Michigan Medicaid 10 Year Retrospective: 2012-2022

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Executive Summary

The Center for Social Change (CSC) at the Michigan Public Health Institute (MPHI) was asked to evaluate the effectiveness of the Michigan Medicaid program over a decade, from 2010 to 2020. The goal was to identify the extent to which health disparities efforts within the program yielded the intended results, and what lessons were learned for future insights. In partnership with the Behavioral and Physical Health and Aging Services Administration (BPHASA), CSC staff conducted an evaluation that assessed the policy impact through contract review, gathered stakeholder insights, and analyzed data in key measures.

Data Analysis

This report followed trends across select quality and access measures from 2011 through MY2020. There was a total of fourteen measures included in the analysis across the eleven years of this study, but not all measures were included in all years. Some measures were added in year 2 of the study, and some specifications changed over the course of the study period leading to them being phased out. Twelve measures were consistently included in the analysis for at least 10 years. Overall improvements were seen in Post Partum Care and Comprehensive Diabetes Care – Medical Attention for Nephropathy. A total of seven measures did not see any improvement but also did not see any poorer performance. A total of four measures saw an increase in disparities.

Stakeholder Insights/Interviews

MPHI conducted 24 interviews with individuals from health plans, current/former Medicaid agency staff, trade associations, health systems, and community organization representatives. Throughout the process, insights and reflections were provided into the successes, lessons learned, and areas for continued improvement.

Among interview responses, there is consensus that strides have been made over the last decade in bringing attention to healthcare disparities in Michigan. The Medicaid Agency continues to emphasize health equity, through different mandated projects, performance improvement plans (PIPs), quality improvement, and patient safety (QIPS) plans. There is still a long way to go in addressing disparities, however, there have been some positive steps taken by the state and health plans to address the health equity issues and make progress in closing the gaps in health care for minorities.

Over the past decade, there has been a gradual shift from equity efforts being a checkbox item to being an integral part of the process. Both health systems and health plans mentioned that within the state of Michigan, health equity language has shifted from being seen as dreaded words, to words that truly drive the daily work, in large part due to MDHHS. MDHHS has made efforts to make language surrounding equity something that is accessible and that people are comfortable discussing through constant new initiatives, reviews, and discussions pushing forward equity. There is consensus among stakeholders that there is a lot of work to be done to create a future where disparities are nonexistent. From a policy standpoint, there is hope for there to be a non-transactional mindset around equity: a need for rethinking the punitive approach if there was not a successful year in health equity, to avoid penalties and look instead at what were the processes and investments in place that have been planted that will grow year over year. Interviewees also noted equity must be non-negotiable, it must continue to become an interwoven aspect of the work being done on the side of healthcare and health access, coupled with the reality that it does require investment, in both time and money.

Contract/Policy Review

Contracts issued from 2010-2023 were assessed for references to health equity, disparities, and Social Determinants of Health (SDOH) to determine the extent to which each concern factored into the priorities of that year. **The following are highlights and key insights:**

- While disparities and SDOH were not mentioned in any contracts until 2016, health equity was first mentioned in Appendix 5 of the 2013 contract (*2013 DCH P4P Bonus Healthcare for a Diverse Membership – Health Equity: MHP submits HEDIS data broken down by R/E to DCH for specified measures*).
- Beginning in 2014, the following language related to health equity was added and included in all subsequent contracts: *"Medicaid Health Equity Project: Contractor will fully and completely participate in the Medicaid Health Equity Project and report all required information to DCH within the specified timeline."*
- From 2016 to 2022, references to health equity, disparities, and SDOH became prominent throughout all contracts, providing an overview of the background for these efforts, methods for addressing disparities, and definitions for the terms.
- In 2023, for the first time, language was added that specified contractors must provide enrollees and families the opportunity to provide feedback to inform health equity initiatives, ensuring that their voices are heard, and their needs are considered.

Equity takes time, and Michigan has invested in doing so throughout the past decade. The "wins" highlighted in this report, and the disparities that have been reduced are a testament to that work. The work, however, remains incomplete. Continued commitment to addressing disparities by MDHHS and the MHPs will be crucial in achieving health equity and improving individual outcomes for Medicaid enrollees in Michigan. Disparities work requires both MDHHS and the MHPs to invest in health equity across all social determinants of health as the state continues to move equity activities from checkbox activities – as evidenced in the MHP contracts and policies beginning in 2011 – to more meaningful actions and core values, as evidenced in the policies and contracting requirements enacted today.

As this work continues, this report recommends the following:

- From the qualitative interviews, there were many suggestions to take this assessment to Medicaid consumers and gauge what changes have been noticed on the ground and at the intake of services.
- Adapt the methodology to represent current statistical and methodological trends to "decenter" the White population and change the reference population to the racial/ethnic group that is currently performing the "best" on each measure.
- Engage stakeholders, specifically Medicaid Health Plans, in a comprehensive conversation about overall quality including a more detailed look into required initiatives and the success of contract requirements.
- Recommend a more robust evaluation of the impact of policy and contract requirements for post-partum care across all racial and ethnic groups to determine what efforts were most successful in the reduction of disparities across the populations. This would include conversations with MHPs to determine what strategies and programs were introduced to mitigate post-partum disparities.

Acknowledgments

Land Acknowledgment

The state of Michigan occupies the ancestral, traditional, and current lands of the Bay Mills Indian Community; Grand Traverse Band of Ottawa and Chippewa Indians; Hannahville Potawatomi Indian Community; Huron Potawatomi, Inc.; Keweenaw Bay Indian Community Tribal; Lac Vieux Desert Band of Lake Superior Chippewa Indians; Little River Band of Ottawa Indians; Little Traverse Bay Band of Odawa Indians; Pokagon Band of Potawatomi; Saginaw Chippewa Indian Tribe; Sault Ste. Marie Tribe of Chippewa Indians; and the Matchebenashshewish Band of Potawatomi. In addition to others that are not federally recognized. We acknowledge the Indigenous stewards of the land who continuously fight for environmental justice and Indigenous sovereignty for the occupied land and the people inhabiting it. We thank the caretakers of this land, who have lived here and continue to live here since time immemorial.

Thank you to the Michigan Department of Health and Human Services (MDHHS) for the important work in equity and for taking the necessary time to reflect on the last decade. In addition, we want to thank the many individuals and organizations for their time to provide insights into the equity efforts on the state level.

- Health Plan staff
- Current/former Medicaid agency staff
- Trade associations
- Health Systems
- Community Organization Representatives

Introduction

Disparities in healthcare, access, and outcomes have been documented in the U.S. for decades. The cost, both financial and social, is unacceptable. A national estimate of the total burden of racial/ethnic health disparities was $451B in 2018 or 2% of the gross domestic product (GDP). Ninety percent of the economic burden was borne by Black/African Americans (69%) and Hispanic/Latinos (21%). Most of this cost is driven by excess premature deaths ($293B) and lost labor market productivity ($81B). Authors estimate that the economic burden in Michigan due to racial/ethnic disparities is over $16B, or between $1,501 and $2000 per person, higher than California, Texas, and New York.[1] The Kellogg Foundation reported that by 2050, 40% of the workforce and consumers in Michigan will be people of color.[2] Eliminating racial/ethnic disparities in healthcare would reduce direct medical care costs, lost productivity, and save life years for Michiganders.

Disparities also exist between socio-economic groups. Poor Michiganders are less likely to have a primary care doctor and less likely to be able to access health care due to cost than their higher-income counterparts.[3] They are more likely to have kidney disease, diabetes, cardiovascular disease, and chronic obstructive pulmonary disease.

It is both a moral and financial imperative to address these disparities and drive healthcare in Michigan toward equity. Federal and state laws and regulations have been in place for years to identify and address disparities. Michigan has largely stepped up to the plate as a leader in this work. In 2020, Governor Gretchen Whitmer signed Executive Order 2020-163 recognizing and addressing Racism as a Public Health Crisis and creating the Black Leadership Advisory Council. During the COVID-19 pandemic, Michigan Lieutenant Governor Garlin Gilchrist convened the COVID-19 Racial Disparities Task Force. While the initial focus was on the racial disparities related to the pandemic, recommendations from the task force are wide-ranging and address policy and program areas intended to support all aspects of health and healthcare services.

As a public payer of healthcare services for the poor, the Medicaid program has a unique place in this work. Michigan Medicaid is required to monitor the quality and appropriateness of the healthcare services delivered by the participating Medicaid Health Plans (MHPs) to their Medicaid enrollees. 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*." The Affordable Care Act (ACA) includes language that prohibits discrimination under any health program or activity that is receiving federal financial assistance. The ACA also includes improved federal data collection efforts by ensuring that federal healthcare programs collect and report data on race, ethnicity, sex, primary language, and disability status.

Michigan Medicaid reprocured its managed care contract in 2015 and again in 2024. In 2015, there were specific provisions added into the contract related to identifying racial/ethnic disparities and moving to equity. These included standardizing requirements for reporting, establishing new programs, and requiring access to community health workers— an evidence-based intervention known to address racial/ethnic disparities. In the 2024 rebid, the Medicaid agency doubled down on its commitment to identifying disparities and moving toward equity by requiring all contracted plans to obtain the Health Equity Accreditation from the National Committee for Quality Assurance (NCQA). The accreditation has rigorous requirements for health plans including data collection, the use of data to monitor disparities, language services, staff diversity, etc. Michigan Medicaid has a long history of leveraging any available mechanism to identify and address disparities. This report represents a retrospective look at key efforts in this work since 2010.

We hope this report serves as a reminder of the outstanding efforts Michigan Medicaid has made to identify and address disparities in quality of care for beneficiaries; of the tremendous progress that has been seen over the past decade; and of the importance of steadfast efforts in continuing this work.

Background

Started in 1965, Medicaid has long provided health insurance coverage for low-income individuals and families. Since then, populations eligible to receive Medicaid have expanded. Since 1996, Michigan has employed the use of managed care and has utilized specific Medicaid Health Plans (MHPs) to manage benefits for the majority of the state's Medicaid population[4]. In 2014, Michigan expanded Medicaid to cover adult Michigan residents from ages 19-64, who were previously not eligible for Medicaid programs, not qualified to enroll in Medicare, and not pregnant at the time of enrollment [5]. This expansion significantly increased Medicaid enrollment throughout the state, providing coverage to hundreds of thousands of previously uninsured individuals. Medicaid expansion has been linked to a reduction in racial/ethnic disparities in rates of uninsured individuals [6].

The Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for the administration and oversight of the Medicare and Medicaid programs in each state. In 2011, CMS established the National Quality Strategy, a roadmap for improving healthcare quality across the nation by focusing on three core aims: better care, healthier people, and affordable care. It outlines six priorities: patient and family engagement, patient safety, care coordination, effective prevention and treatment of chronic disease, improving population health, and making healthcare more affordable. The CMS Equity Strategy, introduced in 2020, addresses disparities in healthcare access, outcomes, and experiences based on race, ethnicity, gender, sexual orientation, disability, and other factors. It aims to achieve health equity by focusing on data-driven approaches, culturally competent care, workforce diversity, and community partnerships. Together, these strategies underscore CMS's commitment to promoting high-quality, equitable healthcare for all Americans, eliminating disparities, and improving health outcomes across diverse populations.

Through the aforementioned initiatives by CMS, and Michigan law, Michigan Medicaid is required to monitor the quality and appropriateness of the healthcare services delivered by the participating Medicaid Health Plans. 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 [7]. 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 [8]. 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 [9].

On a state level, Michigan Public Act 653 of 2006 directed the Michigan Department of Community Health, the predecessor to the current Michigan Department of Health and Human Services, 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[10]. 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.

Michigan Medicaid has a strong track record of close collaboration with its contracted MHPs. This collaboration was essential for incorporating racial/ethnic disparity measurements into the managed care quality oversight process and building reduction of racial/ethnic disparities into quality incentive programs. To affect change across the program, all MHPs need to be clear on the expectations, supportive of the contractual agreements, and committed to the goals. This report represents over a decade of work by the Michigan Medicaid agency, its Medicaid health plans (MHPs), and influential partnerships and dialogue. This report is both a celebration of that monumental level of commitment and perseverance, as well as a call to action to continue to do better.

In 2005, Michigan Medicaid participated in the Center for Health Care Strategies (CHCS) Practice Size Exploratory Project where racial/ethnic disparities in several measures were identified at both the health plan and provider levels. In 2008, Michigan Medicaid was awarded a grant by CHCS (funded by the Robert Wood Johnson Foundation) to participate in the three-year Reducing Disparities at the Practice Site Project. Diabetic-related Healthcare Effectiveness Data and Information Set (HEDIS) measures were tracked by race/ethnicity across time at the participating practices. 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. From 2019 to present, MHPs have been required to focus specific improvement efforts on reducing racial/ethnic disparities in maternal and child health.

Michigan Medicaid began incentivizing Medicaid Health Plans on the reduction of disparities in 2016 and has continued to do ever since, evolving the methodology as necessary. The Medicaid Health Equity Project report was developed by the Quality Improvement and Program Development Section of the Medicaid Managed Care Plan Division. In early 2010, all MHPs were asked to participate in a series of conference calls to frame the problem of disparities in care and to plan the project. During those calls, MHPs provided input and advice in the development of the methodology. A set of initial 8 measures was agreed upon and specifications were developed. There are twelve measures currently reported in the report, though the list has ranged from 8-14 measures in the past. Measures are added and removed based on Medicaid agency priorities, and in alignment with changes to NCQA HEDIS measures.

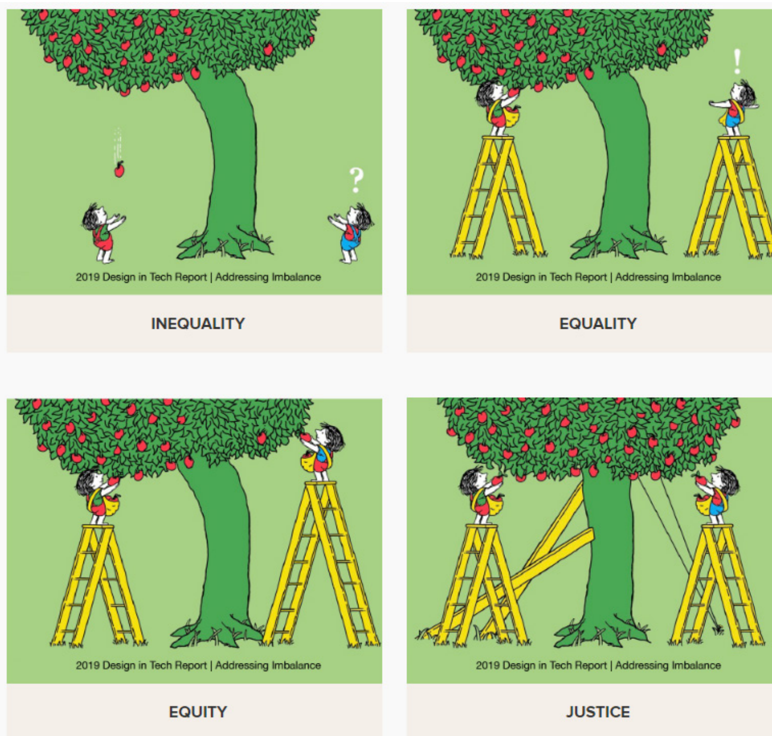
Until now, a comprehensive look across all years of data and policy/contract changes has not been done. The MPHI Center for Social Change is honored to partner with MDHHS to do so. This report documents the beginnings of standardized data collection on racial/ethnic disparities and follows changes in results over time, as well as changes in policy and contract language that support the identification and reduction of disparities. Key stakeholders were engaged to get their thoughts and opinions of these efforts over the past decade, what they have seen, and what they hope to see in the future.

The purpose of this report is to answer the following question: After a decade of measuring disparities in Michigan Medicaid and making contract and policy changes to address them, is there evidence that reductions in disparities have occurred?

Level Setting: Defining Equity and Disparities

Equality provides everyone with the same resources, opportunities, and experiences. Equity acknowledges that every individual has different circumstances and provides access to the resources that are needed based on those circumstances. Treating everyone the same does not give the same results, as every single person faces differences due to structural systems that affect every aspect of life.

Health equality means providing the same care and care opportunities to every person, whereas health equity focuses on understanding what a person needs to gain better access to care that fits their needs. "Health equity means ending institutional and discriminatory barriers that lead to health inequities and inequality. This includes factors within the healthcare system, such as racism and sexism, as well as factors outside the healthcare system, such as poverty and unequal distribution of resources."[11]



Picture 1. "Addressing Imbalance," by Tony Ruth for the 2019 Design in Tech Report.[1]

Racial/ethnic disparities in healthcare quality and access are particularly harmful. The National Committee for Quality Assurance (NCQA) states "Quality health care has been historically unequal, often depending on a population's race, culture, religion, class, gender identity, sexual orientation, geography or language. Health equity is a commitment to provide high-level care to all populations and to remove obstacles and disparities in the health care system."[12] At the center of the intersection of race, class, and health is the Medicaid program. Measuring quality of care for Medicaid beneficiaries, and monitoring for racial/ethnic disparities, represents a powerful opportunity for publicly funded health care to promote fair treatment of state residents regardless of income or racial/ethnic group.

Disparities, as defined in Healthy People 2030, are "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[13]

Over the last decade, MDHHS has focused on health disparities and health equity, with the goals of creating change and embedding equity as part of the daily processes and practice. In 2010, MDHHS produced the Michigan Health Equity Roadmap, with a vision and plan to reverse negative trends for racial and ethnic populations, with the following aims;[14]

1. To encourage Michigan public health and healthcare partners to direct more policy and programmatic attention to the fundamental social and economic determinants that drive racial and ethnic health disparities.
2. To highlight best practices to reduce health inequities with an emphasis on social determinants of health and system improvements within institutions and communities.
3. To invite state and local governments, health providers and insurers, social service agencies, the business community, universities, and civic and community-based organizations to develop collaborative plans to improve both social and health conditions of disparately affected communities.
4. To promote stronger institutional/community partnerships and community engagement with the segments of our population that experience racial and ethnic inequities.

This plan has evolved into different health equity efforts across different parts of MDHHS, including a Social Determinants of Health Strategy, equity assessments in managed care, as well as this report itself.

Methodology

This report utilized a mixed methods approach to gain a deeper understanding of the evolution of the landscape from multiple stakeholders' perspectives. Data alone does not completely tell the story, nor does individuals' input. Providing data allows the report to view one aspect of on-the-ground impact, while interviews and document review allow for key insights and themes. Qualitative research consisted of interviews and a document review of the Medicaid Health Plan's contacts and Michigan Medicaid policies. Interviews were conducted to get insights and reflections into stakeholders' experiences and their views on the impact of health equity efforts from the state. The report also reviewed and compiled data from the Michigan Health Equity Reports from 2011 to MY2020 to analyze trends across time.

Qualitative Interviews

MDHHS staff gathered a list of individuals to gather retrospective insights on the Medicaid program from 2011–2022, with an emphasis on disparities. Throughout these initial conversations with stakeholders, each participant was asked for recommendations for additional interviewees. The final list of those who contributed their thoughts and opinions includes:

- Health Plan staff
- Current/former Medicaid agency staff
- Trade associations
- Health Systems
- Community Organization Representatives

Semi-formal interviews were conducted to allow for an open conversation and input from interviewees. Questions asked in the interviews can be found in Appendix A. Over the course of the project, MPHI conducted 24 virtual interviews.

Contracts & Policies

Project staff reviewed each Medicaid contract issued from 2010-2023 by the State of Michigan for the Comprehensive Health Care Program for MDHHS. Contracts were assessed for references to health equity, disparities, and Social Determinants of Health (SDOH) to determine the extent to which each concern factored into the priorities of that year. Additionally, Pay for Performance (P4P) Bonus criteria were reviewed to evaluate how initiatives related to health equity were prioritized and incentivized each year. Health equity-related P4P bonuses were tabulated by year to document the evolution of their inclusion within the Michigan Medicaid program.

Project staff also reviewed all Medical Services Administration (MSA), Behavioral and Physical Health and Aging Services Administration (BPHASA), and Michigan Medicaid Policy (MMP) Bulletins published by the Michigan Department of Community Health and later MDHHS (starting in 2015).[15] Bulletins related to health equity were compiled to illustrate how policies and state priorities evolved and expanded from 2010–2023.

Measurement Data

Medicaid Health Plans (MHPs) submit audited HEDIS data to MDHHS for each measure that pertains to Medicaid covered benefits. MHPs also submit HEDIS measures broken down by race/ethnicity to MDHHS. MHPs are provided a blank template, annually, to ensure consistency across all plan submissions. MHPs used their audited HEDIS data to draw the total numerators and denominators for each measure, but the data broken down by race/ethnicity is not audited. All template totals match totals reported in the HEDIS Interactive Data Submission System. Race/ethnicity data are taken from Medicaid enrollment forms, which use self-identification to determine race and ethnicity, and from any other source, the MHP has in place to collect this information. This includes care management records, assessments, and other documents. The enrollment information is shared with MHPs on the monthly eligibility file that transmits the new members assigned to each plan. MHPs may also have supplementary systems in place to acquire and store this information (i.e., retrieving it from Electronic Medical Records systems in their provider network). As of the writing of this report, the Office of Management and Budget has released new standards for the collection and reporting of race/ethnicity for all federally funded programs. This report uses the populations in the existing guidance, but later iterations will change based on new requirements.

This report has determined if disparities are present by using pairwise disparities. Pairwise disparities are measured between a subpopulation and the reference population. The White population was used as the reference population because the white population is not exposed to racism. Any disparities from this reference population rate can be an indicator of the health effects of discrimination and racism, though rates for the White population are not always the highest for each measure.

Measures were stratified for the following racial populations: Asian American, Native Hawaiian/ Other Pacific Islander, African American, American Indian/Alaska Native, White, and one ethnicity: Hispanic. Any reference to the Hispanic category was categorized into the Hispanic population and the numbers represented by the racial categories were non-Hispanic. Unknown and declined were collected from 2011 until 2013. After 2013, the unknown/declined category was treated as missing data. Other race/ ethnicity and/or multiracial populations were collected from 2011 until 2014. Use of this category was discontinued after 2014 due to the inconsistent use of the category across MHPs. All HEDIS measures were calculated by specifications provided by the National Committee for Quality Assurance (NCQA) for the year of collection. For some measures, specifications changed during the 2011 to MY2020 collection periods and have been noted later in the report. Table 1 lists all fourteen measures included in this report and the years in which they were collected. Full measure descriptions can be found in Appendix B.

Table 1. List of Measures

Measure	Abbreviation	Years Reported
Breast Cancer Screening	BCS	2011, 2012, 2013, 2015, 2016, 2017, 2018, 2019, 2020, MY2020
Cervical Cancer Screening	CCS	2011, 2012, 2013, 2015, 2016, 2017, 2018, 2019, 2020, MY2020
Chlamydia Screening in Women - Total	CHL	2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, MY2020
Childhood Immunizations Combination 3	CIS	2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, MY2020
Appropriate Asthma Meds (Combined)	ASM	2011, 2012, 2013, 2014, 2015, 2016
Child Access to Care (25 months to 6 years)	CAP	2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020
Adult Access to Care (20-44 years)	AAP	2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, MY2020
Adolescent Immunizations Combo 1	IMA	2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, MY2020
Blood Lead Screening	LSC	2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, MY2020
Well Child Visits 3-6 Years	WCV	2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020
Postpartum Care	PPC	2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, MY2020
HbA1c Testing	CDC1	2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, MY2020
Diabetic Eye Exam	CDC2	2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, MY2020
Diabetic Nephropathy	CDC3	2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020

From 2011 until 2020, the named year is the data submission year, which is the year following the measurement year. To reduce confusion and align with the new HEDIS naming convention, the measurement year (MY) began to be used in MY2020. Please Appendix F for a corresponding table.

Without equity, there is no quality. Differences in rates between racial/ethnic populations and the White reference population rate can be an indicator of the health effects of discrimination and racism. The White population served as the reference population for all comparisons in this report because the White population is not exposed to racial/ethnic discrimination. This report identifies rates by racial/ethnic group and uses the White population as the reference because of how race and racism operate in society. The report also identifies the 'Total' rate, which includes all racial/ethnic groups including White category. The disparity calculation is based on the difference between the racial/ethnic subpopulation and the white reference population, not the overall total.

In this report, two rates were declared significantly different if their 95% confidence intervals (CIs) did not overlap, and significantly the same if their CIs overlap. The 95% confidence intervals were calculated using the following formula:

$$p \pm 1.96 * \sqrt{p(1-p)/n}$$

p = proportion of the eligible population (denominator) who received the service (numerator)

n= number of people in the eligible population (denominator)

Data were considered insufficient for analysis, and results were suppressed if: the numerator (those who received services) was less than 5 and/or the denominator (the population under consideration) was less than 30. Please note on all graphs and tables, only those categories fulfilling the above requirements will appear. Further, we recommend exercising caution when interpreting results with denominators less than 100.

Qualitative Interviews

MPHI conducted 24 interviews with individuals from health plans, current/former Medicaid agency staff, trade associations, health systems, and community organization representatives. Throughout the process, insights and reflections were provided into the successes, lessons learned, and areas for continued improvement. Below is synthesized information gathered from interviewed individuals who were a part of the equity efforts and saw these efforts in action from different perspectives.

