STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

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April 2, 2018

Jennifer Kostesich, Project Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Dear Ms. Kostesich,

Re: Project Number 11-W-00245/5 – Healthy Michigan Plan

Enclosed is the 2017 annual report for Healthy Michigan Plan. The report provides operational information, program enrollment, and policy changes related to the waiver as specified in the Special Terms and Conditions.

Should you have any questions related to the information contained in this report, please contact Jacqueline Coleman by phone at (517) 284-1190, or by e-mail at colemanj@michigan.gov.

Sincerely,

Penny Rutledge, Director
Actuarial Division

cc: Ruth Hughes
Angela Garner

Enclosure (12)

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Healthy Michigan Demonstration

Section 1115 Annual Report

Demonstration Year: 8 (01/01/2017 – 12/31/2017)

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Introduction

On April 1, 2014, Michigan expanded its Medicaid program to include adults with income up to 133 percent of the Federal Poverty Level (FPL). To accompany this expansion, the Michigan Adult Benefits Waiver (ABW) was amended and transformed to establish the Healthy Michigan Plan, through which the Michigan Department of Health & Human Services (MDHHS) will test innovative approaches to beneficiary cost sharing and financial responsibility for health care for the new adult eligibility group. Organized service delivery systems will be utilized to improve coherence and overall program efficiency. The overarching themes used in the benefit design are increasing access to quality health care, encouraging the utilization of high-value services, and promoting beneficiary adoption of healthy behaviors and using evidence-based practice initiatives. The Healthy Michigan Plan provides a full health care benefit package as required under the Affordable Care Act including all of the Essential Health Benefits as required by federal law and regulation. The new adult population with incomes above 100 percent of the FPL are required to make contributions toward the cost of their health care. In addition, all newly eligible adults from 0 to 133 percent of the FPL are subject to copayments consistent with federal regulations.

State law requires MDHHS to partner with the Michigan Department of Treasury to garnish state tax returns and lottery winnings for members consistently failing to meet payment obligations associated with the Healthy Michigan Plan. Prior to the initiation of the garnishment process, members are notified in writing of payment obligations and rights to a review. Debts associated with the MI Health Account are not reported to credit reporting agencies. Members non-compliant with cost-sharing requirements do not face loss of eligibility, denial of enrollment in a health plan, or denial of services.

On December 17, 2015, CMS approved the state's request to amend the Healthy Michigan Section 1115 Demonstration to implement requirements of state law (MCL 400.105d(20)). With this approval, non-medically frail individuals above 100 percent of the FPL with 48 cumulative months of Healthy Michigan Plan coverage will have the choice of one of two coverage options:

1. Select a Qualified Health Plan offered on the Federal Marketplace. These individuals will pay premiums but can enroll in the Healthy Michigan Plan when a healthy behavior requirement is met; or

2. Remain in the Healthy Michigan Plan with increased cost-sharing and contribution obligations. These individuals are also required to meet a healthy behavior requirement.

MDHHS's goals in the demonstration are to:

- Improve access to healthcare for uninsured or underinsured low-income Michigan citizens;
- Improve the quality of healthcare services delivered;
- Reduce uncompensated care;
- Encourage individuals to seek preventive care and encourage the adoption of healthy behaviors;
- Help uninsured or underinsured individuals manage their health care issues;
- Encourage quality, continuity, and appropriate medical care; and

- Study the effects of a demonstration model that infuses market-driven principles into a public healthcare insurance program by examining:
    - The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;
    - The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
    - Whether the availability of affordable health insurance, which provides coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes; and
    - The extent to which beneficiaries feel that the Healthy Michigan Plan has a positive impact on personal health outcomes and financial well-being.

Enrollment and Benefits Information

MDHHS began enrolling new beneficiaries into the program beginning April 1, 2014. Beneficiaries who were enrolled in the ABW were automatically transitioned into the Healthy Michigan Plan effective April 1, 2014. Potential enrollees can apply for the program via the MDHHS website, by calling a toll-free number or by visiting their local MDHHS office. At this time, MDHHS does not anticipate any changes in the population served or the benefits offered. The following tables display new enrollments and disenrollments by month:

Table 1: Healthy Michigan Plan Enrollment Activity January 2017 – December 2017			
Month	Enrollment	New Enrollment	Disenrollment
January 2017	682,491	42,536	28,179
February 2017	686,476	30,255	26,270
March 2017	689,889	30,439	27,026
April 2017	692,197	29,405	27,097
May 2017	696,500	30,082	25,779
June 2017	696,844	27,185	29,121
July 2017	697,968	28,588	27,464
August 2017	698,861	31,078	30,186
September 2017	683,902	30,318	45,277
October 2017	685,877	32,204	30,229
November 2017	690,591	38,676	33,961
December 2017	693,678	33,506	30,418

Most Healthy Michigan Plan beneficiaries elect to choose a health plan as opposed to automatic assignment to a health plan. As of December 18, 2017, 382,042 or, 71 percent, of the State's 536,963 Healthy Michigan Plan health plan enrollees selected a health plan. The remaining managed care enrolled beneficiaries were automatically assigned to a health plan. All Medicaid Health Plan members have an opportunity to change their plan within 90 days of enrollment into the plan. During this year, 24,134 of all Healthy Michigan Plan health plan enrollees changed

health plans. This year, 12,029 or approximately 50 percent, of beneficiaries that changed plans were previously automatically assigned to a health plan. The remaining beneficiaries were those that changed plans after selecting a health plan.

Healthy Michigan Plan members have the opportunity to reduce cost-sharing requirements through the completion of Health Risk Assessments and engaging in healthy behaviors. MDHHS has developed a standard Health Risk Assessment form to be completed annually. Health Risk Assessment forms and reports are located on the MDHHS website. The Health Risk Assessment document is completed in two parts. The member typically completes the first sections of the form with the assistance of the Healthy Michigan Plan enrollment broker. Members that are automatically assigned to a health plan are not surveyed. Completion of the remaining Health Risk Assessment sections (beyond those completed through the State's enrollment broker) requires beneficiaries to schedule an annual appointment, select a Healthy Behavior, and have member results completed by their primary care provider. The primary care provider securely sends the completed Health Risk Assessment to the appropriate Medicaid Health Plan.

Healthy Michigan Plan members that successfully complete the Health Risk Assessment process and agree to address or maintain healthy behaviors may qualify for reduction in copayments and/or contributions and gift cards. The following opportunities are available to Healthy Michigan Plan beneficiaries:

- Reduction in copayments: A 50 percent reduction in copayments is available to members that have agreed to address or maintain healthy behaviors and have paid 2 percent of their income in copayments.
- Reduction in contributions: A 50 percent reduction in contributions can be earned by members that have agreed to address or maintain healthy behaviors and have completed a Health Risk Assessment with a Primary Care Practitioner attestation.
- Gift card incentives: A $50.00 gift card is available to beneficiaries at or below 100 percent FPL that have agreed to address or maintain healthy behaviors and have completed a Health Risk Assessment with a Primary Care Practitioner attestation.

The initial assessment questions section of the Health Risk Assessments completed through the MDHHS enrollment broker had a completion rate of 92 percent this year. MDHHS is encouraged by the high level of participation by beneficiaries at the initial point of contact. The details of Health Risk Assessment completion can be found in the enclosed December 2017 Health Risk Assessment Report.

The following table details the Health Risk Assessment data collected by the enrollment broker for the year:

Table 2: Health Risk Assessment Enrollment Broker Data January 2017 – December 2017					
Month	Number of Completed HRAs	Percent of Total	Number of Refused HRAs	Percent of Total	Total Enrollment Calls
January 2017	3,002	92%	259	8%	3,261
February 2017	4,296	93%	335	7%	4,631
March 2017	5,247	92%	462	8%	5,709
April 2017	4,901	92%	405	8%	5,306
May 2017	5,103	92%	415	8%	5,518
June 2017	5,548	91%	543	9%	6,091
July 2017	4,251	91%	400	9%	4,651
August 2017	4,283	91%	443	9%	4,726
September 2017	4,486	91%	427	9%	4,913
October 2017	3,720	91%	380	9%	4,100
November 2017	4,183	91%	389	9%	4,572
December 2017	5,003	91%	500	9%	5,503
Total	41,117	92%	3,689	8%	44,806

The following table details Health Risk Assessment data collected by the Medicaid Health Plans for the year:

Table 3: Health Risk Assessment Health Plan Data January 2017 – December 2017				
Month	Health Risk Assessments Submitted	Gift Cards Earned	Reductions Earned	Reductions Applied
January 2017	2,042	1,680	357	746
February 2017	2,583	2,067	510	782
March 2017	2,958	2,388	562	692
April 2017	2,799	2,262	531	780
May 2017	3,542	2,874	668	704
June 2017	3,789	3,059	730	692
July 2017	2,568	2,103	458	978
August 2017	3,417	2,732	680	792
September 2017	2,470	1,973	492	868
October 2017	2,801	2,221	573	934
November 2017	3,219	2,520	682	674
December 2017	4,440	3,360	1,073	746
Total	36,628	29,239	7,316	9,388

Enrollment Counts for Year and Year to Date

Healthy Michigan Plan enrollment in this year has remained consistent with previous years. In addition to stable Healthy Michigan Plan enrollment, MDHHS saw the standard number of disenrollments from the plan as reported in the Monthly Enrollment Reports to CMS. Healthy Michigan disenrollment reflects individuals who were disenrolled during a redetermination of

eligibility or switched coverage due to eligibility for other Medicaid program benefits. In most cases beneficiaries disenrolled from the Healthy Michigan Plan due to eligibility for other Medicaid programs. Movement between Medicaid programs is not uncommon and MDHHS expects that beneficiaries will continue to shift between Healthy Michigan and other Medicaid programs as their eligibility changes. Enrollment counts in the table below are for unique members for identified time periods.

Table 4: Enrollment Counts for Year and Year to Date			
Demonstration Population	Total Number of Demonstration Beneficiaries Year Ending – 12/2017	Current Enrollees (year to date)	Disenrolled in Current Year
ABW Childless Adults	N/A	N/A	N/A
Healthy Michigan Adults	971,464	971,464	361,007

Outreach/Innovation Activities to Assure Access

MDHHS utilizes the Healthy Michigan Program website to provide information to both beneficiaries and providers. The Healthy Michigan Plan website contains information on eligibility, how to apply, services covered, cost sharing requirements, frequently asked questions, Health Risk Assessment completion, and provider information. The site also provides a link for members to make MI Health Account payments. MDHHS also has a mailbox, healthymichiganplan@michigan.gov, for questions or comments about the Healthy Michigan Plan.

MDHHS continues to work closely with provider groups through meetings, Medicaid provider policy bulletins, and various interactions with community partners and provider trade associations. MDHHS continues to provide progress reports to the Medical Care Advisory Council (MCAC) at regularly scheduled yearly meetings. These meetings provide an opportunity for attendees to provide program comments or suggestions. The minutes for the 2017 meetings have been attached as an enclosure. MCAC meeting agendas and minutes are also available on the MDHHS website.

Collection and Verification of Encounter Data and Enrollment Data

As a mature managed care state, all Medicaid Health Plans submit encounter data to MDHHS for the services provided to Healthy Michigan Plan beneficiaries following the existing MDHHS data submission requirements. MDHHS continues to utilize encounter data to prepare MI Health Account statements with a low volume of adjustments. MDHHS works closely with the plans in reviewing, monitoring and investigating encounter data anomalies. MDHHS and the Medicaid Health Plans work collaboratively to correct any issues discovered as part of the review process.

Operational/Policy/Systems/Fiscal Developmental Issues

MDHHS regularly meets with the staff of Medicaid Health Plans to address operational issues, programmatic issues, and policy updates and clarifications. Updates and improvements to the Community Health Automated Medicaid Processing System (CHAMPS), the State's Medicaid Management Information System (MMIS) happen continually, and MDHHS strives to keep the

health plans informed and functioning at the highest level. At these meetings, Medicaid policy bulletins and letters that impact the program are discussed, as are other operational issues. Additionally, these operational meetings include a segment of time dedicated to the oversight of the MI Health Account contactor. MDHHS and the health plans receive regular updates regarding MI Health Account activity and functionality. The following policies with Healthy Michigan Plan impact were issued by the State during the year covered by this report:

Table 5: Medicaid Policy Bulletins with Healthy Michigan Plan Impact		
January 2017 – December 2017		
Issue Date	Subject	Link
01/27/2017	Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Code Updates	MSA 17-01
02/01/2017	Healthy Michigan Plan Co-Pay Increases	MSA 17-02
02/01/2017	Medicaid Provider Manual Chapter for Non-Emergency Medical Transportation (NEMT)	MSA 17-03
02/01/2017	Claims for Non-Enrolled Providers	MSA 17-04
02/01/2017	Lead Abatement Services	MSA 17-05
02/24/2017	Pharmacy Claim Reimbursement Changes and Coverage of Medication Therapy Management Services	MSA 17-09
03/01/2017	Early Refills for Prescription Drugs	MSA 17-06
03/01/2017	Enhanced 340B Reporting Requirements	MSA 17-07
03/01/2017	Updates to the Medicaid Provider Manual; Clarification to Bulletin MSA 17-05	MSA 17-08
03/31/2017	Coverage of Physician-Administered Injectable Drugs as Pharmacy Claims for Administration in Residential Treatment Centers	MSA 17-12
03/31/2017	Clinic Billing Format Change to Institutional; FQHC Certification Update	MSA 17-10
05/01/2017	Change in Hospital Facility Ownership Billing	MSA 17-14
05/01/2017	Ambulance Fractional Mileage and Pronouncement of Death Changes	MSA 17-15
06/01/2017	Transportation Rate Changes	MSA 17-17
06/01/2017	Changes to Speech Generating Device (SGD) Policy	MSA 17-18
06/01/2017	Updates to the Medicaid Provider Manual; New Coverage of Existing Code	MSA 17-19
06/30/2017	Billing for Free or Reduced Price Care	MSA 17-21
06/30/2017	Delay of Clinic Billing Format Change to Institutional; Policy Clarifications	MSA 17-24
08/08/2017	Healthy Michigan Plan Operational Protocols	L 17-27
08/16/2017	Healthy Michigan Plan §1115 Demonstration Waiver Extension	L 17-36
09/01/2017	Documenting Health Plan Encounters for the Medicaid Reconciliation Report	MSA 17-26
09/01/2017	Outpatient Behavioral Health Visits	MSA 17-27
09/01/2017	Updates to the Medicaid Provider Manual; Code Updates	MSA 17-30
09/29/2017	Home Help Agency Provider Reimbursement Rates	MSA 17-32
10/04/2017	Healthy Michigan Plan §1115 Demonstration Waiver Extension	L 17-46
10/23/2017	MI Marketplace Option Provider Information and Webinar	L 17-49
11/15/2017	Elimination of the Paper Version of the Facility Admission Notice	MSA 17-33
11/27/2017	Update to Physician Primary Care Rate Eligibility	MSA 17-43
11/27/2017	Inpatient and Outpatient Short Hospital Stay Rate of Reimbursement	MSA 17-47

11/27/2017	Managed Care Network Provider Enrollment in the Community Health Automated Medicaid Processing System (CHAMPS)	MSA 17-48
12/1/2017	Updates to the Early and Periodic Screening, Diagnosis and Treatment Chapter of the Medicaid Provider Manual and 2017 American Academy of Pediatrics Periodicity Schedule	MSA 17-34
12/1/2017	Michigan Department of Health and Human Services (MDHHS) File Transfer Application	MSA 17-36
12/1/2017	Rate Update for Neonatal and Pediatric Critical Care and Intensive Care Services	MSA 17-37
12/1/2017	Modernizing Continuum of Care (MCC) – Changes to Eligibility Inquiry/Response Transactions and CHAMPS Unique Health Plan ID	MSA 17-40
12/1/2017	Maternal Infant Health Program (MIHP) Consultant Authorization for Program Exceptions	MSA 17-41
12/1/2017	Updates to the Medicaid Provider Manual; Clarification to Bulletin MSA 17-10	MSA 17-44
12/1/2017	Peer Recovery Coach Certification	MSA 17-45
12/1/2017	Modernizing Continuum of Care (MCC) Project	MSA 17-46

Financial/Budget Neutrality Development Issues

Healthy Michigan Plan expenditures for all plan eligible groups are included in the budget neutrality monitoring table below as reported in the CMS Medicaid and Children's Health Insurance Program Budget and Expenditure System. Expenditures include those that both occurred and were paid in the same year in addition to adjustments to expenditures paid after the year of service. The State will continue to update data for each demonstration year as it becomes available. This year, MDHHS reported $31,166,314 in administrative costs during the demonstration year in CMS 64.10 WAIV files submitted to CMS.

Table 6: Healthy Michigan Plan Budget Neutrality Monitoring Table					
	DY 5 - PMPM	DY 6 - PMPM	DY 7 - PMPM	DY 8 - PMPM	DY 9 - PMPM
Approved HMP PMPM	$667.36	$602.21	$569.80	$598.86	$629.40
Actual HMP PMPM (YTD)	$477.45	$481.57	$495.43	$449.31	-
Total Expenditures (YTD)	$1,782,967,705	$3,499,679,191	$3,844,235,135	$3,727,176,401	-
Total Member Months (YTD)	3,734,355	7,267,214	7,759,419	8,295,276	-

Beneficiary Month Reporting

The beneficiary counts below include information for each of the designated months during the year, and include retroactive eligibility through December 31, 2017.

Table 7: Healthy Michigan Plan Beneficiary Month Reporting	
January 2017 – December 2017	
Month	Count
January 2017	682,491
February 2017	686,476
March 2017	689,889

April 2017	692,197
May 2017	696,500
June 2017	696,844
July 2017	697,968
August 2017	698,861
September 2017	683,902
October 2017	685,877
November 2017	690,591
December 2017	693,678
Total	8,295,274

Consumer Issues

This year, the total number of Healthy Michigan Plan complaints reported to MDHHS was 336. Complaints reported to MDHHS are detailed by category in the table below. Overall, with over 8.2 million member months during the year, MDHHS is encouraged by its low rate of contacts related to Healthy Michigan Plan complaints. MDHHS will continue to monitor calls to the Beneficiary Helpline to identify issues and improve member experience.

Table 8: Healthy Michigan Plan Complaints Reported to MDHHS January 2017 – December 2017					
	Obtaining Prescriptions	Other Covered Services	Transportation	Other	Total
Count	175	57	25	79	336
Percent	52%	17%	7%	24%	

Quality Assurance/Monitoring Activity

MDHHS completes Performance Monitoring Reports (PMR) for all Medicaid Health Plans that were licensed and approved to provide coverage to Michigan's Medicaid beneficiaries during the reporting period. These reports are based on data submitted by the health plans. Health plans submit data for the following items: grievance and appeal reporting, a log of beneficiary contacts, financial reports, encounter data, pharmacy encounter data, provider rosters, primary care provider-to-member ratio reports, and access to care reports. The measures for the Healthy Michigan Plan population will mirror those used for the traditional Medicaid population. In addition, MDHHS will monitor trends specific to this new population over time.

MDHHS developed Healthy Michigan Plan Performance Monitoring Specifications in 2014. Many of the measures for fiscal year 2015 were informational as MDHHS refined its data collection and analysis process. Performance standards were set for these measures in FY2016 and updated for FY2017. Performance areas include Adults' Access to Ambulatory Health Services, Outreach and Engagement to Facilitate Entry to Primary Care, Adults' Generic Drug Utilization, Plan All-Cause Acute 30-Day Readmissions, and Timely Completion of Initial Health Risk Assessment. Two new Healthy Michigan Plan measures, Transition into Consistently Fail to Pay (CFP) Status and Transition out of Consistently Fail to Pay (CFP) Status were added as informational measures in FY2017, with the intention of adding performance standards in FY2018.

The Pay for Performance Project awards points to Medicaid Health Plans in performance categories based on their delivery of performance criteria. Pay for Performance under the Healthy Michigan Plan began in 2015 and will continue through 2018. For 2017, it is calculated using Cost Sharing and Value-based Services categories.

The Fiscal Year 2017 Focus Bonus Emergency Department Utilization Improvement Project of the Medicaid Health Plans began in 2015. Medicaid Health Plans began submitting deliverables as a part of the 2015 Pay for Performance Project. In compliance with Michigan's Public Act 107, MDHHS will examine emergency department utilization and evaluate the health plan efforts to encourage its proper use. All Medicaid Health Plans were approved to begin their Focus Bonus Emergency Department Utilization Improvement Projects in February 2016. These projects ended in September 2017 and all Medicaid Health Plans submitted final reports documenting their project outcomes. Based on the findings from these projects combined with current departmental priorities, a second three year Focus Bonus Emergency Department Utilization Improvement Project will start in 2018, which must focus on A) integration with behavioral health, B) substance use disorder treatment, or C) dental services.

Managed Care Reporting Requirements

MDHHS has established a variety of reporting requirements for the Medicaid Health Plans, many of which are compiled, analyzed and shared with the plans in the PMRs described in the Quality Assurance/Monitoring Activity section of this report. These reports have historically been used for the traditional Medicaid population, and, as indicated above, will also include information for the Healthy Michigan Plan population.

A Health Risk Assessment Report is published monthly and made available to the public by the Bureau of Medicaid Care Management and Quality Assurance within MDHHS. This December 2017 report included data for Health Risk Assessments completed through December 2017. Information regarding Health Risk Assessments completed through the MDHHS enrollment broker is included above in Table 2.

Completion of the remaining Health Risk Assessment sections (beyond those completed through the State's enrollment broker) requires beneficiary scheduling of an annual appointment, selecting a Healthy Behavior, and completing of member results by a primary care provider. As of December 2017, among beneficiaries who completed the Health Risk Assessment, 85.7 percent agreed to address healthy behaviors, and of those, 60.3 percent chose to address more than one healthy behavior.

During October 2014, MI Health Account quarterly statement activities began and Healthy Michigan Plan members began making payments for contributions and copays to the MI Health Account. Beneficiaries are able to make payments online and by mail. The MI Health Account collection activity was reported in the Healthy Michigan Plan Special Terms and Conditions 31: Assurance of Compliance Report, and this is regularly reported in the MI Health Account Executive Report. This document has been enclosed with this report.

MDHHS has refined the Managed Care Organization grievance and appeal reporting process to collect Healthy Michigan Plan specific data. Grievances are defined in the MDHHS Medicaid Health Plan Grievance/Appeal Summary Reports as an expression of dissatisfaction about any matter other than an action subject to appeal. Appeals are defined as a request for review of the Health Plan's decision that results in any of the following actions:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of a payment for a properly authorized and covered service;
- The failure to provide services in a timely manner, as defined by the State; or
- The failure of the Health Plan to act within the established timeframes for grievance and appeal disposition.

From January to December 2017, there were 931 total appeals among all the Medicaid Health Plans. Medicaid Health Plan decisions were upheld in 49 percent of the appeals. From January to December 2017 there were a total of 6,208 grievances. The greatest number of grievances came from the Access category. Access grievances can include a primary care physician not accepting new patients, limited specialist availability, the refusal of a primary care physician to complete a referral or write a prescription, a lack of services provided by the primary care physician, long wait times for appointments and denied services. Transportation grievances relate to issues with the transportation benefit and often mirror the complaints members directly reported to MDHHS. Grievances related to quality of care pertain to the level of care issues experienced by beneficiaries. Administrative/Service grievances can include issues with claims, enrollment, eligibility, out-of-network providers and benefits not covered. Issues reported under the Billing category pertain to billing issues. MDHHS will continue to monitor the Medicaid Health Plans Grievance/Appeal Summary Reports to ensure levels of grievances remain low and resolution of grievances is completed in a timely manner. MDHHS has included grievance and appeals data reported by the Medicaid Health Plans from this year in the following tables:

Table 9: Managed Care Organization Appeals January 2017 – December 2017				
	Decision Upheld	Overturned	Undetermined/ Withdrawn	Total
Count	459	385	87	931
Percent	49%	41%	9%	

Table 10: Managed Care Organization Grievances January 2017 – December 2017						
	Access	Quality of Care	Administrative/Service	Billing	Transportation	Total
Count	3,050	356	937	755	1,110	6,208
Percent	49%	6%	15%	12%	18%	

Managed Care Delivery System

MDHHS reviewed a number of systems and program related processes and procedures related to health plan implementation of the Healthy Michigan Plan. This included a detailed investigation into how the plans operationalized cost sharing and incentive procedures, how well plans facilitated entry into primary care, and their processes to facilitate completion of the Health

Risk Assessment and appropriately transmitting those Health Risk Assessment results to MDHHS for use in determining eligibility for reductions in cost sharing. On a quarterly basis, MDHHS cross references a random sample of beneficiaries who earned a healthy behaviors incentive based on the attestation on their Health Risk Assessment with beneficiaries who had reductions processed as an additional process to monitor the accurate application of incentives, including cost-sharing reductions. MDHHS is closely monitoring access to care in the Healthy Michigan Plan program for fee-for-service and health plan members. Most recent data indicate that 78.51 percent of Healthy Michigan Plan managed care enrollees have had an ambulatory or preventive care visit within the prior year and 59.9 percent had an ambulatory or preventive care visit within 150 days of enrollment.

MDHHS measures racial/ethnic health disparities through three analyses:

1. MDHHS performs an internal analysis to investigate how Healthy Michigan Plan enrollment by race/ethnicity compares to estimates modelled by the Urban Institute's Health Policy Center.

This analysis is run on an ad hoc basis.

2. MDHHS conducts a Health Equity Analysis which includes quality measures across four health dimensions: Women – Adult Care and Pregnancy Care, Child and Adolescent Care, Access to Care and Living with Illness. This analysis is in its sixth year and began including Healthy Michigan Plan enrollees starting in 2016 (Healthcare Effectiveness Data and Information Set (HEDIS) 2015 data). Analyses are conducted for all Medicaid Managed Care Enrollees and for each Medicaid health plan. Health disparity analyses conducted include pair-wise disparity analyses between all non-white populations and the white reference population. Annual trending of rates is also conducted to monitor for statistically significant increases or decreases in rates for specific racial/ethnic populations. Through this analysis for 2016 (most recent data), racial/ethnic disparities have been identified for all fourteen of the quality measures collected, with the largest disparities identified in the Women – Adult Care and Pregnancy Care health dimension.

An Index of Disparity is also calculated for each quality measure. This index is a valuable tool for measuring inequity in health and has been used to create health equity standards. These started in FY2016 through the Pay for Performance and was expanded to three measures in FY2017. This analysis is run on an annual basis.

3. MDHHS collects race/ethnicity data for internal review for all measures calculated from the MDHHS Medicaid Data Warehouse. Measures which are stratified by race ethnicity include: Adults' Generic Drug Utilization, Timely Completion of Initial Health Risk Assessment, Outreach and Engagement to Facilitate Entry to Primary Care, Adults' Access to Ambulatory Health Services, Adult Body Mass Index Assessment, Breast Cancer Screening, Cervical Cancer Screening, Diabetes Short-Term Complications Admission Rate, COPD or Asthma in Older Adults Admission Rate, Heart Failure Admission Rate, Asthma in Younger Adults Admission Rate, Chlamydia Screening in Women Ages 21 to 24, Comprehensive Diabetes Care: Hemoglobin A1c Testing, Antidepressant Medication Management and Annual Monitoring for Patients on Persistent Medications. This analysis is run on an annual basis.

MDHHS reviews the provider network submitted by the Medicaid Health Plans quarterly to ensure that networks meet the adequacy criteria specified in the contract. In 2015, Medicaid Health Plans were required to maintain a Primary Care Physician to enrollee ratio of at least one full-time Primary Care Physician per 750 members. In 2016, this was revised to an enrollee ratio of at least one full-time Primary Care Physician per 500 members to further strengthen provider networks and improve access to care. Pre and post implementation network review indicate that all plans maintain an adequate network and are in contract compliance. Network capacity is used in calculating the automatic assignment algorithm as outlined below and plans are given additional points for exceeding this measure.

MDHHS uses the capacity report from the State's enrollment broker (current at time of algorithm development) to determine the Open Primary Care Physician to capacity ratio for each county. When the ratio is less than 1:300, 100 points are added to the plan's score for that county.

When the ratio is between 1:300 and 1:450, 50 points are added to the plan's score for that county. 24/7 availability is reviewed annually as part of the comprehensive compliance review and took place in January 2017. All Medicaid Health Plans demonstrated compliance with this criterion.

The External Quality Review (EQR) report includes information on how well plans performed on each aspect of the compliance review, as well as a validation of each plans' HEDIS findings and Performance Improvement Projects. The onsite reviews of plans in 2016 included components specific to the Healthy Michigan Plan. The 2016 – 2017 EQR Technical Report is scheduled to be published in April 2018.

As part of the EQR process, health plans are required to participate in an annual performance improvement project. In 2017, plans began a new three year cycle for Performance

Improvement Projects. Each plan was required to improve quality and reduce disparities in their timeliness of prenatal care measure. Each plan's proposed project was validated by the MDHHS EQR vendor prior to implementation of interventions.

The Healthy Michigan Plan was also incorporated into the Michigan Medicaid Quality Assessment and Improvement Strategy 2015. The Quality Strategy includes detailed information on the methods used to improve care and service delivery to continually improve Michigan's Medicaid program and addresses how Michigan has integrated the Healthy Michigan Plan population throughout the Quality Improvement program. Reporting on the effectiveness of the Healthy Michigan Plan implementation will be included in all future Quality Strategy Annual Reviews.

MDHHS measures health plan performance through annual HEDIS reporting and the internally-derived PMR. All plans are required to undergo the HEDIS reporting process for all members who meet measure-specific eligibility criteria, including Healthy Michigan Plan members. Data for the quarterly PMR comes from the MDHHS Data Warehouse and includes rates specific to Healthy Michigan Plan members. As a result of CMS support via the Adult Medicaid Quality grant, MDHHS was able to build queries to include breakouts by Healthy Michigan Plan and

traditional Medicaid for all measures calculated using the Medicaid Data Warehouse. The Michigan Medicaid HEDIS 2017 Results Statewide Aggregate Report and October 2017 PMR are attached to this report.

MDHHS contracted with Health Services Advisory Group, Inc. to conduct and report results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey for its Medicaid program. MDHHS has included the 2017 Adult Medicaid Health Plan CAHPS Report as an attachment. In 2017, MDHHS conducted a Healthy Michigan Plan specific CAHPS survey. MDHHS has also included the Healthy Michigan Plan CAHPS Report as an attachment.

Additionally, health plan financial information is reviewed on a quarterly basis to assure each plan has adequate working capital, their net worth is not at a negative status and the risk based capital is between 150 percent and 200 percent. Financial reports were reviewed in May 2017, August 2017 and November 2017. All Medicaid Health Plans demonstrated compliance with the contractual financial requirements.

Lessons Learned

MDHHS continues to learn from the experience of launching a program the size and scope of the Healthy Michigan Plan. During the first quarter of the demonstration year, the University of Michigan issued several news articles and publications regarding their studies of the Healthy Michigan Plan. Findings included positive impacts on the State's economy and budget. The University of Michigan has also published findings of substantial decreases in uncompensated care in Michigan after the implementation of the Healthy Michigan Plan.

This year, MDHHS worked to operationalize lessons learned from its Health Risk Assessment process. The redesigned protocol and incentives for the Healthy Risk Assessment and Healthy Behaviors programs are reflective of stakeholder feedback and are intended to increase member engagement. MDHHS and its partners have developed a process that streamlines provider submission of the Health Risk Assessment, decreases document submission barriers, and allows members additional opportunities to participate in the Healthy Behaviors program.

One of this year's greatest challenges included the development of the Healthy Michigan Marketplace plan. MDHHS partnered with Marketplace issuers to discuss and coordinate implementation of the Healthy Michigan Marketplace plan. To bridge any communication gaps MDHHS and Marketplace issuers developed a Frequently Asked Questions document to track questions and concepts for the benefit of discussion and decision making. This successful health plan engagement and dialogue has been integral to the successful operationalization of the Healthy Michigan Marketplace plan.

MDHHS learned lessons from the results from an all Medicaid program Non-Emergency Transportation (NEMT) Survey conducted by Michigan State University's (MSU) Institute for Health Policy (IHP). While this survey was targeted to all Medicaid programs and was not specific to the Healthy Michigan population, it provided valuable insights to the NEMT user

experience. The issues most frequently mentioned by users were tardiness, missed appointments, driver cell phone use, and lack of choice in ride service. The report suggested educating members on the NEMT complaint process, improving and guaranteeing timeliness, expanding service provider choice, establishing driver confirmation calls/notifications, and greater ability to schedule services on short notice. MDHHS will utilize these lessons to improve the value of its services and the member's experience.

Demonstration Evaluation

MDHHS has commissioned the University of Michigan's Institute for Healthcare Policy and Innovation (IHPI) to serve as the Healthy Michigan Plan independent evaluator. The IHPI has developed a comprehensive plan to address the needs of the State and CMS. In accordance with paragraph 67 of the waiver special terms and conditions, the State submitted a draft of its initial evaluation design to CMS on April 28, 2014 and, after a period of revisions, CMS formally approved the evaluation plan on October 22, 2014.

Demonstration evaluation activities for the Healthy Michigan Plan are utilizing an interdisciplinary team of researchers from the IHPI. The activities of the evaluation will carry in seven domains over the course of the five year evaluation period:

I. An analysis of the impact the Healthy Michigan Plan on uncompensated care costs borne by Michigan hospitals;
II. An analysis of the effect of Healthy Michigan Plan on the number of uninsured in Michigan;
III. The impact of Healthy Michigan Plan on increasing healthy behaviors and improving health outcomes;
IV. The viewpoints of beneficiaries and providers of the impact of Healthy Michigan Plan;
V. The impact of Healthy Michigan Plan's contribution requirements on beneficiary utilization;
VI. The impact of the MI Health Accounts on beneficiary healthcare utilization, and;
VII. The cost effectiveness of the Healthy Michigan Marketplace Option.

Below is a summary of the demonstration evaluator key activities for 2016:

Domain I

Domain I will examine the impact of reducing the number of uninsured individuals on uncompensated care costs of Michigan hospitals. This year, IHPI engaged in activities to find and compare baseline uncompensated care results from hospital cost reports and IRS filings to understand the distribution of uncompensated care in Michigan. This included examining hospital cost report data, identifying criteria for identifying hospitals that, prior to the passage of the Affordable Care Act, had been providing a disproportionate share of uncompensated care.

Domain II

Domain II will examine the hypothesis that, when affordable health insurance is available and the applicable for insurance is simplified, the uninsured population will decrease significantly. This year, IHPI analyzed updated data to determine which states offer the most relevant comparison to Michigan's experience and to identify appropriate comparison groups for the cross-state components of the analysis. Additionally, IHPI continued to track the growing academic literature on the effects of the Affordable Care Act on health insurance status.

Domain III
Domain III will assess health behaviors, utilization and health outcomes for individuals enrolled in the Healthy Michigan Plan. IHPI began processing measures for the Healthy Michigan Plan beneficiaries with initial Healthy Michigan Plan enrollment. This included processing of utilization measures related to their second year enrollment. IHPI completed analysis of emergency utilization, healthy behaviors/preventive health services, and hospital admissions

Domain IV
Domain IV will examine beneficiary and provider viewpoints of the Healthy Michigan Plan through surveys. IHPI continued to analyze 2016 Healthy Michigan Voices survey of current enrollees. A report with subgroup analyses, analyses of relationships and multivariate analyses was submitted to MDHHS. The Child Health Evaluation and Research (CHEAR) Team continued to pull samples for the 2017 HMV Surveys. The one-year follow-up survey of beneficiaries who completed the initial HMV Survey in 2016 and the survey of beneficiaries newly enrolled in the Healthy Michigan Plan remain in the field.

Domains V/VI
Domains V and VI entail analyzing data to assess the impact of contributions and the MI Health Account statements on beneficiary utilization of health care services, respectively. This year, IHPI completed analysis of MDHHS administrative data, including impact on cost-sharing requirements and the Healthy Michigan Voices survey data related specifically to Domain V/VI. IHPI began to conduct any remaining analyses on the impact of contribution requirements and impact of the MI Health Account.

Domain VII
Domain VII will evaluate the cost effectiveness of the Healthy Michigan Marketplace Option. The Marketplace Option will not be implemented until April 2018. IHPI worked on the modifications to the proposed evaluation plan based on CMS feedback. Additionally, IHPI began preparations for the Secret Shopper Study and analyses of quality measures by examining trends in data. IHPI has been meeting with MDHHS staff regarding the implementation of the Marketplace Option and cost data that can be utilized for the purposes of this analysis.

Enclosures/Attachments

1. December 2017 Health Risk Assessment Report
2. February 2017 MCAC Minutes
3. June 2017 MCAC Minutes
4. August 2017 MCAC Minutes
5. December 2017 MCAC Minutes
6. January 2018 Performance Monitoring Report
7. January 2018 Performance Monitoring Report: Dental

8. November 2017 MI Health Account Executive Summary
9. Michigan Medicaid HEDIS 2017 Results Statewide Aggregate Report
10. 2017 MDHHS Adult Medicaid Health Plan CAHPS Report
11. 2017 MDHHS Healthy Michigan Plan CAHPS Report

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Medical Services Administration

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Healthy Michigan Plan - Health Risk Assessment Report

December 2017

Produced by:

Quality Improvement and Program Development - Managed Care Plan Divison

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Introduction

Pursuant to PA 107 of 2013, sections 105d(1)e and 105d(12), a Health Risk Assessment has been developed for the Healthy Michigan Plan (form DCH-1315). It is designed as a two part document, where the beneficiary completes the first three sections and the primary care provider completes the last section. It includes questions on a wide range of health issues, a readiness to change assessment, an annual physical exam and a discussion about behavior change with their primary care provider. The topics in the assessment cover all of the behaviors identified in PA 107 including alcohol use, substance use disorders, tobacco use, obesity and immunizations. It also includes the recommended healthy behaviors identified in the Michigan Health and Wellness 4X4 Plan, which are annual physicals, BMI, blood pressure, cholesterol and blood sugar monitoring, healthy diet, regular physical exercise and tobacco use.

Health Risk Assessment Part 1

Health Risk Assessments completion through Michigan ENROLLS

In February 2014, the enrollment broker for the Michigan Department of Health and Human Services (Michigan ENROLLS) began administering the first section of the Health Risk Assessment to Healthy Michigan Plan beneficiaries who call to enroll in a health plan. In addition to asking new beneficiaries all of the questions in Section 1 of the Health Risk Assessment, call center staff inform beneficiaries that an annual preventive visit, including completion of the last three sections of the Health Risk Assessment, is a covered benefit of the Healthy Michigan Plan.

Completion of the Health Risk Assessment is voluntary; callers may refuse to answer some or all of the questions. Beneficiaries who are auto-assigned into a health plan are not surveyed. Survey results from Michigan ENROLLS are electronically transmitted to the appropriate health plan on a monthly basis to assist with outreach and care management.

The data displayed in Part 1 of this report reflect the responses to questions 1-9 of Section 1 of the Health Risk Assessment completed through Michigan ENROLLS. As shown in Table I, a total of 355,769 Health Risk Assessments were completed through Michigan ENROLLS as of December 2017. This represents a completion rate of 94.97%. Responses are reported in Tables 1 through 9. Beneficiaries who participated in the Health Risk Assessment but refused to answer specific questions are included in the total population and their answers are reported as “Refused”. Responses are also reported by age and gender.

Health Risk Assessment Completion through Michigan ENROLLS

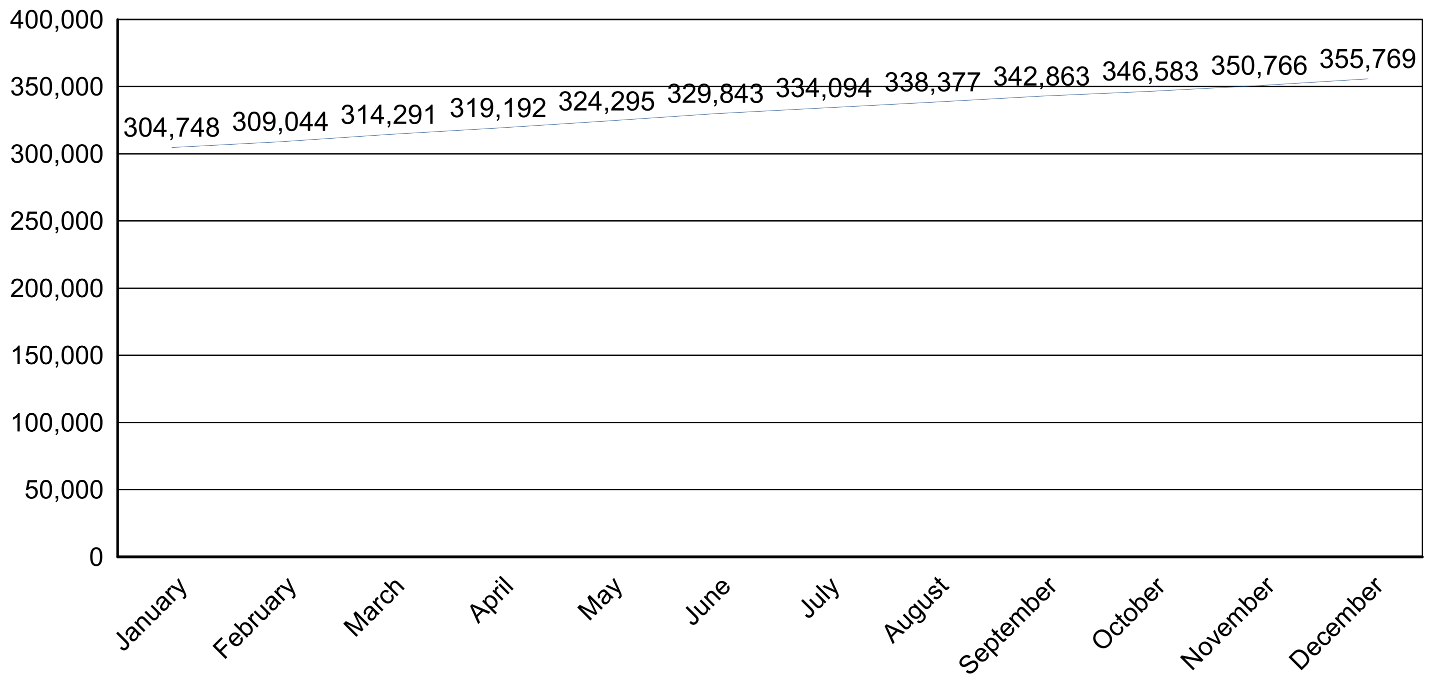
Table I. Count of Health Risk Assessments (HRA) Questions 1-9 Completed with MI Enrolls

MONTH	COMPLETE	DECLINED
January 2017	304,748	14,138 (4.43%)
February 2017	309,044	14,473 (4.47%)
March 2017	314,291	14,935 (4.54%)
April 2017	319,192	15,340 (4.59%)
May 2017	324,295	15,755 (4.63%)
June 2017	329,843	16,298 (4.71%)
July 2017	334,094	16,698 (4.76%)
August 2017	338,377	17,141 (4.82%)
September 2017	342,863	17,568 (4.87%)
October 2017	346,583	17,948 (4.92%)
November 2017	350,766	18,337 (4.97%)
December 2017	355,769	18,837 (5.03%)

Table 11. Demographics of Population that Completed HRA Questions 1-9 with MI ENROLLS

January 2014 - December 2017

AGE GROUP	COMPLETED HRA	
19 - 29	79,593	22.37%
30 - 39	78,171	21.97%
40 - 49	70,472	19.81%
50 - 59	85,169	23.94%
60 +	42,364	11.91%
GENDER		
F	191,114	53.72%
M	164,655	46.28%
FPL		
< 100% FPL	298,047	83.78%
100 - 133% FPL	57,722	16.23%
TOTAL	**355,769**	**100.00%**



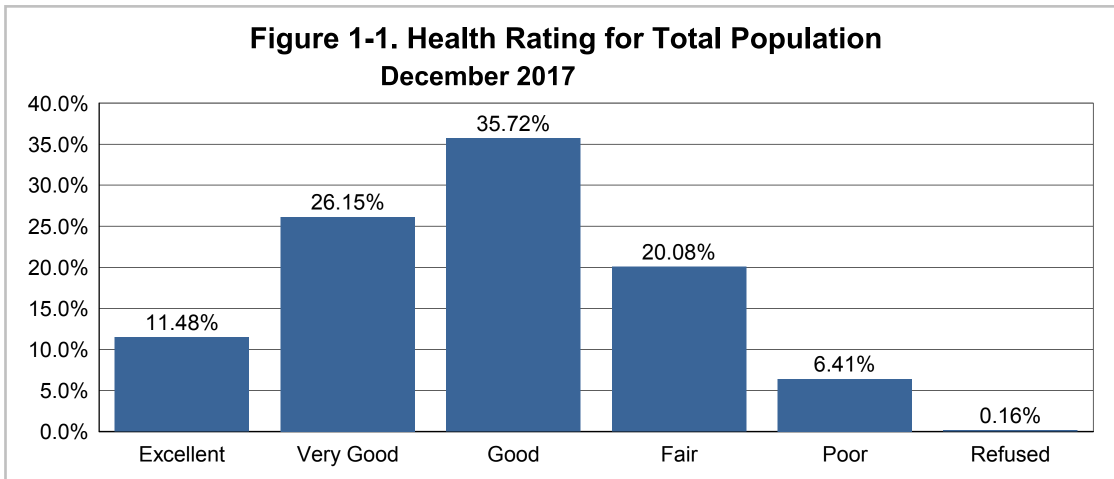
Question 1. General Health Rating

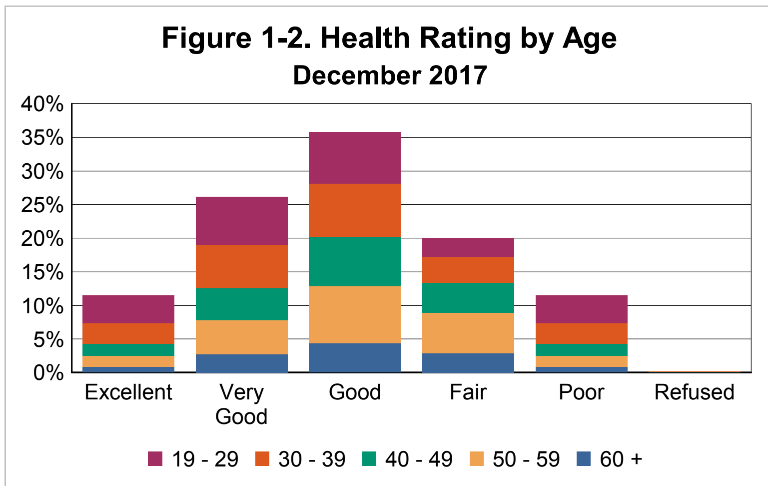
Question 1. In general, how would you rate your health? This question is used to assess self-reported health status. Healthy Michigan Plan enrollees were given the answer options of excellent, very good, good, fair or poor. Table 1 shows the overall answers to this question for December 2017. Among enrollees who completed the survey, this question had a 0.16% refusal rate.

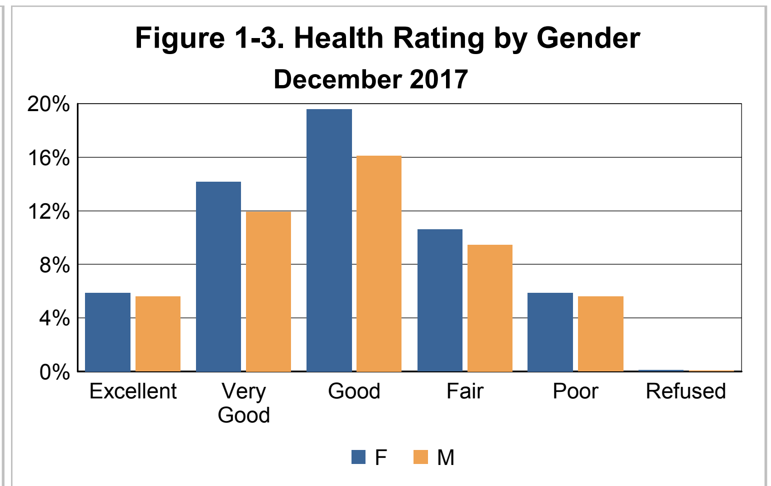
Table 1. Health Rating for Total Population

December 2017

HEALTH RATING	TOTAL	PERCENT
Excellent	40,841	11.48%
Very Good	93,025	26.15%
Good	127,089	35.72%
Fair	71,426	20.08%
Poor	22,816	6.41%
Refused	572	0.16%
TOTAL	**355,769**	**100.00%**







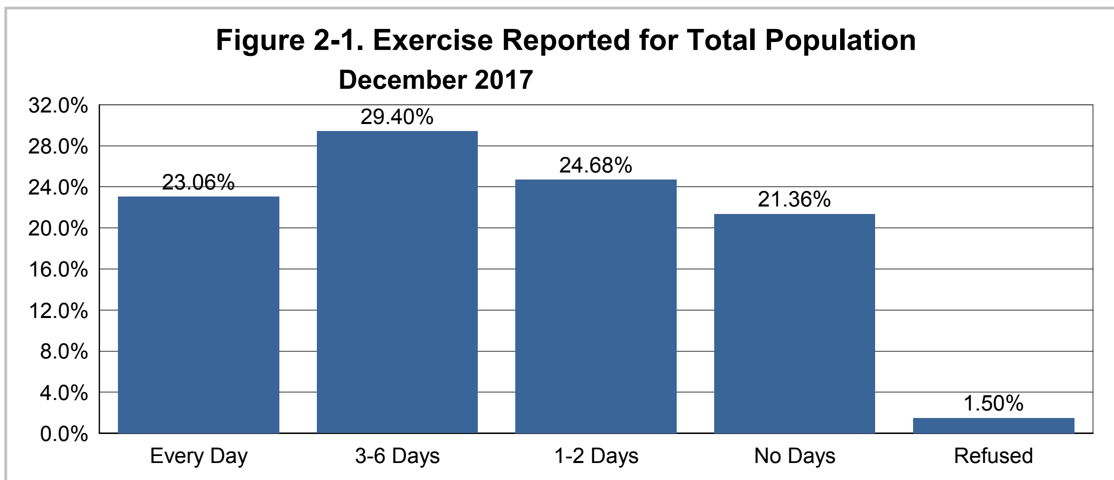
Question 2. Exercise

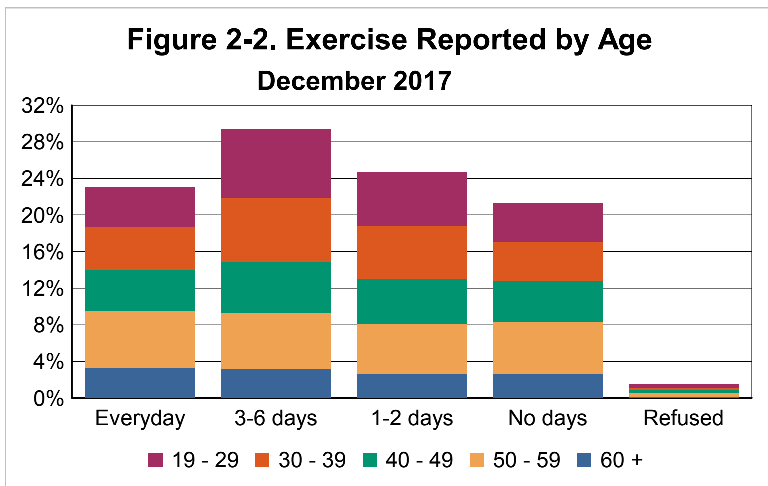
<u>Question 2. In the last 7 days, how often did you exercise for at least 20 minutes a day?</u> This question is used to assess selfreported exercise frequency as an important component of maintaining a healthy weight. Healthy Michigan Plan enrollees were given the answer options of every day, 3-6 days, 1-2 days or 0 days. Table 2 shows the overall answers to this question for December 2017. Among enrollees who participated in the survey, there was a 1.50% refusal rate for this question. Figures 2-1 through 2-3 show the exercise frequency reported for the total population, by age and gender.

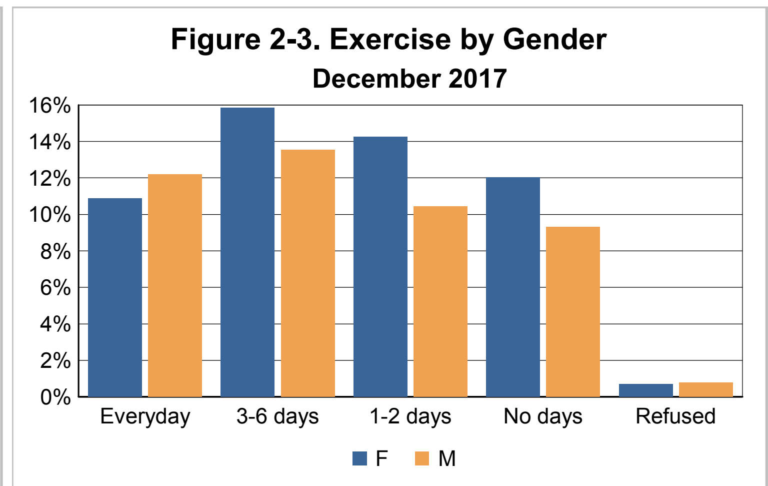
Table 2. Exercise Reported for Total Population

December 2017

EXERCISE	TOTAL	PERCENT
Every Day	82,033	23.06%
3-6 Days	104,610	29.40%
1-2 Days	87,807	24.68%
No Days	75,984	21.36%
Refused	5,335	1.50%
TOTAL	**355,769**	**100.00%**







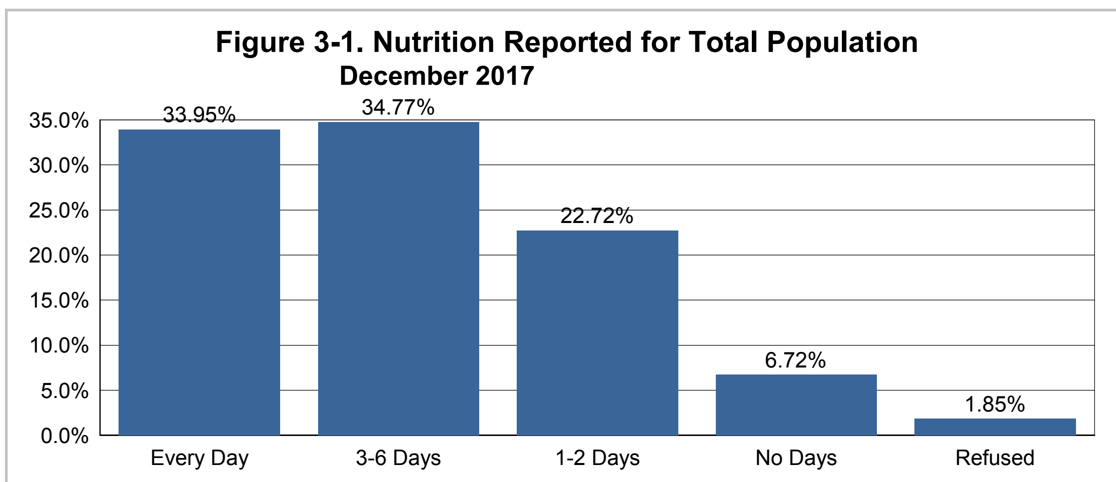
Question 3. Nutrition (Fruits and Vegetables)

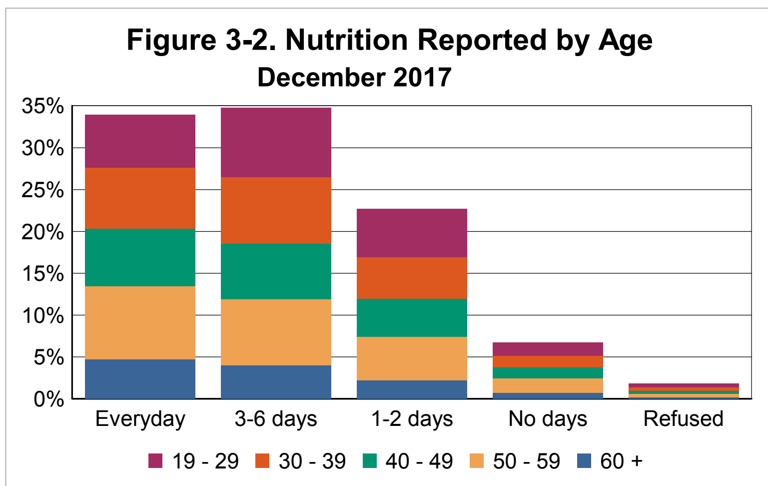
Question 3. In the last 7 days, how often did you eat 3 or more servings of fruits or vegetables in a day? This question is used to assess self-reported nutrition as an important component of maintaining a healthy weight. Healthy Michigan Plan enrollees were given the answer options of every day, 3-6 days, 1-2 days or 0 days. Table 3 shows the overall answers to this question for December 2017. Among enrollees who participated in the survey, there was a 1.85% refusal rate for this question. Figures 3-1 through 3-3 show the nutrition reported for the total population, and by age and gender.

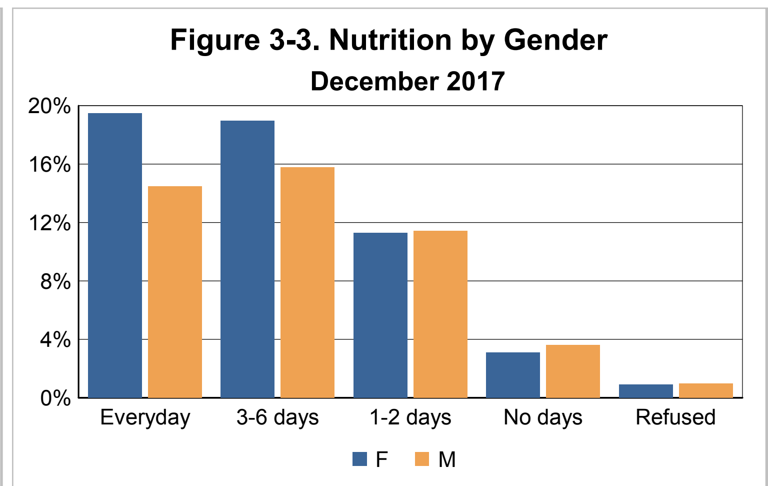
Table 3. Nutrition Reported for Total Population

December 2017

NUTRITION	TOTAL	PERCENT
Every Day	120,790	33.95%
3-6 Days	123,689	34.77%
1-2 Days	80,827	22.72%
No Days	23,898	6.72%
Refused	6,565	1.85%
TOTAL	**355,769**	**100.00%**







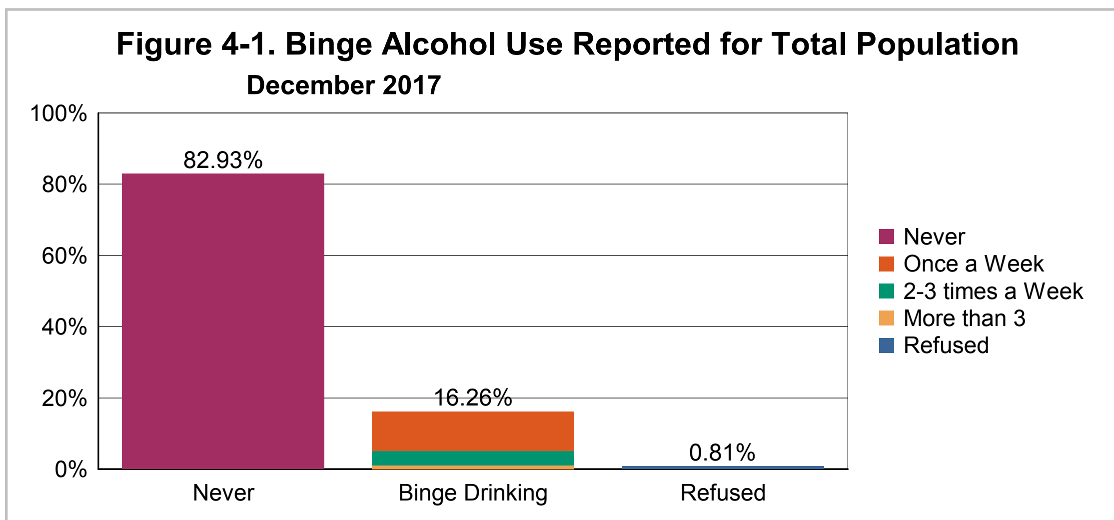
Question 4. Binge Alcohol Use

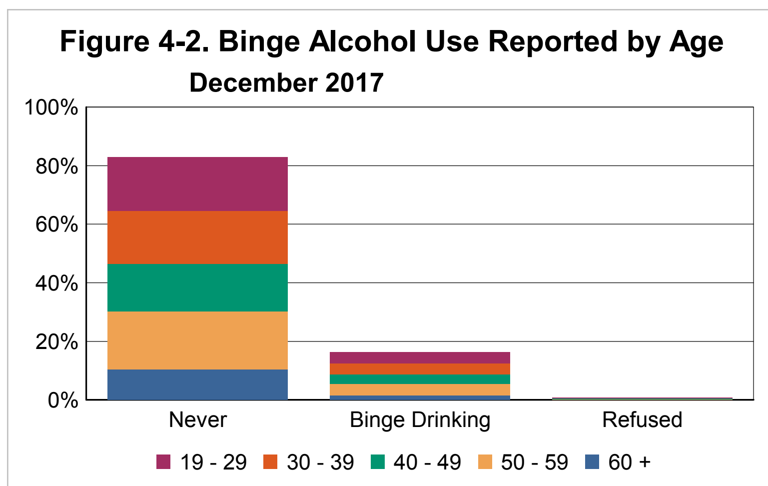
Question 4. In the last 7 days, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks at one time? This question is used to assess self-reported binge alcohol use. Healthy Michigan Plan enrollees were given the answer options of never, once a week, 2-3 a week and more than 3 times during the week. Table 4 shows the combined overall answers to these questions for December 2017. Among enrollees who participated in the survey, there was a 0.81% refusal rate for this question. Figures 4-1 through 4-3 show binge alcohol use status reported for the total population, and by age and gender.

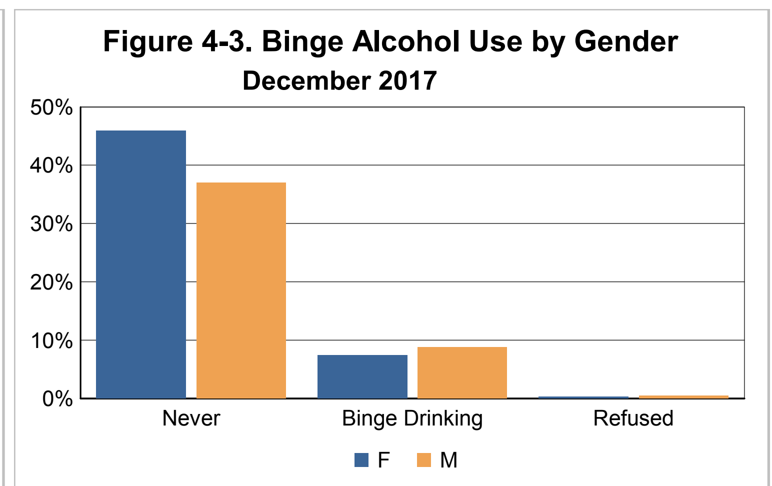
Table 4. Binge Alcohol Use Reported for Total Population

December 2017

ALCOHOL	TOTAL	PERCENT
Never	295,035	82.93%
Once a Week	39,253	11.03%
2-3 times a Week	15,073	4.24%
More than 3	3,515	0.99%
Refused	2,893	0.81%
TOTAL	**355,769**	**100.00%**







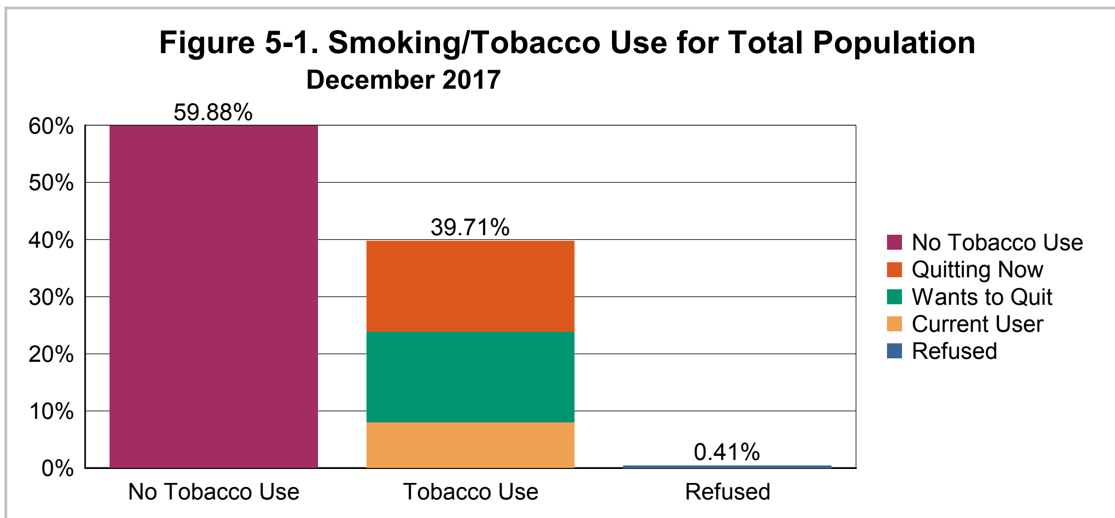
Question 5. Smoking/Tobacco Use

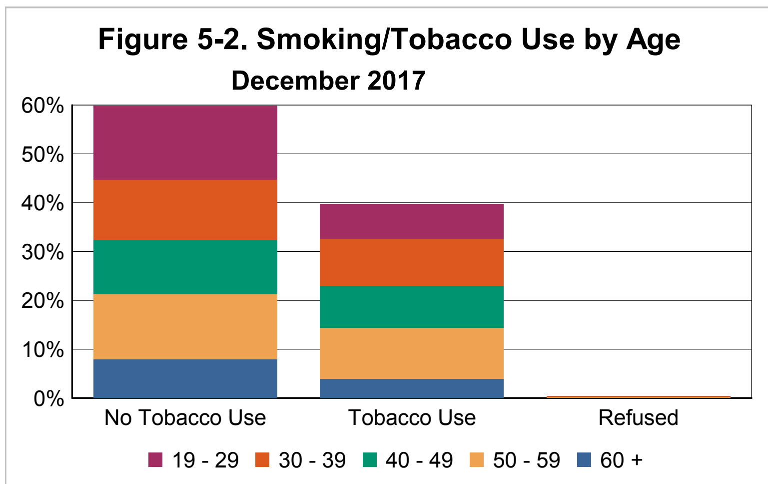
Question 5. In the last 30 days, have you smoked or used tobacco? This question is used to assess self-reported smoking/tobacco use. Healthy Michigan Plan enrollees were given the answer options of yes or no. Enrollees who answered yes, were asked a follow-up question: If YES, do you want to quit smoking or using tobacco? For this follow-up question, enrollees were given the answer options of yes, I am working on quitting or cutting back right now and no. Table 5 shows the combined overall answers to these questions for December 2017. Question 5 had a 0.41% refusal rate. Figures 5-1 through 5-3 show smoking/tobacco use reported for the total population, and by age and gender.

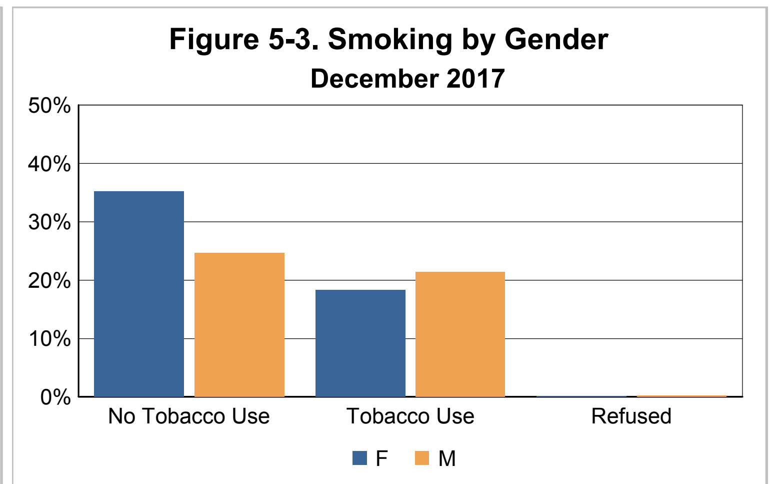
Table 5. Smoking/Tobacco Use Reported for Total Population

December 2017

TOBACCO USE	TOTAL	PERCENT
No Tobacco Use	213,039	59.88%
Quitting Now	56,483	15.88%
Wants to Quit	56,181	15.79%
Current User	28,598	8.04%
Refused	1,468	0.41%
TOTAL	**355,769**	**100.00%**







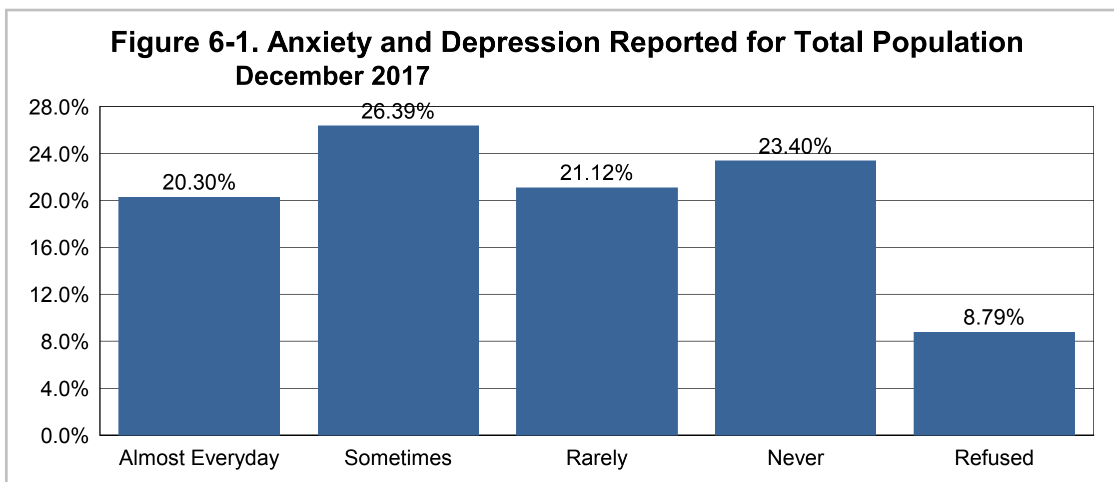
Question 6. Anxiety and Depression

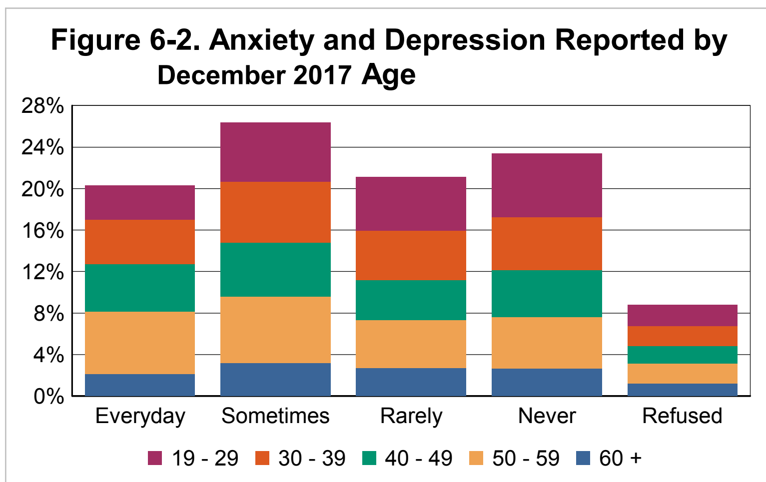
Question 6. In the last 30 days, how often have you felt tense, anxious or depressed? This question is used to assess selfreported mental health status. Healthy Michigan Plan enrollees were given the answer options of almost every day, sometimes, rarely and never. Table 6 shows the overall answers to this question for December 2017. Among enrollees who participated in the survey, there was a 8.79% refusal rate for this question. Figures 6-1 through 6-3 show anxiety and depression reported for the total population, and by age and gender.

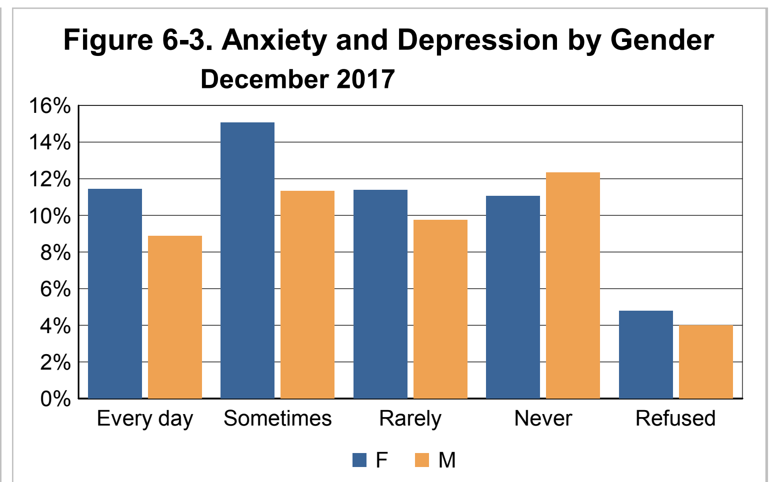
Table 6. Anxiety and Depression Reported for Total Population

December 2017

DEPRESSION	TOTAL	PERCENT
Almost Every day	72,220	20.30%
Sometimes	93,889	26.39%
Rarely	75,138	21.12%
Never	83,235	23.40%
Refused	31,287	8.79%
TOTAL	**355,769**	**100.00%**







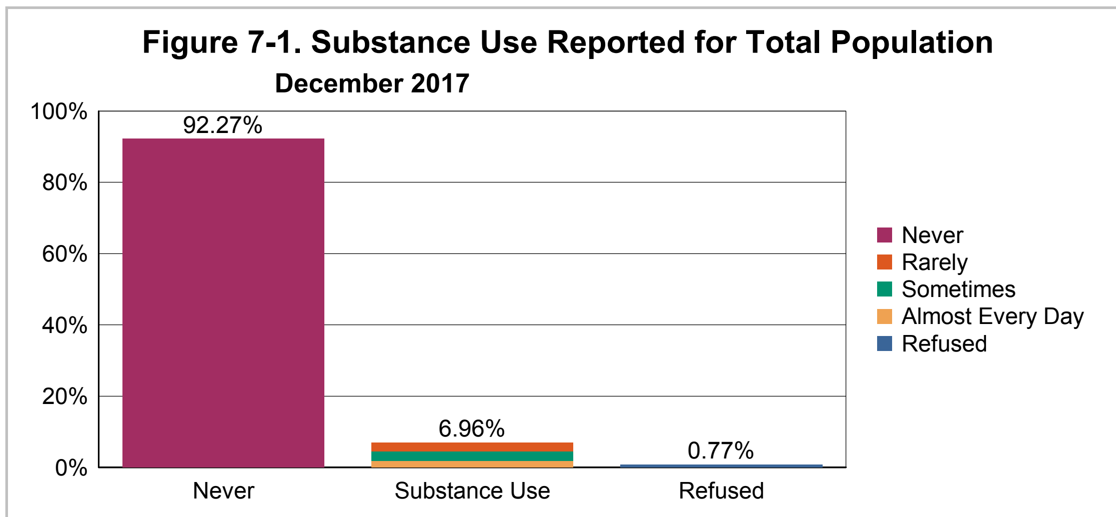
Question 7. Drugs and Substance Use

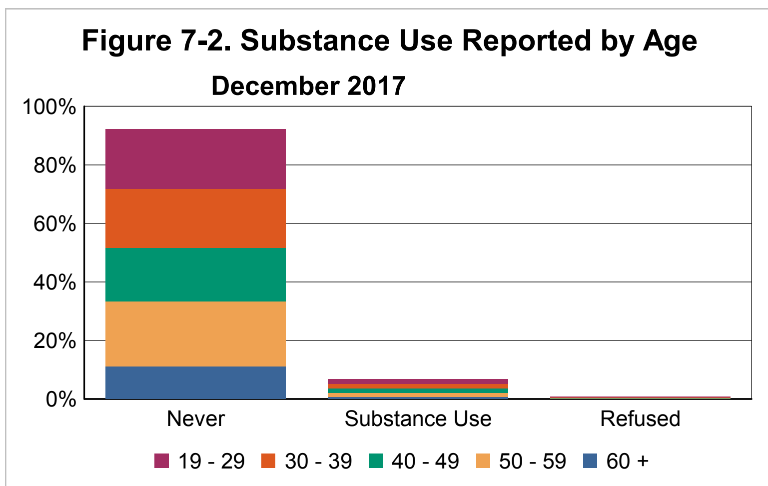
Question 7. Do you use drugs or medications (other than exactly as prescribed for you) which affect your mood or help you to relax? This question is used to assess self-reported substance use. Healthy Michigan Plan enrollees were given the answer options of almost every day, sometimes, rarely and never. Table 7 shows the overall answers to this question for December 2017. Among enrollees who participated in the survey, there was a 0.77% refusal rate for this question. Figures 7-1 through 7-3 show substance use reported for the total population, and by age and gender.

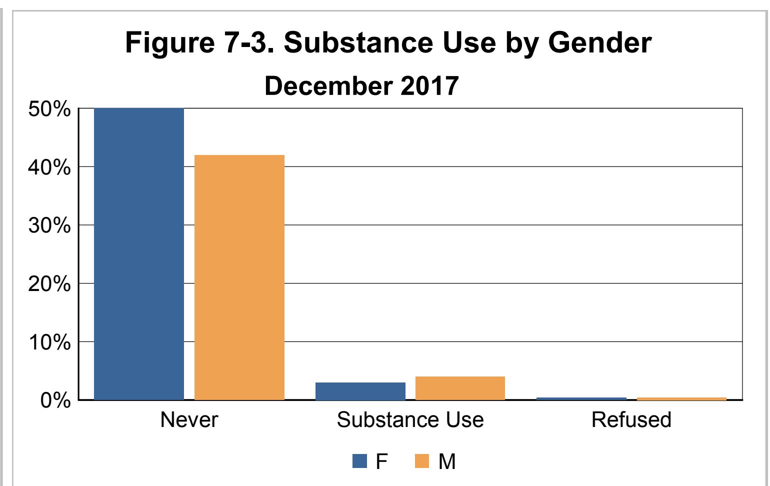
Table 7. Substance Use Reported for Total Population

December 2017

SUBSTANCE USE	TOTAL	PERCENT
Almost Every Day	6,910	1.94%
Sometimes	9,229	2.59%
Rarely	8,612	2.42%
Never	328,265	92.27%
Refused	2,753	0.77%
TOTAL	**355,769**	**100.00%**







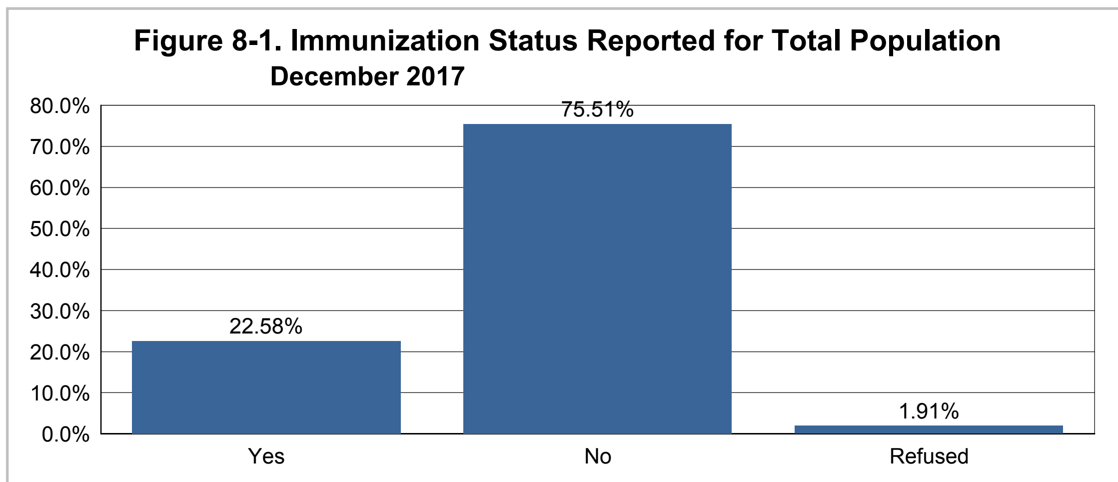
Question 8. Immunization Status (Annual Flu Vaccine)

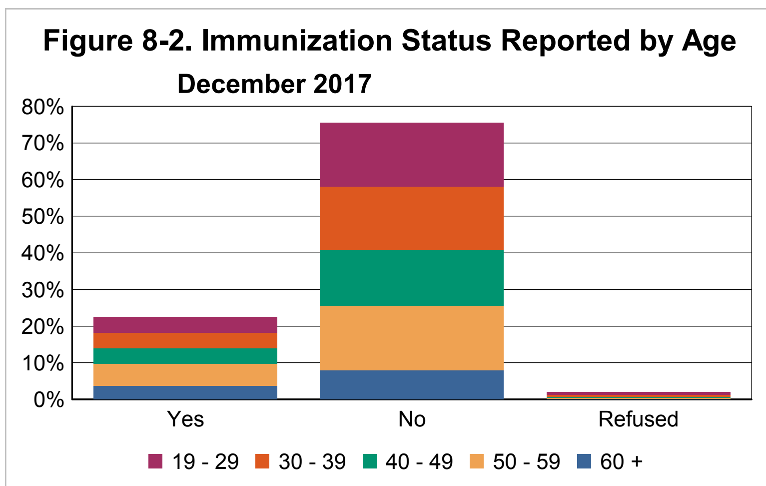
Question 8. The flu vaccine can be a shot in the arm or a spray in the nose. Have you had a flu shot or flu spray in the last year? This question is used to assess self-reported annual flu vaccine as an indicator of immunization status. Healthy Michigan Plan enrollees were given the answer options of yes or no. Table 8 shows the overall answers to this question for December 2017. Among enrollees who participated in the survey, there was a 1.91% refusal rate for this question. Figures 8-1 through 8-3 show immunization status reported for the total population, and by age and gender.

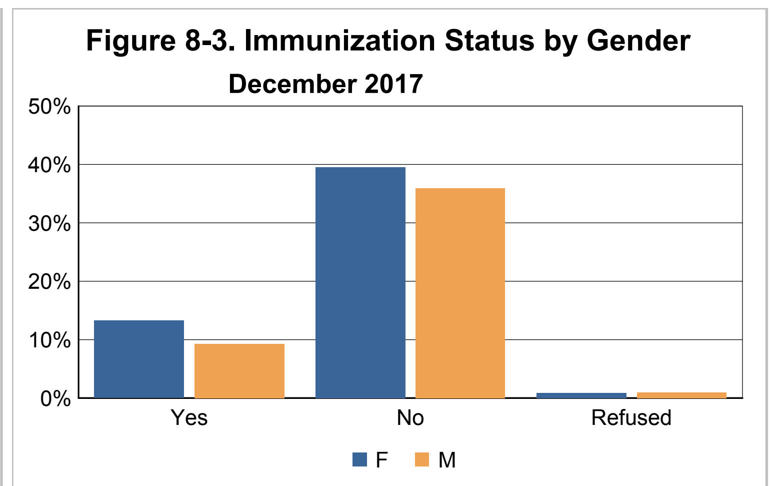
Table 8. Immunization Status Reported for Total Population

December 2017

IMMUNIZATION	TOTAL	PERCENT
Yes	80,319	22.58%
No	268,642	75.51%
Refused	6,808	1.91%
TOTAL	**355,769**	**100.00%**







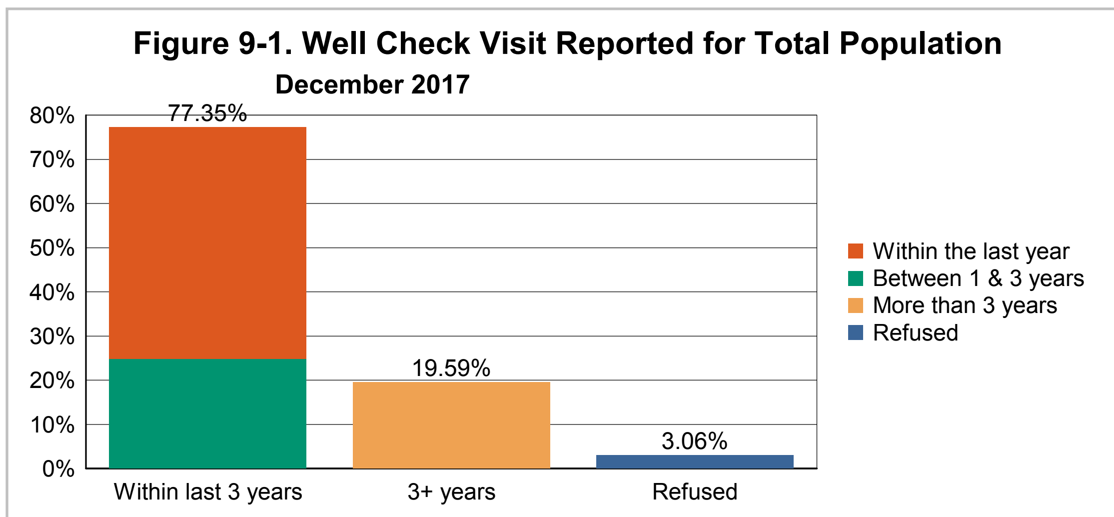
Question 9. Well Check Visit

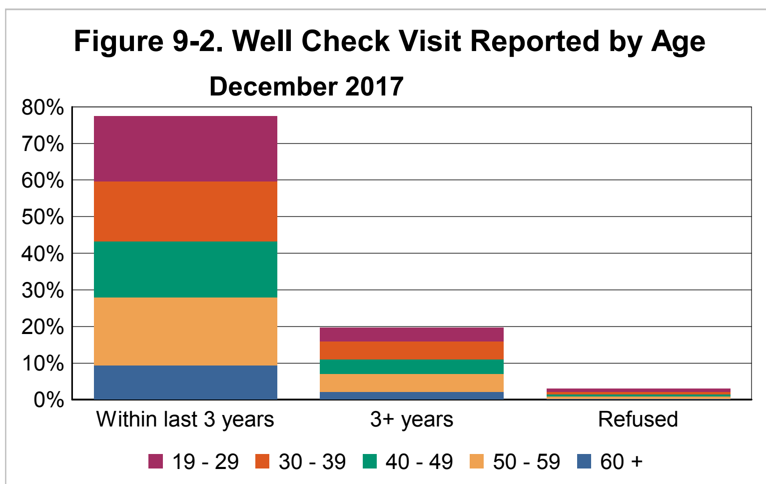
Question 9. A checkup is a visit to a doctor's office that is NOT for a specific problem. How long has it been since your last check-up? This question is used to assess self-reported well check visit. Healthy Michigan Plan enrollees were given the answer options of within the last year, between 1-3 years and more than 3 years. Table 9 shows the overall answers to this question for December 2017. Among enrollees who participated in the survey, there was a 3.06% refusal rate for this question. Figures 9-1 through 9-3 show well check visit reported for the total population, and by age and gender.

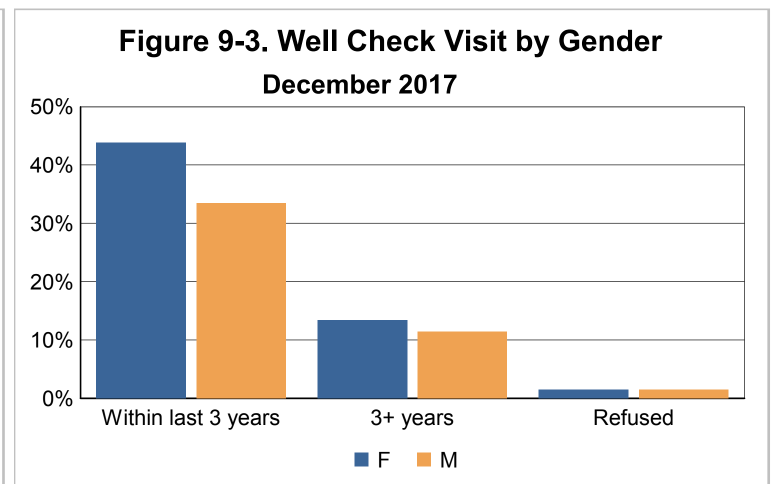
Table 9. Well Check Visit Reported for Total Population

December 2017

CHECK-UP	TOTAL	PERCENT
Within the last year	186,818	52.51%
Between 1 & 3 years	88,360	24.84%
More than 3 years	69,691	19.59%
Refused	10,900	3.06%
TOTAL	**355,769**	**100.00%**







Health Risk Assessment Part 2

Health Risk Assessments completion with Primary Care Provider

In April 2014, the Healthy Michigan Plan was launched, and an initial preventive health visit to a primary care provider was promoted for all new beneficiaries. Beneficiaries were also encouraged to complete the last section of the Health Risk Assessment at this initial appointment. This final section of the Health Risk Assessment is completed jointly by beneficiaries and their primary care provider. It is designed as a tool for identifying annual health behavior goals.

Completion of this section of the Health Risk Assessment is also voluntary. Healthy Michigan Plan Beneficiaries who complete a Health Risk Assessment with a primary care provider attestation and agree to maintain or address healthy behaviors are eligible for an incentive. Of the 938,077 beneficiaries who have been enrolled in a health plan for at least six months, 178,106 or 19.0% have completed the Health Risk Assessment with their primary care provider as of December 2017.

The data displayed in Part 2 of this report reflect the healthy behavior goals selected jointly by Healthy Michigan Plan beneficiaries and their primary care provider in the final section of the Health Risk Assessment. As shown in Table 10, a total of 227,143 Health Risk Assessments were completed with primary care providers as of December 2017. Health Risk Assessment completion is reported by age, gender and Federal Poverty Level in Table 11.

Among beneficiaries who completed the Health Risk Assessment, 194,675 or 85.7% of beneficiaries agreed to address health risk behaviors. In addition, 30,527 or 13.4% of beneficiaries who completed the Health Risk Assessment chose to maintain current healthy behaviors, meaning that 99.1% of beneficiaries are choosing to address or maintain healthy behaviors. The healthy behaviors goal statements selected are reported in Table 12. Healthy behavior goal statements are also reported by age and gender in Figures 10-3 and 10-4.

Of the 194,675 beneficiaries who agreed to address health risk behaviors, 60.3% chose to address more than one healthy behavior. Tables 13 and 14 report the most frequently selected health risk behaviors to address, alone and in combination. Figure 10-5 is a Venn diagram representing the overlapping nature of the multiple healthy behaviors selected.

Health Risk Assessment Completion with Primary Care Provider

Table 10. Count of Health Risk Assessments (HRA) Completed with Primary Care Provider by Attestation

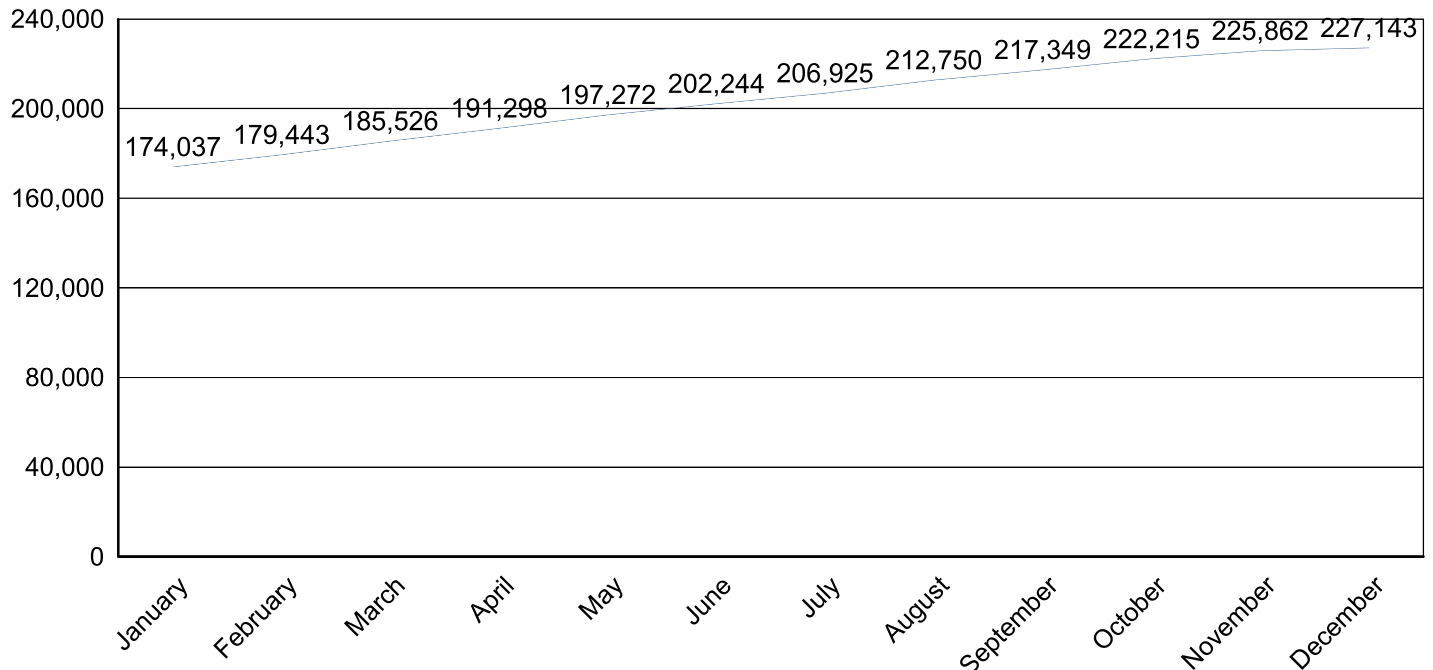
MONTH	COMPLETE	TOTAL
January 2017	4,614	174,037
February 2017	5,299	179,443
March 2017	6,024	185,526
April 2017	5,717	191,298
May 2017	5,895	197,272
June 2017	4,896	202,244
July 2017	4,631	206,925
August 2017	5,763	212,750
September 2017	4,549	217,349
October 2017	4,829	222,215
November 2017*	3,626	225,862
December 2017*	1,276	227,143

* Many completed HRAs for this month have not yet been submitted.

Table 11. Demographics of Population that Completed HRA with Primary Care Provider

September 2014 - December 2017

AGE GROUP	COMPLETED HRA	
19 - 29	44,462	19.57%
30 - 39	40,872	17.99%
40 - 49	42,602	18.76%
50 - 59	63,730	28.06%
60 +	35,477	15.62%
GENDER		
F	130,338	57.38%
M	96,805	42.62%
FPL		
< 100% FPL	188,042	82.79%
100 - 133% FPL	39,101	17.21%
TOTAL	**227,143**	**100.00%**



Healthy Behaviors Statement Selection

Section 4. Healthy Behaviors: In discussion with the beneficiary, primary care providers choose between 4 statements to attest to the healthy behaviors goals that the beneficiary will strive for this year. The 4 statements are:

A. Patient does not have health risk behaviors that need to be addressed at this times

B. Patient has identified at least one behavior to address over the next year to improve their health

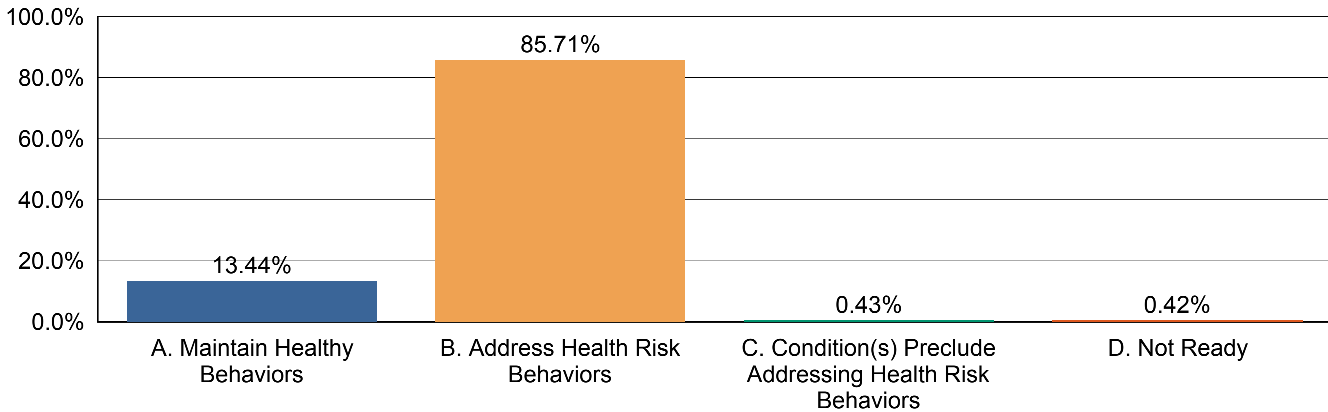
C. Patient has a serious medical, behavioral or social condition or conditions which precludes addressing unhealthy behaviors at this time.

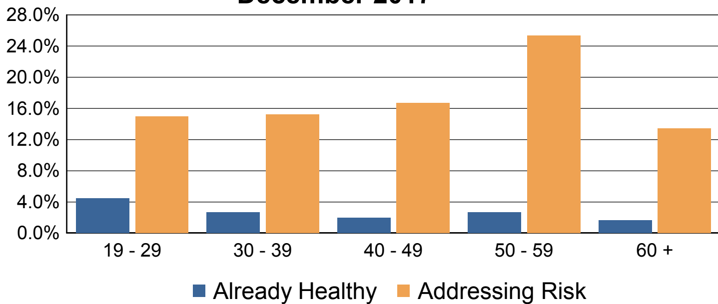
D. Unhealthy behaviors have been identified, patient's readiness to change has been assessed, and patient is not ready to make changes at this time.

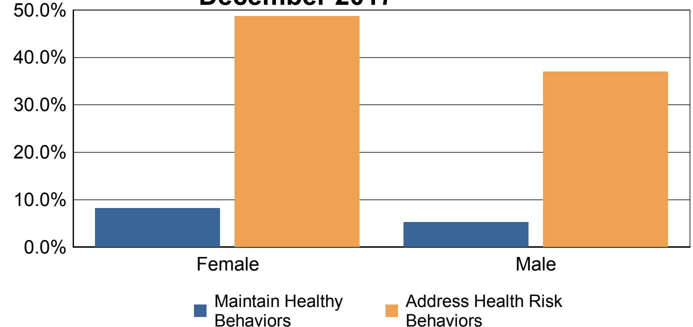
Figures 10-2 through 10-4 show Healthy Behaviors Statement Selections for the total population, and by age and gender.

Table 12. Healthy Behaviors Statement Selection
December 2017

CHECK-UP	TOTAL	PERCENT
A. Maintain Healthy Behaviors	30,527	13.44%
B. Address Health Risk Behaviors	194,675	85.71%
C. Condition(s) Preclude Addressing Health Risk Behaviors	989	0.44%
D. Not Ready	952	0.42%
TOTAL	**227,143**	**100.00%**







Selection of Health Risk Behaviors to Address

Section 4. Healthy Behaviors: In discussion with the beneficiary, when Statement B, "Patient has identified at least one behavior they intend to address over the next year to improve their health" is selected, providers choose one or more of the following 7 statements to identify the healthy behaviors the beneficiary has chosen to address for the year:

1. Increase physical activity, Learn more about nutrition and improve diet, and/or weight loss
2. Reduce/quit tobacco use
3. Annual Influenza vaccine
4. Agrees to follow-up appointment for screening or management (if necessary) of hypertension, cholesterol and/or diabetes
5. Reduce/quit alcohol consumption
6. Treatment for Substance Use Disorder
7. Other: explain ________________________

Of the 194,675 HRAs submitted through December 2017 where the beneficiary chose to address health risk behaviors, 60.32% of beneficiaries chose more than one healthy behavior to address. The top 7 most selected behavior combinations and the rate that each behavior was selected in combination and alone are presented in the tables below:

Table 13. Top 7 Most Selected Health Risk Behavior Combinations

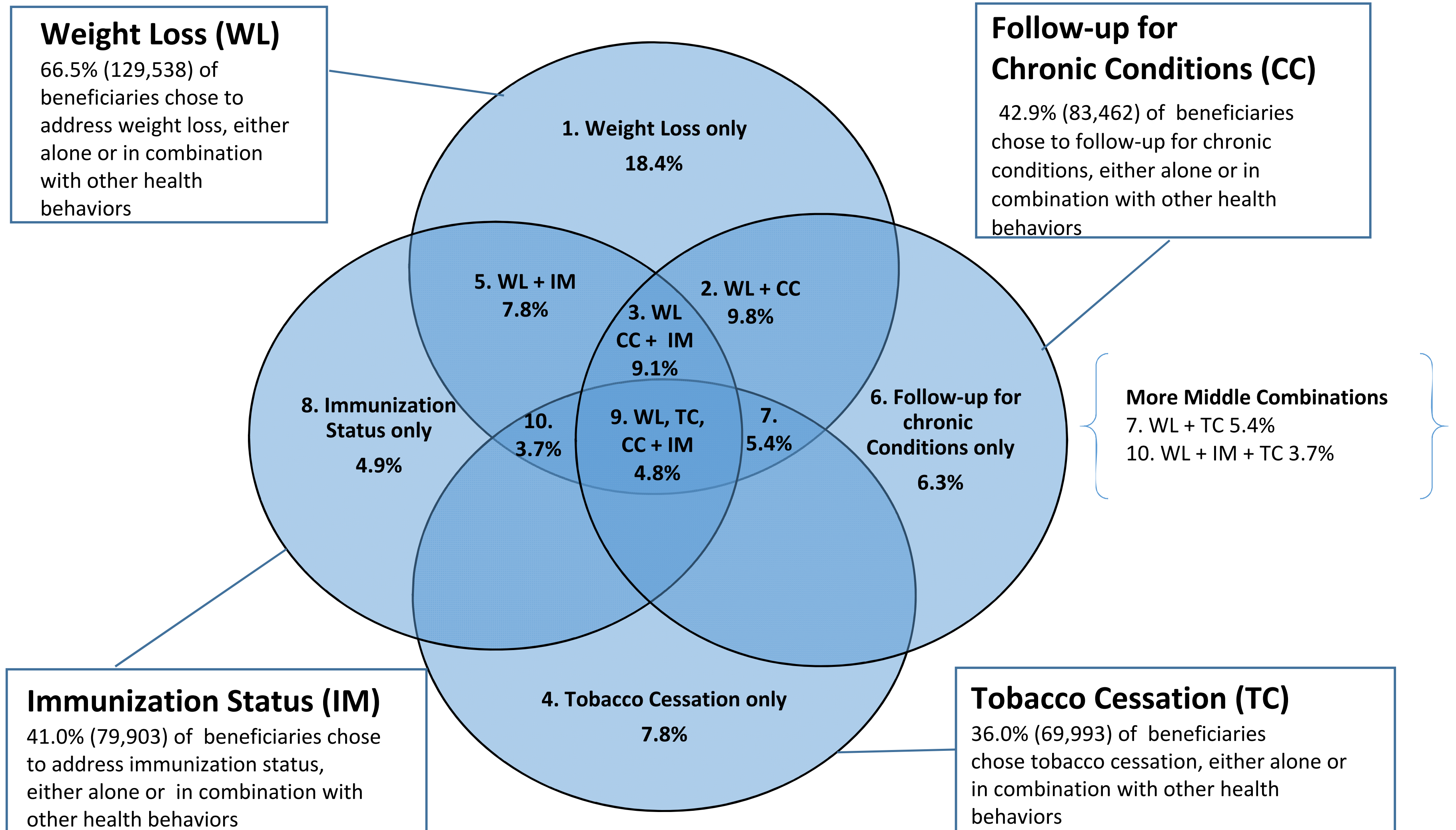
Health Risk Behavior Combination	Count	Percent
1. Weight Loss ONLY	35,759	18.37%
2. Weight Loss, Follow-up for Chronic Conditions	19,003	9.76%
3. Weight Loss, Immunization Status, Follow-up for Chronic Conditions	17,804	9.15%
4. Tobacco Cessation ONLY	15,266	7.84%
5. Weight Loss, Immunization Status	15,153	7.78%
6. Follow-up for Chronic Conditions	12,341	6.34%
7. Weight Loss, Tobacco Cessation	10,516	5.40%
Total for Top 7	125,842	64.64%
Total for All Other Combinations	68,833	35.36%
Total	**194,675**	**100.00%**

Table 14. Health Risk Behaviors Selected in Combination and Alone

Health Risk Behavior	Chose this behavior and at least one more	Chose ONLY this behavior
Weight Loss	66.54%	18.37%
Tobacco Cessation	35.96%	7.84%
Immunization Status (Annual Flu Vaccine)	41.05%	4.91%
Follow-up for Chronic Conditions	42.88%	6.34%
Addressing Alcohol Abuse	4.26%	0.34%
Addressing Substance Abuse	1.15%	0.11%
Other	4.36%	1.77%

Health Risk Assessment Completion with Primary Care Provider

Representation of the overlapping nature of top 10 health risk behavior selections December 2017



Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Thursday, February 16, 2017
Time: 1:00 pm – 4:30 pm
Where: Michigan Public Health Institute (MPHI)
2436 Woodlake Circle
Okemos, MI 48864
Attendees: **Council Members:** Robin Reynolds, Jeff Towns, Kim Singh, Amy Zaagman, Joanne Sheldon (for Loretta Bush), April Stopcyzinski, Pam Lupo, Julie Cassidy (for Emily Schwartzkopf), Alison Hirschel, Marilyn Litka-Klein, Dominick Pallone, Dave Lalumia, Mark Klammer, Marion Owen, Linda Vail, Travar Pettway, Eric Roath, Rebecca Blake, Warren White, Lisa Dedden Cooper, Dave Herbel

Staff: Chris Priest, Farah Hanley, Lynda Zeller, Kathy Stiffler, Brian Keisling, Brian Barrie, Marie LaPres, Pam Diebolt, Erin Emerson, Jon Villasurda, Michelle Best

Welcome, Introductions and Announcements

Robin Reynolds opened the meeting and introductions were made.

Federal Update

Chris Priest reported that the U.S. House of Representatives is scheduled to begin discussing legislation to repeal parts of the Affordable Care Act (ACA) beginning the week of February 27, 2017. Because the details of any potential new legislation and its impact on MDHHS are currently unknown, the Department is continuing to implement its programs as planned while also advocating for the Healthy Michigan Plan at the federal level. MDHHS staff and meeting attendees discussed ways to promote the Healthy Michigan Plan at length, while Robin Reynolds offered to draft a letter of support for the program on behalf of the Medical Care Advisory Council (MCAC).

Budget/Boilerplate Update

2017 Update/2018 Proposed Budget

The Governor submitted a budget proposal for Fiscal Year (FY) 2018 to the legislature on February 8, 2017, which contained a recommendation of $25.6 billion gross and $4.5 billion

general fund (GF) for the Michigan Department of Health and Human Services (MDHHS). Highlights of the Executive Budget Recommendation for MDHHS include:

- $55.5 million GF to fund the Federal Matching Assistance Percentage (FMAP) reduction for the Healthy Michigan Plan across Medicaid and Behavioral Health
- A one percent increase in actuarial soundness for Prepaid Inpatient Health Plans (PIHPs) and Medicaid Health Plans (MHPs)
- A wage increase of $0.50 for direct care workers
- Funding for 72 new full-time staff members across five State hospitals
- Funding for a 200 bed replacement facility for the Caro Center
- $12 million gross ($3 million GF) to expand contracted Non-Emergency Medical Transportation (NEMT) broker services beyond Southeast Michigan
- Funding for 51 additional Pathways to Potential workers
- A recommended increase in the child clothing allowance from $140 per month to $200 per month
- Funding for 95 additional full-time adult services workers
- Increased funding for foster care parent support, as well as an increase in private foster care agency rates
- Funding for an Integrated Service Delivery Information Technology (IT) initiative
- Increase in the emergency shelter per diem rate from $12 to $16
- Additional funding for delivery of in-home meals and services for seniors
- Additional funding for Flint
- $1 million for university autism programs
- $2 million to implement the recommendations of the child lead poisoning elimination board

MDHHS staff noted that there were several earmark eliminations included in the Executive Budget Recommendation, but expressed the Department's support for the Governor's proposed budget for the MDHHS Medical Services Administration.

Flint Update

MDHHS received approval from the Centers for Medicare & Medicaid Services (CMS) on May 9, 2016 for a waiver to provide coverage for children and pregnant women with incomes up to 400% of the Federal Poverty Level (FPL) impacted by Flint water, and the Department is continuing outreach and enrollment efforts among individuals eligible for coverage. On November 14, 2016, MDHHS received CMS approval for a State Plan Amendment to allow Michigan to implement a new health services initiative (HSI) for the enhancement and expansion of the current lead abatement program, effective January 1, 2017. As part of this expansion, the state will provide coordinated and targeted lead abatement services to eligible properties in the impacted areas of Flint, Michigan and other areas within the State of Michigan. As of February 16, 2017, 20 homes in Flint have received or are currently receiving lead abatement services, while 45 additional homes have been targeted for outreach. The

Department is also working to identify additional communities for lead abatement services. A residence located in Flint or other targeted community identified by MDHHS may be eligible for lead abatement services if a Medicaid or Children's Health Insurance Program (CHIP)-eligible child or pregnant woman lives in the home.

Medicaid Managed Care

Provider Surveys

The MHP provider survey that was discussed at the previous MCAC meeting has now been finalized. To conduct the survey, MDHHS will randomly select providers to complete surveys related to their experience working with a specific MHP. If a provider completes the survey for the MHP to which they are assigned, they may complete additional surveys for any MHP they choose. The survey will be distributed to providers electronically by February 28, 2017.

The Department also plans to conduct a phone survey in March 2017 related to beneficiaries' experiences using Medicaid NEMT services. In addition, the Michigan Health Endowment fund has provided a grant to the Michigan League for Public Policy to study various issues related to Medicaid NEMT services.

Healthy Kids Dental Bid

MDHHS is preparing to release a Request for Proposal (RFP) for a new ***Healthy Kids Dental*** contract, and is aiming to issue contracts to more than one statewide vendor. Kathy Stiffler reported that the RFP has been delayed from its initial planned release, and that the new contract is not likely to be in effect by October 1, 2017 as discussed at the previous MCAC meeting. In response to a concern raised by a meeting attendee, MDHHS staff indicated that while the goal in seeking more than one vendor is to provide greater access to services, contracts will only be awarded to vendors that have an adequate provider network.

Health Insurance Claims Assessment (HICA) Tax

In 2016, Governor Snyder vetoed legislation to reconfigure the way Michigan's 6% use tax on Health Maintenance Organizations (HMOs) is utilized. CMS has disallowed the use tax, and it was scheduled to sunset on December 31, 2016. Chris Priest reported that following the previous MCAC meeting, the Michigan House and Senate passed legislation placing a moratorium on the use tax in order to implement the CMS requirement. Legislation to reconfigure the way the use tax is utilized has been re-introduced in the state Senate, with the understanding that the State plans to discuss the details of a potential replacement with CMS after the new administration's leadership is in place.

Other

A meeting attendee requested information on the Department's treatment of Substance Use Disorder (SUD) services. In response, MDHHS staff and meeting attendees discussed several programs within the Medical Services Administration and Behavioral Health and Developmental Disabilities Administration that have been developed for the treatment of SUD.

Healthy Michigan Plan

Second Waiver Update (MI Health Account, Marketplace Protocol, Healthy Behaviors)

Under the terms of the second waiver, beginning April 1, 2018, Healthy Michigan Plan beneficiaries with incomes above 100% of the FPL who do not meet the criteria for "Medically Frail" and who have not completed a Health Risk Assessment (HRA) must leave the Healthy Michigan Plan and receive coverage from the Federally Facilitated Marketplace (FFM). Kathy Stiffler reported that MDHHS has released guidance to the health plans related to eligibility criteria for members of the Healthy Michigan Plan to receive services on the FFM, and that MDHHS is continuing to work with the Department of Insurance and Financial Services (DIFS) to develop coverage parameters for the health plans that serve this population. MDHHS will not require health plans on the FFM to develop a new product specific to Healthy Michigan Plan beneficiaries, but will instead allow the plans to use existing products to provide services to this population, and sign a Memorandum of Understanding (MOU) to implement special coverage provisions required by the second waiver. Approximately 125,000 Healthy Michigan Plan beneficiaries currently have incomes above 100% of the FPL.

The Department is also working to update the Healthy Behavior Protocols and MI Health Account Statement. The revised MI Health Account Statements will be sent to Healthy Michigan Plan beneficiaries beginning April 1, 2017.

A meeting attendee raised a concern regarding the online MI Health Account Portal by reporting that a beneficiary is charged an additional fee if their bank account information is entered incorrectly when attempting to pay their bill. MDHHS staff indicated they would check into this concern.

Behavioral Health Updates

PA 298 – Models

Lynda Zeller introduced Jon Villasurda as the new State Assistant Administrator for the Behavioral Health and Developmental Disabilities Administration, and gave an update on the Stakeholder 298 work group process that was convened to discuss the integration of behavioral health and physical health services. As of February 16, 2017, the work group process is nearly complete, and as a result of the work group's efforts, the Department

submitted an interim report to the legislature containing 70 recommendations in 13 categories to improve behavioral health and physical health outcomes. MDHHS is currently working to complete financial models for the implementation of the group's recommendations, which are due to the legislature on March 15, 2017. A Stakeholder forum is also planned for February 24, 2017 to discuss the work group process. The interim legislative report will be posted for public comment beginning at 3:00 p.m. on February 16, 2017 until February 28, 2017. Following the public comment period, MDHHS will submit a final report to the legislature that will contain the group's 70 recommendations, financial models and service delivery models. After the submission of the final report, the Department will continue to discuss benchmarks and outcomes for the implementation of the report's recommendations with the legislature.

1115 Waiver Status

MDHHS submitted a Section 1115 waiver to CMS in July 2016 to allow the administration of behavioral health services under a single waiver authority. The Department is continuing to work through the approval process with CMS, and MDHHS staff noted that conversations with their federal partners have been constructive.

Other

On February 17, 2017, MDHHS will submit the state's response to the Substance Abuse and Mental Health Services Administration's (SAMHSA) Opioid State Targeted Response (STR) grant. The grant is made available only to states based on demographics, and will award a multi-year grant of $16 million to promote the recommendations of the Opioid Commission Report and the goals of the new opioid commission. The five areas outlined in the report include prevention, treatment, policy and outcomes, regulation, and enforcement.

State Innovation Model (SIM)

On January 1, 2017, the health plans began making payments to providers under the SIM program. Providers were previously reimbursed for these services as part of the Michigan Primary Care Transformation (MiPCT) initiative. Chris Priest also reported that Tom Curtis, who previously worked on the SIM project in the Policy, Planning & Legislative Services Administration, has been hired as the Quality Improvement and Program Development section manager within the Managed Care Plan Division of the Medical Services Administration.

On February 15, 2017, the Medicaid MiPCT evaluation team presented the Medicaid evaluation results of the MiPCT pilot to the MHPs. MiPCT formed the basis for the Patient-Centered Medical Home (PCMH) model within SIM, and the results of the evaluation demonstrated improved outcomes and costs among the high-risk population. Kathy Stiffler offered to share the evaluation results with meeting attendees.

Long-Term Care Services and Supports Updates

Brian Barrie provided an update on several topics related to long-term care services and supports, which include:

- The federal comment period for Michigan's Section 1115 Brain Injury Waiver ended on February 12, 2017, and MDHHS has received CMS approval for its implementation effective April 1, 2017.
- MDHHS established a pilot program to coordinate NEMT services through the MI Choice Waiver agencies, which decreased NEMT prior authorization decisions for beneficiaries from two and a half weeks to approximately 20 minutes in the pilot regions. The Department has received CMS approval for a waiver amendment to expand the program statewide effective April 1, 2017, and is now working toward implementation.
- MDHHS is revising the redetermination process for the home help program by eliminating the requirement that certain beneficiaries whose circumstances are not expected to change submit a Medical Needs Assessment Form (DHS-54A) upon eligibility redetermination.
- MDHHS is working to improve the assessment process for home help program beneficiaries who have complex care needs.
- MDHHS is developing a quality initiative for the Adult Protective Services program in order to better assess outcomes for its beneficiaries.
- MDHHS is in the process of moving the Level of Care Determination (LOCD) operation from the Bridges system into CHAMPS, which will provide the Department with the opportunity to design and implement changes to the LOCD process based on recommendations from the LOCD stakeholder group that met in 2015.
- MDHHS is working with a design team to develop a sustainable program model for nursing facility transitions. The design team has identified 18 core values for the new system to follow, and four action teams have been created to address the pre-nursing facility transition phase, transition phase, post-transition phase, and policy implications of the new sustainable program model.
- Design teams will also begin work in the near future to address changes to Michigan Rehabilitation Services, the Preadmission Screening and Annual Resident Review (PASARR) assessment, the nursing facility admission and discharge processes, person-centered planning, and quality within the Michigan Veterans Administration (VA) homes.

