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External Quality Review of Texas Medicaid and CHIP Managed Care Summary of Activities

State Fiscal Year 2020

Quality, Timeliness, and Access to Healthcare
for Texas Medicaid and CHIP Recipients
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EQRO
Texas External Quality Review Organization

Table of Contents

Table of Contents ii
Table List viii
Figure List ix
Abbreviations x
Executive Brief 2
Introduction 2
EQRO Activities 2
Focus Areas 3
Maternal Health 3
Behavioral Health 4
Health Disparities 6
Conclusion 8
Introduction 9
STAR 12
STAR+PLUS 13
STAR Kids 14
STAR Health 15
CHIP 16
EQRO Responsibilities 17
Protocol 1: Validation of PIPs 18
PIP Timelines and Reporting 18
The COVID-19 Pandemic 19
Summary of Current and On-going PIPs 19
2018 PIPs 19
2019 PIPs 19
2020 PIPs 20
Evaluations and Results 20
2019 PIPs 20
2020 PIPs 21
Discussion 23
Recommendations 23
Protocol 2: Validation of Performance Measures 24

Information Systems, Processes, and Data Used in Performance Measures 24
HEDIS Hybrid Measures 25
Access and Service Measures 26
THSteps Checkups Report 26
Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations 27
Administrative Interviews (AIs) 27
Results 28
Recommendations 28
Evaluation of QAPIs 29
Results 30
Recommendations 32
Protocol 4: Validation of Network Adequacy 33
Appointment Availability Study 33
Relevance 33
Key Findings 34
Recommendations 34
Texas Medicaid NEMT Services Study 34
Relevance 34
Key Findings 35
Recommendations 35
Provider Referral Study 35
Relevance 35
Key Findings 35
Recommendations 35
Protocol 5: Validation of Encounter Data 37
Encounter Data Submissions and MCO Encounter Data Production Capacity 37
Analysis of Encounter Data for Accuracy and Completeness 37
Volume Analysis Based on Service Category 38
Data Validity and Completeness Analysis 38
FSR Analysis 41
Recommendations 41
Review of Medical Records for Consistency with Encounter Data 41
Methodology 41
Results 42

Recommendations 48
Protocol 6: Administration of QOC Surveys 49
Survey Methods 49
Instruments and Sample Selection 49
Survey Fielding 49
Survey Results 50
Experience of Care – Adult Surveys 50
Experience of Care – Child Surveys 51
Experience of Care – STAR Health 18+ and STAR Kids 18+ Surveys 53
Recommendations 53
Protocol 7: Calculation of Performance Measures 54
Measures Overview 54
NCQA HEDIS measures 54
CHIPRA Core Measures 54
Adult Core Measures 54
3M™ Health Information Systems Measures of PPEs 54
AHRQ Prevention Quality Indicators and Pediatric Quality Indicators 55
Dental Quality Alliance Measures 55
Severe Maternal Morbidity / Pregnancy Associated Outcomes 55
Cesarean Section Deliveries 55
Calculations 55
Results and Reporting 57
National QOC Measures 57
Potentially Preventable Events 60
OAP and C-Section Deliveries 65
Recommendations 67
Protocol 9: Conducting Focused Studies of Healthcare Quality 68
Focus Studies 69
SDoH and Their Impact on Health Care Quality Measures in Texas Medicaid and CHIP Populations 69
Quarterly Topic Reports (QTR) 70
Spending, Service Delivery, and Follow-up for STAR+PLUS Members with SMI 70
Health Care Quality Measures for STAR Members with SMI or SED 71
Development of a Personalized Quality-of-Care (PQOC) Index for Maternal Health 73
Documenting and Addressing SDoH by Texas Medicaid Managed Care Plans 74

Issue Briefs 76
Health Teleservices for Prenatal and Postpartum Care 76
Trends in Alternative Payment Models for Increasing Access to Patient-Centered Maternal Care 77
Medical P4Q in STAR+PLUS: MCO Perspectives and Strategies 78
Protocol 10: Assist with Quality Ratings 80
Performance Indicator Dashboard Measures 80
Pay-For-Quality (P4Q) Performance Dashboard 80
MCO Report Cards 80
Structure 81
k-means Clustering for Star Ratings 82
EQRO Recommendations and Texas Managed Care Quality Strategy 89
Follow-Up to Recommendations Made in SFY 2019 89
Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations 89
Protocol 2: Validation of Performance Measures Reported by MCOs 90
Protocol 3: Validation of PIPs 90
Protocol 4: Validation of Encounter Data Reported by MCOs 91
Protocol 5: Validation and Implementation of Surveys 93
Protocol 6: Calculation of Performance Measures 94
Protocol 8: Conducting Focused Studies of Health Care Quality 97
Recommendations Made in SFY 2020 112
Protocol 1: Validation of PIPs 112
Protocol 2: Validation of Performance Measures Reported by MCOs 112
Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations 112
Protocol 4: Validation of Network Adequacy 113
Protocol 5: Validation of Encounter Data Provided by MCOs 115
Protocol 6: Administration of Quality of Care Surveys 117
Protocol 7: Calculation of Performance Measures 117
Protocol 9: Conducting Focused Studies of Health Care Quality 119
Protocol 10: Assist with Quality Rating of MCOs 130
Appendix A: 3M™ Clinical Risk Group (CRG) Classification 131
Appendix B: PIP topics 133
2018 PIPs 133
2019 PIPs 133
2020 PIPs 133

Appendix C: Key Data Elements Used for Evaluating the Validity and Completeness of Managed Care Organization (MCO) Encounter Data 136
Appendix D: Present on Admission (POA) Screening Criteria 138
Appendix E: Summary of Quality Measures Calculated and Reported by the EQRO by Program 139
HEDIS Effectiveness of Care 139
Prevention and Screening 139
Respiratory Conditions 139
Cardiovascular Conditions 140
Diabetes 140
Behavioral Health 141
Overuse/Appropriateness 141
HEDIS Access/Availability of Care 142
HEDIS Utilization and Risk Adjusted Utilization 143
HHSC Maternal Health Measures 143
AHRQ Quality Indicators – Area Measures 144
Prevention Quality Indicators (PQIs) 144
Pediatric Quality Indicators (PDIs) 145
Other CHIPRA Core and CMS Adult Core Measures 145
3M Health Information Systems Measures of PPEs 146
Dental Quality Measures 146
Quality of Care 146
Preventive Dental Services 147
Continuity of Care 148
Utilization of Dental Services 148
Emergency Department Visits for Dental Caries 149
CAHPS Experience of Care 150
CAHPS Health Plan Survey 5.0H, Adult Version 150
CAHPS Health Plan Survey 5.0H, Child Version 150
CAHPS Health Plan Survey 5.0H, Child Version for Children with Chronic Conditions 151
CAHPS Supplemental Measures 152
CAHPS Effectiveness of Care (HEDIS) 152
Survey Measures from the National Survey of Children's Health 153
Use of Consumer Directed Services Reported by MCOs 153
Appendix F: 3M™ Potentially Preventable Complications (PPC) Classification System Definitions 154

PPC Groups 154
PPC Level 154
PPC Categories 155
Appendix G: Measures Used in 2021 Report Card Ratings Calculations 157
Measure Sources 157
CHIP Report Cards 157
Experience of Care Domain 157
Staying Healthy Domain 157
Common Chronic Conditions Domain 157
STAR Child Report Cards 158
Experience of Care Domain 158
Staying Healthy Domain 158
Common Chronic Conditions Domain 158
STAR Adult Report Cards 159
Experience of Care Domain 159
Staying Healthy Domain 159
Common Chronic Conditions Domain 159
STAR+PLUS Report Cards 160
Experience of Care Domain 160
Staying Healthy Domain 160
Common Chronic Conditions Domain 160
STAR Kids Report Cards 161
Experience of Care Domain 161
Staying Healthy Domain 161
Common Chronic Conditions Domain 161
References 162

Table List

Table 1. Texas Medicaid and CHIP managed care programs 9
Table 2. Non-dual-eligible enrollment in Texas Medicaid and CHIP in December 2019 11
Table 3. Enrollment in the CMDS and CHIP dental programs in December 2019 11
Table 4. MCO scores on 2019 PIP second progress report evaluations 20
Table 5. DMO scores on 2019 PIP second progress report evaluations 21
Table 6. MCO Scores on 2020 PIP Plan evaluations 21
Table 7. DMO scores on 2020 PIP plan evaluations 22
Table 8. MCO scores on 2020 PIP first progress report evaluations 22
Table 9. DMO scores on 2020 PIP first progress report evaluations 23
Table 10. HEDIS 2020 (2019 measurement year) measures selected for hybrid reporting 25
Table 11. MCO and DMO 2020 AI scores by federal regulation category and overall 28
Table 12. 2020 QAPI categories 29
Table 13. MCO and DMO 2020 QAPI scores 30
Table 14. Average 2020 QAPI scores by activity 31
Table 15. MMP 2020 QAPI scores 31
Table 16. EQRO network adequacy activities for SFY 2020 33
Table 17. Texas standards for Medicaid and CHIP appointment availability 33
Table 18. Key data field deficiencies in SFY 2019 encounters 39
Table 19. Primary diagnosis POA distribution outside accepted criteria 39
Table 20. Sample sizes for 2020 medical encounter data validation by program 42
Table 21. Detailed information on MCO record deficiencies in the medical record review process 43
Table 22. DOS match rate by program and MCO 43
Table 23. PDx match rate by program and MCO 45
Table 24. PX match rate by program and MCO 46
Table 25. 2020 member and caregiver survey enrollment and fielding periods 50
Table 26. 2020 CAHPS adult member survey results, by program 50
Table 27. 2020 CAHPS STAR Health child member caregiver survey results 52
Table 28. 2019 Medicaid QOC measure results by race/ethnicity 57
Table 29. 2019 Utilization by race/ethnicity 59
Table 30. 2019 PPV results for Texas Medicaid and CHIP 61
Table 31 2019 PPV top reasons 61
Table 32. 2019 PPA results for Texas Medicaid and CHIP 62
Table 33. 2019 PPA top reasons 62
Table 34. 2019 PPR results for Texas Medicaid and CHIP 63
Table 35. 2019 PPR top reasons 64
Table 36. 2019 PPC results for Texas Medicaid and CHIP 64
Table 37. Summary of focused studies conducted in SFY 2020 68
Table 38. Distribution of 2021 report card ratings, by program 82

Figure List

Figure 1. Texas Medicaid and CHIP managed care service areas 10
Figure 2. EQRO timeline for PIP activities 18
Figure 3. Change in adult composite scores from 2018 to 2020 by program 51
Figure 4. Change in adult ratings from 2018 to 2020 by program 51
Figure 5. Change in STAR Health composite scores from 2018 to 2020 52
Figure 6. Change in STAR Health ratings from 2018 to 2020 53
Figure 7. OAP measure trends by program 65
Figure 8. 2019 C-section rates by program 66
Figure 9. 2019 average delivery costs by delivery type 66
Figure 10. Conceptual diagram of 2021 MCO report card structure 82
Figure 11. 2021 CHIP child report card scores clusters and star ratings 84
Figure 12. 2021 STAR child report card scores clusters and star ratings 85
Figure 13. 2021 STAR adult report card scores clusters and star ratings 86
Figure 14. 2021 STAR+PLUS report card scores clusters and star ratings 87
Figure 15. 2021 STAR Kids report card scores clusters and star ratings 88

Abbreviations

Abbreviation	Definition
ACOG	American College of Obstetricians and Gynecologists
ADA	American Dental Association
ADHD	attention-deficit hyperactivity disorder
Aetna	Aetna Better Health
AHRQ	Agency for Healthcare Research and Quality
AI	administrative interview
AIM	Alliance for Innovation on Maternal Health
APM	alternative payment model
APR-DRG	(3M™) All Patient Refined Diagnosis-Related Groups
BCBSTX	Blue Cross Blue Shield of Texas
BCN	beneficiaries with complex needs
BHI	behavioral health integration
BHO	behavioral health organization
C-section	cesarean section
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCC	Children with Chronic Conditions
CCHP	Cook Children's Health Plan
CDC	Centers for Disease Control and Prevention
CFHP	Community First Health Plans
CHC	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
COVID-19	coronavirus disease of 2019
CRA	caries risk assessment
CRG	(3M™) Clinical Risk Group
DCHP	Dell Children's Health Plan
DM	disease management
DMO	dental maintenance organization
DOS	date of service
DQA	Dental Quality Alliance
Driscoll	Driscoll Health Plan
DSHS	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
EQR	external quality review
EQRO	external quality review organization
FFS	(traditional Medicaid) fee-for-service
FirstCare	FirstCare Health Plans
FSR	financial statistical report
HCBS	home and community based services
HCC	hepatocellular carcinoma
HealthSpring	Cigna-HealthSpring
HEDIS®	Healthcare Effectiveness Data and Information Set
Hep C	hepatitis C
HHS	U.S. Department of Health and Human Services
HHSC	(Texas) Health and Human Services Commission
ISCA	Information Systems Capabilities Assessment
LMHA	Local Mental Health Authority
LTSS	Long-Term Services and Supports
MCNA	MCNA Dental
MCO	managed care organization
MCQS	(Texas) Managed Care Quality Strategy
MDCP	Medically Dependent Children Program
MLTSS	Managed Long-Term Services and Supports
MMP	Medicare-Medicaid Plan
MN-LOC	Medical Necessity Level of Care
Molina	Molina Healthcare of Texas
MRSA	Medicaid Rural Service Area

Abbreviation	Definition
MTP	Managed Transportation Program
NAMD	National Association of Medicaid Directors
NCI-CFS	National Core Indicators-Child Family Survey
NCQA	National Committee for Quality Assurance
NEMT	non-emergency medical transportation
NHB	Non-Hispanic black
NHW	Non-Hispanic white
NICU	neonatal intensive care unit
NPI	National Provider Identifier
NTDC	non-traumatic dental condition
OAP	Pregnancy Associated Outcomes (state measure of severe maternal morbidity)
P4Q	Pay-for-Quality
pandemic	The COVID-19 pandemic that affected Texas during 2020
PCHP	Parkland Community Health Plan
PCP	primary care provider
PDI	(AHRQ) Pediatric Quality Indicator
PDx	primary diagnosis
PIP	performance improvement project
POA	present on admission
POS	place of service
PPA	(3M™) Potentially Preventable Admission
PPC	(3M™) Potentially Preventable Complication
PPE	(3M™) Potentially Preventable Event
PPR	(3M™) Potentially Preventable Readmission
PPV	(3M™) Potentially Preventable (ED) Visit
PQI	(AHRQ) Prevention Quality Indicator
PQOC	personalized quality-of-care
PX	procedure (code)
QAPI	quality assessment and performance improvement
QOC	quality-of-care
QTR	quarterly topic report
SA	service area
SDoH	social determinants of health
SED	serious emotional disturbance
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
SOA	summary of activities
Superior	Superior HealthPlan
SWHP	RightCare from Scott & White Health Plan
TCHP	Texas Children's Health Plan
THLC	Texas Healthcare Learning Collaborative
THSteps	Texas Health Steps
TMHP	Texas Medicaid & Healthcare Partnership
UFSRC	University of Florida Survey Research Center
UHC	UnitedHealthCare Community Plan
UMCM	(Texas) Uniform Managed Care Manual
URTI	upper respiratory tract infection
UTHealth-CHCD	University of Texas School of Public Health – Center for Healthcare Data

Executive Brief

Introduction

More than 70 million Americans receive healthcare coverage through Medicaid and the Children's Health Insurance Program (CHIP), funded jointly by states and the U.S. Department of Health and Human Services (HHS). 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. Texas has the one of the largest Medicaid programs in the country, serving well over four million people (CMS, 2021), over 90 percent of whom receive care through a managed care delivery model. 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.

This executive brief is an overview of the activities and findings from the state fiscal year (SFY) 2020 Summary of Activities (SOA) report intended to highlight key findings from annual EQRO activities. The full SOA report is a comprehensive summary of EQRO activities from September 1, 2019, through August 31, 2020, and includes findings regarding the activities that address the quality of managed care provided to Texas Medicaid and CHIP members. The EQRO reorganized the SOA report for SFY 2020 to reflect the updated CMS external quality review (EQR) protocols released in October 2019, including sections for the new protocols related to network adequacy (Protocol 4), and managed care organization (MCO) and dental maintenance organization (DMO) quality rating (Protocol 10). Although CMS has not published guidance for these new protocols, the report describes the EQRO activities in these areas.

EQRO Activities

Each year, the EQRO follows CMS protocols in accordance with 42 C.F.R. § 438 (2016) to monitor the utilization, quality, accessibility, and timeliness of medical and behavioral health services that individuals receive in Texas Medicaid and CHIP through MCOs. The EQRO conducts activities that review delivery of care in the four statewide Medicaid managed care programs – STAR for members needing routine care (primarily includes low-income children and pregnant women); STAR+PLUS for adult members with chronic conditions and disabilities; STAR Kids for children, adolescents, and young adults with chronic conditions and disabilities; and STAR Health for members in state conservatorship – and delivery of care in CHIP (entirely managed care). The EQRO also monitors the dental care that children receive through Medicaid and CHIP DMOs. 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) pediatric measures; and

- in-depth studies to address special topics of importance to Texas, including issue briefs, more in-depth quarterly topic reports (QTRs), and a focus study.

Several aspects of EQRO evaluation activities in SFY 2020 were impacted by the outbreak of the COVID-19 pandemic (hereafter the pandemic) in the United States in March 2020, which triggered major upheaval in healthcare systems. For example, the EQRO extended the fielding period for the CAHPS surveys by two months and increased the sampling pool for the surveys to accommodate the pandemic related challenges to survey data collection. The PIPs usually have a two-year implementation period; however, due to the impact of the pandemic, the Texas Health and Human Services Commission (HHSC) extended the time frame for the 2019 and 2020 PIPs by one year. HHSC also suspended the Pay-for-Quality (P4Q) program for measurement year 2020. The EQRO expects the pandemic to further impact reporting of activities in the SFY 2021 SOA which is reliant on healthcare data collected during the measurement year 2020.

Focus Areas

The executive brief is organized into focus areas based on three recurrent themes from evaluation activities in SFY 2020: (1) maternal health, (2) behavioral health, and (3) health disparities. Each of the three focus areas includes studies conducted, suggested areas for improvement, and a summary of findings. The full SOA report following the brief contains a comprehensive review of the SFY 2020 EQRO activities.

Maternal Health

Medicaid and CHIP provide coverage for about half of all deliveries in Texas and provide prenatal and postpartum care for members. The EQRO continues to work with Texas and other national experts to develop and refine maternal health measures for Texas Medicaid. In SFY 2020, the EQRO conducted several activities to help HHSC develop strategies to identify, understand, and address maternal health disparities in Texas Medicaid and CHIP.

For the EQRO pregnancy associated outcomes (OAP) measure report, the EQRO calculated severe maternal morbidity (SMM) rates for 2019 deliveries following a method adapted from the Alliance on Innovation in Maternal Health (AIM) maternal safety bundles to use administrative data. Consistent with prior years, the SMM rates in 2019 were higher in STAR than in the CHIP Perinatal program, most notably in cases of (pre)eclampsia. SMM rates also varied by race/ethnicity, with Non-Hispanic black (NHB) women having more than twice the SMM rate of Hispanic women.

The EQRO reported on the frequency and costs of cesarean section (C-section) deliveries in Texas Medicaid and CHIP during 2019. The overall rate of C-section deliveries in Texas Medicaid and CHIP was 33.2 percent in 2019. Although the rate is higher in deliveries with complications (51.3 percent), most C-sections (78.3 percent) were for deliveries without identified complications. C-section rates also varied by race/ethnicity, with the lowest C-section rate (32.0 percent) among Hispanic women and the highest rate (37.4 percent) among NHB women.

To help HHSC identify maternal healthcare disparities, the EQRO developed a methodology to calculate a personalized quality-of-care (PQOC) index for women in the STAR program who require maternal health services (the maternal population). The PQOC index combines findings from multiple QOC measures for individual members, resulting in a single measure of quality that estimates the comprehensiveness of recommended care received by members in a way that is tailored to the individual's healthcare needs. The QTR produced from this study included a description of methods and findings as well as recommendations for refining the PQOC index methodology and addressing disparities in the PQOC for the maternal population.

In SFY 2020, the EQRO also conducted two issue brief studies to help HHSC identify strategies for improving access to maternal healthcare. These studies drew on current scientific and state healthcare policy literature to provide recommendations on strategies for using teleservices for perinatal care, and alternative payment models (APMs) for incentivizing obstetric providers to increase access to maternal health services, respectively.

Ongoing Challenges

The EQRO noted several areas for the improvement of maternal healthcare, including rates of C-sections for deliveries without complications, and certain effectiveness measures of chronic and behavioral healthcare. About half of the deliveries with identified complications are by C-section, but 78 percent of C-sections were deliveries without identified complications. In 2019, more than 50,000 C-sections were performed in deliveries without complications. Although complications were more common in STAR+PLUS (21.3 percent of deliveries vs. 14.0 percent overall), most STAR+PLUS C-sections were deliveries without identified complications.

Like prior years, performance on QOC measures for chronic conditions was generally worse for the maternal population, compared to all women in Medicaid, although utilization was generally higher among pregnant women. For example, the maternal population continued to have lower rates on measures of eye exams for Comprehensive Diabetes Care (HEDIS CDC; 41.1 percent vs. 53.3 percent overall), Asthma Medication Ratio (HEDIS AMR; 48.6 percent vs. 61.4 percent overall for ages 19 to 50 years), and Adherence to Antipsychotic Medication for Individuals with Schizophrenia (HEDIS SAA; 39.2 percent vs. 56.3 percent), compared to all women in Texas Medicaid.

Positive Findings and Directions

The EQRO's 2019 QOC reporting revealed several areas of continued success in providing care to the maternal population. As in 2018, the rate of Chlamydia Screening (HEDIS CHL) was higher among the maternal population compared to all women in Medicaid (75.1 percent vs. 50.7 percent overall) as was Access to Preventive/Ambulatory Health Services (HEDIS AAP; 97.0 percent vs. 87.7 percent overall). The PQOC study results also indicated that PQOC in the STAR maternal population skewed slightly toward higher performance and, on average, maternal population members received high-quality care for almost two-thirds of the index measures.

HHSC has also taken several steps to address prior EQRO recommendations for improving the quality of maternal healthcare, including extending the prior Neonatal Intensive Care Unit (NICU) research to specifically examine neonatal abstinence syndrome (NAS). CMS also selected Texas for an Innovator Acceleration Program (IAP) specifically designed to address maternal healthcare measures. The partnership included the Texas Department of State Health Services (DSHS) to integrate vital statistics and other DSHS data in maternal healthcare analyses.

Behavioral Health

Serious mental illness (SMI) continues to be a topic of concern for HHSC and a leading cause of potentially preventable admissions (PPAs) for Texas Medicaid and CHIP members. In 2019, bipolar disorder, schizophrenia, and depressive disorders, combined, accounted for almost 14 percent of total PPA weight[1] and nearly $45 million in total PPA institutional costs. To increase accountability and quality improvement for members with SMI, in 2017, the Texas Legislature passed measures to hold Texas Medicaid MCOs accountable for outcomes among members with SMI. The legislation directed HHSC to establish QOC measures to evaluate the

[1] Each PPE reason has a relative resource weight determined by the estimated intensity of resource use. The total PPE weight reported is the sum of relative weights and thus accounts for both volume and resource use.

performance of MCOs providing care to individuals with SMI. To assist HHSC with this initiative, the EQRO and The University of Texas School of Public Health Center for Healthcare Data (UTHealth-CHCD) conducted studies in 2020 examining healthcare utilization patterns and expenditures for STAR and STAR+PLUS members.

The EQRO study identified STAR member cohorts with and without SMI in adults and with and without serious emotional disturbance (SED) in children and adolescents. For these four cohorts, the EQRO compared health service utilization, quality, and spending (using HEDIS and 3M PPE measures). The study found that in 2018, the prevalence of SMI among adults in STAR was 7.5 percent, the prevalence of SED among children and adolescents in STAR was 7.2 percent, and prevalence of both SMI and SED varied across sociodemographic groups. The prevalence of SMI in the study cohorts was higher among women than among men and increased with age across sex and race/ethnicity categories. Non-Hispanic white (NHW) adults had the highest prevalence of SMI, followed by adults in the "unknown/other" race/ethnicity category. The prevalence of SED in the study cohorts was highest among females aged 13 to 18 years and males aged 6 to 12 years; with the prevalence across age groups higher for males than females. Among race/ethnicity categories, NHW children and adolescents had the highest prevalence of SED.

Based on QOC measures, adult STAR members with SMI had higher healthcare utilization rates and better access to care than adults without SMI, and STAR children and adolescent members with SED had higher healthcare utilization rates than those without SED. The EQRO study also indicated that STAR members with SMI or SED had higher rates of PPEs, including potentially preventable emergency department visits (PPVs), PPAs, potentially preventable readmissions (PPRs), and higher claims expenditures than members without SMI or SED.

Models showed that a co-occurring physical health condition and SMI or SED resulted in significantly higher estimated expenditures than having either a physical health condition, SED, or SMI alone. The EQRO noted that, for STAR members, having either SMI or SED, and physical health comorbidities, resulted in more than the additive estimated costs of having one or the other, suggesting that having comorbidities may increase overall costs of care.

The EQRO subcontracted with UTHealth-CHCD to conduct a study summarizing state Medicaid strategies and measures for assessing the quality of healthcare for members with SMI, including the degree to which Local Mental Health Authority (LMHA) involvement might affect care outcomes. The UTHealth-CHCD study included an environmental scan of the literature on Medicaid members with SMI and used Medicaid claims and enrollment data to examine differences in service delivery and costs for STAR+PLUS members with SMI, reporting separately by LMHA involvement status and by MCO. The analyses showed that in 2017 and 2018, about one-third of STAR+PLUS members had a diagnosis of SMI. The SMI rate in STAR+PLUS was higher for women than men, which is consistent with national reports. In this study, the SMI rate was highest for enrollees between ages 35 and 64 and SMI rates were consistent across the five STAR+PLUS MCOs.

Measures of 7-day and 30-day follow-up care after SMI-related inpatient admissions did not show substantial differences between LMHA- and non-LMHA-involved STAR+PLUS enrollees overall, but they did vary by MCO. Analysis of healthcare costs for SMI-diagnosed STAR+PLUS enrollees who received outpatient care through LMHAs indicated they had much lower estimated per member-year total costs than enrollees who received no services through LMHAs. The average total cost differences appeared primarily due to substantially higher medical care costs, especially for non-SMI-related medical care – $5,461 higher for SMI-diagnosed STAR+PLUS enrollees without LMHA involvement compared to those who were involved with LMHAs. Pharmacy costs were also higher among enrollees without LMHA involvement, although the difference in costs was smaller.

Ongoing Challenges

The findings from the QTRs on Texas Medicaid members with SMI and SED highlight the need for integrated physical and behavioral healthcare and increased attention to preventive care and screening for certain aspects of physical health among members with SMI and SED. For example, among STAR members, the estimated probability of breast cancer screening (among members eligible for the HEDIS BCS measure) was nearly 40 percent lower for adults with SMI than adults without SMI. Furthermore, while some screening rates were higher for adults with SMI, they remained sub-optimal compared to national benchmarks, reflecting disparities in cancer screening rates for the Medicaid population overall. The EQRO also noted that the probability of having adolescent well-care was eight percent lower among members with SED than among members without SED, after adjusting for other factors.

Positive Findings and Directions

Despite these challenges, several indicators of behavioral healthcare effectiveness for Texas Medicaid members are positive. The QTR on SMI and SED among STAR members noted that QOC measure rates for adolescent immunizations for Adolescents (HEDIS IMA Combo 1), well-child care (HEDIS W34), and follow-up care for children prescribed attention-deficit hyperactivity disorder (ADHD) medication (HEDIS ADD) were significantly higher for children and adolescents with SED compared to those without SED. Further, the SMI data from both QTR studies on SMI indicate that in 2018, adult members with SMI in STAR and STAR+PLUS showed higher rates of access to preventative/ambulatory services (HEDIS AAP) compared to those without SMI.

In addition to the QTRs on SMI and SED, Texas has also taken steps to address prior EQRO recommendations for improving the quality of other behavioral healthcare aspects for Texas Medicaid and CHIP members. For example, the statewide topic for 2020 MCO PIPs focused on behavioral health with an option for MCOs to emphasize the integration of behavioral and physical health services. HHSC is addressing recommendations about the availability of behavioral health providers and member satisfaction with behavioral healthcare through a combination of ongoing monitoring using CAHPS member surveys and the appointment availability study, targeted P4Q initiatives to incentivize MCOs to improve healthcare quality, and corrective action plans for MCOs that fail to meet the minimum standard for appointment availability.

Health Disparities

Both MCO-level practices and neighborhood-level social determinants of health (SDoH) may contribute to disparities in care and outcomes for members confronting health disparities. The EQRO continues to work with HHSC exploring QOC measure results across demographic and other member population groups to more clearly interpret results and better direct efforts to improve the equity of care for all Texas Medicaid and CHIP members.

Several studies conducted in SFY 2020 identify disparities in healthcare and outcomes among Texas Medicaid and CHIP members based on race, ethnicity, and rurality. The SMI and SED rates varied by race/ethnicity. The PQOC study showed that disparities in the quality of maternal healthcare persisted after accounting for other factors. American Indian/Alaskan and NHB members had significantly lower PQOC than NHW members, while Hispanic members had significantly higher PQOC than NHW members. Furthermore, the study found a significant interaction between race/ethnicity and rurality. In rural areas, adjusted PQOC index scores were lower among Hispanic members than among NHW members. In urban areas, adjusted PQOC index scores were higher among Hispanic members than among NHW members.

In SFY 2020, the EQRO and UTHealth-CHCD each conducted a study focused on MCO-level practices that influence health disparities among Texas Medicaid members. The EQRO compiled an issue brief for HHSC summarizing the results of a thematic analysis of interviews with MCO staff conducted to provide a more comprehensive understanding of how STAR+PLUS MCOs assess, support, and sustain P4Q performance. The most pressing challenges for STAR+PLUS MCOs trying to improve performance in the medical P4Q program include difficulties assessing the impact of individual initiatives when multiple P4Q initiatives target a single issue, and engaging multi-level stakeholders in quality improvement initiatives. However, STAR+PLUS MCOs have several promising strategies addressing the barriers to P4Q program performance improvement, including member- and provider-level incentives, processes for identifying and reducing service gaps, and events that educate and connect members and providers.

UTHealth-CHCD conducted a state policy literature review and qualitative interviews with representatives from Texas Medicaid MCOs to examine how Medicaid MCOs (1) collect, analyze, and use SDoH data to identify members with unmet social needs and (2) use this information to design interventions that influence prevention strategies and health outcomes. UTHealth-CHCD summarized these study findings in a QTR for HHSC. The report noted that meaningful discussions about SDoH happen at three pivotal points in an MCO's engagement with its members: (1) at the initial screening, (2) once an unmet social need was identified, and (3) when exchanging SDoH data with team members, providers, and in some cases community-based organizations. However, MCOs approach SDoH needs differently due to resource constraints and variation in MCO capacity for SDoH data analyses. Most MCO representatives indicated a lack of processes to evaluate SDoH interventions for effectiveness or impact on health outcomes. Respondents also noted difficulties in member engagement and member enrollment movement between plans as barriers for SDoH interventions. Several MCO representatives expressed interest in a standardized SDoH assessment tool and best practices for generating comparable data across MCOs and programs.

UT Health-CHCD also conducted a focus study using 2018 claims and encounter data to assess the impact of individual sociodemographic characteristics and area-level proxies of SDoH on quality and performance measure outcomes. The study included a diverse set of Medicaid and CHIP members, including children and adolescents in the Texas Medicaid and CHIP populations, adults in the STAR+PLUS and Home and Community Based Services (HCBS) Waiver populations, and pregnant women in Texas Medicaid. Study results indicated that the number of SDoH variables with significant associations varied according to the study population and quality measure. Among children and adolescents, the social and economic and health behavior SDoH variables showed the largest influence on performance measure outcomes. Among pregnant women, three variables (Rate of Adult Smokers, Access to Mental Health Providers, and Rate of Violent Crime) were significantly associated with performance outcomes on all three quality measures (Timeliness of Prenatal Care, Postpartum Care, and Low Birth Weight Babies). However, not every SDoH variable contributed equally to the observed impact of SDoH on quality measure performance.

Ongoing Challenges

Several SFY 2020 studies noted that HHSC should continue to explore potential sources of SDoH data to better understand the social and environmental factors contributing to disparities in the quality of healthcare provided to Texas Medicaid members. For example, the EQRO noted that future studies of PQOC indices in the maternal health population should include more factors that address SDoH, if available. Area-level SDoH variables at the census tract level provide important context related to educational attainment, household income, employment, language, poverty, and housing conditions for the population living in a given area. Census-tract rurality, which encompasses smaller geographic units, may function as a more sensitive measure than county-

level rurality, which encompasses larger areas and may not account for variation within counties. Along these lines, HHSC should continue to explore the possibility of developing a set of best practices and priorities for collecting and reporting SDoH data to improve the comparability of findings across MCOs and product lines. SDoH data collected and coded using a systematic, structured, and standardized method is important for policy decisions and evidence-based models for payment reform.

Positive Findings and Directions

HHSC implemented several strategies to increase the SDoH data available about Texas Medicaid and CHIP members. For example, in addition to the federal and state regulatory categories addressed in the full AI process in SFY 2020, the EQRO inquired about MCO/DMO procedures for SDoH data collection and the strategies the MCOs use to address member needs related to SDoH. HHSC plans to continue working with the EQRO to develop in-depth studies to identify the underlying causes of health disparities.

Conclusion

In SFY 2020, HHSC continued to improve the quality and efficiency of healthcare services in Texas Medicaid and CHIP through initiatives for improving network adequacy, service coordination for special populations, and behavioral healthcare. While there is always room for improvement, 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 SOA report includes a comprehensive list of EQRO recommendations based on SFY 2020 evaluation activities and suggestions for targeted approaches to address ongoing challenges to improving healthcare quality for all Texas Medicaid and CHIP members.

Introduction

More than 70 million Americans receive healthcare coverage through Medicaid and the Children's Health Insurance Program (CHIP), funded jointly by states and the U.S. Department of Health and Human Services. Participation in federal funding for 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 well over four million people (CMS, 2021), over 90 percent of whom receive care 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 findings by the Texas EQRO for activities during state fiscal year (SFY) 2020.

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 provides CHIP medical services entirely through managed care, including CHIP Perinatal coverage for prenatal care. The Texas Health and Human Services Commission (HHSC) website (hhs.texas.gov) provides complete information about these programs.

Table 1. 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 health services with long-term services and supports (LTSS) for adults with a disability or those 65 or older, including individuals also receiving Medicare benefits (dual-eligible members). Dual eligible members receive their acute health services through Medicare. They have the option to join a Medicare-Medicaid Plan (MMP) instead of STAR+PLUS; the MMP provides both Medicare and Medicaid services through a single plan.
STAR Kids	Manages care for children and adults aged 20 years and younger who have disabilities. 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 (CMDS) serves eligible Medicaid members aged 20 and younger, and the CHIP Dental program serves CHIP members aged 18 and younger. Two 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 1 shows the Texas Medicaid and CHIP service areas (SAs) and service providers. During SFY 2020, 18 managed care organizations (MCOs) administered Medicaid services in 13 SAs. For CHIP services were provided by 15 MCOs, and the three Medicaid rural service areas (MRSAs) and Hidalgo SA are combined into one rural service area. In all programs except STAR Health, members can choose from at least two MCOs in every SA. Superior provides all STAR Health services statewide. Both DMOs provide dental services statewide.

Figure 1. Texas Medicaid and CHIP managed care service areas.

