



Institute for Child Health Policy at the University of Florida  
Texas External Quality Review Organization

# **Texas Medicaid STAR Health Program Quality of Care Report**

**Fiscal Year 2010**

**Measurement Period:**

**September 1, 2009 through August 31, 2010**

**The Institute for Child Health Policy**

**University of Florida**

**The External Quality Review Organization  
for Texas Medicaid Managed Care and CHIP**

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# Executive Summary

## ***Introduction***

This report provides an annual update of the quality of care provided to members in the STAR Health program for the State of Texas, prepared by the Institute for Child Health Policy at the University of Florida, the External Quality Review Organization (EQRO) for Texas Medicaid Managed Care. This update is for September 1, 2009 to August 31, 2010, covering fiscal year 2010.

The STAR Health program began on April 1, 2008, to provide coordinated health care services, including medical, dental, behavioral, and unlimited prescription benefits to children, adolescents, and young adults in foster care and kinship care. The Texas Health and Human Services Commission (HHSC) contracts with the Superior Health Plan Network to provide health care services through the STAR Health program to children and adolescents in state conservatorship, to young adults up to age 22 who have a voluntary foster care placement, to young adults under the age of 21 who are no longer in foster care and are receiving transitional Medicaid benefits and to young adults age 21 through the month of their 23<sup>rd</sup> birthday who are participating in the FFCHE program.

This report provides descriptive information about the STAR Health population, and an evaluation of access to care, utilization of services, and the effectiveness of care for STAR Health members.

Results for the following quality of care measures are presented in this report:

- **Access to Care** – *Prenatal and Postpartum Care, and Children and Adolescents' Access to Primary Care Practitioners.*
- **Utilization of Services** – *Frequency of Ongoing Prenatal Care, Well-Child Visits in the First 15 Months of Life, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Adolescent Well-Care Visits, HEDIS<sup>®</sup> Ambulatory Care, AHRQ Pediatric Quality Indicators (PDIs), and HEDIS<sup>®</sup> Mental Health Utilization.*
- **Effectiveness of Care** – *Follow-up Care for Children Prescribed ADHD Medication, Follow-up After Hospitalization for Mental Illness, Readmission within 30 days After an Inpatient Stay for Mental Health, HEDIS<sup>®</sup> Appropriate Testing for Child with Pharyngitis, HEDIS<sup>®</sup> Appropriate Treatment for Children with Upper Respiratory Infection, and HEDIS<sup>®</sup> Chlamydia Screening for Women.*

## ***Methodology***

A detailed description of the methodology used in this report is presented in **Appendix A**. Information regarding the calculation of all measures included in this report can be found in the document “Quality of Care Measures Technical Specifications Report, July 2011.”<sup>1</sup>

Rates for Healthcare Effectiveness and Data Information Set (HEDIS<sup>®</sup>) were calculated using National Committee for Quality Assurance (NCQA) certified software. Discussion of these

results includes comparison with HEDIS® national Medicaid rates, which are derived from rates reported to the NCQA by Medicaid Managed Care plans nationally.<sup>2</sup>

At the request of the HHSC, the EQRO developed a methodology to allow for flexibility in the provider specialty codes when determining eligibility for certain HEDIS® measures. The following measures rely on specific provider specialty codes, and are therefore affected by this change in methodology:

- Prenatal Care
- Children and Adolescents’ Access to Primary Care Providers
- Frequency of Prenatal Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visits
- Follow-up Care for Children Prescribed ADHD Medication
- Follow-up After Hospitalization for Mental Illness

For these measures, the name HEDIS® has been removed from the titles as these measures do not adhere precisely to NCQA specifications and their results are likely inflated from the lifting of provider constraints. Thus, figures displaying results for these measures do not include comparison to HEDIS® national Medicaid rates.

Pediatric Quality Indicators (PDIs) developed by the Agency for Healthcare Research and Quality (AHRQ) were used to evaluate the performance of the STAR Health program related to inpatient admissions for five ambulatory care sensitive conditions (ACSCs) – asthma, gastroenteritis, urinary tract infection, diabetes short-term complications, and perforated appendix. The AHRQ considers ACSCs “conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.”<sup>3</sup>

### **Summary of Findings**

#### Access to Care

- *Prenatal and postpartum care.* Fifty-eight percent of pregnant women in STAR Health received

#### STAR Health Member Demographics

August 2010

Number of members: 32,523

Average member age: 8.2 years

Gender	Percent of STAR Health Members
Female	49%
Male	51%

Race-ethnicity	Percent of STAR Health Members
Hispanic	40%
White, non-Hispanic	30%
Black, non-Hispanic	27%

a prenatal care visit in their first trimester or within 42 days of enrollment. Fifty percent had a postpartum care visit between three and eight weeks after giving birth.

- *Access to primary care practitioners.* Overall, children in the STAR Health program had good access to primary care practitioners (PCPs), with 98 percent visiting a provider during the measurement period.

### Utilization of Services

- *Utilization of prenatal care.* Forty percent of pregnant women in the STAR Health program had greater than 80 percent of the recommended number of prenatal care visits.
- *Children's preventive health care.* Utilization of preventive care in the STAR Health program varied according to the child's age.
  - 54 percent had six or more well-child visits during the first 15 months of life.
  - 88 percent of children three to six years old had at least one well-child visit.
  - 73 percent of adolescents had at least one well-care visit.
- *Ambulatory care.* The rate of outpatient visits in STAR Health was 459 per 1,000 member months. The rate of emergency department visits in STAR Health was 51 per 1,000 member months.
- *Inpatient admissions.* Asthma was the most common ACSC-related inpatient admission among STAR Health members (97 per 100,000). The rate of inpatient admissions for diabetes short-term complications (60 per 100,000) was twice the national average.
- *Mental health utilization.* Seventy-eight percent of STAR Health members received mental health services.

### Effectiveness of Care

- *Follow-up care for children with ADHD.* Most children in STAR Health received appropriate follow-up care for ADHD.
  - 89 percent of children with ADHD in STAR Health had a follow-up visit within 30 days of being dispensed a new ADHD medication.
  - 94 percent had at least two additional follow-up visits with a provider in the nine months after initiating treatment.
- *Mental health treatment.* Among STAR Health members hospitalized for mental illness:
  - 70 percent had a follow-up visit with seven days of discharge from the hospital.
  - 92 percent had a follow-up visit with 30 days of discharge from the hospital.
  - The rate for mental health readmission within 30 days was 22 percent.
- *Respiratory conditions.* Forty-eight percent of children in STAR Health with pharyngitis received appropriate testing from their providers, and 79 percent of children diagnosed with upper respiratory infection received appropriate treatment.

- *Chlamydia screening.* Fifty-seven percent of female members 16 to 20 years old were screened for chlamydia.

**Recommendations**

The performance of STAR Health and the Superior Health Plan Network in delivering accessible, appropriate, and efficient care to children in foster care was equal to or improved for all measures since this study was conducted in fiscal year 2009. There is continued need for improvement in areas that performed poorly in comparison to national practice guidelines or national averages, such as prenatal and postpartum care, potentially avoidable inpatient admissions for diabetes short-term complications, and effectiveness of care for children with respiratory infections.

The EQRO recommends that Superior Health Plan continue efforts that were successful in fiscal year 2009 for improving the quality of care for STAR Health members. More focused efforts are recommended in areas where performance fell below national guidelines and averages.

