



# Measuring the Quality

of Medicaid Managed  
Care in South Carolina

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A Report of HEDIS and CAHPS  
Data for Fiscal Year 2009



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Developed by the Health Services Research Team at the  
University of South Carolina, Institute for Families in Society  
under contract to the SC Department of Health and Human Services  
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## **Acknowledgements and Copyrights**

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HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

CAHPS® refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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# Measuring the Quality of Medicaid Managed Care in South Carolina

A Report of HEDIS and CAHPS Data for Fiscal Year 2009

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# Executive Summary

In 2009, managed care plans met or exceeded the HEDIS 50th percentile national benchmark for these measures:

- **Children and Adolescent Access to Primary Care** (12–24 months; 25 months–6 years; 7–11 years; 12–19 years)
- **Appropriate Treatment for Children With Upper Respiratory Infection** (5–9 years; 10–17 years)
- **Use of Appropriate Drugs for Children With Asthma** (5–9 years; 10–17 years)
- **Annual Dental Visits** (2–3 years; 4–6 years; 7–10 years; 11–14 years 15–18 years)
- **Well-Child Visits in the First 15 Months** (1–5 visits)
- **Adult Access to Preventive/ Ambulatory Health Services** (Ages 20–44 years)
- **Diabetes Care: Annual Eye Exam**
- **Diabetes Care: Urine Screening for Microalbumin or Medical Attention to Nephropathy**
- **Mental Health Follow-Up After Hospitalization** (Within 7 days and Within 30 days)

In 2009, the majority of consumers were very satisfied with managed care.

- Consumer satisfaction with their child's doctors exceeded national benchmarks.
- Eight out of ten consumers rate their personal doctors or specialists 8 or higher on a scale of 0-10.
- Seven out of ten consumers rate their overall health care and health plan 8 or higher on a scale of 0-10.

## Introduction

Improving Medicaid health care in South Carolina requires having accurate, complete, and up-to-date information about the care being provided and its results on ensuring the health of recipients. As a means of obtaining this information, the South Carolina Department of Health and Human Services contracts with the Institute for Families in Society (IFS) at the University of South Carolina to evaluate the Healthcare Effectiveness Data and Information Set (HEDIS) results objectively for Medicaid recipients. In conducting this evaluation, two important data sources that IFS analyzes are the numbers and types of health care services that are provided and what consumers themselves say about their care. These sources show that, overall in fiscal year 2009, South Carolinians received high quality care through Medicaid managed care plans and that they were generally very satisfied with the delivery and quality of that care. IFS has examined the key measures along four dimensions of care: 1) Staying Healthy, 2) Getting Better, 3) Living with Illness, and 4) Satisfaction with Care. This approach to the analysis is designed to encourage consideration of similar measures as a category rather than in isolation, allowing for an exploration of approaches to improve overall performance.

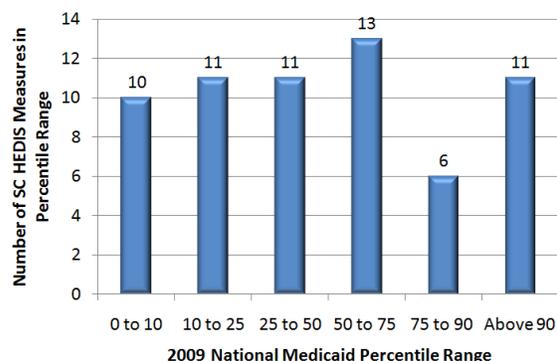
This report analyzes South Carolina Medicaid HEDIS results in several ways. For each of the dimensions of care:

- HEDIS 2009 definitions were applied to each measurement year, allowing for an objective comparison across multiple years.
- A comparison presents the results between managed care and fee-for-service plans relative to the National HEDIS 2009 Medicaid 50th percentiles.
- A performance profile indicates the salient issues associated with each measure with areas for consideration to improve performance.
- A map shows the distribution of the rates by county for each measure providing an opportunity to evaluate the potential impact of population distribution on the overall rate.

## Key Findings

This is the fourth year that IFS has examined the HEDIS and consumer satisfaction results documenting continued improvements across all dimensions of care. Figure 1 shows the 2009 South Carolina Medicaid performance compared with national Medicaid percentiles. The columns represent the number of South Carolina measures falling into the percentile grouping listed on the horizontal axis. Of the 87 measure rates (with age breakdowns), 25 did not have a national benchmark rate. Due to the lack of coding availability, these 25 measures were calculated using modified HEDIS definitions. Of the 62 measures for which national percentile data were available using HEDIS definitions, 10 (or 16.13%) fell below 10%, 11 (or 17.74%) fell between the 10th and 25th percentiles, 11 (or 17.74%) fell between the 25th and 50th percentiles, 13 (or 20.97%) fell between the 50th and 75th percentiles, 6 (or 9.68%) fell between the 75th and 90th percentiles, and 11 (or 17.74%) fell above the 90th percentile. A total of 30 of the 62 rates (or 48%) were at or above the median or 50th percentile of the Medicaid national benchmark. In the first two years of HEDIS measures (2006 and 2007),

**Figure 1 – South Carolina Medicaid HEDIS 2009: Managed Care Plan Performance Compared with National Medicaid Percentiles**



75% of the measure rates were at or below the median or 50th percentile of the Medicaid national benchmark. This trend to measures that are at or above the Medicaid national benchmark is indicative of the emphasis on increased quality and access to care across the different dimensions of care supported by improved claims data documentation and reporting. Although the rates for the individual plans may vary slightly from the statewide aggregate data in this report, the positive upward trend associated with increased access to care and quality outcomes is indisputable.

### **Quality Indicators**

HEDIS is used by more than 90% of America's health plans to measure performance by looking at the total numbers and types of health care services provided to consumers. The 2009 HEDIS measures for South Carolina showed that, on the whole, people in Medicaid managed care received care that was better than or equal to the care delivered in a fee-for-service arrangement.

In 2009, children whose care was provided through Medicaid managed care plans:

- were more likely than those not in a managed care plan to have had at least one yearly dental visit;
- were more likely to have had a well-child visit during the year;
- received appropriate antibiotic treatment for upper respiratory infections at high rates; and
- typically had at least one prescription medication for persistent asthma.

The 2009 HEDIS data also showed that, compared to those receiving fee-for-service care, adults in Medicaid managed care plans:

- were more likely to have a prenatal care visit and more likely to have a postnatal care visit;
- were more likely to have had at least one medication for persistent asthma;
- were more likely to have received follow-up care after being hospitalized for a mental illness;
- received screening for breast cancer at higher rates; and
- had their diabetes monitored at higher rates through urine screenings, dilated eye exams, and blood work.

### **Consumer Experiences**

To find out what consumers think about their health care providers and the quality of care they or their child receives, South Carolina uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. This survey is the national standard for measuring and reporting the experiences of consumers with their health plans. The survey asks health care consumers questions about the care they received, how well they felt they were treated, and how quickly they were seen. Overall, the 2009 CAHPS® survey results showed high levels of satisfaction among the survey respondents.

- About 8 out of every 10 people asked gave high ratings to their personal doctor or nurse, as well as their specialists, while 7 out of every 10 gave high ratings to their health care and health plan overall.
- Although still positive, survey respondents rated their overall health care and health plan lower than they rate their medical providers, which is consistent with national ratings.
- In general, parents rated their experiences with care for their children more positively than adults rated their own care.
- Consumer experiences with their child's doctors exceeded national benchmarks – 93% said that their child's doctor usually or always listened carefully to them, explained things in an understandable way, and spent enough time with them.
- Seventy-seven percent of adult respondents and 82% of children's respondents said that they always or usually received care without long waits, got appointments for routine care as soon as they wanted, and got care for illness or injury as soon as they needed.

# How to Get The Most Out of This Report

## Interpreting and Using the Results in This Report

The primary goal of HEDIS (Healthcare Effectiveness Data and Information Set) is to provide standardized objective measures of the quality of care and services provided to managed care enrollees. These measures can alert the state and providers to areas needing additional attention. For example, an MCO that, according to HEDIS information, is providing fewer childhood immunizations than other MCOs, might analyze its provider network, its policies and its procedures and, based on what it finds, implement a new approach to address the problem. HEDIS information can also affect how the state chooses to purchase services for its public programs. The state may provide incentive opportunities, both financial and non-financial, to encourage MCOs to improve performance on particular HEDIS measures.

As expected, HEDIS results can differ among health plans and across measures for the same health plan. In interpreting the results, the reader should note:

- **How accurate the results are**

To prevent ambiguity, this report uses a standardized methodology requiring the rate to be at or above the NCQA approved threshold level with a sampling error of  $\pm 5\%$  at a 95% confidence level. Each measure is highlighted with an error bar indicating the acceptable range for each measure. For internal purposes, health plans should understand and consider the issue of standard error when implementing interventions.

- **How South Carolina Medicaid HEDIS rates compare to national percentiles**

For each measure, the reported rate is contrasted with the national HEDIS Medicaid 50th percentile. When a measure either does not meet, or it exceeds the 50th percentile, a notation is added indicating the status of the measure relative to the national benchmarks at the 10th or 90th percentile.

- **How South Carolina plans are performing overall**

For each measure, rates are provided for subsequent years using the most current definition allowing for standardization of definitions. This approach ensures an accurate interpretation of trend data across multiple years.

## Interpreting Multi-Year Trends and Aggregate Data

Recalling that one of the major uses of HEDIS data is quality improvement, monitoring a measure's trend over several years can reveal progress toward performance standards or targets. Sometimes the degree of progress can be more important than the status of a measure at a single point in time. Another reason for including multi-year analysis is that it can reveal single-point-in-time aberrations. Rates sharply different from preceding or subsequent years may be erroneously reported or reflect individual and not summary or aggregate data. As an example, the maps related to each of the measures can show variability between counties that significantly modifies the reported rates of an individual plan that also has a presence in counties with lower rates.

When comparing multi-year performance, caution is necessary as the definitions of measures may change in subtle or in major ways from year to year, even though the measures may go by the same name. In some cases, specific procedure codes have been added to, or dropped from, the set of codes specified for a measure. A change in the method of data collection (from administrative to medical records, for instance) can also complicate the trend analyses. The multi-year HEDIS data in this report are carefully selected measures, those with consistency in definition over time. No steady downward trends are evident in the multi-year graphs. Neither are there any recent sharp declines for the managed care population. Declines for some of the measures in the fee-for-

service population may be explained by the rapid increase of enrollment with managed care plans and the corresponding reduction of fee-for-service plan participation. Differences between the managed care and fee-for-service populations can also be a function of different emphases on prevention, disease management, and care coordination activities of the programs. Managed care providers are required to provide, and are monitored for, adherence to these activities.

### Calculation Method

This report uses administrative data (claims and encounters) to identify the eligible population for each HEDIS measure. Medical records are not used to identify the population, thereby prohibiting a sampling of individuals who have received the service. The administrative method is cost-efficient while allowing for comparisons between the managed care and fee-for-service populations. However, the administrative method can produce lower rates due to incomplete data submission by capitated providers or the test results.

### Data Limitations

There are important features to be noted in reading and interpreting the results. First, shortened descriptions are provided for each measure. Second, error bar charts are added to each measure. An error bar chart is a graphic way of summarizing the average scores of patients across health care plans. Along with the average, shown as a colored symbol, the plots show an error bar which is shown as a “T” and an upside-down “T” on top of the symbol. This is used to show the acceptable “range of difference” results between different reports for the same measure.

Why would there be a difference? If we draw another random sample of patients of the same kind (from the same population), it is 95% likely that the mean for the new sample will fall in the area bounded by the two error bars (“T” characters). If the means and the error regions for the two groups overlap, then the results for the groups are probably not significantly different from one another in a statistical sense. Results from additional samples will tend to show that the groups are not distinguishable from one another. In other words, you can have two HEDIS rates that fall between the two error bars (“T” characters) for a health plan and not be different from one another. For some measures, there appear to be considerable degrees of variability. This can be the result of county or geographic differences, or the length of time the health plan has been operational in South Carolina. As such, finding differences across health plans and between aggregate data and individual plans is to be expected.

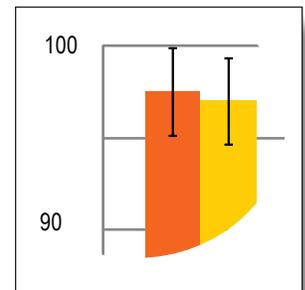


Chart with error bar

### Caveats

- Data for fiscal year 2009 consist of claims adjudicated through September 2009.
- Asthma measures were not compiled for fiscal year 2006 due to the low number of recipients with persistent asthma in managed care.
- The rates are subject to variability due to lack of data associated with NCQA guidelines for exclusions. As an example, women who have undergone a hysterectomy are typically excluded from cervical cancer screenings. This omission holds true for both managed care and fee-for-service measures.
- Medical assistance with smoking cessation and annual flu shots are new measures compiled only for fiscal year 2009.
- The maps are limited to depicting HEDIS rates only for managed care recipients residing in those counties.

# HEDIS

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures for managed care organizations. HEDIS is maintained by the National Committee for Quality Assurance, a not-for-profit organization committed to evaluating and publicly reporting on the quality of managed care organizations. HEDIS measures look at how many of a health plan's enrollees are receiving care that meets national standards. Many of the measures focus on preventive care, such as childhood vaccinations and mammograms. Other measures look at specific care for chronic illnesses, such as asthma or diabetes.

## How HEDIS Information Is Used

Those who might find this document useful include legislators, managers and regulators of state-funded health care programs, health care consumers, and others concerned about the quality of health care provided to enrollees of South Carolina's publicly funded programs.

If a large percentage of patients are not receiving a treatment or preventive service that national guidelines call for, this tells us—medical professionals, providers, and the general public—that something needs to change. This may mean:

- changing the way care is delivered by establishing or refining processes so that critical steps are not missed,
- helping health care providers stay current on the latest guidelines,
- educating South Carolinians about the importance of preventive health care,
- improving access to health care providers in medically underserved areas, and/or
- helping doctors and patients communicate effectively.



# Staying Healthy

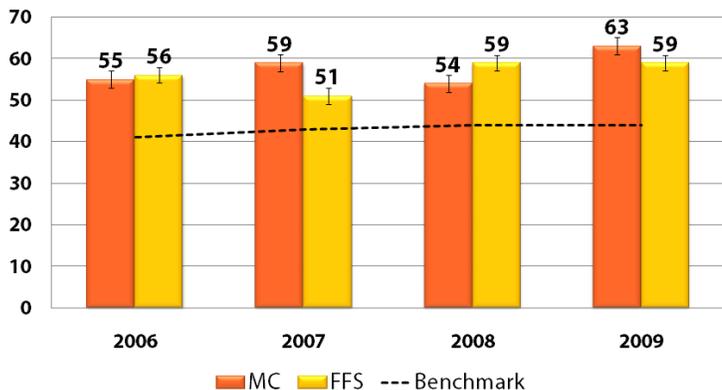


	DESCRIPTION
*	# SURG.PATH. LEVEL
*	# PAP TEST, THIN LA
*	PAID/PREV BILLED C



## Annual Dental Visits

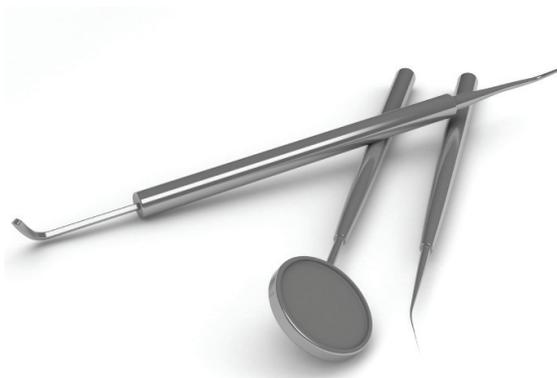
Children in managed care were more likely to have at least one yearly dental visit.



Regardless of the plan type, the rate of children with an annual dental visit exceeded the national benchmark for four consecutive years.

### Who was included and what was measured?

This measure included young people ages 2 through 21 who were enrolled at least 11 months of the measurement year. The percentage shows how many had at least one dental visit during the measurement year.