MDHHS staff and meeting attendees discussed at length the importance of incorporating beneficiary input into the process of designing changes to the long-term care services and supports initiatives highlighted above, in order to ensure that the needs of consumers are being met.

Policy Updates

A policy bulletin handout was distributed to attendees, and several updates were discussed.

The meeting was adjourned at 4:00 p.m.

Next Meeting: Tuesday, May 23, 2017

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Monday, June 26, 2017
Time: 8:30 a.m. – 12:00 p.m.
Where: Peckham Industries
3510 Capital City Blvd.
Lansing, MI 48906-2102
Attendees: **Council Members**: Robin Reynolds, Marilyn Litka-Klein, Barry Cargill, Dominick Pallone, Deb Brinson, Alison Hirschel, Warren White, Amy Zaagman, Stacy Hettiger (for Rebecca Blake), Michelle Best (for Amy Hundley), Linda Vail, Emily Schwarzkopf, Pam Lupo, Robert Sheehan, Dave LaLumia, Kimberly Singh, April Stopczynski, Jeffrey Towns

Staff: Chris Priest, Farah Hanley, Lynda Zeller, Erin Emerson, Dick Miles, Kathy Stiffler, Dave Schneider, Jackie Prokop, Pam Diebolt, Marie LaPres, Cindy Linn

Other Attendees: Mary Vizcarra, Salli Pung

Welcome, Introductions, Announcements

Robin Reynolds opened the meeting and introductions were made.

Federal Updates

Chris Priest reported that the U.S. Senate has released its own version of a bill to repeal and replace the Affordable Care Act (ACA) and discussed the ways in which it would impact the Medicaid program if adopted. If enacted, the bill would:

- Allow states that have not yet expanded Medicaid eligibility to do so at the regular Federal Matching Assistance Percentage (FMAP) rate;
- Gradually decrease the FMAP rate in current expansion states to the regular FMAP beginning in 2021, which, over time, would result in an estimated cost of $800 million General Fund for the State of Michigan;
- Immediately implement cuts to the Disproportionate Share Hospital (DSH) pool that were included as part of the Affordable Care Act (ACA) in states that expanded Medicaid eligibility, while non-expansion states would be exempt from DSH pool cuts;
- Transform the Medicaid program to a per-capita cap model and exclude children who receive a disability eligibility determination;
- Change the base year calculation to allow states to choose eight consecutive fiscal quarters from 2014 through the third quarter of FY 2017 to set their base rate;

- Require the federal Department of Health and Human Services (HHS) to consult with the states before issuing new guidance related to Medicaid;
- Allow states to expand access to mental health and substance use disorders at the regular match rate;
- No longer require states to offer up to 90 days of retroactive Medicaid eligibility for new enrollees beginning October 1, 2017; and
- Gradually reduce states' provider tax limit to 5%.

MDHHS staff and meeting attendees discussed the proposed legislation at length.

Budget/Boilerplate Update

2017 Updates

The legislature has approved a supplemental Fiscal Year (FY) 2017 budget, which includes funding to implement the pilots approved in the FY 2018 budget around the integration of physical health and behavioral health services.

2018 Proposed Budget

The FY 2018 budget has been approved by the legislative conference committee and forwarded to the governor for review. Farah Hanley indicated that nearly all of the priorities established by MDHHS leadership and the governor for the department were approved in the final legislative draft of the budget, which include:

- Funding for the MDHHS Integrated Service Delivery (ISD) initiative to develop a universal caseload concept, which will affect caseworkers in the field, enable the establishment of a universal call center, and support necessary systems changes;
- Full funding for Medicaid Health Plan actuarial soundness (which assumes that the ACA insurer fee will not be reinstated);
- Full funding for the Medicaid program at the Department's caseload projections for FY 2018;
- $500,000 to support a public transit pilot in areas of the state where Non-Emergency Medical Transportation (NEMT) services are currently unavailable;
- $5.7 million for a direct primary care pilot program in Wayne, Oakland, Macomb, Washtenaw and Livingston counties that will work directly with providers to provide services at a lower per-member-per-month payment;
- $240,000 for the I Vaccinate program to minimize the occurrence of vaccine-preventable diseases;
- $45 million to fund a direct care worker wage increase of $0.50;
- Funding for 72 additional staff at state psychiatric hospitals;
- Funding for a new Caro Psychiatric hospital, which was approved through the capital outlay process;

- Funding for the Psychiatric Residential Transition Unit to assist children in the Hawthorn Center for Children in preparing for the community;
- Funding for 95 additional adult services workers;
- An increase in the foster care provider administrative rate;
- Funding for a vapor intrusion office, drinking water unit, and childhood lead poisoning prevention unit within the Population Health Administration;
- Funding for out-state dental clinics; and
- Funding for pregnancy prevention programs.

In addition, a few reductions included in the FY 2018 budget were noted as well, including:

- A $750,000 reduction in funding for the Mental Health and Wellness Commission; and
- A reduction in funding for university autism programs.

Healthy Michigan Plan

Second Waiver Update

MDHHS is continuing to move forward with implementing the terms of the second waiver for the Healthy Michigan Plan. Under the terms of the waiver beginning April 1, 2018, individuals who have been enrolled in the Healthy Michigan Plan for at least 12 months, have incomes above 100% of the federal poverty level (FPL) and do not meet the criteria for “medically frail” may:

- Remain on the Healthy Michigan plan if they choose to engage in one or more healthy behaviors; or
- If they do not agree to engage in one or more healthy behaviors, they will receive insurance coverage from the Federally Facilitated Marketplace (FFM).

Insurance carriers interested in offering plans on the FFM for this population filed rates on June 14, 2017, and MDHHS is working with the Department of Insurance and Financial Services (DIFS) to establish a Marketplace option in all counties for Healthy Michigan Plan beneficiaries. As part of this process, many plans filed two sets of rates to account for the possibility that cost-sharing reductions are not approved in federal law. MDHHS also plans to issue a revised Healthy Behaviors Incentives Protocol and Operational Protocol for the MI Health Accounts, as well as a Healthy Michigan Plan Marketplace Operation Operational Protocol related to the implementation of the Second Waiver. MDHHS staff and meeting attendees discussed at length coverage options and the urgency of assuring at least two health plan product offerings in every county for the Healthy Michigan Plan population (except the Upper Peninsula, which only needs one). An exception will be requested of CMS if less than two offerings are available in all Lower Peninsula counties. Plans continue to work to finalize their networks. Staff noted that dental benefits will not be provided through the health plans for members of the Healthy Michigan Plan Marketplace population.

Healthy Behaviors Update

Kathy Stiffler shared that MDHHS is working to revise the Health Risk Assessment (HRA) form by removing the option to include beneficiary biometric data (e.g., cholesterol levels, blood pressure, etc.) and convert the HRA to an electronic format from the current paper form. This will allow providers to submit the form directly to MDHHS for staff to forward to the correct health plan. The Department's goal with moving to the new submission system is for timelier processing of HRAs and greater beneficiary participation in healthy behaviors. Currently, 18% of Healthy Michigan Plan beneficiaries have completed an HRA and are engaging in one or more healthy behaviors.

Other

The current Healthy Michigan Plan §1115 Demonstration Waiver expires on December 31, 2018, and MDHHS is working to submit a request for extension to the Centers for Medicare & Medicaid Services (CMS) by December 31, 2017.

Medicaid Managed Care

Provider Surveys

MDHHS worked with the Michigan State University Institute for Health Policy to develop and distribute a survey to providers related to their experience in working with the health plans. To conduct the survey, MDHHS randomly selected providers to rate their experience working with a specific health plan. Providers who completed a survey of the health plan to which they were assigned were allowed to survey additional health plans of their choosing. The survey was distributed to 5,607 providers (in anticipation of a low response rate) with a statewide target sample of 2,317. However, only 5% of all providers completed a survey, (11% of the target sample). A draft report showing the results of the survey was distributed to meeting attendees. MDHHS staff indicated that while the Department does not plan to publish the report due to the low response rate, some findings will be shared with individual Medicaid Health Plans.

Healthy Kids Dental Bid Update

MDHHS is currently accepting bids for a new ***Healthy Kids Dental*** contract, and has extended the deadline for submissions to July 31, 2017. Award notices will be posted on www.buy4michigan.com in October or November 2017, with a contract start date of April 1, 2018. While Delta Dental is currently the only provider with a contract to provide services to ***Healthy Kids Dental*** program beneficiaries, the Department aims to award new contracts to more than one statewide vendor. If more than one contract is awarded, a systems change will be required to allow beneficiaries the choice of enrolling in any available plan. Additional information regarding the ***Healthy Kids Dental*** contract award process is available on the web at www.buy4michigan.com.

Prescriber Enrollment – Community Health Automated Medicaid Processing System (CHAMPS)

Despite ongoing outreach efforts by MDHHS, several prescribers providing services to Medicaid beneficiaries are not currently enrolled in CHAMPS as required by CMS. Compliance was expected July 1, 2013, but implementation has again been postponed to allow more time for prescribers to enroll to avoid medication access issues. Further outreach efforts will be implemented.

Behavioral Health Updates

Parity Rule

MDHHS staff provided meeting attendees with copies of a printed presentation detailing the Department's efforts to comply with the Mental Health Parity and Addiction Equity Act of 2008 and gave an overview of the document.

Section 298 – Models

The Stakeholder 298 work group that was convened to discuss the integration of behavioral health and physical health services has submitted a final report containing 72 policy recommendations to the legislature, and it has been forwarded to the Governor for review. MDHHS is now working internally to make preparations for carrying out the recommendations of the report and to develop benchmarks for implementation of the pilots approved in the FY 2018 budget. The Department must also submit a report to the legislature by November 1, 2017 to propose remedies to any potential barriers to implementation.

1115 Waiver Status

MDHHS submitted a Section 1115 Waiver to CMS in July 2016, which would allow the administration of all behavioral health services under a single waiver authority, and is continuing to work through the approval process with its federal partners.

Other

Lynda Zeller addressed several other topics related to behavioral health services, including:

- The Behavioral Health and Developmental Disabilities Administration (BHDDA) is working with other areas of MDHHS and stakeholders to identify specific barriers to access to care for inpatient psychiatric services, in order to develop policy to address the issue.
- A letter was issued by the MDHHS Bureau of Community Based Services to offer guidance to providers regarding the department's process for establishing psychiatric Institute for Mental Disease (IMD) rates.

- BHDDA is working with the National Governor's Association (NGA) to:
  - Explore ways to increase access to health care in rural areas, with an emphasis on behavioral health services; and
  - Improve information sharing among providers related to better care coordination, with a specific focus on behavioral health services.

Long Term Care Services and Supports Updates

Dick Miles provided an update on several initiatives related to Long Term Care that were included in the FY 2018 budget, including:

- The establishment of a nursing facility quality measure initiative to provide a supplemental payment to nursing facilities based on their 5-star ratings from the CMS Nursing Home Compare (NHC) website;
- $150,000 in funding for an electronic visit verification (EVV) system for personal care service providers beginning in 2019;
- A provision that will allow MDHHS additional flexibility for Program of All Inclusive Care for the Elderly (PACE) expansion outside of the regular budget cycle;
- General fund support to continue the Hospice Residence program;
- $3.7 million in funding to support housing and outreach specialists related to nursing facility transitions; and
- A provision to allow MDHHS to explore the implementation of managed long term care supports and services.

In addition to long term care services and supports items included in the FY 2018 budget, Mr. Miles also shared the following updates:

- MDHHS is working to submit a renewal request to CMS for the MI Choice Waiver, which currently expires in October 2018.
- The MI Choice program was converted to a capitated payment model in October 2013, and the Department is continuing to provide assistance to MI Choice waiver agencies as needed to help with the transition.
- The Medicaid Home Help program is in the process of converting to a new time and task care management model for providers.
- As of June 26, 2017, approximately 38,000 beneficiaries are enrolled in the MI Health Link demonstration program for individuals who are dually eligible for Medicare and Medicaid. The demonstration is currently authorized through 2020, MDHHS is continuing to evaluate the program and make improvements where necessary.
- The PACE program is continuing to expand with 2,000 beneficiaries currently enrolled, and MDHHS is preparing to open a new PACE center in Newaygo County.

Policy Updates

A policy bulletin handout was distributed to attendees and several items were discussed.

The meeting was adjourned at 12:00 p.m.

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Wednesday, August 30, 2017
Time: 1:00 p.m. – 4:30 p.m.
Where: Michigan Public Health Institute (MPHI)
2436 Woodlake Circle, Suite 380
Okemos, MI 48864
Attendees: **Council Members:** Robin Reynolds, Amy Zaagman, Jeff Towns, Emily Schwarzkopf, David Herbel, Stacey Hettiger (for Rebecca Blake), Rod Auton, April Stopczyinski, Kim Singh, Michelle Best (for Amy Hundley), Eric Liu, Barry Cargill, Robert Sheehan, Elmer Cerano, Dan Thompson (for Loretta Bush), Dan Wojciak (for Alison Hirschel), Diane Haas, Marilyn Litka-Klein, Debra Brinson, Dominick Pallone

Staff: Chris Priest, Farah Hanley, Dick Miles, Kathy Stiffler, Jackie Prokop, Cindy Linn, Marie LaPres, Jon Villasurda

Other Attendees: Salli Pung

Welcome, Introductions, Announcements

Robin Reynolds opened the meeting and introductions were made.

Medicaid Managed Care

Healthy Kids Dental Bid Update

Kathy Stiffler reported that bids for a new ***Healthy Kids Dental*** contract were due on July 31, 2017. The Joint Evaluation Committee has met to review the submissions, and is currently in the process of developing its final recommendations. The award winner(s) will be announced on www.buy4michigan.com for the new contract(s) to begin on April 1, 2018. **UPDATE:** following the meeting, the start date for the new ***Healthy Kids Dental*** contract was changed to October 1, 2018.

Member Transportation Survey

MDHHS distributed a survey to Medicaid beneficiaries to identify their utilization experience or knowledge of Medicaid transportation services. Surveys were distributed to both users and non-users of Medicaid transportation services. To date, more users have responded to the survey than non-users. MDHHS plans to conclude the survey process at the end of August 2017 or the first week of September, and will share results at the next Medical Care Advisory Council (MCAC) meeting.

Integrated Service Delivery (ISD)

MDHHS is in the process of implementing a new universal caseload system known as ISD to provide a single portal for beneficiaries who receive services from multiple MDHHS programs. ISD will also include an assessment tool that individuals can use to indicate if they would like information on programs offered through any agency within the State of Michigan, and a central call center that beneficiaries may contact with questions. A pilot ISD system has been tested in select areas of the State, and MDHHS hopes to launch the system statewide by the end of 2017. As part of ISD implementation, the DHS-1171 – Assistance Application will be revised to allow individuals to apply for health care coverage in addition to other MDHHS programs when completing the form. ISD implementation will not impact the current Medicaid redetermination process, as its focus will be to improve efficiency in the delivery of services.

Behavioral Health Updates

Section 298

As discussed at the previous MCAC meeting, the Stakeholder 298 workgroup that was convened to discuss the integration of behavioral health and physical health services has submitted a final report to the legislature containing 72 policy recommendations. Following the submission of the report, the legislature directed MDHHS through PA 107 of 2017 to pilot three fully integrated financial models based on the policy recommendations and submit a report back to the legislature by November 1, 2017 identifying any barriers to the integration of behavioral health and physical health services. Any savings found as a result of integration must be re-invested into providing behavioral health services.

In response to a concern raised by a meeting attendee, MDHHS staff indicated that the Department intends to involve relevant stakeholders, including beneficiaries in the implementation process as early as possible to assist in the development of a Request for Information (RFI) that MDHHS plans to release in the next month. If three or more entities respond to the RFI, the Department must initiate a competitive bid process for those interested in participating with the pilot. The pilot models must be implemented by March 1, 2018.

Section 1115 Waiver Update

MDHHS conducted a site visit with the Centers for Medicare & Medicaid Services (CMS) related to the submission of its Section 1115 Waiver request to implement all behavioral health services under a single waiver authority. During the site visit, CMS indicated that the B3 services and supports provisions of the waiver, which would expand housing services and supports, are currently under review with general counsel for the federal department of Health and Human Services (HHS). MDHHS staff noted that CMS will proceed with the waiver approval process once general council issues an opinion, and that the Department's 1915(b) and 1915(c) waivers are still in place pending a decision by CMS.

Other

MDHHS has convened the Michigan Inpatient Psychiatric Access Discussion (MIPAD) to address barriers to access for inpatient psychiatric care.

Long Term Care Services and Supports Updates

Modernizing Continuum of Care (MCC): System and Process Changes

Effective January 2, 2018, MDHHS will implement the MCC project to improve the communication between Bridges and CHAMPS that will reduce processing time for a variety of functions and reduce errors related to admission and enrollment, as well as discharge and disenrollment. Key features of the MCC project include:

- Level of Care (LOC) codes will be replaced by Program Enrollment Type (PET) codes. The PET codes more precisely reflect program options and provide additional information on living arrangements and exemption reasons.
- Specific providers will directly enter admission/discharge or enrollment/disenrollment information in CHAMPS. This will result in real-time changes to the National Provider Identifier (NPI) and the beneficiary's PET code. As part of this change, the MSA-2565-C form will no longer be used for facility admissions.
- Providers will be able to view a roster of all beneficiaries for whom they have submitted admission or enrollment information in CHAMPS. This roster will allow the provider to see an individual's admission or enrollment information, Medicaid status, and information on discharged beneficiaries.
- When a nursing facility enters admission information for an individual who does not have active or pending Medicaid eligibility, a Medicaid Application Patient of Nursing Facility (DHS-4574) will be automatically mailed to the individual.

Three proposed policies that each discuss a different component of the MCC project (1717-MCC, 1718-MCC and 1719-MCC) are currently posted for public comment until October 17, 2017.

Other

In addition to the MCC project, Dick Miles also shared the following updates related to long term care services and supports:

- MDHHS is in the process of seeking a renewal of the MI Choice Home and Community Based Services (HCBS) waiver, which currently expires on December 31, 2018. The Department will hold meetings with interested parties to discuss the waiver extension request beginning in September 2017.
- MDHHS will also host stakeholder meetings to discuss the possibility of moving to a managed long-term care system.

- In 2016, a new Home Help policy section was established within the Bureau of Medicaid Policy and Health System Innovation, and is now nearly fully staffed.
- To comply with federal requirements, MDHHS is working to implement an Electronic Visit Verification (EVV) system to document Home Help provider visits to a client's home. The EVV system must be in place by January 1, 2019.
- MDHHS is working through the Lean process to establish a sustainable business model for nursing facility transitions.

<u>Budget/Boilerplate Update</u>

2018 Budget Update

Farah Hanley reported that the Fiscal Year (FY) 2018 budget has been approved by the Governor, and includes many of the priorities established by Department leadership and the Governor that were discussed at the previous MCAC meeting.

2019 Budget

In FY 2019, MDHHS anticipates approximately $200 million in additional general fund costs due to inflation, increased Medicaid caseload, and a reduction in the Federal Matching Assistance Percentage (FMAP) rate that is due to a rise in per capita income in the State of Michigan. The State of Michigan will also need to contribute an additional $30 million in matching funds for the Healthy Michigan Plan in FY 2019. In addition to increased costs in FY 2019, general fund revenue is expected to decrease by approximately $400 million due to various tax credits taking effect, including a new homestead property tax credit, a transportation earmark from general income tax receipts, and a use tax earmark. Because of this cost and revenue forecast, Farah Hanley advised meeting attendees that MDHHS expects that while the FY 2019 budget will maintain current Department programs, new investments will likely not be included at the same level as in FY 2018.

Statewide Integrated Governmental Management Application (SIGMA)

On October 3, 2017, MDHHS will implement a new system known as SIGMA to improve the way Michigan performs all financial activities, including budgeting, accounting, payments and grant opportunities. Meeting attendees were advised that with the launch of SIGMA at the beginning of a new fiscal year, payment to providers for Pay Cycle 40 will be delayed by one week, from October 5, 2017 to October 12. On October 12, providers will receive payments for two pay cycles.

Healthy Michigan Plan

Waiver Renewal and Protocols Out for Public Comment

MDHHS is in the process of preparing to implement the second waiver for the Healthy Michigan Plan. The Healthy Michigan Plan waiver renewal will include and be based on what is approved in the protocols by the federal government. Under the terms of the waiver beginning April 1, 2018, individuals who have been enrolled in the Healthy Michigan Plan for more than 12 months, have incomes above 100% of the federal poverty level, do not meet the criteria for "medically frail" and choose not to engage in one or more healthy behaviors must leave the Healthy Michigan Plan and receive insurance coverage from the Marketplace. As part of the waiver, MDHHS revised the Healthy Behavior Protocol and MI Health Account Protocol, which define the healthy behaviors process and cost-sharing requirements for Healthy Michigan Plan beneficiaries, and created the Marketplace Option Operational Protocol. MDHHS is accepting public comments on the Healthy Michigan Plan second waiver operational protocols until September 13, 2017, which can be accessed on the web at www.michigan.gov/healthymichiganplan.

Healthy Behavior Protocol

Under the current Health Risk Assessment (HRA) process, MDHHS receives notification that a beneficiary has chosen to participate in the healthy behavior only after the beneficiary completes the HRA with their primary care provider (PCP) and attests to one or more healthy behaviors, and the PCP then submits the HRA to the beneficiary's health plan. As outlined in the revised Healthy Behavior Protocol, MDHHS has modified the HRA form by removing biometric data (e.g., cholesterol levels, blood pressure, etc.) and has added an electronic format and centralized fax number for ease of submission. This will allow for timelier processing of HRAs and help to encourage greater beneficiary participation in the Healthy Behaviors Incentive program. Additionally, a specific group of preventive services that will be identified through encounter data and participation in approved wellness programs will also count as engaging in healthy behaviors.

Marketplace Plan Protocol

Handouts outlining the process for Healthy Michigan Plan beneficiaries to transition to the Marketplace, as well as the process for determining if an individual meets the criteria for "medically frail" as described in the Marketplace Option Operational Protocol, were provided to meeting attendees and discussed at length. In response to an inquiry, MDHHS staff clarified that women who become pregnant after transitioning to Marketplace coverage from the Healthy Michigan Plan may then transition out of the Marketplace and will be exempt from cost-sharing and premium obligations.

MI Health Account Protocol

The MI Health Account Protocol has been updated per state law to indicate that Healthy Michigan Plan beneficiaries with incomes above 100% FPL and participate in one or more healthy behaviors will now have their premium and cost-sharing obligations suspended once their cost-sharing reaches three percent of their income.

Healthy MI Waiver Renewal Update

MDHHS is working to submit a renewal application for the Healthy Michigan Plan §1115 Demonstration Waiver to CMS, which currently expires on December 31, 2018. The waiver renewal application must be submitted by December 31, 2017, and will be posted for public comment prior submission. MDHHS will also host a public hearing to provide an overview and discussion of the Healthy Michigan Plan waiver renewal application where all interested parties will have an opportunity to provide comments. Details regarding the public hearing will be announced at a later date.

MDHHS has finalized which insurance carriers have agreed to provide coverage to current Healthy Michigan Plan beneficiaries who transition to the Marketplace. At least two products will be offered in all counties in the Lower Peninsula, while Blue Cross Blue Shield of Michigan (BCBSM) will offer coverage to the Healthy Michigan Plan population in all 15 counties in the Upper Peninsula. Other health plans that will offer coverage to the Healthy Michigan Plan population include McLaren Health Plan, Meridian Health Plan, Priority Health Choice Inc., and Total Healthcare Inc.

Federal Update

Health Care Reform Update/Marketplace/Rate Filing

Chris Priest reported that the U.S. Senate was unable to pass the proposal to repeal and replace the Affordable Care Act (ACA) that was discussed at the previous MCAC meeting. Congress is scheduled to conduct hearings on a proposal to reduce cost-sharing amounts for health plans operating on the Marketplace during the week of September 5, 2017, and Mr. Priest noted that the outcome of this legislation will have direct implications for the Healthy Michigan Plan. The federal government is continuing to engage with states regarding waiver requests for their Medicaid expansion programs, which include a request from Arkansas to reduce Medicaid eligibility in their expansion program to 100% FPL. If approved, Mr. Priest advised that other states may submit similar requests. Approximately 120,000 Healthy Michigan Plan beneficiaries have incomes above 100% FPL.

Children's Health Insurance Program (CHIP) Reauthorization

CHIP currently expires on September 30, 2017, and must be re-authorized as part of a federal spending bill to continue. While Chris Priest expressed optimism that the program will be renewed, congress is also considering an extension of the FMAP increase for CHIP that was authorized by the ACA. If CHIP is not reauthorized, the State of Michigan currently has the resources to fund the program through the second quarter of 2018 at the current FMAP rate.

Policy Updates

A policy bulletin handout was distributed to attendees and several updates were discussed.

The meeting was adjourned at 4:00 p.m.

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Wednesday, December 6, 2017

Time: 1:00 p.m. – 4:30 p.m.

Where: Michigan Public Health Institute (MPHI)
2436 Woodlake Circle, Suite 380
Okemos, MI 48864

Attendees: **Council Members:** Robin Reynolds, Eric Liu, Dan Thompson (for Loretta Bush), Kim Singh, Alison Hirschel, Emily Schwarzkopf, Michelle Best (for Amy Hundley), David LaLumia, Dianne Haas, Pam Lupo, Deb Brinson, Rod Auton, Barry Cargill, David Herbel, Warren White, Karlene Ketola, Amy Zaagman, Jeff Towns, April Stopczynski

Staff: Kathy Stiffler, Lynda Zeller, Erin Emerson, Brian Keisling, Dick Miles, Jackie Prokop, Pam Diebolt, Marie LaPres, Philip Bergquist, Phil Kurdunowicz

Other Attendees: Jeff Holm, Jane Pilditch

Welcome, Introductions, Announcements

Robin Reynolds opened the meeting and introductions were made. Kathy Stiffler announced that Chris Priest has stepped down from the role of State Medicaid Director, and that she has agreed to serve as acting director until a replacement is named.

Federal Update

Children's Health Insurance Program (CHIP) Reauthorization

Kathy Stiffler reported that CHIP expired on September 30, 2017, and has not yet been re-authorized by congress. While MDHHS staff are optimistic that the program will be renewed, Michigan currently has the resources to fund CHIP at the current Federal Matching Assistance Percentage (FMAP) rate through April or May 2018 if no action is taken. Robin Reynolds offered to draft a letter in support of renewing CHIP on behalf of the Medical Care Advisory Council (MCAC) to send to congress.

Cost Sharing Reductions

MDHHS staff discussed recent changes to cost sharing requirements for beneficiaries, noting that beginning in October 2017, cost sharing reduction (CSR) payments made by the federal government to qualified health plans on behalf of individuals with incomes between 100-250% of the federal poverty level (FPL) who receive health care coverage through the Marketplace were discontinued.

Budget/Boilerplate Update

2019 Budget Update

For details related to the FY 2019 budget, attendees were referred to the update provided by Farah Hanley at the August MCAC meeting, as documented in the meeting minutes. The minutes are available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Numbered Letters >> click "Medical Care Advisory Council (MCAC)" under Provider Liaison Meetings. Overall, the budget is expected to include funding to wrap up several initiatives advocated by Governor Snyder, as this will be the last budget for the current administration.

2018 Supplemental

Erin Emerson reported that the legislature is expected to pass a FY2018 supplemental appropriations bill before the winter recess.

Provider Enrollment Requirements

MDHHS issued bulletin MSA 17-48 on December 1, 2017, which requires all providers with a National Provider Identifier (NPI) to enroll in the Community Health Automated Medicaid Processing System (CHAMPS) by March 1, 2018, per the requirements of the 21st Century Cures Act. The policy also requires prescribing providers to be enrolled in CHAMPS by May 1, 2018. Beginning May 1, 2018, all claims submitted for prescriptions ordered by non-enrolled providers will be denied. Enrollment of atypical providers (e.g., personal care services providers, volunteer Non-Emergency Medical Transportation [NEMT] providers, etc.) in CHAMPS is targeted for fall 2018.

In response to an inquiry, MDHHS staff and meeting attendees discussed implementing a system for pharmacies to request emergency overrides to fill prescriptions ordered by non-enrolled providers.

MDHHS has also issued proposed policy 1635-PE for public comment, which describes provider enrollment fitness criteria outlining federal and state felonies and misdemeanors that would prohibit a provider from participating in the State's Medicaid programs. The Department received many comments on the policy, and as a result, it will be revised and re-issued for public comment in early 2018.

Integrated Service Delivery (ISD)

MDHHS is in the process of implementing a new universal caseload system known as ISD to provide a single portal for beneficiaries who receive services from multiple MDHHS programs. Implementation of ISD will include the use of a new all programs application that will allow individuals to apply for multiple MDHHS programs in a single application, revisions to the

MI Bridges system to improve the user experience, and a new a central call center to assist applicants and beneficiaries. A pilot universal caseload system will be conducted in Gratiot and Shiawassee counties in late January 2018, with a phased rollout statewide to begin in summer 2018 that is projected to complete in mid-2019. While most beneficiaries who contact local MDHHS offices will be assisted through the new universal caseload system, MDHHS plans to exclude certain program enrollees from the system and allow those beneficiaries to maintain a relationship with a single caseworker in order to be better served. Local offices will also maintain the discretion to determine the best way to serve certain beneficiaries on an individual basis.

MDHHS staff and meeting attendees discussed at length the ways in which ISD is expected to improve efficiency in resolving customers' needs.

Medicaid Managed Care

Healthy Kids Dental Bid Update

MDHHS has completed the process for selecting new vendors to provide services under the ***Healthy Kids Dental*** program, and has awarded statewide contracts to Blue Cross Blue Shield of Michigan, which will work with DentaQuest to provide dental benefits, and Delta Dental. While MDHHS initially planned to begin the new contract on April 1, 2018, the start date was delayed until October 1, 2018 to allow additional time to implement systems changes. Beginning October 1, 2018, ***Healthy Kids Dental*** enrollees will have the opportunity to choose their dental plan, though MDHHS is working to implement a process for auto-assigning beneficiaries who do not make a choice.

Member Transportation Survey

MDHHS worked with the Michigan State University Institute for Health Policy to conduct a survey of both users and non-users of Medicaid transportation services. The survey process has been completed, and a final report was distributed to the MCAC via email prior to the meeting. Kathy Stiffler provided an overview of the report, and invited attendees to continue to examine the document and contact her with questions as necessary.

Dental Services for Pregnant Women

Ms. Stiffler reported that MDHHS has obtained funding to provide dental coverage through the health plans for pregnant women enrolled in Medicaid, and that the Department is working to develop a process for identifying Medicaid beneficiaries who are pregnant. MDHHS staff and meeting attendees discussed the issue at length.

Healthy Michigan Plan

Healthy MI Waiver Renewal Update

Since the previous MCAC meeting held on August 30, 2017, MDHHS released the Healthy Michigan Plan Section 1115 Demonstration Waiver extension application for public comment, and conducted a public hearing to discuss the application. Few comments were received during this process, and MDHHS is currently seeking final approval from Governor Snyder for the waiver renewal application. While the current waiver expires on December 31, 2018, the renewal application must be submitted to CMS by December 31, 2017.

Transition to Marketplace for Healthy Michigan Plan Members

Under the terms of the second waiver for the Healthy Michigan Plan beginning April 1, 2018, individuals who have been enrolled in the Healthy Michigan Plan for more than 12 months, have incomes above 100% of the federal poverty level, do not meet the criteria for “medically frail” and choose not to engage in a healthy behavior must leave the Healthy Michigan Plan and receive insurance coverage from the Marketplace. MDHHS has identified approximately 14,000 current Healthy Michigan Plan enrollees who meet the criteria to transition to the Marketplace, and will begin sending notices to these individuals in February 2018. The February notice will include a reminder that the beneficiary may still complete a Health Risk Assessment (HRA) or Medically Frail form and submit documentation to MDHHS by April 1, 2018 to remain enrolled in the Healthy Michigan Plan. The Department is also in the process of sending a letter to all Healthy Michigan Plan beneficiaries to inform them of this change, and has conducted a webinar to share information with providers about this process, as well. Additional information about the implementation of the Healthy Michigan Plan second waiver is available on the MDHHS website at www.michigan.gov/healthymichiganplan >> Healthy Michigan Plan Second Waiver Operational Protocols.

Behavioral Health Updates

Lynda Zeller provided an overview of the current priorities for the Behavioral Health and Developmental Disabilities Administration (BHDDA), which include:

- Improving access to inpatient psychiatric care close to home;
- Increasing diversion efforts to address the prevalence of individuals with mental health/substance use disorders who are among the jail and prison population in Michigan;
- Working to increase cultural and linguistic competencies within the BHDDA system, particularly concerning enabling greater access to services for tribal members and individuals who are deaf or blind; and
- Early intervention for childhood trauma victims.

Section 298 Update

The Michigan legislature directed MDHHS to develop up to three pilots and one demonstration model to test publicly integrated physical health and behavioral health services. The three pilots will test the financial integration for these services at the payer level, while the demonstration model (which will take place in Kent County) will test service integration. MDHHS has worked with MPHI since August 2017 to develop the structure of the pilots based on the legislative requirement and the recommendations of the Stakeholder 298 workgroup, in addition to holding meetings throughout the State of Michigan to gather stakeholder input on the pilot development process. As required by law, a report was submitted to the legislature on November 20, 2017 to show the timelines for implementation of the pilots, barriers to implementation and proposed solutions. The report, along with additional information related to the Section 298 Initiative, is available on the MDHHS website at www.michigan.gov/stakeholder298. MDHHS is now working to issue a Request for Information (RFI) to select the pilot sites, which is planned for release in mid-December 2017. If more than three responses are received, the Department may need to initiate a competitive bid process for those sites interested in participating in the pilot. MDHHS plans begin operating the pilot and demonstration sites by July 1, 2018.

The demonstration model for the Stakeholder 298 Initiative will maintain the current funding mechanism in which physical health services are funded through the Medicaid Health Plans and behavioral health services are funded through the Prepaid Inpatient Health Plans (PIHPs). The demonstration will be established in Kent County through Network180 (the Community Mental Health Services Program [CMHSP] in Kent County) in partnership with any willing MHPs. The partnership is working on a project plan, which must be approved by the Department, and targeting implementation on July 1, 2018. MDHHS has selected the University of Michigan to conduct an evaluation of up to three pilot sites and the demonstration sites, and up to four comparison sites. This will include a baseline survey for each site, as well as a final survey at the conclusion of the pilot and demonstration.

In addition, MDHHS is also working to implement the 76 policy recommendations proposed by the Stakeholder 298 workgroup and will report back to stakeholders in early 2018 with a plan for moving forward with the recommendations.

Section 1115 Waiver Update

Erin Emerson reported that the Section 1115 Waiver request to provide all behavioral health services under a single waiver authority is pending approval, and that CMS has requested to conduct weekly calls with the Department beginning in January 2018 to discuss the waiver.

Long Term Care Updates

Dick Miles provided several updates related to Long Term Care, which include:

- In July 2016, MDHHS submitted a Section 1115 Demonstration Waiver to provide necessary services and supports to persons suffering qualifying brain injuries who, but for the provision of these services, would otherwise be served in an institutional setting. The Brain Injury Waiver (BIW) is still pending approval by CMS, as it contains language related to housing services and supports that is similar to the Behavioral Health Section 1115 Demonstration waiver, which is currently under consideration, as well.
- On October 23, 2017, MDHHS implemented the MiAIMS time and task system statewide for billing encounters by home help and adult protective services providers.
- Proposed Policy 1723-HH, which will allow travel time payment to home help providers for shopping and laundry services, has been issued for public comment. MDHHS is also working to issue a policy to clarify portions of bulletin MSA 15-13, regarding Home Help Agency Provider Standards.
- The MI Choice Waiver currently expires on September 30, 2018, and MDHHS is in the process of holding meetings to solicit stakeholder involvement in the waiver renewal process. Information about upcoming stakeholder meetings and the waiver renewal process is available on the MDHHS website at www.michigan.gov/medicaidproviders >> MI Choice.
- The Department is continuing to work toward resolving ongoing issues related to the Level of Care Determination (LOCD) process.
- Over 39,000 people are now enrolled in the MI Health Link demonstration program for individuals who are dually eligible for Medicare and Medicaid, and Mr. Miles reported that enrollment has stabilized. The demonstration is currently authorized through 2020.
- MDHHS issued bulletin MSA 17-42 on November 27, 2017, which discusses a new Medicaid Provider Manual Chapter for Home and Community Based Services. MSA 17-42 was issued concurrently for public comment review, and interested parties may submit comments until January 1, 2018.
- As required by the 21st Century Cures Act, MDHHS is currently in the process of developing an Electronic Visit Verification (EVV) system to track the services provided by personal care providers, as well as the location and time. The EVV system must be implemented by January 2019.

Managed Long Term Care Services and Supports

Public Act 107 of 2017 (the fiscal year 2018 Appropriations Act) directed the Department to "explore the implementation of a managed care long-term support service" by July 1, 2018. Since the previous MCAC meeting held on August 30, 2017, MDHHS has received funding from the Health Endowment Fund that will allow the Department to partner with contracted entities to continue to take the required steps to explore the many potential options for moving to a managed long term care system. Currently, two elements of Michigan's $2.6 billion long term care programs (State Plan Personal Care and many nursing facility beneficiaries) have no

system for managed care in place. MDHHS plans to begin the first phase of the stakeholder engagement process in December 2017, which will consist of conducting focus groups and interviews with stakeholders.

Policy Updates

A policy bulletin handout was distributed, and several items were discussed.

MCAC Leadership

Robin Reynolds announced that she will be stepping down as chair of the MCAC at the end of 2017, and Emily Schwarzkopf was nominated and confirmed as the new chairperson.

4:30 – Adjourn

Medical Services Administration
Bureau of Medicaid Care Management and Quality Assurance

PERFORMANCE MONITORING REPORT

Composite – All Plans

January 2018

Produced by:
Quality Improvement and Program Development – Managed Care Plan Division

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Executive Summary

This Performance Monitoring Report (PMR) is produced by the Quality Improvement and Program Development (QIPD) Section of the Managed Care Plan Division (MCPD) to track quality, access, and utilization in the Michigan Medicaid program to better support high quality care for beneficiaries.

The Michigan Department of Health and Human Services (MDHHS) monitors the performance of the State's Medicaid Health Plans (MHPs) through twenty-eight (28) key performance measures aimed at improving the quality and efficiency of health care services provided to the Michigan residents enrolled in a Medicaid program. These measures include Medicaid Managed Care specific measures, Healthy Michigan Plan (HMP) measures, and HEDIS measures. **This report focuses only on the Healthy Michigan Plan (HMP) measures.** The following HMP measures will be included in this report:

Healthy Michigan Plan		
Adults' Generic Drug Utilization	*Timely Completion of Initial HRA*	*Completion of Annual HRA*
Outreach & Engagement to Facilitate Entry to PCP	*Adults' Access to Ambulatory Health Services*	*Transition into Consistently Fail to Pay (CFP) Status*
Transition out of Consistently Fail to Pay (CFP) Status		

Data for these measures are represented on a quarterly basis. The body of the report contains a cross-plan analysis of the most current data available for each of these measures. Measurement Periods may vary and are based on the specifications for that individual measure. Appendix A contains specific three letter codes identifying each of the MHPs. Appendix B contains the one-year plan specific analysis for each measure.

MHPs are contractually obligated to achieve specified standards for most measures. The following table displays the number of MHPs meeting or exceeding the standards for the performance measure versus total MHPs, as reported in the Performance Monitoring Report, during the listed quarter for fiscal year 2018 unless otherwise noted.

Table 1: Fiscal Year 2018[1]

Quarterly Reported Measures	Reported in 1st Quarter	Reported in 2nd Quarter	Reported in 3rd Quarter	Reported in 4th Quarter
Adults' Generic Drug Utilization	10/11			
Timely Completion of Initial HRA	5/9			
Completion of Annual HRA	N/A			
Outreach & Engagement to Facilitate Entry to PCP	7/11			
Adults' Access to Ambulatory Health Services	0/11			
Transition into CFP Status	N/A			
Transition out of CFP Status	N/A			

[1] N/A will be shown for measures where the standard is Informational Only.

Healthy Michigan Plan Enrollment

The Healthy Michigan Plan (HMP-MC) enrollment has remained steady over the past year. Due to changes with the way the reports are pulled, current enrollment data is unavailable at this time.

Figure 1: HMP-MC Enrollment, February 2017 – January 2018

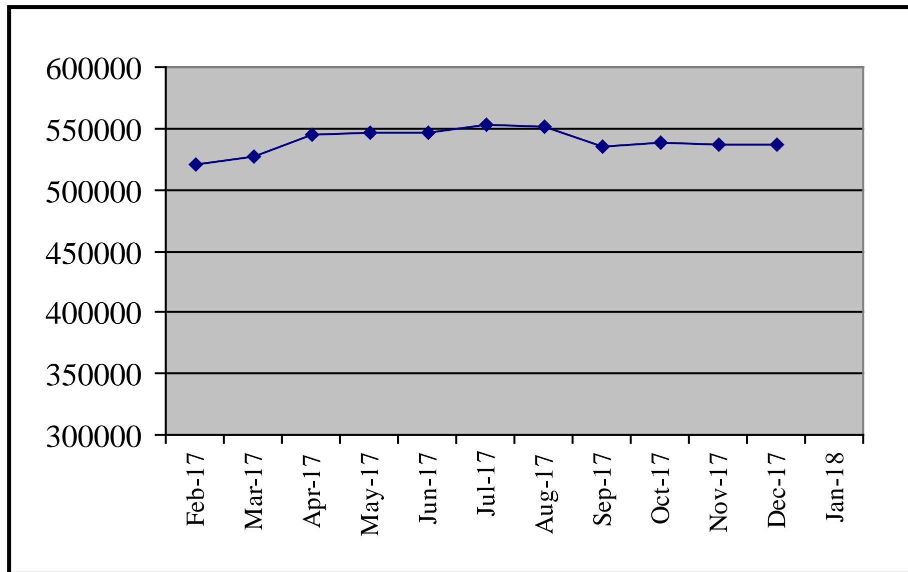
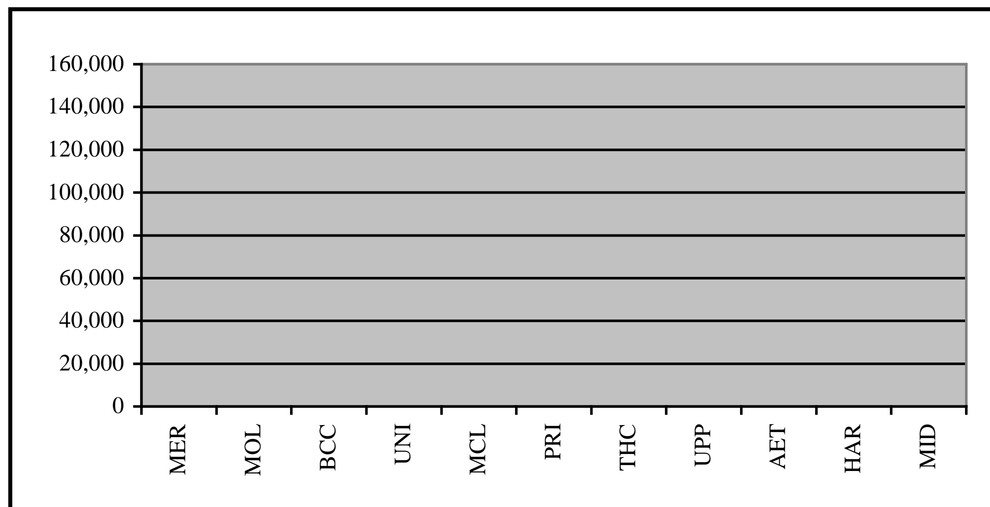


Figure 2: HMP-MC Enrollment by Medicaid Health Plan, January 2018



Medicaid Health Plan News

The Performance Monitoring Report contains data for all Healthy Michigan Medicaid Health Plans, where data is available. Eleven Medicaid Health Plans are contracted with the State of Michigan to provide comprehensive health care services.

Results for the Transition into Consistently Fail to Pay Status, Transition out of Consistently Fail to Pay Status and the Completion of Annual Health Risk Assessment measures will be reported as “Informational Only” until a standard has been set.

Due to a change in methodology the Plan All-Cause Acute 30-Day Readmission measure has been taken out of this report and will be put into a separate PMR.

Cross-Plan Performance Monitoring Analyses

The following section includes a cross-plan analysis for each performance measure. An analysis of the most current data available for each performance measure is included. For detailed questions regarding measurement periods or standards, see the Performance Monitoring Specifications.

Adults' Generic Drug Utilization

Measure
The percentage of generic prescriptions filled for adult members of health plans during the measurement period.

Standard
At or above 84% (as shown on bar graph below)

Measurement Period
April 2017 –June 2017

Data Source
MDHHS Data Warehouse

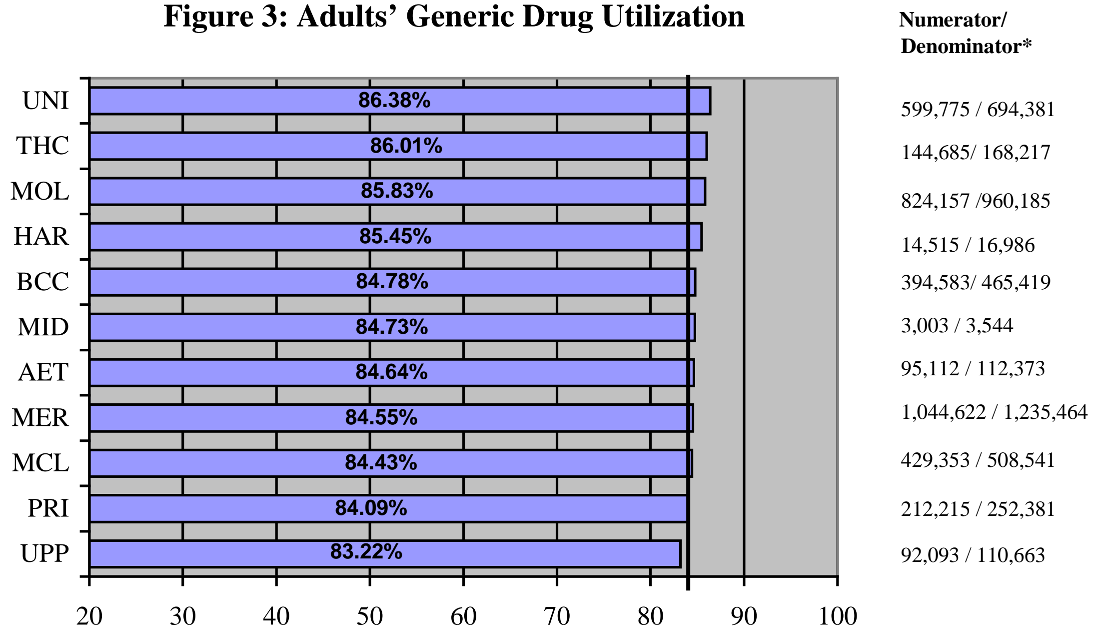
Measurement Frequency
Quarterly

Summary: Ten plans met or exceeded the standard, while one plan (UPP) did not. Results ranged from 83.22% to 86.38%.

Table 2: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	3,926,989	4,640,775	84.62%
Fee For Service (FFS) only	13,053	37,304	34.99%
Managed Care only	3,871,632	4,549,021	85.11%
MA-MC	1,964,327	2,316,504	84.80%
HMP-MC	1,869,654	2,188,425	85.43%

Figure 3: Adults' Generic Drug Utilization



Numerator/ Denominator*

599,775 / 694,381
144,685/ 168,217
824,157 /960,185
14,515 / 16,986
394,583/ 465,419
3,003 / 3,544
95,112 / 112,373
1,044,622 / 1,235,464
429,353 / 508,541
212,215 / 252,381
92,093 / 110,663

Adult's Generic Drug Utilization Percentages

*Numerator depicts the number of eligible beneficiaries who had generic prescriptions filled. Denominator depicts the total number of eligible beneficiaries.

Timely Completion of Initial Health Risk Assessment (HRA)

Measure
The percentage of Healthy Michigan Plan beneficiaries enrolled in a health plan who had a Health Risk Assessment (HRA) completed within 150 days of enrollment in a health plan.

Standard
At or above 9% (as shown on bar graph below)

Enrollment Dates
January 2017 – March 2017

Data Source
MDHHS Data Warehouse

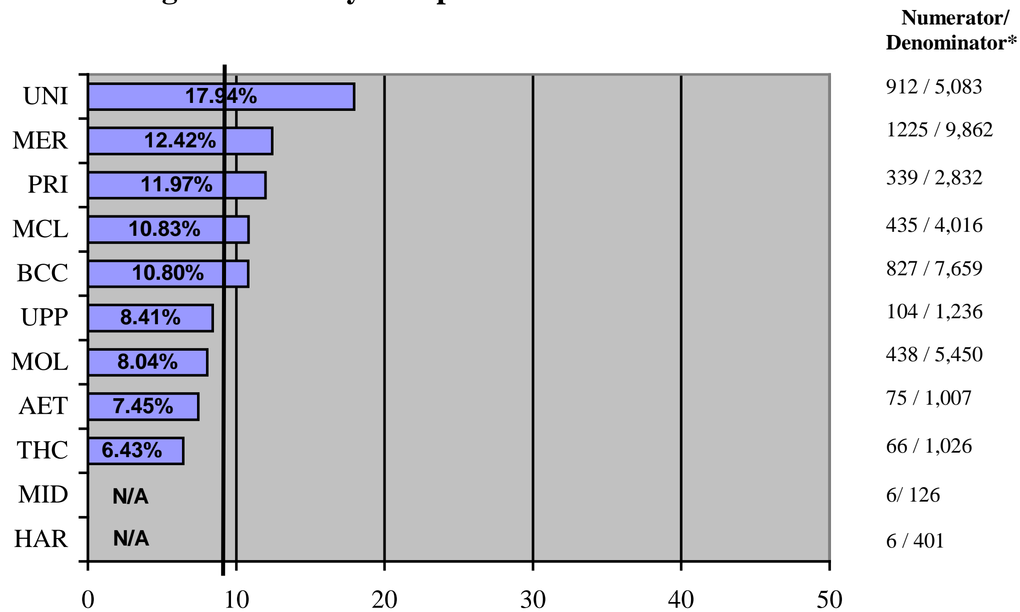
Measurement Frequency
Quarterly

Summary: Five plans met or exceeded the standard, while four plans (AET, MOL, THC, and UPP) did not. Results ranged from 1.50% to 17.94%.

Table 3: Program Total[2]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	4,433	38,698	11.46%

Figure 4: Timely Completion of Initial HRA[3]



Timely Completion of Initial HRA Percentages

*Numerator depicts the number of eligible beneficiaries who completed an HRA within 150 days of enrollment in a health plan. Denominator depicts the total number of eligible beneficiaries.

---

[2] This includes HRAs completed during the HMP FFS period prior to enrollment in a Medicaid health plan.

[3] A rate was not calculated for plans with a numerator under 5 or a denominator under 30.

Completion of Annual Health Risk Assessment (HRA)

Measure
The percentage of new Healthy Michigan Plan beneficiaries enrolled in a health plan who had a second Health Risk Assessment (HRA) completed within one year (defined as 11-15 months) of their first HRA.

Standard
N/A – Informational Only

First Attestation Dates
July 2015 – June 2016

Second Attestation Dates
June 2016 – September 2017

Data Source
MDHHS Data Warehouse

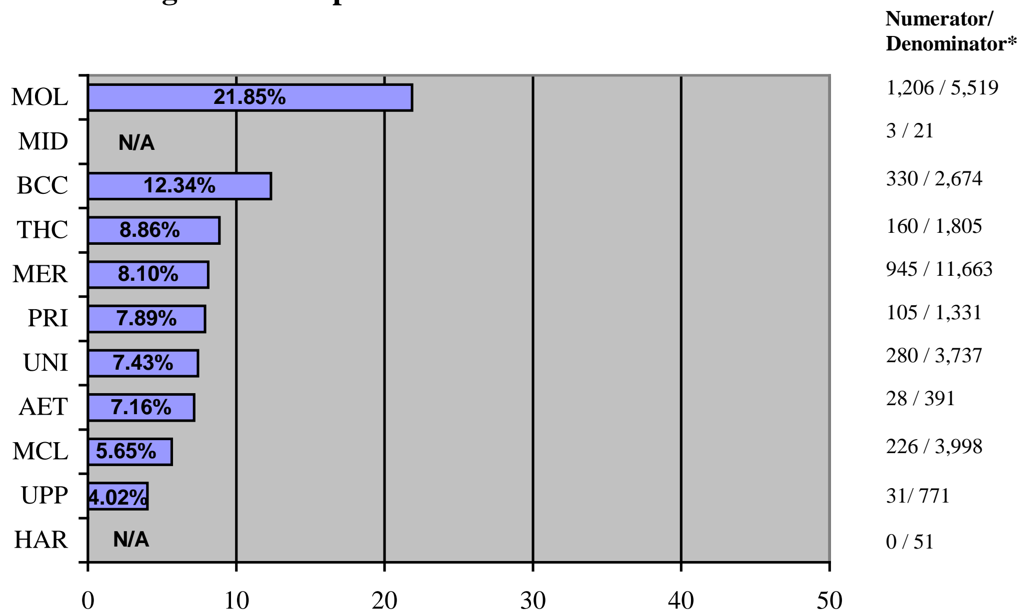
Measurement Frequency
Quarterly

Summary: ***Data for this measure will not be reported this year.***

Table 4: Program Total

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	3,357	33,335	10.07%

Figure 5: Completion of Annual HRA[4]



*Numerator depicts the number of eligible beneficiaries who completed a second HRA within one year (defined as 11-15 months) of their first HRA. Denominator depicts the total number of eligible beneficiaries.

[4] A rate was not calculated for plans with a numerator under 5 or a denominator under 30.

Outreach and Engagement to Facilitate Entry to Primary Care

Measure
The percentage of Healthy Michigan Plan health plan enrollees who have an ambulatory or preventive care visit within 150 days of enrollment into a health plan who had not previously had an ambulatory or preventive care visit since enrollment in Healthy Michigan Plan.

Standard
At or above 50% (as shown on bar graph below)

Enrollment Dates
January 2017 – March 2017

Data Source
MDHHS Data Warehouse

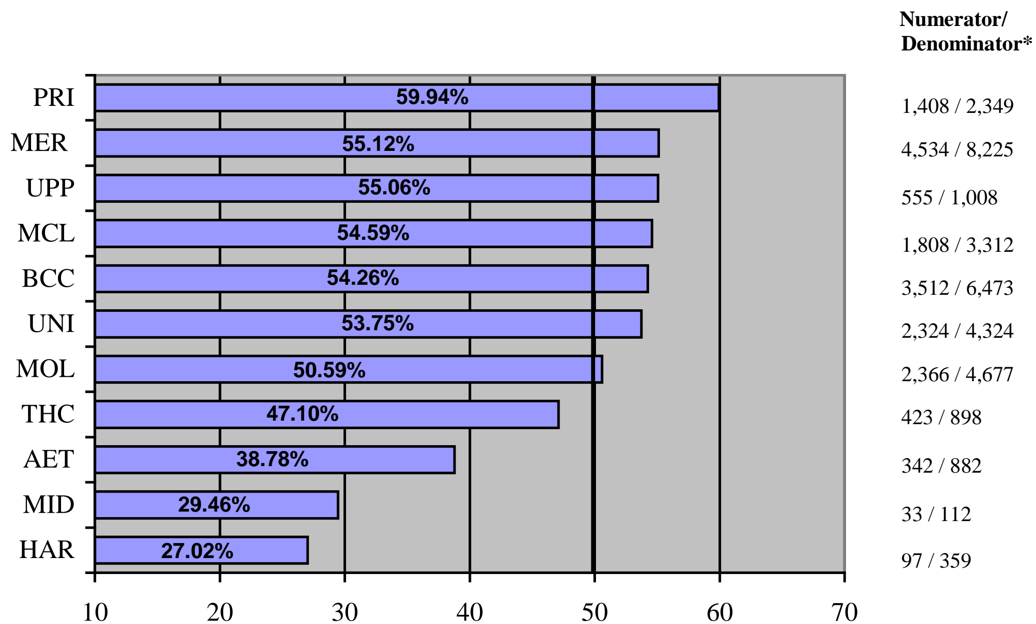
Measurement Frequency
Quarterly

Summary: Seven plans met or exceeded the standard, while four plans (AET, HAR, MID, and THC) did not. Results ranged from 27.02% to 59.94%.

Table 5: Program Total[5]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	23,481	38,698	60.68%

Figure 6: Outreach & Engagement to Facilitate Entry to Primary Care



Outreach & Engagement to Facilitate Entry to Primary Care Percentages
*Numerator depicts the number of eligible beneficiaries who had an ambulatory or preventive care visit within 150 days of enrollment in a health plan. Denominator depicts the total number of eligible beneficiaries.

[5] This includes visits during the HMP FFS period prior to enrollment in a Medicaid health plan.

Adults' Access to Ambulatory Health Services

Measure
The percentage of adults 19 to 64 years old who had an ambulatory or preventive care visit during the measurement period.

Standard
At or above 83% (as shown on bar graph below)

Measurement Period
July 2016 – June 2017

Data Source
MDHHS Data Warehouse

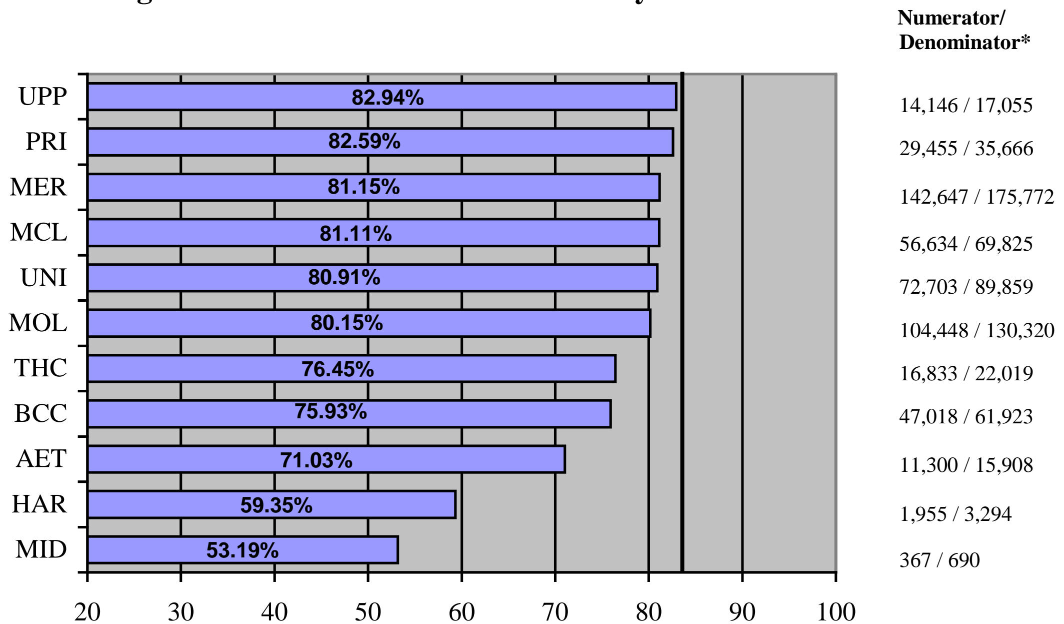
Measurement Frequency
Quarterly

Summary: None of the plans met or exceeded the standard. Results ranged from 53.19% to 82.94%.

Table 6: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	616,044	778,150	79.17%
Fee For Service (FFS) only	9,864	16,413	60.10%
Managed Care only	511,345	637,825	80.17%
MA-MC	226,738	274,699	82.54%
HMP-MC	230,157	298,078	77.21%

Figure 7: Adults' Access to Ambulatory Health Services



Adult's Access to Ambulatory Health Services Percentages

*Numerator depicts the number of eligible beneficiaries who had an ambulatory or preventive care visit. Denominator depicts the total number of eligible beneficiaries.

Transition into Consistently Fail to Pay (CFP) Status

Measure
The percentage of Healthy Michigan Plan beneficiaries who transitioned from non-CFP status into CFP status during the last quarter of the measurement period.

Standard
N/A – Informational Only

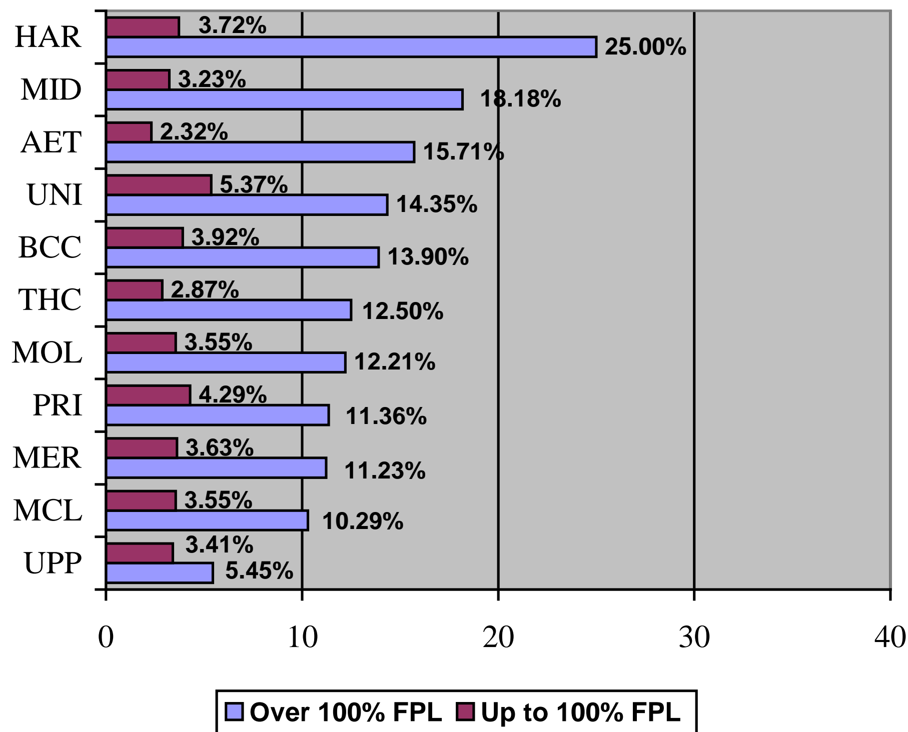
Measurement Period
November 2016 –December 2017

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Summary: The results shown are informational only. In Cohort 1, the results ranged from 5.45% to 25.00% for beneficiaries with income over 100% FPL. The results ranged from 2.32% to 5.37% for beneficiaries with income that never exceeded 100% FPL.
In Cohort 2, the results ranged from 0.00% to 25.00% for beneficiaries with income over 100% FPL. The results ranged from 1.36% to 4.98% for beneficiaries with income that never exceeded 100% FPL.
In Cohort 3, the results ranged from 0.00% to 24.24% for beneficiaries with income over 100% FPL. The results ranged from 1.18% to 3.23% for beneficiaries with income that never exceeded 100% FPL.

Figure 8: Transition into CFP Status - Cohort 1



Transition in to CFP Status Percentages
*In the graphs represented for this measure, FPL represents the Federal Poverty Level.

Figure 9: Transition into CFP Status - Cohort 2

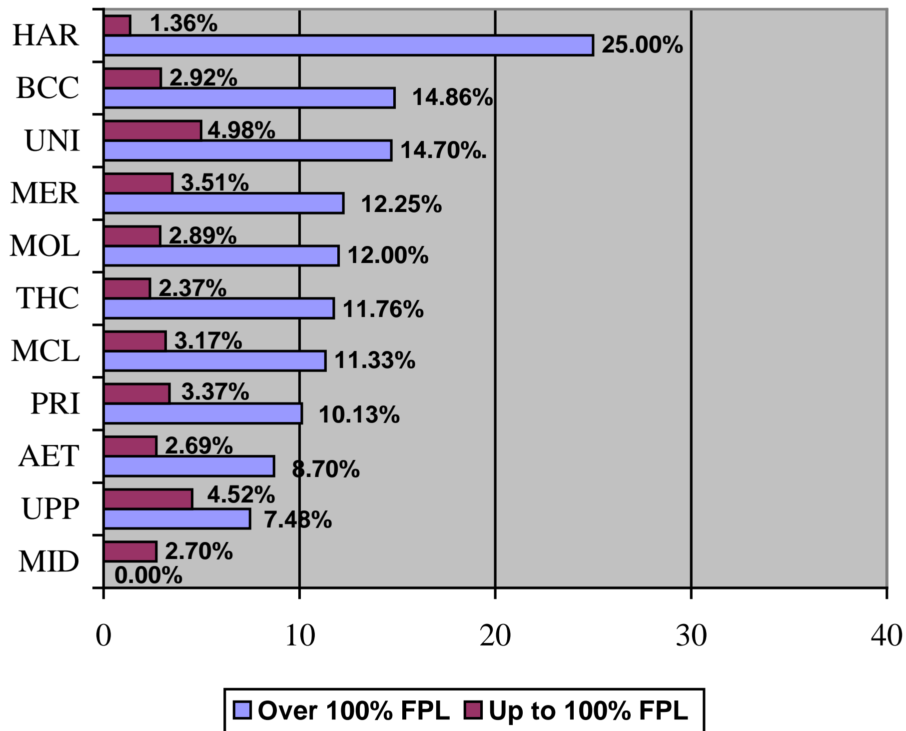
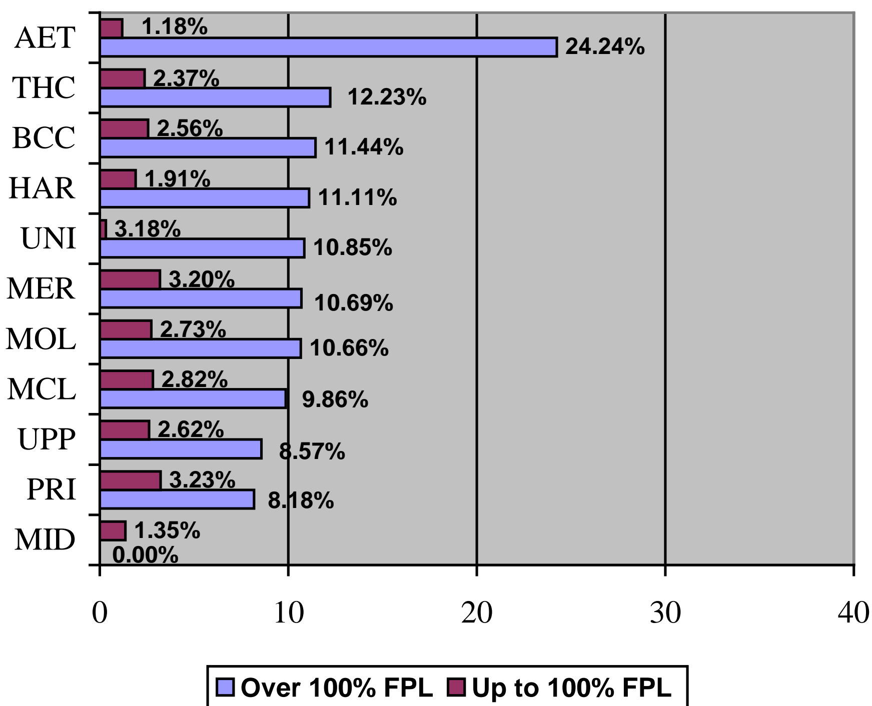


Figure 10: Transition into CFP Status - Cohort 3



Transition out of Consistently Fail to Pay (CFP) Status

Measure
The percentage of Healthy Michigan Plan beneficiaries who transitioned from CFP status to non-CFP status during the last quarter of the measurement period.

Standard
N/A – Informational Only

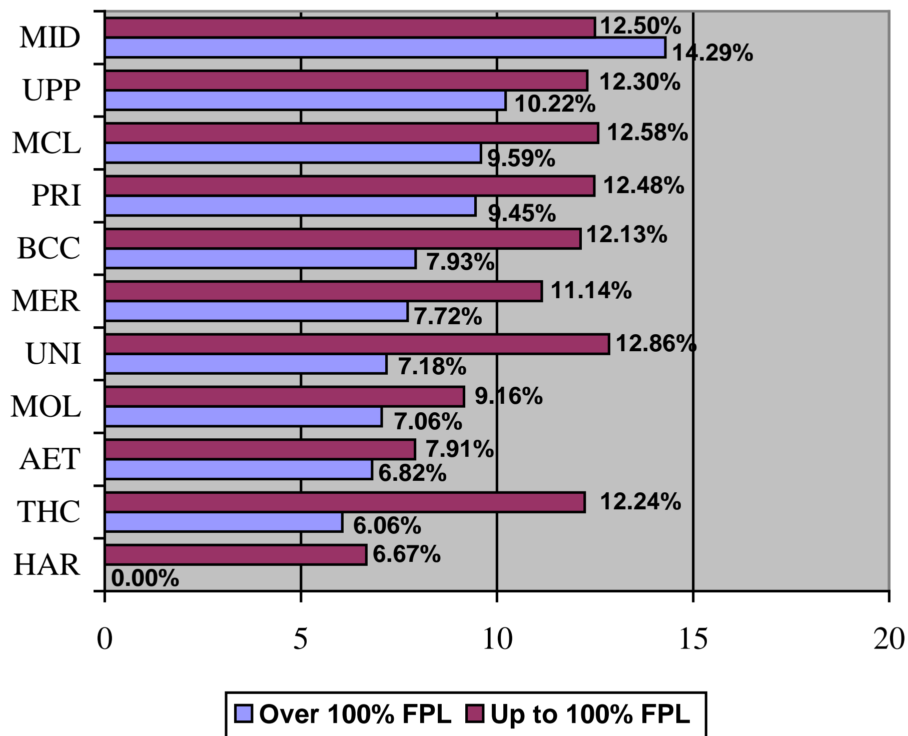
Measurement Period
November 2016 – December 2017

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Summary: The results shown are informational only. In Cohort 1, the results ranged from 0.00% to 14.29% for beneficiaries with income over 100% FPL. The results ranged from 6.67% to 12.86% for beneficiaries with income that never exceeded 100% FPL.
In Cohort 2, the results ranged from 0.00% to 8.03% for beneficiaries with income over 100% FPL. The results ranged from 2.22% to 13.70% for beneficiaries with income that never exceeded 100% FPL.
In Cohort 3, the results ranged from 0.00% to 10.37% for beneficiaries with income over 100% FPL. The results ranged from 0.00% to 10.49% for beneficiaries with income that never exceeded 100% FPL.

Figure 11: Transition out of CFP Status - Cohort 1



Transition out of CFP Status Percentages
*In the graphs represented for this measure, FPL represents the Federal Poverty Level.

Figure 12: Transition out of CFP Status - Cohort 2

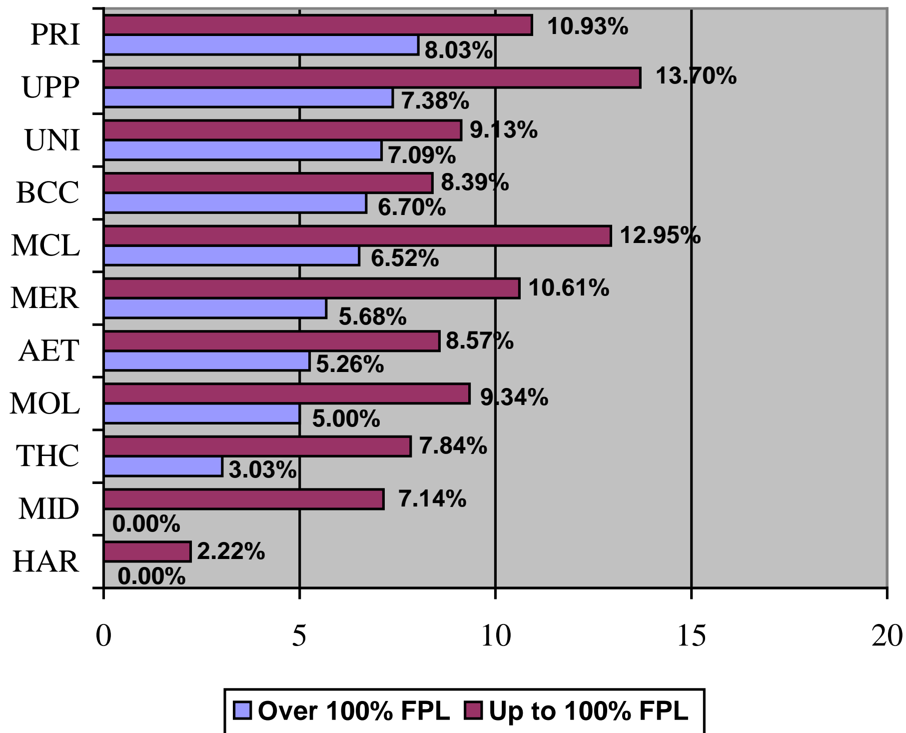
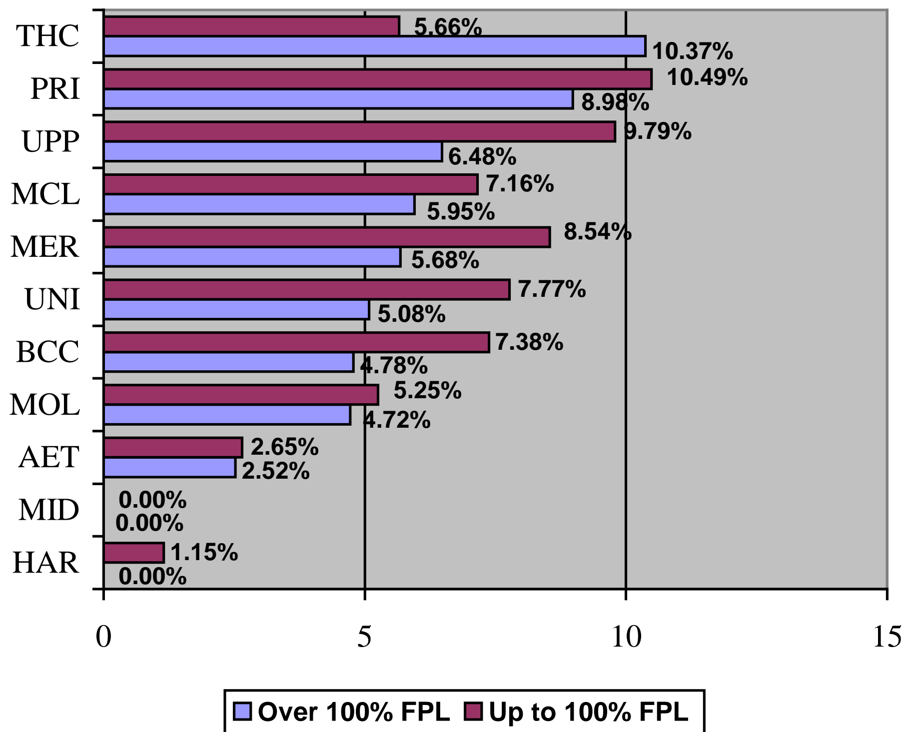


Figure 13: Transition out of CFP Status - Cohort 3



Appendix A: Three Letter Medicaid Health Plan Codes

Below is a list of three letter codes established by MDHHS identifying each Medicaid Health Plan.

AET	Aetna Better Health of Michigan
BCC	Blue Cross Complete of Michigan
HAR	Harbor Health Plan
MCL	McLaren Health Plan
MER	Meridian Health Plan of Michigan
MID	HAP Midwest Health Plan
MOL	Molina Healthcare of Michigan
PRI	Priority Health Choice
THC	Total Health Care
UNI	UnitedHealthcare Community Plan
UPP	Upper Peninsula Health Plan

Appendix B: One Year Plan-Specific Analysis

Aetna Better Health of Michigan – AET

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**84.64%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**7.45%**	**No**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**7.16%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**38.78%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**71.03%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	22.22%	3.80%	N/A	Info Only	16.92%	2.82%	N/A	Info Only	27.63%	4.11%	N/A
Info Only	13.85%	3.91%	N/A	Info Only	4.69%	3.01%	N/A	Info Only	16.92%	2.20%	N/A
Info Only	**15.71%**	**2.32%**	**N/A**	**Info Only**	**8.70%**	**2.69%**	**N/A**	**Info Only**	**24.24%**	**1.18%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	0.00%	0.00%	N/A	Info Only	0.00%	1.89%	N/A	Info Only	0.00%	3.64%	N/A
Info Only	2.33%	5.30%	N/A	Info Only	2.56%	2.72%	N/A	Info Only	0.00%	3.57%	N/A
Info Only	**6.82%**	**7.91%**	**N/A**	**Info Only**	**5.26%**	**8.57%**	**N/A**	**Info Only**	**2.52%**	**2.65%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Blue Cross Complete of Michigan – BCC

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**84.78%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**10.80%**	**Yes**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**12.34%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**54.26%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**75.93%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	16.32%	3.70%	N/A	Info Only	19.88%	4.14%	N/A	Info Only	18.76%	4.16%	N/A
Info Only	15.69%	4.39%	N/A	Info Only	14.63%	3.09%	N/A	Info Only	19.13%	2.95%	N/A
Info Only	**13.90**	**3.92%**	**N/A**	**Info Only**	**14.86%**	**2.92%**	**N/A**	**Info Only**	**11.44%**	**2.56%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	1.09%	2.63%	N/A	Info Only	1.15%	2.52%	N/A	Info Only	0.64%	2.80%	N/A
Info Only	1.08%	3.91%	N/A	Info Only	2.04%	3.16%	N/A	Info Only	5.71%	8.15%	N/A
Info Only	**7.93%**	**12.13%**	**N/A**	**Info Only**	**6.70%**	**8.39%**	**N/A**	**Info Only**	**4.78%**	**7.38%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Harbor Health Plan – HAR

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**85.45%**	**Yes**

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**N/A**	**N/A**

N/A in the "Plan Result" column indicates that the plan had a numerator less than 5 or a denominator less than 30.

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**N/A**	**N/A**

N/A in the "Plan Result" column indicates that the plan had a numerator less than 5 or a denominator less than 30.

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**27.02%**	**No**

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**59.35%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	12.50%	2.15%	N/A	Info Only	0.00%	2.17%	N/A	Info Only	28.00%	1.54%	N/A
Info Only	14.29%	2.24%	N/A	Info Only	12.50%	1.60%	N/A	Info Only	19.23%	1.46%	N/A
Info Only	**25.00%**	**3.72%**	**N/A**	**Info Only**	**25.00%**	**1.36%**	**N/A**	**Info Only**	**11.11%**	**1.91%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	0.00%	0.00%	N/A	Info Only	0.00%	3.45%	N/A	Info Only	0.00%	0.00%	N/A
Info Only	0.00%	0.00%	N/A	Info Only	0.00%	0.00%	N/A	Info Only	6.73%	9.57%	N/A
Info Only	**0.00%**	**6.67%**	**N/A**	**Info Only**	**0.00%**	**2.22%**	**N/A**	**Info Only**	**0.00%**	**1.15%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

McLaren Health Plan – MCL

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**84.43%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**10.83%**	**Yes**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**5.65%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**54.59%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**81.11%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	13.91%	6.42%	N/A	Info Only	15.63%	5.88%	N/A	Info Only	18.73%	5.08%	N/A
Info Only	13.89%	5.14%	N/A	Info Only	10.57%	3.63%	N/A	Info Only	11.53%	2.78%	N/A
Info Only	**10.29%**	**3.55%**	**N/A**	**Info Only**	**11.33%**	**3.17%**	**N/A**	**Info Only**	**9.86%**	**2.82%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	2.34%	3.25%	N/A	Info Only	2.18%	3.56%	N/A	Info Only	2.36%	3.05%	N/A
Info Only	3.32%	4.97%	N/A	Info Only	1.94%	5.77%	N/A	Info Only	5.13%	8.18%	N/A
Info Only	**9.59%**	**12.58%**	**N/A**	**Info Only**	**6.52%**	**12.95%**	**N/A**	**Info Only**	**5.95%**	**7.16%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Meridian Health Plan of Michigan – MER

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**84.55%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**12.42%**	**Yes**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**8.10%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**55.12%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**81.15%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	15.87%	4.94%	N/A	Info Only	13.34%	5.18%	N/A	Info Only	19.84%	4.28%	N/A
Info Only	14.52%	4.61%	N/A	Info Only	14.19%	4.26%	N/A	Info Only	14.73%	3.35%	N/A
Info Only	**11.23%**	**3.63%**	**N/A**	**Info Only**	**12.25%**	**3.51%**	**N/A**	**Info Only**	**10.69%**	**3.20%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	0.94%	3.37%	N/A	Info Only	2.28%	3.03%	N/A	Info Only	1.80%	3.13%	N/A
Info Only	2.19%	4.75%	N/A	Info Only	2.11%	4.59%	N/A	Info Only	0.00%	0.00%	N/A
Info Only	**7.72%**	**11.14%**	**N/A**	**Info Only**	**5.68%**	**10.61%**	**N/A**	**Info Only**	**5.68%**	**8.54%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

HAP Midwest Health Plan – MID

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**84.73%**	**Yes**

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**N/A**	**N/A**

N/A in the "Plan Result" column indicates that the plan had a numerator less than 5 or a denominator less than 30.

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**N/A**	**N/A**

N/A in the "Plan Result" column indicates that the plan had a numerator less than 5 or a denominator less than 30.

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**29.46%**	**No**

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**53.19%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	25.00%	3.33%	N/A	Info Only	25.00%	0.00%	N/A	Info Only	0.00%	0.00%	N/A
Info Only	10.00%	4.17%	N/A	Info Only	N/A	2.90%	N/A	Info Only	16.67%	2.99%	N/A
Info Only	**18.18%**	**3.23%**	**N/A**	**Info Only**	**0.00**	**2.70%**	**N/A**	**Info Only**	**0.00%**	**1.35%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	0.00%	0.00%	N/A	Info Only	0.00%	11.11%	N/A	Info Only	0.00%	0.00%	N/A
Info Only	0.00%	0.00%	N/A	Info Only	0.00%	11.11%	N/A	Info Only	5.36%	8.62%	N/A
Info Only	**14.29%**	**12.50%**	**N/A**	**Info Only**	**0.00%**	**7.14%**	**N/A**	**Info Only**	**0.00%**	**0.00%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Molina Healthcare of Michigan – MOL

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**85.83%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**8.04%**	**No**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**21.85%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**50.59%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**80.15%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	16.04%	4.90%	N/A	Info Only	14.48%	4.99%	N/A	Info Only	20.16%	4.67%	N/A
Info Only	14.35%	4.91%	N/A	Info Only	13.00%	4.10%	N/A	Info Only	13.60%	3.00%	N/A
Info Only	**12.21%**	**3.55%**	**N/A**	**Info Only**	**12.00%**	**2.89%**	**N/A**	**Info Only**	**10.66%**	**2.73%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	1.20%	2.41%	N/A	Info Only	1.75%	2.66%	N/A	Info Only	1.30%	2.52%	N/A
Info Only	1.67%	2.82%	N/A	Info Only	2.35%	3.47%	N/A	Info Only	7.56%	11.04%	N/A
Info Only	**7.06%**	**9.16%**	**N/A**	**Info Only**	**5.00%**	**9.34%**	**N/A**	**Info Only**	**4.72%**	**5.25%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Priority Health Choice – PRI

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**84.09%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**11.97%**	**Yes**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**7.89%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**59.94%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**82.59%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	11.93%	5.24%	N/A	Info Only	15.37%	4.87%	N/A	Info Only	14.40%	4.99%	N/A
Info Only	13.57%	6.90%	N/A	Info Only	13.01%	5.75%	N/A	Info Only	12.42%	4.90%	N/A
Info Only	**11.36%**	**4.29%**	**N/A**	**Info Only**	**10.13%**	**3.37%**	**N/A**	**Info Only**	**8.18%**	**3.23%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	2.16%	2.53%	N/A	Info Only	2.68%	4.14%	N/A	Info Only	1.37%	3.41%	N/A
Info Only	1.15%	5.61%	N/A	Info Only	1.59%	7.66%	N/A	Info Only	6.79%	5.61%	N/A
Info Only	**9.45%**	**12.48%**	**N/A**	**Info Only**	**8.03%**	**10.93%**	**N/A**	**Info Only**	**8.98%**	**10.49%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Total Health Care – THC

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**86.01%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**6.43%**	**No**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**8.86%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**47.10%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**76.45%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	12.50%	3.80%	N/A	Info Only	19.70%	3.73%	N/A	Info Only	19.46%	3.02%	N/A
Info Only	16.92%	3.43%	N/A	Info Only	9.76%	3.55%	N/A	Info Only	15.11%	2.85%	N/A
Info Only	**12.50%**	**2.87%**	**N/A**	**Info Only**	**11.76%**	**2.37%**	**N/A**	**Info Only**	**12.23%**	**2.37%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	0.00%	2.60%	N/A	Info Only	1.71%	3.30%	N/A	Info Only	2.42%	2.71%	N/A
Info Only	2.10%	1.68%	N/A	Info Only	3.33%	3.13%	N/A	Info Only	7.79%	7.62%	N/A
Info Only	**6.06%**	**12.24%**	**N/A**	**Info Only**	**3.03%**	**7.84%**	**N/A**	**Info Only**	**10.37%**	**5.66%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

UnitedHealthcare Community Plan – UNI

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**86.38%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**17.94%**	**Yes**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**7.43%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**53.75%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**80.94%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	13.25%	4.07%	N/A	Info Only	13.74%	3.83%	N/A	Info Only	17.84%	4.15%	N/A
Info Only	13.59%	4.44%	N/A	Info Only	12.04%	3.88%	N/A	Info Only	13.46%	4.93%	N/A
Info Only	**14.35%**	**5.37%**	**N/A**	**Info Only**	**14.70%**	**4.98%**	**N/A**	**Info Only**	**10.85%**	**3.18%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	1.33%	3.05%	N/A	Info Only	1.83%	3.95%	N/A	Info Only	2.75%	3.61%	N/A
Info Only	3.14%	5.19%	N/A	Info Only	2.70%	5.62%	N/A	Info Only	7.66%	12.39%	N/A
Info Only	**7.18%**	**12.86%**	**N/A**	**Info Only**	**7.09%**	**9.13%**	**N/A**	**Info Only**	**5.08%**	**7.77%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Upper Peninsula Health Plan – UPP

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**83.22%**	**No**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**8.41%**	**No**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**4.02%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**55.06%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**82.94%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	10.00%	6.90%	N/A	Info Only	13.95%	6.75%	N/A	Info Only	9.55%	5.92%	N/A
Info Only	11.70%	5.00%	N/A	Info Only	10.21%	4.41%	N/A	Info Only	9.15%	3.95%	N/A
Info Only	**5.45%**	**3.41%**	**N/A**	**Info Only**	**7.48%**	**4.52%**	**N/A**	**Info Only**	**8.57%**	**2.62%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	1.09%	2.25%	N/A	Info Only	4.32%	2.83%	N/A	Info Only	1.79%	3.74%	N/A
Info Only	2.28%	4.69%	N/A	Info Only	3.14%	5.21%	N/A	Info Only	2.70%	7.03%	N/A
Info Only	**10.22%**	**12.30%**	**N/A**	**Info Only**	**7.38%**	**13.70%**	**N/A**	**Info Only**	**6.48%**	**9.79%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Medical Services Administration
Bureau of Medicaid Care Management and Quality Assurance

PERFORMANCE MONITORING REPORT

HEALTHY MICHIGAN PLAN – DENTAL MEASURES

Composite – All Plans

January 2018

Produced by:
Quality Improvement and Program Development – Managed Care Plan Division

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Executive Summary

This Dental Performance Monitoring Report (PMR) is produced by the Quality Improvement and Program Development (QIPD) Section of the Managed Care Plan Division (MCPD) to track quality, access, and utilization in the Michigan Medicaid program to better support high quality care for beneficiaries.

The Michigan Department of Health and Human Services (MDHHS) monitors the performance of the State's Medicaid Health Plans (MHPs) through three (3) key performance measures aimed at improving the quality and efficiency of dental services provided to the Michigan residents enrolled in the Healthy Michigan Plan. The following HMP-Dental measures will be included in this report:

Healthy Michigan Plan		
Diagnostic Dental Services	*Preventive Dental Services*	*Restorative (Dental Fillings) Dental Services*

Data for these measures will be represented on a quarterly basis. The body of the report contains a cross-plan analysis of the most current data available for each of these measures. Measurement Periods may vary and are based on the specifications for that individual measure. Appendix A contains specific three letter codes identifying each of the MHPs. Appendix B contains the one-year plan specific analysis for each measure.

The following table displays the number of MHPs meeting or exceeding the standards for the performance measure versus total MHPs, as reported in the Performance Monitoring Report, during the listed quarter for fiscal year 2018 unless otherwise noted.

Table 1: Fiscal Year 2018[1]

Quarterly Reported Measures	Reported in 1st Quarter	Reported in 2nd Quarter	Reported in 3rd Quarter	Reported in 4th Quarter
Diagnostic Dental Services	N/A			
Preventive Dental Services	N/A			
Restorative (Dental Fillings) Dental Services	N/A			

[1] N/A will be shown for measures where the standard is Informational Only.

Healthy Michigan Plan Enrollment

The Healthy Michigan Plan (HMP-MC) enrollment has remained steady over the past year. Due to changes with the way the reports are pulled, current enrollment data is unavailable at this time.

Figure 1: HMP-MC Enrollment, February 2017 – January 2018

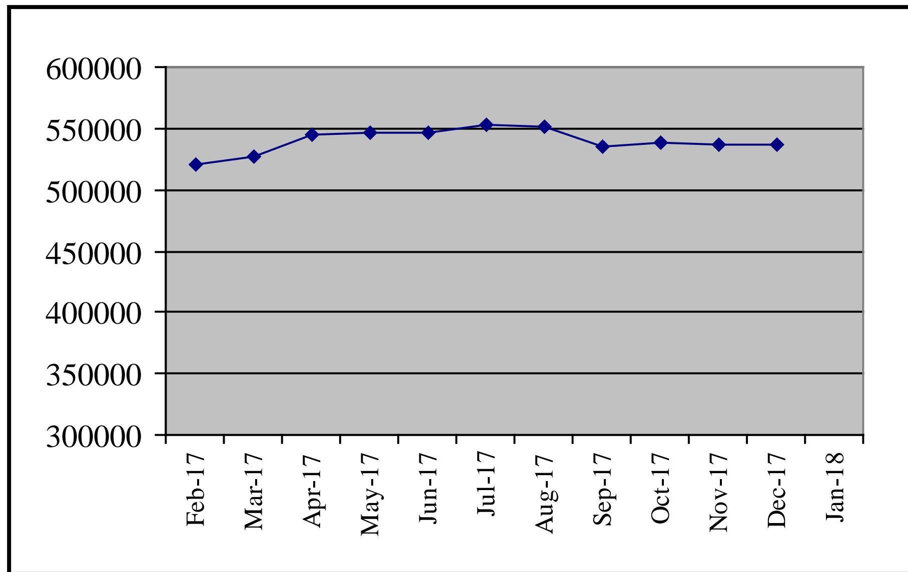
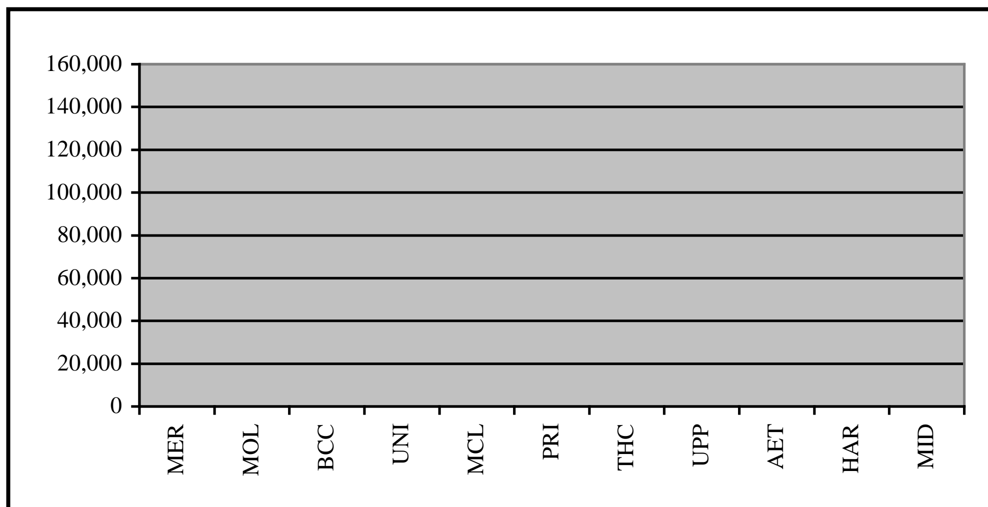


Figure 2: HMP-MC Enrollment by Medicaid Health Plan, January 2018



Medicaid Health Plan News

The Performance Monitoring Report contains data for all Healthy Michigan Medicaid Health Plans, where data is available. Eleven Medicaid Health Plans are contracted with the State of Michigan to provide comprehensive health and services.

Cross-Plan Performance Monitoring Analyses

The following section includes a cross-plan analysis for each performance measure. An analysis of the most current data available for each performance measure is included.

Diagnostic Dental Services

Measure
The percentage of Healthy Michigan Plan enrollees between the ages of 19 and 64 who received at least one diagnostic dental service within the measurement period.

Standard
N/A – Informational Only

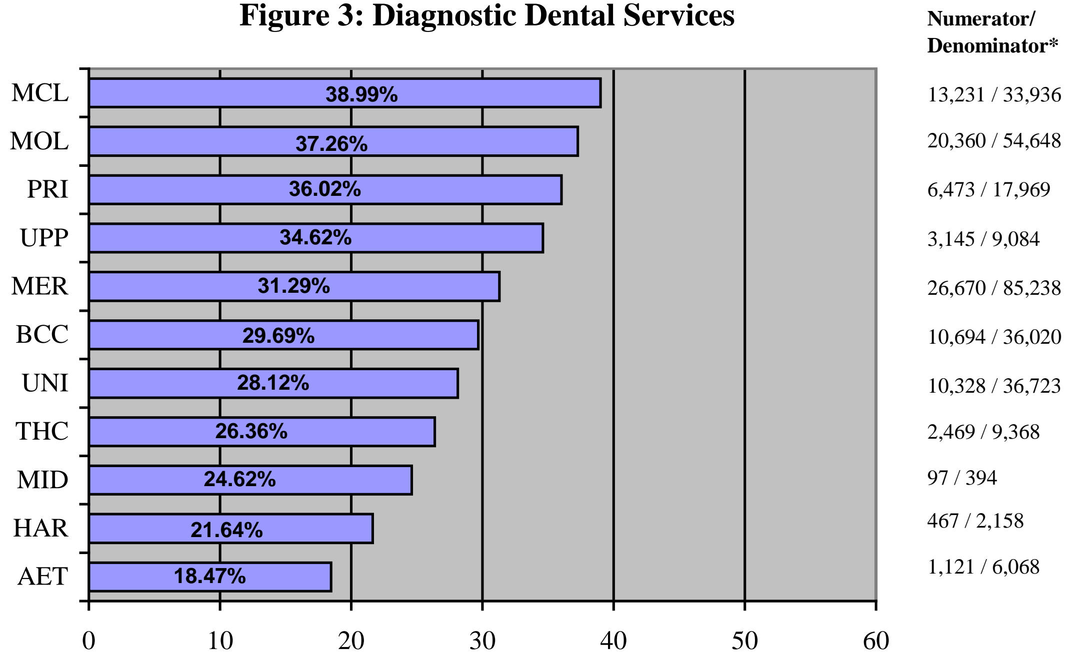
Measurement Period
July 2016 –June 2017

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Table 2: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
HMP Fee For Service (FFS) Only	934	6,732	13.87%
HMP Managed Care (MC) Only	97,849	298,078	32.83%



Diagnostic Dental Services Percentages

*Numerator depicts the number of eligible beneficiaries between the ages of 19 and 64 who had at least one diagnostic dental service. Denominator depicts the total number of eligible beneficiaries.

Preventive Dental Services

Measure
The percentage of Healthy Michigan Plan enrollees between the ages of 19 and 64 who received at least one preventive dental service within the measurement period.

Standard
N/A – Informational Only

Measurement Period
July 2016 –June 2017

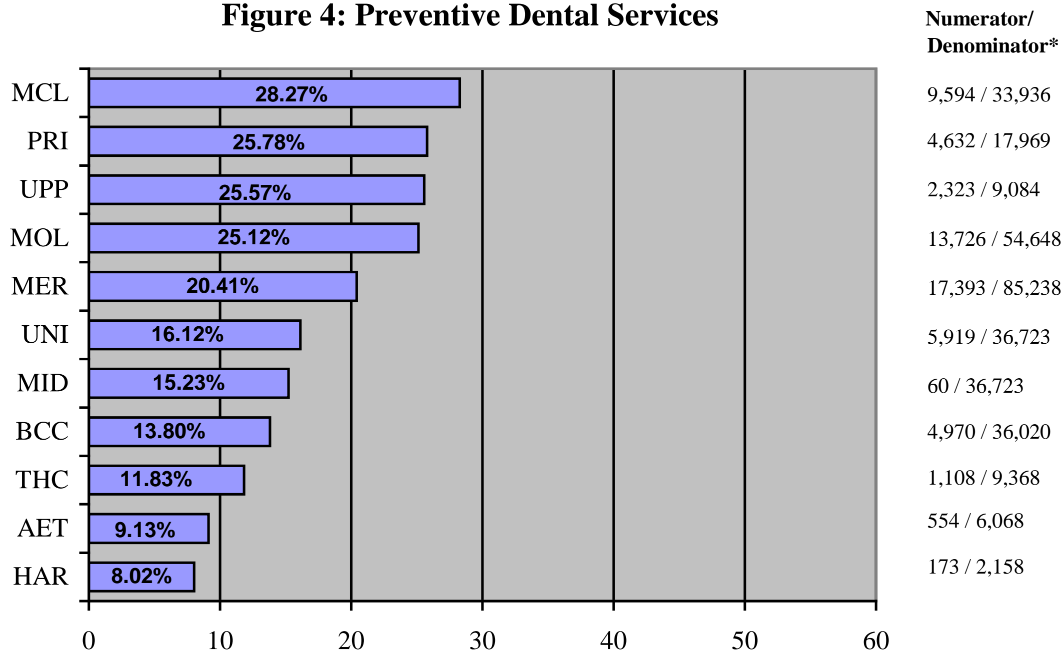
Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Table 3: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
HMP Fee For Service (FFS) Only	496	6,732	7.37%
HMP Managed Care (MC) Only	62,110	298,078	20.84%

Figure 4: Preventive Dental Services



Preventive Dental Services Percentages

*Numerator depicts the number of eligible beneficiaries between the ages of 19 and 64 who had at least one preventive dental service. Denominator depicts the total number of eligible beneficiaries.

Restorative (Dental Fillings) Services

Measure
The percentage of Healthy Michigan Plan enrollees between the ages of 19 and 64 who received at least one preventive dental service within the measurement period.

Standard
N/A – Informational Only

Measurement Period
July 2016 –June 2017

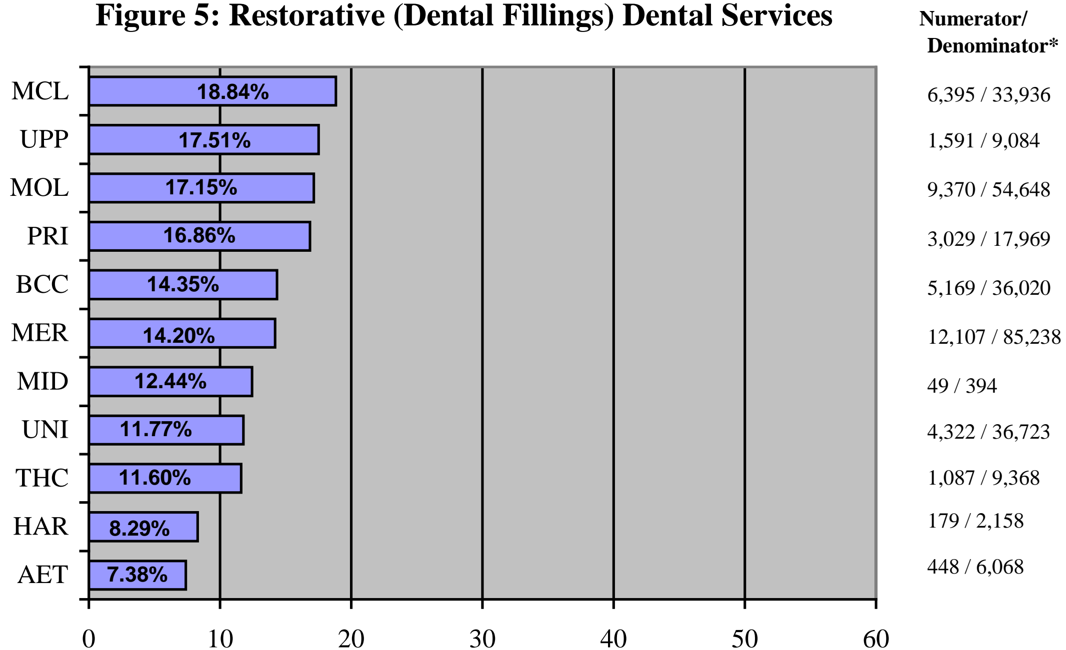
Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Table 4: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
HMP Fee For Service (FFS) Only	373	6,732	5.54%
HMP Managed Care (MC) Only	45,095	298,078	15.13%

Figure 5: Restorative (Dental Fillings) Dental Services



*Numerator depicts the number of eligible beneficiaries between the ages of 19 and 64 who had at least one restorative dental service. Denominator depicts the total number of eligible beneficiaries.

Appendix A: Three Letter Medicaid Health Plan Codes

Below is a list of three letter codes established by MDHHS identifying each Medicaid Health Plan.

AET	Aetna Better Health of Michigan
BCC	Blue Cross Complete of Michigan
HAR	Harbor Health Plan
MCL	McLaren Health Plan
MER	Meridian Health Plan of Michigan
MID	HAP Midwest Health Plan
MOL	Molina Healthcare of Michigan
PRI	Priority Health Choice
THC	Total Health Care
UNI	UnitedHealthcare Community Plan
UPP	Upper Peninsula Health Plan

Appendix B: One Year Plan-Specific Analysis

Aetna Better Health of Michigan – AET

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	19.14%	N/A
	Jul 16 – June 17	**Informational Only**	**18.47%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	19.45%	N/A
	Jul 16 – June 17	**Informational Only**	**9.13%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	7.61%	N/A
	Jul 16 – June 17	**Informational Only**	**7.38%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Blue Cross Complete – BCC

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	30.47%	N/A
	Jul 16 – June 17	**Informational Only**	**29.69%**	**N/A**

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	30.97%	N/A
	Jul 16 – June 17	**Informational Only**	**13.80%**	**N/A**

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	14.76%	N/A
	Jul 16 – June 17	**Informational Only**	**14.35%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Harbor Health Plan – HAR

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	19.50%	N/A
	Jul 16 – June 17	**Informational Only**	**21.64%**	**N/A**

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	19.96%	N/A
	Jul 16 – June 17	**Informational Only**	**8.02%**	**N/A**

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	7.03%	N/A
	Jul 16 – June 17	**Informational Only**	**8.29%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

McLaren Health Plan – MCL

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	40.09%	N/A
	Jul 16 – June 17	**Informational Only**	**38.99%**	**N/A**

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	40.82%	N/A
	Jul 16 – June 17	**Informational Only**	**28..27%**	**N/A**

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	19.46%	N/A
	Jul 16 – June 17	**Informational Only**	**18.84%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Meridian Health Plan of Michigan – MER

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	34.65%	N/A
	Jul 16 – June 17	**Informational Only**	**31.29%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	35.71%	N/A
	Jul 16 – June 17	**Informational Only**	**20.41%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	15.99%	N/A
	Jul 16 – June 17	**Informational Only**	**14.20%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

HAP Midwest Health Plan – MID

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	26.38%	N/A
	Jul 16 – June 17	**Informational Only**	**24.62%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	26.38%	N/A
	Jul 16 – June 17	**Informational Only**	**15.23%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	12.88%	N/A
	Jul 16 – June 17	**Informational Only**	**12.44%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Molina Healthcare of Michigan – MOL

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	38.01%	N/A
	Jul 16 – June 17	**Informational Only**	**37.26%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	38.59%	N/A
	Jul 16 – June 17	**Informational Only**	**25.12%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	17.57%	N/A
	Jul 16 – June 17	**Informational Only**	**17.15%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Priority Health Choice – PRI

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	36.31%	N/A
	Jul 16 – June 17	**Informational Only**	**36.02%**	**N/A**

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	37.57%	N/A
	Jul 16 – June 17	**Informational Only**	**25.78%**	**N/A**

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	17.37%	N/A
	Jul 16 – June 17	**Informational Only**	**16.86%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Total Health Care – THC

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	24.91%	N/A
	Jul 16 – June 17	**Informational Only**	**26.36%**	**N/A**

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	25.33%	N/A
	Jul 16 – June 17	**Informational Only**	**11.83%**	**N/A**

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	11.09%	N/A
	Jul 16 – June 17	**Informational Only**	**11.60%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

UnitedHealthcare Community Plan – UNI

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	28.29%	N/A
	Jul 16 – June 17	**Informational Only**	**28.12%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	28.54%	N/A
	Jul 16 – June 17	**Informational Only**	**16.12%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	12.13%	N/A
	Jul 16 – June 17	**Informational Only**	**11.77%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Upper Peninsula Health Plan – UPP

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	34.08%	N/A
	Jul 16 – June 17	**Informational Only**	**34.62%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	34.67%	N/A
	Jul 16 – June 17	**Informational Only**	**25.57%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	17.45%	N/A
	Jul 16 – June 17	**Informational Only**	**17.51%**	**N/A**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

MAXIMUS

MI HEALTH ACCOUNT

EXECUTIVE SUMMARY REPORT

NOVEMBER 2017

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

MAXIMUS contracts with each Healthy Michigan Plan health plan to operate the MI Health Account (MIHA). The MIHA documents health care costs and payments for health plan members eligible for the Healthy Michigan Plan. Any amount the beneficiary owes to the MIHA is reflected in the quarterly statement that is mailed to the beneficiary. The MIHA quarterly statement shows the total amount owed for co-pays and/or contributions.

A co-pay is a fixed amount beneficiaries pay for a health care service. Before a beneficiary is enrolled in managed care, the beneficiary will pay any co-pays directly to their provider at the time of service. Once enrolled in managed care, co-pays for health plan covered services will be paid into the MIHA.

A contribution is the amount of money that is paid toward health care coverage. **Beneficiaries with incomes at or below 100% of the Federal Poverty Level (FPL) will NOT have a contribution.** Beneficiaries above 100% FPL are required to pay contributions that are based on income and family size. The quarterly statement informs beneficiaries what to pay for co-pays and contributions each month for the next three months, includes payment coupons with instructions on how to make a payment, as well as tips on how to reduce costs (Healthy Behavior incentives). The statement lists the services the beneficiary has received, the amount the beneficiary has paid, what amount they still need to pay, and the amount the health plan has paid.

Quarterly Statement Mailing Guidelines

- The first quarterly statement is mailed six months after a beneficiary joins a health plan. After that, quarterly statements are sent every three months.
- A beneficiary follows his or her own enrollment quarter based on their enrollment effective date.
- Quarterly statements are mailed by the 15th calendar day of each month
- Statements are not mailed to beneficiaries if there are no health care services to display or payment due for a particular quarter.

Chart 1 displays the statement mailing activity for the past three months. It also displays the calendar year totals since January 2017 and the program totals from October 2014 to August 2017.

Chart 1: Account Statement Mailing					
Month Statement Mailed	Statements Mailed	Statements Requiring a Copay Only	Statements Requiring a Contribution Only	Statements Requiring a Copay and Contribution	Percentage of Statements Requiring Payment
Jun-17	107,297	21,166	7,964	12,230	38.55%
Jul-17	127,307	26,431	9,903	14,875	40.22%
Aug-17	105,826	20,676	9,335	12,473	40.15%
Calendar YTD	**862,636**	**180,393**	**70,317**	**104,797**	**41.21%**
Program Total	**2,794,415**	**613,299**	**246,424**	**307,799**	**41.78%**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Payments for the MIHA are due on the 15th of the month following the month they were billed.

Chart 2 displays a collection history of the number of beneficiaries that have paid co-pays and contributions. Completed quarterly payment cycles are explained and reflected in Chart 3. Calendar year totals are from January 2017. Program totals are from October 2014 through August 2017. Please note that beneficiaries that pay both co-pays and contributions will show in each chart.

Copays					
Statement Month	Amount of copays owed	Amount of copays paid	Percentage of copays paid	Number of beneficiaries who owed copays	Number of beneficiaries who paid copays
Jun-17	$258,268.97	$104,532.28	40%	33,396	14,832
Jul-17	$318,978.94	$109,139.64	34%	41,306	16,226
Aug-17	$271,857.79	$91,456.24	34%	33,149	13,115
Calendar YTD	**$2,292,810.76**	**$933,122.68**	**41%**	**285,190**	**128,481**
Program Total	**$6,936,289.87**	**$2,947,038.39**	**42%**	**921,098**	**421,632**
Contributions					
Statement Month	Amount of contributions owed	Amount of contributions paid	Percentage of contributions paid	Number of beneficiaries who owed contributions	Number of beneficiaries who paid contributions
Jun-17	$1,287,429.18	$396,714.68	31%	20,194	8,736
Jul-17	$1,581,050.65	$428,870.87	27%	24,778	9,876
Aug-17	$1,393,758.67	$358,203.23	26%	21,808	8,645
Calendar YTD	**$10,974,487.37**	**$3,464,261.01**	**32%**	**175,114**	**77,314**
Program Total	**$32,309,015.64**	**$11,102,056.22**	**34%**	**554,223**	**262,746**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 displays the total amount collected by completed quarter, by enrollment month. For example, beneficiaries who enrolled in May 2014 received their first quarterly statement in November 2014. These individuals had until February 2015 to pay in full, which constitutes a completed quarter. Please note that the Percentage Collected will change even in completed quarters because payments received are applied to the oldest invoice owed.

