STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

March 31, 2017

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 2016 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 L. Rutledge

Penny Rutledge, Director
Actuarial Division

cc: Ruth Hughes
Angela Garner

Enclosure (11)

Healthy Michigan Demonstration
Section 1115 Annual Report

Demonstration Year: 7 (01/01/2016 – 12/31/2016)

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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 2016 – December 2016

Month	Enrollment	New Enrollment	Disenrollment
January	651,726	46,125	31,225
February	653,704	39,650	37,678
March	649,786	32,240	36,189
April	643,089	32,244	38,969
May	638,757	31,137	35,535
June	637,664	31,813	32,921
July	631,643	31,734	37,771
August	633,395	35,628	33,891
September	638,066	33,787	29,176
October	644,529	31,864	25,507
November	652,657	36,379	28,345
December	660,040	37,451	30,136

Most Healthy Michigan Plan beneficiaries elect to choose a health plan as opposed to automatic assignment to a health plan. As of December 19, 2016, 361,749 or, 71 percent, of the State's 505,770 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, 28,062 of all Healthy Michigan Plan health plan enrollees changed

health plans. This year, 14,488 or approximately 52 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 95 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 2016 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 2016 – December 2016					
Month	Number of Completed HRAs	Percent of Total	Number of Refused HRAs	Percent of Total	Total Enrollment Calls
January	8,609	95%	456	5%	8,609
February	8,227	95%	398	5%	8,227
March	6,195	96%	256	4%	6,195
April	3,723	94%	237	6%	3,723
May	2,756	95%	144	5%	2,756
June	2,467	95%	125	5%	2,467
July	2,856	95%	151	5%	2,856
August	2,288	95%	123	5%	2,288
September	2,933	95%	168	5%	2,933
October	2,649	95%	127	5%	2,649
November	2,753	91%	261	9%	2,753
December	3,482	92%	304	8%	3,482
Total	48,938	95%	2,750	5%	51,688

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 2016 – December 2016				
Month	Health Risk Assessments Submitted	Gift Cards Earned	Reductions Earned	Reductions Applied
January	2,327	1,889	430	940
February	2,214	1,737	461	752
March	2,747	2,149	581	761
April	2,649	2,106	533	774
May	4,211	3,399	801	759
June	2,620	2,107	510	800
July	2,304	1,804	494	1,043
August	4,254	3,523	713	1,156
September	2,802	2,191	599	431
October	2,634	2,116	510	655
November	2,965	2,394	566	704
December	2,486	2,013	468	708
Total	34,213	27,428	6,666	9,483

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. The unique enrollee count will differ from the December 2016 count from the Beneficiary Month Reporting section as a result of disenrollment that occurred during the year.

Table 4: Enrollment Counts for Year and Year to Date

Demonstration Population	Total Number of Demonstration Beneficiaries Year Ending – 12/2016	Current Enrollees (year to date)	Disenrolled in Current Year
ABW Childless Adults	N/A	N/A	N/A
Healthy Michigan Adults	955,128	955,128	397,343

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 2016 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.

This year, MDHHS issued a schedule for Encounter Quality Initiative (EQI) activities. Medicaid Health Plans are scored based on timely submissions of encounter data, site visit availability and the submission of an Explanation of Variances detailing variances and corrective action plans as necessary. MDHHS staff engaged with Medicaid Health Plans on encounter data compliance and preparation for the CMS Managed Care Rule. Updates were made to the

Encounter Quality Initiative methodology to improve data analysis. Additionally, MDHHS staff provided Medicaid Health Plans with additional training and resources to identify and remove duplicate encounter claims.

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 2016 – December 2016

Issue Date	Subject	Link
01/15/2016	Clarification of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Covered Services and Definition of "Medically Necessary"	MSA 16-01
03/01/2016	Medicaid Coverage of Lactation Support Services	MSA 15-46
03/01/2016	Transition to Managed Care Common Formulary	MSA 16-06
03/01/2016	Updates to the Medicaid Provider Manual	MSA 16-07
03/31/2016	Update of Maternal Infant Health Program Staff Qualifications	MSA 16-09
05/04/2016	Coverage of Targeted Case Management Services for Beneficiaries Who Were Served by the Flint Water System	MSA 16-10
05/19/2016	MI Care Team Implementation (Primary Care Health Home Benefit)	MSA 16-13
06/01/2016	Enrollment of Marriage and Family Therapists as Medicaid Providers	MSA 16-14
06/01/2016	New Form for Prior Authorization of Practitioner Services	MSA 16-15
06/01/2016	Ambulance Prior Authorization & Air Ambulance Enrollment Update	MSA 16-16
06/01/2016	Updates to the Medicaid Provider Manual; New Coverage of Existing Code; Clarification to Bulletin MSA 15-44	MSA 16-20
08/01/2016	Coverage of Autism Services for Children Under 21 Years of Age	MSA 16-23
09/01/2016	Blood Lead Poisoning Environmental Investigations	MSA 16-24
09/01/2016	Fee-for-Service Medicaid Transportation Rate and Policy Updates	MSA 16-25
09/01/2016	Updates to the Medicaid Provider Manual; New Coverage of Existing Code	MSA 16-26
09/01/2016	Diabetes Self-Management Education Policy Changes	MSA 16-29
09/28/2016	Medicaid Non-Emergency Medical Transportation (NEMT) Provider Enrollment Requirements	MSA 16-05
09/28/2016	Changes to Eyeglass Repair and Replacement Policy	MSA 16-31
11/01/2016	Changes in Benefit Administration of Maternal Infant Health Program Services for Individuals Enrolled in a Medicaid Health Plan	MSA 16-33
11/30/2016	Timely Filing Billing Limitation	MSA 16-37

Table 5: Medicaid Policy Bulletins with Healthy Michigan Plan Impact Continued		
11/30/2016	Interim Caries Arresting Medicament Application	MSA 16-38
11/30/2016	Peer Mentor Training	MSA 16-39
11/30/2016	Benefits Monitoring Program (BMP)	MSA 16-40
11/30/2016	Updates to the Medicaid Provider Manual; Blood Lead Nursing Assessment Visits	MSA 16-42
12/01/2016	Policy Clarification for Long-Term Acute Care Hospitals (LTACHs)	MSA 16-43
12/29/2016	Standards of Coverage and Documentation for Pull-on Briefs	MSA 16-45
12/29/2016	Coverage of Trauma Services for Children Under 21 Years of Age	MSA 16-46

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. This year, MDHHS reported $29,806,829.00 in administrative costs in the CMS 64.10 WAIV files submitted to CMS. Expenditures include those that both occurred and were paid in the same year in addition to adjustments to expenditures paid in years after the year of service. The State will continue to update data for each demonstration year as it becomes available.

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)	$474.66	$482.06	$477.38	-	-
Total Expenditures (YTD)	$1,772,960,230.00	$3,503,856,050.00	$3,693,496,061.00	-	-
Total Member Months (YTD)	3,735,189	7,268,580	7,737,068	-	-

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, 2016.

Table 7: Healthy Michigan Plan Beneficiary Month Reporting	
January 2016 – December 2016	
Month	Count
January	651,683
February	653,655
March	649,706
April	642,982
May	638,584
June	637,476
July	631,439
August	633,176
September	637,787
October	644,144
November	652,178
December	659,493
Total	7,732,303

Consumer Issues

This year, the total number of Healthy Michigan Plan complaints reported to MDHHS was 477. Complaints reported to MDHHS are detailed by category in the table below. Overall, with over 7.7 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 2016 – December 2016					
	Obtaining Prescriptions	Other Covered Services	Transportation	Other	Total
Count	346	68	43	20	477
Percent	73%	14%	9%	4%	

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 and include 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 will continue in 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.

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 2017. For 2016, it is calculated using Cost Sharing and Incentives and Value Added categories.

The Fiscal Year 2016 –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 will continue through September 2017.

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. MDHHS and the Medicaid Health Plans continue to monitor MI Health Account call center and payment activity.

The MI Health Account Call Center handles questions regarding the MI Health Account welcome letters and MI Health Account yearly statements. MDHHS' Beneficiary Help Line number is listed on all MI Health Account letters. Staff are cross trained to provide assistance on a variety of topics. Commonly asked questions for callers contacting the MI Health Account Call Center relate to general MI Health Account information and payment amounts. Members calling regarding the yearly statements have asked about amounts owed, requested clarification on the contents of the statement, and reported an inability to pay amounts owed. The January 2017 MI Health Account Executive Summary Report has been included as an attachment 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 2016, there were 519 total appeals among all the Medicaid Health Plans. Medicaid Health Plan decisions were upheld in 46 percent of the appeals. From January to December 2016 there were a total of 3,622 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 2016 – December 2016				
	Decision Upheld	Overturned	Undetermined/ Withdrawn	Total
Count	237	260	22	519
Percent	46%	50%	4%	

Table 10: Managed Care Organization Grievances January 2016 – December 2016						
	Access	Quality of Care	Administrative/Service	Billing	Transportation	Total
Count	1,362	244	672	328	1,016	3,622
Percent	38%	7%	19%	9%	28%	

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 82 percent of Healthy Michigan Plan enrollees have had an ambulatory or preventive care visit within the first year of the program and 59 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 fifth year for the traditional Medicaid Managed Care population, and will include 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 2015 (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. This analysis is run on an annual basis.

3. MDHHS collects race/ethnicity data for internal review for all Adult Core Set and Healthy Michigan Plan measures. Measures which are stratified by race ethnicity include: Postpartum Care, 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 1:500, 50 points are added to the plan's score for that county. In January 2016, 24/7 availability was reviewed as part of the annual comprehensive compliance review. 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 2015 included components specific to the Healthy Michigan Plan. The 2015 – 2016 EQR Technical Report is scheduled to be published in April 2017.

As part of the EQR process, health plans are required to participate in an annual performance improvement project. In 2014, plans began a new three year cycle for Performance Improvement Projects. Each plan was required to select a special population (e.g. pregnant women, children, etc.). Each plan's proposed project was validated by the MDHHS EQR vendor prior to implementation of interventions. In 2016, plans are in year three of the project and completed a final evaluation of outcomes.

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. Healthy Michigan Plan members are included in these reports as they become eligible for measures. 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 run fifteen Adult Core Set measures out of the Data Warehouse, including breakouts by Healthy Michigan Plan and traditional Medicaid. In fall of 2015, standards were set for approximately half these measures and plan performance was compared against these standards in 2016. The Michigan Medicaid HEDIS 2016 Results Statewide Aggregate Report and January 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 2016 Adult Medicaid Health Plan CAHPS Report as an attachment. In 2016, MDHHS conducted a Healthy Michigan Plan specific CAHPS survey. MDHHS has also included the Healthy Michigan Plan CAHPS Reports 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 2016, August 2016 and November 2016. 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. The University of Michigan's Institute for Healthcare Policy and Innovation published a summary of the Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan survey findings. This provided the much needed perspective of

Michigan's primary care practitioners. Overall, most primary care practitioners reported that the Health Risk Assessments were a helpful component of caring for Healthy Michigan Plan members. These primary care practitioners found that the Health Risk Assessment process facilitated the discussion and identification of health risks.

While MDHHS learned about some of the positive impacts of the Health Risk Assessment process, MDHHS also learned what can be improved. This year, MDHHS continued crafting proposals to improve the Health Risk Assessment form, submission process, and program participation. Based on feedback collected by the demonstration evaluator, providers are interested in a streamlined approach to document submission. MDHHS is working toward the goal of a single submission portal for providers to securely submit Health Risk Assessments. Additional questions and goals are also being considered for a future improved Health Risk Assessment form to inform service delivery and improve Healthy Behavior program participation. MDHHS continues to identify and embrace measures to improve Healthy Michigan member experiences and outcomes.

As the Healthy Michigan Plan program has matured, MDHHS has incorporated stakeholder feedback into program-related changes. For example, the MI Health Account statements were revised as a direct result of feedback received from members and stakeholders. MDHHS has learned through the revision experience how to incorporate the needs of the department with that of stakeholders in a single member-friendly statement. Additionally, MDHHS has learned through translating these changes into system enhancements that lags in associated reporting can occur.

This year, MDHHS worked with the Medicaid Health Plans to address an unanticipated challenge in the MI Health Account process identifying individuals that left consistent failure to pay status and earned a gift card. MDHHS did not anticipate the system implications associated with issuing gift cards after a member was restored to good payment status. Without reconciling the upgraded payment status with the quarter in which the incentive was earned, a gift card would not have been issued. To insure that members receive earned healthy behaviors, MDHHS and the Medicaid Health Plans designed a quarterly lookback process to identify members previously in consistent failure to pay status that met their payment obligation and earned a gift card.

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. Additionally, IHPI began preliminary analysis of the Medicare cost data. Further, IHPI utilized Medicaid cost data to examine changes in uncompensated care for fiscal years 2013 to 2015. IHPI obtained the most recent IRS Form 990 data and extracted data from the Healthcare Cost and Utilization Project (HCUP) Fast Stats Program. The analyses of this data will complement those conducted with the Cost Report Data. IHPI began its preliminary analysis of studying how uncompensated care has changed among states that implemented Medicaid Expansion.

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 completed a data update with the most recent American Community Survey (ACS) data to investigate and understand the differences in the estimated insurance coverage rates between US Census Bureau data sources. Also, IHPI continues to track academic literature inform their analysis of the Heathy Michigan Plan.

Domain III
Domain III will assess health behaviors, utilization and health outcomes for individuals enrolled in the Healthy Michigan Plan. At the beginning of the year, IHPI determined exclusion criteria for baseline rate analyses. Additionally, IHPI conducted data completeness tests for outpatient visits, Emergency Room visits and inpatient admissions to ensure adequate run-out for claims analysis. They also investigated potential problems with ICD-9 to ICD-10 comparability for classification of chronic disease groups. Lastly, IHPI studied data issues with cost fields.

Domain IV
Domain IV will examine beneficiary and provider viewpoints of the Healthy Michigan Plan through surveys. This year the demonstration evaluator produced the Primary Care Practitioner and Healthy Michigan Voices Beneficiary surveys. In November 2016, data collection for the 2016 Healthy Michigan Voices Survey of current enrollees was completed with 4,108 participants. IHPI completed the descriptive analyses and the analyses of relationships among

subgroups is underway. Additionally, the 2016 Healthy Michigan Voices Survey of those who have been disenrolled is in the field and data collection is expected to be completed by March 2017.

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 updated its analytic plan and further specified cost variables and issues requiring linkages between claims and other data (e.g. enrollment, demographics, survey). They obtained claims data and tested the completeness of information on charges, approved costs and patient out-of-pocket costs. Based on the tests that were conducted to assess the validity of the data, IHPI developed further questions for MDHHS regarding the data structure and definitions.

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 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 2016 Health Risk Assessment Report
2. February 2016 MCAC Minutes
3. May 2016 MCAC Minutes
4. August 2016 MCAC Minutes
5. November 2016 MCAC Minutes
6. January 2017 Performance Monitoring Report
7. January 2017 MI Health Account Executive Summary
8. Michigan Medicaid HEDIS 2016 Results Statewide Aggregate Report
9. 2016 MDHHS Adult Medicaid Health Plan CAHPS Report
10. 2016 MDHHS Healthy Michigan Plan CAHPS Report

State Contacts

If there are any questions about the contents of this report, please contact one of the following people listed below.

Jacqueline Coleman, Waiver Specialist

Phone: (517) 284-1190

Carly Todd, Analyst

Phone: (517) 284-1196

Andrew Schalk, Federal Regulation & Hospital Reimbursement Section Manager

Phone: (517) 284-1195

Penny Rutledge, Actuarial Division Director

Phone: (517) 284-1191

Actuarial Division

Bureau of Medicaid Operations and Actuarial Services

MSA, MDHHS, P.O. Box 30479

Lansing, MI 48909-7979

Fax: (517) 241-5112

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Michigan Department of Health and Human Services

Medical Services Administration

Bureau of Medicaid Care Management and Quality Assurance

Healthy Michigan Plan - Health Risk Assessment Report

December 2016

Produced by:

Quality Improvement and Program Development - Managed Care Plan Divison

Table of Contents

Health Risk Assessment Part 1

Health Risk Assessment Part 2

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 301,746 Health Risk Assessments were completed through Michigan ENROLLS as of December 2016. This represents a completion rate of 95.60%. 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 2016	261,417	11,585 (4.24%)
February 2016	269,644	11,983 (4.26%)
March 2016	275,839	12,239 (4.25%)
April 2016	279,562	12,476 (4.27%)
May 2016	282,318	12,620 (4.28%)
June 2016	284,785	12,745 (4.28%)
July 2016	287,641	12,896 (4.29%)
August 2016	289,929	13,019 (4.30%)
September 2016	292,862	13,187 (4.31%)
October 2016	295,511	13,314 (4.31%)
November 2016	298,264	13,575 (4.35%)
December 2016	301,746	13,879 (4.40%)

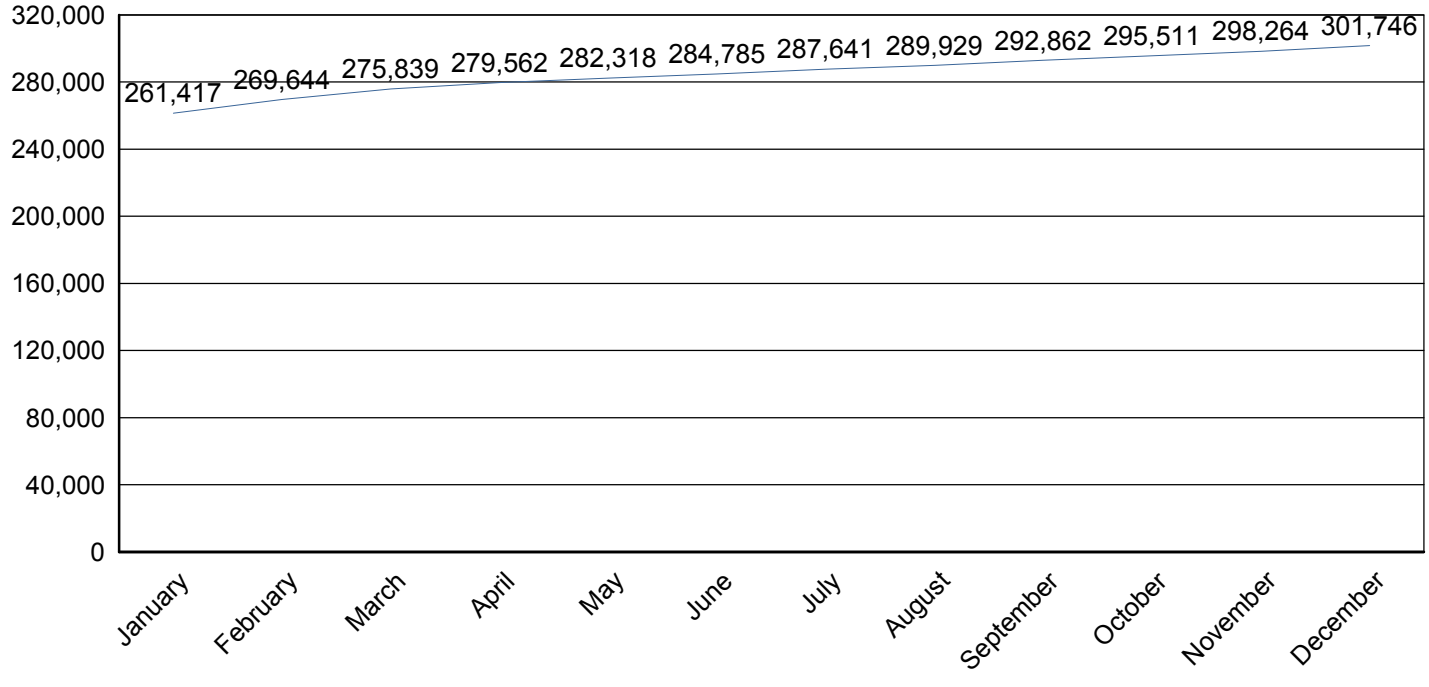
Table 11. Demographics of Population that Completed HRA Questions 1-9 with MI ENROLLS

January 2014 - December 2016

AGE GROUP	COMPLETED HRA	
19 - 29	71,978	23.85%
30 - 39	64,270	21.30%
40 - 49	61,735	20.46%
50 - 59	72,955	24.18%
60 +	30,808	10.21%
GENDER		
F	162,579	53.88%
M	139,167	46.12%
FPL		
< 100% FPL	249,074	82.54%
100 - 133% FPL	52,672	17.46%
TOTAL	**301,746**	**100.00%**

Figure I-1. Health Risk Assessments Completed with MI ENROLLS

December 2016



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 2016. Among enrollees who completed the survey, this question had a 0.17% refusal rate.

Table 1. Health Rating for Total Population

December 2016

HEALTH RATING	TOTAL	PERCENT
Excellent	34,087	11.30%
Very Good	78,094	25.88%
Good	107,842	35.74%
Fair	61,265	20.30%
Poor	19,960	6.62%
Refused	498	0.17%
TOTAL	**301,746**	**100.00%**

Figure 1-1. Health Rating for Total Population

December 2016

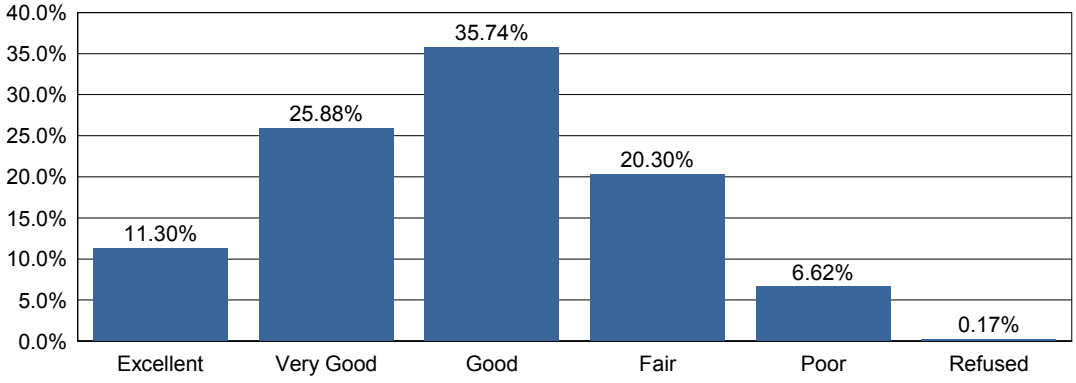


Figure 1-2. Health Rating by Age

December 2016

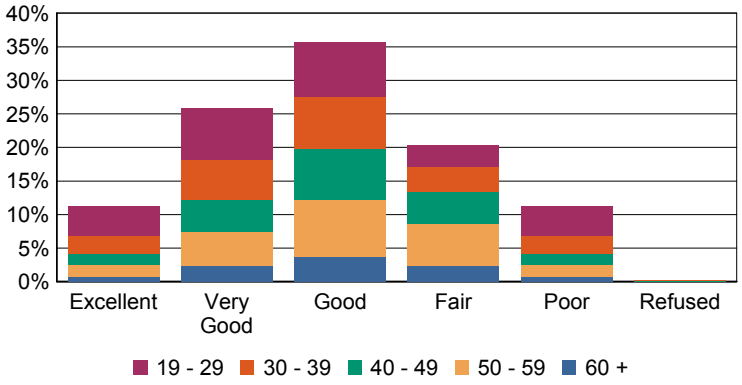
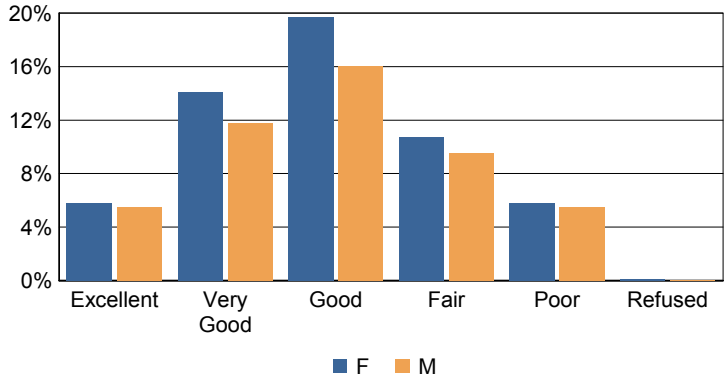


Figure 1-3. Health Rating by Gender

December 2016



Question 2. Exercise

Question 2. In the last 7 days, how often did you exercise for at least 20 minutes a day? 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 2016. Among enrollees who participated in the survey, there was a 1.51% 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 2016

EXERCISE	TOTAL	PERCENT
Every Day	69,176	22.93%
3-6 Days	88,048	29.18%
1-2 Days	74,484	24.68%
No Days	65,475	21.70%
Refused	4,563	1.51%
TOTAL	**301,746**	**100.00%**

Figure 2-1. Exercise Reported for Total Population

December 2016

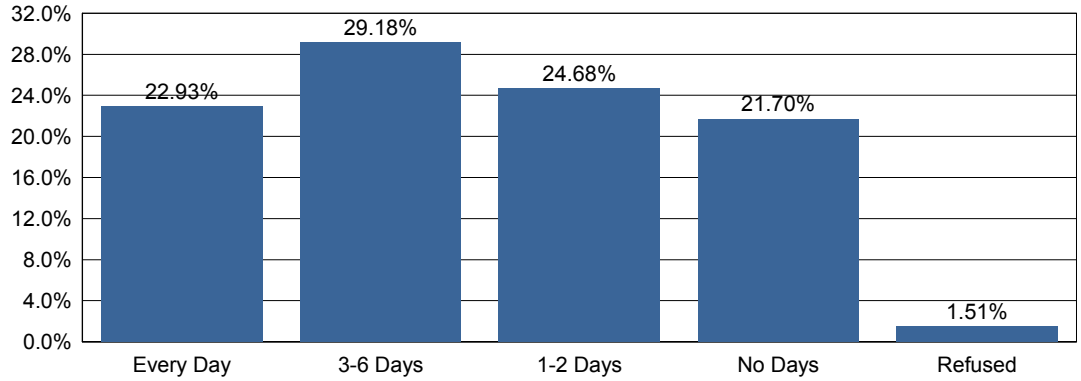


Figure 2-2. Exercise Reported by Age

December 2016

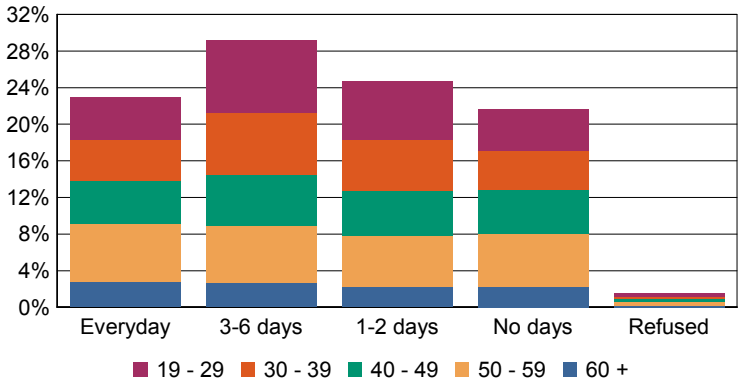
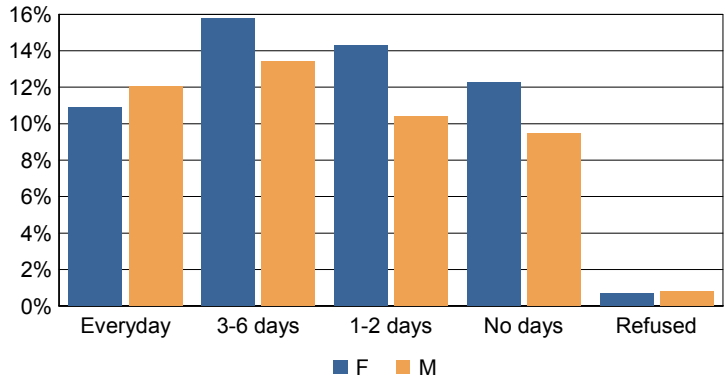


Figure 2-3. Exercise by Gender

December 2016



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 2016. Among enrollees who participated in the survey, there was a 1.87% 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 2016

NUTRITION	TOTAL	PERCENT
Every Day	101,923	33.78%
3-6 Days	104,654	34.68%
1-2 Days	68,866	22.82%
No Days	20,662	6.85%
Refused	5,641	1.87%
TOTAL	**301,746**	**100.00%**

Figure 3-1. Nutrition Reported for Total Population
December 2016

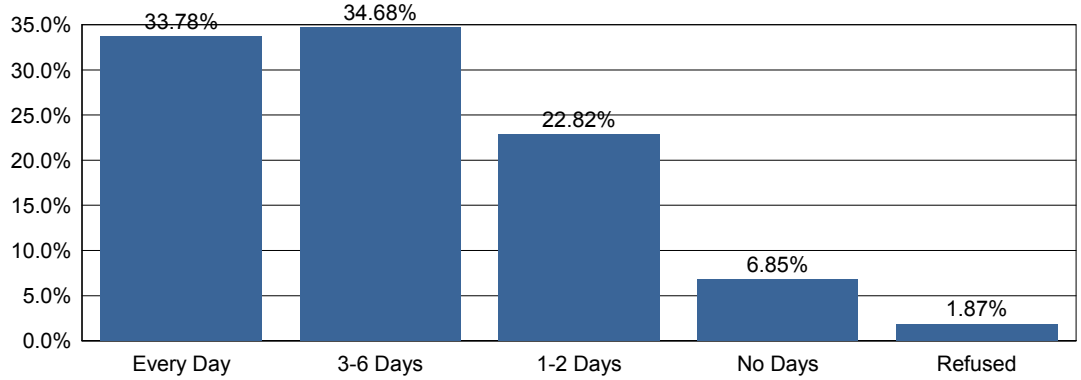


Figure 3-2. Nutrition Reported by Age
December 2016

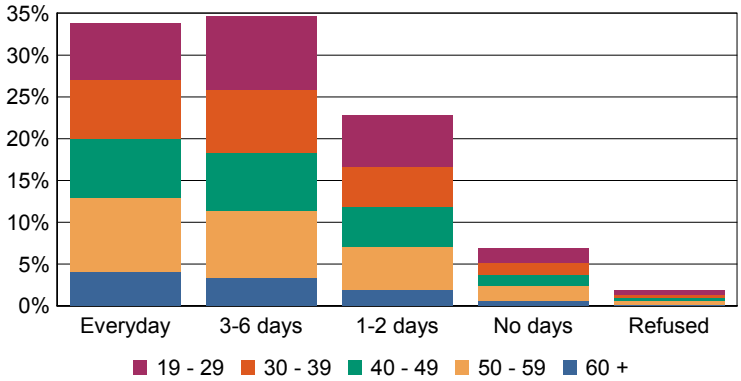
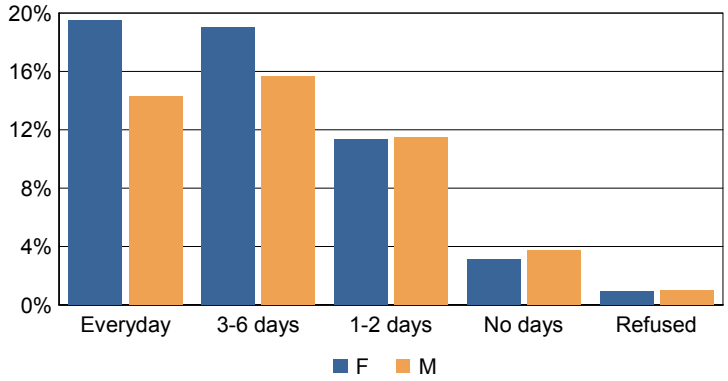


Figure 3-3. Nutrition by Gender
December 2016



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 2016. Among enrollees who participated in the survey, there was a 0.82% 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 2016

ALCOHOL	TOTAL	PERCENT
Never	249,684	82.75%
Once a Week	33,489	11.10%
2-3 times a Week	13,023	4.32%
More than 3	3,066	1.02%
Refused	2,484	0.82%
TOTAL	**301,746**	**100.00%**

Figure 4-1. Binge Alcohol Use Reported for Total Population

December 2016

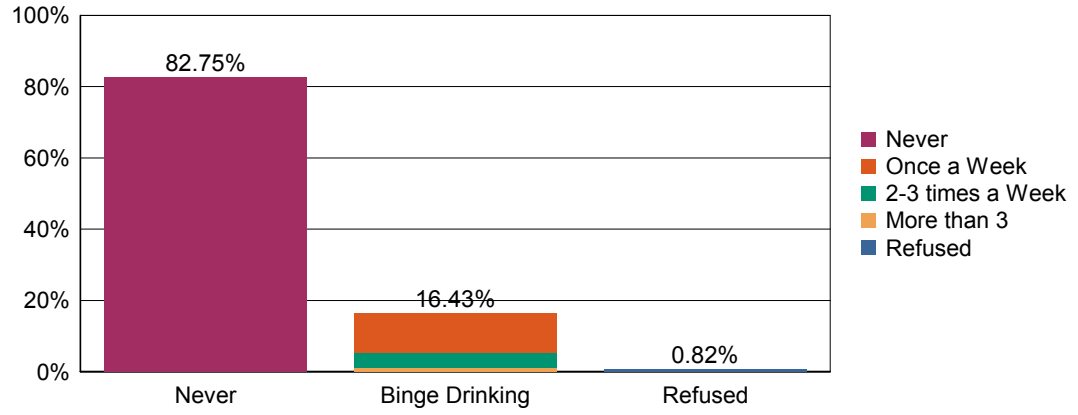


Figure 4-2. Binge Alcohol Use Reported by Age

December 2016

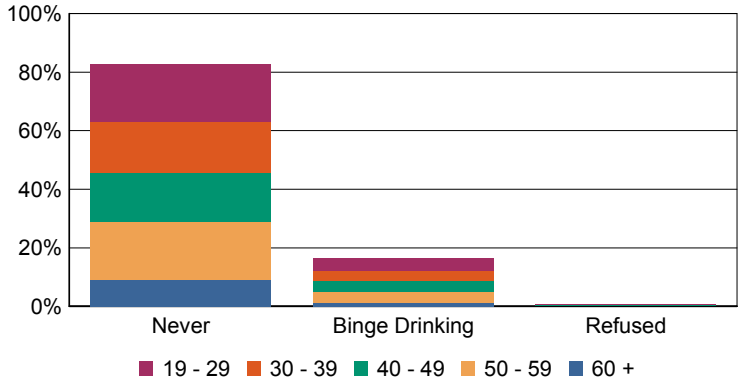
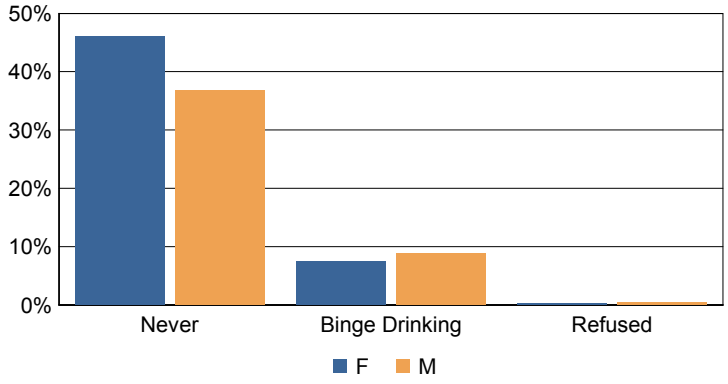


Figure 4-3. Binge Alcohol Use by Gender

December 2016



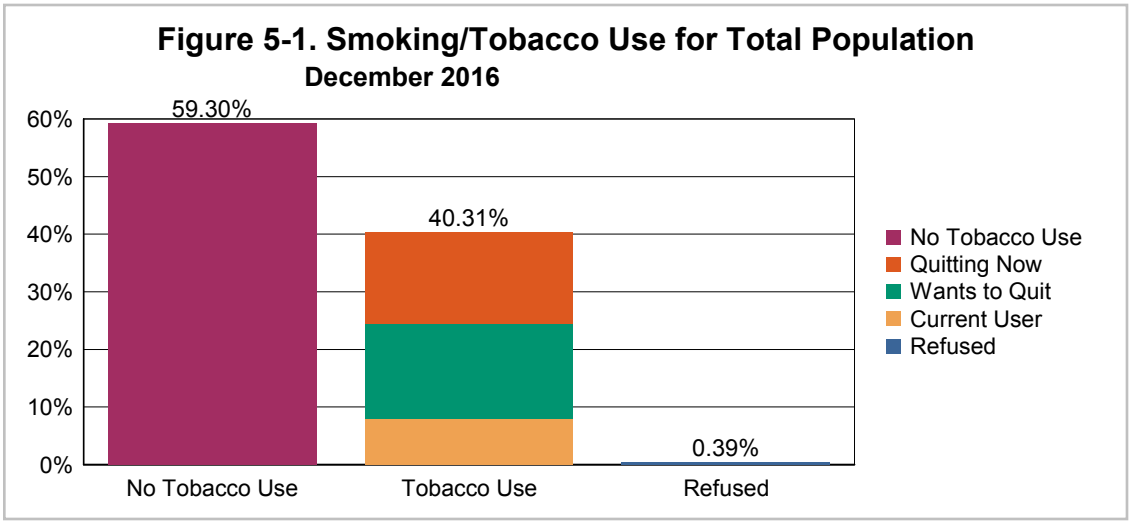
Question 5. Smoking/Tobacco Use

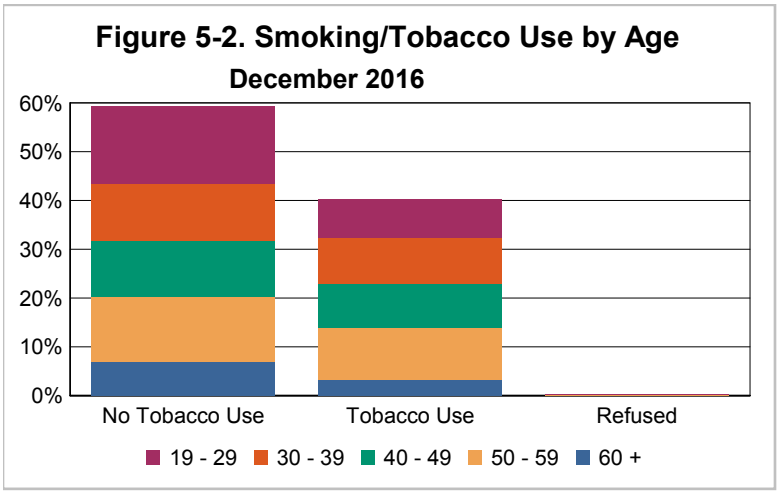
Question 5. In the last 30 days, have you smoked or used tobacco? This question is used to assess self-reported smoking/tobacco use. Healthy Michigan Plan enrollees were given the answer options of yes or no. Enrollees who answered yes, were asked a follow-up question: If YES, do you want to quit smoking 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 2016. Question 5 had a 0.39% refusal rate. Figures 5-1 through 5-3 show smoking/tobacco use reported for the total population, and by age and gender.

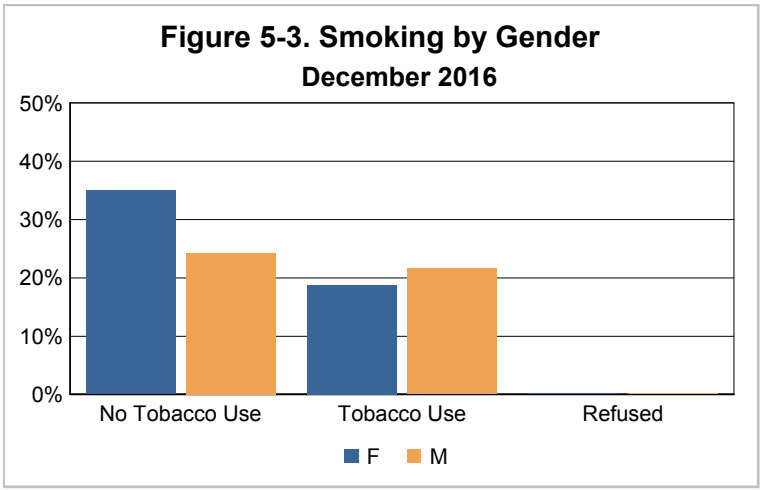
Table 5. Smoking/Tobacco Use Reported for Total Population

December 2016

TOBACCO USE	TOTAL	PERCENT
No Tobacco Use	178,926	59.30%
Quitting Now	47,991	15.90%
Wants to Quit	49,263	16.33%
Current User	24,381	8.08%
Refused	1,185	0.39%
TOTAL	**301,746**	**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 2016. Among enrollees who participated in the survey, there was a 10.07% 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 2016

DEPRESSION	TOTAL	PERCENT
Almost Every day	62,500	20.71%
Sometimes	79,281	26.27%
Rarely	63,839	21.16%
Never	65,753	21.79%
Refused	30,373	10.07%
TOTAL	**301,746**	**100.00%**

Figure 6-1. Anxiety and Depression Reported for Total Population
December 2016

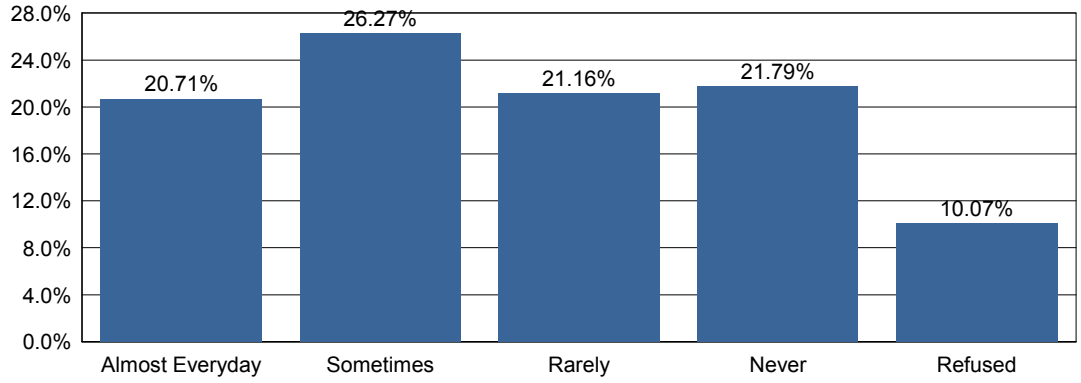


Figure 6-2. Anxiety and Depression Reported by December 2016 Age

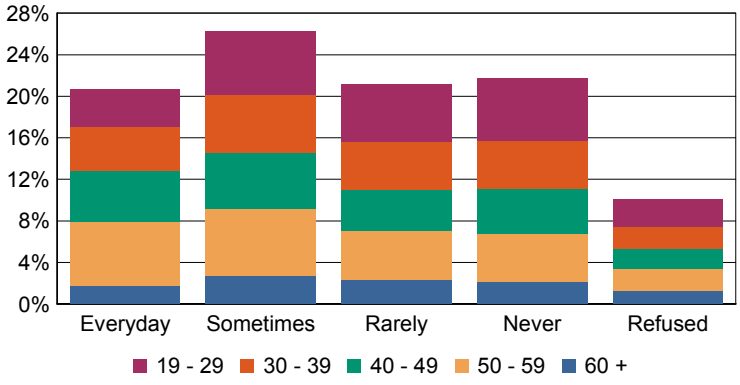
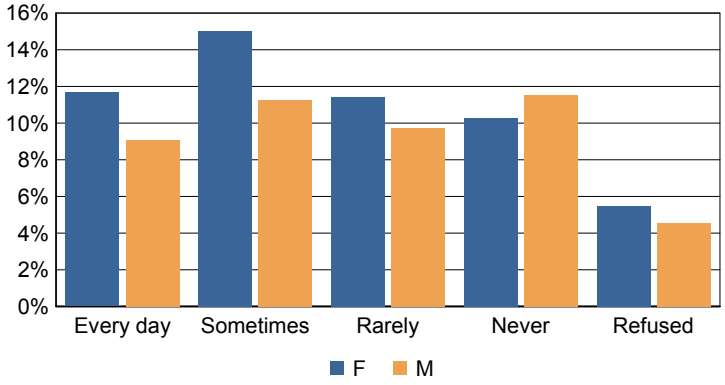


Figure 6-3. Anxiety and Depression by Gender
December 2016



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 2016. Among enrollees who participated in the survey, there was a 0.74% 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 2016

SUBSTANCE USE	TOTAL	PERCENT
Almost Every Day	5,831	1.93%
Sometimes	7,771	2.58%
Rarely	7,085	2.35%
Never	278,816	92.40%
Refused	2,243	0.74%
TOTAL	**301,746**	**100.00%**

Figure 7-1. Substance Use Reported for Total Population

December 2016

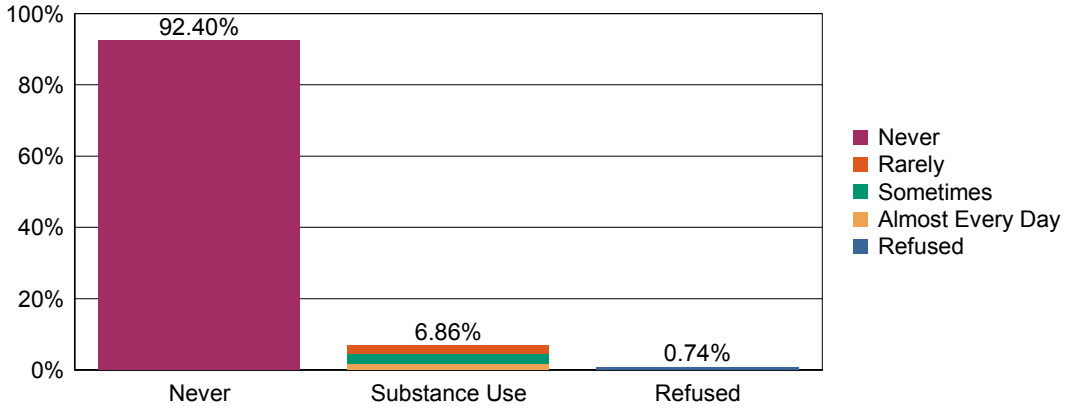


Figure 7-2. Substance Use Reported by Age

December 2016

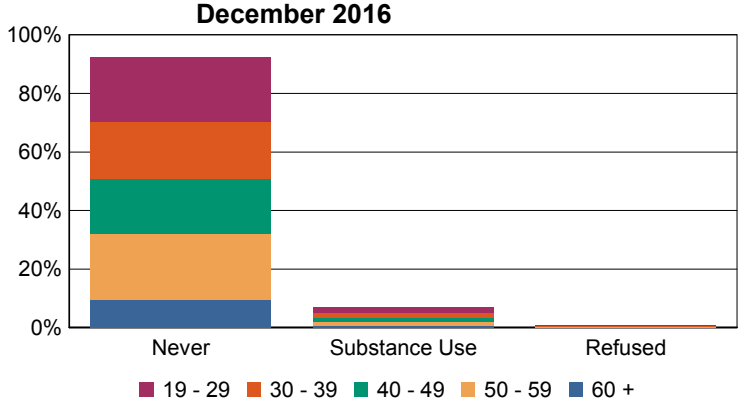
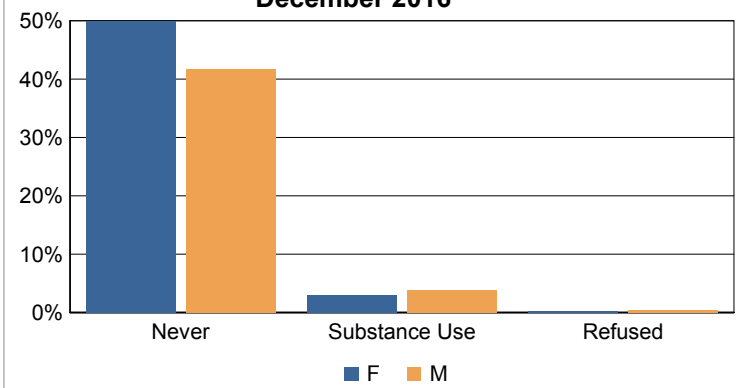


Figure 7-3. Substance Use by Gender

December 2016



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 2016. Among enrollees who participated in the survey, there was a 1.83% 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 2016

IMMUNIZATION	TOTAL	PERCENT
Yes	67,166	22.26%
No	229,066	75.91%
Refused	5,514	1.83%
TOTAL	**301,746**	**100.00%**

Figure 8-1. Immunization Status Reported for Total Population

December 2016

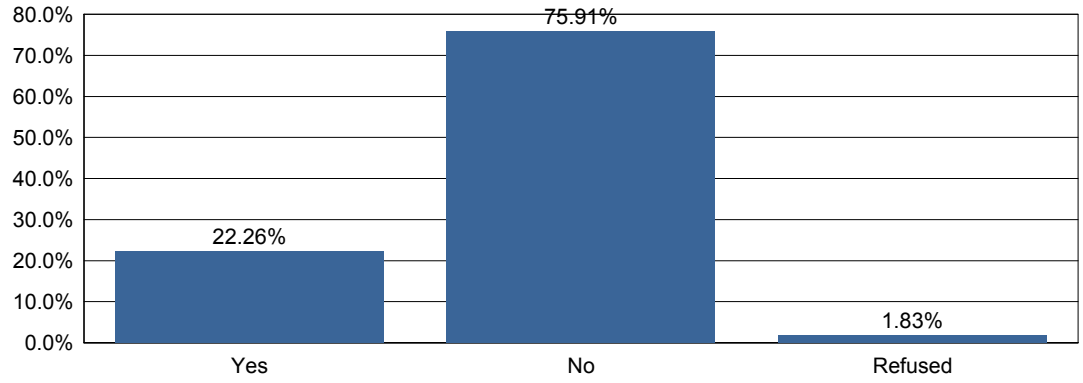


Figure 8-2. Immunization Status Reported by Age

December 2016

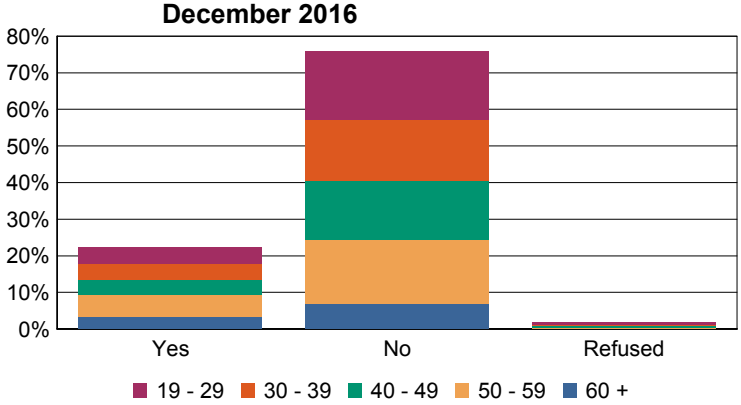
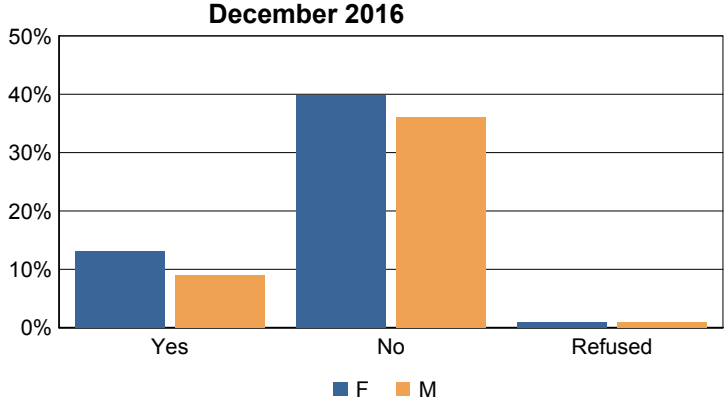


Figure 8-3. Immunization Status by Gender

December 2016



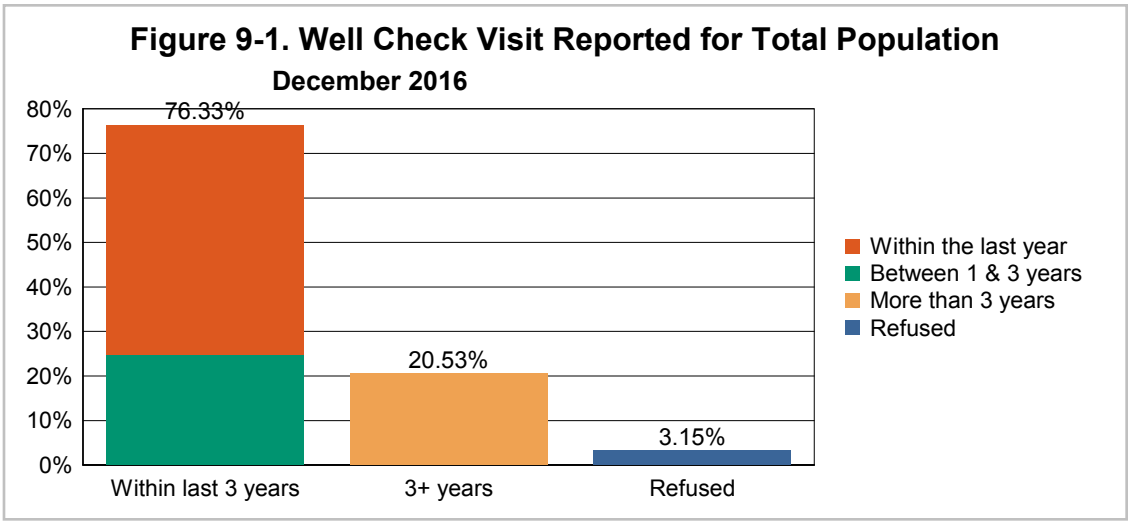
Question 9. Well Check Visit

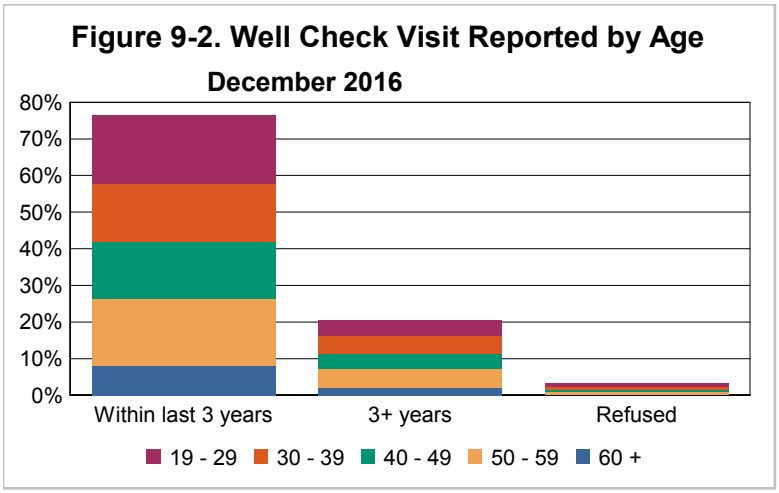
Question 9. A checkup is a visit to a doctor's office that is NOT for a specific problem. How long has it been since your last check-up? This question is used to assess self-reported well check visit. Healthy Michigan Plan enrollees were given the answer options of within the last year, between 1-3 years and more than 3 years. Table 9 shows the overall answers to this question for December 2016. Among enrollees who participated in the survey, there was a 3.15% 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.

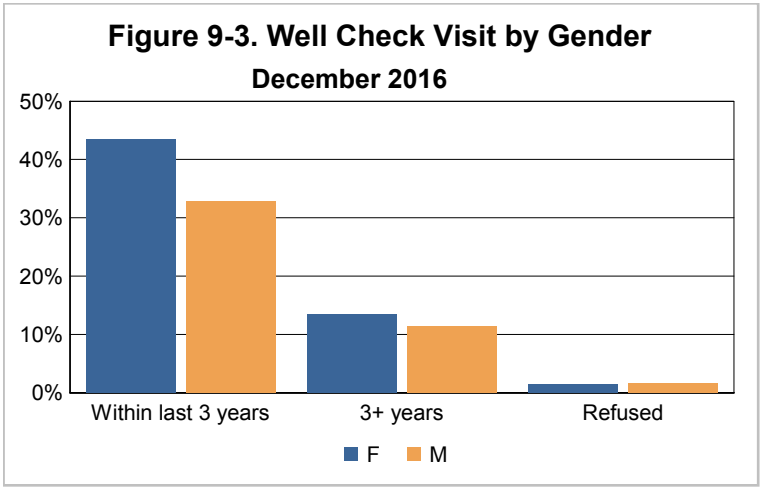
Table 9. Well Check Visit Reported for Total Population

December 2016

CHECK-UP	TOTAL	PERCENT
Within the last year	155,406	51.50%
Between 1 & 3 years	74,904	24.82%
More than 3 years	61,946	20.53%
Refused	9,490	3.15%
TOTAL	**301,746**	**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 763,066 beneficiaries who have been enrolled in a health plan for at least six months, 132,749 or 17.4% have completed the Health Risk Assessment with their primary care provider as of December 2016.

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 162,167 Health Risk Assessments were completed with primary care providers as of December 2016. Health Risk Assessment completion is reported by age, gender and Federal Poverty Level in Table 11.

Among beneficiaries who completed the Health Risk Assessment, 139,124 or 85.8% of beneficiaries agreed to address health risk behaviors. In addition, 21,631 or 13.3% 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 139,124 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 2016	5,139	109,833
February 2016	6,205	116,044
March 2016	6,546	122,605
April 2016	5,667	128,284
May 2016	5,381	133,682
June 2016	5,018	138,727
July 2016	4,274	143,066
August 2016	5,249	148,368
September 2016	4,449	152,843
October 2016	4,487	157,356
November 2016*	3,977	161,355
December 2016*	812	162,167

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

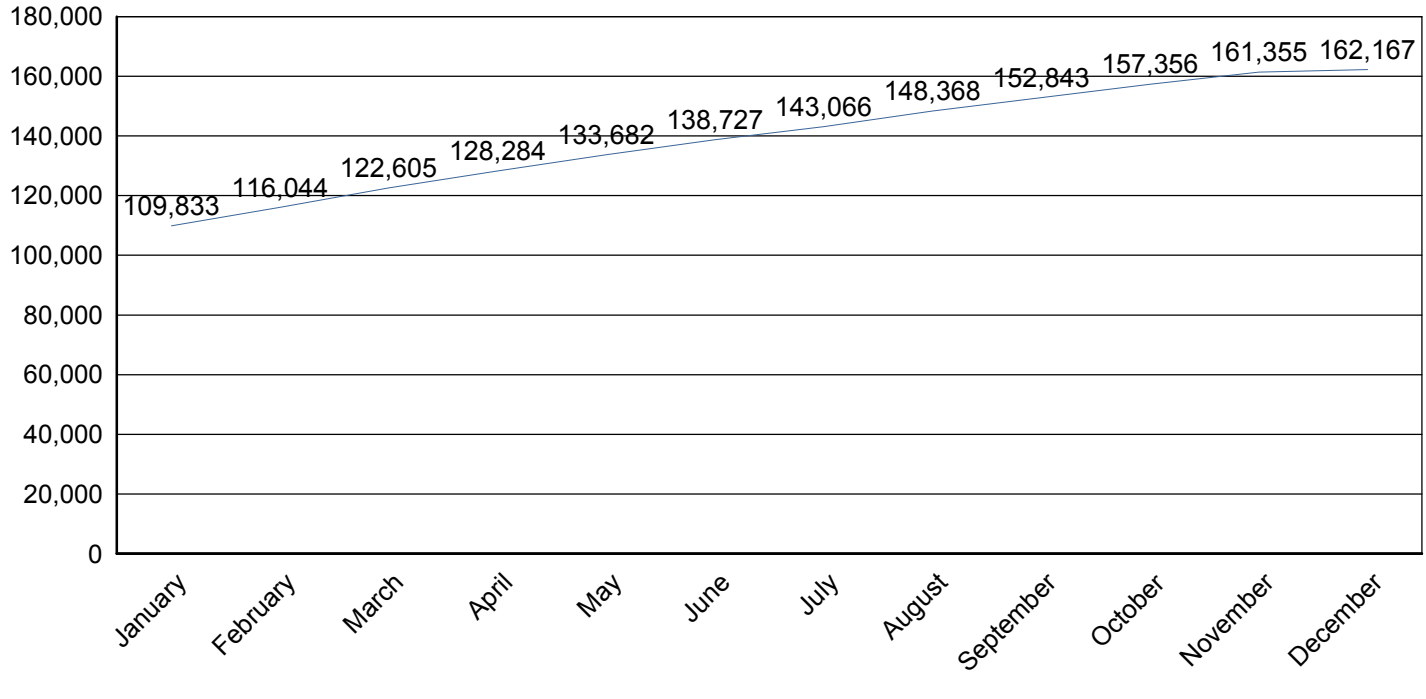
Table 11. Demographics of Population that Completed HRA with Primary Care Provider

September 2014 - December 2016

AGE GROUP	COMPLETED HRA	
19 - 29	32,719	20.18%
30 - 39	28,441	17.54%
40 - 49	31,400	19.36%
50 - 59	46,745	28.83%
60 +	22,862	14.10%
GENDER		
F	93,305	57.54%
M	68,862	42.46%
FPL		
< 100% FPL	131,189	80.90%
100 - 133% FPL	30,978	19.10%
TOTAL	**162,167**	**100.00%**

Figure 10-1. Health Risk Assessments Completed with Primary Care Provider

December 2016



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

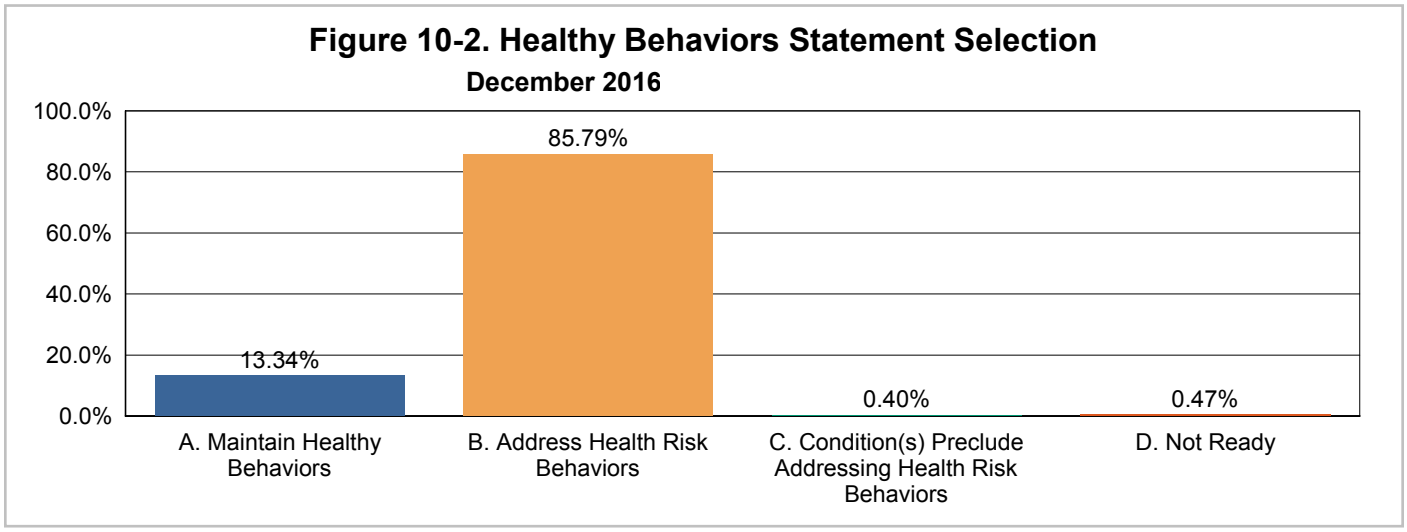
C. Patient has a serious medical, behavioral or social condition or conditions which precludes addressing unhealthy behaviors at this time.

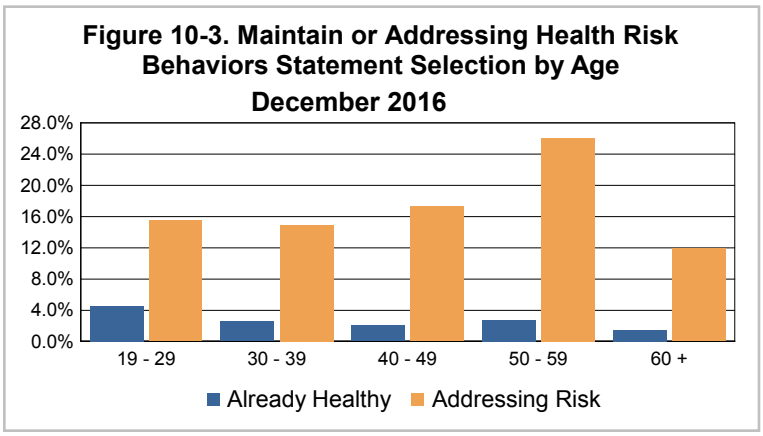
D. Unhealthy behaviors have been identified, patient's readiness to change has been assessed, and patient is not ready to make changes at this time.

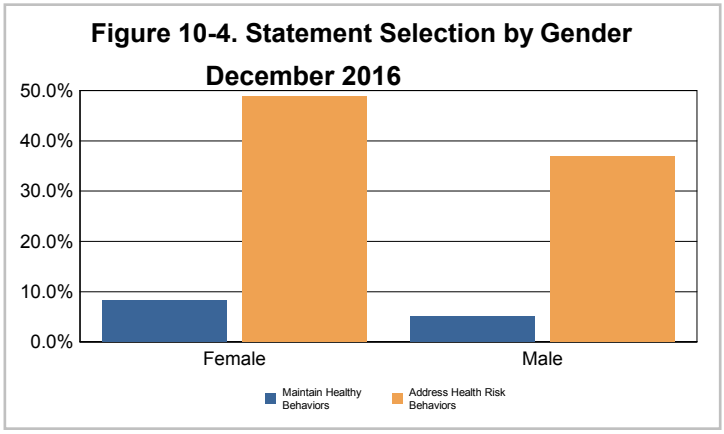
Figures 10-2 through 10-4 show Healthy Behaviors Statement Selections for the total population, and by age and gender.

Table 12. Healthy Behaviors Statement Selection
December 2016

CHECK-UP	TOTAL	PERCENT
A. Maintain Healthy Behaviors	21,631	13.34%
B. Address Health Risk Behaviors	139,124	85.79%
C. Condition(s) Preclude Addressing Health Risk Behaviors	655	0.40%
D. Not Ready	757	0.47%
TOTAL	**162,167**	**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 139,124 HRAs submitted through December 2016 where the beneficiary chose to address health risk behaviors, 60.29% 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

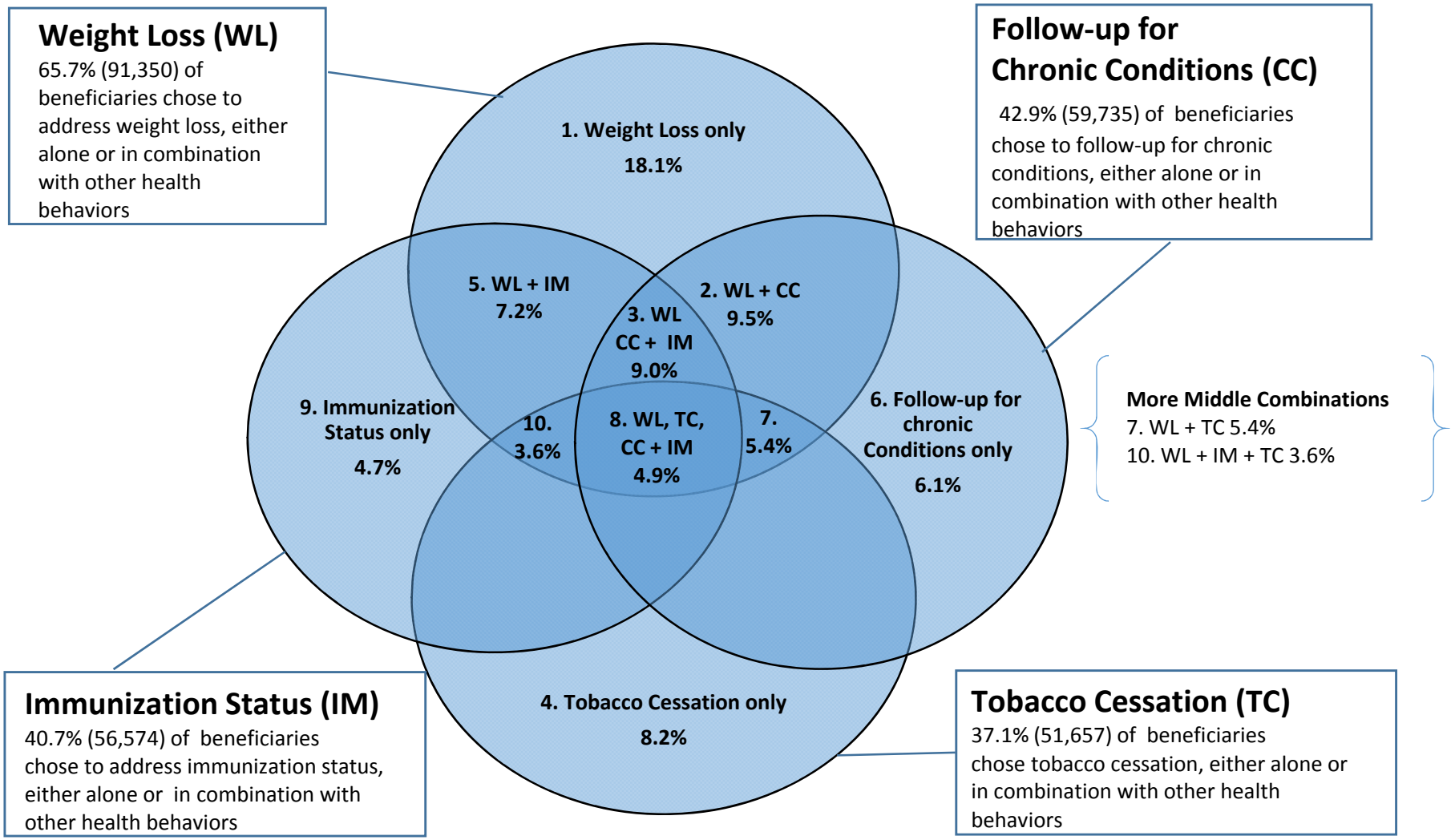
Health Risk Behavior Combination	Count	Percent
1. Weight Loss ONLY	25,117	18.05%
2. Weight Loss, Follow-up for Chronic Conditions	13,203	9.49%
3. Weight Loss, Immunization Status, Follow-up for Chronic Conditions	12,499	8.98%
4. Tobacco Cessation ONLY	11,463	8.24%
5. Weight Loss, Immunization Status	10,062	7.23%
6. Follow-up for Chronic Conditions	8,529	6.13%
7. Weight Loss, Tobacco Cessation	7,611	5.47%
Total for Top 7	88,484	63.60%
Total for All Other Combinations	50,640	36.40%
Total	**139,124**	**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	65.66%	18.05%
Tobacco Cessation	37.13%	8.24%
Immunization Status (Annual Flu Vaccine)	40.66%	4.75%
Follow-up for Chronic Conditions	42.94%	6.13%
Addressing Alcohol Abuse	4.48%	0.36%
Addressing Substance Abuse	1.20%	0.11%
Other	4.88%	2.07%

Health Risk Assessment Completion with Primary Care Provider

Representation of the overlapping nature of top 10 health risk behavior selections December 2016



Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Monday, February 29, 2016

Time: 1:00 pm – 4:30 pm

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

Attendees: **Council Members:** Robin Reynolds, Karlene Ketola, Cheryl Bupp, Marie DeFer, Warren White, Cindy Schnetzler, Jan Hudson, Barry Cargill, Marion Owen, Alison Hirschel, Marilyn Litka-Klein, Robert Sheehan, Amy Zaagman, Elmer Cerano, Linda Vail, Rebecca Blake, Mark Klammer, Kimberly Singh, Dave Lalumia, Andrew Farmer, Eric Roath, Susan Yontz, (for Dave Herbel), William Mayer, April Stopczynski, Lydia Starrs (for Rebecca Cienki)

Staff: Chris Priest, Dick Miles, Kathy Stiffler, Lynda Zeller, Farah Hanley, Jackie Prokop, Brian Keisling, Erin Emerson, Pamela Diebolt, Cindy Linn, Michelle Best, Logan Dreasky

Other Attendees: Marc Arnold, Dominic Pallone

Welcome and Introductions

Robin Reynolds opened the meeting and introductions were made.

Update on Flint

The Michigan Department of Health and Human Services (MDHHS) has submitted a waiver request to the Centers for Medicare and Medicaid Services (CMS) to address issues related to the Flint water crisis. Pending CMS approval, MDHHS will:

- Expand Medicaid eligibility to children up to age 21 and pregnant woman who;
  - Are served by the Flint water system or were served by the Flint water system between April 2014 and the date on which the Flint water system is deemed safe by the appropriate authorities, AND
  - Have household incomes up to 400 percent of the federal poverty level (FPL). Individuals up to age 21 and pregnant women with household income above 400 percent FPL can buy in to unsubsidized coverage under the program.
- Establish a targeted case management group and services for children up to age 21 and pregnant women as described above.
- Utilize Medicaid resources for lead abatement in Flint.

The waiver documents are available on the MDHHS website at www.michigan.gov/mdhhs >> Section 1115 Waiver – Expanded Medicaid Eligibility for Flint Residents. Individuals may submit comments related to the waiver to MSAPolicy@michigan.gov until March 17, 2016. MDHHS expects that up to 15,000 individuals will be newly eligible for Medicaid coverage under the waiver, and is working with its health plan partners in the area on testing and outreach to vulnerable populations.

A council member requested that MDHHS consider submitting a State Plan Amendment to expand Children's Health Insurance Program (CHIP) coverage to lawfully present immigrant children and pregnant women in the Flint area who have resided in the United States for less than five years.

Healthy Michigan Plan

Waiver Approval

MDHHS has received CMS approval for a second waiver related to the Healthy Michigan Plan. Under the terms of the waiver beginning April 1, 2018, which is 48 months after the initial implementation of the Healthy Michigan Plan, individuals who have been enrolled in the Healthy Michigan Plan for at least 12 months and have incomes above 100 percent FPL may either:

- Complete a Health Risk Assessment (HRA) and choose to engage in one or more healthy behaviors, and remain on the Healthy Michigan Plan, or
- Leave the Healthy Michigan Plan and receive insurance from the Federally Facilitated Marketplace (FFM).

Copayment and cost-sharing obligations for beneficiaries who elect to leave the Healthy Michigan Plan and receive insurance through the FFM will remain the same; however, they will only be eligible for reductions in their copayment and cost-sharing requirements if they remain on the Healthy Michigan Plan and choose to engage in one or more healthy behaviors. Wraparound services will be available to Healthy Michigan Plan beneficiaries who purchase coverage on the FFM through Medicaid Fee-for-Service. MDHHS must also seek approval for revised Healthy Behavior Protocols from CMS.

As discussed at the Medical Care Advisory Council (MCAC) meeting in November, Kathy Stiffler announced that MDHHS intends to distribute a Provider Satisfaction Survey for providers who actively participate with the Medicaid Health Plans in the spring of 2016.

A meeting attendee also requested that MDHHS allow beneficiaries to submit their own documentation related to the HRA and Healthy Behavior attestations instead of relying on the Medicaid Health Plans (MHPs).

FY2017 Executive Budget Recommendation

Budget Recommendation

The Governor recommended an appropriation of $24.7 billion gross and $4.4 billion General Fund (GF) for MDHHS in FY 2017, which accounts for an expected decline in traditional Medicaid caseload in FY 2017. Other highlights of the Executive Budget Recommendation include:

- $26.3 million in spending to reflect cost increases driven by a new policy that expands autism coverage for children up to age 21
- $118 million in spending for a 2% actuarial soundness rate increase for Medicaid Health Maintenance Organizations (HMOs) and a 1.5% increase for Prepaid Inpatient Health Plans (PIHPs)
- Approximately $105 million in GF savings anticipated in FY 2017, FY 2018 and FY 2019 from the Healthy Michigan Plan hospital provider tax payments
- $58 million revenue adjustment from the anticipated discontinuation of the use tax on December 31, 2016 and corresponding increase in the Health Insurance Claims Assessment (HICA) tax from 0.75% to 1%
- $7.6 million to support opening a wing at the Center for Forensic Psychiatry in Ypsilanti to treat an additional 30 patients
- Approximately $50 million Gross and $4.9 million GF Information Technology (IT) funding for the Integrated Services Delivery (ISD) Model
- $7.7 million GF for the Michigan State Automated Child Welfare System (MiSACWS)
- $26 million Gross and $9 million GF to expand the ***Healthy Kids Dental*** program in Wayne, Oakland and Macomb Counties to cover children up to age 21
- $5.2 million reduction for the counties related to services for foster care due to the implementation of a county cost-sharing requirement
- $4.7 million Gross and $1 million GF to expand the current supplemental for food-related resources in Flint, including $150,000 for food inspection costs

- $1.1 million to support Child and Adolescent Health Centers in Flint, including 6 additional Pathways to Potential Community Health Workers (CHWs)
- $7 million Gross and $5 million GF for behavioral health services in Flint
- $1.5 million Gross and $1 million GF for additional lead investigations
- $2.2 million GF supplemental appropriation for Flint

In response to an inquiry regarding the proposed IT funding for the ISD model, MDHHS staff noted that the Department intends to streamline service delivery into a single system, and that existing systems are not being replaced.

A meeting attendee also asked whether additional funds will be made available to assist adults who have been exposed to lead in Flint. In response, MDHHS staff noted that most funds appropriated in response to the Flint water crisis are not age-specific, such as supplemental Community Mental Health (CMH) funding, and Local Health Department (LHD) funds for blood lead testing.

Specialty Drugs

The legislature has approved a supplemental appropriation of $164 million Gross and $46 million GF in FY 2016 for coverage of a new hepatitis C drug, and the Governor has requested an additional $164 million Gross and $45 million GF for continued coverage in FY 2017. MDHHS is expecting that approximately 7,200 beneficiaries will qualify for the medication. In addition, the Governor has requested $66.3 million Gross and $44 million GF for coverage of a new cystic fibrosis medication. Both medications are expected to become available on March 1, 2016.

Impact of Minimum Wage Increase

Farah Hanley reported that the Governor has requested funding for an adult home help provider wage increase in FY 2017. No funding has been requested at this time for a wage increase for direct care workers, though the Department has discussed the issue with the legislature.

Integration of Behavioral Health and Physical Health Boilerplate

The Michigan House of Representatives has held hearings to discuss section 298 of the FY 2017 Executive Budget Bill, which would require MDHHS to transfer funds currently provided to Prepaid Inpatient Health Plans (PIHPs) through the Medicaid mental health services, Medicaid substance use disorder services, and Healthy Michigan Plan – behavioral health and autism services lines to the Health Plan services line by September 30, 2017. The consensus is that while people believe there is a great opportunity to discuss whether the current system of integrating behavioral health and physical health is best organized to provide the best outcomes for beneficiaries, there are concerns about language that moves PIHPs and MHPs together. A workgroup has been called by the Lieutenant Governor, which is currently in the process of conducting a call for facts related to the proposed transfer of funds. Lynda Zeller encouraged the MCAC to share facts with her at zellerl2@michigan.gov. A meeting attendee requested that the workgroup consider incarcerated individuals who develop behavioral health issues that were not present prior to imprisonment.

Behavioral Health Updates

Certified Community Behavioral Health Clinics (CCBHCs)

Michigan has been selected for a planning grant to establish CCHBCs, which provide more comprehensive care than Community Mental Health Services Programs (CMHSPs). In order to be chosen as one of the eight states to receive final demonstration grants, MDHHS must submit a final application by October 31, 2016. A request for certification will be sent to clinics eligible to become CCBHCs in Mid-March, and the Department will choose the 10 applicants that present the best opportunity for success in the demonstration. MDHHS must complete all prospective CCHBC site visits by July 2016.

Managed Care

Implementation of Rebid

Kathy Stiffler provided an update on the implementation of new MHP contracts, which became effective on January 1, 2016. MDHHS is continuing to work to develop resources to define MHP expectations in several areas, including coverage of Targeted Case Management (TCM) services for children with elevated blood lead levels. The new contract also includes plans to move coverage of Maternal Infant Health Program (MIHP) services into the MHPs effective October 1, 2016. Kathy noted that that some MHPs have changed service areas as a result of the rebid, and offered to share a map of areas covered by each MHP with the MCAC (see attached map).

Common RX Formulary

MDHHS is working to implement a common drug formulary for all MHPs, and is on track to begin communications with beneficiaries regarding the transition on April 1, 2016 and complete the transition by October 1, 2016. The Department will provide an opportunity for interested stakeholders to submit comments related to the Common Formulary once each quarter.

Eligibility Redetermination Letter

MDHHS staff and meeting attendees discussed ongoing issues with the Medicaid eligibility redetermination process, including inconsistencies in the process among different areas, and beneficiaries with no change in income or assets being denied coverage upon redetermination. As a possible solution to this problem, a meeting attendee requested that MDHHS implement a simplified redetermination process for beneficiaries with no change in circumstances. Attendees also discussed the need for improved coordination among MDHHS and the MHPs for communication with beneficiaries regarding the redetermination process.

Since MI Health Link enrollees who lose eligibility upon redetermination may only be passively enrolled into an Integrated Care Organization (ICO) once per calendar year, MDHHS staff discussed the possibility of requiring ICOs to continue to provide coverage for these individuals for up to 90 days following redetermination. The Department also plans to issue a policy to allow a beneficiary to keep their case open while working through the redetermination process in both Modified Adjusted Gross Income (MAGI) and Supplemental Security Income (SSI) groups, as part of a systems release in June 2016. MDHHS staff and meeting attendees also discussed several ideas for improving the redetermination process, including the possibility of temporarily suspending redetermination while systems problems are addressed, the feasibility of using IRS tax returns for eligibility redeterminations and simplifying beneficiary notices and forms.

Long-Term Care Services and Supports Updates

MI Health Link

Dick Miles provided an update on the MI Health Link Program, and noted that enrollment is a concern. At the end of the passive enrollment period in September, total enrollment in MI Health Link included 42,500 beneficiaries, and has since declined to 32,800. In addition to the issues related to eligibility redeterminations experienced by many Medicaid programs, MI Health Link is also experiencing problems with enrollment discrepancies and systems glitches that MDHHS is working to resolve. Dick also shared that marketing will be a priority for the MI Health Link program in the future, in order to encourage more individuals to voluntarily enroll.

Nursing Home Transition

The State of Michigan was awarded a grant in 2009 to help with nursing home transitions, called "*Money Follows the Person*", and has since used those funds to transition 3,000 individuals. However, due to a recent reduction in funding by the federal government, MDHHS is currently in the process of developing a plan to reduce the size of the program.

Level of Care Determination (LOCD)

MDHHS is currently considering the conflict-free LOCD, and has received funds for the project as part of the implementation grant for MI Health Link. However, some waiver agencies have expressed concern about how the new system will impact their processes. No successful bidders were received after the Department issued a Request for Proposal (RFP) for conflict-free LOCDs in the fall of 2015. MDHHS is in the process of working with CMS to determine CMS's legal authority for the conflict free LOCD mandate.

Policy Updates

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

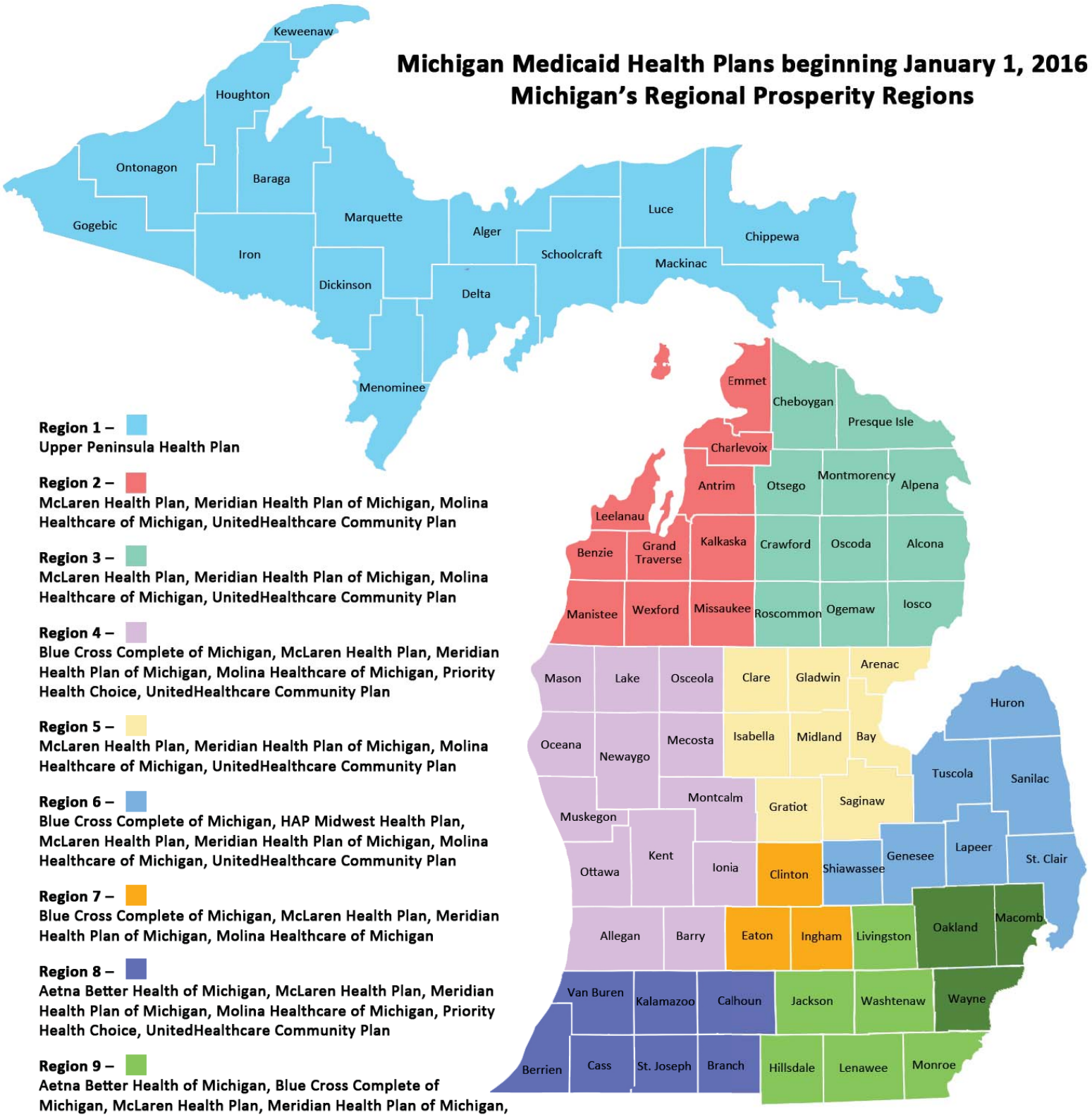
Consumer Representation for 2016 Update

Robin Reynolds welcomed a new MCAC member as a consumer representative, and discussed with MDHHS staff and meeting attendees ideas for reaching out to other beneficiaries who may be interested in providing their input to the MCAC.

