

# **Annual Chart Book**

**Fiscal Year 2008**

## **Texas Medicaid Managed Care STAR Health Quality of Care Measures**

**The Institute for Child Health Policy  
University of Florida**

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

**Measurement Period:  
April 1, 2008 through August 31, 2008**

**Submitted:  
October 20, 2009**

**Final Submitted:  
November 30, 2009**

## Table of Contents

Executive Summary .....	1
Introduction .....	1
STAR Health Descriptive Information	
Chart 1. Total Unduplicated Members .....	7
Chart 2. Total Unduplicated Members by Race/Ethnicity .....	9
STAR Health Pediatric Quality Indicators	
Chart 3. AHRQ Pediatric Quality Indicators .....	10
STAR Health Quality of Care	
Chart 4. HEDIS® Follow-Up after Hospitalization for Mental Illness .....	12
Chart 5. Readmission within 30 Days after an Inpatient Stay for Mental Health .....	13
Chart 6. HEDIS® Mental Health Utilization .....	15
Chart 7. HEDIS® Outpatient Drug Utilization - Average Cost of Prescriptions per Member per Month .....	17
Chart 8. HEDIS® Outpatient Drug Utilization - Average Number of Prescriptions per Member per Year .....	18
Chart 9. Percent of Emergency Department Visits with a Primary Diagnosis of an Ambulatory Care Sensitive Condition .....	19
Endnotes .....	21

## **Executive Summary**

The fiscal year 2008 Annual Quality of Care Report for STAR Health provides the first annual assessment of the quality of care that STAR Health enrollees receive. The measurement period for indicators presented in this report is April 1, 2008, to August 31, 2008, covering fiscal year 2008. It is important to note that all measures regularly included in Quality of Care reports for Medicaid and CHIP are not included in this report because they require at least a full year of data to be reported. For this report, only five months of data was available. 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, and to young adults under the age of 21 who are no longer in foster care and are receiving transitional Medicaid benefits.

The report, which was produced by the Institute for Child Health Policy (IChP), the state's external quality review organization, includes findings from several different quality "domains," or subject areas. In reviewing these results, it is necessary to understand that, generally speaking, the health-care needs of STAR Health members differ from the health-care needs of members of other Medicaid managed care programs such as the STAR program.

Enrollees in STAR Health represent a population with unique health-care needs. Psychological and emotional problems are of particular concern for this population, as many children and youth in foster care have been exposed to complex trauma prior to foster care placement. When compared to most Medicaid-enrolled children in other Medicaid managed care programs, the STAR Health population typically visits the emergency room more often, has a higher rate of children with special health-care needs, under-utilizes preventative outpatient services, utilizes mental health services at a higher rate, and has greater difficulty transitioning into adulthood.

Overall, the STAR Health program showed higher than average performance in key measures associated with the provision of adequate follow-up care for members hospitalized for mental illness. Additionally, STAR Health members experienced lower rates of preventable hospitalizations for two Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs): asthma and gastroenteritis. PDIs are useful indicators of access to primary care and preventative care services, but it is important to note that the benchmarks reflect groups of individuals whose health-care needs may not reflect the level of health-care needs for STAR Health members.

### **Performance Above National Healthcare Effectiveness and Data Information Set (HEDIS®) Average**

1. Follow-up after hospitalization for mental illness within 7 days (52 percent vs. 43 percent).<sup>1</sup>
2. Follow-up after hospitalization for mental illness within 30 days (83 percent vs. 61 percent).<sup>2</sup>

---

<sup>1</sup> The criteria used to determine the HEDIS® measure differ from the criteria used to determine the STAR Health measure, in that the HEDIS criteria include visits only to mental health providers while the STAR Health criteria include visits to any physician.

### Performance Above National AHRQ Pediatric Quality Indicators

3. Inpatient admission rates for:
  - a. Gastroenteritis (118 per 100,000 vs. 183 per 100,000).
  - b. Asthma (108 per 100,000 vs. 181 per 100,000).

STAR Health performance on other indicators falls below the national benchmarks, indicating improvements in performance may be possible, such as: mental health readmission rates, average number of prescriptions per member per year, average cost of prescriptions per member per month, and percentage of emergency department visits involving a primary diagnosis of an ambulatory care sensitive condition (ACSC). ACSCs are medical problems that are potentially treatable through proper outpatient monitoring and timely access to an effective community health-care system. Specifically, reported performance for some measures is less than desired when compared to the national HEDIS<sup>®</sup> average, or the national AHRQ PDI:

### Performance Below National HEDIS<sup>®</sup> Average

1. Mental health utilization (54 percent vs. 9 percent).
2. Average cost of prescriptions per member per month (\$145.71 vs. \$37.80).<sup>3</sup>
3. Average number of prescriptions per member per year (16.3 vs. 10.3).<sup>4</sup>

When considering prescriptions for STAR Health members, it is important to note that the use of psychotropic medications is being monitored separately. STAR Health conducts a review for children in foster care who receive medications for mental or behavioral health conditions to ensure the medication practices are in compliance with parameters developed by the Texas Department of State Health Services (DSHS).

### Performance Below National AHRQ Pediatric Quality Indicators

4. Inpatient admission rates for:
  - a. Diabetes short-term complications (33 per 100,000 vs. 29 per 100,000).
  - b. Urinary tract infections (78 per 100,000 vs. 53 per 100,000).

Again, it is important to note that the benchmarks for these measures reflect performance for groups of individuals that may not have the same health-care needs as members in the STAR Health program. Accordingly, any generalizations about improvement do not necessarily reflect the

---

<sup>2</sup> Ibid.

<sup>3</sup> The criteria used to determine the HEDIS<sup>®</sup> measure differ from the criteria used to determine the STAR Health measure, in that the HEDIS criteria include individuals up to age 34 while the STAR Health criteria include only individuals up to age 21.

<sup>4</sup> Ibid.

needs of STAR Health members and should be avoided. Nevertheless, to address areas of less than desired performance noted above, HHSC Managed Care Operations staff has taken the following actions:

#### Internal Improvements

1. Initiated a review of performance indicator targets for MCO performance measures to determine if the targets reflect current national quality assurance guidelines and are appropriate to the population served in STAR Health.
2. Established analytical reviews, including trending of performance over time.
3. Established a process to share results of analytical reviews with MCOs and document actions taken to improve deficient performance.
4. Initiated quarterly performance management meetings with the ICHP and HHSC staff that oversee contracts with MCOs to improve staff understanding and expertise.

