results demonstrated progress through the measurement periods and improvement in the outcomes of care. Although the improvement was not statistically significant, the results remained equal to or greater than the benchmark. Because of these accomplishments, this PIP should be considered for retirement.

In the CAHPS domain of **quality**, **THC** had average or above-average performance on 8 of the 12 comparable measures. **THC** demonstrated average and above-average performance across the **access** and **timeliness** domains, respectively. Measures that showed below-average performance represented the greatest opportunities for quality improvement. The *Rating of Personal Doctor* measure showed below-average performance for both the adult and child populations. In addition, the child *Rating of All Health Care* and *Rating of Health Plan* measures showed below-average

performance. To improve the *Rating of Personal Doctor* measure, quality improvement activities could target increasing levels of communication between physicians and patients. The activities could also aim to decrease the time between the point when patients need care and when patients receive care by eliminating barriers that may prohibit patients from receiving prompt, adequate care. To improve performance for the *Rating of All Health Care* measure, quality improvement activities should target improving overall satisfaction with patient health care and program experiences. To improve the overall *Rating of Health Plan* measure, quality improvement activities could target changing health plan operations to improve existing activities (e.g., customer service) and improving operations at individual physician offices (e.g., efficiency and ease of scheduling appointments).

Annual Compliance Review

According to 42 CFR 438.358, the State or its EQRO must conduct a review to determine the Medicaid managed care organizations' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement.

MDCH conducted a compliance site visit to evaluate **UPP's** implementation of corrective actions identified in the 2007–2008 site visit. MDCH also assessed **UPP's** compliance with a set of mandatory criteria included in the review for all MHPs, regardless of prior performance.

The next technical report will present an analysis of the combined findings from the 2008–2009 and 2009–2010 site visits.

Performance Measures

As set forth in 42 CFR 438.358, the primary objectives of the performance measure validation process are to evaluate the accuracy of the performance measure data collected by the MHP and determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure. To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough information system evaluation, to assess the ability of each MHP’s support system to report accurate HEDIS measures. The results of this assessment are presented in Table N-1. The table shows each of the performance measures, the rates for each measure for 2009, and the categorized performance for 2009 relative to the national 2008 Medicaid results.

Table N-1—2009 Scores for Performance Measures for UPP			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Pediatric Care	<i>Childhood Immunization—Combo 2</i>	81.2%	★★
	<i>Childhood Immunization—Combo 3</i>	73.8%	★★
	<i>Lead Screening in Children</i>	86.4%	★★★
	<i>Well-Child 1st 15 Months—0 Visits*</i>	1.4%	★★
	<i>Well-Child 1st 15 Months—6+ Visits</i>	60.9%	★★
	<i>Well-Child 3rd–6th Years of Life</i>	60.4%	★★
	<i>Adolescent Well-Care Visits</i>	33.9%	★
	<i>Appropriate Treatment of URI</i>	81.1%	★★
	<i>Children With Pharyngitis</i>	66.4%	★★
Women’s Care	<i>Breast Cancer Screening—Combined Rate</i>	57.9%	★★
	<i>Cervical Cancer Screening</i>	75.9%	★★
	<i>Chlamydia Screening—16 to 20 Years</i>	44.5%	★★
	<i>Chlamydia Screening—21 to 24 Years</i>	51.6%	★★
	<i>Chlamydia Screening—Combined</i>	47.1%	★★
	<i>Timeliness of Prenatal Care</i>	93.2%	★★★
	<i>Postpartum Care</i>	73.2%	★★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table N-1—2009 Scores for Performance Measures for UPP			
Dimension	Performance Measure	Rate for 2009	Performance Level for 2009
Living With Illness	Diabetes Care—HbA1c Testing	89.0%	★★★
	Diabetes Care—Poor HbA1c Control*	25.2%	★★★
	Diabetes Care—Eye Exam	66.9%	★★
	Diabetes Care—LDL-C Screening	82.4%	★★★
	Diabetes Care—LDL-C Level <100	40.6%	★★
	Diabetes Care—Nephropathy	79.1%	★★
	Diabetes Care—Blood Pressure Control (<130/80)	39.4%	★★
	Diabetes Care—Blood Pressure Control (<140/90)	73.5%	★★★
	Asthma—5 to 9 Years	90.8%	★★
	Asthma—10 to 17 Years	86.4%	★★
	Asthma—18 to 56 Years	83.0%	★★
	Asthma—Combined Rate	85.6%	★
	Controlling High Blood Pressure	66.2%	★★★
	Advising Smokers to Quit	72.6%	†
	Discussing Smoking Cessation Strategies	42.3%	†
Access to Care	Children’s Access—12 to 24 Months	97.7%	★★
	Children’s Access—25 Months to 6 Years	87.8%	★★
	Children’s Access—7 to 11 Years	88.3%	★★
	Adolescents’ Access—12 to 19 Years	89.3%	★★
	Adults’ Access—20 to 44 Years	89.2%	★★★
	Adults’ Access—45 to 64 Years	90.1%	★★
* Lower rates indicate better performance for this measure.			
† National percentiles are not available for this analysis.			
★	=	Below-average performance relative to national Medicaid results.	
★★	=	Average performance relative to national Medicaid results.	
★★★	=	Above-average performance relative to national Medicaid results.	