Chart 3: Quarterly Collection

Enrollment Month	Quarterly Pay Cycles	Amount Owed	Amount Collected	Percentage Collected
Apr-14	Oct 2014 - Dec 2014	$23,613.53	$16,116.23	68.25%
	Jan 2015 - Mar 2015	$193,287.16	$143,318.58	74.15%
	Apr 2015 - Jun 2015	$165,636.46	$117,653.53	71.03%
	Jul 2015 - Sep 2015	$163,258.58	$109,811.85	67.26%
	Oct 2015 - Dec 2015	$153,872.56	$101,146.07	65.73%
	Jan 2016 - Mar 2016	$140,343.98	$91,067.55	64.89%
	Apr 2016 - Jun 2016	$188,021.42	$103,731.84	55.17%
	Jul 2016 - Sep 2016	$139,146.16	$57,205.85	41.11%
	Oct 2016 - Dec 2016	$174,857.83	$78,887.19	45.12%
	Jan 2017 - Mar 2017	$172,737.94	$75,852.53	43.91%
	Apr 2017 - Jun 2017	$149,073.20	$59,172.75	39.69%
	Jul 2017 - Sep 2017	$128,909.34	$44,880.43	34.82%
May-14	Nov 2014 - Jan 2015	$35,660.43	$27,464.85	77.02%
	Feb 2015 - Apr 2015	$56,591.54	$42,304.83	74.75%
	May 2015 - Jul 2015	$45,888.47	$33,149.16	72.24%
	Aug 2015 - Oct 2015	$41,697.21	$29,209.07	70.05%
	Nov 2015 - Jan 2016	$39,537.66	$27,750.12	70.19%
	Feb 2016 - Apr 2016	$37,381.78	$25,589.57	68.45%
	May 2016 - Jul 2016	$44,979.42	$25,343.28	56.34%
	Aug 2016 - Oct 2016	$39,636.30	$20,591.50	51.95%
	Nov 2016 - Jan 2017	$45,315.47	$24,210.72	53.43%
	Feb 2017 - Apr 2017	$40,548.19	$20,813.91	51.33%
	May 2017 - Jul 2017	$35,656.43	$17,208.44	48.26%
	Aug 2017 - Oct 2017	$34,916.23	$14,764.56	42.29%

Chart 3 continued on page 5

MAXIMUS

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 4

Chart 3: Quarterly Collection

Enrollment Month	Quarterly Pay Cycles	Amount Owed	Amount Collected	Percentage Collected
Jun-14	Dec 2014 - Feb 2015	$456,202.02	$353,281.18	77.44%
	Mar 2015 - May 2015	$348,483.50	$269,266.45	77.27%
	Jun 2015 - Aug 2015	$346,980.86	$262,985.06	75.79%
	Sep 2015 - Nov 2015	$328,352.05	$240,525.04	73.25%
	Dec 2015 - Feb 2016	$234,997.62	$167,417.30	71.24%
	Mar 2016 - May 2016	$265,222.88	$184,101.49	69.41%
	Jun 2016 - Aug 2016	$221,184.15	$121,490.20	54.93%
	Sep 2016 - Nov 2016	$307,991.20	$184,300.66	59.84%
	Dec 2016 - Feb 2017	$283,411.72	$161,066.51	56.83%
	Mar 2017 - May 2017	$249,568.45	$134,424.46	53.86%
	Jun 2017 - Aug 2017	$227,558.79	$115,983.70	50.97%
	Sep 2017 - Nov 2017	$220,758.55	$94,315.86	42.72%
Jul-14	Jan 2015 - Mar 2015	$340,294.17	$249,847.54	73.42%
	Apr 2015 - Jun 2015	$251,809.63	$183,700.58	72.95%
	Jul 2015 - Sep 2015	$242,498.54	$171,509.90	70.73%
	Oct 2015 - Dec 2015	$221,580.91	$154,007.04	69.50%
	Jan 2016 - Mar 2016	$195,448.70	$134,609.17	68.87%
	Apr 2016 - Jun 2016	$210,933.43	$124,550.26	59.05%
	Jul 2016 - Sep 2016	$164,196.02	$72,614.61	44.22%
	Oct 2016 - Dec 2016	$191,975.20	$90,576.73	47.18%
	Jan 2017 - Mar 2017	$183,826.59	$81,764.73	44.48%
	Apr 2017 - Jun 2017	$158,727.78	$67,631.75	42.61%
	Jul 2017 - Sep 2017	$139,889.76	$55,410.64	39.61%

Chart 3 continued on page 6

MAXIMUS

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 5

Chart 3: Quarterly Collection				
Enrollment Month	**Quarterly Pay Cycles**	**Amount Owed**	**Amount Collected**	**Percentage Collected**
Aug-14	Feb 2015 - Apr 2015	$169,747.38	$126,076.87	74.27%
	May 2015 - Jul 2015	$121,573.71	$86,022.76	70.76%
	Aug 2015 - Oct 2015	$111,077.22	$82,080.99	73.90%
	Nov 2015 - Jan 2016	$103,341.91	$74,791.10	72.37%
	Feb 2016 - Apr 2016	$96,489.74	$67,190.45	69.63%
	May 2016 - Jul 2016	$104,271.55	$54,877.93	52.63%
	Aug 2016 - Oct 2016	$85,945.70	$39,846.12	46.36%
	Nov 2016 - Jan 2017	$101,152.88	$49,207.25	48.65%
	Feb 2017 - Apr 2017	$95,530.52	$45,119.36	47.23%
	May 2017 - Jul 2017	$78,572.48	$34,013.54	43.29%
	Aug 2017 - Oct 2017	$71,578.90	$26,632.64	37.21%
Sep-14	Mar 2015 - May 2015	$212,404.10	$144,336.88	67.95%
	Jun 2015 - Aug 2015	$147,467.83	$99,817.30	67.69%
	Sep 2015 - Nov 2015	$150,091.13	$101,316.07	67.50%
	Dec 2015 - Feb 2016	$120,756.14	$80,530.70	66.69%
	Mar 2016 - May 2016	$135,765.20	$83,158.37	61.25%
	Jun 2016 - Aug 2016	$96,824.71	$38,260.36	39.52%
	Sep 2016 - Nov 2016	$112,707.90	$50,847.90	45.11%
	Dec 2016 - Feb 2017	$111,783.15	$50,976.99	45.60%
	Mar 2017 - May 2017	$104,443.76	$44,547.49	42.65%
	Jun 2017 - Aug 2017	$87,097.68	$34,793.28	39.95%
	Sep 2017 - Nov 2017	$79,005.29	$26,067.43	32.99%
Oct-14	Apr 2015 - Jun 2015	$173,728.65	$117,244.24	67.49%
	Jul 2015 - Sep 2015	$125,478.67	$87,365.07	69.63%
	Oct 2015 - Dec 2015	$124,560.14	$86,310.76	69.29%
	Jan 2016 - Mar 2016	$119,213.93	$81,479.29	68.35%
	Apr 2016 - Jun 2016	$135,637.74	$77,327.62	57.01%
	Jul 2016 - Sep 2016	$100,040.16	$39,810.05	39.79%
	Oct 2016 - Dec 2016	$115,878.11	$52,206.62	45.05%
	Jan 2017 - Mar 2017	$113,172.59	$50,172.63	44.33%
	Apr 2017 - Jun 2017	$96,369.96	$40,171.15	41.68%
	Jul 2017 - Sep 2017	$80,841.21	$30,172.75	37.32%

Chart 3 continued on page 7

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HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 6

Chart 3: Quarterly Collection				
Enrollment Month	**Quarterly Pay Cycles**	**Amount Owed**	**Amount Collected**	**Percentage Collected**
Nov-14	May 2015 - Jul 2015	$194,575.29	$130,166.73	66.90%
	Aug 2015 - Oct 2015	$125,952.62	$86,021.39	68.30%
	Nov 2015 - Jan 2016	$132,709.57	$93,610.78	70.54%
	Feb 2016 - Apr 2016	$133,521.08	$89,425.32	66.97%
	May 2016 - Jul 2016	$154,421.63	$73,249.98	47.44%
	Aug 2016 - Oct 2016	$117,462.76	$45,387.41	38.64%
	Nov 2016 - Jan 2017	$138,281.84	$58,892.27	42.59%
	Feb 2017 - Apr 2017	$133,395.32	$54,167.96	40.61%
	May 2017 - Jul 2017	$113,212.55	$42,646.10	37.67%
	Aug 2017 - Oct 2017	$89,830.25	$29,171.00	32.47%
Dec-14	Jun 2015 - Aug 2015	$105,081.89	$72,727.98	69.21%
	Sep 2015 - Nov 2015	$81,661.22	$58,464.48	71.59%
	Dec 2015 - Feb 2016	$67,280.11	$48,907.44	72.69%
	Mar 2016 - May 2016	$80,038.48	$53,269.46	66.55%
	Jun 2016 - Aug 2016	$67,885.21	$27,501.34	40.51%
	Sep 2016 - Nov 2016	$71,445.39	$30,367.95	42.51%
	Dec 2016 - Feb 2017	$69,797.06	$30,215.74	43.29%
	Mar 2017 - May 2017	$69,239.72	$29,303.48	42.32%
	Jun 2017 - Aug 2017	$58,065.34	$21,748.26	37.45%
	Sep 2017 - Nov 2017	$49,438.91	$15,234.29	30.81%
Jan-15	Jul 2015 - Sep 2015	$211,198.27	$152,677.13	72.29%
	Oct 2015 - Dec 2015	$170,179.60	$121,179.46	71.21%
	Jan 2016 - Mar 2016	$166,192.81	$119,828.31	72.10%
	Apr 2016 - Jun 2016	$191,245.22	$116,374.14	60.85%
	Jul 2016 - Sep 2016	$156,718.40	$67,110.22	42.82%
	Oct 2016 - Dec 2016	$162,995.80	$74,981.56	46.00%
	Jan 2017 - Mar 2017	$165,082.86	$75,742.92	45.88%
	Apr 2017 - Jun 2017	$144,125.64	$63,009.19	43.72%
	Jul 2017 - Sep 2017	$125,682.87	$50,087.17	39.85%

Chart 3 continued on page 8

MAXIMUS

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 7

Chart 3: Quarterly Collection

Enrollment Month	Quarterly Pay Cycles	Amount Owed	Amount Collected	Percentage Collected
Feb-15	Aug 2015 - Oct 2015	$205,963.69	$146,031.98	70.90%
	Nov 2015 - Jan 2016	$132,664.64	$97,746.08	73.68%
	Feb 2016 - Apr 2016	$147,251.63	$109,074.59	74.07%
	May 2016 - Jul 2016	$190,889.95	$103,153.12	54.04%
	Aug 2016 - Oct 2016	$152,985.22	$69,679.61	45.55%
	Nov 2016 - Jan 2017	$153,495.49	$72,102.39	46.97%
	Feb 2017 - Apr 2017	$153,382.43	$72,916.91	47.54%
	May 2017 - Jul 2017	$136,602.96	$61,376.81	44.93%
	Aug 2017 - Oct 2017	$119,820.85	$47,509.47	39.65%
Mar-15	Sep 2015 - Nov 2015	$221,431.17	$148,163.63	66.91%
	Dec 2015 - Feb 2016	$100,513.55	$70,205.03	69.85%
	Mar 2016 - May 2016	$109,991.17	$77,294.49	70.27%
	Jun 2016 - Aug 2016	$125,591.94	$62,137.76	49.48%
	Sep 2016 - Nov 2016	$130,106.83	$63,131.17	48.52%
	Dec 2016 - Feb 2017	$115,208.38	$53,942.60	46.82%
	Mar 2017 - May 2017	$116,591.49	$54,233.25	46.52%
	Jun 2017 - Aug 2017	$107,818.74	$46,308.66	42.95%
	Sep 2017 - Nov 2017	$96,355.92	$33,489.80	34.76%
Apr-15	Oct 2015 - Dec 2015	$276,120.26	$182,036.57	65.93%
	Jan 2016 - Mar 2016	$137,495.37	$97,183.57	70.68%
	Apr 2016 - Jun 2016	$172,066.70	$111,441.18	64.77%
	Jul 2016 - Sep 2016	$149,639.23	$76,778.68	51.31%
	Oct 2016 - Dec 2016	$157,148.64	$77,276.36	49.17%
	Jan 2017 - Mar 2017	$144,968.46	$69,822.15	48.16%
	Apr 2017 - Jun 2017	$138,494.12	$66,393.27	47.94%
	Jul 2017 - Sep 2017	$125,397.09	$54,320.04	43.32%

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HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 8

Chart 3: Quarterly Collection				
Enrollment Month	**Quarterly Pay Cycles**	**Amount Owed**	**Amount Collected**	**Percentage Collected**
May-15	Nov 2015 - Jan 2016	$189,970.60	$127,797.23	67.27%
	Feb 2016 - Apr 2016	$125,099.36	$91,936.17	73.49%
	May 2016 - Jul 2016	$167,116.54	$100,127.85	59.91%
	Aug 2016 - Oct 2016	$144,674.73	$76,979.45	53.21%
	Nov 2016 - Jan 2017	$141,674.96	$71,553.69	50.51%
	Feb 2017 - Apr 2017	$121,496.11	$61,614.22	50.71%
	May 2017 - Jul 2017	$119,165.63	$57,732.33	48.45%
	Aug 2017 - Oct 2017	$109,271.04	$46,625.81	42.67%
Jun-15	Dec 2015 - Feb 2016	$159,388.55	$98,738.70	61.95%
	Mar 2016 - May 2016	$106,252.43	$69,056.95	64.99%
	Jun 2016 - Aug 2016	$98,122.63	$48,370.06	49.30%
	Sep 2016 - Nov 2016	$110,782.26	$51,958.64	46.90%
	Dec 2016 - Feb 2017	$99,958.10	$44,130.74	44.15%
	Mar 2017 - May 2017	$89,832.68	$39,450.06	43.92%
	Jun 2017 - Aug 2017	$82,685.55	$35,734.06	43.22%
	Sep 2017 - Nov 2017	$79,350.51	$27,141.11	34.20%
Jul-15	Jan 2016 - Mar 2016	$150,804.48	$99,467.26	65.96%
	Apr 2016 - Jun 2016	$110,994.64	$65,916.19	59.39%
	Jul 2016 - Sep 2016	$94,070.02	$44,556.38	47.37%
	Oct 2016 - Dec 2016	$97,759.51	$44,667.89	45.69%
	Jan 2017 - Mar 2017	$91,501.28	$38,564.36	42.15%
	Apr 2017 - Jun 2017	$78,725.50	$30,746.55	39.06%
	Jul 2017 - Sep 2017	$72,309.46	$27,627.24	38.21%
Aug-15	Feb 2016 - Apr 2016	$157,846.92	$93,241.52	59.07%
	May 2016 - Jul 2016	$112,609.33	$54,392.34	48.30%
	Aug 2016 - Oct 2016	$95,018.71	$43,032.81	45.29%
	Nov 2016 - Jan 2017	$105,391.53	$44,984.32	42.68%
	Feb 2017 - Apr 2017	$94,430.60	$38,886.83	41.18%
	May 2017 - Jul 2017	$78,751.03	$30,535.10	38.77%
	Aug 2017 - Oct 2017	$73,062.01	$24,451.88	33.47%

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MAXIMUS

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 9

Chart 3: Quarterly Collection				
Sep-15	Mar 2016 - May 2016	$125,800.37	$72,754.12	57.83%
	Jun 2016 - Aug 2016	$80,401.46	$31,723.83	39.46%
	Sep 2016 - Nov 2016	$74,834.31	$34,343.59	45.89%
	Dec 2016 - Feb 2017	$78,651.26	$33,070.99	42.05%
	Mar 2017 - May 2017	$75,905.56	$30,554.90	40.25%
	Jun 2017 - Aug 2017	$62,774.20	$22,817.15	36.35%
	Sep 2017 - Nov 2017	$57,533.31	$16,103.62	27.99%
Oct-15	Apr 2016 - Jun 2016	$145,282.11	$54,438.66	37.47%
	Jul 2016 - Sep 2016	$88,699.48	$34,337.47	38.71%
	Oct 2016 - Dec 2016	$96,307.35	$40,861.22	42.43%
	Jan 2017 - Mar 2017	$94,566.14	$38,387.91	40.59%
	Apr 2017 - Jun 2017	$86,413.41	$31,913.26	36.93%
	Jul 2017 - Sep 2017	$69,582.39	$22,230.33	31.95%
Nov-15	May 2016 - Jul 2016	$172,166.18	$62,694.28	36.41%
	Aug 2016 - Oct 2016	$116,209.42	$43,193.10	37.17%
	Nov 2016 - Jan 2017	$129,461.74	$50,057.65	38.67%
	Feb 2017 - Apr 2017	$122,858.25	$44,526.95	36.24%
	May 2017 - Jul 2017	$109,687.31	$35,198.52	32.09%
	Aug 2017 - Oct 2017	$76,937.85	$22,797.71	29.63%
Dec-15	Jun 2016 - Aug 2016	$157,727.63	$60,382.05	38.28%
	Sep 2016 - Nov 2016	$126,736.98	$47,955.10	37.84%
	Dec 2016 - Feb 2017	$129,611.31	$50,452.92	38.93%
	Mar 2017 - May 2017	$134,824.88	$48,811.87	36.20%
	Jun 2017 - Aug 2017	$114,504.45	$36,873.71	32.20%
	Sep 2017 - Nov 2017	$83,452.34	$22,394.93	26.84%
Jan-16	Jul 2016 - Sep 2016	$204,202.52	$88,426.95	43.30%
	Oct 2016 - Dec 2016	$161,923.29	$68,589.62	42.36%
	Jan 2017 - Mar 2017	$155,741.25	$70,029.78	44.97%
	Apr 2017 - Jun 2017	$146,471.32	$60,099.74	41.03%
	Jul 2017 - Sep 2017	$122,696.36	$44,002.51	35.86%

Chart 3 continued on page 11

MAXIMUS

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 10

Chart 3: Quarterly Collection				
Feb-16	Aug 2016 - Oct 2016	$276,109.87	$134,919.21	48.86%
	Nov 2016 - Jan 2017	$216,695.31	$103,642.09	47.83%
	Feb 2017 - Apr 2017	$198,174.33	$97,975.57	49.44%
	May 2017 - Jul 2017	$186,058.33	$83,610.57	44.94%
	Aug 2017 - Oct 2017	$155,336.00	$61,381.56	39.52%
Mar-16	Sep 2016 - Nov 2016	$248,608.23	$107,025.20	43.05%
	Dec 2016 - Feb 2017	$178,084.09	$76,270.56	42.83%
	Mar 2017 - May 2017	$173,420.92	$73,152.45	42.18%
	Jun 2017 - Aug 2017	$162,533.06	$61,313.71	37.72%
	Sep 2017 - Nov 2017	$139,851.96	$41,701.55	29.82%
Apr-16	Oct 2016 - Dec 2016	$236,627.95	$93,777.18	39.63%
	Jan 2017 - Mar 2017	$184,389.33	$72,615.47	39.38%
	Apr 2017 - Jun 2017	$182,242.36	$68,076.76	37.36%
	Jul 2017 - Sep 2017	$160,203.70	$53,337.89	33.29%
May-16	Nov 2016 - Jan 2017	$240,988.61	$91,828.53	38.10%
	Feb 2017 - Apr 2017	$185,623.25	$67,400.61	36.31%
	May 2017 - Jul 2017	$175,469.44	$60,835.85	34.67%
	Aug 2017 - Oct 2017	$155,213.73	$43,618.66	28.10%
Jun-16	Dec 2016 - Feb 2017	$147,989.82	$60,977.47	41.20%
	Mar 2017 - May 2017	$124,157.55	$45,399.71	36.57%
	Jun 2017 - Aug 2017	$113,561.52	$39,945.45	35.18%
	Sep 2017 - Nov 2017	$106,707.08	$30,004.90	28.12%
Jul-16	Jan 2017 - Mar 2017	$173,131.24	$64,985.91	37.54%
	Apr 2017 - Jun 2017	$149,152.06	$50,608.49	33.93%
	Jul 2017 - Sep 2017	$133,065.27	$38,777.14	29.14%
Aug-16	Feb 2017 - Apr 2017	$188,534.01	$70,605.21	37.45%
	May 2017 - Jul 2017	$161,836.33	$54,373.03	33.60%
	Aug 2017 - Oct 2017	$146,801.65	$41,860.29	28.51%
Sep-16	Mar 2017 - May 2017	$164,892.76	$60,663.36	36.79%
	Jun 2017 - Aug 2017	$127,017.52	$39,791.25	31.33%
	Sep 2017 - Nov 2017	$108,965.69	$27,626.91	25.35%
Oct-16	Apr 2017 - Jun 2017	$210,487.44	$70,625.52	33.55%
	Jul 2017 - Sep 2017	$162,773.71	$44,231.61	27.17%

Chart 3 continued on page 12

MAXIMUS

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 11

Chart 3: Quarterly Collection				
Nov-16	May 2017 - Jul 2017	$180,930.02	$56,588.71	31.28%
	Aug 2017 - Oct 2017	$122,906.82	$30,890.27	25.13%
Dec-16	Jun 2017 - Aug 2017	$172,057.86	$47,490.27	27.60%
	Sep 2017 - Nov 2017	$112,893.03	$24,716.72	21.89%
Jan-17	Jul 2017 - Sep 2017	$235,961.85	$74,382.46	31.52%
Feb-17	Aug 2017 - Oct 2017	$209,238.39	$63,042.48	30.13%
Mar-17	Sep 2017 - Nov 2017	$215,089.71	$63,202.65	29.38%

Payments for the MIHA can be made one of two ways. Beneficiaries can mail a check or money order to the MIHA payment address. The payment coupon is not required to send in a payment by mail. Beneficiaries also have the option to pay online using a bank account.

Chart 4 displays a three month history of the percentage of payments made into the MIHA.

Chart 4: Methods of Payment			
	Jun-17	**Jul-17**	**Aug-17**
Percent Paid Online	31.05%	31.28%	33.13%
Percent Paid by Mail	68.95%	68.72%	66.87%

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Adjustment Activities

Beneficiaries are not required to pay co-pays and/or contributions when specific criteria are met. In these cases, an adjustment is made to the beneficiary's quarterly statement.

This includes populations that are exempt; beneficiaries that are under age 21, pregnant, in hospice and Native American beneficiaries. It also includes beneficiaries who were not otherwise exempt, but have met their five percent maximum cost share and beneficiaries whose Federal Poverty Level is no longer in a range that requires a contribution.

Chart 5A shows the number of beneficiaries that met these adjustments for the specified month, calendar year since January 2017 and the cumulative total for the program from October 2014 through August 2017.

Chart 5A: Adjustment Activities

	Jun-17		Jul-17		Aug-17	
	#	**Total $**	**#**	**Total $**	**#**	**Total $**
Beneficiary is under age 21	525	$32,579.00	649	$38,924.00	544	$32,384.00
Pregnancy	240	$5,572.29	264	$5,684.10	248	$5,955.64
Hospice	0	$0.00	0	$0.00	0	$0.00
Native American	20	$2,099.33	13	$1,717.00	12	$1,525.00
Five Percent Cost Share Limit Met	36,257	$374,305.20	42,136	$389,693.58	32,329	$294,558.89
FPL No longer >100% - Contribution	4	$59.00	4	$31.56	0	$0.00
TOTAL	**37,046**	**$414,614.82**	**43,066**	**$436,050.24**	**33,133**	**$334,423.53**
	June-17 to Aug-17		**Calendar YTD**		**Program YTD**	
	#	**Total $**	**#**	**Total $**	**#**	**Total $**
Beneficiary is under age 21	1,718	$103,887.00	5,203	$321,893.00	17,675	$996,738.29
Pregnancy	752	$17,212.03	1,922	-$46,164.47	8,572	$204,547.53
Hospice	0	$0.00	0	$0.00	0	$0.00
Native American	45	$5,341.33	145	$14,745.33	772	$50,803.67
Five Percent Cost Share Limit Met	110,722	$1,058,557.67	287,142	$2,889,590.87	931,264	$10,588,811.29
FPL No longer >100% - Contribution	8	$90.56	31	$355.32	285	$10,404.69
TOTAL	**113,245**	**$1,185,088.59**	**294,443**	**$3,180,420.05**	**958,568**	**$11,851,305.47**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Healthy Behavior Incentives

Beneficiaries may qualify for reductions in co-pays and/or contributions due to Healthy Behavior incentives. All health plans offer enrolled beneficiaries financial incentives that reward healthy behaviors and personal responsibility. To be eligible for incentives a beneficiary must first complete a health risk assessment (HRA) with their primary care provider (PCP) and agree to address or maintain health behaviors.

Co-pays – Beneficiaries can receive a 50% reduction in co-pays once they have paid 2% of their income in co-pays AND agree to address or maintain healthy behaviors.

Contributions - Beneficiaries can receive a 50% reduction in contributions if they complete an HRA with a PCP attestation AND agree to address or maintain healthy behaviors.

Gift Cards – Beneficiaries at or below 100% FPL receive a $50.00 gift card if they complete an HRA with a PCP attestation AND agree to address or maintain healthy behaviors.

Chart 5B shows the number of beneficiaries that qualified for a reduction in co-pays and/or contributions due to Healthy Behavior incentives for the specified month, calendar year since January 2017 and the cumulative total for the program from October 2014 through August 2017.

Chart 5B: Healthy Behaviors

	Jun-17		Jul-17		Aug-17	
	#	Total $	#	Total $	#	Total $
Co-pay	832	$3,616.50	1,142	$5,123.96	958	$4,609.73
Contribution	1,298	$45,276.50	1,604	$54,608.00	1,483	$49,306.50
Gift Cards	2,529	n/a	3,348	n/a	2,849	n/a
TOTAL	**4,659**	**$48,893.00**	**6,094**	**$59,731.96**	**5,290**	**$53,916.23**
	June 17 to Aug-17		**Calendar YTD**		**Program YTD**	
	#	**Total $**	**#**	**Total $**	**#**	**Total $**
Co-pay	2,932	$13,350.19	7,424	$35,042.92	35,439	$203,497.69
Contribution	4,385	$149,191.00	11,757	$404,135.88	68,313	$2,240,015.77
Gift Cards	8,726	n/a	22,170	n/a	120,603	n/a
TOTAL	**16,043**	**$162,541.19**	**41,351**	**$439,178.80**	**224,355**	**$2,443,513.46**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Typically, beneficiaries will pay a co-pay for the following services:

- Physician Office Visits (including free standing Urgent Care Centers)
- Outpatient Hospital Clinic Visit
- Outpatient Non-Emergent ER Visit (co-pay not required for emergency services)
- Inpatient Hospital Stay (co-pay not required for emergency admissions)
- Pharmacy (brand name and generic)
- Vision Services
- Dental Visits
- Chiropractic Visits
- Hearing Aids
- Podiatric Visits

If a beneficiary receives any of the above services for a chronic condition, the co-pay will be waived and the beneficiary will not be billed. This promotes greater access to high value services that prevent the progression of and complications related to chronic disease.

Chart 6 shows the number of beneficiaries whose co-pays were waived and the dollar amount waived due to receiving services for chronic conditions. Co-pay adjustments for high value services are processed quarterly based on the beneficiaries' individual enrollment and statement cycles.

Chart 6: Waived Copays for High Value Services

Month	# of Beneficiaries with Copays Waived	Total Dollar Amount Waived
Jun-17	38,750	$338,400
Jul-17	46,513	$412,933
Aug-17	50,127	$404,161
Calendar YTD	**328,982**	**$2,851,767**
Program Total	**586,298**	**$5,080,949**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Beneficiaries that do not pay three consecutive months they have been billed co-pays or contributions are considered "consistently failing to pay (CFP)" status. Once a beneficiary is in CFP status, the following language is added to the quarterly statement: "If your account is overdue, you may have a penalty. For example, if you have a healthy behavior reduction, you could lose it. Your information may also be sent to the Michigan Department of Treasury. They can take your overdue amount from your tax refund or future lottery winnings. Your doctor cannot refuse to see you because of an overdue amount." Beneficiaries that are in CFP status and have a total amount owed of at least $50 can be referred to the Department of Treasury for collection. Beneficiaries that have not paid at least 50% of their total contributions and co-pays billed to them in the past 12 months can also be referred to the Department of Treasury for collection.

Chart 7 displays the past due collection history and the number of beneficiaries that have past due balances that can be collected through the Department of Treasury. These numbers are cumulative from quarter to quarter.

Chart 7: Past Due Collection Amounts

Month	# of Beneficiaries with Past Due Co-pays/Contributions	# of Beneficiaries with Past Due Co-pays/Contributions that Can be Sent to Treasury
Jun-17	188,296	72,803
Jul-17	181,845	74,011
Aug-17	186,162	76,552

Chart 8 displays the total amount of past due invoices according to the length of time the invoice has been outstanding. Each length of time displays the unique number of beneficiaries for that time period. The total number of delinquent beneficiaries is also listed along with the corresponding delinquent amount owed.

Chart 8: Delinquent Copay and Contribution Amounts by Aging Category

Days	0-30 Days	31-60 Days	61-90 Days	91-120 Days	>120 Days	TOTAL
Amount Due	$1,050,872.77	$963,386.17	$952,032.00	$917,960.69	$12,563,562.01	**$16,447,813.64**
Number of Beneficiaries That Owe	78,415	74,348	73,141	70,302	193,756	**234,772**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Beneficiaries are mailed a letter that informs them of the amount that could be garnished by the Department of Treasury. This pre-garnishment notice is mailed each year in July. Beneficiaries are given 30 days from the date of the letter to make a payment or file a dispute with the Department of Health and Human Services (DHHS) for the amount owed.

Chart 9 displays the beneficiary payment activity as a result of the pre-garnishment notice.

Chart 9: Pre-Garnishment Notices				
Month/Year	**# of Beneficiaries that Received a Garnishment Notice**	**Total Amount Owed**	**# of Beneficiaries that Paid Following Pre-Garnishment Notice**	**Total Amount Collected**
Jul-15	5,893	$589,770.20	2,981	$78,670.02
Jul-16	41,460	$5,108,153.13	3,832	$404,921.47
Jul-17	68,201	$10,049,454.41	7,345	$805,457.87
Calendar YTD	**68,201**	**$10,049,454.41**	**7,345**	**$805,457.87**
Program Total	**115,554**	**$15,747,377.74**	**14,158**	**$1,289,049.36**

Beneficiaries are referred to the Department of Treasury each year in November if they still owe at least $50 following the pre-garnishment notice.

Chart 10 displays the number of beneficiaries that were referred to Treasury.

Chart 10: Garnishments Sent to Treasury		
Month	**# of Beneficiaries Sent to Treasury for Garnishment**	**Total Amount Sent to Treasury for Garnishment**
Nov-15	4,635	$460,231.19
Nov-16	31,932	$3,946,091.28
Nov-17	49,857	$7,178,042.86

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

The Department of Treasury may garnish tax refunds or lottery winnings up to the amount referred to them from the MI Health Account.

Chart 11 displays collection activities by the Department of Treasury.

Chart 11: Garnishments Collected by Treasury						
Tax Year	Collected by Taxes		Collected by Lottery		Total Garnishments Collected	
	#	Total	#	Total	#	Total
2016	2,151	$207,873.10	7	$485.67	**2,158**	**$208,358.77**
2017	19,400	$2,186,182.40	59	$6,733.49	**19,459**	**$2,192,915.89**
Calendar YTD	**19,400**	**$2,186,182.40**	**59**	**$6,733.49**	**19,459**	**$2,192,915.89**
Program Total	**21,551**	**$2,394,055.50**	**66**	**$7,219.16**	**21,617**	**$2,401,274.66**

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

During 2016, the Michigan Department of Health and Human Services (MDHHS) contracted with 11 health plans to provide managed care services to Michigan Medicaid enrollees. MDHHS expects its contracted Medicaid health plans (MHPs) to support healthcare claims systems, membership and provider files, and hardware/software management tools that facilitate accurate and reliable reporting of the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] measures. MDHHS contracted with Health Services Advisory Group, Inc. (HSAG), to calculate statewide average rates based on the MHPs' rates and evaluate each MHP's current performance level as well as the statewide performance relative to national Medicaid percentiles. MDHHS uses HEDIS rates for the annual Medicaid consumer guide as well as for the annual performance assessment.

MDHHS selected HEDIS measures to evaluate Michigan MHPs. These measures were grouped under the following eight measure domains:

- Child & Adolescent Care
- Women—Adult Care
- Access to Care
- Obesity
- Pregnancy Care
- Living With Illness
- Health Plan Diversity
- Utilization

Of note, measures in the Health Plan Diversity and Utilization measure domains are provided within this report for information purposes only as they assess the health plans' use of services and/or describe health plan characteristics and are not related to performance. Therefore, most of these rates were not evaluated in comparison to national benchmarks, and changes in these rates across years were not analyzed by HSAG for statistical significance.

The performance levels were set at specific, attainable rates and are based on national percentiles. MHPs that met the high performance level (HPL) exhibited rates that were among the top in the nation. The low performance level (LPL) was set to identify MHPs with the greatest need for improvement. Details describing these performance levels are presented in Section 2, "How to Get the Most From This Report."

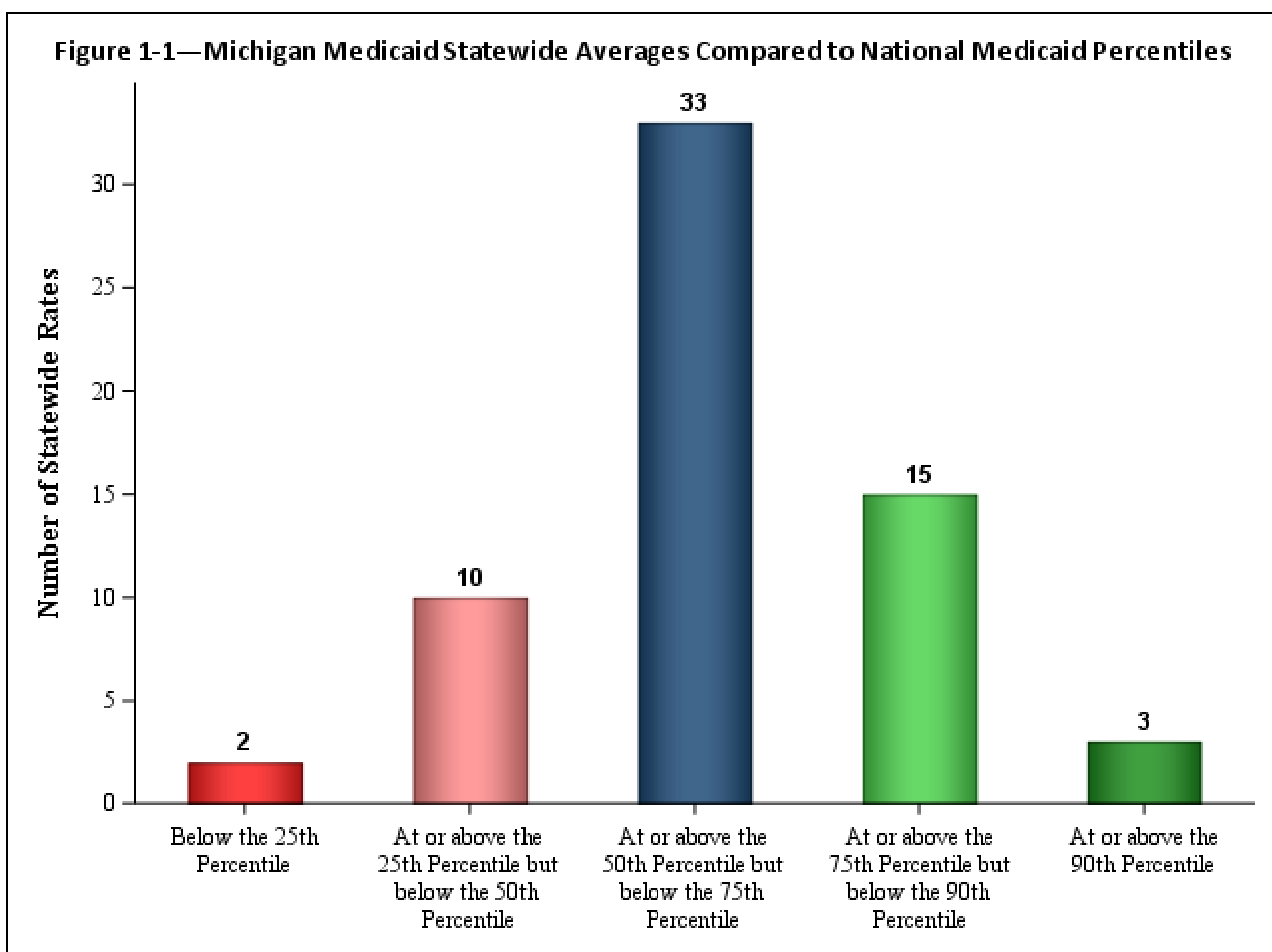
[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

In addition, Section 11 ("HEDIS Reporting Capabilities—Information Systems Findings") provides a summary of the HEDIS data collection processes used by the Michigan MHPs and the audit findings in relation to the National Committee for Quality Assurance's (NCQA's) information system (IS) standards.[1-2]

Summary of Performance

Figure 1-1 compares the Michigan Medicaid program's overall rates with NCQA's Quality Compass® national Medicaid HMO percentiles for HEDIS 2016, which are referred to as "national Medicaid percentiles" throughout this report.[1-3] For measures that were comparable to national Medicaid percentiles, the bars represent the number of Michigan Medicaid Weighted Average (MWA) measure indicator rates that fell into each national Medicaid percentile range.

Figure 1-1—Michigan Medicaid Statewide Averages Compared to National Medicaid Percentiles



[1-2] National Committee for Quality Assurance. *HEDIS® 2017, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*. Washington D.C.

[1-3] Quality Compass® is a registered trademark for the National Committee for Quality Assurance (NCQA).

Of the reported rates that were comparable to national Medicaid percentiles, two of the MWA rates (approximately 3 percent) fell below the national Medicaid 25th percentile, and twelve of the MWA rates (almost 20 percent) fell below the national Medicaid 50th percentile. Eighteen of the MWA rates (about 29 percent) ranked at or above the national Medicaid 75th percentile, and three of the MWA rates (roughly 5 percent) ranked at or above the national Medicaid 90th percentile. A summary of MWA performance for each measure domain is presented on the following pages.

Child & Adolescent Care

For the Child & Adolescent Care domain, half of the MWA rates demonstrated statistically significant improvement from 2016 to 2017. Nearly all MWA rates in this domain ranked at or above the national Medicaid 50th percentile, with three rates ranking at or above the national Medicaid 75th percentile indicating strengths in the areas of well-child visits on or before 15 months of age, lead screenings for children, and administration and documentation of immunizations for adolescents. Additionally, the MWA rates for *Well-Child Visits in the First 15 Months of Life—Six or More Visits* and *Lead Screening in Children* demonstrated statistically significant improvements from 2016 to 2017. Although the MWA for *Appropriate Testing for Children With Pharyngitis* fell below the national Medicaid 50th percentile, four MHPs' rates and the MWA rate for this measure demonstrated statistically significant increases from 2016 to 2017, indicating positive improvement in this area at the statewide level and for select MHPs.

Conversely, the MWA for *Appropriate Treatment for Children With Upper Respiratory Infection* fell below the national Medicaid 50th percentile and three MHPs' rates for this measure demonstrated statistically significant declines from 2016 to 2017, suggesting opportunities for improvement. However, caution should be used when comparing the 2017 rates for this measure to national benchmarks and prior years due to changes to the technical measure specifications for HEDIS 2017.

Women—Adult Care

In the Women—Adult Care domain, all five MWA rates ranked at or above the national Medicaid 50th percentile, with four of these rates ranking at or above the national Medicaid 75th percentile, indicating overall positive performance in the measured areas of cancer and chlamydia screenings for women. Further, four MHPs' rates and the MWA for *Breast Cancer Screening* and three MHPs' rates and the MWA for *Chlamydia Screening in Women—Total* demonstrated statistically significant improvement from 2016 to 2017.

Access to Care

All nine MWA rates ranked at or above the national Medicaid 50th percentile, indicating positive performance in the area of Access to Care. Specifically, the MWA and three MHPs' rates related to access to primary care practitioners (PCPs) for members ages 7 through11 years and members ages 12 through19 years demonstrated statistically significant improvement from 2016 to 2017. Further, the MWA and four MHPs' rates related to appropriate treatment for adults with bronchitis also

demonstrated statistically significant improvement. However, caution should be used when comparing the 2017 *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* rates to national benchmarks and prior years due to changes to the technical measure specifications for HEDIS 2017.

Despite favorable performance compared to national benchmarks for measures related to access to preventive/ambulatory services for adults, these rates demonstrated statistically significant declines in performance. In particular, seven of the 11 MHPs' rates and the MWA exhibited decreases that were statistically significant from 2016 to 2017 for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator, suggesting opportunities for improving access to preventive/ambulatory services for adults ages 20 years and above.

Obesity

All MWA rates related to the obesity domain demonstrated statistically significant improvement from 2016 to 2017. The four MWA rates included in the Obesity domain ranked at or above the national Medicaid 50th percentile, with two MWA rates ranking at or above the national Medicaid 75th percentile and one MWA ranking at or above the national Medicaid 90th percentile. Most favorably, rates for body mass index (BMI) percentile assessments for children and adolescents demonstrated statistically significant improvement for seven MHPs and the MWA, rates for nutrition counseling for children and adolescents demonstrated statistically significant improvement for five MHPs and the MWA, and rates for BMI assessments for adults demonstrated statistically significant improvement for three MHPs and the MWA.

Pregnancy Care

One of the three measures in the Pregnancy Care domain, *Prenatal and Postpartum Care—Postpartum Care,* ranked at or above the national Medicaid 75th percentile. Additionally, the MWA and three MHPs' rates for this measure demonstrated statistically significant increases, indicating improvements in postpartum care from 2016 to 2017.

For the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits* measures, the MWA rates fell below the national Medicaid 50th percentile, indicating opportunities for improvement in prenatal care. Of note, the MWA and three MHPs' timely prenatal care rates demonstrated statistically significant improvement, and three MHPs' ongoing prenatal care rates demonstrated statistically significant improvement. However, four MHPs' ongoing prenatal care rates demonstrated statistically significant declines, indicating mixed results when comparing 2017 MHP and statewide performance to 2016.

Living With Illness

For the Living With Illness domain, most MWA rates (16 of 23 rates) ranked at or above the national Medicaid 50th percentile. Seven MWA rates ranked at or above the national Medicaid 75th percentile,

one of which ranked at or above the national Medicaid 90th percentile, indicating positive performance related to HbA1c control and eye exams for members with diabetes, managing medications for members with asthma, and cessation assistance for smoking/tobacco use.

Additionally, for the *Medication Management for People With Asthma* measure, *Medication Compliance 75%—Total* rates for the MWA and seven MHPs demonstrated statistically significant improvement, and *Medication Compliance 50%—Total* rates for the MWA and four MHPs demonstrated statistically significant improvement, indicating positive performance in this area. Of note, the MWA and four MHPs' rates for poor HbA1c control for diabetic members demonstrated statistically significant improvement, and the MWA and three MHPs' rates for proper HbA1c control for diabetic members demonstrated statistically significant improvement. Further, blood pressure (BP) control rates for members with diabetes demonstrated statistically significant improvement for three MHPs and the MWA, and BP control rates for members with hypertension demonstrated statistically significant improvement for four MHPs and the MWA.

Conversely, the MWA rates for *Antidepressant Medication Management* and *Annual Monitoring for Patients on Persistent Medications* fell at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile, and the MWA for *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* fell below the national Medicaid 25th percentile. Additionally, rates for effective acute phase treatment for members on an antidepressant medication indicated statistically significant declines in performance for four MHPs and the MWA, and rates for effective continuation phase treatment for members on an antidepressant medication indicated statistically significant declines in performance for three MHPs and the MWA.

Health Plan Diversity

Although measures under this domain are not performance measures and are not compared to national Medicaid percentiles, changes observed in the results may provide insights into how select member characteristics affect the MHPs' provision of services and care. Comparing the HEDIS 2016 and 2017 statewide rates for the *Race/Ethnicity Diversity of Membership* measure, the 2017 rates showed slight changes (most less than 1 percentage point) for almost all categories with the exception of the categories including unknown language of members and members for whom English is the language preferred for written materials. For the *Language Diversity of Membership* measure at the statewide level, the percentage of members using English as the preferred spoken language for healthcare increased slightly from the previous year, with a slight decline in the Unknown category. The percentage of Michigan members reporting English as the language preferred for written materials increased in HEDIS 2017 while the Unknown category showed almost an 8 percent decrease from HEDIS 2016. Regarding other language needs, the percentage of members reporting English in HEDIS 2017 increased slightly while Non-English and Unknown decreased from HEDIS 2016.

Utilization

For *Ambulatory Care (Per 1,000 Member Months)—Outpatient Visits* and *Emergency Department Visits,* the Michigan Medicaid unweighted averages for HEDIS 2017 demonstrated a slight increase.[1-4] Because the measure of outpatient visits is not linked to performance, the results for this measure are not comparable to national Medicaid percentiles. However, the increase in emergency department visits may indicate a decline in performance. For the *Inpatient Utilization—General Hospital/Acute Care* measure, the discharges per 1,000 member months increased for two inpatient service types (*Total Inpatient* and *Surgery*). The average length of stay decreased for two services (*Surgery* and *Maternity).*

Limitations and Considerations

Due to changes in Michigan's managed care program in 2016, HAP Midwest Health Plan's (MID's) eligible population decreased substantially. Therefore, HSAG suggests that caution be exercised when comparing MID's HEDIS 2017 rates to prior years' results.

[1-4] For the *Emergency Department Visits* indicator, a lower rate indicates better performance (i.e., low rates of emergency department visits suggest more appropriate service utilization).

2. How to Get the Most From This Report

Introduction

This reader's guide is designed to provide supplemental information to the reader that may aid in the interpretation and use of the results presented in this report.

Michigan Medicaid Health Plan Names

Table 2-1 presents a list of the Michigan MHPs discussed within this report and their corresponding abbreviations.

Table 2-1—2017 Michigan MHP Names and Abbreviations

MHP Name	Abbreviation
Aetna Better Health of Michigan	AET
Blue Cross Complete of Michigan	BCC
Harbor Health Plan	HAR
McLaren Health Plan	MCL
Meridian Health Plan of Michigan	MER
HAP Midwest Health Plan	MID
Molina Healthcare of Michigan	MOL
Priority Health Choice, Inc.	PRI
Total Health Care, Inc.	THC
UnitedHealthcare Community Plan	UNI
Upper Peninsula Health Plan	UPP

Summary of Michigan Medicaid HEDIS 2017 Measures

Within this report, HSAG presents the Michigan Medicaid Weighted Average (MWA) (i.e., statewide average rates) and MHP-specific performance on HEDIS measures selected by MDHHS for HEDIS 2017. These measures were grouped into the following eight domains of care: Child & Adolescent Care, Women—Adult Care, Access to Care, Obesity, Pregnancy Care, Living With Illness, Health Plan Diversity, and Utilization. While performance is reported primarily at the measure indicator level, grouping these measures into domains encourages MHPs and MDHHS to consider the measures as a whole rather than in isolation and to develop the strategic and tactical changes required to improve overall performance.

Table 2-2 shows the selected HEDIS 2017 measures and measure indicators as well as the corresponding domains of care and the reporting methodologies for each measure. The data collection or calculation method is specified by NCQA in the *HEDIS 2017 Volume 2 Technical Specifications*. Data collection methodologies are described in detail in the next section.

Table 2-2—Michigan Medicaid HEDIS 2017 Required Measures

Performance Measures	HEDIS Data Collection Methodology
Child & Adolescent Care	
Childhood Immunization Status—Combinations 2–10	Hybrid
Well-Child Visits in the First 15 Months of Life—Six or More Visits	Hybrid
Lead Screening in Children	Administrative
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Hybrid
Adolescent Well-Care Visits	Hybrid
Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)	Hybrid
Appropriate Treatment for Children With Upper Respiratory Infection	Administrative
Appropriate Testing for Children With Pharyngitis	Administrative
Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase and *Continuation and Maintenance Phase*	Administrative
Women—Adult Care	
Breast Cancer Screening	Administrative
Cervical Cancer Screening	Hybrid
Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years, and *Total*	Administrative
Access to Care	
Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years, and *Ages 12 to 19 Years*	Administrative
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years, Ages 45 to 64 Years, Ages 65 Years and Older, and *Total*	Administrative
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Administrative
Obesity	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total, and *Counseling for Physical Activity—Total*	Hybrid
Adult BMI Assessment	Hybrid

Performance Measures	HEDIS Data Collection Methodology
Pregnancy Care	
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	Hybrid
Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits	Hybrid
Living With Illness	
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed, Medical Attention for Nephropathy, and *Blood Pressure Control (<140/90 mm Hg)*	Hybrid
Medication Management for People with Asthma—Medication Compliance 50%—Total and *Medication Compliance 75%—Total*	Administrative
Asthma Medication Ratio—Total	Administrative
Controlling High Blood Pressure	Hybrid
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications, and *Discussing Cessation Strategies*	Administrative
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	Administrative
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Administrative
Diabetes Monitoring for People With Diabetes and Schizophrenia	Administrative
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	Administrative
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Administrative
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs, Digoxin, Diuretics, and *Total*	Administrative
Health Plan Diversity	
Race/Ethnicity Diversity of Membership	Administrative
Language Diversity of Membership—Spoken Language Preferred for Health Care, Preferred Language for Written Materials, and *Other Language Needs*	Administrative
Utilization	
Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits—Total and *Outpatient Visits—Total*	Administrative
Inpatient Utilization—General Hospital/Acute Care	Administrative

Data Collection Methods

Administrative Method

The administrative method requires that MHPs identify the eligible population (i.e., the denominator) using administrative data, derived from claims and encounters. In addition, the numerator(s), or services provided to the members in the eligible population, are derived solely using administrative data collected during the reporting year. Medical record review data from the prior year may be used as supplemental data. Medical records collected during the current year cannot be used to retrieve information. When using the administrative method, the entire eligible population becomes the denominator, and sampling is not allowed.

Hybrid Method

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

The hybrid method generally produces higher rates because the completeness of documentation in the medical record exceeds what is typically captured in administrative data; however, the medical record review component of the hybrid method is considered more labor intensive. For example, the MHP has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure and chooses to use the hybrid method. After randomly selecting 411 eligible members, the MHP finds that 161 members had evidence of a postpartum visit using administrative data. The MHP then obtains and reviews medical records for the 250 members who did not have evidence of a postpartum visit using administrative data. Of those 250 members, 54 were found to have a postpartum visit recorded in the medical record review. Therefore, the final rate for this measure, using the hybrid method, would be (161 + 54)/411, or 52.3 percent, a 13.1 percentage point increase from the administrative only rate of 39.2 percent.

Understanding Sampling Error

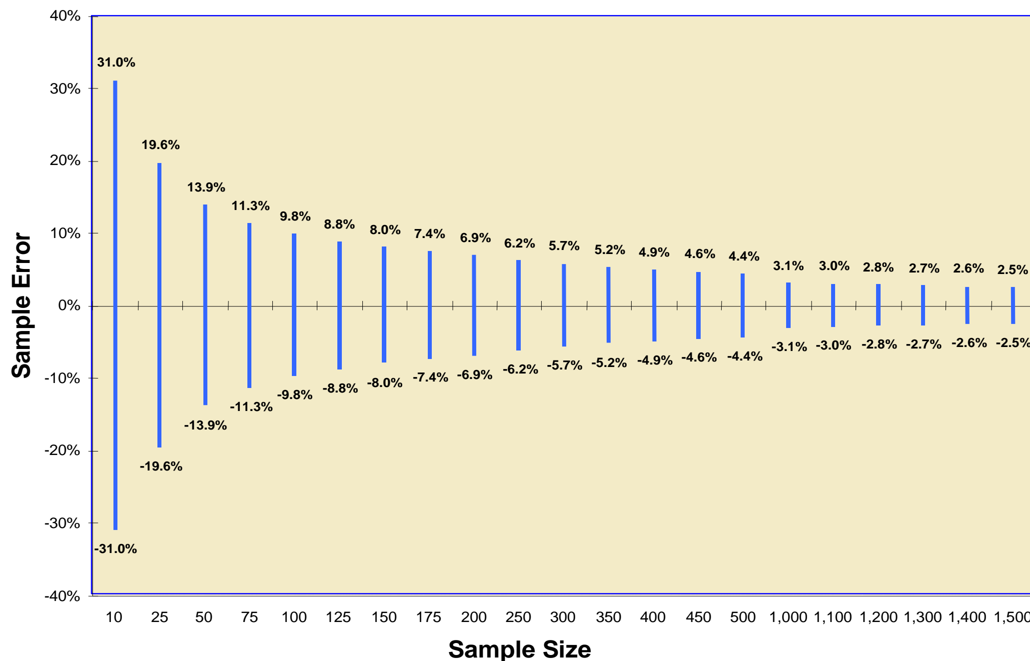
Correct interpretation of results for measures collected using HEDIS hybrid methodology requires an understanding of sampling error. It is rarely possible, logistically or financially, to complete medical record review for the entire eligible population for a given measure. Measures collected using the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

For results to be generalized to the entire eligible population, the process of sample selection must be such that everyone in the eligible population has an equal chance of being selected. The HEDIS hybrid method prescribes a systematic sampling process selecting at least 411 members of the eligible

population. MHP may use a 5 percent, 10 percent, 15 percent, or 20 percent oversample to replace invalid cases (e.g., a male selected for *Postpartum Care*).

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

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



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

Data Sources and Measure Audit Results

MHP-specific performance displayed in this report was based on data elements obtained from the Interactive Data Submission System (IDSS) files supplied by the MHPs. Prior to HSAG's receipt of the MHPs' IDSS files, all of the MHPs were required by MDHHS to have their HEDIS 2017 results examined and verified through an NCQA HEDIS Compliance Audit.

Through the audit process, each measure indicator rate reported by an MHP was assigned an NCQA-defined audit result. HEDIS 2017 measure indicator rates received one of five predefined audit results: *Reportable (R)*, *Small Denominator (NA)*, *Biased Rate (BR), No Benefit (NB), Not Required (NQ),* and *Not Reported (NR)*. The audit results are defined in the "Glossary" section below.

Rates designated as *NA*, *BR*, *NB*, *NQ*, or *NR* are not presented in this report. All measure indicator rates that are presented in this report have been verified as an unbiased estimate of the measure. Please see Section 11 for additional information on NCQA's Information System (IS) standards and the audit findings for the MHPs.

Calculation of Statewide Averages

For all measures, HSAG collected the audited results, numerator, denominator, rate, and eligible population elements reported in the files submitted for MHPs to calculate the statewide weighted averages. Given that the MHPs varied in membership size, the MWA was calculated for most of the measures based on MHPs' eligible populations. Weighting the rates by the eligible population sizes ensured that a rate for an MHP with 125,000 members, for example, had a greater impact on the overall MWA rate than a rate for the MHP with only 10,000 members. For MHPs' rates reported as *NA*, the numerators, denominators, and eligible populations were included in the calculations of the statewide rate. MHP rates reported as *BR*, *NB*, *NQ* or *NR* were excluded from the statewide rate calculation. However, traditional unweighted statewide Medicaid average rates were calculated for utilization-based measures to align with calculations from prior years' deliverables.

Evaluating Measure Results

National Benchmark Comparisons

Benchmark Data

HEDIS 2017 MHP and the statewide average rates were compared to the corresponding national HEDIS benchmarks, which are expressed in percentiles of national performance for different measures. For comparative purposes, HSAG used the most recent data available from NCQA at the time of the publication of this report to evaluate the HEDIS 2017 rates: NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2016, which are referred to as "national Medicaid percentiles" throughout this report. Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%—Total* measure indicator were compared to the NCQA's Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2016.

For measures for which lower rates indicate better performance (e.g., *Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%])*), HSAG inverted the national percentiles to be consistently applied to these measures as with the other HEDIS measures. For example, the 10th percentile (a lower rate) was inverted to become the 90th percentile, indicating better performance.

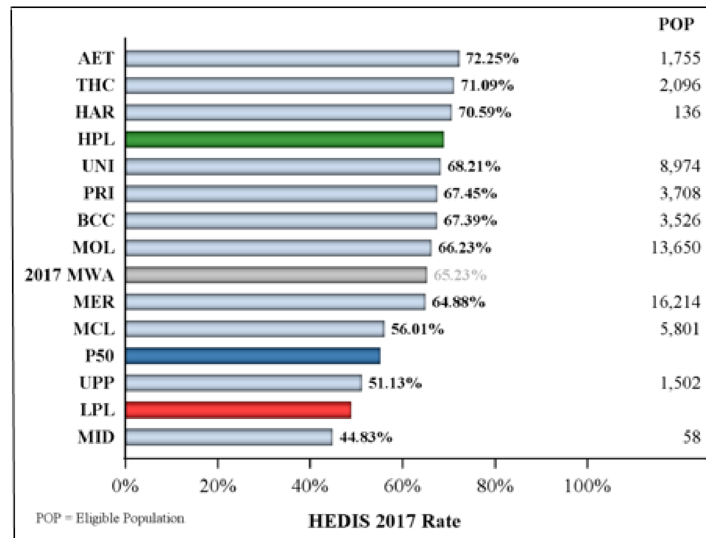
Additionally, benchmarking data (i.e., NCQA's Quality Compass and NCQA's Audit Means and Percentiles) are the proprietary intellectual property of NCQA; therefore, this report does not display any actual percentile values. As a result, rate comparisons to benchmarks are illustrated within this report using proxy displays.

Figure Interpretation

For each performance measure indicator presented in Sections 3 through 8 of this report, the horizontal bar graph figure positioned on the right side of the page presents each MHP's performance against the HEDIS 2017 MWA (i.e., the bar shaded gray); the high performance level (HPL) (i.e., the green shaded bar), representing the national Medicaid 90th percentile; the P50 bar (i.e., the blue shaded bar), representing the national Medicaid 50th percentile; and the low performance level (LPL) (i.e., the red shaded bar), representing the national Medicaid 25th percentile.

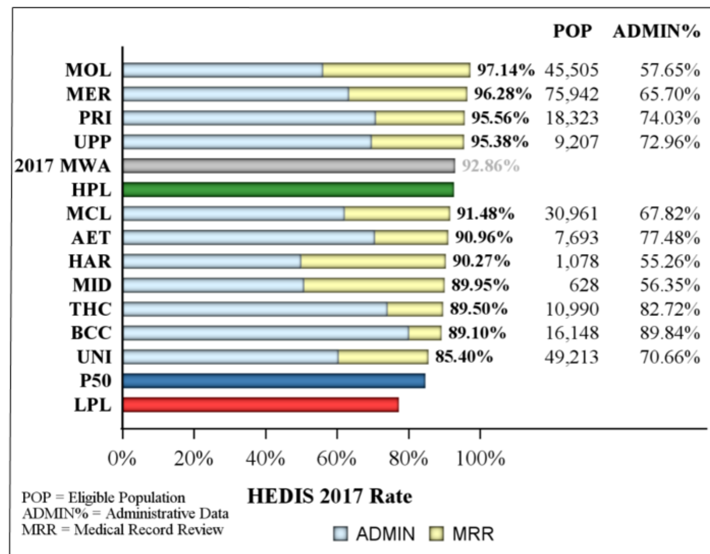
For measures for which lower rates indicate better performance, the 10th percentile (rather than the 90th percentile) and the 75th percentile (rather than the 25th percentile) are considered the HPL and LPL, respectively. An example of the horizontal bar graph figure for measure indicators reported administratively is shown below in Figure 2-2.

Figure 2-2—Sample Horizontal Bar Graph Figure for Administrative Measures



For performance measure rates that were reported using the hybrid method, the "ADMIN%" column presented with each horizontal bar graph figure displays the percentage of the rate derived from administrative data (e.g., claims data and immunization registry). The portion of the bar shaded yellow represents the proportion of the total measure rate attributed to records obtained using the hybrid method, while the portion of the bar shaded light blue indicates the proportion of the measure rate that was derived using the administrative method. This percentage describes the level of claims/encounter data completeness of the MHP data for calculating a particular performance measure. A low administrative data percentage suggests that the MHP relied heavily on medical records to report the rate. Conversely, a high administrative data percentage indicates that the MHP's claims/encounter data were relatively complete for use in calculating the performance measure indicator rate. An administrative percentage of 100 percent indicates that the MHP did not report the measure indicator rate using the hybrid method. An example of the horizontal bar graph figure for measure indicators reported using the hybrid method is shown in Figure 2-3.

Figure 2-3—Sample Horizontal Bar Graph Figure for Hybrid Measures



Percentile Rankings and Star Ratings

In addition to illustrating MHP and statewide performance via side-by-side comparisons to national percentiles, benchmark comparisons are denoted within Appendix B of this report using the percentile ranking performance levels and star ratings defined below in Table 2-3.

Table 2-3—Percentile Ranking Performance Levels

Star Rating	Performance Level
★★★★★	At or above the National Medicaid 90th Percentile
★★★★	At or above the National Medicaid 75th Percentile but below the National Medicaid 90th Percentile
★★★	At or above the National Medicaid 50th Percentile but below the National Medicaid 75th Percentile
★★	At or above the National Medicaid 25th Percentile but below the National Medicaid 50th Percentile
★	Below the National Medicaid 25th Percentile
NA	NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a *Small Denominator (NA)* audit designation.
NR	NR indicates that the MHP chose not to report a rate for this measure indicator.
NB	NB indicates that the required benefit to calculate the measure was not offered.
NQ	NQ indicates that this measure was not included in the 2015 aggregate reports; therefore, the MWA is not presented in this report.

Measures in the Health Plan Diversity and Utilization measure domains are designed to capture the frequency of services provided and characteristics of the populations served. Higher or lower rates in these domains do not necessarily indicate better or worse performance. Further, measures under the Health Plan Diversity measure domain provide insight into how member race/ethnicity or language characteristics are compared to national distributions and are not suggestive of plan performance.

Of note, MHP and statewide average rates were rounded to the second decimal place before performance levels were determined. As HSAG assigned star ratings, an em dash (—) was presented to indicate that the measure indicator was not required and not presented in previous years' HEDIS deliverables or the measure did not have an applicable benchmark; therefore, the performance level was not presented in this report.

HSAG HEALTH SERVICES ADVISORY GROUP

Performance Trend Analysis

In addition to the star rating results, HSAG also compared HEDIS 2017 Medicaid statewide weighted averages and MHP rates to the corresponding HEDIS 2016 rates. HSAG also evaluated the extent of changes observed in the rates between years. Year-over-year performance comparisons are based on the Chi-square test of statistical significance with a p value <0.05 for MHP rate comparisons and a p value <0.01 for statewide weighted average comparisons. Note that statistical testing could not be performed on the membership diversity and utilization-based measures domain given that variances were not available in the IDSS files for HSAG to use for statistical testing.

In general, results from statistical significance testing provide information on whether a change in the rate may suggest improvement or decline in performance. At the statewide level, if the number of MHPs reporting *NR* or *BR* differs vastly from year to year, the statewide performance may not represent all of the contracted MHPs, and any changes observed across years may need to take this factor into consideration. Nonetheless, changes (regardless of whether they are statistically significant) could be related to the following factors independent of any effective interventions designed to improve the quality of care:

- Substantial changes in measure specifications. The "Measure Changes Between HEDIS 2016 and HEDIS 2017" section below lists measures with specification changes made by NCQA.
- Substantial changes in membership composition within the MHP.

Table and Figure Interpretation

Within Sections 3 through 8 and Appendix B of this report, performance measure indicator rates and results of significance testing between HEDIS 2016 and HEDIS 2017 are presented in tabular format. HEDIS 2017 rates shaded green with one cross (+) indicate a statistically significant improvement in performance from the previous year. HEDIS 2017 rates shaded red with two crosses (++) indicate a statistically significant decline in performance from the previous year. The colors used are provided below for reference:

Green Shading+	*Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*
Red Shading++	*Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

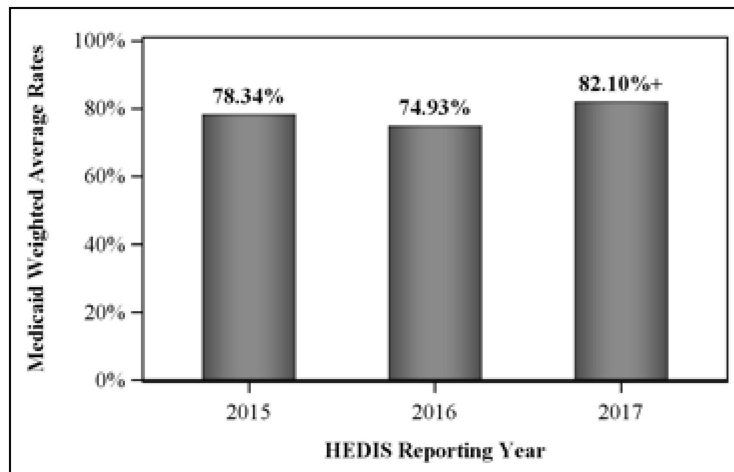
Additionally, benchmark comparisons are denoted within Sections 3 through 8. Performance levels are represented using the following percentile rankings:

Table 2-4—Percentile Ranking Performance Levels

Percentile Ranking and Shading	Performance Level
≥90th	At or above the National Medicaid 90th Percentile
≥75th and ≤89th	At or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile
≥50th and ≤74th	At or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile
≥25th and ≤49th	At or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile
≤25th	Below the national Medicaid 25th percentile

For each performance measure indicator presented in Sections 3 through 8 of this report, the vertical bar graph figure positioned on the left side of the page presents the HEDIS 2015, HEDIS 2016, and HEDIS 2017 MWA rates with significance testing performed between the HEDIS 2016 and HEDIS 2017 weighted averages. Within these figures, HEDIS 2017 rates with one cross ($^{+}$) indicate a statistically significant improvement in performance from HEDIS 2016. HEDIS 2017 rates with two crosses ($^{++}$) indicate a statistically significant decline in performance from HEDIS 2016. An example of the vertical bar graph figure for measure indicators reported is included in Figure 2-4.

Figure 2-4—Sample Vertical Bar Graph Figure Showing Statistically Significant Improvement



Interpreting Results Presented in This Report

HEDIS results can differ among MHPs and even across measures for the same MHP.

The following questions should be asked when examining these data:

How accurate are the results?

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

To show how sampling error affects the accuracy of results, an example was provided in the "Data Collection Methods" section above. When an MHP uses the hybrid method to derive a *Postpartum Care* rate of 52 percent, the true rate is actually ± 5 percent of this rate, due to sampling error. For a 95 percent confidence level, the rate would be between 47 percent and 57 percent. If the target is a rate of 55 percent, it cannot be said with certainty whether the true rate between 47 percent and 57 percent meets or does not meet the target level.

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

How do Michigan Medicaid rates compare to national percentiles?

For each measure, an MHP ranking presents the reported rate in order from highest to lowest, with bars representing the established HPL, LPL, and the national HEDIS 2016 Medicaid 50th percentile. In addition, the HEDIS 2015, 2016, and 2017 MWA rates are presented for comparison purposes.

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

How are Michigan MHPs performing overall?

For each domain of care, a performance profile analysis compares the 2017 MWA for each rate with the 2015 and 2016 MWA and the national HEDIS 2016 Medicaid 50th percentile.

Measure Changes Between HEDIS 2016 and HEDIS 2017

The following is a list of measures with technical specification changes that NCQA announced for HEDIS 2017.[2-1] These changes may have an effect on the HEDIS 2017 rates that are presented in this report.

Childhood Immunization Status

- Added CVX (vaccines administered) codes to the measure.
- Added HIV Type 2 Value Set to the optional exclusions.
- Added optional exclusions for the rotavirus vaccine.

Well-Child Visits in the First 15 Months of Life

- Clarified that services specific to the assessment or treatment of an acute or chronic condition do not count toward the measure.

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

- Clarified that services specific to the assessment or treatment of an acute or chronic condition do not count toward the measure.

Adolescent Well-Care Visits

- Clarified that services specific to the assessment or treatment of an acute or chronic condition do not count toward the measure.

Immunization for Adolescents

- Added the human papillomavirus (HPV) vaccine.
- Added Combination 2 (meningococcal, Tdap, HPV).
- Removed the tetanus, diphtheria toxoids (Td) and meningococcal polysaccharide vaccines.
- Added CVX codes to the measure.

[2-1] National Committee for Quality Assurance. *HEDIS® 2017, Volume 2: Technical Specifications for Health Plans*. Washington, DC: NCQA Publication, 2016.

Appropriate Treatment for Children With Upper Respiratory Infection

- Added instructions to identify emergency department (ED) visits and observation visits that result in an inpatient stay.
- Added a requirement to not include denied claims in the numerator.

Appropriate Testing for Children With Pharyngitis

- Added instructions to identify ED visits and observation visits that result in an inpatient stay.

Breast Cancer Screening

- Clarified that diagnostic screenings are not included in the measure.

Cervical Cancer Screening

- Clarified that reflex testing does not meet criteria in step 2 of the hybrid specification.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

- Revised the allowable gap and anchor date criteria.
- Added instructions to identify ED visits and observation visits that result in an inpatient stay.
- Added two value sets to step 3 of the event/diagnosis criteria (HIV Type 2 Value Set; Disorders of the Immune System Value Set).
- Added a requirement to not include denied claims in the numerator.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

- Included examples of services specific to the assessment or treatment of an acute or chronic condition that do not count toward the *"Counseling for nutrition*" and *"Counseling for physical activity"* indicators.
- Replaced "Each of the 3 rates" with "✓" for the "Measurement year" row in Table *WCC*-1/2.

Prenatal and Postpartum Care

- Clarified that the prenatal visit for the *Timeliness of Prenatal Care* numerator can occur on the date of enrollment.
- Clarified in the Note that the estimated date of delivery (EDD) must be on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.
- Added a Note explaining that the organization may use EDD to identify the first trimester for the *Timeliness of Prenatal Care* rate and use the date of delivery for the *Postpartum Care* rate.
- Replaced "Each of the 2 rates" with a "✓" for the "Measurement year" row in Table *PPC*-1/2.

Frequency of Ongoing Prenatal Care

- Clarified the example calculation in step 2.

Comprehensive Diabetes Care

- Added an administrative method and new value set to identify negative eye exams in the year prior to the measurement year.
- Added glycohemoglobin, glycated hemoglobin and glycosylated hemoglobin as acceptable HbA1c tests.
- Clarified documentation requirements for a negative eye exam.
- Replaced "Each of the 7 rates" with a "✓" for the "Measurement year" row in Table *CDC*-1/2/3.

Controlling High Blood Pressure

- Added a Note clarifying the intent when confirming the diagnosis of hypertension.
- Revised Table *CBP*-1/2/3 to include the medical record data elements only.

Medical Assistance With Smoking and Tobacco Use Cessation

- This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2017, Volume 3: Specifications for Survey Measures*.

Antidepressant Medication Management

- Added a Note clarifying the intent when confirming the diagnosis of hypertension.
- Revised Table *CBP*-1/2/3 to include the medical record data elements only.

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

- Replaced all references to BH ED POS Value Set with ED POS Value Set (the codes in these value sets are the same).
- Added cariprazine to the description of "Miscellaneous antipsychotic agents" in Table *SSD*-D.

Diabetes Monitoring for People With Diabetes and Schizophrenia

- Replaced all references to BH ED POS Value Set with ED POS Value Set (the codes in these value sets are the same).
- Clarified the criteria for optional exclusions.

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

- Replaced all references to BH ED POS Value Set with ED POS Value Set (the codes in these value sets are the same).

Adherence to Antipsychotic Medications for Individuals With Schizophrenia

- Clarified how to calculate number of days covered if both oral medications and long-acting injections are dispensed in the new *Notes* in the Definition section.
- Replaced all references to BH ED POS Value Set with ED POS Value Set (the codes in these value sets are the same).
- Added Cariprazine to the description of “Miscellaneous antipsychotic agents (oral)” in Table *SAA*-A.

Ambulatory Care (Per 1,000 Member Months)

- Added instructions to identify ED visits that result in an inpatient stay.

3. Child & Adolescent Care

Introduction

The Child & Adolescent Care measure domain encompasses the following MDHHS measures:

- *Childhood Immunization Status—Combinations 2–10*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *Lead Screening in Children*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Appropriate Testing for Children With Pharyngitis*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuous and Maintenance Phase*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 3-1 presents the MWA performance for the measure indicators under the Child & Adolescent Care measure domain. The table lists the HEDIS 2017 MWA rates and performance levels, a comparison of the HEDIS 2016 MWA to the HEDIS 2017 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating statistically significant changes from HEDIS 2016 to HEDIS 2017.

Table 3-1—HEDIS 2017 MWA Performance Levels and Trend Results for Child & Adolescent Care

Measure	HEDIS 2017 MWA and Performance Level[1]	HEDIS 2016 MWA–HEDIS 2017 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2017	Number of MHPs With Statistically Significant Decline in HEDIS 2017
Childhood Immunization Status				
Combination 2	76.95%	+0.80	1	0
Combination 3	72.84%	**+1.79+**	2	0
Combination 4	70.43%	**+2.93+**	1	0
Combination 5	61.73%	**+2.95+**	2	0
Combination 6	39.84%	-0.61	0	0
Combination 7	60.05%	**+3.90+**	2	0
Combination 8	39.20%	-0.07	0	0
Combination 9	34.47%	-0.50	0	0
Combination 10	33.98%	+0.06	0	0
Well-Child Visits in the First 15 Months of Life				
Six or More Visits	69.79%	**+3.57+**	1	0
Lead Screening in Children				
Lead Screening in Children	80.98%	**+1.43+**	1	1
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.09%	**+0.98+**	0	2
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	55.69%	**+0.95+**	1	2
Immunizations for Adolescents				
Combination 1	86.73%	-0.26	0	1
Appropriate Treatment for Children With Upper Respiratory Infection[3]				
Appropriate Treatment for Children With Upper Respiratory Infection	88.94%	-0.15	1	3
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	70.91%	**+2.50+**	4	1

Measure	HEDIS 2017 MWA and Performance Level[1]	HEDIS 2016 MWA–HEDIS 2017 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2017	Number of MHPs With Statistically Significant Decline in HEDIS 2017
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	42.54%	-0.04	2	2
Continuation and Maintenance Phase	55.03%	+1.07	1	1

[1] *2017 performance levels were based on comparisons of the HEDIS 2017 MWA measure indicator rates to national Medicaid Quality Compass HEDIS 2016 benchmarks. 2017 performance levels represent the following percentile comparisons:*

≤25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th

[2] *HEDIS 2016 MWA to HEDIS 2017 MWA comparisons were based on a Chi-square test of statistical significance with a p value <0.01 due to large denominators.*

Green Shading+ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

Red Shading++ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

[3] *Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2017 and prior years.*

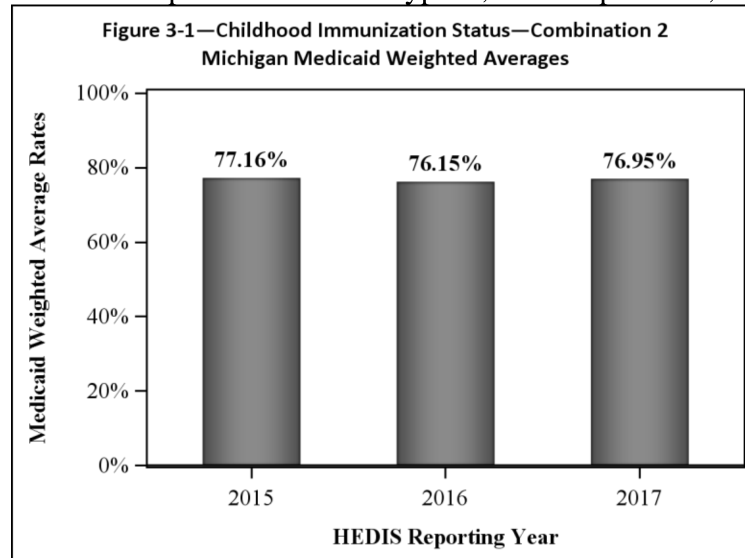
Table 3-1 shows nearly all of the MWA rates pertaining to Child & Adolescent Care ranked at above the national Medicaid 50th percentile, with three rates ranking at or above the national Medicaid 75th percentile, indicating strengths in the areas of well-child visits on or before 15 months of age, lead screenings for children, and administration and documentation of immunizations for adolescents. Additionally, the MWA rates for *Well-Child Visits in the First 15 Months of Life—Six or More Visits* and *Lead Screening in Children* demonstrated statistically significant improvement from 2016 to 2017. Although the MWA for *Appropriate Testing for Children With Pharyngitis* fell below the national Medicaid 50th percentile, four MHPs' rates and the MWA rate for this measure demonstrated statistically significant increases from 2016 to 2017, indicating positive improvement in this area at the statewide level and for select MHPs.

Conversely, the MWA for *Appropriate Treatment for Children With Upper Respiratory Infection* fell below the national Medicaid 50th percentile and three MHPs' rates for this measure demonstrated statistically significant declines from 2016 to 2017, suggesting opportunities for improvement. However, caution should be used when comparing the 2017 rates for this measure to national benchmarks and prior years due to changes to the technical measure specifications for HEDIS 2017.

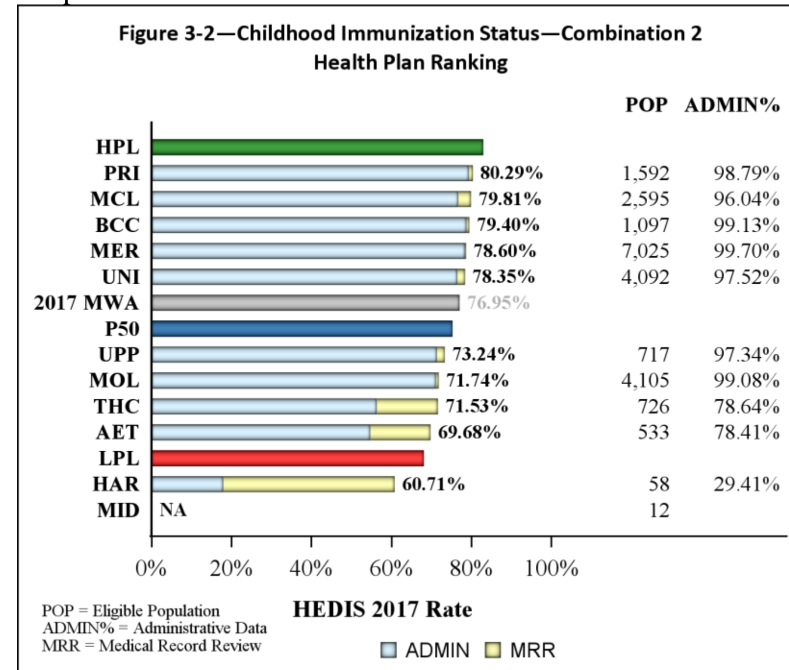
Measure-Specific Findings

Childhood Immunization Status—Combination 2

Childhood Immunization Status—Combination 2 assesses the percentage of children 2 years of age who received the following vaccines by their second birthday: four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenzae type B; three hepatitis B; and one chicken pox.



The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.

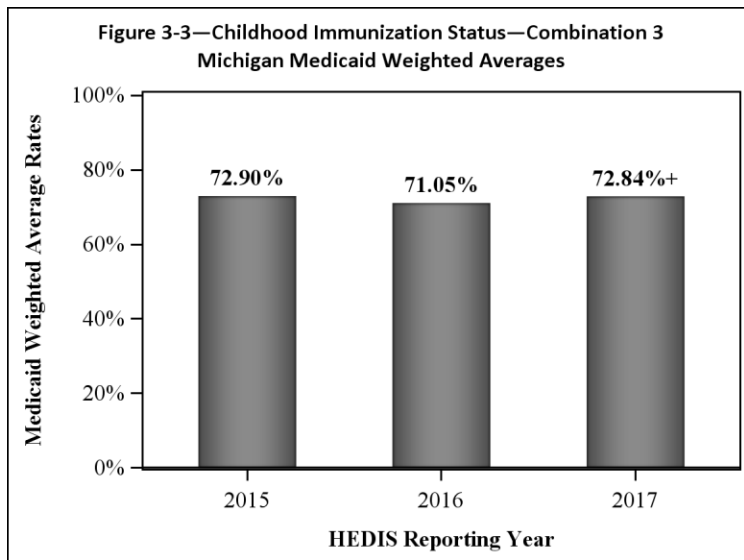


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Five MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 80.29 percent to 60.71 percent.

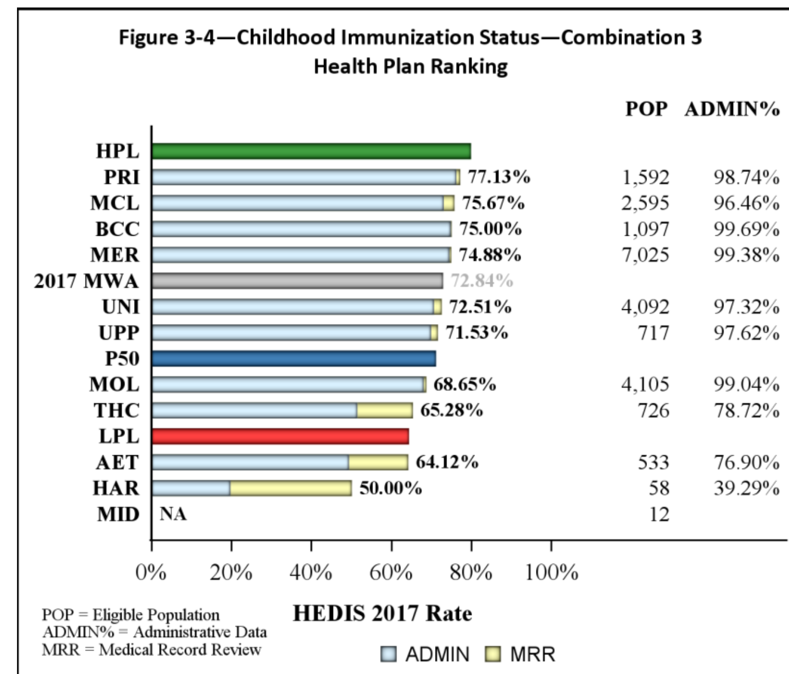
Childhood Immunization Status—Combination 3

Childhood Immunization Status—Combination 3 assesses the percentage of children 2 years of age during the measurement year who received the following vaccines by their second birthday: four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenzae type B; three hepatitis B; one chicken pox; and four pneumococcal conjugate.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.

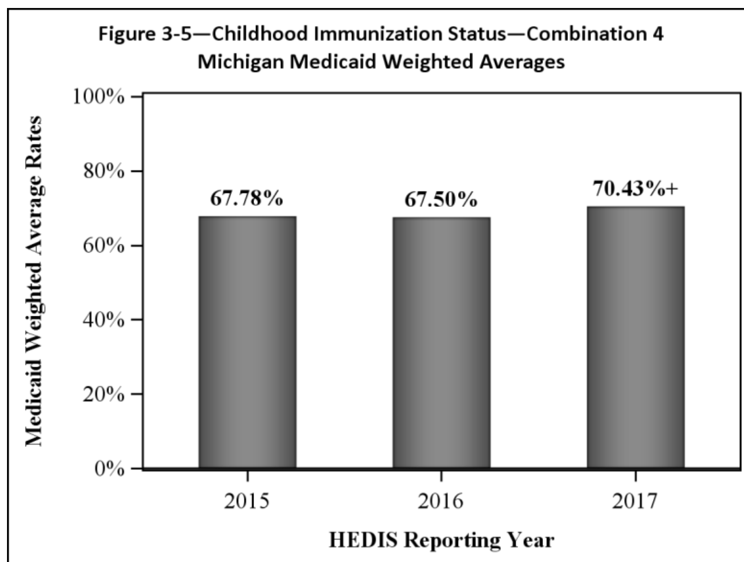


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Six MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. Two MHPs fell below the LPL. MHP performance varied from 77.13 percent to 50.00 percent.

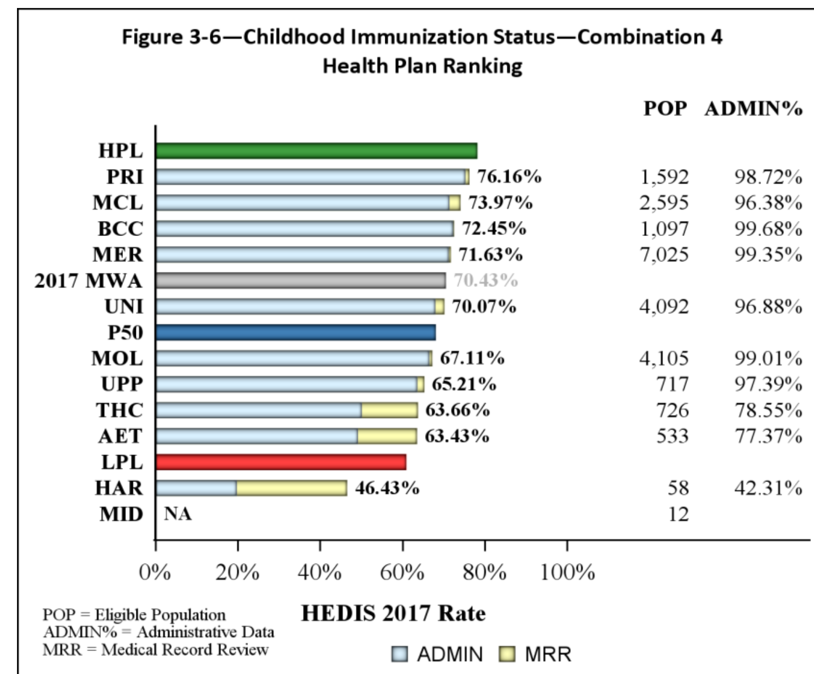
Childhood Immunization Status—Combination 4

Childhood Immunization Status—Combination 4 assesses the percentage of children 2 years of age during the measurement year who received the following vaccines by their second birthday: four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenzae type B; three hepatitis B; one chicken pox; four pneumococcal conjugate; and one hepatitis A.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement from HEDIS 2016.

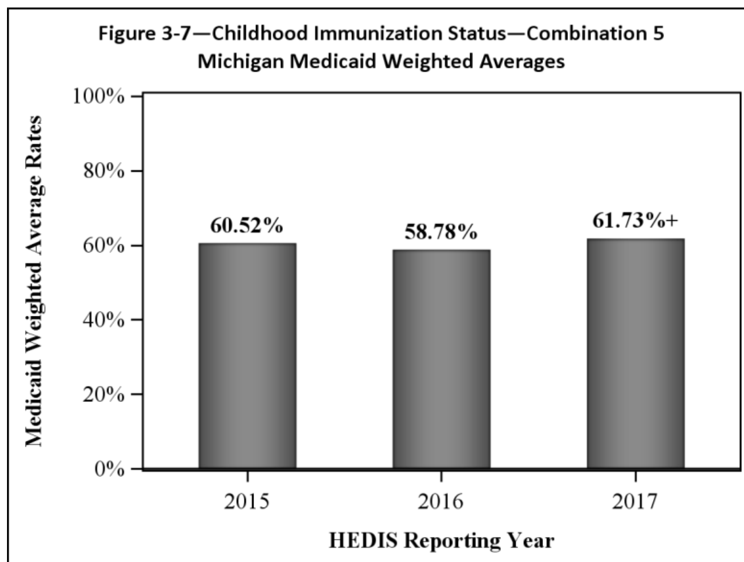


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Five MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 76.16 percent to 46.43 percent.

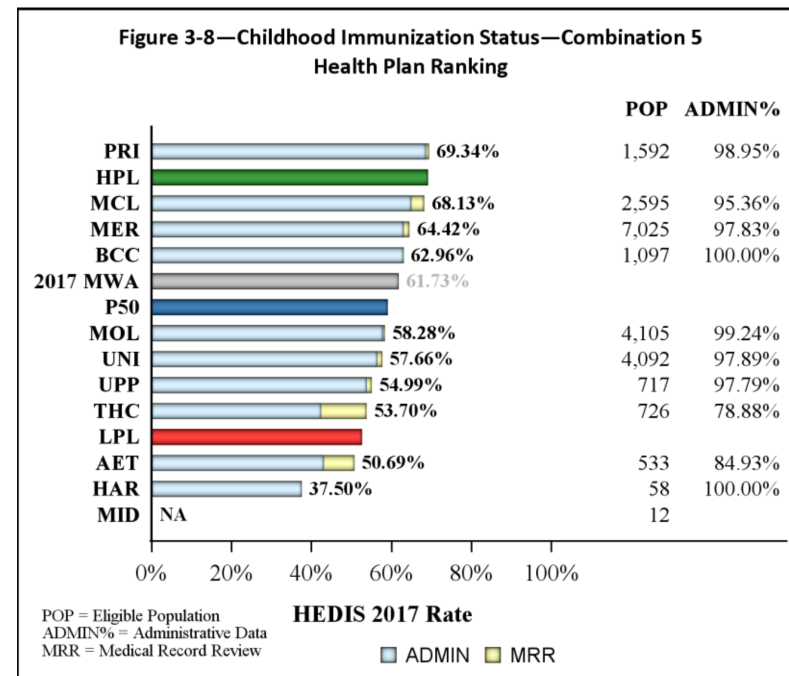
Childhood Immunization Status—Combination 5

Childhood Immunization Status—Combination 5 assesses the percentage of children 2 years of age during the measurement year who received the following vaccines by their second birthday: four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenzae type B; three hepatitis B; one chicken pox; four pneumococcal conjugate; and two or three rotavirus.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.

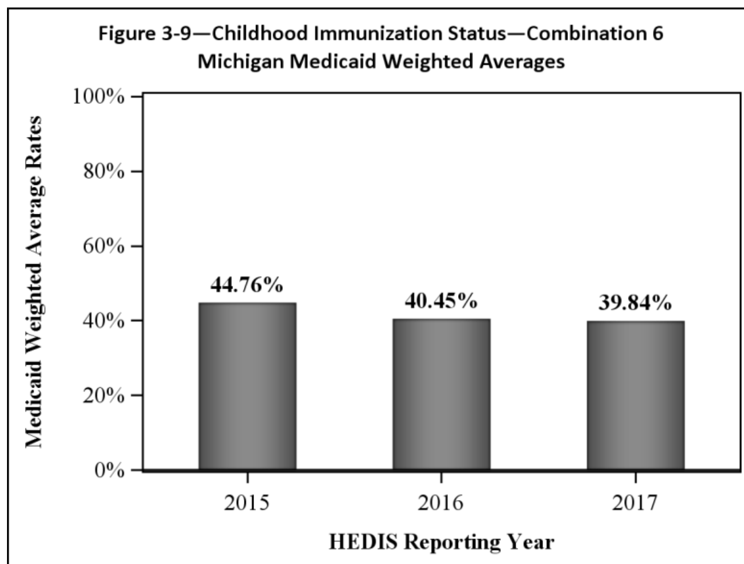


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

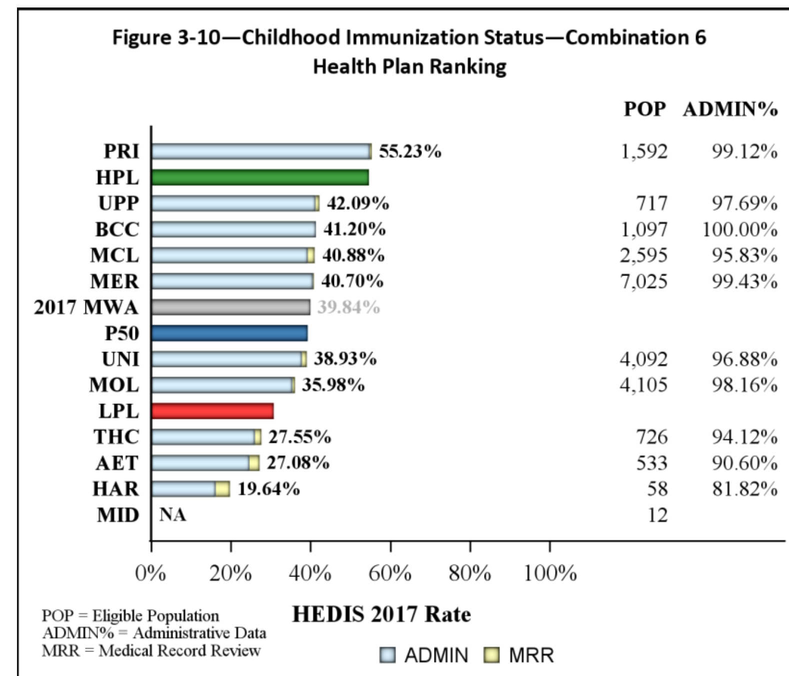
One MHP ranked above the HPL. Two MHPs fell below the LPL. MHP performance varied from 69.34 percent to 37.50 percent.

Childhood Immunization Status—Combination 6

Childhood Immunization Status—Combination 6 assesses the percentage of children 2 years of age during the measurement year who received the following vaccines by their second birthday: four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenzae type B; three hepatitis B; one chicken pox; four pneumococcal conjugate; and two influenza.



The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.

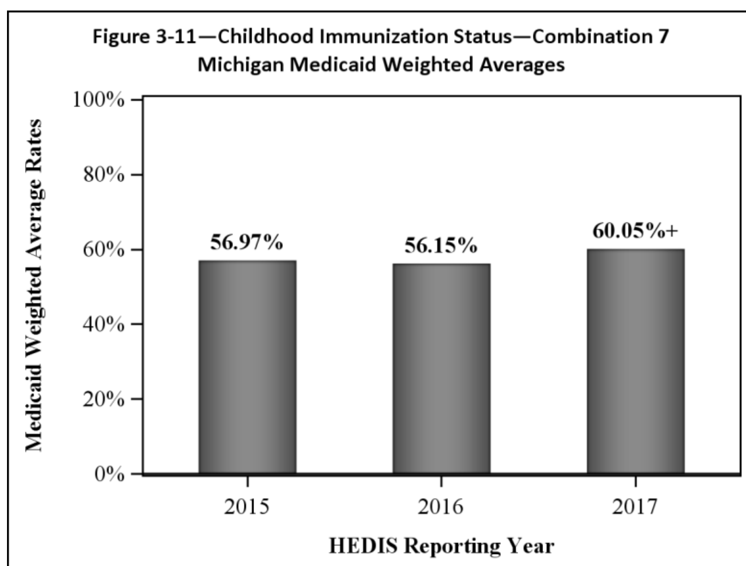


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

One MHP ranked above the HPL. Three MHPs fell below the LPL. MHP performance varied from 55.23 percent to 19.64 percent.

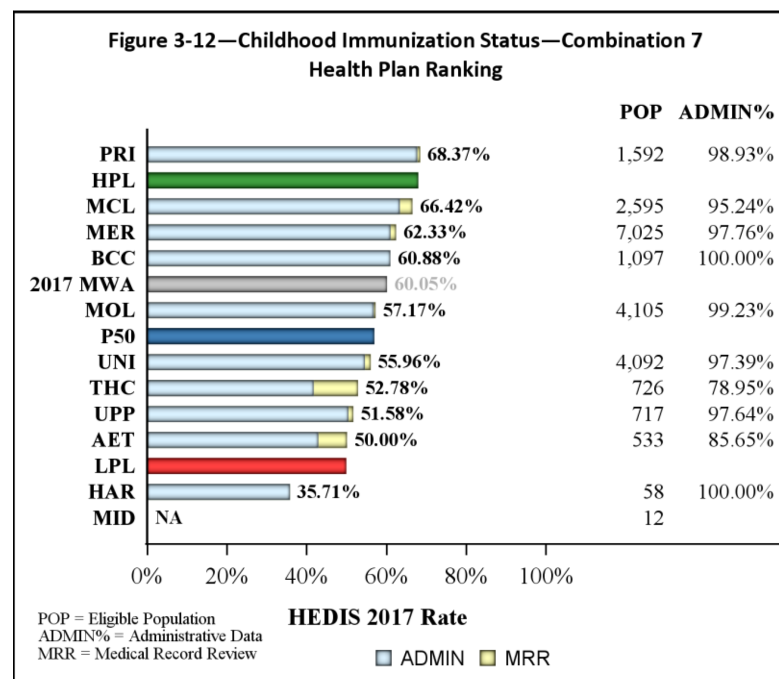
Childhood Immunization Status—Combination 7

Childhood Immunization Status—Combination 7 assesses the percentage of children 2 years of age during the measurement year who received the following vaccines by their second birthday: four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenzae type B; three hepatitis B; one chicken pox; four pneumococcal conjugate; one hepatitis A; and two or three rotavirus.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.

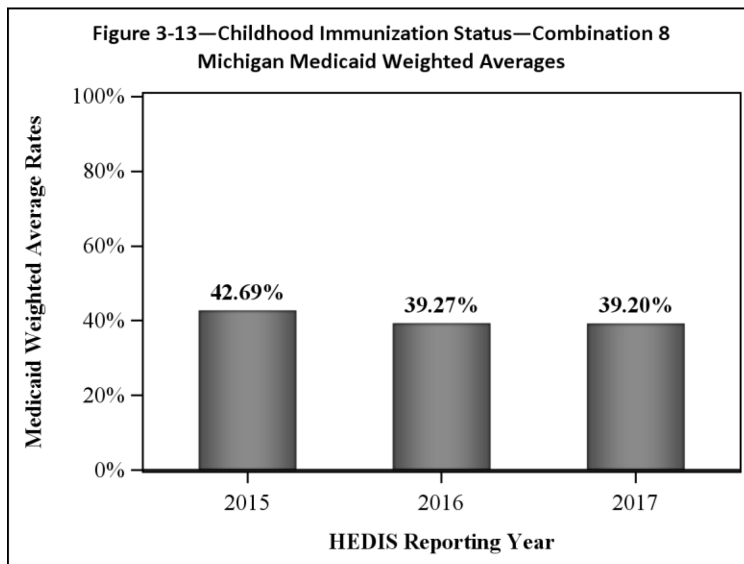


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

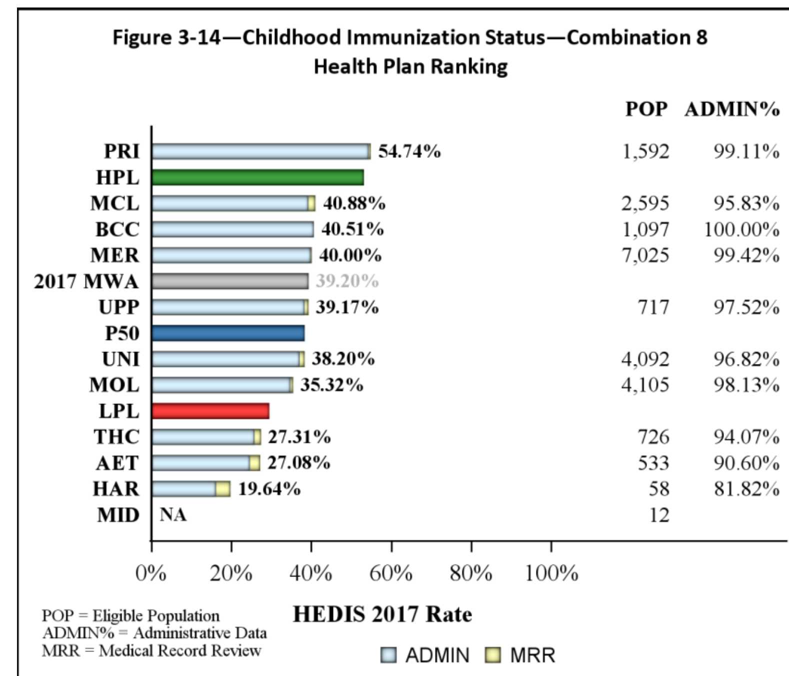
One MHP ranked above the HPL. One MHP fell below the LPL. MHP performance varied from 68.37 percent to 35.71 percent.

Childhood Immunization Status—Combination 8

Childhood Immunization Status—Combination 8 assesses the percentage of children 2 years of age during the measurement year who received the following vaccines by their second birthday: four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenzae type B; three hepatitis B; one chicken pox; four pneumococcal conjugate; one hepatitis A; and two influenza.



The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.



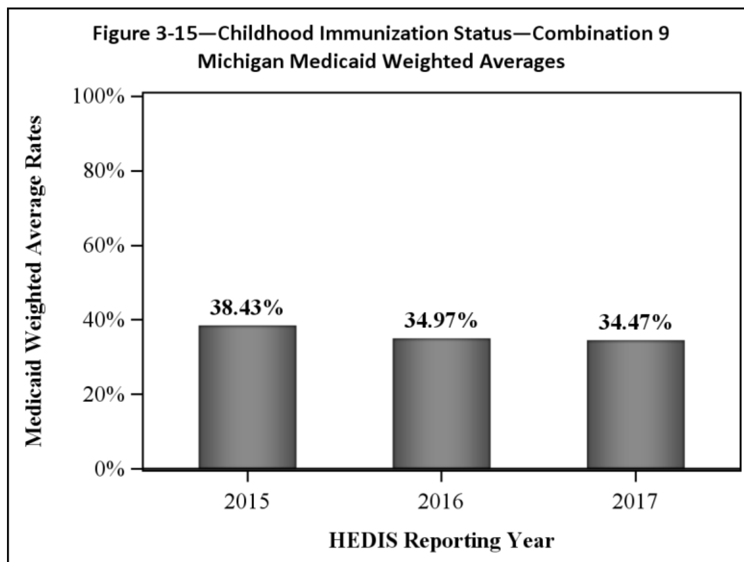
NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

One MHP ranked above the HPL. Three MHPs fell below the LPL. MHP performance varied from 54.74 percent to 19.64 percent.

Childhood Immunization Status—Combination 9

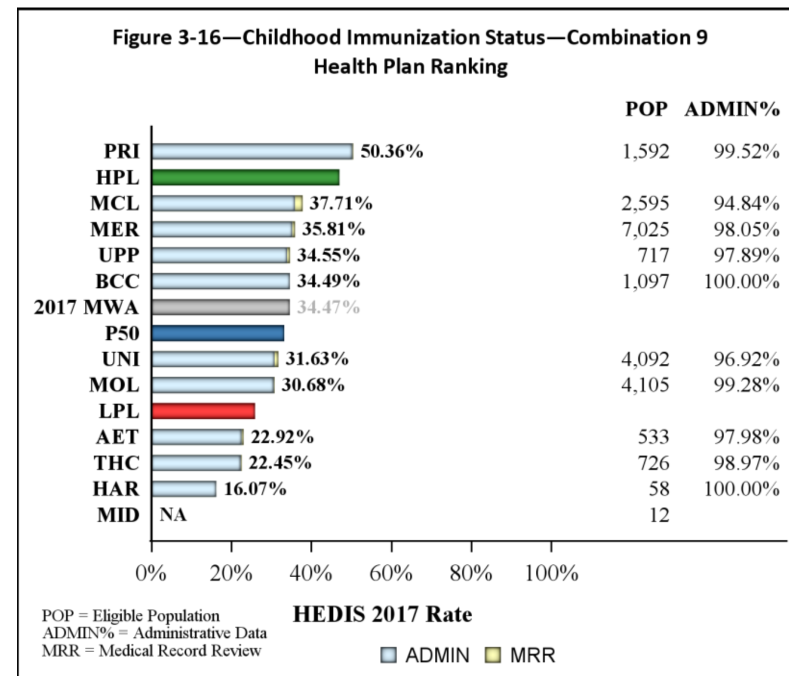
Childhood Immunization Status—Combination 9 assesses the percentage of children 2 years of age during the measurement year who received the following vaccines by their second birthday: four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenzae type B; three hepatitis B; one chicken pox; four pneumococcal conjugate; two or three rotavirus; and two influenza.

Figure 3-15—Childhood Immunization Status—Combination 9
Michigan Medicaid Weighted Averages



The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.

Figure 3-16—Childhood Immunization Status—Combination 9
Health Plan Ranking

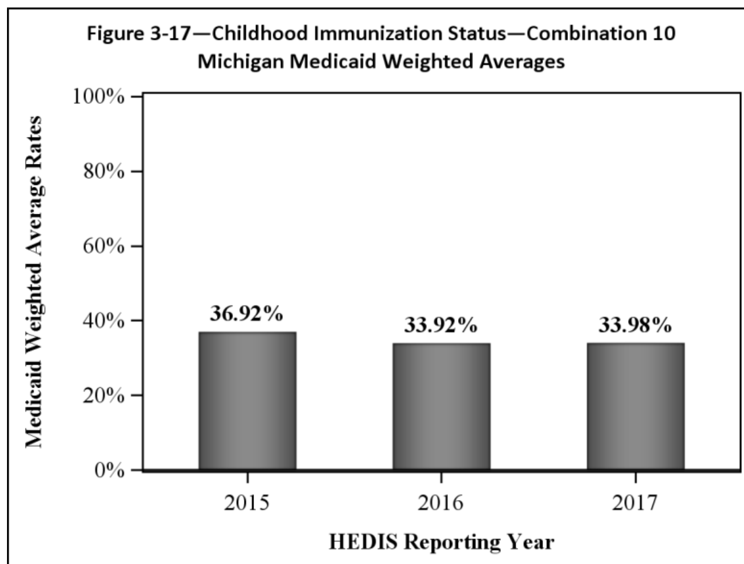


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

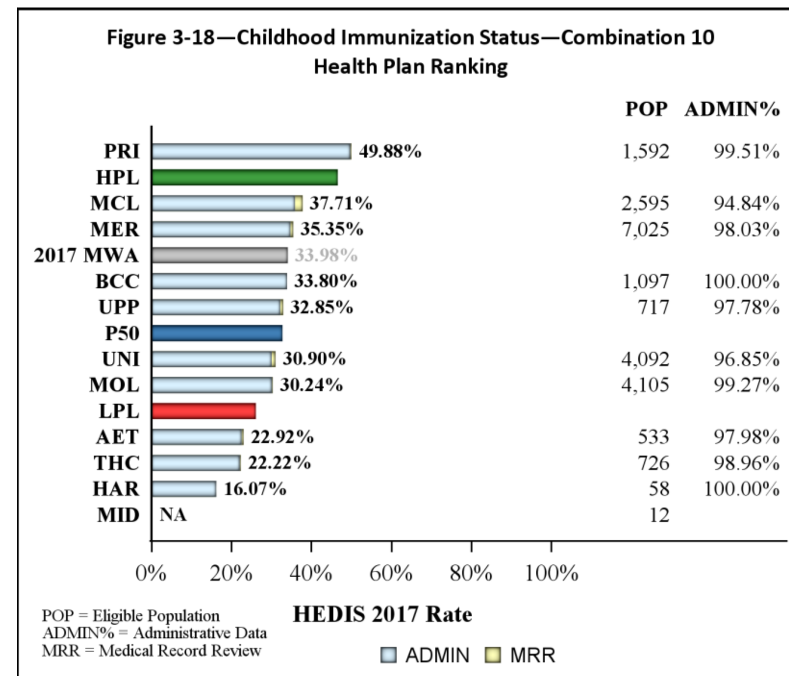
One MHP ranked above the HPL. Three MHPs fell below the LPL. MHP performance varied from 50.36 percent to 16.07 percent.

Childhood Immunization Status—Combination 10

Childhood Immunization Status—Combination 10 assesses the percentage of children 2 years of age during the measurement year who received the following vaccines by their second birthday: four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenzae type B; three hepatitis B; one chicken pox; four pneumococcal conjugate; one hepatitis A; two or three rotavirus; and two influenza.



The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.

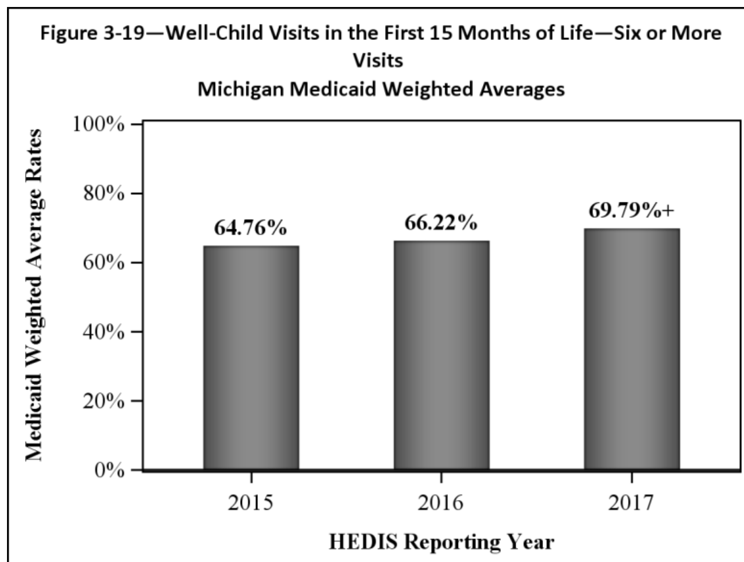


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

One MHP ranked above the HPL. Three MHPs fell below the LPL. MHP performance varied from 49.88 percent to 16.07 percent.

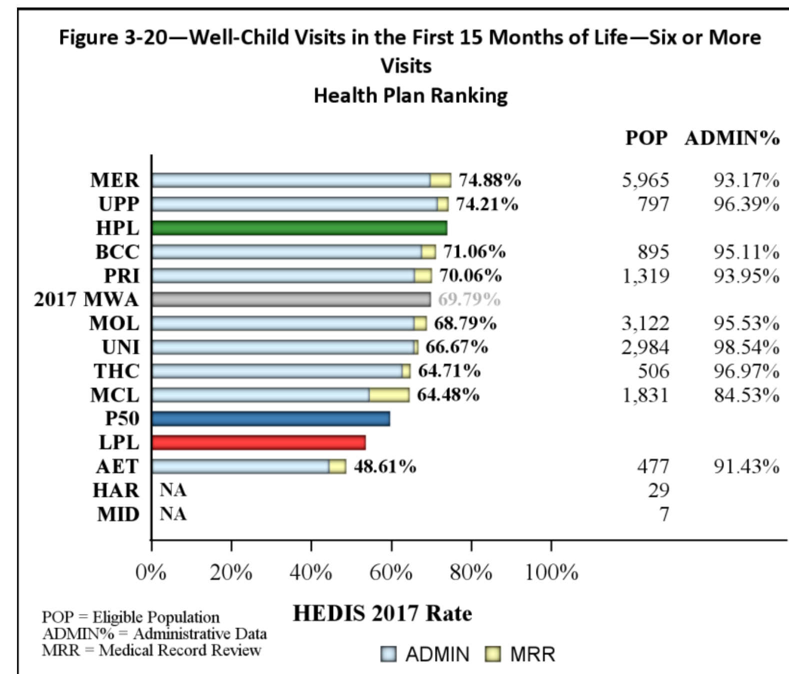
Well-Child Visits in the First 15 Months of Life–Six or More Well-Child Visits

Well-Child Visits in the First 15 Months of Life—Six or More Visits assesses the percentage of members who turned 15 months old during the measurement year and who received six or more well-child visits with a PCP during their first 15 months of life.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.

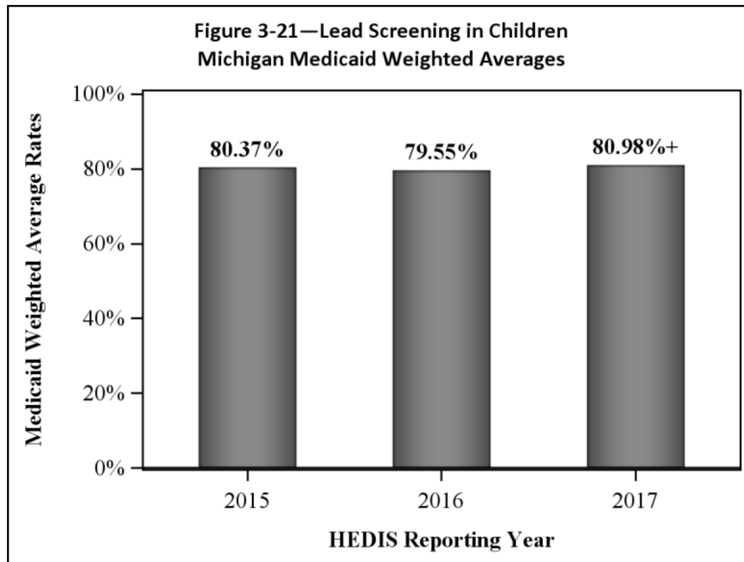


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Two MHPs ranked above the HPL. One MHP fell below the LPL. MHP performance varied from 74.88 percent to 48.61 percent.

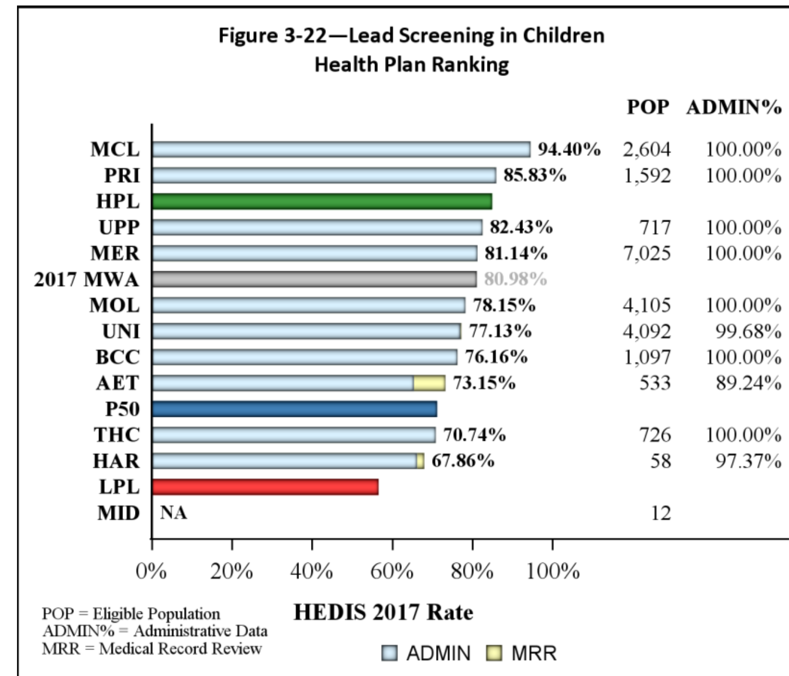
Lead Screening in Children

Lead Screening in Children assesses 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.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.

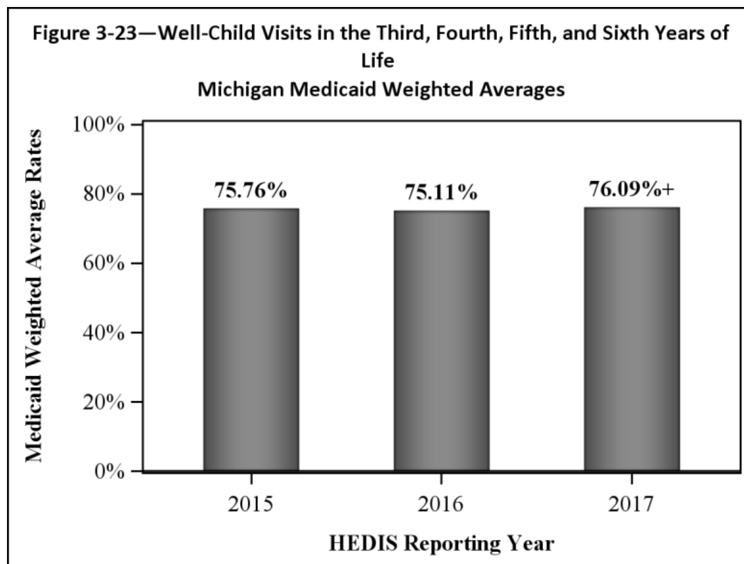


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Two MHPs ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 94.40 percent to 67.86 percent.

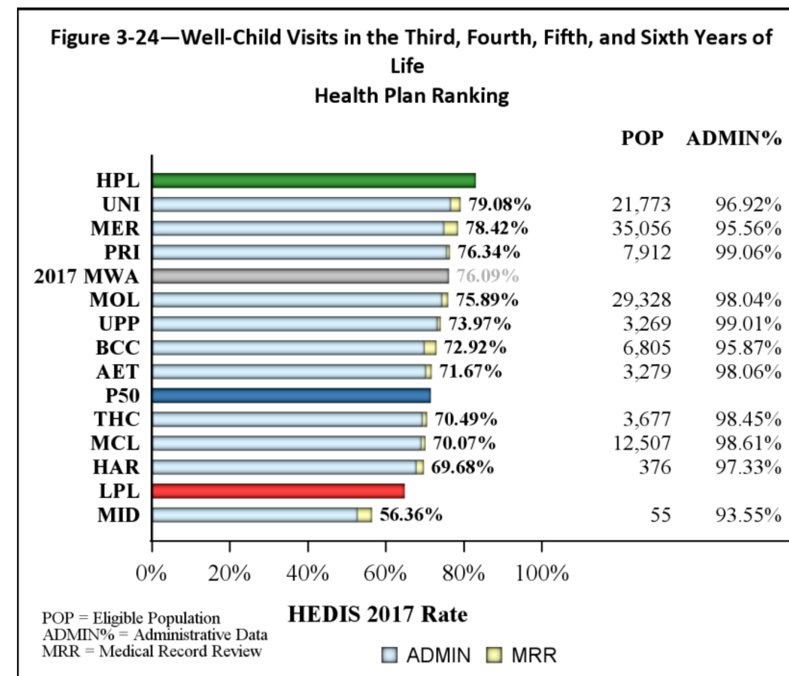
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life is a measure of the percentage of members who were 3, 4, 5, or 6 years old and received one or more well-child visits with a PCP during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

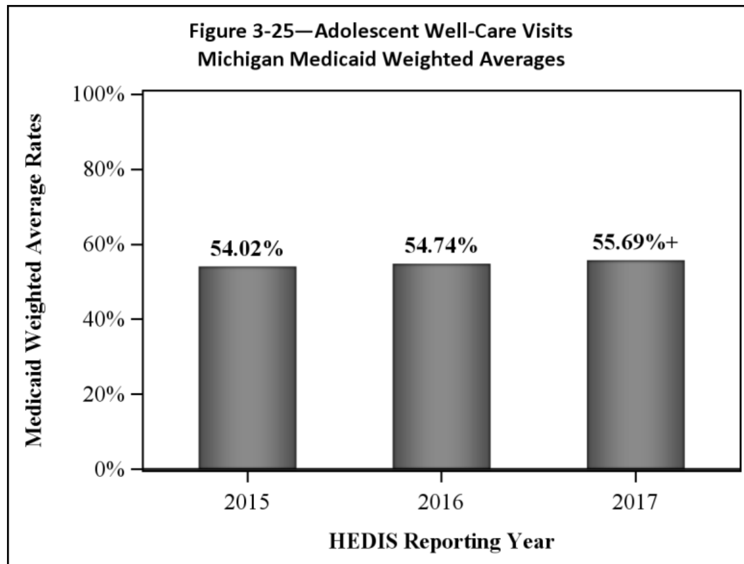
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



Seven MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 79.08 percent to 56.36 percent.

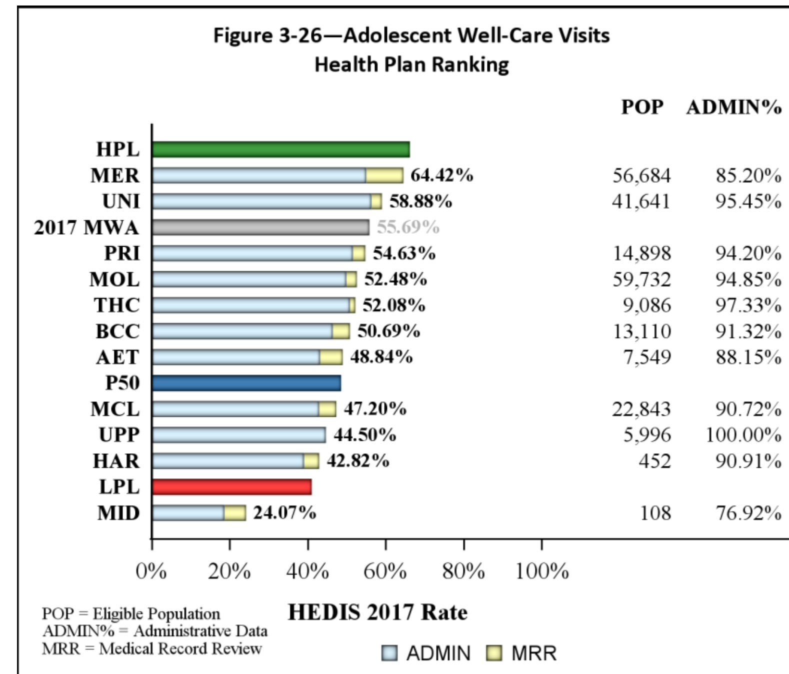
Adolescent Well-Care Visits

Adolescent Well-Care Visits assesses the percentage of members who were 12 to 21 years of age and who had at least one comprehensive well-care visit with a PCP or an obstetrician/gynecologist (OB/GYN) during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

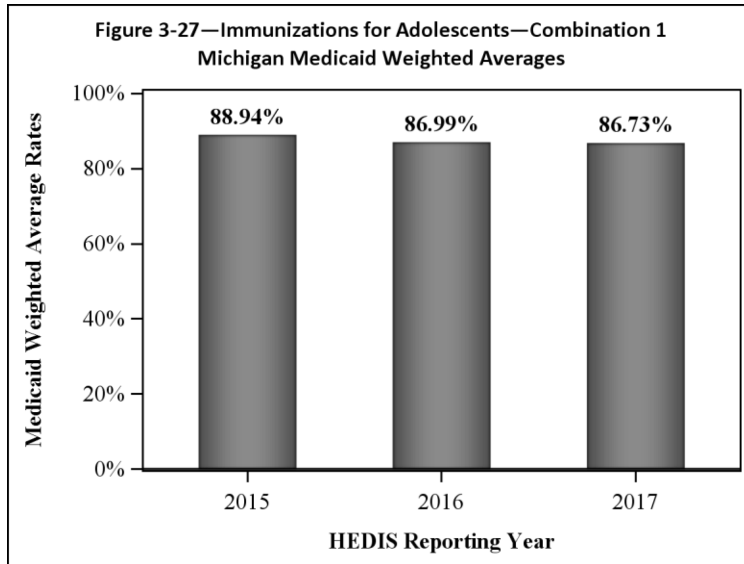
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



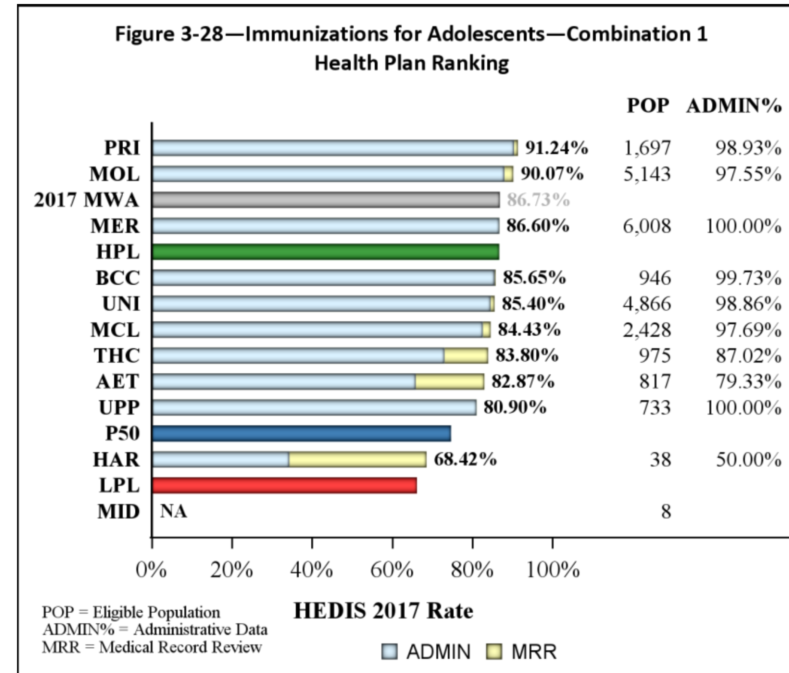
Seven MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 64.42 percent to 24.07 percent.

Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)

Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) assesses the percentage of adolescents 13 years of age who had the following by their 13th birthday: one dose of meningococcal vaccine and acellular pertussis vaccine (Tdap).



The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.



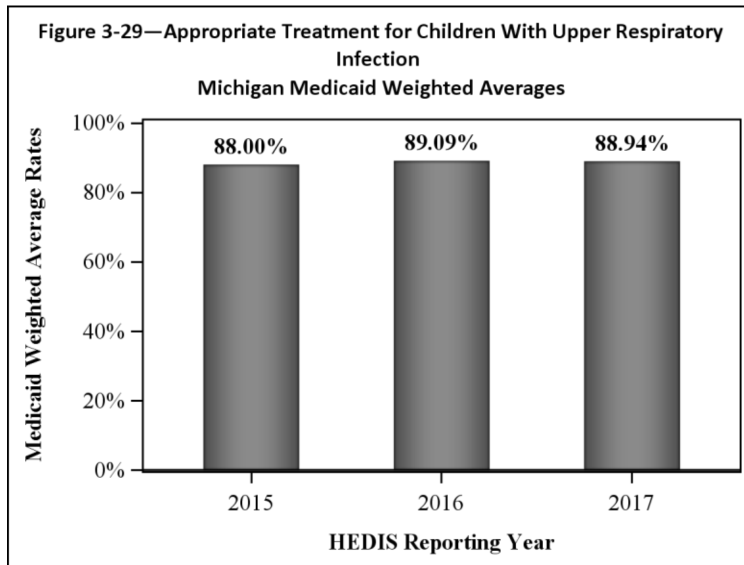
NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Three MHPs and the MWA ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 91.24 percent to 68.42 percent.

Appropriate Treatment for Children With Upper Respiratory Infection

Appropriate Treatment for Children With Upper Respiratory Infection assesses the percentage of children 3 months to 18 years of age who were given a diagnosis of upper respiratory infection and were not dispensed an antibiotic prescription. Due to changes in the technical specifications for this measure indicator, exercise caution when trending rates between 2017 and prior years.

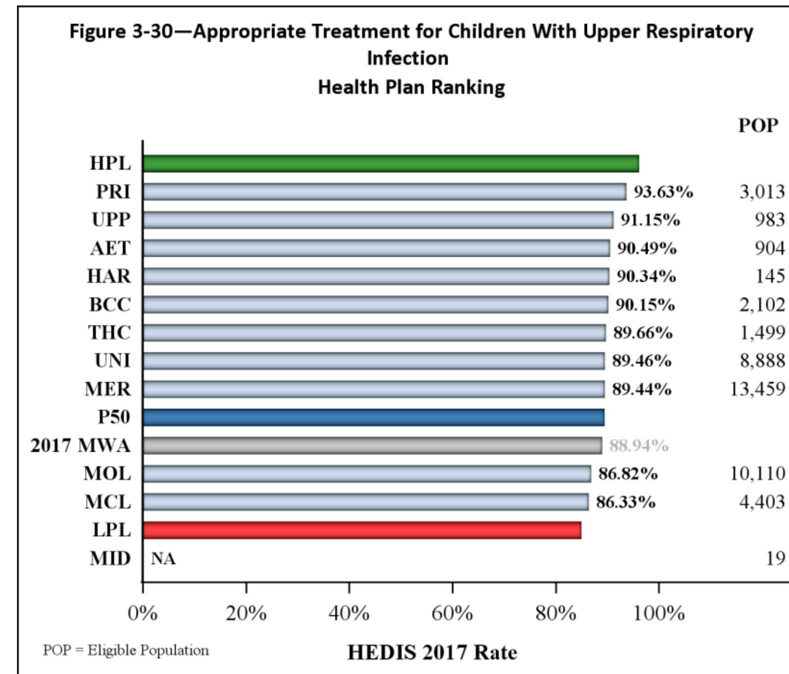
Figure 3-29—Appropriate Treatment for Children With Upper Respiratory Infection
Michigan Medicaid Weighted Averages



Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2017 and prior years.

The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.

Figure 3-30—Appropriate Treatment for Children With Upper Respiratory Infection
Health Plan Ranking

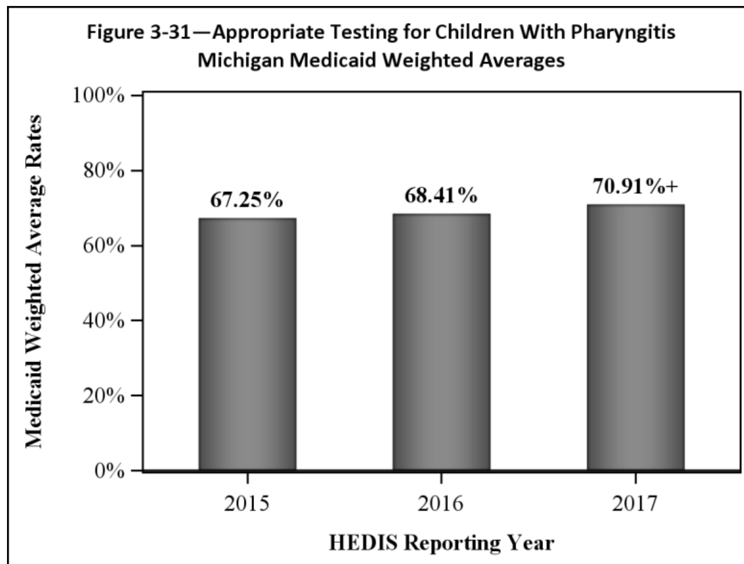


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Eight MHPs ranked above the national Medicaid 50th percentile but below the HPL. No MHPs fell below the LPL. MHP performance varied from 93.63 percent to 86.33 percent.

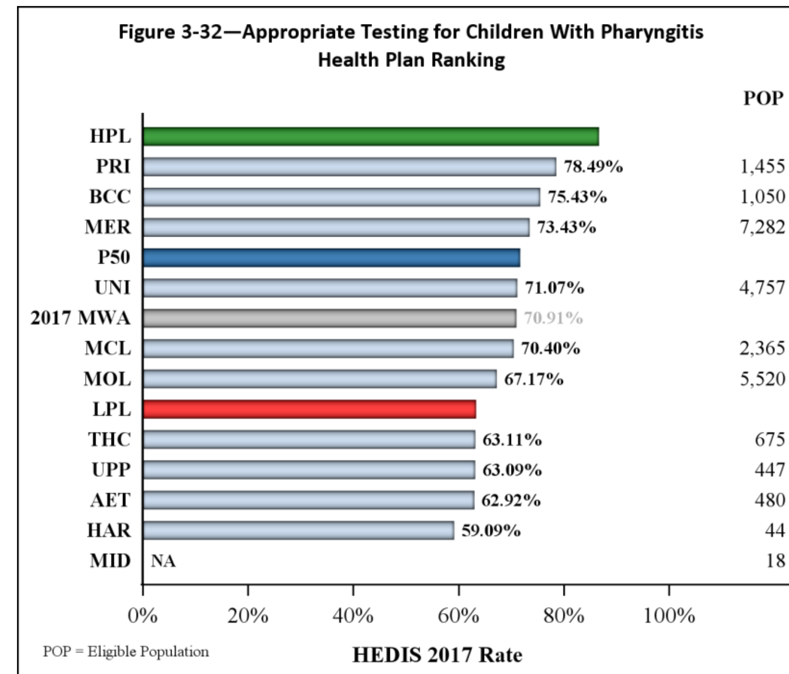
Appropriate Testing for Children With Pharyngitis

Appropriate Testing for Children With Pharyngitis assesses the percentage of children 3–18 years of age who were diagnosed with pharyngitis, were dispensed an antibiotic, and received a group A streptococcus test for the episode.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.

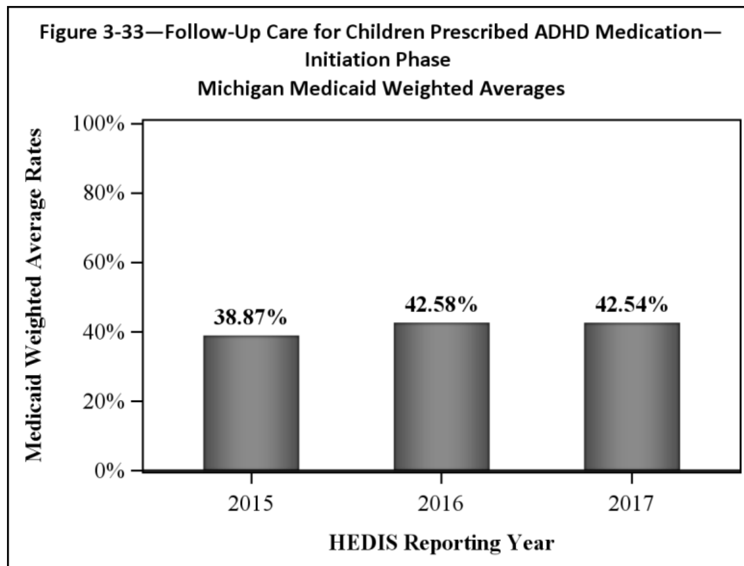


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

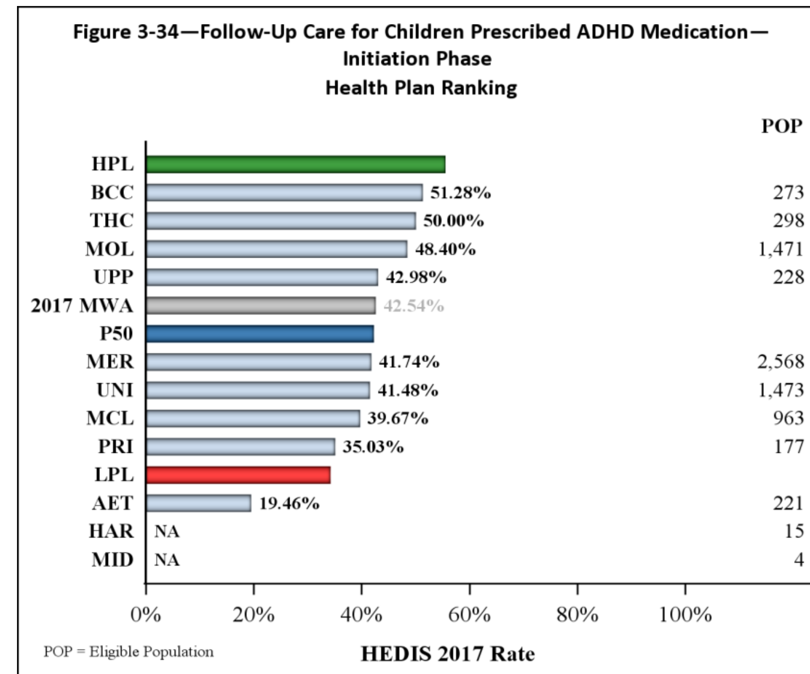
Three MHPs ranked above the national Medicaid 50th percentile but below the HPL. Four MHPs fell below the LPL. MHP performance varied from 78.49 percent to 59.09 percent.

Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase

Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase assesses the percentage of children 6 to 12 years of age who were newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication and who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.



The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.



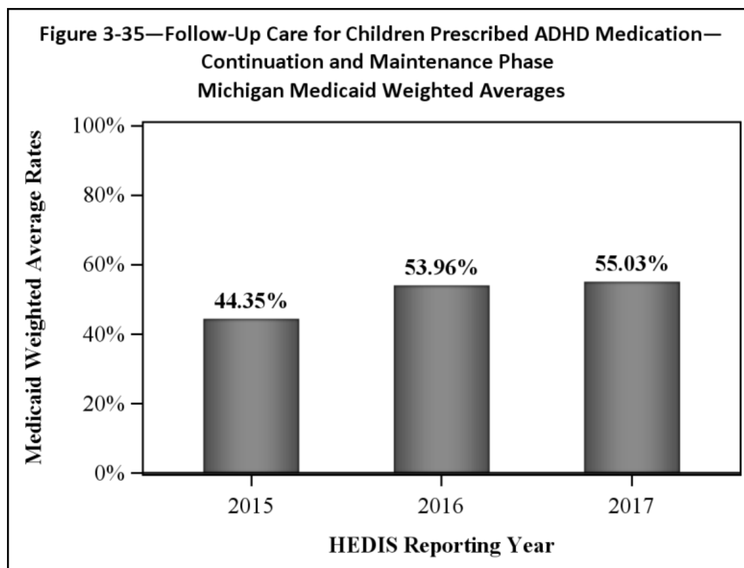
NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Four MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 51.28 percent to 19.46 percent.

Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase

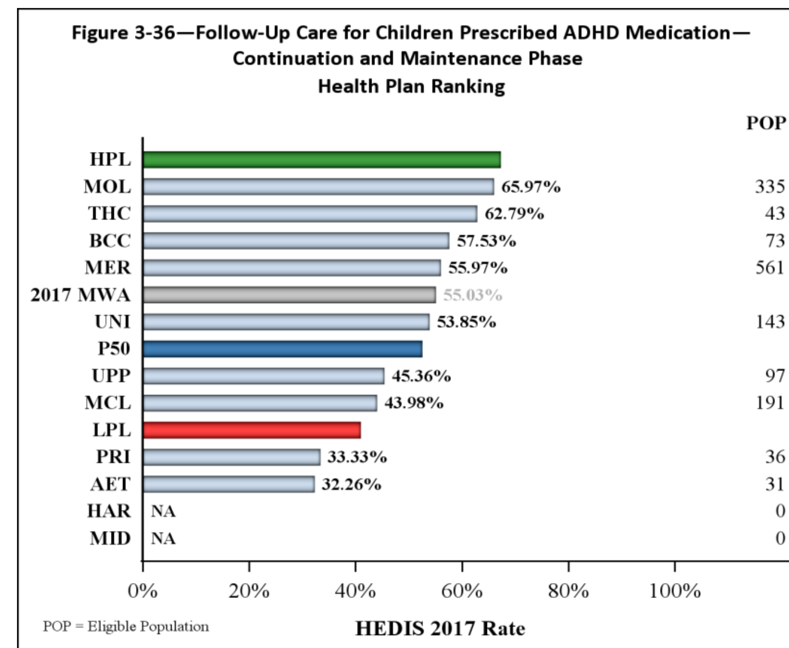
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase assesses the percentage of children 6 to 12 years of age newly prescribed ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the initiation phase ended.

Figure 3-35—Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase Michigan Medicaid Weighted Averages



The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.

Figure 3-36—Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase Health Plan Ranking



NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Five MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. Two MHPs fell below the LPL. MHP performance varied from 65.97 percent to 32.26 percent.

4. Women—Adult Care

Introduction

The Women—Adult Care measure domain encompasses the following MDHHS measures:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years,* and *Total*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 4-1 presents the Michigan MWA performance for the measure indicators under the Women—Adult Care measure domain. The table lists the HEDIS 2017 MWA rates and performance levels, a comparison of the HEDIS 2016 MWA to the HEDIS 2017 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating statistically significant changes from HEDIS 2016 to HEDIS 2017.

Table 4-1—HEDIS 2017 MWA Performance Levels and Trend Results for Women—Adult Care

Measure	HEDIS 2017 MWA and Performance Level[1]	HEDIS 2016 MWA–HEDIS 2017 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2017	Number of MHPs With Statistically Significant Decline in HEDIS 2017
Breast Cancer Screening				
Breast Cancer Screening	62.60%	**+3.02+**	4	1
Cervical Cancer Screening				
Cervical Cancer Screening	64.84%	**+1.05+**	1	1

Measure	HEDIS 2017 MWA and Performance Level[1]	HEDIS 2016 MWA–HEDIS 2017 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2017	Number of MHPs With Statistically Significant Decline in HEDIS 2017
Chlamydia Screening in Women				
Ages 16 to 20 Years	62.27%	**+1.52**+	2	1
Ages 21 to 24 Years	68.89%	+1.04	1	1
Total	65.23%	**+1.37**+	3	1

[1] 2017 performance levels were based on comparisons of the HEDIS 2017 MWA measure indicator rates to national Medicaid Quality Compass HEDIS 2016 benchmarks. 2017 performance levels represent the following percentile comparisons:

≤25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th

[2] HEDIS 2016 MWA to HEDIS 2017 MWA comparisons were based on a Chi-square test of statistical significance with a p value <0.01 due to large denominators.

Green Shading+ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

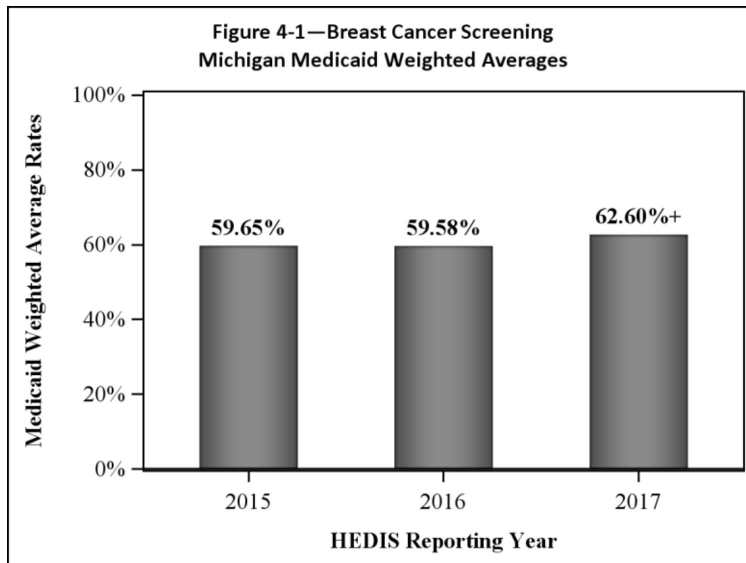
Red Shading++ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

Table 4-1 shows that in the Women—Adult Care domain, all five MWA rates ranked at or above the national Medicaid 50th percentile, with four of these rates ranking at or above the national Medicaid 75th percentile, indicating overall positive performance in the measured areas of cancer and chlamydia screenings for women. Further, four MHPs' rates and the MWA for *Breast Cancer Screening* and three MHPs' rates and the MWA for *Chlamydia Screening in Women—Total* demonstrated statistically significant improvement from 2016 to 2017.

Measure-Specific Findings

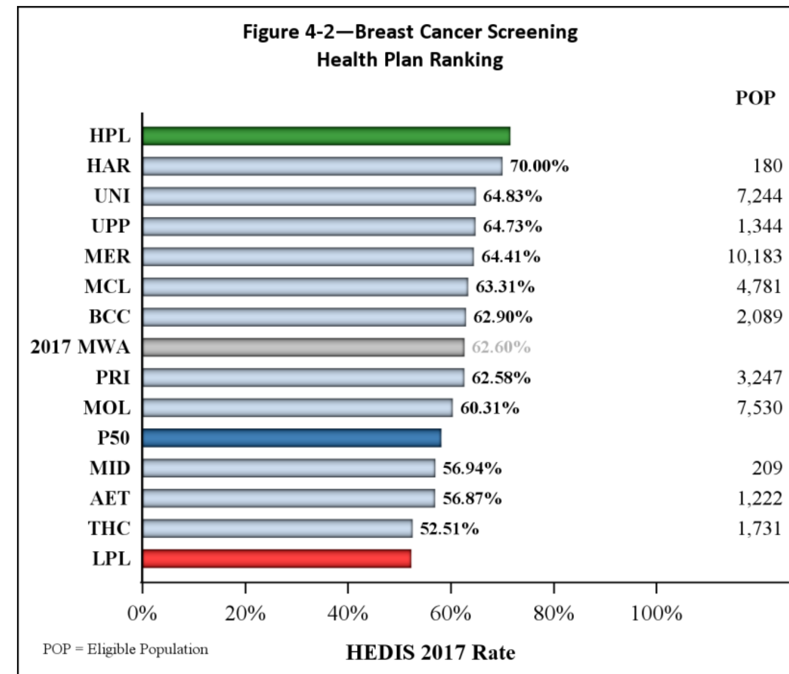
Breast Cancer Screening

Breast Cancer Screening assesses the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer on or after October 1 two years prior to the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.

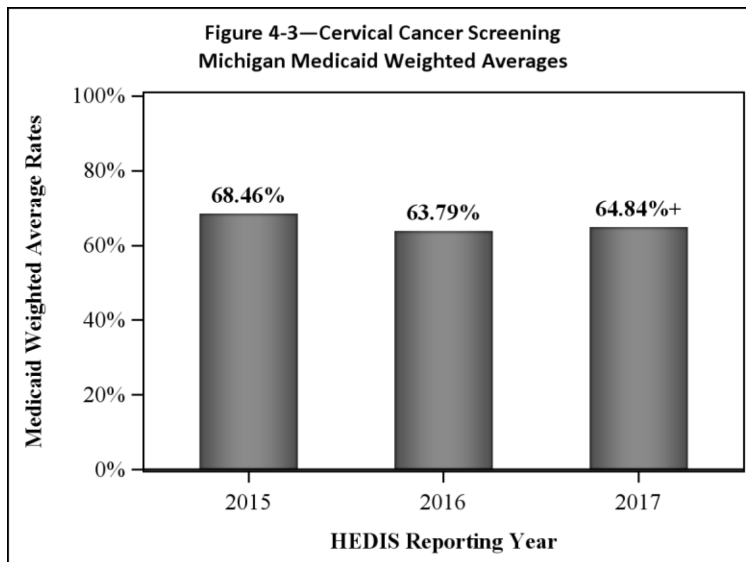


Eight MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. No MHPs fell below the LPL. MHP performance varied from 70.00 percent to 52.51 percent.

Cervical Cancer Screening

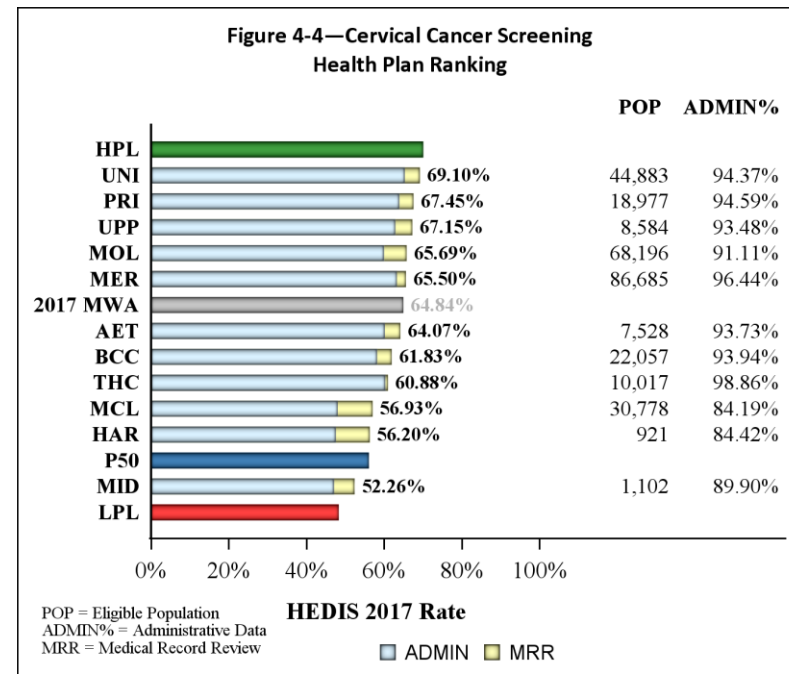
Cervical Cancer Screening assesses the percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria:

- Women ages 21 to 64 who had cervical cytology performed every three years.
- Women ages 30-64 who had cervical cytology/human papillomavirus co-testing every five years.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

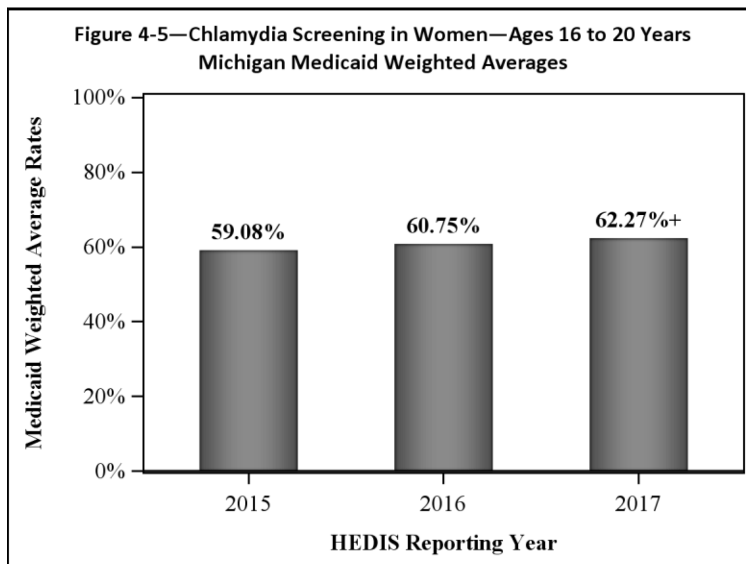
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



Ten MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. No MHPs fell below the LPL. MHP performance varied from 69.10 percent to 52.26 percent.

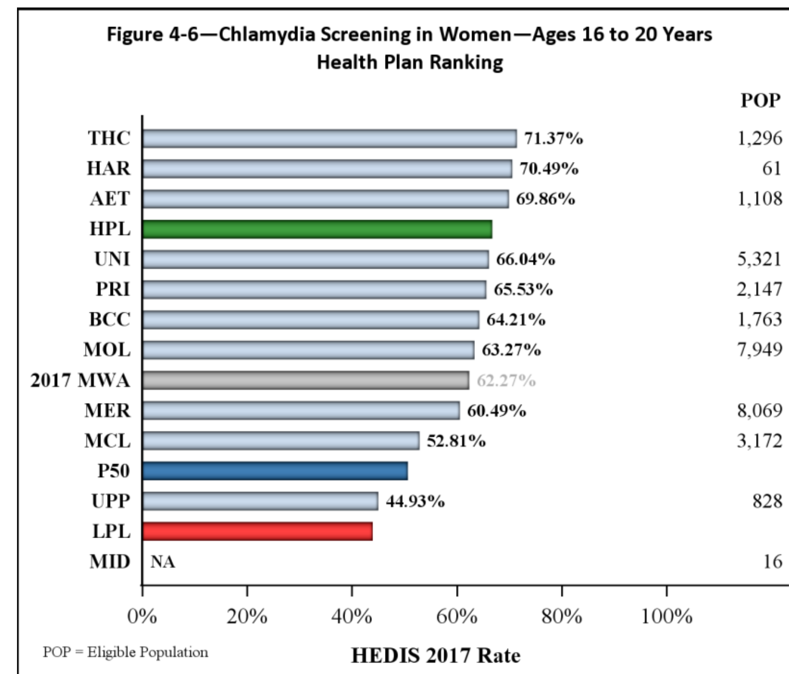
Chlamydia Screening in Women—Ages 16–20 Years

Chlamydia Screening in Women—Ages 16–20 Years assesses the percentage of women 16 to 20 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.

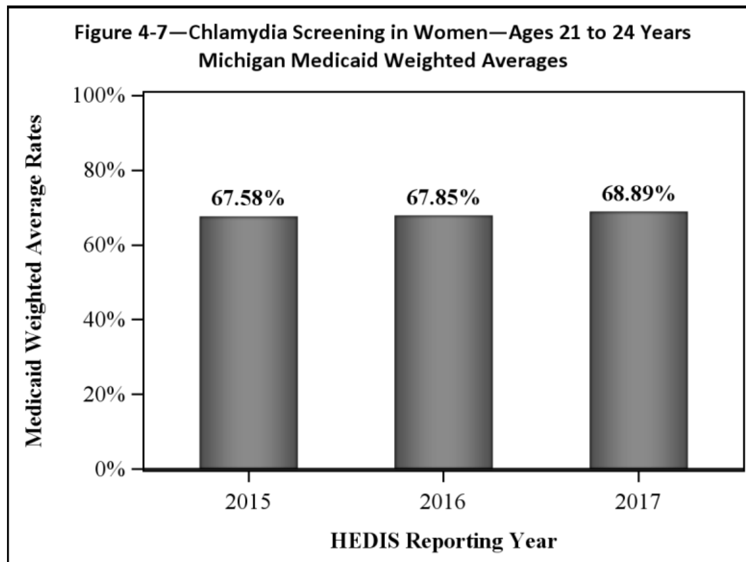


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

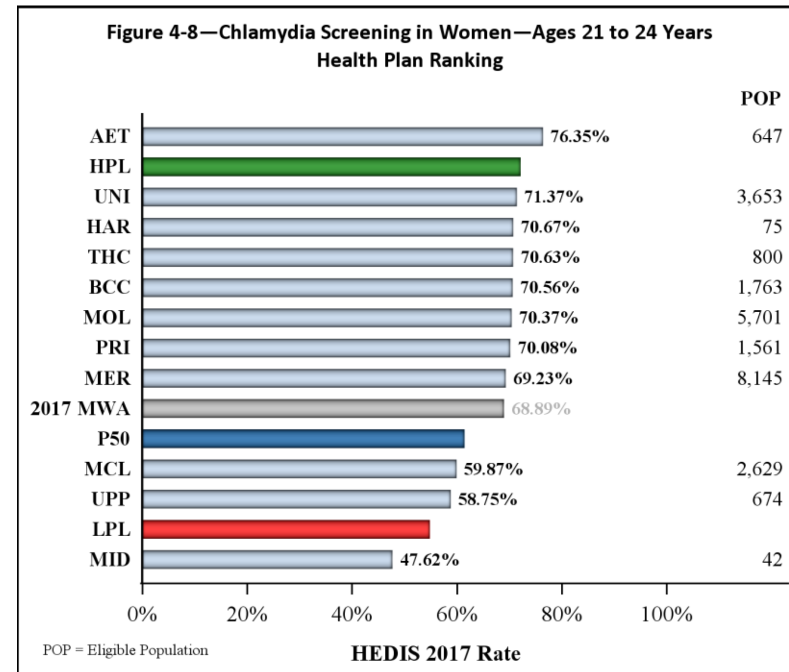
Three MHPs ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 71.37 percent to 44.93 percent.

Chlamydia Screening in Women—21–24 Years

Chlamydia Screening in Women—21–24 Years assesses the percentage of women 21 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.



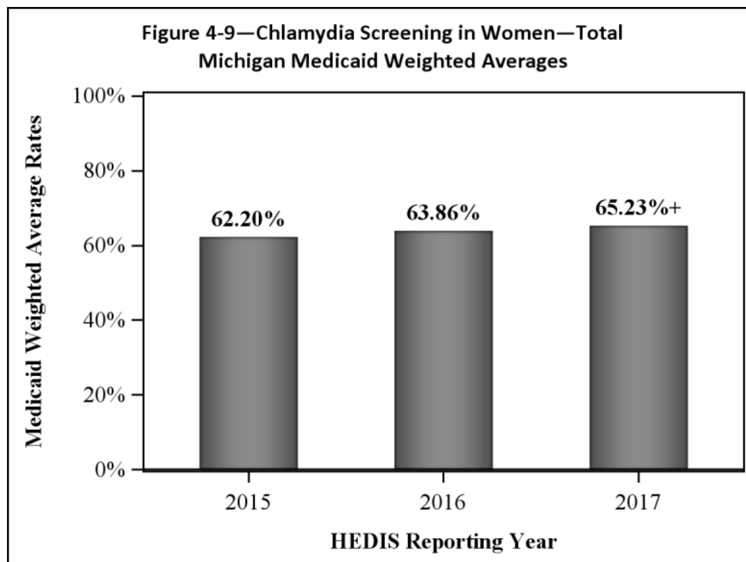
The HEDIS 2017 MWA rate did not demonstrate a statistically significant change from HEDIS 2016.



One MHP ranked above the HPL. One MHP fell below the LPL. MHP performance varied from 76.35 percent to 47.62 percent.

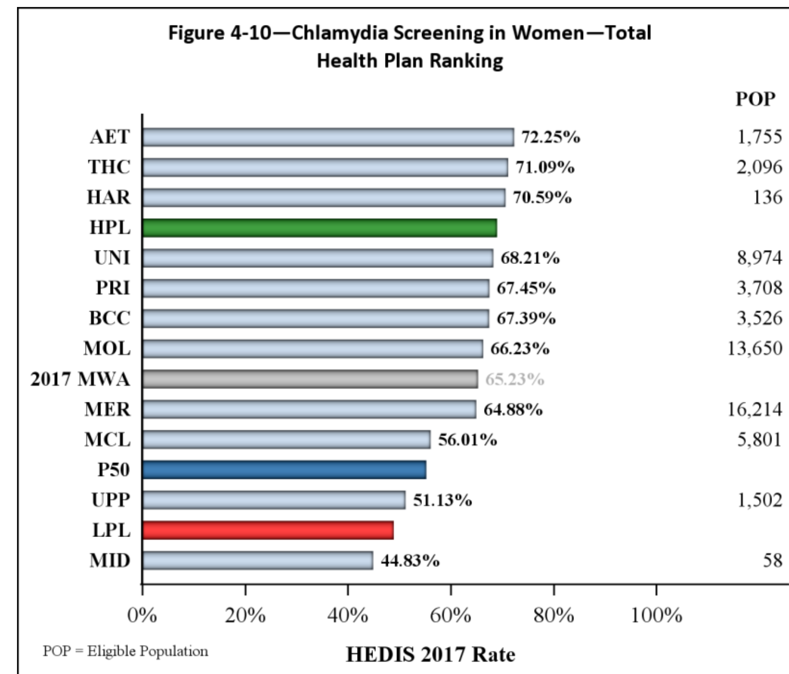
Chlamydia Screening in Women–Total

Chlamydia Screening in Women—Total represents the percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



Three MHPs ranked above the HPL. One MHP fell below the LPL. MHP performance varied from 72.25 percent to 44.83 percent.

5. Access to Care

Introduction

The Access to Care measure domain encompasses the following MDHHS measures:

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years,* and *Ages 12 to 19 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years, Ages 45 to 64 Years, Ages 65 and Older,* and *Total*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 5-1 presents the Michigan MWA performance for the measure indicators under the Access to Care measure domain. The table lists the HEDIS 2017 MWA rates and performance levels, a comparison of the HEDIS 2016 MWA to the HEDIS 2017 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating statistically significant changes from HEDIS 2016 to HEDIS 2017.

Table 5-1—HEDIS 2017 MWA Performance Levels and Trend Results for Access to Care

Measure	HEDIS 2017 MWA and Performance Level[1]	HEDIS 2016 MWA–HEDIS 2017 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2017	Number of MHPs With Statistically Significant Decline in HEDIS 2017
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	96.06%	-0.14	1	1
Ages 25 Months to 6 Years	89.08%	+0.29	3	2
Ages 7 to 11 Years	91.39%	**+0.54+**	3	2
Ages 12 to 19 Years	90.79%	**+0.93+**	3	1

Measure	HEDIS 2017 MWA and Performance Level[1]	HEDIS 2016 MWA–HEDIS 2017 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2017	Number of MHPs With Statistically Significant Decline in HEDIS 2017
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20 to 44 Years	81.68%	**-1.08++**	0	8
Ages 45 to 64 Years	89.21%	**-0.60++**	2	4
Ages 65+ Years	90.26%	-0.89	0	3
Total	84.73%	**-0.89++**	1	7
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[3]				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	29.23%	+2.29+	4	1

[1] 2017 performance levels were based on comparisons of the HEDIS 2017 MWA measure indicator rates to national Medicaid Quality Compass HEDIS 2016 benchmarks. 2017 performance levels represent the following percentile comparisons:

≤25th	*≥25th and ≤49th*	*≥50th and ≤74th*	*≥75th and ≤89th*	*≥90th*

[2] HEDIS 2016 MWA to HEDIS 2017 MWA comparisons were based on a Chi-square test of statistical significance with a p value <0.01 due to large denominators.

Green Shading+ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

Red Shading++ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

[3] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2017 and prior years.

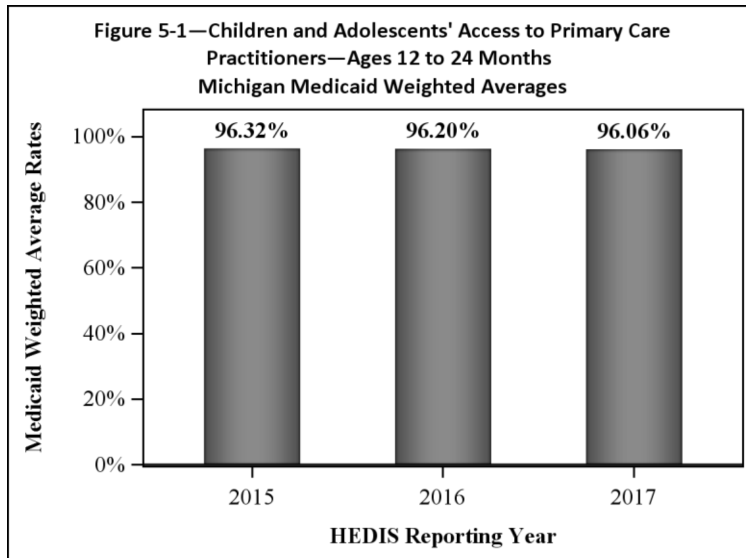
Table 5-1 shows that all nine MWA rates ranked at or above the national Medicaid 50th percentile, indicating positive performance in the area of Access to Care. Specifically, the MWA and three MHPs' rates related to access to primary care practitioners (PCPs) for members ages 7 to 11 years and 12 to 19 years demonstrated statistically significant improvement from 2016 to 2017. Further, the MWA and four MHPs' rates related to appropriate treatment for adults with bronchitis also demonstrated statistically significant improvement. However, caution should be used when comparing the 2017 *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* rates to national benchmarks and prior years due to changes to the technical measure specifications for HEDIS 2017.

Despite favorable performance compared to national benchmarks for measures related to access to preventive/ambulatory services for adults, these rates demonstrated statistically significant declines in performance. In particular, seven of the 11 MHPs' rates and the MWA exhibited decreases that were statistically significant from 2016 to 2017 for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator, suggesting opportunities for improving access to preventive/ambulatory services for adults ages 20 years and above.

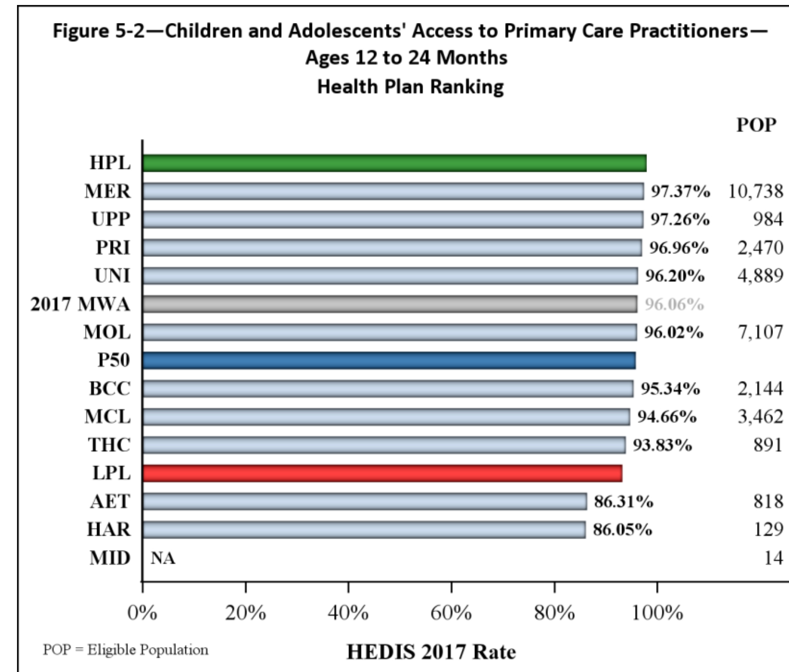
Measure-Specific Findings

Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months

Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months assesses the percentage of members 12 to 24 months of age who had a visit with a PCP during the measurement year.



The HEDIS 2017 MWA rate did not demonstrate a statistically significant change from HEDIS 2016.

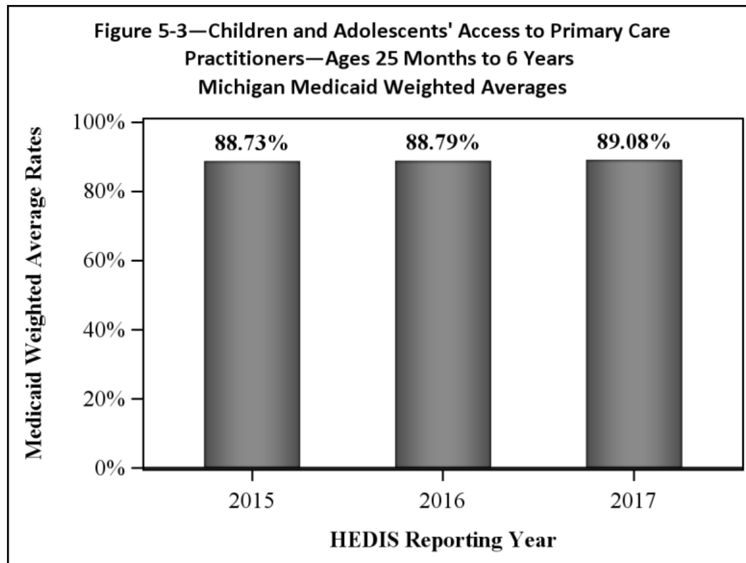


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

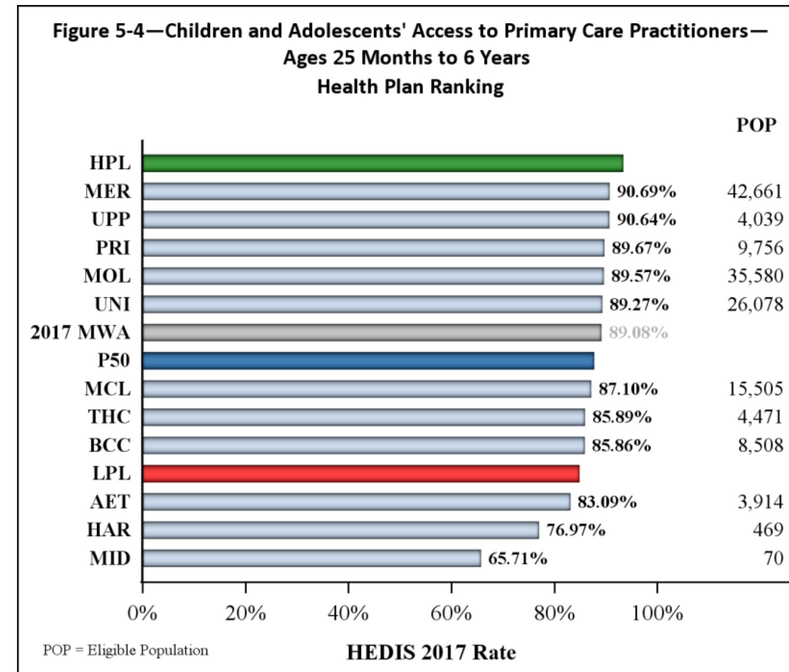
Five MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. Two MHPs fell below the LPL. MHP performance varied from 97.37 percent to 86.05 percent.

Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years

Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years assesses the percentage of members 25 months to 6 years of age who had a visit with a PCP during the measurement year.



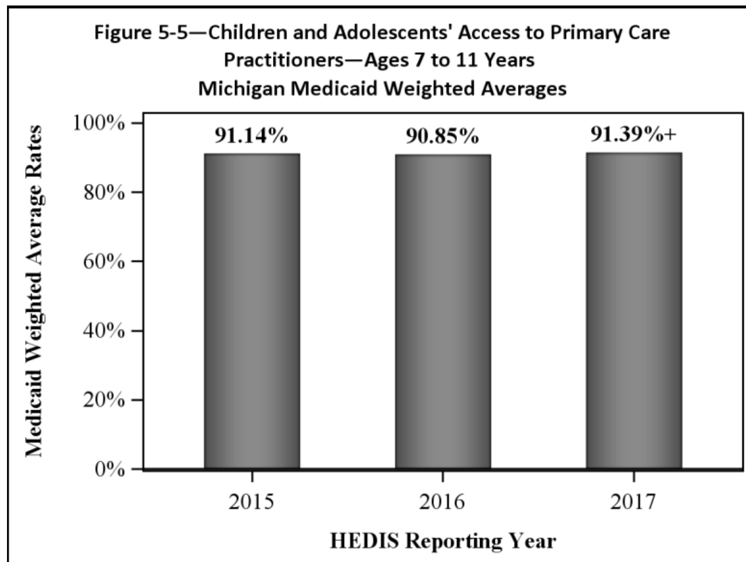
The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.



Five MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. Three MHPs fell below the LPL. MHP performance varied from 90.69 percent to 65.71 percent.

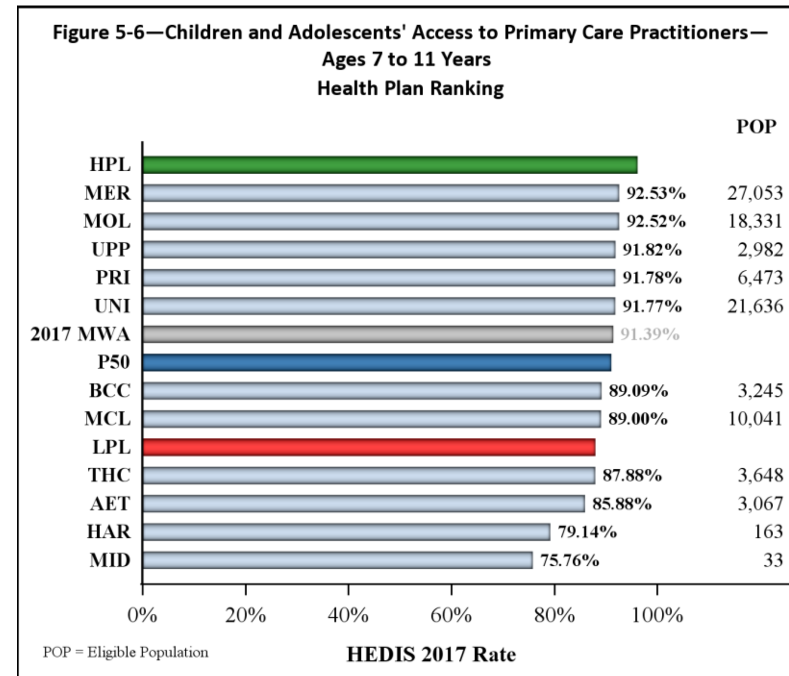
Children and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years

Children and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years assesses the percentage of members 7 to 11 years of age who had a visit with a PCP during the measurement year or the year prior to the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

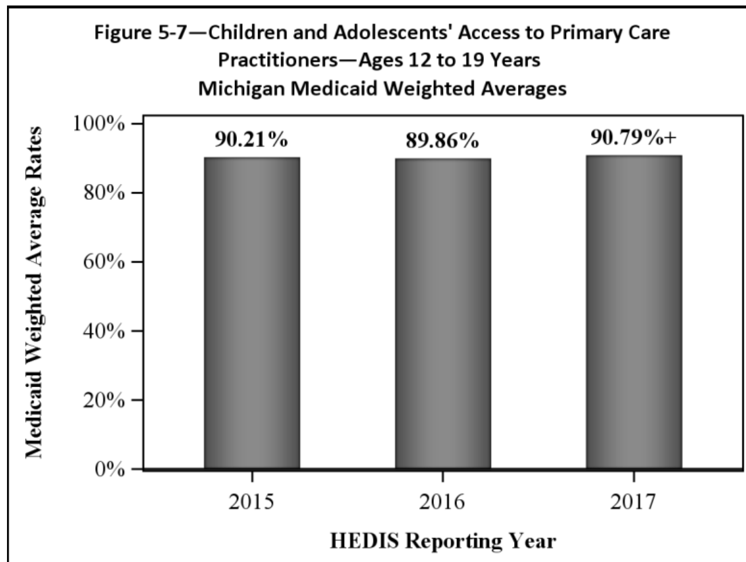
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



Five MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. Four MHPs fell below the LPL. MHP performance varied from 92.53 percent to 75.76 percent.

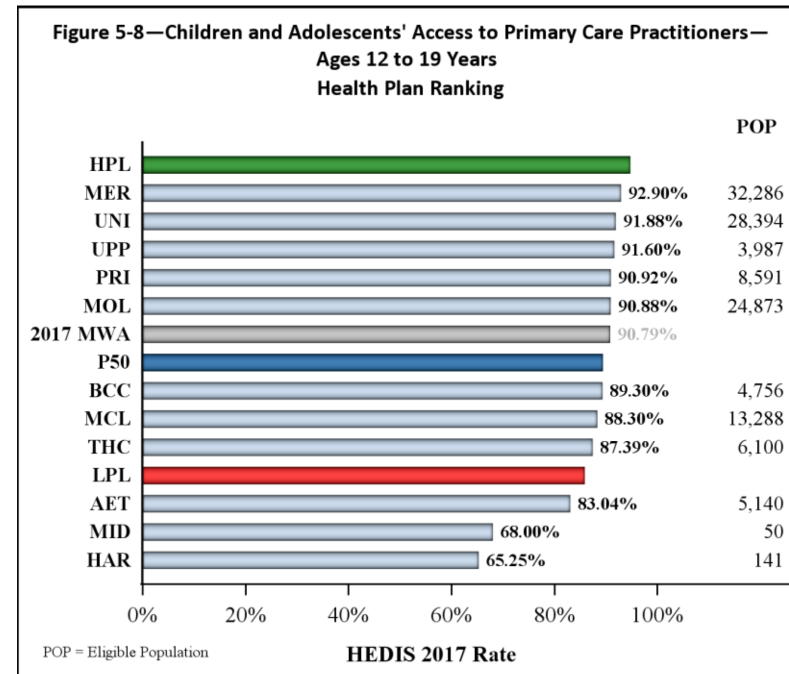
Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years

Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years assesses the percentage of members 12 to 19 years of age who had a visit with a PCP during the measurement year or the year prior to the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

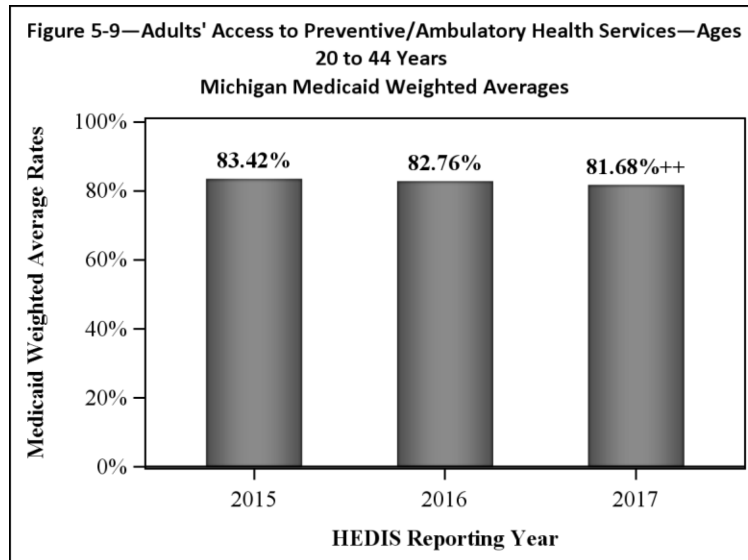
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



Five MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. Three MHPs fell below the LPL. MHP performance varied from 92.90 percent to 65.25 percent.

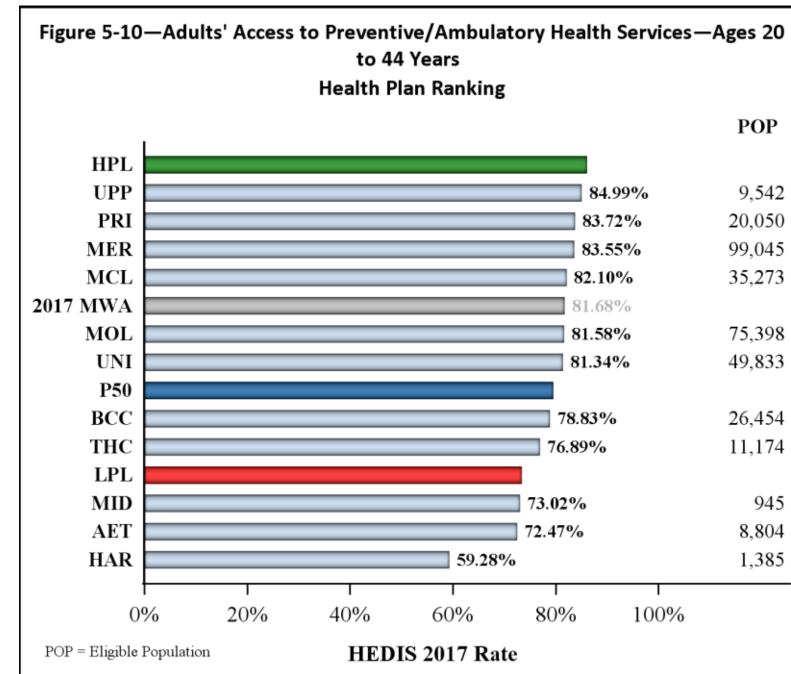
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years

Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years assesses the percentage of members 20 to 44 years of age who had an ambulatory or preventive care visit during the measurement year.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

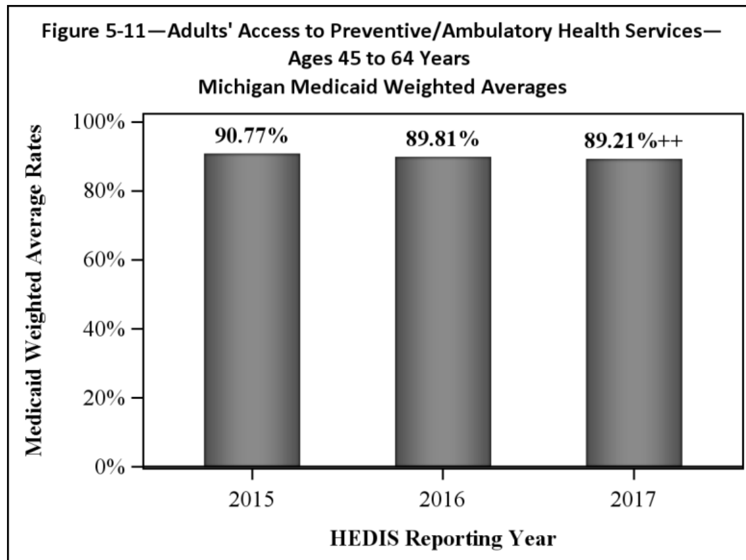
The HEDIS 2017 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2016.



Six MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. Three MHPs fell below the LPL. MHP performance varied from 84.99 percent to 59.28 percent.

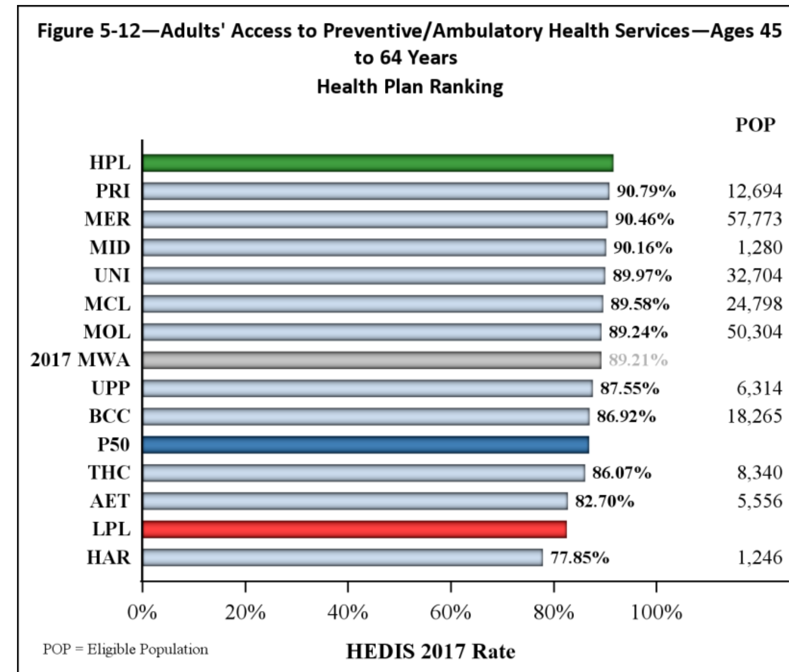
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years

Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years assesses the percentage of members 45 to 64 years of age who had an ambulatory or preventive care visit during the measurement year.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

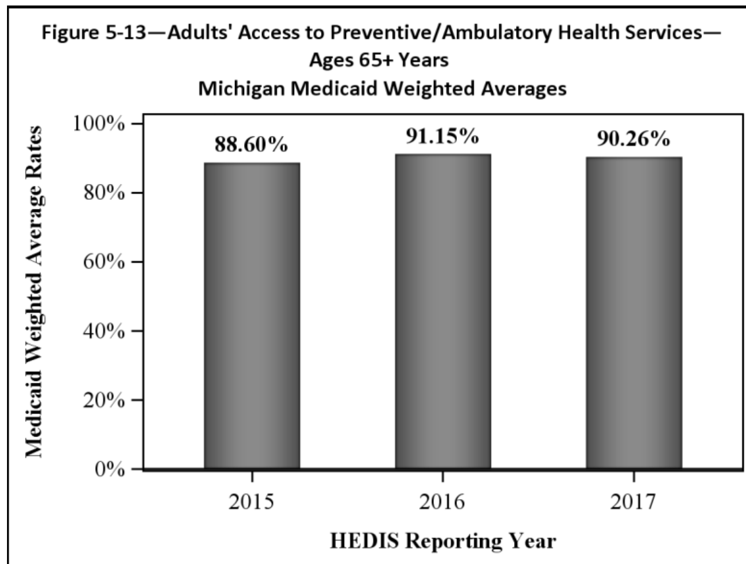
The HEDIS 2017 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2016.



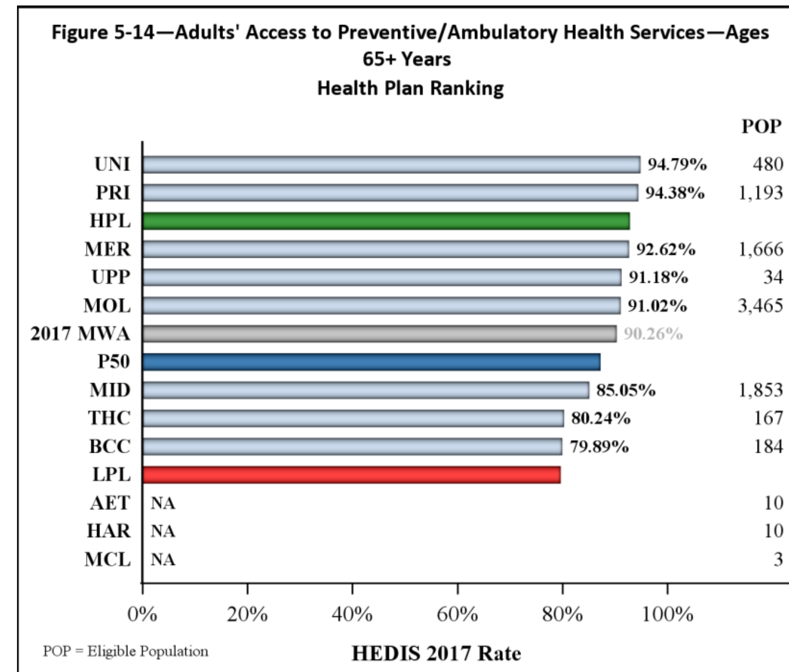
Eight MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 90.79 percent to 77.85 percent.

Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older

Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older assesses the percentage of members 65 years of age or older who had an ambulatory or preventive care visit during the measurement year.



The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.

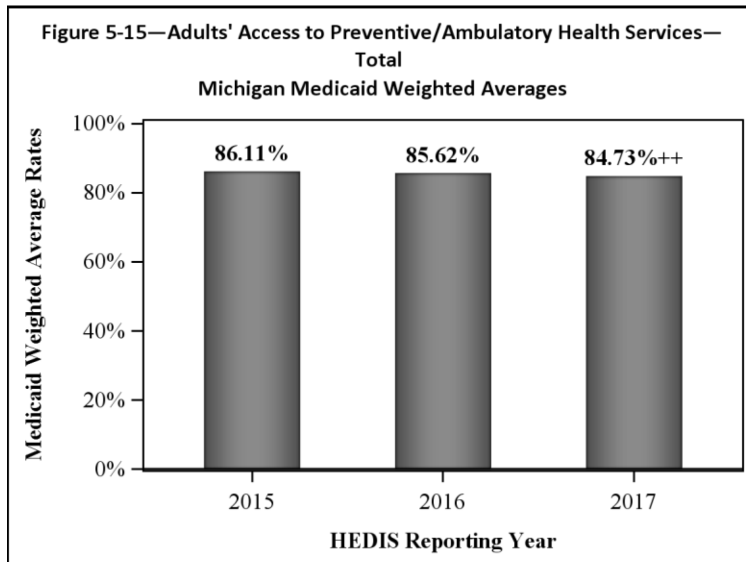


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Two MHPs ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 94.79 percent to 79.89 percent.

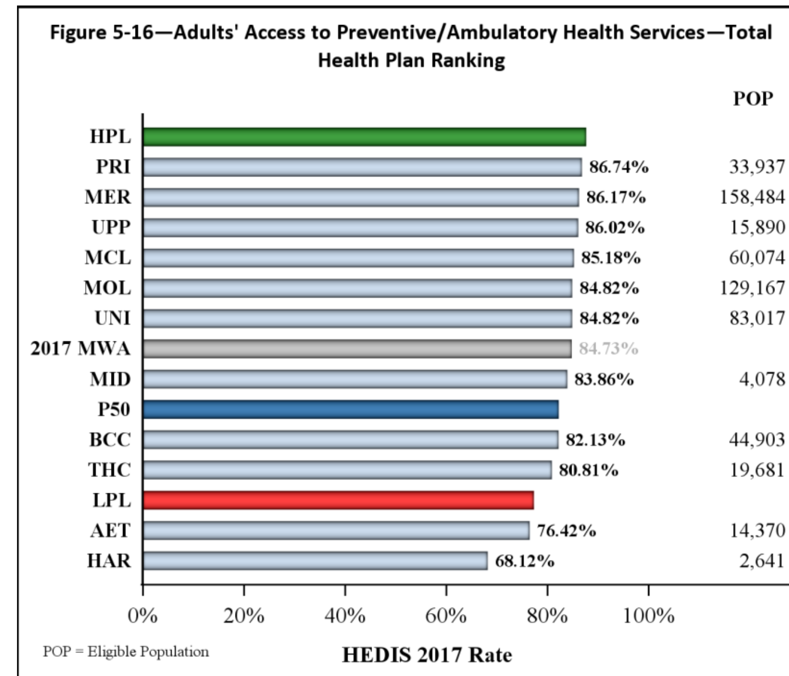
Adults' Access to Preventive/Ambulatory Health Services—Total

Adults' Access to Preventive/Ambulatory Health Services—Total assesses the percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

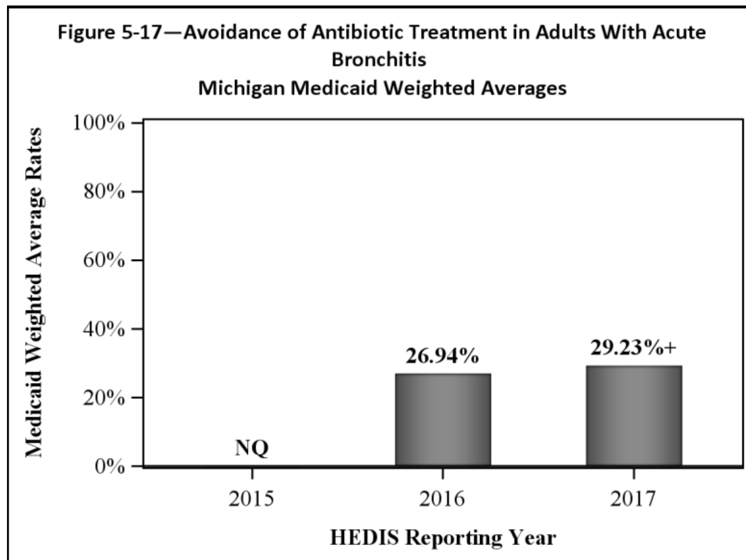
The HEDIS 2017 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2016.



Seven MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. Two MHPs fell below the LPL. MHP performance varied from 86.74 percent to 68.12 percent.

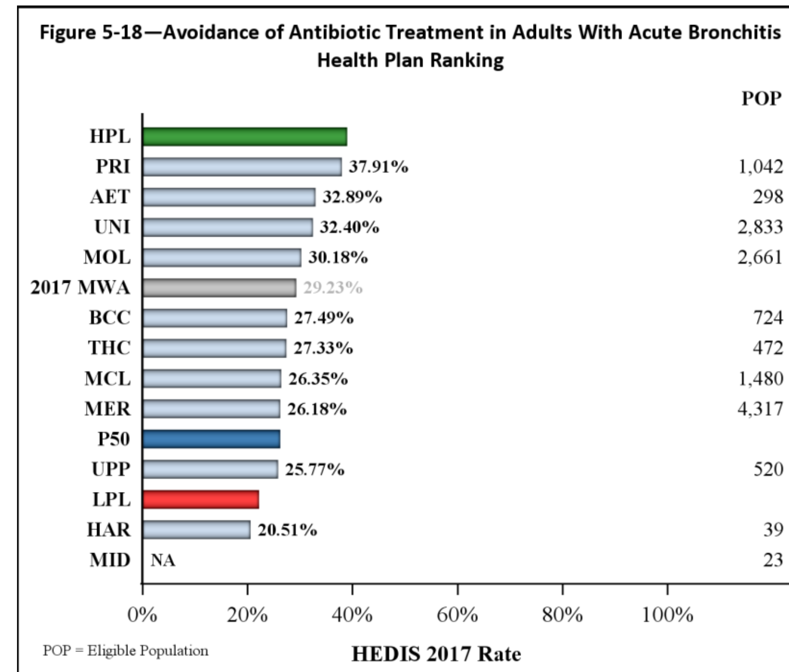
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis assesses the percentage of members 18 to 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. Due to changes in the technical specifications for this measure indicator, exercise caution when trending rates between 2017 and prior years.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.
NQ indicates that this measure was not included in the HEDIS aggregate report for 2015.
Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2017 and prior years.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Eight MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 37.91 percent to 20.51 percent.

6. Obesity

Introduction

The Obesity measure domain encompasses the following MDHHS measures:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total*
- *Adult BMI Assessment*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 6-1 presents the Michigan MWA performance for the measure indicators under the Obesity measure domain. The table lists the HEDIS 2017 MWA rates and performance levels, a comparison of the HEDIS 2016 MWA to the HEDIS 2017 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating statistically significant changes from HEDIS 2016 to HEDIS 2017.

Table 6-1—HEDIS 2017 MWA Performance Levels and Trend Results for Obesity

Measure	HEDIS 2017 MWA and Performance Level[1]	HEDIS 2016 MWA–HEDIS 2017 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2017	Number of MHPs With Statistically Significant Decline in HEDIS 2017
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	82.10%	**+7.17+**	7	0
Counseling for Nutrition—Total	72.21%	**+6.44+**	5	0
Counseling for Physical Activity—Total	61.24%	**+3.36+**	1	1

Measure	HEDIS 2017 MWA and Performance Level[1]	HEDIS 2016 MWA–HEDIS 2017 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2017	Number of MHPs With Statistically Significant Decline in HEDIS 2017
Adult BMI Assessment				
Adult BMI Assessment	92.86%	**+2.94+**	3	0

[1] *2017 performance levels were based on comparisons of the HEDIS 2017 MWA measure indicator rates to national Medicaid Quality Compass HEDIS 2016 benchmarks. 2017 performance levels represent the following percentile comparisons:*

≤25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th

[2] *HEDIS 2016 MWA to HEDIS 2017 MWA comparisons were based on a Chi-square test of statistical significance with a p value <0.01 due to large denominators.*

Green Shading+ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

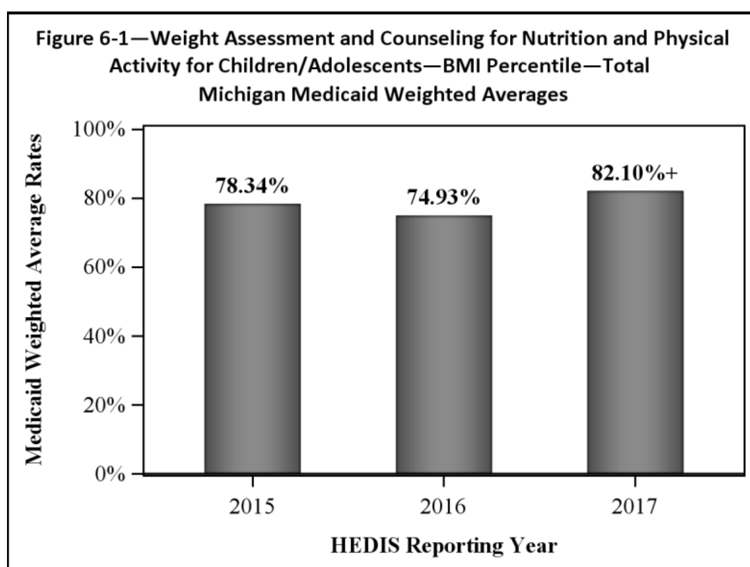
Red Shading++ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

Table 6-1 shows that the four MWA rates included in the Obesity domain ranked at or above the national Medicaid 50th percentile, with two MWA rates ranking at or above the national Medicaid 75th percentile and one MWA rate ranking at or above the national Medicaid 90th percentile. Most favorably, rates for the documentation of body mass index (BMI) percentile assessments for children and adolescents demonstrated statistically significant improvement for seven MHPs and the MWA, rates for nutrition counseling for children and adolescents demonstrated statistically significant improvement for five MHPs and the MWA, and rates for BMI assessments for adults demonstrated statistically significant improvement for three MHPs and the MWA.

Measure-Specific Findings

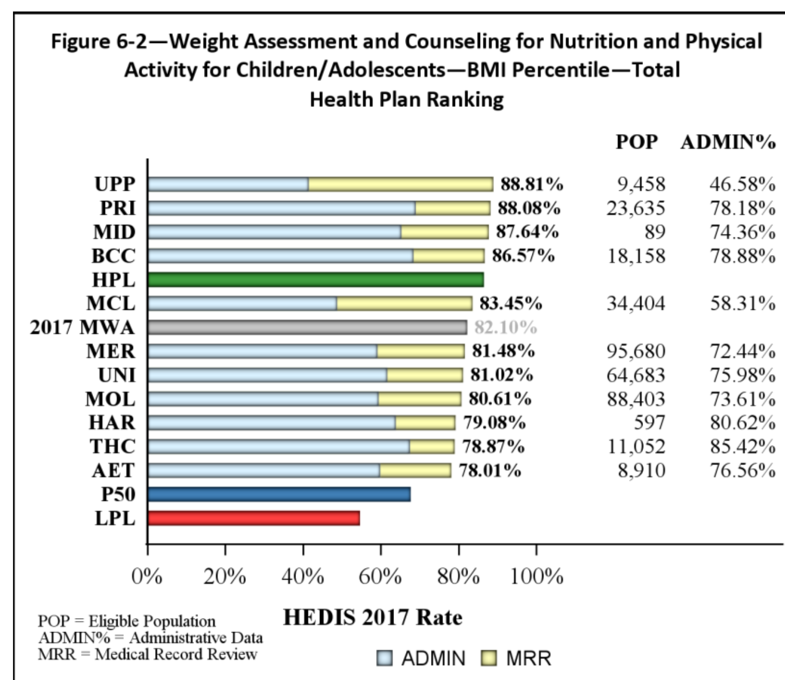
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total assesses the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

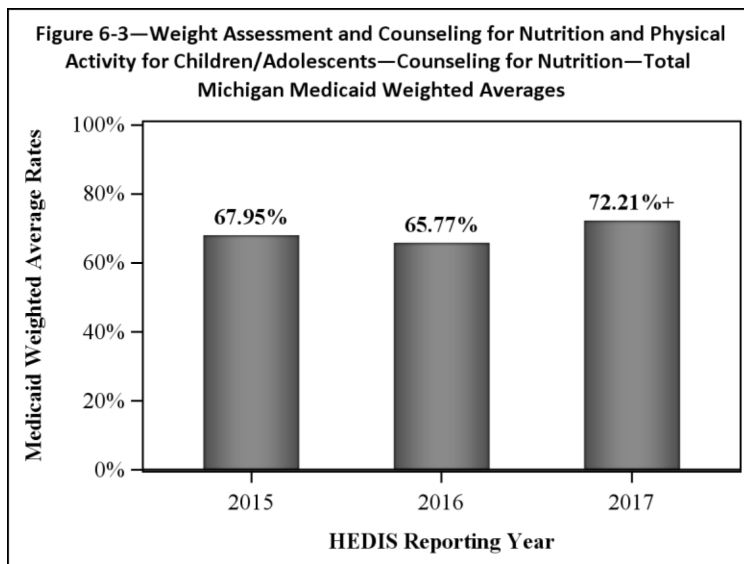
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



Four MHPs ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 88.81 percent to 78.01 percent.

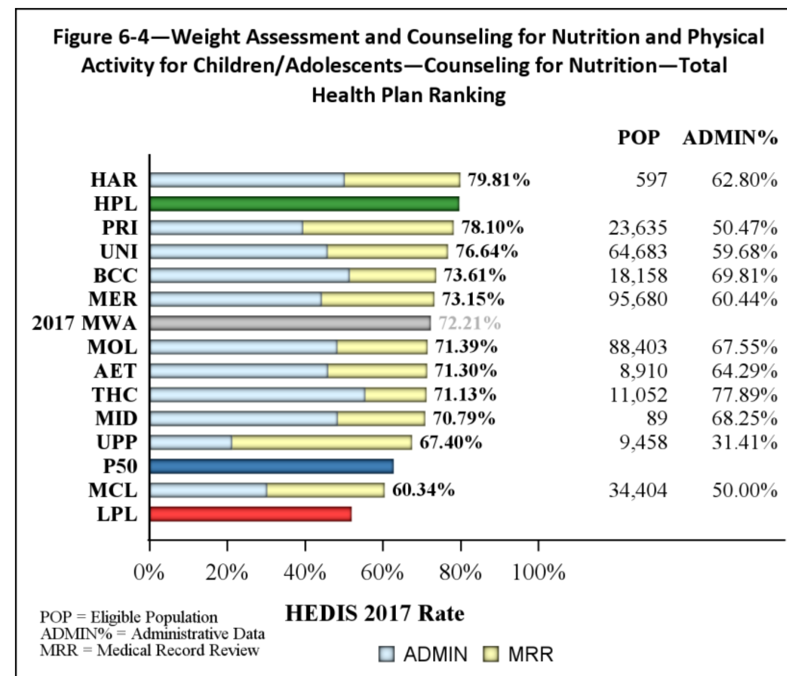
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total assesses the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

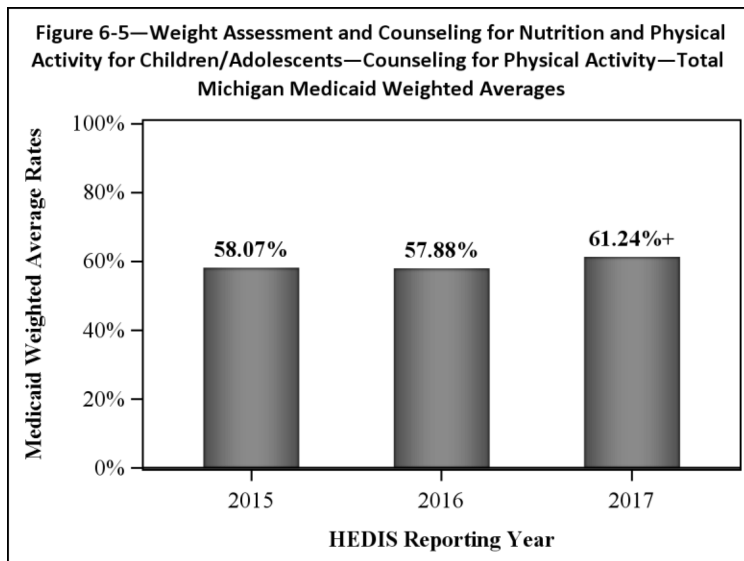
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



One MHP ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 79.81 percent to 60.34 percent.

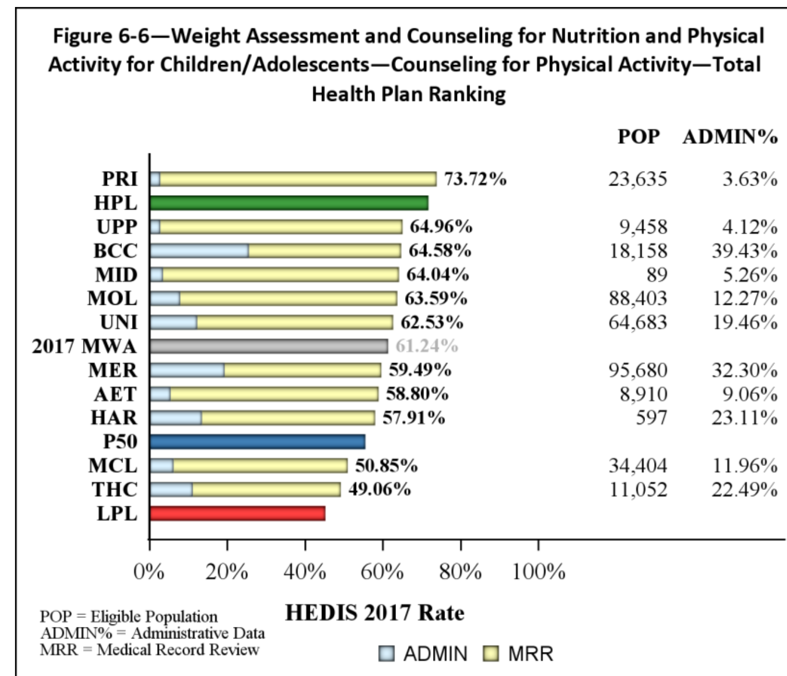
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total assesses the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year. Due to changes in the technical specifications for this measure indicator, exercise caution when trending rates between 2016 and prior years.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

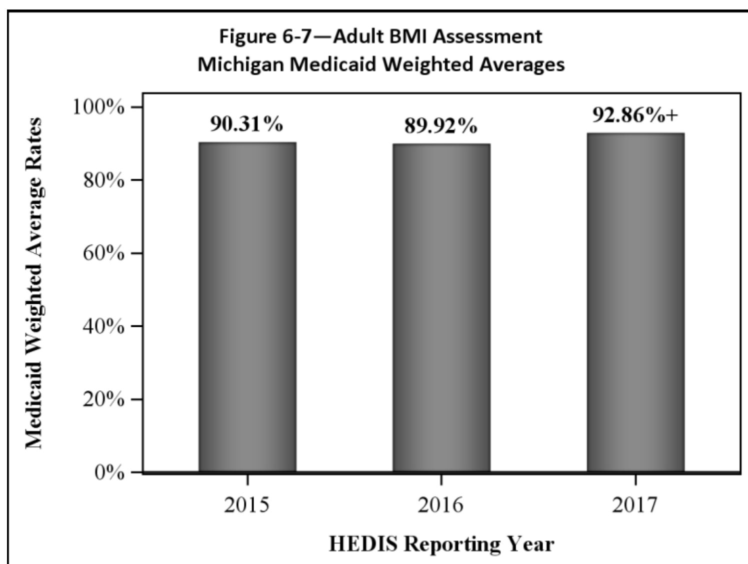
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement from HEDIS 2016.



One MHP ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 73.72 percent to 49.06 percent.

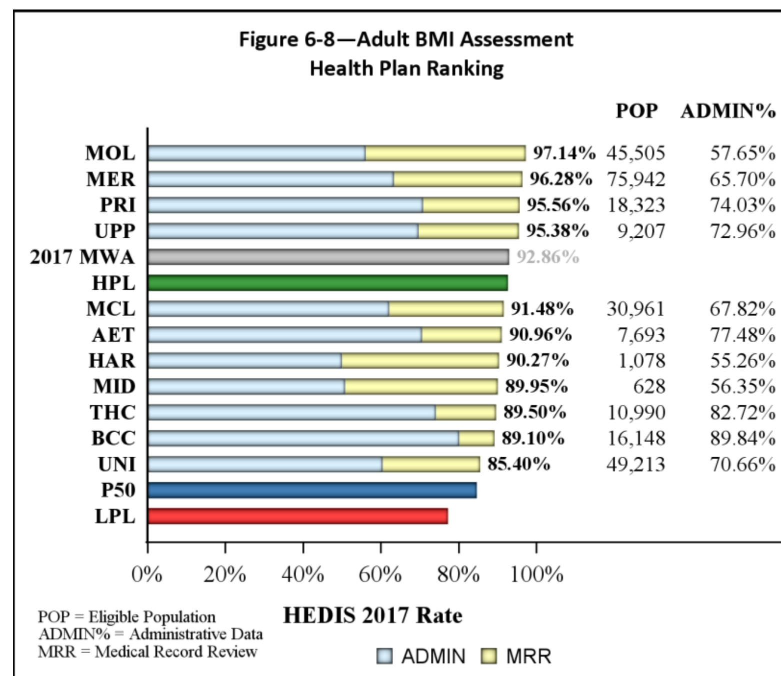
Adult BMI Assessment

Adult BMI Assessment assesses the percentage of members 18 to 74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



Four MHPs and the MWA ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 97.14 percent to 85.40 percent.

7. Pregnancy Care

Introduction

The Pregnancy Care measure domain encompasses the following MDHHS measures:

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*

Please see the “How to Get the Most From This Report” section for guidance on interpreting the figures presented within this section.

For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 7-1 on the following page presents the Michigan MWA performance for the measure indicators under the Pregnancy Care measure domain. The table lists the HEDIS 2017 MWA rates and performance levels, a comparison of the HEDIS 2016 MWA to the HEDIS 2017 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating statistically significant changes from HEDIS 2016 to HEDIS 2017.

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Table 7-1—HEDIS 2017 MWA Performance Levels and Trend Results for Pregnancy Care

Measure	HEDIS 2017 MWA and Performance Level[1]	HEDIS 2016 MWA–HEDIS 2017 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2017	Number of MHPs With Statistically Significant Decline in HEDIS 2017
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.57%	**+2.94**+	3	2
Postpartum Care	68.96%	**+7.23**+	3	0
Frequency of Ongoing Prenatal Care				
≥81 Percent of Expected Visits	56.10%	-0.30	3	4

[1] *2017 performance levels were based on comparisons of the HEDIS 2017 MWA measure indicator rates to national Medicaid Quality Compass HEDIS 2016 benchmarks. 2017 performance levels represent the following percentile comparisons:*

≤25th	*≥25th and ≤49th*	*≥50th and ≤74th*	*≥75th and ≤89th*	*≥90th*

[2] *HEDIS 2016 MWA to HEDIS 2017 MWA comparisons were based on a Chi-square test of statistical significance with a p value <0.01 due to large denominators.*

Green Shading+ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

Red Shading++ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

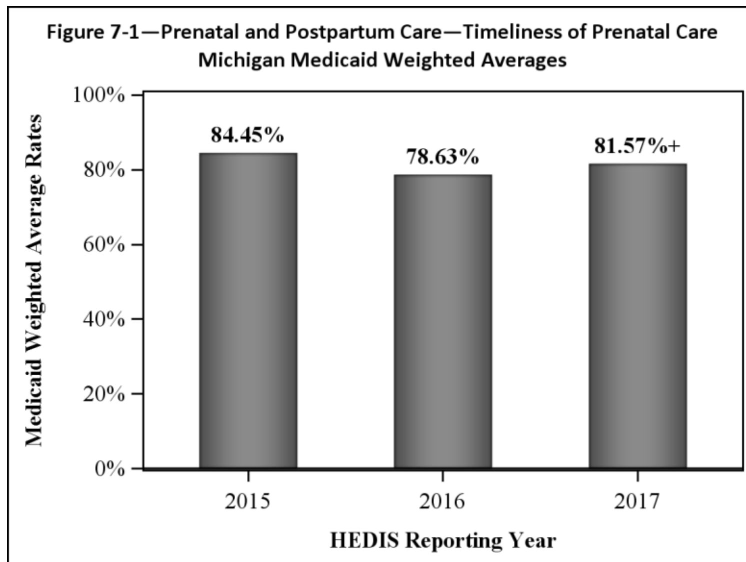
Table 7-1 shows that one of the three measures in the Pregnancy Care domain, *Prenatal and Postpartum Care—Postpartum Care,* ranked at or above the national Medicaid 75th percentile. Additionally, the MWA and three MHPs' rates for this measure demonstrated statistically significant increases, indicating improvements in postpartum care from 2016 to 2017.

For the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits* measures, the MWA rates fell below the national Medicaid 50th percentile, indicating opportunities for improvement in prenatal care. Of note, the MWA and three MHPs' timeliness of prenatal care rates demonstrated statistically significant improvement, and three MHPs' ongoing prenatal care rates demonstrated statistically significant improvement. However, four MHPs' ongoing prenatal care rates demonstrated statistically significant declines, indicating mixed results when comparing 2017 MHP and statewide performance to 2016.

Measure-Specific Findings

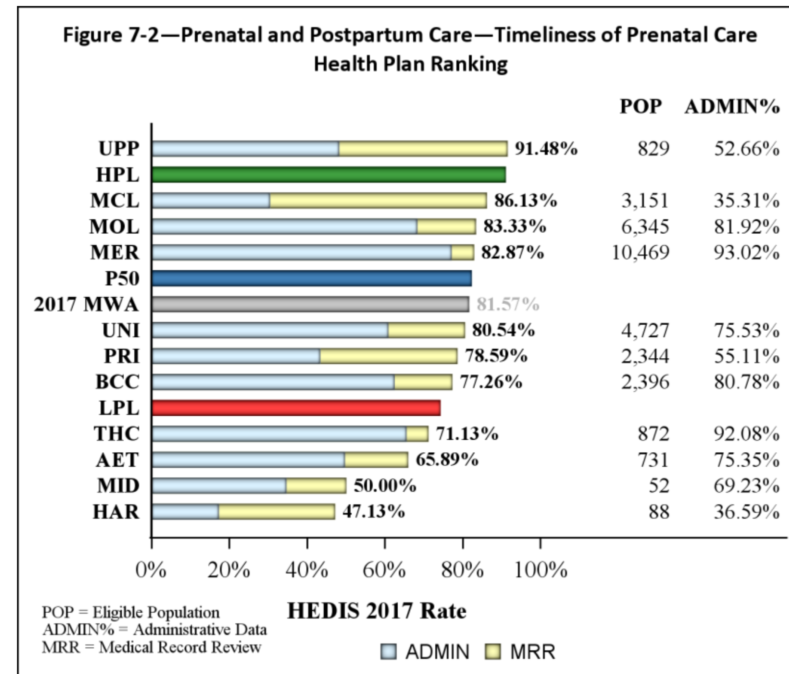
Prenatal and Postpartum Care—Timeliness of Prenatal Care

Prenatal and Postpartum Care—Timeliness of Prenatal Care assesses the percentage of deliveries that received a prenatal care visit as a member of the MHP in the first trimester or within 42 days of enrollment in the MHP.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

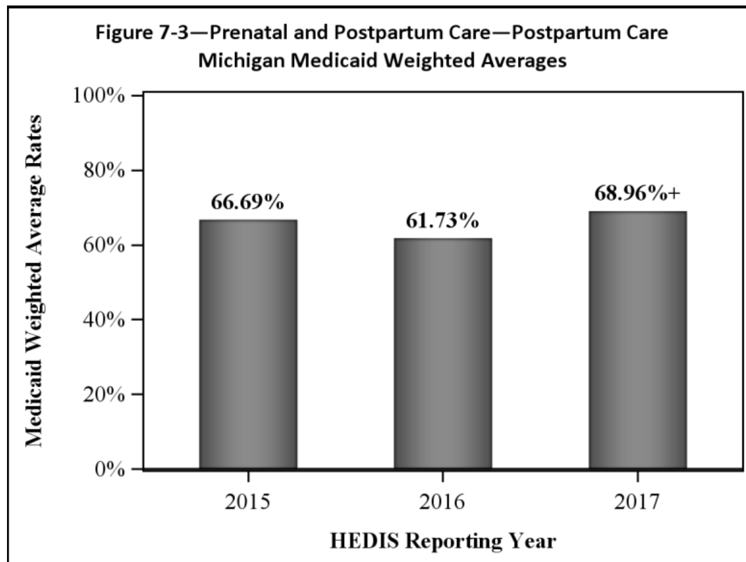
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



One MHP ranked above the HPL. Four MHPs fell below the LPL. MHP performance varied from 91.48 percent to 47.13 percent.

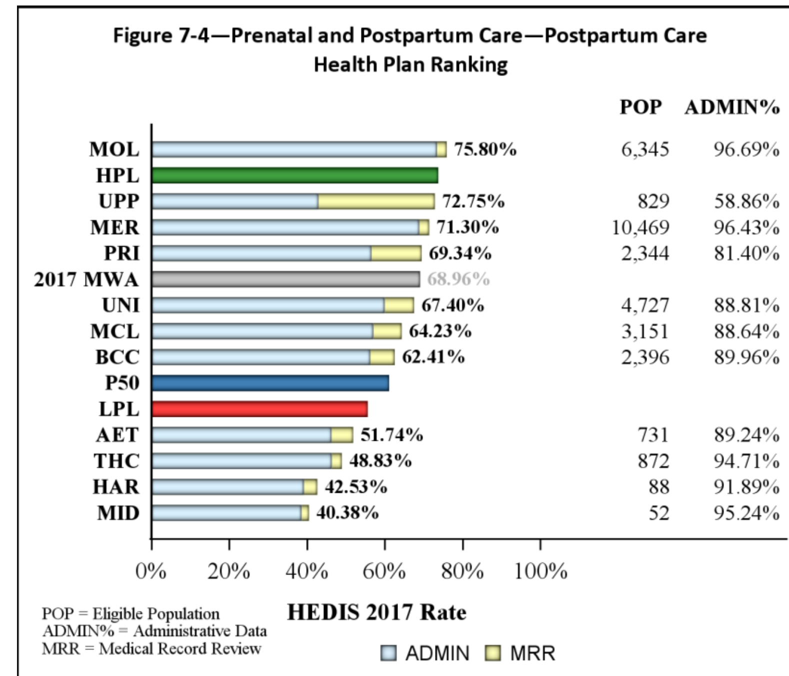
Prenatal and Postpartum Care—Postpartum Care

Prenatal and Postpartum Care—Postpartum Care represents the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

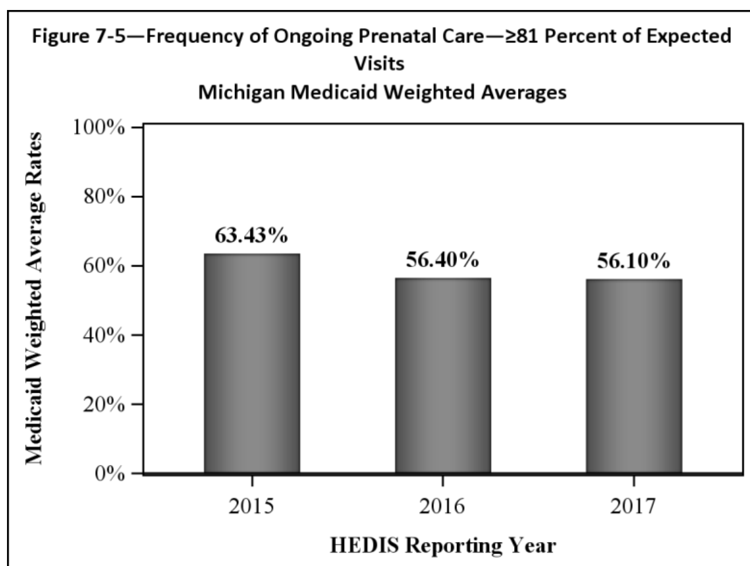
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



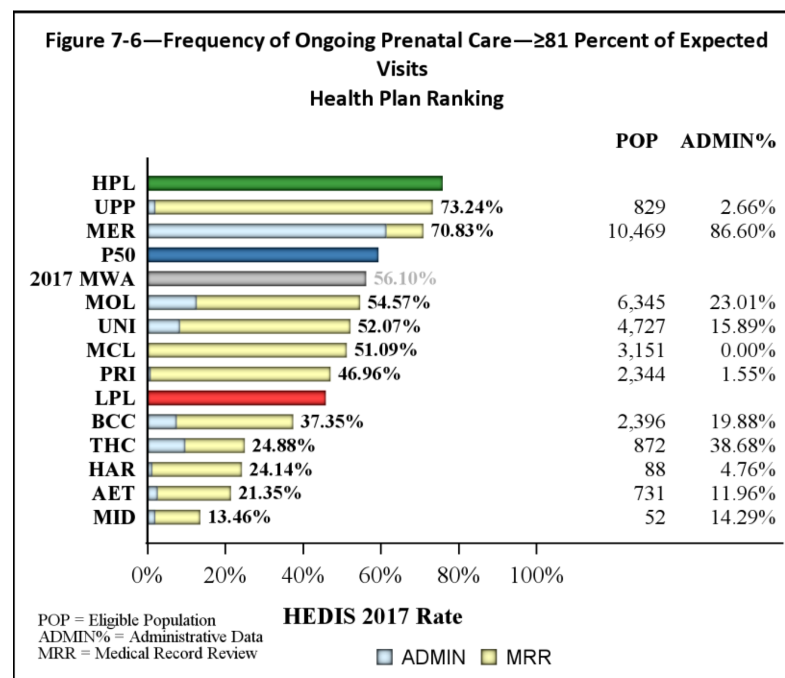
One MHP ranked above the HPL. Four MHPs fell below the LPL. MHP performance varied from 75.80 percent to 40.38 percent.

Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits

Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits represents the percentage of deliveries that had at least 81 percent of the expected prenatal visits.



The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.



Two MHPs ranked above the national Medicaid 50th percentile but below the HPL. Five MHPs fell below the LPL. MHP performance varied from 73.24 percent to 13.46 percent.

8. Living With Illness

Introduction

The Living With Illness measure domain encompasses the following MDHHS measures:

- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%), HbA1c control (<8.0%), Eye Exam (Retinal) Performed, Medical Attention for Nephropathy,* and *Blood Pressure Control (<140/90 mm Hg)*
- *Medication Management for People with Asthma—Medication Compliance 50%—Total* and *Medication Compliance 75%—Total*
- *Asthma Medication Ratio—Total*
- *Controlling High Blood Pressure*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications,* and *Discussing Cessations Strategies*
- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs, Digoxin, Diuretics,* and *Total*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 8-1 presents the Michigan MWA performance for the measure indicators under the Living With Illness measure domain. The table lists the HEDIS 2017 MWA rates and performance levels, a comparison of the HEDIS 2016 MWA to the HEDIS 2017 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating statistically significant changes from HEDIS 2016 to HEDIS 2017.

Table 8-1—HEDIS 2017 MWA Performance Levels and Trend Results for Living With Illness

Measure	HEDIS 2017 MWA and Performance Level[1]	HEDIS 2016 MWA–HEDIS 2017 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2017	Number of MHPs With Statistically Significant Decline in HEDIS 2017
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	87.79%	**+0.90+**	1	0
*HbA1c Poor Control (>9.0%)**	36.07%	**-3.23+**	4	1
HbA1c Control (<8.0%)	53.16%	**+2.25+**	3	2
Eye Exam (Retinal) Performed	62.85%	**+3.24+**	2	0
Medical Attention for Nephropathy	91.14%	-0.14	1	0
Blood Pressure Control (<140/90 mm Hg)	61.73%	**+2.35+**	3	0
Medication Management for People With Asthma				
Medication Compliance 50%—Total[3]	71.33%	**+4.20+**	4	1
Medication Compliance 75%—Total	49.96%	**+6.17+**	7	2
Asthma Medication Ratio				
Total	62.63%	+0.45	0	0
Controlling High Blood Pressure				
Controlling High Blood Pressure	56.75%	**+1.21+**	4	1
Medical Assistance With Smoking and Tobacco Use Cessation[4]				
Advising Smokers and Tobacco Users to Quit	80.15%	**+0.40+**	0	0
Discussing Cessation Medications	55.95%	**+0.91+**	0	0
Discussing Cessation Strategies	45.89%	**+0.69+**	0	0
Antidepressant Medication Management				
Effective Acute Phase Treatment	52.72%	**-7.64++**	2	4
Effective Continuation Phase Treatment	36.03%	**-6.18++**	2	3
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.09%	+0.48	1	2
Diabetes Monitoring for People With Diabetes and Schizophrenia				
Diabetes Monitoring for People With Diabetes and Schizophrenia	69.01%	-0.97	0	1
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	69.64%	-4.82	0	1

Measure	HEDIS 2017 MWA and Performance Level[1]	HEDIS 2016 MWA–HEDIS 2017 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2017	Number of MHPs With Statistically Significant Decline in HEDIS 2017
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	61.16%	+2.40+	2	1
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	87.00%	-0.20	2	3
Digoxin	53.56%	+1.09	0	0
Diuretics	87.08%	+0.20	2	0
Total	86.84%	0.00	3	2

[1] 2017 performance levels were based on comparisons of the HEDIS 2017 MWA measure indicator rates to national Medicaid Quality Compass HEDIS 2016 benchmarks. 2017 performance levels represent the following percentile comparisons:

≤25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th

[2] HEDIS 2016 MWA to HEDIS 2017 MWA comparisons were based on a Chi-square test of statistical significance with a p value <0.01 due to large denominators.

Green Shading+ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

Red Shading++ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

[3] 2017 Performance Levels were based on comparisons of the HEDIS 2017 measure indicator rates to national Medicaid Quality Compass HEDIS 2016 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2016 benchmark.

[4] To align with calculations from prior years, the weighted average for this measure used the eligible population for the survey rather than the number of people who responded as being smokers.

** For this indicator, a lower rate indicates better performance.*

Table 8-1 shows that for the Living With Illness domain, most MWA rates (16 of 23 rates) ranked at or above the national Medicaid 50th percentile. Seven MWA rates ranked at or above the national Medicaid 75th percentile, one of which ranked at or above the national Medicaid 90th percentile, indicating positive performance related to HbA1c control and eye exams for members with diabetes, managing medications for members with asthma, and cessation assistance for smoking/tobacco use.

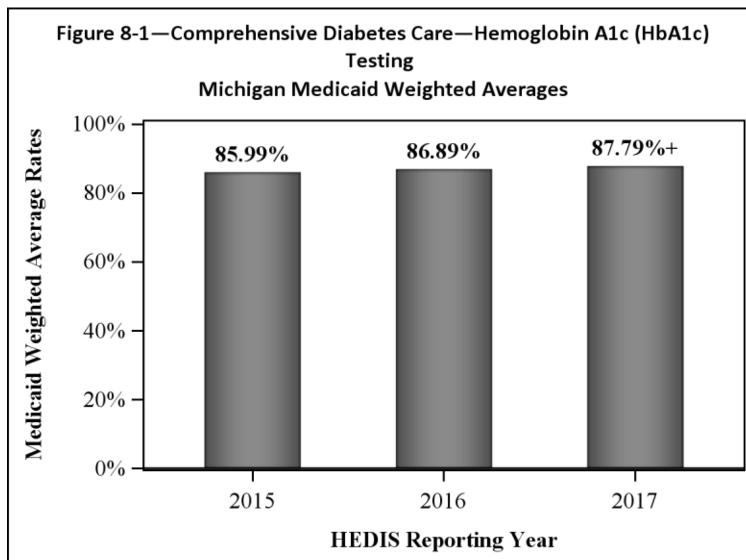
Additionally, for the *Medication Management for People With Asthma* measure, *Medication Compliance 75%—Total* rates for the MWA and seven MHPs demonstrated statistically significant improvement and *Medication Compliance 50%—Total* rates for the MWA and four MHPs demonstrated statistically significant improvement, indicating positive performance in this area. Of note, the MWA and four MHPs' rates for poor HbA1c control for diabetic members demonstrated statistically significant improvement, and the MWA and three MHPs' rates for proper HbA1c control for diabetic members demonstrated statistically significant improvement from HEDIS 2016 to HEDIS 2017. Further, blood pressure (BP) control rates for members with diabetes demonstrated statistically significant improvement for three MHPs and the MWA, and BP control rates for members with hypertension demonstrated statistically significant improvement for four MHPs and the MWA.

Conversely, the MWA rates for *Antidepressant Medication Management* and *Annual Monitoring for Patients on Persistent Medications* fell at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile, and the MWA for *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* fell below the national Medicaid 25th percentile. Additionally, rates for effective acute phase treatment for members on an antidepressant medication indicated statistically significant declines in performance for four MHPs and the MWA, and rates for effective continuation phase treatment for members on an antidepressant medication indicated statistically significant declines in performance for three MHPs and the MWA.

Measure-Specific Findings

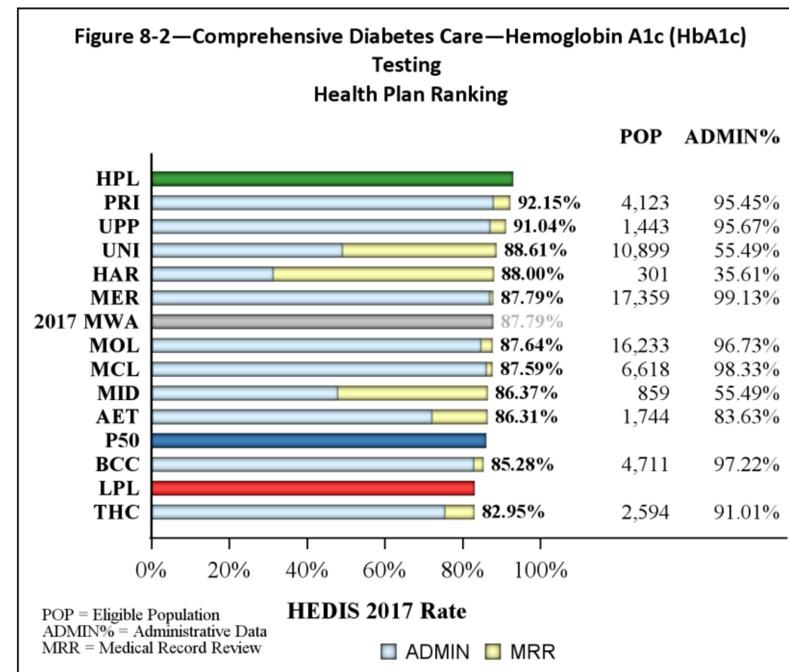
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing

Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. Due to changes in the technical specifications for this measure indicator, exercise caution when trending rates between 2016 and prior years.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

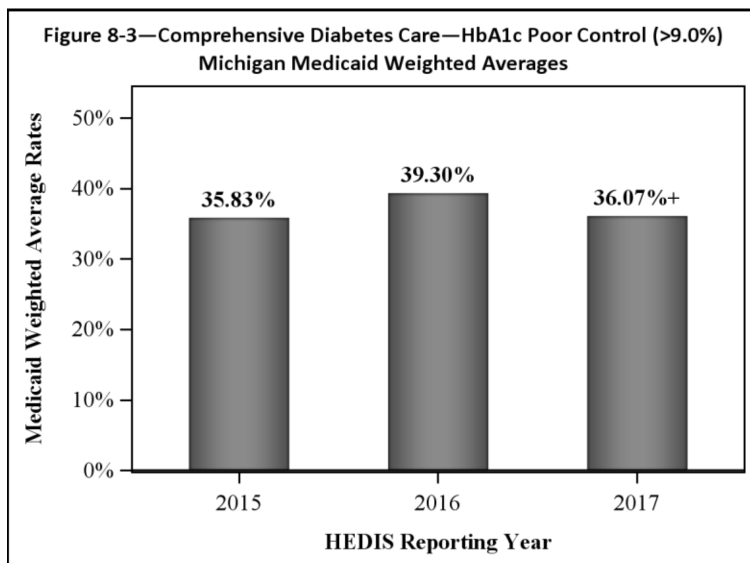
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



Nine MHPs and the MWA ranked above the national Medicaid 50th percentile, but below the HPL. One MHP fell below the LPL. MHP performance varied from 92.15 percent to 82.95 percent.

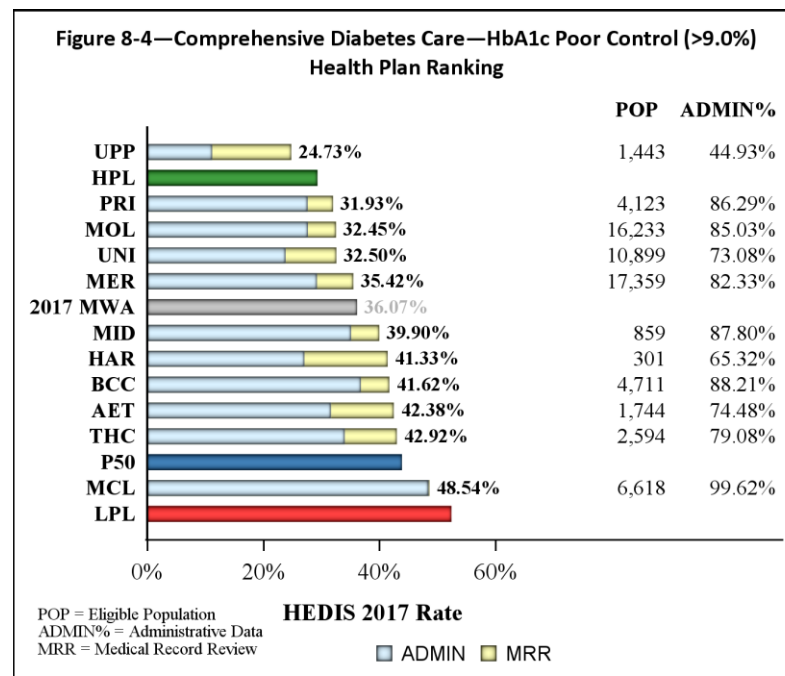
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)

Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%) assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control. For this measure, a lower rate indicates better performance. Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

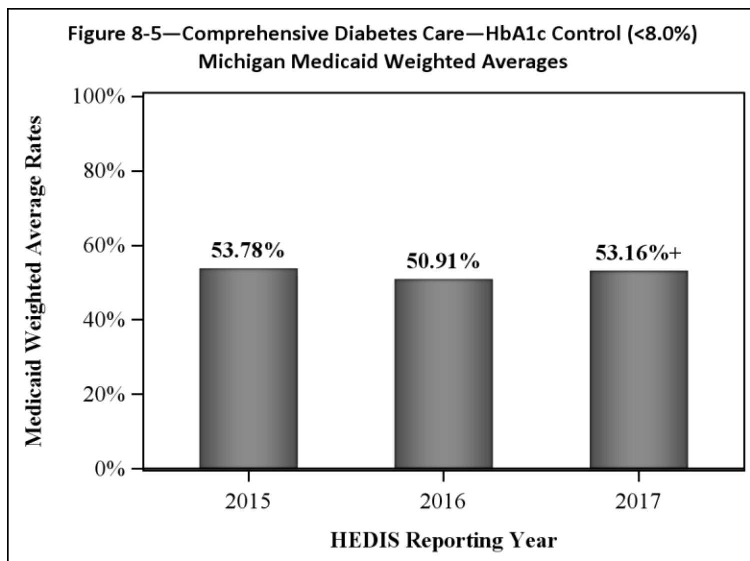
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



One MHP ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 48.54 percent to 24.73 percent.

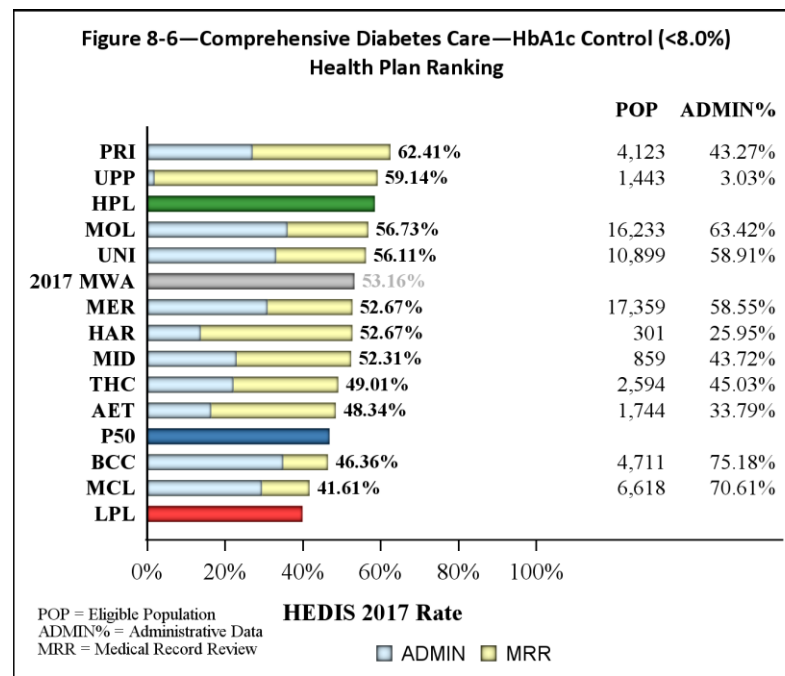
Comprehensive Diabetes Care—HbA1c Control (<8.0%)

Comprehensive Diabetes Care—HbA1c Control (<8.0%) assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c control (<8.0%). Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

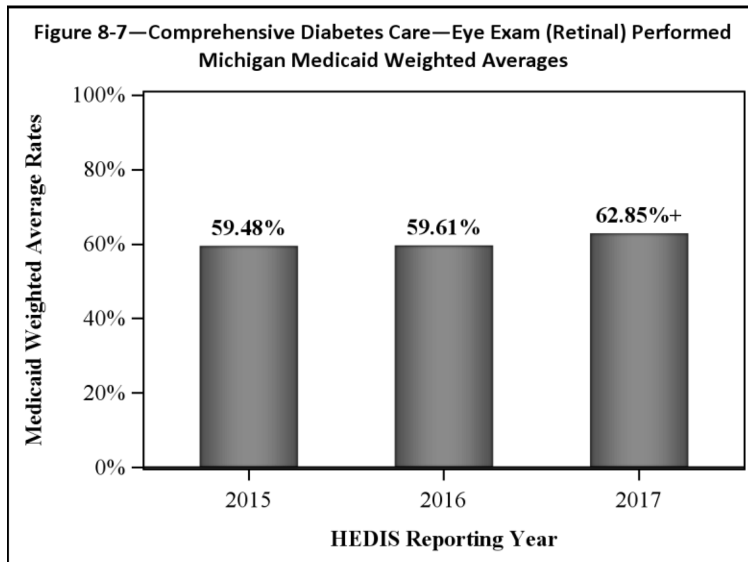
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



Two MHPs ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 62.41 percent to 41.61 percent.

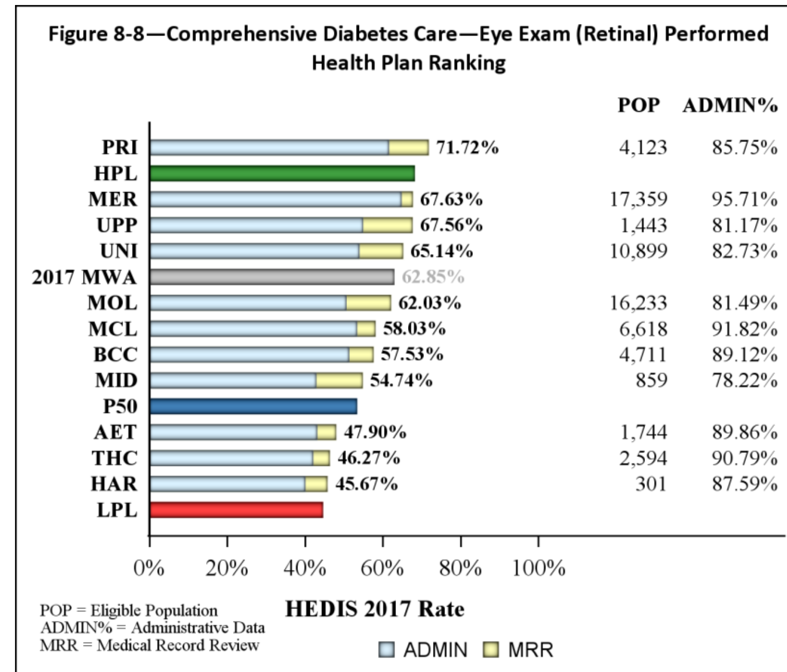
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement from HEDIS 2016.

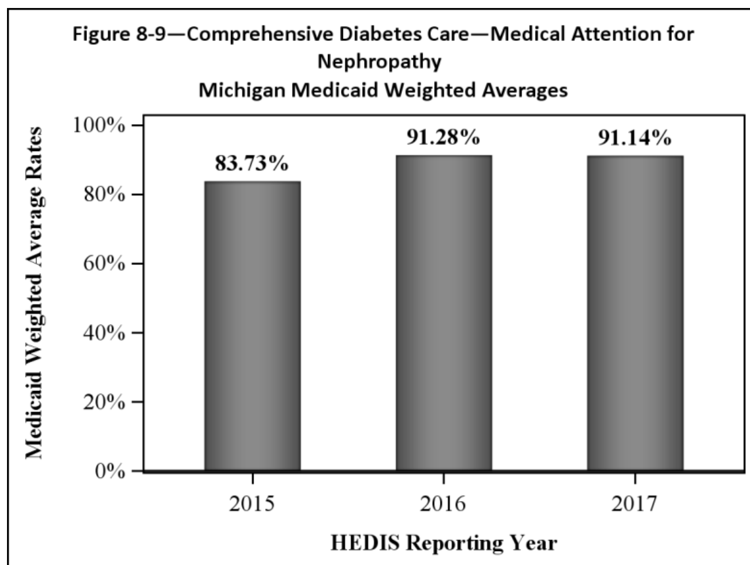


One MHP ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 71.72 percent to 45.67 percent.

