Quality of Care Measures: A Chart Book for the Florida KidCare Program Evaluation, 2005

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June 2006

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Introduction

Assessing the quality of care for all children is essential. In the case of Medicaid managed care and the State Children's Health Insurance Program (SCHIP), states are required to have performance goals and measures to evaluate the quality of care provided by these programs.[1] There are several conceptual frameworks that can be used to organize quality of care assessments. The Institute of Medicine (IOM) has provided a framework for assessing health care quality that includes: 1) the effectiveness of care; 2) the access to and timeliness of care; and, 3) the patient-centeredness of care.[2] Effectiveness of care refers to providing care that is based on the use of systematically acquired evidence as to its benefit in producing better outcomes than the alternatives, which include doing nothing. Access to and timeliness of care refers to a person being able to receive needed care without undue delays. Insurance coverage is essential for good access to care but it is not a guarantee. Geographic barriers, lack of understanding about how to use the health care system, and other factors, can contribute to poor access to care, even among the insured. Finally, care should be patient-centered; that is, all patients should be treated with dignity and respect and they should be involved in the decision-making process about their care.

In addition to the preceding aspects of care, the IOM specifically discusses the important relationship between payment polices and the quality of care provided to enrollees. Ensuring that payment is appropriate for the severity of illness or the case-mix seen among the enrolled population is essential to encourage access to care and the delivery of high quality of care.

Often quality of care assessments are reported for children as a group, without considering their health status. However, children with special health care needs (CSHCN) comprise a unique group who may be more susceptible to adverse health outcomes than healthy children, if there are variations in the quality of their health care. Recent estimates from the 2001 National Survey of CSHCN indicate that 12.8% of children aged 0 to 17 years in the United States, and 13.0% of children in Florida have a special health care need.[3] Previous estimates of the percentages of these children range from 14.8% to 25.2% of the populations studied, depending on the definition of CSHCN used. [4,5,6] Despite differences in how they are identified or in the populations studied, CSHCN require close monitoring to ensure that they have access to high quality health care.[7,8]

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[1] The National Governors Association; Center for Best Practices. *State Efforts to Evaluate the Progress and Success of SCHIP*. August 2001.
[2] The Institute of Medicine. *Crossing the Quality Chasm*. Washington, DC: National Academy Press; 2001.
[3] Blumberg, S, Osborn N, Luke, J, et al. 2003. *Estimating the Prevalence of Uninsured Children: An Evaluation of the Data from the National Survey of Children with Special Health Care Needs, 2001*. Centers for Disease Control and Prevention, National Center for Health Statistics.
[4] Stein, R. Siler, E. 1999. Operationalizing a Conceptually Based Noncategorical Definition: A First Look at US children with Chronic Conditions. *Archives of Pediatric and Adolescent Medicine*. 153: 68-74.
[5] Newacheck P, Strickland B, Shonkoff J, et al. 1998. An Epidemiologic Profile of Children with Special Health Care Needs. *Pediatrics*. 102: 117-123.
[6] Bethell CD, Read D, Neff J, Blumberg SJ, Stein REK, Sharp V, Newacheck r. 2002. Comparison of the Children with Special Health Care Needs Screener to the Questionnaire for Identifying Children with Chronic Conditions – Revised. *Journal of Ambulatory Pediatrics*. 2:49-57.
[7] Newacheck P, McManus M, Fox H, Hung Y, Halfon N. 2000. Access to Health Care for Children with Special Health Care Needs. *Pediatrics*. 105:760-766.
[8] Shatin D, Levin R, Ireys H, Haller V. 1998. Health Care Utilization by Children with Chronic Illnesses: A Comparison of Medicaid and Employer-insured Managed Care. *Pediatrics*. 102:e44.

Purpose

The purpose of this report is to summarize the enrollees' health status, health care expenditures, and quality of care in three components of Florida KidCare: the Healthy Kids program (SCHIP or Title XXI enrollees only), the Medicaid Primary Care Case Management (PCCM) Program, and the Children's Medical Services Network (CMSN, Title XIX enrollees only).

Specifically, the following indicators are contained in this report:

1) Description of the Enrollees by Clinical Risk Groups (CRG)

2) Expenditures
   a) Per Member Per Month (PMPM) Health Care Expenditures
   b) Percent of Expenditures by CRG Category Compared to Enrollee Distribution
   c) PMPM Pharmacy Expenditures

3) Effectiveness
   a) Health Employer Data and Information Set (HEDIS) Well-Child Visits in the 3rd, 4th, 5th, and 6th Years and Adolescent Years
   b) HEDIS Use of Appropriate Medications for Children and Adolescents with Asthma

4) Access to Care
   a) Percent of Hospitalizations with a Primary Diagnosis of an Ambulatory Care Sensitive Condition (ACSC)
   b) Percent of Emergency Room (ER) Use with a Primary Diagnosis of an ACSC
   c) HEDIS Follow-up after Hospitalization for Mental Illness

5) Overall Satisfaction with KidCare
   a) Using CAHPS Composite Scores to Measure Satisfaction
   b) Using CAHPS Composite Scores to Measure Satisfaction by Race

Data Sources and Measures

Four data sources were used to calculate the quality of care indicators: child-level enrollment information, child-level health care claims/encounter data, pharmacy data, and parent telephone survey data. The enrollment files contained information about the child's age, gender, the KidCare Program component in which the child was enrolled, and the number of months the child was enrolled in the program. The child-level claims/encounter data contained Physician's Current Procedural Terminology (CPT) codes and International Classification of Diseases, 9th Revision (ICD 9-CM) codes. The child-level pharmacy data contains information about filled prescriptions including the drug name, dosage, date filled, and refill information. Healthy Kids, Medicaid, and CMSN claims and encounter data were compiled for July 1, 2004 through June 30, 2005. Survey data from families whose children were enrolled in the KidCare Program for 12 months or longer were also used. The surveys were conducted from September through December 2005.

Quality of care measures relying on health care claims and encounter data were calculated using specifications provided in the National Commission on Quality Assurance (NCQA) HEDIS Technical Specifications manual 2004.[9] The only modifications made to the technical specifications were the inclusion of Florida local codes, when necessary, to ensure completeness.

The Consumer Assessment of Health Plans Survey (CAHPS), Version 3.0 was used to assess families' satisfaction with the KidCare program.[10] Specifically, the Medicaid module for children was used with supplemental questions addressing care for CSHCN. Composite items were constructed on a scale from 0 (not satisfied) to 100 (most satisfied). Mean scores for each of the following CAHPS composite constructs were assessed:

1) Parents' experiences with getting needed care;
2) Parents' experiences with getting care quickly;
3) Parents' experiences with how well doctors communicate;
4) Parents' experiences with the courtesy, respect, and helpfulness of the office staff;
5) Parents' experiences with health plan customer service, information, and paperwork;
6) Parents' experiences with prescription medicine;
7) Parents' experiences getting specialized services for their children;
8) Family-centered care; and,
9) Parents' experiences with coordination of their child's care.