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

Next Meeting: May 10, 2016

Michigan Medicaid Health Plans beginning January 1, 2016
Michigan's Regional Prosperity Regions



Region 1 –
Upper Peninsula Health Plan

Region 2 –
McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan

Region 3 –
McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan

Region 4 –
Blue Cross Complete of Michigan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, Priority Health Choice, UnitedHealthcare Community Plan

Region 5 –
McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan

Region 6 –
Blue Cross Complete of Michigan, HAP Midwest Health Plan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan

Region 7 –
Blue Cross Complete of Michigan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan

Region 8 –
Aetna Better Health of Michigan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, Priority Health Choice, UnitedHealthcare Community Plan

Region 9 –
Aetna Better Health of Michigan, Blue Cross Complete of Michigan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, UnitedHealthcare Community Plan

Region 10 –
Aetna Better Health of Michigan, Blue Cross Complete of Michigan, Harbor Health Plan, McLaren Health Plan, Meridian Health Plan of Michigan, Molina Healthcare of Michigan, Total Health Care, UnitedHealthcare Community Plan

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Tuesday, May 10, 2016
Time: 1:00 pm – 4:30 pm
Where: Michigan Public Health Institute (MPHI)
2436 Woodlake Circle
Okemos, MI

Attendees: **Council Members:** Robin Reynolds, David Herbel, Cheryl Bupp, Cindy Schnetzler, Amy Zaagman, Marie DeFer, Dave LaLumia, Barry Cargill, Kimberly Singh, Marilyn Litka-Klein, Elmer Cerano, Alison Hirschel, Dianne Haas, Lisa Braddix (for Kate Kohn-Parrott), Eric Roath, Warren White, Rebecca Blake, April Stopczynski, Pam Lupo, Mark Klammer

Staff: Chris Priest, Kathy Stiffler, Dick Miles, Brian Keisling, Jackie Prokop, Pam Diebolt, Cindy Linn, Marie LaPres, Erin Emerson

Other Attendees: Dominic Pallone

Welcome and Introductions

Robin Reynolds opened the meeting and introductions were made.

Update on Flint

The Michigan Department of Health and Human Services (MDHHS) has received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a waiver to provide coverage for children and pregnant women with incomes up to 400 percent of the federal poverty level (FPL) who were impacted by Flint water. The waiver became effective on May 9, 2016, and 94 people applied for coverage in the first day of implementation. All systems are operating smoothly, and MDHHS is focusing on outreach now that the waiver is operational. Eligible individuals may apply for coverage online at www.michigan.gov/mibridges, over the phone, or in person at any MDHHS County office. MDHHS is also working to implement a system for children and pregnant women over 400 percent of the FPL to buy unsubsidized coverage under the waiver by fall 2016.

Budget Update/Boilerplate

Chris Priest reported that the House of Representatives and the Senate have each passed a budget for fiscal year (FY) 2017, and the two bills are awaiting reconciliation in a conference committee before a final version is submitted to the governor for signature. Several differences in the two budgets were discussed, including the increase in the Private Duty Nursing (PDN)

rate (10 percent increase provided in the House budget, 20 percent increase in the Senate), and the expansion of the Healthy Kids Dental program (the Senate also allocated funds for expansion of adult dental services). The Senate also allocated funds for long-term care housing and outreach specialists in response to a reduction in the federal Money Follows the Person grant.

Healthy Michigan Plan

MDHHS has received CMS approval for a second waiver related to the Healthy Michigan Plan, and is now working to implement its provisions. Under the terms of the waiver beginning April 1, 2018, which is 48 months after the initial implementation of the Healthy Michigan Plan, individuals who have been enrolled in the Healthy Michigan Plan for at least 12 months and have incomes above 100 percent FPL may either:

- Complete a Health Risk Assessment (HRA) and choose to engage in one or more healthy behaviors, and remain on the Healthy Michigan Plan, or
- Leave the Healthy Michigan Plan and receive insurance from the Federally Facilitated Marketplace (FFM).

To implement the waiver, the Department will need to seek approval from CMS for revised Healthy Behavior Protocols, define "medically frail" for purposes of the demonstration, and provide plan guidance to the health plans on the FFM. The health plans must receive guidance by no later than fall 2016 in order to develop products to offer on the FFM beginning April 1, 2018. CMS also requires that at least two plans must be offered in each county. Approximately 120,000 Healthy Michigan Plan beneficiaries currently have incomes above 100 percent FPL, though MDHHS staff noted that the number of individuals who may move to the FFM after April 1, 2018 is difficult to project. A meeting attendee requested that Healthy Michigan Plan beneficiaries be permitted to submit their own paperwork related to Health Risk Assessments to the health plans instead of relying on the physician's office.

Behavioral Health Updates

Integration of Behavioral Health and Physical Health

Since the release of the governor's FY 2017 executive budget recommendation in February 2016, which called for the integration of behavioral health and physical health services, the Lieutenant Governor has convened a stakeholder group to discuss the issue. The stakeholder group has met three times to date, with two additional meetings scheduled through June 2016. The group has defined a set of core concepts to make up the framework for a new system to integrate behavioral health and physical health services, and will discuss critical design elements for a new system and core concepts for boilerplate language at future meetings. The House and Senate budgets also propose language related to the integration of behavioral health and physical health services, and call for ongoing workgroups, as well. The stakeholder group has indicated a preference for the language proposed by the House. Additional information

related to the stakeholder group is available on the MDHHS website at www.michigan.gov/stakeholder298.

Certified Community Behavioral Health Clinics (CCBHCs)

In October 2015, Michigan became one of 25 states to receive a planning grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to establish CCBHCs. The planning grant will allow the State of Michigan to certify at least two clinics to provide intensive person-centered multi-disciplinary evidence-based screening, assessment, and diagnostic treatment and prevention services for individuals with mental health concerns. MDHHS released a request for certification in March 2016 for non-profit and government organizations, tribal health centers and federally qualified health centers to apply for certification as a CCBHC. Responses were due on May 5, 2016, and MDHHS received 28 requests for certification. The Department is now in the process of reviewing the applications to select the potential sites to participate in the planning grant, which it hopes to complete within three to four weeks. Once the sites are selected, MDHHS must conduct site visits and develop a prospective payment system. The Department must also submit an application by October 23, 2016 to be selected as one of eight states to participate in the SAMHSA demonstration grant for CCBHCs.

Eligibility Redetermination Update

MDHHS is in the process of implementing a system for passive redetermination of Medicaid eligibility for beneficiaries with a systems release scheduled in June 2016 for the Modified Adjusted Gross Income (MAGI) group. Passive redetermination for non-MAGI groups will be included in future Bridges releases. Beneficiaries who wish to be part of the passive redetermination process may provide their consent when applying for coverage. Once consent is given the Department will examine federal and state tax returns to determine subsequent eligibility for Medicaid programs without the need for additional action by the caseworker or beneficiary. In response to an inquiry, MDHHS staff and meeting attendees also discussed the income and asset limitations for Medicaid eligibility.

Federal Regulatory Guidance

Chris Priest reported on several pieces of federal regulatory guidance that have been issued by CMS recently, including:

- New rules related to Medicaid managed care with implications for MDHHS payment mechanisms, Prepaid Inpatient Health Plans (PIHPs), and many other areas;
- A new access regulation that requires MDHHS to develop a process by the end of 2016 to determine that access to care would not be harmed if Medicaid Fee-for-Service (FFS) rates are reduced;
- A new outpatient drug regulation that changes the reimbursement methodology for pharmacists as it relates to dispensing fees and ingredient costs; and
- New regulations related to mental health parity.

Chris encouraged meeting attendees to contact MDHHS with any concerns related to any new guidance from CMS, and noted that all federal rules for Medicaid are available on the CMS website at www.medicaid.gov >> Federal Policy Guidance.

Managed Care

Common RX Formulary Update

Kathy Stiffler reported that two stakeholder meetings have been held related to the implementation of a common formulary among all health plans to discuss coding changes that will need to be made as a result of the transition. The transition to a common formulary began on April 1, 2016, with a planned completion date of October 1, 2016.

Provider Surveys

MDHHS is working to develop a survey for primary care providers to give input to MDHHS related to their experience in working with the Medicaid health plans. When the survey is released, providers will be randomly assigned a health plan to evaluate, but may complete additional health plan evaluations as well.

Maternal Infant Health Program (MIHP) Transition

MDHHS has released project #1611-MIHP for public comment, which discusses the planned transition of MIHP services to the Medicaid health plans. This change will be effective October 1, 2016. In addition to accepting written comments on the proposed policy change, MDHHS has also planned meetings with MIHP providers, both in-person and through a webinar, to discuss its impact and help to ensure a smooth transition.

Long Term Care Services and Supports Updates

MI Health Link

Dick Miles announced that Pamela Gourwitz has been hired as the new director of the Integrated Care Division, which oversees the MI Health Link program for individuals who are dually eligible for Medicare and Medicaid, and provided an update on the program. Currently, 30,800 individuals total are enrolled in MI Health Link, including 1,800 individuals in nursing homes. Dick noted that enrollment has declined from 42,500 beneficiaries in September 2015, which is a result in part from beneficiaries losing Medicaid eligibility. As a solution to this problem, he reported that MDHHS is working to implement a new process known as deeming, in which MI Health Link beneficiaries who lose Medicaid eligibility may remain enrolled in MI Health Link for up to 90 days while their eligibility status is resolved. The next passive enrollment period for MI Health Link begins in June 2016, in which all individuals in the four demonstration regions (Upper Peninsula, Southwest Michigan, Wayne County and Macomb County) who are dually eligible for Medicare and Medicaid will be enrolled into MI Health Link if

they have not chosen to opt out. MDHHS is also working with its integrated care organization partners and provider groups to update its marketing strategy for the demonstration in order to encourage more eligible individuals to enroll voluntarily. A stakeholder meeting is planned for fall 2016.

A meeting attendee asked how the process of deeming within MI Health Link would affect PIHPs. In response, Dick noted that the Medical Services Administration has discussed the issue with the Behavioral Health and Developmental Disabilities Administration and determined that the PIHPs who participate with MI Health Link would continue use their own discretion regarding whether to provide services to an individual who has lost Medicaid eligibility. Unlike Integrated Care Organizations, PIHPs are not entitled to retroactive reimbursement for services rendered in the event that a beneficiary's Medicaid eligibility is restored.

A meeting attendee also requested information on why the individuals currently enrolled in MI Health Link chose to remain in the program while others disenrolled. In response, Dick reported that MDHHS is working with Michigan State University (MSU) to conduct a survey of MI Health Link beneficiaries regarding their experience with the demonstration.

Policy Updates

Revised Organizational Chart for MDHHS

MDHHS staff reported on organizational changes within the Department, including the migration of Children's Special Health Care Services (CSHCS) to the Medical Services Administration within the Bureau of Medicaid Care Management and Quality Assurance.

Health Homes/MI Care Team

MDHHS will implement a health home model known as MI Care Team for individuals with certain chronic conditions on July 1, 2016, with the goal of better integrating physical health and behavioral health treatment services. The Department has selected 10 federally qualified health centers in 18 counties throughout the State of Michigan to help implement the program, and expects to serve approximately 10,000-12,000 individuals per year based on available funding.

Other

MDHHS staff also discussed bulletin MSA 16-10, regarding targeted case management services for beneficiaries who were served by the Flint water system, and bulletin MSA 16-11, regarding Flint Water Group medical assistance. The public comment portion of the policy promulgation process for both bulletins is being conducted concurrently with their implementation, and interested parties may submit comments until June 8, 2016. A policy bulletin handout was also distributed to attendees.

A meeting attendee also requested clarification on eligibility requirements for the Women, Infants and Children (WIC) program. In response, MDHHS staff reported that women who are pregnant or nursing, infants and children under the age of five who are eligible for Medicaid are also eligible for WIC. The Department is also preparing to issue a press release to clarify WIC eligibility requirements.

The meeting was adjourned at 3:45 p.m.

Next Meeting: August 9, 2016

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Tuesday, August 9, 2016

Time: 1:00 pm – 4:30 pm

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

Attendees: **Council Members:** Robin Reynolds, Rebecca Blake, Susan Steinke (for Alison Hirschel), Marie DeFer, Michelle Best (for Amy Hundley), Barry Cargill, Amy Zaagman, Priscilla Cheever, Dianne Haas, William Mayer, Pam Lupo, Jeffrey Towns, Vicki Kunz (for Marilyn Litka-Klein), David Herbel, Robert Sheehan, Lisa Dedden Cooper, Kim Singh, Cheryl Bupp, Eric Roath, April Stopczynski, Warren White, Karlene Ketola, Travar Pettway

Staff: Chris Priest, Dick Miles, Kathy Stiffler, Tom Renwick, Deb Eggleston, Jackie Prokop, Erin Emerson, Marie LaPres, Cindy Linn, Susan Kangas, Phillip Bergquist

Other Attendees: Tiffany Stone, Aimee Dedic, Brad Christiansen

Welcome and Introductions

Robin Reynolds opened the meeting and introductions were made.

Update on Flint

The Michigan Department of Health and Human Services (MDHHS) received approval from the Centers for Medicare and Medicaid Services (CMS) on May 9, 2016 to implement a waiver to provide coverage for children and pregnant women with incomes up to 400 percent of the federal poverty level (FPL) who were impacted by Flint water. To date, approximately 23,000 beneficiaries have enrolled in coverage under the waiver, and MDHHS is continuing to work with its partners operating in Genesee County to conduct outreach to eligible individuals.

Budget/Boilerplate Implementation

The State of Michigan budget for Fiscal Year (FY) 2017 (Public Act 268 of 2016) was signed into law on June 29, 2016, and includes an appropriation of $24.8 billion gross and $4.4 billion General Fund (GF) for MDHHS. The FY 2017 GF allocation for MDHHS represents an increase of approximately 5.5% ($230 million) from FY 2016. MDHHS staff discussed several

items contained within in the FY 2017 MDHHS budget, including:

- $110 million GF for coverage of specialty drugs to treat Cystic Fibrosis and Hepatitis C
- $83 million GF to account for a decrease in federal revenues
- $177 million GF to account for an adjustment to the Federal Medical Assistance Percentage (FMAP) for FY 2017
- $7.6 million GF to open a new wing at the Center for Forensic Psychiatry
- $8.9 million GF to complete the expansion of the ***Healthy Kids Dental*** program to cover all beneficiaries up to age 21 in Kent, Oakland and Wayne counties
- $3 million GF to increase non-Medicaid mental health services
- $1.7 million GF for a 15% Medicaid Private Duty Nursing rate increase
- $5.6 million GF for an increase of $5 per day to private foster care agencies that perform case management services
- $2.5 million GF for Senior Community Services
- A large investment in information technology for Integrated Service Delivery at MDHHS county offices and for modernization of the Michigan Statewide Automated Child Welfare Information System (MiSACWIS)
- $2.7 million GF for housing and outreach specialists to offset a reduction in federal resources for the Money Follows the Person Grant
- $172 million total reduction in funding for various MDHHS programs, which includes the discontinuation of the Health Insurance Claims Assessment (HICA)

Chris Priest provided an update on the implementation of the budget, and noted that while the Department's outlook on the budget is positive overall, several items contained in Governor Snyder's executive recommendation did not receive approval from the legislature, including a proposed reserve fund for coverage of specialty drugs.

Federal Regulatory Guidance

L Letter re: RX Reimbursement

On February 11, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a new regulation to change the reimbursement methodology for pharmacists as it relates to dispensing fees and ingredient costs. MDHHS has issued a survey to Michigan pharmacists related to the new rule, and meeting attendees were reminded that completion is mandatory, as the results will be used to determine Medicaid reimbursement rates for outpatient drugs. In response to an inquiry regarding the confidentiality of information submitted with the survey, Chris Priest indicated that MDHHS has been working with legal counsel to ensure the privacy of respondents.

Other

MDHHS is also continuing to work through CMS guidance related to Medicaid managed care and is in the process of establishing a framework to assist all impacted areas.

Healthy Michigan Plan

Beginning April 1, 2018, under the terms of a second waiver for the Healthy Michigan Plan, beneficiaries who have been enrolled in the Healthy Michigan Plan for 48 months and have incomes above 100 percent of the Federal Poverty Level (FPL) may either:

- Remain on the Healthy Michigan Plan, complete a Health Risk Assessment and engage in one or more healthy behaviors, or
- Leave the Healthy Michigan Plan and receive coverage from the Federally Facilitated Marketplace (FFM).

MDHHS is currently working with the Department of Insurance and Financial Services (DIFS) to implement the provisions of the second waiver, including:

- Establishing guidelines for Qualified Health Plans (QHPs) to offer products on the FFM for marketplace-eligible beneficiaries,
- Defining “medically frail” individuals, and
- Revising the Healthy Behaviors protocols.

In response to an inquiry, MDHHS staff noted that QHPs are not required to be Medicaid Health Plans in order to provide coverage to marketplace-eligible beneficiaries.

Managed Care

Provider Surveys

MDHHS is in the process of developing a survey for providers to give input on their experience working with the Medicaid Health Plans, and plans to distribute a draft copy to members of the Medical Care Advisory Council (MCAC) for review by the end of August 2016. When the survey is released, providers will be randomly assigned a health plan to evaluate. Once the survey is completed, the Department will share the results with the Medicaid Health Plans prior to public release.

Other

Kathy Stiffler reported that many areas within the State of Michigan continue to experience a shortage of providers of Non-Emergency Medical Transportation (NEMT) for Medicaid beneficiaries. The Department met with LogistiCare, the State's Medicaid NEMT contractor, and the participating Health Plans on June 6, 2016 to discuss ways to improve access to NEMT services, and Kathy offered to share notes from the meeting with the MCAC. MDHHS staff and meeting attendees also discussed several ideas to improve access to NEMT, including providing mileage reimbursement to Medicaid beneficiaries who own their own vehicles, and providing special arrangements for Maternal Infant Health Program (MIHP) beneficiaries.

Behavioral Health Updates

Integration of Behavioral Health & Physical Health (298)

Following the release of the Governor's Executive Budget Recommendation in February 2016, which called for the integration of behavioral health and physical health services, the Lieutenant Governor convened a work group to discuss the issue. The stakeholder group has met several times to date, and has been working to complete a set of draft recommendations for the integration of behavioral health and physical health services by October 2016 for stakeholder comment before the final report is due to the legislature in mid-January. MDHHS also plans to establish at least three "affinity groups," each consisting of a select group of stakeholders (i.e., consumers and their families, providers, and state association representatives) to provide feedback on the work group's recommendations. Additional information regarding the Stakeholder 298 Work Group is also available on the MDHHS website at www.michigan.gov/stakeholder298.

Certified Community Behavioral Health Clinics (CCBHCs)

In October 2015, the State of Michigan received a planning grant to certify at least two clinics as CCBHCs, which provide intensive person-centered multi-disciplinary evidence-based screening, assessment, and diagnostic treatment and prevention services for individuals with mental health concerns. MDHHS has received 26 applications from potential sites seeking certification as CCBHCs, and plans to choose up to 10 clinics to participate in the demonstration. A minimum of two clinics (one rural and on urban) are needed for MDHHS to submit an implementation grant application for CCBHCs, which is due by October 31, 2016.

Other

MDHHS submitted a Section 1115 waiver application to CMS in July 2016, which will allow the Department to administer behavioral health services under a single waiver authority once approved. The 30 day public comment period for the waiver application is now closed, and the Department is continuing to work through the approval process with CMS.

Eligibility Redetermination Update

Implementation Progress

In June 2016, MDHHS issued a release in Bridges to implement a system for passive redetermination of Medicaid eligibility for the Modified Adjusted Gross Income (MAGI) group, which included approximately 50 percent of the beneficiaries enrolled in MAGI programs. A second release is scheduled for October 2016 to passively enroll the remaining MAGI beneficiaries. Implementation of a system for passive redetermination for non-MAGI groups (e.g., Supplemental Security Income [SSI] recipients) is planned for in future releases beginning in January 2017. Beneficiaries who wish to be a part of the passive redetermination process must provide their consent at the time of application. Once consent is given, MDHHS will be able to access the beneficiary's federal and state tax returns for the purpose of determining subsequent eligibility for Medicaid programs. MDHHS staff and meeting attendees also discussed ideas to simplify the redetermination process.

State Innovation Model (SIM) Update

MDHHS staff provided an update on the implementation of the SIM project and gave an overview of its many components, including: a patient-centered medical home related strategy through accountable systems of care; testing of new community health innovation regions; an investment in health information technology and health information exchange; and a collaborative learning network and overall stakeholder engagement approach to policy development. MDHHS has been actively involved in stakeholder engagement regarding the SIM in recent months, and has scheduled a summit for potential SIM participants on August 10 and 11 to discuss the project.

Michigan was announced as a statewide region for the Comprehensive Primary Care Plus (CPC+) program during the week of August 1, 2016, with Medicare, Blue Cross Blue Shield of Michigan and Priority Health participating as partners. Since this announcement, MDHHS has been exploring opportunities to align its work with Patient Centered Medical Homes (PCMHs) through the SIM initiative to the CPC+ program. MDHHS staff indicated that the CPC+ program has a care model focus similar to that which was included in the Blueprint for Health Innovation and the SIM. The Department is also in the process of developing a concept paper for a custom demonstration option to engage providers that were excluded from the CPC+ program. Medicaid is not included as a participating partner in CPC+, though a practice may

participate with Medicare, Medicaid, and commercial payers by taking part in CPC+ and the PCMH SIM initiative simultaneously. For more information related to the PCMH SIM initiative, providers may visit the MDHHS website at www.michigan.gov/mdhhs >> Doing Business with MDHHS >> Health Care Providers >> State Innovation Model or email SIM@mail.mihealth.org.

Long Term Care Services and Supports Updates

MI Health Link

Dick Miles reported on several updates in the implementation of the MI Health Link program for individuals who are dually eligible for Medicare and Medicaid, including:

- In July 2016, MDHHS implemented a process within the MI Health Link program known as deeming, in which MI Health Link beneficiaries who lose their Medicaid eligibility may remain enrolled in MI Health Link for up to 90 days while their eligibility status is resolved.
- The Department began to passively enroll eligible individuals into MI Health Link on a monthly basis in June 2016, and enrollment in the demonstration has now stabilized at approximately 37,800 beneficiaries. MDHHS is also working to encourage individuals who are dually eligible for Medicare and Medicaid to enroll in MI Health Link voluntarily.
- MDHHS is working collaboratively with the Michigan Association of Health Plans and Integrated Care Organizations to develop a process to address ongoing issues with enrollment discrepancies in Medicare and Medicaid for MI Health Link beneficiaries.
- MDHHS is in the process of working with various stakeholders to organize a summit to educate providers on the MI Health Link program, with a focus on care coordination and person-centered planning. The summit is planned for November 9, 2016.

Home Help

MDHHS is working to develop a new section within the Medical Services Administration that will serve as a single point of accountability for the Home Help program, and will post a position for a Section Manager in the near future. The Department also plans to begin requiring Home Help workers to submit a new Electronic Services Verification (ESV) or Paper Services Verification (PSV) log to receive payment for services beginning in October 2016. The Department is also in the process of implementing the provisions of the Fair Labor Standards Act Home Care Rule, which establishes guidelines for minimum wage, travel and overtime pay.

Conflict-Free Level of Care Determination (LOCD)

As discussed in previous meetings, MDHHS issued a Request for Proposal (RFP) for conflict-free LOCDs in the fall of 2015, but did not receive any successful bidders. The Department has since met with CMS to determine CMS' legal authority to implement the conflict-free LOCD

mandate, whether it is through the use of independent entities or using existing agencies with a firewall.

Brain Injury Waiver

MDHHS is currently accepting public comments on a Section 1115 waiver application that will provide necessary services and supports to individuals suffering a qualifying brain injury. A webinar will be held to discuss the waiver on August 10, 2016, as well as an in-person public hearing on August 17, 2016. Additional information regarding the waiver application is available on the MDHHS website at www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Michigan Brain Injury (BI) Waiver.

Home Health

Dick Miles and participants discussed the fact that the State of Michigan has not allowed enrollment of new Home Health providers in Southeast Michigan since 2013, and that CMS is expanding the moratorium statewide. The Department may be allowed to seek a waiver in certain areas to prevent coverage gaps. A meeting participant also expressed concern about coverage gaps in home health services for beneficiaries who transition from Medicaid to private insurance coverage, and requested information about existing programs within MDHHS that offer assistance with transitioning beneficiaries from Medicaid to private insurance.

Policy Updates

MI Care Team

Bulletin MSA 16-13 was issued on June 1, 2016, and established the MI Care Team Primary Care Health Home benefit effective July 1, 2016. Ten Federally Qualified Health Centers (FQHCs) are participating in MI Care Team, and are currently providing services to 276 beneficiaries with an additional 61 enrollees pending.

Temporary Relocation

MDHHS staff located on the seventh floor of the Capitol Commons Center (400 S. Pine Street in Lansing), have moved temporarily to the fourth floor of the Lewis Cass Building (located at 320 S. Walnut Street in Lansing).

Zika Update

Letter L 16-39, regarding covered services related to the Zika virus was issued to all Medicaid providers on July 11, 2016. To date, 17 Michigan residents have contracted the Zika virus while traveling.

A policy bulletin handout was distributed to meeting attendees, and proposed policy 1611-MIHP, regarding changes in benefit administration of Maternal Infant Health Program services for beneficiaries enrolled in a Medicaid Health Plan was also discussed, in addition to Letter L 16-40, regarding increasing access to Naloxone for opioid overdose.

The meeting was adjourned at 3:45 p.m.

Next Meeting: Wednesday, November 16, 2016

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Wednesday, November 16, 2016

Time: 1:00 pm – 4:30 pm

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

Attendees: **Council Members:** Robin Reynolds, Dianne Haas, Marilyn Litka-Klein, Veronica Perera, Mark Swan (for Jeff Towns), Alison Hirschel, Pam Lupo, Pat Anderson (for Dave LaLumia), Marion Owen, Warren White, Karlene Ketola, Barry Cargill, Dominick Pallone, Kim Singh, Eric Roath, April Stopczynski, Dave Herbel

Staff: Chris Priest, Lynda Zeller, Kathy Stiffler, Brian Keisling, Dick Miles, Jackie Prokop, Erin Emerson, Cindy Linn, Craig Boyce, Michelle Best

Other Attendees: Tiffany Stone

Welcome, Introductions

Robin Reynolds opened the meeting and introductions were made. Chris Priest addressed the results of the November 8, 2016 Presidential election, and reported that the Michigan Department of Health and Human Services (MDHHS) is continuing to work with its federal partners to implement the Department's programs as planned.

Update on Flint

MDHHS received approval from the Centers for Medicare and 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. To date, 24,171 eligible individuals have enrolled in health coverage under the Flint Waiver. MDHHS has also received CMS approval to use Children's Health Insurance Program (CHIP) funding for the purpose of lead abatement in Flint and targeted communities around the State of Michigan. A residence located in Flint or other targeted areas of the state, which will be identified by MDHHS, may be eligible for lead abatement services if a Medicaid or CHIP-eligible child or pregnant woman lives in the home. In response to an inquiry, MDHHS staff discussed some of the non-Medicaid resources available to assist individuals impacted by Flint water who are not eligible for Medicaid or CHIP.

Budget/Boilerplate Update

Medicaid Health Plan (MHP)/Prepaid Inpatient Health Plan (PIHP) Allocation Adjustments for Fiscal Year (FY) 2017

MDHHS staff provided an update on MHP and PIHP rate allocation adjustments for FY 2017, and reported that MHP rates have been reduced by 6% for the Healthy Michigan Plan population, while PIHP rates have been reduced by 3%. MDHHS examined data for FY 2015 for the purpose of setting MHP and PIHP rates for FY 2017, and the allocation reduction is a reflection of reduced utilization during the review period. However, MDHHS staff noted that the MHPs have reported increased utilization, particularly for pharmacy claims, during plan years following FY 2015. For the general Medicaid population, MHP claim costs have decreased by 0.2% for FY 2017, while the actuarial sound rate for PIHPs has increased by 1%. MDHHS staff and meeting attendees discussed the implications of the recently reported increase in utilization at length. MDHHS and the MHPs continue to hold meetings to discuss the rates.

Health Insurance Claim Adjustment (HICA) Tax Update

Chris Priest reported that a bill to reconfigure the way in which the current 6% use tax on Medicaid Health Maintenance Organizations (HMOs) is utilized recently passed the legislature but was vetoed by the governor. CMS has disallowed the use tax, and as a result, it will sunset on December 31, 2016. MDHHS is currently working with the Michigan House and Senate on subsequent legislation to place a moratorium on the use tax in order to implement the CMS requirement. Dominick Pallone indicated that the Michigan Association of Health Plans supports an amendment to the legislation to specify that the use tax will be suspended on December 31, 2016 and not require CMS to provide a written declaration indicating their decision to disallow its use in Michigan. Robin Reynolds will share the proposed amendment with the Medical Care Advisory Council (MCAC) for review, and called for a motion to support sending a letter on behalf of the MCAC in support of the legislation. A motion was made in support of sending a letter on behalf of the MCAC by Barry Cargill, with a second by Dianne Haas. The motion carried. The use tax currently accounts for $460 million in revenue.

Federal Regulatory Guidance Update

Chris Priest provided an overview of new federal regulatory guidance that is anticipated in the final months of the Obama administration, including:

- A State Medicaid Director letter on Community First Choice;
- Additional regulation on pass-through payments;
- A final Payment Error Rate Measurement (PERM) regulation; and

- A potential new rule regarding Disproportionate Share Hospital (DSH) and supplemental payments.

MDHHS has retained Health Management Associates to assist the Department in working through the new federal requirements related to Medicaid managed care.

Medicaid Managed Care

Provider Surveys

MDHHS and the Michigan State University Institute for Health Policy developed a draft survey for providers to give input on their experience working with the Medicaid Health Plans, which has been distributed to the MCAC for review. Once the survey is finalized, the Department will randomly select Primary Care Providers (PCPs) contracted with a Medicaid Health Plan and ask them to provide feedback on a particular plan. When the PCP completes their assigned survey, they may complete additional surveys to provide feedback on their experience working with other Medicaid Health Plans. MDHHS staff and meeting attendees also discussed the possibility of developing future provider surveys for specialist providers to give input on their experience working with the Medicaid Health Plans pending the results of the PCP survey. Meeting attendees were asked to submit comments on the draft survey to Kathy Stiffler by November 28, 2016.

Healthy Kids Dental Bid

Kathy Stiffler announced that MDHHS is planning to bid for a new ***Healthy Kids Dental*** contract, and reported that a Request for Information (RFI) was posted to www.buy4michigan.com on November 7, 2016. Comments from potential bidders were due on November 14, 2016, and MDHHS must respond to the questions by November 23, 2016. Final RFI submissions are due November 30, 2016, though Kathy noted that RFI submissions are not binding, and that potential vendors who did not respond to the RFI may still submit proposals when the bid is issued. MDHHS plans to implement the new contract effective October 1, 2017, and would like to issue contracts to more than one statewide vendor. In response to a meeting participant's concern regarding the proposed timeline for implementation, Kathy noted that the safe transition of members can extend at least 90 days beyond the start date of the new contract.

Medicaid/Other

MDHHS staff announced that Gretchen Backer has been hired as the director of the Program Review Division following the retirement of Sheila Embry, and that Dr. Debra Eggleston will retire as the director of the Office of Medical Affairs effective December 31, 2016.

2016 Access Monitoring Review Plan

MDHHS staff provided an overview of the 2016 Access Monitoring Review Plan, which was developed at the request of CMS to demonstrate that the Department is using data-driven decisions to set Medicaid Fee-for-Service rates and that rate changes do not negatively impact beneficiaries' access to care. The Plan was posted for a 30-day public comment period, which concluded on October 16, 2016, and has been submitted to CMS.

Healthy Michigan Plan

Second Waiver Update

Under the terms of the second waiver, beginning April 1, 2018, Healthy Michigan Plan beneficiaries above 100% of the Federal Poverty Level (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). MDHHS is continuing to work with the Department of Insurance and Financial Services (DIFS) to develop guidelines for health plans on the FFM that will serve this population.

Eligibility Redetermination Update

MDHHS staff reported that the Department began the process of implementing a system of passive redetermination of eligibility for Medicaid beneficiaries in June 2016. As of September 2016, MDHHS has the ability to conduct passive redetermination of eligibility for approximately 80-82% of beneficiaries enrolled in Modified Adjusted Gross Income (MAGI) categories. In order to conduct passive redetermination on the remaining MAGI beneficiaries, the Department must receive their income information from the Internal Revenue Service (IRS). However, MDHHS has experienced systems problems when attempting to retrieve data from the IRS, and is working to resolve the issue. The Department also plans to implement passive redetermination for non-MAGI groups in the future. In order to participate in the passive redetermination process, beneficiaries must provide their consent at the time of application.

Behavioral Health Updates

Integration of Behavioral Health and Physical Health

MDHHS staff provided an update on the Stakeholder 298 work group, which was convened to develop recommendations around the coordination of physical and behavioral health services. The work group is working to complete a report, which is due to the legislature by January 15, 2017. The FY 2017 budget requires a report with policy recommendations; financial model recommendations; and benchmarks for measuring progress toward better coordination, both in terms of delivery and outcome. MDHHS hopes to release a draft report containing policy recommendations, summaries of the affinity groups and consensus recommendations from the

affinity group meetings along with background on the process by November 28, 2016. The draft report will then be posted for public comment for a period of at least 30 days, and MDHHS plans to host at least one public forum to accept comments as well.

Certified Community Behavioral Health Clinics (CCBHCs)

In October 2015, the State of Michigan received a planning grant for CCBHCs, which provide intensive person-centered multi-disciplinary evidence-based screening, assessment, and diagnostic treatment and prevention services for individuals with mental health concerns. MDHHS submitted an application to be one of eight states chosen for a CCBHC demonstration grant, and has selected 14 sites that would serve as CCBHCs in Michigan under the demonstration. No public announcement has been made to identify the sites, as the states have not yet been selected for participation in the demonstration grant; however, MDHHS staff offered to share the names of the proposed CCBHC sites with the MCAC. CMS is expected to announce the eight states chosen to participate in the CCBHC demonstration grant by the end of December 2016, with implementation to begin as early as January 1, 2017. States that are chosen to participate have until June 30, 2017 to establish operational CCBHCs. MDHHS staff indicated that the intent of the CCBHC demonstration is to expand access to care for behavioral health services and maximize the existing health plan provider network, and noted that the program's impact on the budget is currently unknown.

State Innovation Model (SIM)

Leadership Changes

Chris Priest announced that Elizabeth Hertel has left MDHHS and that Matt Lori is now overseeing the SIM project.

Medicare Patient-Centered Medical Home (PCMH) Model

The PCMH model currently operates within the Michigan Primary Care Transformation (MiPCT) project, which will end on December 31, 2016. Beginning January 1, 2017, the PCMH model will move to the SIM, as required by the new contract between MDHHS and the Medicaid Health Plans. Eligible PCMH sites that currently participate in MiPCT and those located within a SIM region may take part in the SIM. For additional information on the PCMH SIM initiative, providers may visit the MDHHS website at www.michigan.gov/mdhhs >> Doing Business with MDHHS >> Health Care Providers >> State Innovation Model or email SIM@mail.mihealth.org.

Long Term Care Services and Supports Updates

MI Health Link

Dick Miles reported that MDHHS hosted a provider summit on November 9, 2016 to discuss MI Health Link, and provided meeting attendees with an update on the implementation of the Demonstration. Enrollment in MI Health Link has remained stable at approximately 37,500 beneficiaries following the implementation of a process known as deeming, in which MI Health Link beneficiaries who lose their Medicaid eligibility may remain enrolled in MI Health Link for up to 90 days while their eligibility status is resolved. MDHHS has also renegotiated its contract with the Integrated Care Organizations (ICOs) to provide services to MI Health Link beneficiaries, which took effect on November 1, 2016. One change noted in the new contract is that beneficiaries who elect hospice services may now remain enrolled in MI Health Link.

Other

Dick Miles also provided meeting attendees with additional updates related to long term care, including:

- A new section has been established within the Medical Services Administration (MSA) to serve as a single point of accountability for the Home Help Program. Michelle Martin has been hired as the manager of the Home Help Section, and MSA is working to provide additional staff for the section, as well.
- Effective October 1, 2016, providers of Home Help services must submit an Electronic Services Verification (ESV) or Paper Services Verification (PSV) form in order to receive payment for services provided under the program. This process requires Home Help Providers to register in the Community Health Automated Medicaid Processing System (CHAMPS).
- The Department is working to implement the new federal managed care rule as it relates to MI Choice Waiver Agencies, which are classified as Prepaid Ambulatory Health Plans (PAHPs). The MI Choice Waiver will need to be renewed in October 2018, and MDHHS will need to make changes to the way the program operates as a result of the new managed care rule.
- MDHHS is in the process of submitting a section 1115 Brain Injury Waiver (BIW) 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 BIW has completed the consultation process, and the Department is targeting an implementation date of April 1, 2017.
- State law requires MDHHS to set up a workgroup related to the Program of All Inclusive Care for the Elderly (PACE), which will begin the week of November 21, 2016. The workgroup will discuss issues such as timely eligibility processing, barriers to new enrollment, and future expansion criteria.
- MDHHS is working to finalize rates MI Choice Waiver Agency rates for FY 2017.

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: Thursday, February 16, 2017

Medical Services Administration
Bureau of Medicaid Care Management and Quality Assurance

PERFORMANCE MONITORING REPORT

HEALTHY MICHIGAN PLAN

Composite – All Plans

January 2017

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

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Healthy Michigan Plan

Appendixes

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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-six (26) 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 HRA*	*Outreach & Engagement to Facilitate Entry to PCP*	*Plan All-Cause Acute 30-Day Readmissions*	*Adults' Access to Ambulatory Health Services*

Data for these five 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. A composite summary of plan performance for all standards is displayed in Appendix A. Appendix B contains specific three letter codes identifying each of the MHPs. Appendix C contains the one-year plan specific analysis for each measure.

Measurement Frequency

The data for each performance measure in this report will be run and represented on a quarterly basis. Measurement Periods may vary and are based on the specifications for that individual measure. In addition to this, Figures 3 through 7 depict only Managed Care Plan data, and not Fee-For-Service (FFS) data.

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 2017 unless otherwise noted.

Table 1: Fiscal Year 2017

Quarterly Reported Measures	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Adults' Generic Drug Utilization	11/11			
Timely Completion of Initial HRA	2/11			
Outreach & Engagement to Facilitate Entry to PCP	0/11			
Plan All-Cause Acute 30-Day Readmissions	3/10			
Adults' Access to Ambulatory Health Services	5/11			

Managed Care Enrollment

The Healthy Michigan Plan (HMP-MC) enrollment has also remained steady over the past year. In January 2017, enrollment was 514,497, down 5,979 enrollees (1.3%) from February 2016. An increase 8,727 enrollees (1.7%) was realized between December 2016 and January 2017.

Figure 1: HMP-MC Enrollment, February 2016 – January 2017[1]

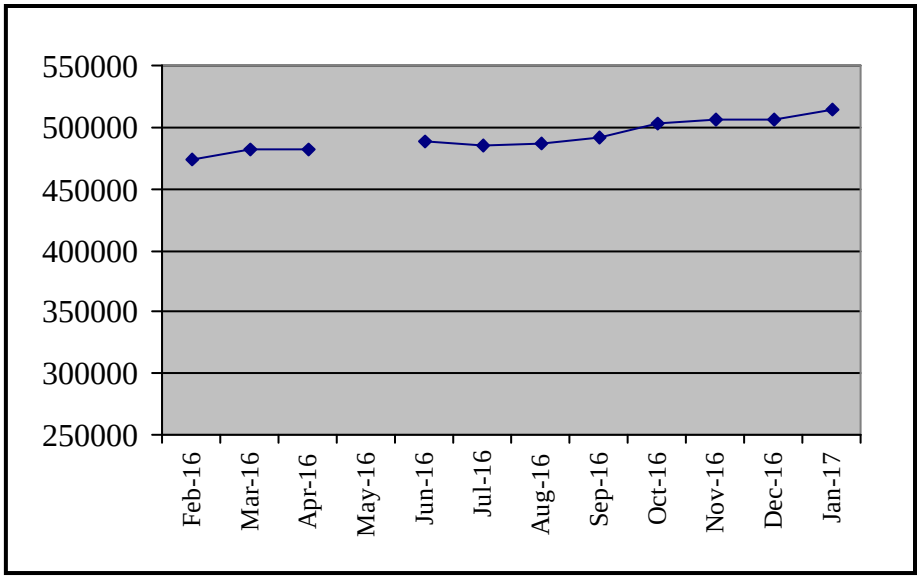
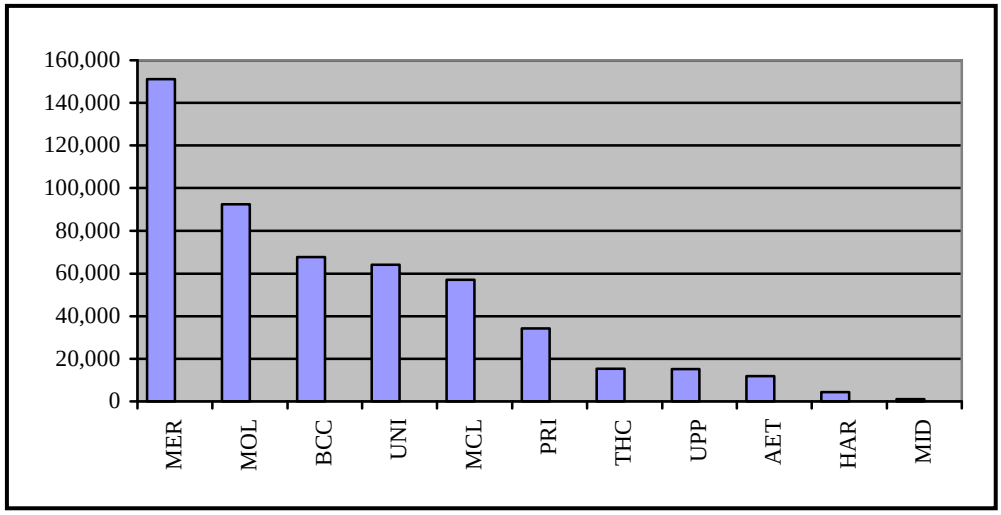


Figure 2: HMP-MC Enrollment by Medicaid Health Plan, January 2017



[1] Enrollment data was not available for HMP-MC Enrollment for May 2016 at the time of publication.

Medicaid Health Plan News

The Performance Monitoring Report contains data for all 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.

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
Percentage of generic prescriptions filled for adult members of health plans during the measurement period.

Standard
At or above 80% (as shown on bar graph below)

Measurement Period
April 2016 –June 2016

Data Source
MDHHS Data Warehouse

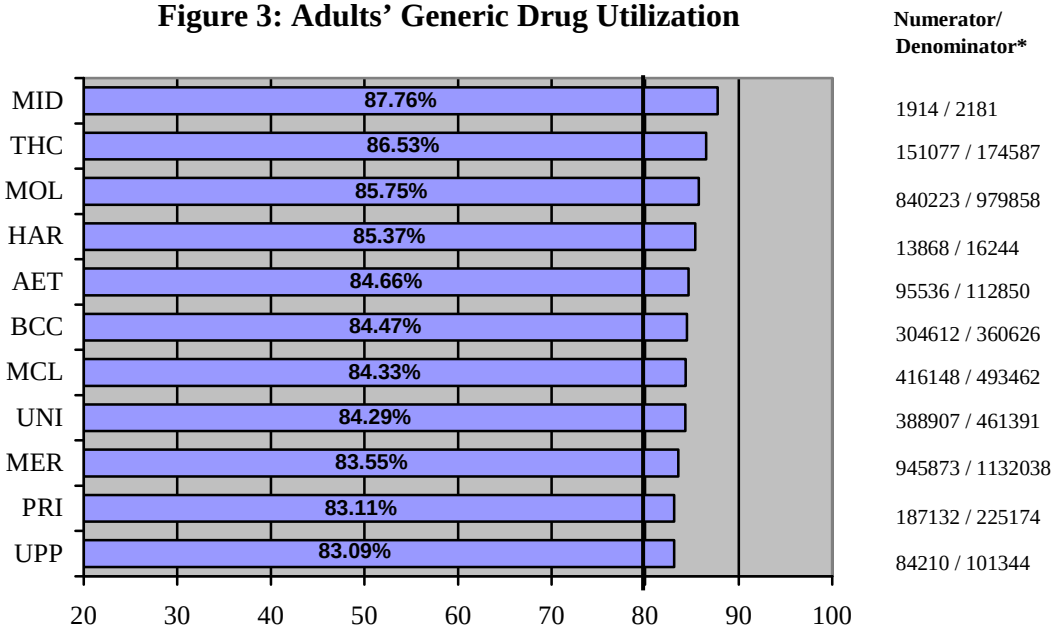
Measurement Frequency
Quarterly

Summary: All of the plans met or exceeded the standard. Results ranged from 83.09% to 87.76%.

Table 2: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	3528242	4206585	83.87%
Fee For Service (FFS) only	22798	50897	44.79%
Managed Care only	3445271	4078533	84.47%
MA-MC	1978833	2345081	84.38%
HMP-MC	1434010	1695233	84.59%

Figure 3: Adults' Generic Drug Utilization



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

Measure
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 15% (as shown on bar graph below)

Enrollment Dates
January 2016 – March 2016

Data Source
MDHHS Data Warehouse

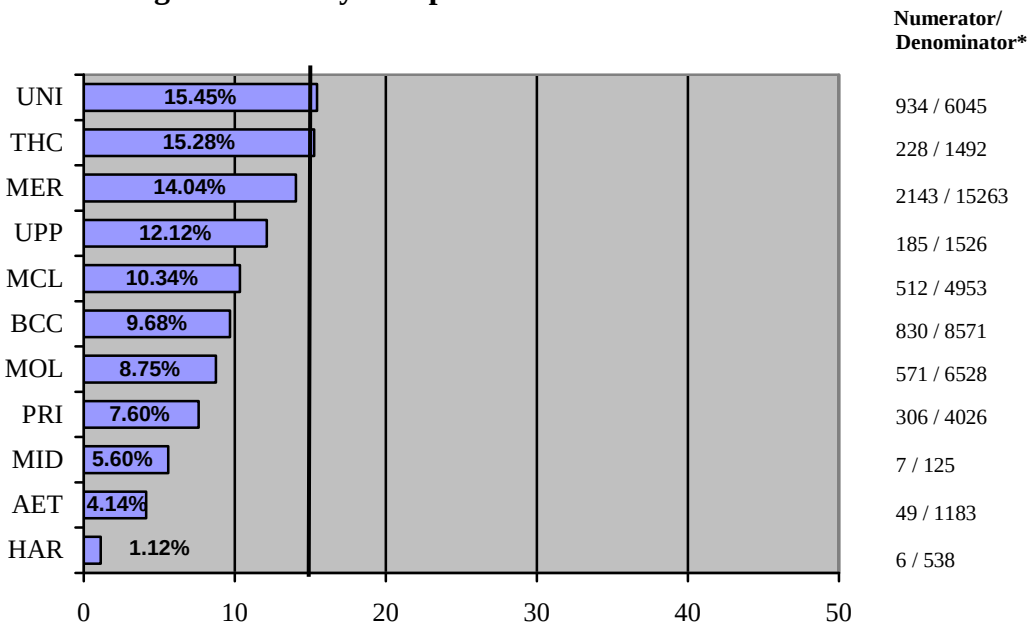
Measurement Frequency
Quarterly

Summary: Two of the plans met or exceeded the standard, while nine plans (AET, BCC, HAR, MCL, MER, MID, MOL, PRI, and UPP). Results ranged from 1.12% to 15.45%.

Table 3: Program Total[2]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	5771	50250	11.48%

Figure 4: Timely Completion of Initial HRA



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.

Outreach and Engagement to Facilitate Entry to Primary Care

Measure
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 60% (as shown on bar graph below)

Enrollment Dates
January 2016 – March 2016

Data Source
MDHHS Data Warehouse

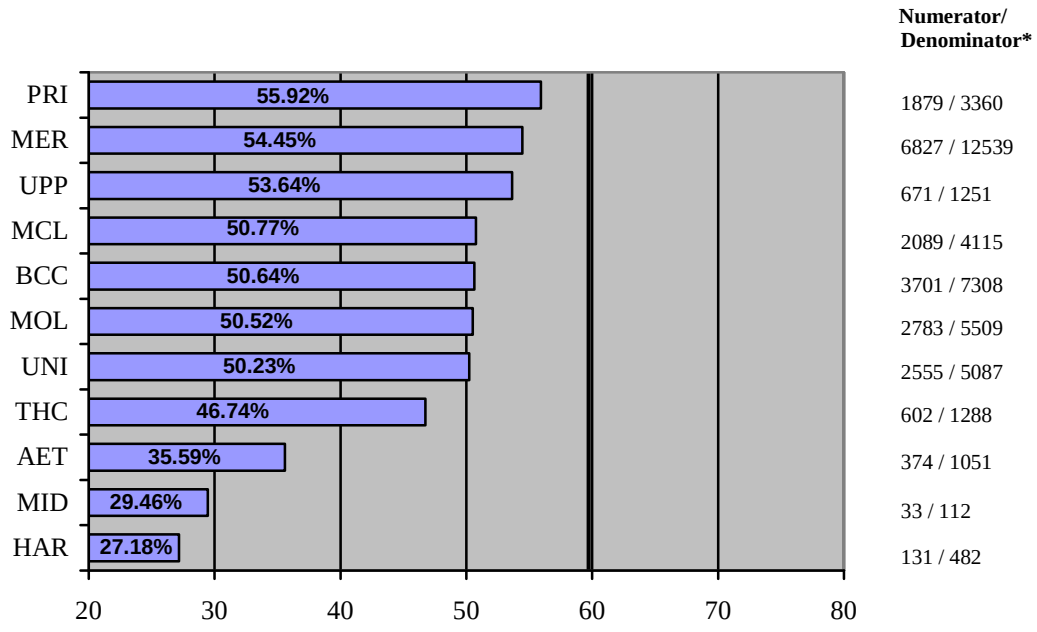
Measurement Frequency
Quarterly

Summary: None of the plans met or exceeded the standard. None of the plans met 10% improvement towards the standard for this quarter. Results ranged from 27.18% to 55.92%.

Table 4: Program Total[3]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	29793	50250	59.29%

Figure 5: 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.

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

Plan All-Cause Acute 30-Day Readmissions

Measure
The percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.

Standard
At or <u>below</u> 16% (as shown on bar graph below)

Enrollment Dates
July 2015 –June 2016

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

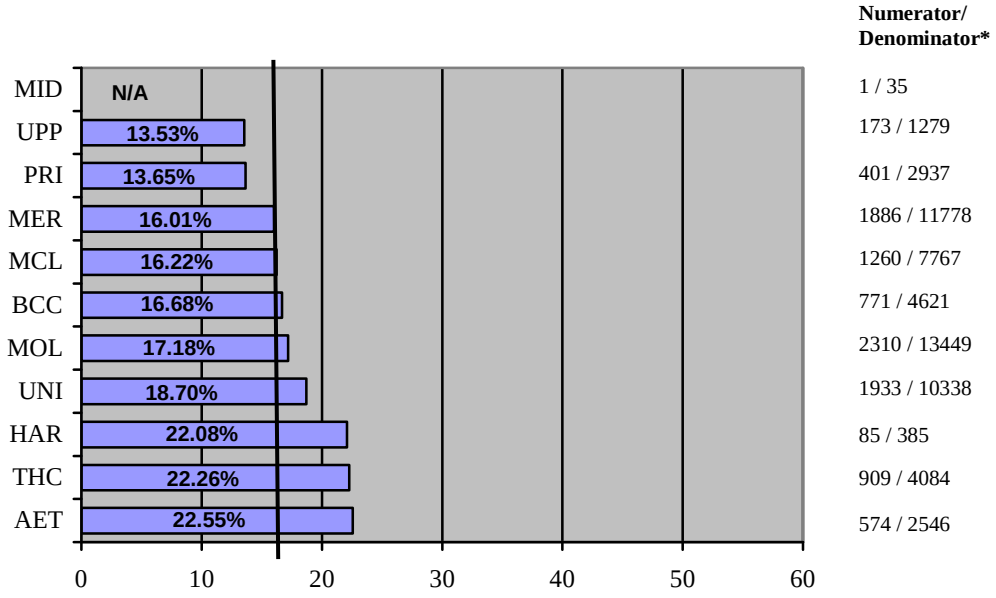
Summary: Two of the plans met or exceeded the standard, while eight plans (AET, BCC, HAR, MCL, MER, MOL, THC, and UNI) did not. Results ranged from 13.53% to 22.55%.

*****This is a reverse measure. A lower rate indicates better performance.***

Table 5: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	12586	70565	17.84%
Fee For Service (FFS) only	1309	6028	21.72%
Managed Care only	10637	60936	17.46%
MA-MC	8022	40265	19.92%
HMP-MC	2551	20198	12.63%

Figure 6: Plan All-Cause Acute 30-Day Readmissions[4]



Plan All-Cause Acute 30-Day Readmissions Percentages

*Numerator depicts the number of acute readmissions for any diagnosis within 30 days of an Index Discharge Date. Denominator depicts the total number of Index Discharge dates during the measurement year, not enrollees.

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

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 2015 –June 2016

Data Source
MDHHS Data Warehouse

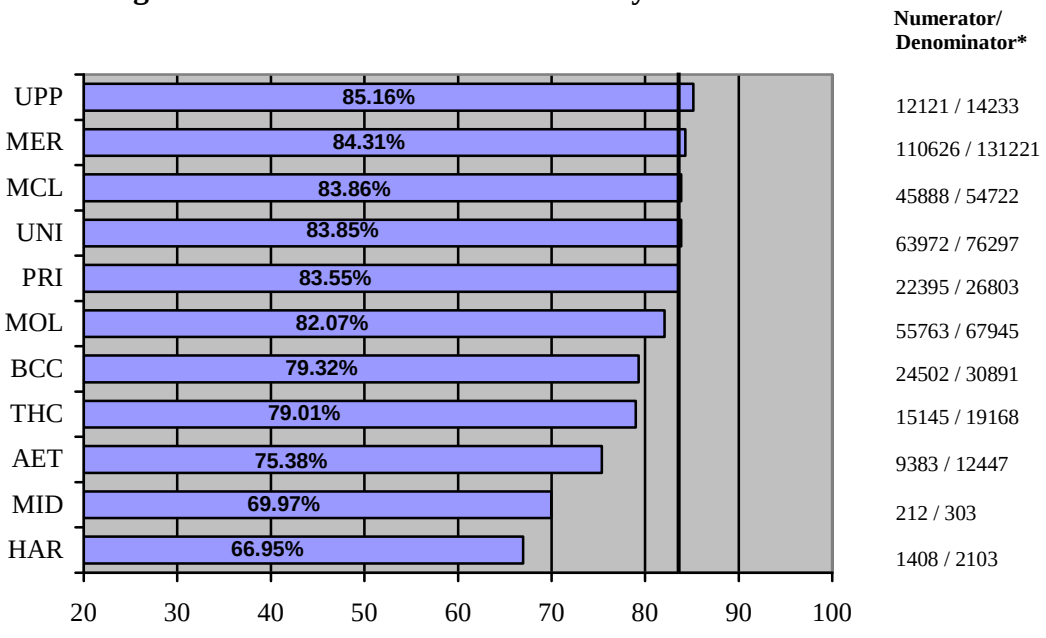
Measurement Frequency
Quarterly

Summary: Five of the plans met or exceeded the standard. While six plans (AET, BCC, HAR, MID, MOL, and THC) did not. Results ranged from 66.95% to 85.16%.

Table 6: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	568936	698992	81.39%
Fee For Service (FFS) only	9752	15408	63.29%
Managed Care only	432216	519700	83.17%
MA-MC	217492	260384	83.53%
HMP-MC	177762	215761	82.39%

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.

Appendix A: Composite Performance Monitoring Summary[5]

January 2017

Plans	Adults Generic Drug Utilization	Timely Completion of Initial HRA	Outreach & Engagement to Facilitate Entry to PCP	Plan All-Cause Acute 30-Day Readmission	Adults' Access to Ambulatory Health Services	Total Standards Achieved
AET	Y	**N**	**N**	**N**	**N**	**1**
BCC	Y	**N**	**N**	**N**	**N**	**1**
HAR	Y	**N**	**N**	**N**	**N**	**1**
MCL	Y	**N**	**N**	**N**	Y	**2**
MER	Y	**N**	**N**	**N**	Y	**2**
MID	Y	**N**	**N**	N/A	**N**	**1**
MOL	Y	**N**	**N**	**N**	**N**	**1**
PRI	Y	**N**	**N**	Y	Y	**3**
THC	Y	Y	**N**	**N**	**N**	**2**
UNI	Y	Y	**N**	**N**	Y	**3**
UPP	Y	**N**	**N**	Y	Y	**3**
Total	**11/11**	**2/11**	**0/11**	**2/10**	**5/11**	

Appendix B: 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, Inc.
HAR	Harbor Health Plan, Inc.
MCL	McLaren Health Plan
MER	Meridian Health Plan
MID	HAP Midwest Health Plan, Inc.
MOL	Molina Healthcare of Michigan
PRI	Priority Health Choice
THC	Total Health Care
UNI	UnitedHealthcare Community Plan
UPP	Upper Peninsula Health Plan

[5] "N/A" in the Plan All-Cause Acute 30-Day Readmission column represents plans who had a denominator under 5 and a numerator under 30.

Appendix C: 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 16 – Jun 16**	**80%**	**84.66%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**4.14%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**35.59%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**22.55%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**75.38%**	**No**

This is a reverse measure. A lower rate indicates better performance.

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

Appendix C: 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 16 – Jun 16**	**80%**	**84.47%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**9.68%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**50.64%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**16.68%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**79.32%**	**No**

****This is a reverse measure. A lower rate indicates better performance.***

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

Appendix C: One Year Plan-Specific Analysis

Harbor Health Plan, Inc. – HAR

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 16 – Jun 16**	**80%**	**85.37%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**1.12%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**27.18%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**22.08%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**66.95%**	**No**

****This is a reverse measure. A lower rate indicates better performance.***

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

Appendix C: 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 16 – Jun 16**	**80%**	**84.33%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**10.34%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**50.77%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**16.22%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**83.86%**	**Yes**

This is a reverse measure. A lower rate indicates better performance.

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

Appendix C: One Year Plan-Specific Analysis

Meridian Health Plan – MER

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 16 – Jun 16**	**80%**	**83.55%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**14.04%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**54.45%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**16.01%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**84.31%**	**Yes**

****This is a reverse measure. A lower rate indicates better performance.***

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

Appendix C: One Year Plan-Specific Analysis

HAP Midwest Health Plan, Inc. – MID

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 16 – Jun 16**	**80%**	**87.76%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**5.60%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**29.46%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**N/A**	**N/A**

This is a reverse measure. A lower rate indicates better performance.
A rate was not calculated for plans with a numerator under 5 or a denominator under 30.

Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**69.97%**	**No**

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

Appendix C: 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 16 – Jun 16**	**80%**	**85.75%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**8.75%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**50.52%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**17.18%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**82.07%**	**No**

This is a reverse measure. A lower rate indicates better performance.

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

Appendix C: 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 16 – Jun 16**	**80%**	**83.11%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**7.60%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**55.92%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**13.65%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**83.55%**	**Yes**

****This is a reverse measure. A lower rate indicates better performance.***

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

Appendix C: 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 16 – Jun 16**	**80%**	**86.53%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**15.25%**	**Yes**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**46.74%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**22.26%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**79.01%**	**No**

****This is a reverse measure. A lower rate indicates better performance.***

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

Appendix C: 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 16 – Jun 16**	**80%**	**84.29%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**15.45%**	**Yes**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**50.23%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**18.70%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**83.85%**	**Yes**

****This is a reverse measure. A lower rate indicates better performance.***

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

Appendix C: 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 16 – Jun 16**	**80%**	**83.09%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**12.12%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**53.64%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**13.53%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**85.16%**	**Yes**

****This is a reverse measure. A lower rate indicates better performance.***

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

MI HEALTH ACCOUNT

EXECUTIVE SUMMARY REPORT

JANUARY 2017

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 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 2016 and the program totals from October 2014 to October 2016.

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
Aug-16	75,685	16,025	7,566	9,395	43.58%
Sep-16	86,801	18,082	7,615	10,633	41.85%
Oct-16	101,250	22,430	9,608	12,427	43.92%
Calendar YTD	**840,703**	**165,668**	**83,549**	**88,522**	**40.17%**
Program Total	**2,130,191**	**396,422**	**158,528**	**179,687**	**34.49%**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 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 2016. Program totals are from October 2014 through October 2016. 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
Aug-16	$189,785.53	$63,260.35	33%	25,420	9,110
Sep-16	$224,566.12	$78,224.99	35%	28,715	10,655
Oct-16	$265,806.58	$69,965.61	26%	34,857	10,113
Calendar YTD	**$1,991,873.91**	**$696,115.18**	**35%**	**253,793**	**95,066**
Program Total	**$4,193,929.02**	**$1,531,713.72**	**37%**	**574,634**	**215,045**
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
Aug-16	$977,330.48	$278,457.57	28%	16,961	6,011
Sep-16	$1,099,741.10	$322,540.79	29%	18,248	6,679
Oct-16	$1,328,806.10	$277,932.77	21%	22,035	6,508
Calendar YTD	**$9,733,043.14**	**$2,904,979.98**	**30%**	**172,050**	**64,350**
Program Total	**$18,862,765.36**	**$5,751,392.74**	**30%**	**338,193**	**127,067**

HEALTHY MICHIGAN PLAN
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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	$23,678.03	$15,094.16	63.75
	Jan 2015 - Mar 2015	$194,071.16	$131,747.04	67.89
	Apr 2015 - Jun 2015	$166,894.45	$102,178.71	61.22
	Jul 2015 - Sep 2015	$163,655.43	$88,036.18	53.79
	Oct 2015 - Dec 2015	$155,099.01	$77,812.60	50.17
	Jan 2016 - Mar 2016	$143,618.04	$68,657.30	47.81
	Apr 2016 - Jun 2016	$193,780.57	$83,640.37	43.16
	Jul 2016 - Sep 2016	$147,826.43	$47,791.88	32.33
	Oct 2016 - Dec 2016	$188,077.54	$60,036.18	31.92
May-14	Nov 2014 - Jan 2015	$35,769.76	$25,404.12	71.02
	Feb 2015 - Apr 2015	$56,661.54	$38,402.76	67.78
	May 2015 - Jul 2015	$45,969.47	$29,318.14	63.78
	Aug 2015 - Oct 2015	$41,375.52	$24,684.92	59.66
	Nov 2015 - Jan 2016	$39,658.82	$23,186.24	58.46
	Feb 2016 - Apr 2016	$38,173.46	$20,724.70	54.29
	May 2016 - July 2016	$46,732.90	$22,045.90	47.17
	Aug 2016 - Oct 2016	$42,121.21	$17,676.50	41.97
Jun-14	Dec 2014 - Feb 2015	$457,077.32	$323,559.71	70.79
	Mar 2015 - May 2015	$349,691.94	$245,822.23	70.30
	Jun 2015 - Aug 2015	$348,734.58	$227,840.27	65.33
	Sep 2015 - Nov 2015	$330,511.14	$201,875.24	61.08
	Dec 2015 - Feb 2016	$240,812.88	$140,477.18	58.33
	Mar 2016 - May 2016	$275,901.98	$156,449.23	56.70
	Jun 2016 - Aug 2015	$234,906.55	$109,272.03	46.52
	Sep 2016 - Nov 2016	$331,788.72	$157,305.18	47.41

Chart 3 continued on page 5

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

Chart 3 continued from page 4

Chart 3: Quarterly Collection				
Enrollment Month	**Quarterly Pay Cycles**	**Amount Owed**	**Amount Collected**	**Percentage Collected**
Jul-14	Jan 2015 - Mar 2015	$340,336.16	$224,585.98	65.99%
	Apr 2015 - Jun 2015	$252,019.77	$157,638.50	62.55%
	Jul 2015 - Sep 2015	$242,586.21	$135,861.05	56.01%
	Oct 2015 - Dec 2015	$222,223.07	$117,558.62	52.90%
	Jan 2016 - Mar 2016	$198,122.85	$100,436.20	50.69%
	Apr 2016 - Jun 2016	$218,491.91	$98,315.37	45.00%
	Jul 2016 - Sep 2016	$175,393.24	$61,307.35	34.95%
	Oct 2016 - Dec 2016	$208,306.31	$67,217.85	32.27%
Aug-14	Feb 2015 - Apr 2015	$169,952.88	$112,656.85	66.29%
	May 2015 - Jul 2015	$121,946.27	$71,555.75	58.68%
	Aug 2015 - Oct 2015	$111,305.54	$65,772.05	59.09%
	Nov 2015 - Jan 2016	$103,758.41	$58,578.82	56.46%
	Feb 2016 - Apr 2016	$98,753.04	$51,857.62	52.51%
	May 2016 - July 2016	$109,661.14	$44,830.08	40.88%
	Aug 2016 - Oct 2016	$93,178.22	$31,665.96	33.98%
Sep-14	Mar 2015 - May 2015	$212,502.42	$116,732.42	54.93%
	Jun 2015 - Aug 2015	$147,593.40	$78,749.80	53.36%
	Sep 2015 - Nov 2015	$150,249.62	$78,749.69	52.41%
	Dec 2015 - Feb 2016	$121,102.64	$61,276.25	50.60%
	Mar 2016 - May 2016	$138,698.21	$62,580.39	45.12%
	Jun 2016 - Aug 2016	$103,820.98	$33,875.62	32.63%
	Sep 2016 - Nov 2016	$123,197.02	$41,800.38	33.93%
Oct-14	Apr 2015 - Jun 2015	$173,628.90	$93,050.57	53.59%
	Jul 2015 - Sep 2015	$125,396.82	$66,853.49	53.31%
	Oct 2015 - Dec 2015	$124,321.49	$64,456.14	51.85%
	Jan 2016 - Mar 2016	$118,837.59	$57,740.07	48.59%
	Apr 2016 - Jun 2016	$137,597.80	$57,480.12	41.77%
	Jul 2016 - Sep 2016	$105,817.66	$32,758.27	30.96%
	Oct 2016 - Dec 2016	$123,818.43	$38,273.30	30.91%

Chart 3 continued on page 6

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

Chart 3 continued from page 5

Chart 3: Quarterly Collection				
Enrollment Month	**Quarterly Pay Cycles**	**Amount Owed**	**Amount Collected**	**Percentage Collected**
Nov-14	May 2015 - Jul 2015	$194,938.88	$102,293.00	52.47%
	Aug 2015 - Oct 2015	$126,130.16	$63,789.10	50.57%
	Nov 2015 - Jan 2016	$133,137.68	$68,436.51	51.40%
	Feb 2016 - Apr 2016	$134,326.41	$64,920.30	48.33%
	May 2016 - July 2016	$157,699.94	$57,803.10	36.65%
	Aug 2016 - Oct 2016	$124,681.58	$35,204.57	28.24%
Dec-14	Jun 2015 - Aug 2015	$104,840.39	$58,490.27	55.79%
	Sep 2015 - Nov 2015	$81,531.22	$44,394.22	54.45%
	Dec 2015 - Feb 2016	$67,214.28	$35,730.49	53.16%
	Mar 2016 - May 2016	$80,357.48	$39,985.53	49.76%
	Jun 2016 - Aug 2016	$69,513.65	$22,647.77	32.58%
	Sep 2016 - Nov 2016	$75,910.69	$22,446.86	29.57%
Jan-15	Jul 2015 - Sep 2015	$210,890.77	$125,380.54	59.45%
	Oct 2015 - Dec 2015	$169,826.10	$91,640.81	53.96%
	Jan 2016 - Mar 2016	$166,240.38	$90,754.71	54.59%
	Apr 2016 - Jun 2016	$192,186.52	$92,167.75	47.96%
	Jul 2016 - Sep 2016	$160,802.23	$55,588.98	34.57%
	Oct 2016 - Dec 2016	$172,905.93	$55,659.67	32.19%
Feb-15	Aug 2015 - Oct 2015	$205,912.77	$116,459.38	56.56%
	Nov 2015 - Jan 2016	$132,552.90	$75,295.20	56.80%
	Feb 2016 - Apr 2016	$147,771.38	$86,169.47	58.31%
	May 2016 - July 2016	$192,083.28	$85,748.21	44.64%
	Aug 2016 - Oct 2016	$156,760.07	$55,097.64	35.15%
Mar-15	Sep 2015 - Nov 2015	$220,919.11	$114,329.67	51.75%
	Dec 2015 - Feb 2016	$100,161.87	$52,619.61	52.53%
	Mar 2016 - May 2016	$109,529.52	$60,821.49	55.53%
	Jun 2016 - Aug 2015	$125,551.80	$53,184.50	42.36%
	Sep 2016 - Nov 2016	$133,357.35	$48,617.90	36.46%
Apr-15	Oct 2015 - Dec 2015	$274,309.84	$139,686.63	50.92%
	Jan 2016 - Mar 2016	$136,837.80	$74,921.49	54.75%
	Apr 2016 - Jun 2016	$171,658.22	$92,381.92	53.82%
	Jul 2016 - Sep 2016	$149,720.98	$64,455.82	43.05%
	Oct 2016 - Dec 2016	$159,813.11	$56,856.42	35.58%

Chart 3 continued on page 7

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

Chart 3 continued from page 6

Chart 3: Quarterly Collection				
Enrollment Month	**Quarterly Pay Cycles**	**Amount Owed**	**Amount Collected**	**Percentage Collected**
May-15	Nov 2015 - Jan 2016	$185,291.91	$99,532.27	53.72%
	Feb 2016 - Apr 2016	$122,155.32	$73,156.79	59.89%
	May 2016 - July 2016	$163,639.15	$84,315.30	51.53%
	Aug 2016 - Oct 2016	$141,809.82	$60,357.77	42.56%
Jun-15	Dec 2015 - Feb 2016	$150,852.37	$71,185.67	47.19%
	Mar 2016 - May 2016	$100,599.94	$51,547.08	51.24%
	Jun 2016 - Aug 2016	$93,341.94	$40,951.77	43.87%
	Sep 2016 - Nov 2016	$104,846.75	$38,747.65	36.96%
Jul-15	Jan 2016 - Mar 2016	$138,741.20	$69,789.05	50.30%
	Apr 2016 - Jun 2016	$102,151.61	$48,419.96	47.40%
	Jul 2016 - Sep 2016	$86,500.84	$34,357.05	39.72%
	Oct 2016 - Dec 2016	$90,025.63	$29,827.01	33.13%
Aug-15	Feb 2016 - Apr 2016	$137,300.38	$60,225.47	43.86%
	May 2016 - July 2016	$97,317.90	$37,685.50	38.72%
	Aug 2016 - Oct 2016	$82,090.11	$29,589.31	36.04%
Sep-15	Mar 2016 - May 2016	$108,668.12	$48,096.32	44.26%
	Jun 2016 - Aug 2016	$69,903.19	$24,798.06	35.47%
	Sep 2016 - Nov 2016	$63,940.41	$23,278.46	36.41%
Oct-15	Apr 2016 - Jun 2016	$121,181.79	$40,828.37	33.69%
	Jul 2016 - Sep 2016	$74,255.26	$24,246.24	32.65%
	Oct 2016 - Dec 2016	$79,804.04	$23,830.07	29.86%
Nov-15	May 2016 - Jul 2016	$141,848.05	$45,696.37	32.22%
	Aug 2016 - Oct 2016	$96,538.34	$28,081.78	29.09%
Dec-15	Jun 2016 - Aug 2016	$130,210.52	$44,858.62	34.45%
	Sep 2016 - Nov 2016	$104,381.33	$29,684.56	28.44%
Jan-16	Jul 2016 - Sep 2016	$168,970.84	$65,725.72	38.90%
	Oct 2016 - Dec 2016	$132,268.43	$42,010.77	31.76%
Feb-16	Aug 2016 - Oct 2016	$237,197.81	$98,971.85	41.73%
Mar-16	Sep 2016 - Nov 2016	$197,021.75	$70,832.27	35.95%
Apr-16	Oct 2016 - Dec 2016	$181,384.06	$54,382.48	29.98%

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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

	Aug-16	Sep-16	Oct-16
Percent Paid Online	31.12%	28.64%	27.52%
Percent Paid by Mail	68.88%	71.36%	72.48%

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 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 2016 and the cumulative total for the program from October 2014 through October 2016.

Chart 5A: Adjustment Activities

	Aug-16		Sep-16		Oct-16	
	#	Total $	#	Total $	#	Total $
Beneficiary is under age 21	783	$50,732.50	706	$46,129.00	763	$50,327.00
Pregnancy	376	$12,335.02	221	$6,301.96	203	$6,069.94
Hospice	0	$0.00	0	$0.00	0	$0.00
Native American	81	$2,248.33	97	$1,968.00	77	$1,253.00
Five Percent Cost Share Limit Met	29,623	$420,484.47	28,618	$377,155.20	31,234	$291,668.54
FPL No longer >100% - Contribution	0	$0.00	0	$0.00	0	$0.00
TOTAL	**30,863**	**$485,800.32**	**29,642**	**$431,554.16**	**32,277**	**$349,318.48**
	Aug-16 to Oct-16		**Calendar YTD**		**Program YTD**	
	#	Total $	#	Total $	#	Total $
Beneficiary is under age 21	2,252	$147,188.50	6,609	$407,063.74	11,418	$671,319.24
Pregnancy	800	$24,706.92	2,876	$93,798.19	7,153	$216,449.76
Hospice	0	$0.00	0	$0.00	0	$0.00
Native American	255	$5,469.33	660	$13,502.66	1,154	$37,730.66
Five Percent Cost Share Limit Met	89,475	$1,089,308.21	288,825	$4,143,239.18	623,236	$8,997,246.32
FPL No longer >100% - Contribution	0	$0.00	0	$0.00	20	$1,152.50
TOTAL	**92,782**	**$1,266,672.96**	**298,970**	**$4,657,603.77**	**642,981**	**$9,923,898.48**

HEALTHY MICHIGAN PLAN
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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 2016 and the cumulative total for the program from October 2014 through October 2016.

Chart 5B: Healthy Behaviors

	Aug-16		Sep-16		Oct-16	
	#	Total $	#	Total $	#	Total $
Co-pay	2,374	$19,665.07	859	$4,060.58	966	$4,421.60
Contribution	3,484	$157,044.58	1,548	$62,472.11	1,624	$65,795.00
Gift Cards	3,408	n/a	1,613	n/a	2,531	n/a
TOTAL	**9,266**	**$176,709.65**	**4,020**	**$66,532.69**	**5,121**	**$70,216.60**
	Aug 16 to Oct-16		**Calendar YTD**		**Program YTD**	
	#	Total $	#	Total $	#	Total $
Co-pay	4,199	$28,147.25	25,722	$175,457.45	26,969	$180,499.97
Contribution	6,656	$285,311.69	22,750	$1,159,985.64	45,800	$1,913,147.33
Gift Cards	7,552	n/a	28,758	n/a	93,523	n/a
TOTAL	**18,407**	**$313,458.94**	**77,230**	**$1,335,443.09**	**166,292**	**$2,093,647.30**

HEALTHY MICHIGAN PLAN
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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
Aug-16	26,114	$219,156
Sep-16	32,490	$284,575
Oct-16	39,421	$353,535
Calendar YTD	**194,924**	**$1,708,435**
Program Total	**194,924**	**$1,708,435**

HEALTHY MICHIGAN PLAN
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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
Aug-16	118,480	47,218
Sep-16	126,874	50,034
Oct-16	128,105	52,073

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	$1,005,409.98	$937,070.06	$821,444.97	$721,709.71	$7,628,581.96	**$11,114,216.68**
Number of Beneficiaries That Owe	77,939	70,807	63,656	58,713	141,565	**187,664**

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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
Calendar YTD	**41,460**	**$5,108,153.13**	**3,832**	**$404,921.47**
Program Total	**47,353**	**$5,697,923.33**	**6,813**	**$483,591.49**

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

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 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

	Collected by Taxes		Collected by Lottery		Total Garnishments Collected	
Tax Year	**#**	**Total**	**#**	**Total**	**#**	**Total**
2015	2,151	$207,873.10	7	$485.67	**2,158**	**$208,358.77**
2016	7,491	$908,366.12	29	$3,136.01	**7,520**	**$911,502.13**
Calendar YTD	**7,491**	**$908,366.12**	**29**	**$3,136.01**	7,520	**$911,502.13**
Program Total	**9,642**	**$1,116,239.22**	**36**	**$3,621.68**	9,678	**$1,119,860.90**

Michigan Department of Health and Human Services

2016 HEDIS Aggregate Report for Michigan Medicaid

November 2016

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

During 2015, 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 35 HEDIS measures to evaluate Michigan MHPs, yielding 98 measure indicators. 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.

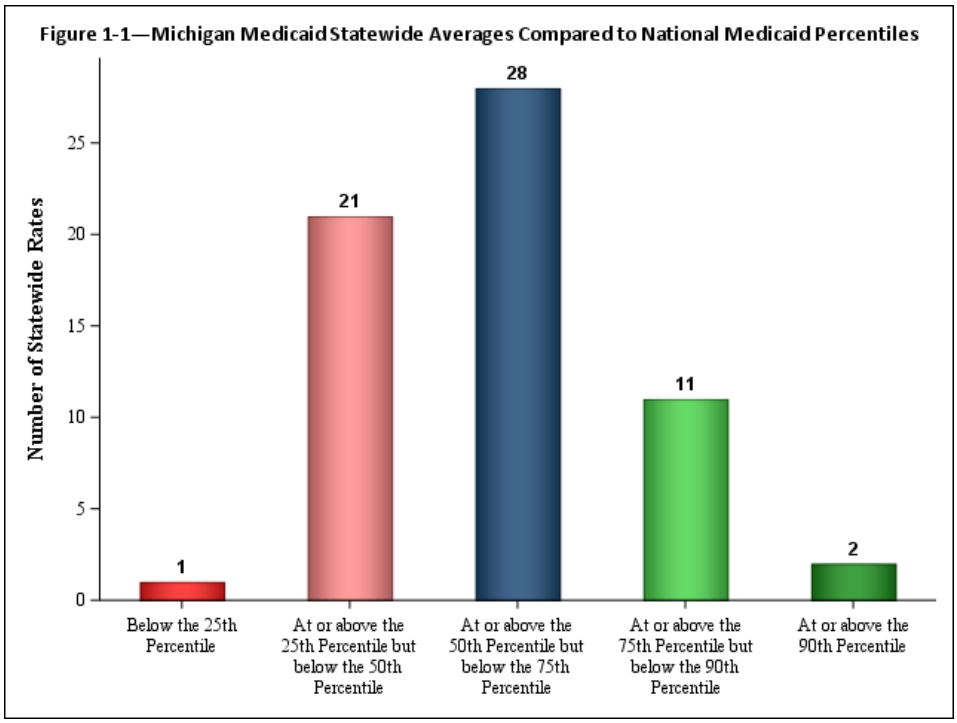
Performance levels for Michigan MHPs were established for 68 measure rates for measures under the majority of the measure domains. The performance levels were set at specific, attainable rates and are based on national percentiles. MHPs that met the high performance level (HPL) exhibited rates that were 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 the NCQA's Quality Compass® national Medicaid HMO percentiles for HEDIS 2015, 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 falling into each national Medicaid percentile range.



Of the 63 measure indicator rates that were reported and comparable to national Medicaid percentiles, less than 2 percent of the MWA rates fell below the national Medicaid 25th percentile, and almost 35 percent of MWA rates fell below the national Medicaid 50th percentile. About 21 percent of the MWA rates ranked at or above the national Medicaid 75th percentile, and roughly 3 percent of the MWA rates ranked at or above the national Medicaid 90th percentile. A summary of MWA performance for each measure domain is presented on the following pages.

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

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

Child & Adolescent Care

All of the HEDIS 2016 MWA *Childhood Immunization Status* measure indicator rates declined from the prior year; seven of these rate declines were statistically significant. Further, six of the *Childhood Immunization Status* measure indicator rates fell below the national Medicaid 50th percentile, which represented an opportunity for improvement. Another opportunity for improvement exists for the MWA *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, which significantly declined from the prior year. However, six measure indicator rates significantly improved from the prior year, and five of these rates ranked at or above than the national Medicaid 50th percentile. One MWA measure indicator rate, *Immunizations for Adolescents—Combination 1*, ranked at or above the national Medicaid 75th percentile despite showing a decline in performance from the prior year.

Women—Adult Care

All three of the HEDIS 2016 MWA *Chlamydia Screening in Women* measure indicator rates increased from the prior year and ranked at or above the national Medicaid 75th percentiles. Two of these rate increases were statistically significant. However, one measure indicator rate showed a significant decline in performance, *Cervical Cancer Screening*.

Access to Care

Three of the four HEDIS 2016 MWA *Children and Adolescents' Access to Primary Care Practitioners* measure indicator rates declined from the prior year and ranked below the national Medicaid 50th percentile. One of these measure indicator rate declines was statistically significant, *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years*. For *Adults' Access to Preventive/Ambulatory Health Services*, three of the four measure indicator rates statistically significantly declined from the prior year and ranked at or greater than the national Medicaid 50th percentile but below the national Medicaid 75th percentile. The remaining indicator, *Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years*, significantly increased from the prior year and ranked at or above the national Medicaid 75th percentile.

Obesity

All three of the HEDIS 2016 MWA *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicator rates declined from the prior year and ranked at or above the national Medicaid 50th percentile but less than the national Medicaid 75th percentile. Two of these rate declines were statistically significant, *BMI Percentile—Total* and *Counseling for Nutrition—Total*. The *Adult BMI Assessment* measure indicator rate demonstrated a statistically significant decline from the prior year; however, 2016 performance ranked at or greater than the national Medicaid 75th percentile.

Pregnancy Care

All of the HEDIS 2016 MWA measure indicators discussed in this report within the Pregnancy Care domain statistically significantly decreased from the prior year and ranked below the national Medicaid 50th percentile.

Living With Illness

HSAG observed varied performance within the Living With Illness domain. The following HEDIS 2016 MWA measure indicator rates within this domain exceeded the national Medicaid 75th percentile: *Comprehensive Diabetes Care—Medical Attention for Nephropathy*; *Medication Management for People With Asthma—Medication Compliance 50%—Total* and *Medication Compliance 75%—Total*; *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications*; and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment.*

Conversely, the following HEDIS 2016 MWA measure indicator rates within this domain ranked below the national Medicaid 50th percentile: *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*; *Controlling High Blood Pressure*; *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia*; *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*; and *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, *Digoxin*, *Diuretics*, and *Total.*

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 2015 and 2016 statewide rates for the *Race/Ethnicity Diversity of Membership* measure, the 2016 rates showed slight changes (less than 1 percentage point) for almost all categories. For the *Language Diversity of Membership* measure, the statewide percentage of members using English as the preferred spoken language for healthcare decreased slightly from the previous year, with a corresponding increase in the Unknown category. The percentage of Michigan members reporting either English or Non-English as the language preferred for written materials decreased in HEDIS 2016, along with a corresponding increase in the percentage of members reporting in the Unknown category. Regarding other language needs, the percentage of members reporting English as another language need increased, and the percentage of members reporting Unknown demonstrated a corresponding decrease in HEDIS 2016.

Utilization

For *Ambulatory Care (Per 1,000 Member Months)—Outpatient Visits* and *Emergency Department Visits*, the Michigan Medicaid unweighted averages for HEDIS 2016 demonstrated an 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 three inpatient service types (*Total Inpatient, Medicine*, and *Surgery*). The average length of stay decreased for all four services (*Total Inpatient, Medicine*, *Surgery*, and *Maternity)*.

[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—2016 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 2016 Measures

Within this report, HSAG presents the Michigan Medicaid Weighted Average (MWA) (i.e., statewide average rates) and MHP-specific performance on 35 HEDIS measures selected by MDHHS for HEDIS 2016. 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 2016 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 2016 Volume 2 Technical Specifications*. Data collection methodologies are described in detail in the next section.

Table 2-2—Michigan Medicaid HEDIS 2016 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/Td)	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—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
Weeks of Pregnancy at Time of Enrollment—Prior to 0 Weeks, 1–12 Weeks, 13–27 Weeks, 28 or More Weeks of Pregnancy, and *Unknown*	—
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. 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

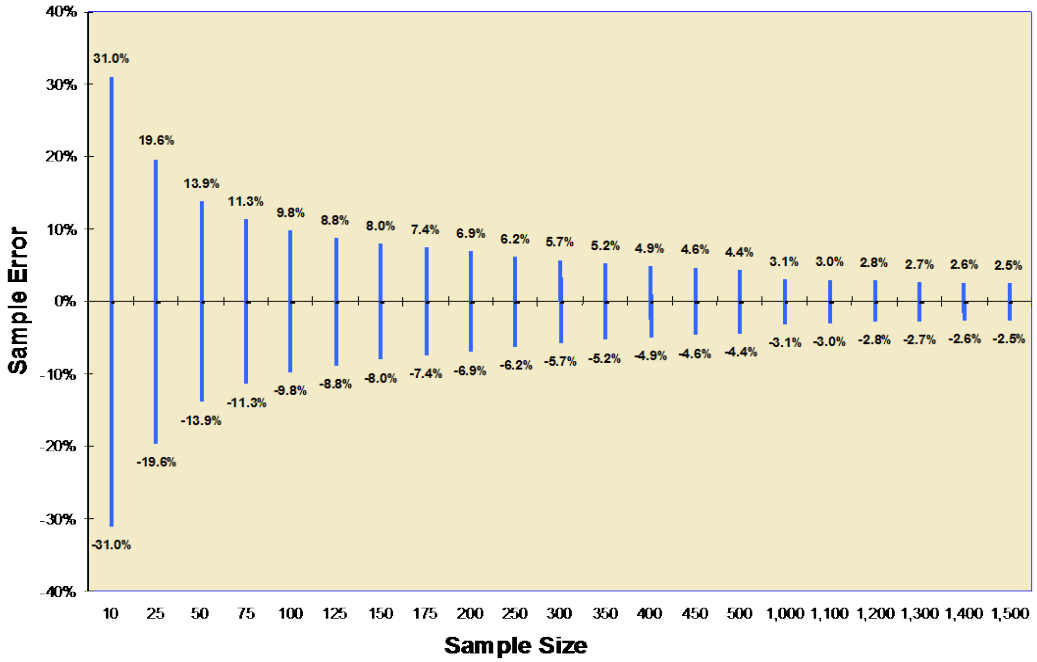
Correct interpretation of results for measures collected using HEDIS hybrid methodology requires an understanding of sampling error. It is rarely possible, logistically or financially, to complete medical record review for the entire eligible population for a given measure. Measures collected using the 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 or the Microsoft (MS) Excel files supplied by the MHPs. Prior to HSAG's receipt of the MHPs' IDSS files or MS Excel files, all of the MHPs were required by MDHHS to have their HEDIS 2016 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 2016 measure indicator rates received one of five predefined audit results: *Reportable (R)*, *Not Applicable (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 10 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 statewide rate for most of the measures was the Medicaid Weighted Average (MWA) rate 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 (MA) rates were calculated for utilization-based measures to align with calculations from prior years' deliverables.

Evaluating Measure Results

National Benchmark Comparisons

Benchmark Data

HEDIS 2016 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 2016 rates: NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2015, 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 2015.

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.

