MEDDIC-MS SSI 2004 Data Book

Medicaid Encounter Data Driven Improvement Core Measure Set
SSI Managed Care

Wisconsin Independent Care (*i*Care) Program

State of Wisconsin

Department of Health and Family Services
Division of Health Care Financing, Bureau of Managed Health Care Programs

November 2005

MEDDIC-MS SSI 2004 Data Book

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MEDDIC-MS SSI 2004 Data Book, Wisconsin Independent Care(iCare)Program, State of Wisconsin, Department of Health and Family Services, November 2005.

Introduction and Background

Independent Care (*i*Care) is a managed care program operated by a private organization under a contract with the Wisconsin Department of Health and Family Services (DHFS). *i*Care serves enrollees with disabilities eligible for supplemental security income (SSI).

MEDDIC-MS SSI, the Medicaid Encounter Data Driven Improvement Core Measure Set for SSI is an automated quality performance measure system specifically designed for SSI managed care. It consists of two sets of measures; *Targeted Performance Improvement Measures* (TPIM), which focus on high priority areas identified by stakeholders. An integrated goal-setting system applies to some of these measures. *Monitoring measures* are utilization or outcome measures.

This Data Book presents the results on the measures based on services provided by iCare in calendar year 2004 with data for trending from previous years.

Accurate quality measurement is central to effective public health policy, and use of standardized performance measures are required by federal law for all state Medicaid managed care programs, including those serving special populations such as individuals with disabilities. Specifically, 42 CFR §438.240(c) requires that states monitor managed care organization (MCO) performance using standardized performance measures and that MCOs submit data necessary for the performance measures to operate.

In October 2003, the Agency for Healthcare Research and Quality (AHRQ) recognized MEDDIC-MS SSI for inclusion in the National Quality Measures Clearinghouse (NQMC®). To view the measure summaries on the NQMC, go to: http://www.qualitymeasures.ahrq.gov/resources/measureindex.aspx and scroll down to "State of Wisconsin."

More information about the MEDDIC-MS SSI measures are available upon request. Contact: Gary R. Ilminen, RN at (608) 261-7839 or ILMINGR@DHFS.STATE.WI.US.

Other performance reports are available on the Wisconsin Medicaid Managed Care Website. To view those reports, please go to: http://www.dhfs.state.wi.us/medicaid7/reports_data/index.htm and scroll down to "Quality Reports."

Care Analysis Projects

In 2001, the DHFS implemented a proactive approach to performance improvement called Care Analysis Projects (CAP). Through CAP, recipient-specific health care needs are identified and the data about those needs are shared with *i*Care. In this way, the DHFS assists directly in quality improvement by allowing focused outreach to individuals with potential unmet care needs.

CAP focuses on several chronic conditions and on the provision of key preventive services. Chronic conditions included are congestive heart failure, asthma, and diabetes.

MEDDIC-MS SSI and CAP work together. CAP provides data-driven targeted intervention and MEDDIC-MS SSI allows accurate, automated performance assessment.

