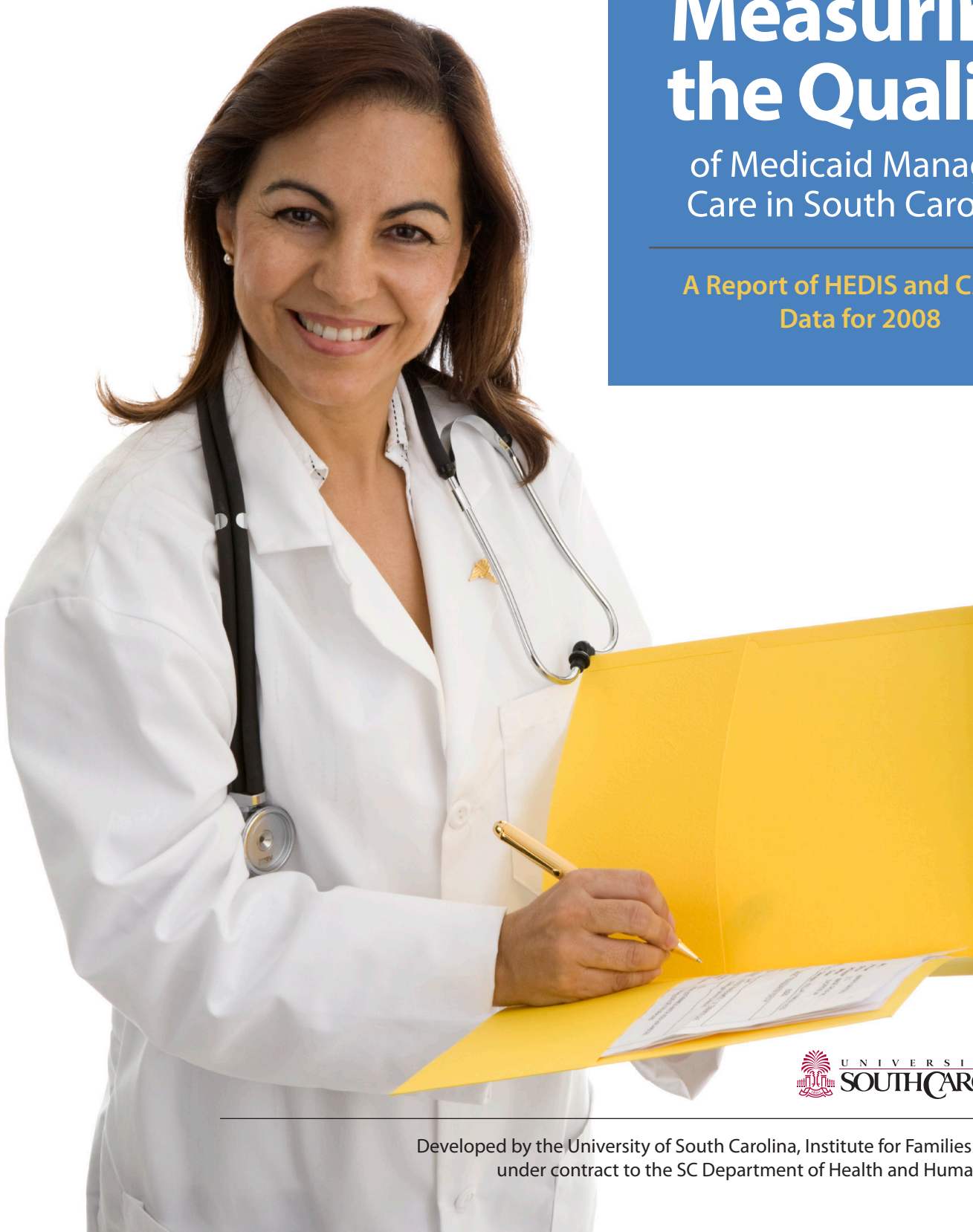


Measuring the Quality

of Medicaid Managed
Care in South Carolina

A Report of HEDIS and CAHPS
Data for 2008



Developed by the University of South Carolina, Institute for Families in Society
under contract to the SC Department of Health and Human Services
May 2009

Measuring the Quality of Medicaid Managed Care in South Carolina

A Report of HEDIS and CAHPS Data for 2008

May 2009

Ana Lòpez– De Fede, PhD
Associate Research Professor

Kathleen Moniz, MSPH
Research Associate

Kathy Mayfield–Smith, MA, MBA
Research Associate Professor

Nagavalli Sudarshan, MEd, MSPH
Research Associate

Verna Brantley, MSPH
Senior Research Associate

Xiaouhi Zhang, MPH
Research Associate

Qiduan Liu, PhD
Senior Research Associate

John Stewart, MS, MPH
Senior Research Associate

Teresa Payne, MSPH
Senior Research Associate

Roland Richard, MPH
Research Associate

Stephanie Watkins, MSPH
Senior Research Associate

Madonna Jackson
Administrative Support

Suggested citation for this report:

Lòpez-De Fede, A., Mayfield-Smith, K., Brantley, V., Liu, Q., Payne, T., Watkins, S., et al. (2009). Measuring the Quality of Medicaid Managed Care in South Carolina: A Report of HEDIS and CAHPS Data for 2008. University of South Carolina, Institute for Families in Society: Columbia, SC.

Measuring the Quality of Medicaid Managed Care in South Carolina

A Report of HEDIS and CAHPS Data for 2008

Table of Contents

Executive Summary	p. 4
HEDIS	
How HEDIS Information Is Used	p. 5
Interpreting and Using the Results in this Report	p. 5
Interpreting Multi-Year Trends	p. 5
Data Limitations	p. 6
Caveats	p. 6
Health Measures for Children	
Asthma Medication Use	p. 8
Childhood Immunizations	p. 9
Well Child Visits Ages 3 Through 6 Years	p. 10
Annual Dental Visits	p. 11
Lead Screening in Children	p. 12
Appropriate Use of Antibiotics: Treatment for Children with Upper Respiratory Infection (URI)	p. 13
Behavioral Health Measures	
Attention-deficit Hyperactivity Disorder (ADHD)	p. 15
Follow-up Care Within 7 Days After Hospitalization for Mental Illness Ages 6 Years and Above	p. 16
Follow-up Care Within 30 Days After Hospitalization for Mental Illness Ages 6 Years and Above	p. 17
Health Measures for Women	
Breast Cancer Screening	p. 19
Cervical Cancer Screening (PAP Test)	p. 20
Prenatal Care Visits	p. 21
Postnatal Care Visits	p. 22
Adult Asthma Health Measures	
Adult Asthma Medication Use	p. 24
Diabetes Care and SC Medicaid Recipients	
Hemoglobin A1c (HbA1c) Test	p. 26
Dilated Eye Exam	p. 27
Lipid Profile (LDL-C) Screening	p. 28
Urine Screening for Microalbumin or Medical Attention for Nephropathy	p. 29
CAHPS®	
What is the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)?	p. 30
Caveats About the Survey	p. 30
Overall Quality and Satisfaction	p. 31
Getting the Care You Need	p. 32
Getting Care Without Long Waits	p. 32
Doctors Who Communicate Well With Their Patients	p. 33
Customer Service	p. 33
Access to Care	p. 34

**HEDIS and CAHPS
Measures Where SC
Met or Exceeded
National Benchmarks**

Diabetes: Dilated Eye Exam
Both managed care and fee-for-service health plans for 3 consecutive years

Children: Appropriate Use of Antibiotics – Treatment for Upper Respiratory Infection (URI)
Both health plans for 3 consecutive years

Children: Annual Dental Visits
Both health plans for 3 consecutive years

Children: Asthma Medication Use
Managed Care for 2 consecutive years

Diabetes: Urine Screening for Microalbumin or Medical Attention for Nephropathy
Managed Care for 3 consecutive years

Women: Postnatal Care Visits
Fee-for-Service for 3 consecutive years

Women: Prenatal Care Visits
Fee-for-Service for 2008

Mental Health: Follow-Up Care Within 30 Days After Hospitalization for Mental Illness—Ages 6 Years and Above
Both health plans for 3 consecutive years

Getting Needed Care: Personal Doctor, Specialist, Health Care, Health Plan
Both health plans for 2 consecutive years

Doctors Communicate Well With Their Patients
Both plans for 2 consecutive years

Customer Service
Managed Care for 2008

Executive Summary

A big part of improving Medicaid health care in South Carolina is having accurate, complete, and up-to-date information about the care being provided and its results. 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 health services provided through Medicaid managed care. 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 2008, 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.

Quality Indicators

The Healthcare Effectiveness Data and Information Set (HEDIS) is used by more than 90 percent of America's health plans to measure performance by looking at the total numbers and types of health care services provided to consumers. The 2008 HEDIS measures for South Carolina showed that, overall, people who received health care services through Medicaid managed care fared better than those whose care was delivered in a fee-for-service arrangement.

In 2008, 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 2008 HEDIS data also showed that, compared to those receiving fee-for-service care, adults in Medicaid managed care plans:

- 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;
- had their diabetes monitored at higher rates through urine screenings, dilated eye exams, and bloodwork.

Consumer Experiences

To find out what consumers think about their health care providers and their quality of care, South Carolina uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. The survey asks health care customers questions about the care they received, how well they felt they were treated, and how quickly they were seen. Overall, the 2008 CAHPS® survey results showed high levels of satisfaction among the recipients of Medicaid managed care.

About 8 out of every 10 people asked gave high ratings to their personal doctor or nurse, as well as their specialists, their health care and health plan overall.

- 81% said that it was not a problem for them to get a doctor with whom they were happy or see a specialist;
- 79% said that they always or usually received care without long waits, got appointments as soon as they wanted, and were seen promptly on arrival;
- 88% said that their doctor always or usually listened carefully to them, explained things in an understandable way, and spent enough time with them; and
- 79% felt that their doctor's office staff treated them with courtesy and respect and provided the assistance that was needed.

