South Carolina Department of
Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

October 14, 2011

The Honorable Hugh K. Leatherman, Sr.
Chairman, Senate Finance Committee
111 Gressette Building
Columbia, South Carolina 29201

The Honorable W. Brian White
Chairman, House Ways & Means Committee
519C Blatt Building
Columbia, South Carolina 29201

Dear Chairman Leatherman and Chairman White:

Attached you will find both the 2011 Medicaid Cost Effectiveness and Medicaid Health Care Performance reports. Required by legislative proviso 21.33, these annual reports not only help hold SCDHHS accountable for its coordinated care strategy and execution, but also provide a management tool for SCDHHS to help improve health plan and provider performance in pursuit of our mission to purchase the most health for those in need at the least cost to our taxpayers.

The two reports find that coordinated care in Medicaid produces higher quality and lower cost compared to the traditional fee for service system. This is not surprising given national research and experience demonstrating similar findings. Going forward I believe we should not stop at asking if Medicaid coordinated care is working better in South Carolina than fee for service — it is, and has steadily been improving. We must instead focus on asking if Medicaid coordinated care in South Carolina is achieving national best practice performance and if not, how can we improve?

A close examination of the Medicaid Health Care Performance report reveals while some South Carolina plans and performance measures rank among the best in the nation, there is considerable variation, which leaves significant room for improvement. The ratings also provide insights on the performance of Medicaid providers in South Carolina. Many of the quality and satisfaction measures described in this report are highly dependent on providers to achieve. Are routine screenings performed during office visits, do providers communicate well with patients, and do providers consistently follow best clinical practices?

All of this must be considered within the context of the federal and state regulations and policy choices under which the plans and providers must operate. For example, federal limitations on patient incentives or penalties for certain health behaviors, the current state policy of carving mental health out of coordinated care, and the myriad of state and federal contractual requirements all effect cost and quality.

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The Department intends to use these reports as a launching pad for our efforts to take our coordinated care system to a higher level of performance. It is possible that in a few years more than 1.5 million South Carolinians will be enrolled in Medicaid. It is crucial under any health reform scenario that as our population ages, and the prevalence of obesity, mental illness and other chronic conditions continue to climb, that we better coordinate care for patients using the best clinical evidence possible. It is just as crucial that we reward high quality/low cost plans and providers by aligning incentives across the continuum of care and pay for value delivered by providers, not volume.

Working with a Coordinated Care Improvement Group of health plan, hospitals, physicians and consumers in a series of open meetings, the department will assemble a series of recommendations for improvement. The first meeting of this group was held October 13, 2011 and will meet monthly for several months. Future dates will be posted at the SCDHHS website as they are scheduled.

We appreciate your continued support of the South Carolina Medicaid program. If you have comments or questions, please contact Bryan Kost at (803) 898-2865.

Sincerely,

Anthony E. Keck
Director

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October 6, 2011

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/vrr

Attachments

Milliman

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

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October 6, 2011

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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, 2010 through March 31, 2011.

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 2010 through March 2011. The expenditures for each program were limited to services included in the MCO capitation rates (i.e., excludes carve-out expenditures) and mental health expenditures that are paid on a fee-for-service 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 6.0% and the MCO program saves 7.0% compared to the FFS program.

Table 1
South Carolina Department of Health and Human Services
Risk Adjusted April 2010 – March 2011 Cost Per Member Per Month (PMPM)

Population	FFS Cost PMPM	MCO Cost PMPM	MHN Cost PMPM
TANF Children	$158.39	$129.19	$129.99
TANF Adult	386.54	391.18	394.24
SSI	929.22	927.12	941.75
Total	296.04	275.28	278.30
Ratio of Total Cost to Total FFS Cost	100.0%	93.0%	94.0%

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 fee-for-service Medicaid programs as a result of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act.

DATA RELIANCE AND IMPORTANT CAVEATS

We used fee-for-service cost and eligibility data for April 2010 through March 2011 dates of service, and several other analyses to determine the cost effectiveness of the Medicaid managed care programs compared to fee-for-service. 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, 2011 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 fee-for-service system.

With the help of MCOs and MHNs, SC DHHS seeks to increase care coordination and disease prevention methods not found in traditional fee-for-service 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 2010 to March 2011 period. In order to consistently assess the cost effectiveness of the two managed care programs compared to FFS, we needed to limit 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 and mental health services paid on a fee-for-service 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 fee-for-service, while the higher delivery costs may occur in an MCO or under the MHN enrollment period. The cost for newborns presents similar challenge with the accounting for the MCO Low Birth Weight and Very Low Birth Weight kicker payments paid on a quarterly basis and the pool reconciled at the end of the contract year.

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

Please refer to our March 9, 2010 and October 4, 2010 MCO rate setting reports for a detailed description of the benefits included in the MCO capitation rates during the April 2010 – March 2011 rate period.

FFS POPULATION COST

To calculate the FFS population cost, we summarized the April 2010 – March 2011 fee-for-service 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 August 31, 2011 allowing for five months of run-out for the April 2010 – March 2011 study period. The Incurred But Not Reported (IBNR) adjustment reflects an estimate of the claims that will be paid after August 31, 2011.

The annual completion factors were developed using a composite of the lag 5 through 16 completion factors for the April 2010 – March 2011 study period and are shown in Table 4 below.

Table 4 South Carolina Department of Health and Human Services April 2010 – March 2011 Completion Factors				
Service Category	**Infants**	**TANF Children**	**TANF Adult**	**SSI**
Hospital Inpatient	0.990	0.995	0.993	0.925
Hospital Outpatient	0.997	0.994	0.993	0.970
Physician	0.995	0.993	0.991	0.978
Lab and X-Ray	0.998	0.995	0.994	0.989
Pharmacy	1.000	1.000	1.000	0.998
DME and Prosthetics	0.994	0.989	0.973	0.980
Ambulance	0.999	0.999	0.997	0.987
Home Health	0.996	0.998	0.987	0.968

We then applied an adjustment for Third Party Liability to reflect recoveries that are not included in the claims data. We used a 0.996 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 fee-for-service 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 2010 – March 2011 FFS population cost.

Table 5 South Carolina Department of Health and Human Services April 2010 – March 2011 FFS Population Cost					
Rate Cell	**Gender**	**FFS April 2010 – March 2011 MCO Eligible Member Months**	**Medical Cost PMPM**	**Rx Cost PMPM**	**Total Cost PMPM**
TANF: 3 - 12 months old	Unisex	109,434	$307.82	$21.00	$328.82
TANF: Age 1 - 6	Unisex	385,889	103.37	25.34	128.71
TANF: Age 7 - 13	Unisex	350,259	108.32	54.01	162.33
TANF: Age 14 - 18	Male	115,019	192.53	55.97	248.50
TANF: Age 14 - 18	Female	116,098	207.11	52.45	259.56
TANF: Age 19 - 44	Male	37,986	273.32	69.50	342.82
TANF: Age 19 - 44	Female	164,900	293.74	78.79	372.53
TANF: Age 45+	Unisex	25,860	484.76	153.23	637.99
SSI	Unisex	300,734	780.82	261.95	1,042.77
TANF Children			$146.47	$40.42	$186.89
TANF Adult			311.94	85.66	397.61
SSI			780.82	261.95	1,042.77
Risk Adjusted					
TANF Children			$124.14	$34.26	$158.39
TANF Adult			303.26	83.28	386.54
SSI			695.79	233.43	929.22

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 fee-for-service program.

Table 6 below shows the development of the MCO population cost.

Table 6
South Carolina Department of Health and Human Services
April 2010 – March 2011 MCO Population Cost

Rate Cell	Gender	April 2010 – March 2011 MCO Eligible Member Months	Medical Capitation PMPM*	Rx Capitation PMPM	Mental Health FFS Cost PMPM	Total Cost PMPM
TANF: 3 - 12 months old	Unisex	253,598	$213.16	$28.54	$0.33	$242.03
TANF: Age 1 - 6	Unisex	1,313,217	83.00	20.60	1.29	104.89
TANF: Age 7 - 13	Unisex	1,121,032	60.26	33.72	5.69	99.67
TANF: Age 14 - 18	Male	300,115	75.90	34.12	10.89	120.90
TANF: Age 14 - 18	Female	329,413	111.91	33.75	13.71	159.37
TANF: Age 19 - 44	Male	95,411	234.18	60.16	6.47	300.81
TANF: Age 19 - 44	Female	511,295	292.66	69.72	9.52	371.90
TANF: Age 45+	Unisex	65,143	453.71	134.04	6.20	593.95
SSI	Unisex	560,287	634.90	189.14	27.25	851.29
TANF Children			$87.49	$28.17	$4.81	$120.47
TANF Adult			299.97	74.60	8.76	383.33
SSI			634.90	189.14	27.25	851.29
Risk Adjusted						
TANF Children			$93.83	$30.21	$5.15	$129.19
TANF Adult			306.11	76.13	8.94	391.18
SSI			691.46	205.98	29.68	927.12

**Includes $1.88 PMPM for FQHC / RHC wraparound payments.*

For the capitation amount component, we summarized the MCO enrollment during the April 2010 – March 2011 analysis period and developed composite capitation rates PMPM using the April 2010 – September 2010 and October 2010 – March 2011 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 $1.88 PMPM for April 2010 – March 2011. We reflected these payments as a flat PMPM amount by rate cell.

For the mental health cost component, we summarized the April 2010 – March 2011 fee-for-service 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 2010 – March 2011 fee-for-service expenditures for service 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 Incurred But Not Reported (IBNR) claims. The claims data used in developing the FFS cost component includes claims paid through August 31, 2011 allowing for five months of run-out for the April 2010 – March 2011 study period. The Incurred But Not Reported (IBNR) adjustment reflects an estimate of the claims that will be paid after August 31, 2011. 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 0.996 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 2010 – March 2011 MHN population cost.

Table 7
South Carolina Department of Health and Human Services
April 2010 – March 2011 MHN Cost Component

Rate Cell	Gender	MHN April 2010 – March 2011 MCO Eligible Member Months	Medical Cost PMPM	Rx Cost PMPM	MHN Management Fee PMPM	Total Cost PMPM
TANF: 3 - 12 months old	Unisex	37,647	$179.99	$20.58	$10.00	$210.57
TANF: Age 1 - 6	Unisex	368,123	90.41	23.52	10.00	123.93
TANF: Age 7 - 13	Unisex	328,084	69.79	46.31	10.00	126.10
TANF: Age 14 - 18	Male	89,218	84.31	44.37	10.00	138.68
TANF: Age 14 - 18	Female	92,065	125.35	42.05	10.00	177.40
TANF: Age 19 - 44	Male	18,803	257.10	80.52	10.00	347.62
TANF: Age 19 - 44	Female	90,484	292.23	90.49	10.00	392.72
TANF: Age 45+	Unisex	14,018	464.92	178.31	10.00	653.23
SSI	Unisex	146,809	691.95	265.62	10.00	967.57
TANF Children			$89.62	$35.47	$10.00	$135.09
TANF Adult			306.51	98.95	10.00	415.46
SSI			691.95	265.62	10.00	967.57
		Risk Adjusted				
TANF Children			$85.97	$34.02	$10.00	$129.99
TANF Adult			290.47	93.78	10.00	394.24
SSI			673.29	258.46	10.00	941.75

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 2010 – March 2011 Risk Scores

Eligibility Group	FFS Population	MCO Population	MHN Population	Total Population
TANF Children	1.180	0.932	1.042	1.000
TANF Adult	1.029	0.980	1.055	1.000
SSI	1.122	0.918	1.028	1.000

SOUTH CAROLINA

Medicaid Health Care Performance CY 2010

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

September 2011

The Institute for Families In Society
Policy and Research Unit on Medicaid and Medicare

UNIVERSITY OF SOUTH CAROLINA

South Carolina Medicaid Health Care Performance CY 2010

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

September 2011

Prepared by the Policy and Research Unit on Medicaid and Medicare,
The Institute for Families in Society,
University of South Carolina
under contract to the
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University of South Carolina, Survey Research Lab

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Lòpez-De Fede, A., Mayfield-Smith, K., Brantley, V., Zhu, S., Zhang, X., Stewart, J., Rodgers, M., & Harris, T. (2011). South Carolina Medicaid health care performance CY 2010: 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

Quality assessment and performance improvement is a central element in South Carolina's value-based purchasing strategy. Almost one million South Carolinians receive their health insurance through a Medicaid managed care plan or fee-for-service. This report is the third submitted by the South Carolina Department of Health and Human Services (DHHS) about the quality of the health care provided by these plans, and the health care providers with whom they partner, to their members and stakeholders. Public reporting of the data supports transparency and accountability.

Another important goal of this report is to measure and improve the quality of care received by Medicaid recipients across types of health plans. Federal law requires various quality monitoring and improvement processes for capitated managed care organizations in Medicaid. However, South Carolinians enrolled in Medicaid are also served by medical home networks (MHN) or fee-for-service arrangements. These health plan arrangements do not have comparable federal requirements for quality monitoring or improvement. As such, the use of administrative claims allows DHHS to measure and monitor quality of care for all recipients applying the same set of evaluation standards.

The 2010 report represents the care received during the period from January 1, 2010, through December 31, 2010, which encompasses the state calendar year (CY) for South Carolinians enrolled in Medicaid. The Institute for Families in Society (IFS), Policy and Research Unit 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 managed care plan-specific and comparative basis. The data presented represent a subset of the Health-care 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.

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. Additional questions address specific experiences related to health and wellness behavior.

Measures Selected for CY 2010 Reporting

The South Carolina Medicaid measurement set for CY 2010 focused on a subset of 18 HEDIS measures corresponding to 43 rates across 6 domains:

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[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). It is the most widely used set of standardized performance measures to evaluate and report on the quality of care delivered by health care organizations.

[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). It is the most comprehensive tool available and has been used extensively with consumers in Medicaid.

Of the forty-three HEDIS rates reported in CY 2010, thirty-one rates increased from CY 2009, indicating progress towards meeting the 75th percentile goal in CY 2011.

- 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);
- Behavior 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).

