SOUTH CAROLINA
Healthy Connections

Proviso Report

Proviso 21.33 Medicaid Cost and Quality Effectiveness

The following is submitted as required by Proviso 21.33 of the
SFY 2012 Appropriations Act

The Department of Health and Human Services shall establish a procedure to assess the various forms of managed care (Health Maintenance Organizations and Medical Home Networks, and any other forms authorized by the department) to measure cost effectiveness and quality. These measures must be compiled on an annual basis. The Healthcare Effectiveness Data and Information Set (HEDIS) shall be utilized for quality measurement and must be performed by an independent third party according to HEDIS guidelines. Cost effectiveness shall be determined in an actuarially sound manner and data must be aggregated in a manner to be determined by a third party in order to adequately compare cost effectiveness of the different managed care programs versus Medicaid fee-for-service. The methodology must use appropriate case-mix and actuarial adjustments that allow cost comparison of managed care organizations, medical home networks, and fee-for-service. The department shall issue annual healthcare report cards for each participating Medicaid managed care plan and Medical Home Network operating in South Carolina and the Medicaid fee-for-service program. The report card measures shall be developed by the department and the report card shall be formatted in a clear, concise manner in order to be easily understood by Medicaid beneficiaries. The results of the cost effectiveness calculations, quality measures and the report cards shall be made public on the department's website no later than ninety days after the end of each fiscal year.

15800 Bluemound Road
Suite 100
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 923 3680

milliman.com

John D. Meerschaert, FSA, MAAA
Principal and Consulting Actuary

john.meerschaert@milliman.com

October 26, 2012

Mr. Anthony Keck
Director
State of South Carolina
Department of Health and Human Services
1801 Main Street
Columbia, SC 29202-8206

Re: Medicaid Cost Effectiveness Analysis

Dear Mr. Keck:

Thank you for the opportunity to assist the South Carolina Department of Health and Human Services with this important project. Our report summarizes the results of our analysis of the cost effectiveness of South Carolina's Medicaid managed care programs as required by Proviso 21.33.

Please call me at 262-796-3434 if you have questions.

Sincerely,

John D Meerschaert, FSA, MAAA
Principal and Consulting Actuary

JDM/laa

Attachments

Milliman Client Report

Milliman

State of South Carolina
Department of Health and Human Services
Medicaid Cost Effectiveness Analysis

Prepared for:
State of South Carolina
Department of Health and Human Services

Prepared by:
Milliman, Inc.

Mathieu Doucet, FSA, MAAA
Actuary

John D. Meerschaert, FSA, MAAA
Principal and Consulting Actuary

15800 Bluemound Road
Suite 100
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 923 3680

milliman.com

October 26, 2012

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I. EXECUTIVE SUMMARY

This report documents our analysis of the cost effectiveness of South Carolina's Medicaid programs as required by Proviso 21.33 for the period April1, 2011 through March 31, 2012.

The South Carolina Department of Health and Human Services (SC DHHS) retained Milliman to assess and measure the cost effectiveness of the two forms of Medicaid managed care, Managed Care Organizations (MCOs) and Medical Home Networks (MHNs). We prepared this analysis to assess the cost effectiveness of the two managed care programs compared to the fee-for-service (FFS) program. Our analysis provides SC DHHS with an actuarially sound determination of the programs' cost effectiveness.

We developed the cost effectiveness comparison based on SC DHHS expenses for MCO eligible Medicaid beneficiaries for the period of April 2011 through March 2012. The expenditures for each program were limited to services included in the MCO capitation rates (i.e., excludes carve-out expenditures) plus the mental health expenditures that are paid on a FFS basis under the MCO program. The MCO expenditures also include the FQHC and RHC wraparound payments SC DHHS made for MCO enrollees. The MHN expenditures include the $10 PMPM management fee, but do not include MHN Shared Savings settlements.

Table 1 shows the results of our analysis. We estimate the MHN program saves 4.4% and the MCO program saves 5.9% compared to the FFS program.

Table 1
South Carolina Department of Health and Human Services
Risk Adjusted April 2011 – March 2012 Cost Per Member Per Month (PMPM)

Population	FFS Cost PMPM	MCO Cost PMPM	MHN Cost PMPM
TANF Children	$135.10	$123.35	$115.67
TANF Adult	346.15	373.35	339.70
SSI	856.65	773.75	883.05
Total	261.20	245.79	249.72
Ratio of Total Cost to Total FFS Cost	100.0%	94.1%	95.6%

The infant and pregnant women populations are excluded from our analysis.

The cost effectiveness comparison does not include SC DHHS administrative expenses incurred to operate the different programs. However, we expect that SC DHHS could save as much as an additional 2% of total cost on administrative expenses by enrolling members into the MCO program compared to the FFS or MHN programs.

Pharmacy rebates were not reflected in the analysis. The exclusion of pharmacy rebates from the analysis recognizes that pharmacy rebates are now treated equally under managed care and FFS Medicaid programs as a result of the Patient Protection and Affordable Care Act .

DATA RELIANCE AND IMPORTANT CAVEATS

We used FFS cost and eligibility data for April 2011 through March 2012 dates of service, and several other analyses to determine the cost effectiveness of the Medicaid managed care programs compared to FFS. This data was provided by SC DHHS. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Milliman has prepared this report for the specific purpose of determining the cost effectiveness of the Medicaid managed care programs. This report should not be used for any other purpose. This report has been prepared solely for the internal business use of and is only to be relied upon by the management of SC DHHS. We anticipate the report will be shared with contracted MCOs, MHNs, and other interested parties. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work. It should only be reviewed in its entirety.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this report.

The terms of Milliman's contract with SC DHHS dated July 1, 2012 apply to this report and its use.

II. BACKGROUND

There are two types of Medicaid managed care plans in South Carolina: traditional Managed Care Organizations (MCOs) and Medical Home Networks (MHNs).

Medicaid MCOs have been operating in South Carolina since 1996. The MCOs are financially responsible for the services in the MCO contract under a full risk capitated payment arrangement. SC DHHS currently contracts with four MCOs.

The MHN program is a primary care case management program and is composed of a Care Coordination Services Organization (CSO) and the PCPs enrolled in that network. The CSO supports the physicians and enrolled members by providing care coordination, disease management, and data management. The PCPs manage the health care of their members, which includes authorizing services provided by other health care providers. The MHNs receive a monthly payment to manage the services delivered to their enrollees. Services are paid through the FFS system.

With the help of MCOs and MHNs, SC DHHS seeks to increase care coordination and disease prevention methods not found in traditional FFS Medicaid.

The South Carolina General Assembly included proviso 21.33 in the fiscal 2011 Appropriations Act:

> *"The Department of Health and Human Services shall establish a procedure to assess the various forms of managed care (Health Maintenance Organizations and Medical Home Networks, and any other forms authorized by the department) to measure cost effectiveness and quality. These measures must be compiled on an annual basis. The Healthcare Effectiveness Data and Information Set (HEDIS) shall be utilized for quality measurement and must be performed by an independent third party according to HEDIS guidelines. Cost effectiveness shall be determined in an actuarially sound manner and data must be aggregated in a manner to be determined by a third party in order to adequately compare cost effectiveness of the different managed care programs versus Medicaid fee-for-service. The methodology must use appropriate case-mix and actuarial adjustments that allow cost comparison of managed care organizations, medical home networks, and fee-for-service. The department shall issue annual healthcare report cards for each participating Medicaid managed care plan and Medical Home Network operating in South Carolina and the Medicaid fee-for-service program. The report card measures shall be developed by the department and the report card shall be formatted in a clear, concise manner in order to be easily understood by Medicaid beneficiaries. The results of the cost effectiveness calculations, quality measures and the report cards shall be made public on the department's website no later than 90 days after the end of each fiscal year."*

This report covers the measurement of the cost effectiveness required by proviso 21.33.

III. METHODOLOGY

This section of our report documents the methodology used in developing an actuarially sound analysis of the cost effectiveness of the Medicaid managed care programs in South Carolina.

GENERAL DESCRIPTION

This analysis compares SC DHHS costs for the FFS program to the two managed care options available to Medicaid enrollees in South Carolina during the April 2011 to March 2012 period. In order to consistently assess the cost effectiveness of the two managed care programs compared to FFS, we limited our analysis to a comparable population and a defined set of services.

- We only included individuals that are eligible to enroll in the MCO program.
- We included the cost of services included in the MCO capitation rate plus the mental health services paid on a FFS basis for all populations. We included the mental health costs in our analysis to provide a more complete comparison of the cost effectiveness.
- We risk adjusted the cost of each population to reflect the differences in population acuity for MCO, MHN, and FFS enrollees.

Not all Medicaid recipients are eligible to enroll in the Medicaid managed care program as defined by Payment Category and Waiver Program codes. Table 2 below shows the ineligible payment categories.

Table 2
South Carolina Department of Health and Human Services
Excluded Payment Category Codes

Payment Category	Description	Payment Category	Description
10	MAO (Nursing Home)	50	Qualified Working Disabled
14	MAO (General Hospital)	52	SLMB
15	MAO (CLTC Waiver)	54	SSI Nursing Home
33	ABD Nursing Home	55	Family Planning
41	Reinstatement	56	COSY / ISCEDC
42	Silver Card and SLMB	70	Refugee Entrant
43	Silver Card and S2 SLMB	90	QMB
48	S2 SLMB	92	Silver Card
49	S3 SLMB		

Table 3 shows the only waiver programs eligible for Medicaid Managed Care. All other waiver program enrollees are excluded.

Table 3
South Carolina Department of Health and Human Services
Included Waiver Programs

Waiver Program Code	Description
HRHI	At Risk Pregnant Women – High
CHPC	Children's Personal Care Aid
HRLO	At Risk Pregnant Women – Low
COSY	Emotionally Disturbed Children in Beaufort
HREX	At Risk Pregnant Women – Ex
ISED	Emotionally Disturbed Children
MCPC	Integrated Personal Care Service CRCF Recipients

We excluded the newborn and pregnant women population from our analysis. Our analysis compares costs on an incurred claims basis and the timing of the delivery makes it difficult for analysis since the pre-natal costs may be incurred FFS, while the higher delivery costs may occur in an MCO or under the MHN enrollment period. The cost for newborns presents a similar challenge due to the timing of the more expense birth month within the TANF 0-2 month rate cell.

We also exclude the Dual Eligible population due to the retroactive nature of the dual status determination.

Please refer to our April 29, 2011 and July 8, 2011 MCO rate setting reports for a detailed description of the benefits included in the MCO capitation rates during the April 2011 – March 2012 rate period.

FFS POPULATION COST

To calculate the FFS population cost, we summarized the April 2011 – March 2012 FFS expenditures for services included in the MCO capitation rates and mental health services for FFS enrollees that would be eligible for the MCO program.

We removed Graduate Medical Education payments and adjusted for incurred but not reported (IBNR) claims. The claims data used in developing the FFS population cost includes claims paid through July 31, 2012 allowing for four months of run-out for the April 2011 – March 2012 study period. The IBNR adjustment reflects an estimate of the claims that will be paid after July 31, 2012.

The annual completion factors were developed using a composite of the lag 4 through 15 completion factors for the April 2011 – March 2012 study period and are shown in Table 4 below.

Table 4 South Carolina Department of Health and Human Services April 2011 – March 2012 Completion Factors				
Service Category	**Infants**	**TANF Children**	**TANF Adult**	**SSI**
Hospital Inpatient	1.0275	1.0089	1.0140	1.1021
Hospital Outpatient	1.0073	1.0098	1.0121	1.0383
Physician	1.0091	1.0106	1.0162	1.0304
Lab and X-Ray	1.0057	1.0089	1.0109	1.0122
Pharmacy	1.0001	1.0001	1.0000	1.0002
DME and Prosthetics	1.0222	1.0137	1.0172	1.0222
Ambulance	1.0032	1.0021	1.0100	1.0228
Home Health	1.0087	1.0034	1.0125	1.0282

We then applied an adjustment for Third Party Liability to reflect recoveries that are not included in the claims data. We used a 0.995 adjustment factor consistent with the MCO capitation rate development. Finally, we applied an adjustment for hospital administrative days to account for administrative hospital day payments that are not included in the claims data. We used a 1.0007 adjustment factor consistent with the MCO capitation rate development.

No other adjustments were required since the FFS data already reflects the provider reimbursement levels and benefit limitations that are assumed in the capitation rate development.

Table 5 below shows the estimated April 2011 – March 2012 FFS population cost. Note that detailed rate cell results are combined into the TANF Children and TANF Adult categories using the total MCO-eligible population demographics (including FFS, MCO and MHN enrollees).

Table 5 South Carolina Department of Health and Human Services April 2011 – March 2012 FFS Population Cost					
Rate Cell	**Gender**	**FFS April 2011 – March 2012 MCO Eligible Member Months**	**Medical Cost PMPM**	**Rx Cost PMPM**	**Total Cost PMPM**
TANF: Age 1 - 6	Unisex	224,330	$89.58	$17.33	$106.91
TANF: Age 7 - 13	Unisex	185,319	102.99	46.42	149.41
TANF: Age 14 - 18	Male	65,552	216.65	49.57	266.22
TANF: Age 14 - 18	Female	62,271	214.52	43.11	257.63
TANF: Age 19 - 44	Male	23,075	266.10	47.49	313.59
TANF: Age 19 - 44	Female	94,552	260.38	46.26	306.64
TANF: Age 45+	Unisex	11,402	507.35	98.89	606.24
SSI	Unisex	228,419	691.69	217.06	908.75
Prior to Risk Adjustment					
TANF Children			$124.18	$34.28	$158.46
TANF Adult			283.23	51.13	334.36
SSI			691.69	217.06	908.75
Risk Adjusted					
TANF Children			$105.87	$29.23	$135.10
TANF Adult			293.21	52.93	346.15
SSI			652.03	204.61	856.65

MCO POPULATION COST

The cost of the MCO population is comprised of three components:

- The capitation amount paid to the MCOs,
- FQHC and RHC wraparound payments made by SC DHHS for MCO enrollees, and
- The cost for mental health services that are reimbursed through the FFS program.

Table 6 below shows the development of the MCO population cost. Note that detailed rate cell results are combined into the TANF Children and TANF Adult categories using the total MCO-eligible population demographics (including FFS, MCO and MHN enrollees).

Table 6
South Carolina Department of Health and Human Services
April 2011 – March 2012 MCO Population Cost

Rate Cell	Gender	April 2011 – March 2012 MCO Eligible Member Months	Medical Capitation PMPM*	Rx Capitation PMPM	Mental Health FFS Cost PMPM	Total Cost PMPM
TANF: Age 1 - 6	Unisex	1,481,853	$79.97	$21.80	$1.15	$102.92
TANF: Age 7 - 13	Unisex	1,307,225	59.18	35.68	3.98	98.84
TANF: Age 14 - 18	Male	348,307	74.41	36.15	7.97	118.53
TANF: Age 14 - 18	Female	376,519	109.09	35.79	9.36	154.24
TANF: Age 19 - 44	Male	112,794	228.22	59.84	1.58	289.64
TANF: Age 19 - 44	Female	574,912	278.98	69.27	5.25	353.50
TANF: Age 45+	Unisex	79,066	432.95	131.29	2.28	566.52
SSI	Unisex	521,778	548.54	172.01	15.15	735.70
Prior to Risk Adjustment						
TANF Children			$83.74	$29.78	$3.63	$117.15
TANF Adult			287.39	74.28	4.40	366.07
SSI			548.31	172.07	15.15	735.53
Risk Adjusted						
TANF Children			$88.14	$31.39	$3.83	$123.35
TANF Adult			293.10	75.75	4.49	373.35
SSI			576.80	181.01	15.94	773.75

**Includes $2.67 PMPM for FQHC / RHC wraparound payments.*

For the capitation amount component, we summarized the MCO enrollment during the April 2011 – March 2012 analysis period and developed composite capitation rates PMPM using the April 2011 – June 2011 and July 2011 – March 2012 capitation rates for the standard benefit package effective during the study period. We removed the Supplemental Teaching Payment component of the MCO capitation rates.

SC DHHS made FQHC and RHC wraparound payments totaling $2.67 PMPM for April 2011 – March 2012. We reflected these payments as a flat PMPM amount by rate cell.

For the mental health cost component, we summarized the April 2011 – March 2012 FFS expenditures for MCO enrollees for mental health services that are excluded from the capitation as defined in the In-Rate Criteria. We removed Graduate Medical Education payments and adjusted for IBNR using the completion factors shown in Table 4.

MHN POPULATION COST

To calculate the MHN population cost, we summarized the April 2011 – March 2012 FFS expenditures for services included in the MCO capitation rates and mental health services for MHN enrollees that would be eligible for the MCO program.

We removed Graduate Medical Education payments and adjusted for IBNR claims. The claims data used in developing the FFS cost component includes claims paid through July 31, 2012 allowing for four months of run-out for the April 2011 – March 2012 study period. The IBNR adjustment reflects an estimate of the claims that will be paid after July 31, 2012. We used the completion factors shown in Table 4.

We then applied an adjustment for Third Party Liability to reflect recoveries that are not included in the claims data. We used a 0.995 adjustment factor consistent with the MCO capitation rate development. Finally, we applied an adjustment for hospital administrative days to account for administrative hospital day payments that are not included in the claims data. We used a 1.0007 adjustment factor consistent with the MCO capitation rate development.

We also added the $10 PMPM MHN management fee to all rate cells.

Table 7 below shows the estimated April 2011 – March 2012 MHN population cost. Note that detailed rate cell results are combined into the TANF Children and TANF Adult categories using the total MCO-eligible population demographics (including FFS, MCO and MHN enrollees).

Table 7
South Carolina Department of Health and Human Services
April 2011 – March 2012 MHN Cost Component

Rate Cell	Gender	MHN April 2011 – March 2012 MCO Eligible Member Months	Medical Cost PMPM	Rx Cost PMPM	MHN Management Fee PMPM	Total Cost PMPM
TANF: Age 1 - 6	Unisex	487,122	$79.22	$22.54	$10.00	$111.76
TANF: Age 7 - 13	Unisex	457,357	61.87	46.14	10.00	118.01
TANF: Age 14 - 18	Male	125,263	84.42	43.80	10.00	138.22
TANF: Age 14 - 18	Female	126,186	123.20	39.81	10.00	173.01
TANF: Age 19 - 44	Male	26,518	216.38	69.36	10.00	295.74
TANF: Age 19 - 44	Female	125,507	268.74	79.03	10.00	357.77
TANF: Age 45+	Unisex	20,654	436.65	147.34	10.00	593.99
SSI	Unisex	208,627	664.31	268.59	10.00	942.90
Prior to Risk Adjustment						
TANF Children			$77.77	$35.61	$10.00	$123.38
TANF Adult			280.78	85.72	10.00	376.50
SSI			664.31	268.59	10.00	942.90
Risk Adjusted						
TANF Children			$72.48	$33.19	$10.00	$115.67
TANF Adult			252.59	77.11	10.00	339.70
SSI			621.69	251.36	10.00	883.05

RISK ADJUSTMENT PROCESS

We used the Restricted Medicaid Rx model for the determination of risk adjustment factors used in this analysis. Medicaid Rx is a pharmacy based diagnosis system developed by the researchers at the University of California, San Diego (UCSD). Medicaid Rx is a standalone pharmacy-based methodology and was not combined with the diagnosis based risk adjustment system. The Restricted Medicaid Rx model excludes prescriptions for GAD (Gastric Acid Disorder), folate and iron deficiency anemias, EENT (Eyes, ears, nose, and throat), insomnia, pain, and low-cost infections. These categories of drugs, as identified by UCSD researchers, may be susceptible to gaming and their inclusion in a risk adjustment model might create an incentive for over prescribing. We used the concurrent national Medicaid Rx weights in our analysis.

The risk scores were developed based on both FFS and encounter pharmacy data. Individual recipients were required to have a minimum of six months of Medicaid eligibility during the data period to be included in the analysis. FFS and MHN enrollees were limited to those meeting MCO eligibility requirements. Retroactive eligibility months were excluded consistent with the MCO rate development methodology as follows:

- Three months of claims and eligibility are removed for SSI and SSI related payment categories,
- Two months of claims and eligibility are removed for all other payment categories

MHN enrollment periods were isolated from FFS enrollment periods.

This methodology is consistent with the methodology used to risk adjust the MCO TANF and SSI capitation rates.

Table 8 shows the average risk scores for the various eligibility categories for each program.