HEDIS

HEDIS (the 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 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.

Interpreting and Using the Results in this Report

The primary goal of HEDIS 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.

Interpreting Multi-Year Trends

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.

When comparing multi-year performance, caution is necessary as the definition 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.

Data Limitations

This document is a selective summary of HEDIS data reported in calendar year 2009 for health care activity carried out in calendar year 2008. Data for calendar year 2008 consist of claims adjudicated through February 28, 2009. Asthma and ADHD measures were not compiled for calendar year 2006 because of the lack of the necessary number of years of data. 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.

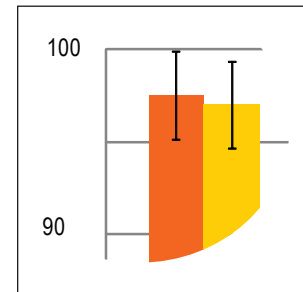


Chart with error bar

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 appears to be considerable degrees of variability. This can be the result of county or geographic differences and the length of time the health plan has been operational in South Carolina.

Caveats

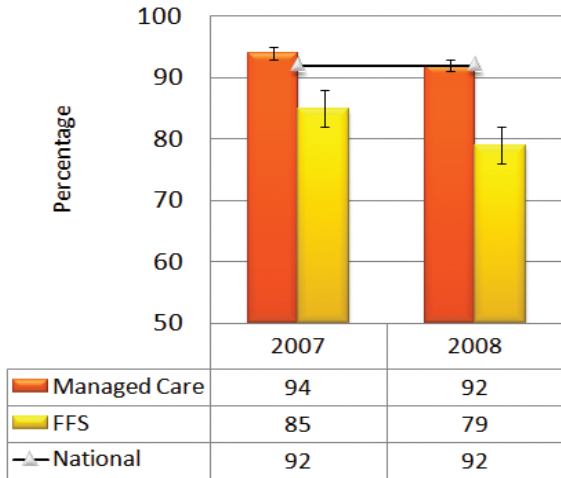
- Data for calendar year 2008 consist of claims adjudicated through February 2009.
- Asthma measures were not compiled for calendar year 2006, due to the low number of recipients with persistent asthma in managed care.
- The rates are subject to variability due to lack of data associated with NCQA guidelines 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.
- The maps are limited to depicting HEDIS rates only for managed care recipients residing in those counties.

Health Measures for Children



Asthma Medication Use

Children in Medicaid Managed Care with persistent asthma were more likely to have at least one prescription for an inhaled corticosteroid than those in fee-for-service.



Measure not taken in 2006.

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.

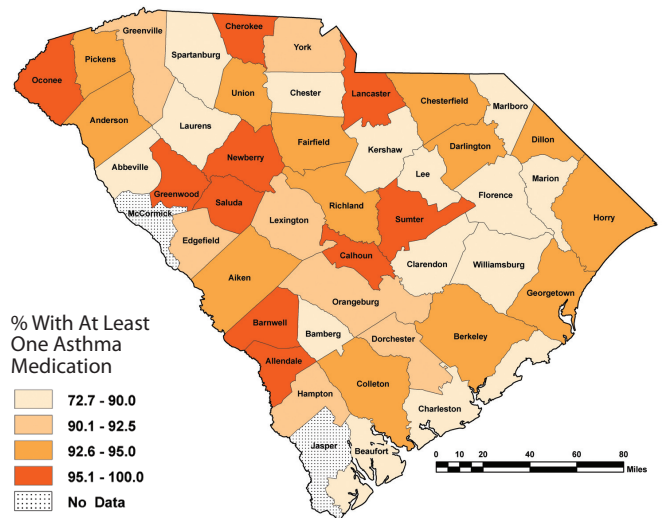


Tips to Improve This Measure

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: *Closing The Quality Gap: A Critical Analysis of Quality Improvement Strategies: Volume 5—Asthma Care*, Structured Abstract. January 2007. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/clinic/tp/asthmgaptp.htm>)

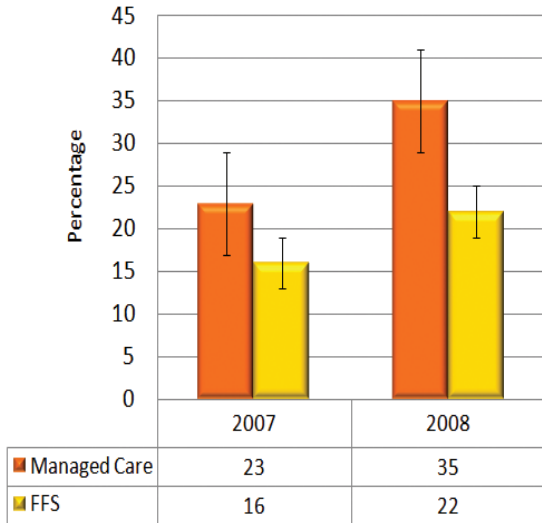
Percentage of Children Ages 5 to 17 With Persistent Asthma Using At Least One Asthma Medication



Source: SC Medicaid Information System, CY 2008
 Created by the University of South Carolina, Institute for Families in Society, May 2009.

Childhood Immunizations

The percentage of children with 4 or more immunizations by the age of 2 is higher for managed care compared to fee-for-service.



This measure captures only information on physician paid claims associated with administering an immunization.

Who was included and what was measured?

Modified HEDIS Definition

This measure included beneficiaries up to the age of 2 years who received immunizations. The percentage shows the percent of children with four or more claims for immunizations by age two.



Tips to Improve This Measure

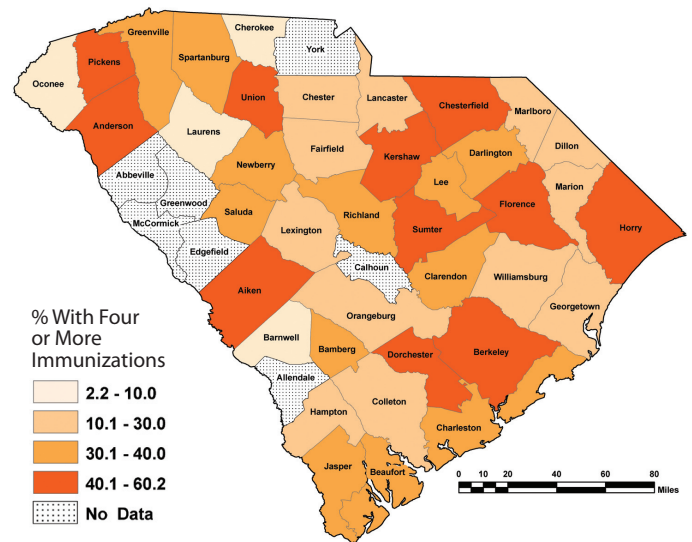
Five ways to improve reporting of immunizations:

- Implementing parent and provider reminder or recall systems.
- Educating targeted parents and providers.
- Reducing out-of-pocket costs for vaccines.
- Expanding access to immunizations through increased clinic hours and other measures.
- Giving feedback to providers.

CDC has found that interventions that didn't 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: The CDC's report, *Vaccine-Preventable Diseases: Improving Vaccination Coverage in Children, Adolescents, and Adults* (1999) is available at <http://www.cdc.gov/mmwr/pdf/rr/rr4808.pdf>)

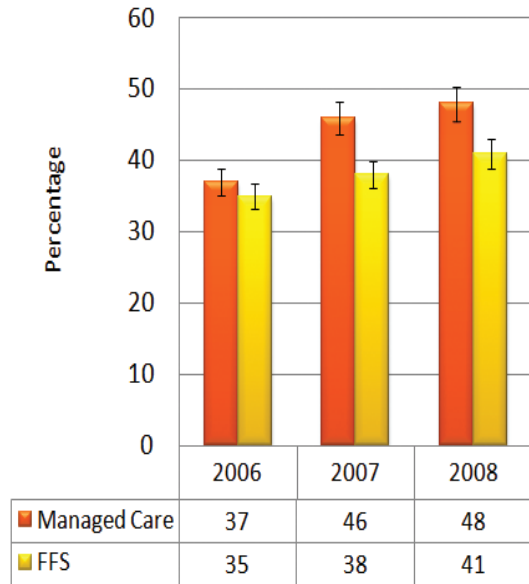
Percentage of Children With Four or More Immunizations by the Age of Two Years



Source: SC Medicaid Information System, CY 2008
Created by the University of South Carolina, Institute for Families in Society, May 2009.

Well-Child Visits—Ages 3 Through 6 Years

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 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.



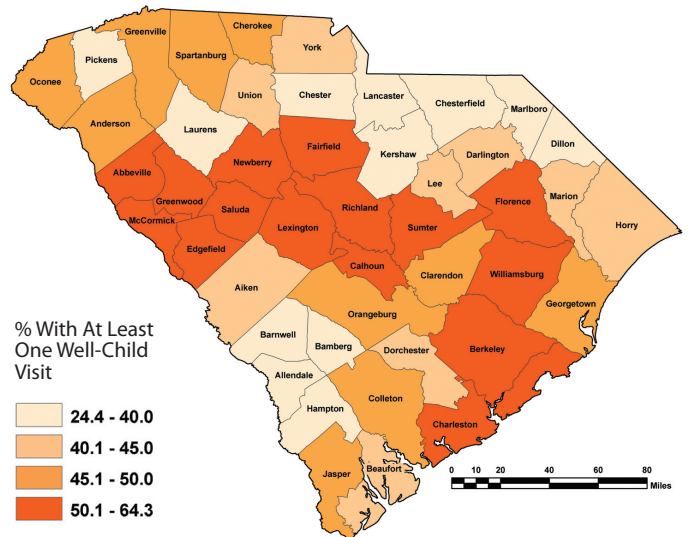
Tips to Improve This Measure

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. (Source: Bethell, C., Reuland, C., Halfon, N., Schor, E. Measuring the quality of preventive and developmental services for young children: national estimates and patterns of clinicians' performance. *Pediatrics* 2004 Jun;113 (6 Suppl):1973-83.)