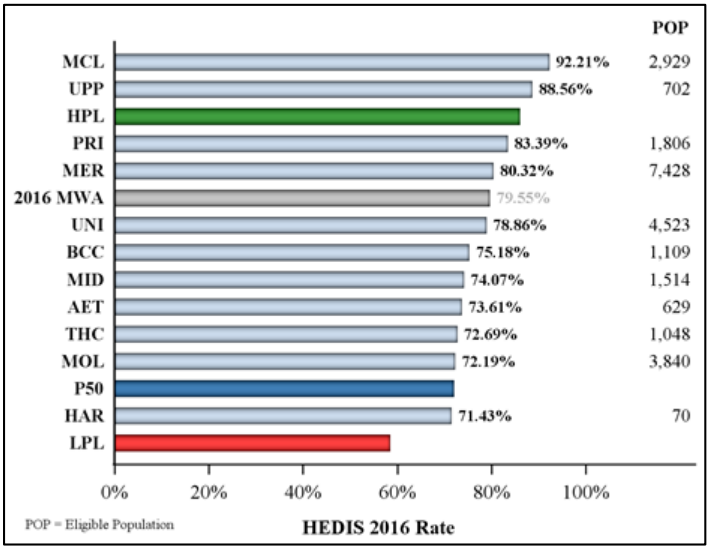
Additionally, benchmarking data (i.e., NCQA's Quality Compass and NCQA's Audit Means and Percentiles) are the proprietary intellectual property of NCQA; therefore, this report does not display any actual percentile values. As a result, rate comparisons to benchmarks are illustrated within this report using proxy displays. Of note, the prior year's reported rates were compared to the NCQA's Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2014.

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 2016 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.

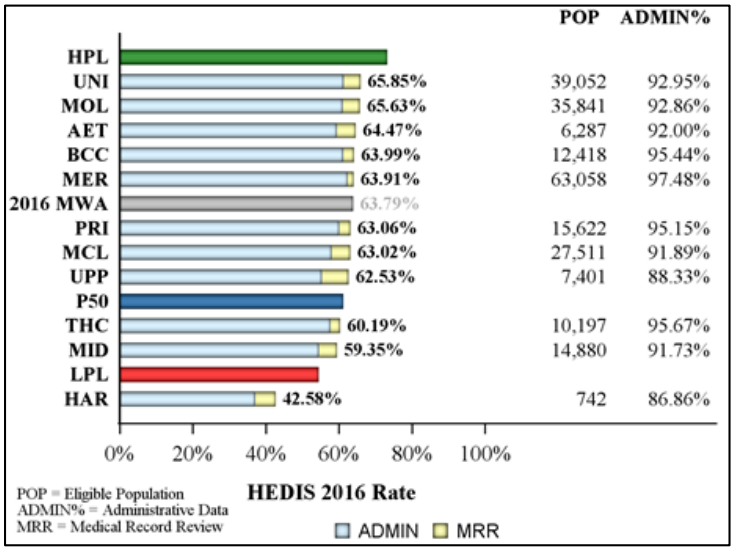
For measures for which lower rates indicate better performance, the 10th percentile (rather than the 90th percentile) and the 75th percentile (rather than the 25th percentile) are considered the HPL and LPL, respectively. An example of the horizontal bar graph figure for measure indicators reported administratively 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 Not Applicable (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 2014 and 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.

Performance Trend Analysis

In addition to the star rating results, HSAG also compared HEDIS 2016 Medicaid statewide weighted averages and MHP rates to the corresponding HEDIS 2015 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 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 2015 to HEDIS 2016" 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 2015 and HEDIS 2016 are presented in tabular format. HEDIS 2016 rates shaded green with one cross ($^{+}$) indicate a statistically significant improvement in performance from the previous year. HEDIS 2016 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 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*
Red Shading^{++}	*Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

Additionally, benchmark comparisons are denoted within Sections 3 through 8. Percentile ranking performance levels are represented using the following shading:

Table 2-4—Percentile Ranking Performance Levels

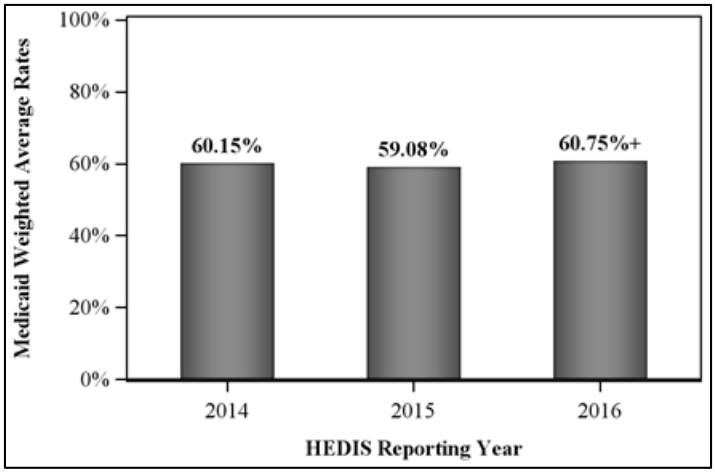
HEDIS 2016 MWA Rates Performance Level Shading	HEDIS 2016 MWA Superscript Designation	Performance Level
Green	G (^{G})	At or above the National Medicaid 90th Percentile
Blue	B (^{B})	At or above the National Medicaid 75th Percentile but below the National Medicaid 90th Percentile
Yellow	Y (^{Y})	At or above the National Medicaid 50th Percentile but below the National Medicaid 75th Percentile
Purple	P (^{P})	At or above the National Medicaid 25th Percentile but below the National Medicaid 50th Percentile
Light Red	LR (^{LR})	Below the National Medicaid 25th Percentile

The shading is provided below for reference:

≤25th^{LR}	≥25th and ≤49th^{P}	≥50th and ≤74th^{Y}	≥75th and ≤89th^{B}	≥90th^{G}

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 2014, HEDIS 2015, and HEDIS 2016 MWA rates with significance testing performed between the HEDIS 2015 and HEDIS 2016 weighted averages. Within these figures, HEDIS 2016 rates with one cross ($^{+}$) indicate a statistically significant improvement in performance from HEDIS 2015. HEDIS 2016 rates with two crosses ($^{++}$) indicate a statistically significant decline in performance from HEDIS 2015. 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 2015 Medicaid 50th percentile. In addition, the 2014, 2015, and 2016 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 2016 MWA for each rate with the 2014 and 2015 MWA and the national HEDIS 2015 Medicaid 50th percentile.

Measure Changes Between HEDIS 2015 to HEDIS 2016

With the release of HEDIS 2016, value sets were updated to include International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS), which were effective October 1, 2015.[2-1] Additionally, the following is a list of measures with technical specification changes that NCQA announced for HEDIS 2016.[2-2,2-3] These changes may have an effect on the HEDIS 2016 rates that are presented in this report.

Childhood Immunization Status

- Added a note to MMR clarifying that the "14-day rule" does not apply to this vaccine.
- Added a new value set to the administrative method to identify hepatitis B vaccines administered at birth.

Appropriate Testing for Children With Pharyngitis

- Changed age requirement from 2–18 years of age to 3–18 years of age.

Follow-up Care for Children Prescribed ADHD Medication

- Added value sets to identify acute inpatient encounters for Step 4 of the event/diagnosis (for both the *Initiation Phase* and the *Continuation and Maintenance Phase*).

Breast Cancer Screening

- Added new value sets to identify bilateral mastectomy.

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

- Removed the BMI value option for members 16–17 years of age from the numerator.
- Revised the physical activity requirement to indicate that notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations does not meet criteria.

2-1 *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Geneva: World Health Organization, 1992. Print.

2-2 National Committee for Quality Assurance. *HEDIS® 2016, Volume 2: Technical Specifications for Health Plans*. Washington, DC: NCQA Publication, 2015.

2-3 National Committee for Quality Assurance. *HEDIS® 2016, Volume 2: Technical Update*. Washington, DC: NCQA Publication, 2015.

Adult BMI Assessment

- Revised the age criteria for BMI and BMI percentile in the numerator.

Prenatal and Postpartum Care

- Deleted the use of infant claims to identify deliveries.
- Clarified the tests that must be included to meet criteria for an obstetric panel in the hybrid specification.

Frequency of Ongoing Prenatal Care

- Deleted the use of infant claims to identify deliveries.

Weeks of Pregnancy at Time of Enrollment

- Deleted the use of infant claims to identify deliveries.

Comprehensive Diabetes Care

- Revised the requirements for urine protein testing for the *Medical Attention for Nephropathy* indicator; a screening or monitoring test meets criteria, whether the result is positive or negative.
- Removed the optional exclusion for polycystic ovaries.
- Added a note clarifying optional exclusions.

Medication Management for People With Asthma

- Deleted all "Long-acting, inhaled beta-2 agonists" from Table MMA-A.

Controlling High Blood Pressure

- Revised a value set used to identify the event/diagnosis.
  - Added HCPCS codes to identify outpatient visits.
  - Renamed the Outpatient CPT Value Set to Outpatient Without UBREV Value Set.
- Clarified how to assign the diabetes flag.
- Removed the criteria for polycystic ovaries when assigning a flag of "not diabetic" in the event/diagnosis.
- Clarified the denominator section of the Hybrid Specification to state that if the hypertension diagnosis is not confirmed, the member is excluded and replaced by a member from the oversample.
- Added a method and value sets to identify nonacute inpatient admissions for optional exclusions.
- Added a note to clarify when organizations may change the diabetes flag that was assigned based on administrative data.

Antidepressant Medication Management

- Added a method and value sets to identify acute and nonacute inpatient discharges for required exclusions (Step 2).
- Changed the description of "SSNRI antidepressants" to "SNRI antidepressants" in Table AMM-C.
- Added levomilnacipran to the description of "SNRI antidepressants" in Table AMM-C.

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

- Added Other Bipolar Disorders Value Set to Step 1 of the event/diagnosis.

Diabetes Monitoring for People With Diabetes and Schizophrenia

- Removed the optional exclusion for polycystic ovaries.

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

- Added a method and value sets to identify discharges for Step 2 of the event/diagnosis.

Adherence to Antipsychotic Medications for Individuals With Schizophrenia

- Revised the index prescription start date (IPSD) time frame.

Annual Monitoring for Patients on Persistent Medications

- Added value sets to identify acute and nonacute inpatient encounters for the optional exclusions.

Inpatient Utilization—General Hospital/Acute Care

- Added a method and value sets to identify acute inpatient discharges in Step 1.

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/Td)*
- *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 Michigan Medicaid Weighted Average (MWA) performance for the measure indicators under the Child & Adolescent Care measure domain. The table lists the HEDIS 2016 MWA rates and performance levels, a comparison of the HEDIS 2015 MWA to the HEDIS 2016 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating statistically significant changes from HEDIS 2015 to HEDIS 2016.

Table 3-1—HEDIS 2016 MWA Performance Levels and Trend Results for Child & Adolescent Care

Measure	HEDIS 2016 MWA and Performance Level[1]	HEDIS 2015 MWA–HEDIS 2016 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2016	Number of MHPs With Statistically Significant Decline in HEDIS 2016
Childhood Immunization Status				
Combination 2	76.15%Y	**-1.01++**	0	0
Combination 3	71.05%P	**-1.85++**	0	2
Combination 4	67.50%P	-0.27	0	1
Combination 5	58.78%Y	**-1.74++**	0	0
Combination 6	40.45%P	**-4.31++**	0	3
Combination 7	56.15%Y	-0.82	0	0
Combination 8	39.27%P	**-3.42++**	0	3
Combination 9	34.97%P	**-3.47++**	0	2
Combination 10	33.92%P	**-3.00++**	0	3
Well-Child Visits in the First 15 Months of Life				
Six or More Visits	66.22%Y	**+1.45+**	1	1
Lead Screening in Children				
Lead Screening in Children	79.55%Y	-0.82	1	0
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	75.11%Y	**-0.65++**	0	1
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	54.74%Y	**+0.72+**	0	1
Immunizations for Adolescents				
Combination 1	86.99%B	**-1.95++**	1	2
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	89.09%Y	**+1.09+**	2	1
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	68.41%P	**+1.15+**	2	1

Measure	HEDIS 2016 MWA and Performance Level[1]	HEDIS 2015 MWA–HEDIS 2016 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2016	Number of MHPs With Statistically Significant Decline in HEDIS 2016
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	42.58%Y	**+3.71+**	3	0
Continuation and Maintenance Phase	53.96%Y	**+9.61+**	2	0

[1] 2016 performance levels were based on comparisons of the HEDIS 2016 MWA measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks. 2016 performance levels represent the following percentile comparisons:

≤25thLR	≥25th and ≤49thP	≥50th and ≤74thY	≥75th and ≤89thB	≥90thG

[2] HEDIS 2015 MWA to HEDIS 2016 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 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

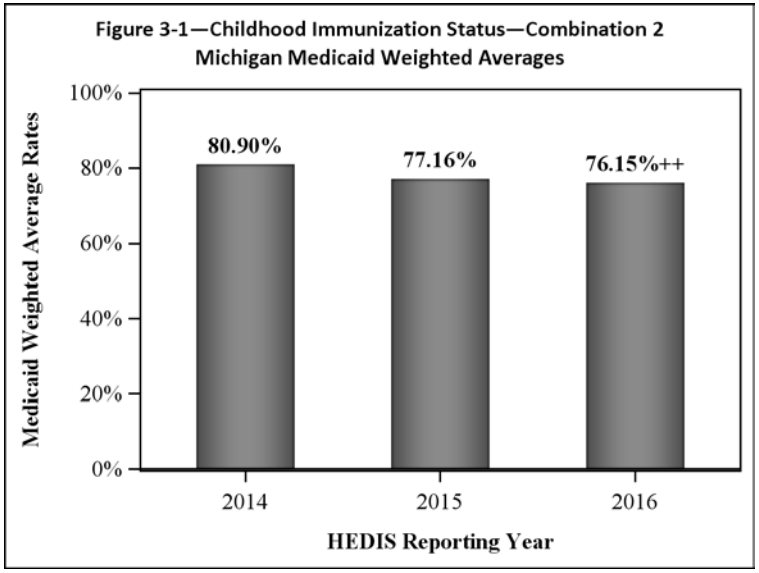
Red Shading++ *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

Table 3-1 shows that all of the HEDIS 2016 MWA *Childhood Immunization Status* measure indicator rates declined from the prior year; seven of these rate declines were statistically significant. Further, six of the *Childhood Immunization Status* measure indicator rates fell below the national Medicaid 50th percentile, which represented an opportunity for improvement. Another opportunity for improvement exists for the MWA *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, which significantly declined from the prior year. However, six measure indicator rates statistically significantly improved from the prior year, and five of these rates ranked at or above the national Medicaid 50th percentile. One MWA measure indicator rate, *Immunizations for Adolescents—Combination 1*, ranked at or above the national Medicaid 75th percentile despite showing a decline in performance from the prior year.

Measure-Specific Findings

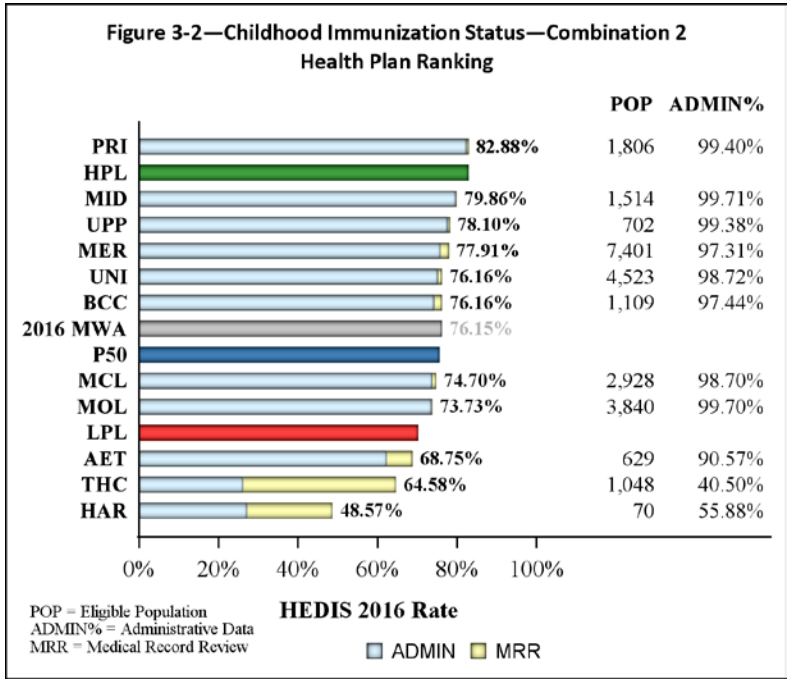
Childhood Immunization Status—Combination 2

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.



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

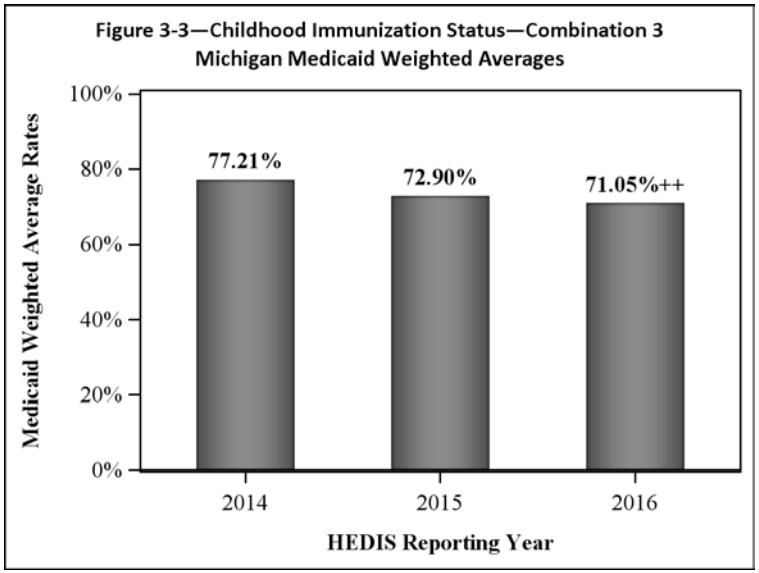
The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.



One MHP ranked above the HPL. Three MHPs fell below the LPL. MHP performance varied from 82.88 percent to 48.57 percent.

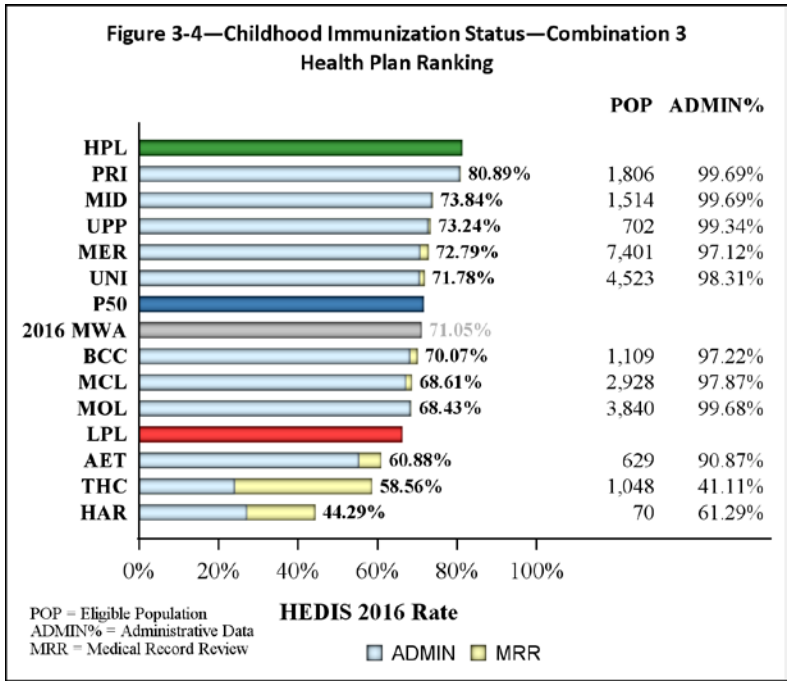
Childhood Immunization Status—Combination 3

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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

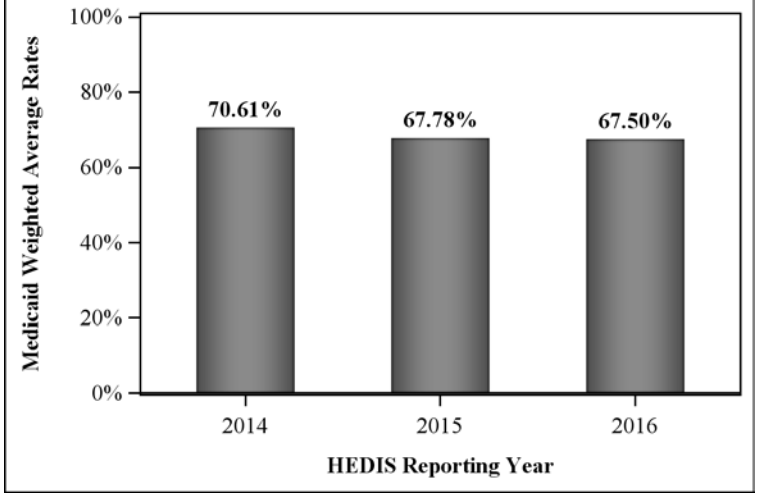


Five MHPs ranked above the national Medicaid 50th percentile but below the HPL. Three MHPs fell below the LPL. MHP performance varied from 80.89 percent to 44.29 percent.

Childhood Immunization Status—Combination 4

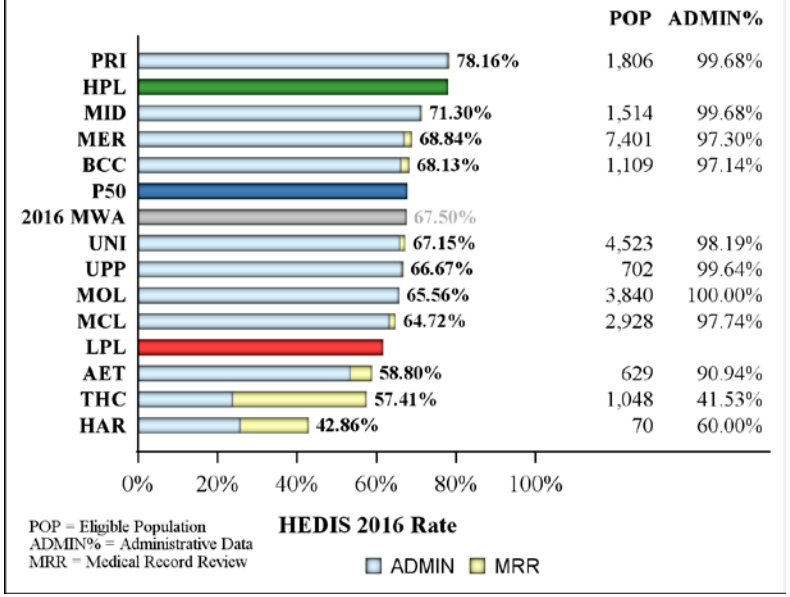
Childhood Immunization Status—Combination 4 assesses the percentage of children 2 years of age during the measurement year who received the following vaccines by their second birthday: four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophilus influenzae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

Figure 3-5—Childhood Immunization Status—Combination 4
Michigan Medicaid Weighted Averages



The HEDIS 2016 MWA rate did not demonstrate a statistically significant change from HEDIS 2015.

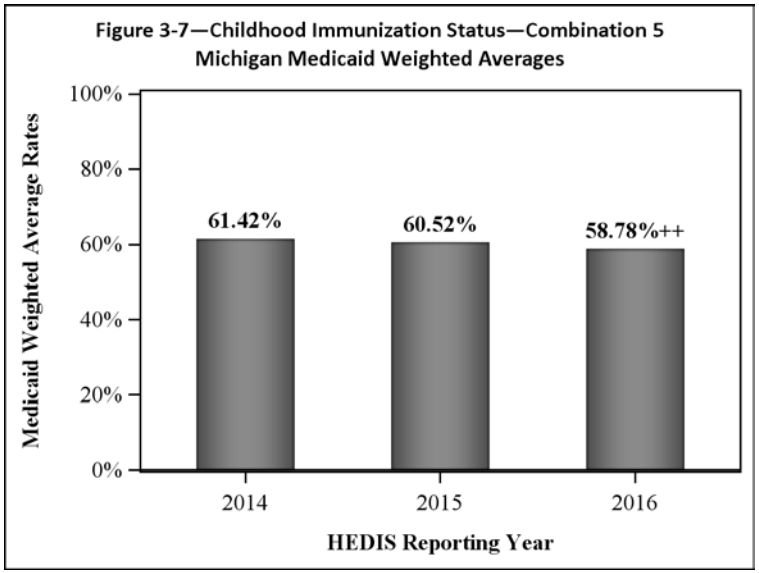
Figure 3-6—Childhood Immunization Status—Combination 4
Health Plan Ranking



One MHP ranked above the HPL. Three MHPs fell below the LPL. MHP performance varied from 78.16 percent to 42.86 percent.

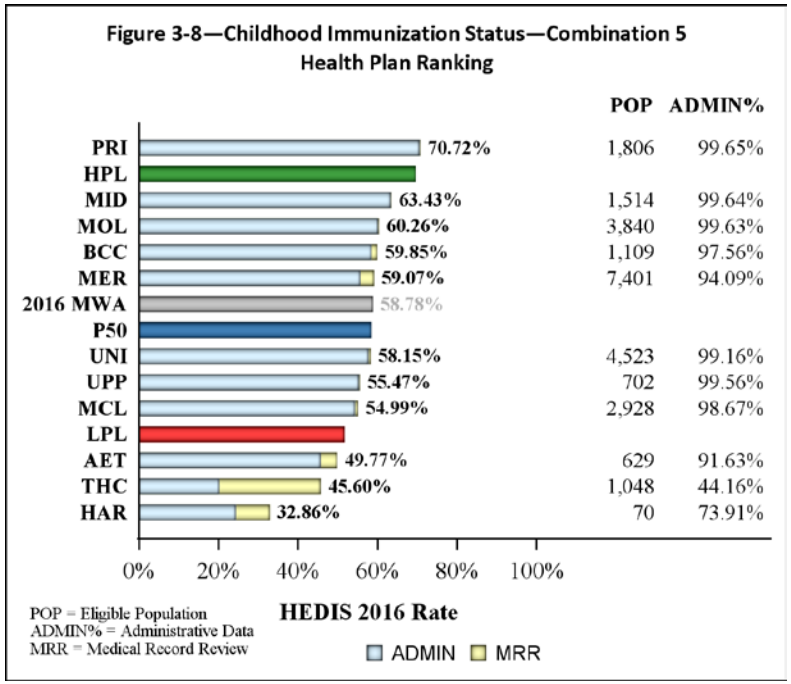
Childhood Immunization Status—Combination 5

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

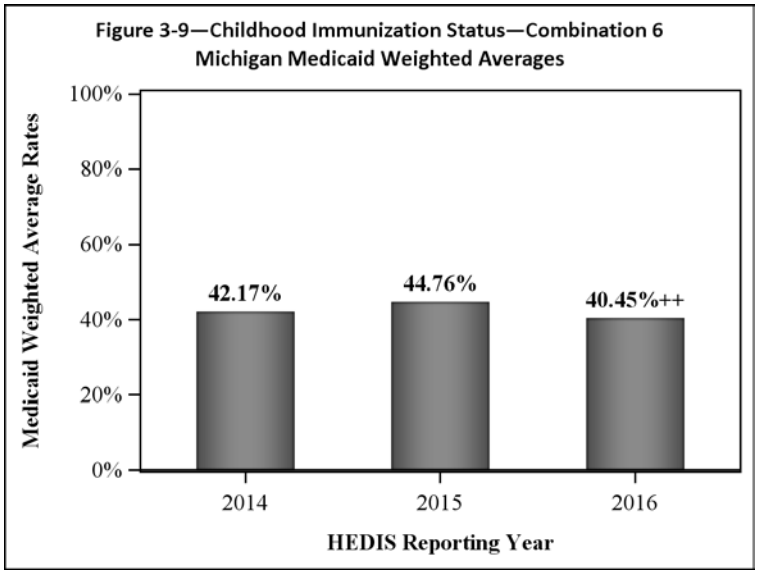
The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.



One MHP ranked above the HPL. Three MHPs fell below the LPL. MHP performance varied from 70.72 percent to 32.86 percent.

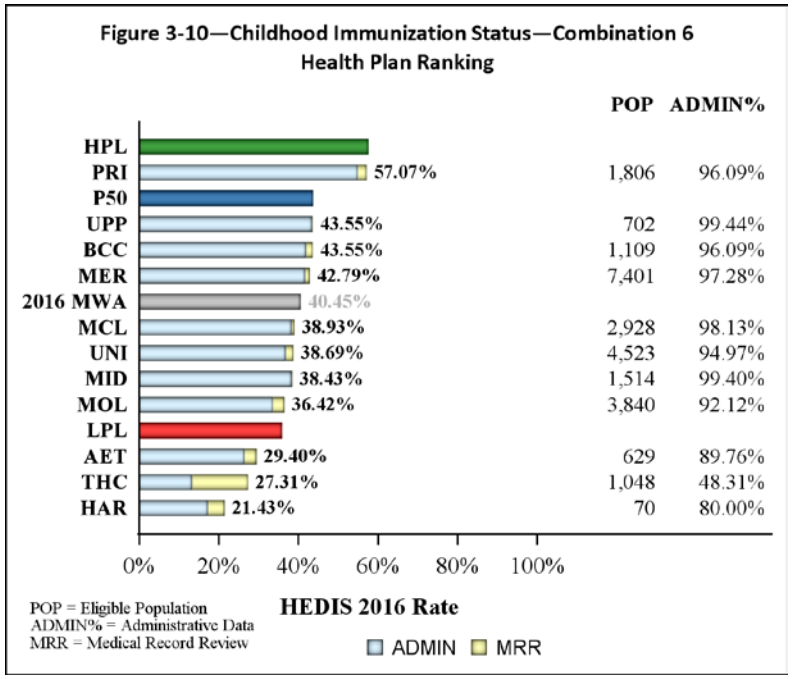
Childhood Immunization Status—Combination 6

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.



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

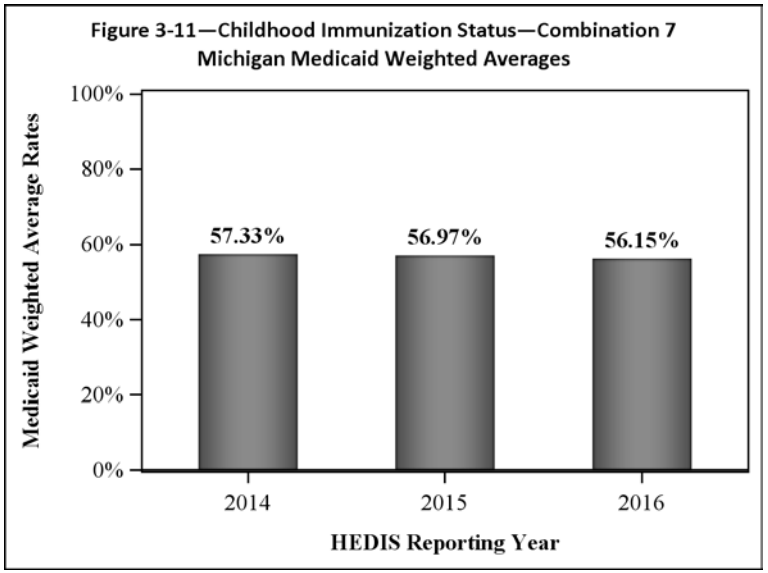
The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.



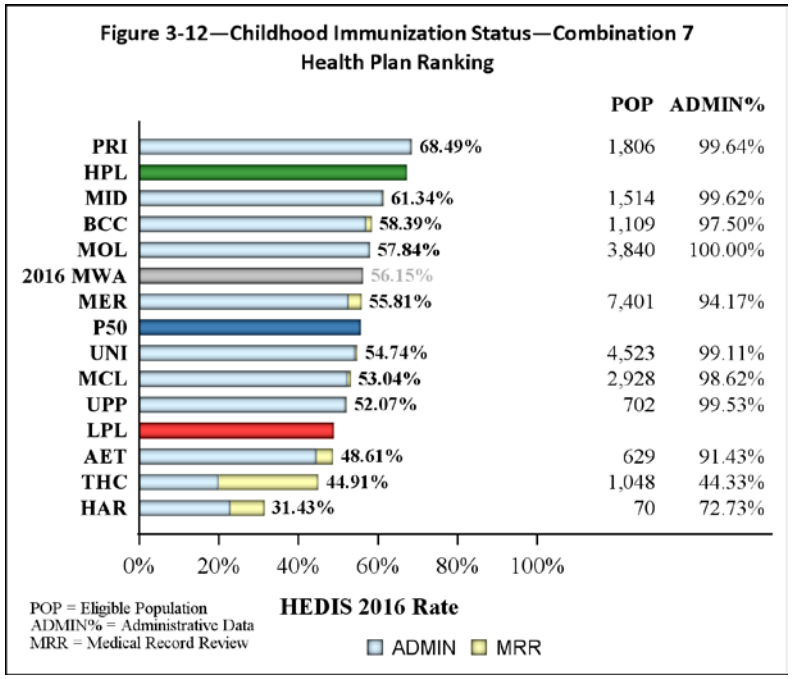
One MHP ranked above the national Medicaid 50th percentile but below the HPL. Three MHPs fell below the LPL. MHP performance varied from 57.07 percent to 21.43 percent.

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.



The HEDIS 2016 MWA rate did not demonstrate a statistically significant change from HEDIS 2015.

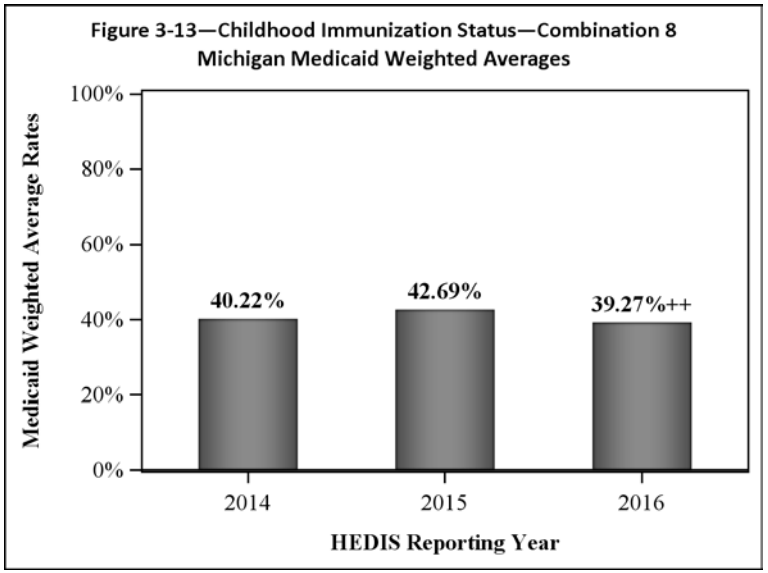


One MHP ranked above the HPL. Three MHPs fell below the LPL. MHP performance varied from 68.49 percent to 31.43 percent.

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.

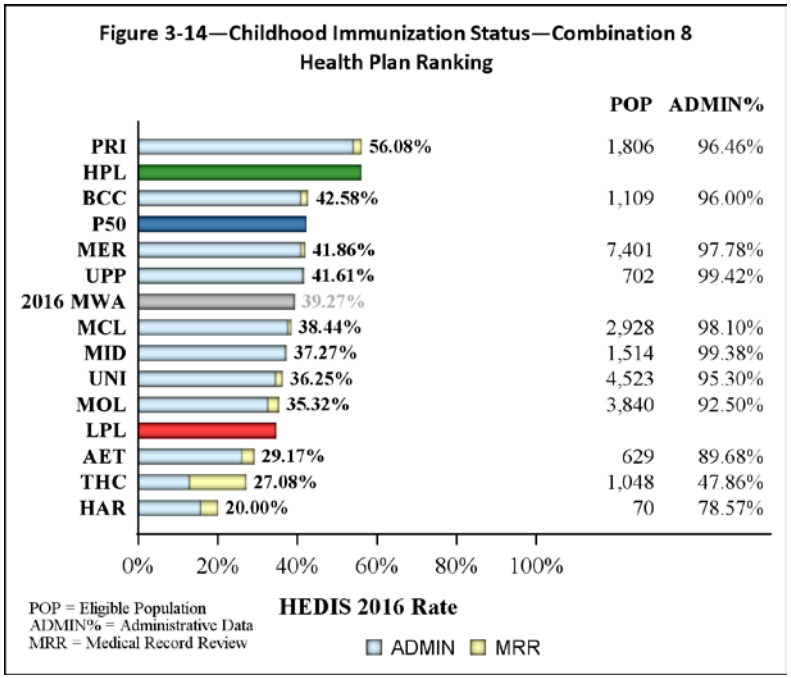
Figure 3-13—Childhood Immunization Status—Combination 8
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

Figure 3-14—Childhood Immunization Status—Combination 8
Health Plan Ranking

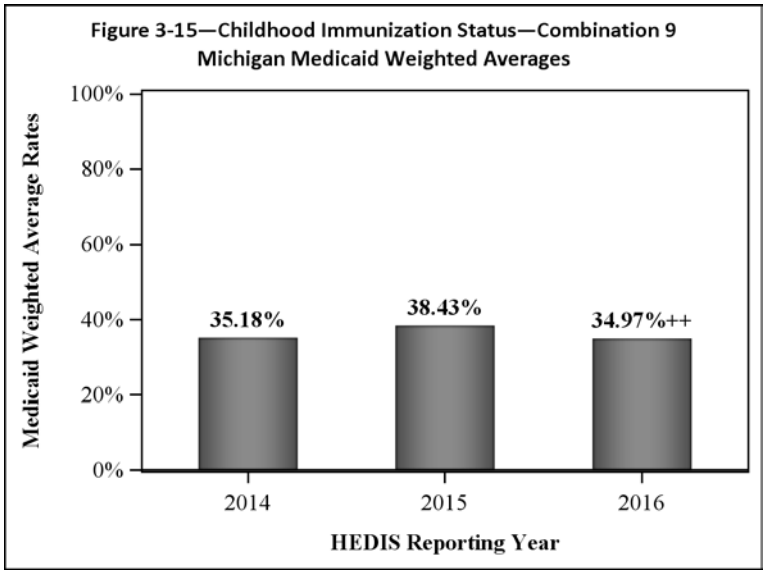


One MHP ranked above the HPL. Three MHPs fell below the LPL. MHP performance varied from 56.08 percent to 20.00 percent.

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.

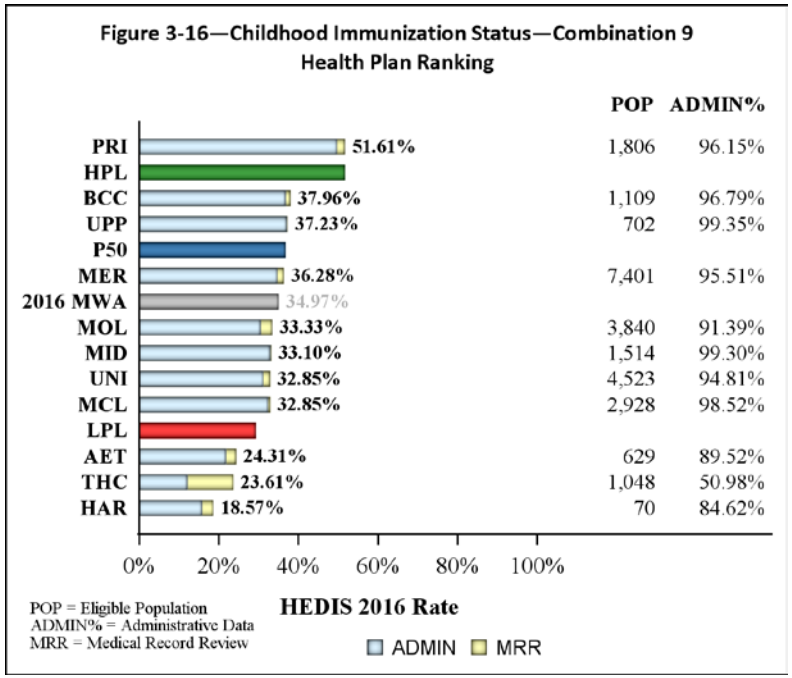
Figure 3-15—Childhood Immunization Status—Combination 9
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

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

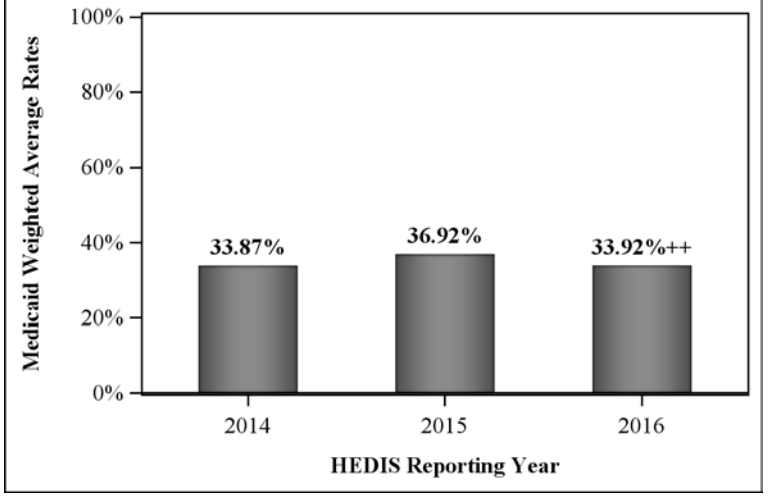


One MHP ranked above the HPL. Three MHPs fell below the LPL. MHP performance varied from 51.61 percent to 18.57 percent.

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.

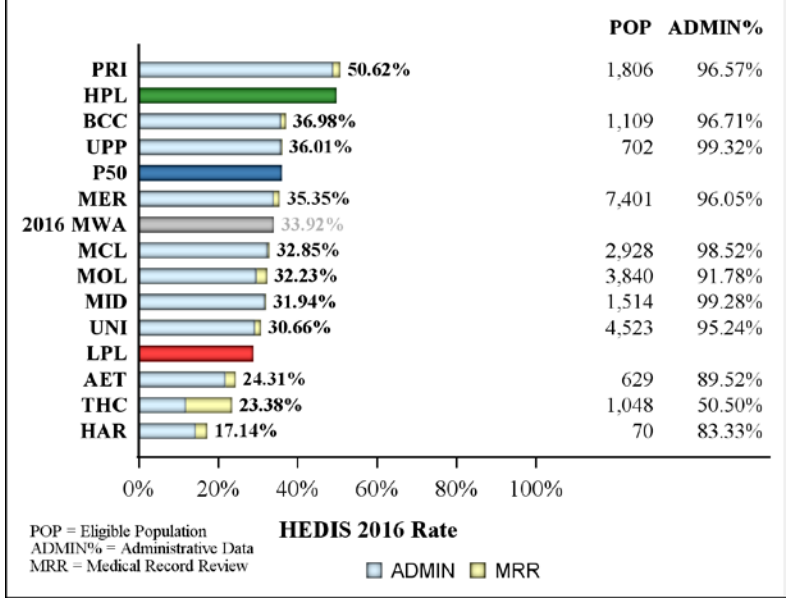
Figure 3-17—Childhood Immunization Status—Combination 10
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

Figure 3-18—Childhood Immunization Status—Combination 10
Health Plan Ranking

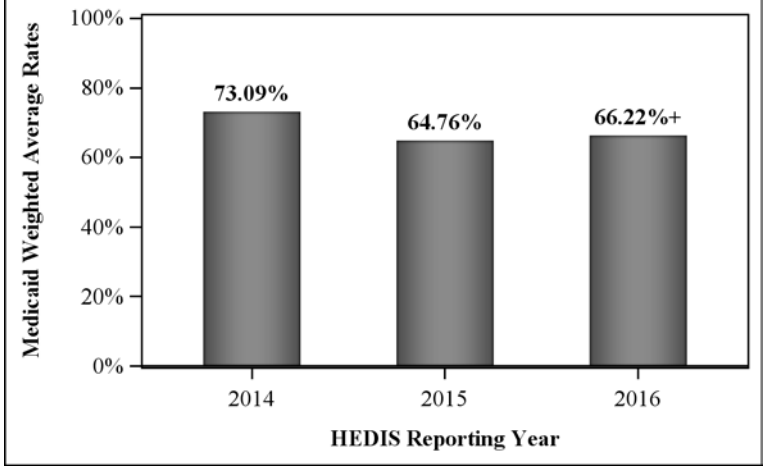


One MHP ranked above the HPL. Three MHPs fell below the LPL. MHP performance varied from 50.62 percent to 17.14 percent.

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.

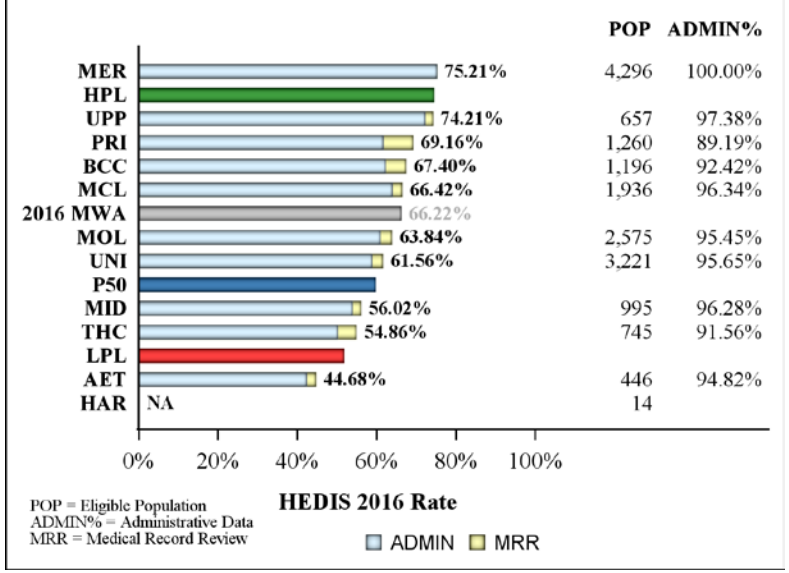
Figure 3-19—Well-Child Visits in the First 15 Months of Life—Six or More Visits
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2015.

Figure 3-20—Well-Child Visits in the First 15 Months of Life—Six or More Visits
Health Plan Ranking

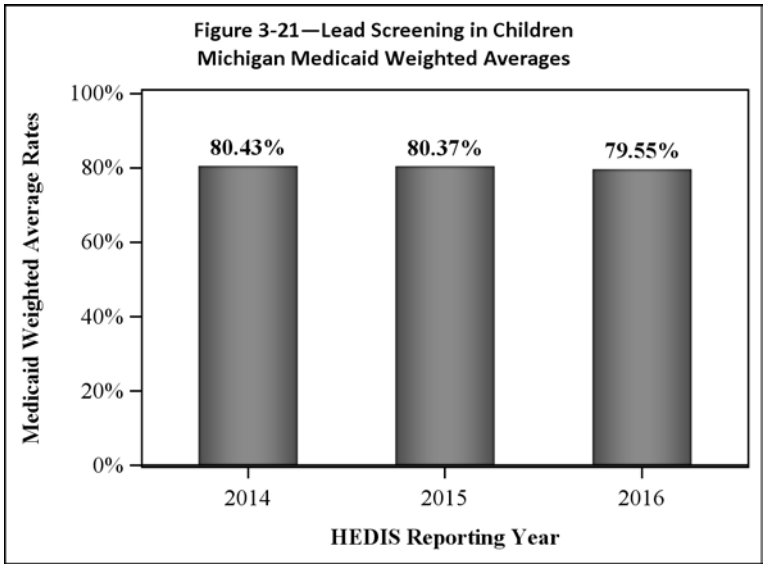


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

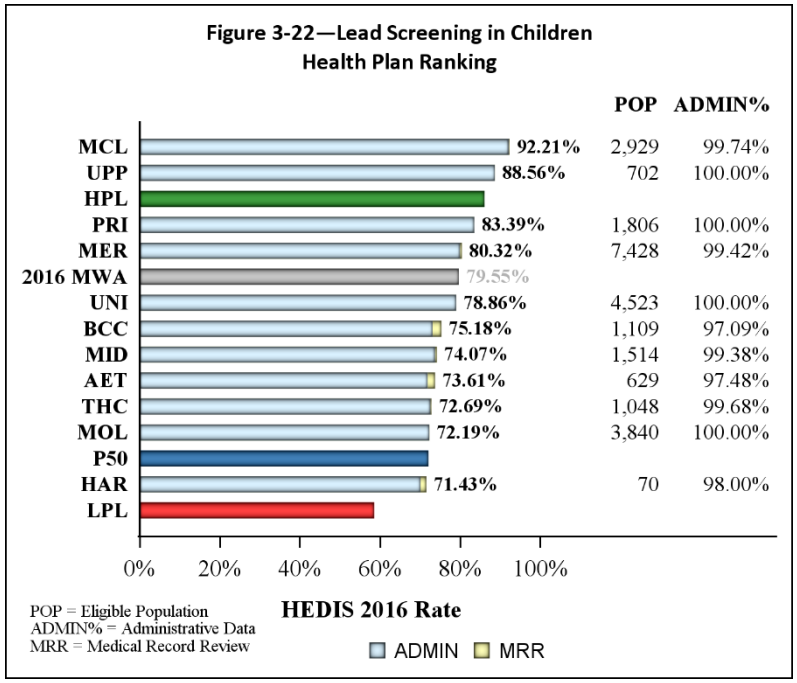
One MHP ranked above the HPL. One MHP fell below the LPL. MHP performance varied from 75.21 percent to 44.68 percent.

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.



The HEDIS 2016 MWA rate did not demonstrate a statistically significant change from HEDIS 2015.

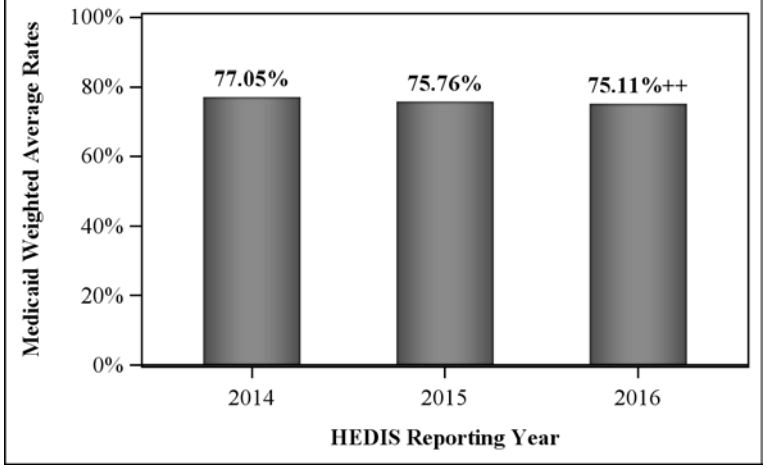


Two MHPs ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 92.21 percent to 71.43 percent.

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.

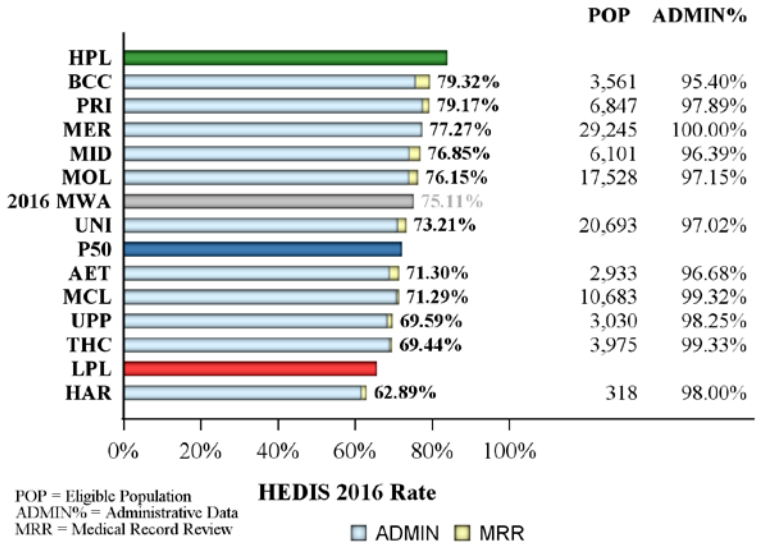
Figure 3-23—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

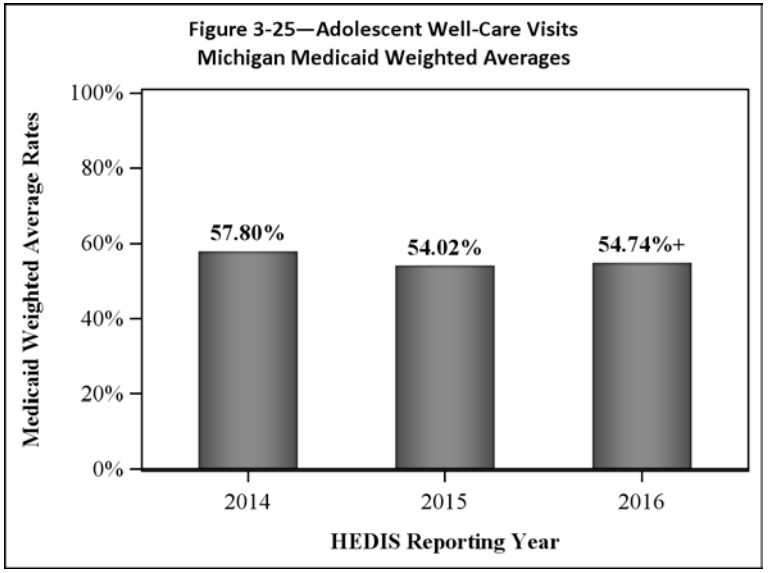
Figure 3-24—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Health Plan Ranking



Six 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 79.32 percent to 62.89 percent.

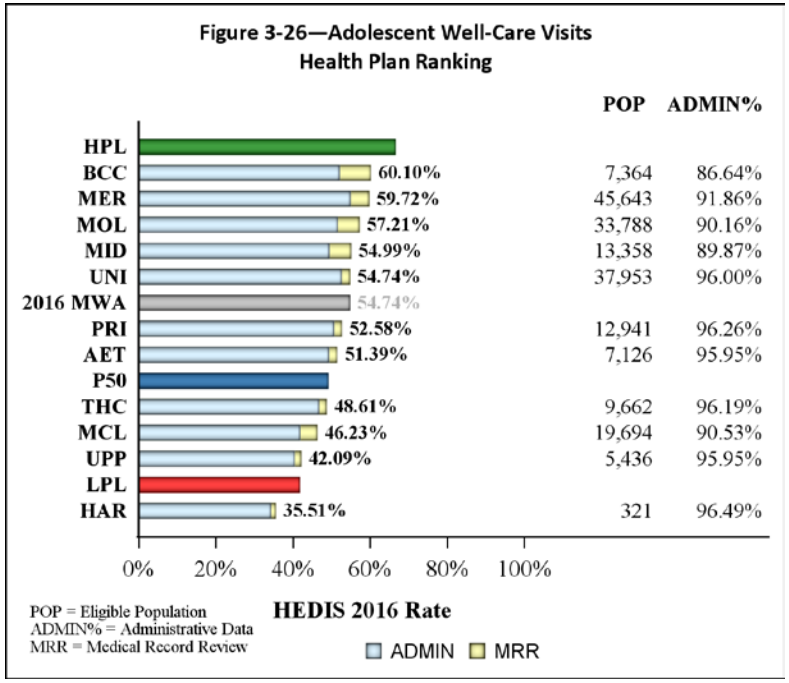
Adolescent Well-Care Visits

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 statistically significant improvement in performance from the previous year.

The HEDIS 2016 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2015.

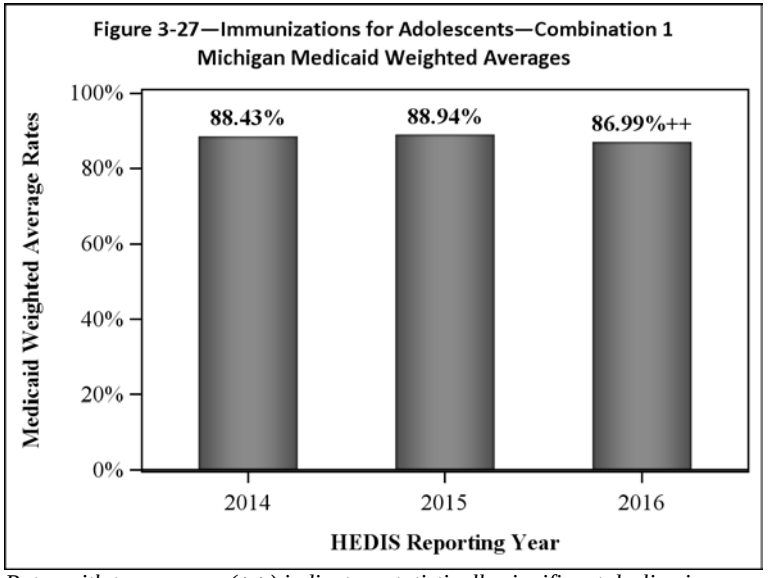


Seven MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 60.10 percent to 35.51 percent.

Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td)

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

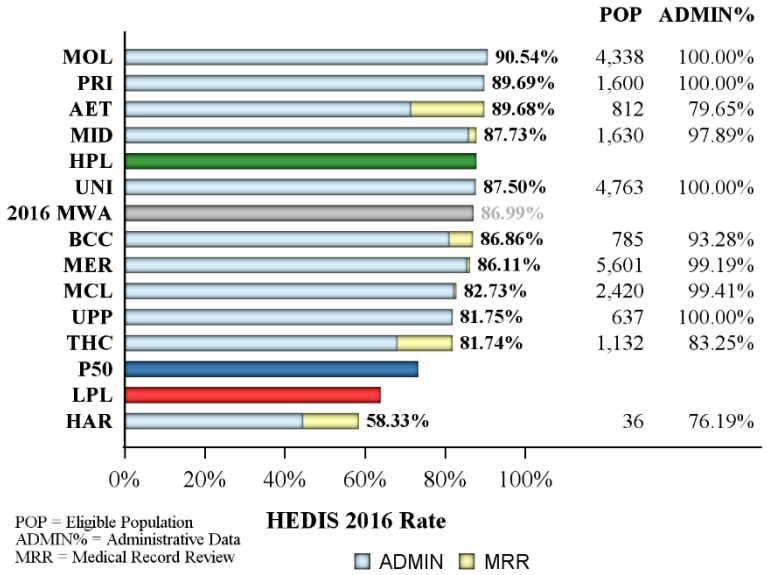
Figure 3-27—Immunizations for Adolescents—Combination 1
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

Figure 3-28—Immunizations for Adolescents—Combination 1
Health Plan Ranking

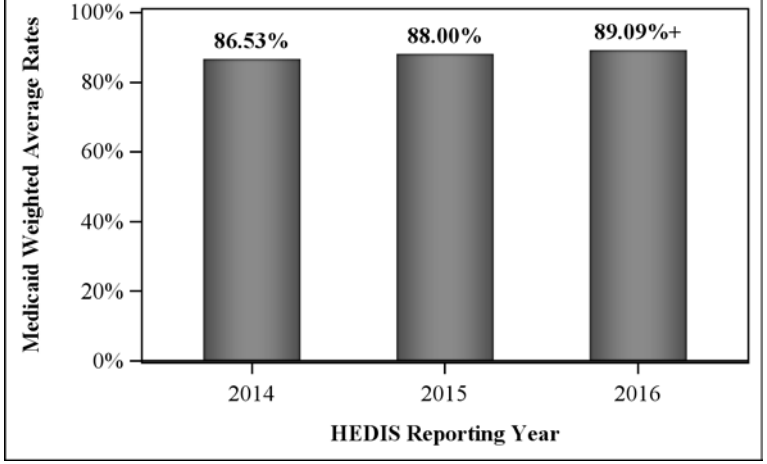


Four MHPs ranked above the HPL. One MHP fell below the LPL. MHP performance varied from 90.54 percent to 58.33 percent.

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.

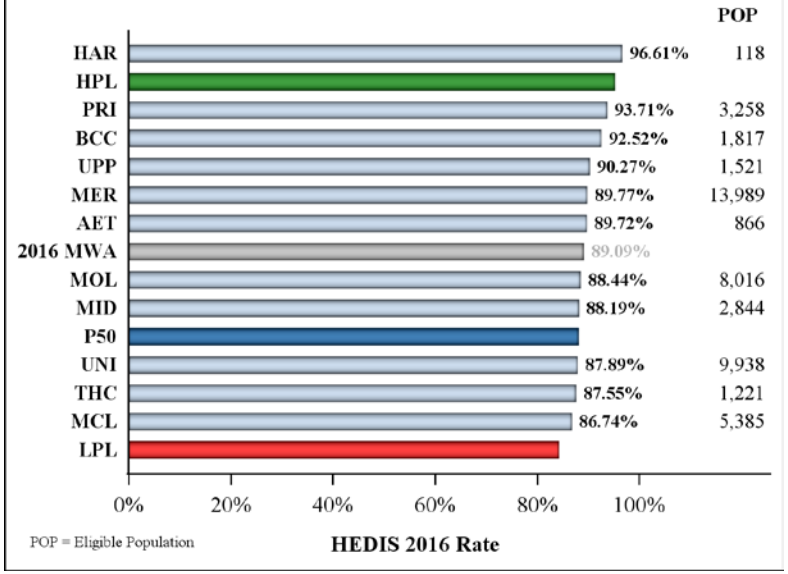
Figure 3-29—Appropriate Treatment for Children With Upper Respiratory Infection
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2015.

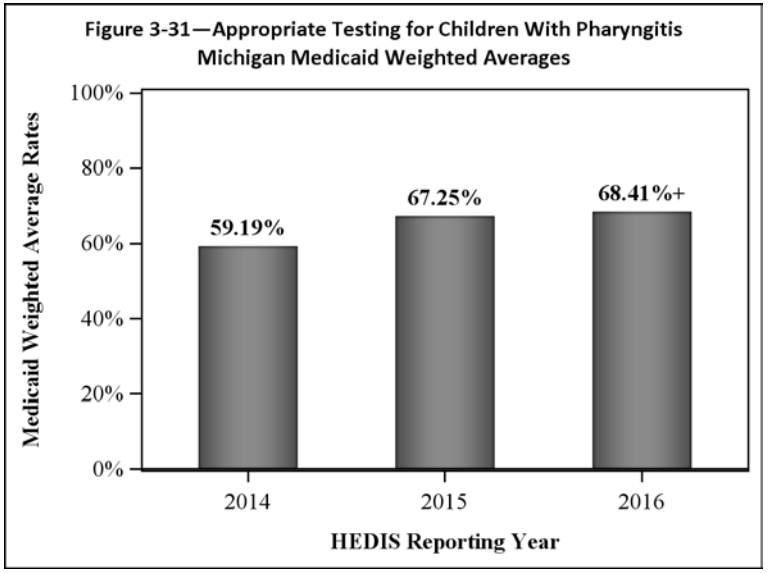
Figure 3-30—Appropriate Treatment for Children With Upper Respiratory Infection
Health Plan Ranking



One MHP ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 96.61 percent to 86.74 percent.

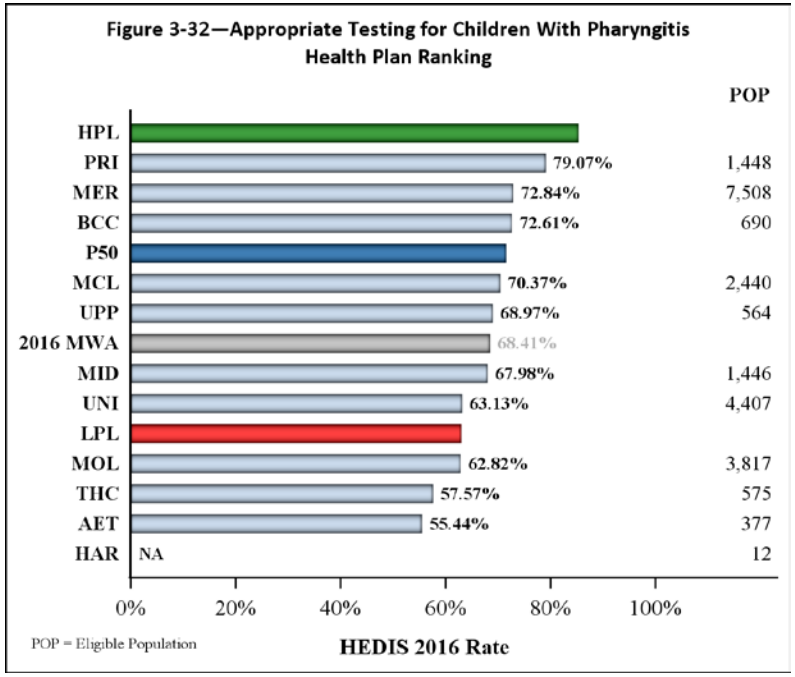
Appropriate Testing for Children With Pharyngitis

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 statistically significant improvement in performance from the previous year.

The HEDIS 2016 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2015.



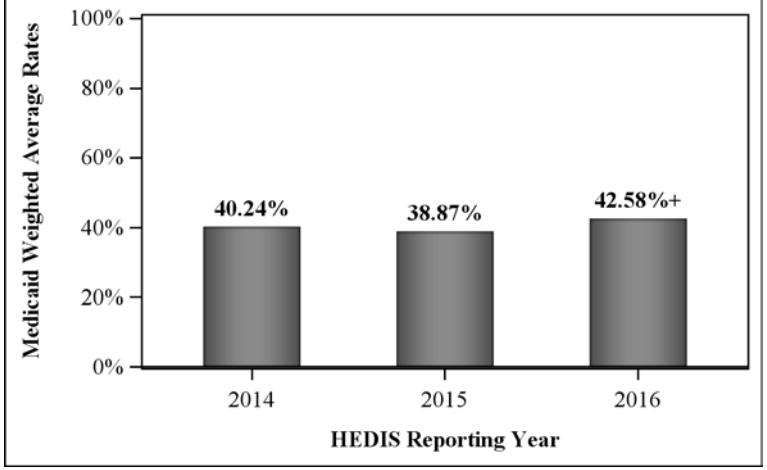
NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Three MHPs ranked above the national Medicaid 50th percentile but below the HPL. Three MHPs fell below the LPL. MHP performance varied from 79.07 percent to 55.44 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.

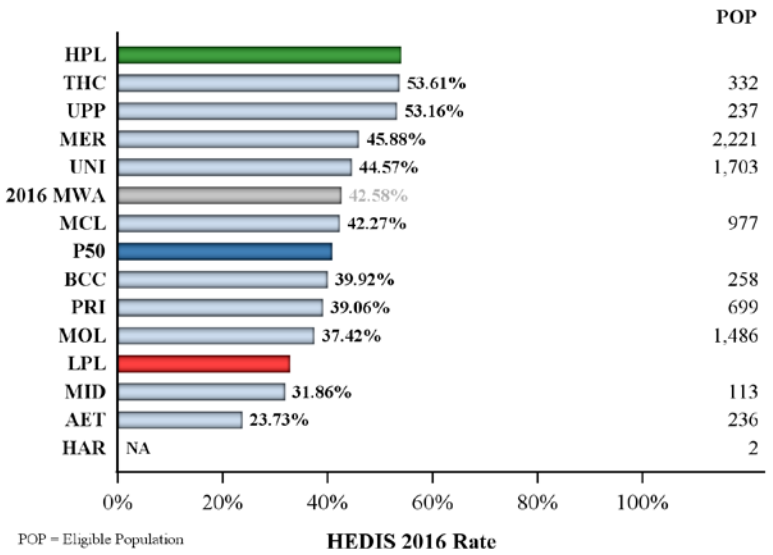
Figure 3-33—Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2015.

Figure 3-34—Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase
Health Plan Ranking



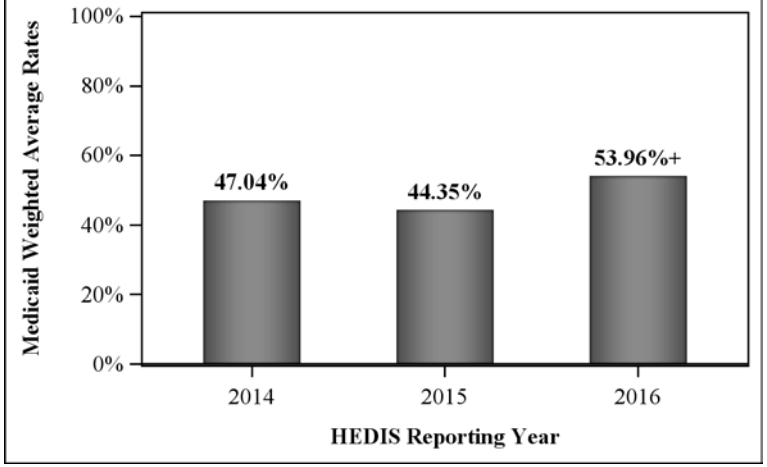
NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

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 53.61 percent to 23.73 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.

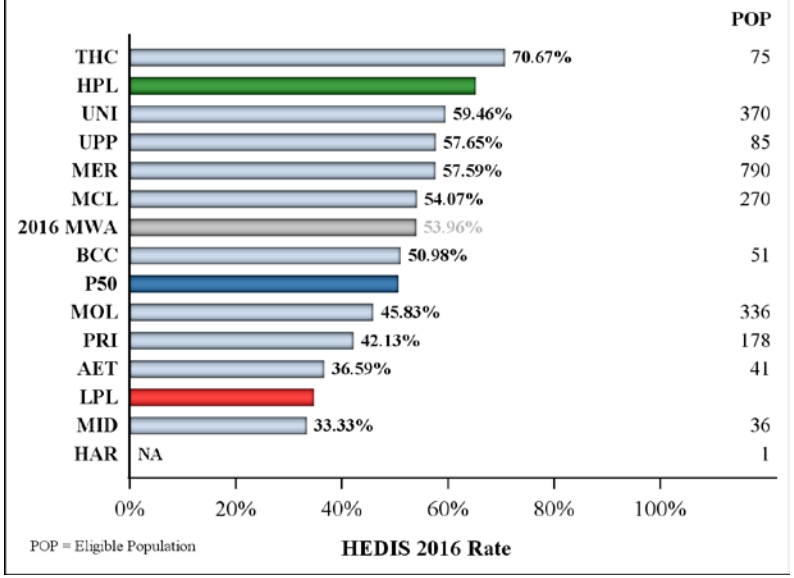
Figure 3-35—Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2015.

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 Not Applicable (NA) audit designation.

One MHP ranked above the HPL. One MHP fell below the LPL. MHP performance varied from 70.67 percent to 33.33 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 2016 MWA rates and performance levels, a comparison of the HEDIS 2015 MWA to the HEDIS 2016 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating statistically significant changes from HEDIS 2015 to HEDIS 2016.

Table 4-1—HEDIS 2016 MWA Performance Levels and Trend Results for Women—Adult Care

Measure	HEDIS 2016 MWA and Performance Level[1]	HEDIS 2015 MWA–HEDIS 2016 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2016	Number of MHPs With Statistically Significant Decline in HEDIS 2016
Breast Cancer Screening				
Breast Cancer Screening	59.58%Y	-0.06	1	3
Cervical Cancer Screening				
Cervical Cancer Screening	63.79%Y	**-4.67++**	1	3

Measure	HEDIS 2016 MWA and Performance Level[1]	HEDIS 2015 MWA–HEDIS 2016 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2016	Number of MHPs With Statistically Significant Decline in HEDIS 2016
Chlamydia Screening in Women				
Ages 16 to 20 Years	60.75%[B]	**+1.67**[+]	2	0
Ages 21 to 24 Years	67.85%[B]	+0.28	2	2
Total	63.86%[B]	**+1.65**[+]	4	1

[1] 2016 performance levels were based on comparisons of the HEDIS 2016 MWA measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks. 2016 performance levels represent the following percentile comparisons:

≤25th[LR]	≥25th and ≤49th[P]	≥50th and ≤74th[Y]	≥75th and ≤89th[B]	≥90th[G]

[2] HEDIS 2015 MWA to HEDIS 2016 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 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

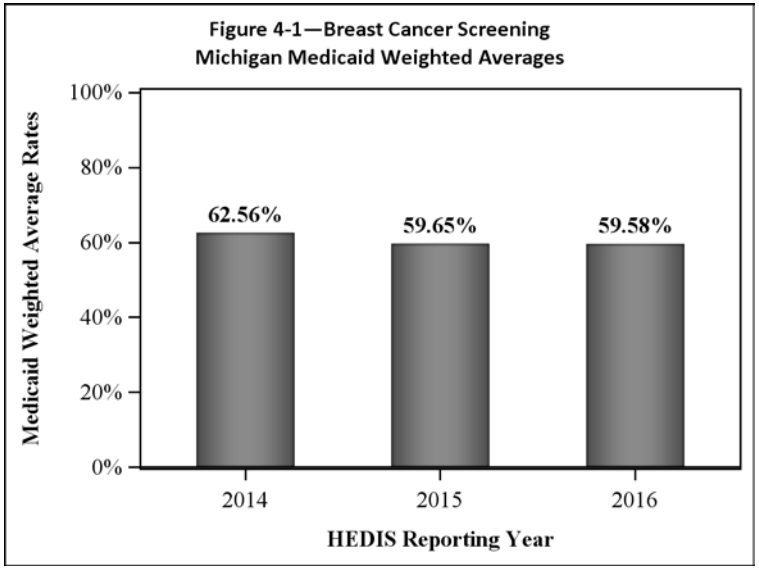
Red Shading[++] *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

Table 4-1 shows that all three of the HEDIS 2016 MWA *Chlamydia Screening in Women* measure indicator rates increased from the prior year and ranked at or above the national Medicaid 75th percentiles. Two of these rate increases were statistically significant. One MWA measure indicator rate showed a statistically significant decline in performance, *Cervical Cancer Screening*.

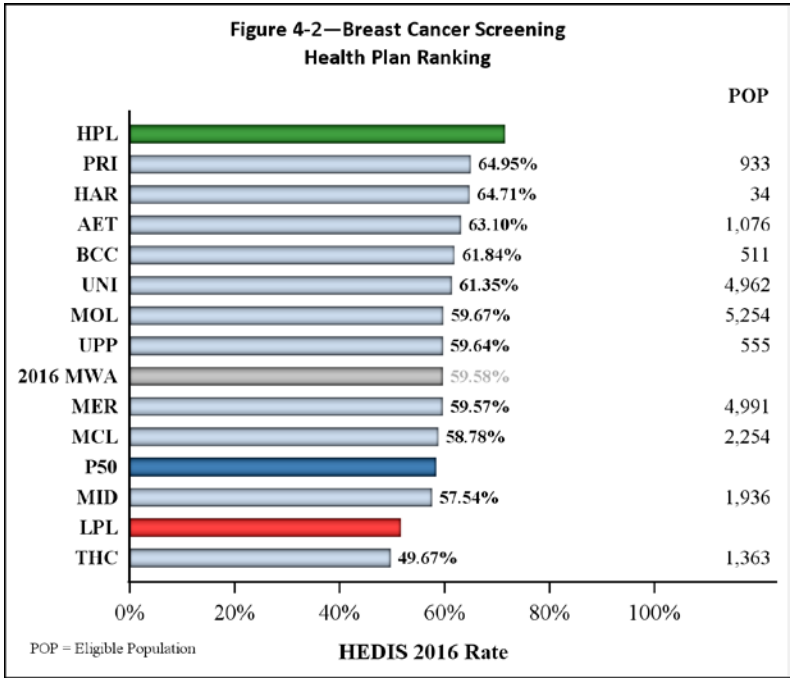
Measure-Specific Findings

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.



The HEDIS 2016 MWA rate did not demonstrate a statistically significant change from HEDIS 2015.

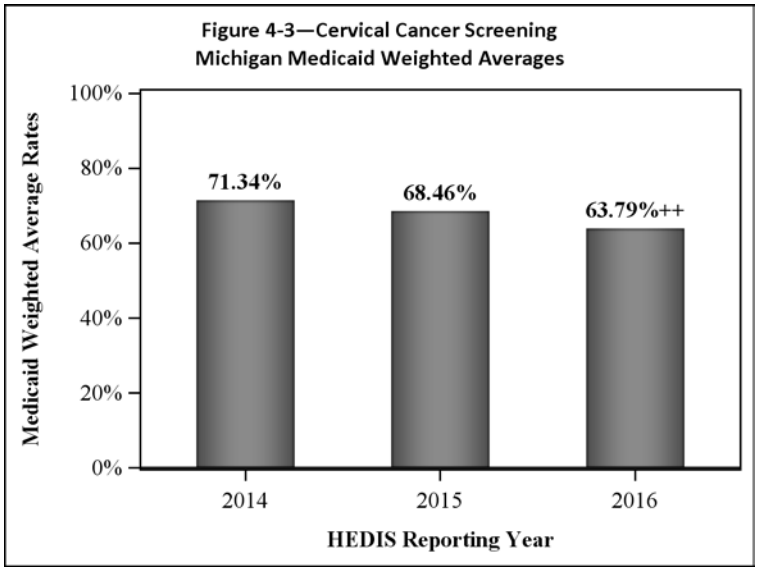


Nine MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 64.95 percent to 49.67 percent.

Cervical Cancer Screening

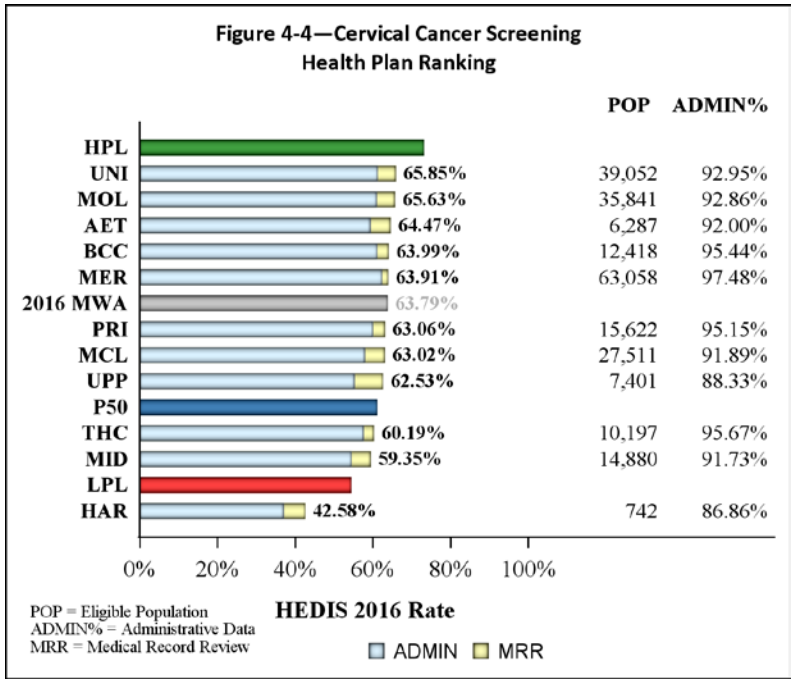
Cervical Cancer Screening assesses the percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria:

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

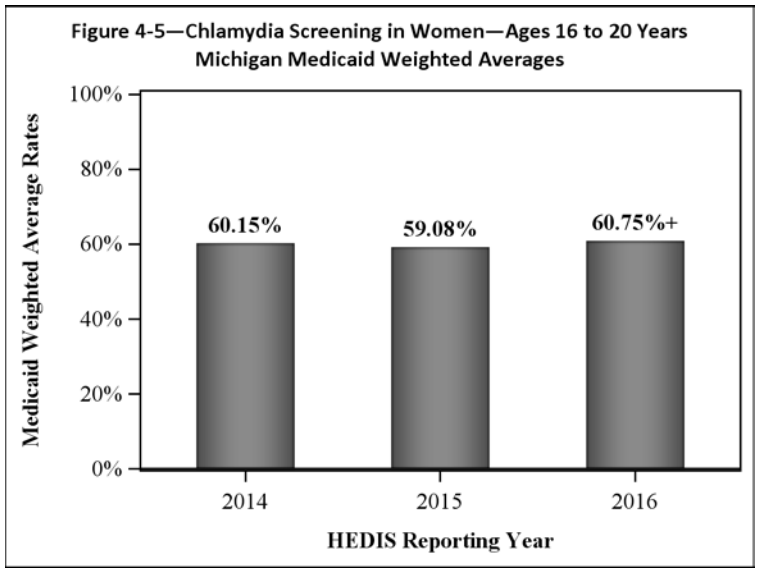
The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.



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 65.85 percent to 42.58 percent.

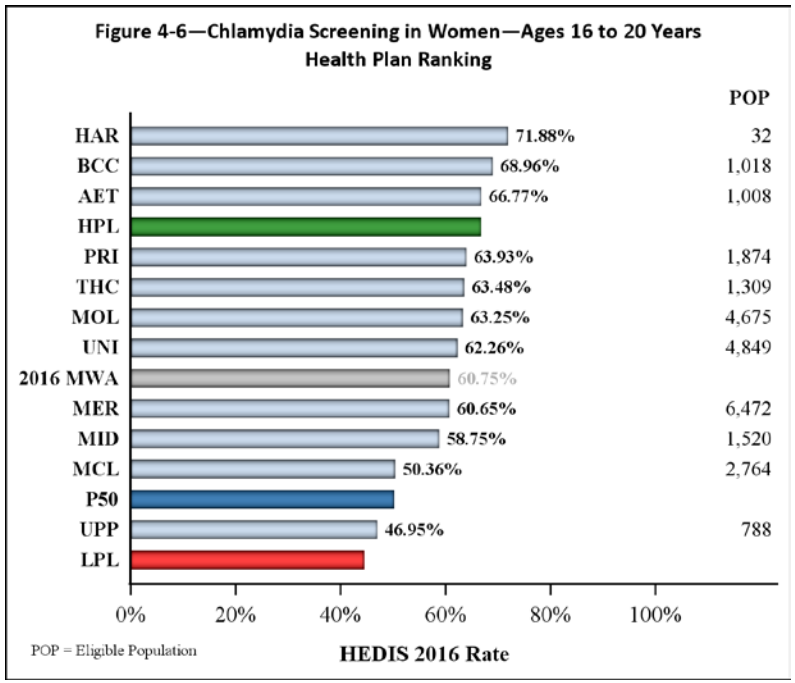
Chlamydia Screening in Women—Ages 16–20 Years

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 statistically significant improvement in performance from the previous year.

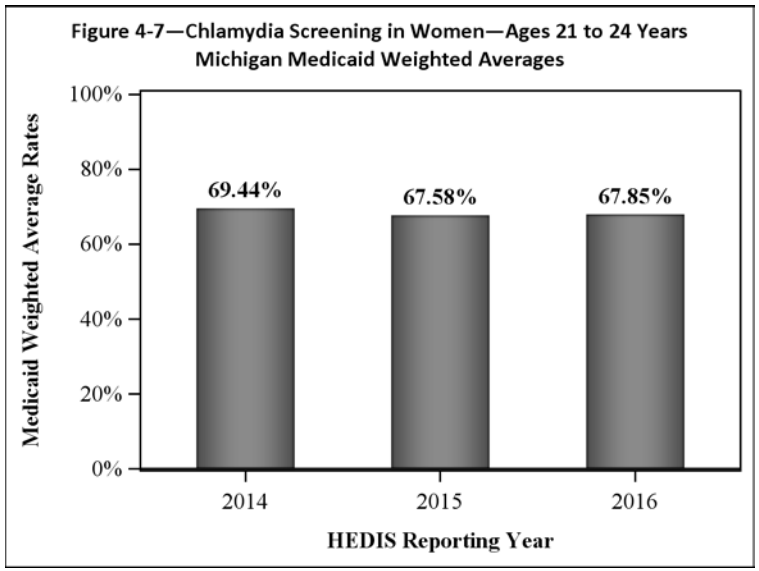
The HEDIS 2016 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2015.



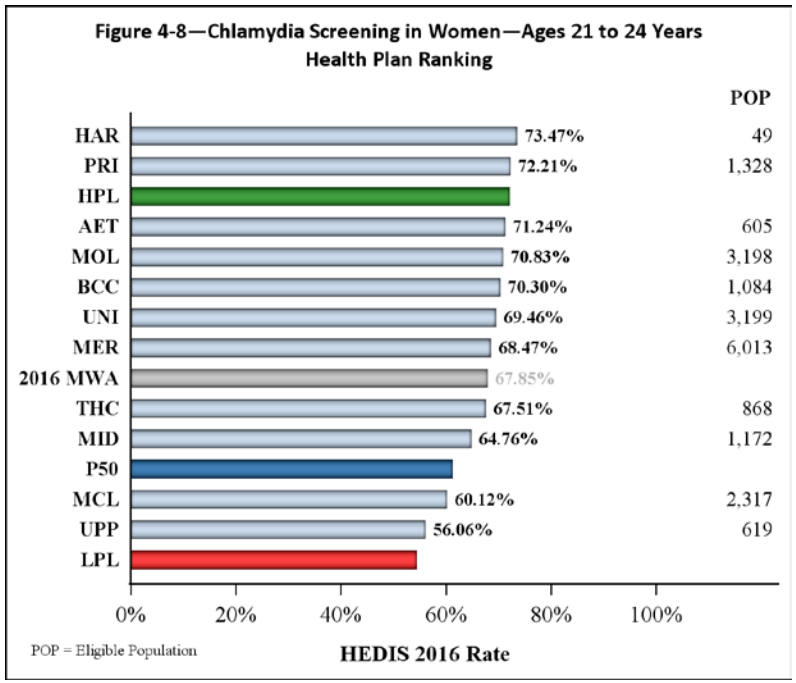
Three MHPs ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 71.88 percent to 46.95 percent.

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.



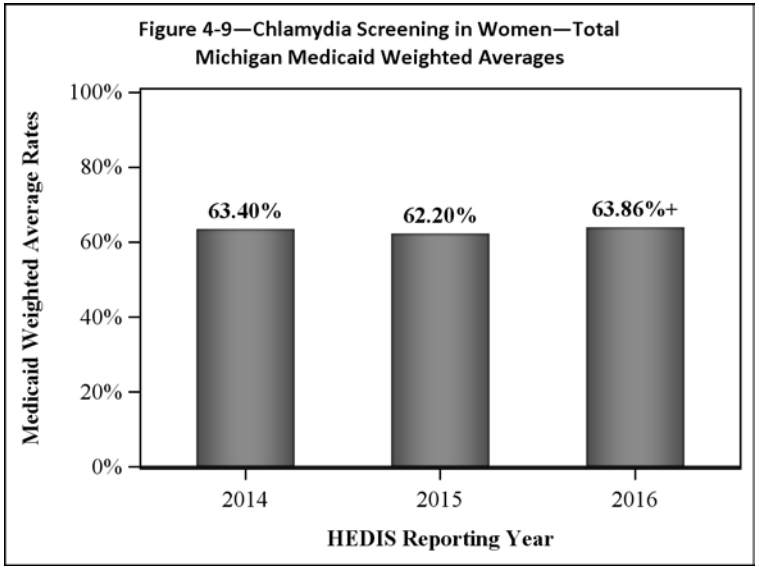
The HEDIS 2016 MWA rate did not demonstrate a statistically significant change from HEDIS 2015.



Two MHPs ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 73.47 percent to 56.06 percent.