Comprehensive Diabetes Care—Medical Attention for Nephropathy

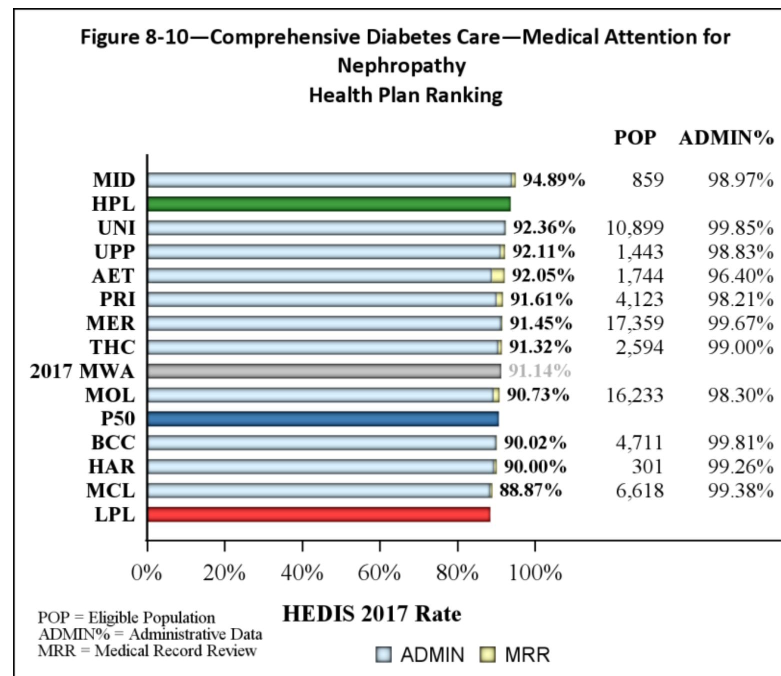
Comprehensive Diabetes Care—Medical Attention for Nephropathy assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy. Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

Figure 8-9—Comprehensive Diabetes Care—Medical Attention for Nephropathy
Michigan Medicaid Weighted Averages



The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.

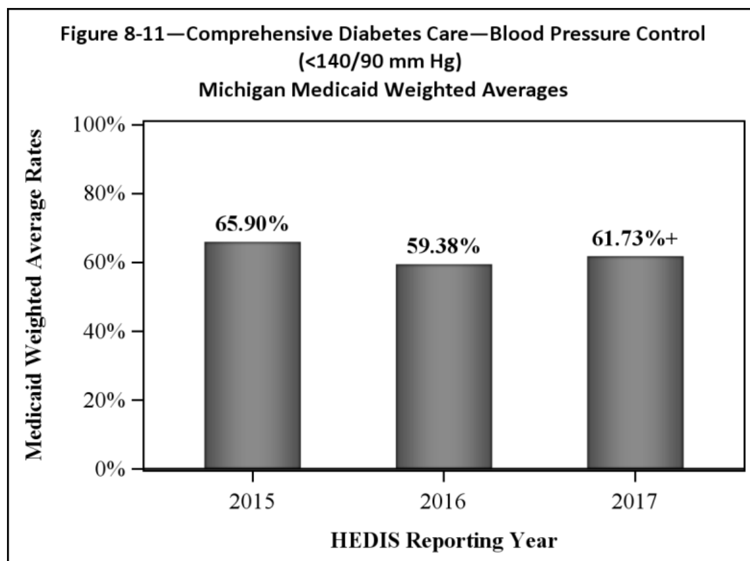
Figure 8-10—Comprehensive Diabetes Care—Medical Attention for Nephropathy
Health Plan Ranking



One MHP ranked above the HPL. No MHPs ranked below the LPL. MHP performance varied from 94.89 percent to 88.87 percent.

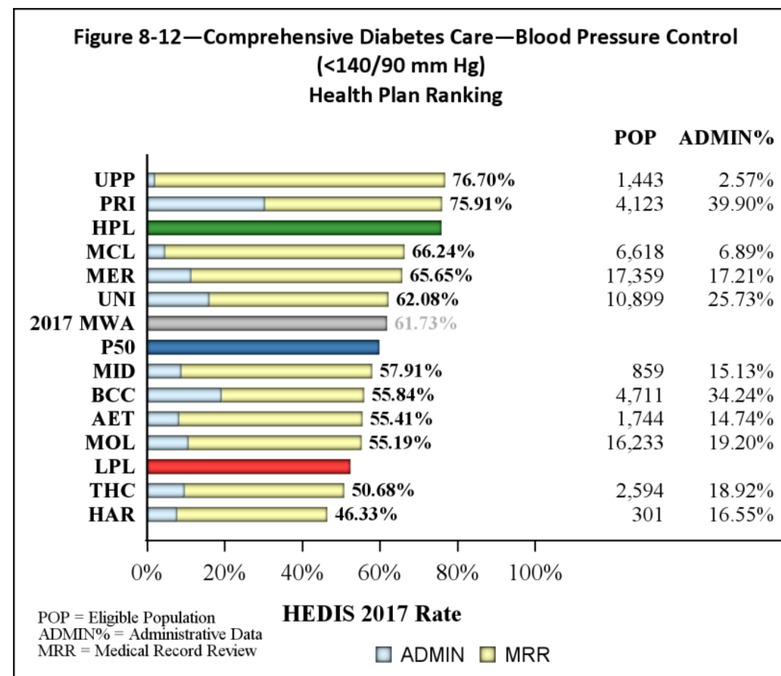
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)

Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had blood pressure control (<140/90 mm Hg). Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

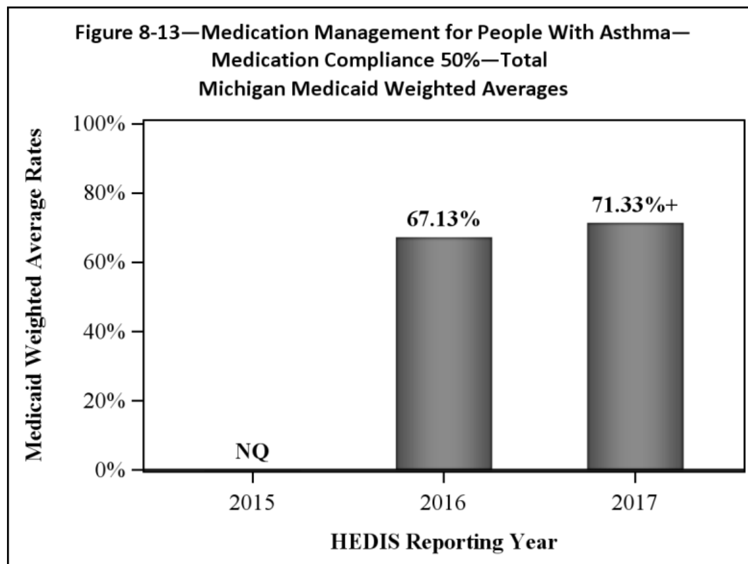
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



Two MHPs ranked above the HPL. Two MHPs fell below the LPL. MHP performance varied from 76.70 percent to 46.33 percent.

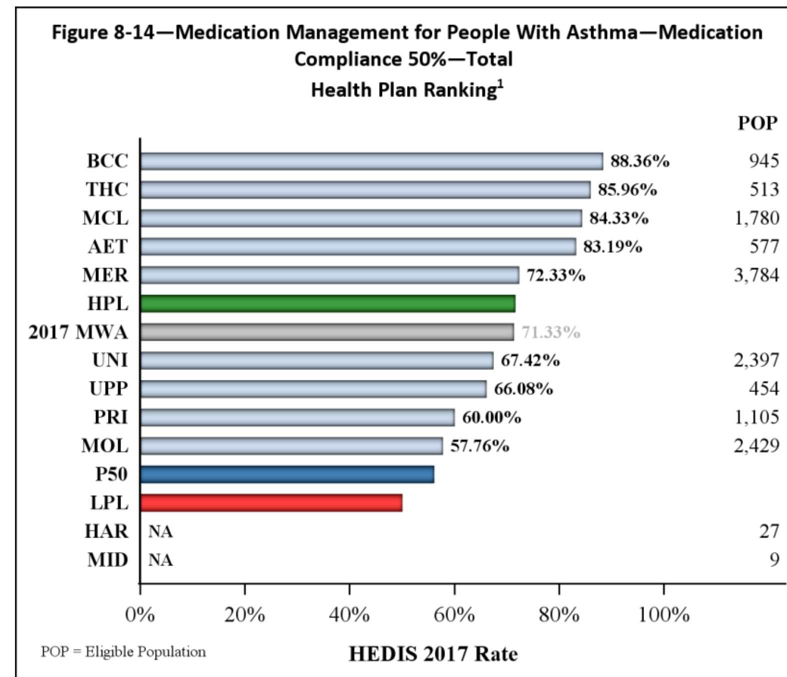
Medication Management for People with Asthma—Medication Compliance 50%—Total

Medication Management for People with Asthma—Medication Compliance 50%—Total assesses the percentage of members 5 to 64 years of age who were identified as having persistent asthma and were dispensed appropriate medications that they continued to take for at least 50 percent of their treatment period.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.
NQ indicates that this measure was not included in the HEDIS aggregate report for 2015.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.

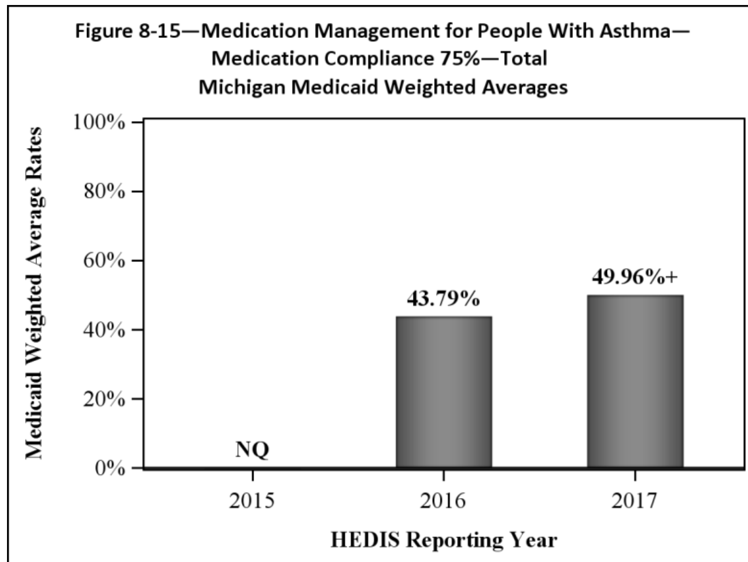


[1] *Quality Compass percentiles for this measure were not available; therefore, the rates for this measure indicator were compared to the NCQA Audit Means and Percentiles.*
NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Five MHPs ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 88.36 percent to 57.76 percent.

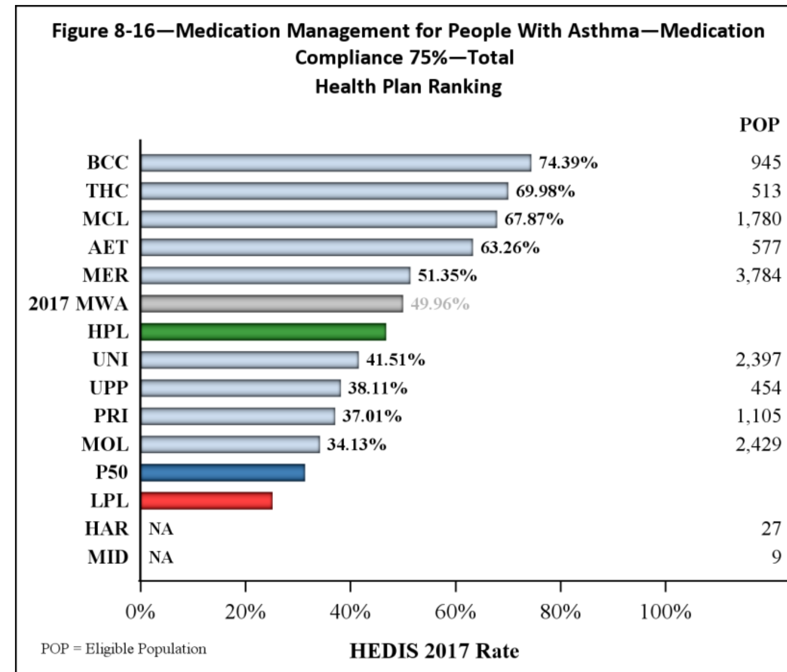
Medication Management for People with Asthma—Medication Compliance 75%—Total

Medication Management for People with Asthma—Medication Compliance 75%—Total assesses the percentage of members 5 to 64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they continued to take for at least 75 percent of their treatment period.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.
NQ indicates that this measure was not included in the HEDIS aggregate report for 2015.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.

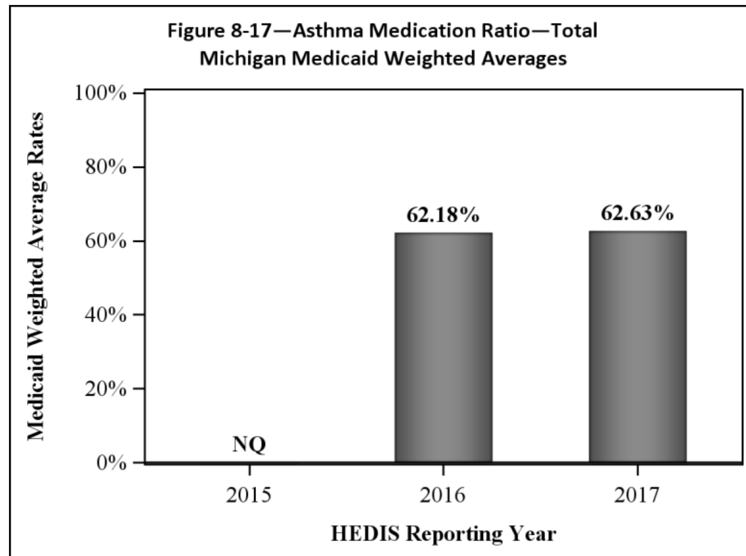


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Five MHPs and the MWA ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 74.39 percent to 34.13 percent.

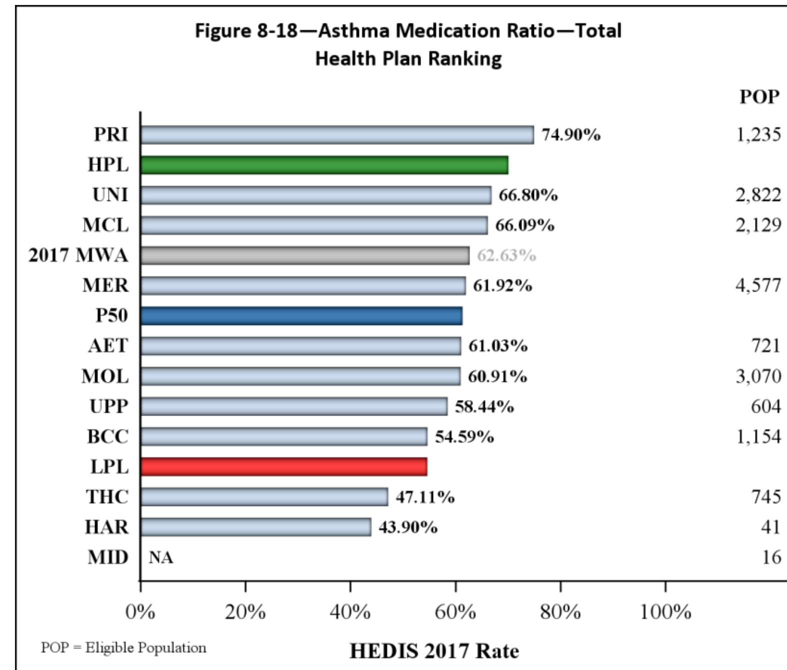
Asthma Medication Ratio—Total

Asthma Medication Ratio—Total assesses the percentage of patients 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.



NQ indicates that this measure was not included in the HEDIS aggregate report for 2015.

The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.

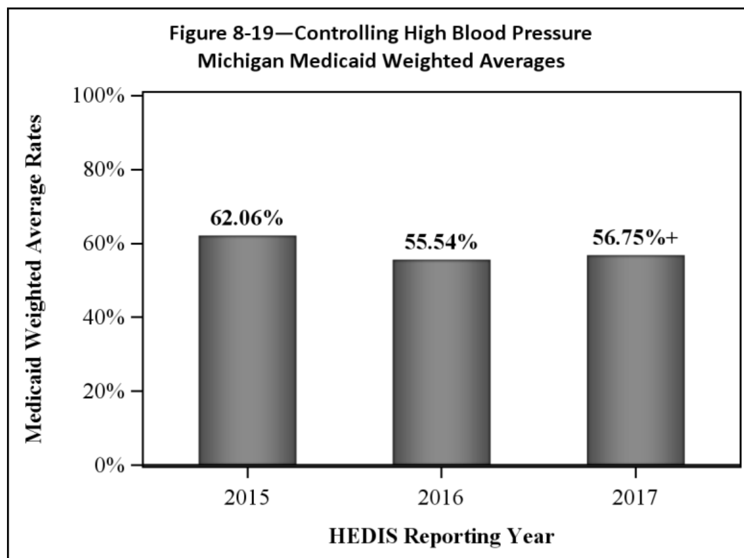


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

One MHP ranked above the HPL. Two MHPs fell below the LPL. MHP performance varied from 74.90 percent to 43.90 percent.

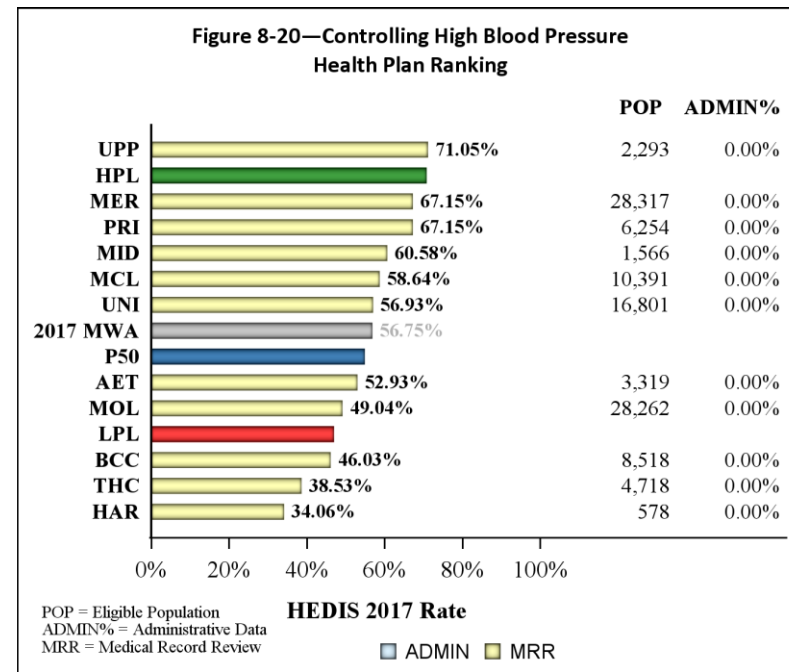
Controlling High Blood Pressure

Controlling High Blood Pressure assesses the percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year based on the following criteria: Members 18 to 59 years of age whose BP was <140/90 mm Hg; Members 60 to 85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg; and Members 60 to 85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

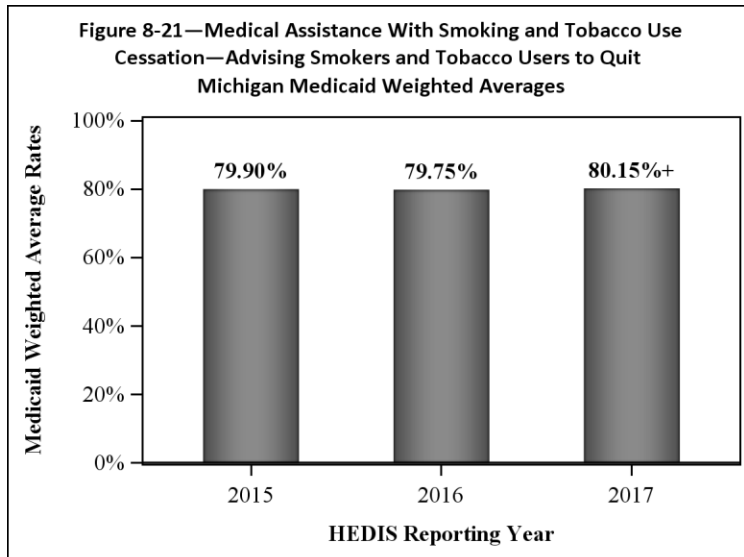
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



One MHP ranked above the HPL. Three MHPs fell below the LPL. MHP performance varied from 71.05 percent to 34.06 percent.

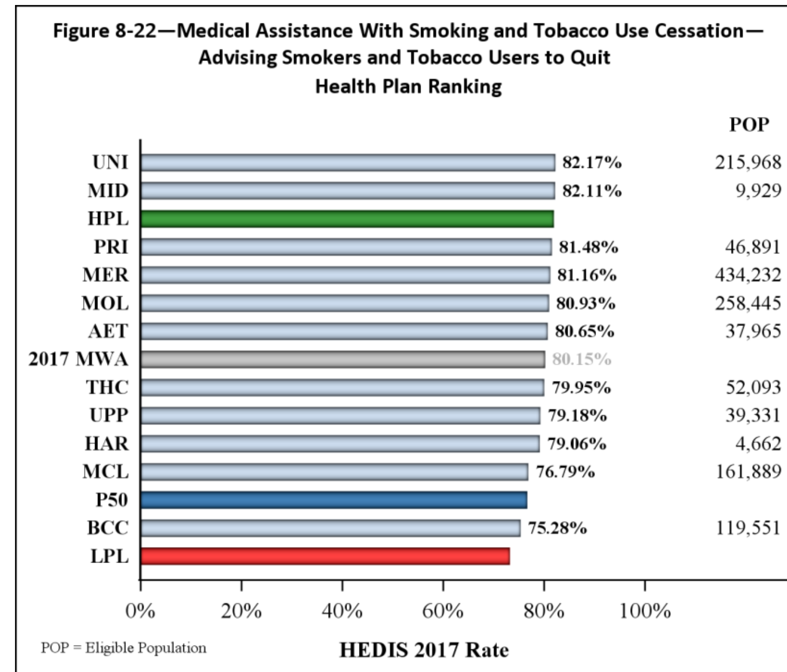
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit

Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit assesses the percentage of members 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

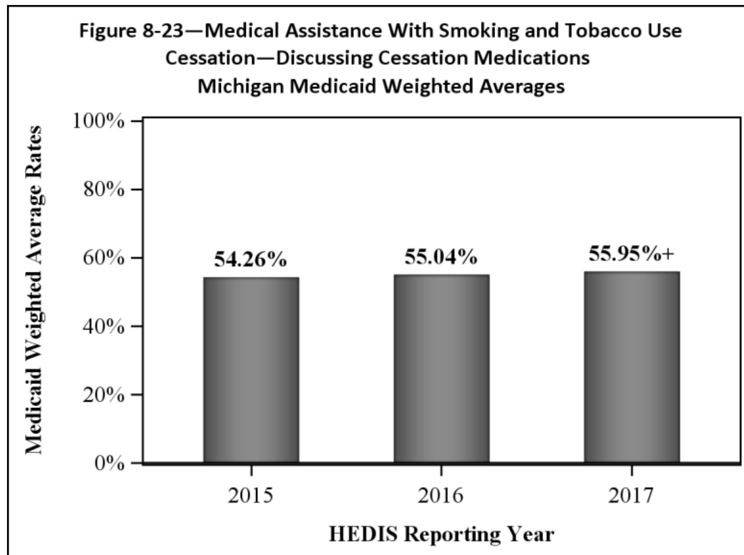
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



Two MHPs ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 82.17 percent to 75.28 percent.

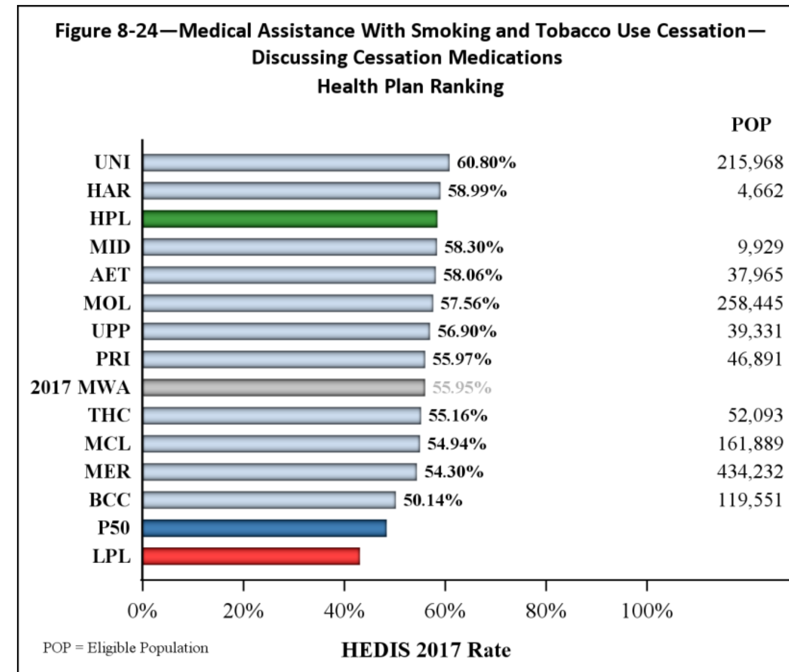
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications

Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications assesses the percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

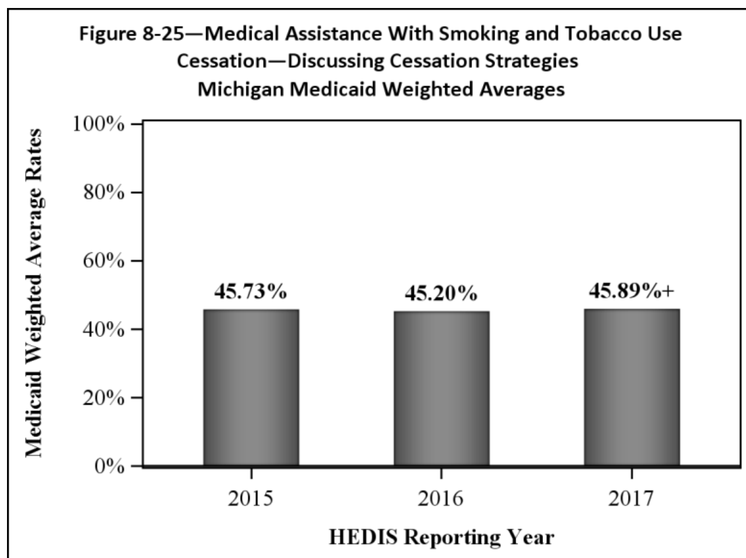
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



Two MHPs ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 60.80 percent to 50.14 percent.

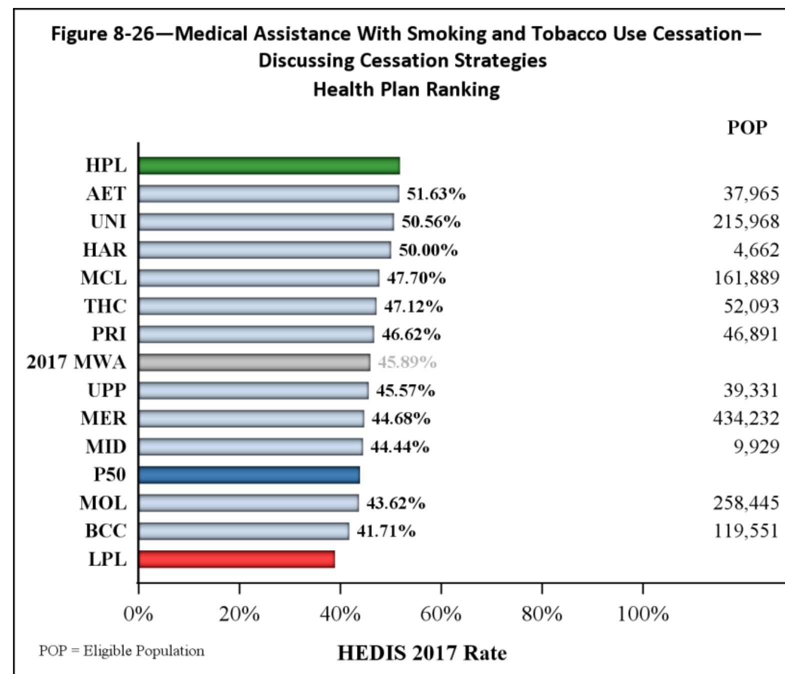
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies

Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies assesses the percentage of members 18 years of age or older who are current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

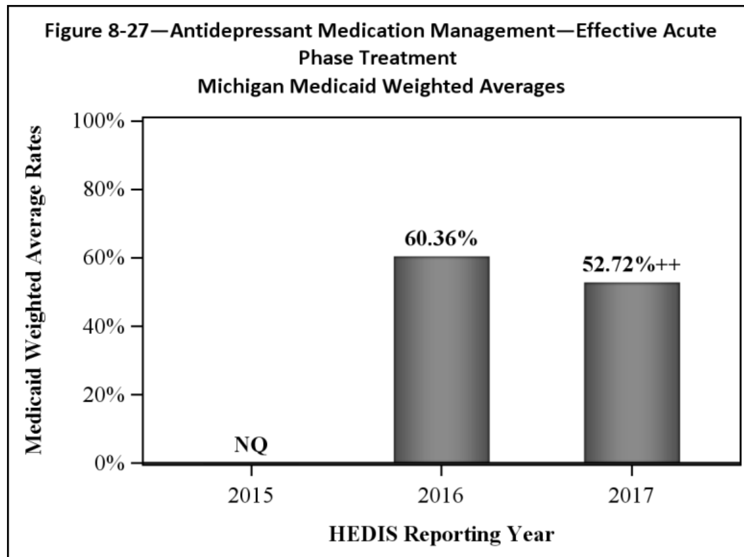
The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.



Nine MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. No MHPs fell below the LPL. MHP performance varied from 51.63 percent to 41.71 percent.

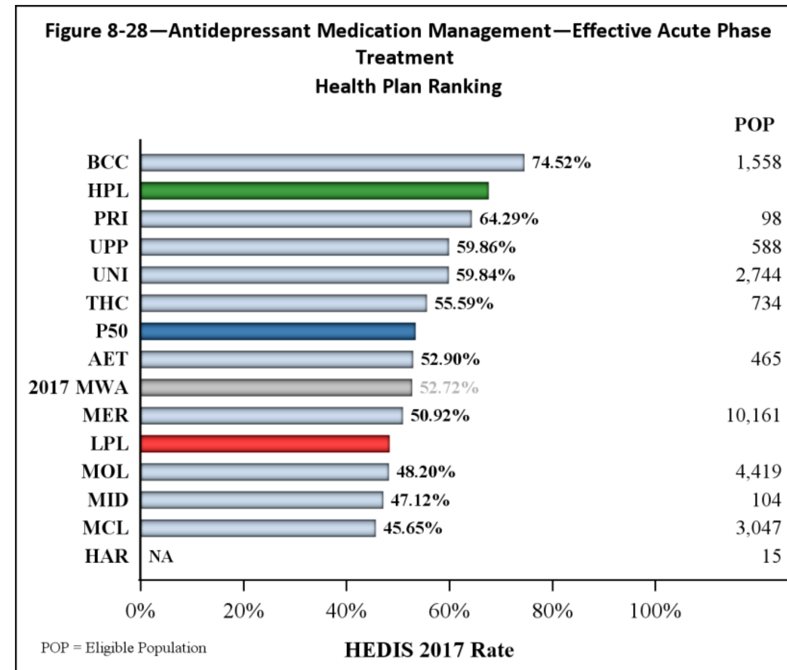
Antidepressant Medication Management—Effective Acute Phase Treatment

Antidepressant Medication Management—Effective Acute Phase Treatment assesses the percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks).



Rates with two crosses (++) indicate a significant decline in performance from the previous year.
NQ indicates that this measure was not included in the HEDIS aggregate report for 2015.

The HEDIS 2017 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2016.

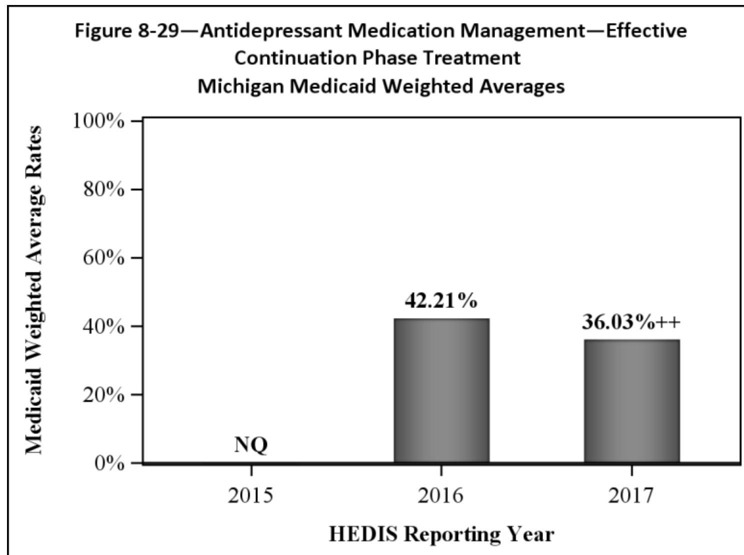


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

One MHP ranked above the HPL. Three MHPs fell below the LPL. MHP performance varied from 74.52 percent to 45.65 percent.

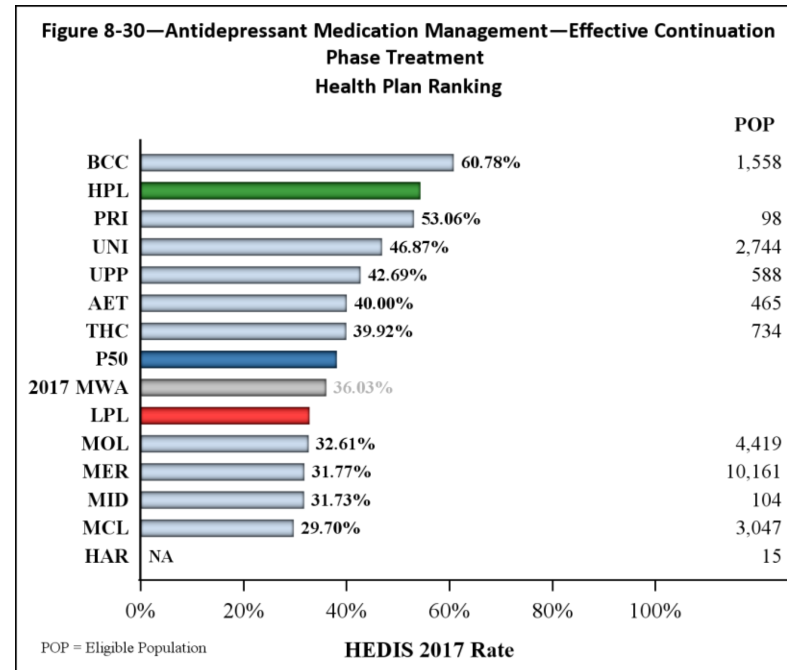
Antidepressant Medication Management—Effective Continuation Phase Treatment

Antidepressant Medication Management—Effective Continuation Phase Treatment assesses the percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months).



Rates with two crosses (++) indicate a significant decline in performance from the previous year.
NQ indicates that this measure was not included in the HEDIS aggregate report for 2015.

The HEDIS 2017 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2016.

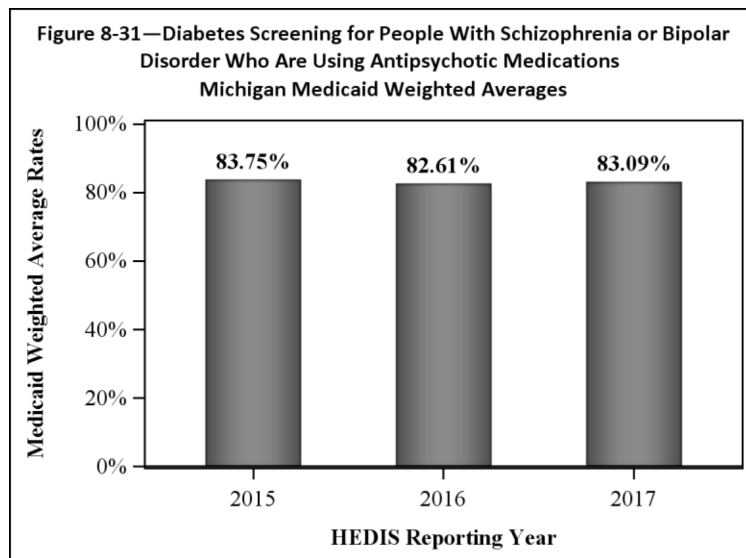


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

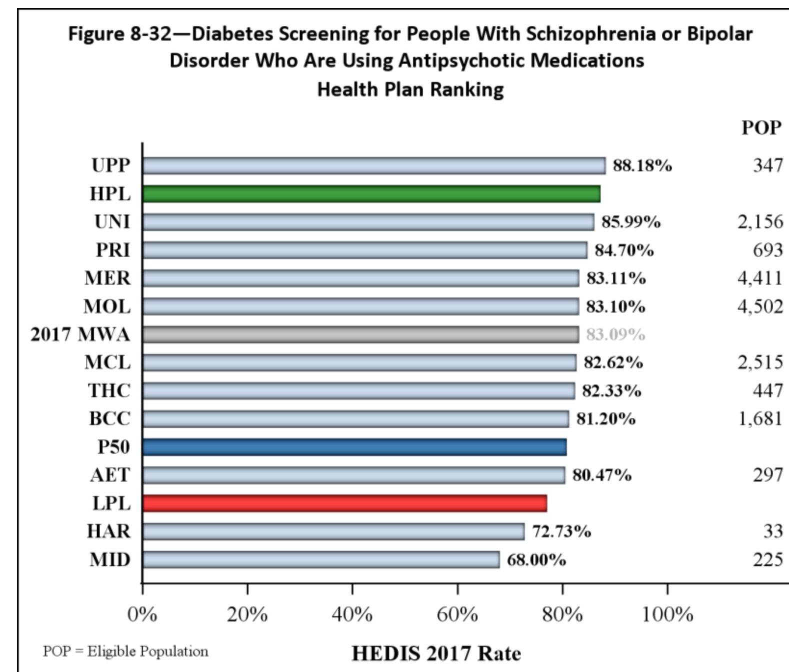
One MHP ranked above the HPL. Four MHPs fell below the LPL. MHP performance varied from 60.78 percent to 29.70 percent.

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications assesses the percentage of members between 18 and 64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.



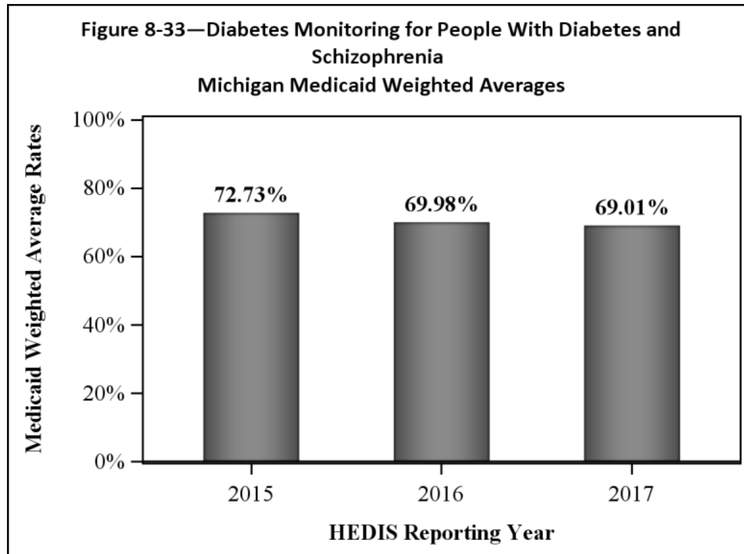
The HEDIS 2017 MWA rate did not demonstrate a statistically significant change from HEDIS 2016.



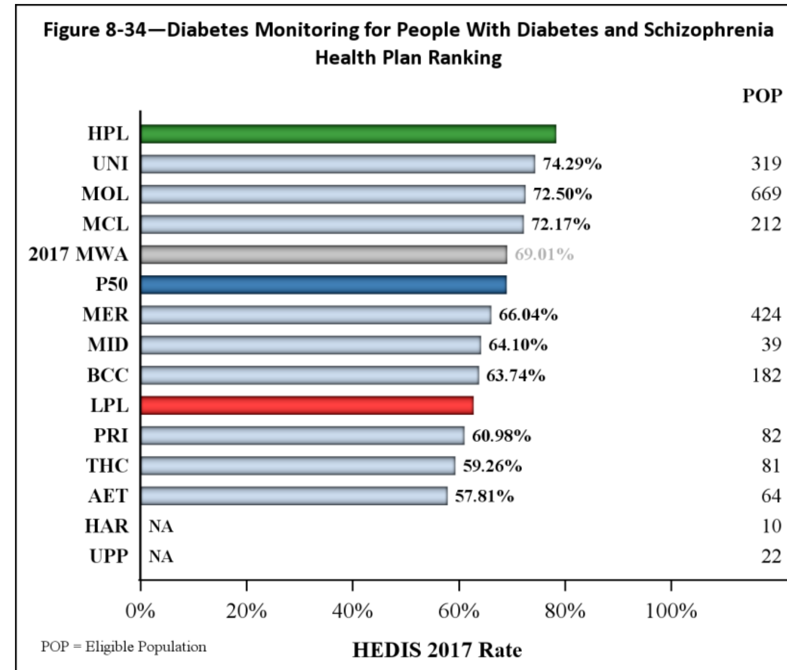
One MHP ranked above the HPL. Two MHPs fell below the LPL. MHP performance varied from 88.18 percent to 68.00 percent.

Diabetes Monitoring for People With Diabetes and Schizophrenia

Diabetes Monitoring for People With Diabetes and Schizophrenia assesses the percentage of members between 18 and 64 years of age with schizophrenia and diabetes, who had both a low-density lipoprotein cholesterol (LDL-C) test and an HbA1c test during the measurement year.



The HEDIS 2017 MWA rate did not demonstrate a statistically significant change from HEDIS 2016.

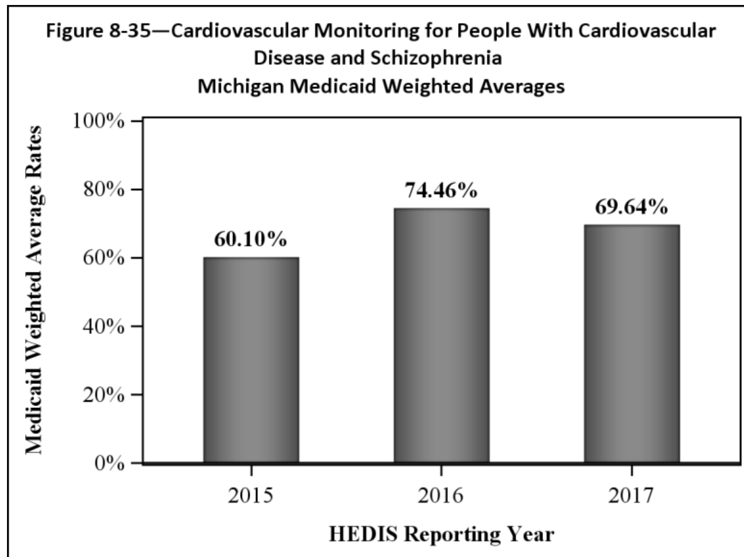


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

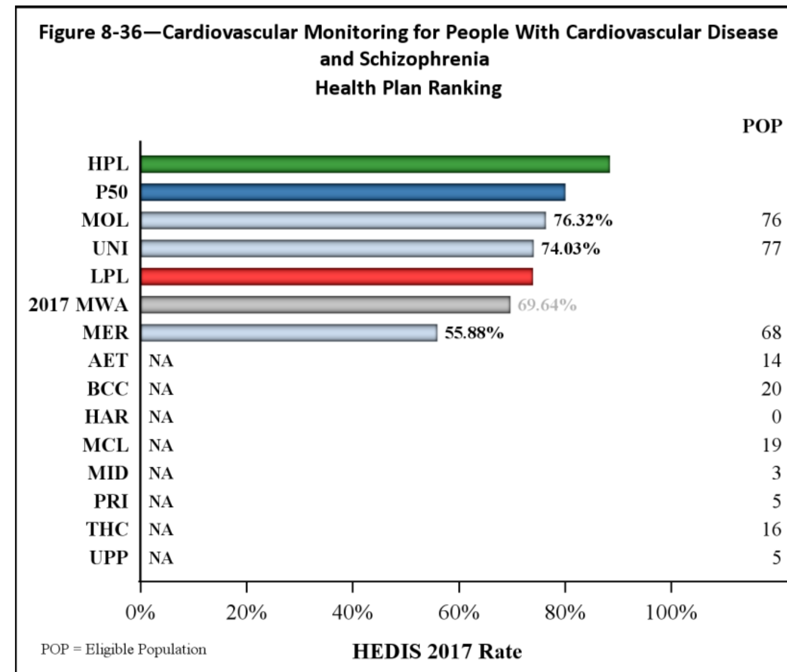
Three MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. Three MHPs fell below the LPL. MHP performance varied from 74.29 percent to 57.81 percent.

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia assesses the percentage of members between 18 and 64 years of age with schizophrenia and cardiovascular disease who had an LDL-C test during the measurement year.



The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.

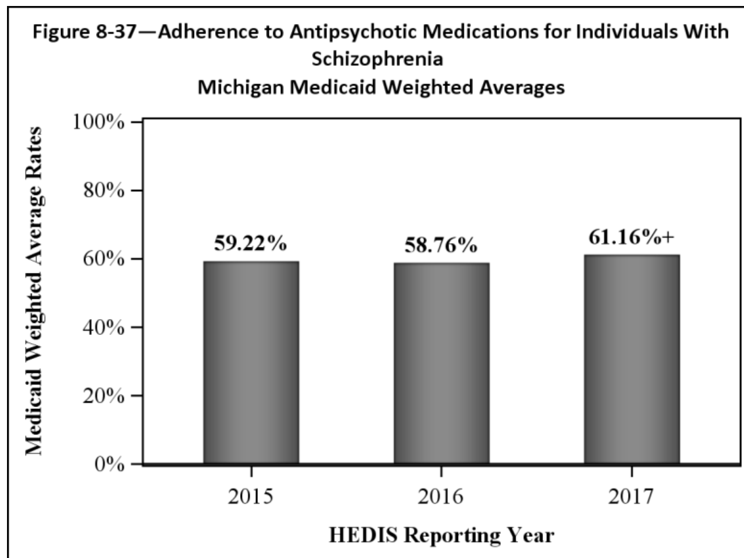


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

No MHPs ranked above the HPL. One MHP and the MWA fell below the LPL. MHP performance varied from 76.32 percent to 55.88 percent.

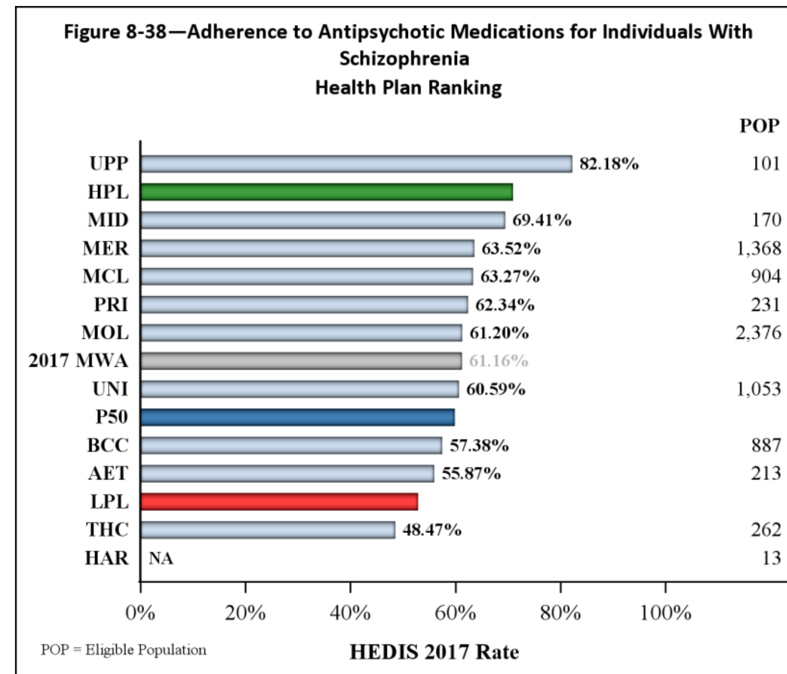
Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Adherence to Antipsychotic Medications for Individuals With Schizophrenia assesses the percentage of members between 19 and 64 years of age with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period. Due to changes in the technical specifications for this measure indicator, exercise caution when trending rates between 2016 and prior years.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS 2017 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2016.

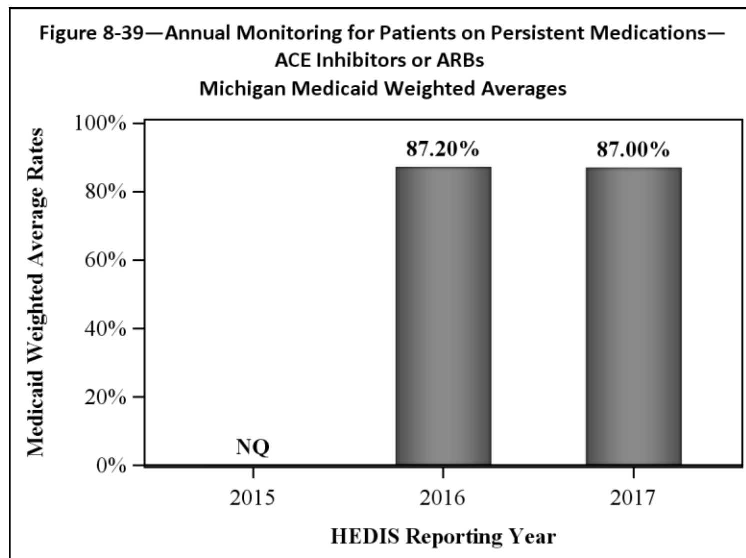


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

One MHP ranked above the HPL. One MHP fell below the LPL. MHP performance varied from 82.18 percent to 48.47 percent.

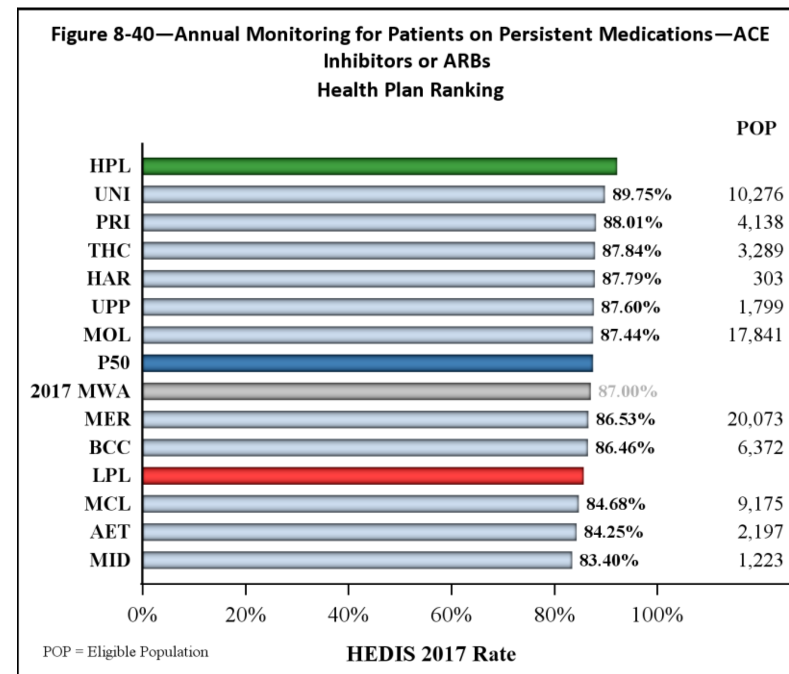
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs

Annual Monitoring for Patients on Persistent Medications–ACE Inhibitors or ARBs assesses the percentage of patients 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) and had at least one serum potassium and serum creatinine therapeutic monitoring test in the measurement year.



NQ indicates that this measure was not included in the HEDIS aggregate report for 2015.

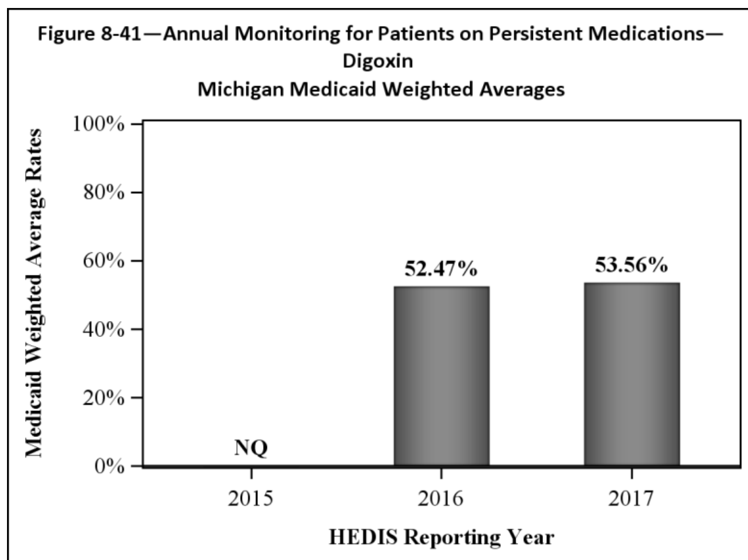
The HEDIS 2017 MWA rate did not demonstrate a statistically significant change from HEDIS 2016.



Six MHPs ranked above the national Medicaid 50th percentile but below the HPL. Three MHPs fell below the LPL. MHP performance varied from 89.75 percent to 83.40 percent.

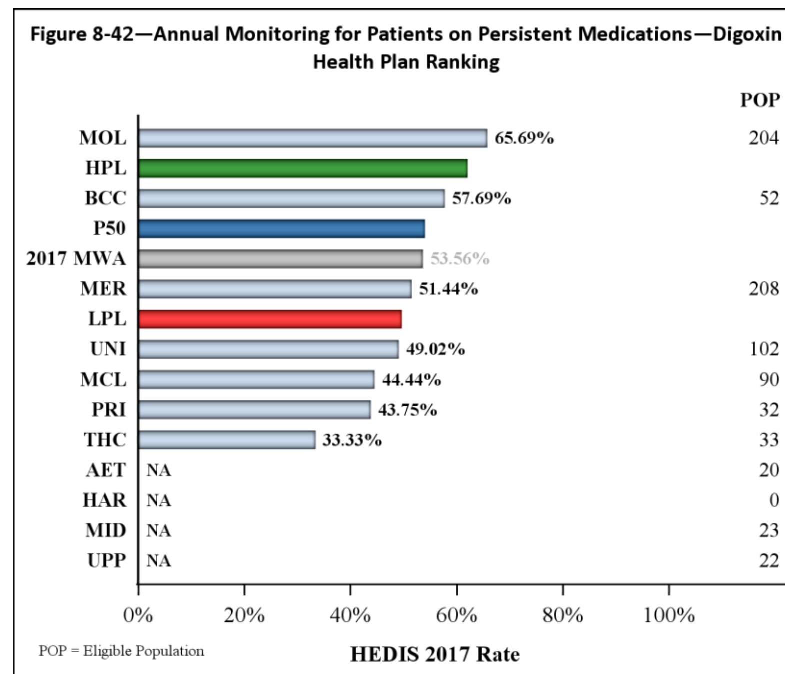
Annual Monitoring for Patients on Persistent Medications—Digoxin

Annual Monitoring for Patients on Persistent Medications—Digoxin assesses the percentage of patients 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for digoxin and had at least one serum potassium, one serum creatinine, and at least one serum digoxin therapeutic monitoring test in the measurement year.



NQ indicates that this measure was not included in the 2015 aggregate report.

The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.

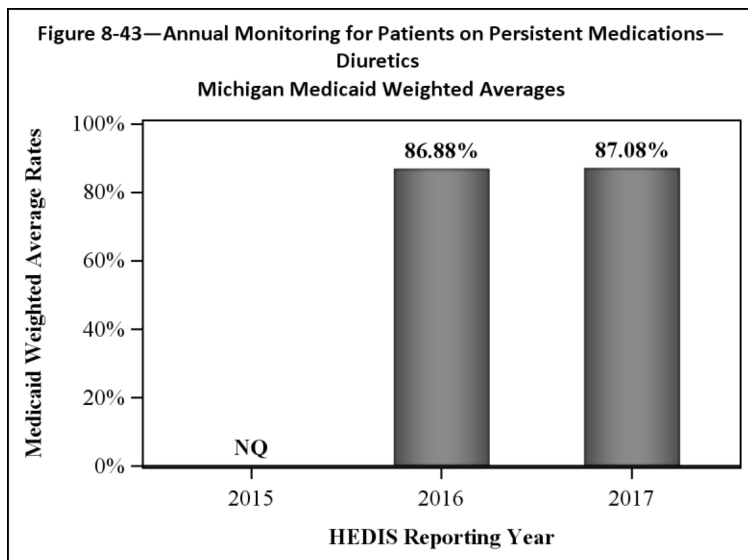


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

One MHP ranked above the HPL. Four MHPs fell below the LPL. MHP performance varied from 65.69 percent to 33.33 percent.

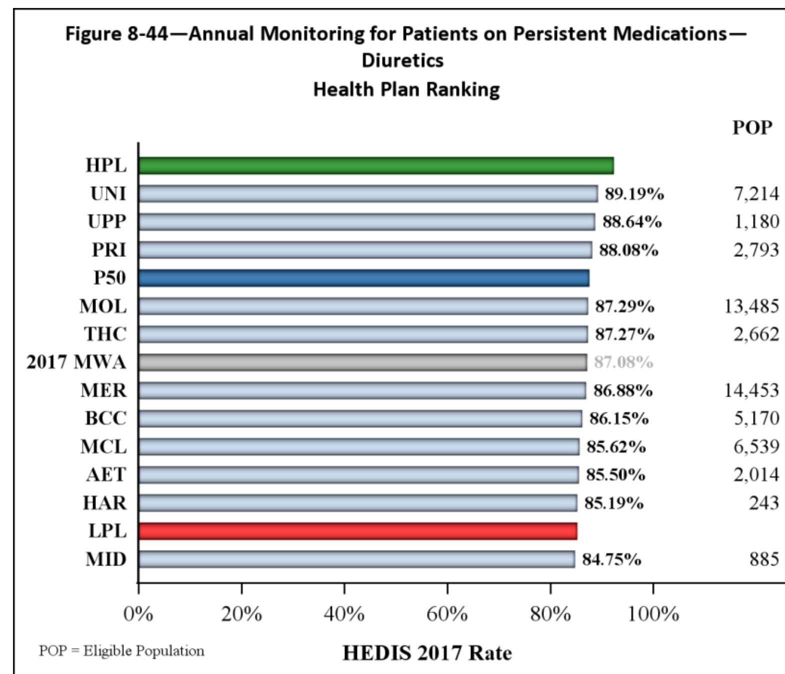
Annual Monitoring for Patients on Persistent Medications—Diuretics

Annual Monitoring for Patients on Persistent Medications—Diuretics assesses the percentage of patients 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for diuretics and had at least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year.



NQ indicates that this measure was not included in the 2015 aggregate report.

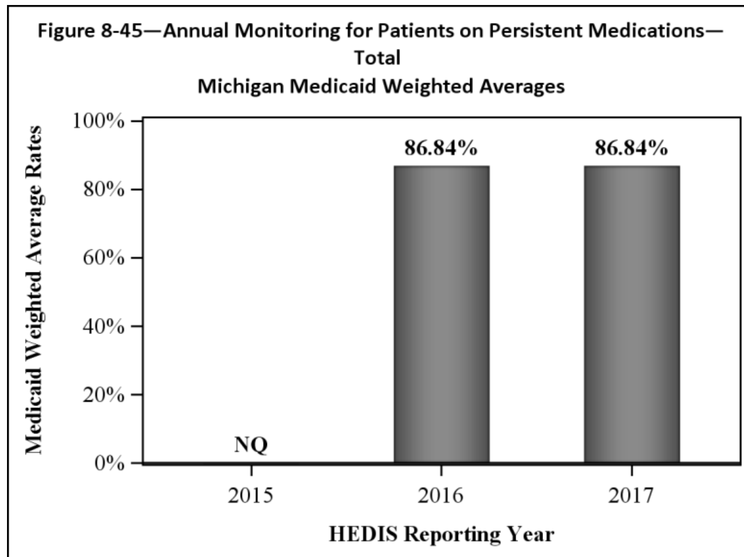
The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.



Three MHPs ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 89.19 percent to 84.75 percent.

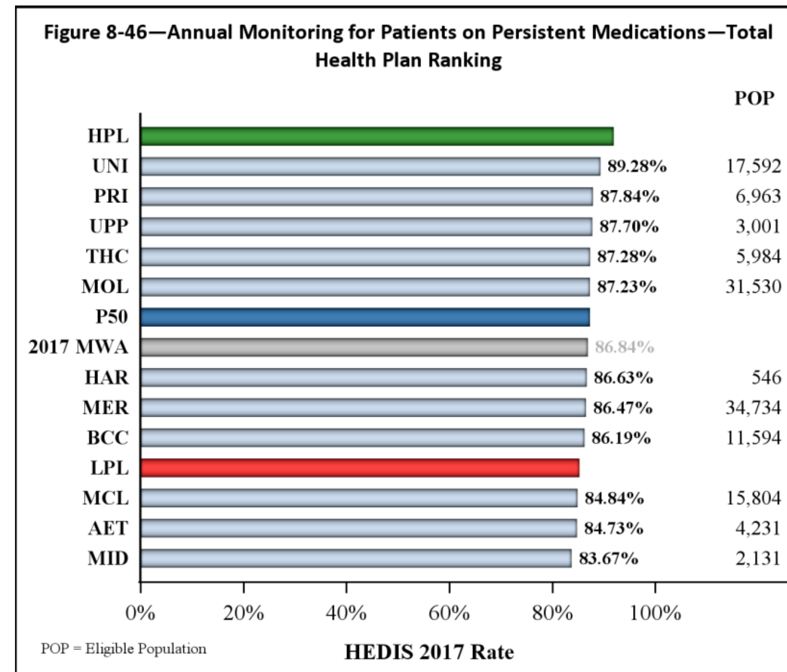
Annual Monitoring for Patients on Persistent Medications—Total

Annual Monitoring for Patients on Persistent Medications–Total assesses the percentage of patients 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for ACE inhibitors or ARBs, digoxin, or diuretics during the measurement year and had at least one therapeutic monitoring event for the agent in the measurement year.



NQ indicates that this measure was not included in the 2015 aggregate report.

The HEDIS 2017 MWA rate did not demonstrate a statistically significant change in performance from HEDIS 2016.



Five MHPs ranked above the national Medicaid 50th percentile but below the HPL. Three MHPs fell below the LPL. MHP performance varied from 89.28 percent to 83.67 percent.

9. Health Plan Diversity

Introduction

The Utilization measure domain encompasses the following MDHHS measures:

- *Race/Ethnicity Diversity of Membership*
- *Language Diversity of Membership*

Summary of Findings

When comparing the HEDIS 2016 and HEDIS 2017 statewide rates for the *Race/Ethnicity Diversity of Membership* measure, the 2017 rates exhibited variability across every category reported by Michigan MHP members.

For the *Language Diversity of Membership* measure at the statewide level, the percentage of members using English as the preferred spoken language for healthcare increased slightly from the previous year, with a slight decline in the Unknown category. The percentage of Michigan members reporting English as the language preferred for written materials increased in HEDIS 2017 while the Unknown category showed almost an 8 percent decrease from HEDIS 2016. Regarding other language needs, the percentage of members reporting English in HEDIS 2017 increased slightly, while Non-English and Unknown decreased from HEDIS 2016.

Race/Ethnicity Diversity of Membership

Measure Definition

Race/Ethnicity Diversity of Membership is an unduplicated count and percentage of members enrolled at any time during the measurement year, by race and ethnicity.

Results

Tables 9-1a and 9-1b show that the statewide rates for different racial/ethnic groups were fairly stable when compared to 2016.

Table 9-1a—MHP and MWA Results for Race/Ethnicity Diversity of Membership

MHP	Eligible Population	White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian and Other Pacific Islanders
AET	62,380	26.93%	60.30%	0.15%	0.66%	0.04%
BCC	222,388	42.89%	35.79%	0.42%	1.63%	0.07%
HAR	14,858	28.46%	51.78%	1.13%	2.09%	0.00%
MCL	227,278	66.67%	17.27%	0.54%	0.00%	0.79%
MER	630,685	61.97%	21.51%	0.49%	0.73%	0.06%
MID	11,618	46.63%	35.69%	0.00%	2.36%	0.29%
MOL	479,738	46.28%	32.97%	0.28%	0.32%	<0.01%
PRI	156,623	61.71%	13.87%	0.55%	0.91%	0.06%
THC	73,500	30.70%	53.90%	0.27%	1.21%	0.06%
UNI	336,235	50.85%	30.38%	0.26%	2.11%	0.01%
UPP	58,886	87.04%	1.46%	2.41%	0.26%	0.05%
HEDIS 2017 MWA		**53.98%**	**27.55%**	**0.45%**	**0.89%**	**0.12%**
HEDIS 2016 MWA		**54.01%**	**28.00%**	**0.49%**	**1.09%**	**0.05%**
HEDIS 2015 MWA		**53.44%**	**29.35%**	**0.33%**	**1.24%**	**0.06%**

Table 9-1b—MHP and MWA Results for Race/Ethnicity Diversity of Membership (Continued)

MPH	Eligible Population	Some Other Race	Two or More Races	Unknown	Declined	Hispanic or Latino *
AET	62,380	0.00%	0.00%	5.66%	6.26%	2.92%
BCC	222,388	6.59%	0.00%	10.00%	2.61%	1.58%
HAR	14,858	0.00%	0.00%	16.54%	0.00%	3.59%
MCL	227,278	5.51%	0.00%	9.22%	0.00%	5.51%
MER	630,685	<0.01%	0.00%	5.76%	9.48%	5.75%
MID	11,618	2.64%	0.00%	12.39%	0.00%	2.64%
MOL	479,738	0.00%	<0.01%	20.15%	0.00%	6.40%
PRI	156,623	<0.01%	0.00%	22.89%	0.00%	10.73%
THC	73,500	2.55%	0.00%	11.31%	0.00%	2.55%
UNI	336,235	0.00%	0.00%	16.40%	0.00%	5.61%
UPP	58,886	1.49%	0.00%	0.00%	7.30%	1.49%
HEDIS 2017 MWA		**1.33%**	**0.00%**	**12.44%**	**3.25%**	**5.46%**
HEDIS 2016 MWA		**1.23%**	**0.00%**	**12.23%**	**2.89%**	**5.64%**
HEDIS 2015 MWA		**0.44%**	**0.00%**	**12.40%**	**2.74%**	**5.40%**

** Starting from HEDIS 2011, the rates associated with members of Hispanic origin were not based on the total number of members in the health plan. Therefore, the rates presented here were calculated by HSAG using the total number of members reported from the Hispanic or Latino column divided by the total number of members in the health plan reported in the MHP IDSS files.*

Language Diversity of Membership

Measure Definition

Language Diversity of Membership is an unduplicated count and percentage of members enrolled at any time during the measurement year by spoken language preferred for healthcare and the preferred language for written materials.

Results

Table 9-2 shows that the percentage of members using English as the preferred spoken language for healthcare increased when compared to the previous year's percentage. The percentage of members with Non-English as the preferred language also increased when compared to the previous year's percentages. The percentage of members in the Unknown category decreased from previous years.

Table 9-2—MHP and MWA Results for Language Diversity of Membership— Spoken Language Preferred for Healthcare

MHP	Eligible Population	English	Non-English	Unknown	Declined
AET	62,380	0.00%	0.00%	100.00%	0.00%
BCC	222,388	97.90%	1.52%	0.59%	0.00%
HAR	14,858	99.04%	0.92%	0.05%	0.00%
MCL	227,278	96.45%	0.77%	2.78%	0.00%
MER	630,685	98.69%	1.29%	0.02%	0.00%
MID	11,618	100.00%	0.00%	0.00%	0.00%
MOL	479,738	98.76%	1.12%	0.12%	0.00%
PRI	156,623	0.00%	0.00%	100.00%	0.00%
THC	73,500	99.21%	0.79%	<0.01%	0.00%
UNI	336,235	95.71%	4.28%	<0.01%	0.00%
UPP	58,886	99.94%	0.03%	0.03%	0.00%
HEDIS 2017 MWA		**88.52%**	**1.49%**	**10.00%**	**0.00%**
HEDIS 2016 MWA		**88.26%**	**1.11%**	**10.63%**	**0.00%**
HEDIS 2015 MWA		**92.88%**	**1.34%**	**5.71%**	**0.07%**

Table 9-3 shows that the percentage of Michigan members reporting either English or Non-English as the language preferred for written materials increased in HEDIS 2017, with English increasing by more than 7 percentage points. In contrast, an almost 8 percent decrease occurred in the percentage of members reporting in the Unknown category. The same five plans that reported 100 percent in the Unknown category last year continued to report all of their members in the Unknown category in HEDIS 2017.

Table 9-3—MHP and MWA Results for Language Diversity of Membership— Preferred Language for Written Materials

MHP	Eligible Population	English	Non-English	Unknown	Declined
AET	62,380	0.00%	0.00%	100.00%	0.00%
BCC	222,388	97.90%	1.52%	0.59%	0.00%
HAR	14,858	0.00%	0.00%	100.00%	0.00%
MCL	227,278	0.00%	0.00%	100.00%	0.00%
MER	630,685	98.69%	1.29%	0.02%	0.00%
MID	11,618	0.00%	0.00%	100.00%	0.00%
MOL	479,738	98.76%	1.12%	0.12%	0.00%
PRI	156,623	0.00%	0.00%	100.00%	0.00%
THC	73,500	99.21%	0.79%	<0.01%	0.00%
UNI	336,235	95.71%	4.28%	<0.01%	0.00%
UPP	58,886	99.94%	0.03%	0.03%	0.00%
HEDIS 2017 MWA		**77.72%**	**1.40%**	**20.88%**	**0.00%**
HEDIS 2016 MWA		**70.13%**	**1.08%**	**28.79%**	**0.00%**
HEDIS 2015 MWA		**70.40%**	**1.27%**	**28.34%**	**0.00%**

Table 9-4 shows that the percentage of Michigan members reporting English as another language need increased in HEDIS 2017. Non-English as another language need also increased, while the Unknown category decreased in HEDIS 2017.

Table 9-4—MHP and MWA Results for Language Diversity of Membership—Other Language Needs

MHP	Eligible Population	English	Non-English	Unknown	Declined
AET	62,380	99.25%	0.63%	0.13%	0.00%
BCC	222,388	0.00%	0.00%	100.00%	0.00%
HAR	14,858	0.00%	0.00%	100.00%	0.00%
MCL	227,278	0.00%	0.00%	100.00%	0.00%
MER	630,685	98.69%	1.29%	0.02%	0.00%
MID	11,618	0.00%	0.00%	100.00%	0.00%
MOL	479,738	98.76%	1.12%	0.12%	0.00%
PRI	156,623	0.00%	0.00%	100.00%	0.00%
THC	73,500	99.21%	0.79%	<0.01%	0.00%
UNI	336,235	0.00%	0.00%	100.00%	0.00%
UPP	58,886	0.00%	0.00%	100.00%	0.00%
HEDIS 2017 MWA		**54.13%**	**0.64%**	**45.23%**	**0.00%**
HEDIS 2016 MWA		**52.71%**	**0.51%**	**46.78%**	**0.00%**
HEDIS 2015 MWA		**42.69%**	**0.51%**	**56.80%**	**0.00%**

10. Utilization

Introduction

The Utilization measure domain encompasses the following MDHHS measures:

- *Ambulatory Care—Total (Per 1,000 Member Months)*
  - *Emergency Department Visits—Total*
  - *Outpatient Visits—Total*
- *Inpatient Utilization—General Hospital/Acute Care*
  - *Total Inpatient—Discharges per 1,000 Member Months—Total*
  - *Total Inpatient—Average Length of Stay—Total*
  - *Maternity—Discharges per 1,000 Member Months—Total*
  - *Maternity—Average Length of Stay—Total*
  - *Surgery—Discharges per 1,000 Member Months—Total*
  - *Surgery—Average Length of Stay—Total*
  - *Medicine—Discharges per 1,000 Member Months—Total*
  - *Medicine—Average Length of Stay—Total*

The following tables present the HEDIS 2017 MHP-specific rates as well as the Michigan Medicaid Average (MA) for HEDIS 2017, HEDIS 2016, and HEDIS 2015. To align with calculations from prior years, HSAG calculated traditional averages for measure indicators in the Utilization measure domain; therefore, the MA is presented rather than the Medicaid Weighted Average (MWA), which was calculated and presented for all other measures. All measures in this domain are designed to describe the frequency of specific services provided by MHPs and are not risk adjusted. Therefore, it is important to assess utilization supplemented by information on the characteristics of each MHP's population.

Summary of Findings

As stated above, reported rates for the MHPs and MA rates for the Utilization measure domain did not take into account the characteristics of the population; therefore, HSAG could not draw conclusions on performance based on the reported utilization results. Nonetheless, combined with other performance metrics, the MHP and MA utilization results provide additional information that MHPs and MDHHS may use to assess barriers or patterns of utilization when evaluating improvement interventions.

Measure-Specific Findings

Ambulatory Care—Total (Per 1,000 Member Months)

The *Ambulatory* Care—*Total (Per 1,000 Member Months)* measure summarizes use of ambulatory care for *Emergency Department Visits—Total* and *Outpatient Visits—Total*. In this section, the results for the total age group are presented.

Results

Table 10-1 shows *Emergency Department Visits—Total* and *Outpatient Visits—Total* per 1,000 member months for ambulatory care for the total age group.

Table 10-1—Ambulatory Care—Total (Per 1,000 Member Months) for Total Age Group

MHP	Member Months	*Emergency Department Visits—Total**	*Outpatient Visits—Total*
AET	522,842	83.32	299.52
BCC	1,700,071	68.98	396.06
HAR	95,693	82.34	251.03
MCL	1,990,833	70.81	552.80
MER	5,556,684	77.48	398.30
MID	83,359	75.28	539.45
MOL	4,372,810	71.94	424.09
PRI	1,339,494	75.21	378.48
THC	655,102	73.95	333.36
UNI	3,028,514	72.58	368.15
UPP	517,563	66.21	341.01
HEDIS 2017 MA		**74.37**	**389.30**
HEDIS 2016 MA		**74.00**	**373.49**
HEDIS 2015 MA		**70.20**	**340.77**

** A lower rate may indicate more favorable performance for this measure indicator (i.e., low rates of emergency department services may indicate better utilization of services).*

For the *Emergency Department Visits—Total* indicator, MHP performance varied, with 66.21 as the lowest number of visits per 1,000 member months and 83.32 as the highest number of visits per 1,000 member months.

Inpatient Utilization—General Hospital/Acute Care—Total

The *Inpatient Utilization—General Hospital/Acute Care—Total* measure summarizes use of acute inpatient care and services in four categories: *Total Inpatient, Medicine, Surgery,* and *Maternity*.

Results

Table 10-2 shows the member months for all ages and the *Total Discharges per 1,000 Member Months* for the total age group. The values in the table below are presented for information purposes only.

Table 10-2—Inpatient Utilization—General Hospital/Acute Care: Total Discharges per 1,000 Member Months for Total Age Group

MHP	Member Months	*Total Inpatient*	*Medicine*	*Surgery*	*Maternity**
AET	522,842	8.43	4.86	2.05	2.05
BCC	1,700,071	7.94	3.87	1.90	2.80
HAR	95,693	9.03	4.85	2.73	0.26
MCL	1,990,833	8.38	1.47	4.09	2.72
MER	5,556,684	8.10	3.74	1.90	3.42
MID	83,359	16.85	12.46	3.59	1.30
MOL	4,372,810	7.42	3.71	1.82	2.65
PRI	1,339,494	7.00	3.10	1.63	3.25
THC	655,102	10.15	6.07	2.30	2.37
UNI	3,028,514	5.59	2.44	1.37	2.49
UPP	517,563	6.54	2.66	1.95	2.61
HEDIS 2017 MA		**8.68**	**4.48**	**2.30**	**2.36**
HEDIS 2016 MA		**8.27**	**4.52**	**1.83**	**2.59**
HEDIS 2015 MA		**8.02**	**4.02**	**1.62**	**3.62**

** The Maternity measure indicators were calculated using member months for members 10 to 64 years of age.*

Table 10-3 displays the *Total Average Length of Stay* for all ages and are presented for information purposes only.

Table 10-3—Inpatient Utilization—General Hospital/Acute Care: Total Average Length of Stay for Total Age Group

MHP	*Total Inpatient*	*Medicine*	*Surgery*	*Maternity*
AET	3.93	3.33	6.35	2.58
BCC	3.92	3.43	6.37	2.65
HAR	4.15	3.53	4.80	2.47*
MCL	3.87	3.61	4.70	2.46
MER	3.99	3.77	6.29	2.55
MID	BR	BR	BR	BR
MOL	4.62	4.04	7.75	2.78
PRI	3.54	3.80	4.35	2.60
THC	4.01	3.45	6.54	2.63
UNI	4.33	4.37	6.56	2.57
UPP	3.79	3.32	5.42	2.80
HEDIS 2017 MA	**4.02**	**3.67**	**5.91**	**2.61**
HEDIS 2016 MA	**3.98**	**3.64**	**6.18**	**2.63**
HEDIS 2015 MA	**3.99**	**3.77**	**6.50**	**2.65**

** Indicates fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.*
BR (Biased Rate) indicates that HAP Midwest's (MID's) rate for this measure was invalid; therefore, the rate is not presented.

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11. HEDIS Reporting Capabilities—Information Systems Findings

HEDIS Reporting Capabilities—Information Systems Findings

NCQA's IS standards are the guidelines used by certified HEDIS compliance auditors to assess an MHP's ability to report HEDIS data accurately and reliably.[11-1] Compliance with the guidelines also helps an auditor to understand an MHP's HEDIS reporting capabilities. For HEDIS 2017, MHPs were assessed on six IS standards. To assess an MHP's adherence to the IS standards, HSAG reviewed several documents for the MHPs. These included the MHPs' final audit reports (FARs), IS compliance tools, and the IDSS files approved by their respective NCQA-licensed audit organization (LO).

All the Michigan MHPs contracted with the same LOs as they did in the prior year to conduct the NCQA HEDIS Compliance Audit™.[11-2] The MHPs were able to select the LO of their choice. Overall, the Michigan MHPs consistently maintain the same LOs across reporting years.

For HEDIS 2017, all but one MHP contracted with an external software vendor for HEDIS measure production and rate calculation. HSAG reviewed the MHPs' FARs and ensured that these software vendors participated in and passed the NCQA's Measure Certification process. MHPs could purchase the software with certified measures and generate HEDIS measure results internally or provide all data to the software vendor to generate HEDIS measures for them. Either way, using software with NCQA-certified measures may reduce the MHPs' burden for reporting and help ensure rate validity. For the MHP that calculated its rate using internally developed source code, the auditor selected a core set of measures and manually reviewed the programming codes to verify accuracy and compliance with HEDIS 2017 technical specifications.

HSAG found that, in general, all MHPs' IS and processes were compliant with the applicable IS standards and the HEDIS determination reporting requirements related to the measures for HEDIS 2016. The following sections present NCQA's IS standards and summarize the audit findings related to each IS standard for the MHPs.

[11-1] National Committee for Quality Assurance. *HEDIS® 2017, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*. Washington D.C.

[11-2] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry

This standard assesses whether:

- Industry standard codes are used and all characters are captured.
- Principal codes are identified and secondary codes are captured.
- Nonstandard coding schemes are fully documented and mapped back to industry standard codes.
- Standard submission forms are used and capture all fields relevant to measure reporting; all proprietary forms capture equivalent data; and electronic transmission procedures conform to industry standards.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure the accurate entry of submitted data in transaction files for measure reporting.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 1.0, Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry*. The auditors confirmed that the MHPs captured all necessary data elements appropriately for HEDIS reporting. A majority of the MHPs accepted industry standard codes on industry standard forms. Any nonstandard code that was used for measure reporting was mapped to industry standard code appropriately. Adequate validation processes such as built-in edit checks, data monitoring, and quality control audits were in place to ensure that only complete and accurate claims and encounter data were used for HEDIS reporting.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

This standard assesses whether:

- The organization has procedures for submitting measure-relevant information for data entry, and whether electronic transmissions of membership data have necessary procedures to ensure accuracy.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 2.0, Enrollment Data—Data Capture, Transfer, and Entry*. Data fields required for HEDIS measure reporting were captured appropriately. Based on the auditors' review, the MHPs processed eligibility files in a timely manner. Enrollment information housed in the MHPs' systems was reconciled against the enrollment files provided by the State. Sufficient data validations were in place to ensure that only accurate data were used for HEDIS reporting.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

This standard assesses whether:

- Provider specialties are fully documented and mapped to HEDIS provider specialties necessary for measure reporting.
- The organization has effective procedures for submitting measure-relevant information for data entry, and whether electronic transmissions of practitioner data are checked to ensure accuracy.
- Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 3.0, Practitioner Data—Data Capture, Transfer, and Entry*. The MHPs had sufficient processes in place to capture all data elements required for HEDIS reporting. Primary care practitioners and specialists were appropriately identified by all MHPs. Provider specialties were fully and accurately mapped to HEDIS-specified provider types. Adequate validation processes were in place to ensure that only accurate provider data were used for HEDIS reporting.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight

This standard assesses whether:

- Forms capture all fields relevant to measure reporting and whether electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off and sign-off).
- Retrieval and abstraction of data from medical records are reliably and accurately performed.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 4.0, Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight*. Medical record data were used by all MHPs to report HEDIS hybrid measures. Medical record abstraction tools were reviewed and approved by the MHPs' auditors for HEDIS reporting. Contracted vendor staff or internal staff used by the MHPs had sufficient qualification and training in the current year's HEDIS technical specifications and the use of MHP-specific abstraction tools to accurately conduct medical record reviews. Sufficient validation processes and edit checks were in place to ensure data completeness and data accuracy.

IS 5.0—Supplemental Data—Capture, Transfer, and Entry

This standard assesses whether:

- Nonstandard coding schemes are fully documented and mapped to industry standard codes.
- The organization has effective procedures for submitting measure-relevant information for data entry and whether electronic transmissions of data have validation procedures to ensure accuracy.
- Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 5.0, Supplemental Data—Capture, Transfer, and Entry*. Supplemental data sources used by the MHPs were verified and approved by the auditors. The auditors performed primary source verification of a sample of records selected from each nonstandard supplemental database used by the MHPs. In addition, the auditors reviewed the supplemental data impact reports provided by the MHPs for reasonability. Validation processes such as reconciliation between original data sources and MHP-specific data systems, edit checks, and system validations ensured data completeness and data accuracy. There were no issues noted regarding how the MHPs managed the collection, validation, and integration of the various supplemental data sources. The auditors continued to encourage the MHPs to explore ways to maximize the use of supplemental data.

IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

This standard assesses whether:

- Nonstandard coding schemes are fully documented and mapped to industry standard codes.
- Data transfers to repository from transaction files are accurate.
- File consolidations, extracts, and derivations are accurate.
- Repository structure and formatting are suitable for measures and enable required programming efforts.
- Report production is managed effectively and operators perform appropriately.
- Measure reporting software is managed properly with regard to development, methodology, documentation, revision control, and testing.
- Physical control procedures ensure measure data integrity such as physical security, data access authorization, disaster recovery facilities, and fire protection.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 7.0, Data Integration—Accurate HEDIS Reporting Control Procedures That Support HEDIS Reporting Integrity*. All the MHPs but one contracted with a software vendor producing NCQA-certified measures to calculate HEDIS rates. For the MHP that did not use a software vendor, the auditor requested, reviewed, and approved source code for a selected core set of HEDIS measures. For all MHPs, the auditors determined that data mapping, data transfers, and file consolidations were sufficient. Adequate validation processes were in place to ensure that only accurate and complete data were used for HEDIS reporting. The auditors did not document any issues with the MHPs' data integration and report production processes. Sufficient vendor oversight was in place for each MHP using a software vendor.

12. Glossary

Glossary

Table 12-1 below provides definitions of terms and acronyms used throughout this report.

Table 12-1—Definition of Terms

Term	Description
ADHD	Attention-deficit/hyperactivity disorder.
Audit Result	The HEDIS auditor's final determination, based on audit findings, of the appropriateness of the MHP to publicly report its HEDIS measure rates. Each measure indicator rate included in the HEDIS audit receives an audit result of *Reportable (R)*, *Small Denominator (NA)*, *Biased Rate (BR), No Benefit (NB), Not Required (NQ), Not Reported (NR), and Unaudited (UN)*.
ADMIN%	Percentage of the rate derived using administrative data (e.g., claims data and immunization registry).
BMI	Body mass index.
BR	Biased Rate; indicates that the MHP's reported rate was invalid, therefore, the rate was not presented.
CVX	Vaccines administered.
Data Completeness	The degree to which occurring services/diagnoses appear in the MHP's administrative data systems.
Denominator	The number of members who meet all criteria specified in a measure for inclusion in the eligible population. When using the administrative method, the entire eligible population becomes the denominator. When using the hybrid method, a sample of the eligible population becomes the denominator.
DTaP	Diphtheria, tetanus toxoids, and acellular pertussis vaccine.
ED	Emergency department.
EDD	Estimated date of delivery.
EDI	Electronic data interchange; the direct computer-to-computer transfer of data.
Encounter Data	Billing data received from a capitated provider. (Although the MHP does not reimburse the provider for each encounter, submission of encounter data allows the MHP to collect the data for future HEDIS reporting.)
FAR	Following the MHP's completion of any corrective actions, an auditor completes the final audit report (FAR), documenting all final findings and results of the HEDIS audit. The FAR includes a summary report, IS capabilities assessment, medical record review validation findings, measure results, and the auditor's audit opinion (the final audit statement).

Term	Description
HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS), developed and maintained by NCQA, is a set of performance measures used to assess the quality of care provided by managed health care organizations.
HEDIS Repository	The data warehouse where all data used for HEDIS reporting are stored.
Hep A	Hepatitis A vaccine.
Hep B	Hepatitis B vaccine.
HiB Vaccine	Haemophilus influenza type B vaccine.
HMO	Health maintenance organization.
HPL	High performance level. (For most performance measures, MDHHS defined the HPL as the most recent national Medicaid 90th percentile. For measures such as *Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%]*, in which lower rates indicate better performance, the 10th percentile [rather than the 90th percentile] is considered the HPL.)
HPV	Human papillomavirus vaccine.
HSAG	Health Services Advisory Group, Inc., the State's external quality review organization.
Hybrid Measures	Measures that can be reported using the hybrid method.
IDSS	The Interactive Data Submission System, a tool used to submit data to NCQA.
IPV	Inactivated polio virus vaccine.
IS	Information system: an automated system for collecting, processing, and transmitting data.
IS Standards	Information System (IS) standards: an NCQA-defined set of standards that measure how an organization collects, stores, analyzes, and reports medical, customer service, member, practitioner, and vendor data.[12-1]
LPL	Low performance level. (For most performance measures, MDHHS defined the LPL as the most recent national Medicaid 25th percentile. For measures such as *Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%]*, in which lower rates in indicate better performance, the 75th percentile [rather than the 25th percentile] is considered the LPL).
Material Bias	For most measures reported as a rate, any error that causes a ± 5 percent difference in the reported rate is considered materially biased. For non-rate measures, any error that causes a ± 10 percent difference in the reported rate or calculation is considered materially biased.
Medical Record Validation	The process that the MHP's medical record abstraction staff uses to identify numerator positive cases.

[12-1] National Committee for Quality Assurance. HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5. Washington D.C.

Term	Description
Medicaid Percentiles	The NCQA national percentiles for each HEDIS measure for the Medicaid product line used to compare the MHP's performance and assess the reliability of the MHP's HEDIS rates.
MDHHS	Michigan Department of Health and Human Services.
MHP	Medicaid health plan.
MMR	Measles, mumps, and rubella vaccine.
MRR	Medical record review.
NA	Small Denominator: indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in an NA designation.
NB	No Benefit: indicates that the required benefit to calculate the measure was not offered.
NCQA	The National Committee for Quality Assurance (NCQA) is a not-for-profit organization that assesses, through accreditation reviews and standardized measures, the quality of care provided by managed healthcare delivery systems; reports results of those assessments to employers, consumers, public purchasers, and regulators; and ultimately seeks to improve the health care provided within the managed care industry.
NR	Not Reported: indicates that the MHP chose not to report the required HEDIS 2016 measure indicator rate. This designation was assigned to rates during previous reporting years to indicate one of the following designations: The MHP chose not to report the required measure indicator rate, or the MHP's reported rate was invalid.
Numerator	The number of members in the denominator who received all the services as specified in the measure.
NQ	Not Required: indicates that the MHP was not required to report this measure.
OB/GYN	Obstetrician/Gynecologist.
PCP	Primary care practitioner.
PCV	Pneumococcal conjugate vaccine.
POP	Eligible population.
Provider Data	Electronic files containing information about physicians such as type of physician, specialty, reimbursement arrangement, and office location.
RV	Rotavirus vaccine.
Software Vendor	A third party, with source code certified by NCQA, that contracts with the MHP to write source code for HEDIS measures. (For the measures to be certified, the vendor must submit programming codes associated with the measure to NCQA for automated testing of program logic, and a minimum percentage of the measures must receive a "Pass" or "Pass With Qualifications" designation.)

Term	Description
URI	Upper respiratory infection.
Quality Compass	NCQA Quality Compass benchmark.
VZV	Varicella zoster virus (chicken pox) vaccine.

Appendix A. Tabular Results

Appendix A presents tabular results for each measure indicator. Where applicable, the results provided include the eligible population and rate as well as the Michigan Medicaid Weighted Average (MWA) for HEDIS 2015, HEDIS 2016, and HEDIS 2017. To align with calculations from prior years, HSAG calculated traditional averages for measure indicators in the Utilization measure domain; therefore, the Medicaid Average (MA) is presented for utilization-based measures. Yellow shading with one cross ($^{+}$) indicates that the HEDIS 2017 rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.

HSAG HEALTH SERVICES ADVISORY GROUP

Child & Adolescent Care Performance Measure Results

Table A-1—MHP and MWA Results for Childhood Immunization Status

Plan	Eligible Population	Combo 2 Rate	Combo 3 Rate	Combo 4 Rate	Combo 5 Rate	Combo 6 Rate	Combo 7 Rate	Combo 8 Rate	Combo 9 Rate	Combo 10 Rate
AET	533	69.68%	64.12%	63.43%	50.69%	27.08%	50.00%	27.08%	22.92%	22.92%
BCC	1,097	79.40%+	75.00%+	72.45%+	62.96%+	41.20%+	60.88%+	40.51%+	34.49%+	33.80%+
HAR	58	60.71%	50.00%	46.43%	37.50%	19.64%	35.71%	19.64%	16.07%	16.07%
MCL	2,595	79.81%+	75.67%+	73.97%+	68.13%+	40.88%+	66.42%+	40.88%+	37.71%+	37.71%+
MER	7,025	78.60%+	74.88%+	71.63%+	64.42%+	40.70%+	62.33%+	40.00%+	35.81%+	35.35%+
MID	12	NA	NA	NA	NA	NA	NA	NA	NA	NA
MOL	4,105	71.74%	68.65%	67.11%	58.28%	35.98%	57.17%+	35.32%	30.68%	30.24%
PRI	1,592	80.29%+	77.13%+	76.16%+	69.34%+	55.23%+	68.37%+	54.74%+	50.36%+	49.88%+
THC	726	71.53%	65.28%	63.66%	53.70%	27.55%	52.78%	27.31%	22.45%	22.22%
UNI	4,092	78.35%+	72.51%+	70.07%+	57.66%	38.93%	55.96%	38.20%+	31.63%	30.90%
UPP	717	73.24%	71.53%+	65.21%	54.99%	42.09%+	51.58%	39.17%+	34.55%+	32.85%+
HEDIS 2017 MWA		**76.95%+**	**72.84%+**	**70.43%+**	**61.73%+**	**39.84%+**	**60.05%+**	**39.20%+**	**34.47%+**	**33.98%+**
HEDIS 2016 MWA		**76.15%**	**71.05%**	**67.50%**	**58.78%**	**40.45%**	**56.15%**	**39.27%**	**34.97%**	**33.92%**
HEDIS 2015 MWA		**77.16%**	**72.90%**	**67.78%**	**60.52%**	**44.76%**	**56.97%**	**42.69%**	**38.43%**	**36.92%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Table A-2—MHP and MWA Results for Immunizations for Adolescents

Plan	Eligible Population	Combination 1 Rate
AET	817	82.87%+
BCC	946	85.65%+
HAR	38	68.42%
MCL	2,428	84.43%+
MER	6,008	86.60%+
MID	8	NA
MOL	5,143	90.07%+
PRI	1,697	91.24%+
THC	975	83.80%+
UNI	4,866	85.40%+
UPP	733	80.90%+
HEDIS 2017 MWA		**86.73%+**
HEDIS 2016 MWA		**86.99%**
HEDIS 2015 MWA		**88.94%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Table A-3—MHP and MWA Results for Well-Child Visits and Adolescent Well-Care Visits

Plan	Well-Child Visits in the First 15 Months of Life—Six or More Visits—Eligible Population	Well-Child Visits in the First 15 Months of Life—Six or More Visits—Rate	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life—Eligible Population	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life—Rate	Adolescent Well-Care Visits—Eligible Population	Adolescent Well-Care Visits—Rate
AET	477	48.61%	3,279	71.67%+	7,549	48.84%+
BCC	895	71.06%+	6,805	72.92%+	13,110	50.69%+
HAR	29	NA	376	69.68%	452	42.82%
MCL	1,831	64.48%+	12,507	70.07%	22,843	47.20%
MER	5,965	74.88%+	35,056	78.42%+	56,684	64.42%+
MID	7	NA	55	56.36%	108	24.07%
MOL	3,122	68.79%+	29,328	75.89%+	59,732	52.48%+
PRI	1,319	70.06%+	7,912	76.34%+	14,898	54.63%+
THC	506	64.71%+	3,677	70.49%	9,086	52.08%+
UNI	2,984	66.67%+	21,773	79.08%+	41,641	58.88%+
UPP	797	74.21%+	3,269	73.97%+	5,996	44.50%
HEDIS 2017 MWA		**69.79%+**		**76.09%+**		**55.69%+**
HEDIS 2016 MWA		**66.22%**		**75.11%**		**54.74%**
HEDIS 2015 MWA		**64.76%**		**75.76%**		**54.02%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile. NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Table A-4—MHP and MWA Results for Lead Screening in Children

Plan	Eligible Population	Rate
AET	533	73.15%+
BCC	1,097	76.16%+
HAR	58	67.86%
MCL	2,604	94.40%+
MER	7,025	81.14%+
MID	12	NA
MOL	4,105	78.15%+
PRI	1,592	85.83%+
THC	726	70.74%
UNI	4,092	77.13%+
UPP	717	82.43%+
HEDIS 2017 MWA		**80.98%+**
HEDIS 2016 MWA		**79.55%**
HEDIS 2015 MWA		**80.37%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Table A-5—MHP and MWA Results for Appropriate Treatment for Children With Upper Respiratory Infection

Plan	Eligible Population	Rate
AET	904	90.49%+
BCC	2,102	90.15%+
HAR	145	90.34%+
MCL	4,403	86.33%
MER	13,459	89.44%+
MID	19	NA
MOL	10,110	86.82%
PRI	3,013	93.63%+
THC	1,499	89.66%+
UNI	8,888	89.46%+
UPP	983	91.15%+
HEDIS 2017 MWA		**88.94%**
HEDIS 2016 MWA		**89.09%**
HEDIS 2015 MWA		**88.00%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Table A-6—MHP and MWA Results for Appropriate Testing for Children With Pharyngitis

Plan	Eligible Population	Rate
AET	480	62.92%
BCC	1,050	75.43%+
HAR	44	59.09%
MCL	2,365	70.40%
MER	7,282	73.43%+
MID	18	NA
MOL	5,520	67.17%
PRI	1,455	78.49%+
THC	675	63.11%
UNI	4,757	71.07%
UPP	447	63.09%
HEDIS 2017 MWA		**70.91%**
HEDIS 2016 MWA		**68.41%**
HEDIS 2015 MWA		**67.25%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Table A-7—MHP and MWA Results for Follow-Up Care for Children Prescribed ADHD Medication Phase—Initiation Phase and Continuation and Maintenance Phase

Plan	Initiation Phase—Eligible Population	Initiation Phase—Rate	Continuation and Maintenance Phase—Eligible Population	Continuation and Maintenance Phase—Rate
AET	221	19.46%	31	32.26%
BCC	273	51.28%+	73	57.53%+
HAR	15	NA	0	NA
MCL	963	39.67%	191	43.98%
MER	2,568	41.74%	561	55.97%+
MID	4	NA	0	NA
MOL	1,471	48.40%+	335	65.97%+
PRI	177	35.03%	36	33.33%
THC	298	50.00%+	43	62.79%+
UNI	1,473	41.48%	143	53.85%+
UPP	228	42.98%+	97	45.36%
HEDIS 2017 MWA		**42.54%+**		**55.03%+**
HEDIS 2016 MWA		**42.58%**		**53.96%**
HEDIS 2015 MWA		**38.87%**		**44.35%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Women—Adult Care Performance Measure Results

Table A-8—MHP and MWA Results for Breast and Cervical Cancer Screening in Women

Plan	Breast Cancer Screening—Eligible Population	Breast Cancer Screening—Rate	Cervical Cancer Screening—Eligible Population	Cervical Cancer Screening—Rate
AET	1,222	56.87%	7,528	64.07%+
BCC	2,089	62.90%+	22,057	61.83%+
HAR	180	70.00%+	921	56.20%+
MCL	4,781	63.31%+	30,778	56.93%+
MER	10,183	64.41%+	86,685	65.50%+
MID	209	56.94%	1,102	52.26%
MOL	7,530	60.31%+	68,196	65.69%+
PRI	3,247	62.58%+	18,977	67.45%+
THC	1,731	52.51%	10,017	60.88%+
UNI	7,244	64.83%+	44,883	69.10%+
UPP	1,344	64.73%+	8,584	67.15%+
HEDIS 2017 MWA		**62.60%+**		**64.84%+**
HEDIS 2016 MWA		**59.58%**		**63.79%**
HEDIS 2015 MWA		**59.65%**		**68.46%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.

Table A-9—MHP and MWA Results for Chlamydia Screening in Women

Plan	Ages 16 to 20 Years—Eligible Population	Ages 16 to 20 Years—Rate	Ages 21 to 24 Years—Eligible Population	Ages 21 to 24 Years—Rate	Total—Eligible Population	Total—Rate
AET	1,108	69.86%+	647	76.35%+	1,755	72.25%+
BCC	1,763	64.21%+	1,763	70.56%+	3,526	67.39%+
HAR	61	70.49%+	75	70.67%+	136	70.59%+
MCL	3,172	52.81%+	2,629	59.87%	5,801	56.01%+
MER	8,069	60.49%+	8,145	69.23%+	16,214	64.88%+
MID	16	NA	42	47.62%	58	44.83%
MOL	7,949	63.27%+	5,701	70.37%+	13,650	66.23%+
PRI	2,147	65.53%+	1,561	70.08%+	3,708	67.45%+
THC	1,296	71.37%+	800	70.63%+	2,096	71.09%+
UNI	5,321	66.04%+	3,653	71.37%+	8,974	68.21%+
UPP	828	44.93%	674	58.75%	1,502	51.13%
HEDIS 2017 MWA		**62.27%+**		**68.89%+**		**65.23%+**
HEDIS 2016 MWA		**60.75%**		**67.85%**		**63.86%**
HEDIS 2015 MWA		**59.08%**		**67.58%**		**62.20%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Access to Care Performance Measure Results

Table A-10—MHP and MWA Results for Children and Adolescents' Access to Primary Care Practitioners

Plan	Ages 12 to 24 Months—Eligible Population	Ages 12 to 24 Months —Rate	Ages 25 Months to 6 Years—Eligible Population	Ages 25 Months to 6 Years—Rate	Ages 7 to 11 Years—Eligible Population	Ages 7 to 11 Years—Rate	Ages 12 to 19 Years—Eligible Population	Ages 12 to 19 Years—Rate
AET	818	86.31%	3,914	83.09%	3,067	85.88%	5,140	83.04%
BCC	2,144	95.34%	8,508	85.86%	3,245	89.09%	4,756	89.30%
HAR	129	86.05%	469	76.97%	163	79.14%	141	65.25%
MCL	3,462	94.66%	15,505	87.10%	10,041	89.00%	13,288	88.30%
MER	10,738	97.37%+	42,661	90.69%+	27,053	92.53%+	32,286	92.90%+
MID	14	NA	70	65.71%	33	75.76%	50	68.00%
MOL	7,107	96.02%+	35,580	89.57%+	18,331	92.52%+	24,873	90.88%+
PRI	2,470	96.96%+	9,756	89.67%+	6,473	91.78%+	8,591	90.92%+
THC	891	93.83%	4,471	85.89%	3,648	87.88%	6,100	87.39%
UNI	4,889	96.20%+	26,078	89.27%+	21,636	91.77%+	28,394	91.88%+
UPP	984	97.26%+	4,039	90.64%+	2,982	91.82%+	3,987	91.60%+
HEDIS 2017 MWA		**96.06%+**		**89.08%+**		**91.39%+**		**90.79%+**
HEDIS 2016 MWA		**96.20%**		**88.79%**		**90.85%**		**89.86%**
HEDIS 2015 MWA		**96.32%**		**88.73%**		**91.14%**		**90.21%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Table A-11—MHP and MWA Results for Adults' Access to Preventive/Ambulatory Health Services

Plan	Ages 20 to 44 Years—Eligible Population	Ages 20 to 44 Years—Rate	Ages 45 to 64 Years—Eligible Population	Ages 45 to 64 Years—Rate	Ages 65+ Years—Eligible Population	Ages 65+ Years—Rate	Total—Eligible Population	Total—Rate
AET	8,804	72.47%	5,556	82.70%	10	NA	14,370	76.42%
BCC	26,454	78.83%	18,265	86.92%+	184	79.89%	44,903	82.13%
HAR	1,385	59.28%	1,246	77.85%	10	NA	2,641	68.12%
MCL	35,273	82.10%+	24,798	89.58%+	3	NA	60,074	85.18%+
MER	99,045	83.55%+	57,773	90.46%+	1,666	92.62%+	158,484	86.17%+
MID	945	73.02%	1,280	90.16%+	1,853	85.05%	4,078	83.86%+
MOL	75,398	81.58%+	50,304	89.24%+	3,465	91.02%+	129,167	84.82%+
PRI	20,050	83.72%+	12,694	90.79%+	1,193	94.38%+	33,937	86.74%+
THC	11,174	76.89%	8,340	86.07%	167	80.24%	19,681	80.81%
UNI	49,833	81.34%+	32,704	89.97%+	480	94.79%+	83,017	84.82%+
UPP	9,542	84.99%+	6,314	87.55%+	34	91.18%+	15,890	86.02%+
HEDIS 2017 MWA		**81.68%+**		**89.21%+**		**90.26%+**		**84.73%+**
HEDIS 2016 MWA		**82.76%**		**89.81%**		**91.15%**		**85.62%**
HEDIS 2015 MWA		**83.42%**		**90.77%**		**88.60%**		**86.11%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Table A-12—MHP and MWA Results for Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

Plan	Eligible Population	Rate[1]
AET	298	32.89%+
BCC	724	27.49%+
HAR	39	20.51%
MCL	1,480	26.35%+
MER	4,317	26.18%+
MID	23	NA
MOL	2,661	30.18%+
PRI	1,042	37.91%+
THC	472	27.33%+
UNI	2,833	32.40%+
UPP	520	25.77%
HEDIS 2017 MWA		**29.23%+**
HEDIS 2016 MWA		**26.94%**
HEDIS 2015 MWA		**NQ**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.
NQ (Not Required) indicates that the MHPs were not required to report this measure during this reporting year; therefore, the MWA is not presented in this report.
[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2017 and prior years.

Obesity Performance Measure Results

Table A-13—MHP and MWA Results for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Plan	Eligible Population	BMI Percentile—Total—Rate	Counseling for Nutrition—Total—Rate	Counseling for Physical Activity—Total—Rate[1]
AET	8,910	78.01%+	71.30%+	58.80%+
BCC	18,158	86.57%+	73.61%+	64.58%+
HAR	597	79.08%+	79.81%+	57.91%+
MCL	34,404	83.45%+	60.34%	50.85%
MER	95,680	81.48%+	73.15%+	59.49%+
MID	89	87.64%+	70.79%+	64.04%+
MOL	88,403	80.61%+	71.39%+	63.59%+
PRI	23,635	88.08%+	78.10%+	73.72%+
THC	11,052	78.87%+	71.13%+	49.06%
UNI	64,683	81.02%+	76.64%+	62.53%+
UPP	9,458	88.81%+	67.40%+	64.96%+
HEDIS 2017 MWA		**82.10%+**	**72.21%+**	**61.24%+**
HEDIS 2016 MWA		**74.93%**	**65.77%**	**57.88%**
HEDIS 2015 MWA		**78.34%**	**67.95%**	**58.07%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.

[1]Due to changes in the technical specifications for this measure, exercise caution when trending rates between HEDIS 2016 and the prior year.

Table A-14—MHP and MWA Results for Adult BMI Assessment

Plan	Eligible Population	Rate
AET	7,693	90.96%+
BCC	16,148	89.10%+
HAR	1,078	90.27%+
MCL	30,961	91.48%+
MER	75,942	96.28%+
MID	628	89.95%+
MOL	45,505	97.14%+
PRI	18,323	95.56%+
THC	10,990	89.50%+
UNI	49,213	85.40%+
UPP	9,207	95.38%+
HEDIS 2017 MWA		**92.86%+**
HEDIS 2016 MWA		**89.92%**
HEDIS 2015 MWA		**90.31%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.

Pregnancy Care Performance Measure Results

Table A-15—MHP and MWA Results for Prenatal and Postpartum Care

Plan	Eligible Population	Timeliness of Prenatal Care—Rate	Postpartum Care—Rate
AET	731	65.89%	51.74%
BCC	2,396	77.26%	62.41%+
HAR	88	47.13%	42.53%
MCL	3,151	86.13%+	64.23%+
MER	10,469	82.87%+	71.30%+
MID	52	50.00%	40.38%
MOL	6,345	83.33%+	75.80%+
PRI	2,344	78.59%	69.34%+
THC	872	71.13%	48.83%
UNI	4,727	80.54%	67.40%+
UPP	829	91.48%+	72.75%+
HEDIS 2017 MWA		**81.57%**	**68.96%+**
HEDIS 2016 MWA		**78.63%**	**61.73%**
HEDIS 2015 MWA		**84.45%**	**66.69%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.

Table A-16—MHP and MWA Results for Frequency of Ongoing Prenatal Care

Plan	≥ 81 Percent of Expected Visits—Eligible Population	≥ 81 Percent of Expected Visits—Rate
AET	731	21.35%
BCC	2,396	37.35%
HAR	88	24.14%
MCL	3,151	51.09%
MER	10,469	70.83%+
MID	52	13.46%
MOL	6,345	54.57%
PRI	2,344	46.96%
THC	872	24.88%
UNI	4,727	52.07%
UPP	829	73.24%+
HEDIS 2017 MWA		**56.10%**
HEDIS 2016 MWA		**56.40%**
HEDIS 2015 MWA		**63.43%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.

Living With Illness Performance Measure Results

Table A-17—MHP and MWA Results for Comprehensive Diabetes Care[1]

Plan	Eligible Population	Hemoglobin A1c (HbA1c) Testing—Rate	HbA1c Poor Control (>9.0%) —Rate*	HbA1c Control (<8.0%)—Rate	Eye Exam (Retinal) Performed —Rate	Medical Attention for Nephropathy —Rate	Blood Pressure Control (<140 90 mm Hg) —Rate
AET	1,744	86.31%+	42.38%+	48.34%+	47.90%	92.05%+	55.41%
BCC	4,711	85.28%	41.62%+	46.36%	57.53%+	90.02%	55.84%
HAR	301	88.00%+	41.33%+	52.67%+	45.67%	90.00%	46.33%
MCL	6,618	87.59%+	48.54%	41.61%	58.03%+	88.87%	66.24%+
MER	17,359	87.79%+	35.42%+	52.67%+	67.63%+	91.45%+	65.65%+
MID	859	86.37%+	39.90%+	52.31%+	54.74%+	94.89%+	57.91%
MOL	16,233	87.64%+	32.45%+	56.73%+	62.03%+	90.73%+	55.19%
PRI	4,123	92.15%+	31.93%+	62.41%+	71.72%+	91.61%+	75.91%+
THC	2,594	82.95%	42.92%+	49.01%+	46.27%	91.32%+	50.68%
UNI	10,899	88.61%+	32.50%+	56.11%+	65.14%+	92.36%+	62.08%+
UPP	1,443	91.04%+	24.73%+	59.14%+	67.56%+	92.11%+	76.70%+
HEDIS 2017 MWA		**87.79%+**	**36.07%+**	**53.16%+**	**62.85%+**	**91.14%+**	**61.73%+**
HEDIS 2016 MWA		**86.89%**	**39.30%**	**50.91%**	**59.61%**	**91.28%**	**59.38%**
HEDIS 2015 MWA		**85.99%**	**35.83%**	**53.78%**	**59.48%**	**83.73%**	**65.90%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
[1]Due to changes in the technical specifications for this measure, exercise caution when trending rates between HEDIS 2016 and the prior year.
** For this indicator, a lower rate indicates better performance.*

Table A-18—MHP and MWA Results for Medication Management for People With Asthma

Plan	Eligible Population	Medication Compliance 50%—Total—Rate	Medication Compliance 75%—Total—Rate
AET	577	83.19%+	63.26%+
BCC	945	88.36%+	74.39%+
HAR	27	NA	NA
MCL	1,780	84.33%+	67.87%+
MER	3,784	72.33%+	51.35%+
MID	9	NA	NA
MOL	2,429	57.76%+	34.13%+
PRI	1,105	60.00%+	37.01%+
THC	513	85.96%+	69.98%+
UNI	2,397	67.42%+	41.51%+
UPP	454	66.08%+	38.11%+
HEDIS 2017 MWA		**71.33%+**	**49.96%+**
HEDIS 2016 MWA		**67.13%**	**43.79%**
HEDIS 2015 MWA		**NQ**	**NQ**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.
NQ (Not Required) indicates that the MHPs were not required to report this measure during this reporting year; therefore, the MWA is not presented in this report.

Table A-19—MHP and MWA Results for Asthma Medication Ratio

Plan	Eligible Population	Rate
AET	721	61.03%
BCC	1,154	54.59%
HAR	41	43.90%
MCL	2,129	66.09%+
MER	4,577	61.92%+
MID	16	NA
MOL	3,070	60.91%
PRI	1,235	74.90%+
THC	745	47.11%
UNI	2,822	66.80%+
UPP	604	58.44%
HEDIS 2017 MWA		**62.63%+**
HEDIS 2016 MWA		**62.18%**
HEDIS 2015 MWA		**NQ**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.
NQ (Not Required) indicates that the MHPs were not required to report this measure during this reporting year; therefore, the MWA is not presented in this report.

Table A-20—MHP and MWA Results for Controlling High Blood Pressure

Plan	Eligible Population	Rate
AET	3,319	52.93%
BCC	8,518	46.03%
HAR	578	34.06%
MCL	10,391	58.64%+
MER	28,317	67.15%+
MID	1,566	60.58%+
MOL	28,262	49.04%
PRI	6,254	67.15%+
THC	4,718	38.53%
UNI	16,801	56.93%+
UPP	2,293	71.05%+
HEDIS 2017 MWA		**56.75%+**
HEDIS 2016 MWA		**55.54%**
HEDIS 2015 MWA		**62.06%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.

Table A-21—MHP and MWA Results for Medical Assistance With Smoking and Tobacco Use Cessation

Plan	Eligible Population	Advising Smokers and Tobacco Users to Quit—Rate	Discussing Cessation Medications—Rate	Discussing Cessation Strategies—Rate
AET	37,965	80.65%+	58.06%+	51.63%+
BCC	119,551	75.28%	50.14%+	41.71%
HAR	4,662	79.06%+	58.99%+	50.00%+
MCL	161,889	76.79%+	54.94%+	47.70%+
MER	434,232	81.16%+	54.30%+	44.68%+
MID	9,929	82.11%+	58.30%+	44.44%+
MOL	258,445	80.93%+	57.56%+	43.62%
PRI	46,891	81.48%+	55.97%+	46.62%+
THC	52,093	79.95%+	55.16%+	47.12%+
UNI	215,968	82.17%+	60.80%+	50.56%+
UPP	39,331	79.18%+	56.90%+	45.57%+
HEDIS 2017 MWA		**80.15%+**	**55.95%+**	**45.89%+**
HEDIS 2016 MWA		**79.75%**	**55.04%**	**45.20%**
HEDIS 2015 MWA		**79.90%**	**54.26%**	**45.73%**

Yellow shading with one cross (+) indicates that the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.

Table A-22—MHP and MWA Results for Antidepressant Medication Management

Plan	Eligible Population	Effective Acute Phase Treatment—Rate	Effective Continuation Phase Treatment—Rate
AET	465	52.90%	40.00%+
BCC	1,558	74.52%+	60.78%+
HAR	15	NA	NA
MCL	3,047	45.65%	29.70%
MER	10,161	50.92%	31.77%
MID	104	47.12%	31.73%
MOL	4,419	48.20%	32.61%
PRI	98	64.29%+	53.06%+
THC	734	55.59%+	39.92%+
UNI	2,744	59.84%+	46.87%+
UPP	588	59.86%+	42.69%+
HEDIS 2017 MWA		**52.72%**	**36.03%**
HEDIS 2016 MWA		**60.36%**	**42.21%**
HEDIS 2015 MWA		**NQ**	**NQ**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.
NQ (Not Required) indicates that the MHPs were not required to report this measure during this reporting year; therefore, the MWA is not presented in this report.

Table A-23—MHP and MWA Results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Plan	Eligible Population	Rate
AET	297	80.47%
BCC	1,681	81.20%+
HAR	33	72.73%
MCL	2,515	82.62%+
MER	4,411	83.11%+
MID	225	68.00%
MOL	4,502	83.10%+
PRI	693	84.70%+
THC	447	82.33%+
UNI	2,156	85.99%+
UPP	347	88.18%+
HEDIS 2017 MWA		**83.09%+**
HEDIS 2016 MWA		**82.61%**
HEDIS 2015 MWA		**83.75%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.

Table A-24—MHP and MWA Results for Diabetes Monitoring for People With Diabetes and Schizophrenia

Plan	Eligible Population	Rate
AET	64	57.81%
BCC	182	63.74%
HAR	10	NA
MCL	212	72.17%+
MER	424	66.04%
MID	39	64.10%
MOL	669	72.50%+
PRI	82	60.98%
THC	81	59.26%
UNI	319	74.29%+
UPP	22	NA
HEDIS 2017 MWA		**69.01%+**
HEDIS 2016 MWA		**69.98%**
HEDIS 2015 MWA		**72.73%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Table A-25—MHP and MWA Results for Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

Plan	Eligible Population	Rate
AET	14	NA
BCC	20	NA
HAR	0	NA
MCL	19	NA
MER	68	55.88%
MID	3	NA
MOL	76	76.32%
PRI	5	NA
THC	16	NA
UNI	77	74.03%
UPP	5	NA
HEDIS 2017 MWA		**69.64%**
HEDIS 2016 MWA		**74.46%**
HEDIS 2015 MWA		**60.10%**

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Table A-26—MHP and MWA Results for Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Plan	Eligible Population	Rate
AET	213	55.87%
BCC	887	57.38%
HAR	13	NA
MCL	904	63.27%$^{+}$
MER	1,368	63.52%$^{+}$
MID	170	69.41%$^{+}$
MOL	2,376	61.20%$^{+}$
PRI	231	62.34%$^{+}$
THC	262	48.47%
UNI	1,053	60.59%$^{+}$
UPP	101	82.18%$^{+}$
HEDIS 2017 MWA		**61.16%$^{+}$**
HEDIS 2016 MWA		**58.76%**
HEDIS 2015 MWA		**59.22%**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.

