TEXAS
Health and Human Services

External Quality Review of Texas Medicaid & CHIP Managed Care Annual Technical Report

State Fiscal Year 2022

Quality, Timeliness & Access to Healthcare for Texas Medicaid & CHIP Recipients

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EQRO
Texas External Quality Review Organization

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Abbreviations

Abbreviation	Definition
AAP	American Academy of Pediatrics
ACOG	American College of Obstetricians and Gynecologists
ADA	American Dental Association
Aetna	Aetna Better Health
AHRQ	Agency for Healthcare Research and Quality
AI	administrative interview
AIM	Alliance for Innovation on Maternal Health
APR-DRG	(3M™) All Patient Refined Diagnosis-Related Groups
ATR	annual technical report
ATRC	annual technical report companion (*Health Plan Performance in Texas Medicaid & CHIP*)
BCBSTX	Blue Cross Blue Shield (of Texas)
C-Section	cesarean section
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCC	(CAHPS) Children with Chronic Conditions (Item Set)
CDC	Centers for Disease Control and Prevention
CFHP	Community First Health Plans
CHCT	Community Health Choice
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMCHP	Children's Medical Center Health Plan
CMDS	Children's Medicaid Dental Services
CMS	Centers for Medicare and Medicaid Services
CookCHP	Cook Children's Health Plan
COVID-19	coronavirus disease of 2019
CRA	caries risk assessment
CRG	(3M™) Clinical Risk Group
DCHP	Dell Children's Health Plan

Abbreviation	Definition
DM	disease management
DMO	dental maintenance organization
DOS	date of service
DQA	Dental Quality Alliance
Driscoll	Driscoll Health Plan
DSHS	(Texas) Department of State Health Services
EAPG	(3M™) Enhanced Ambulatory Patient Groups
ED	emergency department
EDVMRR	encounter data validation: medical record review
EHR	electronic health record
ElPasoHealth	El Paso Health
EQR	external quality review
EQRO	external quality review organization
FFS	(traditional Medicaid) fee-for-service
FSR	financial statistical report
HealthSpring	Cigna-HealthSpring
HEDIS®	Healthcare Effectiveness Data and Information Set
HEDIS-PPC	HEDIS Prenatal and Postpartum care measure (disambiguates from 3M™ PPC)
HHS	(U.S. Department of) Health and Human Services
HHSC	(Texas) Health and Human Services Commission
HPV	human papillomavirus
IAP	Innovation Accelerator Program
ISCA	Information Systems Capabilities Assessment
JIP	joint interface plan
KFF	Kaiser Family Foundation
LTSS	Long-Term Services and Supports
MCNA	MCNA Dental
MCO	managed care organization
MCQS	(Texas) Managed Care Quality Strategy

Abbreviation	Definition
MDCP	Medically Dependent Children Program
MMP	Medicare-Medicaid Plan
MRSA	Medicaid Rural Service Area
MY	measurement year
NCQA	National Committee for Quality Assurance
NEMT	nonemergency medical transportation
NORC	the nonpartisan and objective research organization NORC, at the University of Chicago
NPI	National Provider Identifier
OAP	Pregnancy Associated Outcomes (Texas measure of severe maternal morbidity)
P4Q	Pay-for-Quality
PCHP	Parkland Community Health Plan
PCP	primary care provider
PDI	(AHRQ) Pediatric Quality Indicator
PDx	primary diagnosis
PHE	public health emergency
PIP	performance improvement project
POA	present on admission
POS	place of service
PPA	(3M™) Potentially Preventable Admission
PPC	(3M™) Potentially Preventable Complication
PPD	postpartum depression
PPE	(3M™) Potentially Preventable Event
PPR	(3M™) Potentially Preventable Readmission
PPV	(3M™) Potentially Preventable (ED) Visit
PQI	(AHRQ) Prevention Quality Indicator
PX	procedure (code)
QAPI	quality assessment and performance improvement
QoC	quality-of-care
QTR	quarterly topic report
RCA	root cause analysis
SA	service area
SDoH	social determinants of health
SFH	state fair hearing
SFY	(Texas) state fiscal year
SHCN	special healthcare needs
SK-SAI	STAR Kids Screening and Assessment Instrument
SMI	serious mental illness
SMM	severe maternal morbidity
SWHP	RightCare
TCHP	Texas Children's Health Plan
THLC	Texas Healthcare Learning Collaborative (THLCportal.com)
THSteps	Texas Health Steps
TMHP	Texas Medicaid and Healthcare Partnership
UFSRC	University of Florida Survey Research Center
UHC	UnitedHealthcare
UHC Dental	UnitedHealthcare Dental
UMCC	(Texas) Uniform Managed Care Contract
UMCM	(Texas) Uniform Managed Care Manual
URTI	upper respiratory tract infection

Measurement Years Reflected in External Quality Review Reporting for This Annual Technical Report

The measurement periods for different External Quality Review (EQR) activities vary based on the framework used for evaluation. To reduce confusion, the table below lists the measurement span associated with each protocol for the state fiscal year (SFY) 2022 Annual Technical Report (ATR) reporting period.

Protocol	Measurement Years Reported
Protocol 1: Validation of Performance Improvement Projects (PIPs)	Due to the extension of PIPs, no *Final PIP reports* were reviewed. The PIP elements reviewed were: *PIP Plans* and *First Progress Reports* for 2022 PIPs; *Third Progress Reports* for 2020 PIPs; *Second Progress Reports* for 2021 PIPs
Protocol 2: Validation of Performance Measures	*Administrative Interview (AI) Data*: September 2021–August 2022; *Hybrid Measures*: September 2021–August 2022; *Texas Health Steps (THSteps)*: Checkups due starting in September 2020
Protocol 3: Review of Compliance with Medicaid & CHIP Managed Care Regulations	*AI Interviews*: September 2021–August 2022; *Quality Assessment and Performance Improvement (QAPI) Evaluations*: September 2021–August 2022
Protocol 4: Validation of Network Adequacy	*Appointment Availability*: *Prenatal* – October 2021–November 2021 *Vision* –November 2021–January 2022 *Primary Care* –-February 2022–April 2022 *Behavioral Health* – May 2022–August 2022
Protocol 5: Validation of Encounter Data Reported by MCOs and DMOs	*Accuracy and Completeness:* September 2021–August 2022; *Medical Record Review:* January 2020–December 2020
Protocol 6: Administration of Quality of Care Surveys	*STAR Adult, STAR+PLUS, and STAR Kids Caregiver*: Enrolled for October 2021-March 2022 (fielded April–September 2022); *STAR Health Caregiver*: Enrolled for December 2021–May 2022 (fielded July–October 2022)
Protocol 7: Calculation of Performance Measures	Measurement year January 2021–December 2021
Protocol 9: Conducting Focus Studies of Health Care Quality	Measurement year varies by study, but research conducted between September 2021–August 2022
Protocol 10: Assist with Quality Rating of MCOs and DMOs	*Performance Dashboards:* Measurement year January 2021–December 2021; *MCO Report Cards:* Administrative Data from measurement year January–December 2020, Survey Data for SFY 2022 (see above)

Executive Brief

Introduction

The Kaiser Family Foundation (KFF) reports that more than 90 million Americans receive healthcare coverage through the Children's Health Insurance Program (CHIP) and Medicaid (KFF, 2022), funded jointly by states and the U.S. Department of Health and Human Services (HHS). Texas has one of the largest Medicaid programs in the country, serving five million people (KFF, 2022), over 90 percent of whom receive care through a managed care delivery model. Participation in federal funding for managed care programs requires compliance with guidelines and protocols established by the Centers for Medicare and Medicaid Services (CMS), including external quality review by an organization independent from the state. Since 2002, the Institute for Child Health Policy at the University of Florida has been the external quality review organization (EQRO) for Texas Medicaid and CHIP.

In 2019, CMS identified quality, access, and timeliness as key domains for evaluating MCO and DMO performance in EQR activities (CMS, 2019). The EQRO used all relevant annual activities to draw conclusions about quality, timeliness, and access to care provided by Texas MCOs and DMOs. The Annual Technical Report (ATR) contains a comprehensive overview of the SFY 2022 EQR activities and the specific methods used to assess each EQR protocol. The ATR companion document, *Health Plan Performance in Texas Medicaid & CHIP in SFY 2022* (ATRC) provides MCO-and DMO-specific results from EQR activities in this reporting cycle.

The ATR is a comprehensive summary of EQR activities from September 1, 2021, through August 31, 2022, including findings from EQR evaluation studies addressing the quality of managed care provided to Medicaid and CHIP members, structured around the current CMS EQR protocols (CMS, 2019). Although CMS had not released guidance on activities related to network adequacy (Protocol 4: Validation of Network Adequacy) or quality rating (Protocol 10: Assist with Quality Rating of MCOs and DMOs) for this reporting cycle, the ATR addresses related EQR activities. In addition to the ATR, the EQRO produced plan profiles with MCO- and DMO-specific information from EQR activities for SFY 2022 which are provided in the ATRC.

EQR Activities

Each year, the EQRO follows CMS protocols specified in 42 C.F.R. § 438 (2020) to monitor the utilization, quality, accessibility, and timeliness of medical, behavioral health, and dental services that individuals receive in Medicaid and CHIP through MCOs or DMOs. The EQRO conducts activities that review the delivery of care in the four statewide Medicaid managed care programs – STAR for members needing routine care (primarily including low-income children and pregnant women); STAR+PLUS for adult members who have a disability or are age 65 years or older; STAR Kids for children, adolescents, and young adults with disabilities; STAR Health for members in state conservatorship – and delivery of care in CHIP (entirely managed care). The EQRO also monitors children's dental care through Medicaid and CHIP DMOs. None of the 17 MCOs and 3 DMOs that served Medicaid and CHIP members are exempt from EQR in SFY 2022. Annual evaluation activities include:

- Assessment of MCO and DMO structure and process through administrative interview (AI) studies, quality assessment and performance improvement (QAPI) program evaluations, and performance improvement project (PIP) validation studies.
- Surveys with members and caregivers using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey; and appointment availability studies that follow a "secret shopper" method to evaluate the timeliness of appointments against state-specified standards.

- Quality-of-care (QoC) reporting on standardized performance measures, including National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) measures, Agency for Healthcare Research and Quality (AHRQ) quality indicators, 3M™ measures of Potentially Preventable Events (PPEs), and American Dental Association's Dental Quality Alliance (DQA) measures.
- In-depth studies addressing topics of importance to Texas, including in-depth quarterly topic reports (QTRs), short issue briefs, and annual focus studies.

Quality Strategy

Regulations in 42 C.F.R. § 438 (2020) require Texas to have a public Managed Care Quality Strategy (MCQS) that they review, update, and submit to CMS for approval every three years. In addition, Texas must report to CMS annually on the effectiveness of the MCQS. The EQRO recommendations in the ATR are each aligned to the Texas MCQS. In support of CMS requirements, the EQRO reviewed the current MCQS for compliance with federal standards and made recommendations for strengthening the MCQS in the upcoming revision. With this brief, the EQRO summarizes that review and focuses on how activities during the reporting cycle align with MCQS goals.

The Texas MCQS meets all the requirements of 42 C.F.R. § 438.340 (2020) by including:

- Provisions for MCO/DMO contracts to incorporate required federal standards
- Procedures to evaluate quality and appropriateness of care
- Procedures to identify the race, ethnicity, and primary language of Medicaid enrollees
- Procedures to monitor MCO/DMO regulatory compliance
- Arrangements for annual EQR services
- Policies for MCO/DMO sanctions that follow, at a minimum, federal standards
- An information system capable of supporting all activities in the MCQS
- Standards for MCO/DMO operations meeting or surpassing regulatory guidance for access and quality

CMS encourages alignment of MCQSs with the HHS National Quality Strategy[1] and the CMS Quality Strategy.[2]

The EQR process is part of interrelated quality requirements for Medicaid managed care. For example, per 42 C.F.R. § 438.364(a)(4) and § 457.1250 (2020), states should use the feedback obtained from their EQRO when they examine and update their quality strategy. States, in turn, implement quality strategies through the ongoing QAPI program that contracted MCOs and DMOs must establish for the services these organizations furnish to enrollees. The performance improvement projects (PIPs) and performance measures included in QAPIs are, in turn, validated through the annual EQR. Therefore, states must ensure alignment among the QAPI requirements, the state's quality strategy, and the annual EQR activities (Figure 1).

Figure 1. Relationship between external quality review, state quality strategy, and QAPI program

[1] https://www.ahrq.gov/workingforquality/about/index.html .
[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/CMS-Quality-Strategy

Texas Managed Care Quality Strategy Goals

HHSC uses its MCQS per Title 42, C.F.R. § 438.340 (2020) to assess and improve the quality of healthcare and services provided through the managed care system. HHSC policymaking and program activities related to healthcare value align with six important MCQS goals (Table 1).

Table 1. Texas MCQS goals

Icon	Goal
	Promoting optimal health for Texans at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address the root causes of poor health
	Strengthening person and family engagement as partners in their care to enhance respect for individual's values, preferences, and expressed needs.
	Providing the right care in the right place at the right time to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate.
	Keeping patients free from harm by building a safer healthcare system that limits human error.
	Promoting effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of healthcare costs.
	Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services, and supports providers to participate in team-based, collaborative, and coordinated care.

The EQRO reviewed the Texas quality activities during the reporting cycle for alignment with these goals and their objectives. Many activities have relevance across goals. The EQRO collaborates with Texas and their Medicaid MCOs and DMOs to continuously develop and implement programs that promote quality improvement in the Texas Medicaid healthcare system.

Promoting optimal health for Texans

In evaluating the quality of healthcare, the EQRO assesses the degree to which an MCO or DMO (as described in 42 C.F.R. § 438.310(c)(2) (2020)) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement (as described in 42 C.F.R. § 438.320 (2020)). The activities aligned most closely with this goal are:

- PIP evaluations (EQR Protocol 1)
- AIs and QAPI evaluations (EQR Protocol 3)
- Experience surveys (EQR Protocol 6, and THLCportal.com)
- QoC measure reporting (EQR Protocol 2 and EQR Protocol 7, and THLCportal.com)
- Supporting maternal health initiatives (EQR Protocol 7 and EQR Protocol 9)
- Topic reports (EQR Protocol 9)

The PIPs evaluated during this reporting cycle address integration of behavioral and physical health care, maternal health, weight assessment and counseling, and other topics aligned with the National Quality Strategy and CMS priorities. MCOs are concentrating on improving healthy behaviors such as medication management,

vaccination, and weight management. Other PIPs aim to improve prenatal care and care for those with diabetes or COPD. In evaluating the PIPs, the EQRO found deficiencies in the design of some PIPs, reporting of activities, and responses to EQRO recommendations. In order to fulfil the objectives in promoting optimal health for Texans, the PIPs must not only create meaningful change through intervention, but provide a framework for identifying additional areas for improvement and accurate impact assessment. The EQRO recommends greater attention to accurate reporting in the PIP process and attention to the specific recommendation from the EQRO during the progress reviews.

PIPs also support:

Addressing social drivers of health and integration of public health with Medicaid are also important objectives of this MCQS goal and are addressed in the QAPI evaluation process. The EQRO found that although MCOs had some methods to collect social needs data, many were not aggregating or analyzing the data to address needs; and while some MCOs had social needs interventions, they were not clearly measuring the effects. HHSC should leverage the newly developed Non-Medical Drivers of Health (NMDOH) Action Plan (HHSC, 2023) to assist MCOs in identifying the effects of social drivers on health quality and developing targeted, data-driven interventions. The AIs and QAPI evaluations address key elements of the care delivery system critical to promoting optimal health, including well care, and care coordination programs. The MCO QAPIs also play a major role in ensuring that programs continue to promote optimal health for members.

AIs and QAPIs also support:

Consistently monitoring performance on reliable measures of healthcare quality is critical to assessing managed care CHIP and Medicaid programs. The EQRO evaluates healthcare quality in Texas Medicaid with more than 100 quality measures selected from nationally recognized quality assessment programs using encounter, enrollment, and provider data updated monthly and regularly evaluated for quality and integrity, and data collected in annual surveys. Measures are also used to identify disparities in care.

Since 2020, the COVID-19 pandemic and related Public Health Emergency (PHE) have created many challenges in healthcare delivery systems and also for the quality monitoring and improvement of these systems. Performance measures are affected by enrollment, access, and the quality of services provided. Many of the changes in measure rates for 2021 are related to access and utilization, or experienced substantial denominator changes which may be related to the PHE. Surveys conducted in SFY 2022 showed low and decreasing scores and rates in most domains for STAR and STAR+PLUS, suggesting that members are experiencing difficulties getting the best quality care. Continuing to monitor these measures throughout the PHE and recovery is the only way to continue making progress in quality improvement.

Surveys, QoC measures, and related studies also support:

Maternal health is another area where Texas has placed recent emphasis. However, maternal morbidity rates increased slightly in 2021, and uncomplicated C-Sections rates are still over 30 percent. Monitoring QoC measures related to maternal health must inform the development of interventions and then serve as the method of assessing success. For example, compliance with recommended standards of prenatal care (HEDIS PPC) was significantly associated with lower odds of hemorrhage and (pre)eclampsia.

Several of the studies conducted by the EQRO during the reporting cycle addressed particular quality initiatives, particularly as they relate to disparities in care, maternal or dental health, disease management (DM), and social needs. Each of these studies provides insight into potential factors influencing health outcomes in the Medicaid

and CHIP populations. For example, members in rural areas reported less availability of services through the Medically Dependent Children Program and higher odds of post-partum depression. Race/ethnicity identification is unavailable for up to 38 percent of the population for some QoC measures in STAR and STAR Kids. The EQRO found that an overall deficiency in race/ethnicity identification is increasing and is particularly apparent for infants suggesting a change in the way this information is initially captured. In 2021, Hispanic Medicaid members had more outpatient utilization and less ED, inpatient, mental health, and alcohol and drug services use than both non-Hispanic Black and non-Hispanic White members. Non-Hispanic Black members had worse rates for many QoC measures than Non-Hispanic White or Hispanic members. It will be increasingly challenging to identify and address disparities without improving the quality of demographic information.

An issue brief explored the current state of Texas Medicaid health data collection, storage, exchange, and utilization for quality improvement. The report identifies limitations in the current system, and looks at developing improvements, including potential for integration of a Texas Health Information Exchange.

The EQRO found that although this goal is expansive, Texas engages in a wide variety of initiatives and activities to support the optimal health of Texans. The COVID-19 pandemic and related PHE have affected all phases of the program cycle for meeting the objectives of this goal. However, Texas continues to search for root causes of poor health, monitor utilization, access, and quality in Medicaid and CHIP, and respond to deficiencies or disparities with relevant initiatives.

Strengthening person and family engagement as partners in their care

Major objectives for this goal are to ensure that person-centered practices are evident in all care settings and that recipients consistently report positive experiences. Success on this goal is measured in large part through annual surveys. Member experience is also evaluated through the appointment availability studies. The EQRO monitors MCO engagement through the QAPI evaluations, and the MCO report cards are created to empower members to make informed decisions about their care. The activities aligned most closely with this goal are:

- AIs and QAPI evaluations (EQR Protocol 3)
- Appointment availability studies (EQR Protocol 4)
- Experience surveys (EQR Protocol 6, and THLCportal.com)
- Performance Indicator Dashboard (EQR Protocol 7 and THLCportal.com
- MCO Report Cards (EQR Protocol 10)

Person-centered care not only promotes well-being; it supports independence and improves quality of life. Understanding social needs requires purposeful collection of information. Translating this into person-centered care can include facilitating connections to other services. Through the AIs and QAPI evaluations, the EQRO found that some MCOs had implemented interventions to address social needs, but were not clearly measuring the impacts. The EQRO recommends greater sharing of best practices in addressing social needs. The newly NMDOH Action Plan (HHSC, 2023) has a goal of fostering collaboration aimed at addressing food insecurity, housing, and transportation. HHSC and the Medicaid MCOs and DMOs will be key stakeholders in this initiative. The AIs and QAPI evaluations also address availability and adequacy of services, and provider selection by assessing MCO compliance with related legislative requirements.

AIs and QAPIs also support:

Appointment availability also supports:

The appointment availability studies use a mystery shopper approach to help assess network adequacy. Prenatal appointments, preventive and routine primary care appointments, and behavioral health appointments compliant with wait-time standards were all less available in 2022 compared to prior years. Vision appointment availability improved compared to 2021 in all programs except STAR Health, and was nearly perfect across all programs. Literature review showed that telehealth for vision care was highly successful during the PHE, and the EQRO recommends that Texas investigate this novel approach, but acknowledges that high availability of in-person visits could mitigate the need for expanding telehealth services for vision care. In the behavioral health study, incorrect provider taxonomies or director information excluded more providers than in prior years. Inaccuracy in provider directories continues to be a problem across MCOs and provider types. Without access to accurate provider directories, and when providers fail to have appointments available at the standards set by HHSC, Texans have less control over their own care.

Surveys also support:

The QoC surveys measure the experiences and satisfaction with healthcare provided by the MCOs for adult members and for caregivers of children and adolescent members in Texas Medicaid and CHIP. The EQRO uses survey results to inform HHSC on the impact of quality improvement initiatives and help MCOs identify strengths and weaknesses for targeted quality improvement efforts. Almost all composite scores and ratings scores on the STAR Adult and STAR+PLUS Member surveys decreased from 2020 to 2022. The biggest change was the *Health Care Rating* for STAR Adults which decreased 5.7 percentage points. In the child caregiver surveys, most composite scores increased in STAR Kids but decreased in STAR Health from 2020 to 2022. The biggest changes were decreases in STAR Health for the *Healthcare Rating* (-13.5 percentage points) and the *Health Plan Rating* (-15.8 percentage points). The results of the STAR Child and STAR Health Children with Chronic Conditions composites and summary rates suggest that access is a critical area for improvement in this population. The EQRO recommends working with the MCOs to identify key factors in the evident decreases in member and caregiver satisfaction.

Dashboards, and Report Cards also support:

Results from other quality measures are combined with survey results to assist members when choosing and comparing MCOs through the Performance Indicator Dashboard and MCO report cards. The THLC portal (thlcportal.com) provides comprehensive, detailed, dynamic information about quality of care in Texas Medicaid and CHIP. Measure dashboards include, QoC measures (e.g., HEDIS, AHRQ, DQA, etc.), PPEs, and survey measures and allow users to compare performance results to national benchmarks, compare performance by MCO and service area, and track performance over time. The dashboards also summarize results by demographic groups (age, race/ethnicity, sex, and health status). The performance Indicator Dashboard (also available on the THLC portal, and abstracted in the ATRC) provides a consolidated, comparative view of MCO/DMO performance. Each year, the EQRO helps Texas select measures based on qualitative assessment and review of measure results across programs. Information from the Performance Indicator Dashboard supports ongoing and future quality improvement initiatives by helping Texas identify measures where most MCOs excel or struggle and where MCO performance varies widely.

Since 2013, the MCO report cards continue to provide decision support for Medicaid and CHIP enrollees and their caregivers in selecting an MCO while meeting federal requirements for providing accessible information on health care quality for consumers. Medicaid and CHIP enrollment packets for new members include the appropriate report card, in English and Spanish, with an accompanying information sheet that explains the

report card and includes the web address for the online versions. In addition to the ratings, each report card includes the contact information for the available MCOs.

Ratings on each report card reflect the MCO's performance in a new member's area, providing a more accurate picture of the care available where the member lives. The EQRO collapses the raw performance scores to a uniform, consumer-friendly five-star rating system, with five stars representing the highest performance.

This MCQS goal also has an objective of reducing inpatient days in the last six months of life. HHSC has several initiatives to investigate the use of palliative care and hospice, and evaluate nursing facility quality. The EQRO recommends integrating those activities more fully into the quality assurance review cycle. The activities related to the NMDOH Action Plan will also be important to achieving the goals for person and family engagement.

Increasing engagement is a goal in the CMS National Quality Strategy. Making healthcare more patient-centered is part of the National Quality Strategy aims. This Texas MCQS goal aligns well with these expectations.

Providing the right care in the right place at the right time

This goal includes important objectives of reducing avoidable hospital admissions, emergency department visits, and crisis interventions, while increasing the proportion of disabled individuals living in the community and optimizing care transitions. Reducing institutional care is directly connected to improving the effectiveness of preventive and primary care. The activities most aligned with this goal are:

- PIP evaluations (EQR Protocol 1)
- AIs and QAPI evaluations (EQR Protocol 3)
- Appointment availability studies (EQR Protocol 4)
- QoC measure reporting (EQR Protocol 2 and EQR Protocol 7, and THLCportal.com)
- Supporting maternal health initiatives (EQR Protocol 7 and EQR Protocol 9)

PIPs also support:

PIPs evaluated during the reporting cycle addressed topics related to follow-up care, medication management, reducing preventable events, increasing preventive care, and improving maternal care and disease management (DM) programs. The interventions can be at the member, provider, or MCO level, and address quality of and access to appropriate care. Based on evidence that greater, more sustainable progress comes from extending PIP implementations from one year to two, Texas adopted this policy several years ago. MCOs plan, initiate, and complete PIPs each year and, the EQRO reviews plans for the upcoming PIPs, progress reports for the ongoing PIPs and final PIP reports for the completed PIPs. Due to impacts related to the pandemic and PHE, the 2019 and 2020 PIPs were extended for an additional year, so the EQRO did not have final PIPs (2019) for complete evaluation in this reporting cycle. The ATR includes summaries of all the plan and progress evaluations conducted during SFY 2022 and the ATRC includes specific information on the ongoing PIPs for each MCO and DMO.

AIs and QAPIs also support:

Through the AIs and QAPI evaluations, the EQRO collects information on MCO primary and preventive care programs, care coordination and DM programs for members with complex needs, provider networks, and the design and implementation strength of QAPIs. The QAPIs play a critical role in meeting the goals of the MCQS through a structured approach to improvement. MCOs and DMOs follow a Plan-Do-Study-Act model for change, facilitating advances at the member, provider, and system level. QAPIs specifically address objectives of this MCQS goal including the reduction of avoidable events and improving care transitions

and long-term care through the PIPs, and the QAPI evaluations capture information on the MCO/DMO processes and outcomes in these areas. The AI provides information on how MCOs and DMOs operationalize care delivery and member services. The EQRO provides specific feedback and recommendations to each MCO based on review of the AIs and QAPIs. Based on the AIs, Texas MCOs and DMOs do well at meeting federal and state requirements that guide their programs. However, the EQRO noted deficiencies in provider directories and grievance protocols. Most QAPI deficiencies were related to reporting rather than planning or performance. One highlight from the AI was reported success with transitions to telehealth for both physical and behavioral health needs. Although most physical healthcare has returned to in-person since the height of the COVID-19 pandemic, behavioral health utilization of telehealth has continued to be higher.

Appointment availability also supports:

The appointment availability studies are directly supportive of improving timeliness of care. Callers trying to get prenatal appointments for either high-risk pregnancy or third trimester visits resulted in less than 50 percent compliance with wait time standards in 2020 and even lower rates in 2022. For five MCOs, no providers contacted complied with third trimester appointment standard wait times. In 2022, wait-time compliance for preventive and routine primary care appointments dropped in STAR, STAR+PLUS and STAR Kids compared to SFY 2021, as did the percentage of providers who offered weekend appointments in STAR and STAR Health. Although they are designed to assess compliance with wait-time standards, these studies also provide information about provider directory deficiencies and other provider engagement issues that can impact access to care. A high percentage of calls must be excluded from the wait-time assessment because directory issues (including incorrect contact information, incorrect provider information, or providers not taking new or Medicaid clients) prevent reaching an appointment request. The EQRO is working with HHSC to improve the design of these studies to address these different aspects of access in future. In addition, the EQRO began evaluation of the non-emergency medical transportation services that were recently moved to MCO coverage. These services have a critical role in providing the right care at the right time.

QoC measures, and related studies also support:

QoC reporting is directly supportive of improving quality and timeliness of care. Particular focus on maternal health is reflected in both quality measures and specific studies conducted by the EQRO. The EQRO calculates rates for potentially preventable emergency department visits (PPVs), potentially preventable admissions (PPAs), and potentially preventable readmissions (PPRs) monthly. Providing this information to the MCOs assists them in monitoring their quality initiatives aligned with the MCQS goal objectives. From 2017 through 2019, before the COVID-19 pandemic, the overall PPV rate was trending slightly upward, and the cost per PPV was increasing. In 2020 both at-risk ED visits and PPVs decreased. But in 2021, at-risk ED visits and PPVs both increased again, although not to the 2019 level. PPA rates showed similar trends. The STAR+PLUS, STAR Kids, and STAR Health programs continue to have the highest PPR rates, highlighting the need to improve care coordination in these populations with complex healthcare needs. The increase in maternal morbidity rates, and the high rates of uncomplicated C-Sections highlight the need for continued emphasis on improving maternal health. Rates for prenatal and postpartum care (HEDIS PPC) were below the national average across programs.

This goal aligns with the CMS priorities for quality, access, and timeliness in healthcare. It could be defined as a cornerstone in the overall MCQS because success provides integral support to the other goals. The objectives currently give greater focus to avoiding inappropriate care than to promoting the right care. The goal could be strengthened in the future with quality improvement objectives distinct from the broader goal of promoting

optimal health. Integrated care should also be supported for all programs while continuing to promote community care and optimal care transitions for those with complex or long-term care needs.

Keeping patients free from harm

Promoting patient safety includes preventive care and promotion of healthy practices, and protecting patients from harm within the healthcare system. The activities most aligned with this goal include:

- AIs and QAPI evaluations (EQR Protocol 3)
- QoC measure reporting (EQR Protocol 2 and EQR Protocol 7, and THLCportal.com)
- Performance Indicator Dashboard (EQR Protocol 7 and THLCportal.com)

AIs and QAPIs also support:

The AIs and QAPI evaluations address MCO compliance with standards for availability, continuity, and confidentiality of healthcare services. Deficiencies in these areas can reduce patient safety. Reported issues with provider directories create barriers to getting timely care. The EQRO found issues in the service authorization and grievance procedures for some MCOs, which also may create barriers to timely care. When MCOs are deficient in monitoring or reporting on QAPI activities, their programs are less likely to provide accurate quality assessments or the most value in quality improvement.

QoC measures and dashboards also support:

Measures included in QoC reporting and the Performance Indicator Dashboard that relate directly to patient safety include measures of follow-up care, medication management, screening and immunization, and chronic disease monitoring. Overall, across MCOs and programs, minimum standards on the 2021 Performance Indicator Dashboards were unmet over half the time, while high standards were met less than 30 percent of the time. The AHRQ quality indicators and 3M PPEs evaluate hospital care for appropriateness, and the 3M potentially preventable complications (PPC) measure specifically addresses inpatient safety. Beyond preventing harm, improving patient safety improves efficiency. In 2021, STAR+PLUS PPCs resulted in an estimated $27 million in excess costs. PPRs also indicate a deficiency in hospital care, or coordinated follow-up. In 2021, STAR+PLUS PPRs had an estimated cost of over $100 million and STAR+PLUS members were more likely to have multiple readmissions related to the same initial stay than members in STAR. Severe maternal morbidity events increased in 2021. Rates varied geographically, by race/ethnicity, and by MCO. On average, deliveries with severe morbidity events cost nearly three times as much as other deliveries. In 2021, over 48 thousand uncomplicated deliveries in Texas Medicaid and CHIP were by C-section, creating increased risk for mothers and infants, and substantially higher costs.

Texas uses a robust set of quality measures to ensure patient safety, and this goal aligns directly with the CMS Quality Strategy goal of promoting safety. The EQRO recommends improvements in MCO self-monitoring, and continued use of quality incentive programs that promote patient safety.

Promoting effective practices for people with chronic, complex, and serious conditions

Beyond promoting optimal health for all Texans, this goal addresses the increased difficulties in providing the best care for individuals with additional needs. Texas first supports this goal through the specialized programs STAR+PLUS and STAR Kids. Increased access to disease management and care coordination sets these programs apart. Having separate PIPs, AIs, and QAPIs, and different quality incentive programs allows Texas to optimize their effectiveness.

- PIP evaluations (EQR Protocol 1)
- AIs and QAPI evaluations (EQR Protocol 3)
- Experience surveys (EQR Protocol 6, and THLCportal.com)
- QoC measure reporting (EQR Protocol 2 and EQR Protocol 7, and THLCportal.com)
- Topic reports (EQR Protocol 9)

PIPs also support:

The 2020 PIPs targeted behavioral health issues, and address integration of behavioral and physical health care. This is particularly important for people with chronic, complex, serious conditions. The 2021 PIP topics included medication management, diabetes and COPD management, and reducing preventable admissions and readmissions, which directly align with several main objectives of this MCQS goal. The 2022 PIPs address weight management and maternal care. Improving compliance with weight assessment and counseling for nutritional and physical activity guidelines (HEDIS WCC) is aimed at changing the trend in childhood obesity which can contribute to lifelong health issues.

AIs and QAPIs also support:

The AIs and QAPI capture specific information related to how MCOs identify and serve members with additional healthcare needs. This includes reviewing their provisions for appropriate access, coordination of care, subcontractor relationships, and authorization and utilization management. The EQRO found deficiencies in the monitoring activities for availability and access, and clinical indicators. These are critical to managing care for members with complex care requirements. Texas can look for more ways to incentivize MCOs to improve programs and interventions for members with chronic, complex, and serious conditions. Better alignment of services can also improve efficiency and reduce some of the additional costs of care currently associate with this population.

The EQRO fields several surveys targeting populations with special healthcare needs. The STAR Kids and STAR Health surveys include the Children with Chronic Conditions (CCC) Item Set. The EQRO found that access to specialized service is a particular area of concern with less than half of STAR Kids care givers reporting that they always had the access needed.

Surveys and QoC measures also support:

Many QoC measures address care for populations with special healthcare needs. Texas re-evaluates the measure set annually and works to balance measures of optimal care for all Texans with measures that address more specific conditions or populations. Some measures are evaluated in more than one context, for example management of high blood pressure is evaluated separately for members that also have serious mental illness (SMI). Other measures may be interpreted differently depending on the population, for example PPEs are more common in STAR+PLUS, but the complex conditions seen in this population likely contribute to different drivers of utilization. Evidence of the success of STAR+PLUS and STAR Kids is seen in better performance on measures of chronic disease management, although some rates still fall below national benchmarks, indicating the need for continued improvement. The THLC portal (THLCportal.com) provides results for many QoC measures by health status, allowing for comparison between healthy and members with chronic disease or complex conditions.

The EQRO conducted a major focused study of caregiver experience for STAR Kids members in the Medically Dependent Children Program to meet requirements set by Texas S.B. 1207 86(R). Caregivers reported having low availability of home therapy, personal assistance services, and nursing providers,

particularly for those living in rural areas. Challenges in navigating the complexity of processes for eligibility determination, approvals, and authorization led to gaps in care.

Texas aims to provide needed care to Medicaid members with special healthcare needs by creating targeted delivery programs (STAR+PLUS and STAR Kids). The objectives associated with this MCQS goal target management of complex needs, avoidable excess utilization, medication management, and improved management of behavioral health and substance use disorders. This goal could be strengthened by clarifying aims for management of complex and integrative care needs. The connection to NMDOH may be of greater importance for people with multiple or significant chronic conditions and building this into the goal would further align with the CMS Quality Strategy goal of advancing health equity.

Attracting and retaining high-performing Medicaid providers

No healthcare system can deliver the best quality care without a network of excellent providers, across all specialties in both professional and institutional capacity. Texas has one of the largest Medicaid systems in the country, encompassing many geographic and demographic regions. The State works to ensure provider adequacy by maintaining competitive pricing and supporting efforts to attract providers to underserved areas. Requirements for network adequacy are an important component of the MCO contracts. The activities most aligned with this goal include:

- AIs and QAPI evaluations (EQR Protocol 3)
- Appointment availability studies (EQR Protocol 4)
- Experience surveys (EQR Protocol 6, and THLCportal.com)
- Topic reports (EQR Protocol 9)

AIs and QAPIs also support:

The AIs and QAPI evaluations address availability and capacity of services, provider selection, subcontractor relationships, provider reimbursement, and practice guidelines. A recent focus has been on integration of telehealth. MCOs have leveraged changes necessary during the COVID-19 pandemic to improve their provider availability going forward, particularly in behavioral health. Difficulties in maintaining provider directories were noted in the AI. Accurate directories are a key to connecting members to the best providers, and serve as important self-reporting data for the MCOs, demonstrating compliance with network adequacy.

Appointment availability also supports:

The appointment availability studies most directly address provider network adequacy. MCOs can influence accessibility by adjusting the size and quality of their network. CMS requires all states that contract with an MCO or DMO to deliver Medicaid services must develop and enforce network adequacy standards consistent with 42 C.F.R. § 438.68, (2020). The mystery shopper approach is designed to evaluate compliance with appointment wait time standards. Although longer wait times can be a result of inadequate networks, the studies conducted by the EQRO also uncovered deficiencies in the provider directories. In addition to providing crucial information to members, the MCO directories should accurately reflect the MCO network. The member experience surveys provide additional information about access to care that supports the need for better provider networks.

The experience surveys conducted by the EQRO provide important information about the quality and availability of providers in MCO networks. Personal doctor ratings went down in STAR and STAR+PLUS, as did ratings for

how well doctors communicate. Specialist ratings went down in STAR and for STAR Kids caregivers. The overall findings suggest that provider deficiencies contribute to difficulties getting the best quality care.

Resolving to attract and retain high-performing providers is an important goal for all healthcare systems. Several objectives of this MCQS goal are directly aimed at provider participation. Because of the structure of managed care, HHSC has more oversight over and more ability to incentivize MCOs rather than providers. HHSC should partner with other provider-driven organizations who may be a better position to support providers. The EQRO recommends strengthening this goal by focusing on encouraging MCOs to improve network availability and provider information.

Conclusion

In SFY 2022, HHSC continued to improve the quality and efficiency of healthcare services in Medicaid and CHIP through numerous initiatives to (a) improve the availability of reliable NMDoH data and information on health disparities among members, (b) increase provider availability, and (c) improve service coordination for special populations. In 2022, HHSC began developing a detailed action plan to address non-medical drivers of health to improve data infrastructure and coordination of services focusing on food insecurity, housing, and transportation (HHSC, 2023). While there is always room for improvements, HHSC's efforts to improve the quality of healthcare for Medicaid and CHIP members positively affected several essential aspects of care, including performance on measures of access to preventive care and services for pregnant women and members with SMI. HHSC is also actively addressing areas in need of further quality improvement.

The full ATR includes a comprehensive list of EQRO recommendations based on SFY 2022 evaluation activities and suggestions for targeted approaches to address ongoing challenges to improving healthcare quality for all Medicaid and CHIP members.

Introduction

The Kaiser Family Foundation (KFF) reports that more than 90 million Americans receive healthcare coverage through the Children's Health Insurance Program (CHIP) and Medicaid (KFF, 2022). The U.S. Department of Health and Human Services (HHS) helps states fund their CHIP and Medicaid programs through cost sharing initiatives. Participation in federal funding for state managed care programs requires compliance with the Centers for Medicare and Medicaid Services (CMS) guidelines and protocols, including the provision for external quality review (EQR) by an organization independent from the state. Texas has one of the largest Medicaid programs in the country, serving five million people (KFF, 2022). Over 90 percent of Texas Medicaid members and all children in Texas CHIP receive coverage through a managed care delivery model. Since 2002, the Institute for Child Health Policy at the University of Florida has served as the external quality review organization (EQRO) for Texas Medicaid and CHIP. This report presents the results of Texas EQR activities during SFY 2022.

Texas provides Medicaid medical services through four Medicaid managed care programs serving specific populations (Table 1). Traditional Medicaid fee-for-service (FFS) provides transitional coverage for members moving into or between managed care programs, emergency Medicaid, and maternal healthcare coverage not included in managed care benefits. Texas CHIP managed care includes CHIP Perinatal coverage for prenatal care. Program details are on the Texas Health and Human Services Commission (HHSC) website (hhs.texas.gov).

Table 2. Texas Medicaid and CHIP managed care programs

Program	Description
STAR	Manages care for most Texas Medicaid beneficiaries. This program covers low-income families, including adults and children, pregnant women, and newborns.
STAR+PLUS	Integrates acute care services with long-term services and supports (LTSS) for adults with a disability or individuals age 65 or older. Members dually eligible for Medicare and Medicaid receive LTSS through STAR+PLUS. Dual-eligible members meeting all eligibility criteria for the Dual Demonstration may enroll into a Medicare-Medicaid Plan (MMP) instead of a STAR+PLUS MCO. MMPs provide Medicare and Medicaid services through a single health plan.
STAR Kids	Manages care for children and adults aged who have disabilities through the month of their 21st birthday. This program covers the children in the Medically Dependent Children Program (MDCP) except those in STAR Health.
STAR Health	Manages care for children and young adults in state conservatorship or those covered through a continuation or transition program of the foster care system.
CHIP	Manages care for children in families with income too high to qualify for Medicaid but too low to afford private insurance for their children. Unborn children receive coverage through CHIP Perinatal services.

The Children's Medicaid Dental Services program provides dental services to eligible Medicaid members aged 20 and younger, while the CHIP Dental program provides dental services to CHIP members aged 18 and younger. Three dental maintenance organizations (DMOs) serve most eligible members in Texas Medicaid and CHIP, but STAR Health members receive dental coverage directly through the STAR Health program provider, Superior.

Figure 2 shows the 13 Texas Medicaid and 10 CHIP service areas (SAs) and service providers for the reporting period. In all programs except STAR Health, members can choose from at least two managed care organizations (MCOs) in every SA. Superior provides all STAR Health services statewide. The three DMOs provide dental services statewide.

Figure 2. Texas Medicaid and CHIP managed care service areas

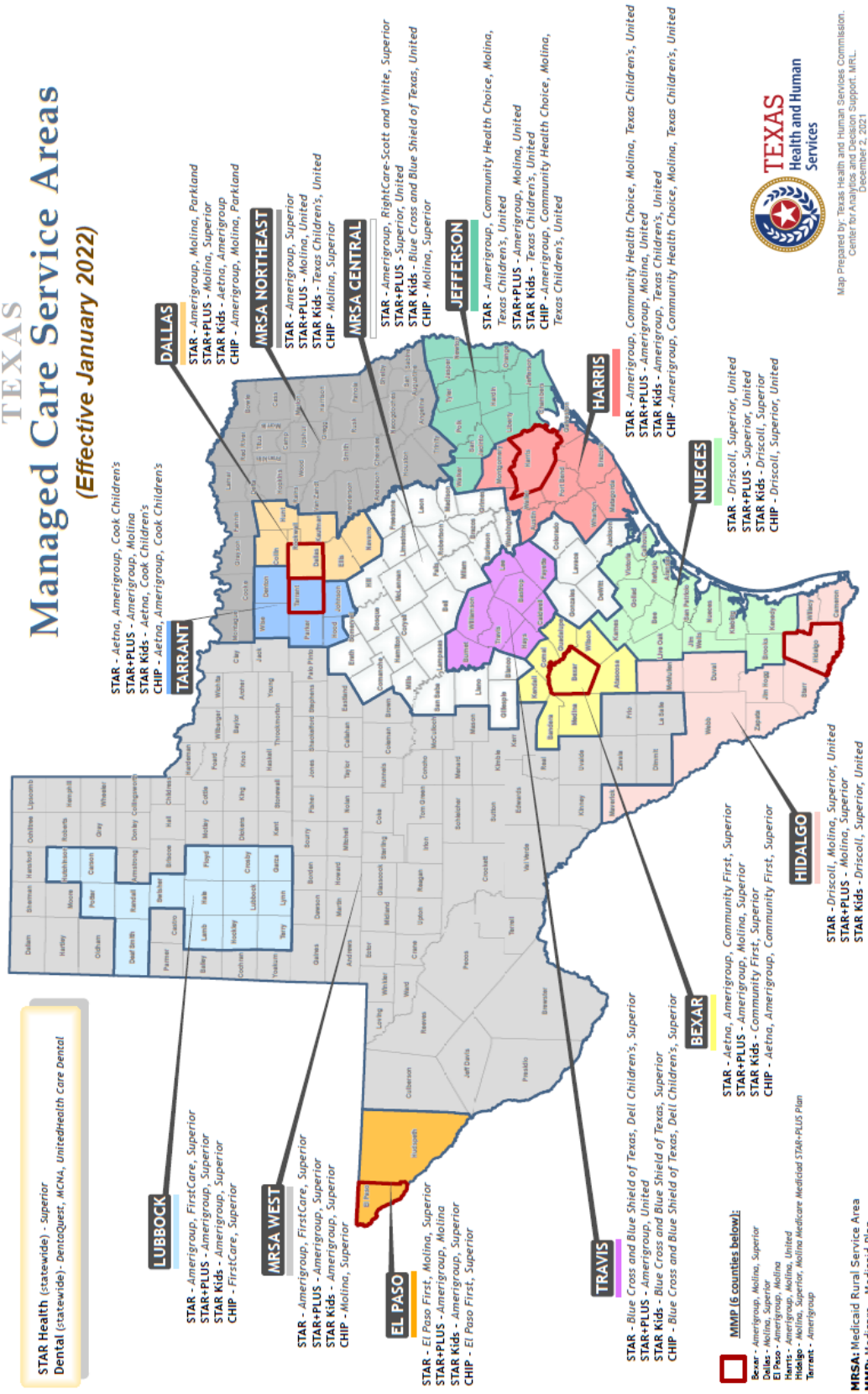


Table 2 shows Medicaid and CHIP enrollment with Texas contracted MCOs as of December 31, 2021, excluding dual-eligible members, and Table 3 shows enrollment with the three DMOs as of December 31, 2021.

Table 3. Non-dual-eligible enrollment in Texas Medicaid and CHIP in December 2021

MCO	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Aetna Better Health (Aetna)	117,098	-	12,727	-	3,160
Amerigroup	785,591	59,048	28,738	-	15,277
Blue Cross Blue Shield (BCBSTX)	51,886	-	8,734	-	1,651
Cigna-HealthSpring (HealthSpring)	-	18,789	-	-	-
Community First Health Plans (CFHP)	154,616	-	7,811	-	4,236
Community Health Choice (CHCT)	361,521	-	-	-	6,802
Cook Children's Health Plan (CookCHP)	151,042	-	9,733	-	5,305
Dell Children's Health Plan (DCHP)	39,434	-	-	-	2,452
Driscoll Health Plan (Driscoll)	227,531	-	10,617	-	1,737
El Paso Health (ElPasoHealth)	89,885	-	-	-	2,595
FirstCare Health Plans (FirstCare)	104,996	-	-	-	1,113
Molina	123,890	35,315	-	-	6,957
Parkland Community Health Plan (PCHP)	215,306	-	-	-	5,812
RightCare (SWHP)	60,566	-	-	-	-
Superior	1,006,874	68,279	30,673	45,578	24,812
Texas Children's Health Plan (TCHP)	501,324	-	30,066	-	16,755
UnitedHealthcare (UHC)	220,935	65,161	29,234	-	2,704
Total	**4,212,495**	**246,592**	**168,333**	**45,578**	**101,368**

Table 4. Enrollment in Medicaid children's and CHIP dental programs in December 2021

DMO	Medicaid Children's Dental	CHIP Dental
DentaQuest	2,106,531	59,999
MCNA Dental (MCNA)	1,410,413	30,662
UnitedHealthcare Dental (UHC Dental)	308,545	10,115
Total	**3,825,489**	**100,776**

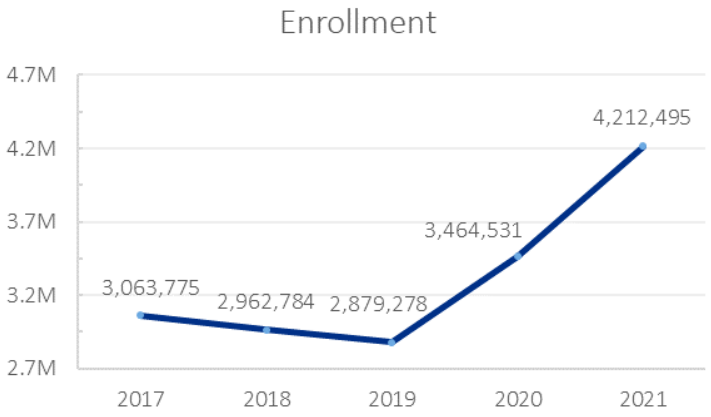
In response to the COVID-19 pandemic, CMS made widespread use of program waivers and other flexibilities to support access to care to Medicaid members, which resulted in significant increases in Medicaid and CHIP enrollment during 2020 (CMS, 2021). The increase in total Medicaid and CHIP enrollment resulted particularly from the enactment of section 6008 of the Families First Coronavirus Response Act. This legislation provides states with a temporary 6.2 percent payment increase in Federal Medical Assistance Percentage funding. States qualify for this enhanced funding by adhering to the Maintenance of Effort requirement, ensuring eligible people enrolled in Medicaid stay enrolled and covered during the Public Health Emergency (PHE), thus members enrolled in Medicaid during 2020 also continued enrollment throughout 2021. Enrollment in Texas

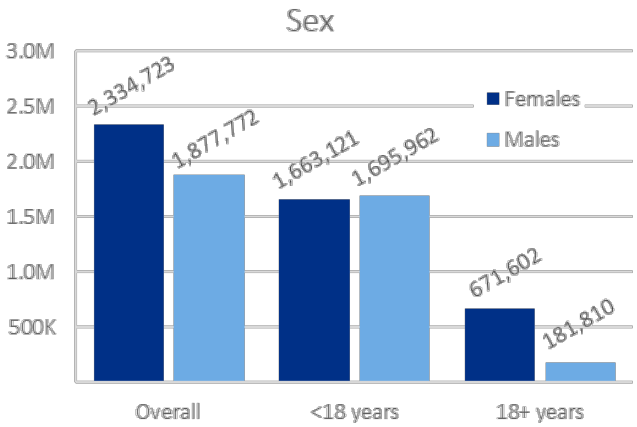
CHIP was declining prior to the PHE. This trend accelerated during the PHE because children that became Medicaid eligible stayed in Medicaid, including CHIP-eligible newborns receiving Medicaid coverage for their first year. Children that would have transitioned to CHIP at age one continued in Medicaid because of the PHE.

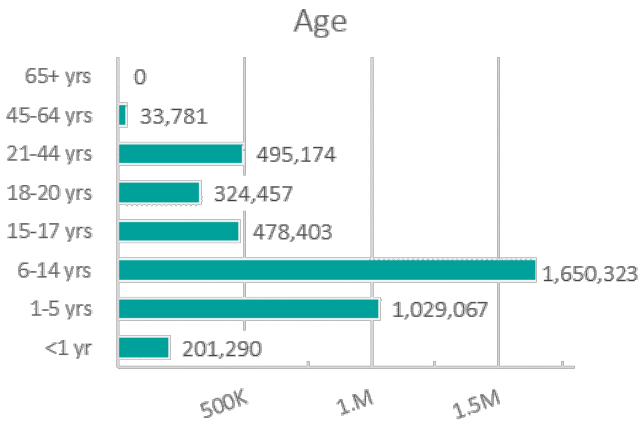
The following summaries show member data as of December 31, 2021, for the STAR, STAR+PLUS, STAR Kids, STAR Health programs, and CHIP. They represent a snapshot of the Texas Medicaid programs and CHIP as of the close of the measurement year (MY) for most of the quality-of-care (QoC) measures reported by the EQRO during SFY 2022. Health status reflects members' 3M™ Clinical Risk Group (CRG) status assigned to Special Healthcare Needs (SHCN) groups. Appendix A describes the health status CRG categories.

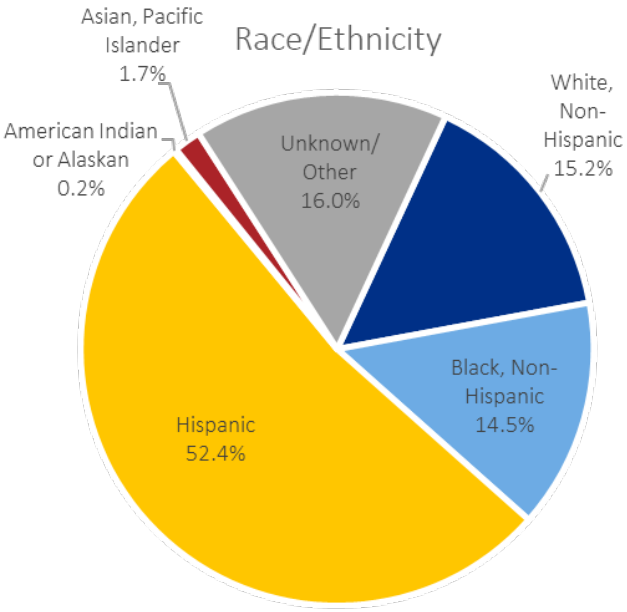
STAR

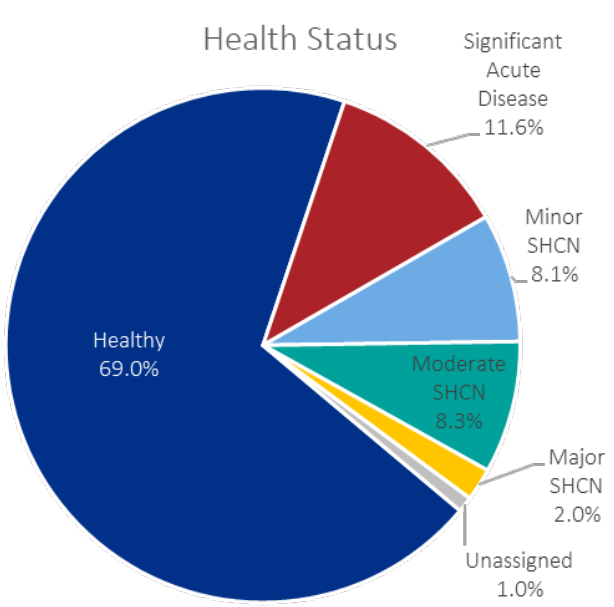
As the main managed care program in Texas Medicaid, the STAR program had 4,212,495 non-dual-eligible members in December 2021. Nearly 80 percent of adult members are women, while members up to age 18 are almost evenly males and females. Although these distributions by sex remained generally consistent, the percentage of adult members has increased during the PHE. As in prior years, a majority of members are Hispanic, and most members are healthy.