#### External Performance Gap Improvements

1. Developed a plan to investigate program, MCO, individual beneficiary, and community factors that may be contributing to low performance in the following areas: mental health utilization, mental health readmission rates, and percentage of emergency department visits involving a primary diagnosis of an ACSC.

This plan includes a requirement that Superior Health Plan Network develop a performance improvement project with the following two overarching goals:

1. Improved follow-up care after an inpatient stay for mental health.
2. Improved treatment for ACSC through reduction of inpatient admissions and/or emergency department visits.

In summary, the report provides comparisons to validated benchmarks for performance. Since STAR Health is a relatively new program, the results provide a baseline performance for measuring effectiveness in each of the domains evaluated. HHSC Managed Care Operations staff will evaluate changes in performance over time, and is already initiating a plan to investigate areas where performance falls below the validated benchmark and to work with the STAR Health MCO to address those factors that will improve future performance when possible.

# Introduction

## Purpose

This report provides the first annual assessment of the quality of care that STAR Health enrollees receive in Texas. The measurement period for indicators presented in this report is April 1, 2008 to August 31, 2008, covering State Fiscal Year (SFY) 2008. It is important to note that all measures regularly included in Quality of Care reports for Medicaid and CHIP are not included in this report because they require at least a full year of data to be reported. For this report, only five months of data was available. 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.<sup>1</sup> 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, and to young adults under the age of 21 who are no longer in foster care and are receiving transitional Medicaid benefits.

Rates for the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) 2009 measures were calculated using National Committee for Quality Assurance (NCQA) certified software. The Health and Human Services Commission (HHSC) approved the use of this software so that all HEDIS<sup>®</sup> results could be reported using an NCQA-recognized tool. Unlike standard reporting for HEDIS<sup>®</sup> measures, the STAR Health report is based on five months of available data from SFY 2008. At HHSC's request, the Institute for Child Health Policy (ICHP) developed a methodology to allow for flexibility in the provider specialty codes when determining eligibility for HEDIS<sup>®</sup> measures. ICHP modified the NCQA specifications to lift provider constraints when determining eligibility for HEDIS<sup>®</sup> measures. Provider specialty codes are an important component for some HEDIS<sup>®</sup> measures and lifting the provider constraints may result in some rate inflation for these measures. 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 seven-day and 30-day follow-up after an inpatient mental health stay. The current methodology allows any visit with a physician provider to count toward compliance with the mental health follow-up measures. The following HEDIS<sup>®</sup> measures rely on specific provider specialty codes, and are therefore affected by this change in methodology:

- HEDIS<sup>®</sup> Follow-Up after Hospitalization for Mental Illness
- HEDIS<sup>®</sup> Mental Health Utilization

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.

This chart book contains the following indicators:

1) Descriptive Information

- Total Unduplicated Members
- Total Unduplicated Members by Race/Ethnicity

2) AHRQ Pediatric Quality Indicators (PDIs)

3) Quality of Care

- HEDIS<sup>®</sup> Follow-Up after Hospitalization for Mental Illness
- Readmission within 30 Days after an Inpatient Stay for Mental Health
- HEDIS<sup>®</sup> Mental Health Utilization
- HEDIS<sup>®</sup> Outpatient Drug Utilization
- Percent of Emergency Department Visits with a Primary Diagnosis of an Ambulatory Care Sensitive Condition (ACSC)

## Data Sources and Measures

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, and the number of months the member was 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.

Information regarding the calculation of all measures included in this report can be found in the document "Quality of Care Measures Technical Report Specifications, October 2009."<sup>2</sup> This document, prepared by the Institute for Child Health Policy, provides specifications for HEDIS<sup>®</sup> and other quality of care measures.

Whenever possible, results from other Medicaid Programs are provided in addition to the overall Texas state mean. NCQA gathers and compiles data from Medicaid managed care plans nationally.<sup>3</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>4</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 for the participating plans. The Medicaid Managed Care Plans 2008 mean results are shown and labeled "HEDIS<sup>®</sup> Mean" in the graphs. For certain HEDIS<sup>®</sup> measures, it will be noted in the key points that the national rate includes adults; STAR Health members are demographically distinct (e.g., in terms of age and mental health status) from the national Medicaid population.

Indicators developed for the Agency for Healthcare Research and Quality (AHRQ) were used to evaluate the performance of the STAR Health Program related to inpatient admissions for various 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>5</sup> The quality indicators use hospital inpatient discharge data and are measured as rates of admission to the hospital. Specifically, this report assessed Pediatric Quality Indicators (PDIs) for child enrollees. The specifications used to calculate rates for these measures come from the PDI version 3.2.<sup>6</sup> Rates are calculated based on the number of hospital discharges divided by the number of people in the area (except for appendicitis). Unlike most other measures provided in this chart book, low quality indicator rates are desired as they suggest a better quality health care system outside of the hospital setting.