Performance Improvement Projects

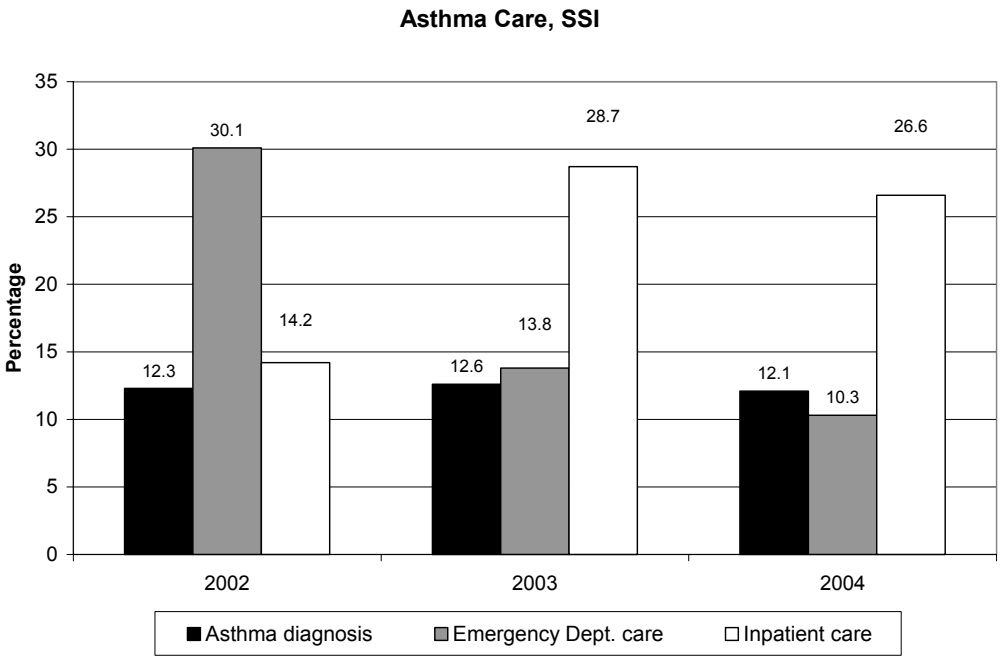
*i*Care completes at least two performance improvement projects annually and reports about them to the DHFS. The projects encourage interventions for performance improvement on topics of importance to *i*Care enrollees.

Note on performance rates:
Some *i*Care enrollees are eligible for services under Medicare as well as the SSI program. As a result, some services may have been obtained under that program and may not be reflected in *i*Care encounter data. To prevent under-reporting of services provided by *i*Care, individuals eligible for Medicare have not been included in the denominators for measures reflecting services covered by Medicare. The narrative with each chart indicates which measures are affected.

Results on Clinical Performance Measures

Asthma care

Monitoring measure



Asthma is a chronic disease of the lungs. Asthma causes episodes where airflow in and out of the lungs is reduced by constriction of the airways and by excess mucous. Asthma affects between 12 and 15 million Americans, including nearly 5 million children. The disease can have fatal complications.

Asthma can be managed with appropriate medications and patient education. Early diagnosis, patient/parent education and appropriate treatment are crucial to effective management and maintenance of good quality of life.

Prevalence--the percentage of enrollees with the diagnosis of asthma—has remained about the same. However, the prevalence of asthma in the SSI population is approximately double that in the general Medicaid/BadgerCare population.

The rate of use of emergency department (ED) care has decreased substantially since 2002. The rate of inpatient care had increased in 2003, but decreased somewhat in 2004. The results for 2002 include enrollees over age 21 years; after that, the results include enrollees over age 18 years.

This measure tracks services for individuals eligible for Medicaid only.