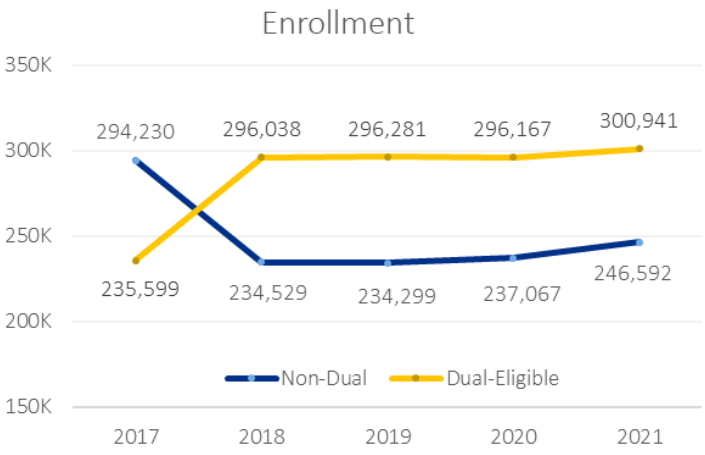


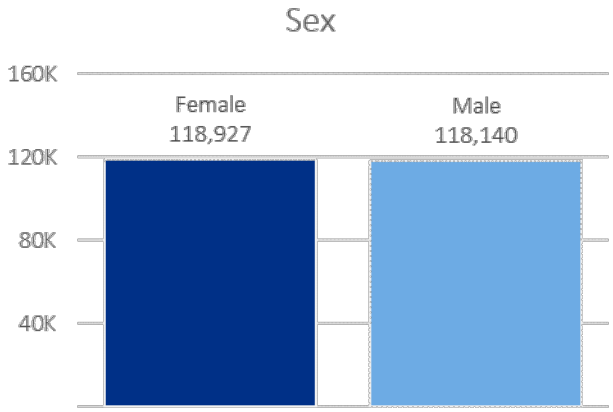


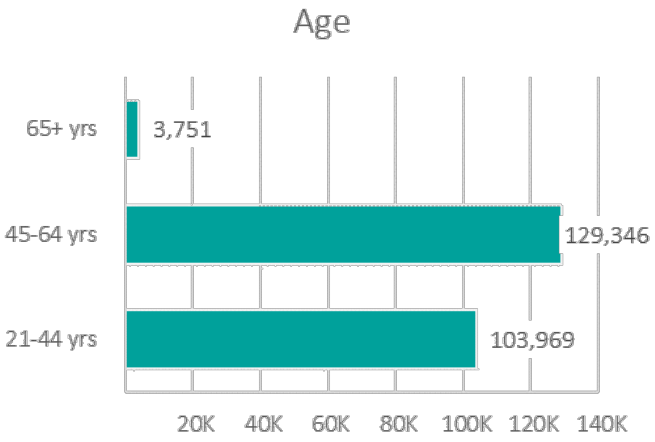


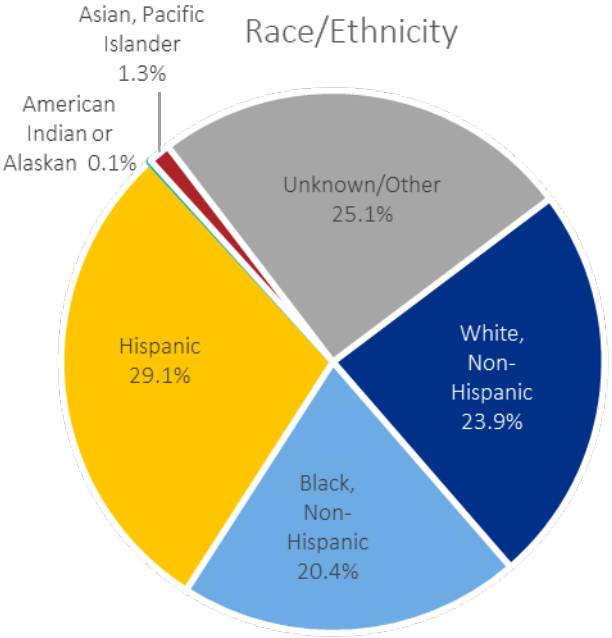
STAR+PLUS

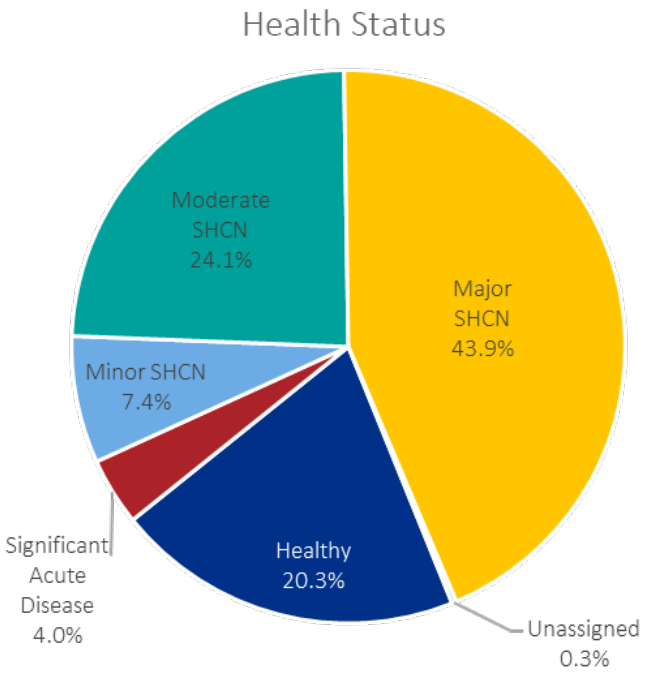
The STAR+PLUS program had 246,592 non-dual-eligible members (among 547,533 total) as of December 2021. Non-dual membership has increased annually since 2018, including a four percent increase since 2020. Distributions by age, sex, and race-ethnicity are similar to those in 2020. One-quarter of STAR+PLUS members had unknown/other race-ethnicity. Over twenty percent were categorized as healthy, despite health status criteria eligibility for this program.





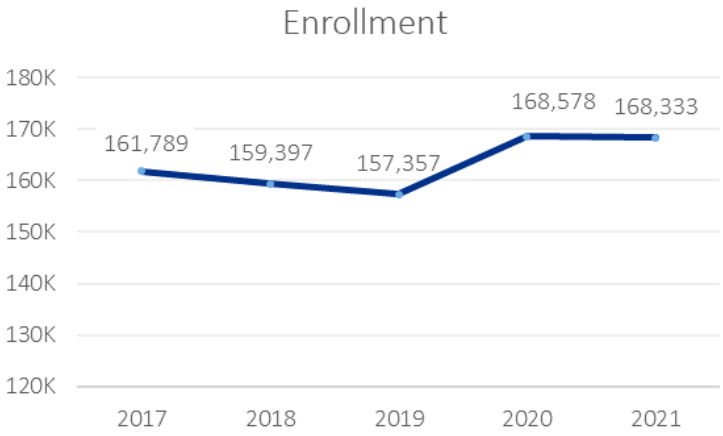


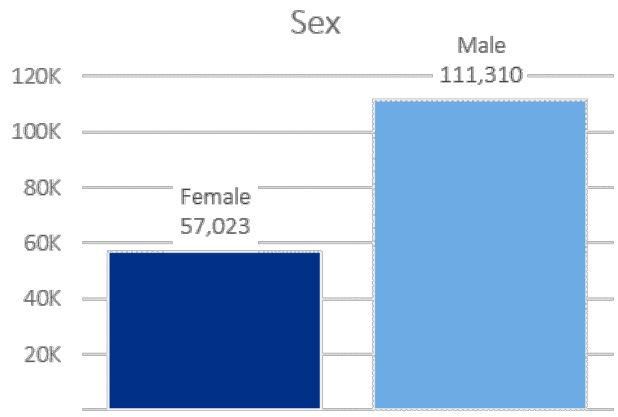


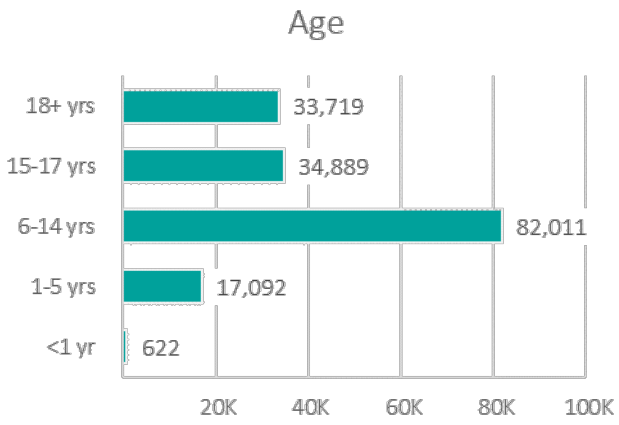


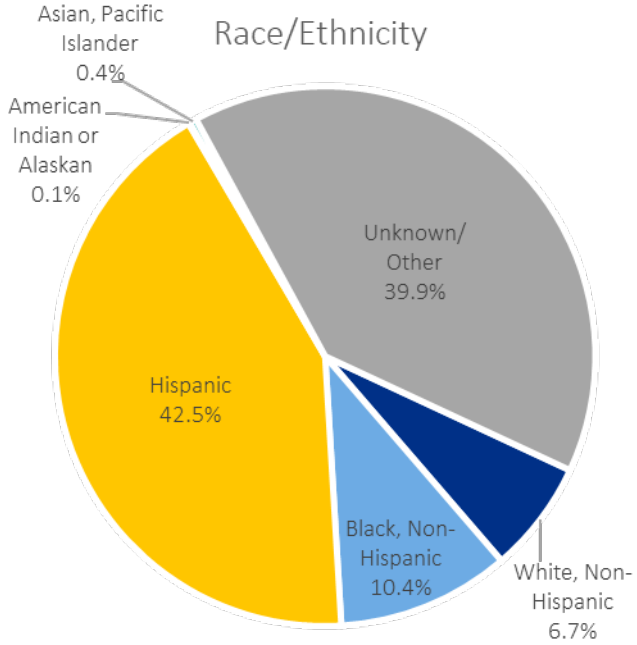
STAR Kids

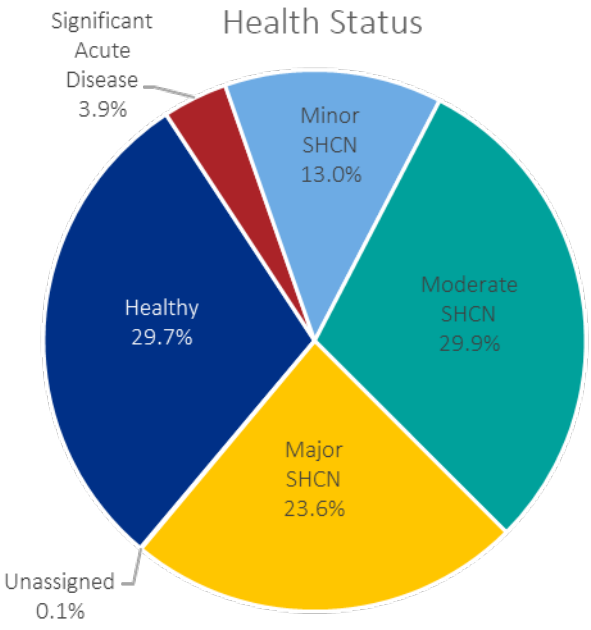
The STAR Kids program had 168,333 non-dual-eligible members as of December 2021. Enrollment remained consistent following a nine percent increase in 2020. Males continue to outnumber females by about two to one, and nearly half of all members are six to 14 years of age. 40 percent of members had an unknown/other race-ethnicity. Member SHCN category is more likely to be minor or moderate in STAR Kids than in STAR+PLUS, and nearly 30 percent had a healthy CRG categorization.





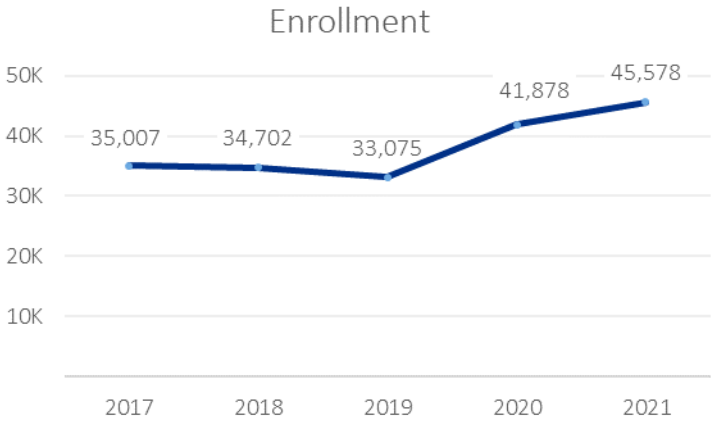


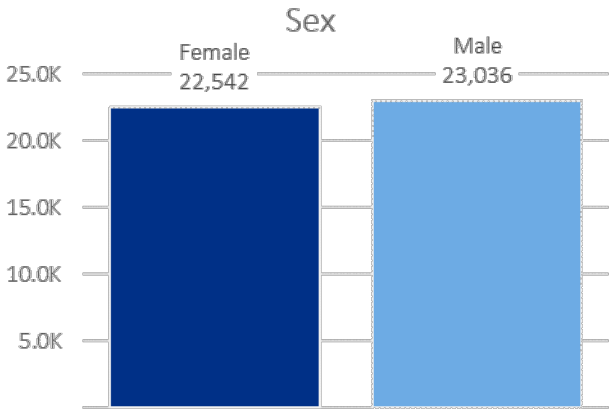


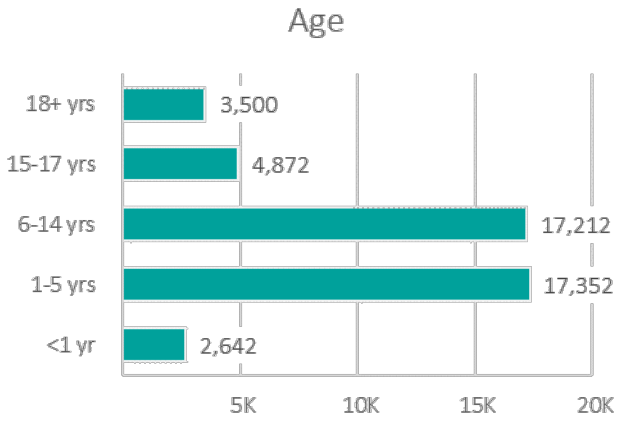


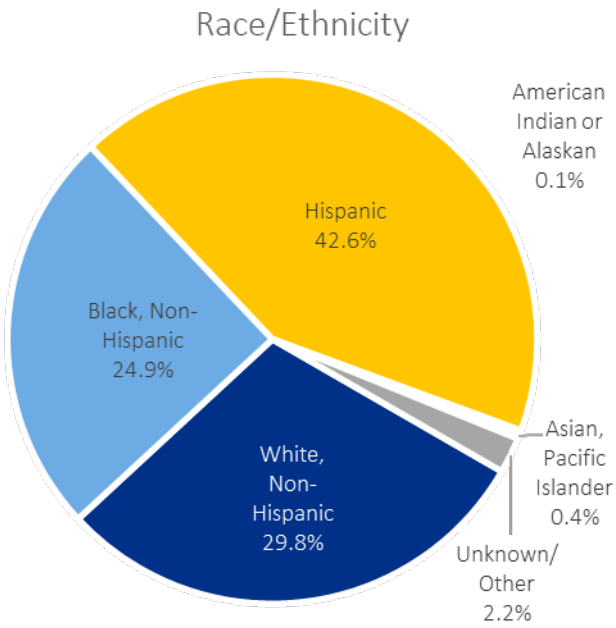
STAR Health

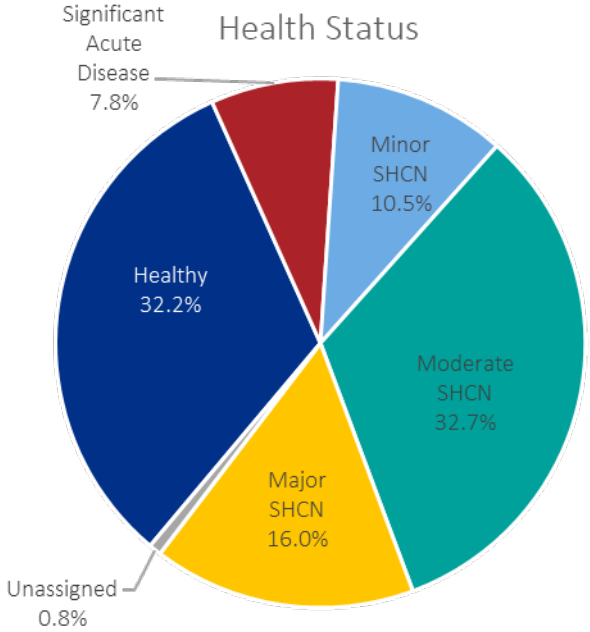
Enrollment in STAR Health increased again in 2021. The 45,578 members in December is a 38 percent increase from 2019. Nearly equal numbers of members are male and female, and the member age distribution is relatively even and consistent compared to prior years. The distribution of race-ethnicities also remains consistent. In 2021, a higher percentage of members had a healthy CRG categorization (32.2 percent) compared to prior years, suggesting that the increase in members is mostly healthy children.





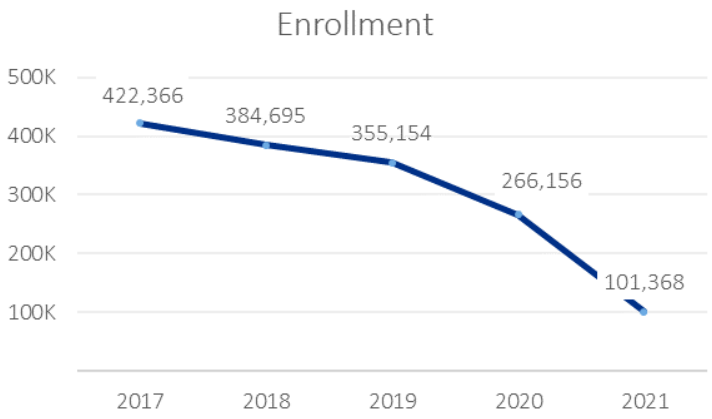


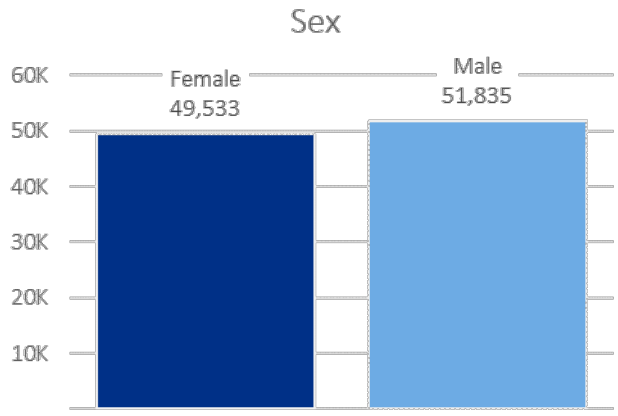


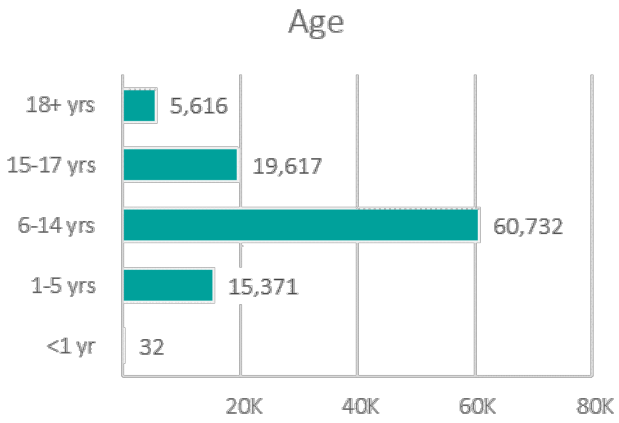


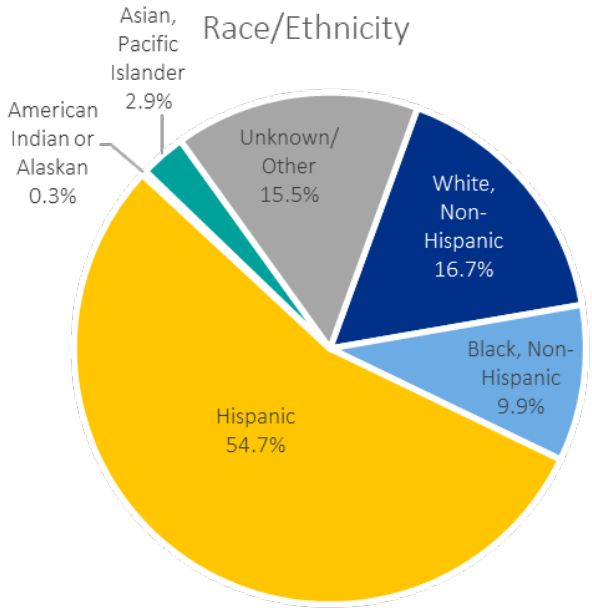
CHIP

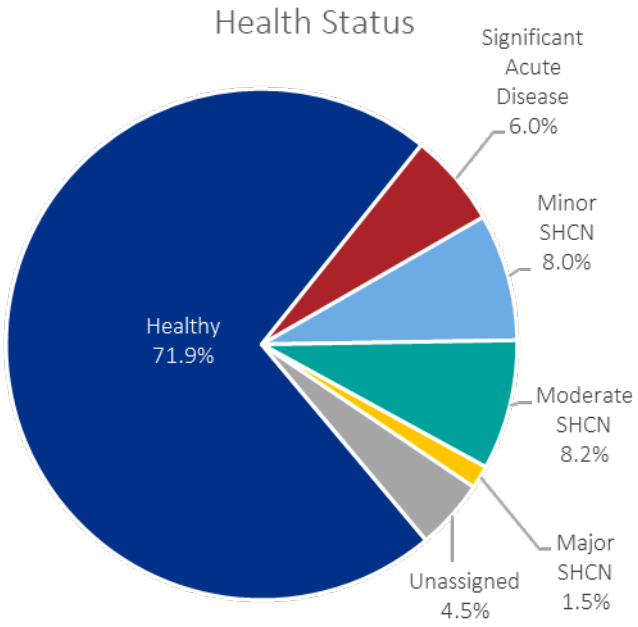
CHIP enrollment has decreased precipitously. A major reason is that CHIP-eligible infants that received Medicaid coverage until age one, then stayed in Medicaid due to the PHE enrollment rules, rather than transfering to CHIP. This impact is also reflected in the decrease seen in the percentage of members under six. The distributions by sex, race-ethnicity, and health status remain consistent. CHIP has the highest percentage of healthy members compared to all the STAR programs.











EQRO Responsibilities

This Annual Technical Report (ATR) summarizes findings from EQR activities conducted in SFY 2022 (September 1, 2021–August 31, 2022), per the requirements of 42 C.F.R. § 438.364 (2020). The EQRO followed the reporting guidelines outlined under 42 C.F.R. § 438.364 (2020) and completed the report in time for HHSC to submit the report to CMS by April 30, 2023. Per reporting requirements under 42 C.F.R § 438.364 (a)(7)(2020), HHSC confirmed that none of the MCOs, MMPs, or DMOs that serve members in Texas Medicaid or CHIP were exempt from EQR activities in SFY 2021.

The EQRO followed the guidance of the CMS EQR Protocols (CMS, 2019) for EQR activities. The EQR protocols covered in this ATR include:

Mandatory protocols:

- **Protocol 1**: Validation of Performance Improvement Projects (PIPs)
- **Protocol 2:** Validation of Performance Measures
- **Protocol 3:** Review of Compliance with Medicaid & CHIP Managed Care Regulations
- **Protocol 4:** Validation of Network Adequacy *(will be mandatory when published– not published at the time of this ATR)*

Optional protocols:

- **Protocol 5:** Validation of Encounter Data Reported by MCOs and DMOs
- **Protocol 6:** Administration of Quality of Care Surveys
- **Protocol 7:** Calculation of Performance Measures
- **Protocol 9:** Conducting Focus Studies of Health Care Quality
- **Protocol 10:** Assist with Quality Rating of MCOs and DMOs *(not published at the time of this ATR)*

This ATR includes an Executive Brief highlighting findings and initiatives of interest to CMS and Texas, particularly in relation to the state Managed Care Quality Strategy to satisfy requirements in 42 CFR 438.340(c)(1)(2020). Also included are activity summaries for the EQR protocols, a summary of recommendations by the EQRO for SFY 2022, and a summary of recommendations from SFY 2021 that includes HHSC actions on each recommendation.

Per 42 C.F.R. § 438.364 (a)(1–2)(2020), the report includes a description of how the EQRO aggregated and analyzed data from all activities conducted per 42 C.F.R. § 438.358 (2020), and how the EQRO made conclusions about the quality, timeliness, and access to the care furnished by the MCOs and DMOs serving Texas Medicaid and CHIP. Each EQR-related activity conducted per 42 C.F.R. § 438.358 (2020) includes a list of objectives, technical methods of data collection and analysis, descriptions of data obtained, including validated performance measurement data for each activity conducted per § 438.358(b)(1)(i) and (ii)(2020), and conclusions drawn from the data. The ATR companion document *Health Plan Performance in Texas Medicaid & CHIP in SFY 2022* (ATRC) includes MCO- and DMO-specific information required under 42 C.F.R. § 438.364(a)(3–6)(2020).

In addition to the EQR activities, the state MCQS is part of the overall Medicaid managed care quality requirements (CMS, 2019). CMS requires each state contracting with an MCO (or DMO) to develop and implement a written quality strategy to assess and improve the quality of Medicaid and CHIP managed care services (42 C.F.R. §438.340, 2020). Texas must review and update this quality strategy every three years and

submit it to CMS for approval. This ATR includes information on the quality goals associated with each set of findings and recommendations in the report.

Table 4 lists the Managed Care Quality Strategy (MCQS) goals for SFY 2021. The full MCQS for SFY 2022 is available at hhs.texas.gov.

Table 5. 2021 Texas MCQS goals referenced in the SFY 2022 ATR

Goal	Description
1	Promoting optimal health for Texans at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health
2	Strengthening person and family engagement as partners in their care to enhance respect for individual's values, preferences, and expressed needs
3	Keeping patients free from harm by contributing to a safer delivery system that limits human error
4	Providing the right care in the right place at the right time to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate
5	Promoting effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of healthcare costs
6	Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers, to participate in team-based, collaborative, and high-value care

Protocol 1: Validation of Performance Improvement Projects (PIPs)

Protocol Overview & Objectives

In 2019, CMS updated the EQR protocols and validation of PIPs is now addressed in Protocol 1 (CMS, 2019). The revised Protocol 1 includes updated templates for PIP reporting and re-ordering of some PIP activities. HHSC implemented these changes for activities in SFY 2022 (for PIPs beginning in SFY 2022 and later). During SFY 2022, the EQRO followed the guidance in EQR Protocol 1 (CMS, 2012a) to evaluate the design, methodological approach, implementation, and validity of results for the mandatory performance improvement projects (PIPs) undertaken by the MCOs and DMOs. Texas requires MCOs and DMOs to conduct PIPs over two years to provide enough time for project implementation and to increase the likelihood of reporting meaningful outcomes.

EQR Activities

Per 42 CFR §438.358(b) (2016), PIP validation is a mandatory EQRO activity. As an ongoing process, the EQRO activities include three major components – an evaluation and validation of the PIP plans, PIP progress reports, and final PIP reports. In September, the EQRO reviews PIP plans for the upcoming year. Every July, the EQRO uses progress reports to evaluate the implementation of the PIPs as they are underway. By October, the MCOs submit the reports for the PIPs they completed in the prior year for final evaluation by the EQRO. However, because the PHE and its impacts on PIP interventions led to the extension of 2019 PIPs, the EQRO did not receive 2019 Final PIP reports in October 2021. The EQRO has provided an overview of the PIP reports it reviewed during SFY 2022 for this report. The SFY 2023 report will include the review of 2019 Final PIP reports.

Methods

HHSC and the EQRO follow the guidance provided in the CMS EQR Protocol 1 to validate the PIPs for each MCO/DMO. As such, HHSC and the EQRO require the MCOs/DMOs to utilize internal data or data provided by the EQRO[3] to report the following:

1. Characteristics of the target population for the PIPs including demographics and utilization of clinical and/or non-clinical services;
2. Prevalence of the problem, supplemented with current literature when applicable;
3. Sampling methodology utilized for the PIP, measures, and interventions, when applicable. This includes:
   a) Sampling methodology for the PIP: a description of how the sample represents the entire enrolled population to which the PIP study indicators (quantifiable measures) apply.
   b) Sampling methodology for measures: a description of how the MCO/DMO will obtain a representative sample for the measure and a description of the sample size and the percentage of the total population that the sample represents.
   c) Sampling methodology for interventions: a description of how the MCO/DMO will obtain a representative sample for the intervention and a description of the sample size and the percentage of the total population that the sample represents.
4. Performance measures utilized to assess the effectiveness of the PIPs with corresponding benchmarks and goals for improvement;

[3] The EQRO requires the MCOs/DMOs to utilize the rates calculated by the EQRO when reporting on the performance measures for the PIPs, when available.

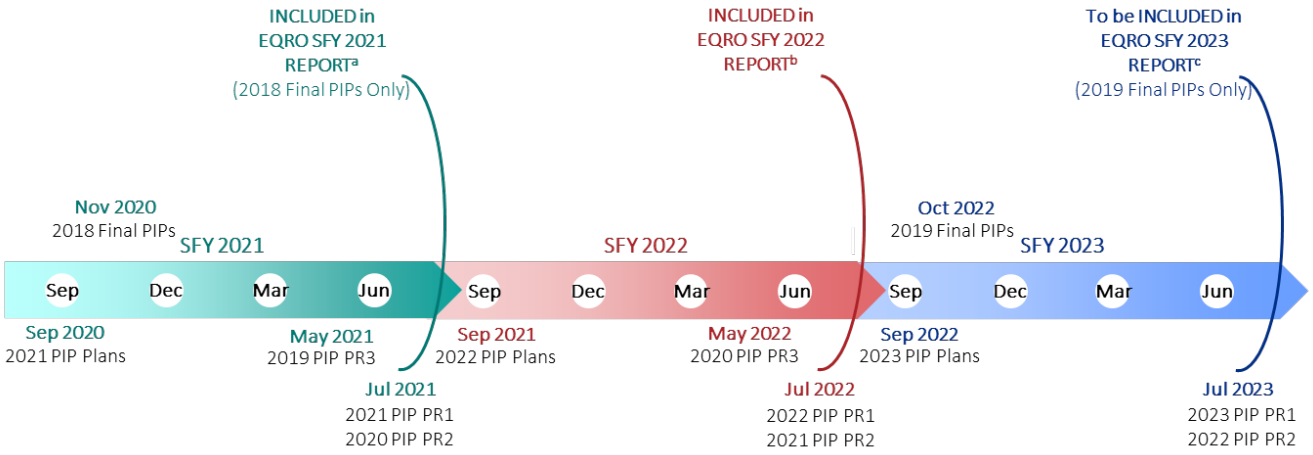
5. Data collection procedures (i.e., steps taken to ensure validity and reliability of data collected, sources of data, frequency of data collection, types of data collected, and data analysis plan);
6. Interventions the MCO implemented for the PIP, along with tracking and monitoring efforts conducted for each intervention. This includes, but is not limited to:
   a) Number and percent of members/providers targeted and reached;
   b) A detailed description of how the MCO/DMO will monitor each intervention for effectiveness throughout implementation; and
   c) Process measures the MCOs/DMOs will utilize to measure the impact and effectiveness of the interventions.
7. The results of the statistical analyses the MCO/DMO used to determine if the PIP measures achieved a statistically significant improvement.

PIP Timelines and Reporting

Due to the COVID-19 pandemic and the impact it had on the implementation of PIPs, HHSC extended the 2019 and 2020 PIPs by one year, making them three-year PIPs instead of two-year PIPs. As a result, HHSC required the MCOs to submit a third progress report in the third year of the PIP, which was 2021 and 2022 for the 2019 and 2020 PIPs, respectively. This extension resulted in no scheduled Final PIP Reports due in SFY 2022. Figure 3 provides a timeline for the PIP reporting activities and reflects the changes made to the timelines for the 2019 and 2020 PIPs.

During SFY 2022, the EQRO reviewed: (a) the 2022 PIP Plans, (b) the third progress reports for 2020 PIPs, (c) the first progress reports for 2022 PIPS, and (d) the second progress reports for 2021 PIPS. This report will focus on an overview of the EQRO's evaluation of the PIP reports completed in SFY 2022.

Figure 3. EQRO timeline for PIP activities



PR1 = Progress Report One; PR2 = Progress Report Two; PR3 = Progress Report Three

[a] The EQRO reported on the complete set of the 2018 PIPs for the SFY 2021 Report.

[b] In SFY 2022, the EQRO could not report on one complete round of PIPs; the 2019 PIP reports were not available because those PIPs were extended for one year. For the SFY 2022 report, the EQRO summarized all the PIP evaluations completed during the reporting year (similarly to the SFY 2020 report).

[c] The EQRO will report on the complete set of the 2019 PIPs for the SFY 2023 Report. The 2020 Final PIPs were also extended and will be reviewed in SFY 2024.

Summary of On-going PIPs

2020 PIPs

In the current reporting year, the EQRO evaluated the 2020 PIP Progress Report 3 submissions received from the MCOs in May 2022. These included preliminary results and any changes to interventions between the submission of Progress Report 2 in July 2021 and May 2022. Topics for the 2020 three-year PIPs, implemented by program, included:

- ADD, Follow-up care for children prescribed ADHD medication, initiation submeasure
- FUH, Follow-up after hospitalization for mental illness
- APM, Metabolic monitoring for children and adolescents on antipsychotics
- FUA, Follow-up after emergency department (ED) visit for alcohol and other drug dependence
- APC, Use of multiple concurrent antipsychotics in children and adolescents
- SSD, Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotics

Both DMOs conducted dental PIPs for Medicaid and CHIP focused on increasing the use of topical fluoride. Unlike the MCO PIPs, these did not extend for a third year and instead concluded in December 2021.

2021 PIPs

In the current reporting year, the EQRO evaluated the 2021 PIP Progress Report 2 submissions received from the MCOs and DMOs in July 2022. These included preliminary results and any changes to interventions between the submission of Progress Report 1 in July 2021 and July 2022. Topics for the 2021 PIPs were implemented by MCO. The selected topics (HEDIS measures used in parentheses) included:

- Reducing hospital admissions for members under the age of 21 years
- Reducing inappropriate use of antibiotics
- Reducing potentially preventable admissions (PPAs) and potentially preventable readmissions (PPRs) by implementing a comprehensive mental health program
- Reducing PPAs for asthma
- Improving compliance with immunizations for adolescents (IMA)
- Improving compliance with breast cancer screening (BCS)
- Increasing appropriate treatment for upper respiratory infection (URI)
- Improving childhood immunization status (CIS)
- Improving comprehensive diabetes care (CDC)
- Improving care for COPD in older adults (PCE)
- Improving compliance with cervical cancer screening (CCS)

For 2021 PIPs the DMOs focused on reducing dental-related potentially preventable ED visits (PPVs).

2022 PIPs

In the current reporting year, the EQRO evaluated the 2022 PIP Plans in September 2021, and the 2022 PIP Progress Report 1 submissions in July 2022. These Progress Reports included preliminary results from the PIP interventions between the implementation date, January 2022, and June 2022. Topics for the 2022 PIPs, implemented by program, included:

- WCC, Weight assessment and counseling for nutrition and physical activity for children/adolescents
- HEDIS-PPC, Prenatal and postpartum care – focusing on social determinants of health (SDoH) and reducing health disparities

Both DMOs conducted dental PIPs for Medicaid and CHIP focused on improving rates of topical sealants.

Evaluations and Results

When evaluating the progress reports, the EQRO assesses compliance on a variety of components, assigning levels including "met," with a corresponding score of 100, "partially met," with a corresponding score of 50, and "not met," with a corresponding score of zero. The progress report score is the average of all component scores. Any MCO that does not implement all recommendations or comply with all instructions outlined in Chapter 10.2.8 on the HHSC Uniform Managed Care Manual in the progress report receives an overall score of 0%, regardless of the scores for individual components.

2020 PIPs

Table 5 provides the scores for the 2020 Progress Report 3 evaluations. Two MCOs (Driscoll and PCHP) failed to address previous recommendations and thus received zero scores on their progress reports. If they had addressed all previous recommendations, PCHP would have scored a 50% for both their STAR and CHIP PIPs and Driscoll would have scored a 53.6% on all three of their PIP Progress Reports. Only two other MCOs (BCBSTX and Molina) had scores less than 90 percent for at least one program.

Table 6. 2020 PIP Progress Report 3 MCO scores

MCO	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Aetna Better Health (Aetna)	92.9%	-	92.9%	-	92.9%
Amerigroup	100%	100%	100%	-	100%
Blue Cross Blue Shield (BCBSTX)	85.7%	-	85.7%	-	85.7%
Children's Medical Center Health Plan[1]	-	-	N/A	-	-
Cigna-HealthSpring[1]	-	N/A	-	-	-
Community First Health Plans (CFHP)	96.4%	-	92.9%	-	92.9%
Community Health Choice (CHCT)	92.9%	-	-	-	92.9%
Cook Children's Health Plan (CookCHP)	100%	-	100%	-	96.4%
Dell Children's Health Plan (DCHP)	100%	-	-	-	100%
Driscoll Health Plan (Driscoll)	0.0%	-	0.0%	-	0.0%
El Paso Health (ElPasoHealth)	92.9%	-	-	-	92.9%
FirstCare	96.4%	-	-	-	96.4%
Molina	78.6%	92.9%	-	-	78.6%
Parkland Community Health Plan (PCHP)	0.0%	-	-	-	0.0%
RightCare (SWHP)	96.4%	-	-	-	-
Superior	96.4%	100%	96.4%	96.4%	96.4%
Texas Children's Health Plan (TCHP)	100%	-	100%	-	100%
UnitedHealthcare (UHC)	96.4%	96.4%	92.9%	-	92.9%

MCO	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Minimum	0.0%	92.9%	0.0%	96.4%	0.0%
Maximum	100%	100%	100%	96.4%	100%
Average	82.8%	97.3%	84.5%	96.4%	81.2%

[1]The CMCHP and HealthSpring Texas Medicaid managed care contracts ended before PIP completion; they did not provide PIP progress reports

2021 PIPs

Table 6 and Table 7 provide the scores for the 2021 Progress Report 2 evaluations. Three MCOs (CHCT, PCHP, and UHC) had zero scores on their progress reports because they did not address all previous recommendations. However, five MCOs (Amerigroup, DCHP, ElPasoHealth, Superior, and UHC) had a score of 100 for at least one program.

Table 7. 2021 PIP Progress Report 2 MCO scores

MCO	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Aetna Better Health (Aetna)	96.4%	-	96.4%	-	96.4%
Amerigroup	96.4%	96.4%	96.4%	-	100%
Blue Cross Blue Shield (BCBSTX)	96.4%	-	96.4%	-	96.4%
Children's Medical Center Health Plan[1]	-	-	N/A	-	-
Cigna-HealthSpring[1]	-	N/A	-	-	-
Community First Health Plans (CFHP)	96.4%	-	96.4%	-	96.4%
Community Health Choice (CHCT)	0.0%	-	-	-	0.0%
Cook Children's Health Plan (CookCHP)	92.9%	-	92.9%	-	92.9%
Dell Children's Health Plan (DCHP)	100%	-	-	-	100%
Driscoll Health Plan (Driscoll)	96.4%	-	96.4%	-	96.4%
El Paso Health (ElPasoHealth)	100%	-	-	-	100%
FirstCare	96.4%	-	-	-	96.4%
Molina	96.4%	96.4%	-	-	96.4%
Parkland Community Health Plan (PCHP)	0.0%	-	-	-	0.0%
RightCare (SWHP)	96.4%	-	-	-	-
Superior	100%	96.4%	96.4%	100%	100%
Texas Children's Health Plan (TCHP)	96.4%	-	96.4%	-	96.4%
UnitedHealthcare (UHC)	0.0%	100%	0.0%	-	0.0%
Minimum	0.0%	96.4%	0.0%	100%	0.0%
Maximum	100%	100%	96.4%	100%	100%
Average	78.8%	97.3%	85.3%	100%	77.9%

[1]The CMCHP and HealthSpring Texas Medicaid managed care contracts ended before PIP completion; they did not provide PIP progress reports

Table 8. 2021 PIP Progress Report 2 DMO scores

DMO	CHIP Dental	Medicaid Dental
DentaQuest	89.3%	89.3%
MCNA Dental (MCNA)	100%	100%

2022 PIPs

Table 8 and Table 9 provide the scores for the 2022 PIP Plans. Nine MCOs (Aetna, BCBSTX, CFHP, CHCT, CookCHP, Driscoll, Molina, PCHP, and SWHP) had scores less than 90 percent for at least one program. The EQRO will combine the PIP Plan scores with the Final PIP Report scores, anticipated in SFY2024, to calculate overall PIP scores for 2022 PIPs.

Table 9. 2022 PIP Plan MCO scores

MCO	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Aetna Better Health (Aetna)	88.1%	-	84.7%	-	84.7%
Amerigroup	96.3%	96.3%	91.1%	-	91.1%
Blue Cross Blue Shield (BCBSTX)	76.8%	-	94.0%	-	90.1%
Community First Health Plans (CFHP)	85.5%	-	87.8%	-	89.9%
Community Health Choice (CHCT)	89.3%	-	-	-	95.5%
Cook Children's Health Plan (CookCHP)	89.7%	-	88.8%	-	88.8%
Dell Children's Health Plan (DCHP)	96.3%	-	-	-	91.1%
Driscoll Health Plan (Driscoll)	80.2%	-	92.3%	-	92.3%
El Paso Health (ElPasoHealth)	96.9%	-	-	-	98.1%
FirstCare	91.7%	-	-	-	94.3%
Molina	90.0%	90.0%	-	-	74.8%
Parkland Community Health Plan (PCHP)	59.4%	-	-	-	60.2%
RightCare (SWHP)	77.1%	-	-	-	-
Superior	96.7%	96.7%	96.7%	96.7%	96.7%
Texas Children's Health Plan (TCHP)	96.7%	-	96.7%	-	96.7%
UnitedHealthcare (UHC)	90.5%	90.5%	95.1%	-	95.1%
Minimum	**59.4%**	**90.0%**	**84.7%**	**96.7%**	**60.2%**
Maximum	**96.9%**	**96.7%**	**96.7%**	**96.7%**	**96.7%**
Average	**87.6%**	**93.3%**	**91.9%**	**96.7%**	**89.3%**

Table 10. 2022 PIP Plan DMO scores

DMO	CHIP Dental	Medicaid Dental
DentaQuest	78.9%	78.9%
MCNA Dental (MCNA)	97.5%	97.5%

DMO	CHIP Dental	Medicaid Dental
UnitedHealthcare Dental (UHCD)	94.7%	94.7%

Table 10 and Table 11 provide the scores for the 2022 PIP Progress Report 1. Scores ranged from zero to 100 percent. Three MCOs (Driscoll, Molina, and Superior) had a score of zero for at least one of their PIPs due to not including all previous recommendations. Average scores by program ranges from zero (STAR Health) to 73.1 percent (CHIP). All DMO PIP Progress Report 1 submissions scored 100%.

Table 11. 2022 PIP Progress Report 1 MCO scores

MCO	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Aetna Better Health (Aetna)	89.3%	89.3%	-	-	92.9%
Amerigroup	100%	100%	100%	-	100%
Blue Cross Blue Shield (BCBSTX)	92.9%	96.4%	-	-	96.4%
Community First Health Plans (CFHP)	85.7%	78.6%	-	-	78.6%
Community Health Choice (CHCT)	78.6%	-	-	-	89.3%
Cook Children's Health Plan (CookCHP)	96.4%	92.9%	-	-	92.9%
Dell Children's Health Plan (DCHP)	100%	-	-	-	100%
Driscoll Health Plan (Driscoll)	0.0%	0.0%	-	-	0.0%
El Paso Health (ElPasoHealth)	96.4%	-	-	-	100%
FirstCare	96.4%	-	-	-	100%
Molina	0.0%	-	0.0%	-	0.0%
Parkland Community Health Plan (PCHP)	57.1%	-	-	-	71.4%
RightCare (SWHP)	92.9%	-	-	-	-
Superior	0.0%	0.0%	0.0%	0.0%	0.0%
Texas Children's Health Plan (TCHP)	92.9%	89.3%	-	-	89.3%
UnitedHealthcare (UHC)	85.7%	89.3%	85.7%	-	89.3%
Minimum	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Maximum	**100%**	**92.9%**	**85.7%**	**0.0%**	**100%**
Average	**73.0%**	**70.6%**	**46.4%**	**0.0%**	**73.1%**

Table 12. 2022 PIP Progress Report 1 DMO scores

DMO	CHIP Dental	Medicaid Dental
DentaQuest	100%	100%
MCNA Dental (MCNA)	100%	100%
UnitedHealthcare Dental (UHCD)	100%	100%

Relevance for Assessing Quality, Access, and Timeliness

2020 PIPs

The 2020 PIPs address integration of behavioral and physical health care. These PIPs will thus also improve the overall quality of healthcare, because integrated care improves health outcomes for patients with co-occurring physical and behavioral health conditions (Palmer & Rossier Markus, 2020). One example is CookCHP's PIP, which seeks to increase prevalence of metabolic monitoring among children and adolescents on antipsychotic medications. This PIP addresses quality of care, as metabolic monitoring can lead to early detection and treatment of conditions which individuals on antipsychotics are at increased risk of developing, such as hyperglycemia, high blood pressure, and obesity (De Hert et al., 2012). The 2020 PIPs also address timeliness of care for members, as several PIPs address timeliness of follow-up care after hospitalization for mental illness. One such PIP is Amerigroup's, which aims to improve rates of follow-up care within seven days after a hospitalization due to mental illness. This improvement in timeliness of care also improves quality, as missing timely follow-up care increases the risk for repeat hospitalization and prevents providers from adjusting medications or providing other interventions. This can ultimately lead to poor member outcomes including worsening of the initial condition or death (Fontanella et al., 2020). Several MCOs implemented interventions in their PIPs specifically to address access to care, such as Amerigroup's intervention of telephonic outreach to members, which included informing members of available transportation resources to facilitate access to follow-up care.

2021 PIPS

In 2021, the MCOs selected PIP topics that aligned with the National Quality Strategy and CMS priorities. These strategies and priorities have an overarching goal of improving quality of care for members, while many PIPs also included interventions which specifically addressed access and timeliness. As an example, Superior's 2021 PIPs for STAR, STAR Kids, STAR Health, and CHIP aim to increase rates of compliance with HPV vaccine administration. This topic addresses quality of care, as compliance with HPV vaccination administration reduces the risk of infection with HPV and development of HPV-associated cancers (Kamolratanakul & Pitisuttithum, 2021). This PIP also addresses timeliness of care, as Superior developed interventions to ensure that members receive vaccinations in a timely fashion, consistent with the recommended vaccination schedule (i.e. distribution of information on dosing schedules). These PIPs included interventions to address barriers to access as well, such as utilizing a mobile clinic to administer vaccinations to members lacking transportation.

2022 PIPS

The 2022 MCO PIPs address maternal health or weight assessment and counseling for nutrition and physical activity for children and adolescents. For DMOs, the PIPs address usage of sealants. Several maternal health PIPs address timeliness by implementing interventions which aim to increase the percentage of members who receive prenatal care within the first trimester and postnatal care seven to 84 days after delivery. Others address access through interventions aiming to overcome barriers stemming from SDoH or non-medical drivers of health (NMDOH), including lack of access to transportation. For example, ElPasoHealth developed an intervention for a maternal health PIP to inform members of their Texas Non-Emergency Medical Transportation (NEMT) benefit via a texted flier, highlighting members' ability to bring children along on this transportation if necessary. This directly addresses some of the barriers to access that ElPasoHealth identified in a root cause analysis. The 2022 PIPs also address quality of care, as both timely maternal healthcare and weight assessment and counseling for nutrition and physical activity for children improve health outcomes—for

instance, weight assessment provides an opportunity for providers to address and prevent complications from childhood obesity, including Type 2 Diabetes, asthma, and cardiovascular disease (Nelson et al., 2015).

Summary of Protocol Findings & Recommendations from EQR Activities

Table 12 provides a summary of the key findings and recommendations from EQR activities associated with Protocol 1 and their relevance to the MCQS.

Table 13. Protocol 1 findings and recommendations

Category	Description
Finding(s)	Several MCOs scored zero on progress reports during this evaluation year because they did not address all previous recommendations. In the 2020 PIP Progress Report 3, two MCOs scored a zero. In the 2021 PIP Progress Report 2, three MCOs scored a zero. In the 2022 PIP Progress Report 2, three MCOs scored a zero. Each of these MCOs could have scored significantly higher, ranging from 50 to 96.4 percent, had they addressed previous EQRO recommendations. This has been an ongoing issue for PCHP and Driscoll. PCHP did not address all previous recommendations on 2019 Progress Report 3, 2020 Progress Report 2, 2020 Progress Report 3, and 2021 Progress Report 2. Driscoll did not address all previous recommendations on: 2019 Progress Report 3, 2020 Progress Report 3, and 2022 Progress Report 1.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	MCOs, including Driscoll, PCHP, CHCT, UHC, Molina, and Superior should ensure that their progress reports for all PIPs address all previous recommendations made by the EQRO.
Finding(s)	Lower scores were often due to errors or omissions in measure reporting, issues reporting target and reach data correctly, and providing insufficient justification for modifications made to PIPs. For example, PCHP, BCBSTX, and Molina lost points due to reporting re-measurements using incorrect time frames. Both BCBSTX and Molina lost points in measure reporting, because they did not utilize data from the QoC tables or THLCportal.com in baseline data, and thus the EQRO could not verify or validate their numerators and denominators.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	MCOs, including PCHP, BCBSTX, Molina (who scored lowest on 2020 PIP Progress Report 3), and DentaQuest (who scored lowest on 2021 PIP Progress Report 2), should report all measures both accurately and completely, report target data correctly, and provide justification for all modifications made to PIPs.
Finding(s)	In the 2022 PIP Plans, PCHP received the lowest scores due to their use of an old version of the PIP template that did not include all the CMS required information for the PIPs.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	PCHP should ensure that it utilizes the most up-to-date versions of templates (available in the Uniform Managed Care Manual) to ensure that they address all necessary questions for CMS compliance.

Protocol 2: Validation of Performance Measures

Protocol Overview & Objectives

This protocol guides the validation of the performance measures specified by states for inclusion in the quality assessment and performance improvement (QAPI) programs conducted by the MCOs and DMOs. Texas combines both performance measurement options in 42 C.F.R. § 438.330 (2016), by requiring the MCOs and DMOs to (1) calculate quality measures determined by the state and submit the results, and (2) submit data allowing the state to calculate performance measures. Protocol 2 (CMS, 2019) is a mandatory EQRO activity (42 C.F.R. § 438.358, 2016) requiring the EQRO to validate Texas Medicaid and CHIP performance measure results, assessing the accuracy of MCO reported results and evaluating how well the calculated measures follow Texas requirements. To provide the most consistent calculations across many programs and MCOs, Texas enlists the EQRO to calculate over 100 QoC measures annually instead of requiring all of these to be MCO reported and subject to validation under Protocol 2. To validate these measures, the EQRO uses an external auditor certified by the National Committee for Quality Assurance (NCQA). Measures calculated by the EQRO provide standard, reliable results for use in quality evaluations and research. The related Protocol 7: Calculation of Performance Measures, specifically addresses performance measures calculated by the EQRO. Under Protocol 2, the EQRO validates a limited number of performance measures Texas requires MCOs to calculate and report. The state requires MCOs to calculate select Healthcare Effectiveness Data and Information Set (HEDIS®) measures following the hybrid method specifications. The EQRO also evaluates other service and access indicators that Texas requires MCOs to calculate, including rates for Texas Health Steps (THSteps) checkups.

To evaluate MCO performance related to Protocol 2, the EQRO uses strategies including:

- A review of information related to the Information Systems Capabilities Assessment (ISCA) process recommended by CMS (CMS, 2019), collected through the administrative interviews (AIs) addressed under Protocol 3: Review of Compliance with Medicaid & CHIP Managed Care Regulations.
- A review of audit reports by NCQA certified auditors (for HEDIS measures) and related documentation.
- A direct review of measure specifications and results, including a comparison to EQRO-calculated results.

EQR Activities

Information Systems, Processes & Data Used in Performance Measures

As part of the AI process, the EQRO asks questions related to Information Systems and Data Acquisition. All four MCOs participating in the AI process in SFY 2022 (see Protocol 3: Review of Compliance with Medicaid & CHIP Managed Care Regulations) indicated that they underwent a formal ISCA within the past two years. Two MCOs indicated that the review was part of their standard internal controls audit. All four MCOs underwent an audit by an NCQA certified auditor for the purpose of reporting HEDIS measures. Regardless of whether they submit data to NCQA, all MCOs must provide the EQRO with the attestation of an NCQA certified auditor that their hybrid data and rates and any supplemental data submitted to the EQRO meet all NCQA audit standards. The first part of the NCQA HEDIS audit process is a review of an organization's overall information systems capabilities for collecting, storing, analyzing, and reporting health information relevant to calculation of reportable HEDIS measures. Each MCO must provide an attestation of reportability from an NCQA-certified auditor with all hybrid measure results submitted.

In the AI, MCOs reported an average experience of their programming staff between three and eight years, and only one reported turnover during the year. The cumulative staff experience helps build important institutional knowledge and should improve efficiency in any data-driven initiatives. Three MCOs reported a major change in encounter or enrollment processing systems in the past three years. These changes highlight the need for continuous evaluation of MCO/DMO information systems. Only Molina reported that they tracked electronic health record (EHR) use among primary care providers and that for primary care providers (PCPs) and specialists combined, 13 percent used an EHR system. Superior only provided information on specialists, but indicated that 95 percent use an EHR system. All MCOs reported weekly internal claim audits and that at least 95 percent of claims are complete within three months. All four MCOs always deny late filed claims. Three MCOs have a third party generate the EOB (explanation of benefits) and other payment reports.

The AI includes questions about the validation of provider identification and taxonomy information. All MCOs indicated that they validate National Provider Identifier (NPI) and indicated that they reject or deny claims without NPI. However, three MCOs indicated that some provider categories do not have NPIs, specifically those with Atypical Provider Identifiers (APIs). All MCOs indicated taxonomy validation against the services and the provider credentials. However, the EQRO has noted universal deficiencies in NPI and taxonomy fill. Texas is engaged in several initiatives to improve provider data, both in encounters and the provider data warehouse.

MCO reported measures

HEDIS Hybrid Measures

Hybrid method specifications include sampling based on administrative criteria, followed by medical record review from the sample to determine compliance. For HEDIS MY 2021, MCOs reported their hybrid method results for six HEDIS measures for the programs listed in Table 13. The EQRO compiles the results with EQRO calculated measures (see Protocol 7: Calculation of Performance Measures) in the QoC Reports and on the Texas Healthcare Learning Collaborative (THLC) portal (thlcportal.com). Statewide rate calculation includes reported hybrid rates weighted by the eligible MCO denominator identified by the EQRO.

Table 14. HEDIS MY 2020 measures selected for hybrid reporting

Measure	Description	Programs
CBP	Controlling High Blood Pressure	STAR, STAR+PLUS
CDC	Comprehensive Diabetes Care	STAR, STAR+PLUS
CIS	Childhood Immunization Status	CHIP, STAR, STAR Kids
IMA	Immunizations for Adolescents	CHIP, STAR, STAR Kids
HEDIS-PPC	Prenatal and Postpartum Care	STAR
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	CHIP, STAR, STAR Kids

In addition to the NCQA certified auditor report and related documentation that MCOs must submit with the measure results to the EQRO, the EQRO also requires each MCO to provide the member-level data used to support the measure calculations. First, the EQRO validates the measures by verifying that each submitted rate is consistent with the submitted member data. Then, the EQRO compares the submitted rates with EQRO-calculated administrative rates and prior years' results to identify trends. Finally, the EQRO uses data analysis and communication with HHSC and the submitting MCO to identify and trace any inconsistencies in the

measure's eligible population, denominator, and numerator. For example, the EQRO identified inconsistencies in how MCOs count exceptions and contraindications.