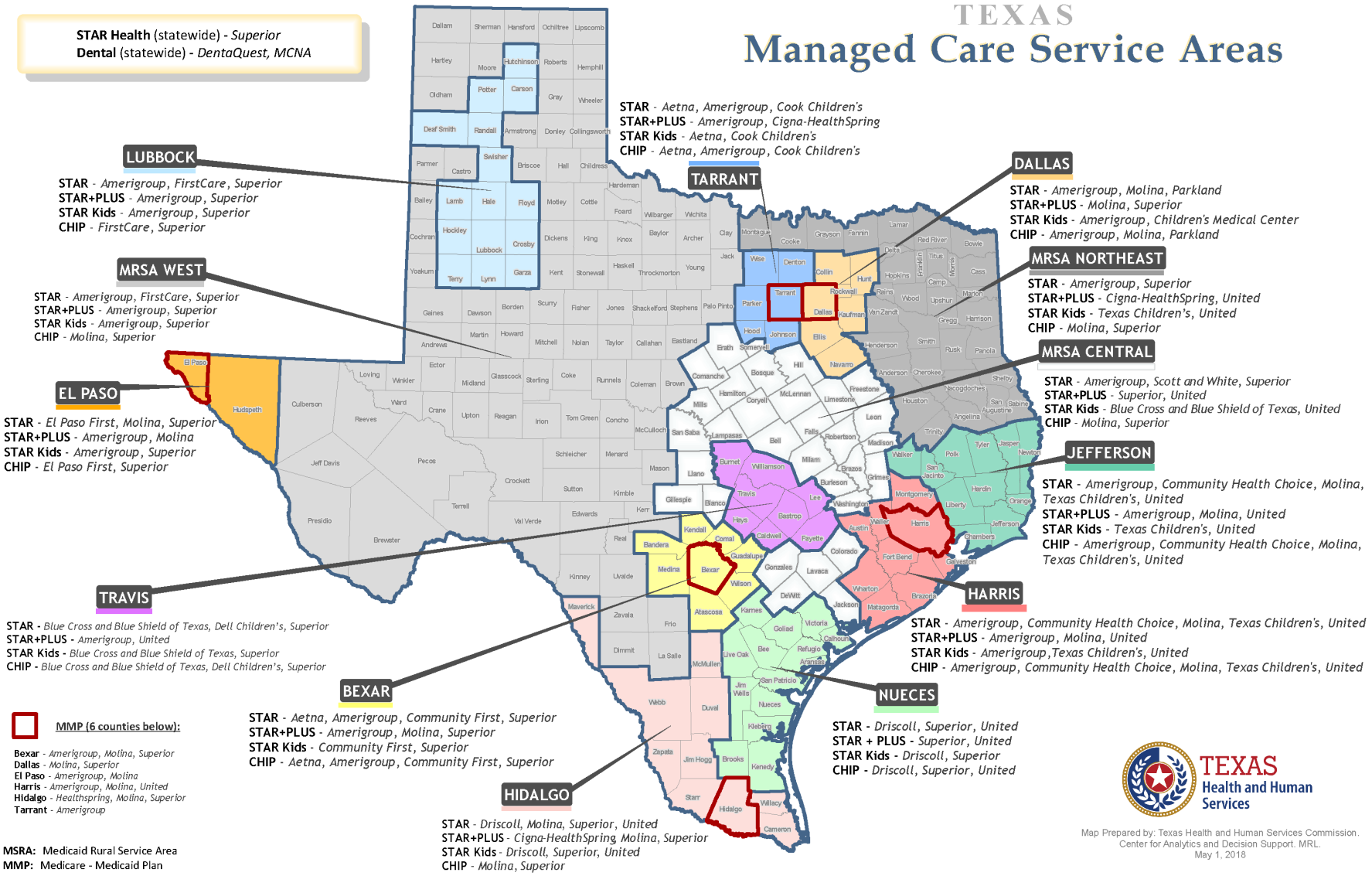


Table 2 shows Medicaid and CHIP enrollment with Texas contracted MCOs as of December 2019, excluding dual-eligible members, and Table 3 shows enrollment with the two DMOs as of December 2019.

Table 2. Non-dual-eligible enrollment in Texas Medicaid and CHIP in December 2019

MCO	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Aetna Better Health (Aetna)	70,481	–	4,486	–	9,059
Amerigroup	527,232	57,151	25,917	–	56,657
Blue Cross Blue Shield of Texas (BCBSTX)	31,501	–	7,802	–	5,323
Children's Medical Center Health Plan (CMCHP)[1]	–	–	8,233	–	–
Cigna-HealthSpring (HealthSpring)	–	19,152	–	–	–
Community First Health Plans (CFHP)	106,519	–	7,428	–	15,862
Community Health Choice (CHC)	244,892	–	–	–	25,795
Cook Children's Health Plan (CCHP)	102,604	–	9,313	–	19,388
Dell Children's Health Plan (DCHP)	23,699	–	–	–	6,864
Driscoll Health Plan (Driscoll)	158,511	–	9,982	–	6,442
El Paso Health	63,763	–	–	–	8,245
FirstCare Health Plans (FirstCare)	73,422	–	–	–	4,453
Molina Healthcare of Texas (Molina)	90,778	34,586	–	–	19,605
Parkland Community Health Plan (Parkland)	150,133	–	–	–	21,035
RightCare from Scott & White Health Plan (SWHP)	43,245	–	–	–	–
Superior HealthPlan (Superior)	710,968	64,944	27,766	33,075	92,478
Texas Children's Health Plan (TCHP)	340,834	–	27,216	–	55,446
UnitedHealthCare Community Plan (UHC)	140,696	58,466	29,214	–	8,502
Total	**2,879,278**	**234,299**	**157,357**	**33,075**	**355,154**

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

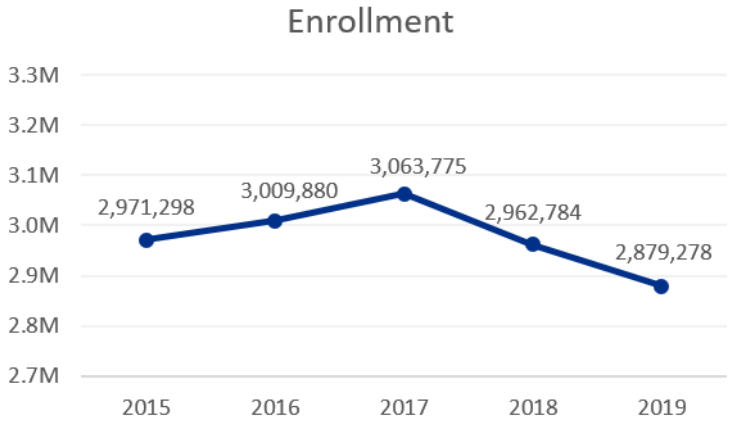
Table 3. Enrollment in the CMDS and CHIP dental programs in December 2019

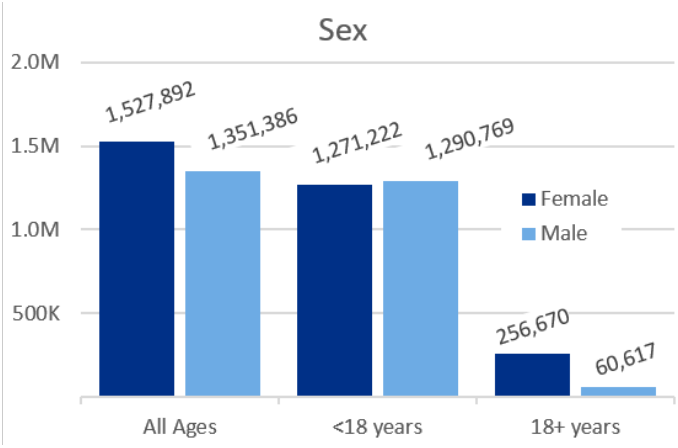
DMO	CMDS	CHIP Dental
MCNA Dental (MCNA)	1,187,018	128,341
DentaQuest	1,608,938	227,020
Total	**2,795,956**	**355,361**

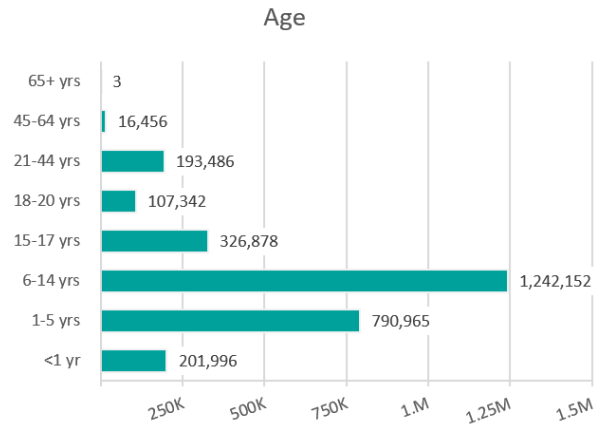
The following summaries for the STAR, STAR+PLUS, STAR Kids, STAR Health programs, and CHIP show member data as of December 2019. They represent a snapshot of the Texas Medicaid programs and CHIP as of the close of the measurement year for most of the quality-of-care (QOC) measures reported by the EQRO during SFY 2020. Health status reflects members' 3M™ Clinical Risk Group (CRG) status assigned to Special Healthcare Needs (SHCN) groups. The health status CRG categories are described in Appendix A.

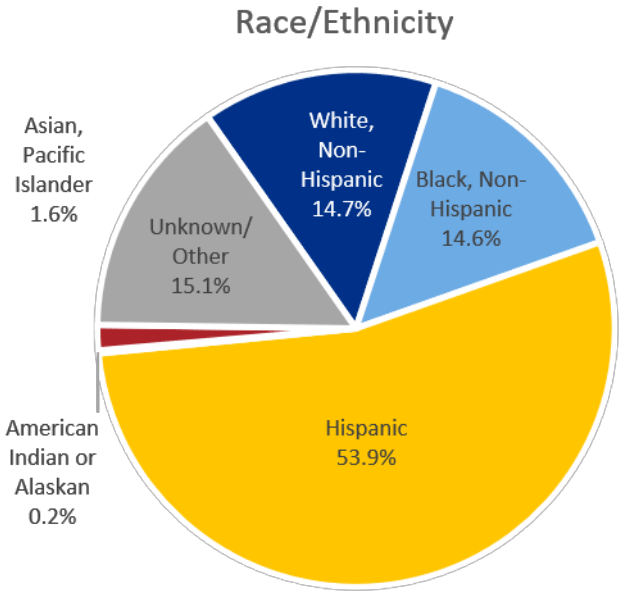
STAR

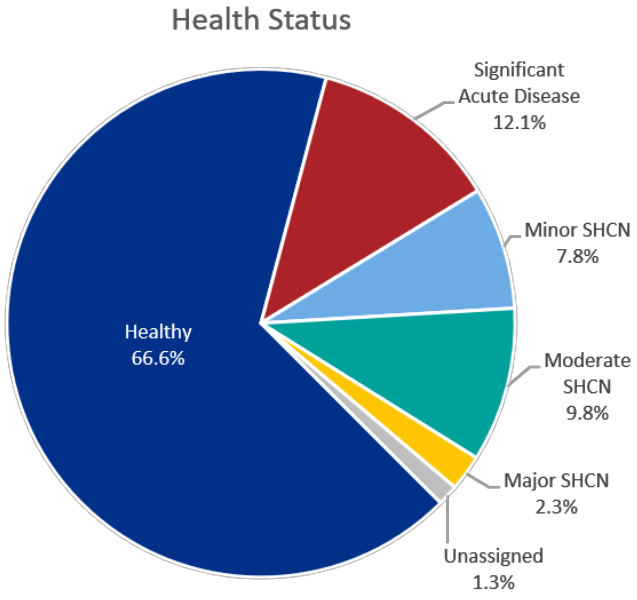
As the main managed care program in Texas Medicaid, the STAR program had 2,879,278 non-dual-eligible members as of December 2019. The distributions by age and sex have not changed much from 2018. Over 80 percent of adult members are women, while members younger than 19 years old are distributed almost evenly between males and females. A majority of the members are Hispanic, and most members are healthy.





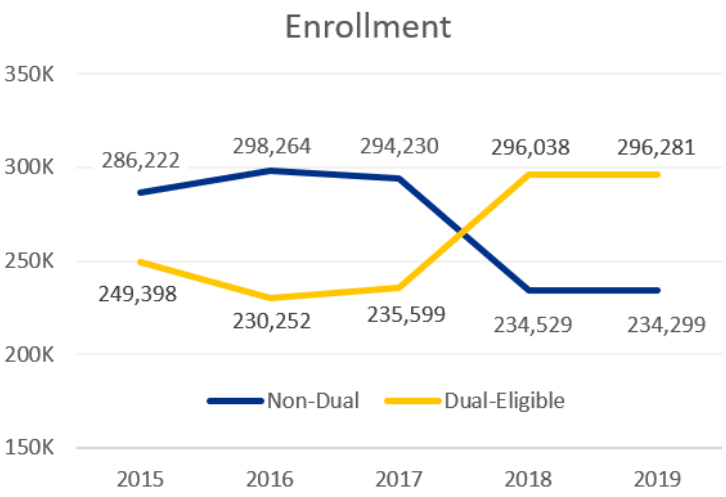


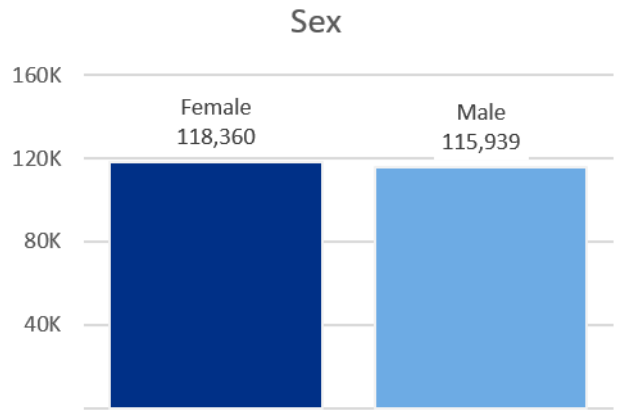


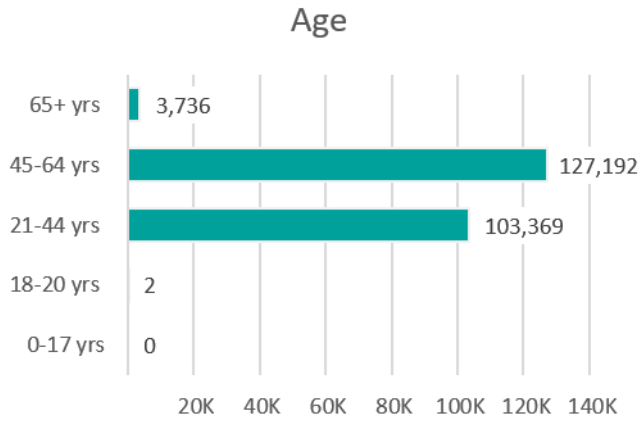


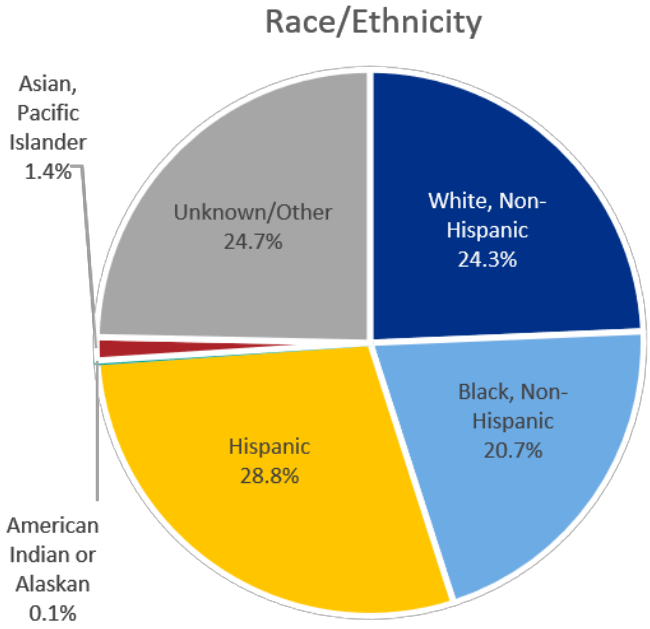
STAR+PLUS

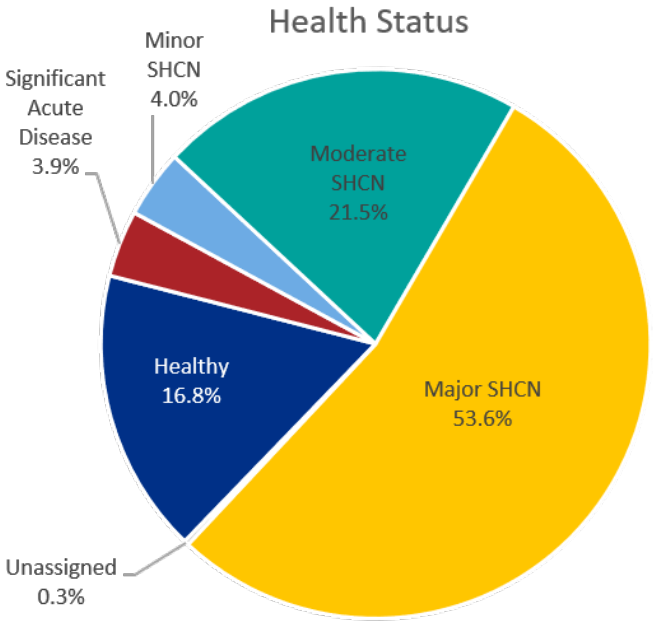
The STAR+PLUS program had 234,299 non-dual-eligible members (among 530,580 total) as of December 2019. After a drop in non-dual-eligible members mirrored by an increase in dual-eligible members in 2018, membership has remained constant. Distributions by age, sex, race-ethnicity, and health status are similar to those in 2017. One-quarter of STAR+PLUS members had unknown/other race-ethnicity. Close to seventeen percent were categorized as healthy, despite health status criteria eligibility for this program.





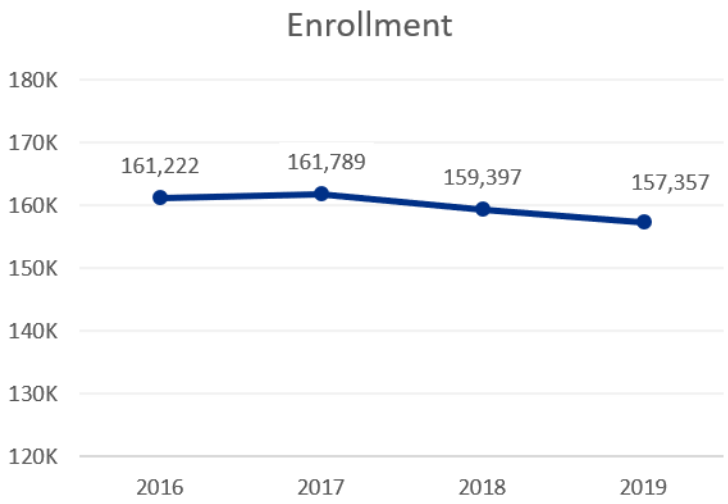


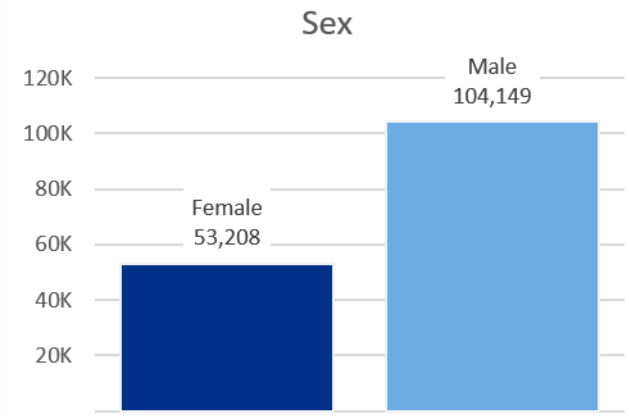


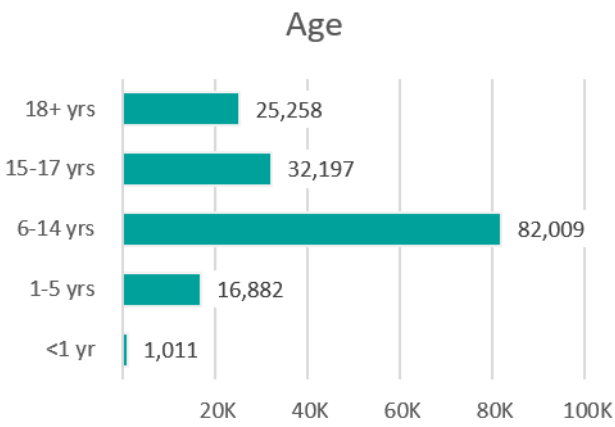


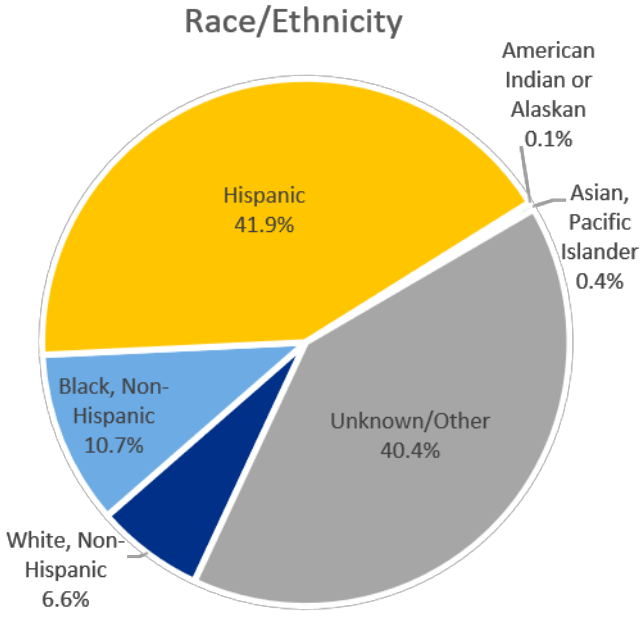
STAR Kids

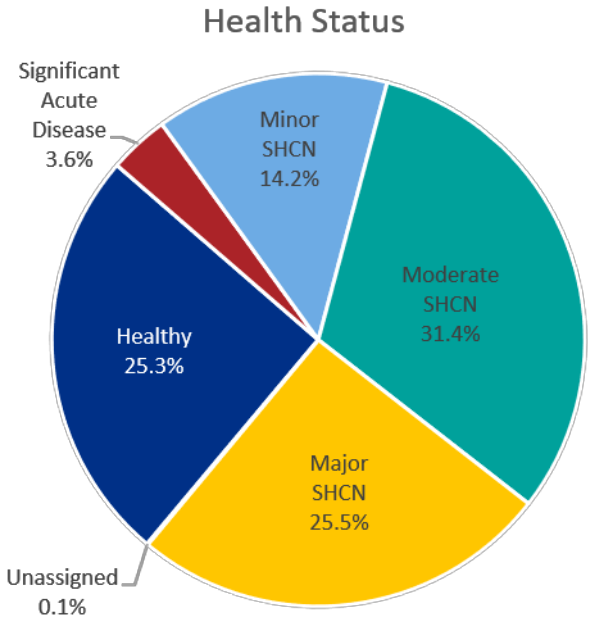
The STAR Kids program had 157,357 non-dual-eligible members as of December 2019. Enrollment has dropped slightly since the STAR Kids program began in November 2016. Males continue to outnumber females by about two to one, and nearly half of all members are six to 14 years of age. Over 40 percent of members had an unknown/other race-ethnicity. Member SHCN category is more likely to be minor or moderate in STAR Kids than in STAR+PLUS, where the most common category is major SHCN.





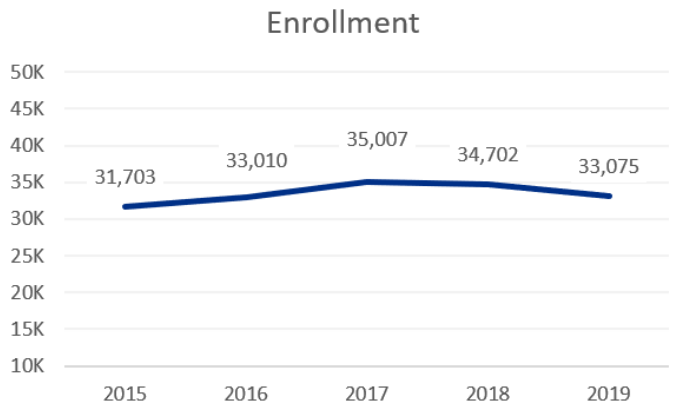


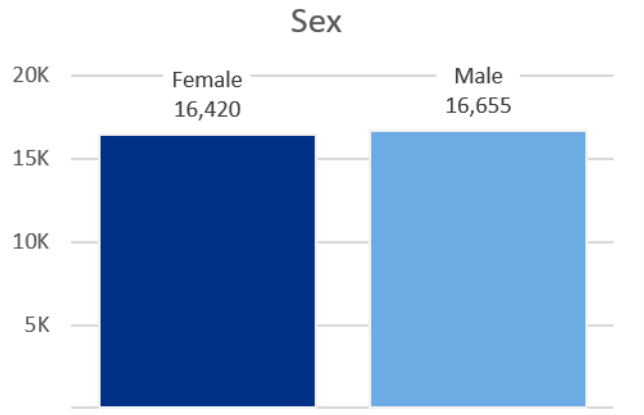


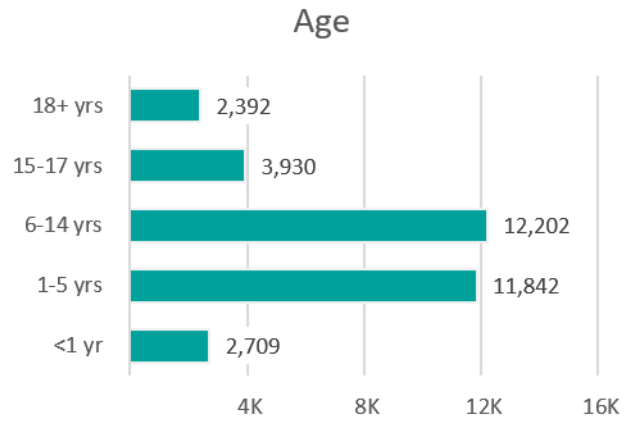


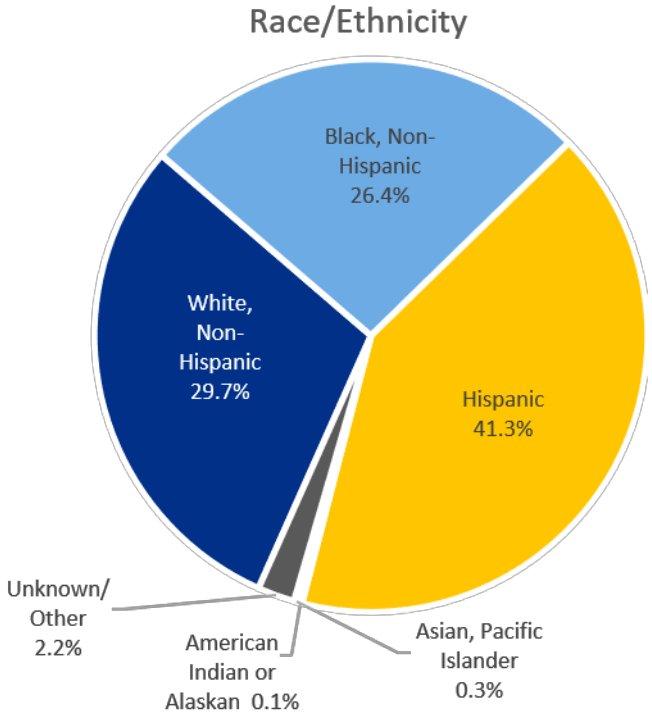
STAR Health

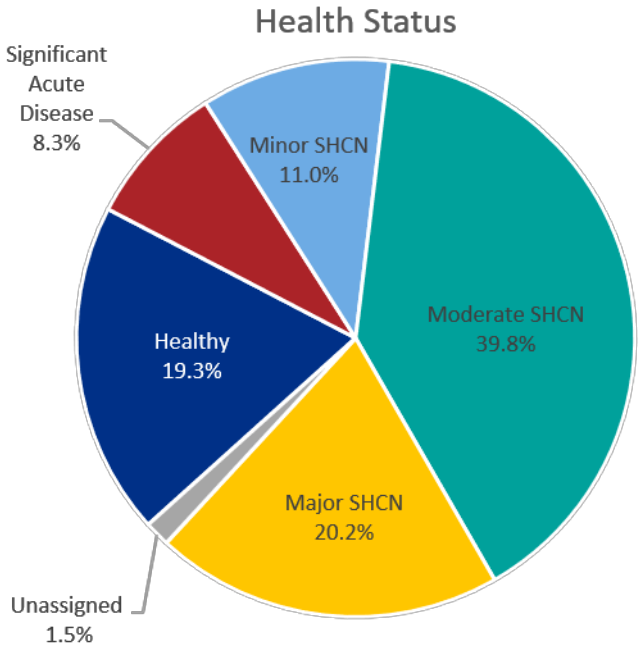
December 2019 enrollment in STAR Health remains consistent with prior years. Equal numbers of members are male and female, and the member age distribution is relatively even and consistent across years. Although almost 20 percent of members are categorized as healthy, an increasing majority of members covered in the STAR Health program have special healthcare needs.





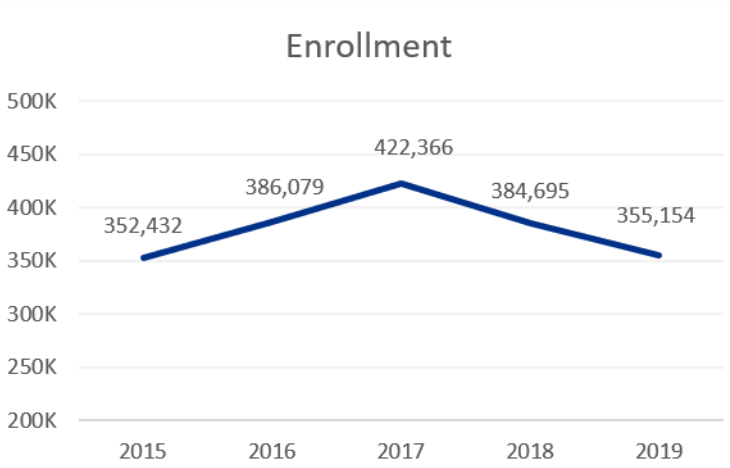


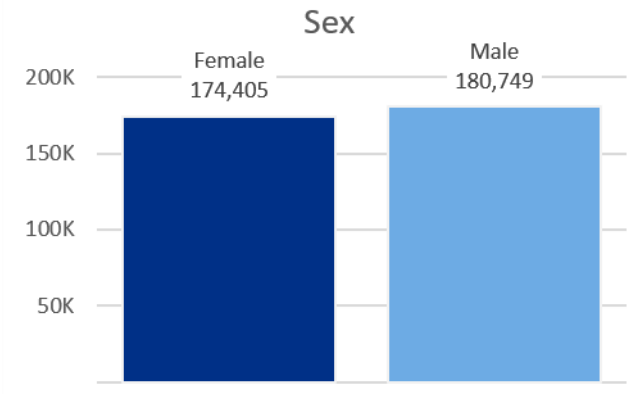


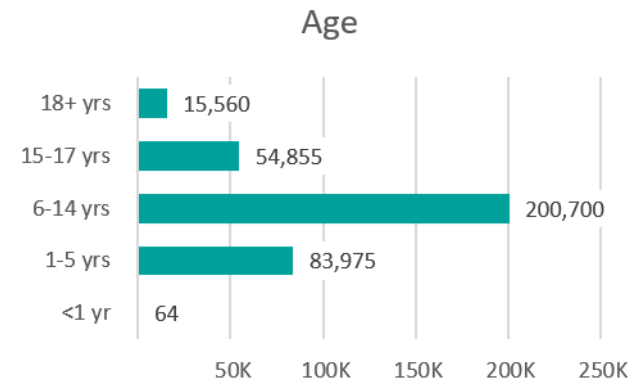


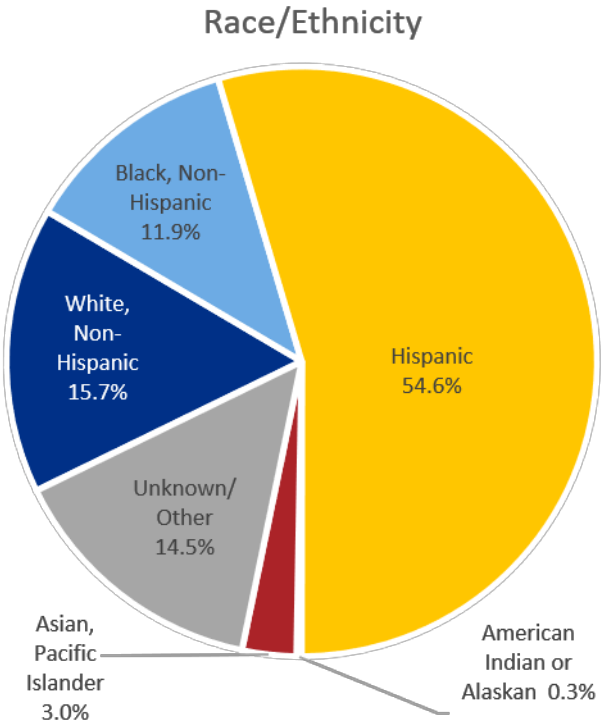
CHIP

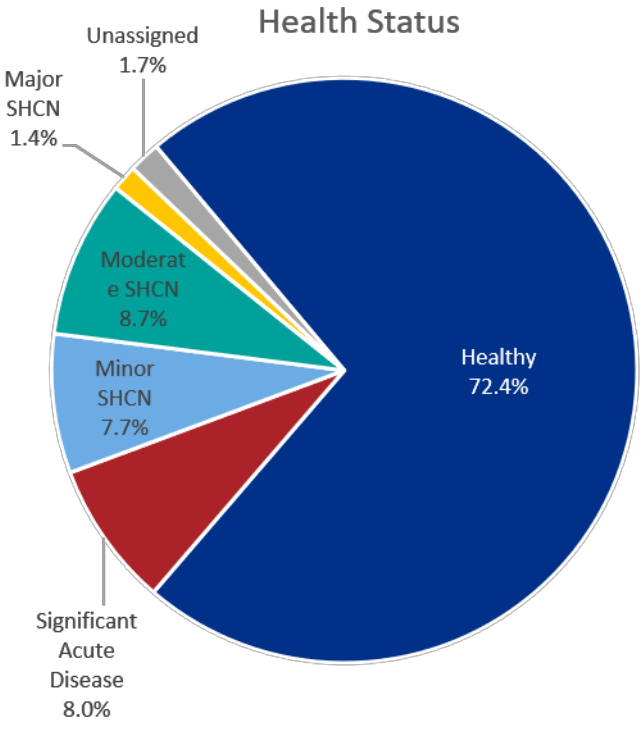
Although CHIP enrollment expanded by about 20 percent from 2015 to 2017, enrollment in December 2019 was only slightly higher than in 2015. The percentage of members having an unknown/other race-ethnicity reached 44 percent in December 2018; however, in 2019, this rate fell to less than 15 percent. CHIP has the highest percentage of healthy members compared to STAR programs.











EQRO Responsibilities

This summary of activities (SOA) report summarizes the activities the EQRO conducted during SFY 2020, including evaluations of MCO activities, quality improvement programs, and administrative performance measures for the 2019 measurement year. It also summarizes findings from member surveys the EQRO conducted in 2020. The EQRO followed the guidance of the CMS EQR Toolkit (CMS, 2019a) and revised CMS EQR Protocols (CMS, 2019b). The revised EQR protocols covered in this report include:

Mandatory protocols:

Protocol 1: Validation of PIPs
(formerly protocol 3).

Protocol 2: Validation of performance measures

Protocol 3: Review of compliance with Medicaid and CHIP managed care regulations
(formerly protocol 1).

Protocol 4: Validation of network adequacy
(NEW PROTOCOL; no published guidance)

Optional protocols:

Protocol 5: Validation of encounter data *(formerly protocol 4)*.

Protocol 6: Administration or validation of QOC surveys *(formerly protocol 5)*.

Protocol 7: Calculation of additional performance measures *(formerly protocol 6)*.

Protocol 9: Conducting focus studies of healthcare quality *(formerly protocol 8)*.

Protocol 10: Assist with quality ratings
(NEW PROTOCOL; no published guidance)

Following guidelines in 42 C.F.R § 438.364 (2016), the EQRO completed this report for the state of Texas to submit to CMS. In addition to this introduction to Texas Medicaid and CHIP managed care, the report includes an Executive Brief highlighting findings and initiatives of interest to Texas, Activity Reports for the EQR protocols listed above, a summary of recommendations by the EQRO, and a progress report on the recommendations from the prior year's report.

In addition to the EQRO activities, the state quality strategy is part of the overall Medicaid managed care quality requirements (CMS, 2019b). The SOA report should reflect how the quality assessment and improvement activities reviewed support the quality strategy. Texas is required to develop and implement a written quality strategy[2] to assess and improve the quality of Medicaid and CHIP managed care services (42 CFR §438.340, 2016). This quality strategy is reviewed and updated every three years and must be approved by CMS. In this report, the EQRO provides a consolidated review of findings, recommendations and relevance to the quality strategy for last year and the current year. Prior year recommendations include information about follow-up actions by HHSC.

[2] Links to the quality strategy document are available at https://hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/quality-strategy.