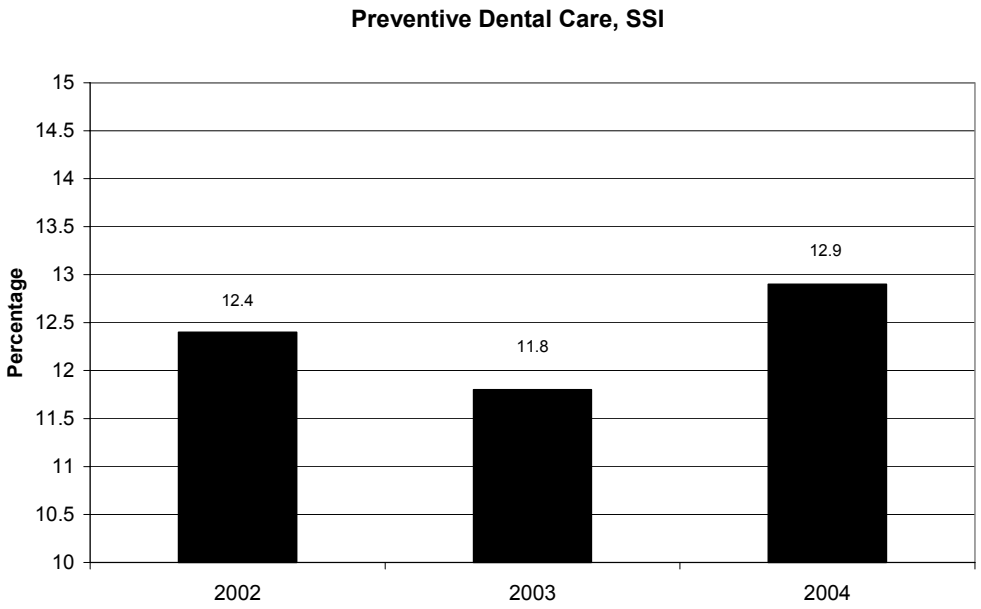
Dental (preventive) services

Targeted performance improvement measure

Preventive dental services include initial and comprehensive dental examinations, prophylaxis, topical application of fluoride and application of sealants.

Dental care can prevent development of dental caries, tooth loss, oral infections, abscesses and other problems.

In 2004, 12.9 percent of iCare enrollees age 18+ years had at least one dental encounter where preventive services were provided, up from 11.8 percent in 2003. This is a slightly higher rate than 2002 when 12.4 percent of enrollees age 22 and older had such dental visits.



In 2003, the age cohort was lowered to 18 years from 21 and the 15-18 years of age cohort was dropped due to very small numbers of enrollees in that age group. Direct comparison should be made with caution due to the difference in the age cohorts.

Diabetes care

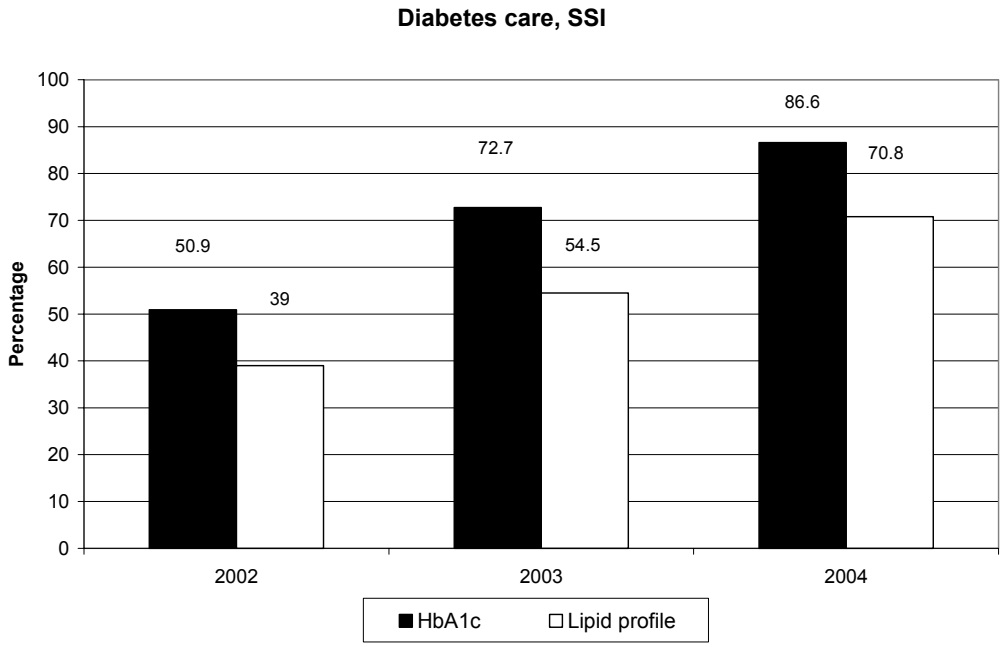
Targeted performance improvement measure

Diabetes mellitus is a chronic condition that can affect the heart, kidneys and eyes. But, with proper care, serious problems can be reduced or prevented. Individuals with disabilities are at higher risk for complications of diabetes, so effective diabetes care is very important.

Two blood tests are important for effective diabetes care.

One is the hemoglobin A1c (HbA1c), a blood test that indicates the level of blood sugar control over time.

The other test is the lipid profile, a blood test that monitors the levels of "fats" (lipids) in the blood stream.