"A lesson we are still learning today is that you really need to understand the problem you are trying to fix. We often look at disparity but don't understand how we got there. Many people think if you throw a lot of money at something it will be fixed in a few years, which for most cases, is not true. Other issues will take a long time to fix. Issues also cause other issues; we need to take a more holistic view. We need stories and data to make significant changes."

A Medicaid Director

Infrastructure has been a success. That is visible in the contracts and requirements. The state [Michigan] acknowledges disparities. The program isn't intended just to reimburse- there should be outcomes and improvement of life. I can see a big category is the acknowledgment of inequities in behavioral health treatment and access. The department has made great strides in acknowledging disparities in terms of minority and rural populations as a whole. Clear success in terms of investment.

Health Plan

The conversation has normalized around disparities and equity. They are no longer bad words, nor new words. People cringe and shudder less than they used to. We have normalized quality reporting by race/ethnicity. Health Plans are used to seeing their rates, moving towards transparency and accountability.

Former Medicaid Employee

Changes within the health equity space put Michigan into a good position with the alignment of COVID 19 pandemic, for the call on how racism works in the large systems, specifically how state institutions respond to racism. When it was nationally brought up in 2020, it was not new to Michigan or the Medicaid agency. Many other programs did not have that. There was considerable infrastructure to report by race and ethnicity.

Former Medicaid employee

Over the last ten years, there has been a dedicated effort to measure quantitative outcomes. If you're not measuring something you can't influence it. The fact that there is a process and consistent measurements – same with the plans – the fact that there is a united approach to find the measurement, make them public and transparent, and not just internal to the program is a success.

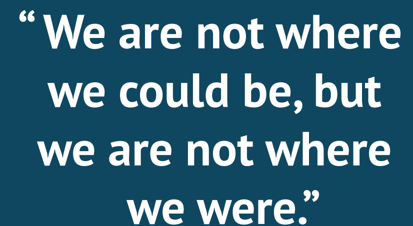
Trade Association

Successes

Among interview responses, there is consensus that strides have been made over the last decade in bringing attention to healthcare disparities in Michigan. The Medicaid Agency continues to emphasize health equity, through different mandated projects, performance improvement plans (PIPs), quality improvement, and patient safety (QIPS) plans. There is still a long way to go in addressing disparities, however, there have been some positive steps taken by the state and health plans to address the health equity issues and make progress in closing the gaps in health care for minorities. The state continues to hold health plans accountable for their efforts and incentivizes them for the work they do to make progress on reducing disparities. Through conversations, health plans also discussed moving beyond incentivized efforts and working with providers to understand the patient experience from a health equity standpoint.

Many health plans and Medicaid employees mentioned the efforts in Maternal and Child Health (MCH), specifically the black and brown communities where MCH disparities are high. These efforts brought a lot of attention to social determinants of health (SDOH) and needing to have people who are providing care reflect the community they serve. Interviewees noted great strides have been made in this area, however, work remains to be done. Though there are a lot of efforts within this space, many note that the ideal outcomes from these efforts have not been met or there has not been long enough time for the outcomes to be noticed due to the complicated and long-term data collection efforts. With maternal health, some efforts might be seen through generations and need more time for assessment.

According to respondents, the inclusion of Community Health Workers (CHW) in the MHP contracts as well as their general recognition has been a huge success. CHWs are utilized in care management and care coordination strategies by health plans, with some exceeding the required ratio. CHWs have been instrumental in bringing aid to the home and the community level, where health mostly occurs, moving beyond a provider's office. The inclusion of CHWs is an evidence-based approach to addressing disparities since CHWs themselves are representative of the communities they serve. CHW services are now covered by the Medicaid Health Plans and in Fee-for-Services Medicaid (as of 2023). Success is incremental and a long-term effort in equity work, but as one interviewee stated, "We are not where we could be, but we are not where we were." Another interviewee brought attention to Michigan being one of the states that was at the forefront of equity work. Michigan focused on health equity before it became a top priority for most other states and the federal government.



Over the past decade, there has been a gradual shift from equity efforts being a checkbox item to being an integral part of the process. Both health systems and health plans mentioned that within the state of Michigan, health equity language has shifted from being seen as dreaded words, to words that truly drive the daily work, in large part due to MDHHS. MDHHS has made efforts to make language surrounding equity something that is accessible and that people are comfortable discussing through constant new initiatives, reviews, and discussions pushing forward equity.

All around, interviewees mentioned MDHHS, specifically the Medicaid program, being a partner that is 'aware'. They are aware of the differences between regions and the efforts that go on into each geographic area. They acknowledge the good intentions and innovations occurring across the state but also when things are not working, they have successfully shown the ability to pivot and make necessary adjustments to programs and equity efforts alike.

Many interviewed individuals mentioned that 10 years is a short time to truly measure and understand any long-term successes and that because there is such a long road ahead in changing the effects of inequities and the structural systems that have perpetuated them, it is hard to say that there is any one single success.

Lessons Learned

Throughout the conversations, many people acknowledged that equity is a long-term goal and that many challenges exist in moving the needle in health disparities. The main lesson is that there is still a long way to go and a lot to learn. A former Medicaid Director shared, "A lesson we are still learning today is that you really need to understand the problem you are trying to fix. We often look at the disparity but don't understand how we got there. Many people think if you throw a lot of money at something it will be fixed in a few years, which in most cases, is not true. Other issues will take a long time to fix. Issues also cause other issues; we need to take a more holistic view. We need stories and data to make significant changes."

There was an overwhelming consensus that there needs to be a continuation of understanding and investment in healthcare that goes beyond the walls of a hospital or provider. According to Healthy People 2030, 80% of an individual's health is determined outside the hospital or health clinic.[16] Interviewees noted the great importance of the social determinants of health and praised the impact community-based efforts have made, noting more investment may be needed in the future to continue these efforts and close in performance. This could include investment in the expansion of CHWs, funding for community organizations, or partnerships between community-level health plans and providers. Recently, there was a lot of excitement surrounding the 'in lieu of services' model and the impact it can have on these challenges while solutions may not be clear cut. Across interviewees, it was clear that understanding and recognition of health disparities have expanded, and individuals working in this space more readily acknowledge the influence that social conditions have upon the health of individuals enrolled in Medicaid programs.

Over the past decade, services have expanded to meet the needs of beneficiaries, however, one theme prevailed across interviews: the struggle to address access to care. There continues to be a gap in understanding of the best ways to address access and ensure folks can receive the services available to them. There is a need for a culturally humble frame of mind within health equity work to understand the root causes and possible solutions for different populations going against the traditional one-size-fits-all approach. In addition, this work is a continuous cycle of improvement in need of assessment to help understand what is working and what efforts could be improved upon. Interviewees noted the need for continuous evaluation; however, it was expressed there is currently no evaluation process that focuses on the efforts to reduce disparities at the state and health plan levels in Medicaid.

The desire for interventions to have immediate effects on outcomes is not being realized as quickly as some wanted, which interviewees have noted has impacted investment moving forward. There is a consensus among interviewees that progress on health disparities is slow and needs continual investment for the impact to be realized over a longer period of time, which is not always an easy business case to make. It is clear that not only do disparities need to be measured, but the effectiveness of the efforts in trying to address them to assess long-term impact also needs to be reviewed. There needs to be a goal of taking health equity concepts and successfully and reliably implementing them. Over the past decade, the data and experiences of folks have solidified the fact that there is no quick fix to address health inequities. It is important for stakeholders to recognize that progress may be slow to be realized, however the slow progress does not negate the important work that is being done.

As efforts move forward, equity should be prioritized as a component of workforce development to create a sustainable delivery of all services, from on-the-ground frontline work to administrative levels. Burnout is a real issue within healthcare and equity workspaces. This is evident across the field with nurses, CHWs, and even Medicaid directors. The average tenure for a Medicaid Director is 21 months, with each one having a different outlook on equity and different priorities that need to be addressed. This provides a big lesson in reflection on how the work is being conducted as it continues to move forward. During the pandemic, nurses and public health staff left the field in record numbers. The looming nurse shortage was made even worse during that time, as nurses left the workplace, and clinical training site disruptions impacted the flow of new nurses being trained. Workforce shortages impact access to care, which often impacts equity. Unfortunately, equity work is put into the background when there are staffing shortages, as the main priority is taking care of those who come through the door. Many of the interviewees noted a need for an increase in the workforce, especially for equity work, i.e. creating separate departments or positions of additional aid rather than putting extra work on existing employees that could lead to burnout. There is a need to continue investment in equity-focused work even as the popularity of the buzzword “equity” may wain.

Hopes for the Next 10 Years

> **"A lesson we are still learning today is that you really need to understand the problem you are trying to fix. We often look at disparity but don't understand how we got there. Many people think if you throw a lot of money at something it will be fixed in a few years, which for most cases, is not true. Other issues will take a long time to fix. Issues also cause other issues; we need to take a more holistic view. We need stories and data to make significant changes."**
>
> **A Medicaid Director**

Part of looking back across the previous decade of this work is also looking forward to the next decade. Overwhelmingly, when projecting what the landscape will look like in Michigan Medicaid within the next 10 years, the hope is that disparities in quality of care will be eliminated, and services will be delivered equitably across populations. There is consensus among stakeholders that there is a lot of work to do before that future state is a reality. From a policy standpoint, there is hope for there to be a non-transactional mindset around equity: a need for rethinking the punitive approach if there was not a successful year in health equity, to avoid penalties and look instead at what were the processes and investments in place that have been planted that will grow year over year. Interviewees also noted equity must be non-negotiable, it must continue to become an interwoven aspect of the work being done on the side of healthcare and health access, coupled with the reality that it does require investment, in both time and money.

Many organizations hope for reimbursement to reach outside the hospital walls into the comminutes and community-based organizations where many aspects of health are being influenced and conducted. One interviewee said it best, "equity is not a destination; it is part of the course." When looking towards the future all interviewees wanted to see Michigan continue to blaze a path towards not only examining health disparities but eliminating them.

Across the Michigan Medicaid landscape, there have been moves in the right direction, as systems, plans, and CBOs continue to better understand barriers to care and how they can bridge them. Michigan has made strides in data collection and still will continue to find thorough, diligent, and transparent ways of collecting data that tell the stories of the disparities as well as the efforts to address them.

Medicaid Contract & Policy Trends

Contract Language

Contracts with Medicaid Health Plans are largely considered one of the best and most sustainable mechanisms for changes in the Medicaid program. Medicaid agencies develop contract language annually and receive approval from CMS before the contract is finalized. Some Medicaid agencies, including Michigan, involve health plans in conversations around potential changes before they are finalized. The level of collaboration between Medicaid agencies and contracted health plans varies between states. Changes in contract language often reflect the priorities of state agencies. Health plan adherence to contract provisions is assessed annually through the compliance review process.

Medicaid health plan contract language was reviewed for references to health equity, disparities, and Social Determinants of Health (SDOH) from 2010 – 2023. Please note that MDHHS changed its name from the Michigan Department of Community Health (DCH) in 2015. While disparities and SDOH were not mentioned in any contracts until 2016, health equity was first mentioned in Appendix 5 of the 2013 contract (*2013 DCH P4P Bonus Healthcare for a Diverse Membership – Health Equity: MHP submits HEDIS data broken down by R/E to DCH for specified measures*).

Beginning in 2014, the following language related to health equity was added to all subsequent contracts: "*Medicaid Health Equity Project: Contractor will fully and completely participate in the Medicaid Health Equity Project and report all required information to DCH within the specified timeline.*"

From 2016 to 2022, references to health equity, disparities, and SDOH became prominent throughout all contracts, providing an overview of the background for these efforts, methods for addressing disparities, and definitions for the terms. In 2023, for the first time, language was added that specified contractors must provide enrollees and families the opportunity to provide feedback to inform health equity initiatives, ensuring that their voices are heard, and their needs are taken into account. This feedback can help to improve the effectiveness and relevance of the initiatives and can also increase the sense of ownership and engagement among the beneficiaries themselves. By actively involving beneficiaries in the decision-making process, MHPs can better understand the unique challenges and barriers faced by this population and can develop more targeted and effective strategies to address health disparities and promote health equity. The following is the contract language from 2016-2022:

EXHIBIT A

STATEMENT OF WORK

Contract Activities

Background

Contractors must provide the spectrum of primary and preventive care and use the principles of population health management to prevent chronic disease and coordinate care along the continuum of health and well-being. Effective utilization of these principles will maintain or improve the physical and psychosocial well-being of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum. This includes the management of high utilizers. Population health management also includes an overarching emphasis on health promotion and disease prevention and will incorporate community-based health and wellness strategies with a strong focus on the Social Determinants of Health, creating Health Equity, and supporting efforts to build more resilient communities.

X. Population Health Management

B. Addressing Health Disparities:

1. General

   a. Contractor recognizes that Population Health management interventions are designed to address the Social Determinants of Health, reduce disparities in health outcomes experienced by different subpopulations of Enrollees, and ultimately achieve Health Equity.

      i. Contractor must provide Enrollees and families the opportunity to provide feedback to inform health equity initiatives. (Added FY23)

D. Providing Care Management Services and Other Targeted Interventions

2. Targeted Interventions for Subpopulations Experiencing Health Disparities:

   c. Contractor must fully and completely participate in the Medicaid Health Equity Project and report all required information to MDHHS within the specified timeframe.

XI. Quality Improvement and Program Development

G. Medicaid Health Equity Project

Contractor must fully and completely participate in the Medicaid Health Equity Project and associated initiatives and report all required information to MDHHS within the specified timeline.

DEFINITIONS

- Community-based health – A strong focus on the social determinants of health, creating Health Equity, and supporting efforts to build more resilient communities by coordinating population health improvement strategies.
- Health Equity – When all people have the opportunity to attain their full health potential, and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance.

Pay for Performance Bonuses

Bonus mechanisms are often used to incentivize improvement in health plan quality scores. State Medicaid agencies use financial incentives to reward plans that have made progress in a specific area of interest. Like health plan contracts, incentive mechanisms often reflect the priorities of Medicaid leadership. Michigan Medicaid has employed financial incentives for contracted health plans for decades. Pay for Performance (P4P) Bonuses were assessed to determine how health equity initiatives were prioritized and incentivized each year. Appendix 5 of each contract outlines the requirements and evaluation criteria to receive the P4P Bonuses.

Appendix C of this report includes a table that details the P4P Bonuses related to health equity from 2010-2023 (Please note: The table does not include all bonus criteria, only criteria related directly to health equity). With the exception of the *2013 DCH P4P Bonus - Healthcare for a Diverse Membership* (whereby MHPs were required to submit HEDIS data broken down by race and ethnicity to DCH for specified measures), nothing specific to health equity was included in any bonus criteria until 2016.

The 2016 P4P was developed to promote health equity and reduce racial and ethnic disparities among the Michigan Medicaid managed care population and focused on the five key areas listed below. The 2017 P4P included the same key areas and target populations as 2016, except for NEMT and Tobacco Cessation.

1. Medicaid Health Equity: MHPs will implement a health equity program and complete an annual project template. DHHS will monitor efforts to reduce R/E disparities in two selected HEDIS measures (Postpartum Care & Childhood Immunizations Status – Combination 3).
2. Chlamydia Screening (CHL): MHPs will describe and implement programs/efforts to improve screening and treatment rates, and narrow any health disparities in their population due to sex or R/E. This project will target CHL screening for men ages 16-18 and women ages 16 -24 years as well as CHL screening rates by R/E.
3. Population Health Management: MHPs will implement a Population Health Management program, a Community Health Worker (CHW) program and other procedures to address SDOH for their members.
4. Non-Emergent Medical Transportation (NEMT)
5. Tobacco Cessation

The 2018 P4P included requirements for both population health management and health equity. MHPs were required to implement a Population Health Management program to address SDOH for their members including submitting their population health management approaches, interventions, and community collaboration projects. MHPs were also required to implement a health equity program in which MDHHS would monitor efforts to reduce racial and ethnic disparities in five selected HEDIS measures: Childhood Immunization Status Combo 3, Postpartum Care, Chlamydia (CHL) Screening in Women, Child Access to Care (25mon – 6yrs) and Adult Access to Care (20-44yrs). The goal was for all measures to have an Index Disparity less than 5% for the MI Medicaid managed care population. The 2018 P4P also provided a performance bonus for the integration of behavioral and physical health services, including the implementation of Joint Care Management Processes and Follow-Up After Hospitalizations for Mental Illness within 30 Days (FUH).

The 2019 and 2020 P4Ps further sought to address SDOH by focusing on the Low Birth Weight (LBW) Project, a multi-year statewide initiative to align MDHHS efforts to promote health equity in maternity and infant care by involving the MHPs, existing home visiting programs, and CHW programs to design and implement a meaningful P4P project utilizing a three-prong approach: preconception, timeliness of prenatal care, postpartum care. The 2019-2020 P4Ps also sought to lower inappropriate Emergency Department (ED) utilization in the MI Medicaid managed care population, by concentrating on one of three topics: integration with behavioral health, substance use disorder treatment, or dental services. It further attempted to integrate behavioral and physical health services by adding Plan All-cause Readmission (PCR) and Follow-up After ED Visit for Alcohol and Other Drug Dependence (FUA). Finally, 2019-2020 saw the inclusion of Plan-Specific Health Equity Measures (2 per plan): Comprehensive Diabetes Care (HbA1c Testing), Cervical Cancer Screening, Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life, Postpartum Care, and Chlamydia Screening.

The 2021 P4P saw continued emphasis on the Low Birth Weight (LBW) Project and integration of behavioral and physical health services. It also introduced population health management initiatives that focused the economic impact of COVID-19. MDHHS required MHPs to address all of the focus areas in their SDOH programs (food insecurity, housing, utility assistance, employment, education, and training) and BH programs (stress, depression, and anxiety).

The 2022 P4P required MHPs to continue addressing the same SDOH/BH areas and target populations that were outlined in the 2020 contract, however it also required MHPs to broaden their stratification of data by race/ethnicity, region, age, and gender. The 2022 performance bonus criteria also included low birth weight, quality of care for LGBTQ+ populations, multiple HEDIS measures (Adults' access to preventive/ambulatory health services; Asthma medication ratio; controlling high blood pressure; comprehensive diabetes control – eye exam; lead screening in children; children immunization combo 3; chlamydia screening in women; prenatal and postpartum care; well child visits in first 30 months), and Health Equity Scoring (1 point for statistically significant improvement in rate disparity between African American and White beneficiaries, and 1 point for statistically significant improvement in rate disparity between Hispanic and White beneficiaries for the HEDIS measures mentioned above).

The 2023 performance bonus included the same criteria as 2022, with the addition of a new HEDIS measure (kidney health evaluations for patients with diabetes) and the establishment of Regional Collaboratives which seek to have the health plans work together and with outside partners to help improve the care of children within the State. The 2023 population health management initiative also included new measures to gather contextual analysis (i.e., social, cultural, economic, etc.) from

health plans to better understand the barriers to improving rates for low birth weight and childhood immunizations. It also required MHPs to provide flow charts and process explanations for how they plan to coordinate high-risk pregnant women of color to reduce the likelihood for low birth weight and congenital syphilis.

In summary, the table included in Appendix C outlines how P4P bonuses related to health equity and population health management have evolved from 2010-2023, with each year seeing an increased focus on reducing racial and ethnic disparities, addressing social determinants of health, and promoting health equity among the Michigan Medicaid Managed Care Population.

Medicaid Policy Trends

All Medical Services Administration (MSA), Behavioral and Physical Health and Aging Services Administration (BPHASA), and Michigan Medicaid Policy (MMP) Bulletins published by MDCH and later MDHHS were reviewed and compiled to illustrate how policies and state priorities related to health equity evolved and expanded from 2010-2023. Appendix D includes a table listing relevant policy changes with links to the corresponding bulletin. The table illustrates a progression towards more integrated and equitable healthcare delivery, especially evident with initiatives like the Medicaid Health Equity Project and integration of services under ACA guidelines. Each year introduced new programs or expansions while building upon existing frameworks, indicating a commitment to continuous improvement in healthcare accessibility and quality.

For example, significant attention has been given to maternal and child health throughout the years, starting in 2010 with the Maternal Infant Health Program (MIHP) policy changes, which emphasized risk identification, and required WIC referrals and home visits, followed by breastfeeding support, family planning services, and expanded coverage for infants and children in subsequent years.

Starting in 2015, there was also a consistent effort to expand access to behavioral health services, including but not limited to 1.) enrolling more psychologists, social workers, and professional counselors as Medicaid Providers to provide greater access to care for behavioral health services, 2.) removing visit limits, and 3.) establishing specialized care homes for opioid addiction and other behavioral health issues.

The policy section outlines the changes and trends in contracting and policy implementation over the years. One notable example of policy and contracting coinciding with each other is the Flint Water Crisis, where a waiver was approved for expanded Medicaid for those impacted by the crisis in 2016.

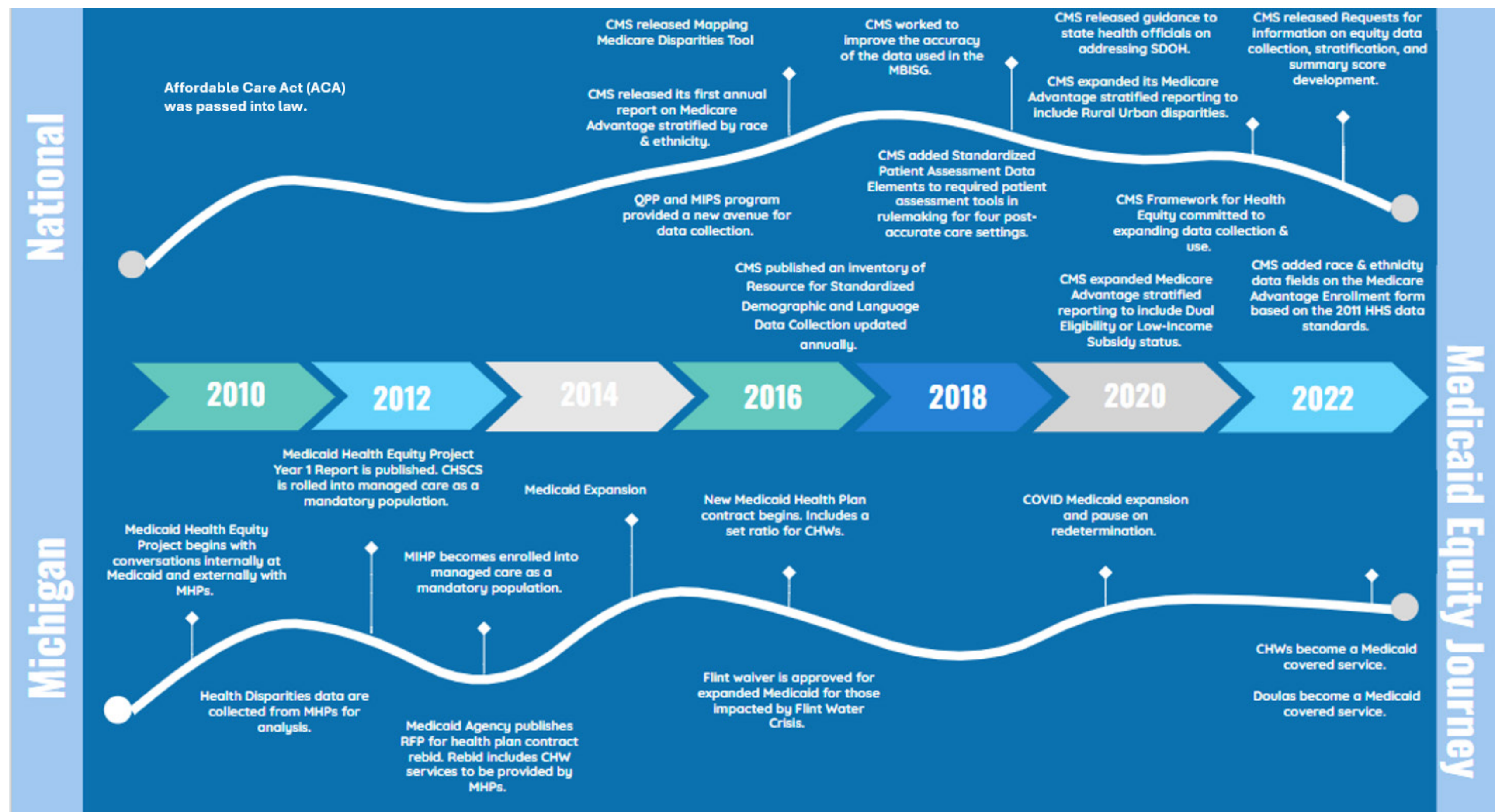
In terms of notable years and movements, 2013 saw the implementation of the Affordable Care Act (ACA) changes for Medicaid. In 2014, the MI Health Link Program was introduced, integrating all physical health care, pharmacy, long term supports and services, and behavioral health care for individuals who are dually eligible for full Medicare and full Medicaid.

In 2015, the Medicaid Agency published an RFP for a health plan contract rebid, which included CHW services to be provided by MHPs. In 2016, the new Medicaid Health Plan contract began, which included a set ratio for CHWs as well as medical assistance and targeted case management for those impacted by the Flint Water Crisis. Also starting in 2016, contracts began including language related to health equity, social determinants of health, and the reduction of racial and ethnic disparities.

2018 saw the introduction of the Opioid Health Home Pilot Program which provided coverage and reimbursement for Opioid Health Home Services, as well as a new performance bonus measure aimed at integrating behavioral and physical health services. In 2019, the focus was on improving the health of the MI Medicaid population and addressing SDOH, with the introduction of the Low Birth Weight (LBW) Project.