Protocol 1: Validation of PIPs

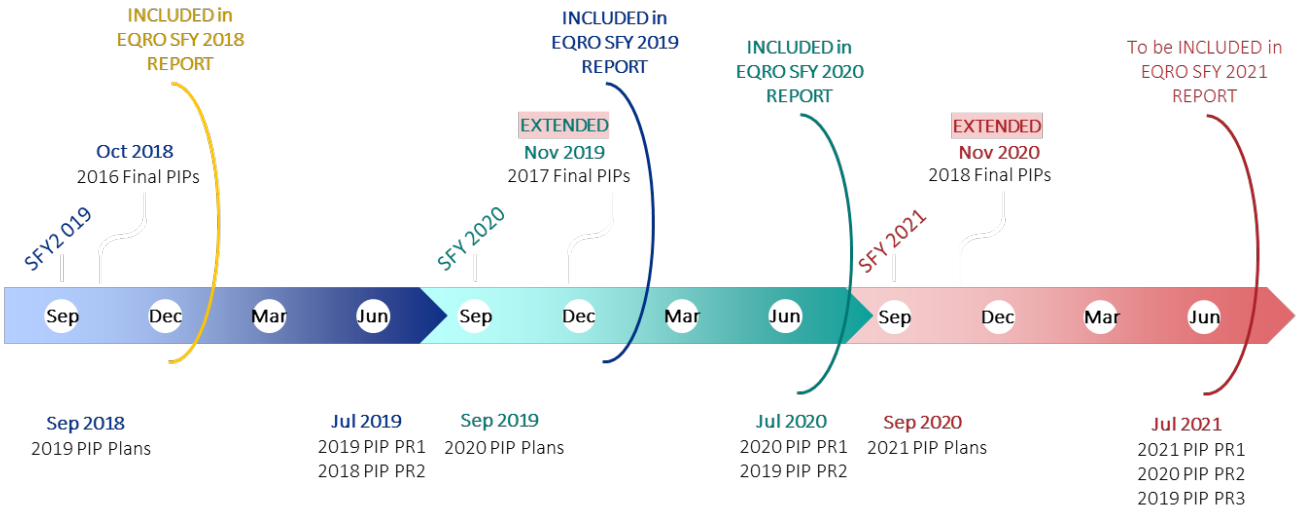
In 2019, CMS updated the EQR protocols, and validation of PIPs is now addressed in Protocol 1 (CMS, 2019b). The new protocol includes updated templates for PIP reporting and re-ordering of some PIP activities. HHSC will implement these changes for PIPs that begin in SFY 2020 and later (reported on beginning with the SFY 2022 SOA report). During SFY 2020, the EQRO followed the guidance in EQR Protocol 3 (CMS, 2012a) to evaluate the design, methodological approach, implementation, and validity of results for the mandatory PIPs undertaken by the MCOs and DMOs. However, this report follows the naming conventions in the updated protocols, making PIP validation Protocol 1. Texas requires MCOs and DMOs to conduct PIPs over two years to provide sufficient time for project implementation and to increase the likelihood of reporting meaningful outcomes. The overall PIP score includes both the PIP Plan score, reflecting the strength of design, and the Final PIP score, reflecting the analysis, results, and interpretation by the MCO.

Per 42 C.F.R. § 438.358 (2016), PIP validation is a mandatory EQRO activity. As an ongoing process, the EQRO activities include three major components. Every July, the EQRO uses progress reports to evaluate the implementation of the PIPs as they are underway. In September, the EQRO reviews PIP plans for the upcoming year. By November, the MCOs submit the reports for the PIPs they completed in the prior year for final evaluation by the EQRO. In previous reports, the EQRO included the review of the final PIP reports for the PIPs *completed* during the reporting year, but these reports are not received or reviewed by the EQRO until the following SFY. For example, the review of the final PIP reports for the 2017 PIPs *completed* in December 2018 was included in the SFY 2019 report even though the reports were received and reviewed during SFY 2020. Going forward, the EQRO will report on final PIP reviews in the SFY in which they occur, thus the review of the 2018 PIPs completed in December 2019 will be included in the SFY 2021 report. This change allows for more timely completion of the report.

PIP Timelines and Reporting

Figure 2 provides a timeline for the PIP reporting activities. During SFY 2020, the EQRO: (a) reviewed the 2020 PIP plans, (b) reviewed the first progress reports for 2020 PIPS, (c) reviewed the second progress reports for 2019 PIPS, and (d) reviewed the final 2017 PIP reports (findings included in the EQRO SFY 2019 report).

Figure 2. EQRO timeline for PIP activities



The COVID-19 Pandemic

The outbreak of the COVID-19 pandemic (hereafter the pandemic) in the United States in March 2020 triggered nationwide stay-at-home orders and increased healthcare burdens for MCOs.[3] PIPs usually have a two-year implementation period; however, due to the impact of the pandemic, HHSC extended the time frame for the 2019 and 2020 PIPs by one year. The original implementation of 2019 PIPs from January 1, 2019 – December 31, 2020, now extends until December 31, 2021. In May 2021, MCOs and DMOs will submit a third PIP Progress Report for the 2019 PIPs. Similarly, the original implementation of the 2020 PIPs from January 1, 2020 – December 31, 2021, now extends until December 31, 2022. In addition, seven MCOs selected a 2020 PIP that utilizes the HEDIS®[4] ADD measure, which does not follow the calendar year. The original implementation for the PIPs addressing the ADD measure was March 1, 2020 – February 28, 2022. Implementation for these PIPs now extends until February 28, 2023. In May 2022, all MCOs and DMOs will submit a third PIP Progress Report for the 2020 PIPs.

Summary of Current and On-going PIPs

The PIP topics implemented by each MCO and their interventions are summarized by year in Appendix B

2018 PIPs

The MCOs and DMOs completed their 2018 PIPs in December 2019 and submitted final PIP reports in November 2020. The EQRO will include final and overall results for the 2018 PIPs in the SFY 2021 SOA report. Topics for the 2018 two-year PIPs were generally implemented by program and included:

- Weight assessment and counseling for nutrition and physical activity for children/adolescents
- Prenatal and postpartum care
- Potentially Preventable Emergency Department Visits (PPVs) for upper respiratory tract infection (URTI)
- Self-directed care

Seven of the 2018 STAR PIPs focused on a sub-population within the prenatal and postpartum care topic. These sub-populations included members with depression (Aetna and Parkland), members who identify as African American[5] (Amerigroup and DCHP), only postpartum members (CFHP), members with or at high risk for postpartum depression (SWHP), and members with maternal substance use (UHC).

Both DMOs conducted dental PIPs for Medicaid and CHIP focused on increasing the use of dental sealants.

2019 PIPs

In the current reporting year, the EQRO evaluated the 2019 PIP Progress Report 2. The MCOs and DMOs submitted the 2019 PIP Progress Report 2 in July 2020 and reported preliminary results and any changes to interventions between submission of Progress Report 1 in July 2019 and July 2020. All MCOs focused on the statewide PIP topic, improving care for beneficiaries with complex needs (BCN). The measures used to evaluate progress include:

- the percentage of members with depression and/or anxiety who had high utilization, defined by three or more emergency department (ED) visits or two or more inpatient stays in one measurement year;

[3] Texas Exec. Order No. GA 14, executed March 31, 2020. Available: https://gov.texas.gov/uploads/files/press/EO-GA-14_Statewide_Essential_Service_and_Activity_COVID-19_IMAGE_03-31-2020.pdf.
[4] The Healthcare Effectiveness Data and Information Set (HEDIS) is the set of healthcare measures curated by the National Committee for Quality Assurance (NCQA). Information is available at https://www.ncqa.org/hedis/.
[5] African American is the racial identifier used by the MCOs to categorize members for these populations.

- the rate of members with anxiety and/or depression who had any PPV during the measurement year;
- and the rate of members with anxiety and/or depression who had any Potentially Preventable Admission (PPA) during the measurement year.

For 2019 PIPs the DMOs both established a collaborative data-sharing agreement with an MCO with the aim of reducing dental-related PPVs.

2020 PIPs

In the current reporting year, the EQRO evaluated the 2020 PIP Plans and the 2020 PIP Progress Report 1. The Progress Report 1 reported preliminary results from the PIP interventions between the implementation start date and June 2020. The statewide topic for 2020 MCO PIPs focused on behavioral health with an option to emphasize integration of behavioral and physical health services. Performance measures used to measure progress include:

- Initiation of Follow-up Care for Children Prescribed ADHD Medication
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence
- Follow-up After Hospitalization for Mental Illness
- Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder who are using antipsychotics

Both DMOs conducted dental PIPs for Medicaid and CHIP focused on improving use of topical fluoride treatment.

Evaluations and Results

When evaluating the progress reports, the EQRO assesses compliance on a variety of components. The EQRO scores each component as "Yes – Component Met" (100%), "Partially Met" (50%), or "No – Not Met" (0%). The progress report score is the average of all component scores. Any MCO or DMO that does not implement all recommendations or comply with all instructions outlined in Chapter 10.2.8 of the HHSC Uniform Managed Care Manual, receives an overall progress report score of zero, regardless of the scores for individual components. As mentioned previously, the impact of the pandemic affected the implementation of some of the PIPs. Some interventions that involved in-person outreach paused, and MCOs and DMOs reallocated resources to meet member needs due to the pandemic. The EQRO did not deduct points from progress report scores if documentation showed justified changes to the implementation of PIPs due to the pandemic.

2019 PIPs

Table 4 and Table 5 provide the scores for the 2019 PIP second progress report evaluations. Four MCOs (CMCHP, Driscoll, HealthSpring, and Molina) had zero scores on their progress reports due to failure to address previous recommendations. Three other MCOs (Aetna, FirstCare, and Parkland) had scores less than 90 percent.

Table 4. MCO scores on 2019 PIP second progress report evaluations

MCO	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Aetna Better Health (Aetna)	89.3%	-	92.9%	-	92.9%
Amerigroup	100.0%	100.0%	100.0%	-	100.0%
Blue Cross Blue Shield of Texas (BCBSTX)	96.4%	-	96.4%	-	96.4%
Children's Medical Center Health Plan (CMCHP)	-	-	0.0%	-	-

MCO	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Cigna-HealthSpring (HealthSpring)	-	0.0%	-	-	-
Community First Health Plans (CFHP)	100.0%	-	100.0%	-	100.0%
Community Health Choice (CHC)	100.0%	-	-	-	100.0%
Cook Children's Health Plan (CCHP)	96.4%	-	96.4%	-	96.4%
Dell Children's Health Plan (DCHP)	100.0%	-	-	-	100.0%
Driscoll Health Plan (Driscoll)	0.0%	-	0.0%	-	0.0%
El Paso Health	100.0%	-	-	-	100.0%
FirstCare Health Plans (FirstCare)	75.0%	-	-	-	78.6%
Molina Healthcare of Texas (Molina)	0.0%	0.0%	-	-	0.0%
Parkland Community Health Plan (Parkland)	89.3%	-	-	-	92.9%
RightCare from Scott & White Health Plan (SWHP)	96.4%	-	-	-	-
Superior HealthPlan (Superior)	100.0%	100.0%	100.0%	100.0%	100.0%
Texas Children's Health Plan (TCHP)	100.0%	-	100.0%	-	96.4%
UnitedHealthCare Community Plan (UHC)	100.0%	100.0%	100.0%	-	100.0%
Minimum	0.0%	0.0%	0.0%	100.0%	0.0%
Maximum	100.0%	100.0%	100.0%	100.0%	100.0%
Average	83.9%	60.0%	78.6%	100.0%	83.6%

Table 5. DMO scores on 2019 PIP second progress report evaluations

DMO	CMDS	CHIP Dental
DentaQuest	96.4%	96.4%
MCNA Dental	100.0%	100.0%

2020 PIPs

Table 6 and Table 7 provide the scores for the 2020 PIP plan evaluations. Only two MCOs (Aetna and Parkland) had scores less than 90 percent. The PIP Plan scores will be combined with the final PIP report scores (anticipated in SFY 2024) to calculate the overall PIP score.

Table 6. MCO Scores on 2020 PIP Plan evaluations

MCO	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Aetna Better Health (Aetna)	82.6%	-	82.6%	-	82.6%
Amerigroup	97.2%	97.2%	97.2%	-	97.2%
Blue Cross Blue Shield of Texas (BCBSTX)	90.1%	-	90.1%	-	90.1%
Cigna-HealthSpring (HealthSpring)	-	96.2%	-	-	-
Community First Health Plans (CFHP)	90.5%	-	90.5%	-	90.5%
Community Health Choice (CHC)	98.3%	-	-	-	98.3%
Cook Children's Health Plan (CCHP)	97.2%	-	97.2%	-	97.2%

MCO	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Dell Children's Health Plan (DCHP)	98.3%	-	-	-	98.3%
Driscoll Health Plan (Driscoll)	95.8%	-	95.8%	-	95.8%
El Paso Health	100.0%	-	-	-	100.0%
FirstCare Health Plans (FirstCare)	100.0%	-	-	-	100.0%
Molina Healthcare of Texas (Molina)	96.4%	95.6%	-	-	96.4%
Parkland Community Health Plan (Parkland)	82.6%	-	-	-	82.6%
RightCare from Scott & White Health Plan (SWHP)	100.0%	-	-	-	-
Superior HealthPlan (Superior)	100.0%	93.4%	100.0%	100.0%	100.0%
Texas Children's Health Plan (TCHP)	95.2%	-	95.2%	-	95.2%
UnitedHealthCare Community Plan (UHC)	98.2%	100.0%	97.2%	-	97.2%
Minimum	82.6%	93.4%	82.6%	100.0%	82.6%
Maximum	100.0%	100.0%	100.0%	100.0%	100.0%
Average	95.2%	96.5%	94.0%	100.0%	94.8%

Table 7. DMO scores on 2020 PIP plan evaluations

DMO	CMDS	CHIP Dental
DentaQuest	97.0%	97.0%
MCNA Dental	100.0%	100.0%

Table 8 and Table 9 provide the scores for the 2020 PIP first progress report evaluations. Scores ranged from 64.3 percent to 100 percent. Average scores by program ranged from 90.0 percent (STAR+PLUS) to 96.0 percent (STAR).

Table 8. MCO scores on 2020 PIP first progress report evaluations

MCO	STAR	STAR Kids	STAR+PLUS	STAR Health	CHIP
Aetna Better Health (Aetna)	92.9%	92.9%	-	-	92.9%
Amerigroup	100.0%	100.0%	100.0%	-	100.0%
Blue Cross Blue Shield of Texas (BCBSTX)	100.0%	100.0%	-	-	100.0%
Cigna-HealthSpring (HealthSpring)	-	-	64.3%	-	-
Community First Health Plans (CFHP)	92.9%	92.9%	-	-	92.9%
Community Health Choice (CHC)	96.4%	-	-	-	96.4%
Cook Children's Health Plan (CCHP)	92.9%	92.9%	-	-	92.9%
Dell Children's Health Plan (DCHP)	100.0%	-	-	-	100.0%
Driscoll Health Plan (Driscoll)	100.0%	100.0%	-	-	100.0%
El Paso Health	100.0%	-	-	-	100.0%
FirstCare Health Plans (FirstCare)	96.4%	-	-	-	96.4%

MCO	STAR	STAR Kids	STAR+PLUS	STAR Health	CHIP
Molina Healthcare of Texas (Molina)	89.3%	-	96.4%	-	89.3%
Parkland Community Health Plan (Parkland)	92.9%	-	-	-	92.9%
RightCare from Scott & White Health Plan (SWHP)	96.4%	-	-	-	-
Superior HealthPlan (Superior)	92.9%	92.9%	89.3%	92.9%	92.9%
Texas Children's Health Plan (TCHP)	92.9%	92.9%	-	-	92.9%
UnitedHealthCare Community Plan (UHC)	100.0%	82.1%	100.0%	-	85.7%
Minimum	89.3%	82.1%	64.3%	92.9%	85.7%
Maximum	100.0%	100.0%	100.0%	92.9%	100.0%
Average	96.0%	94.1%	90.0%	92.9%	95.0%

Table 9. DMO scores on 2020 PIP first progress report evaluations

DMO	CMDS	CHIP Dental
DentaQuest	96.4%	96.4%
MCNA Dental	100.0%	100.0%

Discussion

The pandemic impacted the implementation of some PIP activities. However, this did not negatively impact the PIP Progress Report scores because the EQRO did not deduct points when documentation showed justified modifications.

For the 2019 Progress Report 2, 26 of the 51 PIPs scored 100 percent, indicating that these MCO/DMOs fully complied with each evaluation component. Eight of the 51 PIPs received a score of zero because they did not incorporate previous PIP evaluation recommendations. Additional reasons for lower scores include errors or omissions in reporting, insufficient justification for modifications to the PIP, and making non-pandemic-related modifications that are unlikely to help meet the PIP goals.

Eighteen of the 50 PIPs for the 2020 Progress Report 1 scored 100 percent. The high average program scores (≥90 percent) indicate successful implementation of the PIPs, overall. Reasons for lower scores include insufficient justification for retiring or implementing new interventions, failure to report sufficient tracking and monitoring data for interventions, and inconsistencies with data reporting.

Recommendations

Opportunities for improvement in the PIPs arose from not addressing previous EQRO recommendations and insufficient details of modifications made to the PIPs. The EQRO recommends:

- The MCOs should ensure that they comply with all previous recommendations.
- The MCOs should provide sufficient details for all modifications to their PIPs.

Protocol 2: Validation of Performance Measures

Combining both performance measurement options in 42 CFR § 438.330 (2016), Texas requires 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, 2019a) is a mandatory EQRO activity (42 C.F.R. § 438.358, 2016) requiring the EQRO to validate Medicaid and CHIP performance measure results, assessing the accuracy of MCO reported results and evaluating how well the calculated measures follow Texas requirements. Only a limited number of performance measures are calculated and reported by the MCOs and thus subject to Protocol 2 review. The state requires MCOs to calculate select 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:

- review of information related to the Information Systems Capabilities Assessment (ISCA) process recommended by CMS (CMS, 2019a), collected through the administrative Interviews (AIs) addressed by Protocol 3,
- review of audit reports by National Committee for Quality Assurance (NCQA) certified auditors (for HEDIS measures) and related documentation, and
- direct review of measure specification and results, including comparison to EQRO calculated results.

The related Protocol 7 specifically addresses performance measures calculated by the EQRO. To provide the most consistent calculations across many programs and MCOs, Texas requires the EQRO to calculate over 100 QOC measures annually. Measures calculated by the EQRO provide standard, reliable results for use in quality evaluations and research.

Information Systems, Processes, and Data Used in Performance Measures

As part of the AI, the EQRO asks questions related to Information Systems and Data Acquisition. Of the nine MCOs participating in the AI process in SFY 2020 (Protocol 3), four provided external SOC (service organization control) audit reports and one provided an ISCA report for their parent entity. One provided documentation of HITRUST® certification. As part of contracting procedures, HHSC conducts IT readiness reviews. One MCO provided this report as documentation of a recent assessment. Only one MCO did not undergo an audit by an NCQA certified auditor to submit data to NCQA. 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. All MCOs that indicated that they submit data to NCQA also report using third-party NCQA certified software to calculate HEDIS measures.

All MCO/DMOs reported that the average experience of their programming staff was four years or more, and turnover is relatively low. The cumulative staff experience helps build important institutional knowledge and should improve efficiency in any data-driven initiatives. Five MCOs reported a major change in encounter or enrollment processing systems in the past three years. This change highlights the need for continuous evaluation of MCO/DMO information systems. Among the MCO/DMOs that reported using Electronic Health Record (EHR) systems in their networks, all reported that at least 50 percent of primary care providers (PCPs) and specialists used an EHR system. All but two MCO/DMOs reported that at least 98 percent of claims are complete within three months. The other two, Parkland and CMCHP, report having 94 percent of claims complete by three months. The frequency of internal claim audits varies from weekly to quarterly by the

MCO/DMO and whether the claims are processed in-house or by a third party. All but one of the MCOs had a third party generate the explanation of benefits (EOB) and other payment reports.

The AI includes questions about the validation of provider identification and taxonomy information. All MCOs indicated that they validate NPI (National Provider Identifier) in encounters and about half indicated taxonomy validation. The AI also collects information about ongoing procedures to improve provider information accuracy that HHSC can use to guide statewide initiatives.

The first part of the NCQA HEDIS audit process (required of all MCOs for the hybrid measures reported) is a review of an organization's overall information systems capabilities for collecting, storing, analyzing and reporting health information. Each MCO must provide an attestation of reportability from an NCQA-certified auditor with all hybrid measure results submitted.

HEDIS Hybrid Measures

Hybrid method specifications include sampling based on administrative criteria, followed by medical record review from the sample to determine compliance. The MCOs report their hybrid method results for 11 HEDIS measures for the programs listed in Table 10. Results are compiled with EQRO calculated measures (Protocol 7) in the QOC Reports and on the Texas Healthcare Learning Collaborative (THLC) portal (THLCportal.com).

Table 10. HEDIS 2020 (2019 measurement year) measures selected for hybrid reporting

Abbreviation	Description	Programs
ABA	Adult Body Mass Index (BMI) Assessment	STAR+PLUS
AWC	Adolescent Well-Care Visits	CHIP, STAR, STAR Kids
CBP	Controlling High Blood Pressure	STAR, STAR+PLUS
CCS	Cervical Cancer Screening	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
PPC	Prenatal and Postpartum Care	STAR
W15	Well-Child Visits in the First 15 Months of Life	STAR
W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	CHIP, STAR, STAR Kids
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 must be submitted to the EQRO with the measure results, 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, submitted rates are compared with EQRO-calculated administrative rates and prior years' results to identify trends. Next, the EQRO uses data analysis and communication with HHSC and the submitting MCO to identify and trace any inconsistencies in the measure's (a) eligible population, (b) denominator, and (c) numerator. For example, the EQRO identified inconsistencies in how MCOs count exceptions and contraindications, and discrepancies seen in administrative rates helped identify differences in provider specialty identification.

In addition to required hybrid measure rates, the MCOs may also submit supplemental data for use in HEDIS measures calculated by the EQRO (Protocol 7). 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 quality assessment and performance improvement (QAPI) programs carried out by the MCOs and DMOs and evaluated by the EQRO (Protocol 3). All MCOs and DMOs scored 100/100 on the EQRO assessment of "Systems, Processes, & Outcomes Measurements & Results" and "Internal/External Comparisons," which are addressed in the "Improvement Opportunities" section of the EQRO review, and all scored 100/100 on reporting the results in the "Availability and Accessibility (of) Access to Care Monitoring & Results" area. In the "Activities and Ongoing Quality Indicators" area, Molina was the only MCO that failed to report results for the "Clinical Indicator Monitoring" activity, while several MCOs (Aetna, Amerigroup, and Parkland) provided only partial reporting for the "Service Indicator Monitoring" activity.

THSteps Checkups Report

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 check-up completeness and required check-up reports. According to Chapter 12 of the Texas Uniform Managed Care Manual (UMCM) that covers Frew requirements (HHSC, 2020), MCOs must submit annual reporting on compliance with THSteps check-up 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 in the final development of 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. Although most MCOs provide reports passing the EQRO validation process, no MCO is providing required THSteps checkups to 70 percent of eligible members. Over five years, the overall rate for annual checkups improved only slightly, and the check-up rate for new members showed no improvement.

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

Following the guidance in EQR Protocol 3 (CMS, 2019b), the EQRO determines the extent to which Texas Medicaid and CHIP MCOs comply with federal quality standards (42 C.F.R. § 438 and 42 C.F.R. § 457, 2016). Including:

- 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 review initiatives to fulfill the requirements of this protocol. First, AIs allow the EQRO to complete comprehensive MCO regulatory compliance assessments. The AIs assist in identifying the structural strengths and weaknesses in MCO quality improvement programs. Second, the EQRO conducts a thorough review of quality improvement programs through the QAPI program evaluations.

Administrative Interviews (AIs)

The EQRO developed a web-based AI tool that allows MCOs to provide information across 10 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

The EQRO updates the tool annually. MCO responses support a comprehensive review of MCO compliance with Texas requirements and federal regulations (42 C.F.R. § 438, 2016). In addition to administering the AI tool and evaluating the responses, the EQRO conducts follow-up on-site visits with all MCOs and DMOs every three years. Based on the review of the AI responses, the EQRO assigns scores in each federal regulation category and combines them into an overall score. Along with their score report, the EQRO also provides recommendations to each MCO and DMO. Table 11 shows the final AI scores by category and overall averages by MCO/DMO.

Results

In 2020, seven MCOs and one DMO participated in full AI activities. The EQRO evaluated CMCHP's AI tool responses, but the plan did not participate in a site visit because they exited STAR Kids service in August 2020. Overall, in 2020, the average compliance scores by category ranged from 93.5 to 100 (fully compliant) across categories. Individual MCO and DMO scores within categories were all at least 78. The average overall score in 2020 was 95.

Table 11. MCO and DMO 2020 AI scores by federal regulation category and overall

MCO	A. General Provisions	B. State Responsi-bilities	C. Member Rights & Protections	D. Health Plan Standards	F. Grievance & Appeal System	Overall Score
Blue Cross Blue Shield of Texas (BCBSTX)	94.3	100	94.6	94.1	78.0	87.8
Children's Medical Center Health Plan (CMCHP)	94.3	100	96.7	98.5	89.7	94.0
Community Health Choice (CHC)	93.4	100	96.7	94.3	91.0	91.6
Dell Children's Health Plan (DCHP)	96.7	100	100.0	100.0	98.6	98.6
Driscoll Health Plan (Driscoll)	96.7	100	100.0	99.3	98.3	98.1
MCNA Dental (MCNA)	97.4	100	100.0	100.0	98.1	98.4
Parkland Community Health Plan (Parkland)	95.9	100	100.0	96.0	95.0	96.1
RightCare from Scott & White Health Plan (SWHP)	95.9	100	89.4	98.5	95.4	95.4
Texas Children's Health Plan (TCHP)	95.9	100	98.3	95.5	96.9	95.5
Average	95.6	100	97.3	97.4	93.5	95.0

Site visits in 2020 were completed virtually via video conference calls due to the pandemic restrictions. During virtual site visits, the EQRO addressed areas of regulatory non-compliance with the MCOs and DMO. If necessary, the EQRO also asked the MCOs and DMO to provide additional documentation supporting compliance or policy and procedure revisions enacted to address regulatory deficiencies.

In addition to the federal and state regulatory categories addressed in the full AI process, the EQRO inquired about MCO and DMO procedures for collecting social determinants of health (SDoH) data and the interventions MCOs and DMOs are employing to address member needs related to SDoH. Several MCOs provided examples of internally funded interventions, including providing local school supplies, hygiene promotion and supply, and food drives. Most MCOs refer to external community resources to address member SDoH needs.

Recommendations

- The MCOs and DMOs should monitor state and federal regulations to ensure compliance.
- MCOs and DMOs should systemically collect member SDoH data to address needs that may impact health and well-being.
- MCOs and DMOs should consider evaluating the impact of SDoH-related interventions and referrals to community resources on the health and well-being of members.

- MCOs and DMOs are encouraged to share SDoH related interventions and best practices with other entities, including HHSC, to further improve care coordination and the health outcomes for Texas Medicaid and CHIP managed care members.

Evaluation of QAPIs

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 (2016). 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; and
5. systematic analysis.

PIPs (element four) are addressed in this report under Protocol 1 (CMS, 2019b); however, due to the timing of implementation, the PIP evaluation primarily followed the guidance in the 2012 version of CMS EQR Protocol 3 (CMS, 2012a, p. 3). The EQRO QAPI program evaluations address the other four elements following the guidance in the revised CMS EQR protocol 3 (CMS, 2019b). Overall, the EQRO QAPI program evaluation process includes 17 activities (Table 12). Seven, which address the four essential QAPI elements other than PIPs, make up 70 percent of the final overall QAPI score. The other 10 activities together comprise 30 percent of the final overall QAPI score.

Table 12. 2020 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 & Access to Care Monitoring & 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 & Supports (LTSS) B4: Clinical Practice Guidelines B7: Credentialing and Re-Credentialing B8: MDCP Qualified Providers B9: Delegation of QAPI Program Activities B10: Corrective Action Plans B11: Previous Year's Recommendations (*not included in the overall score*)

In addition to scoring plan performance across all 17 activities based on whether requirements for each component are "met" (fully), "partially met", or "not met", 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, although this additional recommendation score is not included in calculating the current overall score.

Results

MCO and DMO QAPIs

Table 13 shows the overall 2020 score for each MCO or DMO. The average score was 95.6 (SD = 4.4). The three lowest scoring plans, Aetna (85.8 percent), Molina (88.5 percent), and FirstCare (88.8 percent), did not provide all requested information. Aetna and FirstCare did not report the results of their respective Texas Department of Insurance (TDI) audit for Activity B10. Molina did not submit *Appendix C - Clinical Indicator Monitoring for Activity B6a*. The EQRO considered scores more than half a standard deviation below the mean (<93.4 percent) as "below average" (25 percent of plans) and considered scores more than half a standard deviation above the mean (>97.8 percent) as "above average" (35 percent of plans).

Table 13. MCO and DMO 2020 QAPI scores

MCO or DMO	Score (%)	Peer Comparison
Aetna Better Health (Aetna)	85.8	Below Average
Amerigroup	94.9	–
Blue Cross Blue Shield of Texas (BCBSTX)	99.4	Above Average
Children's Medical Center Health Plan (CMCHP)	95.0	–
Cigna-HealthSpring (HealthSpring)	97.1	–
Community First Health Plans (CFHP)	95.0	–
Community Health Choice (CHC)	99.7	Above Average
Cook Children's Health Plan (CCHP)	100	Above Average
Dell Children's Health Plan (DCHP)	100	Above Average
DentaQuest	93.1	Below Average
Driscoll Health Plan (Driscoll)	96.3	–
El Paso Health	100	Above Average
FirstCare Health Plans (FirstCare)	88.8	Below Average
MCNA Dental (MCNA)	100	Above Average
Molina Healthcare of Texas, Inc. (Molina)	88.5	Below Average
Parkland Community Health Plan (Parkland)	90.2	Below Average
RightCare from Scott & White Health Plan (SWHP)	95.6	–
Superior HealthPlan (Superior)	96.0	–
Texas Children's Health Plan (TCHP)	97.4	–
UnitedHealthcare Community Plan (UHC)	98.3	Above Average
Overall Average	**95.6**	**–**

The EQRO evaluated the QAPI program summary reports by section to identify areas of high performance and opportunities for both systematic and individual improvement. Table 14 shows the average QAPI program performance by activity. Performance on activities contributing to the final score ranged from 71.4 to 100 percent. The activity with the lowest performance was "Corrective Action Plans" for TDI audits. As noted above, the low score for this activity was due to two MCOs not providing the requested information. The activity with

the next lowest score (79.2 percent) was "incorporation of the previous year's recommendations," which demonstrated a 4.2 percentage point decrease from the previous year.

Table 14. Average 2020 QAPI scores by activity

Activity	Score (%)
Required Documentation Overall	100
A1: Role of Governing Body	100
A2: Structure of Quality Improvement Committee(s)	98.9
A3: Adequate Resources	97.5
A4: Improvement Opportunities	98.8
B1: Program Description	91.9
B2: Overall Effectiveness	92.5
B3: Effectiveness of Long-Term Services and Supports (LTSS)	95.8
B4: Clinical Practice Guidelines	100
B5: Availability and Access to Care Monitoring and Results	95.8
B6a: Clinical Indicator Monitoring	92.5
B6b: Service Indicator Monitoring	93.8
B7: Credentialing and Re-credentialing	98.0
B8: MDCP Qualified Providers	100
B9: Delegation of QAPI Activities	96.8
B10: Corrective Action Plans	71.4
B11: Previous Year's Recommendations	79.2

MMP QAPIs

Table 15 shows the overall 2020 score for each MMP. The average score was 98.5 percent (SD = 1.6). The lowest score was for UnitedHealthcare (96.3 percent), and this was primarily due to UnitedHealthcare not incorporating all the previous year's recommendations. Scores more than half a standard deviation below the mean (<97.7 percent) were considered "below average" and scores more than half a standard deviation above the mean (>99.3 percent) were considered "above average".

Table 15. MMP 2020 QAPI scores

MMP	Score (%)	Peer Comparison
Amerigroup	100	Above Average
Cigna-HealthSpring (HealthSpring)	97.5	Below Average
Molina Healthcare of Texas, Inc. (Molina)	98.8	–
Superior HealthPlan (Superior)	100	Above Average
UnitedHealthcare Community Plan (UHC)	96.3	Below Average
MMP Average	**98.5**	–

When the EQRO summarized MMP QAPI program performance scores by activity, all but three of the activity scores were 100 percent. The average of MMP scores was 90 percent for *Overall Effectiveness*, which demonstrated a 3.3 percentage point improvement from the previous year; 92.5 percent for *Program Description*, which remained unchanged from the previous year; and 90 percent for *Previous Recommendations,* which demonstrated a 10-percentage point decrease because one MMP did not incorporate all of the previous year's recommendations.

Recommendations

Each year the EQRO makes recommendations on areas of opportunities for improvement for each MCO or DMO. Those that fail to incorporate these recommendations receive a deduction of points on the same activities as the previous year in addition to a lower level of compliance with the previous year's recommendations. Each MCO or DMO should be striving to achieve improvement in its structure and processes and utilize strategies that aim for continuous quality improvement. This year, multiple MCOs did not incorporate the previous year's recommendations, which resulted in a percentage point decrease for the activity for the MCOs and MMPs.

- The EQRO recommends that MCOs, DMOs, and MMPs incorporate the previous year's recommendations and that HHSC consider corrective action plans for those that consistently do not incorporate the EQRO's recommendations.

Protocol 4: Validation of Network Adequacy

Although CMS has not released details for this new protocol the EQRO conducted several activities related to network adequacy described here. Table 16 provides a summary of projects for the reporting period.

Table 16. EQRO network adequacy activities for SFY 2020

Study	Description
Appointment Availability Study	A mystery shopper research design allowed assessment of MCO compliance with appointment wait time standards for three types of care: vision care, prenatal care, and primary care.
Texas Medicaid NEMT Services Study	Telephone-based surveys gathered information on member satisfaction and experience with non-emergency medical transportation (NEMT) services provided by the Texas Medical Transportation Program (MTP), that identified potential transportation needs among Texas Medicaid members.
Provider Referral Study	Telephone-based surveys gathered information on provider experiences with the referral process and identified potential barriers to specialty referrals for Texas Medicaid and CHIP members.

Appointment Availability Study

Relevance

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 (NAIC, 2020). According to the Texas Uniform Managed Care Terms & Conditions, Section 8.1.3 (HHSC, 2019), MCOs that participate in Texas Medicaid and CHIP must ensure that all members have timely access to all covered services. Appointment wait time standards are shown in Table 17. The EQRO conducts the appointment availability study annually to help HHSC assess compliance with Medicaid managed care regulations for network adequacy. The vision care study was completed prior to the March 2020 start of the pandemic, but the prenatal care and primary care studies were impacted by the pandemic. While the results still provide much useful information, the EQRO recommended that HHSC not use them for assessing liquidated damages and corrective action plans given the unknown effects of the pandemic. A behavioral healthcare study originally planned for 2020 was cancelled, allowing for extended fielding time for the primary care and prenatal studies.

Table 17. 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
Initial outpatient behavioral health visits (child and adult)	Within 14 calendar days
Preventive health services for adults	Within 90 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

Key Findings

- Inaccuracies in provider contact information continue to create challenges in reaching providers. While the percentage of unreachable providers decreased in the 2020 vision and prenatal sub-studies relative to 2018, the percentage of unreachable primary care providers increased in 2020. Furthermore, over 90 percent of prenatal calls to providers in the BCBSTX directory resulted in wrong number/unreachable calls.
- The percentage of providers contacted from the STAR Health directory that said they did not accept Medicaid increased from three percent in 2018 to 11.8 percent in 2020.
- In 2020, the percentage of compliant vision appointments decreased in CHIP, STAR, STAR+PLUS, and STAR Kids programs relative to 2018.

Recommendations

- Superior should continue to work with STAR Health providers and provider office staff to improve the consistency of responses about provider availability and Medicaid acceptance for vision appointments.
- HHSC should continue current efforts to work with stakeholders, including the enrollment broker, contract administrator and data processor, providers, and the MCOs, to improve provider contact information accuracy.
- HHSC should particularly encourage the MCOs to carefully examine the member-facing directory information regularly, as this directly impacts member access to care.
- MCOs should educate providers and provider office staff about the appointment guidelines for routine vision care to increase the percentage of providers that meet appointment standards for vision care in CHIP, STAR, STAR Kids, and STAR+PLUS.
- HHSC should consider conducting a study that examines network adequacy for vision care in Texas Medicaid and the barriers that Texas Medicaid members face in accessing vision care.
- To better understand the availability of telehealth services for Texas Medicaid members, the EQRO recommends that HHSC consider including a standard question on the availability of different types of teleservices in all four SFY 2021 Appointment Availability Studies.
- HHSC should consider a study that uses Texas Medicaid and CHIP member experience data to identify telemedicine barriers and gaps in health service access and use this information to target strategies for improving network adequacy.