In 2003, the measure age cohorts were changed from 15-20 and 21-75 years to 18-75 years. The youngest age cohort had too few enrollees in the denominator to show any values in 2002. Only the 21-75 year old age cohort is compared in this chart in the 2002 data. Steady improvement has occurred in care for diabetes.

In 2002, the HbA1c test rates for enrollees age 21-75 was 50.9 percent. In 2003, the HbA1c rate increased to 72.7 percent for 18-75 year-olds. The rate improved again in 2004, increasing to 86.6 percent. The rate for lipid profiles was 39 percent in 2002 (age 21-75). In 2003, it was 54.5 percent and increased to 70.8 percent in 2004 (18-75 year-olds). This measure tracks services for individuals eligible for Medicaid only.

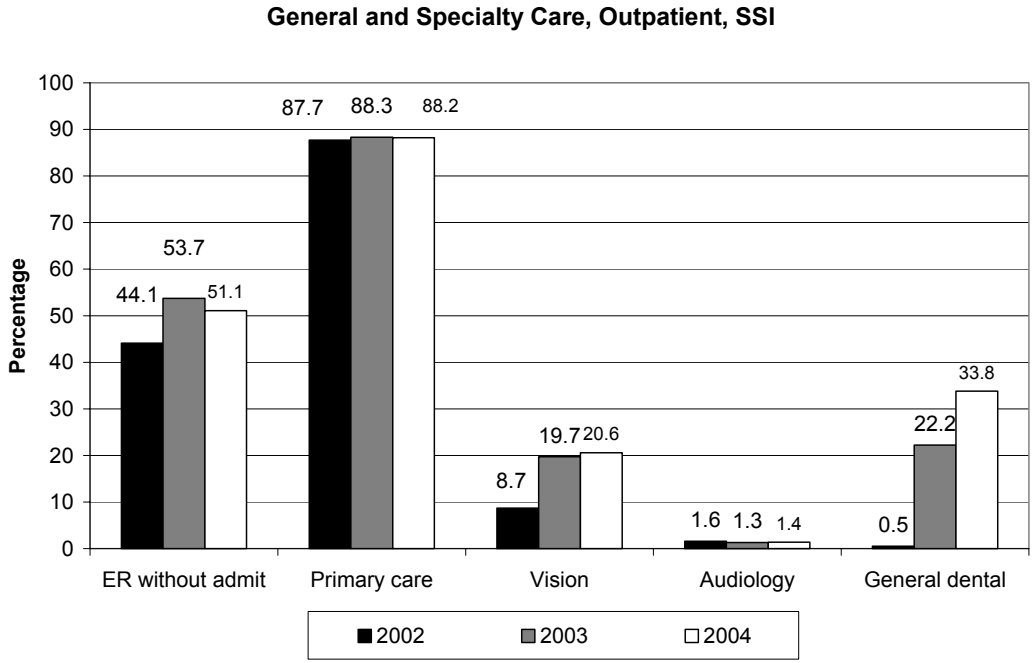
Diabetes care services have been included in the Care Analysis Project since 2001 and iCare conducted a performance improvement project on diabetes care in 2002.

General and specialty care-outpatient

Monitoring measure

This measure assesses access to emergency care that does not result in subsequent hospitalization, access to primary care, vision care, audiology services and general dental care. Access to these outpatient or ambulatory care services is essential for overall health maintenance and improvement.

The measure tracks what percentage of *i*Care enrollees had access to those services on at least one occasion during the look-back period. The measure includes enrollees that are eligible for Medicaid only-not Medicare also-in the denominator.