Table N-1 shows that UPP’s rates for nine of the performance measures were above average compared to the national Medicaid HEDIS 2008 results. The measures with above-average rates included *Lead Screening in Children*, *Timeliness of Prenatal Care*, *Postpartum Care*, four measures of *Comprehensive Diabetes Care*, *Controlling High Blood Pressure*, and *Adults’ Access to Preventive/Ambulatory Health Services—20 to 44 Years*. These measures represented areas of relative strength for UPP.

The table also shows that the rates for 24 of the performance measures ranked within their respective national Medicaid HEDIS 2008 average performance ranges. These measures represented neither areas of relative strength nor high-priority opportunities for improvement.

Two measures reported rates that were below average compared to the national Medicaid HEDIS 2008 results. These measures were *Adolescent Well-Care Visits* and *Use of Appropriate Medications for People With Asthma—Combined Rate*. These measures represented opportunities for improvement for **UPP**.

Validation of Performance Improvement Projects (PIPs)

Table N-2 presents the scoring for each of the steps in the CMS PIP protocol. The table shows the number of elements within each step and, of those, the number that were scored as *Met*, *Partially Met*, *Not Met*, or *NA*; the total percentage scores for evaluation and critical elements *Met*; and the validation status for the PIP.

Table N-2—2008–2009 PIP Validation Results for UPP						
Step		Number of Elements				
		Total	<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>	<i>NA</i>
I.	Review the Selected Study Topic(s)	6	6	0	0	0
II.	Review the Study Question(s)	2	2	0	0	0
III.	Review the Selected Study Indicator(s)	7	6	0	0	1
IV.	Review the Identified Study Population	3	3	0	0	0
V.	Review Sampling Methods (if sampling was used)	6	0	0	0	6
VI.	Review Data Collection Procedures	11	6	0	0	5
VII.	Assess Improvement Strategies	4	3	0	0	1
VIII.	Review Data Analysis and the Interpretation of Study Results	9	8	0	0	1
IX.	Assess for Real Improvement	4	1	0	3	0
X.	Assess for Sustained Improvement	1	Not Assessed			
Totals for all Steps		53	35	0	3	14
Percentage Score of Evaluation Elements <i>Met</i>		92%				
Percentage Score of Critical Elements <i>Met</i>		100%				
Validation Status		<i>Met</i>				