The CSHCN Screener was used to determine if the child had special health care needs at the time of application. The CSHCN Screener uses parent reports to assess whether the child: 1) has activity limitations when compared to other children of his or her age; 2) needs or uses medications; 3) needs or uses specialized therapies such as physical therapy; 4) has an above-routine need for the use of medical, mental

[9] National Commission on Quality Assurance. *HEDIS Technical Specifications, 2003*. Washington, DC: National Commission on Quality Assurance; 2002.
[10] National Commission on Quality Assurance. HEDIS 2003: Specifications for Survey Measures. Washington, D.C.: 2002.

health or educational services; or, 5) needs or receives treatment or counseling for an emotional, behavioral or developmental problem.[11] For each of these areas, the respondent is also asked if the child has limitations, medication dependency, or uses/needs services because of a condition that has lasted or is expected to last for 12 months or longer. The CSHCN Screener is based on the following Maternal and Child Health Bureau definition:

> CSHCN are children *"who have or are at elevated risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount not usually required by children."*[12]

If the child had one or more of the consequences listed above due to a condition that had last or was expected to last for 12 months or longer, then he or she was considered to have special health care needs.

Populations

For the quality of care indicators relying on information found in health care claims and encounter data, the children's quality of care is reported for different health status groups using the CRGs, which is fully described in *Section 1. Description of the Enrollees.* The Healthy Kids enrollees (N=218,782) included in the analyses represent a census of Title XXI children who were enrolled in the program for the previously specified time frame and at least six months so that their health status could be classified. Similarly, the CMSN enrollees (N=33,618) included in the analyses represent a census of Title XIX children who were enrolled in the program for the previously specified time frame and at least six months so that their health status could be classified. The Medicaid PCCM enrollees (N=739,545) included in these analyses represent a census of Title XIX children who were enrolled in the program for the previously specified time frame and at least six months so that their health status could be classified. In addition to the information for enrollees by CRG category, whenever possible, information is also presented for those recent enrollees who cannot be assigned to a CRG category because of their limited experience in the program. Results for the Healthy Kids program are presented first in each section, followed by the Medicaid PCCM and CMSN results.

The telephone survey data were obtained from families whose children were enrolled in one of the KidCare Program components for 12 months or longer (see Table 1). Our final response rate was 50% and the final cooperation rate was 61%. Telephone calls were made to families from 10 AM to 9 PM, 7 days per week. A minimum of 30 attempts were made to contact families and searches were conducted in an attempt to update the families' contact information. Surveys were conducted in both English and Spanish. Respondents were selected by asking to speak to the person in the family who was most knowledgeable about the child's health. In 81% of the cases, this was the child's mother; fathers responded in 10% of the families. In the remaining 9% of the cases, the respondent was a grandparent or other relative. We compared families who responded to those who did not in terms of child age, child gender, family income, and health status using the

[11] Bethell CD, Read D, Stein REK, Blumberg SJ, Wells N, and Newacheck PW. 2002 "Identifying Children With Special Health Care Needs: Development And Evaluation of a Short Screening Instrument." *Ambulatory Pediatric* 2:38-48.
[12] Maternal and Child Health Bureau. 1995. *Definition of Children with Special Health Care Needs* Division of Services for Children with Special Health Care Needs. Rockville, MD.

CRGs. No significant differences were found between respondents and non-respondents in any of these categories. When reporting families' satisfaction with their children's medical homes, results are reported for each program and by the number of condition consequences the children were experiencing as a result of their conditions.

Table 1. KidCare Program Survey Completion Levels, Fiscal Year 2004-2005

Surveys	Completed Interviews (Sample n)	Confidence Interval (%) *P*<=0.05
Children's Medical Services Network	300	± 5.33
Medicaid		
Medicaid HMO enrollees	256	±6.12
MediPass Only (HMO option not available in county)	283	±5.81
MediPass (HMO option available)	263	±6.04
Healthy Kids	299	±5.66
MediKids	301	±5.49

Format

A chart book format is used to display the findings for Florida KidCare enrollees. The chart book includes:

1) A narrative that describes the:
    a) significance of the quality of care indicator,
    b) results,
    c) implications of the findings and recommendations for future improvement, if needed, and
2) data presented in chart form by program.

National averages for these indicators are not currently available for SCHIP. But, comparisons can be made in the Medicaid programs. The NCQA gathers and compiles data from Medicaid managed care plans.[13] NCQA reports the national results at the 25th, 50th, 75th, and 90th percentiles for the participating plans. For comparison purposes to the SCHIP findings, the NCQA Medicaid managed care plans results are shown at the 50th percentile and are labeled "average" in the graphs. This is not available for all of the quality of care indicators and is not available based on the children's health status.

[13] The information that NCQA compiles for Medicaid Managed Care Programs can be viewed at www.ncqa.org

Section 1. Description of the Enrollees

DISTRIBUTION OF ENROLLEES BY CRG CATEGORY

Significance: The Clinical Risk Group (CRG) system classifies individuals into mutually exclusive clinical categories.[14] The use of the CRG system to create risk profiles is essential to understanding the illness burden within each KidCare program component and to place the health care expenditures and health care use patterns in a context.

Specifically, the CRG software reads all ICD-9-CM diagnosis codes from all health care encounters, except those associated with providers known to frequently report unreliable codes (e.g., non-clinician providers and ancillary testing providers). It assigns all diagnosis codes to a diagnostic category (acute or chronic[15]) and body system, and assigns all procedure codes to a procedure category.[16] Each individual is grouped to a hierarchically defined core health status group, and then to a CRG category and severity level, if chronically ill. Enrollees over the age of one who were enrolled in the program for 6 months or longer and enrollees under the age of 1 who were enrolled for 3 months or longer are included in CRG classification process; continuity of enrollment is required to classify individuals accurately. Children who have not been enrolled for the minimum number of months are not assigned a CRG classification.

The CRG system classifies children into the following nine health status categories:
(1) **Healthy** includes children who are enrolled in the health insurance program, but have not accessed services during the classification period ("non-users") and children who have used the health care system, but were seen for preventive care and for minor illnesses.

(2) **Significant Acute** includes children with conditions or acute illnesses, which occurred within six months prior to classification, and could be precursors to developing a chronic disease or place the individual at risk in the future for needing services of an amount and type greater than that for non-chronically ill persons. Examples in this group are head injury with coma, prematurity, and meningitis.

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[14] Neff JM, Sharp V, Muldoon J, Graham J, Popalisky J, Gay, J. 2001. Identifying and Classifying Children with Chronic Conditions Using Administrative Data with the Clinical Risk Group Classification System. *Journal of Ambulatory Pediatrics*, 2(1): 72-29.
[15] The CRG definition of a chronic health condition contains three components: a) physical, mental, emotional, behavioral or developmental disorder; b) expected to last at least 12 months or longer or having sequelae that last at least 12 months or longer; and, c) requires ongoing treatment and/or monitoring.
[16] Chronic and acute illnesses are generally classified only if there has been at least two outpatient encounters for that diagnosis separated by at least a day. There are a few diagnoses that require only one outpatient encounter based diagnosis, and these include the codes for mental retardation, Down's Syndrome, blindness, and procedural codes such as chemotherapy and renal dialysis.

(3) **Single Minor Chronic** includes children with illnesses that can usually be managed effectively throughout an individual's life with typically few complications and limited effect upon the individual's ability, death and future need for medical care. This category includes attention deficit / hyperactive disorders (ADHD), minor eye problems (excluding near-sightedness and other refractory disorders), hearing loss, migraine headache, some dermatological conditions, and depression.