Texas Medicaid NEMT Services Study

Relevance

Lack of reliable transportation can be a barrier to accessing healthcare, particularly for elderly, disabled, or low-income individuals. Federal Medicaid regulations (42 C.F.R. § 431.53, 2016) require that HHSC ensure transportation to and from covered healthcare is available for all eligible Texas Medicaid members. Texas NEMT services include three transportation services (mass transit, demand response transportation services, and mileage reimbursement) and two types of ancillary services (advanced funds and meals/lodging). The EQRO conducted this study to help HHSC assess compliance with Medicaid managed care regulations for NEMT services.

Key Findings

- Overall, 79 percent of respondents said it was "easy" or "very easy" to find transportation to the doctor or dentist. Over half of all respondents said they never missed a medical or dental appointment because of lack of transportation.
- Overall, demand response transportation services and meals and lodging were the most frequently used services. Advanced funds were the least frequently utilized.
- A substantial percentage of members (75.6 percent) did not use public mass transit in the past 12 months.
- Overall, 89.1 percent of all respondents said they were "satisfied" or "very satisfied" with the transportation services they had received from Medicaid in the past 12 months.

Recommendations

- The NEMT survey results suggest that member experience is generally positive, but it does not provide information on how the services could be improved to meet specific member needs. HHSC should consider adding questions to later iterations of the client satisfaction surveys to assess member priorities for NEMT services. These items could include questions about how members use NEMT services and the availability of services for special needs populations. A clear understanding of member priorities for NEMT services provides an important context for interpreting variation in general member satisfaction levels and can help the MTP tailor the programs to better suit members.

Provider Referral Study

Relevance

Continuity of care is an important component of network adequacy. Several studies, including those conducted by the EQRO, suggest that providers regularly face barriers in the specialty referrals process. These barriers limit access to health services and exacerbate problems with fragmented care for members with complex healthcare needs (Kim et al., 2015). The EQRO conducted this study to help HHSC identify and address key challenges that Texas Medicaid and CHIP providers face during the referral process.

Key Findings

- Specialist and PCP responses on the 2020 referral survey share some broad similarities. Psychiatry is consistently identified as one of the most difficult specialties for referral, although specialists identified a shorter wait time for an appointment (one or two weeks) compared to PCPs (one month or more). Specialists and PCPs also identified cardiology as one of the easiest specialties for a referral.
- Specialists most frequently identified prior authorization for services, limited appointment availability, and limited specialist networks as the primary barriers to care.
- Specialists had more to say on open-ended questions compared to prior years. This could be because of the change in survey format (moving from online and mail to telephone-based), because specialty categories listed for PCPs lack salience for specialists, or both.

Recommendations

- MCOs should continue efforts to identify and reduce barriers to accessing psychiatric services and behavioral health care for Medicaid and CHIP members

- HHSC should consider a study that identifies the challenges that specialists in Texas Medicaid face with the prior authorization process and examine strategies that other state Medicaid programs use to address barriers to care.
- Given the increasing importance and utilization of teleservices, HHSC should continue to ask about teleservices on future provider surveys and may want to consider adding questions about the actions that providers are taking to protect health information for Medicaid and CHIP members.

Protocol 5: Validation of Encounter Data

Texas Medicaid and CHIP MCOs and DMOs submit encounter data to Texas Medicaid & Healthcare Partnership (TMHP), the contract administrators for Texas Medicaid and CHIP. Encounter data should include substantially 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, 2019b). 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. review of Texas requirements for encounter data submissions,
2. review of MCO encounter data production capacity,
3. analysis of encounter data for accuracy and completeness,
4. review of medical/dental records for consistency with encounter data, and
5. submission of findings (completed for each step).

Encounter Data Submissions and MCO Encounter Data Production Capacity

The EQRO conducts an ongoing review of the encounter data submission system. Documentation of encounter data submission requirements and processing are included in the joint interface plan (JIP) between TMHP and the MCOs. Before implementing changes, HHSC and TMHP consult with the EQRO to evaluate how changes might affect encounter data quality and usability. The EQRO reviews the entire JIP annually. The EQRO also evaluates provider data in the TMHP system.

As part of EQR Protocol 3 activities, the EQRO conducts AI evaluations that include two major sections related to MCO encounter data production. Section nine of the AI tool addresses health plan information systems, and section 10 addresses MCO data acquisition. These AI findings, and other evaluations of MCO information systems and processes are described under Protocol 2, as they relate to the validation of performance measures.

Analysis of Encounter Data for Accuracy and Completeness

The EQRO continues to work with HHSC to ensure Texas meets current data quality criteria standards and is prepared for future data requirements by setting high data quality assessment standards. 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 that are 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, 2019b), the EQR Toolkit (CMS, 2012b), 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 five types of data to the EQRO:

1. encounter data,
2. state paid claims (processed by TMHP),
3. pharmacy encounter data (processed by TMHP-Pharmacy),
4. provider data, and
5. member enrollment data.

To allow for full adjudication and processing of all claims for services during the certification period (SFY 2019), 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 2019 for the certification of SFY 2019 data.

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

1. A volume analysis quantifying the number of paid, denied, and voided claims by MCO or DMO, month, and service category.
2. A 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 for 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.

Overall, the EQRO found no unexpected changes or variations in the encounter volume analyses. In STAR, January typically has the highest volume while June typically has a lower volume than other months. The institutional percentage of encounters by MCO/SA typically ranges from 10 to 25, with higher percentages seen in the MRSA, possibly due to higher use of Federally Qualified Health Centers (FQHC) and rural health clinics; the highest rate was for SWHP in MRSA-Central (>30 percent). For STAR+PLUS, several MCOs had substantial changes in volume. HealthSpring in Hidalgo increased by 30 percent from May to August 2019, while UHC volume declined approximately 20 percent over the same period and across SAs. The institutional percentage of encounters varies more in STAR+PLUS, ranging from less than ten percent (all MCOs in Hidalgo, El Paso, and Nueces SAs) to over 40 percent (UHC in MRSA-Central). This variation suggests underlying differences in the care delivery model that affect QOC measures. In STAR Kids, encounter volumes were generally consistent. However, the claims volume for Driscoll doubled in August 2019. Large single-month changes are indicative of a processing issue. When MCOs experience a processing issue and do not provide HHSC or the EQRO with accurate information, it can affect the use of the data for QOC measures. Volumes in STAR Health, CHIP, and Medicaid and CHIP dental were generally consistent throughout the year.

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 missing or did not meet validity standards (Appendix C);
- present on admission (POA) indicators, used in calculating the 3M Potentially Preventable Complications (PPC) measure;
- provider information, including submitted national provider identifier (NPI) and taxonomy; and
- 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 2019 data, the EQRO included 17 encounter fields in the review and considered validity check rates below 99 percent to be areas of concern. In most cases, 100 percent of data passed validity checks; however, an annual review of data is vital to ensuring that the data used in QOC assessment and rate-setting meets quality standards. In past years, the EQRO has identified data issues resulting from recent processing changes and worked with HHSC and the MCOs to identify root causes and make corrections so that the final data pass certification testing. Table 18 shows deficiencies found in key fields.

Table 18. Key data field deficiencies in SFY 2019 encounters

Program	MCO	SA	Deficiency
STAR	Driscoll	Nueces	1.83 percent of Medicaid IDs were invalid
CHIP	CFHP	Bexar	1.34 percent of Medicaid IDs were invalid
CHIP	UHC	Nueces	1.49 percent of pharmacy claims had an invalid dispensing unit.

The EQRO has reported the issue of invalid dispensing units for UHC in previous reports. Additionally, several other MCOs across programs and SAs had more than 0.5 percent invalid dispensing. Investigation of claims shows that many of these cases are claims for asthma rescue inhalers. When the pharmacy dispensing unit is "EA" (each), the quantity should be an integer (e.g., one inhaler), not the inhaler volume.

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 D provides a full description of these criteria.

Almost all primary diagnoses should be present on admission (POA code = *Y*) and 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 cases (Table 19). One cause could be a high number of maternity stays. Hospitals will code significant complications of delivery in the primary diagnosis, although the admission was for delivery.

Table 19. Primary diagnosis POA distribution outside accepted criteria

Program	MCO	SA	Criteria	Rate
STAR	El Paso Health	El Paso	High (≥10%) Primary POA = *N*	11.6%
STAR	SHP	El Paso	High (≥10%) Primary POA = *N*	11.5%
STAR	Molina	Hidalgo	High (≥10%) Primary POA = *N*	11.2%
STAR	Molina	El Paso	High (≥10%) Primary POA = *N*	11.1%
STAR	UHC	Jefferson	High (≥10%) Primary POA = *N*	10.7%
STAR	SHP	MRSA-Northeast	High (≥10%) Primary POA = *N*	10.5%
STAR	Driscoll	Hidalgo	High (≥10%) Primary POA = *N*	10.4%

Program	MCO	SA	Criteria	Rate
STAR+PLUS	Molina	Harris	High (≥1%) Primary POA = *W*	2.1%
STAR+PLUS	Amerigroup	Harris	High (≥1%) Primary POA = *W*	1.6%
STAR+PLUS	UHC	Harris	High (≥1%) Primary POA = *W*	1.3%
STAR Kids	Amerigroup	Harris	High (≥1%) Primary POA = *W*	2.4%
STAR Kids	UHC	Jefferson	High (≥1%) Primary POA = *W*	2.0%
STAR Kids	TCHP	Harris	High (≥1%) Primary POA = *W*	1.7%
STAR Kids	UHC	Harris	High (≥1%) Primary POA = *W*	1.5%
CHIP	UHC	Harris	High (≥1%) Primary POA = *W*	2.0%
CHIP	TCHP	Harris	High (≥1%) Primary POA = *W*	1.3%

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 D provides a description of 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 and CHIP Perinatal failed to meet the criteria. When the aggregated data fails these overall checks, at least one and likely multiple contributing hospitals have 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, the EQRO is hindered in its ability to provide 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. When the rendering provider is not the individual providing the service, the taxonomy reported or associated with the NPI may not reflect service provider qualifications. Some billable services are regularly provided by individuals not eligible for an NPI.

In STAR and CHIP, less than 75 percent of professional encounters included both a rendering NPI for an individual and a taxonomy. This rate was less than 50 percent for STAR Health, less than 30 percent for STAR Kids, and less than 20 percent for STAR+PLUS. Many STAR Kids and STAR+PLUS services can be provided by caregivers that do not have NPI, but the EQRO has no clear way to identify these encounters, and without alternative identifiers, the lack of NPI still creates an information deficit on these encounters.

Dental Data

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 added evaluation of the risk indicator to the data certification process for SFY 2017 and found that caries assessment codes were missing in up to four percent of

dental exam encounters across programs and DMOs. This measure showed improvement in SFY 2018, but in SFY 2019, appropriate codes were still missing more than two percent of the time.

FSR Analysis

The EQRO compared payment dollars documented in the encounter data to payment dollars in the MCO self-reported FSR. According to the standard set by HHSC for SFY 2019, the encounter data and the FSR must agree within three percent for the data to be certified. All MCO/SA combinations across all programs met this standard. 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 improvement in the data quality. Over time, the agreement standard has increased due to the diligent work by all stakeholders to improve data processes.

Recommendations

- HHSC should work with the EQRO, TMHP, and the MCOs/DMOs to improving the system for monitoring monthly encounters submissions for anomalies and communicating about issues or discrepancies.
- MCOs should work with their network hospitals to improve POA reporting.
- HHSC should continue to investigate provider identification deficiencies, including identification of providers not eligible for NPI.
- DMOs should promote CRA coding with provider outreach in addition to denial of claims.

Review of Medical Records for Consistency with Encounter Data

The EQRO annually validates encounter data for accuracy and completeness by comparing encounters against a representative sample of dental or medical records. Although the CMS guidance for these activities has since been updated in the revised Protocol 5 (CMS, 2019b), the EQRO applied the previous EQR Protocol 4 (CMS, 2012a) to these activities because it was the most current guidance available when the project began. Through SFY 2020, the EQRO alternated samples types annually, including either dental or medical records each year. The 2020 Encounter Data Validation: Medical Record Review (EDVMRR) sample included only Medicaid medical encounters. Beginning with SFY 2021, the EQRO plans to sample medical records annually, alternating between CHIP and Medicaid samples each year, while continuing to review dental samples every other year.

Methodology

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, 2018, through December 31, 2018, and the sample allowed at least six months claim lag for adjudication.

Sampling

The EQRO identified member-provider pairs having a paid (qualifying) encounter for a medical exam in an outpatient office or clinic visit during the sample period. 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 20) using the lowest MCO match rate from the previous physical health EDVMRR for DOS and accounted for the expected record return rate (70 percent based on the previous EDVMRR). The EQRO requested the member medical record for the entire study period (2018) from the provider associated with the qualifying encounter for each of the selected member-provider pairs in the qualified sample pool.

Table 20. Sample sizes for 2020 medical encounter data validation by program

Program	Previous low DOS match rate by MCO	Sample size required per MCO	Total records requested
STAR	82.2%	77	1760
STAR+PLUS	81.1%	67	480
STAR Kids	54.8%	127	1820
STAR Health	93.9%	35	50
Total	-	-	4110

Record Retrieval

Records initially received did not meet the sufficient sample size for eight MCOs. To obtain additional records, HHSC asked the MCOs to request delinquent records from providers and send them to the EQRO. The EQRO also extended the period for collecting records by one month. Four MCOs still failed to meet the sample size required for reliable rates.

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. Date of Service (DOS) – 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. Place of Service (POS) – 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. Primary diagnosis (PDx) – 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. Procedure (PX) – 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 EQRO 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. Medical records accounted for in the *All Encounter* file were excluded from evaluation. The review team also matched items in the medical record to enrollment and excluded any services in the record occurring outside the member enrollment in the sampled Program-MCO.

Results

Record Availability

Overall, the EQRO reviewed 76 percent of the 4,110 requested member-records. For 528 requests (13 percent), the EQRO received no response, while 428 requests (10 percent) resulted in a notice of either a bad provider address or that the member was not a patient or was not seen during the requested period.

Record return rates by program ranged from 71 percent (STAR+PLUS) to 84 percent (STAR Health). As noted in the tables above, four MCOs did not meet the sample size requirements for at least one program. Table 21 provides detailed response data for the deficient MCOs, by program.

Table 21. Detailed information on MCO record deficiencies in the medical record review process

MCO	Records Requested (needed)	Reviewable Record Received	No Response	Bad Address	Not a Patient	Not seen during the requested period	Record sent but outside of the requested period
STAR - Aetna	110 (77)	63	16	23	4	0	4
STAR - Parkland	110 (77)	68	20	14	7	0	1
STAR - TCHP	110 (77)	74	11	15	6	1	3
STAR+PLUS - UHC	96 (67)	65	19	7	0	4	1
STAR Kids - TCHP	182 (127)	111	24	26	8	9	4
STAR Kids - UHC	182 (127)	120	27	16	10	7	2

The most common reasons for the record deficiencies in Table 21 were no response (40 percent) and bad addresses (35 percent).

Match Rates

The EQRO reviewed records for 3,112 members across all programs. Overall, match rates for STAR+PLUS were the lowest, while rates were highest for STAR Health. The STAR and STAR Kids match rates were similar, and program averages were consistently above 90 percent. Unmatched data were present in the encounter about eight times as often as found in the medical record.

Aetna, Amerigroup, CFHP, Driscoll, SWHP, and Superior had consistently below-average match rates in the STAR program. For STAR+PLUS, Molina and UHC had consistently below-average match rates, while In the STAR Kids program, Amerigroup, BCBSTX, CMCHP, and TCHP had consistently below-average match rates.

The overall match rate for DOS was 90.6 percent for the 10,130 DOS considered. Table 22 shows the DOS match rates by program and MCO.

Table 22. DOS match rate by program and MCO

STAR MCO	In Record/Not in Encounter	In Encounter/ Not in Record	DOS Match Rate	Low Return/ Not Reliable[1]
Aetna Better Health (Aetna)	0.0%	14.5%	85.5%	NR
Amerigroup	0.8%	10.0%	89.2%	-
Blue Cross Blue Shield of Texas (BCBSTX)	0.0%	6.0%	94.0%	-
Community First Health Plans (CFHP)	1.1%	9.8%	89.0%	-
Community Health Choice (CHC)	0.4%	4.0%	95.5%	-
Cook Children's Health Plan (CCHP)	1.9%	2.3%	95.7%	-
Dell Children's Health Plan (DCHP)	0.0%	2.2%	97.8%	-
Driscoll Health Plan (Driscoll)	0.2%	14.5%	85.3%	-

STAR MCO	In Record/Not in Encounter	In Encounter/ Not in Record	DOS Match Rate	Low Return/ Not Reliable[1]
El Paso Health	1.3%	3.5%	95.3%	-
FirstCare Health Plans (FirstCare)	1.5%	2.5%	96.0%	-
Molina Healthcare of Texas, Inc. (Molina)	0.4%	5.9%	93.8%	-
Parkland Community Health Plan (Parkland)	2.2%	4.9%	93.0%	NR
RightCare from Scott & White Health Plan (SWHP)	0.9%	8.8%	90.3%	-
Superior HealthPlan (Superior)	3.0%	7.2%	89.8%	-
Texas Children's Health Plan (TCHP)	1.7%	3.9%	94.3%	NR
UnitedHealthcare Community Plan (UHC)	0.7%	7.1%	92.2%	-
Average	**1.0%**	**7.0%**	**92.0%**	**-**

STAR+PLUS MCO	In Record/Not in Encounter	In Encounter/ Not in Record	DOS Match Rate	Low Return/ Not Reliable[1]
Amerigroup	0.7%	6.7%	92.7%	-
Cigna-HealthSpring (HealthSpring)	2.4%	16.5%	81.1%	-
Molina Healthcare of Texas, Inc. (Molina)	0.2%	22.9%	76.8%	-
Superior HealthPlan (Superior)	1.3%	12.7%	86.0%	-
UnitedHealthcare Community Plan (UHC)	1.5%	20.9%	77.7%	NR
Average	**1.1**	**16.3%**	**82.6%**	**-**

STAR Kids MCO	In Record/Not in Encounter	In Encounter/ Not in Record	DOS Match Rate	Low Return/ Not Reliable[1]
Aetna Better Health (Aetna)	0.9%	4.3%	94.8%	-
Amerigroup	0.6%	7.5%	91.9%	-
Blue Cross Blue Shield of Texas (BCBSTX)	0.5%	13.5%	86.0%	-
Children's Medical Center Health Plan (CMCHP)	0.6%	7.6%	91.8%	-
Community First Health Plans (CFHP)	0.8%	3.2%	96.0%	-
Cook Children's Health Plan (CCHP)	1.3%	6.8%	91.9%	-
Driscoll Health Plan (Driscoll)	0.7%	8.1%	91.2%	-
Superior HealthPlan (Superior)	0.7%	6.1%	93.2%	-
Texas Children's Health Plan (TCHP)	2.0%	6.4%	91.6%	NR
UnitedHealthcare Community Plan (UHC)	0.8%	6.2%	93.0%	NR
Average	**0.8%**	**7.0%**	**92.2%**	**-**

STAR Health MCO	In Record/Not in Encounter	In Encounter/ Not in Record	DOS Match Rate	Low Return/ Not Reliable[1]
Superior HealthPlan (Superior)	2.1%	2.1%	95.8%	-

[1] NR = Low record return rate resulted in a sample less than that required for reliable results.

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, except for STAR+PLUS (82.7 percent). STAR Health had the highest match rate (96.8 percent) among programs. Across programs, DCHP in STAR had the highest POS match rate (97.8 percent), while Molina in STAR+PLUS had the lowest POS match rate (77.1 percent).

Table 23. PDx match rate by program and MCO

STAR MCO	In Record/Not in Encounter	In Encounter/ Not in Record	PDx Match Rate	Low Return/ Not Reliable[1]
Aetna Better Health (Aetna)	0.0%	18.7%	81.3%	NR
Amerigroup	0.8%	9.6%	89.6%	-
Blue Cross Blue Shield of Texas (BCBSTX)	0.0%	7.3%	92.7%	-
Community First Health Plans (CFHP)	1.1%	12.1%	86.7%	-
Community Health Choice (CHC)	0.4%	4.5%	95.1%	-
Cook Children's Health Plan (CCHP)	1.9%	3.5%	94.6%	-
Dell Children's Health Plan (DCHP)	0.0%	3.4%	96.6%	-
Driscoll Health Plan (Driscoll)	0.2%	14.7%	85.1%	-
El Paso Health	1.3%	3.8%	95.0%	-
FirstCare Health Plans (FirstCare)	1.5%	2.5%	96.0%	-
Molina Healthcare of Texas, Inc. (Molina)	0.4%	8.2%	91.4%	-
Parkland Community Health Plan (Parkland)	2.2%	4.3%	93.5%	NR
RightCare from Scott & White Health Plan (SWHP)	0.9%	9.7%	89.4%	-
Superior HealthPlan (Superior)	3.0%	7.2%	89.8%	-
Texas Children's Health Plan (TCHP)	1.7%	5.2%	93.0%	NR
UnitedHealthcare Community Plan (UHC)	0.7%	7.8%	91.4%	-
Average	**1.0%**	**7.9%**	**91.1%**	**-**

STAR PLUS MCO	In Record/Not in Encounter	In Encounter/ Not in Record	PDx Match Rate	Low Return/ Not Reliable[1]
Amerigroup	0.7%	7.3%	92.0%	-
Cigna-HealthSpring (HealthSpring)	2.4%	17.5%	80.1%	-
Molina Healthcare of Texas, Inc. (Molina)	0.2%	23.2%	76.6%	-
Superior HealthPlan (Superior)	1.3%	16.8%	81.9%	-
UnitedHealthcare Community Plan (UHC)	1.5%	22.0%	76.6%	NR
Average	**1.1%**	**17.7%**	**81.2%**	**-**

STAR Kids MCO	In Record/Not in Encounter	In Encounter/ Not in Record	PDx Match Rate	Low Return/ Not Reliable[1]
Aetna Better Health (Aetna)	0.9%	4.6%	94.5%	-
Amerigroup	0.6%	12.4%	87.0%	-
Blue Cross Blue Shield of Texas (BCBSTX)	0.5%	14.3%	85.3%	-
Children's Medical Center Health Plan (CMCHP)	0.6%	10.8%	88.6%	-
Community First Health Plans (CFHP)	0.8%	4.6%	94.6%	-
Cook Children's Health Plan (CCHP)	1.3%	8.6%	90.1%	-
Driscoll Health Plan (Driscoll)	0.7%	8.7%	90.6%	-
Superior HealthPlan (Superior)	0.7%	6.8%	92.4%	-
Texas Children's Health Plan (TCHP)	2.0%	9.4%	88.6%	NR
UnitedHealthcare Community Plan (UHC)	0.8%	7.0%	92.2%	NR
Average	**0.8%**	**8.6%**	**90.6%**	**-**

STAR Health MCO	In Record/Not in Encounter	In Encounter/ Not in Record	PDx Match Rate	Low Return/ Not Reliable[1]
Superior HealthPlan (Superior)	2.1%	1.1%	96.8%	-

[1] NR = Low record return rate resulted in a sample less than that required for reliable results.

The EQRO considered over 20 thousand procedures, with an overall match rate of 91.3 percent. Rates for STAR MCOs ranged from 86.2 percent for SWHP to 97.4 percent for CCHP, which was the same as the highest program rate (STAR Health). Rates were similar for MCOs in STAR Kids, while STAR+PLUS had two MCOs with rates less than 80 percent (Molina, and UHC). Table 24 shows the PX match rates by program and MCO.

Table 24. PX match rate by program and MCO

STAR MCO	In Record/Not in Encounter	In Encounter/ Not in Record	PX Match Rate	Low Return/ Not Reliable[1]
Aetna Better Health (Aetna)	0.3%	11.7%	88.1%	NR
Amerigroup	0.5%	7. 3%	92.2%	-
Blue Cross Blue Shield of Texas (BCBSTX)	0.2%	5.6%	94.3%	-
Community First Health Plans (CFHP)	0.6%	9.8%	89.6%	-
Community Health Choice (CHC)	0.8%	3.4%	95.8%	-
Cook Children's Health Plan (CCHP)	0.9%	1.6%	97.4%	-
Dell Children's Health Plan (DCHP)	0.3%	5.4%	94.3%	-
Driscoll Health Plan (Driscoll)	0.4%	11.8	87.8%	-
El Paso Health	1.1%	3.6%	95.3%	-
FirstCare Health Plans (FirstCare)	1.3%	3.5%	95.2%	-
Molina Healthcare of Texas, Inc. (Molina)	0.7%	7.8%	91.5%	-
Parkland Community Health Plan (Parkland)	1.0%	3.8%	95.2%	NR

STAR MCO	In Record/Not in Encounter	In Encounter/ Not in Record	PX Match Rate	Low Return/ Not Reliable[1]
RightCare from Scott & White Health Plan (SWHP)	0.6%	13.2%	86.2%	-
Superior HealthPlan (Superior)	1.6%	6.5%	91.9%	-
Texas Children's Health Plan (TCHP)	2.2%	4.5%	93.3%	NR
UnitedHealthcare Community Plan (UHC)	0.5%	9.5%	90.1%	-
Average	**0.8%**	**6.9%**	**92.3%**	**-**

STAR+PLUS MCO	In Record/Not in Encounter	In Encounter/ Not in Record	PX Match Rate	Low Return/ Not Reliable[1]
Amerigroup	0.8%	4.9%	94.3%	-
Cigna-HealthSpring (HealthSpring)	2.1%	14.1%	83.8%	-
Molina Healthcare of Texas, Inc. (Molina)	1.3%	19.7%	79.0%	-
Superior HealthPlan (Superior)	1.2%	10.4%	88.4%	-
UnitedHealthcare Community Plan (UHC)	1.2%	26.7%	72.1%	NR
Average	**1.3%**	**14.7%**	**84.0%**	**-**

STAR Kids MCO	In Record/Not in Encounter	In Encounter/ Not in Record	PX Match Rate	Low Return/ Not Reliable[1]
Aetna Better Health (Aetna)	0.9%	4.1%	94.9%	-
Amerigroup	0.7%	7.7%	91.6%	-
Blue Cross Blue Shield of Texas (BCBSTX)	0.5%	11.3%	88.2%	-
Children's Medical Center Health Plan (CMCHP)	1.2%	6.8%	92.0%	-
Community First Health Plans (CFHP)	1.1%	3.7%	95.2%	-
Cook Children's Health Plan (CCHP)	0.9%	6.1%	93.0%	-
Driscoll Health Plan (Driscoll)	0.5%	6.6%	92.9%	-
Superior HealthPlan (Superior)	1.0%	5.8%	93.2%	-
Texas Children's Health Plan (TCHP)	1.7%	8.4%	89.9%	NR
UnitedHealthcare Community Plan (UHC)	0.4%	6.0%	93.5%	NR
Average	**0.8%**	**6.5%**	**92.7%**	**-**

STAR Health MCO	In Record/Not in Encounter	In Encounter/ Not in Record	PX Match Rate	Low Return/ Not Reliable[1]
Superior HealthPlan (Superior)	1.0%	1.5%	97.4%	-

[1] Low record return rate resulted in a sample less than that required for reliable results.

Recommendations

- HHSC should continue efforts to improve provider address directories to improve the return rate for requested records.
  NOTE: Although the pandemic undoubtedly impacted the ability to obtain records in the second quarter of the year, the EDVMRR study for Medicaid started in October of 2019. The EQRO conducted all scheduled record requests (via mail-out and telephonic follow-up) before the pandemic affected Texas. Bad provider addresses were the primary reason for a lower return rate and the insufficient sample size for some MCOs.
- The overall match rates were high across review categories and programs, except for STAR+PLUS. The complex healthcare needs and types of services provided for STAR+PLUS members may contribute to increased challenges in the documentation and subsequent coding for each visit. However, the exact reason for low match rates in the STAR+PLUS program remains unknown. The encounter data rates must match the medical record for HHSC and the EQRO to accurately calculate QOC measures. The EQRO recommends that HHSC consider additional studies to identify factors influences match rates across programs and MCOs, specifically examining the case complexity in STAR+PLUS.

Protocol 6: Administration of QOC Surveys

The EQRO conducts annual and biennial consumer QOC surveys to measure the experiences and satisfaction of adult members and caregivers of child and adolescent members in Texas Medicaid and CHIP. These surveys assist the EQRO in monitoring and evaluating the quality of healthcare provided to the members. In addition, the results assist members in choosing among MCOs, inform HHSC on the impact of quality improvement initiatives, and help MCOs identify areas of strengths and weaknesses so they can better target their quality improvement efforts. The EQRO develops the research design for all surveys with input from HHSC and through careful planning to assure the sampling strategy follows applicable AHRQ guidelines and meets survey objectives.

During SFY 2020, the EQRO designed and conducted the following biennial member surveys:

- STAR adult members
- STAR+PLUS members
- STAR Kids (children's) caregivers
- STAR Health (children's) caregivers
- STAR Health members aged 18+ (new)
- STAR Kids members aged 18+ (new)

Survey Methods

Instruments and Sample Selection

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey is a widely used instrument for measuring and reporting consumer experiences with health plans, health services, and providers. The survey indicators of health plan performance (such as personal doctor and health plan ratings) include individual questions and composite measures that combine results from closely related survey items. The EQRO utilizes the most recent NCQA version of the CAHPS Health Plan Survey, CAHPS 5.0H. This version includes the full complement of AHRQ-specified measures along with the *Children with Chronic Conditions* (CCC) Item Set, and several NCQA-specified supplemental individual items, composites, and item sets such as *Coordination of Care*, *Smoking Cessation*, and *Flu Vaccination* summary items.

The EQRO selected participants for the CAHPS surveys from stratified random samples of child members (17 years or younger) or adult members (18 years or older), continuously enrolled (having 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 (MCO/SA) or 300 for MCOs 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 CHIP, STAR, STAR+PLUS, STAR Health, and STAR Kids.

Survey Fielding

The EQRO contracted with the University of Florida Survey Research Center (UFSRC) and NORC at the University of Chicago to conduct the 2020 member and caregiver experience-of-care surveys using CATI (Computer-Assisted Telephone Interviewing) systems. Each year, the EQRO carefully selects survey research firms to conduct telephone surveys based on reputation, quality, and cost. UFSRC and NORC are both NCQA accredited and have experience conducting Texas EQRO-related telephone surveys.

The EQRO fielded the experience-of-care surveys for six to seven months. Due to the pandemic and election year polling, the EQRO extended the fielding period by two months. Both vendors needed to subcontract some survey fielding, and the sampling pool for the surveys was increased to accommodate survey collection challenges. The EQRO sent advance notification letters written in English and Spanish to members or caregivers requesting their participation. The survey vendor began calls approximately four days after each advance mailing. Table 25 lists the member surveys conducted by the EQRO in SFY 2020 and their enrollment and fielding periods.

Table 25. 2020 member and caregiver survey enrollment and fielding periods

Survey	Enrollment Period	Fielding Period	Completed Surveys
STAR Adult Member	September 2019 – February 2020	May 2020 – October 2020	7,439
STAR+PLUS Member	October 2019 –March 2020	May 2020 – October 2020	5,067
STAR Kids Caregiver	October 2019 –March 2020	May 2020 – October 2020	5,463
STAR Kids 18+ Member	October 2019 –March 2020	May 2020 – October 2020	113
STAR Health Caregiver	December 2019 – May 2020	July 2020 – October 2020	207
STAR Health 18+ Member	December 2019 – May 2020	July 2020 – October 2020	65

Survey Results

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.

Experience of Care – Adult Surveys

Table 26 shows 2020 statewide adult survey results by program. STAR Adults and STAR+PLUS member responses scored met or exceeded national benchmarks for composites and ratings except for the specialist rating by STAR+PLUS members. All results, including results by MCO and national benchmarks, are available on the THLC portal (THLCportal.com).

Table 26. 2020 CAHPS adult member survey results, by program

Category[1]	Survey Question	Texas STAR Adults	Texas STAR+PLUS	National Benchmarks
Experience Composite	Getting Needed Care	60.2%	58.3%	55%
Experience Composite	Getting Care Quickly	59.5%	62.6%	59%
Experience Composite	How Well Doctors Communicate	83.2%	80.1%	77%
Experience Composite	Customer Service	77.9%	71.9%	69%
Rating	Personal Doctor Rating	68.9%	69.4%	69%
Rating	Specialist Rating	72.6%	67.5%	69%
Rating	Health Plan Rating	65.8%	61.2%	61%
Rating	Health Care Rating	64.6%	56.3%	56%

[1] Experience Composite rates are the percent responding that they "Always" had a positive experience. Ratings are the percent responding with ratings of 9 or 10.

Composite scores (Figure 3) and ratings scores (Figure 4) increased from 2018 to 2020 for STAR, but mostly decreased for STAR+PLUS. The biggest change was for healthcare rating in STAR (+6.3 percent), while specialist rating score dropped by 4.8 percent in STAR+PLUS. Specialists are particularly important to meeting the challenging needs of STAR+PLUS members. Limited access and availability of in-person healthcare due to the pandemic may have affected results.

Figure 3. Change in adult composite scores from 2018 to 2020 by program

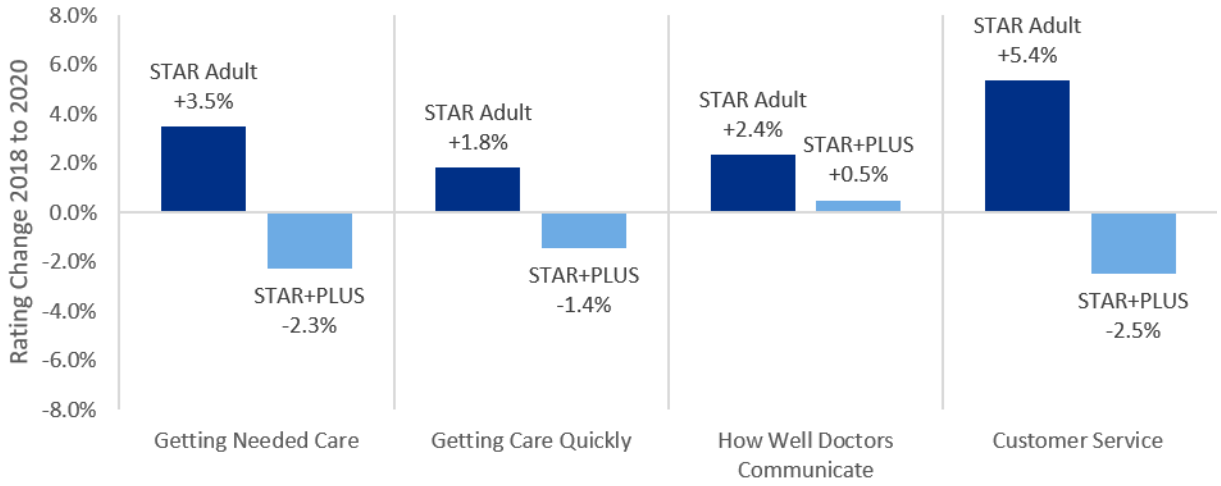
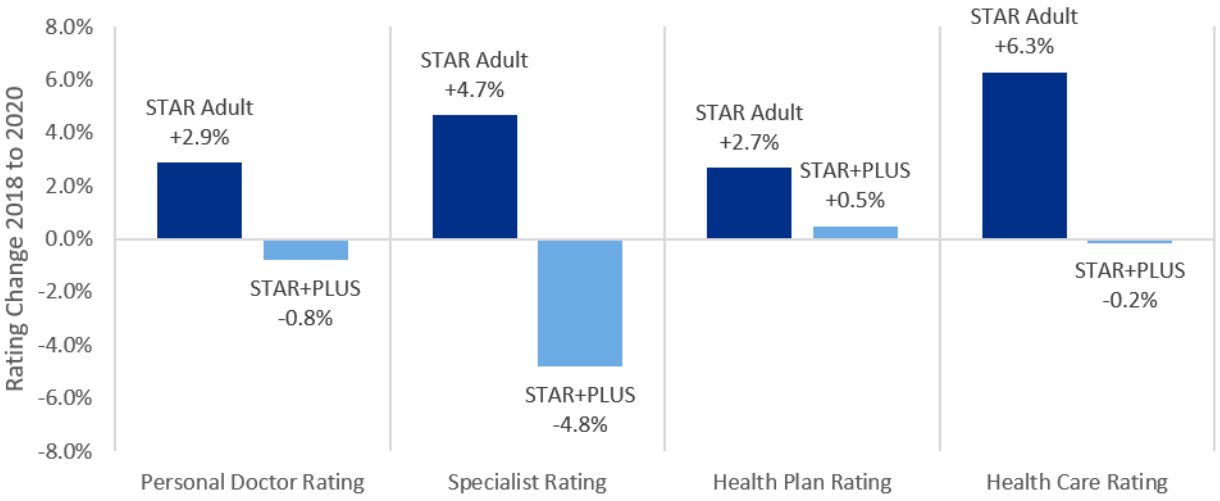


Figure 4. Change in adult ratings from 2018 to 2020 by program



Experience of Care – Child Surveys

The STAR Health Biennial Caregiver and STAR Kids Biennial Caregiver surveys faced fielding issues related to the pandemic. Although the EQRO received fewer than expected completed surveys, the number met the standards for reportability. Table 27 shows 2020 statewide child survey results for STAR Health and STAR Kids. All results, including results by MCO and national benchmarks, are available on the THLC portal (THLCportal.com).