In addition to required hybrid measure rates, the MCOs may also submit supplemental data for use in HEDIS measures calculated by the EQRO (see Protocol 7: Calculation of Performance Measures). Approval from an NCQA-certified HEDIS auditor must accompany submitted supplemental data. Submissions must conform to either standard or non-standard data types, as defined by NCQA. The most common type of submitted supplemental data is laboratory results.

Access and Service Measures

Measurement is an important part of the QAPI programs carried out by the MCOs and DMOs and evaluated by the EQRO (see Protocol 3: Review of Compliance with Medicaid & CHIP Managed Care Regulations). All MCOs and DMOs, except for TCHP, scored 100/100 on the EQRO assessment of "Systems, Processes, and Outcomes Measurements and Results" and "Internal/External Comparisons," addressed in the "Improvement Opportunities" section of the EQRO review. In the "Availability and Accessibility (of) Access to Care Monitoring and Results" area, nine of 20 MCOs scored 10/10, while two MCOs (PCHP and Superior) had a weighted score less than 8/10 In the "Activities and Ongoing Quality Indicators" area, 13 of 20 scored 10/10, however the same two MCOs (PCHP and Superior) had a weighted score less than 8/10.

Texas Health Steps Checkups

Following the Frew Consent Decree (Frew) of 1996 (*Frew et al. V. Phillips et al.*, 1996), HHSC became subject to corrective action orders, including an independent study of medical checkup completeness and required checkup reports. According to Chapter 12 of the Texas Uniform Managed Care Manual (UMCM) that covers Frew requirements (HHSC, 2022a), MCOs must submit annual reporting on compliance with THSteps checkup requirements. The EQRO independently calculates compliance rates using the encounter and enrollment data in the Texas Medicaid data warehouse and provides a comparative report to HHSC. The EQRO works closely with HHSC to develop reporting specifications and provides continuing technical assistance to HHSC and the MCO stakeholders to support these reports. In addition, the EQRO provides ad hoc support to the MCOs if their submitted report does not pass validation. This support includes phone conferences and providing member data from EQRO calculations to assist in rectifying any errors in their reporting. During SFY 2022, the EQRO evaluated compliance for members with a checkup due starting in SFY 2020. Because of the PHE, HHSC made several changes to the check-up requirements, including extended time and allowance for telehealth. After reviewing the data, the EQRO suggested that validating checkup reports following the standard methodology would provide the best conformation of MCO reporting given the significant challenges created by the PHE changes, including regional and temporal differences in the impact of the PHE. Still, several MCOs reported rates that differed from the EQRO calculations by more than the allowable standard. Overall, the EQRO calculated rates are slightly lower than MCO reported rates for new member checkups and slightly higher for existing members. The EQRO found that MCO rates for providing required THSteps checkups to existing members were between 30 and 65 percent among STAR MCOs and between 35 and 75 among STAR Kids MCOs. For new members, rates were only between 25 and 55 percent among STAR MCOs and between 10 and 35 among STAR Kids MCOs. Rates are typically lower than HEDIS well visit rates because of differences in requirements.

COVID-19 Pandemic Impacts

The public health efforts to curb the spread of the COVID-19 pandemic reduced the number of in-person visits and vaccination appointments across the U.S. in 2020 (Patel Murthy et al., 2021), and may have contributed to

the low percentage of THSteps checkups. The American Academy of Pediatrics (AAP) has provided guidance throughout the COVID-19 pandemic (AAP, 2022), and support the national "Catch-Up to Get Ahead" initiative.[4] Despite a rebound in outpatient visits, the AAP reports that a significant number of children remain behind on well-child care and immunizations. The EQRO will continue to assist in monitoring the long-term impacts of the COVID-19 pandemic.

Relevance for Assessing Quality, Access & Timeliness

Performance measure validation is important for ensuring the accurate assessment of healthcare quality, timeliness, and access and understanding the processes that affect these domains of care for members. Performance on MCO reported measures in MY 2021 was generally below the national average and fell below the 25th percentile across all programs for prenatal and postpartum care (HEDIS-PPC). Measures for the management of chronic conditions including high blood pressure (CBP) and diabetes (CDC) showed consistently better performance in STAR+PLUS than in STAR, but all were below national averages. The only MCO reported measure where performance was consistently above the national average was the weight assessment and counseling for nutrition and physical activity measure (WCC), for which performance on the counseling sub-measures was above average, but not performance on BMI-percentile documentation. Hybrid specifications can increase identification of compliant members on measures where medical records are likely to provide important additional information. Thus, including the MCO reported hybrid rates provides the most favorable comparison to national benchmarks. The relatively poor performance seen suggests important areas for improvement.

Summary of Protocol Findings & Recommendations from EQR Activities

No recommendations for Protocol 2.

[4] https://www.hhs.gov/immunization/catch-up/index.html

Protocol 3: Review of Compliance with Medicaid & CHIP Managed Care Regulations

Protocol Overview & Objectives

Following guidance in CMS EQRO Protocol 3 (CMS, 2019), the EQRO determines the extent to which Texas Medicaid and CHIP MCOs and DMOs comply with federal quality standards 42 C.F.R. § 438 (2020) and 42 C.F.R. § 457 (2020)

- Availability of services § 438.206
- Assurances of adequate capacity and services § 438.207
- Coordination and continuity of care § 438.208
- Coverage and authorization of services § 438.210
- Provider selection § 438.214
- Confidentiality § 438.224
- Grievance and appeal systems § 438.228
- Sub-contractual relationships and delegation § 438.230
- Practice guidelines § 438.236
- Health information systems § 438.242
- Quality assessment and performance improvement program § 438.330

The EQRO conducts two major reviews to fulfill the requirements of this protocol. First, the AIs (administrative interviews) allow the EQRO to complete comprehensive MCO and DMO regulatory compliance assessments. The AIs assist the EQRO with identifying the structural strengths and opportunities for improvement in MCO and DMO quality improvement programs. Second, the EQRO conducts a thorough review of quality improvement programs through the QAPI program evaluations.

EQR Activities

AIs

The EQRO developed a web-based AI tool that allows MCOs and DMOs to provide information across ten major areas:

1. Organizational Structure
2. Member Enrollment and Disenrollment
3. Children's Programs and Preventive Care
4. Care Coordination and Disease Management (DM) Programs for Members with Chronic Conditions or SHCN
5. Member Services
6. Member Complaints and Appeals
7. Provider Network and Reimbursement
8. Authorization and Utilization Management
9. Information Systems
10. Data Acquisition

Methods & Analyses

The EQRO reviews federal regulatory updates and incorporates these updates into the AI web-based tool and evaluation protocols. The EQRO works with HHSC to appropriately define and measure levels of compliance for each regulatory item. Compliance level include "met," with a corresponding score of 100, "partially met," with a corresponding score of 50, and "not met," with a corresponding score of zero. The EQRO deems an MCO or DMO fully compliant when it meets all regulation components across all product lines. Each year, the EQRO rotates the group of MCOs and DMOs participating in full AI review (including assessment of all regulatory areas, through the web-based responses and an on-site visit) such that each MCO and DMO participates in the full AI review process every three years. SFY 2022 is the first year of the current three-year reporting cycle, which will run SFY 2022–2024. Table 14 shows the AI rotation plan for SFY 2020 through SFY 2024.

Table 15. MCO and DMO participation in AI review by evaluation year

SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Blue Cross Blue Shield (BCBSTX)	Aetna Better Health (Aetna)	Amerigroup	Blue Cross Blue Shield (BCBSTX)	Aetna Better Health (Aetna)
Children's Medical Center Health Plan (CMCHP)[1]	Cook Children's Health Plan (CookCHP)	Molina	Community Health Choice (CHCT)	Cook Children's Health Plan (CookCHP)
Community Health Choice (CHCT)	Community First Health Plans (CFHP)	Superior	Dell Children's Health Plan (DCHP)	Community First Health Plans (CFHP)
Dell Children's Health Plan (DCHP)	DentaQuest	UnitedHealthcare (UHC)	Driscoll Health Plan (Driscoll)	DentaQuest
Driscoll Health Plan (Driscoll)	El Paso Health (ElPasoHealth)	-	MCNA Dental (MCNA)	El Paso Health (ElPasoHealth)
MCNA Dental (MCNA)	FirstCare	-	Parkland Community Health Plan (PCHP)	FirstCare
Parkland Community Health Plan (PCHP)	United Healthcare Dental (UHCD)	-	RightCare (SWHP)	United Healthcare Dental (UHCD)
RightCare (SWHP)	-	-	Texas Children's Health Plan (TCHP)	-
Texas Children's Health Plan (TCHP)	-	-	-	-

[1] CMCHP exited Medicaid service beginning in SFY 2021.

After confirming the point of contact for each selected MCO or DMO, the EQRO opens the updated web-based tool for the selected MCOs and DMOs to complete all questions and upload supporting documentation. If an MCO or DMO fails to include all necessary information, the EQRO contacts the MCO or DMO representative for follow-up on missing information and documentation. The responses support a comprehensive review of MCO and DMO compliance with Texas requirements and the federal regulations 42 C.F.R. § 438 (2020). The EQRO evaluates each MCO and DMO using the established compliance thresholds. Each MCO and DMO receives a scored plan evaluation. After rigorous review, the EQRO compiles the evaluation results for all MCOs and DMOs under review into a preliminary Summary of Scores report.

In addition to administering the AI tool and evaluating the responses, the EQRO conducts follow-up site visits with the MCOs and DMOs under review. The EQRO determines the necessary site visit length, date, and time to cover all regulatory and non-regulatory questions. Next, the EQRO develops a site visit agenda along with a list of questions to clarify and confirm compliance. This year, the EQRO completed site visits virtually via video conference calls. During site visits, the EQRO addresses areas where MCOs and DMOs are non-compliant with regulations and asks the MCOs and DMOs to provide additional documentation supporting compliance or to revise their policies and procedures to address deficiencies. After completing all site visits, the EQRO allows each MCO and DMO to demonstrate compliance with all identified regulatory deficiencies by submitting revised policies and procedures, which they have finalized and implemented. Once MCOs and DMOs provide updates with supporting documentation, the EQRO incorporates findings into the results and develops a Site Visit Report for each MCO and DMO.

Results

In SFY 2022, four MCOs participated in full AI activities. The EQRO conducted virtual site visits this year. The results reported in this section are based on the original review and do not include the EQRO's determination of regulatory compliance after receiving additional documentation. Based on the review of the AI responses, the EQRO assigned scores in each federal regulatory category and combined them into an overall score. Along with the score report, the EQRO also provided recommendations to each MCO on becoming compliant with regulations. The average overall score in 2022 was 97.8, and scores ranged from 87.5 to 99.6. Individual MCO scores within categories were all at least 50.0. Table 15 shows the final scores and averages across MCOs and Table 16 compares rates of MCO compliance with prior year AI recommendations.

Table 16. 2022 MCO AI scores by federal regulation category and overall

MCO	A. General Provisions	B. State Responsibilities	C. Member Rights & Protections	D. Health Plan Standards	F. Grievance & Appeal System	Overall, AI Evaluation Score
Amerigroup	99.2	100	100	100	100	99.8
Molina	96.7	100	100	98.1	96.1	97.2
Superior	97.5	50.0	100	99.0	98.1	97.6
UHC	95.8	100	98.3	100	94.0	96.5
MCO Average	97.3	87.5	99.6	99.3	97.0	97.8

Table 17. 2022 MCO compliance with prior AI recommendations

MCO	Previous Year Recommendations	Recommendations Implemented	Compliance
Amerigroup	19	19	100%
Molina	25	19	76.0%
Superior	19	18	94.7%
UHC	18	12	66.7%
MCO Average Compliance	-	-	84.4%

In addition to the federal and state regulatory categories addressed in the full AI process, the EQRO inquired about SDoH and the utilization of medical and behavioral health telehealth services. The EQRO asked each MCO to describe procedures the MCO used for collecting SDoH data and interventions the MCO employed to address member needs related to SDoH. Most MCOs reported that they refer members to external community resources to address SDoH needs. Several MCOs provided examples of internally funded interventions, including providing school supplies, hygiene supplies, and food drives. With regards to telehealth, MCOs supported providers shifting to telehealth for the delivery of physical and behavioral health by providing education on using telehealth effectively and the updated requirements for claims submission. The MCOs reported that most services have returned to in-person delivery. An exception was behavioral health services; some MCOs reported that as much as 50% of all behavioral health services continue via telehealth modalities.

QAPI Evaluations

The EQRO annually reviews the Texas Medicaid MCO, DMO, and MMP quality improvement programs to evaluate aspects of structure and processes that contribute to their success and to assess compliance as specified in 42 C.F.R. § 438.330 (2020).[5] The EQRO QAPI program evaluations assess compliance with federal regulations and state standards, and the presence and strength of the five essential elements of a QAPI program, as defined by CMS (CMS, 2016).

1. Design and scope
2. Governance and leadership
3. Feedback, data systems, and monitoring
4. PIPs
5. Systematic analysis

Methods & Analyses

Overall, the EQRO QAPI program evaluation process includes 16 activities (Table 17). Seven, which address the four essential QAPI elements other than PIPs, make up 70 percent of the final overall QAPI score. The other nine activities comprise 30 percent of the final overall QAPI score.

Table 18. 2022 QAPI categories

Activities Addressing Essential Elements Combined Weight = 70% of Overall Score	Additional Activities Combined Weight = 30% of Overall Score
A1: Role of Governing Body (*CMS Element 2*) **A3:** Adequate Resources (*CMS Element 2*) **A4:** Improvement Opportunities (*CMS Elements 3 &5*) **B1:** Program Description (*CMS Elements 1 & 3*) **B5:** Availability and Access to Care Monitoring and Results (*CMS Elements 3 & 5*) **B6a:** Clinical Indicator Monitoring (*CMS Elements 3 & 5*) **B6b:** Service Indicator Monitoring (*CMS Elements 3 & 5*)	Required Documentation **A2:** Structure of QI Committee(s) **B2:** Overall Effectiveness **B3:** Effectiveness of Long-Term Services and Supports (LTSS) **B4:** Clinical Practice Guidelines **B7:** Credentialing and Re-Credentialing **B8:** Delegation of QAPI Program Activities **B9:** Corrective Action Plans **B10:** Previous Year's Recommendations

[5] This report addresses PIPs (element four) under Protocol 1 (CMS, 2019). Due to the time of implementation, the PIP evaluation primarily followed the guidance in the 2012 version of CMS EQR Protocol 3 (CMS, 2012b). EQRO QAPI program evaluations address the other four elements following the guidance in the revised CMS EQR Protocol 3 (CMS, 2019).

Using the same compliance scoring levels applied in the AI ("met," with a corresponding score of 100, "partially met," with a corresponding score of 50, and "not met," with a corresponding score of zero), the EQRO scores plan performance across all components in 16 activities. In addition, the EQRO provides recommendations to the MCOs on any component not fully met. The EQRO also reviews whether the MCOs fully incorporated prior-year recommendations and scores the actions taken in response to each recommendation. However, the EQRO does not include this additional recommendation score when calculating the current overall score.

Results

MCO & DMO QAPI Results

Table 18 shows the score for each MCOs or DMOs SFY 2022 QAPI. The average score was 96.0 percent (SD = 3.8). The EQRO considered scores more than half a standard deviation below the mean (<94.1 percent) as "below average" (15 percent of MCOs and DMOs) and considered scores more than half a standard deviation above the mean (>97.9 percent) as "above average" (35 percent of MCOs and DMOs).

Four MCOs and one DMO improved from their SFY 2021 QAPI evaluations, with FirstCare showing the greatest improvement from 90.0 percent on the SFY 2021 QAPI evaluation to 95.1 percent on the SFY 2022 QAPI evaluation. MCNA matched their previous year's score of 100 percent. The two lowest-scoring plans were PCHP (84.4 percent) and Superior (88.9 percent) both of which received the greatest number of recommendations for activities relating to care and indicator monitoring, and availability and accessibility. PCHP lost points by failing to including data in *Appendix B: Access to Care Monitoring and Results*, for example, the MCO did not include information on actions undertaken to improve performance during the measurement year for any of the seventeen indicators. Superior lost points on *Activity B6b: Activities and Ongoing Quality Indicators* by reporting incorrect or incomplete data for indicators included in *Appendix D: Service Indicator Monitoring*, such as incorrectly utilizing data from MY 2020 rather than MY 2021 when reporting “Member Quality Complaints.”

Table 19. 2022 MCO and DMO QAPI scores

MCO or DMO	Score	Peer Comparison
Aetna Better Health (Aetna)	97.4%	Average
Amerigroup	98.3%	Above Average
Blue Cross Blue Shield (BCBSTX)	98.0%	Above Average
Cigna-HealthSpring (HealthSpring)	95.8%	Average
Community First Health Plans (CFHP)	96.6%	Average
Community Health Choice (CHCT)	96.5%	Average
Cook Children's Health Plan (CookCHP)	97.7%	Average
Dell Children's Health Plan (DCHP)	94.6%	Average
DentaQuest	97.5%	Average
Driscoll Health Plan (Driscoll)	95.4%	Average
El Paso Health (ElPasoHealth)	97.4%	Average
FirstCare	95.1%	Average
MCNA Dental (MCNA)	100%	Above Average
Molina	92.7%	Below Average

MCO or DMO	Score	Peer Comparison
Parkland Community Health Plan (PCHP)	84.4%	Below Average
RightCare (SWHP)	98.4%	Above Average
Superior	88.9%	Below Average
Texas Children's Health Plan (TCHP)	99.2%	Above Average
UnitedHealthcare (UHC)	98.0%	Above Average
UnitedHealthcare Dental (UHCD)	98.8%	Above Average
MCO Average	**96.0%**	-

The EQRO evaluated the MCO/DMO QAPI program summary reports by section to identify areas of high performance and opportunities for both systematic and individual improvement. Table 19 shows the average QAPI program performance by activity. Performance on activities contributing to the final score ranged from 90.8 percent to 100 percent. The activity with the lowest performance was *Availability and Access to Care Monitoring and Results*. The low score for this activity was due to one MCO, PCHP, not reporting actions undertaken to improve performance for any of the seventeen indicators, nor any analysis of the effectiveness of actions taken. The activity with the next lowest score (91.7 percent) was *Corrective Action Plans*. This low score was due to one MCO, FirstCare, not providing all required information in *Appendix F: Texas Department of Insurance Audit Corrective Action Plans*. For the *Program Description* activity, the EQRO saw improvement Activity B1.5, which evaluates the establishment of goals that represent the MCOs' philosophy, purpose, or desired outcome. Only two MCOs received recommendations for improvement of goals. However, eight of the MCOs and DMOs failed to fully meet the criteria to develop specific, action-oriented objective statements written in measurable and observable terms. Twelve MCOs and DMOs had opportunities for improvement in describing how they are accomplishing goals and objectives. Indicator monitoring, evaluated in activities B5, B6a, and B6b, offers additional opportunities for improvement. Three-quarters of the MCOs and DMOs scored "partially met" for at least one component of these activities, primarily due to incomplete or inaccurate documentation of results or percent change analyses of results.

Table 20. 2022 Average MCO/DMO QAPI scores by activity

Activity	Score
Required Documentation Overall	100%
A1: Role of Governing Body	100%
A2: Structure of Quality Improvement Committee(s)	96.8%
A3: Adequate Resources	97.5%
A4: Improvement Opportunities	99.2%
B1: Program Description	94.1%
B2: Overall Effectiveness	97.5%
B3: Effectiveness of Long-Term Services and Supports (LTSS)	100%
B4: Clinical Practice Guidelines	97.1%
B5: Availability and Access to Care Monitoring and Results	90.8%
B6a: Clinical Indicator Monitoring	95.0%

Activity	Score
B6b: Service Indicator Monitoring	94.2%
B7: Credentialing and Re-credentialing	98.7%
B8: Delegation of QAPI Activities	97.4%
B9: Corrective Action Plans	91.7%
B10: Previous Year's Recommendations	85.3%

MMP QAPI Results

Table 20 shows the 2022 score for each Medicare-Medicaid Plan (MMP). The average score was 95.7 percent (SD = 3.6). The EQRO considered scores more than half a standard deviation below the mean (<93.9 percent) as "below average" and scores more than half a standard deviation above the mean (>97.5 percent) "above average."

The lowest score was for Molina (91.3 percent). This low score was primarily due to Molina failing to include a percent change analysis for the effectiveness of actions taken and not reporting future actions for several indicators reported in *Appendix B: Availability and Access to Care Monitoring and Results*. Three of the MMPs, Molina, Superior, and UHC, incompletely or incorrectly evaluated the effectiveness of actions to improve availability and accessibility of care monitoring and results.

Table 21. 2022 MMP QAPI scores

MMP	Score	Peer Comparison
Amerigroup	99.7%	Above Average
Cigna-HealthSpring (HealthSpring)	94.8%	Average
Molina	91.3%	Below Average
Superior	93.8%	Below Average
UnitedHealthcare (UHC)	99.2%	Above Average
MMP Average	**95.7%**	-

The EQRO evaluated the MMP QAPI program summary reports by section to identify areas of high performance and opportunities for both systematic and individual improvement. Table 21 shows the average MMP QAPI program performance by activity. Performance on activities contributing to the final score ranged from 90.0 to 100 percent. The activity with the lowest performance was *Overall Effectiveness*. The lower level of performance was largely due to HealthSpring reporting barriers encountered in the section where it should have reported the factors that contributed to the success of the QAPI. Two activities tied for the next lowest score (93.3 percent): *Availability and Access to Care Monitoring and Results* and *Clinical Indicator Monitoring*. HealthSpring, Molina, Superior, and UHC scored “partially met” for at least one component of these two activities, most often due to incorrect or incomplete evaluations of effectiveness of actions for these two activities.

Table 22. 2022 Average MMP QAPI scores by activity

Activity	Score
Required Documentation Overall	100%
A1: Role of Governing Body	100%
A2: Structure of Quality Improvement Committee(s)	100%
A3: Adequate Resources	95.0%
A4: Improvement Opportunities	100%
B1: Program Description	96.3%
B2: Overall Effectiveness	90.0%
B3: Effectiveness of Long-Term Services and Supports (LTSS)	100%
B4: Clinical Practice Guidelines	98.3%
B5: Availability and Access to Care Monitoring and Results	93.3%
B6a: Clinical Indicator Monitoring	93.3%
B6b: Service Indicator Monitoring	95.0%
B7: Credentialing and Re-credentialing	100%
B8: Delegation of QAPI Activities	100%
B9: Corrective Action Plans	-
B10: Previous Year's Recommendations	90.0%

Texas EQRO Report Compliance Review Results

This section provides compiled compliance review results organized by regulatory standards.

In conjunction with the AI activities, the EQRO assessed agreement of both the Texas Uniform Managed Care Contract (UMCC) and program specific contracts with federal regulations. For each regulation, the EQRO scored contracts using the same compliance scoring levels applied in the MCO/DMO AI ("met," with a corresponding score of 100, "partially met," with a corresponding score of 50, and "not met," with a corresponding score of zero). On the following pages, Table 22 shows Texas compliance (for the UMCC) with 42 C.F.R. § 438 Subpart D (2020) by program. All contracts fully met all 52 federal regulations reviewed.

For the MCO/DMO AI reviews, Table 23 shows MCO scores for compliance with 42 C.F.R. § 438 Subpart D (2020) QAPI standards for MCOs that underwent a compliance review in the SFY 2022 AI evaluation year, by regulation. The compliance review results for MCOs/DMO reported on in the SFY 2021 evaluation year lacked available information for several categories (438.207, 438.224, and 438.330) at the time of the SFY 2021 report. Table 24 shows the updated reporting for SFY 2021. The regulations in category 438.230 refer to contracting requirements reviewed in the EQRO assessment of the UMCC compliance. All contracts met these requirements but this category does not contribute to the MCO scores (marked with pass/fail only).

Table 23. SFY2022 Review scores for compliance of Texas UMCC and program contracts with regulations in 42 C.F.R. § 438 Subpart D by program

Program	438.206	438.207	438.208	438.210	438.228	438.230	438.236	438.242	438.330	Overall[1]
STAR	100	100	100	100	100	100	100	100	100	100
STAR+PLUS	100	100	100	100	100	100	100	100	100	100
STAR Kids	100	100	100	100	100	100	100	100	100	100
STAR Health	100	100	100	100	100	100	100	100	100	100
CHIP	100	100	100	100	100	100	100	100	100	100

[1] Overall score is the average across all 52 federal regulations reviewed. Regulations 438.214 and 438.224 do not apply to the UMCC.

Table 24. SFY2022 AI and QAPI review scores for compliance with regulations in 42 C.F.R. § 438 Subpart D by MCO and program

MCO and Program	438.206	438.207[1]	438.208[1]	438.210[1]	438.214	438.224	438.228	438.230[1]	438.236	438.242[1,2]	438.330[1,2]	Overall[1,2]
Amerigroup Overall	100	100	100	100	100	100	100	pass	100	100	98.9	99.9
Amerigroup STAR	100	100	100	100	100	100	100	pass	100	100	98.6	99.9
Amerigroup STAR+PLUS	100	100	100	100	100	100	100	pass	100	100	99.1	99.9
Amerigroup STAR Kids	100	100	100	100	100	100	100	pass	100	100	99.1	99.9
Amerigroup CHIP	100	100	100	100	100	100	100	pass	100	100	98.6	99.9
Molina Overall	100	100	100	96.2	100	100	96.1	pass	100	91.7	95.1	97.9
Molina STAR	100	100	100	100	100	100	96.1	pass	100	91.7	94.5	98.2
Molina STAR+PLUS	100	100	100	100	100	100	96.1	pass	100	91.7	96.3	98.4
Molina CHIP	100	100	100	84.6	100	100	96.1	pass	100	91.7	94.5	96.7
Superior Overall	100	100	100	92.3	100	100	98.1	pass	83.3	94.4	94.0	96.2
Superior STAR	100	100	100	92.3	100	100	98.1	pass	83.3	94.4	93.1	96.1
Superior STAR+PLUS	100	100	100	92.3	100	100	98.1	pass	83.3	94.4	95.4	96.3
Superior STAR Kids	100	100	100	92.3	100	100	98.1	pass	83.3	94.4	95.4	96.3
Superior STAR Health	100	100	100	92.3	100	100	98.1	pass	83.3	94.4	93.1	96.1
Superior CHIP	100	100	100	92.3	100	100	98.1	pass	83.3	94.4	93.1	96.1

MCO and Program	438.206	438.207[1]	438.208[1]	438.210[1]	438.214	438.224	438.228	438.230[1]	438.236	438.242[1,2]	438.330[1,2]	Overall[1,2]
UHC Overall	100	100	100	100	100	100	94.0	pass	100	97.2	98.9	99.0
UHC STAR	100	100	100	100	100	100	94.0	pass	100	97.2	98.6	99.0
UHC STAR+PLUS	100	100	100	100	100	100	94.0	pass	100	97.2	99.1	99.0
UHC STAR Kids	100	100	100	100	100	100	94.0	pass	100	97.2	99.1	99.0
UHC CHIP	100	100	100	100	100	100	94.0	pass	100	97.2	98.6	99.0

[1] This category (marked pass/fail) does not contribute to the MCO overall compliance score. Pass indicates that the contract met compliance requirement (as reflected in Table 22).

[2] The EQRO assesses MCO compliance with select regulations through the work done for the PIP evaluations, data certification, and encounter data validation. The EQRO has reported the results of these regulations under protocols 1, 2, or 5 of this report.

Table 25. SFY2021 AI and QAPI review scores for compliance with regulations in 42 C.F.R. § 438 Subpart D by MCO and program (updated to include regulations in 438.207, 438.224, and 438.330

MCO and Program	438.206	438.207[1]	438.208[1]	438.210[1]	438.214	438.224	438.228	438.230[1]	438.236	438.242[1,2,3]	438.330[1,2]	Overall[1,2,3]
Aetna Overall	100	100	100	92.3	100	100	97.2	-	100	100	100	99.0
Aetna STAR	100	100	100	92.3	100	100	97.0	-	100	100	100	98.9
Aetna STAR Kids	100	100	100	92.3	100	100	97.0	-	100	100	100	98.9
Aetna CHIP	100	100	100	92.3	100	100	98.7	-	100	100	100	99.1
CFHP Overall	100	100	100	98.7	100	100	99.2	-	91.7	100	98.7	98.8
CFHP STAR	100	100	100	100	100	100	100	-	91.7	100	99.3	99.1
CFHP STAR Kids	100	100	100	100	100	100	100	-	91.7	100	97.5	98.9
CFHP CHIP	100	100	100	96.2	100	100	96.8	-	91.7	100	99.3	98.4
CookCHP Overall	100	100	92.9	76.9	100	100	92.3	-	100	100	100	96.2
CookCHP STAR	100	100	92.9	76.9	100	100	95.5	-	100	100	100	96.5
CookCHP STAR Kids	100	100	92.9	76.9	100	100	95.5	-	100	100	100	96.5
CookCHP CHIP	100	100	92.9	76.9	100	100	80.7	-	100	100	100	95.1
ElPasoHealth Overall	100	100	100	97.9	100	100	93.2	-	100	100	100	99.1

MCO and Program	438.206	438.207[1]	438.208[1]	438.210[1]	438.214	438.224	438.228	438.230[1]	438.236	438.242[1,2,3]	438.330[1,2]	Overall[1,2,3]
ElPasoHealth STAR	100	100	100	100	100	100	98.3	-	100	100	100	99.8
ElPasoHealth CHIP	100	100	100	95.8	100	100	84.6	-	100	100	100	98.0
FirstCare Overall	100	100	100	91.7	100	100	90.6	-	100	100	95.2	97.8
FirstCare STAR	100	100	100	91.7	100	100	93.3	-	100	100	95.2	98.0
FirstCare CHIP	100	100	100	91.7	100	100	88.1	-	100	100	95.2	97.5
DentaQuest Overall				100	100	100	100	-	91.7	100	100	98.9
DentaQuest Medicaid Dental	100	100	100	100	100	100	97.2	-	91.7	100	100	98.9
DentaQuest CHIP Dental	100	100	100	100	100	100	96.2	-	91.7	100	100	98.8
UHCD Overall	100	100	100	95.5	90	100	99.0	-	83.3	100	100	96.8
UHCD Medicaid Dental	100	100	100	95.5	90	100	99.0	-	83.3	100	100	96.8
UHC Dental CHIP Dental	100	100	100	95.5	90	100	98.7	-	83.3	100	100	96.8

[1] The reported scores do not include the regulations that address state contract requirements. The EQRO did not conduct a review of the state contract for SFY2021, however, Table 22 includes state contract compliance with the applicable regulations as of SFY2022

[2] The EQRO assesses MCO compliance with select regulations through the work done for the PIP evaluations, data certification, and encounter data validation. The EQRO has reported the results of these regulations under protocols 1, 2, or 5 of this report.

[3] Two regulations with implementation of January 1, 2021 (part way through the SFY) were not included in the reported scores.

Relevance for Assessing Quality, Access & Timeliness

The quality improvement program implemented by MCOs, DMOs, and MMPs includes indicators which the organization uses to evaluate accessibility, availability, and quality of the healthcare services provided to members. Through QAPI program summary reports, the MCOs, DMOs, and MMPs report indicator results and analyses of these results, which the EQRO uses to identify areas where the quality improvement program needs revision to enhance overall effectiveness of the program. However, inaccurate information provided by the MCOs, DMOs, and MMPs hinders the EQRO in accurately assessing quality, access, and timeliness of care. To effectively use the indicators to monitor access to care and improvements in quality of care, MCOs, DMOs, and MMPs must ensure that their reports include complete and accurate information.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 26. Protocol 3 AI findings and recommendations

Category	Description
Finding(s)	Several MCOs reported challenges obtaining and incorporating provider URL information into provider directories.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs, including Molina, Superior, and UHC, should establish systems to incorporate complete provider website URL information in their provider directories.
Finding(s)	Several MCOs did not have compliant procedures for the associated timeframes and notification protocols for standard and expedited service authorization decisions, including extension protocols.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs, including Molina and Superior, should ensure their representatives make standard and expedited service authorization decisions and notifications within the federally required timeframes.
Finding(s)	Several MCOs reported state-compliant CHIP grievance system protocols; however, these system protocols were not compliant with updated federal guidelines.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs with a CHIP product line need to evaluate their procedures to ensure that CHIP grievance system protocols align with Medicaid grievance system protocols, excluding the Medicaid requirement of continuation of benefits pending the appeal, a state fair hearing, or both.
Finding(s)	Some MCOs reported data collection on member SDoH needs. However, many MCOs and DMOs had not implemented procedures to aggregate collected information on SDoH needs.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	MCOs and DMOs need to systemically collect data on the SDoH or NMDOH needs of members to aggregate needs by populations to impact member health and well-being effectively.

Category	Description
Finding(s)	While some MCOs had implemented specific SDoH-related interventions, they failed to clearly measure the direct and indirect effects.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	MCOs should consider evaluating the impact of plan-driven SDoH- or NMDOH-related interventions and referrals to community resources on the health and well-being of members.
Finding(s)	MCOs reported several multi-agency collaborations to address SDoH needs in members.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should encourage MCOs to share SDoH- and NMDOH-related interventions and best practices with other entities, including HHSC, to further address unmet needs that may impact the health of Texans enrolled in Medicaid and CHIP programs.
Finding(s)	MCOs reported successful transition by their providers to medical and behavioral health telehealth in response to the public health emergency. Many MCOs discussed the importance of provider communication and education to ensure that providers adopted correct billing codes and modifiers to facilitate payment for telehealth services.
MCQS Goal(s)	Goals 1, 3, 6
Recommendation(s)	MCOs should continue exploring the efficiency of utilizing medical and behavioral health telehealth services and their impact on health outcomes.
Finding(s)	MCOs reported that many health services have transitioned back to in-person settings while many behavioral health services continue via telehealth modalities.
MCQS Goal(s)	Goals 1, 6
Recommendation(s)	MCOs should continue exploring the efficacy of utilizing behavioral health telehealth services and their impact on the health outcomes of Texans enrolled in Medicaid and CHIP programs.

Table 27. Protocol 3 QAPI findings and recommendations

Category	Description
Finding(s)	Many MCOs lost points due to QAPI program objectives that were not specific, action-oriented statements written in measurable and observable terms that define how goals would be met. For example, one program objective was: "develop and/or enhance relationships with a community organization." This objective is not specific or written in measurable terms.
MCQS Goal(s)	Goals 1, 4
Recommendation(s)	The EQRO recommends that MCOs develop objectives which are specific, action-oriented, measurable, and observable. This recommendation applies to Aetna, CookCHP, DCHP, Driscoll, ElPasoHealth, FirstCare, PCHP, SWHP, and UHC Dental.

Category	Description
Finding(s)	Many MCOs and MMPs reported results and data for MY 2020 instead of MY 2021 (the measurement year for the QAPI) in multiple areas of the QAPI report.
MCQS Goal(s)	Goals 1, 4
Recommendation(s)	The EQRO recommends that Aetna, Amerigroup, BCBSTX, CFHP, CHCT, DCHP, Driscoll, FirstCare, Superior, and SWHP utilize data from the measurement year for the QAPI to report results on performance.
Finding(s)	Many MCOs, MMPs, and DMOs lost points in all three indicator monitoring sections (availability and accessibility, service, and clinical) for the effectiveness of actions section. The three main opportunities for improvement were: MCOs/MMPs 1) did not include a percent change analysis for all indicators, 2) reported incorrect metrics for an indicator (i.e., the unit of analysis was not consistent for all rates reported), and 3) did not accurately interpret the effectiveness of actions.
MCQS Goal(s)	Goals 1, 4
Recommendation(s)	The EQRO recommends that Aetna, Amerigroup, BCBSTX, CFHP, CHCT, CookCHP, DentaQuest, DCHP, ElPasoHealth, FirstCare, Molina, PCHP, Superior, and UHC include a percent change analysis for all indicator monitoring and ensure they correctly interpretation of results and use consistent units of analysis for each indicator.

Protocol 4: Validation of Network Adequacy

Protocol Overview & Objectives

A key component of network adequacy is accessibility, or a health plan's ability to provide enrollees with timely access to providers, including primary care and specialty physicians. MCOs can influence accessibility by adjusting the size and quality of their network. CMS requires all states that contract with an MCO or DMO to deliver Medicaid services must develop and enforce network adequacy standards consistent with 42 C.F.R. § 438.68, (2020).

Per 42 C.F.R. § 438.358 (b)(1)(iv)(2020), the mandatory EQR activities must include validation of MCO network adequacy during the preceding 12 months to comply with requirements outlined in § 438.68 (2020) and, if the State enrolls Indigenous people in the MCO, in § 438.14(b)(1)(2020). As of December 2022, CMS has not released the network adequacy protocol details. However, the EQRO conducts several activities that assess network adequacy for Texas Medicaid and CHIP members. Table 27 summarizes the EQRO activities associated with network adequacy during the reporting period.

Table 28. EQRO network adequacy activities for SFY 2022

Activity	Description
MCO Administrative Interviews	Assess MCO compliance with access and timeliness as part of the MCO compliance assessment process. Protocol 3: Review of Compliance with Medicaid & CHIP Managed Care Regulations, includes additional information on this process and the results.
Appointment Availability Study	This mystery shopper study assesses MCO compliance with appointment wait time standards for four types of care: vision care, prenatal care, behavioral health care, and primary care.

EQR Activities

Administrative Compliance with Access and Timeliness

Protocol 3: Review of Compliance with Medicaid & CHIP Managed Care Regulations, addresses availability of services, adequate capacity, coverage of authorized services, and provider selection through the AI (member services, provider network, and authorization sections) and the QAPI evaluations.

Appointment Availability Study

Tex. S.B. 760, 84th Leg., R.S. (2015), directed HHSC to establish and implement a process for direct monitoring of an MCO's provider network, including the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider.

Methods and Analysis

To fulfill this direction, Section 8.1.3 of the UMCC specifies that Texas Medicaid and CHIP MCOs must assure that all members have access to all covered services on a timely basis, consistent with medically appropriate guidelines and accepted practice parameters (HHSC, 2022b). Table 28 outlines the guidelines for timely access.

Table 29. Texas standards for Medicaid and CHIP appointment availability

Level/Type of Care	Appointment Requirements
Urgent care (child and adult)	Within 24 hours
Routine primary care (child and adult)	Within 14 calendar days
Preventive health services for new child members	No later than 90 calendar days after enrollment
Preventive health services for adults	Within 90 calendar days
Initial outpatient behavioral health visits (child and adult)	Within 14 calendar days
Prenatal care (not high-risk)	Within 14 calendar days
Prenatal care (high-risk)	Within 5 calendar days
Prenatal care (new member in 3rd trimester)	Within 5 calendar days
Vision care (ophthalmology, therapeutic optometry)	Access without PCP referral

The EQRO conducts the appointment availability study annually to help HHSC assess network adequacy compliance with Medicaid managed care regulations. The EQRO uses a mystery shopper approach to assess the availability of appointments. For each sub-study, the EQRO selects the provider sample from directories provided by each MCO four weeks before calls start. Callers pose as members enrolled in STAR+PLUS and STAR and caregivers looking for a provider for their child enrolled in STAR, STAR Health, STAR Kids, or CHIP. Following written call scripts tailored to each program and sub-study, callers attempt to request an initial outpatient appointment, then record the call disposition and wait time results for the first appointment date they receive for any provider with an available appointment. The EQRO developed telephone scripts and tools for the study in conjunction with HHSC, and callers enter all data into a database using a secured REDCap application. HHSC reviews and approves all tools before the beginning of data collection. The research team completed the SFY 2022 Prenatal sub-study calls between October and November 2021, Vision Care sub-study calls between November 2021 and January 2022, Primary Care sub-study calls between February and April 2022, and Behavioral Health Care sub-study calls between May and August 2022.

The call disposition codes include:

Appointments Available Denominator for Wait-Time compliance rates

13: "Appointment Available"

14: "Appointment Available with a Different Provider"

Additional Calls Eligible for Vision Care Compliance Denominator

8: "Needs Additional Information"

11: "Needs Referral"

Other Confirmed Provider Calls

5: "Does not Accept Medicaid/CHIP"

6: "Not Accepting the Plan"

7: "Not Accepting New Patients"

Exclusions (replaced in sample)

3: "No Contact After Three Attempts"

4: "Wrong Number/Unreachable

Ineligible Provider Types (replaced in sample)

9: "Specialist/Wrong Provider Type"

10: "Does Not Accept Adult/Child"

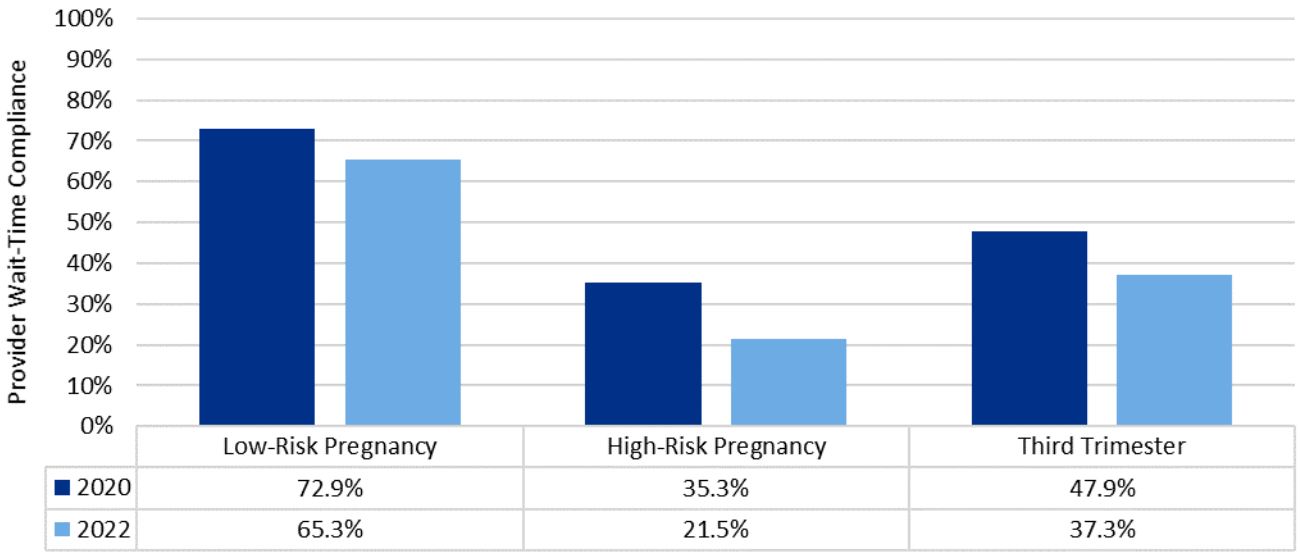
12: "Does Not Perform Exam"

The EQRO calculated the rate of compliance with wait time standards as the percentage of calls with an appointment available within the established wait standard among the calls with an appointment available (dispositions 13 and 14). The EQRO calculated descriptive statistics on compliance rates as specified in the Texas UMCC. These statistics included the minimum, median, and maximum days for an appointment and information on office characteristics, such as weekend appointment availability and telehealth options.

Results

Compliance with low-risk, high-risk, and 3rd-trimester prenatal appointment wait-time standards all decreased in SFY 2022 compared to SFY 2020 (Figure 4). High-risk prenatal care compliance decreased by 13.8 percentage points and appointments available for 3rd-trimester dropped by 12.6 percentage points in SFY 2022 compared to SFY 2020.

Figure 4. Compliance with prenatal appointment wait-time standards by year



In SFY 2022, compliance with vision health appointment standards increased in STAR, CHIP, STAR+PLUS, and STAR Kids, compared to SFY 2020 (Table 29). STAR Health had 100 percent compliance in 2020, but had the lowest percentage of compliant providers for vision healthcare wait-times among all programs in 2022. Amerigroup had the lowest rate of compliance with vision wait time standards in the STAR program and CHIP, and one of the lowest rates of overall appointment availability in STAR Kids.

Table 30. Compliance with vision health appointment wait-time standards by program and year

Year	STAR Adult	STAR Child	STAR+PLUS	STAR Kids	STAR Health	CHIP
2021	95.7%	94.5%	93.0%	93.2%	100.0%	96.9%
2022	99.0%	98.9%	99.4%	100.0%	97.6%	99.1%
Change	+3.3%	+4.4%	+6.4%	+6.8%	-2.4%	+2.2%

In SFY 2022, the percentages of providers compliant with standards for both preventive (Table 30) and routine primary care (Table 31) decreased compared to SFY 2021 in STAR, STAR+PLUS and STAR Kids. In STAR Health, although the rate of routine primary care wait-time compliance decreased slightly, the overall availability of

appointments increased. CHIP had the only increase for routine primary care wait time. One MCO, CookCHP, had the lowest rate of compliance with preventive care wait time standards in both the STAR program and CHIP, and one of the lowest rates of overall appointment availability in STAR Kids.

Table 31. Compliance with preventive care appointment wait-time standards by program and year

Year	STAR Adult	STAR Child	STAR+PLUS	STAR Kids	STAR Health	CHIP
2021	100.0%	99.9%	100.0%	100.0%	100.0%	99.9%
2022	99.0%	99.6%	98.7%	99.3%	100.0%	99.9%
Change	-1.0%	-0.3%	-1.3%	-0.7%	0.0%	0.0%

Table 32. Compliance with routine primary care appointment wait-time standards by program and year

Year	STAR Adult	STAR Child	STAR+PLUS	STAR Kids	STAR Health	CHIP
2021	97.9%	97.40%	97.9%	95.9%	100.0%	95.90%
2022	96.4%	96.80%	97.7%	92.4%	92.5%	97.60%
Change	-1.5%	-0.6%	-0.2%	-3.5%	-7.5%	1.7%

In SFY 2022, compliance with behavioral health appointment wait time standards decreased compared to 2021 in all programs except STAR Kids, where the rate was lowest in 2020 (Table 32). In 2022, the lowest rate and the biggest drop in compliance was in STAR Health where compliance was 100 percent in 2021 and only 70 percent in 2022, noting that the denominators were only 24 and 10 in 2021 and 2022, respectively. Amerigroup had the highest percentage of excluded providers in STAR, STAR+PLUS, STAR Kids, and CHIP.

Table 33. Compliance with behavioral health care appointment wait-time standards by program and year

Year	STAR Adult	STAR Child	STAR+PLUS	STAR Kids	STAR Health	CHIP
2021	87.2%	87.2%	87.5%	75.4%	100.0%	88.1%
2022	81.9%	83.7%	81.5%	79.5%	70.0%	78.0%
Change	-5.3%	-3.5%	-6.0%	4.1%	-30.0%	-10.1%

Relevance for Assessing, Quality, Access & Timeliness

The appointment availability study under Protocol 4 is directly relevant to understanding the timeliness of care (based on the number of appointments that meet wait time standards). The results of the Appointment Availability studies indicate a decrease in compliance with appointment wait times, indicating that members may be getting less timely access to care.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 34 lists the key findings and recommendations from EQR activity for Protocol 4 and its relevance to the MCQS.

Table 34. Key findings and recommendations from the SFY 2021 Appointment Availability sub-studies

Category	Description
Finding(s):	The percentage of providers compliant with UMCC standards for high-risk pregnancy was 13.8 percentage points lower, and for low-risk pregnancy was 7.6 percentage points lower in SFY 2022 compared to SFY 2020. For the third trimester, the compliance was 10.6 percentage points lower compared to SFY 2020.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should consult with MCOs and conduct root cause analyses (RCAs) to identify the driving factors behind lower rates of provider compliance among prenatal health providers and use the results to identify strategies for improving provider compliance. The EQRO recommends that HHSC conduct an in-depth study on appointment wait times to: (1) better understand the challenges that MCOs encounter when trying to increase the percentage of providers that are compliant with appointment standards and (2) more effectively target MCO incentives to increase the percentage of providers that meet appointment availability standards.
Finding(s):	In SFY 2022, none of the providers for Aetna, CookCHP, Molina, SWHP, and UHC complied with wait time standards for prenatal care in the third trimester. SWHP providers had zero percent compliance with high-risk pregnancy appointment standards.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should strongly encourage Aetna, CookCHP, Molina, SWHP, and UHC to conduct RCAs to identify the drivers for non-compliance with appointment standards. Aetna, CookCHP, Molina, SWHP, and UHC should use the RCA to identify specific approaches that they can use to encourage providers to make appointments available within five calendar days.
Finding(s):	In SFY 2022, the percentage of excluded providers increased, and the total appointments available decreased in all prenatal sub-studies compared with SFY 2020.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should consult with MCOs to better understand the key factors contributing to errors in the provider taxonomy for prenatal directories and why many providers in the prenatal sample did not offer prenatal appointments. HHSC should encourage the MCOs to carefully examine the member-facing directory information they provided for the appointment availability study, especially Amerigroup, Molina, and Aetna, which had the highest percentage of excluded providers in the prenatal sub-studies. Updated provider directories with accurate provider contact information will help reduce the overall number of calls needed for each MCO and help increase the size of the sample for assessing compliance with call wait times.
Finding(s):	The EQRO excluded more providers from the behavioral health sub-study in SFY 2022 compared to SFY 2021 because of incorrect taxonomies or other directory information.
MCQS Goal(s)	Goal 4
Recommendation(s)	The EQRO recommends that HHSC continue to work with MCOs and TMHP to improve provider directory information quality.

Category	Description
Finding(s):	In SFY 2022, the median number of days to wait for a high-risk appointment was nine days, and the third trimester was seven days, both higher than the UMCC standard of five days.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	The EQRO recommends that HHSC work with providers to understand what factors contribute to longer wait times for appointments and develop a strategy for decreasing the wait time for High-risk and Third Trimester appointments. BCBSTX, DCHP, Molina, PCHP, and ElPasoHealth should work with their providers to understand what factors contribute to longer wait times for prenatal appointments and develop a strategy for decreasing the wait time for prenatal appointments.
Finding(s):	In SFY 2022, compliance with vision health appointment standards decreased in STAR Health compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	The EQRO recommends that HHSC conduct an in-depth study on appointment wait times to: (1) better understand the challenges that MCOs encounter when trying to increase the percentage of providers that are compliant with appointment standards and (2) more effectively target Amerigroup and Superior health incentives to increase the percentage of providers that meet appointment availability standards. HHSC should work with Amerigroup and Superior to identify factors contributing to non-compliance with wait time standards.
Finding(s):	In SFY 2022, the percentage of contacted providers who did not accept Medicaid/CHIP increased in STAR, STAR+PLUS, STAR Kids, and CHIP compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should consult with Superior to better understand the key factors contributing to errors in the provider taxonomy for vision directories and why so many providers in the vision sample did not conduct regular vision exams. HHSC should consult with MCOs and providers to better understand the key factors limiting the number of providers participating in the Medicaid programs and work with MCOs to identify ways to overcome these challenges.
Finding(s):	Few providers offered telehealth appointments in SFY 2022.
MCQS Goal(s)	Goals 3, 4, 5
Recommendation(s)	HHSC should conduct an environmental scan of the literature on the effectiveness of virtual appointments for vision care and the strategies other state Medicaid programs are using to increase availability of telehealth for vision care and use this information to inform strategies for improving access to and the availability of vision appointments among Texas Medicaid members.

Category	Description
Finding(s):	In SFY 2022 compliance with preventive and routine primary care appointment wait-time standards dropped in STAR, STAR+PLUS and STAR Kids compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should strongly encourage Aetna and CookCHP to conduct RCA analyses to identify the drivers for low compliance with appointment standards. Aetna and CookCHP should use the RCAs to identify specific approaches that they can use to encourage providers to make appointments available within 90 working days. HHSC should work with CookCHP to identify the factors contributing to non-compliance with wait time standards for preventative care appointments especially because this MCO has the lowest rate of compliance with preventive wait time standards in the STAR program and CHIP, and one of the lowest percentages of available appointments in STAR Kids. HHSC should work with Aetna to identify the factors contributing to non-compliance with wait time standards for routine care, especially because this MCO has the lowest rate of compliance with routine wait time standards in the STAR Kids program and CHIP, and one of the lowest compliance rates in STAR.
Finding(s):	In SFY 2022, the percentage of contacted providers who did not accept Medicaid increased in STAR, STAR Health, and STAR Kids compared to SFY 2021.
MCQS Goal(s)	Goals 3, 4, 5
Recommendation(s)	HHSC should consult with CookCHP to better understand the key factors that contribute to errors in the provider taxonomy for PCP directories and why so many of the providers in the PCP sample did not accept Medicaid. HHSC should consult with MCOs and providers to better understand the key factors limiting the number of providers participating in the Medicaid programs and work with MCOs to identify ways to overcome these challenges.
Finding(s):	The percentage of providers who offered weekend appointments decreased in STAR and STAR Health in SFY 2022 compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should work with Superior to increase weekend appointments for primary care. This would improve access to and the availability of primary care appointments for Texans in the STAR Health program.
Finding(s):	In SFY 2022, compliance with behavioral health care appointment wait time standards decreased in STAR, STAR+PLUS, STAR Health, and CHIP compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should conduct RCAs to identify the driving factors behind lower rates of provider compliance among behavioral health care health providers and use the results to identify strategies for improving provider compliance. HHSC should more effectively target MCO incentives to increase the percentage of providers that meet appointment availability standards. HHSC should work with Superior to identify the factors contributing to non-compliance with wait time standards for behavioral health care.

Category	Description
Finding(s):	Providers that accepted Medicaid in STAR, STAR Kids, STAR Health, and STAR+PLUS decreased in SFY 2022 compared with SFY 2021.
MCQS Goal(s)	Goals 3, 4, 5
Recommendation(s)	HHSC should consult with MCOs and providers to better understand the key factors limiting the number of providers participating in the Medicaid programs and work with MCOs to identify ways to overcome these challenges.
Finding(s):	In the SFY 2022 behavioral health care sub-study, the percentage of excluded providers increased in CHIP, STAR Health, and STAR+PLUS.
MCQS Goal(s)	Goals 3, 5, 6
Recommendation(s)	HHSC should encourage the MCOs to carefully examine the member-facing directory information they provided for the appointment availability study, especially Amerigroup, which had the highest percentage of excluded providers in STAR, STAR+PLUS, STAR Kids, and CHIP. Updated provider directories with accurate provider contact information will help reduce the overall number of calls needed for each MCO and help increase the size of the sample for assessing compliance with call wait times.
Finding(s):	The percentage of providers that offered telehealth services or weekend behavioral health appointments decreased across all the programs in SFY 2022 compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5, 6
Recommendation(s)	HHSC should work with MCOs to increase weekend appointments and telehealth services for behavioral health care. Increasing alternatives for behavioral health care appointments will improve access to and availability of behavioral health care.