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

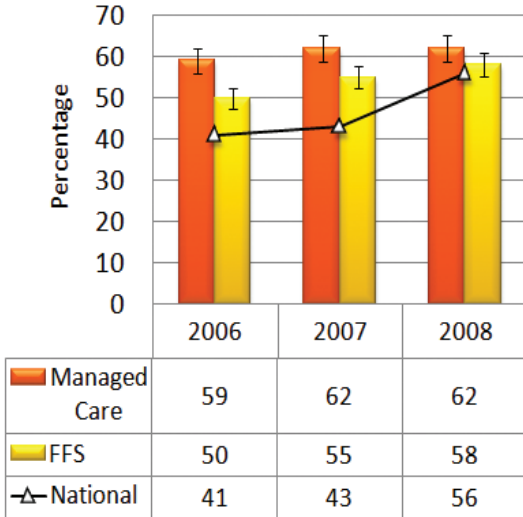
Percentage of Children Ages 3 to 6 With At Least One Well-Child Visit



Source: SC Medicaid Information System, CY 2008
Created by the University of South Carolina, Institute for Families in Society, May 2009.

Annual Dental Visits

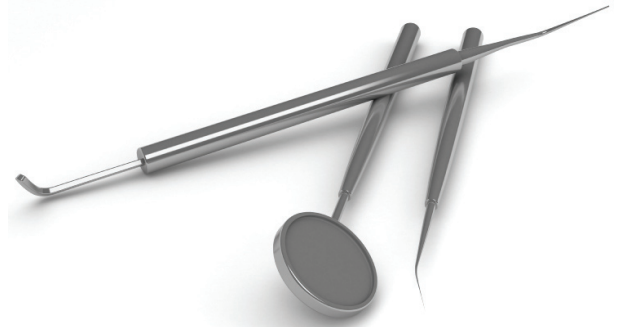
Children in managed care were more likely to have at least one yearly dental visit.



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



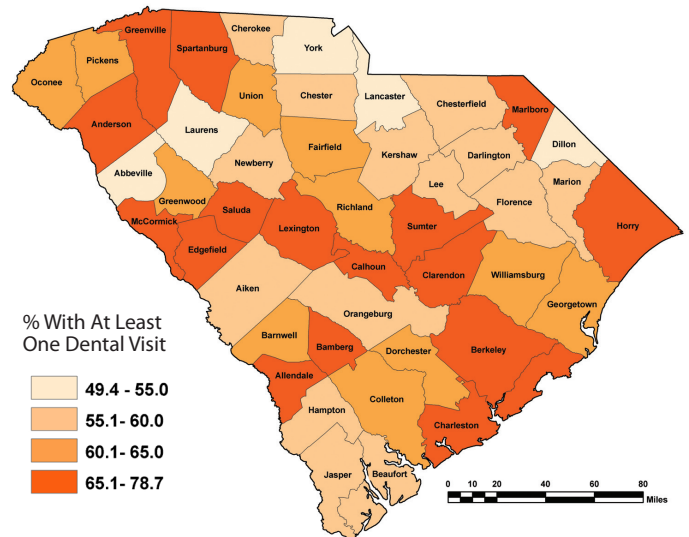
Tips to Improve This Measure

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.

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

The South Carolina Medicaid Program exceeds the national benchmark for this measure.

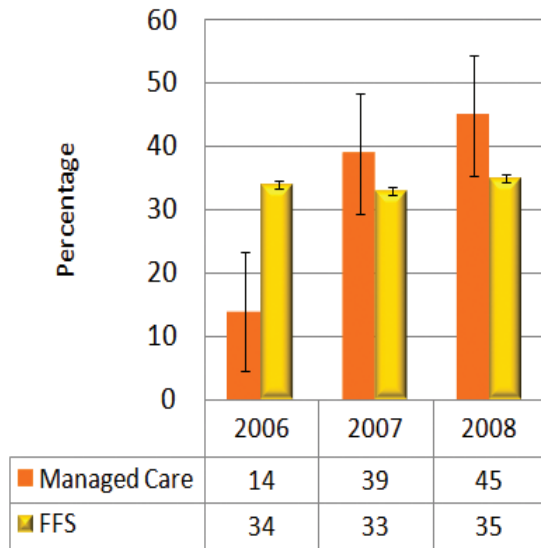
Percentage of Young People Ages 2 to 21 With At Least One Dental Visit



Source: SC Medicaid Information System, CY 2008
 Created by the University of South Carolina, Institute for Families in Society, May 2009.

Lead Screening

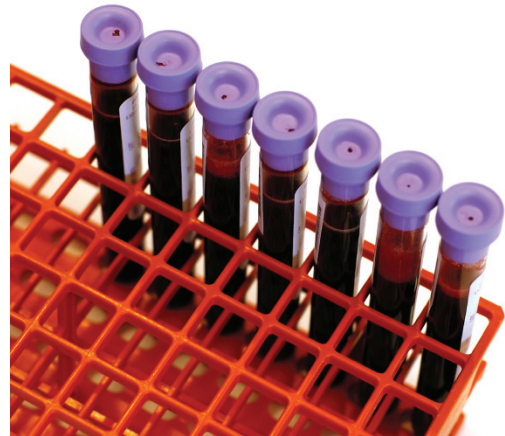
Starting in 2007, children in managed care were screened for lead at rates equal to or better than those in fee-for-service.



Who was included and what was measured?

Modified HEDIS Measure

The percentage of children 1 to 3 years of age at the end of the Calendar Year who had one or more capillary or venous lead blood tests for lead poisoning.

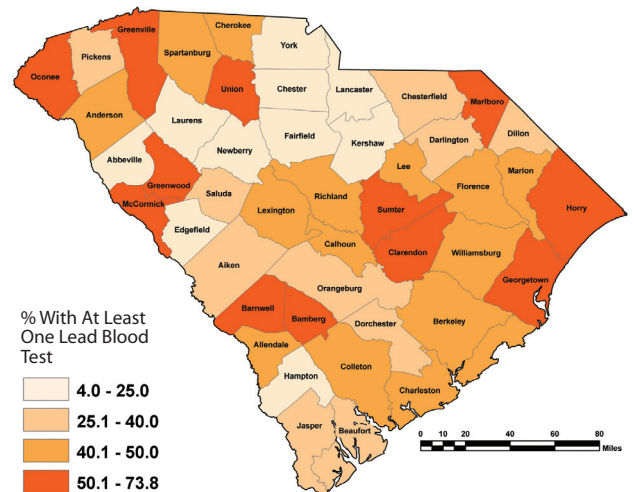


Tips to Improve This Measure

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 Calendar Year. This modified measure includes those recipients that were continuously enrolled for 11 months during CY2008 and also enrolled at the end of 2007 (anchor date) or 2 years vs. 3 years if claims/encounter data.

This modification is necessary due to the rapid growth of Medicaid managed care and the lag of encounter data to adequately capture this measurement without the modified definition.

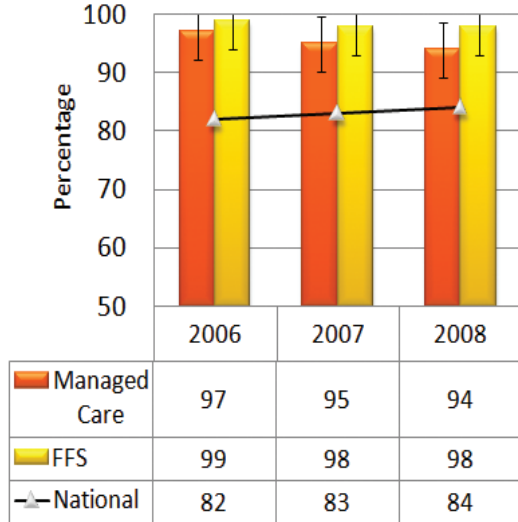
Percentage of Children Ages 1 to 3 Years With At Least One Lead Blood Test



Source: SC Medicaid Information System, CY 2008
 Created by the University of South Carolina, Institute for Families in Society, May 2009.

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

Children in the SC Medicaid Program were likely to receive appropriate antibiotic treatment for URI.



Regardless of the plan type, the rate of children with a URI who received appropriate care exceeded the national benchmark for three consecutive years.

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.

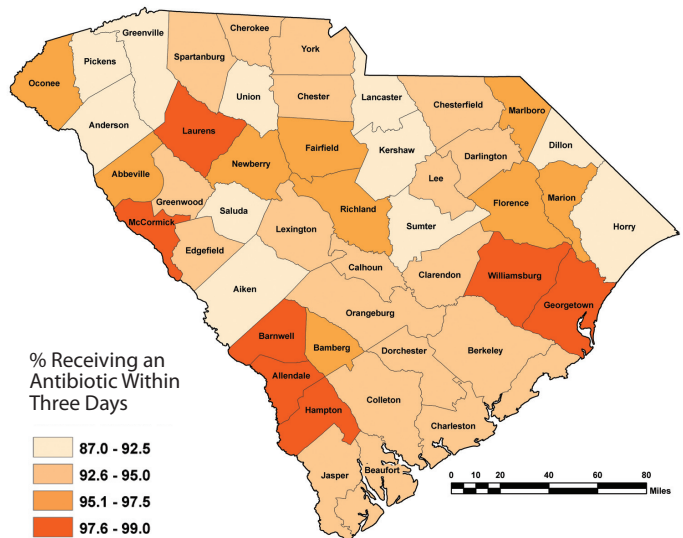


Tips to Improve This Measure

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.