Table 27. 2020 CAHPS STAR Health child member caregiver survey results

Category[1]	Survey Question	Texas STAR Health	Texas STAR Kids	National Benchmarks
Experience Composite	Getting Needed Care	66.9%	66.0%	61%
Experience Composite	Getting Care Quickly	79.9%	75.0%	73%
Experience Composite	How Well Doctors Communicate	89.1%	81.4%	81%
Experience Composite	Customer Service	78.7%	76.3%	68%
Ratings	Personal Doctor Rating	83.9%	79.8%	78%
Ratings	Specialist Rating	69.4%	82.2%	74%
Ratings	Health Plan Rating	81.5%	74.0%	71%
Ratings	Health Care Rating	80.9%	77.4%	70%
Children with Chronic Conditions	Access to specialized Services	67.2%	51.4%	53%
Children with Chronic Conditions	Personal Doctor Who Knows Child	92.9%	90.6%	91%
Children with Chronic Conditions	Coordination of Care	LD[2]	80.4%	77%
Children with Chronic Conditions	Getting Needed Information	87.0%	76.8%	76%
Children with Chronic Conditions	Access to Prescription Medicines	81.7%	74.9%	69%

[1] Experience Composite rates are the percent responding that they "Always" had a positive experience. Ratings are the percent responding with ratings of 9 or 10. Only respondents that met chronic conditions criteria contribute to the Children with Chronic Conditions composites and rates.
[2] LD = Low denominator.

Most STAR Health and STAR Kids composite scores (Figure 5) increased from 2018 to 2020, except for the Getting Care Quickly composite which dropped slightly for STAR Kids and by 5.3% for STAR Health. The pandemic may have affected results. All rating scores (Figure 6) increased for STAR Kids and STAR Health from 2018 to 2020, with the biggest change occurring for health plan rating in STAR Health (+16.7 percent).

Figure 5. Change in STAR Health composite scores from 2018 to 2020

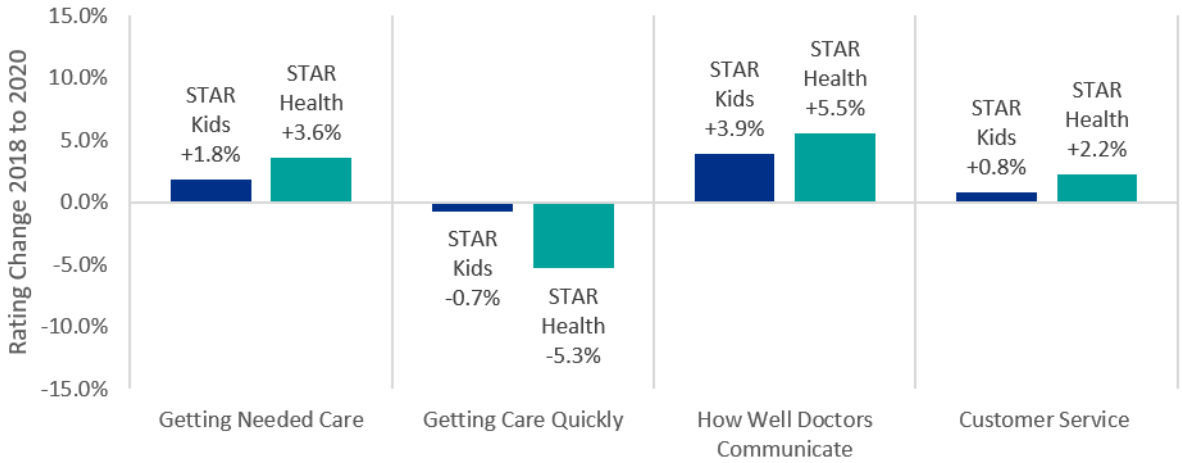
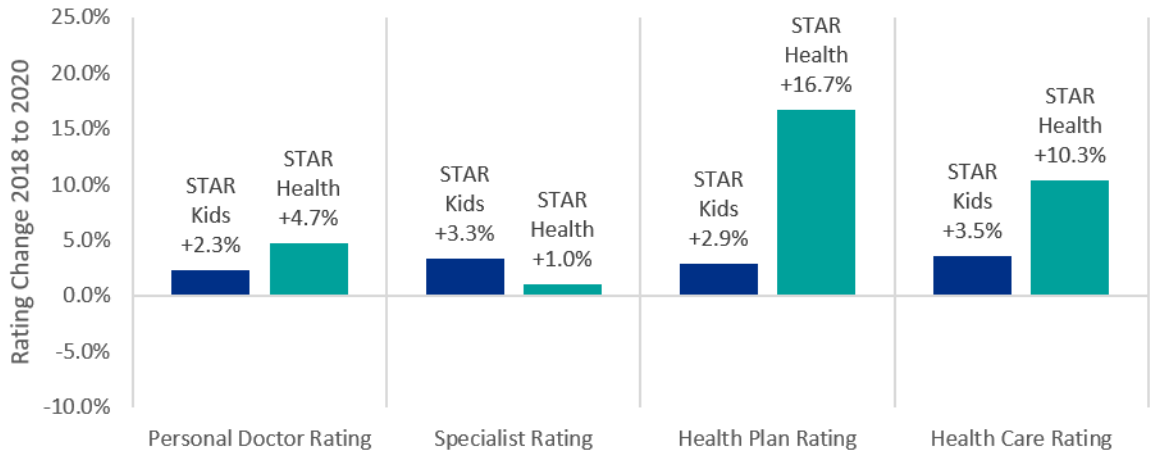


Figure 6. Change in STAR Health ratings from 2018 to 2020



Experience of Care – STAR Health 18+ and STAR Kids 18+ Surveys

The EQRO began fielding experience of care surveys for members ages 18 and older in the STAR Health and STAR Kids programs in CY2020. The EQRO previously excluded these adult populations from experience of care surveys for these programs because the caregiver surveys are specific to caregivers of children less than 18 years old. Members ages 18 and older were given the CAHPS Health Plan Survey 5.0 Adult Questionnaire (Medicaid) with relevant questions adapted from the STAR Health and STAR Kids caregiver surveys. Because of the hybrid nature of the survey, available national percentiles are not appropriate benchmarks for comparison.

Numbers of completed surveys were low for both cohorts, each of which had a target of 300, statewide. The STAR Kids 18+ survey had 113 completes and the STAR Health 18+ survey had only 65 completes. Many STAR Kids 18+ members were not able to answer questions about their own health due to disabilities. Many members in the STAR Health 18+ survey that met enrollment criteria were not reachable using the available contact information. The foster care population, especially among this age group, may be more transient. Both surveys were also negatively impacted by fielding issues caused by the pandemic.

Recommendations

- HHSC should consider allowing proxies in future versions of the STAR Kids 18+ and STAR Health 18+ surveys to ensure more participation in these challenged populations. Without an increase in the numbers of completed surveys, the results will have extremely limited value.

Protocol 7: Calculation of Performance Measures

States use performance measures to monitor and compare the MCOs performance over time and inform the selection and evaluation of quality improvement activities. This optional CMS EQR Protocol specifies that the EQRO should calculate measures in accordance with Texas specifications and report results compared to established benchmarks and standards (CMS, 2019b).

Measures Overview

Texas contracted with the EQRO to conduct comprehensive QOC evaluations across all Medicaid programs. Appendix E summarizes the QOC measures calculated and reported by the EQRO for the 2019 measurement year, by program.

To support the calculation of QOC measures and all EQRO functions, the EQRO maintains a monthly updated data warehouse including medical, dental, and pharmacy encounter extracts; enrollment extracts; and provider data. 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 Texas Medicaid and CHIP members. Measures come from nationally recognized quality assessment programs.

NCQA HEDIS measures

NCQA has stewarded HEDIS for more than 20 years. More than 90 percent of health plans in the United States use HEDIS (NCQA, 2020) to assess healthcare quality. Texas includes over 50 HEDIS measures in Medicaid and CHIP performance evaluations.

CHIPRA Core Measures

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided for the U.S. Department of Health and Human Services (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). In addition, the EQRO 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 HHS Office of Population Affairs contraceptive care measure for adults is another measure calculated for Texas Medicaid members by the EQRO. 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 and 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, 2020c, 2020b).

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, 2020).

Severe Maternal Morbidity / Pregnancy Associated Outcomes

In 2017, Texas asked the EQRO to examine whether Texas could use the Alliance for Innovation on Maternal Health (AIM; AIM, 2020) outcome measures for severe maternal morbidity (SMM) to evaluate the quality of maternal healthcare in the Texas Medicaid and CHIP programs. This year, the EQRO continued working with HHSC to improve maternal healthcare by partnering with HHSC in a CMS Medicaid Innovation Accelerator Program[6] 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 produced a comprehensive report of the OAP measure results based on this specification.

Cesarean Section Deliveries

The CHIPRA measures include a measure of cesarean section (C-section) births stewarded by The Joint Commission (The Joint Commission, 2020) and AHRQ stewards several C-section measures in their IQI (Inpatient Quality Indicators) measures set (AHRQ, 2020a). 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 could be calculated using only administrative data. Texas also asked the EQRO to categorize deliveries based on the presence or absence of complications. Based on the specifications developed, the EQRO produced a comprehensive report of the performance measure results covering four years.

Calculations

The EQRO uses NCQA-certified software, Quality Spectrum™ (Inovalon, 2018) to calculate HEDIS measures, and contracts with the NCQA-certified auditor DTS Group (www.dtsg.com) to fully evaluate the measure calculation process for HEDIS, AHRQ, dental QOC, 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 11 HEDIS measures with hybrid sampling methodology, the EQRO receives measure results from the MCOs. MCOs are also required to submit NCQA audit certification for each measure and the member-level data from each hybrid sample. Protocol 2 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 Quality Spectrum.

[6] 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. Information is available at https://www.medicaid.gov/resources-for-states/medicaid-innovation-accelerator-program/index.html.

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 different methods.
- The availability of health and sociodemographic characteristics of members enrolled in Medicaid plans nationally is limited. It is not clear how these attributes 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 across the industry. Health plans participating in NCQA HEDIS reporting tend to be older, more likely to be federally qualified, and more likely to be affiliated with a national managed care company.

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 method for applying the 3M Core Grouping Software to the Texas 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 Texas Medicaid and CHIP populations. The area measures use program enrollee populations as general denominators rather than census-based population standards provided by AHRQ. The DTS Group auditors review the software adaptations.

Dental services are designated as essential services and are required for children in federally supported Medicaid programs or CHIP. 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 other measures 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 Texas Medicaid and CHIP data, monitors changes in CMS guidelines and initiatives, and provides information to HHSC related to the management of Texas Medicaid and CHIP.

The EQRO continues to work with Texas and other national experts to develop maternal healthcare measures for Texas Medicaid. In addition to refining the OAP and C-section measures, the EQRO provided reporting on selected QOC measures for subpopulations of pregnant Medicaid members and participants in the Healthy Texas Women program.

Results and Reporting

National QOC Measures

Most QOC measure results are publicly available on the THLC portal (thlcportal.com). The dashboards allow users to compare performance results to national benchmarks, compare performance by MCO and service area, and track performance over time. Results are also summarized 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.

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 where additional study is needed to fully understand the results. For example, medically challenged 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. Maternity care measures can be difficult to interpret when primary or specialized care occurs in the same visits as pregnancy care. For example, pregnant women are more likely to have multiple prescribers for opioids. The measure is designed to identify potential misuse of opioids though 'doctor shopping' to obtain multiple prescriptions. However, pregnant women may be more likely to receive routine care from multiple providers (a PCP and an OBGYN, for example).

Identifying disparities in care also requires comparison of 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, performance on many measures is better among females. Results for many measures show racial/ethnic and geographic disparities. Health status was a factor in performance on some measures, but explanation of the results requires further investigation. Continuing to probe these issues provides Texas with information necessary to improve care for all Medicaid and CHIP members.

Table 28 shows Overall Medicaid results for Hispanic, Non-Hispanic white (NHW), and Non-Hispanic black (NHB) members. Across the measures shown, Hispanic members generally had higher rates while NHB members usually had the lowest rates. However, NHW members had the lowest rates for screening measures and were most likely to receive an inappropriate prescription for antibiotics. Rates for behavior health measures and access to care were consistently low for NHB members compared to Hispanic and NHW members.

Table 28. 2019 Medicaid QOC measure results by race/ethnicity

Code	Screening Measure	Submeasure	Hispanic	Non-Hispanic white	Non-Hispanic black
BCS	Breast Cancer Screening	Total	57.57%	43.75%	51.82%
CHL	Chlamydia Screening in Women	Total	51.60%	46.21%	56.76%
DEV-CH	CHIPRA Developmental Screening in the First Three Years of Life	Total All Ages	50.91%	43.41%	45.00%

Code	Chronic Condition Measure	Submeasure	Hispanic	Non-Hispanic white	Non-Hispanic black
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD[1]		33.77%	22.29%	24.49%
PCE	Pharmacotherapy Management for COPD[1] Exacerbation	Systemic Corticosteroids	56.76%	64.43%	66.00%
PCE	Pharmacotherapy Management for COPD1 Exacerbation	Bronchodilators	74.37%	79.52%	81.28%
MMA	Medication Management for People with Asthma	Age 5 to 64 75% Covered	24.28%	36.81%	25.11%
AMR	Asthma Medication Ratio	5 to 64 Ratios > 0.50	68.66%	67.84%	62.61%
CDC	Comprehensive Diabetes Care	Eye Exam	54.74%	46.57%	48.17%
SPD	Statin Therapy for Patients with Diabetes	Statin Therapy	66.42%	64.35%	63.95%
SPD	Statin Therapy for Patients with Diabetes	Statin Adherence	57.71%	65.45%	56.10%

Code	Behavioral Health Measure	Submeasure	Hispanic	Non-Hispanic white	Non-Hispanic black
MPT	Mental Health Utilization	Any Services	8.77%	13.94%	10.37%
AMM	Antidepressant Medication Management	Acute Phase Treatment	51.38%	61.10%	46.02%
AMM	Antidepressant Medication Management	Continuation Phase	34.20%	45.65%	32.08%
ADD	Follow-Up Care for Children Prescribed ADHD Medication	Initiation	44.62%	42.36%	35.87%
ADD	Follow-Up Care for Children Prescribed ADHD Medication	Continuation and Maintenance	59.99%	54.87%	56.13%
FUH	Follow-Up after Hospitalization for Mental Illness	Total Follow Up within 7 Days	31.63%	30.46%	27.34%
FUH	Follow-Up after Hospitalization for Mental Illness	Total Follow Up within 30 Days	53.07%	52.62%	47.42%
FUM	Follow-Up After Emergency Department Visit for Mental Illness	Total Follow Up within 7 Days	39.05%	37.21%	32.04%
FUM	Follow-Up After Emergency Department Visit for Mental Illness	Total Follow Up within 30 Days	52.81%	52.65%	44.96%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Total Follow Up within 7 Days	3.94%	5.80%	3.91%
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Total Follow Up within 30 Days	6.23%	7.78%	5.61%

Code	Behavioral Health Measure	Submeasure	Hispanic	Non-Hispanic white	Non-Hispanic black
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	80% Coverage	58.09%	66.73%	50.18%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Combined - All Ages	41.19%	37.78%	39.25%

Code	Appropriate Use Measure	Submeasure	Hispanic	Non-Hispanic white	Non-Hispanic black
CWP	Appropriate Testing for Pharyngitis	Total	78.37%	74.61%	76.63%
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	All Ages	59.35%	52.16%	61.45%
URI	Appropriate Treatment for Upper Respiratory Infection	Total	87.86%	84.78%	88.34%

Code	Access to Care Measure	Submeasure	Hispanic	Non-Hispanic white	Non-Hispanic black
CAP	Children and Adolescents' Access to Primary Care Practitioners	All Members	93.71%	89.73%	85.53%
AAP	Adults' Access to Preventive/Ambulatory Health Services	All members	87.16%	83.69%	81.52%

[1] Chronic obstructive pulmonary disease

Utilization measures (Table 29) do not have a defined correct value but monitoring use across member groups provides important information about care patterns that can inform quality initiatives. In 2019, Hispanic Medicaid members had more outpatient visits, fewer ED visits, and fewer hospitalizations than NHW or NHB members. Mental health utilization (Table 28) was highest for NHW members.

Table 29. 2019 Utilization by race/ethnicity

Code	Utilization Measure	Submeasure	Hispanic	Non-Hispanic white	Non-Hispanic black
AMB	Ambulatory Care	Outpatient Visits / 1000 MM	391.81	377.27	291.35
AMB	Ambulatory Care	ED Visits / 1000 MM	54.45	71.29	72.87
IPU	Inpatient Acute	Total Inpatient Stays / 1000 MM	7.84	10.76	9.03

The EQRO continues to work with HHSC to explore QOC measure results across demographic and other member population groups to more clearly interpret results and better direct efforts to improve care for all Texas Medicaid and CHIP members.

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 Texas Medicaid to contain costs while improving patient outcomes. Specifically, Texas Government Codes § 354.1445 and § 354.1446 (2016) address potentially preventable readmissions (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 EQRO analyzed 2019 encounter and eligibility data for non-dual Texas 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:

- Potentially Preventable Emergency Department Visits (PPVs) are ED visits that may result from a lack of adequate access to care or ambulatory care coordination.
- Potentially Preventable Admissions (PPAs) are facility admissions that are avoidable through improved care coordination, effective primary care, and improved population health.
- Potentially Preventable Readmissions (PPRs) 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.
- Potentially Preventable Complications (PPCs) 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. Technical notes on all PPE calculations are also available in the resources section of the portal.

Potentially Preventable Emergency Department Visits (PPVs)

High rates of PPVs may represent a failure to provide adequate primary care to the patient. Since 2017, the overall PPV rate has trended slightly upward and the cost per PPV has increased. Of the approximately 2.3 million Medicaid and CHIP ED visits at risk for PPVs in 2019, the EQRO identified 1.4 million (62.1 percent) as PPVs. These PPVs account for $492 million in institutional costs paid (excluding the associated professional costs). Table 30 summarizes 2019 PPV results by program.

Table 30. 2019 PPV results for Texas Medicaid and CHIP

Measure	STAR	STAR+ PLUS	STAR Kids	STAR Health	FFS	CHIP
Member-Months at Risk for PPVs	31,061,291	2,678,864	1,862,809	367,513	4,144,616	4,127,218
ED Visits at Risk of being PPVs	1,607,897	299,218	105,766	24,066	140,463	98,217
Total PPVs	1,002,553	191,931	66,302	15,236	77,440	60,421
Total PPV Weights	286,012.33	57,268.51	19,124.16	4,335.15	22,752.41	17,553.88
Total PPV Expenditure ($Millions)	$326.14M	$101.23M	$23.22M	$3.81M	$15.25M	$22.32M
PPV Rate (Total PPV Weights per 1,000 Member-Months)	9.21	21.38	10.27	11.80	5.49	4.25

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

In 2019, the PPV rate was higher among females (9.66 vs. 8.65 for males), and the rate for rural members was slightly higher (10.22) than the rates for urban or micropolitan members (9.05 and 9.81, respectively). 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 substantially lower PPV rate (7.91) than NHW or NHB members (10.31 and 10.23, respectively).

Table 31 shows the top five PPV reasons across Texas Medicaid and CHIP in 2019 based on EAPG categories ranked by total PPV weight. The leading reason by far continues to be URTI, with a total cost of over $75 million during 2019. 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 31 2019 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 Respiratory Tract & Otitis Media	344,611	24.4%	18.4%	$77.47M	15.7%
627	Non-Bacterial Gastroenteritis, Nausea & Vomiting	107,758	7.6%	9.8%	$43.18M	8.8%
808	Viral Illness	80,792	5.7%	7.3%	$21.16M	4.3%
674	Contusion, Open Wound & other Trauma to Skin & Subcutaneous Tissue	80,891	5.7%	6.6%	$23.64M	4.8%
628	Abdominal Pain	68,426	4.8%	6.4%	$42.59M	8.7%

Potentially Preventable Admissions (PPAs)

Admissions that are avoidable with proper outpatient care are identified as PPAs. They may result from inefficiencies in hospital or ambulatory care, poor access to outpatient care, or inadequate ambulatory care service coordination. Since 2017, the PPA rate is generally constant, while total expenditures trend upward. The EQRO identified approximately 271,000 inpatient admissions from Texas Medicaid and CHIP as being at risk for being PPAs in 2019. Of these, over 39,000 admissions (14.4 percent) were identified as PPAs. These PPAs account for $299 million in institutional costs paid. Table 32 summarizes 2019 PPA results by program. The PPA rate was highest in the STAR+PLUS program with a rate more than four times that of any other program, including STAR Kids.

Table 32. 2019 PPA results for Texas Medicaid and CHIP

Measure	STAR	STAR+ PLUS	STAR Kids	STAR Health	FFS	CHIP
Member-Months at Risk for PPAs	31,061,291	2,678,864	1,862,809	367,513	4,144,616	4,127,218
Admissions at Risk of being PPAs	158,036	68,081	19,970	4,979	15,411	4,728
Total PPAs	13,859	16,553	4,005	1,286	2,288	1,126
Total PPA Weights	10,072.24	24,913.65	3,888.56	900.23	2,275.11	793.63
Total PPA Expenditure ($Millions)	$82.88M	$153.60M	$32.95M	$8.92M	$13.64M	$7.43M
PPA Rate (Total PPA Weights per 1,000 Member-Months)	0.32	9.30	2.09	2.45	0.66	0.19

In 2019, the PPA rate was higher among males (1.06 vs. 0.91 for females). Rural members had a slightly higher (1.08) PPA rate than urban members (0.96), but members in micropolitan counties had the highest rate (1.14). As with PPVs, older members generally had higher PPA rates, although the rate was higher for children aged 1 to 5 years than for other children. Hispanic members had a substantially lower PPA rate (0.62) than NHW or NHB members (1.52 and 1.27, respectively).

Table 33 shows the top five PPA reasons across Texas Medicaid and CHIP in 2019 based on APR-DRG categories ranked by total PPA weight. Heart failure and pneumonia continue to top this list, together accounting for total costs over $60 million during 2019.

Table 33. 2019 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	3,218	8.2%	11.5%	$30.95M	10.3%
139	Other Pneumonia	3,995	10.2%	9.9%	$32.04M	10.7%
140	Chronic Obstructive Pulmonary Disease	1,874	4.8%	5.7%	$15.03M	5.0%
161	Cardiac Defibrillator & Heart Assist Implant	183	0.5%	5.4%	$16.93M	5.7%
753	Bipolar Disorders	3,747	9.6%	5.3%	$18.35M	6.1%

Heart failure occurs as a top PPA reason in STAR+PLUS, while pneumonia is the most common reason for PPAs in STAR. Although bipolar disorders ranked fifth, if considered together with the sixth-ranked reason for PPAs (Major Depressive Disorders & Other/Unspecified Psychoses) and schizophrenia (ranked 11th), these serious mental illnesses would rank first, accounting for almost 14 percent of total PPA weight and total costs of nearly $45 million in 2019. 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.

Potentially Preventable Readmissions (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 in the Texas Medicaid and CHIP population and compare MCOs. Of the approximately 466,000 admissions from Medicaid and CHIP that were at risk for having PPRs in 2019, the EQRO identified over 20,000 (4.4 percent) as having PPRs. These account for $262 million in institutional costs paid. Table 34 summarizes 2019 PPR results by program.

Table 34. 2019 PPR results for Texas Medicaid and CHIP

Measure	STAR	STAR+ PLUS	STAR Kids	STAR Health	FFS	CHIP
Admissions at Risk for PPRs	311,443	53,682	16,490	4,929	74,953	4,178
Initial Admissions Resulting in PPRs	6,210	8,326	1,915	861	2,438	249
Total PPRs	7,601	12,933	2,841	1,386	3,089	317
Total PPR Weights	6,694.24	16,576.10	3,580.05	966.29	4,192.42	254.42
Total PPR Expenditure ($Millions)	$64.69M	$106.29M	$40.32M	$12.01M	$21.45M	$2.91M
PPR Rate (Total PPR Weights per 1,000 Admissions)	21.49	308.78	217.10	196.04	55.93	60.89

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

Table 35 shows the top five PPR reasons across Texas Medicaid and CHIP in 2019 based on APR-DRG categories ranked by total PPR weight. Although septicemia is a less common reason for PPRs, its severity makes it an important driver of potentially preventable costs. Heart failure is the leading reason for PPAs and a leading driver of PPRs. The most important drivers of PPRs are the serious mental illness conditions of schizophrenia, bipolar disorder, and major depression. Together, these accounted for costs of over $58 million in 2019. Regardless of the diagnoses for the initial admission, readmissions for these conditions are considered clinically related, and also contribute PPR weight to other categories. The high rate of PPRs for mental health reasons highlights the need to improve care coordination for co-occurring physical and mental health conditions.

Table 35. 2019 PPR top reasons

APR-DRG	Description	PPRs (n)	Percent of Total PPRs	Percent of Total PPR Weights	PPR Expenditures	Percent of Total PPR Expenditures
750	Schizophrenia	3,375	12.0%	7.7%	$17.58M	7.1%
720	Septicemia & Disseminated Infections	1,190	4.2%	7.6%	$16.93M	6.9%
753	Bipolar Disorders	3,662	13.0%	7.2%	$21.23M	8.6%
751	Major Depressive Disorders & Other/Unspecified Psychoses	2,988	10.6%	5.8%	$15.38M	6.2%
194	Heart Failure	889	3.2%	4.5%	$8.73M	3.5%

Potentially Preventable Complications (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. Admissions may be at risk for some PPC categories but not others and a single admission can have multiple complications. 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 F provides definitions for the PPC groups. The EQRO evaluated over 414,000 admissions from Texas Medicaid and CHIP that were at risk for PPCs in 2019. 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 from PPC calculations all data from hospitals failing to meet data quality standards. In the annual data quality reports described in Protocol 5, the EQRO addressed the quality of POA data at the MCO level, and Appendix D provides a summary of the screening criteria.

Table 36 shows PPC results by program. The 2019 PPC analysis identified 4,080 eligible admissions with at least one PPC. In 2019, the PPC rate (total PPC weight per at-risk admission) was more than four times higher in STAR+PLUS than in STAR Kids and more than ten times higher than in any other managed care program. The total estimated cost of the STAR+PLUS PPCs (nearly $21 million) was more than twice the estimated cost of all other PPCs across all managed care programs.

Table 36. 2019 PPC results for Texas Medicaid and CHIP

Measure	STAR	STAR+ PLUS	STAR Kids	STAR Health	FFS	CHIP
Admissions at Risk for PPCs	245,752	55,113	15,298	3,852	91,290	3,518
Admissions with PPCs	980	1,767	107	10	1,209	7
Total PPCs	1,160	2,311	119	10	1,656	7
Total PPC Weights	729.19	1987.44	131.78	9.46	1,405.76	6.25
PPC Rate (Total PPC Weights per 1,000 Admissions)	2.97	36.06	8.61	2.46	15.40	1.78

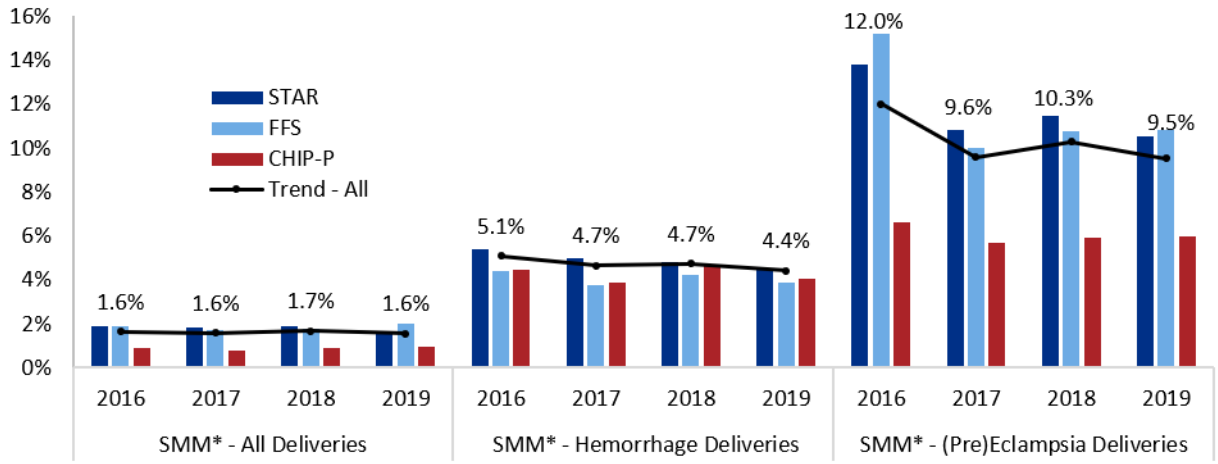
Renal Failure without dialysis was the most common PPC for STAR+PLUS members, while Shock and Septicemia contributed the most PPC weights. Septicemia and Shock also contributed the most weight among STAR members, but here the most common PPC reason, by far, was obstetric complications. As in 2018, the PPC rate was more than 15 for FFS members. This group includes undocumented immigrants and others who may require emergency Medicaid services, but further investigation is needed to determine why this population has more PPCs.

OAP and C-Section Deliveries

The EQRO calculated overall SMM rates for 2019 deliveries following a method adapted from the AIM maternal safety bundles for evaluating SMM statewide using administrative data. The OAP report considered SMM among all deliveries, among deliveries with hemorrhage, and among deliveries with severe hypertension. For all three cohorts, the EQRO reported rates for all SMM cases and rates excluding those SMM cases identified only by transfusion. This approach is consistent with The Centers for Disease Control and Prevention (CDC) reporting on SMM (CDC, 2020a) and the American College of Obstetricians and Gynecologists (ACOG) recommendations (ACOG et al., 2016).

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 2016 through 2019. Rates were consistently higher in STAR than in CHIP Perinatal, most notably in cases of (pre)eclampsia. Overall rates have trended down over this period.

Figure 7. OAP measure trends by program



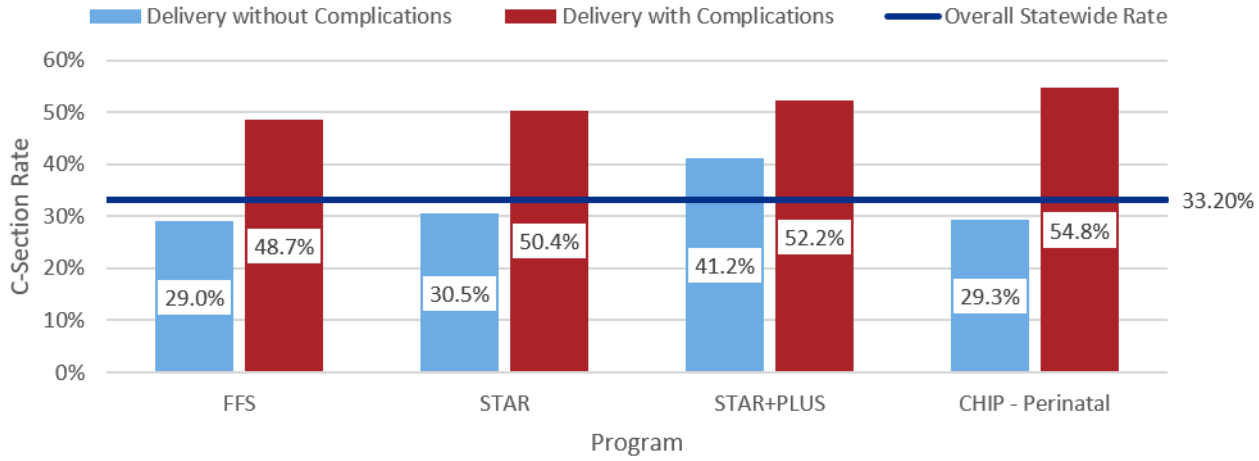
*SMM = Severe maternal morbidity, excluding cases identified by transfusion only.

Overall, deliveries with SMM (excluding those identified by transfusion only) incurred more than twice the cost of deliveries without SMM, or approximately an additional $20 million. In 2019, SMM rates varied geographically and by race/ethnicity, with NHB women having more than twice the rate of SMM as Hispanic women.

In 2019, the rate of C-section deliveries in Texas Medicaid and CHIP was 33.2 percent. Figure 8 shows C-section rates among deliveries with and without complications by program. C-section rates varied by race/ethnicity and geography. Hispanic women had the lowest C-section rate (32 percent) and NHB women had the highest rate (37.4 percent). Women in STAR+PLUS had a much higher rate (41 percent) of C-sections for uncomplicated deliveries. Although complications were more common in STAR+PLUS (21 percent of deliveries vs. 14 percent

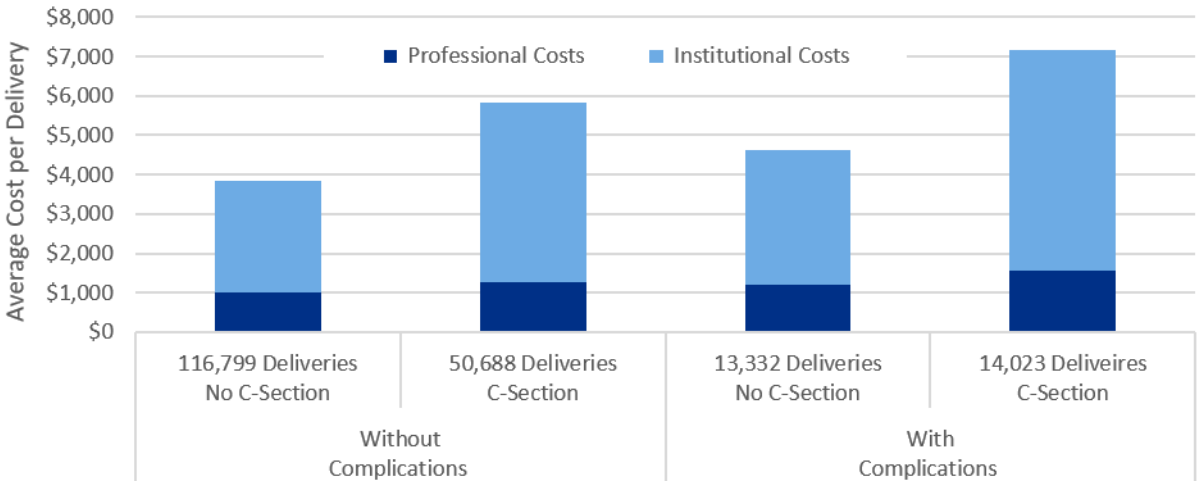
overall), a large majority of deliveries were not identified with complications, so the reason for the higher rate of C-sections among these deliveries is unknown.

Figure 8. 2019 C-section rates by program



Although about half of deliveries with complications are by C-section, only 22 percent of C-section deliveries were identified with complications. Over 50 thousand C-sections were performed in deliveries without complications. Compared to uncomplicated deliveries without C-section, these uncomplicated C-section deliveries incurred additional costs totaling over $100 million. Figure 9 shows average costs for C-section and vaginal deliveries, with and without complications.

Figure 9. 2019 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 that were pregnant during 2019. As reported last year, performance on care measures for chronic conditions was generally worse for pregnant women although utilization was generally higher.

Recommendations

- HHSC should continue to explore QOC measure results across demographic and other member population groups to more clearly interpret results and better direct efforts to improve care for all Texas Medicaid and CHIP members.
- The EQRO suggests investigating relationships between PPEs for specific conditions and patterns of preventive care for those conditions.
- 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 should continue to prioritize behavioral health integration (BHI) and maternal healthcare, and work with the EQRO to define useful and reliable QOC measures for these special populations.

Protocol 9: Conducting Focused Studies of Healthcare Quality

During SFY 2020, the EQRO carried out multiple studies of Texas Medicaid and CHIP programs, initiatives, and areas of specific interest to the state. Several studies were conducted under subcontract by the University of Texas School of Public Health Center for Healthcare Data (UTHealth-CHCD) Table 37 provides a summary of the studies described in this report.