Protocol 5: Validation of Encounter Data Reported by MCOs and DMOs

Protocol Overview & Objectives

Protocol 5 provides guidance to EQROs on validating the accuracy and completeness of encounter data submitted by MCOs and DMOs. Texas Medicaid and CHIP MCOs and DMOs submit encounter data to Texas Medicaid and Healthcare Partnership (TMHP), the contract administrators for Texas Medicaid and CHIP. Encounter data should include most of the same information found on the original claims. Texas uses these data to determine capitation payment rates, assess and improve quality, and monitor program integrity (CMS, 2019). Texas can require corrective action plans for the MCOs or DMOs not meeting minimum standards for complete and accurate data. The five activities included in this optional CMS EQR protocol include:

1. A review of Texas requirements for encounter data submissions
2. A review of MCO encounter data production capacity
3. An analysis of encounter data for accuracy and completeness
4. A review of medical/dental records for consistency with encounter data
5. Submission of findings (completed for each step)

EQR Activities

Evaluation of Encounter Data Submissions & MCO Encounter Data Production Capacity

Methods

The EQRO conducts an ongoing review of the encounter data submission system. The joint interface plan (JIP) between TMHP and the MCO/DMOs includes encounter data submission requirements and processing documentation. Before implementing changes, HHSC and TMHP consult with the EQRO to evaluate how changes might affect encounter data quality and usability. The EQRO also participates in monthly information calls with representatives from HHSC, the contract data brokers and administrators, and the MCO/DMOs to discuss data exchange issues. The EQRO reviews the entire JIP annually. The EQRO also evaluates provider data in the TMHP system.

As part of EQR Protocol 3: Review of Compliance with Medicaid & CHIP Managed Care Regulations activities, the EQRO conducts AI evaluations, including two major sections that address MCO encounter data production. Section nine of the AI tool addresses MCO information systems, and section 10 addresses MCO data acquisition. The EQRO describes these AI findings and other evaluations of MCO information systems and processes as they relate to the validation of performance measures under Protocol 2: Validation of Performance Measures.

Analysis of Encounter Data for Accuracy & Completeness

The EQRO works with HHSC to ensure Texas meets current data quality assessment criteria standards and is prepared for the future by setting high data quality assessment goals. High quality, complete encounter data are vital to calculating accurate HEDIS, Agency for Healthcare Research and Quality (AHRQ) Quality Indicators, 3M™ Potentially Preventable Events (PPEs), and other QoC measures. Inaccurately coded data or data missing key elements may lead to biased or incalculable measures. MCOs or DMOs with data deficiencies are also difficult to include in quality incentive programs.

The EQRO developed procedures for annually certifying the quality of Texas Medicaid and CHIP encounter data by following guidance in EQR Protocol 5 (CMS, 2019), the EQR Toolkit (CMS, 2012c), the CMS Encounter Data

Toolkit (Byrd et al., 2013), and Texas Government Code § 533.0131 (2001). The EQRO certifies data for each program by MCO or DMO and SA (i.e., by plan code).

Each month, TMHP provides six types of data to the EQRO:

1. Medical and dental encounter data
2. State paid claims (processed by TMHP)
3. Pharmacy encounter and claims data (processed by TMHP-Pharmacy)
4. Provider data
5. Member enrollment data
6. Non-emergency medical transportation data (began in SFY 2023 – not certified in SFY2022 activities)

To allow for full adjudication and processing of all claims for services during the certification period (SFY 2021), the EQRO uses data received for a minimum of four months beyond the end of the certification period. The EQRO used information received through December 2021 for the certification of SFY 2021 data.

The EQRO provided three types of analysis for certifying the data:

1. Volume analysis quantifying the number of paid, denied, and voided claims by MCO or DMO, month, and service category.
2. Data validity and completeness analysis identifying the percentage of missing and invalid data values from key header and detail encounter fields.
3. A comparison of payment dollars documented in the encounter data with payment dollars reported in the MCO self-reported Financial Statistical Report (FSR).

Volume Analysis Based on Service Category

The EQRO evaluated the volume and distribution of claims for unexpected or unexplained changes and consistency across programs, months, and MCOs/DMOs. Changes in claim volume and distribution can result from normal alterations in business practices and are not necessarily cause for concern. For example, CHIP encounter volume generally declined of the certification period, which is consistent with decreasing enrollment.

In STAR, monthly volume generally increased over the certification period, although a noticeable dip in volume in February 2021 preceded an increased volume in March 2021 across MCOs. The distribution of institutional and professional encounters was consistent with prior years, with higher percentages of institutional encounters seen in the Medicaid Rural Service Areas (MRSAs), possibly due to higher use of Federally Qualified Health Centers (FQHC) and rural health clinics. As in STAR, the MRSA had greater proportion of institutional encounters compared to professional encounters in STAR+PLUS. These variations suggest underlying differences in the care delivery model that could affect QoC measures. In STAR+PLUS, encounter volume was noticeably higher in the first three months of SFY2021 and generally stable otherwise and STAR Kids encounter volume was noticeably higher in March 2021. STAR Health encounters show a noticeable decline in February 2021, followed by increased volume in March 2021. Changes related to the COVID-19 pandemic make it more challenging to identify other issues during SFY 2021, although it is likely that the consistent dip in February 2021 volume is related. Large single-month changes can also indicate a processing issue. When MCOs experience a processing issue and do not provide HHSC or the EQRO with accurate data or information explaining the issue, it can affect the use of the data for QoC measures.

In STAR, professional encounters had much higher percentage denied or void than institutional encounters, and percentage of unpaid encounters varied by MCO. For example, UHC-Nueces had almost half of professional encounters denied or void, while Molina, Superior and TCHP all had relatively low percentages of encounters unpaid. Across all STAR+PLUS MCOs and most STAR Kids MCOs, the percentages of unpaid encounters were less than 20 percent, although similarly to STAR, the percentage of unpaid professional encounters was higher than that of institutional encounters in both programs.

Data Validity and Completeness Analysis

The EQRO examined the encounters submitted by MCOs/DMOs for the presence and validity of critical data elements, including:

- Encounter records in which key fields were either missing or did not meet validity standards
- Present on admission (POA) indicators, used in calculating the 3M Potentially Preventable Complications (PPC) measure
- Provider information, including submitted NPI and taxonomy
- Dental-specific coding

Key Fields

The EQRO annually reexamines the fields it evaluates, and the standards used for measuring overall completeness and validity. Data quality has improved over time due to advances in the data management systems of the MCOs/DMOs and TMHP. Compliance with previous recommendations from the annual data certification process and prioritizing data quality also contribute to improvement. For SFY 2021 data, the EQRO included 17 encounter fields in the review of medical encounters and 10 pharmacy encounter fields. Appendix B provides the field lists and descriptions. The EQRO considered validity check rates below 95 percent to be areas of concern and highlighted rates below 99 percent to bring them to the attention of the MCOs and HHSC. All MCOs passed these key field reviews, but the EQRO highlighted several deficiencies:

- In STAR, 1.6 percent of encounters for Driscoll in the Nueces SA had invalid/missing member ID; this is a slight improvement over the prior year rate (2.4 percent).
- In STAR+PLUS, 2 percent of inpatient encounters for Superior in the Lubbock SA were missing the admission date; this is the same as in the prior year.
- In CHIP, 3.5 percent of encounters for CFHP in the Bexar SA had invalid/missing member ID; this is a slight improvement over the prior year rate (4 percent).

An annual review of data is vital to ensuring that the data used in QoC assessment and rate-setting meets quality standards. For example, in past years, the EQRO identified data issues resulting from recent processing changes during this review and worked with HHSC and the MCOs to identify root causes and make corrections so that the final data passed certification testing.

POA Indicators

Valid coding of POA for reported diagnoses is critical to the EQRO's efforts to calculate the 3M PPC measure. When POA codes are missing or invalid, the calculation of PPC rates may misclassify or exclude them. The missing data limits the ability of the EQRO to provide HHSC with accurate and complete information about PPCs for Texas Medicaid and CHIP services. To determine valid coding of POA for reported diagnoses, the EQRO evaluated the distribution of valid POA codes (*Y*, *N*, *U*, or *W*) among reported non-exempt primary diagnoses

with POA codes on acute inpatient institutional encounter records and applied 3M recommended screening criteria to POA for secondary diagnoses. Appendix C provides a full description of these criteria.

Almost all primary diagnoses should be present on admission (POA code = '*Y*'). The EQRO found that POA distributions for primary diagnoses were within their accepted ranges for most MCO/SAs. However, POA was *not* present on admission (POA code = '*N*') more than 10 percent of the time in some STAR encounters (Table 34). One cause could be a high proportion of maternity stays. Hospitals will code significant delivery complications in the primary diagnosis, although the admission was for delivery. A high number of primary POA were clinically undetermined (POA code = 'W') for TCHP CHIP encounters in Harris.

Table 35. Primary diagnosis POA distribution outside accepted criteria

Program	MCO	SA	Criteria	Rate
STAR	Driscoll	Hidalgo	High (≥10%) Primary POA = *N*	10.1%
STAR	FirstCare	MRSA West	High (≥10%) Primary POA = *N*	10.5%
STAR	Molina	Hidalgo	High (≥10%) Primary POA = *N*	11.0%
STAR	Molina	Jefferson	High (≥10%) Primary POA = *N*	10.1%
STAR	UHC	Jefferson	High (≥10%) Primary POA = *N*	10.4%
CHIP	THCP	Harris	High (≥1%) Primary POA = *W*	1.7%

To avoid bias in PPC calculations and risk adjustment, 3M recommends screening POA distributions at the hospital level and excluding all data from hospitals that fail to pass the screening tests. Appendix C lists POA codes and the four hospital data screening criteria. The EQRO applied these screening criteria to POA codes for secondary diagnoses aggregated by MCO and SA in each program. The results showed that data for most MCO/SAs in STAR failed to meet the criteria. When the aggregated data fails these overall checks, hospitals in the MCO networks likely failed the screening, leading to the exclusion of all data from those hospitals from PPC calculations for both the MCO- and the hospital-level PPC reporting. To prevent data exclusions, the EQRO recommends that MCOs work with the hospitals in their networks that have failed POA data quality checks to improve submissions.

Provider Information

Adequate provider identification is critical to the EQRO's efforts to calculate HEDIS measures, conduct provider surveys, obtain medical records for validating encounter data, and calculate the hybrid HEDIS measures. When NPI and/or taxonomy codes are missing from the encounter data, or when the NPI and taxonomy code do not match an individual in the master provider data, this prevents the EQRO from providing HHSC with accurate and complete information about Texas Medicaid and CHIP services. The evaluation of provider data completeness included checking the fill rate in professional encounter detail items for rendering NPI and taxonomy. The EQRO also assessed whether the reported rendering NPI identified an individual based on the master provider data; if the rendering NPI did not identify an individual, the associated taxonomy may not reflect the actual qualifications of the service provider. Moreover, to highlight key areas where improvements in provider data completeness may have a direct positive impact on calculations of quality measures, the EQRO evaluated the completeness of provider data in a subset of procedures, including:

- All CPT codes except 7xxxx (Radiology) and 8xxxx (Pathology/Lab)

- HCPCS G-codes (professional procedures/services that would otherwise be coded in CPT but for which there are no CPT codes)
- HCPCS H-codes (rehabilitative services)
- HCPCS T-codes (Texas Medicaid agency codes) except T1019-T1022 (home health)

In STAR, individual NPI with taxonomy was present on 74.5 percent of selected procedures which is a slight improvement over the prior year (70.9 percent), but no MCO had a rate over 90 percent and the lowest rate (for PCHP) was only 33 percent. Rates were similar in CHIP. STAR+PLUS continues to have very low percentage of encounters with individual rendering NPI and taxonomy. Even considering only selected procedures, only 50.2 percent of encounters included the individual rendering NPI with taxonomy, which is less than in the prior year. STAR Kids has similar deficiencies, and only 33.9 percent of encounters for selected procedures included an individual rendering NPI with taxonomy, but this is an improvement over the prior year. Although the rate in STAR Health is still low at 62.7 percent, this is a substantial improvement over the prior year when the rate was 45.7 percent. The state has had several ongoing initiatives to try and improve the quality of provider data, both in encounters and in the master provider data, that seem to be bringing improvement in some cases, however the overall quality of provider data is still not meeting the desired standards.

Dental Data

As in the medical encounters, a noticeable overall drop in volume occurred in February 2021, followed by increased volume in March 2021. The new DMO, UHCD experienced some challenges in their first year and more than half their encounters had denied or void status, although the percentage of claims with paid status increased in the later months of the certification period. Almost all DMO encounters from MCNA and DentaQuest include an individual NPI as the rendering provider and include taxonomy about 98 percent of the time (an improvement from the prior year rate of about 90 percent). However, UHCD encounters had a rendering NPI only slightly over half the time.

Required tooth and tooth surface identification continue to be high for MCNA and DentaQuest, but are only on about 70 percent of UHCD encounters. Several dental QoC measures included in the Pay-for-Quality (P4Q) program require identifying members with elevated caries risk. Caries risk assessment (CRA) is a required part of a complete dental exam, and providers should code CRA on all dental exam encounters. The EQRO highlighted the need to improve the rate of CRA coding several years ago, and the measure improved slightly, but appropriate codes are still missing more than two percent of the time. The DMOs correctly deny these claims, but the data is still unrecoverable. For UHCD, CRA coding is missing over six percent of the time.

FSR Analysis

The EQRO compared payment dollars documented in the encounter data to payment dollars in the MCO/DMO self-reported FSR. According to the standard set by HHSC for SFY 2020, the encounter data and the FSR must agree within two percent for the EQRO to certify the MCO/DMO submitted data. All MCO/DMOs met this standard in all programs and SAs. When the EQRO finds discrepancies in the FSR, it discusses them first with HHSC and the MCO or DMO and then may investigate the data further; in the past, this has led to corrections and improved data quality. Over time, the agreement standard has increased due to the diligent work of all stakeholders to improve data processes.

Review of Medical & Dental Records for Consistency with Encounter Data

The EQRO annually validates encounter data for accuracy and completeness by comparing encounters against a representative dental or medical records sample. Through SFY 2022, the EQRO alternated sample types

annually, including either dental or medical records each year. The 2022 Encounter Data Validation: Medical Record Review (EDVMRR) sample included only Medicaid medical encounters.

EDVMRR Methods

The EDVMRR study examined medical encounters and records for members in Texas Medicaid managed care programs (STAR, STAR+PLUS, STAR Kids, and STAR Health). The EQRO validated the dates of service (DOS), place of service (POS) codes, primary diagnoses (PDx) and procedures (PX). Encounters were for services from January 1, 2020, through December 31, 2020, and the sample allowed at least six months claim lag for adjudication.

Sampling

During the sample period, the EQRO identified member-provider pairs with a paid (qualifying) encounter for a medical exam in an outpatient office or clinic visit. Eligible providers were those currently active with an MCO and having adequate contact information for record requests. The sample pool included no more than one randomly selected qualified member-provider pair for any member. The EQRO calculated the MCO sample size for each program (Table 35) using the lowest MCO match rate from the 2020 EDVMRR for DOS and accounted for the expected record return rate (76 percent based on the previous EDVMRR). The EQRO requested the member medical record for the entire study period (MY 2020) from the provider associated with the qualifying encounter for each of the selected member-provider pairs in the qualified sample pool.

Table 36. 2020 medical encounter data validation sample sizes by program

Program	Previous Low DOS Match Rate by MCO	Sample Size Required per MCO	Total Records Requested
STAR	85.3%	82	1,856
STAR+PLUS	76.8%	85	600
STAR Kids	86.0%	79	1,008
STAR Health	95.8%	28	40
Total	-	-	3,504

Record Retrieval

To increase the record return rate and help MCOs meet the required sample size, the EQRO modified its approach for obtaining provider addresses for the record retrieval process by: 1) utilizing the service facility address from the encounter, and 2) requesting that the MCOs verify and/or correct the address the EQRO had on file. The EQRO provided HHSC with a file for each MCO that contained a list of members, ICNs and corresponding provider information.

Analysis

The EQRO EDVMRR team used a standardized review protocol and assessed inter-rater reliability on 20 percent of the sample to ensure accuracy. Reviewers had a 99 percent agreement rate.

The EQRO calculated the following final match rates:

1. DOS (Date of Service) – The denominator for this match rate is the total number of DOS in the encounters and in the medical records. A DOS was numerator compliant when the DOS in the medical record matched the DOS in the encounter data.

2. POS (Place of Service) – The denominator for this match rate is the total number of POS in the encounters and in the medical records. A POS was numerator compliant when the POS in the medical record matched the POS in the encounter data.
3. PDx (Primary diagnosis) – The denominator for this match rate is the total number of primary diagnoses in the encounters and in the medical records. A primary diagnosis was numerator compliant when the primary diagnosis in the medical record matched the primary diagnosis in the encounter data.
4. PX (Procedure) – The denominator for this match rate is the total number of PX in the encounters and in the medical records. A PX was numerator compliant when the PX in the medical record matched the PX in the encounter data.

The review team cross-checked services found in the medical record but not in the sample encounter file against an *All Encounter* file to identify if a different provider conducted the service in the record and excluded medical records accounted for in the *All Encounter* file from the evaluation. By matching medical records to member enrollment, the review team excluded any services in the record occurring outside the member's enrollment in the sampled Program-MCO.

Results

Record Availability Results

Eleven of the 17 MCOs either verified or updated the addresses the EQRO had on file. The service facility address that the EQRO pulled from the encounter data yielded a higher overall return rate than the provider addresses provided by the MCOs. As an example, the EQRO received the response "not a patient" for 91 of the 388 (23.5 percent) records requested for Superior, but only one of those was a record with an EQRO provided address while the other 90 were requested using the address Superior supplied. Superior was able to obtain 54 percent of the outstanding "not a patient" records by calling the provider offices. The overall return rate using the EQRO service facility addresses was 76.5 percent, while the return rate using MCO-supplied addresses was only 62.0 percent.

The number of records initially received did not meet the required sample size for seven of the 17 MCOs. To obtain the outstanding records, HHSC asked the seven MCOs to request delinquent records from providers and send the records to the EQRO. The EQRO granted the MCOs a one-month extension for record collection. PCHP did not send additional records to the EQRO; therefore, the MCO did not meet its required sample size.

Overall, the EQRO received and reviewed 81 percent of the 3,504 requested member records. For 381 requests (11 percent), the EQRO received no response, while 258 requests (7 percent) resulted in a notice of either a bad provider address, that the member was not a patient, or the provider did not see the member during the requested period.

Record return rates by program ranged from 78 percent (STAR Health) to 82 percent (STAR). As noted above, PCHP was the only MCO that did not meet the sample size requirements. The most common reason for their record deficiencies was "no response," which accounted for 31 records (27 percent). Table 36 provides detailed record availability information for all MCOs that serve the Medicaid population.

Table 37. Detailed information on EDVMRR record availability by MCO

MCO	Reviewable Records Received	No Response	Bad Address	Not a Patient	Patient Not Seen During the Requested Period	Care Outside of Time Frame
Aetna Better Health (Aetna)	219	4	2	1	0	2
Amerigroup	283	42	16	2	3	2
Blue Cross Blue Shield (BCBSTX)	176	22	4	4	8	14
Cigna-HealthSpring (HealthSpring)	95	17	3	0	4	1
Community First Health Plans (CFHP)	178	35	12	0	1	1
Community Health Choice (CHCT)	100	3	8	2	1	2
Cook Children's Health Plan (CookCHP)	175	22	19	5	7	0
Dell Children's Health Plan (DCHP)	114	1	1	0	0	0
Driscoll Health Plan (Driscoll)	199	20	4	3	1	1
El Paso Health (ElPasoHealth)	105	5	2	1	3	0
FirstCare	89	14	6	2	3	1
Molina	186	33	9	5	2	1
Parkland Community Health Plan (PCHP)	78	31	5	0	0	2
RightCare (SWHP)	86	14	4	5	7	0
Superior	289	38	13	43	3	2
Texas Children's Health Plan (TCHP)	177	37	5	5	4	0
UnitedHealthcare (UHC)	282	43	6	7	7	3
Total	2,831	381	119	85	54	32

Match Rate Results

The EQRO reviewed records for 2,831 members across all programs. The overall match rate for STAR+PLUS was the lowest compared to the overall match rates for all programs, while rates were highest for STAR. The STAR Health and STAR Kids match rates were similar overall and across MCOs, with exception of the CookCHP STAR Kids match rate (86.9 percent), which was lower than the other MCOs due to its low match rates for DOS, POS, and PDx. Program averages were consistently above 90 percent (data not shown).

For DOS, the average match rate across all programs and MCOs was 93.2 percent for the 7,526 DOS considered. Table 37, Table 38, Table 39, and Table 40 show the DOS match rates by program and MCO.

Table 38. STAR DOS match rate by program and MCO

STAR MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	DOS Match Rate
Aetna Better Health (Aetna)	0.0%	1.5%	98.5%
Amerigroup	0.5%	4.7%	94.8%

STAR MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	DOS Match Rate
Blue Cross Blue Shield (BCBSTX)	0.0%	5.4%	94.6%
Community First Health Plans (CFHP)	3.4%	4.2%	92.4%
Community Health Choice (CHCT)	0.8%	2.5%	96.6%
Cook Children's Health Plan (CookCHP)	0.0%	0.6%	99.4%
Dell Children's Health Plan (DCHP)	0.9%	1.9%	97.2%
Driscoll Health Plan (Driscoll)	0.0%	4.8%	95.2%
El Paso Health (ElPasoHealth)	0.4%	3.6%	96.0%
FirstCare	1.1%	2.1%	96.8%
Molina	1.5%	5.8%	92.7%
Parkland Community Health Plan (PCHP)	0.3%	4.9%	94.8%[1]
RightCare (SWHP)	0.4%	7.3%	92.3%
Superior	2.0%	6.9%	91.2%
Texas Children's Health Plan (TCHP)	0.0%	3.3%	96.7%
UnitedHealthcare (UHC)	1.6%	6.1%	92.3%
Average	**0.8%**	**4.2%**	**94.9%**

[1] Rate is unreliable because MCO did not meet the sample size requirement.

Table 39. STAR+PLUS DOS match rate by program and MCO

STAR+PLUS MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	DOS Match Rate
Amerigroup	4.7%	10.4%	84.9%
Cigna-HealthSpring (HealthSpring)	0.0%	6.8%	93.2%
Molina	1.6%	10.5%	87.9%
Superior	0.8%	4.1%	95.1%
UnitedHealthcare (UHC)	0.6%	9.5%	89.9%
Average	**1.4%**	**8.3%**	**90.3%**

Table 40. STAR Kids DOS match rate by program and MCO

STAR Kids MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	DOS Match Rate
Aetna Better Health (Aetna)	1.3%	3.8%	95.0%
Amerigroup	1.0%	2.6%	96.4%
Blue Cross Blue Shield (BCBSTX)	1.9%	2.6%	95.5%
Community First Health Plans (CFHP)	0.5%	9.7%	89.7%
Cook Children's Health Plan (CookCHP)	1.2%	11.9%	86.9%
Driscoll Health Plan (Driscoll)	0.7%	5.6%	93.7%

STAR Kids MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	DOS Match Rate
Superior	0.0%	10.5%	89.5%
Texas Children's Health Plan (TCHP)	0.5%	7.8%	91.7%
UnitedHealthcare (UHC)	3.1%	3.5%	93.4%
Average	**1.1%**	**6.7%**	**92.2%**

Table 41. STAR Health DOS match rate by program and MCO

STAR Health MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	DOS Match Rate
Superior	0.0%	5.7%	94.3%

The POS match rates (not shown) are very similar to DOS rates, with almost all unmatched POS associated with unmatched DOS. The match rate was 90 percent or higher across programs. STAR had the highest match rate (95.1 percent) among programs. Across MCOs and programs, CookCHP in STAR had the highest POS match rate (99.4 percent), while Amerigroup in STAR+PLUS had the lowest POS match rate (85.3 percent).

The EQRO reviewed 7,526 PDx with an average match rate of 92.5 percent across MCOs. The match rates ranged from 84.2 percent for Amerigroup (STAR+PLUS) to 99.4 percent for CookCHP (STAR). Table 41, Table 42, Table 43, and Table 44 show the PDx match rates by program and MCO.

Table 42. STAR PDx match rate by program and MCO

STAR MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	PDx Match Rate
Aetna Better Health (Aetna)	0.0%	1.5%	98.5%
Amerigroup	0.5%	4.7%	94.8%
Blue Cross Blue Shield (BCBSTX)	0.0%	7.4%	92.6%
Community First Health Plans (CFHP)	3.4%	5.7%	90.8%
Community Health Choice (CHCT)	0.8%	5.1%	94.1%
Cook Children's Health Plan (CookCHP)	0.0%	0.6%	99.4%
Dell Children's Health Plan (DCHP)	0.9%	1.9%	97.2%
Driscoll Health Plan (Driscoll)	0.0%	6.2%	93.8%
El Paso Health (ElPasoHealth)	0.4%	5.4%	94.2%
FirstCare	1.1%	2.7%	96.3%
Molina	1.5%	5.8%	92.7%
Parkland Community Health Plan (PCHP)	0.3%	5.9%	93.7%[1]
RightCare (SWHP)	0.4%	7.3%	92.3%
Superior	2.0%	6.9%	91.2%
Texas Children's Health Plan (TCHP)	0.0%	3.3%	96.7%

STAR MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	PDx Match Rate
UnitedHealthcare (UHC)	1.6%	5.8%	92.6%
Average	**0.8%**	**4.9%**	**94.2%**

[1] Rate is unreliable because MCO did not meet the sample size requirement.

Table 43. STAR+PLUS PDx match rate by program and MCO

STAR+PLUS MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	PDx Match Rate
Amerigroup	4.7%	11.1%	84.2%
Cigna-HealthSpring (HealthSpring)	0.0%	8.5%	91.5%
Molina	1.6%	12.6%	85.8%
Superior	0.8%	4.9%	94.3%
UnitedHealthcare (UHC)	0.6%	9.1%	90.2%
Average	**1.4%**	**9.2%**	**89.3%**

Table 44. STAR Kids PDx match rate by program and MCO

STAR Kids MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	PDx Match Rate
Aetna Better Health (Aetna)	1.3%	4.6%	94.1%
Amerigroup	1.0%	5.2%	93.8%
Blue Cross Blue Shield (BCBSTX)	1.9%	2.6%	95.5%
Community First Health Plans (CFHP)	0.5%	10.3%	89.2%
Cook Children's Health Plan (CookCHP)	1.2%	12.5%	86.3%
Driscoll Health Plan (Driscoll)	0.7%	5.6%	93.7%
Superior	0.0%	10.5%	89.5%
Texas Children's Health Plan (TCHP)	0.5%	8.3%	91.2%
UnitedHealthcare (UHC)	3.1%	4.2%	92.7%
Average	**1.1%**	**7.3%**	**91.6%**

Table 45. STAR Health PDx match rate by program and MCO

STAR Health MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	PDx Match Rate
Superior	0.0%	9.2%	90.8%

The EQRO reviewed 17,993 thousand procedures, with an overall match rate of 94.1 percent. The match rates ranged from 83.5 percent for CFHP (STAR Kids) to 99.2 percent for Aetna (STAR). Table 45, Table 46, Table 47, and Table 48 show the PX match rates by program and MCO.

Table 46. STAR PX match rate by program and MCO

STAR MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	PX Match Rate
Aetna Better Health (Aetna)	0.0%	0.8%	99.2%
Amerigroup	0.4%	5.0%	94.7%
Blue Cross Blue Shield (BCBSTX)	0.0%	5.6%	94.4%
Community First Health Plans (CFHP)	1.8%	3.6%	94.5%
Community Health Choice (CHCT)	0.3%	6.3%	93.4%
Cook Children's Health Plan (CookCHP)	0.0%	0.9%	99.1%
Dell Children's Health Plan (DCHP)	0.8%	3.0%	96.2%
Driscoll Health Plan (Driscoll)	0.1%	5.0%	94.8%
El Paso Health (ElPasoHealth)	0.1%	5.2%	94.6%
FirstCare	0.5%	1.0%	98.4%
Molina	0.7%	8.3%	91.0%
Parkland Community Health Plan (PCHP)	0.2%	4.8%	95.0%[1]
RightCare (SWHP)	0.2%	4.9%	94.8%
Superior	0.8%	6.3%	92.9%
Texas Children's Health Plan (TCHP)	0.0%	4.1%	95.9%
UnitedHealthcare (UHC)	0.7%	3.8%	95.6%
Average	**0.4%**	**4.4%**	**95.2%**

[1] Rate is unreliable because MCO did not meet the sample size requirement.

Table 47. STAR+PLUS PX match rate by program and MCO

STAR+PLUS MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	PX Match Rate
Amerigroup	3.3%	6.3%	90.4%
Cigna-HealthSpring (HealthSpring)	0.2%	6.8%	93.0%
Molina	1.0%	6.3%	92.7%
Superior	0.5%	4.1%	95.5%
UnitedHealthcare (UHC)	0.3%	7.9%	91.8%
Average	**1.0%**	**6.3%**	**92.8%**

Table 48. STAR Kids PX match rate by program and MCO

STAR Kids MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	PX Match Rate
Aetna Better Health (Aetna)	0.8%	2.6%	96.6%
Amerigroup	0.8%	2.1%	97.1%
Blue Cross Blue Shield (BCBSTX)	1.0%	2.2%	96.8%

STAR Kids MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	PX Match Rate
Community First Health Plans (CFHP)	0.5%	16.1%	83.5%
Cook Children's Health Plan (CookCHP)	0.6%	7.9%	91.5%
Driscoll Health Plan (Driscoll)	0.5%	5.5%	94.1%
Superior	0.0%	7.7%	92.3%
Texas Children's Health Plan (TCHP)	0.2%	7.9%	91.9%
UnitedHealthcare (UHC)	1.9%	3.9%	94.2%
Average	**0.7%**	**6.7%**	**92.6%**

Table 49. STAR Health PX match rate by program and MCO

STAR Health MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	PX Match Rate
Superior	0.4%	7.0%	92.6%

Relevance for Assessing Quality, Access & Timeliness

A great deal of information about patient health and service usage comes from encounter data. This data must be complete, accurate, and reliable to support meaningful evaluation of quality, timeliness, and access to care. One way the EQRO ensures that this data is appropriate for these evaluations is through encounter data validation. The EQRO assesses the completeness and accuracy of encounter data that supports calculation of the measures used to evaluate managed care performance in Texas Medicaid and CHIP.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 49, and Table 50 list the key findings and recommendations from EQR activities associated with Protocol 5, evaluation of encounter data and review of medical records, and their relevance to the MCQS.

Table 50. Protocol 5 encounter data evaluation summary of findings and recommendations

Category	Description
Finding(s)	Driscoll and CFHP had deficits in member ID reporting or validity, and Superior had deficits on admission dates.
MCQS Goal(s)	Goals 3, 4, 6
Recommendation(s)	HHSC should continue to monitor key fields in encounter data for validity and completeness. Although data quality is generally very good, without monitoring changes in data processing can lead to unexpected data loss.
Finding(s)	Despite several ongoing initiatives to try and improve the quality of provider data, both in encounters and in the master provider data, the overall quality of provider data is still not meeting the desired standards.
MCQS Goal(s)	Goal 4
Recommendation(s)	HHSC should continue current initiatives and investigate what causes deficits in the reported provider information

Category	Description
Finding(s)	UHC Dental data was deficient in several important elements.
MCQS Goal(s)	Goals 3, 4, 6
Recommendation(s)	HHSC should work with UHC Dental to improve their data quality. HHSC should consider earlier analysis of data quality for new MCOs/DMOs, or following other major changes in programs.

Table 51. Protocol 5 review of medical records summary of findings and recommendations

Category	Description
Finding(s)	To improve the record return rate and accuracy of provider addresses, the EQRO sent each MCO a list of ICNs and provider addresses for each member in the sample and requested that MCOs verify the provider addresses and make corrections where needed. Aetna, BCBSTX, DCHP, PCHP, and UHC did not update or verify the provider addresses. Superior updated several of the provider addresses, however 23.5 percent of the records requested came back to the EQRO as "not a patient." Because unverified or incorrect addresses led to lower record return rates compared to previous studies, the EQRO and HHSC requested that the MCOs retrieve the outstanding records needed to meet the sample size requirements.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	The EQRO recommends HHSC consider a new approach to obtaining records that will hold the MCOs accountable for meeting the sample size requirements for the study. One approach would be for HHSC to require the MCOs to obtain the records for the sample population and submit them to HHSC and the EQRO.
Finding(s)	PCHP had the opportunity, as did all the MCOs, to verify or correct the provider addresses at the start of the study, however, they took no action. Further, when given the opportunity to retrieve the outstanding records to meet the sample size requirements, PCHP did not provide any additional records. Consequently, the EQRO did not receive enough records to meet the sample size requirements making PCHP's match rates unreliable.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	PHCP should work to ensure that all provider addresses are accurate at the start of each EDVMRR study, by improving their provider address reporting, and by taking advantage of the opportunity to correct addresses or retrieve any outstanding records to ensure meeting the required sample size.
Finding(s)	The provider addresses pulled from the EQRO encounters at the beginning of the study resulted in an overall higher return rate (77 percent) than the addresses provided by the MCOs (62 percent). The EQRO addresses yielded a higher return rate than the MCO addresses for the following MCOs: Amerigroup, ElPasoHealth, FirstCare, SWHP, Superior, and TCHP.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	The EQRO recommends that MCOs, especially Amerigroup, ElPasoHealth, FirstCare, SWHP, Superior, and TCHP, examine their provider directories to identify factors that could influence the accuracy of provider addresses.

Category	Description
Finding(s)	The overall match rates for MCOs were high across review categories (i.e., DOS, POS, PDx and PX). However, several MCOs performed below average. The MCOs that scored below average across review categories were Amerigroup, CFHP, CookCHP, Molina and Superior. The primary reason for the lower match rates for these MCOs was that the encounter data included DOS, POS, PDx, and/or PXs that were not documented in the medical record.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	The EQRO recommends that Amerigroup, CFHP, CookCHP, Molina and Superior work with their providers to determine why information in the encounter data is not documented in the medical records.

Protocol 6: Administration of Quality of Care Surveys

Protocol Overview & Objectives

Protocol 6 provides guidance for administering and validating consumer or provider surveys. Surveys are a valuable resource for assessing the experience of managed care members and creating a person-centered healthcare environment for Texas Medicaid and CHIP members. The EQRO follows the CMS guidelines outlined in Protocol 6 to conduct the annual and biennial consumer QoC surveys used to monitor and evaluate the quality of healthcare provided to members.

The QoC surveys measure the experiences and satisfaction with healthcare provided by the MCOs for adult members in Texas Medicaid and CHIP and caregivers of children and adolescent members in Medicaid and CHIP. The EQRO uses survey results to assist members when choosing MCOs, inform HHSC on the impact of quality improvement initiatives, and help MCOs identify strengths and weaknesses for targeting quality improvement efforts. The EQRO develops the research design for all surveys with input from HHSC while ensuring the sampling strategy follows applicable AHRQ guidelines and meets survey objectives.

During SFY 2022, the EQRO designed and conducted the following biennial member surveys:

- STAR Adult Members
- STAR+PLUS Members
- STAR Kids Caregivers
- STAR Health Caregivers

EQR Activities

Instruments & Sample Selection

The *Consumer Assessment of Healthcare Providers and Systems* (CAHPS) Health Plan Survey is a widely used instrument for measuring and reporting experiences with healthcare plans, services, and providers. The survey indicators for MCO performance (e.g., personal doctor and MCO ratings) include individual questions and composite measures that combine closely related survey item scores. Following the guidance in Protocol 6, Activity I.3, the EQRO chose to use the NCQA-validated CAHPS 5.0H version of the CAHPS Health Plan survey. In addition to the complete set of AHRQ specified measures, this version includes several NCQA-specified supplemental individual items, composites, and item sets such as Coordination of Care, Smoking Cessation, Flu Vaccination summary items, and the Children with Chronic Conditions (CCC) Item Set.

Following the sampling plan guidance in Protocol 6, Activity I.4 the EQRO selected participants for CAHPS surveys from stratified random samples of adult members (18-64 years old) and child members (17 years or younger) who were continuously enrolled (no more than one 30-day gap) with the same MCO for at least six months. The stratified samples included representation from each MCO operating in the program, with target numbers of completed survey interviews at 200 per plan code or 300 per MCO operating in a single SA. The EQRO selected these targets based on power analyses informed by item completion rates, known population sizes, historical performance, and an acceptable margin of error balanced against the feasibility of large-scale surveys in STAR, STAR+PLUS, STAR Kids, and STAR Health.

Survey Fielding

Each year, the EQRO carefully selects survey research firms to conduct telephone surveys based on reputation, quality, and cost. The EQRO contracted with the University of Florida Survey Research Center (UFSRC) and the

nonpartisan and objective research organization NORC, at the University of Chicago (hereafter NORC) to conduct the SFY 2022 member and caregiver experience-of-care surveys using CATI (Computer-Assisted Telephone Interviewing) and CAWI (Computer-Assisted Web Interviewing) systems. Both UFSRC and NORC have experience conducting Texas EQRO-related telephone surveys, and UFSRC is NCQA-accredited.

The EQRO fielded the experience-of-care surveys for six to seven months using strategies from Protocol 6, Activity I.5 to maximize response rates. The EQRO sent advance letters written in English and Spanish to members or caregivers requesting their participation. Members received advanced notification letters with unique log-in information that linked to the online version of the survey. After three weeks of online fielding, survey vendors began calling members who did not complete the survey online. The EQRO calculated survey response rates based on the standard methodology and final disposition categories of the American Association of Public Opinion Research (AAPOR). Table 51 lists the member surveys conducted by the EQRO in SFY 2021 and their enrollment and fielding periods.

Table 52. 2022 survey enrollment and fielding periods

Survey	Enrollment Period	Fielding Period	Completed Surveys
STAR Adult Member	October 2021-March 2022	April 2022-September 2022	5,667
STAR+PLUS Member	October 2021-March 2022	May 2022-September 2022	2,759
STAR Kids Caregiver	October 2021-March 2022	May 2022-September 2022	5,519
STAR Health Caregiver	December 2021-May 2022	July 2022-October 2022	276

Survey Analyses & Reporting

The EQRO performed various quality assurance checks outlined in Protocol 6, Activity I.6, including checking the sample for consistency, survey material reviews, telephone interviewer reviews and monitoring, and data quality controls. The EQRO developed methods listed in Activity I.8 to process and analyze the final data. The final data incorporated sample weights and non-response adjustments. The survey reports included outcome measure results for statewide Medicaid/CHIP programs, MCOs, and any state-specified groups of interest.

Scoring for the CAHPS surveys follows AHRQ top-box reporting; scores represent the percentage of members who rated their healthcare a nine or 10 (on a scale from zero to 10 with higher scores indicating greater satisfaction) or reported “always” having a positive experience.

Survey Results

Experience of Care – Adult Surveys

Table 52 shows the 2022 STAR Adult and STAR+PLUS member survey results for individual survey questions. The THLC portal (thlcportal.com) has the full list of survey results, including results by MCO and comparisons to national CAHPS benchmarks.

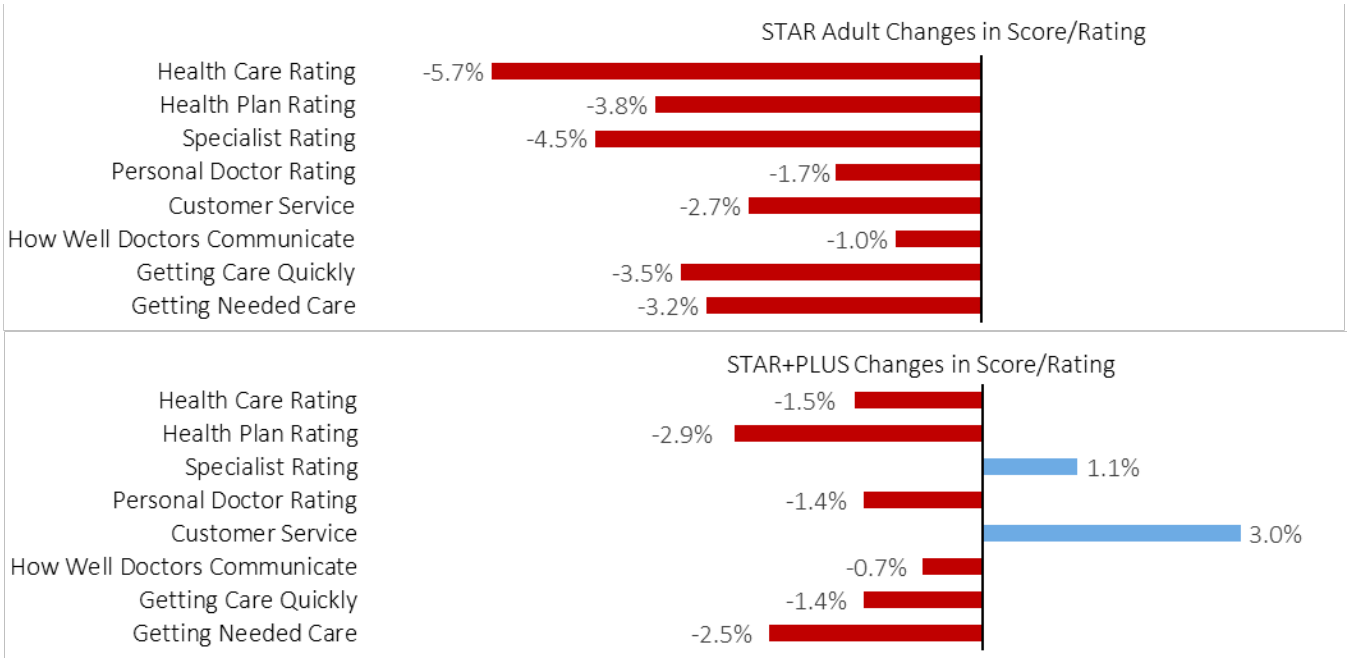
Table 53. 2022 CAHPS STAR Adult and STAR+PLUS survey results

Survey Question	STAR Adult	STAR+PLUS
Always Getting Needed Care	56.7%	55.3%
Always Getting Care Quickly	55.7%	60.6%
How Well Doctors Communicate (Always Communicate Well)	82.0%	79.2%

Survey Question	STAR Adult	STAR+PLUS
Customer Service (Always Positive Experience)	74.8%	74.6%
Personal Doctor Rating (Caregiver Ratings of 9 or 10)	67.2%	68.0%
Specialist Rating (Caregiver Ratings of 9 or 10)	68.1%	68.6%
Health Plan Rating (Caregiver Ratings of 9 or 10)	62.0%	58.3%
Health Care Rating (Caregiver Ratings of 9 or 10)	58.9%	54.8%

Composite scores on the STAR Adult and STAR+PLUS Member surveys decreased between 2020 and 2022 (Figure 5), except for the STAR+PLUS *Customer Service* composite (+3.0 percent). Survey rating scores also decreased between 2020 to 2022, except for the *Specialist Rating* for STAR+PLUS (+1.1 percent). The biggest change between 2020 and 2022 was the *Health Care Rating* for STAR Adult (-5.7 percent).

Figure 5. Changes in STAR Adult and STAR+PLUS composite scores and ratings between 2020 and 2022



Experience of Care – Child Surveys

Table 53 and Table 54 show the 2022 STAR Kids Caregiver and STAR Health Caregiver survey results for individual survey questions and the CCC composite and summary rates, respectively. The THLC portal (thlcportal.com) provides the full survey results, including results by MCO and comparisons to national CAHPS benchmarks. The results of the STAR Child and STAR Health CCC composites and summary rates suggest that access is a critical area for improvement in this population. *Access to Specialized Services* scores were below 50 percent for STAR Kids and only 56.7 percent for STAR Health.

Table 54. 2022 CAHPS STAR Kids and STAR Health survey results

Survey Question	STAR Kids	STAR Health
Always Getting Needed Care	68.7%	59.8%
Always Getting Care Quickly	74.8%	83.0%

Survey Question	STAR Kids	STAR Health
How Well Doctors Communicate (Always Communicate Well)	84.0%	81.6%
Customer Service (Always Positive Experience)	79.6%	77.0%
Personal Doctor Rating (Caregiver Ratings of 9 or 10)	80.7%	77.4%
Specialist Rating (Caregiver Ratings of 9 or 10)	80.6%	64.0%
Health Plan Rating (Caregiver Ratings of 9 or 10)	73.0%	65.7%
Health Care Rating (Caregiver Ratings of 9 or 10)	77.9%	67.4%

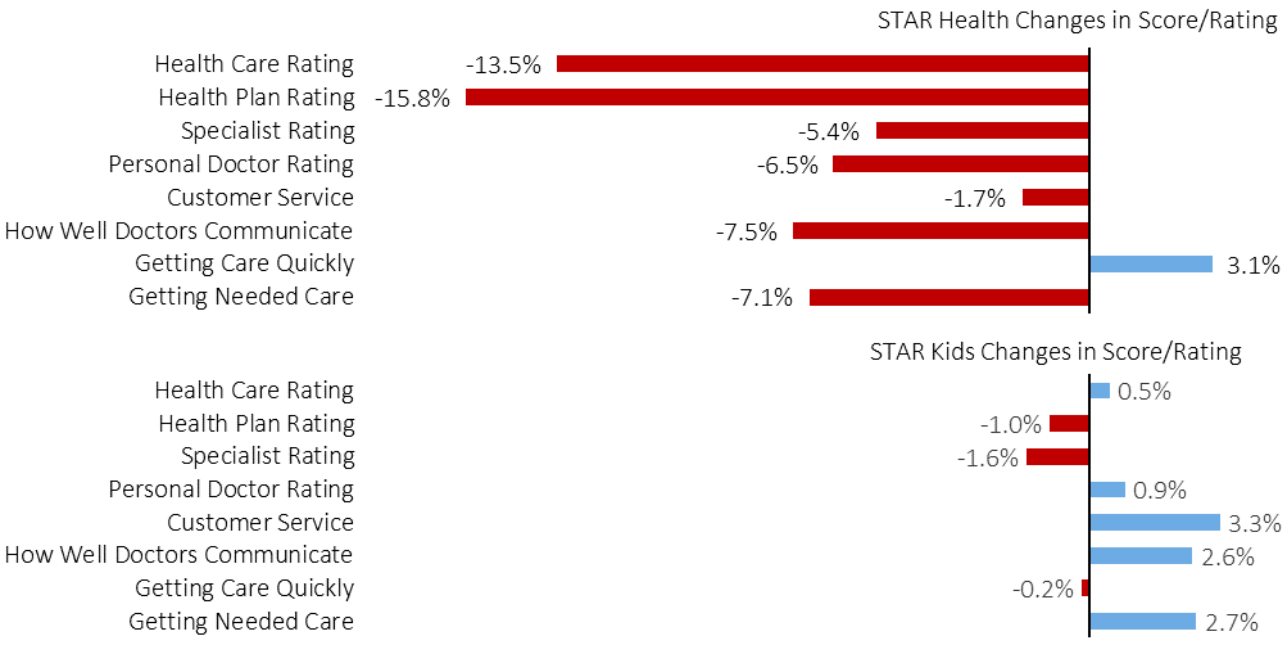
Table 55. 2022 CAHPS STAR Kids and STAR Health CCC composites and summary rates

Summary or Composite Measure[a]	STAR Kids	STAR Health
Access to Specialized Services	49.2%	51.5%
Personal Doctor Who Knows Child	92.8%	92.4%
Coordination of Care for Children with Chronic Conditions	81.5%	67.3%
Getting Needed Information	81.5%	84.7%
Access to Prescription Medicines	73.8%	75.9%

[a] Only respondents that met chronic conditions criteria contribute to the CCC composites and rates.

Between 2020 and 2022, most composite scores increased on the STAR Kids Caregiver survey while scores decreased for the STAR Health Caregiver survey except for *Getting Care Quickly* (Figure 6). The *How Well Doctors Communicate* composite in STAR Health changed the most between 2020 and 2022 (-7.5 percent). Survey ratings for STAR Kids and STAR Health mostly decreased. The biggest rating change between 2020 and 2022 were substantial decreases in STAR Health for the *Healthcare Rating* (-13.5 percent) and the *Health Plan Rating* (-15.8 percent).

Figure 6. Changes in STAR Health and STAR Kids Caregiver composite scores and ratings between 2020 and 2022



COVID-19 Pandemic Impacts

The COVID-19 pandemic and PHE continued to affect survey completion rates in SFY 2022, which limited the number of respondents on the surveys. It is difficult to assess whether the ongoing PHE contributed to general decreases in scores and ratings across most domains and programs.

Relevance for Assessing Quality, Access & Timeliness

Consumer surveys can assess the characteristics of providers and practices that serve Medicaid/CHIP enrollees, their accessibility and availability, and their experience with the Medicaid/CHIP program. The low and decreasing scores and rates in many domains suggest that members are experiencing difficulties getting the best quality care, either due to barriers to access or provider deficiencies. Children with chronic conditions still lack access to needed care.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 5 lists the key findings and recommendations from EQR activities associated with Protocol 6 and their relevance to the MCQS.

Table 5. Findings and recommendations from QoC surveys

Category	Description
Finding(s)	Composite scores on the STAR Adult and STAR+PLUS Member surveys decreased between 2020 and 2022, except for the STAR+PLUS *Customer Service* composite. The biggest change between 2020 and 2022 was the *Health Care Rating* for STAR Adult (-5.7 percent).
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should work with the STAR MCOs to identify the key factors that contributed to the decrease in STAR adult member satisfaction with healthcare and identify the strategies that STAR MCOs are using to improve the quality of care in those health domains.
Finding(s)	Between 2020 and 2022, most composite scores increased on the STAR Kids Caregiver survey while scores decreased for the STAR Health Caregiver survey except for *Getting Care Quickly*.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should work with Superior and stakeholders in STAR Health to identify the key barriers and facilitators to improving caregiver satisfaction with healthcare and the MCO and use this information to develop strategies to improve caregiver satisfaction.

Protocol 7: Calculation of Performance Measures

Protocol Overview & Objectives

Protocol 7 provides guidance to states on the calculation of additional (non-QAPI) performance measures to monitor the care provided by MCOs to enrollees covered by Medicaid and CHIP. States use performance measures to monitor and compare the performance of MCOs over time and inform the selection and evaluation of quality improvement activities. This optional CMS EQR protocol specifies that the EQRO should calculate measures per Texas specifications and report results compared to established benchmarks and standards (CMS, 2019). The EQRO uses an external NCQA certified auditor to review measures calculated as part of Protocol 7 activities. MCO-specific results on select performance measures are available in the ATRC.

EQR Activities

Methods & Analyses

Texas contracted with the EQRO to conduct comprehensive QoC evaluations across all Texas Medicaid programs. Appendix D summarizes the QoC measures calculated and reported by the EQRO for MY 2021. MCO-specific results for measures on the Performance Indicator Dashboards are available in the ATRC.

Measures

To support the calculation of QoC measures and all EQRO functions, the EQRO maintains and updates monthly a data warehouse capturing enrollment, dental and medical encounters and claims, pharmacy, and provider data. With input from the EQRO, Texas selects QoC measures each year to facilitate quality incentive programs, initiative planning, CMS reporting, and other program administration objectives to improve healthcare quality for Medicaid and CHIP members. Measures come from nationally recognized quality assessment programs.

NCQA HEDIS measures

NCQA has stewarded HEDIS, the most widely used set of healthcare performance measures in the United States, for more than 20 years (NCQA, 2020). Texas includes over 50 HEDIS measures in Texas Medicaid and CHIP performance evaluations.

CHIPRA Core Measures

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided for HHS to establish a set of core QoC measures for children’s healthcare (CMS, 2020b). Many of the measures included are part of the HEDIS measure reporting set (including the NCQA CAHPS Survey Measures described in Protocol 6: Administration of Quality of Care Surveys). The EQRO also calculates the developmental screening measure stewarded by Oregon Health and Science University, the contraceptive care measures stewarded by the U.S. Office of Population Affairs, and the CMS measure of dental services. The EQRO submits CHIPRA core-measure results to CMS on behalf of Texas Medicaid and CHIP.

Adult Core Measures

The Patient Protection and Affordable Care Act of 2010 (42 U.S.C. § 1139B) required HHS to establish a core set of measures for adult healthcare (CMS, 2020a). As in the CHIPRA core set, many of the included measures are part of the HEDIS and AHRQ measure reporting set (including the adult CAHPS survey). The EQRO also calculates the HHS Office of Population Affairs contraceptive care measures for adults. In addition to measure calculation, the EQRO submits adult core measure results to CMS on behalf of Texas Medicaid.

3M Health Information Systems Measures of PPEs

3M has been a leader in healthcare data processing, payment systems, and analytics for over 30 years. Their software uses administrative data to identify the occurrence and expenditures associated with PPEs (3M Health Information Systems, 2018).

AHRQ Prevention Quality Indicators & Pediatric Quality Indicators

AHRQ serves as the lead federal agency for improving the safety and quality of America's healthcare system. The Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI) track performance based on administrative hospital inpatient data (AHRQ, 2022c, 2022b).

Dental Quality Alliance Measures

Established by the American Dental Association (ADA), the Dental Quality Alliance™ (DQA) develops evidence-based performance measures for oral healthcare (ADA, 2022).

Severe Maternal Morbidity/Pregnancy Associated Outcomes

In 2017, Texas asked the EQRO to examine whether Texas could use the American College of Obstetricians and Gynecologists (ACOG) Alliance for Innovation on Maternal Health (AIM)[6] outcome measures for severe maternal morbidity (SMM) to evaluate the quality of maternal healthcare in the Texas Medicaid and CHIP programs. Since then, the EQRO has continued working with HHSC to improve maternal healthcare by partnering with HHSC in a CMS Medicaid Innovation Accelerator Program[7] (IAP) addressing maternal mortality and SMM. Through this program, HHSC developed a roadmap for future progress and received technical recommendations to improve the EQRO specification for the statewide measure of pregnancy associated outcomes (OAP). The EQRO produces a comprehensive report of the OAP measure results annually based on this specification, and following relevant updates to the AIM measures. The overall SMM rates (excluding transfusion-only) are part of QoC reporting and this will be a STAR P4Q measure starting with MY 2022.

Cesarean Section Deliveries

The CHIPRA measures include a measure of cesarean section (C-Section) births stewarded by The Joint Commission (The Joint Commission, 2021) and AHRQ stewards several C-Section measures in the Inpatient Quality Indicators (AHRQ, 2022a). These measure definitions include requirements for vital statistics or medical record reviews, so it is impossible to calculate them from administrative data alone. Texas asked the EQRO to develop a C-Section measure that aligned with national standards and was calculable using only administrative data that also captured a comprehensive view of all C-Sections in Texas Medicaid. The EQRO produced a comprehensive report of the performance measure results for HHSC based on these specifications, which include all C-Sections, regardless of parity, and stratified based on presence of delivery complications. The rates for the C-Section measures (CES) are part of QoC reporting and uncomplicated C-Section rate will be a STAR P4Q measure starting with MY 2022.

[6] https://www.acog.org/practice-management/patient-safety-and-quality/partnerships/alliance-for-innovation-on-maternal-health-aim.

[7] CMS launched the Medicaid Innovation Accelerator Program (IAP) in July 2014 to support state Medicaid agencies by offering targeted technical support, tool development, and cross-state learning opportunities. Additional information about this program is available at medicaid.gov.

Calculations

The EQRO uses NCQA-certified software, QSI-XL™ (Inovalon, 2022) to calculate HEDIS measures, and contracts with the NCQA-certified auditor DTS Group (dtsg.com) to fully evaluate the measure calculation process for HEDIS, AHRQ, dental QoC, maternal health, and other measures requested by Texas.

Some HEDIS measures rely on medical record abstraction through hybrid method specifications. These include sampling based on administrative criteria, followed by medical record review from the sample to determine compliance. For HEDIS MY 2021, the EQRO received measure results from the MCOs for seven measures with a hybrid sampling methodology. For each of the measures submitted, the EQRO also requires MCOs to submit NCQA audit certification and the member-level data from their hybrid samples. Protocol 2: Validation of Performance Measures, describes these activities. To produce overall statewide rates for these measures, the EQRO uses the MCO reported rates, weighted by their eligible populations identified by the EQRO using QSI-XL (Inovalon, 2022).