Throughout 2020-2021, Medicaid issued many new policies in response to the COVID-19 Pandemic including suspending all Medicaid renewals and closures, expanding telemedicine services, and covering COVID-19 vaccine services. In response, the FY2021 MHP contract included the following language: "To address the economic impact of COVID-19 and continue to meet the growing needs of MI Medicaid beneficiaries, MDHHS is requesting the health plans to broaden and expand their focus on Social Determinants of Health and Behavioral Health."

Overall, the timeline shows a continued focus on improving access to care, addressing health disparities, and promoting health equity.



Picture 2. Journey Map Timeline of Highlights of National and Michigan Medicaid Specific Efforts in Disparities and Health Equity Efforts.

Analysis of Healthcare Quality Measures

To conduct an analysis of healthcare quality measures spanning the years 2011 to 2020, data was gathered on the following measures: Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), Chlamydia Screening Combined (CHL), HbA1c Testing (CDC1), Childhood Immunizations Combo 3 (CIS), Appropriate Asthma Medications Combined (ASM), Child Access to Care 24 Months to 6 Years (CAP), Adult Access to Care 20-44 years (AAP), Adolescent Immunizations Combo 1 (IMA), Blood Lead Screening (LSC), Well-Child Visits 3-6 years (W34), Post-Partum Care (PPC), Diabetic Eye Exam (CDC2), and Diabetic Nephropathy (CDC3). Full measure descriptions can be found in Appendix B. Revisions to the specifications and data collection and reporting criteria from the National Committee for Quality Assurance (NCQA) and other applicable reporting criteria have impacted the methodology of data collection and categorization in Michigan across all years included in this report. From 2011 until 2020, the named year is the data submission year, which is the year following the measurement year.

For each measure, trends across the decade were examined and disparities, the difference in rates by race and ethnicity, were assessed. Race and ethnicity were reported for the following groups: White, American Indian/Alaskan Native, Asian American/Native Hawaiian/OPI, Black or African American, Hispanic, Some Other Race/Multiracial, and Unknown/Declined. This involved gathering numerical values representing the number of cases for each racial/ethnic group for each year from 2011 to 2020. These values were then compared to the total number of individuals reported (denominator) for each year to calculate the respective rates for each racial/ethnic group. The rates were then analyzed to identify trends over the decade and to assess any disparities or differences between the racial/ethnic groups. As previously indicated, differences in rates between racial/ethnic populations and the White reference population rate can be an indicator of the health effects of discrimination and racism. The White population served as the reference population for all comparisons in this report because the White population is not exposed to racial/ethnic discrimination and could reasonably be used as a proxy for 'standard of care.'

If a population performed worse than the White reference population on a particular metric, the disparity gap is represented as a negative number and noted in red if it is statistically significant. If a population performed better than the White reference population on a particular metric, the disparity gap is represented as a positive number and noted in green if it is statistically significant. 'NS' means that the disparity gap is not statistically significant, and therefore there is no disparity. It should be noted that in instances when populations outperform the White reference population, it is still referred to as a 'disparity gap.' This was intentional. When looking at this data and the efforts behind closing the gaps, the goal behind equity work is to make sure there is no gap, i.e., the disparity gap = zero. So, whether the disparity gap is positive or negative, there is still a gap, which means populations are receiving disparate levels of care on certain metrics. It is also important to note this because, for certain measures in which certain populations are outperforming the White reference population, there may be problematic reasons behind the overperformance. For example, there have been studies[17] that have shown Black/African American and Latina populations are tested for chlamydia at higher rates than any other population, possibly due to the provider's implicit bias and perceptions of sexual activity among these populations.[18] For this reason, caution is urged when discussing whether the overperformance of the Black/African American population on this metric should be considered a success or not.

Please note, for the measurement year 2020 (MY2020), two measures, Children and Adolescents Access to PCP 25 Months-6 Years and Comprehensive Diabetes Care-Medical Attention for Nephropathy, were removed because low-level disparity had been demonstrated since the measurement year 2011; one measure, Well Child Visits 3-6 Years, was replaced by Child and Adolescent Well-Care Visits 3-11 years.

Additional consideration should be noted for 2020 and MY2020 as a global pandemic began in March 2020, requiring individuals to stay at home and avoid non-emergent medical care. Rates during this period may reflect the environmental situation during the measurement period.

*For each graph representing a measure, population (n) has been included for each race and ethnicity. The population is reported for the last year that data was reported for that population.

Breast Cancer Screening

Michigan has performed better than the HEDIS 50th percentile since 2011 until the last reported year, MY2020. The variation in total screening rates in Michigan largely echoed the variation seen in the HEDIS 50th percentile, indicating Michigan is echoing trends occurring across the nation. When breaking the Michigan rates down by race/ethnicity, it is clear that the variation in racial/ethnic groups widely differs from the statewide trend with certain groups outperforming the white population while others drastically underperformed.

The Hispanic population outperformed the White population for 8 out of 10 years collected. American Indian/Alaskan Native have had lower screening rates than all other racial/ethnic groups across the past decade. While the American Indian/Alaskan Native population is smaller than the other racial/ethnic groups, the large gap in screening rates between the American Indian/Alaskan Native and White populations demonstrates a large disparity is present. It should be noted that gains have been made in disparities reduction when comparing 2011 to MY2020. In 2011, the 4 primary racial/ethnic groups all had a statistically significant disparity from the White population. In MY2020, only 2 of those same groups, Asian and Hispanic, still had a statistically significant disparity from the White population. In MY2020, the Hispanic and Asian American/Native Hawaiian/OPI groups no longer had a statistically significant disparity present which had begun in 2019.

In 2011, the White population had a breast cancer screening rate of 58.2%, compared to 54.0% of the Black/African American population, representing a statistically significant disparity gap of -4.20%. Both populations saw increases in screening rates in 2015 (W=64.0%, B/AA=61.2%) – the year after revisions were made to the measure specifications. Although both saw incremental decreases each year thereafter, by 2020 both populations still had higher screening rates than a decade previously (W=61.5%, B/AA=58.3%), with a reduced disparity gap of -3.1%.

Please note, the breast cancer screening measure was not collected in 2014 due to changes in the measure specifications by the NCQA. The specifications were updated to align with new age recommendations for breast cancer screening. The original age guidelines were 40-69; they were revised to 50-74. While this may render rate trending unsound, it does not inherently impact the gap between racial and ethnic groups and the white reference rate.

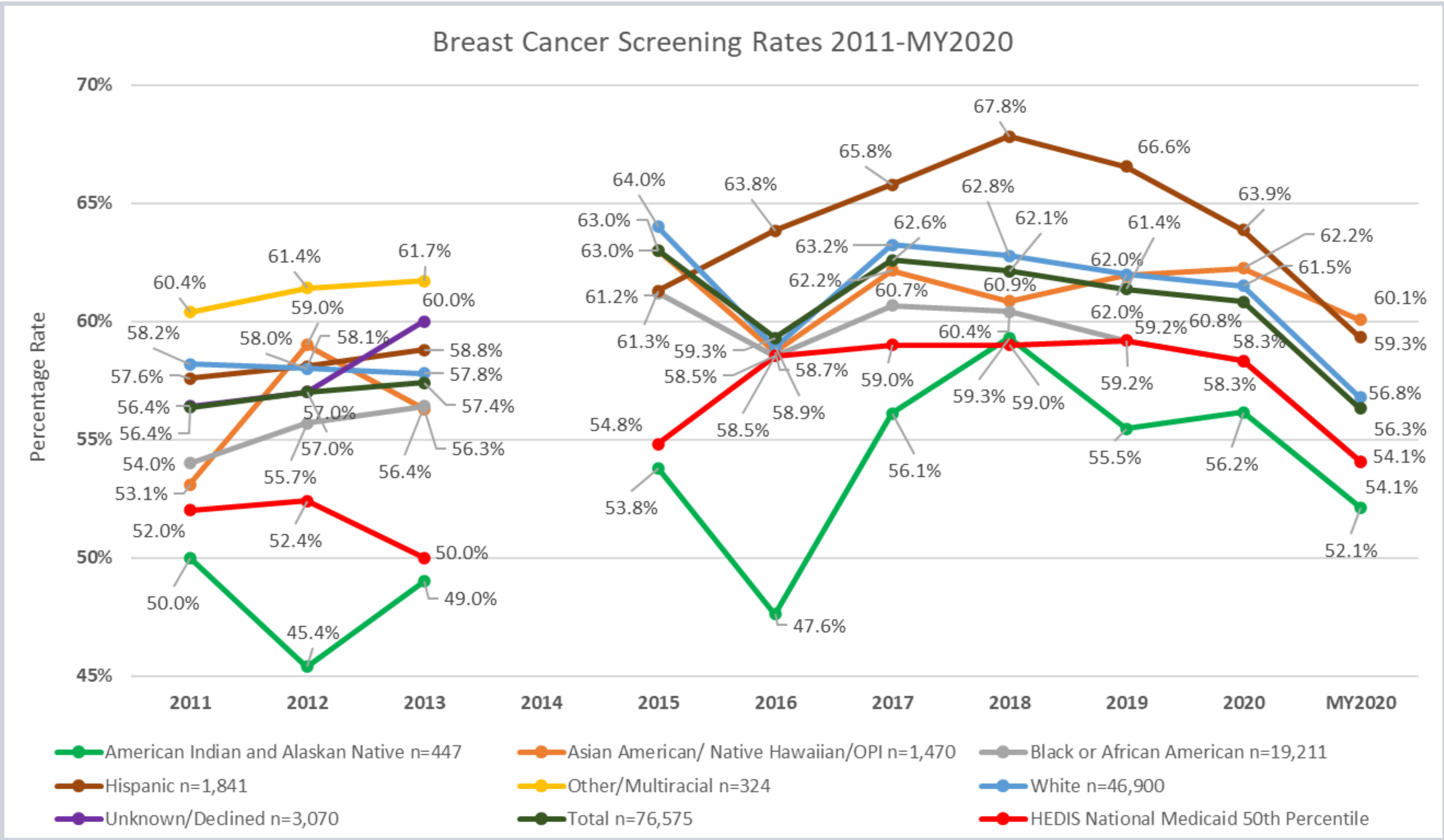


Figure 1. Breast Cancer Screening Rates 2011-MY2020.

Please note: Breast Cancer Screening was not collected in 2014 due to revisions in measure specifications by the NCQA. Care should be taken when comparing results across this time period.

Breast Cancer Screening												
Race		**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**MY2020**
White	*Rate*	58.2%	58.0%	57.8%		64.0%	58.9%	63.2%	62.8%	62.0%	61.5%	56.8%
	Reference Population (RP)	RP	RP	RP		RP	RP	RP	RP	RP	RP	RP
American Indian / Alaskan Native	*Rate*	50.0%	45.4%	49.0%		53.8%	47.6%	56.1%	59.3%	55.4%	56.2%	52.1%
	% Difference from RP	-8.2%	-12.6%	-8.8%		-10.2%	-11.3%	-7.1%	-3.5%	-6.5%	-5.4%	-4.6%
	Difference from RP	Below	Below	Below		Below	Below	Below	Below	Below	Below	Below
Asian American / Native Hawaiian / Other Pacific Islander	*Rate*	53.1%	59.0%	56.3%		63.0%	58.7%	62.2%	60.8%	62.0%	62.2%	60.1%
	% Difference from RP	-5.1%	1.0%	-1.5%		1.0%	-0.2%	-1.1%	-1.9%	0.0%	0.7%	3.3%
	Difference from RP	Below	NS	Below		Below	NS	Below	Below	NS	NS	NS
Black / African American	*Rate*	54.0%	55.7%	56.4%		61.2%	58.5%	60.7%	60.4%	59.2%	58.3%	54.1%
	% Difference from RP	-4.2%	-2.3%	-1.4%		-2.8%	-0.4%	-2.6%	-2.4%	-2.8%	-3.2%	-2.7%
	Difference from RP	Below	Below	Below		Below	NS	Below	Below	Below	Below	Below

Race		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	MY2020
Hispanic	*Rate*	57.6%	58.1%	58.8%		61.3%	63.8%	65.8%	67.8%	66.6%	63.9%	59.3%
	% Difference from RP	-0.6%	0.1%	1.0%		-2.7%	4.9%	2.6%	5.1%	4.6%	2.4%	2.5%
	Difference from RP	Below	NS	NS		Below	NS	NS	NS	NS	NS	NS
Other / Multiracial*	*Rate*	60.40%	61.40%	61.70%								
	% Difference from RP	2.2%	3.4%	3.9%								
	Difference from RP	NS	NS	NS								
Unknown / Declined**	*Rate*	56.4%	57.0%	60.0%								
	% Difference from RP	-1.8%	-1.0%	2.2%								
	Difference from RP	Below	Below	NS								
Total	**Rate**	**56.4%**	**57.0%**	**57.4%**		**63.0%**	**59.3%**	**62.6%**	**62.1%**	**61.4%**	**60.8%**	**56.3%**

Table 2. Breast Cancer Screening 2011-MY2020
Rate= Numerator (number of people who received intervention)/ Denominator (number of people eligible to receive intervention); NS = Not significantly different than White reference population; Above/Below = Significantly higher/lower than White reference population.

Please note: Breast Cancer Screening was not collected in 2014 due to revisions in measure specifications by the NCQA.

*The Other/Multiracial category was not collected after 2013, due to the inconsistent use of this category across MHPs.

**Unknown/Declined was not collected after 2013. Those classified as unknown/declined were treated as missing data after that date.

Cervical Cancer Screening

Between 2015 and 2019 Michigan's total cervical cancer screening rate outperformed the HEDIS 50th percentile, with Michigan dipping below that HEDIS marker for the remaining three years. Beginning in 2011, the Hispanic and Black/African American populations were receiving screenings at a higher than the White population. The American Indian/Alaskan Native and Asian American/Native Hawaiian/OPI populations were performing statistically significantly worse, meaning they received fewer screenings, than the White population until 2013. The cervical cancer screening measure was not collected in 2014 due to changes in the measure specifications by the NCQA. The NCQA added to the primary HPV testing method to the measure so that screening by any of the three methods (Cytology screening every 3 years for women 21–64; Co-testing every 5 years for women 30–64; Primary HPV testing every 5 years for women 30–64) as recommended by the U.S. Preventive Services Task Force are numerator compliant.

When the cervical cancer screening measure resumed collection in 2015, the majority of racial/ethnicity groups outperformed the White population, with the exception of the American Indian/Alaskan Native group with statistically significant disparities only present in that population. Demonstrating improvement in disparities across the decade, the cervical cancer screening measure did not have any statistically significant disparities present in MY2020, compared to 4 present in populations (American Indian/Alaskan Native, Asian American/Native Hawaiian/OPI, Other/Multiracial and Unknown/Declined) in 2011 when the data was first reported by MDHHS.

In 2011, the cervical cancer screening rate was 67.3% for the White population and 68.1% for the Black/African American population, representing a disparity gap of +0.8% (not statistically significant). By 2020, the screening rate was 58.0% for the White population and 61.6% for the Black/African American population, representing an increased disparity gap of +3.7% (not statistically significant).

In 2019, cervical cancer screening measure was included as part of a pay for performance program instituted by MDHHS. The measure was required for all plans.

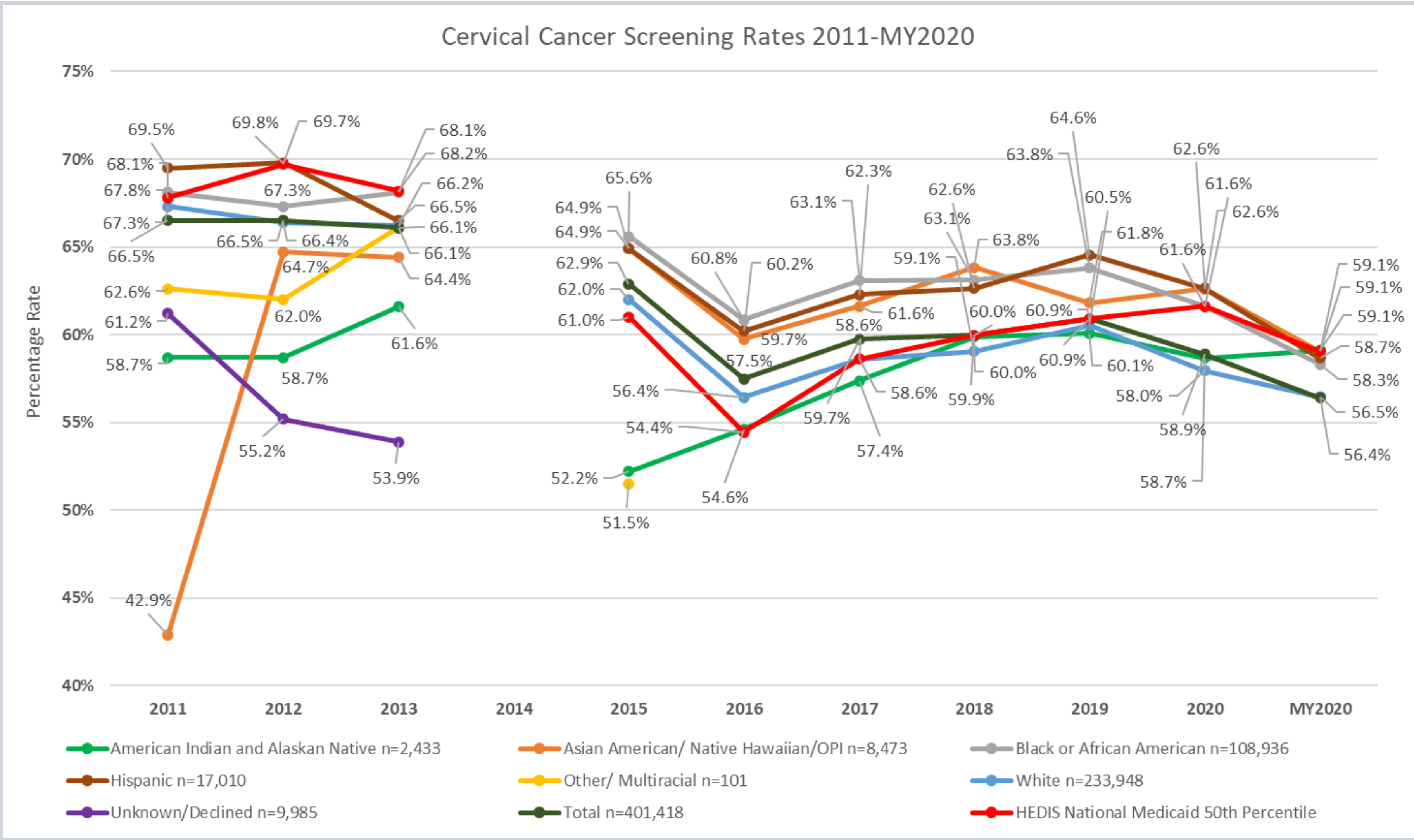


Figure 2. Cervical Cancer Screening Rates 2011-MY2020.

Please note: Cervical Cancer Screening was not collected in 2014 due to revisions in measure specifications by the NCQA. Care should be taken when comparing results across this time period.

Cervical Cancer Screening												
Race		**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**MY2020**
White	*Rate*	67.3%	66.4%	66.2%		62.0%	56.4%	58.6%	59.0%	60.5%	57.9%	56.4%
	Reference Population (RP)	RP	RP	RP		RP	RP	RP	RP	RP	RP	RP
American Indian / Alaskan Native	*Rate*	58.7%	58.7%	61.6%		52.2%	54.6%	57.3%	59.8%	60.0%	58.6%	59.1%
	% Difference from RP	-8.6%	-7.7%	-4.6%		-9.8%	-1.8%	-1.2%	0.8%	-0.4%	0.7%	2.6%
	Difference from RP	Below	Below	Below		Below	Below	Below	NS	Below	NS	NS
Asian American / Native Hawaiian / Other Pacific Islander	*Rate*	42.9%	64.7%	64.4%		64.9	59.7%	61.6%	63.8%	61.8%	62.6%	59.0%
	% Difference from RP	-24.4%	-1.7%	-1.8%		2.9%	3.3%	3.0%	4.7%	1.2%	4.6%	2.6%
	Difference from RP	Below	Below	Below		NS	NS	NS	NS	NS	NS	NS
Black / African American	*Rate*	68.1%	67.3%	68.1%		65.6%	60.8%	63.0%	63.1%	63.7%	61.6%	58.3%
	% Difference from RP	0.8%	0.9%	1.9%		3.6%	4.4%	4.4%	4.0%	3.2%	3.6%	1.8%
	Difference from RP	NS	Above	NS		Above	NS	NS	NS	NS	NS	NS

Race		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	MY2020
Hispanic	*Rate*	69.5%	69.8%	66.5%		64.9%	60.2%	62.2%	62.6%	64.5%	62.6%	58.6%
	% Difference from RP	2.2%	3.4%	0.3%		2.9%	3.7%	3.6%	3.5%	4.0%	4.6%	2.2%
	Difference from RP	NS	Above	NS		NS	NS	NS	NS	NS	NS	NS
Other / Multiracial*	*Rate*	62.6%	62.0%	66.1%		51.5%						
	% Difference from RP	-4.7%	-4.4%	-0.1%		-10.5%						
	Difference from RP	Below	Below	NS		Below						
Unknown / Declined**	*Rate*	61.2%	55.2%	53.9%								
	% Difference from RP	-6.1%	-11.2%	-12.3%								
	Difference from RP	Below	Below	Below								
Total	**Rate**	**66.5%**	**66.5%**	**66.1%**		**62.9%**	**57.4%**	**59.7%**	**59.9%**	**60.9%**	**58.9%**	**56.4%**

Table 3. Cervical Cancer Screening 2011-MY2020

Rate= Numerator (number of people who received intervention)/ Denominator (number of people eligible to receive intervention); --= Population size not included due to small number; NS = Not significantly different than White reference population; Above/Below = Significantly higher/ lower than White reference population.

Please note: Cervical Cancer Screening was not collected in 2014 due to revisions in measure specifications by the NCQA.

*The Other/Multiracial category was not collected after 2013, due to the inconsistent use of this category across MHPs.

**Unknown/Declined was not collected after 2013. Those classified as unknown/declined were treated as missing data after that date.

Chlamydia Screening in Women

The screening rates for chlamydia in women exhibited relatively stable rates with some fluctuation and most rates for all races decreased for MY2020. The Black/African American population shows the highest rates for screening between 70.5% to 76.3%, which is a consistent trend over the years. The White population rates are on par with and follow the timeline trends of the HEDIS National 50th percentile, with rates between 53.3% and 65.8%. Asian American/Native Hawaiian/OPI has shown the highest rate of changes, climbing from 48.6% in 2011 and 2015 to 69.4% in 2020. This is a rare example of a measure in which the Black/African American population has the highest quality of care for any individual year and the only measure for which Black/African Americans have the highest rates across all years. In 2011, the chlamydia screening rate was 54.8% for the White population and 73.2% for the Black/African American population, representing a statistically significant disparity gap of +18.4%. Throughout the decade, screening rates for both populations increased slightly (W=59.3%, B/AA=75.4%), ending in 2020 with a slightly decreased, but statistically significant disparity gap of +16.1%.

In FY2016, a pay-for-performance incentive was introduced in the health plan contract that focused on reducing disparities in the chlamydia screening rate. The are difference between the African American/Black population and the White reference population in 2016 was 13.7, the smallest of any measurement year. The difference between the African American/Black rate and the White reference population in 2011 was 18.2. That gap was still 18.2 during the last measurement year (MY2022).