(Source: *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies: Volume 4—Antibiotic Prescribing Behavior, Structured Abstract*. January 2006. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/clinic/tp/medigapt.htm>)

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



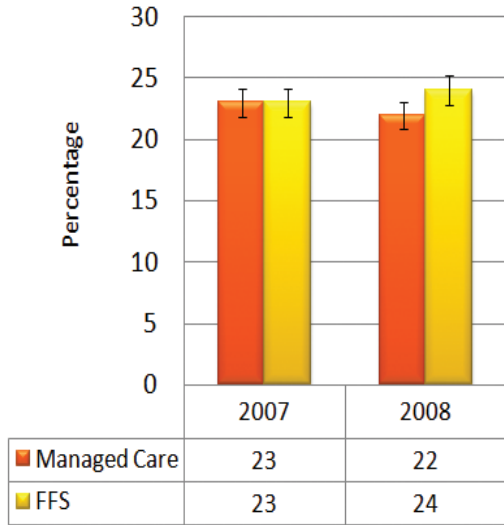
Source: SC Medicaid Information System, CY 2008
Created by the University of South Carolina, Institute for Families in Society, May 2009.

Behavioral Health Measures



Attention-deficit Hyperactivity Disorder (ADHD)

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



Measure not taken in 2006.

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.



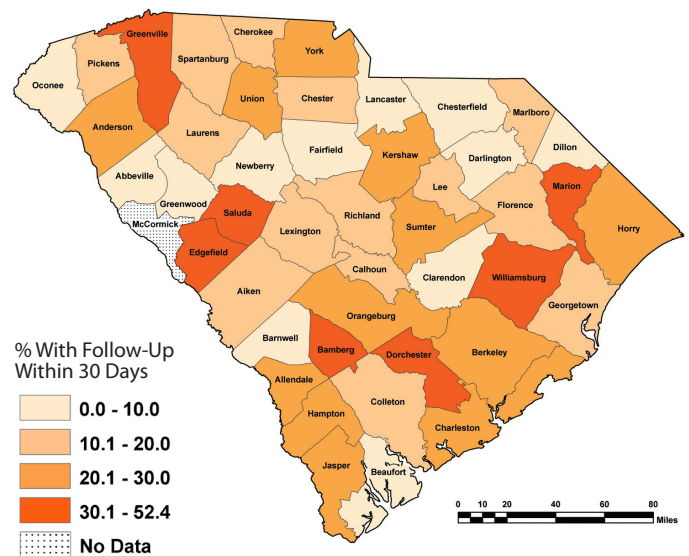
Tips to Improve This Measure

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.

(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, October 1997.)

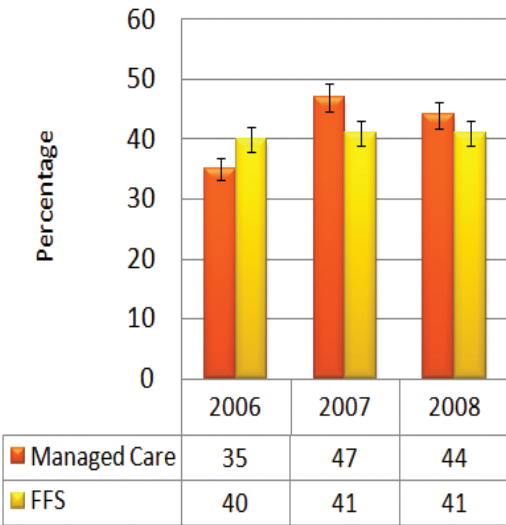
Percentage of Children Ages 6 to 12 Years With an ADHD Prescription Who Had a Follow-Up With Practitioner During 30-Day Initiation Phase



Source: SC Medicaid Information System, CY 2008
 Created by the University of South Carolina, Institute for Families in Society, May 2009.

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

In 2007 and 2008, recipients in managed care were more likely to receive follow-up care within 7 days after hospitalization for mental illness.



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.



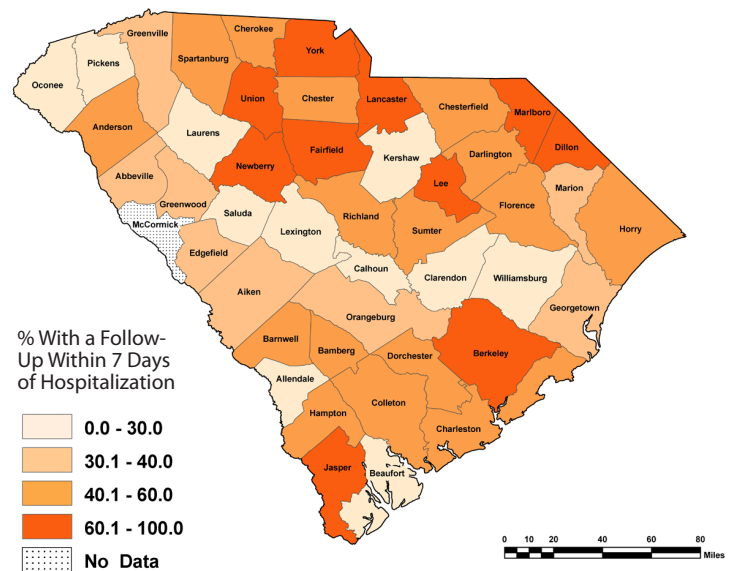
Tips to Improve This Measure

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 and 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 and Calsyn 1998).

Klinkenberg, W., and Calsyn, R. 1998. Predictors of Psychiatric Hospitalization: A Multivariate Analysis. *Administration and Policy in Mental Health*. 25 (4): 403

NCQA (National Committee for Quality Assurance). 2006. *The State of Health Care Quality, 2006*. Washington, D.C.: National Committee for Quality Assurance.

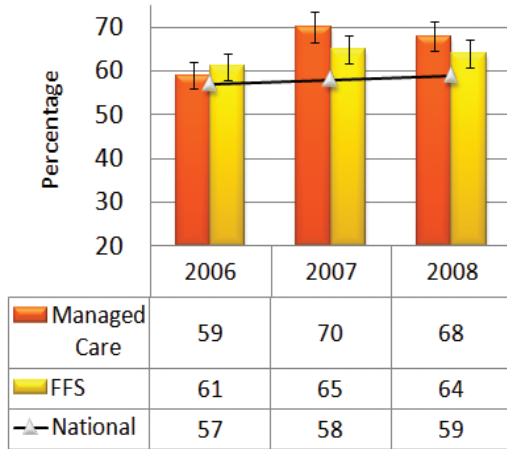
Percentage of Individuals Ages 6 and Above With a Follow-Up with Practitioner Within 7 Days of Hospitalization for Mental Illness



Source: SC Medicaid Information System, CY 2008
Created by the University of South Carolina, Institute for Families in Society, May 2009.

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

In 2007 and 2008, recipients in managed care were more likely to receive follow-up care within 30 days after hospitalization for mental illness.



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



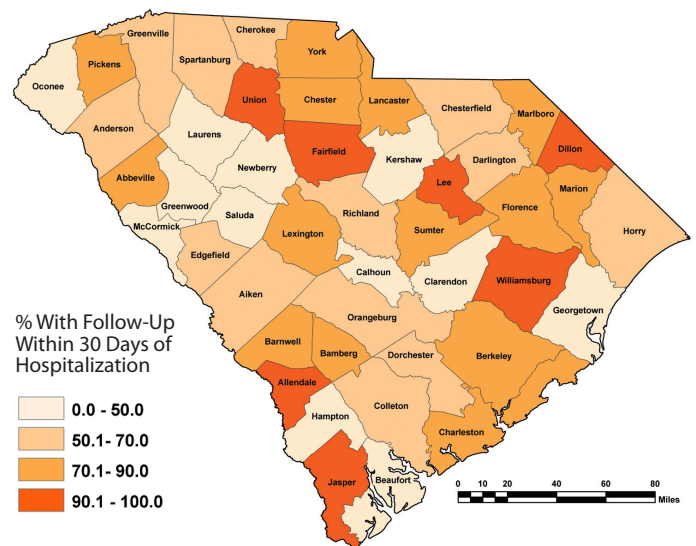
Tips to Improve This Measure

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 and 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 and Calsyn 1998).

Klinkenberg, W., and Calsyn, R. 1998. Predictors of Psychiatric Hospitalization: A Multivariate Analysis. *Administration and Policy in Mental Health*. 25 (4): 403

NCQA (National Committee for Quality Assurance). 2006. *The State of Health Care Quality, 2006*. Washington, D.C.: National Committee for Quality Assurance.

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



Source: SC Medicaid Information System, CY 2008
Created by the University of South Carolina, Institute for Families in Society, May 2009.

Health Measures for Women

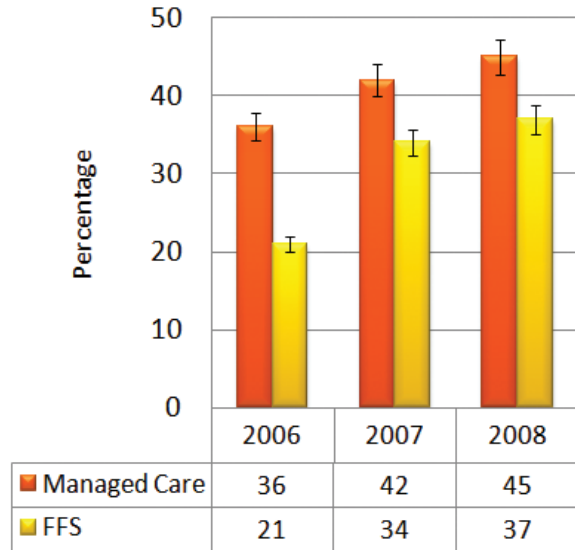


DESCRIPTION
* # SURG.PATH. LEVEL
* # PAP TEST, THIN LA
* PAID/PREV BILLED C



Breast Cancer Screening

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



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.



