Michigan Department of Community Health
Medical Services Administration
Managed Care Plan Division
Quality Improvement and Program Development Section

Medicaid Health Equity Project

Year 1 Report (HEDIS 2011)

June 2012

Monica Kwasnik, MA
Senior Quality Analyst
Quality Improvement and Program Development Section
Managed Care Plan Division
Michigan Department of Community Health
kwasnikm@michigan.gov
(517) 373-6096

Background

Racial and ethnic disparities in healthcare and outcomes exist in both publicly and privately funded health programs. Racial and ethnic minority populations experience poorer outcomes than the general population for almost every health condition. The combined costs of racial and ethnic health disparities and premature death in the US between 2003 and 2006 were estimated by the Joint Center for Political and Economic Studies at $1.24 trillion. It is projected that eliminating these health disparities would have reduced *direct medical care expenditures* in the US by $229.4 billion for the same time period[1]. Michigan Medicaid has both an ideological and financial interest in determining what, if any, racial/ethnic disparities exist in the health care services we provide and/or the outcomes to beneficiaries.

Introduction

Michigan Medicaid is required to monitor the quality and appropriateness of the healthcare services delivered by our fourteen participating Medicaid Health Plans (MHPs) to the 1.2 million beneficiaries in their care[2]. Federal regulations require that MHPs provide services "in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds."[3] Both federal and state laws address the need to reduce racial/ethnic disparities in healthcare and outcomes. The Affordable Care Act (ACA) includes language that prohibits discrimination under any health program or activity that is receiving federal financial assistance[4]. The ACA also includes improved federal data collection efforts by ensuring that federal health care programs collect and report data on race, ethnicity, sex, primary language, and disability status[5]. On a state level, Michigan Public Act 653 of 2006 directs the Michigan Department of Community Health to develop strategies to reduce racial and ethnic disparities, including the compilation of racial and ethnic specific data including, but not limited to, morbidity and mortality[6].

In an effort to comply with federal and state law, and toward the end of ensuring high quality healthcare for all Medicaid Managed Care beneficiaries, the Quality Improvement and Program Development Section of the Medicaid Managed Care Plan Division developed the *Medicaid Health Equity Project*.

In early 2010, all Medicaid health plans were asked to participate in conference calls to frame the problem of disparities in care and plan the project. During those calls, Michigan Medicaid solicited MHPs for input and advice in the development of the methodology. A set of initial

---

[1] LaVeist RA, Gaskin DJ, Richard P. The Economic Burden of health Inequalities in the United States. Washington, DC: Joint Center for Political and Economic Studies; September 2009

[2] Michigan Medicaid Managed Care Enrollment Report, January 2012

[3] Balanced Budget Act of 1997. 42 CFR 438.206(e)(2). Cultural Considerations.

[4] Patient Protection and Affordable Care Act, PUBLIC LAW 111–148, Sec. 1557

[5] Patient Protection and Affordable Care Act, PUBLIC LAW 111–148, Sec. 4302

[6] Michigan Compiled Laws, 2006 PA 653. Signed by Gov. Jennifer M. Granholm on January 8, 2006

measures was agreed upon and specifications were developed. Final instructions and a data submission template were distributed with a deadline of July 15, 2011. All fourteen Michigan MHPs submitted data.

Methods

Data Collection

As a means of measuring quality consistently across plans, and to facilitate comparison across states, MHPs submit audited Health Effectiveness Data and Information Set (HEDIS) data to DCH for each measure that pertains to Medicaid covered benefits[7]. All Medicaid Managed Care Plans were asked to submit the following subset of HEDIS 2011 measures broken down by race/ethnicity to DCH:

Breast Cancer Screening
Cervical Cancer Screening
Chlamydia Screening (Combined)
HbA1c Testing
Childhood Immunizations Combo 3
Appropriate Asthma Meds (Combined)
Child Access to Care (25 months to 6 years)
Adult Access to Care (20-44 years)

For Hybrid measures (those which allow health plans to use both their internal administrative databases as well as medical record review to determine compliance rates) plans submitted only administrative data for this report. This could result in underreporting by health plans and may possibly affect rates. MHPs were provided with a blank template to ensure consistency across all plan submissions (see Appendix A). Plans used their audited HEDIS data to draw the initial numbers (total numerators and denominators), but the final data broken down by race/ethnicity was not audited. Data from all MHPs were aggregated by race/ethnicity and compiled for each measure. A Michigan Medicaid Managed Care aggregated average was then developed for each racial/ethnic group for each of the eight measures. Racial/ethnic differences in rates were apparent for each measure.