Domain	Recommendations	Rationale	HHSC Recommendations/Responses
Prenatal and postpartum care	<ul style="list-style-type: none"> <li>• Ensure that all qualifying STAR Health members are enrolled in existing perinatal case management and care coordination programs (e.g., high-risk OB).</li> <li>• Focus quality improvement efforts on existing perinatal programs, including Performance Improvement Projects (PIPs) that assess changes in program performance using the measures presented in this report.</li> <li>• Consider implementing the successful strategies of health plans awarded by NCQA for innovation in multicultural health care:<sup>4</sup> <ul style="list-style-type: none"> <li>○ Face-to-face contact</li> </ul> </li> </ul>	<p>The rate of prenatal and postpartum care visits among pregnant women in STAR Health was low, at 58 percent and 50 percent, respectively.</p> <p>Utilization of prenatal visits was also below national standards, with one-third having fewer than 61 percent of the expected number of prenatal care visits.</p>	<p>There were a total of 260 live births to women in the STAR Health program in FY 2010.</p> <ul style="list-style-type: none"> <li>• Members who have been identified as needing prenatal and postpartum care are enrolled with an OB case manager.</li> <li>• MCO has identified dedicated OB case managers who do telephonic screening and outreach to members.</li> <li>• Although lower than national standards, 40 percent of women in STAR Health had more than 80 percent of expected prenatal care visits in fiscal year 2010 compared to 29 percent in fiscal year 2009.</li> <li>• HHSC will recommend the MCO consider developing a performance improvement</li> </ul>

	<p>with outreach workers with common cultural background/experience.</p> <ul style="list-style-type: none"> <li>○ Incentives to providers for completing prenatal registration forms to facilitate risk stratification and initiate outreach.</li> <li>○ Care coordination among in-house perinatal program staff, community agency representatives, providers, social workers, and non-medical support (e.g., doulas).</li> </ul> <ul style="list-style-type: none"> <li>● Consider implementing or improving upon maternal home visitation programs that include community health nurses and medical social workers.<sup>5, 6</sup></li> </ul>		<p>project (PIP) to improve rates of prenatal and postpartum care visits for pregnant women.</p>
<p>Diabetes care management</p>	<ul style="list-style-type: none"> <li>● Ensure that all qualifying STAR Health members are enrolled in the existing diabetes disease management (DM) program in coordination with the contracted disease management organization (DMO).</li> <li>● Focus quality improvement efforts on the diabetes DM program for STAR Health members,</li> </ul>	<p>The rate of potentially avoidable inpatient stays for diabetes short-term complications was twice the national average.</p>	<ul style="list-style-type: none"> <li>● Members who have been diagnosed with a diabetic condition are enrolled in a disease management program for diabetes care management.</li> <li>● Inpatient admission rates for diabetes short-term complications improved from 90 per 100,000 members in fiscal year 2009 to 60 per 100,000 members in fiscal year 2010. HHSC will continue to monitor to ensure these rates continue</li> </ul>

	<p>including the use of appropriate corrective action against the DMO when contractual standards are not met.</p> <ul style="list-style-type: none"> <li>• Ensure that provider networks for STAR Health members include outpatient services for diabetes care adequate to meet the needs of this population.</li> </ul>		<p>to improve and administer corrective action if appropriate.</p> <ul style="list-style-type: none"> <li>• MCO performs dual case management for members with a diagnosis of diabetes and Behavioral Health.</li> <li>• MCO is investigating different interventions to address the needs for this population.</li> </ul>
<p>Appropriate treatment for children with upper respiratory infections</p>	<ul style="list-style-type: none"> <li>• Ensure that primary care providers (PCPs) of STAR Health members are following proper and up-to-date clinical practice guidelines for treatment of children with pharyngitis.</li> <li>• Consider physician training programs for PCPs of STAR Health members to reduce inappropriate antibiotic prescribing: <ul style="list-style-type: none"> <li>○ Train providers in the use of an interactive booklet to facilitate primary care consultations for childhood upper respiratory tract infections.<sup>7, 8</sup></li> <li>○ Implement a physician behavior-change strategy that includes guideline dissemination, small-group education,</li> </ul> </li> </ul>	<p>The rates of appropriate testing for children with pharyngitis and appropriate treatment of children with upper respiratory infection were lower in STAR Health than the HEDIS® national averages.</p> <p>These findings suggest that many STAR Health primary care providers are inappropriately prescribing antibiotic medications to children presenting with upper respiratory complaints.</p>	<ul style="list-style-type: none"> <li>• MCO currently has a performance improvement project (PIP) addressing asthma which will require follow-up with all patients who visit the emergency room with a respiratory complaint. Members who have been identified with upper respiratory conditions and determined to be asthma related are enrolled in a disease management program for asthma.</li> <li>• HHSC will incorporate the HEDIS measures “Appropriate testing for Children with Upper Respiratory Infections” and “Appropriate Testing for Children with Pharyngitis” into the Performance Indicator Dashboard to monitor inappropriate use of antibiotic prescribing.</li> <li>• MCO has interventions for reducing the use of antibiotics to treat viruses. They provide cold kits to a large provider community</li> </ul>

	updates, educational materials, and prescribing feedback, targeting the treatment of children ages 2 to 6 years old. <sup>9</sup>		and Fluvention outreach. <ul style="list-style-type: none"> <li>• MCO will add this measure to their provider profiling which tracks how providers are doing in comparison to their peers.</li> </ul>
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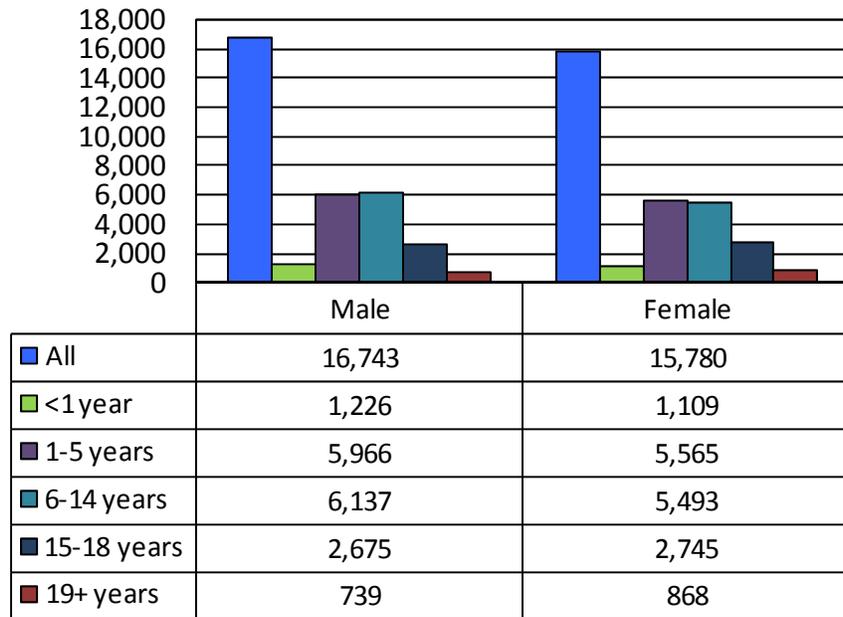
## The STAR Health Population

**Figure 1** provides the total number of unduplicated members in STAR Health during August 2010 by sex and age.

There were 32,523 members in STAR Health during August 2010. Fifty-one percent of members were male, and 49 percent were female.

The mean age of members was 8.2 years (SD= 6.12). Seven percent were under one year of age, 35 percent were between one and five years old, 36 percent were between six and 14 years old, 17 percent were between 15 and 18 years old, and five percent were 19 years of age and older.

**Figure 1. The Total Number of Unduplicated Members in STAR Health during August 2010**

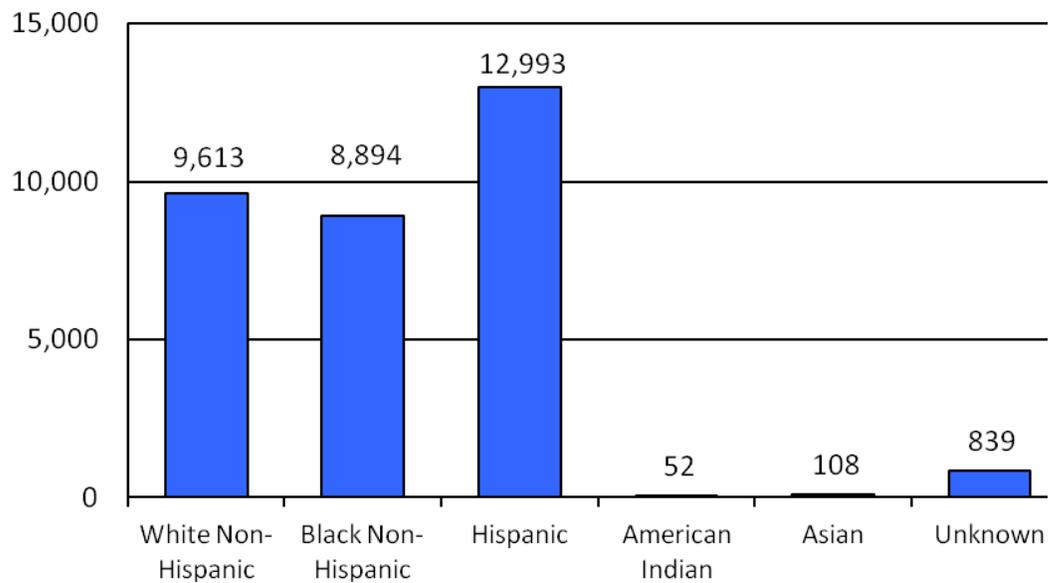


Reference: Table 1

**Figure 2** provides the total number of unduplicated members in STAR Health in August 2010, distributed by race and ethnicity.