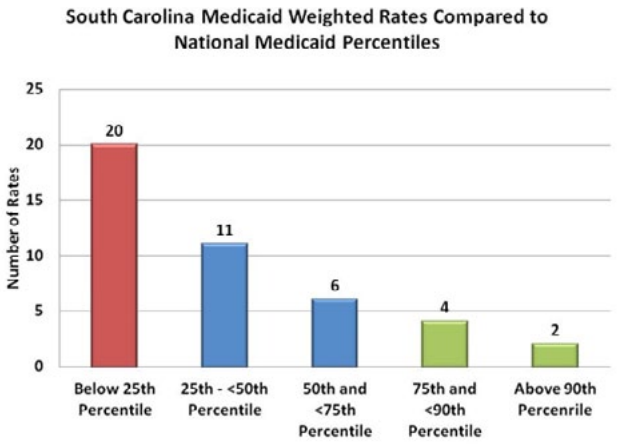
The performance measures reflect many significant public health issues, such as cancer, heart disease, smoking, diabetes, the care of pregnant women and children, affecting the lives of South Carolinians.

Key Findings

Results from the CY 2010 SC Medicaid Program demonstrate that managed care plans performed well overall compared to the 2010 rates for fee-for-service. The results will be compared with other Medicaid plans around the country. Throughout this report, we will give results of tests of statistical significance comparing the performance of individual plans with that of the Medicaid Mean of plans reporting HEDIS data for 2010 (represented by the 2010 National Medicaid Mean, obtained from NCQA's Quality Compass® database). South Carolina performed best, relative to this national benchmark on seven measures across the domains. Of the 43 rates, 6 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 2010.

South Carolina health plans performed best relative to select children measures across the seven domains: Appropriate Testing for Children with Pharyngitis; Well-Child Visits Zero Visits (12 –24 months); Use of Appropriate Medication for People with Asthma (5–50 years); Follow-Up with Percent Prescribed ADHD Medication (Continuation Phase); Initiation and Engagement of Alcohol and Other Drug Dependent Treatment (13–17 years); and Children and Adolescent Access to Primary Care Practitioners (12–24 months). Although this represents a major milestone, the program statewide fell at or below the 25th percentile in (20 rates). The 25th percentile ranks these results nationally with plans ranking among the lowest of all Medicaid plans reporting HEDIS data for 2010 (Figure 1).

Figure 1



In areas of *consumer experience and satisfaction*, this report includes seven global and composite measures for adults and children. There is considerable variability across health plans in performance on these measures for both children and adults. Several plans and fee-for-service improved on selected measures pushing the overall state performance in the upward direction. The state and individual health plans perform the best in measures related to provider communication. Of the fourteen measures comparable to national benchmarks, SC Medicaid performed above the 50th percentile on two measures, above the 75th percentile on six measures and above the 90th percentile on six measures.

Health behaviors related to smoking account for significant health care costs in Medicaid. Over one-third (34%) 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.

Summary of Overall Results

Although DHHS Medicaid performed well statewide on many measures in this report, the health plans did not meet Medicaid national averages for several indicators of quality of care (Health Plans Report Card). DHHS has undertaken initiatives on reducing the rates of low weight births, reduction in 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. These efforts will allow the Medicaid program to continue to provide efficient, value-based, high-quality health care. The end result will be improving the health of all South Carolinians.

The overall 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. The reader is encouraged to use the legend to interpret the results.

2010 South Carolina Medicaid Health Plans Report Card

		Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Statewide Overall
PEDIATRIC CARE	**Adolescent Well-Care Visits**	★	★	★★	★	★	★	★
	Appropriate Use of Antibiotics: Treatment for Children With Upper Respiratory Infection (URI) †	★★★	★	★★	★★	★★★	★	★★
	Appropriate Testing for Children With Pharyngitis	★★★★	★★★	★★★	★★★★	★★★	★★★★	★★★
	Emergency Department (ED) Visits Per 1000 *(New Measure)*‡							
	Ages <1 Years	★★	★★	★★	★★	★	★	★
	Ages 1-9 Years	★	★	★	★	★	★	★
	Ages 10-19 Years	★★	★★	★★	★★★	★★	★★	★★
	Lead Screening in Children Age 2 Years and Under	★	★	★	★	★	★	★
	Well-Child Visits							
	Ages 0 Through 15 Months: 0 Visits*	★★★★	★★★★	★★★	★★★	★★★	★★★★	★★★
	Ages 0 Through 15 Months: 6 or More Visits	★	★	★★	★★	★	★	★
	Ages 3 Through 6 Years	★	★	★★	★	★	★	★
WOMEN'S CARE	**Breast Cancer Screening: Total**	★	★	★★★	★★	★★★	★	★
	Cervical Cancer Screening (PAP Test)	★	★	★★	★	★★★	★	★
	Chlamydia Screening *(New Measure)*							
	16 to 20 Years	★★★	★★★	★★★	★★★	★★★	★★★	★★★
	21 to 24 Years	★★★	★★	★★★	★★★	★★★	★★	★★
	Combined Rate	★★★	★★★	★★★	★★★	★★★	★★	★★
	Emergency Department (ED) Visits Per 1000 - Ambulatory Care *(New Measure)* ‡							
	Ages 20-44 Years	★★★★	★★★★	★★★	★★★★★	★★★	★	★★
	Ages 45-64 Years	★★★★	★★★★★	★★★★	★★★	★★★	★★★	★★★
	Ages 65-74 Years	NSI	NSI	NSI	★★★★	NSI	★★★	★★★★
	Prenatal and Postpartum Care							
	Timeliness of Prenatal Care	★★	★★	★★	★	★★	★	★
	Postpartum Care	★★★	★★	★★★	★★	★★	★★	★★
LIVING WITH ILLNESS	**Comprehensive Diabetes Care**							
	HbA1c Testing	★★	★	★★	★	★★	★	★
	Eye Exam	★	★	★★	★★	★	★	★
	LDL-C Screening	★★	★	★★	★	★	★	★
	Medical Attention for Diabetic Nephropathy	★★	★★★	★★★	★	★★	★	★
	Use of Appropriate Medications for People With Asthma							
	Ages 5-11 Years	★★★★★	★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★
	Ages 12-50 Years	★★★★★	★★★★★	★★★★★	★★★★★	★★★★	★★★★★	★★★★
	Combined Rate	★★★★★	★★★★	★★★★★	★★★★★	★★★★	★★★★★	★★★★★
BEHAVIORAL HEALTH	**Attention-Deficit Hyperactivity Disorder (ADHD): % Ages 6 to 12 Years With an ADHD Prescription Who Had a Follow-Up During 30-Day**							
	Initiation Phase	★★★★	★★★★★	★★★★★	★★★★	★★★★	★★★★	★★★★
	Continuation and Maintenance Phase	★★★★	★★★★★	★★★★★	★★★	★★★★★	★★★★	★★★★
	Follow-up Care After Hospitalization for Mental Illness - Ages 6 Years and Above							
	Within 7 Days	★★	★★★	★★★	★★	★★	★★	★★
	Within 30 Days	★★★	★★★	★★★	★★	★★★	★★	★★
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment *(New Measure)*							
	Initiation (Ages 13-17 Years)	★★★	★★★★★	★★★	★★★★	★★★★★	★★★★	★★★
	Initiation (Ages 18+)	★★	★★	★	★	★	★	★
	Initiation (Total)	★★	★★	★★	★	★	★	★
	Engagement (Ages 13-17 Years)	★★★★	★★★★★	★★★★	★★★★	★★★★★	★★★★	★★★★
	Engagement (Ages 18+)	★★★	★★★	★★★	★★	★★★	★★	★★
	Engagement (Total)	★★★	★★★	★★★	★★	★★★	★★	★★
ACCESS TO CARE	**Child and Adolescent Access to Primary Care**							
	Ages 12-24 Months	★★★★	★★★	★★★★★	★★★★★	★★★★★	★★	★★★★
	Ages 25 Months - 6 Years	★	★	★★★★	★	★	★	★
	Ages 7-11 Years	★	★	★★★★	★	★★	★	★★
	Ages 12-19 Years	★	★	★★★	★	★★	★	★★
	Adult Access to Preventative Ambulatory Health Services							
	Ages 20-44 Years	★★	★★	★★★★	★	★★★	★	★
	Ages 45-64 Years	★	★	★★★★	★	★	★	★

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

† = Inverse rate (higher is better)
‡ = Higher is better
* = Inverted measure (lower is better)
NSI = Not sufficient information.

Note: Ratings are for CY 2010 compared to 2010 NCQA Medicaid Benchmark.
Data Source: SC Medicaid claims 1/1/10–12/31/10 adjudicated through 5/2011.

Health Plans Report Card

		Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Healthcare	Fee-for-Service	Statewide Overall
SATISFACTION AND EXPERIENCE WITH PROVIDER NETWORK	**Doctor Communicates Well with Patient**							
	Adult	★★★★★	★★★★★	★★★★★	★★★★★	★★★★	★★★★★	★★★★★
	Child	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
	Rating of Personal Doctor							
	Adult	★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
	Child	★★★★★	★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
SATISFACTION AND EXPERIENCE WITH ACCESS TO CARE AND HEALTH PLAN	**Get Needed Care**							
	Adult	★★	★★	★★★★	★★★★	★★★	★★★★★	★★★★
	Child	★★★★	★★★	★★★★★	★★★★★	★★★★★	★★★	★★★★
	Get Care Quickly							
	Adult	★★★★★	★★★	★★★★	★★★★★	★★★★	★★★★★	★★★★★
	Child	★★★★★	★★★	★★★★★	★★★★★	★★	★★★	★★★★
	Customer Service							
	Adult	★★	★★★	★★★★★	★★	★★★★★	★★★★	★★★★
	Child	★★★★★	★★★★★	★★★★★	★★★★	★★★★	★★★	★★★★
	Overall Rating of Health Plan							
	Adult	★	★★	★★★★	★★★★	★★	★★★★	★★★
	Child	★★	★★	★★★★★	★★★★★	★★★★	★★★	★★★
EXPERIENCE WITH CARE	**Overall 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

Note: Ratings are for CY 2010 compared to 2010 NCQA Medicaid Benchmark.
Data Source: CAHPS 4.0 Adult and Child Surveys

Recommendations

This report provides a road map for quality improvement efforts. A focus on low-performing areas will substantially result in quality improvement. Targeted efforts on the following indicators would support quality improvement with movement towards South Carolina achieving, at minimum, the 75th National Medicaid Percentile Benchmark. Targeted efforts across the following dimensions are recommended for quality improvement in CY 2011.

PEDIATRIC CARE

The ***Adolescent Well-Care Visits*** rates are below the 50th National Medicaid Percentile Benchmark. This is the third consecutive year this measure's rates were below the 25th percentile. A major reason for this poor outcome is the Medicaid policy to pay for adolescent well-care visits every other year and not annually 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. Changing this reimbursement policy would result in 56% of adolescents enrolled in Medicaid receiving annual well-care visits.

Emergency Department (ED) Visits per 1000 (Birth to 19 Years) is a newly reported measure requiring the focused efforts at the agency and health plan levels. 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).

Lead Screening (<2 Years) is a Medicaid-specific HEDIS measure. Elevated blood lead levels (BLLs) are a significant and preventable health issue that can adversely affect children's physical and mental health. Elevated BLLs can cause damage to a child's brain, kidneys, bone marrow, central nervous system, and other body systems. At high levels, it can even cause coma, convulsions, and death. Nationally, children in Medicaid are a high-risk group and comprise almost 80% of children with elevated BLLs. Screening children for elevated BLLs is not only important from a health stand point; it is significant from a financial perspective.

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 clinical outcomes and reduce avoidable hospitalizations, a targeted focus on improving well-child visits for infants and young children must improve to performance levels at the 50th National Medicaid Percentile Benchmark.

WOMEN'S CARE

Breast and Cervical Cancer Screenings rates are below the 50th 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 is an important health care priority.

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 key outcomes linked with low prenatal and postpartum rates.

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 2010

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

September 2011

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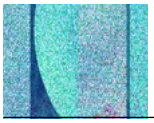
Dimensions of Care *(continued)*



Introduction

Purpose of the Report

This report presents the results of the South Carolina Medicaid Program Healthcare Effectiveness Data and Information Set (HEDIS®) 2010 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 2010 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 2010 and obtained through Medicaid administrative claims and encounter records. IFS followed the guidelines in *HEDIS® 2010 Volume 2: Technical Specifications* in developing this report.

The administrative claims of 810,547 individuals provided the data for the quality HEDIS component of 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. Survey items in addition to the core CAHPS® questions include targeted questions related to health and wellness behavior. IFS followed the guidelines in *HEDIS® 2010 Volume 3: Specifications for Survey Measures*.

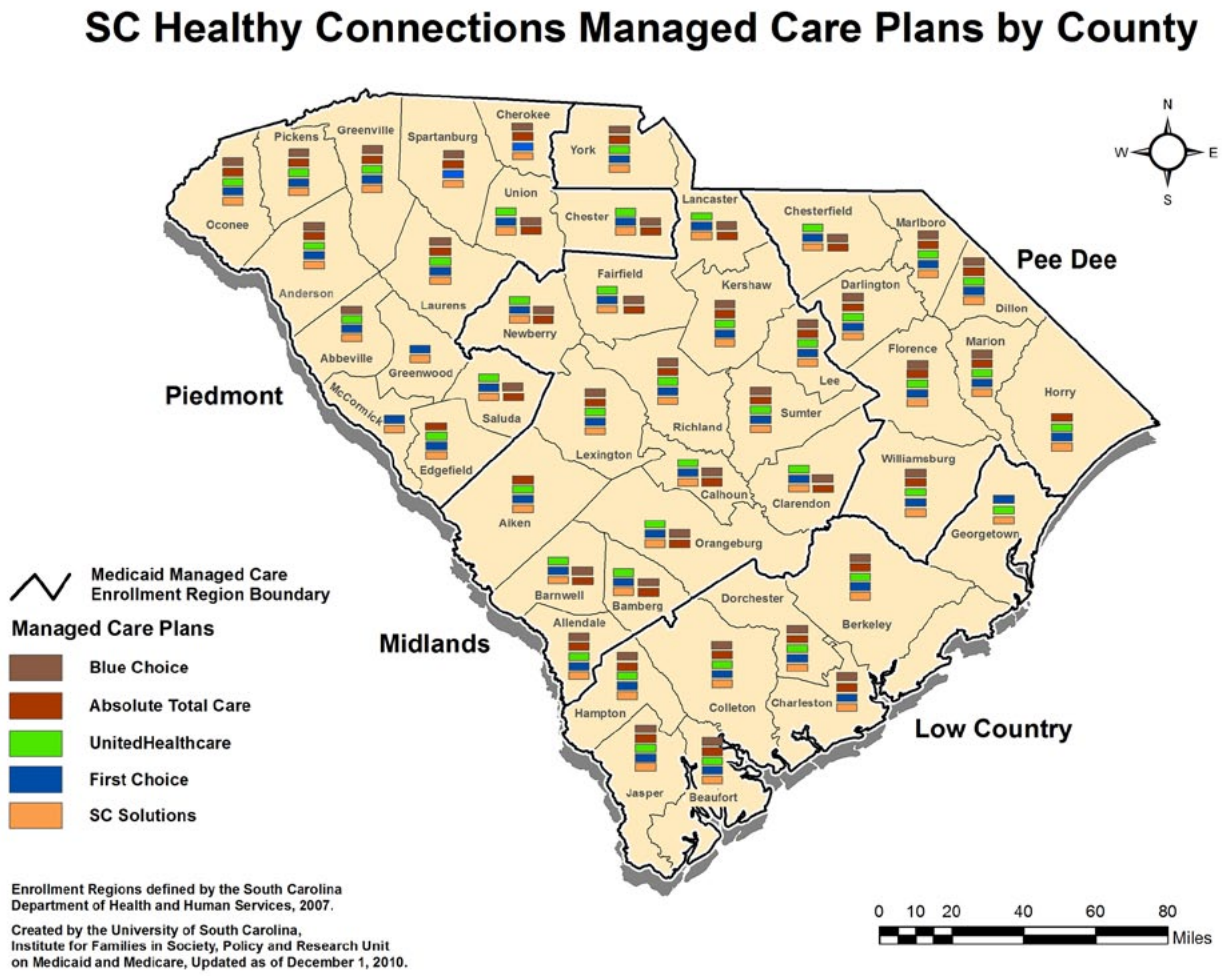
Survey Process

A stratified random sample of child and adult participants enrolled in the Medicaid health plans during CY 2010 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 300 surveys was completed for adult members and 300 for child members for each health plan, and 500 each for children and adults in fee-for-service. A total of 4,274 surveys was completed with an overall response rate of 40% (4,274 completed/10,693 sampled) which is above the standard Medicaid response rate. The response rates by group were: Adults—36% (2,028 completed/5,629 sample) and Children—44% (2,246 completed/5,064 sample).