Results

Table 1 shows all HEDIS 2011 numerators, denominators, and rates for the eight Year 1 measures, for all racial/ethnic populations for which we have Medicaid Managed Care data. The rates varied by race/ethnicity for each of the measures.

[7] For a detailed discussion of HEDIS data specifications see HEDIS 2011 Technical Specification created and maintained by the National Committee for Quality Assurance (NCQA)

Table 1. Michigan Medicaid Managed Care Select HEDIS 2011 Measures by Race/Ethnicity. All Populations.

Race/ Ethnicity*	Breast Cancer Screening (BCS)			Cervical Cancer Screening (CCS)			Chlamydia Testing Total (CHL)			HbA1c Testing (CDC)			Childhood Imms Combo 3 (CIS)			Appropriate Asthma Meds Total (ASM)			Access to Care 25 months-6 yrs (CAP)			Access to Care 20-44 yrs (AAP)		
	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%
AI/AN	37	74	50.0	125	213	58.7	53	110	48.2	47	61	77.0	31	44	70.5	32	33	97.0	196	217	90.3	261	288	90.6
Asian	43	81	53.1	Insufficient Data			20	54	37.0	Insufficient Data			69	86	80.2	39	39	100.0	353	374	34.4	218	275	79.3
African American	8662	16030	54.0	28658	42078	68.1	17302	23638	73.2	6658	9231	72.1	5986	9794	61.1	5921	6930	85.4	47326	55086	85.9	51063	64062	79.7
Hispanic	450	781	57.6	2039	2934	69.5	1155	1886	61.2	641	847	75.7	864	1192	72.5	578	648	89.2	10379	11325	91.	4261	5187	82.1
NH/OPI	Insufficient Data			36	84	42.9	Insufficient Data			Insufficient Data			Insufficient Data			Insufficient Data			78	97	80.4	81	110	73.6
Other/ Multiracial	262	434	60.4	862	1378	62.6	162	269	60.2	437	523	83.6	231	289	79.9	150	161	93.2	1794	1926	93.1	1120	1337	83.8
White	11106	19076	58.2	40784	60582	67.3	13715	25022	54.8	9961	12193	81.7	12384	17389	71.2	7585	8574	88.5	87181	94986	91.8	75938	88415	85.9
Unknown/ Declined	286	507	56.4	1201	1962	61.2	593	989	60.0	384	515	74.6	1410	2020	69.8	363	402	90.3	4759	5278	90.2	2324	2921	79.6

*In the HEDIS data collection process, members are identified first with a race, then an ethnicity of Hispanic, Non-Hispanic, Unknown, or Declined. For this study, all Hispanic beneficiaries, regardless of race, were moved into the category Hispanic. They are not duplicated in the race categories.

There are data available for eight racial/ethnic groups (American Indian/Alaskan Native, Asian, African American, Hispanic/Latino, Native Hawaiian/Other Pacific Islander, Other/Multiracial, White, Unknown/Declined). For the measures in this report, however, African American, Hispanic/Latino, and White beneficiaries make up over 90% of the eligible population. Table 2 below is the same as Table 1, except that it shows only the African American, Hispanic/Latino, and White populations.