There were 12,993 Hispanic members in STAR Health, comprising 40 percent of the STAR Health population during August 2010. Thirty percent of STAR Health members were White, non-Hispanic, and 27 percent were Black, non-Hispanic.

**Figure 2. The Distribution of STAR Health Members by Race-Ethnicity during August 2010**



Reference: Table 2

## Access to Care

### *Prenatal and Postpartum Care*

**Figure 3** provides the percentage of live birth deliveries among women in STAR Health who received prenatal care in their first trimester (or within 42 days of enrollment in STAR Health), and who had a postpartum visit on or between 21 days and 56 days after delivery. There were 260 live births to women in STAR Health between September 1, 2009 and August 31, 2010 (SFY 2010).

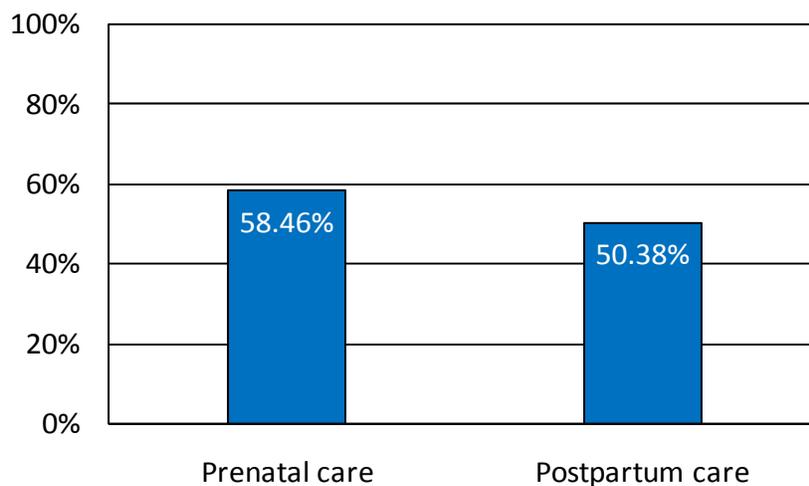
**Fifty-eight percent of women in STAR Health received prenatal care in their first trimester of pregnancy or within 42 days of enrollment.** This rate is slightly higher than in fiscal year 2009, when 53 percent received prenatal care during their first trimester.

**Half of women in STAR Health had a postpartum care visit between three and eight weeks after giving birth (50 percent).** This rate is slightly higher than in fiscal year 2009, when 46 percent received a postpartum visit.

While rates of prenatal and postpartum care in STAR Health were higher than in the prior measurement year, access to care is still considerably low, given the importance of these visits to the health of both mother and infant.<sup>10</sup>

The STAR Health program performed below the 10<sup>th</sup> percentile for Medicaid Managed Care Plans reporting to the NCQA on these measures. The HEDIS<sup>®</sup> means for prenatal and postpartum care were 83 percent and 64 percent, respectively.

**Figure 3. Access to Prenatal and Postpartum Care in STAR Health**



Reference: Table PPC

**Children and Adolescents' Access to Primary Care Practitioners**

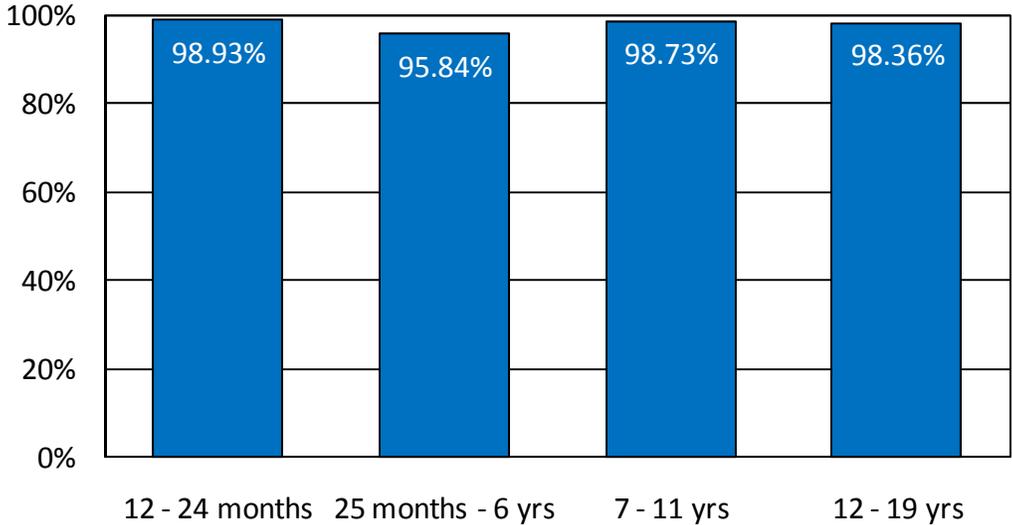
**Figure 4** provides the percentage of children and adolescents in STAR Health who had a visit with a provider during the measurement period, distributed by age. Rates are presented separately for four age groups: 12 to 24 months of age, 25 months to six years old, seven to 11 years old, and 12 to 19 years old.

**Rates of access to STAR Health providers were very high across age cohorts**, with greater than 95 percent of members visiting a provider during the measurement period.

- 99 percent of members 12 to 24 months old had a visit with a provider.
- 96 percent of members 25 months to six years old had a visit with a provider.
- 99 percent of members seven to 11 years old had a visit with a provider.
- 98 percent of members 12 to 19 years old had a visit with a provider.

In fiscal year 2009, rates of access to providers were only available for the 25 month to six year old and seven to 11 year old cohorts. Rates for these cohorts improved slightly since fiscal year 2009. In addition, access to PCPs in STAR Health was better than in Medicaid Managed Care Plans reporting to the NCQA on this measure (above the HEDIS<sup>®</sup> 90 percentile for each age cohort).

**Figure 4. Children and Adolescents' Access to Primary Care Practitioners**



Reference: Table CAP

## Utilization of Services

### Frequency of Prenatal Care

**Figure 5** provides the results for the Frequency of Ongoing Prenatal Care (FPC) measure. This measure examines women's use of prenatal care services relative to guidelines recommended by the American College of Obstetricians and Gynecologists for frequency/scheduling of prenatal care. The FPC measure tracks women who had a live delivery in the past year to determine the percentage of recommended prenatal visits they had (the ratio of observed-to-expected prenatal care visits). The results are presented as the percentage of members who received less than 21 percent, 21 to 40 percent, 41 to 60 percent, 61 to 80 percent, and more than 80 percent of the number of expected prenatal care visits.