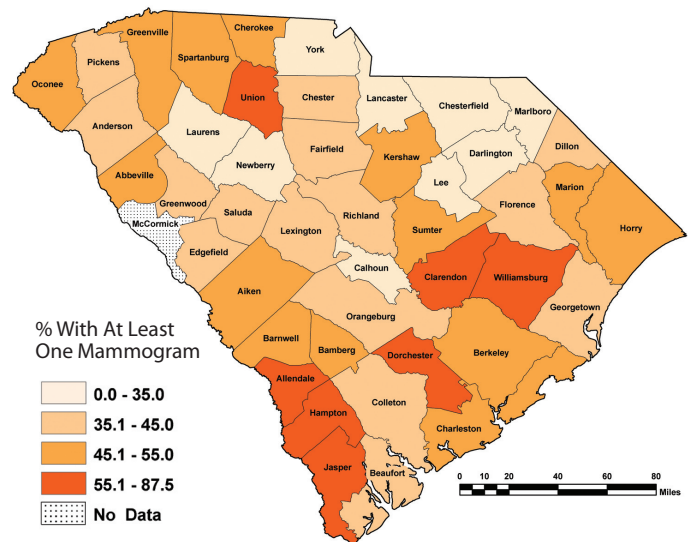
Tips to Improve This Measure

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.

(Source: <http://www.cancer.gov/cancertopics/pdq/screening/breast/Patient/page2#Keypoint2>).

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

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

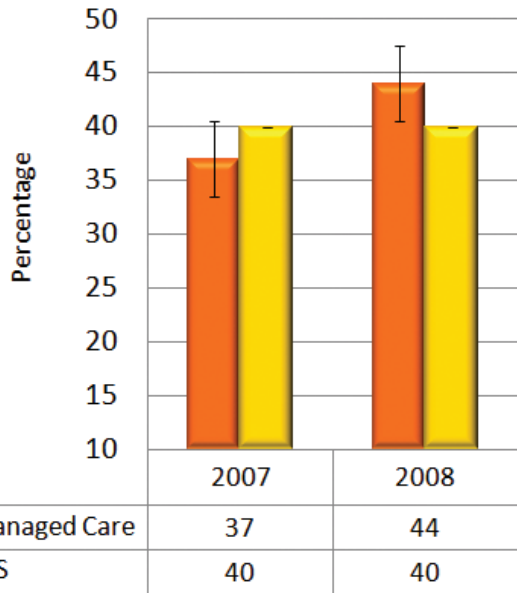


Source: SC Medicaid Information System, CY 2008
 Created by the University of South Carolina, Institute for Families in Society, May 2009.

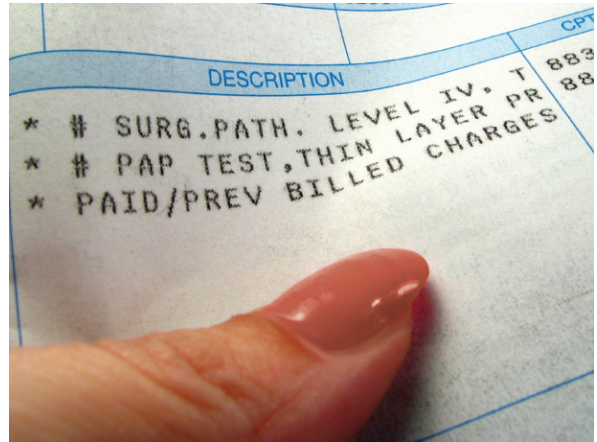
Cervical Cancer Screening (PAP Test)

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.



Measure not taken in 2006.



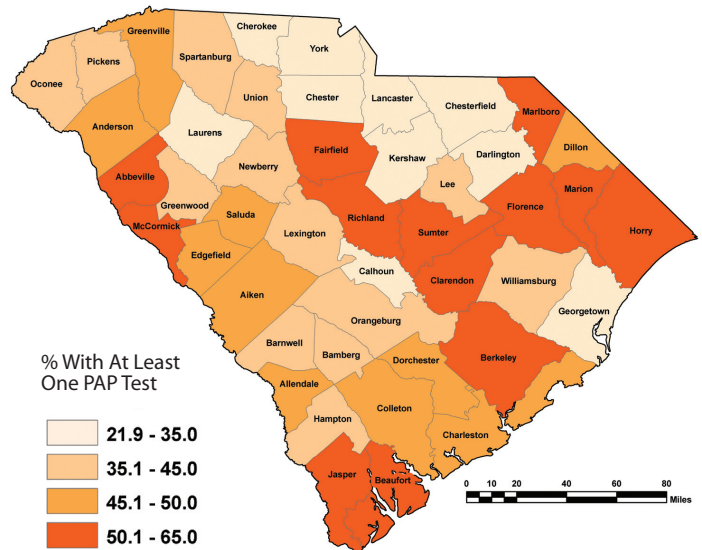
Tips to Improve This Measure

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 (Source: American Cancer Society.: *Cancer Facts and Figures 2008*. Atlanta, Ga: American Cancer Society, 2008).

These rates have been improving steadily, with a 70% drop between 1950 and 1970 and a 40% drop between 1970 and 1999 (Ries L., Eisner, M., Kosary, C., et al.: *SEER Cancer Statistics Review, 1973-1999*. Bethesda, Md: National Cancer Institute, 2002.).

This improvement has been attributed largely to screening with the Papanicolaou (PAP) test.

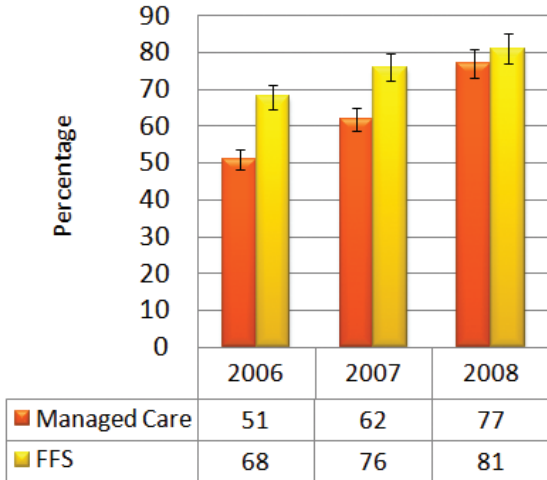
Percentage of Women Ages 21 to 64 Years With At Least One PAP Test for Cervical Cancer



Source: SC Medicaid Information System, CY 2008
 Created by the University of South Carolina, Institute for Families in Society, May 2009.

Prenatal Care Visits

The number of women receiving prenatal care visits in managed care has increased by more than 25 percent between 2006 and 2008.



In 2008, the fee-for-service component of the SC Medicaid Program met the national benchmark.

Who was included and what was measured?

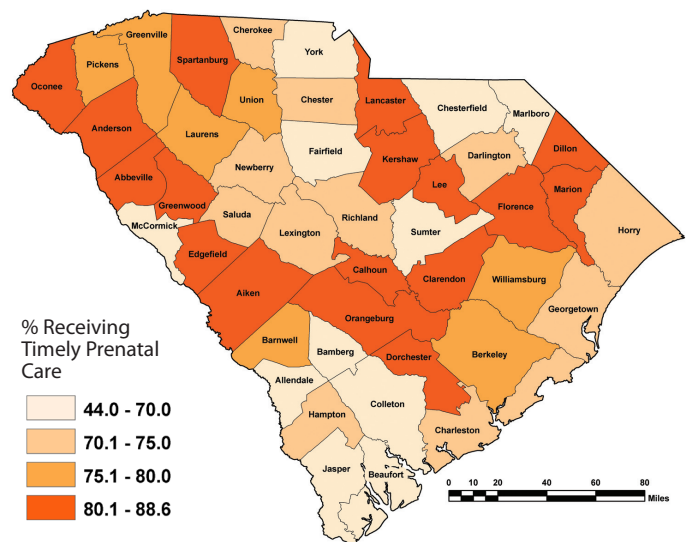
This measure included the percentage of women with deliveries who received a prenatal care visit in the first trimester or within 42 days of enrollment in the plan.



Tips to Improve This Measure

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 underreporting 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.

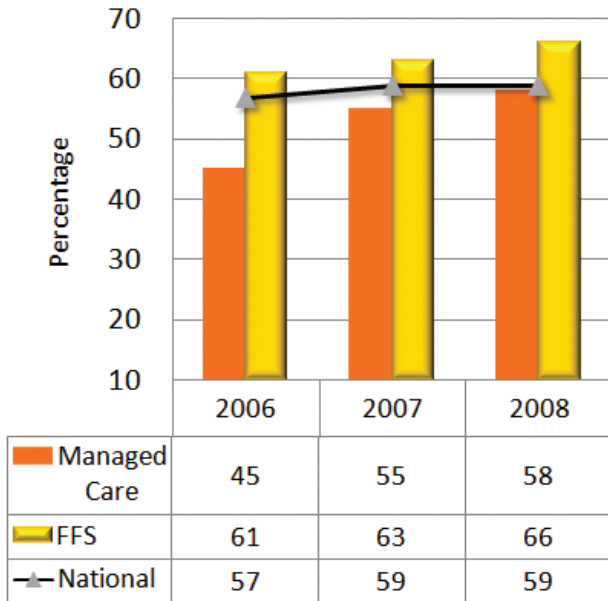
Percentage of Women with Deliveries Who Received a Prenatal Care Visit In the First Trimester or Within 42 Days of Enrollment in the Plan



Source: SC Medicaid Information System, CY 2008
 Created by the University of South Carolina, Institute for Families in Society, May 2009.

Postnatal Care Visits

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



Who was included and what was measured?