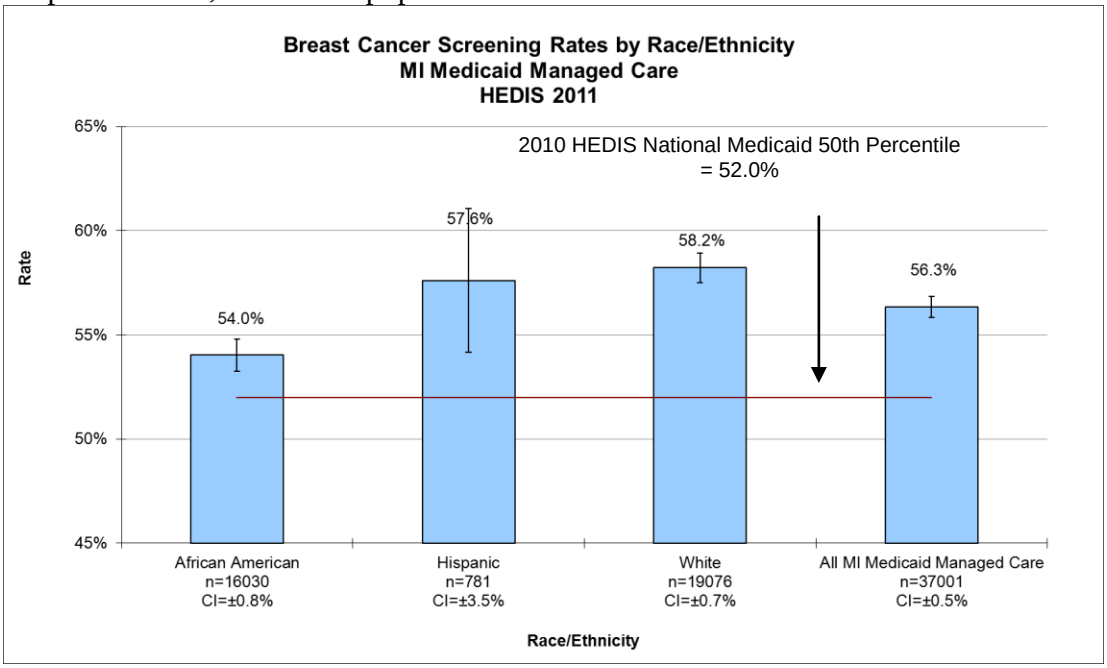
Rates are in the shaded column.

Table 2. Michigan Medicaid Managed Care Select HEDIS 2011 Measures by Race/Ethnicity. African American, Hispanic/Latino, White only.

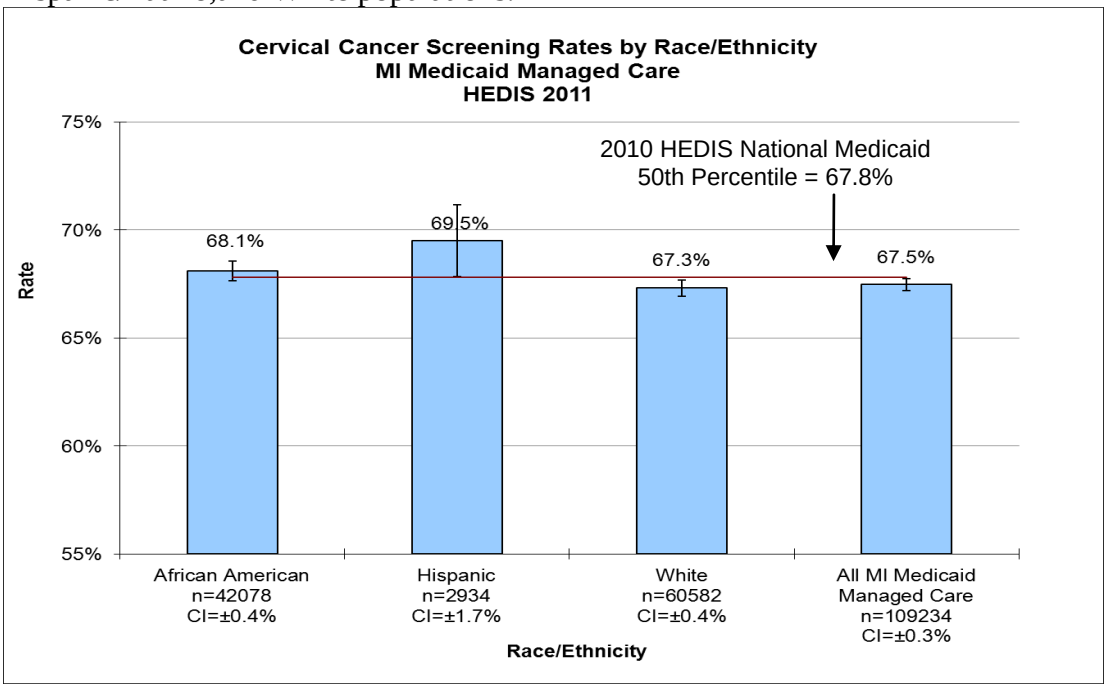
Race/ Ethnicity *	Breast Cancer Screening (BCS)			Cervical Cancer Screening (CCS)			Chlamydia Testing Total (CHL)			HbA1c Testing (CDC)			Childhood Imms Combo 3 (CIS)			Appropriate Asthma Meds Total (ASM)			Access to Care 25 months-6 yrs (CAP)			Access to Care 20-44 yrs (AAP)		
	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%
African American	8662	16030	**54.0**	28658	42078	**68.1**	17302	23638	**73.2**	6658	9231	**72.1**	5986	9794	**61.1**	5921	6930	**85.4**	47326	55086	**85.9**	51063	64062	**79.7**
Hispanic	450	781	**57.6**	2039	2934	**69.5**	1155	1886	**61.2**	641	847	**75.7**	864	1192	**72.5**	578	648	**89.2**	10379	11325	**91.**	4261	5187	**82.1**
White	11106	19076	**58.2**	40784	60582	**67.3**	13715	25022	**54.8**	9961	12193	**81.7**	12384	17389	**71.2**	7585	8574	**88.5**	87181	94986	**91.8**	75938	88415	**85.9**