Table 8
South Carolina Department of Health and Human Services
April 2011 – March 2012 Risk Scores

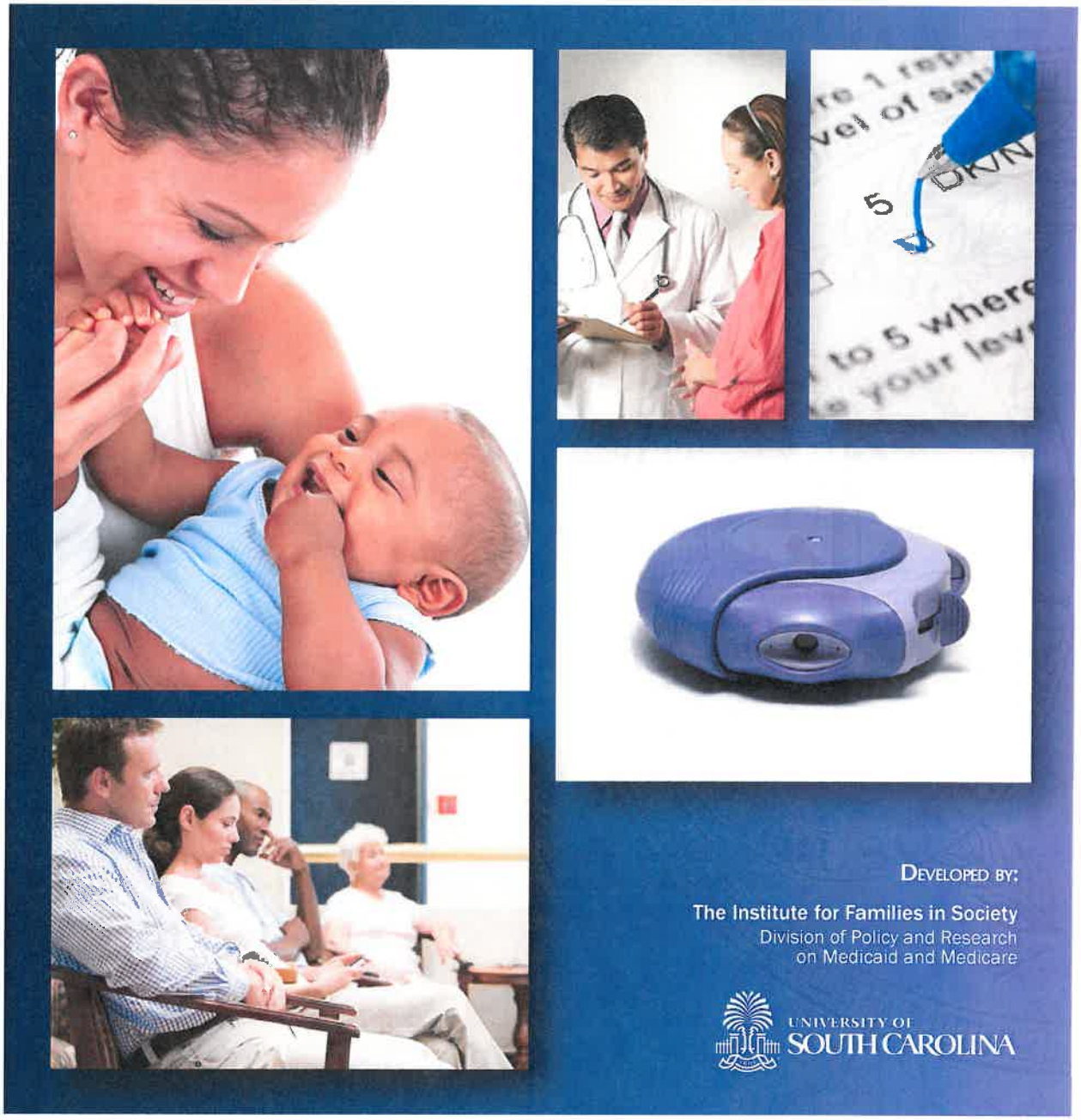
Eligibility Group	FFS Population	MCO Population	MHN Population	Total Population
TANF Children	1.173	0.948	1.073	1.000
TANF Adult	0.966	0.981	1.112	1.000
SSI	1.061	0.951	1.069	1.000

SC Medicaid Health Care Performance

Calendar Year 2011

A Report on Quality, Access to Care, and Consumer Satisfaction

September 2012



DEVELOPED BY:

The Institute for Families in Society
Division of Policy and Research
on Medicaid and Medicare

UNIVERSITY OF SOUTH CAROLINA

South Carolina Medicaid Health Care Performance CY 2011

A Report on Quality, Access to Care, and Consumer Experience and Satisfaction

September 2012

Prepared by the Division of Policy and Research on Medicaid and Medicare,
The Institute for Families in Society,
University of South Carolina
under contract to the
South Carolina Department of Health and Human Services

Ana Lòpez-De Fede, PhD
Research Professor

Kathy Mayfield-Smith, MA, MBA
Research Associate Professor

Verna Brantley, MSPH
Senior Research Associate

Serena Zhu, MS, ME
Senior Research Associate

John Stewart, MS, MPH
Senior Research Associate

Matt Rodgers, BS
GIS Analyst

James Hardin, PhD
Research Professor

Tammy Harris, MSPH
Research Associate

Xiaohui Zhang, MPH
Research Associate

ACKNOWLEDGEMENT

The authors acknowledge the following organizations for their support and provision of data and information needed to conduct this evaluation:

South Carolina Department of Health and Human Services

University of South Carolina, Institute for Families in Society

University of South Carolina, Survey Research Lab

Suggested citation for this report:

Lòpez-De Fede, A., Mayfield-Smith, K., Brantley, V., Zhu, S., Stewart, J., Rodgers, M., Hardin, J., Harris, T., & Zhang, X. (2012). South Carolina Medicaid health care performance CY 2011: A report on quality, access to care, and consumer experience and satisfaction. Columbia, SC: University of South Carolina, Institute for Families in Society.

Executive Summary

This report is the fourth submitted by the South Carolina Department of Health and Human Services (DHHS) on the quality of the health care provided by Medicaid health plans, and the health care providers with whom they partner, to their members and stakeholders. Public reporting of the data supports transparency and accountability. Quality assessment and performance improvement are a central element in South Carolina's value-based purchasing strategy. Another important goal of this report is to measure and improve the quality of care received by Medicaid recipients across types of health plans.[1]

For the first time, approximately 73% (742,112) of South Carolinians receive their health insurance through a Medicaid managed care plan or fee-for-service. Over 50% of enrollment was associated with a managed care organization (MCO) health plan. This enrollment pattern makes the MCO the principal health care plan model of the South Carolina Medicaid Program.

Over fifty percent of enrollment was associated with a Managed Care Organization (MCO) health plan. This enrollment pattern makes the MCO the principal health care plan model of the South Carolina Medicaid Program.

The 2011 report represents the care received during the period from January 1, 2011, through December 31, 2011, which encompasses the state calendar year (CY) for South Carolinians enrolled in Medicaid.[2] The Institute for Families in Society (IFS) Division of Policy and Research on Medicaid and Medicare at the University of South Carolina conducted this assessment under contract with DHHS. Performance is reported on a statewide program basis and on a managed care plan-specific and comparative basis. The data presented represent a subset of the Healthcare Effectiveness Data and Information Set (HEDIS®) measures. This assessment examined a broad range of clinical and service areas that are of importance to Medicaid recipients, policy makers, and program staff.

Medicaid recipient characteristics related to health status and demographic factors differ across health care plans. Risk adjustment of HEDIS® rates allows for a fairer comparison of patient outcomes across plans. The purpose of risk adjustments is to level the playing field in reporting rates across all health care plans. As such, the rates were adjusted for differing recipient population or provider characteristics that independently influence the results of a given measure and are not randomly distributed across health care plans. (See Appendix C–Risk Adjustment Methodology.) The risk adjustment relies on readily available administrative data that can be used to assess risk factors relating to the patient's overall health status (Clinical Risk Group/CRG), age, gender, race, and residence (rural-urban census track). Research has shown that risk adjustment methods that rely solely on this type of administrative data perform quite well when compared with methods that require additional record abstracting.

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1 Federal law requires various quality monitoring and improvement processes for capitated managed care organizations (MCO) in Medicaid. As in previous reports, the use of administrative claims allows DHHS to measure and monitor quality of care for all recipients applying the same set of evaluation standards to all plans – MCO, medical home networks (MHN), and fee-for-service (FFS).

2 Some measures span a period of 3 years requiring unique member affiliations. This approach may result in lower or higher rates than those reported by the individual plans.

Consumer experience with care is measured using the Consumer Assessment of Healthcare Providers and Services (CAHPS®) survey. The CAHPS® examines what consumers think about their experiences with their doctors, specialists, care coordinators, health plans, and overall health care as well as specific experiences related to health and wellness behavior.

Measures Selected for CY 2011 Reporting

In CY 2011, progress continues towards meeting the 75th percentile National Medicaid Benchmark goal. Eighteen percent (8 measures of 43) were at or above the 75th percentile (Figure 1).

The South Carolina Medicaid measurement set for CY 2011 focused on a subset of 18 HEDIS® measures corresponding to 43 rates across 6 domains:

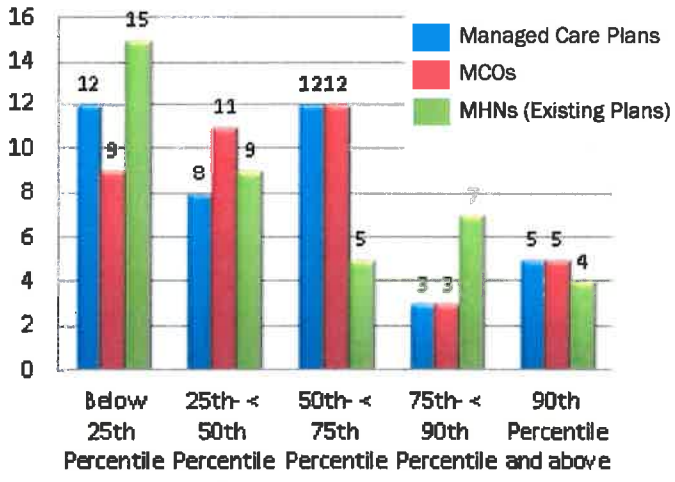
- Pediatric Care (e.g., well-child visits, lead screening, emergency department visits);
- Women's Care (e.g., cancer and chlamydia screening, prenatal and postpartum care);
- Living with Illness (e.g., diabetes and asthma care);
- Behavioral Health (e.g., ADHD care, follow-up after hospitalization for mental illness);
- Access to Care (e.g., child and adolescent access to primary care, adult access to preventative ambulatory care); and
- Consumer Experience With Care (e.g., rating of overall health care).

The performance measures reflect many significant public health issues, such as cancer, heart disease, smoking, diabetes, the care of pregnant women and children, affecting the lives of South Carolinians.

Key Findings

Results from the CY 2011 SC Medicaid Program demonstrate that managed care plans continue to make significant progress towards meeting the 75th National Medicaid Managed Care Benchmark (Figure 1). The HEDIS® results will be compared with other Medicaid plans around the country. Throughout this report, results are compared to the performance of individual plans with that of the National Medicaid Mean of plans reporting HEDIS® data for 2012 (represented by the 2012 National Medicaid Mean, obtained from NCQA's Quality Compass® database). South Carolina performed best, relative to this national benchmark on 7 measures

Figure 1: South Carolina Medicaid CY2011 Managed Care Rates Compared With National Medicaid Percentiles



across the domains. Of the 43 rates, 8 rates were at or above the 75th National Medicaid Percentile Benchmark. The 75th percentile ranks these results with those of the top 25% of all Medicaid plans reporting HEDIS® data for 2011 (Figure 2).

In 2011, enrollment in managed care plans expanded substantially beyond children and pregnant women to include the populations with more complex conditions–elderly and disabled–some of the most expensive and needy of Medicaid enrollees. In spite of this change, the SC Medicaid adjusted rates indicate a positive movement in the number of measures achieving the 50th and above National Medicaid percentiles (Figure 3). This finding would seem to support the ability of managed care plans to effectively serve complex populations moving from a fee-for-service to a coordinated care environment. It is anticipated that the rates will continue to trend upward towards the 50th National Medicaid Percentile with some annual variability to account for the shift of more complex enrollees enrolling with a managed care organization.

Figure 2: SC Medicaid CY 2011 Managed Care vs FFS Rates Compared with National Medicaid Percentiles

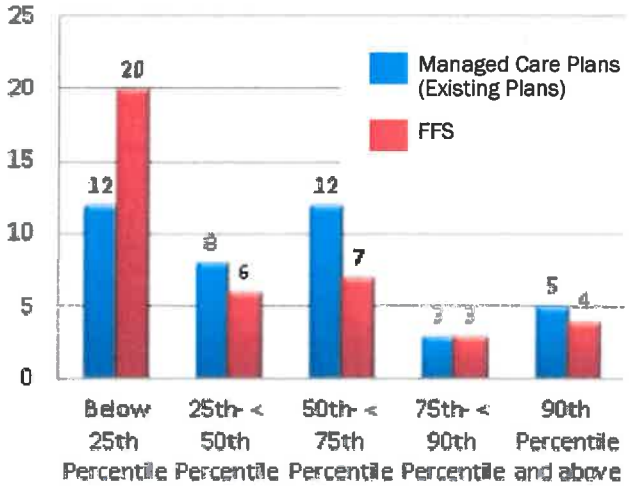
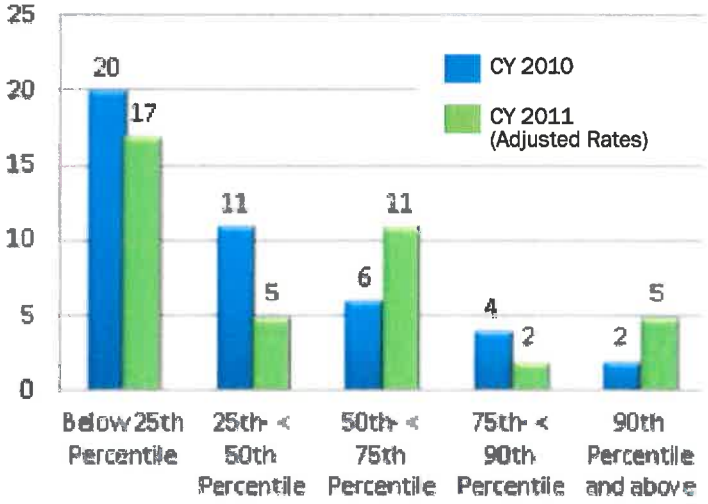


Figure 3: SC Medicaid CY 2010 and CY 2011 *Adjusted Statewide* Compared with Corresponding National Medicaid Percentiles



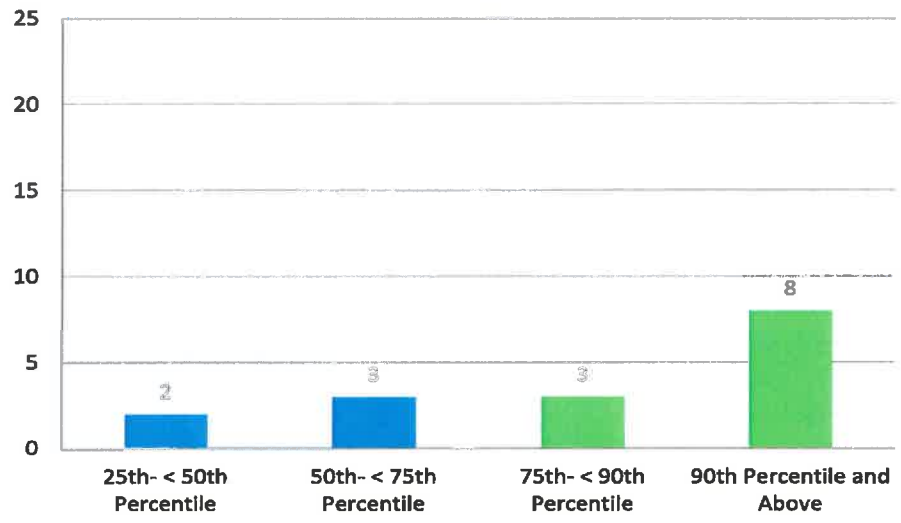
South Carolina managed care health plans performed best relative to select behavioral health measures: Follow-up After Inpatient Hospitalization for Mental Illness; Follow-up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder ADHD Medication; Initiation and Engagement of Alcohol and Other Drug Dependent Treatment. This finding represents a major milestone for the South Carolina Medicaid Program supporting the movement towards patient centered medical homes (PCMH) and the emphasis on behavioral health through the carve-in of these services in MCO's plans.

It is anticipated that the rates will continue to trend upward towards the 50th National Medicaid Percentile with some annual variability to account for the shift of more complex enrollees enrolling with a managed care organization.

In areas of ***consumer experience and satisfaction***, this report includes 8 measures (4 global ratings and 4 composite measures) for both adults and children. Although the state as a whole performs well on these measures, there is considerable variability across health plans in performance, particularly on the composite measures for both children and adults. The state and individual health plans perform the best in measures related to personal physicians, provider communication and child's overall healthcare. Of the 16 measures comparable to national benchmarks (Figure 4), SC Medicaid (including all current health plans) performed at the 50th up to the 74th percentile on 3 measures, at the 75th up to the 90th percentile on 3 measures and at or above the 90th percentile on 8 measures.

Health behaviors related to smoking account for significant health care costs in Medicaid. Approximately one-third (33 %) of adult survey respondents indicated that they currently smoke. Survey results suggest opportunities for health plans to educate both physicians and members about effective "stop smoking" strategies.

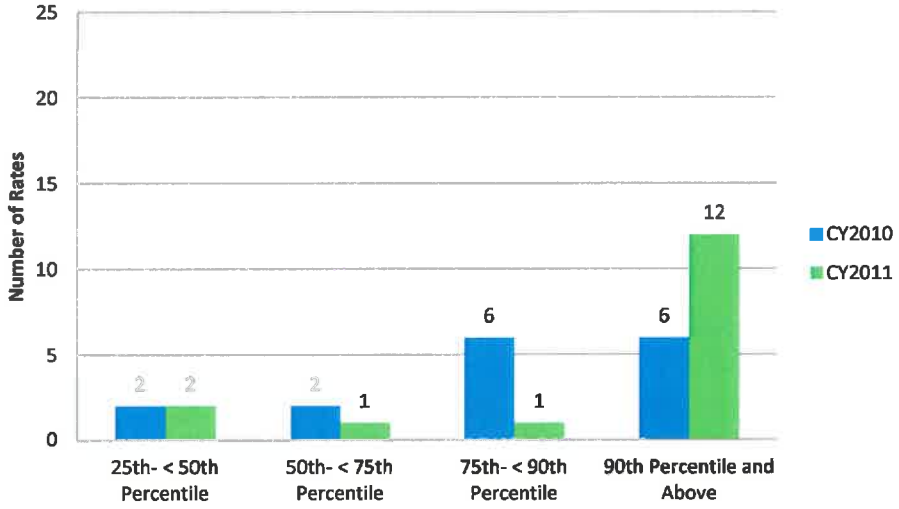
Figure 4. South Carolina Medicaid CY 2011 Statewide CAHPS Rates Compared with Corresponding National Medicaid Percentiles



In looking at change in performance, it is important to examine only those health plans that served SC Medicaid in both CY 2010 and CY 2011. The two new MHNs did not operate in CY 2010 and operated for only 9 months of CY 2011; therefore, they were not included in this analysis. For those

health plans that operated in both CY 2010 and CY 2011, Figure 5 shows a very positive movement toward better performance in measures of consumer experience and satisfaction. Most health plans, as well as fee-for-service, improved on several measures while declining on others. In total, however, the state's performance moved toward the highest rating by doubling the number of measures at or above the 90th percentile from 6 in CY 2010 to 12 in CY 2011.

Figure 5: SC Medicaid CY 2010 and CY 2011 Statewide CAHPS Rates
(Exluding New Plans) Compared with Corresponding National Medicaid Percentiles



Summary of Overall Results

DHHS Medicaid managed care health plans performed well statewide on many measures in this report; the lower rates associated with fee-for-service across measures resulted in the Medicaid Program not meeting Medicaid national averages for several indicators of quality of care (see *Health Plans Report Card,* page v). The DHHS initiatives on improving birth outcomes, reduction in unnecessary emergency department and inpatient hospital stays, increasing behavioral health screenings, pediatric asthma care coordination, and emphasis on the certification of provider practices as patient-centered medical homes yield improved CY 2011 rates. These efforts will continue to pay dividends for the Medicaid program—efficient, value-based, high-quality health care. The end result will be improving the health of all South Carolinians.

The results are organized in a report card format summary of the plans (in alphabetic order by name) for each measure by dimension of care compared to National Medicaid Percentile Benchmarks and the state weighted average. For example, a plan with three stars for Well-Child Visits (ages 3 to 6) in the Pediatric Care dimension indicates that the plan performed between the 50th and 74th percentiles. A plan with a plus star "★⊕" indicates they are at the upper range of the percentile group. Thus, a plan with three stars and a plus is closer to the 74th percentile than the 50th percentile. The reader is encouraged to use the legend to interpret the results.