(4) **Multiple Minor Chronic** includes children with two or more minor chronic conditions.

(5) **Single Dominant Chronic or Single Moderate Chronic** Dominant Chronic are those illnesses that are serious, and often result in progressive deterioration, debility, death, and the need for more extensive medical care. Examples in this group include diabetes, sickle cell anemia, chronic obstructive lung disease and schizophrenia. Moderate Chronic conditions are those illnesses that are variable in their severity and progression, but can be complicated and require extensive care and sometimes contribute to debility and death. This category includes asthma, epilepsy, and major depressive disorders.

(6) **Chronic Pairs** includes children with dominant chronic and/or moderate chronic conditions in two organ systems.

(7) **Chronic Triplets** includes children with chronic and/or moderate chronic conditions in three or more organ systems.

(8) **Metastatic Malignancies** includes acute leukemia under active treatment and other active malignant conditions that affect children.

(9) **Catastrophic Conditions** are those illnesses that are severe, often progressive, and are either associated with long term dependence on medical technology, or are life defining conditions that dominate the medical care required. Examples in this group include cystic fibrosis, spina bifida, muscular dystrophy, respirator dependent pulmonary disease and end stage renal disease on dialysis.

In the analyses presented in this report, several CRG categories are combined for ease of presentation and estimation. Importantly, the fifth category combines the major chronic CRG categories. Due to the small number of children having malignancies or catastrophic conditions, merging the major conditions into one category increases the population size and reduces the impact of any one outlier unduly impacting expenditure estimates.
(1) **Healthy** (CRG category #1)
(2) **Significant acute** (CRG category #2)
(3) **Minor Chronic** which combines single minor chronic (CRG category #3) and multiple minor chronic (CRG category #4)
(4) **Moderate Chronic** which combines single dominant chronic and single moderate chronic (CRG category #5)
(5) **Major Chronic** which combines chronic pairs (CRG category #6), chronic triplets (CRG category #7), metastatic malignancies (CRG category #8), and catastrophic conditions (CRG category #9)

Findings: New enrollees, who cannot be assigned a CRG category, comprised about 27% of all Healthy Kids, 24% of all Medicaid PCCM, and 22% of all CMSN enrollees.

Of those enrollees with a CRG category, 82% of the Healthy Kids enrollees and 72% of the Medicaid PCCM enrollees are healthy, but only 24% of CMSN enrollees are similarly classified (see Charts 1-1 A, B, and C). Seven percent of Healthy Kids enrollees, 9% of those in the PCCM program, and 5% of CMSN enrollees are classified with significant acute conditions, which may place them at risk for future long-term sequelae. Among Healthy Kids enrollees with a CRG classification, 6% have a minor chronic condition, 6% have a moderate chronic condition, and less than one percent have a major chronic condition. In the Medicaid PCCM population with a CRG classification, 7% have a minor chronic condition, 10% have a moderate chronic condition, and less than two percent have a major chronic condition. In the CMSN program though, 28% of enrollees with a CRG category have a major chronic condition, while 33% have a moderate chronic condition, and 9% have a minor chronic condition.

Implications: The health status of children in Healthy Kids and Medicaid PCCM are similar, with 82% and 72% of children classified in the healthy category. The favorable case-mix of enrollees in Florida (as evidence by a high proportion of healthy enrollees) may be due to the fact that Florida actively pre-screens enrollees for the presence of special health care needs and refers them to CMSN for further eligibility screening and possible enrollment. Thus, in Florida children with more moderate to severe chronic conditions are not in the PCCM or Title XXI Programs, rather they are served through CMSN. In Texas, for example, children with moderate to severe chronic conditions remained enrolled in the PCCM or Title XXI Programs and are not served through a separate system of care.

Almost 76% of enrollees in CMSN with a CRG classification have significant acute or chronic conditions. However, 24% of them are classified as healthy. All children in CMSN must meet medical eligibility criteria. Children in CMSN who were classified as healthy are those children who did not use health care services during the classification period or they were only seen for minor conditions such as otitis media or upper respiratory infections and their underlying chronic conditions were not recorded.

Children with acute or chronic conditions require the same basic primary care as healthy children and also may require specialized services. The quality of care that these children receive for both routine and specialized care should be assessed routinely. Understanding the health status of the program's enrollees is the first step in examining the quality of care that they receive.

The following charts and tables are contained in this section:

Chart 1-1A. Percent Distribution of Unduplicated Enrollees by CRG Category: Healthy Kids
Chart 1-1B. Percent Distribution of Unduplicated Enrollees by CRG Category: Medicaid PCCM
Chart 1-1C. Percent Distribution of Unduplicated Enrollees by CRG Category: CMSN

Chart 1-1A. Percent Distribution of Unduplicated Enrollees by CRG Category: Healthy Kids

N=252,642 (an additional 95,199 new enrollees not assigned to CRGs)
July 1, 2004 to June 30, 2005

	Healthy	Significant Acute	Minor Chronic	Moderate Chronic	Major Chronic
Percentage	81.55%	6.60%	5.65%	5.51%	0.62%

Chart 1-1B. Percent Distribution of Unduplicated Enrollees by CRG Category: Medicaid PCCM

N=561,540 (an additional 178,005 new enrollees not assigned to CRGs)
July 1, 2004 to June 30, 2005

	Healthy	Significant Acute	Minor Chronic	Moderate Chronic	Major Chronic
Percentage	72.01%	8.66%	7.33%	10.33%	1.66%

Chart 1-1C. Percent Distribution of Unduplicated Enrollees by CRG Category: CMSN

N=26,221 (an additional 7,397 new enrollees not assigned to CRGs)
July 1, 2004 to June 30, 2005

	Healthy	Significant Acute	Minor Chronic	Moderate Chronic	Major Chronic
Percentage	24.34%	5.38%	8.95%	33.10%	28.21%

Section 2. Expenditures

PMPM HEALTH CARE EXPENDITURES BY CRG CATEGORY
PERCENT OF EXPENDITURES BY CRG CATEGORY

Significance: Information about the health care expenditures are provided as descriptive information only. Because actual paid amounts are not available for the Healthy Kids enrollees' encounters, the Florida Medicaid fee schedule was applied to all health care claims and encounter data. The prescription drug costs were calculated using a wholesale price index (WPI), which very likely overstates the exact amount paid for the prescriptions.

Findings: Charts 2-1 A, B, and C show the per-member per-month (PMPM) health care expenditures by CRG category. Overall, Healthy Kids enrollees, with CRG classifications, have PMPM expenditures of about $69. However these charges vary from a low of $34 PMPM for those who are healthy to a high of $944 PMPM for those with major conditions. Medicaid enrollees, with a CRG classification, averaged $128 PMPM, with healthy enrollees averaging $51 PMPM and those with major conditions averaging $1,404 PMPM. Overall, CMSN averaged $1,194 PMPM. Only $96 PMPM was spent on average for CMSN enrollees classified as healthy compared to $3098 PMPM for CMSN enrollees with major conditions.

As expected, expenditures associated with those who have significant acute or chronic conditions consume large percentages of the KidCare health care dollars. Although enrollees with significant acute or chronic conditions comprise only 13% of the Healthy Kids enrollee pool, they account for 44% of the health care expenditures. Medicaid enrollees with significant acute or chronic conditions comprise only 21% of the program enrollment, but they account for 53% of the health care expenditures. Almost 59% of the CMSN enrollees are CRG classified as having a significant acute or chronic condition and they comprise 82% of the expenditures by the CMSN program.