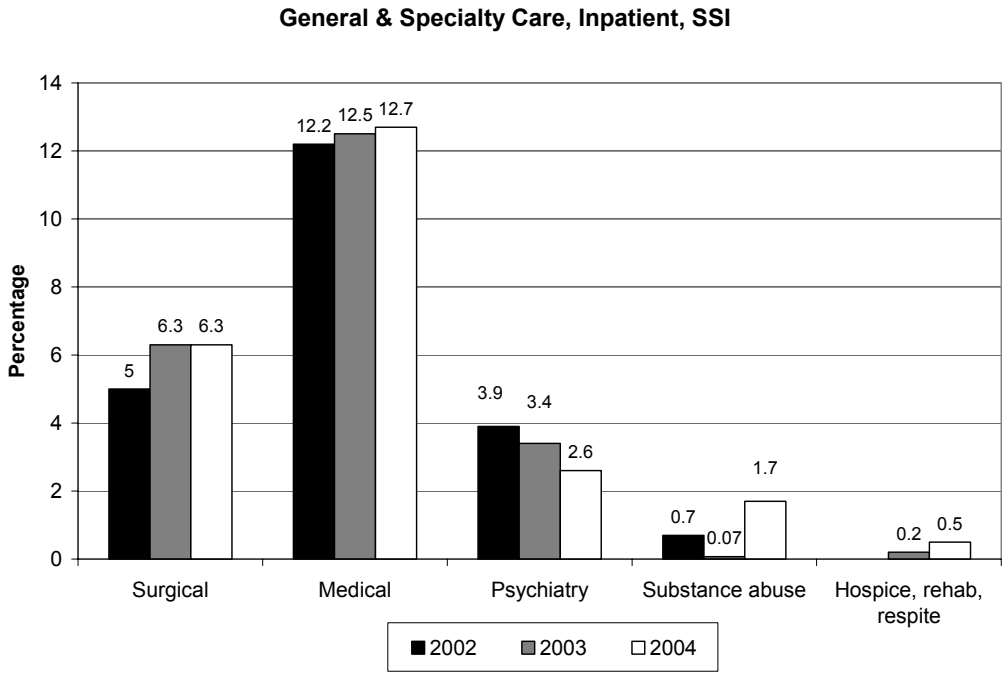


About half of eligible enrollees had at least one emergency room visit that did not result in admission to the hospital in 2004, similar to 2002 and 2003. Nearly nine out of ten enrollees had at least one primary care visit in each year. Vision care use increased slightly and audiology care use remained about the same. Access to general dental services increased substantially for the second consecutive year.

The age cohort for the 2003 and 2004 data includes enrollees 18 years of age and over; the 2002 data is for enrollees 21 years of age and over.

General and specialty care-inpatient

Monitoring measure



Some conditions may require care or services that cannot be provided on an ambulatory or outpatient basis. Those conditions may require hospitalization, referred to as inpatient care.

Inpatient care may be necessary for many different conditions. For the purposes of the *i*Care performance monitoring program, five general categories of care are used: surgery, medical, psychiatric, substance abuse and hospice/rehabilitation/respite.

This monitoring measure is useful as a tool in assessing access and utilization of inpatient care services. By itself, this measure is not an all-inclusive indicator of sufficiency of access to services, or of appropriateness of care. However, when used in conjunction with other data such as satisfaction, grievance and appeal data, outpatient care data and other measures, it provides a reasonable basis for assessment of overall service delivery. This data reflects utilization by Medicaid-eligible enrollees only.

Inpatient medical and surgical care use patterns trended up slightly since 2002, as did inpatient care for substance abuse disorders and use of rehabilitation/hospice and respite care. Use of inpatient psychiatry trended down between 2002 and 2004.