2011 South Carolina Medicaid Health Plans Report Card

		Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	New Plans: Carolina Medical Homes	New Plans: Palmetto Physician Connections	Weighted State Average
PEDIATRIC CARE	Adolescent Well-Care Visits	★	★	★	★	★	★	★	★	★
	Ambulatory Care- Emergency Department Visits (Visits/1000MM)*									
	Ages <1	★★	★★★	★★★	★★	★★★	★★★	★	★★	★★
	Ages 1-9	★★★	★★★	★★★	★	★★★	★★★	★	★★★	★★
	Ages 10-19	★	★★★	★★	★	★★★	N/A	★★	★★	★★
	Appropriate Testing for Children With Pharyngitis	★★★	★★	★★★	★★★★	★★★	★★★	NSI	NSI	★★★
	Appropriate Treatment for Children With Upper Respiratory Infection†	★★	★	★★	★★	★★	★	NSI	NSI	★
	Lead Screening in Children	★	★	★★	★	★	★	NSI	NSI	★
	Well-Child Visits in the First 15 Months of Life									
	Zero visits*	★★	★★	★★★	★★★★	★★★★	★	NSI	NSI	★★
	Five visits	★★★★★	★★★★★	★★★★½	★★★	★★★★★	★★★	NSI	NSI	★★★★★
	Six or More visits	★★	★	★★	★★★★	★	★★	NSI	NSI	★★
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★	★	★	★	★	★	★	★	★
	OVERALL SCORE FOR PEDIATRIC CARE	★★	★★	★★⊕	★★	★★⊕	★⊕	NSI	NSI	★★
WOMEN'S CARE	Breast Cancer Screening	★	★	★★★	★	★★	★	★★	★	★
	Cervical Cancer Screening	★	★	★	★	★	★	★	★	★
	Chlamydia Screening in Women									
	16-20 Years	★★★	★★★	★★	★★	★★	★★★	NSI	★★	★★
	21-24 Years	★★★★	★★★	★★★	★★	★★★★	★★	NSI	NSI	★★★
	Total	★★★	★★★	★★	★★	★★★	★★★	★★★★	★★	★★★
	Prenatal and Postpartum Care									
	Timeliness of Prenatal Care	★★★★	★★	★★	★★★	★★	★	★★★★★	★★★★	★★
	Postpartum Care	★★	★★★	★★★	★★★★	★★★	★	★★	★	★★
	OVERALL SCORE FOR WOMEN'S CARE	★★⊕	★★⊕	★★⊕	★★	★★⊕	★⊕	NSI	NSI	★★
LIVING WITH ILLNESS	Comprehensive Diabetes Care									
	HbA1c Testing	★★	★	★★	★	★★	★	★	★★	★
	Eye Exams	★	★	★	★	★	★	★	★	★
	LDL-C Screening	★	★	★	★	★	★	★	★	★
	Med Att Diabetic Nephropathy	★★	★★	★★	★	★★	★	★	★★★★	★
	Use of Appropriate Medications for People with Asthma**									
	5-11 Years	★★★	★★	★★	★★	★	★	NSI	NSI	★
	Total	★★★	★	★★★★	★★★	★	★	NSI	NSI	★
	OVERALL SCORE FOR LIVING WITH ILLNESS	★★	★⊕	★★	★⊕	★⊕	★	NSI	NSI	★
BEHAVIORAL HEALTH	Follow-Up After Hospitalization for Mental Illness									
	7 Days	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	NSI	★★★★★
	30 Days	★★★	★★★★	★★★★	★★★	★★	★★	★	NSI	★★
	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication									
	Initiation	★★★★	★★	★★★★	★★	★★★	★★	NSI	NSI	★★★
	Continuation	★★★	★★★	★★★★	★★	★★★	★★	NSI	NSI	★★★
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment									
	Initiation - 13-17 Years	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	NSI	NSI	★★★★★
	Engagement - 13-17 Years	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	NSI	NSI	★★★★★
	Initiation - 18+	★★★★	★★★	★★★	★★★	★★★	★★★★	★★	★★★★	★★★
	Engagement - 18+	★★★★★	★★★★	★★★★	★★★★	★★★★	★★★	NSI	★★	★★★★
	Initiation - Total	★★★★	★★★	★★★★	★★★★	★★★	★★★★	★★★★	★★★★	★★★★
	Engagement - Total	★★★★★	★★★★★	★★★★★	★★★★	★★★★	★★★★	★★	★★★★	★★★★
	OVERALL SCORE FOR BEHAVIORAL HEALTH	★★★★⊕	★★★★	★★★★⊕	★★★⊕	★★★⊕	★★★⊕	NSI	NSI	★★★★
ACCESS TO CARE	Adults' Access to Preventive/Ambulatory Health Services									
	20-44 Years	★★	★★	★★★	★	★★	★	★	★	★
	45-64 Years	★	★	★★★★★	★	★★	★	★	★★	★
	Children and Adolescents' Access to Primary Care Practitioners									
	12-24 Months	★★★★	★★	★★★★★	★★★★★	★★★★	★★	★	★	★★
	25 Months-6 Years	★★	★	★★★★	★★	★★	★	★	★★	★
	7-11 Years	★★	★	★★★★★	★	★★	★	★	★	★
	12-19 Years	★	★	★★★★	★	★	★	★	★	★
	OVERALL SCORE FOR ACCESS TO CARE	★★	★⊕	★★★★⊕	★★	★★	★	★	★⊕	★
	OVERALL PLAN PERFORMANCE	★★⊕	★★⊕	★★★	★★⊕	★★⊕	★★	NSPI	NSPI	

★★★★★ 90th Percentile or above
★★★★ 75th to 89th Percentile
★★★ 50th to 74th Percentile
★★ 25th to 49th Percentile

★ Below 25th Percentile
⊕ Upper Range of Percentile Group
NSI Denominator less than 30
NSPI Insufficient Plan Information
N/A Not Applicable

† Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]
* Inverted measure: lower rates indicate better performance
** Using 2010 NCQA National Medicaid Benchmarks. 2011 National Benchmark not available due to definitional change in age categories.

2011 South Carolina Medicaid Health Plans Report Card

CONSUMER EXPERIENCE AND SATISFACTION	Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	*New Plans* Carolina Medical Homes	*New Plans* Palmetto Physician Connection	State Overall
How Well Doctors Communicate									
Adult	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Child	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Rating of Personal Doctor									
Adult	★★★★★	★★★★★	★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Child	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Get Needed Care									
Adult	★	★★★	★★	★★★★	★★	★★★★★	★	★★	★★
Child	★★★	★★★★	★★★★	★★★★★	★★★	★★★★★	★★	★★★	★★★★
Get Care Quickly									
Adult	★★★★	★★★★★	★★★★	★★★★★	★★★★	★★★★★	★★	★★★★	★★★★★
Child	★★★★★	★★★	★★★★	★★★★★	★★★	★★★★★	★★	★★★★	★★★★
Customer Service									
Adult	★★★★	★★★	★★★★	★★★★	★★★★	★★	★	★	★★★
Child	★★★★	★★★	★★★★	★★★	★★★★★	★★	★	★	★★★
Rating of Health Plan									
Adult	★★	★	★★★★	★★★★	★★	★★★	★	★★	★★
Child	★★★★	★★★	★★★★★	★★★★★	★★★★	★★★★	★	★★	★★★
Rating of Health Care									
Adult	★★★★	★★★	★★★★★	★★★★★	★★★★	★★★	★★★	★★★	★★★★
Child	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★	★★★★★	★★★★★

★★★★★ 90th Percentile or above
★★★★ 75th to 89th Percentile
★★★ 50th to 74th Percentile
★★ 25th to 49th Percentile
★ Below 25th Percentile

Recommendations

This report provides a road map for quality improvement efforts. A focus on low-performing areas will result in substantial quality improvement. Targeted efforts on the following indicators would support quality improvement with movement towards South Carolina achieving the 75th National Medicaid Percentile Benchmark. Efforts across the following dimensions are recommended for quality improvement in CY 2012.

PEDIATRIC CARE

The ***Adolescent Well-Care Visits*** rates are below the 50th National Medicaid Percentile Benchmark. This is the fourth consecutive year this measure's rates were below the 25th percentile. To improve provider and plan compliance with adolescent well-care visits guidelines, the policy has been changed allowing annual reimbursement as required by the HEDIS® measure. Annual visits during adolescence allow providers to conduct physical examinations for growth, assess behavior, and deliver anticipatory guidance on issues related to violence, injury prevention, and nutrition, as well as to screen for sexual activity, smoking, and depression. ***Improvement at or above the 50th National Medicaid Percentile Benchmark has been set for providers and health care plans.***

Emergency Department (ED) Visits per 1000 (Birth to 19 Years) is a measure requiring focused efforts at the agency and health plan levels. In the second year of reporting this measure, improvements are documented in Medicaid recipients below 19 years of age. One health plan has initiated efforts to test the use of technology with high users of ED services to reduce inappropriate visits. Inappropriate use of ED results in higher health care costs requiring careful attention to medical home care coordination and greater access to primary care providers (PCP). While improvements continue to be made across all age groups, the reduction of unnecessary ED visits is a critical component of coordinated care.

The ***Well-Child Visits (Infants and Young Children)*** measure assesses whether infants and young children receive the number of well-child visits recommended by current clinical guidelines. These well-child visits offer the opportunity for evaluation of growth and development, the administration of vaccinations, the assessment of behavioral issues, and delivery of anticipatory guidance on such issues as injury prevention, violence prevention, sleep position, and nutrition. ***To improve developmental well-child visits for infants and young children, the rates must improve to performance levels at or above the 50th National Medicaid Percentile Benchmark for six or more visits.***

WOMEN'S CARE

Breast and Cervical Cancer Screenings weighted statewide average rate is below the 25th National Medicaid Percentile Benchmark. In the past three years, the Medicaid program has not been able to meet this benchmark. According to SC DHEC, South Carolina ranks 9th in the nation for estimated

deaths from cervical cancer and 25th for deaths from breast cancer. ***Compliance with screening guidelines must be an important health care priority of Medicaid health care plans.***

Prenatal and Postpartum Care continues to fall below the 50th National Medicaid Percentile Benchmark. Preventive medicine is fundamental to prenatal and postpartum care. Timely and frequent prenatal care visits allow health problems to be detected at an earlier stage. Poor outcomes include spontaneous abortion, low-birth-weight babies, large-for-gestational-age babies, and neonatal infection and death. Recently, DHHS in collaboration with key stakeholders launched the Birth Outcomes Initiative to address low birth weight, unnecessary C-sections, and low prenatal and postpartum rates. Managed care plans have been incentivized to make substantial improvements.

LIVING WITH ILLNESS

Comprehensive Diabetes Care is essential to reduce many serious complications such as heart disease and kidney disease associated with poor diabetes care management. South Carolina ranks 10th-highest of the 50 states in diagnosed diabetes with approximate costs of $928 million annually in hospital and emergency department costs. Control of diabetes can significantly reduce the rate of such complications and improve quality of life.

ACCESS TO CARE

Adult Access to Preventative Ambulatory Care rates measure the ability of health care members to obtain health care services when they need them, and use them when necessary. Renewed efforts at the plan level, with a focus on geographic variability and attention to women's care measures with comprehensive diabetes care, would support higher rates for this measure.

CONSUMER EXPERIENCE AND SATISFACTION WITH CARE

Consumer Experience and Satisfaction With Access to Care measures examine whether or not consumers can get appointments for routine and specialty care and get tests and treatment when needed. Efforts should be focused at the plan level to target variation in the ability to access specialty services for both children and adults. This is a critical issue in managing chronic care conditions and individuals with special health conditions.

South Carolina Medicaid Health Care Performance CY 2011

A Report on Quality, Access to Care, and Consumer Experience and Satisfaction

Table of Contents

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Introduction

Purpose of the Report

This report presents the results of the South Carolina Medicaid Program Healthcare Effectiveness Data and Information Set (HEDIS®) 2011 assessment. This report was designed to be used by the South Carolina Department of Health and Human Services (DHHS), health plan program managers, and key stakeholders to assess plan performance in the context of managed care and fee-for-service delivery systems. It provides the opportunity to examine performance from the perspective of statewide weighted averages and national benchmarks to identify opportunities for improvement and set quality improvement goals at the plan and state levels.

Overall, the report card indicates that Medicaid managed care health plans' rates for quality continue to be better than rates for fee-for-service.

Improving the health care of all Medicaid recipients requires having accurate, complete, and up-to-date information about the care being provided and its results on ensuring the health of recipients. DHHS is committed to promoting improvements in health care by reporting on the performance of health plans serving Medicaid recipients–managed care organizations (MCO), medical home networks (MHN), and fee-for-service (FFS). This year, DHHS continues its commitment to advancing health care quality by releasing the second report card rating the performance of MCO, MHN, and FFS health plans. The 2011 South Carolina Medicaid Health Plans Report Card highlights plan-specific indicators of performance and consumer satisfaction with health care. The report card illustrates the comparison of Medicaid managed care health plans (i.e., MCO and MHN) with FFS and national benchmarks for selected quality and consumer experiences with care measures. Overall, the report card indicates that Medicaid managed care health plans' rates for quality continue to be better than rates for fee-for-service.

Background

As a means of obtaining this information, DHHS retained the services of the Institute for Families in Society (IFS) at the University of South Carolina to evaluate performance and consumer satisfaction measures objectively for each health care plan. The selected measures represent a broad range of measures that are important to Medicaid recipients, policy makers, stakeholders, and DHHS program staff. IFS conducts this annual assessment by using a subset of HEDIS® measures. Developed by the National Committee for Quality Assurance (NCQA), HEDIS® is the most commonly used set of standardized performance measures for reporting quality of care delivered by health care organizations. HEDIS® includes clinical measures of care, as well as measures of access to care and utilization of services. To conduct the HEDIS® analysis, IFS uses Sightlines™ Performance Measurement, from Verisk Health. Sightlines™ Performance Measurement is a collection of tools for calculating HEDIS® measures, creating and submitting reports, building custom health care quality measures, and translating data into required formats. Lastly, Verisk Health is an NCQA HEDIS® measures beta tester on new measures. The relationship between IFS and Verisk Health facilitates the interpretation of the data across differing health plans, i.e., MCO, MHN, and FFS. This report is submitted to the SC Department of Health and Human Services as the quality analysis component of the report mandated by the South Carolina Legislature.

Data Sources and Year

This report contains information about health plans including results from standardized quality measures, and consumer experience and satisfaction surveys. The data presented in this report are largely from care provided to members during calendar year CY 2011 and obtained through Medicaid administrative claims and encounter records. IFS followed the guidelines in *HEDIS® 2012 Volume 2: Technical Specifications* in developing this report.

Also, the report utilizes results from the Consumer Assessment of Healthcare Providers and Services (CAHPS®) 4.0H Adult Medicaid and the 4.0H Child Medicaid surveys. The CAHPS® survey is the national standard for measuring and reporting on the experiences of consumers with their health plan and overall health care. The CAHPS® is a set of survey tools developed jointly by the Agency for Healthcare Research and Quality (AHRQ) and the National Council on Quality Assurance (NCQA). It is the most comprehensive tool available and has been used extensively with consumers in Medicaid. The CAHPS® 4.0H Adult Medicaid and 4.0H Child Medicaid Surveys measure those aspects of care for which plan members are the best and/or the only source of information. The CAHPS® examines what consumers think about their experiences with their doctors, specialists, care coordinators, health plans and overall health care. It also includes questions related to the consumer's health and wellness behavior. IFS followed the guidelines in *HEDIS® 2012 Volume 3: Specifications for Survey Measures.*

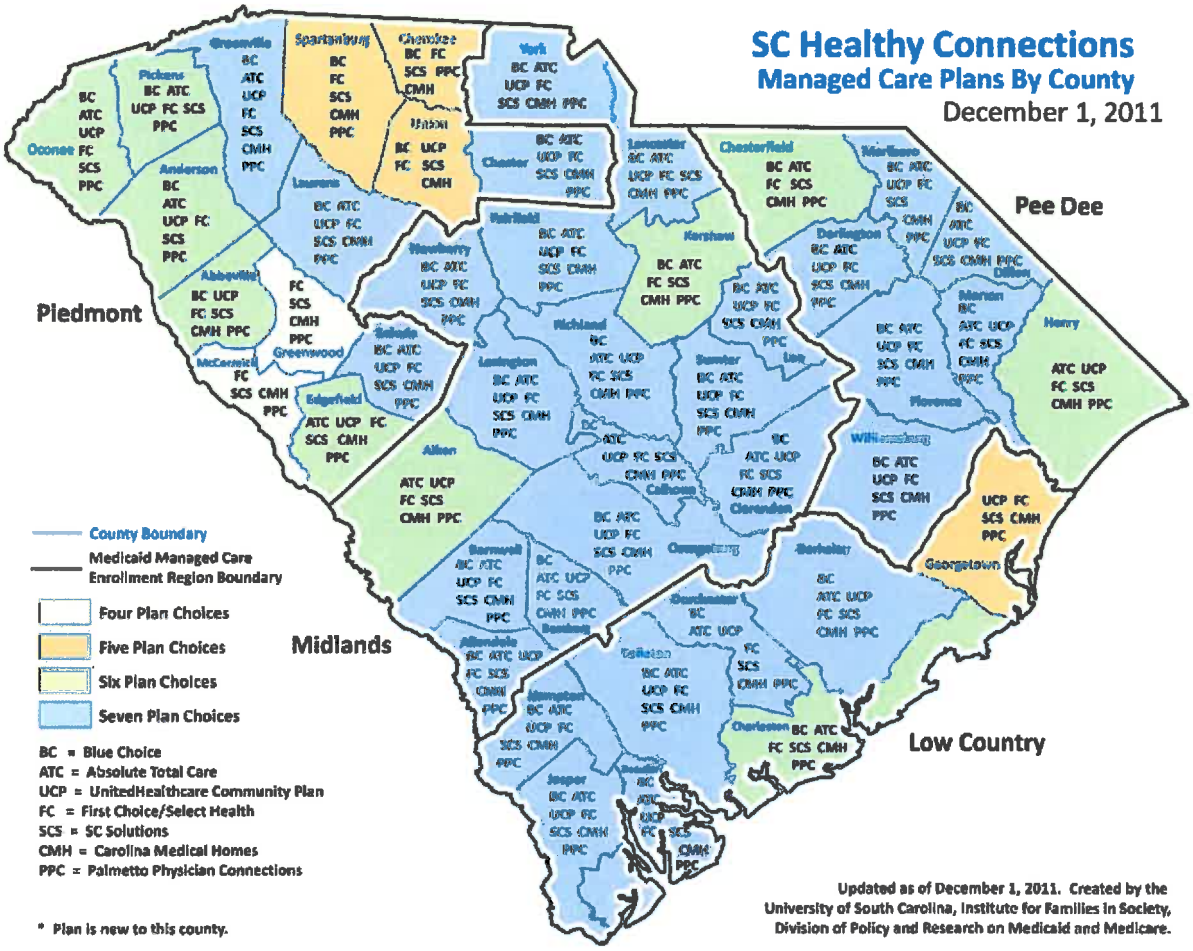
Survey Process

A stratified random sample of child and adult participants enrolled in the Medicaid health plans during CY 2011 were selected. For Medicaid participants, the CAHPS® requires that participants be enrolled for at least six months. Following NCQA requirements, the survey samples no more than one member per household. The survey was conducted by the University of South Carolina (USC) Institute for Families in Society and the USC Survey Research Lab at the Institute for Public Service and Policy Research (IPSPR), a certified CAHPS® vendor. A minimum of 411 surveys was completed for adult members and for child members for each health plan and fee-for-service. A total of 6,262 surveys was completed with an overall response rate of 31% (6,262 completed/20,510 sampled).

Geographic Presence of Health Plans

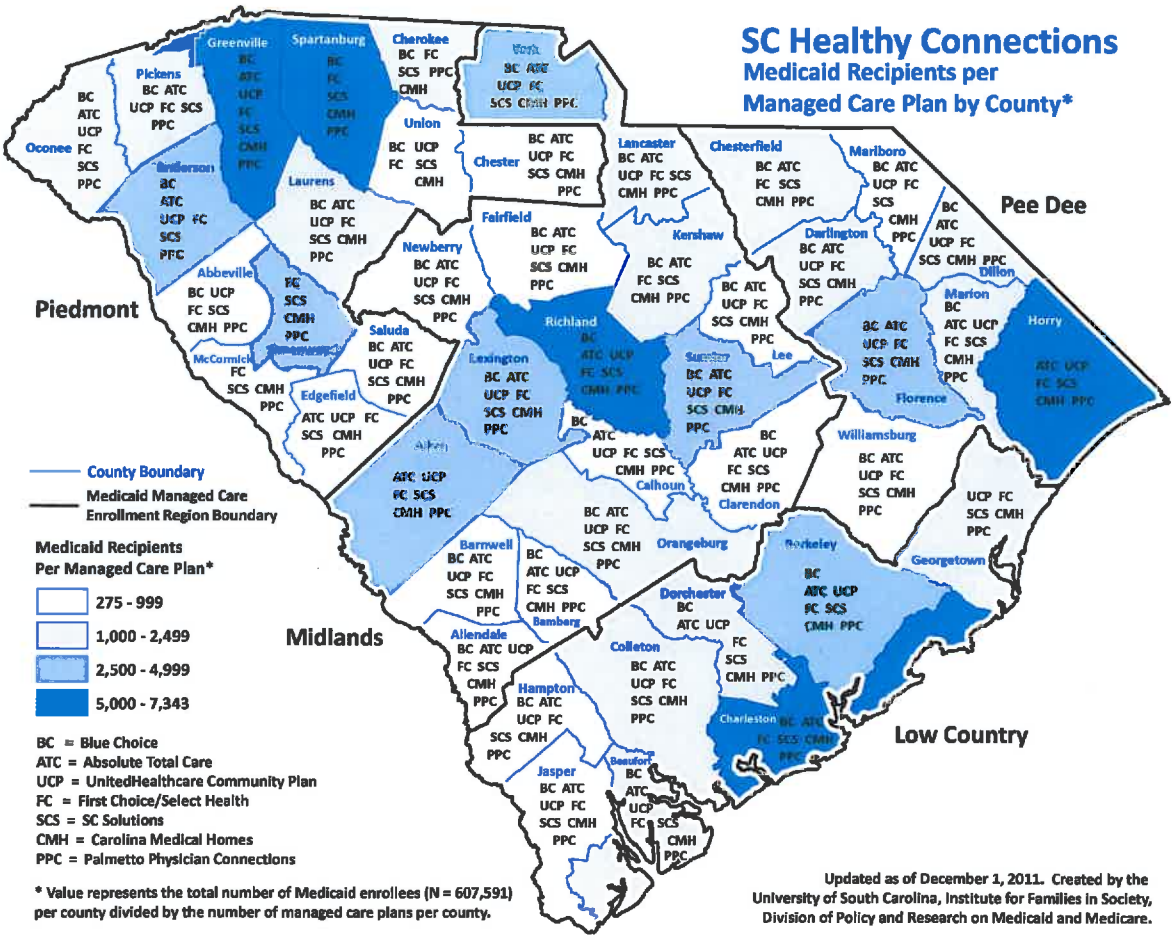
In 2011, South Carolina Medicaid managed care enrollment grew from 524,476 to 607,591, an increase of 15.8 %. In the same year the number of managed care plans serving Medicaid recipients in the state increased from five to seven. In January 2011, a minimum of two plans existed in each of the state's 46 counties; by year's end a minimum of four managed care plans served each county and all seven plans existed in 29 counties (Figure 6). The presence of multiple managed care plans in individual counties offers Medicaid recipients choice in the acquisition of health care services. Multiple local managed care provider networks, however, also can result in a decreased ability by individual plans to influence health care provider procedures and protocols, particularly when individual providers are affiliated with multiple plans. The presence of multiple managed care plans thus may reduce the leverage individual plans can exert to improve local health outcomes, health care quality, and consumer satisfaction.