Implications and Recommendations: When Congress enacted the Title XXI legislation creating the SCHIP, there was a widespread belief that enrollees in this program would be healthy.[17] The majority of Healthy Kids enrollees in Florida are in fact healthy. However, a substantial share of enrollees have significant acute or chronic conditions. As seen in public insurance programs nationally, the few enrollees

[17] Szilagyi PG, Shenkman E, Brach C. et al. (2003). Children With Special Health Care Needs Enrolled in the State Children's Health Insurance Program (SCHIP): Patient Characteristics and Health Care Needs. *Pediatrics*, 112: e508 - 520.

with chronic conditions account for a large share of the health care dollars. Coordinated care case management and targeted disease management programs may have a positive impact on promoting quality of care while controlling health care expenditures.

The charts contained in this section are:

Chart 2-1A. Per Member Per Month Health Care Expenditures by CRG Category: Healthy Kids
Chart 2-1B. Per Member Per Month Health Care Expenditures by CRG Category: Medicaid PCCM
Chart 2-1C. Per Member Per Month Health Care Expenditures by CRG Category: CMSN

Chart 2-2A. Percent of Expenditures by CRG Category Compared to Enrollee Distribution: Healthy Kids
Chart 2-2B. Percent of Expenditures by CRG Category Compared to Enrollee Distribution: Medicaid PCCM
Chart 2-2C. Percent of Expenditures by CRG Category Compared to Enrollee Distribution: CMSN

Chart 2-1A. Per Member Per Month Health Care Expenditures by CRG Category: Healthy Kids

July 1, 2004 to June 30, 2005

	Overall with CRGs	Healthy	Significant Acute	Minor Chronic	Moderate Chronic	Major Chronic	CRG Unassigned
PMPM Expenditures	$68.53	$33.63	$166.01	$197.76	$236.16	$943.94	$66.12

Chart 2-1B. Per Member Per Month Health Care Expenditures by CRG Category: Medicaid PCCM

July 1, 2004 to June 30, 2005

Chart 2-1C. Per Member Per Month Health Care Expenditures by CRG Category: CMSN

July 1, 2004 to June 30, 2005

	Overall with CRGs	Healthy	Significant Acute	Minor Chronic	Moderate Chronic	Major Chronic	CRG Unassigned
PMPM Expenditures	$1,193.65	$96.25	$384.17	$404.08	$722.98	$3,097.81	$860.29

Chart 2-2A. Percent of Expenditures by CRG Category Compared to Enrollee Distribution: Healthy Kids

July 1, 2004 to June 30, 2005

	Healthy	Significant Acute	Minor Chronic	Moderate Chronic	Major Chronic	CRG Unassigned
Percentage of Expenditures	29.40%	11.80%	12.00%	13.90%	6.30%	26.70%
Percentage of Enrollees	59.20%	4.80%	4.10%	4.00%	0.40%	27.40%

Chart 2-2B. Percent of Expenditures by CRG Category Compared to Enrollee Distribution: Medicaid PCCM

July 1, 2004 to June 30, 2005

	Healthy	Significant Acute	Minor Chronic	Moderate Chronic	Major Chronic	CRG Unassigned
Percentage of Expenditures	21.20%	8.60%	9.40%	21.10%	13.50%	26.20%
Percentage of Enrollees	54.70%	6.60%	5.60%	7.80%	1.30%	24.10%

Chart 2-2C. Percent of Expenditures by CRG Category Compared to Enrollee Distribution: CMSN

July 1, 2004 to June 30, 2005

	Healthy	Significant Acute	Minor Chronic	Moderate Chronic	Major Chronic	CRG Unassigned
Percentage of Expenditures	21.20%	8.60%	9.40%	21.10%	13.50%	26.20%
Percentage of Enrollees	54.70%	6.60%	5.60%	7.80%	1.30%	24.10%

AVERAGE COST OF PRESCRIPTIONS PER MEMBER PER MONTH

Significance: General information is provided about pharmacy expenditures due to the national concern about the rising costs of prescription medications, particularly within Medicaid programs. Between 2002 and 2003 the average retail prescription price increased 6.7% nationally and increased 8.1% in Florida[18].

Findings: Overall pharmacy expenditures are about $12 PMPM for Healthy Kids, $37 for Medicaid PCCM, and $313 for CMSN. Compared to enrollees in other CRG categories, enrollees with major chronic conditions have the highest PMPM pharmacy expenditures for Healthy Kids ($87), Medicaid PCCM ($296) and CMSN ($591). Notably, drug expenditures are higher in all CRG categories for CMSN than for Medicaid PCCM or Healthy Kids.

Implications and Recommendations: PMPM pharmacy expenditures increase with worsening health status in all three programs. Pharmacy expenditures are highest for enrollees with major chronic conditions in CMSN, which is likely related to the severity distribution of CMSN enrollees within each CRG category. While pharmacy costs make up a small proportion of the overall health care costs in all three programs, the significance is different. When proposing policies to contain health care costs via pharmacy expenditures, it is recommended that differential considerations be made across the three Florida KidCare programs.

The charts contained in this section are:

Chart 2-3A. Per Member Per Month Pharmacy Expenditures by CRG Category: Healthy Kids
Chart 2-3B. Per Member Per Month Pharmacy Expenditures by CRG Category: Medicaid PCCM
Chart 2-3C. Per Member Per Month Pharmacy Expenditures by CRG Category: CMSN

[18] The Kaiser Family Foundation State Health Facts, www.statehealthfacts.org, June 2005.

Chart 2-3A. Average Cost of Prescriptions Per Member Per Month by CRG Category: Healthy Kids

July 1, 2004 to June 30, 2005

	Overall, with CRGs	Healthy	Significant Acute	Minor Chronic	Moderate Chronic	Major Chronic	CRG Unassigned
PMPM Expenditures	$11.98	$7.89	$21.82	$25.48	$38.91	$87.40	$9.88

Chart 2-3B. Average Cost of Prescriptions Per Member Per Month by CRG Category: Medicaid PCCM

July 1, 2004 to June 30, 2005

	Overall, with CRGs	Healthy	Significant Acute	Minor Chronic	Moderate Chronic	Major Chronic	CRG Unassigned
PMPM Expenditures	$36.94	$15.14	$44.95	$72.33	$111.73	$296.48	$28.00

Chart 2-3C. Average Cost of Prescriptions Per Member Per Month by CRG Category: CMSN

July 1, 2004 to June 30, 2005

	Overall, with CRGs	Healthy	Significant Acute	Minor Chronic	Moderate Chronic	Major Chronic	CRG Unassigned
PMPM Expenditures	$313.26	$55.70	$124.65	$168.14	$342.98	$591.36	$191.79

Section 3. Effectiveness Measures

HEDIS WELL-CHILD VISITS IN THE 3RD, 4TH, 5TH, AND 6TH YEARS OF LIFE
HEDIS ADOLESCENT WELL CARE VISITS

Significance: Access to preventive care visits is a fundamental component of pediatric health care for all children including those with special health care needs. Preventive care visits that meet the AAP periodicity schedule are associated with a decrease in avoidable inpatient admissions for infants, across various racial and ethnic groups, income levels, and health status.[19] Preventive care visits are also critically important given the marked increase in the incidence of learning difficulties, accidents, and violence among children – a cluster of conditions that are called the "new morbidities" of childhood. These visits provide an opportunity for anticipatory guidance to parents about issues such as home safety, seat belt and care seat use, and normal developmental changes. Such interventions have been shown to increase parents' awareness of important developmental milestones and to reduce injury. Moreover, preventive care visits may be especially important for low-income children who are more likely than their more affluent counterparts to have these "new morbidities."[20] In addition, preventive care visits are a critical time to provide immunizations and to screen for anemia and lead poisoning.