The graphs below illustrate the results of the quality measures by race/ethnicity for the three largest populations enrolled in Medicaid Managed Care.

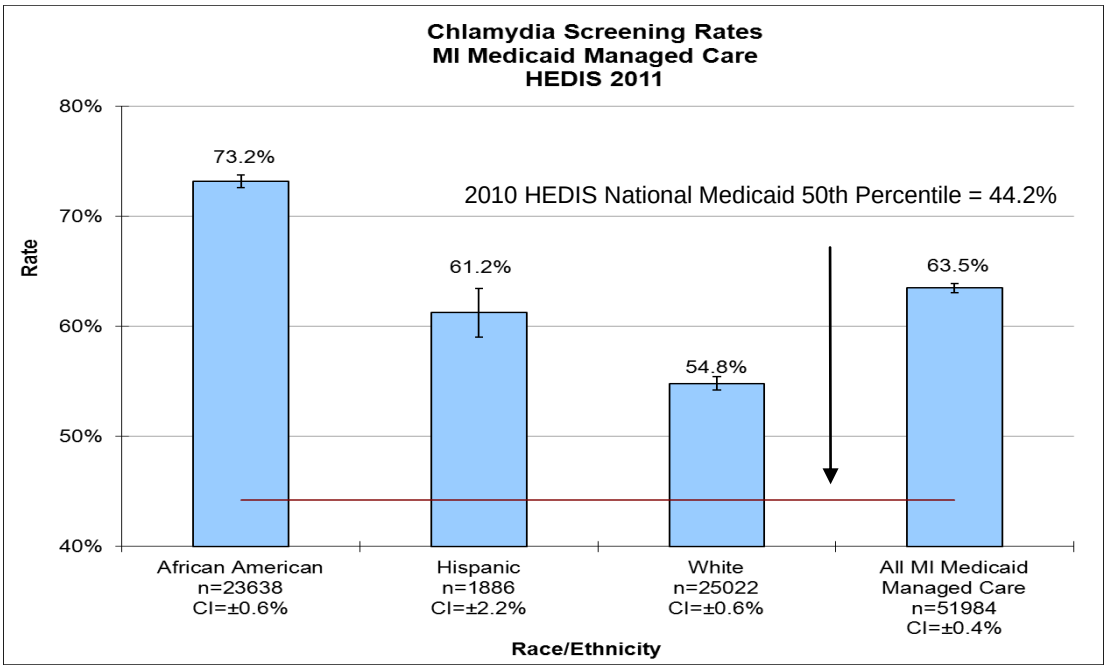
Graph 1. Breast Cancer Screening Rates, Summary of All Plans Combined. African American, Hispanic/Latino, and White populations.