Figure 6. SC Healthy Connections Managed Care Plans by County



The number of enrollees within a designated geographic area can influence access to care, network development and quality monitoring. Currently, there are no requirements on the minimum number of enrollees per plan necessary to ensure network adequacy and quality monitoring. As such, all plans are eligible to serve populations statewide. Figure 7 illustrates the number of Medicaid recipients per South Carolina Medicaid managed care plan for CY 2011.

Figure 7. SC Healthy Connections Medicaid Recipients per Managed Care Plan by County



Using This Report

Dimensions of Care

The CY 2011 Medicaid Health Plans Report Card is organized along six dimensions of care designed to encourage consideration of similar measures together. The dimensions of care are the following:

1) **Pediatric Care** involves health promotion and disease prevention for children and adolescents;
2) **Women's Care** examines cancer prevention, use of emergency department visits and timeliness of prenatal and postpartum care;
3) **Living With Illness** examines comprehensive diabetes care and use of appropriate medications for people with asthma;
4) **Behavioral Health addresses compliance with ADHD and follow-up** care after an inpatient hospital stay and the initiation and engagement of alcohol and drug dependence treatment;
5) **Access to Care** reports on children and adolescent access to primary care and adult access to preventive ambulatory health services; and
6) **Consumer Experience and Satisfaction With Care** provides information on the experiences of consumers with their health plan and overall health care.

(See Appendix A: Descriptions of Measures).

Appendix B provides the reader the 2011 National Medicaid Percentile Benchmarks for each measure.

Calculating Measure Rates

All measures were constructed using the HEDIS® and CAHPS® quality performance systems. All of the performance measure rates are based on services, care, and experiences of members who enrolled in the SC Medicaid Program throughout calendar year 2011. The HEDIS® scores are based on the number of members enrolled in the plan who are eligible and who received the service based on administrative records (claims and encounters). These records do not include information from medical charts or laboratory results available to medical providers and health plans. Restricting the data to administrative records allows for a comparison between managed care organizations and fee-for-service rates. The accuracy of this information relies on the administrative records submitted by providers for services rendered to Medicaid patients in CY 2011. All administrative records were adjudicated through March 31, 2012.

The CAHPS® measures are based on a stratified, randomly selected list of children and adult Medicaid recipients enrolled in a designated health plan for at least six months during CY 2011. These members completed the CAHPS® survey by mail or telephone and were asked to report their experiences with their health care plans, services, and their doctors. These measures are collected and calculated using survey methodology with detailed specifications contained in *HEDIS® 2012, Volume 3: Specifications for Survey Measures*.

Rating Method

Plans should focus their efforts on reaching and/or maintaining the National Medicaid Mean Benchmark for each key measure, rather than the comparison to other South Carolina Plans. Plans reporting rates at or above the 75th National Medicaid percentile are considered high performing and rank in the top 25% of all Medicaid health plans. Similarly, plans reporting rates below the 25th National Medicaid percentile are considered low performing and rank in the bottom 25% of all Medicaid health plans.

Plans reporting rates at or above the 75th National Medicaid percentile are considered high performing and rank in the top 25% of all Medicaid health plans. Similarly, plans reporting rates below the 25th National Medicaid percentile are considered low performing and rank in the bottom 25% of all Medicaid health plans.

Star Ratings

The performance summary report card presented depicts the performance of each health plan and the overall Medicaid program using a one to five-star rating. The assignment of stars corresponds to a comparison of each measure's result to NCQA's HEDIS® 2012 National Medicaid Percentile Benchmarks. Rates were rounded to two digits for purposes of star ratings.

5 stars – indicates a score at or above the 90th percentile
4 stars – indicates a score at or between the 75th and 89th percentiles
3 stars – indicates a score at or between the 50th and 74th percentiles
2 stars – indicates a score at or between the 25th and 49th percentiles
1 star – indicates a score at or below the 24th percentile

The "Overall Score" measure ratings are calculated by averaging the number of stars for the measures within each dimension. The designation of a plus following an "Overall Score" star indicates a value in the upper level threshold for that dimension. A designation of "Not Sufficient Information" (NSI) means that the health plan has too few members (less than 30) who were enrolled long enough to meet the HEDIS® requirements to be able to report a meaningful score for that performance measure. This is common with newer health plans. An NSI designation does not evaluate the quality of the service nor does it mean the services are not being provided for these measures by the health plan.

SC Medicaid Weighted Averages

Consistent with the methodology used nationally, the principal measure of overall South Carolina Medicaid performance on a given key measure is the weighted average rate. The use of a weighted

average, based on the health plan's eligible population for that measure, provides the most representative rate for the overall South Carolina Medicaid population. Weighting the rate by the health plan eligible population size ensures that a rate for a plan with 125,000 members, for example, has a greater impact on the overall South Carolina Medicaid rate than a rate for a plan with only 10,000 members. Rates reported as NA or NR were not included in the calculations of these averages.

The weighted state rates were calculated for each measure within each of the five dimensions using the formula of the total number of recipients that met each measure criteria divided by the total number of eligible recipients. This proportion was then multiplied by 100 to be considered the weighted state rate.

A deviation from the above calculation of the weighted state rate for the measure Appropriate Use of Antibiotics Treatment for Children With Upper Respiratory Infection (URI) was an inverted weighted state rate. This inverted weighted state rate was calculated by the formula: 100-(total number of recipients that met each measure criteria divided by the total number of eligible recipients)*100. Another deviation from the above calculation of the weighted state was the Ambulatory Care measure. This weighted state rate was calculated by the formula: (total number of recipients that met each measure criteria divided by the total number of member months)*1000. Plan-level rates that meet or exceed the corresponding SC Medicaid Weighted Average appear in blue.

Plan HEDIS® Adjusted Rates

State-based health outcomes across the nation show significant disparities that are in part due to nonhomogeneous regional characteristics (for example, racial profiles, age, and other factors). Although each performance measure is calculated using all data from patients across the state, the data are treated as a sample in the sense that the measurements reflect a possible year's worth of outcomes for the enrolled patients. The means of the person-level outcomes for 53 unique measures [sub-measure] of a specific plan were calculated to produce IFS crude rates (excluding measure [sub-measure] with denominator less than 30). The difference of the IFS crude rates and provider calculated rates were modeled adjusting for the proportions of male patients, clinical risk group statuses (CRGs), geographic social deprivation index groups (SADIs), and the combination of the measure and sub-measure. Once estimated, the regression model was used to generate adjustments based on the predicted difference between the IFS crude rates and the provider calculated rates excluding AMB women only sub-measures (member-months).

Geographic Variation

Some measures are able to be represented at a county level. This geographical representation of data is presented to further understanding of variations in the quality of care in the Medicaid program. Selected measures were mapped to reflect areas for targeted improvements.

General Considerations for Interpreting Report Card Results

All data analyses have limitations and those presented in this report card are no exception. The reader is cautioned that several caveats must be taken into consideration in interpreting the report card.

Reported Rates

HEDIS® rates may vary among plans and across measures for the same plan. The rates reported are adjusted to account for geographical population and provider characteristics. NCQA's HEDIS® protocol is designed so that the method produces results with a sampling error of ± 5% at a 95% confidence level. As such, the upper limits for measures using combined rates for differing age groups will vary from the individual rate. This is a function of the size of the numerator and denominator for each individual rate. Rates were rounded to two digits for purposes of star ratings.

SC Medicaid Rates Compared to National Medicaid Percentiles

For each measure, the Medicaid health plan ranking presents the reported rate compared to the HEDIS® 2012 National Medicaid Percentile Benchmark. In addition, the 2008, 2009, 2010, and 2011 South Carolina Medicaid weighted averages are presented for comparison purposes. South Carolina plans with reported rates above the 90th percentile rank in the top 10% of all Medicaid health plans nationally. Similarly, plans reporting rates below the 25th percentile rank in the bottom 25% nationally for that measure.

Claims and Encounter Data

A plan's ability (or that of its contracted vendor) to submit complete claims and encounter data can affect performance on reports generated using administrative data. Per NCQA's specifications, a member for whom no administrative data is found or whose record does not contain the necessary documentation is considered to have an incomplete record and is not reflected in the rates.

Case-Mix Adjustment

IFS and DHHS worked on new methodologies for analyzing SC Medicaid HEDIS® results using a case-mix adjustment model. The specifications for collecting HEDIS® measures do not allow case-mix adjustment or risk adjustment for existing co-morbidities, disability (physical or mental), or severity of disease. Therefore, it is difficult to determine whether differences among plan rates were due to differences in the quality of care or use of services or differences in the health of the populations served by the plans

Demographic Differences in Plan Membership

In addition to disability status, the populations served by each plan differ in other demographic characteristics such as age, gender, and geographic residence. The impact of these differences on reported HEDIS® rates is accounted for in the calculation of the rates.

Overlapping Provider Networks

Many providers caring for SC Medicaid recipients have contracts with multiple plans. Overlapping provider networks can affect the ability of any one plan to influence provider behavior over another plan with a larger enrolled population.

Variation in Data Collection Procedures Reported by Plans and SC Medicaid Health Plan Report

Each plan collects and reports its own HEDIS® data. Although there are standard specifications for collecting HEDIS® measures, factors that may influence the collection of HEDIS® data by plan include: a) use of software to calculate the administrative measures, b) completeness of administrative data due to claim lags, c) staffing changes among the plan's HEDIS® team, and d) size of the Medicaid population enrolled in the plan.

The size of the enrolled population can result in variable results when the plan reports using a hybrid method versus the use of administrative claims. Correct interpretation of the effect of sampling error when comparing the results of this report with reported plan rates using the hybrid method must be taken into consideration. As an example, sample error gets smaller as the sample size gets larger.

Choice of Administrative or Hybrid Data Collection

HEDIS® measures are collected through one of two data collection methods—the administrative method or the hybrid method—for measures that allow either method. IFS calculated the administrative measures using programs developed by statistical staff and a Certified HEDIS® Software Vendor. The administrative method requires plans to identify the denominator and numerator using claims or encounter data or data from other administrative databases. For measures collected through the administrative method, the denominator includes all members who satisfy all criteria specified in the measure including any age and continuous enrollment requirements. These members are known as the "eligible population." The numerator includes all members in the eligible population (denominator) who are found through administrative data to have received the service (e.g., visits, treatment). The plan's HEDIS® rate is based on all members who received the services (numerator) divided by all members who were eligible to receive the service (denominator).

Some health plans use the hybrid method to report HEDIS® rates. This method requires plans to use both administrative and medical record data to identify both the members who receive the service (numerator) and the members who are eligible to receive the service (denominator). Plans may collect medical record data using their own staff and a plan-developed data collection tool, contract with a vendor for the tool and staffing, or both. To identify the population eligible to receive the service (denominator), plans draw a systematic sample of members from the measure's total eligible population. This sample must consist of a minimum of 411 members who qualify after accounting for valid exclusions and contraindications. The members who received the service (numerator) are identified from the sample eligible (411 or greater). The measure's rate is based on members who received the service divided by members who are eligible to have received the service. It is important to note that performance on a hybrid measure can be impacted by the ability of a plan or its contracted vendor to locate and obtain member medical records. According to NCQA's specifications, members for whom no medical record documentation is found are considered noncompliant with the measure.

Dimensions of Care

Pediatric Care

Pediatric Care

Overview

Child and adolescent measures provide a framework to ensure they lead healthy lives by ensuring they receive the number of recommended scheduled visits and appropriate care consistent with current clinical guidelines. These pediatric measures were selected to highlight the care of children and adolescents in the SC Medicaid Program. Trend data is provided for select measures with maps highlighting county variability amenable to intervention strategies. Improved statewide performance was noted for most pediatric measures. Statewide rates showed marked improvement with two measures - Appropriate Testing for Children with Pharyngitis and Well-Child Visits for Children in the First 15 months of Life (zero and 6+ plus visits). Lead Screening; Adolescent Care; and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life are measures requiring improvement.

Pediatric Care Measures and Descriptions

Measure	Measure Description
Adolescent Well-Care Visits (AWC)	The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.
Appropriate Testing for Children With Pharyngitis (CWP)	The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).
Ambulatory Care (AMB)	This measure summarizes utilization of ambulatory care for ED visits in the following categories: • **AMB - AMB ER <1 Visit/1000** • **AMB - AMB ER 1-9 Visit/1000** • **AMB - AMB ER 10-19 Visit/1000**
Lead Screening in Children (LSC)	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.
Well-Child Visits in the First 15 Months of Life (W15)	The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: • No well-child visits† • Five well-child visits • Six or more well-child visits †=*Inverted measure (lower is better.)*
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.

2011 South Carolina Medicaid Health Plans Report Card
Pediatric Care Measures

		Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	New Plans: Carolina Medical Homes	New Plans: Palmetto Physician Connections	Weighted State Average
PEDIATRIC CARE	Adolescent Well-Care Visits	★	★	★	★	★	★	★	★	★
	Ambulatory Care- Emergency Department Visits (Visits/1000MM)*									
	Ages <1	★★	★★★	★★★	★★	★★★	★★★	★	★★	★★
	Ages 1-9	★★★	★★★	★★★	★	★★★	★★★	★	★★★	★★
	Ages 10-19	★	★★★	★★	★	★★★	N/A	★★	★★	★★
	Appropriate Testing for Children With Pharyngitis	★★★	★★	★★★	★★★★	★★★	★★★	NSI	NSI	★★★
	Appropriate Treatment for Children With Upper Respiratory Infection†	★★	★	★★	★★	★★	★	NSI	NSI	★
	Lead Screening in Children	★	★	★★	★	★	★	NSI	NSI	★
	Well-Child Visits in the First 15 Months of Life									
	Zero visits*	★★	★★	★★★	★★★★	★★★★	★	NSI	NSI	★★
	Five visits	★★★★★	★★★★★	★★★★★	★★★	★★★★★	★★★	NSI	NSI	★★★★★
	Six or More visits	★★	★	★★	★★★★	★	★★	NSI	NSI	★★
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★	★	★	★	★	★	★	★	★
	OVERALL SCORE FOR PEDIATRIC CARE	★★	★★	★★⊕	★★	★★⊕	★⊕	NSI	NSI	★★

★★★★★ 90th Percentile or above
★★★★ 75th to 89th Percentile
★★★ 50th to 74th Percentile
★★ 25th to 49th Percentile
★ Below 25th Percentile
⊕ Upper Range of Percentile Group
NSI Denominator less than 30
NSPI Insufficient Plan Information
N/A Not Applicable
† Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]
* Inverted measure: lower rates indicate better performance
** Using 2010 NCQA National Medicaid Benchmarks. 2011 National Benchmark not available due to definitional change in age categories.

SC Medicaid HEDIS Rates
Pediatric Care - CY 2011

		Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Carolina Medical Homes	Palmetto Physician Connections	Weighted State Average	NCQA National Medicaid Mean
PEDIATRIC CARE											
Adolescent Well-Care Visits	Reported Rate	28.8	22.1	36.0	31.2	29.1	8.1	21.7	17.6	24.3	48.1
Ambulatory Care *	AMB ER <1 Visit/1000	94.9	88.9	91.1	99.7	82.2	90.6	120.6	104.8	96.6	91.1
	AMB ER 1-9 Visit/1000	47.7	48.1	46.8	57.0	44.3	45.9	58.3	47.3	49.4	49.2
	AMB ER 10-19 Visit/1000	48.1	38.0	42.5	51.2	39.5	N/A	44.6	43.0	43.8	41.4
Appropriate Testing for Children With Pharyngitis	Reported Rate	74.5	68.0	73.5	75.7	74.4	70.7	NSI	NSI	72.8	64.9
Appropriate Treatment for Children With Upper Respiratory Infection †	Reported Rate	84.0	80.5	86.1	83.8	86.1	79.2	NSI	NSI	83.3	87.2
Lead Screening in Children	Reported Rate	38.9	42.3	55.6	50.4	49.1	40.9	NSI	NSI	46.2	66.2
Well-Child Visits in the First 15 Months of Life	Zero visits *	2.0	2.6	0.8	0.6	0.7	3.5	NSI	NSI	1.7	2.2
	Five visits	22.4	24.9	24.8	18.3	26.4	17.3	NSI	NSI	22.4	16.1
	Six or More visits	53.7	45.1	58.5	70.1	41.6	58.3	NSI	NSI	54.6	60.2
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Reported Rate	57.7	50.8	60.3	62.2	54.2	42.1	46.4	40.4	51.9	71.9

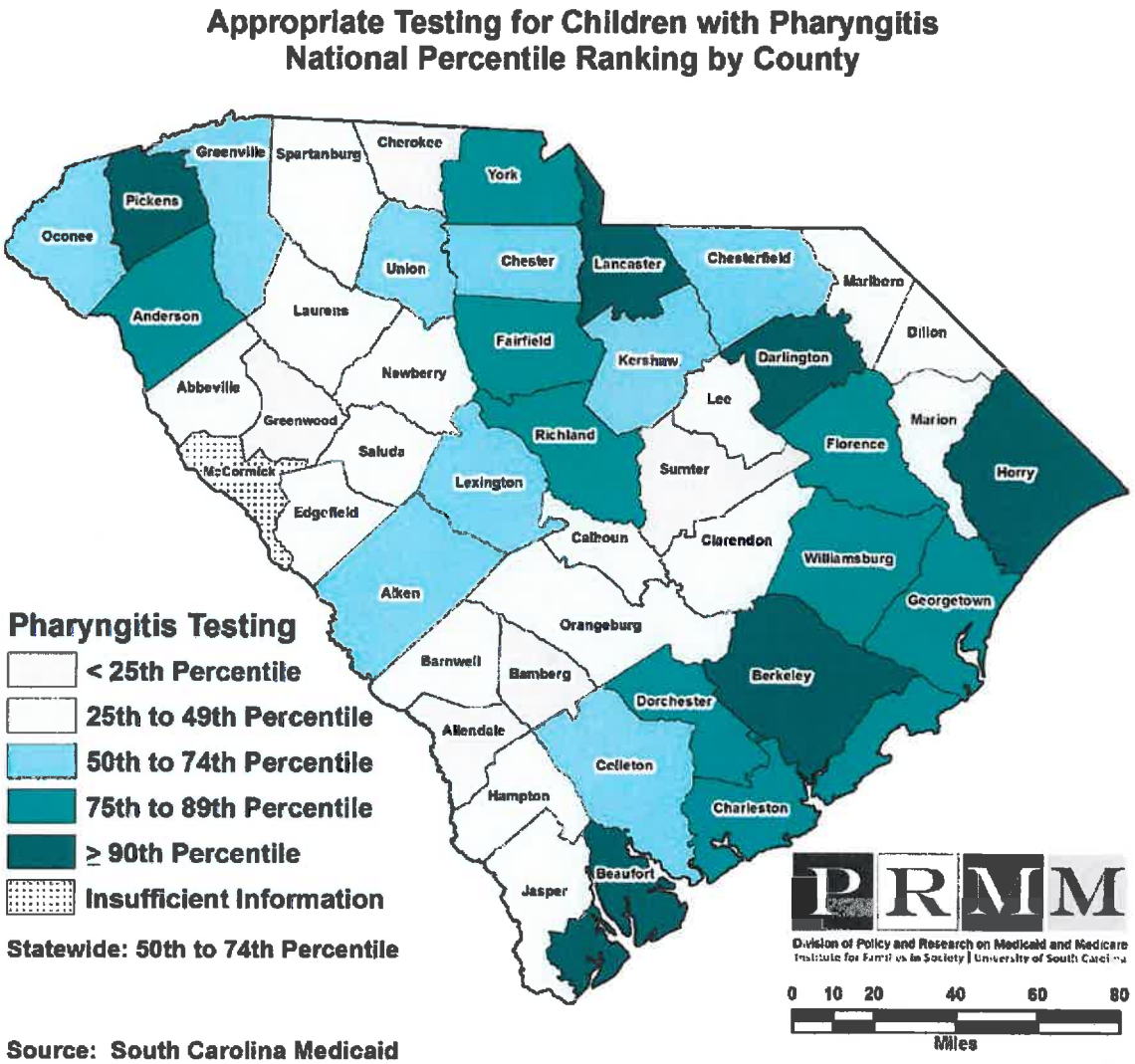
Green background: NCQA 75th percentile and above; or for inverted measures, below NCQA 25th percentile
White background: between NCQA 25th and 74th percentile
Red background: below NCQA 25th percentile; or for inverted measures, NCQA 75th percentile and above
NSI: denominator less than 30
Blue Rates: weighted state average and above; or for inverted measures, weighted state average and below
† Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]
* Inverted measure: lower rates indicate better performance
** Using 2010 NCQA National Medicaid Benchmarks

Pediatric Care Statewide Trends

		Weighted State Rates				NCQA National Medicaid Mean	Change from 2008 to 2011	Change from 2009 to 2011	Change from 2010 to 2011
		2008	2009	2010	2011 (Adjusted)				
Adolescent Well-Care Visits	Reported Rate	21.5	24.6	27.5	24.3	48.1	UP	DOWN	DOWN
Ambulatory Care*	AMB ER <1 Visit/1000	49.0	44.0	44.9	96.6	91.1	UP	UP	UP
	AMB ER 1-9 Visit/1000	44.3	40.2	42.4	49.4	49.2	UP	UP	UP
	AMB ER 10-19 Visit/1000	90.3	73.1	84.2	43.8	41.4	DOWN	DOWN	DOWN
Appropriate Testing for Children With Pharyngitis	Reported Rate	65.0	67.2	72.6	72.8	64.9	UP	UP	UP
Appropriate Treatment for Children With Upper Respiratory Infection†	Reported Rate	81.5	81.3	82.7	83.3	87.2	UP	UP	UP
Lead Screening in Children	Reported Rate	45.5	40.5	48.7	46.2	66.2	UP	UP	DOWN
Well-Child Visits in the First 15 Months of Life	Zero Visits*	4.0	3.5	1.9	1.7	16.1	DOWN	DOWN	DOWN
	Five Visits	25.6	21.9	22.2	22.4	60.2	DOWN	UP	UP
	Six or More Visits	40.1	33.3	50.9	54.6	2.2	UP	UP	UP
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Reported Rate	49.1	50.5	55.8	51.8	71.9	UP	UP	DOWN

UP: Indicates the SC State Weighted Rate change is significantly higher.
DOWN: Indicates the SC State Weighted Rate change is significantly lower.
†: Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]
*: Inverted measure: lower rates indicate better performance
**: Using 2010 NCQA National Medicaid Benchmarks. 2011 National Benchmark not available due to definitional change in Age Categories.