Findings: Among three, four, five, and six year olds, 48% of Healthy Kids enrollees had well-child visits compared to 65% of enrollees in Medicaid PCCM and 70% of CMSN enrollees. Children enrolled in the Healthy Kids program did not meet the HEDIS benchmarks for well child visits, but children enrolled in Medicaid PCCM and CMSN exceeded the HEDIS benchmarks for well child visits.

In contrast, adolescents in each of the three programs met or exceeded the HEDIS average of 38% of adolescents receiving preventive care visits. Among adolescents in KidCare, 41% of Healthy Kids, 38% of Medicaid PCCM, and 49% of CMSN enrollees had a preventive care visit.

Implications and Recommendations: The provision of preventive care services is one of the hallmarks of good managed care. Many studies have shown that preventive care reduces long term health care costs, and therefore, it is in the best interest of the state to maximize the number of KidCare clients who receive preventive care. In the 2005 chartbook, none of the programs performed better than the HEDIS average for either well-child or adolescent well-care. Importantly, this year, two programs exceeded the HEDIS average for well-child visits

[19] Hakim RB, Bye BV. Effectiveness of compliance with pediatric preventive care guidelines among Medicaid beneficiaries. Pediatrics. 2001;108:90-97.
[20] Busey S, Schum TR, Meurer JR. Parental perceptions of well-child care visits in an inner-city clinic. Archives of Pediatric and Adolescent Medicine. 2002; 156:62-66.

and all three programs met or exceeded the HEDIS average for adolescent preventive care visits. This is a marked improvement in performance for the KidCare program components evaluated in this report.

The following charts are presented in this section:

Chart 3-1A. HEDIS Well-Child Visits in the 3rd, 4th, 5th, and 6th Years and Adolescent Years: Healthy Kids
Chart 3-1B. HEDIS Well-Child Visits in the 3rd, 4th, 5th, and 6th Years and Adolescent Years: Medicaid PCCM
Chart 3-1C. HEDIS Well-Child Visits in the 3rd, 4th, 5th, and 6th Years and Adolescent Years: CMSN

Chart 3-1A. HEDIS Well-Child Visits in the 3rd, 4th, 5th, and 6th Years and Adolescent Years: Healthy Kids

July 1, 2004 to June 30, 2005

	HEDIS 2004 Average, 3-6 Years	Overall, 3-6 Years		HEDIS 2004 Average, Adolescents	Overall, Adolescents
Percentage	59.90%	47.69%		37.60%	41.49%

Chart 3-1B. HEDIS Well-Child Visits in the 3rd, 4th, 5th, and 6th Years and Adolescent Years: Medicaid PCCM

July 1, 2004 to June 30, 2005

Chart 3-1C. HEDIS Well-Child Visits in the 3rd, 4th, 5th, and 6th Years and Adolescent Years: CMSN

July 1, 2004 to June 30, 2005

HEDIS USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA

Significance: The HEDIS measure that assesses the use of appropriate medications for people with persistent asthma was selected to evaluate the effectiveness of care for asthmatic children enrolled in KidCare. Asthma is a common chronic disease that affects an estimated 14 million adults and children. [21] Morbidity and mortality from asthma is largely preventable and health care costs associated with the disease can be reduced if medication guidelines are followed by practitioners and patients. The National Heart Blood and Lung Institute (NHBLI) recommends five classes of long-term control medication for asthma and their use among enrollees can be assessed using the HEDIS measure "Use of Appropriate Medications for People with Asthma." [22]

Economic impacts of asthma have increased dramatically in the past 20 years. Nearly 9.2 million children have a diagnosis of asthma and the annual health care costs for adults and children with the disease are more than $12 billion.[23] Given the high costs of asthma and the effects on long term health; the importances of diagnosis, appropriate treatment and medication, and disease management practices have become increasingly important. Asthma is characterized by airway inflammation which, if untreated, may lead to permanent airway damage. Current asthma care guidelines recommend inhaled anti-inflammatory medications—such as corticosteroids and cromolyn—as first-line treatment.

Little information is available about the experiences of children with asthma in SCHIP; however, pediatric Medicaid patients with asthma tend to have higher rates of emergency room (ER) use and inpatient stays and a lower likelihood of having a prescription filled for controller medications when compared to children in commercial health plans.[24] In another recent national study examining the appropriate use of controller medication for 13,352 children ages three to fifteen years with asthma, only 39% of them had filled prescriptions for recommended controller medications.[25] Appropriate medication management for those with asthma has been associated with reduced symptoms, reduced inpatient and ER use, and improved quality of life.

Findings: Children aged 6-14 years and adolescents (15 years and older), with an asthma diagnosis, were included in this measure based on the HEDIS criteria. The number of enrollees with asthma, the population of interest, is shown above each of the figures in this section. All three KidCare programs exceeded the HEDIS average for recommended medication use among children 6-14 years with asthma; 65% of Healthy Kids, 70% of Medicaid PCCM, and 79% of CMSN youngsters with asthma were found to be compliant with the HEDIS medication

[21] Pieoro LT, Potoski M, Talbert JC, Doherty DE. Asthma prevalence, cost, and adherence with expert guidelines on the utilization of health care services and costs in a state Medicaid population. *Health Services Research*. 2001;36(2): 357-371.
[22] National Commission on Quality Assurance. *HEDIS 2003: Technical Specifications*. Washington, DC: 2002.
[23] Rosenwasser LJ. Incorporating Omalizumab into asthma treatment guidelines: Consensus panel recommendations. *Pharmacy and Therapeutics*. 2003; 28(6):400-410.
[24] Finkelstein JA, Barton MB, Donahue JG, et al. Comparing asthma care for Medicaid and non-Medicaid children in a health maintenance organization. Arch Pediatr Adolesc Med. 2000;154:563-568.
[25] Donahue JG, Fuhlbrigge AL, Finkelstein JA, et al. Asthma pharmacotherapy and utilization by children in 3 managed care organizations. *Journal of Allergy and Clinical Immunology*. 2000; 106:1108-1114.

criteria. Among adolescents 15 years and older, only 54% of Healthy Kids and 58% of Medicaid PCCM were found to be compliant with the HEDIS medication criteria; neither program met or exceeded the HEDIS average of 61% compliance for adolescents. With 72% compliance among adolescents, the CMSN program exceeded the HEDIS average by 11 percentage points.