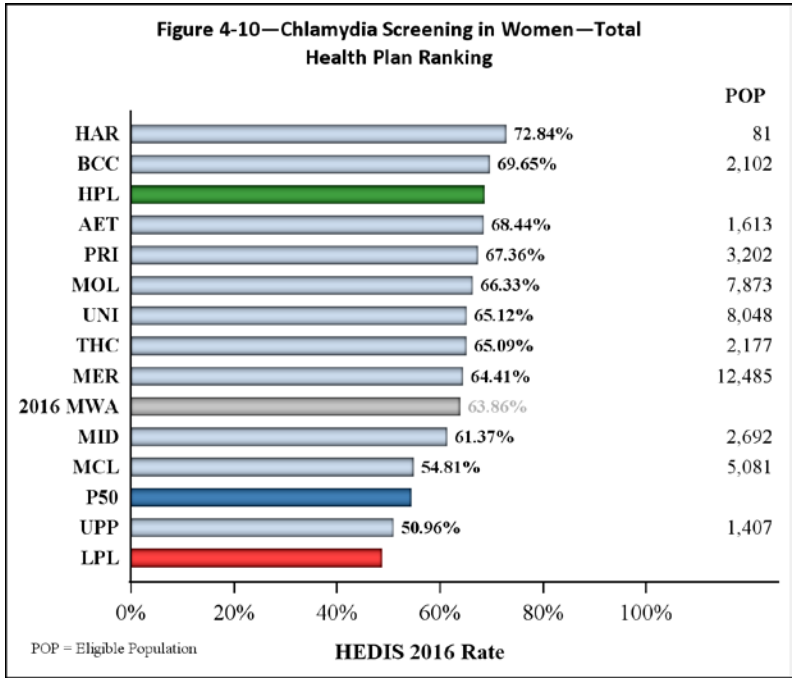
Chlamydia Screening in Women–Total

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 statistically significant improvement in performance from the previous year.

The HEDIS 2016 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2015.



Two MHPs ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 72.84 percent to 50.96 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 2016 MWA rates and performance levels, a comparison of the HEDIS 2015 MWA to the HEDIS 2016 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating statistically significant changes from HEDIS 2015 to HEDIS 2016.

Table 5-1—HEDIS 2016 MWA Performance Levels and Trend Results for Access to Care

Measure	HEDIS 2016 MWA and Performance Level[1]	HEDIS 2015 MWA–HEDIS 2016 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2016	Number of MHPs With Statistically Significant Decline in HEDIS 2016
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	96.20%P	-0.12	0	1
Ages 25 Months to 6 Years	88.79%Y	+0.06	2	3
Ages 7 to 11 Years	90.85%P	-0.29	1	2
Ages 12 to 19 Years	89.86%P	**-0.35++**	1	4

Measure	HEDIS 2016 MWA and Performance Level[1]	HEDIS 2015 MWA–HEDIS 2016 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2016	Number of MHPs With Statistically Significant Decline in HEDIS 2016
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20 to 44 Years	82.76%Y	**-0.65++**	1	4
Ages 45 to 64 Years	89.81%Y	**-0.96++**	0	4
Ages 65+ Years	91.15%B	**+2.55+**	1	0
Total	85.62%Y	**-0.49++**	1	4
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	26.94%Y	—	—	—

[1] 2016 performance levels were based on comparisons of the HEDIS 2016 MWA measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks. 2016 performance levels represent the following percentile comparisons:

≤25thLR	≥25th and ≤49thP	≥50th and ≤74thY	≥75th and ≤89thB	≥90thG

[2] HEDIS 2015 MWA to HEDIS 2016 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 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

Red Shading++ *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

— indicates that the measure was not presented in the HEDIS 2015 deliverables; therefore, the 2015–2016 MWA comparison values and the number of MHPs with statistically significant improvement or decline in HEDIS 2016 are not presented in this report. This symbol may also indicate that the performance levels for 2016 were not determined because the measure did not have an applicable benchmark.

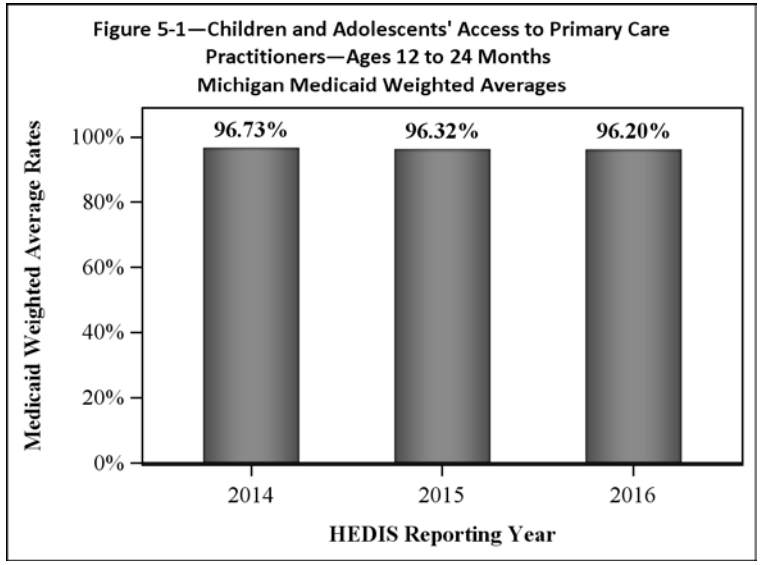
Table 5-1 shows that three of the four HEDIS 2016 MWA *Children and Adolescents' Access to Primary Care Practitioners* measure indicator rates declined from the prior year and ranked below the national Medicaid 50th percentile. One of these measure indicator rate declines was statistically significant, *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years*.

For *Adults' Access to Preventive/Ambulatory Health Services*, three of the four MWA measure indicator rates statistically significantly declined from the prior year and ranked at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile. The remaining indicator, *Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years*, statistically significantly increased from the prior year and ranked at or above the national Medicaid 75th percentile.

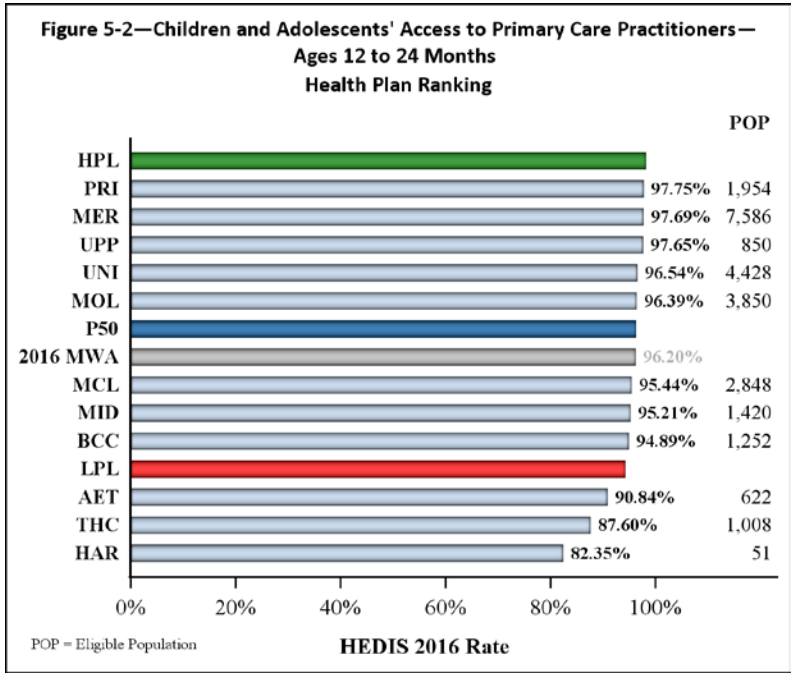
Measure-Specific Findings

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.



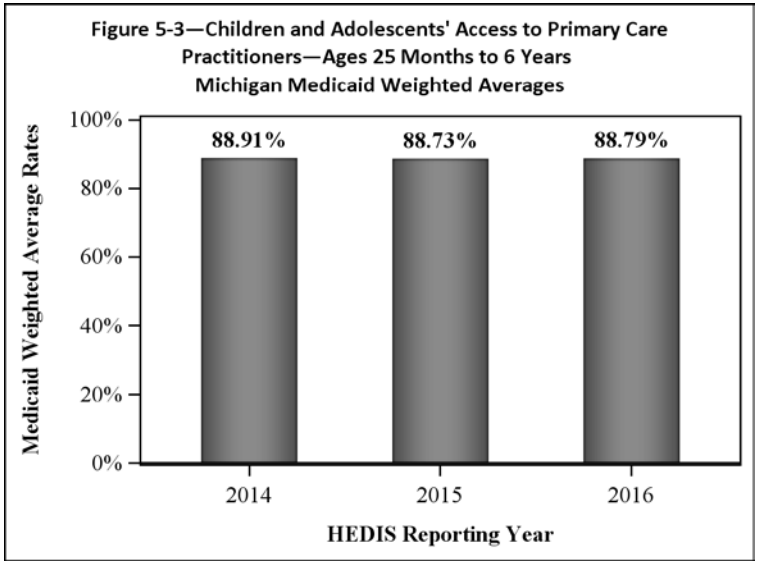
The HEDIS 2016 MWA rate did not demonstrate a statistically significant change from HEDIS 2015.



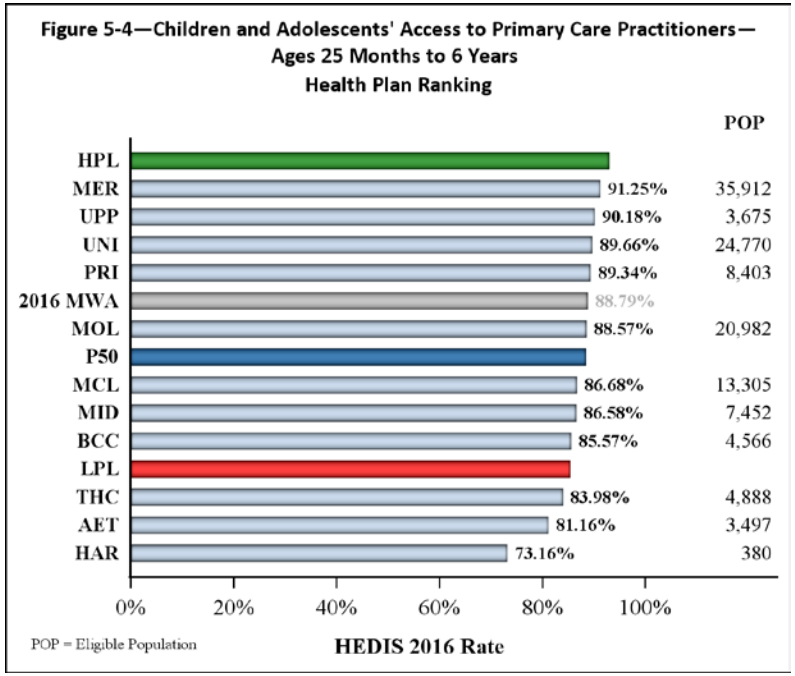
Five MHPs ranked above the national Medicaid 50th percentile but below the HPL. Three MHPs fell below the LPL. MHP performance varied from 97.75 percent to 82.35 percent.

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.



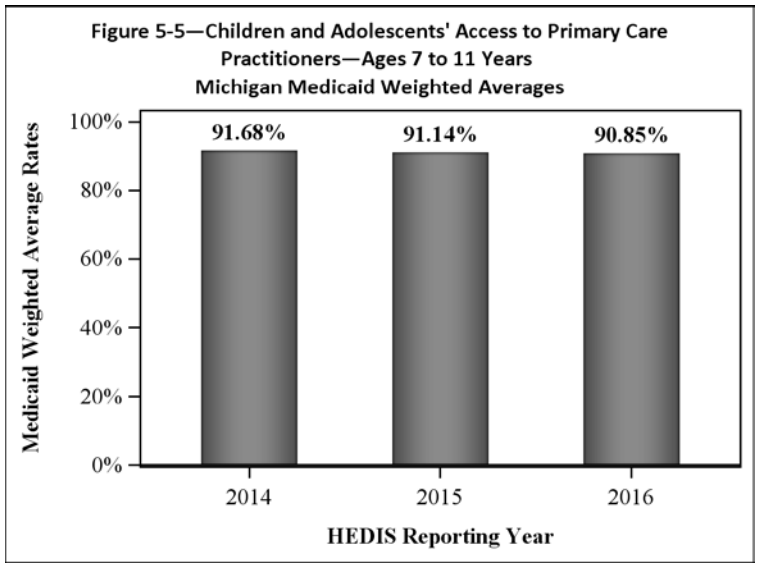
The HEDIS 2016 MWA rate did not demonstrate a statistically significant change from HEDIS 2015.



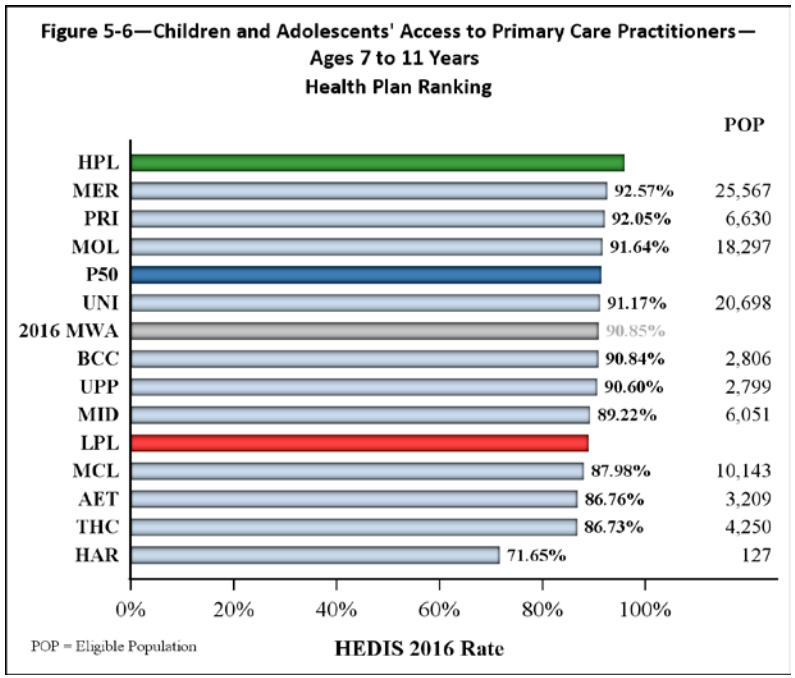
Five MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. Three MHPs fell below the LPL. MHP performance varied from 91.25 percent to 73.16 percent.

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.



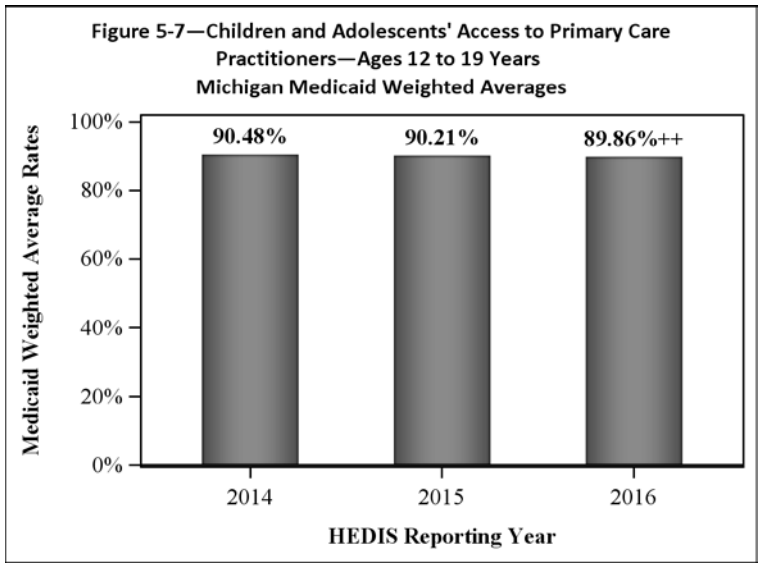
The HEDIS 2016 MWA rate did not demonstrate a statistically significant change from HEDIS 2015.



Three MHPs ranked above the national Medicaid 50th percentile but below the HPL. Four MHPs fell below the LPL. MHP performance varied from 92.57 percent to 71.65 percent.

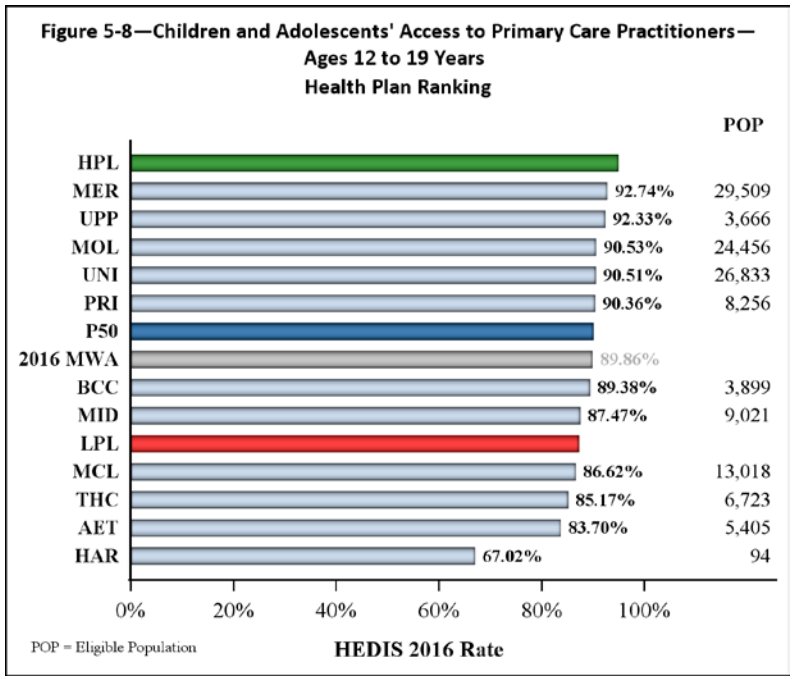
Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years

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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

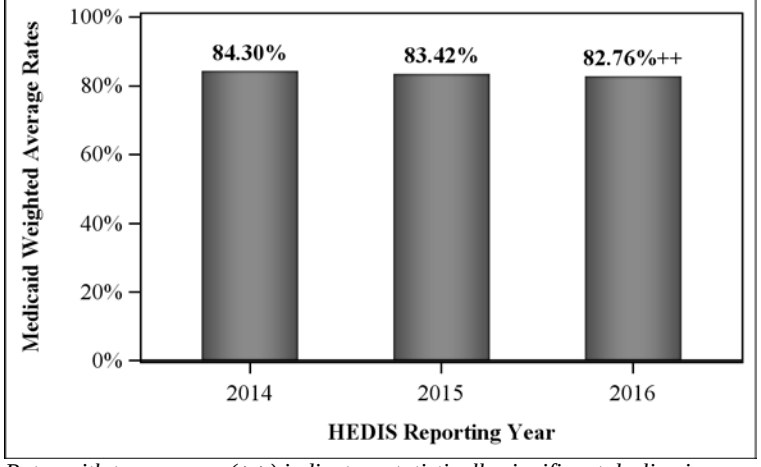


Five MHPs ranked above the national Medicaid 50th percentile but below the HPL. Four MHPs fell below the LPL. MHP performance varied from 92.74 percent to 67.02 percent.

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.

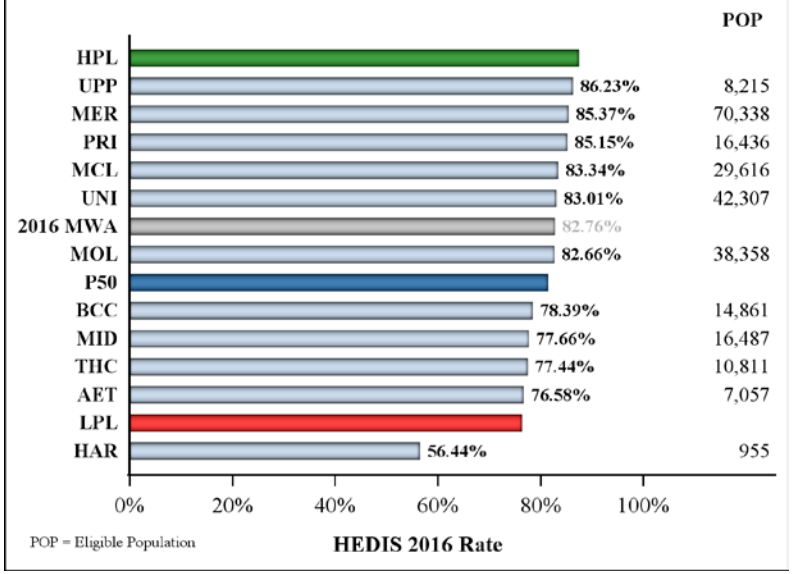
Figure 5-9—Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

Figure 5-10—Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years
Health Plan Ranking

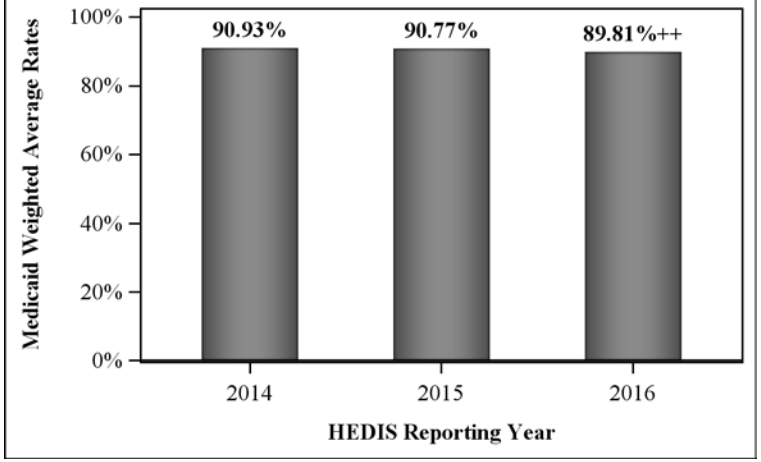


Six MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 86.23 percent to 56.44 percent.

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.

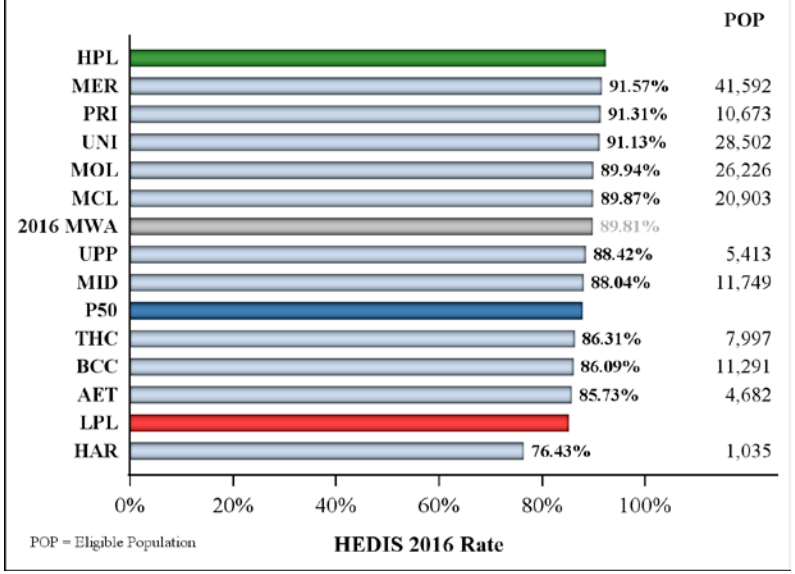
Figure 5-11—Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

Figure 5-12—Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years
Health Plan Ranking

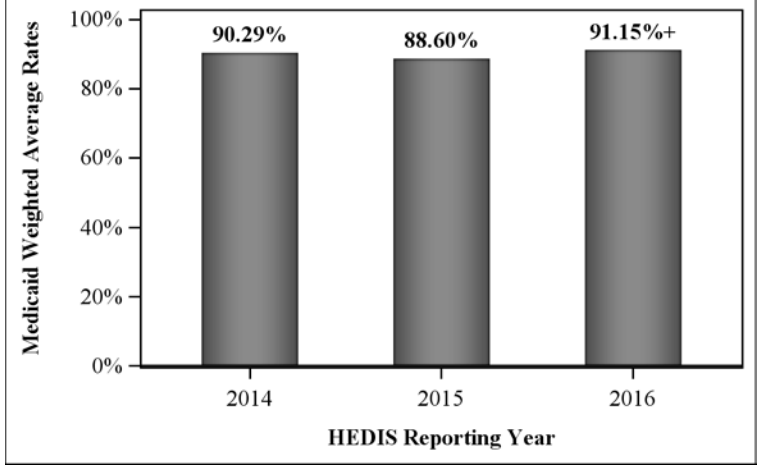


Seven MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 91.57 percent to 76.43 percent.

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.

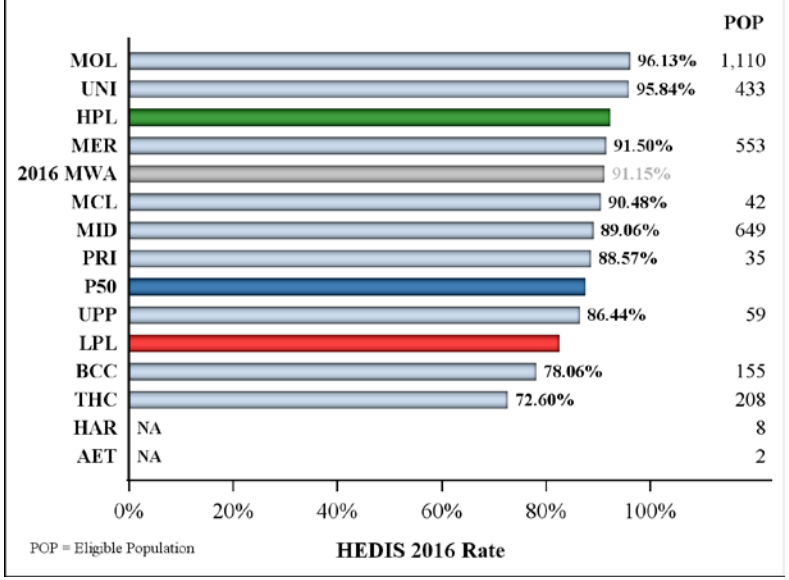
Figure 5-13—Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2015.

Figure 5-14—Adults' Access to Preventive/Ambulatory Health Services—Ages 65+ Years
Health Plan Ranking

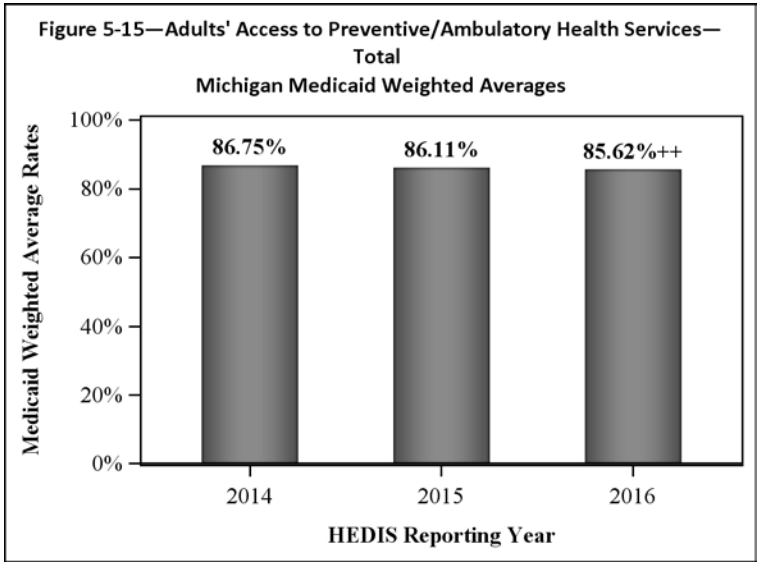


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Two MHPs ranked above the HPL. Two MHPs fell below the LPL. MHP performance varied from 96.13 percent to 72.60 percent.

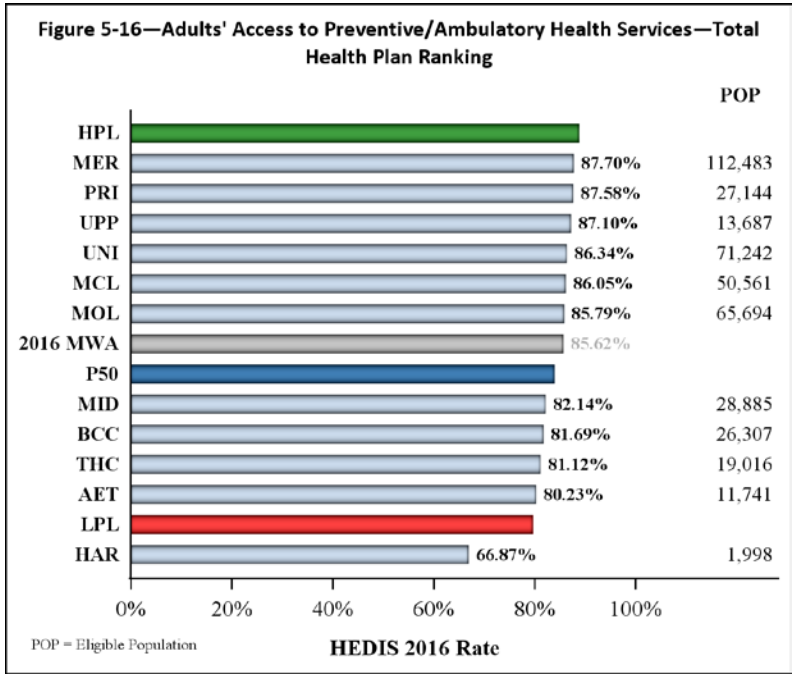
Adults' Access to Preventive/Ambulatory Health Services—Total

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 statistically significant decline in performance from the previous year.

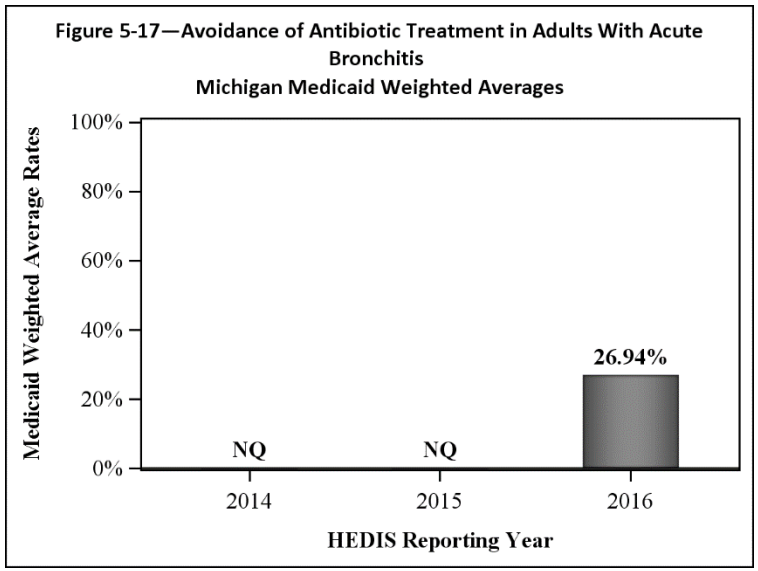
The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.



Six 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 87.70 percent to 66.87 percent.

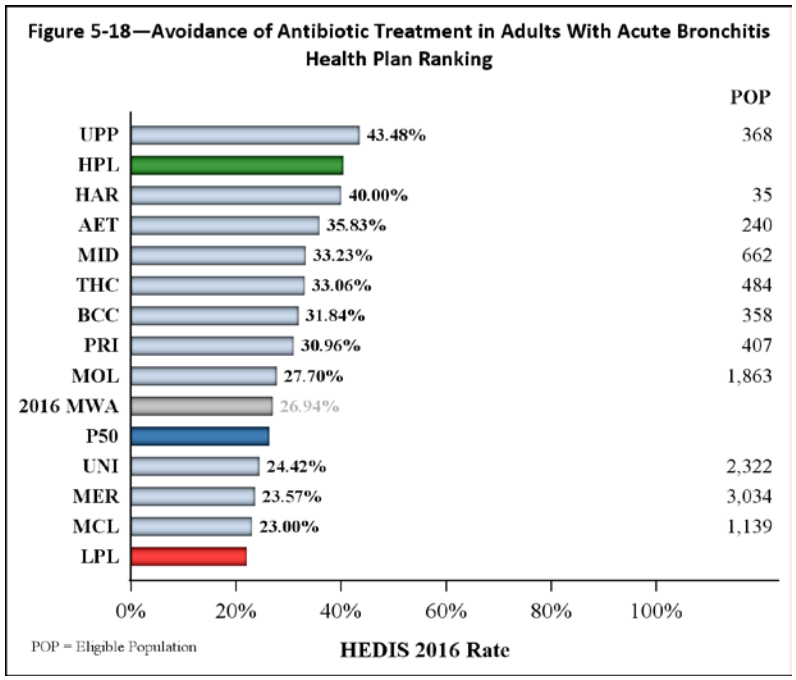
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

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.



NQ indicates that this measure was not included in the 2014 and 2015 aggregate reports.

This measure was added to the MDHHS' HEDIS 2016 measure set for all MHPs; therefore, historical MWA rates were not presented.



One MHP ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 43.48 percent to 23.00 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—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 2016 MWA rates and performance levels, a comparison of the HEDIS 2015 MWA to the HEDIS 2016 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating statistically significant changes from HEDIS 2015 to HEDIS 2016.

Table 6-1—HEDIS 2016 MWA Performance Levels and Trend Results for Obesity

Measure	HEDIS 2016 MWA and Performance Level[1]	HEDIS 2015 MWA–HEDIS 2016 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2016	Number of MHPs With Statistically Significant Decline in HEDIS 2016
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	74.93%Y	**-3.41++**	1	4
Counseling for Nutrition—Total	65.77%Y	**-2.19++**	1	2
Counseling for Physical Activity—Total[3]	57.88%Y	-0.19	1	3

Measure	HEDIS 2016 MWA and Performance Level[1]	HEDIS 2015 MWA–HEDIS 2016 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2016	Number of MHPs With Statistically Significant Decline in HEDIS 2016
Adult BMI Assessment				
Adult BMI Assessment	89.92%B	**-0.39++**	2	1

[1] 2016 performance levels were based on comparisons of the HEDIS 2016 MWA measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks. 2016 performance levels represent the following percentile comparisons:

≤25thLR	≥25th and ≤49thP	≥50th and ≤74thY	≥75th and ≤89thB	≥90thG

[2] HEDIS 2015 MWA to HEDIS 2016 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 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

Red Shading++ *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

[3] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

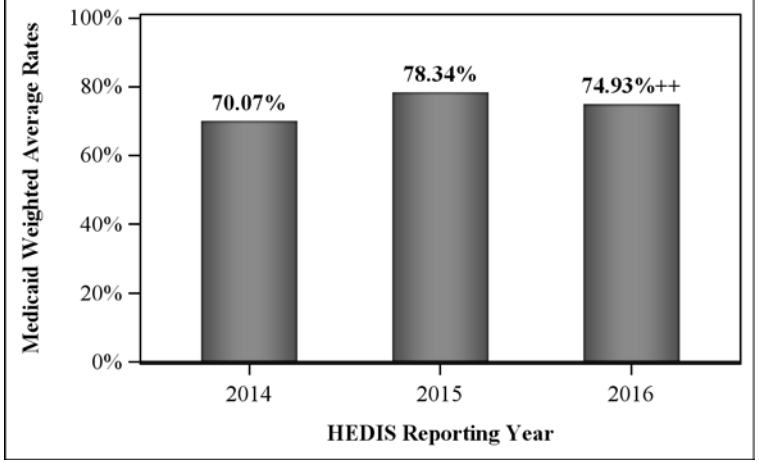
Table 6-1 shows that all three of the HEDIS 2016 MWA *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicator rates declined from the prior year and ranked at or above the national Medicaid 50th percentile but less than the national Medicaid 75th percentile. Two of these rate declines were statistically significant, *BMI Percentile—Total* and *Counseling for Nutrition—Total*. The MWA *Adult BMI Assessment* measure indicator rate demonstrated a statistically significant decline from the prior year; however, the 2016 performance ranked at or greater than the national Medicaid 75th percentile.

Measure-Specific Findings

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

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

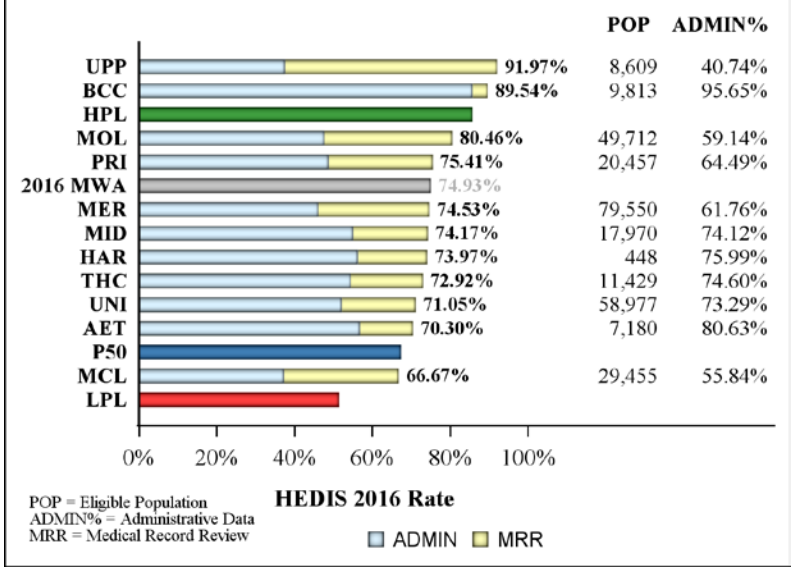
Figure 6-1—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

Figure 6-2—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total
Health Plan Ranking

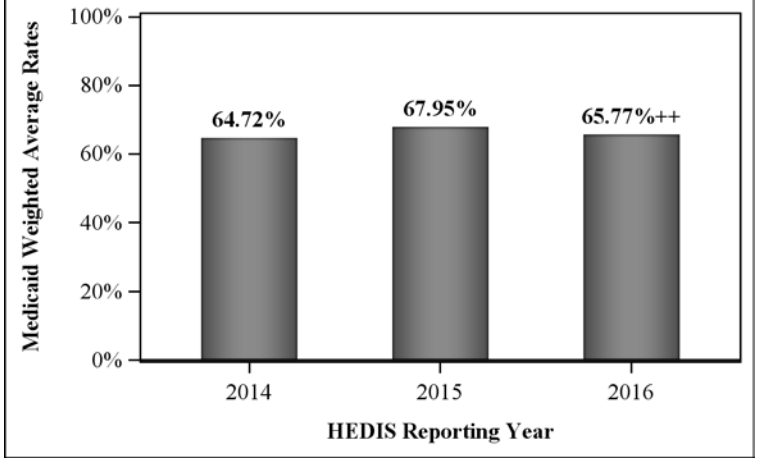


Two MHPs ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 91.97 percent to 66.67 percent.

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.

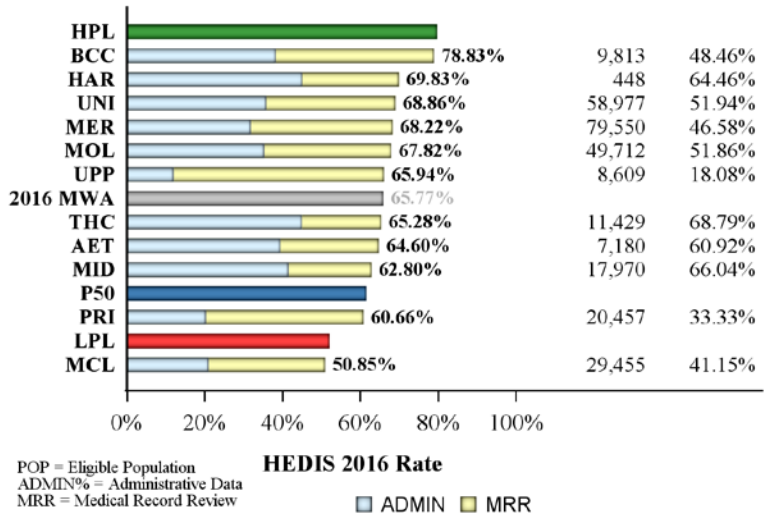
Figure 6-3—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

Figure 6-4—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total
Health Plan Ranking

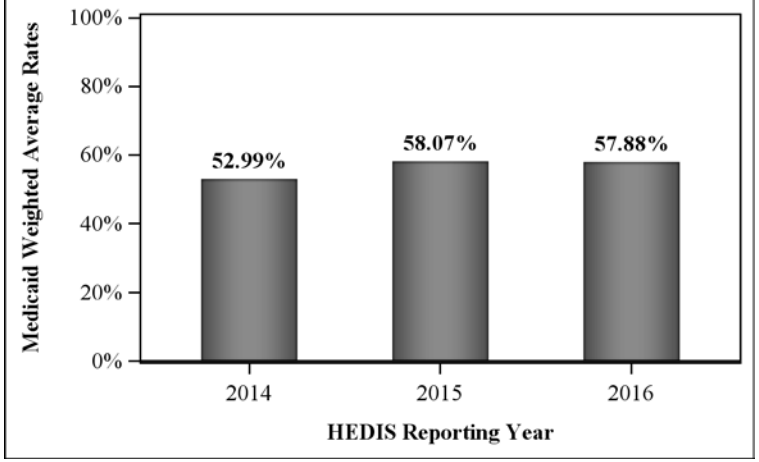


Nine MHPs and the MWA ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 78.83 percent to 50.85 percent.

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

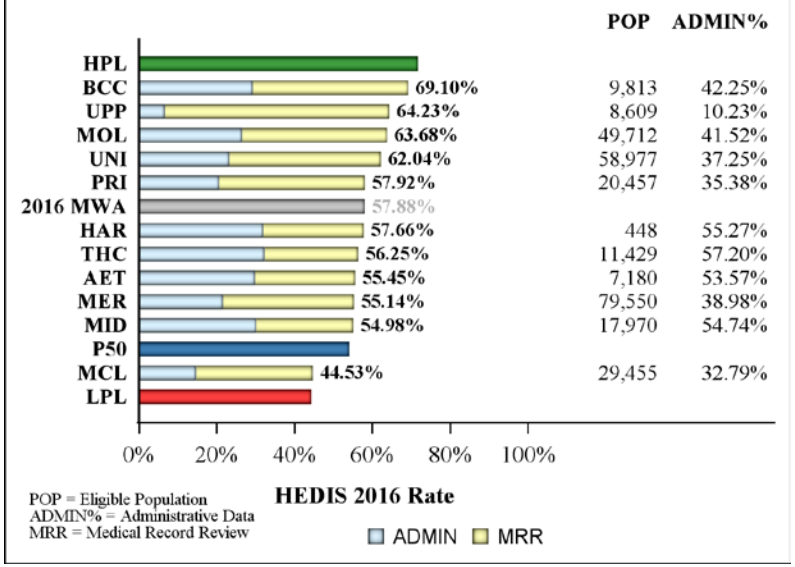
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total assesses the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during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

Figure 6-5—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total
Michigan Medicaid Weighted Averages



The HEDIS 2016 MWA rate did not demonstrate a statistically significant change from HEDIS 2015.

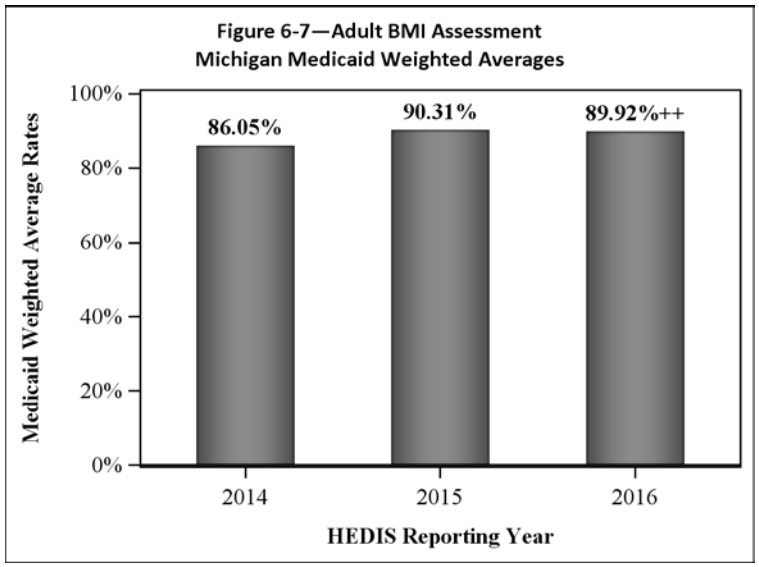
Figure 6-6—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total
Health Plan Ranking



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 44.53 percent.

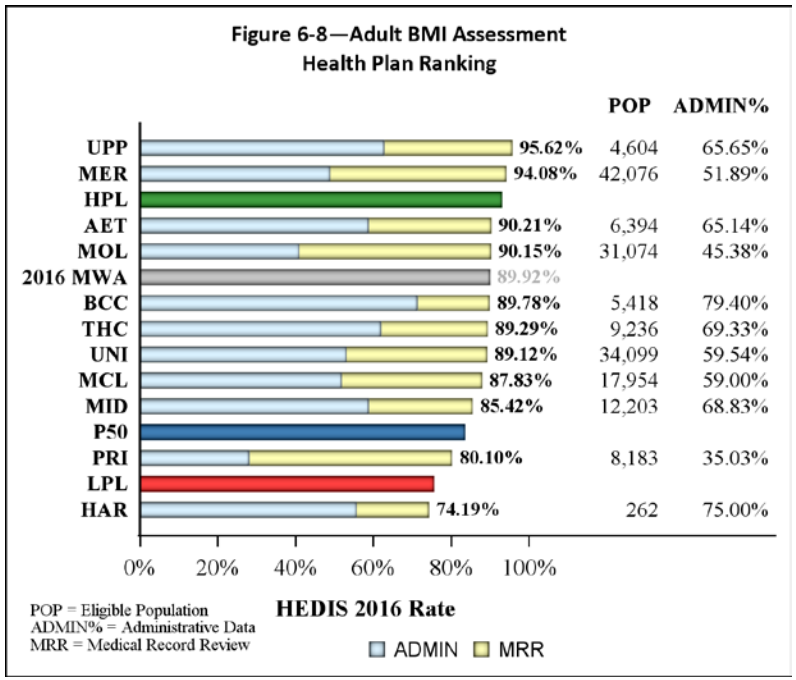
Adult BMI Assessment

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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.



Two MHPs ranked above the HPL. One MHP fell below the LPL. MHP performance varied from 95.62 percent to 74.19 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 and rates for the *Weeks of Pregnancy at Time of Enrollment* measure indicators are displayed in Appendices A, B, and C.

Summary of Findings

Table 7-1 presents the Michigan MWA performance for the measure indicators under the Pregnancy Care measure domain. The table lists the HEDIS 2016 MWA rates and performance levels, a comparison of the HEDIS 2015 MWA to the HEDIS 2016 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating statistically significant changes from HEDIS 2015 to HEDIS 2016.

Table 7-1—HEDIS 2016 MWA Performance Levels and Trend Results for Pregnancy Care

Measure	HEDIS 2016 MWA and Performance Level[1]	HEDIS 2015 MWA–HEDIS 2016 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2016	Number of MHPs With Statistically Significant Decline in HEDIS 2016
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	78.63%P	**-5.81**++	0	7
Postpartum Care	61.73%P	**-4.96**++	0	3

Measure	HEDIS 2016 MWA and Performance Level[1]	HEDIS 2015 MWA–HEDIS 2016 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2016	Number of MHPs With Statistically Significant Decline in HEDIS 2016
Frequency of Ongoing Prenatal Care				
≥81 Percent of Expected Visits	56.40%P	**-7.03++**	1	5

[1] 2016 performance levels were based on comparisons of the HEDIS 2016 MWA measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks. 2016 performance levels represent the following percentile comparisons:

≤25thLR	≥25th and ≤49thP	≥50th and ≤74thY	≥75th and ≤89thB	≥90thG

[2] HEDIS 2015 MWA to HEDIS 2016 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 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

Red Shading++ *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

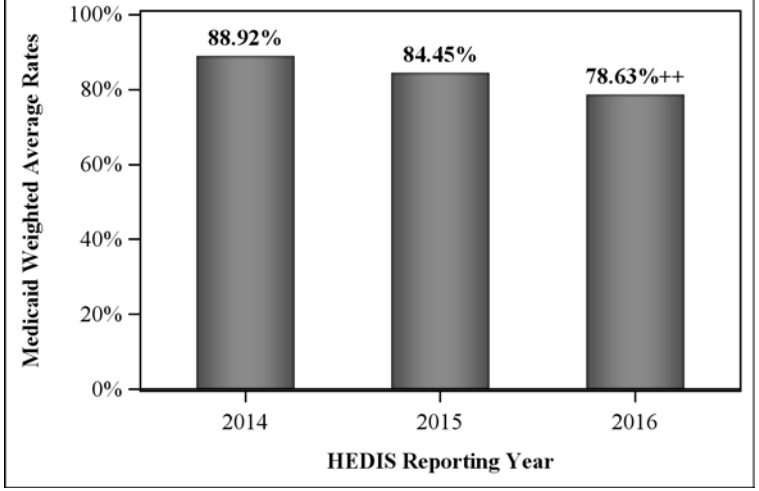
Table 7-1 shows that all of the HEDIS 2016 MWA Pregnancy Care measure domain indicators discussed in this section of the report statistically significantly decreased from the prior year and ranked below the national Medicaid 50th percentile.

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.

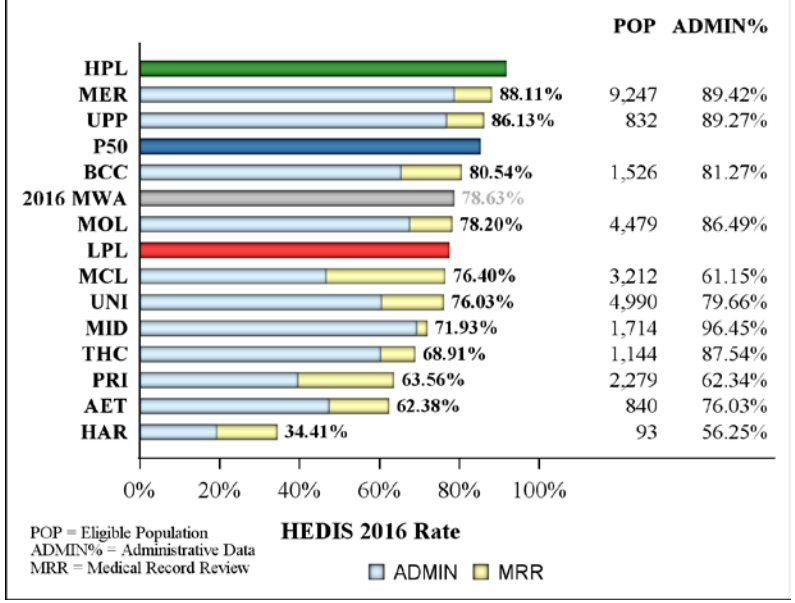
Figure 7-1—Prenatal and Postpartum Care—Timeliness of Prenatal Care
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

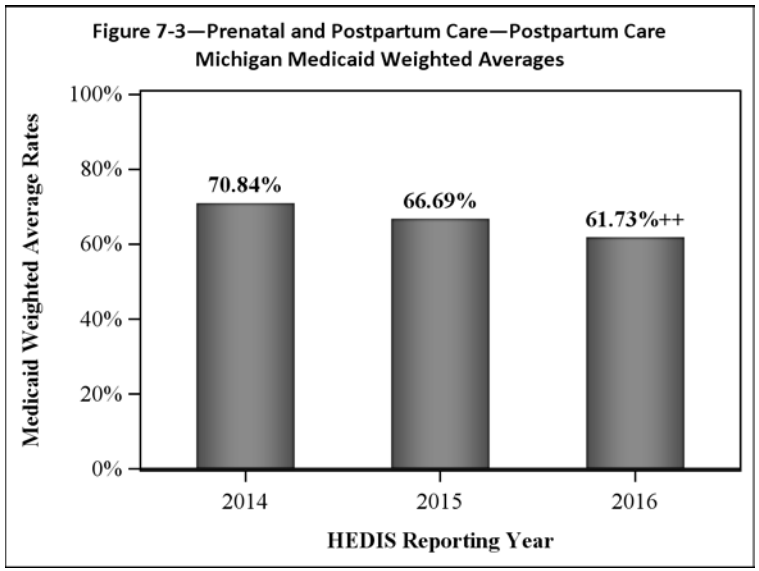
Figure 7-2—Prenatal and Postpartum Care—Timeliness of Prenatal Care
Health Plan Ranking



Two MHPs ranked above the national Medicaid 50th percentile but below the HPL. Seven MHPs fell below the LPL. MHP performance varied from 88.11 percent to 34.41 percent.

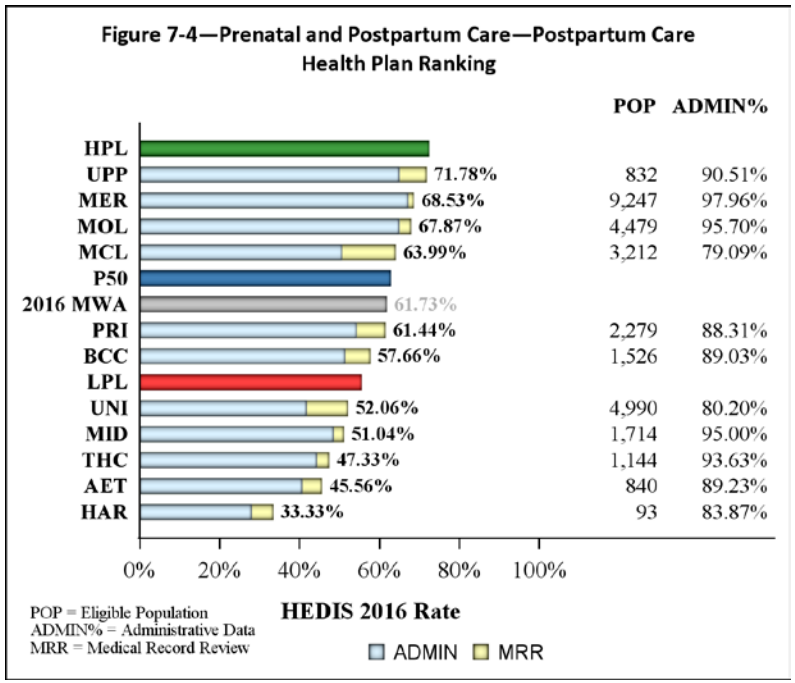
Prenatal and Postpartum Care—Postpartum Care

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

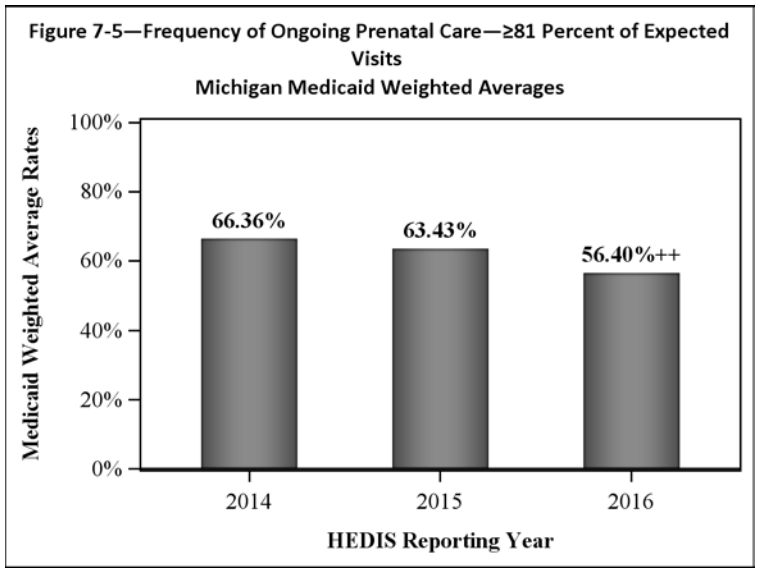
The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.



Four MHPs ranked above the national Medicaid 50th percentile but below the HPL. Five MHPs fell below the LPL. MHP performance varied from 71.78 percent to 33.33 percent.

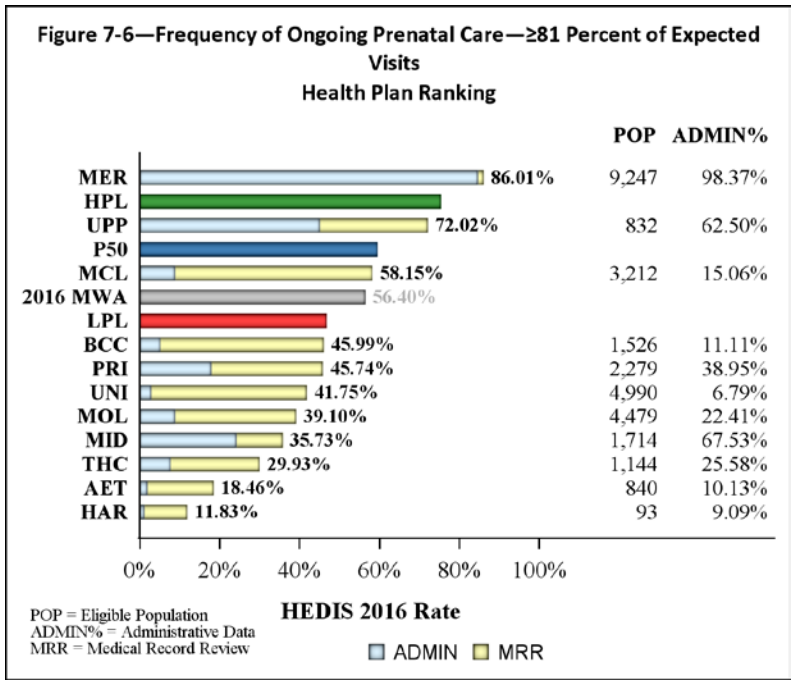
Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits

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.



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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.



One MHP ranked above the HPL. Eight MHPs fell below the LPL. MHP performance varied from 86.01 percent to 11.83 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 2016 MWA rates and performance levels, a comparison of the HEDIS 2015 MWA to the HEDIS 2016 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating statistically significant changes from HEDIS 2015 to HEDIS 2016.

Table 8-1—HEDIS 2016 MWA Performance Levels and Trend Results for Living With Illness

Measure	HEDIS 2016 MWA and Performance Level[1]	HEDIS 2015 MWA–HEDIS 2016 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2016	Number of MHPs With Statistically Significant Decline in HEDIS 2016
Comprehensive Diabetes Care[3]				
Hemoglobin A1c (HbA1c) Testing	86.89%Y	**+0.90+**	1	1
*HbA1c Poor Control (>9.0%)**	39.30%Y	**3.48++**	1	4
HbA1c Control (<8.0%)	50.91%Y	**-2.87++**	0	5
Eye Exam (Retinal) Performed	59.61%Y	+0.13	1	1
Medical Attention for Nephropathy	91.28%G	**+7.55+**	10	0
Blood Pressure Control (<140/90 mm Hg)	59.38%P	**-6.52++**	0	5
Medication Management for People With Asthma				
Medication Compliance 50%—Total	67.13%B	—	—	—
Medication Compliance 75%—Total	43.79%G	—	—	—
Asthma Medication Ratio				
Total	62.18%Y	—	—	—
Controlling High Blood Pressure				
Controlling High Blood Pressure	55.54%P	**-6.53++**	0	8
Medical Assistance With Smoking and Tobacco Use Cessation[4]				
Advising Smokers and Tobacco Users to Quit	79.75%B	**-0.15++**	0	0
Discussing Cessation Medications	55.04%B	**+0.79+**	1	0
Discussing Cessation Strategies	45.20%Y	**-0.53++**	0	0
Antidepressant Medication Management				
Effective Acute Phase Treatment	60.36%B	—	—	—
Effective Continuation Phase Treatment	42.21%B	—	—	—
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	82.61%Y	-1.14	1	2
Diabetes Monitoring for People With Diabetes and Schizophrenia				
Diabetes Monitoring for People With Diabetes and Schizophrenia	69.98%Y	-2.74	0	1
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	74.46%P	**+14.36+**	1	1

Measure	HEDIS 2016 MWA and Performance Level[1]	HEDIS 2015 MWA–HEDIS 2016 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS 2016	Number of MHPs With Statistically Significant Decline in HEDIS 2016
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	58.76%P	-0.46	1	1
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	87.20%P	—	—	—
Digoxin	52.47%P	—	—	—
Diuretics	86.88%P	—	—	—
Total	86.84%P	—	—	—

[1] 2016 performance levels were based on comparisons of the HEDIS 2016 MWA measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks. 2016 performance levels represent the following percentile comparisons:

≤25thLR	≥25th and ≤49thP	≥50th and ≤74thY	≥75th and ≤89thB	≥90thG

[2] HEDIS 2015 MWA to HEDIS 2016 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 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

Red Shading++ *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

[3] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

[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.*

— indicates that the measure was not presented in the HEDIS 2015 deliverables; therefore, the 2015–2016 MWA comparison values and number of MHPs with statistically significant improvement or decline in HEDIS 2016 are not presented in this report. This symbol may also indicate that the performance levels for 2016 were not determined because the measure did not have an applicable benchmark.

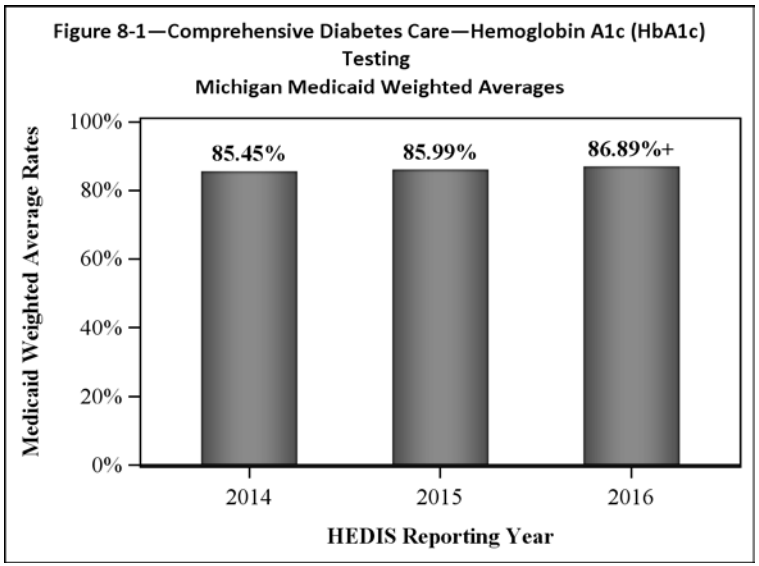
Table 8-1 shows varied performance within the Living With Illness domain. The following HEDIS 2016 MWA measure indicator rates within this domain exceeded the national Medicaid 75th percentile: *Comprehensive Diabetes Care—Medical Attention for Nephropathy*; *Medication Management for People With Asthma—Medication Compliance 50%—Total* and *Medication Compliance 75%—Total*; *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications*; and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment.*

Conversely, the following HEDIS 2016 MWA measure indicator rates within this domain ranked below the national Medicaid 50th percentile: *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*; *Controlling High Blood Pressure*; *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*; *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*; and *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, *Digoxin*, *Diuretics*, and *Total.*

Measure-Specific Findings

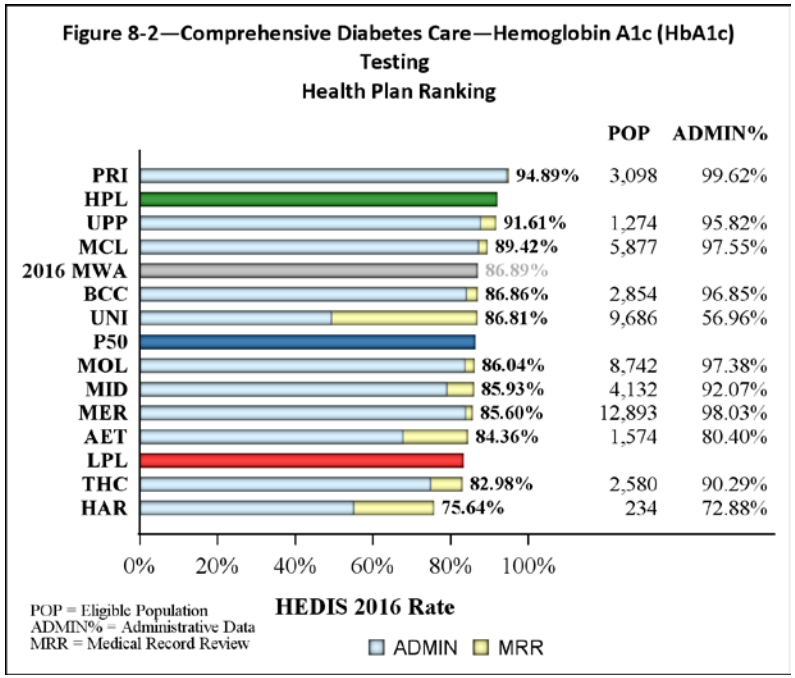
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing

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, exercise caution when trending rates between 2016 and prior years.



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

The HEDIS 2016 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2015.

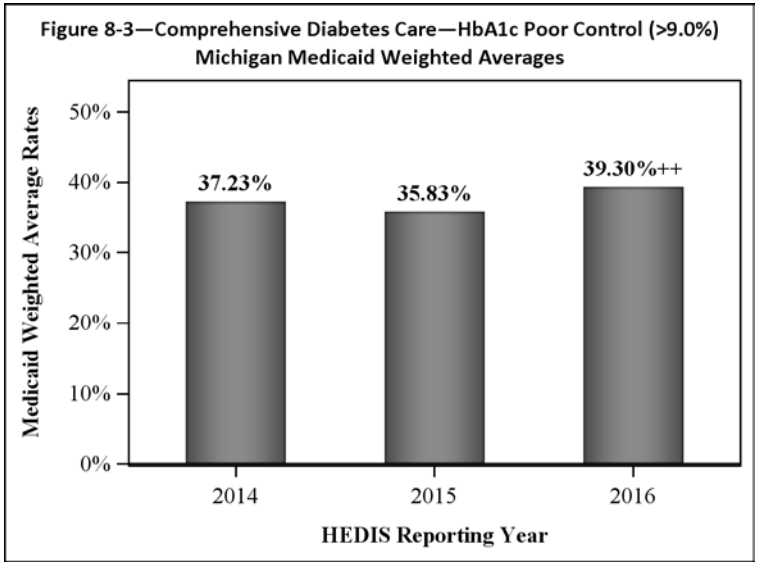


One MHP ranked above the HPL. Two MHPs fell below the LPL. MHP performance varied from 94.89 percent to 75.64 percent.

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.

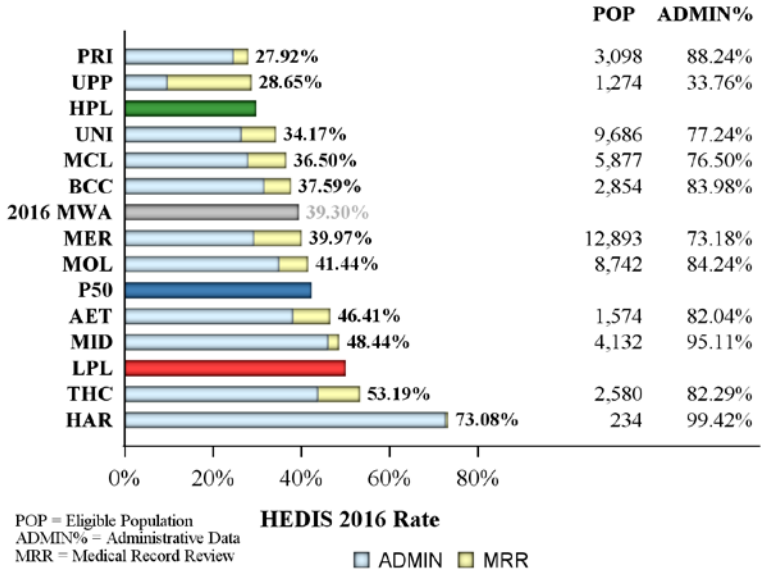
Figure 8-3—Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

Figure 8-4—Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)
Health Plan Ranking

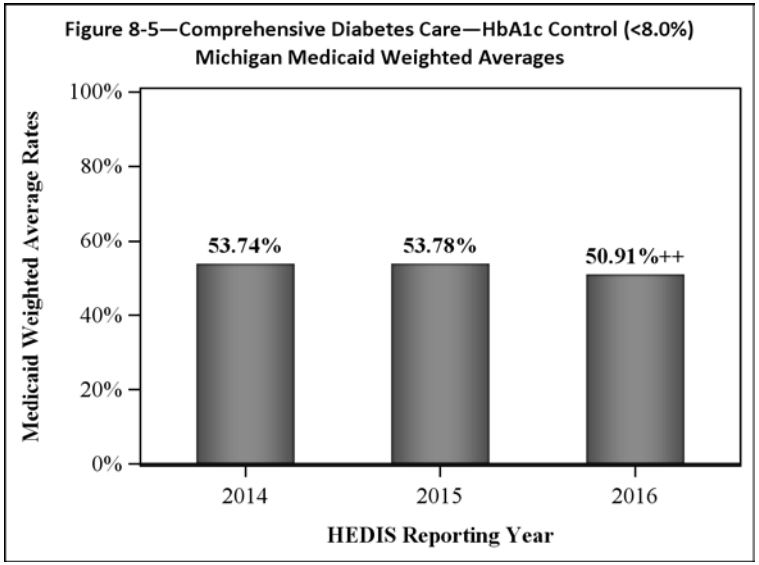


Two MHPs ranked above the HPL. Two MHPs fell below the LPL. MHP performance varied from 73.08 percent to 27.92 percent.

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.

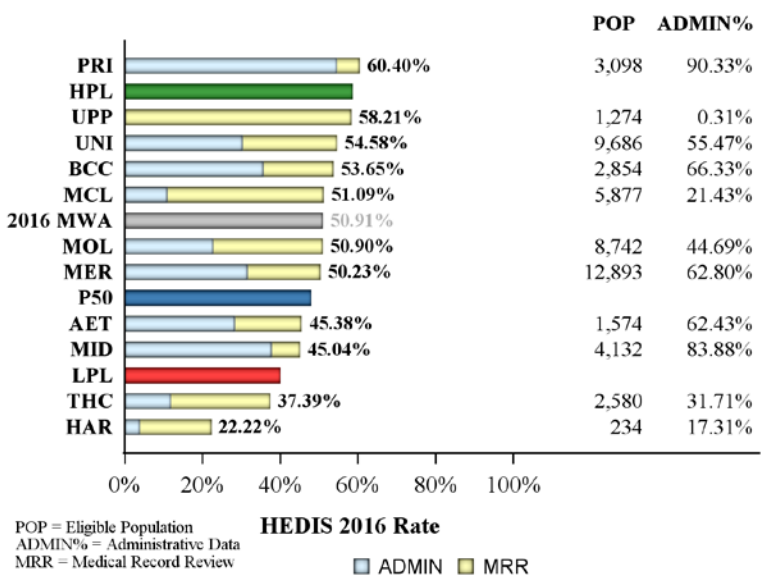
Figure 8-5—Comprehensive Diabetes Care—HbA1c Control (<8.0%)
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

Figure 8-6—Comprehensive Diabetes Care—HbA1c Control (<8.0%)
Health Plan Ranking

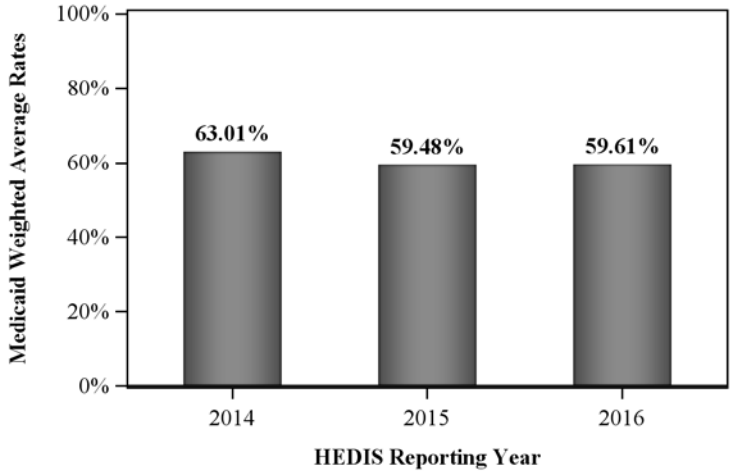


One MHP ranked above the HPL. Two MHPs fell below the LPL. MHP performance varied from 60.40 percent to 22.22 percent.

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed

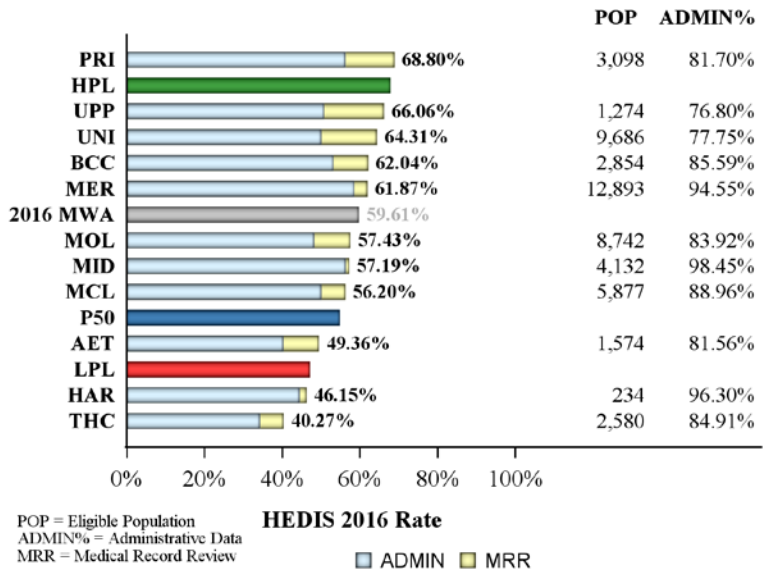
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

Figure 8-7—Comprehensive Diabetes Care—Eye Exam (Retinal) Performed
Michigan Medicaid Weighted Averages



The HEDIS 2016 MWA rate did not demonstrate a statistically significant change from HEDIS 2015.

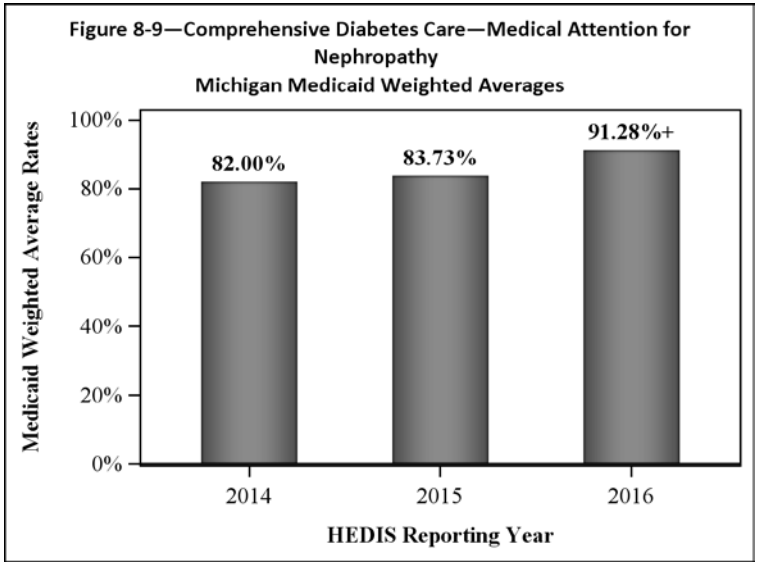
Figure 8-8—Comprehensive Diabetes Care—Eye Exam (Retinal) Performed
Health Plan Ranking



One MHP ranked above the HPL. Two MHPs fell below the LPL. MHP performance varied from 68.80 percent to 40.27 percent.

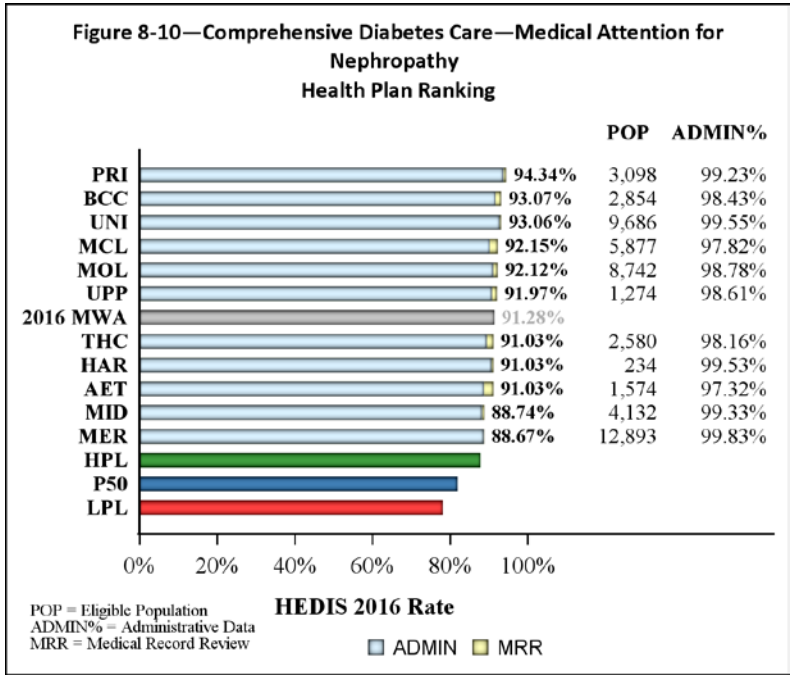
Comprehensive Diabetes Care—Medical Attention for Nephropathy

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.



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

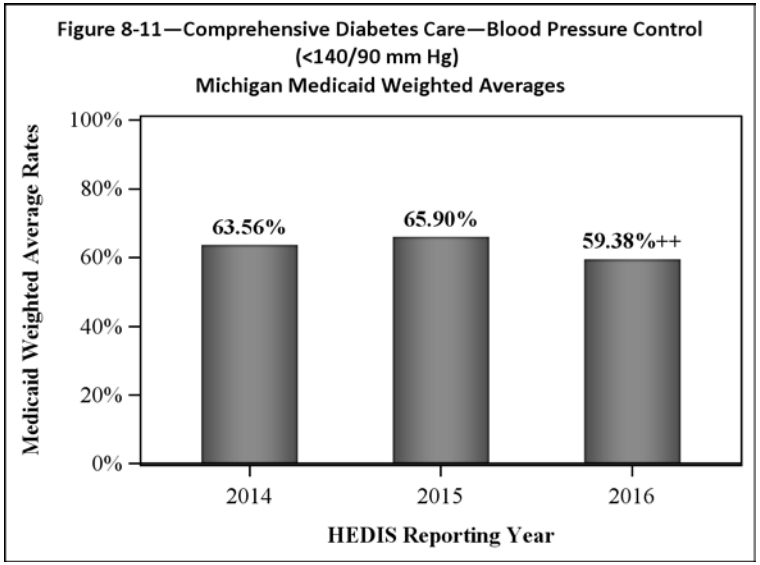
The HEDIS 2016 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2015.



All 11 MHPs and the MWA ranked above the HPL. MHP performance varied from 94.34 percent to 88.67 percent.

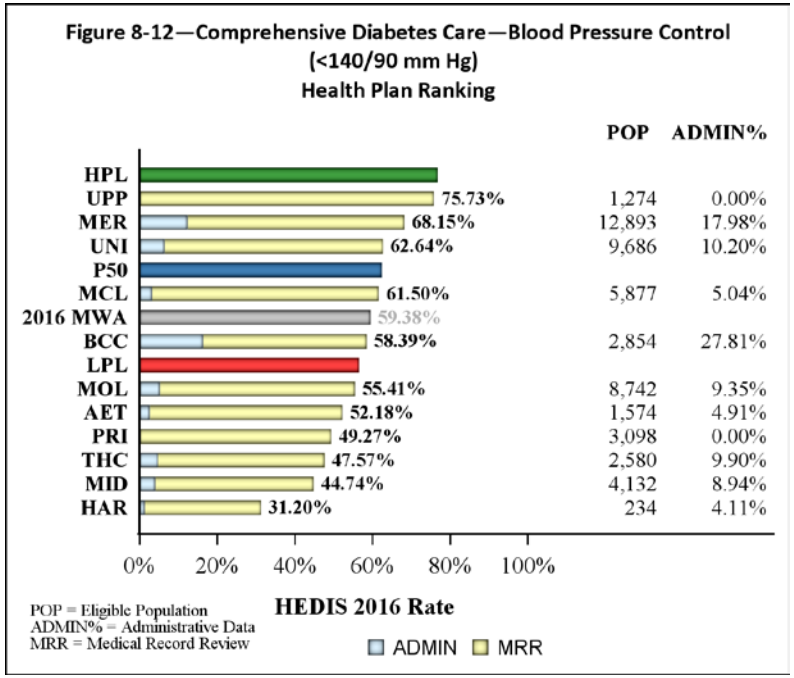
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)

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

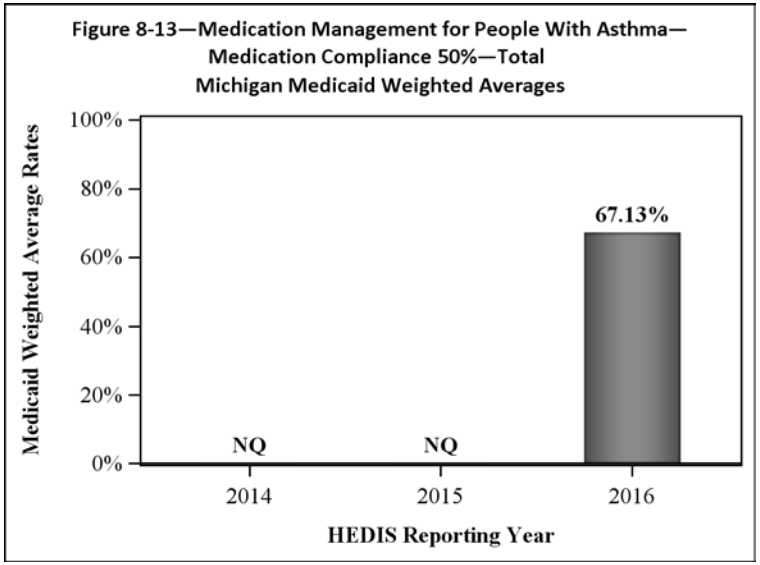
The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.



Three MHPs ranked above the national Medicaid 50th percentile but below the HPL. Six MHPs fell below the LPL. MHP performance varied from 75.73 percent to 31.20 percent.

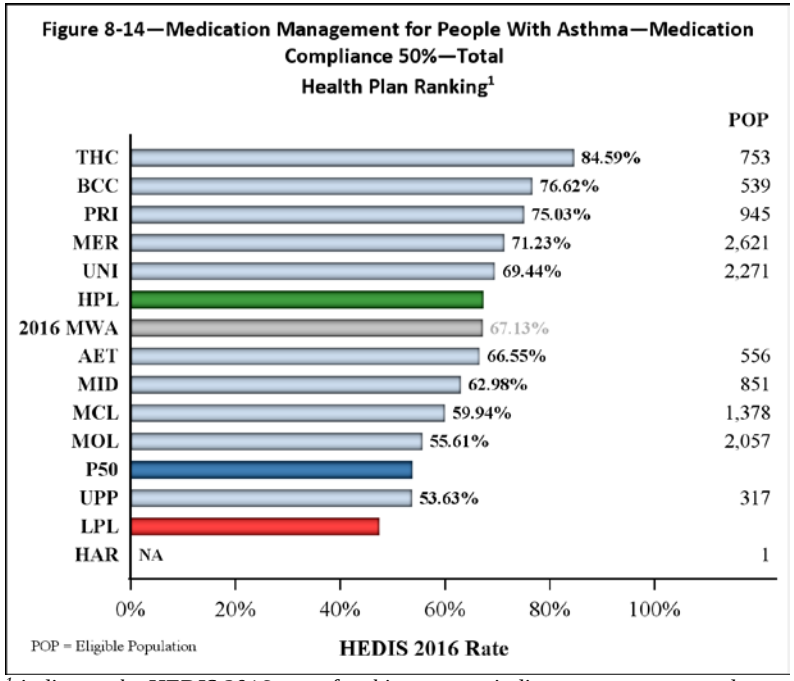
Medication Management for People with Asthma—Medication Compliance 50%—Total

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.



NQ indicates that this measure was not included in the 2014 and 2015 aggregate reports.

This measure was added to the MDHHS' HEDIS 2016 measure set for all MHPs; therefore, historical MWA rates were not presented.

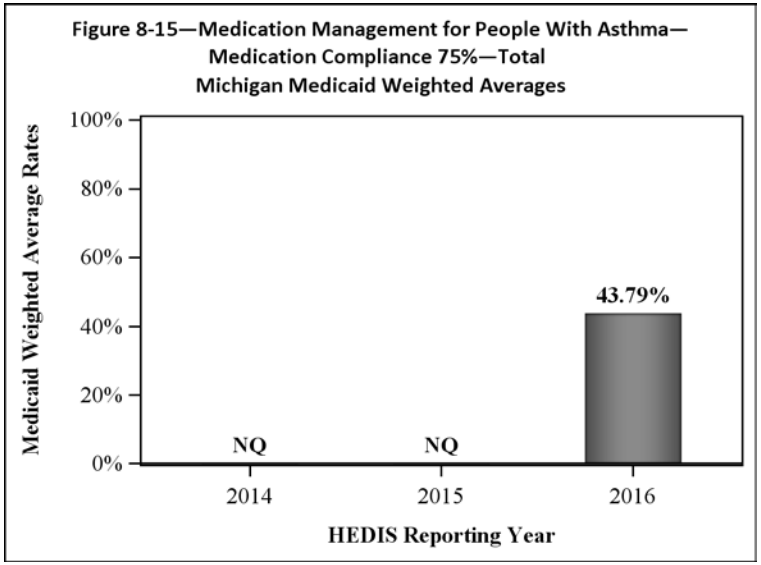


[1] indicates the HEDIS 2016 rates for this measure indicator were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS 2015 benchmarks. NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Five MHPs ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 84.59 percent to 53.63 percent.

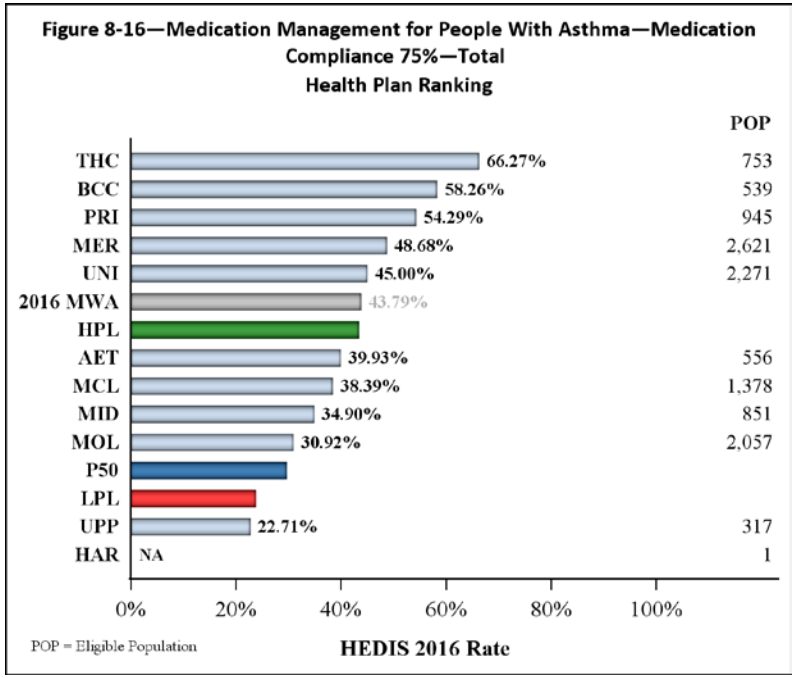
Medication Management for People with Asthma—Medication Compliance 75%—Total

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.