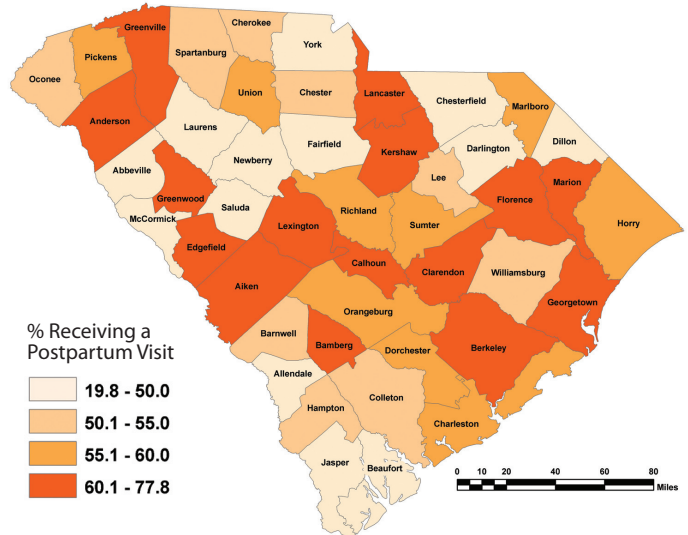
This measure included the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.



Tips to Improve This Measure

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 underreporting 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.

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



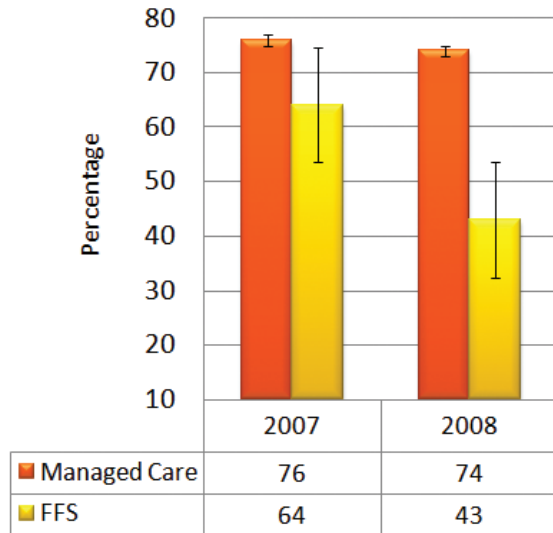
Source: SC Medicaid Information System, CY 2008
 Created by the University of South Carolina, Institute for Families in Society, May 2009.

Adult Asthma Health Measures



Adult Asthma Medication Use

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.



Not measured in 2006.

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.

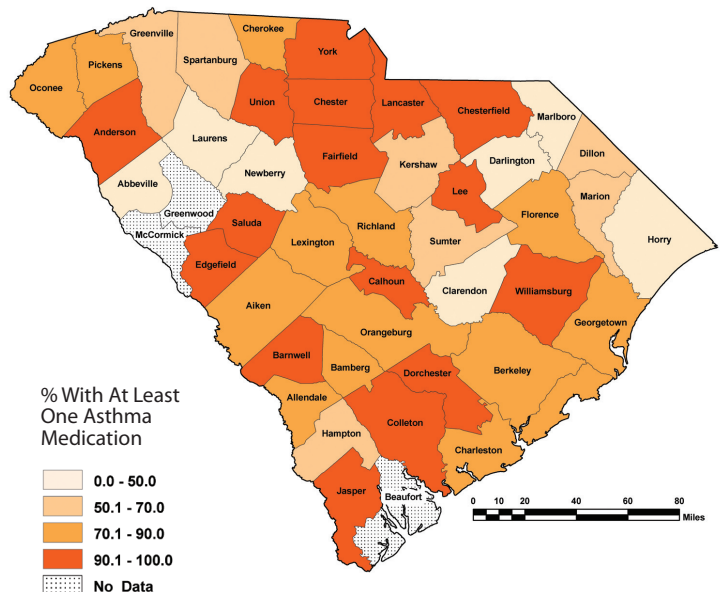


Tips to Improve This Measure

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: *Closing The Quality Gap: A Critical Analysis of Quality Improvement Strategies*: Volume 5—Asthma Care, Structured Abstract. January 2007. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/clinic/tp/asthmgaptp.htm>)

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

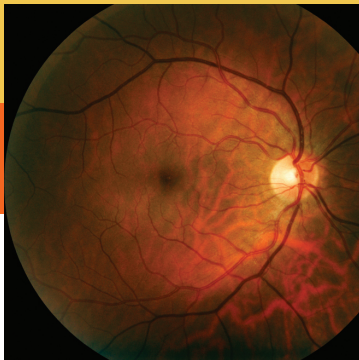


Source: SC Medicaid Information System, CY 2008
 Created by the University of South Carolina, Institute for Families in Society, May 2009.

Diabetes Care and SC Medicaid Recipients

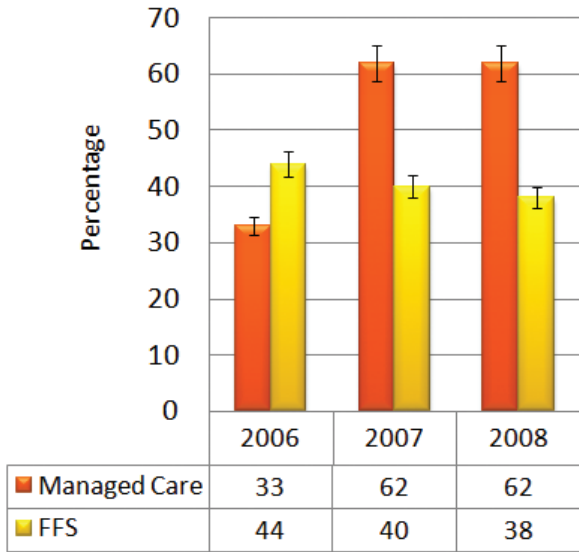
Across all measures associated with care for adults with diabetes, managed care recipients fared the same or better than those enrolled in fee-for-service. The measures that provide a profile of efforts to prevent complications such as kidney disease, blindness and amputations are critical preventive care indicators for those with diabetes. As an example:

- Regular hemoglobin A1c testing can indicate to patients and physicians when more effective blood sugar control is needed.
- Annual fasting lipid profiles track control of cholesterol and triglyceride levels.
- Annual dilated eye exams can identify early signs of diabetic retinopathy.
- Control of blood pressure is essential to prevent kidney disease and stroke.



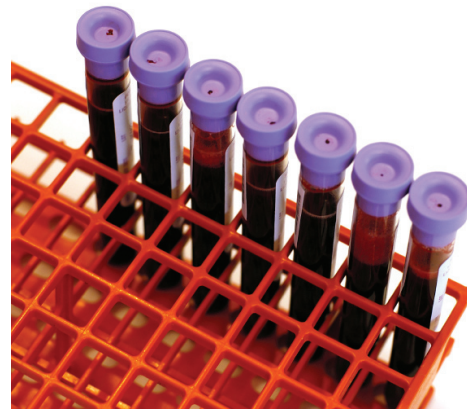
Hemoglobin A1c (HbA1c) Test

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.



Tips to Improve This Measure

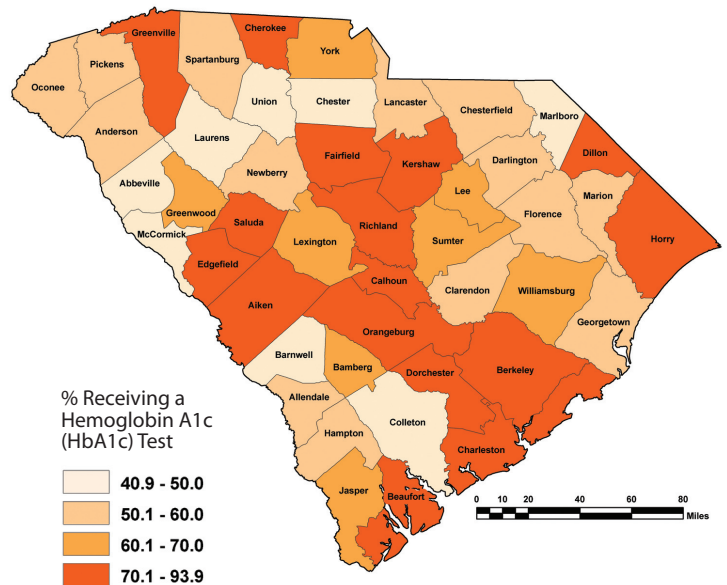
Diabetes affects more than 17 million people in the United States alone. Taking into account undiagnosed cases and cases of impaired glucose tolerance; one in seven Americans, either has diabetes or is at high risk for developing it. Despite a high-quality evidence base to aid providers in treating diabetes 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: Shojanian K., et al. *Diabetes Mellitus Care*. Vol. 2 of: Shojanian, K., McDonald, K., Wachter, R., Owens, D. *Closing The Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9* (Contract No. 290-02-0017 to the Stanford University-UCSF Evidence-based Practice Center). AHRQ Publication No. 04-0051-2. Rockville, MD: Agency for Healthcare Research and Quality. September 2004

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



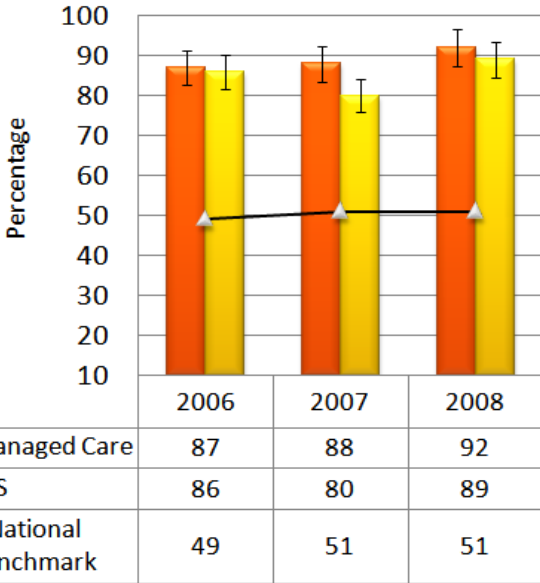
Source: SC Medicaid Information System, CY 2008
 Created by the University of South Carolina, Institute for Families in Society, May 2009.

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.