Geographic Presence of Health Plans

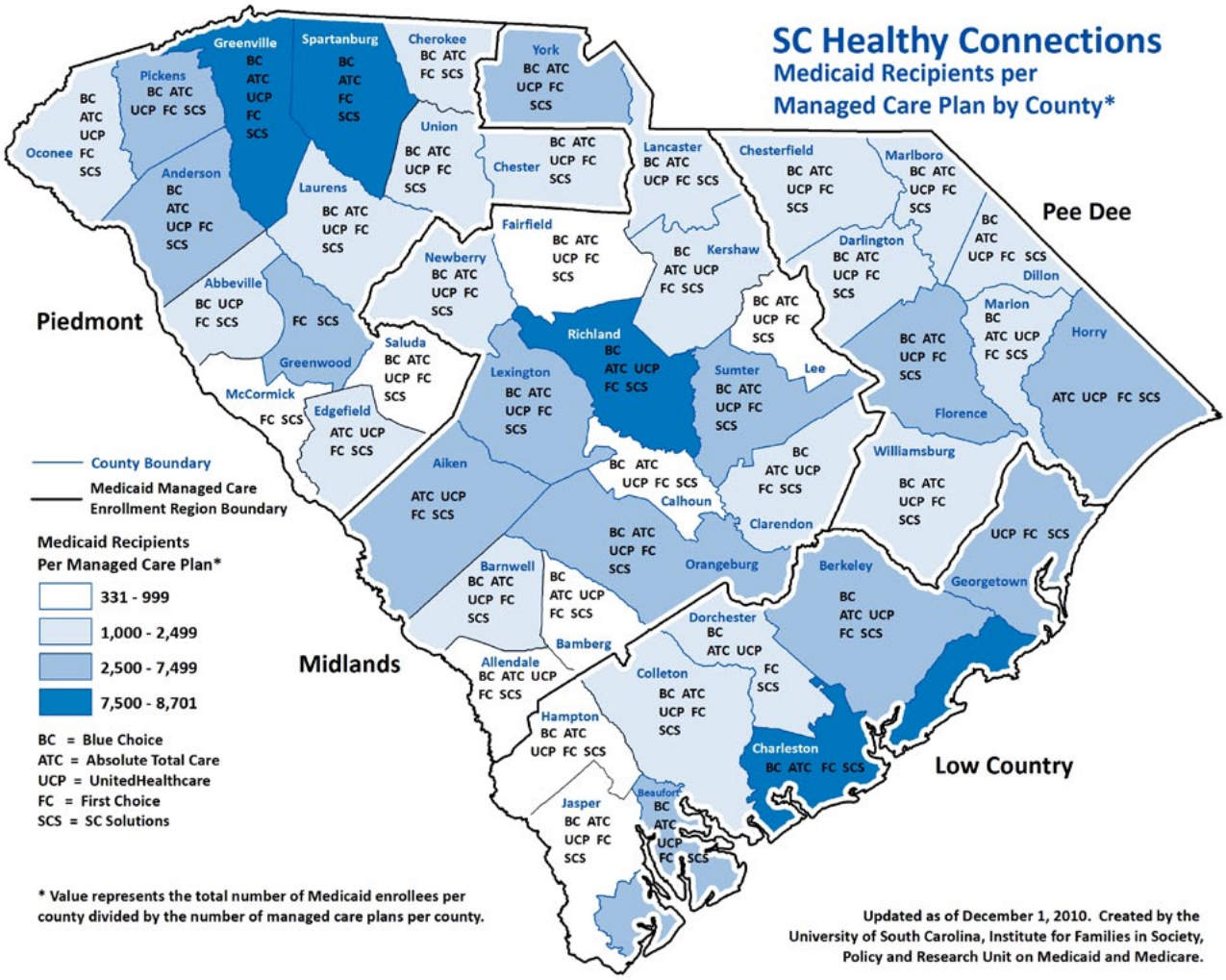
This report contains information on five managed care plans. In CY 2010, the number of managed care plans available in South Carolina decreased from six to five, as Carolina Crescent merged with Absolute Total Care. Two of the five remaining plans—SC Solutions and First Choice—maintained a presence in all 46 counties; Absolute Total Care and United Health Care maintained a presence in the majority of counties. BlueChoice added service in Saluda County, increasing the local availability of this plan from 39 to 40 counties. As of December 2010, all five plans were available in 36 counties and in each of the state's four health regions—Low Country, Midlands, Pee Dee, and Piedmont. The fee-for-service health plan is not highlighted (Figure 2: SC Medicaid Managed Care Health Plans Geographic Presence).

Figure 2



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 3 illustrates the number of Medicaid recipients per South Carolina Medicaid managed care plan for CY 2010.

Figure 3



Using this Report

Dimensions of Care

The CY 2010 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 (Appendix A: Descriptions of Measures).

Appendix B provides the reader the 2010 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 (CY) 2010. 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 2010. All administrative records were adjudicated through May 31, 2011.

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 2010. These members completed the CAHPS® survey by 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® 2010, Volume 3: Specifications for Survey Measures*.

Rating Method

The purpose of identifying performance levels is to facilitate the comparison of services provided to South Carolina Medicaid recipients to national percentiles and to foster a climate of continuous value-based quality improvement. 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 percentile are considered high performing and rank in the top 25% of all Medicaid health plans. Similarly, plans reporting rates below the 25th 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® 2010 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

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.

South Carolina 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.

Performance Trend Analysis

For purposes of this analysis, trend data are shown for the SC State Weighted Rates for CY 2008–10 compared to the 2010 Medicaid National Average. Trends are shown using the following symbols:

▲ Indicates the SC State Weighted Rate change is significantly higher.

▼ Indicates the SC State Weighted Rate change is significantly lower.

The symbols correspond to each trend period consisting of the measurement of rate change from CY 2008 to CY 2010, and the rate change from CY 2009 and CY 2010.

As an example, a downward triangle (▼) denotes a significant decline in performance, as denoted by a significant increase in the 2010 rate from the 2009 rate. An upward triangle (▲) denotes a significant improvement in performance, as indicated by a significant decrease of the 2010 rate from the 2009 rate.

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.

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 the upper limits for each measure. 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.

South Carolina Medicaid Rates Compared to National Medicaid Percentiles

For each measure, the Medicaid health plan ranking presents the reported rate compared to the HEDIS 2010 National Medicaid Percentile Benchmark. In addition, the 2008, 2009, and 2010 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.

New Measures

New measures for the 2010 calendar measurement year are considered first year measures, and consistent with NCQA policy, individual plan rates should be cautiously interpreted. Interpretation of new measures are best at the statewide aggregate level viewed as opportunities for quality improvement.

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.

Lack of Case-Mix Adjustment

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. IFS and DHHS are working on new methodologies for analyzing SC Medicaid HEDIS® results which may clarify this issue for future reports.

Demographic Differences in Plan Membership

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

Overlapping Provider Networks

Many providers caring for SC Medicaid recipients have contracts with multiple plans. Overlapping provider networks may 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 great variability and generalized ability of the 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

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* • 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.

South Carolina Medicaid
HEDIS 2010
Pediatric Measures–CY 2010

	Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Statewide Overall
Adolescent Well-Care Visits	★	★	★★	★	★	★	★
Appropriate Use of Antibiotics: Treatment for Children With Upper Respiratory Infection (URI)†	★★★	★	★★	★★	★★★	★	★★
Appropriate Testing for Children With Pharyngitis	★★★★	★★★	★★★	★★★★	★★★	★★★★	★★★
Emergency Department Visits *(New Measure)* ‡							
Ages <1	★★	★★	★★	★★	★	★	★
Ages 1-9	★	★	★	★	★	★	★
Ages 10-19	★★	★★	★★	★★★	★★	★★	★★
Lead Screening in Children Age 2 Years and Under	★	★	★	★	★	★	★
Well-Child Visits							
Ages 0 Through 15 Months: 0 Visits*	★★★★	★★★★	★★★	★★★	★★★	★★★★	★★★
Ages 0 Through 15 Months: 6 or More Visits	★	★	★★	★★	★	★	★
Ages 3 Through 6 Years	★	★	★★	★	★	★	★

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

† = Inverse rate (higher is better)
‡ = Higher is better
* = Inverted measure (lower is better)

Note: Ratings are for CY 2010 compared to 2010 NCQA Medicaid Benchmark.
Data Source: SC Medicaid claims 1/1/10–12/31/10 adjudicated through 5/2011.

South Carolina Medicaid
Pediatric HEDIS Rates–CY 2010

	Measure	Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Weighted State Average	NCQA National Medicaid Mean
PEDIATRIC CARE	Adolescent Well-Care Visits	24.5	20.4	39.4 ↑	23.7	28.3 ↑	17.2	27.5	47.7
	Appropriate Testing for Children With Pharyngitis	75.1 ↑	72.8 ↑	72.3	77.8 ↑	72.8 ↑	74.7 ↑	72.6	62.3
	Appropriate Treatment for Children With Upper Respiratory Infection† †	85.5 ↑	78.6	84.5 ↑	83.6 ↑	85.6 ↑	80.2	82.7	86.0
	Emergency Department Visits Per 1,000 (New Measure) ‡								
	Age <1 Year	89.6 ↑	86.8 ↑	87.8 ↑	87.1 ↑	80.8	78.1	84.2	98.3
	Ages 1-9	45.2 ↑	45.2 ↑	44.5	48.2 ↑	42.7	43.6	44.9	56.3
	Ages 10-19	44.8 ↑	44.2 ↑	40.3	47.6 ↑	41.3	40.4	42.4	46.9
	Lead Screening in Children	34.8	41.7	56.4 ↑	55.3 ↑	54.1 ↑	43.3	48.7	66.4
	Well-Child Visits								
	Ages 0-15 Months: Zero Visits Rate *	2.8 ↑	3.8 ↑	0.8	1.2	2.3 ↑	4.6 ↑	1.9	2.3
	Ages 0-15 Months: Six or More visits Rate	49.1	49.2	59.1 ↑	58.5 ↑	49.1	44.6	50.9	59.4
	Ages 3-6 Years	53.5	46.5	65.5 ↑	50.1	53.7	44.9	55.8	71.6

Above NCQA 75th Percentile
Below NCQA 25th Percentile
↑ Higher than weighted state average

† = Inverse rate (higher is better)
‡ = Higher is better
* = Inverted measure (lower is better)

South Carolina Medicaid
Pediatric Trends–CY 2010

	Measure	Weighted State Rates 2008	2009	2010	2010 Medicaid National Average	Change from 2008 to 2010	Change from 2009 to 2010
PEDIATRIC CARE	Adolescent Well-Care Visits	21.5	24.6	27.5	47.7	▲	▲
	Appropriate Testing for Children With Pharyngitis	65.0	67.2	72.6	62.3	▲	▲
	Appropriate Treatment for Children With Upper Respiratory Infection†	81.5	81.3	82.7	86.0	▲	▲
	Emergency Department Visits Per 1,000 (New Measure) ‡						
	Age <1 Year	90.3	73.1	84.2	98.3		▲
	Ages 1-9	49.0	44.0	44.9	56.3		▲
	Ages 10-19	44.3	40.2	42.4	46.9		▲
	Lead Screening in Children	45.5	40.5	48.7	66.4	▲	▲
	Well-Child Visits						
	Ages 0-15 Months: Zero Visits Rate *	4.0	3.5	1.9	2.3	▼	▼
	Ages 0-15 Months: Six or More visits Rate	40.1	33.3	50.9	59.4	▲	▲
	Ages 3-6 Years	49.1	50.5	55.8	71.6	▲	▲