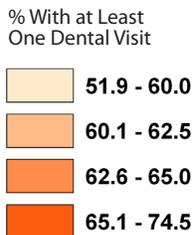
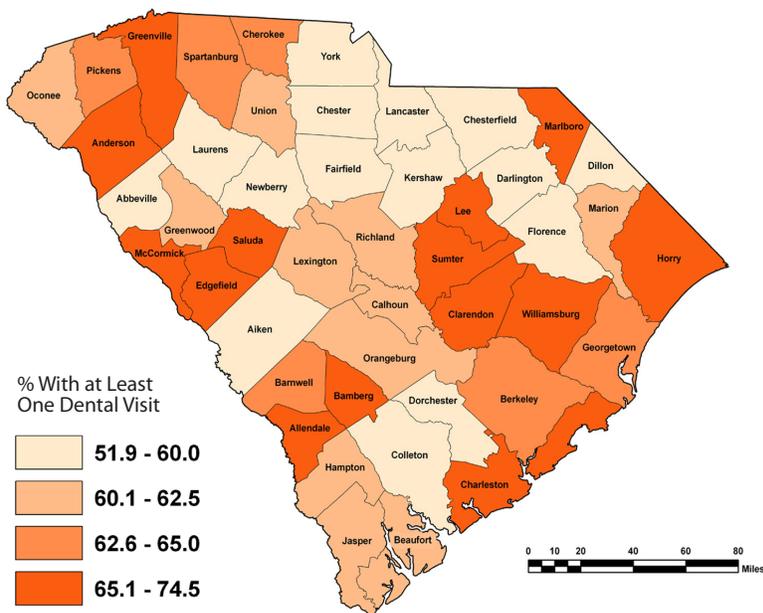
## Background Information

Leading health experts stress that oral health is integral to general health and well-being. Poor oral health and untreated oral conditions not only can result in irreversible dental decay, but also are associated with many diseases and conditions such as diabetes. The South Carolina Medicaid Program exceeds the national benchmark for this measure.

Source:

MayoClinic.com. (2007, February). *Oral health: A window to your overall health*. Available at <http://www.mayoclinic.com/health/dental/DE00001>

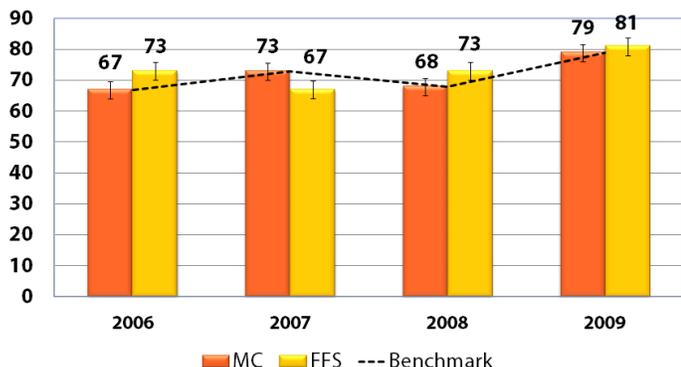
## Percentage of Young People Ages 2 to 21 With at Least One Dental Visit



Source: SC Medicaid Information System, FY 2009  
 Created by the University of South Carolina, Institute for Families in Society, December 2009

## Child and Adolescent Access to Primary Care - Ages 1 to 19 Years

Regardless of the age group, child and adolescent access to primary care exceeded the national benchmark for four consecutive years.



Note: In 2009, there is not a statistical difference between child and adolescent access to primary care by plan type.

### Who was included and what was measured?

This measure included the percentage of members 12 months to 19 years of age who had a visit with a primary care practitioner. This measure is used to assess the percentage of members 12 months through 24 months, 25 months through 6 years, 7 years through 11 years and 12 years through 19 years of age who had a visit with a primary care practitioner. The organization reports four separate percentages for each product line:

- Children 12 months through 24 months and 25 months through 6 years who had a visit with a primary care practitioner during the measurement year.
- Children 7 years through 11 years and adolescents 12 years through 19 years who had a visit with a primary care practitioner during the measurement year or the year prior to the measurement year.



## Background Information

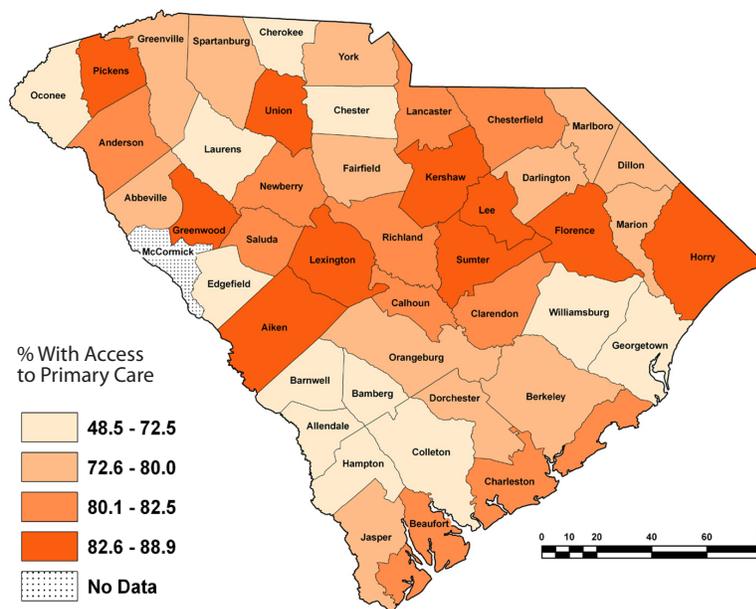
Access to primary care has been shown to correlate with reduced hospital use while preserving quality (IOM, 1996; Bingham, Quinn, Richardson, Miles, & Gabbe, 2005); Bodenheimer, 2008). This measure does not explicitly measure a member's access to primary care. However, studies show that inappropriate care and overuse of new technologies can be reduced through shared decision-making between well-informed physicians and patients.

Physicians have a central role to play in fostering these quality-enhancing strategies that can help to slow the growth of health care expenditures (Bodenheimer, 2008). Encouraging and making available access to primary care services is one potential strategy to lower hospital utilization while maintaining the quality of care delivered (IOM, 1996). Studies show that access to primary care is correlated with reduced hospital use while preserving quality (Bodenheimer, 2008; Bingham et al., 2005).

Sources:

1. Bingham, J., Quinn, D., Richardson, M., Miles, P., & Gabbe, S. Using a healthcare matrix to assess patient care in terms of aims for improvement and core competencies. *Joint Commission Journal on Quality and Patient Safety*, 31(2), 98-105.
2. Bodenheimer, T. (2008). Coordinating care—A perilous journey through the health care system. *New England Journal of Medicine*, 358(10), 1064-1071.
3. Institute of Medicine. (1996). *Primary Care: America's health in a new era*. Washington, DC: National Academy Press.

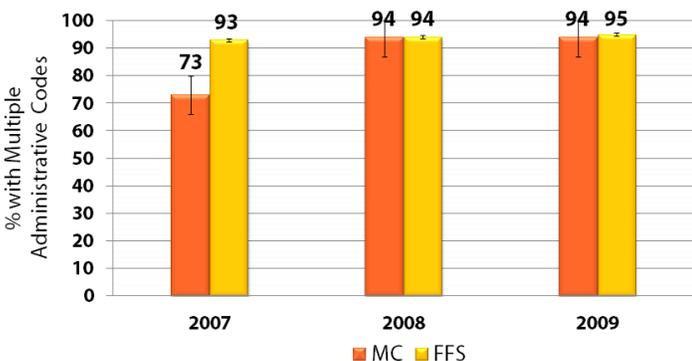
## Percentage of Children and Adolescents Ages 1 to 19 Years With Access to Primary Care



Source: SC Medicaid Information System, FY 2009  
Created by the University of South Carolina, Institute for Families in Society, December 2009

# Childhood Immunizations

Over 90% of children in the SC Medicaid Program had more than one vaccination by their second birthday.



Note:  
There is not a statistical difference between the managed care and fee-for-service rates.  
2007 MC data reflects lower numbers of encounter data with administrative codes.

Who was included and what was measured?

### Modified HEDIS Definition

This measure included children with more than one vaccination administration code by their second birthday.



## Background Information

### Five ways to improve reporting of immunizations:

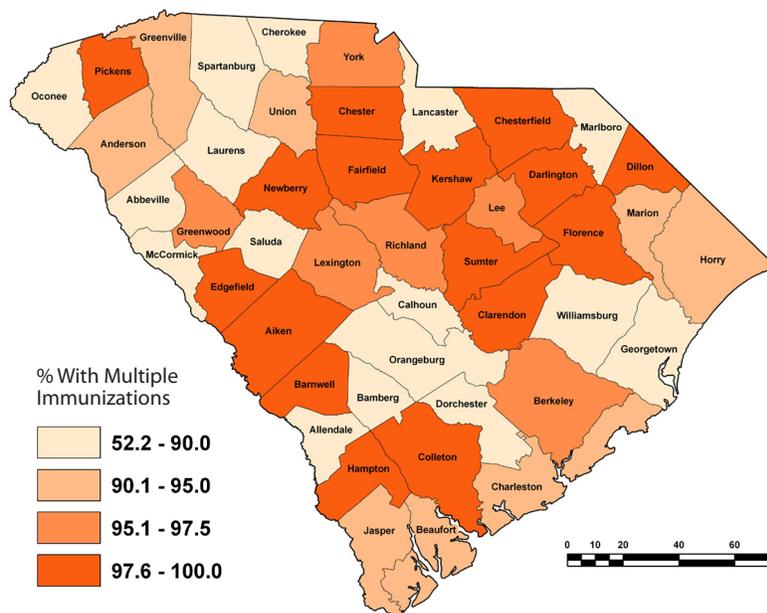
- Implement parent and provider reminder or recall systems.
- Educate targeted parents and providers.
- Reduce out-of-pocket costs for vaccines.
- Expand access to immunizations through increased clinic hours and other measures.
- Give feedback to providers.

CDC has found that interventions that did not measurably increase immunization rates include general provider education, having families keep medical records, school and child care interventions (not including school immunization requirements), and “standing orders” for childhood vaccinations.

### Source:

US Centers for Disease Control and Prevention. (1999). *Vaccine-preventable diseases: Improving vaccination coverage in children, adolescents, and adults. Morbidity and Mortality Weekly Report*, 48 (No. RR-8), 1-16. Available at <http://www.cdc.gov/mmwr/pdf/rr/rr4808.pdf>

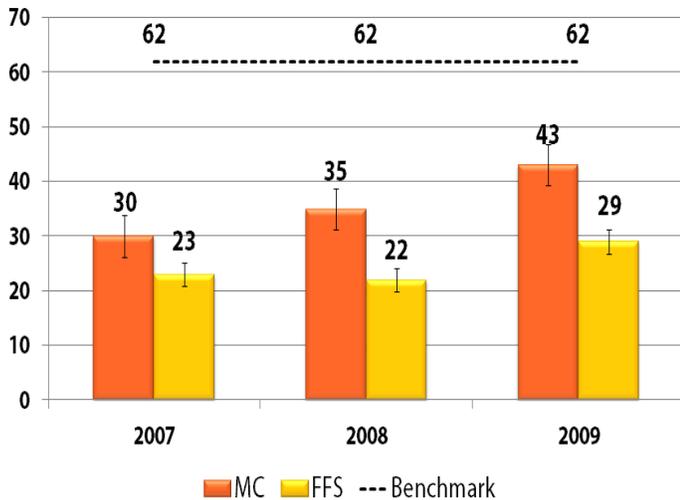
## Percentage of Children With Multiple Immunizations By the Age of Two Years



Source: SC Medicaid Information System, FY 2009  
Created by the University of South Carolina, Institute for Families in Society, December 2009

## Lead Screening in Children

Children in managed care were screened for lead at rates equal to or better than those in fee-for-service.



### Background Information

The measure requires a window of three years of claims/encounter data to retrieve the two-year history, depending on when the recipient turns two years old during the measurement year. Research studies have found that children eligible for Medicaid were at increased risk for lead exposure and that children living in poverty had higher levels of lead exposure than those who were not living in poverty. This finding forms the basis for the current national Medicaid policy, which targets Medicaid eligible children for preventive and screening measures, including routine blood lead testing. The HEDIS performance measure for lead screening among Medicaid eligible children provides baseline data that plans can use to determine geographic areas where increased blood lead testing is needed, as well as areas where blood lead levels are low enough to limit outreach efforts to achieve the national benchmark. Health plans can implement the CDC recommendation that scientific information be provided to health care providers regarding Medicaid blood lead screening policies and related data, assuming that healthcare providers are more likely to implement clinical practice guidelines if they know that the guidelines are based on scientific evidence. In addition, evidence suggests that lead screening practices are influenced by physician perceptions of the level of importance of lead poisoning prevention.

#### Sources:

1. Jones, R., Homa, D., & Meyer, P., et al. (2009). Trends in blood lead levels and blood lead testing among U.S. children aged 1 to 5 years, 1988–2004. *Pediatrics*, 123, e376–385. doi:10.1542/peds.2007-3608
2. US Department of Health and Human Services. (2000). *Healthy people 2010* (Conference ed, in 2 vols). Washington, DC: Author. 2000. Available at <http://www.healthypeople.gov>
3. President’s Task Force on Environmental Health Risks and Safety Risks to Children. (2000). *Eliminating childhood lead poisoning: A federal strategy targeting lead paint hazards*. Washington, DC: US Department of Housing and Urban Development and US Environmental Protection Agency. Available at <http://www.cdc.gov/nceh/lead/about/fedstrategy2000.pdf>
4. US Centers for Disease Control and Prevention. (2000). Recommendations for blood lead screening of young children enrolled in Medicaid: Targeting a group at high risk—United States. *Morbidity and Mortality Weekly Report*, 49 (No. RR-14), 1133-1137. Available at <http://www.cdc.gov/mmwr/PDF/rr/rr4914.pdf>

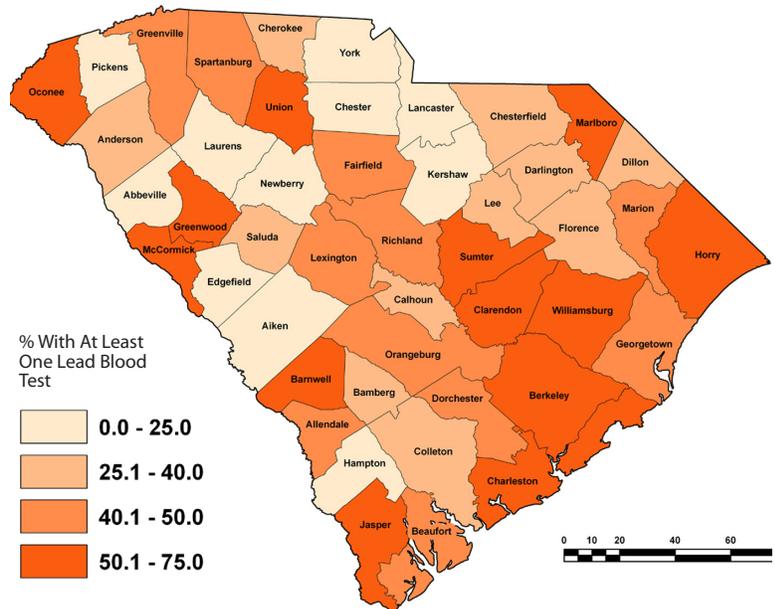
### Who was included and what was measured?

#### Modified HEDIS Definition

The percentage of children 0 to 2 years of age at the end of the measurement year who had one or more capillary or venous lead blood tests for lead poisoning.



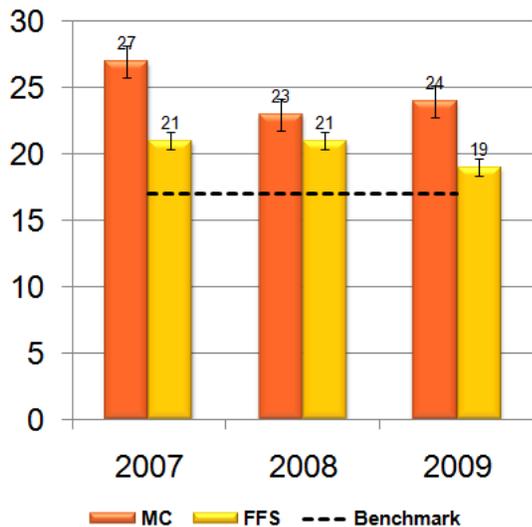
### Percentage of Children Ages 0 to 2 Years With At Least One Lead Blood Test



Source: SC Medicaid Information System, FY 2009  
 Created by the University of South Carolina, Institute for Families in Society, December 2009

## Well-Child Visits—Ages 0 Through 15 Months

Children in managed care were more likely to have a well-child visit than those in fee-for-service.



### Who was included and what was measured?

This measure included the percentage of members who turned 15 months old in the measurement year, were continuously enrolled with the health plan from 31 days of age and received five or more visits with a primary care practitioner during their first 15 months of life.



### Background Information

Well-child visits during the preschool and early school years are particularly important. A child can be helped through early detection of vision, speech and language problems. Intervention can improve communication skills and avoid or reduce language and learning problems. The American Academy of Pediatrics (AAP) recommends annual well-child visits for 2 to 6 year-olds.