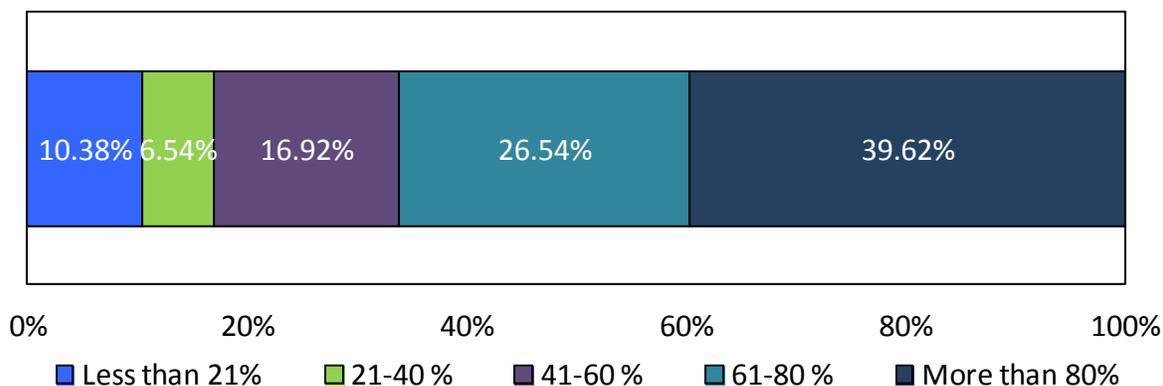
There were 260 live births to women in STAR Health between September 1, 2009 and August 31, 2010 (SFY 2010). Among these women:

- 10 percent had less than 21 percent of expected prenatal care visits;
- 7 percent had 21 to 40 percent of expected prenatal care visits;
- 17 percent had 41 to 60 percent of expected prenatal care visits;
- 27 percent had 61 to 80 percent of expected prenatal care visits; and
- 40 percent had more than 80 percent of expected prenatal care visits.

The percentage of women in STAR Health that had greater than 80 percent of expected prenatal care visits was considerably lower than the HEDIS<sup>®</sup> average for this measure (40 vs. 62 percent).

A larger percentage of women in STAR Health in fiscal year 2010 had more than 80 percent of expected prenatal care visits than in fiscal year 2009 (40 vs. 29 percent).

**Figure 5. Frequency of Prenatal Care – Percent of STAR Health Members Receiving the Expected Number of Prenatal Care Visits**



Reference: Table FPC

### Well-Child and Adolescent Well-Care Visits

**Figure 6** provides the percentage of members who had a well-child or adolescent well-care visit in STAR Health during the measurement period of September 1, 2009 and August 31, 2010. Utilization of well-child and adolescent well-care visits was higher than in fiscal year 2009 for all age groups.

**Fifty-four percent of members had six or more well-child visits between birth and 15 months of life**, compared to 40 percent in fiscal year 2009 (a 14 percentage point increase).

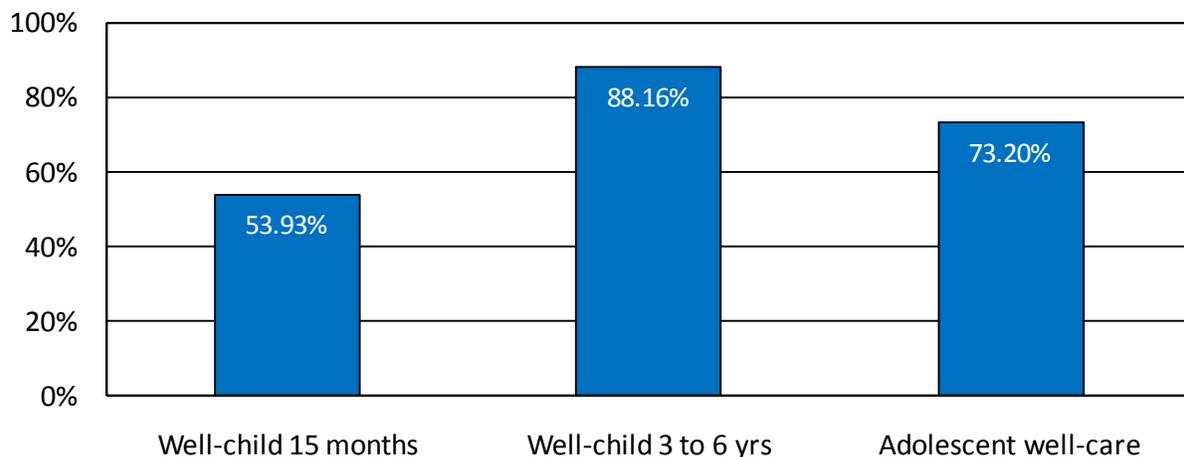
**Eighty-eight percent of members three to six years old had at least one well-child visit**, compared to 81 percent in fiscal year 2009 (a 7 percentage point increase).

**Seventy-three percent of members 12 to 21 years old had at least one well-care visit**, compared with 65 percent in fiscal year 2009 (an 8 percentage point increase).

The STAR Health program performed above the HEDIS® 90<sup>th</sup> percentile for well-child visits among members three to six years old (88 vs. 72 percent), and for adolescent well-care visits (73 vs. 48 percent).

The percentage of STAR Health members who had six or more well-child visits in their first 15 months of life was lower than the HEDIS® mean for this measure (54 v 59 percent).

**Figure 6. Well-Child and Adolescent Well-Care Visits**



Reference: Tables W15, W34, and AWC

**Utilization of Ambulatory Care**

**Outpatient Care**

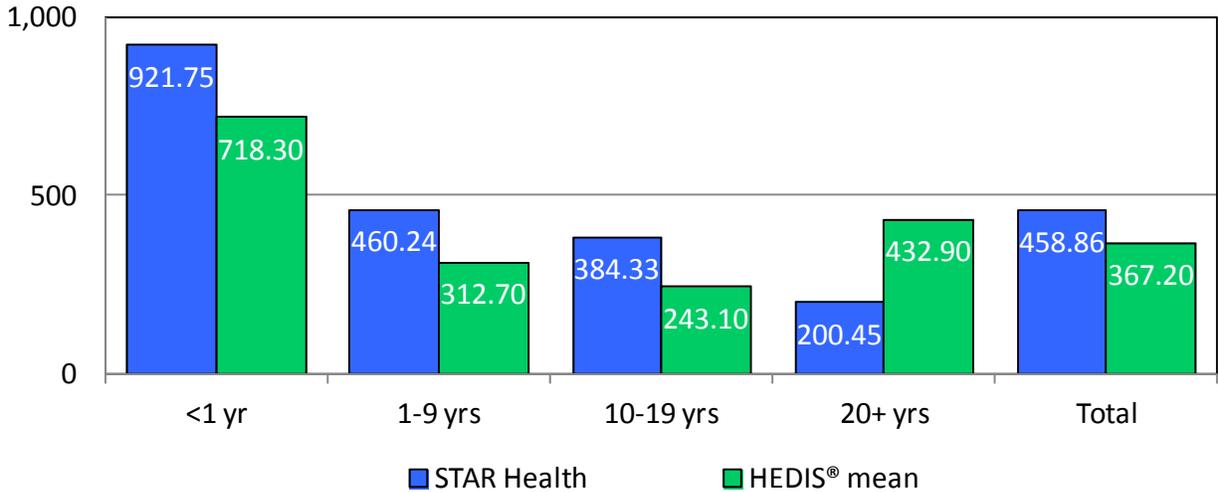
**Figure 7** provides results for the HEDIS® Ambulatory Care outpatient measure, showing the rate of outpatient visits per 1,000 member months in STAR Health, distributed by age group.

STAR Health members had 459 outpatient visits per 1,000 member months during the measurement year. This rate is higher than the national HEDIS® average of 367 per 1,000 member months.

Utilization of outpatient care in STAR Health was highest for members less than one year old, and generally declined with age. The rate of outpatient visits was:

- 922 per 1,000 member months among members less than one year old.
- 460 per 1,000 member months among members one to nine years old.
- 384 per 1,000 member months among members 10 to 19 years old.
- 200 per 1,000 member months among members 20 years of age and older.

**Figure 7. HEDIS® Ambulatory Care – Rates of Outpatient Visits per 1,000 Member Months in STAR Health**



## Emergency Department Utilization

**Figure 8** provides results for the HEDIS® Ambulatory Care emergency department (ED) measure, showing the rate of ED visits per 1,000 member months in STAR Health, distributed by age group.