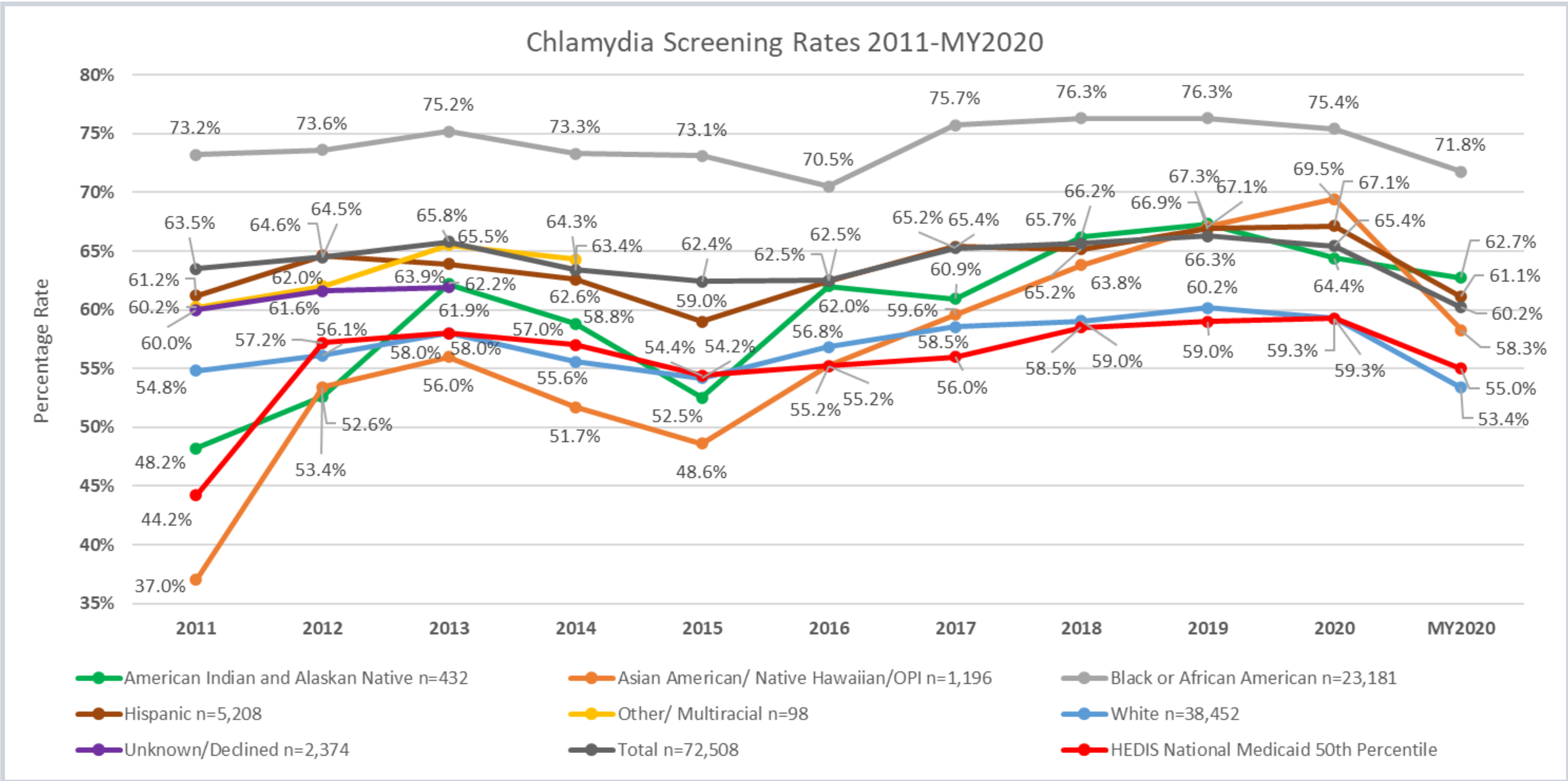


Figure 3. Chlamydia Screening Rates 2011-MY2020.

Chlamydia Screening in Women												
Race		**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**MY2020**
White	*Rate*	54.8%	56.1%	58.0%	55.6%	54.2%	56.8%	58.5%	59.0%	60.1%	59.2%	53.3%
	Reference Population (RP)	RP	RP	RP	RP	RP	RP	RP	RP	RP	RP	RP
American Indian / Alaskan Native	*Rate*	48.2%	52.6%	62.2%	58.8%	52.5%	62.0%	60.9%	66.1%	67.3%	64.4%	62.7%
	% Difference from RP	-6.6%	-3.5%	4.2%	3.2%	-1.7%	5.2%	2.3%	7.1%	7.1%	5.1%	9.3%
	Difference from RP	Below	Below	NS	NS	Below	NS	NS	NS	NS	NS	NS
Asian American / Native Hawaiian / Other Pacific Islander	*Rate*	37.0%	53.4%	56.0%	51.7%	48.6%	55.2%	59.5%	63.8%	67.0%	69.4%	58.2%
	% Difference from RP	-17.8%	-2.7%	-2.0%	-3.9%	-5.6%	-1.6%	1.0%	4.7%	6.9%	10.1%	4.9%
	Difference from RP	Below	Below	Below	Below	Below	Below	NS	NS	NS	NS	NS
Black / African American	*Rate*	73.2%	73.6%	75.2%	73.3%	73.1%	70.5%	75.7%	76.3%	76.3%	75.4%	71.7%
	% Difference from RP	18.4%	17.5%	17.2%	17.7%	18.9%	13.6%	17.1%	17.2%	16.1%	16.1%	18.4%
	Difference from RP	Above	Above	Above	Above	Above	NS	Above	Above	Above	Above	Above

Race		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	MY2020
Hispanic	*Rate*	61.2%	64.6%	63.9%	62.6%	59.0%	62.4%	65.3%	65.1%	66.9%	67.1%	61.1%
	% Difference from RP	6.4%	8.5%	5.9%	7.0%	4.8%	5.6%	6.8%	6.1%	6.7%	7.8%	7.7%
	Difference from RP	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Other / Multiracial*	*Rate*	60.2%	62.0%	65.5%	64.3%							
	% Difference from RP	5.4%	5.9%	7.5%	8.7%							
	Difference from RP	NS	NS	NS	NS							
Unknown / Declined**	*Rate*	60.0%	61.6%	61.9%								
	% Difference from RP	5.2%	5.5%	3.9%								
	Difference from RP	NS	NS	NS								
Total	**Rate**	**63.5%**	**64.5%**	**65.8%**	**63.4%**	**62.4%**	**62.5%**	**65.2%**	**65.6%**	**66.2%**	**65.4%**	**60.2%**

Table 4. Chlamydia Screening in Women 2011-MY2020

Rate= Numerator (number of people who received intervention)/ Denominator (number of people eligible to receive intervention); --= Population size not included due to small number; NS = Not significantly different than White reference population; Above/Below = Significantly higher/ lower than White reference population.

*The Other/Multiracial category was not collected after 2014, due to the inconsistent use of this category across MHPs.

**Unknown/Declined was not collected after 2013. Those classified as unknown/declined were treated as missing data after that date.

Childhood Immunization Status– Combination 3

Across the past decade, from 2011 to MY2020, the rates of Childhood Immunization Status-Combination 3, remained relatively stable. This is evidenced by the HEDIS National 50th percentile beginning in 2011 at 71% and ending in MY2020 at 70.5%. When looking at the breakdown of each race/ethnicity group, there is a bit more variation year to year in rates, however, no noticeable trend across the decade for any of the race/ethnic groups is present. Rates for the Hispanic population within the Childhood Immunization Status Measure had the overall highest rate, mostly staying between 70%-80% for ten years. The Black/African American population saw the lowest childhood immunization rates throughout the decade, staying below 65% for all years. In 2011, the White population had a childhood immunization rate of 71.2%, compared to 61.1% of the Black/African American population, representing a statistically significant disparity gap of -10.1%. Although the disparity gap decreased to -3.4% in 2012, it increased again in 2013 and remained high throughout the decade, ending in 2020 with a -12.9% gap. The Hispanic population saw some small changes both increasing and decreasing but staying in the 70.0% area. All measures in comparison to the white population were either below the white rate or they were statistically not significant (NS).

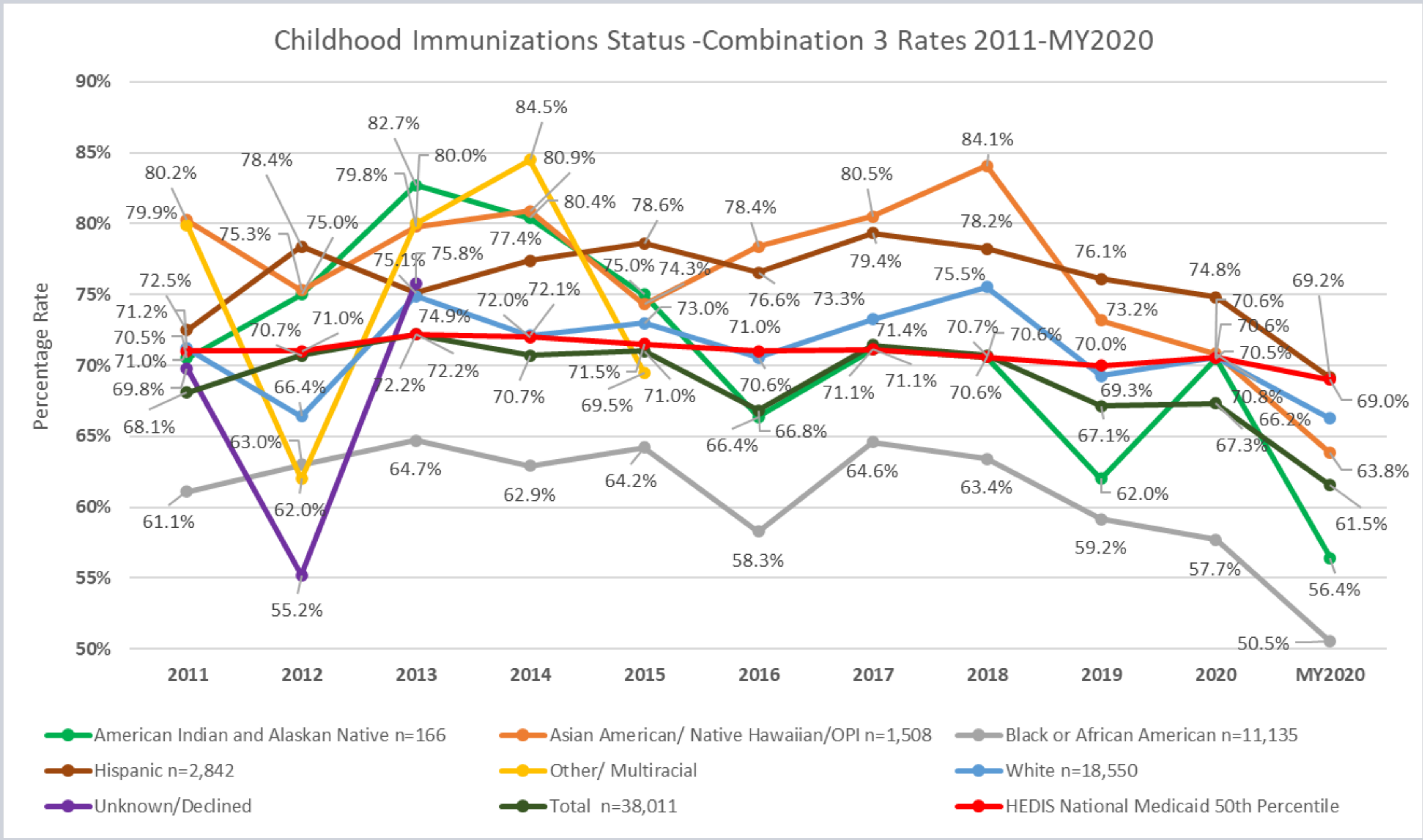


Figure 5. Childhood Immunizations Status – Combination 3 Rates 2011- MY2020.

Childhood Immunizations Status-Combination 3												
Race		**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**MY2020**
White	*Rate*	71.2%	66.4%	74.9%	72.1%	73.0%	70.5%	73.2%	75.5%	69.2%	70.5%	66.2%
	Reference Population (RP)	RP	RP	RP	RP	RP	RP	RP	RP	RP	RP	RP
American Indian / Alaskan Native	*Rate*	70.5%	75.0%	82.7%	80.4%	75.0%	66.3%	71.1%	70.5%	62.0%	70.4%	56.4%
	% Difference from RP	-0.7%	8.6%	7.8%	8.3%	2.0%	-4.2%	-2.1%	-4.9%	-7.2%	-0.1%	-9.8%
	Difference from RP	NS	NS	NS	NS	NS	Below	Below	Below	Below	NS	Below
Asian American / Native Hawaiian / Other Pacific Islander	*Rate*	80.2%	75.3%	79.8%	80.9%	74.3%	78.3%	80.5%	84.0%	73.1%	70.8%	63.8%
	% Difference from RP	9.0%	8.9%	4.9%	8.9%	1.3%	7.8%	7.2%	8.5%	3.9%	0.2%	-2.4%
	Difference from RP	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	Below
Black / African American	*Rate*	61.1%	63.0%	64.7%	62.9%	64.2%	58.2%	64.6%	63.4%	59.1%	57.6%	50.5%
	% Difference from RP	-10.1%	-3.4%	-10.2%	-9.2%	-8.8%	-12.2%	-8.6%	-12.1%	-10.1%	-12.8%	-15.7%
	Difference from RP	Below	Below	Below	Below	Below	Below	Below	Below	Below	Below	Below

Race		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	MY2020
Hispanic	*Rate*	72.5%	78.4%	75.1%	77.4%	78.6%	76.5%	79.3%	78.2%	76.0%	74.8%	69.1%
	% Difference from RP	1.3%	12.0%	0.2%	5.3%	5.6%	6.0%	6.0%	2.7%	6.8%	4.2%	2.9%
	Difference from RP	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Other / Multiracial*	*Rate*	79.9%	62.0%	80.0%	84.5%	69.5%						
	% Difference from RP	8.7%	-4.4%	5.1%	12.4%	-3.5%						
	Difference from RP	NS	Below	NS	NS	NS						
Unknown / Declined**	*Rate*	69.8%	55.2%	75.8%								
	% Difference from RP	-1.4%	-11.2%	0.9%								
	Difference from RP	Below	Below	NS								
Total	**Rate**	**68.0%**	**70.7%**	**72.2%**	**70.7%**	**71.0%**	**66.8%**	**71.4%**	**70.7%**	**67.1%**	**67.3%**	**61.5%**

Table 6. Childhood Immunizations Status-Combination 3.

Rate= Numerator (number of people who received intervention)/ Denominator (number of people eligible to receive intervention); --= Population size not included due to small number; NS = Not significantly different than White reference population; Above/Below = Significantly higher/lower than White reference population.

*The Other/Multiracial category was not collected after 2014, due to the inconsistent use of this category across MHPs.

**Unknown/Declined was not collected after 2013. Those classified as unknown/declined were treated as missing data after that date.

Appropriate Asthma Medications (Combined)

The measure, Appropriate Asthma Medications (Combined), was only collected until the measure was retired in 2015. From 2011 until it was retired in 2015, the rates across racial/ethnic groups remained relatively stable. Michigan's total population performed below the HEDIS National Medicaid 50th Percentile across all five years. The largest disparity was present for the Black/African American population in comparison to the White population, with differences ranging from approximately 3-8%. In 2011, 88.5% of the White population had appropriate asthma medications compared to 85.4% of the Black/African American population, representing a statistically significant disparity gap of -3.1%. By 2015, this gap increased to -5.7%. The Black/African American population was the only racial/ethnic population to have a disparity present for all five measurement years. The Hispanic population had no statistically significant difference present from the White population across the measurement period and was performing slightly better than the White population during that time.

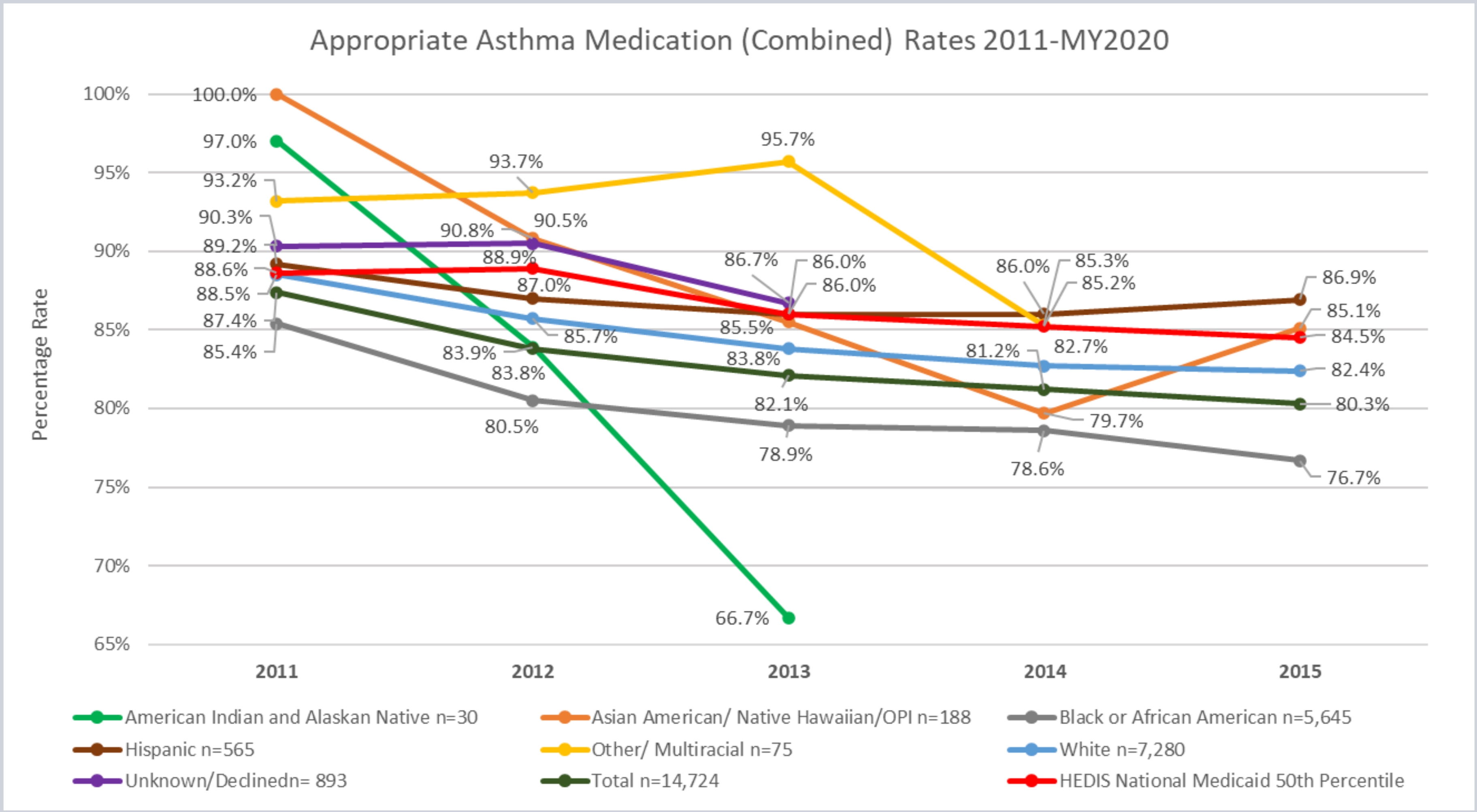


Figure 6. Appropriate Asthma Medication (Combined) Rates 2011-2015.

Appropriate Asthma Medications (Combined)						
Race		**2011**	**2012**	**2013**	**2014**	**2015**
White	*Rate*	88.5%	85.7%	83.8%	82.7%	82.4%
	Reference Population (RP)	RP	RP	RP	RP	RP
American Indian / Alaskan Native	*Rate*	97.0%	83.9%	66.7%	--	--
	% Difference from RP	8.5%	-1.8%	-17.1%	--	--
	Difference from RP	NS	NS	Below	--	--
Asian American / Native Hawaiian / Other Pacific Islander	*Rate*	100.0%	90.8%	85.5%	79.7%	85.1%
	% Difference from RP	11.5%	5.1%	1.7%	-3.0%	2.7%
	Difference from RP	NS	NS	NS	Below	NS
Black / African American	*Rate*	85.4%	80.5%	78.9%	78.6%	76.7%
	% Difference from RP	-3.1%	-5.2%	-4.9%	-4.1%	-5.7%
	Difference from RP	Below	Below	Below	Below	Below
Hispanic	*Rate*	89.2%	87.0%	86.0%	86.0%	86.9%
	% Difference from RP	0.7%	1.3%	2.2%	3.3%	4.5%
	Difference from RP	NS	NS	NS	NS	NS
Other / Multiracial*	*Rate*	93.2%	93.7%	95.7%	85.3%	
	% Difference from RP	4.7%	8.0%	11.9%	2.6%	
	Difference from RP	NS	NS	NS	NS	
Unknown / Declined**	*Rate*	90.3%	90.8%	86.7%		
	% Difference from RP	1.8%	5.1%	2.9%		
	Difference from RP	NS	NS	NS		
Total	**Rate**	**87.3%**	**83.8%**	**82.1%**	**81.2%**	**80.3%**

Table 7. Appropriate Asthma Medications (Combined) 2011-2015.

Rate= Numerator (number of people who received intervention)/ Denominator (number of people eligible to receive intervention); --= Population size not included due to small number; NS = Not significantly different than White reference population; Above/Below = Significantly higher/ lower than White reference population

Please note: Appropriate Asthma Medication was not collected after 2015.

*The Other/Multiracial category was not collected after 2014, due to the inconsistent use of this category across MHPs.

**Unknown/Declined was not collected after 2013. Those classified as unknown/declined were treated as missing data after that date.

Child Access to Care (25 Months-6 Years)

When examining Child Access to Care (25 Months- 6 Years), the HEDIS National 50th Percentile remained relatively stable from 2011 until 2019. Rates for this measure in Michigan, remained similarly stable, with the exception of 2015, during which rates dipped for the year, across all ethnic and racial groups. With the exception of the Black/African American population, other racial/ethnic groups at some point outperformed the White population across the decade. The Black/African American population is the only racial/ethnic group to have persistent disparities present across the decade. In 2011, 91.8% of the White population had child access to care, compared to 85.9% of the Black/African American population, representing a statistically significant disparity gap of -5.9%. This gap steadily increased each year, remaining statistically significant through 2020, which had a disparity gap of -10.66%. The Hispanic population both began and ended the decade with a statistically significant disparity present. It should be noted that this measure was removed in 2020.

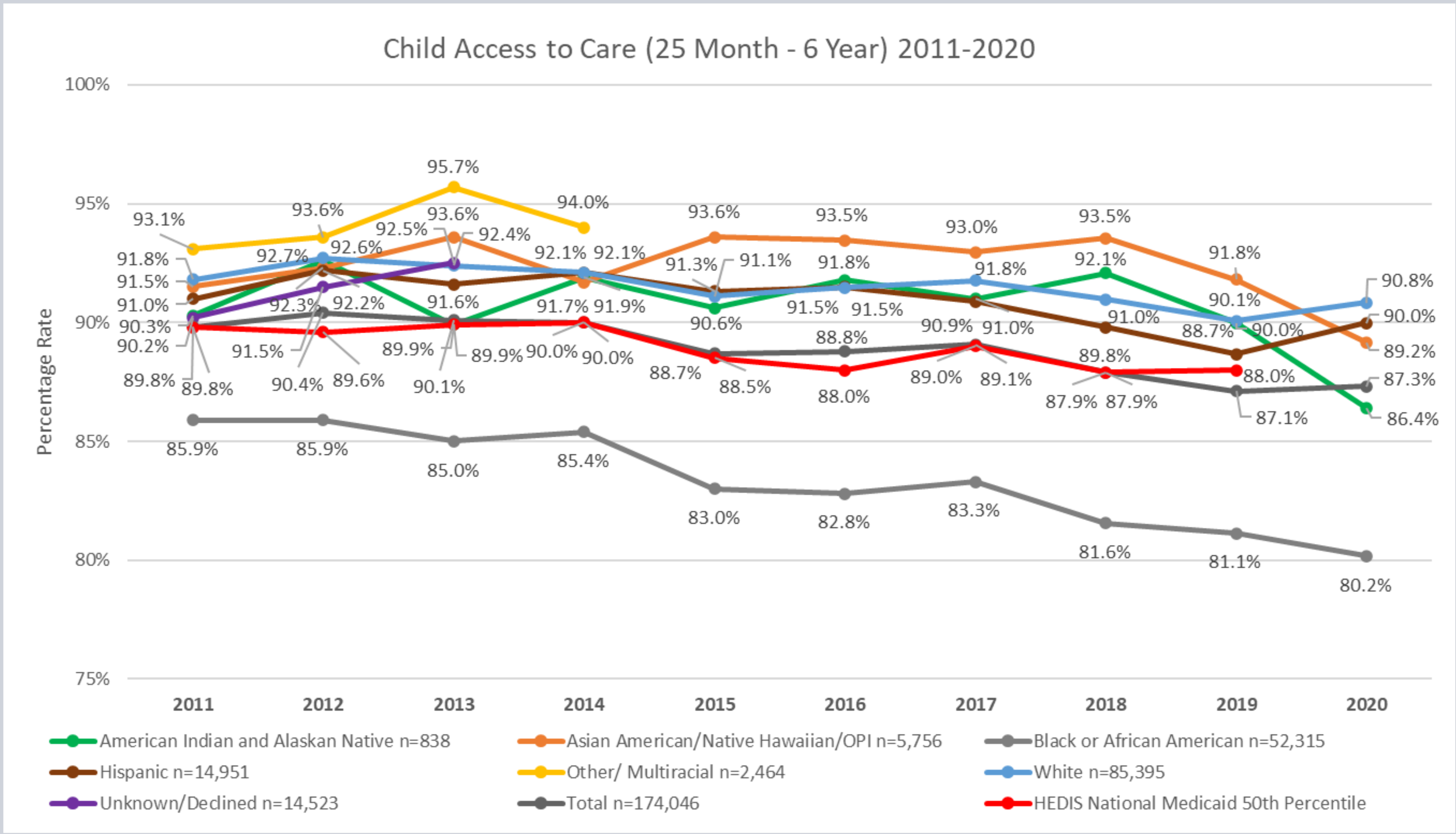


Figure 7. Child Access to Care (25 Months – 6 Year) 2011-2020.