Table 37. Summary of focused studies conducted in SFY 2020

Study	Description
FOCUS STUDY: SDoH and Their Impact on Health Care Quality Measures in Texas Medicaid and CHIP Populations	*Conducted by UTHealth-CHCD* This study assessed the impact of SDoH on QOC measure outcomes. Specifically, the study focused on children and adolescents in the Texas Medicaid and CHIP populations, adults in the STAR+PLUS and Home and Community Based Services (HCBS) Waiver populations, and pregnant women in Texas Medicaid for 2018.
QUARTERLY TOPIC REPORT (QTR): Spending, Service Delivery, and Follow-up for STAR+PLUS Members with SMI	*Conducted by UTHealth-CHCD* This study summarized Medicaid strategies and measures for assessing healthcare quality for members with SMI, including the degree to which Local Mental Health Authority (LMHA) involvement might affect care outcomes. The study also examined differences in service delivery and costs, based on LMHA status, for STAR+PLUS members with SMI.
QTR: Health Care Quality Measures for STAR Members with SMI or Serious Emotional Disturbance (SED)	This study identified member cohorts with and without SMI (adults) or SED (children) in the STAR program and compared health service utilization, quality, and spending (using HEDIS and PPE measures) for these cohorts. The study also investigated measure results pointing toward actionable improvements in care for members with SMI or SED by modeling specific factors contributing to differences in outcomes.
QTR: Development of a Personalized Quality-of-Care (PQOC) index for maternal Health	This demonstration and feasibility study identified measures relevant to the care of the STAR maternal population, and feasible for inclusion in a PQOC. Selected measures were included in a PQOC index calculation, demonstrating how the methodology can help understand maternal healthcare disparities. The EQRO also reviewed other measures to consider for inclusion in future PQOC index models.
QTR: Documenting and Addressing SDoH by Texas Medicaid Managed Care Plans	*Conducted by UTHealth-CHCD* This study examined how Medicaid MCOs collect, analyze, and use data on SDoH to identify members with unmet social needs and design interventions that influence health outcomes, particularly prevention strategies. The study reviewed the strategies used in other states and interviews with representatives from the Texas Medicaid MCOs.
ISSUE BRIEF: Health Teleservices for Prenatal and Postpartum Care	This brief reviewed scientific literature, policies, and programs to understand the benefits and recommended use of teleservices for perinatal care.
ISSUE BRIEF: Trends in Alternative Payment Models (APMs) for Increasing Access to Patient-Centered Maternal Care	This brief summarized the APMs used to incentivize obstetric providers to increase access to patient-centered maternal health services and how states implement these payment models in Medicaid policy.

Study	Description
ISSUE BRIEF: Medical P4Q in STAR+PLUS: MCO Perspectives and Strategies	This brief summarized the results of a thematic analysis of interviews with MCO staff conducted to provide a more comprehensive understanding of how STAR+PLUS MCOs assess, support, and sustain P4Q performance.

Focus Studies

SDoH and Their Impact on Health Care Quality Measures in Texas Medicaid and CHIP Populations

Study Aims

Aim 1: Identify significant associations between area-level SDoH variables and key QOC measures for children and adolescents in the Texas Medicaid and CHIP populations, adults in the STAR+PLUS and HCBS Waiver populations, and pregnant women in Texas Medicaid for 2018.

Aim 2: Estimate the degree to which individual SDoH variables contribute to the collective SDoH impact by analyzing the associations between individual SDoH variables and each QOC measure's performance outcomes for the study populations.

The study included 24 SDoH proxy indicators as independent variables, divided into five categories: individual demographic attributes, health behaviors (county-level), availability and access to healthcare (county-level), social and economic environment (county-level), and physical environment (county-level).

The outcome measures in this study included HEDIS measures of the effectiveness of care and care utilization including measures of prevention and screening, diabetes care, behavioral healthcare, medication management and care coordination, and overuse/appropriateness of care; and AHRQ admission rate indicators. The EQRO only used eight QOC measures to stratify the results in the HCBS Waiver subpopulation. Due to the limited number of members in either the denominator or numerator at a county level, the EQRO could not use the other three QOC measures.

Key Findings

- For each study population, the model's ability to accurately predict whether an individual would meet the numerator performance criteria for a QOC measure increased when the model included county-level SDoH variables as compared to models that only included race/ethnicity.
- The number of SDoH variables with significant associations varied by study population and per QOC measure, but not every SDoH variable contributed equally to the observed impact of SDoH on QOC measure performance.
- Among children and adolescents, the variables in the social and economic environment and health behavior categories showed the largest influence on the performance measure outcomes.
- Among pregnant women, three variables (*Rate of Adult Smokers, Access to Mental Health Providers*, and *Rate of Violent Crime*) were significantly associated with performance outcomes on all three QOC measures (*Timeliness of Prenatal Care*, *Postpartum Care*, and *Low Birth Weight Babies*).
- Among STAR+PLUS and HCBS Waiver populations, age and gender contributed significantly to predicting QOC measure results. In STAR+PLUS, the *Breast Cancer Screening* measure showed the largest increase in concordance rate associated with the addition of SDoH variables. In this case, the concordance rate represents the predictive ability of the regression models based on the variables included in the model. The increase in concordance indicates that the predictive ability of the model for the *Breast Cancer Screening* measure increased with the addition of SDoH variables.

- The Rate of Adult Smoking was significantly associated with higher ED utilization among STAR+PLUS adults, higher preventable hospitalization among HCBS Waiver adults, and higher acute inpatient admissions for both STAR+PLUS and HCBS Waiver adults

Recommendations

- HHSC should consider collecting standardized member-level SDoH data. This information could be collected during Medicaid and CHIP enrollment, from the claims data (via diagnostic codes related to SDoH (e.g., Z codes)), or as part of the biennial member surveys.
- HHSC should use the focus study findings to prioritize interventions and strategies that target important SDoH for Medicaid members – emphasizing SDoH categories with more influence on outcomes (e.g., social and economic environment variables) or individual SDoH variables associated with multiple performance measures. For example, since the *Rate of Adult Smoking* was significantly associated with higher ED utilization among STAR+PLUS adults, higher preventable hospitalization among HCBS Waiver adults, and higher acute inpatient admissions for both STAR+PLUS and HCBS Waiver adults, a possible strategy could focus on designing and developing population-specific smoking cessation interventions, campaigns, and peer support groups.

Quarterly Topic Reports (QTR)

Spending, Service Delivery, and Follow-up for STAR+PLUS Members with SMI

Study Aims

Aim 1: Examine the payment and quality arrangements that various states have tried for adults with SMI in Medicaid, including those with LMHA involvement. As part of this, review state innovations for addressing costs, services provided, service utilization, and performance measures.

Aim 2: Use Texas Medicaid claims and enrollment data from January 1, 2017, through December 31, 2018, to examine differences in service delivery and the healthcare costs of STAR+PLUS members with SMI, stratified by LMHA status and by MCO. Criteria for an SMI diagnosis were: one inpatient medical claim or two outpatient medical claims during 2017 or 2018 with any diagnosis code of one or more of the following: psychotic disorders, bipolar disorders, major depressive disorders, and OCD.

Key Findings

- The claims analyses showed that SMI-diagnosed STAR+PLUS members represent about one-third of all STAR+PLUS members in 2017 and 2018. The SMI rate is higher for females than males and highest for enrollees between ages 35 and 64. The rate of SMI is consistent across the five STAR+PLUS MCOs.
- LMHA-involved enrollees had higher rates of 7-day and 30-day follow-up after a mental health (MH)-related ED visit, but differences in 30-day readmission rates among LMHA-involved enrollees varied by enrollee SMI diagnosis. Seven-day, 30-day, and overall follow-up rates were consistent across MCOs for members with LMHA involvement.
- Measures of 7-day and 30-day follow-up care after SMI-related inpatient admissions did not show substantial differences between LMHA- and non-LMHA-involved STAR+PLUS enrollees overall, but they did vary across MCOs. MCOs showed varying degrees of utilization of LMHAs as service providers for their SMI-diagnosed enrollees.
- Furthermore, follow-up rates after SMI-related inpatient admissions were below the national rates reported by NCQA for Medicaid HMO enrollees.

- The analyses identified high rates of SMI-related and all-cause readmissions among STAR+PLUS SMI-diagnosed Medicaid enrollees, particularly among individuals diagnosed with psychotic disorders. The 30-day readmission rates varied substantially among MCOs. Differences in 30-day readmissions also appeared to vary among the SMI diagnosis groups by LMHA service utilization and readmission type.
- Analysis of healthcare costs for SMI-diagnosed STAR+PLUS enrollees who received outpatient care through an LMHA indicated they had much lower estimated per member-year total costs than enrollees who received no services through any LMHA. The average total cost differences appeared primarily due to substantially higher medical care costs, especially for non SMI-related medical care – $5,461 higher for SMI-diagnosed STAR+PLUS enrollees without LMHA involvement compared to those who were involved with an LMHA. Pharmacy costs were also higher among enrollees without LMHA involvement, although the difference in costs was smaller.

Recommendations

- STAR+PLUS MCOs should evaluate the use of the receipt of follow-up care within seven days following a MH-related ED visit as a tool for monitoring longitudinal outcomes related to health service use and mental health indicators.
- HHSC should conduct further studies to determine how MCO practice variation relates to differences among MCOs on the 7-day and 30-day follow-up care indicators.
- STAR+PLUS MCOs should estimate the cost per episode of care provided by LMHA providers as compared to non-LMHA providers to clarify whether differences in total costs were due to more efficient care concerning outcomes or to cost-of-service differences between sites of care.,
- STAR+PLUS MCOs should track health indicators, service use, and QOC measures longitudinally for LMHA and non-LMHA service recipients.
- HHSC should review the availability of LMHAs, both geographically and in terms of staffing, to determine how these contribute to differences in LMHA use across MCOs and assess the LMHAs' capacity to accommodate greater utilization by MCOs.

Health Care Quality Measures for STAR Members with SMI or SED

Study Aims

Aim 1: Identify member cohorts with and without SMI (adults) or SED (children) in the STAR program, further categorized by demographic characteristics and SMI or SED diagnosis.

Aim 2: Compare health service utilization, quality, and spending (using HEDIS and PPE measures) among the cohorts, by SMI or SED diagnosis.

Aim 3: Investigate measure results from Aim 2 by modeling specific factors that contribute to these differences.

Key Findings:

- The prevalence of SMI and SED in STAR varies by sociodemographic group:
    - The prevalence of SMI was higher among women than among men. The prevalence of SMI increased with age across sex and race/ethnicity groups. Among race/ethnicity groups, NHW adults had the highest prevalence of SMI, followed by adults of unknown/other race/ethnicity. Adults living in rural counties had the highest prevalence of SMI compared to those in micropolitan or metropolitan counties. Adults with physical health (PH) conditions had a higher prevalence of SMI than other adults. The EQRO's findings are consistent with literature showing a higher prevalence of SMI among these sociodemographic groups.

    - The overall prevalence of SED in children and adolescents was higher for males compared to females. The prevalence was highest among females aged 13 to 18 years and males aged 6 to 12 years. Among race/ethnicity groups, NHW children and adolescents had the highest prevalence of SED. Rural children and adolescents had a higher prevalence of SED compared to those living in micropolitan or metropolitan counties. Children and adolescents with physical health conditions had a higher prevalence of SED compared to those without physical health conditions.
- Adults with SMI had higher rates of healthcare utilization and better performance on screening and access to care measures compared to adults without SMI.
- Children and adolescents with SED had higher healthcare utilization rates and better performance on prevention and screening measures than children without SED.
- STAR members with SMI or SED had higher rates of PPEs, including PPVs, PPAs, and PPRs, compared to members without SMI or SED.
- STAR members with SMI or SED had higher expenditures compared to members without SMI or SED.

Recommendations

- STAR MCOs should refine and develop targeted efforts to improve outcomes for members with SMI and SED who have physical health conditions. These members are identified as beneficiaries with complex needs (BCNs) because their health and/or social needs are more likely to result in high levels of costly but preventable services and utilization. The 2019 PIP topic of interest focused on BCNs. Once the 2019 BCN PIPs are complete, HHSC and STAR MCOs should use the results to enhance efforts to improve outcomes.
- STAR MCOs should identify successful PIPs that improved outcomes for beneficiaries with high utilization and complex needs and plan pilot interventions to assess the impact of these programs. HHSC should work with the MCOs to share their successful programs at the annual PIP workshop where plans share best practices.
- HHSC should conduct studies to understand the facilitators and barriers that MCOs face in implementing BHI. The QAPI reports can be leveraged to address MCO challenges by sharing existing MCO efforts such as BHI implementation resources, provider guidelines, and guides for holding regular integration workgroups.
- STAR MCOs should expand on efforts to incentivize health providers to integrate primary care and mental health services and consider offering BHI as a value-added service for members.
- STAR MCOs should consider offering telehealth services for members with SMI and SED in areas with a low number of providers to address appointment availability and network adequacy challenges.
- STAR MCOs should work with providers to identify avenues to successfully incorporate BHI services into their clinical workflows.
- STAR MCOs should work with providers to provide technical assistance and guidance for providers to implement evidence-based BHI programs targeted at improving chronic disease outcomes for people with SMI and SED.
- STAR MCOs should work with providers to provide incentives for providers to implement targeted and tailored interventions to improve care management for members with SMI and SED with comorbid chronic conditions. Incentives could be financial, but MCOs should also consider mission and peer-driven incentives such as training and recognition awards.

Development of a Personalized Quality-of-Care (PQOC) Index for Maternal Health

Study Aims

Aim 1: Identify and select measures relevant to understanding overall healthcare quality for STAR maternal population and are statistically feasible for inclusion in a PQOC index, including HEDIS measures.

Aim 2: Use the measures identified in Aim 1 to develop, test, and report on PQOC index scores within the STAR maternal population – demonstrating how the methodology can be used to understand maternal health disparities (across factors such as rurality and race/ethnicity).

Aim 3: Conduct a review of other measures that may be included in future iterations of the PQOC index for maternal health, including the viability of these measures based on data availability and quality.

Key Findings

- Using HEDIS PPC to determine member eligibility for this study resulted in the exclusion of approximately half of all women in STAR who were pregnant during 2018. Compared to excluded members, the study population had a higher burden of acute and chronic conditions. These exclusions occurred primarily due to the enrollment criteria for the HEDIS PPC measure.
- Nearly 80 percent of the study population was eligible for three or four of the PQOC index measures, including HEDIS PPC, 3M PPV, and the CMS Contraceptive Care measures. While this finding suggests that the PQOC index can function well as a tool for comprehensive QOC evaluation, certain index measures of chronic physical healthcare (HEDIS AMR, MMA), behavioral healthcare (HEDIS AMM, FUH, FUM), and treatment for substance abuse (HEDIS FUA, IET) only factored into scores for a small percentage of the study population. The EQRO did not have access to, and therefore did not include measures for other important aspects of care, such as prenatal screening, perinatal counseling and education, or delivery. The index did not include these measures because the availability, completeness, and validity of data needed to calculate them has not been established.
- The statistical model used to understand disparities in PQOC in the STAR maternal population had an R-square value of 0.056 – meaning that the demographic, health, and health service factors included in the model explained only 5.6 percent of the variation in PQOC index scores. This finding suggests that future studies should consider other unmeasured factors in maternal healthcare disparities.
- Disparities in PQOC by rurality were not as pronounced as for other factors considered in this study. This result may be because rurality lacked the specificity to reliably detect an association with PQOC.
- This study showed that PQOC in the STAR maternal population skewed slightly toward higher performance, with more than half of the study members having PQOC index scores between 0.500 and 0.799. The mean PQOC index score was 0.638, meaning that, on average, members had high-quality care for nearly two-thirds of the measures in the index.
- The descriptive analysis and statistical model showed disparities in PQOC index scores, with the strongest disparities observed for health service factors such as the number of outpatient visits, number of months enrolled, and MCO. The mean adjusted PQOC index score among members who had five outpatient visits during the measurement year was 0.879, compared to 0.566 among members who had no outpatient visits. Conversely, adjusted PQOC index scores decreased as the number of months enrolled increased. Several MCOs had significantly lower adjusted PQOC index scores than Superior, with the lowest observed in Molina (0.603).

- This study also showed disparities in PQOC for maternal health according to race/ethnicity, which persist after accounting for other factors. American Indian/Alaskan and NHB members had significantly lower PQOC than WNH members, while Hispanic members had significantly higher PQOC than NHW members. Furthermore, the study found a significant interaction between race/ethnicity and rurality. In rural areas, adjusted PQOC index scores were lower among Hispanic members than among NHW members. In urban areas, adjusted PQOC index scores were higher among Hispanic members than among NHW members.

Recommendations

To improve on the PQOC index methodology:

- HHSC should continue efforts to secure access to Texas vital statistics data – such as birth certificates and death certificates – and make this information available to the EQRO to conduct a more comprehensive evaluation of the quality of maternal healthcare.
- To improve the comprehensiveness of the PQOC index in addressing care that is relevant to maternal health, HHSC should conduct studies to assess the feasibility of calculating additional measures and including them in future iterations of the PQOC index. This work may include determining the availability of registry data for certain measures and the reliability of administrative-only versions of measures that have hybrid specifications.
- Future studies of PQOC in the maternal population should include more factors that address SDoH, to the extent that data are available. Area-level SDoH variables at the census tract level can provide important context related to educational attainment, household income, employment, language, poverty, and housing conditions for the population living in a given area. Census-tract rurality may function as a more sensitive measure than county-level rurality.

To address disparities in PQOC for maternal health:

- STAR MCOs should use information on the frequency of outpatient visits to identify risk for disparities in PQOC in the maternal population. Members who have no outpatient visits in a given year are more likely to experience lower quality healthcare when they seek care and are more likely to have PPEs. STAR MCOs should continue existing quality improvement efforts that target this population. Furthermore, HHSC should focus state-level maternal healthcare improvement efforts on MCOs that have lower PQOC among their members after controlling for other factors.
- STAR MCOs should focus efforts to reduce maternal mortality and SMM, emphasizing the demonstrated racial/ethnic disparities in PQOC. Quality improvement efforts in facilities that serve a greater proportion of NHB members should include interventions found to be successful in other states, such as the distribution of emergency toolkits and evidence-based guidelines. To facilitate these strategies, STAR MCOs should increase efforts to promote AIM Maternal Safety Bundles among their hospital providers and make tools for implementing best practices in maternal healthcare available to primary care providers and outpatient settings.

Documenting and Addressing SDoH by Texas Medicaid Managed Care Plans

Study Aims

Aim 1: Conduct a systematic literature review to document how MCOs collect and use SDoH data on the unmet social needs of Medicaid members, including assessment tools and examples of interventions.

Aim 2: Conduct in-depth interviews with staff members from all Texas Medicaid MCOs to document current SDoH screening practices and MCO interventions developed to address unmet social needs.

Key Findings

Literature Review Findings:

- In 41 states that include managed care in their Medicaid programs, MCOs in 20 states conduct some form of SDoH screening. In 18 states screening is required, but the processes for selecting questions and the number of questions included in the tools varies.
- In the 20 states where Medicaid agencies emphasize SDoH in their MCO contracts, payment incentives for addressing SDoH were not common. States have indicated that the absence of designated funding mechanisms to support SDoH interventions has limited MCOs' investments and affected program sustainability.

MCO Survey Findings:

- MCOs noted that meaningful discussions about SDoH happen at three pivotal points in an MCO's engagement with its members: (1) at the initial screening, (2) once an unmet social need was identified, and (3) when exchanging SDoH data with team members, providers and in some cases, community-based organizations.
- Nine MCOs use Aunt Bertha (a nonprofit online platform for referrals to social service providers in their communities). Among other MCOs, approaches to addressing SDoH needs vary, largely due to resource constraints.
- Capacity levels in SDoH analysis varied among MCOs, from no analysis to ad hoc analysis to highly structured regular reporting. Many MCOs are working with providers to capture Z codes on claims, while some plans are using predictive modeling of nonclinical data to leverage and support organizational planning and intervention resource allocation.
- Most MCO representatives interviewed indicated they do not evaluate the effectiveness of their SDoH interventions or the impact on health outcomes.
- The absence of a single standardized screening tool and the limited evidence base and data collected on SDoH interventions indicate that the impact of interventions on health outcomes is unknown.
- Representatives from 14 of the 17 MCOs mentioned community partnerships as key to addressing members' SDoH. Partnerships with Aunt Bertha, community-based organizations, and clinical providers were essential to SDoH efforts.
- Various challenges discourage MCOs from assisting members with nonmedical concerns such as housing and food insecurity or parenting skills integral to improving health outcomes and lowering costs. Interviewees mentioned the unique role of an insurance company in a member's life, difficulties engaging members, and member movement between plans as limiting interventions around SDoH.

Recommendations

- MCOs should train member-facing staff in relationship-centered communication skills to effectively discuss member needs and the importance of SDoH data collection. This training should include information about sensitivity to member issues and attitudes and rapport and relationships with members during contact.

- HHSC and the MCOs should develop a framework for consistent screening and assessment of member SDoH needs, including a standardized survey that draws on questions from existing validated screening tools (e.g., the CMS Health-Related Social Needs [HRSN] Screening Tool, The National Association of Community Health Centers Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences [PRAPARE], Kaiser Permanente's My Life Situation Survey, and American Academy of Family Physicians EveryONE Project). This framework should include a common data collection process for SDoH information, established intervals for measurement, and data collection methods related to intervention activities and effectiveness.
- HHSC should develop a protocol for collecting and sharing SDoH screening data across plans. This protocol should easily integrate into the MCO staff workflow. This data could include SDoH intervention successes and failures to promote best practices.
- HHSC should create an information platform with up-to-date community-based resources that all MCOs can access. Developing a state system or partnering with an existing provider such as Aunt Bertha or 211 would allow all MCOs to have a similar referral and reporting capabilities. Such platforms have the potential to reduce the challenge of keeping up with the ever-changing landscape of social services and resource availability.
- HHSC and the MCOs should establish a statewide task force of community influencers to guide the continuing dialogue on SDoH measurement and interventions by Texas MCOs. For example, HHSC could establish a coalition of MCO representatives, providers, social service agencies, and public health researchers to prioritize SDoH needs.
- HHSC should pilot alternate payment strategies to encourage continued MCO investment in SDoH interventions, including financial rewards and redefining priority SDoH investments (for reimbursement) as medical expenses instead of administrative expenses. HHSC could use the pilot to establish methods and metrics for incentivizing MCOs to support financial investments in SDoH.

Issue Briefs

Health Teleservices for Prenatal and Postpartum Care

Study Aim

Review current scientific literature, policies, and programs to understand the benefits and recommended use of teleservices for perinatal care.

Key Findings

- The benefits of teleservices for perinatal care are more evident for prenatal care than postpartum care. For prenatal care, research supports the use of teleservices for monitoring chronic conditions (e.g., asthma, diabetes, and hypertension). For postpartum care, teleservices research is restricted to studies focused on providing support to promote health behaviors and mental health (e.g., breastfeeding, mental health counseling).
- The most researched modality for perinatal care teleservices is telemonitoring of health conditions. Evidence suggests that telemonitoring increases compliance of self-monitoring of conditions (e.g., asthma, diabetes, and hypertension) with high acceptability among clients and providers.

Recommendations:

- HHSC should consider supporting initiatives to improve equitable access to broadband and technologies that facilitate the use of teleservices.

- HHSC should assess the feasibility and cost of teleservice programs and incentivize MCOs to implement teleservice programs as a value-add service.
- HHSC should pilot teleservices in specific geographic areas or populations to assess feasibility and cost.
- HHSC should work with mHealth (the use of mobile and wireless devices (cell phones, tablets, etc.) to improve health outcomes, health care services, and health research) programs to determine how to comply with reimbursement policies.
- HHSC should conduct future studies to determine continuity of care for clients who use teleservices.
    - HHSC should work with MCOs to hold stakeholder meetings to identify ways to address appointment availability challenges.
    - HHSC should work with MCOs to Identify ways to improve broadband connectivity, which is crucial for implementing teleservices.
    - MCOs should work with providers to provide tools to increase awareness of the availability and benefits of teleservices.
- MCOs should offer providers technical assistance and guidance on providing teleservices care.
- MCOs should work with providers to identify avenues to successfully integrate teleservices into clinical workflows.
    - MCOs should work with providers to identify avenues for ensuring patient privacy and HIPAA compliance for teleservices.
    - MCOs should work with providers to incentivize the uptake of teleservices.

Trends in Alternative Payment Models for Increasing Access to Patient-Centered Maternal Care

Study Aim

Summarize the APMs used to incentivize obstetric providers to increase access to patient-centered maternal health services and describe how states implement these payment models in Medicaid policy.

Key Findings

- FFS reimbursement models incentivize providers to focus more on the number of services provided to a patient rather than the quality of those services. This negatively impacts maternal healthcare because it increases perinatal care costs and encourages unnecessary interventions that can risk the mother and her child's health.
- APMs incentivize providers to use evidence-based and patient-centered approaches to perinatal care to reduce practices associated with poor perinatal outcomes. The diversity of APM frameworks also allows the flexibility to tailor initiatives to the local context or a specific maternal condition.
- APMs for perinatal care can be challenging to implement because there are few studies on the effectiveness of these approaches for improving the quality of, or access to, maternal healthcare. Additionally, few established metrics for measuring access to care capture whether women receive gold standard care and access to pregnancy risk screening. Model frameworks and quality metrics must be chosen carefully to ensure provider accountability and incentivize high-quality care access.

Recommendations

- HHSC should identify a set of evidence-based indicators that provide information on access to appropriate care and pregnancy risk screening for women in Texas Medicaid. These indicators should be chosen based on whether: (1) they address key issues for improving maternal healthcare for women in Texas, (2) the data is available to adequately support reliable performance measurement, and (3) the use of the measure is supported or recommended by an organization such as the Joint Commission or NQF to help ensure the use of reliable and valid QOC measures. If possible, these indicators should include measures that provide information on patient experience in addition to the utilization of care, such as CAHPS measures.
- When developing a supplemental payment program, HHSC should be clear in defining the accountable provider for financial incentives to support improvements in quality of, and access to, perinatal care services, making sure that the accountable provider is prepared to effectively enact program and delivery reforms and that the role of the accountable provider aligns with the quality improvement goals of the program.
- HHSC should involve stakeholder input from providers and MCOs when designing a supplemental payment program to encourage increased rates of pregnancy risk screening and improved access to maternal healthcare. Stakeholder engagement will ensure that the proposed model properly aligns incentives and value and provides critical feedback on any factors outside the scope of practice improvements that the provider can make. MCO and provider feedback is also important for understanding which incentives and delivery models are likely to be the most effective.
- HHSC should draw on implementation science models when developing a method to assess whether supplemental payments impact the quality of, and access to, maternal health services for women in Texas Medicaid. After selecting a set of evidence-based indicators, HHSC should plan to pilot the indicators to ensure the feasibility of their use, establish a baseline for the quality of maternal healthcare and access to maternal health services, and develop a pre-post-intervention study to assess the effectiveness of the supplemental payment program for improving the quality of care and access to health services for women in Texas Medicaid.

Medical P4Q in STAR+PLUS: MCO Perspectives and Strategies

Study Aim

Conduct interviews with staff from all five Texas Medicaid STAR+PLUS MCOs to better understand the strategies that MCOs use to assess and improve their P4Q performance.

Key Findings

- The complex care needs of the STAR+PLUS population present unique challenges for MCOs in improving performance on P4Q measures, including challenges in assessing provider performance for members with multiple chronic conditions, promoting integrated care, and evaluating interventions with multiple components.
- The most pressing challenges for STAR+PLUS MCOs trying to improve performance in the medical P4Q program include difficulties assessing the impact of individual initiatives when multiple P4Q initiatives target a single issue and engaging multi-level stakeholders in quality improvement initiatives.

- STAR+PLUS MCOs have several promising strategies to help address the barriers that limit performance improvement in the medical P4Q program, including member- and provider-level incentives, processes for identifying and reducing service gaps, and events that educate and connect members and providers. More research is needed to assess whether these strategies lead to measurable improvement in provider engagement and member care quality.

Recommendations

- HHSC should determine whether STAR+PLUS MCOs have established policies for (a) identifying and responding to providers who consistently drop non-compliant or non-responsive members from their panels and (b) reaching out to members who have an increased risk of being dropped from a provider panel.
- STAR+PLUS MCOs should expand on health information technology (IT) systems to improve access to timely and accurate data. In particular, health IT systems should support data collection from laboratory vendors, which can facilitate the monitoring of performance on the Comprehensive Diabetes Care – HbA1c Control measure.
- STAR+PLUS MCOs should conduct studies to evaluate the effectiveness of their approaches to meeting P4Q goals. These include, but are not limited to, strategies that: (a) follow a multi-level approach to improve quality by combining provider- and member-level incentives; and (b) involve regular wellness or condition-specific events that educate and connect members and providers.
- STAR+PLUS MCOs should implement or expand on existing initiatives to partner with providers and provider stakeholder groups to develop resources to facilitate P4Q improvement. Resources should address issues such as proper medical coding to support P4Q measure reporting, service gap identification and root cause analysis, and tracking P4Q performance at the provider level.
- STAR+PLUS MCOs should identify and implement effective and sustainable strategies to offset the administrative burden experienced by providers associated with monitoring P4Q performance.

Protocol 10: Assist with Quality Ratings

Although CMS has not released details for this new protocol the EQRO participates in several activities related to quality rating. The EQRO presents performance measures (Protocol 7) with ranking and comparison to benchmarks on the THLC portal (thlcportal.com). This report also discusses the P4Q programs in Protocol 7. In another important activity in this area, the EQRO develops annual MCO report cards to support the state's ongoing efforts to improve healthcare quality and support consumer choice in Texas Medicaid and CHIP.

Performance Indicator Dashboard Measures

The Performance Indicator Dashboard for Quality Measures is a selection of quality measures with particular importance for Texas Medicaid and CHIP. The EQRO helps Texas select measures based on qualitative assessment and review of measure results across programs. Annual high and minimum standards for the Performance Indicator Dashboard come from EQRO calculations using measure results, annual measure trends, and publicly available national benchmark data. Chapter 10 of the UMCM provides published details on these standards (HHSC, 2020). The most current and detailed results on Performance Indicator Dashboard measures are available to HHSC and MCO users on the THLC portal (thlcportal.com). The dashboard helps Texas identify measures where most MCOs excel or struggle, and measures where MCO performance varies widely. This information supports ongoing and future quality improvement initiatives.

Pay-For-Quality (P4Q) Performance Dashboard

Texas requires that a percentage of MCO premiums are based on QOC measure performance (Texas Government Codes § 354.1445 and § 536.051, 2016). The EQRO worked extensively with HHSC to develop the medical and dental P4Q programs for Texas Medicaid and CHIP. The medical programs include HEDIS and other core measures, including survey measures, and PPEs. Complete details on the programs are available in Chapter 6 of the UMCM (HHSC, 2020). To help HHSC and the MCOs track P4Q performance, the EQRO created the P4Q Performance Dashboard on the THLC portal (thlcportal.com). Developed during SFY 2019 and launched for the public during this reporting year, the dashboard provides information by measure and by MCO for each P4Q program, including the measure contribution category (measured against self, against benchmarks, and bonus measures), and level of reward or loss. The dashboard allows stakeholders to see which measures contribute either positively or negatively 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 the provision of accessible information on healthcare quality for consumers.

The EQRO produced 62 unique report cards (by program and service area) for distribution in 2021. 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.

The report cards organize information about MCO performance 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. 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. Appendix G details the individual measures included in each report card domain.

The EQRO selects measures for report cards based on HHSC priorities, the impact of the measure for the population, CMS and 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, and
2. administrative data for select HEDIS measures on MCO performance.

The MCO report cards created for distribution in 2021 use the results of member and caregiver surveys conducted in spring and summer of 2020 (Protocol 6) and administrative measure results for measurement year 2019 (Protocol 7). The EQRO fielded 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 did 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 healthcare quality, including age, education, and health status.

Structure

The MCO report cards for CHIP, STAR children, STAR adults, and STAR+PLUS begin with an overall composite summary of relative MCO performance that equally weights each of the three domains:

- 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).

Domain ratings appear below the overall composite rating, and finally, ratings for the individual measures the domain comprises appear under each domain rating.

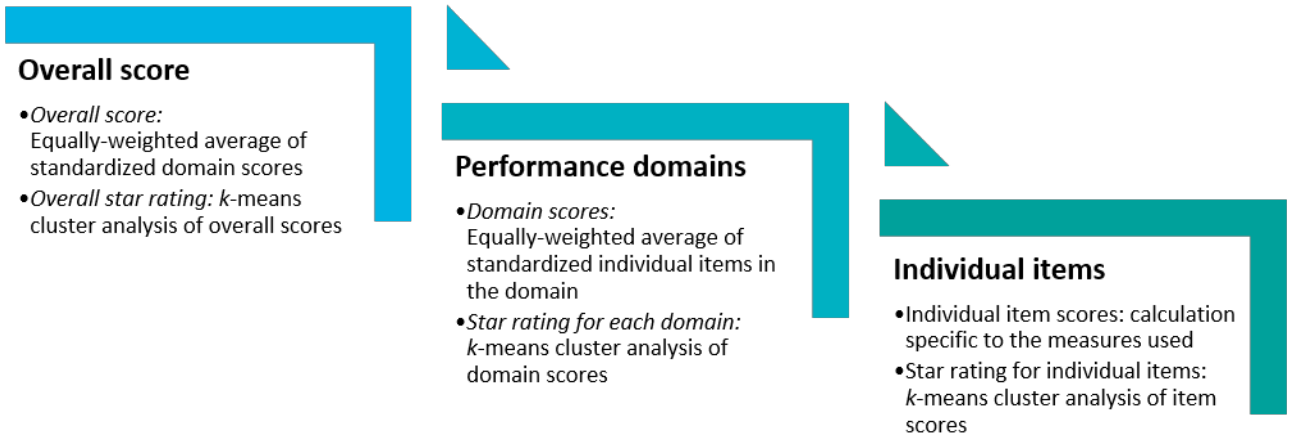
In a similar three-tiered structure, the MCO report cards for STAR Kids begin with an overall composite rating of relative MCO performance that assigns equal weight to each of the three domains:

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

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

Figure 10 illustrates the tiered structure of the report cards and how the five most natural performance clusters map to ratings of one to five stars. The prominent placement of the overall composite rating guides users to the broadest and most generally applicable information on the report card, while the individual item ratings allow users with specific needs to select the MCO that will best meet those needs. Standardization of scores within each tier (item, domain, and overall) allows the EQRO to composite measures with different natural scales and variation without biasing the result.

Figure 10. Conceptual diagram of 2021 MCO report card structure



k-means Clustering for Star Ratings

The EQRO uses *k*-means clustering to assign star ratings based on similarities in performance. Given the observed distribution of performance scores for each measure, cluster assignment minimizes within-cluster variance and maximizes between-cluster variance, thus the rating levels are maximally different. Highlighting performance contrasts among available MCOs supports consumer choice.

Table 38 shows the number of plan codes (MCO/SA) in each star rating category for the overall MCO quality composite for each type of report card. 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 38. Distribution of 2021 report card ratings, by program

Program	Total Plan Codes[1]	5 Stars	4 Stars	3 Stars	2 Stars	1 Star	No Rating
CHIP	32	3	7	9	5	4	4
STAR Children	44	6	10	18	5	5	0
STAR Adults	44	3	10	13	10	8	0
STAR+PLUS	30	2	9	11	3	5	0
STAR Kids[2]	28	1	3	9	8	7	0

[1] Plan codes identify MCO by SA.

[2] In the Dallas SA, Aetna Better Health of Texas began serving STAR Kids and Children's Medical Center Health Plan exited STAR Kids as of September 2020. CMCHP was included in the rating process, while Aetna was not. Aetna appears on report cards with no rating and a note indicating that they are new to the SA, while CMCHP does not appear.

The following figures show the distribution of scores for the overall quality composite for each type of report card, mapping scores to the corresponding rating for CHIP (Figure 11), STAR Child (Figure 12), STAR Adult (Figure 13), STAR+PLUS (Figure 14), and STAR Kids (Figure 15). Ratings for domain composites and individual items on the five types of report card likewise depend on the distribution of scores among all plan codes in a program for that composite or item. The top row in each chart shows program performance by plan code. The remaining rows present the same performance scores sorted by SA to show variations within and among SAs. The five vertical bands indicate the five performance clusters calculated by the EQRO. Each cluster corresponds to a rating of one to five stars on the report cards. The *k*-means clusters depend solely on the distribution of performance data, and vary across measures, programs, and years.