Table A-27—MHP and MWA Results for Annual Monitoring for Patients on Persistent Medications

Plan	ACE Inhibitors or ARBs—Eligible Population	ACE Inhibitors or ARBs—Rate	Digoxin—Eligible Population	Digoxin—Rate	Diuretics—Eligible Population	Diuretics—Rate	Total—Eligible Population	Total—Rate
AET	2,197	84.25%	20	NA	2,014	85.50%	4,231	84.73%
BCC	6,372	86.46%	52	57.69%+	5,170	86.15%	11,594	86.19%
HAR	303	87.79%+	0	NA	243	85.19%	546	86.63%
MCL	9,175	84.68%	90	44.44%	6,539	85.62%	15,804	84.84%
MER	20,073	86.53%	208	51.44%	14,453	86.88%	34,734	86.47%
MID	1,223	83.40%	23	NA	885	84.75%	2,131	83.67%
MOL	17,841	87.44%+	204	65.69%+	13,485	87.29%	31,530	87.23%+
PRI	4,138	88.01%+	32	43.75%	2,793	88.08%+	6,963	87.84%+
THC	3,289	87.84%+	33	33.33%	2,662	87.27%	5,984	87.28%+
UNI	10,276	89.75%+	102	49.02%	7,214	89.19%+	17,592	89.28%+
UPP	1,799	87.60%+	22	NA	1,180	88.64%+	3,001	87.70%+
HEDIS 2017 MWA		**87.00%**		**53.56%**		**87.08%**		**86.84%**
HEDIS 2016 MWA		**87.20%**		**52.47%**		**86.88%**		**86.84%**
HEDIS 2015 MWA		**NQ**		**NQ**		**NQ**		**NQ**

Yellow shading with one cross (+) indicates the HEDIS 2017 MHP or MWA rate was at or above the Quality Compass HEDIS 2016 national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation.
NQ (Not Required) indicates that the MHPs were not required to report this measure during this reporting year; therefore, the MWA is not presented in this report.

Health Plan Diversity and Utilization Measure Results

The Health Plan Diversity and Utilization measures' MHP and MWA results are presented in tabular format in Section 9 and Section 10 of this report.

Appendix B. Trend Tables

Appendix B includes trend tables for the MHPs. Where applicable, each measure's HEDIS 2015, HEDIS 2016, and HEDIS 2017 rates are presented. HEDIS 2016 and HEDIS 2017 rates were compared based on a Chi-square test of statistical significance with a p value <0.05. Values in the 2016–2017 Comparison column that are shaded green with one cross ($^{+}$) indicate statistically significant improvement from the previous year. Values in the 2016–2017 Comparison column shaded red with two crosses ($^{++}$) indicate statistically significantly decline in performance from the previous year.

Details regarding the trend analysis and performance ratings are found in Section 2.

Table B-1—AET Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	71.93%	68.75%	69.68%	+0.93	★★
Combination 3	67.92%	60.88%	64.12%	+3.24	★
Combination 4	65.80%	58.80%	63.43%	+4.63	★★
Combination 5	55.66%	49.77%	50.69%	+0.92	★
Combination 6	31.13%	29.40%	27.08%	-2.32	★
Combination 7	54.01%	48.61%	50.00%	+1.39	★★
Combination 8	30.42%	29.17%	27.08%	-2.09	★
Combination 9	25.94%	24.31%	22.92%	-1.39	★
Combination 10	25.47%	24.31%	22.92%	-1.39	★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	51.42%	44.68%	48.61%	+3.93	★
Lead Screening in Children					
Lead Screening in Children	79.25%	73.61%	73.15%	-0.46	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.32%	71.30%	71.67%	+0.37	★★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	52.88%	51.39%	48.84%	-2.55	★★★
Immunizations for Adolescents					
Combination 1	83.05%	89.68%	82.87%	-6.81[++]	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection[3]					
Appropriate Treatment for Children With Upper Respiratory Infection	89.35%	89.72%	90.49%	+0.77	★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	54.85%	55.44%	62.92%	+7.48[+]	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	19.16%	23.73%	19.46%	-4.27	★

Table B-1—AET Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Continuation and Maintenance Phase	21.43%	36.59%	32.26%	-4.33	★
Women – Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	68.11%	63.10%	56.87%	-6.23[++]	★★
Cervical Cancer Screening					
Cervical Cancer Screening	72.35%	64.47%	64.07%	-0.40	★★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	68.48%	66.77%	69.86%	+3.09	★★★★★
Ages 21 to 24 Years	75.70%	71.24%	76.35%	+5.11[+]	★★★★★
Total	70.77%	68.44%	72.25%	+3.81[+]	★★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	93.32%	90.84%	86.31%	-4.53[++]	★
Ages 25 Months to 6 Years	82.82%	81.16%	83.09%	+1.93[+]	★
Ages 7 to 11 Years	87.47%	86.76%	85.88%	-0.88	★
Ages 12 to 19 Years	85.52%	83.70%	83.04%	-0.66	★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	77.95%	76.58%	72.47%	-4.11[++]	★
Ages 45 to 64 Years	86.35%	85.73%	82.70%	-3.03[++]	★★
Ages 65+ Years	NA	NA	NA	—	NA
Total	81.17%	80.23%	76.42%	-3.81[++]	★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[3]					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	35.83%	32.89%	-2.94	★★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	77.12%	70.30%	78.01%	+7.71[+]	★★★★
Counseling for Nutrition—Total	70.52%	64.60%	71.30%	+6.70[+]	★★★★
Counseling for Physical Activity—Total[4]	64.39%	55.45%	58.80%	+3.35	★★★

Table B-1—AET Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	88.56%	90.21%	90.96%	+0.75	★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	70.62%	62.38%	65.89%	+3.51	★
Postpartum Care	52.13%	45.56%	51.74%	+6.18	★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	27.49%	18.46%	21.35%	+2.89	★
Living With Illness					
Comprehensive Diabetes Care[4]					
Hemoglobin A1c (HbA1c) Testing	85.66%	84.36%	86.31%	+1.95	★★★
*HbA1c Poor Control (>9.0%)**	40.99%	46.41%	42.38%	-4.03	★★★
HbA1c Control (<8.0%)	52.41%	45.38%	48.34%	+2.96	★★★
Eye Exam (Retinal) Performed	59.77%	49.36%	47.90%	-1.46	★★
Medical Attention for Nephropathy	85.41%	91.03%	92.05%	+1.02	★★★★
Blood Pressure Control (<140/90 mm Hg)	52.16%	52.18%	55.41%	+3.23	★★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	66.55%	83.19%	+16.64+	★★★★★
Medication Compliance 75%—Total	—	39.93%	63.26%	+23.33+	★★★★★
Asthma Medication Ratio					
Total	—	41.49%	61.03%	+19.54+	★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	48.72%	39.91%	52.93%	+13.02+	★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	81.50%	79.92%	80.65%	+0.73	★★★★
Discussing Cessation Medications	58.00%	55.74%	58.06%	+2.32	★★★★
Discussing Cessation Strategies	44.80%	46.22%	51.63%	+5.41	★★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	37.84%	52.90%	+15.06+	★★
Effective Continuation Phase Treatment	—	24.59%	40.00%	+15.41+	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NB	83.87%	80.47%	-3.40	★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	66.00%	57.81%	-8.19	★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	—	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NB	51.37%	55.87%	+4.50	★★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	82.94%	84.25%	+1.31	★
Digoxin	—	NA	NA	—	NA
Diuretics	—	83.69%	85.50%	+1.81	★★

Table B-1—AET Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Total	—	83.16%	84.73%	+1.57	★
Health Plan Diversity[5]					
Race/Ethnicity Diversity of Membership					
Total—White	15.94%	18.01%	26.93%	+8.92	—
Total—Black or African American	73.61%	70.29%	60.30%	-9.99	—
Total—American-Indian and Alaska Native	0.09%	0.12%	0.15%	+0.03	—
Total—Asian	0.63%	0.60%	0.66%	+0.06	—
Total—Native Hawaiian and Other Pacific Islander	0.00%	0.03%	0.04%	+0.01	—
Total—Some Other Race	0.00%	0.00%	0.00%	0.00	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	9.73%	9.89%	5.66%	-4.23	—
Total—Declined	0.00%	1.07%	6.26%	+5.19	—
Total—Hispanic or Latino	—	2.58%	2.92%	+0.34	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	99.38%	0.00%	0.00%	0.00	—
Spoken Language Preferred for Health Care—Non-English	0.00%	0.00%	0.00%	0.00	—
Spoken Language Preferred for Health Care—Unknown	0.62%	100.00%	100.00%	0.00	—
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	99.38%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—Non-English	0.00%	0.00%	0.00%	0.00	—

Table B-1—AET Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Preferred Language for Written Materials—Unknown	0.62%	100.00%	100.00%	0.00	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—English	0.00%	99.34%	99.25%	-0.09	—
Other Language Needs—Non-English	0.00%	0.15%	0.63%	+0.48	—
Other Language Needs—Unknown	100.00%	0.50%	0.13%	-0.37	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	—
Utilization[5]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	86.43	83.70	83.32	-0.38	★
Outpatient Visits—Total	311.47	267.80	299.52	+31.72	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	8.57	7.76	8.43	+0.67	—
Total Inpatient—Average Length of Stay—Total	4.08	3.81	3.93	+0.12	—
Maternity—Discharges per 1,000 Member Months—Total	2.94	2.20	2.05	-0.15	—
Maternity—Average Length of Stay—Total	2.68	2.83	2.58	-0.25	—
Surgery—Discharges per 1,000 Member Months—Total	1.79	1.34	2.05	+0.71	—
Surgery—Average Length of Stay—Total	6.70	6.03	6.35	+0.32	—

Table B-1—AET Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Medicine—Discharges per 1,000 Member Months—Total	4.74	4.81	4.86	+0.05	—
Medicine—Average Length of Stay—Total	3.69	3.52	3.33	-0.19	—

[1] HEDIS 2016 to HEDIS 2017 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05.

Green Shading[+] *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

Red Shading[++] *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

[2] 2017 Performance Levels were based on comparisons of the HEDIS 2017 measure indicator rates to Quality Compass national Medicaid HEDIS 2016 percentiles, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the NCQA national Medicaid Audit Means and Percentiles HEDIS 2016 percentiles.
[3] Due to changes in the technical specifications for this measure in HEDIS 2017, exercise caution when trending rates between 2017 and prior years.
[4] Due to changes in the technical specifications for this measure in HEDIS 2016, exercise caution when trending rates between 2016 and prior years.
[5] Significance testing was not performed for utilization-based or health plan description measure indicator rates; any performance levels for 2017 or 2016–2017 comparisons provided for these measures are for informational purposes only.
** For this indicator, a lower rate indicates better performance.*
— indicates that the measure was not presented in the previous years' deliverables; therefore, the HEDIS 2015 and/or 2016 rate is not presented in this report. This symbol may also indicate that the 2016–2017 comparison was not performed because the 2016 and/or 2017 rate was not reportable or that the 2017 performance levels were not determined because the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation. For HEDIS 2017 rates designated as NA, the 2017 performance level is also presented as NA.
NB indicates that the required benefit to calculate the measure was not offered.

2017 Performance Levels represent the following percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Table B-2—BCC Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	76.16%	76.16%	79.40%	+3.24	★★★★
Combination 3	72.75%	70.07%	75.00%	+4.93	★★★
Combination 4	69.59%	68.13%	72.45%	+4.32	★★★
Combination 5	58.39%	59.85%	62.96%	+3.11	★★★
Combination 6	50.12%	43.55%	41.20%	-2.35	★★★
Combination 7	56.93%	58.39%	60.88%	+2.49	★★★
Combination 8	48.66%	42.58%	40.51%	-2.07	★★★
Combination 9	40.88%	37.96%	34.49%	-3.47	★★★
Combination 10	39.90%	36.98%	33.80%	-3.18	★★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	65.21%	67.40%	71.06%	+3.66	★★★★
Lead Screening in Children					
Lead Screening in Children	73.97%	75.18%	76.16%	+0.98	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	85.64%	79.32%	72.92%	**-6.40[++]**	★★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	61.07%	60.10%	50.69%	**-9.41[++]**	★★★
Immunizations for Adolescents					
Combination 1	85.64%	86.86%	85.65%	-1.21	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection[3]					
Appropriate Treatment for Children With Upper Respiratory Infection	92.98%	92.52%	90.15%	**-2.37[++]**	★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	78.69%	72.61%	75.43%	+2.82	★★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	40.26%	39.92%	51.28%	+11.36[+]	★★★★

Table B-2—BCC Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Continuation and Maintenance Phase	44.55%	50.98%	57.53%	+6.55	★★★
Women – Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	61.98%	61.84%	62.90%	+1.06	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	69.83%	63.99%	61.83%	-2.16	★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	66.71%	68.96%	64.21%	**-4.75[++]**	★★★★
Ages 21 to 24 Years	76.03%	70.30%	70.56%	+0.26	★★★★
Total	70.77%	69.65%	67.39%	-2.26	★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	94.94%	94.89%	95.34%	+0.45	★★
Ages 25 Months to 6 Years	88.45%	85.57%	85.86%	+0.29	★★
Ages 7 to 11 Years	94.36%	90.84%	89.09%	**-1.75[++]**	★★
Ages 12 to 19 Years	91.58%	89.38%	89.30%	-0.08	★★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	81.94%	78.39%	78.83%	+0.44	★★
Ages 45 to 64 Years	87.29%	86.09%	86.92%	+0.83[+]	★★★
Ages 65+ Years	76.69%	78.06%	79.89%	+1.83	★★
Total	83.32%	81.69%	82.13%	+0.44	★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[3]					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	31.84%	27.49%	-4.35	★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	90.51%	89.54%	86.57%	-2.97	★★★★★
Counseling for Nutrition—Total	79.56%	78.83%	73.61%	-5.22	★★★★

Table B-2—BCC Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Counseling for Physical Activity—Total[4]	74.94%	69.10%	64.58%	-4.52	★★★★
Adult BMI Assessment					
Adult BMI Assessment	92.94%	89.78%	89.10%	-0.68	★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	85.64%	80.54%	77.26%	-3.28	★★
Postpartum Care	63.75%	57.66%	62.41%	+4.75	★★★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	35.04%	45.99%	37.35%	-8.64++	★
Living With Illness					
Comprehensive Diabetes Care[4]					
Hemoglobin A1c (HbA1c) Testing	89.05%	86.86%	85.28%	-1.58	★★
*HbA1c Poor Control (>9.0%)**	33.03%	37.59%	41.62%	+4.03	★★★
HbA1c Control (<8.0%)	57.85%	53.65%	46.36%	-7.29++	★★
Eye Exam (Retinal) Performed	62.41%	62.04%	57.53%	-4.51	★★★
Medical Attention for Nephropathy	84.85%	93.07%	90.02%	-3.05	★★
Blood Pressure Control (<140/90 mm Hg)	65.69%	58.39%	55.84%	-2.55	★★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	76.62%	88.36%	+11.74+	★★★★★
Medication Compliance 75%—Total	—	58.26%	74.39%	+16.13+	★★★★★
Asthma Medication Ratio					
Total	—	53.96%	54.59%	+0.63	★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	49.64%	54.99%	46.03%	-8.96++	★
Medical Assistance With Smoking and Tobacco Use Cessation					

Table B-2—BCC Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Advising Smokers and Tobacco Users to Quit	77.38%	77.27%	75.28%	-1.99	★★
Discussing Cessation Medications	53.23%	52.86%	50.14%	-2.72	★★★
Discussing Cessation Strategies	44.19%	46.70%	41.71%	-4.99	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	75.97%	74.52%	-1.45	★★★★★
Effective Continuation Phase Treatment	—	59.74%	60.78%	+1.04	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	74.86%	89.19%	81.20%	-7.99++	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	67.74%	60.34%	63.74%	+3.40	★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	—	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	53.57%	52.40%	57.38%	+4.98	★★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	86.52%	86.46%	-0.06	★★

Table B-2—BCC Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Digoxin	—	NA	57.69%	—	★★★
Diuretics	—	84.75%	86.15%	+1.40	★★
Total	—	85.56%	86.19%	+0.63	★★
Health Plan Diversity[5]					
Race/Ethnicity Diversity of Membership					
Total—White	37.28%	36.95%	42.89%	+5.94	—
Total—Black or African American	43.76%	44.44%	35.79%	-8.65	—
Total—American-Indian and Alaska Native	0.32%	0.38%	0.42%	+0.04	—
Total—Asian	1.50%	1.20%	1.63%	+0.43	—
Total—Native Hawaiian and Other Pacific Islander	0.00%	0.08%	0.07%	-0.01	—
Total—Some Other Race	3.50%	3.47%	6.59%	+3.12	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	13.64%	13.48%	10.00%	-3.48	—
Total—Declined	0.00%	0.00%	2.61%	+2.61	—
Total—Hispanic or Latino	0.00%	—	1.58%	—	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	99.08%	99.17%	97.90%	-1.27	—
Spoken Language Preferred for Health Care—Non-English	0.38%	0.37%	1.52%	+1.15	—
Spoken Language Preferred for Health Care—Unknown	0.54%	0.46%	0.59%	+0.13	—
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	99.08%	99.17%	97.90%	-1.27	—

Table B-2—BCC Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Preferred Language for Written Materials—Non-English	0.38%	0.37%	1.52%	+1.15	—
Preferred Language for Written Materials—Unknown	0.54%	0.46%	0.59%	+0.13	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—English	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—Unknown	100.00%	100.00%	100.00%	0.00	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	—
Utilization[5]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	70.55	70.18	68.98	-1.20	★★
Outpatient Visits—Total	356.57	554.98	396.06	-158.9	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	9.78	9.18	7.94	-1.24	—
Total Inpatient—Average Length of Stay—Total	3.76	4.31	3.92	-0.39	—
Maternity—Discharges per 1,000 Member Months—Total	3.99	2.80	2.80	0.00	—
Maternity—Average Length of Stay—Total	2.69	2.94	2.65	-0.29	—
Surgery—Discharges per 1,000 Member Months—Total	2.22	2.44	1.90	-0.54	—
Surgery—Average Length of Stay—Total	6.37	6.75	6.37	-0.38	—

Table B-2—BCC Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Medicine—Discharges per 1,000 Member Months—Total	4.74	4.54	3.87	-0.67	—
Medicine—Average Length of Stay—Total	3.17	3.65	3.43	-0.22	—

[1] HEDIS 2016 to HEDIS 2017 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05.

Green Shading+ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

Red Shading++ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

[2] 2017 Performance Levels were based on comparisons of the HEDIS 2017 measure indicator rates to Quality Compass national Medicaid HEDIS 2016 percentiles, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the NCQA national Medicaid Audit Means and Percentiles HEDIS 2016 percentiles.

[3] Due to changes in the technical specifications for this measure in HEDIS 2017, exercise caution when trending rates between 2017 and prior years.

[4] Due to changes in the technical specifications for this measure in HEDIS 2016, exercise caution when trending rates between 2016 and prior years.

[5] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2017 or 2016–2017 comparisons provided for these measures are for informational purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the measure was not presented in the previous years' deliverables, and therefore, the HEDIS 2015 and/or 2016 rate is not presented in this report. This symbol may also indicate that the 2016–2017 Comparison was not performed because the 2016 and/or 2017 rate was not reportable, or the 2017 performance levels were not determined because the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation. For HEDIS 2017 rates designated as NA, the 2017 performance level is also presented as NA.

2017 Performance Levels represent the following percentile comparisons:

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Table B-3—HAR Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	50.59%	48.57%	60.71%	+12.14	★
Combination 3	45.88%	44.29%	50.00%	+5.71	★
Combination 4	44.71%	42.86%	46.43%	+3.57	★
Combination 5	36.47%	32.86%	37.50%	+4.64	★
Combination 6	22.35%	21.43%	19.64%	-1.79	★
Combination 7	35.29%	31.43%	35.71%	+4.28	★
Combination 8	21.18%	20.00%	19.64%	-0.36	★
Combination 9	16.47%	18.57%	16.07%	-2.50	★
Combination 10	15.29%	17.14%	16.07%	-1.07	★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	37.50%	NA	NA	—	NA
Lead Screening in Children					
Lead Screening in Children	72.94%	71.43%	67.86%	-3.57	★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.44%	62.89%	69.68%	+6.79	★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	32.93%	35.51%	42.82%	+7.31[+]	★★
Immunizations for Adolescents					
Combination 1	NA	58.33%	68.42%	+10.09	★★
Appropriate Treatment for Children With Upper Respiratory Infection[3]					
Appropriate Treatment for Children With Upper Respiratory Infection	83.33%	96.61%	90.34%	**-6.27**[++]	★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	NA	NA	59.09%	—	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	NA	NA	NA	—	NA

Table B-3—HAR Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Continuation and Maintenance Phase	NA	NA	NA	—	NA
Women – Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	67.44%	64.71%	70.00%	+5.29	★★★★
Cervical Cancer Screening					
Cervical Cancer Screening	51.98%	42.58%	56.20%	+13.62[+]	★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	NA	71.88%	70.49%	-1.39	★★★★★
Ages 21 to 24 Years	NA	73.47%	70.67%	-2.80	★★★★
Total	64.44%	72.84%	70.59%	-2.25	★★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	82.30%	82.35%	86.05%	+3.70	★
Ages 25 Months to 6 Years	68.62%	73.16%	76.97%	+3.81	★
Ages 7 to 11 Years	71.26%	71.65%	79.14%	+7.49	★
Ages 12 to 19 Years	63.16%	67.02%	65.25%	-1.77	★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	56.51%	56.44%	59.28%	+2.84	★
Ages 45 to 64 Years	75.19%	76.43%	77.85%	+1.42	★
Ages 65+ Years	NA	NA	NA	—	NA
Total	64.64%	66.87%	68.12%	+1.25	★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[3]					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	40.00%	20.51%	-19.49	★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	79.03%	73.97%	79.08%	+5.11	★★★★
Counseling for Nutrition—Total	74.94%	69.83%	79.81%	+9.98[+]	★★★★★

Table B-3—HAR Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Counseling for Physical Activity—Total[4]	60.61%	57.66%	57.91%	+0.25	★★★
Adult BMI Assessment					
Adult BMI Assessment	94.52%	74.19%	90.27%	+16.08^{+}	★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	55.56%	34.41%	47.13%	+12.72	★
Postpartum Care	49.21%	33.33%	42.53%	+9.20	★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	28.57%	11.83%	24.14%	+12.31^{+}	★
Living With Illness					
Comprehensive Diabetes Care[4]					
Hemoglobin A1c (HbA1c) Testing	87.30%	75.64%	88.00%	+12.36^{+}	★★★
*HbA1c Poor Control (>9.0%)**	33.33%	73.08%	41.33%	-31.75^{+}	★★★
HbA1c Control (<8.0%)	53.97%	22.22%	52.67%	+30.45^{+}	★★★★
Eye Exam (Retinal) Performed	52.38%	46.15%	45.67%	-0.48	★★
Medical Attention for Nephropathy	88.89%	91.03%	90.00%	-1.03	★★
Blood Pressure Control (<140/90 mm Hg)	57.14%	31.20%	46.33%	+15.13^{+}	★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	NA	NA	—	NA
Medication Compliance 75%—Total	—	NA	NA	—	NA
Asthma Medication Ratio					
Total	—	NA	43.90%	—	★
Controlling High Blood Pressure					
Controlling High Blood Pressure	54.95%	31.39%	34.06%	+2.67	★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	80.83%	78.41%	79.06%	+0.65	★★★
Discussing Cessation Medications	63.11%	54.51%	58.99%	+4.48	★★★★★
Discussing Cessation Strategies	49.17%	45.28%	50.00%	+4.72	★★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	NA	NA	—	NA
Effective Continuation Phase Treatment	—	NA	NA	—	NA
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NA	NA	72.73%	—	★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	NA	NA	—	NA
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	—	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NA	NA	NA	—	NA
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	87.30%	87.79%	+0.49	★★★

Table B-3—HAR Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Digoxin	—	NA	NA	—	NA
Diuretics	—	85.20%	85.19%	-0.01	★★
Total	—	86.41%	86.63%	+0.22	★★
Health Plan Diversity[5]					
Race/Ethnicity Diversity of Membership					
Total—White	23.82%	2.39%	28.46%	+26.07	—
Total—Black or African American	60.13%	44.08%	51.78%	+7.70	—
Total—American-Indian and Alaska Native	0.09%	10.69%	1.13%	-9.56	—
Total—Asian	0.00%	15.88%	2.09%	-13.79	—
Total—Native Hawaiian and Other Pacific Islander	1.53%	0.00%	0.00%	0.00	—
Total—Some Other Race	3.77%	0.00%	0.00%	0.00	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	10.66%	26.96%	16.54%	-10.42	—
Total—Declined	0.00%	0.00%	0.00%	0.00	—
Total—Hispanic or Latino	3.77%	—	3.59%	—	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	100.00%	72.57%	99.04%	+26.47	—
Spoken Language Preferred for Health Care—Non-English	0.00%	0.51%	0.92%	+0.41	—
Spoken Language Preferred for Health Care—Unknown	0.00%	26.93%	0.05%	-26.88	—
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	0.00%	0.00%	0.00%	0.00	—

Table B-3—HAR Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Preferred Language for Written Materials—Non-English	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—Unknown	100.00%	100.00%	100.00%	0.00	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—English	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—Unknown	100.00%	100.00%	100.00%	0.00	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	—
Utilization[5]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	72.44	79.99	82.34	+2.35	★
Outpatient Visits—Total	248.66	241.28	251.03	+9.75	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	8.67	9.83	9.03	-0.80	—
Total Inpatient—Average Length of Stay—Total	4.39	3.89	4.15	+0.26	—
Maternity—Discharges per 1,000 Member Months—Total	2.18	1.76	0.26	-1.50	—
Maternity—Average Length of Stay—Total	2.80	2.47	2.47	0.00	—
Surgery—Discharges per 1,000 Member Months—Total	1.81	2.09	2.73	+0.64	—
Surgery—Average Length of Stay—Total	7.65	5.67	4.80	-0.87	—

Table B-3—HAR Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Medicine—Discharges per 1,000 Member Months—Total	5.36	6.06	4.85	-1.21	—
Medicine—Average Length of Stay—Total	3.73	3.56	3.53	-0.03	—

[1] HEDIS 2016 to HEDIS 2017 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05.

Green Shading[+] *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

Red Shading[++] *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

[2] 2017 Performance Levels were based on comparisons of the HEDIS 2017 measure indicator rates to Quality Compass national Medicaid HEDIS 2016 percentiles, with the exception of the Medications Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the NCQA national Medicaid Audit Means and Percentiles HEDIS 2016 percentiles.

[3] Due to changes in the technical specifications for this measure in HEDIS 2017, exercise caution when trending rates between 2017 and prior years.

[4] Due to changes in the technical specifications for this measure in HEDIS 2016, exercise caution when trending rates between 2016 and prior years.

[5] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2017 or 2016–2017 comparisons provided for these measures are for informational purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the measure was not presented in the previous years' deliverables; therefore, the HEDIS 2015 and/or 2016 rate is not presented in this report. This symbol may also indicate that the 2016–2017 Comparison was not performed because the 2016 and/or 2017 rate was not reportable or that the 2017 performance levels were not determined because the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation. For HEDIS 2017 rates designated as NA, the 2017 performance level is also presented as NA.

2017 Performance Levels represent the following percentile comparisons:

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Table B-4—MCL Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	72.75%	74.70%	79.81%	+5.11	★★★★
Combination 3	69.59%	68.61%	75.67%	+7.06^{+}	★★★★
Combination 4	64.96%	64.72%	73.97%	+9.25^{+}	★★★★
Combination 5	55.72%	54.99%	68.13%	+13.14^{+}	★★★★
Combination 6	38.69%	38.93%	40.88%	+1.95	★★★
Combination 7	52.55%	53.04%	66.42%	+13.38^{+}	★★★★
Combination 8	37.96%	38.44%	40.88%	+2.44	★★★
Combination 9	31.63%	32.85%	37.71%	+4.86	★★★
Combination 10	31.14%	32.85%	37.71%	+4.86	★★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	68.37%	66.42%	64.48%	-1.94	★★★
Lead Screening in Children					
Lead Screening in Children	84.91%	92.21%	94.40%	+2.19	★★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.94%	71.29%	70.07%	-1.22	★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	46.96%	46.23%	47.20%	+0.97	★★
Immunizations for Adolescents					
Combination 1	89.29%	82.73%	84.43%	+1.70	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection[3]					
Appropriate Treatment for Children With Upper Respiratory Infection	82.94%	86.74%	86.33%	-0.41	★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	66.88%	70.37%	70.40%	+0.03	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	45.42%	42.27%	39.67%	-2.60	★★

Table B-4—MCL Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Continuation and Maintenance Phase	57.34%	54.07%	43.98%	-10.09^{++}	★★
Women – Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	50.02%	58.78%	63.31%	+4.53^{+}	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	55.47%	63.02%	56.93%	-6.09	★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	50.19%	50.36%	52.81%	+2.45	★★★
Ages 21 to 24 Years	55.96%	60.12%	59.87%	-0.25	★★
Total	52.38%	54.81%	56.01%	+1.20	★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	96.28%	95.44%	94.66%	-0.78	★★
Ages 25 Months to 6 Years	88.95%	86.68%	87.10%	+0.42	★★
Ages 7 to 11 Years	89.67%	87.98%	89.00%	+1.02^{+}	★★
Ages 12 to 19 Years	87.72%	86.62%	88.30%	+1.68^{+}	★★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	81.53%	83.34%	82.10%	-1.24^{++}	★★★
Ages 45 to 64 Years	89.61%	89.87%	89.58%	-0.29	★★★
Ages 65+ Years	83.63%	90.48%	NA	—	NA
Total	84.36%	86.05%	85.18%	-0.87^{++}	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[3]					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	23.00%	26.35%	+3.35^{+}	★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	76.16%	66.67%	83.45%	+16.78^{+}	★★★★
Counseling for Nutrition—Total	56.45%	50.85%	60.34%	+9.49^{+}	★★
Counseling for Physical Activity—Total[4]	44.28%	44.53%	50.85%	+6.32	★★

Table B-4—MCL Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	86.86%	87.83%	91.48%	+3.65	★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	86.86%	76.40%	86.13%	+9.73[+]	★★★
Postpartum Care	69.34%	63.99%	64.23%	+0.24	★★★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	60.83%	58.15%	51.09%	-7.06[++]	★★
Living With Illness					
Comprehensive Diabetes Care[4]					
Hemoglobin A1c (HbA1c) Testing	83.19%	89.42%	87.59%	-1.83	★★★
*HbA1c Poor Control (>9.0%)**	34.82%	36.50%	48.54%	12.04[++]	★★
HbA1c Control (<8.0%)	45.80%	51.09%	41.61%	-9.48[++]	★★
Eye Exam (Retinal) Performed	52.49%	56.20%	58.03%	+1.83	★★★
Medical Attention for Nephropathy	82.85%	92.15%	88.87%	-3.28	★★
Blood Pressure Control (<140/90 mm Hg)	62.44%	61.50%	66.24%	+4.74	★★★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	59.94%	84.33%	+24.39[+]	★★★★★
Medication Compliance 75%—Total	—	38.39%	67.87%	+29.48[+]	★★★★★
Asthma Medication Ratio					
Total	—	65.18%	66.09%	+0.91	★★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	54.99%	54.74%	58.64%	+3.90	★★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	75.71%	77.60%	76.79%	-0.81	★★★

Table B-4—MCL Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Discussing Cessation Medications	42.98%	50.54%	54.94%	+4.40	★★★★
Discussing Cessation Strategies	39.94%	42.25%	47.70%	+5.45	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	58.33%	45.65%	-12.68[++]	★
Effective Continuation Phase Treatment	—	39.15%	29.70%	-9.45[++]	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.07%	81.62%	82.62%	+1.00	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	61.93%	63.59%	72.17%	+8.58	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	67.65%	NA	NA	—	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	67.20%	66.45%	63.27%	-3.18	★★★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	86.14%	84.68%	-1.46[++]	★
Digoxin	—	56.25%	44.44%	-11.81	★
Diuretics	—	86.37%	85.62%	-0.75	★★

Table B-4—MCL Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Total	—	86.02%	84.84%	-1.18[++]	★
Health Plan Diversity[5]					
Race/Ethnicity Diversity of Membership					
Total—White	65.46%	68.72%	66.67%	-2.05	—
Total—Black or African American	15.84%	15.26%	17.27%	+2.01	—
Total—American-Indian and Alaska Native	0.31%	0.55%	0.54%	-0.01	—
Total—Asian	0.90%	0.71%	0.00%	-0.71	—
Total—Native Hawaiian and Other Pacific Islander	0.07%	0.07%	0.79%	+0.72	—
Total—Some Other Race	<0.01%	5.05%	5.51%	+0.46	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	12.43%	9.64%	9.22%	-0.42	—
Total—Declined	4.99%	<0.01%	0.00%	0.00	—
Total—Hispanic or Latino	4.65%	5.05%	5.51%	+0.46	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	98.64%	96.40%	96.45%	+0.05	—
Spoken Language Preferred for Health Care—Non-English	0.62%	0.20%	0.77%	+0.57	—
Spoken Language Preferred for Health Care—Unknown	<0.01%	3.40%	2.78%	-0.62	—
Spoken Language Preferred for Health Care—Declined	0.74%	<0.01%	0.00%	0.00	—
Preferred Language for Written Materials—English	0.00%	NR	0.00%	—	—
Preferred Language for Written Materials—Non-English	0.00%	NR	0.00%	—	—
Preferred Language for Written Materials—Unknown	100.00%	100.00%	100.00%	0.00	—
Preferred Language for Written Materials—Declined	0.00%	NR	0.00%	—	—
Other Language Needs—English	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—Unknown	100.00%	100.00%	100.00%	0.00	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	—
Utilization[5]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	69.79	70.80	70.81	+0.01	★★
Outpatient Visits—Total	475.45	430.13	552.80	+122.67	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	7.59	7.42	8.38	+0.96	—
Total Inpatient—Average Length of Stay—Total	3.55	3.45	3.87	+0.42	—
Maternity—Discharges per 1,000 Member Months—Total	3.81	2.65	2.72	+0.07	—
Maternity—Average Length of Stay—Total	2.56	2.33	2.46	+0.13	—
Surgery—Discharges per 1,000 Member Months—Total	1.55	2.01	4.09	+2.08	—
Surgery—Average Length of Stay—Total	5.09	4.85	4.70	-0.15	—

Table B-4—MCL Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Medicine—Discharges per 1,000 Member Months—Total	3.31	3.47	1.47	-2.00	—
Medicine—Average Length of Stay—Total	3.62	3.27	3.61	+0.34	—

[1] HEDIS 2016 to HEDIS 2017 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05.

Green Shading+ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

Red Shading++ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

[2] 2017 Performance Levels were based on comparisons of the HEDIS 2017 measure indicator rates to Quality Compass national Medicaid HEDIS 2016 percentiles, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the NCQA national Medicaid Audit Means and Percentiles HEDIS 2016 percentiles.
[3] Due to changes in the technical specifications for this measure in HEDIS 2017, exercise caution when trending rates between 2017 and prior years.
[4] Due to changes in the technical specifications for this measure in HEDIS 2016, exercise caution when trending rates between 2016 and prior years.
[5] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2017 or 2016–2017 comparisons provided for these measures are for informational purposes only.
** For this indicator, a lower rate indicates better performance.*
— indicates that the measure was not presented in the previous years' deliverables; therefore, the HEDIS 2015 and/or 2016 rate is not presented in this report. This symbol may also indicate that the 2016–2017 Comparison was not performed because the 2016 and/or 2017 rate was not reportable or that the 2017 performance levels were not determined because the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation. For HEDIS 2017 rates designated as NA, the 2017 performance level is also presented as NA.
NR indicates that the auditor determined that the HEDIS 2015 or HEDIS 2016 rate was materially biased or that the MHP chose not report a rate for this measure indicator. For HEDIS 2017, NR indicates that the MHP chose not to report a rate for this measure indicator.

2017 Performance Levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table B-5—MER Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	78.89%	77.91%	78.60%	+0.69	★★★★
Combination 3	74.25%	72.79%	74.88%	+2.09	★★★
Combination 4	65.43%	68.84%	71.63%	+2.79	★★★
Combination 5	61.72%	59.07%	64.42%	+5.35	★★★★
Combination 6	46.64%	42.79%	40.70%	-2.09	★★★
Combination 7	55.45%	55.81%	62.33%	+6.52	★★★★
Combination 8	42.69%	41.86%	40.00%	-1.86	★★★
Combination 9	40.84%	36.28%	35.81%	-0.47	★★★
Combination 10	37.82%	35.35%	35.35%	0.00	★★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	74.54%	75.21%	74.88%	-0.33	★★★★★
Lead Screening in Children					
Lead Screening in Children	81.48%	80.32%	81.14%	+0.82	★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	79.17%	77.27%	78.42%	+1.15	★★★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	55.92%	59.72%	64.42%	+4.70	★★★★
Immunizations for Adolescents					
Combination 1	89.39%	86.11%	86.60%	+0.49	★★★★★
Appropriate Treatment for Children With Upper Respiratory Infection[3]					
Appropriate Treatment for Children With Upper Respiratory Infection	89.73%	89.77%	89.44%	-0.33	★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	70.95%	72.84%	73.43%	+0.59	★★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	45.72%	45.88%	41.74%	**-4.14**[++]	★★

Table B-5—MER Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Continuation and Maintenance Phase	55.14%	57.59%	55.97%	-1.62	★★★
Women – Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	65.27%	59.57%	64.41%	+4.84[+]	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	76.94%	63.91%	65.50%	+1.59	★★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	58.63%	60.65%	60.49%	-0.16	★★★★
Ages 21 to 24 Years	67.98%	68.47%	69.23%	+0.76	★★★★
Total	62.39%	64.41%	64.88%	+0.47	★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	97.66%	97.69%	97.37%	-0.32	★★★★
Ages 25 Months to 6 Years	91.70%	91.25%	90.69%	**-0.56**[++]	★★★
Ages 7 to 11 Years	92.85%	92.57%	92.53%	-0.04	★★★
Ages 12 to 19 Years	92.88%	92.74%	92.90%	+0.16	★★★★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	85.52%	85.37%	83.55%	**-1.82**[++]	★★★★
Ages 45 to 64 Years	92.36%	91.57%	90.46%	**-1.11**[++]	★★★★
Ages 65+ Years	89.69%	91.50%	92.62%	+1.12	★★★★
Total	87.57%	87.70%	86.17%	**-1.53**[++]	★★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[3]					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	23.57%	26.18%	+2.61[+]	★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	75.17%	74.53%	81.48%	+6.95[+]	★★★★
Counseling for Nutrition—Total	69.37%	68.22%	73.15%	+4.93	★★★★

Table B-5—MER Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Counseling for Physical Activity—Total[4]	53.36%	55.14%	59.49%	+4.35	★★★
Adult BMI Assessment					
Adult BMI Assessment	91.65%	94.08%	96.28%	+2.20	★★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	90.02%	88.11%	82.87%	**-5.24++**	★★★
Postpartum Care	70.07%	68.53%	71.30%	+2.77	★★★★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	85.38%	86.01%	70.83%	**-15.18++**	★★★★
Living With Illness					
Comprehensive Diabetes Care[4]					
Hemoglobin A1c (HbA1c) Testing	87.03%	85.60%	87.79%	+2.19	★★★
*HbA1c Poor Control (>9.0%)**	45.54%	39.97%	35.42%	-4.55	★★★★
HbA1c Control (<8.0%)	45.38%	50.23%	52.67%	+2.44	★★★★
Eye Exam (Retinal) Performed	63.86%	61.87%	67.63%	+5.76+	★★★★
Medical Attention for Nephropathy	81.69%	88.67%	91.45%	+2.78	★★★
Blood Pressure Control (<140/90 mm Hg)	72.77%	68.15%	65.65%	-2.50	★★★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	71.23%	72.33%	+1.10	★★★★★
Medication Compliance 75%—Total	—	48.68%	51.35%	+2.67+	★★★★★
Asthma Medication Ratio					
Total	—	69.48%	61.92%	**-7.56++**	★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	74.46%	67.79%	67.15%	-0.64	★★★★
Medical Assistance With Smoking and Tobacco Use Cessation					

Table B-5—MER Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Advising Smokers and Tobacco Users to Quit	80.81%	80.16%	81.16%	+1.00	★★★★
Discussing Cessation Medications	58.61%	55.69%	54.30%	-1.39	★★★★
Discussing Cessation Strategies	47.99%	44.88%	44.68%	-0.20	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	70.45%	50.92%	**-19.53++**	★★
Effective Continuation Phase Treatment	—	50.24%	31.77%	**-18.47++**	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.96%	80.27%	83.11%	+2.84+	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	92.37%	73.63%	66.04%	**-7.59++**	★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	57.42%	80.00%	55.88%	**-24.12++**	★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	52.48%	61.59%	63.52%	+1.93	★★★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	87.38%	86.53%	**-0.85++**	★★

Table B-5—MER Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Digoxin	—	52.38%	51.44%	-0.94	★★
Diuretics	—	87.53%	86.88%	-0.65	★★
Total	—	87.22%	86.47%	**-0.75**++	★★
Health Plan Diversity[5]					
Race/Ethnicity Diversity of Membership					
Total—White	63.62%	62.24%	61.97%	-0.27	—
Total—Black or African American	21.24%	21.29%	21.51%	+0.22	—
Total—American-Indian and Alaska Native	0.34%	0.45%	0.49%	+0.04	—
Total—Asian	0.84%	0.77%	0.73%	-0.04	—
Total—Native Hawaiian and Other Pacific Islander	0.06%	0.06%	0.06%	0.00	—
Total—Some Other Race	<0.01%	<0.01%	<0.01%	0.00	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	5.65%	5.66%	5.76%	+0.10	—
Total—Declined	8.24%	9.53%	9.48%	-0.05	—
Total—Hispanic or Latino	5.65%	5.66%	5.75%	+0.09	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	98.72%	98.87%	98.69%	-0.18	—
Spoken Language Preferred for Health Care—Non-English	1.28%	1.13%	1.29%	+0.16	—
Spoken Language Preferred for Health Care—Unknown	<0.01%	<0.01%	0.02%	+0.02	—
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	98.72%	98.87%	98.69%	-0.18	—

Table B-5—MER Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Preferred Language for Written Materials—Non-English	1.28%	1.13%	1.29%	+0.16	—
Preferred Language for Written Materials—Unknown	<0.01%	<0.01%	0.02%	+0.02	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—English	98.72%	98.87%	98.69%	-0.18	—
Other Language Needs—Non-English	1.28%	1.13%	1.29%	+0.16	—
Other Language Needs—Unknown	<0.01%	<0.01%	0.02%	+0.02	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	—
Utilization[5]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	35.59	80.18	77.48	-2.70	★
Outpatient Visits—Total	220.85	392.51	398.30	+5.79	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	7.76	8.23	8.10	-0.13	—
Total Inpatient—Average Length of Stay—Total	3.70	3.86	3.99	+0.13	—
Maternity—Discharges per 1,000 Member Months—Total	4.43	2.65	3.42	+0.77	—
Maternity—Average Length of Stay—Total	2.45	2.50	2.55	+0.05	—
Surgery—Discharges per 1,000 Member Months—Total	1.13	1.02	1.90	+0.88	—
Surgery—Average Length of Stay—Total	5.90	5.73	6.29	+0.56	—

Table B-5—MER Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Medicine—Discharges per 1,000 Member Months—Total	3.81	5.33	3.74	-1.59	—
Medicine—Average Length of Stay—Total	3.98	3.98	3.77	-0.21	—

[1] HEDIS 2016 to HEDIS 2017 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05.

Green Shading+ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

Red Shading++ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

[2] 2017 Performance Levels were based on comparisons of the HEDIS 2017 measure indicator rates to Quality Compass national Medicaid HEDIS 2016 percentiles, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the NCQA national Medicaid Audit Means and Percentiles HEDIS 2016 percentiles.

[3] Due to changes in the technical specifications for this measure in HEDIS 2017, exercise caution when trending rates between 2017 and prior years.

[4] Due to changes in the technical specifications for this measure in HEDIS 2016, exercise caution when trending rates between 2016 and prior years.

[5] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2017 or 2016–2017 comparisons provided for these measures are for informational purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the measure was not presented in the previous years' deliverables; therefore, the HEDIS 2015 and/or 2016 rate is not presented in this report. This symbol may also indicate that the 2016–2017 Comparison was not performed because the 2016 and/or 2017 rate was not reportable or that the 2017 performance levels were not determined because the measure did not have an applicable benchmark.

2017 Performance Levels represent the following percentile comparisons:

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Table B-6—MID Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	79.59%	79.86%	NA	—	NA
Combination 3	73.79%	73.84%	NA	—	NA
Combination 4	70.38%	71.30%	NA	—	NA
Combination 5	62.29%	63.43%	NA	—	NA
Combination 6	72.06%	38.43%	NA	—	NA
Combination 7	59.64%	61.34%	NA	—	NA
Combination 8	68.75%	37.27%	NA	—	NA
Combination 9	61.02%	33.10%	NA	—	NA
Combination 10	58.47%	31.94%	NA	—	NA
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	59.61%	56.02%	NA	—	NA
Lead Screening in Children					
Lead Screening in Children	77.62%	74.07%	NA	—	NA
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.91%	76.85%	56.36%	-20.49++	★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	54.26%	54.99%	24.07%	-30.92++	★
Immunizations for Adolescents					
Combination 1	87.10%	87.73%	NA	—	NA
Appropriate Treatment for Children With Upper Respiratory Infection[3]					
Appropriate Treatment for Children With Upper Respiratory Infection	88.35%	88.19%	NA	—	NA
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	65.50%	67.98%	NA	—	NA
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	32.77%	31.86%	NA	—	NA

Table B-6—MID Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Continuation and Maintenance Phase	35.05%	33.33%	NA	—	NA
Women – Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	56.39%	57.54%	56.94%	-0.60	★★
Cervical Cancer Screening					
Cervical Cancer Screening	65.21%	59.35%	52.26%	-7.09++	★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	59.47%	58.75%	NA	—	NA
Ages 21 to 24 Years	67.40%	64.76%	47.62%	-17.14++	★
Total	62.42%	61.37%	44.83%	-16.54++	★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	94.47%	95.21%	NA	—	NA
Ages 25 Months to 6 Years	86.08%	86.58%	65.71%	-20.87++	★
Ages 7 to 11 Years	89.51%	89.22%	75.76%	-13.46++	★
Ages 12 to 19 Years	88.21%	87.47%	68.00%	-19.47++	★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	80.58%	77.66%	73.02%	-4.64++	★
Ages 45 to 64 Years	88.77%	88.04%	90.16%	+2.12+	★★★★
Ages 65+ Years	92.52%	89.06%	85.05%	-4.01++	★★
Total	83.84%	82.14%	83.86%	+1.72+	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[3]					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	33.23%	NA	—	NA
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	75.67%	74.17%	87.64%	+13.47+	★★★★★
Counseling for Nutrition—Total	69.34%	62.80%	70.79%	+7.99	★★★
Counseling for Physical Activity—Total[4]	63.26%	54.98%	64.04%	+9.06	★★★★

Table B-6—MID Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	85.16%	85.42%	89.95%	+4.53	★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	87.83%	71.93%	50.00%	-21.93[++]	★
Postpartum Care	62.53%	51.04%	40.38%	-10.66	★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	62.29%	35.73%	13.46%	-22.27[++]	★
Living With Illness					
Comprehensive Diabetes Care[4]					
Hemoglobin A1c (HbA1c) Testing	86.96%	85.93%	86.37%	+0.44	★★★
*HbA1c Poor Control (>9.0%)**	36.59%	48.44%	39.90%	-8.54[+]	★★★
HbA1c Control (<8.0%)	54.81%	45.04%	52.31%	+7.27[+]	★★★
Eye Exam (Retinal) Performed	57.63%	57.19%	54.74%	-2.45	★★★
Medical Attention for Nephropathy	81.93%	88.74%	94.89%	+6.15[+]	★★★★★
Blood Pressure Control (<140/90 mm Hg)	73.93%	44.74%	57.91%	+13.17[+]	★★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	62.98%	NA	—	NA
Medication Compliance 75%—Total	—	34.90%	NA	—	NA
Asthma Medication Ratio					
Total	—	60.26%	NA	—	NA
Controlling High Blood Pressure					
Controlling High Blood Pressure	66.18%	53.86%	60.58%	+6.72[+]	★★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	81.27%	81.74%	82.11%	+0.37	★★★★★

Table B-6—MID Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Discussing Cessation Medications	50.46%	52.57%	58.30%	+5.73	★★★★
Discussing Cessation Strategies	45.85%	44.21%	44.44%	+0.23	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	37.50%	47.12%	+9.62	★
Effective Continuation Phase Treatment	—	23.44%	31.73%	+8.29	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.87%	81.58%	68.00%	-13.58[++]	★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	53.85%	65.69%	64.10%	-1.59	★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	—	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	58.25%	5.04%	69.41%	+64.37[+]	★★★★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	86.17%	83.40%	-2.77[++]	★
Digoxin	—	54.55%	NA	—	NA
Diuretics	—	84.95%	84.75%	-0.20	★

Table B-6—MID Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Total	—	85.43%	83.67%	-1.76	★
Health Plan Diversity[5]					
Race/Ethnicity Diversity of Membership					
Total—White	44.39%	43.61%	46.63%	+3.02	—
Total—Black or African American	38.67%	37.40%	35.69%	-1.71	—
Total—American-Indian and Alaska Native	0.13%	0.18%	0.00%	-0.18	—
Total—Asian	2.11%	2.02%	2.36%	+0.34	—
Total—Native Hawaiian and Other Pacific Islander	0.19%	0.18%	0.29%	+0.11	—
Total—Some Other Race	0.00%	4.58%	2.64%	-1.94	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	14.52%	12.03%	12.39%	+0.36	—
Total—Declined	0.00%	0.00%	0.00%	0.00	—
Total—Hispanic or Latino	4.75%	4.58%	2.64%	-1.94	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	100.00%	100.00%	100.00%	0.00	—
Spoken Language Preferred for Health Care—Non-English	0.00%	0.00%	0.00%	0.00	—
Spoken Language Preferred for Health Care—Unknown	0.00%	0.00%	0.00%	0.00	—
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—Non-English	0.00%	0.00%	0.00%	0.00	—

Table B-6—MID Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Preferred Language for Written Materials—Unknown	100.00%	100.00%	100.00%	0.00	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—English	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—Unknown	100.00%	100.00%	100.00%	0.00	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	—
Utilization[5]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	66.72	66.64	75.28	+8.64	★
Outpatient Visits—Total	370.50	405.99	539.45	+133.46	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	7.62	9.24	16.85	+7.61	—
Total Inpatient—Average Length of Stay—Total	4.00	3.87	BR	—	—
Maternity—Discharges per 1,000 Member Months—Total	3.14	2.77	1.30	-1.47	—
Maternity—Average Length of Stay—Total	2.57	2.52	BR	—	—
Surgery—Discharges per 1,000 Member Months—Total	1.63	2.16	3.59	+1.43	—
Surgery—Average Length of Stay—Total	6.86	6.26	BR	—	—

Table B-6—MID Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Medicine—Discharges per 1,000 Member Months—Total	3.87	5.06	12.46	+7.40	—
Medicine—Average Length of Stay—Total	3.58	3.38	BR	—	—

[1] HEDIS 2016 to HEDIS 2017 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05.

Green Shading+ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

Red Shading++ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

[2] 2017 Performance Levels were based on comparisons of the HEDIS 2017 measure indicator rates to Quality Compass national Medicaid HEDIS 2016 percentiles, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the NCQA national Medicaid Audit Means and Percentiles HEDIS 2016 percentiles.

[3] Due to changes in the technical specifications for this measure in HEDIS 2017, exercise caution when trending rates between 2017 and prior years.

[4] Due to changes in the technical specifications for this measure in HEDIS 2016, exercise caution when trending rates between 2016 and prior years.

[5] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2017 or 2016–2017 comparisons provided for these measures are for informational purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the measure was not presented in the previous years' deliverables; therefore, the HEDIS 2015 and/or 2016 rate is not presented in this report. This symbol may also indicate that the 2016–2017 Comparison was not performed because the 2016 and/or 2017 rate was not reportable or that the 2017 performance levels were not determined because the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation. For HEDIS 2017 rates designated as NA, the 2017 performance level is also presented as NA.

BR (Biased Rate) indicates that the MHP's rate for this measure was invalid; therefore, the rate is not presented.

2017 Performance Levels represent the following percentile comparisons:

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Table B-7—MOL Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	75.05%	73.73%	71.74%	-1.99	★★
Combination 3	71.08%	68.43%	68.65%	+0.22	★★
Combination 4	65.43%	65.56%	67.11%	+1.55	★★
Combination 5	59.23%	60.26%	58.28%	-1.98	★★
Combination 6	37.05%	36.42%	35.98%	-0.44	★★
Combination 7	54.74%	57.84%	57.17%	-0.67	★★★
Combination 8	35.71%	35.32%	35.32%	0.00	★★
Combination 9	31.77%	33.33%	30.68%	-2.65	★★
Combination 10	30.70%	32.23%	30.24%	-1.99	★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	55.09%	63.84%	68.79%	+4.95	★★★★
Lead Screening in Children					
Lead Screening in Children	74.33%	72.19%	78.15%	+5.96+	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.09%	76.15%	75.89%	-0.26	★★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	58.00%	57.21%	52.48%	-4.73	★★★
Immunizations for Adolescents					
Combination 1	92.59%	90.54%	90.07%	-0.47	★★★★★
Appropriate Treatment for Children With Upper Respiratory Infection[3]					
Appropriate Treatment for Children With Upper Respiratory Infection	89.65%	88.44%	86.82%	**-1.62++**	★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	63.02%	62.82%	67.17%	+4.35+	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	31.66%	37.42%	48.40%	+10.98+	★★★

Table B-7—MOL Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Continuation and Maintenance Phase	33.03%	45.83%	65.97%	+20.14+	★★★★
Women – Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	58.34%	59.67%	60.31%	+0.64	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	69.47%	65.63%	65.69%	+0.06	★★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	62.05%	63.25%	63.27%	+0.02	★★★★
Ages 21 to 24 Years	70.22%	70.83%	70.37%	-0.46	★★★★
Total	64.78%	66.33%	66.23%	-0.10	★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	96.11%	96.39%	96.02%	-0.37	★★★
Ages 25 Months to 6 Years	87.38%	88.57%	89.57%	+1.00+	★★★
Ages 7 to 11 Years	90.98%	91.64%	92.52%	+0.88+	★★★
Ages 12 to 19 Years	89.86%	90.53%	90.88%	+0.35	★★★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	84.10%	82.66%	81.58%	**-1.08++**	★★★
Ages 45 to 64 Years	91.54%	89.94%	89.24%	**-0.70++**	★★★
Ages 65+ Years	91.33%	96.13%	91.02%	**-5.11++**	★★★★
Total	87.62%	85.79%	84.82%	**-0.97++**	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[3]					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	27.70%	30.18%	+2.48	★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	77.85%	80.46%	80.61%	+0.15	★★★★
Counseling for Nutrition—Total	68.01%	67.82%	71.39%	+3.57	★★★★
Counseling for Physical Activity—Total[4]	60.40%	63.68%	63.59%	-0.09	★★★★

Table B-7—MOL Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	93.36%	90.15%	97.14%	+6.99+	★★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	76.33%	78.20%	83.33%	+5.13	★★★
Postpartum Care	71.02%	67.87%	75.80%	+7.93+	★★★★★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	43.58%	39.10%	54.57%	+15.47+	★★
Living With Illness					
Comprehensive Diabetes Care[4]					
Hemoglobin A1c (HbA1c) Testing	84.99%	86.04%	87.64%	+1.60	★★★
*HbA1c Poor Control (>9.0%)**	32.23%	41.44%	32.45%	-8.99+	★★★★
HbA1c Control (<8.0%)	59.82%	50.90%	56.73%	+5.83	★★★★
Eye Exam (Retinal) Performed	56.29%	57.43%	62.03%	+4.60	★★★★
Medical Attention for Nephropathy	85.65%	92.12%	90.73%	-1.39	★★★
Blood Pressure Control (<140/90 mm Hg)	62.03%	55.41%	55.19%	-0.22	★★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	55.61%	57.76%	+2.15	★★★
Medication Compliance 75%—Total	—	30.92%	34.13%	+3.21+	★★★
Asthma Medication Ratio					
Total	—	61.35%	60.91%	-0.44	★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	61.96%	53.60%	49.04%	-4.56	★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	84.18%	83.54%	80.93%	-2.61	★★★★

Table B-7—MOL Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Discussing Cessation Medications	55.34%	56.32%	57.56%	+1.24	★★★★
Discussing Cessation Strategies	48.81%	45.94%	43.62%	-2.32	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	51.46%	48.20%	-3.26++	★
Effective Continuation Phase Treatment	—	34.29%	32.61%	-1.68	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.19%	84.61%	83.10%	-1.51	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	73.17%	71.16%	72.50%	+1.34	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	79.07%	63.33%	76.32%	+12.99	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	69.45%	66.61%	61.20%	-5.41++	★★★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	88.15%	87.44%	-0.71	★★★
Digoxin	—	54.92%	65.69%	+10.77	★★★★★
Diuretics	—	87.55%	87.29%	-0.26	★★

Table B-7—MOL Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Total	—	87.64%	87.23%	-0.41	★★★
Health Plan Diversity[5]					
Race/Ethnicity Diversity of Membership					
Total—White	44.42%	47.85%	46.28%	-1.57	—
Total—Black or African American	34.04%	32.33%	32.97%	+0.64	—
Total—American-Indian and Alaska Native	0.20%	0.26%	0.28%	+0.02	—
Total—Asian	0.66%	0.36%	0.32%	-0.04	—
Total—Native Hawaiian and Other Pacific Islander	0.00%	0.00%	<0.01%	0.00	—
Total—Some Other Race	0.00%	0.00%	0.00%	0.00	—
Total—Two or More Races	<0.01%	<0.01%	<0.01%	0.00	—
Total—Unknown	20.67%	19.20%	20.15%	+0.95	—
Total—Declined	0.00%	0.00%	0.00%	0.00	—
Total—Hispanic or Latino	7.45%	6.63%	6.40%	-0.23	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	98.61%	98.99%	98.76%	-0.23	—
Spoken Language Preferred for Health Care—Non-English	1.20%	0.91%	1.12%	+0.21	—
Spoken Language Preferred for Health Care—Unknown	0.19%	0.10%	0.12%	+0.02	—
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	98.61%	98.99%	98.76%	-0.23	—
Preferred Language for Written Materials—Non-English	1.20%	0.91%	1.12%	+0.21	—

Table B-7—MOL Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Preferred Language for Written Materials—Unknown	0.19%	0.10%	0.12%	+0.02	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—English	98.61%	98.99%	98.76%	-0.23	—
Other Language Needs—Non-English	1.20%	0.91%	1.12%	+0.21	—
Other Language Needs—Unknown	0.19%	0.10%	0.12%	+0.02	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	—
Utilization[5]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	75.53	75.32	71.94	-3.38	★★
Outpatient Visits—Total	395.04	410.12	424.09	+13.97	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	8.12	8.97	7.42	-1.55	—
Total Inpatient—Average Length of Stay—Total	4.51	4.45	4.62	+0.17	—
Maternity—Discharges per 1,000 Member Months—Total	3.93	2.97	2.65	-0.32	—
Maternity—Average Length of Stay—Total	2.65	2.73	2.78	+0.05	—
Surgery—Discharges per 1,000 Member Months—Total	1.80	1.90	1.82	-0.08	—
Surgery—Average Length of Stay—Total	7.63	7.44	7.75	+0.31	—

Table B-7—MOL Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Medicine—Discharges per 1,000 Member Months—Total	3.93	4.98	3.71	-1.27	—
Medicine—Average Length of Stay—Total	4.21	4.03	4.04	+0.01	—

[1] HEDIS 2016 to HEDIS 2017 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05.

Green Shading+ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

Red Shading++ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

[2] 2017 Performance Levels were based on comparisons of the HEDIS 2017 measure indicator rates to Quality Compass national Medicaid HEDIS 2016 percentiles, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the NCQA national Medicaid Audit Means and Percentiles HEDIS 2016 percentiles.
[3] Due to changes in the technical specifications for this measure in HEDIS 2017, exercise caution when trending rates between 2017 and prior years.
[4] Due to changes in the technical specifications for this measure in HEDIS 2016, exercise caution when trending rates between 2016 and prior years.
[5] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2017 or 2016–2017 comparisons provided for these measures are for informational purposes only.
** For this indicator, a lower rate indicates better performance.*
— indicates that the measure was not presented in the previous years' deliverables; therefore, the HEDIS 2015 and/or 2016 rate is not presented in this report. This symbol may also indicate that the 2016–2017 Comparison was not performed because the 2016 and/or 2017 rate was not reportable or that the 2017 performance levels were not determined because the measure did not have an applicable benchmark.

2017 Performance Levels represent the following percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Table B-8—PRI Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	85.75%	82.88%	80.29%	-2.59	★★★★
Combination 3	84.28%	80.89%	77.13%	-3.76	★★★★
Combination 4	81.57%	78.16%	76.16%	-2.00	★★★★
Combination 5	74.45%	70.72%	69.34%	-1.38	★★★★★
Combination 6	64.13%	57.07%	55.23%	-1.84	★★★★★
Combination 7	72.48%	68.49%	68.37%	-0.12	★★★★★
Combination 8	63.39%	56.08%	54.74%	-1.34	★★★★★
Combination 9	58.23%	51.61%	50.36%	-1.25	★★★★★
Combination 10	57.49%	50.62%	49.88%	-0.74	★★★★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	74.14%	69.16%	70.06%	+0.90	★★★★
Lead Screening in Children					
Lead Screening in Children	83.78%	83.39%	85.83%	+2.44	★★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	83.28%	79.17%	76.34%	-2.83	★★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	55.59%	52.58%	54.63%	+2.05	★★★
Immunizations for Adolescents					
Combination 1	86.00%	89.69%	91.24%	+1.55	★★★★★
Appropriate Treatment for Children With Upper Respiratory Infection[3]					
Appropriate Treatment for Children With Upper Respiratory Infection	94.20%	93.71%	93.63%	-0.08	★★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	77.32%	79.07%	78.49%	-0.58	★★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	34.11%	39.06%	35.03%	-4.03	★★

Table B-8—PRI Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Continuation and Maintenance Phase	30.30%	42.13%	33.33%	-8.80	★
Women – Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	63.09%	64.95%	62.58%	-2.37	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	68.92%	63.06%	67.45%	+4.39	★★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	61.60%	63.93%	65.53%	+1.60	★★★★
Ages 21 to 24 Years	73.17%	72.21%	70.08%	-2.13	★★★★
Total	65.12%	67.36%	67.45%	+0.09	★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	97.52%	97.75%	96.96%	-0.79	★★★
Ages 25 Months to 6 Years	89.00%	89.34%	89.67%	+0.33	★★★
Ages 7 to 11 Years	92.16%	92.05%	91.78%	-0.27	★★★
Ages 12 to 19 Years	91.35%	90.36%	90.92%	+0.56	★★★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	84.56%	85.15%	83.72%	**-1.43**++	★★★★
Ages 45 to 64 Years	92.29%	91.31%	90.79%	-0.52	★★★★
Ages 65+ Years	91.16%	88.57%	94.38%	+5.81	★★★★★
Total	87.44%	87.58%	86.74%	**-0.84**++	★★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[3]					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	30.96%	37.91%	+6.95+	★★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	87.13%	75.41%	88.08%	+12.67+	★★★★★
Counseling for Nutrition—Total	75.15%	60.66%	78.10%	+17.44+	★★★★
Counseling for Physical Activity—Total[4]	67.54%	57.92%	73.72%	+15.80+	★★★★★

Table B-8—PRI Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	87.07%	80.10%	95.56%	+15.46+	★★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	78.24%	63.56%	78.59%	+15.03+	★★
Postpartum Care	66.18%	61.44%	69.34%	+7.90+	★★★★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	65.87%	45.74%	46.96%	+1.22	★★
Living With Illness					
Comprehensive Diabetes Care[4]					
Hemoglobin A1c (HbA1c) Testing	92.57%	94.89%	92.15%	-2.74	★★★★
*HbA1c Poor Control (>9.0%)**	24.86%	27.92%	31.93%	+4.01	★★★★
HbA1c Control (<8.0%)	62.86%	60.40%	62.41%	+2.01	★★★★★
Eye Exam (Retinal) Performed	67.86%	68.80%	71.72%	+2.92	★★★★★
Medical Attention for Nephropathy	87.14%	94.34%	91.61%	-2.73	★★★
Blood Pressure Control (<140/90 mm Hg)	67.29%	49.27%	75.91%	+26.64+	★★★★★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	75.03%	60.00%	**-15.03++**	★★★
Medication Compliance 75%—Total	—	54.29%	37.01%	**-17.28++**	★★★
Asthma Medication Ratio					
Total	—	84.31%	74.90%	**-9.41++**	★★★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	61.86%	44.13%	67.15%	+23.02+	★★★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	83.17%	79.10%	81.48%	+2.38	★★★★
Discussing Cessation Medications	52.96%	51.75%	55.97%	+4.22	★★★★
Discussing Cessation Strategies	42.97%	43.60%	46.62%	+3.02	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	61.09%	64.29%	+3.20	★★★★
Effective Continuation Phase Treatment	—	45.87%	53.06%	+7.19	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.38%	84.21%	84.70%	+0.49	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	79.31%	65.52%	60.98%	-4.54	★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	—	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	55.95%	58.06%	62.34%	+4.28	★★★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	87.19%	88.01%	+0.82	★★★
Digoxin	—	56.25%	43.75%	-12.50	★
Diuretics	—	85.64%	88.08%	+2.44+	★★★

Table B-8—PRI Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Total	—	86.41%	87.84%	+1.43+	★★★
Health Plan Diversity[5]					
Race/Ethnicity Diversity of Membership					
Total—White	60.18%	61.56%	61.71%	+0.15	—
Total—Black or African American	15.85%	13.23%	13.87%	+0.64	—
Total—American-Indian and Alaska Native	0.42%	0.56%	0.55%	-0.01	—
Total—Asian	1.25%	0.91%	0.91%	0.00	—
Total—Native Hawaiian and Other Pacific Islander	0.08%	0.06%	0.06%	0.00	—
Total—Some Other Race	0.00%	<0.01%	<0.01%	0.00	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	22.22%	23.67%	22.89%	-0.78	—
Total—Declined	0.00%	0.00%	0.00%	0.00	—
Total—Hispanic or Latino	11.86%	10.06%	10.73%	+0.67	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	0.00%	0.00%	0.00%	0.00	—
Spoken Language Preferred for Health Care—Non-English	0.00%	0.00%	0.00%	0.00	—
Spoken Language Preferred for Health Care—Unknown	100.00%	100.00%	100.00%	0.00	—
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—Non-English	0.00%	0.00%	0.00%	0.00	—

Table B-8—PRI Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Preferred Language for Written Materials—Unknown	100.00%	100.00%	100.00%	0.00	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—English	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—Unknown	100.00%	100.00%	100.00%	0.00	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	—
Utilization[5]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	80.37	76.40	75.21	-1.19	★
Outpatient Visits—Total	345.24	382.40	378.48	-3.92	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	7.60	6.99	7.00	+0.01	—
Total Inpatient—Average Length of Stay—Total	3.46	NR	3.54	—	—
Maternity—Discharges per 1,000 Member Months—Total	5.56	3.18	3.25	+0.07	—
Maternity—Average Length of Stay—Total	2.56	NR	2.60	—	—
Surgery—Discharges per 1,000 Member Months—Total	1.25	1.62	1.63	+0.01	—
Surgery—Average Length of Stay—Total	4.81	NR	4.35	—	—

Table B-8—PRI Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Medicine—Discharges per 1,000 Member Months—Total	3.16	3.11	3.10	-0.01	—
Medicine—Average Length of Stay—Total	3.85	NR	3.80	—	—

[1] HEDIS 2016 to HEDIS 2017 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05.

Green Shading+ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

Red Shading++ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

[2] 2017 Performance Levels were based on comparisons of the HEDIS 2017 measure indicator rates to Quality Compass national Medicaid HEDIS 2016 percentiles, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the NCQA national Medicaid Audit Means and Percentiles HEDIS 2016 percentiles.
[3] Due to changes in the technical specifications for this measure in HEDIS 2017, exercise caution when trending rates between 2017 and prior years.
[4] Due to changes in the technical specifications for this measure in HEDIS 2016, exercise caution when trending rates between 2016 and prior years.
[5] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2017 or 2016–2017 comparisons provided for these measures are for informational purposes only.
** For this indicator, a lower rate indicates better performance.*
— indicates that the measure was not presented in the previous years' deliverables; therefore, the HEDIS 2015 and/or 2016 rate is not presented in this report. This symbol may also indicate that the 2016–2017 Comparison was not performed because the 2016 and/or 2017 rate was not reportable or that the 2017 performance levels were not determined because the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation. For HEDIS 2017 rates designated as NA, the 2017 performance level is also presented as NA.
NR indicates that the auditor determined that the HEDIS 2015 or HEDIS 2016 rate was materially biased or that the MHP chose not report a rate for this measure indicator. For HEDIS 2017, NR indicates that the MHP chose not to report a rate for this measure indicator.

2017 Performance Levels represent the following percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Table B-9—THC Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	70.14%	64.58%	71.53%	+6.95+	★★
Combination 3	65.28%	58.56%	65.28%	+6.72+	★★
Combination 4	61.34%	57.41%	63.66%	+6.25	★★
Combination 5	49.07%	45.60%	53.70%	+8.10+	★★
Combination 6	31.25%	27.31%	27.55%	+0.24	★
Combination 7	46.53%	44.91%	52.78%	+7.87+	★★
Combination 8	30.09%	27.08%	27.31%	+0.23	★
Combination 9	25.00%	23.61%	22.45%	-1.16	★
Combination 10	24.31%	23.38%	22.22%	-1.16	★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	52.08%	54.86%	64.71%	+9.85+	★★★
Lead Screening in Children					
Lead Screening in Children	71.99%	72.69%	70.74%	-1.95	★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.75%	69.44%	70.49%	+1.05	★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	50.00%	48.61%	52.08%	+3.47	★★★
Immunizations for Adolescents					
Combination 1	84.26%	81.74%	83.80%	+2.06	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection[3]					
Appropriate Treatment for Children With Upper Respiratory Infection	86.35%	87.55%	89.66%	+2.11	★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	56.74%	57.57%	63.11%	+5.54+	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	34.07%	53.61%	50.00%	-3.61	★★★★

Table B-9—THC Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Continuation and Maintenance Phase	35.85%	70.67%	62.79%	-7.88	★★★★
Women – Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	48.41%	49.67%	52.51%	+2.84	★★
Cervical Cancer Screening					
Cervical Cancer Screening	58.15%	60.19%	60.88%	+0.69	★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	66.69%	63.48%	71.37%	+7.89+	★★★★★
Ages 21 to 24 Years	72.24%	67.51%	70.63%	+3.12	★★★★
Total	68.75%	65.09%	71.09%	+6.00+	★★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	93.42%	87.60%	93.83%	+6.23+	★★
Ages 25 Months to 6 Years	82.77%	83.98%	85.89%	+1.91+	★★
Ages 7 to 11 Years	86.47%	86.73%	87.88%	+1.15	★
Ages 12 to 19 Years	85.31%	85.17%	87.39%	+2.22+	★★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	77.34%	77.44%	76.89%	-0.55	★★
Ages 45 to 64 Years	86.52%	86.31%	86.07%	-0.24	★★
Ages 65+ Years	76.49%	72.60%	80.24%	+7.64	★★
Total	80.62%	81.12%	80.81%	-0.31	★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[3]					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	33.06%	27.33%	-5.73	★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	68.98%	72.92%	78.87%	+5.95+	★★★★
Counseling for Nutrition—Total	61.81%	65.28%	71.13%	+5.85	★★★★
Counseling for Physical Activity—Total[4]	56.71%	56.25%	49.06%	-7.19++	★★

Table B-9—THC Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	83.28%	89.29%	89.50%	+0.21	★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	68.52%	68.91%	71.13%	+2.22	★
Postpartum Care	44.68%	47.33%	48.83%	+1.50	★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	31.25%	29.93%	24.88%	-5.05	★
Living With Illness					
Comprehensive Diabetes Care[4]					
Hemoglobin A1c (HbA1c) Testing	82.04%	82.98%	82.95%	-0.03	★
*HbA1c Poor Control (>9.0%)**	47.95%	53.19%	42.92%	-10.27[+]	★★★
HbA1c Control (<8.0%)	43.84%	37.39%	49.01%	+11.62[+]	★★★
Eye Exam (Retinal) Performed	35.01%	40.27%	46.27%	+6.00[+]	★★
Medical Attention for Nephropathy	80.67%	91.03%	91.32%	+0.29	★★★
Blood Pressure Control (<140/90 mm Hg)	51.14%	47.57%	50.68%	+3.11	★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	84.59%	85.96%	+1.37	★★★★★
Medication Compliance 75%—Total	—	66.27%	69.98%	+3.71	★★★★★
Asthma Medication Ratio					
Total	—	34.24%	47.11%	+12.87[+]	★
Controlling High Blood Pressure					
Controlling High Blood Pressure	51.56%	43.05%	38.53%	-4.52	★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	78.73%	78.16%	79.95%	+1.79	★★★★
Discussing Cessation Medications	51.91%	50.69%	55.16%	+4.47	★★★★
Discussing Cessation Strategies	42.11%	42.29%	47.12%	+4.83	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	89.55%	55.59%	-33.96[++]	★★★
Effective Continuation Phase Treatment	—	73.34%	39.92%	-33.42[++]	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.84%	77.60%	82.33%	+4.73	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	65.66%	57.45%	59.26%	+1.81	★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	—	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	57.30%	56.16%	48.47%	-7.69	★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	85.62%	87.84%	+2.22[+]	★★★
Digoxin	—	51.28%	33.33%	-17.95	★
Diuretics	—	85.07%	87.27%	+2.20[+]	★★

Table B-9—THC Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Total	—	85.15%	87.28%	+2.13[+]	★★★
Health Plan Diversity[5]					
Race/Ethnicity Diversity of Membership					
Total—White	28.52%	31.09%	30.70%	-0.39	—
Total—Black or African American	58.81%	54.16%	53.90%	-0.26	—
Total—American-Indian and Alaska Native	0.17%	0.23%	0.27%	+0.04	—
Total—Asian	1.24%	1.15%	1.21%	+0.06	—
Total—Native Hawaiian and Other Pacific Islander	0.09%	0.07%	0.06%	-0.01	—
Total—Some Other Race	2.14%	2.45%	2.55%	+0.10	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	9.04%	10.84%	11.31%	+0.47	—
Total—Declined	0.00%	0.00%	0.00%	0.00	—
Total—Hispanic or Latino	2.14%	2.45%	2.55%	+0.10	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	99.48%	99.38%	99.21%	-0.17	—
Spoken Language Preferred for Health Care—Non-English	0.48%	0.44%	0.79%	+0.35	—
Spoken Language Preferred for Health Care—Unknown	0.04%	0.18%	<0.01%	-0.18	—
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	99.48%	99.38%	99.21%	-0.17	—
Preferred Language for Written Materials—Non-English	0.48%	0.44%	0.79%	+0.35	—
Preferred Language for Written Materials—Unknown	0.04%	0.18%	<0.01%	-0.18	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—English	99.48%	99.38%	99.21%	-0.17	—
Other Language Needs—Non-English	0.48%	0.44%	0.79%	+0.35	—
Other Language Needs—Unknown	0.04%	0.18%	<0.01%	-0.18	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	—
Utilization[5]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	76.06	72.75	73.95	+1.20	★
Outpatient Visits—Total	322.80	320.89	333.36	+12.47	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	9.91	10.45	10.15	-0.30	—
Total Inpatient—Average Length of Stay—Total	4.35	4.34	4.01	-0.33	—
Maternity—Discharges per 1,000 Member Months—Total	2.89	2.70	2.37	-0.33	—
Maternity—Average Length of Stay—Total	2.79	2.66	2.63	-0.03	—
Surgery—Discharges per 1,000 Member Months—Total	1.97	2.35	2.30	-0.05	—
Surgery—Average Length of Stay—Total	7.69	7.63	6.54	-1.09	—

Table B-9—THC Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Medicine—Discharges per 1,000 Member Months—Total	5.90	6.10	6.07	-0.03	—
Medicine—Average Length of Stay—Total	3.78	3.64	3.45	-0.19	—

[1] HEDIS 2016 to HEDIS 2017 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05.

Green Shading+ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

Red Shading++ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

[2] 2017 Performance Levels were based on comparisons of the HEDIS 2017 measure indicator rates to Quality Compass national Medicaid HEDIS 2016 percentiles, with the exception of the Medications Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the NCQA national Medicaid Audit Means and Percentiles HEDIS 2016 percentiles.

[3] Due to changes in the technical specifications for this measure in HEDIS 2017, exercise caution when trending rates between 2017 and prior years.

[4] Due to changes in the technical specifications for this measure in HEDIS 2016, exercise caution when trending rates between 2016 and prior years.

[5] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2017 or 2016–2017 comparisons provided for these measures are for informational purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the measure was not presented in the previous years' deliverables; therefore, the HEDIS 2015 and/or 2016 rate is not presented in this report. This symbol may also indicate that the 2016–2017 Comparison was not performed because the 2016 and/or 2017 rate was not reportable or that the 2017 performance levels were not determined because the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation. For HEDIS 2017 rates designated as NA, the 2017 performance level is also presented as NA.

2017 Performance Levels represent the following percentile comparisons:

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Table B-10—UNI Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	76.16%	76.16%	78.35%	+2.19	★★★
Combination 3	71.29%	71.78%	72.51%	+0.73	★★★
Combination 4	69.59%	67.15%	70.07%	+2.92	★★★
Combination 5	60.34%	58.15%	57.66%	-0.49	★★
Combination 6	40.15%	38.69%	38.93%	+0.24	★★
Combination 7	59.37%	54.74%	55.96%	+1.22	★★
Combination 8	38.93%	36.25%	38.20%	+1.95	★★★
Combination 9	34.55%	32.85%	31.63%	-1.22	★★
Combination 10	33.82%	30.66%	30.90%	+0.24	★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	57.64%	61.56%	66.67%	+5.11	★★★
Lead Screening in Children					
Lead Screening in Children	81.51%	78.86%	77.13%	-1.73	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.81%	73.21%	79.08%	+5.87	★★★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	52.30%	54.74%	58.88%	+4.14	★★★★
Immunizations for Adolescents					
Combination 1	88.81%	87.50%	85.40%	-2.10	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection[3]					
Appropriate Treatment for Children With Upper Respiratory Infection	87.20%	87.89%	89.46%	+1.57[+]	★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	62.65%	63.13%	71.07%	+7.94[+]	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	40.80%	44.57%	41.48%	-3.09	★★
Continuation and Maintenance Phase	54.00%	59.46%	53.85%	-5.61	★★★
Women – Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	64.01%	61.35%	64.83%	+3.48[+]	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	67.68%	65.85%	69.10%	+3.25	★★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	59.26%	62.26%	66.04%	+3.78[+]	★★★★
Ages 21 to 24 Years	68.99%	69.46%	71.37%	+1.91	★★★★
Total	62.71%	65.12%	68.21%	+3.09[+]	★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	96.06%	96.54%	96.20%	-0.34	★★★
Ages 25 Months to 6 Years	88.67%	89.66%	89.27%	-0.39	★★★
Ages 7 to 11 Years	91.35%	91.17%	91.77%	+0.60[+]	★★★
Ages 12 to 19 Years	90.50%	90.51%	91.88%	+1.37[+]	★★★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	83.78%	83.01%	81.34%	**-1.67[++]**	★★★
Ages 45 to 64 Years	92.16%	91.13%	89.97%	**-1.16[++]**	★★★★
Ages 65+ Years	97.31%	95.84%	94.79%	-1.05	★★★★★
Total	86.90%	86.34%	84.82%	**-1.52[++]**	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[3]					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	24.42%	32.40%	+7.98[+]	★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	77.37%	71.05%	81.02%	+9.97[+]	★★★★
Counseling for Nutrition—Total	71.53%	68.86%	76.64%	+7.78[+]	★★★★
Counseling for Physical Activity—Total[4]	62.53%	62.04%	62.53%	+0.49	★★★

Table B-10—UNI Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	91.79%	89.12%	85.40%	-3.72	★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	85.68%	76.03%	80.54%	+4.51	★★
Postpartum Care	63.82%	52.06%	67.40%	+15.34+	★★★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	62.81%	41.75%	52.07%	+10.32+	★★
Living With Illness					
Comprehensive Diabetes Care[4]					
Hemoglobin A1c (HbA1c) Testing	84.58%	86.81%	88.61%	+1.80	★★★
*HbA1c Poor Control (>9.0%)**	32.22%	34.17%	32.50%	-1.67	★★★★
HbA1c Control (<8.0%)	57.22%	54.58%	56.11%	+1.53	★★★★
Eye Exam (Retinal) Performed	63.19%	64.31%	65.14%	+0.83	★★★★
Medical Attention for Nephropathy	83.33%	93.06%	92.36%	-0.70	★★★★
Blood Pressure Control (<140/90 mm Hg)	66.81%	62.64%	62.08%	-0.56	★★★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	69.44%	67.42%	-2.02	★★★★
Medication Compliance 75%—Total	—	45.00%	41.51%	-3.49++	★★★★
Asthma Medication Ratio					
Total	—	64.68%	66.80%	+2.12	★★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	62.63%	52.32%	56.93%	+4.61	★★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	77.23%	78.86%	82.17%	+3.31	★★★★★

Table B-10—UNI Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Discussing Cessation Medications	55.72%	59.35%	60.80%	+1.45	★★★★★
Discussing Cessation Strategies	43.60%	48.02%	50.56%	+2.54	★★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	49.55%	59.84%	+10.29+	★★★★
Effective Continuation Phase Treatment	—	31.59%	46.87%	+15.28+	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.54%	85.54%	85.99%	+0.45	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	68.46%	74.48%	74.29%	-0.19	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	87.88%	80.00%	74.03%	-5.97	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	58.57%	60.02%	60.59%	+0.57	★★★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	88.68%	89.75%	+1.07+	★★★
Digoxin	—	45.69%	49.02%	+3.33	★
Diuretics	—	88.75%	89.19%	+0.44	★★★

Table B-10—UNI Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Total	—	88.41%	89.28%	+0.87+	★★★
Health Plan Diversity[5]					
Race/Ethnicity Diversity of Membership					
Total—White	50.34%	50.65%	50.85%	+0.20	—
Total—Black or African American	32.58%	31.80%	30.38%	-1.42	—
Total—American-Indian and Alaska Native	0.21%	0.24%	0.26%	+0.02	—
Total—Asian	2.40%	2.37%	2.11%	-0.26	—
Total—Native Hawaiian and Other Pacific Islander	0.01%	<0.01%	0.01%	0.00	—
Total—Some Other Race	0.00%	0.00%	0.00%	0.00	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	14.45%	14.94%	16.40%	+1.46	—
Total—Declined	0.00%	0.00%	0.00%	0.00	—
Total—Hispanic or Latino	5.52%	5.30%	5.61%	+0.31	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	95.71%	95.33%	95.71%	+0.38	—
Spoken Language Preferred for Health Care—Non-English	4.26%	4.67%	4.28%	-0.39	—
Spoken Language Preferred for Health Care—Unknown	0.03%	<0.01%	<0.01%	0.00	—
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	95.71%	95.33%	95.71%	+0.38	—
Preferred Language for Written Materials—Non-English	4.26%	4.67%	4.28%	-0.39	—

Table B-10—UNI Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Preferred Language for Written Materials—Unknown	0.03%	<0.01%	<0.01%	0.00	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—English	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—Unknown	100.00%	100.00%	100.00%	0.00	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	—
Utilization[5]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	73.86	73.22	72.58	-0.64	★★
Outpatient Visits—Total	361.16	367.42	368.15	+0.73	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	6.95	6.59	5.59	-1.00	—
Total Inpatient—Average Length of Stay—Total	4.17	4.23	4.33	+0.10	—
Maternity—Discharges per 1,000 Member Months—Total	3.57	2.74	2.49	-0.25	—
Maternity—Average Length of Stay—Total	2.51	2.62	2.57	-0.05	—
Surgery—Discharges per 1,000 Member Months—Total	1.55	1.61	1.37	-0.24	—
Surgery—Average Length of Stay—Total	6.97	6.76	6.56	-0.20	—

Table B-10—UNI Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Medicine—Discharges per 1,000 Member Months—Total	3.10	3.06	2.44	-0.62	—
Medicine—Average Length of Stay—Total	3.99	3.92	4.37	+0.45	—

[1] HEDIS 2016 to HEDIS 2017 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05.

Green Shading[+] *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

Red Shading[++] *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

[2] 2017 Performance Levels were based on comparisons of the HEDIS 2017 measure indicator rates to Quality Compass national Medicaid HEDIS 2016 percentiles, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the NCQA national Medicaid Audit Means and Percentiles HEDIS 2016 percentiles.

[3] Due to changes in the technical specifications for this measure in HEDIS 2017, exercise caution when trending rates between 2017 and prior years.

[4] Due to changes in the technical specifications for this measure in HEDIS 2016, exercise caution when trending rates between 2016 and prior years.

[5] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2017 or 2016–2017 comparisons provided for these measures are for informational purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the measure was not presented in the previous years' deliverables; therefore, the HEDIS 2015 and/or 2016 rate is not presented in this report. This symbol may also indicate that the 2016–2017 Comparison was not performed because the 2016 and/or 2017 rate was not reportable or that the 2017 performance levels were not determined because the measure did not have an applicable benchmark.

2017 Performance Levels represent the following percentile comparisons:

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Table B-11—UPP Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	80.29%	78.10%	73.24%	-4.86	★★
Combination 3	75.18%	73.24%	71.53%	-1.71	★★★
Combination 4	68.37%	66.67%	65.21%	-1.46	★★
Combination 5	58.88%	55.47%	54.99%	-0.48	★★
Combination 6	57.66%	43.55%	42.09%	-1.46	★★★
Combination 7	55.23%	52.07%	51.58%	-0.49	★★
Combination 8	54.50%	41.61%	39.17%	-2.44	★★★
Combination 9	48.18%	37.23%	34.55%	-2.68	★★★
Combination 10	46.23%	36.01%	32.85%	-3.16	★★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	76.16%	74.21%	74.21%	0.00	★★★★★
Lead Screening in Children					
Lead Screening in Children	86.37%	88.56%	82.43%	-6.13++	★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.80%	69.59%	73.97%	+4.38	★★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	48.91%	42.09%	44.50%	+2.41	★★
Immunizations for Adolescents					
Combination 1	86.62%	81.75%	80.90%	-0.85	★★★
Appropriate Treatment for Children With Upper Respiratory Infection[3]					
Appropriate Treatment for Children With Upper Respiratory Infection	89.17%	90.27%	91.15%	+0.88	★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	68.41%	68.97%	63.09%	-5.88++	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	46.50%	53.16%	42.98%	-10.18++	★★★
Continuation and Maintenance Phase	47.96%	57.65%	45.36%	-12.29	★★
Women – Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	58.09%	59.64%	64.73%	+5.09+	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	67.88%	62.53%	67.15%	+4.62	★★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	42.16%	46.95%	44.93%	-2.02	★★
Ages 21 to 24 Years	45.43%	56.06%	58.75%	+2.69	★★
Total	43.25%	50.96%	51.13%	+0.17	★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	98.17%	97.65%	97.26%	-0.39	★★★
Ages 25 Months to 6 Years	90.86%	90.18%	90.64%	+0.46	★★★
Ages 7 to 11 Years	90.73%	90.60%	91.82%	+1.22	★★★
Ages 12 to 19 Years	92.99%	92.33%	91.60%	-0.73	★★★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	86.49%	86.23%	84.99%	-1.24++	★★★★
Ages 45 to 64 Years	90.91%	88.42%	87.55%	-0.87	★★★
Ages 65+ Years	84.21%	86.44%	91.18%	+4.74	★★★★
Total	87.87%	87.10%	86.02%	-1.08++	★★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[3]					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	43.48%	25.77%	-17.71++	★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	85.64%	91.97%	88.81%	-3.16	★★★★★
Counseling for Nutrition—Total	59.12%	65.94%	67.40%	+1.46	★★★
Counseling for Physical Activity—Total[4]	57.42%	64.23%	64.96%	+0.73	★★★★

Table B-11—UPP Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	91.97%	95.62%	95.38%	-0.24	★★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	91.24%	86.13%	91.48%	+5.35+	★★★★★
Postpartum Care	75.91%	71.78%	72.75%	+0.97	★★★★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	71.05%	72.02%	73.24%	+1.22	★★★★
Living With Illness					
Comprehensive Diabetes Care[4]					
Hemoglobin A1c (HbA1c) Testing	89.23%	91.61%	91.04%	-0.57	★★★★
*HbA1c Poor Control (>9.0%)**	28.10%	28.65%	24.73%	-3.92	★★★★★
HbA1c Control (<8.0%)	58.58%	58.21%	59.14%	+0.93	★★★★★
Eye Exam (Retinal) Performed	62.96%	66.06%	67.56%	+1.50	★★★★
Medical Attention for Nephropathy	82.66%	91.97%	92.11%	+0.14	★★★★
Blood Pressure Control (<140/90 mm Hg)	75.36%	75.73%	76.70%	+0.97	★★★★★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	53.63%	66.08%	+12.45+	★★★★
Medication Compliance 75%—Total	—	22.71%	38.11%	+15.40+	★★★★
Asthma Medication Ratio					
Total	—	64.55%	58.44%	-6.11	★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	70.07%	63.99%	71.05%	+7.06+	★★★★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	79.97%	79.43%	79.18%	-0.25	★★★

Table B-11—UPP Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Discussing Cessation Medications	54.92%	55.95%	56.90%	+0.95	★★★★
Discussing Cessation Strategies	46.79%	45.39%	45.57%	+0.18	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	61.13%	59.86%	-1.27	★★★★
Effective Continuation Phase Treatment	—	40.34%	42.69%	+2.35	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	87.20%	87.20%	88.18%	+0.98	★★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	NA	NA	—	NA
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	—	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	71.08%	60.22%	82.18%	+21.96+	★★★★★

Table B-11—UPP Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	87.49%	87.60%	+0.11	★★★
Digoxin	—	NA	NA	—	NA
Diuretics	—	89.29%	88.64%	-0.65	★★★
Total	—	87.94%	87.70%	-0.24	★★★
Health Plan Diversity[5]					
Race/Ethnicity Diversity of Membership					
Total—White	87.42%	87.07%	87.04%	-0.03	—
Total—Black or African American	1.45%	1.41%	1.46%	+0.05	—
Total—American-Indian and Alaska Native	2.38%	2.53%	2.41%	-0.12	—
Total—Asian	0.32%	0.28%	0.26%	-0.02	—
Total—Native Hawaiian and Other Pacific Islander	0.09%	0.06%	0.05%	-0.01	—
Total—Some Other Race	1.24%	1.39%	1.49%	+0.10	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	<0.01%	<0.01%	0.00%	0.00	—
Total—Declined	7.09%	7.25%	7.30%	+0.05	—
Total—Hispanic or Latino	1.24%	1.39%	1.49%	+0.10	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	99.96%	99.93%	99.94%	+0.01	—
Spoken Language Preferred for Health Care—Non-English	0.02%	0.04%	0.03%	-0.01	—
Spoken Language Preferred for Health Care—Unknown	0.02%	0.03%	0.03%	0.00	—
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—

Table B-11—UPP Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Preferred Language for Written Materials—English	99.96%	99.93%	99.94%	+0.01	—
Preferred Language for Written Materials—Non-English	0.02%	0.04%	0.03%	-0.01	—
Preferred Language for Written Materials—Unknown	0.02%	0.03%	0.03%	0.00	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—English	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—Unknown	100.00%	100.00%	100.00%	0.00	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	—
Utilization[5]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	66.62	64.81	66.21	+1.40	★★
Outpatient Visits—Total	325.60	334.91	341.01	+6.10	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	6.23	6.34	6.54	+0.20	—
Total Inpatient—Average Length of Stay—Total	3.59	3.60	3.79	+0.19	—
Maternity—Discharges per 1,000 Member Months—Total	3.17	2.05	2.61	+0.56	—
Maternity—Average Length of Stay—Total	2.60	2.72	2.80	+0.08	—
Surgery—Discharges per 1,000 Member Months—Total	1.29	1.63	1.95	+0.32	—

Table B-11—UPP Trend Table

Measure	HEDIS 2015	HEDIS 2016	HEDIS 2017	2016–2017 Comparison[1]	2017 Performance Level[2]
Surgery—Average Length of Stay—Total	5.27	4.69	5.42	+0.73	—
Medicine—Discharges per 1,000 Member Months—Total	2.83	3.20	2.66	-0.54	—
Medicine—Average Length of Stay—Total	3.56	3.46	3.32	-0.14	—

[1] HEDIS 2016 to HEDIS 2017 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05.

Green Shading+ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant improvement from the HEDIS 2016 MWA.*

Red Shading++ *Indicates that the HEDIS 2017 MWA demonstrated a statistically significant decline from the HEDIS 2016 MWA.*

[2] 2017 Performance Levels were based on comparisons of the HEDIS 2017 measure indicator rates to Quality Compass national Medicaid HEDIS 2016 percentiles, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the NCQA national Medicaid Audit Means and Percentiles HEDIS 2016 percentiles.

[3] Due to changes in the technical specifications for this measure in HEDIS 2017, exercise caution when trending rates between 2017 and prior years.

[4] Due to changes in the technical specifications for this measure in HEDIS 2016, exercise caution when trending rates between 2016 and prior years.

[5] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2017 or 2016–2017 comparisons provided for these measures are for informational purposes only.

** For this indicator, a lower rate indicates better performance.*

— indicates that the measure was not presented in the previous years' deliverables; therefore, the HEDIS 2015 and/or 2016 rate is not presented in this report. This symbol may also indicate that the 2016–2017 Comparison was not performed because the 2016 and/or 2017 rate was not reportable or that the 2017 performance levels were not determined because the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate, resulting in a Small Denominator (NA) audit designation. For HEDIS 2017 rates designated as NA, the 2017 performance level is also presented as NA.

2017 Performance Levels represent the following percentile comparisons:

★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Appendix C. Performance Summary Stars

Introduction

This section presents the MHPs' performance summary stars for each measure within the following measure domains:

- Child & Adolescent Care
- Women—Adult Care
- Access to Care
- Obesity
- Pregnancy Care
- Living With Illness
- Utilization

Performance ratings were assigned by comparing the MHPs' HEDIS 2017 rates to the HEDIS 2016 Quality Compass national Medicaid benchmarks (from ★ representing *Poor Performance* to ★★★★★ representing *Excellent Performance*). Please note, HSAG assigned performance ratings to only one measure in the Utilization measure domain, *Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits*. Measures in the Health Plan Diversity domain and the remaining utilization-based measure rates were not evaluated based on comparisons to national benchmarks; however, rates for these measure indicators are presented in Appendices A and B. Additional details about the performance comparisons and star ratings are found in Section 2.

Child & Adolescent Care Performance Summary Stars

Table C-1—Child & Adolescent Care Performance Summary Stars (Table 1 of 3)

MHP	Childhood Immunization Status—Combination 2	Childhood Immunization Status—Combination 3	Childhood Immunization Status—Combination 4	Childhood Immunization Status—Combination 5	Childhood Immunization Status—Combination 6	Childhood Immunization Status—Combination 7
AET	★★	★	★★	★	★	★★
BCC	★★★★	★★★	★★★	★★★	★★★	★★★
HAR	★	★	★	★	★	★
MCL	★★★★	★★★★	★★★★	★★★★	★★★	★★★★
MER	★★★★	★★★	★★★	★★★★	★★★	★★★★
MID	NA	NA	NA	NA	NA	NA
MOL	★★	★★	★★	★★	★★	★★★
PRI	★★★★	★★★★	★★★★	★★★★★	★★★★★	★★★★★
THC	★★	★★	★★	★★	★	★★
UNI	★★★	★★★	★★★	★★	★★	★★
UPP	★★	★★★	★★	★★	★★★	★★

NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate.

Table C-2—Child & Adolescent Care Performance Summary Stars (Table 2 of 3)

MHP	Childhood Immunization Status—Combination 8	Childhood Immunization Status—Combination 9	Childhood Immunization Status—Combination 10	Well-Child Visits in the First 15 Months of Life—Six or More Visits	Lead Screening in Children	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
AET	★	★	★	★	★★★	★★★
BCC	★★★	★★★	★★★	★★★★	★★★	★★★
HAR	★	★	★	NA	★★	★★
MCL	★★★	★★★	★★★	★★★	★★★★★	★★
MER	★★★	★★★	★★★	★★★★★	★★★★	★★★★
MID	NA	NA	NA	NA	NA	★
MOL	★★	★★	★★	★★★★	★★★	★★★
PRI	★★★★★	★★★★★	★★★★★	★★★★	★★★★★	★★★
THC	★	★	★	★★★	★★	★★
UNI	★★★	★★	★★	★★★	★★★	★★★★
UPP	★★★	★★★	★★★	★★★★★	★★★★	★★★

NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate.

Table C-3—Child & Adolescent Care Performance Summary Stars (Table 3 of 3)

MHP	*Adolescent Well-Care Visits*	*Immunizations for Adolescents — Combination 1 (Meningococcal, Tdap)*	*Appropriate Treatment for Children With Upper Respiratory Infection*	*Appropriate Testing for Children With Pharyngitis*	*Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*	*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
AET	★★★	★★★★	★★★	★	★	★
BCC	★★★	★★★★	★★★	★★★	★★★★	★★★
HAR	★★	★★	★★★	★	NA	NA
MCL	★★	★★★★	★★	★★	★★	★★
MER	★★★★	★★★★★	★★★	★★★	★★	★★★
MID	★	NA	NA	NA	NA	NA
MOL	★★★	★★★★★	★★	★★	★★★	★★★★
PRI	★★★	★★★★★	★★★★	★★★	★★	★
THC	★★★	★★★★	★★★	★	★★★★	★★★★
UNI	★★★★	★★★★	★★★	★★	★★	★★★
UPP	★★	★★★	★★★	★	★★★	★★

NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate.

Women—Adult Care Performance Summary Stars

Table C-4—Women—Adult Care Performance Summary Stars

MHP	*Breast Cancer Screening*	*Cervical Cancer Screening*	*Chlamydia Screening in Women—Ages 16 to 20 Years*	*Chlamydia Screening in Women—Ages 21 to 24 Years*	*Chlamydia Screening in Women—Total*
AET	★★	★★★★	★★★★★	★★★★★	★★★★★
BCC	★★★	★★★	★★★★	★★★★	★★★★
HAR	★★★★	★★★	★★★★★	★★★★	★★★★★
MCL	★★★	★★★	★★★	★★	★★★
MER	★★★	★★★★	★★★★	★★★★	★★★★
MID	★★	★★	NA	★	★
MOL	★★★	★★★★	★★★★	★★★★	★★★★
PRI	★★★	★★★★	★★★★	★★★★	★★★★
THC	★★	★★★	★★★★★	★★★★	★★★★★
UNI	★★★	★★★★	★★★★	★★★★	★★★★
UPP	★★★	★★★★	★★	★★	★★

NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate.

Access to Care Performance Summary Stars

Table C-5—Access to Care Performance Summary Stars (Table 1 of 2)

MHP	Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months	Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years	Children and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years	Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years	Adults' Access to Preventive/ Ambulatory Health Services—Ages 20 to 44 Years	Adults' Access to Preventive/ Ambulatory Health Services—Ages 45 to 64 Years
AET	★	★	★	★	★	★★
BCC	★★	★★	★★	★★	★★	★★★
HAR	★	★	★	★	★	★
MCL	★★	★★	★★	★★	★★★	★★★
MER	★★★★	★★★	★★★	★★★★	★★★★	★★★★
MID	NA	★	★	★	★	★★★★
MOL	★★★	★★★	★★★	★★★	★★★	★★★
PRI	★★★	★★★	★★★	★★★	★★★★	★★★★
THC	★★	★★	★	★★	★★	★★
UNI	★★★	★★★	★★★	★★★	★★★	★★★★
UPP	★★★	★★★	★★★	★★★	★★★★	★★★

NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate.

Table C-6—Access to Care Performance Summary Stars (Table 2 of 2)

MHP	Adults' Access to Preventive/ Ambulatory Health Services—Ages 65 Years and Older	Adults' Access to Preventive/ Ambulatory Health Services—Total	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
AET	NA	★	★★★★
BCC	★★	★★	★★★
HAR	NA	★	★
MCL	NA	★★★	★★★
MER	★★★★	★★★★	★★★
MID	★★	★★★	NA
MOL	★★★★	★★★	★★★
PRI	★★★★★	★★★★	★★★★
THC	★★	★★	★★★
UNI	★★★★★	★★★	★★★
UPP	★★★★	★★★★	★★

NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate.

Obesity Performance Summary Stars

Table C-7—Obesity Performance Summary Stars

MHP	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Percentile Documentation—Total	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Counseling for Nutrition—Total	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Counseling for Physical Activity—Total	Adult BMI Assessment
AET	★★★★	★★★★	★★★	★★★★
BCC	★★★★★	★★★★	★★★★	★★★
HAR	★★★★	★★★★★	★★★	★★★★
MCL	★★★★	★★	★★	★★★★
MER	★★★★	★★★★	★★★	★★★★★
MID	★★★★★	★★★	★★★★	★★★★
MOL	★★★★	★★★★	★★★★	★★★★★
PRI	★★★★★	★★★★	★★★★★	★★★★★
THC	★★★★	★★★★	★★	★★★★
UNI	★★★★	★★★★	★★★	★★★
UPP	★★★★★	★★★	★★★★	★★★★★

Pregnancy Care Performance Summary Stars

Table C-8—Pregnancy Care Performance Summary Stars

MHP	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*	*Prenatal and Postpartum Care—Postpartum Care*	*Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*
AET	★	★	★
BCC	★★	★★★	★
HAR	★	★	★
MCL	★★★	★★★	★★
MER	★★★	★★★★	★★★★
MID	★	★	★
MOL	★★★	★★★★★	★★
PRI	★★	★★★★	★★
THC	★	★	★
UNI	★★	★★★	★★
UPP	★★★★★	★★★★	★★★★

Living With Illness Performance Summary Stars

Table C-9—Living With Illness Performance Summary Stars (Table 1 of 4)

MHP	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*	*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)**	*Comprehensive Diabetes Care—HbA1c Control (<8.0%)*	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*	*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
AET	★★★	★★★	★★★	★★	★★★★	★★
BCC	★★	★★★	★★	★★★	★★	★★
HAR	★★★	★★★	★★★★	★★	★★	★
MCL	★★★	★★	★★	★★★	★★	★★★
MER	★★★	★★★★	★★★★	★★★★	★★★	★★★
MID	★★★	★★★	★★★	★★★	★★★★★	★★
MOL	★★★	★★★★	★★★★	★★★★	★★★	★★
PRI	★★★★	★★★★	★★★★★	★★★★★	★★★	★★★★★
THC	★	★★★	★★★	★★	★★★	★
UNI	★★★	★★★★	★★★★	★★★★	★★★★	★★★
UPP	★★★★	★★★★★	★★★★★	★★★★	★★★★	★★★★★

** A lower rate indicates better performance for this measure indicator.*

Table C-10—Living With Illness Performance Summary Stars (Table 2 of 4)

MHP	Medication Management for People With Asthma—Medication Compliance 50%—Total[1]	Medication Management for People With Asthma—Medication Compliance 75%—Total	Asthma Medication Ratio—Total	Controlling High Blood Pressure	Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications
AET	★★★★★	★★★★★	★★	★★	★★★★	★★★★
BCC	★★★★★	★★★★★	★★	★	★★	★★★
HAR	NA	NA	★	★	★★★	★★★★★
MCL	★★★★★	★★★★★	★★★★	★★★	★★★	★★★★
MER	★★★★★	★★★★★	★★★	★★★★	★★★★	★★★★
MID	NA	NA	NA	★★★	★★★★★	★★★★
MOL	★★★	★★★	★★	★★	★★★★	★★★★
PRI	★★★	★★★	★★★★★	★★★★	★★★★	★★★★
THC	★★★★★	★★★★★	★	★	★★★★	★★★★
UNI	★★★★	★★★★	★★★★	★★★	★★★★★	★★★★★
UPP	★★★★	★★★★	★★	★★★★★	★★★	★★★★

[1] Indicates the HEDIS 2017 rates for this measure indicator were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS 2016 benchmarks.
NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate.

Table C-11—Living With Illness Performance Summary Stars (Table 3 of 4)

MHP	Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies	Antidepressant Medication Management—Effective Acute Phase Treatment	Antidepressant Medication Management—Effective Continuation Phase Treatment	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Diabetes Monitoring for People With Diabetes and Schizophrenia	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
AET	★★★★	★★	★★★	★★	★	NA
BCC	★★	★★★★★	★★★★★	★★★	★★	NA
HAR	★★★★	NA	NA	★	NA	NA
MCL	★★★	★	★	★★★	★★★	NA
MER	★★★	★★	★	★★★	★★	★
MID	★★★	★	★	★	★★	NA
MOL	★★	★	★	★★★	★★★	★★
PRI	★★★	★★★★	★★★★	★★★★	★	NA
THC	★★★	★★★	★★★	★★★	★	NA
UNI	★★★★	★★★★	★★★★	★★★★	★★★	★★
UPP	★★★	★★★★	★★★	★★★★★	NA	NA

NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate.

Table C-12—Living With Illness Performance Summary Stars (Table 4 of 4)

MHP	*Adherence to Antipsychotic Medications for Individuals With Schizophrenia*	*Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*	*Annual Monitoring for Patients on Persistent Medications—Digoxin*	*Annual Monitoring for Patients on Persistent Medications—Diuretics*	*Annual Monitoring for Patients on Persistent Medications—Total*
AET	★★	★	NA	★★	★
BCC	★★	★★	★★★	★★	★★
HAR	NA	★★★	NA	★★	★★
MCL	★★★	★	★	★★	★
MER	★★★	★★	★★	★★	★★
MID	★★★★	★	NA	★	★
MOL	★★★	★★★	★★★★★	★★	★★★
PRI	★★★	★★★	★	★★★	★★★
THC	★	★★★	★	★★	★★★
UNI	★★★	★★★	★	★★★	★★★
UPP	★★★★★	★★★	NA	★★★	★★★

NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate.

Utilization Performance Summary Stars

Table C-13—Utilization Performance Summary Stars

MHP	*Ambulatory Care—Total (Per 1,000 Member Months)—Emergency Department Visits—Total**
AET	★
BCC	★★
HAR	★
MCL	★★
MER	★
MID	★
MOL	★★
PRI	★
THC	★
UNI	★★
UPP	★★

** A lower rate may indicate more favorable performance for this measure indicator (i.e., low rates of emergency department services may indicate better utilization of services). Therefore, Quality Compass percentiles were reversed to align with performance (e.g., the 10th percentile [a lower rate] was inverted to become the 90th percentile, indicating better performance).*

2017 Michigan Department of Health and Human Services

Adult Medicaid Health Plan CAHPS® Report

September 2017

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

The Michigan Department of Health and Human Services (MDHHS) periodically assesses the perceptions and experiences of members enrolled in the MDHHS Medicaid health plans (MHPs) and the Fee-for-Service (FFS) population as part of its process for evaluating the quality of health care services provided to adult members in the MDHHS Medicaid Program. MDHHS contracted with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey for the MDHHS Medicaid Program.[1-1,1-2] The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and that will aid in improving overall member satisfaction.

This report presents the 2017 CAHPS results of adult members enrolled in an MHP or FFS. The surveys were completed in the spring of 2017. The standardized survey instrument selected was the CAHPS 5.0H Adult Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set.[1-3,1-4]

Report Overview

A sample of at least 1,350 adult members was selected from the FFS population and each MHP, with one exception.[1-5] Harbor Health Plan did not have enough eligible members to meet the sampling goal of 1,350 members; therefore, the sample size for Harbor Health Plan was 1,349 adult members.

Results presented in this report include four global ratings: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often. Five composite measures are reported: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making. Additionally, overall rates for three Effectiveness of Care measures are reported: Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications, and Discussing Cessation Strategies.

[1-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-2] HSAG surveyed the FFS Medicaid population. The 11 MHPs contracted with various survey vendors to administer the CAHPS survey.
[1-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-4] The 2017 CAHPS results were reported to NCQA for the 11 MHPs. The 2017 CAHPS survey results for the FFS population were not reported to NCQA.
[1-5] Some MHPs elected to oversample their population.

HSAG presents aggregate statewide results and compares them to national Medicaid data and the prior year's results, where appropriate. Throughout this report, two statewide aggregate results are presented for comparative purposes:

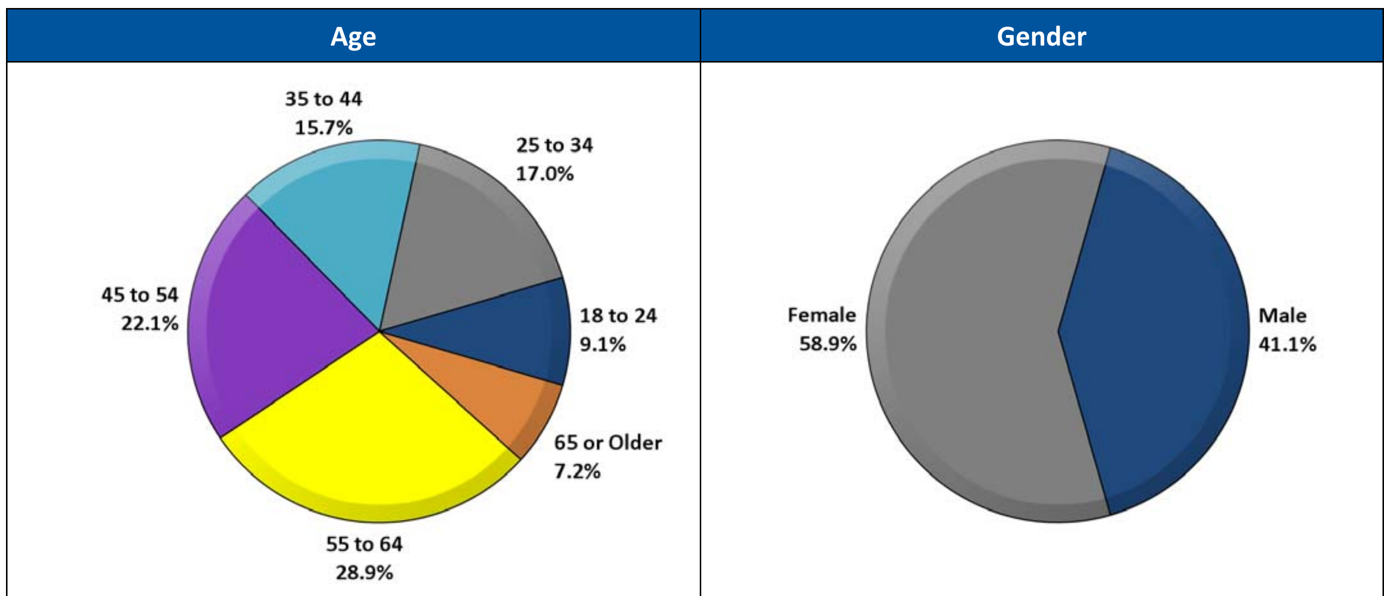
- MDHHS Medicaid Program – Combined results for FFS and the MHPs.
- MDHHS Medicaid Managed Care Program – Combined results for the MHPs.

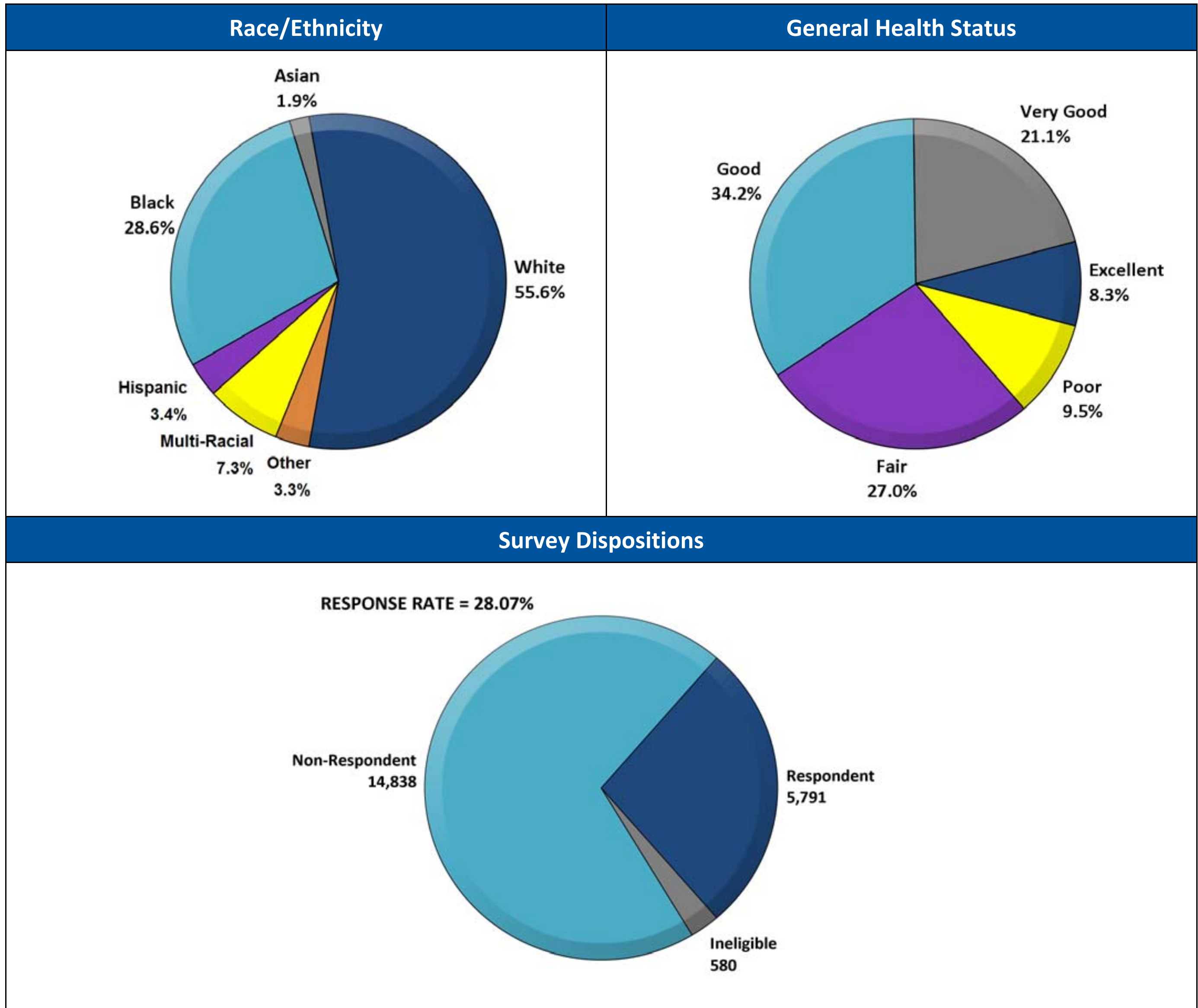
Key Findings

Survey Dispositions and Demographics

Table 1-1 provides an overview of the MDHHS Medicaid Program adult member demographics and survey dispositions. Please note, some percentages displayed in the table below may not total 100.0% due to rounding.

Table 1-1—Member Demographics and Survey Dispositions




Race/Ethnicity
Asian 1.9%
Black 28.6%
White 55.6%
Hispanic 3.4%
Multi-Racial 7.3%
Other 3.3%
General Health Status
Very Good 21.1%
Good 34.2%
Excellent 8.3%
Poor 9.5%
Fair 27.0%
Survey Dispositions
RESPONSE RATE = 28.07%
Non-Respondent 14,838
Respondent 5,791
Ineligible 580

National Comparisons and Trend Analysis

A three-point mean score was determined for the four CAHPS global ratings and four CAHPS composite measures. The resulting three-point mean scores were compared to the National Committee for Quality Assurance's (NCQA's) 2017 HEDIS Benchmarks and Thresholds for Accreditation to derive the overall member satisfaction ratings (i.e., star ratings) for each CAHPS measure.[1-6,1-7] In addition, a trend analysis was performed that compared the 2017 CAHPS results to their corresponding 2016 CAHPS results. Table 1-2 provides highlights of the National Comparisons and Trend Analysis findings for the MDHHS Medicaid Program. The numbers presented below the stars represent the three-point mean score for each measure, while the stars represent overall member satisfaction ratings when the three-point means were compared to NCQA HEDIS Benchmarks and Thresholds for Accreditation.

Table 1-2—National Comparisons and Trend Analysis MDHHS Medicaid Program

Measure	National Comparisons	Trend Analysis
Global Ratings		
Rating of Health Plan	★★★ 2.47	—
Rating of All Health Care	★★★ 2.39	—
Rating of Personal Doctor	★★★ 2.52	—
Rating of Specialist Seen Most Often	★★★ 2.53	—
Composite Measures		
Getting Needed Care	★★★★ 2.41	—
Getting Care Quickly	★★★ 2.44	—
How Well Doctors Communicate	★★★★★ 2.66	—
Customer Service	★★★★ 2.60	—
Star Assignments Based on Percentiles ★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th		
▲ *statistically significantly higher in 2017 than in 2016.* ▼ *statistically significantly lower in 2017 than in 2016.* — *indicates the 2017 score is not statistically significantly different than the 2016 score.*		

[1-6] National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA; May 4, 2017.