Child Access to Care (25 Months - 6 Years)												
Race		**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**MY2020**
White	*Rate*	91.8%	92.7%	92.4%	92.1%	91.1%	91.4%	91.7%	90.9%	90%	90.8%	
	Reference Population (RP)	RP	RP	RP	RP	RP	RP	RP	RP	RP	RP	
American Indian / Alaskan Native	*Rate*	90.3%	92.6%	89.9%	91.9%	90.6%	90.9%	91.7%	90.9%	89.9%	86.4%	
	% Difference from RP	-1.5%	-0.1%	-2.5%	-0.2%	-0.5%	-0.4%	0.0%	0.0%	-0.1%	-4.4%	
	Difference from RP	NS	NS	NS	NS	NS	NS	NS	NS	NS	Below	
Asian American / Native Hawaiian / Other Pacific Islander	*Rate*	89.6%	92.3%	93.6%	91.7%	93.6%	93.4%	92.9%	93.5%	91.8%	89.1%	
	% Difference from RP	-2.1%	-0.4%	1.2%	-0.4%	2.5%	1.9%	1.1%	2.5%	1.7%	-1.6%	
	Difference from RP	Below	NS	NS	NS	Above	NS	NS	Above	NS	Below	
Black / African American	*Rate*	85.9%	85.9%	85.0%	85.4%	83.0%	82.8%	83.3%	81.5%	81.1%	80.1%	
	% Difference from RP	-5.9%	-6.8%	-7.4%	-6.7%	-8.1%	-8.6%	-8.4%	-9.4%	-8.9%	-10.6%	
	Difference from RP	Below	Below	Below	Below	Below	Below	Below	Below	Below	Below	

Race		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	MY2020
Hispanic	*Rate*	91.0%	92.2%	91.6%	92.1%	91.3%	91.4%	90.8%	89.8%	88.6%	89.9%	
	% Difference from RP	-0.8%	-0.5%	-0.8%	0.0%	0.2%	0.0%	-0.8%	-1.1%	-1.4%	-0.8%	
	Difference from RP	Below	Below	Below	NS	NS	NS	Below	Below	Below	Below	
Other / Multiracial*	*Rate*	93.1%	93.6%	95.7%	94.0%							
	% Difference from RP	1.3%	0.9%	3.3%	1.9%							
	Difference from RP	NS	NS	Above	Above							
Unknown / Declined**	*Rate*	90.2%	91.5%	92.5%								
	% Difference from RP	-1.6%	-1.2%	0.1%								
	Difference from RP	Below	Below	NS								
Total	**Rate**	**89.8%**	**90.4%**	**90.1%**	**90.0%**	**88.7%**	**88.7%**	**89.0%**	**87.8%**	**87.1%**	**87.3%**	

Table 8. Child Access to Care (25 Months-6 Years) 2011-2020.

Rate= Numerator (number of people who received intervention)/ Denominator (number of people eligible to receive intervention); --= Population size not included due to small number; NS = Not significantly different than White reference population; Above/Below = Significantly higher/lower than White reference population.

Please note: Child Access to Care (25 months to 6 years) was not collected in MY2020 due to revisions in measure specifications by the NCQA.

*The Other/Multiracial category was not collected after 2014, due to the inconsistent use of this category across MHPs.

**Unknown/Declined was not collected after 2013. Those classified as unknown/declined were treated as missing data after that date.

Adult Access to Preventive/Ambulatory Health Services (20-44 years)

The rates for Adult Access to Preventive/Ambulatory Health Services for adults aged 20-44 years, had a slight downward trend over the reporting period with a sharp decline happening in MY2020. Statistically significant disparities were present for both the Hispanic and Black/African American populations across the decade. The disparity between the White reference population and the Black/African American population remained constant, in terms of size, across the decade, with little progress being made on remediating the disparity present. In 2011, 85.9% of the White population had adult access to preventive/ambulatory care, compared to 79.7% of the Black/African American population, representing a statistically significant -6.2% disparity gap. This gap remained consistent and statistically significant throughout the decade ending with a disparity gap of -7.7% in MY2020. The Asian American/Native Hawaiian/OPI population had statistically significant disparities present for 7 out of 11 years. The population with the least number of disparities when compared to the white population was the American Indian/Alaskan Native population with disparities present only 2 out of 11 years.

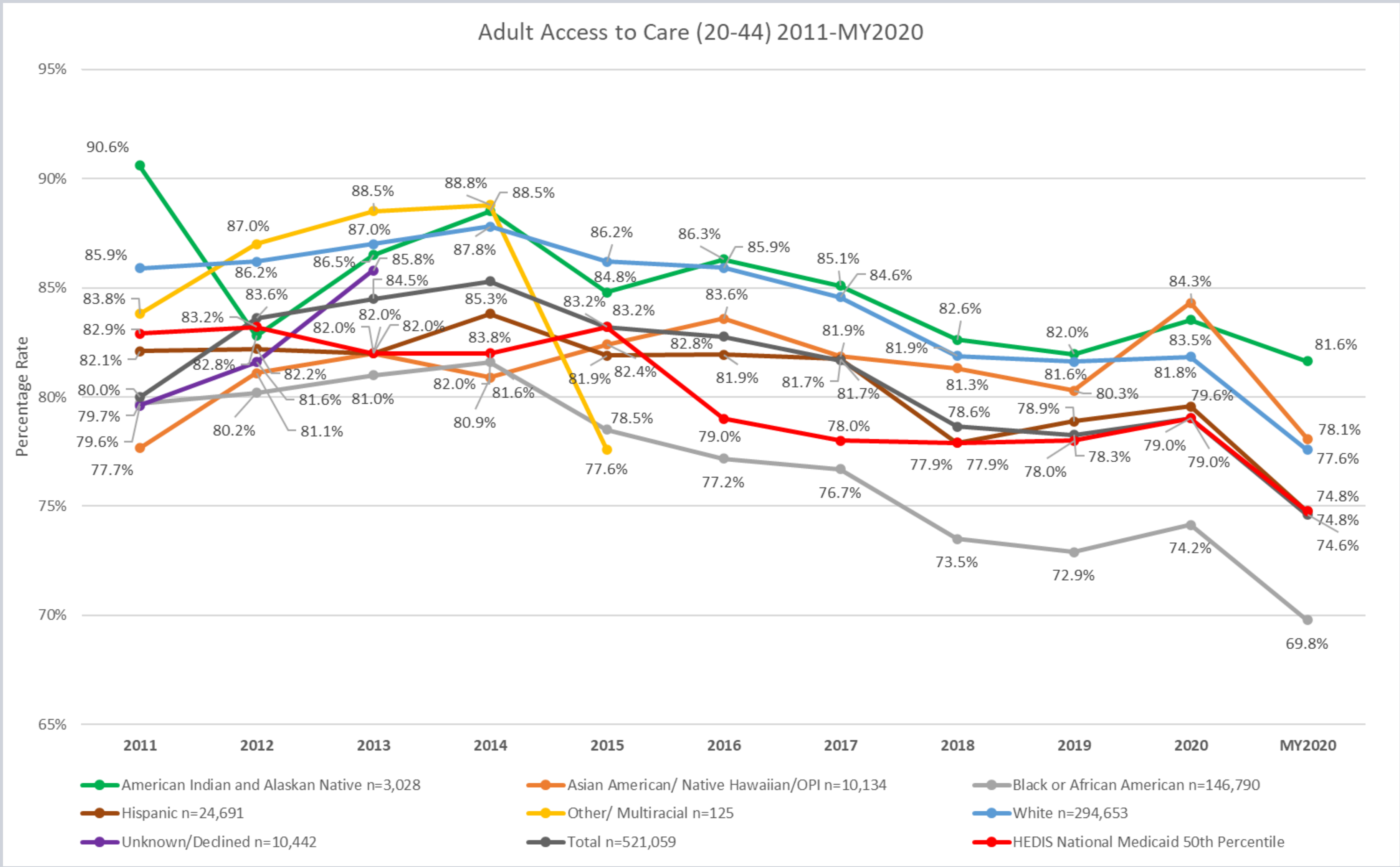


Figure 8. Adult Access to Care (20-44) 2011-MY2020.

Adult Access to Preventive/Ambulatory Health Services (20-44 Years)												
Race		**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**MY2020**
White	*Rate*	85.9%	86.2%	87.0%	87.8%	86.20%	85.9%	84.5%	81.8%	81.6%	81.8%	77.5%
	Reference Population (RP)	RP	RP	RP	RP	RP	RP	RP	RP	RP	RP	RP
American Indian / Alaskan Native	*Rate*	90.6%	82.8%	86.5%	88.5%	84.8%	86.2%	85.0%	82.6%	81.9%	83.5%	81.6%
	% Difference from RP	4.7%	-3.4%	-0.5%	0.7%	-1.4%	0.3%	0.5%	0.7%	0.3%	1.6%	4.0%
	Difference from RP	NS	Below	NS	NS	Below	NS	NS	NS	NS	NS	NS
Asian American / Native Hawaiian / Other Pacific Islander	*Rate*	79.3%	81.1%	82.0%	80.9%	82.4%	83.5%	81.8%	81.3%	80.2%	84.3%	78.0%
	% Difference from RP	-6.6%	-5.1%	-5.0%	-6.9%	-3.8%	-2.3%	-2.7%	-0.5%	-1.3%	2.4%	0.5%
	Difference from RP	Below	Below	Below	Below	Below	Below	Below	NS	Below	NS	NS
Black / African American	*Rate*	79.7%	80.2%	81.0%	81.6%	78.5%	77.1%	76.6%	73.5%	72.9%	74.1%	69.7%
	% Difference from RP	-6.2%	-6.0%	-6.0%	-6.2%	-7.7%	-8.7%	-7.8%	-8.3%	-8.7%	-7.6%	-7.7%
	Difference from RP	Below	Below	Below	Below	Below	Below	Below	Below	Below	Below	Below

Race		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	MY2020
Hispanic	*Rate*	82.1%	82.2%	82.0%	83.8%	81.9%	81.9%	81.7%	77.8%	78.8%	79.5%	74.7%
	% Difference from RP	-3.8%	4.0%	-5.0%	-4.0%	-4.3%	-3.9%	-2.8%	-3.9%	-2.7%	-2.2%	-2.8%
	Difference from RP	Below	Below	Below	Below	Below	Below	Below	Below	Below	Below	Below
Other / Multiracial*	*Rate*	83.8%	87.0%	88.5%	88.8%	77.6%						
	% Difference from RP	-2.1%	0.8%	1.5%	1.0%	-8.6%						
	Difference from RP	Below	NS	NS	NS	Below						
Unknown / Declined**	*Rate*	79.6%	81.6%	85.8%								
	% Difference from RP	-6.3%	-4.6%	-1.2%								
	Difference from RP	Below	Below	Below								
Total	**Rate**	**79.9%**	**83.6%**	**84.5%**	**85.3%**	**83.2%**	**82.7%**	**81.6%**	**78.6%**	**78.2%**	**79.0%**	**74.6%**

Table 9. Adult Access to Preventive/ Ambulatory Health Services (20-44 Years) 2011-MY2020.

Rate= Numerator (number of people who received intervention)/ Denominator (number of people eligible to receive intervention); --= Population size not included due to small number; NS = Not significantly different than White reference population; Above/Below = Significantly higher/lower than White reference population.

Please note:

*The Other/Multiracial category was not collected after 2014, due to the inconsistent use of this category across MHPs.

**Unknown/Declined was not collected after 2013. Those classified as unknown/declined were treated as missing data after that date.

Immunizations for Adolescents – Combination 1

From 2011 until MY2020, Michigan has consistently performed better than the HEDIS National 50th Percentile for the Immunizations for Adolescents-Combination 1 measure. The decade began with a large gap between the HEDIS 50th and the lowest-performing racial/ethnic group in 2011. There was roughly a 30-percentage point gap between the two. Throughout the decade, that gap closed significantly, with the HEDIS 50th ending with a higher rate than the Black/African American population and the Michigan total within 1.0%. The American Indian/Alaskan Native and Asian American/Native Hawaiian/OPI population had few disparities present across the decade when compared to the White reference population. The Black/African American population had a disparity present when compared to the White reference population for 10 out of 11 years. In 2012, the White population had an immunization rate of 74.6% compared to 72.4% for the Black/African American population, representing a statistically significant disparity gap of -2.2%. This gap fluctuated throughout the decade but remained statistically significant for all years (except 2020), ending in MY2020 with a gap of -2.1%. The Hispanic population did not have any disparities present when compared to the White population during this timeframe.

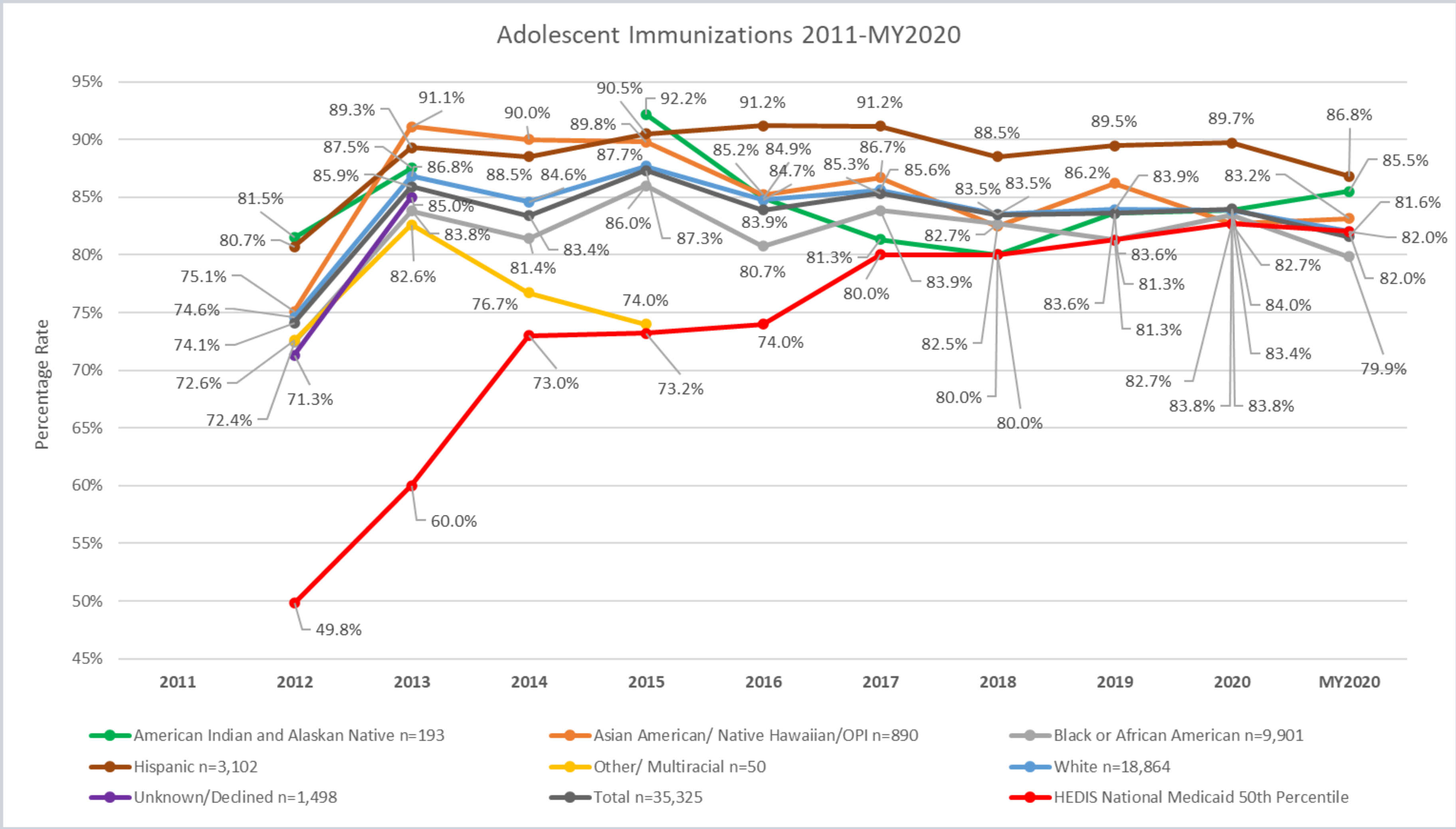


Figure 9. Adolescent Immunizations 2011- MY2020.

Immunizations for Adolescents- Combination 1												
Race		**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**MY2020**
White	*Rate*		74.6%	86.8%	84.6%	87.7%	84.7%	85.6%	83.5%	83.9%	83.8%	82.0%
	Reference Population (RP)		RP	RP	RP	RP	RP	RP	RP	RP	RP	RP
American Indian / Alaskan Native	*Rate*		81.5%	87.5%	--	92.2%	84.9%	81.3%	80.0%	83.6%	83.8%	85.4%
	% Difference from RP		6.9%	0.7%	--	4.5%	0.1%	-4.3%	-3.5%	-0.3%	0.0%	3.4%
	Difference from RP		NS	NS	--	NS	NS	Below	Below	NS	NS	NS
Asian American / Native Hawaiian / Other Pacific Islander	*Rate*		75.1%	91.1%	90.0%	89.8%	85.1%	86.7%	82.4%	86.1%	82.6%	83.1%
	% Difference from RP		0.5%	4.3%	5.4%	2.1%	0.4%	1.0%	-1.0%	2.2%	-1.1%	1.1%
	Difference from RP		NS	NS	NS	NS	NS	NS	Below	NS	Below	NS
Black / African American	*Rate*		72.4%	83.8%	81.4%	86.0%	80.7%	83.8%	82.6%	81.2%	83.4%	79.8%
	% Difference from RP		-2.2%	-3.0%	-3.2%	-1.7%	-4.0%	-1.7%	-0.8%	-2.6%	-0.4%	-2.1%
	Difference from RP		Below	Below	Below	Below	Below	Below	Below	Below	NS	Below

Race		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	MY2020
Hispanic	*Rate*		80.7%	89.3%	88.5%	90.5%	91.1%	91.1%	88.5%	89.4%	89.7%	86.8%
	% Difference from RP		6.1%	2.5%	3.9%	2.8%	6.4%	5.5%	4.9%	5.5%	5.8%	4.7%
	Difference from RP		NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Other / Multiracial*	*Rate*		72.6%	82.6%	76.7%	74.0%						
	% Difference from RP		-2.0%	-4.2%	-7.9%	-13.7%						
	Difference from RP		Below	Below	Below	Below						
Unknown / Declined**	*Rate*		71.3%	85.0%								
	% Difference from RP		-3.3%	-1.8%								
	Difference from RP		Below	Below								
Total	**Rate**		**74.1%**	**85.9%**	**83.4%**	**87.3%**	**83.9%**	**85.3%**	**83.4%**	**83.6%**	**83.9%**	**81.5%**

Table 12. Immunizations for Adolescents – Combined 1 2011-My2020.

Rate= Numerator (number of people who received intervention)/ Denominator (number of people eligible to receive intervention); --= Population size not included due to small number; NS = Not significantly different than White reference population; Above/Below = Significantly higher/lower than White reference population

Please note: Adult Immunization Combo 1 data was not collected in 2011 due to revisions in measure specifications by the NCQA.

*The Other/Multiracial category was not collected after 2014, due to the inconsistent use of this category across MHPs.

**Unknown/Declined was not collected after 2013. Those classified as unknown/declined were treated as missing data after that date.

Lead Screening in Children

Michigan rates were above the HEDIS National 50th Percentile from 2011 until MY2020. In 2011, Medicaid Managed Care Performance Monitoring Standards stipulated that *"Children at the age of 2 years old receive at least one blood lead test on/before 2nd birthday,"* with a minimum standard of >=80% continuous enrollment (increased from the 2010 minimum standard of >=75%). By 2012, contracts stipulated: *Blood lead testing for children under 6 years of age; children must be tested by 12 months of age and 24 months of age*. The HEDIS 50th converged with the Michigan total rate in 2015, and then the Michigan rate was higher for the rest of the time period. The Michigan rates for blood lead screening in children increased in 2016 to reflect the Flint water crisis that occurred during that period. From that point, screening rates trended downwards, with the exception of the Asian American/Native Hawaiian/OPI which spiked in 2018, with a high rate of 88.58%. Consistently across the decade, Asian American/Native Hawaiian/OPI, Hispanic, American Indian/Alaskan Native populations performed better than the White reference population. The Black/African American population began the decade in 2011 with no disparity present, only to end in MY2020 with a statistically significant -7.4% disparity gap compared to the White population.

The Flint water crisis – which started on April 25, 2014, when the city of Flint switched its water supply – significantly impacted blood lead screening practices in Michigan. Following the crisis, there was a notable increase in the number of children in Flint receiving lead tests earlier than before. Specifically, the percentage of children tested by 12 months of age rose by 10 percentage points. However, the overall proportion of Medicaid-eligible children who were tested did not change significantly, which highlights the ongoing challenges in achieving widespread lead testing and underscores the importance of primary prevention efforts to reduce lead exposure.

On October 3, 2023, Governor Whitmer signed a bill that requires all 1- and 2-year-olds in Michigan to be tested for lead exposure. Prior to that, only children enrolled in Medicaid were required to undergo testing for lead poisoning, but starting in 2024, physicians treating any minor must test them at 12 and 24 months of age.

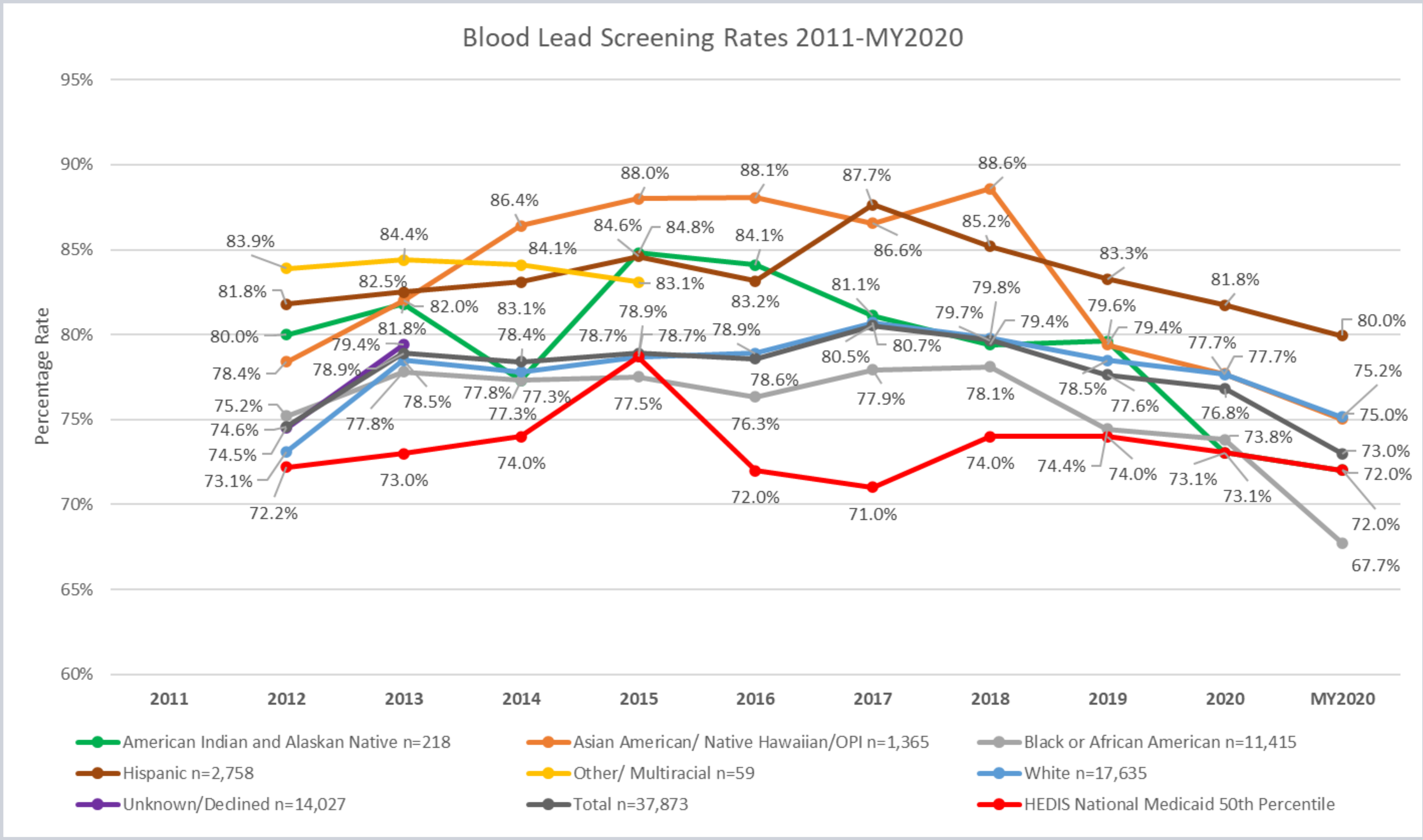


Figure 10. Blood Lead Screening Rates 2011-MY2020.