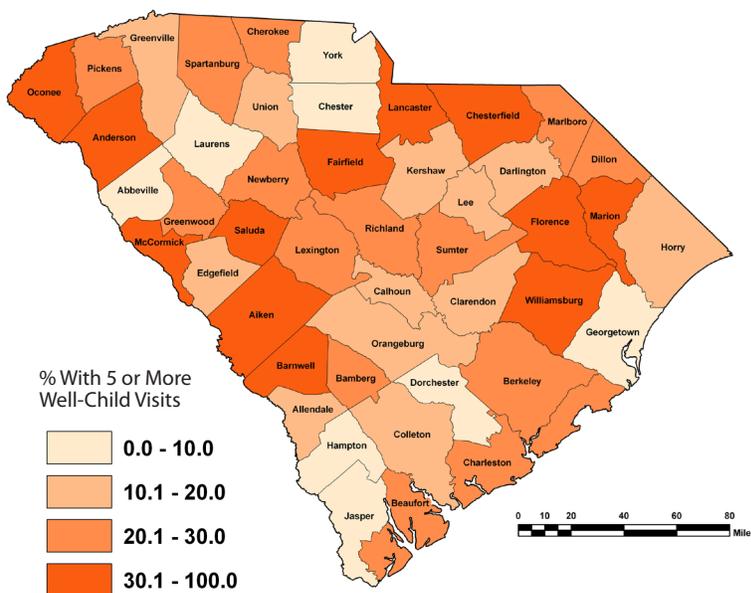
To enhance reporting, a list of CPT Codes and ICD-9 Codes is provided to use with claims/encounter data to capture this HEDIS measure.

Codes to Identify Well-Child Visits (must be used on claim/encounter) CPT Codes	ICD-9-CM Codes
99382, 99383, 99392, 99393	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Source:

Bethell, C., Reuland, C., Halfon, N., & Schor, E. (2004). Measuring the quality of preventive and developmental services for young children: National estimates and patterns of clinicians' performance. *Pediatrics*, 113 (6 Suppl), 1973-1983.

### Percentage of Children Ages 0 Through 15 Months of Age With 5 or More Well-Child Visits

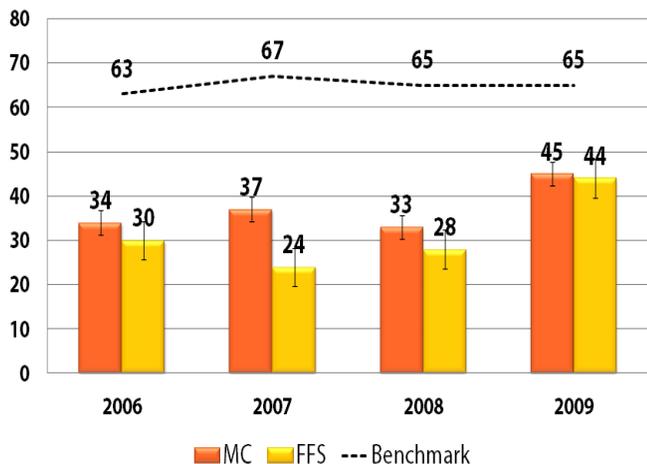


Source: SC Medicaid Information System, FY 2009  
Created by the University of South Carolina, Institute for Families in Society, December 2009

## Well-Child Visits—Ages 3 Through 6 Years

Who was included and what was measured?

Regardless of plan type, rates indicate results below the national benchmarks for fiscal years 2006–2009.



This measure included children who were 3, 4, 5, or 6 years old who were enrolled at least 11 months of the measurement year. The percentage shows how many of these children received at least one well-child visit.



### Background Information

Well-child visits during the preschool and early school years are particularly important. A child can be helped through early detection of vision, speech and language problems. Intervention can improve communication skills and avoid or reduce language and learning problems. The American Academy of Pediatrics (AAP) recommends annual well-child visits for 2 to 6 year-olds.

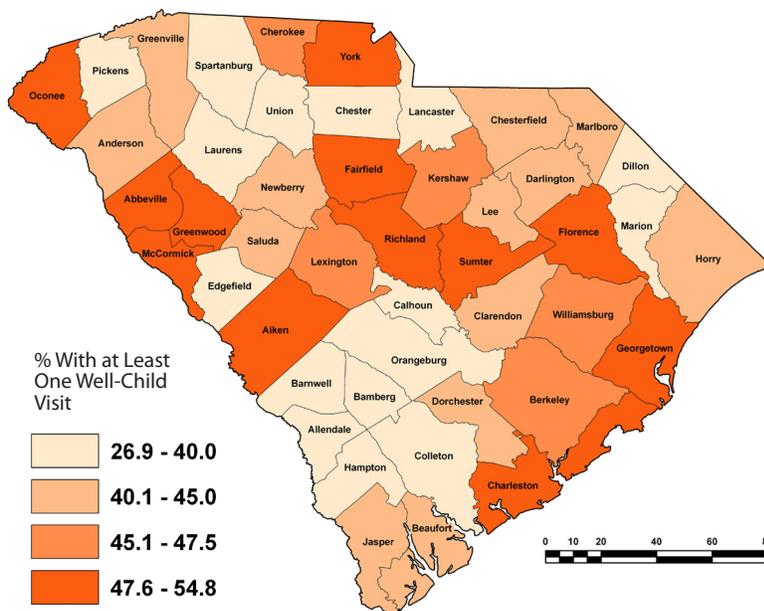
To enhance reporting, a list of CPT Codes and ICD-9 Codes is provided to use with claims/encounter data to capture this HEDIS measure.

Codes to Identify Well-Child Visits (must be used on claim/encounter) CPT Codes	ICD-9-CM Codes
99382, 99383, 99392, 99393	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Source:

Bethell, C., Reuland, C., Halfon, N., & Schor, E. (2004). Measuring the quality of preventive and developmental services for young children: National estimates and patterns of clinicians' performance. *Pediatrics*, 113 (6 Suppl), 1973-1983.

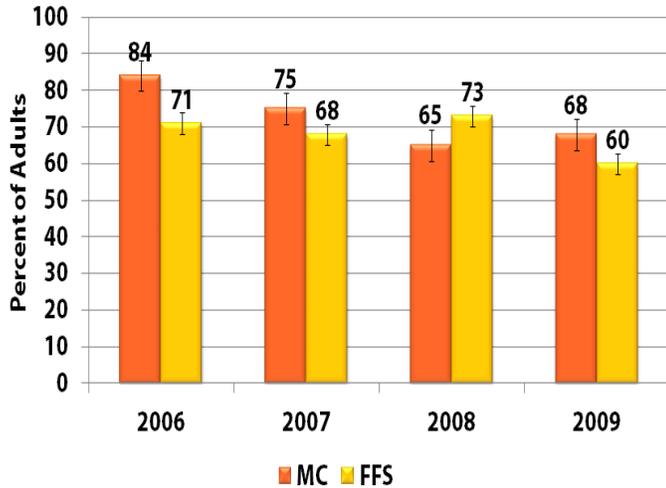
### Percentage of Children Ages 3 to 6 With At Least One Well-Child Visit



Source: SC Medicaid Information System, FY 2009  
Created by the University of South Carolina, Institute for Families in Society, December 2009

## Adult Access to Preventive Ambulatory Health Services

All plans exceed national benchmarks.



### Who was included and what was measured?

This measure is used to assess the percentage of Medicaid members 20 through 44 years, 45 through 64 years, and 65 years and older who had an ambulatory or preventive care visit.



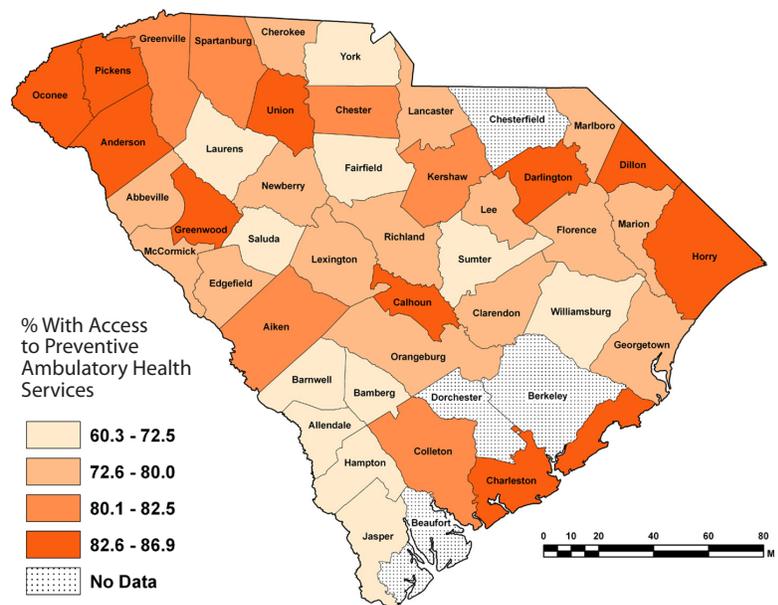
### Background Information

Access to primary care has been shown to correlate with reduced hospital use while preserving quality (IOM, 1996; Bingham et al., 2005; Bodenheimer, 2008), this measure does not explicitly measure a member's access to primary care. However, studies show that inappropriate care and overuse of new technologies can be reduced through shared decision-making between well-informed physicians and patients. Physicians have a central role to play in fostering these quality-enhancing strategies that can help to slow the growth of health care expenditures (Bodenheimer, 2008). Encouraging and making available access to primary care services is one potential strategy to lower hospital utilization while maintaining the quality of care delivered (IOM, 1996). Studies show that access to primary care is correlated with reduced hospital use while preserving quality (Bodenheimer, 2008; Bingham et al., 2005).

#### Sources:

1. Bingham, J., Quinn, D., Richardson, M., Miles, P., & Gabbe, S. Using a healthcare matrix to assess patient care in terms of aims for improvement and core competencies. *Joint Commission Journal on Quality and Patient Safety*, 31(2), 98-105.
2. Bodenheimer, T. (2008). Coordinating care—A perilous journey through the health care system. *New England Journal of Medicine*, 358(10), 1064-1071.
3. Institute of Medicine. (1996). *Primary care: America's health in a new era*. Washington, DC: National Academy Press.

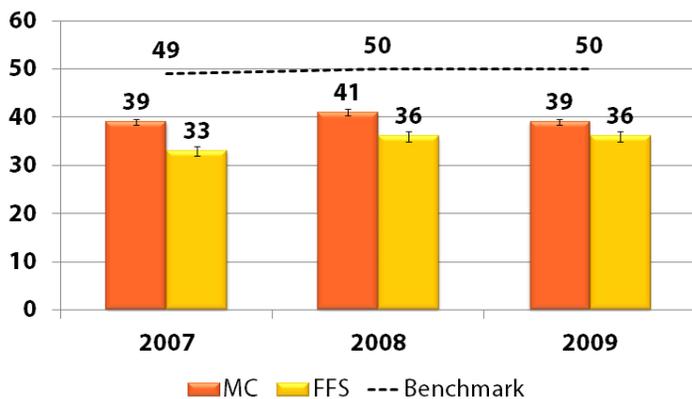
### Percentage of Adults Ages 20 and Older With Access to Preventive Ambulatory Health Services



Source: SC Medicaid Information System, FY 2009  
 Created by the University of South Carolina, Institute for Families in Society, December 2009

## Breast Cancer Screening

Women enrolled in managed care received a screening for breast cancer at higher rates than women in fee-for-service.



Note: Managed care plans meet the 10th percentile benchmark for each fiscal year with rates at or above 38.

### Who was included and what was measured?

This measure included women ages 40 to 69 who were enrolled at least 11 months of the measurement year. The percentage shows how many of these women received at least one mammogram during the measurement year or the previous year.



### Background Information

Periodic screening mammography has been shown to save lives by detecting breast cancer early, when it is most treatable. Breast cancer is the most frequently diagnosed non-skin cancer in women and the second leading cause of cancer death for women in the United States.

This measure may be improved by reporting those excluded from this measure who have undergone bilateral or unilateral mastectomy procedures.

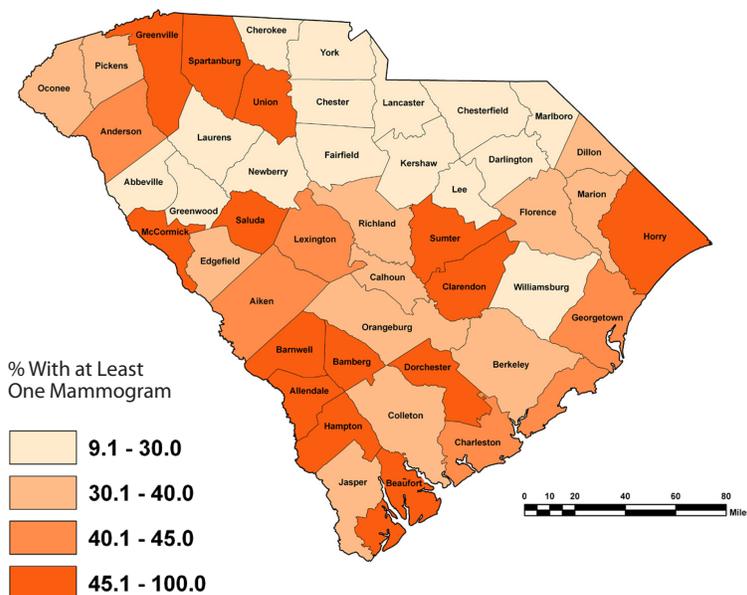
The following are a few examples of current interventions performed by health plans to help improve breast cancer screening rates:

- Distribute reminder postcards to plan members.
- Educate members through targeted mailings, newsletter articles, on-hold messages and telephonic outreach.
- Distribute annual provider reports identifying eligible panel members in need of a breast cancer screening.
- Host the mobile mammography unit in areas with low mammography rates for plan members.

Source:

National Cancer Institute. (2009). Breast Cancer Screening PDQ®. Retrieved from <http://www.cancer.gov/cancertopics/pdq/screening/breast/Patient/page2#Keypoint2>

### Percentage of Women Ages 40 to 69 With at Least One Mammogram in the Previous Year

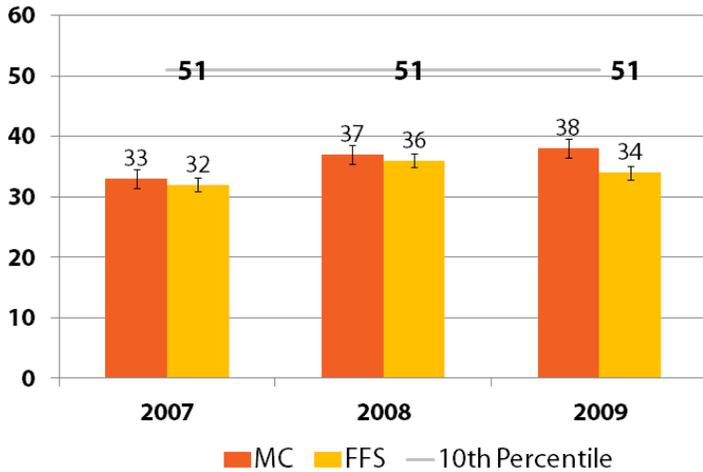


Source: SC Medicaid Information System, FY 2009

Created by the University of South Carolina, Institute for Families in Society, December 2009

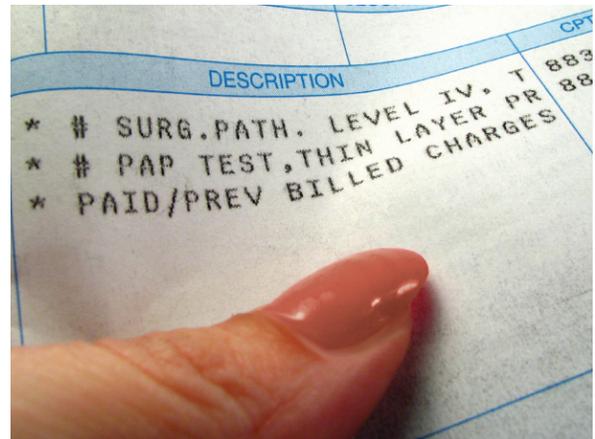
## Cervical Cancer Screening (PAP Test)

Regardless of the health plan, cervical cancer screening for eligible recipients has increased between 2007 and 2009.



### Who was included and what was measured?

This measure included the number of women 21-64 years of age who were enrolled at least 11 months of the measurement year. The percentage shows how many of these women received one or more PAP tests to screen for cervical cancer.



### Background Information

In the United States in 2008, it is estimated that 11,070 cases of invasive cervical cancer will be diagnosed and that 3,870 women will die of the disease (American Cancer Society, 2008). These rates have been improving steadily, with a 70% drop between 1950 and 1970 (Ries et al., 2002) and a 40% drop between 1970 and 1999. This improvement has been attributed largely to screening with the Papanicolaou (PAP) test.