Mammography (screening) and malignancy detection

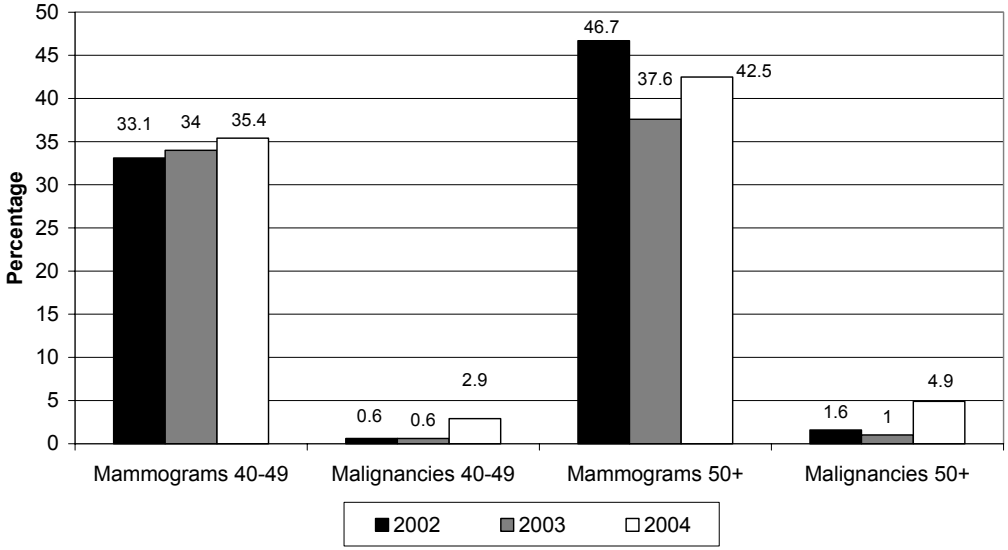
Monitoring measure

The American Cancer Society and the National Cancer Institute each recommend that women over age 40 have regular screening mammograms.

Early detection of breast cancer dramatically improves outcomes of treatment and long-term survival. Mammography is recognized as a highly effective method for early detection of breast cancer.

The provision of screening mammography is important for women served in the *i*Care program because of the benefits of early detection and treatment.

Screening Mammograms & Malignancy Detection Rate, Age 40-49 & 50+ Years, SSI

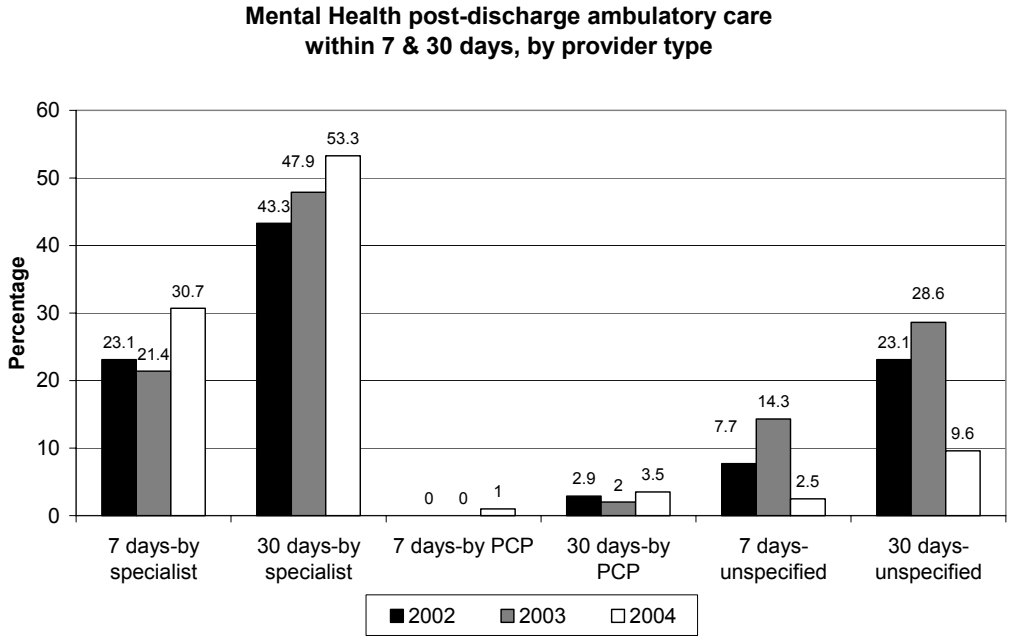


The screening mammography rate for women between the ages of 40 and 49 years has increased slowly since 2002, increasing from 33.1 to 35.4 percent. The malignancy detection rate from 0.6 percent in 2002 to 2.9 percent in 2004. For women over 50 years of age, the screening mammography rate increased to 42.5 percent in 2004 from 37.6 percent in 2003, but did not equal the 2002 rate of 46.7 percent. The malignancy detection rate for women over 50 years of age increased to 4.9 percent in 2004.