Lead Screening in Children											
Race		**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**MY2020**
White	*Rate*		73.1%	78.5%	77.8%	78.7%	78.9%	80.7%	79.8%	78.5%	77.7%	75.2%
	Reference Population (RP)		RP	RP	RP	RP	RP	RP	RP	RP	RP	RP
American Indian / Alaskan Native	*Rate*		80.0%	81.8%	77.3%	84.8%	84.1%	81.1%	79.4%	79.6%	73.1%	72.0%
	% Difference from RP		6.9%	3.3%	-0.5%	6.1%	5.2%	0.4%	-0.4%	1.1%	-4.6%	-3.1%
	Difference from RP		NS	NS	NS	NS	NS	NS	NS	NS	Below	Below
Asian American / Native Hawaiian / Other Pacific Islander	*Rate*		78.4%	82.0%	86.4%	88.0%	88.1%	86.1%	88.6%	79.4%	77.7%	75.0%
	% Difference from RP		5.3%	3.5%	8.6%	9.3%	9.1%	5.7%	8.8%	0.9%	0.0%	-0.1%
	Difference from RP		NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Black / African American	*Rate*		75.2%	77.8%	77.3%	77.5%	76.3%	77.9%	78.1%	74.4%	73.8%	67.7%
	% Difference from RP		2.1%	-1.4%	-0.5%	-1.2%	-2.6%	-2.8%	-1.7%	-4.1%	-3.8%	-7.4%
	Difference from RP		NS	NS	NS	Below	Below	Below	Below	Below	Below	Below

Race		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	MY2020
Hispanic	*Rate*		81.8%	82.5%	83.1%	84.6%	83.2%	87.7%	85.2%	83.3%	81.8%	80.0%
	% Difference from RP		8.7%	4.0%	5.3%	5.9%	4.3%	7.0%	5.4%	4.8%	4.1%	4.8%
	Difference from RP		NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Other / Multiracial*	*Rate*		83.9%	84.4%	84.1%	83.1%						
	% Difference from RP		10.8%	5.9%	6.3%	4.4%						
	Difference from RP		NS	NS	NS	NS						
Unknown / Declined**	*Rate*		74.5%	79.4%								
	% Difference from RP		1.4%	0.9%								
	Difference from RP		NS	NS								
Total	**Rate**		**74.6%**	**78.9%**	**78.4%**	**78.9%**	**78.6%**	**80.5%**	**79.7%**	**77.6%**	**76.8%**	**73.0%**

Table 10. Lead Screening in Children 2011-MY2020.

Rate= Numerator (number of people who received intervention)/ Denominator (number of people eligible to receive intervention); --= Population size not included due to small number; NS = Not significantly different than White reference population; Above/Below = Significantly higher/lower than White reference population

Please note: Blood Lead Screening was not collected in 2011 due to revisions in measure specifications by the NCQA.

*The Other/Multiracial category was not collected after 2014, due to the inconsistent use of this category across MHPs.

**Unknown/Declined was not collected after 2013. Those classified as unknown/declined were treated as missing data after that date.

Well Child Visits (3-6 Years)

The rates of well-child visits remained high, with minor disparities observed among different demographic groups. Asian American/Native Hawaiian/OPI individuals consistently display higher rates compared to other groups, with percentages ranging from 76.99% to 80.45%. Hispanic individuals also show relatively high rates, ranging from 73.0% to 79.8%. Some Other Race/Multiracial individuals exhibit rates slightly above the average, ranging from 69.3% to 77.5%. Black or African American population rates were the lowest throughout the years. The differences between the populations were not large, and the trends stayed mostly the same for all populations. With few exceptions, the disparity gap in well-child visits between the White population and all other populations remained small and not statistically significant, except for the Black/African American population. In 2012, the rate of well-child visits for the White population was 73.8% versus 72.2% for the Black/African American population, representing a statistically significant -1.6% disparity gap. From 2012 – 2020, there was a consistent, statistically significant, annual increase in disparity with 2020 having the largest gap at -7.4%.

This measure was not collected after 2020; in MY2020, this measure was replaced by Child and Adolescent Well-Care Visits 3-11 Years.

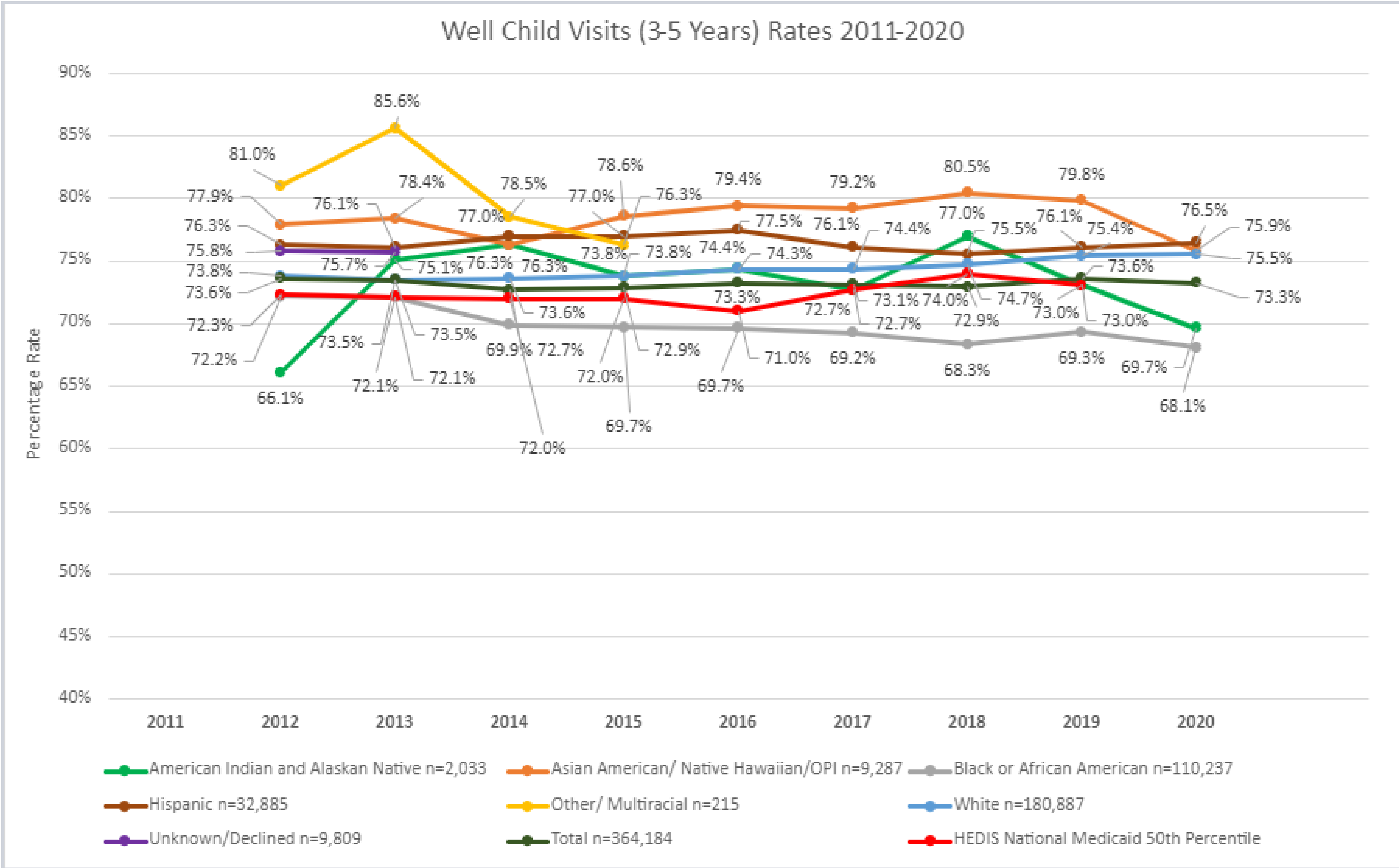


Figure 11. Well Child Visits (3-5 years) Rates 2011-My2020.

Well Child Visits (3-6 Years)											
Race		**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
White	*Rate*		73.8%	73.5%	73.6%	73.8%	74.4%	74.4%	74.7%	75.4%	75.5%
	Reference Population (RP)		RP	RP	RP	RP	RP	RP	RP	RP	RP
American Indian / Alaskan Native	*Rate*		66.1%	75.1%	76.3%	73.8%	74.3%	72.7%	77.0%	73.0%	69.7%
	% Difference from RP		-7.7%	1.6%	2.7%	0.0%	0.0%	-1.7%	2.3%	-2.4%	-5.9%
	Difference from RP		Below	NS	NS	NS	NS	Below	NS	Below	Below
Asian American / Native Hawaiian / Other Pacific Islander	*Rate*		77.9%	78.4%	76.3%	78.6%	79.4%	79.2%	80.5%	79.8%	75.9%
	% Difference from RP		4.1%	4.9%	2.7%	4.8%	5.0%	4.9%	5.7%	4.7%	0.3%
	Difference from RP		NS	NS	NS	NS	NS	NS	NS	NS	NS
Black / African American	*Rate*		72.2%	72.1%	69.9%	69.7%	69.7%	69.2%	68.3%	69.3%	68.1%
	% Difference from RP		-1.6%	-1.4%	-3.7%	-4.1%	-4.7%	-5.1%	-6.4%	-6.1%	-7.4%
	Difference from RP		Below	Below	Below	Below	Below	Below	Below	Below	Below

Race		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Hispanic	*Rate*		76.3%	76.1%	77.0%	77.0%	77.5%	76.1%	75.5%	76.1%	76.5%
	% Difference from RP		2.5%	2.6%	3.4%	3.2%	3.1%	1.7%	0.8%	0.7%	1.0%
	Difference from RP		NS	NS	NS	NS	NS	NS	NS	NS	NS
Other / Multiracial*	*Rate*		81.0%	85.6%	78.5%						
	% Difference from RP		7.2%	12.1%	4.9%						
	Difference from RP		NS	NS	NS						
Unknown / Declined**	*Rate*		75.8%	75.7%							
	% Difference from RP		2.0%	2.2%							
	Difference from RP		NS	NS							
Total	**Rate**		**73.6%**	**73.5%**	**72.7%**	**72.9%**	**73.3%**	**73.1%**	**72.9%**	**73.6%**	**73.3%**

Table 11. Well Child Visits (3 -6 Years) 2011-2020

Rate= Numerator (number of people who received intervention)/ Denominator (number of people eligible to receive intervention); --= Population size not included due to small number; NS = Not significantly different than White reference population; Above/Below = Significantly higher/lower than White reference population.

Please note: Well Child Visits 3-6 Years was not collected in 2011 due to revisions in measure specifications by the NCQA.

*The Other/Multiracial category was not collected after 2014, due to the inconsistent use of this category across MHPs.

**Unknown/Declined was not collected after 2013. Those classified as unknown/declined were treated as missing data after that date.

Post-Partum Care

Overall, the rates saw a rise between 2012 and 2019, but disparities were prevalent between Black/African American, Asian American/Native Hawaiian/OPI and American Indian and Alaskan Native. The largest disparity gap in postpartum care was between White and Black/African American populations. In 2012, 62.6% of the White population received postpartum care compared to 46.3% of the Black/African American population, representing a statistically significant -16.3% disparity gap. Although there was a gradual increase in rates of the Black/African American population receiving postpartum care, and a decrease in the disparity gap between these two populations, the gap remained at a statistically significant -9.9% in 2020. As HEDIS 50th percentile rose most of the population rates fell towards My2020. Asian American / Native Hawaiian/OPI saw higher rates throughout most of the years but fell in 2019 and stayed lower, ending as the second lowest rate for the population. In FY 2016 and FY2018, MHPs were incentivized to focus on reducing disparities in maternal health. The gap between the African American population and the White population was the smallest in 2017 at 9.2% but had risen to 12.8% by MY 2020.

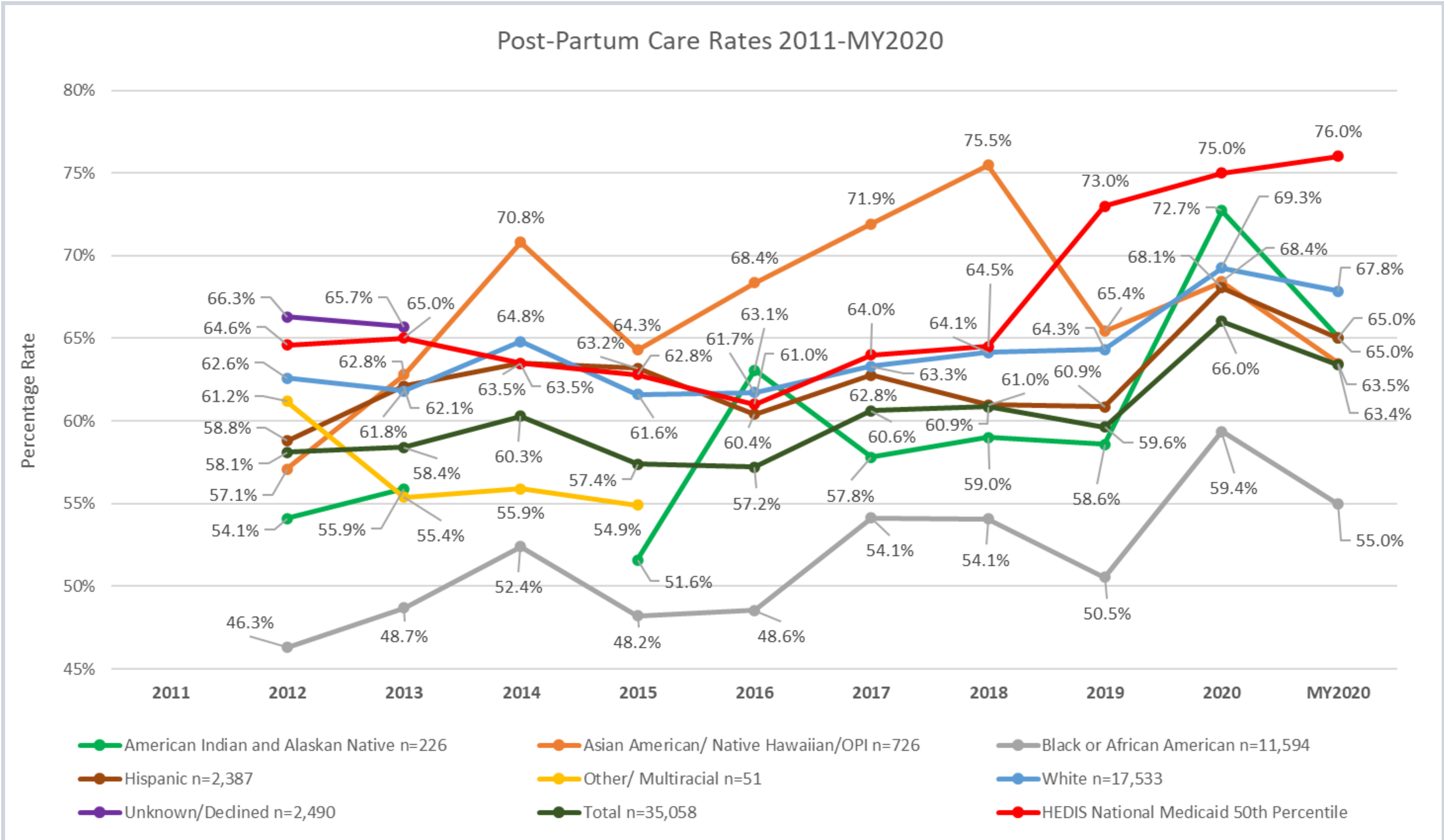


Figure 12. Post Partum Care 2011-MY2020.

Post Partum Care											
Race		**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**MY2020**
White	*Rate*		62.6%	61.8%	64.8%	61.6%	61.7%	63.3%	64.1%	64.3%	69.3%	67.8%
	Reference Population (RP)		RP	RP	RP	RP	RP	RP	RP	RP	RP	RP
American Indian / Alaskan Native	*Rate*		54.1%	55.9%	--	51.6%	63.1%	57.8%	59.0%	58.6%	72.7%	65.0%
	% Difference from RP		-8.5%	-5.9%	--	-10.0%	1.3%	-5.5%	-5.1%	-5.7%	3.5%	-2.8%
	Difference from RP		Below	Below	--	Below	NS	Below	Below	Below	NS	Below
Asian American / Native Hawaiian / Other Pacific Islander	*Rate*		57.1%	62.8%	70.8%	64.3%	68.4%	71.9%	75.5%	65.4%	68.4%	63.5%
	% Difference from RP		-5.5%	1.0%	6.0%	2.7%	6.6%	8.6%	11.3%	1.1%	-0.9%	-4.3%
	Difference from RP		Below	NS	NS	NS	NS	NS	NS	Above	Below	Below
Black / African American	*Rate*		46.3%	48.7%	52.4%	48.2%	48.6%	54.1%	54.1%	50.5%	59.4%	55.0%
	% Difference from RP		-16.3%	-13.1%	-12.4%	-13.4%	-13.2%	-9.2%	-10.1%	-13.8%	-9.9%	-12.9%
	Difference from RP		Below	Below	Below	Below	Below	Below	Below	Below	Below	Below

Race		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	MY2020
Hispanic	*Rate*		58.8%	62.1%	63.5%	63.2%	60.4%	62.7%	61.0%	60.9%	68.1%	65.0%
	% Difference from RP		-3.8%	0.3%	-1.3%	1.6%	-1.3%	-0.6%	-3.2%	-3.5%	-1.2%	-2.8%
	Difference from RP		Below	NS	Below	NS	Below	NS	Below	Below	Below	Below
Other / Multiracial*	*Rate*		61.2%	55.4%	55.9%	54.9%						
	% Difference from RP		-1.4%	-6.4%	-8.9%	-6.7%						
	Difference from RP		Below	Below	Below	Below						
Unknown / Declined**	*Rate*		66.3%	65.7%								
	% Difference from RP		3.7%	3.9%								
	Difference from RP		NS	NS								
Total	**Rate**		**58.1%**	**58.4%**	**60.3%**	**57.4%**	**57.2%**	**60.6%**	**60.8%**	**59.6%**	**66.0%**	**63.4%**

Table 12. Post Partum Care 2012- MY2020.

Rate= Numerator (number of people who received intervention)/ Denominator (number of people eligible to receive intervention); --= Population size not included due to small number; NS = Not significantly different than White reference population; Above/Below = Significantly higher/lower than White reference population.

Please note: Post-Partum Care was not collected in 2011 due to revisions in measure specifications by the NCQA.

*The Other/Multiracial category was not collected after 2014, due to the inconsistent use of this category across MHPs.

**Unknown/Declined was not collected after 2013. Those classified as unknown/declined were treated as missing data after that date.

Comprehensive Diabetes Care – HbA1C Testing

There has been an overall upward trend for most races, in line with the HEDIS 50th percentile trend. Most rates plateaued between 2019 and 2020 and fell in MY2020. Asian American/Native Hawaiian/OPI demonstrated higher rates than other races with a peak at 91.5% in 2018. American Indian/Alaskan Native showed the most inconsistent rates, with the lowest point at 76.8% in 2014 and the highest in 2017 at 90.1%, which fell to 82.7% in MY2020. Hispanic population consistently climbed throughout the years coming very close to the HEDIS 50th percentile rates and trend. The screening rates for the Black/African American population were the lowest, starting at 72.1% in 2011 and going to 76.5% in MY2020, after a consistent climb in rates, though still the lowest of all populations. The Black/African American population is the only population that performed statistically significantly worse than the White reference population for each year, with the Black/African American population performing far below the White reference population. In 2011, the HbA1C testing rate was 81.7% for the White population and 72.1% for the Black/African American population, representing a statistically significant disparity gap of -9.6%. Both populations saw increases in testing rates throughout the decade, and by 2020 the testing rate for the White population was 87.5% compared to 82.6% for the Black/African American population, with a reduced disparity gap of -4.9%. The Asian American/Native Hawaiian/OPI population did not exhibit any statistically significant disparities from the White reference population across the decade. The number of disparities remained relatively consistent across the decade, echoing the stagnant rates across the decade.

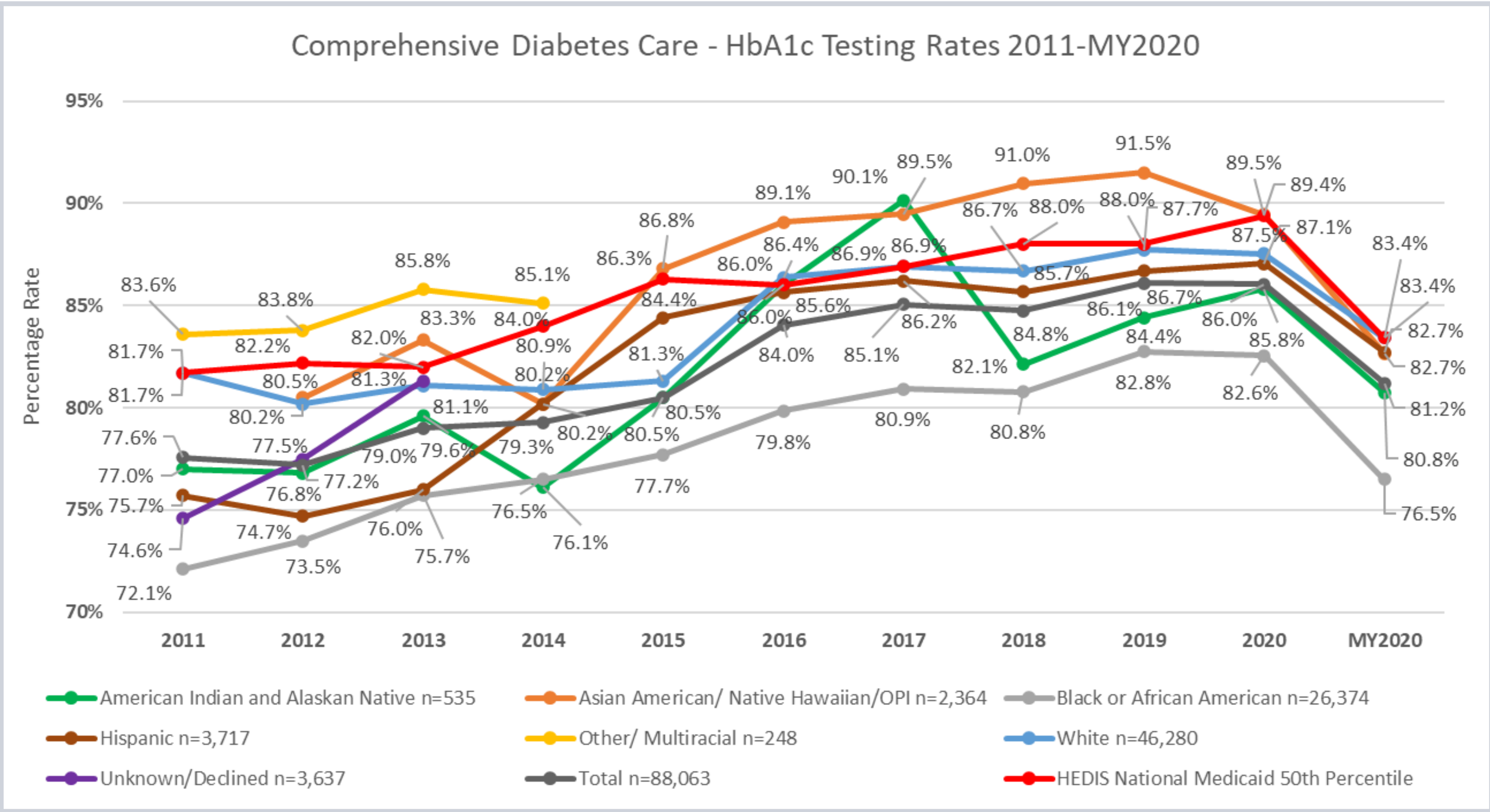


Figure 4. Comprehensive Diabetes Care -HbA1c Testing Rates 2011-MY2020.

Comprehensive Diabetes Care-HbA1c Testing												
Race		**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**MY2020**
White	*Rate*	81.7%	80.2%	81.1%	80.9%	81.3%	86.3%	86.9%	86.6%	87.7%	87.5%	83.4%
	Reference Population (RP)	RP	RP	RP	RP	RP	RP	RP	RP	RP	RP	RP
American Indian / Alaskan Native	*Rate*	77.0%	76.8%	79.6%	76.1%	80.5%	86.0%	90.1%	82.1%	84.4%	85.8%	80.7%
	% Difference from RP	-4.7%	-3.4%	-1.5%	-4.8%	-0.8%	-0.3%	3.2%	-4.5%	-3.3%	-1.7%	-2.6%
	Difference from RP	Below	NS	Below	Below	NS	NS	NS	Below	Below	Below	Below
Asian American / Native Hawaiian / Other Pacific Islander	*Rate*	--	80.5%	83.3%	80.2%	86.8%	89.0%	89.4%	90.9%	91.5%	89.4%	82.6%
	% Difference from RP	--	0.3%	2.2%	-0.7%	5.5%	2.7%	2.5%	4.2%	3.7%	1.9%	-0.7%
	Difference from RP	--	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Black / African American	*Rate*	72.1%	73.5%	75.7%	76.5%	77.7%	79.8%	80.9%	80.7%	82.7%	82.5%	76.5%
	% Difference from RP	-9.6%	-6.7%	-5.4%	-4.4%	-3.6%	-6.5%	-5.9%	-5.9%	-4.9%	-4.9%	-6.9%
	Difference from RP	Below	Below	Below	Below	Below	Below	Below	Below	Below	Below	Below

Race		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	MY2020
Hispanic	*Rate*	75.7%	74.7%	76.0%	80.2%	84.4%	85.6%	86.2%	85.6%	86.6%	87.0%	82.7%
	% Difference from RP	-6.0%	-5.5%	-5.1%	-0.7%	3.1%	-0.7%	-0.7%	-1.0%	-1.0%	-0.4%	-0.6%
	Difference from RP	Below	Below	Below	NS	NS	NS	NS	Below	Below	NS	NS
Other / Multiracial*	*Rate*	83.6%	83.8%	85.8%	85.1%							
	% Difference from RP	1.9%	3.6%	4.7%	4.2%							
	Difference from RP	NS	NS	NS	NS							
Unknown / Declined**	*Rate*	74.6%	77.5%	81.3%								
	% Difference from RP	-7.1%	-2.7%	0.2%								
	Difference from RP	Below	Below	NS								
Total	**Rate**	**77.5%**	**77.2%**	**79.0%**	**79.3%**	**80.5%**	**84.0%**	**85.0%**	**84.7%**	**86.0%**	**86.0%**	**81.2%**

Table 5. Comprehensive Diabetes Care – HbA1c Testing 2011-MY2020.