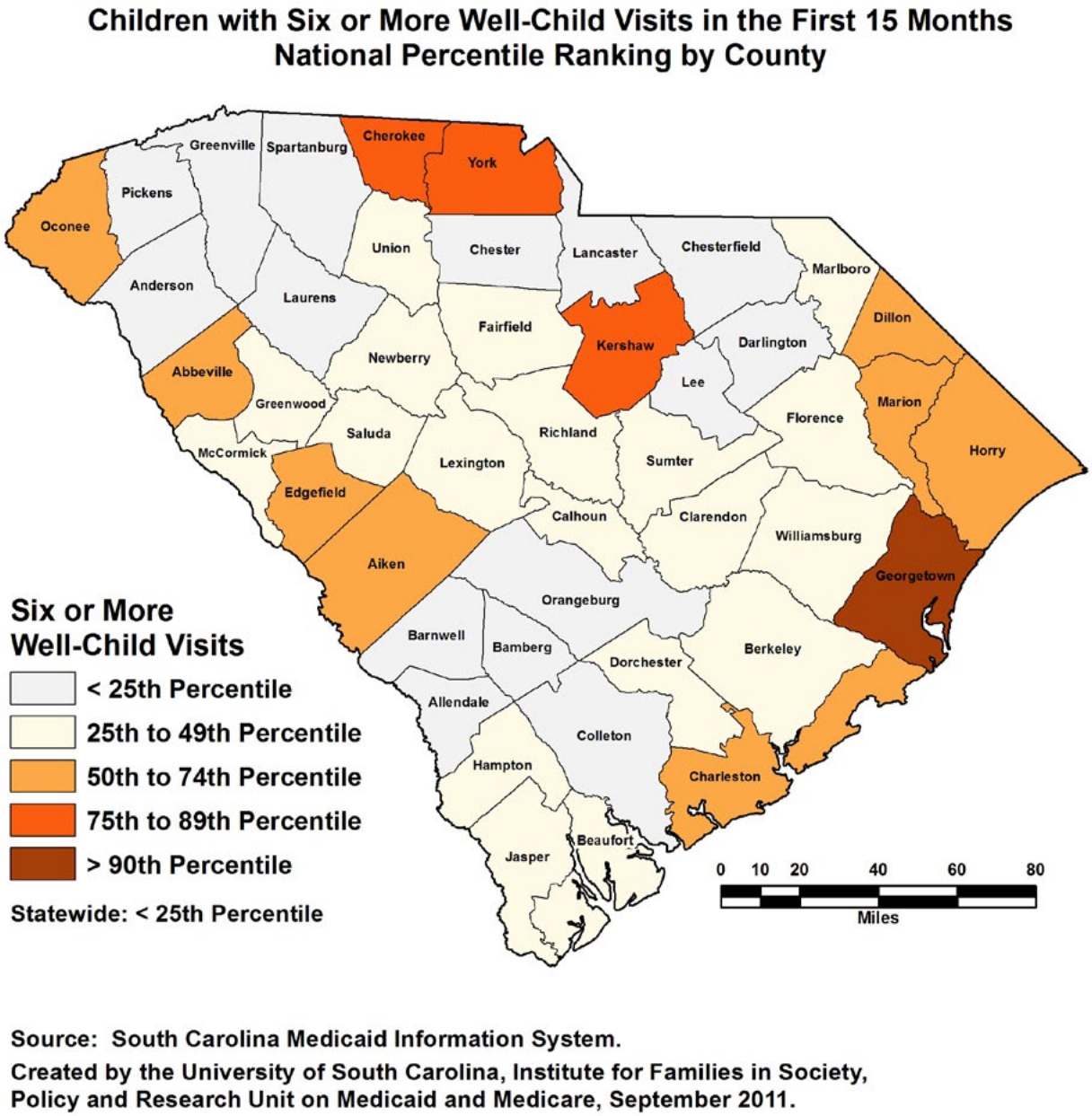
† = Inverse rate (higher is better)
‡ = Higher is better
* = Inverted measure (lower is better)

▲ Indicates the SC State Weighted Rate change is significantly higher.

▼ Indicates the SC State Weighted Rate change is significantly lower.

For measures with adequate numbers of members we included county-specific rates. This map highlights a measure amenable to quality improvement with targeted initiatives at the provider and recipient level.

Figure 4

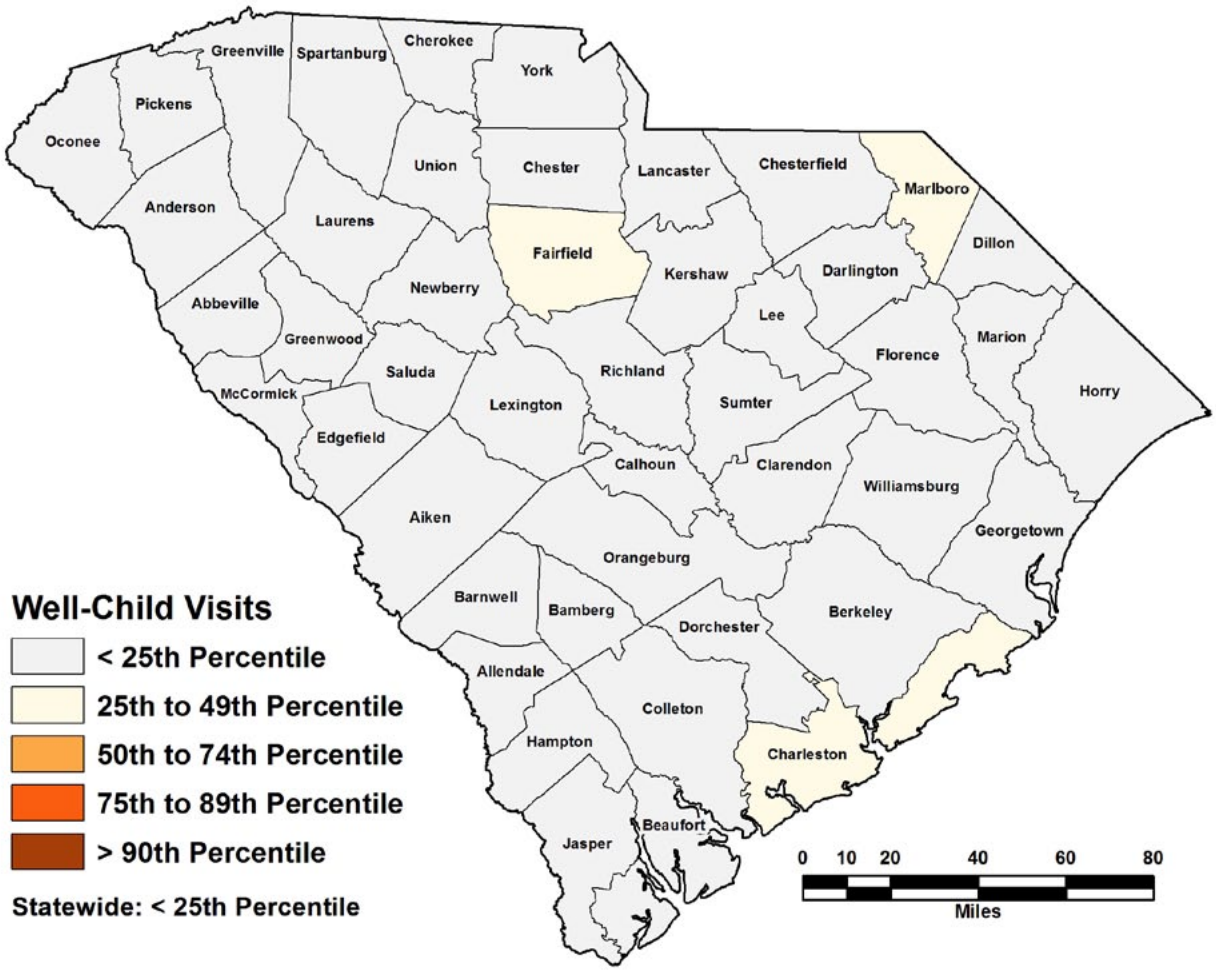


Source: South Carolina Medicaid Information System.
Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, September 2011.

For measures with adequate numbers of members we included county-specific rates. This map highlights a measure amenable to quality improvement with targeted initiatives at the provider and recipient level.

Figure 5

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
National Percentile Ranking by County



Source: South Carolina Medicaid Information System.
Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, September 2011.

Dimensions of 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

South Carolina Medicaid
HEDIS 2010
Women's Care Measures–CY 2010

	Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Statewide Overall
Breast Cancer Screening: Total	★	★	★★★	★★	★★★	★	★
Cervical Cancer Screening (PAP Test)	★	★	★★	★	★★★	★	★
Chlamydia Screening *(New Measure)*							
16 to 20 Years	★★★	★★★	★★★	★★★	★★★	★★★	★★★
21 to 24 Years	★★★	★★	★★★	★★★	★★★	★★	★★
Combined Rate	★★★	★★★	★★★	★★★	★★★	★★	★★
Emergency Department (ED) Visits Per 1000 - Ambulatory Care *(New Measure)* ‡							
Ages 20-44	★★★★	★★★★	★★★	★★★★★	★★★	★	★★
Ages 45-64	★★★★	★★★★★	★★★★	★★★	★★★	★★★	★★★
Ages 65-74	NSI	NSI	NSI	★★★★	NSI	★★★	★★★★
Prenatal and Postpartum Care							
Timeliness of Prenatal Care	★★	★★	★★	★	★★	★	★
Postpartum Care	★★★	★★	★★★	★★	★★	★★	★★

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

‡ = Higher is better

NSI = Not sufficient information.

Note: Ratings are for CY 2010 compared to 2010 NCQA Medicaid Benchmark.

Data Source: SC Medicaid claims 1/1/10–12/31/10 adjudicated through 5/2011.

South Carolina Medicaid
Women's Care HEDIS Rates–CY 2010

	Measure	Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Weighted State Average	NCQA National Medicaid Mean
WOMEN'S CARE	Breast Cancer Screening	45.1	36.9	54.1	50.5	54.2	43.7	44.7	52.4
	Cervical Cancer Screening	58.1	54.2	67.1	46.3	70.3	43.7	51.2	65.8
	Chlamydia Screening in Women								
	Ages 16-20 Years	57.2	56.3	54.3	53.2	58.0	52.6	52.6	54.4
	Ages 21-24 Years	67.9	58.1	65.6	65.7	65.5	56.9	58.8	61.6
	Combined Rate	59.6	55.5	56.6	55.5	61.1	54.5	55.0	56.7
	Emergency Department Visits Per 1,000 (New Measure) ‡								
	Ages 20-44	134.9	127.4	119.5	144.7	117.8	65.2	96.1	105.2
	Ages 45-64	109.6	116.8	103.4	99.3	98.4	88.8	94.5	79.6
	Age 65-74	NSI	NSI	NSI	57.6	NSI	50.3	51.0	57.5
	Prenatal and Postpartum Care								
	Timeliness of Prenatal Care	82.4	81.1	84.3	76.8	81.1	68.2	78.2	83.4
	Postpartum Care	66.8	59.6	65.7	61.3	63.9	63.1	63.0	64.1

Above NCQA 75th Percentile
Below NCQA 25th Percentile
Higher than weighted state average

‡ = Higher is better

South Carolina Medicaid
Women's Care Trends–CY 2010

	Measure	Weighted State Rates 2008	2009	2010	2010 Medicaid National Average	Change from 2008 to 2010	Change from 2009 to 2010
WOMEN'S CARE	Breast Cancer Screening	39.4	41.3	44.7	52.4	▲	▲
	Cervical Cancer Screening	49.1	47.3	51.2	65.8	▲	▲
	Chlamydia Screening in Women						
	Ages 16-20 Years	53.0	51.7	52.6	54.4	▼	▲
	Ages 21-24 Years	55.0	55.8	58.8	61.6	▲	▲
	Combined Rate	54.0	53.3	55.0	56.7	▲	▲
	Emergency Department Visits Per 1,000 (New Measure) ‡						
	Ages 20-44	-	71.6	96.1	105.2		▲
	Ages 45-64	-	77.2	94.5	79.6		▲
	Age 65-74	-	33.4	51.0	57.5		▲
	Prenatal and Postpartum Care						
	Timeliness of Prenatal Care	58.0	69.7	78.2	83.4	▲	▲
	Postpartum Care	64.7	64.8	63.0	64.1	▼	▼

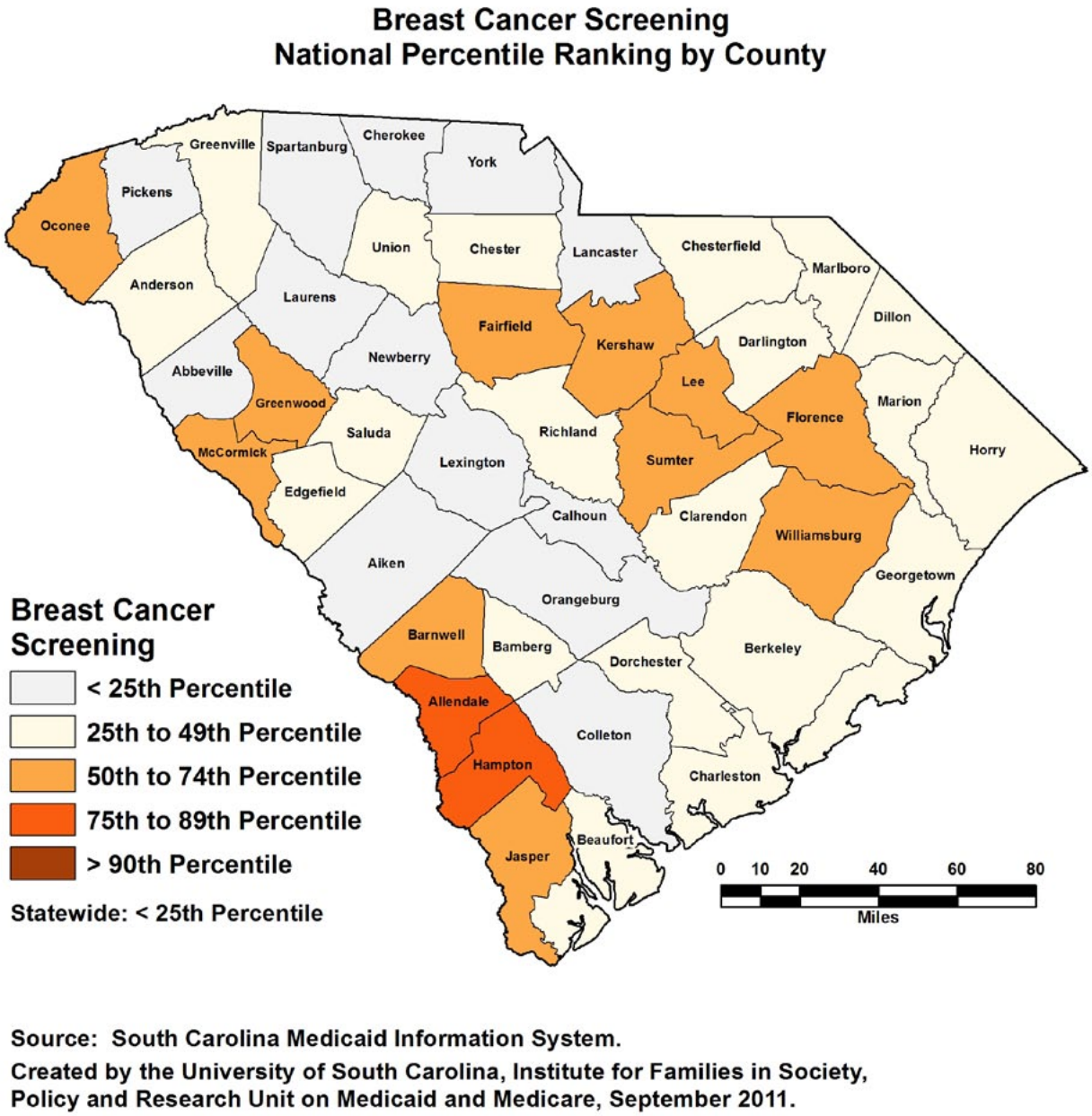
‡ = Higher is better
— = NA

▲ Indicates the SC State Weighted Rate change is significantly higher.