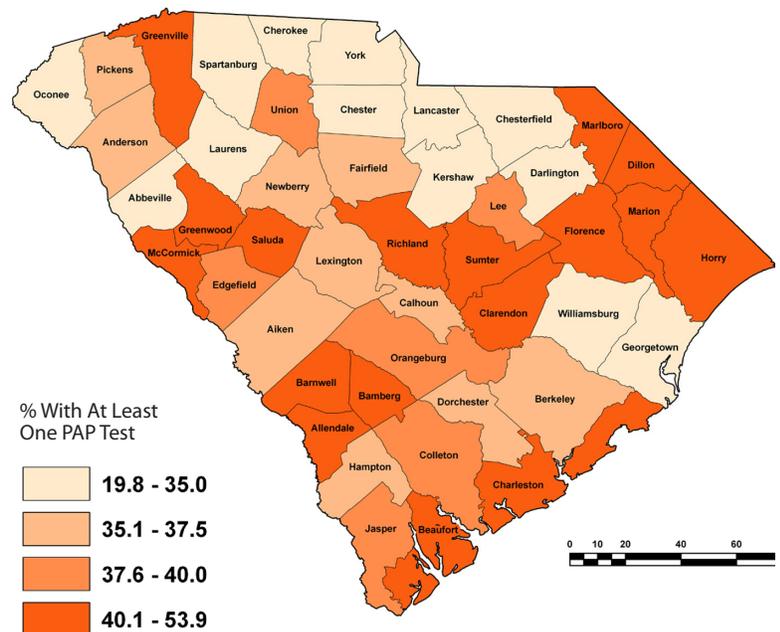
The following are a few examples of current interventions performed by health plans to help improve cervical cancer screening rates:

- Distribute reminder postcards to plan members.
- Educate members through targeted mailings, newsletter articles, on-hold messages and telephonic outreach.
- Maximize opportunities with internal departments who come in contact with female members to remind them to get screened.
- Distribute annual provider reports identifying eligible panel members in need of a cervical cancer screening.

Source:

1. American Cancer Society. (2008). *Cancer Facts and Figures 2008*. Atlanta, Ga: American Cancer Society.
2. Ries L., Eisner, M., Kosary, C., Hankey, B., Miller, B., Clegg, L., Edwards, B. (Eds.). (2002). *SEER cancer statistics review, 1973-1999*. Bethesda, MD: National Cancer Institute.

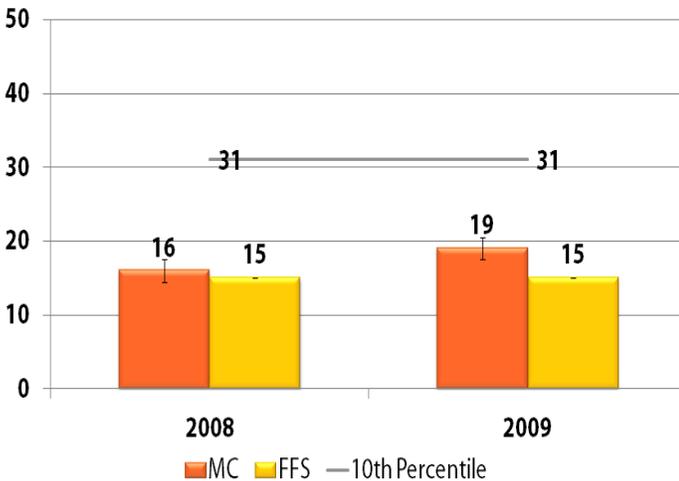
### Percentage of Women Ages 21 to 64 Years With At Least One PAP Test for Cervical Cancer



Source: SC Medicaid Information System, FY 2009  
 Created by the University of South Carolina, Institute for Families in Society, December 2009

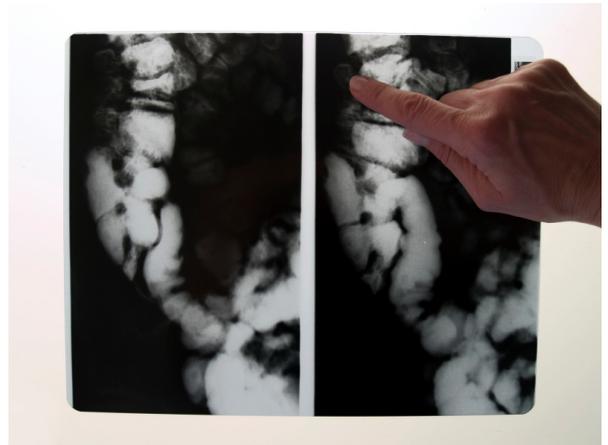
## Colorectal Cancer Screening

Adults in managed care were more likely to be screened for colorectal cancer than those in fee-for-service.



Who was included and what was measured?

This measure included the percentage of adults 50 to 80 years of age who had appropriate screening for colorectal cancer.



### Background Information

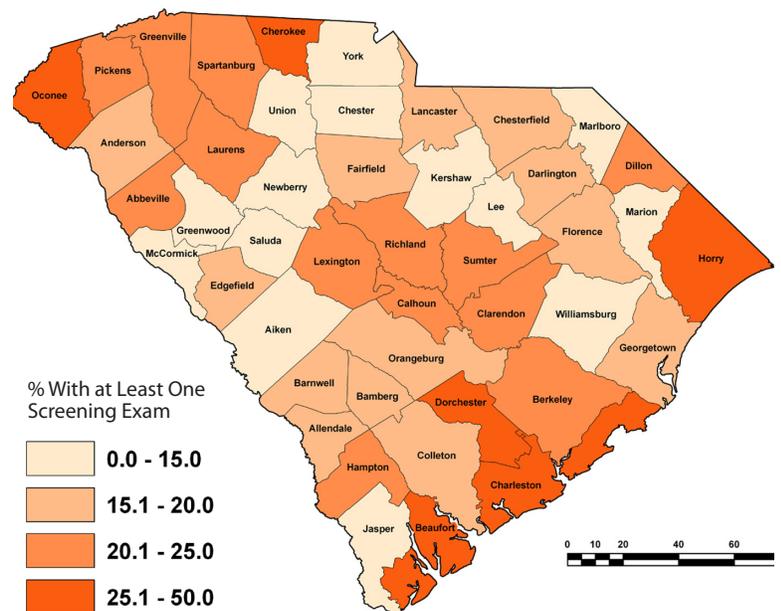
Colorectal cancer is the third most common cancer and the second leading cause of cancer-related deaths among men and women in the United States. An estimated 108,000 new cases of colorectal cancer will be diagnosed in 2008. One's chances of being diagnosed with colorectal cancer increase dramatically after age 50; 9 out of 10 people diagnosed with the cancer are over 50. Fewer than 1 in 6 cases are associated with a family history of the disease.

Colorectal cancer places a significant economic burden on society, with treatment costing over \$6.5 billion per year. Unlike other screening tests that only detect disease, some methods of CRC screening can detect premalignant polyps and guide their removal, which, in theory, can prevent the cancer from developing. This measure is based on several organizations' clinical guidelines -- United States Preventive Services Task Force (USPSTF), American Cancer Society (ACS), and Agency for Healthcare Research and Quality (AHRQ)/American Gastroenterological Association.

Sources:

1. National Committee for Quality Assurance (NCQA). (2008). *HEDIS® 2009: Healthcare effectiveness data & information set. Vol. 1, Narrative*. Washington, DC: Author.
2. US Cancer Statistics Working Group. (2009). *United States cancer statistics: 1999-2005 incidence and mortality web-based report*. Atlanta, GA: US Department of Health and Human Services, US Centers for Disease Control and Prevention, and National Cancer Institute.
3. Horner, M. J., Ries, L. A. G., Krapcho, M., Neyman, N., Aminou, R., Howlander, N., . . . Edwards, B. K. (Eds). (2009). *SEER Cancer Statistics Review, 1975-2006*. Bethesda, MD: National Cancer Institute. Based on November 2008 SEER data submission, posted to the SEER web site and available at [http://seer.cancer.gov/csr/1975\\_2006/](http://seer.cancer.gov/csr/1975_2006/)

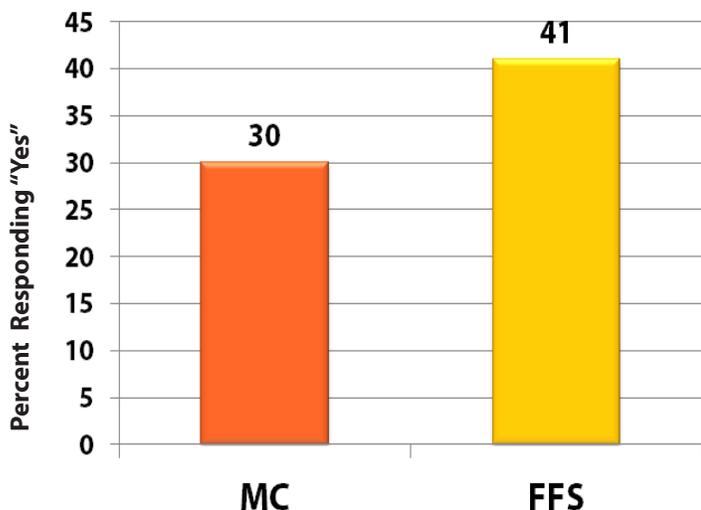
### Percentage of Adults With at Least One Colorectal Cancer Screening Exam



Source: SC Medicaid Information System, FY 2009  
 Created by the University of South Carolina, Institute for Families in Society, December 2009

## Flu Shot

Have you had a flu shot since September 1, 2008?  
(N = 797)



Note: Measure is drawn from data results of the 2009 SC CAHPS 4.0 set of additional questions.

Who was included and what was measured?

This measure uses survey data to assess the percentage of members 50 to 64 years of age who received an influenza vaccination between September 1 of the measurement year and the date on which the CAHPS® 4.0 Adult Survey was completed.



### Background Information

The disease burden of influenza is large, and the potential for prevention is high. Influenza infections result in significant health care expenditures each year, and vaccination is safe and effective. This measure facilitates the achievement of national goals to increase the demand for adult vaccination by improving provider and public awareness to effectively deliver vaccines to adults and to monitor and improve the performance of the nation's immunization program. This measure looks at the percentage of members 50 to 64 years of age who received an influenza vaccination. The specifications for this measure are consistent with current recommendations from the Advisory Committee on Immunization Practices (ACIP), which recommends yearly influenza vaccinations for persons aged 50 to 64 years because this group has an increased prevalence of persons with high-risk medical conditions and age-specific strategies have been more successful to increase vaccine coverage than those based on medical conditions.

Healthy adults in this age group without high-risk conditions will benefit by reduced number of illnesses, physician visits, workdays missed and antibiotic use,

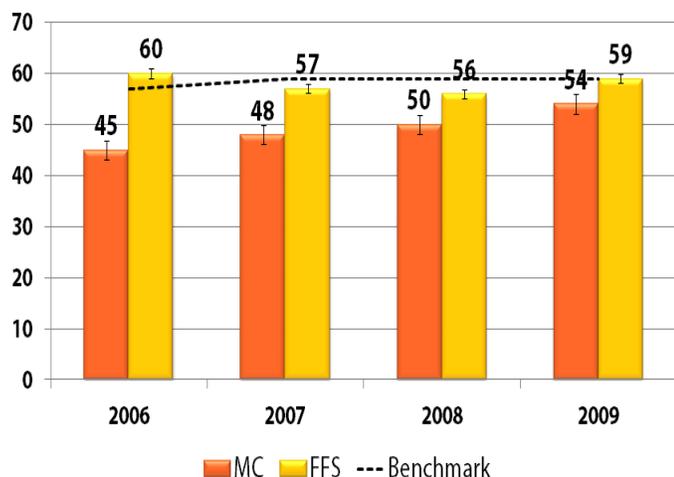
and will have reduced disease transmission from contacts who are at high-risk for influenza-related complications. Organizations can implement a variety of interventions for increasing coverage. Successful vaccination programs combine publicity and education for health care workers and other potential vaccine recipients. Programs include identifying persons at high risk, patient reminder/recall systems, assessment of practice-level vaccination rates with feedback to health care providers and staff, and efforts to remove administrative and financial barriers that prevent persons from receiving the vaccine. Organizations can also contribute to cooperative and community-wide immunization clinics scheduled just prior to the start of the flu season.

Sources:

1. National Committee for Quality Assurance (NCQA). (2008). *HEDIS® 2009: Healthcare effectiveness data & information set. Vol. 1, Narrative*. Washington, DC: Author (p. 90).
2. Infectious Diseases Society of America (2009, January). *Study shows workplace benefits of influenza vaccination in 50-64 year olds*. [News Release]. Available at <http://www.idsociety.org/content.aspx?id=14210>

## Postnatal Care Visits

Women in fee-for-service were more likely to receive postnatal care visits at rates above the national benchmark than women in managed care.



### Background Information

This modified measure was created to address the inability of the current management information and reporting systems to link mothers to infant births consistently across managed care and fee-for-service plans. This limitation may result in an under-reporting of the percentage of women who received appropriate prenatal and postpartum care. It is estimated that changes to the reporting and information management systems will address this barrier in the CY 2009 reporting period of HEDIS.

The Centers for Disease Control and Prevention’s Healthy People 2010 initiative sets a national goal of increasing to 90% the proportion of pregnant women who receive early and adequate prenatal care. Early and adequate prenatal care may reduce the incidence of low-birth-weight newborns, infant mortality and long-term health complications for the mother and infant. Prenatal visits give providers the opportunity to monitor the health of the mother and fetus and to educate the mother about proper nutrition, avoidance of risk behaviors, maintaining preventive care appointments, and the importance of well-child visits during the first years of life. In addition to advocating prenatal care, the American College of Obstetricians and Gynecologists recommends that women have a postpartum visit four to six weeks after delivery so their doctors can detect any complications, provide assistance and answer questions. The following are a few examples of current interventions performed by health plans to help improve prenatal care rates:

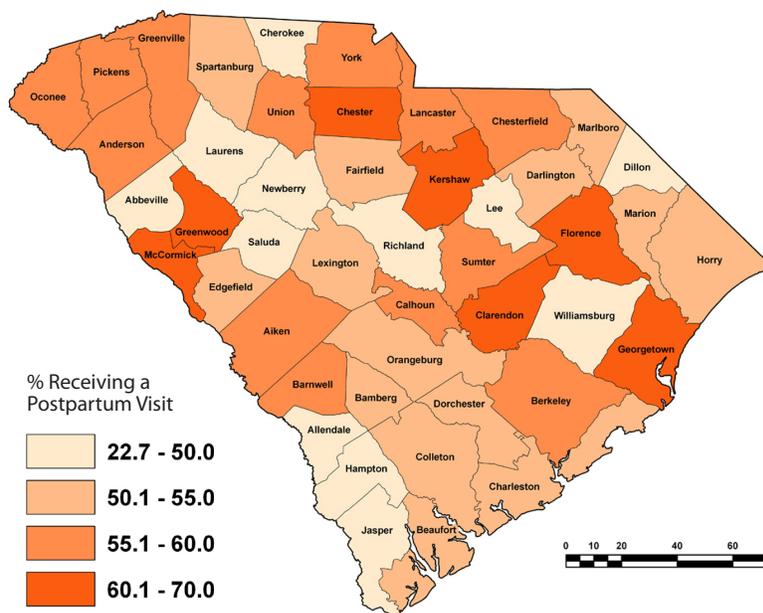
- Published articles regarding prenatal care and postpartum care in the member and provider newsletter.
- Distributed a monthly prenatal mailer to all women ages 18 to 42 identified by pharmacy data as receiving a prenatal vitamin.

### Who was included and what was measured?

This measure included the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.



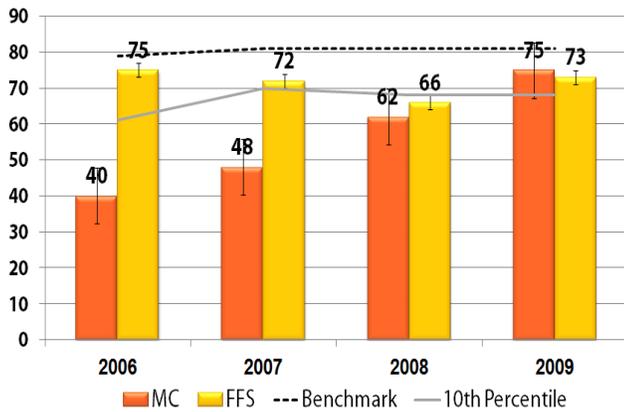
### Percentage of Women With a Postpartum Visit Between 21 and 56 Days After Delivery



Source: SC Medicaid Information System, FY 2009  
 Created by the University of South Carolina, Institute for Families in Society, December 2009

## Prenatal Care Visits

The number of women receiving prenatal care visits in managed care has increased by more than 35% between 2006 and 2009.



In 2009, regardless of plan, the SC Medicaid Program met or exceeded the 10th Percentile.

### Background Information

This modified measure was created to address the inability of the current management information and reporting systems to link mothers to infant births consistently across managed care and fee-for-service plans. This limitation may result in an under-reporting of the percentage of women who received appropriate prenatal and postpartum care. It is estimated that changes to the reporting and information management systems will address this barrier in the CY 2009 reporting period of HEDIS.