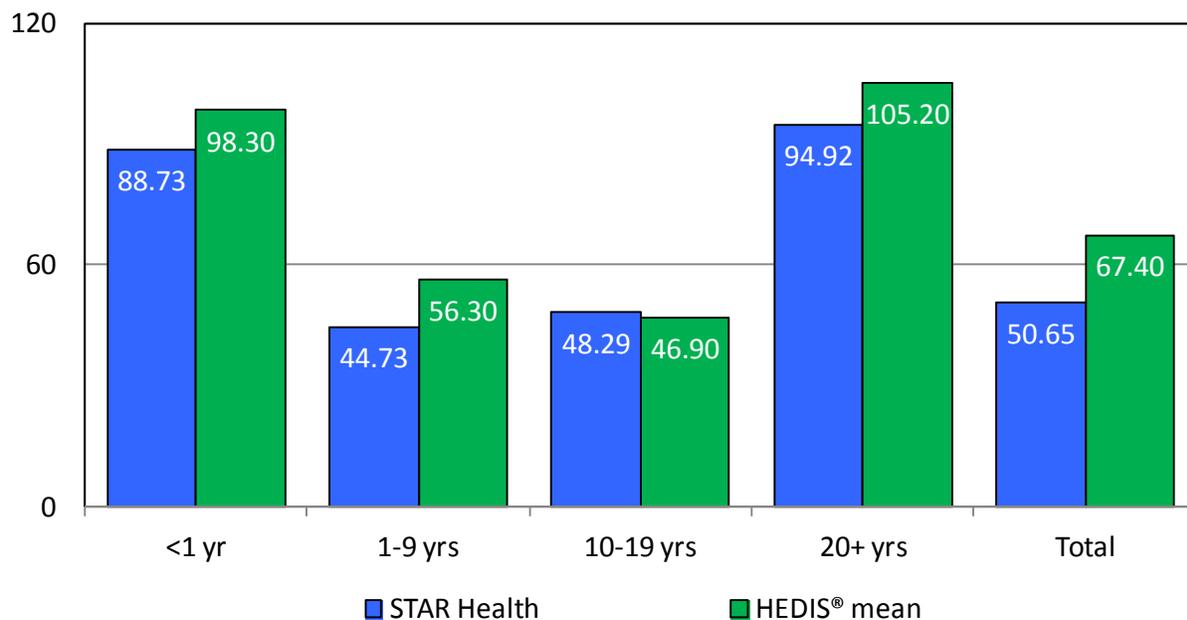
STAR Health members had 51 ED visits per 1,000 member months during the measurement year. This rate is lower than the national HEDIS® average of 67 per 1,000 member months.

Rates of ED visits in STAR Health were highest for members 20 years of age and older, and for members less than one year old.

The rate of ED visits was:

- 89 per 1,000 member months among members less than one year old.
- 45 per 1,000 member months among members one to nine years old.
- 48 per 1,000 member months among members 10 to 19 years old.
- 95 per 1,000 member months among members 20 years of age and older.

**Figure 8. HEDIS® Ambulatory Care - Rates of ED Visits per 1,000 Member Months in STAR Health**



## **AHRQ Pediatric Quality Indicators**

The Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs) use hospital inpatient discharge data to calculate rates of admission for various ambulatory care sensitive conditions (ACSC) for children and adolescents. PDIs screen for inpatient stays that were potentially avoidable with better access to care in outpatient settings. This information is useful for monitoring trends, comparing the performance of health plans and service delivery models, and addressing access to care issues.

**Figure 9** presents AHRQ Pediatric Quality Indicator PDIs results for asthma, diabetes short-term complications, gastroenteritis, and urinary tract infection for members in the STAR Health program. The result for perforated appendix is not shown due to an insufficient number of cases in the denominator.

**Table 1** describes each of the four AHRQ PDIs shown here. Discussion of PDIs in the key points below includes comparisons with national rates reported by AHRQ. It should be noted that these AHRQ national estimates are based on data collected in 2008 and are area-level indicators, including commercial and Medicaid populations.

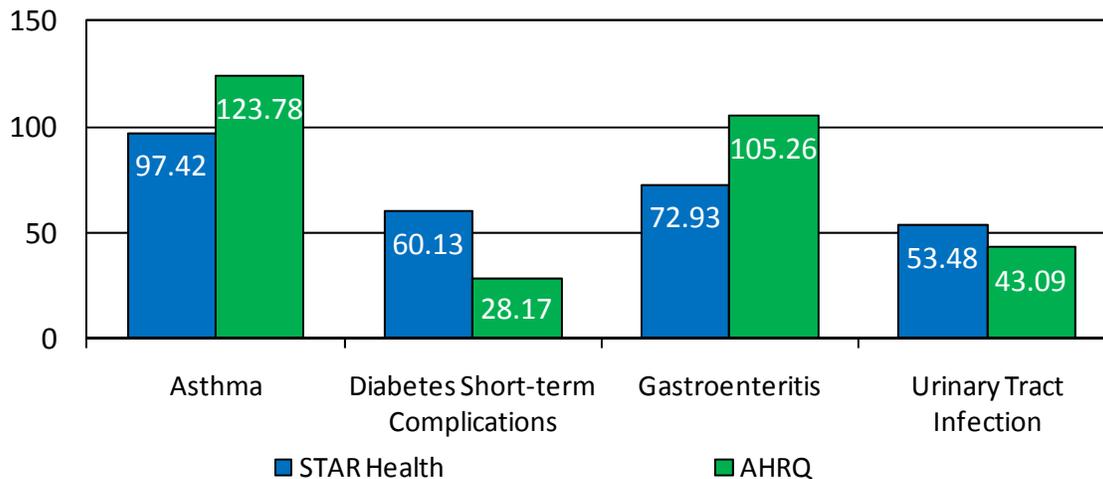
**The highest inpatient PDI admission rate in STAR Health was for asthma and the lowest was for urinary tract infection.**

Compared with AHRQ national estimates:

- The asthma inpatient admission rate was lower in STAR Health than reported nationally (97 vs. 124 per 100,000).
- The diabetes short-term complications inpatient admission rate in STAR Health was more than double the national rate (60 vs. 28 per 100,000).
- The gastroenteritis inpatient admission rate was lower in STAR Health than reported nationally (73 vs. 105 per 100,000).
- The urinary tract infection inpatient admission rate was slightly higher in STAR Health than reported nationally (53 vs. 43 per 100,000).

Since fiscal year 2009, PDI rates in STAR Health declined for all conditions except urinary tract infection.

**Figure 9. AHRQ Pediatric Quality Indicators**



Reference: Table PDI

**Table 1. AHRQ Pediatric Quality Indicators**

AHRQ Indicator Number	Indicator Name	Description
PDI 14	Asthma Admission Rate	Number of admissions for long-term asthma per 100,000 population
PDI 15	Diabetes Short-term Complications Admission Rate	Number of admissions for diabetes short-term complications per 100,000 population
PDI 16	Gastroenteritis Admission Rate	Number of admissions for pediatric gastroenteritis per 100,000 population
PDI 17	Perforated Appendix Admission Rate	Number of admissions for perforated appendix as a share of all admissions for appendicitis within an area
PDI 18	Urinary Tract Infection Admission Rate	Number of admissions for urinary tract infection per 100,000 population

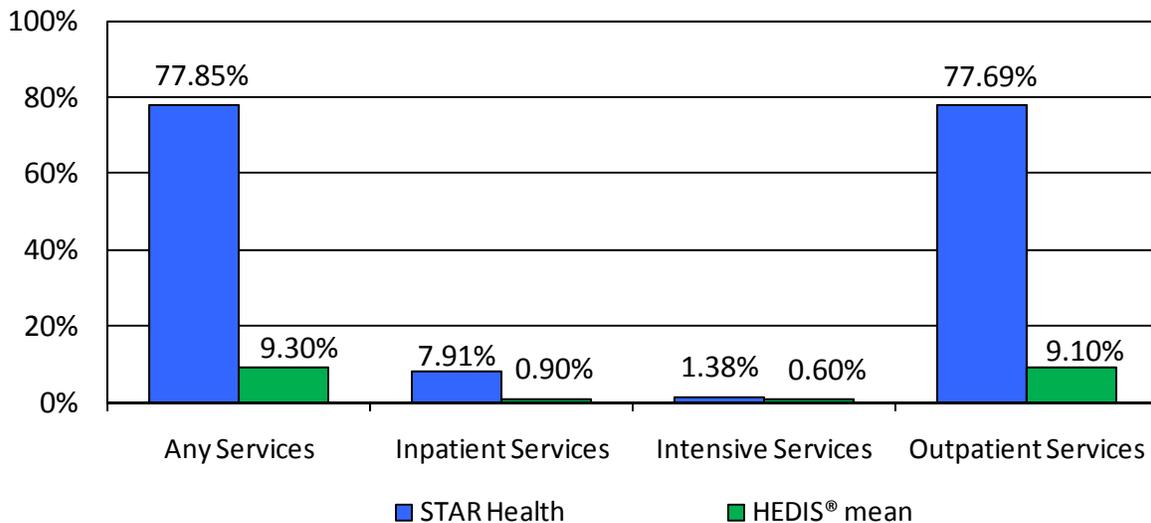
## Mental Health Utilization

**Figure 10** presents results for the HEDIS® Mental Health Utilization measure for the STAR Health program. This measure provides the percentage of STAR Health members receiving any type of mental health services during the measurement period.