[1-7] NCQA does not publish national benchmarks and thresholds for the Shared Decision Making composite measure; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

The National Comparisons results indicated one composite measure scored at or above the 90th percentile, How Well Doctors Communicate. Two composite measures scored between the 75th and 89th percentiles, Getting Needed Care and Customer Service. Additionally, the Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often global ratings, and the Getting Care Quickly composite measure scored at or between the 50th and 74th percentiles.

Results from the trend analysis showed that the MDHHS Medicaid Program did not score statistically significantly *higher* or *lower* in 2017 than in 2016 on any of the measures.

Statewide Comparisons

HSAG calculated top-box rates (i.e., rates of satisfaction) for each global rating and composite measure and overall rates for the Effectiveness of Care measures. HSAG compared the MHP and FFS results to the MDHHS Medicaid Managed Care Program average to determine if plan or program results were statistically significantly different than the MDHHS Medicaid Managed Care Program average. Table 1-3 through Table 1-5 show the results of this analysis for the global ratings, composite measures, and Effectiveness of Care measures, respectively.

Table 1-3—Statewide Comparisons: Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Fee-for-Service	—	—	—	—
Aetna Better Health of Michigan	↓	—	—	—
Blue Cross Complete of Michigan	—	—	—	—
HAP Midwest Health Plan	—	—	—	—
Harbor Health Plan	—	—	—	—+
McLaren Health Plan	↓	—	—	—
Meridian Health Plan of Michigan	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—
Priority Health Choice, Inc.	—	—	—	—
Total Health Care, Inc.	—	—	—	—
UnitedHealthcare Community Plan	—	—	—	—
Upper Peninsula Health Plan	—	—	—	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
↑ *indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average.*
↓ *indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average.*
— *indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average.*

Table 1-4—Statewide Comparisons: Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Fee-for-Service	—	—	—	—+	—
Aetna Better Health of Michigan	↓	—	—	—	—
Blue Cross Complete of Michigan	—	—	—	—	—
HAP Midwest Health Plan	—	—	↑	—	—
Harbor Health Plan	↓	—	—	—+	—+
McLaren Health Plan	↑	—	—	—	—
Meridian Health Plan of Michigan	—	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—	—
Priority Health Choice, Inc.	—	—	—	—	—
Total Health Care, Inc.	—	—	—	—	—
UnitedHealthcare Community Plan	—	—	—	—	—
Upper Peninsula Health Plan	—	—	↑	—	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
↑ *indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average.*
↓ *indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average.*
— *indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average.*

Table 1-5—Statewide Comparisons: Effectiveness of Care Measures

Plan Name	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies
Fee-for-Service	—	—	—
Aetna Better Health of Michigan	—	—	—
Blue Cross Complete of Michigan	—	—	—
HAP Midwest Health Plan	—	—	—
Harbor Health Plan	—	—	—
McLaren Health Plan	—	—	—
Meridian Health Plan of Michigan	—	—	—
Molina Healthcare of Michigan	—	—	—
Priority Health Choice, Inc.	—	—	—
Total Health Care, Inc.	—	—	—
UnitedHealthcare Community Plan	—	—	—
Upper Peninsula Health Plan	—	—	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
↑ *indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average.*
↓ *indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average.*
— *indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average.*

The results from the Statewide Comparisons presented in Table 1-3 through Table 1-5 revealed that the following plans had one measure that was statistically significantly *higher* than the MDHHS Medicaid Managed Care Program average:

- HAP Midwest Health Plan
- McLaren Health Plan
- Upper Peninsula Health Plan

Conversely, the following plan had two measures that were statistically significantly *lower* than the MDHHS Medicaid Managed Care Program average:

- Aetna Better Health of Michigan

The following plans had one measure that was statistically significantly *lower* than the MDHHS Medicaid Managed Care Program average:

- Harbor Health Plan
- McLaren Health Plan

Key Drivers of Satisfaction

HSAG focused the key drivers of satisfaction analysis on the following three global ratings: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. HSAG evaluated these global ratings to determine if particular CAHPS items (i.e., questions) are strongly correlated with one or more of these measures. These individual CAHPS items, which HSAG refers to as "key drivers" are driving levels of satisfaction with each of the three measures. Table 1-6 provides a summary of the key drivers identified for the MDHHS Medicaid Program.

Table 1-6—MDHHS Medicaid Program Key Drivers of Satisfaction

Rating of Health Plan
Respondents reported that their health plan's customer service did not always give them the information or help they needed.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Respondents reported that information in written materials or on the Internet about how the health plan works did not always provide the information they needed.
Respondents reported that forms from their health plan were often not easy to fill out.
Respondents reported that it was often not easy to obtain appointments with specialists.
Rating of All Health Care
Respondents reported that when they talked about starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for them.
Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Rating of Personal Doctor
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.

2017 CAHPS Performance Measures

The CAHPS 5.0H Adult Medicaid Health Plan Survey with the HEDIS supplemental item set includes 58 core questions that yield 12 measures of satisfaction. These measures include four global rating questions, five composite measures, and three Effectiveness of Care measures. The global measures (also referred to as global ratings) reflect overall satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., "Getting Needed Care" or "Getting Care Quickly"). The Effectiveness of Care measures assess the various aspects of providing medical assistance with smoking and tobacco use cessation.

Table 2-1 lists the measures included in the CAHPS 5.0H Adult Medicaid Health Plan Survey with the HEDIS supplemental item set.

Table 2-1—CAHPS Measures

Global Ratings	Composite Measures	Effectiveness of Care Measures
Rating of Health Plan	Getting Needed Care	Advising Smokers and Tobacco Users to Quit
Rating of All Health Care	Getting Care Quickly	Discussing Cessation Medications
Rating of Personal Doctor	How Well Doctors Communicate	Discussing Cessation Strategies
Rating of Specialist Seen Most Often	Customer Service	
	Shared Decision Making	

How CAHPS Results Were Collected

NCQA mandates a specific HEDIS survey methodology to ensure the collection of CAHPS data is consistent throughout all plans to allow for comparisons. In accordance with NCQA requirements, the sampling procedures and survey protocol were adhered to as described below.

Sampling Procedures

MDHHS provided HSAG with a list of all eligible members for the sampling frame, per HEDIS specifications. HSAG inspected a sample of the file records to check for any apparent problems with the files, such as missing address elements. The MHPs contracted with separate survey vendors to perform sampling. Following HEDIS requirements, members were sampled who met the following criteria:

- Were 18 years of age or older as of December 31, 2016.
- Were currently enrolled in an MHP or FFS.
- Had been continuously enrolled in the plan or program for at least five of the last six months (July through December) of 2016.
- Had Medicaid as a payer.

Next, a systematic sample of members was selected for inclusion in the survey. For each MHP, no more than one member per household was selected as part of the survey samples. A sample of at least 1,350 adult members was selected from the FFS population and each MHP, with one exception.[2-1] Harbor Health Plan did not have enough eligible members to meet the sampling goal of 1,350 members; therefore, the sample size for Harbor Health Plan was 1,349 adult members. Table 3-1 in the Results section provides an overview of the sample sizes for each plan and program.

Survey Protocol

The survey administration protocol employed by all of the MHPs and FFS was a mixed-mode methodology, which allowed for two methods by which members could complete a survey. The first, or mail phase, consisted of sampled members receiving a survey via mail. Non-respondents received a reminder postcard, followed by a second survey mailing and reminder postcard.

The second phase, or telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI) of members who did not mail in a completed survey. At least three CATI calls to each non-respondent were attempted.[2-2] It has been shown that the addition of the telephone phase aids in the reduction of

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[2-1] Some MHPs elected to oversample their population.

[2-2] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2017 Survey Measures.* Washington, DC: NCQA; 2016.

non-response bias by increasing the number of respondents who are more demographically representative of a plan's population.[2-3]

Table 2-2 shows the standard mixed-mode (i.e., mail followed by telephone follow-up) CAHPS 5.0H timeline used in the administration of the CAHPS surveys.

Table 2-2—CAHPS 5.0H Mixed-Mode Methodology Survey Timeline

Task	Timeline
Send first questionnaire with cover letter to the adult member.	0 days
Send a postcard reminder to non-respondents 4-10 days after mailing the first questionnaire.	4 – 10 days
Send a second questionnaire (and letter) to non-respondents approximately 35 days after mailing the first questionnaire.	35 days
Send a second postcard reminder to non-respondents 4-10 days after mailing the second questionnaire.	39 – 45 days
Initiate CATI interviews for non-respondents approximately 21 days after mailing the second questionnaire.	56 days
Initiate systematic contact for all non-respondents such that at least three telephone calls are attempted at different times of the day, on different days of the week, and in different weeks.	56 – 70 days
Telephone follow-up sequence completed (i.e., completed interviews obtained or maximum calls reached for all non-respondents) approximately 14 days after initiation.	70 days

[2-3] Fowler FJ Jr., Gallagher PM, Stringfellow VL, et al. "Using Telephone Interviews to Reduce Nonresponse Bias to Mail Surveys of Health Plan Members." *Medical Care*. 2002; 40(3): 190-200.

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How CAHPS Results Were Calculated and Displayed

HSAG used the CAHPS scoring approach recommended by NCQA in Volume 3 of HEDIS Specifications for Survey Measures. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, HSAG performed a number of analyses to comprehensively assess member satisfaction. In addition to individual plan results, HSAG calculated an MDHHS Medicaid Program average and an MDHHS Medicaid Managed Care Program average. HSAG combined results from FFS and the MHPs to form the MDHHS Medicaid Program average. HSAG combined results from the MHPs to form the MDHHS Medicaid Managed Care Program average. This section provides an overview of each analysis.

Who Responded to the Survey

The administration of the CAHPS survey is comprehensive and is designed to achieve the highest possible response rate. NCQA defines the response rate as the total number of completed surveys divided by all eligible members of the sample.[2-4] HSAG considered a survey completed if members answered at least three of the following five questions: 3, 15, 24, 28, and 35. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible criteria), were mentally or physically incapacitated, or had a language barrier.

$$\text{Response Rate} = \frac{\text{Number of Completed Surveys}}{\text{Sample - Ineligibles}}$$

Demographics of Adult Members

The demographics analysis evaluated demographic information of adult members. MDHHS should exercise caution when extrapolating the CAHPS results to the entire population if the respondent population differs significantly from the actual population of the plan or program.

National Comparisons

HSAG conducted an analysis of the CAHPS survey results using NCQA HEDIS Specifications for Survey Measures. Although NCQA requires a minimum of at least 100 responses on each item in order to obtain a reportable CAHPS Survey result, HSAG presented results with less than 100 responses. Therefore, caution should be exercised when evaluating measures' results with less than 100 responses, which are denoted with a cross (+).

[2-4] National Committee for Quality Assurance. *HEDIS® 2017*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2016.

Table 2-3 shows the percentiles that were used to determine star ratings for each CAHPS measure.

Table 2-3—Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

In order to perform the National Comparisons, a three-point mean score was determined for each CAHPS measure. HSAG compared the resulting three-point mean scores to published NCQA HEDIS Benchmarks and Thresholds for Accreditation to derive the overall member satisfaction ratings for each CAHPS measure.[2-5]

Table 2-4 shows the NCQA HEDIS Benchmarks and Thresholds for Accreditation used to derive the overall adult Medicaid member satisfaction ratings on each CAHPS measure.[2-6] NCQA does not publish national benchmarks and thresholds for Shared Decision Making; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

Table 2-4—Overall Adult Medicaid Member Satisfaction Ratings Crosswalk

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.53	2.48	2.43	2.35
Rating of All Health Care	2.46	2.43	2.38	2.32
Rating of Personal Doctor	2.57	2.53	2.50	2.43
Rating of Specialist Seen Most Often	2.59	2.56	2.51	2.48
Getting Needed Care	2.45	2.41	2.35	2.28
Getting Care Quickly	2.49	2.45	2.40	2.33
How Well Doctors Communicate	2.64	2.58	2.54	2.48
Customer Service	2.61	2.58	2.54	2.48

[2-5] For detailed information on the derivation of three-point mean scores, please refer to *HEDIS® 2017*, *Volume 3: Specifications for Survey Measures.*

[2-6] National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA; May 4, 2017.

Statewide Comparisons

Global Ratings and Composite Measures

For purposes of the Statewide Comparisons analysis, HSAG calculated question summary rates for each global rating and global proportions for each composite measure, following NCQA HEDIS Specifications for Survey Measures.[2-7] The scoring of the global ratings and composite measures involved assigning top-box responses a score of one, with all other responses receiving a score of zero. A "top-box" response was defined as follows:

- "9" or "10" for the global ratings;
- "Usually" or "Always" for the Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composites;
- "Yes" for the Shared Decision Making composite.

Medical Assistance with Smoking and Tobacco Use Cessation

HSAG calculated three rates that assess different facets of providing medical assistance with smoking and tobacco use cessation:

- Advising Smokers and Tobacco Users to Quit
- Discussing Cessation Medications
- Discussing Cessation Strategies

These rates assess the percentage of smokers or tobacco users who were advised to quit, were recommended cessation medications, and were provided cessation methods or strategies, respectively. Responses of "Sometimes," "Usually," and "Always" were used to determine if the member qualified for inclusion in the numerator. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results. Please exercise caution when reviewing the trend analysis results for the medical assistance with smoking and tobacco use cessation measures, as the 2017 results contain members who responded to the survey and indicated that they were current smokers or tobacco users in 2016 and 2017.

Weighting

Both a weighted MDHHS Medicaid Program rate and a weighted MDHHS Medicaid Managed Care Program rate were calculated. Results were weighted based on the total eligible population for each plan's or program's adult population. The MDHHS Medicaid Program average includes results from both the MHPs and the FFS population. The MDHHS Medicaid Managed Care Program average is limited to the results of the MHPs (i.e., the FFS population is not included). For the Statewide

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[2-7] National Committee for Quality Assurance. *HEDIS® 2017*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2016.

Comparisons, no threshold number of responses was required for the results to be reported. Measures with less than 100 responses are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

MHP Comparisons

The results of the MHPs were compared to the MDHHS Medicaid Managed Care Program average. Two types of hypothesis tests were applied to these results. First, a global *F* test was calculated, which determined whether the difference between MHP means was significant. If the *F* test demonstrated MHP-level differences (i.e., p value < 0.05), then a *t* test was performed for each MHP. The *t* test determined whether each MHP's mean was statistically significantly different from the MDHHS Medicaid Managed Care Program average. This analytic approach follows the Agency for Healthcare Research and Quality's (AHRQ's) recommended methodology for identifying significant plan-level performance differences.

Fee-for-Service Comparisons

The results of the FFS population were compared to the MDHHS Medicaid Managed Care Program average. One type of hypothesis test was applied to these results. A *t* test was performed to determine whether the results of the FFS population were statistically significantly different (i.e., p value < 0.05) from the MDHHS Medicaid Managed Care Program average results.

Trend Analysis

A trend analysis was performed that compared the 2017 CAHPS scores to the corresponding 2016 CAHPS scores to determine whether there were statistically significant differences. A *t* test was performed to determine whether results in 2016 were statistically significantly different from results in 2017. A difference was considered statistically significant if the two-sided *p* value of the *t* test was less than 0.05. The two-sided *p* value of the *t* test is the probability of observing a test statistic as extreme as or more extreme than the one actually observed by chance. Measures with less than 100 responses are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

Key Drivers of Satisfaction Analysis

HSAG performed an analysis of key drivers of satisfaction for the following measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. The purpose of the key drivers of satisfaction analysis is to help decision makers identify specific aspects of care that will most benefit from quality improvement (QI) activities. The analysis provides information on: 1) how well the MDHHS Medicaid Program is performing on the survey item and 2) how important that item is to overall satisfaction.

The performance on a survey item was measured by calculating a problem score, in which a negative experience with care was defined as a problem and assigned a "1," and a positive experience with care (i.e., non-negative) was assigned a "0." The higher the problem score, the lower the member satisfaction with the aspect of service measured by that question. The problem score could range from 0 to 1.

For each item evaluated, the relationship between the item's problem score and performance on each of the three measures was calculated using a Pearson product moment correlation, which is defined as the covariance of the two scores divided by the product of their standard deviations. Items were then prioritized based on their overall problem score and their correlation to each measure. Key drivers of satisfaction were defined as those items that:

- Had a problem score that was greater than or equal to the median problem score for all items examined.
- Had a correlation that was greater than or equal to the median correlation for all items examined.

Limitations and Cautions

The findings presented in this CAHPS report are subject to some limitations in the survey design, analysis, and interpretation. MDHHS should consider these limitations when interpreting or generalizing the findings.

Case-Mix Adjustment

The demographics of a response group may impact member satisfaction. Therefore, differences in the demographics of the response group may impact CAHPS results. NCQA does not recommend case-mix adjusting Medicaid CAHPS results to account for these differences; therefore, no case-mix adjusting was performed on these CAHPS results.[2-8]

Non-Response Bias

The experiences of the survey respondent population may be different than that of non-respondents with respect to their health care services and may vary by plan or program. Therefore, MDHHS should consider the potential for non-response bias when interpreting CAHPS results.

Causal Inferences

Although this report examines whether respondents report differences in satisfaction with various aspects of their health care experiences, these differences may not be completely attributable to an MHP or the FFS population. These analyses identify whether respondents give different ratings of satisfaction with their MHP or the FFS population. The survey by itself does not necessarily reveal the exact cause of these differences.

Missing Phone Numbers

The volume of missing telephone numbers may impact the response rates and the validity of the survey results. For instance, a certain segment of the population may be more likely to have missing phone information than other segments.

[2-8] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services; 2008.

HSAG HEALTH SERVICES ADVISORY GROUP

Survey Vendor Effects

The CAHPS survey was administered by multiple survey vendors. NCQA developed its Survey Vendor Certification Program to ensure standardization of data collection and the comparability of results across health plans. However, due to the different processes employed by the survey vendors, there is still the small potential for vendor effects. Therefore, survey vendor effects should be considered when interpreting the CAHPS results.

3. Results

Who Responded to the Survey

A total of 21,209 surveys were distributed to adult members. A total of 5,791 surveys were completed. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was considered complete if members answered at least three of the following five questions on the survey: 3, 15, 24, 28, and 35. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible criteria), were mentally or physically incapacitated, or had a language barrier.

Table 3-1 shows the total number of members sampled, the number of surveys completed, the number of ineligible members, and the response rates.

Table 3-1—Total Number of Respondents and Response Rates

Plan Name	Sample Size	Completes	Ineligibles	Response Rates
MDHHS Medicaid Program	**21,209**	**5,791**	**580**	**28.07%**
Fee-for-Service	1,350	419	117	33.98%
MDHHS Medicaid Managed Care Program	**19,859**	**5,372**	**463**	**27.70%**
Aetna Better Health of Michigan	1,485	328	23	22.44%
Blue Cross Complete of Michigan	1,825	413	30	23.01%
HAP Midwest Health Plan	1,350	445	73	34.85%
Harbor Health Plan	1,349	242	45	18.56%
McLaren Health Plan	1,350	420	22	31.63%
Meridian Health Plan of Michigan	1,890	567	26	30.42%
Molina Healthcare of Michigan	2,700	719	63	27.27%
Priority Health Choice, Inc.	1,890	442	38	23.87%
Total Health Care, Inc.	2,160	505	45	23.88%
UnitedHealthcare Community Plan	1,700	472	63	28.83%
Upper Peninsula Health Plan	2,160	819	35	38.54%

Demographics of Adult Members

Table 3-2 depicts the ages of members who completed a CAHPS survey.

Table 3-2—Adult Member Demographics: Age

Plan Name	18 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 and Older
MDHHS Medicaid Program	**9.1%**	**17.0%**	**15.7%**	**22.1%**	**28.9%**	**7.2%**
Fee-for-Service	6.3%	10.9%	7.8%	15.3%	21.1%	38.6%
MDHHS Medicaid Managed Care Program	**9.4%**	**17.5%**	**16.3%**	**22.7%**	**29.5%**	**4.7%**
Aetna Better Health of Michigan	9.5%	14.8%	21.1%	23.7%	30.0%	0.9%
Blue Cross Complete of Michigan	7.9%	21.4%	19.9%	21.4%	28.7%	0.7%
HAP Midwest Health Plan	1.3%	6.8%	9.4%	19.3%	24.0%	39.2%
Harbor Health Plan	7.0%	14.8%	12.2%	18.3%	44.8%	3.0%
McLaren Health Plan	8.2%	17.4%	16.9%	25.8%	30.8%	1.0%
Meridian Health Plan of Michigan	11.5%	19.6%	15.7%	22.0%	28.8%	2.3%
Molina Healthcare of Michigan	9.4%	17.1%	15.8%	26.5%	26.5%	4.7%
Priority Health Choice, Inc.	15.5%	25.3%	18.8%	17.6%	22.0%	0.7%
Total Health Care, Inc.	8.8%	14.8%	14.2%	28.3%	31.8%	2.1%
UnitedHealthcare Community Plan	11.6%	21.0%	15.9%	20.8%	29.0%	1.7%
Upper Peninsula Health Plan	9.4%	17.0%	17.8%	21.8%	33.0%	1.0%

Please note, percentages may not total 100.0% due to rounding.

Table 3-3 depicts the gender of members who completed a CAHPS survey.

Table 3-3—Adult Member Demographics: Gender

Plan Name	Male	Female
MDHHS Medicaid Program	**41.1%**	**58.9%**
Fee-for-Service	36.2%	63.8%
MDHHS Medicaid Managed Care Program	**41.5%**	**58.5%**
Aetna Better Health of Michigan	38.9%	61.1%
Blue Cross Complete of Michigan	47.5%	52.5%
HAP Midwest Health Plan	38.0%	62.0%
Harbor Health Plan	54.7%	45.3%
McLaren Health Plan	46.7%	53.3%
Meridian Health Plan of Michigan	39.1%	60.9%
Molina Healthcare of Michigan	41.0%	59.0%
Priority Health Choice, Inc.	31.1%	68.9%
Total Health Care, Inc.	46.0%	54.0%
UnitedHealthcare Community Plan	40.5%	59.5%
Upper Peninsula Health Plan	40.4%	59.6%
Please note, percentages may not total 100.0% due to rounding.		

Table 3-4 depicts the race and ethnicity of members who completed a CAHPS survey.

Table 3-4—Adult Member Demographics: Race/Ethnicity

Plan Name	White	Hispanic	Black	Asian	Other	Multi-Racial
MDHHS Medicaid Program	**55.6%**	**3.4%**	**28.6%**	**1.9%**	**3.3%**	**7.3%**
Fee-for-Service	66.5%	3.7%	16.9%	2.2%	3.7%	7.1%
MDHHS Medicaid Managed Care Program	**54.7%**	**3.3%**	**29.5%**	**1.9%**	**3.3%**	**7.3%**
Aetna Better Health of Michigan	28.3%	2.6%	58.8%	1.9%	1.6%	6.8%
Blue Cross Complete of Michigan	44.7%	4.0%	39.5%	3.0%	3.7%	5.2%
HAP Midwest Health Plan	36.3%	3.0%	48.6%	4.3%	3.4%	4.3%
Harbor Health Plan	14.8%	2.6%	71.7%	1.7%	3.5%	5.7%
McLaren Health Plan	72.0%	3.0%	11.4%	0.5%	2.0%	11.2%
Meridian Health Plan of Michigan	67.0%	4.5%	16.1%	0.9%	2.2%	9.2%
Molina Healthcare of Michigan	51.2%	3.0%	32.1%	2.0%	3.8%	7.9%
Priority Health Choice, Inc.	62.6%	8.0%	13.2%	2.6%	3.5%	10.1%
Total Health Care, Inc.	32.9%	1.5%	54.3%	1.5%	2.5%	7.3%
UnitedHealthcare Community Plan	50.4%	4.5%	28.9%	3.2%	5.7%	7.2%
Upper Peninsula Health Plan	89.0%	1.2%	0.6%	0.4%	3.4%	5.4%
Please note, percentages may not total 100.0% due to rounding.						

Table 3-5 depicts the general health status of members who completed a CAHPS survey.

Table 3-5—Adult Member Demographics: General Health Status

Plan Name	Excellent	Very Good	Good	Fair	Poor
MDHHS Medicaid Program	**8.3%**	**21.1%**	**34.2%**	**27.0%**	**9.5%**
Fee-for-Service	4.3%	14.5%	32.5%	36.6%	12.0%
MDHHS Medicaid Managed Care Program	**8.6%**	**21.6%**	**34.3%**	**26.2%**	**9.3%**
Aetna Better Health of Michigan	8.4%	24.1%	32.8%	26.6%	8.1%
Blue Cross Complete of Michigan	11.5%	22.1%	39.5%	19.1%	7.8%
HAP Midwest Health Plan	6.0%	16.4%	32.6%	35.1%	9.9%
Harbor Health Plan	9.4%	12.8%	33.2%	34.0%	10.6%
McLaren Health Plan	9.5%	19.8%	34.4%	25.1%	11.2%
Meridian Health Plan of Michigan	8.0%	25.1%	29.5%	26.2%	11.2%
Molina Healthcare of Michigan	8.6%	20.8%	32.3%	29.0%	9.2%
Priority Health Choice, Inc.	8.6%	20.9%	37.1%	22.5%	10.9%
Total Health Care, Inc.	8.3%	20.5%	31.9%	30.3%	8.9%
UnitedHealthcare Community Plan	9.7%	21.2%	34.3%	26.1%	8.6%
Upper Peninsula Health Plan	7.8%	26.2%	38.4%	20.4%	7.3%
Please note, percentages may not total 100.0% due to rounding.					

National Comparisons

In order to assess the overall performance of the MDHHS Medicaid Program, HSAG scored each CAHPS measure on a three-point scale using an NCQA-approved scoring methodology. HSAG compared the plans' and programs' three-point mean scores to NCQA HEDIS Benchmarks and Thresholds for Accreditation.[3-1]

Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating (i.e., Poor) and five is the highest possible rating (i.e., Excellent), as shown in Table 3-6.

Table 3-6—Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

The results presented in the following two tables represent the three-point mean scores for each measure, while the stars represent overall member satisfaction ratings with the three-point means when compared to NCQA HEDIS Benchmarks and Thresholds for Accreditation.

[3-1] National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA; May 4, 2017.

Table 3-7 shows the overall member satisfaction ratings on each of the four global ratings.

Table 3-7—National Comparisons: Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
MDHHS Medicaid Program	★★★ **2.47**	★★★ **2.39**	★★★ **2.52**	★★★ **2.53**
Fee-for-Service	★★ 2.37	★★ 2.36	★★★★ 2.53	★★★ 2.54
MDHHS Medicaid Managed Care Program	★★★ **2.47**	★★★ **2.39**	★★★ **2.51**	★★★ **2.53**
Aetna Better Health of Michigan	★★ 2.37	★ 2.29	★★ 2.43	★★ 2.50
Blue Cross Complete of Michigan	★★★★ 2.48	★★★ 2.38	★★ 2.47	★ 2.46
HAP Midwest Health Plan	★★★★ 2.51	★★★ 2.39	★★★★★ 2.57	★★★★ 2.56
Harbor Health Plan	★ 2.34	★★ 2.37	★★ 2.48	★★★+ 2.54
McLaren Health Plan	★★ 2.42	★★ 2.32	★ 2.42	★★★ 2.51
Meridian Health Plan of Michigan	★★★★ 2.50	★★★ 2.38	★★ 2.49	★★★★ 2.58
Molina Healthcare of Michigan	★★★ 2.47	★★★ 2.42	★★★★ 2.53	★★★ 2.51
Priority Health Choice, Inc.	★★★★ 2.52	★★★★ 2.43	★★★ 2.51	★★★★★ 2.61
Total Health Care, Inc.	★★★★ 2.50	★★★★★ 2.46	★★★★★ 2.58	★ 2.47
UnitedHealthcare Community Plan	★★★★ 2.51	★★ 2.32	★★ 2.46	★★★★ 2.56
Upper Peninsula Health Plan	★★★★ 2.48	★★★ 2.42	★★★★★ 2.58	★★ 2.49

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

The MDHHS Medicaid Program and the MDHHS Medicaid Managed Care Program scored at or between the 50th and 74th percentiles for all four global ratings: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often.

Table 3-8 shows the overall member satisfaction ratings on four of the composite measures.[3-2]

Table 3-8—National Comparisons: Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
MDHHS Medicaid Program	★★★★ **2.41**	★★★ **2.44**	★★★★★ **2.66**	★★★★ **2.60**
Fee-for-Service	★★★ 2.38	★★★ 2.41	★★★★★ 2.64	★+ 2.41
MDHHS Medicaid Managed Care Program	★★★★ **2.41**	★★★ **2.44**	★★★★★ **2.66**	★★★★★ **2.61**
Aetna Better Health of Michigan	★★ 2.33	★★ 2.35	★★★★★ 2.65	★★ 2.53
Blue Cross Complete of Michigan	★★★★★ 2.45	★★★★ 2.45	★★★★ 2.63	★★★★ 2.60
HAP Midwest Health Plan	★★★★★ 2.45	★★★★★ 2.52	★★★★★ 2.70	★★★★ 2.60
Harbor Health Plan	★★ 2.29	★★ 2.38	★★★★ 2.60	★★★★★+ 2.64
McLaren Health Plan	★★★★★ 2.47	★★★ 2.43	★★★★ 2.58	★★★ 2.54
Meridian Health Plan of Michigan	★★★ 2.40	★★★ 2.43	★★★★ 2.63	★★★★★ 2.63
Molina Healthcare of Michigan	★★★★ 2.43	★★★ 2.44	★★★★ 2.63	★★★★★ 2.62
Priority Health Choice, Inc.	★★★★ 2.41	★★★ 2.40	★★★★★ 2.69	★★★★★ 2.64
Total Health Care, Inc.	★★★★ 2.42	★★★★ 2.48	★★★★★ 2.67	★★★★★ 2.64
UnitedHealthcare Community Plan	★★★ 2.40	★★★ 2.42	★★★★ 2.63	★★★★★ 2.62
Upper Peninsula Health Plan	★★★ 2.39	★★★★ 2.47	★★★★★ 2.74	★★★★★ 2.62

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

[3-2] NCQA does not publish national benchmarks and thresholds for Shared Decision Making; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

The MDHHS Medicaid Program scored at or above the 90th percentile for one composite measure, How Well Doctors Communicate, and the MDHHS Medicaid Managed Care Program scored at or above the 90th percentile for two composite measures: How Well Doctors Communicate and Customer Service. The MDHHS Medicaid Program scored at or between the 75th and 89th percentiles for two composite measures: Getting Needed Care and Customer Service, and the MDHHS Medicaid Managed Care Program scored at or between the 75th and 89th percentiles for one composite measure, Getting Needed Care. Additionally, the MDHHS Medicaid Program and the MDHHS Medicaid Managed Care Program both scored at or between the 50th and 74th percentiles for the Getting Care Quickly composite measure.

Statewide Comparisons

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates (i.e., rates of satisfaction) for each global rating and composite measure. A "top-box" response was defined as follows:

- "9" or "10" for the global ratings;
- "Usually" or "Always" for the Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composites;
- "Yes" for the Shared Decision Making composite.

HSAG also calculated overall rates for the Effectiveness of Care measures, Medical Assistance with Smoking and Tobacco Use Cessation. Refer to the Reader's Guide section for more detailed information regarding the calculation of these measures.

The MDHHS Medicaid Program and MDHHS Medicaid Managed Care Program results were weighted based on the eligible population for each adult population (i.e., FFS and/or MHPs). HSAG compared the MHP results to the MDHHS Medicaid Managed Care Program average to determine if the MHP results were statistically significantly different than the MDHHS Medicaid Managed Care Program average. Additionally, HSAG compared the FFS results to the MDHHS Medicaid Managed Care Program results to determine if the FFS results were statistically significantly different than the MDHHS Medicaid Managed Care Program results. The NCQA adult Medicaid national averages also are presented for comparison.[3-3] Colors in the figures note statistically significant differences. Green indicates a top-box rate that was statistically significantly higher than the MDHHS Medicaid Managed Care Program average. Conversely, red indicates a top-box rate that was statistically significantly lower than the MDHHS Medicaid Managed Care Program average. Blue represents top-box rates that were not statistically significantly different from the MDHHS Medicaid Managed Care Program average. Health plan/program rates with fewer than 100 respondents are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

In some instances, the top-box rates presented for two plans were similar, but one was statistically different from the MDHHS Medicaid Managed Care Program average and the other was not. In these instances, it was the difference in the number of respondents between the two plans that explains the different statistical results. It is more likely that a significant result will be found in a plan with a larger number of respondents.

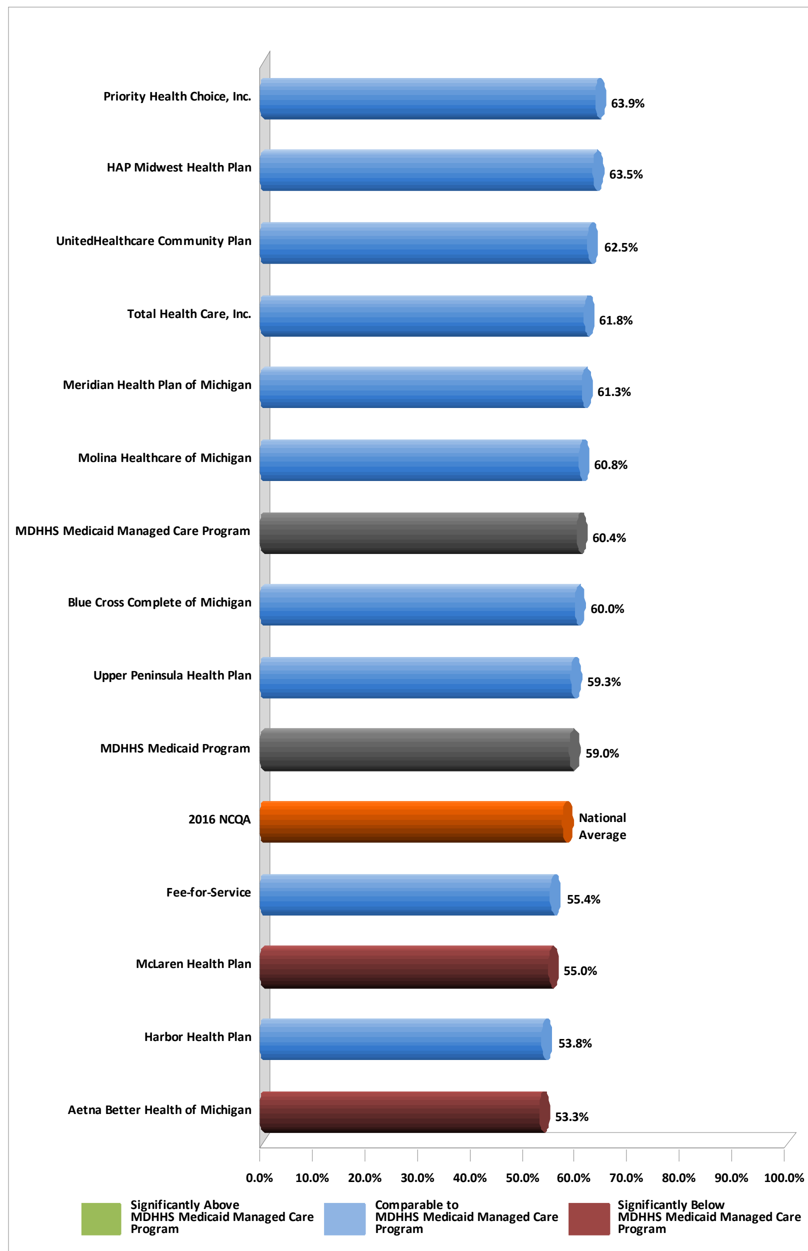
[3-3] The source for the national data contained in this publication is Quality Compass® 2016 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2016 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of AHRQ.

Global Ratings

Rating of Health Plan

Adult members were asked to rate their health plan on a scale of 0 to 10, with 0 being the “worst health plan possible” and 10 being the “best health plan possible.” Figure 3-1 shows the Rating of Health Plan top-box rates.

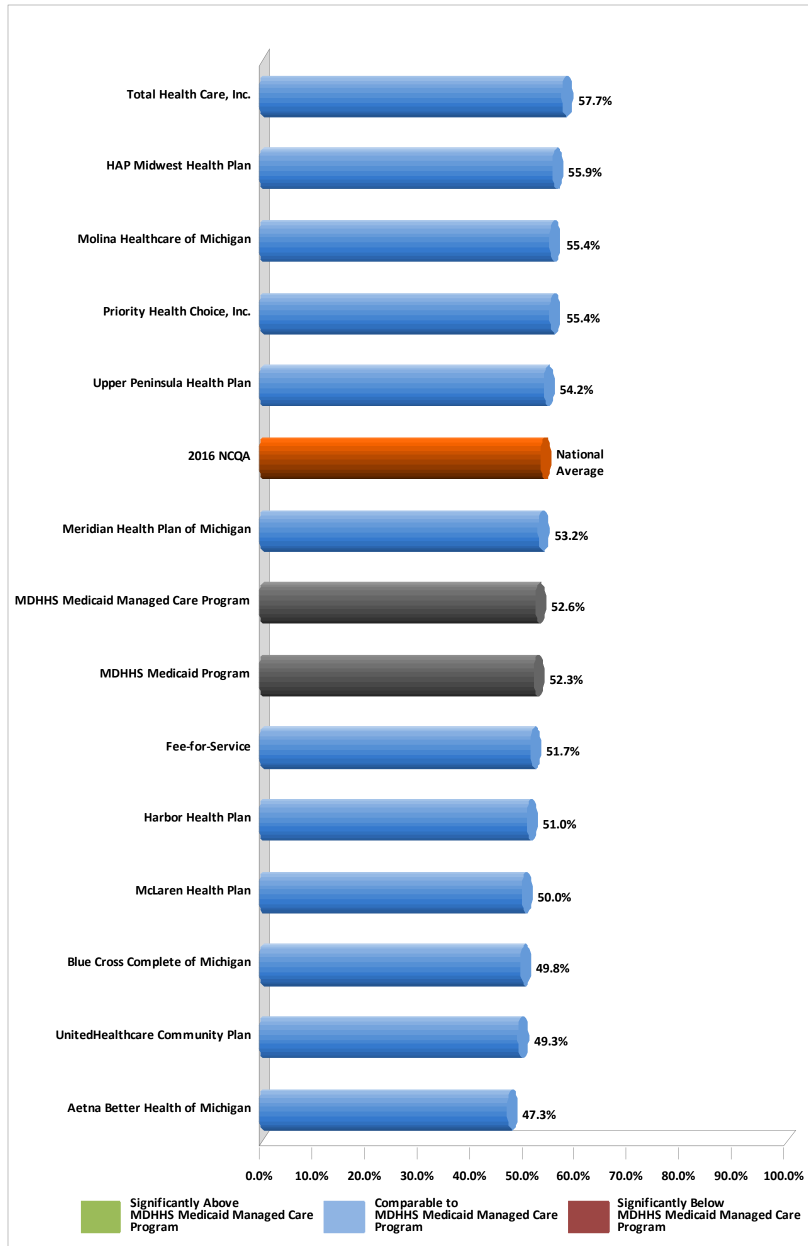
Figure 3-1—Rating of Health Plan Top-Box Rates



Rating of All Health Care

Adult members were asked to rate all their health care on a scale of 0 to 10, with 0 being the "worst health care possible" and 10 being the "best health care possible." Figure 3-2 shows the Rating of All Health Care top-box rates.

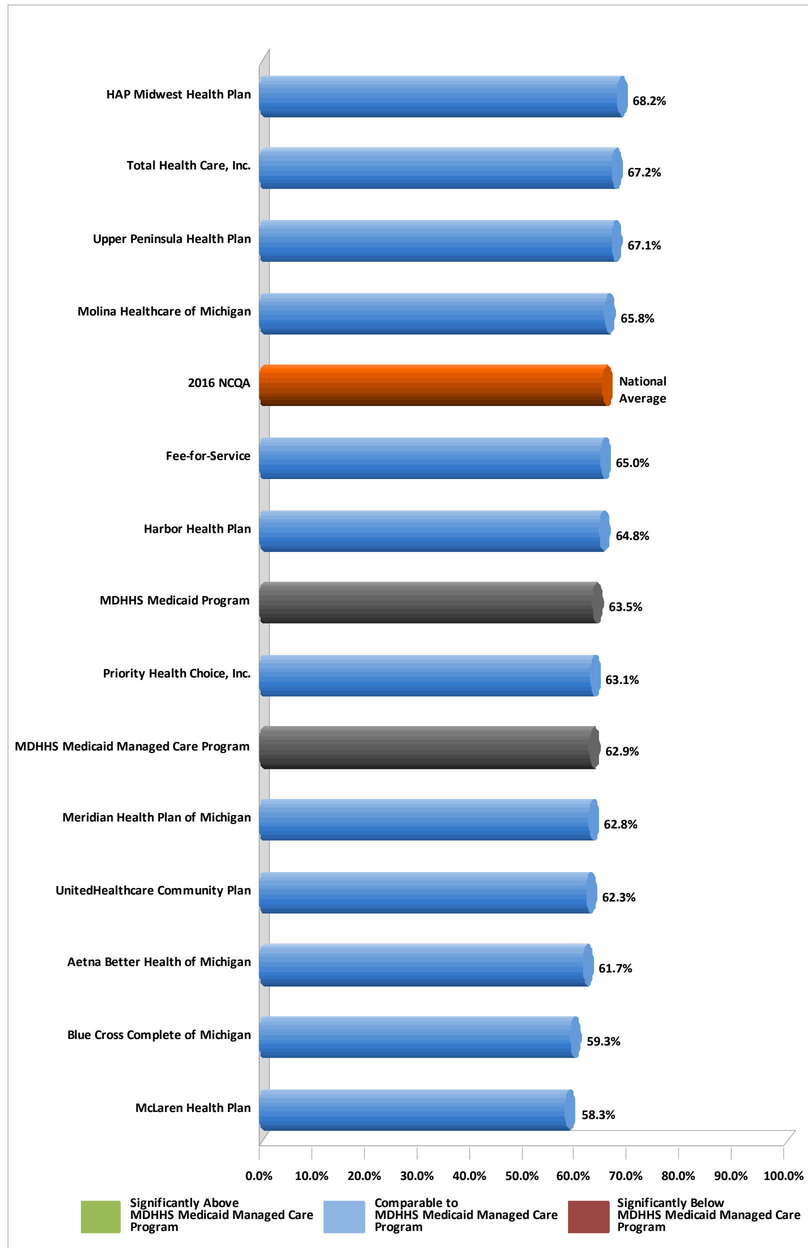
Figure 3-2—Rating of All Health Care Top-Box Rates



Rating of Personal Doctor

Adult members were asked to rate their personal doctor on a scale of 0 to 10, with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible." Figure 3-3 shows the Rating of Personal Doctor top-box rates.

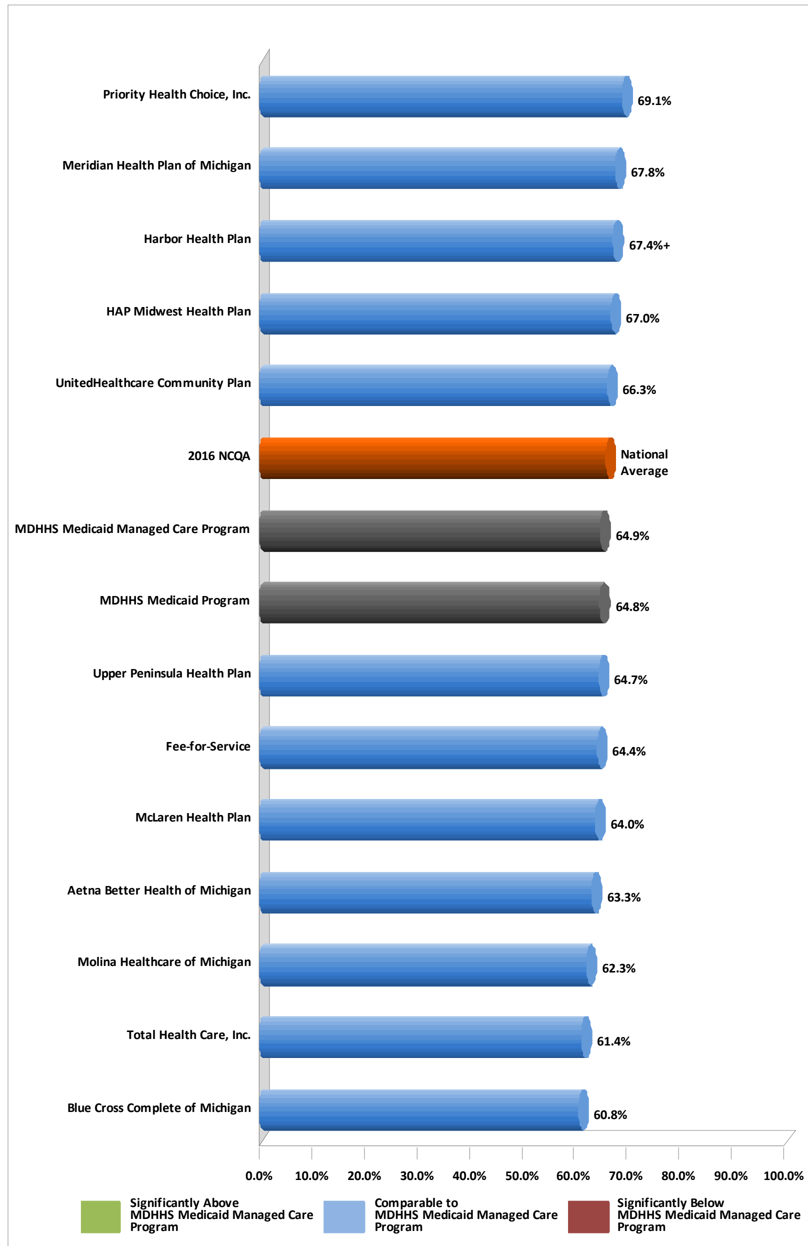
Figure 3-3—Rating of Personal Doctor Top-Box Rates



Rating of Specialist Seen Most Often

Adult members were asked to rate their specialist on a scale of 0 to 10, with 0 being the “worst specialist possible” and 10 being the “best specialist possible.” Figure 3-4 shows the Rating of Specialist Seen Most Often top-box rates.

Figure 3-4—Rating of Specialist Seen Most Often Top-Box Rates



Note: + indicates fewer than 100 responses

Composite Measures

Getting Needed Care

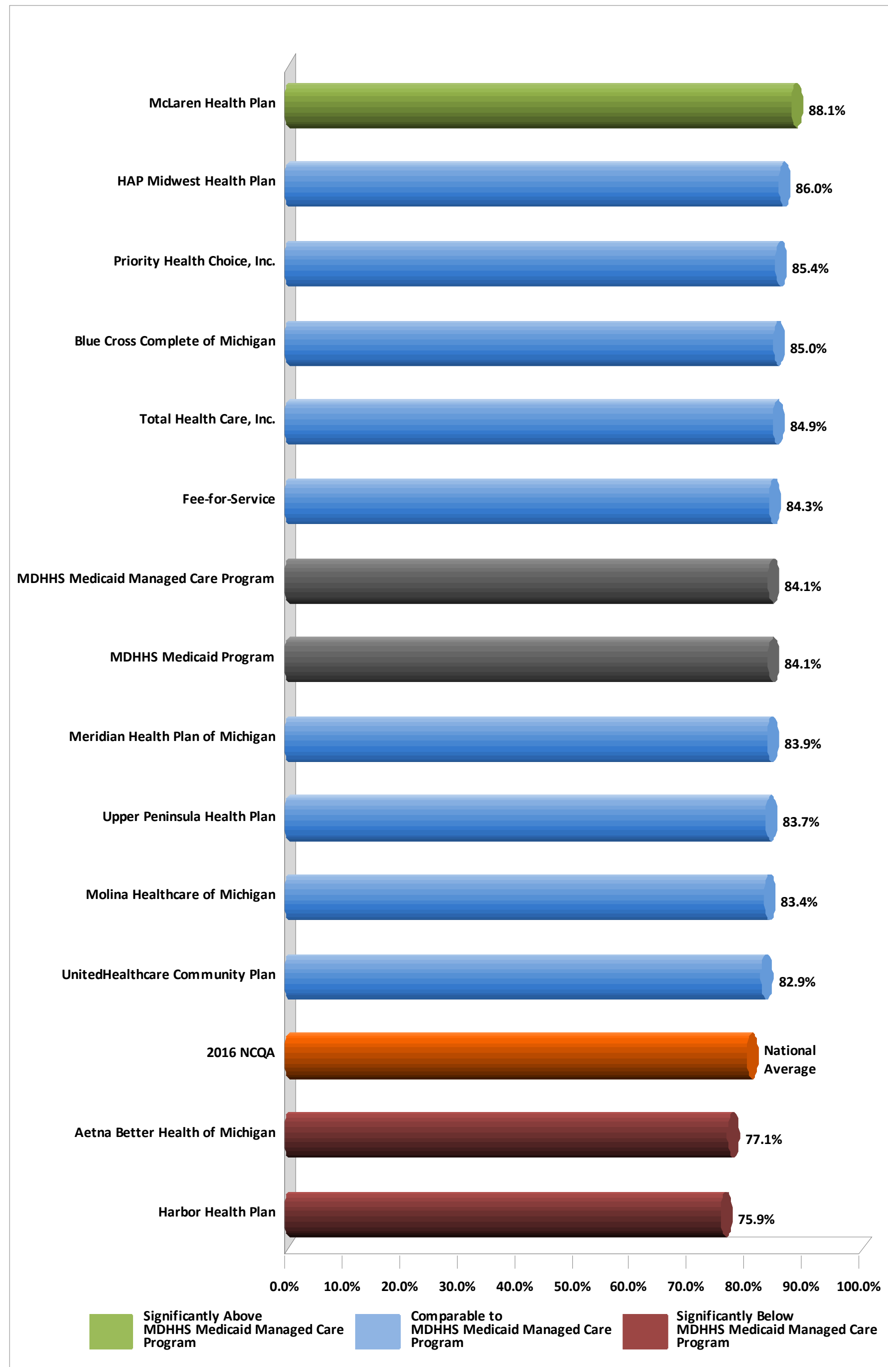
Two questions (Questions 14 and 25 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often it was easy to get needed care:

- **Question 14**. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 25.** In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Getting Needed Care composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-5 shows the Getting Needed Care top-box rates.

Figure 3-5—Getting Needed Care Top-Box Rates



Getting Care Quickly

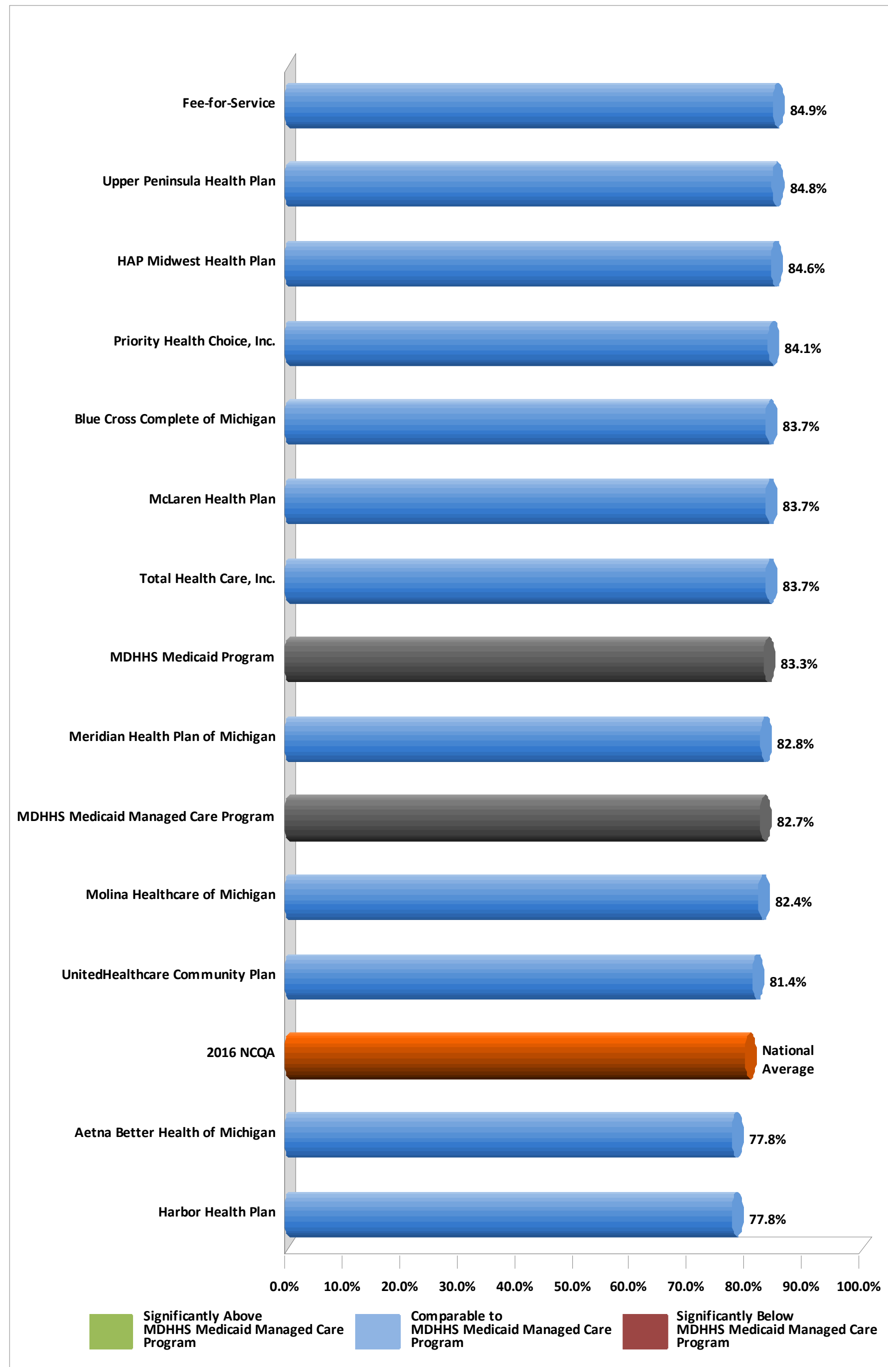
Two questions (Questions 4 and 6 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members received care quickly:

- **Question 4**. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
    - Never
    - Sometimes
    - Usually
    - Always
- **Question 6**. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
    - Never
    - Sometimes
    - Usually
    - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Getting Care Quickly composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-6 shows the Getting Care Quickly top-box rates.

Figure 3-6—Getting Care Quickly Top-Box Rates



How Well Doctors Communicate

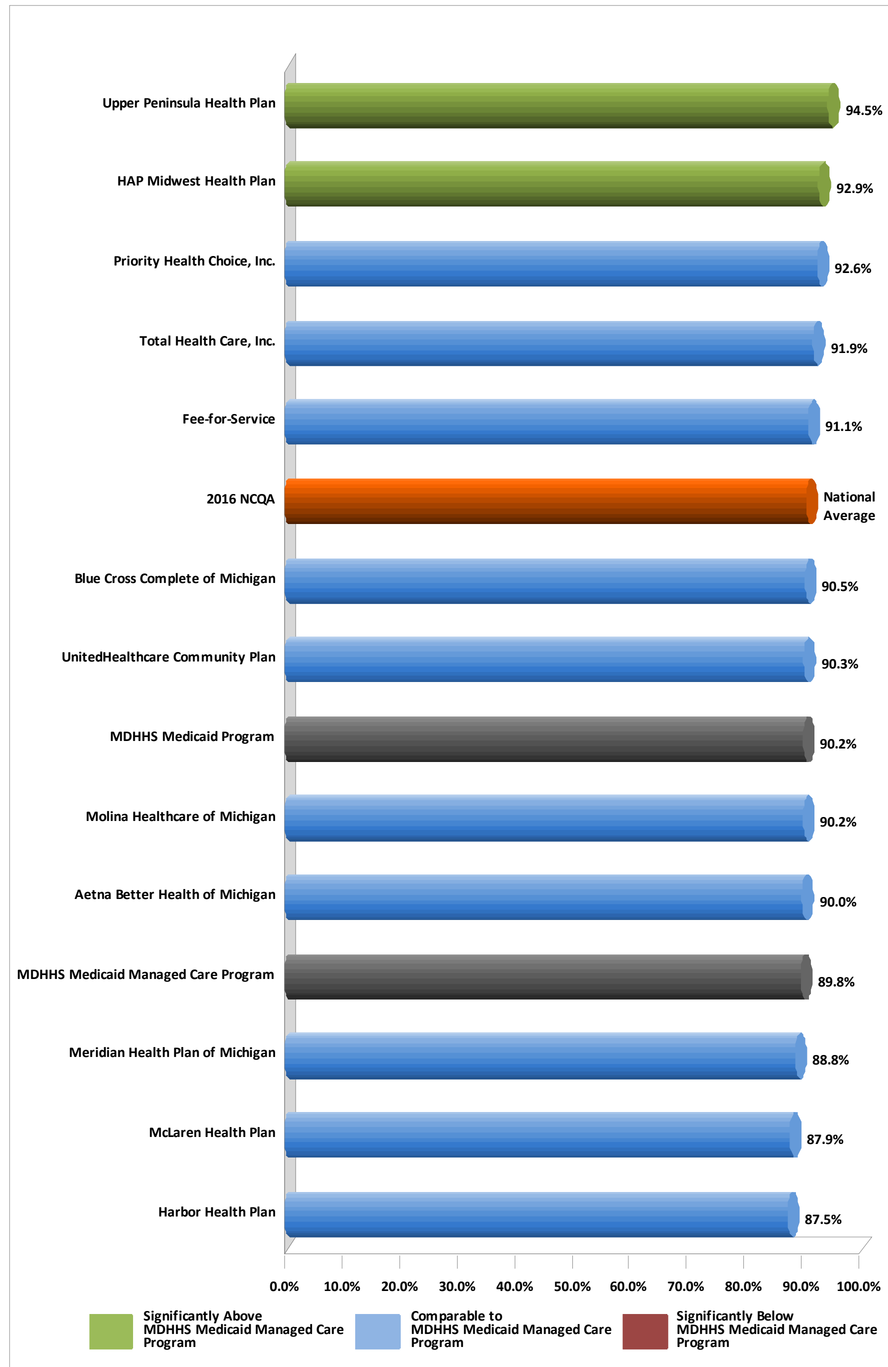
A series of four questions (Questions 17, 18, 19, and 20 in the CAHPS Adult Medicaid Health Plan Survey) was asked to assess how often doctors communicated well:

- **Question 17**. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 18**. In the last 6 months, how often did your personal doctor listen carefully to you?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 19**. In the last 6 months, how often did your personal doctor show respect for what you had to say?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 20**. In the last 6 months, how often did your personal doctor spend enough time with you?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the How Well Doctors Communicate composite measure, which was defined as a response of “Usually” or “Always.”

Figure 3-7 shows the How Well Doctors Communicate top-box rates.

Figure 3-7—How Well Doctors Communicate Top-Box Rates



Customer Service

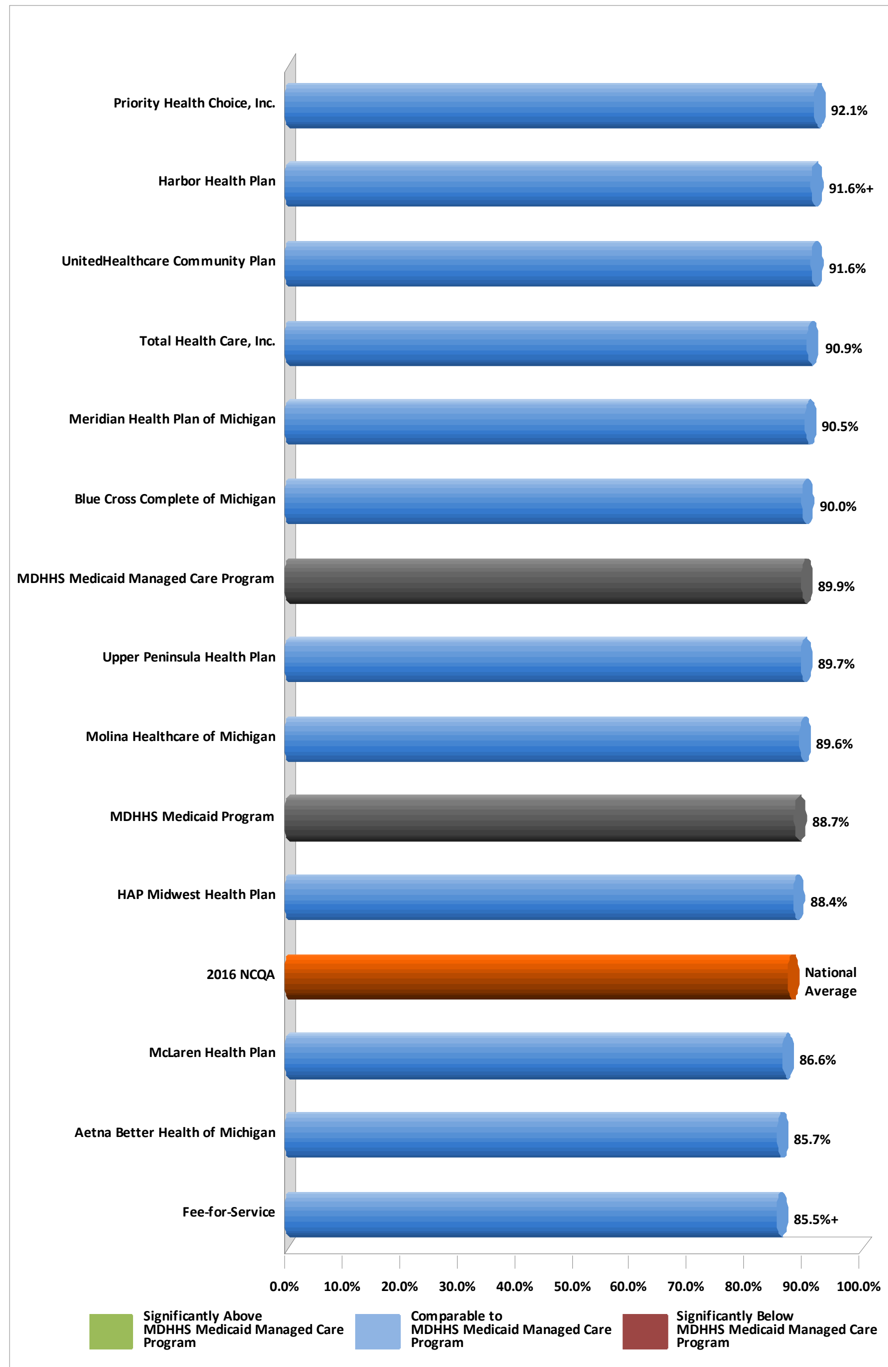
Two questions (Questions 31 and 32 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members were satisfied with customer service:

- **Question 31**. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
    - Never
    - Sometimes
    - Usually
    - Always
- **Question 32**. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?
    - Never
    - Sometimes
    - Usually
    - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Customer Service composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-8 shows the Customer Service top-box rates.

Figure 3-8—Customer Service Top-Box Rates



Note: + indicates fewer than 100 responses

Shared Decision Making

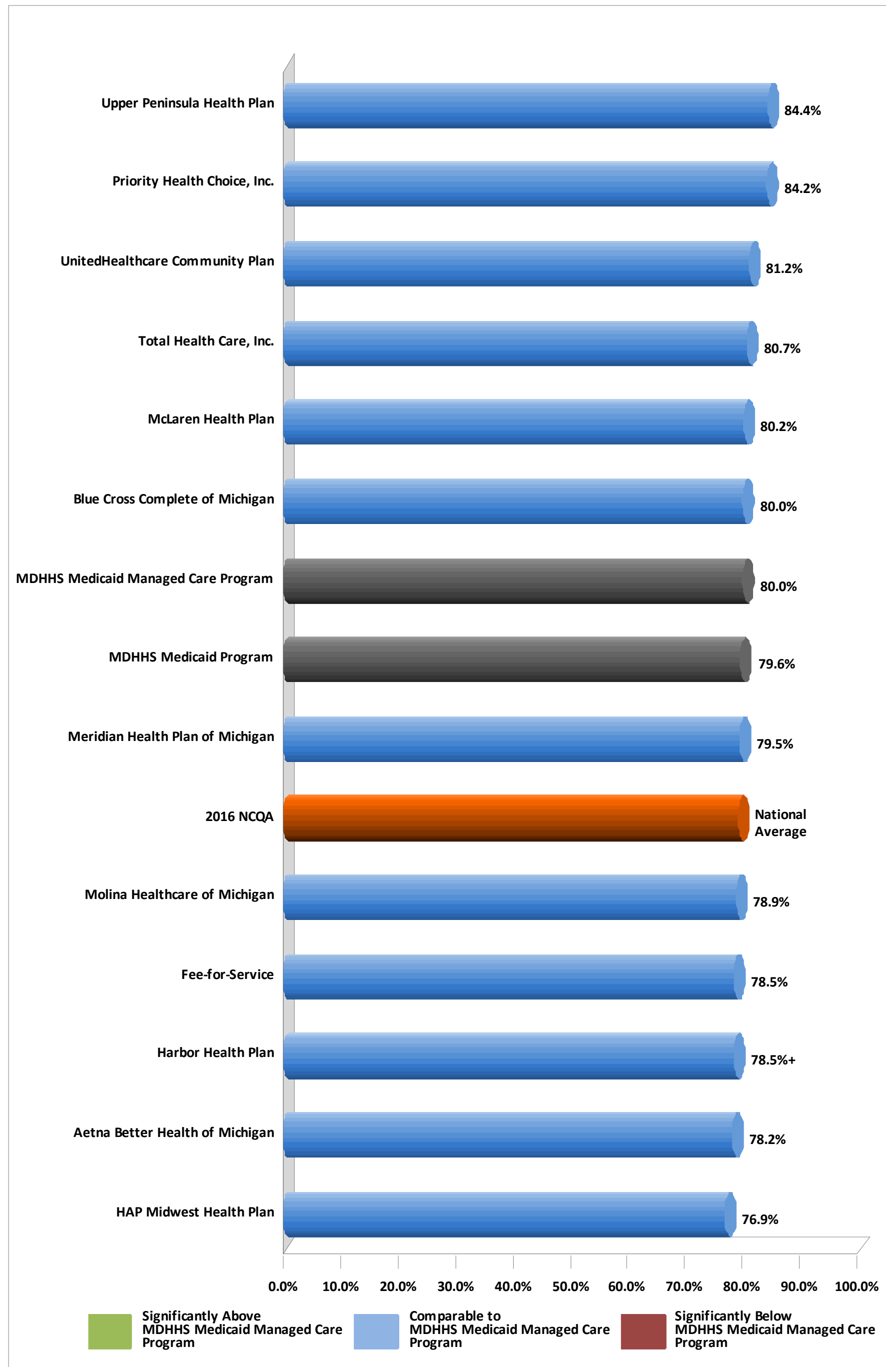
Three questions (Questions 10, 11, and 12 in the CAHPS Adult Medicaid Health Plan Survey) were asked regarding the involvement of adult members in decision making when starting or stopping a prescription medicine:

- **Question 10**. Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?
    - Yes
    - No
- **Question 11**. Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?
    - Yes
    - No
- **Question 12**. When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?
    - Yes
    - No

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Shared Decision Making composite measure, which was defined as a response of "Yes."

Figure 3-9 shows the Shared Decision Making top-box rates.

Figure 3-9—Shared Decision Making Top-Box Rates



Note: + indicates fewer than 100 responses

Effectiveness of Care Measures

Medical Assistance with Smoking and Tobacco Use Cessation

Advising Smokers and Tobacco Users to Quit

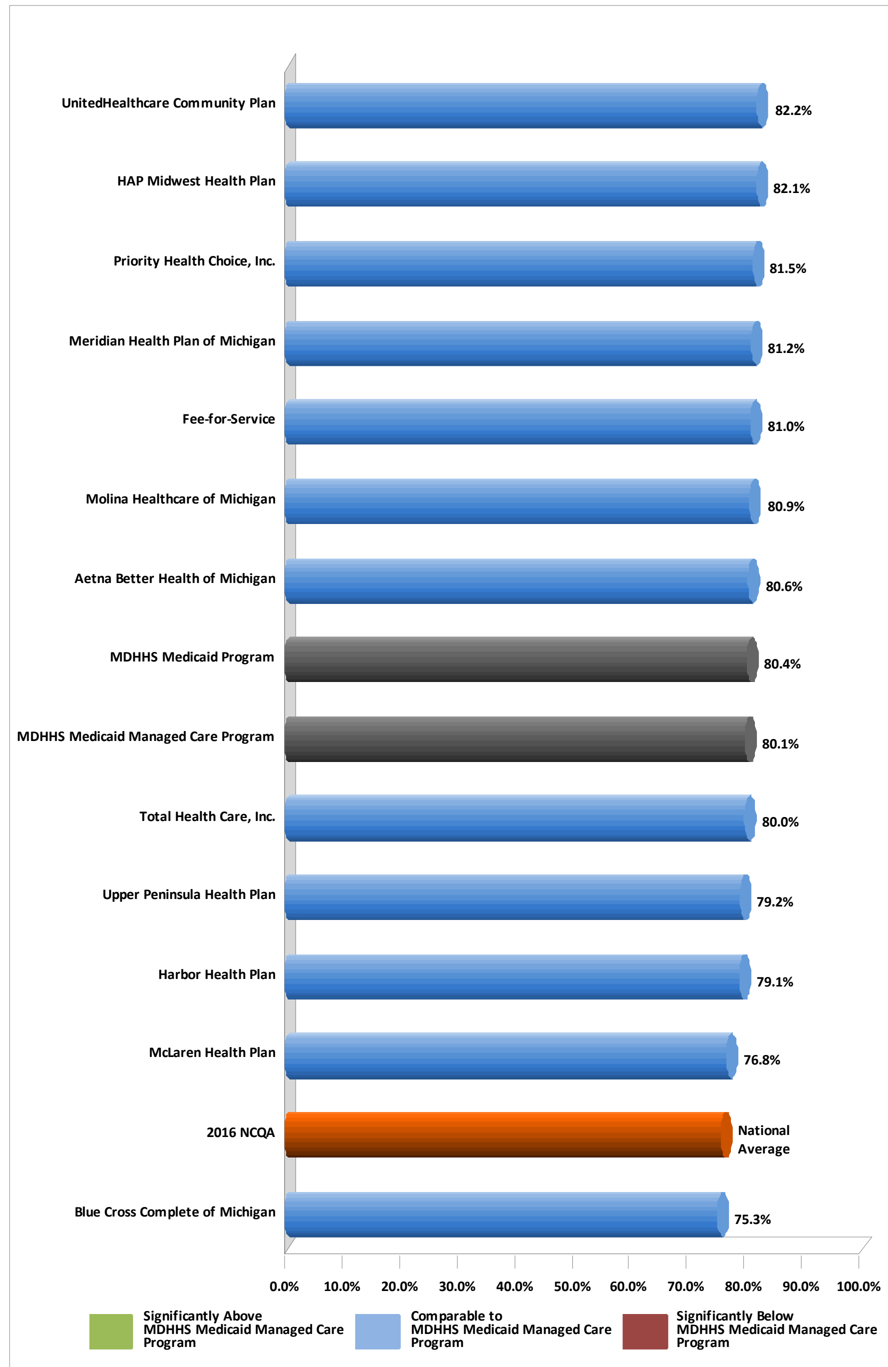
Adult members were asked how often they were advised to quit smoking or using tobacco by a doctor or other health provider (Question 40 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 40**. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?
    - Never
    - Sometimes
    - Usually
    - Always

The results of this measure represent the percentage of smokers/tobacco users who answered "Sometimes," "Usually," or "Always" to this question. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior years' results.

Figure 3-10 shows the Advising Smokers and Tobacco Users to Quit rates.

Figure 3-10—Advising Smokers and Tobacco Users to Quit Rates



Discussing Cessation Medications

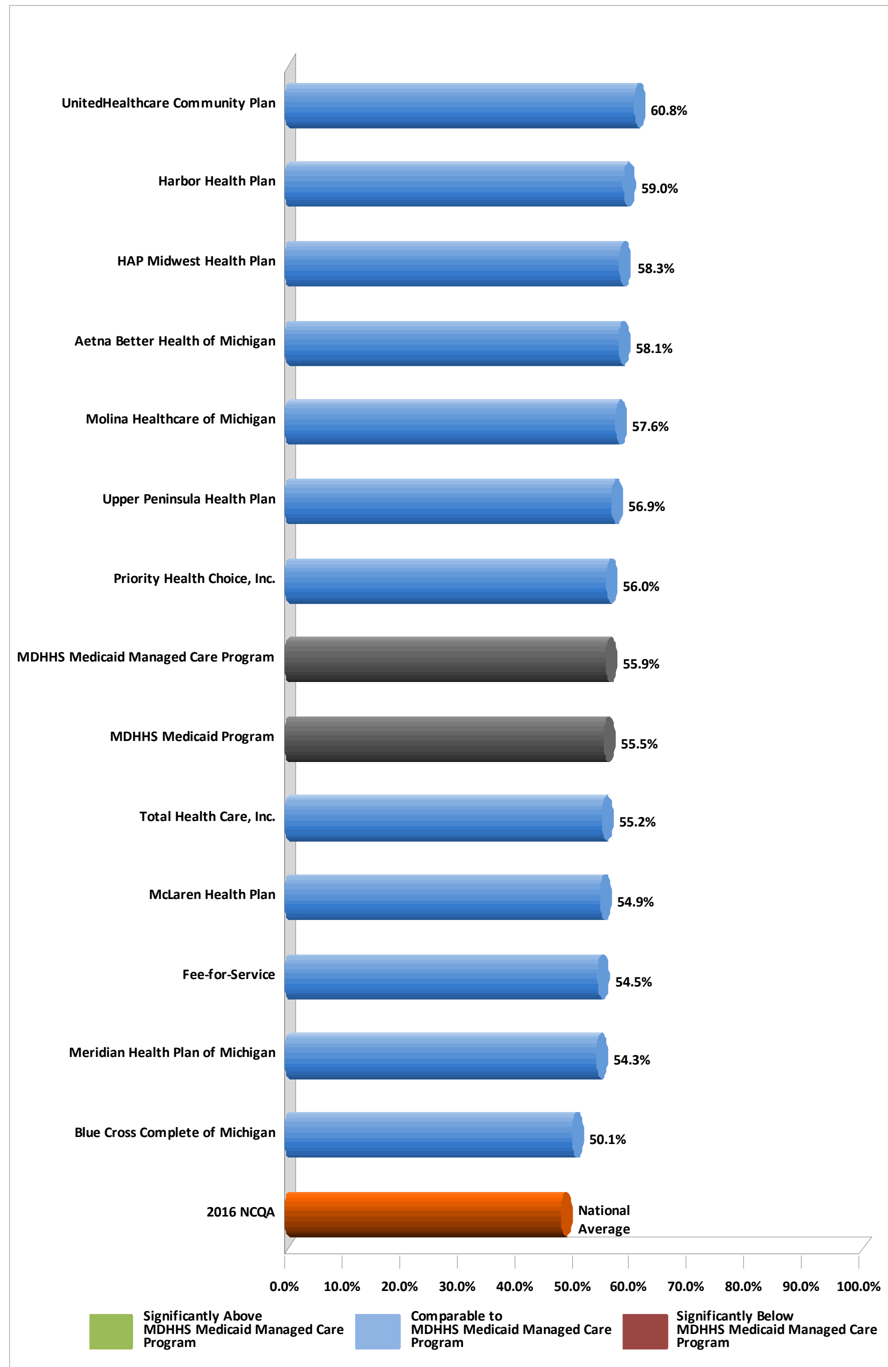
Adult members were asked how often medication was recommended or discussed by a doctor or other health provider to assist them with quitting smoking or using tobacco (Question 41 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 41**. In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.
    - Never
    - Sometimes
    - Usually
    - Always

The results of this measure represent the percentage of smokers/tobacco users who answered "Sometimes," "Usually," or "Always" to this question. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior years' results.

Figure 3-11 shows the Discussing Cessation Medications rates.

Figure 3-11—Discussing Cessation Medications Rates



Discussing Cessation Strategies

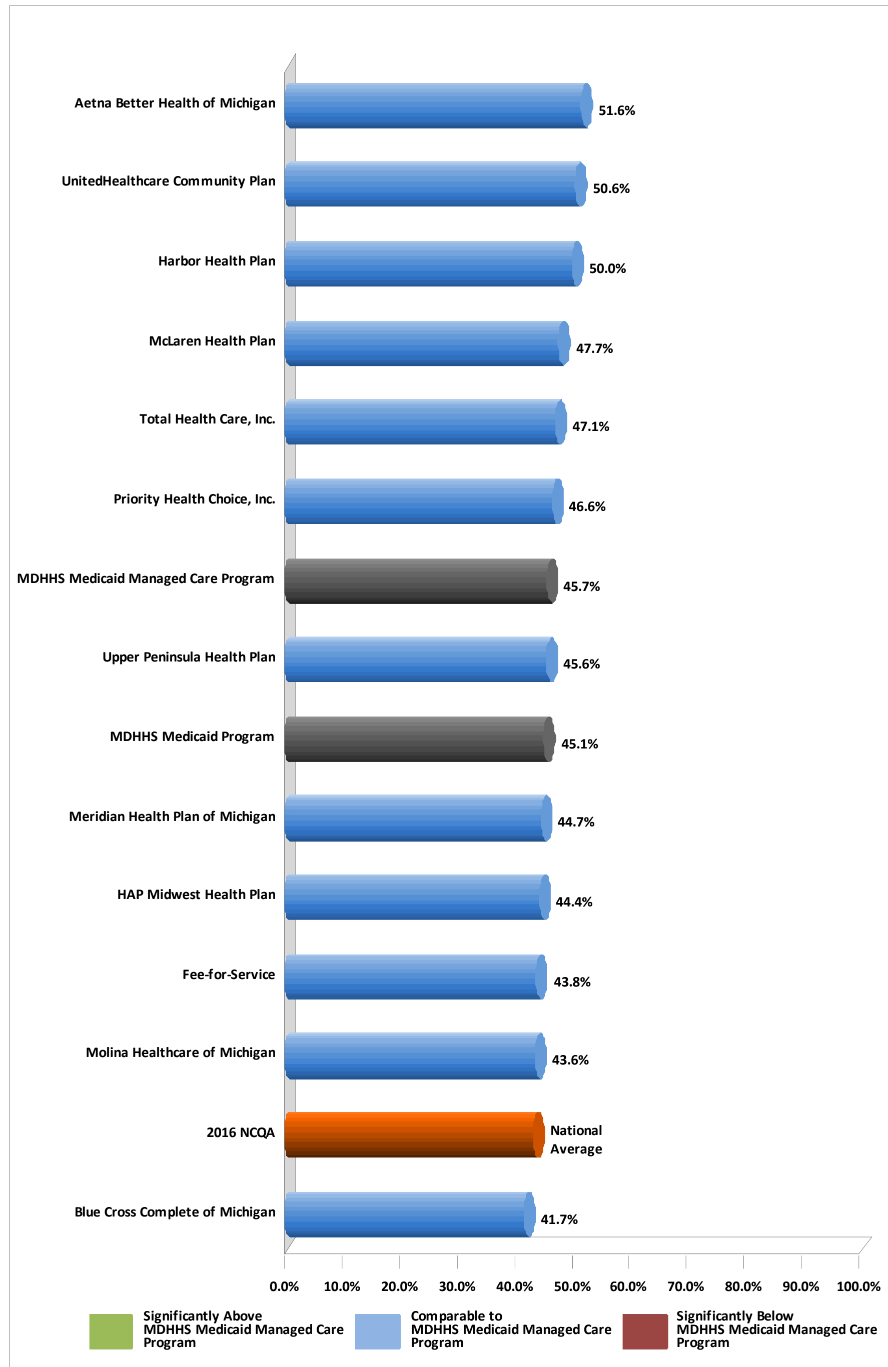
Adult members were asked how often their doctor or health provider discussed or provided methods and strategies other than medication to assist them with quitting smoking or using tobacco (Question 42 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 42**. In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.
    - Never
    - Sometimes
    - Usually
    - Always

The results of this measure represent the percentage of smokers/tobacco users who answered "Sometimes," "Usually," or "Always" to this question. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior years' results.

Figure 3-12 shows the Discussing Cessation Strategies rates.

Figure 3-12—Discussing Cessation Strategies Rates



Summary of Results

Table 3-9 provides a summary of the Statewide Comparisons results for the global ratings.

Table 3-9—Statewide Comparisons: Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Fee-for-Service	—	—	—	—
Aetna Better Health of Michigan	↓	—	—	—
Blue Cross Complete of Michigan	—	—	—	—
HAP Midwest Health Plan	—	—	—	—
Harbor Health Plan	—	—	—	—+
McLaren Health Plan	↓	—	—	—
Meridian Health Plan of Michigan	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—
Priority Health Choice, Inc.	—	—	—	—
Total Health Care, Inc.	—	—	—	—
UnitedHealthcare Community Plan	—	—	—	—
Upper Peninsula Health Plan	—	—	—	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
↑ *indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average.*
↓ *indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average.*
— *indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average.*

Table 3-10 provides a summary of the Statewide Comparisons for the composite measures.

Table 3-10—Statewide Comparisons: Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Fee-for-Service	—	—	—	—+	—
Aetna Better Health of Michigan	↓	—	—	—	—
Blue Cross Complete of Michigan	—	—	—	—	—
HAP Midwest Health Plan	—	—	↑	—	—
Harbor Health Plan	↓	—	—	—+	—+
McLaren Health Plan	↑	—	—	—	—
Meridian Health Plan of Michigan	—	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—	—
Priority Health Choice, Inc.	—	—	—	—	—
Total Health Care, Inc.	—	—	—	—	—
UnitedHealthcare Community Plan	—	—	—	—	—
Upper Peninsula Health Plan	—	—	↑	—	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
↑ *indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average.*
↓ *indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average.*
— *indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average.*

Table 3-11 provides a summary of the Statewide Comparisons for the Effectiveness of Care measures.

Table 3-11—Statewide Comparisons: Effectiveness of Care Measures

Plan Name	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies
Fee-for-Service	—	—	—
Aetna Better Health of Michigan	—	—	—
Blue Cross Complete of Michigan	—	—	—
HAP Midwest Health Plan	—	—	—
Harbor Health Plan	—	—	—
McLaren Health Plan	—	—	—
Meridian Health Plan of Michigan	—	—	—
Molina Healthcare of Michigan	—	—	—
Priority Health Choice, Inc.	—	—	—
Total Health Care, Inc.	—	—	—
UnitedHealthcare Community Plan	—	—	—
Upper Peninsula Health Plan	—	—	—

+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
↑ *indicates the plan's score is statistically significantly higher than the MDHHS Medicaid Managed Care Program average.*
↓ *indicates the plan's score is statistically significantly lower than the MDHHS Medicaid Managed Care Program average.*
— *indicates the plan's score is not statistically significantly different than the MDHHS Medicaid Managed Care Program average.*

4. Trend Analysis

Trend Analysis

The completed surveys from the 2017 and 2016 CAHPS results were used to perform the trend analysis presented in this section. The 2017 CAHPS top-box scores were compared to the 2016 CAHPS top-box scores to determine whether there were statistically significant differences. Statistically significant differences between 2017 scores and 2016 scores are noted with triangles. Scores that were statistically significantly higher in 2017 than in 2016 are noted with upward triangles (▲). Scores that were statistically significantly lower in 2017 than in 2016 are noted with downward triangles (▼). Scores in 2017 that were not statistically significantly different from scores in 2016 are noted with a dash (–). Measures that did not meet the minimum number of 100 responses required by NCQA are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

Global Ratings

Rating of Health Plan

Adult members were asked to rate their health plan on a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible." Table 4-1 shows the 2016 and 2017 top-box responses and the trend results for Rating of Health Plan.

Table 4-1—Rating of Health Plan Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS Medicaid Program	**60.7%**	**59.0%**	**—**
Fee-for-Service	58.6%	55.4%	—
MDHHS Medicaid Managed Care Program	**61.4%**	**60.4%**	**—**
Aetna Better Health of Michigan	53.0%	53.3%	—
Blue Cross Complete of Michigan	67.1%	60.0%	▼
HAP Midwest Health Plan	54.1%	63.5%	▲
Harbor Health Plan	50.0%	53.8%	—
McLaren Health Plan	59.2%	55.0%	—
Meridian Health Plan of Michigan	63.0%	61.3%	—
Molina Healthcare of Michigan	59.6%	60.8%	—
Priority Health Choice, Inc.	64.9%	63.9%	—
Total Health Care, Inc.	61.8%	61.8%	—
UnitedHealthcare Community Plan	60.5%	62.5%	—
Upper Peninsula Health Plan	61.9%	59.3%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were two statistically significant differences between scores in 2017 and scores in 2016 for this measure. HAP Midwest Health Plan scored statistically significantly *higher* in 2017 than in 2016. Conversely, Blue Cross Complete of Michigan scored statistically significantly *lower* in 2017 than in 2016.

Rating of All Health Care

Adult members were asked to rate all their health care on a scale of 0 to 10, with 0 being the "worst health care possible" and 10 being the "best health care possible." Table 4-2 shows the 2016 and 2017 top-box responses and the trend results for Rating of All Health Care.

Table 4-2—Rating of All Health Care Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS Medicaid Program	**54.2%**	**52.3%**	**—**
Fee-for-Service	55.1%	51.7%	—
MDHHS Medicaid Managed Care Program	**53.9%**	**52.6%**	**—**
Aetna Better Health of Michigan	44.8%	47.3%	—
Blue Cross Complete of Michigan	56.2%	49.8%	—
HAP Midwest Health Plan	49.7%	55.9%	—
Harbor Health Plan	48.3%	51.0%	—
McLaren Health Plan	53.0%	50.0%	—
Meridian Health Plan of Michigan	54.0%	53.2%	—
Molina Healthcare of Michigan	53.9%	55.4%	—
Priority Health Choice, Inc.	53.0%	55.4%	—
Total Health Care, Inc.	54.4%	57.7%	—
UnitedHealthcare Community Plan	54.7%	49.3%	—
Upper Peninsula Health Plan	56.3%	54.2%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were no statistically significant differences between scores in 2017 and scores in 2016 for this measure.

Rating of Personal Doctor

Adult members were asked to rate their personal doctor on a scale of 0 to 10, with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible." Table 4-3 shows the 2016 and 2017 top-box responses and the trend results for Rating of Personal Doctor.

Table 4-3—Rating of Personal Doctor Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS Medicaid Program	**64.0%**	**63.5%**	**—**
Fee-for-Service	66.4%	65.0%	—
MDHHS Medicaid Managed Care Program	**63.2%**	**62.9%**	**—**
Aetna Better Health of Michigan	60.5%	61.7%	—
Blue Cross Complete of Michigan	66.4%	59.3%	▼
HAP Midwest Health Plan	61.1%	68.2%	▲
Harbor Health Plan	59.8%	64.8%	—
McLaren Health Plan	62.4%	58.3%	—
Meridian Health Plan of Michigan	64.0%	62.8%	—
Molina Healthcare of Michigan	63.0%	65.8%	—
Priority Health Choice, Inc.	62.2%	63.1%	—
Total Health Care, Inc.	64.6%	67.2%	—
UnitedHealthcare Community Plan	61.7%	62.3%	—
Upper Peninsula Health Plan	63.3%	67.1%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were two statistically significant differences between scores in 2017 and scores in 2016 for this measure. HAP Midwest Health Plan scored statistically significantly *higher* in 2017 than in 2016. Conversely, Blue Cross Complete of Michigan scored statistically significantly *lower* in 2017 than in 2016.

Rating of Specialist Seen Most Often

Adult members were asked to rate their specialist on a scale of 0 to 10, with 0 being the "worst specialist possible" and 10 being the "best specialist possible." Table 4-4 shows the 2016 and 2017 top-box responses and the trend results for Rating of Specialist Seen Most Often.

Table 4-4—Rating of Specialist Seen Most Often Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS Medicaid Program	**64.8%**	**64.8%**	**—**
Fee-for-Service	62.2%	64.4%	—
MDHHS Medicaid Managed Care Program	**65.6%**	**64.9%**	**—**
Aetna Better Health of Michigan	57.3%	63.3%	—
Blue Cross Complete of Michigan	62.0%	60.8%	—
HAP Midwest Health Plan	65.7%	67.0%	—
Harbor Health Plan	66.7%	67.4%+	—
McLaren Health Plan	64.9%	64.0%	—
Meridian Health Plan of Michigan	68.8%	67.8%	—
Molina Healthcare of Michigan	66.7%	62.3%	—
Priority Health Choice, Inc.	68.1%	69.1%	—
Total Health Care, Inc.	63.2%	61.4%	—
UnitedHealthcare Community Plan	62.1%	66.3%	—
Upper Peninsula Health Plan	64.6%	64.7%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were no statistically significant differences between scores in 2017 and scores in 2016 for this measure.

Composite Measures

Getting Needed Care

Two questions (Questions 14 and 25 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often it was easy to get needed care. Table 4-5 shows the 2016 and 2017 top-box responses and trend results for the Getting Needed Care composite measure.

Table 4-5—Getting Needed Care Composite Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS Medicaid Program	**83.1%**	**84.1%**	**—**
Fee-for-Service	85.9%	84.3%	—
MDHHS Medicaid Managed Care Program	**82.2%**	**84.1%**	**—**
Aetna Better Health of Michigan	73.7%	77.1%	—
Blue Cross Complete of Michigan	82.0%	85.0%	—
HAP Midwest Health Plan	82.9%	86.0%	—
Harbor Health Plan	78.2%	75.9%	—
McLaren Health Plan	84.0%	88.1%	—
Meridian Health Plan of Michigan	83.4%	83.9%	—
Molina Healthcare of Michigan	80.2%	83.4%	—
Priority Health Choice, Inc.	84.8%	85.4%	—
Total Health Care, Inc.	83.2%	84.9%	—
UnitedHealthcare Community Plan	80.2%	82.9%	—
Upper Peninsula Health Plan	86.3%	83.7%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were no statistically significant differences between scores in 2017 and scores in 2016 for this measure.

Getting Care Quickly

Two questions (Questions 4 and 6 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members received care quickly. Table 4-6 shows the 2016 and 2017 top-box responses and trend results for the Getting Care Quickly composite measure.

Table 4-6—Getting Care Quickly Composite Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS Medicaid Program	**84.0%**	**83.3%**	**—**
Fee-for-Service	87.1%	84.9%	—
MDHHS Medicaid Managed Care Program	**82.9%**	**82.7%**	**—**
Aetna Better Health of Michigan	78.8%	77.8%	—
Blue Cross Complete of Michigan	82.3%	83.7%	—
HAP Midwest Health Plan	82.4%	84.6%	—
Harbor Health Plan	78.7%	77.8%	—
McLaren Health Plan	80.3%	83.7%	—
Meridian Health Plan of Michigan	83.8%	82.8%	—
Molina Healthcare of Michigan	82.5%	82.4%	—
Priority Health Choice, Inc.	83.3%	84.1%	—
Total Health Care, Inc.	85.7%	83.7%	—
UnitedHealthcare Community Plan	83.4%	81.4%	—
Upper Peninsula Health Plan	86.8%	84.8%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were no statistically significant differences between scores in 2017 and scores in 2016 for this measure.

How Well Doctors Communicate

A series of four questions (Questions 17, 18, 19, and 20 in the CAHPS Adult Medicaid Health Plan Survey) was asked to assess how often doctors communicated well. Table 4-7 shows the 2016 and 2017 top-box responses and trend results for the How Well Doctors Communicate composite measure.

Table 4-7—How Well Doctors Communicate Composite Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS Medicaid Program	**90.6%**	**90.2%**	**—**
Fee-for-Service	89.9%	91.1%	—
MDHHS Medicaid Managed Care Program	**90.9%**	**89.8%**	**—**
Aetna Better Health of Michigan	88.1%	90.0%	—
Blue Cross Complete of Michigan	91.6%	90.5%	—
HAP Midwest Health Plan	89.6%	92.9%	—
Harbor Health Plan	90.1%	87.5%	—
McLaren Health Plan	90.9%	87.9%	—
Meridian Health Plan of Michigan	92.4%	88.8%	▼
Molina Healthcare of Michigan	88.6%	90.2%	—
Priority Health Choice, Inc.	91.6%	92.6%	—
Total Health Care, Inc.	90.9%	91.9%	—
UnitedHealthcare Community Plan	89.7%	90.3%	—
Upper Peninsula Health Plan	92.4%	94.5%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There was one statistically significant difference between scores in 2017 and scores in 2016 for this measure. Meridian Health Plan of Michigan scored statistically significantly *lower* in 2017 than in 2016.

Customer Service

Two questions (Questions 31 and 32 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members were satisfied with customer service. Table 4-8 shows the 2016 and 2017 top-box responses and trend results for the Customer Service composite measure.

Table 4-8—Customer Service Composite Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS Medicaid Program	**87.2%**	**88.7%**	**—**
Fee-for-Service	82.0%+	85.5%+	—
MDHHS Medicaid Managed Care Program	**89.0%**	**89.9%**	**—**
Aetna Better Health of Michigan	84.4%	85.7%	—
Blue Cross Complete of Michigan	88.1%	90.0%	—
HAP Midwest Health Plan	88.6%	88.4%	—
Harbor Health Plan	84.5%	91.6%+	▲
McLaren Health Plan	86.9%	86.6%	—
Meridian Health Plan of Michigan	90.1%	90.5%	—
Molina Healthcare of Michigan	89.4%	89.6%	—
Priority Health Choice, Inc.	91.5%	92.1%	—
Total Health Care, Inc.	86.8%	90.9%	—
UnitedHealthcare Community Plan	89.6%	91.6%	—
Upper Peninsula Health Plan	89.0%	89.7%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There was one statistically significant difference between scores in 2017 and scores in 2016 for this measure. Harbor Health Plan scored statistically significantly *higher* in 2017 than in 2016.

Shared Decision Making

Three questions (Questions 10, 11, and 12 in the CAHPS Adult Medicaid Health Plan Survey) were asked regarding the involvement of adult members in decision making when starting or stopping a prescription medicine. Table 4-9 shows the 2016 and 2017 top-box responses and trend results for the Shared Decision composite measure.

Table 4-9—Shared Decision Making Composite Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS Medicaid Program	**79.8%**	**79.6%**	**—**
Fee-for-Service	77.7%	78.5%	—
MDHHS Medicaid Managed Care Program	**80.5%**	**80.0%**	**—**
Aetna Better Health of Michigan	74.7%	78.2%	—
Blue Cross Complete of Michigan	81.3%	80.0%	—
HAP Midwest Health Plan	80.3%	76.9%	—
Harbor Health Plan	73.4%	78.5%+	—
McLaren Health Plan	83.2%	80.2%	—
Meridian Health Plan of Michigan	81.9%	79.5%	—
Molina Healthcare of Michigan	78.0%	78.9%	—
Priority Health Choice, Inc.	81.2%	84.2%	—
Total Health Care, Inc.	76.8%	80.7%	—
UnitedHealthcare Community Plan	79.1%	81.2%	—
Upper Peninsula Health Plan	84.4%	84.4%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were no statistically significant differences between scores in 2017 and scores in 2016 for this measure.

Effectiveness of Care Measures

Medical Assistance with Smoking and Tobacco Use Cessation

Advising Smokers and Tobacco Users to Quit

One question (Question 40 in the CAHPS Adult Medicaid Health Plan Survey) was asked to determine how often adult members were advised to quit smoking or using tobacco by a doctor or other health provider. Table 4-10 shows the 2016 and 2017 rates and trend results for the Advising Smokers and Tobacco Users to Quit measure.

Table 4-10—Advising Smokers and Tobacco Users to Quit Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS Medicaid Program	**81.0%**	**80.4%**	**—**
Fee-for-Service	84.5%	81.0%	—
MDHHS Medicaid Managed Care Program	**79.7%**	**80.1%**	**—**
Aetna Better Health of Michigan	79.9%	80.6%	—
Blue Cross Complete of Michigan	77.3%	75.3%	—
HAP Midwest Health Plan	81.7%	82.1%	—
Harbor Health Plan	78.4%	79.1%	—
McLaren Health Plan	77.6%	76.8%	—
Meridian Health Plan of Michigan	80.2%	81.2%	—
Molina Healthcare of Michigan	83.5%	80.9%	—
Priority Health Choice, Inc.	79.1%	81.5%	—
Total Health Care, Inc.	78.2%	80.0%	—
UnitedHealthcare Community Plan	78.9%	82.2%	—
Upper Peninsula Health Plan	79.4%	79.2%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were no statistically significant differences between scores in 2017 and scores in 2016 for this measure.

Discussing Cessation Medications

One question (Question 41 in the CAHPS Adult Medicaid Health Plan Survey) was asked to ascertain how often medication was recommended or discussed by a doctor or health provider to assist adult members with quitting smoking or using tobacco. Table 4-11 shows the 2016 and 2017 rates and trend results for the Discussing Cessation Medications measure.

Table 4-11—Discussing Cessation Medications Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS Medicaid Program	**55.1%**	**55.5%**	**—**
Fee-for-Service	55.1%	54.5%	—
MDHHS Medicaid Managed Care Program	**55.1%**	**55.9%**	**—**
Aetna Better Health of Michigan	55.7%	58.1%	—
Blue Cross Complete of Michigan	52.9%	50.1%	—
HAP Midwest Health Plan	52.6%	58.3%	—
Harbor Health Plan	54.5%	59.0%	—
McLaren Health Plan	50.5%	54.9%	—
Meridian Health Plan of Michigan	55.7%	54.3%	—
Molina Healthcare of Michigan	56.3%	57.6%	—
Priority Health Choice, Inc.	51.7%	56.0%	—
Total Health Care, Inc.	50.7%	55.2%	—
UnitedHealthcare Community Plan	59.4%	60.8%	—
Upper Peninsula Health Plan	56.0%	56.9%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were no statistically significant differences between scores in 2017 and scores in 2016 for this measure.

Discussing Cessation Strategies

One question (Question 42 in the CAHPS Adult Medicaid Health Plan Survey) was asked to ascertain how often methods or strategies other than medication were discussed or provided by a doctor or health provider to assist adult members with quitting smoking or using tobacco. Table 4-12 shows the 2016 and 2017 rates and trend results for the Discussing Cessation Strategies measure.

Table 4-12—Discussing Cessation Strategies Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS Medicaid Program	**44.5%**	**45.1%**	**—**
Fee-for-Service	42.3%	43.8%	—
MDHHS Medicaid Managed Care Program	**45.2%**	**45.7%**	**—**
Aetna Better Health of Michigan	46.2%	51.6%	—
Blue Cross Complete of Michigan	46.7%	41.7%	—
HAP Midwest Health Plan	44.2%	44.4%	—
Harbor Health Plan	45.3%	50.0%	—
McLaren Health Plan	42.2%	47.7%	—
Meridian Health Plan of Michigan	44.9%	44.7%	—
Molina Healthcare of Michigan	45.9%	43.6%	—
Priority Health Choice, Inc.	43.6%	46.6%	—
Total Health Care, Inc.	42.3%	47.1%	—
UnitedHealthcare Community Plan	48.0%	50.6%	—
Upper Peninsula Health Plan	45.4%	45.6%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were no statistically significant differences between scores in 2017 and scores in 2016 for this measure.

Key Drivers of Satisfaction

HSAG performed an analysis of key drivers for three measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. The analysis provides information on (1) how well the MDHHS Medicaid Program is performing on the survey item (i.e., question), and (2) how important the item is to overall satisfaction.

Key drivers of satisfaction are defined as those items that (1) have a problem score that is greater than or equal to the program's median problem score for all items examined, and (2) have a correlation that is greater than or equal to the program's median correlation for all items examined. For additional information on the assignment of problem scores, please refer to the Reader's Guide section. Table 5-1 depicts those items identified for each of the three measures as being key drivers of satisfaction for the MDHHS Medicaid Program.

Table 5-1—MDHHS Medicaid Program Key Drivers of Satisfaction

Rating of Health Plan
Respondents reported that their health plan's customer service did not always give them the information or help they needed.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Respondents reported that information in written materials or on the Internet about how the health plan works did not always provide the information they needed.
Respondents reported that forms from their health plan were often not easy to fill out.
Respondents reported that it was often not easy to obtain appointments with specialists.
Rating of All Health Care
Respondents reported that when they talked about starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for them.
Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Rating of Personal Doctor
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.

The results from the key drivers of satisfaction analysis identified the following item as a key driver for all three global ratings: Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers. When compared with the 2016 key drivers of satisfaction results, two items were not identified as key drivers in this year's results. The following item was no longer identified as a key driver for the Rating of All Health Care global rating: Respondents reported that it was often not easy to obtain appointments with specialists. Additionally, the following item was not identified as a key driver for the Rating of Personal Doctor global rating: Respondents reported that it was not always easy to get the care, tests, or treatment they thought they needed through their health plan. These changes in the results of the key drivers of satisfaction analysis indicate possible improvements in the Getting Needed Care composite measure.

6. Survey Instrument

Survey Instrument

The survey instrument selected was the CAHPS 5.0H Adult Medicaid Survey with the HEDIS supplemental item set. This section provides a copy of the survey instrument.

CAHPS® 5.0H Adult Questionnaire (Medicaid)

SURVEY INSTRUCTIONS

- Answer each question by marking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☑ Yes ➔**If Yes, Go to Question 1**

☐ No

{This box should be placed on the Cover Page}

Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call {SURVEY VENDOR TOLL-FREE TELEPHONE NUMBER}.

1. **Our records show that you are now in {INSERT HEALTH PLAN NAME/ STATE MEDICAID PROGRAM NAME}. Is that right?**
   - 1☐ Yes ➔**If Yes, Go to Question 3**
   - 2☐ No

2. **What is the name of your health plan? (Please print)**

   ____

YOUR HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your own health care. Do <u>not</u> include care you got when you stayed overnight in a hospital. Do <u>not</u> include the times you went for dental care visits.

3. **In the last 6 months, did you have an illness, injury, or condition that <u>needed care right away</u> in a clinic, emergency room, or doctor's office?**
   - 1☐ Yes
   - 2☐ No ➔**If No, Go to Question 5**

4. **In the last 6 months, when you <u>needed care right away</u>, how often did you get care as soon as you needed?**
   - 1☐ Never
   - 2☐ Sometimes
   - 3☐ Usually
   - 4☐ Always

5. **In the last 6 months, did you make any appointments for a <u>check-up or routine care</u> at a doctor's office or clinic?**
   - 1☐ Yes
   - 2☐ No ➔**If No, Go to Question 7**

6. **In the last 6 months, how often did you get an appointment for a <u>check-up or routine care</u> at a doctor's office or clinic as soon as you needed?**
   - 1☐ Never
   - 2☐ Sometimes
   - 3☐ Usually
   - 4☐ Always

7. In the last 6 months, not counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?

0☐ None ➔**If None, Go to Question 15**

1☐ 1 time

2☐ 2

3☐ 3

4☐ 4

5☐ 5 to 9

6☐ 10 or more times

8. In the last 6 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?

1☐ Yes

2☐ No

9. In the last 6 months, did you and a doctor or other health provider talk about starting or stopping a prescription medicine?

1☐ Yes

2☐ No ➔**If No, Go to Question 13**

10. Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?

1☐ Yes

2☐ No

11. Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?

1☐ Yes

2☐ No

12. When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?

1☐ Yes

2☐ No

13. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

00☐ 0 Worst health care possible

01☐ 1

02☐ 2

03☐ 3

04☐ 4

05☐ 5

06☐ 6

07☐ 7

08☐ 8

09☐ 9

10☐ 10 Best health care possible

14. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

YOUR PERSONAL DOCTOR

15. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

1 ☐ Yes
2 ☐ No ➔**If No, Go to Question 24**

16. In the last 6 months, how many times did you visit your personal doctor to get care for yourself?

0 ☐ None ➔**If None, Go to Question 23**
1 ☐ 1 time
2 ☐ 2
3 ☐ 3
4 ☐ 4
5 ☐ 5 to 9
6 ☐ 10 or more times

17. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

18. In the last 6 months, how often did your personal doctor listen carefully to you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

19. In the last 6 months, how often did your personal doctor show respect for what you had to say?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

20. In the last 6 months, how often did your personal doctor spend enough time with you?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

21. In the last 6 months, did you get care from a doctor or other health provider besides your personal doctor?

1☐ Yes
2☐ No ➔**If No, Go to Question 23**

22. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

23. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

00☐ 0 Worst personal doctor possible
01☐ 1
02☐ 2
03☐ 3
04☐ 4
05☐ 5
06☐ 6
07☐ 7
08☐ 8
09☐ 9
10☐ 10 Best personal doctor possible

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, do not include dental visits or care you got when you stayed overnight in a hospital.

24. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments to see a specialist?

1☐ Yes
2☐ No ➔**If No, Go to Question 28**

25. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

26. How many specialists have you seen in the last 6 months?

0☐ None ➔**If None, Go to Question 28**
1☐ 1 specialist
2☐ 2
3☐ 3
4☐ 4
5☐ 5 or more specialists

27. We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

00☐ 0 Worst specialist possible
01☐ 1
02☐ 2
03☐ 3
04☐ 4
05☐ 5
06☐ 6
07☐ 7
08☐ 8
09☐ 9
10☐ 10 Best specialist possible

YOUR HEALTH PLAN

The next questions ask about your experience with your health plan.

28. In the last 6 months, did you look for any information in written materials or on the Internet about how your health plan works?

1☐ Yes
2☐ No ➔**If No, Go to Question 30**

29. In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

30. In the last 6 months, did you get information or help from your health plan's customer service?

1☐ Yes
2☐ No ➔**If No, Go to Question 33**

31. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

32. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

33. In the last 6 months, did your health plan give you any forms to fill out?

1☐ Yes
2☐ No ➔**If No, Go to Question 35**

34. In the last 6 months, how often were the forms from your health plan easy to fill out?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

35. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

- 00 ☐ 0 Worst health plan possible
- 01 ☐ 1
- 02 ☐ 2
- 03 ☐ 3
- 04 ☐ 4
- 05 ☐ 5
- 06 ☐ 6
- 07 ☐ 7
- 08 ☐ 8
- 09 ☐ 9
- 10 ☐ 10 Best health plan possible

ABOUT YOU

36. In general, how would you rate your overall health?

- 1 ☐ Excellent
- 2 ☐ Very Good
- 3 ☐ Good
- 4 ☐ Fair
- 5 ☐ Poor

37. In general, how would you rate your overall <u>mental or emotional</u> health?

- 1 ☐ Excellent
- 2 ☐ Very Good
- 3 ☐ Good
- 4 ☐ Fair
- 5 ☐ Poor

38. Have you had either a flu shot or flu spray in the nose since July 1, 2016?

- 1 ☐ Yes
- 2 ☐ No
- 3 ☐ Don't know

39. Do you now smoke cigarettes or use tobacco every day, some days, or not at all?

- 1 ☐ Every day
- 2 ☐ Some days
- 3 ☐ Not at all → **If Not at all, Go to Question 43**
- 4 ☐ Don't know → **If Don't know, Go to Question 43**

40. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

41. In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

42. In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

43. Do you take aspirin daily or every other day?

1☐ Yes
2☐ No
3☐ Don't know

44. Do you have a health problem or take medication that makes taking aspirin unsafe for you?

1☐ Yes
2☐ No
3☐ Don't know

45. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?

1☐ Yes
2☐ No

46. Are you aware that you have any of the following conditions? Mark one or more.

a☐ High cholesterol
b☐ High blood pressure
c☐ Parent or sibling with heart attack before the age of 60

47. Has a doctor ever told you that you have any of the following conditions? Mark one or more.

a☐ A heart attack
b☐ Angina or coronary heart disease
c☐ A stroke
d☐ Any kind of diabetes or high blood sugar

48. In the last 6 months, did you get health care 3 or more times for the same condition or problem?

1☐ Yes
2☐ No → **If No, Go to Question 50**

49. Is this a condition or problem that has lasted for at least 3 months? Do not include pregnancy or menopause.

1 ☐ Yes

2 ☐ No

50. Do you now need or take medicine prescribed by a doctor? Do not include birth control.

1 ☐ Yes

2 ☐ No ➔ **If No, Go to Question 52**

51. Is this medicine to treat a condition that has lasted for at least 3 months? Do not include pregnancy or menopause.

1 ☐ Yes

2 ☐ No

52. What is your age?

1 ☐ 18 to 24

2 ☐ 25 to 34

3 ☐ 35 to 44

4 ☐ 45 to 54

5 ☐ 55 to 64

6 ☐ 65 to 74

7 ☐ 75 or older

53. Are you male or female?

1 ☐ Male

2 ☐ Female

54. What is the highest grade or level of school that you have completed?

1 ☐ 8th grade or less

2 ☐ Some high school, but did not graduate

3 ☐ High school graduate or GED

4 ☐ Some college or 2-year degree

5 ☐ 4-year college graduate

6 ☐ More than 4-year college degree

55. Are you of Hispanic or Latino origin or descent?

1 ☐ Yes, Hispanic or Latino

2 ☐ No, Not Hispanic or Latino

56. What is your race? Mark one or more.

a ☐ White

b ☐ Black or African-American

c ☐ Asian

d ☐ Native Hawaiian or other Pacific Islander

e ☐ American Indian or Alaska Native

f ☐ Other

57. Did someone help you complete this survey?

[1] ☐ Yes ➔ **If Yes, Go to Question 58**

[2] ☐ No ➔ **Thank you. Please return the completed survey in the postage-paid envelope.**

58. How did that person help you? Mark one or more.

[a] ☐ Read the questions to me

[b] ☐ Wrote down the answers I gave

[c] ☐ Answered the questions for me

[d] ☐ Translated the questions into my language

[e] ☐ Helped in some other way

THANK YOU

Please return the completed survey in the postage-paid envelope.

2017 Michigan Department of Health and Human Services

Healthy Michigan Plan CAHPS® Report

October 2017

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Key Drivers of Satisfaction 5-1

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Introduction

The Michigan Department of Health and Human Services (MDHHS) assesses the perceptions and experiences of members enrolled in the MDHHS Healthy Michigan Plan (HMP) health plans as part of its process for evaluating the quality of health care services provided to eligible adult members in the HMP Program. MDHHS contracted with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey for the HMP Program.[1-1] The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and that will aid in improving overall member satisfaction.

This report presents the 2017 CAHPS results of adult members enrolled in an HMP health plan. The survey instrument selected was the CAHPS 5.0 Adult Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set.[1-2] The surveys were completed by adult members from May to July 2017.

Report Overview

A sample of 1,350 adult members was selected from each HMP health plan. There were less than 1,350 adult members eligible for inclusion in the survey for HAP Midwest Health Plan; therefore, each member from HAP Midwest Health Plan's eligible population was included in the sample. Results presented in this report include four global ratings: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often. Five composite measures are reported: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making. Overall rates for three Effectiveness of Care measures related to Medical Assistance with Smoking and Tobacco Use Cessation are reported: Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications, and Discussing Cessation Strategies. HSAG presents HMP health plan results and aggregate statewide results (i.e., the MDHHS HMP Program) and compares them to national Medicaid data.

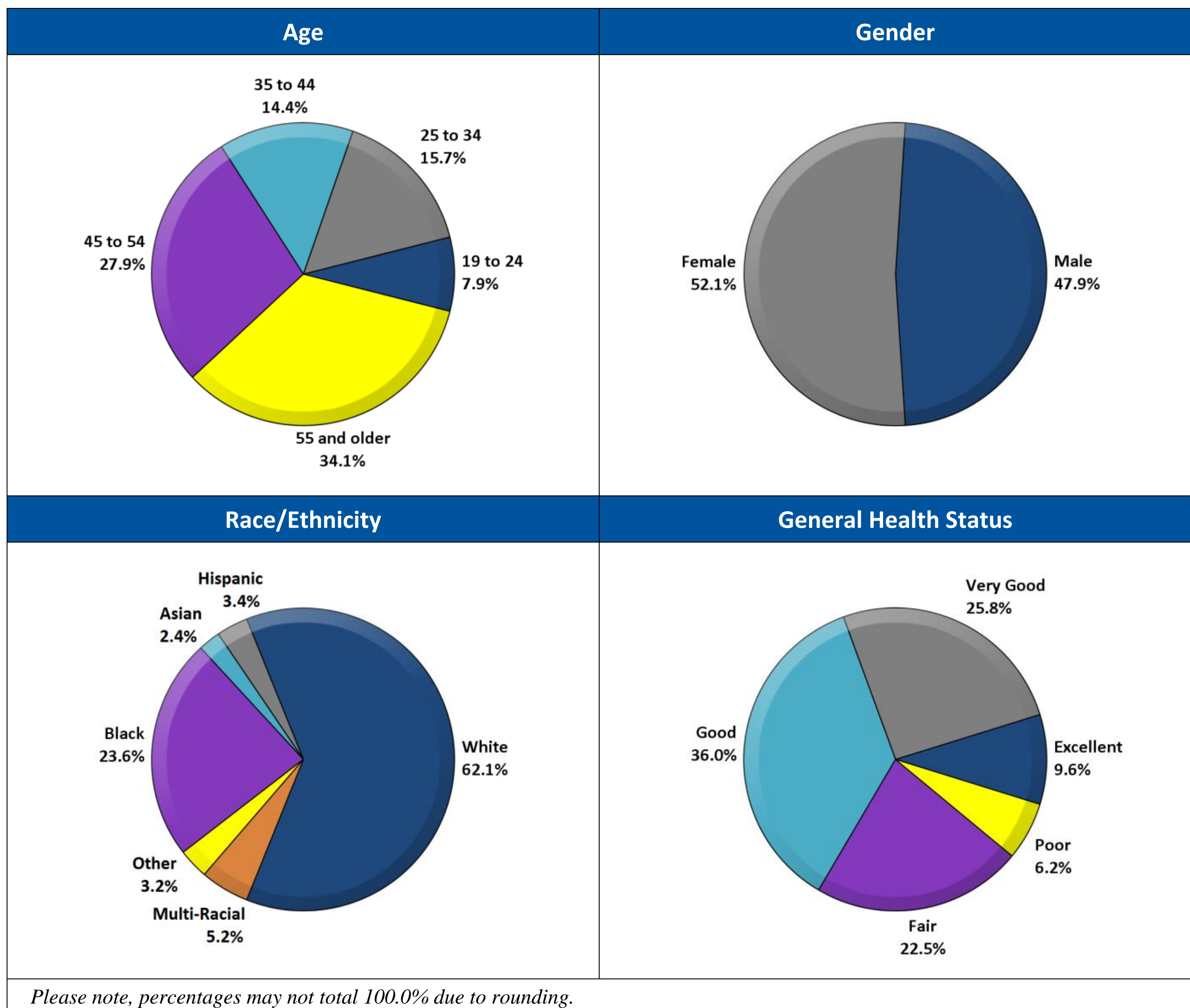
[1-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Key Findings

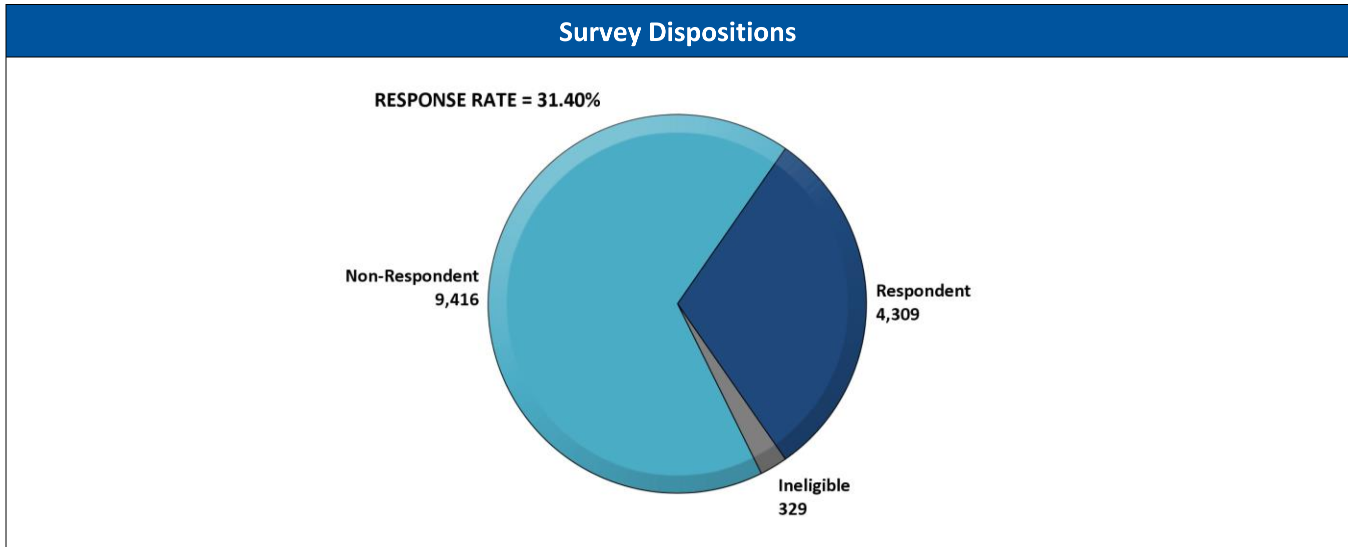
Survey Demographics and Dispositions

Table 1-1 provides an overview of the adult member demographics and survey dispositions for the MDHHS HMP Program.