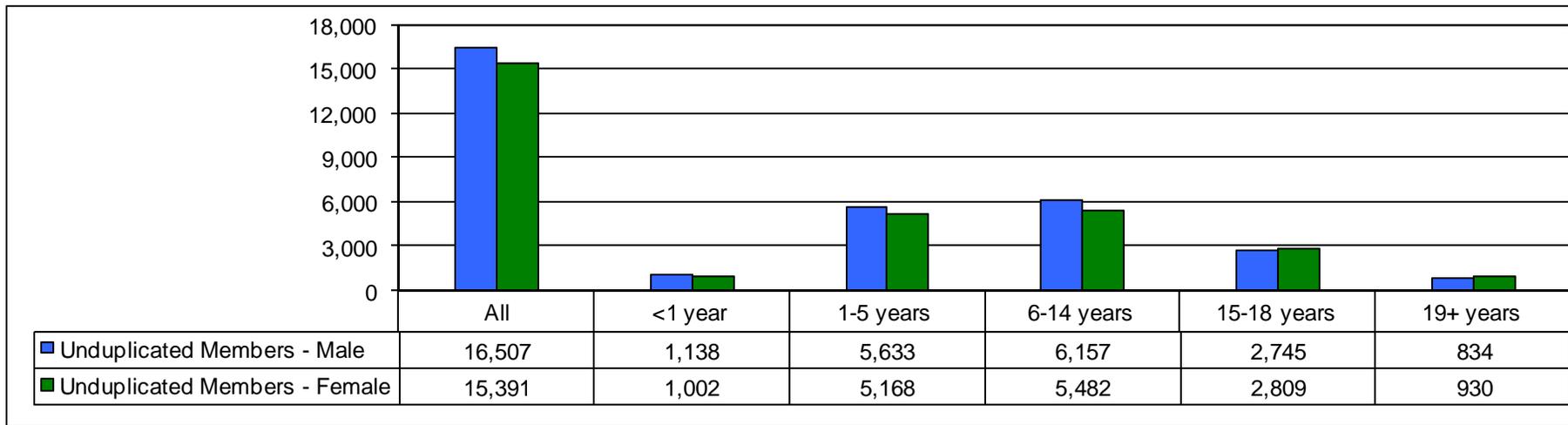
Pediatric admissions for the following ambulatory care sensitive conditions (ACSCs) were assessed: (1) Asthma; (2) Diabetes Short-term Complications; (3) Gastroenteritis; and (4) Urinary Tract Infection. The age eligibility for these measures is up to age 17. A fifth PDI that provides rates of admissions for perforated appendix – which is normally reported in Quality of Care reports for Texas HHSC – was not assessed in the present report because the rate calculated for perforated appendix had a low denominator value (fewer than 30 eligible members).

In addition to the narrative and graphs contained in this chart book, technical appendices were provided to HHSC that contain all of the data to support key findings.<sup>7</sup> The interested reader can review those for more details. The corresponding reference table is listed beneath each graph.

## Chart 1. Total Unduplicated Members

STAR Health - August 2008

STAR Health Unduplicated Members = 31,898



### Reference: STAR Health Table 1

**Note:** The eligibility figures used in the chart are for August 2008.

### Key Points:

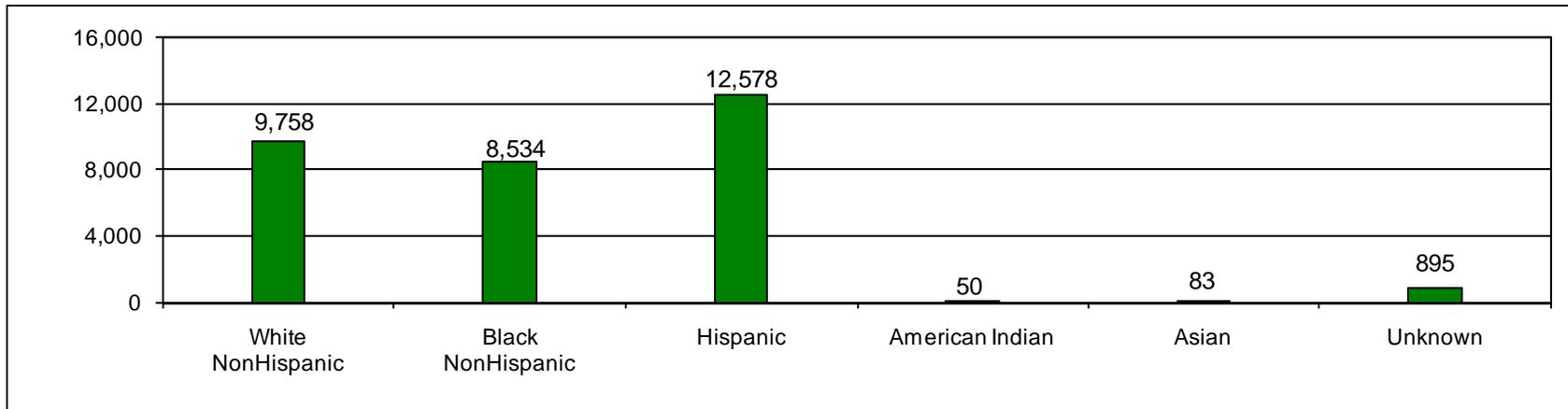
1. Chart 1 provides the total number of unduplicated members in the STAR Health Program, distributed by gender and age. During the measurement period, there were 31,898 unduplicated members in STAR Health.
2. Fifty-two percent of STAR Health members were male and 48 percent were female. Males were more numerous than females among members 14 years of age and younger, whereas females were more numerous than males among members 15 years of age and older.

3. Across age groups, six to 14 year olds comprised the largest percentage of STAR Health members, at 36 percent, followed by members one to five years of age (34 percent), members 15 to 18 years of age (17 percent), members less than one year of age (seven percent), and members 19 years of age and older (six percent).
  
4. The mean age of STAR Health members was 8.42 years old (SD = 6.14).

## Chart 2. Total Unduplicated Members by Race/Ethnicity

STAR Health - August 2008

STAR Health Unduplicated Members = 31,898



### Reference: STAR Health Table 2

Note: The eligibility figures used in the chart are for August 2008.

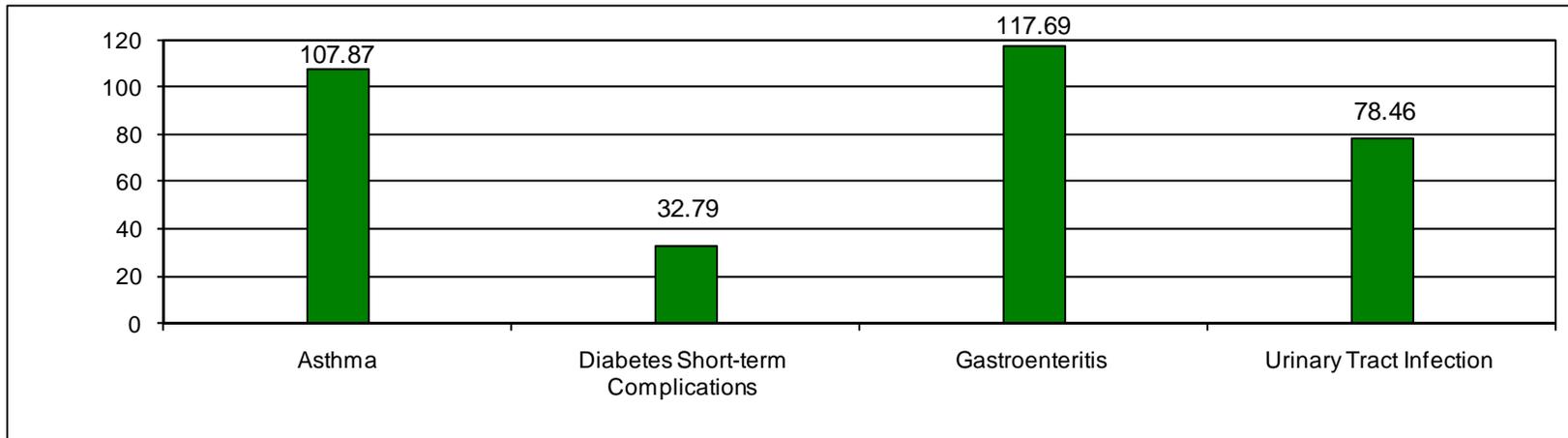
### Key Points:

1. Chart 2 provides the distribution of STAR Health members by race/ethnicity for August 2008.
2. The largest racial/ethnic group in STAR Health was Hispanic, accounting for 39 percent of members, followed by White, non-Hispanic members (31 percent) and Black, non-Hispanic members (27 percent).
3. Asian and American Indian members accounted for less than one percent of all STAR Health members.
4. Three percent of members in STAR Health were of unknown race/ethnicity.

### Chart 3. AHRQ Pediatric Quality Indicators

STAR Health - April 1, 2008 to August 31, 2008

STAR Health Asthma Eligible = 27,812  
STAR Health Diabetes Eligible = 18,298  
STAR Health Universe for All Other Measures = 33,138



**Reference: STAR Health Table PDI09**

**Note:** Rates are per 100,000 enrollees except for Perforated Appendix, which is per 100 admissions. The denominator for perforated appendix was less than 30; therefore this rate is not reported this year.

**Key Points:**

1. 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 the outpatient setting. This information is useful for monitoring trends, comparing health plan performance, and addressing access to care issues.
2. Chart 3 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. **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 the AHRQ. It should be noted that these AHRQ national estimates are based on data collected in 2003 and are area-level indicators, including commercial and Medicaid populations.

3. Gastroenteritis was the most common ACSC-related inpatient admission among STAR Health enrollees. The gastroenteritis inpatient admission rate was 118 per 100,000 members in the STAR Health Program, which is lower than the national AHRQ rate of 183 per 100,000.
4. The asthma inpatient admission rate was 108 per 100,000 members in the STAR Health Program, which is lower than the national AHRQ rate of 181 per 100,000.
5. The diabetes short-term complications inpatient admission rate was 33 per 100,000 members in the STAR Health Program, which is slightly higher than the national AHRQ rate of 29 per 100,000.
6. The urinary tract infection inpatient admission rate was 78 per 100,000 members in the STAR Health Program, which is higher than the national AHRQ rate of 53 per 100,000.
7. In summary, the STAR Health Program performed well on two PDI measures – asthma and gastroenteritis - with inpatient admission rates for these conditions below the national rates. The diabetes short-term complications inpatient admission rate in the STAR Health Program was only slightly higher than the national rate, whereas the inpatient admission rate for urinary tract infection was noticeably higher than the national rate.
  - HHSC may wish to take measures to decrease inpatient admissions for urinary tract infections (UTI) in the STAR Health Program. Improved diagnosis and management of pediatric UTI in outpatient settings may reduce the number of children visiting the emergency department for this condition. Diagnosing a UTI is usually based on the presence of specific symptoms (e.g., painful urination, frequency, and urgency); however diagnosis in children is complicated by the fact that children often present with nonspecific symptoms (e.g., fever alone, irritability, and poor eating). Since UTI is a common problem in the pediatric population that is often missed on physical exam, children who present to the physician’s office with a fever and nonspecific UTI symptoms should be tested.<sup>8</sup> Recommended testing includes a urine dipstick and urine culture to determine drug sensitivities to guide treatment which generally should last seven to 14 days.<sup>9</sup>

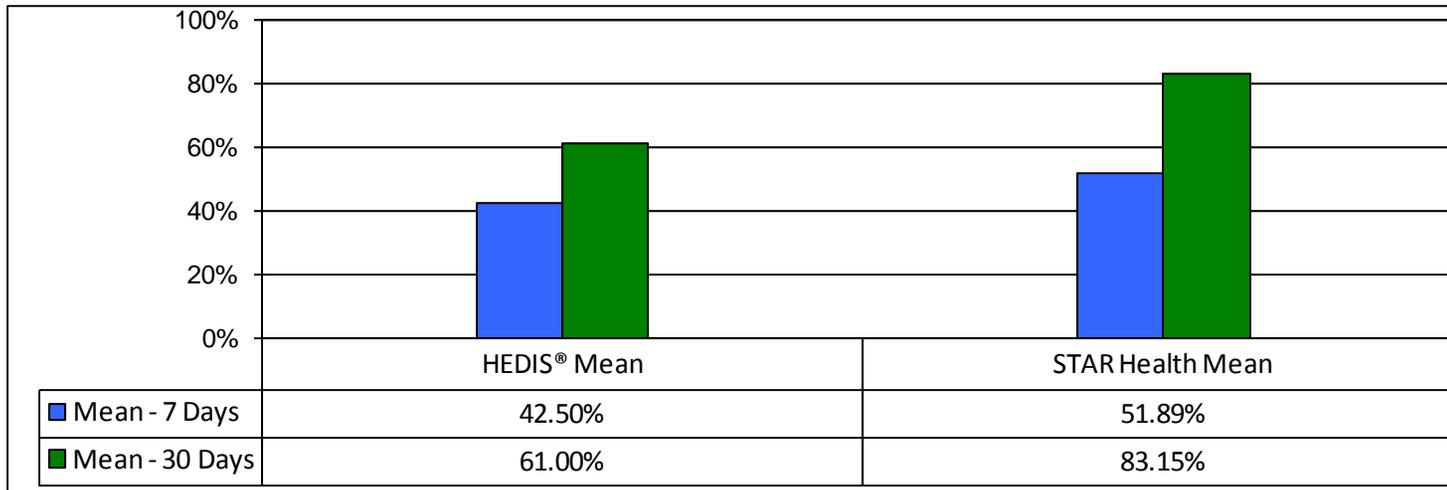
**Table 1. AHRQ Pediatric Quality Indicators**