NQ indicates that this measure was not included in the 2014 and 2015 aggregate reports.

This measure was added to the MDHHS' HEDIS 2016 measure set for all MHPs; therefore, historical MWA rates were not presented.

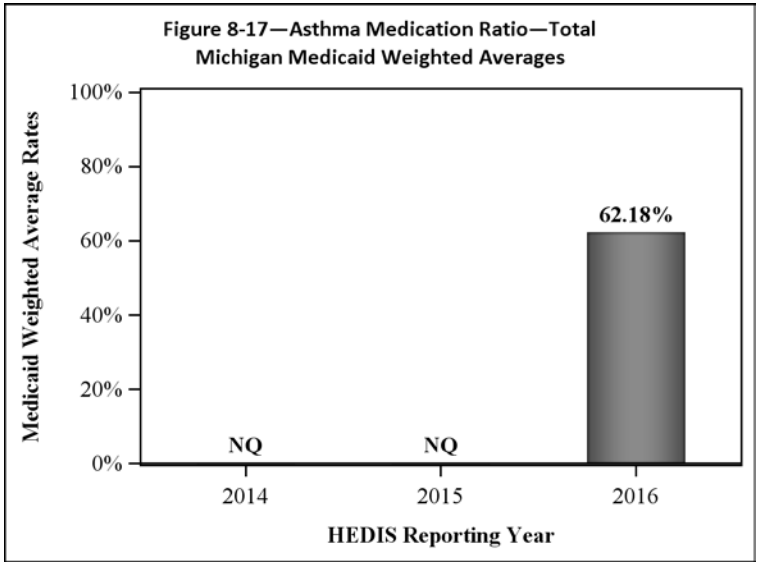


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Five MHPs and the MWA ranked above the HPL. One MHP fell below the LPL. MHP performance varied from 66.27 percent to 22.71 percent.

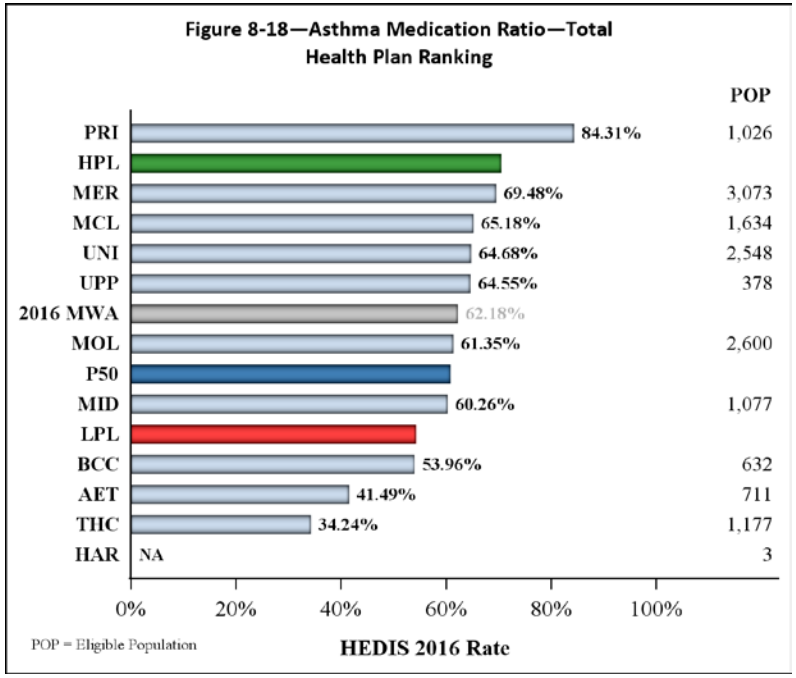
Asthma Medication Ratio—Total

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 2014 and 2015 aggregate reports.

This measure was added to the MDHHS' HEDIS 2016 measure set for all MHPs; therefore, historical MWA rates were not presented.

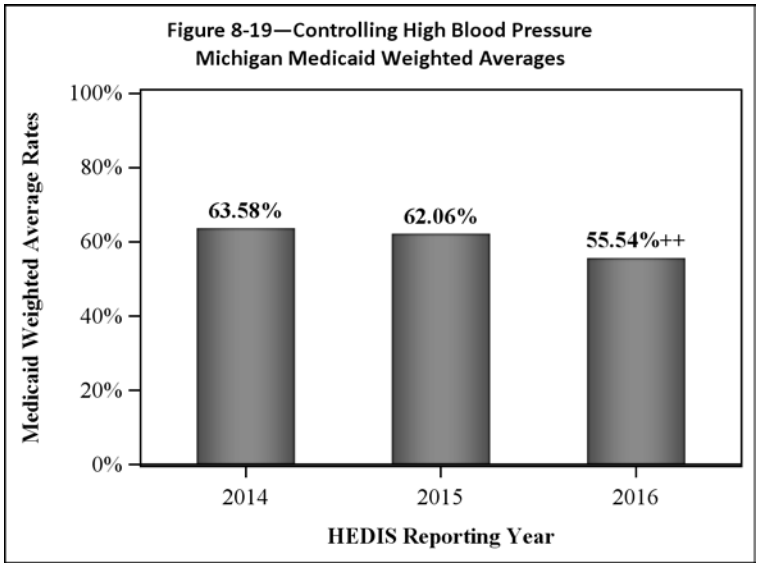


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

One MHP ranked above the HPL. Three MHPs fell below the LPL. MHP performance varied from 84.31 percent to 34.24 percent.

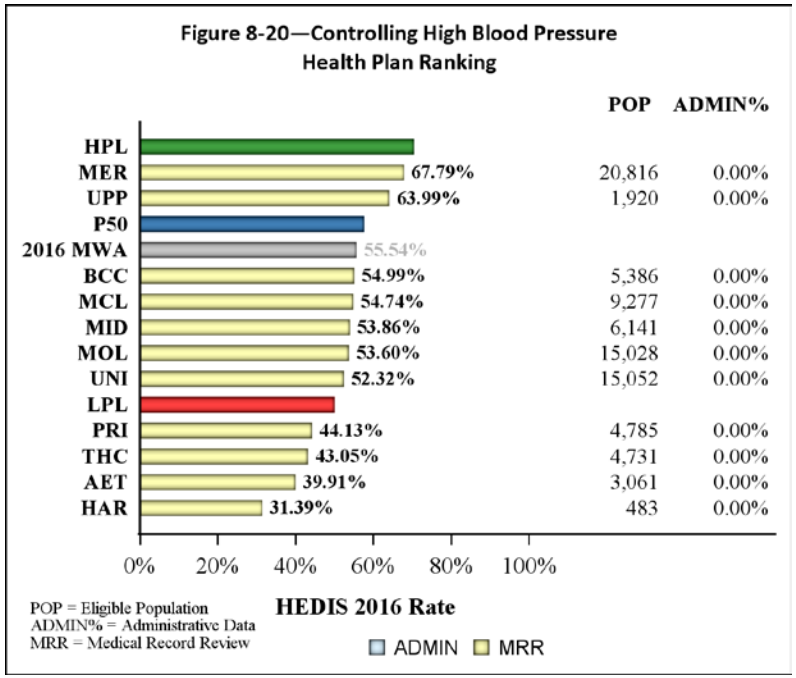
Controlling High Blood Pressure

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 <40/90 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 two crosses (++) indicate a statistically significant decline in performance from the previous year.

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

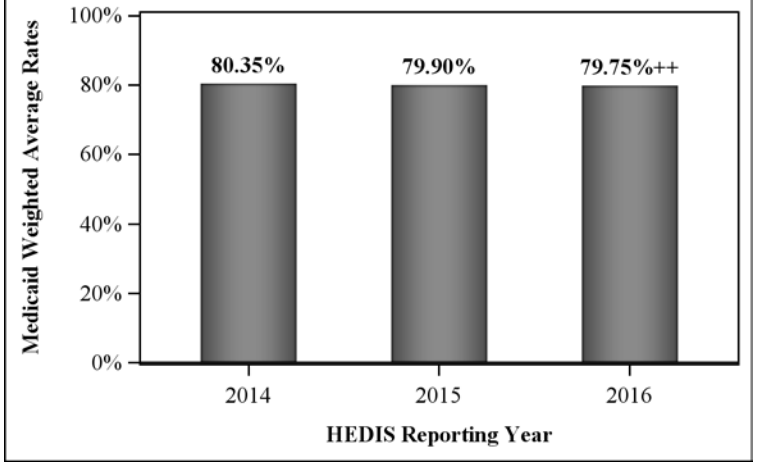


Two MHPs ranked above the national Medicaid 50th percentile but below the HPL. Four MHPs fell below the LPL. MHP performance varied from 67.79 percent to 31.39 percent.

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.

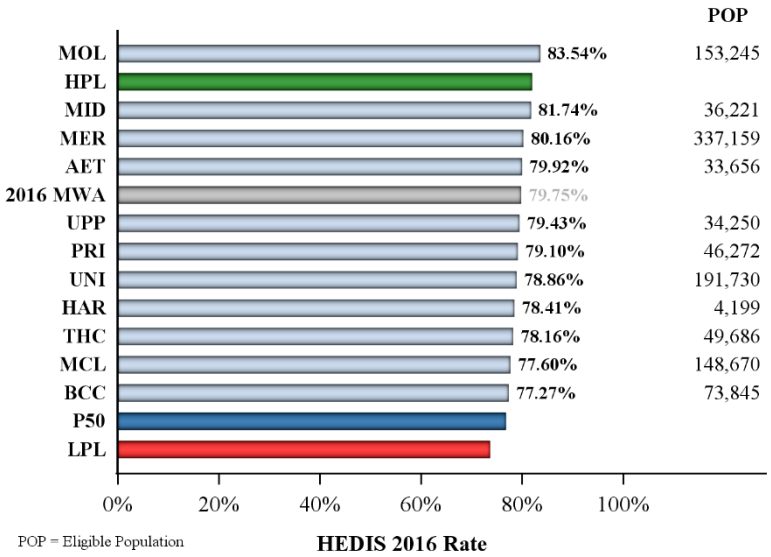
Figure 8-21—Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.

Figure 8-22—Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit
Health Plan Ranking

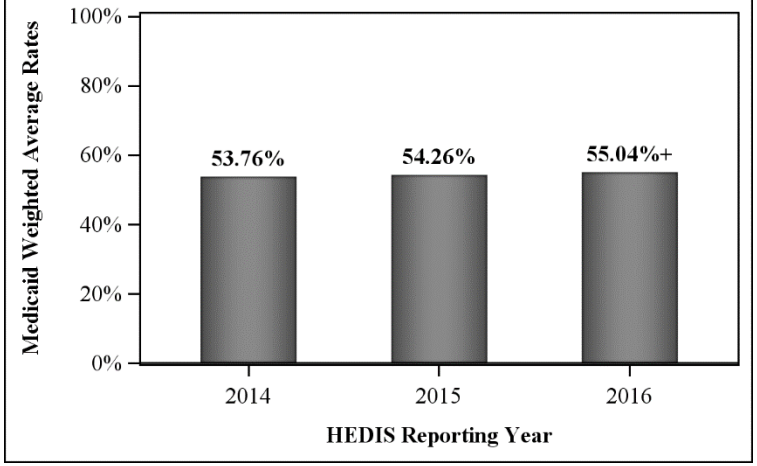


One MHP ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 83.54 percent to 77.27 percent.

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.

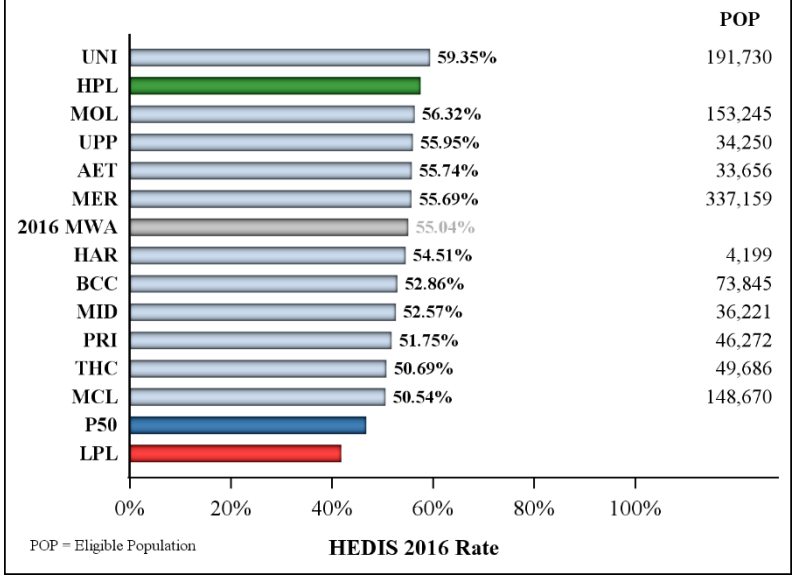
Figure 8-23—Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2015.

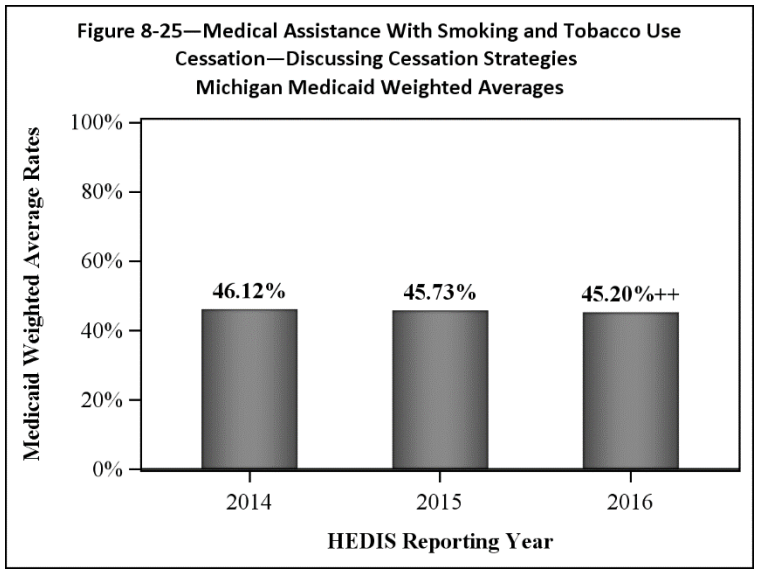
Figure 8-24—Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications
Health Plan Ranking



One MHP ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 59.35 percent to 50.54 percent.

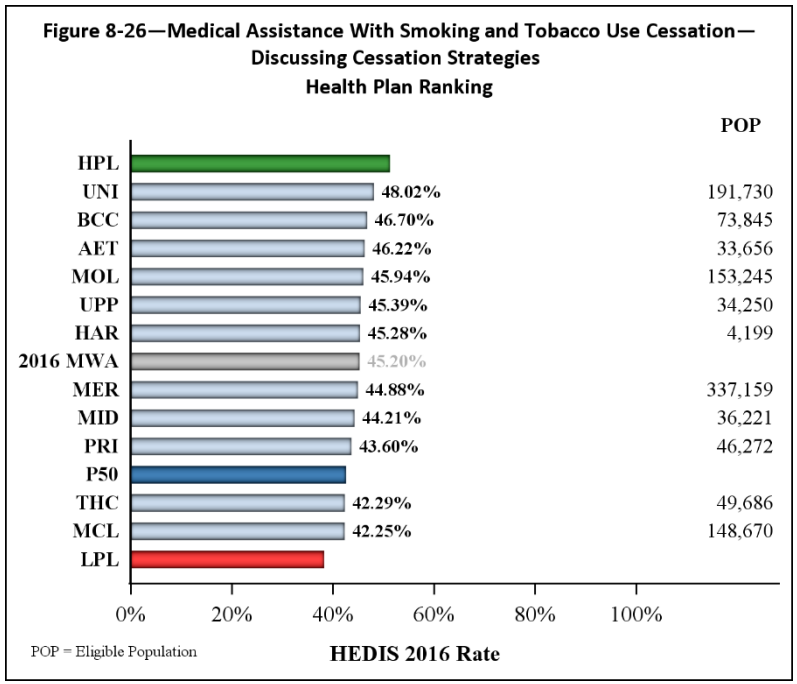
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies

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

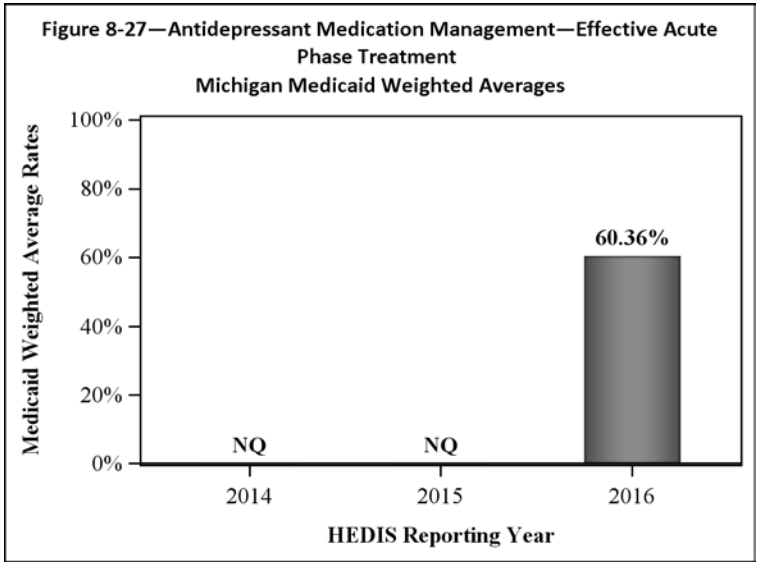
The HEDIS 2016 MWA rate demonstrated a statistically significant decline in performance from HEDIS 2015.



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 48.02 percent to 42.25 percent.

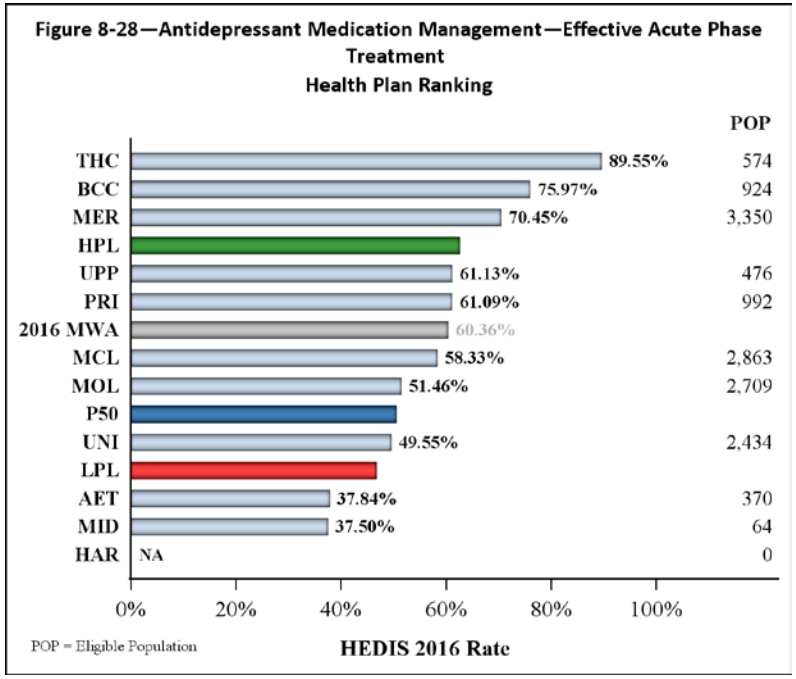
Antidepressant Medication Management—Effective Acute Phase Treatment

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).



NQ indicates that this measure was not included in the 2014 and 2015 aggregate reports.

This measure was added to the MDHHS' HEDIS 2016 measure set for all MHPs; therefore, historical MWA rates were not presented.

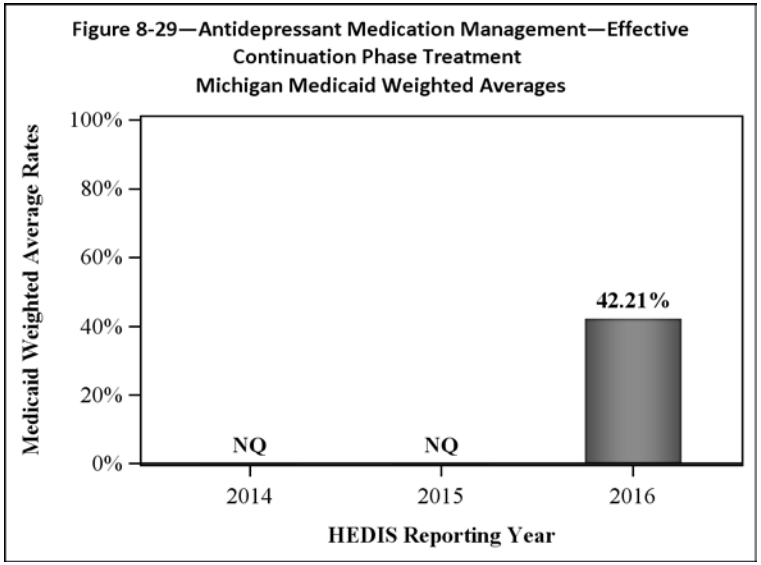


NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Three MHPs ranked above the HPL. Two MHPs fell below the LPL. MHP performance varied from 89.55 percent to 37.50 percent.

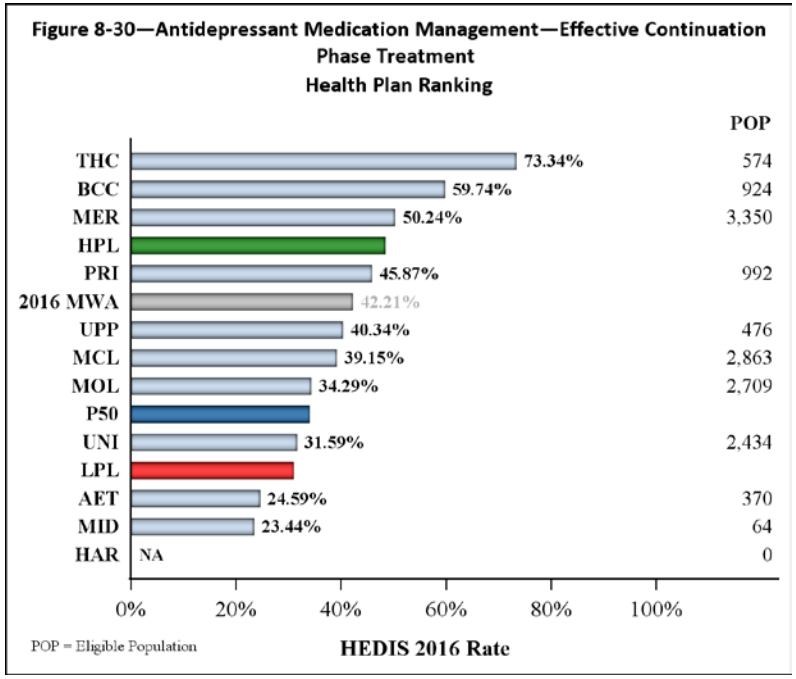
Antidepressant Medication Management—Effective Continuation Phase Treatment

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).



NQ indicates that this measure was not included in the 2014 and 2015 aggregate reports.

This measure was added to the MDHHS' HEDIS 2016 measure set for all MHPs; therefore, historical MWA rates were not presented.



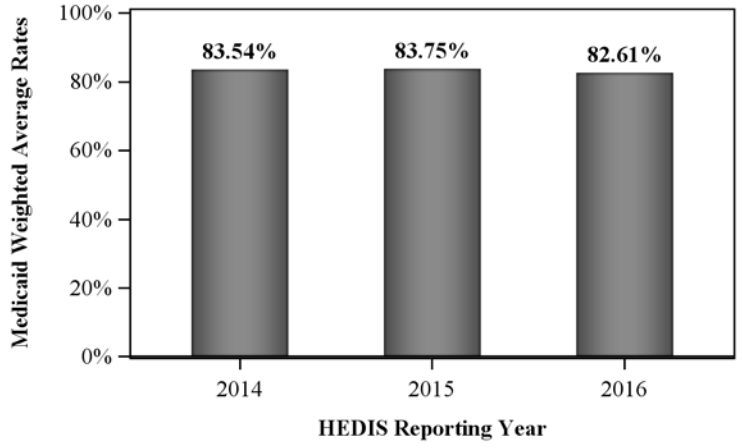
NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Three MHPs ranked above the HPL. Two MHPs fell below the LPL. MHP performance varied from 73.34 percent to 23.44 percent.

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

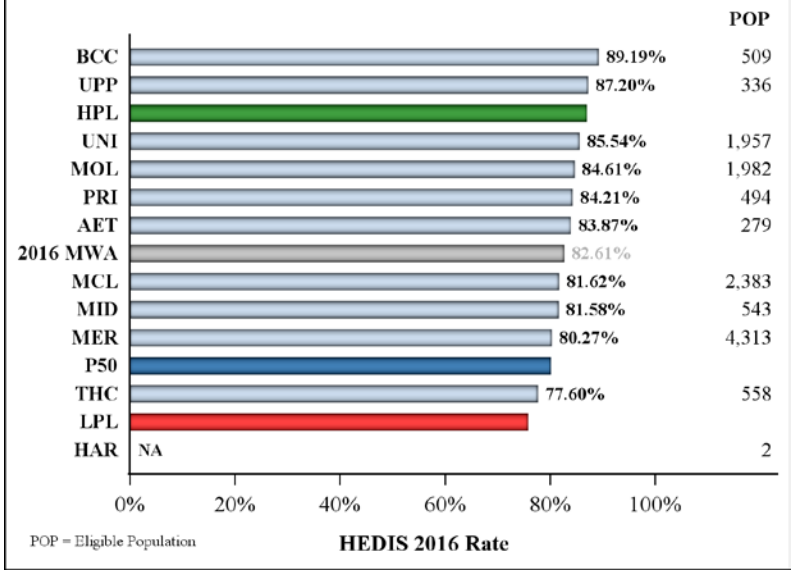
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications assesses the percentage of members between 18 and 64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Figure 8-31—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
Michigan Medicaid Weighted Averages



The HEDIS 2016 MWA rate did not demonstrate a statistically significant change from HEDIS 2015.

Figure 8-32—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
Health Plan Ranking



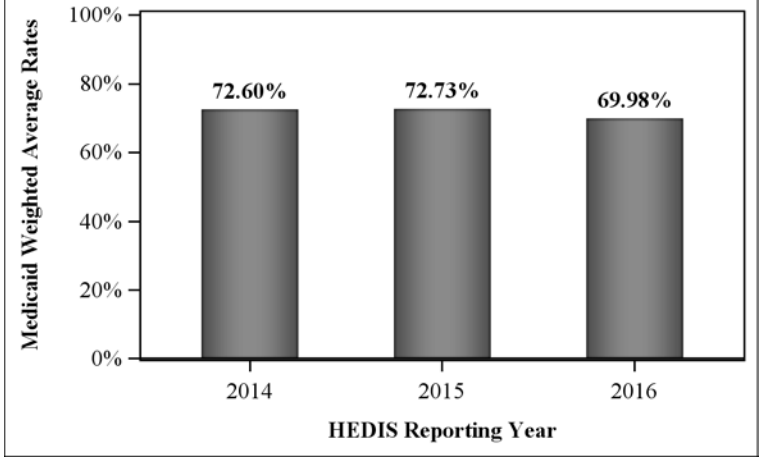
NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Two MHPs ranked above the HPL. No MHPs fell below the LPL. MHP performance varied from 89.19 percent to 77.60 percent.

Diabetes Monitoring for People With Diabetes and Schizophrenia

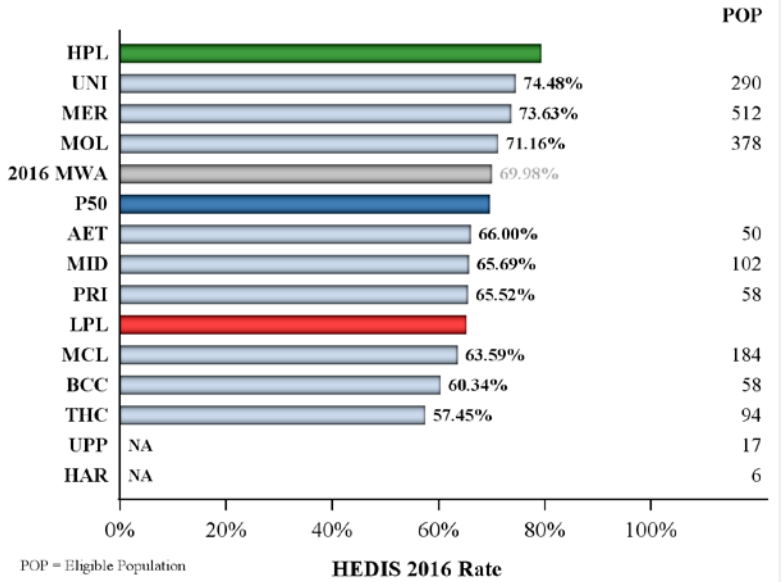
Diabetes Monitoring for People With Diabetes and Schizophrenia assesses the percentage of members between 18 and 64 years of age with schizophrenia and diabetes, who had both a low-density lipoprotein cholesterol (LDL-C) test and an HbA1c test during the measurement year.

Figure 8-33—Diabetes Monitoring for People With Diabetes and Schizophrenia
Michigan Medicaid Weighted Averages



The HEDIS 2016 MWA rate did not demonstrate a statistically significant change from HEDIS 2015.

Figure 8-34—Diabetes Monitoring for People With Diabetes and Schizophrenia
Health Plan Ranking



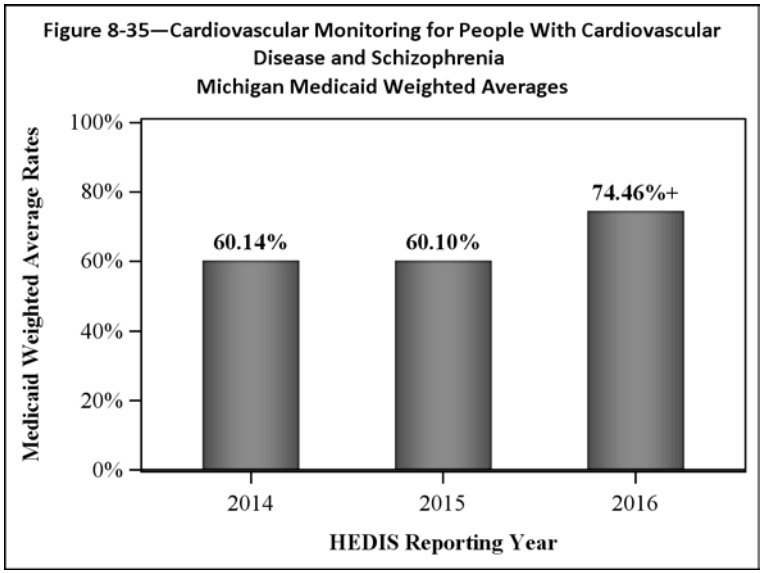
NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

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 74.48 percent to 57.45 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.

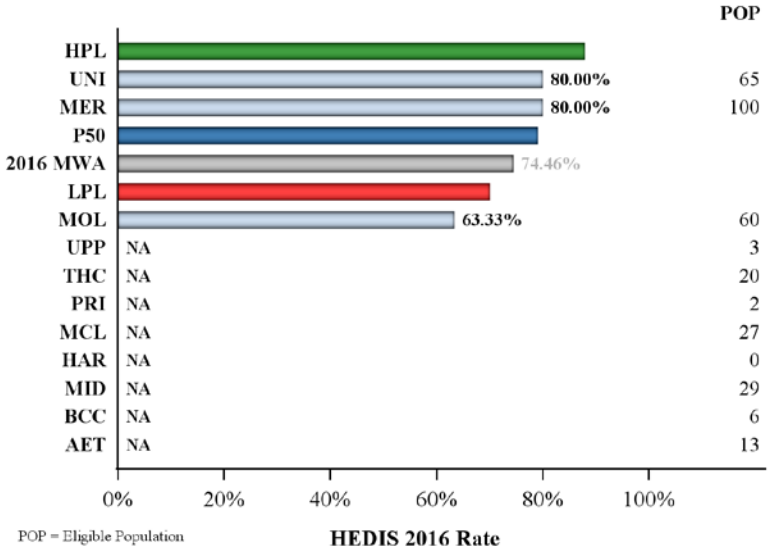
Figure 8-35—Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
Michigan Medicaid Weighted Averages



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

The HEDIS 2016 MWA rate demonstrated a statistically significant improvement in performance from HEDIS 2015.

Figure 8-36—Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
Health Plan Ranking



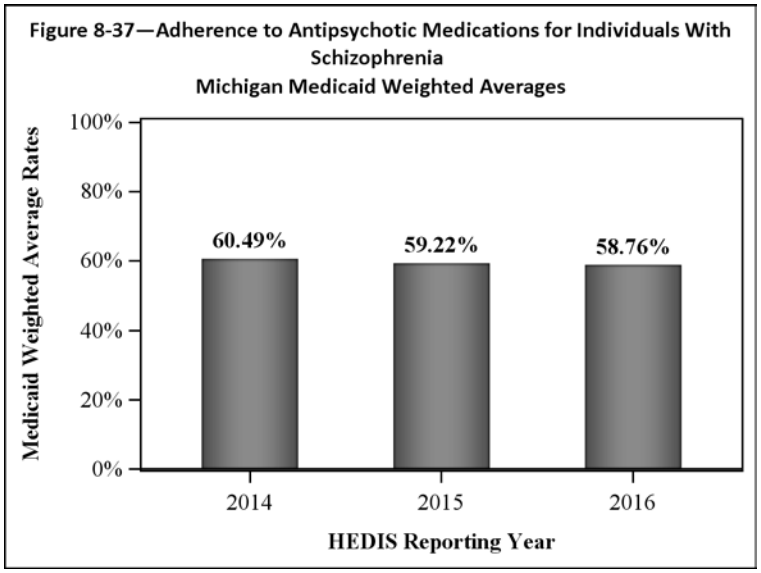
NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Two MHPs ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 80.00 percent to 63.33 percent.

Adherence to Antipsychotic Medications for Individuals With Schizophrenia

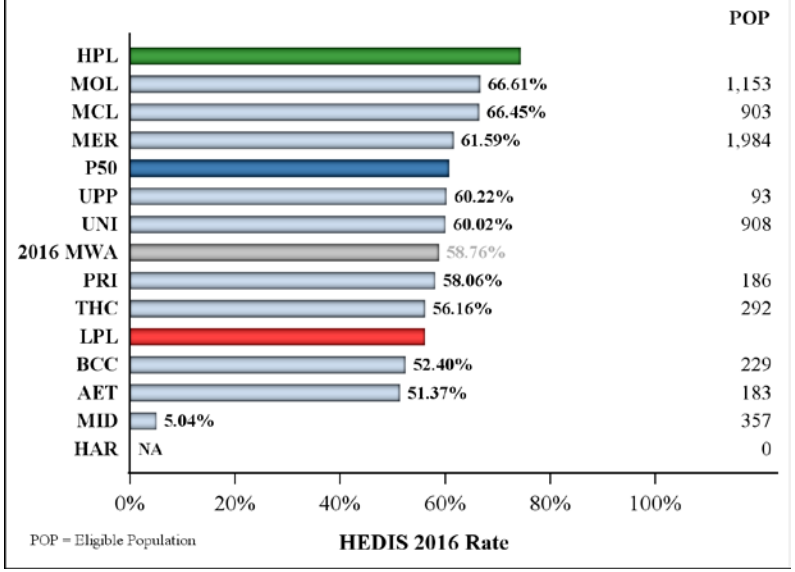
Adherence to Antipsychotic Medications for Individuals With Schizophrenia assesses the percentage of members between 19 and 64 years of age with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period. Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

Figure 8-37—Adherence to Antipsychotic Medications for Individuals With Schizophrenia
Michigan Medicaid Weighted Averages



The HEDIS 2016 MWA rate did not demonstrate a statistically significant change from HEDIS 2015.

Figure 8-38—Adherence to Antipsychotic Medications for Individuals With Schizophrenia
Health Plan Ranking



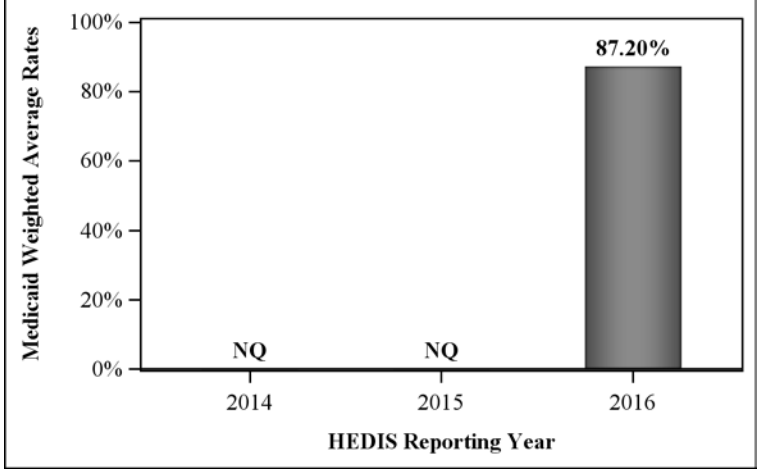
NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Three MHPs ranked above the national Medicaid 50th percentile but below the HPL. Three MHPs fell below the LPL. MHP performance varied from 66.61 percent to 5.04 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.

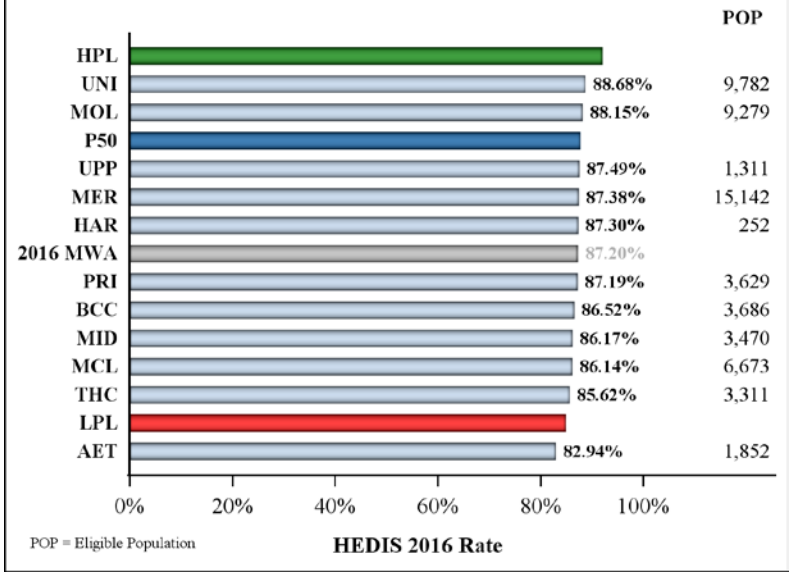
Figure 8-39—Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs
Michigan Medicaid Weighted Averages



NQ indicates that this measure was not included in the 2014 and 2015 aggregate reports.

This measure was added to the MDHHS' HEDIS 2016 measure set for all MHPs; therefore, historical MWA rates were not presented.

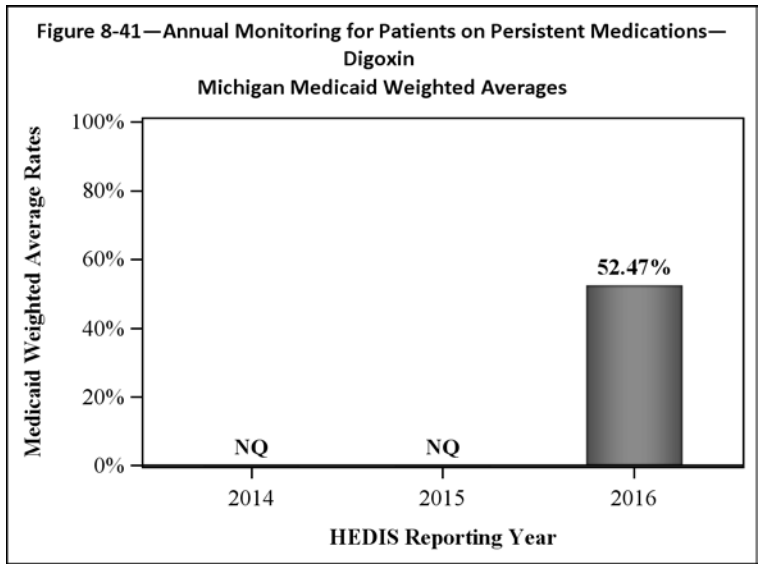
Figure 8-40—Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs
Health Plan Ranking



Two MHPs ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 88.68 percent to 82.94 percent.

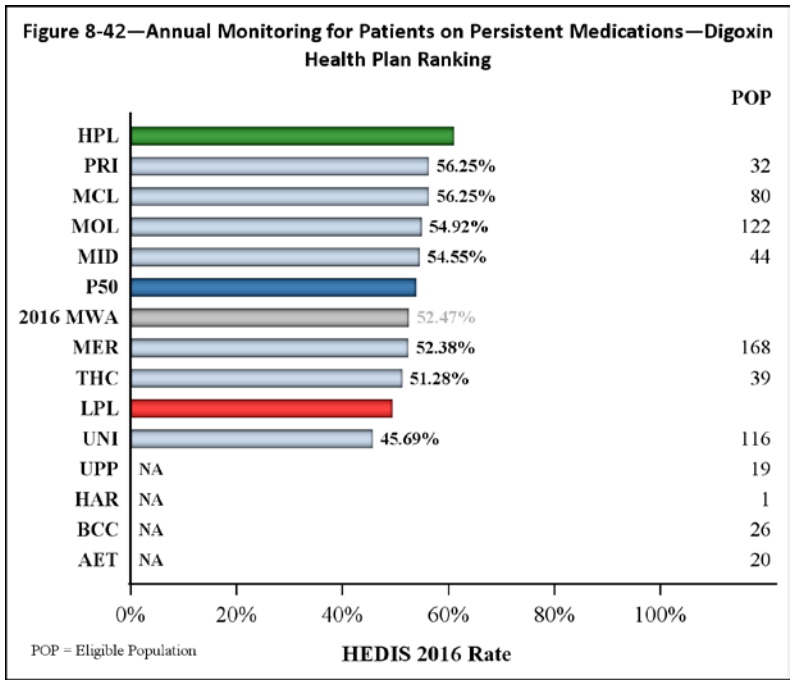
Annual Monitoring for Patients on Persistent Medications—Digoxin

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 2014 and 2015 aggregate reports.

This measure was added to the MDHHS' HEDIS 2016 measure set for all MHPs; therefore, historical MWA rates were not presented.



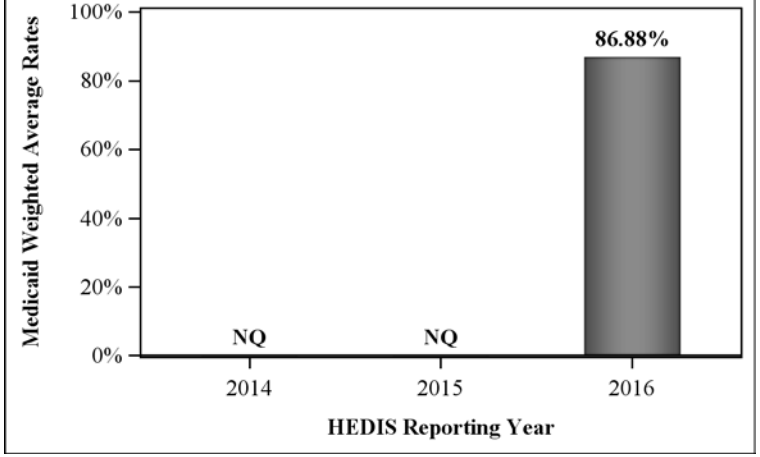
NA indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Four MHPs ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 56.25 percent to 45.69 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.

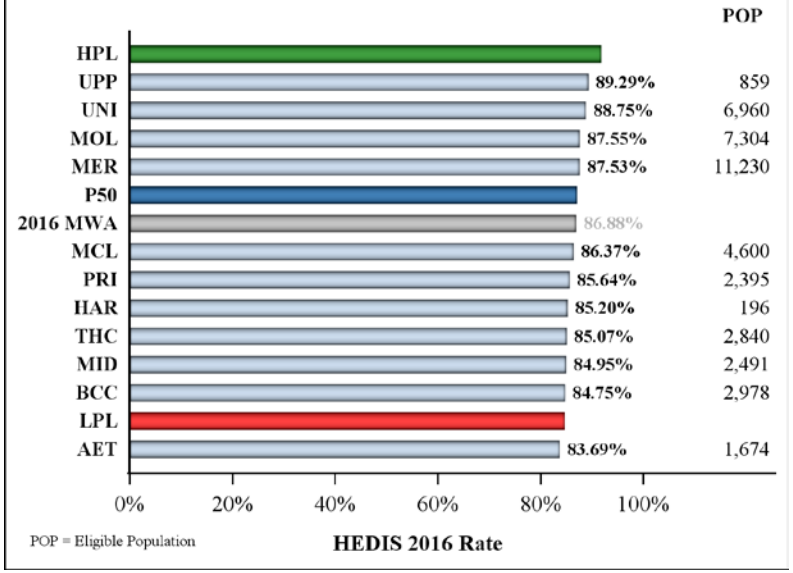
Figure 8-43—Annual Monitoring for Patients on Persistent Medications—Diuretics
Michigan Medicaid Weighted Averages



NQ indicates that this measure was not included in the 2014 and 2015 aggregate reports.

This measure was added to the MDHHS' HEDIS 2016 measure set for all MHPs; therefore, historical MWA rates were not presented.

Figure 8-44—Annual Monitoring for Patients on Persistent Medications—Diuretics
Health Plan Ranking

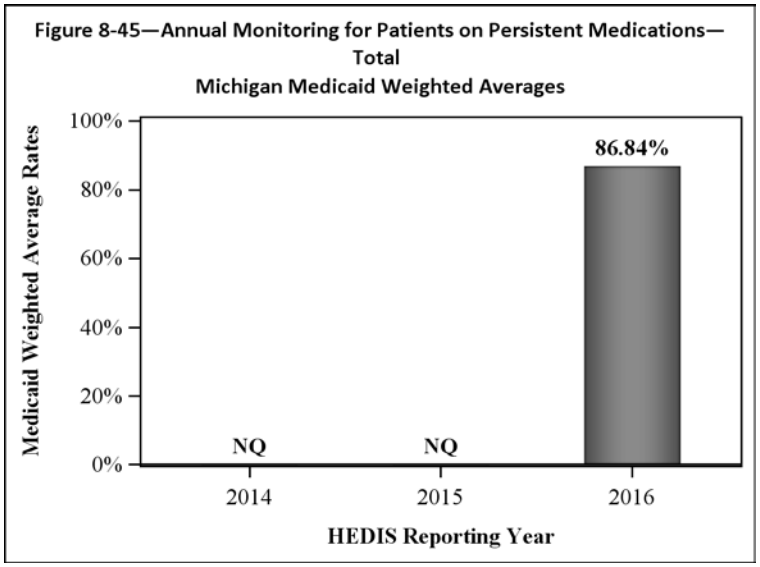


Four MHPs ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 89.29 percent to 83.69 percent.

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.

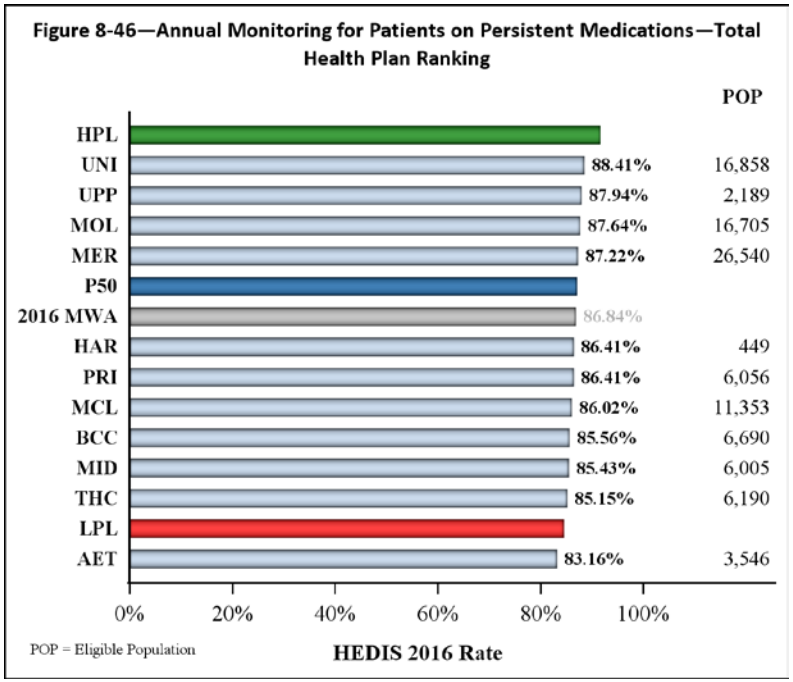
Figure 8-45—Annual Monitoring for Patients on Persistent Medications—Total
Michigan Medicaid Weighted Averages



NQ indicates that this measure was not included in the 2014 and 2015 aggregate reports.

This measure was added to the MDHHS' HEDIS 2016 measure set for all MHPs; therefore, historical MWA rates were not presented.

Figure 8-46—Annual Monitoring for Patients on Persistent Medications—Total
Health Plan Ranking



Four MHPs ranked above the national Medicaid 50th percentile but below the HPL. One MHP fell below the LPL. MHP performance varied from 88.41 percent to 83.16 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 2015 and HEDIS 2016 statewide rates for the *Race/Ethnicity Diversity of Membership* measure, the 2016 rates exhibited a range of minor increases and decreases 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 decreased slightly from the previous year, with a corresponding decline in the Unknown category. The percentage of Michigan members reporting either English or Non-English as the language preferred for written materials increased in HEDIS 2016. There was a corresponding decrease in the percentage of members in the Unknown category. Regarding other language needs, the percentage of members reporting Non-English and Unknown in HEDIS 2016 decreased slightly.

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 2015.

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	56,253	18.01%	70.29%	0.12%	0.60%	0.03%
BCC	125,919	36.95%	44.44%	0.38%	1.20%	0.08%
HAR	13,363	2.39%	44.08%	10.69%	15.88%	0.00%
MCL	246,612	68.72%	15.26%	0.55%	0.71%	0.07%
MER	588,359	62.24%	21.29%	0.45%	0.77%	0.06%
MID	133,884	43.61%	37.40%	0.18%	2.02%	0.18%
MOL	385,916	47.85%	32.33%	0.26%	0.36%	0.00%
PRI	154,088	61.56%	13.23%	0.56%	0.91%	0.06%
THC	89,248	31.09%	54.16%	0.23%	1.15%	0.07%
UNI	251,544	50.65%	31.80%	0.24%	2.37%	<0.01%
UPP	57,429	87.07%	1.41%	2.53%	0.28%	0.06%
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%**
HEDIS 2014 MWA		**52.18%**	**29.18%**	**0.18%**	**0.89%**	**0.05%**

Table 9-1b—MHP and MWA Results for Race/Ethnicity Diversity of Membership (Continued)

MHP	Eligible Population	Some Other Race	Two or More Races	Unknown	Declined
AET	56,253	0.00%	0.00%	9.89%	1.07%
BCC	125,919	3.47%	0.00%	13.48%	0.00%
HAR	13,363	0.00%	0.00%	26.96%	0.00%
MCL	246,612	5.05%	0.00%	9.64%	<0.01%
MER	588,359	<0.01%	0.00%	5.66%	9.53%
MID	133,884	4.58%	0.00%	12.03%	0.00%
MOL	385,916	0.00%	<0.01%	19.20%	0.00%
PRI	154,088	<0.01%	0.00%	23.67%	0.00%
THC	89,248	2.45%	0.00%	10.84%	0.00%
UNI	251,544	0.00%	0.00%	14.94%	0.00%
UPP	57,429	1.39%	0.00%	<0.01%	7.25%
HEDIS 2016 MWA		**1.23%**	**0.00%**	**12.23%**	**2.89%**
HEDIS 2015 MWA		**0.44%**	**0.00%**	**12.40%**	**2.74%**
HEDIS 2014 MWA		**0.44%**	**0.00%**	**15.54%**	**1.55%**

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 decreased when compared to the previous year's percentage. The percentage of members with Non-English as the preferred language decreased slightly when compared to the previous year's percentages. The percentage of members in the Unknown category also increased 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	56,253	0.00%	0.00%	100.00%	0.00%
BCC	125,919	99.17%	0.37%	0.46%	0.00%
HAR	13,363	72.57%	0.51%	26.93%	0.00%
MCL	246,612	96.40%	0.20%	3.40%	<0.01%
MER	588,359	98.87%	1.13%	<0.01%	0.00%
MID	133,884	100.00%	0.00%	0.00%	0.00%
MOL	385,916	98.99%	0.91%	0.10%	0.00%
PRI	154,088	0.00%	0.00%	100.00%	0.00%
THC	89,248	99.38%	0.44%	0.18%	0.00%
UNI	251,544	95.33%	4.67%	<0.01%	0.00%
UPP	57,429	99.93%	0.04%	0.03%	0.00%
HEDIS 2016 MWA		**88.26%**	**1.11%**	**10.63%**	**0.00%**
HEDIS 2015 MWA		**92.88%**	**1.34%**	**5.71%**	**0.07%**
HEDIS 2014 MWA		**90.43%**	**1.55%**	**8.01%**	**0.00%**

Table 9-3 shows that the percentage of Michigan members reporting either English or Non-English as the language preferred for written materials decreased in HEDIS 2016, along with a corresponding increase in the percentage of members reporting in the Unknown category. The percentage of Michigan members reporting either English or Unknown was the language preferred for written materials in HEDIS 2016. Five of the six plans that reported 100 percent in the Unknown category last year continued to report all of their members in the Unknown category in HEDIS 2016.

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	56,253	0.00%	0.00%	100.00%	0.00%
BCC	125,919	99.17%	0.37%	0.46%	0.00%
HAR	13,363	0.00%	0.00%	100.00%	0.00%
MCL	246,612	NR	NR	100.00%	NR
MER	588,359	98.87%	1.13%	<0.01%	0.00%
MID	133,884	0.00%	0.00%	100.00%	0.00%
MOL	385,916	98.99%	0.91%	0.10%	0.00%
PRI	154,088	0.00%	0.00%	100.00%	0.00%
THC	89,248	99.38%	0.44%	0.18%	0.00%
UNI	251,544	95.33%	4.67%	<0.01%	0.00%
UPP	57,429	99.93%	0.04%	0.03%	0.00%
HEDIS 2016 MWA		**70.13%**	**1.08%**	**28.79%**	**0.00%**
HEDIS 2015 MWA		**70.40%**	**1.27%**	**28.34%**	**0.00%**
HEDIS 2014 MWA		**55.36%**	**0.77%**	**43.87%**	**0.00%**

NR indicates that the MHP chose not to report a rate for this measure indicator.

Table 9-4 shows that the percentage of Michigan members reporting English as another language need increased in HEDIS 2016. Non-English as another language need remained the same, while the Unknown category decreased in HEDIS 2016.

Table 9-4—MHP and MWA Results for Language Diversity of Membership—Other Language Needs

MHP	Eligible Population	English	Non-English	Unknown	Declined
AET	56,253	99.34%	0.15%	0.50%	0.00%
BCC	125,919	0.00%	0.00%	100.00%	0.00%
HAR	13,363	0.00%	0.00%	100.00%	0.00%
MCL	246,612	0.00%	0.00%	100.00%	0.00%
MER	588,359	98.87%	1.13%	<0.01%	0.00%
MID	133,884	0.00%	0.00%	100.00%	0.00%
MOL	385,916	98.99%	0.91%	0.10%	0.00%
PRI	154,088	0.00%	0.00%	100.00%	0.00%
THC	89,248	99.38%	0.44%	0.18%	0.00%
UNI	251,544	0.00%	0.00%	100.00%	0.00%
UPP	57,429	0.00%	0.00%	100.00%	0.00%
HEDIS 2016 MWA		**52.71%**	**0.51%**	**46.78%**	**0.00%**
HEDIS 2015 MWA		**42.69%**	**0.51%**	**56.80%**	**0.00%**
HEDIS 2014 MWA		**45.84%**	**0.75%**	**53.40%**	**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 2016 MHP-specific rates as well as the Michigan Medicaid Average (MA) for HEDIS 2016, HEDIS 2015, and HEDIS 2014. 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	482,366	83.70	267.80
BCC	993,434	70.18	554.98
MID	1,117,893	66.64	405.99
HAR	85,447	79.99	241.28
MCL	1,982,083	70.80	430.13
MER	4,848,025	80.18	392.51
MOL	2,965,960	75.32	410.12
PRI	1,237,839	76.40	382.40
THC	751,682	72.75	320.89
UNI	2,979,024	73.22	367.42
UPP	490,914	64.81	334.91
HEDIS 2016 MA		74.00	373.49
HEDIS 2015 MA		70.20	340.77
HEDIS 2014 MA		73.41	325.25

** 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 64.81 as the lowest number of visits per 1,000 member months and 83.70 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	482,366	7.76	4.81	1.34	2.20
BCC	993,434	9.18	4.54	2.44	2.80
MID	1,117,893	9.24	5.06	2.16	2.77
HAR	85,447	9.83	6.06	2.09	1.76
MCL	1,982,083	7.42	3.47	2.01	2.65
MER	4,848,025	8.23	5.33	1.02	2.65
MOL	2,965,960	8.97	4.98	1.90	2.97
PRI	1,237,839	6.99	3.11	1.62	3.18
THC	751,682	10.45	6.10	2.35	2.70
UNI	2,979,024	6.59	3.06	1.61	2.74
UPP	490,914	6.34	3.20	1.63	2.05
HEDIS 2016 MA		8.27	4.52	1.83	2.59
HEDIS 2015 MA		8.02	4.02	1.62	3.62
HEDIS 2014 MA		8.38	4.03	1.45	4.80

** 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	3.81	3.52	6.03	2.83
BCC	4.31	3.65	6.75	2.94
MID	3.87	3.38	6.26	2.52
HAR	3.89	3.56	5.67	2.47
MCL	3.45	3.27	4.85	2.33
MER	3.86	3.98	5.73	2.50
MOL	4.45	4.03	7.44	2.73
PRI	NR	NR	NR	NR
THC	4.34	3.64	7.63	2.66
UNI	4.23	3.92	6.76	2.62
UPP	3.60	3.46	4.69	2.72
HEDIS 2016 MA	3.98	3.64	6.18	2.63
HEDIS 2015 MA	3.99	3.77	6.50	2.65
HEDIS 2014 MA	3.89	3.87	6.51	2.57

NR indicates that the MHP chose not to report a rate for this measure indicator.

11. HEDIS Reporting Capabilities—Information Systems Findings

HEDIS Reporting Capabilities—Information Systems Findings

NCQA's information systems (IS) standards are the guidelines used by certified HEDIS compliance auditors to assess an MHP's ability to report HEDIS data accurately and reliably.[10-1] Compliance with the guidelines also helps an auditor to understand an MHP's HEDIS reporting capabilities. For HEDIS 2016, MHPs were assessed on seven 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 interactive data submission system (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™.[10-2] 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 2016, 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 2016 technical specifications.

HSAG found that, in general, the 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.

[10-1] National Committee for Quality Assurance. HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5. Washington D.C.

[10-2] 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*. All enrollment data were received from the State. 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 data elements required for HEDIS reporting. Primary care practitioners (PCPs) 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 were sufficiently qualified and trained 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 checking 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 6.0—Member Call Center Data—Capture, Transfer, and Entry

This standard assesses whether:

- Member call center data are reliably and accurately captured.

IS 6.0, Member Call Center Data—Capture, Transfer, and Entry was not applicable to the measures required for reporting by the MHPs because the call center measures were not part of the MDHHS-required HEDIS 2016 performance measures.

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, 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.

Glossary

Table 12-1 below provides definitions of terms and acronyms used through 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), Not Applicable (NA), Biased Rate (BR), No Benefit (NB), Not Required (NQ),* and *Not Reported (NR).*
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.
Continuous Enrollment Requirement	The minimum amount of time that a member must be enrolled in the MHP to be eligible for inclusion in a measure to ensure that the MHP has a sufficient amount of time to be held accountable for providing services to that member.
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.
EDI	Electronic data interchange; the direct computer-to-computer transfer of data.
Electronic Data	Data that are maintained in a computer environment versus a paper environment.
Encounter Data	Billing data received from a capitated provider. (Although the MHP does not reimburse the provider for each encounter, submission of encounter data allows the MHP to collect the data for future HEDIS reporting.)
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment.
EQR	External quality review.

Term	Description
Exclusions	Conditions outlined in HEDIS measure specifications that describe when a member should not be included in the denominator.
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).
FY	Fiscal year.
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.)
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]
IT	Information technology; the technology used to create, store, exchange, and use information in its various forms.

[12-1] National Committee for Quality Assurance. HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5. Washington D.C.

Term	Description
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 auditors follow to verify that the MHP's medical record abstraction meets industry standards and abstracted data are accurate
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	Not Applicable; 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 health care delivery systems; reports results of those assessments to employers, consumers, public purchasers, and regulators; and ultimately seeks to improve the health care provided within the managed care industry.
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.

Term	Description
POP	Eligible population.
PPC	Prenatal and Postpartum Care.
Provider Data	Electronic files containing information about physicians such as type of physician, specialty, reimbursement arrangement, and office location.
Retroactive Enrollment	When the effective date of a member's enrollment in the MHP occurs prior to the date that the MHP is notified of that member's enrollment. Medicaid members who are retroactively enrolled in the MHP must be excluded from a HEDIS measure denominator if the time period from the date of enrollment to the date of notification exceeds the measure's allowable gap specifications.
Revenue Codes	Cost codes for facilities to bill based on the categories of services, procedures, supplies, and materials.
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.)
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 2014, HEDIS 2015, and HEDIS 2016. 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 the HEDIS 2016 rate was at or above the Quality Compass HEDIS 2015 national Medicaid 50th percentile benchmark.

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	629	68.75%	60.88%	58.80%	49.77%	29.40%	48.61%	29.17%	24.31%	24.31%
BCC	1,109	76.16%+	70.07%	68.13%+	59.85%+	43.55%	58.39%+	42.58%+	37.96%+	36.98%+
HAR	70	48.57%	44.29%	42.86%	32.86%	21.43%	31.43%	20.00%	18.57%	17.14%
MCL	2,928	74.70%	68.61%	64.72%	54.99%	38.93%	53.04%	38.44%	32.85%	32.85%
MER	7,401	77.91%+	72.79%+	68.84%+	59.07%+	42.79%	55.81%+	41.86%	36.28%	35.35%
MID	1,514	79.86%+	73.84%+	71.30%+	63.43%+	38.43%	61.34%+	37.27%	33.10%	31.94%
MOL	3,840	73.73%	68.43%	65.56%	60.26%+	36.42%	57.84%+	35.32%	33.33%	32.23%
PRI	1,806	82.88%+	80.89%+	78.16%+	70.72%+	57.07%+	68.49%+	56.08%+	51.61%+	50.62%+
THC	1,048	64.58%	58.56%	57.41%	45.60%	27.31%	44.91%	27.08%	23.61%	23.38%
UNI	4,523	76.16%+	71.78%+	67.15%	58.15%	38.69%	54.74%	36.25%	32.85%	30.66%
UPP	702	78.10%+	73.24%+	66.67%	55.47%	43.55%	52.07%	41.61%	37.23%+	36.01%+
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%**
HEDIS 2014 MWA		**80.90%**	**77.21%**	**70.61%**	**61.42%**	**42.17%**	**57.33%**	**40.22%**	**35.18%**	**33.87%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 national Medicaid 50th percentile.

Table A-2—MHP and MWA Results for Immunizations for Adolescents

Plan	Eligible Population	Combination 1 Rate
AET	812	89.68%+
BCC	785	86.86%+
HAR	36	58.33%
MCL	2,420	82.73%+
MER	5,601	86.11%+
MID	1,630	87.73%+
MOL	4,338	90.54%+
PRI	1,600	89.69%+
THC	1,132	81.74%+
UNI	4,763	87.50%+
UPP	637	81.75%+
HEDIS 2016 MWA		**86.99%+**
HEDIS 2015 MWA		**88.94%**
HEDIS 2014 MWA		**88.43%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 national Medicaid 50th percentile.

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 or More Visits—Eligible Population	Well-Child Visits in the First 15 Months of Life 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	446	44.68%	2,933	71.30%	7,126	51.39%+
BCC	1,196	67.40%+	3,561	79.32%+	7,364	60.10%+
HAR	14	NA	318	62.89%	321	35.51%
MCL	1,936	66.42%+	10,683	71.29%	19,694	46.23%
MER	4,296	75.21%+	29,245	77.27%+	45,643	59.72%+
MID	995	56.02%	6,101	76.85%+	13,358	54.99%+
MOL	2,575	63.84%+	17,528	76.15%+	33,788	57.21%+
PRI	1,260	69.16%+	6,847	79.17%+	12,941	52.58%+
THC	745	54.86%	3,975	69.44%	9,662	48.61%
UNI	3,221	61.56%+	20,693	73.21%+	37,953	54.74%+
UPP	657	74.21%+	3,030	69.59%	5,436	42.09%
HEDIS 2016 MWA		**66.22%+**		**75.11%+**		**54.74%+**
HEDIS 2015 MWA		**64.76%**		**75.76%**		**54.02%**
HEDIS 2014 MWA		**73.09%**		**77.05%**		**57.80%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 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 Not Applicable (NA) audit designation.

Table A-4—MHP and MWA Results for Lead Screening in Children

Plan	Eligible Population	Rate
AET	629	73.61%+
BCC	1,109	75.18%+
HAR	70	71.43%
MCL	2,929	92.21%+
MER	7,428	80.32%+
MID	1,514	74.07%+
MOL	3,840	72.19%+
PRI	1,806	83.39%+
THC	1,048	72.69%+
UNI	4,523	78.86%+
UPP	702	88.56%+
HEDIS 2016 MWA		**79.55%+**
HEDIS 2015 MWA		**80.37%**
HEDIS 2014 MWA		**80.43%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 national Medicaid 50th percentile.

Table A-5—MHP and MWA Results for Appropriate Treatment for Children With Upper Respiratory Infection

Plan	Eligible Population	Rate
AET	866	89.72%+
BCC	1,817	92.52%+
HAR	118	96.61%+
MCL	5,385	86.74%
MER	13,989	89.77%+
MID	2,844	88.19%+
MOL	8,016	88.44%+
PRI	3,258	93.71%+
THC	1,221	87.55%
UNI	9,938	87.89%
UPP	1,521	90.27%+
HEDIS 2016 MWA		**89.09%+**
HEDIS 2015 MWA		**88.00%**
HEDIS 2014 MWA		**86.53%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 national Medicaid 50th percentile.

Table A-6—MHP and MWA Results for Appropriate Testing for Children With Pharyngitis

Plan	Eligible Population	Rate
AET	377	55.44%
BCC	690	72.61%+
HAR	12	NA
MCL	2,440	70.37%
MER	7,508	72.84%+
MID	1,446	67.98%
MOL	3,817	62.82%
PRI	1,448	79.07%+
THC	575	57.57%
UNI	4,407	63.13%
UPP	564	68.97%
HEDIS 2016 MWA		**68.41%**
HEDIS 2015 MWA		**67.25%**
HEDIS 2014 MWA		**59.19%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 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 Not Applicable (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	236	23.73%	41	36.59%
BCC	258	39.92%	51	50.98%+
HAR	2	NA	1	NA
MCL	977	42.27%+	270	54.07%+
MER	2,221	45.88%+	790	57.59%+
MID	113	31.86%	36	33.33%
MOL	1,486	37.42%	336	45.83%
PRI	699	39.06%	178	42.13%
THC	332	53.61%+	75	70.67%+
UNI	1,703	44.57%+	370	59.46%+
UPP	237	53.16%+	85	57.65%+
HEDIS 2016 MWA		**42.58%+**		**53.96%+**
HEDIS 2015 MWA		**38.87%**		**44.35%**
HEDIS 2014 MWA		**40.24%**		**47.04%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 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 Not Applicable (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	1,076	63.10%+	6,287	64.47%+
BCC	511	61.84%+	12,418	63.99%+
HAR	34	64.71%+	742	42.58%
MCL	2,254	58.78%+	27,511	63.02%+
MER	4,991	59.57%+	63,058	63.91%+
MID	1,936	57.54%	14,880	59.35%
MOL	5,254	59.67%+	35,841	65.63%+
PRI	933	64.95%+	15,622	63.06%+
THC	1,363	49.67%	10,197	60.19%
UNI	4,962	61.35%+	39,052	65.85%+
UPP	555	59.64%+	7,401	62.53%+
HEDIS 2016 MWA		**59.58%+**		**63.79%+**
HEDIS 2015 MWA		**59.65%**		**68.46%**
HEDIS 2014 MWA		**62.56%**		**71.34%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 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	1,008	66.77%+	605	71.24%+	1,613	68.44%+
BCC	1,018	68.96%+	1,084	70.30%+	2,102	69.65%+
HAR	32	71.88%+	49	73.47%+	81	72.84%+
MCL	2,764	50.36%+	2,317	60.12%	5,081	54.81%+
MER	6,472	60.65%+	6,013	68.47%+	12,485	64.41%+
MID	1,520	58.75%+	1,172	64.76%+	2,692	61.37%+
MOL	4,675	63.25%+	3,198	70.83%+	7,873	66.33%+
PRI	1,874	63.93%+	1,328	72.21%+	3,202	67.36%+
THC	1,309	63.48%+	868	67.51%+	2,177	65.09%+
UNI	4,849	62.26%+	3,199	69.46%+	8,048	65.12%+
UPP	788	46.95%	619	56.06%	1,407	50.96%
HEDIS 2016 MWA		**60.75%+**		**67.85%+**		**63.86%+**
HEDIS 2015 MWA		**59.08%**		**67.58%**		**62.20%**
HEDIS 2014 MWA		**60.15%**		**69.44%**		**63.40%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 national Medicaid 50th percentile.

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	622	90.84%	3,497	81.16%	3,209	86.76%	5,405	83.70%
BCC	1,252	94.89%	4,566	85.57%	2,806	90.84%	3,899	89.38%
HAR	51	82.35%	380	73.16%	127	71.65%	94	67.02%
MCL	2,848	95.44%	13,305	86.68%	10,143	87.98%	13,018	86.62%
MER	7,586	97.69%+	35,912	91.25%+	25,567	92.57%+	29,509	92.74%+
MID	1,420	95.21%	7,452	86.58%	6,051	89.22%	9,021	87.47%
MOL	3,850	96.39%+	20,982	88.57%+	18,297	91.64%+	24,456	90.53%+
PRI	1,954	97.75%+	8,403	89.34%+	6,630	92.05%+	8,256	90.36%+
THC	1,008	87.60%	4,888	83.98%	4,250	86.73%	6,723	85.17%
UNI	4,428	96.54%+	24,770	89.66%+	20,698	91.17%	26,833	90.51%+
UPP	850	97.65%+	3,675	90.18%+	2,799	90.60%	3,666	92.33%+
HEDIS 2016 MWA		**96.20%**		**88.79%+**		**90.85%**		**89.86%**
HEDIS 2015 MWA		**96.32%**		**88.73%**		**91.14%**		**90.21%**
HEDIS 2014 MWA		**96.73%**		**88.91%**		**91.68%**		**90.48%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 national Medicaid 50th percentile.

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	7,057	76.58%	4,682	85.73%	2	NA	11,741	80.23%
BCC	14,861	78.39%	11,291	86.09%	155	78.06%	26,307	81.69%
HAR	955	56.44%	1,035	76.43%	8	NA	1,998	66.87%
MCL	29,616	83.34%+	20,903	89.87%+	42	90.48%+	50,561	86.05%+
MER	70,338	85.37%+	41,592	91.57%+	553	91.50%+	112,483	87.70%+
MID	16,487	77.66%	11,749	88.04%+	649	89.06%+	28,885	82.14%
MOL	38,358	82.66%+	26,226	89.94%+	1,110	96.13%+	65,694	85.79%+
PRI	16,436	85.15%+	10,673	91.31%+	35	88.57%+	27,144	87.58%+
THC	10,811	77.44%	7,997	86.31%	208	72.60%	19,016	81.12%
UNI	42,307	83.01%+	28,502	91.13%+	433	95.84%+	71,242	86.34%+
UPP	8,215	86.23%+	5,413	88.42%+	59	86.44%	13,687	87.10%+
HEDIS 2016 MWA		**82.76%+**		**89.81%+**		**91.15%+**		**85.62%+**
HEDIS 2015 MWA		**83.42%**		**90.77%**		**88.60%**		**86.11%**
HEDIS 2014 MWA		**84.30%**		**90.93%**		**90.29%**		**86.75%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 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 Not Applicable (NA) audit designation.

Table A-12—MHP and MWA Results for Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

Plan	Eligible Population	Rate
AET	240	35.83%+
BCC	358	31.84%+
HAR	35	40.00%+
MCL	1,139	23.00%
MER	3,034	23.57%
MID	662	33.23%+
MOL	1,863	27.70%+
PRI	407	30.96%+
THC	484	33.06%+
UNI	2,322	24.42%
UPP	368	43.48%+
HEDIS 2016 MWA		**26.94%+**
HEDIS 2015 MWA		**NQ**
HEDIS 2014 MWA		**NQ**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 national Medicaid 50th percentile.

NQ indicates that the MHPs were not required to report this measure during this reporting year; therefore, the MWA is not presented in this report.

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	7,180	70.30%+	64.60%+	55.45%+
BCC	9,813	89.54%+	78.83%+	69.10%+
HAR	448	73.97%+	69.83%+	57.66%+
MCL	29,455	66.67%	50.85%	44.53%
MER	79,550	74.53%+	68.22%+	55.14%+
MID	17,970	74.17%+	62.80%+	54.98%+
MOL	49,712	80.46%+	67.82%+	63.68%+
PRI	20,457	75.41%+	60.66%	57.92%+
THC	11,429	72.92%+	65.28%+	56.25%+
UNI	58,977	71.05%+	68.86%+	62.04%+
UPP	8,609	91.97%+	65.94%+	64.23%+
HEDIS 2016 MWA		**74.93%+**	**65.77%+**	**57.88%+**
HEDIS 2015 MWA		**78.34%**	**67.95%**	**58.07%**
HEDIS 2014 MWA		**70.07%**	**64.72%**	**52.99%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 national Medicaid 50th percentile.

[1] *Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.*

Table A-14—MHP and MWA Results for Adult BMI Assessment

Plan	Eligible Population	Rate
AET	6,394	90.21%+
BCC	5,418	89.78%+
HAR	262	74.19%
MCL	17,954	87.83%+
MER	42,076	94.08%+
MID	12,203	85.42%+
MOL	31,074	90.15%+
PRI	8,183	80.10%
THC	9,236	89.29%+
UNI	34,099	89.12%+
UPP	4,604	95.62%+
HEDIS 2016 MWA		**89.92%+**
HEDIS 2015 MWA		**90.31%**
HEDIS 2014 MWA		**86.05%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 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	840	62.38%	45.56%
BCC	1,526	80.54%	57.66%
HAR	93	34.41%	33.33%
MCL	3,212	76.40%	63.99%+
MER	9,247	88.11%+	68.53%+
MID	1,714	71.93%	51.04%
MOL	4,479	78.20%	67.87%+
PRI	2,279	63.56%	61.44%
THC	1,144	68.91%	47.33%
UNI	4,990	76.03%	52.06%
UPP	832	86.13%+	71.78%+
HEDIS 2016 MWA		**78.63%**	**61.73%**
HEDIS 2015 MWA		**84.45%**	**66.69%**
HEDIS 2014 MWA		**88.92%**	**70.84%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 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	840	18.46%
BCC	1,526	45.99%
HAR	93	11.83%
MCL	3,212	58.15%
MER	9,247	86.01%+
MID	1,714	35.73%
MOL	4,479	39.10%
PRI	2,279	45.74%
THC	1,144	29.93%
UNI	4,990	41.75%
UPP	832	72.02%+
HEDIS 2016 MWA		**56.40%**
HEDIS 2015 MWA		**63.43%**
HEDIS 2014 MWA		**66.36%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 national Medicaid 50th percentile.

Table A-17—MHP and MWA Results for Weeks of Pregnancy at Time of Enrollment

Plan	Eligible Population	Prior to 0 Weeks—Rate	1 to 12 Weeks—Rate	13 to 27 Weeks—Rate	28 or More Weeks—Rate	Unknown —Rate
AET	1,030	45.92%	9.61%	21.46%	17.09%	5.92%
BCC	1,972	27.99%	11.26%	30.83%	23.53%	6.39%
HAR	142	16.90%	13.38%	31.69%	35.21%	2.82%
MCL	3,856	31.56%	11.98%	32.13%	20.25%	4.07%
MER	10,814	29.54%	12.22%	36.06%	20.84%	1.35%
MID	2,085	39.57%	11.65%	26.47%	18.08%	4.22%
MOL	5,835	33.16%	10.01%	28.89%	23.00%	4.94%
PRI	411	17.76%	9.49%	22.87%	47.45%	2.43%
THC	430	40.23%	13.49%	27.21%	17.91%	1.16%
UNI	5,952	36.81%	10.69%	29.54%	17.88%	5.09%
UPP	996	28.21%	13.76%	32.63%	20.18%	5.22%
HEDIS 2016 MWA		**32.63%**	**11.40%**	**31.45%**	**20.82%**	**3.70%**
HEDIS 2015 MWA		**30.34%**	**9.55%**	**39.34%**	**17.35%**	**3.42%**
HEDIS 2014 MWA		**29.72%**	**9.27%**	**40.51%**	**17.12%**	**3.38%**

Living With Illness Performance Measure Results

Table A-18—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	1,574	84.36%	46.41%	45.38%	49.36%	91.03%+	52.18%
BCC	2,854	86.86%+	37.59%+	53.65%+	62.04%+	93.07%+	58.39%
HAR	234	75.64%	73.08%	22.22%	46.15%	91.03%+	31.20%
MCL	5,877	89.42%+	36.50%+	51.09%+	56.20%+	92.15%+	61.50%
MER	12,893	85.60%	39.97%+	50.23%+	61.87%+	88.67%+	68.15%+
MID	4,132	85.93%	48.44%	45.04%	57.19%+	88.74%+	44.74%
MOL	8,742	86.04%	41.44%+	50.90%+	57.43%+	92.12%+	55.41%
PRI	3,098	94.89%+	27.92%+	60.40%+	68.80%+	94.34%+	49.27%
THC	2,580	82.98%	53.19%	37.39%	40.27%	91.03%+	47.57%
UNI	9,686	86.81%+	34.17%+	54.58%+	64.31%+	93.06%+	62.64%+
UPP	1,274	91.61%+	28.65%+	58.21%+	66.06%+	91.97%+	75.73%+
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%**
HEDIS 2014 MWA		**85.45%**	**37.23%**	**53.74%**	**63.01%**	**82.00%**	**63.56%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 national Medicaid 50th percentile.

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

** For this indicator, a lower rate indicates better performance.*

Table A-19—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	556	66.55%+	39.93%+
BCC	539	76.62%+	58.26%+
HAR	1	NA	NA
MCL	1,378	59.94%+	38.39%+
MER	2,621	71.23%+	48.68%+
MID	851	62.98%+	34.90%+
MOL	2,057	55.61%+	30.92%+
PRI	945	75.03%+	54.29%+
THC	753	84.59%+	66.27%+
UNI	2,271	69.44%+	45.00%+
UPP	317	53.63%	22.71%
HEDIS 2016 MWA		**67.13%+**	**43.79%+**
HEDIS 2015 MWA		**NQ**	**NQ**
HEDIS 2014 MWA		**NQ**	**NQ**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 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 Not Applicable (NA) audit designation.

NQ 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 Asthma Medication Ratio

Plan	Eligible Population	Rate
AET	711	41.49%
BCC	632	53.96%
HAR	3	NA
MCL	1,634	65.18%+
MER	3,073	69.48%+
MID	1,077	60.26%
MOL	2,600	61.35%+
PRI	1,026	84.31%+
THC	1,177	34.24%
UNI	2,548	64.68%+
UPP	378	64.55%+
HEDIS 2016 MWA		**62.18%+**
HEDIS 2015 MWA		**NQ**
HEDIS 2014 MWA		**NQ**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 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 Not Applicable (NA) audit designation.

NQ 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-21—MHP and MWA Results for Controlling High Blood Pressure

Plan	Eligible Population	Rate
AET	3,061	39.91%
BCC	5,386	54.99%
HAR	483	31.39%
MCL	9,277	54.74%
MER	20,816	67.79%+
MID	6,141	53.86%
MOL	15,028	53.60%
PRI	4,785	44.13%
THC	4,731	43.05%
UNI	15,052	52.32%
UPP	1,920	63.99%+
HEDIS 2016 MWA		**55.54%**
HEDIS 2015 MWA		**62.06%**
HEDIS 2014 MWA		**63.58%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 national Medicaid 50th percentile.

Table A-22—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	33,656	79.92%+	55.74%+	46.22%+
BCC	73,845	77.27%+	52.86%+	46.70%+
HAR	4,199	78.41%+	54.51%+	45.28%+
MCL	148,670	77.60%+	50.54%+	42.25%
MER	337,159	80.16%+	55.69%+	44.88%+
MID	36,221	81.74%+	52.57%+	44.21%+
MOL	153,245	83.54%+	56.32%+	45.94%+
PRI	46,272	79.10%+	51.75%+	43.60%+
THC	49,686	78.16%+	50.69%+	42.29%
UNI	191,730	78.86%+	59.35%+	48.02%+
UPP	34,250	79.43%+	55.95%+	45.39%+
HEDIS 2016 MWA		**79.75%+**	**55.04%+**	**45.20%+**
HEDIS 2015 MWA		**79.90%**	**54.26%**	**45.73%**
HEDIS 2014 MWA		**80.35%**	**53.76%**	**46.12%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 national Medicaid 50th percentile.

Table A-23—MHP and MWA Results for Antidepressant Medication Management

Plan	Eligible Population	Effective Acute Phase Treatment—Rate	Effective Continuation Phase Treatment—Rate
AET	370	37.84%	24.59%
BCC	924	75.97%+	59.74%+
HAR	0	NA	NA
MCL	2,863	58.33%+	39.15%+
MER	3,350	70.45%+	50.24%+
MID	64	37.50%	23.44%
MOL	2,709	51.46%+	34.29%+
PRI	992	61.09%+	45.87%+
THC	574	89.55%+	73.34%+
UNI	2,434	49.55%	31.59%
UPP	476	61.13%+	40.34%+
HEDIS 2016 MWA		**60.36%+**	**42.21%+**
HEDIS 2015 MWA		**NQ**	**NQ**
HEDIS 2014 MWA		**NQ**	**NQ**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 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 Not Applicable (NA) audit designation.

NQ 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-24—MHP and MWA Results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Plan	Eligible Population	Rate
AET	279	83.87%+
BCC	509	89.19%+
HAR	2	NA
MCL	2,383	81.62%+
MER	4,313	80.27%+
MID	543	81.58%+
MOL	1,982	84.61%+
PRI	494	84.21%+
THC	558	77.60%
UNI	1,957	85.54%+
UPP	336	87.20%+
HEDIS 2016 MWA		**82.61%+**
HEDIS 2015 MWA		**83.75%**
HEDIS 2014 MWA		**83.54%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 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 Not Applicable (NA) audit designation.

Table A-25—MHP and MWA Results for Diabetes Monitoring for People With Diabetes and Schizophrenia

Plan	Eligible Population	Rate
AET	50	66.00%
BCC	58	60.34%
HAR	6	NA
MCL	184	63.59%
MER	512	73.63%+
MID	102	65.69%
MOL	378	71.16%+
PRI	58	65.52%
THC	94	57.45%
UNI	290	74.48%+
UPP	17	NA
HEDIS 2016 MWA		**69.98%+**
HEDIS 2015 MWA		**72.73%**
HEDIS 2014 MWA		**72.60%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 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 Not Applicable (NA) audit designation.

Table A-26—MHP and MWA Results for Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

Plan	Eligible Population	Rate
AET	13	NA
BCC	6	NA
HAR	0	NA
MCL	27	NA
MER	100	80.00%+
MID	29	NA
MOL	60	63.33%
PRI	2	NA
THC	20	NA
UNI	65	80.00%+
UPP	3	NA
HEDIS 2016 MWA		**74.46%**
HEDIS 2015 MWA		**60.10%**
HEDIS 2014 MWA		**60.14%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 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 Not Applicable (NA) audit designation.

Table A-27—MHP and MWA Results for Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Plan	Eligible Population	Rate
AET	183	51.37%
BCC	229	52.40%
HAR	0	NA
MCL	903	66.45%+
MER	1,984	61.59%+
MID	357	5.04%
MOL	1,153	66.61%+
PRI	186	58.06%
THC	292	56.16%
UNI	908	60.02%
UPP	93	60.22%
HEDIS 2016 MWA		**58.76%**
HEDIS 2015 MWA		**59.22%**
HEDIS 2014 MWA		**60.49%**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 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 Not Applicable (NA) audit designation.

Table A-28—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	1,852	82.94%	20	NA	1,674	83.69%	3,546	83.16%
BCC	3,686	86.52%	26	NA	2,978	84.75%	6,690	85.56%
HAR	252	87.30%	1	NA	196	85.20%	449	86.41%
MCL	6,673	86.14%	80	56.25%+	4,600	86.37%	11,353	86.02%
MER	15,142	87.38%	168	52.38%	11,230	87.53%+	26,540	87.22%+
MID	3,470	86.17%	44	54.55%+	2,491	84.95%	6,005	85.43%
MOL	9,279	88.15%+	122	54.92%+	7,304	87.55%+	16,705	87.64%+
PRI	3,629	87.19%	32	56.25%+	2,395	85.64%	6,056	86.41%
THC	3,311	85.62%	39	51.28%	2,840	85.07%	6,190	85.15%
UNI	9,782	88.68%+	116	45.69%	6,960	88.75%+	16,858	88.41%+
UPP	1,311	87.49%	19	NA	859	89.29%+	2,189	87.94%+
HEDIS 2016 MWA		**87.20%**		**52.47%**		**86.88%**		**86.84%**
HEDIS 2015 MWA		**NQ**		**NQ**		**NQ**		**NQ**
HEDIS 2014 MWA		**NQ**		**NQ**		**NQ**		**NQ**

Yellow shading with one cross (+) indicates the HEDIS 2016 MHP or MWA rate was at or above the Quality Compass HEDIS 2015 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 Not Applicable (NA) audit designation.