The Centers for Disease Control and Prevention’s Healthy People 2010 initiative sets a national goal of increasing to 90% the proportion of pregnant women who receive early and adequate prenatal care. Early and adequate prenatal care may reduce the incidence of low-birth-weight newborns, infant mortality and long-term health complications for the mother and infant. Prenatal visits give providers the opportunity to monitor the health of the mother and fetus and to educate the mother about proper nutrition, avoidance of risk behaviors, maintaining preventive care appointments, and the importance of well-child visits during the first years of life. In addition to advocating prenatal care, the American College of Obstetricians and Gynecologists recommends that women have a postpartum visit four to six weeks after delivery so their doctors can detect any complications, provide assistance and answer questions. The following are a few examples of current interventions performed by health plans to help improve prenatal care rates:

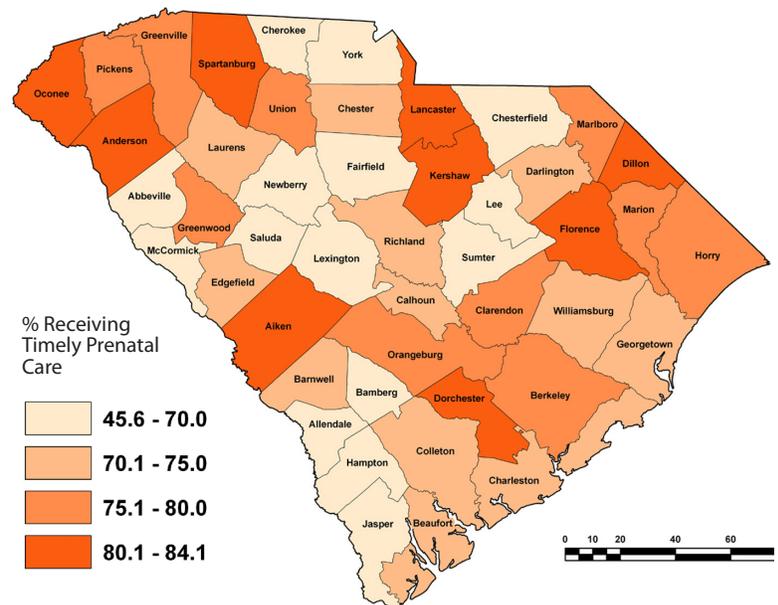
- Published articles regarding prenatal care and postpartum care in the member and provider newsletter.
- Distributed a monthly prenatal mailer to all women ages 18 to 42 identified by pharmacy data as receiving a prenatal vitamin.

### Who was included and what was measured?

This measure included the percentage of women with deliveries who received a prenatal care visit in the first trimester or within 42 days of enrollment in the plan.



### Percentage of Women With Deliveries Who Received a Prenatal Care Visit in the First Trimester or Within 42 Days of Enrollment in the Plan



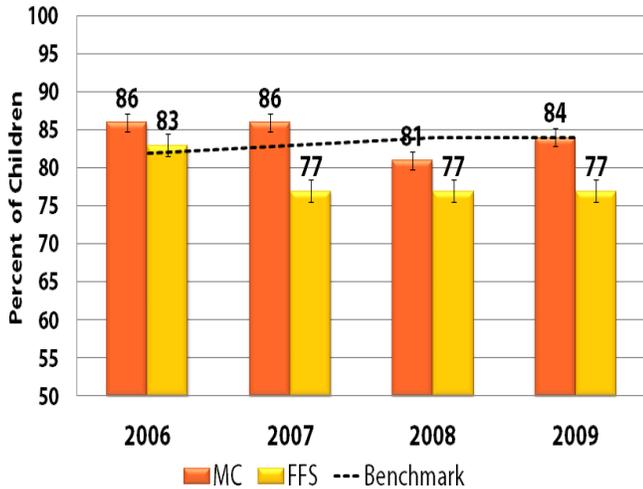
Source: SC Medicaid Information System, FY 2009  
 Created by the University of South Carolina, Institute for Families in Society, December 2009

# Getting Better



## Appropriate Use of Antibiotics: Treatment for Children With Upper Respiratory Infection (URI)

Children in managed care were more likely to exhibit appropriate use of antibiotics for children with upper respiratory infection.



### Who was included and what was measured?

This measure included the percentage of children 3 months to 18 years who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic on or within the three days after the episode date.

The numerator for this measure consists of episodes that were inappropriately treated with antibiotics. The inverted rate is  $1 - (\text{num}/\text{den})$ , so a higher inverted rate indicates better care.



### Background Information

In the South Carolina Medicaid Program, quality improvement efforts appear generally effective at reducing both inappropriate treatment with antibiotics and inappropriate selection of antibiotics. While no single QI strategy was more effective than others, active clinician education may be more effective than passive education, particularly for addressing the antibiotic treatment decision.

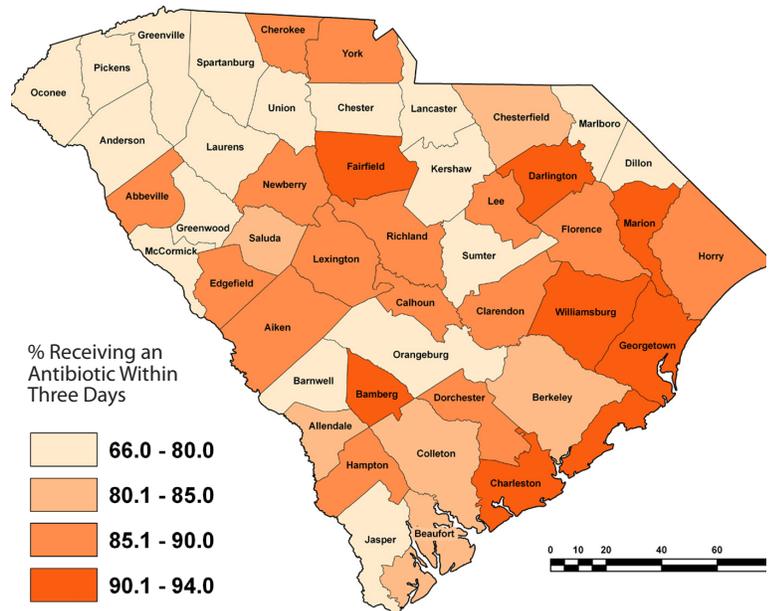
The following are a few examples of current interventions performed by health plans to help improve appropriate use of antibiotics for treatment of URI rates:

- Provide clinical guidelines for practitioners.
- Distribute exam room posters and tools for practitioners to share with consumers.

Source:

Agency for Healthcare Research and Quality. (2006, January). *Closing the quality gap: A critical analysis of quality improvement strategies: Volume 4—Antibiotic prescribing behavior, structured abstract*. Rockville, MD: Author. Available at <http://www.ahrq.gov/clinic/tp/medigaptp.htm>

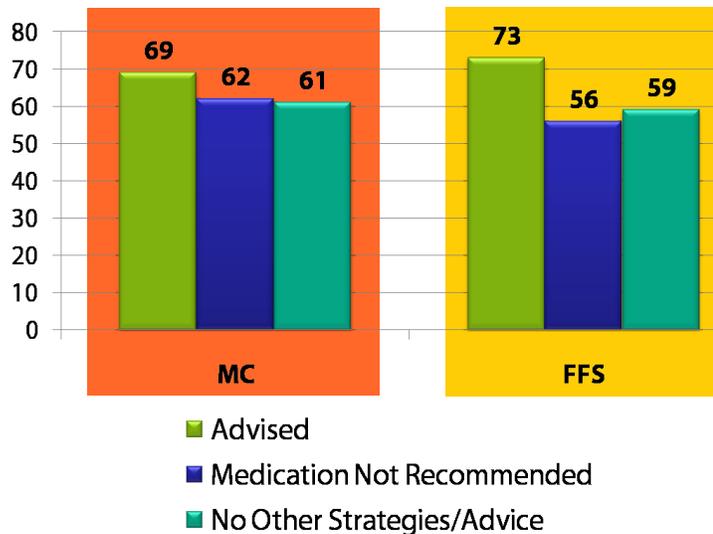
### Percentage of Children Ages 3 Months to 18 Years With a URI Diagnosis Who Received an Antibiotic Within Three Days



Source: SC Medicaid Information System, FY 2009  
Created by the University of South Carolina, Institute for Families in Society, December 2009

## Medical Assistance With Smoking Cessation

As part of prevention efforts, 50% or more adult smokers in the SC Medicaid program were likely to receive medical assistance with smoking cessation.



Measure is drawn from data results of the 2009 SC CAHPS 4.0 set of additional questions.

### Who was included and what was measured?

This measure included members 18 years and older who were current smokers, who were seen by a health plan practitioner during the measurement year for whom smoking cessation methods or strategies were recommended or discussed.



### Background Information

Smoking is the leading preventable cause of death in the United States, causing more than 430,700 deaths each year (CDC, 2006; Cokkinides et al., 2005). Over 47 million Americans smoke, despite the risks (CDC, 2006). Seventy percent of smokers are interested in stopping smoking completely; smokers report that they would be more likely to stop smoking if a doctor advised them to quit (Cokkinides et al., 2005). Getting even brief advice to quit is associated with a 30% increase in the number of people who quit (Maciosek et al., 2006). Specifications for this measure are consistent with current recommendations from the United States Preventive Services Task Force (USPSTF, 2004). Quitting smoking reduces the risk of lung and other cancers, heart attack, stroke and chronic lung disease (CDC, 2006). Evidence suggests that tracking smoking status as a “vital sign” leads to more aggressive counseling and higher quit rates (Cokkinides et al., 2005; Maciosek et al., 2006).

#### Sources:

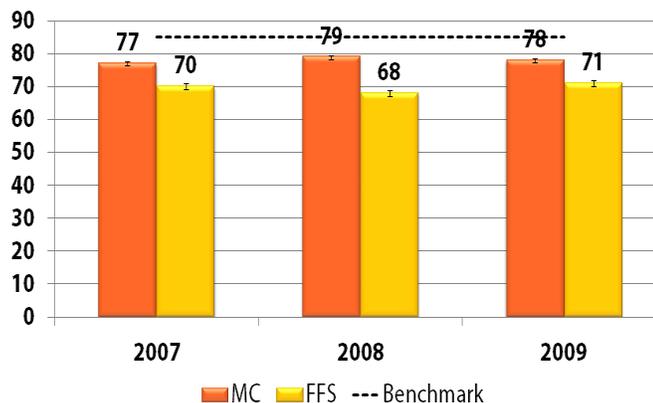
1. US Centers for Disease Control and Prevention (CDC) (2007). Cigarette smoking among adults--United States, 2006. *Morbidity and Mortality Weekly Report*, 56(44), 1157-1161.
2. Cokkinides, V. E., Ward, E., Jemal, A., & Thun, M. J. (2000, January) Under-use of smoking-cessation treatments: Results from the National Health Interview Survey, 2000. *American Journal of Preventive Medicine*, 28(1), 119-122.
3. Maciosek, M. V., Coffield, A. B., Edwards, N. M., Flottemesch, T. J., Goodman, M. J., & Solberg, L. I. (2006, July). Priorities among effective clinical preventive services: Results of a systematic review and analysis. *American Journal of Preventive Medicine*, 31(1), 52-61.
4. US Department of Health and Human Services (2004). *The health consequences of smoking: A report of the Surgeon General*. Rockville, MD: Author.

# Living With Illness and Disability



## Asthma Care Asthma Medication Use - Adults

Adults (18 to 56 years) with persistent asthma in managed care were more likely to have at least one medication for asthma than those in fee-for-service.



Note: Managed care plans meet the 10th percentile benchmark for each fiscal year.

### Who was included and what was measured?

This measure included beneficiaries ages 18 to 56 with persistent asthma who were enrolled at least 11 months during the measurement year and at least 11 months of the year prior to the measurement year.

The percentage shows how many of these beneficiaries had at least one prescription for inhaled corticosteroids, cromolyn sodium and nedocromil, leukotriene modifiers or methylxanthines.



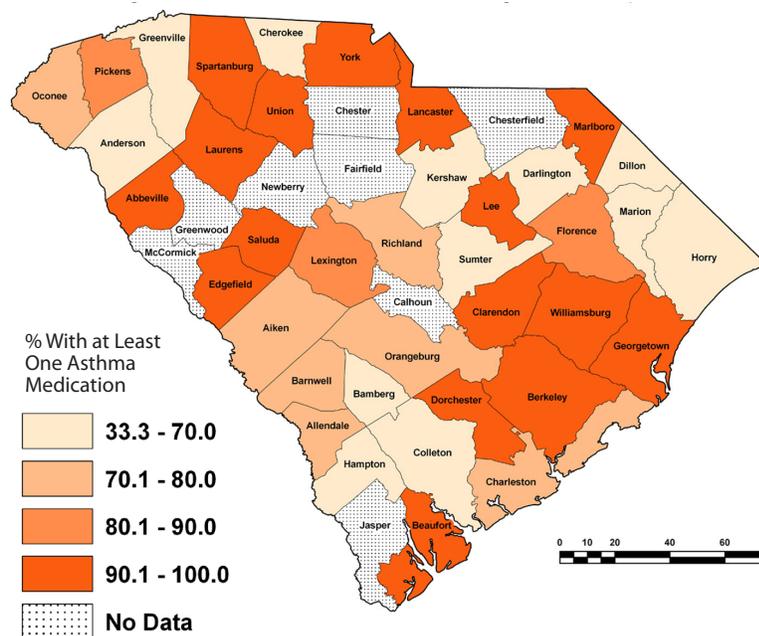
### Background Information

A wide variety of types of QI interventions have been found to improve the outcomes and processes of care for children and adults with asthma. Young children with asthma benefit most from QI strategies that also include their caregivers or parents. General populations with asthma can have clinically significant improvements in spirometric measures after participating in self-monitoring, self-management, or patient education interventions—especially interventions that are based on theoretical frameworks, are of relatively long durations, and utilize combinations of educational modalities.

Source:

Agency for Healthcare Research and Quality. (2007, January). *Closing the quality gap: A critical analysis of quality improvement strategies: Volume 5—Asthma care* [Structured abstract]. Rockville, MD: Author. Available at <http://www.ahrq.gov/clinic/tp/asthmgaptp.htm>

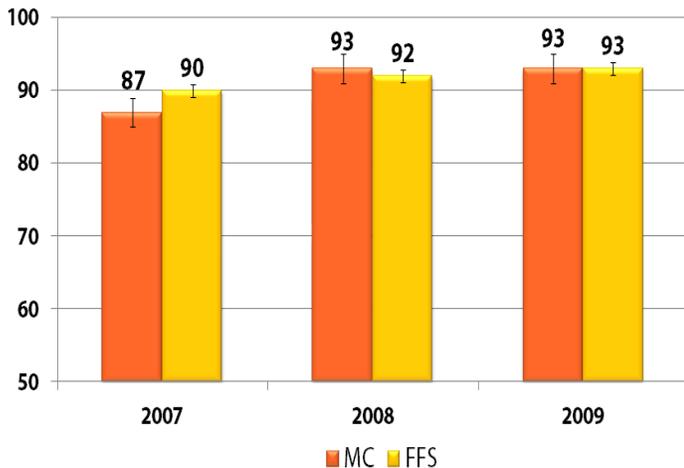
### Percentage of Adults Ages 18 to 56 With Persistent Asthma Using at Least One Asthma Medication



Source: SC Medicaid Information System, FY 2009  
Created by the University of South Carolina, Institute for Families in Society, December 2009

## Asthma Care Asthma Medication Use - Children

SC rates are above the national benchmark (90th percentile) for children in age groups 5–9 years and 10–17 years.



### Who was included and what was measured?

This measure included beneficiaries ages 5 through 17 with persistent asthma who were enrolled at least 11 months during the measurement year and at least 11 months of the year prior to the measurement year.

The percentage shows how many of these beneficiaries had at least one prescription for inhaled corticosteroids, cromolyn sodium and nedocromil, leukotriene modifiers, or methylxanthines.