<b>AHRQ Indicator Number</b>	<b>Indicator Name</b>	<b>Description</b>
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 infection per 100,000 population

## Chart 4. HEDIS® Follow-Up after Hospitalization for Mental Illness

STAR Health - April 1, 2008 to August 31, 2008

STAR Health Mental Health Hospitalizations = 819



Reference: STAR Health Table FUH09

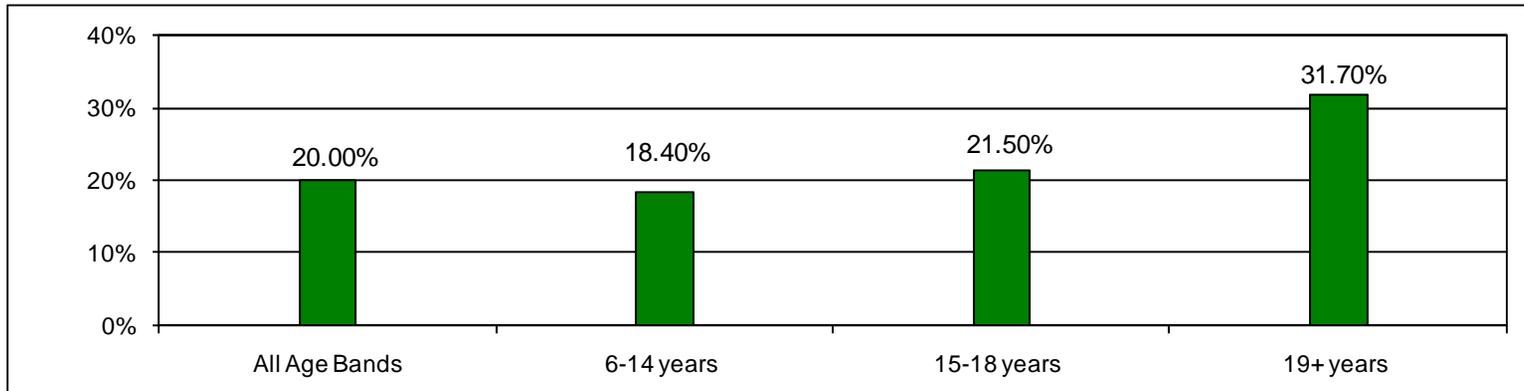
### Key Points:

1. Chart 4 provides the percentage of STAR Health enrollees 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. Rates for this measure are slightly inflated due to lifting the provider type constraints in calculations, which should be taken into consideration when comparing rates with the national HEDIS® means (which specify that follow-up occur with a mental health provider).
2. At the seven-day follow-up period, STAR Health performed above the national HEDIS® mean of 43 percent, with 52 percent of STAR Health members receiving seven-day follow-up care after hospitalization for a mental illness.
3. At the 30-day follow-up period, STAR Health performed above the national HEDIS® mean of 61 percent, with 83 percent of STAR Health members receiving 30-day follow-up care after hospitalization for a mental illness.
4. The results suggest that the STAR Health Program is providing adequate seven-day and 30-day follow-up care to members hospitalized for mental illness. (Note: Seven-day and 30-day follow-up rates may be slightly inflated due to lifting provider constraints.)

## Chart 5. Readmission within 30 Days after an Inpatient Stay for Mental Health

STAR Health - April 1, 2008 to August 31, 2008

STAR Health Inpatient Mental Health Stays = 1,437



Reference: STAR Health Table MHRadmit09

Note: Denominators less than 30 were observed for members less than one year of age and for members one to five years of age; rates are therefore not reported for these age groups.

### Key Points:

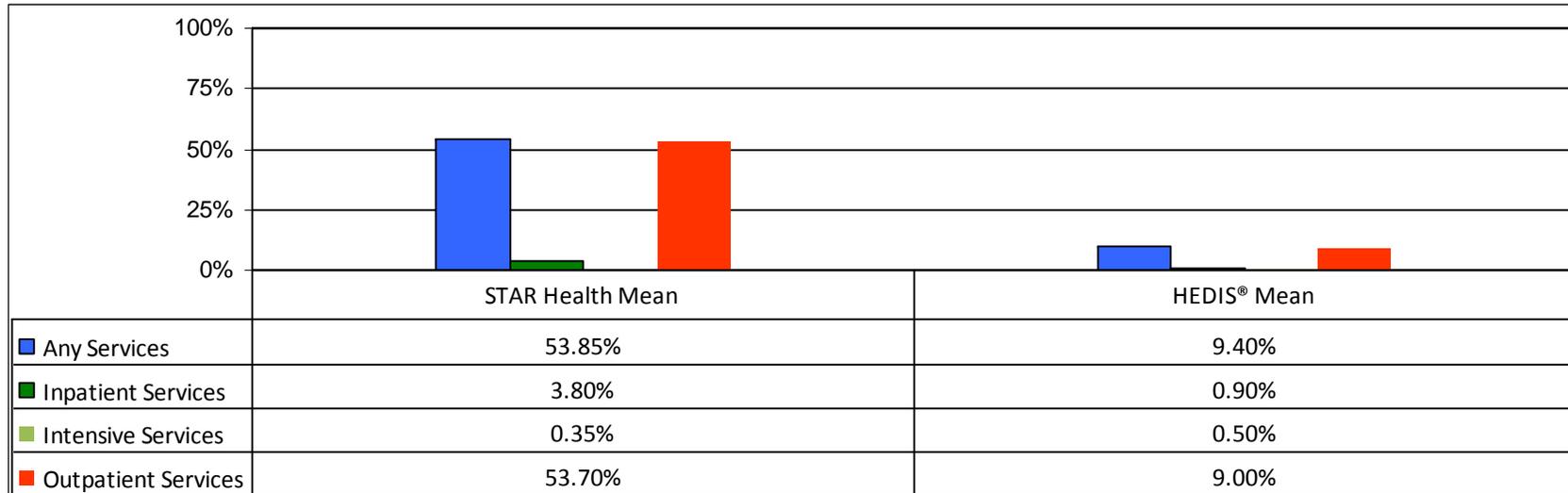
1. Chart 5 provides the percentage of STAR Health enrollees who were readmitted within 30 days following an inpatient stay for mental health problems, distributed by age. Mental health readmissions are frequently used as a measure of an adverse outcome, which potentially result from efforts to contain behavioral health care costs such as reducing the initial length of stay.<sup>10</sup> For this measure, lower rates of readmission indicate better performance.
2. In the STAR Health Program overall, one in five members (20 percent) were readmitted to the hospital within 30 days following an inpatient stay for mental health.
3. The highest percentage of readmission was observed among members 19 years of age and older (32 percent). Members in this age group include young adults who have left foster care and are receiving transitional Medicaid services and those who have a voluntary foster care placement. The transition of care for members in this age group may be particularly challenging, which may explain in part the higher readmission rate.
4. HHSC may wish to examine why approximately one in three STAR Health young adults were readmitted within 30 days of an inpatient mental health stay.