Implications and Recommendations: Several studies have demonstrated that both SCHIP and Medicaid face the challenges of delivering adequate asthma care to low-income families with young children[26]. Reaching out to families more aggressively so that their children receive appropriate medications can be a significant factor in reducing morbidity and mortality from this common childhood disease. Additional information should be gathered to identify factors contributing to the low compliance with recommended asthma medications. For example, the pharmacy claims data used for this measure only contains information about prescriptions that the family filled. It does not contain information about whether the physician ordered the medication. Medical record reviews should be conducted to examine whether physicians are ordering the recommended asthma medications. Strategies directed toward the families and the physicians can be formulated once factors contributing to the low compliance rates are more fully identified.

The following charts are included in this section:

Chart 3-2A. HEDIS Use of Appropriate Medications for Children and Adolescents with Asthma: Healthy Kids
Chart 3-2B. HEDIS Use of Appropriate Medications for Children and Adolescents with Asthma: Medicaid PCCM
Chart 3-2C. HEDIS Use of Appropriate Medications for Children and Adolescents with Asthma: CMSN

[26] Halterman JS, Aligne CA, Auinger P, et al. Inadequate therapy for asthma among children in the United States. *Pediatrics*. 2000;105(1):272-276.

Chart 3-2A. HEDIS Use of Appropriate Medications for Children and Adolescents with Asthma: Healthy Kids

N=2,872 for Ages 6-14, N=729 for Ages 15 and older
July 1, 2004 to June 30, 2005

	HEDIS 2004 Child Average	Overall, children	HEDIS 2004 Adolescent Average	Overall, adolescent
Ages 5-9	61.30%	65.00%	61.40%	53.60%

Chart 3-2B. HEDIS Use of Appropriate Medications for Children and Adolescents with Asthma: Medicaid PCCM

N=7,829 for Ages 6-14, N=1,987 for Ages 15 and older
July 1, 2004 to June 30, 2005

	HEDIS 2004 Child Average	Overall, children	HEDIS 2004 Adolescent Average	Overall, adolescent
Column 1	61.30%	70.00%	61.40%	58.00%

Chart 3-2C. HEDIS Use of Appropriate Medications for Children and Adolescents with Asthma: CMSN

N=1,394 for Ages 6-14, N=417 for Ages 15 and older
July 1, 2004 to June 30, 2005

	HEDIS 2004 Child Average	Overall, children	HEDIS 2004 Adolescent Average	Overall, adolescent
Column 1	61.30%	79.00%	61.40%	71.90%

Section 4. Access to Care Measures

PERCENT OF HOSPITALIZATIONS WITH PRIMARY DIAGNOSIS OF AN AMBULATORY CARE SENSITIVE CONDITION AND PERCENT OF ER USE WITH PRIMARY DIAGNOSIS OF AN AMBULATORY CARE SENSITIVE CONDITION

Significance: Access to care refers to the ability to obtain needed medical care and can be measured in a variety of ways.[27] Two different access measures are used in the SCHIP quality assessment. The first measure addresses the use of inpatient and emergency room facilities for ambulatory care sensitive conditions (ACSCs), which IOM specifically recommends as an access to care indicator.[28] ACSCs refer to those conditions that are not expected to result in inpatient or ER use if there is good access to care in the outpatient setting. ACSCs include:

1. Immunization preventable conditions such as pertussis, rheumatic fever, tetanus, polio, and hemophilus meningitis,
2. Chronic conditions such as asthma, diabetes with ketoacidosis or hyperosmolar coma, diabetes with specified manifestations, diabetes without specified complications, grand mal seizures, and hypoglycemia, and
3. Acute conditions such as cellulitis, dehydration, gastroenteritis, pneumonia, and kidney/urinary tract infections, ear, nose, and throat infections, ruptured appendix, and untyped conditions such as failure to thrive, congenital syphilis, and nutritional deficiency.

The second indicator is a HEDIS measure that addresses children's access to primary care practitioners. Low-income families, especially those with young children tend to use primary care at much lower rates than higher income groups.[29] Linkages with primary care providers can have a positive effect on both the quality and costs of care. Therefore, assessing the degree to which children in SCHIP have access to their primary care practitioners is an important quality of care indicator.

ACSCs are those conditions that should not result in an inpatient stay or an ER visit, if there is good access to care in the outpatient setting. Preventable hospitalizations and ER visits are costly and do not reflect good quality of or access to care for enrollees. Prior research has

[27] Miller RH and Luft HS. HMO plan performance update: An analysis of the literature, 1997-2001. *Health Affairs*. 2002;21(4):63-
[28] Gaskin DJ, Hoffman C. Racial and ethnic differences in preventable hospitalizations across 10 states. *Medical Care Research and Review*. 2000;57(1):85-107.
[29] Kotagal UR, Schoettker PJ, Atherton HD, et al. Relationship between early primary care and emergency department use in early infancy by the Medicaid population. *Arch Pediatr Adolesc Med*. 2002;156:710-716.

demonstrated that large states like Florida (notably New York and California) are at risk for having high rates of preventable hospitalizations, particularly among their Hispanic and Black non-Hispanic populations.[30] One study examining hospital discharge abstracts in 10 states found that 18% of all discharges were for ACSCs. However, the greatest risk for preventable hospitalizations due to these conditions was found among Hispanic children, working age Black non-Hispanic adults, and Hispanic elderly patients. In addition to racial and ethnic variations in the incidence of preventable hospitalizations, low-income persons in general and those on Medicaid also are at increased risk for such events. Persons who have preventable hospitalizations are also more likely to be seen in the ER for such conditions and to use the ER for their routine care.[31] In one study, in a small state, 20% of all ER uses among Medicaid recipients were for ACSCs.[32] The incidence of inpatient and ER use for ACSCs is considered a strong marker of access to care. The information about the incidence of inpatient and ER use for ACSCs among minorities is provided as background information only. Information about race and ethnicity has only recently been collected for Title XXI enrollees and more time needs to elapse before there is sufficient data to report this measure by race and ethnicity for Healthy Kids enrollees.

Findings: Twenty-three percent of inpatient stays and 21% of ER visits for Healthy Kids enrollees were for ACSCs. For Medicaid PCCM, 35% of inpatient stays were for an ACSC and 36% of ER visits were for ACSCs. CMSN performed similarly to Medicaid PCCM, with 35% of inpatient stays and 33% of ER visits by CMSN enrollees for ACSCs. These findings represent the percentage of visits for ACSCs and not the percentage of unique children with such visits.

Hospitalization and ER use due to ACSCs varies by age of the enrollee. In all three programs, enrollees aged 1-5 years had higher levels of hospitalizations for ACSCs than children of other ages. For Healthy Kids and CMSN, enrollees age 1-5 years had higher rates of ER use for ACSCs than children of other ages; for Medicaid PCCM enrollees, the highest rates of ER use for ACSCs was found for infants under the age of one year, followed by children aged 1-5 years.

Implications and Recommendations: The findings for the KidCare programs are similar to those found nationally among low income populations. The rate of hospitalization and ER use for Healthy Kids enrollees for ACSCs was lower than for both Medicaid PCCM and CMSN, suggesting the Title 19 (low-income) populations in Medicaid and CMSN have lower access to preventive care than the Title 21 (modest-income) families whose children are enrolled in Healthy Kids.