The EQRO compares HEDIS measure results to benchmark percentiles compiled by NCQA from nationally gathered Medicaid managed care plan results. These national benchmarks provide a commonly used standard for comparison but have some limitations:

- Rates from the national benchmarks combine administrative and hybrid results and reflect an unknown mix of methods.
- It is unclear how the health and sociodemographic characteristics of members enrolled in Medicaid and CHIP plans nationally compare with Texans enrolled in Medicaid programs and CHIP.
- Submission of HEDIS data to NCQA is a voluntary process. The MCOs that choose to submit HEDIS data may not accurately represent all MCOs serving Medicaid programs across the industry.

The 3M measures of PPEs evaluate health outcomes, safety, efficiency, utilization rates, and costs associated with potentially avoidable care. Identified PPEs represent opportunities for improving efficiency and quality, timeliness and access to care, and better care coordination. The EQRO worked extensively with 3M to develop the most effective risk adjustment method for applying the 3M Core Grouping Software to the Medicaid and CHIP populations, providing actionable information and reliable metrics that support P4Q initiatives.

To calculate the AHRQ PDI and PQI measures, the EQRO adapts AHRQ software to summarize results specific to the Medicaid and CHIP population by using program enrollee populations as general denominators rather than census-based population standards provided by AHRQ. The DTS Group auditors review these software adaptations.

For federally supported Medicaid programs or CHIP, CMS designates dental services as essential and requires coverage for children. The EQRO, working closely with HHSC, developed an evaluation program for oral health that is scientifically sound and promotes accountability and improvement in the dental coverage programs. Some measures are adapted to reflect the age groups in specific dental programs, while others evaluate services associated with Texas initiatives such as the THSteps program.

The CMS child and adult core measure sets provide national- and state-level snapshots of healthcare quality for adults and children enrolled in Medicaid and CHIP. Submission of results to CMS is voluntary. However, CMS supports improvements in uniform data collection and reporting and helps states understand how to use these

data to improve healthcare quality. The EQRO manages the submission of Medicaid and CHIP data, monitors changes in CMS guidelines and initiatives, and provides information to HHSC related to the management of Medicaid and CHIP.

Results & Reporting

QoC Measures

Most QoC measure results are publicly available on the THLC portal (thlcportal.com). By adding results reporting for more member groups (for example, demographic groups) and special populations, including members with serious mental illness (SMI), pregnant women, and MDCP members, the EQRO enables HHSC to identify areas of concern. The information provided by these reports can also identify cases needing additional study. For example, medically complex populations tend to have worse rates on measures of potential overuse of antibiotics, but this could be because treatment choices are based on higher risk among these members.

Identifying disparities in care also requires comparing QoC measure results for different member groups. Based on the EQRO reports, HHSC can identify specific targets for further investigation, such as those described above, and general trends emerge. For example, results for many measures show racial/ethnic and geographic disparities. Compared to both non-Hispanic Black and non-Hispanic White members, Hispanic Medicaid members had more outpatient utilization and less ED, inpatient, mental health, and alcohol and drug services use. Rates were higher on many performance measures important for children, including well-child visits and developmental screening, and medication management for ADHD, asthma, and antipsychotics for Hispanic members than for non-Hispanic Black and non-Hispanic White members. Rates for breast cancer screening rates, testing for diabetes and COPD management, statin therapy management, and follow-up care after mental health or alcohol and drug treatment hospitalization were also better for Hispanic members. Rates for non-Hispanic Black members and non-Hispanic White members were worse than rates of Hispanic members on most of these measures, but were better on few measures, including appropriate antibiotic use and chlamydia testing. The level of compliance for was higher for Hispanic members on dental preventive measures. Hispanic members had fewer dental caries related ED visits than both non-Hispanic Black and non-Hispanic White members. Health status was a factor in performance on some measures. Variability in services related to geographic differences may contribute to some of these demographic disparities. Continuing to probe these issues provides Texas with information necessary to improve care for all Medicaid and CHIP members.

Medicaid reporting includes members in the STAR, STAR+PLUS, STAR Health, and STAR Kids managed care programs, and those covered through FFS. The STAR managed care plans cover about 90 percent of Medicaid members each month, and FFS coverage typically covers gaps between or before managed care enrollment. For MY 2021, the EQRO will submit Medicaid Adult, Medicaid Child, and CHIP measures to CMS. On the following pages, Table 55 and Table 56 show rates for the CMS child and adult core measures, respectively. MCO-specific results are available in the ATRC. Results are also available on the THLC portal (thlcportal.com).

Table 56. CMS child core measures

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate	CHIP Denominator	CHIP Rate
ADD	Follow-Up Care for Children Prescribed ADHD[a] Medication	Continuation and Maintenance Phase	6,642	54.9	270	43.0
ADD	Follow-Up Care for Children Prescribed ADHD[a] Medication	Initiation Phase	43,676	39.8	3,239	34.6
AMB	Ambulatory Care: ED	ED visits per member month (age <1)	2,646,109	74.2	278	39.6
AMB	Ambulatory Care: ED	ED visits per member month (age 1-9)	21,852,146	37.8	953,924	17.0
AMB	Ambulatory Care: ED	ED visits per member month (age 10-19)	20,352,617	28.2	1,309,454	14.0
AMB	Ambulatory Care: ED	ED visits per member month (age 0-19)	44,850,872	35.6	2,263,656	15.2
AMR	Asthma Medication Ratio	(age 5-11)	21,383	75.2	350	87.7
AMR	Asthma Medication Ratio	(age 12-18)	20,630	67.9	318	77.7
AMR	Asthma Medication Ratio	(age 5-18)	42,013	71.6	668	82.9
APM	Metabolic Monitoring. for Children & Adolescents (C/A) on Antipsychotics	Blood Glucose (age 1-11)	13,910	42.9	128	37.5
APM	Metabolic Monitoring For C/A on Antipsychotics	Blood Glucose (age 12-17)	24,559	61.2	299	61.9
APM	Metabolic Monitoring For C/A on Antipsychotics	Blood Glucose (age 1-17)	38,469	54.5	427	54.6
APM	Metabolic Monitoring For C/A on Antipsychotics	Cholesterol (age 1-11)	13,910	32.6	128	29.7
APM	Metabolic Monitoring For C/A on Antipsychotics	Cholesterol (age 12-17)	24,559	43.1	299	40.5
APM	Metabolic Monitoring For C/A on Antipsychotics	Cholesterol (age 1-17)	38,469	39.3	427	37.2
APM	Metabolic Monitoring For C/A on Antipsychotics	Blood Glucose and Cholesterol (age 1-11)	13,910	30.7	128	26.6
APM	Metabolic Monitoring For C/A on Antipsychotics	Blood Glucose and Cholesterol (age 12-17)	24,559	41.9	299	39.1
APM	Metabolic Monitoring For C/A on Antipsychotics	Blood Glucose and Cholesterol (age 1-17)	38,469	37.9	427	35.4
APP	Use of First-Line Psychosocial Care for Children & Adolescents (C/A) on Antipsychotics	(age 1-11)	5,593	40.3	111	36.0
APP	Use of First-Line Psychosocial Care for C/A on Antipsychotics	(age 12-17)	8,603	45.3	269	45.0
APP	Use of First-Line Psychosocial Care for C/A on Antipsychotics	(age 1-17)	14,196	43.3	380	42.4
CCP	Contraceptive Care - Postpartum Women	LARC - 3 Days (age 15-20)	16,463	1.6	N/A	
CCP	Contraceptive Care - Postpartum Women	LARC - 60 Days (age 15-20)	16,463	15.4	N/A	
CCP	Contraceptive Care - Postpartum Women	Most or Moderately effective contraception - 3 Days (age 15-20)	16,463	3.1	N/A	

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate	CHIP Denominator	CHIP Rate
CCP	Contraceptive Care - Postpartum Women	Most or Moderately effective contraception - 60 Days (age 15-20)	16,463	36.4	N/A	
CCW	Contraceptive Care - All Women	LARC (age 15-20)	392,743	3.5	N/A	
CCW	Contraceptive Care - All Women	Most or moderately effective contraception - (age 15-20)	392,743	16.9	N/A	
CHL	Chlamydia Screening in Women	(age 16-20)	125,809	47.2	1,521	37.9
CIS	Childhood Immunization Status	DTaP	Hybrid	70.0	Hybrid	81.0
CIS	Childhood Immunization Status	IPV	Hybrid	84.4	Hybrid	90.7
CIS	Childhood Immunization Status	MMR	Hybrid	84.7	Hybrid	90.9
CIS	Childhood Immunization Status	HiB	Hybrid	84.7	Hybrid	92.1
CIS	Childhood Immunization Status	Hep B	Hybrid	83.4	Hybrid	86.1
CIS	Childhood Immunization Status	VZV	Hybrid	84.6	Hybrid	90.2
CIS	Childhood Immunization Status	PCV	Hybrid	72.7	Hybrid	82.3
CIS	Childhood Immunization Status	Hep A	Hybrid	84.1	Hybrid	91.5
CIS	Childhood Immunization Status	RV	Hybrid	69.2	Hybrid	81.6
CIS	Childhood Immunization Status	Flu	Hybrid	39.5	Hybrid	52.7
CIS	Childhood Immunization Status	Combo 3	Hybrid	62.8	Hybrid	72.1
CIS	Childhood Immunization Status	Combo 7	Hybrid	54.9	Hybrid	66.7
CIS	Childhood Immunization Status	Combo 10	Hybrid	29.6	Hybrid	40.2
CPC	CAHPS Health Plan Survey	Getting Needed Care - % Always	CAHPS	67.5	CAHPS	66.7
CPC	CAHPS Health Plan Survey	Getting Care Quickly - % Always	CAHPS	64.6	CAHPS	71.3
CPC	CAHPS Health Plan Survey	How Well Doctors Communicate - % Always	CAHPS	84.7	CAHPS	81.2
CPC	CAHPS Health Plan Survey	Customer Service - % Always	CAHPS	79.2	CAHPS	73.8
CPC	CAHPS Health Plan Survey	Coordination of Care	CAHPS		CAHPS	
CPC	CAHPS Health Plan Survey	Rating: All Health Care	CAHPS	76.4	CAHPS	69.5
CPC	CAHPS Health Plan Survey	Rating: Personal Doctor	CAHPS	78.4	CAHPS	76.7
CPC	CAHPS Health Plan Survey	Rating: Specialist	CAHPS		CAHPS	
CPC	CAHPS Health Plan Survey	Rating: Health Plan	CAHPS	78.0	CAHPS	75.8

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate	CHIP Denominator	CHIP Rate
DEV	Developmental Screening - First Three Years of Life	Children screened by 12 months of age	215,269	46.2	1	0
DEV	Developmental Screening - First Three Years of Life	Children screened by 24 months of age	214,509	47.8	740	55.8
DEV	Developmental Screening - First Three Years of Life	Children screened by 36 months of age	179,076	45.1	6,089	46.7
DEV	Developmental Screening - First Three Years of Life	Children Total	608,854	46.5	6,830	47.7
FUA	Follow-Up After ED Visit for Alcohol & Oth. Drug Abuse or Dep.	Follow-up within 30 days (age 13-17)	1,449	5.0	31	3.2
FUA	Follow-Up After ED Visit for Alcohol & Oth. Drug Abuse or Dep.	Follow-up within 7 days (age 13-17)	1,449	3.5	31	0
FUH	Follow-Up After Hospitalization for Mental Illness	Follow-up within 30 days (age 6-17)	24,583	68.5	833	69.0
FUH	Follow-Up After Hospitalization for Mental Illness	Follow-up within 7 days (age 6-17)	24,583	42.9	833	41.5
FUM	Follow-Up After ED Visit for Mental Illness	Follow-up within 30 days (age 6-17)	5,097	58.2	214	66.8
FUM	Follow-Up After ED Visit for Mental Illness	Follow-up within 7 days (age 6-17)	5,097	43.9	214	51.4
IMA	Immunizations for Adolescents	Meningococcal	Hybrid	86.4	Hybrid	88.3
IMA	Immunizations for Adolescents	Tdap	Hybrid	86.6	Hybrid	88.5
IMA	Immunizations for Adolescents	HPV	Hybrid	42.5	Hybrid	43.7
IMA	Immunizations for Adolescents	Combination 1	Hybrid	85.3	Hybrid	87.4
IMA	Immunizations for Adolescents	Combination 2	Hybrid	41.6	Hybrid	42.9
OEV	Oral Evaluation, Dental Services	(age <1)	74,353	29.5	6	33.3
OEV	Oral Evaluation, Dental Services	(age 1-2)	442,565	58.2	1,837	52.2
OEV	Oral Evaluation, Dental Services	(age 3-5)	584,156	67.6	26,797	60.8
OEV	Oral Evaluation, Dental Services	(age 6-7)	395,263	70.7	21,719	64.7
OEV	Oral Evaluation, Dental Services	(age 8-9)	369,935	70.6	26,650	65.2
OEV	Oral Evaluation, Dental Services	(age 10-11)	359,427	69.4	26,993	64.0
OEV	Oral Evaluation, Dental Services	(age 12-14)	560,784	66.6	42,251	60.9
OEV	Oral Evaluation, Dental Services	(age 15-18)	646,267	59.0	49,934	53.9
OEV	Oral Evaluation, Dental Services	(age 19-20)	215,351	41.4	N/A	-
OEV	Oral Evaluation, Dental Services	(age 0-20)	3,648,101	63.3	196,187	60.5
PPC	Prenatal & Postpartum Care	Timeliness of Prenatal Care	154,230	65.0	15	66.7
SFM	Sealant Receipt on Permanent First Molars	Rate 1 - At Least One Sealant	126,058	66.45	8,422	65.5
SFM	Sealant Receipt on Permanent First Molars	Rate 2 - All Four Molars Sealed	126,058	43.37	8,422	44.8

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate	CHIP Denominator	CHIP Rate
TFL	Topical Fluoride for Children	Dental or oral health services (age 1-2)	414,484	48	898	34.3
TFL	Topical Fluoride for Children	Dental or oral health services (age 3-5)	552,984	36.4	13,430	33.5
TFL	Topical Fluoride for Children	Dental or oral health services (age 6-7)	375,670	35.3	10,692	35.1
TFL	Topical Fluoride for Children	Dental or oral health services (age 8-9)	350,458	35.6	13,108	35.5
TFL	Topical Fluoride for Children	Dental or oral health services (age 10-11)	340,600	34.8	13,251	34.7
TFL	Topical Fluoride for Children	Dental or oral health services (age 12-14)	532,130	32.2	20,519	31.9
TFL	Topical Fluoride for Children	Dental or oral health services (age 15-18)	608,864	25.9	24,972	24.6
TFL	Topical Fluoride for Children	Dental or oral health services (age 19-20)	196,288	14.6	N/A	
TFL	Topical Fluoride for Children	Dental or oral health services (age 1-20)	3,371,478	33.7	96,870	31.5
TFL	Topical Fluoride for Children	Dental services (age 1-2)	414,484	38.8	898	26.7
TFL	Topical Fluoride for Children	Dental services (age 3-5)	552,984	35.2	13,430	32.4
TFL	Topical Fluoride for Children	Dental services (age 6-7)	375,670	35.3	10,692	35.0
TFL	Topical Fluoride for Children	Dental services (age 8-9)	350,458	35.6	13,108	35.4
TFL	Topical Fluoride for Children	Dental services (age 10-11)	340,600	34.8	13,251	34.7
TFL	Topical Fluoride for Children	Dental services (age 12-14)	532,130	32.2	20,519	31.9
TFL	Topical Fluoride for Children	Dental services (age 15-18)	608,864	25.8	24,972	24.5
TFL	Topical Fluoride for Children	Dental services (age 19-20)	196,288	14.6	N/A	
TFL	Topical Fluoride for Children	Dental services (age 1-20)	3,371,478	32.3	96,870	31.2
TFL	Topical Fluoride for Children	Oral health services (age 1-2)	414,484	12.7	898	6.0
TFL	Topical Fluoride for Children	Oral health services (age 3-5)	552,984	0.45	13,430	0.3
TFL	Topical Fluoride for Children	Oral health services (age 6-7)	375,670	0.01	10,692	0.0
TFL	Topical Fluoride for Children	Oral health services (age 8-9)	350,458	0.01	13,108	0.0
TFL	Topical Fluoride for Children	Oral health services (age 10-11)	340,600	0.01	13,251	0.0
TFL	Topical Fluoride for Children	Oral health services (age 12-14)	532,130	0.01	20,519	0.0
TFL	Topical Fluoride for Children	Oral health services (age 15-18)	608,864	0.01	24,972	0.0
TFL	Topical Fluoride for Children	Oral health services (age 1-20)	3,371,478	1.64	96,870	0.1
W30	Well-Child Visits in the First 30 Months of Life	Six or more well-child visits - first 15 months	217,375	56.8	N/A	

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate	CHIP Denominator	CHIP Rate
W30	Well-Child Visits in the First 30 Months of Life	Two or more well-child visits for ages 15 months to 30 months	183,337	70.3	3,453	79.0
WCC	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents (C/A)	BMI Percentile Documentation (age 3-11)	Hybrid	74.7	Hybrid	74.6
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	BMI Percentile Documentation (age 12-17)	Hybrid	75.0	Hybrid	76.2
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	BMI Percentile Documentation (age 3-17)	Hybrid	74.8	Hybrid	75.3
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	Counseling for Nutrition (age 3-11)	Hybrid	73.5	Hybrid	73.6
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	Counseling for Nutrition (age 12-17)	Hybrid	73.6	Hybrid	73.1
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	Counseling for Nutrition (age 3-17)	Hybrid	73.5	Hybrid	73.4
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	Counseling for Physical Activity (age 3-11)	Hybrid	67.9	Hybrid	68.2
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	Counseling for Physical Activity (age 12-17)	Hybrid	73.4	Hybrid	74.4
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	Counseling for Physical Activity (age 3-17)	Hybrid	70.0	Hybrid	70.8
WCV	Child and Adolescent Well-Care Visits	(age 3-11)	1,679,308	64.4	36,786	64.7
WCV	Child and Adolescent Well-Care Visits	(age 12-17)	1,037,438	60.6	29,438	62.9
WCV	Child and Adolescent Well-Care Visits	(age 18-21)	370,614	30.5	4,271	44.4
WCV	Child and Adolescent Well-Care Visits	(age 3-21)	3,087,360	59.1	70,495	62.7

[a] ADHD = Attention Deficit Hyperactivity Disorder

Table 57. CMS adult core measures

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	(age 18-64)	7,582	43.6
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	(age 65+)	22	59.1
AMM	Antidepressant Medication Management	Effective Acute Phase Treatment (age 18-64)	36,557	54.5
AMM	Antidepressant Medication Management	Effective Acute Phase Treatment (age 65+)	171	62.6
AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment (age 18-64)	36,557	36.3
AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment (age 65+)	171	48.0
AMR	Asthma Medication Ratio	(age 19-50)	8,758	63.2

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate
AMR	Asthma Medication Ratio	(age 51-64)	3,135	55.3
AMR	Asthma Medication Ratio	Total	11,893	61.1
BCS	Breast Cancer Screening	(age 50-64)	48,798	44.0
BCS	Breast Cancer Screening	(age 65-74)	1,149	29.9
CBP	Controlling High Blood Pressure	(age 18-64)	Hybrid	53.3
CBP	Controlling High Blood Pressure	(age 65-85)	Hybrid	75.8
CCP	Contraceptive Care - Postpartum Women	LARC - 3 Days (age 21-44)	109,863	0.8
CCP	Contraceptive Care - Postpartum Women	LARC - 60 Days (age 21-44)	109,863	11.7
CCP	Contraceptive Care - Postpartum Women	Most or Moderately effective contraception - 3 Days (21-44)	109,863	11.2
CCP	Contraceptive Care - Postpartum Women	Most or Moderately effective contraception - 60 Days (21-44)	109,863	38.7
CCS	Cervical Cancer Screening	(age 21-64)	Hybrid	57.2
CCW	Contraceptive Care - All Women	LARC (age 21-44)	355,824	9.1
CCW	Contraceptive Care - All Women	Most or Moderately effective contraception (age 21-44)	355,824	28.4
CHL	Chlamydia Screening in Women	(age 21-24)	66,634	55.4
COB	Concurrent Use of Opioids & Benzodiazepines	(age 18-64)	33,595	15.9
COB	Concurrent Use of Opioids & Benzodiazepines	(age 65+)	172	13.4
COL	Colorectal Cancer Screening	(age 50-64)	101,822	25.4
COL	Colorectal Cancer Screening	(age 65-75)	2,490	16.9
CPA	CAHPS Health Plan Survey	Getting Needed Care - Global Proportion of % Always	Survey	59.2
CPA	CAHPS Health Plan Survey	Getting Care Quickly - Global Proportion of % Always	Survey	55.6
CPA	CAHPS Health Plan Survey	How Well Doctors Communicate - % Always	Survey	79.5
CPA	CAHPS Health Plan Survey	Customer Service - % Always	Survey	73.5
CPA	CAHPS Health Plan Survey	Rating: All Health Care	Survey	61.3
CPA	CAHPS Health Plan Survey	Rating: Personal Doctor	Survey	72.1
CPA	CAHPS Health Plan Survey	Rating: Health Plan	Survey	66.9
FUA	Follow-Up After ED Visit for Alcohol & Other Drug Abuse or Dependence	Follow-up within 30 days of ED (age 18-64)	6,740	5.9
FUA	Follow-Up After ED Visit for Alcohol & Other Drug Abuse or Dependence	Follow-up within 30 days of ED (age 65+)	12	8.3
FUA	Follow-Up After ED Visit for Alcohol & Other Drug Abuse or Dependence	Follow-up within 7 days of ED (age 18-64)	6,740	3.5

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate
FUA	Follow-Up After ED Visit for Alcohol & Other Drug Abuse or Dependence	Follow-up within 7 days of ED (age 65+)	12	8.3
FUH	Follow-Up After Hospitalization for Mental Illness	Follow-up within 30 days after discharge (age 18-64)	18,321	51.4
FUH	Follow-Up After Hospitalization for Mental Illness	Follow-up within 30 days after discharge (age 65+)	32	31.3
FUH	Follow-Up After Hospitalization for Mental Illness	Follow-up within 7 days after discharge (age 18-64)	18,321	31.0
FUH	Follow-Up After Hospitalization for Mental Illness	Follow-up within 7 days after discharge (age 65+)	32	18.8
FUM	Follow-Up After ED Visit for Mental Illness	30-day follow-up after ED visit for mental illness (age 18-64)	7,694	40.0
FUM	Follow-Up After ED Visit for Mental Illness	30-day follow-up after ED visit for mental illness (age 65+)	18	44.4
FUM	Follow-Up After ED Visit for Mental Illness	7-day follow-up after ED visit for mental illness (age 18-64)	7,694	25.5
FUM	Follow-Up After ED Visit for Mental Illness	7-day follow-up after ED visit for mental illness (age 65+)	18	38.9
FVA	Flu Vaccinations for Adults	(age 18-64)	905,995	38.4
HVL	HIV Viral Load Suppression	(age 18-64)	8,780	70.4
HVL	HIV Viral Load Suppression	(age 65+)	932	76.3
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Alcohol (age 18-64)	13,163	39.7
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Alcohol (age 65+)	205	54.6
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Opioid (age 18-64)	4,165	42.9
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Opioid (age 65+)	58	24.1
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Other Drug (age 18-64)	28,999	41.3
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Other Drug (age 65+)	180	37.2
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Total (age 18-64)	42,263	40.4
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Total (age 65+)	408	44.6
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Alcohol (age 18-64)	13,163	7.6
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Alcohol (age 65+)	205	3.9
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Opioid (age 18-64)	4,165	13.8
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Opioid (age 65+)	58	5.2
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Other Drug (age 18-64)	28,999	9.8
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Other Drug (age 65+)	180	3.3
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Total (age 18-64)	42,263	9.6
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Total (age 65+)	408	4.2

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate
MSC	Medical Assistance with Smoking & Tobacco Use Cessation	Advising Smokers and Tobacco Users to Quit (age 18-64)	266,280	61.0
MSC	Medical Assistance with Smoking & Tobacco Use Cessation	Discussing Cessation Medications (age 18-64)	268,062	38.8
MSC	Medical Assistance with Smoking & Tobacco Use Cessation	Discussing Cessation Strategies (age 18-64)	262,596	30.5
MSC	Medical Assistance with Smoking & Tobacco Use Cessation	Percentage of Current Smokers/Tobacco Users (age 18-64)	1,417,896	19.2
OHD	Use of Opioids at High Dosage in Persons Without Cancer	(age 18-64)	35,244	0.9
OHD	Use of Opioids at High Dosage in Persons Without Cancer	(age 65+)	175	0.6
PCR	Plan All-Cause Readmissions	Observed Readmission Rate	68,871	12.6
PCR	Plan All-Cause Readmissions	Expected Readmission Rate	68,871	11.2
PCR	Plan All-Cause Readmissions	O/E Ratio	N/A	1.1
PCR	Plan All-Cause Readmissions	Outlier Rate	56,221	76.4
PPC	Prenatal & Postpartum Care	Postpartum visit between 7 and 84 days	154,230	67.8
PQI01	Diabetes Short-Term Complications Admission Rate	(age 18-64)	12,152,747	21.8
PQI01	Diabetes Short-Term Complications Admission Rate	(age 65+)	91,916	32.6
PQI05	Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	(age 40-64)	2,756,177	65.9
PQI05	COPD Admission Rate	(age 65+)	91,916	80.5
PQI08	Heart Failure Admission Rate	(age 18-64)	12,152,747	56.0
PQI08	Heart Failure Admission Rate	(age 65+)	91,916	709.3
PQI15	Asthma in Younger Adults Admission Rate	(age 18-39)	9,396,570	2.2
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Non-Medicare 80% Coverage (age 18+)	22,917	55.8
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	(age 18-64)	37,374	78.7

Some measures showed notable changes in rates compared to MY 2020. Adult Access to Preventive/Ambulatory Health Services (AAP) dropped by nine percentage points while Ambulatory Care (AMB) utilization remained generally consistent for older adults but decreased substantially for those aged 20 to 44 (outpatient dropped by nearly 30 percent and ED use by more than 10 percent). At the same time, AMB rates for children increased, particularly ED use (increased by more than 25 percent for children under 10 and over 10 percent for adolescents aged 10 to 19). For Well-Child Visits in the first 30 Months (W30), the percent of children receiving all required visits decreased by over five percentage points. For older children, the Well-Child and Adolescent Well-Care Visits (WCV) were generally consistent with the prior year. For CHIP, WCV rates increased, particularly for adolescents aged 12 to 17.

Breast Cancer Screening (BCS) rate in STAR decreased more than five percentage points. Cervical Cancer Screening (CCS) also decreased slightly in STAR, but by more than five percentage points in the Healthy Texas Women program.

Appropriate Testing for Pharyngitis (CWP) rate decreased across all programs. Follow-Up After High-Intensity Care for Substance Use Disorder improved for teens aged 13 to 17 (follow-up with-in 7 days increased by 11 percent).

Potentially Preventable Events

Since the 2011 passage of Senate Bill 7 (Texas 82nd legislature, regular session), Texas has required a quality-based outcomes payment program for Medicaid to contain costs while improving patient outcomes. Specifically, Texas Government Codes § 354.1445 and § 354.1446 (2016) address PPRs and PPCs, respectively. This inclusion of provisions to reduce PPEs goes beyond the payment reforms enacted by other states, such as Maryland and New York. As a result, the National Association of Medicaid Directors (NAMD) recognized the Texas legislation for incentivizing innovations and improvements in hospital-based care, patient management, and follow-up (NAMD, 2015). The Texas P4Q program (see Protocol 10: Assist with Quality Rating of MCOs and DMOs) contributed to reductions in all the PPEs included in the program and substantial associated cost reductions (Dudensing, 2016).

The EQRO analyzed 2021 encounter and eligibility data for non-dual Medicaid and CHIP members using 3M Health Information Systems software (3M Health Information Services, 2016). This software classifies events as PPEs based on the 3M grouping systems for (1) ambulatory care using Enhanced Ambulatory Patient Groups (EAPGs) or (2) inpatient care using All Patient Refined Diagnosis-Related Groups (APR-DRGs), and by considering other factors such as diagnosis codes, procedure codes, and the source of the admission.

The analyses included calculating PPE rates and expenditures, identifying the conditions contributing the most events to each program, and examining rates by gender, age, race, rurality, and area. The EQRO also calculated actual-to-expected (A/E) ratios for programs and MCOs within programs.

The EQRO conducted analyses for four types of PPEs:

- PPVs (Potentially Preventable Emergency Department Visits) are ED visits that may result from a lack of adequate access to care or ambulatory care coordination.
- PPAs (Potentially Preventable Admissions) are facility admissions that are avoidable through improved care coordination, effective primary care, and improved population health.

- PPRs (Potentially Preventable Readmissions) are return hospitalizations that may be caused by deficiencies in care during the initial hospital stay, poor coordination of services at the time of discharge, or poor coordination of services during follow-up.
- PPCs (Potentially Preventable Complications) are complications that arise after hospitalization because of poor clinical care or poor coordination of services during the inpatient stay.

The EQRO provided PPE results in an annual report that included summaries of data and analysis of rates at the state and program levels. Results are also available on the THLC portal (thlcportal.com). Statewide results are available publicly. Detailed results by MCO are available to HHSC and MCO users on a monthly basis to support timely interventions. Technical notes on all PPE calculations are also available in the resources section of the portal.

PPVs

High rates of PPVs may represent a failure to provide adequate primary care to the patient. From 2017 through 2019, the overall PPV rate trended slightly upward, and the cost per PPV increased. However, in 2020 both at-risk ED visits and PPVs decreased. In 2021 both have increased substantially. Of the two million Medicaid and CHIP ED visits at risk for PPVs in 2020, the EQRO identified 61.1 percent as PPVs. At the same time, eligibility changes due to the PHE lead to an overall increase in member-months, which make up the PPV rate denominator. The PPV rate increased slightly from 2020, but the current rate of 6.79 is still less than the 2019 rate of 9.2. Overall, PPVs in 2021 accounted for $559 million in institutional costs paid (excluding the associated professional costs). Table 57 summarizes the 2021 PPV results by program.

Table 58. 2021 PPV results for Medicaid and CHIP

Measure	STAR	STAR+PLUS	STAR kids	STAR Health	FFS	CHIP
Member-Months at Risk for PPVs	43,489,518	2,792,440	1,994,095	497,560	4,462,420	2,027,616
ED Visits at Risk of being PPVs	1,635,738	258,276	87,005	26,845	62,880	27,808
Total PPVs	1,002,863	160,853	52,328	17,075	32,881	15,983
Total PPV Weights	291,742.35	48,426.54	15,238.23	4,898.79	9,953.00	4,757.24
Total PPV Expenditure ($Millions)	$411.20M	$109.04M	$19.81M	$4.95M	$6.28M	$7.73M
PPV Rate (Total PPV Weights per 1,000 Member-Months)	6.71	17.34	7.64	9.85	2.23	2.35

The PPV rate was highest in the STAR+PLUS program, with a rate that was twice the overall rate across other programs. This difference is understandable because STAR+PLUS manages care for a population with complex healthcare needs. However, STAR Kids also serves a population with complex healthcare needs and has less than half the PPV rate of STAR+PLUS.

In 2021, the PPV rate was higher among females (7.15 vs. 6.32 for males), and the rate for rural members (7.84) and micropolitan members (7.83) were slightly higher than the rates for urban (6.60). In general, older members had higher PPV rates, although the rate was higher for children aged 1 to 5 years than for other children. Hispanic members had a lower PPV rate (5.77) than non-Hispanic White or non-Hispanic Black members (7.63 and 7.52, respectively).

Table 58 shows the top five PPV reasons across Medicaid and CHIP in 2021 based on EAPG categories ranked by total PPV weight. The leading reason continues to be upper respiratory tract infection (URTI), with a total cost of over $70 million during 2021. The list includes the same other four reasons as in 2021 but numbers of PPVs have increased substantially for all, and particularly EAPG 627 which has more than doubled in frequency compared to 2020. Not only do these PPVs represent an overuse of hospital resources, but URTI may have better outcomes when treated in a primary care setting.

Table 59. 2021 PPV top reasons

EAPG	Description	PPVs (n)	Percent of Total PPVs	Percent of Total PPV Weights	PPV Expenditures	Percent of Total PPV Expenditures
562	Infections of Upper Resp. Tract & Otitis Media	277,384	21.6%	16.1%	$72.91M	13.0%
627	Non-Bacterial Gastroenteritis, Nausea & Vomiting	105,834	8.3%	10.5%	$52.42M	9.4%
808	Viral Illness	74,961	5.8%	7.3%	$23.87M	4.3%
628	Abdominal Pain	72,113	5.6%	7.3%	$59.45M	10.6%
674	Contusion, Open Wound & other Trauma to Skin & Subcutaneous Tissue	70,792	5.5%	6.2%	$25.11M	4.5%

PPAs

Admissions that are avoidable with proper outpatient care are PPAs. They may result from inefficiencies in hospital or ambulatory care, poor access to outpatient care, or inadequate ambulatory care service coordination. From 2017 through 2019, the overall PPA rate trended slightly upward and the cost per PPA increased. However, in 2020, PPA rate decreased because of the COVID-19 pandemic and PHE. In 2021, PPA rate was at the similar level as 2020, which was lower than 2019. This may be the result of increased member-month denominator and possible lack of ambulatory care access. Of the approximately 267,000 inpatient admissions from Medicaid and CHIP in 2021, 12.6 percent were PPAs. These PPAs account for $320 million in institutional costs paid. Table 59 summarizes 2021 PPA results by program. The PPA rate was highest in the STAR+PLUS program, with a rate more than six times that of any other program, including STAR Kids.

Table 60. 2021 PPA results for Medicaid and CHIP

Measure	STAR	STAR+ PLUS	STAR Kids	STAR Health	FFS	CHIP
Member-Months at Risk for PPAs	43,489,518	2,792,440	1,994,095	497,560	4,462,420	2,027,616
Admissions at Risk of being PPAs	170,791	64,753	17,283	5,120	6,934	2,129
Total PPAs	13,369	14,597	2,922	1,284	1,042	346
Total PPA Weights	11,033.14	24,201.64	3,011.08	860.59	1,593.58	244.89
Total PPA Expenditure ($Millions)	$98.19M	$178.24M	$28.59M	$8.35M	$7.21M	$2.09M
PPA Rate (Total PPA Weights per 1,000 Member-Months)	0.25	8.67	1.51	1.73	0.36	0.12

In 2021, the PPA rate was higher among males (0.85 vs. 0.66 for females). Rural members and micropolitan members had very similar PPA rate (0.80 and 0.79, respectively), they were slightly higher than urban members (0.73). Older members had higher PPA rates. Hispanic members had a lower PPA rate (0.47) than non-Hispanic White or non-Hispanic Black members (1.05 and 1.04, respectively).

Table 60 shows the top five PPA reasons across Medicaid and CHIP in 2021 based on APR-DRG categories ranked by total PPA weight. Heart failure and pneumonia continue to top this list. Together they accounted for over $64 million in total costs during 2021.

Table 61. 2021 PPA top reasons

APR-DRG	Description	PPAs (n)	Percent of Total PPAs	Percent of Total PPA Weights	PPA Expenditures	Percent of Total PPA Expenditures
194	Heart Failure	3,455	10.3%	14.1%	$42.86M	13.3%
161	Cardiac Defibrillator & Heart Assist Implant	195	0.6%	6.9%	$19.64M	6.1%
751	Major Depressive Disorders & Other/Unspecified Psychoses	4,695	14.0%	6.7%	$20.68M	6.4%
139	Other Pneumonia	2,034	6.1%	6.4%	$21.81M	6.8%
753	Bipolar Disorders	3,977	11.9%	6.0%	$20.55M	6.4%

Heart failure (APR-DRG 194) is the top PPA reason in STAR+PLUS, while APR-DRG 751 (major depressive disorders) is the most common APR-DRG for PPAs in STAR. Overall, in 2021, major depressive disorder (ranked third), considered together with bipolar disorders (ranked fifth), and schizophrenia (ranked eighth), make SMIs account for over 16 percent of total PPA weight, and these PPAs had a combined cost over $50 million. Some form of mental health disorder was among the top ten PPA conditions for all managed care programs. Medication management is critical for the effective treatment of these conditions, which could reduce PPAs substantially.

PPRs

A PPR is a potentially avoidable readmission, clinically related to (and occurring within a specified time interval from) an initial hospital admission. The underlying reason for readmission must be related to the care rendered during or immediately following a prior admission. The EQRO used a 30-day readmission window to evaluate PPRs among Medicaid and CHIP MCOs. Of the approximately 430,000 admissions among Medicaid and CHIP members at risk for having PPRs in 2021, the EQRO identified over 18,000 (4.2 percent) as having PPRs. These account for $270 million in institutional costs paid. Table 61 summarizes 2021 PPR results by program.

Table 62. 2021 PPR results for Medicaid and CHIP

Measure	STAR	STAR+ PLUS	STAR Kids	STAR Health	FFS	CHIP
Admissions at Risk for PPRs	308,751	46,063	13,752	4,937	54,883	1,991
Initial Admissions Resulting in PPRs	6,485	7,232	1,710	926	1,654	140
Total PPRs	8,178	11,498	2,561	1,521	2,195	183

Measure	STAR	STAR+ PLUS	STAR Kids	STAR Health	FFS	CHIP
Total PPR Weights	6,956.20	14,676.47	3,313.92	1,019.15	2,988.29	141.62
Total PPR Expenditure ($Millions)	$83.40M	$116.39M	$41.16M	$12.57M	$16.58M	$1.78M
PPR Rate (Total PPR Weights per 1,000 Admissions)	22.53	318.62	240.98	206.43	54.45	71.13

The STAR+PLUS, STAR Kids, and STAR Health programs have the highest PPR rates, highlighting the need to improve care coordination in these populations with complex healthcare needs. The high percentage of obstetrical admission among the candidate admissions partially drives the low PPR rate seen in the STAR program. Obstetrical admissions typically have very low rates of readmission.

Table 62 shows the top five PPR reasons across Medicaid and CHIP in 2021 based on APR-DRG categories ranked by total PPR weight. Heart failure is the leading reason for PPAs and a leading driver of PPRs. The most important drivers of PPRs are the SMIs bipolar disorder, schizophrenia, and major depression. Together, these accounted for costs of over $63 million in 2021. Also, readmissions for these conditions are considered PPRs, regardless of the diagnoses for the initial admission, thus they contribute PPR weight to other categories (based on the initial admission). The high rate of mental health PPRs highlights the need to improve care coordination for co-occurring physical and mental health conditions.

Table 63. 2021 PPR top reasons

APR-DRG	Description	PPRs (n)	Percent of Total PPRs	Percent of Total PPR Weights	PPR Expenditures	Percent of Total PPR Expenditures
753	Bipolar Disorders	4,008	15.3%	8.1%	$25.51M	9.4%
720	Septicemia & Disseminated Infections	992	3.8%	7.6%	$18.77M	6.9%
750	Schizophrenia	3,319	12.7%	7.3%	$18.56M	6.8%
751	Major Depressive Disorders & Other or Unspecified Psychoses	3,598	13.8%	6.4%	$20.70M	7.6%
194	Heart Failure	860	3.3%	4.9%	$10.81M	4.0%

PPCs

PPCs are complications that arise during an inpatient stay because of improper care or treatment and do not represent the progression of the underlying disease. A single admission can have multiple complications, and an admission may be at risk for some PPC categories but not others. Unlike the other PPEs that rely on administrative condition groupings (i.e., EAPG and APR-DRG) to categorize events, 3M defined PPC conditions specifically for identifying PPEs. Appendix E provides definitions for the PPC groups. The EQRO evaluated over 400,000 admissions from Medicaid and CHIP that were at risk for PPCs in 2021. The identification of PPCs depends on accurate POA indicators. The EQRO and 3M found that many hospitals were inconsistent in POA coding, which could significantly bias results. To avoid bias, particularly as it would affect risk adjustment, 3M developed a systematic data quality evaluation that applies to data at the hospital level. The EQRO excludes all data from hospitals failing to meet data quality standards from PPC calculations. In the annual data quality

reports described in Protocol 5: Validation of Encounter Data Reported by MCOs and DMOs, the EQRO addressed the quality of POA data at the MCO level. Appendix E summarizes the screening criteria.

Table 63 shows PPC results by program. The 2021 PPC analysis identified 4,385 eligible admissions with at least one PPC. The total estimated cost of the STAR+PLUS PPCs (over $27 million) was much higher than the estimated cost of PPCs across all other managed care programs.

Table 64. 2021 PPC results for Medicaid and CHIP

Measure	STAR	STAR+ PLUS	STAR Kids	STAR Health	FFS	CHIP
Admissions at Risk for PPCs	254,777	49,745	13,067	3,932	79,646	1,643
Admissions with PPCs	1,115	1,943	102	8	1,216	1
Total PPCs	1,330	2,540	118	10	1,643	1
Total PPC Weights	936.16	2,188.70	119.43	11.55	1,411.51	1.37
PPC Rate (Total PPC Weights per 1,000 Admissions)	3.67	44.00	9.14	2.94	17.72	0.83

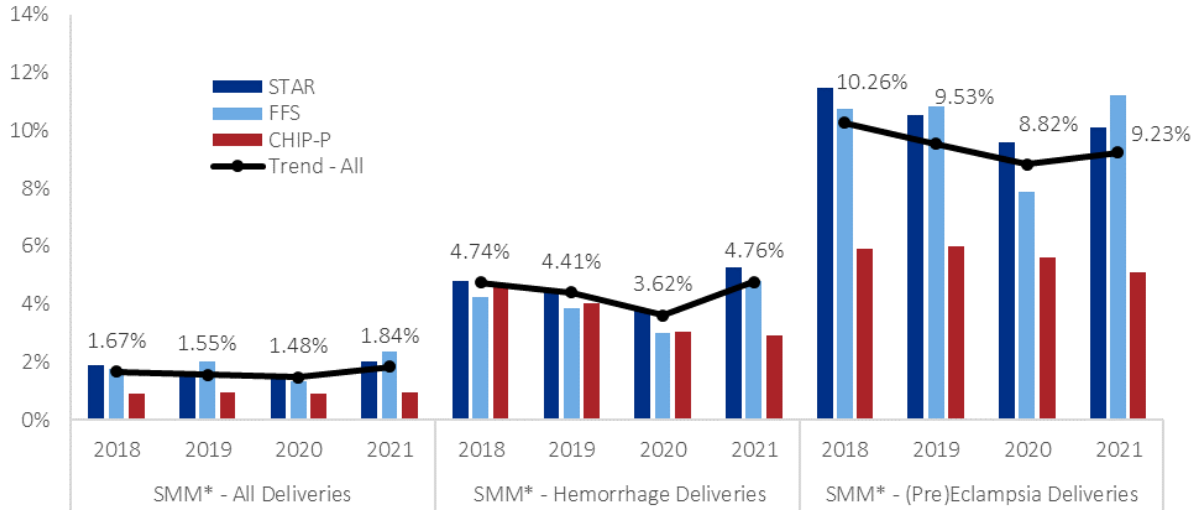
Renal failure (without dialysis) was the most common PPC for STAR+PLUS members, while septicemia/severe infections contributed the most PPC weights. Septicemia/severe infections and shock contributed the most weight among STAR members. The PPC rate was also high for FFS members. This group includes undocumented immigrants and others who may require emergency Medicaid services but determining why this population has more PPCs requires further investigation.

OAP and C-Section Deliveries

The EQRO identified 2021 deliveries for the OAP and C-Section measures following the method developed through the IAP program. The EQRO calculated overall SMM rates for these deliveries following the method, also developed through the IAP, which allowed the calculation of measures in the AIM maternal safety bundles from statewide administrative data. The OAP report includes measures of SMM among all deliveries, among deliveries with hemorrhage, and among deliveries with severe hypertension. The EQRO reported rates for all SMM cases and rates, excluding those SMM cases identified only by transfusion for all three cohorts. This approach is consistent with The Centers for Disease Control and Prevention (CDC) reporting on SMM (CDC, 2021) and ACOG recommendations (ACOG et al., 2016; Reaffirmed 2021).

Figure 7 shows the OAP measure rates (excluding SMM identified by transfusion only) for all deliveries, deliveries with hemorrhage, and deliveries with (pre)eclampsia in STAR, FFS, and CHIP Perinatal with overall trends for 2018 through 2021. Overall, rates increased over MY 2020, most notably for deliveries with hemorrhage where the rate is more consistent with rates before MY 2020. Rates were consistently higher in STAR than in CHIP Perinatal, most notably in (pre)eclampsia cases. Women with higher risk pregnancies having a greater chance of Medicaid eligibility may contribute to these differences. Although the numbers of deliveries are relatively small for the STAR+PLUS program, the percentage of deliveries with diagnosed (pre)eclampsia was higher than average (11.0 percent vs. 6.7 percent) and the SMM rate among those cases was also higher (19.4 percent).

Figure 7. OAP measure trends by program

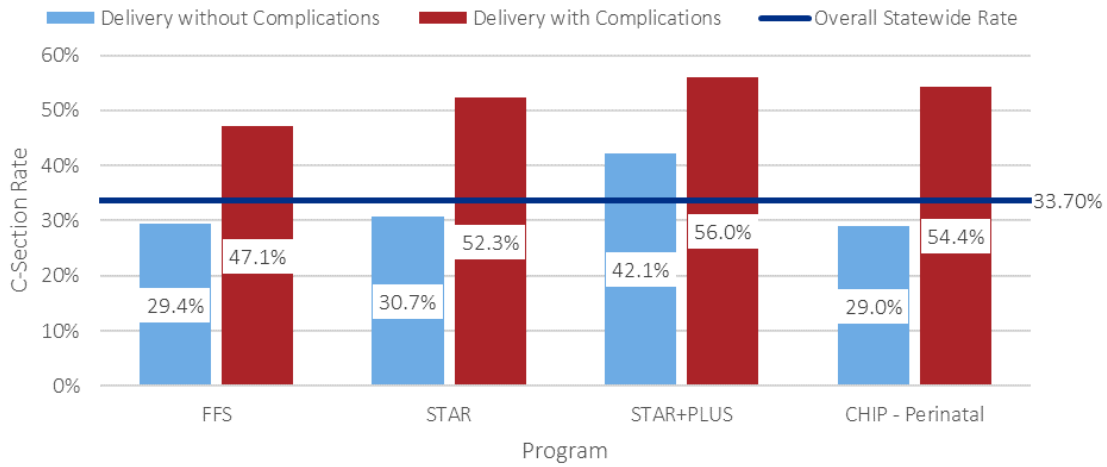


SMM* = Severe maternal morbidity, excluding cases identified by transfusion only.

Overall, deliveries with SMM (excluding those identified by transfusion only) incurred an average of 2.9 times the cost of deliveries without SMM, resulting in a total added expenditure of $35 million. In 2021, SMM rates varied geographically and by race/ethnicity, with non-Hispanic Black women having 1.83 times the SMM rate of Hispanic women, who have the lowest SMM rates. The overall SMM rates among STAR MCOs ranged from 1.6 percent to 2.9 percent.

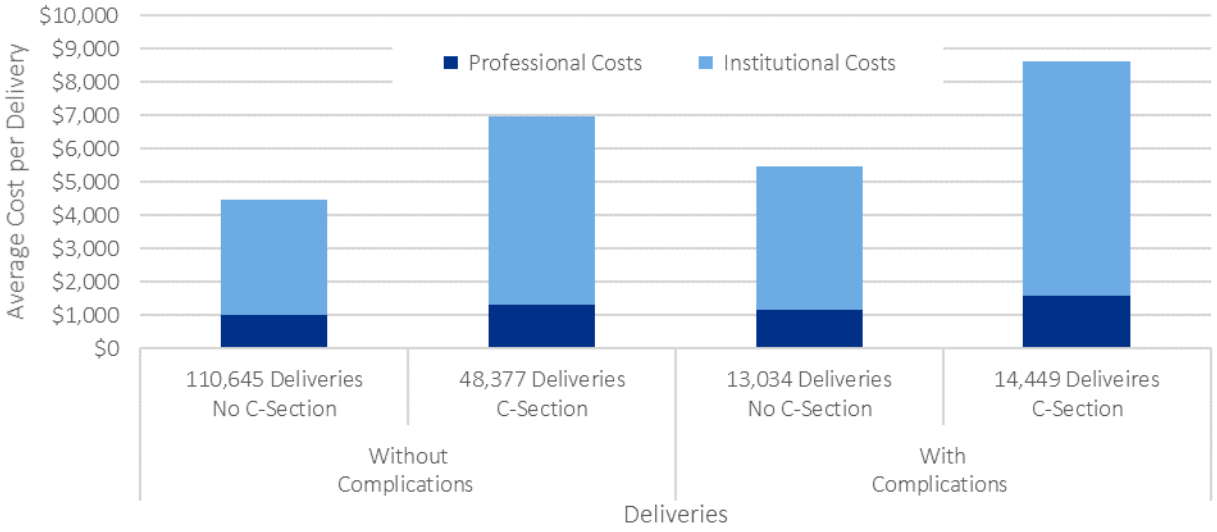
In 2021, the rate of C-Section deliveries in Texas Medicaid and CHIP was 34 percent. Figure 8 shows C-Section rates among deliveries with and without complications by program. C-Section rates varied by race/ethnicity and geography. Overall, Hispanic women had the lowest C-Section rate (33.6 percent), and non-Hispanic Black women had the highest rate (38.2 percent). Women in STAR+PLUS had the highest program rate (42.1 percent) of C-Sections for uncomplicated deliveries. However, complications were more common in STAR+PLUS (25.0 percent of deliveries vs. 14.7 percent overall). Other health concerns, not indicated by the delivery complication definition, may impact delivery decisions in this complex-needs group.

Figure 8. 2021 C-Section rates by program



Although more than half of deliveries with complications are by C-Section, only 23.0 percent of C-Section deliveries were with diagnosed complications. Over 48 thousand C-Sections were in deliveries without complications. Compared to uncomplicated deliveries without C-Section, these uncomplicated C-Section deliveries incurred additional costs totaling over $121 million. Figure 9 shows average C-Section and vaginal delivery costs, with and without complications.

Figure 9. 2021 average delivery costs by delivery type



In addition to examining SMM and C-Section rates, the EQRO looked at selected HEDIS measure results for women pregnant during 2021. Although performance on care measures for chronic conditions was generally worse for pregnant women, utilization was generally higher.

COVID-19 Pandemic Impacts

The EQRO noted changes in utilization patterns in February 2021 that may have been related to the COVID-19 pandemic and PHE. Although Covid-19 cases showed wave peaks in Texas in January and September 2021, the highest level of new cases in Texas was in January 2022. Vaccination rates, civic response, and for Medicaid, the hold on disenrollment had notable impacts on quality measures. A larger portion of members may have third party insurance, while maintaining Medicaid eligibility because of the PHE.

Relevance for Assessing, Quality, Access & Timeliness

Consistently monitoring performance on reliable measures of healthcare quality is critical to assessing managed care CHIP and Medicaid programs. Ensuring that rate calculations are comparable across programs, MCOs or DMOs, and over time are important to usability of measures in quality improvement initiatives and payment plans.

Many of the changes in measure rates for 2021 are related to access and utilization, or experienced substantial denominator changes which may have been related to the PHE. Continuing to monitor these measures throughout the PHE and recovery is the only way to continue making progress in quality improvement. Based on the 2021 QoC measure results, Texas is below national averages on measures of access, particularly for adults, and measures of utilization were below national averages for mental health and alcohol and drug services. Well-child care continues to be above national average in Texas, including immunization for adolescents, however

some vaccines for children have lower than average compliance. Measures related to management for chronic diseases show mixed results in Texas, with asthma medication management above average but diabetes and cardiovascular care below average. Texas programs may focus more on promoting quality access and timeliness of care for children. Although behavior health has received considerable attention in recent years, Texas is generally preforming below or near national averages on mental health QoC measures that address quality access and timeliness. Maternal health is another area where Texas has placed recent emphasis, however, maternal morbidity rates increased slightly in 2021, and uncomplicated C-Sections rates are still over 30 percent. To improve quality, access, and timeliness, monitoring QoC measures must inform development of interventions and then serve as the method of assessing success.

High rates of PPVs may represent a failure to provide adequate primary care to the patient. From 2017 through 2019, the overall PPV rate trended slightly upward, and the cost per PPV increased. However, in 2020 both at-risk ED visits and PPVs decreased. In 2021, at-risk ED visits and PPVs increased, but not to 2019 level. PPAs may result from inefficiencies in hospital or ambulatory care, poor access to outpatient care, or inadequate ambulatory care service coordination. From 2017 through 2019, the overall PPA rate trended slightly upward and the cost per PPA increased. However, in 2020 both at-risk admissions and PPAs decreased. In 2021, at-risk PPAs and PPAs increased, but not to 2019 level. For both PPA and PPV in 2021, CHIP and FFS PPE numbers decreased. According to CHIP enrollment data, CHIP member months decrease in 2021 compared to 2020, this may result in fewer PPE numbers. The STAR+PLUS, STAR Kids, and STAR Health programs have the highest PPR rates, highlighting the need to improve care coordination in these populations with complex healthcare needs.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 64 lists the key findings and recommendations from EQR activities associated with Protocol 7 and their relevance to the MCQS.

Table 65. Findings and recommendations associated with the calculation of performance measures

Category	Description
Finding(s)	In 2021, Hispanic Medicaid members had more outpatient utilization and less ED, inpatient, mental health, and alcohol and drug services use than both non-Hispanic Black and non-Hispanic White members.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should continue to explore QoC measure results across demographic and other member population groups to interpret results more clearly and better direct efforts to improve care for all Medicaid and CHIP members.
Finding(s)	URTI remains the most common reason for PPVs and the second most common PPVs, Non-Bacterial Gastroenteritis, Nausea & Vomiting, have doubled since 2020. SMIs account for more PPAs than heart failure, which is the leading single reason, and SMIs are the leading causes for PPRs.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	HHSC should investigate common reasons for PPEs to better understand what members are most at risk and to plan targeted interventions to reduce PPEs.

Category	Description
Finding(s)	SMM rates increased especially in cases with hemorrhage.
MCQS Goal(s)	Goals 1, 2, 3, 4
Recommendation(s)	HHSC should encourage initiatives to improve hospital patient safety, including the AIM bundles developed by ACOG and continue to investigate the underlying drivers of maternal health disparities
Finding(s)	Nearly 50 thousand C-Sections occurred in deliveries without complications. These represent substantial additional cost ($150 million) and potential risk.
MCQS Goal(s)	Goals 1, 2, 3, 4
Recommendation(s)	HHSC should consider a PIP or interventions to reduce C-Sections in uncomplicated deliveries.
Finding(s)	MCO performance across Performance Indicator Dashboard measures varies. Some MCOs achieve the high standard on more than 50 percent of measures, while others fail to meet the minimum standard on more than 40 percent of measures. FirstCare has the most measures failing to meet the minimum standard, while Driscoll has the most measures achieving high standards.
MCQS Goal(s)	Goals 1, 4, 6
Recommendation(s)	HHSC should continue leveraging the THLC portal (thlcportal.com) dashboards to help all Texas Medicaid and CHIP stakeholders identify and understand trends in healthcare quality across state programs.