**Seventy-eight percent of STAR Health members received mental health services of any type.** The most commonly utilized mental health service among STAR Health members was outpatient services (78 percent).

Utilization of mental health services in STAR Health increased since fiscal year 2009, when 73 percent of members received mental health services. All rates were considerably above the HEDIS® national means – a difference that reflects the greater mental health care needs of the foster care population in general.<sup>11</sup>

**Figure 10. HEDIS® Mental Health Utilization**



Reference: Table MPT

## Effectiveness of Care

### ADHD in Children

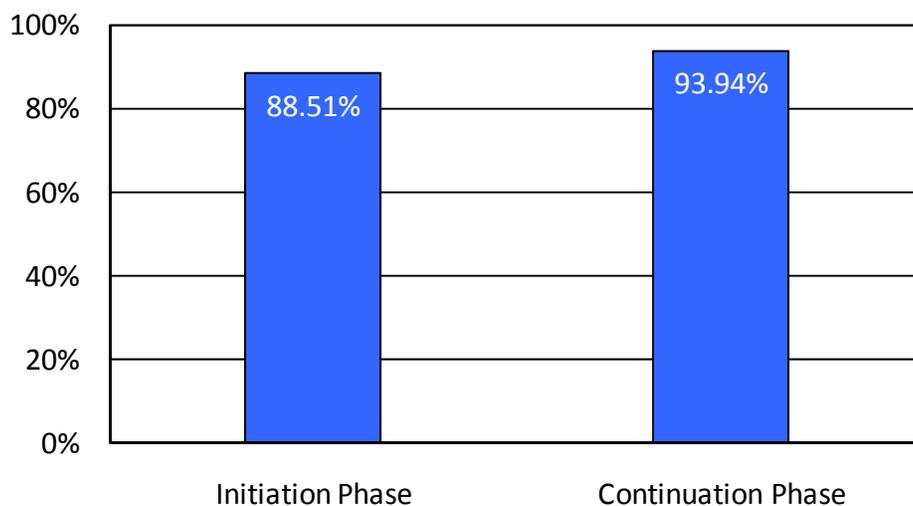
**Figure 11** presents results for the Follow-up Care for Children Prescribed ADHD Medication measure, which provides the percentage of children six to 12 years of age newly diagnosed with ADHD, who received follow-up care during the measurement period.

Two separate rates are reported: 1) The *Initiation Phase* shows the percentage of children with an ambulatory prescription dispensed for ADHD medication who had a follow-up visit with a provider within 30 days after beginning medication treatment; and 2) The *Continuation and Maintenance Phase* shows the percentage of children with an ambulatory prescription dispensed for ADHD medication who continued taking the medication for at least 210 days (30 weeks), and who had at least two follow-up visits with the provider within nine months after the end of the initiation phase.

**Eighty-nine percent of children in STAR Health who were dispensed a new medication to treat ADHD had a follow-up visit with a provider within 30 days of prescription (the *Initiation Phase* of ADHD treatment).**

Among children in STAR Health who took ADHD medication continuously for 30 weeks, **94 percent had at least two additional follow-up visits with a provider in the nine months after initiating treatment (the *Continuation and Maintenance Phase* of ADHD treatment).**

**Figure 11. Follow-up Care for Children Prescribed ADHD Medication**



Reference: Table ADD

Adherence to ADHD medication and follow-up care in STAR Health improved since fiscal year 2009 for the *Initiation Phase* of treatment (89 vs. 83 percent) and for the *Continuation/Maintenance Phase* of treatment (94 vs. 91 percent).

Care provided to children with ADHD in STAR Health was considerably better than reported by Medicaid Managed Care Plans to the NCQA, and was above the HEDIS<sup>®</sup> 90<sup>th</sup> percentile for both the *Initiation and Continuation/Maintenance Phases* of ADHD medication treatment. (Note: The HEDIS<sup>®</sup> mean was 37 percent for the *Initiation Phase* and 42 percent for the *Continuation/Maintenance Phase* of ADHD medication treatment).

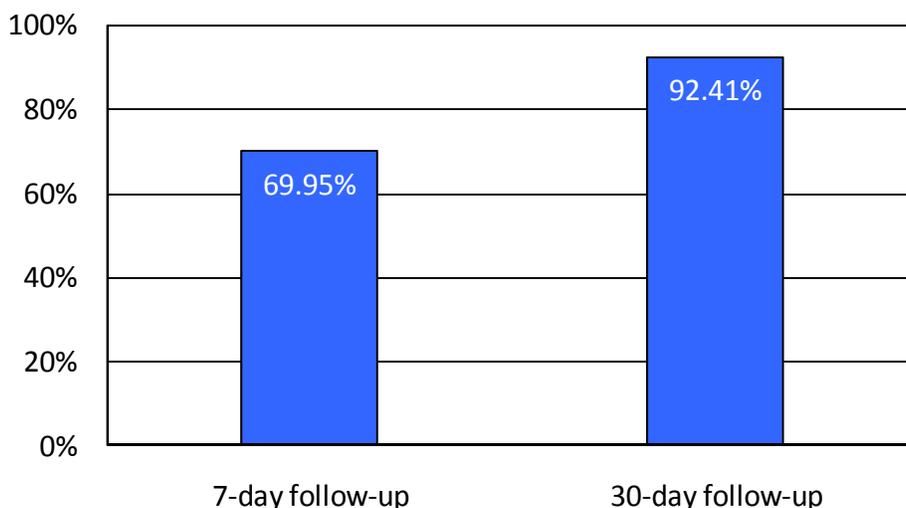
### **Follow-up Care for Mental Illness**

**Figure 12** provides the percentage of STAR Health members six years of age or older who were hospitalized for mental illness and who had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a physician provider during the measurement period. Two percentages are shown – one for follow-up within seven days of discharge, and one for follow-up within 30 days of discharge. There were 2,439 STAR Health members eligible for this measure.

**Seventy percent of STAR Health members who were hospitalized for the treatment of a mental health disorder received follow-up care within one week of discharge.**

**At 30 days post-discharge, 92 percent of STAR Health members had received follow-up care after hospitalization for a mental illness.**

**Figure 12. Follow-up after Hospitalization for Mental Illness**



Reference: Table FUH

Post-discharge mental health care for members has improved since fiscal year 2009 for 7-day follow-up (70 vs. 61 percent) and 30-day follow-up (92 vs. 88 percent).

In addition, post-discharge mental health care was considerably better in STAR Health than in Medicaid Managed Care Plans reporting to the NCQA on this measure, and was above the HEDIS® 90<sup>th</sup> percentile for both 7-day and 30-day follow-up. (Note: The HEDIS® mean was 43 percent for 7-day follow-up and 60 percent for 30-day follow-up).