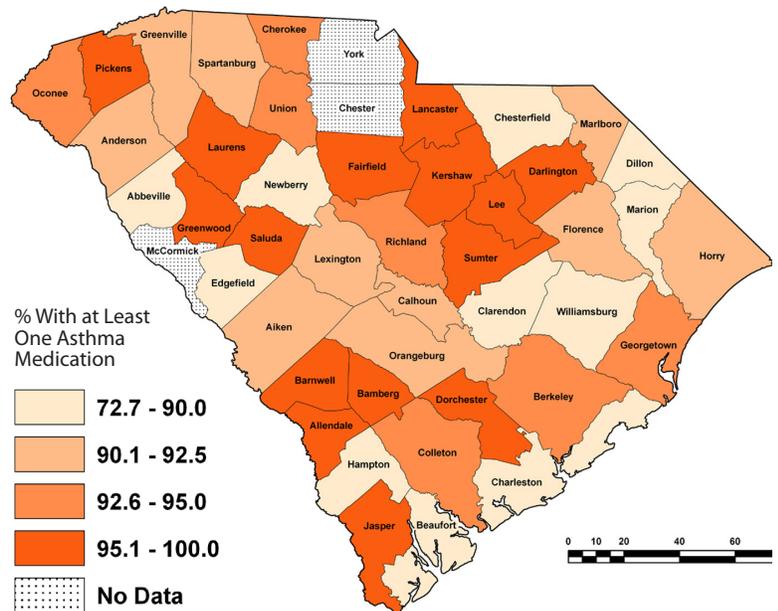
### Background Information

A wide variety of types of QI interventions have been found to improve the outcomes and processes of care for children and adults with asthma. Young children with asthma benefit most from QI strategies that also include their caregivers or parents. General populations with asthma can have clinically significant improvements in spirometric measures after participating in self-monitoring, self-management, or patient education interventions—especially interventions that are based on theoretical frameworks, are of relatively long durations, and utilize combinations of educational modalities.

Source:

Agency for Healthcare Research and Quality (2007, January). *Closing the quality gap: A critical analysis of quality improvement strategies: Volume 5—Asthma care* [Structured abstract]. Rockville, MD: Author. Available at <http://www.ahrq.gov/clinic/tp/asthmgaptp.htm>

### Percentage of Children Ages 5 to 17 With Persistent Asthma Using at Least One Asthma Medication



Source: SC Medicaid Information System, FY 2009  
Created by the University of South Carolina, Institute for Families in Society, December 2009

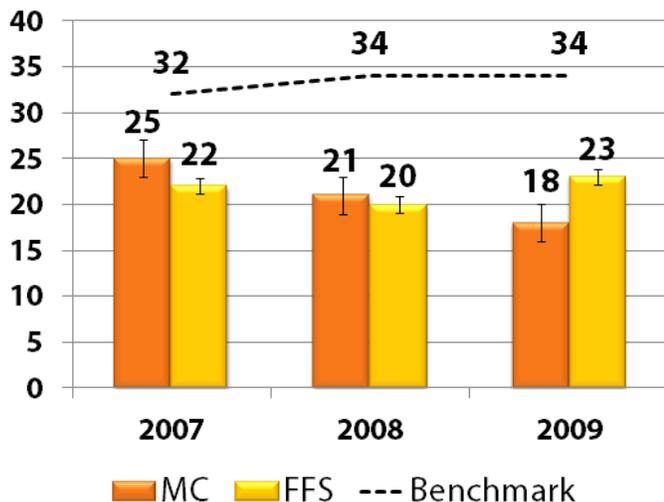
## Behavioral Health

### Attention-deficit Hyperactivity Disorder (ADHD)

Regardless of plan types, children with a prescription for an ADHD medication had follow-up care at or above the 10th percentile of the Medicaid national benchmark. In 2009, children in fee-for-service were more likely to have a follow-up visit with a practitioner during the 30-day ADHD medication initiation phase.

Who was included and what was measured?

This measure included the percentage of children ages 6 to 12 (as of the index prescription start date) with an ambulatory prescription for an ADHD medication who had one follow-up visit with a practitioner during the 30-day initiation phase.



Follow-up care is recommended by the American Academy of Pediatrics to prevent adverse effects.

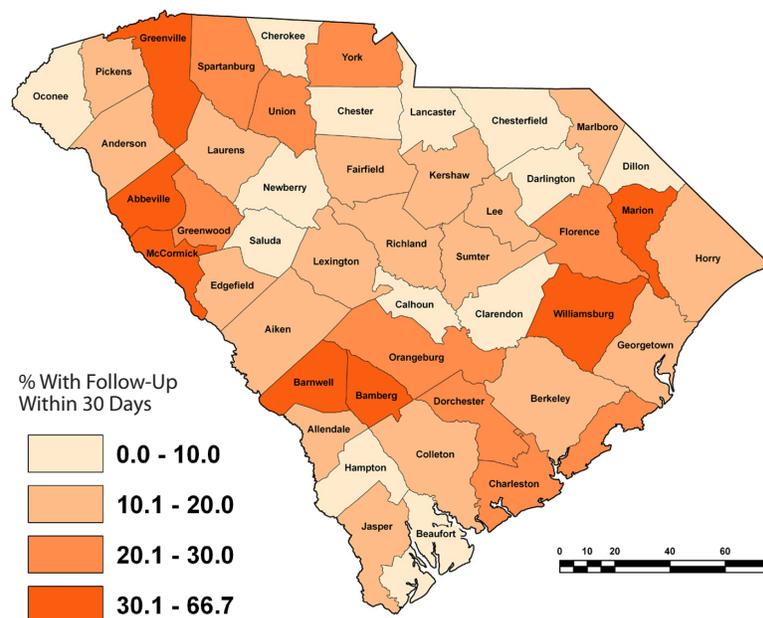
### Background Information

The American Academy of Child and Adolescent Psychiatry (AACAP) recommends the initiation of psychopharmacological treatment for members diagnosed with ADHD. The medications that are the most effective are a class of drugs known as stimulants. Adherence to best practice protocol for ADHD is measured through the Healthcare Effectiveness Data and Information Set (HEDIS) used by health plans, nationwide, to benchmark performance among plans.

ADHD often co-occurs with other problems, such as: antisocial behavior, anxiety and depressive disorders, conduct disorder, or drug abuse, which can make a condition diagnosis more difficult. In these instances, a referral to a behavioral health provider may be appropriate.

Source: (1997). Practice parameters for the assessment and treatment of children, adolescents, and adults with attention-deficit/hyperactivity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36(10S). Supplemental: 85S-121S.

### Percentage of Children Ages 6 to 12 Years With an ADHD Prescription Who Had a Follow-Up With Practitioner During 30-Day Initiation Phase

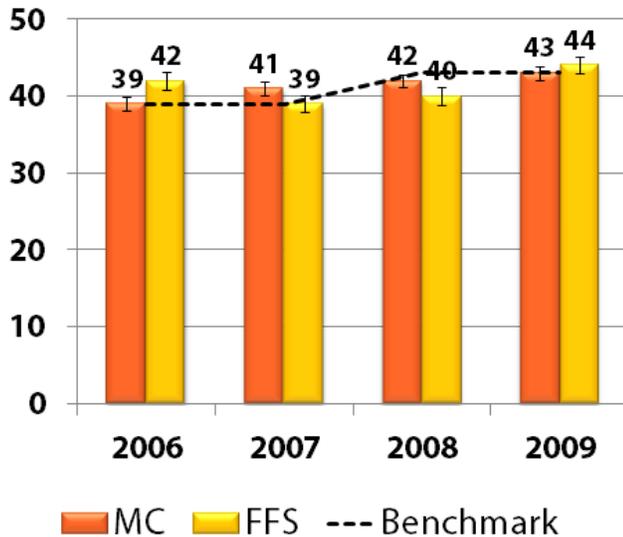


Source: SC Medicaid Information System, FY 2009  
 Created by the University of South Carolina, Institute for Families in Society, December 2009

## Behavioral Health

# Follow-up Care Within 7 Days After Hospitalization for Mental Illness Ages 6 Years and Above

Recipients in the SC Medicaid program were likely to receive follow-up care within 7 days after hospitalization for mental illness at or above the 50th percentile of the Medicaid national benchmark.



Who was included and what was measured?

This measure included the percentage of individuals ages 6 and above who had one follow-up care visit with a practitioner within 7 days after hospitalization for mental illness.



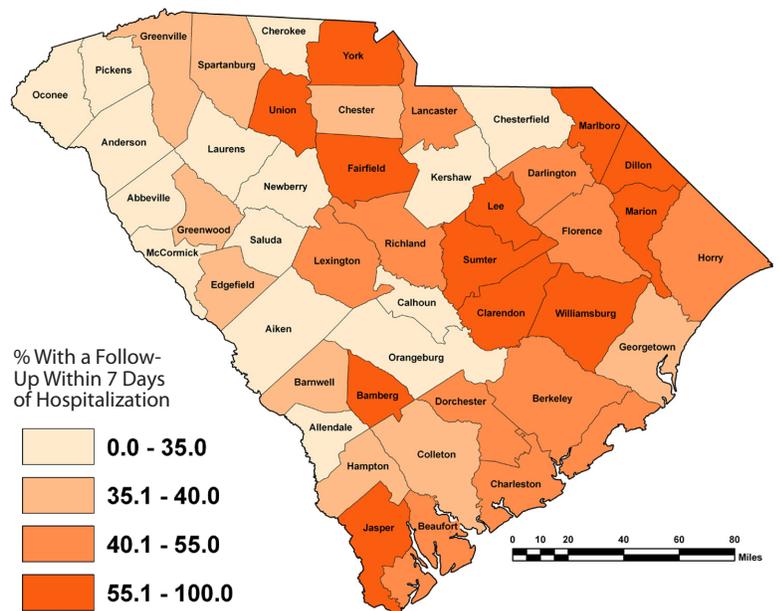
### Background Information

Follow-up care after a hospitalization for mental illness supports the patient’s transition back to the community and may reduce rehospitalizations for some individuals (Klinkenberg & Calsyn, 1998) or help facilitate necessary readmission before individuals reach a crisis stage (NCQA, 2006). Monitoring medication adherence is a necessary component of quality care. About two of five patients hospitalized for a psychiatric condition are rehospitalized within one year, often because of poor adherence to prescribed medications (Klinkenberg & Calsyn, 1998).

Sources:

1. Klinkenberg, W., & Calsyn, R. (1998). Predictors of psychiatric hospitalization: A multivariate analysis. *Administration and Policy in Mental Health*, 25(4), 403.
2. National Committee for Quality Assurance. (2006). *The state of health care quality, 2006*. Washington, DC: Author.

### Percentage of Individuals Ages 6 and Above With a Follow-Up with Practitioner Within 7 Days of Hospitalization for a Mental Illness

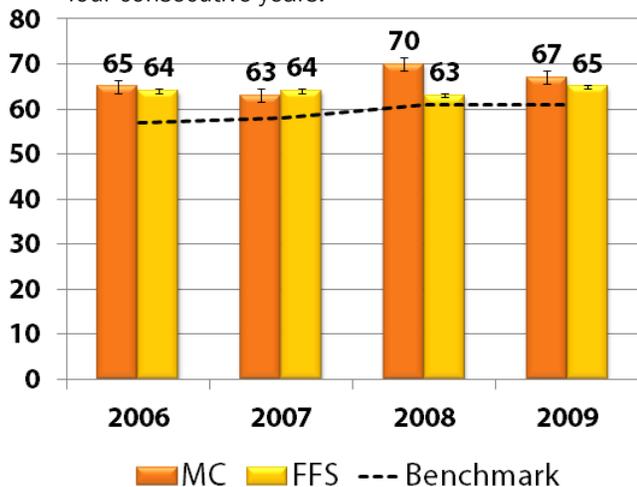


Source: SC Medicaid Information System, FY 2009  
Created by the University of South Carolina, Institute for Families in Society, December 2009

## Behavioral Health

# Follow-up Care Within 30 Days After Hospitalization for Mental Illness Ages 6 Years and Above

Recipients in the SC Medicaid program were likely to receive follow-up care within 30 days after hospitalization for mental illness at or above the 50th percentile of the Medicaid national benchmark for four consecutive years.



Regardless of the plan type, the rate of follow-up care within 30 days of hospitalization exceeded the national benchmark for four consecutive years.

### Who was included and what was measured?

This measure included the percentage of individuals age 6 and above who had one follow-up care visit with a practitioner within 30 days after hospitalization for mental illness.



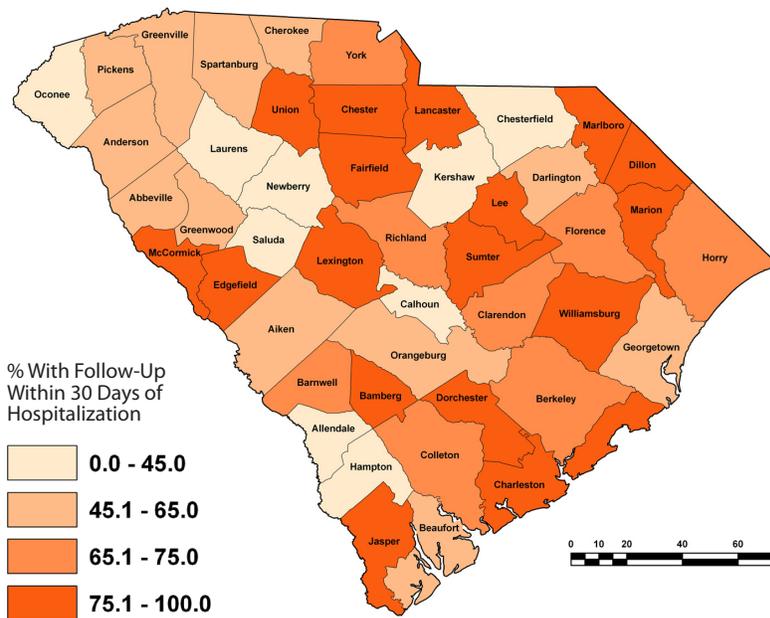
## Background Information

Follow-up care after a hospitalization for mental illness supports the patient's transition back to the community and may reduce rehospitalizations for some individuals (Klinkenberg & Calsyn, 1998) or help facilitate necessary readmission before individuals reach a crisis stage (NCQA, 2006). Monitoring medication adherence is a necessary component of quality care. About two of five patients hospitalized for a psychiatric condition are rehospitalized within one year, often because of poor adherence to prescribed medications (Klinkenberg & Calsyn 1998).

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1. Klinkenberg, W., & Calsyn, R. (1998). Predictors of psychiatric hospitalization: A multivariate analysis. *Administration and Policy in Mental Health*, 25(4), 403.
2. National Committee for Quality Assurance. (2006). *The state of health care quality, 2006*. Washington, DC: Author.

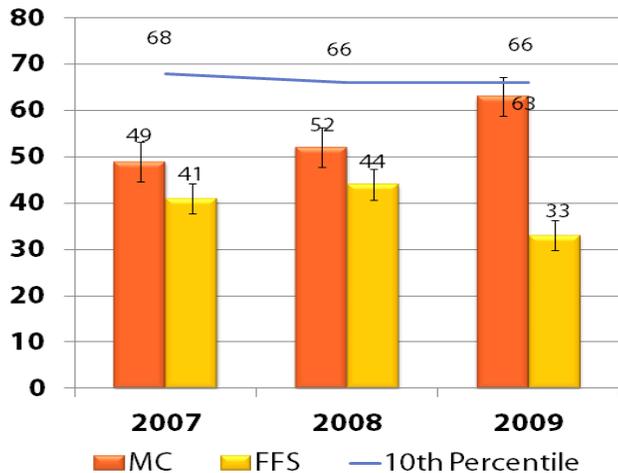
## Percentage of Individuals Ages 6 and Above With a Follow-Up with Practitioner Within 30 Days of Hospitalization for a Mental Illness



Source: SC Medicaid Information System, FY 2009  
Created by the University of South Carolina, Institute for Families in Society, December 2009

## Diabetes Care Hemoglobin A1c (HbA1c) Test

Adults with diabetes enrolled in Medicaid managed care were more likely to have an HbA1c test than those in fee-for-service.



### Who was included and what was measured?

This measure included the percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who were enrolled at least 11 months during the measurement year and who had a hemoglobin A1c (HbA1c) test during the measurement year.



### Background Information

Diabetes affects more than 17 million people in the United States alone. Taking into account undiagnosed cases and cases of impaired glucose tolerance, one in seven Americans either has diabetes or is at high risk for developing it. Despite a high-quality evidence base to aid providers in treating diabetes and screening for its complications, the quality of diabetes care remains less than optimal, with many patients not receiving established processes of care (such as eye and foot screening) or achieving optimal outcomes (such as controlled glycosylated hemoglobin levels).

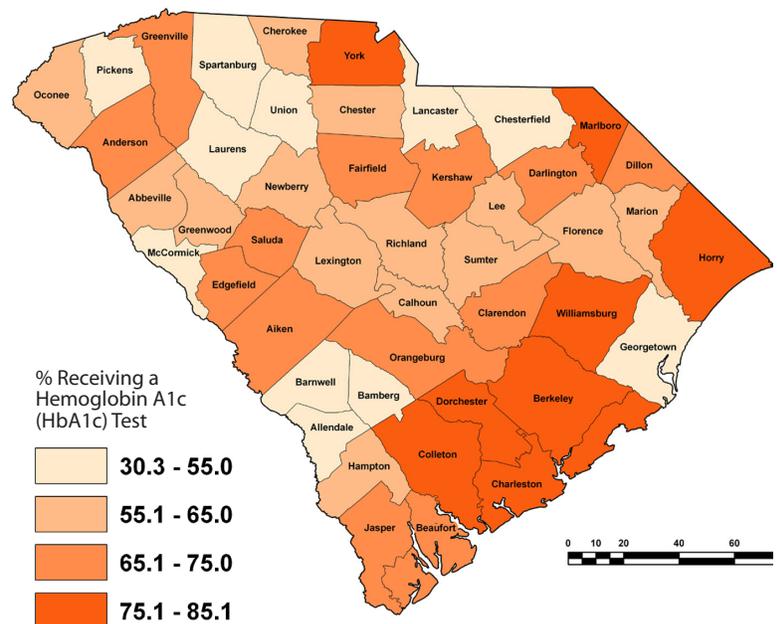
Multifaceted interventions may be more likely to exert positive effects on glycemic control and (to a lesser extent) provider adherence than single interventions. These include the following interventions:

- 1) provider reminder systems;
- 2) facilitated relay of clinical data to providers;
- 3) audit and feedback;
- 4) provider education;
- 5) patient education;
- 6) promotion of self-management; and
- 7) patient reminder systems.