Figure 11. 2021 CHIP child report card scores clusters and star ratings

Figure 12. 2021 STAR child report card scores clusters and star ratings

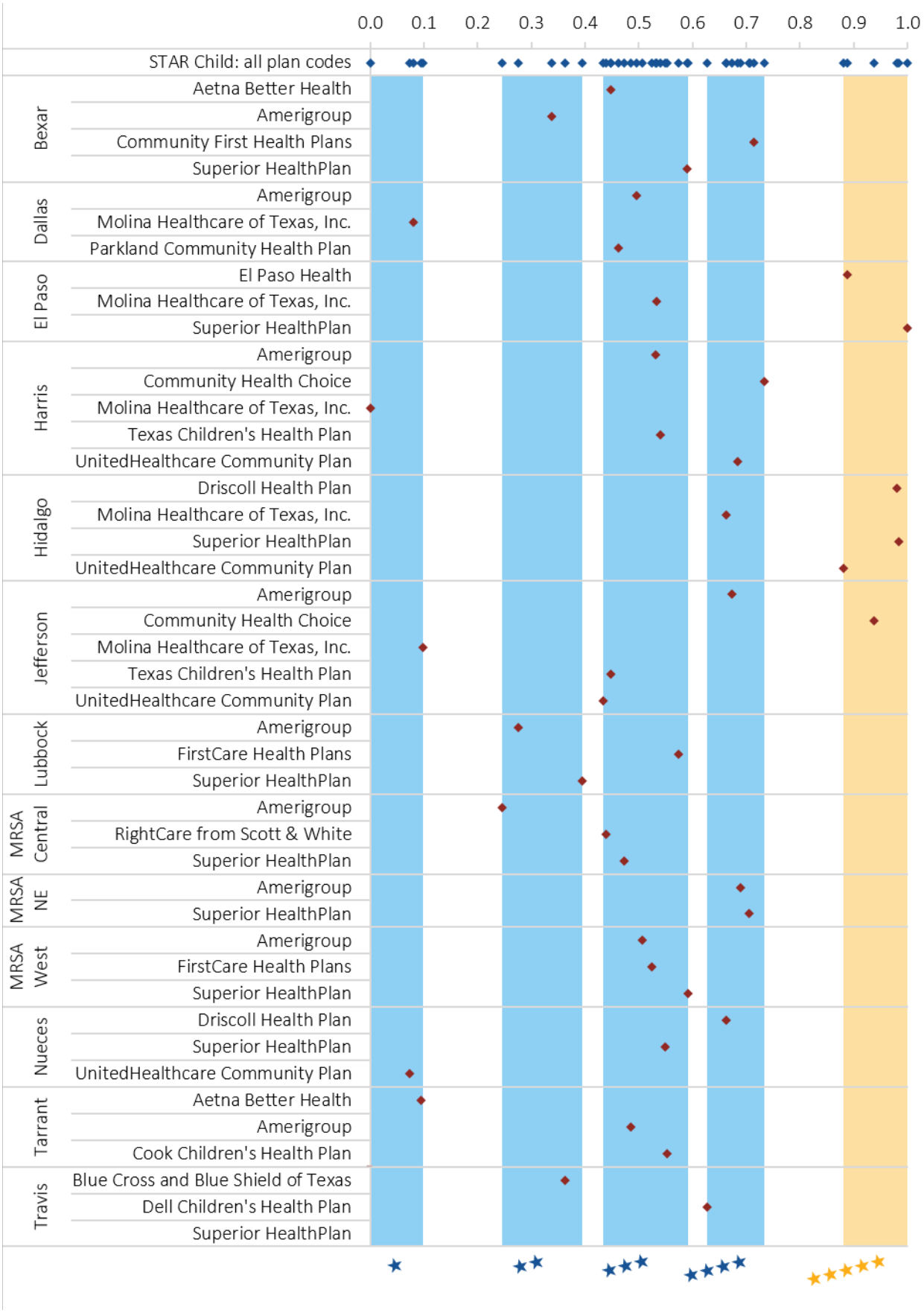


Figure 13. 2021 STAR adult report card scores clusters and star ratings

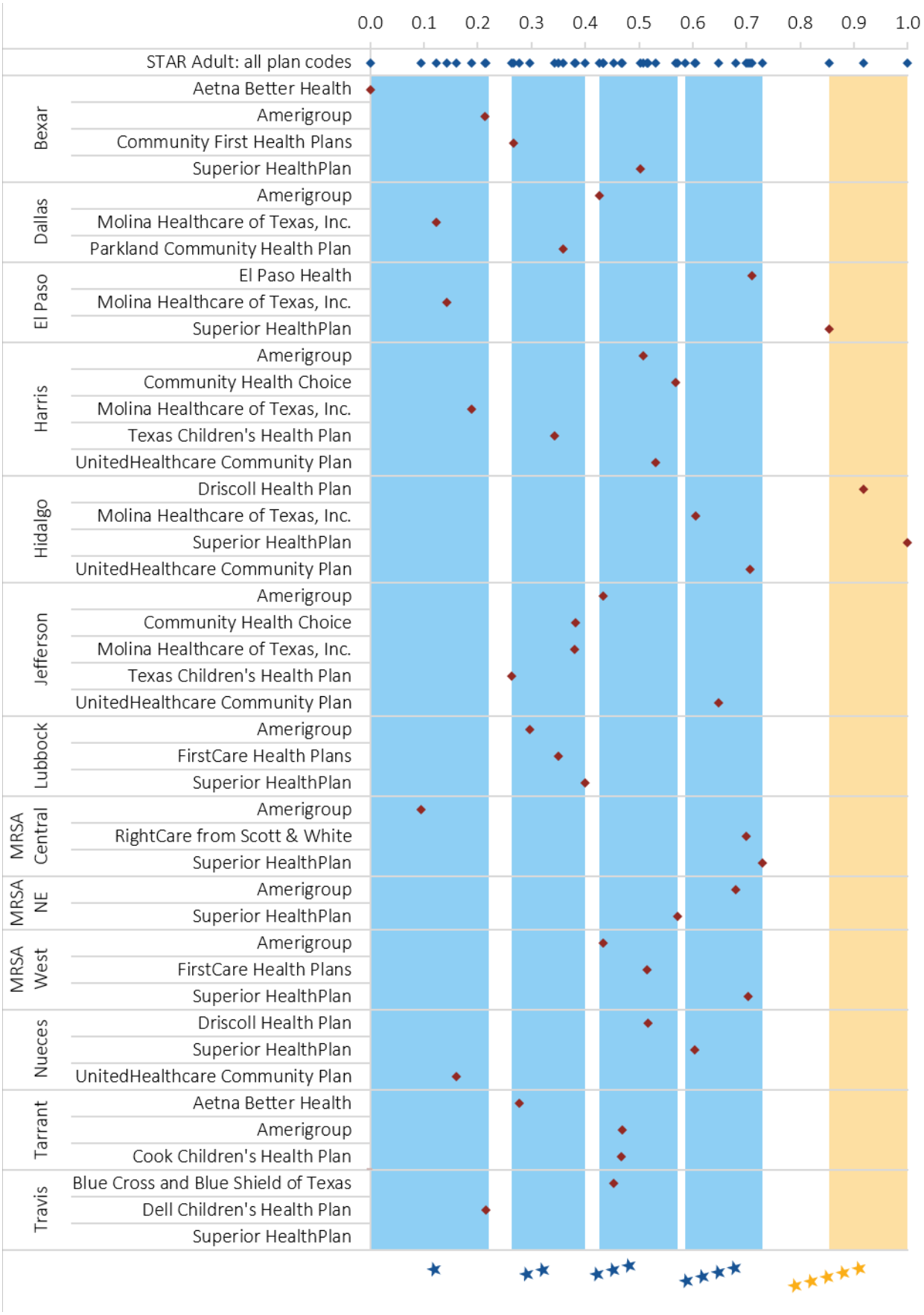


Figure 14. 2021 STAR+PLUS report card scores clusters and star ratings

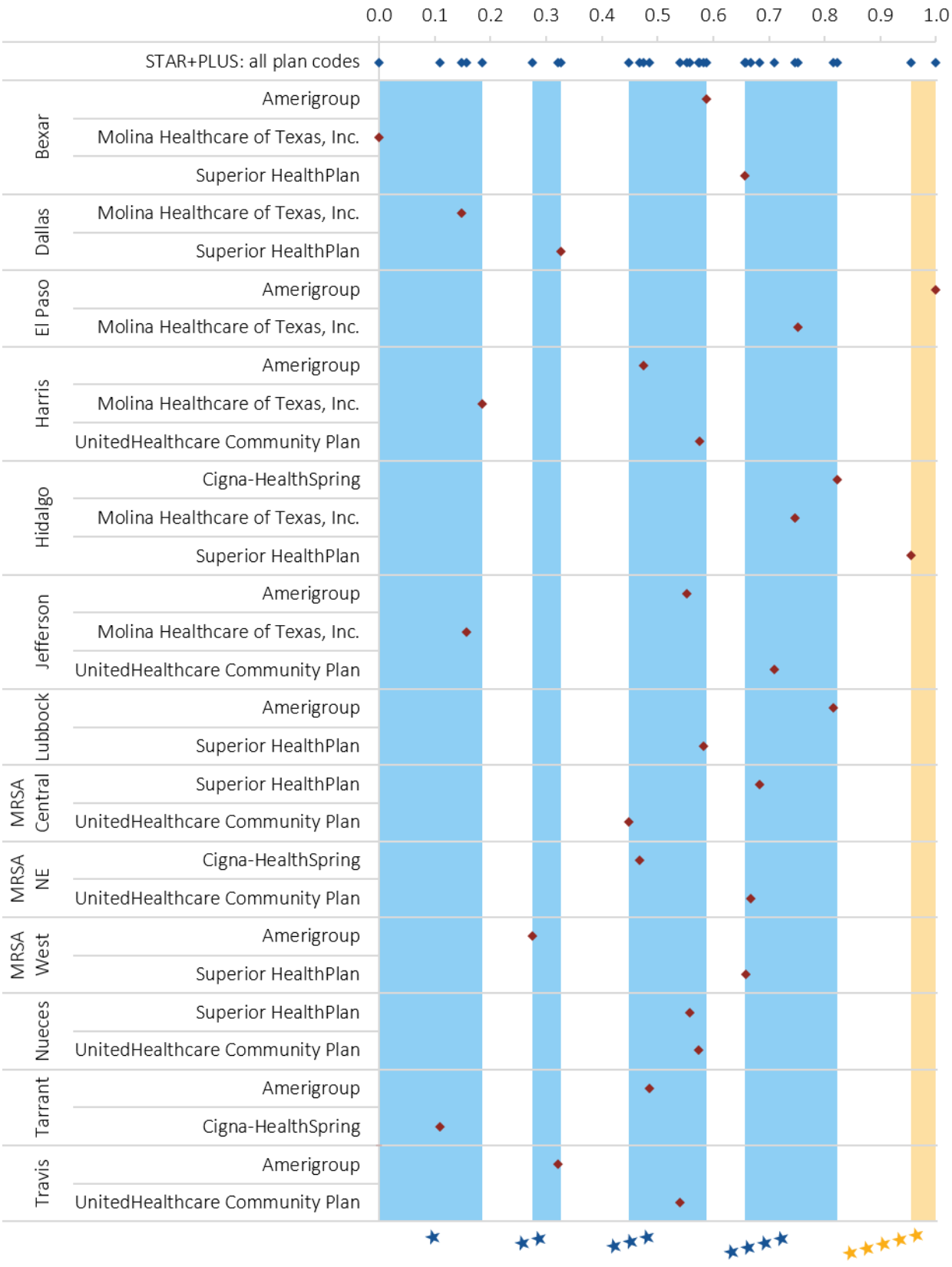
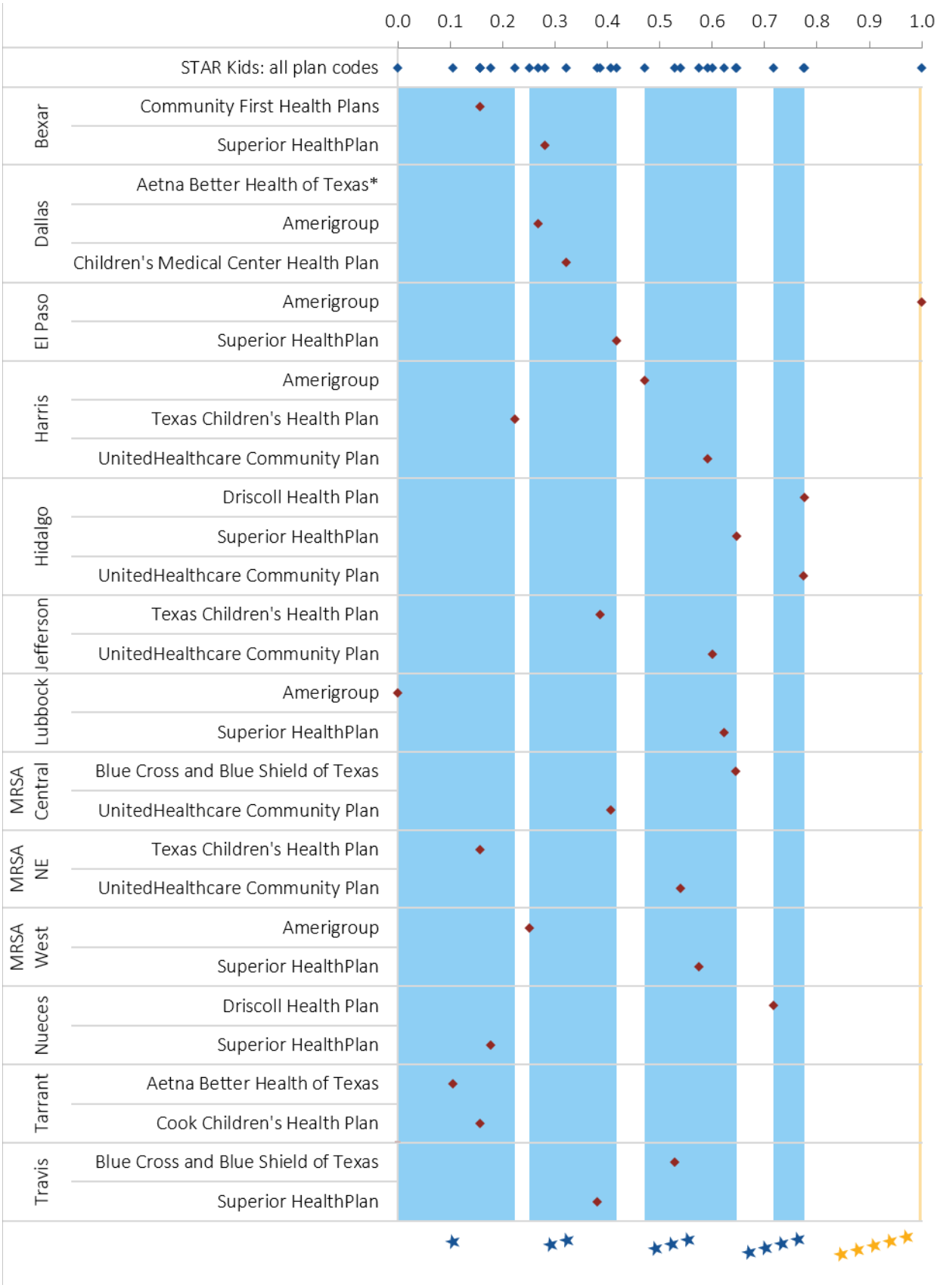


Figure 15. 2021 STAR Kids report card scores clusters and star ratings



*Aetna Better Health of Texas began serving STAR Kids in Dallas in September 2020.

EQRO Recommendations and Texas Managed Care Quality Strategy

Texas is required to develop and implement a written quality strategy[1] to assess and improve the quality of Medicaid and CHIP managed care services (42 CFR §438.340, 2016). This quality strategy is reviewed and updated every three years and must be approved by CMS.

The 2018 Texas Managed Care Quality Strategy (MCQS) has three goals:

G1. Transition from volume-based purchasing models to a pay-for-performance model
G2. Improve member satisfaction with care.
G3. Reduce payments for low quality care.

HHSC achieves these goals through the following mechanisms:

M1. Program integrity monitoring through both internal and external processes
M2. Implementation of financial incentives for high performing MCOs and financial disincentives for poor performing MCOs.
M3. Developing and implementing targeted initiatives that encourage the adoption by MCOs of evidence-based clinical and administrative practices.

The following tables list EQRO key findings and recommendations for last year and the current year. Prior year recommendations include information about follow-up actions by HHSC. When applicable, the tables also include information on which of the MCQS goals (G1, G2, or G3) and/or mechanisms (M1, M2, or M3) are affected by the finding and recommendation.

Follow-Up to Recommendations Made in SFY 2019

Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations

Administrative Interviews (AIs)

Summary	Description
Key Findings	MCOs failed to update documentation related to CMS regulations.
Significance	Texas may fail to meet federal standards if MCOs fail to keep up with regulations.
Recommendations	The MCOs should better monitor changes to state and federal regulations and ensure that their policies and procedures align with the most current regulations in place.
Follow-up	The EQRO assesses MCO/DMO compliance once every three years. The EQRO and HHSC do not have immediate follow-up to determine if the MCOs made the necessary revisions to their policies and procedures.

[1] Links to the quality strategy document are available at https://hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/quality-strategy.

Summary	Description
Key Findings	MCO DM eligibility determination processes were inconsistent.
Significance	EQRO is unable to evaluate DM programs fully without better information from the MCOs, and comparisons between MCOs would improve with more standardized criteria.
MCQS Relevance	G3; M1
Recommendations	HHSC should examine MCO criteria used to determine DM eligibility, and the services offered through these programs. The addition of more in-depth questions on DM eligibility and management in the AI would be a step towards this goal. HHSC should consider establishing basic standard DM eligibility criteria for all MCOs to follow. This would improve the EQROs ability to evaluate DM programs and provide meaningful comparisons between MCOs, programs, and across time. Standardization would also increase the ability to efficiently implement statewide improvement initiatives.
Follow-up	The summaries of the MCO DM programs are no longer contract deliverables. HHSC encourages MCOs to develop DM programs that are reflective of the communities they serve. Therefore, establishing DM standards would hinder plans ability to specialize services to members.

Protocol 2: Validation of Performance Measures Reported by MCOs

Summary	Description
Recommendations	None

Protocol 3: Validation of PIPs

Summary	Description
Key Findings	MCOs lost points due to incomplete reporting, or due to discrepancies between the data reported on the final PIP report and the data available on the QOC tables and THLC portal (THLCportal.com).
Significance	Incomplete reporting hinders the EQRO PIP validation process Data discrepancies result in misinterpretation of results and make it difficult to assess the overall effectiveness of the PIP.
MCQS Relevance	G1; M3
Recommendations	The MCOs should follow HHSC and EQRO guidance on completing PIPs and PIP reporting. The MCOs should utilize the data provided in the QOC tables and on the THLC portal (THLCportal.com) to calculate rates when applicable.
Follow-up	HHSC and the EQRO held a virtual workshop in May 2020 to provide guidance on reporting for the PIPs and the sources for data. HHSC and the EQRO will be able to determine whether the MCOs implemented the above recommendations once they submit the 2018 final PIP reports.

Summary	Description
Key Findings	Some well-planned PIPs (with high PIP plan scores) failed to produce significant improvements.
Significance	Each PIP represents a large investment by the MCO, HHSC, and the EQRO, with the purpose of improving the quality of care.
MCQS Relevance	G1; M3
Recommendations	HHSC should work with the EQRO and MCOs to identify barriers to implementing impactful PIPs and to make modifications to the PIP process that address the barriers identified.
Follow-up	HHSC worked with the EQRO and MCOs to identify barriers to implementing impactful PIPs and to develop a new process for the PIPs that addresses these barriers. HHSC originally planned to implement these changes starting with the SFY 2022 PIPs. However, to respond to changes in the CMS EQR PIP protocol, and constraints resulting from the pandemic HHSC delayed some modifications until further notice.

Protocol 4: Validation of Encounter Data Reported by MCOs

Analysis of Encounter Data for Accuracy and Completeness

Summary	Description
Key Findings	Some MCOs had more than expected unpaid claims. Rates were high in CHIP perinatal, which could be due to submission of claims for services payable through FFS.
Significance	Unpaid claims may show problems with MCO coverage or care delivery indicating a possible need for further investigation. At a minimum, high volume of unpaid claims represents inefficiency in MCO administrative processes.
MCQS Relevance	G1; M1
Recommendations	The proportion of unpaid claims in CHIP Perinatal exceeds that in other programs. This is likely due to providers being unclear about coverage and payer differences, but rates were high enough for some MCOs to suggest a need for HHSC to investigate further.
Follow-up	The EQRO continues to monitor claim status. HHSC is prioritizing data quality and developing enforceable performance standards. HHSC is working with MCOs that had high volume of denied or voided CHIP Perinatal claims to better understand the underlying causes.

Summary	Description
Key Findings	The EQRO found dispensing information (units and amounts) incorrectly coded on pharmacy encounters more often than expected. POA reporting continues to be of poor quality from many providers. Rendering provider information continues to be incomplete or fails to identify an individual with appropriate taxonomy.
Significance	Data quality deficiencies impair or potentially bias the quality evaluations.
MCQS Relevance	G1; M1
Recommendations	MCOs (UHC in particular) should review coding practices for asthma inhaler pharmacy claims. HHSC should investigate ways to encourage better POA reporting across all providers. Although POA coding has improved, many hospitals continue to submit data that does not pass screening criteria and is thus excluded from PPC calculations. This affects the overall quality of PPC reporting. HHSC should continue to prioritize improvement in provider data in encounters. Provider information on encounters continues to be incomplete on a substantial percentage of professional encounters. Except in rare circumstances, every encounter item should identify the individual who performed the service and their appropriate taxonomy.
Follow-up	The EQRO saw a slight reduction in incorrectly coded dispensing information. POA coding continues to be a problem for many providers. The new data quality standards HHSC set for the MCOs will require MCOs to develop action plans to address this deficiency. The MCOs will need to work with their provider networks to address coding deficiencies at the hospital level. HHSC continues to work with the MCOS and TMHP to improve provider data in encounters. An area of concern is the identification of encounters with services performed by individuals without NPI, and lack of sufficient specialty information in both medical and dental encounters.

Review of Dental Records for Consistency with Encounter Data

Summary	Description
Key Findings	Providers continue to submit claims for exams without including CRA.
Significance	CRA are used in calculating dental P4Q measures.
MCQS Relevance	G1; M1
Recommendations	HHSC should continue to work with the DMOs to achieve 100 percent compliance on required CRA. Although the rate of missing assessments has gone down, this is still an area for improvement. Although the DMOs may deny claims with missing assessments, the goal should be to improve provider compliance with this requirement.
Follow-up	The EQRO had several follow-up calls with the DMOs to review encounters and discuss the importance of not only denying deficient claims but encouraging providers to conduct and document CRA appropriately; however, compliance rates in SFY 2019 were still below 97 percent for CHIP and below 99 percent for Medicaid.

Summary	Description
Key Findings	Poor provider data impeded data collection.
Significance	Poor provider data in the EQRO warehouse also reflects problems in provider directories, thus affecting not only EQRO and administrative functions, but also affecting members' access to care.
MCQS Relevance	G2; M1, M2
Recommendations	HHSC should continue its ongoing efforts to improve provider data quality. Although record review rate in EDVDRR improved, lack of accurate provider data continues to affect the efficiency of the review process.
Follow-up	Poor provider data impeded data collection for the EDVMRR project this year. The EQRO reached out the MCOs for assistance in making record requests. HHSC is working with the EQRO to develop alternative strategies for contacting providers, while continuing to work on overall improvements to the provider data systems. HHSC is again requesting provider addresses from the DMOs for the next EDVDRR.

Protocol 5: Validation and Implementation of Surveys

Summary	Description
Key Findings	Although performance on child caregiver surveys were generally good, CHIP ratings for *Getting Needed Care* and *Getting Care Quickly* were below national averages.
Significance	Access to timely needed care improves health outcomes.
MCQS Relevance	G2; M1
Recommendations	Based on child caregiver survey results, the EQRO recommends that HHSC focus on providing timely appointments and expanding access to specialty care.
Follow-up	HHSC implemented corrective action plans for failure to meet minimum standards for appointment availability. The non-emergent component of Getting Care Quickly is included in the CHIP report cards. The emergent component of Getting Care Quickly is a CHIP Bonus Pool measure in the 2018 and 2019 P4Q programs, and Getting Needed Care is a CHIP Bonus Pool measure in the 2021 P4Q program. The specialist component of Getting Needed Care and both components of Getting Care Quickly are included in the Performance Indicator Dashboard for 2019.

Summary	Description
Key Findings	Although ratings for MCO and Behavioral Health Organization (BHO) delivery of behavioral healthcare were similar across most categories, the global treatment rating was notably higher for adults in MCOs, and higher for BHOs in STAR Kids.
Significance	All delivery systems should provide consistent delivery of high-quality treatment.
MCQS Relevance	G3; M1
Recommendations	Differences in ratings for behavioral health delivery organization (MCO or BHO) and by age suggest a need for further investigation.
Follow-up	In addition to surveys, HHSC is monitoring this area through the appointment availability surveys and through P4Q (Getting Needed Care and Getting Specialized Services).

Summary	Description
Key Findings	Dental Plan Costs and Services and overall Dental Plan Rating had lower ratings in CHIP compared to Medicaid.
Significance	Member satisfaction is equally Important to CHIP and Medicaid dental coverage recipients.
MCQS Relevance	G2
Recommendations	Differences in member experiences between the Medicaid dental and CHIP dental programs also suggest an area for investigation and improvement.
Follow-up	HHSC will work with the EQRO and the DMOs to determine if there are areas for additional study about member expectations and experience. HHSC will explore other ways to hold plans accountable to survey measures including the possibility of a new performance indicator dashboard for dental measures.

Protocol 6: Calculation of Performance Measures

Summary	Description
Key Findings	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.
Significance	HHSC can use tools like the Performance Indicator Dashboard to identify areas of consistently high performance and areas for improvement across or among MCOs.
MCQS Relevance	G3; M1
Recommendations	The Performance Indicator Dashboards provide an excellent way to identify MCOs that are struggling to meet state standards across multiple service dimensions and identifies areas of care that challenge many MCOs or programs. HHSC should leverage this information to develop targeted improvement initiatives and to share best practices from the higher performing MCOs.
Follow-up	HHSC implemented corrective action plans for MCOs with 1/3 or more of their dashboard measures below minimum standards for 2018.

Summary	Description
Key Findings	Although performance was better on many HEDIS measures for members with SMI, these members have higher PPEs.
Significance	HEDIS measures rates may be higher when overall utilization is higher. PPEs are costly and represent deficiencies in care.
Recommendations	HHSC should continue to work with the EQRO to understand the needs of members with SMI. In many cases, performance on HEDIS measures is better for these members; however, an increased number of PPEs among those with SMI suggests deficiencies in care. Discovering more about how these members interact with the healthcare system could lead to better measures of quality and performance.
Follow-up	The EQRO provided HHSC with two topic reports related to the quality of care for members with SMI or SED. In addition, the EQRO continued to provide QOC measure reporting for Medicaid members with SMI or SED, and the utilization dashboard for special populations including SMI/SED. HHSC will continue to investigate disparities affecting this vulnerable population.

Summary	Description
Key Findings	The maternal population had higher utilization and higher rates for some HEDIS measures, but lower rates for most behavioral health measures.
Significance	Better birth outcomes require attention to comprehensive care during pregnancy.
Recommendations	The EQRO suggests developing a maternal healthcare dashboard, which brings measures of general healthcare quality and measures specific to maternal healthcare together into a comprehensive picture of maternal healthcare. The significant differences in QOC measure results for the maternal population suggest the need for continuing to focus on this population.
Follow-up	The EQRO provided a topic report addressing overall quality of care for the maternal population. The C-section and SMM reports were also continued and enhanced this year. In addition, the Better Birth Outcomes initiatives included a study of NICU transfers, and an extension of prior NICU research to specifically look at neonatal abstinence syndrome (NAS). In addition, HHSC was selected for a CMS Innovation Accelerator Program (IAP) program specifically to address maternal healthcare measures. The EQRO and The Texas Department of State Health Services (DSHS) partnered with HHSC in this program, with a goal of integrating vital statistics and other DSHS data in maternal healthcare analyses.

Summary	Description
Key Findings	Upper respiratory tract infections contributed to PPVs in 2018 much more than any other condition. Many conditions that lead to PPVs may receive better treatment in a primary care setting.
Significance	Better primary care for applicable conditions could reduce PPEs and increase the appropriate treatment for these conditions. Better primary care could increase effective preventive care.
MCQS Relevance	G2
Recommendations	The EQRO suggests investigating treatment patterns, specifically treatment location, for URTI and acute illnesses such as gastroenteritis. Reducing the dependence on emergency care and promoting appropriate primary care could improve HEDIS AAB and URI rates and both PPV and PPA rates. HHSC interventions should emphasize preventive primary care. Many of the top reasons for PPV and PPAs should respond to prevention-focused care, such as vaccinations, management of patient medications, and counseling and resources to help reduce tobacco use in patient households.
Follow-up	HHSC continues to track these measures, HEDIS URI and PPVs are now P4Q measures. HHSC is always working to improve and encourage prevention-focused medicine, but the priority of the pandemic has limited initiatives for increasing primary care. HHSC is working with the EQRO on several studies designed to examine the impacts of the pandemic on patterns of care.

Summary	Description
Key Findings	At least one mental health disorder was among the top ten PPA and PPR conditions for all managed care programs.
Significance	Managing behavioral health outside of the hospital improves many aspects of overall patient health. Often, patients have co-occurring conditions. Hospitalizations for mental health reasons are expensive.
Recommendations	HHSC should work to develop better medication management programs and programs to coordinate care after discharge for patients with SMI. Medication management is critical to effectively treating bipolar and other mental health disorders. Some form of mental health disorder was among the top ten PPA and PPR conditions for all managed care programs.
Follow-up	HHSC continues to target behavioral health issues, and particularly care for members with SMI or SED. Several EQRO projects provided greater insight into patterns of care in this population. This will enable HHSC to better target specific needs such as coordination of discharge for patients with SMI or SED.

Summary	Description
Key Findings	The EQRO must exclude approximately 40 percent of discharges from PPC calculations because hospital data does not pass POA quality screening.
Significance	PPC rates are potentially biased because of missing data.
MCQS Relevance	G3; M1
Recommendations	Improving POA reporting should still be a priority. The EQRO must exclude approximately 40 percent of discharges from PPC calculations because hospital data does not pass POA quality screening. Information is lost from evaluation of MCOs and program performance because the EQRO cannot accurately measure performance in the excluded hospitals. Certain conditions are still identifiable as areas for concern, including septicemia, pneumonia, respiratory failure, renal failure, and urinary tract infections.
Follow-up	Data quality initiatives which will require MCOs to meet submission standards or develop corrective action plans will incentivize MCOs to work with their provider networks to improve POA reporting.

Protocol 8: Conducting Focused Studies of Health Care Quality

Focus Study: STAR Kids Implementation

Feasibility study recommendations

Summary	Description
Key Findings	The EQRO found high rates of missing values in important STAR Kids Screening and Assessment Instrument (SK-SAI) fields for some MCOs.
Significance	Missing and invalid data in important SK-SAI fields can prevent reliable comparisons at the MCO level and can bring the validity of overall rates into question.
MCQS Relevance	G3; M1
Recommendations	The EQRO suggests additional training with MCOs to ensure that they populate SK-SAI data fields correctly and consistently.
Follow-up	Based on findings of the SFY 2020 STAR Kids SAI/ISP Measures study, MCOs improved on completeness of important SK-SAI fields. The EQRO will report on all the findings from this study in the SOA report for SFY 2021.

Summary	Description
Key Findings	The EQRO received only one-quarter of the SK-SAI or ISP records for MDCP members requested for this study. Causes could include issues with implementation such as the extension of determinations of medical necessity for MDCP, or issues with MCO procedures for data transfer.
Significance	The low number of records received for MDCP members prevented reliable assessment of more specific functional status measures from the MDCP module, as well as important service plan fields in the ISP records.
MCQS Relevance	G3; M1
Recommendations	HHSC should review and improve on procedures for obtaining SK-SAI data, as needed, to facilitate the identification and sharing of these data to ensure a sufficient number of MDCP records for future studies. The EQRO recommends additional study of STAR Kids ISP forms for MDCP members, which if cross-referenced with claims data, could be used to validate whether members in MDCP are receiving authorized services.
Follow-up	HHSC worked with the EQRO to establish procedures for transmitting all SK-SAI and SK-ISP data to the EQRO annually. HHSC has contracted with the EQRO to conduct an annual study of STAR Kids SAI/ISP measures through which the EQRO will assess the quality and completeness of data. In addition, HHSC is working with the EQRO to establish methods for validating provision of services authorized on ISPs for STAR Kids MDCP members

Summary	Description
Key Findings	Because of limited access to data sources, this study did not address certain domains in the STAR Kids measurement framework that are relevant to managed care – such as provider network adequacy and grievances and appeals.
Significance	Provider network adequacy is an important factor in availability and access to care. Measures based on grievances and appeals are important for understanding member experience and satisfaction with care, particularly in cases of denied authorizations or services.
MCQS Relevance	G2; M1
Recommendations	HHSC should implement or continue existing efforts to identify and develop measures in domains that were outside the scope of this study, such as provider network adequacy and grievances and appeals.
Follow-up	HHSC continues to work with the EQRO to better understand this area and develop improvement strategies. The EQRO continues to monitor appointment availability, but developing new measures is challenging due to the impact of the pandemic. HHSC is considering the addition of consumer experience data in the STAR Kids MCO report cards.

Overall recommendations

Summary	Description
Key Findings	Potential reductions in access to special therapies, such as physical, occupational, and speech therapy, presented concerns for STAR Kids MCOs during the transition. The pre/post-implementation study subsequently showed decreases in access to special therapies for members in MDCP.
Significance	MDCP members have the greatest need for special therapies and are at risk of negative health and functional outcomes from reduced or interrupted access. Changes to approval processes for special therapies that may have occurred in the transition between fee-for-service and STAR Kids posed serious potential risks for these members.
Recommendations	The EQRO recommends additional study of MCO approval processes for physical, occupational, and speech therapies to understand barriers to access that caregivers may be experiencing, such as low availability of therapy services in specific service areas. To address concerns about the shift to managed care for MDCP members, the EQRO recommends a mixed-methods study involving closed-ended surveys combined with focus groups or qualitative interviews with caregivers and families of MDCP members. This design can elicit the most important services for families and the most common barriers to receiving these services, and then explore the context in which families experience barriers to care to reveal practical solutions for addressing these barriers.
Follow-up	The EQRO designed and will conduct a mixed-methods focus study to better understand barriers to services for MDCP members, including families' experiences with MCO approval of special therapies. The study will use survey data collected as part of the SFY 2020 STAR Kids Biennial Survey to inform the development of focus group protocols and tools, and the EQRO will be conduction focus groups with caregivers of MDCP members in 2021.

Summary	Description
Key Findings	STAR Kids MCO performance on administrative measures showed significant variation in models controlling for other factors. Driscoll performed well in all statistical models, showing higher performance on measures and lower costs. Conversely, Children's Medical Center showed lower performance on measures than the other MCOs.
Significance	Statistically significant differences across MCOs on certain measures suggest that MCO practices play a role in performance.
Recommendations	HHSC should focus on high- and low-performing MCOs. HHSC and STAR Kids MCOs should consider collaborative training sessions with these MCOs to encourage the dissemination of best practices.
Follow-up	The EQRO hosts an annual forum for all MCOs and DMOs. This provides an important opportunity for collaborative training across a wide variety of quality performance topics.

Summary	Description
Key Findings	Some families of low-risk members may be less likely to schedule appointments for the SK-SAI because they are not aware of the need for assessment, are self-sufficient, or are accustomed to the less-involved level of assessment under traditional FFS Medicaid. For high-risk members, such as those in MDCP, some MCOs reported that denials of medical necessity could occur due to the more stringent assessment criteria of the SK-SAI.
Significance	Challenges related to the SK-SAI may vary according to the needs of STAR Kids members. It is important to tailor approaches to assessment to ensure that all members receive a timely assessment, regardless of acuity, to avoid hindering delivery of needed services.
MCQS Relevance	G3; M2
Recommendations	HHSC should prepare for high- and low-risk member assessments. In the STAR Kids MCO Interview Report, the EQRO recommended that MCOs have documented practices for service coordinators to prepare families for MDCP eligibility determinations. For example, service coordinators should inform families about steps they can take if TMHP denies the MCO request for medical necessity status, including their right to a fair hearing. Service coordinators should also help families identify alternative services if they lose their fair hearing. Concerning lower-risk members, MCOs should monitor the participation of members who have less complex needs to encourage engagement with service coordinators and improve the rates and timeliness of completing the SK-SAI (at both initial assessment and reassessment).
Follow-up	HHSC is working with the EQRO to identify ways to encourage MCOs to have documented practices for service coordinators, through PIPs, Quality Improvement activities and disseminating best practices in the Quality Forum.