Table 1-1—Survey Demographics and Dispositions



Please note, percentages may not total 100.0% due to rounding.



National Comparisons and Trend Analysis

A three-point mean score was determined for the four CAHPS global ratings and four of the CAHPS composite measures. The resulting three-point means scores were compared to the National Committee for Quality Assurance's (NCQA's) 2017 HEDIS Benchmarks and Thresholds for Accreditation to derive the overall member satisfaction ratings (i.e., star ratings) for each CAHPS measure.[1-3,1-4] In addition, a trend analysis was performed that compared the 2017 CAHPS results to their corresponding 2016 CAHPS results. Table 1-2 provides highlights of the National Comparisons and Trend Analysis findings for the MDHHS HMP Program. The numbers presented below represent the three-point mean score for each measure, while the stars represent overall member satisfaction ratings when the three-point means were compared to NCQA HEDIS Benchmarks and Thresholds for Accreditation.[1-5]

[1-3] National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA; May 4, 2017.

[1-4] NCQA does not publish national benchmarks and thresholds for the Shared Decision Making composite measure; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

[1-5] Given the potential differences in demographic make-up of the HMP population and services received from the HMP health plans compared to the adult Medicaid population, caution should be exercised when interpreting the comparisons to Adult Medicaid NCQA HEDIS Benchmarks and Thresholds for Accreditation.

Table 1-2—National Comparisons and Trend Analysis MDHHS HMP Program

Measure	National Comparisons	Trend Analysis
Global Rating		
Rating of Health Plan	★★★ 2.45	—
Rating of All Health Care	★★ 2.34	—
Rating of Personal Doctor	★★ 2.47	—
Rating of Specialist Seen Most Often	★★ 2.49	—
Composite Measure		
Getting Needed Care	★★ 2.34	▼
Getting Care Quickly	★★★ 2.40	—
How Well Doctors Communicate	★★★★★ 2.65	—
Customer Service	★★ 2.53	—

Star Assignments Based on Percentiles
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *indicates the 2017 score is not statistically significantly different than the 2016 score.*

The National Comparisons results indicated that the How Well Doctors Communicate composite measure scored at or above the 90th percentile. The Rating of Health Plan global rating and Getting Care Quickly composite measure scored at or between the 50th and 74th percentiles. The Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often global ratings, and the Getting Needed Care and Customer Service composite measures scored at or between the 25th and 49th percentiles.

Results from the trend analysis showed that the MDHHS HMP Program scored statistically significantly *lower* in 2017 than in 2016 on one measure, Getting Needed Care.

Statewide Comparisons

HSAG calculated top-box rates (i.e., rates of satisfaction) for each global rating and composite measure and overall rates for the Effectiveness of Care measures. HSAG compared the HMP health plan results to the MDHHS HMP Program average to determine if plan results were statistically significantly different from the MDHHS HMP Program average. Table 1-3 through 1-5 show the results of this analysis for the global ratings, composite measures, and Effectiveness of Care measures, respectively.

Table 1-3—Statewide Comparisons: Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Aetna Better Health of Michigan	↓	—	—	—
Blue Cross Complete of Michigan	—	—	—	—
HAP Midwest Health Plan	↓+	—+	—+	—+
Harbor Health Plan	—	↓	—	—
McLaren Health Plan	↑	↑	—	—
Meridian Health Plan of Michigan	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—
Priority Health Choice, Inc.	↑	↑	—	—
Total Health Care, Inc.	—	—	—	—
UnitedHealthcare Community Plan	—	—	—	—
Upper Peninsula Health Plan	↑	—	—	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
↑ *indicates the plan's score is statistically significantly higher than the MDHHS HMP Program average.*
↓ *indicates the plan's score is statistically significantly lower than the MDHHS HMP Program average.*
— *indicates the plan's score is not statistically significantly different than the MDHHS HMP Program average.*

Table 1-4—Statewide Comparisons: Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Aetna Better Health of Michigan	—	—	—	—+	—+
Blue Cross Complete of Michigan	—	—	—	—	—
HAP Midwest Health Plan	—+	—+	—+	—+	—+
Harbor Health Plan	—	—	—	—	—+
McLaren Health Plan	—	—	—	—	—
Meridian Health Plan of Michigan	—	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—	—
Priority Health Choice, Inc.	—	—	—	—	—
Total Health Care, Inc.	—	—	—	—	—
UnitedHealthcare Community Plan	—	—	—	—+	—
Upper Peninsula Health Plan	—	—	—	—	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
↑ *indicates the plan's score is statistically significantly higher than the MDHHS HMP Program average.*
↓ *indicates the plan's score is statistically significantly lower than the MDHHS HMP Program average.*
— *indicates the plan's score is not statistically significantly different than the MDHHS HMP Program average.*

Table 1-5—Statewide Comparisons: Effectiveness of Care Measures

Plan Name	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies
Aetna Better Health of Michigan	—	—	—
Blue Cross Complete of Michigan	—	—	—
HAP Midwest Health Plan	↓+	↓+	—+
Harbor Health Plan	—	—	—
McLaren Health Plan	—	—	—
Meridian Health Plan of Michigan	—	↑	—
Molina Healthcare of Michigan	—	—	—
Priority Health Choice, Inc.	↑	—	—
Total Health Care, Inc.	—	—	—
UnitedHealthcare Community Plan	—	—	—
Upper Peninsula Health Plan	—	—	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
↑ *indicates the plan's score is statistically significantly higher than the MDHHS HMP Program average.*
↓ *indicates the plan's score is statistically significantly lower than the MDHHS HMP Program average.*
— *indicates the plan's score is not statistically significantly different than the MDHHS HMP Program average.*

The following plans scored statistically significantly *higher* than the MDHHS HMP Program average on at least one measure:

McLaren Health Plan

- Rating of Health Plan
- Rating of All Health Care

Meridian Health Plan of Michigan

- Discussing Cessation Medications

Priority Health Choice, Inc.

- Rating of Health Plan
- Rating of All Health Care
- Advising Smokers and Tobacco Users to Quit

Upper Peninsula Health Plan

- Rating of Health Plan

Conversely, the following plans scored statistically significantly *lower* than the MDHHS HMP Program average on at least one measure:

Aetna Better Health of Michigan

- Rating of Health Plan

HAP Midwest Health Plan

- Rating of Health Plan
- Advising Smokers and Tobacco Users to Quit
- Discussing Cessation Medications

Harbor Health Plan

- Rating of All Health Care

Key Drivers of Satisfaction

HSAG focused the key drivers of satisfaction analysis on the following three global ratings: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. HSAG evaluated these global ratings to determine if particular CAHPS items (i.e., questions) are strongly correlated with one or more of these measures. These individual CAHPS items, which HSAG refers to as "key drivers" are driving levels of satisfaction with each of the three measures. Table 1-6 provides a summary of the key drivers identified for the MDHHS HMP Program.

Table 1-6—MDHHS HMP Program Key Drivers of Satisfaction

Rating of Health Plan
Respondents reported that their health plan's customer service did not always give them the information or help they needed.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Respondents reported that information in written materials or on the Internet about how the health plan works did not always provide the information they needed.
Respondents reported that forms from their health plan were often not easy to fill out.
Respondents reported that it was often not easy to obtain appointments with specialists.
Rating of All Health Care
Respondents reported that when they talked about starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for them.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Respondents reported that information in written materials or on the Internet about how the health plan works did not always provide the information they needed.
Respondents reported that it was often not easy to obtain appointments with specialists.
Rating of Personal Doctor
Respondents reported that it was not always easy to get the care, tests, or treatment they thought they needed through their health plan.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.

2. Reader's Guide

2017 CAHPS Performance Measures

The CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set includes 58 core questions that yield 12 measures. These measures include four global rating questions, five composite measures, and three Effectiveness of Care measures. The global measures (also referred to as global ratings) reflect overall satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., "Getting Needed Care" or "Getting Care Quickly"). The Effectiveness of Care measures assess the various aspects of providing medical assistance with smoking and tobacco use cessation.

Table 2-1 lists the measures included in the CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set.

Table 2-1—CAHPS Measures

Global Ratings	Composite Measures	Effectiveness of Care Measures
Rating of Health Plan	Getting Needed Care	Advising Smokers and Tobacco Users to Quit
Rating of All Health Care	Getting Care Quickly	Discussing Cessation Medications
Rating of Personal Doctor	How Well Doctors Communicate	Discussing Cessation Strategies
Rating of Specialist Seen Most Often	Customer Service	
	Shared Decision Making	

HSAG HEALTH SERVICES ADVISORY GROUP

How CAHPS Results Were Collected

Sampling Procedures

MDHHS provided HSAG with a list of all eligible adult members in the HMP Program for the sampling frame. HSAG inspected a sample of the file records to check for any apparent problems with the files, such as missing address elements. HSAG sampled adult members who met the following criteria:

- Were 19 years of age or older as of February 28, 2017.
- Were currently enrolled in an HMP health plan.
- Had been continuously enrolled in the plan for the last six months of the measurement year (September 1, 2016 through February 28, 2017).

Next, a sample of members was selected for inclusion in the survey. For each HMP health plan, no more than one member per household was selected as part of the survey samples. A sample of 1,350 adult members was selected from each HMP health plan. HAP Midwest Health Plan had less than 1,350 adult members who were eligible for inclusion in the survey; therefore, each member from HAP Midwest Health Plan's eligible population was included in the sample. Table 3-1 in the Results section provides an overview of the sample sizes for each plan. HSAG tried to obtain new addresses for members selected for the sample by processing sampled members' addresses through the United States Postal Service's National Change of Address (NCOA) system.

Survey Protocol

The survey administration protocol employed was a mixed-mode methodology, which allowed for two methods by which members could complete a survey. The first, or mail phase, consisted of sampled members receiving a survey via mail. All sampled members received an English version of the survey, with the option of completing the survey in Spanish. Non-respondents received a reminder postcard, followed by a second survey mailing and postcard reminder.

The second phase, or telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI) of members who did not mail in a completed survey. At least three CATI calls to each non-respondent were attempted. It has been shown that the addition of the telephone phase aids in the reduction of non-response bias by increasing the number of respondents who are more demographically representative of a plan's population.[2-1]

[2-1] Fowler FJ Jr., Gallagher PM, Stringfellow VL, et al. "Using Telephone Interviews to Reduce Nonresponse Bias to Mail Surveys of Health Plan Members." *Medical Care*. 2002; 40(3): 190-200.

Table 2-2 shows the standard mixed-mode (i.e., mail followed by telephone follow-up) CAHPS timeline used in the administration of the HMP CAHPS survey.

Table 2-2—CAHPS 5.0 Mixed-Mode Methodology Survey Timeline

Task	Timeline
Send first questionnaire with cover letter to the adult member.	0 days
Send a postcard reminder to non-respondents 4-10 days after mailing the first questionnaire.	4-10 days
Send a second questionnaire (and letter) to non-respondents approximately 35 days after mailing the first questionnaire.	35 days
Send a second postcard reminder to non-respondents 4-10 days after mailing the second questionnaire.	39-45 days
Initiate CATI interviews for non-respondents approximately 21 days after mailing the second questionnaire.	56 days
Initiate systematic contact for all non-respondents such that at least three telephone calls are attempted at different times of the day, on different days of the week, and in different weeks.	56 – 70 days
Telephone follow-up sequence completed (i.e., completed interviews obtained or maximum calls reached for all non-respondents) approximately 14 days after initiation.	70 days

How CAHPS Results Were Calculated and Displayed

HSAG used the CAHPS scoring approach recommended by NCQA in Volume 3 of HEDIS Specifications for Survey Measures. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, HSAG performed a number of analyses to comprehensively assess member satisfaction. In addition to individual plan results, HSAG calculated an MDHHS HMP Program average. HSAG combined results from the HMP health plans to form the HMP Program average. This section provides an overview of each analysis.

Who Responded to the Survey

The response rate was defined as the total number of completed surveys divided by all eligible members of the sample. HSAG considered a survey completed if members answered at least three of the following five questions: 3, 20, 29, 33, and 41. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (did not meet the eligibility criteria), were mentally or physically incapacitated, or had a language barrier.

$$\text{Response Rate} = \frac{\text{Number of Completed Surveys}}{\text{Sample - Ineligibles}}$$

Demographics of Adult Members

The demographics analysis evaluated the following demographic information of adult members' responses to the CAHPS 5.0 Adult Medicaid Health Plan Survey: age, gender, race/ethnicity, and general health status. HSAG calculated HMP health plan-level and MDHHS HMP Program-level rates for each demographic category and stratified the results based on the following groups:

- Member Age: 19-24, 25-34, 35-44, 45-54, and 55 and older
- Member Gender: Male and Female
- Member Race/Ethnicity: Multi-Racial, Hispanic, White, Black or African American, Asian, and Other
- Member General Health Status: Excellent, Very Good, Good, Fair, and Poor

MDHHS should exercise caution when extrapolating the CAHPS results to the entire population if the respondent population differs significantly from the actual population of the plan.

National Comparisons

HSAG conducted an analysis of the CAHPS survey results using NCQA HEDIS Specifications for Survey Measures. Although NCQA requires a minimum of 100 responses on each item in order to report the item as a reportable CAHPS Survey result, HSAG presented results with fewer than 100 responses, which are denoted with a cross (+). Caution should be exercised when evaluating measures' results with fewer than 100 responses.

Table 2-3 shows the percentiles that were used to determine star ratings for each CAHPS measure.

Table 2-3—Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

In order to perform the National Comparisons, a three-point mean score was determined for each CAHPS measure.[2-2] HSAG compared the resulting three-point mean scores to published NCQA HEDIS Benchmarks and Thresholds for Accreditation to derive the overall member satisfaction ratings for each CAHPS measure.

Table 2-4, on the following page, shows the NCQA HEDIS Benchmarks and Thresholds for Accreditation used to derive the overall member satisfaction ratings on each CAHPS measure.[2-3] NCQA does not publish national benchmarks and thresholds for Shared Decision Making; therefore, this CAHPS measure was excluded from the National Comparisons analysis. In addition, there are no national benchmarks available for this population; therefore, national adult Medicaid data were used for comparative purposes.[2-4]

[2-2] For detailed information on the derivation of three-point mean scores, please refer to *HEDIS® 2017, Volume 3: Specifications for Survey Measures.*

[2-3] National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA; May 4, 2017.

[2-4] Given the potential differences in demographic make-up of the HMP population and services received from the HMP health plans compared to the adult Medicaid population, caution should be exercised when interpreting the comparisons to Adult Medicaid NCQA HEDIS Benchmarks and Thresholds for Accreditation.

Table 2-4—Overall Member Satisfaction Ratings Crosswalk

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.53	2.48	2.43	2.35
Rating of All Health Care	2.46	2.43	2.38	2.32
Rating of Personal Doctor	2.57	2.53	2.50	2.43
Rating of Specialist Seen Most Often	2.59	2.56	2.51	2.48
Getting Needed Care	2.45	2.41	2.35	2.28
Getting Care Quickly	2.49	2.45	2.40	2.33
How Well Doctors Communicate	2.64	2.58	2.54	2.48
Customer Service	2.61	2.58	2.54	2.48

Global Ratings and Composite Measures

Statewide Comparisons

For purposes of the Statewide Comparisons analysis, HSAG calculated question summary rates for each global rating and global proportions for each composite measure, following NCQA HEDIS Specifications for Survey Measures.[2-5] The scoring of the global ratings and composite measures involved assigning top-box responses a score of one, with all other responses receiving a score of zero. A "top-box" response was defined as follows:

- "9" or "10" for the global ratings.
- "Usually" or "Always" for the Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composites.
- "Yes" for the Shared Decision Making composite.

Medical Assistance with Smoking and Tobacco Use Cessation

HSAG calculated three rates that assess different facets of providing medical assistance with smoking and tobacco use cessation:

- Advising Smokers and Tobacco Users to Quit
- Discussing Cessation Medications
- Discussing Cessation Strategies

These rates assess the percentage of smokers or tobacco users who were advised to quit, were recommended cessation medications, and were provided cessation methods or strategies, respectively.

[2-5] National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2016.

Responses of "Sometimes," "Usually," and "Always" were used to determine if the member qualified for inclusion in the numerator. The 2017 rates presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results. Please exercise caution when reviewing the trend analysis results for the medical assistance with smoking and tobacco use cessation measures, as the 2017 results contain members who responded to the survey and indicated that they were current smokers or tobacco users in 2016 or 2017.

Weighting

A weighted MDHHS HMP Program average was calculated. Results were weighted based on the total eligible population for each plan's adult HMP population.

HMP Health Plan Comparisons

The results of the HMP health plans were compared to the MDHHS HMP Program average. Two types of hypothesis tests were applied to these results. First, a global F test was calculated, which determined whether the difference between HMP health plans' means was significant. If the F test demonstrated plan-level differences (i.e., p value < 0.05), then a t test was performed for each HMP health plan. The t test determined whether each HMP health plan's mean was statistically significantly different from the MDHHS HMP Program average. This analytic approach follows the Agency for Healthcare Research and Quality's (AHRQ's) recommended methodology for identifying significant plan-level performance differences.

Trend Analysis

A trend analysis was performed that compared the 2017 CAHPS scores to the corresponding 2016 CAHPS scores to determine whether there were statistically significant differences. A t test was performed to determine whether results in 2016 were statistically significantly different from results in 2017. A difference was considered statistically significant if the two-sided p value of the t test was less than 0.05. The two-sided p value of the t test is the probability of observing a test statistic as extreme as or more extreme than the one actually observed by chance.

Key Drivers of Satisfaction Analysis

HSAG performed an analysis of key drivers of satisfaction for the following measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. The purpose of the key drivers of satisfaction analysis is to help decision makers identify specific aspects of care that will most benefit from quality improvement (QI) activities. The analysis provides information on: 1) how well the MDHHS HMP Program is performing on the survey item and 2) how important that item is to overall satisfaction.

Table 2-5 provides a list of the survey items considered for the key drivers analysis for the Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor global ratings.

Table 2-5—Correlation Matrix

	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Q4. Received Care as Soon as Wanted	✓	✓	✓
Q7. Received Appointment as Soon as Wanted	✓	✓	✓
Q13. Doctor Talked About Specific Things to Prevent Illness	✓	✓	✓
Q15. Doctor Talked About Reasons to Take a Medicine	✓	✓	✓
Q16. Doctor Talked About Reasons Not to Take a Medicine	✓	✓	✓
Q17. Doctor Asked About Best Medicine Choice for You	✓	✓	✓
Q19. Getting Care Believed Necessary	✓	✓	✓
Q22. Doctor Explained Things in Way They Could Understand	✓	✓	✓
Q23. Doctor Listened Carefully	✓	✓	✓
Q24. Doctor Showed Respect.	✓	✓	✓
Q25. Doctor Spent Enough Time with Patient	✓	✓	✓
Q27. Doctor Seemed Informed and Up-to-Date About Care from Other Doctors or Health Providers	✓	✓	✓
Q30. Seeing a Specialist	✓	✓	
Q34. Information in Written Materials or on the Internet About Health Plan Provided Information Needed	✓	✓	
Q36. Obtaining Help Needed from Customer Service	✓	✓	
Q37. Health Plan Customer Service Treated with Courtesy and Respect	✓	✓	
Q39. Forms from Health Plan Easy to Fill Out	✓	✓	

The performance on a survey item was measured by calculating a problem score, in which a negative experience with care was defined as a problem and assigned a "1," and a positive experience with care (i.e., non-negative) was assigned a "0." The higher the problem score, the lower the member satisfaction with the aspect of service measured by that question. The problem score could range from 0 to 1.

For each item evaluated, the relationship between the item's problem score and performance on each of the three measures was calculated using a Pearson product moment correlation, which is defined as the covariance of the two scores divided by the product of their standard deviations. Items were then prioritized based on their overall problem score and their correlation to each measure. Key drivers of satisfaction were defined as those items that:

- Had a problem score that was greater than or equal to the median problem score for all items examined.
- Had a correlation that was greater than or equal to the median correlation for all items examined.

Limitations and Cautions

The findings presented in this CAHPS report are subject to some limitations in the survey design, analysis, and interpretation. MDHHS should consider these limitations when interpreting or generalizing the findings.

Case-Mix Adjustment

The demographics of a response group may impact member satisfaction. Therefore, differences in the demographics of the response group may impact CAHPS results. NCQA does not recommend case-mix adjusting Medicaid CAHPS results to account for these differences; therefore, no case-mix adjusting was performed on these CAHPS results.[2-6]

Non-Response Bias

The experiences of the survey respondent population may be different than that of non-respondents with respect to their health care services and may vary by plan or program. Therefore, MDHHS should consider the potential for non-response bias when interpreting CAHPS results.

Causal Inferences

Although this report examines whether respondents report differences in satisfaction with various aspects of their health care experiences, these differences may not be completely attributable to the plan. These analyses identify whether respondents give different ratings of satisfaction with their plan. The survey by itself does not necessarily reveal the exact cause of these differences.

[2-6] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services; 2008.

Missing Phone Numbers

The volume of missing telephone numbers may impact the response rates and the validity of the survey results. For instance, a certain segment of the population may be more likely to have missing phone information than other segments.

National Data for Comparisons

While comparisons to national data were performed for the survey measures, it is important to note that the survey instrument utilized for the 2017 survey administration was the standard CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set; however, the population being surveyed was not a standard adult Medicaid population. There are currently no available benchmarks for this population; therefore, caution should be exercised when interpreting the comparisons to NCQA national data.

Who Responded to the Survey

A total of 14,054 surveys were distributed to adult members. A total of 4,309 surveys were completed. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible members of the sample. For additional information, please refer to the Reader's Guide section of this report.

Table 3-1 shows the total number of members sampled, the number of surveys completed, the number of ineligible members, and the response rates.

Table 3-1—Total Number of Respondents and Response Rates

Plan Name	Sample Size	Completes	Ineligibles	Response Rates
MDHHS HMP Program	**14,054**	**4,309**	**329**	**31.40%**
Aetna Better Health of Michigan	1,350	322	23	24.27%
Blue Cross Complete of Michigan	1,350	431	29	32.63%
HAP Midwest Health Plan	554	84	18	15.67%
Harbor Health Plan	1,350	333	39	25.40%
McLaren Health Plan	1,350	444	21	33.41%
Meridian Health Plan of Michigan	1,350	437	29	33.08%
Molina Healthcare of Michigan	1,350	427	32	32.40%
Priority Health Choice, Inc.	1,350	494	26	37.31%
Total Health Care, Inc.	1,350	411	33	31.21%
UnitedHealthcare Community Plan	1,350	381	65	29.65%
Upper Peninsula Health Plan	1,350	545	14	40.79%

Demographics of Adult Members

Table 3-2 depicts the ages of members who completed a CAHPS survey.

Table 3-2—Adult Member Demographics: Age

Plan Name	19 to 24	25 to 34	35 to 44	45 to 54	55 and older
MDHHS HMP Program	**7.9%**	**15.7%**	**14.4%**	**27.9%**	**34.1%**
Aetna Better Health of Michigan	11.2%	15.1%	15.7%	26.6%	31.4%
Blue Cross Complete of Michigan	6.9%	18.7%	16.1%	23.6%	34.8%
HAP Midwest Health Plan	4.8%	20.5%	20.5%	25.3%	28.9%
Harbor Health Plan	3.7%	13.0%	14.0%	37.3%	32.0%
McLaren Health Plan	5.3%	12.6%	15.1%	30.6%	36.5%
Meridian Health Plan of Michigan	9.7%	17.4%	12.8%	25.1%	35.0%
Molina Healthcare of Michigan	8.9%	14.4%	13.6%	30.4%	32.8%
Priority Health Choice, Inc.	8.0%	15.6%	14.8%	25.8%	35.9%
Total Health Care, Inc.	8.2%	15.0%	14.5%	26.4%	35.9%
UnitedHealthcare Community Plan	11.5%	17.4%	14.2%	29.0%	27.9%
Upper Peninsula Health Plan	6.9%	16.4%	12.8%	27.1%	36.8%
Please note, percentages may not total 100.0% due to rounding.					

Table 3-3 depicts the gender of members who completed a CAHPS survey.

Table 3-3—Adult Member Demographics: Gender

Plan Name	Male	Female
MDHHS HMP Program	**47.9%**	**52.1%**
Aetna Better Health of Michigan	52.9%	47.1%
Blue Cross Complete of Michigan	52.4%	47.6%
HAP Midwest Health Plan	60.2%	39.8%
Harbor Health Plan	62.3%	37.7%
McLaren Health Plan	45.9%	54.1%
Meridian Health Plan of Michigan	42.1%	57.9%
Molina Healthcare of Michigan	43.3%	56.7%
Priority Health Choice, Inc.	43.2%	56.8%
Total Health Care, Inc.	51.2%	48.8%
UnitedHealthcare Community Plan	48.0%	52.0%
Upper Peninsula Health Plan	42.6%	57.4%
Please note, percentages may not total 100.0% due to rounding.		

Table 3-4 depicts the race and ethnicity of members who completed a CAHPS survey.

Table 3-4—Adult Member Demographics: Race/Ethnicity

Plan Name	White	Hispanic	Black	Asian	Other	Multi-Racial
MDHHS HMP Program	**62.1%**	**3.4%**	**23.6%**	**2.4%**	**3.2%**	**5.2%**
Aetna Better Health of Michigan	40.3%	3.2%	46.4%	2.6%	2.6%	4.9%
Blue Cross Complete of Michigan	50.7%	2.6%	35.1%	2.1%	4.2%	5.2%
HAP Midwest Health Plan	66.3%	4.8%	16.9%	0.0%	4.8%	7.2%
Harbor Health Plan	18.9%	3.4%	66.5%	2.8%	4.0%	4.3%
McLaren Health Plan	82.3%	2.8%	6.5%	2.1%	2.8%	3.7%
Meridian Health Plan of Michigan	70.2%	3.0%	15.4%	2.6%	2.1%	6.8%
Molina Healthcare of Michigan	54.9%	6.2%	26.3%	2.4%	4.3%	6.0%
Priority Health Choice, Inc.	79.4%	5.6%	6.8%	2.5%	1.6%	4.1%
Total Health Care, Inc.	41.8%	2.3%	42.8%	2.8%	3.5%	6.8%
UnitedHealthcare Community Plan	59.9%	3.8%	18.5%	4.9%	6.0%	6.8%
Upper Peninsula Health Plan	92.6%	1.3%	0.2%	0.4%	1.7%	3.9%
Please note, percentages may not total 100.0% due to rounding.						

Table 3-5 depicts the general health status of members who completed a CAHPS survey.

Table 3-5—Adult Member Demographics: General Health Status

Plan Name	Excellent	Very Good	Good	Fair	Poor
MDHHS HMP Program	**9.6%**	**25.8%**	**36.0%**	**22.5%**	**6.2%**
Aetna Better Health of Michigan	10.8%	24.5%	34.7%	22.0%	8.0%
Blue Cross Complete of Michigan	8.7%	31.2%	31.5%	23.5%	5.2%
HAP Midwest Health Plan	7.3%	25.6%	46.3%	18.3%	2.4%
Harbor Health Plan	11.7%	22.2%	34.6%	23.8%	7.7%
McLaren Health Plan	9.8%	21.1%	39.1%	23.1%	6.9%
Meridian Health Plan of Michigan	8.6%	28.4%	34.9%	20.7%	7.4%
Molina Healthcare of Michigan	10.2%	22.0%	35.0%	25.3%	7.6%
Priority Health Choice, Inc.	8.2%	25.4%	40.6%	21.5%	4.3%
Total Health Care, Inc.	9.9%	27.7%	31.7%	26.5%	4.2%
UnitedHealthcare Community Plan	11.8%	24.5%	35.2%	21.0%	7.5%
Upper Peninsula Health Plan	8.1%	29.1%	38.1%	19.3%	5.4%
Please note, percentages may not total 100.0% due to rounding.					

National Comparisons

In order to assess the overall performance of the MDHHS HMP Program, HSAG scored the four global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and four of the composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service) on a three-point scale using an NCQA-approved scoring methodology. HSAG compared the plans' and program's three-point mean scores to NCQA HEDIS Benchmarks and Thresholds for Accreditation.[3-1]

Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating (i.e., Poor) and five is the highest possible rating (i.e., Excellent), as shown in Table 3-6.

Table 3-6—Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

The results presented in the following two tables represent the three-point mean scores for each measure, while the stars represent the overall member satisfaction ratings when the three-point means were compared to NCQA HEDIS Benchmarks and Thresholds for Accreditation.[3-2]

[3-1] National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA; May 4, 2017.

[3-2] Given the potential differences in demographic make-up of the HMP population and services received from the HMP health plans compared to the adult Medicaid population, caution should be exercised when interpreting the comparisons to Adult Medicaid NCQA HEDIS Benchmarks and Thresholds for Accreditation.

Table 3-7 shows the overall member satisfaction ratings on each of the four global ratings.

Table 3-7—National Comparisons – Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
MDHHS HMP Program	★★★ **2.45**	★★ **2.34**	★★ **2.47**	★★ **2.49**
Aetna Better Health of Michigan	★ 2.31	★ 2.19	★★ 2.47	★★★ 2.52
Blue Cross Complete of Michigan	★★ 2.41	★★ 2.35	★ 2.37	★★ 2.49
HAP Midwest Health Plan	★+ 2.25	★+ 2.30	★+ 2.29	★+ 2.37
Harbor Health Plan	★★ 2.35	★ 2.21	★★ 2.48	★ 2.46
McLaren Health Plan	★★★★★ 2.54	★★★★ 2.43	★★ 2.46	★★★ 2.51
Meridian Health Plan of Michigan	★★★ 2.45	★★ 2.33	★★ 2.48	★★★★ 2.56
Molina Healthcare of Michigan	★★★ 2.45	★★ 2.37	★★★ 2.50	★ 2.38
Priority Health Choice, Inc.	★★★★★ 2.53	★★★ 2.39	★★★ 2.52	★★ 2.50
Total Health Care, Inc.	★★★ 2.44	★★★ 2.39	★★★★ 2.53	★★ 2.50
UnitedHealthcare Community Plan	★★★ 2.46	★ 2.31	★★ 2.49	★★★ 2.54
Upper Peninsula Health Plan	★★★★ 2.51	★★ 2.34	★★ 2.48	★ 2.45

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

The MDHHS HMP Program scored at or between the 50th and 74th percentiles for the Rating of Health Plan global rating. In addition, the MDHHS HMP Program scored at or between the 25th and 49th percentiles for the Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often global ratings. The MDHHS HMP Program did not score at or above the 75th percentile nor below the 25th percentile for any of the global ratings.

Table 3-8 shows the overall member satisfaction ratings on four of the composite measures.[3-3]

Table 3-8—National Comparisons – Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
MDHHS HMP Program	★★ **2.34**	★★★ **2.40**	★★★★★ **2.65**	★★ **2.53**
Aetna Better Health of Michigan	★ 2.24	★★ 2.35	★★★★★ 2.68	★★★★+ 2.60
Blue Cross Complete of Michigan	★★★ 2.40	★★★ 2.41	★★★★ 2.63	★★ 2.50
HAP Midwest Health Plan	★★+ 2.29	★+ 2.28	★★★+ 2.54	★+ 2.42
Harbor Health Plan	★★ 2.33	★★★★ 2.46	★★★★★ 2.67	★★★ 2.57
McLaren Health Plan	★★★★ 2.42	★★★ 2.41	★★★★★ 2.64	★ 2.43
Meridian Health Plan of Michigan	★★ 2.30	★★★ 2.41	★★★★★ 2.65	★★★ 2.56
Molina Healthcare of Michigan	★★ 2.30	★★ 2.37	★★★★ 2.60	★★ 2.50
Priority Health Choice, Inc.	★★ 2.33	★★ 2.39	★★★★★ 2.67	★★★★ 2.59
Total Health Care, Inc.	★★★ 2.37	★★ 2.35	★★★★★ 2.66	★★★★ 2.60
UnitedHealthcare Community Plan	★★ 2.30	★★ 2.37	★★★★★ 2.65	★+ 2.45
Upper Peninsula Health Plan	★★★ 2.35	★★★★ 2.46	★★★★★ 2.67	★★ 2.52

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

The MDHHS HMP Program scored at or above the 90th percentile for the How Well Doctors Communicate composite measure. In addition, the MDHHS HMP Program scored at or between the 50th and 74th percentiles for the Getting Care Quickly composite measure, and scored at or between the 25th and 49th percentiles for the Getting Needed Care and Customer Service composite measures. The MDHHS HMP Program did not score below the 25th percentile for any of the composite measures.

[3-3] NCQA does not publish national benchmarks and thresholds for Shared Decision Making; therefore, this CAHPS measure was excluded from the National Comparisons analysis.

Statewide Comparisons

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates (i.e., rates of satisfaction) for each global rating and composite measure. HSAG also calculated overall rates for the Effectiveness of Care measures. Refer to the Reader's Guide section for more detailed information regarding the calculation of these measures.

The MDHHS HMP Program results were weighted based on the eligible population for each adult population (i.e., HMP health plans). HSAG compared the HMP health plan results to the MDHHS HMP Program average to determine if the HMP health plan results were statistically significantly different than the MDHHS HMP Program average. The NCQA adult Medicaid national averages also are presented for comparison.[3-4,3-5] Colors in the figures note statistically significant differences. Green indicates a top-box rate that was statistically significantly higher than the MDHHS HMP Program average. Conversely, red indicates a top-box rate that was statistically significantly lower than the MDHHS HMP Program average. Blue represents top-box rates that were not statistically significantly different from the MDHHS HMP Program average. Health plan/program rates with fewer than 100 respondents are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

In some instances, the top-box rates presented for two plans may be similar, but one was statistically significantly different from the MDHHS HMP Program average, and the other was not. In these instances, it was the difference in the number of respondents between the two plans that explains the different statistical results. It is more likely that a significant result will be found in a plan with a larger number of respondents.

[3-4] Given the potential differences in demographic make-up of the HMP population and services received from the HMP health plans compared to the adult Medicaid population, caution should be exercised when interpreting the comparisons to Adult Medicaid national averages.

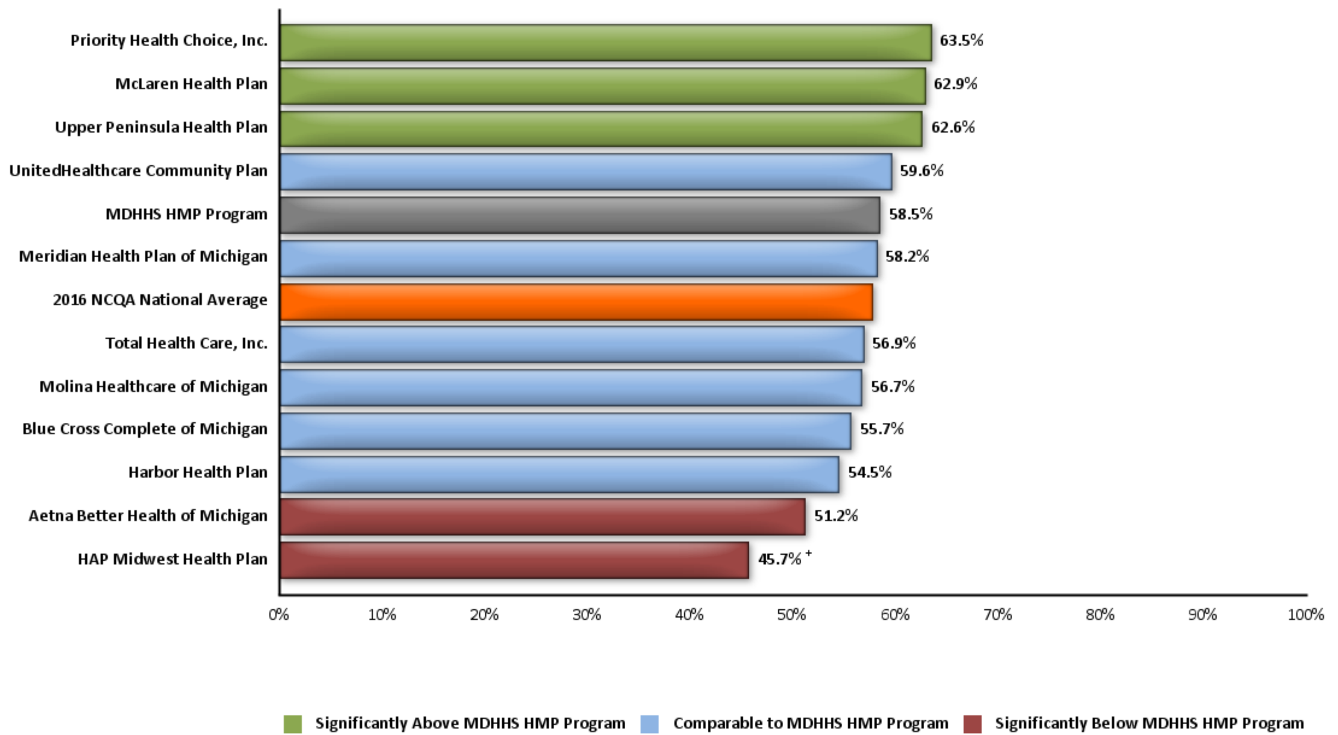
[3-5] The source for the national data contained in this publication is Quality Compass® 2016 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2016 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of AHRQ.

Global Ratings

Rating of Health Plan

Adult members were asked to rate their health plan on a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible." Figure 3-1 shows the Rating of Health Plan top-box rates.

Figure 3-1—Rating of Health Plan Top-Box Rates

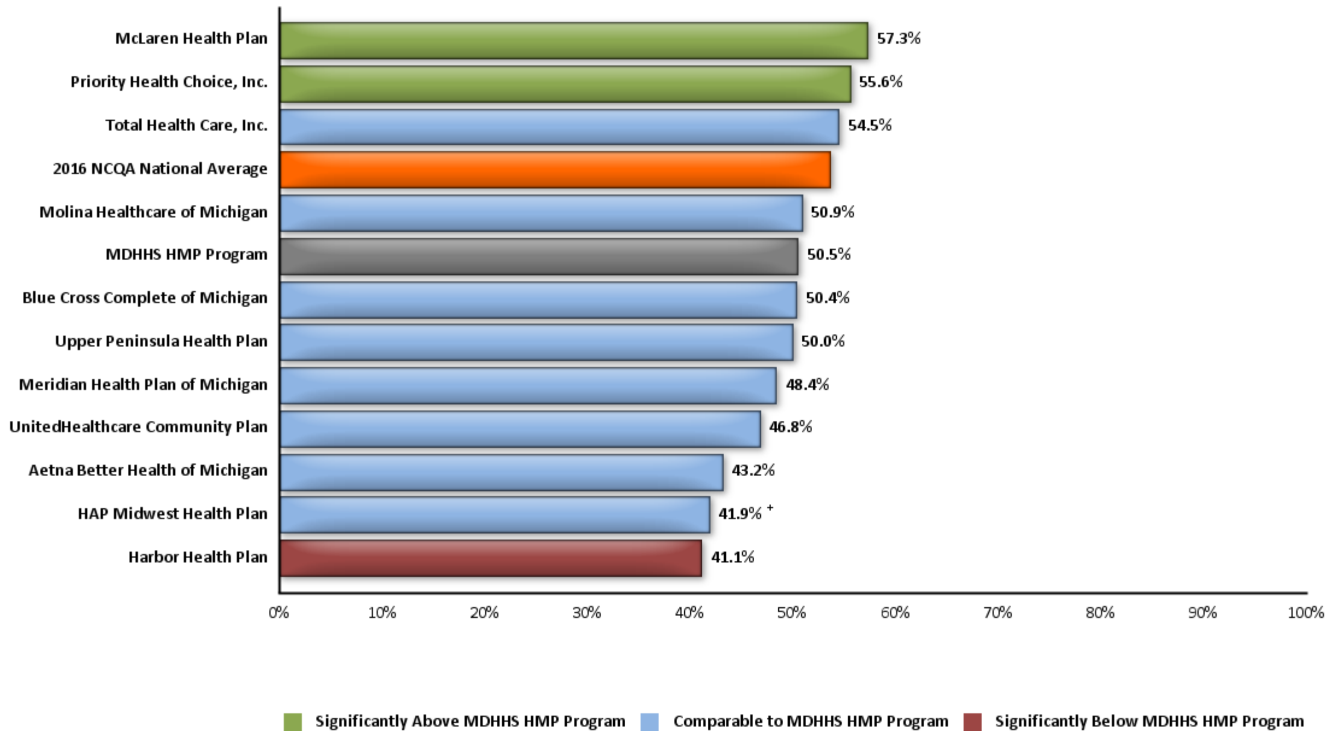


Note: + indicates fewer than 100 responses

Rating of All Health Care

Adult members were asked to rate all their health care on a scale of 0 to 10, with 0 being the "worst health care possible" and 10 being the "best health care possible." Figure 3-2 shows the Rating of All Health Care top-box rates.

Figure 3-2—Rating of All Health Care Top-Box Rates

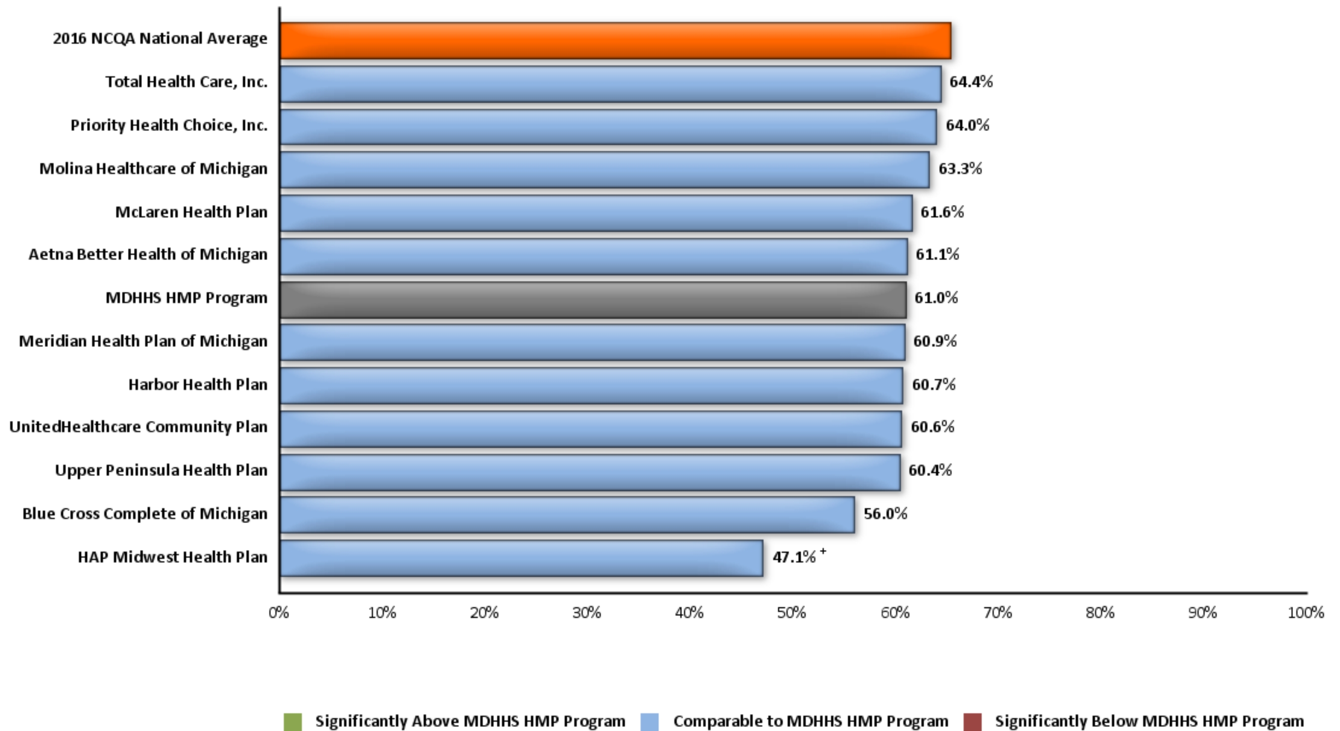


Note: + indicates fewer than 100 responses

Rating of Personal Doctor

Adult members were asked to rate their personal doctor on a scale of 0 to 10, with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible." Figure 3-3 shows the Rating of Personal Doctor top-box rates.

Figure 3-3—Rating of Personal Doctor Top-Box Rates

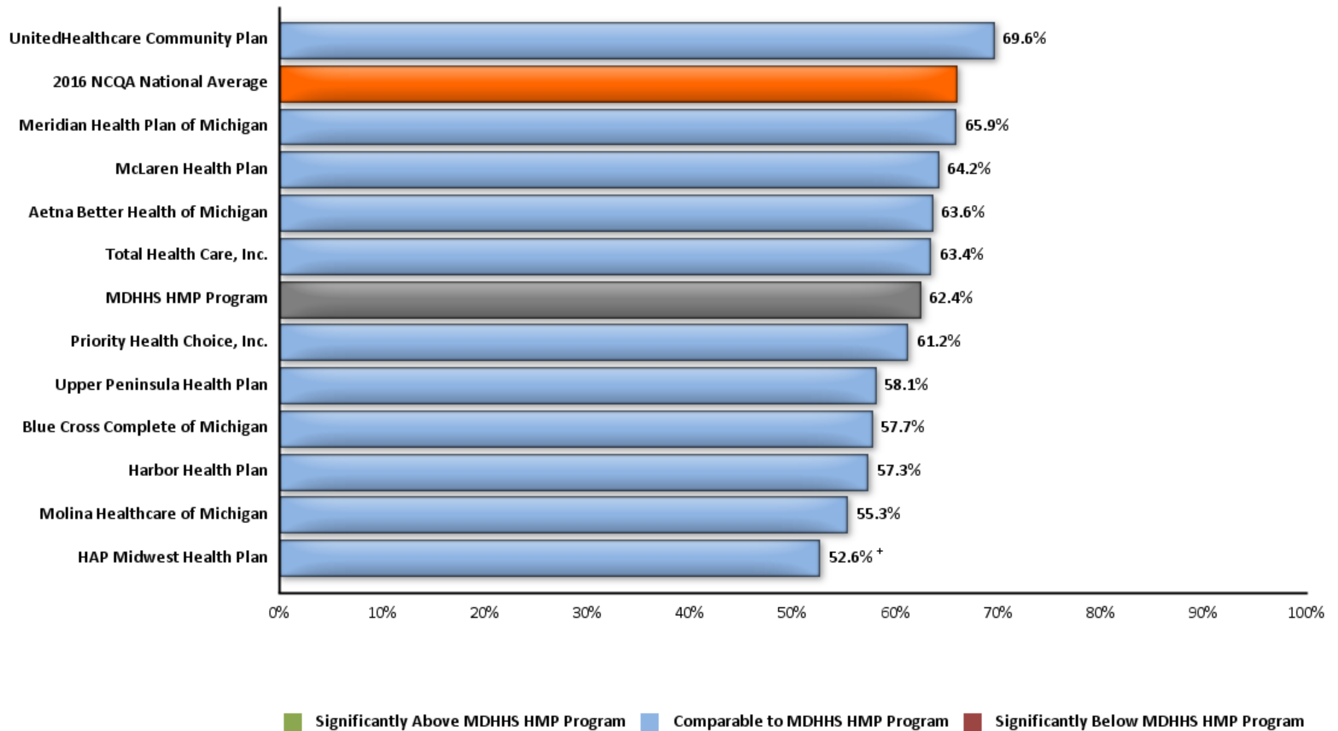


Note: + indicates fewer than 100 responses

Rating of Specialist Seen Most Often

Adult members were asked to rate their specialist on a scale of 0 to 10, with 0 being the "worst specialist possible" and 10 being the "best specialist possible." Figure 3-4 shows the Rating of Specialist Seen Most Often top-box rates.

Figure 3-4—Rating of Specialist Seen Most Often Top-Box Rates



Note: + indicates fewer than 100 responses

Composite Measures

Getting Needed Care

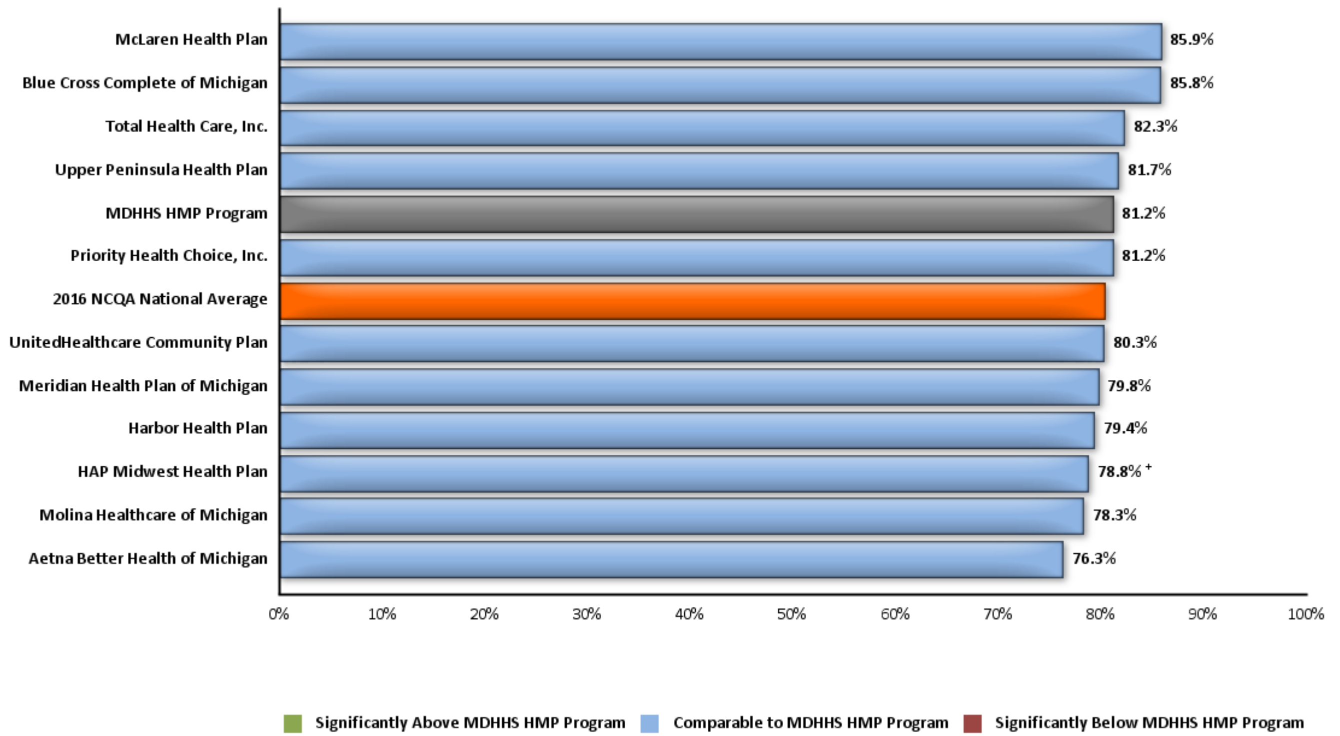
Two questions (Questions 19 and 30 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often it was easy to get needed care:

- **Question 19**. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
    - Never
    - Sometimes
    - Usually
    - Always
- **Question 30**. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
    - Never
    - Sometimes
    - Usually
    - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Getting Needed Care composite measure, which was defined as a response of “Usually” or “Always.”

Figure 3-5 shows the Getting Needed Care top-box rates.

Figure 3-5—Getting Needed Care Top-Box Rates



Note: + indicates fewer than 100 responses

Getting Care Quickly

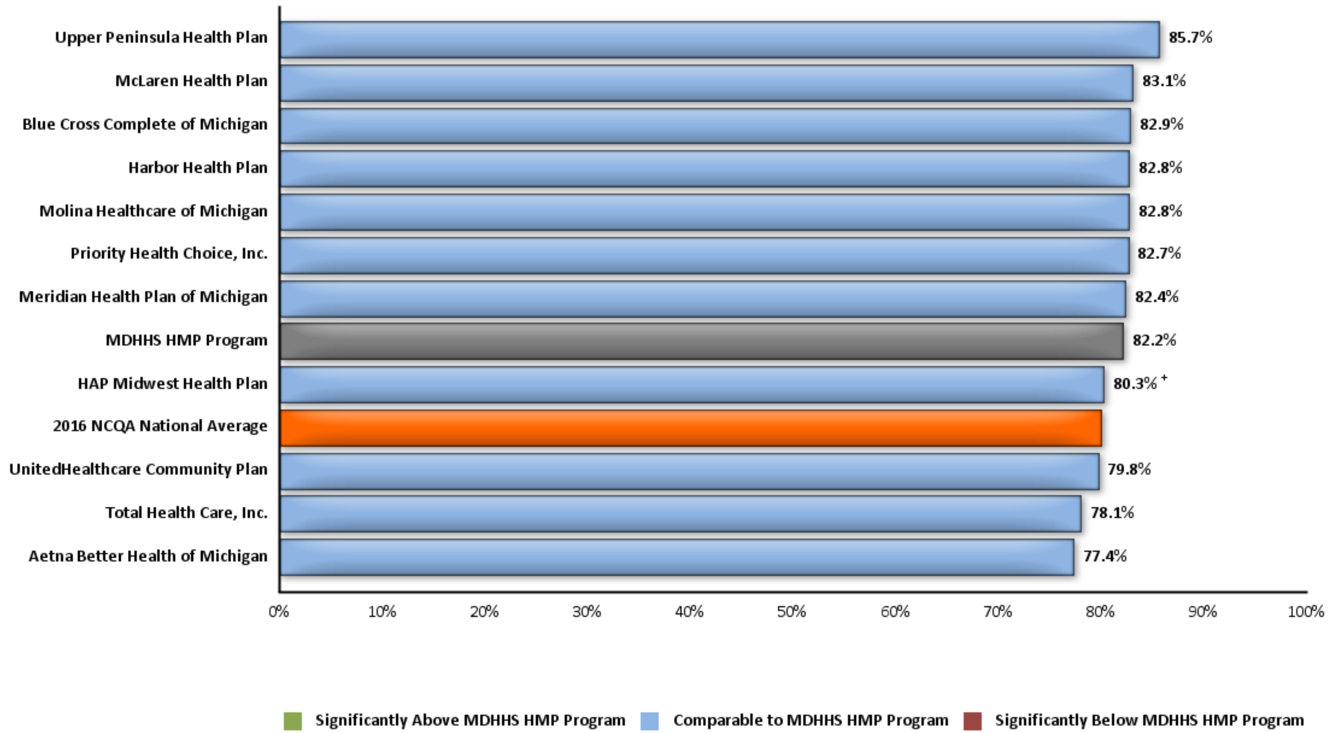
Two questions (Questions 4 and 7 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members received care quickly:

- **Question 4**. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 7**. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Getting Care Quickly composite measure, which was defined as a response of "Usually" or "Always.

Figure 3-6 shows the Getting Care Quickly top-box rates.

Figure 3-6—Getting Care Quickly Top-Box Rates



Note: + indicates fewer than 100 responses

How Well Doctors Communicate

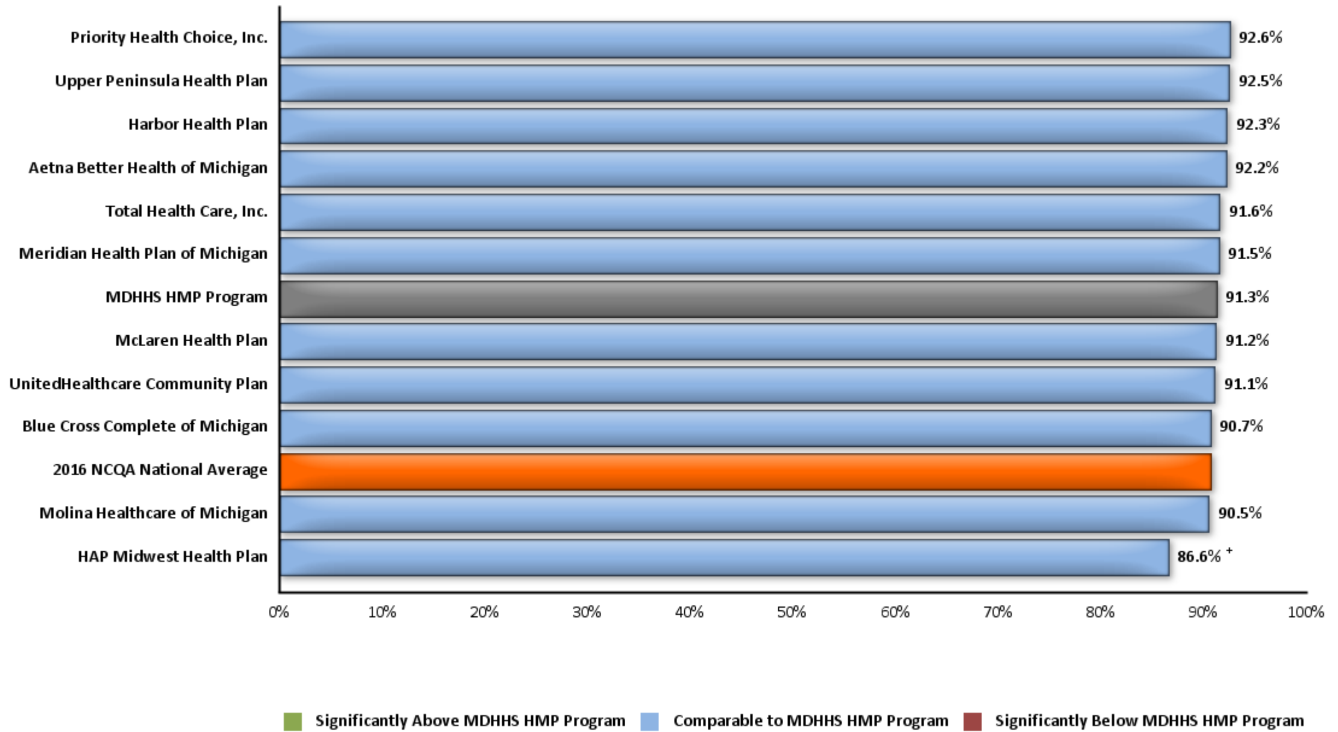
A series of four questions (Questions 22, 23, 24, and 25 in the CAHPS Adult Medicaid Health Plan Survey) was asked to assess how often doctors communicated well:

- **Question 22**. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 23**. In the last 6 months, how often did your personal doctor listen carefully to you?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 24**. In the last 6 months, how often did your personal doctor show respect for what you had to say?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 25**. In the last 6 months, how often did your personal doctor spend enough time with you?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the How Well Doctors Communicate composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-7 shows the How Well Doctors Communicate top-box rates.

Figure 3-7—How Well Doctors Communicate Top-Box Rates



Note: + indicates fewer than 100 responses

Customer Service

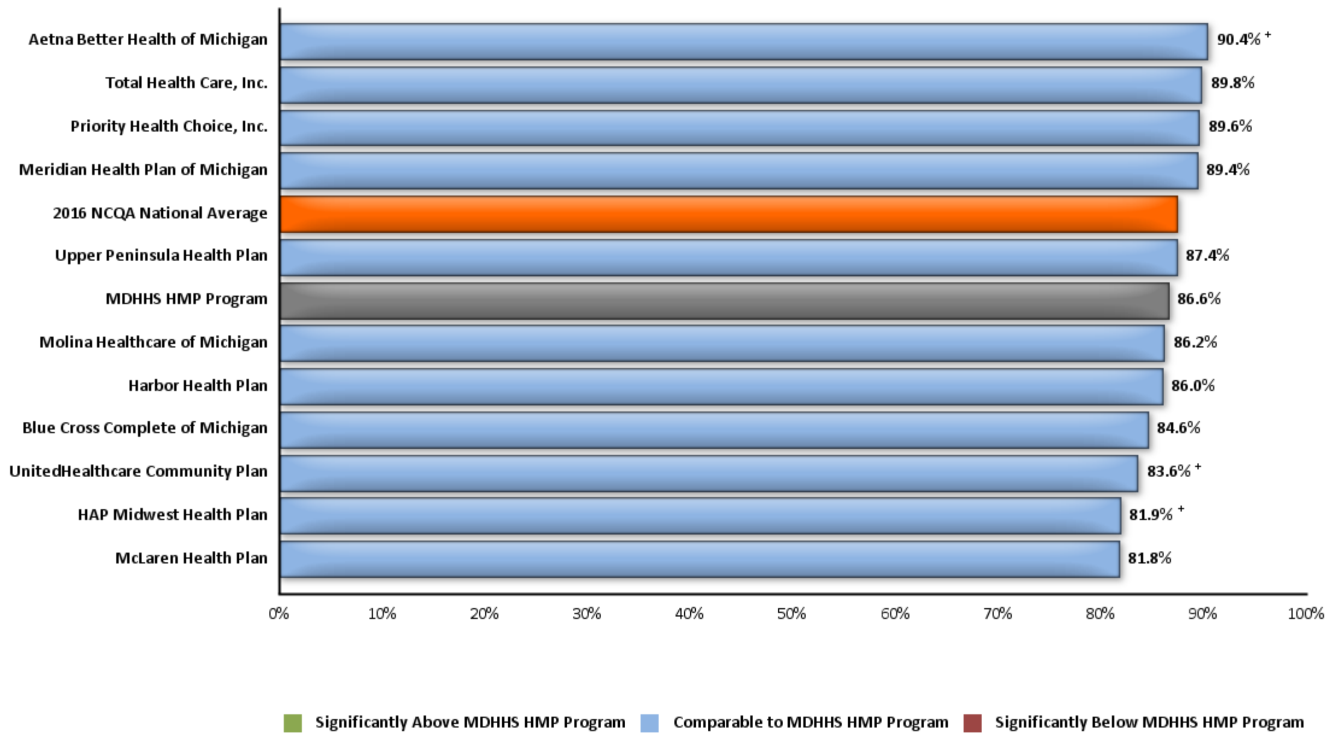
Two questions (Questions 36 and 37 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members were satisfied with customer service:

- **Question 36**. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 37**. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Customer Service composite measure, which was defined as a response of "Usually" or "Always."

Figure 3-8 shows the Customer Service top-box rates.

Figure 3-8—Customer Service Top-Box Rates



Note: + indicates fewer than 100 responses

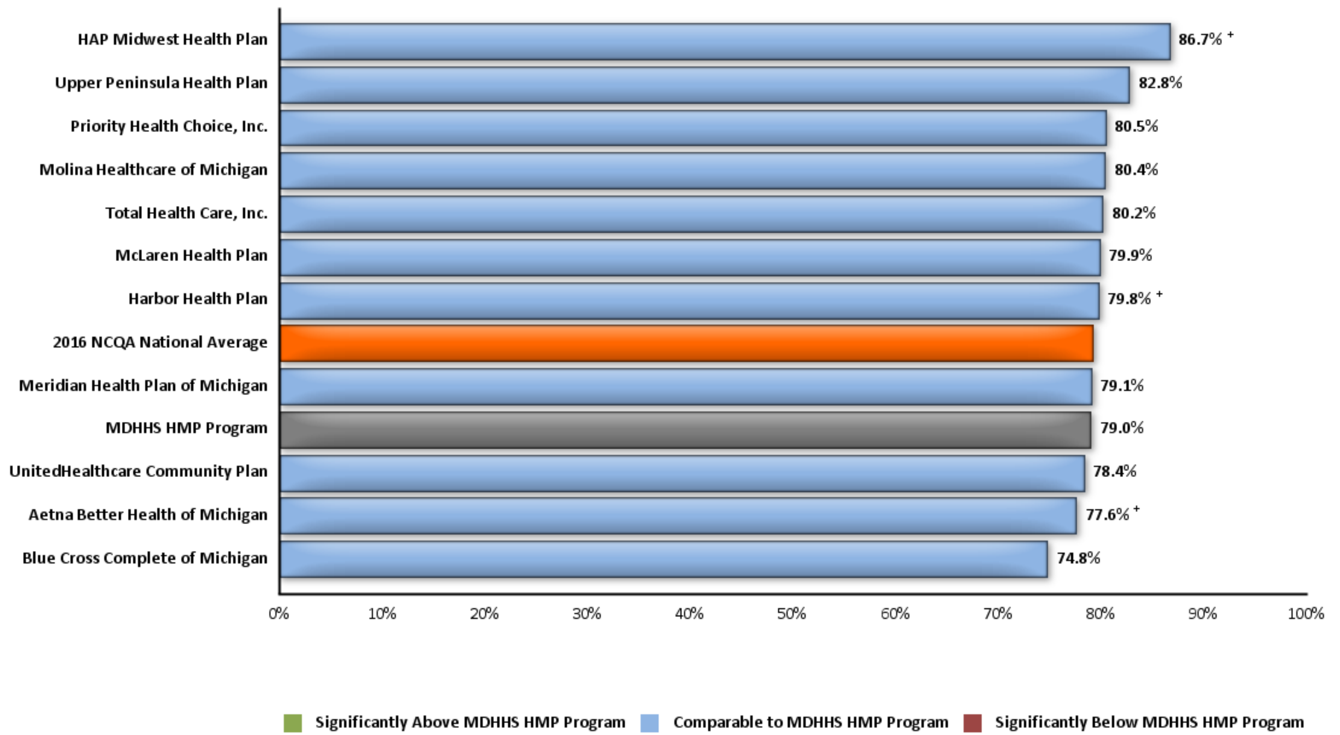
Shared Decision Making

Three questions (Questions 15, 16, and 17 in the CAHPS Adult Medicaid Health Plan Survey) were asked regarding the involvement of adult members in decision making when starting or stopping a prescription medicine:

- **Question 15**. Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?
    - Yes
    - No
- **Question 16**. Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?
    - Yes
    - No
- **Question 17**. When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?
    - Yes
    - No

For purposes of the Statewide Comparisons analysis, HSAG calculated top-box rates for the Shared Decision Making composite measure, which was defined as a response of "Yes."

Figure 3-9 shows the Shared Decision Making top-box rates.



Note: + indicates fewer than 100 responses

Effectiveness of Care Measures

Medical Assistance with Smoking and Tobacco Use Cessation

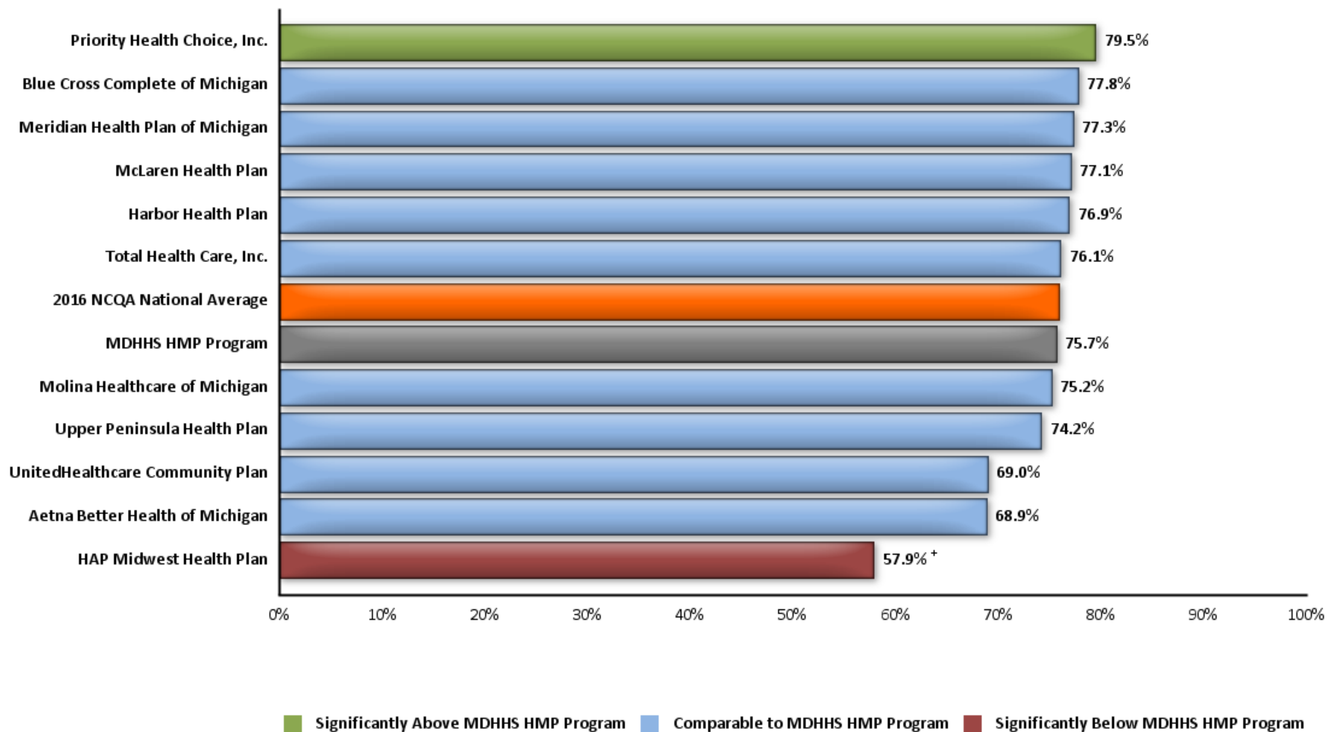
Advising Smokers and Tobacco Users to Quit

Adult members were asked how often they were advised to quit smoking or using tobacco by a doctor or other health provider (Question 46 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 46**. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?
  - Never
  - Sometimes
  - Usually
  - Always

The results of this measure represent the percentage of smokers/tobacco users who answered "Sometimes," "Usually," or "Always" to this question. Figure 3-10 shows the Advising Smokers and Tobacco Users to Quit rates.

Figure 3-10—Advising Smokers and Tobacco Users to Quit Rates



Note: + indicates fewer than 100 responses

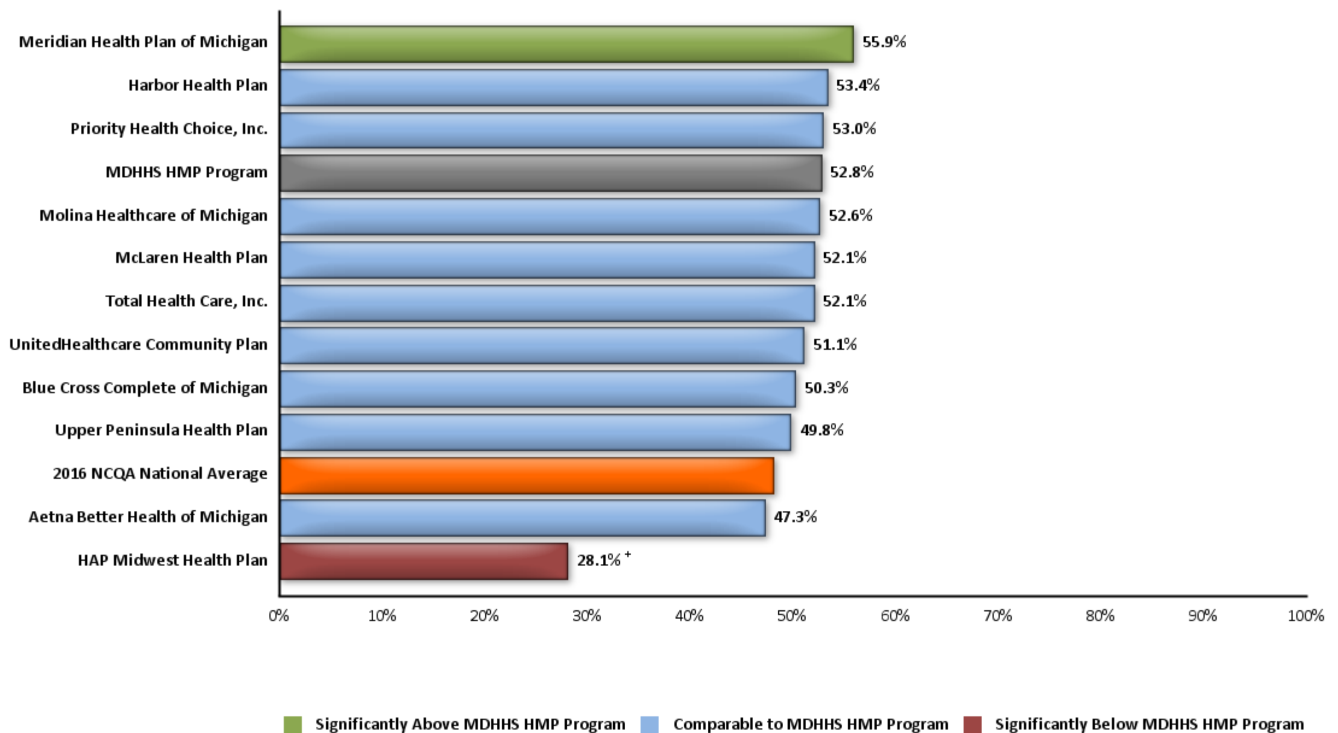
Discussing Cessation Medications

Adult members were asked how often medication was recommended or discussed by a doctor or other health provider to assist them with quitting smoking or using tobacco (Question 47 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 47**. In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.
  - Never
  - Sometimes
  - Usually
  - Always

The results of this measure represent the percentage of smokers/tobacco users who answered "Sometimes," "Usually," or "Always" to this question. Figure 3-11 shows the Discussing Cessation Medications rates.

Figure 3-11—Discussing Cessation Medications Rates



Note: + indicates fewer than 100 responses

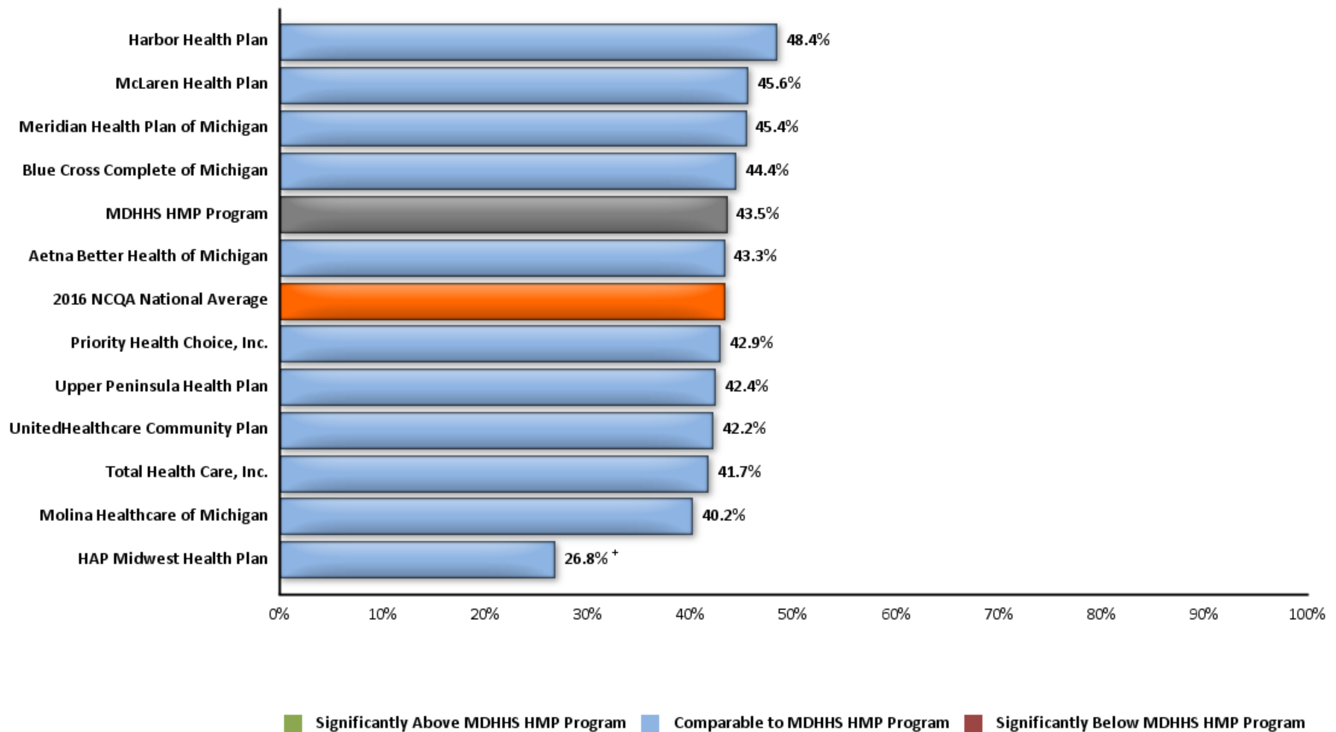
Discussing Cessation Strategies

Adult members were asked how often their doctor or health provider discussed or provided methods and strategies other than medication to assist them with quitting smoking or using tobacco (Question 48 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 48**. In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.
  - Never
  - Sometimes
  - Usually
  - Always

The results of this measure represent the percentage of smokers/tobacco users who answered "Sometimes," "Usually," or "Always" to this question. Figure 3-12 shows the Discussing Cessation Strategies rates.

Figure 3-12—Discussing Cessation Strategies Rates



Note: + indicates fewer than 100 responses

Summary of Results

Table 3-9 provides a summary of the Statewide Comparisons results for the global ratings.

Table 3-9—Statewide Comparisons: Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Aetna Better Health of Michigan	↓	—	—	—
Blue Cross Complete of Michigan	—	—	—	—
HAP Midwest Health Plan	↓+	—+	—+	—+
Harbor Health Plan	—	↓	—	—
McLaren Health Plan	↑	↑	—	—
Meridian Health Plan of Michigan	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—
Priority Health Choice, Inc.	↑	↑	—	—
Total Health Care, Inc.	—	—	—	—
UnitedHealthcare Community Plan	—	—	—	—
Upper Peninsula Health Plan	↑	—	—	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
↑ *indicates the plan's score is statistically significantly higher than the MDHHS HMP Program average.*
↓ *indicates the plan's score is statistically significantly lower than the MDHHS HMP Program average.*
— *indicates the plan's score is not statistically significantly different than the MDHHS HMP Program average.*

Table 3-10 provides a summary of the Statewide Comparisons for the composite measures.

Table 3-10—Statewide Comparisons: Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Aetna Better Health of Michigan	—	—	—	—+	—+
Blue Cross Complete of Michigan	—	—	—	—	—
HAP Midwest Health Plan	—+	—+	—+	—+	—+
Harbor Health Plan	—	—	—	—	—+
McLaren Health Plan	—	—	—	—	—
Meridian Health Plan of Michigan	—	—	—	—	—
Molina Healthcare of Michigan	—	—	—	—	—
Priority Health Choice, Inc.	—	—	—	—	—
Total Health Care, Inc.	—	—	—	—	—
UnitedHealthcare Community Plan	—	—	—	—+	—
Upper Peninsula Health Plan	—	—	—	—	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
↑ *indicates the plan's score is statistically significantly higher than the MDHHS HMP Program average.*
↓ *indicates the plan's score is statistically significantly lower than the MDHHS HMP Program average.*
— *indicates the plan's score is not statistically significantly different than the MDHHS HMP Program average.*

Table 3-11 provides a summary of the Statewide Comparisons for the Effectiveness of Care measures.

Table 3-11—Statewide Comparisons: Effectiveness of Care Measures

Plan Name	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies
Aetna Better Health of Michigan	—	—	—
Blue Cross Complete of Michigan	—	—	—
HAP Midwest Health Plan	↓+	↓+	—+
Harbor Health Plan	—	—	—
McLaren Health Plan	—	—	—
Meridian Health Plan of Michigan	—	↑	—
Molina Healthcare of Michigan	—	—	—
Priority Health Choice, Inc.	↑	—	—
Total Health Care, Inc.	—	—	—
UnitedHealthcare Community Plan	—	—	—
Upper Peninsula Health Plan	—	—	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
↑ *indicates the plan's score is statistically significantly higher than the MDHHS HMP Program average.*
↓ *indicates the plan's score is statistically significantly lower than the MDHHS HMP Program average.*
— *indicates the plan's score is not statistically significantly different than the MDHHS HMP Program average.*

Trend Analysis

The completed surveys from the 2017 and 2016 CAHPS results were used to perform the trend analysis presented in this section. The 2017 CAHPS top-box scores were compared to the 2016 CAHPS top-box scores to determine whether there were statistically significant differences. Statistically significant differences between 2017 scores and 2016 scores are noted with triangles. Scores that were statistically significantly higher in 2017 than in 2016 are noted with upward triangles (▲). Scores that were statistically significantly lower in 2017 than in 2016 are noted with downward triangles (▼). Scores in 2017 that were not statistically significantly different from scores in 2016 are noted with a dash (—). Measures that did not meet the minimum number of 100 responses required by NCQA are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

Global Ratings

Rating of Health Plan

Adult members were asked to rate their health plan on a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible." Table 4-1 shows the 2016 and 2017 top-box responses and the trend results for Rating of Health Plan.

Table 4-1—Rating of Health Plan Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS HMP Program	**57.1%**	**58.5%**	**—**
Aetna Better Health of Michigan	48.0%	51.2%	—
Blue Cross Complete of Michigan	57.0%	55.7%	—
HAP Midwest Health Plan	52.6%+	45.7%+	—
Harbor Health Plan	53.9%	54.5%	—
McLaren Health Plan	59.4%	62.9%	—
Meridian Health Plan of Michigan	56.2%	58.2%	—
Molina Healthcare of Michigan	55.0%	56.7%	—
Priority Health Choice, Inc.	66.1%	63.5%	—
Total Health Care, Inc.	58.9%	56.9%	—
UnitedHealthcare Community Plan	56.7%	59.6%	—
Upper Peninsula Health Plan	60.1%	62.6%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were no statistically significant differences between scores in 2017 and scores in 2016 for this measure.

Rating of All Health Care

Adult members were asked to rate all their health care on a scale of 0 to 10, with 0 being the "worst health care possible" and 10 being the "best health care possible." Table 4-2 shows the 2016 and 2017 top-box responses and the trend results for Rating of All Health Care.

Table 4-2—Rating of All Health Care Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS HMP Program	**52.6%**	**50.5%**	**—**
Aetna Better Health of Michigan	45.3%	43.2%	—
Blue Cross Complete of Michigan	54.6%	50.4%	—
HAP Midwest Health Plan	53.6%+	41.9%+	—
Harbor Health Plan	42.1%	41.1%	—
McLaren Health Plan	58.0%	57.3%	—
Meridian Health Plan of Michigan	51.3%	48.4%	—
Molina Healthcare of Michigan	52.5%	50.9%	—
Priority Health Choice, Inc.	56.6%	55.6%	—
Total Health Care, Inc.	57.8%	54.5%	—
UnitedHealthcare Community Plan	47.6%	46.8%	—
Upper Peninsula Health Plan	53.0%	50.0%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were no statistically significant differences between scores in 2017 and scores in 2016 for this measure.

Rating of Personal Doctor

Adult members were asked to rate their personal doctor on a scale of 0 to 10, with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible." Table 4-3 shows the 2016 and 2017 top-box responses and the trend results for Rating of Personal Doctor.

Table 4-3—Rating of Personal Doctor Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS HMP Program	**61.7%**	**61.0%**	**—**
Aetna Better Health of Michigan	57.1%	61.1%	—
Blue Cross Complete of Michigan	65.0%	56.0%	▼
HAP Midwest Health Plan	40.7%+	47.1%+	—
Harbor Health Plan	52.1%	60.7%	—
McLaren Health Plan	66.2%	61.6%	—
Meridian Health Plan of Michigan	59.1%	60.9%	—
Molina Healthcare of Michigan	62.8%	63.3%	—
Priority Health Choice, Inc.	62.6%	64.0%	—
Total Health Care, Inc.	64.2%	64.4%	—
UnitedHealthcare Community Plan	57.8%	60.6%	—
Upper Peninsula Health Plan	67.5%	60.4%	▼

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were two statistically significant differences between scores in 2017 and scores in 2016 for this measure.

The following scored statistically significantly *lower* in 2017 than in 2016:

- Blue Cross Complete of Michigan
- Upper Peninsula Health Plan

Rating of Specialist Seen Most Often

Adult members were asked to rate their specialist on a scale of 0 to 10, with 0 being the "worst specialist possible" and 10 being the "best specialist possible." Table 4-4 shows the 2016 and 2017 top-box responses and the trend results for Rating of Specialist Seen Most Often.

Table 4-4—Rating of Specialist Seen Most Often Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS HMP Program	**62.5%**	**62.4%**	**—**
Aetna Better Health of Michigan	63.7%	63.6%	—
Blue Cross Complete of Michigan	71.6%	57.7%	▼
HAP Midwest Health Plan	80.0%+	52.6%+	—
Harbor Health Plan	61.1%	57.3%	—
McLaren Health Plan	70.4%	64.2%	—
Meridian Health Plan of Michigan	58.0%	65.9%	—
Molina Healthcare of Michigan	60.0%	55.3%	—
Priority Health Choice, Inc.	69.9%	61.2%	—
Total Health Care, Inc.	68.2%	63.4%	—
UnitedHealthcare Community Plan	57.6%	69.6%	▲
Upper Peninsula Health Plan	61.6%	58.1%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were two statistically significant differences between scores in 2017 and scores in 2016 for this measure.

The following scored statistically significantly *higher* in 2017 than in 2016:

- UnitedHealthcare Community Plan

The following scored statistically significantly *lower* in 2017 than in 2016:

- Blue Cross Complete of Michigan

Composite Measures

Getting Needed Care

Two questions in the CAHPS Adult Medicaid Health Plan Survey (Questions 19 and 30) were asked to assess how often it was easy to get needed care. Table 4-5 shows the 2016 and 2017 top-box responses and trend results for the Getting Needed Care composite measure.

Table 4-5—Getting Needed Care Composite Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS HMP Program	**83.8%**	**81.2%**	▼
Aetna Better Health of Michigan	75.9%	76.3%	—
Blue Cross Complete of Michigan	84.9%	85.8%	—
HAP Midwest Health Plan	86.3%+	78.8%+	—
Harbor Health Plan	74.8%	79.4%	—
McLaren Health Plan	85.9%	85.9%	—
Meridian Health Plan of Michigan	85.8%	79.8%	▼
Molina Healthcare of Michigan	82.9%	78.3%	—
Priority Health Choice, Inc.	84.7%	81.2%	—
Total Health Care, Inc.	82.6%	82.3%	—
UnitedHealthcare Community Plan	79.4%	80.3%	—
Upper Peninsula Health Plan	85.0%	81.7%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were two statistically significant differences between scores in 2017 and scores in 2016 for this measure.

The following scored statistically significantly *lower* in 2017 than in 2016:

- MDHHS HMP Program
- Meridian Health Plan of Michigan

Getting Care Quickly

Two questions in the CAHPS Adult Medicaid Health Plan Survey (Questions 4 and 7) were asked to assess how often adult members received care quickly. Table 4-6 shows the 2016 and 2017 top-box responses and trend results for the Getting Care Quickly composite measure.

Table 4-6—Getting Care Quickly Composite Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS HMP Program	**81.4%**	**82.2%**	**—**
Aetna Better Health of Michigan	76.5%	77.4%	—
Blue Cross Complete of Michigan	81.6%	82.9%	—
HAP Midwest Health Plan	80.7%+	80.3%+	—
Harbor Health Plan	75.5%	82.8%	▲
McLaren Health Plan	82.8%	83.1%	—
Meridian Health Plan of Michigan	81.5%	82.4%	—
Molina Healthcare of Michigan	81.7%	82.8%	—
Priority Health Choice, Inc.	83.1%	82.7%	—
Total Health Care, Inc.	84.6%	78.1%	▼
UnitedHealthcare Community Plan	78.7%	79.8%	—
Upper Peninsula Health Plan	82.6%	85.7%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were two statistically significant differences between scores in 2017 and scores in 2016 for this measure.

The following scored statistically significantly *higher* in 2017 than in 2016:

- Harbor Health Plan

The following scored statistically significantly *lower* in 2017 than in 2016:

- Total Health Care, Inc.

How Well Doctors Communicate

A series of four questions (Questions 22, 23, 24, and 25 in the CAHPS Adult Medicaid Health Plan Survey) was asked to assess how often doctors communicated well. Table 4-7 shows the 2016 and 2017 top-box responses and trend results for the How Well Doctors Communicate composite measure.

Table 4-7—How Well Doctors Communicate Composite Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS HMP Program	**91.0%**	**91.3%**	**—**
Aetna Better Health of Michigan	90.4%	92.2%	—
Blue Cross Complete of Michigan	94.0%	90.7%	—
HAP Midwest Health Plan	91.7%+	86.6%+	—
Harbor Health Plan	92.4%	92.3%	—
McLaren Health Plan	93.8%	91.2%	—
Meridian Health Plan of Michigan	90.4%	91.5%	—
Molina Healthcare of Michigan	87.8%	90.5%	—
Priority Health Choice, Inc.	91.8%	92.6%	—
Total Health Care, Inc.	93.5%	91.6%	—
UnitedHealthcare Community Plan	90.6%	91.1%	—
Upper Peninsula Health Plan	93.4%	92.5%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were no statistically significant differences between scores in 2017 and scores in 2016 for this measure.

Customer Service

Two questions (Questions 36 and 37 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members were satisfied with customer service. Table 4-8 shows the 2016 and 2017 top-box responses and trend results for the Customer Service composite measure.

Table 4-8—Customer Service Composite Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS HMP Program	**88.5%**	**86.6%**	**—**
Aetna Better Health of Michigan	92.6%	90.4%+	—
Blue Cross Complete of Michigan	92.6%	84.6%	▼
HAP Midwest Health Plan	96.4%+	81.9%+	—
Harbor Health Plan	89.8%	86.0%	—
McLaren Health Plan	86.7%+	81.8%	—
Meridian Health Plan of Michigan	89.3%	89.4%	—
Molina Healthcare of Michigan	87.4%	86.2%	—
Priority Health Choice, Inc.	89.0%	89.6%	—
Total Health Care, Inc.	87.9%	89.8%	—
UnitedHealthcare Community Plan	86.7%	83.6%+	—
Upper Peninsula Health Plan	87.2%+	87.4%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There was one statistically significant difference between scores in 2017 and scores in 2016 for this measure.

The following scored statistically significantly *lower* in 2017 than in 2016:

- Blue Cross Complete of Michigan

Shared Decision Making

Three questions (Questions 15, 16, and 17 in the CAHPS Adult Medicaid Health Plan Survey) were asked regarding the involvement of adult members in decision making when starting or stopping a prescription medicine. Table 4-9 shows the 2016 and 2017 top-box responses and trend results for the Shared Decision composite measure.

Table 4-9—Shared Decision Making Composite Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS HMP Program	**79.7%**	**79.0%**	**—**
Aetna Better Health of Michigan	78.9%	77.6%+	—
Blue Cross Complete of Michigan	82.1%	74.8%	▼
HAP Midwest Health Plan	NA	86.7%+	NT
Harbor Health Plan	71.6%	79.8%+	▲
McLaren Health Plan	82.3%	79.9%	—
Meridian Health Plan of Michigan	80.1%	79.1%	—
Molina Healthcare of Michigan	79.6%	80.4%	—
Priority Health Choice, Inc.	81.0%	80.5%	—
Total Health Care, Inc.	73.4%	80.2%	—
UnitedHealthcare Community Plan	76.0%	78.4%	—
Upper Peninsula Health Plan	82.6%	82.8%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*
NA *indicates that results for this measure are not displayed because too few members responded to the questions.*
NT *indicates the results for this measure are not trendable.*

There were two statistically significant differences between scores in 2017 and scores in 2016 for this measure.

The following scored statistically significantly *higher* in 2017 than in 2016:

- Harbor Health Plan

The following scored statistically significantly *lower* in 2017 than in 2016:

- Blue Cross Complete of Michigan

Effectiveness of Care Measures

Medical Assistance with Smoking and Tobacco Use Cessation

Advising Smokers and Tobacco Users to Quit

One question (Question 46 in the CAHPS Adult Medicaid Health Plan Survey) was asked to determine how often adult members were advised to quit smoking or using tobacco by a doctor or other health provider. Table 4-10 shows the 2016 and 2017 rates and trend results for the Advising Smokers and Tobacco Users to Quit measure.

Table 4-10—Advising Smokers and Tobacco Users to Quit Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS HMP Program	**76.5%**	**75.7%**	**—**
Aetna Better Health of Michigan	72.1%	68.9%	—
Blue Cross Complete of Michigan	79.6%	77.8%	—
HAP Midwest Health Plan	66.7%+	57.9%+	—
Harbor Health Plan	75.9%	76.9%	—
McLaren Health Plan	79.4%	77.1%	—
Meridian Health Plan of Michigan	75.9%	77.3%	—
Molina Healthcare of Michigan	76.9%	75.2%	—
Priority Health Choice, Inc.	83.3%	79.5%	—
Total Health Care, Inc.	75.9%	76.1%	—
UnitedHealthcare Community Plan	70.3%	69.0%	—
Upper Peninsula Health Plan	74.2%	74.2%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were no statistically significant differences between scores in 2017 and scores in 2016 for this measure.

Discussing Cessation Medications

One question (Question 47 in the CAHPS Adult Medicaid Health Plan Survey) was asked to ascertain how often medication was recommended or discussed by their doctor or health provider to assist adult members with quitting smoking or using tobacco. Table 4-11 shows the 2016 and 2017 rates and trend results for the Discussing Cessation Medications measure.

Table 4-11—Discussing Cessation Medications Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS HMP Program	**52.5%**	**52.8%**	**—**
Aetna Better Health of Michigan	50.3%	47.3%	—
Blue Cross Complete of Michigan	51.0%	50.3%	—
HAP Midwest Health Plan	28.6%+	28.1%+	—
Harbor Health Plan	51.8%	53.4%	—
McLaren Health Plan	51.5%	52.1%	—
Meridian Health Plan of Michigan	56.4%	55.9%	—
Molina Healthcare of Michigan	50.0%	52.6%	—
Priority Health Choice, Inc.	54.9%	53.0%	—
Total Health Care, Inc.	53.1%	52.1%	—
UnitedHealthcare Community Plan	50.0%	51.1%	—
Upper Peninsula Health Plan	48.8%	49.8%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were no statistically significant differences between scores in 2017 and scores in 2016 for this measure.

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Discussing Cessation Strategies

One question (Question 48 in the CAHPS Adult Medicaid Health Plan Survey) was asked to ascertain how often methods or strategies other than medication were discussed or provided by their doctor or health provider to assist adult members with quitting smoking or using tobacco. Table 4-12 shows the 2016 and 2017 rates and trend results for the Discussing Cessation Strategies measure.

Table 4-12—Discussing Cessation Strategies Trend Analysis

Plan Name	2016	2017	Trend Results
MDHHS HMP Program	**43.3%**	**43.5%**	**—**
Aetna Better Health of Michigan	43.5%	43.3%	—
Blue Cross Complete of Michigan	45.1%	44.4%	—
HAP Midwest Health Plan	25.0%+	26.8%+	—
Harbor Health Plan	48.5%	48.4%	—
McLaren Health Plan	45.7%	45.6%	—
Meridian Health Plan of Michigan	43.9%	45.4%	—
Molina Healthcare of Michigan	40.1%	40.2%	—
Priority Health Choice, Inc.	46.8%	42.9%	—
Total Health Care, Inc.	44.4%	41.7%	—
UnitedHealthcare Community Plan	41.5%	42.2%	—
Upper Peninsula Health Plan	41.4%	42.4%	—

\+ *indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*
— *not statistically significantly different in 2017 than in 2016.*

There were no statistically significant differences between scores in 2017 and scores in 2016 for this measure.

Key Drivers of Satisfaction

HSAG performed an analysis of key drivers for three measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. The analysis provides information on: (1) how well the MDHHS HMP Program is performing on the survey item (i.e., question), and (2) how important the item is to overall satisfaction.

Key drivers of satisfaction are defined as those items that (1) have a problem score that is greater than or equal to the program's median problem score for all items examined, and (2) have a correlation that is greater than or equal to the program's median correlation for all items examined. For additional information on the assignment of problem scores, please refer to the Reader's Guide section.

Table 5-1 depicts those items identified for each of the three measures as being key drivers of satisfaction for the MDHHS HMP Program.

Table 5-1—MDHHS HMP Program Key Drivers of Satisfaction

Rating of Health Plan
Respondents reported that their health plan's customer service did not always give them the information or help they needed.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Respondents reported that information in written materials or on the Internet about how the health plan works did not always provide the information they needed.
Respondents reported that forms from their health plan were often not easy to fill out.
Respondents reported that it was often not easy to obtain appointments with specialists.
Rating of All Health Care
Respondents reported that when they talked about starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for them.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Respondents reported that information in written materials or on the Internet about how the health plan works did not always provide the information they needed.
Respondents reported that it was often not easy to obtain appointments with specialists.
Rating of Personal Doctor
Respondents reported that it was not always easy to get the care, tests, or treatment they thought they needed through their health plan.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.

The following key driver was identified for all three global ratings:

- Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.

Additionally, the following key drivers were identified for the Rating of Health Plan and Rating of All Health Care global ratings:

- Respondents reported that it was often not easy to obtain appointments with specialists.
- Respondents reported that information in written materials or on the Internet about how the health plans work did not always provide the information they needed.

When compared with the 2016 key drivers of satisfaction results, more items were identified as key drivers in this year's results. The following item was identified as a new key driver for the Rating of Health Plan global rating in 2017: Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers. The following item was identified as a new key driver for the Rating of Personal Doctor global rating in 2017: Respondents reported that it was not always easy to get the care, tests, or treatment they thought they needed through their health plan. Additionally, the following item was identified as a new key driver for the Rating of All Health Care global rating in 2017: Respondents reported that information in written materials or on the Internet about how the health plan works did not always provide the information they needed. These changes in the results of the key drivers of satisfaction analysis indicate possible declines in respondents' perceptions of coordination of care and health plan materials.

Supplemental Items Results

MDHHS elected to add five supplemental questions to the CAHPS Adult Medicaid Health Plan Survey. These five questions focused on the number of times members had gone to an emergency room, the number of days members waited between making an appointment and seeing a health provider, members' access to after hours care, and whether members received help with transportation to their doctors' offices or clinics.

Emergency Room Care

Members were asked how many times they had gone to an emergency room to receive care for themselves in the last 6 months (Question 5). Table 6-1 displays the responses for this question.

Table 6-1—How Many Times Visited Emergency Room

	None		1 time		2		3		4		5 to 9		10 or more times	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
MDHHS HMP Program	**606**	**41.7%**	**484**	**33.3%**	**202**	**13.9%**	**91**	**6.3%**	**44**	**3.0%**	**20**	**1.4%**	**7**	**0.5%**
Aetna Better Health of Michigan	28	29.5%	37	38.9%	17	17.9%	6	6.3%	5	5.3%	1	1.1%	1	1.1%
Blue Cross Complete of Michigan	59	42.4%	50	36.0%	19	13.7%	8	5.8%	3	2.2%	0	0.0%	0	0.0%
HAP Midwest Health Plan	7	36.8%	6	31.6%	3	15.8%	3	15.8%	0	0.0%	0	0.0%	0	0.0%
Harbor Health Plan	41	36.9%	29	26.1%	24	21.6%	7	6.3%	6	5.4%	3	2.7%	1	0.9%
McLaren Health Plan	74	46.8%	58	36.7%	14	8.9%	7	4.4%	2	1.3%	2	1.3%	1	0.6%
Meridian Health Plan of Michigan	61	39.6%	51	33.1%	23	14.9%	9	5.8%	7	4.5%	3	1.9%	0	0.0%
Molina Healthcare of Michigan	62	41.6%	49	32.9%	18	12.1%	10	6.7%	7	4.7%	2	1.3%	1	0.7%
Priority Health Choice, Inc.	73	40.8%	65	36.3%	23	12.8%	12	6.7%	4	2.2%	1	0.6%	1	0.6%
Total Health Care, Inc.	63	45.0%	42	30.0%	20	14.3%	6	4.3%	4	2.9%	3	2.1%	2	1.4%
UnitedHealthcare Community Plan	49	39.5%	40	32.3%	18	14.5%	12	9.7%	2	1.6%	3	2.4%	0	0.0%
Upper Peninsula Health Plan	89	47.8%	57	30.6%	23	12.4%	11	5.9%	4	2.2%	2	1.1%	0	0.0%

Please note: Results presented in this table are based on respondents that answered "Yes" to Question 3.

Number of Days to See a Health Provider

Members were asked how many days they waited between making an appointment and seeing a health provider in the last 6 months (Question 8). Table 6-2 displays the responses for this question.

Table 6-2—Number of Days to See a Health Provider

	Same day		1 day		2 to 3 days		4 to 7 days		8 to 14 days		15 to 30 days		31 to 60 days		61 to 90 days		91 days or longer	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
MDHHS HMP Program	**272**	**10.5%**	**199**	**7.7%**	**576**	**22.3%**	**608**	**23.5%**	**392**	**15.2%**	**327**	**12.6%**	**114**	**4.4%**	**54**	**2.1%**	**43**	**1.7%**
Aetna Better Health of Michigan	25	14.8%	16	9.5%	35	20.7%	29	17.2%	27	16.0%	19	11.2%	11	6.5%	4	2.4%	3	1.8%
Blue Cross Complete of Michigan	28	10.6%	24	9.1%	51	19.4%	58	22.1%	45	17.1%	41	15.6%	8	3.0%	5	1.9%	3	1.1%
HAP Midwest Health Plan	7	20.0%	5	14.3%	7	20.0%	7	20.0%	5	14.3%	3	8.6%	0	0.0%	1	2.9%	0	0.0%
Harbor Health Plan	17	8.9%	9	4.7%	35	18.3%	50	26.2%	31	16.2%	34	17.8%	9	4.7%	3	1.6%	3	1.6%
McLaren Health Plan	14	5.2%	20	7.4%	64	23.7%	68	25.2%	40	14.8%	42	15.6%	8	3.0%	11	4.1%	3	1.1%
Meridian Health Plan of Michigan	36	12.9%	21	7.5%	64	22.9%	61	21.8%	43	15.4%	33	11.8%	14	5.0%	1	0.4%	7	2.5%
Molina Healthcare of Michigan	35	12.7%	17	6.2%	62	22.5%	63	22.9%	37	13.5%	40	14.5%	10	3.6%	8	2.9%	3	1.1%
Priority Health Choice, Inc.	27	8.8%	28	9.2%	74	24.2%	72	23.5%	54	17.6%	29	9.5%	8	2.6%	7	2.3%	7	2.3%
Total Health Care, Inc.	32	13.0%	21	8.5%	60	24.3%	63	25.5%	31	12.6%	20	8.1%	14	5.7%	3	1.2%	3	1.2%
UnitedHealthcare Community Plan	28	12.0%	18	7.7%	50	21.4%	62	26.5%	29	12.4%	22	9.4%	15	6.4%	4	1.7%	6	2.6%
Upper Peninsula Health Plan	23	7.3%	20	6.3%	74	23.5%	75	23.8%	50	15.9%	44	14.0%	17	5.4%	7	2.2%	5	1.6%

Please note: Results presented in this table are based on respondents that answered "Yes" to Question 6.

After Hours Care

Members were asked how often it was easy to receive the after hours care they thought they needed in the last 6 months (Question 10). Table 6-3 displays the responses for this question.

Table 6-3—How Often Received After Hours Care

	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
MDHHS HMP Program	**40**	**8.9%**	**65**	**14.5%**	**83**	**18.5%**	**261**	**58.1%**
Aetna Better Health of Michigan	3	15.0%	6	30.0%	2	10.0%	9	45.0%
Blue Cross Complete of Michigan	4	11.4%	7	20.0%	6	17.1%	18	51.4%
HAP Midwest Health Plan	0	0.0%	1	14.3%	1	14.3%	5	71.4%
Harbor Health Plan	6	21.4%	3	10.7%	5	17.9%	14	50.0%
McLaren Health Plan	1	2.0%	5	10.0%	6	12.0%	38	76.0%
Meridian Health Plan of Michigan	1	1.9%	7	13.2%	11	20.8%	34	64.2%
Molina Healthcare of Michigan	6	11.1%	9	16.7%	14	25.9%	25	46.3%
Priority Health Choice, Inc.	3	6.0%	10	20.0%	10	20.0%	27	54.0%
Total Health Care, Inc.	5	12.5%	3	7.5%	6	15.0%	26	65.0%
UnitedHealthcare Community Plan	5	9.8%	9	17.6%	8	15.7%	29	56.9%
Upper Peninsula Health Plan	6	9.8%	5	8.2%	14	23.0%	36	59.0%

Please note: Results presented in this table are based on respondents that answered "Yes" to Question 9.

Members were asked what reasons limited their ability to receive after hours care (Question 11). Table 6-4 displays the responses for this question.

Table 6-4—Reason Not Easy to Receive After Hours Care

	Unsure where to go for after hours care		Unsure where to find a list of doctor's offices or clinics open for after hours care		Doctor's office or clinic with after hours care was too far away		Office or clinic hours for after hours care did not meet your needs		Some other reason	
	N	%	N	%	N	%	N	%	N	%
MDHHS HMP Program	**36**	**22.5%**	**48**	**30.0%**	**29**	**18.1%**	**41**	**25.6%**	**69**	**43.1%**
Aetna Better Health of Michigan	2	20.0%	3	30.0%	3	30.0%	2	20.0%	2	20.0%
Blue Cross Complete of Michigan	5	35.7%	4	28.6%	2	14.3%	6	42.9%	4	28.6%
HAP Midwest Health Plan	1	50.0%	1	50.0%	1	50.0%	1	50.0%	1	50.0%
Harbor Health Plan	4	40.0%	5	50.0%	3	30.0%	1	10.0%	4	40.0%
McLaren Health Plan	2	22.2%	3	33.3%	0	0.0%	0	0.0%	5	55.6%
Meridian Health Plan of Michigan	2	11.8%	5	29.4%	1	5.9%	5	29.4%	7	41.2%
Molina Healthcare of Michigan	6	22.2%	8	29.6%	9	33.3%	5	18.5%	13	48.1%
Priority Health Choice, Inc.	5	27.8%	7	38.9%	2	11.1%	4	22.2%	6	33.3%
Total Health Care, Inc.	2	15.4%	4	30.8%	2	15.4%	5	38.5%	5	38.5%
UnitedHealthcare Community Plan	3	16.7%	5	27.8%	0	0.0%	5	27.8%	6	33.3%
Upper Peninsula Health Plan	4	18.2%	3	13.6%	6	27.3%	7	31.8%	16	72.7%

Please note: Results presented in this table are based on respondents that answered "Yes" to Question 9 and did not answer "Always" to Question 10.
**Respondents can choose more than one response for this question. Therefore, percentages will not total 100%.*

Transportation

Members were asked if their health plan had helped them with transportation to get to doctors' offices or clinics (Question 40). Table 6-5 displays the responses for this question.

Table 6-5—Helped with Transportation to Doctors' Offices or Clinics

	Yes		No	
	N	%	N	%
MDHHS HMP Program	**401**	**9.6%**	**3,794**	**90.4%**
Aetna Better Health of Michigan	37	12.0%	272	88.0%
Blue Cross Complete of Michigan	40	9.6%	377	90.4%
HAP Midwest Health Plan	1	1.2%	82	98.8%
Harbor Health Plan	81	24.9%	244	75.1%
McLaren Health Plan	23	5.3%	411	94.7%
Meridian Health Plan of Michigan	44	10.3%	385	89.7%
Molina Healthcare of Michigan	43	10.5%	368	89.5%
Priority Health Choice, Inc.	27	5.6%	452	94.4%
Total Health Care, Inc.	35	8.6%	371	91.4%
UnitedHealthcare Community Plan	34	9.3%	332	90.7%
Upper Peninsula Health Plan	36	6.7%	500	93.3%

Survey Instrument

The survey instrument selected was the CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set. This section provides a copy of the survey instrument.

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

DataStat

Your privacy is protected. The research staff will not share your personal information with anyone without your OK. Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call 1-800-839-3455.

SURVEY INSTRUCTIONS

- **Please be sure to fill the response circle completely. Use only black or blue ink or dark pencil to complete the survey.**

- **You are sometimes told to skip over some questions in the survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:**

● **Yes ➔ *Go to Question 1***
○ **No**

↓ START HERE ↓

1. Our records show that you are now in [HEALTH PLAN NAME]. Is that right?

○ Yes ➔ ***Go to Question 3***
○ No

2. What is the name of your health plan? (Please print)

____

YOUR HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

3. **In the last 6 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?**

   - ○ Yes
   - ○ No ➔ ***Go to Question 6***

4. **In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?**

   - ○ Never
   - ○ Sometimes
   - ○ Usually
   - ○ Always

5. **In the last 6 months, how many times did you go to an emergency room to get care for yourself?**

   - ○ None
   - ○ 1 time
   - ○ 2
   - ○ 3
   - ○ 4
   - ○ 5 to 9
   - ○ 10 or more times

6. **In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?**

   - ○ Yes
   - ○ No ➔ ***Go to Question 9***

7. **In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?**

   - ○ Never
   - ○ Sometimes
   - ○ Usually
   - ○ Always

8. **In the last 6 months, not counting the times you needed health care right away, how many days did you usually have to wait between making an appointment and actually seeing a health provider?**

   - ○ Same day
   - ○ 1 day
   - ○ 2 to 3 days
   - ○ 4 to 7 days
   - ○ 8 to 14 days
   - ○ 15 to 30 days
   - ○ 31 to 60 days
   - ○ 61 to 90 days
   - ○ 91 days or longer

9. **After hours care is health care when your usual doctor's office or clinic is closed.**

   In the last 6 months, did you need to visit a doctor's office or clinic for after hours care?

   - ○ Yes
   - ○ No ➔ ***Go to Question 12***

10. **In the last 6 months, how often was it easy to get the after hours care you thought you needed?**

    - ○ Never
    - ○ Sometimes
    - ○ Usually
    - ○ Always ➔ ***Go to Question 12***

11. Were any of the following a reason it was not easy to get the after hours care you thought you needed? Mark one or more.

- ○ You did not know where to go for after hours care
- ○ You weren't sure where to find a list of doctor's offices or clinics in your health plan or network that are open for after hours care
- ○ The doctor's office or clinic that had after hours care was too far away
- ○ Office or clinic hours for after hours care did not meet your needs
- ○ Some other reason

12. In the last 6 months, not counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?

- ○ None ➔ ***Go to Question 20***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

13. In the last 6 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?

- ○ Yes
- ○ No

14. In the last 6 months, did you and a doctor or other health provider talk about starting or stopping a prescription medicine?

- ○ Yes
- ○ No ➔ ***Go to Question 18***

15. Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?

- ○ Yes
- ○ No

16. Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?

- ○ Yes
- ○ No

17. When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?

- ○ Yes
- ○ No

18. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Worst Health Care Possible										Best Health Care Possible

19. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

YOUR PERSONAL DOCTOR

20. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

- ○ Yes
- ○ No ➔ ***Go to Question 29***

21. In the last 6 months, how many times did you visit your personal doctor to get care for yourself?

- ○ None ➔ ***Go to Question 28***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

22. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

23. In the last 6 months, how often did your personal doctor listen carefully to you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

24. In the last 6 months, how often did your personal doctor show respect for what you had to say?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

25. In the last 6 months, how often did your personal doctor spend enough time with you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

26. In the last 6 months, did you get care from a doctor or other health provider besides your personal doctor?

- ○ Yes
- ○ No ➔ ***Go to Question 28***

27. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

28. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10

Worst Personal Doctor Possible — Best Personal Doctor Possible

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, do <u>not</u> include dental visits or care you got when you stayed overnight in a hospital.

29. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care.

In the last 6 months, did you make any appointments to see a specialist?

- ○ Yes
- ○ No ➔ ***Go to Question 33***

30. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

31. How many specialists have you seen in the last 6 months?

- ○ None ➔ ***Go to Question 33***
- ○ 1 specialist
- ○ 2
- ○ 3
- ○ 4
- ○ 5 or more specialists

32. We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Worst Specialist Possible										Best Specialist Possible

YOUR HEALTH PLAN

The next questions ask about your experience with your health plan.

33. In the last 6 months, did you look for any information in written materials or on the Internet about how your health plan works?

- ○ Yes
- ○ No ➔ ***Go to Question 35***

34. In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

35. In the last 6 months, did you get information or help from your health plan's customer service?

- ○ Yes
- ○ No ➔ ***Go to Question 38***

36. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

37. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

38. In the last 6 months, did your health plan give you any forms to fill out?

- ○ Yes
- ○ No ➔ ***Go to Question 40***

39. In the last 6 months, how often were the forms from your health plan easy to fill out?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

40. Some health plans help with transportation to doctors' offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your health plan to get help with transportation?

- ○ Yes
- ○ No

41. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Worst Health Plan Possible										Best Health Plan Possible

ABOUT YOU

42. In general, how would you rate your overall health?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

43. In general, how would you rate your overall mental or emotional health?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

44. Have you had either a flu shot or flu spray in the nose since July 1, 2016?

- ○ Yes
- ○ No
- ○ Don't know

45. Do you now smoke cigarettes or use tobacco every day, some days, or not at all?

- ○ Every day
- ○ Some days
- ○ Not at all ➔ ***Go to Question 49***
- ○ Don't know ➔ ***Go to Question 49***

46. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

47. In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

48. In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

49. Do you take aspirin daily or every other day?

- ○ Yes
- ○ No
- ○ Don't know

50. Do you have a health problem or take medication that makes taking aspirin unsafe for you?

- ○ Yes
- ○ No
- ○ Don't know

51. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?

- ○ Yes
- ○ No

52. Are you aware that you have any of the following conditions? Mark one or more.

- ○ High cholesterol
- ○ High blood pressure
- ○ Parent or sibling with heart attack before the age of 60

53. Has a doctor ever told you that you have any of the following conditions? Mark one or more.

- ○ A heart attack
- ○ Angina or coronary heart disease
- ○ A stroke
- ○ Any kind of diabetes or high blood sugar

54. In the last 6 months, did you get health care 3 or more times for the same condition or problem?

- ○ Yes
- ○ No ➔ ***Go to Question 56***

55. Is this a condition or problem that has lasted for at least 3 months? Do <u>not</u> include pregnancy or menopause.

- ○ Yes
- ○ No

56. Do you now need or take medicine prescribed by a doctor? Do not include birth control.

- ○ Yes
- ○ No ➔ ***Go to Question 58***

57. Is this medicine to treat a condition that has lasted for at least 3 months? Do not include pregnancy or menopause.

- ○ Yes
- ○ No

58. What is your age?

- ○ 18 to 24
- ○ 25 to 34
- ○ 35 to 44
- ○ 45 to 54
- ○ 55 to 64
- ○ 65 to 74
- ○ 75 or older

59. Are you male or female?

- ○ Male
- ○ Female

60. What is the highest grade or level of school that you have completed?

- ○ 8th grade or less
- ○ Some high school, but did not graduate
- ○ High school graduate or GED
- ○ Some college or 2-year degree
- ○ 4-year college graduate
- ○ More than 4-year college degree

61. Are you of Hispanic or Latino origin or descent?

- ○ Yes, Hispanic or Latino
- ○ No, Not Hispanic or Latino

62. What is your race? Mark one or more.

- ○ White
- ○ Black or African-American
- ○ Asian
- ○ Native Hawaiian or other Pacific Islander
- ○ American Indian or Alaska Native
- ○ Other

63. Did someone help you complete this survey?

- ○ Yes ➔ ***Go to Question 64***
- ○ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

64. How did that person help you? Mark one or more.

- ○ Read the questions to me
- ○ Wrote down the answers I gave
- ○ Answered the questions for me
- ○ Translated the questions into my language
- ○ Helped in some other way

Thanks again for taking the time to complete this survey! Your answers are greatly appreciated.

When you are done, please use the enclosed prepaid envelope to mail the survey to:

DataStat, 3975 Research Park Drive, Ann Arbor, MI 48108