Protocol 9: Conducting Focus Studies of Health Care Quality

Protocol Overview & Objectives

Protocol 9 outlines the steps involved in identifying a topic, collecting the data, analyzing, and interpreting results for focused studies. States may direct their EQROs to conduct focus studies for quality improvement, administrative, legislative, or other purposes.

EQR Activities

During SFY 2022, the EQRO conducted multiple studies of Texas Medicaid and CHIP programs, initiatives, and areas of specific interest to the state. Table 65 summarizes the studies, including a major focus study, quarterly topic reports (QTRs), and several issue briefs. Short synopses of the major studies follow. At the end of the Protocol 9 section, the major report findings and recommendations are summarized in Table 66 (STAR Kids Focus Study), Table 67 (QTR 1), Table 68 (QTR 2), and Table 69 (QTR 4).

Table 66. Focused studies conducted in SFY 2022

Study	Description
STAR Kids Focus Study: *Caregiver Experience of Care for Members in the Medically Dependent Children Program*	In 2019, Texas passed S.B. 1207 86(R), which mandates Texas Medicaid to conduct studies to improve healthcare access and quality for STAR Kids MDCP members. This report describes the methods and findings of a mixed-methods study conducted by the EQRO to address these evaluation needs.
QTR 1: *Social Determinants of Maternal Health Outcomes and Health Services Utilization in 2019 and 2020 among Women in Texas Medicaid and CHIP*	This study combines Texas Medicaid encounter data and county-level Social Vulnerability Index[8] data to examine pregnancy-associated outcomes, mental health diagnoses, and patterns of perinatal care utilization among women in Texas Medicaid who gave birth in 2019 or in 2020.
QTR 2: *Health Disparities in Texas Medicaid Managed Care Programs in the Context of Social Determinants of Health*	This study examines the association between social vulnerability, race/ethnicity, rurality, and gender and selected QoC measures for Medicaid members in 2019. It focused on preventive care for children, adolescents, and women, effective management of chronic and mental health conditions, and healthcare safety.
QTR 3: *Participation in DM Programs in Texas Medicaid and CHIP* *In Review*	This study examines DM program participation and the factors influencing Medicaid member participation in Texas in 2019–2021. It combined MCO-reported quantitative data on eligible and active DM members with thematic analysis of MCO survey responses.
QTR 4: *Rider 36-Texas Medicaid Managed Care Denials and Appeals Process*	This study examines the denial and appeals process within MCOs providing coverage for STAR Kids, STAR Health, and STAR+PLUS.
Issue Brief 1: *Patterns of Midwife-Assisted Delivery among Women Enrolled in Texas Medicaid and CHIP*	This brief examines encounter data associated with midwife-attended deliveries in 2020, among women in Texas Medicaid, to help HHSC better understand patterns of midwife utilization.

[8] Information on the CDC/ATSDR Social Vulnerability Index is at: https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

Study	Description
Issue Brief 2: *Adult Dental Services in Medicaid: Opportunities for Improving Health Quality for Texans*	This brief examines the importance of comprehensive adult dental care, current state Medicaid programs, and their potential to impact adult oral health.
Issue Brief 3: *Driving Texas Medicaid Quality Improvement with Health Data: An Overview of the Challenges and the Road Ahead*	This brief explores the current state of Texas Medicaid health data collection, storage, exchange, and utilization for quality improvement. The report identifies limitations in the current system, and looks at developing improvements.

STAR Kids Focus Study: Caregiver Experience of Care for Members in the Medically Dependent Children Program

This focus study is a continuation of the SFY 2021 mixed-methods study to assess the evaluation needs of STAR Kids. While the earlier study uncovered findings related to network adequacy, care coordination, and member and caregiver characteristics and resources, low participation and under-representation of Hispanic and non-Hispanic Black caregivers were limiting. This follow-up study employed several strategies for improving caregiver participation and collected additional information on the facilitators and barriers to care for STAR Kids caregivers. The summary of findings and recommendations is in Table 65. The study had three main objectives:

1. Identify the most important services for families of STAR Kids members in MDCP.
2. Identify the most common barriers and facilitators to receiving these services
3. Explore the context in which families experience barriers and facilitators to care.

As in the prior-year focus study, caregivers noted insufficiencies in the number of network providers in their local area, particularly for home nursing and therapies. Issues with accessing and replacing medical supplies were also common, sometimes leading caregivers to pay out-of-pocket or reuse supplies. Service coordination by the STAR Kids MCO was important in caregiver experiences and satisfaction with care. Many caregivers took on the role of primary coordinators of their child's care, which led to stress and burden. Most caregivers expressed satisfaction with the STAR Kids annual assessment, although caregivers had mixed opinions on the assessments conducted virtually during the COVID-19 pandemic. Eligibility for programs and services, authorizations, and approvals were salient topics for caregivers. Some caregivers questioned the need for requalification for MDCP, given the severity of their child's condition. Caregivers also expressed fears of losing eligibility due to underutilization of specific service types and related stressful experiences reapproving services in cases where they had lost their eligibility for MDCP. The study revealed more barriers than facilitators to care. Caregivers with positive experiences accessing care described having good communication and relationships with providers, good coordination of care between and among providers, and available and attentive service coordinators. These factors helped caregivers obtain referrals and approvals and navigate the eligibility process. System-level factors such as the co-location of providers in a single facility and having third-party insurance were also facilitators to care.

QTR 1: Social Determinants of Maternal Health Outcomes and Health Services Utilization in 2019 and 2020 among Women in Texas Medicaid and CHIP

This study combines Texas Medicaid encounter data and county-level Social Vulnerability Index (SVI) data for women in Texas Medicaid who gave birth in 2019 or 2020. The focus of the study was the association between

pregnancy-associated outcomes, mental health diagnoses, and patterns of perinatal care utilization. The summary of findings and recommendations is in Table 66. The study had three main objectives:

1. Identify and describe significant differences in the frequency of maternal delivery outcomes, including severe morbidity and C-Section deliveries (with and without complications) for women in STAR and CHIP-Perinatal programs.
2. Identify and describe the occurrence of postpartum depression (PPD) diagnoses and patterns of postpartum maternal health services utilization (including postpartum care visits, emergency department visits, and mental health visits) in the first six months after delivery for women in STAR.
3. Use the results of the SVI analysis and an environmental scan of the literature on postpartum care among women in Medicaid to identify potential barriers to care among mothers and make recommendations on approaches that HHSC could use to improve access to and the quality of postpartum care for women in Texas Medicaid.

The EQRO used descriptive statistics and binomial logistic regression models to assess the relationship between SVI quintile and SMM, (pre)eclampsia, hemorrhage, C-sections, and C-sections with complications among deliveries to mothers enrolled in STAR and CHIP-P, and PPD diagnoses for women enrolled in STAR at two, four, and six months after delivery. All prenatal logistic regression models included maternal age at delivery, race-ethnicity category, rurality, HEDIS-PPC prenatal care compliance, SA, and MCO. All postpartum logistic regression models included maternal age at delivery, race-ethnicity, rurality, SMM status, and HEDIS-PPC postpartum care compliance as covariates.

The EQRO conducted a systematic scoping review to identify and map the available policy information on perinatal care utilization among women in Medicaid, focusing on the social determinants of pre-and postpartum care utilization. This information provided context for discussing the results and summarizing the strategies used by other states to improve the quality of pre-and postpartum care and access to timely PPD screening among women in Medicaid.

All the pregnancy and delivery outcome measures (SMM, (pre)eclampsia, hemorrhage, and C-section) displayed statistically significant variation on at least one of the sociodemographic factors (race-ethnicity, delivery age, rurality). The odds of SMM and (pre)eclampsia were higher among non-Hispanic Black women than non-Hispanic White women. These results align with prior research on the prevalence of SMM in the US, among women in Texas, and women in Texas Medicaid and CHIP (CDC, 2020; DSHS, 2022).

The results also indicate variation in the rates of SMI diagnoses and the odds of PPD diagnoses. Among STAR mothers, the SMI rate was highest for Non-Hispanic White women, while for CHIP-P mothers, the SMI rate was slightly higher for Hispanic women than for other races-ethnicities. Variations in these rates are harder to interpret and suggest the need for additional research. Non-Hispanic White women had higher rates of SMI diagnoses and increased odds of PPD diagnoses than non-Hispanic Black mothers. However, this may result from underdiagnoses due to differences in the availability or effectiveness of screening for mental health disorders among minorities in Medicaid and CHIP (MACPAC, 2021; SAMHSA, 2015). Fewer women received mental health treatment than had diagnosed SMI. HEDIS-PPC prenatal and postpartum care compliance rates were higher for older mothers and lower for non-Hispanic Black mothers than other race-ethnicity groups.

Prenatal care compliance rates were highest in rural areas, while postpartum care compliance rates were highest in metropolitan areas. Compliance with HEDIS-PPC prenatal and postpartum care measures was

significantly associated with positive health outcomes, including lower odds of hemorrhage and (pre)eclampsia. Compliance with HEDIS-PPC prenatal and postpartum care measures was also associated with higher odds of PPD diagnosis. The association between SVI quintile, pregnancy, delivery outcomes, and maternal care utilization is also unclear and worth additional research.

While SVI quintiles were significantly associated with variation in the odds of several measures, the results varied. In some cases, increases in SVI percentiles were associated with increases in the odds of poor health outcomes. In other cases, they were associated with increased odds of positive health outcomes. This contradiction may result from the level of analysis used in the study. This study relied on county-level data on SVI rather than census tract-level data and may lack the granularity needed to identify clear patterns between increases in social vulnerability and health outcomes among mothers in Texas Medicaid and CHIP. Understanding the relationship between social vulnerability and maternal health and delivery outcomes will require additional research.

Average county-level COVID-19 caseloads were significantly associated with variation in the odds of several health and service utilization outcomes in the study, including C-sections and hemorrhage. While the odds of PPD diagnoses did not vary based on the average COVID-19 caseload during the postpartum period, the odds of PPD diagnosis did vary significantly between the 2019 and 2020 cohorts. Identifying whether other COVID-related changes in health policy and access to health services, such as increased telehealth availability, were significantly associated with increases in PPD diagnoses and other changes in maternal health and service utilization outcomes among women in Texas Medicaid and CHIP will require additional research.

QTR 2: Health Disparities in Texas Medicaid Managed Care Programs in the Context of Social Determinants of Health

This study examines the association between social vulnerability, race/ethnicity, rurality, and gender and healthcare quality in Texas Medicaid. It focused on preventive care for children, adolescents, and women, effective management of chronic and mental health conditions, and healthcare safety. The summary of findings and recommendations is in Table 67. The study had three main objectives:

1. Examine disparities in preventive care for children, adolescents, and women, by gender (when applicable), race/ethnicity, rurality, and social vulnerability.
2. Examine disparities in management of chronic and mental health conditions by gender, race/ethnicity, rurality, and social vulnerability.
3. Examine disparities in healthcare safety across gender, race/ethnicity, rurality, and social vulnerability.

The EQRO conducted univariate, bivariate, and multivariable analyses to describe disparities in members' compliance with QoC measures across patient characteristics and social vulnerability. First, the EQRO described the sociodemographic characteristics of the population for each QoC measure. Second, the EQRO estimated the probability of compliance with each QoC measure across different member characteristics, i.e., gender, race-ethnicity category, rurality, and SVI quintiles, and described them with crosstabulations and figures. Finally, the research team performed multivariable logistic regressions to estimate (a) whether compliance with each QoC measure was significantly associated with members' gender, race-ethnicity, and rurality and (b) whether increases in the SVI score were associated with changes in compliance, by gender, race-ethnicity, and rurality categories. The multivariable analyses controlled for other potential confounding variables (when applicable), including member age, Medicaid program, MCO, and SA.

The analysis showed that, even within a vulnerable population such as Texas Medicaid enrollees, there were significant differences in terms of SVI. The average SVI score for the population of Texas is 7.07. The SVI for the population in the STAR, STAR Kids, and STAR+PLUS programs, on average, is higher (8.4). Half of the Texas Medicaid population has SVI scores that range between 7 and 10. Therefore, analyzing differences in healthcare quality across SDoH dimensions for Texas Medicaid members is relevant for addressing health disparities. Overall, the statistical analysis of gender did not detect significant differences in healthcare quality by gender when controlling for SVI score. However, the results suggested that higher social vulnerability (i.e., increases in the SVI score) was associated with significant reductions in the healthcare quality among female members for three measures. Hispanic members were the were the largest racial/ethnic group for all the selected QoC measures analyzed in this study. In terms of compliance with QoC measures, the results of the statistical analyses showed significantly higher odds of compliance amongst Hispanics for non-Hispanic White members for two well-care measures (W15, and AWC) when controlling for SVI score. The other QoC measures did not show significant differences for non-Hispanic White members. The results of the analysis of the race-ethnicity categories indicated that, all else equal, as the SVI score increased, the odds of complying with the QoC measures did not change significantly for Hispanic members, except for adolescent well care (AWC), for which the odds of having at least one visit increased with higher SVI scores, and for asthma medication ratio (AMR), for which the odds of compliance decreased.

The simple descriptive statistics showed that members living in rural and micropolitan areas had higher compliance rates with diabetes care (CDC), controlling high blood pressure (CBP), and asthma medication management (AMM). However, the results of the rurality analysis showed decreased compliance with increased SVI score only for one measure. Compliance was lower among non-metropolitan residents for two well-care measure (W15, AWC), HEDIS-PPC postpartum care, and FUH, and higher for hospital complications (PPC), all representing worse healthcare quality.

This study's results suggest that social vulnerability could be relevant for determining differences in healthcare quality across non-metropolitan residents. However, the interaction between rurality and social vulnerability deserves further investigation. When the EQRO accounted for demographic, Medicaid membership, and other relevant SDoH dimensions, the evidence suggested that members in rural and micropolitan areas had lower compliance on W15 as the average social vulnerability of their census tract increased. However, the EQRO observed that PPCs were negatively associated with higher SVI scores, indicating that patients with higher levels of social vulnerability had lower odds of hospital complications. This negative association deserves further investigation to understand what it reflected and whether it applied to all non-metropolitan residents or varied by SDoH within such populations.

QTR 3: Participation in DM Programs in Texas Medicaid and CHIP

This study examines DM program participation and the factors influencing Medicaid member participation in Texas in 2019–2021. It combined MCO-reported quantitative data on eligible and active DM members with thematic analysis of MCO survey responses. This study was still in review as of December 2022.

QTR 4: Rider 36 – Texas Medicaid Managed Care Denials and Appeals Process

This study examines best practices, member appeals and state fair hearing (SFH) request outcomes, and MCO compliance with federal regulations in Texas Medicaid managed care programs. The summary of findings and recommendations is in Table 69. The study had three main objectives:

1. Identify best practices and outcomes in other states related to the Medicaid managed care denial and appeals process.
2. Examine the percentage of denials Medicaid MCOs upheld or overturned on appeal between January 1, 2014, and December 31, 2020, by MCO and Medicaid program.
3. Examine MCO compliance with the federal code of regulations for the grievance and appeals process regarding the qualifications of hearing officers, the timeliness of the review, and the denial notification process.

The EQRO conducted a literature review to assess best practices using guidance from Arskey and O'Malley (Arksey & O'Malley, 2005) to identify best practices related to Medicaid MCO appeals and denials processes in other states. To examine the outcomes of member appeals and SFH requests, the EQRO summarized four years (October 1, 2017, through December 31, 2020) of appeal and SFH data from the nine MCOs that provide STAR Kids coverage. In addition, the EQRO collected and summarized seven years (January 1, 2014, through December 31, 2020) of appeal and SFH data from the five MCOs that provided STAR Health and/or STAR+PLUS coverage during the study period. To assess MCO compliance with federal regulations, the EQRO identified the federal regulations related to the qualifications of hearing officers, timeliness of the appeal review process, and the denial notification process and utilized the results of the mandatory compliance reviews conducted in previous years for each MCO included in the study. The EQRO extracted compliance scores for the identified regulations from the most recent compliance review and factored in all subsequent follow-up correspondence to obtain updated policies and procedures for each MCO to compile a compliance score for the applicable regulations.

The study indicated that while 42 C.F.R. § 438, Subpart F (2020) outlines the requirements for the Medicaid managed care appeals process and reporting structure, how states report appeals data varies. Further, MCO-reported data is not always accurate, indicating a need for additional efforts to improve reporting overall. A key finding in this study was the extent of the data discrepancies the EQRO identified in the MCO-reported data. As a result, not all the findings related to the outcomes of appeals and SFH requests in this report accurately reflect the true percentages of outcomes, which indicates a need for management of the quality of data reported by the MCOs. For MCO compliance with the federal regulations for the appeals process, most MCO policies and procedures had a high level of compliance with the federal regulations. However, documentation from HealthSpring and from Superior were not fully compliant with the regulations for timeliness of the review process. Further, documentation from Aetna, CookCHP, HealthSpring, Superior, and UHC were not fully compliant with all the regulations related to the notification process for denials.

Relevance for Assessing Quality, Access & Timeliness

Each study has relevance to assessing quality, access, and timeliness. For example, the STAR Kids Focus Study examined the barriers and facilitators to receiving MDCP Care, with findings directly applicable to improving healthcare quality and access to care. The study on health disparities in QoC measure results has implications for understanding how SDoH and NMDOH affect the quality of care and the measurement of healthcare quality. The Rider 36 study is directly relevant to assessing the quality of care Texas Medicaid members are receiving.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 66, Table 67, Table 68, and Table 69 list the key findings and recommendations from major reports included in the EQR activities associated with Protocol 9, and their relevance to the MCQS.

Table 67. Findings and recommendations from the SFY 2021 STAR Kids Focus Study

Category	Description
Finding(s)	MDCP caregivers reported having low availability of home therapy, personal assistance services, and nursing providers, particularly for those living in rural areas. In addition to network adequacy issues, caregivers attributed these unmet needs to high provider turnover, provider time constraints, and low provider pay.
MCQS Goal(s)	Goals 1, 3, 5,6
Recommendation(s)	STAR Kids MCOs should continue to focus network adequacy efforts in rural areas. Potential strategies may include: (1) Sharing best practices in the recruitment of home health providers with other MCOs in collaborative contexts, such as stakeholder and advisory group meetings or jointly conducted performance improvement projects; and (2) Establishing longer-term solutions to ensure local availability of home health providers in rural areas, such as provision of local training and certification programs. STAR Kids MCOs should ensure that home health providers have incentives to serve members in hard-to-reach areas. One potential strategy is to include provisions in contracts with home health agencies to ensure: (1) adequate provider reimbursement for travel expenses to hard-to-reach areas; and (2) availability of hourly pay supplementation for providers to account for lower caseloads that result from having to travel long distances to reach clients. These provisions may include cost-sharing between the MCO and the home health agency to cover these expenses and supplements. Texas Medicaid should authorize an increase in pay rates for personal assistance service providers to be more competitive with other entry-level community jobs. Texas Medicaid should ensure flexibility to allow caregivers to increase pay rates for home health providers when a member is not using authorized hours up to the total estimated costs of the original service plan.
Finding(s)	Caregivers described challenges in navigating the complexity of processes for eligibility determination, approvals, and authorization for services and finding new providers and supply companies. These challenges contributed to caregiver stress and burden and led to gaps in care for members.
MCQS Goal(s)	Goals 1, 2, 5, 6
Recommendation(s)	STAR Kids MCOs should build on efforts to develop and disseminate resources for caregivers that explain processes for eligibility determination, approvals, and authorization for services in accessible language and multiple formats (e.g., mail- and web-based). These resources should include information on the individuals and organizations caregivers can reach out to with specific questions and how to reach them. STAR Kids MCOs should revisit policies for updating provider network directories to ensure that updates, including the lists of active providers who accept Medicaid and treat members with complex conditions, are frequently occurring and distributed to families of STAR Kids members in formats that are accessible to them.

Category	Description
Finding(s)	Many caregivers report functioning as their child's primary care coordinator for specific services, such as prescription medicines and medical supplies, leading to gaps in care for members and increasing stress and burden for caregivers.
MCQS Goal(s)	Goals 2, 6
Recommendation(s)	STAR Kids MCOs should enhance the training of service coordinators to emphasize the challenges caregivers face in accessing medications and medical supplies for their children. Training materials and service coordination policies should address potential scenarios experienced by caregivers, such as being drawn into the coordination process by providers, paying out-of-pocket for medications and supplies, having to reuse supplies, and being unable to locate care to address highly specialized needs. STAR Kids MCOs should consider or build upon programs to provide STAR Kids MDCP caregivers with services that reduce their coordination and travel burden, such as automatic medication refills, home delivery of medications, and delivery tracking for supplies. Texas Medicaid and STAR Kids MCOs should conduct periodic reviews to identify caregivers at high risk of stress or burden due to care coordination and then conduct outreach with these caregivers to provide special assistance. These reviews may include: (1) Identifying caregivers who have recently experienced changes to their MCO service coordinator; (2) Focusing on MCOs or service areas with higher rates on caregiver burden measures calculated from the STAR Kids Screening and Assessment Instrument (SK-SAI); (3) Using member-level SK-SAI data to identify individual caregivers with high level of burden.
Finding(s)	Low representation of Hispanic caregivers, who comprise the majority of STAR Kids MDCP, limited the study. Furthermore, some interviews with Hispanic caregivers lacked sufficient MCQS Goal(s) detail to ensure a thorough understanding of their experiences and satisfaction with care.
MCQS Goal(s)	Goals 1, 2, 5
Recommendation(s)	HHSC should consider authorizing a study conducted by the EQRO that focuses on Hispanic caregivers of STAR Kids MDCP members and leverages multiple data sources to ensure thoroughly understand the experiences of this important subgroup. This study might include the following: • Stratification of study participants according to third-party insurance status will allow for more reliable measures of differences in experience between those who do and do not have third-party insurance. • Use caregiver survey or SK-SAI data to quantitatively assess differences in experience with access to and quality of healthcare according to third-party insurance status, MCO, SA, and other individual, geographic, and service delivery factors. • Supplementation of quantitative data with qualitative interviews of Hispanic caregivers, incorporating more time to identify appropriate bilingual (English/Spanish) interviewers, train them in rigorous qualitative data collection methods, and conduct regular quality monitoring of interview data and feedback.

Table 68. Findings and recommendations from the study on social determinants of maternal health

Category	Description
Finding(s)	Compliance with HEDIS-PPC prenatal and postpartum care measures was significantly associated with positive health outcomes, including lower odds of hemorrhage and (pre)eclampsia. Compliance with HEDIS-PPC prenatal and postpartum care measures was also associated with higher odds of postpartum depression diagnosis.
MCQS Goal(s)	Goals 1, 5, 6
Recommendation(s)	HHSC and the MCOs should continue efforts to improve access to prenatal and postpartum services for women in Medicaid and CHIP. These efforts should include identifying and responding to the barriers to access for minority women and women in rural areas.
Finding(s)	Mothers in micropolitan and rural counties had higher odds of PPD diagnoses than mothers in metropolitan counties.
MCQS Goal(s)	Goals 1, 3, 6
Recommendation(s)	HHSC should conduct additional research on maternal mental health to identify the causes of disparities in maternal mental health screening, maternal mental health outcomes, and barriers to effective maternal mental health treatment.
Finding(s)	Average county-level COVID-19 caseloads were significantly associated with variation in the odds of several health and service utilization outcomes, including C-Section deliveries and hemorrhage.
MCQS Goal(s)	Goals 1, 3, 6
Recommendation(s)	HHSC should consider additional research studies examining how the onset of the COVID-19 pandemic affected access to health services for managed care members across different Medicaid programs.
Finding(s)	While the odds of PPD diagnoses did not vary based on the average COVID-19 caseload during the postpartum period, the odds of PPD diagnosis did vary significantly between the 2019 and 2020 cohorts, with higher odds of PPD diagnoses in 2020.
MCQS Goal(s)	Goals 1, 2, 3, 5
Recommendation(s)	HHSC should conduct additional research to identify whether other COVID-related changes in health policy and access to health services, such as increased telehealth availability, were significantly associated with increases in PPD diagnoses and other changes in maternal health and service utilization outcomes among women in Texas Medicaid and CHIP.
Finding(s)	The odds of SMM and (pre)eclampsia were higher among non-Hispanic Black women than non-Hispanic White women, consistent with the broader literature on racial and ethnic disparities in SMM.
MCQS Goal(s)	Goals 1, 2, 3, 6
Recommendation(s)	HHSC and the MCOs should continue efforts to improve the quality of maternal care and access to health services for minority women and women with high-risk pregnancies. One evidence-based approach to care that HHSC could consider is the Centering Pregnancy model, that some other state Medicaid programs have adopted with some success.

Table 69. Findings and recommendations from the study on health disparities in Texas Medicaid managed care programs

Category	Description
Finding(s)	Incomplete sociodemographic information for members limits the ability to identify and tailor interventions. Up to 38 percent of the population in some of the QoC measures for STAR and STAR Kids programs were in the "Other/Unknown" racial and ethnic category. The heterogeneity in the Other/Unknown category poses challenges for identifying race-ethnicity-based differences among members in these groups.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should work with the MCOs to identify the source of missing sociodemographic information in the enrollment files and define a strategy to improve the data quality. The EQRO also suggests defining, pilot-testing, and operationalizing different classifications of ethnic and racial categories to allow for more precise identification of the members that the dataset currently classifies as a homogeneous category.
Finding(s)	The results of this study suggest the need for more in-depth analyses of QoC disparities by focusing on specific population groups. A narrower focus into specific SDoH dimensions could help HHSC better identify the needs of Medicaid members and improve their quality of care, thus reducing disparities. For example, understanding the relationship between different SDoH dimensions and QoC measures within the rural population can be crucial to improve the design of interventions that address disparities for this group.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	In addition to the current analyses using composite SDoH scores, HHSC should conduct additional analyses on disparities in QoC measures based on SDoH dimensions or variables, such as housing instability, food insecurity, rurality, and access to public transportation. The EQRO recommends that HHSC continue to identify ways to collect detailed and systematic information about specific SDoH for Texas Medicaid enrollees. This approach would help HHSC discern the most relevant issues for different members and prioritize targeted solutions.
Finding(s)	Non-Hispanic Black members displayed lower compliance rates than non-Hispanic White members for almost all QoC measures. In particular, non-Hispanic Black members had significantly lower odds of compliance with CBP.
MCQS Goal(s)	Goals 1, 2, 5
Recommendation(s)	HHSC should select one or more sociodemographic groups with lower compliance with QoC measures, identify the SDoH-related barriers to care and develop evidence-based intervention strategies to reduce disparities in healthcare quality between members. To accurately analyze disparities by race/ethnicity, sampling strategies for hybrid measures would need to stratify the population by race and ethnic groups and oversample smaller demographic groups. Given the additional burden this may create for MCOs, a viable alternative for the state is to invest in a Health Information Exchange system so that desired data is available and accessible electronically. HHSC should consider working with the MCOs to design and implement focused interventions to improve the effective management of chronic and mental health conditions and healthcare quality for non-Hispanic Black members.

Category	Description
Finding(s)	The calculation of hybrid HEDIS measures CBP and CDC, relies on medical record data from a random sample of Texas Medicaid members sampled at the MCO level. This approach aligns with NCQA standards; however, it can create challenges when extrapolating results to a non-state level and may lead to the underrepresentation of vulnerable populations.
MCQS Goal(s)	Goals 1, 3, 4
Recommendation(s)	HHSC should consider expanding its data collection structure and integrating Health Information Exchange systems for hybrid measures. This approach will increase the coverage and accuracy of health quality measures, especially for underrepresented sub-populations.
Finding(s)	This study found that the frequency of compliance on the AWC measure was higher among all other race-ethnicity categories than it was among non-Hispanic White members. Further, compliance increased as the SVI increased. This pattern is at odds with the other QoC measures, for which higher vulnerability is associated with lower compliance.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should conduct additional studies of patterns of compliance on the AWC measure. HHSC should focus on identifying whether the pattern revealed in this study reflects more complex healthcare needs among vulnerable members rather than the better quality of care they receive.
Finding(s)	QoC measures reflect differences in patients' needs and differences in access to and the provision of healthcare. This study revealed significant disparities in QoC measure results based on the SVI score and sociodemographic category, with increased disparity among members with higher SVI scores. SDoH impacts people's healthcare needs and healthcare-seeking behavior, but it may also affect how healthcare providers meet patients' needs and manage their care.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should conduct a more in-depth examination of how SDoH affects access to and the provision of care, including the interaction between healthcare workers and beneficiaries, and the management of routine activities such as contacting and monitoring patients for scheduling follow-up visits and managing care. HHSC should also work with the MCOs to develop methods to identify and share MCO and provider best practices for a) collecting systematic data on SDoH, b) addressing SDoH-related disparities and barriers to healthcare provision, c) identifying resources that could facilitate the management of healthcare for HHSC beneficiaries across the social vulnerability spectrum.

Category	Description
Finding(s)	While this study identified some of the associations between SDoH (as measured through SVI), examining the causal relationships between SDoH dimensions and quality of healthcare is essential to identify what the healthcare system needs to address and to develop evidence-based strategies for reducing SDoH-related disparities.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should consider utilizing methods that allow for causal inference in more studies on the effects of SDoH on the quality of healthcare. For example, HHSC could pilot specific training programs for healthcare workers to meet SDoH-related needs by randomly selecting from its partnering providers. Similarly, it could test alternative approaches to meet SDoH-related member needs through experimental and quasi-experimental program evaluation designs, such as the provision of vouchers (randomized or staggered) to improve housing conditions or access to transportation and monitoring improvements in QoC measures

Table 70. Findings and recommendations from the study on Rider 36

Category	Description
Finding(s)	States employ a variety of practices to oversee the Medicaid MCO appeal process. Starting in 2020, Texas required MCOs to submit more details of the appeals data, which will allow Texas to conduct and report more in-depth summaries of MCO appeals data (HHSC, 2022c, Chapter 24.5.6). However, some states reportedly conduct more in-depth studies to improve MCO reporting of appeal data, validate MCO-reported data, and identify the types of services denied and reasons for the denials (Qlarant, 2021a, 2021c).
MCQS Goal(s)	Goals 1, 4, 5
Recommendation(s)	HHSC should consider conducting a more in-depth review of the updated MCO-reported quarterly appeals data to identify the most common types of services denied and overturned upon member appeal and the reason for the denials. This approach will allow a more meaningful interpretation of the appeals and SFH outcomes. HHSC should calculate the number of appeals per 1,000 members to compare the number of appeals between MCOs. This approach should enable meaningful comparisons of how outcomes of the appeals process related to the volume of appeals in relation to MCO size. HHSC should consider identifying how the impact of the appeals and SFH process and decisions impact member satisfaction.
Finding(s)	The EQRO reviewed seven years of MCO-reported appeals data for this report and identified opportunities for improvement in MCO reporting. The EQRO identified data discrepancies in the MCOs' first data submission and provided each MCO with a detailed summary of the discrepancies and the exact information that needed to be corrected. However, almost all MCOs resubmitted the appeal data with outstanding data discrepancies across all measurement years. As a result, not all the findings in this report related to the outcomes of appeals and SFH requests accurately reflect the true percentages of outcomes.
MCQS Goal(s)	Goals 1, 4, 5

Category	Description
Recommendation(s)	HHSC should work with the MCOs to improve their data reporting to ensure accurate data reporting. HHSC should conduct a record review of a random sample of MCO appeals documentation to validate the quarterly MCO-reported appeals data.
Finding(s)	MCOs had high compliance with the federal regulations for the appeals process. However, HealthSpring and Superior were not fully compliant with all regulations related to the timeliness of the review process. In addition, Aetna, CookCHP, HealthSpring, Superior, and UHC were not fully compliant with all the regulations related to the notification process for denials. Further, the compliance review results are based on MCO documentation in the policies and procedures. Therefore, the results do not indicate how often and to what extent each MCO meets the requirements of the regulations in practice.
MCQS Goal(s)	Goals 1, 4, 5
Recommendation(s)	MCOs that are not fully compliant with all applicable regulations for the appeals process should update all policies and procedures to ensure full compliance with the timeliness of the review and notification of denials. HHSC should conduct a record review of the MCO universe of appeals documentation to identify the extent to which MCOs comply with the regulations in practice and compliance levels determined based on the current document review of MCO policies and procedures.

Protocol 10: Assist with Quality Rating of MCOs and DMOs

Protocol Overview & Objectives

As of December 2022, CMS has not published guidance for Protocol 10, however, the EQRO participates in several activities related to quality rating. The EQRO presents performance measures (see Protocol 7: Calculation of Performance Measures) with ranking and comparison to benchmarks on the THLC portal (thlcportal.com). In addition, MCOs are held accountable for maintaining performance on a range of measures that are part of the Performance Indicator Dashboards. The EQRO assists in measure selection, calculates minimum standards, and presents performance details and summaries on the THLC portal (thlcportal.com). To help satisfy the requirements of Tex. Govt. Code § 536.051, the EQRO assisted HHSC in developing the P4Q programs to assign a percentage of premiums paid to MCOs and DMOs based on performance. Selected measures address areas of care with both high significance and capacity for improvement. In another important activity in this area of quality rating, the EQRO develops annual MCO report cards to support the state's ongoing efforts to improve health care quality by supporting consumer choice in Medicaid and CHIP.

EQR Activities

Quality Measure Reporting

The THLC portal (thlcportal.com) provides comprehensive, detailed, dynamic information about quality of care in Texas Medicaid and CHIP. Measure dashboards include, QoC measures (e.g., HEDIS, AHRQ, DQA, etc.), PPEs, and Survey measures and allow users to compare performance results to national benchmarks, compare performance by MCO and service area, and track performance over time. The dashboards also summarize results by demographic groups (age, race/ethnicity, sex, and health status). Each dashboard includes a download function for the visual dashboard and the data, and a data downloader allows users to select data across dimensions for bulk extraction. The THLC portal also serves as a notification center for availability or changes in QoC measure data and a repository for QoC measure documentation.

Performance Indicator Dashboards

Chapter 10 of the UMCM provides published details on the standards for the Performance Indicator Dashboards and compliance requirements (HHSC, 2022a). The EQRO publishes MCO performance on the Performance Indicator Dashboards for all programs on the THLC portal, organized by measure and MCO. Each year, the EQRO helps Texas select measures based on qualitative assessment and review of measure results across programs. Information from the Performance Indicator Dashboard supports ongoing and future quality improvement initiatives by helping Texas identify measures where most MCOs excel or struggle and where MCO performance varies widely.

MCOs must meet or surpass the minimum standards on more than two-thirds of measures on the program Performance Indicator Dashboard or HHSC can impose remedies including corrective action plans. Table 70 shows the rules for setting minimum- and high-performance standards for measures on the Performance Indicator Dashboards.

Table 71. Performance Indicator Dashboard standards setting rules

Type of Measure	Performance Standard	Description
All Measures	Minimum	When available, the minimum is the state mean for the measure or the national 50th percentile. If program performance declines and reduces the state mean below the prior year's value, the prior year's state mean is the minimum standard.
HEDIS	High	The standard is the upper bound of the NCQA HEDIS percentile in which the state mean falls. If the state mean is lower than the 50th percentile, the 50th percentile is the standard. If the state mean is higher than the 95th percentile, the 95th percentile is the standard.
CAHPS	High	The standard is the upper bound of the CAHPS percentile published by AHRQ in which the state mean falls. If the state mean is lower than the 50th percentile, the 50th percentile is the standard. If the state mean is higher than the 95th percentile, the 95th percentile is the standard.
Measures without National Benchmarks	High	The standard is the state mean of the most current results available for a complete calendar year plus or minus 5%, depending on which direction indicates improvement.

P4Q

Complete details on the P4Q Performance Dashboard are available in Chapter 6 of the UMCM (HHSC, 2022a). Under the program, developed through extensive collaboration between the EQRO and HHSC, three percent of MCO capitation is at risk. The EQRO assesses measure performance for the at-risk pool in two ways: (1) performance against benchmarks, and (2) performance against self. For each MCO, the EQRO sums the recoupments and incentives to determine the total P4Q at-risk portion. A high-performing MCO can receive up to the entire three percent of at-risk capitation, while a low-performing MCO can lose up to the entire three percent. Any recouped monies go into the bonus pool. HHSC distributes these funds to MCOs based on performance on bonus measures. HHSC suspended the P4Q program during the PHE, but will be resume with MY 2022. The P4Q dashboard on the THLC portal (thlcportal.com) allows stakeholders to see which measures positively or negatively contribute to P4Q scores and the relative performance of the MCOs.

MCO Report Cards

Texas is one of many states, including California, New York, Florida, Illinois, and Ohio, using report cards to provide decision support for Medicaid and CHIP enrollees and their caregivers in selecting an MCO. The EQRO has produced report cards for Texas since 2013, working with HHSC each year to select relevant measures and establish an appropriate methodology for assigning ratings. The MCO report cards meet federal requirements for providing accessible information on health care quality for consumers. The EQRO produced unique report cards for each program and service area for distribution during this reporting period. Medicaid and CHIP enrollment packets for new members include the appropriate report card, in English and Spanish, with an accompanying information sheet that explains the report card and includes the web address for the online versions. In addition to the ratings, each report card includes the contact information for the available MCOs.

Ratings on each report card reflect the MCO's performance only in a new member's area, providing a more accurate picture of the care available where the member lives. The EQRO collapses the raw performance scores to a uniform, consumer-friendly five-star rating system, with five stars representing the highest performance.

Measures & Data Sources

The EQRO selects measures for report cards based on HHSC priorities, the impact of the measure for the population, CMS/NCQA recommendations, observed differences in performance, and feedback from enrollees and other stakeholders. The MCO report cards draw on two primary sources of information:

1. CAHPS surveys that the EQRO conducts to ascertain member perspectives of and experiences with MCO and provider quality
2. Administrative data for select HEDIS measures on MCO performance

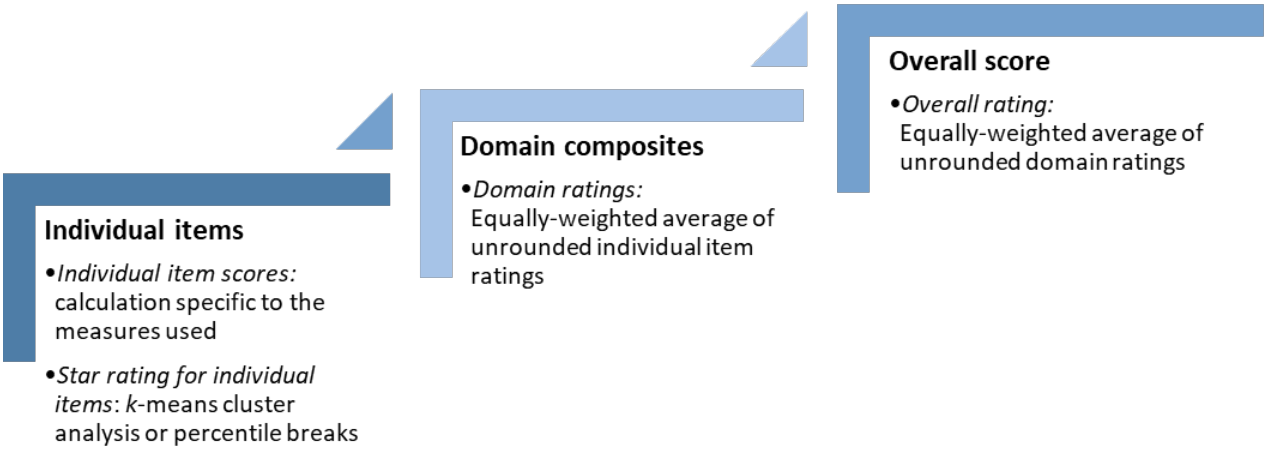
The MCO report cards for this reporting period use the results from member and caregiver surveys conducted in the spring and summer of 2022 (see Protocol 6: Administration of Quality of Care Surveys) and administrative measure results for MY 2021 (see Protocol 7: Calculation of Performance Measures).

The EQRO fields abbreviated 15-minute surveys for each report card type, supplementing the longer biennial member survey to meet plan code (MCO + SA) level sample size requirements or when the EQRO does not conduct the biennial survey during the timeframe. With 200 completed interviews per plan code targeted, the EQRO collected over 33 thousand completed interviews from attempts to contact over 300 thousand members or caregivers. Following AHRQ guidance, case-mix adjustment at the plan code level corrected for potential bias from respondent characteristics unrelated to health care quality, including age, education, and health status.

Structure

The report cards organize MCO performance information using a three-tiered hierarchical structure to allow new enrollees and their caregivers to compare MCOs at the desired level of detail and make an informed decision. The MCO report cards for CHIP, STAR children, STAR adults, and STAR+PLUS begin with an overall composite summary of relative MCO performance that averages the star ratings for several domains. Each of the five types of report cards includes three or four domain composites and an overall composite. The domains comprise different items by type of report card to account for the needs of the populations. Domain ratings appear below the overall composite rating, and ratings for the individual measures within the domain appear under each domain rating. Figure 9 shows this calculation cascade graphically.

Figure 10. Relationships among individual items, domains, and overall score on MCO Report Cards



Domain Composite & Overall Quality Rating Calculations

Ratings for the domain composites are the averages of the unrounded individual item ratings, and the overall composite rating is the average of the unrounded domain ratings. The EQRO rounds composite ratings to the nearest half star. If no rating results for more than half of the individual items in a composite, the report card will display "No rating."

The domains for STAR, STAR+PLUS, and CHIP include:

- Experience of Care summarizes member and caregiver experience measures from a subset of the CAHPS surveys and provides information on what members think about the quality of the MCO (e.g., How Well Doctors Communicate or Rating of Health Plan).
- Staying Healthy summarizes measures of preventive healthcare (e.g., well-care visits for CHIP or prenatal visits for STAR Adult).
- Common Chronic Conditions summarizes measures relating to managing select chronic conditions (e.g., asthma for STAR Child or diabetes for STAR+PLUS).
- Experience with the Health Plan: summarizes information relating to adult/caregiver experience with the health plan (CAHPS Rating of Health Plan).[9]

In a similar three-tiered structure, the MCO report cards for STAR Kids begin with an overall composite rating of relative MCO performance that assigns equal weight to each of the three domains:

- Getting Care summarizes measures of member and caregiver experience of care and access to routine primary care.
- Services and Support summarizes member and caregiver experience measures discussing and coordinating care and for the MCO overall.
- Mental and Behavioral Health summarizes the experience of getting emotional and behavioral counseling, follow-up care after hospitalization for mental illness, and metabolic monitoring for members taking antipsychotic medication.

[9] CHIP report cards do not include an "Experience with the Health Plan" domain.

- **Experience with the Health Plan:** summarizes information relating to adult/caregiver experience with the MCO (CAHPS Rating of Health Plan).

Appendix F provides details on the domain structure and content for each of the five report card types.

Star Rating Modifications for the SFY 2022 CMS reporting period

In consultation with HHSC, the EQRO changed report card star ratings calculation and categorization for this reporting period. The proposed scoring system considers three types of measures: administrative measures scored by *k*-means clustering and potentially adjusted according to national benchmarks, survey measures scored by percentiles and potentially adjusted for reliability and statistical significance, and composite measures scored as the average of component ratings. All three types of measure use a scale of one to five stars in half-star increments.

The scores on administrative measures follow NCQA HEDIS methods. Measures with an optional hybrid specification use only administrative data without supplementation through medical record review because QoC reporting of hybrid measures is at the MCO level, not the plan code level. Survey-derived individual report card items follow AHRQ definitions with two exceptions: care coordination and transition to care as an adult on the STAR Kids report card use items from the National Survey of Children's Health (NSCH). Composite measures use unrounded ratings, where applicable.

Administrative measures use k-means clustering to identify rating levels, as in previous years; additionally, these measures incorporate information about performance relative to national benchmarks. Survey measures use the same approach as the Medicare C and D Star Ratings (CMS, 2020c), a percentile-based method adjusted for significance and reliability. Composite measures ratings average the component ratings (not scores) to increase interpretability by improving the intuitiveness of the composite ratings.

The k-means clustering algorithm is a type of unsupervised learning: it partitions observations into a set number of clusters, calculates new cluster centers based on this assignment, reassigns each observation to the nearest cluster center, then iterates until convergence. Setting k=5, the final clusters correspond to ordered ratings of one to five stars. Comparison of allowed metastable configurations then identifies the global minimum within-cluster variance for final cluster assignment. The final rating for HEDIS measures is adjusted down when statewide performance is in the bottom quartile according to the NCQA national percentiles or will be adjusted up when statewide performance is in the top quartile nationally. To prevent overcorrection when plan code performance is significantly different from statewide performance, clusters in the lowest 10 percent of scores nationally will not receive an upward adjustment, and clusters in the top ten percent of scores nationally will not receive a downward adjustment.

Survey scores include non-response weights for any significant differences in response propensity by age, sex, and race/ethnicity; and case-mix adjustment by member health status, respondent age, and education. The EQRO calculated scores, case-mix adjustments, and standard errors using version 5.0 of the CAHPS analysis macro (CAHPS Consortium, 2020). The percentile-based method for the survey measures first assigns a base rating group according to the percentile breaks listed in Table 2 using the weighted adjusted scores; this procedure follows the process used to calculate the Medicare C and D Star Ratings (CMS, 2020c). This base group is adjusted toward the middle when reliability is low (less than 0.70 but not less than 0.60), or the score is not significantly different from the grand mean of all scores on a two-tailed *t*-test ($p<0.05$) after finite-population correction. Scores with very low reliability (<0.60) will not receive a rating. One- and five-star ratings

will occur only for scores significantly below or above the grand mean and either not low reliability or at least one standard error below or above the percentile cut point. In uncommon cases, this adjustment procedure can result in a lower score receiving a higher rating or vice versa, due solely to uncertainty; such instances will receive a "No rating" assignment. This procedure allows for sampling variation and the potential non-representativeness of the respondent pool. This approach to rating the survey measures will tend to increase the variation in ratings overall but may limit extreme (one- or five-star) ratings. Where data was insufficient to compute a reliable rating (reliability ≥ 0.7), the report cards indicate "No rating," and a clarifying note informs users that this is due to lack of information and does not indicate poor quality. MCOs may receive ratings for domain composites and individual measures without receiving an overall rating. Table 71 and Table 72 summarize the rating decision rules and adjustments described above.

Table 72. Survey measure ratings decision rules

Percentile band	Base group	Sig. below, low reliability	Sig. below, not low reliability	Not sig., low reliability	Not sig., not low reliability	Sig. above, low reliability	Sig. above, not low reliability
<15th by >1 SE	1	1	1	2	2	2	2
<15th by ≤1 SE	1	2	1	2	2	2	2
≥15th to <30th	2	2	2	3	2	3	2
≥30th to <60th	3	2	2	3	3	4	4
≥60th to <80th	4	3	4	3	4	4	4
≥80th by ≤1 SE	5	4	4	4	4	4	5
>80th by >1 SE	5	4	4	4	4	5	5

Table 73. Administrative measure ratings adjusted for national benchmarks

Base cluster	Statewide performance in the bottom quartile nationally	Statewide performance in the middle two quartiles nationally	Statewide performance in the top quartile nationally
A	1	1	2
B	1.5	2	3
C	2	3	4
D	3	4	4.5
E	4	5	5

Relevance for Assessing Quality, Access & Timeliness

The Performance Dashboards and MCO Report Cards provide a way for MCOs and members to view and compare information on the quality of care.

Summary of Protocol Findings & Recommendations from EQR Activities

No recommendations for Protocol 10.

EQRO Recommendation Summary

As noted in the Introduction, Texas is required to develop and implement a written quality strategy to assess and improve the quality of Medicaid and CHIP managed care services (42 C.F.R. § 438.340 (2016). Per 42 C.F.R. § 438.364 (a)(4)(2016), the EQRO is expected to provide recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)(2020)) including how the State can target goals and objectives in the quality strategy, under § 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.

This section has two parts, the first half brings together the EQRO recommendations from EQR activities for SFY 2022 and their relevance to the current MCQS. The second half includes: (a) the EQRO recommendations for SFY 2021, (b)their relevance to Texas's MCQS at the time of the recommendations, and (c) HHSC's response to the prior year's recommendations. Table 4, in the ATR introduction, describes the MCQS goals. Additional information on the current and past MCQS is available at hhs.texas.gov.[10]

SFY 2022 Recommendations

Protocol 1: Validation of PIPs

Category	Description
Finding(s)	Several MCOs scored zero on progress reports during this evaluation year because they did not address all previous recommendations. In the 2020 PIP Progress Report 3, two MCOs scored a zero. In the 2021 PIP Progress Report 2, three MCOs scored a zero. In the 2022 PIP Progress Report 2, three MCOs scored a zero. Each of these MCOs could have scored significantly higher, ranging from 50 to 96.4 percent, had they addressed previous EQRO recommendations. This has been an ongoing issue for PCHP and Driscoll. PCHP did not address all previous recommendations on 2019 Progress Report 3, 2020 Progress Report 2, 2020 Progress Report 3, and 2021 Progress Report 2. Driscoll did not address all previous recommendations on: 2019 Progress Report 3, 2020 Progress Report 3, and 2022 Progress Report 1.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	MCOs, including Driscoll, PCHP, CHCT, UHC, Molina, and Superior should ensure that their progress reports for all PIPs address all previous recommendations made by the EQRO.

[10] https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/quality-strategy

Category	Description
Finding(s)	Lower scores were often due to errors or omissions in measure reporting, issues reporting target and reach data correctly, and providing insufficient justification for modifications made to PIPs. For example, PCHP, BCBSTX, and Molina lost points due to reporting re-measurements using incorrect time frames. Both BCBSTX and Molina lost points in measure reporting, because they did not utilize data from the QoC tables or THLCportal.com in baseline data, and thus the EQRO could not verify or validate their numerators and denominators.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	MCOs, including PCHP, BCBSTX, Molina (who scored lowest on 2020 PIP Progress Report 3), and DentaQuest (who scored lowest on 2021 PIP Progress Report 2), should report all measures both accurately and completely, report target data correctly, and provide justification for all modifications made to PIPs.
Finding(s)	In the 2022 PIP Plans, PCHP received the lowest scores due to their use of an old version of the PIP template that did not include all the CMS required information for the PIPs.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	PCHP should ensure that it utilizes the most up-to-date versions of templates (available in the Uniform Managed Care Manual) to ensure that they address all necessary questions for CMS compliance.

Protocol 2: Validation of Performance Measures Reported by MCOs

No recommendations

Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations

AI Interviews

Category	Description
Finding(s)	Several MCOs reported challenges obtaining and incorporating provider URL information into provider directories.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs, including Molina, Superior, and UHC, should establish systems to incorporate complete provider website URL information in their provider directories.
Finding(s)	Several MCOs did not have compliant procedures for the associated timeframes and notification protocols for standard and expedited service authorization decisions, including extension protocols.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs, including Molina and Superior, should ensure their representatives make standard and expedited service authorization decisions and notifications within the federally required timeframes.

Category	Description
Finding(s)	Several MCOs reported state-compliant CHIP grievance system protocols; however, these system protocols were not compliant with updated federal guidelines.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs with a CHIP product line need to evaluate their procedures to ensure that CHIP grievance system protocols align with Medicaid grievance system protocols, excluding the Medicaid requirement of continuation of benefits pending the appeal, a state fair hearing, or both.
Finding(s)	Some MCOs reported data collection on member SDoH needs. However, many MCOs and DMOs had not implemented procedures to aggregate collected information on SDoH needs.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	MCOs and DMOs need to systemically collect data on the SDoH or NMDOH needs of members to aggregate needs by populations to impact member health and well-being effectively.
Finding(s)	While some MCOs had implemented specific SDoH-related interventions, they failed to clearly measure the direct and indirect effects.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	MCOs should consider evaluating the impact of plan-driven SDoH- or NMDOH-related interventions and referrals to community resources on the health and well-being of members.
Finding(s)	MCOs reported several multi-agency collaborations to address SDoH needs in members.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should encourage MCOs to share these SDoH- or NMDOH-related interventions and best practices with other entities, including HHSC, to further address unmet needs that may impact the health of Texans enrolled in Medicaid and CHIP programs.
Finding(s)	MCOs reported successful transition by their providers to medical and behavioral health telehealth in response to the public health emergency. Many MCOs discussed the importance of provider communication and education to ensure that providers adopted correct billing codes and modifiers to facilitate payment for telehealth services.
MCQS Goal(s)	Goals 1, 3, 6
Recommendation(s)	MCOs should continue exploring the efficiency of utilizing medical and behavioral health telehealth services and their impact on health outcomes.
Finding(s)	MCOs reported that many health services have transitioned back to in-person settings while many behavioral health services continue via telehealth modalities.
MCQS Goal(s)	Goals 1, 6
Recommendation(s)	MCOs should continue exploring the efficacy of utilizing behavioral health telehealth services and their impact on the health outcomes of Texans enrolled in Medicaid and CHIP programs.

QAPI Evaluations

Category	Description
Finding(s)	Many MCOs lost points due to QAPI program objectives that were not specific, action-oriented statements written in measurable and observable terms that define how goals would be met. For example, one program objective was: "develop and/or enhance relationships with a community organization." This objective is not specific or written in measurable terms.
MCQS Goal(s)	Goals 1, 4
Recommendation(s)	The EQRO recommends that MCOs develop objectives which are specific, action-oriented, measurable, and observable. This recommendation applies to Aetna, CookCHP, DCHP, Driscoll, ElPasoHealth, FirstCare, PCHP, SWHP, and UHC Dental.
Finding(s)	Many MCOs and MMPs reported results and data for MY 2020 instead of MY 2021 (the measurement year for the QAPI) in multiple areas of the QAPI report.
MCQS Goal(s)	Goals 1, 4
Recommendation(s)	The EQRO recommends that Aetna, Amerigroup, BCBSTX, CFHP, CHCT, DCHP, Driscoll, FirstCare, Superior, and SWHP utilize data from the measurement year for the QAPI to report results on performance.
Finding(s)	Many MCOs, MMPs, and DMOs lost points in all three indicator monitoring sections (availability and accessibility, service, and clinical) for the effectiveness of actions section. The three main opportunities for improvement were: MCOs/MMPs 1) did not include a percent change analysis for all indicators, 2) reported incorrect metrics for an indicator (i.e., the unit of analysis was not consistent for all rates reported), and 3) did not accurately interpret the effectiveness of actions.
MCQS Goal(s)	Goals 1, 4
Recommendation(s)	The EQRO recommends that Aetna, Amerigroup, BCBSTX, CFHP, CHCT, CookCHP, DentaQuest, DCHP, ElPasoHealth, FirstCare, Molina, PCHP, Superior, and UHC include a percent change analysis for all indicator monitoring and ensure they correctly interpretation of results and use consistent units of analysis for each indicator.