NQ 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 Measure 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 2014, HEDIS 2015, and HEDIS 2016 rates are presented. HEDIS 2015 and HEDIS 2016 rates were compared based on a Chi-square test of statistical significance with a *p* value <0.05. Values in the 2015–2016 Comparison column that are shaded green with one cross ($^{+}$) indicate statistically significant improvement from the previous year. Values in the 2015–2016 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 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	73.61%	71.93%	68.75%	-3.18	★
Combination 3	68.29%	67.92%	60.88%	**-7.04⁺⁺**	★
Combination 4	65.05%	65.80%	58.80%	**-7.01⁺⁺**	★
Combination 5	53.01%	55.66%	49.77%	-5.89	★
Combination 6	27.78%	31.13%	29.40%	-1.73	★
Combination 7	51.16%	54.01%	48.61%	-5.40	★
Combination 8	27.31%	30.42%	29.17%	-1.26	★
Combination 9	23.61%	25.94%	24.31%	-1.64	★
Combination 10	23.38%	25.47%	24.31%	-1.17	★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	49.75%	51.42%	44.68%	**-6.74⁺⁺**	★
Lead Screening in Children					
Lead Screening in Children	82.41%	79.25%	73.61%	-5.63	★★★
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	74.73%	74.32%	71.30%	-3.02	★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	57.52%	52.88%	51.39%	-1.50	★★★
Immunizations for Adolescents					
Combination 1	84.98%	83.05%	89.68%	**+6.63⁺**	★★★★★
Appropriate Treatment for Children With Upper Respiratory Infection					
Appropriate Treatment for Children With Upper Respiratory Infection	88.45%	89.35%	89.72%	+0.38	★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	50.62%	54.85%	55.44%	+0.59	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	25.25%	19.16%	23.73%	+4.57	★

Table B-1—AET Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Continuation and Maintenance Phase	27.91%	21.43%	36.59%	+15.16	★★
Women – Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	66.81%	68.11%	63.10%	**-5.00⁺⁺**	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	70.92%	72.35%	64.47%	**-7.88⁺⁺**	★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	68.26%	68.48%	66.77%	-1.71	★★★★★
Ages 21 to 24 Years	77.30%	75.70%	71.24%	-4.46	★★★★
Total	70.99%	70.77%	68.44%	-2.33	★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	94.60%	93.32%	90.84%	-2.48	★
Ages 25 Months to 6 Years	82.98%	82.82%	81.16%	-1.67	★
Ages 7 to 11 Years	88.05%	87.47%	86.76%	-0.71	★
Ages 12 to 19 Years	85.79%	85.52%	83.70%	**-1.82⁺⁺**	★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	80.06%	77.95%	76.58%	-1.37	★★
Ages 45 to 64 Years	87.53%	86.35%	85.73%	-0.62	★★
Ages 65+ Years	NA	NA	NA	—	NA
Total	82.82%	81.17%	80.23%	-0.94	★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	35.83%	—	★★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	71.53%	77.12%	70.30%	**-6.83⁺⁺**	★★★
Counseling for Nutrition—Total	62.50%	70.52%	64.60%	-5.91	★★★
Counseling for Physical Activity—Total[3]	48.15%	64.39%	55.45%	**-8.94⁺⁺**	★★★

Table B-1—AET Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	84.62%	88.56%	90.21%	+1.65	★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	84.35%	70.62%	62.38%	**-8.23**$^{++}$	★
Postpartum Care	66.12%	52.13%	45.56%	-6.57	★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	36.74%	27.49%	18.46%	**-9.03**$^{++}$	★
Weeks of Pregnancy at Time of Enrollment[4]					
Prior to 0 Weeks	47.83%	44.23%	45.92%	+1.69	—
1–12 Weeks	4.83%	6.07%	9.61%	+3.54	—
13–27 Weeks	26.00%	27.63%	21.46%	-6.18	—
28 or More Weeks	16.58%	17.51%	17.09%	-0.42	—
Unknown	4.75%	4.55%	5.92%	+1.37	—
Living With Illness					
Comprehensive Diabetes Care[3]					
Hemoglobin A1c (HbA1c) Testing	84.33%	85.66%	84.36%	-1.30	★★
*HbA1c Poor Control (>9.0%)**	38.47%	40.99%	46.41%	**5.42**$^{++}$	★★
HbA1c Control (<8.0%)	52.59%	52.41%	45.38%	**-7.03**$^{++}$	★★
Eye Exam (Retinal) Performed	62.82%	59.77%	49.36%	**-10.41**$^{++}$	★★
Medical Attention for Nephropathy	82.90%	85.41%	91.03%	**+5.62**$^{+}$	★★★★★
Blood Pressure Control (<140/90 mm Hg)	50.13%	52.16%	52.18%	+0.02	★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	—	66.55%	—	★★★★
Medication Compliance 75%—Total	—	—	39.93%	—	★★★★
Asthma Medication Ratio					
Total	—	—	41.49%	—	★

Table B-1—AET Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	50.00%	48.72%	39.91%	**-8.81**$^{++}$	★
Medical Assistance with Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	82.72%	81.50%	79.92%	-1.58	★★★★
Discussing Cessation Medications	57.92%	58.00%	55.74%	-2.26	★★★★
Discussing Cessation Strategies	47.95%	44.80%	46.22%	+1.42	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	—	37.84%	—	★
Effective Continuation Phase Treatment	—	—	24.59%	—	★
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	NB	83.87%	—	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	NR	NA	66.00%	—	★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NR	NA	NA	—	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NB	NB	51.37%	—	★

Table B-1—AET Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	—	82.94%	—	★
Digoxin	—	—	NA	—	NA
Diuretics	—	—	83.69%	—	★
Total	—	—	83.16%	—	★
Health Plan Diversity[4]					
Race/Ethnicity Diversity of Membership					
Total—White	14.64%	15.94%	18.01%	+2.07	—
Total—Black or African American	76.62%	73.61%	70.29%	-3.32	—
Total—American-Indian and Alaska Native	0.09%	0.09%	0.12%	+0.03	—
Total—Asian	0.77%	0.63%	0.60%	-0.04	—
Total—Native Hawaiian and Other Pacific Islander	0.00%	0.00%	0.03%	+0.03	—
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	7.88%	9.73%	9.89%	+0.16	—
Total—Declined	0.00%	0.00%	1.07%	+1.07	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	99.20%	99.38%	0.00%	-99.38	—
Spoken Language Preferred for Health Care—Non-English	0.00%	0.00%	0.00%	0.00	—
Spoken Language Preferred for Health Care—Unknown	0.80%	0.62%	100.00%	+99.38	—
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	99.20%	99.38%	0.00%	-99.38	—

Table B-1—AET Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Preferred Language for Written Materials—Non-English	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—Unknown	0.80%	0.62%	100.00%	+99.38	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—English	0.00%	0.00%	99.34%	+99.34	—
Other Language Needs—Non-English	0.00%	0.00%	0.15%	+0.15	—
Other Language Needs—Unknown	100.00%	100.00%	0.50%	-99.50	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	—
Utilization[4]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*ED Visits—Total**	87.58	86.43	83.70	-2.73	★
Outpatient Visits—Total	308.37	311.47	267.80	-43.68	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	8.90	8.57	7.76	-0.81	—
Total Inpatient—Average Length of Stay—Total	4.19	4.08	3.81	-0.27	—
Maternity—Discharges per 1,000 Member Months—Total	3.55	2.94	2.20	-0.75	—
Maternity—Average Length of Stay—Total	2.63	2.68	2.83	+0.14	—
Surgery—Discharges per 1,000 Member Months—Total	1.68	1.79	1.34	-0.45	—
Surgery—Average Length of Stay—Total	7.68	6.70	6.03	-0.67	—

Table B-1—AET Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Medicine—Discharges per 1,000 Member Months—Total	4.86	4.74	4.81	+0.07	—
Medicine—Average Length of Stay—Total	3.73	3.69	3.52	-0.17	—

[1] HEDIS 2015 to HEDIS 2016 comparisons were based on a Chi-square test of statistical significance with a p value <0.05.

Green Shading[+] *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

Red Shading[++] *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

[2] 2016 performance levels were based on comparisons of the HEDIS 2016 measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS 2015 benchmark.

[3] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

[4] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2016 or 2015–2016 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 2014 and/or 2015 rate is not presented in this report. This symbol may also indicate that the 2015–2016 comparison was not performed because the 2015 and/or 2016 rate was not reportable, or the 2016 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 Not Applicable (NA) audit designation. For HEDIS 2016 rates designated as NA, the 2016 performance level is also presented as NA.

NB indicates that the required benefit to calculate the measure was not offered.

NR indicates that the auditor determined the HEDIS 2014 or HEDIS 2015 rate was materially biased or the MHP chose not report a rate for this measure indicator. For HEDIS 2016, NR indicates that the MHP chose not to report a rate for this measure indicator.

2016 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 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	77.13%	76.16%	76.16%	0.00	★★★
Combination 3	74.94%	72.75%	70.07%	-2.68	★★
Combination 4	68.37%	69.59%	68.13%	-1.46	★★★
Combination 5	62.04%	58.39%	59.85%	+1.46	★★★
Combination 6	49.39%	50.12%	43.55%	-6.57	★★
Combination 7	58.39%	56.93%	58.39%	+1.46	★★★
Combination 8	45.74%	48.66%	42.58%	-6.08	★★★
Combination 9	41.61%	40.88%	37.96%	-2.92	★★★
Combination 10	39.17%	39.90%	36.98%	-2.92	★★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	64.97%	65.21%	67.40%	+2.19	★★★★
Lead Screening in Children					
Lead Screening in Children	77.61%	73.97%	75.18%	+1.22	★★★
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	72.45%	85.64%	79.32%	**-6.33**++	★★★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	45.99%	61.07%	60.10%	-0.97	★★★★
Immunizations for Adolescents					
Combination 1	88.32%	85.64%	86.86%	+1.22	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection					
Appropriate Treatment for Children With Upper Respiratory Infection	95.51%	92.98%	92.52%	-0.46	★★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	74.41%	78.69%	72.61%	**-6.08**++	★★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	NR	40.26%	39.92%	-0.34	★★

Table B-2—BCC Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Continuation and Maintenance Phase	NR	44.55%	50.98%	+6.43	★★★
Women—Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	59.88%	61.98%	61.84%	-0.14	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	68.86%	69.83%	63.99%	-5.84	★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	58.04%	66.71%	68.96%	+2.25	★★★★★
Ages 21 to 24 Years	69.21%	76.03%	70.30%	**-5.73**++	★★★★
Total	62.11%	70.77%	69.65%	-1.12	★★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	94.71%	94.94%	94.89%	-0.05	★★
Ages 25 Months to 6 Years	84.16%	88.45%	85.57%	**-2.88**++	★★
Ages 7 to 11 Years	93.13%	94.36%	90.84%	**-3.52**++	★★
Ages 12 to 19 Years	92.20%	91.58%	89.38%	**-2.20**++	★★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	79.05%	81.94%	78.39%	**-3.55**++	★★
Ages 45 to 64 Years	84.90%	87.29%	86.09%	-1.21	★★
Ages 65+ Years	76.98%	76.69%	78.06%	+1.38	★
Total	80.67%	83.32%	81.69%	**-1.63**++	★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	31.84%	—	★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	79.08%	90.51%	89.54%	-0.97	★★★★★
Counseling for Nutrition—Total	67.40%	79.56%	78.83%	-0.73	★★★★

Table B-2—BCC Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Counseling for Physical Activity—Total[3]	55.47%	74.94%	69.10%	-5.84	★★★★
Adult BMI Assessment					
Adult BMI Assessment	87.10%	92.94%	89.78%	-3.16	★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	86.00%	85.64%	80.54%	-5.11	★★
Postpartum Care	64.86%	63.75%	57.66%	-6.08	★★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	43.73%	35.04%	45.99%	**+10.95**[+]	★
Weeks of Pregnancy at Time of Enrollment[4]					
Prior to 0 Weeks	21.41%	18.83%	27.99%	+9.17	—
1–12 Weeks	15.09%	11.74%	11.26%	-0.48	—
13–27 Weeks	39.90%	42.00%	30.83%	-11.17	—
28 or More Weeks	20.92%	20.34%	23.53%	+3.19	—
Unknown	2.68%	7.09%	6.39%	-0.70	—
Living With Illness					
Comprehensive Diabetes Care[3]					
Hemoglobin A1c (HbA1c) Testing	87.41%	89.05%	86.86%	-2.19	★★★
*HbA1c Poor Control (>9.0%)**	41.42%	33.03%	37.59%	+4.56	★★★
HbA1c Control (<8.0%)	48.36%	57.85%	53.65%	-4.20	★★★
Eye Exam (Retinal) Performed	64.05%	62.41%	62.04%	-0.36	★★★
Medical Attention for Nephropathy	84.85%	84.85%	93.07%	**+8.21**[+]	★★★★★
Blood Pressure Control (<140/90 mm Hg)	65.33%	65.69%	58.39%	**-7.30**[++]	★★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	—	76.62%	—	★★★★★
Medication Compliance 75%—Total	—	—	58.26%	—	★★★★★

Table B-2—BCC Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Asthma Medication Ratio					
Total	—	—	53.96%	—	★
Controlling High Blood Pressure					
Controlling High Blood Pressure	64.63%	49.64%	54.99%	+5.35	★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	78.01%	77.38%	77.27%	-0.11	★★★
Discussing Cessation Medications	51.52%	53.23%	52.86%	-0.37	★★★★
Discussing Cessation Strategies	42.51%	44.19%	46.70%	+2.51	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	—	75.97%	—	★★★★★
Effective Continuation Phase Treatment	—	—	59.74%	—	★★★★★
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	NR	74.86%	89.19%	**+14.34**[+]	★★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	NR	67.74%	60.34%	-7.40	★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NR	NA	NA	—	NA

Table B-2—BCC Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[3]					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NR	53.57%	52.40%	-1.17	★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	—	86.52%	—	★★
Digoxin	—	—	NA	—	NA
Diuretics	—	—	84.75%	—	★★
Total	—	—	85.56%	—	★★
Health Plan Diversity[4]					
Race/Ethnicity Diversity of Membership					
Total—White	0.00%	37.28%	36.95%	-0.32	—
Total—Black or African American	0.00%	43.76%	44.44%	+0.67	—
Total—American-Indian and Alaska Native	0.00%	0.32%	0.38%	+0.06	—
Total—Asian	0.00%	1.50%	1.20%	-0.31	—
Total—Native Hawaiian and Other Pacific Islander	0.00%	0.00%	0.08%	+0.08	—
Total—Some Other Race	0.00%	3.50%	3.47%	-0.03	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	100.00%	13.64%	13.48%	-0.16	—
Total—Declined	0.00%	0.00%	0.00%	0.00	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	99.01%	99.08%	99.17%	+0.10	—
Spoken Language Preferred for Health Care—Non-English	0.39%	0.38%	0.37%	-0.02	—
Spoken Language Preferred for Health Care—Unknown	0.60%	0.54%	0.46%	-0.08	—

Table B-2—BCC Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	99.01%	99.08%	99.17%	+0.10	—
Preferred Language for Written Materials—Non-English	0.39%	0.38%	0.37%	-0.02	—
Preferred Language for Written Materials—Unknown	0.60%	0.54%	0.46%	-0.08	—
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[4]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*Emergency Department Visits—Total**	63.82	70.55	70.18	-0.37	★★
Outpatient Visits—Total	256.20	356.57	554.98	+198.41	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	10.07	9.78	9.18	-0.60	—
Total Inpatient—Average Length of Stay—Total	3.67	3.76	4.31	+0.55	—
Maternity—Discharges per 1,000 Member Months—Total	5.59	3.99	2.80	-1.20	—
Maternity—Average Length of Stay—Total	2.79	2.69	2.94	+0.25	—

Table B-2—BCC Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Surgery—Discharges per 1,000 Member Months—Total	1.95	2.22	2.44	+0.23	—
Surgery—Average Length of Stay—Total	5.88	6.37	6.75	+0.37	—
Medicine—Discharges per 1,000 Member Months—Total	4.66	4.74	4.54	-0.21	—
Medicine—Average Length of Stay—Total	3.41	3.17	3.65	+0.48	—

[1] HEDIS 2015 to HEDIS 2016 comparisons were based on a Chi-square test of statistical significance with a p value <0.05.

Green Shading[+] *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

Red Shading[++] *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

[2] 2016 performance levels were based on comparisons of the HEDIS 2016 measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS 2015 benchmark.

[3] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

[4] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2016 or 2015–2016 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 2014 and/or 2015 rate is not presented in this report. This symbol may also indicate that the 2015–2016 comparison was not performed because the 2015 and/or 2016 rate was not reportable, or the 2016 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 Not Applicable (NA) audit designation. For HEDIS 2016 rates designated as NA, the 2016 performance level is also presented as NA.

NB indicates that the required benefit to calculate the measure was not offered.

NR indicates that the auditor determined the HEDIS 2014 or HEDIS 2015 rate was materially biased or the MHP chose not report a rate for this measure indicator. For HEDIS 2016, NR indicates that the MHP chose not to report a rate for this measure indicator.

2016 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 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	58.82%	50.59%	48.57%	-2.02	★
Combination 3	50.59%	45.88%	44.29%	-1.60	★
Combination 4	50.59%	44.71%	42.86%	-1.85	★
Combination 5	41.18%	36.47%	32.86%	-3.61	★
Combination 6	21.18%	22.35%	21.43%	-0.92	★
Combination 7	41.18%	35.29%	31.43%	-3.87	★
Combination 8	21.18%	21.18%	20.00%	-1.18	★
Combination 9	18.82%	16.47%	18.57%	+2.10	★
Combination 10	18.82%	15.29%	17.14%	+1.85	★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	NA	37.50%	NA	—	NA
Lead Screening in Children					
Lead Screening in Children	61.18%	72.94%	71.43%	-1.51	★★
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	58.84%	64.44%	62.89%	-1.55	★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	33.00%	32.93%	35.51%	+2.58	★
Immunizations for Adolescents					
Combination 1	NA	NA	58.33%	—	★
Appropriate Treatment for Children With Upper Respiratory Infection					
Appropriate Treatment for Children With Upper Respiratory Infection	93.28%	83.33%	96.61%	**+13.28⁺**	★★★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	NA	NA	NA	—	NA
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	NA	NA	NA	—	NA
Continuation and Maintenance Phase	NA	NA	NA	—	NA
Women—Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	32.35%	67.44%	64.71%	-2.74	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	50.61%	51.98%	42.58%	**-9.40⁺⁺**	★
Chlamydia Screening in Women					
Ages 16 to 20 Years	NA	NA	71.88%	—	★★★★★
Ages 21 to 24 Years	NA	NA	73.47%	—	★★★★★
Total	NA	64.44%	72.84%	+8.40	★★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	70.42%	82.30%	82.35%	+0.05	★
Ages 25 Months to 6 Years	63.56%	68.62%	73.16%	+4.54	★
Ages 7 to 11 Years	55.17%	71.26%	71.65%	+0.39	★
Ages 12 to 19 Years	67.50%	63.16%	67.02%	+3.86	★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	48.24%	56.51%	56.44%	-0.07	★
Ages 45 to 64 Years	68.58%	75.19%	76.43%	+1.24	★
Ages 65+ Years	NA	NA	NA	—	NA
Total	58.43%	64.64%	66.87%	+2.23	★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	40.00%	—	★★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	67.89%	79.03%	73.97%	-5.06	★★★
Counseling for Nutrition—Total	63.55%	74.94%	69.83%	-5.11	★★★

Table B-3—HAR Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Counseling for Physical Activity—Total[3]	48.49%	60.61%	57.66%	-2.95	★★★
Adult BMI Assessment					
Adult BMI Assessment	81.67%	94.52%	74.19%	**-20.33**$^{++}$	★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	68.42%	55.56%	34.41%	**-21.15**$^{++}$	★
Postpartum Care	36.84%	49.21%	33.33%	**-15.87**$^{++}$	★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	44.74%	28.57%	11.83%	**-16.74**$^{++}$	★
Weeks of Pregnancy at Time of Enrollment[4]					
Prior to 0 Weeks	51.92%	23.17%	16.90%	-6.27	—
1–12 Weeks	19.23%	7.32%	13.38%	+6.06	—
13–27 Weeks	17.31%	42.68%	31.69%	-10.99	—
28 or More Weeks	11.54%	26.83%	35.21%	+8.38	—
Unknown	0.00%	0.00%	2.82%	+2.82	—
Living With Illness					
Comprehensive Diabetes Care[3]					
Hemoglobin A1c (HbA1c) Testing	84.00%	87.30%	75.64%	**-11.66**$^{++}$	★
*HbA1c Poor Control (>9.0%)**	46.00%	33.33%	73.08%	**39.74**$^{++}$	★
HbA1c Control (<8.0%)	52.00%	53.97%	22.22%	**-31.75**$^{++}$	★
Eye Exam (Retinal) Performed	38.00%	52.38%	46.15%	-6.23	★
Medical Attention for Nephropathy	88.00%	88.89%	91.03%	+2.14	★★★★★
Blood Pressure Control (<140/90 mm Hg)	36.00%	57.14%	31.20%	**-25.95**$^{++}$	★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	—	NA	—	NA
Medication Compliance 75%—Total	—	—	NA	—	NA

Table B-3—HAR Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Asthma Medication Ratio					
Total	—	—	NA	—	NA
Controlling High Blood Pressure					
Controlling High Blood Pressure	43.37%	54.95%	31.39%	**-23.57**$^{++}$	★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	NA	80.83%	78.41%	-2.42	★★★
Discussing Cessation Medications	NA	63.11%	54.51%	-8.60	★★★★
Discussing Cessation Strategies	NA	49.17%	45.28%	-3.88	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	—	NA	—	NA
Effective Continuation Phase Treatment	—	—	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	NA	—	NA
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

Table B-3—HAR Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[3]					
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%	—	★★
Digoxin	—	—	NA	—	NA
Diuretics	—	—	85.20%	—	★★
Total	—	—	86.41%	—	★★
Health Plan Diversity[4]					
Race/Ethnicity Diversity of Membership					
Total—White	13.41%	23.82%	2.39%	-21.43	—
Total—Black or African American	35.36%	60.13%	44.08%	-16.05	—
Total—American-Indian and Alaska Native	0.04%	0.09%	10.69%	+10.60	—
Total—Asian	0.00%	0.00%	15.88%	+15.88	—
Total—Native Hawaiian and Other Pacific Islander	0.00%	1.53%	0.00%	-1.53	—
Total—Some Other Race	2.32%	3.77%	0.00%	-3.77	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	48.86%	10.66%	26.96%	+16.29	—
Total—Declined	0.00%	0.00%	0.00%	0.00	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	100.00%	100.00%	72.57%	-27.43	—
Spoken Language Preferred for Health Care—Non-English	0.00%	0.00%	0.51%	+0.51	—
Spoken Language Preferred for Health Care—Unknown	0.00%	0.00%	26.93%	+26.93	—

Table B-3—HAR Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
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	—
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[4]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*Emergency Department Visits—Total**	60.06	72.44	79.99	+7.55	★
Outpatient Visits—Total	166.78	248.66	241.28	-7.38	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	7.81	8.67	9.83	+1.16	—
Total Inpatient—Average Length of Stay—Total	4.32	4.39	3.89	-0.50	—
Maternity—Discharges per 1,000 Member Months—Total	3.99	2.18	1.76	-0.42	—

Table B-3—HAR Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Maternity—Average Length of Stay—Total	2.27	2.80	2.47	-0.33	—
Surgery—Discharges per 1,000 Member Months—Total	1.30	1.81	2.09	+0.28	—
Surgery—Average Length of Stay—Total	8.95	7.65	5.67	-1.98	—
Medicine—Discharges per 1,000 Member Months—Total	4.59	5.36	6.06	+0.70	—
Medicine—Average Length of Stay—Total	3.87	3.73	3.56	-0.17	—

[1] HEDIS 2015 to HEDIS 2016 comparisons were based on a Chi-square test of statistical significance with a p value <0.05.

Green Shading+ *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

Red Shading++ *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

[2] 2016 performance levels were based on comparisons of the HEDIS 2016 measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS 2015 benchmark.

[3] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

[4] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2016 or 2015–2016 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 2014 and/or 2015 rate is not presented in this report. This symbol may also indicate that the 2015–2016 comparison was not performed because the 2015 and/or 2016 rate was not reportable, or the 2016 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 Not Applicable (NA) audit designation. For HEDIS 2016 rates designated as NA, the 2016 performance level is also presented as NA.

NB indicates that the required benefit to calculate the measure was not offered.

NR indicates that the auditor determined the HEDIS 2014 or HEDIS 2015 rate was materially biased or the MHP chose not report a rate for this measure indicator. For HEDIS 2016, NR indicates that the MHP chose not to report a rate for this measure indicator.

2016 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 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	83.70%	72.75%	74.70%	+1.95	★★
Combination 3	83.45%	69.59%	68.61%	-0.97	★★
Combination 4	72.99%	64.96%	64.72%	-0.24	★★
Combination 5	61.56%	55.72%	54.99%	-0.73	★★
Combination 6	44.04%	38.69%	38.93%	+0.24	★★
Combination 7	55.47%	52.55%	53.04%	+0.49	★★
Combination 8	41.36%	37.96%	38.44%	+0.49	★★
Combination 9	35.77%	31.63%	32.85%	+1.22	★★
Combination 10	33.33%	31.14%	32.85%	+1.70	★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	78.10%	68.37%	66.42%	-1.95	★★★★
Lead Screening in Children					
Lead Screening in Children	83.21%	84.91%	92.21%	**+7.30⁺**	★★★★★
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	67.64%	74.94%	71.29%	-3.65	★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	52.80%	46.96%	46.23%	-0.73	★★
Immunizations for Adolescents					
Combination 1	86.13%	89.29%	82.73%	**-6.57⁺⁺**	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection					
Appropriate Treatment for Children With Upper Respiratory Infection	80.67%	82.94%	86.74%	**+3.80⁺**	★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	59.15%	66.88%	70.37%	**+3.49⁺**	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	42.14%	45.42%	42.27%	-3.15	★★★
Continuation and Maintenance Phase	44.79%	57.34%	54.07%	-3.26	★★★
Women—Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	53.36%	50.02%	58.78%	**+8.77⁺**	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	65.21%	55.47%	63.02%	**+7.54⁺**	★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	48.47%	50.19%	50.36%	+0.17	★★★
Ages 21 to 24 Years	59.66%	55.96%	60.12%	**+4.16⁺**	★★
Total	52.34%	52.38%	54.81%	**+2.44⁺**	★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	96.11%	96.28%	95.44%	-0.85	★★
Ages 25 Months to 6 Years	85.40%	88.95%	86.68%	**-2.27⁺⁺**	★★
Ages 7 to 11 Years	87.78%	89.67%	87.98%	**-1.68⁺⁺**	★
Ages 12 to 19 Years	86.97%	87.72%	86.62%	**-1.10⁺⁺**	★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	81.02%	81.53%	83.34%	**+1.81⁺**	★★★
Ages 45 to 64 Years	89.40%	89.61%	89.87%	+0.26	★★★
Ages 65+ Years	86.47%	83.63%	90.48%	+6.84	★★★★
Total	83.97%	84.36%	86.05%	**+1.69⁺**	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	23.00%	—	★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	70.07%	76.16%	66.67%	**-9.49⁺⁺**	★★
Counseling for Nutrition—Total	54.26%	56.45%	50.85%	-5.60	★
Counseling for Physical Activity—Total[3]	38.69%	44.28%	44.53%	+0.24	★★

Table B-4—MCL Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	84.67%	86.86%	87.83%	+0.97	★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	95.13%	86.86%	76.40%	-10.46++	★
Postpartum Care	77.37%	69.34%	63.99%	-5.35	★★★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	84.18%	60.83%	58.15%	-2.68	★★
Weeks of Pregnancy at Time of Enrollment[4]					
Prior to 0 Weeks	23.01%	28.41%	31.56%	+3.15	—
1–12 Weeks	10.18%	11.16%	11.98%	+0.82	—
13–27 Weeks	43.85%	42.76%	32.13%	-10.63	—
28 or More Weeks	17.95%	13.63%	20.25%	+6.62	—
Unknown	4.99%	4.02%	4.07%	+0.05	—
Living With Illness					
Comprehensive Diabetes Care[3]					
Hemoglobin A1c (HbA1c) Testing	83.94%	83.19%	89.42%	+6.23+	★★★
*HbA1c Poor Control (>9.0%)**	41.06%	34.82%	36.50%	+1.68	★★★
HbA1c Control (<8.0%)	48.36%	45.80%	51.09%	+5.30	★★★
Eye Exam (Retinal) Performed	56.75%	52.49%	56.20%	+3.72	★★★
Medical Attention for Nephropathy	86.86%	82.85%	92.15%	+9.31+	★★★★★
Blood Pressure Control (<140/90 mm Hg)	59.31%	62.44%	61.50%	-0.94	★★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	—	59.94%	—	★★★★
Medication Compliance 75%—Total	—	—	38.39%	—	★★★★
Asthma Medication Ratio					
Total	—	—	65.18%	—	★★★★

Table B-4—MCL Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	77.62%	54.99%	54.74%	-0.24	★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	73.51%	75.71%	77.60%	+1.89	★★★
Discussing Cessation Medications	45.85%	42.98%	50.54%	+7.56+	★★★
Discussing Cessation Strategies	42.23%	39.94%	42.25%	+2.30	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	—	58.33%	—	★★★★
Effective Continuation Phase Treatment	—	—	39.15%	—	★★★
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	82.37%	79.07%	81.62%	+2.55	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	56.45%	61.93%	63.59%	+1.66	★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	67.65%	NA	—	NA

Table B-4—MCL Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[3]					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	66.96%	67.20%	66.45%	-0.76	★★★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	—	86.14%	—	★★
Digoxin	—	—	56.25%	—	★★★
Diuretics	—	—	86.37%	—	★★
Total	—	—	86.02%	—	★★
Health Plan Diversity[4]					
Race/Ethnicity Diversity of Membership					
Total—White	68.59%	65.46%	68.72%	+3.26	—
Total—Black or African American	17.92%	15.84%	15.26%	-0.58	—
Total—American-Indian and Alaska Native	0.21%	0.31%	0.55%	+0.24	—
Total—Asian	1.05%	0.90%	0.71%	-0.19	—
Total—Native Hawaiian and Other Pacific Islander	0.07%	0.07%	0.07%	0.00	—
Total—Some Other Race	<0.01%	<0.01%	5.05%	+5.05	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	12.13%	12.43%	9.64%	-2.79	—
Total—Declined	0.03%	4.99%	<0.01%	-4.99	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	99.25%	98.64%	96.40%	-2.24	—
Spoken Language Preferred for Health Care—Non-English	0.73%	0.62%	0.20%	-0.42	—
Spoken Language Preferred for Health Care—Unknown	0.02%	<0.01%	3.40%	+3.40	—

Table B-4—MCL Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Spoken Language Preferred for Health Care—Declined	<0.01%	0.74%	<0.01%	-0.74	—
Preferred Language for Written Materials—English	0.00%	0.00%	NR	—	—
Preferred Language for Written Materials—Non-English	0.00%	0.00%	NR	—	—
Preferred Language for Written Materials—Unknown	100.00%	100.00%	100.00%	0.00	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	NR	—	—
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[4]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*Emergency Department Visits—Total**	79.75	69.79	70.80	+1.01	★★
Outpatient Visits—Total	312.85	475.45	430.13	-45.32	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	9.29	7.59	7.42	-0.17	—
Total Inpatient—Average Length of Stay—Total	3.86	3.55	3.45	-0.10	—
Maternity—Discharges per 1,000 Member Months—Total	5.48	3.81	2.65	-1.16	—
Maternity—Average Length of Stay—Total	2.60	2.56	2.33	-0.23	—

Table B-4—MCL Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Surgery—Discharges per 1,000 Member Months—Total	1.49	1.55	2.01	+0.47	—
Surgery—Average Length of Stay—Total	5.80	5.09	4.85	-0.24	—
Medicine—Discharges per 1,000 Member Months—Total	4.43	3.31	3.47	+0.16	—
Medicine—Average Length of Stay—Total	4.17	3.62	3.27	-0.35	—

[1] HEDIS 2015 to HEDIS 2016 comparisons were based on a Chi-square test of statistical significance with a p value <0.05.

Green Shading+ *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

Red Shading++ *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

[2] 2016 performance levels were based on comparisons of the HEDIS 2016 measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS 2015 benchmark.

[3] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

[4] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2016 or 2015–2016 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 2014 and/or 2015 rate is not presented in this report. This symbol may also indicate that the 2015–2016 comparison was not performed because the 2015 and/or 2016 rate was not reportable, or the 2016 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 Not Applicable (NA) audit designation. For HEDIS 2016 rates designated as NA, the 2016 performance level is also presented as NA.

NB indicates that the required benefit to calculate the measure was not offered.

NR indicates that the auditor determined the HEDIS 2014 or HEDIS 2015 rate was materially biased or the MHP chose not report a rate for this measure indicator. For HEDIS 2016, NR indicates that the MHP chose not to report a rate for this measure indicator.

2016 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 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	85.42%	78.89%	77.91%	-0.98	★★★
Combination 3	80.79%	74.25%	72.79%	-1.46	★★★
Combination 4	72.92%	65.43%	68.84%	+3.41	★★★
Combination 5	65.51%	61.72%	59.07%	-2.65	★★★
Combination 6	47.69%	46.64%	42.79%	-3.85	★★
Combination 7	60.65%	55.45%	55.81%	+0.36	★★★
Combination 8	44.91%	42.69%	41.86%	-0.83	★★
Combination 9	40.28%	40.84%	36.28%	-4.56	★★
Combination 10	38.66%	37.82%	35.35%	-2.47	★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	78.24%	74.54%	75.21%	+0.67	★★★★★
Lead Screening in Children					
Lead Screening in Children	83.33%	81.48%	80.32%	-1.16	★★★★
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	82.52%	79.17%	77.27%	-1.90	★★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	62.33%	55.92%	59.72%	+3.81	★★★
Immunizations for Adolescents					
Combination 1	89.73%	89.39%	86.11%	**-3.28⁺⁺**	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection					
Appropriate Treatment for Children With Upper Respiratory Infection	86.55%	89.73%	89.77%	+0.04	★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	65.56%	70.95%	72.84%	**+1.90⁺**	★★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	43.97%	45.72%	45.88%	+0.16	★★★

Table B-5—MER Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Continuation and Maintenance Phase	51.04%	55.14%	57.59%	+2.45	★★★
Women—Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	68.69%	65.27%	59.57%	**-5.71⁺⁺**	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	74.71%	76.94%	63.91%	**-13.03⁺⁺**	★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	60.19%	58.63%	60.65%	**+2.01⁺**	★★★★
Ages 21 to 24 Years	70.32%	67.98%	68.47%	+0.49	★★★★
Total	64.11%	62.39%	64.41%	**+2.02⁺**	★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	97.74%	97.66%	97.69%	+0.04	★★★★
Ages 25 Months to 6 Years	91.85%	91.70%	91.25%	**-0.46⁺⁺**	★★★★
Ages 7 to 11 Years	93.84%	92.85%	92.57%	-0.28	★★★
Ages 12 to 19 Years	93.65%	92.88%	92.74%	-0.13	★★★★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	87.08%	85.52%	85.37%	-0.14	★★★★
Ages 45 to 64 Years	92.41%	92.36%	91.57%	**-0.79⁺⁺**	★★★★
Ages 65+ Years	92.31%	89.69%	91.50%	+1.81	★★★★
Total	88.65%	87.57%	87.70%	+0.12	★★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	23.57%	—	★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	58.93%	75.17%	74.53%	-0.64	★★★
Counseling for Nutrition—Total	62.41%	69.37%	68.22%	-1.15	★★★

Table B-5—MER Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Counseling for Physical Activity—Total[3]	48.72%	53.36%	55.14%	+1.78	★★★
Adult BMI Assessment					
Adult BMI Assessment	87.50%	91.65%	94.08%	+2.43	★★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	94.13%	90.02%	88.11%	-1.91	★★★
Postpartum Care	76.35%	70.07%	68.53%	-1.54	★★★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	87.09%	85.38%	86.01%	+0.63	★★★★★
Weeks of Pregnancy at Time of Enrollment[4]					
Prior to 0 Weeks	26.74%	26.88%	29.54%	+2.65	—
1–12 Weeks	9.88%	10.49%	12.22%	+1.72	—
13–27 Weeks	45.50%	44.07%	36.06%	-8.01	—
28 or More Weeks	17.72%	18.15%	20.84%	+2.69	—
Unknown	0.15%	0.41%	1.35%	+0.94	—
Living With Illness					
Comprehensive Diabetes Care[3]					
Hemoglobin A1c (HbA1c) Testing	90.31%	87.03%	85.60%	-1.43	★★
*HbA1c Poor Control (>9.0%)**	30.21%	45.54%	39.97%	**-5.57**[+]	★★★
HbA1c Control (<8.0%)	60.26%	45.38%	50.23%	+4.85	★★★
Eye Exam (Retinal) Performed	62.84%	63.86%	61.87%	-1.99	★★★
Medical Attention for Nephropathy	78.03%	81.69%	88.67%	**+6.98**[+]	★★★★★
Blood Pressure Control (<140/90 mm Hg)	77.06%	72.77%	68.15%	-4.62	★★★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	—	71.23%	—	★★★★★
Medication Compliance 75%—Total	—	—	48.68%	—	★★★★★

Table B-5—MER Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Asthma Medication Ratio					
Total	—	—	69.48%	—	★★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	76.69%	74.46%	67.79%	**-6.67**[++]	★★★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	80.81%	80.81%	80.16%	-0.65	★★★★
Discussing Cessation Medications	55.28%	58.61%	55.69%	-2.92	★★★★
Discussing Cessation Strategies	47.80%	47.99%	44.88%	-3.11	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	—	70.45%	—	★★★★★
Effective Continuation Phase Treatment	—	—	50.24%	—	★★★★★
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	85.85%	86.96%	80.27%	**-6.69**[++]	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	90.91%	92.37%	73.63%	**-18.74**[++]	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	57.54%	57.42%	80.00%	**+22.58**[+]	★★★

Table B-5—MER Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[3]					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	53.69%	52.48%	61.59%	+9.11+	★★★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	—	87.38%	—	★★
Digoxin	—	—	52.38%	—	★★
Diuretics	—	—	87.53%	—	★★★
Total	—	—	87.22%	—	★★★
Health Plan Diversity[4]					
Race/Ethnicity Diversity of Membership					
Total—White	64.87%	63.62%	62.24%	-1.38	—
Total—Black or African American	21.47%	21.24%	21.29%	+0.05	—
Total—American-Indian and Alaska Native	0.15%	0.34%	0.45%	+0.11	—
Total—Asian	1.03%	0.84%	0.77%	-0.07	—
Total—Native Hawaiian and Other Pacific Islander	0.07%	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	5.92%	5.65%	5.66%	+0.01	—
Total—Declined	6.49%	8.24%	9.53%	+1.29	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	97.73%	98.72%	98.87%	+0.15	—
Spoken Language Preferred for Health Care—Non-English	2.27%	1.28%	1.13%	-0.15	—
Spoken Language Preferred for Health Care—Unknown	0.00%	<0.01%	<0.01%	0.00	—

Table B-5—MER Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	97.73%	98.72%	98.87%	+0.15	—
Preferred Language for Written Materials—Non-English	2.27%	1.28%	1.13%	-0.15	—
Preferred Language for Written Materials—Unknown	0.00%	<0.01%	<0.01%	0.00	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—English	97.73%	98.72%	98.87%	+0.15	—
Other Language Needs—Non-English	2.27%	1.28%	1.13%	-0.15	—
Other Language Needs—Unknown	0.00%	<0.01%	<0.01%	0.00	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	—
Utilization[4]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*Emergency Department Visits—Total**	78.89	35.59	80.18	+44.58	★
Outpatient Visits—Total	368.55	220.85	392.51	+171.66	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	7.40	7.76	8.23	+0.47	—
Total Inpatient—Average Length of Stay—Total	3.62	3.70	3.86	+0.16	—
Maternity—Discharges per 1,000 Member Months—Total	5.71	4.43	2.65	-1.78	—

Table B-5—MER Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Maternity—Average Length of Stay—Total	2.44	2.45	2.50	+0.05	—
Surgery—Discharges per 1,000 Member Months—Total	0.92	1.13	1.02	-0.10	—
Surgery—Average Length of Stay—Total	6.04	5.90	5.73	-0.18	—
Medicine—Discharges per 1,000 Member Months—Total	3.15	3.81	5.33	+1.51	—
Medicine—Average Length of Stay—Total	4.16	3.98	3.98	0.00	—

[1] HEDIS 2015 to HEDIS 2016 comparisons were based on a Chi-square test of statistical significance with a p value <0.05.

Green Shading+ *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

Red Shading++ *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

[2] 2016 performance levels were based on comparisons of the HEDIS 2016 measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS 2015 benchmark.

[3] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

[4] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2016 or 2015–2016 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 2014 and/or 2015 rate is not presented in this report. This symbol may also indicate that the 2015–2016 comparison was not performed because the 2015 and/or 2016 rate was not reportable, or the 2016 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 Not Applicable (NA) audit designation. For HEDIS 2016 rates designated as NA, the 2016 performance level is also presented as NA.

NB indicates that the required benefit to calculate the measure was not offered.

NR indicates that the auditor determined the HEDIS 2014 or HEDIS 2015 rate was materially biased or the MHP chose not report a rate for this measure indicator. For HEDIS 2016, NR indicates that the MHP chose not to report a rate for this measure indicator.

2016 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 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	77.62%	79.59%	79.86%	+0.27	★★★★
Combination 3	74.70%	73.79%	73.84%	+0.05	★★★
Combination 4	70.56%	70.38%	71.30%	+0.91	★★★
Combination 5	68.61%	62.29%	63.43%	+1.14	★★★
Combination 6	39.66%	72.06%	38.43%	-33.64++	★★
Combination 7	64.96%	59.64%	61.34%	+1.70	★★★
Combination 8	38.20%	68.75%	37.27%	-31.48++	★★
Combination 9	37.71%	61.02%	33.10%	-27.92++	★★
Combination 10	36.74%	58.47%	31.94%	-26.53++	★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	64.25%	59.61%	56.02%	-3.59	★★
Lead Screening in Children					
Lead Screening in Children	74.70%	77.62%	74.07%	-3.54	★★★
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	72.80%	75.91%	76.85%	+0.94	★★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	61.17%	54.26%	54.99%	+0.73	★★★
Immunizations for Adolescents					
Combination 1	88.69%	87.10%	87.73%	+0.63	★★★★★
Appropriate Treatment for Children With Upper Respiratory Infection					
Appropriate Treatment for Children With Upper Respiratory Infection	88.29%	88.35%	88.19%	-0.16	★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	50.20%	65.50%	67.98%	+2.48	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	33.74%	32.77%	31.86%	-0.91	★
Continuation and Maintenance Phase	36.88%	35.05%	33.33%	-1.72	★
Women—Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	58.95%	56.39%	57.54%	+1.15	★★
Cervical Cancer Screening					
Cervical Cancer Screening	66.42%	65.21%	59.35%	-5.86	★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	59.48%	59.47%	58.75%	-0.72	★★★★
Ages 21 to 24 Years	69.71%	67.40%	64.76%	-2.64	★★★
Total	63.17%	62.42%	61.37%	-1.05	★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	96.08%	94.47%	95.21%	+0.75	★★
Ages 25 Months to 6 Years	86.07%	86.08%	86.58%	+0.51	★★
Ages 7 to 11 Years	90.73%	89.51%	89.22%	-0.28	★★
Ages 12 to 19 Years	88.27%	88.21%	87.47%	-0.73	★★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	81.66%	80.58%	77.66%	-2.93++	★★
Ages 45 to 64 Years	88.91%	88.77%	88.04%	-0.72	★★★
Ages 65+ Years	82.36%	92.52%	89.06%	-3.46	★★★
Total	84.30%	83.84%	82.14%	-1.71++	★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	33.23%	—	★★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	65.94%	75.67%	74.17%	-1.50	★★★
Counseling for Nutrition—Total	64.72%	69.34%	62.80%	-6.55++	★★★
Counseling for Physical Activity—Total[3]	61.31%	63.26%	54.98%	-8.28++	★★★

Table B-6—MID Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	81.27%	85.16%	85.42%	+0.26	★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	78.83%	87.83%	71.93%	**-15.91**$^{++}$	★
Postpartum Care	58.88%	62.53%	51.04%	**-11.49**$^{++}$	★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	55.72%	62.29%	35.73%	**-26.56**$^{++}$	★
Weeks of Pregnancy at Time of Enrollment[4]					
Prior to 0 Weeks	27.84%	30.15%	39.57%	+9.42	—
1–12 Weeks	8.37%	7.71%	11.65%	+3.95	—
13–27 Weeks	40.38%	37.09%	26.47%	-10.62	—
28 or More Weeks	18.55%	20.72%	18.08%	-2.63	—
Unknown	4.86%	4.34%	4.22%	-0.12	—
Living With Illness					
Comprehensive Diabetes Care[3]					
Hemoglobin A1c (HbA1c) Testing	81.33%	86.96%	85.93%	-1.04	★★
*HbA1c Poor Control (>9.0%)**	44.59%	36.59%	48.44%	**11.85**$^{++}$	★★
HbA1c Control (<8.0%)	47.56%	54.81%	45.04%	**-9.78**$^{++}$	★★
Eye Exam (Retinal) Performed	62.37%	57.63%	57.19%	-0.44	★★★
Medical Attention for Nephropathy	84.00%	81.93%	88.74%	**+6.81**$^{+}$	★★★★★
Blood Pressure Control (<140/90 mm Hg)	62.96%	73.93%	44.74%	**-29.19**$^{++}$	★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	—	62.98%	—	★★★★
Medication Compliance 75%—Total	—	—	34.90%	—	★★★★
Asthma Medication Ratio					
Total	—	—	60.26%	—	★★

Table B-6—MID Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	55.72%	66.18%	53.86%	**-12.32**$^{++}$	★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	80.24%	81.27%	81.74%	+0.47	★★★★
Discussing Cessation Medications	50.30%	50.46%	52.57%	+2.11	★★★★
Discussing Cessation Strategies	44.48%	45.85%	44.21%	-1.64	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	—	37.50%	—	★
Effective Continuation Phase Treatment	—	—	23.44%	—	★
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	77.30%	82.87%	81.58%	-1.29	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	58.95%	53.85%	65.69%	+11.84	★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	—	NA

Table B-6—MID Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[3]					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	66.02%	58.25%	5.04%	**-53.21**++	★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	—	86.17%	—	★★
Digoxin	—	—	54.55%	—	★★★
Diuretics	—	—	84.95%	—	★★
Total	—	—	85.43%	—	★★
Health Plan Diversity[4]					
Race/Ethnicity Diversity of Membership					
Total—White	43.49%	44.39%	43.61%	-0.78	—
Total—Black or African American	36.09%	38.67%	37.40%	-1.27	—
Total—American-Indian and Alaska Native	0.06%	0.13%	0.18%	+0.05	—
Total—Asian	2.32%	2.11%	2.02%	-0.09	—
Total—Native Hawaiian and Other Pacific Islander	0.22%	0.19%	0.18%	-0.01	—
Total—Some Other Race	0.09%	0.00%	4.58%	+4.58	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	17.73%	14.52%	12.03%	-2.49	—
Total—Declined	0.00%	0.00%	0.00%	0.00	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	99.76%	100.00%	100.00%	0.00	—
Spoken Language Preferred for Health Care—Non-English	0.09%	0.00%	0.00%	0.00	—
Spoken Language Preferred for Health Care—Unknown	0.14%	0.00%	0.00%	0.00	—

Table B-6—MID Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
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	—
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[4]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*Emergency Department Visits—Total**	64.86	66.72	66.64	-0.07	★★
Outpatient Visits—Total	391.56	370.50	405.99	+35.49	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	9.03	7.62	9.24	+1.62	—
Total Inpatient—Average Length of Stay—Total	3.92	4.00	3.87	-0.13	—
Maternity—Discharges per 1,000 Member Months—Total	4.83	3.14	2.77	-0.37	—
Maternity—Average Length of Stay—Total	2.68	2.57	2.52	-0.06	—

Table B-6—MID Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Surgery—Discharges per 1,000 Member Months—Total	1.33	1.63	2.16	+0.54	—
Surgery—Average Length of Stay—Total	6.51	6.86	6.26	-0.61	—
Medicine—Discharges per 1,000 Member Months—Total	4.68	3.87	5.06	+1.20	—
Medicine—Average Length of Stay—Total	3.98	3.58	3.38	-0.19	—

[1] HEDIS 2015 to HEDIS 2016 comparisons were based on a Chi-square test of statistical significance with a p value <0.05.

Green Shading+ *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

Red Shading+- *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

[2] 2016 performance levels were based on comparisons of the HEDIS 2016 measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS 2015 benchmark.

[3] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

[4] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2016 or 2015–2016 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 2014 and/or 2015 rate is not presented in this report. This symbol may also indicate that the 2015–2016 comparison was not performed because the 2015 and/or 2016 rate was not reportable, or the 2016 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 Not Applicable (NA) audit designation. For HEDIS 2016 rates designated as NA, the 2016 performance level is also presented as NA.

NB indicates that the required benefit to calculate the measure was not offered.

NR indicates that the auditor determined the HEDIS 2014 or HEDIS 2015 rate was materially biased or the MHP chose not report a rate for this measure indicator. For HEDIS 2016, NR indicates that the MHP chose not to report a rate for this measure indicator.

2016 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 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	81.46%	75.05%	73.73%	-1.32	★★
Combination 3	78.81%	71.08%	68.43%	-2.65	★★
Combination 4	70.86%	65.43%	65.56%	+0.14	★★
Combination 5	60.71%	59.23%	60.26%	+1.03	★★★
Combination 6	39.07%	37.05%	36.42%	-0.63	★★
Combination 7	54.53%	54.74%	57.84%	+3.09	★★★
Combination 8	37.31%	35.71%	35.32%	-0.39	★★
Combination 9	30.68%	31.77%	33.33%	+1.57	★★
Combination 10	28.92%	30.70%	32.23%	+1.53	★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	61.79%	55.09%	63.84%	**+8.75⁺**	★★★
Lead Screening in Children					
Lead Screening in Children	76.32%	74.33%	72.19%	-2.15	★★★
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	77.08%	72.09%	76.15%	+4.07	★★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	54.73%	58.00%	57.21%	-0.79	★★★
Immunizations for Adolescents					
Combination 1	87.76%	92.59%	90.54%	-2.05	★★★★★
Appropriate Treatment for Children With Upper Respiratory Infection					
Appropriate Treatment for Children With Upper Respiratory Infection	87.22%	89.65%	88.44%	**-1.21⁺⁺**	★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	55.53%	63.02%	62.82%	-0.19	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	38.16%	31.66%	37.42%	**+5.76⁺**	★★

Table B-7—MOL Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Continuation and Maintenance Phase	47.19%	33.03%	45.83%	**+12.80⁺**	★★
Women—Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	61.07%	58.34%	59.67%	+1.33	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	70.00%	69.47%	65.63%	-3.85	★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	62.42%	62.05%	63.25%	+1.21	★★★★
Ages 21 to 24 Years	71.31%	70.22%	70.83%	+0.60	★★★★
Total	65.34%	64.78%	66.33%	+1.54	★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	95.92%	96.11%	96.39%	+0.28	★★★
Ages 25 Months to 6 Years	88.23%	87.38%	88.57%	**+1.19⁺**	★★★
Ages 7 to 11 Years	91.59%	90.98%	91.64%	**+0.66⁺**	★★★
Ages 12 to 19 Years	89.37%	89.86%	90.53%	**+0.67⁺**	★★★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	85.21%	84.10%	82.66%	**-1.45⁺⁺**	★★★
Ages 45 to 64 Years	91.68%	91.54%	89.94%	**-1.60⁺⁺**	★★★
Ages 65+ Years	92.51%	91.33%	96.13%	**+4.80⁺**	★★★★★
Total	88.07%	87.62%	85.79%	**-1.83⁺⁺**	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	27.70%	—	★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	76.27%	77.85%	80.46%	+2.61	★★★★
Counseling for Nutrition—Total	67.85%	68.01%	67.82%	-0.19	★★★
Counseling for Physical Activity—Total[3]	55.88%	60.40%	63.68%	+3.28	★★★

Table B-7—MOL Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	85.23%	93.36%	90.15%	-3.21	★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	83.63%	76.33%	78.20%	+1.87	★★
Postpartum Care	72.79%	71.02%	67.87%	-3.15	★★★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	41.15%	43.58%	39.10%	-4.48	★
Weeks of Pregnancy at Time of Enrollment[4]					
Prior to 0 Weeks	34.20%	35.66%	33.16%	-2.50	—
1–12 Weeks	8.37%	7.53%	10.01%	+2.48	—
13–27 Weeks	37.18%	35.28%	28.89%	-6.38	—
28 or More Weeks	16.56%	16.82%	23.00%	+6.18	—
Unknown	3.70%	4.71%	4.94%	+0.22	—
Living With Illness					
Comprehensive Diabetes Care[3]					
Hemoglobin A1c (HbA1c) Testing	81.86%	84.99%	86.04%	+1.05	★★
*HbA1c Poor Control (>9.0%)**	41.81%	32.23%	41.44%	**9.21⁺⁺**	★★★
HbA1c Control (<8.0%)	50.22%	59.82%	50.90%	**-8.92⁺⁺**	★★★
Eye Exam (Retinal) Performed	65.27%	56.29%	57.43%	+1.14	★★★
Medical Attention for Nephropathy	80.97%	85.65%	92.12%	**+6.47⁺**	★★★★★
Blood Pressure Control (<140/90 mm Hg)	58.63%	62.03%	55.41%	**-6.63⁺⁺**	★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	—	55.61%	—	★★★
Medication Compliance 75%—Total	—	—	30.92%	—	★★★
Asthma Medication Ratio					
Total	—	—	61.35%	—	★★★

Table B-7—MOL Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	64.86%	61.96%	53.60%	**-8.36⁺⁺**	★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	82.54%	84.18%	83.54%	-0.64	★★★★★
Discussing Cessation Medications	53.54%	55.34%	56.32%	+0.98	★★★★
Discussing Cessation Strategies	48.22%	48.81%	45.94%	-2.87	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	—	51.46%	—	★★★
Effective Continuation Phase Treatment	—	—	34.29%	—	★★★
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	84.63%	86.19%	84.61%	-1.58	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	70.80%	73.17%	71.16%	-2.01	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	80.26%	79.07%	63.33%	**-15.74⁺⁺**	★

Table B-7—MOL Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[3]					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	68.80%	69.45%	66.61%	-2.85	★★★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	—	88.15%	—	★★★
Digoxin	—	—	54.92%	—	★★★
Diuretics	—	—	87.55%	—	★★★
Total	—	—	87.64%	—	★★★
Health Plan Diversity[4]					
Race/Ethnicity Diversity of Membership					
Total—White	45.86%	44.42%	47.85%	+3.43	—
Total—Black or African American	35.17%	34.04%	32.33%	-1.71	—
Total—American-Indian and Alaska Native	0.14%	0.20%	0.26%	+0.07	—
Total—Asian	0.81%	0.66%	0.36%	-0.30	—
Total—Native Hawaiian and Other Pacific Islander	0.00%	0.00%	0.00%	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	18.02%	20.67%	19.20%	-1.47	—
Total—Declined	0.00%	0.00%	0.00%	0.00	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	98.69%	98.61%	98.99%	+0.39	—
Spoken Language Preferred for Health Care—Non-English	1.10%	1.20%	0.91%	-0.29	—
Spoken Language Preferred for Health Care—Unknown	0.20%	0.19%	0.10%	-0.10	—

Table B-7—MOL Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	98.69%	98.61%	98.99%	+0.39	—
Preferred Language for Written Materials—Non-English	1.10%	1.20%	0.91%	-0.29	—
Preferred Language for Written Materials—Unknown	0.20%	0.19%	0.10%	-0.10	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—English	98.69%	98.61%	98.99%	+0.39	—
Other Language Needs—Non-English	1.10%	1.20%	0.91%	-0.29	—
Other Language Needs—Unknown	0.20%	0.19%	0.10%	-0.10	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	—
Utilization[4]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*Emergency Department Visits—Total**	77.49	75.53	75.32	-0.21	★
Outpatient Visits—Total	394.93	395.04	410.12	+15.08	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	7.91	8.12	8.97	+0.85	—
Total Inpatient—Average Length of Stay—Total	4.33	4.51	4.45	-0.06	—
Maternity—Discharges per 1,000 Member Months—Total	4.01	3.93	2.97	-0.96	—
Maternity—Average Length of Stay—Total	2.57	2.65	2.73	+0.08	—

Table B-7—MOL Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Surgery—Discharges per 1,000 Member Months—Total	1.70	1.80	1.90	+0.10	—
Surgery—Average Length of Stay—Total	7.38	7.63	7.44	-0.19	—
Medicine—Discharges per 1,000 Member Months—Total	3.77	3.93	4.98	+1.05	—
Medicine—Average Length of Stay—Total	4.08	4.21	4.03	-0.18	—

[1] HEDIS 2015 to HEDIS 2016 comparisons were based on a Chi-square test of statistical significance with a p value <0.05.

Green Shading[+] *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

Red Shading[++] *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

[2] 2016 performance levels were based on comparisons of the HEDIS 2016 measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS 2015 benchmark.

[3] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

[4] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2016 or 2015–2016 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 2014 and/or 2015 rate is not presented in this report. This symbol may also indicate that the 2015–2016 comparison was not performed because the 2015 and/or 2016 rate was not reportable, or the 2016 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 Not Applicable (NA) audit designation. For HEDIS 2016 rates designated as NA, the 2016 performance level is also presented as NA.

NB indicates that the required benefit to calculate the measure was not offered.

NR indicates that the auditor determined the HEDIS 2014 or HEDIS 2015 rate was materially biased or the MHP chose not report a rate for this measure indicator. For HEDIS 2016, NR indicates that the MHP chose not to report a rate for this measure indicator.

2016 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 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	86.00%	85.75%	82.88%	-2.87	★★★★★
Combination 3	83.54%	84.28%	80.89%	-3.38	★★★★
Combination 4	81.57%	81.57%	78.16%	-3.41	★★★★★
Combination 5	70.02%	74.45%	70.72%	-3.73	★★★★★
Combination 6	66.09%	64.13%	57.07%	**-7.06**$^{++}$	★★★★
Combination 7	69.04%	72.48%	68.49%	-4.00	★★★★★
Combination 8	64.86%	63.39%	56.08%	**-7.31**$^{++}$	★★★★★
Combination 9	56.27%	58.23%	51.61%	-6.62	★★★★★
Combination 10	55.77%	57.49%	50.62%	**-6.87**$^{++}$	★★★★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	74.39%	74.14%	69.16%	-4.98	★★★★
Lead Screening in Children					
Lead Screening in Children	84.28%	83.78%	83.39%	-0.40	★★★★
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	76.69%	83.28%	79.17%	-4.11	★★★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	65.56%	55.59%	52.58%	-3.01	★★★
Immunizations for Adolescents					
Combination 1	95.00%	86.00%	89.69%	+3.69	★★★★★
Appropriate Treatment for Children With Upper Respiratory Infection					
Appropriate Treatment for Children With Upper Respiratory Infection	94.39%	94.20%	93.71%	-0.49	★★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	75.52%	77.32%	79.07%	+1.75	★★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	33.09%	34.11%	39.06%	+4.95	★★

Table B-8—PRI Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Continuation and Maintenance Phase	29.73%	30.30%	42.13%	+11.83	★★
Women—Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	67.56%	63.09%	64.95%	+1.86	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	77.32%	68.92%	63.06%	-5.86	★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	65.40%	61.60%	63.93%	+2.32	★★★★
Ages 21 to 24 Years	73.25%	73.17%	72.21%	-0.96	★★★★★
Total	67.91%	65.12%	67.36%	+2.25	★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	96.96%	97.52%	97.75%	+0.23	★★★★
Ages 25 Months to 6 Years	88.74%	89.00%	89.34%	+0.33	★★★
Ages 7 to 11 Years	92.22%	92.16%	92.05%	-0.11	★★★
Ages 12 to 19 Years	90.69%	91.35%	90.36%	**-0.99**$^{++}$	★★★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	85.27%	84.56%	85.15%	+0.60	★★★★
Ages 45 to 64 Years	91.39%	92.29%	91.31%	-0.97	★★★★
Ages 65+ Years	95.50%	91.16%	88.57%	-2.59	★★★
Total	87.55%	87.44%	87.58%	+0.14	★★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	30.96%	—	★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	84.81%	87.13%	75.41%	**-11.72**$^{++}$	★★★
Counseling for Nutrition—Total	77.47%	75.15%	60.66%	**-14.49**$^{++}$	★★
Counseling for Physical Activity—Total[3]	71.65%	67.54%	57.92%	**-9.62**$^{++}$	★★★

Table B-8—PRI Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	90.82%	87.07%	80.10%	-6.97	★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	90.23%	78.24%	63.56%	**-14.67⁺⁺**	★
Postpartum Care	71.55%	66.18%	61.44%	-4.74	★★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	65.21%	65.87%	45.74%	**-20.12⁺⁺**	★
Weeks of Pregnancy at Time of Enrollment[4]					
Prior to 0 Weeks	26.03%	24.88%	17.76%	-7.12	—
1–12 Weeks	12.65%	11.95%	9.49%	-2.46	—
13–27 Weeks	44.77%	48.05%	22.87%	-25.18	—
28 or More Weeks	16.55%	15.12%	47.45%	+32.32	—
Unknown	0.00%	0.00%	2.43%	+2.43	—
Living With Illness					
Comprehensive Diabetes Care[3]					
Hemoglobin A1c (HbA1c) Testing	91.85%	92.57%	94.89%	+2.32	★★★★★
*HbA1c Poor Control (>9.0%)**	23.75%	24.86%	27.92%	+3.06	★★★★★
HbA1c Control (<8.0%)	64.09%	62.86%	60.40%	-2.46	★★★★★
Eye Exam (Retinal) Performed	66.67%	67.86%	68.80%	+0.94	★★★★★
Medical Attention for Nephropathy	83.12%	87.14%	94.34%	**+7.20⁺**	★★★★★
Blood Pressure Control (<140/90 mm Hg)	68.38%	67.29%	49.27%	**-18.02⁺⁺**	★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	—	75.03%	—	★★★★★
Medication Compliance 75%—Total	—	—	54.29%	—	★★★★★
Asthma Medication Ratio					
Total	—	—	84.31%	—	★★★★★

Table B-8—PRI Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	62.93%	61.86%	44.13%	**-17.72⁺⁺**	★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	84.49%	83.17%	79.10%	-4.07	★★★
Discussing Cessation Medications	53.85%	52.96%	51.75%	-1.21	★★★
Discussing Cessation Strategies	43.44%	42.97%	43.60%	+0.63	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	—	61.09%	—	★★★★
Effective Continuation Phase Treatment	—	—	45.87%	—	★★★★
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	79.84%	82.38%	84.21%	+1.84	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	65.57%	79.31%	65.52%	-13.79	★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	—	NA

Table B-8—PRI Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[3]					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	66.67%	55.95%	58.06%	+2.11	★★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	—	87.19%	—	★★
Digoxin	—	—	56.25%	—	★★★
Diuretics	—	—	85.64%	—	★★
Total	—	—	86.41%	—	★★
Health Plan Diversity[4]					
Race/Ethnicity Diversity of Membership					
Total—White	57.80%	60.18%	61.56%	+1.38	—
Total—Black or African American	16.09%	15.85%	13.23%	-2.62	—
Total—American-Indian and Alaska Native	0.13%	0.42%	0.56%	+0.13	—
Total—Asian	0.75%	1.25%	0.91%	-0.34	—
Total—Native Hawaiian and Other Pacific Islander	0.01%	0.08%	0.06%	-0.01	—
Total—Some Other Race	0.00%	0.00%	<0.01%	0.00	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	25.22%	22.22%	23.67%	+1.45	—
Total—Declined	0.00%	0.00%	0.00%	0.00	—
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	—

Table B-8—PRI Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
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	—
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[4]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*Emergency Department Visits—Total**	79.95	80.37	76.40	-3.97	★
Outpatient Visits—Total	340.92	345.24	382.40	+37.16	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	7.25	7.60	6.99	-0.61	—
Total Inpatient—Average Length of Stay—Total	3.37	3.46	NR	—	—
Maternity—Discharges per 1,000 Member Months—Total	5.69	5.56	3.18	-2.38	—
Maternity—Average Length of Stay—Total	2.54	2.56	NR	—	—

Table B-8—PRI Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Surgery—Discharges per 1,000 Member Months—Total	1.10	1.25	1.62	+0.38	—
Surgery—Average Length of Stay—Total	4.71	4.81	NR	—	—
Medicine—Discharges per 1,000 Member Months—Total	2.93	3.16	3.11	-0.05	—
Medicine—Average Length of Stay—Total	3.77	3.85	NR	—	—

[1] HEDIS 2015 to HEDIS 2016 comparisons were based on a Chi-square test of statistical significance with a p value <0.05.

Green Shading[+] *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

Red Shading[++] *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

[2] 2016 performance levels were based on comparisons of the HEDIS 2016 measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS 2015 benchmark.

[3] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

[4] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2016 or 2015–2016 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 2014 and/or 2015 rate is not presented in this report. This symbol may also indicate that the 2015–2016 comparison was not performed because the 2015 and/or 2016 rate was not reportable, or the 2016 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 Not Applicable (NA) audit designation. For HEDIS 2016 rates designated as NA, the 2016 performance level is also presented as NA.

NB indicates that the required benefit to calculate the measure was not offered.

NR indicates that the auditor determined the HEDIS 2014 or HEDIS 2015 rate was materially biased or the MHP chose not report a rate for this measure indicator. For HEDIS 2016, NR indicates that the MHP chose not to report a rate for this measure indicator.

2016 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 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	70.07%	70.14%	64.58%	-5.56	★
Combination 3	64.27%	65.28%	58.56%	-6.71++	★
Combination 4	60.56%	61.34%	57.41%	-3.94	★
Combination 5	51.74%	49.07%	45.60%	-3.47	★
Combination 6	22.97%	31.25%	27.31%	-3.94	★
Combination 7	49.65%	46.53%	44.91%	-1.62	★
Combination 8	22.27%	30.09%	27.08%	-3.01	★
Combination 9	18.10%	25.00%	23.61%	-1.39	★
Combination 10	17.87%	24.31%	23.38%	-0.93	★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	49.28%	52.08%	54.86%	+2.78	★★
Lead Screening in Children					
Lead Screening in Children	69.14%	71.99%	72.69%	+0.69	★★★
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	72.24%	68.75%	69.44%	+0.69	★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	52.21%	50.00%	48.61%	-1.39	★★
Immunizations for Adolescents					
Combination 1	87.70%	84.26%	81.74%	-2.52	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection					
Appropriate Treatment for Children With Upper Respiratory Infection	85.71%	86.35%	87.55%	+1.20	★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	52.90%	56.74%	57.57%	+0.82	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	40.85%	34.07%	53.61%	+19.55+	★★★★

Table B-9—THC Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Continuation and Maintenance Phase	NA	35.85%	70.67%	+34.82+	★★★★★
Women—Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	54.65%	48.41%	49.67%	+1.26	★
Cervical Cancer Screening					
Cervical Cancer Screening	64.65%	58.15%	60.19%	+2.04	★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	69.64%	66.69%	63.48%	-3.21	★★★★
Ages 21 to 24 Years	74.33%	72.24%	67.51%	-4.73++	★★★★
Total	71.25%	68.75%	65.09%	-3.66++	★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	93.34%	93.42%	87.60%	-5.82++	★
Ages 25 Months to 6 Years	81.98%	82.77%	83.98%	+1.21	★
Ages 7 to 11 Years	86.77%	86.47%	86.73%	+0.26	★
Ages 12 to 19 Years	85.40%	85.31%	85.17%	-0.14	★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	77.68%	77.34%	77.44%	+0.10	★★
Ages 45 to 64 Years	86.53%	86.52%	86.31%	-0.22	★★
Ages 65+ Years	NA	76.49%	72.60%	-3.90	★
Total	80.84%	80.62%	81.12%	+0.50	★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	33.06%	—	★★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	69.44%	68.98%	72.92%	+3.94	★★★
Counseling for Nutrition—Total	59.95%	61.81%	65.28%	+3.47	★★★
Counseling for Physical Activity—Total[3]	50.46%	56.71%	56.25%	-0.46	★★★

Table B-9—THC Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	79.13%	83.28%	89.29%	+6.01+	★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	72.62%	68.52%	68.91%	+0.39	★
Postpartum Care	52.20%	44.68%	47.33%	+2.66	★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	33.41%	31.25%	29.93%	-1.32	★
Weeks of Pregnancy at Time of Enrollment[4]					
Prior to 0 Weeks	30.29%	46.17%	40.23%	-5.94	—
1–12 Weeks	8.70%	7.42%	13.49%	+6.06	—
13–27 Weeks	38.02%	27.61%	27.21%	-0.40	—
28 or More Weeks	16.86%	13.92%	17.91%	+3.99	—
Unknown	6.14%	4.87%	1.16%	-3.71	—
Living With Illness					
Comprehensive Diabetes Care[3]					
Hemoglobin A1c (HbA1c) Testing	81.16%	82.04%	82.98%	+0.94	★
*HbA1c Poor Control (>9.0%)**	56.08%	47.95%	53.19%	+5.25	★
HbA1c Control (<8.0%)	38.75%	43.84%	37.39%	-6.45++	★
Eye Exam (Retinal) Performed	34.19%	35.01%	40.27%	+5.27+	★
Medical Attention for Nephropathy	82.07%	80.67%	91.03%	+10.36+	★★★★★
Blood Pressure Control (<140/90 mm Hg)	51.06%	51.14%	47.57%	-3.57	★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	—	84.59%	—	★★★★★
Medication Compliance 75%—Total	—	—	66.27%	—	★★★★★
Asthma Medication Ratio					
Total	—	—	34.24%	—	★

Table B-9—THC Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	39.91%	51.56%	43.05%	-8.52++	★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	80.47%	78.73%	78.16%	-0.57	★★★
Discussing Cessation Medications	53.91%	51.91%	50.69%	-1.22	★★★
Discussing Cessation Strategies	47.24%	42.11%	42.29%	+0.18	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	—	89.55%	—	★★★★★
Effective Continuation Phase Treatment	—	—	73.34%	—	★★★★★
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	83.84%	77.60%	-6.25++	★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	62.69%	65.66%	57.45%	-8.21	★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	—	NA

Table B-9—THC Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[3]					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NA	57.30%	56.16%	-1.13	★★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	—	85.62%	—	★★
Digoxin	—	—	51.28%	—	★★
Diuretics	—	—	85.07%	—	★★
Total	—	—	85.15%	—	★★
Health Plan Diversity[4]					
Race/Ethnicity Diversity of Membership					
Total—White	28.94%	28.52%	31.09%	+2.57	—
Total—Black or African American	61.86%	58.81%	54.16%	-4.65	—
Total—American-Indian and Alaska Native	0.08%	0.17%	0.23%	+0.06	—
Total—Asian	1.36%	1.24%	1.15%	-0.09	—
Total—Native Hawaiian and Other Pacific Islander	0.10%	0.09%	0.07%	-0.02	—
Total—Some Other Race	2.39%	2.14%	2.45%	+0.31	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	5.27%	9.04%	10.84%	+1.80	—
Total—Declined	0.00%	0.00%	0.00%	0.00	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	99.51%	99.48%	99.38%	-0.10	—
Spoken Language Preferred for Health Care—Non-English	0.49%	0.48%	0.44%	-0.04	—
Spoken Language Preferred for Health Care—Unknown	0.00%	0.04%	0.18%	+0.14	—

Table B-9—THC Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	99.51%	99.48%	99.38%	-0.10	—
Preferred Language for Written Materials—Non-English	0.49%	0.48%	0.44%	-0.04	—
Preferred Language for Written Materials—Unknown	0.00%	0.04%	0.18%	+0.14	—
Preferred Language for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	—
Other Language Needs—English	99.51%	99.48%	99.38%	-0.10	—
Other Language Needs—Non-English	0.49%	0.48%	0.44%	-0.04	—
Other Language Needs—Unknown	0.00%	0.04%	0.18%	+0.14	—
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	—
Utilization[4]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*Emergency Department Visits—Total**	73.94	76.06	72.75	-3.31	★
Outpatient Visits—Total	289.31	322.80	320.89	-1.92	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	10.18	9.91	10.45	+0.54	—
Total Inpatient—Average Length of Stay—Total	3.72	4.35	4.34	-0.01	—
Maternity—Discharges per 1,000 Member Months—Total	5.16	2.89	2.70	-0.20	—
Maternity—Average Length of Stay—Total	2.53	2.79	2.66	-0.14	—

Table B-9—THC Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Surgery—Discharges per 1,000 Member Months—Total	1.77	1.97	2.35	+0.37	—
Surgery—Average Length of Stay—Total	6.84	7.69	7.63	-0.05	—
Medicine—Discharges per 1,000 Member Months—Total	4.99	5.90	6.10	+0.20	—
Medicine—Average Length of Stay—Total	3.44	3.78	3.64	-0.14	—

[1] HEDIS 2015 to HEDIS 2016 comparisons were based on a Chi-square test of statistical significance with a p value <0.05.

Green Shading+ *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

Red Shading++ *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

[2] 2016 performance levels were based on comparisons of the HEDIS 2016 measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS 2015 benchmark.

[3] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

[4] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2016 or 2015–2016 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 2014 and/or 2015 rate is not presented in this report. This symbol may also indicate that the 2015–2016 comparison was not performed because the 2015 and/or 2016 rate was not reportable, or the 2016 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 Not Applicable (NA) audit designation. For HEDIS 2016 rates designated as NA, the 2016 performance level is also presented as NA.

NB indicates that the required benefit to calculate the measure was not offered.

NR indicates that the auditor determined the HEDIS 2014 or HEDIS 2015 rate was materially biased or the MHP chose not report a rate for this measure indicator. For HEDIS 2016, NR indicates that the MHP chose not to report a rate for this measure indicator.

2016 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 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	76.73%	76.16%	76.16%	0.00	★★★
Combination 3	72.34%	71.29%	71.78%	+0.49	★★★
Combination 4	67.82%	69.59%	67.15%	-2.43	★★
Combination 5	57.32%	60.34%	58.15%	-2.19	★★
Combination 6	35.30%	40.15%	38.69%	-1.46	★★
Combination 7	54.74%	59.37%	54.74%	-4.62	★★
Combination 8	34.19%	38.93%	36.25%	-2.68	★★
Combination 9	29.47%	34.55%	32.85%	-1.70	★★
Combination 10	28.80%	33.82%	30.66%	-3.16	★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	84.18%	57.64%	61.56%	+3.92	★★★
Lead Screening in Children					
Lead Screening in Children	79.56%	81.51%	78.86%	-2.64	★★★
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	80.80%	74.81%	73.21%	-1.61	★★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	61.46%	52.30%	54.74%	+2.45	★★★
Immunizations for Adolescents					
Combination 1	86.63%	88.81%	87.50%	-1.31	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection					
Appropriate Treatment for Children With Upper Respiratory Infection	86.63%	87.20%	87.89%	+0.69	★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	49.65%	62.65%	63.13%	+0.48	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	39.69%	40.80%	44.57%	+3.77+	★★★

Table B-10—UNI Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Continuation and Maintenance Phase	47.89%	54.00%	59.46%	+5.46	★★★★
Women—Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	64.85%	64.01%	61.35%	-2.66++	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	73.16%	67.68%	65.85%	-1.84	★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	62.73%	59.26%	62.26%	+3.00+	★★★★
Ages 21 to 24 Years	70.54%	68.99%	69.46%	+0.47	★★★★
Total	65.46%	62.71%	65.12%	+2.41+	★★★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	97.74%	96.06%	96.54%	+0.49	★★★
Ages 25 Months to 6 Years	91.15%	88.67%	89.66%	+0.99+	★★★
Ages 7 to 11 Years	92.79%	91.35%	91.17%	-0.18	★★
Ages 12 to 19 Years	92.17%	90.50%	90.51%	+0.01	★★★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	85.15%	83.78%	83.01%	-0.77++	★★★
Ages 45 to 64 Years	92.69%	92.16%	91.13%	-1.03++	★★★★
Ages 65+ Years	90.93%	97.31%	95.84%	-1.46	★★★★★
Total	88.19%	86.90%	86.34%	-0.56++	★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	24.42%	—	★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	68.13%	77.37%	71.05%	-6.33++	★★★
Counseling for Nutrition—Total	66.67%	71.53%	68.86%	-2.68	★★★
Counseling for Physical Activity—Total[3]	51.58%	62.53%	62.04%	-0.49	★★★

Table B-10—UNI Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	86.11%	91.79%	89.12%	-2.67	★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	87.87%	85.68%	76.03%	**-9.65**$^{++}$	★
Postpartum Care	66.31%	63.82%	52.06%	**-11.76**$^{++}$	★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	59.57%	62.81%	41.75%	**-21.06**$^{++}$	★
Weeks of Pregnancy at Time of Enrollment[4]					
Prior to 0 Weeks	32.20%	33.09%	36.81%	+3.72	—
1–12 Weeks	8.07%	8.50%	10.69%	+2.18	—
13–27 Weeks	37.76%	35.70%	29.54%	-6.17	—
28 or More Weeks	16.92%	17.77%	17.88%	+0.11	—
Unknown	5.06%	4.93%	5.09%	+0.16	—
Living With Illness					
Comprehensive Diabetes Care[3]					
Hemoglobin A1c (HbA1c) Testing	86.03%	84.58%	86.81%	+2.22	★★★
*HbA1c Poor Control (>9.0%)**	35.77%	32.22%	34.17%	+1.94	★★★★
HbA1c Control (<8.0%)	55.13%	57.22%	54.58%	-2.64	★★★★
Eye Exam (Retinal) Performed	66.41%	63.19%	64.31%	+1.11	★★★★
Medical Attention for Nephropathy	82.18%	83.33%	93.06%	**+9.72**$^{+}$	★★★★★
Blood Pressure Control (<140/90 mm Hg)	62.31%	66.81%	62.64%	-4.17	★★★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	—	69.44%	—	★★★★★
Medication Compliance 75%—Total	—	—	45.00%	—	★★★★★
Asthma Medication Ratio					
Total	—	—	64.68%	—	★★★

Table B-10—UNI Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	62.50%	62.63%	52.32%	**-10.31**$^{++}$	★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	80.56%	77.23%	78.86%	+1.63	★★★
Discussing Cessation Medications	57.11%	55.72%	59.35%	+3.63	★★★★★
Discussing Cessation Strategies	44.64%	43.60%	48.02%	+4.42	★★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	—	49.55%	—	★★
Effective Continuation Phase Treatment	—	—	31.59%	—	★★
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	83.61%	86.54%	85.54%	-1.00	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	67.51%	68.46%	74.48%	+6.02	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	85.33%	87.88%	80.00%	-7.88	★★★

Table B-10—UNI Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[3]					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	59.14%	58.57%	60.02%	+1.45	★★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	—	88.68%	—	★★★
Digoxin	—	—	45.69%	—	★
Diuretics	—	—	88.75%	—	★★★
Total	—	—	88.41%	—	★★★
Health Plan Diversity[4]					
Race/Ethnicity Diversity of Membership					
Total—White	49.94%	50.34%	50.65%	+0.30	—
Total—Black or African American	36.00%	32.58%	31.80%	-0.78	—
Total—American-Indian and Alaska Native	0.13%	0.21%	0.24%	+0.03	—
Total—Asian	0.00%	2.40%	2.37%	-0.03	—
Total—Native Hawaiian and Other Pacific Islander	0.00%	0.01%	<0.01%	-0.01	—
Total—Some Other Race	1.17%	0.00%	0.00%	0.00	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	12.76%	14.45%	14.94%	+0.49	—
Total—Declined	0.00%	0.00%	0.00%	0.00	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	82.65%	95.71%	95.33%	-0.38	—
Spoken Language Preferred for Health Care—Non-English	4.81%	4.26%	4.67%	+0.41	—
Spoken Language Preferred for Health Care—Unknown	12.55%	0.03%	<0.01%	-0.03	—

Table B-10—UNI Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	0.00%	95.71%	95.33%	-0.38	—
Preferred Language for Written Materials—Non-English	0.00%	4.26%	4.67%	+0.41	—
Preferred Language for Written Materials—Unknown	100.00%	0.03%	<0.01%	-0.03	—
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[4]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*Emergency Department Visits—Total**	76.22	73.86	73.22	-0.64	★
Outpatient Visits—Total	381.96	361.16	367.42	+6.26	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	7.92	6.95	6.59	-0.35	—
Total Inpatient—Average Length of Stay—Total	3.91	4.17	4.23	+0.06	—
Maternity—Discharges per 1,000 Member Months—Total	4.40	3.57	2.74	-0.83	—
Maternity—Average Length of Stay—Total	2.46	2.51	2.62	+0.10	—

Table B-10—UNI Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Surgery—Discharges per 1,000 Member Months—Total	1.64	1.55	1.61	+0.06	—
Surgery—Average Length of Stay—Total	6.66	6.97	6.76	-0.22	—
Medicine—Discharges per 1,000 Member Months—Total	3.60	3.10	3.06	-0.04	—
Medicine—Average Length of Stay—Total	3.73	3.99	3.92	-0.08	—

[1] HEDIS 2015 to HEDIS 2016 comparisons were based on a Chi-square test of statistical significance with a p value <0.05.

Green Shading[+] *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

Red Shading[++] *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

[2] 2016 performance levels were based on comparisons of the HEDIS 2016 measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS 2015 benchmark.

[3] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

[4] Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2016 or 2015–2016 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 2014 and/or 2015 rate is not presented in this report. This symbol may also indicate that the 2015–2016 comparison was not performed because the 2015 and/or 2016 rate was not reportable, or the 2016 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 Not Applicable (NA) audit designation. For HEDIS 2016 rates designated as NA, the 2016 performance level is also presented as NA.

NB indicates that the required benefit to calculate the measure was not offered.

NR indicates that the auditor determined the HEDIS 2014 or HEDIS 2015 rate was materially biased or the MHP chose not report a rate for this measure indicator. For HEDIS 2016, NR indicates that the MHP chose not to report a rate for this measure indicator.

2016 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 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 2	75.18%	80.29%	78.10%	-2.19	★★★
Combination 3	72.51%	75.18%	73.24%	-1.95	★★★
Combination 4	63.50%	68.37%	66.67%	-1.70	★★
Combination 5	52.07%	58.88%	55.47%	-3.41	★★
Combination 6	45.01%	57.66%	43.55%	**-14.11**$^{++}$	★★
Combination 7	48.42%	55.23%	52.07%	-3.16	★★
Combination 8	40.88%	54.50%	41.61%	**-12.90**$^{++}$	★★
Combination 9	36.50%	48.18%	37.23%	**-10.95**$^{++}$	★★★
Combination 10	34.79%	46.23%	36.01%	**-10.22**$^{++}$	★★★
Well-Child Visits in the First 15 Months of Life					
Six or More Visits	76.89%	76.16%	74.21%	-1.95	★★★★
Lead Screening in Children					
Lead Screening in Children	85.47%	86.37%	88.56%	+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	70.07%	70.80%	69.59%	-1.22	★★
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	51.82%	48.91%	42.09%	**-6.81**$^{++}$	★★
Immunizations for Adolescents					
Combination 1	86.62%	86.62%	81.75%	-4.87	★★★★
Appropriate Treatment for Children With Upper Respiratory Infection					
Appropriate Treatment for Children With Upper Respiratory Infection	87.49%	89.17%	90.27%	+1.10	★★★
Appropriate Testing for Children With Pharyngitis					
Appropriate Testing for Children With Pharyngitis	68.05%	68.41%	68.97%	+0.57	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	44.08%	46.50%	53.16%	+6.66	★★★★
Continuation and Maintenance Phase	47.29%	47.96%	57.65%	+9.69	★★★
Women—Adult Care					
Breast Cancer Screening					
Breast Cancer Screening	61.00%	58.09%	59.64%	+1.55	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	71.53%	67.88%	62.53%	-5.35	★★★
Chlamydia Screening in Women					
Ages 16 to 20 Years	42.97%	42.16%	46.95%	+4.79	★★
Ages 21 to 24 Years	57.19%	45.43%	56.06%	**+10.63**$^{+}$	★★
Total	47.42%	43.25%	50.96%	**+7.71**$^{+}$	★★
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	97.86%	98.17%	97.65%	-0.52	★★★★
Ages 25 Months to 6 Years	90.21%	90.86%	90.18%	-0.68	★★★
Ages 7 to 11 Years	90.12%	90.73%	90.60%	-0.13	★★
Ages 12 to 19 Years	92.73%	92.99%	92.33%	-0.66	★★★
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	87.25%	86.49%	86.23%	-0.26	★★★★
Ages 45 to 64 Years	90.89%	90.91%	88.42%	**-2.50**$^{++}$	★★★
Ages 65+ Years	84.96%	84.21%	86.44%	+2.23	★★
Total	88.38%	87.87%	87.10%	-0.77	★★★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis					
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	—	43.48%	—	★★★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	73.24%	85.64%	91.97%	**+6.33**$^{+}$	★★★★★
Counseling for Nutrition—Total	57.42%	59.12%	65.94%	**+6.81**$^{+}$	★★★
Counseling for Physical Activity—Total[3]	52.31%	57.42%	64.23%	**+6.81**$^{+}$	★★★

Table B-11—UPP Trend Table

Table B-11—UPP Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adult BMI Assessment					
Adult BMI Assessment	87.10%	91.97%	95.62%	+3.65⁺	★★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	91.18%	91.24%	86.13%	-5.11⁺⁺	★★★
Postpartum Care	76.80%	75.91%	71.78%	-4.14	★★★★
Frequency of Ongoing Prenatal Care					
≥81 Percent of Expected Visits	78.89%	71.05%	72.02%	+0.97	★★★★
Weeks of Pregnancy at Time of Enrollment[4]					
Prior to 0 Weeks	21.68%	23.80%	28.21%	+4.42	—
1–12 Weeks	18.19%	16.53%	13.76%	-2.77	—
13–27 Weeks	42.32%	40.51%	32.63%	-7.88	—
28 or More Weeks	13.10%	15.30%	20.18%	+4.88	—
Unknown	4.71%	3.87%	5.22%	+1.35	—
Living With Illness					
Comprehensive Diabetes Care[3]					
Hemoglobin A1c (HbA1c) Testing	87.04%	89.23%	91.61%	+2.37	★★★★
*HbA1c Poor Control (>9.0%)**	27.01%	28.10%	28.65%	+0.55	★★★★★
HbA1c Control (<8.0%)	63.69%	58.58%	58.21%	-0.36	★★★★
Eye Exam (Retinal) Performed	64.60%	62.96%	66.06%	+3.10	★★★★
Medical Attention for Nephropathy	81.20%	82.66%	91.97%	+9.31⁺	★★★★★
Blood Pressure Control (<140/90 mm Hg)	73.72%	75.36%	75.73%	+0.36	★★★★
Medication Management for People With Asthma					
Medication Compliance 50%—Total	—	—	53.63%	—	★★
Medication Compliance 75%—Total	—	—	22.71%	—	★
Asthma Medication Ratio					
Total	—	—	64.55%	—	★★★

Table B-11—UPP Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Controlling High Blood Pressure					
Controlling High Blood Pressure	70.65%	70.07%	63.99%	-6.08	★★★
Medical Assistance With Smoking and Tobacco Use Cessation					
Advising Smokers and Tobacco Users to Quit	77.91%	79.97%	79.43%	-0.54	★★★★
Discussing Cessation Medications	48.53%	54.92%	55.95%	+1.03	★★★★
Discussing Cessation Strategies	42.58%	46.79%	45.39%	-1.40	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	—	61.13%	—	★★★★
Effective Continuation Phase Treatment	—	—	40.34%	—	★★★
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	96.61%	87.20%	87.20%	0.00	★★★★★
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

Table B-11—UPP Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[3]					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	68.49%	71.08%	60.22%	-10.87	★★
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	—	—	87.49%	—	★★
Digoxin	—	—	NA	—	NA
Diuretics	—	—	89.29%	—	★★★
Total	—	—	87.94%	—	★★★
Health Plan Diversity[4]					
Race/Ethnicity Diversity of Membership					
Total—White	88.82%	87.42%	87.07%	-0.35	—
Total—Black or African American	1.57%	1.45%	1.41%	-0.04	—
Total—American-Indian and Alaska Native	1.82%	2.38%	2.53%	+0.14	—
Total—Asian	0.45%	0.32%	0.28%	-0.04	—
Total—Native Hawaiian and Other Pacific Islander	0.06%	0.09%	0.06%	-0.03	—
Total—Some Other Race	0.00%	1.24%	1.39%	+0.15	—
Total—Two or More Races	0.00%	0.00%	0.00%	0.00	—
Total—Unknown	7.27%	<0.01%	<0.01%	-0.00	—
Total—Declined	0.00%	7.09%	7.25%	+0.17	—
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	99.96%	99.96%	99.93%	-0.03	—
Spoken Language Preferred for Health Care—Non-English	0.03%	0.02%	0.04%	+0.02	—
Spoken Language Preferred for Health Care—Unknown	0.01%	0.02%	0.03%	+0.01	—

Table B-11—UPP Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	—
Preferred Language for Written Materials—English	99.96%	99.96%	99.93%	-0.03	—
Preferred Language for Written Materials—Non-English	0.03%	0.02%	0.04%	+0.02	—
Preferred Language for Written Materials—Unknown	0.01%	0.02%	0.03%	+0.01	—
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[4]					
Ambulatory Care—Total (Per 1,000 Member Months)					
*Emergency Department Visits—Total**	71.39	66.62	64.81	-1.82	★★
Outpatient Visits—Total	342.08	325.60	334.91	+9.31	—
Inpatient Utilization—General Hospital/Acute Care—Total					
Total Inpatient—Discharges per 1,000 Member Months—Total	6.90	6.23	6.34	+0.11	—
Total Inpatient—Average Length of Stay—Total	3.57	3.59	3.60	+0.01	—
Maternity—Discharges per 1,000 Member Months—Total	4.81	3.17	2.05	-1.12	—
Maternity—Average Length of Stay—Total	2.56	2.60	2.72	+0.12	—

Table B-11—UPP Trend Table

Measure	HEDIS 2014	HEDIS 2015	HEDIS 2016	2015–2016 Comparison[1]	2016 Performance Level[2]
Surgery—Discharges per 1,000 Member Months—Total	1.18	1.29	1.63	+0.34	—
Surgery—Average Length of Stay—Total	4.46	5.27	4.69	-0.58	—
Medicine—Discharges per 1,000 Member Months—Total	2.84	2.83	3.20	+0.37	—
Medicine—Average Length of Stay—Total	4.23	3.56	3.46	-0.10	—

[1] *HEDIS 2015 to HEDIS 2016 comparisons were based on a Chi-square test of statistical significance with a p value <0.05.*

Green Shading+ *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant improvement from the HEDIS 2015 MWA.*

Red Shading+* *Indicates that the HEDIS 2016 MWA demonstrated a statistically significant decline from the HEDIS 2015 MWA.*

[2] *2016 performance levels were based on comparisons of the HEDIS 2016 measure indicator rates to national Medicaid Quality Compass HEDIS 2015 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS 2015 benchmark.*

[3] *Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.*

[4] *Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any performance levels for 2016 or 2015–2016 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 2014 and/or 2015 rate is not presented in this report. This symbol may also indicate that the 2015–2016 comparison was not performed because the 2015 and/or 2016 rate was not reportable, or the 2016 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 Not Applicable (NA) audit designation. For HEDIS 2016 rates designated as NA, the 2016 performance level is also presented as NA.