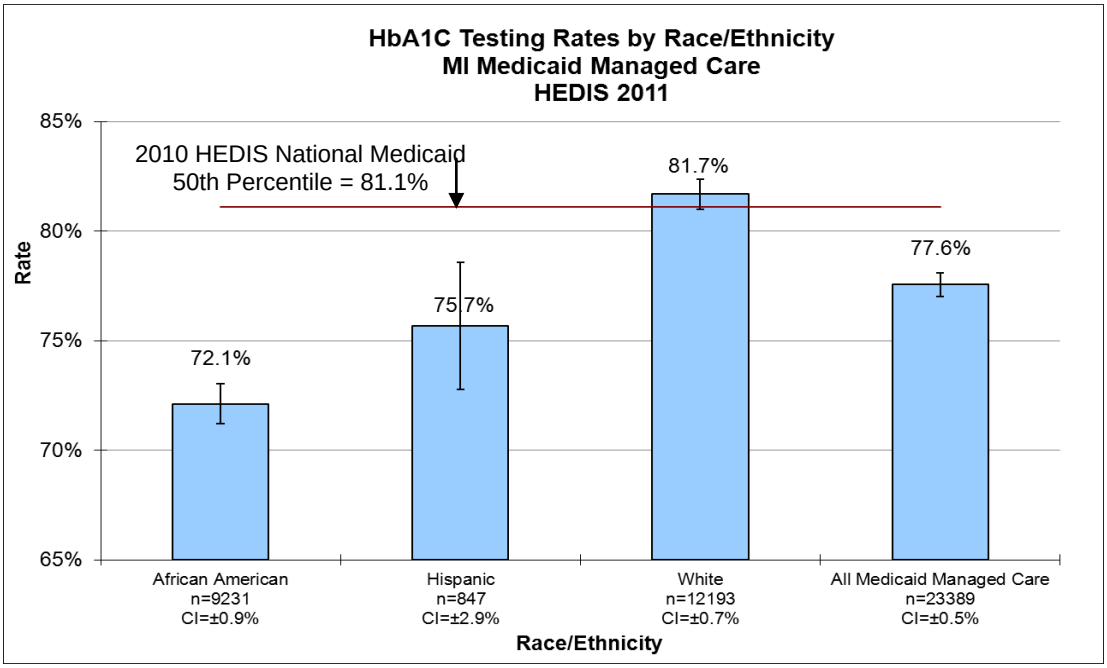
Graph 2. Cervical Cancer Screening, Summary of All Plans Combined. African American, Hispanic/Latino,and White populations.



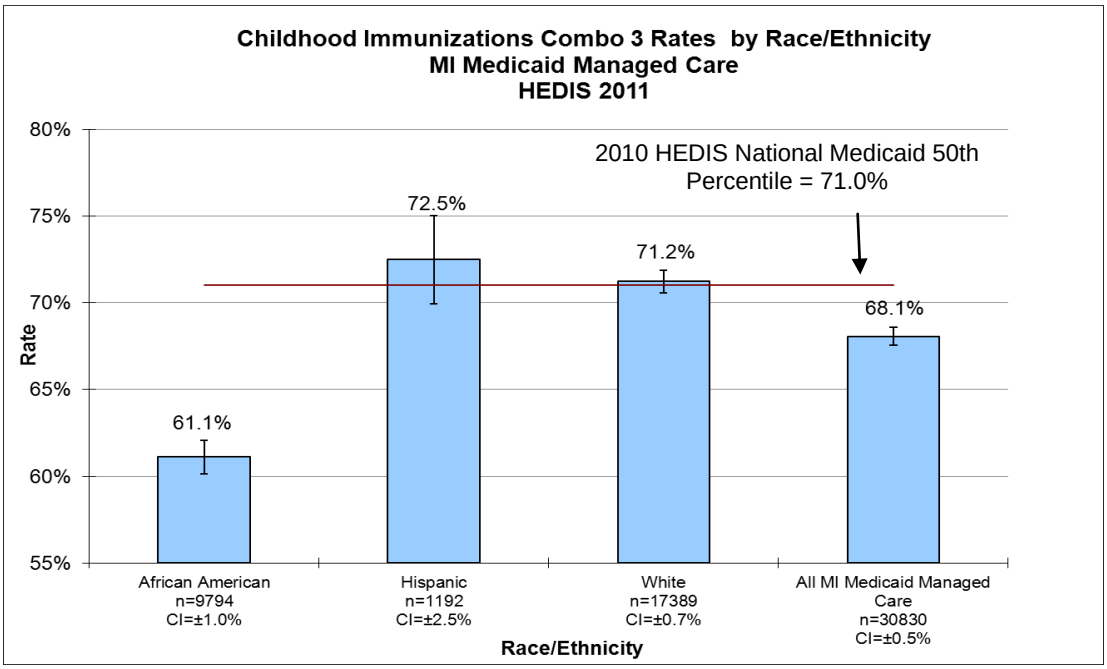
Graph 3. Chlamydia Screening Rates, Summary of All Plans Combined. African American, Hispanic/Latino, and White populations.