- The transition to adulthood presents many developmental challenges for the young adult (i.e., finishing school, becoming financially independent), particularly for young adults phasing out of foster care. Youth in the foster care system have greater difficulty transitioning into adulthood, in part because they have significantly more mental health problems than the general population and require ongoing supportive services well into young adulthood.<sup>11</sup> Research has found that only 10 percent of young adults leaving the foster care system nationwide actually receive supportive, transitional services designed to facilitate a successful transition into adulthood.<sup>12</sup> A lack of appropriate transitional services including access to outpatient mental health services may account for why one in three young adults in STAR Health are readmitted to the hospital after a mental health stay. HHSC may wish to examine more closely the availability and coordination of transitional living services and outpatient mental health services to reduce the rate of readmission for young adults with mental health problems.

## Chart 6. HEDIS® Mental Health Utilization

STAR Health - April 1, 2008 to August 31, 2008

STAR Health Total Member Months = 154,944



### Reference: STAR Health Table MPT09

**Note:** Rates are reported as per Member Year adjusted to accommodate the shorter time period

### Key Points:

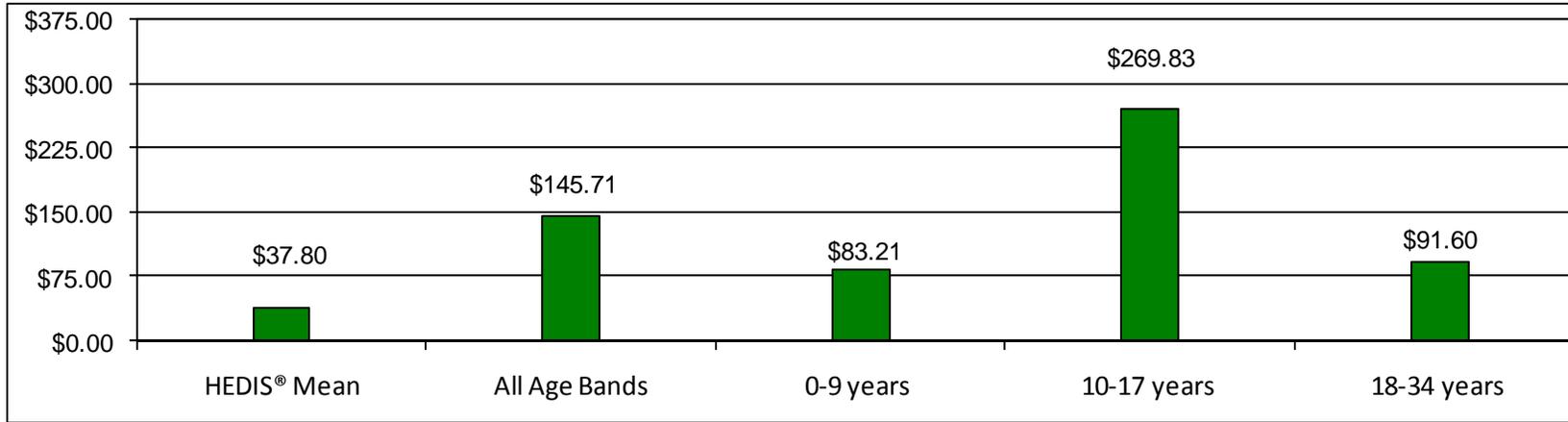
1. Chart 6 presents the HEDIS® Mental Health Utilization measure for the STAR Health Program. This measure provides the percentage of STAR Health members receiving mental health services during the measurement period, including any mental health services, inpatient services, intermediate services (defined as intensive outpatient or partial hospitalization), and outpatient services. It should be noted that the HEDIS® calculations for this measure were adjusted to reflect the five month reporting period.
2. For all four categories of mental health services, rates of mental health services utilization were higher in STAR Health than the national HEDIS® mean. Fifty-four percent of STAR Health members received mental health services of any type, compared with nine percent nationally. The utilization of mental health services in the STAR Health Program occurred primarily in outpatient settings (54 percent). Four percent of STAR Health members received inpatient mental health services.
3. The high utilization of mental health services among members in STAR Health would be expected given the research findings. Children in foster care utilize both inpatient and outpatient mental health services at significantly greater rates (four- to 15-fold) than their Medicaid

eligible peers, presumably because of a greater likelihood of having a mental health diagnosis.<sup>13,14</sup> Furthermore, high placement rates and episodic care have been shown to increase the probability of mental health service use among children in foster care.<sup>15</sup>