The 2008–2009 validation of **UPP**'s PIP on *Breast Cancer Screening Disparity* resulted in a validation status of *Met* with an overall score of 92 percent and a score of 100 percent for critical elements. While **UPP** demonstrated compliance with all applicable requirements for Steps I through VIII of the CMS protocol for validating PIPs, HSAG identified opportunities for improvement in Steps VI and IX that **UPP** will need to address prior to the next annual submission.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The detailed results for **UPP**'s composite CAHPS scores are shown in Table N-3. The table presents each of the CAHPS measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table N-3—2009 CAHPS Child and Adult Composite Scores for UPP			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Getting Needed Care</i>	66.9%	2.54	*
<i>Getting Care Quickly</i>	76.0%	2.69	*
<i>How Well Doctors Communicate</i>	76.9%	2.71	★★★
<i>Customer Service</i>	NA	NA	*
<i>Shared Decision Making</i>	70.8%	2.65	**
Adult			
<i>Getting Needed Care</i>	56.1%	2.38	★★★
<i>Getting Care Quickly</i>	57.5%	2.43	★★★
<i>How Well Doctors Communicate</i>	66.0%	2.52	★★
<i>Customer Service</i>	56.6%	2.32	★★
<i>Shared Decision Making</i>	62.9%	2.53	—
<p>The top-box percentage indicates the percentage of responses of “Always” or “Definitely Yes.”</p> <p>Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.</p> <p>* The results for these measures are not comparable to the distribution of NCQA national survey results due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.</p> <p>** The child <i>Shared Decision Making</i> composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys. National data was not publically available for the child <i>Shared Decision Making</i> composite because it was a first-year measure.</p> <p>— Benchmarks and thresholds were not publically available for the adult <i>Shared Decision Making</i> composite and therefore not used in this analysis.</p> <p>NA = Composites that do not meet the minimum number of 100 responses are denoted as Not Applicable (NA).</p> <p>★ = Below-average performance (<25th percentile) relative to national Medicaid results.</p> <p>★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results.</p> <p>★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.</p>			

UPP showed above-average performance on the only comparable 2009 child CAHPS composite measure, *How Well Doctors Communicate*.

UPP showed above-average performance on two of the four 2009 adult CAHPS composite measures: *Getting Needed Care* and *Getting Care Quickly*. **UPP** showed average performance for the remaining two measures: *How Well Doctors Communicate* and *Customer Service*.

UPP’s detailed scores for the global ratings are presented in Table N-4. The table shows each of the four CAHPS global measures, the top-box percentages, the three-point mean scores, and the overall performance levels for 2009.

Table N-4—2009 CAHPS Child and Adult Global Ratings for UPP			
CAHPS Measures	Top-Box Percentage	Three-Point Mean Score	Performance Level
Child			
<i>Rating of All Health Care</i>	59.2%	2.48	★
<i>Rating of Personal Doctor</i>	68.8%	2.60	★★★
<i>Rating of Specialist Seen Most Often</i>	64.3%	2.52	★★
<i>Rating of Health Plan</i>	62.1%	2.50	★★
Adult			
<i>Rating of All Health Care</i>	48.2%	2.27	★★
<i>Rating of Personal Doctor</i>	61.5%	2.46	★★
<i>Rating of Specialist Seen Most Often</i>	59.1%	2.42	★★
<i>Rating of Health Plan</i>	51.1%	2.33	★★
The top-box percentage indicates the percentage of respondents rating 9 or 10 on a scale of 0 to 10. Performance levels are based on a comparison to NCQA accreditation benchmarks and thresholds for the adult Medicaid population and to the distribution of NCQA national survey results for the child Medicaid population.			
★ = Below-average performance (<25th percentile) relative to national Medicaid results. ★★ = Average performance (≥25th to <75th percentile) relative to national Medicaid results. ★★★ = Above-average performance (≥ 75th percentile) relative to national Medicaid results.			

UPP showed above-average performance on one 2009 child CAHPS global rating, *Rating of Personal Doctor*. UPP showed average performance on two of the four global ratings: *Rating of Specialist Seen Most Often* and *Rating of Health Plan*. However, *Rating of All Health Care* showed below-average performance, indicating that opportunities exist for quality improvement activities aimed at improving member satisfaction.

UPP showed average performance on all four 2009 adult CAHPS global ratings: *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.

Assessment of Follow-up on Prior Recommendations

Annual Compliance Reviews

During the 2007–2008 compliance site visit, MDCH identified recommendations for **UPP** for the following standards:

- ◆ Provider
- ◆ Member
- ◆ Quality/Utilization
- ◆ MIS/Data Reporting/Claims Processing
- ◆ Fraud and Abuse

MDCH evaluated **UPP**'s progress in implementing corrective actions to address these recommendations. Results will be included in the next technical report.