Protocol 4: Validation of Network Adequacy

Appointment Availability

Category	Description
Finding(s):	The percentage of providers compliant with UMCC standards for high-risk pregnancy was 13.8 percentage points lower, and for low-risk pregnancy was 7.6 percentage points lower in SFY 2022 compared to SFY 2020. For the third trimester, the compliance was 10.6 percentage points lower compared to SFY 2020.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should consult with MCOs and conduct root cause analyses (RCAs) to identify the driving factors behind lower rates of provider compliance among prenatal health providers and use the results to identify strategies for improving provider compliance. The EQRO recommends that HHSC conduct an in-depth study on appointment wait times to: (1) better understand the challenges that MCOs encounter when trying to increase the percentage of providers that are compliant with appointment standards and (2) more effectively target MCO incentives to increase the percentage of providers that meet appointment availability standards.
Finding(s):	In SFY 2022, none of the providers for Aetna, CookCHP, Molina, SWHP, and UHC complied with wait time standards for prenatal care in the third trimester. SWHP providers had zero percent compliance with high-risk pregnancy appointment standards.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should strongly encourage Aetna, CookCHP, Molina, SWHP, and UHC to conduct RCAs to identify the drivers for non-compliance with appointment standards Aetna, CookCHP, Molina, SWHP, and UHC should use the RCA to identify specific approaches that they can use to encourage providers to make appointments available within five working days.
Finding(s):	In SFY 2022, the percentage of excluded providers increased, and the total appointments available decreased in all prenatal sub-studies compared with SFY 2020.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should consult with MCOs to better understand the key factors contributing to errors in the provider taxonomy for prenatal directories and why many providers in the prenatal sample did not offer prenatal appointments. HHSC should encourage the MCOs to carefully examine the member-facing directory information they provided for the appointment availability study, especially Amerigroup, Molina, and Aetna, which had the highest percentage of excluded providers in the prenatal sub-studies. Updated provider directories with accurate provider contact information will help reduce the overall number of calls needed for each MCO and help increase the size of the sample for assessing compliance with call wait times.
Finding(s):	The EQRO excluded more providers from the behavioral health sub-study in SFY 2022 compared to SFY 2021 because of incorrect taxonomies or other directory information.
MCQS Goal(s)	Goal 4
Recommendation(s)	The EQRO recommends that HHSC continue to work with MCOs and TMHP to improve provider directory information quality.

Category	Description
Finding(s):	In SFY 2022, the median number of days to wait for a high-risk appointment was nine days, and the third trimester was seven days, both higher than the UMCC standard of five days.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	The EQRO recommends that HHSC work with providers to understand what factors contribute to longer wait times for appointments and develop a strategy for decreasing the wait time for High-risk and Third Trimester appointments. BCBSTX, DCHP, Molina, PCHP, and ElPasoHealth should work with their providers to understand what factors contribute to longer wait times for prenatal appointments and develop a strategy for decreasing the wait time for prenatal appointments.
Finding(s):	In SFY 2022, compliance with vision health appointment standards decreased in STAR Health compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	The EQRO recommends that HHSC conduct an in-depth study on appointment wait times to: (1) better understand the challenges that MCOs encounter when trying to increase the percentage of providers that are compliant with appointment standards and (2) more effectively target Amerigroup and Superior health incentives to increase the percentage of providers that meet appointment availability standards. HHSC should work with Amerigroup and Superior to identify factors contributing to non-compliance with wait time standards.
Finding(s):	In SFY 2022, the percentage of contacted providers who did not accept Medicaid/CHIP increased in STAR, STAR+PLUS, STAR Kids, and CHIP compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should consult with Superior to better understand the key factors contributing to errors in the provider taxonomy for vision directories and why so many providers in the vision sample did not conduct regular vision exams. HHSC should consult with MCOs and providers to better understand the key factors limiting the number of providers participating in the Medicaid programs and work with MCOs to identify ways to overcome these challenges.
Finding(s):	Few providers offered telehealth appointments in SFY 2022.
MCQS Goal(s)	Goals 3, 4, 5
Recommendation(s)	HHSC should conduct an environmental scan of the literature on the effectiveness of virtual appointments for vision care and the strategies other state Medicaid programs are using to increase availability of telehealth for vision care and use this information to inform strategies for improving access to and the availability of vision appointments among Texas Medicaid members.

Category	Description
Finding(s):	In SFY 2022 compliance with preventive and routine primary care appointment wait-time standards dropped in STAR, STAR+PLUS and STAR Kids compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should strongly encourage Aetna and CookCHP to conduct RCA analyses to identify the drivers for low compliance with appointment standards Aetna and CookCHP should use the RCAs to identify specific approaches that they can use to encourage providers to make appointments available within 90 working days. HHSC should work with CookCHP to identify the factors contributing to non-compliance with wait time standards for preventive, especially because this MCO has the lowest rate of compliance with preventive wait time standards in the STAR program and CHIP, and one of the lowest percentages of available appointments in STAR Kids. HHSC should work with Aetna to identify the factors contributing to non-compliance with wait time standards for routine care, especially because this MCO has the lowest rate of compliance with routine wait time standards in the STAR Kids program and CHIP, and one of the lowest compliance rates in STAR.
Finding(s):	In SFY 2022, the percentage of contacted providers who did not accept Medicaid increased in STAR, STAR Health, and STAR Kids compared to SFY 2021.
MCQS Goal(s)	Goals 3, 4, 5
Recommendation(s)	HHSC should consult with CookCHP to better understand the key factors that contribute to errors in the provider taxonomy for PCP directories and why so many of the providers in the PCP sample did not accept Medicaid. HHSC should consult with MCOs and providers to better understand the key factors limiting the number of providers participating in the Medicaid programs and work with MCOs to identify ways to overcome these challenges.
Finding(s):	The percentage of providers who offered weekend appointments decreased in STAR and STAR Health in SFY 2022 compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should work with Superior to increase weekend appointments for primary care. This would improve access to and the availability of primary care appointments for Texans in the STAR Health program.
Finding(s):	In SFY 2022, compliance with behavioral health care appointment wait time standards decreased in STAR, STAR+PLUS, STAR Health, and CHIP compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should conduct RCAs to identify the driving factors behind lower rates of provider compliance among behavioral health care health providers and use the results to identify strategies for improving provider compliance. HHSC should more effectively target MCO incentives to increase the percentage of providers that meet appointment availability standards. HHSC should work with Superior to identify the factors contributing to non-compliance with wait time standards for behavioral health care.

Category	Description
Finding(s):	Providers that accepted Medicaid in STAR, STAR Kids, STAR Health, and STAR+PLUS decreased in SFY 2022 compared with SFY 2021.
MCQS Goal(s)	Goals 3, 4, 5
Recommendation(s)	HHSC should consult with MCOs and providers to better understand the key factors limiting the number of providers participating in the Medicaid programs and work with MCOs to identify ways to overcome these challenges.
Finding(s):	In the SFY 2022 behavioral health care sub-study, the percentage of excluded providers increased in CHIP, STAR Health, and STAR+PLUS.
MCQS Goal(s)	Goals 3, 5, 6
Recommendation(s)	HHSC should encourage the MCOs to carefully examine the member-facing directory information they provided for the appointment availability study, especially Amerigroup, which had the highest percentage of excluded providers in STAR, STAR+PLUS, STAR Kids, and CHIP. Updated provider directories with accurate provider contact information will help reduce the overall number of calls needed for each MCO and help increase the size of the sample for assessing compliance with call wait times.
Finding(s):	The percentage of providers that offered telehealth services or weekend behavioral health appointments decreased across all the programs in SFY 2022 compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5, 6
Recommendation(s)	HHSC should work with MCOs to increase weekend appointments and telehealth services for behavioral health care. Increasing alternatives for behavioral health care appointments will improve access to and availability of behavioral health care.

Protocol 5: Validation of Encounter Data Provided by MCOs

Encounter Data Evaluation

Category	Description
Finding(s)	Driscoll and CFHP had deficits in member ID reporting or validity, and Superior had deficits on admission dates.
MCQS Goal(s)	Goals 3, 4, 6
Recommendation(s)	HHSC should continue to monitor key fields in encounter data for validity and completeness. Although data quality is generally very good, without monitoring changes in data processing can lead to unexpected data loss.
Finding(s)	Despite several ongoing initiatives to try and improve the quality of provider data, both in encounters and in the master provider data, the overall quality of provider data is still not meeting the desired standards.
MCQS Goal(s)	Goal 4
Recommendation(s)	HHSC should continue current initiatives and investigate what causes deficits in the reported provider information.

Category	Description
Finding(s)	UHC Dental data was deficient in several important elements.
MCQS Goal(s)	Goals 3, 4, 6
Recommendation(s)	HHSC should work with UHC Dental to improve their data quality. HHSC should consider earlier analysis of data quality for new MCOs/DMOs, or following other major changes in programs.

Review of Medical Records

Category	Description
Finding(s)	To improve the record return rate and accuracy of provider addresses, the EQRO sent each MCO a list of ICNs and provider addresses for each member in the sample and requested that MCOs verify the provider addresses and make corrections where needed. Aetna, BCBSTX, DCHP, PCHP, and UHC did not update or verify the provider addresses. Superior updated several of the provider addresses, however 23.5 percent came back as "not a patient." Because unverified or incorrect addresses led to lower record return rates compared to previous studies, the EQRO and HHSC requested that the MCOs retrieve the outstanding records needed to meet the sample size requirements.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	The EQRO recommends HHSC consider a new approach to obtaining records that will hold the MCOs accountable for meeting the sample size requirements for the study. One approach would be for HHSC to require the MCOs to obtain the records for the sample population and submit them to HHSC and the EQRO.
Finding(s)	PCHP had the opportunity, as did all the MCOs, to verify or correct the provider addresses at the start of the study, however, they took no action. Further, when given the opportunity to retrieve the outstanding records to meet the sample size requirements, PCHP did not provide any additional records. Consequently, the EQRO did not receive enough records to meet the sample size requirements making PCHP's match rates unreliable.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	PHCP should work to ensure that all provider addresses are accurate at the start of each EDVMRR study, by improving their provider address reporting, and by taking advantage of the opportunity to correct addresses or retrieve any outstanding records to ensure meeting the required sample size.
Finding(s)	The provider addresses pulled from the EQRO encounters at the beginning of the study resulted in an overall higher return rate (77 percent) than the addresses provided by the MCOs (62 percent). The EQRO addresses yielded a higher return rate than the MCO addresses for the following MCOs: Amerigroup, ElPasoHealth, FirstCare, SWHP, Superior, and TCHP.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	The EQRO recommends that MCOs, especially Amerigroup, ElPasoHealth, FirstCare, SWHP, Superior, and TCHP, examine their provider directories to identify factors that could influence the accuracy of provider addresses.

Category	Description
Finding(s)	The overall match rates for MCOs were high across review categories (i.e., DOS, POS, PDx and PX). However, several MCOs performed below average. The MCOs that scored below average across review categories were Amerigroup, CFHP, CookCHP, Molina and Superior. The primary reason for the lower match rates for these MCOs was that the encounter data included DOS, POS, PDx, and/or PXs that were not documented in the medical record.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	The EQRO recommends that Amerigroup, CFHP, CookCHP, Molina and Superior work with their providers to determine why information in the encounter data is not documented in the medical records.

Protocol 6: Administration of Quality of Care Surveys

Category	Description
Finding(s)	Composite scores on the STAR Adult and STAR+PLUS Member surveys decreased between 2020 and 2022, except for the STAR+PLUS *Customer Service* composite. The biggest change between 2020 and 2022 was the *Health Care Rating* for STAR Adult (-5.7 percent).
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should work with the STAR MCOs to identify the key factors that contributed to the decrease in STAR adult member satisfaction with healthcare and identify the strategies that STAR MCOs are using to improve the quality of care in those health domains.
Finding(s)	Between 2020 and 2022, most composite scores increased on the STAR Kids Caregiver survey while scores decreased for the STAR Health Caregiver survey except for *Getting Care Quickly*.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should work with Superior and stakeholders in STAR Health to identify the key barriers and facilitators to improving caregiver satisfaction with healthcare and the MCO and use this information to develop strategies to improve caregiver satisfaction.

Protocol 7: Calculation of Performance Measures

Category	Description
Finding(s)	In 2021, Hispanic Medicaid members had more outpatient utilization and less ED, inpatient, mental health, and alcohol and drug services use than both non-Hispanic Black and non-Hispanic White members.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should continue to explore QoC measure results across demographic and other member population groups to interpret results more clearly and better direct efforts to improve care for all Medicaid and CHIP members.

Category	Description
Finding(s)	URTI remains the most common reason for PPVs and the second most common PPVs, Non-Bacterial Gastroenteritis, Nausea & Vomiting, have doubled since 2020. SMIs account for more PPAs than heart failure, which is the leading single reason, and SMIs are the leading causes for PPRs.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	HHSC should investigate common reasons for PPEs to better understand what members are most at risk and to plan targeted interventions to reduce PPEs.
Finding(s)	SMM rates increased especially in cases with hemorrhage.
MCQS Goal(s)	Goals 1, 2, 3, 4
Recommendation(s)	HHSC should encourage initiatives to improve hospital patient safety, including the AIM bundles developed by ACOG and continue to investigate the underlying drivers of maternal health disparities
Finding(s)	Nearly 50 thousand C-Sections occurred in deliveries without complications. These represent substantial additional cost ($150 million) and potential risk.
MCQS Goal(s)	Goals 1, 2, 3, 4
Recommendation(s)	HHSC should consider a PIP or interventions to reduce C-Sections in uncomplicated deliveries.
Finding(s)	MCO performance across Performance Indicator Dashboard measures varies. Some MCOs achieve the high standard on more than 50 percent of measures, while others fail to meet the minimum standard on more than 40 percent of measures. FirstCare has the most measures failing to meet the minimum standard, while Driscoll has the most measures achieving high standards.
MCQS Goal(s)	Goals 1, 4, 6
Recommendation(s)	HHSC should continue leveraging the THLC portal (thlcportal.com) dashboards to help all Texas Medicaid and CHIP stakeholders identify and understand trends in healthcare quality across state programs.

Protocol 9: Conducting Focus Studies of Health Care Quality

STAR Kids Focus Study

Category	Description
Finding(s)	Caregivers reported having low availability of home therapy, personal assistance services, and nursing providers, particularly for those living in rural areas. In addition to network adequacy issues, caregivers attributed these unmet needs to high provider turnover, provider time constraints, and low provider pay.
MCQS Goal(s)	Goals 1, 3, 5,6
Recommendation(s)	STAR Kids MCOs should continue to focus network adequacy efforts in rural areas. Potential strategies may include: (1) Sharing best practices in the recruitment of home health providers with other MCOs in collaborative contexts, such as stakeholder and advisory group meetings or jointly conducted performance improvement projects; and (2) Establishing longer-term solutions to ensure local availability of home health providers in rural areas, such as provision of local training and certification programs. STAR Kids MCOs should ensure that home health providers have incentives to serve members in hard-to-reach areas. One potential strategy is to include provisions in contracts with home health agencies to ensure: (1) adequate provider reimbursement for travel expenses to hard-to-reach areas; and (2) availability of hourly pay supplementation for providers to account for lower caseloads that result from having to travel long distances to reach clients. These provisions may include cost-sharing between the MCO and the home health agency to cover these expenses and supplements. Texas Medicaid should authorize an increase in pay rates for personal assistance service providers to be more competitive with other entry-level community jobs. Texas Medicaid should ensure flexibility to allow caregivers to increase pay rates for home health providers when a member is not using authorized hours up to the total estimated costs of the original service plan.
Finding(s)	Caregivers described challenges in navigating the complexity of processes for eligibility determination, approvals, and authorization for services and finding new providers and supply companies. These challenges contributed to caregiver stress and burden and led to gaps in care for members.
MCQS Goal(s)	Goals 1, 2, 5, 6
Recommendation(s)	STAR Kids MCOs should build on efforts to develop and disseminate resources for caregivers that explain processes for eligibility determination, approvals, and authorization for services in accessible language and multiple formats (e.g., mail- and web-based). These resources should include information on the individuals and organizations caregivers can reach out to with specific questions and how to reach them. STAR Kids MCOs should revisit policies for updating provider network directories to ensure that updates, including the lists of active providers who accept Medicaid and treat members with complex conditions, are frequently occurring and distributed to families of STAR Kids members in formats that are accessible to them.

Category	Description
Finding(s)	Many caregivers report functioning as their child's primary care coordinator for specific services, such as prescription medicines and medical supplies, leading to gaps in care for members and increasing stress and burden for caregivers.
MCQS Goal(s)	Goals 2, 6
Recommendation(s)	STAR Kids MCOs should enhance the training of service coordinators to emphasize the challenges caregivers face in accessing medications and medical supplies for their children. Training materials and service coordination policies should address potential scenarios experienced by caregivers, such as being drawn into the coordination process by providers, paying out-of-pocket for medications and supplies, having to reuse supplies, and being unable to locate care to address highly specialized needs. STAR Kids MCOs should consider or build upon programs to provide STAR Kids MDCP caregivers with services that reduce their coordination and travel burden, such as automatic medication refills, home delivery of medications, and delivery tracking for supplies. Texas Medicaid and STAR Kids MCOs should conduct periodic reviews to identify caregivers at high risk of stress or burden due to care coordination and then conduct outreach with these caregivers to provide special assistance. These reviews may include: (1) Identifying caregivers who have recently experienced changes to their MCO service coordinator; (2) Focusing on MCOs or service areas with higher rates on caregiver burden measures calculated from the STAR Kids Screening and Assessment Instrument (SK-SAI); (3) Using member-level SK-SAI data to identify individual caregivers with high level of burden.
Finding(s)	The study was limited by the low representation of Hispanic caregivers, who comprise the majority of STAR Kids MDCP. Furthermore, some interviews with Hispanic caregivers lacked sufficient detail to ensure a thorough understanding of their experiences and satisfaction with care.
MCQS Goal(s)	Goals 1, 2, 5
Recommendation(s)	HHSC should consider authorizing a study conducted by the EQRO that focuses on Hispanic caregivers of STAR Kids MDCP members and leverages multiple data sources to ensure thoroughly understand the experiences of this important subgroup. This study might include the following: • Stratification of study participants according to third-party insurance status will allow for more reliable measures of differences in experience between those who do and do not have third-party insurance. • Use caregiver survey or SK-SAI data to quantitatively assess differences in experience with access to and quality of healthcare according to third-party insurance status, MCO, SA, and other individual, geographic, and service delivery factors. • Supplementation of quantitative data with qualitative interviews of Hispanic caregivers, incorporating more time to identify appropriate bilingual (English/Spanish) interviewers, train them in rigorous qualitative data collection methods, and conduct regular quality monitoring of interview data and feedback.

Quarterly Topic Reports

Study on Social Determinants of Maternal Health

Category	Description
Finding(s)	Compliance with HEDIS-PPC prenatal and postpartum care measures was significantly associated with positive health outcomes, including lower odds of hemorrhage and (pre)eclampsia. Compliance with HEDIS-PPC prenatal and postpartum care measures was also associated with higher odds of postpartum depression diagnosis.
MCQS Goal(s)	Goals 1, 5, 6
Recommendation(s)	HHSC and the MCOs should continue efforts to improve access to prenatal and postpartum services for women in Medicaid and CHIP. These efforts should include identifying and responding to the barriers to access for minority women and women in rural areas.
Finding(s)	Mothers in micropolitan and rural counties had higher odds of PPD diagnoses than mothers in metropolitan counties.
MCQS Goal(s)	Goals 1, 3, 6
Recommendation(s)	HHSC should conduct additional research on maternal mental health to identify the causes of disparities in maternal mental health screening, maternal mental health outcomes, and barriers to effective maternal mental health treatment.
Finding(s)	Average county-level COVID-19 caseloads were significantly associated with variation in the odds of several health and service utilization outcomes, including C-Section deliveries and hemorrhage.
MCQS Goal(s)	Goals 1, 3, 6
Recommendation(s)	HHSC should consider additional research studies examining how the onset of the COVID-19 pandemic affected access to health services for managed care members across different Medicaid programs.
Finding(s)	While the odds of PPD diagnoses did not vary based on the average COVID-19 caseload during the postpartum period, the odds of PPD diagnosis did vary significantly between the 2019 and 2020 cohorts, with higher odds of PPD diagnoses in 2020.
MCQS Goal(s)	Goals 1, 2, 3, 5
Recommendation(s)	HHSC should conduct additional research to identify whether other COVID-related changes in health policy and access to health services, such as increased telehealth availability, were significantly associated with increases in PPD diagnoses and other changes in maternal health and service utilization outcomes among women in Texas Medicaid and CHIP.

Category	Description
Finding(s)	The odds of SMM and (pre)eclampsia were higher among non-Hispanic Black women than non-Hispanic White women, consistent with the broader literature on racial and ethnic disparities in SMM.
MCQS Goal(s)	Goals 1, 2, 3, 6
Recommendation(s)	HHSC and the MCOs should continue efforts to improve the quality of maternal care and access to health services for minority women and women with high-risk pregnancies. One evidence-based approach to care that HHSC could consider is the Centering Pregnancy model, that some other state Medicaid programs have adopted with some success.

Study on Health Disparities in Texas Medicaid Managed Care Programs

Category	Description
Finding(s)	Incomplete sociodemographic information for members limits the ability to identify and tailor interventions. Up to 38 percent of the population in some of the QoC measures for STAR and STAR Kids programs were in the "Other/Unknown" racial and ethnic category. The heterogeneity in the Other/Unknown category poses challenges for identifying race-ethnicity-based differences among members in these groups.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should work with the MCOs to identify the source of missing sociodemographic information in the enrollment files and define a strategy to improve the data quality. The EQRO also suggests defining, pilot-testing, and operationalizing different classifications of ethnic and racial categories to allow for more precise identification of the members that the dataset currently classifies as a homogeneous category.
Finding(s)	The results of this study suggest the need for more in-depth analyses of QoC disparities by focusing on specific population groups. A narrower focus into specific SDoH dimensions could help HHSC better identify the needs of Medicaid members and improve their quality of care, thus reducing disparities. For example, understanding the relationship between different SDoH dimensions and QoC measures within the rural population can be crucial to improve the design of interventions that address disparities for this group.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	In addition to the current analyses using composite SDoH scores, HHSC should conduct additional analyses on disparities in QoC measures based on SDoH dimensions or variables, such as housing instability, food insecurity, rurality, and access to public transportation. The EQRO recommends that HHSC continue to identify ways to collect detailed and systematic information about specific SDoH for Texas Medicaid enrollees. This approach would help HHSC discern the most relevant issues for different members and prioritize targeted solutions.

Category	Description
Finding(s)	Non-Hispanic Black members displayed lower compliance rates than non-Hispanic White members for almost all QoC measures. In particular, non-Hispanic Black members had significantly lower odds of compliance with CBP.
MCQS Goal(s)	Goals 1, 2, 5
Recommendation(s)	HHSC should select one or more sociodemographic groups with lower compliance with QoC measures, identify the SDoH-related barriers to care and develop evidence-based intervention strategies to reduce disparities in healthcare quality between members. To accurately analyze disparities by race/ethnicity, sampling strategies for hybrid measures would need to stratify the population by race and ethnic groups and oversample smaller demographic groups. Given the additional burden this may create for MCOs, a viable alternative for the state is to invest in a Health Information Exchange system so that desired data is available and accessible electronically. HHSC should consider working with the MCOs to design and implement focused interventions to improve the effective management of chronic and mental health conditions and healthcare quality for non-Hispanic Black members.
Finding(s)	The calculation of hybrid HEDIS measures CBP and CDC, relies on medical record data from a random sample of Texas Medicaid members sampled at the MCO level. This approach aligns with NCQA standards; however, it can create challenges when extrapolating results to a non-state level and may lead to the underrepresentation of vulnerable populations.
MCQS Goal(s)	Goals 1, 3, 4
Recommendation(s)	HHSC should consider expanding its data collection structure and integrating Health Information Exchange systems for hybrid measures. This could increase the coverage and accuracy of health quality measures, especially for underrepresented sub-populations.
Finding(s)	This study found that the frequency of compliance on the AWC measure was higher among all other race-ethnicity categories than it was among non-Hispanic White members. Further, compliance increased as the SVI increased. This pattern is at odds with the other QoC measures, for which higher vulnerability is associated with lower compliance.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should conduct additional studies of patterns of compliance on the AWC measure. HHSC should focus on identifying whether the pattern revealed in this study reflects more complex healthcare needs among vulnerable members rather than the better quality of care they receive.

Category	Description
Finding(s)	QoC measures reflect differences in patients' needs and differences in access to and the provision of healthcare. This study revealed significant disparities in QoC measure results based on the SVI score and sociodemographic category, with increased disparity among members with higher SVI scores. SDoH impacts people's healthcare needs and healthcare-seeking behavior, but it may also affect how healthcare providers meet patients' needs and manage their care.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should conduct a more in-depth examination of how SDoH affects access to and the provision of care, including the interaction between healthcare workers and beneficiaries, and the management of routine activities such as contacting and monitoring patients for scheduling follow-up visits and managing care. HHSC should also work with the MCOs to develop methods to identify and share MCO and provider best practices for a) collecting systematic data on SDoH, b) addressing SDoH-related disparities and barriers to healthcare provision, c) identifying resources that could facilitate the management of healthcare for HHSC beneficiaries across the social vulnerability spectrum.
Finding(s)	While this study identified some of the associations between SDoH (as measured through SVI), examining the causal relationships between SDoH dimensions and quality of healthcare is essential to identify what the healthcare system needs to address and to develop evidence-based strategies for reducing SDoH-related disparities.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should consider utilizing methods that allow for causal inference in more studies on the effects of SDoH on the quality of healthcare. For example, HHSC could pilot specific training programs for healthcare workers to meet SDoH-related needs by randomly selecting from its partnering providers. Similarly, it could test alternative approaches to meet SDoH-related member needs through experimental and quasi-experimental program evaluation designs, such as the provision of vouchers (randomized or staggered) to improve housing conditions or access to transportation and monitoring improvements in QoC measures

Study on Rider 36

Category	Description
Finding(s)	States employ a variety of practices to oversee the Medicaid MCO appeal process. Starting in 2020, Texas required MCOs to submit more details of the appeals data, which will allow Texas to conduct and report more in-depth summaries of MCO appeals data (HHSC, 2022c, Chapter 24.5.6). However, some states reportedly conduct more in-depth studies to improve MCO reporting of appeal data, validate MCO-reported data, and identify the types of services denied and reasons for the denials (Qlarant, 2021a, 2021c).
MCQS Goal(s)	Goals 1, 4, 5

Category	Description
Recommendation(s)	HHSC should consider conducting a more in-depth review of the updated MCO-reported quarterly appeals data to identify the most common types of services denied and overturned upon member appeal and the reason for the denials. This approach will allow a more meaningful interpretation of the appeals and SFH outcomes. HHSC should calculate the number of appeals per 1,000 members to compare the number of appeals between MCOs. This approach should enable meaningful comparisons of how outcomes of the appeals process related to the volume of appeals in relation to MCO size. HHSC should consider identifying how the impact of the appeals and SFH process and decisions impact member satisfaction.
Finding(s)	The EQRO reviewed seven years of MCO-reported appeals data for this report and identified opportunities for improvement in MCO reporting. The EQRO identified data discrepancies in the MCOs' first data submission and provided each MCO with a detailed summary of the discrepancies and the exact information that needed to be corrected. However, almost all MCOs resubmitted the appeal data with outstanding data discrepancies across all measurement years. As a result, not all the findings in this report related to the outcomes of appeals and SFH requests accurately reflect the true percentages of outcomes.
MCQS Goal(s)	Goals 1, 4, 5
Recommendation(s)	HHSC should work with the MCOs to improve their data reporting to ensure accurate data reporting. HHSC should conduct a record review of a random sample of MCO appeals documentation to validate the quarterly MCO-reported appeals data.
Finding(s)	MCOs had high compliance with the federal regulations for the appeals process. However, HealthSpring and Superior were not fully compliant with all regulations related to the timeliness of the review process. In addition, Aetna, CookCHP, HealthSpring, Superior, and UHC were not fully compliant with all the regulations related to the notification process for denials. Further, the compliance review results are based on MCO documentation in the policies and procedures. Therefore, the results do not indicate how often and to what extent each MCO meets the requirements of the regulations in practice.
MCQS Goal(s)	Goals 1, 4, 5
Recommendation(s)	MCOs that are not fully compliant with all applicable regulations for the appeals process should update all policies and procedures to ensure full compliance with the timeliness of the review and notification of denials. HHSC should conduct a record review of the MCO universe of appeals documentation to identify the extent to which MCOs comply with the regulations in practice and compliance levels determined based on the current document review of MCO policies and procedures.

Protocol 10: Assist with Quality Rating of MCOs

No recommendations.

HHSC Follow Up on EQRO Recommendations from SFY 2021

Protocol 1: Validation of PIPs

Category	Description
Finding(s)	A common reason for the loss of points on the Final PIP evaluation was due to measurement issues, which included MCOs/DMOs not conducting the statistical analyses according to their data analysis plan, reporting inconsistent data when compared to EQRO data files, and MCOs/DMOs not achieving a statistically significant improvement for all reported measures.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	All MCOs/DMOs should ensure their data analysis plans are appropriate for the reported measures and conduct the statistical analyses according to their data analysis plan for the Final PIP.
HHSC Actions	All MCOs/DMOs who score 5% below the median score are offered technical assistance to increase their scores and better their performance.
Finding(s)	During the 2018 PIPs, NCQA modified the HEDIS® technical specifications for the PPC measure for MY 2019 (re-measurement 2 of the 2018 PIPs). Rates for the postpartum sub-measure were inflated in the second re-measurement year of the 2018 PIPs (MY 2019) compared to baseline (MY 2017) because of the HEDIS® technical specification modifications for the PPC measure. Several MCOs that focused on PPC significantly improved from baseline in the postpartum sub-measure but not in the prenatal sub-measure. However, when asked to describe factors that may have influenced the results, nine MCOs did not discuss the technical specification modifications.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	The EQRO recommends MCOs monitor HEDIS® technical specification modifications that can influence PIP results and discuss the potential impacts in the Final PIPs when reviewing MCO performance, even if they did not achieve a significant improvement.
HHSC Actions	HHSC communicates HEDIS technical specification modifications that can influence PIP results.

Protocol 2: Validation of Performance Measures Reported by MCOs

No recommendations

Protocol 3: Review of Compliance with Medicaid & CHIP Managed Care Regulations

AI Interviews

Category	Description
Finding(s)	Several MCOs and DMOs reported challenges obtaining provider URL information and incorporating it into provider directories.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs and DMOs, including Aetna, CFHP, FirstCare, and UHC Dental, should establish systems to incorporate provider website URLs in their provider directories.
HHSC Actions	HHSC imposes corrective action plans (CAPs) on MCOs for deficiencies found during AI interviews.

Category	Description
Finding(s)	Many MCOs and DMOs requested clarification on the appropriate machine-readable format posted on their publicly facing websites.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	Aetna, CFHP, CookCHP, DentaQuest, FirstCare, and UHC Dental should provide machine-readable provider directories on their websites.
HHSC Actions	HHSC imposes corrective action plans (CAPs) on MCOs for deficiencies found during AI interviews.
Finding(s)	Several MCOs and DMOs did not have compliant procedures for the associated timeframes and notification protocols for expedited service authorization decisions.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs and DMOS, including CFHP, CookCHP, El Paso Health, FirstCare, and UHC Dental, should ensure their representatives make expedited service authorization decisions and notifications within the federally required timeframes.
HHSC Actions	HHSC imposes corrective action plans (CAPs) on MCOs for deficiencies found during AI interviews.
Finding(s)	Several MCOs and DMOs reported having state-compliant CHIP grievance system protocols; however, these system protocols were not compliant with updated federal guidelines.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs and DMOs with a CHIP product line need to evaluate their procedures to ensure that CHIP grievance system protocols align with Medicaid grievance system protocols, excluding the Medicaid requirement of continuation of benefits pending the appeal, a state fair hearing, or both.
HHSC Actions	HHSC imposes corrective action plans (CAPs) on MCOs for deficiencies found during AI interviews.
Finding(s)	Some MCOs and DMOs reported data collection on member SDoH needs. However, many MCOs and DMOs had not implemented procedures to aggregate the collected information.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	MCOs and DMOs need to systemically collect data on members' SDoH needs to aggregate needs by populations to impact member health and well-being effectively.
HHSC Actions	HHSC is convening an internal workgroup focused on SDoH. HHSC has added to the STAR+PLUS contract mandatory screening and referral. HHSC has developed an action plan to address NMDOH
Finding(s)	While some MCOs and DMOs had implemented specific SDoH related interventions, they had not clearly measured the direct and indirect effects for all of them.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	MCOs and DMOs should consider evaluating the impact of plan-driven SDoH-related interventions and referrals to community resources on members' health and well-being.
HHSC Actions	MCOs were encouraged to have housing related interventions to reduce Behavioral Health related PPAs for their 2023 PIPs. The NMDOH Action Plan specifically addresses housing as a priority.

Category	Description
Finding(s)	MCOs and DMOs reported several multi-agency collaborations to address SDoH needs in members.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	MCOs and DMOs should share SDoH-related interventions and best practices with other entities, including HHSC, to further address unmet needs that may impact the health of Texans enrolled in Medicaid and CHIP programs.
HHSC Actions	HHSC conducted a Quality Forum Webinars on SDoH where MCOs shared SDoH related interventions and best practices. The NMDOH Action Plan promotes collaboration through workgroups and stakeholder engagement.
Finding(s)	MCOs reported rapid transition by their providers to medical and behavioral health telehealth in response to the COVID public health emergency. Many MCOs discussed the importance of provider communication to ensure that providers adopted correct billing codes and modifiers to facilitate payment for telehealth services.
MCQS Goal(s)	Goals 1, 3, 6
Recommendation(s)	MCOs should continue exploring the efficiency of utilizing medical and behavioral health telehealth services and their impact on health outcomes.
HHSC Actions	HHSC continues to monitor the results of QoC. HHSC is working with the EQRO to study the impact of telehealth on behavioral health outcomes. Once HHSC studies this impact, we will collaborate with MCOs and share results in MCO meetings.

QAPI Evaluations

Category	Description
Finding(s)	This year, many of the MCOs and MMPs did not provide complete and accurate indicator goals, results, and/or analyses of results.
MCQS Goal(s)	Goals 1, 4
Recommendation(s)	The EQRO recommends that MCOs report complete and accurate goals, results, and analyses of results for the indicators used to monitor members' access to care and improvements in the quality of healthcare received by the members.
HHSC Actions	HHSC imposes corrective action plans (CAPs) on MCOs for deficiencies found in their QAPIs.
Finding(s)	This year, many of the MCOs and MMPs did not incorporate all recommendations from the previous year.
MCQS Goal(s)	Goals 1, 4
Recommendation(s)	The EQRO recommends that HHSC continue to emphasize the importance of incorporating prior year recommendations to the MCOs and MMPs.
HHSC Actions	HHSC imposes CAPs on MCOs for deficiencies found in their QAPIs.

Protocol 4: Validation of Network Adequacy

Appointment Availability

Category	Description
Finding(s)	STAR Kids MCOs need to reverse the downward trend in compliance with behavioral health appointment wait time standards. STAR Kids had the lowest percentage of compliant providers for behavioral health care appointment standards among all programs. The percentage of STAR Kids providers compliant with UMCM standards was 13.1 percentage points lower in 2021 than in 2018.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	STAR Kids MCOs should conduct root cause analyses (RCAs) to identify the driving factors behind lower rates of provider adherence to appointment standards among behavioral health providers and use the results to identify strategies for improving provider compliance.
HHSC Actions	HHSC imposes CAPs on MCOs for deficiencies found in Appointment Availability Studies. These CAPs include RCAs.
Finding(s)	In 2021, compliance with behavioral health appointment wait time standards decreased in CHIP, STAR+PLUS, and STAR Kids, compared to 2018.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	The EQRO recommends that HHSC conduct an in-depth study on behavioral health appointment wait times to: (1) better understand the challenges that MCOs encounter when trying to improve provider adherence to appointment standards and (2) more effectively target MCO incentives for providers that meet appointment availability standards.
HHSC Actions	HHSC and the EQRO are planning to study this in a Quarterly Topic Report in SFY 2023.
Finding(s)	CookCHP has the most room to improve compliance with wait time standards for behavioral health. CookCHP had the lowest percentage of providers in compliance with wait time standards for all product lines they serve (STAR, STAR Kids, CHIP).
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should strongly encourage CookCHP to conduct an RCA to identify the drivers for poor provider adherence to appointment standards CookCHP should use the RCA to identify specific approaches that they can use to encourage providers to make appointments available within 14 working days.
HHSC Actions	HHSC imposes CAPs on MCOs for deficiencies found in Appointment Availability Studies. These CAPs include RCAs.
Finding(s)	The EQRO excluded fewer providers from the behavioral health sub-study sample in 2021 because of incorrect taxonomies or other directory information.
MCQS Goal(s)	Goal 4
Recommendation(s)	The EQRO recommends that HHSC continue to work with MCOs and TMHP to improve provider directory information quality.
HHSC Actions	HHSC continues to work with TMHP in several different initiatives to improve provider directory information quality.

Category	Description
Finding(s)	In STAR Health, the percentage of appointments available dropped by 17.7 percentage points.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	The EQRO recommends that Superior (SHP) conduct an RCA to understand the decrease in available primary care appointments between 2020 and 2021 and use this information to identify ways to increase the percentage of providers with available appointments.
HHSC Actions	HHSC imposes CAPs on MCOs for deficiencies found in Appointment Availability Studies. These CAPs include RCAs.
Finding(s)	In 2021, the percentage of providers compliant with primary care standards for preventive and routine primary care decreased in CHIP and STAR+PLUS compared to 2020.
MCQS Goal(s)	Goals 1, 3
Recommendation(s)	As with behavioral health, the EQRO recommends that HHSC conduct an in-depth study on appointment wait times to: (1) better understand the challenges that MCOs encounter when trying to increase the percentage of providers that are compliant with appointment standards and (2) more effectively target MCO incentives to increase the percentage of providers that meet appointment availability standards.
HHSC Actions	HHSC and the EQRO are planning to study this in a Quarterly Topic Report in SFY 2023.

Medicaid Unmet Transportation Need Study

Category	Description
Finding(s)	A larger percentage of adult clients identified having unmet medical transportation needs (21.6 percent vs. 7.4 percent) and less familiarity with NEMT services (35 percent vs. 22.2 percent) compared to caregivers for younger clients.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	The EQRO recommends that HHSC develop targeted information campaigns about NEMT services tailored to older Medicaid clients (21+) to help increase awareness. Targeted information campaigns may help HHSC towards its MCQS goal of providing the right care for clients at the right time by facilitating client knowledge about access to care.
HHSC Actions	Since transportation was carved into Medicaid, members get their transportation needs met through their MCOs and this information is readily available on websites and member handbooks etc.

Category	Description
Finding(s)	Difficulty getting transportation that meets scheduling needs and distance to the bus/train stops were two of the more frequently noted barriers to medical transportation.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	Texas H.B. 1576, 86(R)(2019) directs HHSC to carve into managed care all NEMT services provided to clients enrolled in managed care Medicaid. As part of this shift in 2021, the EQRO recommends that HHSC encourage the MCOs to identify transportation strategies that provide members with scheduling flexibility and limit the distance that Medicaid members must travel to access transportation, which will help facilitate the use of NEMT services and the accessibility of care. The EQRO also recommends that HHSC do the same for newly enrolled Medicaid clients.
HHSC Actions	HHSC continues to improve accessibility of care through NEMT.
Finding(s)	A small percentage of clients (6.7 percent) said they reached out to their MCO or provider for help with transportation. Among those that did reach out, 46.5 percent said they 'usually' or 'always' received help. The percentage of adult clients that reached out to their MCO or provider was larger (12.9 percent) than the percentage of caregivers for children (2.8 percent).
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	The EQRO also recommends that HHSC conduct at least one follow-up study on unmet transportation needs among Medicaid beneficiaries after the transition above to assess whether there are any changes in the percentage of beneficiaries with unmet transportation needs or changes in levels of awareness among beneficiaries.
HHSC Actions	HHSC will continue to have the EQRO conduct the unmet need transportation study.

Protocol 5: Validation of Encounter Data Provided by MCOs

Encounter Data Submissions and MCO Encounter Data Production Capacity

Category	Description
Finding(s)	Variations in encounter submissions suggest underlying differences in the care delivery model that could affect QoC measures. While changes related to COVID-19 make it more challenging to identify other issues during SFY 2020, large single-month changes can also indicate a processing issue. When MCOs experience a processing issue and do not provide HHSC or the EQRO with accurate data or information explaining the issue, it can affect the use of the data for QoC measures.
MCQS Goal(s)	Goals 1, 3, 4
Recommendation(s)	HHSC should work with the EQRO, TMHP, and the MCOs/DMOs to improve the system to monitor monthly encounter submissions for anomalies and communicate about issues or discrepancies.
HHSC Actions	HHSC continues to work with the Encounter Data Validation Workgroup and other internal departments to communicate about issues or discrepancies.

Category	Description
Finding(s)	The EQRO found that for most MCO/SAs primary diagnoses, POA distributions were within the accepted ranges. However, primary diagnosis was coded not present on admission (POA code = N) more than 10 percent of the time for some MCOs.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	MCOs should work with their network hospitals to improve POA reporting.
HHSC Actions	HHSC conducted a Quality Forum Webinar on the impact of working with hospitals on data quality to improve POA reporting.
Finding(s)	In general, provider data quality went down relative to the prior year.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	HHSC should continue improving the provider information system, including identifying providers not eligible for NPI.
HHSC Actions	HHSC continues to work to improve the provider information system, with a new system in progress to address these deficiencies.
Finding(s)	The EQRO highlighted the need to improve the rate of CRA coding several years ago, and the measure improved slightly, but appropriate codes are still missing more than two percent of the time. The DMOs correctly deny these claims, but the data is still lost.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	DMOs should promote CRA coding with provider outreach in addition to denial of claims.
HHSC Actions	HHSC has communicated the importance of data quality with CRA coding with individual meetings and communications to DMOs.

Review of Medical and Dental Records for Consistency with Encounter Data

Encounter Data Validation Medical Record Review-CHIP

Category	Description
Finding(s)	The EQRO utilized the service facility address rather than the provider address from the Master Provider file when generating the mail-out for the study. In addition, after exhausting all measures to obtain records, the EQRO provided each MCO that had not met the required sample size with a list of outstanding records and the associated member and provider details for the MCO to obtain the outstanding records. The EQRO had a higher record return rate (78 percent) for this study compared to the record return rate for CHIP in the 2017 EDVMRR study (58 percent), which may have been due to the new approach the EQRO utilized for identifying provider addresses and obtaining records.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	The EQRO recommends utilizing the same approach for identifying provider addresses and requesting records for all EDV studies. To improve the record return rate and accuracy of provider addresses, the EQRO recommends reaching out to the MCOs before conducting the first mailing for the study to provide the MCOs with a list of ICNs and provider addresses for each member in the respective MCO sample and request that each MCO verify the provider addresses and make corrections where needed.
HHSC Actions	HHSC and the EQRO continue to work together to iterate the EDVMMR process to improve return rates.
Finding(s)	The EQRO did not receive enough records to meet the sample size requirements for FirstCare or HealthSpring after exhausting all record retrieval efforts because records were returned due to incorrect provider addresses. Therefore, the EQRO provided FirstCare and HealthSpring with a list of outstanding records and requested that both MCOs retrieve them and submit the records to the EQRO. HealthSpring obtained and submitted enough outstanding records to the EQRO to meet the sample size requirements.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	HHSC should provide each MCO with the provider information the EQRO has at the time of sampling for each ICN in the sample and ask each MCO to verify and/or correct all provider addresses at the start of the study.
HHSC Actions	HHSC and the EQRO continue to work together to iterate the EDVMMR process to improve return rates.
Finding(s)	FirstCare did not obtain and submit enough records to meet the sample size requirements, resulting in the EQRO deeming all FirstCare's match rates unreliable.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	FirstCare should ensure that all provider addresses are the most accurate addresses available at the start of each EDVMRR study. Further, FirstCare should take advantage of the opportunity to retrieve any outstanding records and submit them to the EQRO within the specified timeframe to ensure it meets the required sample size.
HHSC Actions	HHSC and the EQRO continue to work together to iterate the EDVMMR process to improve return rates.

Category	Description
Finding(s)	The overall match rates for MCOs were high across review categories (i.e., DOS, POS, PDx, and PX). However, several MCOs performed below average. The MCOs that scored below average across review categories were CFHP, FirstCare, PCHP, TCHP, and UHC. The primary reason for the lower match rates for these MCOs was that the encounter data included DOS, POS, PDx, and/or PXs that were not documented in the medical record.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	CFHP, FirstCare, PCHP, TCHP, and UHC should examine why what is in the encounter data is not documented in the medical record.
HHSC Actions	HHSC imposes CAPs on plans that perform poorly on EDV.

Encounter Data Validation Dental Record Review

Category	Description
Finding(s)	For previous dental EDV studies, the EQRO provided the DMOs with the ICNs and associated member and provider details, and the DMOs provided the EQRO with the corresponding provider addresses. The EQRO followed the same approach to identify provider addresses and obtain records for the most recent dental EDV study. MCNA and DentaQuest met the required sample size and had a higher record return rate (75 percent) for this study compared to the record return rate for the 2019 EDVDRR study (71 percent), which may have been due to improved DMO provider addresses since the EQRO used the same record retrieval methodology across dental EDV studies.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	The EQRO recommends that MCNA and DentaQuest examine their provider directories to identify factors that could influence the accuracy of provider addresses. The EQRO recommends utilizing the same approach for identifying provider addresses and requesting records for all EDV studies.
HHSC Actions	HHSC continues to work with DMOs on provider directories and will improve upon the approach for requesting records for all EDV studies.
Finding(s)	Match rates for all review categories (e.g., DOS, POS, and PX) were 90 percent or higher across programs and DMOs except MCNA (CHIP), which had had the lowest PX match rate at 89.4 percent.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	MCNA should explore why what is in the encounter data is not documented in the dental record for CHIP.
HHSC Actions	HHSC shares the Data Quality report with the MCOs and DMOs. HHSC is monitoring system in place for assessing CAPs.

Protocol 6: Administration of Quality of Care Surveys

Category	Description
Finding(s)	CHIP caregiver ratings on *Dental Plan Costs and Services* and overall *Dental Plan Rating* were much lower when compared to the Medicaid group, suggesting this is an area for improvement.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should do a deeper dive into the dental coverage for children in Medicaid and CHIP and identify potential factors that explain why members in CHIP express more dissatisfaction with dental services than Medicaid members.
HHSC Actions	HHSC strives to increase satisfaction with dental services in CHIP, but due to other priorities, HHSC will defer studying potential factors.

Protocol 7: Calculation of Performance Measures

Category	Description
Finding(s)	In 2020, Hispanic Medicaid members had fewer ED visits, fewer hospitalizations, and fewer C-sections than non-Hispanic White or non-Hispanic Black members.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should continue to explore QoC measure results across demographic and other member population groups to interpret results more clearly and better direct efforts to improve care for all Medicaid and CHIP members.
HHSC Actions	The THLC portal does have QoC measure results in demographic and other member population groups. HHSC will continue to look for other types of analysis along these lines.
Finding(s)	Renal Failure without dialysis was the most common PPC for STAR+PLUS members, while Shock and Septicemia contributed the most PPC weights. Septicemia and Shock also contributed the most weight among STAR members, but here the most common PPC reason, by far, was obstetric complications.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	The EQRO suggests investigating relationships between PPEs for specific conditions and patterns of preventive care for those conditions.
HHSC Actions	HHSC will continue to look for ways to study the relationships between PPEs and specific conditions and patterns of preventative care.
Finding(s)	MCO performance across Performance Indicator Dashboard measures varies; Some MCOs achieve the high standard on more than 60 percent of measures while others fail to meet the minimum standard on more than 40 percent of measures.
MCQS Goal(s)	Goals 1, 4, 6
Recommendation(s)	HHSC should continue leveraging the THLC portal (thlcportal.com) dashboards to help all Medicaid and CHIP stakeholders identify and understand trends in healthcare quality across state programs.
HHSC Actions	HHSC will continue leveraging the THLC Portal dashboards.

Category	Description
Finding(s)	SMM rates were consistently higher in STAR than in CHIP Perinatal between 2017-2020, most notably in (pre)eclampsia cases. Overall rates have trended down over this period.
MCQS Goal(s)	Goals 1, 2, 3, 4
Recommendation(s)	HHSC should continue to investigate the underlying drivers of maternal health disparities.
HHSC Actions	HHSC held a Quality Forum Webinar regarding maternal health and spoke about maternal health disparities with the MCOs and other stakeholders.
Finding(s)	Medicaid and CHIP covered over 50 thousand C-sections in deliveries without complications. Compared to uncomplicated deliveries without C-section, these deliveries incurred additional costs totaling over $100 million.
MCQS Goal(s)	Goals 1, 2, 3, 4
Recommendation(s)	HHSC should do a deeper investigation of C-section deliveries.
HHSC Actions	HHSC held a Quality Forum Webinar regarding maternal health and spoke about maternal health disparities with the MCOs and other stakeholders. HHSC continues to look for ways to reduce C-section deliveries.

Protocol 9: Conducting Focused Studies of Health Care Quality

STAR Kids Focus Study

Category	Description
Finding(s)	While access to specialist care has improved for STAR Kids MDCP members, improved network adequacy could address significant remaining barriers in access to physical, occupational, and speech therapies.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	STAR Kids MCOs should focus network adequacy efforts on ensuring that provider networks have sufficient special therapy providers with experience treating children with complex conditions. To achieve this, MCOs should: (1) identify and leverage strategies that have been successful in building networks of specialist providers, and particularly those who treat rare and complex conditions; and (2) share best practices in recruitment of special therapy providers with each other in collaborative contexts, such as stakeholder and advisory group meetings or jointly conducted performance improvement projects. STAR Kids MCOs should develop or improve existing policies and procedures for providing special therapies to STAR Kids MDCP members that account for specific member conditions and needs; caregiver limitations, assets, and preferences; and unexpected changes to members' health or living conditions.
HHSC Actions	The EQRO did provide a study reporting on Caregivers and Barriers in FY 2023.

Category	Description
Finding(s)	Although caregiver access to and satisfaction with service coordination for STAR Kids MDCP members has improved, many caregivers report functioning as their child's primary care coordinator for specific types of services, such as prescription medicines and medical supplies.
MCQS Goal(s)	Goals 2, 6
Recommendation(s)	STAR Kids MCOs should enhance the training of service coordinators to emphasize the challenges caregivers face in accessing medications and medical supplies for their children. Training materials and service coordination policies should address potential scenarios experienced by caregivers, such as being drawn into the coordination process by pharmacies and suppliers, filling expensive medications for rare conditions, or navigating the approval process with primary private insurance and Medicaid coverage. STAR Kids MCOs should consider or build upon programs to provide STAR Kids MDCP caregivers with services that reduce coordination and travel burden for caregivers, such as automatic medication refills, home delivery of medications, and delivery tracking for supplies.
HHSC Actions	HHSC and the MDCP Advisory Committee are engaging with external stakeholders to look at potential policy changes in detail.

Category	Description
Finding(s)	Low participation in the focus groups and under-representation of Hispanic and non-Hispanic Black caregivers limited the study. Without reaching thematic saturation, important issues for caregivers likely remain that the study did not uncover.
MCQS Goal(s)	Goals 2, 5
Recommendation(s)	HHSC should consider renewing this study in 2022, incorporating changes to methods to address participation issues encountered this year. Recommended strategies include: • Expanding the study to encompass all service areas statewide. The STAR Kids MDCP population is small (less than 4,700 in 2019) and including all service areas will produce a larger sample for recruitment. • Oversampling members in under-represented racial/ethnic groups. Given expected racial/ethnic differences in response rates in EQRO survey studies, such as lower response among caregivers of non-Hispanic Black members, oversampling can help correct non-response bias and improve representation. • Conducting semi-structured interviews rather than focus groups. Interviews are simpler to coordinate and may improve the participation of caregivers who are intimidated by focus group dynamics. • Reducing the number of points of interaction during telephone recruitment. Each point of interaction presents a risk of losing a prospective participant to follow-up. Interviews can be scheduled, and email addresses collected on the first call. • Coordinating the study with the existing STAR Kids biennial survey. The proposed study would coincide with the 2022 biennial survey and could contribute to the respondent burden. If feasible, adding a recruitment script to the end of the biennial survey tool could improve recruitment and participation. • Partnering with institutional and community groups that advocate for children with disabilities in Texas, such as the STAR Kids Managed Care Advisory Committee; Every Child, Inc.; and Texas Parent to Parent. The recruitment efforts may be improved with access to communication channels and community and family networks that these groups maintain.
HHSC Actions	HHSC is preparing to conduct another focus study and examining the Hispanic population more closely.

Quarterly Topic Reports

Examining Equity in Utilization of Teleservices and Quality of Care among Medicaid Members with Differing Social Vulnerabilities Before and During COVID-19

Category	Description
Finding(s)	The number of in-person face-to-face visits declined, and teleservice use increased during the COVID-19 study period.
MCQS Goal(s)	Goals 1, 3
Recommendation(s)	HHSC should continue to work with MCOs to maintain teleservice uptake through flexible teleservices reimbursement policies. HHSC should examine the decline in face-to-face visits during the COVID-19 study period to determine whether the decline was due to substituting face-to-face visits with teleservices or whether services not amenable to teleservices were not provided during the COVID-19 study period. MCOs should work with providers to provide outreach to patients who did not engage in needed face-to-face visits that are not amenable to teleservices during the COVID-19 study period. MCOs should identify and advocate for the use of teleservices delivery platforms that are accessible for persons with limited technology and connectivity resources to address disparities in teleservice use. HHSC should examine the extent to which MCOs are increasing accessibility of teleservices for persons with limited access.
HHSC Actions	The state of Texas passed legislation continuing teleservice flexibility first started during COVID-19 pandemic and is monitoring service utilization as the pandemic period closes.
Finding(s)	Members who did not engage in face-to-face or teleservice visits before the COVID-19 study period had lower odds of using teleservices during the COVID-19 study period.
MCQS Goal(s)	Goals 3, 6
Recommendation(s)	MCOs should work with providers to implement evidence-based strategies that eliminate disparities in care utilization, such as direct support professionals, including community health workers and patient navigators/care coordinators. HHSC should investigate barriers to accessing care for members who are not engaged in care.
HHSC Actions	HHSC is looking at ways to encourage MCOs to use direct support professionals including community health workers.

Category	Description
Finding(s)	Across programs, non-Hispanic Black members and members in rural areas had lower odds of using teleservices.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should work across agencies to address disparities in technology access among underserved sociodemographic groups and geographic areas. HHSC should work with MCOs to ensure that they thoughtfully implement efforts to sustain the expanded use of teleservices to limit further worsening the disparities in access to care among rural and non-Hispanic Black populations. MCOs should work with providers to implement teleservices using accessible and user-friendly platforms for persons with limited access to digital devices (e.g., smartphones, tablets, or computers), broadband access, and limited digital literacy skills.
HHSC Actions	The state of Texas passed legislation continuing teleservice flexibility first started during COVID-19 pandemic and is monitoring service utilization as the pandemic ends.
Finding(s)	Members with BH or chronic conditions had higher odds of using teleservices during the COVID-19 study period.
MCQS Goal(s)	Goals 2, 3, 5
Recommendation(s)	HHSC should conduct a study to identify which specific chronic or BH conditions were associated with teleservices use to understand utilization and gaps in services by condition and to examine the relationship between utilization of teleservices and disease management for these conditions. HHSC should investigate barriers to care for members with BH or chronic conditions who did not access teleservices during the COVID-19 study period.
HHSC Actions	HHSC is monitoring utilization of teleservices and BH condition as the COVID-19 pandemic ends.
Finding(s)	Higher county-level cumulative count of COVID-19 cases was associated with decreased odds of using teleservices among adults in STAR and STAR+PLUS. However, children living in counties with a high cumulative count of COVID-19 had higher odds of having a teleservice visit.
MCQS Goal(s)	Goals 2, 3
Recommendation(s)	HHSC should work with MCOs to examine county-level facilitators and barriers that influenced the implementation of teleservices for adults during the COVID-19 study period. HHSC should investigate whether MCOs had practices that might have prioritized teleservice use for children but not for adults in these higher-need areas.
HHSC Actions	HHSC is monitoring utilization of teleservices and BH condition as the COVID-19 pandemic ends.