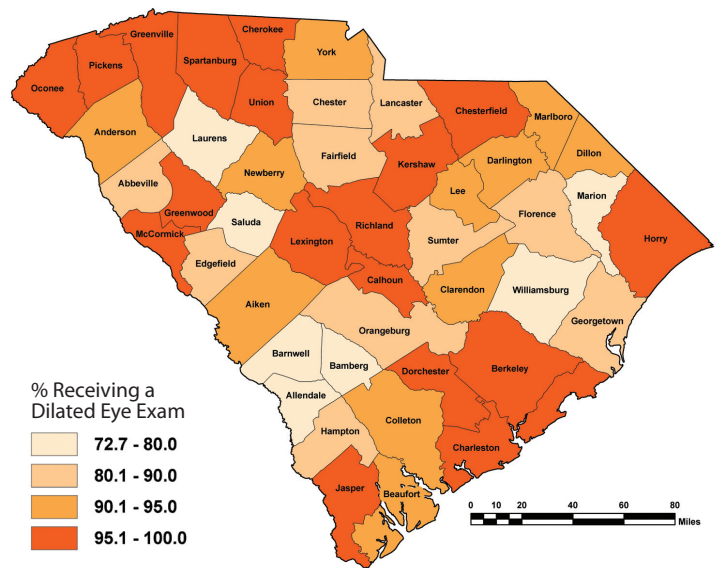
Tips to Improve This Measure

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.

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

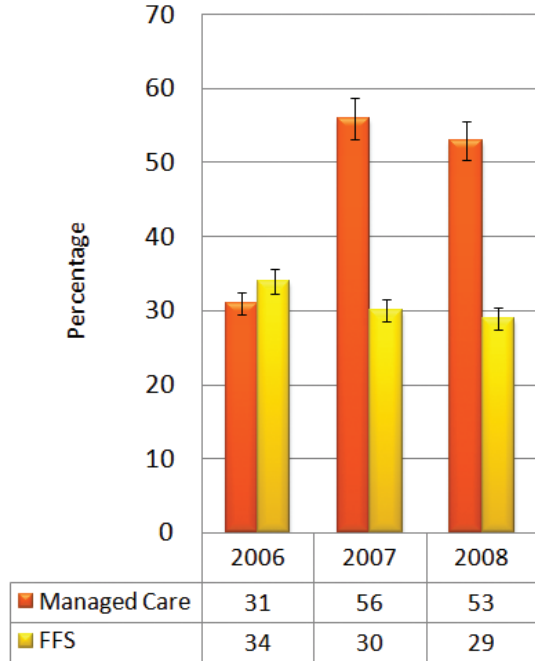


Source: SC Medicaid Information System, CY 2008
 Created by the University of South Carolina, Institute for Families in Society, May 2009.

Source: Shojania K., et al. *Diabetes Mellitus Care*. Vol. 2 of: Shojania, K., McDonald, K., Wachter, R., Owens, D. *Closing The Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9* (Contract No. 290-02-0017 to the Stanford University-UCSF Evidence-based Practice Center). AHRQ Publication No. 04-0051-2. Rockville, MD: Agency for Healthcare Research and Quality. September 2004

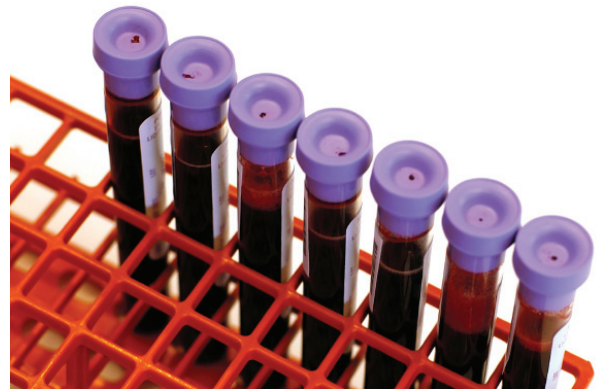
Lipid Profile (LDL-C) Screening

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.



Tips to Improve This Measure

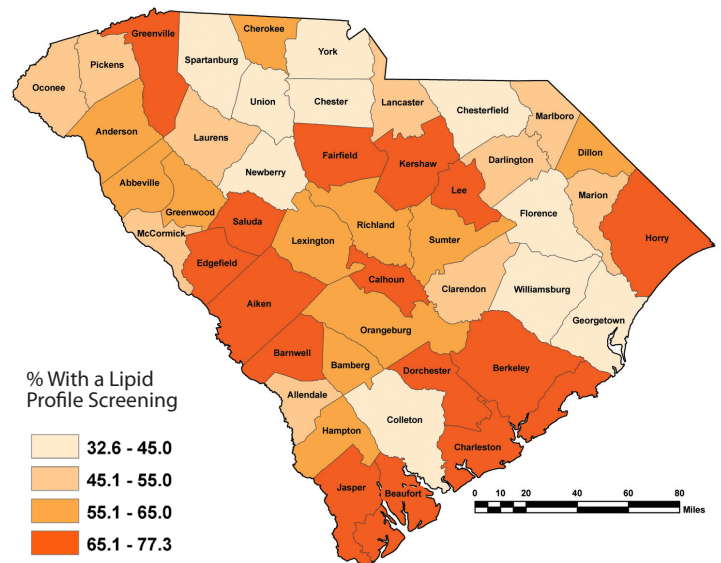
Diabetes affects more than 17 million people in the United States alone. Taking into account undiagnosed cases and cases of impaired glucose tolerance; one in seven Americans, either has diabetes or is at high risk for developing it. Despite a high-quality evidence base to aid providers in treating diabetes 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: Shojanian K., et al. *Diabetes Mellitus Care*. Vol. 2 of: Shojanian, K., McDonald, K., Wachter, R., Owens, D. *Closing The Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9* (Contract No. 290-02-0017 to the Stanford University-UCSF Evidence-based Practice Center). AHRQ Publication No. 04-0051-2. Rockville, MD: Agency for Healthcare Research and Quality. September 2004

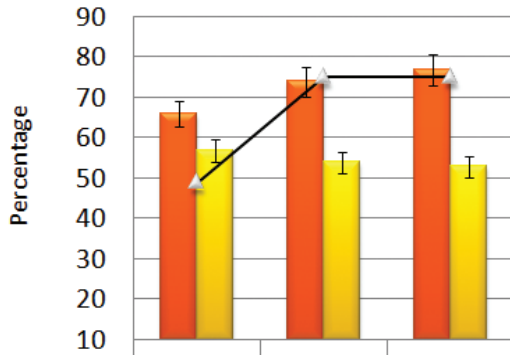
Percentage of Adults Ages 18 to 75 With Diabetes Who Had a Lipid Profile Screening in the Measurement Year



Source: SC Medicaid Information System, CY 2008
Created by the University of South Carolina, Institute for Families in Society, May 2009.

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.



	2006	2007	2008
Managed Care	66	74	77
FFS	57	54	53
National Benchmark	49	75	75

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.



Tips to Improve This Measure

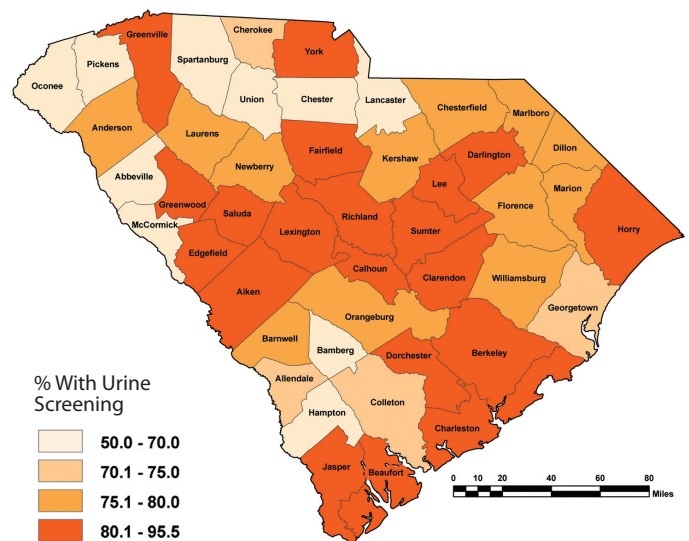
Diabetes affects more than 17 million people in the United States alone. Taking into account undiagnosed cases and cases of impaired glucose tolerance; one in seven Americans, either has diabetes or is at high risk for developing it. Despite a high-quality evidence base to aid providers in treating diabetes 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: Shojanian K., et al. *Diabetes Mellitus Care*. Vol. 2 of: Shojanian, K., McDonald, K., Wachter, R., Owens, D. *Closing The Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9* (Contract No. 290-02-0017 to the Stanford University-UCSF Evidence-based Practice Center). AHRQ Publication No. 04-0051-2. Rockville, MD: Agency for Healthcare Research and Quality. September 2004

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, CY 2008
Created by the University of South Carolina, Institute for Families in Society, May 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. Results for the years 2006 to 2008 are presented in this report.

Caveats About the Survey

Survey results were collected in 2006 (baseline) and 2007 using CAHPS[®] Version 3.0. Survey results for 2008 (baseline) 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 are presented without distinction for the health care plan.



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?