▼ Indicates the SC State Weighted Rate change is significantly lower.

For measures with adequate numbers of members we included county-specific rates. This map highlights a measure amenable to quality improvement with targeted initiatives at the provider and recipient level.

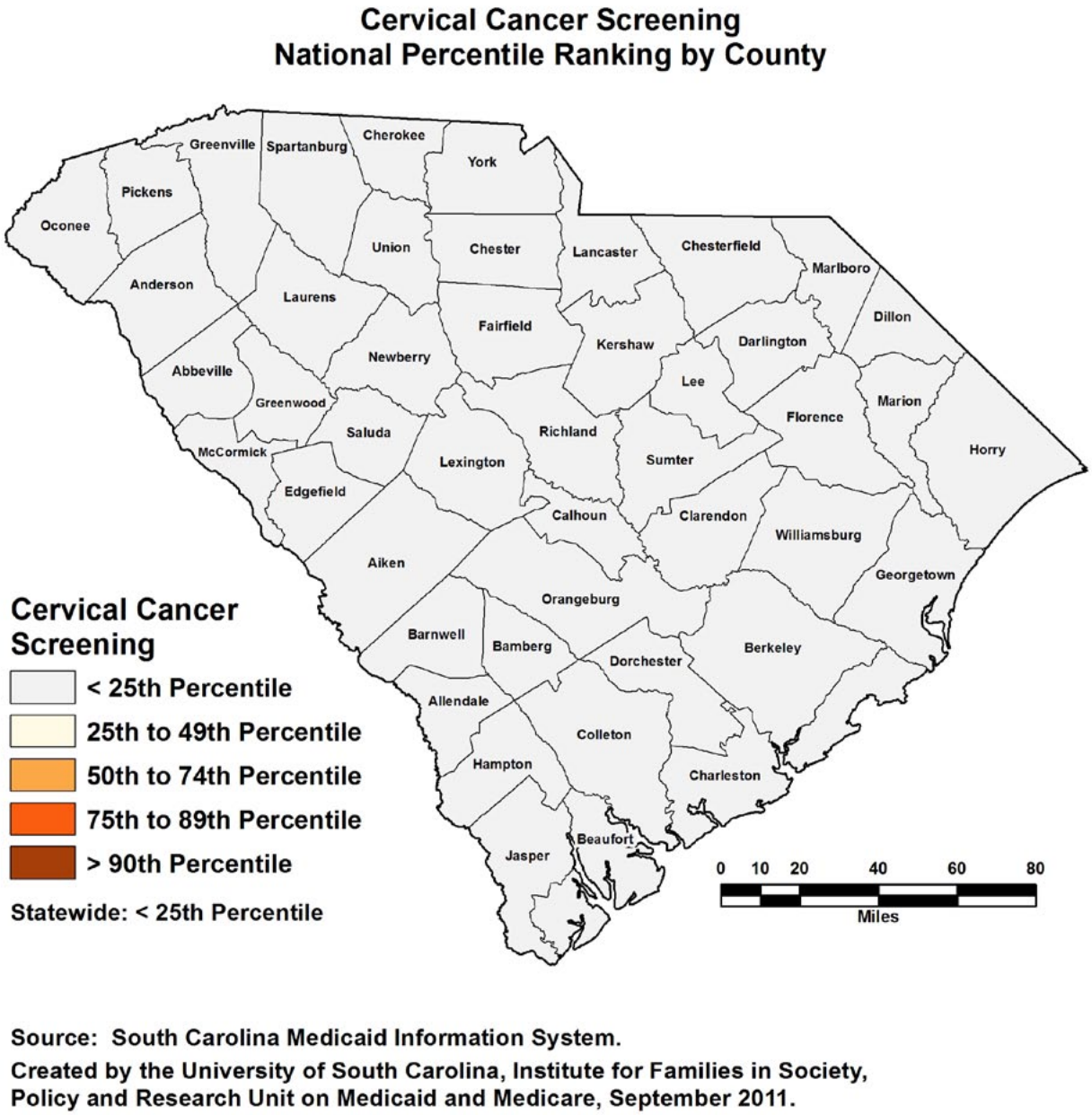
Figure 6



Source: South Carolina Medicaid Information System.
Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, September 2011.

For measures with adequate numbers of members we included county-specific rates. This map highlights a measure amenable to quality improvement with targeted initiatives at the provider and recipient level.

Figure 7



Source: South Carolina Medicaid Information System.
Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, September 2011.

Dimensions of Care

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 5–50 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 - 12-50 Years • ASM - Rate - 5-11 Years • ASM - Rate - Total

South Carolina Medicaid
HEDIS 2010
Living With Illness Measures–CY 2010

	Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Statewide Overall
Comprehensive Diabetes Care							
HbA1c Testing	★★	★	★★	★	★★	★	★
Eye Exam	★	★	★★	★★	★	★	★
LDL-C Screening	★★	★	★★	★	★	★	★
Medical Attention for Diabetic Nephropathy	★★	★★★	★★★	★	★★	★	★
Use of Appropriate Medications for People With Asthma							
Ages 5-11 years	★★★★★	★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★
Ages 12-50 years	★★★★★	★★★★★	★★★★★	★★★★★	★★★★	★★★★★	★★★★
Combined Rate	★★★★★	★★★★	★★★★★	★★★★★	★★★★	★★★★★	★★★★★

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

Note: Ratings are for CY 2010 compared to 2010 NCQA Medicaid Benchmark.
Data Source: SC Medicaid claims 1/1/10–12/31/10 adjudicated through 5/2011.

South Carolina Medicaid
Living With Illness HEDIS Rates–CY 2010

	Measure	Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Weighted State Average	NCQA National Medicaid Mean
LIVING WITH ILLNESS	Comprehensive Diabetes Care								
	HbA1c Testing	76.2 ↑	67.8 ↑	77.9 ↑	52.2 ↑	75.5 ↑	32.1	43.6	80.6
	Eye Exams	38.7 ↑	40.0 ↑	47.6 ↑	41.3 ↑	38.6 ↑	35.8	36.9	52.7
	LDL-C Screening	68.6 ↑	62.7 ↑	68.7 ↑	46.6 ↑	64.6 ↑	26.1	37.0	74.2
	Medical Attention for Diabetic Nephropathy	77.4 ↑	78.6 ↑	79.3 ↑	64.2 ↑	75.5 ↑	48.9	56.4	76.9
	Use of Appropriate Medications for People with Asthma								
	5-11 Years	96.4 ↑	95.0	95.5 ↑	97.6 ↑	97.3 ↑	97.9 ↑	95.3	91.8
	12-50 Years	92.8 ↑	92.6 ↑	91.9 ↑	91.1 ↑	89.2	91.8 ↑	89.6	86.0
	Combined Rate	93.8 ↑	91.1	93.6 ↑	94.1 ↑	91.5	94.2 ↑	92.5	88.6

Above NCQA 75th Percentile
Below NCQA 25th Percentile
↑ Higher than weighted state average

South Carolina Medicaid
Living With Illness Trends–CY 2010

	Measure	Weighted State Rates 2008	2009	2010	2010 Medicaid National Average	Change from 2008 to 2010	Change from 2009 to 2010
LIVING WITH ILLNESS	Comprehensive Diabetes Care						
	HbA1c Testing	39.4	40.8	43.6	80.6	▲	▲
	Eye Exams	90.0	42.0	36.9	52.7	▼	▼
	LDL-C Screening	31.7	33.4	37.0	74.2	▲	▲
	Medical Attention for Diabetic Nephropathy	59.2	55.3	56.4	76.9	▼	▲
	Use of Appropriate Medications for People with Asthma						
	(Ages 5-11)*	95.1	94.9	95.3	91.8		▲
	(Ages 12-50)*	71.9	89.8	89.6	86.0		▼
	(Combined Rates)	87.1	92.5	92.5	88.6	▲	▼

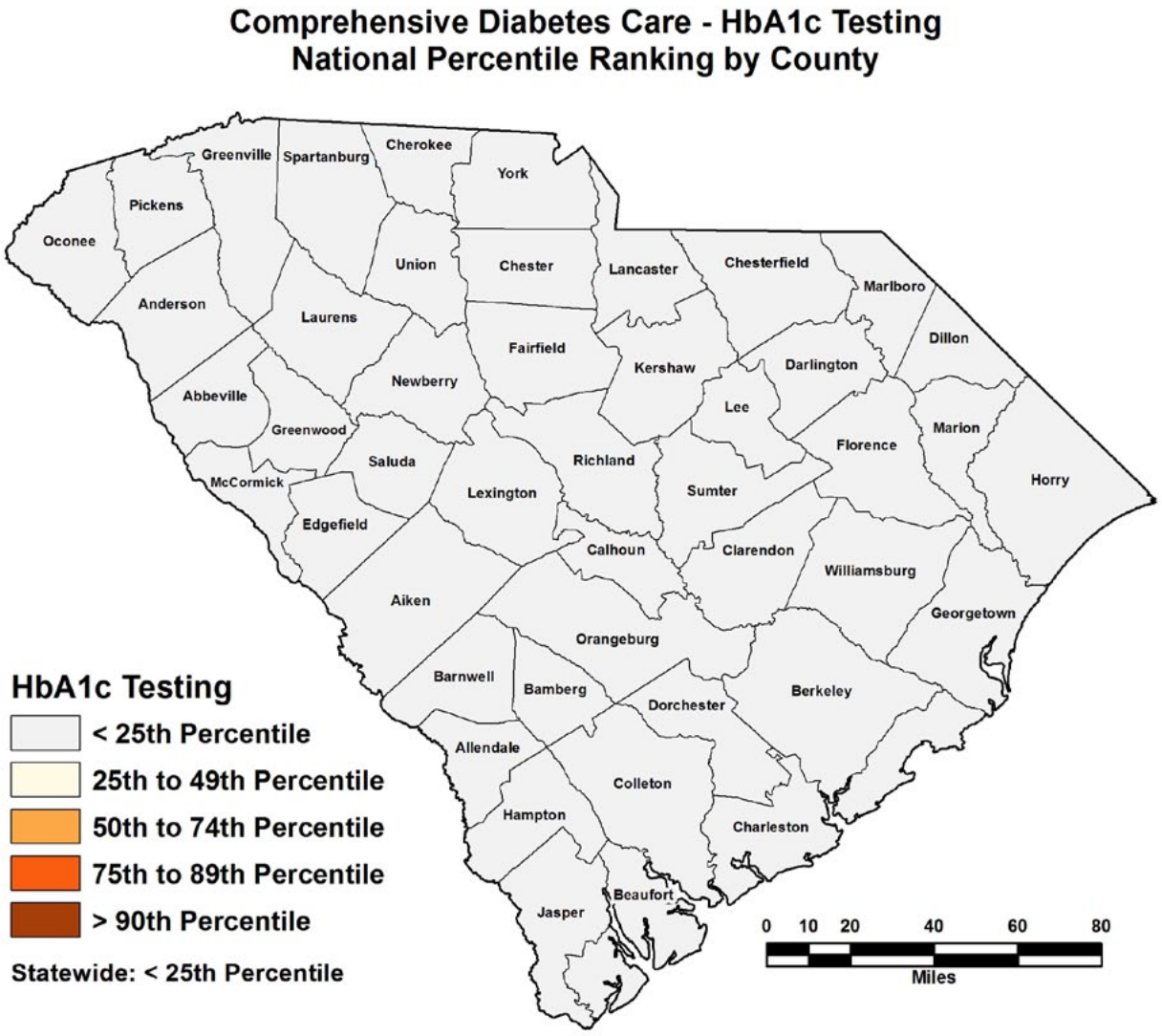
*Compare with caution. (Age groups for 2009 and 2010 are 5-11 Years and 12-50 Years.)

▲ Indicates the SC State Weighted Rate change is significantly higher.

▼ Indicates the SC State Weighted Rate change is significantly lower.

For measures with adequate numbers of members we included county-specific rates. This map highlights a measure amenable to quality improvement with targeted initiatives at the provider and recipient level.