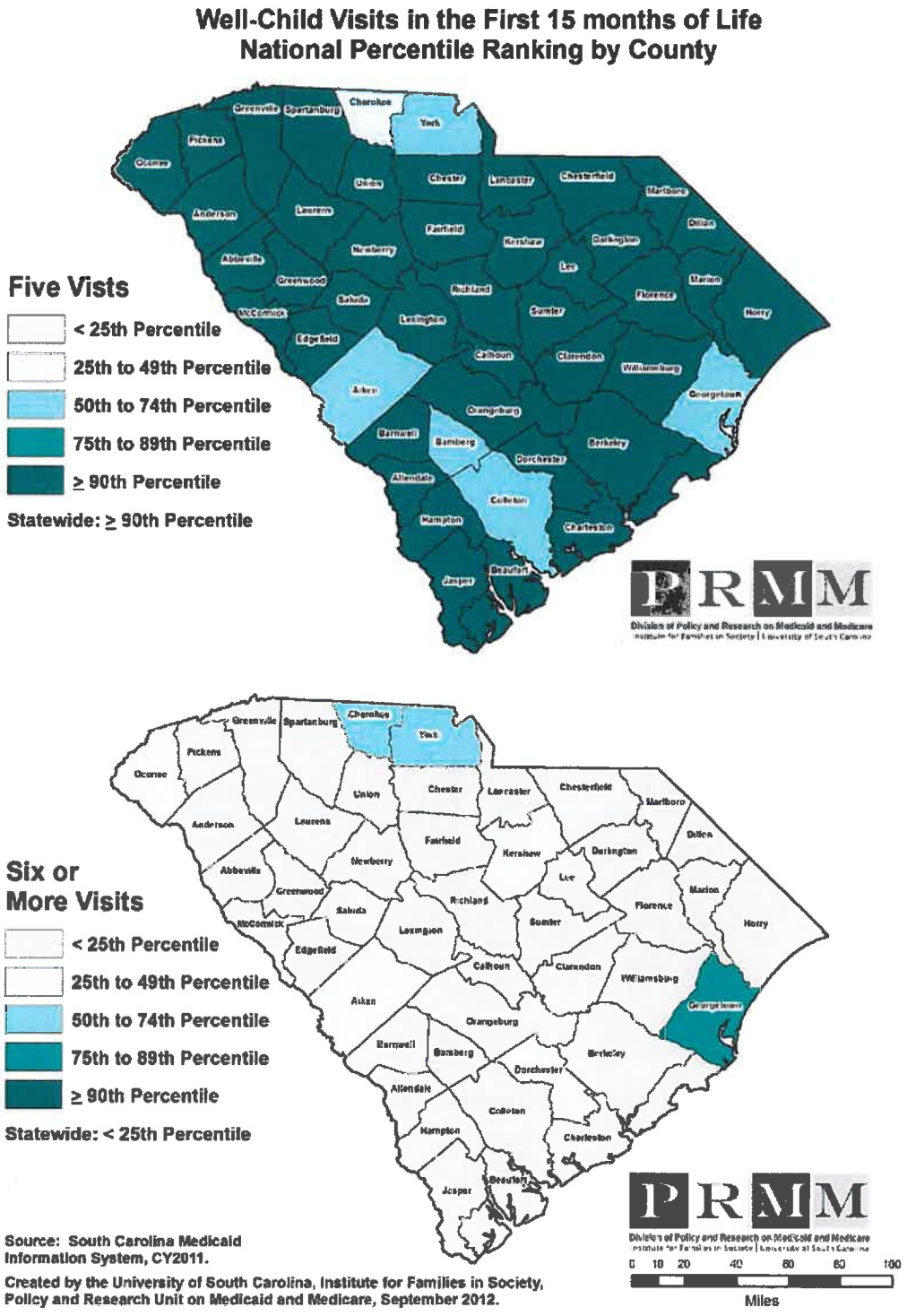
Figure 8. Appropriate Testing for Children with Pharyngitis - National Percentile Ranking by County



Source: South Carolina Medicaid Information System, CY2011.

Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, September 2012.

Figure 9. Well-Child Visits in the First 15 Months of Life - National Percentile Ranking by County



Dimensions of Care

Women's Care

Women's Care

Overview

Appropriate preventive care for women ameliorates health conditions resulting in serious illness, complications at birth, and early death. Targeted preventive health care for women continues to present with mixed results. In South Carolina, breast and cervical cancers rank among the leading causes of serious illness and deaths for women. Timeliness of prenatal care affects rates of low weight births, infant and maternal complications, and mortality. Although rates continue to increase, South Carolina statewide Medicaid rates fall below the Medicaid National Medicaid Mean on cancer screenings and timeliness of prenatal and postpartum care. Trend data is provided for select measures with maps highlighting county variability amenable to intervention strategies.

Women's Care Measures and Descriptions

Measure	Description
Breast Cancer Screening (BCS)	The percentage of women 40–69 years of age who had a mammogram to screen for breast cancer.
Cervical Cancer Screening (CCS)	The percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer.
Chlamydia Screening in Women (CHL)	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
Prenatal and Postpartum Care (PPC)	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. • *Timeliness of Prenatal Care:* The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. • *Postpartum Care:* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.
Ambulatory Care (AMB)	This measure summarizes utilization of ambulatory care for ED visits in the following categories: • AMB - AMB ER 20-44 Visit/1000 • AMB - AMB ER 45-64 Visit/1000 • AMB - AMB ER 65-74 Visit/1000

2011 South Carolina Medicaid Health Plans Report Card
Women's Care Measures

		Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	*New Plans* Carolina Medical Homes	*New Plans* Palmetto Physician Connections	Weighted State Average
WOMEN'S CARE	Breast Cancer Screening	★	★	★★★	★	★★	★	★★	★	★
	Cervical Cancer Screening	★	★	★	★	★	★	★	★	★
	Chlamydia Screening in Women									
	16-20 Years	★★★	★★★	★★	★★	★★	★★★	NSI	★★	★★
	21-24 Years	★★★★	★★★	★★★	★★	★★★★	★★	NSI	NSI	★★★
	Total	★★★	★★★	★★	★★	★★★	★★★	★★★★	★★	★★★
	Prenatal and Postpartum Care									
	Timeliness of Prenatal Care	★★★★	★★	★★	★★★	★★	★	★★★★½	★★★★	★★
	Postpartum Care	★★	★★★	★★★	★★★★	★★★	★	★★	★	★★
	OVERALL SCORE FOR WOMEN'S CARE	★★⊕	★★⊕	★★⊕	★★	★★⊕	★⊕	NSI	NSI	★★
	Ambulatory Care/ Emergency Department Visits Per 1,000*									
	Ages 20-44	★★★	★★★	★★★★	★★★	★★★	★★★★★	★★★	★★★	★★★★
	Ages 45-64	★★	★	★★	★★	★	★★★★★	★★	★★★★	★★
	Ages 65-74	NSI	NSI	★	★	NSI	★	★	★★	★

★★★★★ 90th Percentile or above
★★★★ 75th to 89th Percentile
★★★ 50th to 74th Percentile
★★ 25th to 49th Percentile

★ Below 25th Percentile
⊕ Upper Range of Percentile Group
NSI Denominator less than 30
NSPI Insufficient Plan Information
N/A Not Applicable

† Inverse rate: the measure is reported as an inverted rate [1 - (numerator/ eligible population)]
* Inverted measure: lower rates indicate better performance
** Using 2010 NCQA National Medicaid Benchmarks. 2011 National Benchmark not available due to definitional change in age categories.

SC Medicaid HEDIS Rates
Women's Care - CY 2011

		Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Carolina Medical Homes	Palmetto Physician Connections	Weighted State Average	NCQA National Medicaid Mean
WOMEN'S CARE											
Breast Cancer Screening	Reported Rate	44.8	43.7	53.9	43.2	51.3	28.5	49.1	39.3	44.2	51.3
Cervical Cancer Screening	Reported Rate	50.6	46.2	56.8	35.2	59.6	29.5	28.2	39.9	43.3	67.2
Chlamydia Screening in Women	16-20 Years	57.9	54.4	51.6	52.5	52.6	54.6	NSI	50.6	53.5	54.6
	21-24 Years	68.7	66.1	66.7	58.5	69.4	61.2	NSI	NSI	65.1	62.3
	Total	61.5	58.8	55.7	54.4	59.7	57.4	67.7	51.5	58.3	57.5
Prenatal and Postpartum Care	Timeliness of Prenatal Care	90.6	80.9	81.9	88.9	80.3	63.2	93.2	91.7	83.8	83.7
	Postpartum Care	64.0	67.9	65.8	70.6	64.7	54.0	62.5	49.8	62.4	64.4

Green background: NCQA 75th percentile and above; or for inverted measures, below NCQA 25th percentile

White background: between NCQA 25th and 74th percentile

Red background: below NCQA 25th percentile; or for inverted measures, NCQA 75th percentile and above

NSI: denominator less than 30

Blue Rates: weighted state average and above; or for inverted measures, weighted state average and below

† Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]

* Inverted measure: lower rates indicate better performance

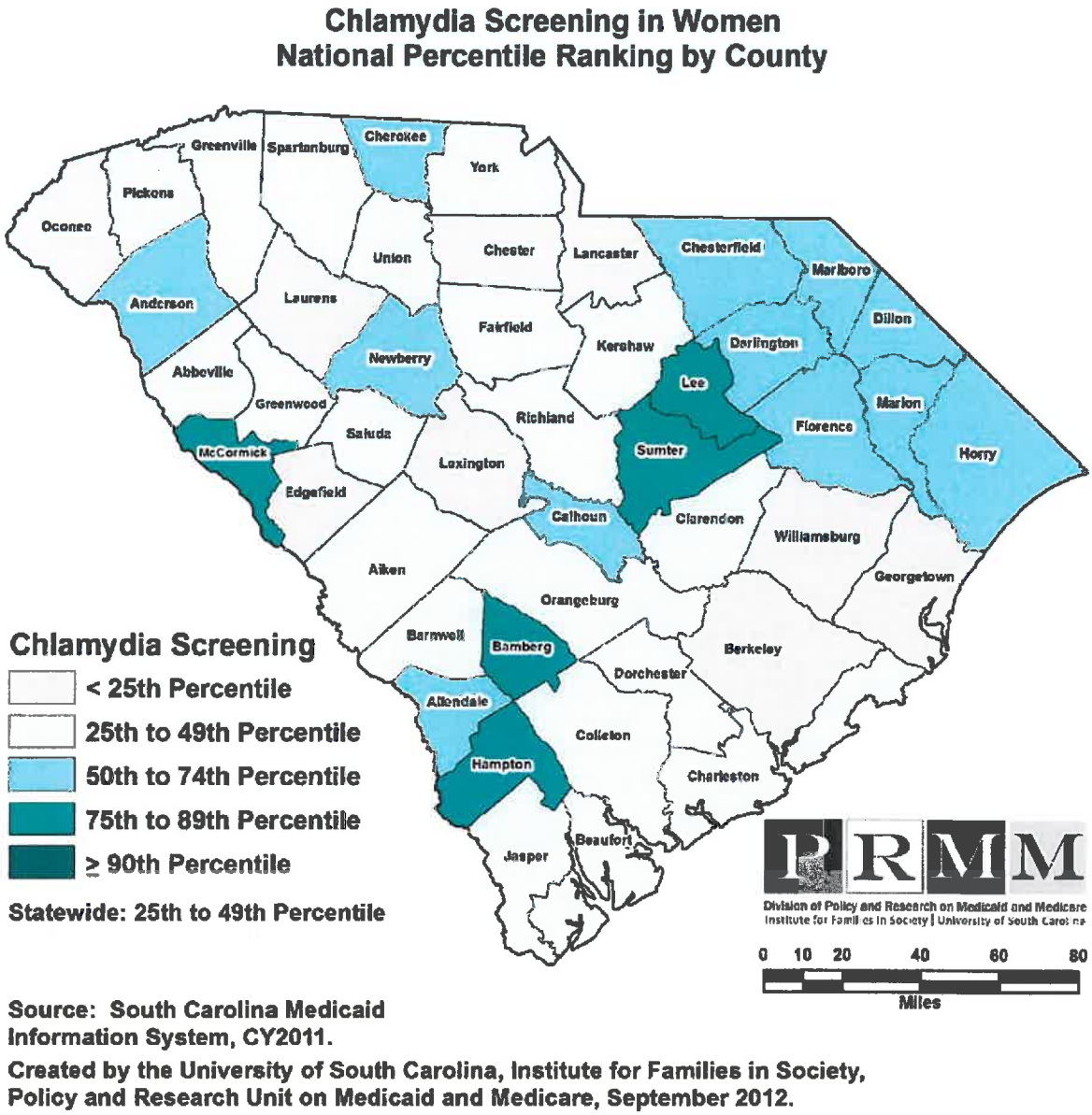
** Using 2010 NCQA National Medicaid Benchmarks

Women's Care Statewide Trends

		Weighted State Rates				NCQA National Medicaid Mean	Change from 2008 to 2011	Change from 2009 to 2011	Change from 2010 to 2011
		2008	2009	2010	2011 (Adjusted)				
WOMEN'S CARE									
Breast Cancer Screening	Reported Rate	39.4	41.3	44.7	44.2	51.3	UP	UP	DOWN
Cervical Cancer Screening	Reported Rate	49.1	47.3	51.2	43.3	67.2	DOWN	DOWN	DOWN
Chlamydia Screening in Women	16-20 Years	53.0	51.7	52.6	53.5	54.6	UP	UP	UP
	21-24 Years	55.0	55.8	58.8	65.1	62.3	UP	UP	UP
	Total	54.0	53.3	55.0	58.3	57.5	UP	UP	UP
Prenatal and Postpartum Care	Timeliness of Prenatal Care	58.0	69.7	78.2	83.8	83.7	UP	UP	UP
	Postpartum Care	64.7	64.8	63.0	62.4	64.4	DOWN	DOWN	DOWN
Ambulatory Care/ Emergency Department Visits Per 1,000*									
	Ages 20-44	N/A	71.6	96.1	79.4	N/A	N/A	UP	DOWN
	Ages 45-64	N/A	77.2	94.5	82.9	N/A	N/A	UP	DOWN
	Ages 65-74	N/A	33.4	51.0	64.8	N/A	N/A	UP	UP

UP: Indicates the SC State Weighted Rate change is significantly higher.
DOWN: Indicates the SC State Weighted Rate change is significantly lower.
†: Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]
*: Inverted measure: lower rates indicate better performance
**: Using 2010 NCQA National Medicaid Benchmarks. 2011 National Benchmark not available due to definitional change in Age Categories.

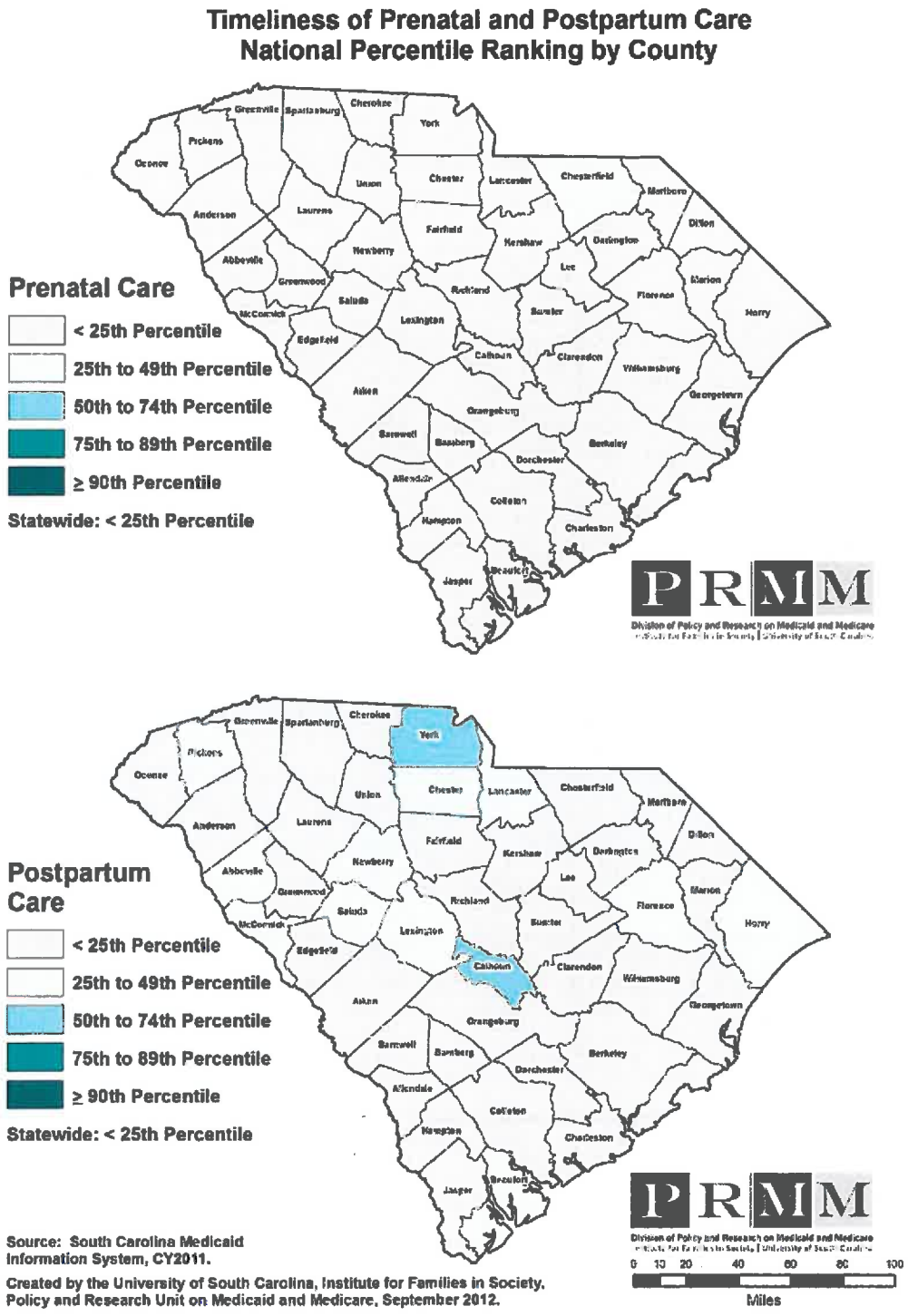
Figure 10. Chlamydia Screening in Women - National Percentile Ranking by County



Source: South Carolina Medicaid Information System, CY2011.

Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, September 2012.

Figure 11. Timeliness of Prenatal and Postpartum Care - National Percentile Ranking by County



Dimensions of Care

Living With Illness

Living With Illness

Overview

This section provides information on how well-care is provided to Medicaid recipients with chronic conditions, including appropriate use of health care resources and treatments. Diabetes is a serious condition with long-term complications such as heart disease, kidney disease, and blindness. Asthma is an obstructive lung disease with much of the complications successfully managed by long-term control medications. These two measures examine the rates of two key conditions associated with living with chronic illness in the Medicaid population. Although rates have increased for comprehensive diabetes care, this report examines individual components of care indicating the need for quality improvement to prevent long-term complications—testing HbA1c and LDL-C levels, eye exam, and attention to diabetic nephropathy. Since 2008, great strides have been made in the rates measuring Use of Appropriate Medication for People with Asthma. These measures focus on persistent asthma with ED pediatric rates indicating the need for further work to alleviate asthma-related complications.