Source:

Shojania, K., Ranji, S., Shaw, L., Charo, L., Lai, J., . . . Owens, D. (2004, September). Closing the quality gap: A critical analysis of quality improvement strategies, Volume 2 – Diabetes mellitus care. (AHRQ Publication No. 04-0051-2). Rockville, MD: Agency for Healthcare Research and Quality. Available at: <http://www.ahrq.gov/clinic/tp/dbgap2tp.htm>

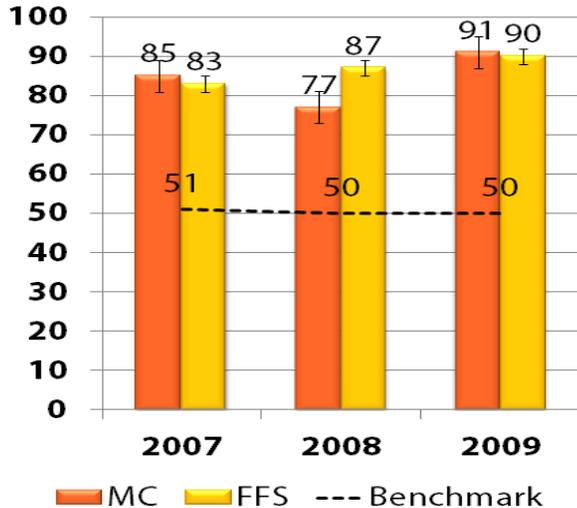
### Percentage of Adults Ages 18 to 75 With Diabetes Who Received a Hemoglobin A1c (HbA1c) Test in the Measurement Year



Source: SC Medicaid Information System, FY 2009  
Created by the University of South Carolina, Institute for Families in Society, December 2009

## Diabetes Care Dilated Eye Exam

Regardless of health plan, the SC Medicaid program has exceeded national benchmarks for this measure.



### Who was included and what was measured?

This measure included the percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who were enrolled at least 11 months during the measurement year and who had a dilated eye exam test during the measurement year.



### Background Information

Diabetes affects more than 17 million people in the United States alone. Taking into account undiagnosed cases and cases of impaired glucose tolerance, one in seven Americans either has diabetes or is at high risk for developing it. Despite a high-quality evidence base to aid providers in treating diabetes and screening for its complications, the quality of diabetes care remains less than optimal, with many patients not receiving established processes of care (such as eye and foot screening) or achieving optimal outcomes (such as controlled glycosylated hemoglobin levels).

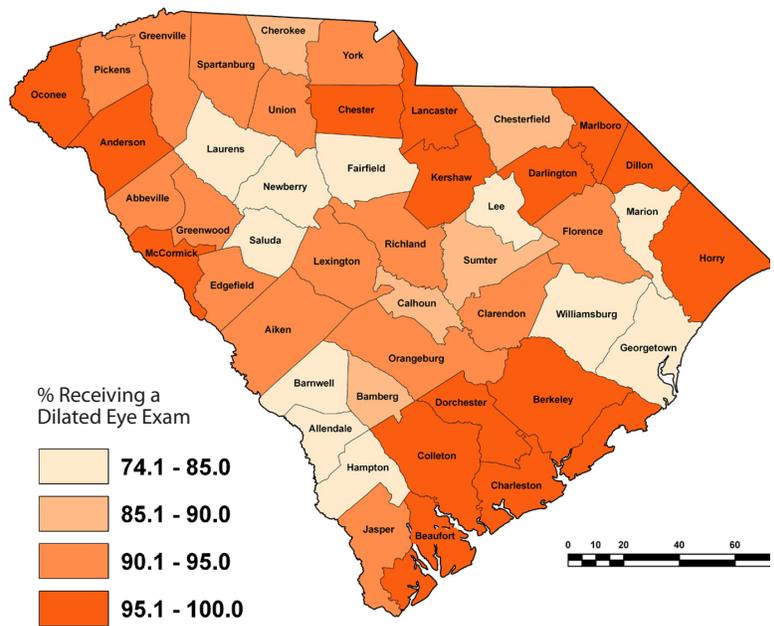
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- 4) provider education;
- 5) patient education;
- 6) promotion of self-management; and
- 7) patient reminder systems.

Source:

Shojania, K., Ranji, S., Shaw, L., Charo, L., Lai, J., . . . Owens, D. (2004, September). Closing the quality gap: A critical analysis of quality improvement strategies, Volume 2 – Diabetes mellitus care. (AHRQ Publication No. 04-0051-2). Rockville, MD: Agency for Healthcare Research and Quality. Available at: <http://www.ahrq.gov/clinic/tp/dbgap2tp.htm>

### Percentage of Adults Ages 18 to 75 With Diabetes Who Had a Dilated Eye Exam in the Measurement Year



% Receiving a Dilated Eye Exam

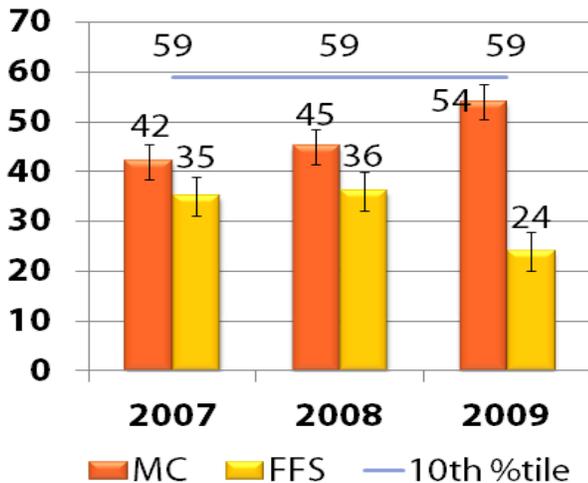
- 74.1 - 85.0
- 85.1 - 90.0
- 90.1 - 95.0
- 95.1 - 100.0



Source: SC Medicaid Information System, FY 2009  
Created by the University of South Carolina, Institute for Families in Society, December 2009

## Diabetes Care Lipid Profile (LDL-C) Screening

Adults with diabetes in managed care were more likely to have a lipid profile screening within the past two years.



### Who was included and what was measured?

This measure included the percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who were enrolled at least 11 months during the measurement year and who had a lipid profile performed during the measurement year or the year prior to the measurement year.



### Background Information

Diabetes affects more than 17 million people in the United States alone. Taking into account undiagnosed cases and cases of impaired glucose tolerance, one in seven Americans either has diabetes or is at high risk for developing it. Despite a high-quality evidence base to aid providers in treating diabetes and screening for its complications, the quality of diabetes care remains less than optimal, with many patients not receiving established processes of care (such as eye and foot screening) or achieving optimal outcomes (such as controlled glycosylated hemoglobin levels).

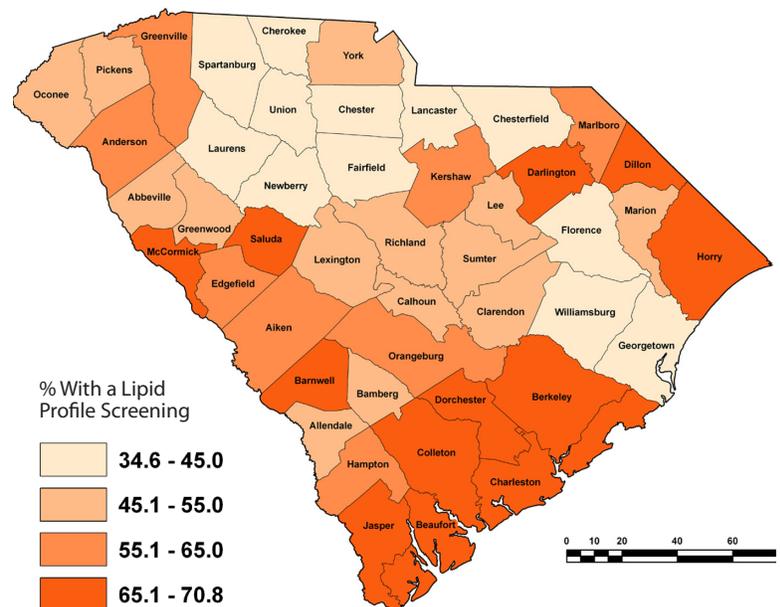
Multifaceted interventions may be more likely to exert positive effects on glycemic control and (to a lesser extent) provider adherence than single interventions. These include the following interventions:

- 1) provider reminder systems;
- 2) facilitated relay of clinical data to providers;
- 3) audit and feedback;
- 4) provider education;
- 5) patient education;
- 6) promotion of self-management; and
- 7) patient reminder systems.

Source:

Shojania, K., Ranji, S., Shaw, L., Charo, L., Lai, J., . . . Owens, D. (2004, September). Closing the quality gap: A critical analysis of quality improvement strategies, Volume 2 - Diabetes mellitus care. (AHRQ Publication No. 04-0051-2). Rockville, MD: Agency for Healthcare Research and Quality. Available at: <http://www.ahrq.gov/clinic/tp/dbgap2tp.htm>

### Percentage of Adults Ages 18 to 75 With Diabetes Who Had a Lipid Profile Screening in the Measurement Year



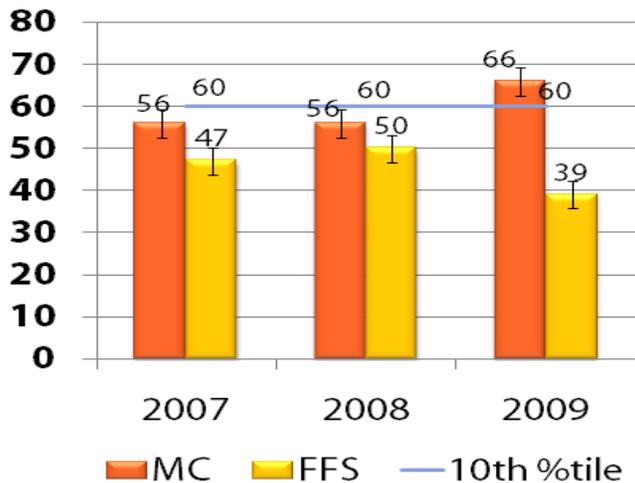
Source: SC Medicaid Information System, FY 2009  
Created by the University of South Carolina, Institute for Families in Society, December 2009

## Diabetes Care Urine Screening for Microalbumin or Medical Attention for Nephropathy

Adults with diabetes enrolled in managed care were more likely to receive a urine screening during the past two years at or above the 10th percentile of the Medicaid national benchmark.

Who was included and what was measured?

This measure included the percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who were enrolled at least 11 months during the measurement year and who had a urine screening for microalbumin performed during the measurement year or the year prior to the measurement year.



### Background Information

Diabetes affects more than 17 million people in the United States alone. Taking into account undiagnosed cases and cases of impaired glucose tolerance, one in seven Americans either has diabetes or is at high risk for developing it. Despite a high-quality evidence base to aid providers in treating diabetes and screening for its complications, the quality of diabetes care remains less than optimal, with many patients not receiving established processes of care (such as eye and foot screening) or achieving optimal outcomes (such as controlled glycosylated hemoglobin levels).

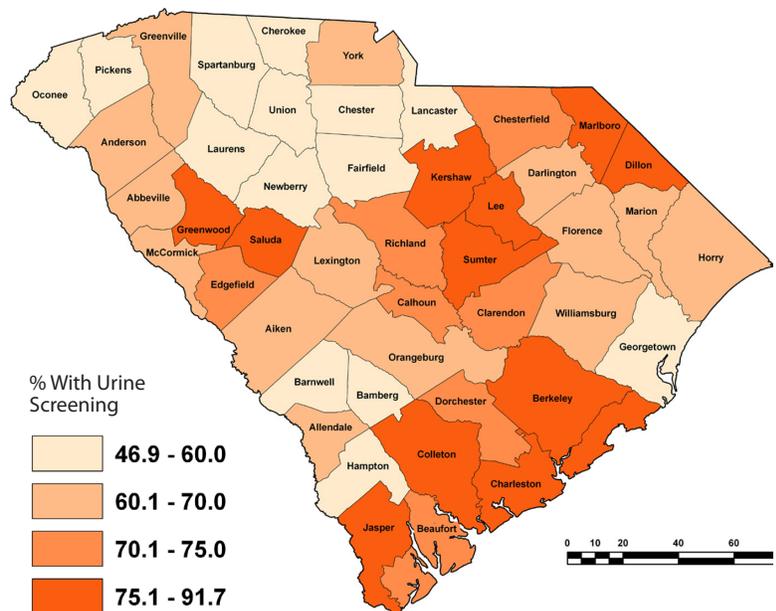
Multifaceted interventions may be more likely to exert positive effects on glycemic control and (to a lesser extent) provider adherence than single interventions. These include the following interventions:

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- 2) facilitated relay of clinical data to providers;
- 3) audit and feedback;
- 4) provider education;
- 5) patient education;
- 6) promotion of self-management; and
- 7) patient reminder systems.

Source:

Shojania, K., Ranji, S., Shaw, L., Charo, L., Lai, J., . . . Owens, D. (2004, September). Closing the quality gap: A critical analysis of quality improvement strategies, Volume 2 - Diabetes mellitus care. (AHRQ Publication No. 04-0051-2). Rockville, MD: Agency for Healthcare Research and Quality. Available at: <http://www.ahrq.gov/clinic/tp/dbgap2tp.htm>

### Percentage of Adults Ages 18 to 75 With Diabetes Who Had a Urine Screening for Microalbumin in the Measurement Year



Source: SC Medicaid Information System, FY 2009  
Created by the University of South Carolina, Institute for Families in Society, December 2009

# CAHPS®

## What is the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)?

CAHPS® is a survey to examine what consumers think about their experiences with their doctors, health plan, and overall quality of health care. For example, it asks how well they are able to communicate with their doctors, schedule appointments, or find answers to their questions. With these results, the SC Medicaid Program is able to evaluate our state's progress in providing effective and accessible medical care. Access, availability, and communication all play an important role in achieving effective care. That's why Medicaid has been conducting annual beneficiary satisfaction surveys to measure consumer perceptions of their medical care. Since 1997, this survey has become the national standard for measuring and reporting on the experiences of consumers with their health plans.

## Caveats About the Survey

Survey results were collected in 2006 (baseline) and 2007 using CAHPS® Version 3.0. Survey results for 2008 (baseline) and 2009 were collected using CAHPS® Version 4.0. There were no statistically significant differences in the findings between fee-for-service and managed care plans across the data series. As such, the results for the global ratings of personal doctor, specialists, health care and health plan are presented without distinction for the health care plan. The composite measures were modified in CAHPS® Version 4.0, therefore, are presented only for 2009 for both children and adults. The maps are limited to depicting CAHPS rates only for managed care recipients residing in those counties.



In the last 6 months, not counting the times you needed care away, how often did you get an appointment for your health care provider's office or clinic as soon as you thought you needed?

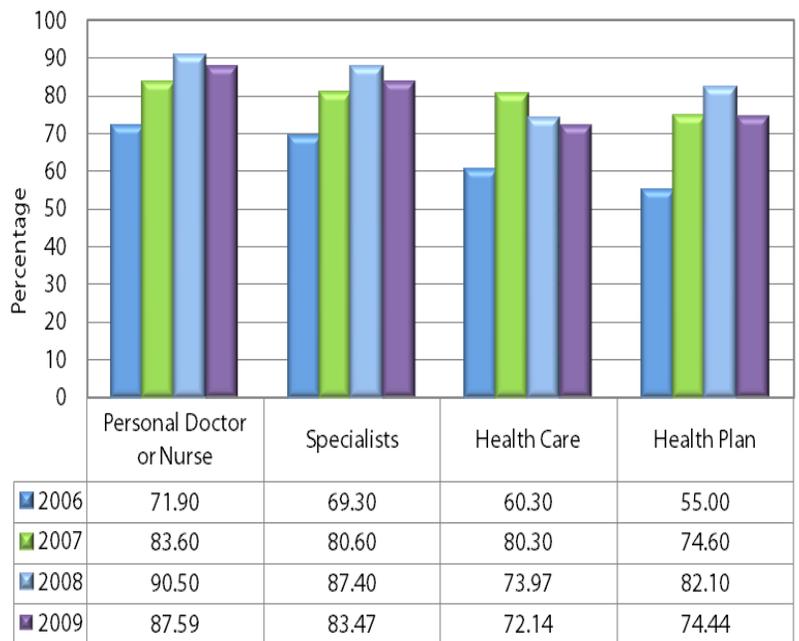
- 1  Never
- 2  Sometimes
- 3  Usually

## Overall Quality and Satisfaction 2006-2009

Overall, the majority of survey respondents are very satisfied with managed care. Shown at the right are the percentages of participants who indicated a high degree of satisfaction (a rating of “8,” “9,” or “10”).