Performance Measures

UPP had two measures with below-average performance compared to the national Medicaid HEDIS 2007 performance standards. These measures were *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Use of Appropriate Medications for People With Asthma—5 to 9 Years*. During 2008, **UPP** implemented several improvement strategies to target these measures. Examples of strategies for well-child visits included member incentives, routine and targeted member and provider education, outreach calls and mailings, and participation in community health fairs. For the asthma measures, **UPP** distributed the updated asthma guidelines via provider newsletters, provider manuals, and new provider orientation packets and posted them on the plan's Web site. These strategies resulted in performance improvement, especially in the asthma measure, for which the rate increased by 2.8 percentage points.

Performance Improvement Projects (PIPs)

UPP received scores of *Met* for all applicable evaluation and critical elements in the 2007–2008 validation of its PIP. Therefore, there was no need for **UPP** to follow-up on any prior recommendations.

Recommendations and Summary Assessment Related to Quality, Timeliness, and Access

The current review of **UPP** showed both strengths and opportunities for improvement.

The 2007–2008 compliance site visit resulted in recommendations across the three domains of **quality** and **timeliness** of, and **access** to, services provided by **UPP**. While MDCH evaluated **UPP**'s progress in addressing these recommendations as well as performance related to a set of mandatory criteria, results from the 2008–2009 compliance site visits will be included in the next technical report.

UPP demonstrated mixed performance on measures in the **quality** domain, but showed at least average performance across measures in the **timeliness** and **access** domains. For performance measures in the **quality** domain, nine measures showed above-average performance, including *Timeliness of Prenatal Care and Postpartum Care* and four measures of *Comprehensive Diabetes Care*. Twenty-four measures ranked within their respective national HEDIS 2008 average performance ranges. Two measures in the **quality** domain (*Adolescent Well-Care Visits* and *Use of Appropriate Medications for People With Asthma—Combined Rate*) ranked below average. The rates for these two measures, along with two other asthma measures (*10 to 17 Years* and *18 to 56 Years*), declined from last year's rates by more than 2 percentage points. **UPP** implemented interventions to address these lower well-care and asthma rates. The plan should continue these interventions to improve the rates for these measures. For the **timeliness** domain, three of the nine measures (*Lead Screening in Children* and *Timeliness of Prenatal Care and Postpartum Care*) performed above the national 2008 HEDIS averages, while the remaining six measures ranked within their respective average performance ranges. For the **access** domain, three measures (*Timeliness of Prenatal Care, Postpartum Care, and Adults' Access to Preventive/Ambulatory Health Services—20 to 44 Years*) showed above-average performance; the remaining five measures had average performance.

The EQR activities related to the validation of PIPs addressed the validity and reliability of the MHP's processes for conducting valid PIPs. Therefore, all PIPs were assigned to the **quality** domain. **UPP** demonstrated strong performance related to the quality of its PIP and a thorough understanding of the requirements for Activities I through VIII of the CMS protocol for conducting PIPs. To strengthen the study, **UPP** should address all *Points of Clarification* and *Not Met* scores. **UPP**'s results did not reflect improvement from baseline to the first remeasurement. **UPP** plans to continue provider interventions since reported provider changes may have affected the success of the improvement strategies. HSAG recommends that the health plan continue reporting of screening rates for eligible women 52 to 69 years of age, in addition to the rates for the study population, to evaluate for a reduction in the disparity between the two age groups.

In the CAHPS domain of **quality**, **UPP** had average or above-average performance on 12 of the 13 comparable measures. **UPP** demonstrated above-average performance in the **access** and **timeliness** domains. Measures that showed below-average performance represented the greatest opportunities for quality improvement. **UPP** had no measures for which both the child and adult Medicaid populations had below-average performance. However, the child *Rating of All Health Care* measure had below-average performance and could be targeted for quality improvement activities aimed at

improving member satisfaction. To improve the *Rating of All Health Care* measure, quality improvement activities could target member: satisfaction with physicians, member perception of access to care, experience with care, and experience with the health plan.