NB indicates that the required benefit to calculate the measure was not offered.

NR indicates that the auditor determined the HEDIS 2014 or HEDIS 2015 rate was materially biased or the MHP chose not report a rate for this measure indicator. For HEDIS 2016, NR indicates that the MHP chose not to report a rate for this measure indicator.

2016 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 2016 rates to the HEDIS 2015 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	★★★★	★★★	★★★	★★★	★★	★★★
MOL	★★	★★	★★	★★★	★★	★★★
PRI	★★★★★	★★★★	★★★★★	★★★★★	★★★★	★★★★★
THC	★	★	★	★	★	★
UNI	★★★	★★★	★★	★★	★★	★★
UPP	★★★	★★★	★★	★★	★★	★★

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	★★	★★	★★	★★	★★★	★★★
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/Td)*	*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	NA
MCL	★★	★★★★	★★	★★	★★★	★★★
MER	★★★	★★★★	★★★	★★★	★★★	★★★
MID	★★★	★★★★★	★★★	★★	★	★
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	★★	★★	★★★★	★★★	★★★
MOL	★★★	★★★	★★★★	★★★★	★★★★
PRI	★★★	★★★	★★★★	★★★★★	★★★★
THC	★	★★	★★★★	★★★★	★★★★
UNI	★★★	★★★	★★★★	★★★★	★★★★
UPP	★★★	★★★	★★	★★	★★

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	★★	★★	★★	★★	★★	★★★
MOL	★★★	★★★	★★★	★★★	★★★	★★★
PRI	★★★★	★★★	★★★	★★★	★★★★	★★★★
THC	★	★	★	★	★★	★★
UNI	★★★	★★★	★★	★★★	★★★	★★★★
UPP	★★★★	★★★	★★	★★★	★★★★	★★★

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	★★★★	★★★	★★
MER	★★★★	★★★★	★★
MID	★★★	★★	★★★★
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	NA	★	★★★	★★★★
MCL	★★★★	★★★★	★★★★	★★	★★★	★★★
MER	★★★★★	★★★★★	★★★★	★★★★	★★★★	★★★★
MID	★★★★	★★★★	★★	★★	★★★★	★★★★
MOL	★★★	★★★	★★★	★★	★★★★★	★★★★
PRI	★★★★★	★★★★★	★★★★★	★	★★★	★★★
THC	★★★★★	★★★★★	★	★	★★★	★★★
UNI	★★★★★	★★★★★	★★★	★★	★★★	★★★★★
UPP	★★	★	★★★	★★★	★★★★	★★★★

[1] *indicates the HEDIS 2016 rates for this measure indicator were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS 2015 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	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	★	★★	NA	★★	★★
HAR	NA	★★	NA	★★	★★
MCL	★★★	★★	★★★	★★	★★
MER	★★★	★★	★★	★★★	★★★
MID	★	★★	★★★	★★	★★
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).*

State of Michigan

Department of Health and Human Services

2016 Michigan Department of Health and Human Services Adult Medicaid Health Plan CAHPS® Report

November 2016

HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 100 ◆ Phoenix, AZ 85016

Phone 602.264.6382 ◆ Fax 602.241.0757

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) program 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 2016 CAHPS results of adult members enrolled in an MHP or FFS.[1-3] The surveys were completed in the spring of 2016. The standardized 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.[1-4]

Report Overview

A sample of at least 1,350 adult members was selected from the FFS population and each MHP.[1-5] 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 five Effectiveness of Care measures are reported: Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications, Discussing Cessation Strategies, Aspirin Use, and Discussing Aspirin Risks and Benefits.

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.

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 The health plan name for one of the MHPs changed since the adult MHP population was surveyed in 2015. Aetna Better Health of Michigan was previously referred to as CoventryCares.

1-4 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

1-5 Some MHPs elected to oversample their population.

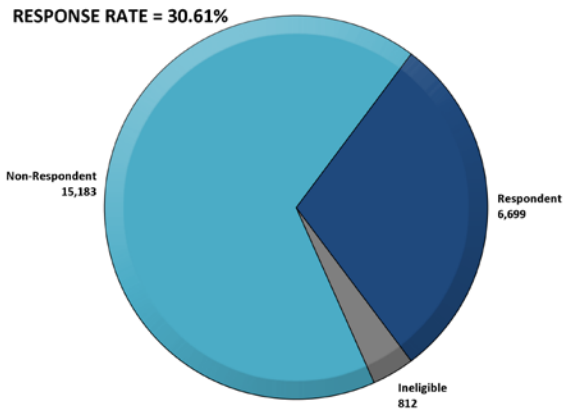
Key Findings

Survey Dispositions and Demographics

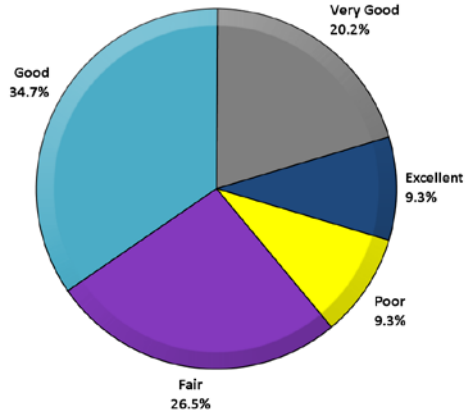
Figure 1-1 provides an overview of the MDHHS Medicaid Program survey dispositions and adult member demographics.

Figure 1-1: Survey Dispositions and Member Demographics

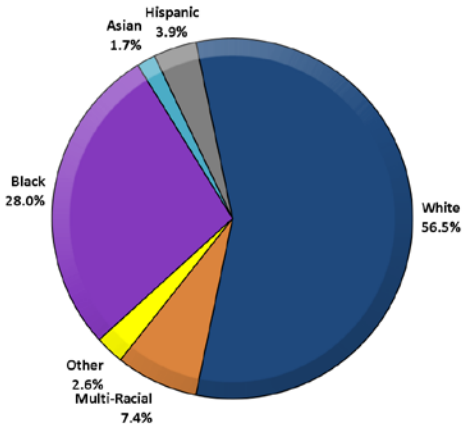
Survey Dispositions



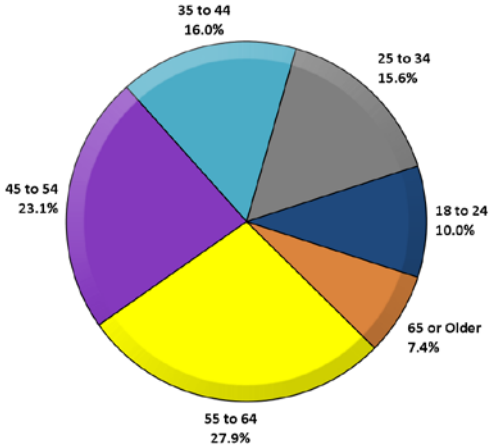
General Health Status



Race/Ethnicity



Age



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 CAHPS composite measures. The resulting three-point mean scores were compared to the National Committee for Quality Assurance's (NCQA's) 2016 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 2016 CAHPS results to their corresponding 2015 CAHPS results. Table 1-1 provides highlights of the National Comparisons and Trend Analysis findings for the MDHHS Medicaid 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.

Table 1-1: National Comparisons and Trend Analysis MDHHS Medicaid Program

Measure	National Comparisons	Trend Analysis
Global Rating		
Rating of Health Plan	★★★ 2.48	—
Rating of All Health Care	★★★ 2.37	—
Rating of Personal Doctor	★★★ 2.50	—
Rating of Specialist Seen Most Often	★★★ 2.52	—
Composite Measure		
Getting Needed Care	★★★ 2.40	—
Getting Care Quickly	★★★ 2.45	—
How Well Doctors Communicate	★★★★★ 2.64	—
Customer Service	★★★★ 2.59	—

Star Assignments Based on Percentiles

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

▲ statistically significantly higher in 2016 than in 2015.

▼ statistically significantly lower in 2016 than in 2015.

— indicates the 2016 score is not statistically significantly different than the 2015 score.

1-6 National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA; January 21, 2016.

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 on the previous page indicated 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 Needed Care and Getting Care Quickly composite measures scored at or between the 50th and 74th percentiles. The How Well Doctors Communicate composite measure scored at or above the 90th percentile, and the Customer Service composite measure scored at or between the 75th and 89th percentiles.

Results from the trend analysis showed that the MDHHS Medicaid Program did not score significantly *higher* or *lower* in 2016 than in 2015 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 1-2 through Table 1-4 show the results of this analysis for the global ratings, composite measures, and Effectiveness of Care measures, respectively.

Table 1-2: 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 1-3: 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 1-4: Statewide Comparisons—Effectiveness of Care Measures					
Plan Name	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies	Aspirin Use	Discussing Aspirin Risks and Benefits
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 following plans scored statistically significantly *higher* than the MDHHS Medicaid Managed Care Program average on at least one measure:

- Blue Cross Complete of Michigan
- Fee-for-Service
- HAP Midwest Health Plan
- McLaren Health Plan
- Molina Healthcare of Michigan
- Priority Health Choice, Inc.
- Total Health Care, Inc.
- Upper Peninsula Health Plan

Conversely, the following plans scored statistically significantly *lower* than the MDHHS Medicaid Managed Care Program average on at least one measure:

- Aetna Better Health of Michigan
- HAP Midwest Health Plan
- Harbor Health Plan
- Upper Peninsula Health Plan

Key Drivers of Satisfaction

HSAG focused the key drivers of satisfaction analysis on three measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. HSAG evaluated each of these measures to determine if particular CAHPS items (i.e., questions) strongly correlated with these measures, which HSAG refers to as "key drivers." These individual CAHPS items are driving levels of satisfaction with each of the three measures. Table 1-5 provides a summary of the key drivers identified for the MDHHS Medicaid Program.

Table 1-5: 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 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 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.

2016 CAHPS Performance Measures

The CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set includes 58 core questions that yield 14 measures. These measures include four global rating questions, five composite measures, and five 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 and managing aspirin use for the primary prevention of cardiovascular disease.

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	Aspirin Use
	Shared Decision Making	Discussing Aspirin Risks and Benefits

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 in the FFS population 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, 2015.
- 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 2015.
- Had Medicaid as a payer.

Next, a 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.[2-1] Table 3-1 in the Results section provides an overview of the sample sizes for each plan and program.

[2-1] Some MHPs elected to oversample their population.

Survey Protocol

The survey administration protocol employed by all of the MHPs and FFS, with the exception of Aetna Better Health of Michigan, McLaren Health Plan, Total Health Care, Inc., and Upper Peninsula Health Plan, was a mixed-mode methodology, which allowed for two methods by which members could complete a survey.[2-2] 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.[2-3] 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.[2-4] The survey administration protocol employed by Aetna Better Health of Michigan, McLaren Health Plan, Total Health Care, Inc., and Upper Peninsula Health Plan was a mixed-mode methodology with an Internet option, which allowed sampled members the option to complete the survey via mail, telephone, or Internet.

Table 2-2 shows the standard mixed-mode (i.e., mail followed by telephone follow-up) CAHPS timeline used in the administration of the CAHPS surveys.

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 four to 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 four to 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

[2-2] Blue Cross Complete of Michigan, Meridian Health Plan of Michigan, and Molina Healthcare of Michigan utilized an enhanced mixed-mode survey methodology pre-approved by NCQA.

[2-3] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2016 Survey Measures.* Washington, DC: NCQA; 2015.

[2-4] 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.

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.[2-5] 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, were removed from the sample during deduplication, or had a language barrier.

$$Response\ Rate = \frac{Number\ of\ Completed\ Surveys}{Sample - Ineligibles}$$

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 100 responses on each item in order to report the item as a valid 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 (+).

[2-5] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2015.

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.[2-6]

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.[2-7] 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	2.55	2.49	2.43	2.37
Rating of All Health Care	2.45	2.42	2.36	2.31
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	2.42	2.37	2.31
Getting Care Quickly	2.49	2.46	2.42	2.36
How Well Doctors Communicate	2.64	2.58	2.54	2.48
Customer Service	2.61	2.58	2.54	2.48

2-6 For detailed information on the derivation of three-point mean scores, please refer to *HEDIS® 2016, Volume 3: Specifications for Survey Measures.*

2-7 National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2016.* Washington, DC: NCQA; January 21, 2016.

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.[2-8] 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.

Aspirin Use and Discussion

HSAG calculated two rates that assess different facets of managing aspirin use for the primary prevention of cardiovascular disease:

- Aspirin Use
- Discussing Aspirin Risks and Benefits

[2-8] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2015.

The Aspirin Use measure assesses the percentage of members at risk for cardiovascular disease who are currently taking aspirin. The Discussing Aspirin Risks and Benefits measure assesses the percentage of members who discussed the risks and benefits of using aspirin with a doctor or other health provider. Responses of "Yes" 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.

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 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 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.

FFS 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 *F* test was performed to determine whether the results of the FFS population were 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 2016 CAHPS scores to the corresponding 2015 CAHPS scores to determine whether there were significant differences. A *t*-test was performed to determine whether results in 2015 were significantly different from results in 2016. A difference was considered significant if the two-sided *p* value of the *t*-test was less than or equal to 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. 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 CAHPS results to account for these differences; therefore, no case-mix adjusting was performed on these CAHPS results.[2-9]

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 program. These analyses identify whether respondents give different ratings of satisfaction with their MHP or the FFS program. 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.

[2-9] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services; 2008.

Mode Effects

The CAHPS survey was administered via standard or enhanced mixed-mode (FFS and all MHPs except Aetna Better Health of Michigan, McLaren Health Plan, Total Health Care, Inc., and Upper Peninsula Health Plan) and mixed-mode with Internet enhancement (Aetna Better Health of Michigan, McLaren Health Plan, Total Health Care, Inc., and Upper Peninsula Health Plan) methodologies. The mode in which a survey is administered may have an impact on respondents' assessments of their health care experiences. Therefore, mode effects should be considered when interpreting the CAHPS results.

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.

Priority Health Choice, Inc. Survey Results

Priority Health Choice, Inc.'s 2016 CAHPS results were calculated using adult Medicaid and Healthy Michigan Plan data.[2-10] Caution should be taken when interpreting and comparing Priority Health Choice, Inc.'s 2016 CAHPS results to other MHPs and previous year's CAHPS results.

[2-10] The 2016 CAHPS results for Priority Health Choice, Inc. are based on the data file submitted in June 2016, which combined adult Medicaid and Healthy Michigan Plan data, instead of adult Medicaid data only.

Who Responded to the Survey

A total of 22,694 surveys were distributed to adult members. A total of 6,699 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, were removed from the sample during deduplication, 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	**22,694**	**6,699**	**812**	**30.61%**
Fee-for-Service	1,350	444	113	35.89%
MDHHS Medicaid Managed Care Program	**21,344**	**6,255**	**699**	**30.30%**
Aetna Better Health of Michigan	1,499	301	26	20.43%
Blue Cross Complete of Michigan	1,830	513	36	28.60%
HAP Midwest Health Plan	1,355	436	118	35.25%
Harbor Health Plan	1,426	365	82	27.16%
McLaren Health Plan	1,350	417	43	31.91%
Meridian Health Plan of Michigan	1,893	641	51	34.80%
Molina Healthcare of Michigan	2,768	803	102	30.12%
Priority Health Choice, Inc.	3,200	1,007	71	32.18%
Total Health Care, Inc.	2,160	491	48	23.25%
UnitedHealthcare Community Plan	1,703	491	80	30.25%
Upper Peninsula Health Plan	2,160	790	42	37.30%

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	**10.0%**	**15.6%**	**16.0%**	**23.1%**	**27.9%**	**7.4%**
Fee-for-Service	5.9%	8.0%	9.8%	13.9%	20.8%	41.6%
MDHHS Medicaid Managed Care Program	**10.3%**	**16.1%**	**16.5%**	**23.8%**	**28.4%**	**4.9%**
Aetna Better Health of Michigan	9.5%	16.3%	21.4%	23.1%	26.4%	3.4%
Blue Cross Complete of Michigan	11.6%	15.5%	15.3%	27.1%	29.0%	1.6%
HAP Midwest Health Plan	1.4%	4.6%	9.3%	18.8%	21.8%	44.1%
Harbor Health Plan	3.7%	12.1%	16.7%	28.8%	37.8%	0.9%
McLaren Health Plan	9.9%	14.1%	24.0%	22.5%	25.7%	3.7%
Meridian Health Plan of Michigan	14.2%	19.2%	18.1%	21.9%	22.5%	4.1%
Molina Healthcare of Michigan	13.3%	16.9%	15.0%	24.7%	28.9%	1.3%
Priority Health Choice, Inc.	10.8%	20.3%	14.6%	23.3%	30.0%	1.0%
Total Health Care, Inc.	7.6%	15.0%	18.9%	24.8%	30.7%	3.0%
UnitedHealthcare Community Plan	14.0%	16.7%	17.6%	24.4%	25.6%	1.7%
Upper Peninsula Health Plan	10.2%	17.2%	15.9%	23.5%	32.1%	1.0%
Please note, percentages may not total 100% 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	**42.0%**	**58.0%**
Fee-for-Service	39.0%	61.0%
MDHHS Medicaid Managed Care Program	**42.2%**	**57.8%**
Aetna Better Health of Michigan	40.5%	59.5%
Blue Cross Complete of Michigan	46.7%	53.3%
HAP Midwest Health Plan	39.8%	60.2%
Harbor Health Plan	59.1%	40.9%
McLaren Health Plan	41.6%	58.4%
Meridian Health Plan of Michigan	37.8%	62.2%
Molina Healthcare of Michigan	42.3%	57.7%
Priority Health Choice, Inc.	37.7%	62.3%
Total Health Care, Inc.	42.8%	57.2%
UnitedHealthcare Community Plan	42.1%	57.9%
Upper Peninsula Health Plan	42.8%	57.2%
Please note, percentages may not total 100% 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	**56.5%**	**3.9%**	**28.0%**	**1.7%**	**2.6%**	**7.4%**
Fee-for-Service	67.8%	4.6%	17.8%	2.1%	3.0%	4.6%
MDHHS Medicaid Managed Care Program	**55.6%**	**3.9%**	**28.7%**	**1.6%**	**2.6%**	**7.6%**
Aetna Better Health of Michigan	17.8%	2.8%	70.0%	0.7%	2.1%	6.6%
Blue Cross Complete of Michigan	38.2%	5.3%	45.3%	2.8%	2.4%	5.9%
HAP Midwest Health Plan	39.8%	2.6%	42.9%	3.3%	4.0%	7.5%
Harbor Health Plan	12.6%	1.5%	75.7%	1.5%	1.5%	7.2%
McLaren Health Plan	74.6%	2.5%	10.8%	1.3%	1.5%	9.3%
Meridian Health Plan of Michigan	68.3%	3.3%	18.1%	0.3%	2.7%	7.3%
Molina Healthcare of Michigan	51.0%	4.3%	29.9%	1.7%	3.0%	10.1%
Priority Health Choice, Inc.	72.4%	7.1%	9.5%	2.4%	1.1%	7.6%
Total Health Care, Inc.	34.3%	3.1%	50.0%	1.3%	3.1%	8.3%
UnitedHealthcare Community Plan	49.6%	3.5%	31.6%	2.3%	6.2%	6.8%
Upper Peninsula Health Plan	88.2%	2.3%	0.6%	0.5%	1.9%	6.3%
Please note, percentages may not total 100% 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	**9.3%**	**20.2%**	**34.7%**	**26.5%**	**9.3%**
Fee-for-Service	5.5%	12.6%	32.2%	32.4%	17.4%
MDHHS Medicaid Managed Care Program	**9.6%**	**20.8%**	**34.9%**	**26.0%**	**8.7%**
Aetna Better Health of Michigan	8.1%	21.4%	28.8%	29.5%	12.2%
Blue Cross Complete of Michigan	12.0%	23.4%	34.1%	23.2%	7.3%
HAP Midwest Health Plan	4.7%	11.0%	34.9%	35.8%	13.6%
Harbor Health Plan	8.1%	18.8%	32.9%	30.6%	9.5%
McLaren Health Plan	8.3%	21.6%	37.0%	25.5%	7.6%
Meridian Health Plan of Michigan	11.4%	22.4%	36.0%	23.9%	6.3%
Molina Healthcare of Michigan	9.6%	18.5%	33.0%	29.5%	9.4%
Priority Health Choice, Inc.	10.6%	23.8%	35.6%	23.0%	6.9%
Total Health Care, Inc.	7.4%	17.2%	35.7%	28.9%	10.8%
UnitedHealthcare Community Plan	12.3%	20.8%	32.6%	24.1%	10.2%
Upper Peninsula Health Plan	9.4%	23.8%	38.6%	21.0%	7.2%
Please note, percentages may not total 100% due to rounding.					

National Comparisons

In order to assess the overall performance of the MDHHS Medicaid 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 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 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 when the three-point means were compared to NCQA HEDIS Benchmarks and Thresholds for Accreditation.

[3-1] National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA; January 21, 2016.

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	★★★ 2.48	★★★ 2.37	★★★ 2.50	★★★ 2.52
Fee-for-Service	★★ 2.41	★★★ 2.38	★★★★ 2.54	★★★ 2.51
MDHHS Medicaid Managed Care Program	★★★ 2.48	★★★ 2.37	★★★ 2.50	★★★ 2.53
Aetna Better Health of Michigan	★ 2.32	★ 2.20	★★ 2.45	★ 2.37
Blue Cross Complete of Michigan	★★★★★ 2.58	★★★★ 2.43	★★★★ 2.56	★★ 2.49
HAP Midwest Health Plan	★★ 2.37	★★ 2.33	★★ 2.48	★★★ 2.54
Harbor Health Plan	★ 2.30	★ 2.28	★★ 2.43	★★★★ 2.56
McLaren Health Plan	★★★ 2.47	★★ 2.35	★★ 2.48	★★★ 2.51
Meridian Health Plan of Michigan	★★★★ 2.52	★★★ 2.39	★★★ 2.52	★★★★ 2.57
Molina Healthcare of Michigan	★★★ 2.46	★★★ 2.39	★★ 2.49	★★★ 2.53
Priority Health Choice, Inc.	★★★★★ 2.56	★★★ 2.38	★★★ 2.50	★★★★ 2.56
Total Health Care, Inc.	★★★★ 2.49	★★★ 2.40	★★★ 2.52	★★ 2.50
UnitedHealthcare Community Plan	★★★ 2.48	★★★ 2.38	★★ 2.48	★★★ 2.52
Upper Peninsula Health Plan	★★★★ 2.50	★★★★ 2.42	★★★★ 2.53	★★★ 2.52

+ 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 global ratings.

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	★★★ 2.40	★★★ 2.45	★★★★★ 2.64	★★★★ 2.59
Fee-for-Service	★★★★ 2.44	★★★★★ 2.51	★★★★ 2.63	★+ 2.47
MDHHS Medicaid Managed Care Program	★★★ 2.39	★★★ 2.45	★★★★★ 2.64	★★★★ 2.60
Aetna Better Health of Michigan	★ 2.28	★ 2.34	★★★★ 2.61	★★★ 2.54
Blue Cross Complete of Michigan	★★★★ 2.42	★★★★ 2.46	★★★★★ 2.67	★★★★★ 2.61
HAP Midwest Health Plan	★★ 2.35	★★★ 2.42	★★★★ 2.61	★★★★ 2.59
Harbor Health Plan	★★ 2.35	★★ 2.40	★★★★★ 2.65	★★ 2.53
McLaren Health Plan	★★★ 2.40	★★ 2.39	★★★★ 2.62	★★★ 2.54
Meridian Health Plan of Michigan	★★★ 2.40	★★★ 2.45	★★★★★ 2.68	★★★★★ 2.64
Molina Healthcare of Michigan	★★ 2.35	★★★ 2.43	★★★★ 2.59	★★★★★ 2.61
Priority Health Choice, Inc.	★★★★ 2.43	★★★ 2.45	★★★★★ 2.64	★★★★★ 2.64
Total Health Care, Inc.	★★★ 2.41	★★★★★ 2.52	★★★★★ 2.67	★★★ 2.54
UnitedHealthcare Community Plan	★★★ 2.39	★★★★ 2.48	★★★★★ 2.64	★★★★ 2.60
Upper Peninsula Health Plan	★★★★★ 2.45	★★★★ 2.48	★★★★★ 2.67	★★★★★ 2.63

+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

The MDHHS Medicaid Program and the MDHHS Medicaid Managed Care Program both scored at or above the 90th percentile for the How Well Doctors Communicate composite measure, and scored at or between the 75th and 89th percentiles for the Customer Service composite measure. In addition, the MDHHS Medicaid Program and the MDHHS Medicaid Managed Care Program both scored at or between the 50th and 74th percentiles for the Getting Needed Care and Getting Care Quickly composite measures. The MDHHS Medicaid Program and MDHHS Medicaid Managed Care Program did not score below the 50th percentile for any of the composite measures.

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.

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: 1) Medical Assistance with Smoking and Tobacco Use Cessation and 2) Aspirin Use and Discussion. 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 significantly different than the MDHHS Medicaid Managed Care Program average. Additionally, HSAG compared the FFS results to the MDHHS Medicaid Managed Care Program average to determine if the FFS results were significantly different than the MDHHS Medicaid Managed Care Program average. The NCQA adult Medicaid national averages also are presented for comparison.[3-3] Colors in the figures note significant differences. Green indicates a top-box rate that was significantly higher than the MDHHS Medicaid Managed Care Program average. Conversely, red indicates a top-box rate that was significantly lower than the MDHHS Medicaid Managed Care Program average. Blue represents top-box rates that were not 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.

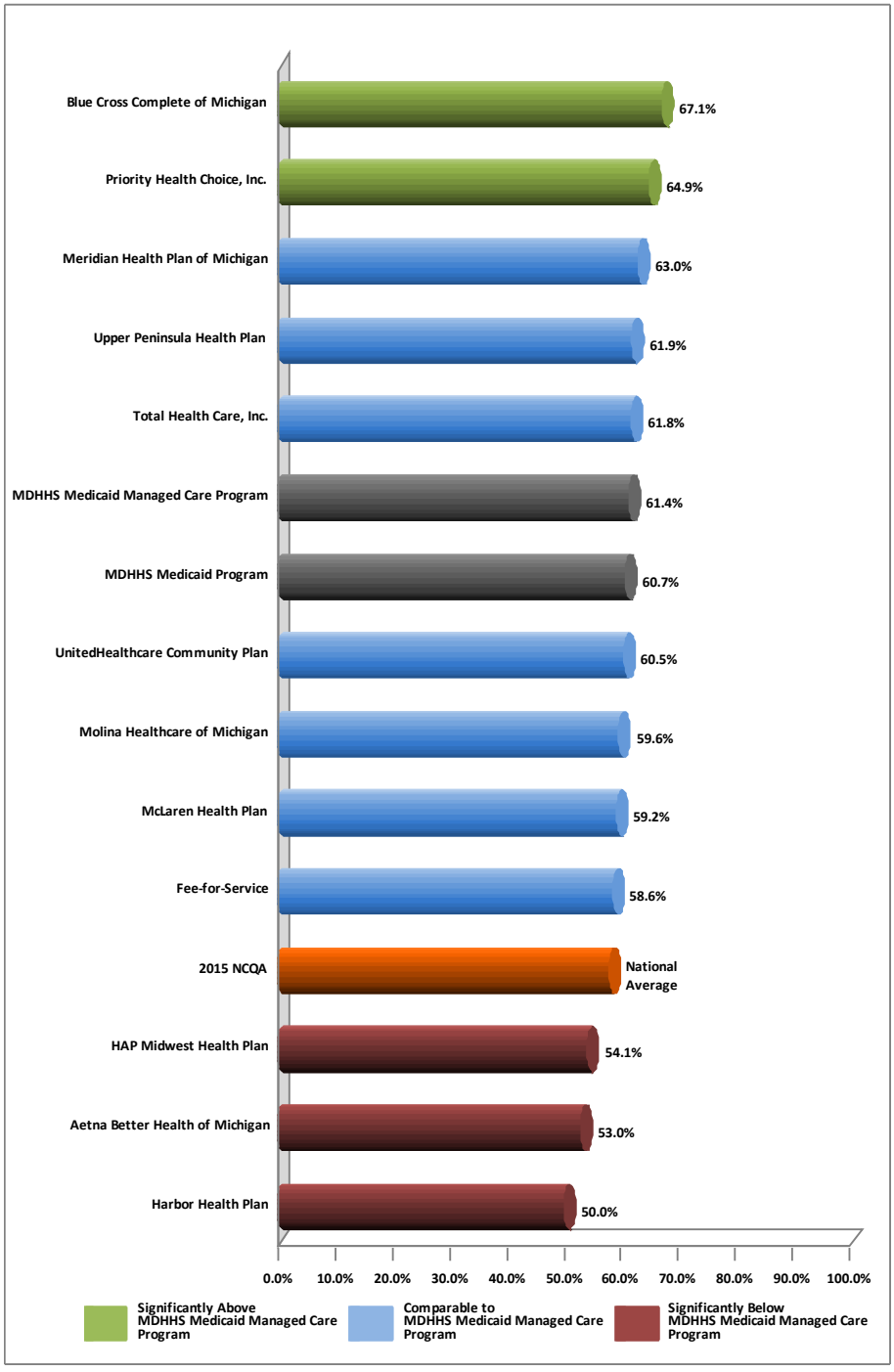
[3-3] The source for the national data contained in this publication is Quality Compass® 2015 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2015 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these 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.

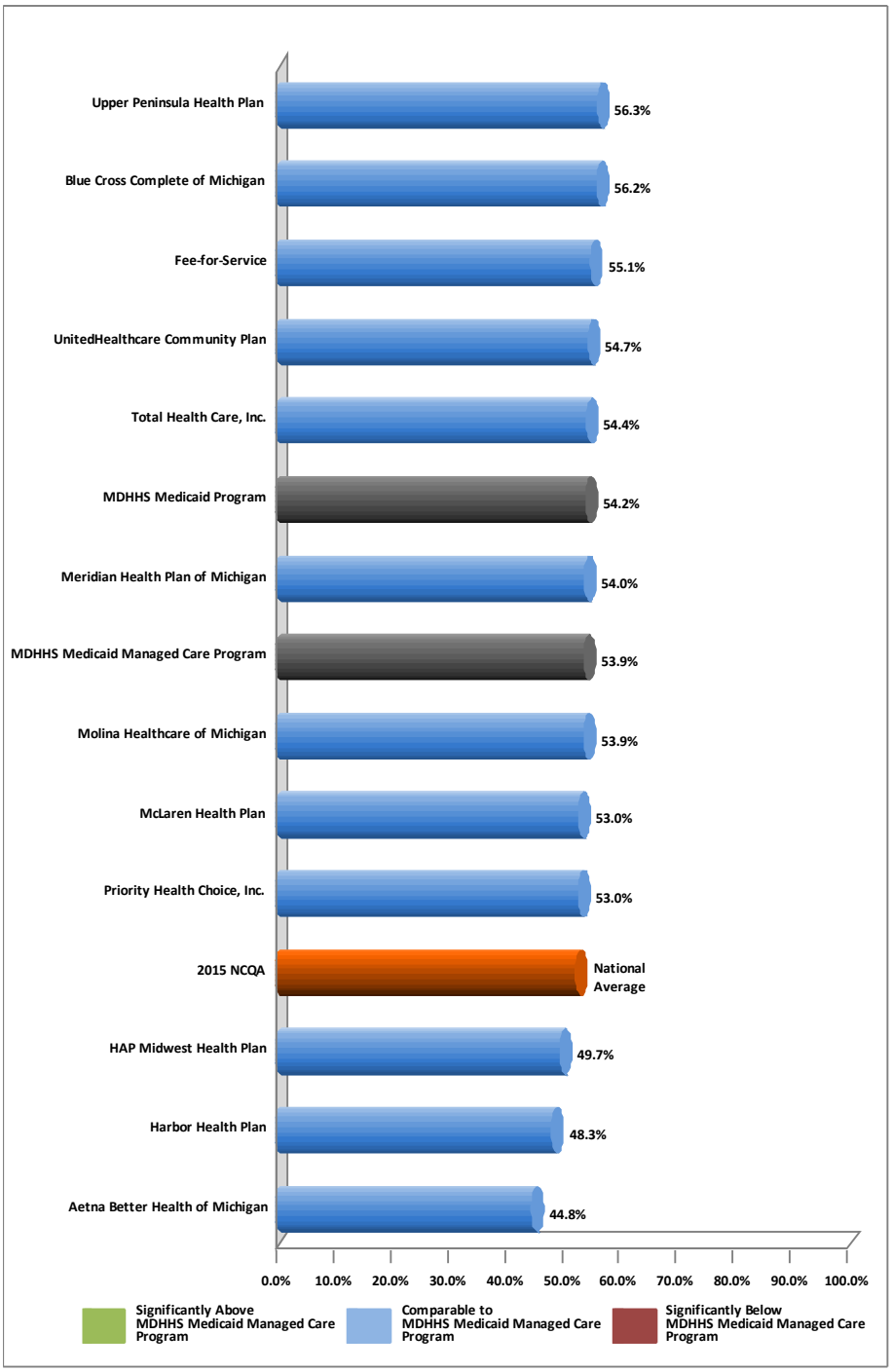
Figure 3-1: Rating of Health Plan Top-Box Rates



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.

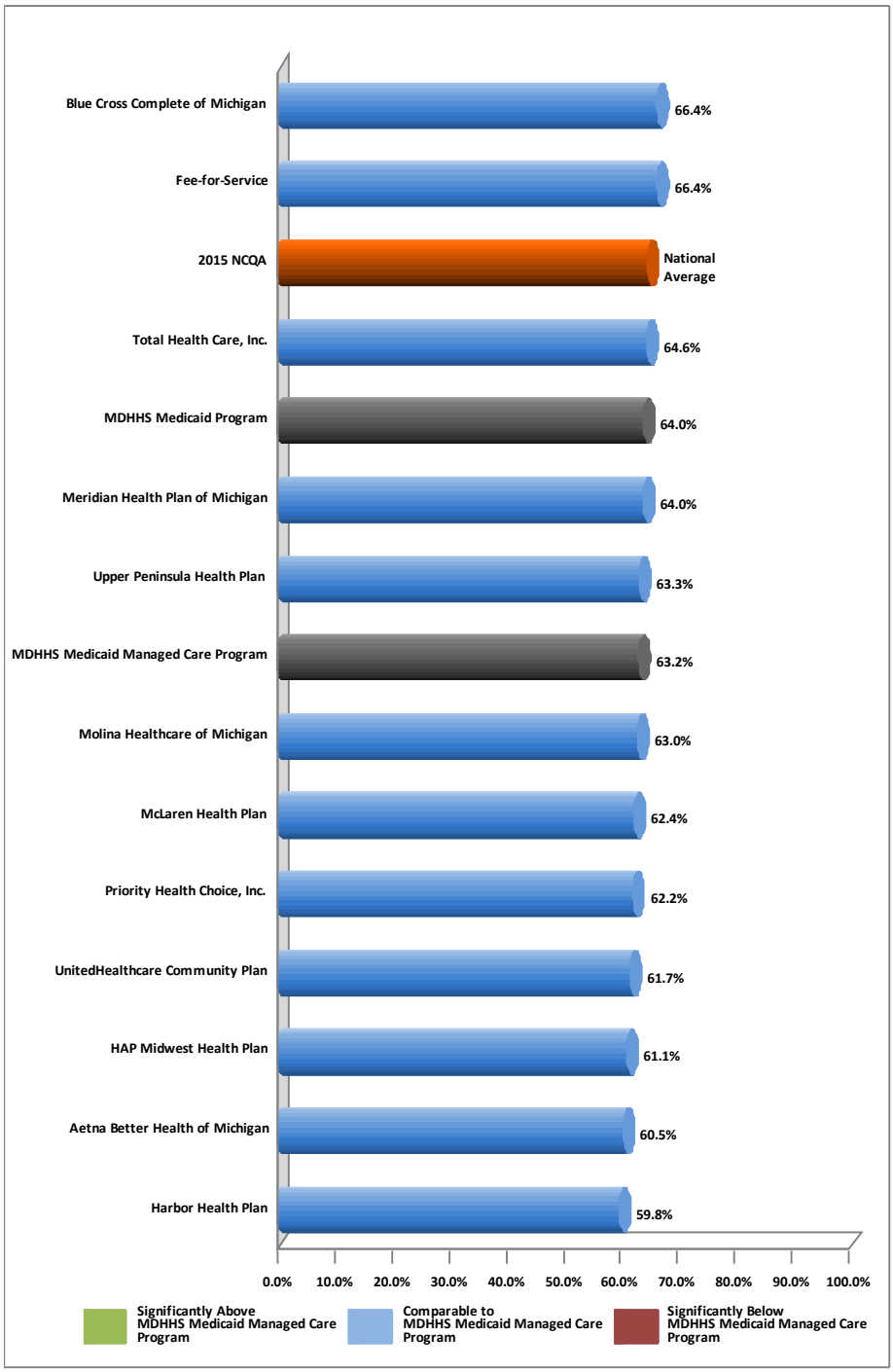
Figure 3-2: Rating of All Health Care Top-Box Rates



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.

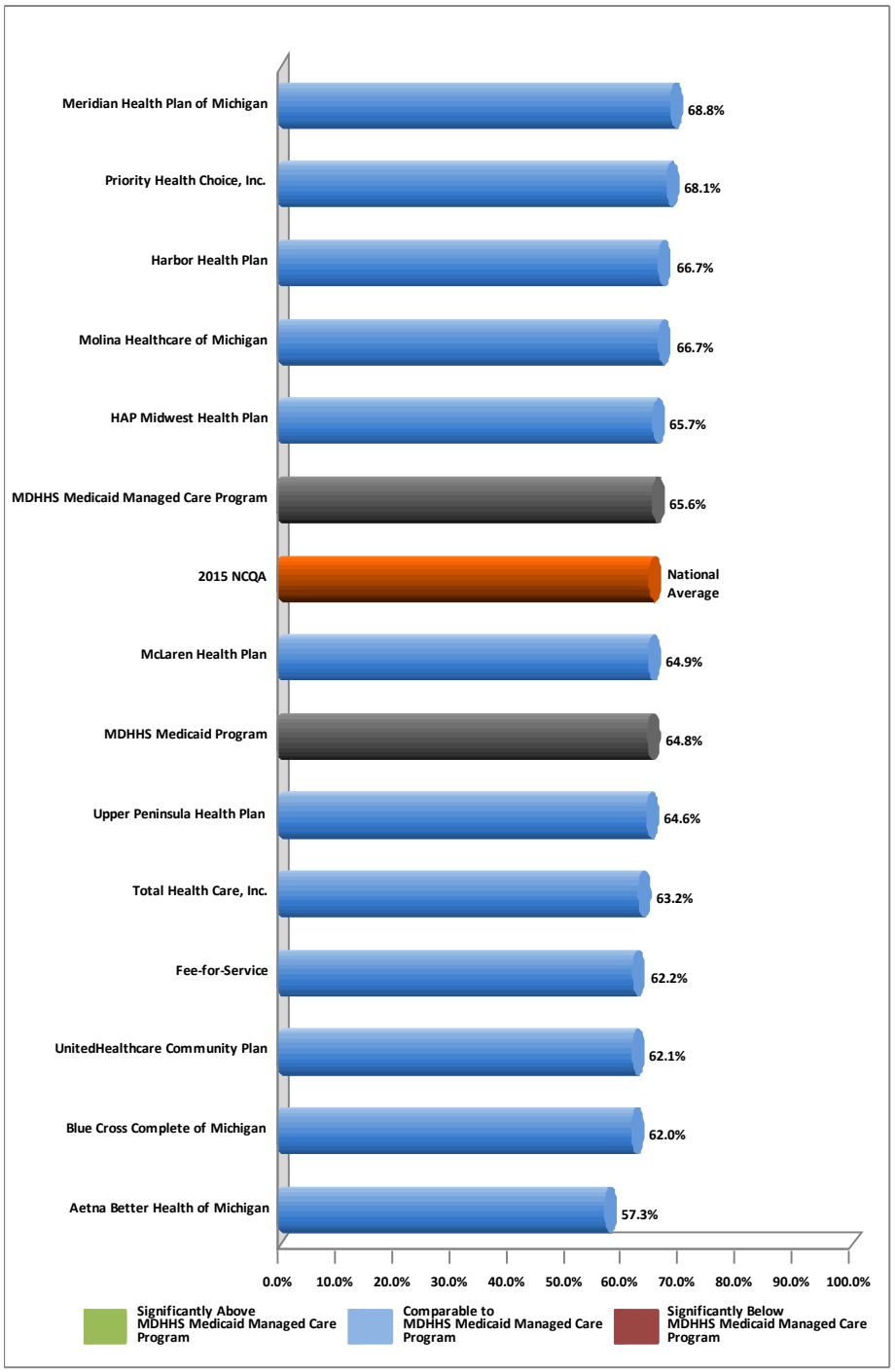
Figure 3-3: Rating of Personal Doctor Top-Box Rates



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



Composite Measures

Getting Needed Care

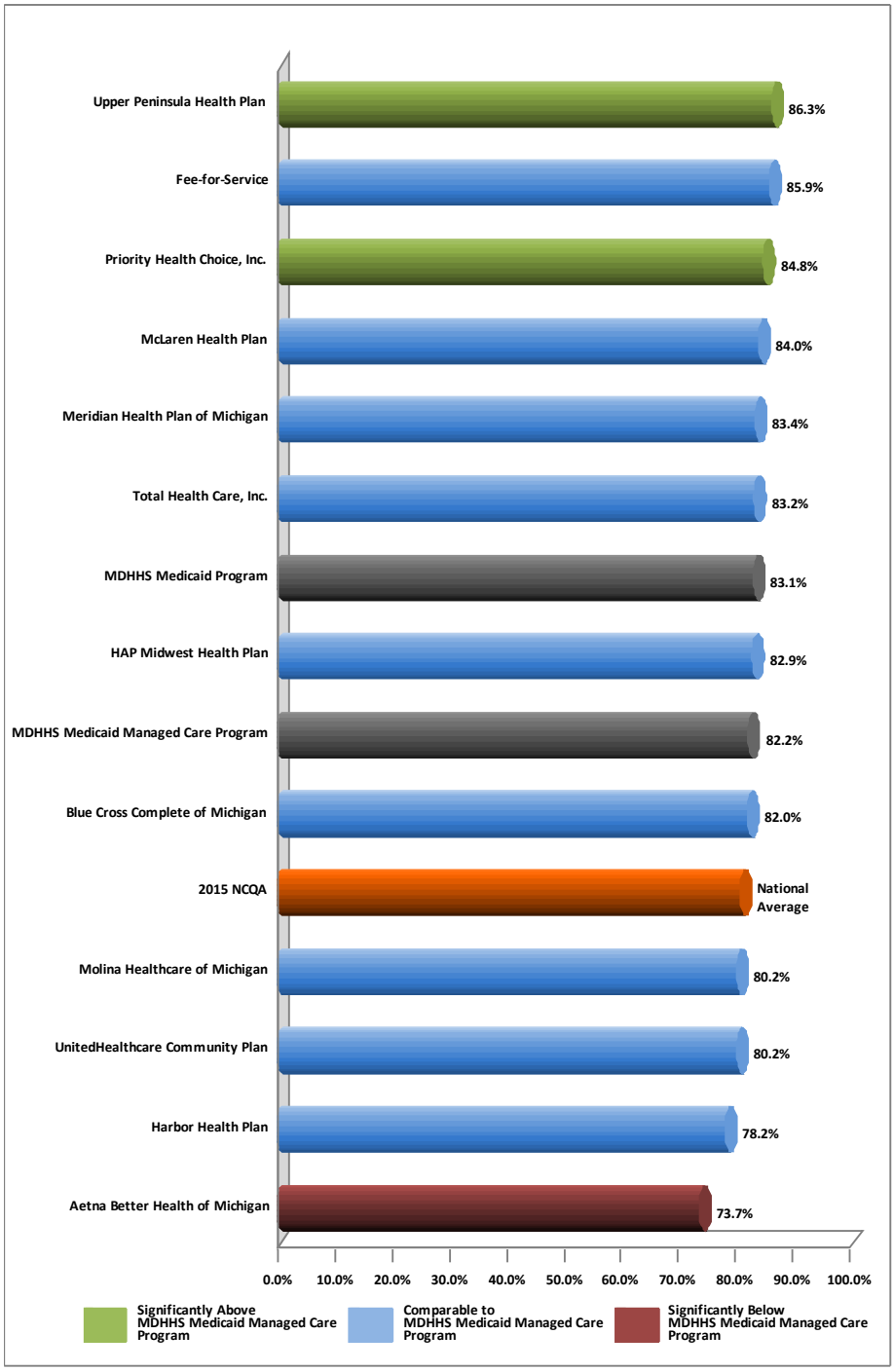
Two questions (Questions 14 and 25 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often it was easy to get needed care:

- **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

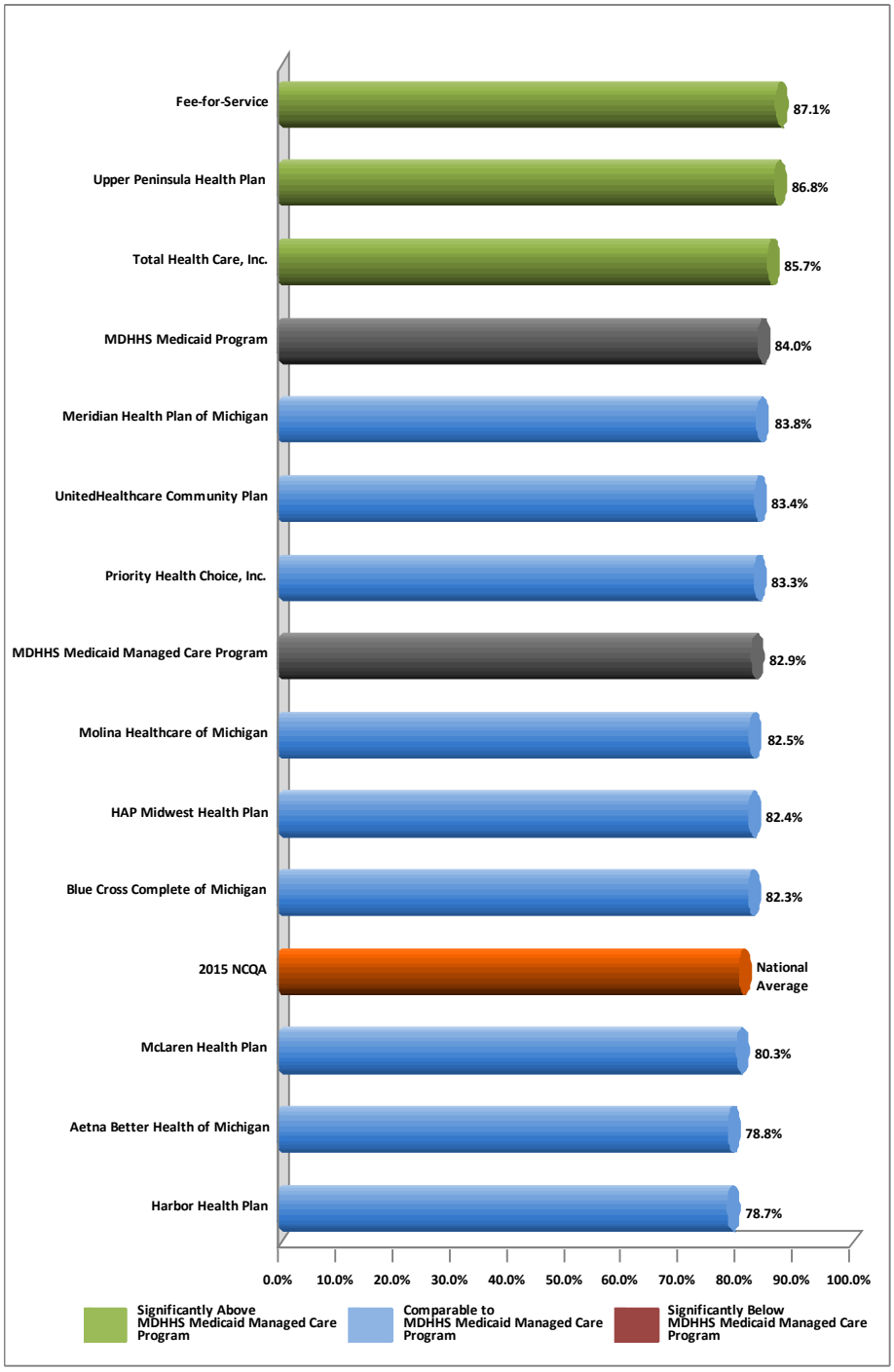
Two questions (Questions 4 and 6 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members received care quickly:

- **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

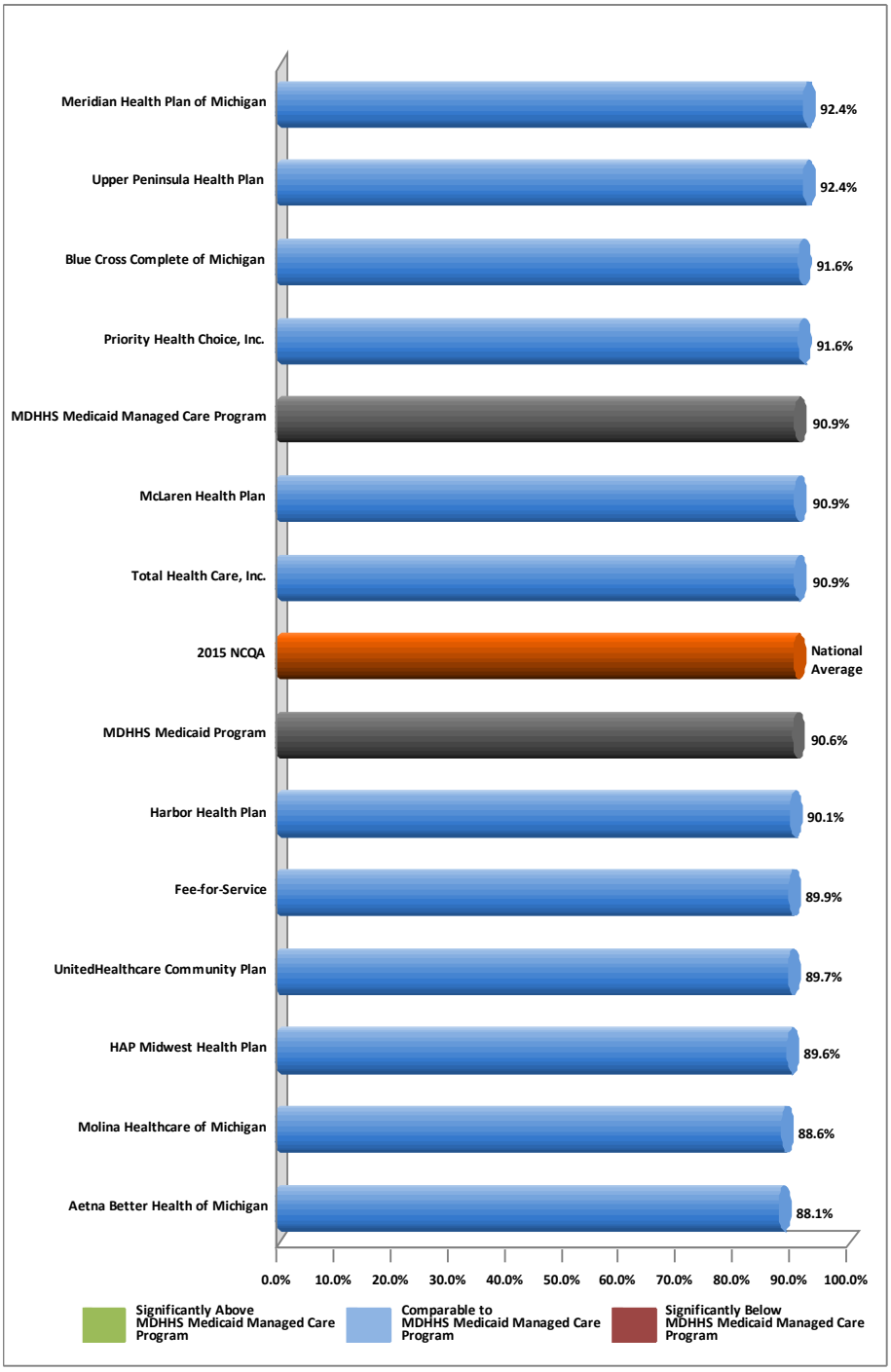
A series of four questions (Questions 17, 18, 19, and 20 in the CAHPS Adult Medicaid Health Plan Survey) was asked to assess how often doctors communicated well:

- **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

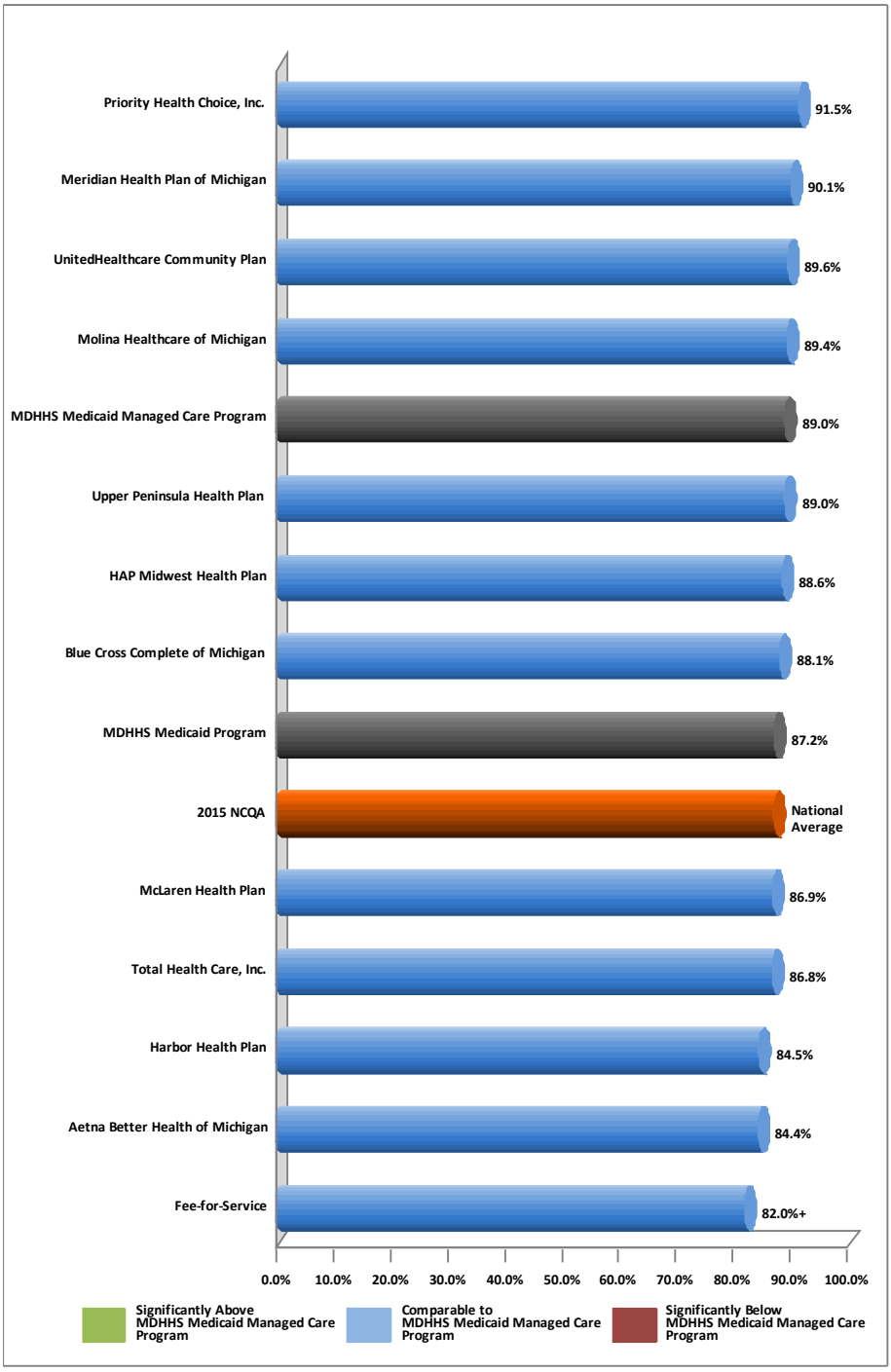
Two questions (Questions 31 and 32 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members were satisfied with customer service:

- **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

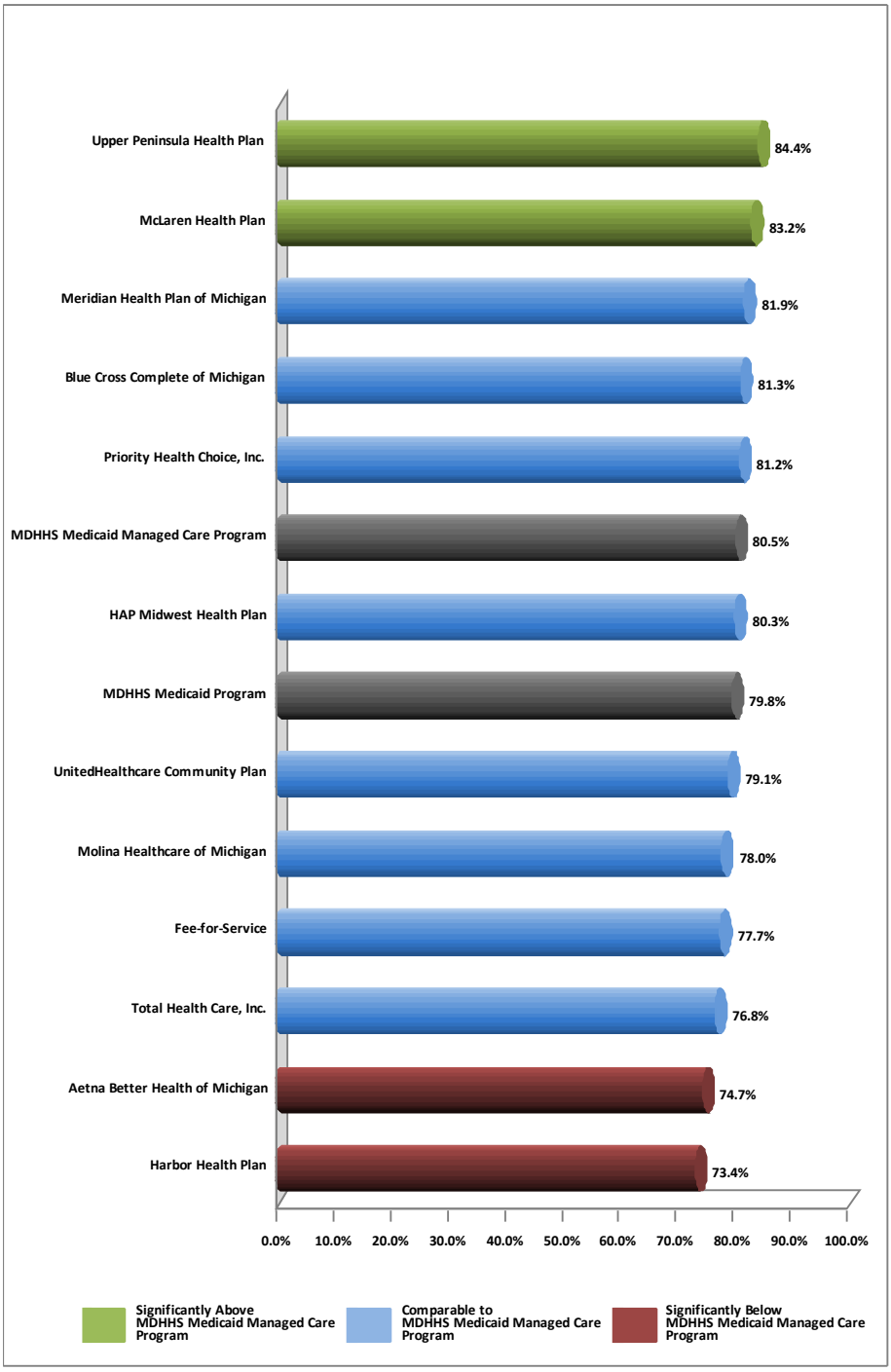
Three questions (Questions 10, 11, and 12 in the CAHPS Adult Medicaid Health Plan Survey) were asked regarding the involvement of adult members in decision making when starting or stopping a prescription medicine:

- **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

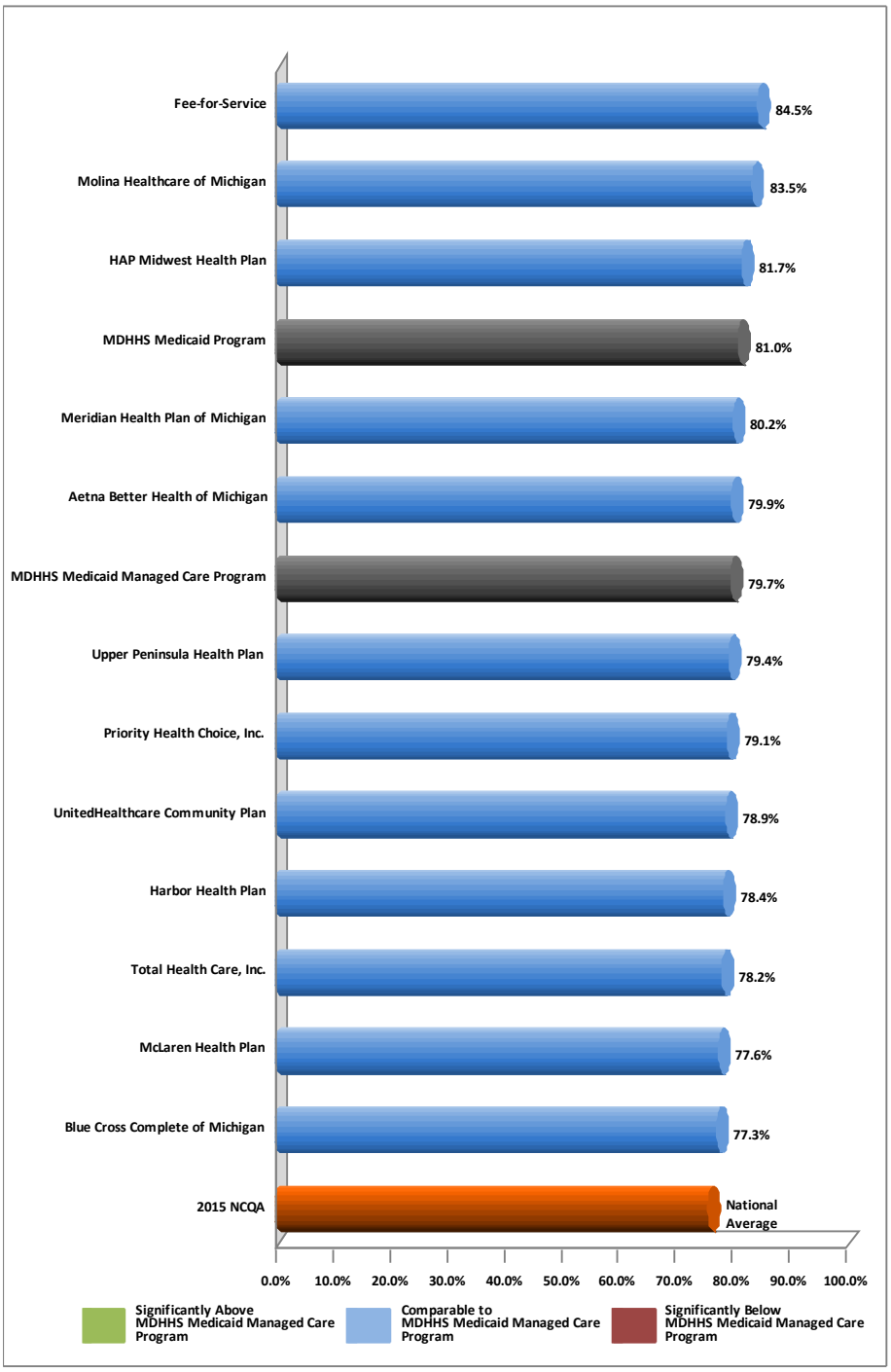
Adult members were asked how often they were advised to quit smoking or using tobacco by a doctor or other health provider (Question 40 in the CAHPS Adult Medicaid Health Plan Survey):

- **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 year's 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

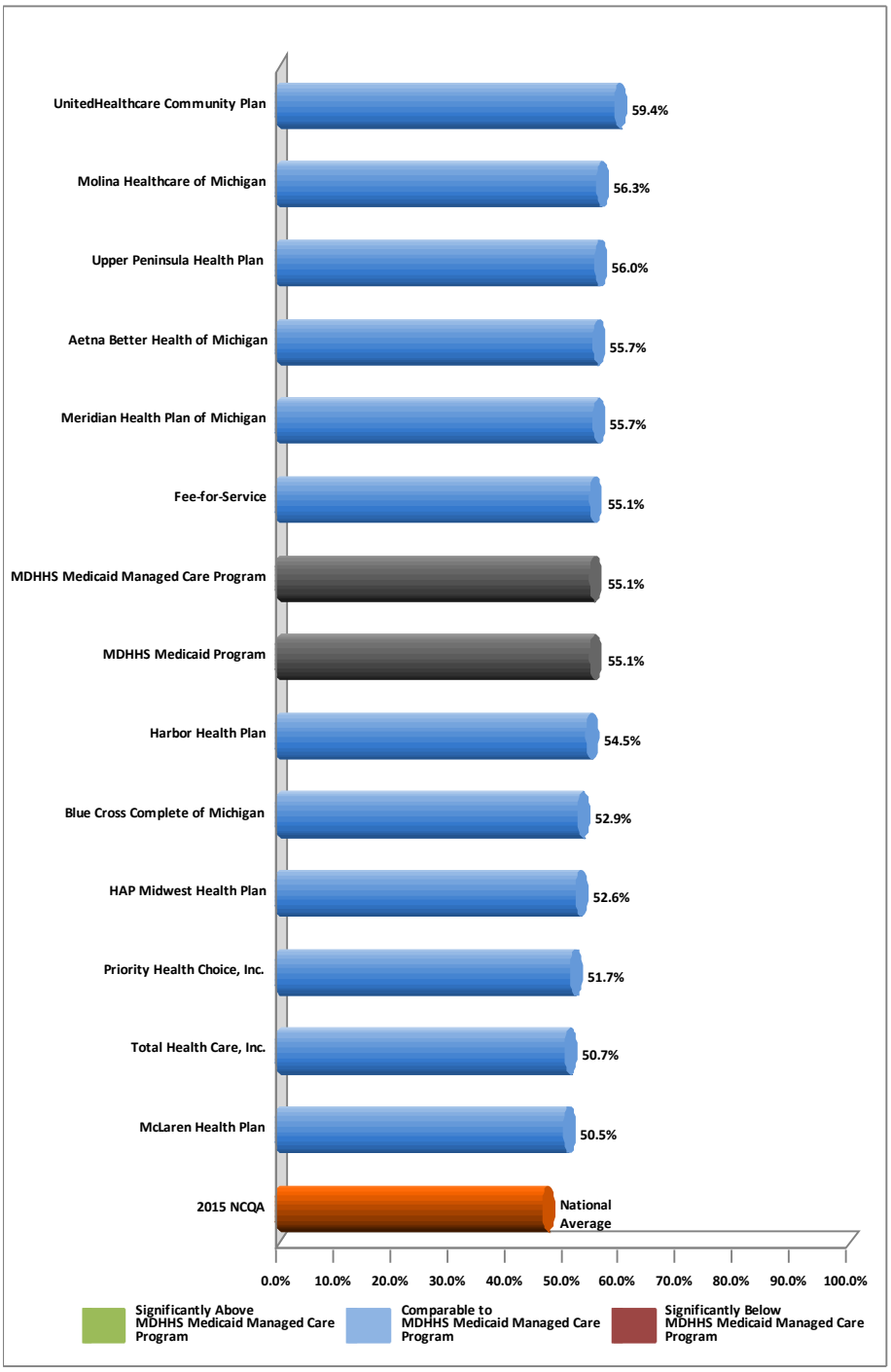
Adult members were asked how often medication was recommended or discussed by a doctor or other health provider to assist them with quitting smoking or using tobacco (Question 41 in the CAHPS Adult Medicaid Health Plan Survey):

- **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 year's results.

Figure 3-11 shows the Discussing Cessation Medications rates.

Figure 3-11: Discussing Cessation Medications Rates



Discussing Cessation Strategies

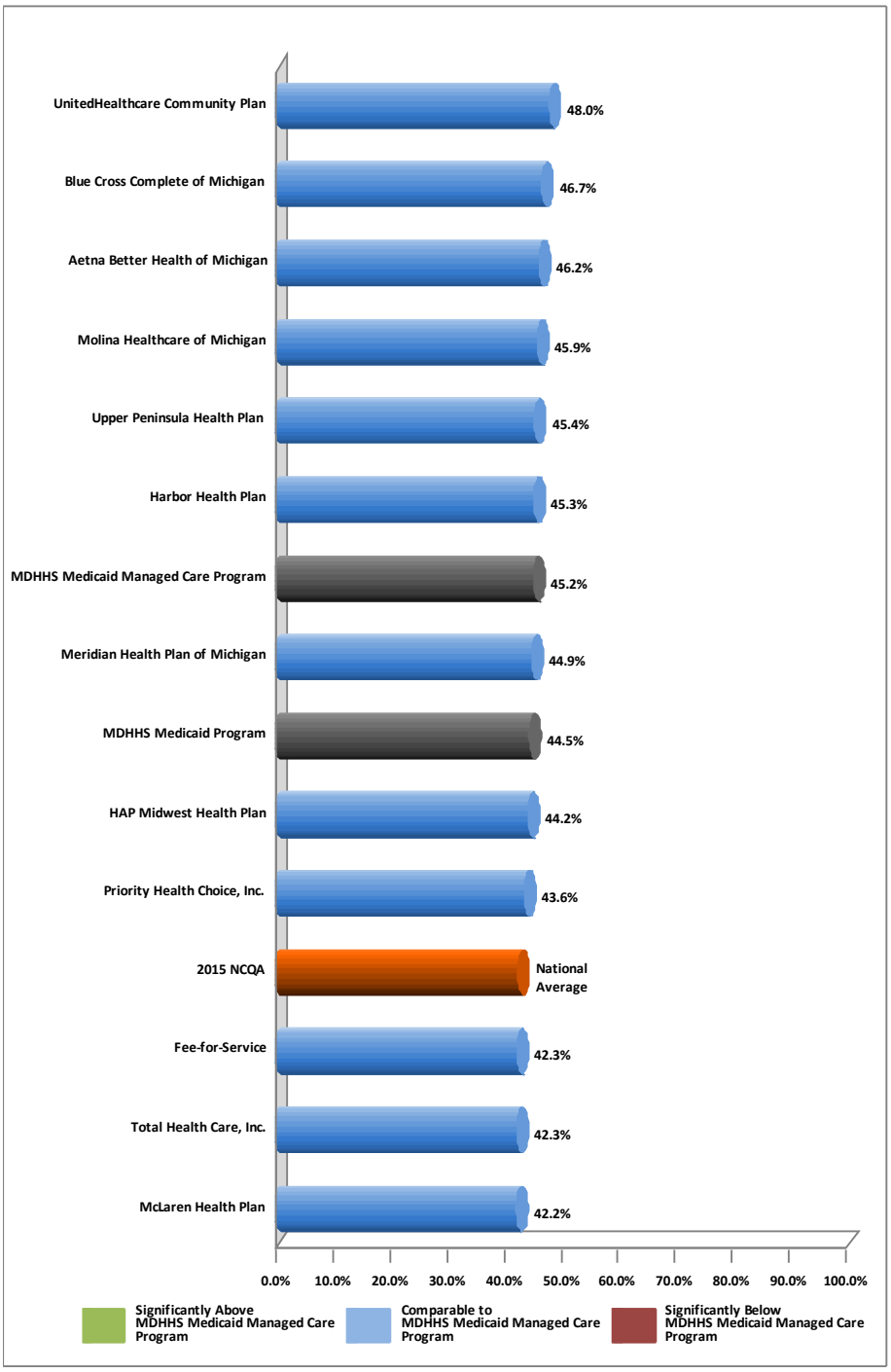
Adult members were asked how often their doctor or health provider discussed or provided methods and strategies other than medication to assist them with quitting smoking or using tobacco (Question 42 in the CAHPS Adult Medicaid Health Plan Survey):

- **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 year's results.

Figure 3-12 shows the Discussing Cessation Strategies rates.

Figure 3-12: Discussing Cessation Strategies Rates



Aspirin Use and Discussion[3-4]

Aspirin Use

Adult members were asked if they currently take aspirin daily or every other day (Question 43 in the CAHPS Adult Medicaid Health Plan Survey):

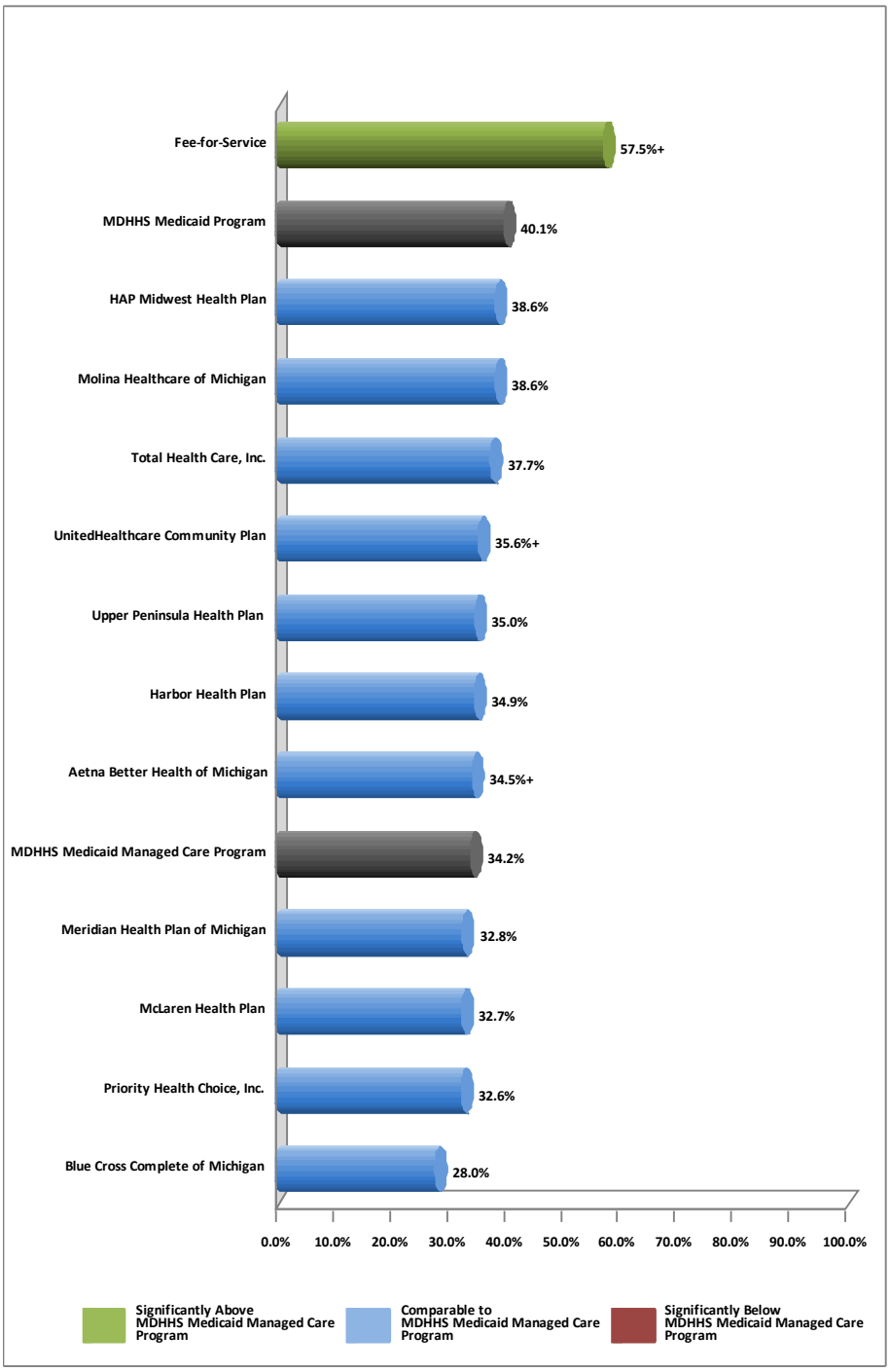
- **Question 43.** Do you take aspirin daily or every other day?
  - Yes
  - No
  - Don't know

The results of this measure represent the percentage of respondents who answered "Yes" to this question. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results.

[3-4] NCQA does not publish national averages for the Aspirin Use and Discussion measures.

Figure 3-13 shows the Aspirin Use rates.

Figure 3-13: Aspirin Use Rates



Note: + indicates fewer than 100 responses

Discussing Aspirin Risks and Benefits

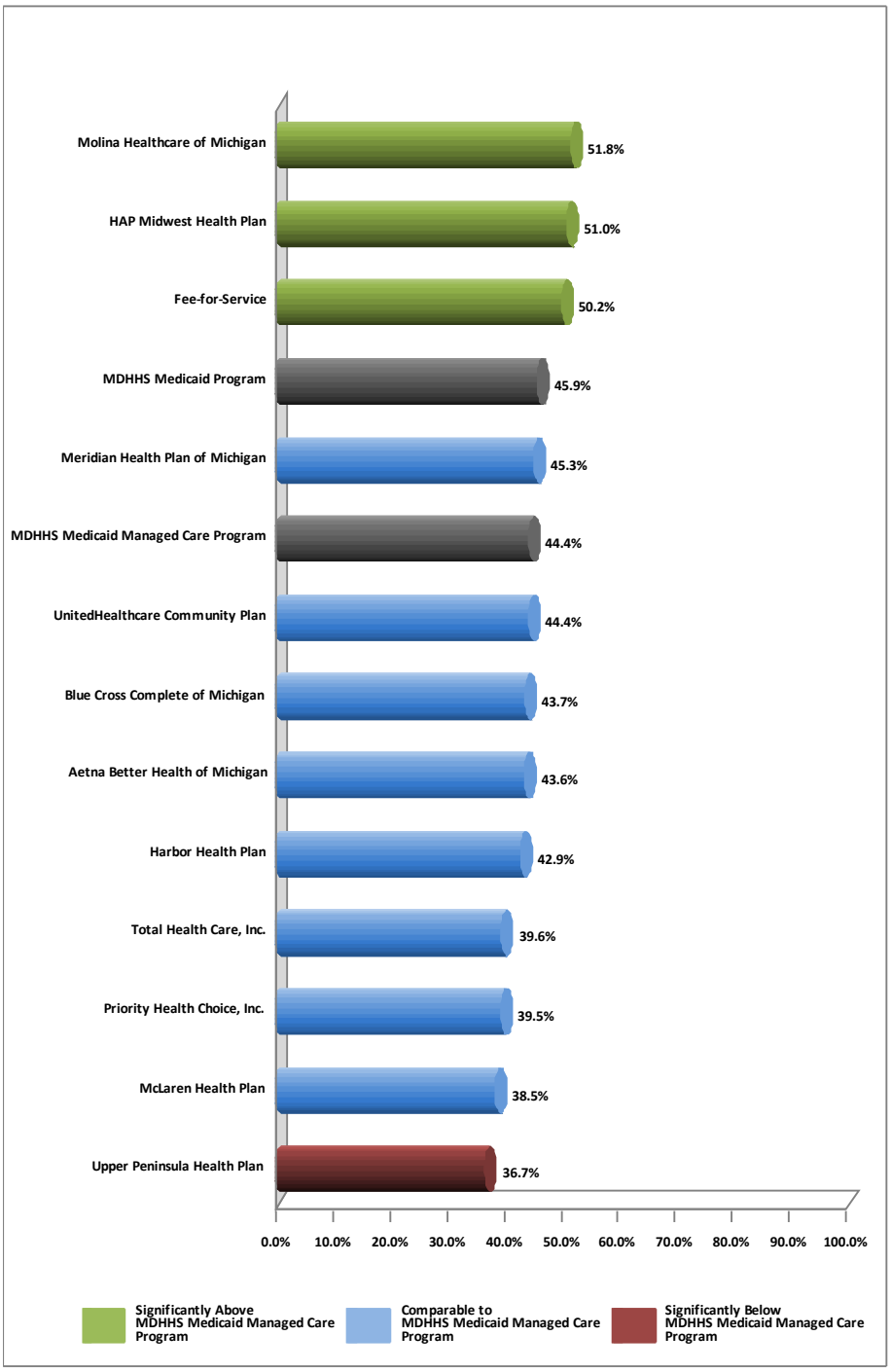
Adult members were asked if a doctor or health provider discussed with them the risks and benefits of aspirin to prevent a heart attack or stroke (Question 45 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 45**. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?
  - Yes
  - No

The results of this measure represent the percentage of respondents who answered "Yes" to this question. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results.

Figure 3-14 shows the Discussing Aspirin Risks and Benefits rates.

Figure 3-14: Discussing Aspirin Risks and Benefits 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	Aspirin Use	Discussing Aspirin Risks and Benefits
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.

Trend Analysis

The completed surveys from the 2016 and 2015 CAHPS results were used to perform the trend analysis presented in this section. The 2016 CAHPS scores were compared to the 2015 CAHPS scores to determine whether there were statistically significant differences. Statistically significant differences between 2016 scores and 2015 scores are noted with triangles. Scores that were statistically significantly higher in 2016 than in 2015 are noted with upward triangles (▲). Scores that were statistically significantly lower in 2016 than in 2015 are noted with downward triangles (▼). Scores in 2016 that were not statistically significantly different from scores in 2015 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 2015 and 2016 top-box responses and the trend results for Rating of Health Plan.

Table 4-1: Rating of Health Plan Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**60.9%***	**60.7%**	**—**
Fee-for-Service	57.6%	58.6%	—
MDHHS Medicaid Managed Care Program	**61.3%****	**61.4%**	**—**
Aetna Better Health of Michigan	54.0%	53.0%	—
Blue Cross Complete of Michigan	63.0%	67.1%	—
HAP Midwest Health Plan	58.2%	54.1%	—
Harbor Health Plan	56.3%	50.0%	—
McLaren Health Plan	59.4%	59.2%	—
Meridian Health Plan of Michigan	60.7%	63.0%	—
Molina Healthcare of Michigan	61.5%	59.6%	—
Priority Health Choice, Inc.	62.4%	64.9%	—
Total Health Care, Inc.	59.4%	61.8%	—
UnitedHealthcare Community Plan	63.9%	60.5%	—
Upper Peninsula Health Plan	59.8%	61.9%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 60.6%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 60.9%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 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 2015 and 2016 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	2015	2016	Trend Results
MDHHS Medicaid Program	**52.2%***	**54.2%**	**—**
Fee-for-Service	56.9%	55.1%	—
MDHHS Medicaid Managed Care Program	**51.7%****	**53.9%**	**—**
Aetna Better Health of Michigan	43.8%	44.8%	—
Blue Cross Complete of Michigan	53.7%	56.2%	—
HAP Midwest Health Plan	50.5%	49.7%	—
Harbor Health Plan	46.7%	48.3%	—
McLaren Health Plan	50.6%	53.0%	—
Meridian Health Plan of Michigan	50.3%	54.0%	—
Molina Healthcare of Michigan	55.4%	53.9%	—
Priority Health Choice, Inc.	56.1%	53.0%	—
Total Health Care, Inc.	51.4%	54.4%	—
UnitedHealthcare Community Plan	51.9%	54.7%	—
Upper Peninsula Health Plan	55.4%	56.3%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 52.3%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 51.7%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 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 2015 and 2016 top-box responses and the trend results for Rating of Personal Doctor.