Many factors play a role in the occurrence of potentially avoidable inpatient and ER uses. In addition to poverty and other socioeconomic factors, the supply of primary care physicians plays a large role in ER use rates, including potentially avoidable visits.[33] Studies of the early Medicaid expansions in the 1990s indicate that ER use declined among those providers who had office hours in the evenings and on

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[30] Gaskin DJ, Hoffman C. Racial and ethnic differences in preventable hospitalizations across 10 states. *Medical Care Research and Review*. 2000;57(1):85-107.
[31] Oster A, Bindman AB. Emergency department visits for ambulatory care sensitive conditions: Insights into preventable hospitalizations. *Medical Care*. 2003;41(2):198-207.
[32] Croke A. *Reducing ED Over-Utilization*. Rhode Island, Neighborhood Health Plan, 2003.
[33] Halfon N, Newacheck PW, Wood D. Routine emergency room use for sick care by children in the United States. *Peditatrics*. 1996;98:28-34.

weekends.[34] Thus the programs should: 1) review the adequacy of their primary care networks; and, 2) consider factors that may be limiting access to care for their enrollees such as restricted office hours and language and cultural barriers.

The following charts are presented in this section:

Chart 4-1A. Percent of Hospitalizations with a Primary Diagnosis of an Ambulatory Care Sensitive Condition by Child's Age: Healthy Kids
Chart 4-1B. Percent of Hospitalizations with a Primary Diagnosis of an Ambulatory Care Sensitive Condition by Child's Age: Medicaid PCCM
Chart 4-1C. Percent of Hospitalizations with a Primary Diagnosis of an Ambulatory Care Sensitive Condition by Child's Age: CMSN
Chart 4-2A. Percent of ER Use with a Primary Diagnosis of an Ambulatory Care Sensitive Condition by Child's Age: Healthy Kids
Chart 4-2B. Percent of ER Use with a Primary Diagnosis of an Ambulatory Care Sensitive Condition by Child's Age: Medicaid PCCM
Chart 4-2C. Percent of ER Use with a Primary Diagnosis of an Ambulatory Care Sensitive Condition by Child's Age: CMSN

[34] Alessandrini EA, Shaw KN, Bilker WB, et al. Effects of Medicaid managed care on health care use: Infant emergency department and ambulatory services. *Pediatrics*. 2001;108(1):103-110.

Chart 4-1A. Percent of Hospitalizations with Primary Diagnosis of an Ambulatory Care Sensitive Condition by Child's Age: Healthy Kids

July 1, 2004 to June 30, 2005

	Overall	Age <1	Age 1-5 years	Age 6-14 years	Age 15+ years
Percentage	23.09%		38.84%	25.13%	17.93%

Chart 4-1B. Percent of Hospitalizations with Primary Diagnosis of an Ambulatory Care Sensitive Condition by Child's Age: Medicaid PCCM

July 1, 2004 to June 30, 2005

	Overall	Age <1	Age 1-5 years	Age 6-14 years	Age 15+ years
Percentage	35.25%	39.95%	52.06%	31.76%	16.42%

Chart 4-1B. Percent of Hospitalizations with Primary Diagnosis of an Ambulatory Care Sensitive Condition by Child's Age: CMSN

July 1, 2004 to June 30, 2005

	Overall	Age <1	Age 1-5 years	Age 6-14 years	Age 15+ years
Percentage	34.94%	32.86%	39.43%	33.48%	29.74%

Chart 4-2A. Percent of ER Use with a Primary Diagnosis of an Ambulatory Care Sensitive Condition by Child's Age: Healthy Kids

July 1, 2004 to June 30, 2005

	Overall	Age <1	Age 1-5 years	Age 6-14 years	Age 15+ years
Percentage	21.05%		35.51%	22.61%	17.27%

Chart 4-2B. Percent of ER Use with a Primary Diagnosis of an Ambulatory Care Sensitive Condition by Child's Age: Medicaid PCCM

July 1, 2004 to June 30, 2005

	Overall	Age <1	Age 1-5 years	Age 6-14 years	Age 15+ years
Percentage	36.35%	46.75%	44.95%	28.11%	20.70%

Chart 4-2C. Percent of ER Use with a Primary Diagnosis of an Ambulatory Care Sensitive Condition by Child's Age: CMSN

July 1, 2004 to June 30, 2005

	Overall	Age <1	Age 1-5 years	Age 6-14 years	Age 15+ years
Percentage	32.71%	34.11%	40.87%	28.87%	21.73%

HEDIS FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Significance: Ensuring continuity of care and providing follow-up in the community after inpatient stays for mental illness has been shown to reduce enrollees' health care costs and to improve their outcomes of care.[35] One small study conducted in a regional managed care company showed that 17.6% of patients discharged from any of seven psychiatric hospitals in the region were readmitted to a hospital during a 6-month follow-up period; about 7% of the readmissions occurred within 30 days of discharge.[36] HEDIS contains a measure designed to assess outpatient follow-up at 7 days and 30 days after discharge from an inpatient stay for mental illness.

Findings: About 30% of enrollees in Healthy Kids, who had a mental illness inpatient stay, received outpatient follow-up within seven days of their discharge; the HEDIS average is seven day follow-up is 37%. Within 30 days of discharge though, over 61% of Healthy Kids enrollees received an outpatient follow-up, exceeding the HEDIS average of 56% for this measure. For enrollees in Medicaid PCCM, 53% received an out-patient follow-up within seven days of discharge and 73% received follow-up within 30 days of discharge. CMSN had the highest rates of follow-up, with 66% of enrollees receiving outpatient follow-up within seven days and 85% receiving outpatient follow-up within 30 days. Both Medicaid and CMSN exceed the HEDIS averages for out-patient follow-up after a mental illness discharge for seven and 30 days.

Rates of general out-patient follow-up are much higher than specific mental health follow-up for all three KidCare program components. For Healthy Kids, only 20% of enrollees discharged received mental health follow-up within 7 days compared to 30% who received any type of outpatient follow-up. For Medicaid PCCM, only 4% of enrollees discharged for mental illness received mental health follow-up within seven days compared to 53% who received any type of follow-up. The same pattern occurs within CMSN, with only 6% of discharged enrollees receiving specific mental health follow-up within seven days.

Implications and Recommendations: All three programs should consider ways to improve access to mental health follow-up. While outpatient follow-up, in general, is higher than the HEDIS average for Medicaid PCCM and CMSN, specific mental health follow-up is very low for those two programs. The Healthy Kids program does better at connecting their enrollees with a mental health discharge with mental health follow-up, but that program's overall follow-up does not exceed the HEDIS average.

The following charts are included in this section:

[35] Fortney, J., Sullivan, G., Williams, K., Jackson, C., Morton, S.C., and Kogel, P., "Measuring continuity of care for clients of public mental health systems", *Health Services Research*, 2003, 38(4):1157-1175.
[36] Lyons, J.S., O'Mahoney, M.T., Miller, S.I., Neme,, J., Kabat, J., and Miller, F, "Predicting readmission to the psychiatric hospital in a managed care environment: implications for quality indicators", *American Journal of Psychiatry*, 1997, 154(3):337-340.