Rate= Numerator (number of people who received intervention)/ Denominator (number of people eligible to receive intervention); --= Population size not included due to small number; NS = Not significantly different than White reference population; Above/Below = Significantly higher/lower than White reference population.

*The Other/Multiracial category was not collected after 2014, due to the inconsistent use of this category across MHPs.

**Unknown/Declined was not collected after 203. Those classified as unknown/declined were treated as missing data after that date.

Comprehensive Diabetes Care- Eye Exams

Overall, diabetic eye exam rates increased between 2012 to 2020, for all populations, however, they saw a drastic fall for MY2020. Black/ African American populations consistently saw the lowest rates and the highest disparity from other populations. For example, in 2012, the White population had an exam rate of 47.2%, while the Black/African American population had a rate of 41.0%, representing a statistically significant -6.20% disparity gap. This disparity gap fluctuated throughout the 2012 – 2020 period, however, it remained statistically significant all the way through 2020 when the gap increased to -7.97%. American Indian and Alaskan Native saw an initial fall from 2012 through 2015, then remained on trend with the other populations as the rates climbed. With the remainder populations clustering around each other and the HEDIS 50th percentile.

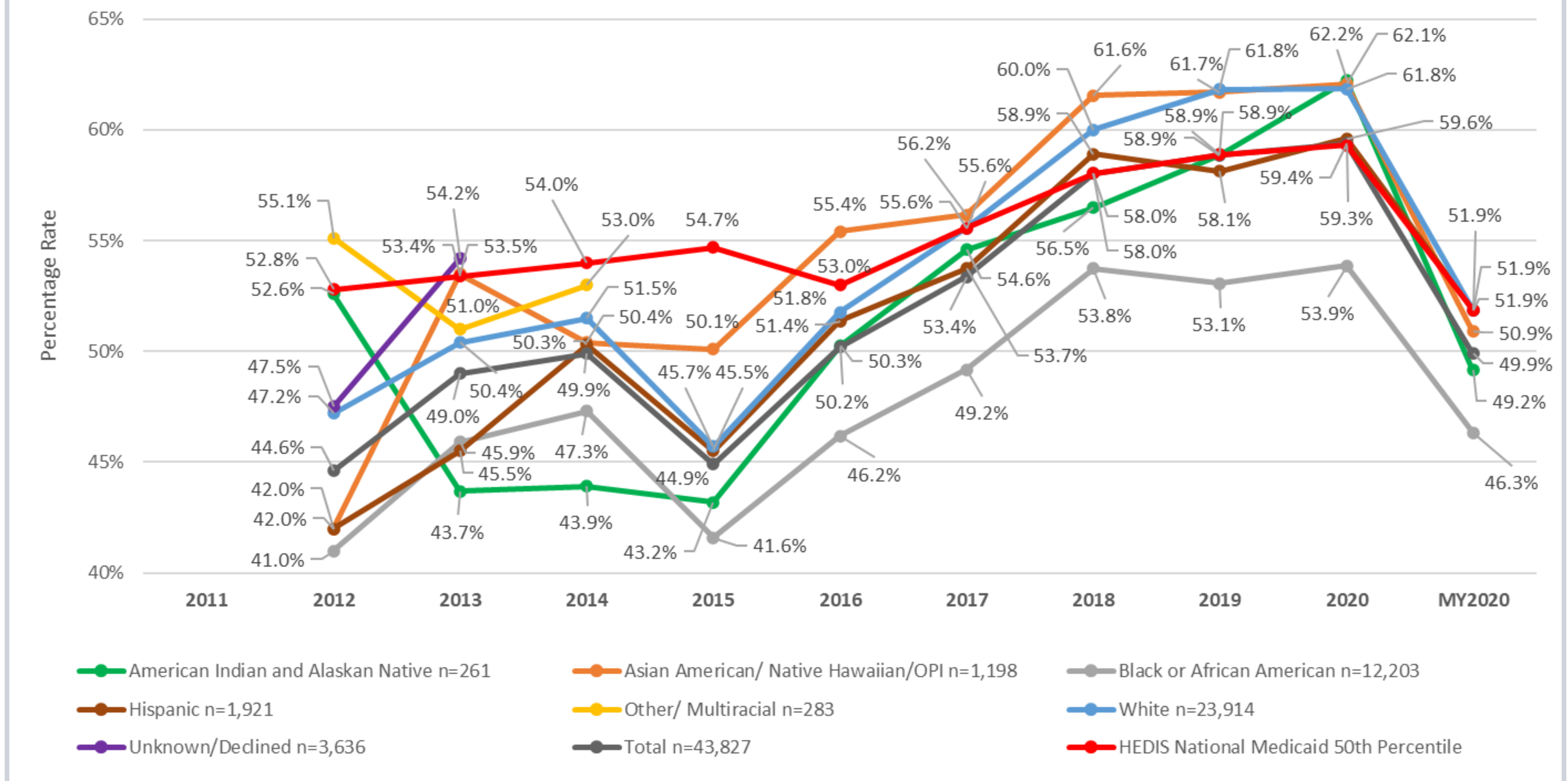


Figure 13. Comprehensive Diabetes Care – Eye Exam Rates 2011-MY2020.

Comprehensive Diabetes Care- Eye Exams												
Race		**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**MY2020**
White	*Rate*		47.2%	50.4%	51.5%	45.7%	51.8%	55.6%	60.0%	61.8%	61.8%	51.9%
	Reference Population (RP)		RP	RP	RP	RP	RP	RP	RP	RP	RP	RP
American Indian / Alaskan Native	*Rate*		52.6%	43.7%	43.9%	43.2%	50.3%	54.6%	56.5%	58.9%	62.2%	49.2%
	% Difference from RP		5.4%	-6.7%	-7.6%	-2.5%	-1.5%	-1.0%	-3.5%	-2.9%	0.4%	-4.7%
	Difference from RP		NS	Below	Below	Below	Below	Below	Below	Below	NS	Below
Asian American / Native Hawaiian / Other Pacific Islander	*Rate*		42.0%	53.5%	50.4%	50.1%	55.4%	56.2%	61.6%	61.7%	62.1%	50.9%
	% Difference from RP		-5.2%	3.1%	-1.1%	4.4%	3.6%	0.6%	1.6%	-0.1%	0.2%	-1.0%
	Difference from RP		Below	NS	Below	NS	NS	NS	NS	NS	NS	Below
Black / African American	*Rate*		41.0%	45.9%	47.3%	41.6%	46.2%	49.2%	53.8%	53.1%	53.9%	46.3%
	% Difference from RP		-6.2%	-5.0%	-4.2%	-4.1%	-5.6%	-6.4%	-6.2%	-8.8%	-8.0%	-5.6%
	Difference from RP		Below	Below	Below	Below	Below	Below	Below	Below	Below	Below

Race		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	MY2020
Hispanic	*Rate*		42.0%	45.5%	50.3%	45.5%	51.4%	53.7%	58.9%	58.1%	59.6%	51.9%
	% Difference from RP		-5.2%	-4.9%	-1.2%	-0.2%	-0.4%	-1.8%	-1.1%	-3.7%	-2.2%	0.0%
	Difference from RP		Below	Below	Below	NS	NS	Below	Below	Below	Below	NS
Other / Multiracial*	*Rate*		55.1%	51.0%	53.0%							
	% Difference from RP		7.9%	0.6%	1.5%							
	Difference from RP		NS	NS	NS							
Unknown / Declined**	*Rate*		47.5%	54.2%								
	% Difference from RP		0.3%	3.8%								
	Difference from RP		NS	NS								
Total	**Rate**		**44.6%**	**49.0%**	**49.9%**	**44.9%**	**50.2%**	**53.4%**	**58.0%**	**58.9%**	**59.4%**	**49.9%**

Table 13. Comprehensive Diabetes Care – Eye Exams 2012-MY2020.

Rate= Numerator (number of people who received intervention)/ Denominator (number of people eligible to receive intervention); --= Population size not included due to small number; NS = Not significantly different than White reference population; Above/Below = Significantly higher/lower than White reference population

Please note: Diabetic Eye Exam was not collected in 2011 due to revisions in measure specifications by the NCQA.

*The Other/Multiracial category was not collected after 2014, due to the inconsistent use of this category across MHPs.

**Unknown/Declined was not collected after 2013. Those classified as unknown/declined were treated as missing data after that date.

Comprehensive Diabetes Care– Medical Attention for Nephropathy

Diabetic Nephropathy: The screening rates for most populations were at an upward trend with a big rise in 2016 from the 70s and 80s to the 90th percentile area. After 2016, most stayed in the 80th percentile area. The screening rates for diabetic nephropathy showed improvement over the decade, with disparities narrowing among certain racial and ethnic groups. Although it was not statistically significant, the disparity gap between the White and Black/African American populations decreased between 2012 and 2020 from 1.30% to -0.11%, with screening rates for each population reaching almost 90% in 2020. American Indian/Alaskan Native individuals consistently demonstrate the highest rates, ranging from 78.60% to 93.00%, showing a slight fluctuation but generally high levels of diagnosis. Asian American, Hispanic, Black/African American, and White populations stayed clustered around each other throughout the decade. It should be noted that the collection of this measure ended in 2020 due to low-level disparity that had been demonstrated since the measurement year 2011.

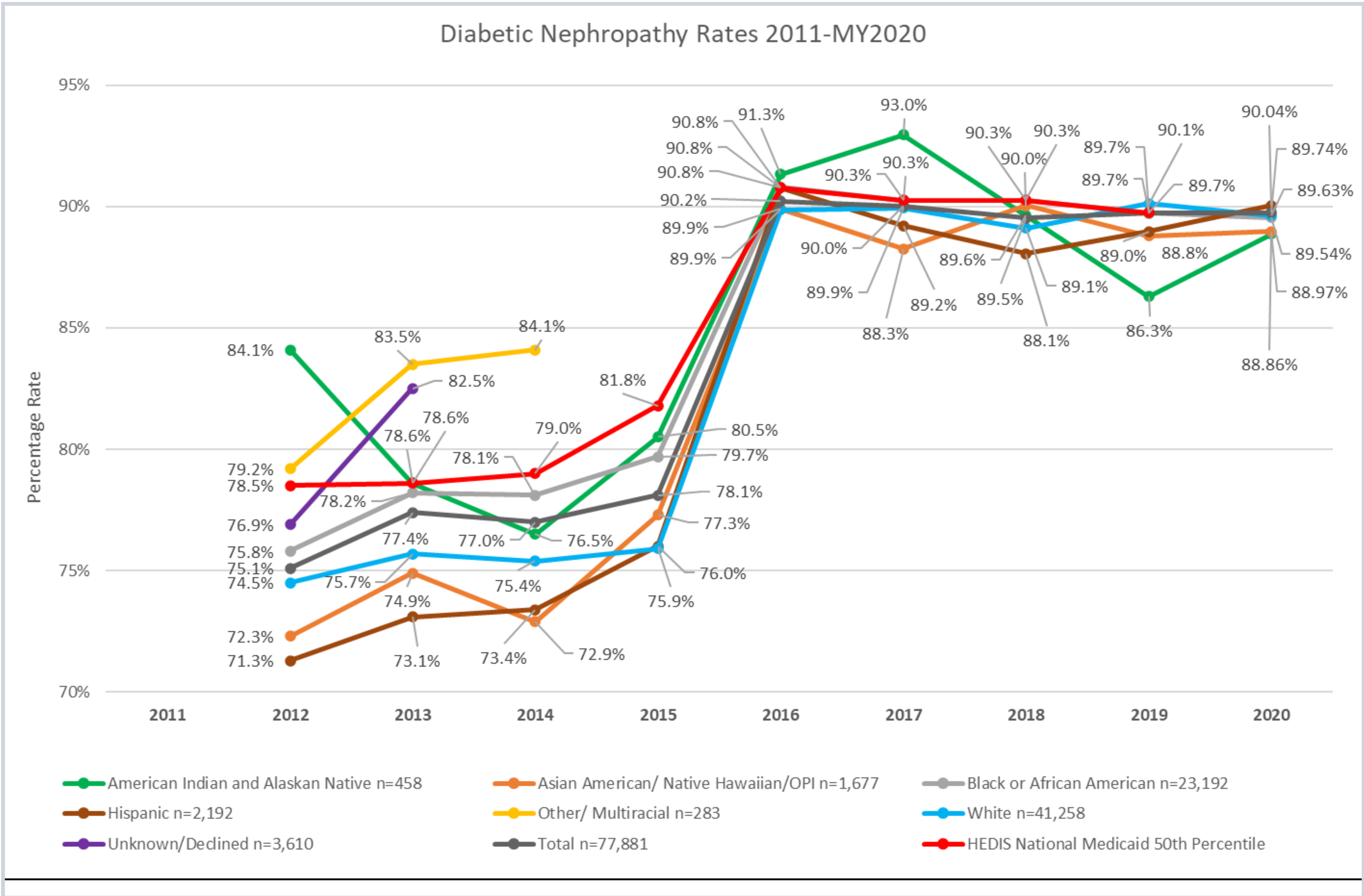


Figure 14. Comprehensive Diabetes Care- Nephropathy Rates 2011-2020.

Comprehensive Diabetes Care- Nephropathy 2011-2020 Rates											
Race		**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**MY2020**
White	*Rate*		74.5%	75.7%	75.4%	75.9%	89.9%	89.9%	89.1%	90.1%	89.6%	
	Reference Population (RP)		RP	RP	RP	RP	RP	RP	RP	RP	RP	
American Indian / Alaskan Native	*Rate*		84.1%	78.6%	76.5%	80.5%	91.3%	93.0%	89.6%	86.3%	88.9%	
	% Difference from RP		9.6%	2.9%	1.1%	4.6%	1.5%	3.0%	0.5%	-3.8%	-0.8%	
	Statistical Difference from RP		NS	NS	NS	NS	NS	NS	NS	Below	Below	
Asian American / Native Hawaiian / Other Pacific Islander	*Rate*		72.3%	74.9%	72.9%	77.3%	89.9%	88.3%	90.0%	88.8%	89.0%	
	% Difference from RP		-2.2%	-0.8%	-2.5%	1.4%	0.0%	-1.7%	0.9%	-1.3%	-0.7%	
	Statistical Difference from RP		Below	Below	Below	NS	NS	Below	NS	Below	Below	
Black / African American	*Rate*		75.8%	78.2%	78.1%	79.7%	90.8%	90.3%	90.3%	89.7%	89.5%	
	% Difference from RP		1.3%	2.5%	2.7%	3.8%	0.9%	0.3%	1.1%	-0.4%	-0.1%	
	Statistical Difference from RP		NS	NS	NS	NS	NS	NS	NS	NS	NS	

Race		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	MY2020
Hispanic	*Rate*		71.3%	73.1%	73.4%	76.0%	90.8%	89.2%	88.1%	89.0%	90.0%	
	% Difference from RP		-3.2%	-2.6%	-2.0%	-0.1%	0.9%	-0.7%	-1.1%	-1.2%	0.4%	
	Statistical Difference from RP		Below	Below	Below	NS	NS	NS	Below	Below	NS	
Other / Multiracial*	*Rate*		79.2%	83.5%	84.1%							
	% Difference from RP		4.7%	7.8%	8.7%							
	Statistical Difference from RP		NS	NS	NS							
Unknown / Declined**	*Rate*		76.9%	82.5%								
	% Difference from RP		2.4%	7.0%								
	Statistical Difference from RP		NS	NS								
Total	**Rate**		**75.1%**	**77.4%**	**77.0%**	**78.1%**	**90.2%**	**90.0%**	**89.5%**	**89.7%**	**89.6%**	

Table 14. Comprehensive Diabetes Care – Nephropathy 2011-2020.

Rate= Numerator (number of people who received intervention)/ Denominator (number of people eligible to receive intervention); --= Population size not included due to small number; NS = Not significantly different than White reference population; Above/Below = Significantly higher/lower than White reference population

Please note: Diabetic Nephropathy was included 2011 or MY2020.

*The Other/Multiracial category was not collected after 2014, due to the inconsistent use of this category across MHPs.

**Unknown/Declined was not collected after 2013. Those classified as unknown/declined were treated as missing data after that date.

Discussion

The overarching question driving this work was this: After over a decade of collection and reporting of racial/ethnic disparities in quality of care in Michigan Medicaid and emphasizing the reduction of disparities via contract language, financial incentives, and policy initiatives, what improvements can be seen? As disparities identification and reduction have been priorities for Michigan Medicaid for many years, the Medicaid agency has used program and policy levers to drive health plan innovation in developing interventions to address health disparities. Michigan Medicaid continues to prioritize health equity and Michigan Medicaid health plans continue to innovate to decrease disparities among racial/ethnic populations. This report highlights a small section of this work.

This report followed trends across select quality and access measures from 2011 through MY2020. There was a total of fourteen measures included in the analysis across the eleven years of this study, but not all measures were included in all years. Some measures were added in year 2 of the study, and some specifications changed over the course of the study period leading to them being phased out. Twelve measures were consistently included in the analysis for at least 10 years. For measurement year 2020 (MY2020), two measures, Children and Adolescents Access to PCP 25 Months-6 Years and Comprehensive Diabetes Care-Medical Attention for Nephropathy were removed; one measure, Well Child Visits 3-6 Years, was replaced by Child and Adolescent Well-Care Visits 3-11 years.

Throughout the ten-year period examined, the gaps between the White reference population and the other racial/ethnic groups varied in any given year. However, by examining the first and last year of the period, there were significant changes across all racial/ethnic groups in comparison to the White reference population. In Figure 16 below, for most racial and ethnic groups the disparity gap became smaller over time, however, for the Black/African American population, the disparity gap increased for a majority of measures. Please see Appendix E for a full list of measures performing better/worse.

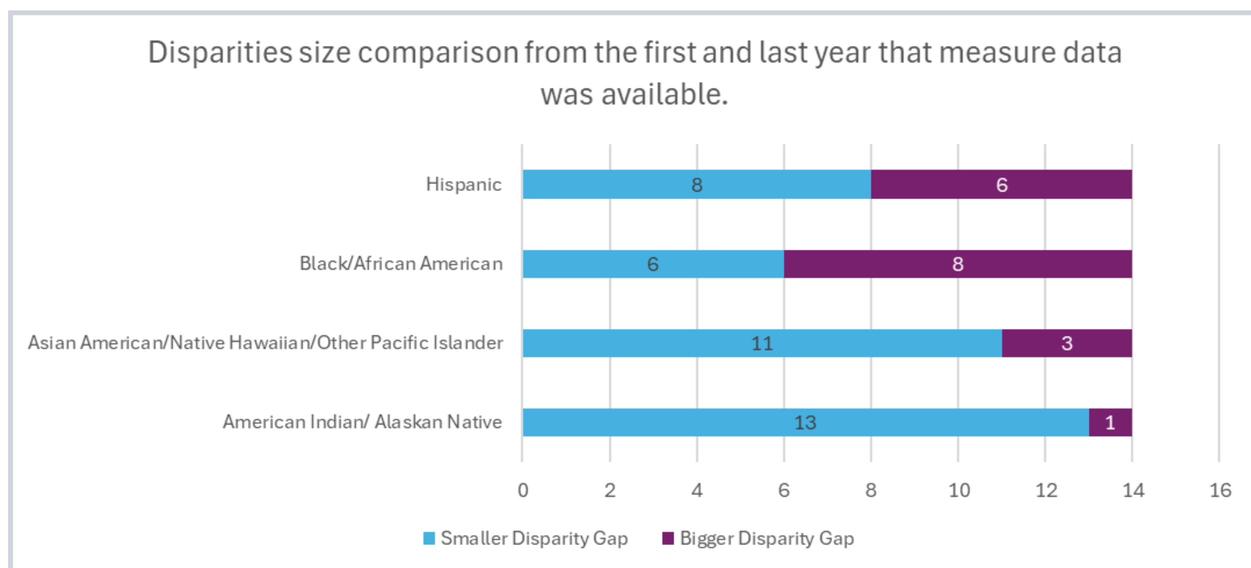


Figure 16. Disparities Size Comparison From The First and Last Year that Measure Data was Available

Successes:

- Post-Partum Care: smaller disparities across all racial/ethnic populations
- Comprehensive Diabetes Care- Medical Attention for Nephropathy: smaller disparities across all populations

Mixed:

- Immunizations for Adolescents: Smaller disparities present in all but Asian American/Native Hawaiian/OPI
- Breast Cancer Screening: Smaller disparities are present in all but the Hispanic population
- Chlamydia Screening in Women: Smaller disparities are present in all but the Hispanic population
- Comprehensive Diabetes Care- HbA1c Testing: Smaller disparities present in all but Asian American/Native Hawaiian/OPI
- Adult access to Preventive/Ambulatory Health Services (20-44 years): Smaller disparities present in all but African American Population
- Lead Screening in Children: Smaller disparities present in all but Asian American/Native Hawaiian/OPI
- Comprehensive Diabetes Care- Eye Exams: Smaller disparities present in all but African American Population

Opportunities:

- Childhood Access to Care (25 Months- 6 Years): Larger disparities are present in all but Asian American/Native Hawaiian/OPI populations.
- Cervical Cancer Screening: One-half of population groups have larger disparities present.
- Childhood Immunization Status- Combination 3: One-half of population groups have larger disparities present.
- Well Child Visits (3-6 years): One-half of population groups have larger disparities present.

The circumstances surrounding the data analysis in this report aim to fill in the bigger picture of Michigan's dive into disparities reduction over the past decade. Stakeholders highlighted the clear commitment MDHHS has made to equity and identified ways in which equity is ingrained in the way Michigan Medicaid does business. As leadership and staff changed over the past decade, the imperative to close the gap between racial and ethnic groups remains. Stakeholders noted the areas of interest for the state that shifted focus for the MHPs and Medicaid staff leading to the reduction of disparities in these areas. These interviews tie into the intentional focus highlighted in the Medicaid contracts throughout this time period as well.

The Medicaid contracts have included intentional focus and efforts to curb disparities including pay-for-performance measures focused on postpartum care and childhood immunizations. We can see these intentional efforts impacted all racial and ethnic groups in the case of post-partum care. Across the decade, all racial and ethnic populations saw a reduction in disparities in this measure. While disparities are still present in this area, the size of those disparities have been reduced. Childhood immunizations, however, present a bit more complicated of a story when combining the intentional effort made by staff and stakeholders and the data collected throughout this time period. Disparities reduction was noted for immunizations for adolescents in all but the Asian American/Pacific Islander/OPI population. However, for Childhood Immunizations- Combination 3, disparities were reduced for Asian American/Native Hawaiian/OPI and Native American/Alaskan Native population groups. African American and Hispanic groups saw an increase in disparities present for this measure. The complicating factors such as the COVID-19 pandemic greatly impacted the immunization efforts of MDHHS and MHPs during this decade. The intentional efforts put forth by MDHHS to highlight these two areas to work on through contracting and policy levers were noted many times by stakeholders throughout this work and led to impacts on racial and ethnic populations across the board.

As MDHHS moves forward in this work, the disparities that remain are not to be seen as a failure, but as a lesson that health equity cannot be achieved in a short period of time. The longstanding work of closing disparate gaps in health care not only is the work of health professionals and health plans across the state of Michigan but also relies on the work of health equity leaders to continue to dismantle the systemic barriers and oppressive nature of the health systems within the state. This work takes time, and Michigan has invested in doing so throughout the past decade. The “wins” highlighted in this report, and the disparities we’ve seen reduced are a testament to that work. The work, however, remains incomplete. Continued commitment to addressing disparities by MDHHS and the MHPs will be crucial in achieving health equity and improving individual outcomes for Medicaid enrollees in Michigan. Disparities work requires both MDHHS and the MHPs to invest in health equity across all social determinants of health as the state continues to move equity activities from checkbox activities, as evidenced in the MHP contracts and policies beginning in 2011 to more meaningful actions and core values as evidenced today in the policies and contracting requirements enacted.

Recommendations

- Continue to monitor health equity disparities within the Medicaid population in Michigan and publish the results.
- From the qualitative interviews there were many suggestions to take this assessment to Medicaid consumers and gauge what changes have been noticed on the ground and intake of services.
- Adapt the methodology to represent current statistical and methodological trends to "decenter" the White population and change the reference population to the racial/ethnic group that is currently performing the "best" on each measure.
- Engage stakeholders, specifically Medicaid Health Plans, in a comprehensive conversation about overall quality including a more detailed look into required initiatives and the success of contract requirements.
- Recommend a more robust evaluation of the impact of policy and contract requirements for post-partum care across all racial and ethnic groups to determine what efforts were most successful in the reduction of disparities across the populations. This would include conversations with MHPs to determine what strategies and programs were introduced to mitigate post-partum disparities.
- Conduct an evaluation that starts in MY2020 and ends in MY2024 specific to the pandemic and unwinding period to determine the effects of the COVID-19 pandemic on healthcare quality and health disparities.
- Create small populations report to report on disparities in populations not included in this decade of reports due to small population numbers leading to the exclusion of these groups.