This measure tracks services for individual eligible for Medicaid only.

Mental health follow-up care within 7 and 30 days of inpatient discharge

Targeted Performance Improvement Measure



Research[1] has shown that follow-up care on an outpatient basis for individuals who have had inpatient care for mental illness or substance abuse is effective in reducing readmission to the inpatient setting for the same diagnosis.

This measure evaluates provision of follow-up care by both specialty care providers and primary care providers within 7 days of discharge and within 30 days of discharge from inpatient treatment. Since appropriate service codes appear on encounter records, but at times the provider type is not specified, the measure set includes these encounters in the category of "unspecified" to prevent underreporting.

The chart displays the overall results for 2002 through 2004. The age cohort was changed in 2003 from 21+ to 18+. Also, the chart reflects follow-up care for mental health diagnoses only, since the denominator for substance abuse services was too small to report accurately.

The rates for specialist follow-up care within 7 and 30 days increased from 2002 to 2004. Rates of follow-up care provided within 7 days and 30 days of discharge by primary care providers remained about the same in the period, while follow-up by other or "unspecified" providers decreased.

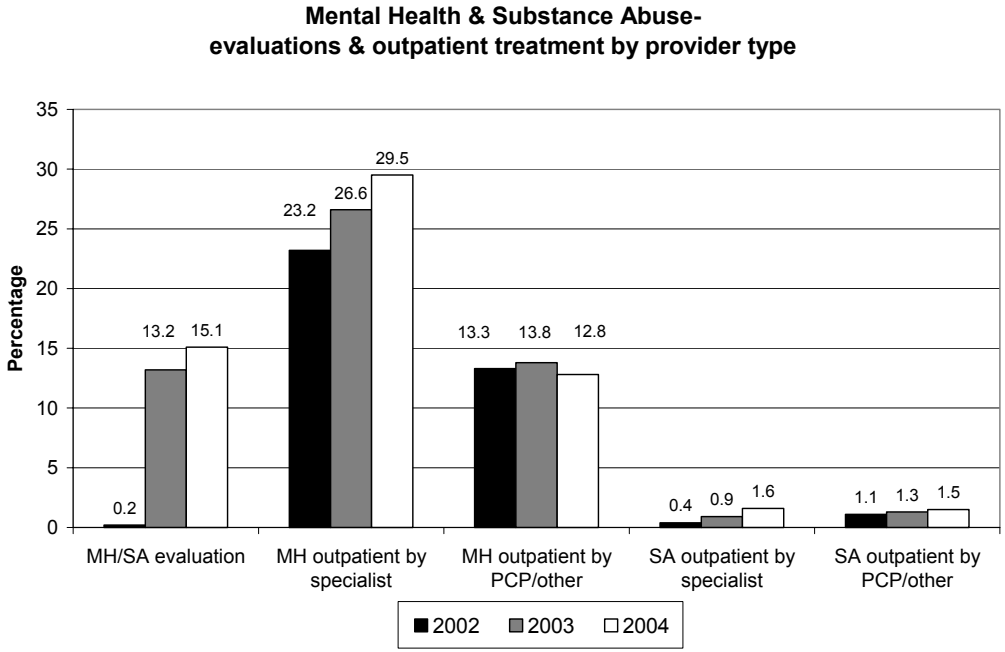
[1] *Evaluation and the Health Professions, Special Edition, State Medicaid Quality Programs*, "Outpatient Utilization Patterns and Quality Outcomes after First Acute Episode of Mental Health Hospitalization," Delmarva Foundation, December 2000.

Mental health/substance abuse-evaluations and outpatient care

Monitoring measure

Monitoring the rate of mental health and substance abuse (MH/SA)evaluation and treatment services is useful to detect access trends.

Statewide data shows that psychiatric disorders are the second most prevalent affecting SSI program recipients, being diagnosed in 32 percent of the population. Substance abuse is the 12th most prevalent diagnosis in this population. In some instances, the two diagnoses occur together. Thus, access to mental health and substance abuse care is very important.