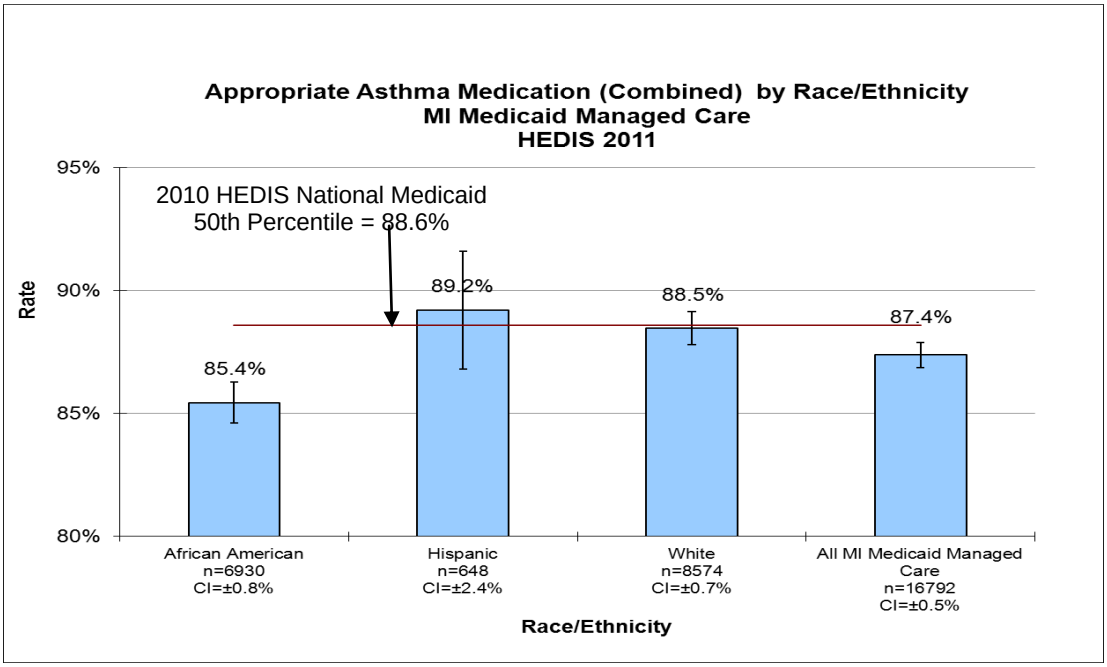
Graph 4. HbA1c Testing Rates, Summary of All plans Combined. African American, Hispanic/Latino, and White populations.



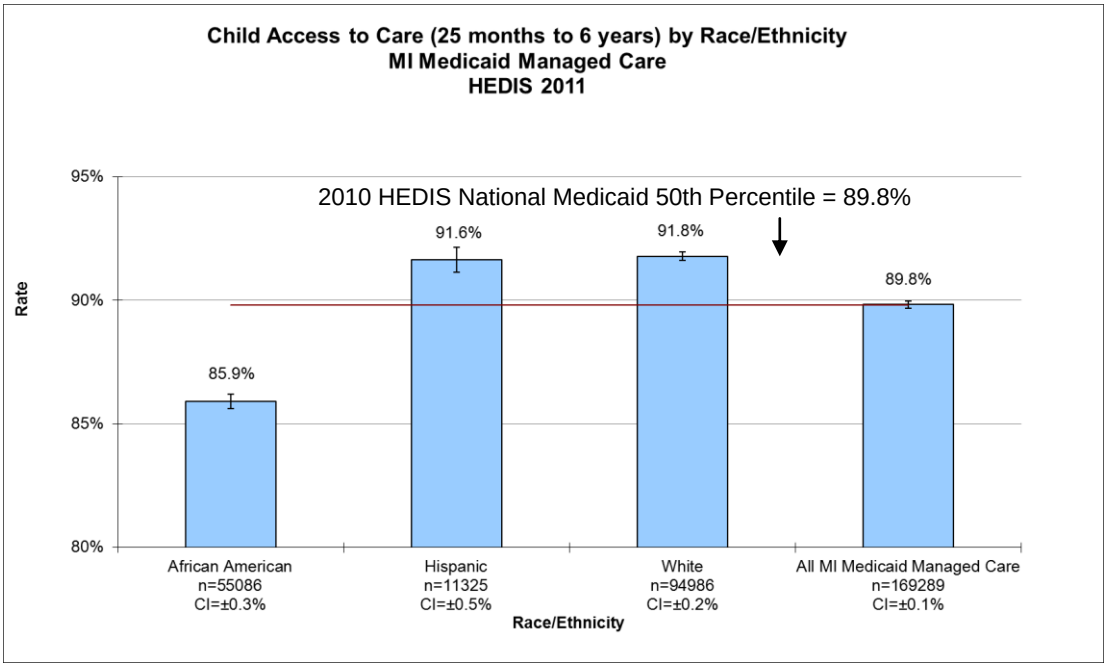
Graph 5. Childhood Immunization Rates for Combination 3. Summary of All plans Combined. African American, Hispanic/Latino,and White populations.