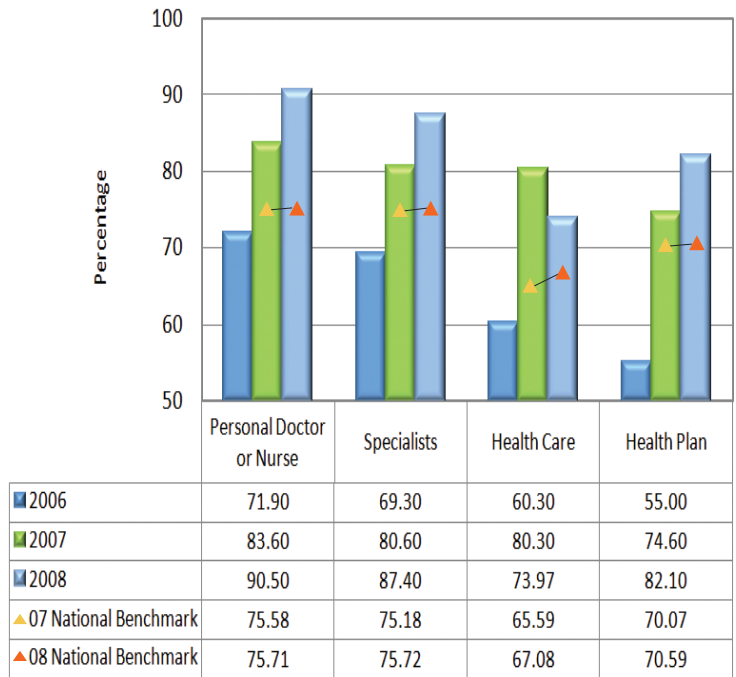
- 1 Never
- 2 Sometimes
- 3 Usually

Overall Quality and Satisfaction 2006-2008

Overall, the majority of participants are very satisfied with managed care. Although satisfaction has been very good, it has continued to increase to its highest level in 2008. Between 2006 and 2008, satisfaction has increased about 18 percent with personal doctor, 18 percent with specialists, almost 20 percent with overall healthcare and almost 27 percent with their health plan.

On all four measures, SC Medicaid Managed Care substantially exceeded the National Benchmarks in 2007 and 2008.

Shown at the right are the percentages of participants who indicated a high degree of satisfaction (a rating of 8, 9, or 10).



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.



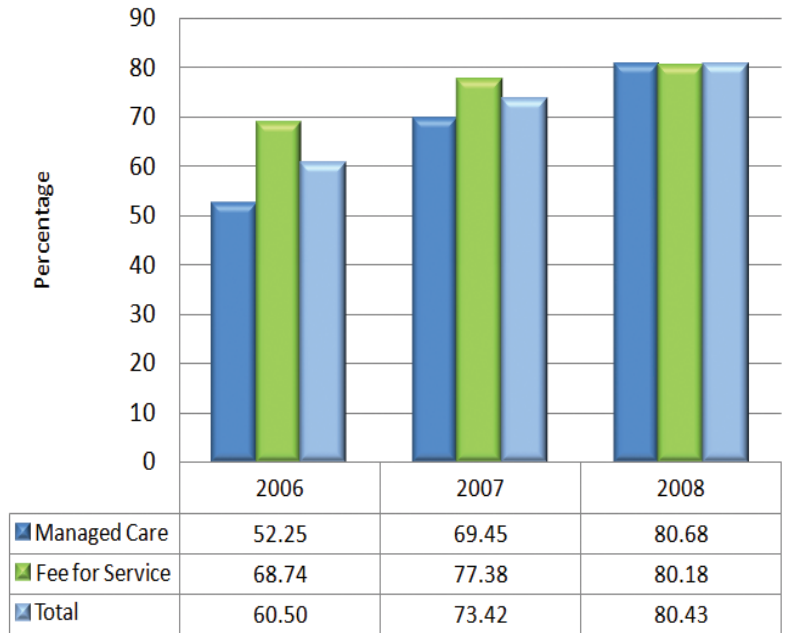
Getting the Care You Need

In 2008, more than 80% of respondents said that it was “not a problem” to:

- get a personal doctor with whom they were happy.
- see a specialist.
- get the care they or a doctor believed necessary.
- get health care without any delays pending approval from Medicaid.

Ratings of consumer experiences have improved substantially between 2006 and 2008 for all plan types. Managed Care ratings have increased the greatest amount (28 percent).

Percent of survey respondents who said that it was “not a problem”:

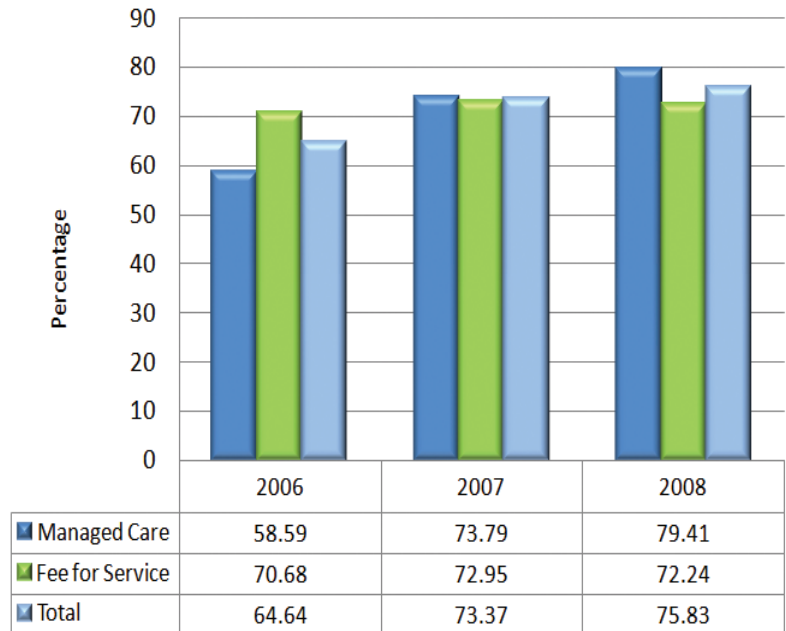


Getting Care Without Long Waits

Between 2006 and 2008, the percent of people in managed care getting care quickly increased 21 percent to 79.4% of participants who said they “usually” or “always”:

- received the help or advice they needed when they called their doctor’s office during regular office hours.
- received an appointment for regular or routine health care as soon as they wanted.
- received immediate care for an illness or injury as soon as they wanted.
- were taken to the exam room within 15 minutes of their appointment.

Percent of survey respondents who said “always” or “usually”:



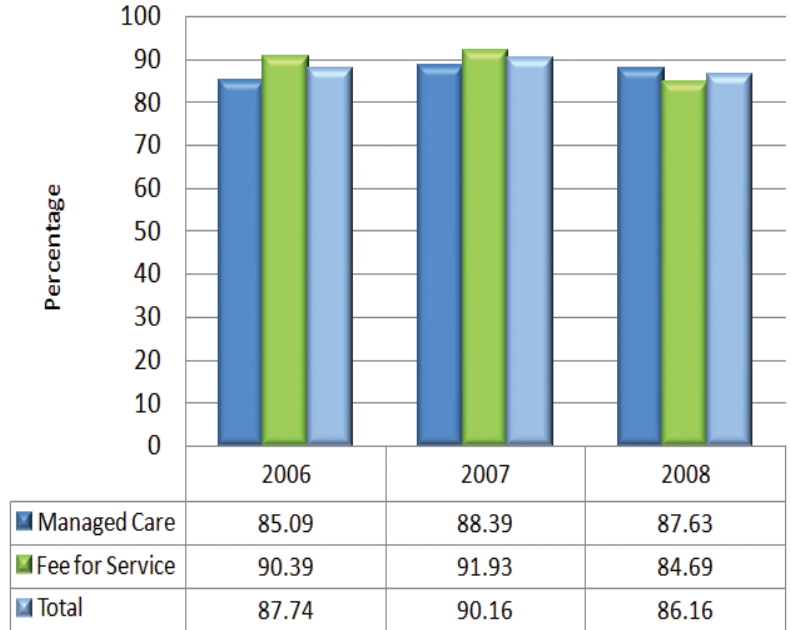
Doctors Who Communicate Well With Their Patients

In 2008, more than 86% of participants said that their doctor “usually” or “always”:

- listened carefully to them.
- explained things in a way they could understand.
- showed respect for what they had to say.
- spent enough time with them.

In 2008, participants in managed care rated their experiences slightly above the national benchmark.

Percent of survey respondents who said “always” or “usually”:



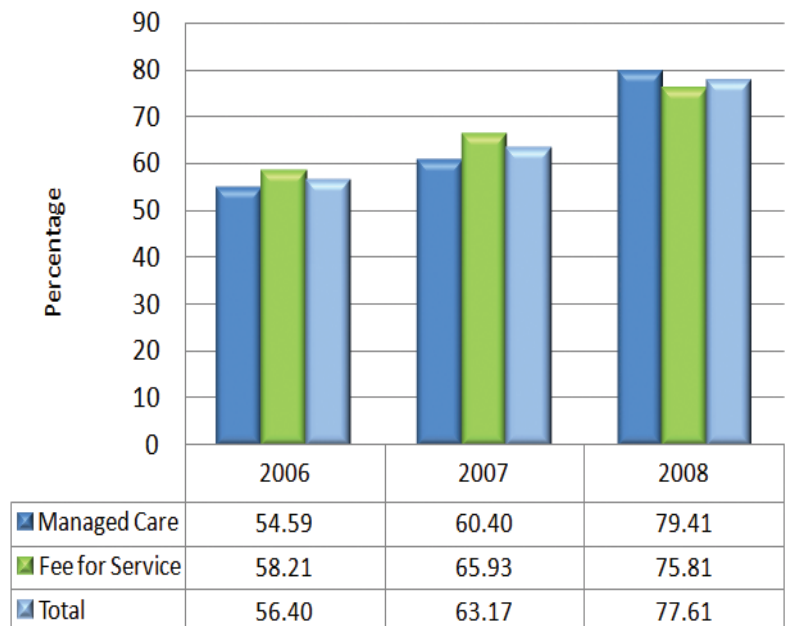
Customer Service

In 2008, more than 79 percent of participants in Managed Care said that it was “not a problem to”:

- find information about my health plan.
- get the help I need when I called.
- deal with the paperwork.

Since 2006, participant ratings of their experiences on this measure have increased 21% overall. In Managed Care, ratings have increased 25% to 79.41%, which met the national benchmark.

Percent of survey respondents who said “always” or “usually”:



Access To Care

In 2008, a series of studies were 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 providers commonly share 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 subspecialty study found that eighty-seven percent of Medicaid children with special health care need 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 outside the 30 miles radius of their home. Even when providers were available closer to home, these children often travel 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 miles radius as the guidepost for setting up network providers.