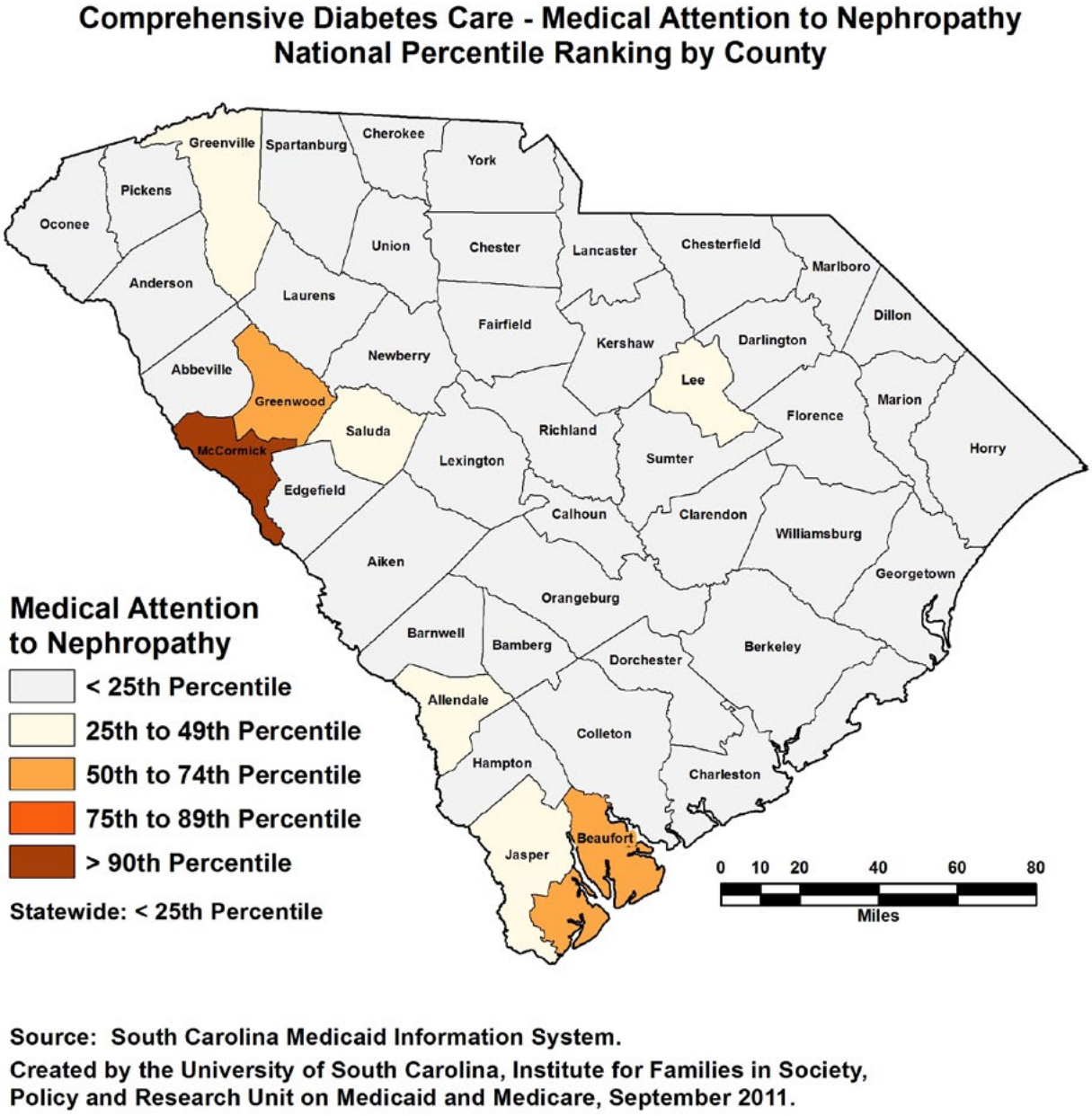
Figure 8



Source: South Carolina Medicaid Information System.
Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, September 2011.

For measures with adequate numbers of members we included county-specific rates. This map highlights a measure amenable to quality improvement with targeted initiatives at the provider and recipient level.

Figure 9



Source: South Carolina Medicaid Information System.
Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, September 2011.

Dimensions of Care

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; and • 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.
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.

South Carolina Medicaid
HEDIS 2010
Behavioral Health Measures–CY 2010

	Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Statewide Overall
Attention-Deficit Hyperactivity Disorder (ADHD): % Ages 6 to 12 Years With an ADHD Prescription Who Had a Follow-Up During 30-Day							
Initiation Phase	★★★★	★★★★★	★★★★★	★★★★	★★★★	★★★★	★★★★
Continuation and Maintenance Phase	★★★★	★★★★★	★★★★★	★★★	★★★★★	★★★★	★★★★
Follow-up Care After Hospitalization for Mental Illness - Ages 6 Years and Above							
Within 7 Days	★★	★★★	★★★	★★	★★	★★	★★
Within 30 Days	★★★	★★★	★★★	★★	★★★	★★	★★
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment *(New Measure)*							
Initiation (Ages 13-17 Years)	★★★	★★★★★	★★★	★★★★	★★★★★	★★★★	★★★
Initiation (Ages 18+)	★★	★★	★	★	★	★	★
Initiation (Total)	★★	★★	★★	★	★	★	★
Engagement (Ages 13-17 Years)	★★★★	★★★★★	★★★★	★★★★	★★★★★	★★★★	★★★★
Engagement (Ages 18+)	★★★	★★★	★★★	★★	★★★	★★	★★
Engagement (Total)	★★★	★★★	★★★	★★	★★★	★★	★★

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

Note: Ratings are for CY 2010 compared to 2010 NCQA Medicaid Benchmark.
Data Source: SC Medicaid claims 1/1/10–12/31/10 adjudicated through 5/2011.

South Carolina Medicaid
Behavioral Health HEDIS Rates–CY 2010

BEHAVIORAL HEALTH

Measure	Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Weighted State Average	NCQA National Medicaid Mean
Attention-Deficit Hyperactivity Disorder (ADHD): % Ages 6 to 12 Years Prescribed an ADHD Medication Who had a Follow-Up Within 30 Days								
Initiation Phase	45.3 ↑	49.4 ↑	52.1 ↑	42.1	45.2 ↑	45.6 ↑	44.7	36.6
Continuation	56.8 ↑	61.7 ↑	63.5 ↑	48.0	62.5 ↑	54.8 ↑	51.8	41.7
Follow-up Care After Hospitalization for Mental Illness - Ages 6 Years and Above								
Within 7 Days	42.0 ↑	44.1 ↑	43.8 ↑	39.6 ↑	40.5 ↑	31.2	32.8	42.9
Within 30 Days	66.4 ↑	67.6 ↑	66.7 ↑	61.7 ↑	68.1 ↑	53.1	55.5	60.2
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (New Measure)								
Initiation (Ages 13-17 Years)	49.5 ↑	65.2 ↑	52.0 ↑	54.0 ↑	72.2 ↑	55.8 ↑	48.8	42.5
Initiation (Ages 18+)	39.2 ↑	40.1 ↑	36.4 ↑	25.2	35.4 ↑	30.5 ↑	30.2	44.7
Initiation (Total)	39.6 ↑	41.2 ↑	38.6 ↑	26.9	37.1 ↑	31.5	31.5	44.3
Engagement (13-17 Years)	27.1	50.0 ↑	36.7 ↑	32.5 ↑	52.0 ↑	35.1 ↑	30.0	17.7
Engagement (18+)	10.8 ↑	10.9 ↑	10.7 ↑	4.5	12.3 ↑	4.5	5.6	11.8
Engagement (Total)	12.0 ↑	13.5 ↑	14.9 ↑	6.2	14.4 ↑	5.8	7.4	12.3

Above NCQA 75th Percentile
Below NCQA 25th Percentile
↑ Higher than weighted state average

South Carolina Medicaid
Behavioral Health Trends–CY 2010

	Measure	Weighted State Rates 2008	2009	2010	2010 Medicaid National Average	Change from 2008 to 2010	Change from 2009 to 2010
BEHAVIORAL HEALTH	Attention-Deficit Hyperactivity Disorder (ADHD): % Ages 6 to 12 Years Prescribed an ADHD Medication Who Had a Follow-Up Within 30 Days						
	Initiation Phase	20.3	42.7	44.7	36.6	▲	▲
	Continuation	26.2	49.1	51.8	41.7	▲	▲
	Follow-up Care After Hospitalization for Mental Illness - Ages 6 Years and Above						
	Within 7 Days	41.8	4.5	32.8	42.9		
	Within 30 Days	66.2	11.2	55.5	60.2		
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (New Measure)						
	Initiation (Ages 13-17 Years)	-	61.9	48.8	42.5		▼
	Initiation (Ages 18+)	-	38.8	30.2	44.7		▼
	Initiation (Total)	-	40.3	31.5	44.3		▼
	Engagement (13-17 Years)	-	28.6	30.0	17.7		▲
	Engagement (18+)	-	13.6	5.6	11.8		▼
	Engagement (Total)	-	14.6	7.4	12.3		▼

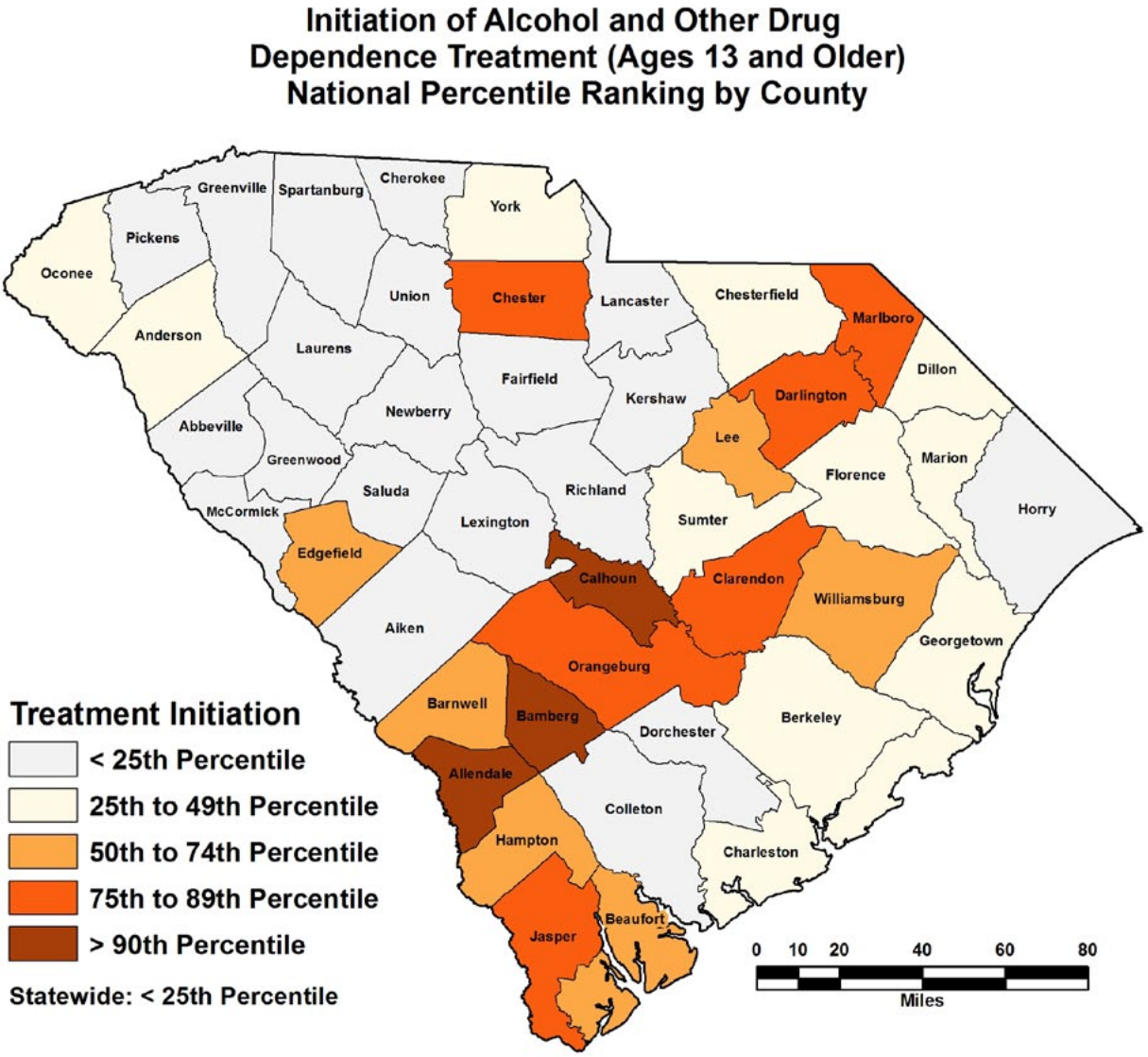
— = NA

▲ Indicates the SC State Weighted Rate change is significantly higher.

▼ Indicates the SC State Weighted Rate change is significantly lower.

For measures with adequate numbers of members we included county-specific rates. This map highlights a measure amenable to quality improvement with targeted initiatives at the provider and recipient level.

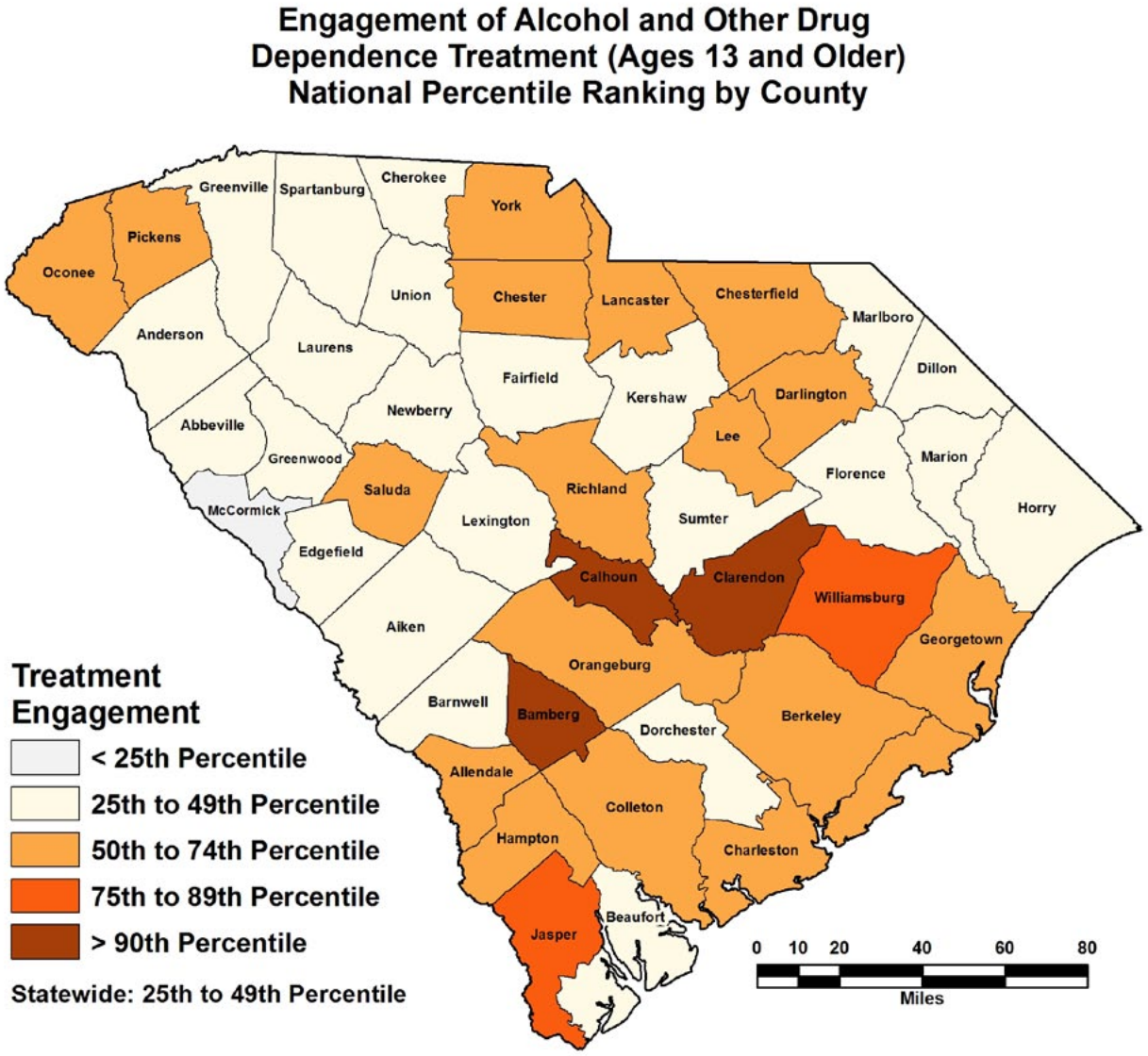
Figure 10



Source: South Carolina Medicaid Information System.
Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, September 2011.