## Chart 7. HEDIS® Outpatient Drug Utilization - Average Cost of Prescriptions per Member per Month

STAR Health - April 1, 2008 to August 31, 2008

STAR Health Cost of Prescriptions = \$22,577,231



Reference: STAR Health Table ORX09

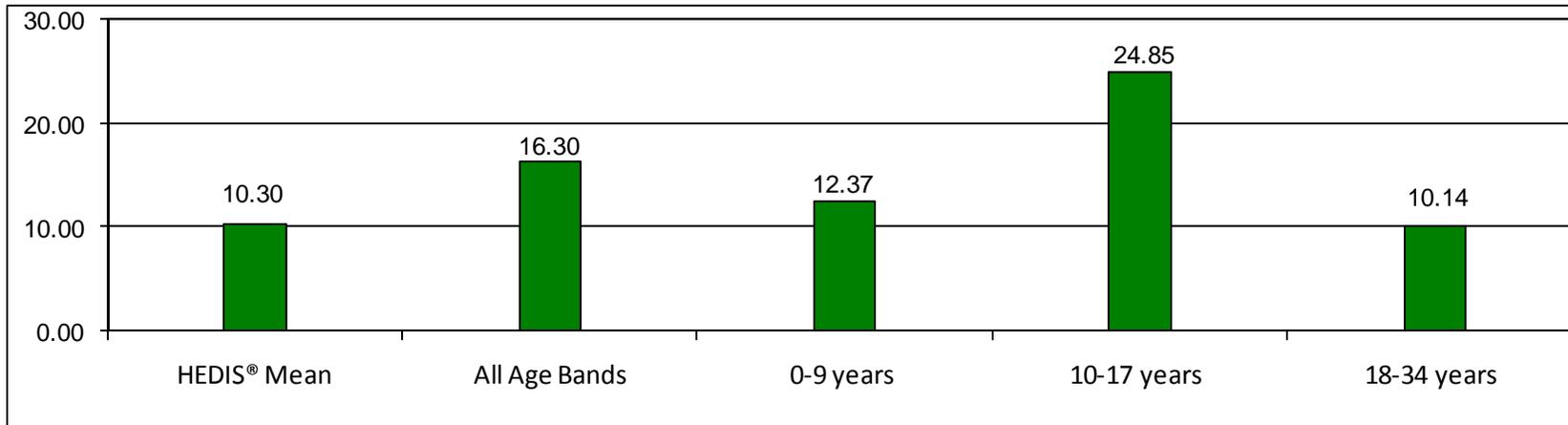
### Key Points:

1. Chart 7 provides results for the HEDIS® Outpatient Drug Utilization measure, showing the average cost of prescriptions per member per month, distributed by age. It should be noted that the “18 to 34 years” age group is part of HEDIS® specifications for this measure; in the present report, this age group includes STAR Health members up to age 21.
2. The average cost of prescriptions per member per month in the STAR Health Program was \$145.71, which is considerably greater than the national HEDIS® mean of \$37.80. (Note: For this measure, interpreting STAR Health results in relation to the national HEDIS® mean should be done with the knowledge that adults are included in the national rate.)
3. There was variation across the age bands in the average cost of prescriptions per member per month, with members between 10 and 17 years of age having the highest cost of prescriptions, at \$269.83. Members up to nine years of age had the lowest average cost of prescriptions per member per month, at \$83.21.

## Chart 8. HEDIS® Outpatient Drug Utilization - Average Number of Prescriptions per Member per Year

STAR Health - April 1, 2008 to August 31, 2008

STAR Health Number of Prescriptions = 210,529



Reference: STAR Health Table ORX09

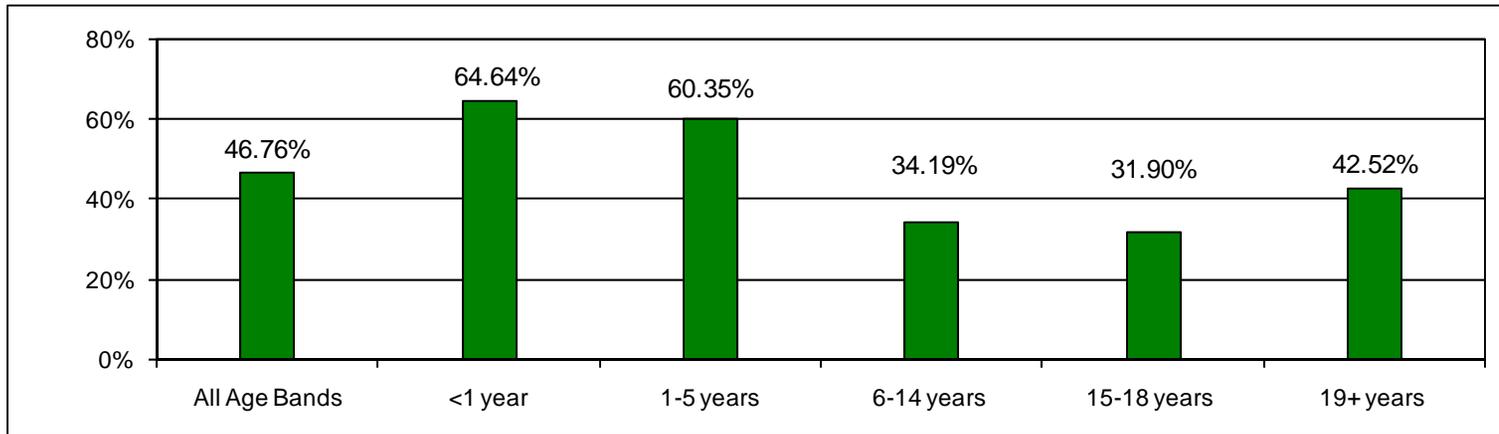
### Key Points:

1. Chart 8 provides results for the HEDIS® Outpatient Drug Utilization measure, showing the mean annual number of prescriptions per member in the STAR Health Program during the measurement period, distributed by age. It should be noted that the “18 to 34 years” age group is part of HEDIS® specifications for this measure; in the present report, this age group includes STAR Health members up to age 21.
2. The average annual number of prescriptions per member in the STAR Health Program was 16.30, which is greater than the national HEDIS® mean of 10.30. (Note: For this measure, interpreting STAR Health results in relation to the national HEDIS® mean should be done with the knowledge that adults are included in the national rate.)
3. Ten to 17 year olds had the highest mean annual number of prescriptions per member, at 24.85. The lowest mean annual number of prescriptions per member was observed in the 18 to 34 year old age category (10.14). It should be noted that the “18 to 34 years” age category is part of HEDIS® specifications for this measure; in the present report, this age group includes STAR Health members up to age 21.