Living With Illness Measures and Descriptions

Measure	Description
Comprehensive Diabetes Care (CDC)	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following. • Hemoglobin A1c (HbA1c) testing • Eye exam (retinal) performed • LDL-C screening • Medical attention for nephropathy * *Additional exclusion criteria are required for this indicator that will result in a different eligible population from all other indicators. This indicator is only reported for the commercial and Medicaid product lines.*
Use of Appropriate Medications for People With Asthma (ASM)	The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year in the following categories: • ASM - Rate - 5-11 Years • ASM - Rate - Total

2011 South Carolina Medicaid Health Plans Report Card
Living With Illness Measures

		Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	*New Plans* Carolina Medical Homes	*New Plans* Palmetto Physician Connections	Weighted State Average
LIVING WITH ILLNESS	Comprehensive Diabetes Care									
	HbA1c Testing	★★	★	★★	★	★★	★	★	★★	★
	Eye Exams	★	★	★	★	★	★	★	★	★
	LDL-C Screening	★	★	★	★	★	★	★	★	★
	Med Att Diabetic Nephropathy	★★	★★	★★	★	★★	★	★	★★★★	★
	Use of Appropriate Medications for People with Asthma**									
	5-11 Years	★★★	★★	★★	★★	★	★	NSI	NSI	★
	Total	★★★	★	★★★★	★★★	★	★	NSI	NSI	★
	OVERALL SCORE FOR LIVING WITH ILLNESS	★★	★⊕	★★	★⊕	★⊕	★	NSI	NSI	★

★★★★★ 90th Percentile or above
★★★★ 75th to 89th Percentile
★★★ 50th to 74th Percentile
★★ 25th to 49th Percentile

★ Below 25th Percentile
⊕ Upper Range of Percentile Group
NSI Denominator less than 30
NSPI Insufficient Plan Information
N/A Not Applicable

† Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]
* Inverted measure: lower rates indicate better performance
** Using 2010 NCQA National Medicaid Benchmarks. 2011 National Benchmark not available due to definitional change in age categories.

SC Medicaid HEDIS Rates
Living With Illness - CY 2011

		Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Carolina Medical Homes	Palmetto Physician Connections	Weighted State Average	NCQA National Medicaid Mean
LIVING WITH ILLNESS											
Comprehensive Diabetes Care	HbA1c Testing	81.9	73.9	80.8	57.8	78.5	17.6	40.3	77.6	63.6	82.0
	Eye Exams	37.7	32.9	37.6	31.1	25.1	10.5	0.0	41.5	27.1	53.1
	LDL-C Screening	68.2	65.8	68.8	51.3	66.3	10.1	28.6	63.7	52.9	74.7
	Med Att Diabetic Neph.	76.1	75.3	77.6	65.0	74.3	31.8	55.2	83.3	67.3	77.7
Use of Appropriate Medications for People with Asthma **	5-11 Years	92.4	90.9	90.7	91.8	87.7	74.2	NSI	NSI	88.0	91.8
	Total	89.5	84.2	90.9	88.9	77.1	61.3	NSI	NSI	82.0	88.6

Green background: NCQA 75th percentile and above; or for inverted measures, below NCQA 25th percentile

White background: between NCQA 25th and 74th percentile

Red background: below NCQA 25th percentile; or for inverted measures, NCQA 75th percentile and above

NSI: denominator less than 30

Blue Rates: weighted state average and above; or for inverted measures, weighted state average and below

† Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]

* Inverted measure: lower rates indicate better performance

** Using 2010 NCQA National Medicaid Benchmarks

Living With Illness Statewide Trends

		Weighted State Rates				NCQA National Medicaid Mean	Change from 2008 to 2011	Change from 2009 to 2011	Change from 2010 to 2011
		2008	2009	2010	2011 (Adjusted)				
Comprehensive Diabetes Care	HbA1c Testing	39.4	40.8	43.6	63.6	82.0	UP	UP	UP
	Eye Exams	90.0	42.0	36.9	27.1	53.1	DOWN	DOWN	DOWN
	LDL-C Screening	31.7	33.4	37.0	52.9	74.7	UP	UP	UP
	Med Att Diabetic Neph.	59.2	55.3	56.4	67.3	77.7	UP	UP	UP
Use of Appropriate Medications for People with Asthma**	5-11 Years	95.1	94.9	95.3	88.0	91.8	DOWN	DOWN	DOWN
	Total	87.1	92.5	92.5	82.0	88.6	DOWN	DOWN	DOWN

UP: Indicates the SC State Weighted Rate change is significantly higher.
DOWN: Indicates the SC State Weighted Rate change is significantly lower.
†: Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]
*: Inverted measure: lower rates indicate better performance
**: Using 2010 NCQA National Medicaid Benchmarks. 2011 National Benchmark not available due to definitional change in Age Categories.

Figure 12. Comprehensive Diabetes Care - National Percentile Ranking by County

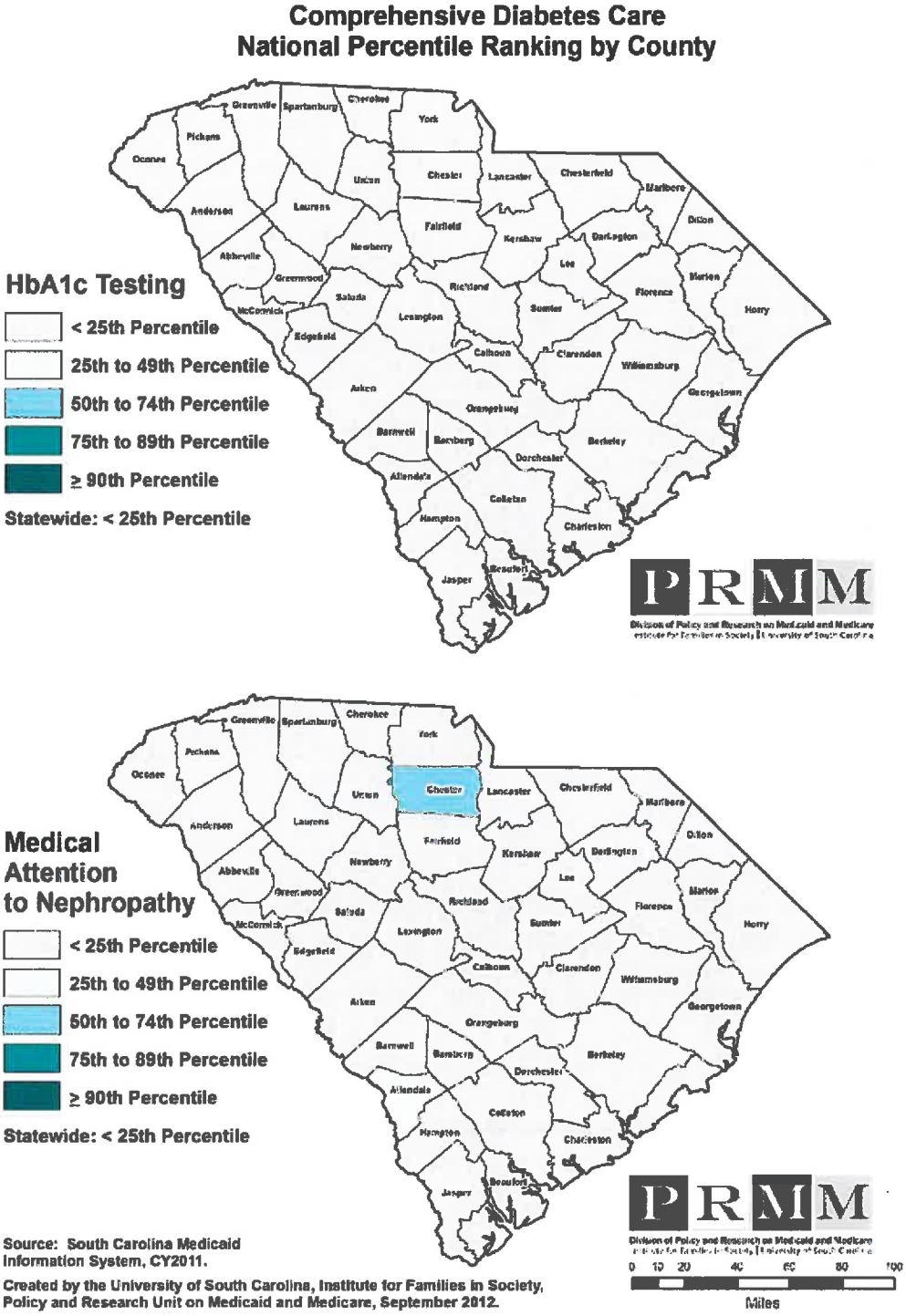
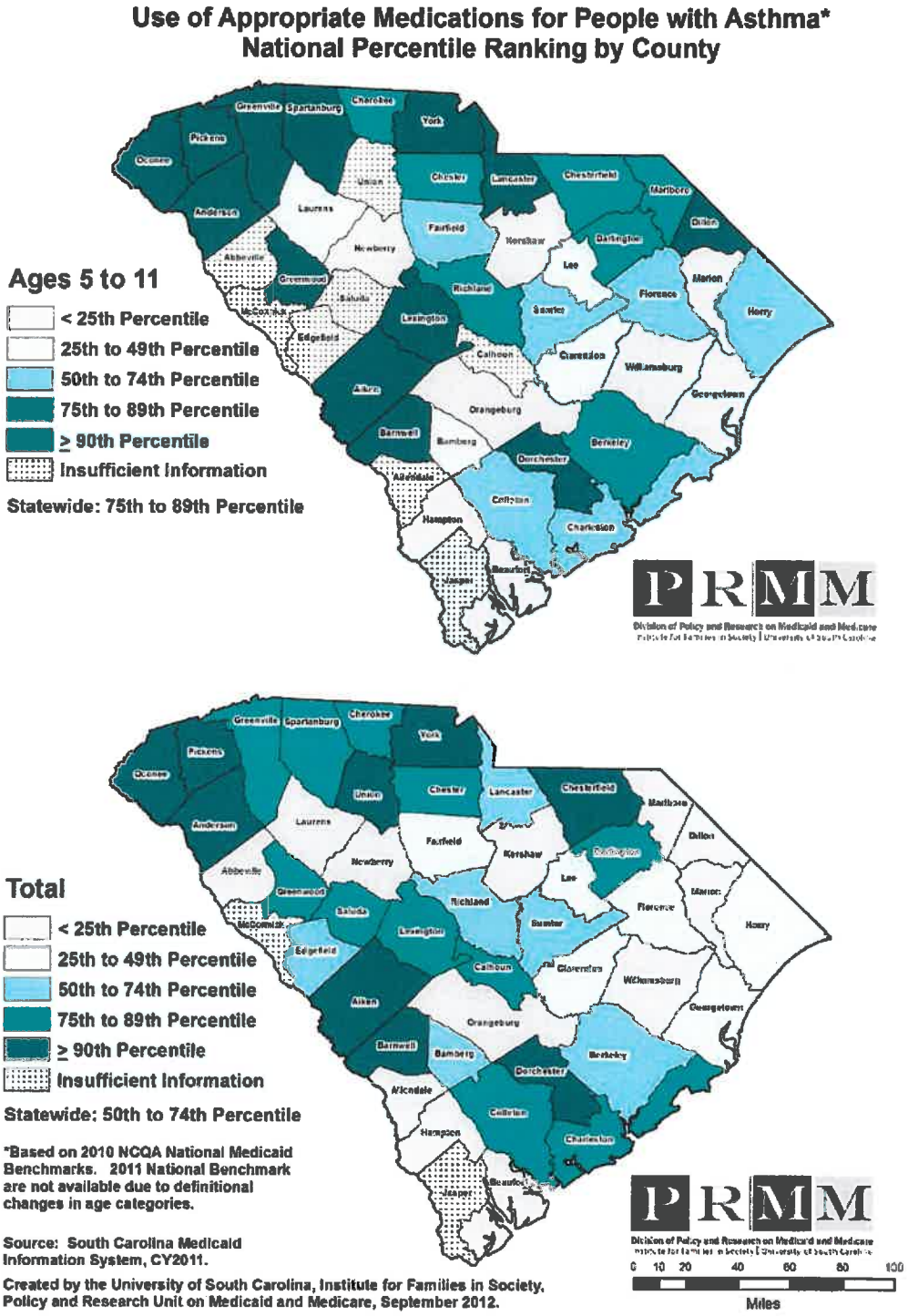


Figure 13. Use of Appropriate Medications for People with Asthma - National Percentile Ranking by County



Dimensions of Care

Behavioral Health

Behavioral Health

Overview

Management of ADHD medication addresses how well providers perform in treating children with ADHD. Once diagnosed, children treated with medications should be managed within 30 days of initiating and continuing medications. Follow-Up After Hospitalizations for a Mental Illness addresses continuity of care between the hospital and primary care provider. Lastly the Initiation and Engagement of Medicaid recipients in Treatment for Alcohol and Other Drug Dependence is critical in ensuring the well-being of adolescents and adults. Trend data is provided for select measures with maps highlighting county variability amenable to intervention strategies. Primary care providers play an essential role in the coordination of behavioral health care. These measures highlight the opportunity for exploring initiatives that strengthen the coordination of behavioral health services at differing levels of the system of care.

Behavioral Health Measures and Descriptions

Measure	Description
Follow-Up After Hospitalization for Mental Illness (FUH)	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: • The percentage of members who received follow-up within 30 days of discharge. • The percentage of members who received follow-up within 7 days of discharge.
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. • Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. • Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. IPSD: Index Prescription Start Date. The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

2011 South Carolina Medicaid Health Plans Report Card
Behavioral Health Measures

		Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	*New Plans* Carolina Medical Homes	Palmetto Physician Connections	Weighted State Average
BEHAVIORAL HEALTH	Follow-Up After Hospitalization for Mental Illness									
	7 Days	★★★★⯪	★★★★★★★★★★	★★★★★	★★⯪★★★★★★			★★★★★	NSI	★★★★⯪
	30 Days	★★★	★★★★	★★★★	★★★	★★	★★	★	NSI	★★
	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication									
	Initiation	★★★★	★★	★★★★	★★	★★★	★★	NSI	NSI	★★★
	Continuation	★★★	★★★	★★★★	★★	★★★	★★	NSI	NSI	★★★
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment									
	Initiation - 13-17 Years	★★★★★	★★★★★★★★★★		★★★★★	★★★★★★★★★★		NSI	NSI	★★★★★
	Engagement - 13-17 Years	★★★★★	★★★★★★★★★★		★★★★★	★★★★★★★★★★		NSI	NSI	★★★★★
	Initiation - 18+	★★★★	★★★	★★★	★★★	★★★	★★★★	★★	★★★★	★★★
	Engagement - 18+	★★★★★	★★★★	★★★★	★★★★	★★★★	★★★	NSI	★★	★★★★
	Initiation - Total	★★★★	★★★	★★★★	★★★★	★★★	★★★★	★★★★	★★★★	★★★★
	Engagement - Total	★★★★★	★★★★★★★★★★		★★★★	★★★★	★★★★	★★	★★★★	★★★★
	OVERALL SCORE FOR BEHAVIORAL HEALTH	★★★★●	★★★★	★★★★●	★★★●	★★★●	★★★●	NSI	NSI	★★★★

★★★★★ 90th Percentile or above
★★★★ 75th to 89th Percentile
★★★ 50th to 74th Percentile
★★ 25th to 49th Percentile
★ Below 25th Percentile
● Upper Range of Percentile Group
NSI Denominator less than 30
NSPI Insufficient Plan Information
N/A Not Applicable
† Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]
* Inverted measure: lower rates indicate better performance
** Using 2010 NCQA National Medicaid Benchmarks. 2011 National Benchmark not available due to definitional change in age categories.

SC Medicaid HEDIS Rates
Behavioral Health - CY 2011

		Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Carolina Medical Homes	Palmetto Physician Connections	Weighted State Average	NCQA National Medicaid Mean
BEHAVIORAL HEALTH											
Follow-Up After Hospitalization for Mental Illness	7 Days	93.6	97.7	100.0	92.6	84.3	85.9	75.7	NSI	90.0	44.6
	30 Days	70.3	75.6	78.6	70.4	57.3	64.4	43.4	NSI	65.7	63.8
Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication	Initiation	44.4	37.1	44.0	32.4	40.3	37.8	NSI	NSI	39.3	38.1
	Continuation	50.4	46.2	59.9	34.7	50.8	39.7	NSI	NSI	47.0	43.9
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation - 13-17 Years	78.9	88.2	80.0	75.5	93.7	99.1	NSI	NSI	85.9	44.7
	Engagement - 13-17 Years	62.1	71.3	64.0	54.9	70.0	75.3	NSI	NSI	66.3	19.9
	Initiation - 18+	51.7	44.5	46.2	47.3	40.8	53.0	35.0	48.4	45.9	42.7
	Engagement - 18+	25.3	23.2	22.4	19.9	21.2	17.9	NSI	11.9	20.3	13.6
	Initiation - Total	54.8	48.3	52.5	50.5	44.8	56.5	50.9	59.1	52.2	42.9
	Engagement - Total	29.5	27.5	30.2	23.7	24.9	22.2	10.9	25.7	24.3	14.2

Green background: NCQA 75th percentile and above; or for inverted measures, below NCQA 25th percentile

White background: between NCQA 25th and 74th percentile

Red background: below NCQA 25th percentile; or for inverted measures, NCQA 75th percentile and above

NSI: denominator less than 30

Blue Rates: weighted state average and above; or for inverted measures, weighted state average and below

† Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]

* Inverted measure: lower rates indicate better performance

** Using 2010 NCQA National Medicaid Benchmarks

Behavioral Health Statewide Trends

		Weighted State Rates				NCQA National Medicaid Mean	Change from 2008 to 2011	Change from 2009 to 2011	Change from 2010 to 2011
		2008	2009	2010	2011 (Adjusted)				
Follow-Up After Hospitalization for Mental Illness	7 Days	41.8	4.5	32.8	90.0	44.6	UP	UP	UP
	30 Days	66.2	11.2	55.5	65.7	63.8	DOWN	UP	UP
Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication	Initiation	20.3	42.7	44.7	39.3	38.1	UP	DOWN	DOWN
	Continuation	26.2	49.1	51.8	47.0	43.9	UP	DOWN	DOWN
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation-13-17 Years	N/A	61.9	48.8	85.9	44.7	N/A	UP	UP
	Engagement-13-17 Years	N/A	28.6	30.0	66.3	19.9	N/A	UP	UP
	Initiation-18+	N/A	38.8	30.2	45.9	42.7	N/A	UP	UP
	Engagement-18+	N/A	13.6	5.6	20.3	13.6	N/A	UP	UP
	Initiation-Total	N/A	40.3	31.5	52.2	42.9	N/A	UP	UP
	Engagement-Total	N/A	14.6	7.4	24.3	14.2	N/A	UP	UP

UP: Indicates the SC State Weighted Rate change is significantly higher.
DOWN: Indicates the SC State Weighted Rate change is significantly lower.
†: Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]
*: Inverted measure: lower rates indicate better performance
**: Using 2010 NCQA National Medicaid Benchmarks. 2011 National Benchmark not available due to definitional change in Age Categories.
N/A: Rate not available

Figure 14. Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication - National Percentile Ranking by County