For measures with adequate numbers of members we included county-specific rates. This map highlights a measure amenable to quality improvement with targeted initiatives at the provider and recipient level.

Figure 11



Source: South Carolina Medicaid Information System.
Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, September 2011.

Dimensions of 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; and • 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. The organization reports three separate percentages for each product line: • Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year; and • Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

South Carolina Medicaid HEDIS 2010 Access to Care Measures–CY 2010	Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Statewide Overall
Child and Adolescent Access to Primary Care							
Ages 12-24 months	★★★★	★★★	★★★★★	★★★★★	★★★★★	★★	★★★★
Ages 25 months - 6 years	★	★	★★★★	★	★	★	★
Ages 7-11 years	★	★	★★★★	★	★★	★	★★
Ages 12-19 years	★	★	★★★	★	★★	★	★★
Adult Access to Preventative Ambulatory Health Services							
Ages 20-44 years	★★	★★	★★★★	★	★★★	★	★
Ages 45-64 years	★	★	★★★★	★	★	★	★

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

Note: Ratings are for CY 2010 compared to 2010 NCQA Medicaid Benchmark.
Data Source: SC Medicaid claims 1/1/10–12/31/10 adjudicated through 5/2011.

South Carolina Medicaid Access to Care HEDIS Rates–CY 2010	Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Health Care	Fee-For-Service	Weighted State Average	NCQA National Medicaid Mean
ACCESS TO CARE								
Children and Adolescents' Access to Primary Care Practitioners								
Ages 12-24 Months	97.5	97.4	99.0 ↑	98.7 ↑	98.6 ↑	96.4	97.6	95.2
Ages 25 Months-6 Years	84.6	77.0	91.7 ↑	80.3	85.6	84.2	86.0	88.3
Ages 7-11 Years	86.3	80.9	94.3 ↑	79.7	88.4 ↑	86.8	87.6	90.3
Ages 12-19 Years	82.0	75.7	90.8 ↑	79.5	85.0 ↑	84.4	84.7	87.9
Adult's Access to Preventive/Ambulatory Health Services								
Ages 20-44 Years	79.1 ↑	77.9 ↑	87.0 ↑	74.4	82.9 ↑	69.9	75.2	80.5
Ages 45-64 Years	80.7 ↑	76.6 ↑	90.0 ↑	75.9 ↑	82.1 ↑	73.6	75.8	85.3

Above NCQA 75th Percentile
Below NCQA 25th Percentile
↑ Higher than weighted state average

South Carolina Medicaid
Access to Care Trends–CY 2010

	Measure	Weighted State Rates 2008	2009	2010	2010 Medicaid National Average	Change from 2008 to 2010	Change from 2009 to 2010
ACCESS TO CARE	Children and Adolescents' Access to Primary Care Practitioners						
	Ages 12-24 Months	96.1	95.4	97.6	95.2	▲	▲
	Ages 25 Months-6 Years	80.4	82.9	86.0	88.3	▲	▲
	Ages 7-11 Years	78.7	85.0	87.6	90.3	▲	▲
	Ages 12-19 Years	74.7	83.0	84.7	87.9	▲	▲
	Adult's Access to Preventive/Ambulatory Health Services						
	Ages 20-44 Years	74.9	73.1	75.2	80.5	▲	▲
	Ages 45-64 Years	75.5	75.5	75.8	85.3	▲	▲

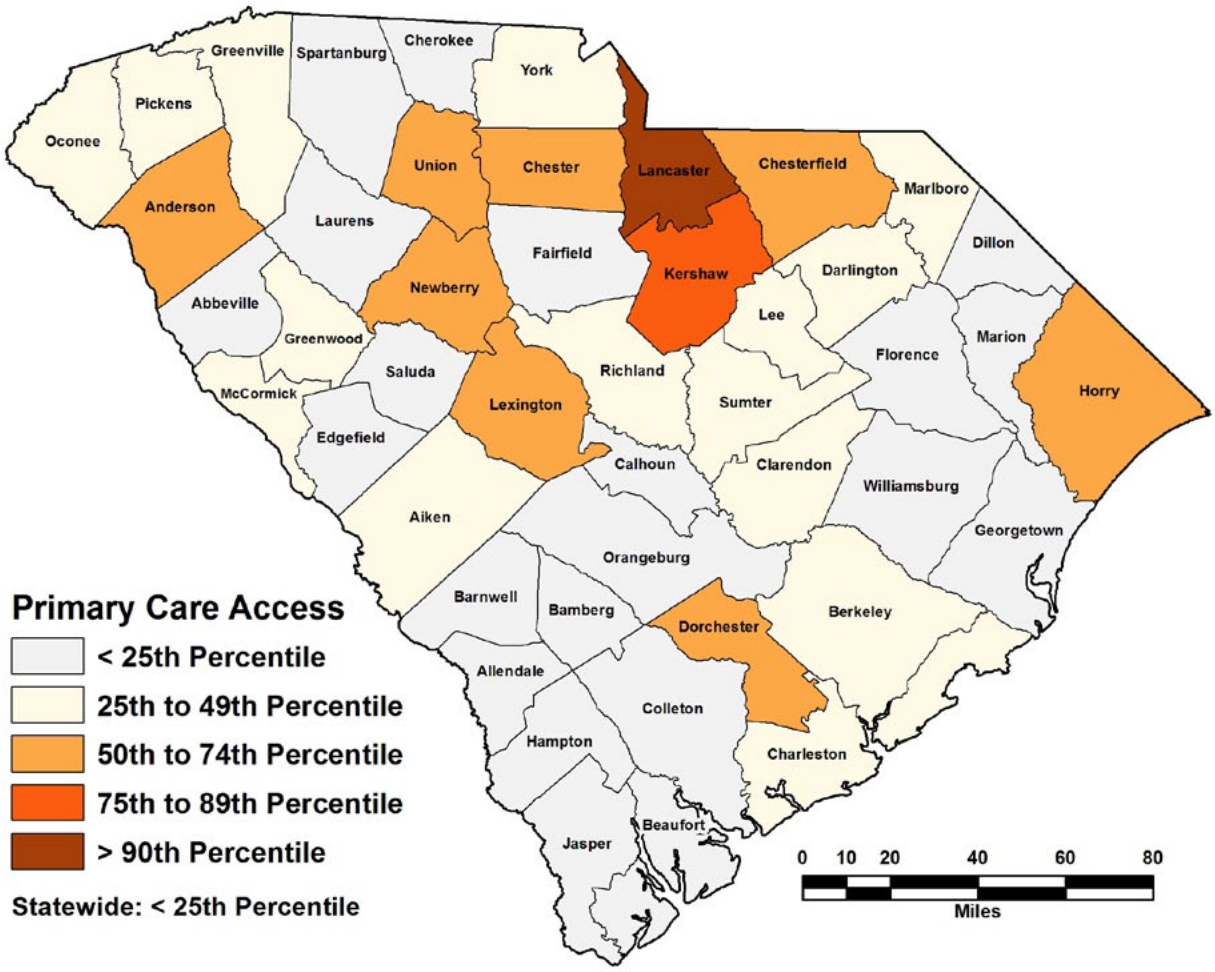
▲ Indicates the SC State Weighted Rate change is significantly higher.

▼ Indicates the SC State Weighted Rate change is significantly lower.

For measures with adequate numbers of members we included county-specific rates. This map highlights a measure amenable to quality improvement with targeted initiatives at the provider and recipient level.

Figure 12

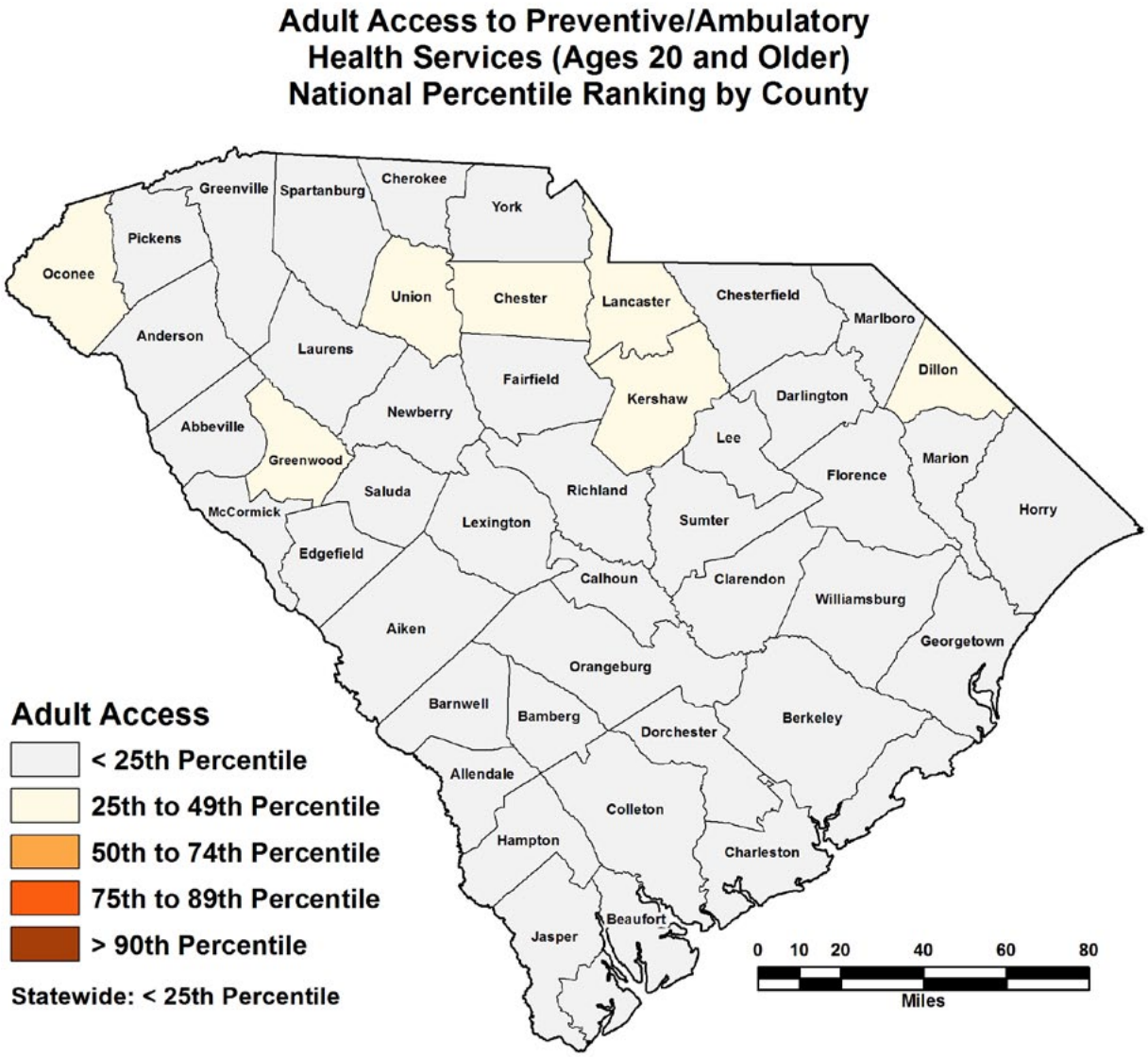
Children Ages 25 Months to 6 Years with Access to Primary Care
National Percentile Ranking by County



Source: South Carolina Medicaid Information System.
Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, September 2011.

For measures with adequate numbers of members we included county-specific rates. This map highlights a measure amenable to quality improvement with targeted initiatives at the provider and recipient level.