Category	Description
Finding(s)	Teleservice use during the COVID-19 study period varied by MCO and SA.
MCQS Goal(s)	Goals 2, 3
Recommendation(s)	HHSC should conduct future studies to identify area-level barriers to accessing resources that facilitate teleservices. HHSC should work with MCOs to improve the use of teleservices by implementing evidence-based strategies that increase access to resources crucial for implementing teleservices, such as addressing limited broadband connectivity in under-resourced areas.
HHSC Actions	HHSC is monitoring utilization of teleservices as the COVID-19 pandemic ends.
Finding(s)	Members who used teleservices during the COVID-19 study period had increased odds of having a PPV or PPA during the same period.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	HHSC should examine the temporal association between teleservices and PPVs and PPAs during the COVID-19 study period to assess the extent to which teleservice use preceded a PPE (suggesting that teleservices were not sufficient to prevent the ED visit or hospital admission) and the extent to which it followed a PPE (suggesting that teleservices may have been part of follow-up after discharge).
HHSC Actions	HHSC is monitoring utilization of teleservices as the COVID-19 pandemic ends.

Texas Medicaid MCO Strategies to Promote HPV Vaccination Among Medicaid Providers and Members

Category	Description
Finding(s)	Vaccine hesitancy, delays getting children in for preventive care visits, and missed clinical opportunities are important barriers to increasing the percentage of teens with a timely HPV vaccine initiation and the percentage that are up to date (UTD) on the HPV vaccine in Medicaid and CHIP.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	HHSC should require all MCOs to specifically address HPV vaccine hesitancy as one of their upcoming Performance Improvement Projects (PIPs). HHSC should determine whether all Medicaid MCOs have established policies for (a) identifying and effectively responding to providers with consistently low rates of timely HPV vaccine initiation, consistently low rates of members that are UTD, or both, and (b) identifying and effectively reaching out to members that are not UTD, are at risk for initiating the HPV vaccine after age 13, or both. MCOs should also incorporate evidence-based strategies for addressing vaccine hesitancy when communicating directly with members.
HHSC Actions	HHSC has shared the results with Policy internal team who plans to reach out to providers to close gaps in system. The office of the Medical Director (OMD) is part of Community of Practice Group sharing strategies across states to decrease vaccine hesitancy across vaccines and promote better internal and external processes.

Category	Description
Finding(s)	MCOs identified provider-patient communication as an important way to address vaccine hesitancy among parents of teens.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	HHSC should encourage MCOs to pursue alternative payment models (APMs) that incentivize providers to strengthen provider communication about the HPV vaccine. MCOs should conduct studies to evaluate the utilization and effectiveness of their educational resources to help strengthen provider communication about the HPV vaccine. MCOs should use evidence-based approaches when training providers to recommend the HPV vaccine. The National Institute for Health (NIH) currently recommends the training resources available from the Gillings School of Public Health at the University of North Carolina: hpviq.org.
HHSC Actions	HHSC has several initiatives aimed at increasing rates of immunization for HPV and is working with the Department of State Health Services to increase immunizations.
Finding(s)	The descriptive analysis of HPV vaccine records suggests disparities in the number of teens with a timely HPV vaccine initiation and teens that are UTD on the HPV vaccine associated with age, rurality, ethnicity, and Medicaid service delivery models.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC and the MCOs should do a deeper dive to examine the root causes of these potential vaccination disparities and use the information to strengthen their quality improvement strategies for child vaccination.
HHSC Actions	HHSC has several initiatives aimed at increasing rates of immunization for HPV and is working with the Department of State Health Services to increase immunizations.
Finding(s)	The percentage of 11-year-old members that initiated an HPV vaccination is >20 percentage points below all other ages. A lower rate among younger members is consistent with the literature. However, it is unclear whether this difference was moderated by COVID-19-related social distancing policies, parental decisions to delay HPV vaccination, or both.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should conduct a study to compare the differences in rates of HPV vaccination among the members in this cohort to a pre-COVID-19 cohort of members aged 11-16 years as of December 2018. HHSC should also conduct a study to assess how rates of routine childhood vaccination differ before and after March 2020 and identify the strategies MCOs are using to encourage members to return to provider offices for vaccination.
HHSC Actions	HHSC has several initiatives aimed at increasing rates of immunization for HPV and is working with the Department of State Health Services to increase immunizations.

Examining Transition to the Medicaid for Breast and Cervical Cancer Program for Women Diagnosed with Cervical Cancer

Category	Description
Finding(s)	Most members in MBCC do not experience cervical cancer treatment delays.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	HHSC should continue to work with BCCS providers to maintain flexibilities that allow them to submit MBCC eligibility documentation electronically and facilitate quicker processing of MBCC applications.
HHSC Actions	HHSC will continue to work with BCCS providers.
Finding(s)	There is a lack of awareness of the BCCS and MBCC programs by patients and local Medicaid offices.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should work across agencies to increase awareness of BCCS and MBCC, especially within the local community where underserved women seek information about services. HHSC should work with BCCS providers and MCOs to increase awareness of the programs and resources offered among Texas residents. Given that the BCCS and MBCC programs serve specific geographical areas, HHSC should work with each program to ensure tailored strategies to increase awareness in specific geographical areas for targeted outreach.
HHSC Actions	HHSC has been working internally to address this problem in Access and Eligibility Services and internal training so that individuals are aware of the program. Awareness is also promoted by website and HHSC continues to make updates to website.

Category	Description
Finding(s)	Both BCCS providers and MCOs identified communication challenges and difficulties reaching patients.
MCQS Goal(s)	Goals 1, 2, 3, 6
Recommendation(s)	BCCS providers and MCOs should implement evidence-based strategies to reach hard-to-reach populations, such as the use of healthcare navigators, and consider limited access to technology and connectivity resources among underserved populations. MCOs should promote the Lifeline Assistance Program, which provides Medicaid members with a free cell phone with minutes, texts, and data (FCC, 2021). MCOs should also consider implementing or continue implementing value-added services that improve member access to communication technology. HHSC should investigate barriers to accessing care for members who are not engaged in treatment. MCOs should work with clinicians to implement evidence-based programs that eliminate disparities in the initiation of treatment. For example, direct support professionals, including community health workers, and patient navigators/care coordinators, improve continuity of care by supporting patients in addressing barriers that prevent patients from engaging in timely cancer treatment. HHSC should work with BCCS and MBCC programs to increase knowledge of cervical cancer through public health education strategies targeted at under-served populations served by the programs. Improving cervical cancer education could improve engagement for women diagnosed with cervical cancer by increasing knowledge about the disease and the importance of timely screening and treatment.
HHSC Actions	HHSC continues to investigate ways of reaching hard to reach populations and increasing the number of providers available.
Finding(s)	Patients lack access and proximity to cervical cancer specialists who accept MBCC.
MCQS Goal(s)	Goals 3, 6
Recommendation(s)	MCOs should conduct a study to assess the number of cervical cancer specialists who cover MBCC services in their service area and focus on improving clinician availability in areas identified as lacking clinicians who cover MBCC services. Although all MCOs cited transportation as a barrier, none of the MBCC providers reported referring patients to Medicaid's NEMT services. MCOs should increase awareness of the non-emergency medical transportation program among staff.
HHSC Actions	HHSC has since carved in NEMT into Medicaid managed care. HHSC continues to work with MCOs on increasing awareness of NEMT services.
Finding(s)	MCOs do not provide MBCC specific value-added services or resources.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	HHSC should work with MCOs to identify evidence-based interventions such as cervical cancer patient navigation programs designed to reduce barriers to initiating or supporting continuity of care that MCOs could implement as value-added services.
HHSC Actions	HHSC continues to work with MCOs to identify evidence-based interventions to reduce barriers.

Category	Description
Finding(s)	BCCS providers do not provide follow-up services once patients enroll in MBCC.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should support data sharing between BCCS and MBCC through Med-IT to support follow-up. HHSC should consider extending the recertification requirement to every 12 months, given that cervical cancer treatment duration may take more than six months.
HHSC Actions	HHSC is assessing policy changes that can support these recommendations.
Finding(s)	HHSC should update information about cervical cancer resources and train BCCS providers on determining MBCC eligibility for patients.
MCQS Goal(s)	Goals 4, 6
Recommendation(s)	HHSC should update the HTW website and inform the providers that HTW covers cervical cancer diagnostic services. The HTW website currently lists that HTW only covers screening services. HHSC should train BCCS providers on MBCC qualifying cervical cancer diagnosis criteria. HHSC should provide training opportunities for BCCS providers focused on determining income eligibility for patients who are self-employed or with non-traditional employment.
HHSC Actions	HHSC strives to provide up to date information for services covered by HTW. There have been legislative changes to HTW after this study was completed.

Texas Medicaid STAR Kids Descriptive Analysis of Individual Service Plans for MDCP members

Category	Description
Finding(s)	The percentage of Hispanic members authorized for financial management services was lower than that of non-Hispanic White or non-Hispanic Black members.
MCQS Goal(s)	Goals 2, 5
Recommendation(s)	HHSC should conduct additional studies to explore ways to provide financial management services to Hispanic members not normally authorized for this type of HCBS service. The STAR Kids ISP Narrative form (Form 2603) includes items that address service preferences, including a discussion of preferences for CDS. A study that incorporates analysis of this form for MDCP members may help to understand racial/ethnic differences in authorization for FMS. To determine whether a study of STAR Kids ISP Narrative form data would be feasible, the EQRO recommends first identifying the availability and quality of data in this form collected by STAR Kids MCOs.
HHSC Actions	HHSC is conducting a focus study regarding understanding challenges and barriers for caregivers, stratified by race and ethnicity, resulting in differences in authorization.

Category	Description
Finding(s)	A substantial percentage of caregivers (29 percent) reported some other caregiver burden that the 12 categories assessed in the SK-SAI did not capture.
MCQS Goal(s)	Goals 2, 5
Recommendation(s)	HHSC should conduct further studies of "other" caregiver burden responses. Qualitative analysis of these open-ended responses may reveal new sources of caregiver burden and potentially inform modifications to the SK-SAI to ensure these sources of caregiver burden are more systematically assessed.
HHSC Actions	HHSC is conducting a focus study regarding understanding challenges and barriers for caregivers, stratified by race and ethnicity

Protocol 10: Assist with Quality Rating of MCOs

No recommendations

Appendices

Appendix A: 3M™ Clinical Risk Group Classification

The 3M™ Clinical Risk Groups (CRG) classification system describes the health status and burden of illness of individuals in a population. The CRG system, a categorical clinical model, classifies each member of the population based on their burden of medical conditions, assigning each to a single mutually exclusive risk category. The system classifies individuals based on one or more chronic conditions or combinations of conditions, with breakouts for condition-specific severity of illness, and for individuals without a chronic condition, by one or more significant acute illnesses or other significant health events, such as delivery or newborn birth. Those without a chronic or significant acute condition are in various groups for "healthy." The CRG system stratifies populations for risk adjustment, predicting healthcare utilization and cost, tracking health outcomes, and analyzing the health of populations. Grouping assigns individuals to nine status categories[11]

Status 9 – *Catastrophic Conditions*. Catastrophic conditions include long-term dependency on medical technology (e.g., dialysis, respirator, total parenteral nutrition) and life-defining chronic diseases or conditions that dominate the medical care required (e.g., acquired quadriplegia, severe cerebral palsy, cystic fibrosis, history of heart transplant).

Status 8 – *Malignancy, Under Active Treatment*. A malignancy under active treatment.

Status 7 – *Dominant Chronic Disease in Three or More Organ Systems*. Three or more (usually) dominant Primary Chronic Diseases (PCDs). In selected instances, criteria for one of the three PCDs may be met by selected moderate chronic PCDs.

Status 6 – *Significant Chronic Disease in Multiple Organ Systems*. Two or more dominant or moderate chronic PCDs.

Status 5 – *Single Dominant or Moderate Chronic Disease*. A single dominant or moderate chronic PCD.

Status 4 – *Minor Chronic Disease in Multiple Organ Systems.* Two or more minor chronic PCDs.

Status 3 – *Single Minor Chronic Disease*. A single minor chronic PCD.

Status 2 – *History of Significant Acute Disease*.[12]

Prospective Model – Within the most recent six months of the analysis period, one or more significant acute Episode Diagnostic Categories (EDCs) or significant Episode Procedure Categories (EPCs) along with the absence of any validated PCDs present.

Concurrent Model – differs in that certain acute EDCs, i.e., pregnancy, can override the assignment to chronic illness CRGs in Status 3-6 or Status 3-4.

Status 1 – *Healthy*. For the Prospective Model, the Healthy Status is defined by the absence of any significant acute EDCs or EPCs occurring within the last six months of the analysis period along with the absence of any validated PCDs reported at any time during the analysis period.

[11] Extracted from the 3M™ Clinical Risk Groups (CRG) Classification Methodology, Methodology overview, Software version 2.0 February 2019.

[12] The Prospective and Concurrent models classify individuals based on the same information and share most grouping logic and specifications. Differences can result in an assignment to a different base CRG or severity level.

For some reports, the EQRO further groups these categories based on levels (minor, moderate, and major) of special healthcare needs (SHCN). These group definitions are:

3M CRG Status	Special Healthcare Need (SHCN) group
Status 1 – *Healthy*	Healthy
Status 2 – *History of Significant Acute Disease*	Significant Acute Disease
Status 3 – *Single Minor Chronic Disease* Status 4 – *Minor Chronic Disease in Multiple Organ Systems*	SHCN – Minor (Minor Chronic Disease)
Status 5 – *Single Dominant or Moderate Chronic Disease*	SHCN – Moderate (Moderate Chronic Disease)
Status 6 – *Significant Chronic Disease in Multiple Organ Systems* Status 7 – *Dominant Chronic Disease in Three or More Organ Systems* Status 8 – *Malignancy, Under Active Treatment* Status 9 – *Catastrophic Conditions*	SHCN – Major (Major or Catastrophic Disease)

Appendix B: Key Data Elements Used for Evaluating the Validity & Completeness of Managed Care Organization (MCO) Encounter Data

Medical Encounter Header Key Fields

Fields	V21 Field Name	Description
Member ID	H_MBR_PRMRY_MBR_ID_NO	Submitted member primary identification number.
Start Date of Service[1]	H_FRM_SVC_DT	The date on which the first services were rendered.
End Date of Service	H_TO_SVC_DT	The date on which the last services were rendered.
Adjudication Date	H_ADJDCTN_DT	The date the MCO paid the claim.
Amount Paid	H_PD_AMT	The total amount paid by the MCO for the encounter.
Primary Diagnosis (TXN_TYP = I or P)	H_PRNCPL_DIAG_CD	Principal Diagnosis Code: The principal diagnosis (ICD-10-CM) listed on the encounter. (Excludes dental encounters)
Type of Bill (TXN_TYP = I)	H_TYP_OF_BILL	This code indicates (1) the type of facility (e.g., hospital), (2) the type of care (e.g., inpatient), and (3) the frequency code (e.g., interim) for the submitted institutional encounter. (Institutional encounters only)
FAC (TXN_TYP = I)	HI_ENCR_FIN_ARNGMNT_CD	The code indicating the MCO designated financial arrangement between the MCO and its provider/subcontractor for the submitted institutional encounter. (Institutional encounters only)
Admission Date	H_ADMSN_DT	The date the member was admitted to a healthcare facility.
Discharge Date	H_DCHG_DT	The date the member was discharged from the facility.
Discharge Status (TXN_TYP = I)	HI_PTNT_STS_CD	A code submitted only on an 837 institutional encounter that identifies the patient status as of the end of statement date. (Institutional encounters only)
Billing Provider NPI[2]	HP_BLNG_PRV_NTNL_PRV_ID	Billing Provider National Provider Identifier

[1] Start date is part of the primary record key in the data warehouse. The EQRO reviews this field at the time of data loading for consistency with expectations. It defines the record cohort for evaluating the other key fields, so cannot be missing or invalid in that analysis.

[2] Billing provider NPI is part of the provider data analysis along with rendering NPI and taxonomies.

Medical Encounter Detail Key Fields

Fields	V21 Field Name	Description
Start Date of Service	D_FRM_SVC_DT	The date on which the first services for the detail were rendered.
End Date of Service	D_TO_SVC_DT	The date that the last services were rendered for the detail. In most situations, from and to dates are the same for details.
Amount Paid (TXN_TYP = P or D)	D_PD_AMT	The total amount paid by the MCO for an individual detail regardless of where the service was provided and/or who provided the service. (Dental or professional encounters only)
Place of Service (TXN_TYP = P or D)	D_PLC_OF_SVC_CD	A code that identifies where the service was performed. (Dental or professional encounters only)
FAC (TXN_TYP = P or D)	D_ENCR_FIN_ARNGMNT_CD	The code that indicates the MCO designated financial arrangement between the MCO and its provider/subcontractor for the submitted encounter detail line (Dental or professional encounters only)
Service Code (TXN_TYP = P or D)	D_PROC_CD	A procedure code submitted by a provider to define the service(s) rendered. (Dental or professional encounters only)
Revenue Code (TXN_TYP = I)	D_LN_RVNU_CD	A revenue code pertaining to the detail. (Institutional encounters only)

Pharmacy Encounter Key Fields

Fields	Description
Member ID	Submitted member primary identification number.
Amount Paid	The total amount paid by the MCO for a prescription
Prescription Date	The date the prescription was written
Fill Date	The date the prescription was filled
NDC	The Food and Drug Administration's National Drug Code for the prescribed drug
TCN	The pharmacy claim number
Quantity	The quantity dispensed (must match with units to be valid)
Days Supplied	Days covered by the prescription
Prescribing NPI	The individual prescriber's National Provider Identifier
Dispensing Pharmacy NPI	The billing National Provider Identifier for the dispensing pharmacy

Appendix C: Present on Admission (POA) Screening Criteria

Primary Diagnosis POA Codes

The percentage of reported non-exempt primary diagnoses with POA codes on acute inpatient institutional encounter records (Transaction Type = 'I,' and Type of Bill in '11x', '12x', or '41x') is reported, along with the distribution of valid POA codes ('Y,' 'N,' 'U,' 'W'). The expectation is that most primary diagnoses are present on admission ('Y'). The percentages of POA with values 'U' and 'W' should be very low as these indicate a deficiency in the data collection process. POA codes and the values the EQRO considers areas of concern for primary diagnoses are:

POA Code	Description	EQRO Area of Concern
Y	Diagnosis was present at the time of inpatient admission	<90%
N	Diagnosis was not present at the time of inpatient admission	≥10%
U	Documentation was insufficient to determine if the condition was present at the time of inpatient admission	≥1%
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission	≥1%

Secondary Diagnoses POA Codes

The POA codes for secondary diagnoses are critical to calculating PPC rates. When hospital providers do not accurately report these POA, PPC rates and risk adjustment are biased. For inclusion in PPC calculations, data screening at the provider level uses four criteria developed by 3M. First, POA indicator value "U" (no information in the record) is mapped to "N" (not present on admission), and value "W" (clinically undetermined) is mapped to "Y" (present on admission). The EQRO then evaluates the distribution of POA indicators (Y/N) for all non-exempt pre-existing secondary diagnoses for the encounters indicated for each criterion. The criteria for assessing secondary diagnoses are:

Screening	Definition	Grey zone	Red zone
1	Identifies high percent non-POA (POA = N) for pre-existing secondary diagnosis codes (excluding exempt codes).	5% to < 7.5%	≥ 7.5%
2	Identifies extremely high percent present on admission (POA = Y) for secondary diagnosis codes (excluding exempt, pre-existing, and OB 7600x-7799x codes).	93% to < 96%	≥ 96%
3	Identifies extremely low percent present on admission (POA = Y) for secondary diagnosis codes (excluding exempt, pre-existing, and OB 7600x-7799x codes).	> 70% to 77%	≤ 70%
4	Identifies high percent present on admission (POA = Y) for elective surgery secondary diagnosis codes.	≤ 30% to < 40%	≥ 40%

Appendix D: Summary of Quality Measures Calculated & Reported by the EQRO by Program

HEDIS Effectiveness of Care

A - Calculated using administrative data; H - Calculated using HEDIS hybrid methodology
Red signals a new measures or changes in reporting.
[a] MDCP = STAR Kids MDCP, SMI = STAR+PLUS Severe Mental Illness, Mat = Pregnant during the MY, HTW = Healthy Texas Women
[b] Included on the HHSC performance dashboard

Prevention & Screening

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a]
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	H[b]	H[b]	-	-	H[b]	-	-	-
CIS	Childhood Immunization Status	H/A[b]	H/A[b]	-	A	H/A[b]	A	-	-
IMA	Immunizations for Adolescents	H/A[b]	H/A[b]	-	A	H/A[b]	A	-	-
BCS	Breast Cancer Screening	-	A	A[a]	-	-	A	A	SMI
CCS	Cervical Cancer Screening	-	A[b]	H[b]	-	-	A	-	~~SMI, Mat~~, HTW
CHL	Chlamydia Screening in Women	A[b]	A[b]	A[b]	A	A	A	A	All

Respiratory Conditions

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a]
CWP	Appropriate Testing for Children w/ Pharyngitis	A[b]	A[b]	A	A	A[b]	A	A	MDCP, SMI
SPR	Use of Spirometry Testing in Assessment and Diagnosis of COPD	-	-	A[b]	-	-	-	A	SMI
PCE	Pharmacotherapy Management of COPD Exacerbation	-	-	A[b]	-	-	-	A	SMI
AMR	Asthma Medication Ratio	A[b]	A[b]	A[b]	A	A[b]	A	A	MDCP, SMI, Mat

Cardiovascular Conditions

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a]
CBP	Controlling High Blood Pressure	-	H[b]	H[b]	-	-	-	-	-
SPC	Statin Therapy for Patients w/ Cardiovascular Disease	-	A	A[b]	-	-	-	A	SMI
CRE	Cardiac Rehabilitation	-	A	A	-	-	A	A	-

Diabetes

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a]
CDC	Hemoglobin A1c (HbA1c) Testing	-	H/A[b]	H/A[b]	-	-	-	-	-
CDC	HbA1c Control (<8.0%)	-	H[b]	H[b]	-	-	-	-	-
CDC	HbA1c Poor Control (>9.0%)	-	H[b]	H[b]	-	-	-	-	-
CDC	Eye Exam	-	A[b]	A[b]	-	-	A	A	SMI, Mat
KED	Kidney Health Evaluation for Patients with Diabetes	-	A	A	-	-	A	A	
SPD	Statin Therapy for Patients w/ Diabetes	-	A	A[b]	-	-	A	A	SMI

Behavioral Health

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a]
AMM	Antidepressant Medication Management	-	A[b]	A[b]	A	-	A	A	SMI, Mat, HTW
ADD	Follow-Up Care for Children Prescribed ADHD Medication	A[b]	A[b]	-	A[b]	A[b]	A	A	MDCP
FUH	Follow-Up after Hospitalization for Mental Illness	A[b]	A[b]	A[b]	A[b]	A[b]	A	A	SMI, Mat
FUM	Follow-Up After Emergency Department Visits for Mental Illness	A	A[b]	A[b]	A[b]	A[b]	A	A	SMI, Mat
FUI	Follow-Up after High-Intensity Care for Substance Use Disorder	A[b]	A[b]	A[b]	A[b]	A[b]	A	A	SMI, Mat
FUA	Follow-Up After Emergency Department Visits for Alcohol and Other Drug Dependence	A	A[b]	A[b]	A	A	A	A	SMI, Mat
POD	Pharmacotherapy for Opioid Use Disorder	-	A	A	-	-	A	A	SMI, Mat
SSD	Diabetes Screening for People W/ Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	-	A	A[b]	-	-	A	A	SMI, Mat
SMD	Diabetes Monitoring for People W/ Diabetes and Schizophrenia	-	A	A[b]	-	-	A	A	SMI
SMC	Cardiovascular Monitoring for People W/ Cardiovascular Disease and Schizophrenia	-	-	A[b]	-	-	-	A	SMI
SAA	Adherence to Antipsychotic Medications for Individuals W/ Schizophrenia	-	A	A[b]	-	-	A	A	SMI, Mat
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	A[b]	A[b]	-	A[b]	A[b]	A	A	MDCP

Overuse/Appropriateness

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a]
URI	Appropriate Treatment for Upper Respiratory Infection	A[b]	A[b]	A	A	A[a]	A	A	MDCP, SMI
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis	A	A[b]	A[b]	A	A	A	A	MDCP, SMI, Mat
HDO	Use of Opioids at High Dosage	-	A[b]	A[b]	-	-	A	A	SMI, Mat
UOP	Use of Opioids from Multiple Providers	-	A[b]	A[b]	-	-	A	A	SMI, Mat
COU	Risk of Continued Opioid Use	-	A	A	-	A	A	A	MDCP, SMI, Mat

HEDIS Access/Availability of Care

A - Calculated using administrative data; H - Calculated using HEDIS hybrid methodology
Red signals a new measures or changes in reporting.
[a] MDCP = STAR Kids MDCP, SMI = STAR+PLUS Severe Mental Illness, Mat = Pregnant during the MY, HTW = Healthy Texas Women
[b] Included on the HHSC performance dashboard

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a]
AAP	Adults' Access to Preventive/Ambulatory Health Services	-	A	A[b]	-	-	A	A	SMI, Mat, HTW
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	A	A[b]	A[b]	A	A[b]	A	A	SMI, ~~Mat~~
HEDIS-PPC	Prenatal and Postpartum Care	A	H[b]	A[b]	A	A	A	A	SMI, ~~Mat~~
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	A[b]	A[b]	-	A[b]	A[b]	A	A	MDCP

HEDIS Utilization & Risk Adjusted Utilization

A - Calculated using administrative data; H - Calculated using HEDIS hybrid methodology
Red signals a new measures or changes in reporting.
[a] MDCP = STAR Kids MDCP, SMI = STAR+PLUS Severe Mental Illness, Mat = Pregnant during the MY, HTW = Healthy Texas Women
[b] Included on the HHSC performance dashboard

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a]
W30	Well-Child Visits in the First 30 Months of Life	A[b]	A[b]	-	A[b]	A[b]	A	A	MDCP
WCV	Child and Adolescent Well-Care Visits	A[b]	A[b]	-	A[b]	A[b]	A	A	MDCP
AMB	Ambulatory Care	A	A	A	A	A	A	A	MDCP, SMI, Mat
IPU	Inpatient Utilization–General Hospital/Acute Care	A	A	A	-	A	A	A	MDCP, SMI, Mat
IAD	Identification of Alcohol and Other Drug Services	A	A	A	-	A	A	A	SMI, Mat
MPT	Mental Health Utilization	A	A	A	A	A	A	A	MDCP
PCR	Plan All-Cause Readmission	-	A[b]	A[b]	-	A	A	A	MDCP, SMI, Mat

HHSC Maternal Health Measures

I = Calculated by the EQRO

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a]
OAP	Pregnancy Associated Outcomes	I	I	I	I	I	I	i	I
CES	Cesarean Sections	I	-	I	I			I	I

AHRQ Quality Indicators – Area Measures

A = Calculated using administrative data
[a] Included on the HHSC performance dashboard (prospective for STAR Kids)

Prevention Quality Indicators (PQIs)

Code	Prevention Quality Indicators (PQI)	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS
PQI 1	Diabetes short-term complications	-	A[a]	A[a]	-	-	A
PQI 3	Diabetes long-term complications	-	A[a]	A[a]	-	-	A
PQI 5	COPD or asthma in older adults	-	A[a]	A[a]	-	-	A
PQI7	Hypertension	-	A[a]	A[a]	-	-	A
PQI 8	Heart failure	-	A[a]	A[a]	-	-	A
PQI 11	Bacterial pneumonia	-	A[a]	A[a]	-	-	A
PQI 12	Urinary tract infection	-	A[a]	A[a]	-	-	A
PQI 14	Uncontrolled diabetes	-	A[a]	A[a]	-	-	A
PQI 15	Asthma in younger adults	-	A[a]	A[a]	-	-	A
PQI 16	Lower extremity amputation among patients w/ diabetes	-	A[a]	A[a]	-	-	A
PQI 90	Prevention Quality Overall Composite	-	A	A	-	-	A
PQI 91	Prevention Quality Acute Composite	-	A	A	-	-	A
PQI 92	Prevention Quality Chronic Composite	-	A	A	-	-	A
PQI 93	Prevention Quality Diabetes Composite	-	A	A	-	-	A

Pediatric Quality Indicators (PDIs)

Code	Pediatric Quality Indicators (PDI)	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS
PDI 14	Asthma	A[a]	A[a]	-	A[a]	A	A
PDI 15	Diabetes short-term complications	A[a]	A[a]	-	A[a]	A	A
PDI 16	Gastroenteritis	A[a]	A[a]	-	A[a]	A	A
PDI 18	Urinary tract infection	A[a]	A[a]	-	A[a]	A	A
PDI 90	Pediatric Quality Overall Composite	A	A	-	A	A	A
PDI 91	Pediatric Quality Acute Composite	A	A	-	A	A	A
PDI 92	Pediatric Quality Chronic Composite	A	A	-	A	A	A

Other CHIPRA Core & CMS Adult Core Measures

A - Calculated using administrative data; T – Provided by HHSC
Red signals new measures or changes in reporting.
[a] MDCP = STAR Kids MDCP, SMI = STAR+PLUS Severe Mental Illness, Mat = Pregnant during the MY, HTW = Healthy Texas Women
[b] Included on the HHSC performance dashboard

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a].
DEV	Developmental Screening in the First 3 Years of Life	A[b]	A[b]		A[b]	A[b]	A	A	MDCP
CCP	Contraceptive Care - Postpartum Women	-	A	A	A	A	A	-	-
CCW	Contraceptive Care - All Women	-	A	A	A	A	A	-	HTW
COB	Concurrent Use of Opioid and Benzodiazepines	-	A	A	-	A	A	-	-
LBW	Low Birth Weight Infants	-	T[b]	T	T	T	T	-	-
HLV	HIV Viral Suppression	T	T[b]	T[b]	T	T[b]	T	-	-

3M Health Information Systems Measures of PPEs

A - Calculated using administrative data
[a] Included on the HHSC performance dashboard

Code	Potentially Preventable Events (PPE) Measure	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS
PPV	Potentially Preventable Emergency Department (ED) Visits	A[a]	A[a]	A[a]	A	A[a]	A
PPA	Potentially Preventable Admissions	A[a]	A[a]	A[a]	A	A[a]	A
PPR	Potentially Preventable Readmissions	A[a]	A[a]	A[a]	A	A[a]	A
PPC	Potentially Preventable Complications	A	A	A[a]	A	A[a]	A
PPC	Potentially Preventable Ancillary Services	A	A	A	A	A	A

Dental Quality Measures

A = Calculated using administrative data
Red signals a new measures or changes in reporting.

Quality of Care

Type	Annual Dental Visits (ADV) Submeasure	CMDS	CHIP Dental
HEDIS	% Of members enrolled for at least 11 of the past 12 months who had at least one annual dental visit	A	A
HEDIS	As above, aged 2 to 3 years	A	A
HEDIS	As above, aged 4 to 6 years	A	A
HEDIS	As above, aged 7 to 10 years	A	A
HEDIS	As above, aged 11 to 14 years	A	A
HEDIS	As above, aged 15 to 18 years	A	A
HEDIS	As above, aged 19 to 20 years	A	-

Preventive Dental Services

Type	Annual Dental Visits (ADV) Submeasure	CMDS	CHIP Dental
PDENT	**CMS PDENT-CH** - % of members, aged 1 yr. and older, enrolled for 90 days who had at least one preventive dental service during the federal fiscal year	A	A
THSteps	THSteps Care Measures a) Percent of members (aged 1 to 20 years) receiving exactly one THSteps Dental Checkup per year b) Percent of members (aged 1 to 20 years) receiving at least two THSteps Dental Checkup per year Combined Rate=0.5*rate of one checkup + Rate of at least two checkups Based on recommended standards of THSteps dental checkup visits (2 visits per year), the sub-measure of one checkup will receive 50% of the weight of the sub-measure of at least two checkups.	A	-
THSteps	% Of members (aged 1 to 20 years) receiving more than two THSteps Dental Checkups per year	A	-
THSteps	% Of new members (aged 1 to 20 years) receiving at least one THSteps Dental Checkup w/in 90 days of enrollment	A	-
DQA	**Sealants in Years 6 to 9**- *RETIRED*	-	-
DQA	**Sealants in Years 10 to 14** - *RETIRED*	-	-
DQA	**Oral Evaluation** - % of members enrolled for at least 6 months who received a comprehensive or periodic oral evaluation w/in the reporting year	A	A
DQA	**Topical Fluoride** (for children with elevated risk of caries)- *RETIRED*	-	-
DQA	**Sealant Receipt on Permanent 1st Molars** 1) % Of enrolled children who ever received sealants on at least one permanent first molar tooth by their 10th birthdate 2) % Of enrolled children who ever received sealants on all four permanent first molar teeth by their 10th birthdate."	A	A
DQA	**Sealant Receipt on Permanent 2nd Molars** 1) % Of enrolled children who ever received sealants on at least one permanent second molar tooth by their 15th birthdate 2) % Of enrolled children who ever received sealants on all four permanent second molar teeth by their 15th birthdate."	A	A
DQA	**Topical Fluoride -** % of enrolled children who received at least two topical fluoride applications s as (a) dental OR oral health services, (b) dental services, and (c) oral health services within the reporting year	A	A

Continuity of Care

Type	Annual Dental Visits (ADV) Submeasure	CMDS	CHIP Dental
DQA	Care Continuity- % of members, aged 1 yr. and older, enrolled in two consecutive years for at least 6 months in each year who received a comprehensive or periodic oral evaluation in both years	A	A

DQA Measures

A - Calculated using administrative data

Utilization of Dental Services

Type	Measure	CMDS	CHIP Dental
HHSC	% Of members enrolled for at least 11 of the past 12 months who had at least one orthodontic service during the MY*	A	A
DQA	Utilization of Services - % of members enrolled for at least 6 months who received at least one dental service w/in the reporting year *	A	A
DQA	Treatment Services -- % of members enrolled for at least 6 months who received a treatment service w/in the reporting year *	A	A
DQA	Total Amount Paid Per-Member Per-Month for Dental Services	A	A

Emergency Department Visits for Dental Caries

Type	Measure	CMDS	CHIP Dental
DQA	Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children -- Number of emergency department visits for caries-related reasons per 100,000 member-months for all enrolled children	A	A
DQA	Follow-Up After Emergency Department Visits for Dental Caries in Children -- Percentage of ambulatory care sensitive Emergency Department (ED) visits for dental caries among children in the reporting period for which the member visited a dentist w/in 7 days of the ED visit.	A	A
DQA	Follow-Up After Emergency Department Visits for Dental Caries in Children -- Percentage of ambulatory care sensitive Emergency Department (ED) visits for dental caries among children in the reporting period for which the member visited a dentist w/in 30 days of the ED visit.	A	A

CAHPS Health Plan Survey 5.0H Experience of Care

S(A) - Conducted annually; S(B) - Conducted biennially
Red indicates a new measure or change in reporting
[a] CPA = Adult Version, CPC = Child Version, CCC = Child Version with Children with Chronic Conditions
[b] Only on the CMS Core Survey
[c] Included on the HHSC performance dashboard

Version[a]	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	Medicaid-Statewide[b]	CHIP-Statewide[b]
CPA	Rating of All Health Care	-	S (B)	S (B)	-	-	S (A)	-
CPA	Rating of Personal Doctor	-	S (A)[c]	S (A)[c]	-	-	S (A)	-
CPA	Rating of Specialist Seen Most Often	-	S (B)	S (B)	-	-	S (A)	-
CPA	Rating of Health Plan	-	S (A)[c]	S (A)[c]	-	-	S (A)	-
CPA	Customer Service	-	S (B)	S (B)	-	-	S (A)	-
CPA	Getting Care Quickly	-	S (A)[c]	S (A)	-	-	S (A)	-
CPA	% Good access to urgent care	-	S (A)	S (A)[c]	-	-	S (A)	-
CPA	% Good access to routine care	-	S (A)	S (A)[c]	-	-	S (A)	-
CPA	Getting Needed Care	-	S (A)[c]	S (A)	-	-	S (A)	-
CPA	% Good access to specialist appointments	-	S (A)	S (A)[c]	-	-	S (A)	-
CPA	% Good access to non-specialist appointments	-	S (A)	S (A)	-	-	S (A)	-
CPA	How Well Doctors Communicate (good experience w/ doctors' communication)	-	S (A)[c]	S (A)[c]	-	-	S (A)	-
CPA	Coordination of Care *DISCONTINUED*	-	-	-	-	-	~~S (A)~~	-
CPC	Rating of All Health Care			-	-	S (B)	S (A)	S (A)
CPC	Rating of Personal Doctor	S (A)[c]	S (A)[c]	-	-	S (B)[c]	S (A)	S (A)
CPC	Rating of Specialist Seen Most Often			-	-	S (B)	S (A)	S (A)
CPC	Rating of Health Plan	S (A)[c]	S (A)[c]	-	-	S (A)[c]	S (A)	S (A)
CPC	Customer Service			-	-	S (B)	S (A)	S (A)
CPC	Getting Care Quickly	S (A)[c]	S (A)	-	-	S (A)[c]	S (A)	S (A)

Version[a]	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	Medicaid-Statewide[b]	CHIP-Statewide[b]
CPC	% Good access to urgent care	S (A)	S (A)[c]	-	-	S (A)	S (A)	S (A)
CPC	% Good access to routine care	S (A)[c]	S (A)[c]	-	-	S (A)	S (A)	S (A)
CPC	Getting Needed Care			-	-	S (A)[c]	S (A)	S (A)
CPC	% Good access to specialist appointments			-	-	S (A)	S (A)	S (A)
CPC	% Good access to non-specialist appointments			-	-	S (A)	S (A)	S (A)
CPC	How Well Doctors Communicate (good experience w/ doctors' communication)	S (A)[c]	S (A)[c]	-	-	-	S (A)	S (A)
CPC	Coordination of Care *DISCONTINUED*	-	-	-	-	-	~~S (A)~~	-
CCC	Access to Specialized Services	-	-	-	-	S (A)[c]	-	-
CCC	Access to medical equipment	-	-	-	-	S (A)	-	-
CCC	Access to special therapy	-	-	-	-	S (A)	-	-
CCC	Access to behavioral health treatment or counseling	-	-	-	-	S (A)[c]	-	-
CCC	Family-Centered Care: Personal Doctor Who Knows Child	-	-	-	-	S (A)[c]	-	-
CCC	Coordination of Care for Children w/ Chronic Conditions	-	-	-	-	S (B)	-	-
CCC	Access to Prescription Medicines	-	-	-	-	S (A)	-	-
CCC	Family-Centered Care: Getting Needed Information	-	-	-	-	S (A)	-	-

CAHPS Health Plan Survey 5.0H Effectiveness of Care

S(A) - Conducted annually; S(B) - Conducted biennially
[a] CPA = Adult Version, CPC = Child Version, CCC = Child Version with Children with Chronic Conditions
[b] Only on the CMS Core Survey

HEDIS Code	Measure	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	Medicaid-Statewide[a]	CHIP-Statewide[a]
MSC	Medical Assistance w/ Smoking Cessation and Tobacco Use	-	-	-	-	-	S (A)	-
FVA	Flu Vaccinations for Adults Ages 18-64	-	-	-	-	-	S (A)	-

Survey Measures from the National Survey of Children's Health

S(A) - Conducted annually; S(B) - Conducted biennially
[a] Only on the CMS Core Survey

Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	Medicaid-Statewide[a]	CHIP-Statewide[a]
Help arranging or coordinating child's care (any source)	-	-	-	-	S (A)[a]	-	-
Discussion of transition to care as an adult (ages 12-17)	-	-	-	-	S (A)[a]	-	-
% Very satisfied w/ communication among child's providers	-	-	-	-	-	-	-

Use of Consumer Directed Services Reported by MCOs

T - Calculated by HHSC
[a] Included on the HHSC performance dashboard
[b] HCBS = home and community-based services

Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	Medicaid-Statewide[a]	CHIP-Statewide[a]
% Members Utilizing Consumer Directed Services (CDS) Personal Care	-	-	-	-	T[a],	-	-
% Members Utilizing Consumer Directed Services (CDS) MDCP Respite	-	-	-	-	T[a],	-	-
% Members Utilizing Consumer Directed Services (CDS) HCBS[b] Personal Attendant	-	-	T[a]	-	-	-	-
% Members Utilizing Consumer Directed Services (CDS) Non-HCBS[b] Primary Home Care	-	-	T[a]	-	-	-	-

Appendix E: 3M™ Potentially Preventable Complications Classification System Definitions

These Potentially Preventable Complications (PPC) definitions are Extracted from the 3M™ Potentially Preventable Complications (PPC) Classification System Methodology Overview[13].

Major PPC Groups

PPC Group	Group Description
1	Extreme Complications
2	Cardiovascular-Respiratory Complications
3	Gastrointestinal Complications
4	Perioperative Complications
5	Infectious Complications
6	Malfunctions, Reactions, etc.
7	Obstetrical Complications
8	Other Medical and Surgical Complications

PPC Level Descriptions

PPC Level	Type	Group Description
1	Other	Potentially serious complications that do not rise to the same level of clinical significance as major complications because they are not as consistently likely to pose a serious or sustained threat to health or to result in as great an increase in hospital resource use.
2	Major	Those complications that have the most consistent and significant impact on acute and chronic health and cause the largest increase in hospital resource use.
3	Monitor	Complications that can vary in their association with problems in the quality of care due to inconsistency in the application and interpretation of coding criteria from one hospital to another. This level contains just two PPCs – Renal failure without dialysis and Clostridium Difficile Colitis. Although these complications should not be used for definitive quality assessments, they should be monitored to check for changes in occurrence.

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PPC Categories with Group and Weight

PPC Category[a]	PPC Description	PPC Group	HCUP PPC Weight V38
1	Stroke & Intracranial Hemorrhage	2	0.9039
2	Extreme CNS Complications	1	0.4633
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	2	0.4569
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1	1.7106
5	Pneumonia & Other Lung Infections	2	1.2970
6	Aspiration Pneumonia	2	0.9264
7	Pulmonary Embolism	2	0.9635
8	Other Pulmonary Complications	2	0.8447
9	Shock	1	1.0616
10	Congestive Heart Failure	2	0.4215
11	Acute Myocardial Infarction	2	0.4080
13	Other Acute Cardiac Complications	2	0.3708
14	Ventricular Fibrillation/Cardiac Arrest	1	0.5104
15	Peripheral Vascular Complications except Venous Thrombosis	2	1.5090
16	Venous Thrombosis	2	1.2464
17	Major Gastrointestinal Complications without Transfusion	3	1.2438
18	Major Gastrointestinal Complications with Transfusion	3	1.5322
19	Major Liver Complications	3	0.7269
20	Other Gastrointestinal Complications	3	1.0848
21	Clostridium Difficile Colitis	5	1.3374
22	This category intentionally excluded. Category 22 was retired and Categories 65 and 66 were added.	x	x
23	Genitourinary Complications Except Urinary Tract Infection	8	0.5927
24	Renal Failure without Dialysis	8	0.4250
25	Renal Failure with Dialysis	1	2.9041
26	Diabetic Ketoacidosis & Coma	8	0.5297
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	8	0.9763
28	In-Hospital Trauma and Fractures	8	0.3846
29	Poisonings except from Anesthesia	6	0.1351
30	Poisonings due to Anesthesia	6	
31	Pressure Ulcer	8	2.7328
32	Transfusion Incompatibility Reaction	6	0.4156
33	Cellulitis	5	0.9128
34	Other Infections	5	1.3198

PPC Category[a]	PPC Description	PPC Group	HCUP PPC Weight V38
35	Septicemia & Severe Infections	5	1.2404
36	Acute Mental Health Changes	8	0.3335
37	Post-Procedural Infection & Deep Wound Disruption Without Procedure	4	1.3681
38	Post-Procedural Wound Infection & Deep Wound Disruption with Procedure	4	2.4643
39	Reopening Surgical Site	4	1.6782
40	Peri-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Procedure	4	0.7260
41	Peri-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Procedure	4	1.0269
42[b]	Accidental Puncture/Laceration during Invasive Procedure	4	0.6227
44	Other Surgical Complication - Moderate	8	1.0823
45[c]	Post-Procedural Foreign Bodies and Substance Reaction	4	0.5990
47	Encephalopathy	8	0.7349
48	Other Complications of Medical Care	8	1.0747
49	Iatrogenic Pneumothorax	6	0.4897
50	Mechanical Complication of Device, Implant & Graft	6	1.1623
51	Gastrointestinal Ostomy Complications	6	1.5360
52	Infection, Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection	6	1.1149
53	Infection, Inflammation and Clotting complications of Peripheral Vascular Catheters and Infusions	6	0.5286
54	Central Venous Catheter-Related Infection	6	2.9646
59	Medical & Anesthesia Obstetric Complications	7	0.1259
60	Major Puerperal Infection and Other Major Obstetric Complications	7	1.0779
61	Other Complications of Obstetrical Surgical & Perineal Wounds	7	0.2041
63	Post-Procedural Respiratory Failure with Tracheostomy	1	7.5726
64	Other In-Hospital Adverse Events	8	
65	Urinary Tract Infection	5	0.6778
66	Catheter-Related Urinary Tract Infection	5	0.8001

[a] Starting with PPC Version 36, 6 PPC categories (PPCs 12, 55, 56, 57, 58, 62) are suspended by 3M for further evaluation.
[b] In ICD-10, PPC 43 has been eliminated and the accidental cuts during medical procedures will be captured in PPC 42.
[c] Starting with PPC Version 36, PPC 46 – Post-Procedural Substance Reaction and Non-O.R. Procedure for Foreign Body has been eliminated and its content has been combined with PPC 45 – Post-Procedural Foreign Bodies. PPC 45 has been renamed to Post-Procedural Foreign Bodies and Substance Reaction.

Appendix F: Measures Used in Report Card Rating Calculations

Measure Sources

Report card measures come from three major sources:

1. CAHPS® - Consumer Assessment of Healthcare Providers and Systems,
2. HEDIS® - Healthcare Effectiveness Data and Information Set – reported in Quality of Care (QoC) tables
3. NSCH - National Survey of Children's Health

CHIP Report Cards

Domain	Report Card Text	Specification	Data Source
Experience of Care	Children get appointments as soon as needed	Non-emergent component of CAHPS *Getting Care Quickly*	CHIP Caregiver Annual Report Card Survey
Experience of Care	Doctors listen carefully, explain clearly, and spend enough time with people	CAHPS *How Well Doctors Communicate*	CHIP Caregiver Annual Report Card Survey
Experience of Care	Parents give high ratings to their child's personal doctor	CAHPS *Rating of Personal Doctor*	CHIP Caregiver Annual Report Card Survey
Experience of Care	Parents give high ratings to the health plan	CAHPS *Rating of Health Plan*	CHIP Caregiver Annual Report Card Survey
Staying Healthy	Children and teens get regular checkups	Composite: HEDIS *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* (W34); HEDIS *Adolescent Well-Care Visits* (AWC).	CHIP QoC Tables
Staying Healthy	Children and teens get their vaccines	Composite: HEDIS *Childhood Immunization Status* (CIS), *combination 10*; HEDIS *Immunizations for Adolescents* (IMA), *combination 2*	CHIP QoC Tables
Common Chronic Conditions	Children get medicine for asthma	HEDIS *Asthma Medication Ratio* (AMR)	CHIP QoC Tables
Common Chronic Conditions	Children see the doctor for ADHD (Attention Deficit Hyperactivity Disorder)	HEDIS *Follow-Up Care for Children Prescribed ADHD Medication* (ADD), *initiation phase*	CHIP QoC Tables

STAR Child Report Cards

Domain	Report Card Text	Specification	Data Source
Experience of Care	Children get appointments as soon as needed	Non-emergent component of CAHPS *Getting Care Quickly*	STAR Child Caregiver Annual Report Card Survey
Experience of Care	Doctors listen carefully, explain clearly, and spend enough time with people	CAHPS *How Well Doctors Communicate*	STAR Child Caregiver Annual Report Card Survey
Experience of Care	Parents give high ratings to their child's personal doctor	CAHPS *Rating of Personal Doctor*	STAR Child Caregiver Annual Report Card Survey
Experience of Care	Parents give high ratings to the health plan	CAHPS *Rating of Health Plan*	STAR Child Caregiver Annual Report Card Survey
Staying Healthy	Babies get regular checkups	HEDIS *Well-Child Visits in the First 15 Months of Life* (W15), *six or more well-child visits*	STAR QoC Tables
Staying Healthy	Children and teens get regular checkups	Composite: HEDIS *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* (W34); HEDIS *Adolescent Well-Care Visits* (AWC)	STAR QoC Tables
Staying Healthy	Children and teens get their vaccines	Composite: HEDIS *Childhood Immunization Status* (CIS), *Combination 10*; HEDIS *Immunizations for Adolescents* (IMA), *Combination 2*	STAR QoC Tables
Common Chronic Conditions	Children get medicine for asthma	HEDIS *Asthma Medication Ratio* (AMR)	STAR QoC Tables
Common Chronic Conditions	Children see the doctor for ADHD (Attention Deficit Hyperactivity Disorder)	HEDIS *Follow-Up Care for Children Prescribed ADHD Medication* (ADD), *initiation phase*	STAR QoC Tables

STAR Adult Report Cards

Domain	Report Card Text	Specification	Data Source
Experience of Care	People get care, tests, and treatment easily	Component of CAHPS *Getting Needed Care*	STAR Adult Member Annual Report Card Survey
Experience of Care	Doctors listen carefully, explain clearly, and spend enough time with people	CAHPS *How Well Doctors Communicate*	STAR Adult Member Annual Report Card Survey
Experience of Care	People give high ratings to their personal doctor	CAHPS *Rating of Personal Doctor*	STAR Adult Member Annual Report Card Survey
Experience of Care	People give high ratings to the health plan	CAHPS *Rating of Health Plan*	STAR Adult Member Annual Report Card Survey
Staying Healthy	Women get checkups during pregnancy	HEDIS *Prenatal and Postpartum Care* (PPC), *timeliness of prenatal care*	STAR QoC Tables
Staying Healthy	New mothers get checkups after giving birth	HEDIS *Prenatal and Postpartum Care* (PPC), *postpartum care*	STAR QoC Tables
Staying Healthy	People get regular yearly checkups	HEDIS *Adults' Access to Preventive/Ambulatory Health Services* (AAP)	STAR QoC Tables
Staying Healthy	Women get regular screenings for cervical cancer	HEDIS *Cervical Cancer Screening* (CCS)	STAR QoC Tables
Common Chronic Conditions	People get care for depression and constant low mood	HEDIS *Antidepressant Medication Management* (AMM), *acute phase*	STAR QoC Tables
Common Chronic Conditions	People get care for diabetes	Composite of two components of HEDIS *Comprehensive Diabetes Care* (CDC): *HbA1c testing*; and *Eye exam (retinal) performed*.	STAR QoC Tables

STAR+PLUS Report Cards

Domain	Report Card Text	Specification	Data Source
Experience of Care	People get care, tests, and treatment easily	Component of CAHPS *Getting Needed Care*	STAR+PLUS Member Annual Report Card Survey
Experience of Care	Doctors listen carefully, explain clearly, and spend enough time with people	CAHPS *How Well Doctors Communicate*	STAR+PLUS Member Annual Report Card Survey
Experience of Care	People give high ratings to their personal doctor	CAHPS *Rating of Personal Doctor*	STAR+PLUS Member Annual Report Card Survey
Experience of Care	People give high ratings to the health plan	CAHPS *Rating of Health Plan*	STAR+PLUS Member Annual Report Card Survey
Staying Healthy	People get regular yearly checkups	HEDIS *Adults' Access to Preventive/Ambulatory Health Services* (AAP)	STAR+PLUS QoC Tables
Staying Healthy	Women get regular screenings for breast and cervical cancer	Composite: HEDIS *Breast Cancer Screening* (BCS); HEDIS *Cervical Cancer Screening* (CCS)	STAR+PLUS QoC Tables
Common Chronic Conditions	People get care for depression and constant low mood	HEDIS *Antidepressant Medication Management* (AMM), *acute phase*	STAR+PLUS QoC Tables
Common Chronic Conditions	Doctors follow up after urgent treatment for alcohol, opioid, or other drug use	HEDIS *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* (IET), *initiation of AOD treatment*	STAR+PLUS QoC Tables
Common Chronic Conditions	Doctors follow up after urgent treatment for mental illness	Composite: HEDIS *Follow-Up after Hospitalization for Mental Illness* (FUH), *7-Day*; HEDIS *Follow-Up After Emergency Department Visit for Mental Illness* (FUM), *7-Day*	STAR+PLUS QoC Tables
Common Chronic Conditions	People get tests and treatment for COPD (Chronic Obstructive Pulmonary Disease)	Composite: HEDIS *Pharmacotherapy Management of COPD Exacerbation* (PCE); HEDIS *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* (SPR).	STAR+PLUS QoC Tables
Common Chronic Conditions	People get care for diabetes	Composite of two components of HEDIS *Comprehensive Diabetes Care* (CDC): *HbA1c testing*; and *Eye exam (retinal) performed*.	STAR+PLUS QoC Tables

STAR Kids Report Cards

Domain	Report Card Text	Specification	Data Source
Getting Care	People get care, tests, and treatment easily	Component of CAHPS *Getting Needed Care*	STAR Kids Caregiver Annual Report Card Survey
Getting Care	People get regular checkups	Composite: HEDIS *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* (W34); HEDIS *Adolescent Well-Care Visits* (AWC)	STAR Kids QoC Tables
Getting Care	People get special therapy easily	Component of CAHPS *Getting Specialized Services*	STAR Kids Caregiver Annual Report Card Survey
Getting Care	People get prescription medicines easily	CAHPS *Getting Prescription Medicine*	STAR Kids Caregiver Annual Report Card Survey
Services and Support	People get help arranging or coordinating care	NSCH K5Q20_R, part of Indicator 4.12e *Effective care coordination*	STAR Kids Caregiver Annual Report Card Survey
Services and Support	Doctors and other health providers answer questions	CAHPS *Family-Centered Care: Getting Needed Information*	STAR Kids Caregiver Annual Report Card Survey
Services and Support	Doctors discuss eventual transition to adult care for adolescents (12-17)	NSCH TREATADULT, part of Indicator 4.15 *Transition to adult health care, age 12-17 years*	STAR Kids Caregiver Annual Report Card Survey
Services and Support	People give high ratings to the health plan	CAHPS *Rating of Health Plan*	STAR Kids Caregiver Annual Report Card Survey
Mental and Behavioral Health	People get emotional and behavioral counseling easily	Component of CAHPS *Getting Specialized Services*	STAR Kids Caregiver Annual Report Card Survey
Mental and Behavioral Health	Doctors follow up after hospitalization for mental illness	HEDIS *Follow-Up After Hospitalization for Mental Illness* (FUH), *7-Day*	STAR Kids QoC Tables
Mental and Behavioral Health	Health monitoring for people using antipsychotics	HEDIS *Metabolic Monitoring for Children and Adolescents on Antipsychotics* (APM)	STAR Kids QoC Tables

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