Chart 4-3A. HEDIS Follow-up after Hospitalization for Mental Illness: Healthy Kids
Chart 4-3B. HEDIS Follow-up after Hospitalization for Mental Illness: Medicaid PCCM
Chart 4-3C. HEDIS Follow-up after Hospitalization for Mental Illness: CMSN

Chart 4-3A. HEDIS Follow-up after Hospitalization for Mental Illness: Healthy Kids

Number of Discharges=390 for Ages 6-14, Number of Discharges=485 for Ages 15 and older
July 1, 2004 to June 30, 2005

	Any Outpatient Follow-up within 7 Days	Any Outpatient Follow-up within 30 Days	Mental Health Outpatient Follow-up within 7 Days	Mental Health Outpatient Follow-up within 30 Days
HEDIS 2004 average	37.00%	55.80%		
Overall, ages 6+	29.71%	61.14%	19.43%	44.91%
Ages 6-14	33.08%	68.21%	18.72%	49.49%
Ages 15 and older	27.01%	55.46%	20.00%	41.24%

Chart 4-3B. HEDIS Follow-up after Hospitalization for Mental Illness: Medicaid PCCM

Number of Discharges=1,603 for Ages 6-14, Number of Discharges=1,940 for Ages 15 and older
July 1, 2004 to June 30, 2005

	Any Outpatient Follow-up within 7 Days	Any Outpatient Follow-up within 30 Days	Mental Health Outpatient Follow-up within 7 Days	Mental Health Outpatient Follow-up within 30 Days
HEDIS 2004 average	37.00%	55.80%		
Overall, ages 6+	52.64%	72.51%	4.01%	13.04%
Ages 6-14	57.70%	74.92%	4.80%	14.16%
Ages 15 and older	48.45%	70.52%	3.35%	12.11%

Chart 4-3C. HEDIS Follow-up after Hospitalization for Mental Illness: CMSN

Number of Discharges=190 for Ages 6-14, Number of Discharges=165 for Ages 15 and older
July 1, 2004 to June 30, 2005

	Any Outpatient Follow-up within 7 Days	Any Outpatient Follow-up within 30 Days	Mental Health Outpatient Follow-up within 7 Days	Mental Health Outpatient Follow-up within 30 Days
HEDIS 2004 average	37.00%	55.80%		
Overall, ages 6+	66.20%	84.51%	6.20%	18.87%
Ages 6-14	71.58%	84.74%	5.79%	18.95%
Ages 15 and older	60.00%	84.24%	6.67%	18.79%

Section 5. Overall Satisfaction with KidCare

Significance: Customer health plan satisfaction is an important aspect of the quality of health care received and the overall health care experience. The analyses presented in this section use CAHPS 3.0 composite scores to determine parental satisfaction with KidCare.[37] Specifically, the Medicaid module for children was used with supplemental questions addressing care for CSHCN. CAHPS reports composite scores that are easy to interpret and concise. The following CAHPS composites were assessed for state fiscal year 2004-2005:

1) Parents' experiences with getting needed care;
2) Parents' experiences with getting care quickly;
3) Parents' experiences with how well medical providers communicate;
4) Parents' experiences with the courtesy, respect, and helpfulness of the office staff;
5) Parents' experiences with health plan customer service, information, and paperwork;
6) Parents' experiences with getting prescription medicine;
7) Parents' experiences getting specialized services for their children;
8) Family-centered care, including having a personal doctor or nurse, shared decision-making, and getting needed information;
9) Parents' experiences with coordination of their child's care.

For each question, parents have a choice of two, three, or four answers. Each answer receives a score between 0 and 100%, and the mean score for each question is calculated. For example, in assessing the parents' experiences related to the child getting needed care, the parent could choose that getting needed care was, "a big problem ", "a small problem", or "not a problem". These answers receive a score of 0%, 50%, and 100%, respectively. The higher the mean score, the better the program was at getting a child needed care.

Findings: Chart 5-1 illustrates the results of the CAHPS composite scores for the overall KidCare program. The two lowest scoring assessments were getting needed care quickly (65) and care coordination (69); these two topics were the lowest scores in 2003-2004 as well. The highest assessment was parents' experiences with prescription medicine (88), followed closely by satisfaction with office staff helpfulness (87) and communication with providers (86).

Chart 5-2 illustrates similar results by four ethnic-racial groups: Hispanic, white non-Hispanic, black non-Hispanic, and other non-Hispanic. Results confirm those found in Chart 5-1, such that getting needed are quickly and coordinated care had the lowest mean scores, while prescription medicine had the highest mean scores by race.

Implications and Recommendations: Overall parental satisfaction in the Florida KidCare program is high. With the exception of getting needed care quickly and care coordination, parents scored most components of the program above 75%. While this positive feedback is

[37] National Commission on Quality Assurance. HEDIS 2003: Specifications for Survey Measures. Washington, D.C.: 2002.

encouraging, it also points out areas for improvement. Care coordination is essential to avoid duplicative treatment which is costly and unnecessary. Likewise, children who receive care later than they need it might result in higher costs to treat a condition that has escalated unnecessarily.

The following charts are included in this section:

Chart 5-1. Using CAHPS Composite Scores to Measure Satisfaction with the KidCare Program
Chart 5-2. Using CAHPS Composite Scores to Measure Satisfaction with the KidCare Program, by Race

Chart 5-1. Using CAHPS Composite Scores to Measure Satisfaction with the KidCare Program

***** Each answer receives a score between 0 and 100%, and the mean score for each question is calculated. For example, in assessing the parents' experiences related to the child getting needed care, the parent could choose that getting needed care was, "a big problem ", "a small problem", or "not a problem". These answers receive a score of 0%, 50%, and 100%, respectively. The higher the mean score, the better the program was at getting a child needed care.

	Getting Needed Care	Getting Care Quickly	Provider Communication	Office Staff Helpfulness	Health Plan Customer Service	Getting Medications	Specialty Services	Having a Personal Doctor	Shared Decision-making	Getting Needed Information	Coordinated Care
Mean	84	65	86	87	78	88	73	77	78	83	69

Chart 5-2. Using CAHPS Composite Scores to Measure Satisfaction with the KidCare Program, by Race

*Each answer receives a score between 0 and 100%, and the mean score for each question is calculated. For example, in assessing the parents' experiences related to the child getting needed care, the parent could choose that getting needed care was, "a big problem ", "a small problem", or "not a problem". These answers receive a score of 0%, 50%, and 100%, respectively. The higher the mean score, the better the program was at getting a child needed care.

	Getting Needed Care	Getting Care Quickly	Provider Communication	Office Staff Helpfulness	Health Plan Customer Service	Getting Medications	Specialty Services	Having a Personal Doctor	Shared Decision-making	Getting Needed Information	Coordinated Care
Mean, Hispanic	86	67	85	87	80	87	73	77	76	82	71
Mean, Black	84	58	86	85	84	93	81	80	78	80	81
Mean, White	81	68	88	91	75	87	64	75	81	86	59
Mean, Other	85	59	80	81	55	80	79	74	77	73	56

Section 6. Acronym List

AAP- American Academy of Pediatrics

ACSC- Ambulatory Care Sensitive Condition

CAHPS- Consumer Assessment of Health Plans Survey

CMSN- Children's Medical Services Network

CRG- Clinical Risk Group

CSHCN- Children with Special Health Care Needs

ER- Emergency Room

HEDIS- Health Employer Data and Information Set

HMO- Health Maintenance Organization

ICD-9-CM- International Classification of Diseases, 9th Revision

IOM- Institute of Medicine

MCO- Managed Care Organization

NCQA- National Commission on Quality Assurance

PCCM- Primary care Case Management

PMPM- Per Member Per Month

SCHIP- State Children's Health Insurance Program