Appendix A: Qualitative Interview Guide

10-Year Medicaid Retrospective Interview Guide

Introduction: We are conducting a retrospective look at health equity and efforts surrounding health disparities over the last 10 years within the Medicaid program. We would love to ask you some questions about your time within the Medicaid program and what thoughts you had regarding these efforts. The goal is to evaluate what programs have been successful at producing improvements, and conversely which programs might not have produced unintended outcomes. In addition, identifying industry-wide common programs that are consistently producing positive improvements.

Name:

Position while in Medicaid, or positions held over the last 10 years:

Time period/years worked in Medicaid:

Main Interview Questions

1. Tell us about your thoughts on efforts surrounding disparities and health equity within the Medicaid program and your time there.
2. In your opinion, what goals have been met over the last 10 years?
3. What important lessons do you think were learned over the decade?
4. What efforts do you think worked well? Please discuss what you think contributed to their positive impact.
5. Are there efforts that you think should continue into the next decade?
6. Looking back at your time within the Medicaid program, what efforts would you change and how so?
7. In what ways did the program produce or contribute to the intended outcomes in the short, and long term?
8. For whom, in what ways, and in what circumstances?
9. What unintended outcomes (positive and negative) were produced with health equity efforts?
10. To what extent can changes within the health equity space be attributed to the program?
11. How have you seen COVID-19 affect equity efforts?
12. What are your overall thoughts on equity within the Medicaid program?
13. What are your hopes for the next 10 years within the equity space of Medicaid?
14. What other individuals do you think would be good to contact to gather information on this topic?
15. Is there anything else you would like to share with us?

Appendix B:
Full Measure List and Descriptions

- Breast Cancer Screening: This measure assesses women 50-74 years of age who had at least one mammogram to screen for breast cancer in the past two years.
- Cervical Cancer Screening: This measure assesses women who were screened for cervical cancer using any of the following criteria:
  - Women 21-64 years of age who had cervical cytology performed in the last 3 years.
  - Women 30-64 years of age who had high-risk human papillomavirus testing performed within the last 5 years.
  - Women 30-64 years of age who had cervical cytology/high-risk human papillomavirus contesting within the last 5 years.
- Chlamydia Screening in Women: This measure assesses the percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
- Comprehensive Diabetes Care- HbA1c Testing: The percentage of members 18-75 years of age with diabetes (types 1 and 2) who an HbA1c test performed during the year.
- Childhood Immunization Status- Combination 3: This measure compiles the percentage of children 2 years of age who had Combination 3 vaccines by their second birthday. Combination 3 includes DTaP, IPV, MMR, HiB, HepB, VZV and PCV vaccinations.
- Appropriate Asthma Medications (Combined): The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.
- Child Access to Care (25 months- 6 years): This measure assesses the number of children within this age group who had a visit with their primary care practitioner during the measure year.
- Adult Access to Preventive/Ambulatory Health Services (20-44 years): The percentage of members 20 years and older who had an ambulatory or preventive care visit.
- Immunizations for Adolescents-Combination 1: This measure assesses adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series by their 13th birthday.

- Lead Screening in Children: The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.
- Well Child Visits (3-6 years): This measure assesses the percentage of members 3-6 years of age who had one or more well-child visits with a primary care practitioner during the measurement year.
- Post-Partum Care: The percentage of deliveries in which women had a post-partum visit on or between 7 and 84 days after delivery.
- Comprehensive Diabetes Care- Eye Exams: The percentage of members 18-75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.
- Comprehensive Diabetes Care-Medical Attention for Nephropathy: The percentage of members who had a nephropathy screening or monitoring test during the measurement year or evidence of nephropathy during the measurement year.

Appendix C: P4P Bonuses related to health equity from 2010–2023 in Michigan

Year	Performance Bonuses Tied to Health Equity
2010[19]	No mention of health equity
2011[20]	No mention of health equity
2012[21]	No mention of health equity
2013[22]	2013 DCH P4P Bonus Healthcare for a Diverse Membership: 1. Race/Ethnicity (R/E) and preferred language data collection reporting (MHP fully and accurately reports the following on the HEDIS IDSS): a. Race/Ethnicity Diversity of Membership (RDM) b. Language Diversity of Membership (LDM) 2. Provider Network (MHP collects and reports on race/ethnicity/language (R/E/L) proficiency for network providers. a. MHP publishes practitioner language information in the provider directory for all PCPs and Specialists b. MHP notifies network providers (incl. hospitals) at least annually, that written and spoken language services are available to members in any setting (ambulatory, inpatient, and outpatient). (Based on Section H of the current MHP contract, Enrollee Services) c. MHP collects and reports on the number of members requesting and number of members receiving language translation/interpretation services for the 6 month period 1/1/2013-6/30/2013 3. Health Equity (MHP submits HEDIS data broken down by R/E to DCH for specified measures
2014[23]	No mention of health equity
2015[24]	No mention of health equity
2016[25]	2016 Pay for Performance on Population Health and Health Equity The purpose of the 2016 P4P is to promote health equity and reduce R/E disparities among the MI Medicaid managed care population and will focus on five specific areas: 1. Medicaid Health Equity: MHPs will implement a health equity program and complete an annual Medicaid Health Equity Project template. DHHS will monitor efforts to reduce R/E disparities in two selected HEDIS measures (Postpartum Care & Childhood Immunizations Status – Combination 3). 2. Chlamydia Screening (CHL): MHPs will describe and implement programs/efforts to improve screening and treatment rates, and narrow any health disparities in their population due to sex or R/E. This project will target CHL screening for men ages 16-18 and women ages 16 -24 years as well as CHL screening rates by R/E. 3. Population Health Management: MHPs will implement a Population Health Management program, a Community Health Worker (CHW) program and other procedures to address SDOH for their members. 4. Non-Emergent Medical Transportation (NEMT) 5. Tobacco Cessation

2017[26]	2017 Pay for Performance on Population Health and Health Equity The purpose of the 2017 P4P is to continue to promote health equity and efforts to reduce R/E disparities among the MI Medicaid managed care population and will focus on three specific areas: 1. Medicaid Health Equity: MHPs will implement a health equity program and complete an annual Medicaid Health Equity Project template. MDHHS will monitor efforts to reduce R/E disparities in two selected HEDIS measures (Postpartum Care & Childhood Immunizations Status – Combination 3). 2. Chlamydia Screening: MHPs will describe and implement programs/efforts to improve screening and treatment rates and narrow any health disparities in their population due to sex or R/E. This project will target CHL screening for men ages 16-18 and women ages 16 -24 years as well as CHL screening rates by R/E. 3. Population Health Management: MHPs will implement a Population Health Management program and other procedures to address SDOH for their members.
2018[27]	2018 Pay for Performance on Population Health Management: MHPs will implement a Population Health Management program and other procedures to address SDOH for their members. MHPs must submit 1. Population Health Management Approaches 2. Population Health Management Intervention 3. Community Collaboration Projects 2018 Pay for Performance on Health Equity: MHPs will implement a health equity program. MDHHS will monitor efforts to reduce R/E disparities in the five HEDIS measures listed below. The goal is for all of the measures to have an Index of Disparity less than 5% for the MI Medicaid managed care population. 1. Childhood Immunization Status Combo 3 2. Postpartum Care 3. Chlamydia (CHL) Screening in Women 4. Child Access to Care (25 months to 6 years) 5. Adult Access to Care (20-44 years) FY18 Performance Bonus - Integration of Behavioral Health and Physical Health Services 1. Implementation of Joint Care Management Processes 2. Follow-up After Hospitalizations for Mental Illness within 30 Days (FUH)

2019[28]	2019 Pay for Performance Population Health Management Intervention The purpose of the 2019 P4P is to improve the health of the MI Medicaid population and address SDOH. MHPs annually report their initiatives to MDHHS. 1. Low Birth Weight (LBW) Project: MCPD is launching this multi-year statewide P4P initiative to align MDHHS efforts to promote health equity in maternity care and infant care. For FY2018, the goal is to involve the MHPs, existing home visiting programs, and CHW programs to design and implement a meaningful P4P project. The evidence-based intervention will utilize a three-prong approach: preconception, timeliness of prenatal care, postpartum care. 2. Emergency Department (ED) Utilization: For the next three fiscal years, the ED utilization Focus Bonus will concentrate on one of the three topics to lower inappropriate ED utilization in the MI Medicaid Managed Care population. These topics include: A) integration with behavioral health, B) substance use disorder treatment, or C) dental services. FY19 Performance Bonus - Integration of Behavioral Health and Physical Health Services 1. Implementation of Joint Care Management Processes 2. Follow-up After Hospitalizations for Mental Illness within 30 Days (FUH) 3. Plan All-cause Readmission (PCR) 4. Follow-up After ED Visit for Alcohol and Other Drug Dependence (FUA) FY19 Performance Bonus Measures Template – Plan-Specific Health Equity Measures (Two per Plan) 1. Comprehensive Diabetes Care (HbA1c Testing) 2. Cervical Cancer Screening 3. Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life 4. Prenatal and Postpartum Care – Postpartum Care 5. Chlamydia Screening
2020[29]	(Same as FY 2019)

2021[30]	2021 Focus Bonus - Low Birth Weight (LBW) Project The purpose of the LBW project model will be to encourage active participation by using data analysis to identify partnerships and risk factors associated with LBW (including social determinants of health). The evidence-based intervention will utilize a three-prong approach: preconception, timeliness of prenatal care, post-partum care Population Health Management (PHM) focusing on Social Determinants of Health (SDoH) and Behavioral Health (BH) To address the economic impact of COVID-19 and continue to meet the growing needs of MI Medicaid beneficiaries, MDHHS is requesting the health plans to broaden and expand their focus on SDOH and BH. The MHP requirements for this program are: 1. Complete the MDHHS designed template and receive approval for their program, which includes: Needs assessment, Referral process, Community partnerships and Data collection. The MHPs must also address all the focus areas in their program: a. SDOH: Food insecurity, Housing, Utility assistance, and Employment, education, and training b. BH: Stress, Depression, and Anxiety FY21 Performance Bonus - Integration of Behavioral Health and Physical Health Services 1. Implementation of Joint Care Management Processes 2. Follow-up After Hospitalizations for Mental Illness within 30 Days (FUH) 3. Follow-up After ED Visit for Alcohol and Other Drug Dependence (FUA)
2022[31]	FY22 Performance Bonus Template included: • HEDIS Measures: Adults' access to preventive/ambulatory health services; Asthma medication ratio; controlling high blood pressure; comprehensive diabetes control – eye exam; lead screening in children; children immunization combo 3; chlamydia screening in women; prenatal and postpartum care; well child visits in first 30 months. • Health Equity Scoring – 1 point for statistically significant improvement in rate disparity between African American and White beneficiaries, and 1 point for statistically significant improvement in rate disparity between Hispanic and White beneficiaries (for HEDIS measures mentioned above) • Low Birth Weight • Lesbian, Bisexual, Transgender, Queer/Questioning (LGBTQ+) Care Quality Population Health Management (PHM) focusing on Social Determinants of Health (SDoH) and Behavioral Health (BH) • Focus on the same SDoH/BH areas and target populations & subgroups • Broaden stratification of data by race/ethnicity, region, age, gender, etc. FY22 Performance Bonus - Integration of Behavioral Health and Physical Health Services 1. Implementation of Joint Care Management Processes 2. Follow-up After Hospitalizations for Mental Illness within 30 Days (FUH) 3. Follow-up After ED Visit for Alcohol and Other Drug Dependence

2023[32]	FY23 Performance Bonus Template included: • HEDIS Measures: Adults' access to preventive/ambulatory health services; Asthma medication ratio; controlling high blood pressure; eye exam for patients with diabetes; lead screening in children; children immunization combo 3; chlamydia screening in women; prenatal and postpartum care; well child visits in first 30 months; kidney health evaluation for patients with diabetes. • Health Equity Scoring – 1 point for statistically significant improvement in rate disparity between African American and White beneficiaries, and 1 point for statistically significant improvement in rate disparity between Hispanic and White beneficiaries (for HEDIS measures mentioned above) • Low Birth Weight • Lesbian, Bisexual, Transgender, Queer/Questioning (LGBTQ+) Care Quality Population Health Management (PHM) For FY23, the health plans will complete a spreadsheet created by MDHHS with their CY21 screening and referral data. • Also in FY23, MDHHS is introducing a new measure performance component to Appendix 5C to garner contextual analysis (i.e. societal, cultural, economic, etc.) from the health plans related to barriers improving rates for the following measures: Low Birth Weight (LBW) and Childhood Immunizations-Combo 3. • Also in FY23, the health plans will provide a flow chart and process explanation for how the plan to coordinate high-risk pregnant women of color to reduce the likelihood for LBW and congenital syphilis. FY23 Performance Bonus - Integration of Behavioral Health and Physical Health Services 1. Implementation of Joint Care Management Processes 2. Follow-up After Hospitalizations for Mental Illness within 30 Days (FUH) 3. Follow-up After ED Visit for Alcohol and Other Drug Dependence

Appendix D: Policies and State Priorities related to health equity from 2010-2023

Please note, this is not an exhaustive list of policies implemented during that period but represents those most likely to have an impact on disparities. Entries in italics represent notable progress towards improving health equity but may not have been associated with an official policy.

Policy	Bulletin Link
2010	
Medicaid Health Equity Project begins conversations internally at Medicaid and externally with MHPs	
Maternal Infant Health Program Policy changes: • Use Maternal Risk Identifier & new Infant Risk Identifier to determine needed services; • Require that all MIHP beneficiaries be referred to a local WIC Program; and • Require a maternal home visit, or documentation why the visit could not be done.	MSA 10-18
Medicaid Eligibility Reviews at Closure – (Effective July 1, 2010) Individuals who are no longer eligible for Medicaid under the category in which they currently receive coverage, will be reviewed for eligibility in the other Medicaid categories before the individual's current Medicaid coverage ends.	MSA 10-19
2011	
Health Disparities data are collected from MHPs and analysis is completed	
2012	
Medicaid Health Equity Project Year 1 report is published, reports are published annually. CSHCS is rolled into managed care as a mandatory population.	
Enrollment of Children's Special Health Care Services (CSHCS)/Medicaid (MA) Beneficiaries into Medicaid Health Plans (MHP)	MSA 12-46

2013	
Affordable Care Act (ACA) Changes for Medicaid – In compliance with the ACA, the eligibility process will change from the current method to a new method identified as a Modified Adjusted Gross Income (MAGI) methodology.	MSA 13-35
Telemedicine – (Effective October 1, 2013) There are no distance requirements between the originating and distant site when providing telemedicine services for Fee-For-Service (FFS) Medicaid beneficiaries.	MSA 13-34
2014	
MI Health Link Program – (Effective March 1, 2015) This program will integrate into a single coordinated delivery system all physical health care, pharmacy, long term supports and services, and behavioral health care for individuals who are dually eligible for full Medicare and full Medicaid.	MSA 14-57
Expansion of Breast Pump Policy	MSA 14-60
Healthy Michigan Plan/Medicaid Expansion – The Healthy Michigan Plan (HMP) is a new category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan Public Act 107 of 2013 that will begin April 1, 2014. The benefit design of HMP ensures beneficiary access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors.	MSA 14-11
Phase-Out of the Plan First! Family Planning Waiver – Plan First! is Michigan's Section 1115 Demonstration Waiver for family planning services. Under the ACA, women currently enrolled in Plan First! must apply for comprehensive healthcare coverage under HMP or through other options on the Federally Facilitated Marketplace	MSA 14-12
2015	
Medicaid Agency publishes RFP for health plan contract rebid. Rebid includes CHW services to be provided my MHPs.	
MIChild Transition to Medicaid Expansion – MDHHS is converting the MIChild program to a Medicaid expansion program. Although individuals will be enrolled in a Medicaid expansion program as a result of this policy, the program will continue to be referred to as the MIChild program. All Medicaid coverages and conditions will apply in accordance with current Medicaid policy. Children currently enrolled in MIChild will transition from their current health plan to an MHP.	MSA 15-51

Enrollment of Psychologists, Social Workers, and Professional Counselors as Medicaid Providers – In order to provide greater access to care for behavioral health services, MDHHS will begin enrolling Psychologists, Social Workers, and Professional Counselors as Medicaid providers. Fee-for-Service outpatient behavioral health visits will be increased from 10 to a maximum of 20 combined visits in a 12-month period, per beneficiary, by all providers of behavioral health services.	MSA 15-44
2016	
New Medicaid Health Plan contract begins. Includes a set ratio for CHWs. Flint waiver is approved for expanded Medicaid for those impacted by Flint Water Crisis.	
Coverage of Trauma Services for Children Under 21 Years of Age	MSA 16-46
MI Care Team Implementation (Primary Care Health Home Benefit) – (Effective July 1, 2016) MDHHS will implement a new care management and care coordination primary care Health Home benefit called the MI Care Team. The goals of the program are to ensure seamless transitions of care and to connect eligible beneficiaries with needed clinical and social services. MDHHS expects the benefit will enhance patient outcomes and quality of care, while simultaneously shifting people from EDs and hospitals to a primary care setting.	MSA 16-13
Flint Water Group Medical Assistance – Through an approved Section 1115 Demonstration Waiver and related State Plan Amendments, MDHHS will offer a new Medicaid eligibility category referred to as the Flint Water Group (FWG). Eligibility for the FWG will be determined using the MAGI methodology. FWG eligibility is limited to pregnant women and children up to age 21 with household income up to and including 400% of the federal poverty level (FPL) who were served by the Flint water system on or between April 1, 2014, and the date the water is deemed safe by the appropriate authorities.	MSA 16-11
Coverage of Targeted Case Management Services for Beneficiaries Who Were Served by the Flint Water System	MSA 16-10
Medicaid Coverage of Lactation Support Services	MSA 15-46
2017	
Outpatient Behavioral Health Visits - (Effective October 1, 2017) In order to provide greater access and to support coordination of care for behavioral health services, MDHHS will remove the 20-visit maximum limitation for outpatient behavioral health services (psychotherapy services). The restriction is lifted for Fee-for-Service and MHP beneficiaries.	MSA 17-27
Family Planning Services for Maternity Outpatient Medical Services (MOMS) Program Enrollees	MSA 16-47

2018	
Opioid Health Home Pilot Program – (Effective October 1, 2018) Pursuant to the requirements of Section 2703 of the Patient Protection and Affordable Care Act and the State Plan and Alternative Benefit Plan Amendments, the purpose of this policy is to provide for the coverage and reimbursement of Opioid Health Home services. The policy applies to Fee-for-Service (FFS) and managed care beneficiaries enrolled in Medicaid, HMP, or MIChild who meet Opioid Health Home eligibility criteria.	MSA 18-27
Inpatient Long-Acting Reversible Contraception (LARC) Reimbursement	MSA 18-22
Expanded Access to Dental Benefits for Pregnant Women	MSA 18-18
2019	
HMP Updates & Changes - Work Requirements: Proposed changes requiring 80 hours of work per month for beneficiaries between 19-62 years of age. (Ultimately not adopted)	MSA 19-35
2020*	
COVID-19 Response: Coverage of COVID-19 Vaccine Services	MSA 20-75
COVID-19 Response: Suspending All Medicaid Renewals	MSA 20-37
Expansion of Behavioral Health Homes (BHH) and Opioid Health Homes	MSA 20-48 MSA 20-31
COVID-19 Response: CSHCS Eligibility and Renewal Requirements	MSA 20-24
COVID-19 Response: Suspending all Medicaid Closures	MSA 20-19
COVID-19 Response: Telemedicine Policy Expansion	MSA 20-13
**There were many additional policies implemented in response to the COVID-19 pandemic, this does not constitute an exhaustive list.*	

2021	
Coverage of Gender Affirmation Services	MSA 21-28
Certified Community Behavioral Health Clinic (CCBHC) Demonstration sites will provide a robust set of coordinated, integrated, and comprehensive services to all persons with any mental illness or substance use disorder (SUD) diagnosis.	MSA 21-34
COVID-19 Response: Suspending Periodic Income Reviews for CSHCS Beneficiaries	MSA 21-12
Opioid Health Home (OHH) Expansion	MSA 21-25
Fee-for-Service Coverage of Alcohol Use Disorder & Opioid Use Disorder Treatment	MSA 21-19
COVID-19 Response: CSHCS Coverage of COVID-19 Vaccine Services & FDA Emergency Use Authorization Drugs, Devices, & Biological Products for COVID-19 Prevention & Treatment	MSA 21-07
2022	
Expansion of Opioid Heath Homes and Behavioral Health Homes	MMP 22-27 HASA 22-09
CSHCS Eligibility for Adults over 21 Years of Age - Sickle Cell	HASA 22-14
Update of Blood Lead Reference Value (BLRV) and Recommendations on the Medical Management of Childhood Lead Exposure	HASA 22-11
Postpartum Extension from 60 Days to 12 Months	HASA 22-08

2023	
Medicaid Coverage of CHW/CHR Services	MMP 23-74
Continuous Eligibility for Medicaid and MIChild for Children Under 19 Years of Age	MMP 23-73
Targeted Case Management Services for Recently Incarcerated Beneficiaries - Targeted case management (TCM) services are part of a comprehensive health benefit available to individuals with chronic or complex physical or behavioral health care needs and were recently released from an incarcerated setting.	MMP 23-37
Plan First Family Planning Program (Implementation of this policy is contingent upon approval of a State Plan Amendment by CMS)	MMP 23-36
Michigan Diabetes Prevention Program (MiDPP) - MiDPP is an evidence-based program based on the CDC Diabetes Prevention Program. It is a unique Medicaid preventive benefit that provides a formal behavioral modification approach to preventing type 2 diabetes.	MMP 23-33
Resuming Renewals for all Medicaid Programs	MMP 23-29
Repealing the Suspension of Medicaid Closures	MMP 23-30
Maternal Infant Health Program Telehealth – (Effective May 12, 2023) MIHP agencies will be allowed to provide up to 40% of all professional visits across the total agency caseload via telehealth. At least 60% of all professional visits across the total agency caseload must be provided in person.	MMP 23-17
End of Federal Public Health Emergency & Unwinding of COVID-19 Response Policies	MMP 23-27
Flint Family Supports Coordination Policy Extends Post-Delivery Coverage to 12 Months	MMP 23-15
Behavioral Health Home (BHH) Expansion	MMP 23-16
Medicaid Coverage of Services Performed by Behavioral Health Program Graduates – (Effective February 4, 2023) Medicaid will cover and reimburse outpatient behavioral health services provided by graduates of a board-approved master's or doctoral-level psychology, social work, counseling, or marriage and family therapy educational training program who have completed all the requirements for a limited or temporary license as specified in the applicable licensing rules but have not obtained the license from the Michigan Department of Licensing and Regulatory Affairs (LARA).	MMP 23-02

Appendix E: List of Measures Performing Better/Worse for Last Year of Measurement

Race/ Ethnicity	American Indian/ Alaskan Native		Asian American/ Native Hawaiian/ Other Pacific Islander		Black/ African American		Hispanic	
	First Year	Last Year	First Year	Last Year	First Year	Last Year	First Year	Last Year
Breast Cancer Screening	-8.2%	-5.3%	-5.2%	0.7%	-4.4%	-3.1%	-0.6%	2.3%
Cervical Cancer Screening	-8.6%	0.7%	-24.4%	4.6%	0.8%	3.6%	2.2%	4.%
Chlamydia Screening in Women-Total	-6.6%	5.1%	-17.8%	10.1%	18.4%	16.1%	6.4%	7.8%
HbA1c Testing	-4.7%	-1.7%	0.3%	1.9%	-9.6%	-4.9%	-6.0%	-0.4%
Child Immunization Combination 3	-0.7%	-0.0%	9.0%	0.2%	-10.1%	-12.8%	1.3%	4.2%
Appropriate Asthma Meds (Combined)	8.5%	-1.8%	11.5%	2.7%	-3.1%	-5.7%	0.7%	5.4%
Child Access to Care (25 months to 6 years)	-1.5%	-4.4%	-2.1%	-1.6%	-5.9%	-10.6%	-0.8%	-0.8%
Adult Access to Care (20 to 44 years)	4.7%	1.6%	-6.6%	2.4%	-6.2%	-7.6%	-3.8%	-2.2%
Adolescents Immunizations for Combo 1	6.9%	0.0%	0.5%	-1.1%	-2.2%	-0.4%	6.1%	5.8%
Blood Lead Screening	6.9%	-4.6%	5.3%	0.0%	2.1%	-3.8%	8.7%	4.1%
Well Child Visits 3-6 years	-7.7%	-2.4%	4.1%	4.7%	-1.6%	-6.1%	2.5%	0.6%
Postpartum Care	-8.5%	3.4%	-5.5%	-0.8%	-16.3%	-9.9%	-3.8%	-1.2%
Diabetes Eye Exam	5.4%	0.3%	-5.2%	0.2%	-6.2%	-7.9%	-5.2%	-2.2%
Diabetic Nephropathy	9.6%	-3.8%	-2.2%	-1.3%	1.3%	-0.3%	-3.2%	-1.1%

Appendix F: Years of Reports and its corresponding Measurement Year Data.

Year of the Report Shown on Graphs	Year of Measurement Data
2011	**2010**
2012	**2011**
2013	**2012**
2014	**2013**
2015	**2014**
2016	**2015**
2017	**2016**
2018	**2017**
2019	**2018**
2020	**2019**
MY2020	**2020**

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Michigan Medicaid
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2012-2022