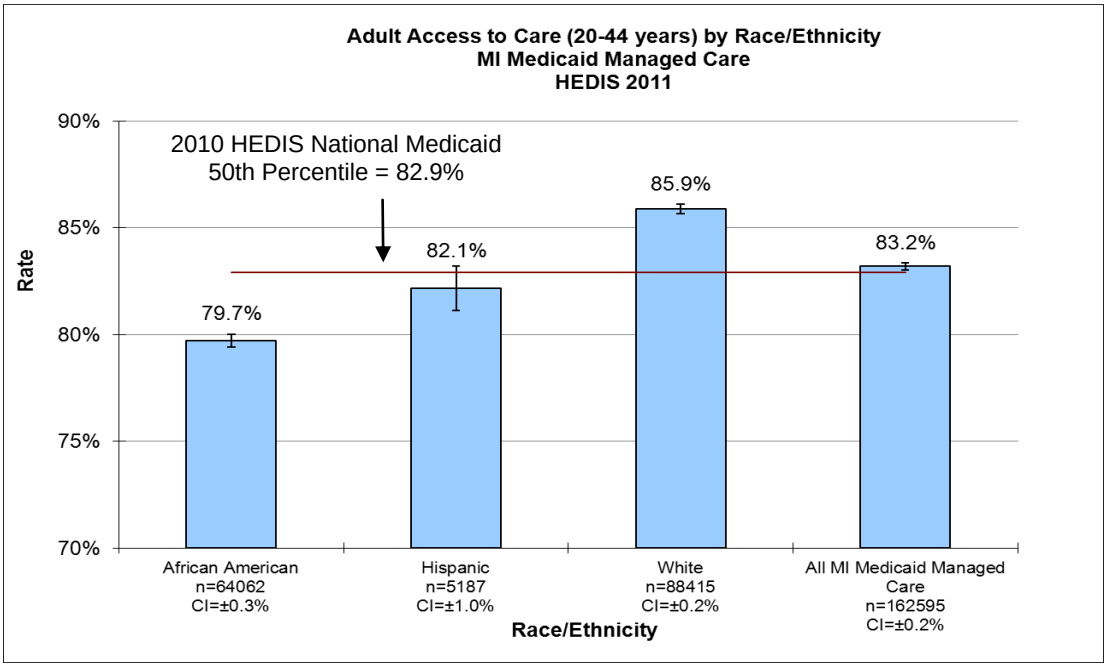
Graph 6. Rates of Use of Appropriate Asthma Medications (Combined). Summary of All plans Combined. African American, Hispanic/Latino, and White populations.



Graph 7. Childhood Access to Care Rates (25 mos-6 yrs.) Summary of All plans Combined. African American, Hispanic/Latino, and White populations.



Graph 8. Adult Access to Care Rates (20-44 yrs.) Summary of All plans Combined. African American, Hispanic/Latino, and White populations.



There were racial/ethnic differences in rates for all measures. The difference between the African American, Hispanic/Latino, and White rates are summarized in Table 3.

Table 3. Rate differences. White, African American, and Hispanic/Latino. Michigan Medicaid Managed Care. HEDIS 2011.