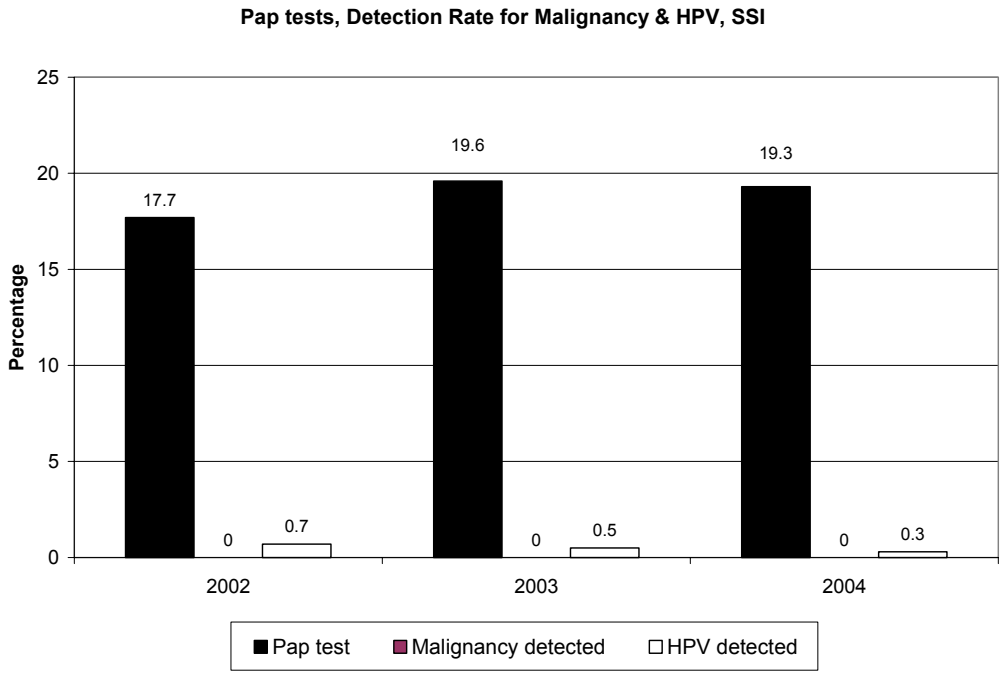
Evaluations are tracked using all provider types and outpatient care is tracked by provider type, that is, specialists in mental health or substance abuse and primary care providers (PCP). Many mental health and substance abuse conditions can be successfully treated on a day treatment or outpatient basis. Often, people prefer such treatment to inpatient care.

The 2004 evaluation rate was 15.1 percent for all ages and provider types, up from 13.2 percent in 2003. The rate for mental health outpatient care provided by specialists increased to 29.5 percent in 2004 from 26.6 percent in 2003 and up from 23.2 percent 2002. The rate for such care by PCPs remained about the same in 2004 as in 2002. The rate of outpatient care for substance abuse by specialists and PCP/other providers increased slightly.

This measure tracks provision of evaluations and outpatient care to individuals eligible for Medicaid only.

Pap tests-cervical cancer screening

Monitoring measure



According to the Centers for Disease Control (CDC), cervical cancer remains a leading preventable cause of death among women.

Early detection is relatively easy and is the key to a high probability of survival. The most common method for early detection is called the "Pap test."

The Pap test is generally performed every three years, beginning when the woman becomes sexually active or by age 18 years. Thus, the Pap test is not required annually, and the measure is designed to take this into account.

The rate of provision of Pap tests has increased somewhat since 2002. Outcome measure results, the rate of detection of malignancy, for this service was 0.

Human Papillomavirus (HPV) infection is believed to be a causal factor in many cases of cervical cancer. According to the Centers for Disease Control and Prevention (CDC), more than 90 percent of cervical cancers are caused by HPV infections. This measure assesses the detection rate for HPV infection. The HPV detection rate was 0.3 percent in 2004, compared to 0.7 percent in 2002.

This measure tracks services for individual eligible for Medicaid only.

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