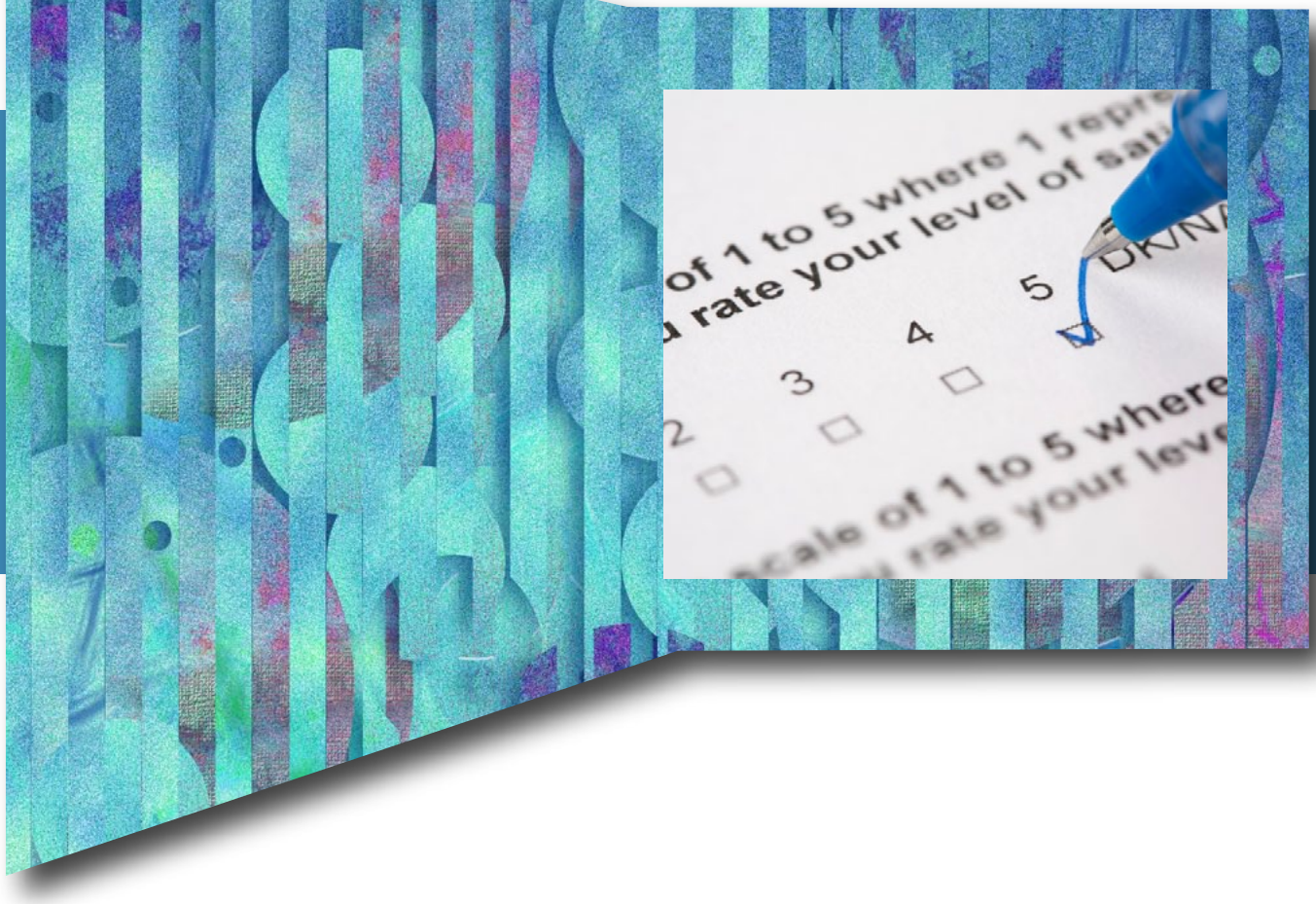
Figure 13



Source: South Carolina Medicaid Information System.
Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, September 2011.

Dimensions of Care

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. 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.

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 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?"
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

Adult Measure Results

Adult measures reported for CAHPS® include four rating and four composite measures. Additionally included this year are the summary ratings for three questions about Medical Assistance with Smoking Cessation. 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 Choice	First Choice	SC Solutions	United Health-care	Fee-for-Service	Statewide Overall	National Percentiles			
								25th	50th	75th	90th
Satisfaction and Experience with Provider Networks											
How Well Doctors Communicate	2.71	2.70	2.76	2.66	2.63	2.74	2.70	2.48	2.54	2.58	2.64
Rating of Personal Doctor	2.53	2.60	2.66	2.61	2.54	2.72	2.63	2.38	2.42	2.48	2.54
Rating of Specialists	2.59	2.61	2.58	2.63	2.64	2.66	2.62	2.39	2.44	2.49	2.53
Satisfaction and Experience with Access to Care and Health Plan											
Get Needed Care	2.14	2.20	2.34	2.37	2.29	2.49	2.32	2.10	2.24	2.32	2.40
Get Care Quickly	2.52	2.37	2.41	2.49	2.42	2.57	2.48	2.26	2.35	2.41	2.46
Customer Service	2.36	2.44	2.55	2.38	2.64	2.63	2.50	2.31	2.40	2.47	2.53
Rating of Health Plan	2.21	2.33	2.49	2.50	2.35	2.52	2.41	2.31	2.38	2.46	2.54
Satisfaction and Experience with Care											
Rating of Health Care	2.30	2.36	2.45	2.35	2.34	2.43	2.38	2.23	2.27	2.33	2.39

Experience and Satisfaction with Provider Networks: Overall for adults, experience with the provider network is positive across plans and for the state as a whole. Many doctors and specialists are enrolled with multiple plans, therefore, it is difficult to determine the impact of the health plan on these measures.

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. This 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 is a domain where there is variability between health plans' performance particularly in getting appointments with specialists and getting tests or treatment through the health plan (Getting Needed Care).

Consumer overall ratings of health plans is an area needing attention. Customer service is one area that affects consumers' views of their health plan. The variability in performance across plans suggests opportunities for improvement at the plan level.

Experience and Satisfaction with Care: Ratings of overall health care are very positive with most plans achieving at or above the 75th percentile.

Individual Measure–Medical Assistance with Smoking Cessation: Health behaviors related to smoking account for significant health care costs in Medicaid. Over one-third (34%) of adult respondents indicated that they currently smoke either every day or some days. This percentage was consistent across all plans and is comparable to 2009 levels. A majority of consumers (65% or greater) in all but one plan reported being advised to quit smoking by their doctor or other health care provider. Approximately one-third of smoking consumers reported receiving specific advice regarding either medication or other strategies to stop smoking, with as many as 47% and 45% 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.

Questions	Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Healthcare	Fee-for-Service	Statewide Overall
Medical Assistance with Smoking Cessation							
Advised to Quit	65	66	65	73	57	74	66
Discussed Medication	35	33	31	47	28	32	34
Discussed Other Strategies	34	29	28	45	25	42	33

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.

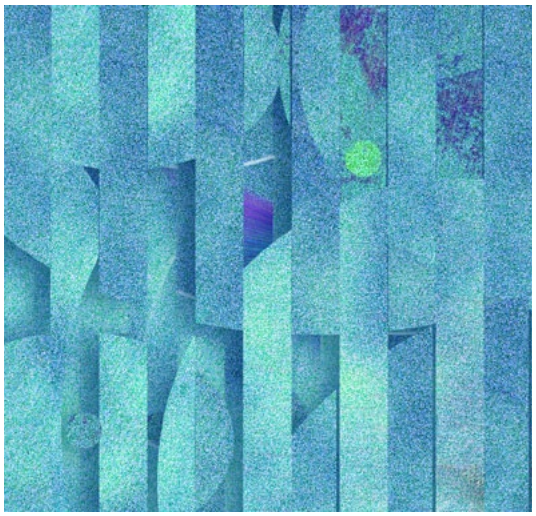
Measure	Absolute Total Care	Blue Choice	First Choice	SC Solutions	United Healthcare	Fee-for-Service	Statewide Overall	National Percentiles			
								25th	50th	75th	90th
Satisfaction and Experience with Provider Networks											
How Well Doctors Communicate	2.81	2.75	2.83	2.87	2.86	2.86	2.83	2.63	2.68	2.72	2.75
Rating of Personal Doctor	2.79	2.62	2.82	2.83	2.75	2.78	2.77	2.58	2.62	2.65	2.69
Rating of Specialists	2.39	2.65	2.71	2.68	2.57	2.63	2.62	2.53	2.59	2.62	2.66
Satisfaction and Experience with Access to Care and Health Plan											
Get Needed Care	2.44	2.41	2.53	2.53	2.57	2.42	2.47	2.29	2.36	2.44	2.50
Get Care Quickly	2.70	2.65	2.69	2.74	2.59	2.64	2.67	2.54	2.61	2.66	2.69
Customer Service	2.53	2.61	2.56	2.48	2.52	2.42	2.51	2.31	2.40	2.47	2.53
Rating of Health Plan	2.55	2.51	2.69	2.70	2.62	2.60	2.61	2.51	2.57	2.62	2.67
Satisfaction and Experience with Care											
Rating of Health Care	2.61	2.50	2.66	2.69	2.66	2.64	2.63	2.49	2.52	2.57	2.59

Experience and Satisfaction with Provider Network: Overall for children, experience with the provider network is positive, particularly on measures related to their personal doctor. 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.

Experience and Satisfaction with Access to Care and Health Plan: Consumers report better experience and higher satisfaction with Access to Care measures for children than for adults for all plans. Families continue to report a strong level of satisfaction with Customer Service and are able to find needed information and get help when they call their health plan. However, overall ratings of the health plan show more variability.

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

Appendix A:
Descriptions of Measures



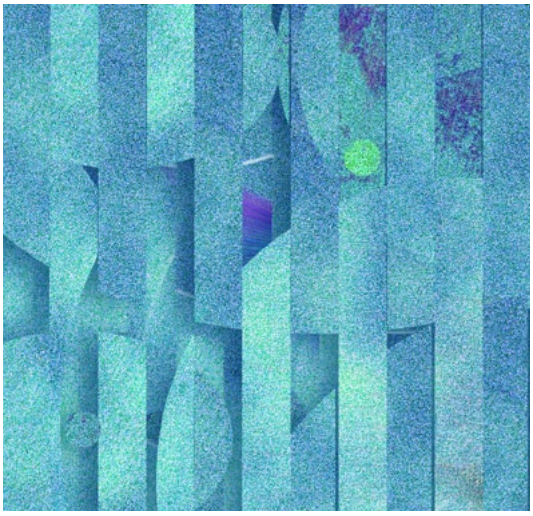
Appendix A: Descriptions of Measures

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† • 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

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 5–50 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 - 12-50 Years • 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.
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; and • 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. The organization reports three separate percentages for each product line: • Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year; and • Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to 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 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?"
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:
Measures With National Benchmarks



Appendix B: Measures With National Benchmarks

		Weighted	NCQA National Medicaid Benchmarks					
		State Average	Mean	P10	P25	P50	P75	P90
PEDIATRIC CARE	**Adolescent Well-Care Visits**	27.5	47.7	34.4	38.8	46.8	56	63.2
	Appropriate Testing for Children With Pharyngitis	72.6	62.3	40.2	54.3	65.5	73.5	80.9
	Appropriate Treatment for Children With Upper Respiratory Infection †	82.7	86.0	77.7	82.1	85.8	90.6	94.9
	Emergency Department Visits Per 1,000 (New Measure) ‡							
	Age <1 Year	84.2	98.3	70.6	87.2	99.3	110.2	127.2
	Ages 1-9	44.9	56.3	41.9	50.2	56.6	62.3	71.3
	Ages 10-19	42.4	46.9	31.8	39.6	46.2	54	62
	Lead Screening in Children	48.7	66.4	42.3	57.6	71.6	81	88.4
	Well-Child Visits							
	Ages 0-15 Months: Zero Visits Rate *	1.9	2.3	0.5	0.7	1.4	2.9	5.1
	Ages 0-15 Months: Six or More visits Rate	50.9	59.4	40.9	52.2	60.1	69.7	76.3
	Ages 3-6 Years	55.8	71.6	59.9	65.9	71.8	77.3	82.5
WOMEN'S CARE	**Breast Cancer Screening**	44.7	52.4	39.8	46.2	52	59.6	63.8
	Cervical Cancer Screening	51.2	65.8	50.4	61	67.8	72.9	78.9
	Chlamydia Screening in Women							
	Ages 16-20 Years	52.6	54.4	43.8	48.5	53	61.1	66.4
	Ages 21-24 Years	58.8	61.6	49.5	55.8	62.4	69.1	73.4
	Combined Rate	55.0	56.7	44.2	50.6	55.7	63.7	69.5
	Emergency Department Visits Per 1,000 (New Measure) ‡							
	Ages 20-44	96.1	105.2	68.8	81.7	107.7	126.6	144.5
	Ages 45-64	94.5	79.6	46.1	60.1	82.9	101	113.2
	Age 65-74	51.0	57.5	0	20.3	35.2	51.1	80
	Prenatal and Postpartum Care							
	Timeliness of Prenatal Care	78.2	83.4	70.6	80.3	86	90	92.7
	Postpartum Care	63.0	64.1	53	58.7	65.5	70.3	74.4
LIVING WITH ILLNESS	**Comprehensive Diabetes Care**							
	HbA1c Testing	43.6	80.6	69.4	76	81.1	86.4	90.2
	Eye Exams	36.9	52.7	32.1	41.4	54	63.7	70.1
	LDL-C Screening	37.0	74.2	62.6	69.3	75.4	80.1	84
	Medical Attention for Diabetic Nephropathy	56.4	76.9	65.7	72.5	77.7	82.7	86.2
	Use of Appropriate Medications for People with Asthma							
	5-11 Years	95.3	91.8	88.2	90	92.2	93.9	95.5
	12-50 Years	89.6	86.0	79.9	83.8	86.3	89.1	90.7
	Combined Rate	92.5	88.6	84.6	86.7	88.6	90.8	92.8
BEHAVIORAL HEALTH	**Attention-Deficit Hyperactivity Disorder (ADHD): % Ages 6 to 12 Years Prescribed an ADHD Medication Who Had a Follow-Up Within 30 Days**							
	Initiation Phase	44.7	36.6	24.8	30.9	35.7	42.2	48.1
	Continuation	51.8	41.7	24.8	34.7	42.1	50.7	57.6
	Follow-up Care After Hospitalization for Mental Illness - Ages 6 Years and Above							
	Within 7 Days	32.8	42.9	18.2	29.6	43.5	59.1	64.3
	Within 30 Days	55.5	60.2	31.8	49	62.6	74.3	83.6
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (New Measure)							
	Initiation (Ages 13-17 Years)	48.8	42.5	22.4	32.3	41.4	54.1	62.7
	Initiation (Ages 18+)	30.2	44.7	32.5	38.1	43.9	49.8	58.6
	Initiation (Total)	31.5	44.3	31.8	38.4	43.9	48.8	57.3
	Engagement (13-17 Years)	30.0	17.7	2.5	7.1	13.9	25.7	40
	Engagement (18+)	5.6	11.8	2.5	3.4	8.5	16.7	22.2
	Engagement (Total)	7.4	12.3	2.3	4.1	10.2	17.6	21.4
ACCESS TO CARE	**Children and Adolescents' Access to Primary Care Practitioners**							
	Ages 12-24 Months	97.6	95.2	90.6	95.1	96.8	97.9	98.5
	Ages 25 Months-6 Years	86.0	88.3	81	87.1	89.8	92.2	94.1
	Ages 7-11 Years	87.6	90.3	85	87.7	91.3	93.4	95.6
	Ages 12-19 Years	84.7	87.9	80.6	85.4	88.9	91.8	93.7
	Adult's Access to Preventive/Ambulatory Health Services							
	Ages 20-44 Years	75.2	80.5	67.4	78	82.9	86.7	88.5
	Ages 45-64 Years	75.8	85.3	73.2	83.2	88.1	90.1	91.3

Above NCQA 75th percentile

Below NCQA 25th percentile

† = Inverse rate (higher is better)

‡ = Higher is better

* = Inverted measure (lower is better)

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