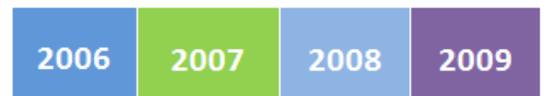
Satisfaction has been very good and has continued to increase on three of the four measures through 2008. The majority of survey respondents rate their medical care providers highly. About 8 out of 10 rate their personal doctors (87%) or specialists (83%) “8,” “9,” or “10.”

Respondents rate their health plans (74%) and overall healthcare (73%) highly, but lower than they rate their personal doctors and specialists. This is consistent with national ratings for Medicaid health plans.



Survey participants were asked to rate their satisfaction with the following on a scale from “0” (worst possible) to “10” (best possible). Shown at right are the average rates of satisfaction based on all responses received.

Overall, survey respondent satisfaction increased from 2006 to a high in 2008. Although the average ratings are slightly less in 2009, all ratings are very positive, averaging more than 9 for personal doctor and more than 8 for all other global ratings.



Average Rating

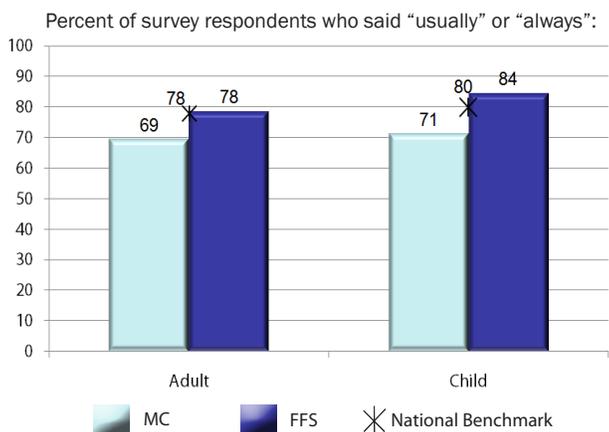
	2006	2007	2008	2009
Personal Doctor or Nurse	8.67	8.94	9.18	9.09
Specialists	8.36	8.66	8.92	8.82
Health Care	8.19	8.72	8.56	8.34
Health Plan	7.89	8.57	8.81	8.36

## Getting Needed Care

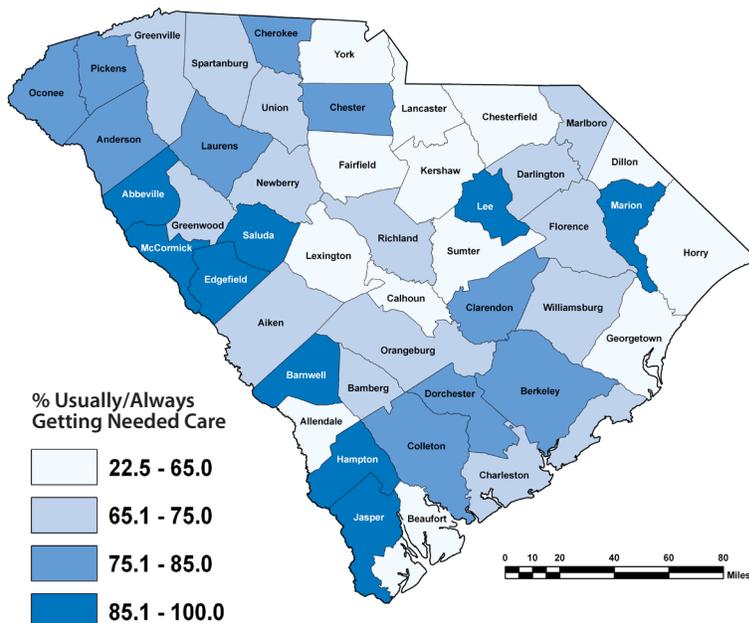
In 2009, 69% or more of survey respondents said that it was “usually” or “always” easy to get:

- appointments for themselves or their children with specialists.
- the care, tests, or treatment they thought they or their child needed through their health plan.

Ratings of consumer experiences for both children and adults in managed care were within range of the national benchmark, while ratings for adults and children in fee-for-service met or exceeded national benchmarks.



## Percentage of CAHPS Respondents Stating They “Usually” or “Always” Get Needed Care



Data Source: South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS), 2009 Survey of Medicaid Consumers.

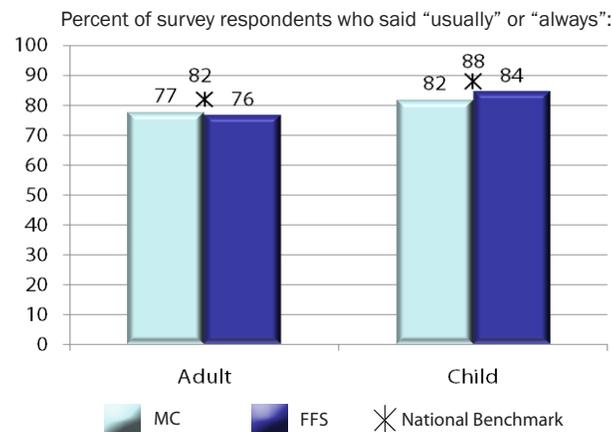
Created by the University of South Carolina, Institute for Families in Society, December 2009.

## Getting Care Quickly

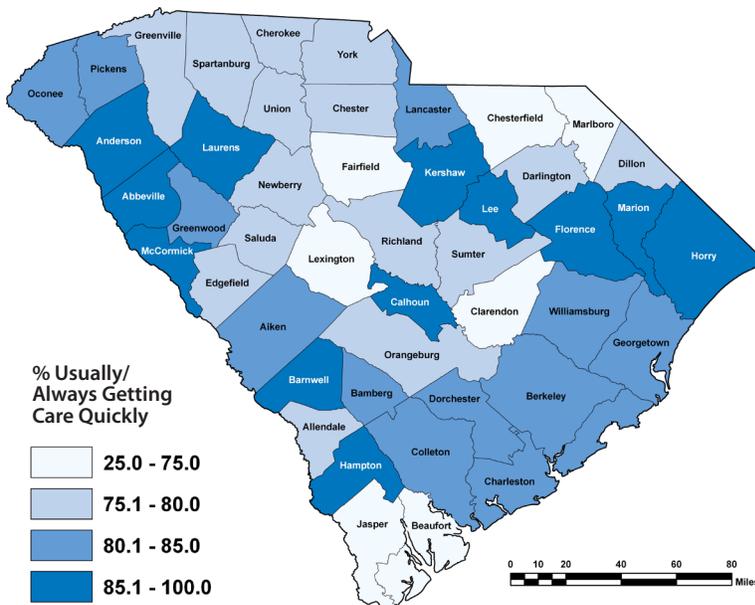
In 2009, more than 75% of survey respondents said that they “usually” or “always”:

- got care as soon as they thought they needed for themselves or their child for an illness, injury or condition.
- got an appointment for routine health care at their or their child’s doctor’s office as soon as needed.

Ratings of consumer experiences for both children and adults regardless of plan type were within range of national benchmarks.



## Percentage of CAHPS Respondents Stating They “Usually” or “Always” Get Care Quickly



Data Source: South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS), 2009 Survey of Medicaid Consumers.

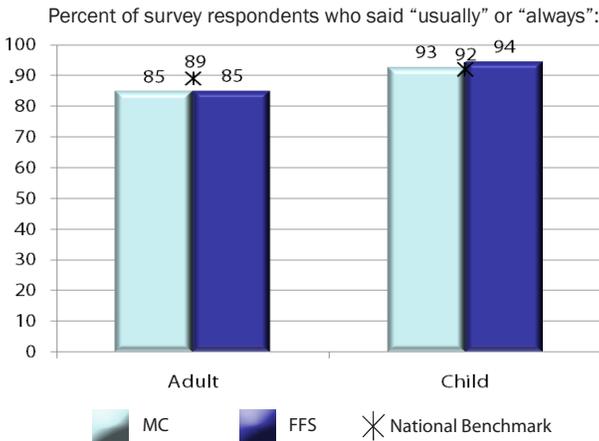
Created by the University of South Carolina, Institute for Families in Society, December 2009.

## Doctors Who Communicate Well With Their Patients

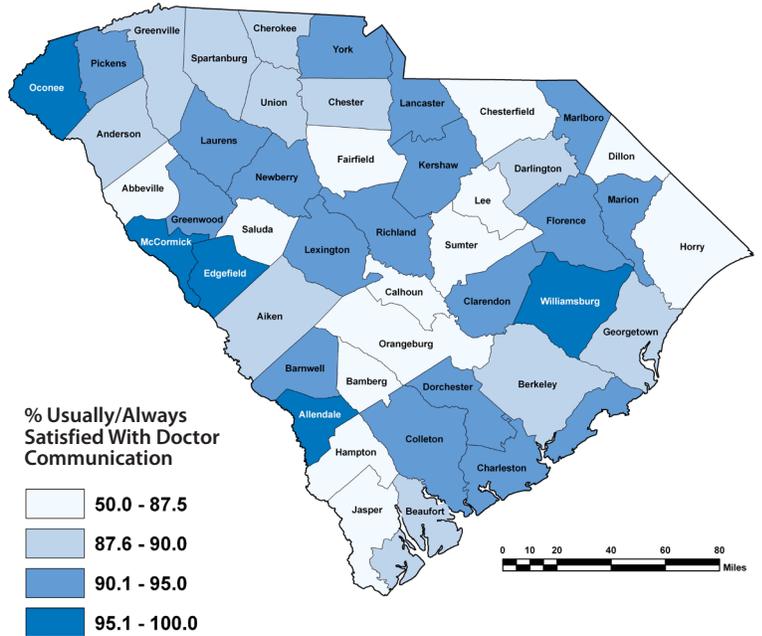
In 2009, 85% of adult respondents and at least 93% of respondents for children said that their personal doctor or their child's personal doctor "usually" or "always":

- explained things to themselves or their child in a way that was easy to understand.
- listened carefully to them.
- showed respect for what they had to say.
- spent enough time with them.

Ratings of consumer experiences with their doctors or their child's doctors were within range of or exceeded national benchmarks.



## Percentage of CAHPS Respondents Stating They Are "Usually" or "Always" Satisfied With How Well Doctors Communicate



Data Source: South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS), 2009 Survey of Medicaid Consumers.

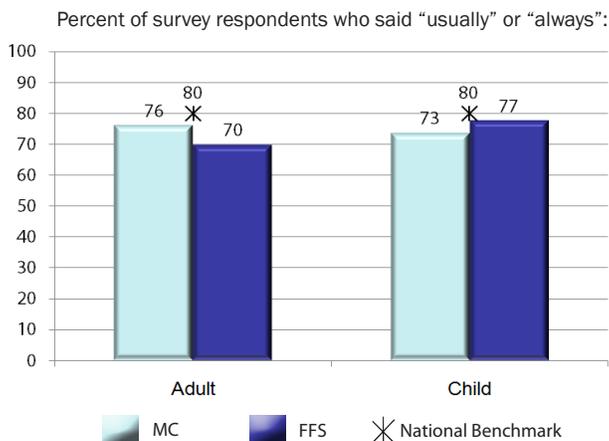
Created by the University of South Carolina, Institute for Families in Society, December 2009.

## Health Plan Information/ Customer Service

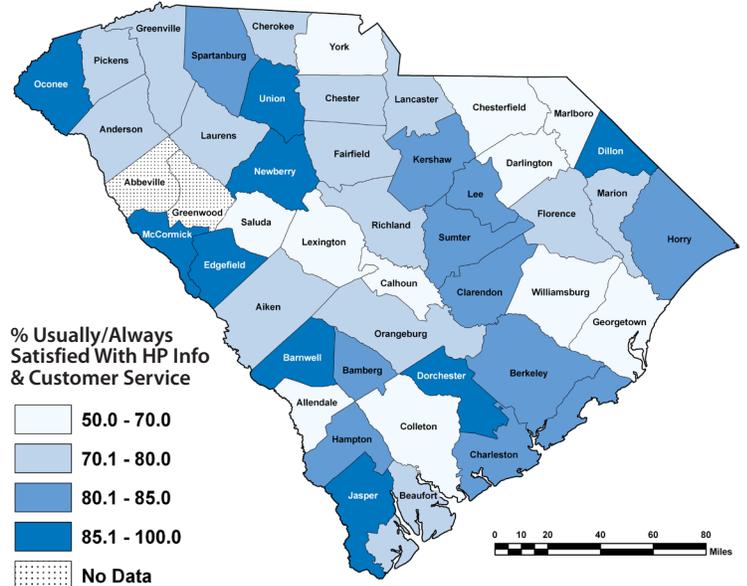
In 2009, 70% or more of survey respondents said that "usually" or "always" their or their child's health plan's:

- customer service gave them the information or help they needed.
- customer service staff treated them with courtesy and respect.

Ratings of consumer experiences were within range of national benchmarks.



## Percentage of CAHPS Respondents Stating They Are "Usually" or "Always" Satisfied With Health Plan Information and Customer Service



Data Source: South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS), 2009 Survey of Medicaid Consumers.

Created by the University of South Carolina, Institute for Families in Society, December 2009.

## Access To Care

In 2008 and 2009, a series of studies was started to examine access to care within the SC Medicaid Managed Care Program. The first two reports in this series are completed: *Distance Analysis of Children with Special Health Care Needs Access to Pediatric Subspecialists* and *Women of Childbearing Age: Access to OB-GYN Providers*. Each report investigates geographic proximity to fee-for-service and managed care health plan network identified providers. Due to the overlap of providers commonly shared across managed care plans, the analyses examine the difference in access to care for all patients participating in managed care or fee-for-service programs. A further analysis compares “actual” distance to providers using paid claims to identify the OB/GYN or pediatric subspecialists providing the service. Geographic proximity to health care providers is an important component of access to health care services.

The Balanced Budget Act of 1997 (BBA) gave states new authority to require certain Medicaid beneficiaries to enroll in managed care plans and also required the establishment of consumer protections for Medicaid managed care enrollees in areas such as access to and quality of care (Pub. Law. No. 105-33, § 4701, 111 Stat. 251, 489; § 4705(a), 111 Stat. at 498). BBA requires safeguards to ensure enrollees have access to care including requiring plans to maintain provider networks that provide enrollees with sufficient geographic access to providers. State Medicaid programs set geographic access standards within their managed care programs. These State standards ensure that enrollees in managed care plans can physically access services as required by policy or indicated by the MCO and approved by SC DHHS. An executive summary of the findings from this series on access to care is available from the SC Department of Health and Human Services, Division of Care Management.

The approach for each of the access to care studies involves geocoding the addresses of providers, distinguishing between those within the approved health care plan network from those enrolled in fee-for-service. MapInfo MapMarker® Plus spatially finds the providers and Medicaid recipients. This information is entered in the ESRI ArcView® extension, "Shortest Network Path," to calculate the shortest distance on the South Carolina road network (including streets, state and U.S. highways, and Interstate highways) between the home and the nearest provider. These computationally intensive spatial analyses represent an alternative calculation method to measuring trip-to-provider length using a straight line, or “as-the-crow flies” method. The analyses create point-to-point travel distances representing Medicaid recipient’s likely path of travel to a provider, instead of generalized straight line or zone based distance estimates.

The analysis from the study examining access to OB/GYN providers shows that over ninety percent of all Medicaid recipients were within 30 miles of an OB/GYN provider from their home. This finding holds true regardless of the choice of the Medicaid recipient to participate in a managed care plan or to remain in fee-for-service. The current requirements for managed care health plans to set up provider networks considering a 30-mile radius is suitable given the current distribution of providers and Medicaid recipients. The access to pediatric subspecialists study found that eighty-seven percent of Medicaid children with special health care needs have access to a pediatric subspecialty care provider within 30 miles of their home. Of those with paid claims, children classified with complex medical conditions had the most frequent number of visits to a pediatric subspecialty provider outside the 30-mile radius of their home. Even when providers were available closer to home, these children often traveled to one of four hospital-based specialty clinics. These clinics and providers were associated with the Medical University of South Carolina, Palmetto Richland, Greenville Hospital, or McLeod Regional Hospital Center. In summary, these studies found no geographical access difference between recipients enrolled in managed care or fee-for-service using the 30-mile radius as the guidepost for setting up network providers.