Measure	2011 White Rate	2011 African American Rate	Rate Difference	2011 Hispanic/Latino Rate	Rate Difference
Breast Cancer Screening (BCS)	58.2	54.0	-4.2*	57.6	-0.6
Cervical Cancer Screening (CCS)	67.3	68.1	0.8*	69.5	2.2*
Chlamydia Screening (CHL)	54.8	73.2	18.4*	61.2	6.4*
HbA1c Testing for Diabetics (CDC)	81.7	72.1	-9.6*	75.7	-6.0*
Childhood Immunizations (CIS)	71.2	61.1	-10.1*	72.5	1.3
Appropriate Asthma Medications Total (ASM)	88.5	85.4	-3.1*	89.2	0.7
Childhood Access to Care 25mos.– 6 yrs (CAP)	91.8	85.4	-6.4*	91.0	-0.8
Adult Access to Care 20-44 yrs. (AAP)	85.9	79.7	-6.2*	82.1	-3.8*

* = Difference is statistically significant

Measuring Disparity

Table 3 provides an absolute measure of inequity. The African American rate is subtracted from the White rate and the difference is the "Rate Difference". The same process was undertaken for the Hispanic/Latino population. Where rates for minority populations fell below White rates, cells are highlighted in yellow. Where rates for minority populations exceeded White rates, cells are highlighted in orange. Within this set of eight measures, the largest negative difference between White rates and African American rates can be found in Childhood Immunizations Combo 3, where the gap between African American children and White children is 10.1 percentage points. It should also be noted that both African American and Hispanic/Latino women were screened for Chlamydia at significantly higher rates than for White women.

Discussion

All eight of the Year 1 measures collected exhibited racial/ethnic differences to varying degrees, though a consistent pattern of disparities was not identified. Rates for African American Medicaid beneficiaries fell below that of White beneficiaries for every measure except cervical cancer and chlamydia screening. The cervical cancer screening rate for African American women was 0.8 percentage points higher than for White women, and the chlamydia testing rate for African American women was 18.4 percentage points higher than for White women. Both the chlamydia and cervical cancer screening rate are higher for Hispanic women than for White women. The Hispanic rates for childhood immunizations combo 3 and appropriate asthma medications are slightly higher than the White rate.

This information is important to decipher what lies behind the Michigan aggregate rate for each measure. For example, the HEDIS 2011 Adult Access to Care (20-44) rate for Michigan Medicaid Managed Care overall (all races/ethnicities combined) is 83.2, which is higher than the HEDIS 2011 Medicaid national 50th percentile. That overall rate of 83.2, however, does not convey the following disparate findings: While the White rate for the measure is *higher* than the 50th percentile and *higher* than the overall MI rate, the African American and Hispanic/Latino rates are *below* the 50th percentile and *below* the overall MI rate.

These rate differences will be tracked over time to determine if racial/ethnic inequity within particular measures is getting better, worse, or staying the same. It is important to note that changes in the equity status of a measure do not indicate an improvement in overall quality for a particular racial/ethnic category; it just means that the gap between the minority population rate and the White reference rate is getting smaller. All eight of the statewide aggregate rates for Year 1 measures increased between 2010 and 2011 except Chlamydia screening. With the submission of the 2012 Medicaid Health Equity data from the MHPs, we can determine how equitably those advances in quality healthcare are being made across all racial/ethnic populations.

Disparities identification and reduction have been priorities for Michigan Medicaid for several years. Between 2008 and 2010, MHPs were required to conduct an annual Performance Improvement Project (PIP) specifically aimed at reducing an identified disparity in one of their quality measures. In 2005, Michigan Medicaid participated in the Center for Health Care Strategies' Practice Size Exploratory Project (PSEP) where racial/ethnic disparities in a number of measures were identified by health plan, and by provider. Results were disseminated to health plans and to providers for their information. In 2008, Michigan Medicaid was awarded a grant by the Center for Health Care Strategies (funded by the Robert Wood Johnson Foundation) to participate in the three year, Reducing Disparities at the Practice Site Project. This project focused on six high volume Medicaid practices in Detroit/Wayne County and facilitated the introduction of the Patient Centered Medical Home into the practice. Diabetic-related HEDIS measures were tracked by race/ethnicity across time at the participating practices. The Medicaid Health Equity Project is the next step in the states strategy to identify and reduce health disparities in Medicaid. As new populations are integrated into Managed Care from the Fee-For-Service model, new measures may be added to the Medicaid Health Equity Project.