## Chart 9. Percent of Emergency Department Visits with a Primary Diagnosis of an Ambulatory Care Sensitive Condition

STAR Health - April 1, 2008 to August 31, 2008

STAR Health ED Visits = 5,173



Reference: STAR Health Table ACSC09

### Key Points:

1. Chart 9 provides the percentage of emergency department visits among STAR Health enrollees during the measurement period who had a primary diagnosis of an ambulatory care sensitive condition (ACSC), distributed by age. ACSCs are medical problems that are potentially treatable through proper outpatient monitoring and an effective community health care system. Therefore, admission of members with ACSCs to the emergency room may be considered an indication that outpatient monitoring and community health care systems are underperforming; they represent trips to the emergency room that could potentially have been prevented. For this measure, the higher the percentage, the lower the health plan performance.
2. In the STAR Health Program overall, 47 percent of visits to the emergency department involved an ACSC.
3. There was variation among age groups on this measure. The highest percentage of emergency department visits involving an ACSC was observed among infants less than one year of age (65 percent). The lowest percentage of emergency department visits involving an ACSC was observed among adolescents 15 to 18 years of age (32 percent).
4. The STAR Health Program currently does not have a specific HHSC Performance Indicator Dashboard Standard for this measure. However, for other Texas Medicaid Programs, the HHSC Performance Indicator Dashboard Standard for this measure is 24 percent (for CHIP) and 32 percent (STAR, STAR+PLUS).<sup>16</sup> The STAR Health Program was well above both HHSC Performance Indicator Dashboard Standards for

this measure, suggesting a need for program-wide improvement in reducing the percentage of emergency department visits with a primary diagnosis of an ACSC, notably for children under 5 years of age.

- Results from the National Survey of Child and Adolescent Well-Being (NSCAW) found that 31 percent of children in foster care visited the emergency department annually, with those at greatest risk having a chronic health condition and being under the age of six.<sup>17</sup> The NSCAW findings suggest that children in foster care may rely on emergency department visits as a substitute for outpatient care. Research has shown that children in foster care, particularly infants and toddlers, under-utilize preventative outpatient services compared to their Medicaid eligible peers, and visit the emergency department at greater rates.<sup>18</sup> Furthermore, children with a history of multiple foster care placements visit the emergency department more often than children with fewer or no placements.<sup>19</sup>
- Identifying children in foster care who are more likely to visit the emergency department (i.e., those with chronic health conditions, younger children, those with multiple placements) and providing them with preventative care through a medical home would likely reduce the rate of emergency department visits.<sup>20</sup> The American Academy of Pediatrics (AAP) recommends that children in foster care have a physical exam before or soon after a foster care placement, and comprehensive physical, mental, and developmental evaluations within one month of placement.<sup>21</sup> Similarly, the STAR Health contract requires Superior HealthPlan Network to ensure that children in foster care receive a physical health screening within 21 days of enrollment and a behavioral health screening within 30 days of enrollment. Therefore, HHSC may wish to monitor Superior's compliance with contract requirements as a way to reduce ambulatory utilization for potentially-avoidable sensitive conditions.
- The AAP also recommends that children in foster care have more frequent health evaluations than children living with parents due to the preponderance of health and developmental problems in this population and the inherent stress of transitioning in and/or out of foster care placements. Implementing these recommendations and ensuring children in foster care have access to comprehensive preventive care through a medical home model may serve to reduce unnecessary visits to the emergency department.

## Endnotes

<sup>1</sup> Texas Health and Human Services Commission. January 2009. "Texas Medicaid and CHIP in Perspective." Available at <http://www.hhsc.state.tx.us/medicaid/reports/PB7/PinkBookTOC.html>.

<sup>2</sup> ICHP (The Institute for Child Health Policy). 2009. *Quality of Care Measures Technical Report Specifications, October 2009*. Gainesville, FL: The Institute for Child Health Policy, University of Florida.

<sup>3</sup> The information that NCQA compiles for Medicaid Managed Care Programs can be viewed at [www.ncqa.org](http://www.ncqa.org).

<sup>4</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>5</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>6</sup> Technical specifications for the PDI can be viewed at [http://www.qualityindicators.ahrq.gov/pqi\\_overview.htm](http://www.qualityindicators.ahrq.gov/pqi_overview.htm).

<sup>7</sup> ICHP (The Institute for Child Health Policy). 2009. *Quality of Care Measures Technical Report Specifications, October 2009*. Gainesville, FL: The Institute for Child Health Policy, University of Florida.

<sup>8</sup> Zorc, J. J., D. A. Kiddoo, and K. N. Shaw. 2005. "Diagnosis and Management of Pediatric Urinary Tract Infections." *Clinical Microbiology Review* 18(2): 417-422.

<sup>9</sup> Zorc, J. J., D. A. Kiddoo, and K. N. Shaw. 2005.

<sup>10</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 Rate." *Psychiatric Services* 55(5): 560-565.

<sup>11</sup> Society for Research in Child Development, Social Policy Report Brief. 2009. "Youth in Foster Care: Easing the Transition to Adulthood." Available at <http://www.srcd.org>.

<sup>12</sup> Society for Research in Child Development, Social Policy Report Brief. 2009.

<sup>13</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>14</sup> Halfron, N., G. Berkowitz, and L. Klee. 1992. "Mental Health Services Utilization by Children in Foster Care in California." *Pediatrics* 89(6): 1238-1244.

<sup>15</sup> Ruben, D. M., E. A. Alessandrini, C. Feudtner, D. S. Mandell, A. Russell Localio, and T. Hadley. 2004. "Placement Stability and Mental Health Costs for Children in Foster Care." *Pediatrics* 113(5): 1336-1341.

<sup>16</sup> HHSC (Texas Health and Human Services Commission). 2009. "HHSC Uniform Managed Care Manual – Performance Indicator Dashboard, Version 1.4." Available at <http://www.hhsc.state.tx.us/Medicaid/UMCM/default.html>.

<sup>17</sup> Jee, S. H., T. C. Antonucci, M. Aida, M. A. Szilagyi, and P. G. Szilagyi. 2005. "Emergency Department Utilization by Children in Foster Care." *Ambulatory Pediatrics* 5(2): 102-106.

<sup>18</sup> Rubin, D., E. A. Alessandrini, C. Feudtner, A. R. Localio, and T. Hadley. 2004. "Placement Changes and Emergency Department Visits in the First Year of Foster Care." *Pediatrics* 114(3): 354-360.

<sup>19</sup> Rubin et al. 2004.

<sup>20</sup> Jee et al. 2005.

<sup>21</sup> American Academy of Pediatrics: Committee on Early Childhood, Adoption, and Dependent Care. 2002. "Health Care of Young Children in Foster Care." *Pediatrics* 109(3), 536-540.