### ***Mental Health Readmission***

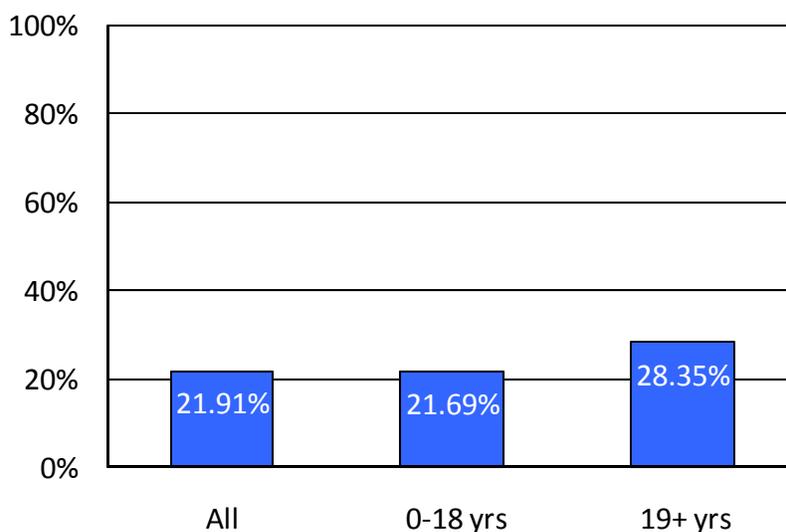
**Figure 13** provides the percentage of STAR Health members who were readmitted within 30 days following an inpatient stay for a mental health disorder, distributed by age. Mental health readmissions are frequently used as a measure of an adverse outcome, which potentially results from efforts to contain behavioral health care costs, such as reducing the initial length of stay.<sup>12</sup> For this measure, lower rates of readmission indicate better performance.

#### **Twenty-two percent of STAR Health members were readmitted to the hospital within 30 days of an inpatient stay for mental health related issues.**

The mental health readmission rate for members 19 years and older was higher than for members 18 years of age and younger (28 vs. 22 percent). It should be noted that members 19 years and older represent five percent of the STAR Health population (1,607 vs. 32,523 members).<sup>13</sup>

The mental health readmission rate has remained unchanged since fiscal year 2009.

**Figure 13. Readmission within 30 days after an Inpatient Stay for Mental Health**



Reference: Table MHRadmit

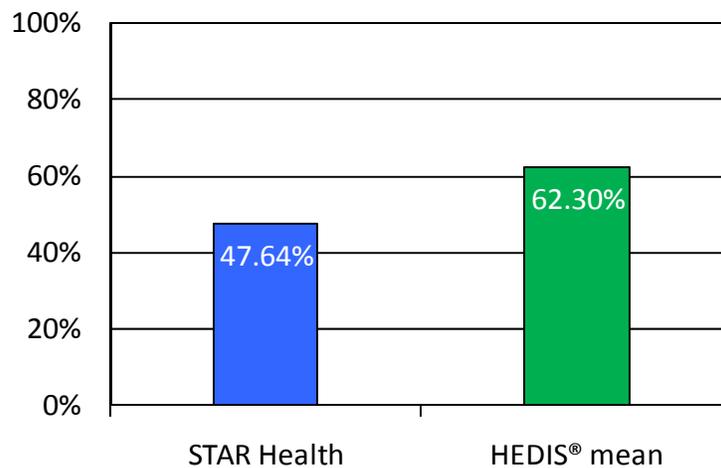
### **Appropriate Testing for Children with Pharyngitis**

**Figure 14** provides the percentage of children 2 to 18 years of age in STAR Health who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus test for the episode during the measurement period.

**Forty-eight percent of children in STAR Health with pharyngitis received appropriate testing.** This result was below the national HEDIS<sup>®</sup> mean of 62 percent, falling between the 10<sup>th</sup> and 25<sup>th</sup> percentile for Medicaid Managed Care Plans reporting to NCQA on this measure.

The percentage of children receiving appropriate testing for pharyngitis in fiscal year 2010 was comparable to the percentage in fiscal year 2009 (48 vs. 48 percent).

**Figure 14. HEDIS<sup>®</sup> Appropriate Testing for Children with Pharyngitis**



Reference: Table CWP

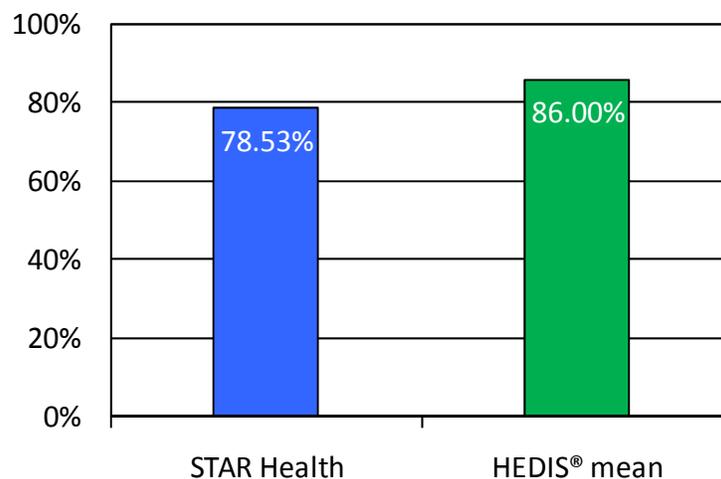
### ***Appropriate Treatment for Children with Upper Respiratory Infection***

**Figure 15** provides the percentage of children three months to 18 years of age who received a diagnosis of upper respiratory infection (URI) and who were not dispensed an antibiotic prescription. Pediatric clinical guidelines do not recommend antibiotic treatment for most upper respiratory infections. Thus, high percentages on this measure indicate good performance.

**Seventy-nine percent of children in STAR Health received appropriate treatment for upper respiratory infection.** This result was lower than the national HEDIS<sup>®</sup> mean of 86 percent.

The percentage of children receiving appropriate treatment for upper respiratory infection in fiscal year 2010 was comparable to the percentage in fiscal year 2009 (79 vs. 78 percent).

**Figure 15. HEDIS<sup>®</sup> Appropriate Treatment for Children with Upper Respiratory Infection**



Reference: Table URI

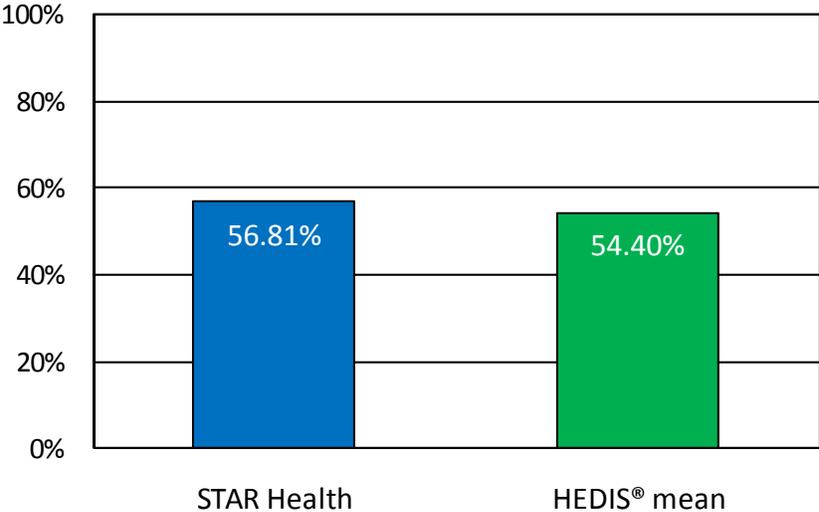
**Chlamydia Screening in Women**

**Figure 16** provides the percentage of women who were identified as sexually active and who had at least one test for Chlamydia during the measurement period. HEDIS<sup>®</sup> specifications report two age cohorts – 16 to 20 years old and 21 to 24 years old – and a total rate. However, because fewer than 30 members were in the denominator for the 21- to 24-year-old age group, the results shown below are for the 16- to 20-year-old age group only.

**Fifty-seven percent of STAR Health members 16 to 20 years old were screened for Chlamydia.** The STAR Health program performed slightly above the national average for Medicaid Managed Care Plans reporting to NCQA on this measure.

There was a slight improvement in the percentage of women being screened for chlamydia in the STAR Health program for this reporting period when compared to fiscal year 2009 (57 vs. 52 percent).

**Figure 16. HEDIS<sup>®</sup> Chlamydia Screening in Women**



Reference: Table CHL

## Appendix A: Detailed Methodology

Three data sources were used to calculate the quality of care indicators: (1) member-level enrollment information, (2) member-level health care claims/encounter data, and (3) member-level pharmacy data. The enrollment files contain information about the person's age, gender, the MCO in which the member is enrolled, and the number of months the member has been enrolled in the program. The member-level claims/encounter data contain Current Procedural Terminology (CPT) codes, International Classification of Diseases, 9th Revision (ICD-9-CM) codes, place of service (POS) codes, and other information necessary to calculate the quality of care indicators. The member-level pharmacy data contain information about filled prescriptions, including the drug name, dose, date filled, and refill information.