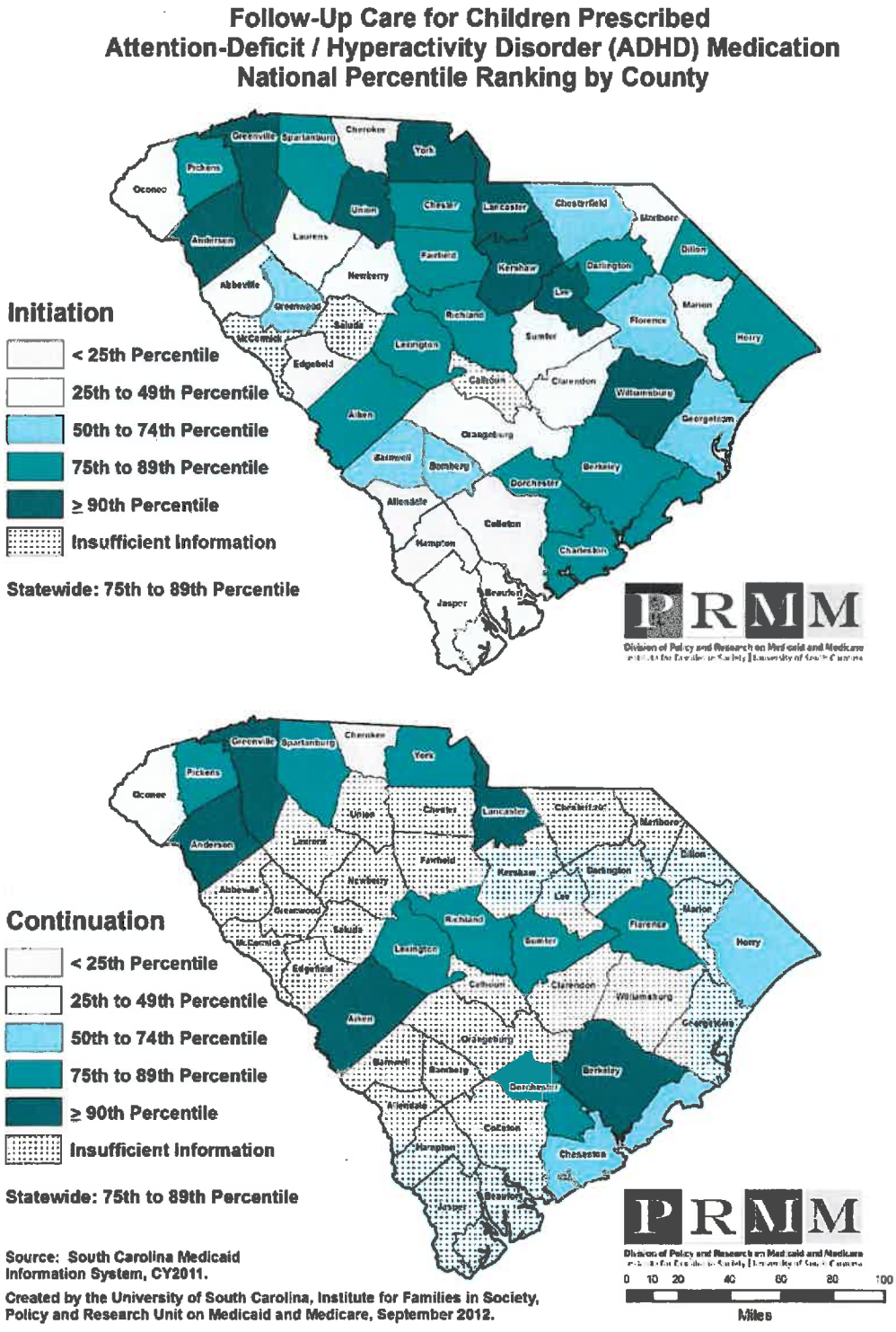
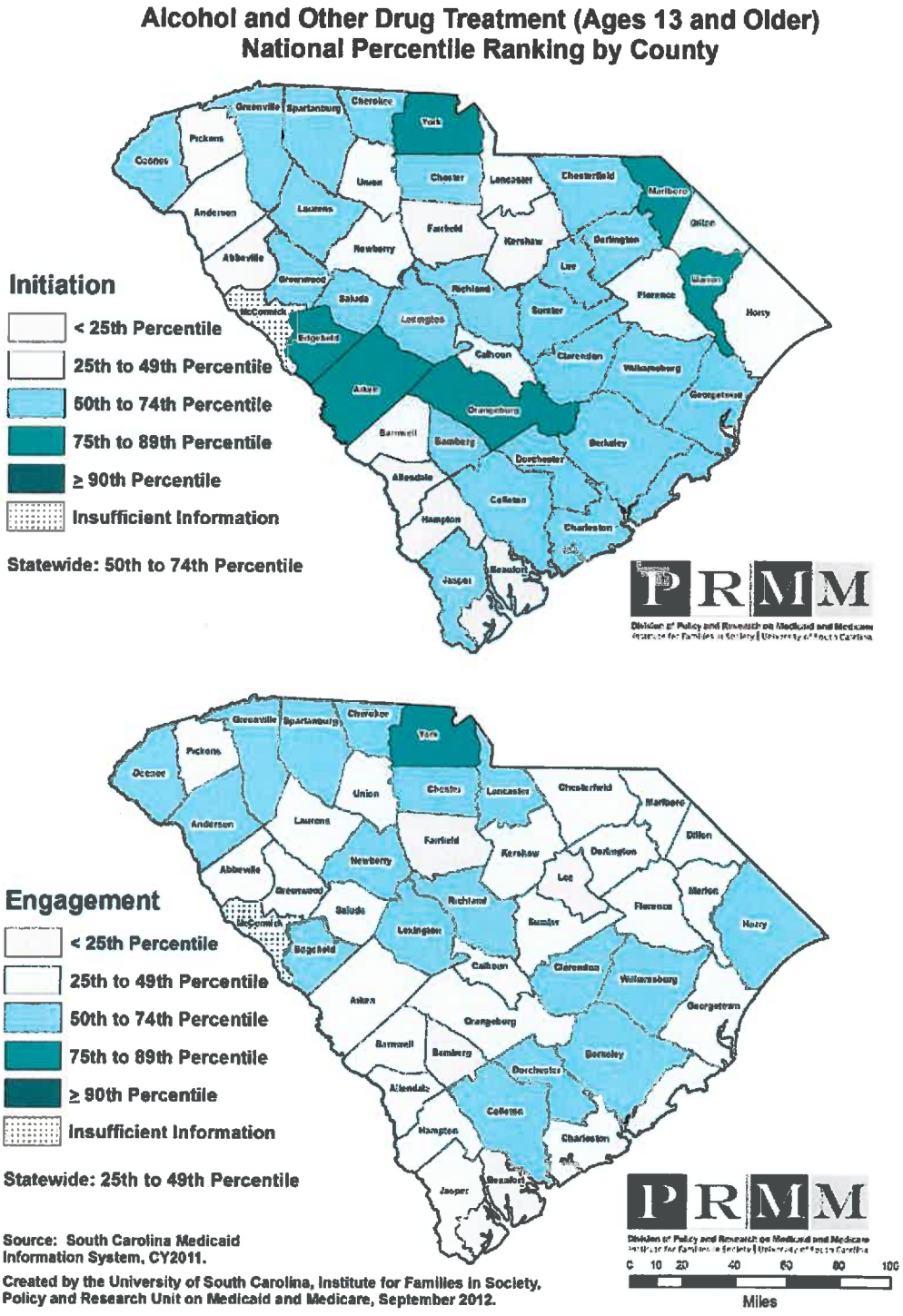


Figure 15. Alcohol and Other Drug Treatment (Ages 13 and Older)- National Percentile Ranking by County



Dimensions of Care

Access to Care

Access to Care

Overview

Access to routine health care allows for early diagnosis of health problems and the opportunity for timely treatment to avoid long-term complications. Regular access to care provides continuity of care for children and adults. Access to care has been found to be closely associated with better treatment compliance, lower ED use, and avoidable inpatient hospital stays. The SC Medicaid Weighted State Average rates for Access to Care measures fall below the National Medicaid Mean across all age groups, except for children at or below the age of 24 months. The national efforts on ensuring that every individual has access to a medical home with an identified primary care provider has been identified as an essential component of best clinical practice. The results of the rates for these measures challenge the SC Medicaid health care plans to improve on these measures as a critical strategy to reduce ED visits, improve care coordination, and reduce avoidable hospital stays. Trend data is provided for select measures with maps highlighting county variability amenable to intervention strategies.

Access to Care Measures and Descriptions	
Measure	Description
Children and Adolescents' Access to Primary Care Practitioners (CAP)	The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line: • Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year; • Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.
Adults' Access to Preventive/Ambulatory Health Services (AAP)	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.

2011 South Carolina Medicaid Health Plans Report Card

Access to Care Measures

		Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Carolina Medical Homes	Palmetto Physician Connections	Weighted State Average
								New Plans		
ACCESS TO CARE	Adults' Access to Preventive/Ambulatory Health Services									
	20-44 Years	★★	★★	★★★	★	★★	★	★	★	★
	45-64 Years	★	★	★★★★★	★	★★	★	★	★★	★
	Children and Adolescents' Access to Primary Care Practitioners									
	12-24 Months	★★★★	★★	★★★★★★★★★★		★★★★	★★	★	★	★★
	25 Months-6 Years	★★	★	★★★★	★★	★★	★	★	★★	★
	7-11 Years	★★	★	★★★★★	★	★★	★	★	★	★
	12-19 Years	★	★	★★★★	★	★	★	★	★	★
	OVERALL SCORE FOR ACCESS TO CARE	★★	★⊕	★★★★⊕	★★	★★	★	★	★⊕	★

★★★★★ 90th Percentile or above
★★★★ 75th to 89th Percentile
★★★ 50th to 74th Percentile
★★ 25th to 49th Percentile

★ Below 25th Percentile
⊕ Upper Range of Percentile Group
NSI Denominator less than 30
NSPI Insufficient Plan Information
N/A Not Applicable

† Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]
* Inverted measure: lower rates indicate better performance
** Using 2010 NCQA National Medicaid Benchmarks. 2011 National Benchmark not available due to definitional change in age categories.

SC Medicaid HEDIS Rates

Access to Care - CY 2011

		Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Carolina Medical Homes	Palmetto Physician Connections	Weighted State Average	NCQA National Medicaid Mean
ACCESS TO CARE											
Adults' Access to Preventive/Ambulatory Health Services	20-44 Years	80.1	80.1	85.5	72.4	82.0	63.0	70.3	71.5	75.6	81.2
	45-64 Years	82.0	81.9	91.2	73.8	85.1	59.3	68.2	85.4	78.4	86.0
Children and Adolescents' Access to Primary Care Practitioners	12-24 Months	98.0	95.9	99.6	99.7	97.9	95.1	92.4	86.9	95.7	96.1
	25 Months-6 Years	89.0	79.8	92.2	88.8	88.3	78.3	78.1	88.8	85.4	88.3
	7-11 Years	88.8	79.7	95.8	82.2	88.4	76.8	84.1	76.1	84.0	90.2
	12-19 Years	84.4	73.4	92.3	82.2	85.3	75.8	78.1	79.9	81.4	88.1

Green background: NCQA 75th percentile and above; or for inverted measures, below NCQA 25th percentile

White background: between NCQA 25th and 74th percentile

Red background: below NCQA 25th percentile; or for inverted measures, NCQA 75th percentile and above

NSI: denominator less than 30

Blue Rates: weighted state average and above; or for inverted measures, weighted state average and below

† Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]

* Inverted measure: lower rates indicate better performance

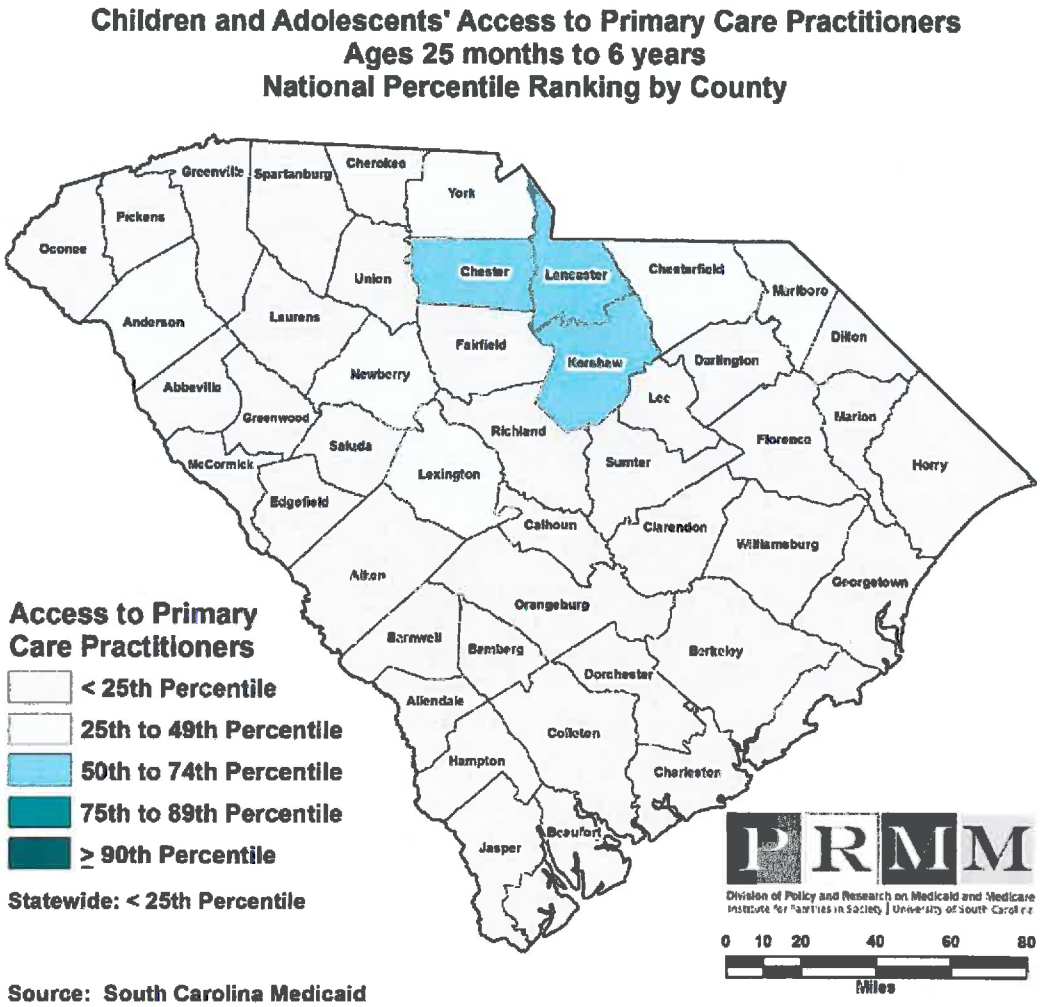
** Using 2010 NCQA National Medicaid Benchmarks

Access to Care Statewide Trends

		Weighted State Rates				NCQA National Medicaid Mean	Change from 2008 to 2011	Change from 2009 to 2011	Change from 2010 to 2011
		2008	2009	2010	2011 (Adjusted)				
Adults' Access to Preventive/ Ambulatory Health Services	20-44 Years	74.9	73.1	75.2	75.6	81.2	UP	UP	UP
	45-64 Years	75.5	75.5	75.8	78.4	86.0	UP	UP	UP
Children and Adolescents' Access to Primary Care Practitioners	12-24 Months	96.1	95.4	97.6	95.7	96.1	DOWN	UP	DOWN
	25 Months-6 Years	80.4	82.9	86.0	85.4	88.3	UP	UP	DOWN
	7-11 Years	78.7	85.0	87.6	84.0	90.2	UP	DOWN	DOWN
	12-19 Years	74.7	83.0	84.7	81.4	88.1	UP	DOWN	DOWN

UP: Indicates the SC State Weighted Rate change is significantly higher.
DOWN: Indicates the SC State Weighted Rate change is significantly lower.
†: Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]
*: Inverted measure: lower rates indicate better performance
**: Using 2010 NCQA National Medicaid Benchmarks. 2011 National Benchmark not available due to definitional change in Age Categories.

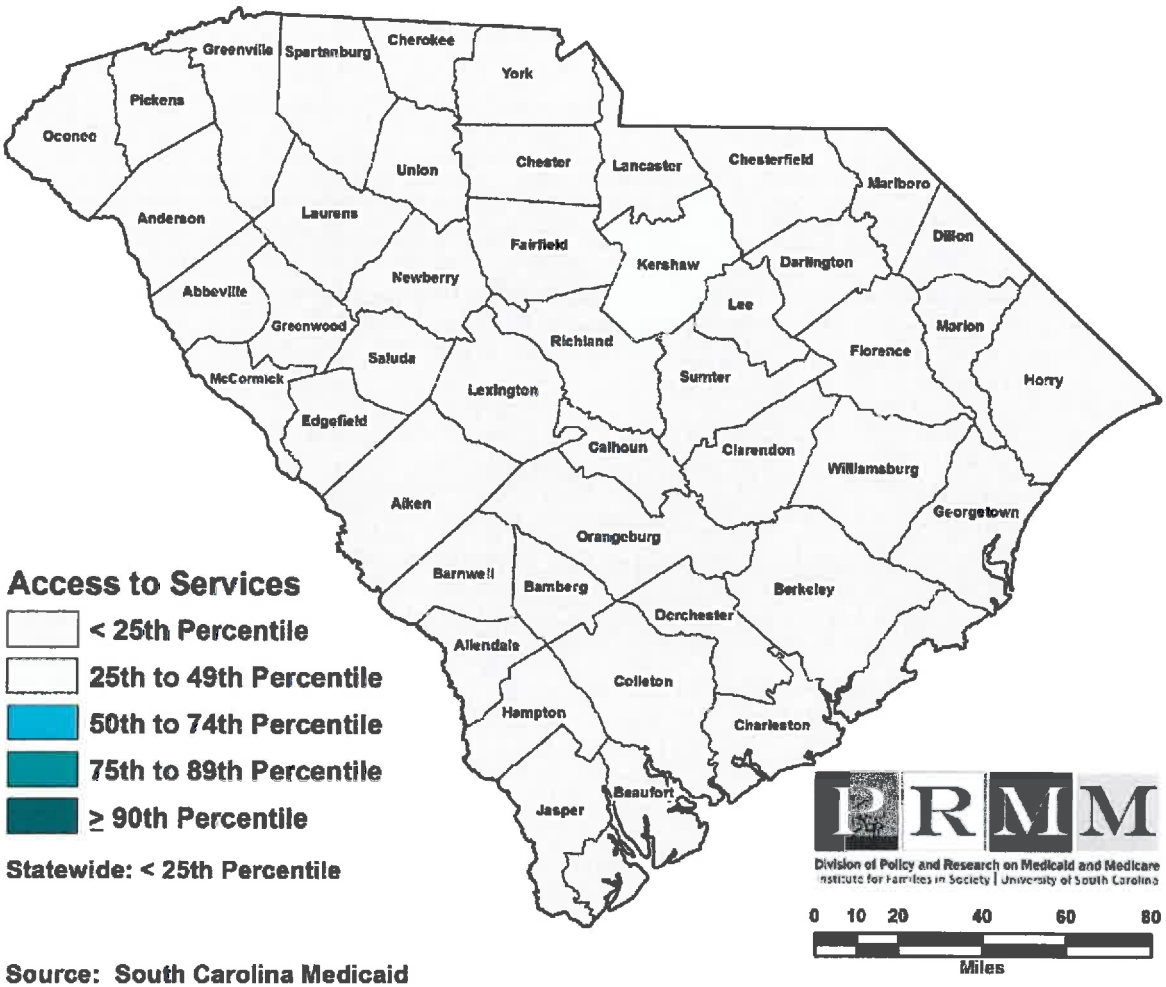
Figure 16. Children and Adolescents' Access to Primary Care Practitioners Ages 25 Months to 6 Years - National Percentile Ranking by County



Source: South Carolina Medicaid Information System, CY2011.

Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, September 2012.

Figure 17. Adults' Access to Preventative/Ambulatory Health Services - Ages 20 to 44
National Percentile Ranking by County



Source: South Carolina Medicaid Information System, CY2011.

Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, September 2012.

Dimensions of Care

Consumer Experience and Satisfaction

Consumer Experience and Satisfaction

Overview

Consumer experience and satisfaction are important aspects of value-based purchasing. Measures of consumer experience provide useful information for consumers, health plans and those making program, policy and health care purchasing decisions. For the purposes of this report, the CAHPS® results are summarized for adults and children in three domains: Satisfaction and Experience with Provider Networks, Satisfaction and Experience with Access to Care and Health Plan, and Satisfaction and Experience with Care. Additionally for adults, summary results are reported for three questions about Medical Assistance with Smoking Cessation.

Consumer Experience and Satisfaction Measures and Descriptions

Measure	Measure Description
Satisfaction and Experience with Provider Network (Adults and Children)	
Satisfaction with Provider Communication	The average of the responses "never," "sometimes," "usually," or "always" when members were asked how often their doctor listened to them carefully, explained things in a way they could understand, showed respect for what they had to say, and spent enough time with them.
Satisfaction with Personal Doctor	The average of member responses on a scale of 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor, when asked "How would you rate your personal doctor?"
Satisfaction with Specialist	The average of member responses on a scale of 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, when asked "How would you rate your specialist?"
Satisfaction and Experience with Access to Care and Health Plan (Adults and Children)	
Getting Needed Care	The average of the responses "never," "sometimes," "usually," or "always" when members were asked if, in the last 6 months not counting when care was needed immediately, they were able to get care or get an appointment for health care at a doctor's office or clinic as soon as needed.
Getting Care Quickly	The average of the responses "never," "sometimes," "usually," or "always" when members were asked if, in the last 6 months not counting when care was needed immediately, they were able to get care or get an appointment for health care at a doctor's office or clinic as soon as needed.
Satisfaction with Customer Service	The average of the responses "never," "sometimes," "usually," or "always" when members were asked if, in the last 6 months when they used their health plan's customer service, they received the information they needed and were treated with courtesy and respect.
Rating of Health Plan	The average of member responses on scale of 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, when asked "How would you rate your health plan?"
Satisfaction and Experience With Care (Adults and Children)	
Rating of Health Care	The average of member responses on scale of 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, when asked "How would you rate your health care?"

Consumer Experience and Satisfaction Measures and Descriptions (cont'd.)	
Measure	Measure Description
Medical Assistance with Smoking and Tobacco Use Cessation (Adults Only)	
Smoking Cessation	This measure is collected using the CAHPS survey methodology to arrive at an average that represents the percentage of members 18 years of age and older who were current smokers or tobacco users seen by the plan during the measurement year. For these members, the following facets of providing medical assistance with smoking cessation are assessed: • Advising Smokers and Tobacco Users to Quit - Those who received advice to quit. • Discussing Cessation Medications - Those for whom cessation medications were recommended or discussed. • Discussing Cessation Strategies - Those for whom cessation methods or strategies were recommended or discussed.

Adult Measure Results

Adult measures reported for CAHPS® include four rating and four composite measures. The following table presents the average for each health plan compared to fee-for-service, overall State Medicaid, and the NCQA National Percentile Benchmarks.

Satisfaction and Experience with Provider Networks:

Overall for adults, consumer experience with the provider network is very positive across plans and for the state as a whole. Consumers responses indicated almost all plans, including new plans and fee-for-service, are performing at the 90th percentile on all measures related to personal doctors and level of communication from doctors. Many doctors and specialists are enrolled with multiple health plans, therefore, it is difficult to determine the impact of the health plan on these measures.