Table 4-3: Rating of Personal Doctor Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**63.3%***	**64.0%**	**—**
Fee-for-Service	69.7%	66.4%	—
MDHHS Medicaid Managed Care Program	**62.6%****	**63.2%**	**—**
Aetna Better Health of Michigan	60.0%	60.5%	—
Blue Cross Complete of Michigan	63.7%	66.4%	—
HAP Midwest Health Plan	64.1%	61.1%	—
Harbor Health Plan	63.5%	59.8%	—
McLaren Health Plan	56.6%	62.4%	—
Meridian Health Plan of Michigan	62.5%	64.0%	—
Molina Healthcare of Michigan	68.1%	63.0%	—
Priority Health Choice, Inc.	68.5%	62.2%	▼
Total Health Care, Inc.	62.4%	64.6%	—
UnitedHealthcare Community Plan	62.7%	61.7%	—
Upper Peninsula Health Plan	64.7%	63.3%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 63.6%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 62.8%.*

There was one statistically significant difference between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- Priority Health Choice, Inc.

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 2015 and 2016 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	2015	2016	Trend Results
MDHHS Medicaid Program	**65.4%***	**64.8%**	**—**
Fee-for-Service	69.4%	62.2%	—
MDHHS Medicaid Managed Care Program	**64.9%****	**65.6%**	**—**
Aetna Better Health of Michigan	61.0%	57.3%	—
Blue Cross Complete of Michigan	62.1%	62.0%	—
HAP Midwest Health Plan	61.1%	65.7%	—
Harbor Health Plan	62.5%+	66.7%	—
McLaren Health Plan	62.0%	64.9%	—
Meridian Health Plan of Michigan	68.2%	68.8%	—
Molina Healthcare of Michigan	66.8%	66.7%	—
Priority Health Choice, Inc.	70.7%	68.1%	—
Total Health Care, Inc.	64.2%	63.2%	—
UnitedHealthcare Community Plan	64.9%	62.1%	—
Upper Peninsula Health Plan	65.4%	64.6%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 65.8%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 65.3%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 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 2015 and 2016 top-box responses and trend results for the Getting Needed Care composite measure.

Table 4-5: Getting Needed Care Composite Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**83.5%***	**83.1%**	**—**
Fee-for-Service	89.8%	85.9%	—
MDHHS Medicaid Managed Care Program	**82.8%****	**82.2%**	**—**
Aetna Better Health of Michigan	79.0%	73.7%	—
Blue Cross Complete of Michigan	82.9%	82.0%	—
HAP Midwest Health Plan	80.1%	82.9%	—
Harbor Health Plan	87.6%	78.2%	▼
McLaren Health Plan	84.2%	84.0%	—
Meridian Health Plan of Michigan	83.3%	83.4%	—
Molina Healthcare of Michigan	82.9%	80.2%	—
Priority Health Choice, Inc.	84.0%	84.8%	—
Total Health Care, Inc.	82.6%	83.2%	—
UnitedHealthcare Community Plan	81.4%	80.2%	—
Upper Peninsula Health Plan	86.5%	86.3%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 83.5%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 82.7%.*

There was one statistically significant difference between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- Harbor Health Plan

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 2015 and 2016 top-box responses and trend results for the Getting Care Quickly composite measure.

Table 4-6: Getting Care Quickly Composite Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**83.5%***	**84.0%**	**—**
Fee-for-Service	90.0%	87.1%	—
MDHHS Medicaid Managed Care Program	**82.8%****	**82.9%**	**—**
Aetna Better Health of Michigan	85.1%	78.8%	▼
Blue Cross Complete of Michigan	82.9%	82.3%	—
HAP Midwest Health Plan	81.0%	82.4%	—
Harbor Health Plan	80.1%	78.7%	—
McLaren Health Plan	79.4%	80.3%	—
Meridian Health Plan of Michigan	83.1%	83.8%	—
Molina Healthcare of Michigan	83.3%	82.5%	—
Priority Health Choice, Inc.	86.6%	83.3%	—
Total Health Care, Inc.	81.9%	85.7%	—
UnitedHealthcare Community Plan	82.5%	83.4%	—
Upper Peninsula Health Plan	85.9%	86.8%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 83.4%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 82.6%.*

There was one statistically significant difference between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- Aetna Better Health of Michigan

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 2015 and 2016 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	2015	2016	Trend Results
MDHHS Medicaid Program	**90.0%***	**90.6%**	—
Fee-for-Service	95.3%	89.9%	▼
MDHHS Medicaid Managed Care Program	**89.4%****	**90.9%**	—
Aetna Better Health of Michigan	89.6%	88.1%	—
Blue Cross Complete of Michigan	91.1%	91.6%	—
HAP Midwest Health Plan	88.2%	89.6%	—
Harbor Health Plan	91.3%	90.1%	—
McLaren Health Plan	89.4%	90.9%	—
Meridian Health Plan of Michigan	89.2%	92.4%	▲
Molina Healthcare of Michigan	90.0%	88.6%	—
Priority Health Choice, Inc.	90.1%	91.6%	—
Total Health Care, Inc.	86.4%	90.9%	▲
UnitedHealthcare Community Plan	89.9%	89.7%	—
Upper Peninsula Health Plan	92.4%	92.4%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 90.2%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 89.5%.*

There were three statistically significant differences between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- FFS

The following scored statistically significantly *higher* in 2016 than in 2015:

- Meridian Health Plan of Michigan
- Total Health Care, Inc.

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 2015 and 2016 top-box responses and trend results for the Customer Service composite measure.

Table 4-8: Customer Service Composite Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**87.3%***	**87.2%**	—
Fee-for-Service	86.6%+	82.0%+	—
MDHHS Medicaid Managed Care Program	**87.4%****	**89.0%**	—
Aetna Better Health of Michigan	88.1%	84.4%	—
Blue Cross Complete of Michigan	90.2%	88.1%	—
HAP Midwest Health Plan	84.8%	88.6%	—
Harbor Health Plan	93.8%+	84.5%	▼
McLaren Health Plan	86.7%	86.9%	—
Meridian Health Plan of Michigan	86.9%	90.1%	—
Molina Healthcare of Michigan	88.7%	89.4%	—
Priority Health Choice, Inc.	88.9%	91.5%	—
Total Health Care, Inc.	88.0%	86.8%	—
UnitedHealthcare Community Plan	86.0%	89.6%	—
Upper Peninsula Health Plan	91.0%	89.0%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 87.3%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 87.3%.*

There was one statistically significant difference between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- Harbor Health Plan

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 2015 and 2016 top-box responses and trend results for the Shared Decision composite measure.

Table 4-9: Shared Decision Making Composite Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**79.6%***	**79.8%**	**—**
Fee-for-Service	80.2%	77.7%	—
MDHHS Medicaid Managed Care Program	**79.5%****	**80.5%**	**—**
Aetna Better Health of Michigan	74.9%	74.7%	—
Blue Cross Complete of Michigan	81.2%	81.3%	—
HAP Midwest Health Plan	80.2%	80.3%	—
Harbor Health Plan	77.1%+	73.4%	—
McLaren Health Plan	78.0%	83.2%	—
Meridian Health Plan of Michigan	80.1%	81.9%	—
Molina Healthcare of Michigan	80.2%	78.0%	—
Priority Health Choice, Inc.	79.3%	81.2%	—
Total Health Care, Inc.	73.7%	76.8%	—
UnitedHealthcare Community Plan	80.4%	79.1%	—
Upper Peninsula Health Plan	83.0%	84.4%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 79.6%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 79.5%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 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 2015 and 2016 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	2015	2016	Trend Results
MDHHS Medicaid Program	**80.5%***	**81.0%**	**—**
Fee-for-Service	87.4%	84.5%	—
MDHHS Medicaid Managed Care Program	**79.8%****	**79.7%**	**—**
Aetna Better Health of Michigan	81.5%	79.9%	—
Blue Cross Complete of Michigan	77.4%	77.3%	—
HAP Midwest Health Plan	81.3%	81.7%	—
Harbor Health Plan	80.8%	78.4%	—
McLaren Health Plan	75.7%	77.6%	—
Meridian Health Plan of Michigan	80.8%	80.2%	—
Molina Healthcare of Michigan	84.2%	83.5%	—
Priority Health Choice, Inc.	83.2%	79.1%	—
Total Health Care, Inc.	78.7%	78.2%	—
UnitedHealthcare Community Plan	77.2%	78.9%	—
Upper Peninsula Health Plan	80.0%	79.4%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 80.5%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 79.7%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 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 their doctor or health provider to assist adult members with quitting smoking or using tobacco. Table 4-11 shows the 2015 and 2016 rates and trend results for the Discussing Cessation Medications measure.

Table 4-11: Discussing Cessation Medications Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**54.4%***	**55.1%**	**—**
Fee-for-Service	56.8%	55.1%	—
MDHHS Medicaid Managed Care Program	**54.1%****	**55.1%**	**—**
Aetna Better Health of Michigan	58.0%	55.7%	—
Blue Cross Complete of Michigan	53.2%	52.9%	—
HAP Midwest Health Plan	50.5%	52.6%	—
Harbor Health Plan	63.1%	54.5%	—
McLaren Health Plan	43.0%	50.5%	▲
Meridian Health Plan of Michigan	58.6%	55.7%	—
Molina Healthcare of Michigan	55.3%	56.3%	—
Priority Health Choice, Inc.	53.0%	51.7%	—
Total Health Care, Inc.	51.9%	50.7%	—
UnitedHealthcare Community Plan	55.7%	59.4%	—
Upper Peninsula Health Plan	54.9%	56.0%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 54.3%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 54.0%.*

There was one statistically significant difference between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *higher* in 2016 than in 2015:

- McLaren Health Plan

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 their doctor or health provider to assist adult members with quitting smoking or using tobacco. Table 4-12 shows the 2015 and 2016 rates and trend results for the Discussing Cessation Strategies measure.

Table 4-12: Discussing Cessation Strategies Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**45.5%***	**44.5%**	**—**
Fee-for-Service	43.5%	42.3%	—
MDHHS Medicaid Managed Care Program	**45.7%****	**45.2%**	**—**
Aetna Better Health of Michigan	44.8%	46.2%	—
Blue Cross Complete of Michigan	44.2%	46.7%	—
HAP Midwest Health Plan	45.8%	44.2%	—
Harbor Health Plan	49.2%	45.3%	—
McLaren Health Plan	39.9%	42.2%	—
Meridian Health Plan of Michigan	48.0%	44.9%	—
Molina Healthcare of Michigan	48.8%	45.9%	—
Priority Health Choice, Inc.	43.0%	43.6%	—
Total Health Care, Inc.	42.1%	42.3%	—
UnitedHealthcare Community Plan	43.6%	48.0%	—
Upper Peninsula Health Plan	46.8%	45.4%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 45.0%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 45.2%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 for this measure.

Aspirin Use and Discussion

Aspirin Use

One question (Question 43 in the CAHPS Adult Medicaid Health Plan Survey) was asked to determine if adult members take aspirin daily or every other day. Table 4-13 shows the 2015 and 2016 rates and trend results for the Aspirin Use measure.

Table 4-13: Aspirin Use Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**38.1%***	**40.1%**	**—**
Fee-for-Service	60.0%+	57.5%+	—
MDHHS Medicaid Managed Care Program	**35.6%****	**34.2%**	**—**
Aetna Better Health of Michigan	36.6%+	34.5%+	—
Blue Cross Complete of Michigan	29.2%	28.0%	—
HAP Midwest Health Plan	42.9%+	38.6%	—
Harbor Health Plan	32.5%+	34.9%	—
McLaren Health Plan	23.9%+	32.7%	—
Meridian Health Plan of Michigan	37.4%	32.8%	—
Molina Healthcare of Michigan	33.6%	38.6%	—
Priority Health Choice, Inc.	31.4%+	32.6%	—
Total Health Care, Inc.	41.7%	37.7%	—
UnitedHealthcare Community Plan	41.2%	35.6%+	—
Upper Peninsula Health Plan	42.9%	35.0%	—

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 38.3%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 35.7%.*

There were no statistically significant differences between scores in 2016 and scores in 2015 for this measure.

Discussing Aspirin Risks and Benefits

One question (Question 45 in the CAHPS Adult Medicaid Health Plan Survey) was asked to determine if a doctor or health provider discussed with adult members the risks and benefits of aspirin to prevent a heart attack or stroke. Table 4-14 shows the 2015 and 2016 rates and trend results for the Discussing Aspirin Risks and Benefits measure.

Table 4-14: Discussing Aspirin Risks and Benefits Trend Analysis

Plan Name	2015	2016	Trend Results
MDHHS Medicaid Program	**48.0%***	**45.9%**	**—**
Fee-for-Service	51.4%	50.2%	—
MDHHS Medicaid Managed Care Program	**47.6%****	**44.4%**	**—**
Aetna Better Health of Michigan	46.8%	43.6%	—
Blue Cross Complete of Michigan	47.2%	43.7%	—
HAP Midwest Health Plan	55.4%	51.0%	—
Harbor Health Plan	41.7%+	42.9%	—
McLaren Health Plan	38.8%	38.5%	—
Meridian Health Plan of Michigan	47.9%	45.3%	—
Molina Healthcare of Michigan	50.8%	51.8%	—
Priority Health Choice, Inc.	43.9%	39.5%	—
Total Health Care, Inc.	44.6%	39.6%	—
UnitedHealthcare Community Plan	52.4%	44.4%	—
Upper Peninsula Health Plan	44.5%	36.7%	▼

+ indicates fewer than 100 responses. Caution should be exercised when evaluating these results.

▲ *statistically significantly higher in 2016 than in 2015.*

▼ *statistically significantly lower in 2016 than in 2015.*

— *not statistically significantly different in 2016 than in 2015.*

**The MDHHS Medicaid Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 48.2%.*

***The MDHHS Medicaid Managed Care Program 2015 average includes two MHPs that were not active in 2016. There is no plan specific trend analysis for these two MHPs. An adjusted 2015 rate, which excludes these plans, would be 47.8%.*

There was one statistically significant difference between scores in 2016 and scores in 2015 for this measure.

The following scored statistically significantly *lower* in 2016 than in 2015:

- Upper Peninsula Health Plan

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 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 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.

Survey Instrument

The survey instrument selected was the CAHPS 5.0 Adult Medicaid 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 1-888-506-5134.

SURVEY INSTRUCTIONS

- **Please be sure to fill the response circle <u>completely</u>. Use only <u>black or blue ink</u> or <u>dark pencil</u> to complete the survey.**

Correct Mark ● **Incorrect Marks** 

- **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 Michigan Medicaid Fee-For-Service. 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 5***

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, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- ○ Yes
- ○ No ➔ ***Go to Question 7***

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

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?

- ○ None ➔ ***Go to Question 15***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 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?

- ○ Yes
- ○ No

9. 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 13***

10. Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?

- ○ Yes
- ○ No

11. Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?

- ○ Yes
- ○ 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?

- ○ Yes
- ○ 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?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Worst Health Care Possible										Best Health Care Possible

14. 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

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?

- ○ Yes
- ○ 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?

- ○ None ➔ ***Go to Question 23***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

18. In the last 6 months, how often did your personal doctor listen carefully to you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

19. In the last 6 months, how often did your personal doctor show respect for what you had to say?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

20. In the last 6 months, how often did your personal doctor spend enough time with you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

21. 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 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ 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?

○	○	○	○	○	○	○	○	○	○	○
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.

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?

- ○ Yes
- ○ 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

26. How many specialists have you seen in the last 6 months?

- ○ None ➔ ***Go to Question 28***
- ○ 1 specialist
- ○ 2
- ○ 3
- ○ 4
- ○ 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?

○	○	○	○	○	○	○	○	○	○	○
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.

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?

- ○ Yes
- ○ 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

30. In the last 6 months, did you get information or help from your health plan's customer service?

- ○ Yes
- ○ 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

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

33. In the last 6 months, did your health plan give you any forms to fill out?

- ○ Yes
- ○ No ➔ ***Go to Question 35***

34. In the last 6 months, how often were the forms from your health plan easy to fill out?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ 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?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10

Worst Health Plan Possible — Best Health Plan Possible

ABOUT YOU

36. In general, how would you rate your overall health?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

37. In general, how would you rate your overall <u>mental or emotional</u> health?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

38. Have you had either a flu shot or flu spray in the nose since July 1, 2015?

- ○ Yes
- ○ No
- ○ Don't know

39. 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 43***
- ○ 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ 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.

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ 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.

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

43. Do you take aspirin daily or every other day?

- ○ Yes
- ○ No
- ○ Don't know

44. Do you have a health problem or take medication that makes taking aspirin unsafe for you?

- ○ Yes
- ○ No
- ○ 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?

- ○ Yes
- ○ No

46. 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

47. 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

48. 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 50***

49. Is this a condition or problem that has lasted for at least 3 months? Do <u>not</u> include pregnancy or menopause.

- ○ Yes
- ○ No

50. Do you now need or take medicine prescribed by a doctor? Do <u>not</u> include birth control.

- ○ Yes
- ○ No ➔ ***Go to Question 52***

51. Is this medicine to treat a condition that has lasted for at least 3 months? Do <u>not</u> include pregnancy or menopause.

- ○ Yes
- ○ No

52. 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

53. Are you male or female?

- ○ Male
- ○ Female

54. 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

55. Are you of Hispanic or Latino origin or descent?

- ○ Yes, Hispanic or Latino
- ○ No, Not Hispanic or Latino

56. 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

57. Did someone help you complete this survey?

- ○ Yes ➔ ***Go to Question 58***
- ○ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

58. 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

CD Contents

The accompanying CD includes all of the information from the Executive Summary, Reader's Guide, Results, Trend Analysis, Key Drivers of Satisfaction, and Survey Instrument sections of this report. The CD also contains electronic copies of comprehensive crosstabulations that show responses to each survey question stratified by select categories. The following content is included in the CD:

- 2016 Michigan Adult Medicaid CAHPS Report
- MDHHS Adult Medicaid Program Crosstabulations
- MDHHS Adult Medicaid Plan-level Crosstabulations

2016 Michigan Department of Health and Human Services Healthy Michigan Plan CAHPS® Report

February 2017

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

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 2016 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 August to November 2016.

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 five Effectiveness of Care measures are reported: Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications, Discussing Cessation Strategies, Aspirin Use, and Discussing Aspirin Risks and Benefits. HSAG presents aggregate statewide results (i.e., the MDHHS HMP Program) and compares them to national Medicaid data.

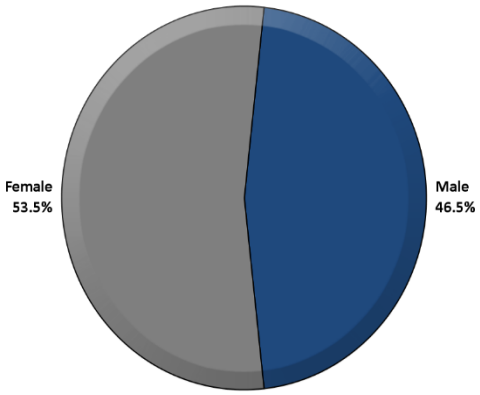
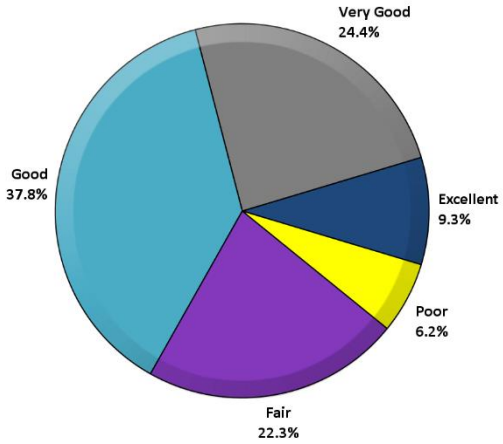
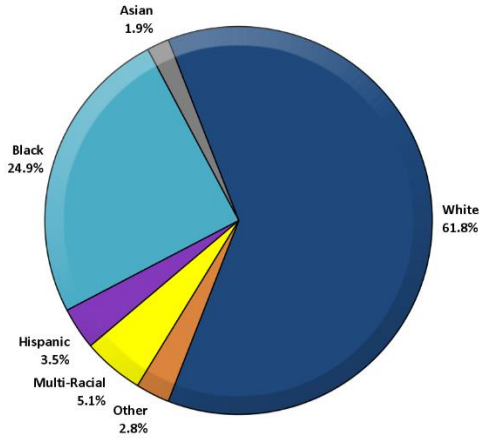
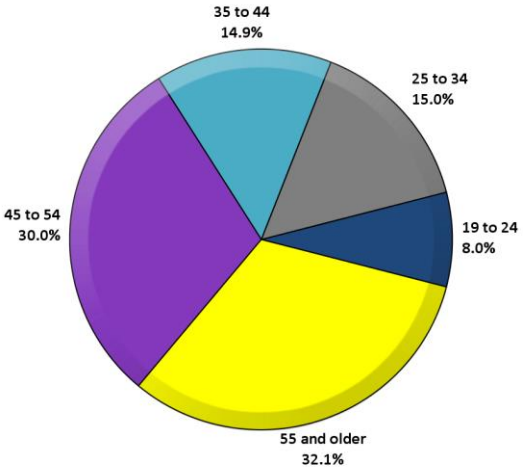
[1-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Key Findings

Survey Demographics and Dispositions

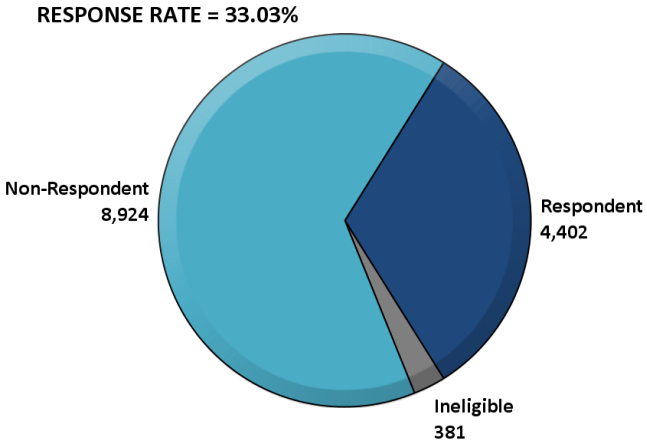
Table 1-1 provides an overview of the adult member demographics and survey dispositions for the MDHHS HMP Program.

Table 1-1 – Survey Demographics and Dispositions

Gender	General Health Status
	
Race/Ethnicity	**Age**
	

Please note, percentages may not total 100.0% due to rounding.

Survey Dispositions



National Comparisons

A three-point mean score was determined for the four CAHPS global ratings and four CAHPS composite measures. The resulting three-point means scores were compared to the National Committee for Quality Assurance's (NCQA's) 2016 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] Table 1-2 provides highlights of the National Comparisons 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]

Table 1-2 – National Comparisons MDHHS HMP Program

Measure	National Comparisons
Global Rating	
Rating of Health Plan	★★★ 2.43
Rating of All Health Care	★★★ 2.37
Rating of Personal Doctor	★★ 2.49
Rating of Specialist Seen Most Often	★★★ 2.52
Composite Measure	
Getting Needed Care	★★★ 2.39
Getting Care Quickly	★★ 2.40
How Well Doctors Communicate	★★★★★ 2.66
Customer Service	★★★★ 2.59
Star Assignments Based on Percentiles ★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th	

1-3 National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA; January 21, 2016.

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.

The National Comparisons results on the previous page indicated that the How Well Doctors Communicate composite measure scored at or above the 90th percentile. The Customer Service composite measure scored at or between the 75th and 89th percentiles. The Rating of Health Plan, Rating of All Health Care, and Rating of Specialist Seen Most Often global ratings, and the Getting Needed Care composite measure scored at or between the 50th and 74th percentiles. The Rating of Personal Doctor global rating and the Getting Care Quickly composite measure scored at or between the 25th and 49th percentiles.

Statewide Comparisons

HSAG calculated top-box rates (i.e., rates of satisfaction) for each global rating, composite measure, and Effectiveness of Care measure. HSAG compared the HMP health plan results to the MDHHS HMP Program average to determine if plan results were statistically significantly different than 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	—+	—+	—+	—+	NA
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.
NA indicates that results for this measure are not displayed because too few members responded to the questions.

Table 1-5 – Statewide Comparisons – Effectiveness of Care Measures

Plan Name	Advising Smokers and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies	Aspirin Use	Discussing Aspirin Risks and Benefits
Aetna Better Health of Michigan	—	—	—	—+	—+
Blue Cross Complete of Michigan	—	—	—	—+	—
HAP Midwest Health Plan	—+	—+	—+	NA	—+
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.
NA indicates that results for this measure are not displayed because too few members responded to the questions.

The following plans scored statistically significantly *higher* than the MDHHS HMP Program average on at least one measure:

Blue Cross Complete of Michigan

- Rating of Personal Doctor

McLaren Health Plan

- Rating of All Health Care
- Rating of Personal Doctor

Priority Health Choice, Inc.

- Rating of Health Plan

Total Health Care, Inc.

- Rating of All Health Care

Upper Peninsula Health Plan

- Rating of Personal Doctor
- Shared Decision Making

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
- Rating of All Health Care
- Getting Needed Care

HAP Midwest Health Plan

- Rating of Personal Doctor

Harbor Health Plan

- Rating of All Health Care
- Rating of Personal Doctor
- Getting Needed Care
- Shared Decision Making

Meridian Health Plan of Michigan

- Rating of Specialist Seen Most Often

Total Health Care, Inc.

- Shared Decision Making

UnitedHealthcare Community Plan

- Rating of Specialist Seen Most Often

Key Drivers of Satisfaction

HSAG focused the key drivers of satisfaction analysis on three measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. HSAG evaluated each of these measures to determine if particular CAHPS items (i.e., questions) strongly correlated with these measures, which HSAG refers to as "key drivers." These individual survey items 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 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 it was often not easy to obtain appointments with specialists.
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.

2016 CAHPS Performance Measures

The CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set includes 58 core questions that yield 14 measures. These measures include four global rating questions, five composite measures, and five Effectiveness of Care measures. The global measures (also referred to as global ratings) reflect overall satisfaction with 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 and managing aspirin use for the primary prevention of cardiovascular disease.

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	Aspirin Use
	Shared Decision Making	Discussing Aspirin Risks and Benefits

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 June 30, 2016.
- Were currently enrolled in an HMP health plan.
- Had been continuously enrolled in the plan for at least five of the first six months of the measurement year (January 1, 2016 through June 30, 2016).

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.

Survey Protocol

The HMP CAHPS survey process 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. 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. 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, 15, 24, 28, and 35. Eligible members included the entire random 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.

$$\textit{Response Rate} = \frac{\textit{Number of Completed Surveys}}{\textit{Random Sample - Ineligibles}}$$

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 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. Results with fewer than 11 responses are denoted as "Not Applicable." Therefore, caution should be exercised when evaluating measures' results with fewer than 100 responses, which are denoted with a cross (+).

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.[2-2]

Table 2-4 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]

Table 2-4 – Overall Member Satisfaction Ratings Crosswalk

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.55	2.49	2.43	2.37
Rating of All Health Care	2.45	2.42	2.36	2.31
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	2.42	2.37	2.31
Getting Care Quickly	2.49	2.46	2.42	2.36
How Well Doctors Communicate	2.64	2.58	2.54	2.48
Customer Service	2.61	2.58	2.54	2.48

2-2 For detailed information on the derivation of three-point mean scores, please refer to *HEDIS® 2016, Volume 3: Specifications for Survey Measures.*

2-3 National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA; January 21, 2016.

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.

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. Responses of "Sometimes," "Usually," and "Always" were used to determine if the member qualified for inclusion in the numerator. The rates presented do not follow NCQA's methodology of calculating a rolling average using the current and prior year's results. HSAG calculated these rates using one year of data (i.e., baseline year data).

[2-5] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2015.

Aspirin Use and Discussion

HSAG calculated two rates that assess different facets of managing aspirin use for the primary prevention of cardiovascular disease:

- Aspirin Use
- Discussing Aspirin Risks and Benefits

The Aspirin Use measure assesses the percentage of members at risk for cardiovascular disease who are currently taking aspirin. The Discussing Aspirin Risks and Benefits measure assesses the percentage of members who discussed the risks and benefits of using aspirin with a doctor or other health provider. Responses of "Yes" were used to determine if the member qualified for inclusion in the numerator. The rates presented do not follow NCQA's methodology of calculating a rolling average using the current and prior year's results. HSAG calculated these rates using one year of data (i.e., baseline year data).

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. Measures with fewer than 100 responses are denoted with a cross (+). Results with fewer than 11 responses are denoted as "Not Applicable." Caution should be used when evaluating rates derived from fewer than 100 respondents.

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 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.

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 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.

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.

[2-6] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services; 2008.

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 2016 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.

3. Results

Who Responded to the Survey

A total of 13,707 surveys were distributed to adult members. A total of 4,402 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 HMP Program	**13,707**	**4,402**	**381**	**33.03%**
Aetna Better Health of Michigan	1,350	368	28	27.84%
Blue Cross Complete of Michigan	1,350	412	35	31.33%
HAP Midwest Health Plan	207	40	4	19.70%
Harbor Health Plan	1,350	379	48	29.11%
McLaren Health Plan	1,350	494	37	37.62%
Meridian Health Plan of Michigan	1,350	437	40	33.36%
Molina Healthcare of Michigan	1,350	435	44	33.31%
Priority Health Choice, Inc.	1,350	475	28	35.93%
Total Health Care, Inc.	1,350	405	32	30.73%
UnitedHealthcare Community Plan	1,350	422	52	32.51%
Upper Peninsula Health Plan	1,350	535	33	40.62%

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	**8.0%**	**15.0%**	**14.9%**	**30.0%**	**32.1%**
Aetna Better Health of Michigan	10.6%	16.7%	16.7%	30.3%	25.8%
Blue Cross Complete of Michigan	6.0%	14.5%	17.7%	29.9%	31.9%
HAP Midwest Health Plan	7.7%	17.9%	23.1%	20.5%	30.8%
Harbor Health Plan	4.1%	10.6%	13.6%	38.5%	33.3%
McLaren Health Plan	6.9%	15.8%	13.4%	29.2%	34.7%
Meridian Health Plan of Michigan	9.5%	17.1%	13.7%	28.0%	31.7%
Molina Healthcare of Michigan	9.8%	16.6%	16.6%	29.2%	27.8%
Priority Health Choice, Inc.	5.7%	15.3%	14.0%	29.8%	35.1%
Total Health Care, Inc.	6.8%	12.6%	14.6%	33.8%	32.2%
UnitedHealthcare Community Plan	13.5%	15.9%	15.9%	28.3%	26.3%
Upper Peninsula Health Plan	7.2%	14.5%	13.4%	26.4%	38.6%
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	**46.5%**	**53.5%**
Aetna Better Health of Michigan	47.8%	52.2%
Blue Cross Complete of Michigan	54.0%	46.0%
HAP Midwest Health Plan	60.5%	39.5%
Harbor Health Plan	61.4%	38.6%
McLaren Health Plan	45.6%	54.4%
Meridian Health Plan of Michigan	38.9%	61.1%
Molina Healthcare of Michigan	44.4%	55.6%
Priority Health Choice, Inc.	40.9%	59.1%
Total Health Care, Inc.	44.6%	55.4%
UnitedHealthcare Community Plan	45.1%	54.9%
Upper Peninsula Health Plan	44.9%	55.1%
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	**61.8%**	**3.5%**	**24.9%**	**1.9%**	**2.8%**	**5.1%**
Aetna Better Health of Michigan	43.4%	3.1%	47.0%	1.1%	0.6%	4.8%
Blue Cross Complete of Michigan	43.4%	4.5%	38.2%	4.2%	4.5%	5.2%
HAP Midwest Health Plan	79.5%	2.6%	10.3%	0.0%	0.0%	7.7%
Harbor Health Plan	16.6%	2.7%	72.2%	1.6%	1.9%	4.9%
McLaren Health Plan	79.3%	4.5%	7.6%	1.8%	2.1%	4.7%
Meridian Health Plan of Michigan	73.1%	3.5%	14.3%	1.2%	2.8%	5.1%
Molina Healthcare of Michigan	56.6%	4.9%	25.6%	1.2%	5.2%	6.6%
Priority Health Choice, Inc.	81.5%	5.2%	6.0%	1.7%	1.1%	4.5%
Total Health Care, Inc.	46.9%	1.5%	42.0%	1.5%	3.4%	4.6%
UnitedHealthcare Community Plan	60.0%	4.2%	19.6%	4.2%	4.2%	7.8%
Upper Peninsula Health Plan	92.1%	0.9%	0.6%	0.6%	3.0%	2.8%
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	**9.3%**	**24.4%**	**37.8%**	**22.3%**	**6.2%**
Aetna Better Health of Michigan	11.1%	22.2%	33.5%	27.4%	5.8%
Blue Cross Complete of Michigan	12.8%	28.3%	32.5%	22.4%	3.9%
HAP Midwest Health Plan	5.0%	27.5%	42.5%	20.0%	5.0%
Harbor Health Plan	7.0%	21.0%	38.2%	25.8%	8.1%
McLaren Health Plan	8.6%	23.1%	40.6%	21.6%	6.1%
Meridian Health Plan of Michigan	7.4%	24.5%	37.4%	22.2%	8.5%
Molina Healthcare of Michigan	8.6%	24.2%	39.8%	23.0%	4.4%
Priority Health Choice, Inc.	8.1%	27.0%	38.9%	19.3%	6.8%
Total Health Care, Inc.	11.1%	22.2%	34.3%	24.7%	7.6%
UnitedHealthcare Community Plan	11.0%	22.2%	41.4%	19.4%	6.0%
Upper Peninsula Health Plan	8.3%	27.4%	39.4%	19.7%	5.3%
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 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 2016*. Washington, DC: NCQA; January 21, 2016.

[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	★★★ 2.43	★★★ 2.37	★★ 2.49	★★★ 2.52
Aetna Better Health of Michigan	★ 2.27	★ 2.25	★★ 2.43	★★★ 2.53
Blue Cross Complete of Michigan	★★★ 2.44	★★★ 2.41	★★★★ 2.53	★★★★★ 2.62
HAP Midwest Health Plan	★★+ 2.37	★★★★+ 2.43	★+ 2.22	★★★★★+ 2.73
Harbor Health Plan	★★ 2.37	★ 2.21	★ 2.35	★ 2.47
McLaren Health Plan	★★★ 2.48	★★★★★ 2.47	★★★★ 2.56	★★★★★ 2.63
Meridian Health Plan of Michigan	★★ 2.41	★★★ 2.36	★★ 2.43	★ 2.43
Molina Healthcare of Michigan	★★ 2.38	★★★ 2.36	★★ 2.47	★★ 2.50
Priority Health Choice, Inc.	★★★★★ 2.55	★★★★ 2.43	★★★ 2.50	★★★★ 2.58
Total Health Care, Inc.	★★★ 2.46	★★★★ 2.44	★★★★ 2.53	★★★ 2.52
UnitedHealthcare Community Plan	★★★ 2.44	★★ 2.31	★★ 2.46	★ 2.45
Upper Peninsula Health Plan	★★★ 2.46	★★★ 2.37	★★★★ 2.56	★ 2.46

+ 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, Rating of All Health Care, and Rating of Specialist Seen Most Often global ratings. In addition, the MDHHS HMP Program scored at or between the 25th and 49th percentile for the Rating of Personal Doctor global rating. 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	★★★ 2.39	★★ 2.40	★★★★★ 2.66	★★★★ 2.59
Aetna Better Health of Michigan	★ 2.27	★ 2.34	★★★★★ 2.64	★★★★★ 2.66
Blue Cross Complete of Michigan	★★★★★ 2.45	★★★ 2.45	★★★★★ 2.71	★★★★★ 2.68
HAP Midwest Health Plan	★★★★★+ 2.47	★★★+ 2.42	★★★+ 2.56	★★★★★+ 2.79
Harbor Health Plan	★ 2.28	★ 2.29	★★★★★ 2.70	★★★★ 2.58
McLaren Health Plan	★★★★★ 2.48	★★★ 2.43	★★★★★ 2.71	★★★+ 2.54
Meridian Health Plan of Michigan	★★★★ 2.43	★★ 2.41	★★★★ 2.62	★★★★ 2.58
Molina Healthcare of Michigan	★★★ 2.39	★★ 2.41	★★★ 2.57	★★ 2.52
Priority Health Choice, Inc.	★★★★★ 2.46	★★★ 2.42	★★★★★ 2.64	★★★★★ 2.61
Total Health Care, Inc.	★★★★ 2.42	★★★★★ 2.51	★★★★★ 2.72	★★★★ 2.59
UnitedHealthcare Community Plan	★ 2.27	★★ 2.36	★★★★ 2.59	★★ 2.51
Upper Peninsula Health Plan	★★★ 2.41	★★ 2.38	★★★★★ 2.72	★★★★+ 2.58

+ 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, and scored at or between the 75th and 89th percentiles for the Customer Service composite measure. In addition, the MDHHS HMP Program scored at or between the 50th and 74th percentiles for the Getting Needed Care composite measure, and scored at or between the 25th and 49th percentiles for the Getting Care Quickly composite measure. 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. 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: 1) Medical Assistance with Smoking and Tobacco Use Cessation and 2) Aspirin Use and Discussion. 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 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 (+). Results with fewer than 11 responses are denoted as "Not Applicable." 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 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.

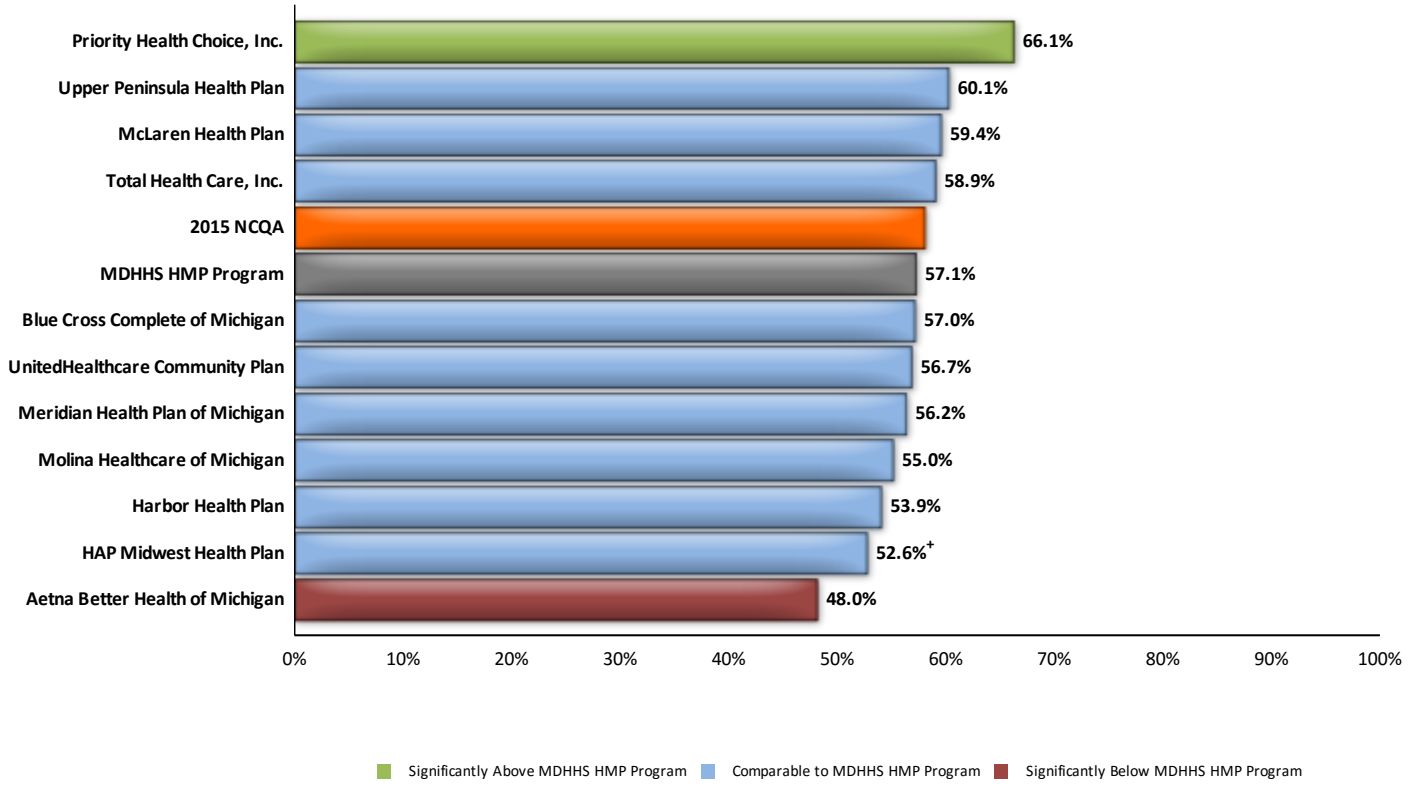
[3-5] The source for the national data contained in this publication is Quality Compass® 2015 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2015 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these 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

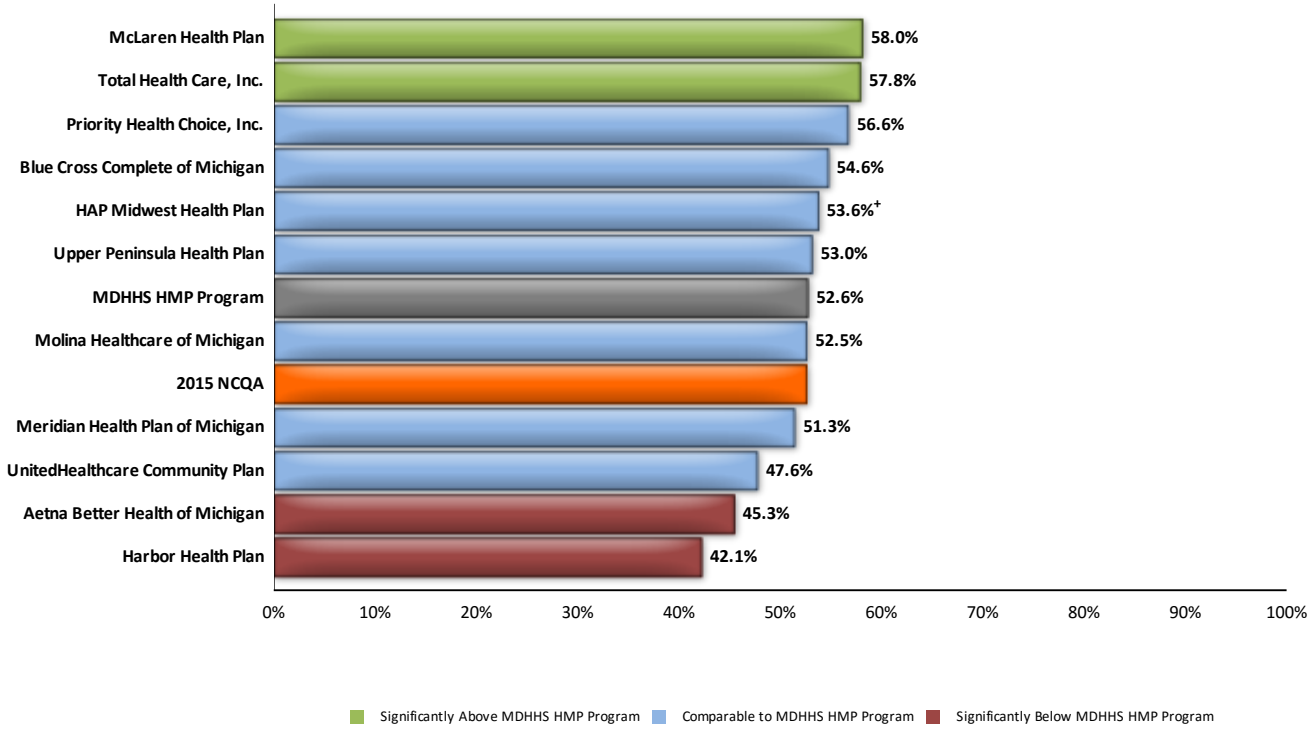


Note: + indicates fewer than 100 responses

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

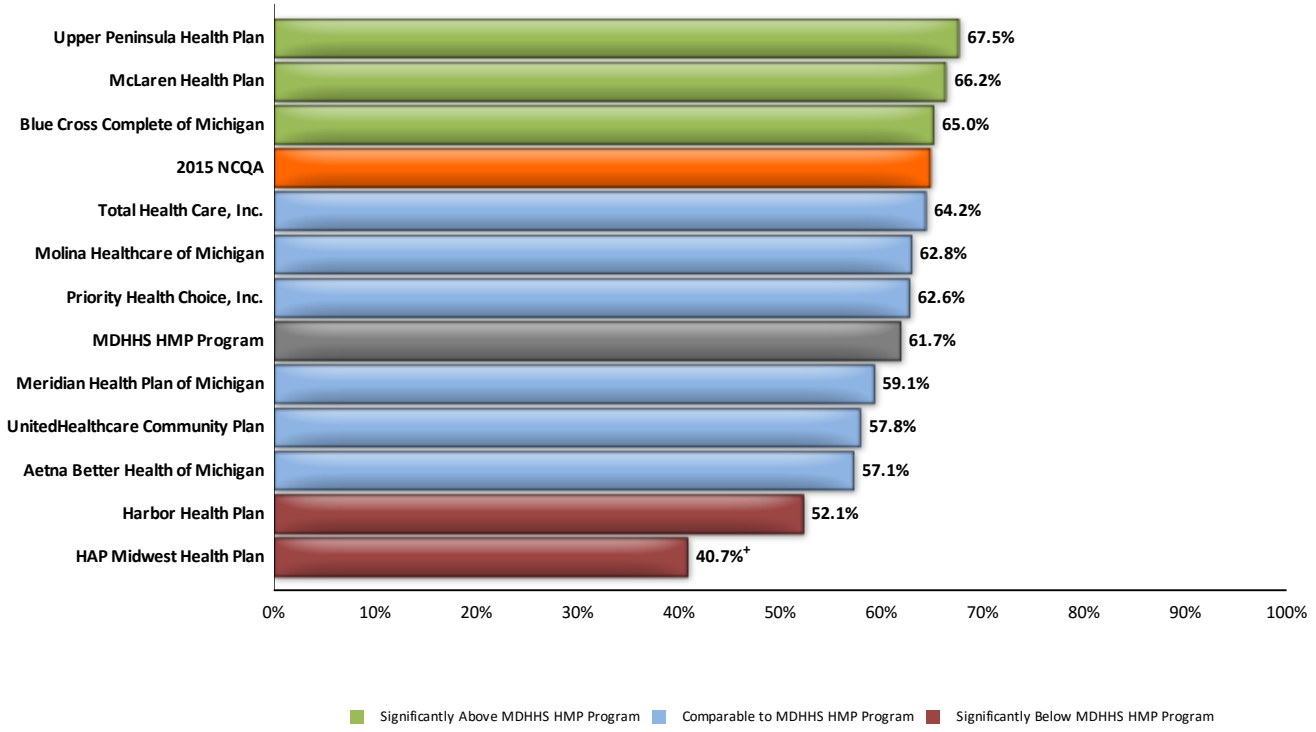


Note: + indicates fewer than 100 responses

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

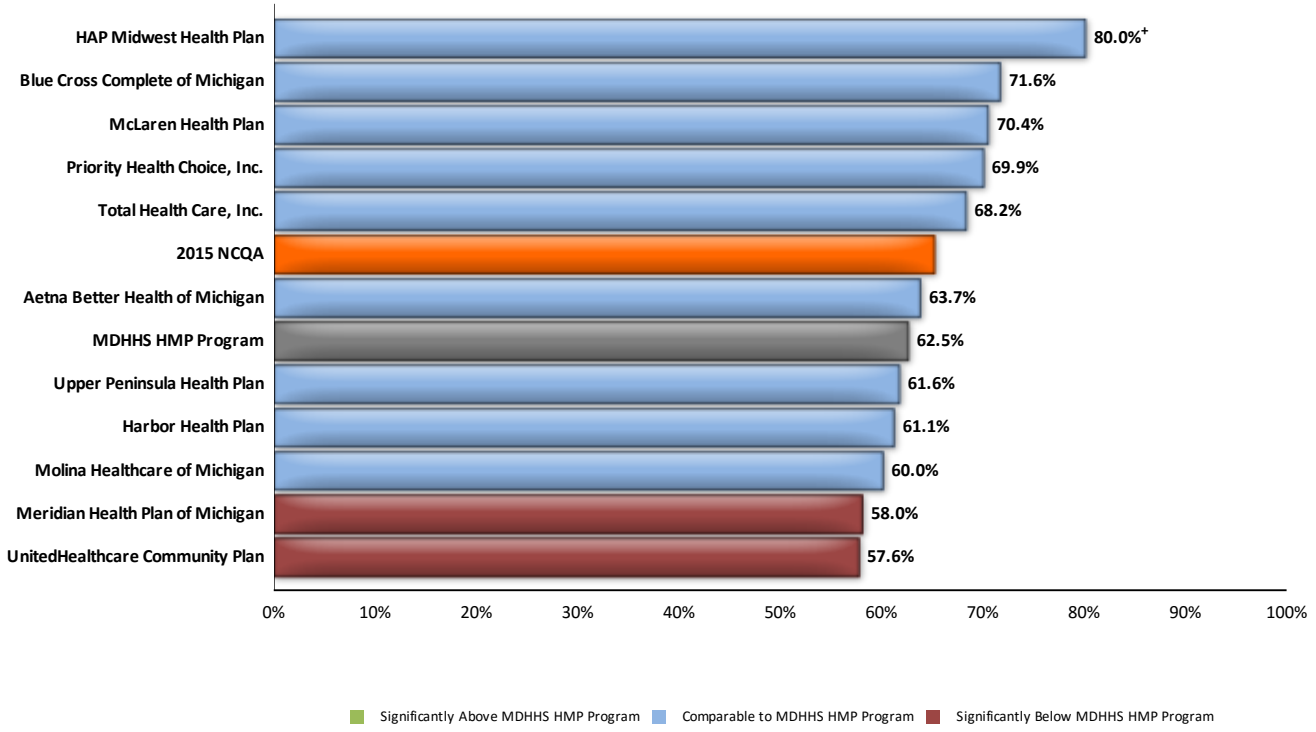


Note: + indicates fewer than 100 responses

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

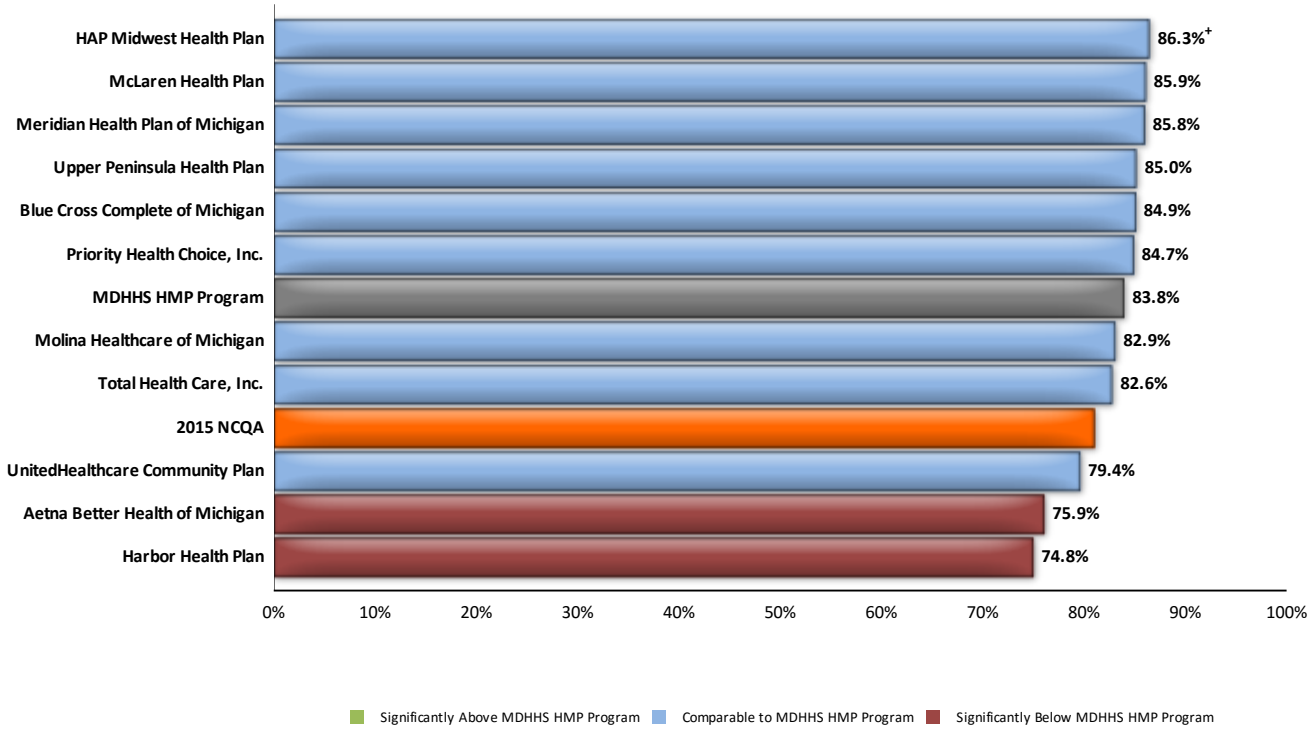
Two questions (Questions 14 and 25 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often it was easy to get needed care:

- **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



Note: + indicates fewer than 100 responses

Getting Care Quickly

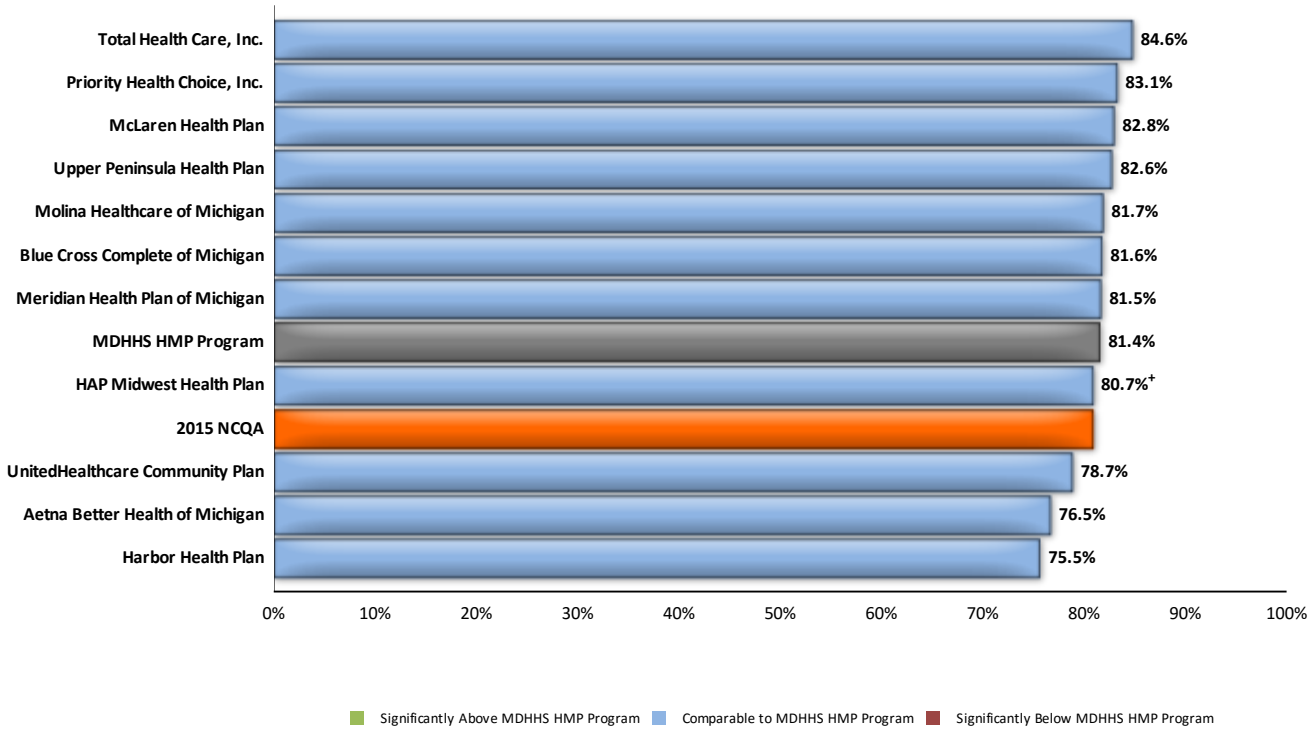
Two questions (Questions 4 and 6 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members received care quickly:

- **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



Note: + indicates fewer than 100 responses

How Well Doctors Communicate

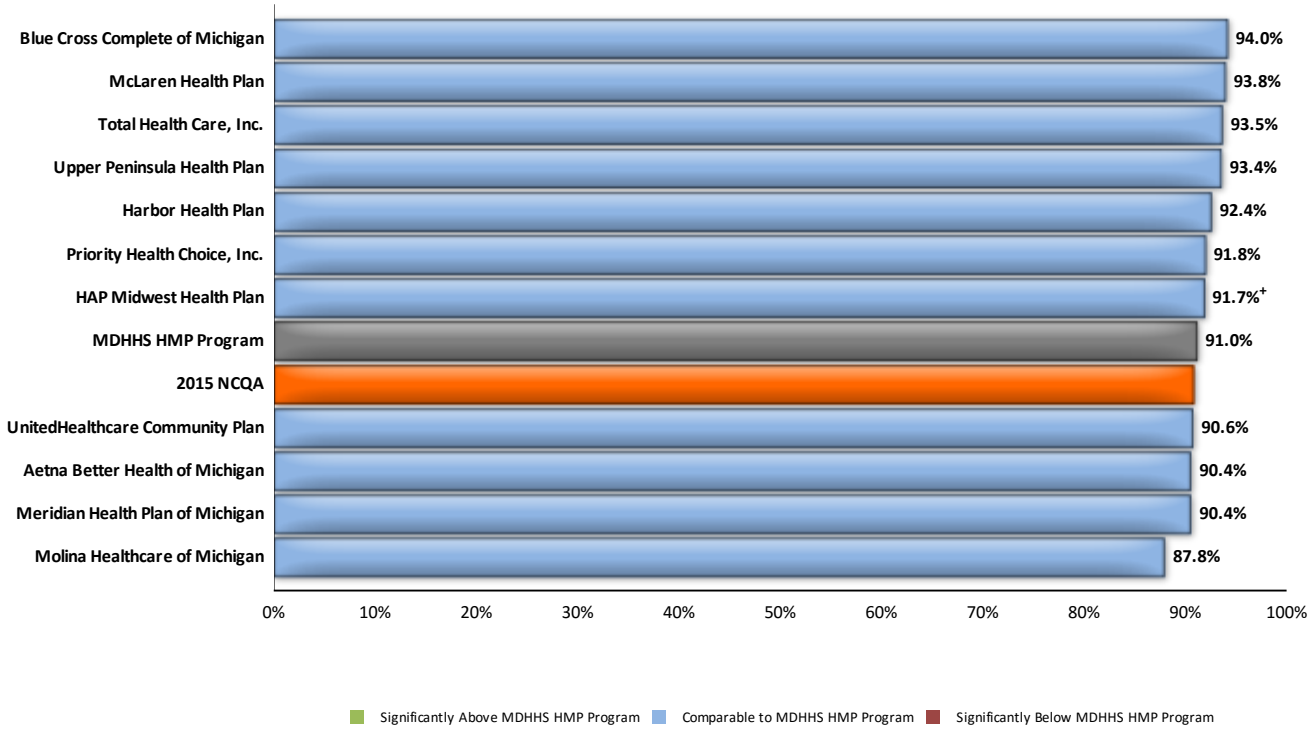
A series of four questions (Questions 17, 18, 19, and 20 in the CAHPS Adult Medicaid Health Plan Survey) was asked to assess how often doctors communicated well:

- **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



Note: + indicates fewer than 100 responses

Customer Service

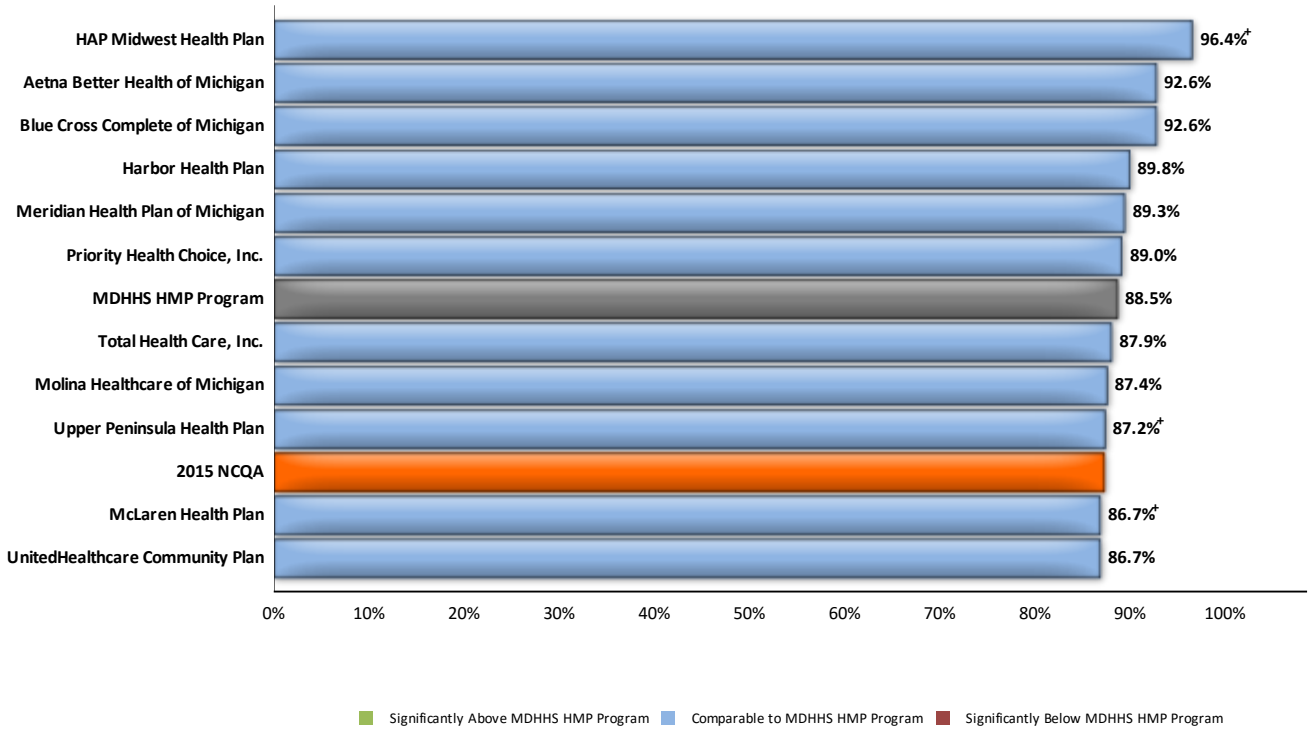
Two questions (Questions 31 and 32 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members were satisfied with customer service:

- **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

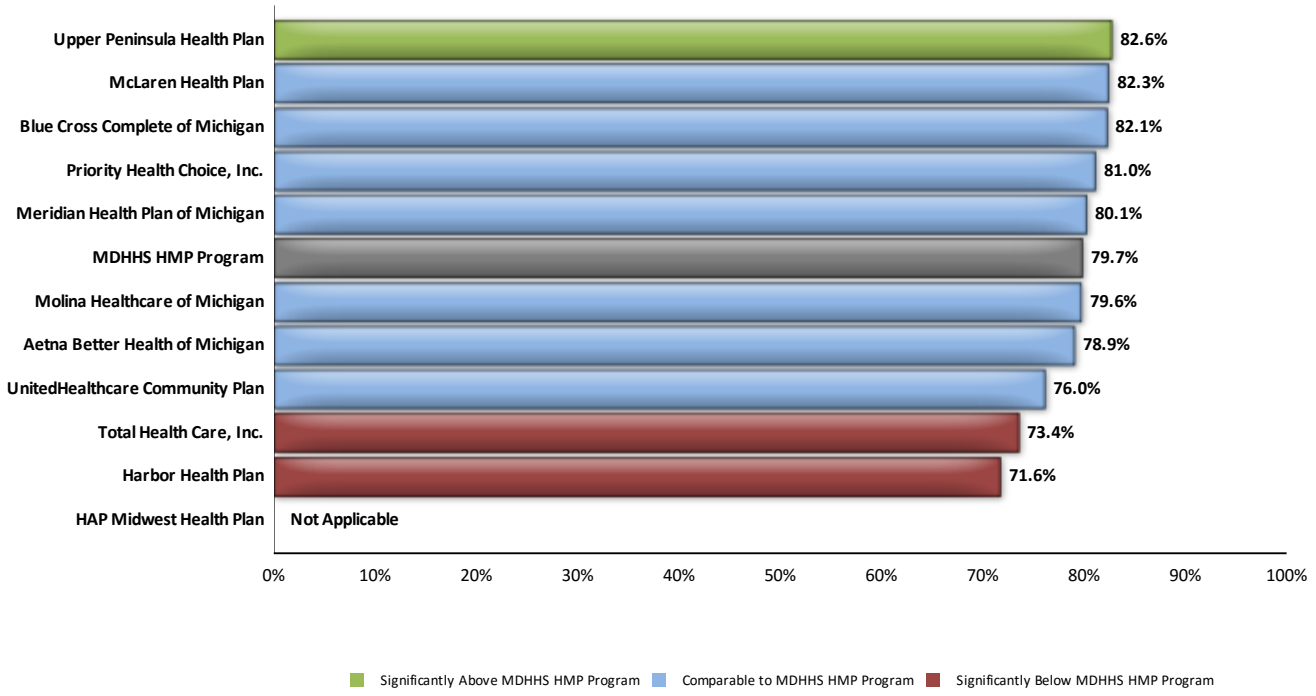
Three questions (Questions 10, 11, and 12 in the CAHPS Adult Medicaid Health Plan Survey) were asked regarding the involvement of adult members in decision making when starting or stopping a prescription medicine:

- **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[3-6]



3-6 In some instances, HMP health plans had fewer than 11 respondents to a survey question. HAP Midwest Health Plan had fewer than 11 respondents to the Shared Decision Making Composite Measure; therefore, a top-box rate could not be presented for this HMP health plan, which is indicated as "Not Applicable" in the figure.

Effectiveness of Care Measures

Medical Assistance with Smoking and Tobacco Use Cessation

Advising Smokers and Tobacco Users to Quit

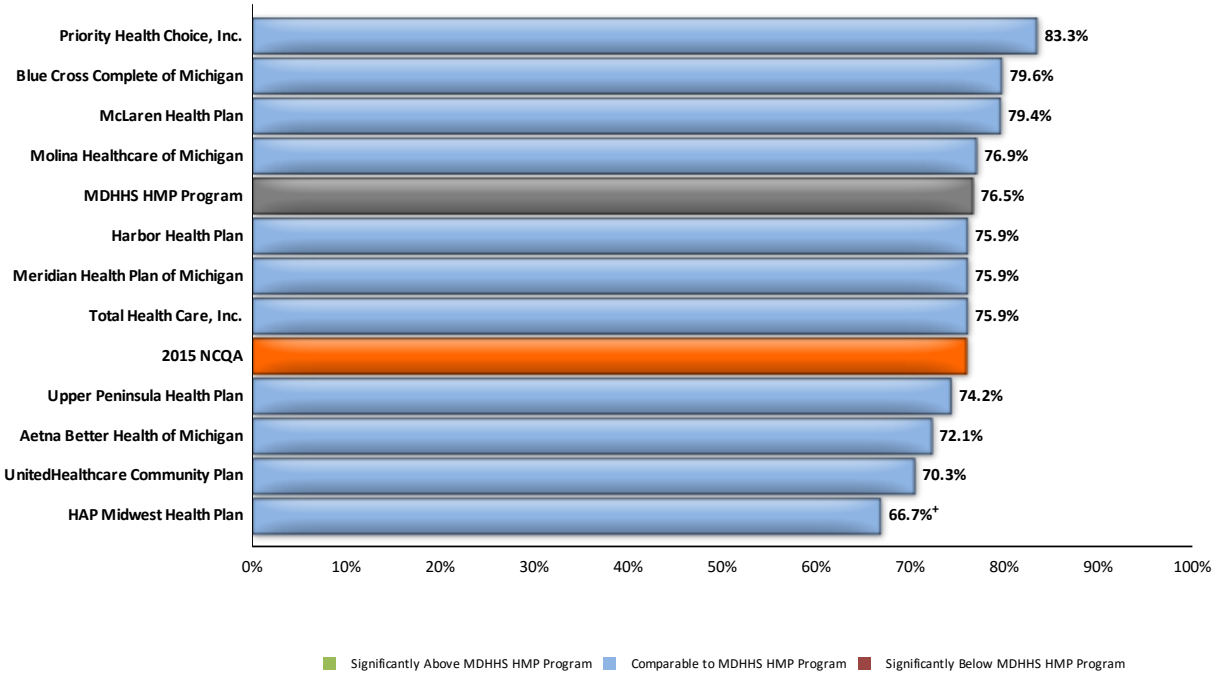
Adult members were asked how often they were advised to quit smoking or using tobacco by a doctor or other health provider (Question 40 in the CAHPS Adult Medicaid Health Plan Survey):

- **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.

Figure 3-10 shows the Advising Smokers and Tobacco Users to Quit rates.

Figure 3-10 – Advising Smokers and Tobacco Users to Quit Top-Box Rates



Note: + indicates fewer than 100 responses

Discussing Cessation Medications

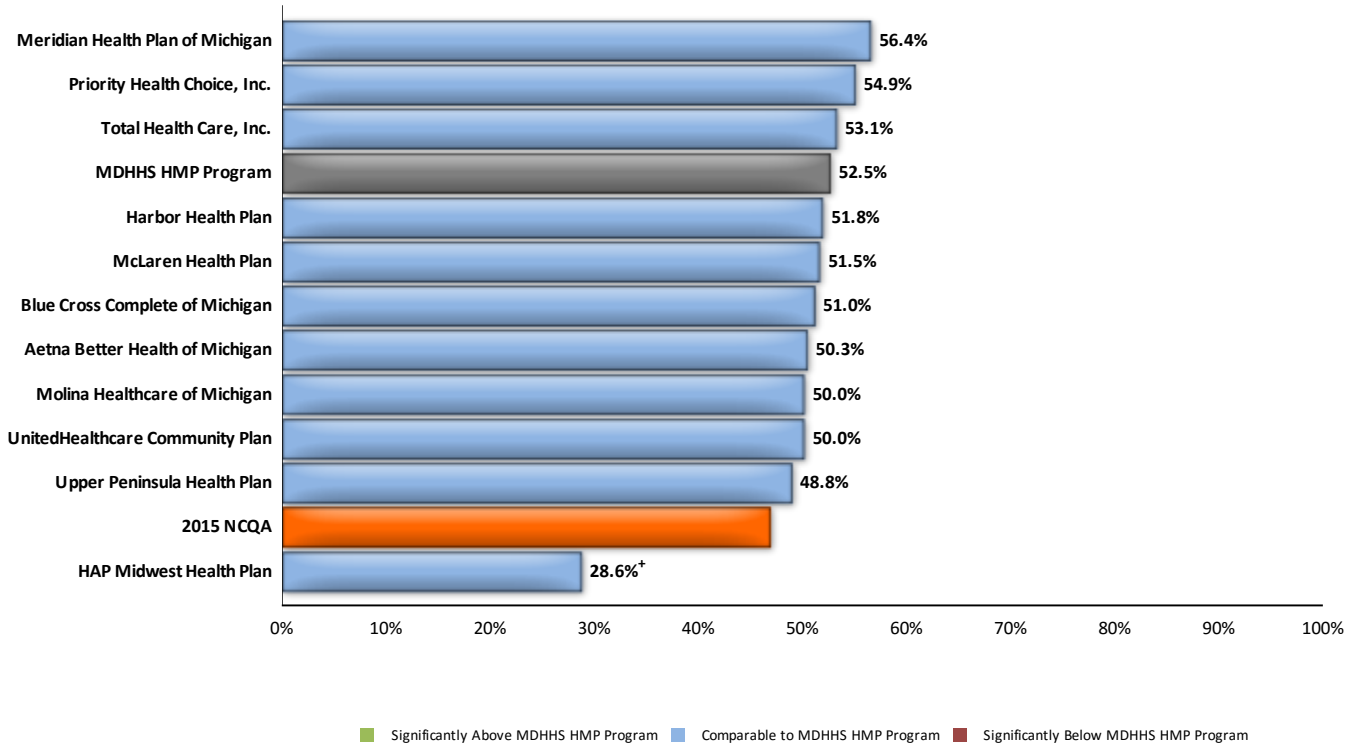
Adult members were asked how often medication was recommended or discussed by a doctor or other health provider to assist them with quitting smoking or using tobacco (Question 41 in the CAHPS Adult Medicaid Health Plan Survey):

- **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.

Figure 3-11 shows the Discussing Cessation Medications rates.

Figure 3-11 – Discussing Cessation Medications Top-Box Rates



Note: + indicates fewer than 100 responses

Discussing Cessation Strategies

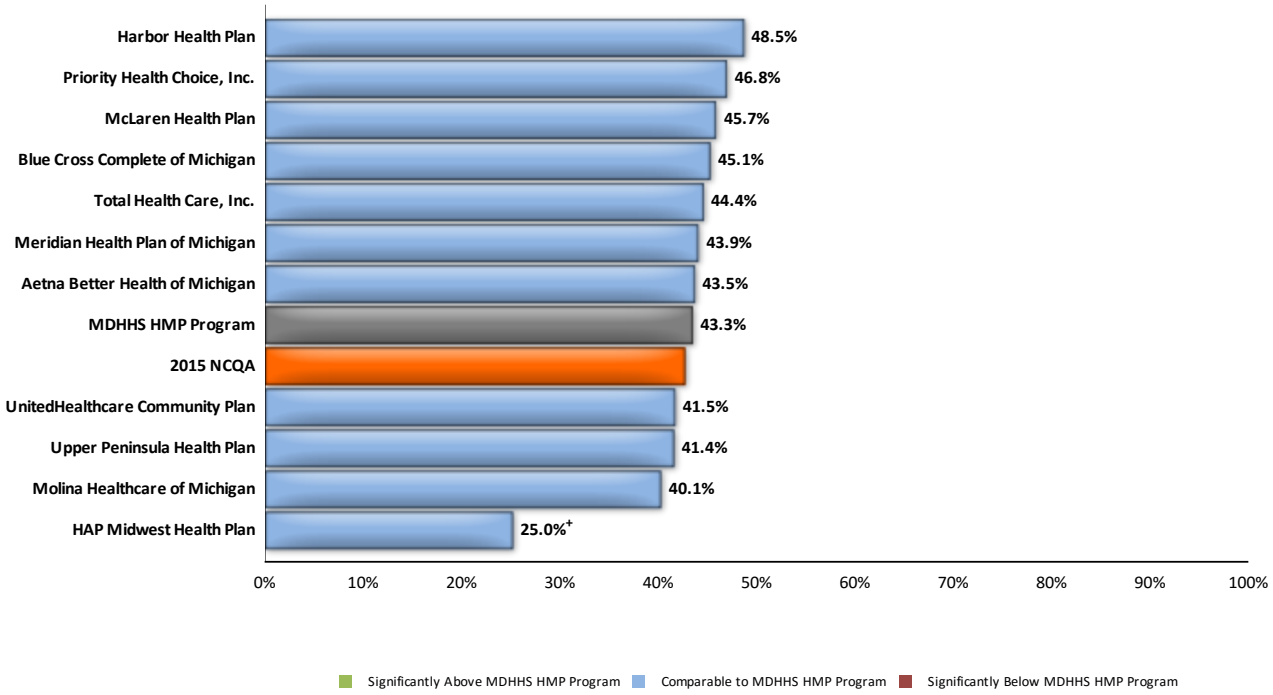
Adult members were asked how often their doctor or health provider discussed or provided methods and strategies other than medication to assist them with quitting smoking or using tobacco (Question 42 in the CAHPS Adult Medicaid Health Plan Survey):

- **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.

Figure 3-12 shows the Discussing Cessation Strategies rates.

Figure 3-12 – Discussing Cessation Strategies Top-Box Rates



Note: + indicates fewer than 100 responses

Aspirin Use and Discussion[3-7]

Aspirin Use

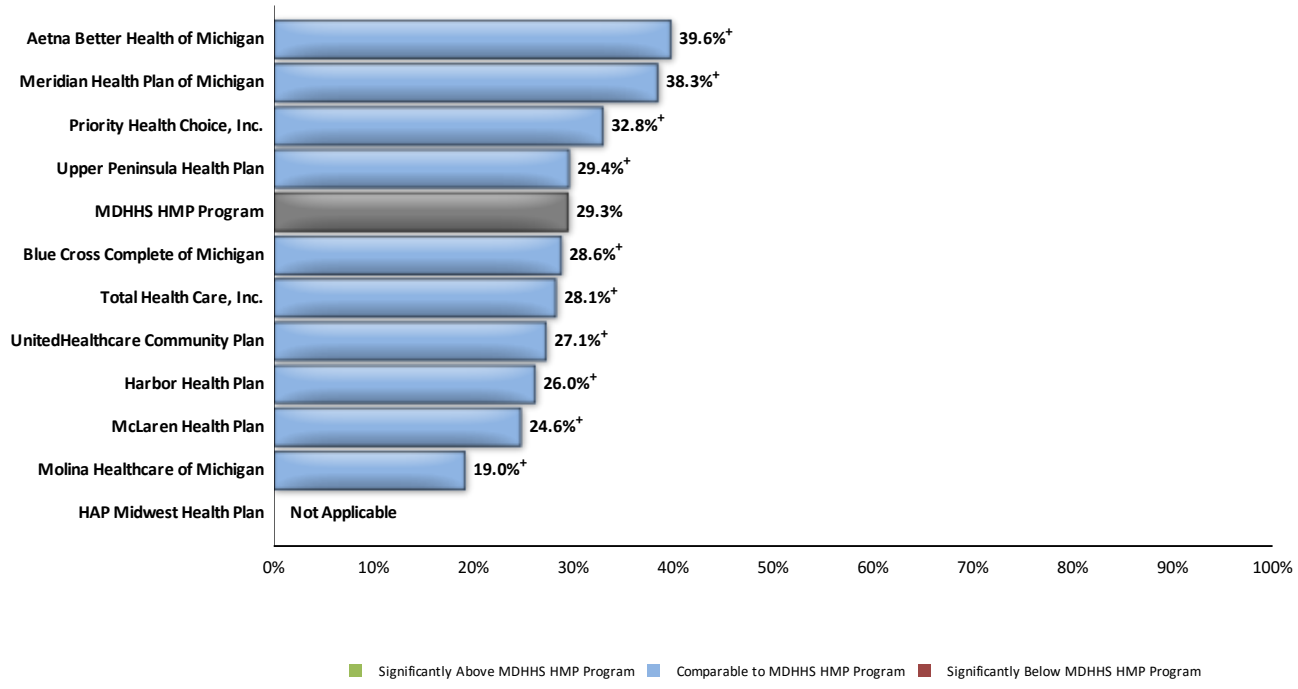
Adult members were asked if they currently take aspirin daily or every other day (Question 43 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 43.** Do you take aspirin daily or every other day?
  - Yes
  - No
  - Don't know

The results of this measure represent the percentage of respondents who answered "Yes" to this question.

Figure 3-13 shows the Aspirin Use rates.

Figure 3-13 – Aspirin Use Top-Box Rates[3-8]



Note: + indicates fewer than 100 responses

3-7 NCQA does not publish national averages for the Aspirin Use and Discussion measures.

3-8 In some instances, HMP health plans had fewer than 11 respondents to a survey question. HAP Midwest Health Plan had fewer than 11 respondents to the Aspirin Use Effectiveness of Care measure; therefore, a top-box rate could not be presented for this HMP health plan, which is indicated as "Not Applicable" in the figure.

Discussing Aspirin Risks and Benefits

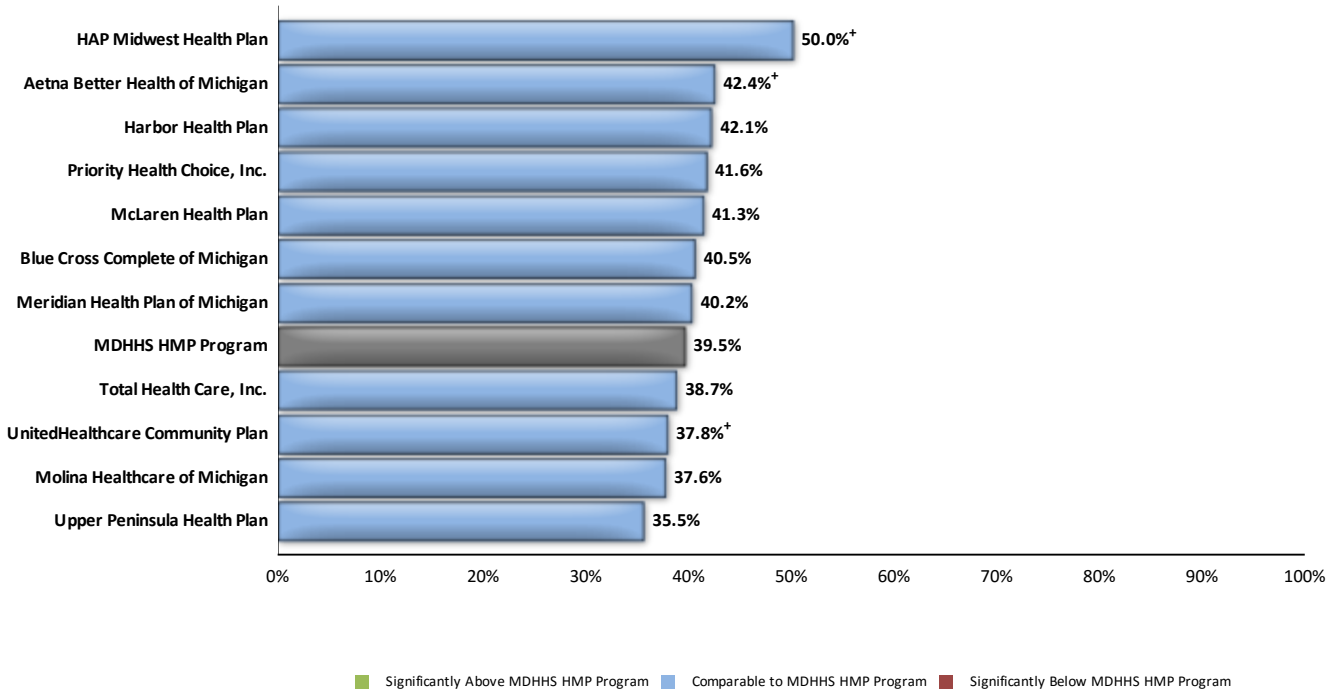
Adult members were asked if a doctor or health provider discussed with them the risks and benefits of aspirin to prevent a heart attack or stroke (Question 45 in the CAHPS Adult Medicaid Health Plan Survey):

- **Question 45**. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?
  - Yes
  - No

The results of this measure represent the percentage of respondents who answered "Yes" to this question.

Figure 3-14 shows the Discussing Aspirin Risks and Benefits rates.

Figure 3-14 – Discussing Aspirin Risks and Benefits Top-Box 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	—+	—+	—+	—+	NA
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.
NA indicates that results for this measure are not displayed because too few members responded to the questions.

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	Aspirin Use	Discussing Aspirin Risks and Benefits
Aetna Better Health of Michigan	—	—	—	—+	—+
Blue Cross Complete of Michigan	—	—	—	—+	—
HAP Midwest Health Plan	—+	—+	—+	NA	—+
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.
NA indicates that results for this measure are not displayed because too few members responded to the questions.

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 4-1 depicts those items identified for each of the three measures as being key drivers of satisfaction for the MDHHS HMP Program.

Table 4-1 – 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 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 it was often not easy to obtain appointments with specialists.
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.

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 <u>completely</u>. Use only <u>black or blue ink</u> or <u>dark pencil</u> to complete the survey.**

Correct Mark ● **Incorrect Marks** 

- **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 5***

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, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- ○ Yes
- ○ No ➔ ***Go to Question 7***

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

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?

- ○ None ➔ ***Go to Question 15***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 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?

- ○ Yes
- ○ No

9. 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 13***

10. Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?

- ○ Yes
- ○ No

11. Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?

- ○ Yes
- ○ 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?

- ○ Yes
- ○ 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?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Worst Health Care Possible										Best Health Care Possible

14. 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

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?

- ○ Yes
- ○ 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?

- ○ None ➔ ***Go to Question 23***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

18. In the last 6 months, how often did your personal doctor listen carefully to you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

19. In the last 6 months, how often did your personal doctor show respect for what you had to say?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

20. In the last 6 months, how often did your personal doctor spend enough time with you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

21. 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 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ 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?

○	○	○	○	○	○	○	○	○	○	○
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.

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?

- ○ Yes
- ○ 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

26. How many specialists have you seen in the last 6 months?

- ○ None ➔ ***Go to Question 28***
- ○ 1 specialist
- ○ 2
- ○ 3
- ○ 4
- ○ 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?

○	○	○	○	○	○	○	○	○	○	○
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.

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?

- ○ Yes
- ○ 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

30. In the last 6 months, did you get information or help from your health plan's customer service?

- ○ Yes
- ○ 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

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

33. In the last 6 months, did your health plan give you any forms to fill out?

- ○ Yes
- ○ No ➔ ***Go to Question 35***

34. In the last 6 months, how often were the forms from your health plan easy to fill out?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ 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?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10

Worst Health Plan Possible — Best Health Plan Possible

ABOUT YOU

36. In general, how would you rate your overall health?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

37. In general, how would you rate your overall <u>mental or emotional</u> health?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

38. Have you had either a flu shot or flu spray in the nose since July 1, 2015?

- ○ Yes
- ○ No
- ○ Don't know

39. 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 43***
- ○ 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ 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.

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ 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.

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

43. Do you take aspirin daily or every other day?

- ○ Yes
- ○ No
- ○ Don't know

44. Do you have a health problem or take medication that makes taking aspirin unsafe for you?

- ○ Yes
- ○ No
- ○ 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?

- ○ Yes
- ○ No

46. 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

47. 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

48. 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 50***

49. Is this a condition or problem that has lasted for at least 3 months? Do <u>not</u> include pregnancy or menopause.

- ○ Yes
- ○ No

50. Do you now need or take medicine prescribed by a doctor? Do <u>not</u> include birth control.

- ○ Yes
- ○ No ➔ ***Go to Question 52***

51. Is this medicine to treat a condition that has lasted for at least 3 months? Do <u>not</u> include pregnancy or menopause.

- ○ Yes
- ○ No

52. 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

53. Are you male or female?

- ○ Male
- ○ Female

54. 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

55. Are you of Hispanic or Latino origin or descent?

- ○ Yes, Hispanic or Latino
- ○ No, Not Hispanic or Latino

56. 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

57. Did someone help you complete this survey?

- ○ Yes ➔ ***Go to Question 58***
- ○ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

58. 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