A six-month time lag was used for the claims and encounter data. Prior analyses with Texas data showed that, on average, over 96 percent of the claims and encounters are complete by that time period.

Information regarding the calculation of all measures included in this report can be found in the document "Quality of Care Measures Technical Specifications Report, July 2011."<sup>14</sup> This document, prepared by the Institute for Child Health Policy, provides specifications for HEDIS<sup>®</sup> and other quality of care measures.

Quality of care indicators in this report include: 1) The Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) 2010 measures; 2) The Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs); and 3) measures developed by the EQRO.

Rates for HEDIS<sup>®</sup> measures were calculated using National Committee for Quality Assurance (NCQA) certified software. In addition, an NCQA auditor certified all of the HEDIS<sup>®</sup> results presented in this report. The letters of certification from the auditor and a letter from NCQA with their seal of the certified results are available from the Texas Health and Human Services Commission (HHSC). Discussion of results includes comparison with HEDIS<sup>®</sup> national Medicaid rates, which are derived from rates reported to the NCQA by Medicaid Managed Care plans nationally.<sup>15</sup> Submission of HEDIS<sup>®</sup> data to NCQA is a voluntary process; therefore, health plans that submit HEDIS<sup>®</sup> data are not fully representative of the industry. Health plans participating in NCQA HEDIS<sup>®</sup> reporting tend to be older, are more likely to be federally qualified, and are more likely to be affiliated with a national managed care company than the overall population of health plans in the United States.<sup>16</sup> NCQA reports the national results as a mean and at the 10<sup>th</sup>, 25<sup>th</sup>, 50<sup>th</sup>, 75<sup>th</sup>, and 90<sup>th</sup> percentiles. The Medicaid Managed Care Plans 2010 mean results are shown and labeled "HEDIS<sup>®</sup> Mean" in the figures.

At the request of HHSC, the EQRO developed a methodology to allow for flexibility in the provider specialty codes when determining eligibility for certain HEDIS<sup>®</sup> measures. As in the prior reporting period (SFY 2009), the EQRO modified the NCQA specifications to lift provider constraints when determining eligibility for these measures. Provider specialty codes are an important component for some HEDIS<sup>®</sup> measures and lifting the provider constraints may result in inflation of rates. For example, NCQA specifications require that a mental health provider be the provider of record for a beneficiary to be considered compliant with the HEDIS<sup>®</sup> measures for 7-day and 30-day follow-up after an inpatient mental health stay. The current methodology

allows a visit with any provider to count toward compliance with the mental health follow-up measures.

The following measures rely on specific provider specialty codes, and are therefore affected by this change in methodology:

- Prenatal Care
- Children and Adolescents' Access to Primary Care Providers
- Frequency of Ongoing Prenatal Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visits
- Follow-up Care for Children Prescribed ADHD Medication
- Follow-up After Hospitalization for Mental Illness

For these measures, the name HEDIS<sup>®</sup> has been removed from the titles, as these measures do not adhere precisely to NCQA specifications, and their results are likely inflated due to the lifting of provider constraints. Thus, the discussion of results for these measures does not include comparison to HEDIS<sup>®</sup> national Medicaid rates and instead focuses on STAR Health performance in fiscal year 2010, compared to fiscal year 2009.

Pediatric Quality Indicators (PDIs) developed by the Agency for Healthcare Research and Quality (AHRQ) were used to evaluate the performance of STAR Health related to inpatient admissions for ambulatory care sensitive conditions (ACSCs). The AHRQ considers ACSCs "conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease."<sup>17</sup> The specifications used to calculate rates for these measures come from AHRQ PDI and PQI versions 4.2. Rates are calculated based on the number of hospital discharges divided by the number of people in the area (except for perforated appendix). Unlike most other measures provided in this report, low PDI rates are desired as they suggest a better quality health care system outside the hospital setting.

PDIs assess pediatric admissions for the following ACSCs: (1) Asthma; (2) Diabetes Short-Term Complications; (3) Gastroenteritis; (4) Perforated Appendix; and (5) Urinary Tract Infection. The age eligibility for these measures is up through 17 years old.

In addition to the narrative and figures contained in this report, technical appendices were provided to HHSC that contain all of the data to support key findings.<sup>18</sup> The interested reader can review those for more details. The corresponding reference table is listed beneath each figure.

## Endnotes

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<sup>1</sup> ICHP (The Institute for Child Health Policy). 2011.<sup>a</sup> *Quality of Care Measures Technical Specifications Report, July 2011*. Gainesville, FL: The Institute for Child Health Policy, University of Florida.

<sup>2</sup> The information that NCQA compiles for Medicaid Managed Care Programs can be viewed at [www.ncqa.org](http://www.ncqa.org).

<sup>3</sup> AHRQ (Agency for Healthcare Research and Quality). 2004. *AHRQ Quality Indicators—Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions*. Rockville, MD: AHRQ. Revision 4. (November 24, 2004). AHRQ Pub. No. 02-R0203.

<sup>4</sup> [http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS\\_InnovativePrac07.pdf](http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS_InnovativePrac07.pdf)

<sup>5</sup> <http://www.ahrq.gov/about/casestudies/pcm/pcm2008c.htm>

<sup>6</sup> Flynn, L., M. Budd, M., and J. Modelski. 2008. "Enhancing resource utilization among pregnant adolescents." *Public Health Nursing* 25(2): 140-148.

<sup>7</sup> Briel, M. 2010. "Interactive booklet reduces antibiotic prescribing for respiratory tract infections in children, but not parent satisfaction." *Evidence Based Nursing* 13(1): 11-12.

<sup>8</sup> Francis, N.A., C.C. Butler, K. Hood, S. Simpson, F. Wood, and J. Nuttall. 2009. "Effect of using an interactive booklet about childhood respiratory tract infections in primary care consultations on reconsulting and antibiotic prescribing: A cluster randomized controlled trial." *British Medical Journal* 339: b2885.

<sup>9</sup> Finkelstein, J.A., S.S. Huang, K. Kleinman, S.L. Rifas-Shiman, C.J. Stille, J. Daniel, N. Sciff, R. Steingard, S. B. Soumerai, D. Ross-Degnan, D. Goldmann, R. Platt. 2008. "Impact of a 16-community trial to promote judicious antibiotic use in Massachusetts." *Pediatrics* 121(1): e15-23.

<sup>10</sup> American Academy of Pediatrics, American College of Obstetricians and Gynecologists. 2008. *Guidelines for perinatal care, 6th edition*. Washington DC: American College of Obstetricians and Gynecologists.

<sup>11</sup> Harman, J. S., G. E. Childs, and K. J. Kellcher. 2000. "Mental Health Care Utilization and Expenditures by Children in Foster Care." *Archives of Pediatric and Adolescent Medicine*, 154: 1114-1117.

<sup>12</sup> Figueroa, R., J. Harman, and J. Engberg. 2004. "Use of claims data to examine the impact of length of inpatient psychiatric stay on readmission rates." *Psychiatric Services* 55(5): 560-565.

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<sup>13</sup> ICHP. 2011.<sup>b</sup> *Texas Medicaid Managed Care, STAR Health, Quality of Care Report, Fiscal Year 2010: Technical Appendix*. Gainesville, FL: The Institute for Child Health Policy, University of Florida.

<sup>14</sup> ICHP, 2011.<sup>a</sup>

<sup>15</sup> The information that NCQA compiles for Medicaid Managed Care Programs can be viewed at [www.ncqa.org](http://www.ncqa.org).

<sup>16</sup> Beaulieu, N.D., and A.M. Epstein. 2002. "National Committee on Quality Assurance health-plan accreditation: Predictors, correlates of performance, and market impact." *Medical Care* 40 (4): 325-337.

<sup>17</sup> AHRQ, 2004.

<sup>18</sup> ICHP, 2011.<sup>b</sup>