Measure	Absolute Total Care	Blue Cross	First Choice	United-Healthcare	Carolina Medical Homes*	Palmetto Physician Connec-tions*	SC Solutions	Fee-For-Service	State Overall	25th	50th	75th	90th
Satisfaction and Experience with Provider Networks													
How Well Doctors Communicate	2.74	2.69	2.67	2.70	2.71	2.70	2.74	2.70	2.71	2.48	2.54	2.58	2.64
Rating of Personal Doctor	2.69	2.57	2.55	2.61	2.57	2.57	2.68	2.69	2.62	2.40	2.45	2.51	2.56
Rating of Specialists	2.51	2.73	2.38	2.69	2.63	2.70	2.58	2.65	2.61	2.41	2.46	2.50	2.56
Satisfaction and Experience With Access to Care and Health Plan													
Get Needed Care	2.08	2.29	2.19	2.26	2.17	2.19	2.41	2.42	2.25	2.18	2.28	2.35	2.42
Get Care Quickly	2.45	2.53	2.46	2.46	2.37	2.44	2.51	2.50	2.47	2.32	2.39	2.43	2.47
Customer Service	2.48	2.42	2.51	2.50	2.31	2.25	2.47	2.33	2.41	2.32	2.40	2.47	2.53
Rating of Health Plan	2.37	2.23	2.46	2.34	2.27	2.33	2.52	2.43	2.37	2.31	2.38	2.46	2.54
Satisfaction and Experience With Care													
Rating of Health Care	2.38	2.33	2.45	2.36	2.30	2.29	2.46	2.33	2.36	2.23	2.29	2.35	2.39

Red=Below 25th percentile
Green=75th percentile and above
*=New Plan

Satisfaction and Experience with Access to Care and Health Plan:
Access to care is critical to quality of care and the overall health of the Medicaid population. In this domain overall, health plans did not perform as well as fee-for-service. There is significant variability across health plans' performance particularly in getting appointments with specialists and getting tests or treatment through the health plan (*Getting Needed Care*). Compared to CY 2010, only one plan improved performance in this area in CY 2011, while three plans performed at a lower percentile ranking including one below the 25th percentile. This, in conjunction with the low performance of the two new plans, pushed the overall state average to below the 50th percentile. This is clearly an area where all plans should focus efforts to improve the consumer's access to care, particularly specialists and additional lab work and tests.

Most health plans and the state as a whole performed better on measures relating to how quickly they were able to get care or schedule appointments at a doctor's office or clinic (*Getting Care Quickly*). All plans except one of the new plans performed at the 75th percentile or above.

Consumers' overall rating of health plans is an area needing attention. *Getting Needed Care* and *Customer Service* are two areas that affects consumers' views of their health plan. The variability in performance across plans in both of these areas suggests opportunities for improvement at the plan level.

Satisfaction and Experience with Care:
Ratings of overall health care are very positive with most established health plans achieving at or above the 75th percentile while fee-for-service is between 50th and 74th percentile.

Individual Measure–Medical Assistance with Smoking Cessation

Health behaviors related to smoking account for significant health care costs in Medicaid. One-third (33%) of adult respondents indicated that they currently smoke either every day or some days. This percentage was fairly consistent across all health plans with the highest being 38% and fee-for-service having the lowest percentage (21%) of active smokers. The numbers are comparable to 2009 and 2010 levels. Two-thirds (66% or greater) of smoking consumers reported being advised to quit smoking by their doctor or other health care provider, ranging from 60% to 70% across plans and 73% for fee-for-service. More than one-third of smoking consumers reported receiving specific advice regarding either medication or other strategies to stop smoking, with as many as 44% and 48% in one plan receiving counseling in these strategies. These results offer opportunities for plans to educate both physicians and members about effective "stop smoking" strategies.

While last year's CAHPS® measures will serve as a baseline for consumer experience measures for monitoring the potential impact of Medicaid rate cuts on access to services, this year's measures will serve as the baseline for withholds and incentives.

CAHPS ADULT SC Medicaid

Questions	Absolute Total Care	Blue Choice	First Choice	SC Solutions	United-Healthcare	Fee-For-Service	Carolina Medical	Palmetto Physician Connections	State Medicaid Rate
Medical Assistance with Smoking Cessation									
Advised to Quit	64%	62%	69%	70%	69%	73%	62%	60%	66%
Discussed Medication	42%	33%	42%	38%	44%	38%	33%	36%	38%
Discussed Other Strategies	39%	36%	42%	48%	40%	34%	34%	35%	39%

Child Measure Results

Child measures on CAHPS® include the same eight measures listed for adults The following table presents the average for each health plan compared to fee-for-service, overall State Medicaid, and the NCQA National Percentile Benchmarks.

Measure	Absolute Total Care	Blue Cross	First Choice	United-Healthcare	Carolina Medical Homes*	Palmetto Physician Connec-tions*	SC Solutions	Fee-For-Service	State Overall	National Percentiles 25th	50th	75th	90th
Satisfaction and Experience with Provider Network													
How Well Doctors Communicate	2.86	2.83	2.81	2.82	2.80	2.76	2.84	2.85	2.82	2.63	2.68	2.72	2.75
Rating of Personal Doctor	2.80	2.71	2.85	2.81	2.72	2.76	2.75	2.78	2.78	2.58	2.62	2.65	2.69
Rating of Specialists	2.64	2.66	2.62	2.77	2.64	2.80	2.73	2.76	2.71	2.53	2.59	2.62	2.66
Satisfaction and Experience With Access to Care and Health Plan													
Get Needed Care	2.38	2.45	2.46	2.38	2.31	2.41	2.65	2.52	2.46	2.29	2.36	2.44	2.50
Get Care Quickly	2.71	2.62	2.68	2.65	2.56	2.67	2.69	2.77	2.67	2.54	2.61	2.66	2.69
Customer Service	2.50	2.42	2.47	2.72	2.17	2.28	2.46	2.33	2.42	2.31	2.40	2.47	2.53
Rating of Health Plan	2.62	2.58	2.72	2.66	2.45	2.54	2.69	2.62	2.61	2.51	2.57	2.62	2.67
Satisfaction and Experience With Care													
Rating of Health Care	2.69	2.62	2.65	2.69	2.55	2.61	2.68	2.73	2.66	2.49	2.52	2.57	2.59

Red=Below 25th percentile
Green=75th percentile and above
*=New Plan

Satisfaction and Experience with Provider Network:
As with the adult measures, overall caregiver experience with the children's provider network is very positive, particularly on measures related to their personal doctor. Caregiver responses indicated all plans, including new plans and fee-for-service, are performing at the 90th percentile on all measures related to personal doctors and level of communication from doctors, and most plans on measures related to specialists. Many doctors are enrolled with multiple health plans, therefore, it is difficult to determine the impact of the health plan on these measures. There is greater variability in ratings of specialists which will require improvement efforts at the plan level.

Satisfaction and Experience with Access to Care and Health Plan:
As in previous years, caregivers report better experience and higher satisfaction with most Access to Care measures for children than for adults for all plans. While there is variability in performance across plans, all but one new plan is performing at or above the 50th percentile on measures related to both *Getting Needed Care* and *Getting Care Quickly.* The state overall is performing at or above the 75th percentile. Families continue to report a strong level of satisfaction with *Customer Service* with the established health plans and are able to find needed information and get help when they call their health plan. Overall ratings of the health plan are also positive for established plans.

Satisfaction and Experience with Health Care:
Ratings of overall health care are very positive with most plans achieving the 90th percentile.

Appendices


SOUTH CAROLINA
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Appendix A: Descriptions of Measures

Measure	Description
Pediatric Care	
Adolescent Well Care Visits (AWC)	The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.
Appropriate Testing for Children With Pharyngitis (CWP)	The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).
Ambulatory Care (AMB)	This measure summarizes utilization of ambulatory care for ED visits in the following categories: • AMB - AMB ER <1 Visit/1000 • AMB - AMB ER 1-9 Visit/1000 • AMB - AMB ER 10-19 Visit/1000
Lead Screening in Children (LSC)	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.
Well-Child Visits in the First 15 Months of Life (W15)	The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: • No well-child visits† • Five well-child visits • Six or more well-child visits †=*Inverted measure (lower is better.)*
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	The percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.
Women's Care	
Measure	Description
Breast Cancer Screening (BCS)	The percentage of women 40–69 years of age who had a mammogram to screen for breast cancer.
Cervical Cancer Screening (CCS)	The percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer.
Chlamydia Screening in Women (CHL)	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
Prenatal and Postpartum Care (PPC)	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. • *Timeliness of Prenatal Care:* The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. • *Postpartum Care:* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.
Ambulatory Care (AMB)	This measure summarizes utilization of ambulatory care for ED visits in the following categories: • AMB - AMB ER 20-44 Visit/1000 • AMB - AMB ER 45-64 Visit/1000 • AMB - AMB ER 65-74 Visit/1000

Appendix A: Descriptions of Measures *(continued)*

Measure	Description
Living With Illness	
Comprehensive Diabetes Care (CDC)	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following. • Hemoglobin A1c (HbA1c) testing • Eye exam (retinal) performed • LDL-C screening • Medical attention for nephropathy * *Additional exclusion criteria are required for this indicator that will result in a different eligible population from all other indicators. This indicator is only reported for the commercial and Medicaid product lines.*
Use of Appropriate Medications for People With Asthma (ASM)	The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year in the following categories: • ASM - Rate - 5-11 Years • ASM - Rate - Total
Behavioral Health	
Follow-Up After Hospitalization for Mental Illness (FUH)	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: • The percentage of members who received follow-up within 30 days of discharge • The percentage of members who received follow-up within 7 days of discharge
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. • Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. • Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. IPSD: Index Prescription Start Date. The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Access to Care	
Children and Adolescents' Access to Primary Care Practitioners (CAP)	The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line: • Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year. • Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.
Adults' Access to Preventive/Ambulatory Health Services (AAP)	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.

Consumer Measures and Descriptions	
Measure	Measure Description
Satisfaction and Experience with Provider Network (Adults and Children)	
Satisfaction with Provider Communication	The average of the responses "never," "sometimes," "usually," or "always" when members were asked how often their doctor listened to them carefully, explained things in a way they could understand, showed respect for what they had to say, and spent enough time with them.
Satisfaction with Personal Doctor	The average of member responses on a scale of 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor, when asked "How would you rate your personal doctor?"
Satisfaction with Specialist	The average of member responses on a scale of 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, when asked "How would you rate your specialist?"
Satisfaction and Experience with Access to Care and Health Plan (Adults and Children)	
Getting Needed Care	The average of the responses "never," "sometimes," "usually," or "always" when members were asked if, in the last 6 months not counting when care was needed immediately, they were able to get care or get an appointment for health care at a doctor's office or clinic as soon as needed.
Getting Care Quickly	The average of the responses "never," "sometimes," "usually," or "always" when members were asked if, in the last 6 months not counting when care was needed immediately, they were able to get care or get an appointment for health care at a doctor's office or clinic as soon as needed.
Satisfaction with Customer Service	The average of the responses "never," "sometimes," "usually," or "always" when members were asked if, in the last 6 months when they used their health plan's customer service, they received the information they needed and were treated with courtesy and respect.
Rating of Health Plan	The average of member responses on scale of 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, when asked "How would you rate your health plan?"
Satisfaction and Experience With Care (Adults and Children)	
Rating of Health Care	The average of member responses on scale of 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, when asked "How would you rate your health care?"
Medical Assistance with Smoking and Tobacco Use Cessation (Adults Only)	
Smoking Cessation	This measure is collected using the CAHPS survey methodology to arrive at an average that represents the percentage of members 18 years of age and older who were current smokers or tobacco users seen by the plan during the measurement year. For these members, the following facets of providing medical assistance with smoking cessation are assessed: • Advising Smokers and Tobacco Users to Quit - Those who received advice to quit • Discussing Cessation Medications - Those for whom cessation medications were recommended or discussed • Discussing Cessation Strategies - Those for whom cessation methods or strategies were recommended or discussed

Appendix B: SC Medicaid Health Plan Performance CY 2011

		Weighted State Average	NCQA National Medicaid Benchmarks					
			Mean	P10	P25	P50	P75	P90
PEDIATRIC CARE								
Adolescent Well-Care Visits	Reported Rate	24.3	48.1	35	39.6	46.1	57.2	64.1
Ambulatory Care*	AMB ER <1 Visit/1000	96.6	91.1	61.2	81.1	92.9	105	120
	AMB ER 1-9 Visit/1000	49.4	49.2	35.5	44.3	49.1	54.4	64.1
	AMB ER 10-19 Visit/1000	43.8	41.4	28.2	35.2	41.2	47	54.4
Appropriate Testing for Children With Pharyngitis	Reported Rate	72.8	64.9	45.1	55.1	68.1	75.7	83
Appropriate Treatment for Children With Upper Respiratory Infection†	Reported Rate	83.3	87.2	79.2	83.4	87.5	91.9	94.8
Lead Screening in Children	Reported Rate	46.2	66.2	34.6	55.5	72.2	80.5	87.6
Well-Child Visits in the First 15 Months of Life	Zero visits*	1.7	2.2	0.5	0.8	1.6	2.7	4.4
	Five visits	22.4	16.1	8.3	11.9	16.5	19.8	21.9
	Six or More visits	54.6	60.2	41.9	52.2	61.3	68.9	77.1
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Reported Rate	51.8	71.9	60.9	66.1	72.3	77.6	82.9
WOMEN'S CARE								
Breast Cancer Screening	Reported Rate	44.2	51.3	38.7	45.3	52.4	57.4	62.9
Cervical Cancer Screening	Reported Rate	43.3	67.2	53	64	69.7	74.2	78.7
Chlamydia Screening in Women	16-20 Years	53.5	54.6	42.9	48.7	53.6	60.6	66.7
	21-24 Years	65.1	62.3	50.5	57.6	62.5	68.7	72.2
	Total	58.3	57.5	46	51.5	57.2	63.4	69.1
Prenatal and Postpartum Care	Timeliness of Prenatal Care	83.8	83.7	71.4	80.3	86	90	93.2
	Postpartum Care	62.4	64.4	53.7	59.6	64.6	70.6	75.2
LIVING WITH ILLNESS								
Comprehensive Diabetes Care	HbA1c Testing	63.6	82	73.6	77.6	82.2	87.1	90.9
	Eye Exams	27.1	53.1	34	43.8	52.8	63.7	70.6
	LDL-C Screening	52.9	74.7	63.7	70.4	75.4	80.3	84.2
	Med Att Diabetic Neph.	67.3	77.7	68.1	73.9	78.5	82.5	86.9
Use of Appropriate Medications for People with Asthma**	5-11 Years	88.0	91.8	88.2	90	92.2	93.9	95.5
	Total	82.0	88.6	84.6	86.7	88.6	90.8	92.8
BEHAVIORAL HEALTH								
Follow-Up After Hospitalization for Mental Illness	7 Days	90.0	44.6	23	33.1	45.1	53.9	68.3
	30 Days	65.7	63.8	36	57.1	66.6	74.6	82.6
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Initiation	39.3	38.1	24.9	31.8	38.3	43.6	50.7
	Continuation	47.0	43.9	23	34.7	45.2	52.6	62.5
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation - 13-17 Years	85.9	44.7	24.6	33.1	44.9	54.7	65.1
	Engagement - 13-17 Years	66.3	19.9	4.4	7.6	19.4	27.4	38.1
	Initiation - 18+	45.9	42.7	31	34.6	40.4	48.4	59.4
	Engagement - 18+	20.3	13.6	2.1	5.4	13.3	19.9	25
	Initiation - Total	52.2	42.9	30	35.7	40.8	48.8	60.7
	Engagement - Total	24.3	14.2	2	5.7	14.5	20.5	25.9
ACCESS TO CARE								
Adults' Access to Preventive/Ambulatory Health Services	20-44 Years	75.6	81.2	69.3	78.5	83.2	86.4	88.4
	45-64 Years	78.4	86	78.7	84.5	87.4	89.8	91
Children and Adolescents' Access to Primary Care Practitioners	12-24 Months	95.7	96.1	92.6	95.1	97	97.8	98.6
	25 Months-6 Years	85.4	88.3	82	86.8	89.6	91.2	92.7
	7-11 Years	84.0	90.2	85.2	87.9	91.3	93.3	94.7
	12-19 Years	81.4	88.1	81.1	86.5	89.7	91.9	93.4

Green background: NCQA 75th percentile and above; or for inverted measures, below NCQA 25th percentile
White background: between NCQA 25th and 74th percentile
Red background: below NCQA 25th percentile; or for inverted measures, NCQA 75th percentile and above

NSI: denominator less than 30
Blue rates: Weighted state average and above; or for inverted measures, weighted state average and below
† Inverse rate: the measure is reported as an inverted rate [1 - (numerator/eligible population)]
* Inverted measure: lower rates indicate better performance
** Using 2010 NCQA National Medicaid Benchmarks. 2011 National Benchmark not available due to definitional change in Age Categories

Appendix C: Risk Adjustment Methodology

Adjusted Rates CY2011 Report Card – 10-3-12

State-based health outcomes across the nation show significant disparities that are in part due to nonhomogeneous regional characteristics (for example, racial profiles, age, and other factors). Although each performance measure is calculated using all data from patients across the state, the data are treated as a sample in the sense that the measurements reflect a possible year's worth of outcomes for the enrolled patients. The means of the person-level outcomes for 53 unique measure[sub-measure] of a specific plan were calculated to produce IFS crude rates (excluding measure [sub-measure] with denominator less than 30). The difference of the IFS crude rates and provider calculated rates were modeled adjusting for the proportions of male patients, clinical risk group statuses (CRGs), geographic social deprivation index groups (SADIs), and the combination of the measure and sub-measure. Once estimated, the regression model was used to generate adjustments based on the predicted difference between the IFS crude rates and the provider calculated rates excluding AMB women only sub-measures (member-months).

The adjustment is made up of an overall adjustment (independent of the measure and sub-measure), and a measure [sub-measure]-specific adjustment; both adjustments are subtracted from the crude rate. The overall adjustment for a particular plan is a linear combination of the percentages of the plan's customers:

```
Overall Adjustment
              0.052 + (-0.309)(%male)    + (-0.115)(%crg2)    + ( 0.046)(%crg3)
                    + ( 2.137)(%crg4)    + (-0.301)(%crg5)    + ( 0.060)(%crg6)
                    + (-0.984)(%crg7)    + (-0.575)(%crg8)    + ( 4.166)(%crg9)
                    + (-0.035)(%sadi1)   + (-0.074)(%sadi2)
```

The measure[sub-measure] specific adjustment is added to the overall adjustment depending on which measure[sub-measure] rate adjustment is needed.

```
Specific measure-submeasure adjustments
      aap1       aap2       add1       add2       amb1       amb2       amb3       asm0       asm1
    -0.017      0.042      0.237      0.282      0.150      0.159      0.148      0.363      0.415
      asm2       asm3       asm4       awc0       bcs0       cap1       cap2       cap3       cap4
     0.394      0.106      0.359      0.118     -0.016      0.162      0.109      0.130      0.122
      ccs0       cdc1       cdc4       cdc5       cdc7       chl0       chl1       chl2       cwp0
     0.035      0.109      0.131      0.093      0.167     -0.045     -0.030     -0.075      0.163
      lsc0       ppc1       ppc2       uri0       w151       w152       w153       w154       w155
     0.178     -0.101     -0.077      0.181      0.182      0.189      0.194      0.214      0.230
      w156       w157       w340
     0.219      0.037      0.100
```

Adjusted rate = Calculated Rate – (Specific adjustment + overall adjustment)

In addition, some of the measures are further adjusted because of poor health outcomes in the South relative to the rest of the country. These adjustments bring the state average closer to the national average so that comparisons of HEDIS measures can be fairly made against national benchmarks. This simple adjustment is written

$$P_{ai} = P_i + A_i$$

where i indexes the specific HEDIS measure, and the performance P_i is augmented by the regional adjustment A_i ($A_i \geq 0$ for all i) to define the adjusted performance P_{ai}. These adjustments are in addition to the ones outlined above.

Largest in-sample increase is for submeasure 7 of measure w15 for plan HM1600/UHC/United Health Care

Adjusted rate = rate - (specific measure/submeasure adjustment + overall adjustment)

= 0.279 - (0.037 + 0.052 + (-0.309)*(%male) + (-0.115)*(%crg2) + (0.046)*(%crg3)
+ (2.137)*(%crg4) + (-0.301)*(%crg5) + (0.060)*(%crg6)
+ (-0.984)*(%crg7) + (-0.575)*(%crg8) + (4.166)*(%crg9)
+ (-0.035)*(%sadi1) + (-0.074)*(%sadi2))

= 0.279 - (0.037 + 0.052 + (-0.309)*(0.494) + (-0.115)*(0.178) + (0.046)*(0.022)
+ (2.137)*(0.001) + (-0.301)*(0.068) + (0.060)*(0.014)
+ (-0.984)*(0.000) + (-0.575)*(0.000) + (4.166)*(0.000)
+ (-0.035)*(0.697) + (-0.074)*(0.154))

= 0.279 - (-0.137)

= 0.416

Largest in-sample decrease is for submeasure 2 of measure add for plan HM1600/UHC/United Health Care

Adjusted rate = rate - (specific measure/submeasure adjustment + overall adjustment)

= 0.618 - (0.282 + 0.052 + (-0.309)*(%male) + (-0.115)*(%crg2) + (0.046)*(%crg3)
+ (2.137)*(%crg4) + (-0.301)*(%crg5) + (0.060)*(%crg6)
+ (-0.984)*(%crg7) + (-0.575)*(%crg8) + (4.166)*(%crg9)
+ (-0.035)*(%sadi1) + (-0.074)*(%sadi2))

= 0.618 - (0.282 + 0.052 + (-0.309)*(0.605) + (-0.115)*(0.000) + (0.046)*(0.513)
+ (2.137)*(0.013) + (-0.301)*(0.250) + (0.060)*(0.105)
+ (-0.984)*(0.000) + (-0.575)*(0.000) + (4.166)*(0.013)
+ (-0.035)*(0.781) + (-0.074)*(0.096))

= 0.618 - (0.149)

= 0.469


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