Summary	Description
Key Findings	The measures feasibility study identified the National Core Indicators-Child Family Survey (NCI-CFS) as a potential source of meaningful LTSS measures for STAR Kids members.
Significance	The NCI-CFS is one of the only validated and reliable sources of caregiver experience and satisfaction with LTSS received by children with chronic illness and disability. This domain of healthcare quality is particularly important to assess in STAR Kids.
MCQS Relevance	G2, G3; M1
Recommendations	The EQRO suggests regular NCI-CFS studies with families of STAR Kids members. The EQRO identified the NCI-CFS as a source of meaningful LTSS measures and recommended that HHSC conduct regular NCI-CFS studies with families of STAR Kids members, stratified by MCO to allow for comparisons.
Follow-up	The EQRO designed a protocol for conducting the NCI-CFS study with families of STAR Kids members that produces sufficient samples at the MCO level to permit reliable comparisons among the MCOs.

Summary	Description
Key Findings	Members in MDCP, who have higher rates of third-party insurance, may show lower utilization and performance because HHSC and the EQRO do not have access to third-party claims data.
Significance	Accurate calculation of administrative measures of access to and QOC measures requires all relevant data sources. Accounting for third-party insurance for STAR Kids members in MDCP, will allow for more meaningful comparison to other Medicaid populations and national benchmarks.
MCQS Relevance	G3; M1
Recommendations	The EQRO suggests HEDIS hybrid studies for MDCP members. Members in MDCP, who have higher rates of third-party insurance, may show lower utilization and performance because HHSC and the EQRO do not have access to third-party claims data. To address this concern, HHSC should consider conducting hybrid studies of HEDIS well-care measures among STAR Kids members enrolled in MDCP to test the extent to which third-party insurance may influence administrative measure findings.
Follow-up	HHSC is working with the EQRO to determine what effects third-party responsibility may have on MCO performance measures.

QTR 1: Provider Directory Data Quality – Key Issues and Recommendations for Best Practices

Summary	Description
Key Findings	The EQRO found incomplete provider records, records that failed USPS validation, and much more commonly a lack of agreement between provider data sources.
Significance	The lack of data standards and of centralized data governance responsibilities creates numerous deficiencies in data quality and alignment. These failures in the system create barriers for members trying to access appropriate care.
MCQS Relevance	G3; M1
Recommendations	HHSC should collaborate with plans and providers to improve the quality and completeness of provider data and improve data accuracy standards. Accurate provider data elements are critical for objective evaluation, rate-setting activities, monitoring network adequacy, and ensuring member access to appropriate providers. The EQRO recommends establishing enforceable data accuracy standards and enhancing the current guidelines for required critical directory elements with a set of rules to standardize address information (such as using USPS standards for address information). In addition, HHSC should establish a standard approach and timeline for monitoring whether plans follow up with inactive providers and whether the plans remove them from provider directories.
Follow-up	HHSC Quality Assurance continues to work with TMHP and internal divisions to address provider data elements and integrity.

QTR 2: New Measures for Managed Long-Term Services and Supports

Summary	Description
Key Findings	No single assessment form in use fully addresses all core Managed Long-Term Services and Supports (MLTSS) assessment elements. No single care planning form in use fully addresses all core MLTSS care planning elements Certain core and supplemental elements are not present or sufficiently addressed, in any form.
Significance	Complete information on MLTSS forms is essential for accurate quality measurement of MLTSS.
MCQS Relevance	G3; M1
Recommendations	HHSC should ensure that the Medical Necessity Level of Care (MN-LOC) form includes fields to collect: (1) Home safety risk assessment; (2) Family and friend caregiver names, availability, and contact information; (3) Member's living arrangement; and (4) List of the member's current providers. Additionally, HHSC could revise the MN-LOC form to collect supplemental assessment elements such as information on social risk resources and social support. HHSC should consider modifying the STAR+PLUS HCBS Program ISP form to collect the frequency at which members receive authorized LTSS and expanding the use of this form to include other STAR+PLUS members who receive LTSS but are not in the STAR+PLUS HCBS program. In addition, HHSC should consider more extensive revisions to the ISP form to collect other core elements that are missing from the form, including: individualized member goals; plans of care for medical needs, functional needs, and cognitive impairment; plan for care manager follow-up; emergency plan; and involvement of family or friend caregivers in care planning. HHSC should add indicators or check boxes that care managers can use to specify when a member does not have a need, condition, or circumstance related to the measure element. This will ensure that forms meet the requirements for documenting "negative findings."
Follow-up	HHSC is working with Policy & Program and Utilization Review to update the appropriate LTSS forms so that all required information will be captured. The LTSS Forms workgroup is committed to meeting all EQRO recommendations from the QTR.

Summary	Description
Key Findings	The EQRO found that evaluators can use certain combinations of the state and STAR+PLUS MCO forms to collect most of the core elements and many of the supplemental elements needed to calculate the new MLTSS measures. However, MCOs that utilize national data collection platforms noted that standardized forms developed by the state would be challenging to implement.
Significance	Substantial deficits remain in the forms that can result in missing data elements required for LTSS HEDIS measure calculation. Finding a comprehensive solution will require understanding how MCOs currently integrate and use care plan forms.
MCQS Relevance	G3; M1
Recommendations	For MCOs that use national data systems, HHSC should conduct further studies to understand the challenges these MCOs face in integrating state-specific forms.
Follow-up	HHSC is working with Policy & Program to modify the STAR+PLUS MCO forms (1700 Forms) to ensure that they capture all the necessary data elements needed to calculate the MLTSS measures recommended by the EQRO.

Summary	Description
Key Findings	All MCOs have the infrastructure needed to transmit case management records electronically, but face challenges to regular use of electronic portals, including low rates of portal use by providers.
Significance	Reliable and timely transmission of care plans to PCPs is necessary for compliance on the LTSS Shared Care Plan with PCPs measure.
Recommendations	The EQRO recommends electronic transmission as the preferred mode for MCOs to share care plans. To facilitate this, HHSC and STAR+PLUS MCOs should consider provider education and incentives to encourage use of electronic portals by PCPs.
Follow-up	HHSC encourages MCO usage of provider portals when overseeing corrective action plans and other initiatives. HHSC will look for other methods to encourage use of electronic portals.

QTR 3: Pregnancy Risk, Service Management, and Delivery Outcomes among Pregnant Women in the Texas STAR Medicaid Managed Care Program

Summary	Description
Key Findings	Adding the ICD-10 codes for the supervision of a high-risk pregnancy to the present HHSC criteria for identifying high-risk pregnancies may help capture more women at risk for poor pregnancy outcomes.
Significance	Identifying at-risk and complex pregnancies allows for earlier interventions that could prevent poor outcomes.
Recommendations	The EQRO recommends including the ICD-10 codes for the supervision of high-risk pregnancy in the HHSC criteria for identifying high-risk pregnancy.
Follow-up	In response to state legislation, HHSC surveyed MCOs to capture current screening, outreach, care coordination, and service management efforts for high-risk pregnancies. HHSC will encourage MCOs to use the risk assessment tool, to be developed by DSHS in accordance with SB 748, to standardize the process of identifying pregnant members who are at increased risk.

Summary	Description
Key Findings	Significant variation exists in the way that different MCOs identify a high-risk pregnancy.
Significance	Determining the quality or effectiveness of care is difficult when information about risk and intervention is limited.
MCQS Relevance	G3; M1
Recommendations	HHSC should work with the MCOs to gain a better understanding of how each MCO identifies women with high-risk pregnancies for MSHCN inclusion. Then, HHSC should consider using this information to refine and standardize the criteria for all MCOs to use for identifying high-risk pregnancy. HHSC should work with the MCOs to identify barriers to implementing service plans for high-risk pregnancies and develop successful approaches to overcome these barriers. HHSC should consider additional in-depth studies to identify specific ways that service plans affect the timeliness, quality, and cost of care that MSHCN receive during pregnancy.
Follow-up	HHSC is pursuing an enhanced prenatal and postpartum care coordination requirement provided to high-risk pregnant women in STAR and CHIP. HHSC participated with the EQRO as a partner in a CMS Medicaid Innovation Accelerator Program on maternal mortality and severe maternal morbidity.

QTR 4: Social Determinants of Health: Asthma, Type 2 Diabetes, and ADHD among Children in Texas Medicaid

Summary	Description
Key Findings	The EQRO found differences in the prevalence of asthma, type 2 diabetes, and attention-deficit hyperactivity disorder (ADHD) by socioeconomic vulnerability status.
Significance	Interventions could be more successful when they account for SDoH.
Recommendations	MCOs should ensure that their SDoH screening tools include questions related to economic stability, education, food security, health and clinical care, neighborhood and physical environment, and social and community context including perceived racial discrimination, to develop interventions targeting vulnerable sociodemographic groups. MCOs can address these topics using standardized screening tools, such as the Protocol for Responding to and Assessing Patients' Assets, Risk, and Experiences (NACHC, 2020). HHSC should consider incentivizing the implementation of SDoH focused interventions.
Follow-up	The EQRO, in collaboration with partners at the University of Texas, School of Public Health, conducted a qualitative study to understand what Texas Medicaid MCOs are presently collecting regarding SDoH, and what actions they are taking to address SDoH. The EQRO reported on this study as a QTR for SFY 2020.

Summary	Description
Key Findings	Social vulnerability factors such as employment, income, and vehicle access can directly affect whether a provider network can meet the needs of members.
Significance	When access to care is limited, management of controllable conditions like asthma, type 2 diabetes, and ADHD, may be ineffective.
Recommendations	HHSC and the MCOs should analyze geographic network adequacy separately for each sociodemographic group to better address geographic disparities and ensure that they meet Medicaid contract standards for all members.
Follow-up	HHSC continues to monitor geographic disparities, and in particular investigating the interaction with care during the pandemic.

Summary	Description
Key Findings	The prevalence of asthma, type 2 diabetes, and ADHD were higher in Nueces and Hidalgo.
Significance	Differences may be due to social vulnerability factors, or other demographic differences.
Recommendations	The EQRO recommends conducting further studies in Nueces and Hidalgo to identify the factors that are contributing to the higher rates of asthma, type 2 diabetes, and ADHD in these SAs.
Follow-up	Although constraints related to the pandemic prevented specific studies in this area, HHSC remains committed to following-up on disparities in these SAs.

Summary	Description
Key Findings	Addressing SDoH is one of the four overarching goals listed in Healthy People 2020 (Breen, 2017).
Significance	The conditions of daily life that constitute SDoH are the major driving factors, outside of the health system, that influence differences in injury, illness, and early death.
Recommendations	MCOs should collaborate with community partners (e.g., local libraries, HeadStart) to promote health literacy through health education programs (Jacobs et al., 2016). Two promising interventions are: (a) eHealth educational interventions tailored to people with low health and technology literacy skills (Han et al., 2017); and (b) community-based educational interventions led by community health workers to help improve health literacy.
Follow-up	HHSC encourages and will continue to encourage MCOs to collaborate with community partners for health literacy and health education programs through use of PIPs and other quality improvement programs.

Summary	Description
Key Findings	The EQRO saw an increase in members having unknown/other race-ethnicity in enrollment data across multiple studies.
Significance	Without understanding the makeup of this population, demographic analyses are challenging.
Recommendations	Children in the unknown/other category for race-ethnicity now comprise the largest group after Hispanics, which warrants further investigation to help develop and implement successful demographic-specific interventions for this group.
Follow-up	HHSC will continue to monitor the number of unknown/other race-ethnicity, dissecting which populations and which programs are most effected and will work with the EQRO and MCOs on identifying potential solutions.

Issue Brief 1: Texas Medicaid: Brief Analysis of Adult Cirrhosis, Hepatitis C Virus, and Liver Cancer

Summary	Description
Key Findings	In 2017, the overall prevalence of hepatitis C (Hep C) in Texas Medicaid among members aged 45 to 64 years was 5.9 percent, and the overall prevalence of cirrhosis in the same group was 3.3 percent.
Significance	As of 2017, chronic liver disease was the 11th leading cause of death in the United States and rates of chronic liver disease and cirrhosis are expected to continue rising (Kochanek et al., 2019).
Recommendations	Efforts to improve public health outcomes through early diagnosis should focus on improving access to care for border populations and increasing screening for Hep C among Hispanic members, who may be under-diagnosed for Hep C.
Follow-up	HHSC will continue to work with the EQRO to investigating the prevalence of Hep C and hepatocellular carcinoma (HCC) in border populations. However, given the pandemic response, other priorities may be given precedence

Summary	Description
Key Findings	The EQRO found differences in prevalence of liver disease by race/ethnicity and geographic area.
Significance	Texas has one of the nation's highest rates of liver cancer mortality (Asrani et al., 2013; CDC, 2020b), in part because the Hispanic adults of South Texas have the highest incidence of HCC in the country (Islami et al., 2017).
Recommendations	The EQRO recommends further investigation into the prevalence and the populations with Hep C and HCC, particularly in southern Texas, and Non-Hispanic black members in the Hidalgo SA.
Follow-up	HHSC will continue to work with the EQRO to investigating the prevalence of Hep C and HCC. However, given the pandemic response, other priorities may be given precedence

Summary	Description
Key Findings	The EQRO saw an increase in members having unknown/other race-ethnicity in enrollment data across multiple studies.
Significance	Without understanding the makeup of this population, demographic analyses are challenging.
Recommendations	The EQRO saw an increase in members having unknown/other race-ethnicity in enrollment data across multiple studies. Without understanding the makeup of this population, demographic analyses are challenging. HHSC should investigate this trend further.
Follow-up	HHSC will continue to work with the EQRO to investigating the prevalence of Hep C and HCC in border populations. However, given the pandemic response, other priorities may be given precedence

Issue Brief 2: Trends in Emergency Department Visits for Non-Traumatic Dental Conditions in Texas Medicaid and the Children's Health Insurance Program, 2013-2017

Summary	Description
Key Findings	About one percent of pediatric ED visits related to Non-Traumatic Dental Conditions (NTDCs). The rate was higher for members aged five years and younger compared to other age groups. During the years 2013 to 2017, Medicaid and CHIP paid approximately $44 million for ED visits for NTDCs.
Significance	Improvements that address preventive dental health – including member education and access to preventive dental services – can help reduce the incidence and costs associated with ED visits for NTDCs.
Recommendations	MCOS and DMOs should focus efforts on educating Medicaid and CHIP members about preventive oral healthcare and the resources for dental treatment available in their communities. HHSC should work with the DMOs to improve access to preventive dental services, which may increase rates of early diagnosis and dental treatment and reduce the number of ED visits related to NTDCs.
Follow-up	DMOs participating in Texas Medicaid and CHIP are approximately halfway through a two-part, four-year implementation to partner with MCOs and/or providers to reduce the number of PPVs for dental-related reasons. Over the past two years, the importance of early detection and treatment, along with best practices, have been presented at the annual Quality Forum. Quality Assurance plans to work with DMOs and MCOs through the Quarterly Quality Meeting and requests for comment to identify the best information to share between medical and dental plans to improve quality of care and reduce NTDCs. Quality Assurance will examine several options for data sharing which may include contract changes, new reporting, grants, or other data sharing initiatives.

Summary	Description
Key Findings	Among members aged five years and younger, approximately 45 percent of ED visits for NTDCs were due to complications of dental caries. The proportion of visits due to complications of dental caries increased with age, reaching 65 percent of visits among members aged 6 to 12 years.
Significance	Dental caries is a potentially preventable disease, and more appropriately treated in the dental office than in the ED.
Recommendations	The EQRO suggests continuing to monitor the number of ED visits related to potentially preventable dental conditions. The diagnosis codes used in this study align with specifications for the DQA measure of ED visits for dental caries in children (DQA, 2019), which the EQRO reports for Texas Medicaid and CHIP annually. Texas approved the DQA measure for inclusion in the 2020 dental P4Q program. Future studies may use this measure to examine the association of ED visits for NTDCs with the frequency of regular preventive dental visits.
Follow-up	The DQA ED Visit measure will be a bonus pool measure for the 2021 P4Q programs

Issue Brief 3: Accounting for Health Teleservices in Measures of Network Adequacy

Summary	Description
Key Findings	Rural areas showed the greatest increase in teleservice utilization between 2017 and 2018.
Significance	Despite increases, teleservice utilization is less than one percent that of outpatient visits. Expanding the positive impact of teleservices requires understanding the care patterns that drive teleservice use or disuse.
Recommendations	The EQRO recommends further studies to understand how MCOs are expanding teleservice delivery in areas like El Paso, Tarrant, and Bexar, which had the highest increase in utilization rates. HHSC should work with the EQRO to develop a way to calculate teleservice provider-to-enrollee ratios at the SA level, and better measure teleservices utilization.
Follow-up	HHSC is working with the EQRO to develop a study for SFY 2021 to understand changes in Teleservice utilization. The study will address the impact of the pandemic and geographic differences across rural and urban areas and between SA.

Summary	Description
Key Findings	The EQRO has identified measure concepts from the National Quality Framework model that apply to teleservices.
Significance	The EQRO can gather data on Texas Medicaid member experience with teleservice access and efficiency by incorporating these measure concepts into new, teleservice specific member surveys. Similarly, the EQRO could add specific questions about each MCO's teleservice programs to the EQRO's existing AI. Collectively, these methods will provide key insights into teleservice use across Texas, enabling HHSC, MCOs, and other stakeholders to make strategic changes that improve access to care in Texas Medicaid.
Recommendations	HHSC should consider a flexible approach to measuring network adequacy that incorporates a combination of qualitative and quantitative standards. At minimum, Texas should continue to allow MCOs to use telemedicine as a mitigating factor in any network adequacy corrective actions.
Follow-up	Through the Appointment Availability initiative, beginning state fiscal year 2021, telehealth will be assessed to obtain further information on accessibility of services.

MCO Report Cards

Summary	Description
Recommendations	None

Appointment Availability Studies

Summary	Description
Key Findings	In all three SFY 2018 sub-studies, the percentage of calls excluded because the provider did not answer after three attempts or was otherwise not reachable (e.g., wrong number), increased over prior years.
Significance	Members depend on the MCO provider directories to reach needed resources. Poor quality directories are a barrier to receiving care.
MCQS Relevance	G2; M1
Recommendations	The EQRO recommends that HHSC continue implementing strategies put into place to improve the quality of directory information, including maintaining a dialog with the MCOs about the barriers to updating provider information and the importance of timely updates to provider information. The decrease in the number of unreachable providers and providers with incorrect directory information between the SFY 2016 study of behavioral healthcare and the SFY 2018 study of behavioral healthcare is a positive change.
Follow-up	HHSC Quality Assurance continues to work with the Network Adequacy Workgroup that works with TMHP and other internal divisions to address provider data elements and integrity. HHSC is working on a system-wide solution.

Summary	Description
Key Findings	Providers and staff gave inconsistent responses when the EQRO made multiple calls to the same office.
Significance	Inconsistent information causes confusion for members and inaccurate information can create barriers to care.
MCQS Relevance	G2; M1
Recommendations	Many of the plans have clear guidelines for handling member calls that come directly to the MCO. The EQRO recommends that HHSC encourage plans to develop similar call guidelines and training for their network provider offices to help reduce the inconsistency in call responses and potential confusion about provider availability.
Follow-up	HHSC provides presentations on the result to the MCOs. For plans that do not meet standards, corrective actions and liquidated damages are assessed, which provides a forum for MCOs to educate the provider-base on the requirements.

Summary	Description
Key Findings	Between 29 and 42 percent of providers, by program, offered weekend appointments.
Significance	After-hours services improve access to care. The number of providers offering these services suggests that wider adoption of these models is possible.
Recommendations	While not required, offering weekend appointments and affiliate after-hours can help improve access to care for members. The EQRO recommends that MCOs work with their providers to encourage the use of affiliate after-hours and weekend appointments to help improve the availability of care for members.
Follow-up	HHSC provides the results of the studies to the MCOs and highlight the need for increasing after-hour and weekend appointments.

Primary Care Provider Specialty Referral Study

Summary	Description
Recommendations	None

STAR Health Psychiatry Directory Study

Summary	Description
Key Findings	Out of the 654 providers in the MCO directory, the EQRO could only verify 112 with valid directory information and confirmed participation in STAR Health. Although providers responding to the follow-up survey reported no problems when asked about updating provider information, only 10 providers responded.
Significance	Over 80 percent of the providers in the MCO directory had flawed directory information. Members depend on the MCO provider directory to reach needed resources. Poor quality directories are a barrier to receiving care.
MCQS Relevance	G2; M1
Recommendations	The EQRO recommends that HHSC work with Superior on targeted outreach initiatives to ensure providers know how and when to update their directory information. The EQRO also recommends that HHSC examine the processes used by Superior and other MCOs for updating provider information, identify the most effective strategies for maintaining timely and accurate directory information, and encourage Superior and the other MCOs to implement best practices for improving the quality of provider directory information.
Follow-up	In addition to presenting best practices at the Annual Quality Forum, Quality Assurance will work with other HHSC departments to find ways to improve provider data for all MCOs.

Non-Emergency Medical Transportation (NEMT) Client Satisfaction Study

Summary	Description
Key Findings	Only two Managed Transportation Organizations met the 95 percent benchmark for member satisfaction.
Significance	Lack of transportation can be a barrier to accessing healthcare, particularly for elderly, disabled, or low-income individuals. Federal Medicaid regulations require provision of transportation for certain health services.
Recommendations	HHSC should consider adding questions to the SFY 2020 NEMT surveys that help assess stakeholder priorities for NEMT services. These items could include questions about how members use NEMT services, questions about the challenges to timely service delivery for transportation providers, and questions about the availability of services for special needs populations.
Follow-up	HHSC will consider incorporating questions related to stakeholder priorities for NEMT services in future member experience surveys. NEMT services will be carved in to managed care in 2021, which could significantly affect survey results. HHSC will wait until the carve in process is complete before changing the survey.

Recommendations Made in SFY 2020

Protocol 1: Validation of PIPs

Summary	Description
Key Findings	Opportunities for improvement in the PIPs arose from not addressing previous EQRO recommendations and insufficient details of modifications made to the PIPs.
Significance	The HHSC strategy to develop and implement targeted initiatives encouraging MCOs to adopt evidence-based clinical and administrative practices to improve the quality of care for members is evaluated through the PIP validation process. When MCO reporting of PIP information is incomplete, the EQRO is hindered in completing this mandatory activity
MCQS Relevance	G3; M1
Recommendations	The MCOs should ensure that they comply with all previous recommendations. The MCOs should provide sufficient details for all modifications to their PIPs.

Protocol 2: Validation of Performance Measures Reported by MCOs

Summary	Description
Recommendations	None

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

Administrative Interviews (AIs)

Summary	Description
Key Findings	MCOs failed to update documentation related to CMS regulations.
Significance	Texas may fail to meet federal standards if MCOs fail to keep up with regulations.
Recommendations	The MCOs and DMOs should monitor state and federal regulations to ensure compliance.

Summary	Description
Key Findings	Most MCOs refer to external community resources to address member SDoH needs, but several provided examples of internally funded interventions.
Significance	MCOs can benefit from establishing best practices for the collection and evaluation of member SDoH data, and using the information to improve interventions.
Recommendations	MCOs and DMOs should systemically collect member SDoH data to address needs that may impact health and well-being. MCOs and DMOs should consider evaluating the impact of SDoH-related interventions and referrals to community resources on members' health and well-being. MCOs and DMOs are encouraged to share SDoH related interventions and best practices with other entities, including HHSC, to further improve care coordination and the health outcomes for Texas Medicaid and CHIP managed care members.

Evaluation of QAPIs

Summary	Description
Key Findings	Most MCOs and MMPs did not fully incorporate the previous year's recommendations, which resulted in a 4.2 percentage point decrease in the overall score for this activity.
Significance	QAPIs are an important component of monitoring program integrity and HHSC strategy to develop and implement targeted initiatives to encourage MCOs to adopt evidence-based clinical and administrative practices for improving the quality of care for members. Each MCO should be striving to achieve improvement in its structure and processes and utilize strategies that aim for continuous quality improvement.
MCQS Relevance	G3; M1
Recommendations	The EQRO recommends that MCOs, DMOs, and MMPs incorporate the previous year's recommendations and that HHSC consider corrective action plans for those that consistently do not incorporate the EQRO's recommendations.

Protocol 4: Validation of Network Adequacy

Appointment Availability Studies

Summary	Description
Key Findings	Inaccuracies in provider contact information continue to create challenges in reaching providers. While the percentage of unreachable providers decreased in the 2020 Vision and Prenatal sub-studies relative to 2018, the percentage of unreachable primary care providers increased in 2020. Furthermore, over 90 percent of prenatal calls to providers in the BCBSTX directory resulted in wrong number/unreachable calls.
Significance	Members depend on the MCO provider directories to reach needed resources. Poor quality directories are a barrier to receiving care.
MCQS Relevance	G2; M1
Recommendations	HHSC should continue current efforts to work with stakeholders, including the enrollment broker, TMHP, providers, and the MCOs, to improve provider data accuracy. HHSC should also encourage the MCOs to carefully examine the member-facing directory information they provide for the Appointment Availability Study.

Summary	Description
Key Findings	The percentage of providers contacted from the STAR Health directory that said they did not accept Medicaid increased from three percent in 2018 to 11.8 percent in 2020.
Significance	The providers listed in the member-facing directories should be an accurate representation of the providers willing to accept Medicaid clients. Inaccurate information about provider availability confuses members, limits access to care, and can reduce member satisfaction.
MCQS Relevance	G2; M1
Recommendations	Superior should continue to work with STAR Health providers and provider office staff to improve the consistency of responses about provider availability and Medicaid acceptance for vision appointments.

Summary	Description
Key Findings	In 2020, the percentage of compliant vision appointments decreased in CHIP, STAR, STAR+PLUS, and STAR Kids programs relative to 2018.
Significance	Timely and appropriate vision screenings and eye exams can help detect these eye diseases while still treatable, ultimately stopping or avoiding vision loss.
Recommendations	HHSC should consider conducting a study that examines network adequacy for vision care in Texas Medicaid and the barriers that Texas Medicaid members face in accessing vision care. HHSC should consider a study that uses Texas Medicaid and CHIP member experience data to identify telemedicine barriers and gaps in health service access and use this information to target strategies for improving network adequacy. To better understand the availability of telehealth services for Texas Medicaid members, the EQRO recommends that HHSC consider including a standard question on the availability of different types of teleservices in all four 2021 Appointment Availability Studies.

Texas Medicaid Non-Emergency Medical Transportation (NEMT) Services Study

Summary	Description
Key Findings	Overall, 79 percent of respondents said it was "easy" or "very easy" to find transportation to the doctor or dentist. Over half of all respondents said they never missed a medical or dental appointment because of lack of transportation. Overall, demand response transportation services and meals and lodging were the most frequently used services. Advanced funds were the least frequently utilized. A substantial percentage of members (75.6 percent) said they did not use public mass transit in the past 12 months. Overall, 89.1 percent of all respondents said they were "satisfied" or "very satisfied" with the transportation services they had received from Medicaid in the past 12 months.
Significance	Federal Medicaid regulations require transportation for certain health services. Lack of transportation can be a barrier to accessing healthcare, particularly for elderly, disabled, or low-income individuals. Understanding NEMT utilization patterns and member experience with Medicaid transportation services can help the MTP tailor the programs to different members' needs
MCQS Relevance	G2
Recommendations	The NEMT survey results suggest that member experience is generally positive, but it does not provide information on how the services could be improved to meet specific member needs. HHSC should consider adding questions to later iterations of the client satisfaction surveys to assess member priorities for NEMT services. These items could include questions about how members use NEMT services and the availability of services for special needs populations. A clear understanding of member priorities for NEMT services provides an important context for interpreting variation in general member satisfaction levels and can help the MTP tailor the programs to better suit members

Provider Referral Study

Summary	Description
Key Findings	Specialist responses on the 2020 referral survey share some broad similarities with PCP responses on prior versions of the survey. Psychiatry is consistently identified as one of the most difficult specialties for referral, although specialists identified a shorter wait time for an appointment (one or two weeks) compared to PCPs (one month or more). Specialists and PCPs also identified cardiology as one of the easiest specialties for a referral. Specialists most frequently identified prior authorization for services, limited appointment availability, and limited specialist networks as the primary barriers to care.
Significance	Behavioral healthcare is an essential component of overall health and lack of access to health services is an important contributor to the underuse of behavioral health services. Addressing barriers to accessing behavioral healthcare is important for improving the quality of member care and member satisfaction with care.
MCQS Relevance	G2
Recommendations	MCOs should continue efforts to identify and reduce barriers to accessing psychiatric services and behavioral health care for Medicaid and CHIP members. HHSC should consider a study that identifies the challenges that specialists in Texas Medicaid face with the prior authorization process and examine strategies that other state Medicaid programs use to address barriers to care. Given the increasing importance of teleservices, HHSC should continue to ask about teleservices on future provider surveys and may want to consider adding questions about the actions the providers are taking to protect health information for Medicaid and CHIP members.

Protocol 5: Validation of Encounter Data Provided by MCOs

Analysis of Encounter Data for Accuracy and Completeness

Summary	Description
Key Findings	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 more than 10 percent of the time in some cases. One cause could be a high number of maternity stays. Hospitals will code significant complications of delivery in the primary diagnosis, although the admission was for delivery.
Significance	Valid coding of POA for reported diagnoses is critical to the EQRO's efforts to calculate the 3M PPC measure, which is important for monitoring the quality of care that MCOs provide for members and incentivizing MCOs to improve performance.
MCQS Relevance	G3; M1
Recommendations	MCOs should work with their network hospitals to improve POA reporting.

Summary	Description
Key Findings	In STAR and CHIP, less than 75 percent of professional encounters included both a rendering NPI for an individual and a taxonomy. This rate was less than 50 percent for STAR Health, less than 30 percent for STAR Kids, and less than 20 percent for STAR+PLUS. Many STAR Kids and STAR+PLUS services can be provided by caregivers that do not have NPI, but the EQRO has no clear way to identify these encounters, and without alternative identifiers, the lack of NPI still creates an information deficit on these encounters.
Significance	Adequate provider identification is critical to the EQRO's efforts to calculate QOC measures, conduct provider surveys, and obtain medical records for validating encounter data.
MCQS Relevance	G3; M1
Recommendations	HHSC should continue to investigate provider identification deficiencies, including identification of providers not eligible for NPI. HHSC should work with the EQRO, TMHP, and the MCOs/DMOs to improve the system for monitoring monthly encounters submissions for anomalies and communicating about issues or discrepancies.

Summary	Description
Key Findings	The EQRO added evaluation of the risk indicator to the data certification process for SFY 2017 and found that caries assessment codes were missing in up to four percent of dental exam encounters across programs and DMOs. This measure showed improvement in SFY 2018, but in SFY 2019, appropriate codes were still missing more than two percent of the time.
Significance	CRA are used in calculating dental P4Q measures. Increasing the accuracy and reliability of CRA coding is important for monitoring the integrity of the dental plans and will help HHSC incentivize MCOs to improve the quality of member care as outlined in the Managed Care Quality Improvement Strategy.
MCQS Relevance	G3; M1
Recommendations	DMOs should promote CRA coding with provider outreach in addition to denial of claims.

Review of Medical Records for Consistency with Encounter Data

Summary	Description
Key Findings	Inaccuracies in provider addresses resulted in lower return rates and insufficient sample sizes for some MCOs.
Significance	Low response rates reduce the reliability of medical record review data. Reliable medical record review data is important for monitoring program integrity and will help HHSC meet its goals to reduce payments for low-quality care as outlined in the Managed Care Quality Improvement Strategy.
MCQS Relevance	G3; M1
Recommendations	HHSC should continue efforts to improve provider address directories to improve the return rate for requested records.

Summary	Description
Key Findings	The overall match rates were high across review categories and programs, except for STAR+PLUS. The complex healthcare needs and types of services provided for STAR+PLUS members may contribute to increased challenges in the documentation and subsequent coding for each visit. However, the exact reason for low match rates in the STAR+PLUS program remains unknown.
Significance	The encounter data rates must match the medical record for HHSC and the EQRO to accurately assess the quality of care and monitor program integrity and help HHSC meet its goals for transitioning to a pay-for-performance model and reducing payments for low-quality care as outlined in the Managed Care Quality Improvement Strategy.
MCQS Relevance	G1, G3; M1, M3
Recommendations	HHSC should consider additional studies to identify factors that influence match rates across programs and MCOs, specifically examining the case complexity in STAR+PLUS.

Protocol 6: Administration of Quality of Care Surveys

Summary	Description
Key Findings	The STAR Kids 18+ survey and the STAR Health 18+ survey had low response rates because many eligible members could not be reached or had disabilities that otherwise prevented them from answering the survey questions.
Significance	Low response rates on the CAHPS surveys reduce the representativeness and reliability of information about member's experiences. Representative and reliable member experience data is important for meeting HHSC's goal to improve member satisfaction as outlined in the Managed Care Quality Improvement Strategy.
MCQS Relevance	G2; M1
Recommendations	HHSC should consider allowing proxies in future versions of the STAR Kids 18+ and STAR Health 18+ surveys to ensure more participation in these challenged populations. Without an increase in the numbers of completed surveys, the results will have extremely limited value.

Protocol 7: Calculation of Performance Measures

Summary	Description
Key Findings	In 2019, Hispanic Medicaid members had more outpatient visits, fewer ED visits, and fewer hospitalizations than NHW or NHB members. Mental health utilization was highest for NHW members.
Significance	Understanding the factors that contribute to racial and ethnic variation in health outcomes is integral to developing and implementing successful initiatives to ensure member access to high quality care and develop pay-for-performance models with measurable effects on health outcomes.
MCQS Relevance	G1; M2, M3
Recommendations	HHSC should continue to explore quality measure results across demographic and other member population groups to more clearly interpret results and better direct efforts to improve care for all Texas Medicaid and CHIP members.

Summary	Description
Key Findings	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. As in 2018, the PPC rate for FFS members was more than 15. This group includes undocumented immigrants and others who may require emergency Medicaid services, but further investigation is needed to determine why this population has more PPCs.
Significance	QOC measures rates for services may be higher when overall utilization is higher. PPEs are costly and represent deficiencies in care. Understanding the relationships between care patterns and PPEs for specific conditions is important for implementing evidence-based approaches for incentivizing MCOs to improve the quality of care for members.
MCQS Relevance	G1; M3
Recommendations	The EQRO suggests investigating relationships between PPEs for specific conditions and patterns of preventive care for those conditions

Summary	Description
Key Findings	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.
Significance	HHSC can use tools like the Performance Indicator Dashboard to identify areas of consistently high performance and improvement areas across or among MCOs. These tools are important for monitoring and communicating information about program integrity and MCO performance and helping HHSC achieve the goals outlined in the Quality Improvement Strategy.
MCQS Relevance	G1; M1, M3
Recommendations	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.

Summary	Description
Key Findings	Although bipolar disorders ranked fifth, if considered together with the sixth-ranked reason for PPAs and schizophrenia (ranked 11th), these serious mental illnesses would rank first, accounting for almost 14 percent of total PPA weight and total costs of nearly $45 million in 2019.
Significance	Understanding the factors that contribute to variation in behavioral health outcomes is integral to developing and implementing successful initiatives to ensure member access to high quality care and develop pay-for-performance models with measurable effects on health outcomes.
MCQS Relevance	G1; M2, M3
Recommendations	HHSC should continue to prioritize behavioral health integration (BHI) and work with the EQRO to define useful and reliable QOC measures for these special populations.

Summary	Description
Key Findings	SMM rates were consistently higher in STAR than in CHIP Perinatal between 2016-2019, most notably in cases of (pre)eclampsia. Overall rates have trended down over this period. Over 50 thousand C-sections were performed in deliveries without complications. Compared to uncomplicated deliveries without C-section, these uncomplicated C-section deliveries incurred additional costs totaling over $100 million. As reported last year, performance on QOC measures for chronic conditions was generally worse for pregnant women, although utilization was generally higher.
Significance	Better birth outcomes require attention to comprehensive care during pregnancy.
MCQS Relevance	G3; M3
Recommendations	HHSC should continue to prioritize maternal healthcare and work with the EQRO to define useful and reliable QOC measures for these special populations.

Protocol 9: Conducting Focused Studies of Health Care Quality

Focus Study: SDoH and Their Impact on Health Care Quality Measures in Texas Medicaid and CHIP Populations

Summary	Description
Key Findings	For each study population, the model's ability to accurately predict whether an individual would meet the numerator performance criteria for a quality measure increased when the model included county-level SDoH variables compared to models that only included race/ethnicity. The number of SDoH variables with significant associations varied by study population and per quality measure, but not every SDoH variable contributed equally to the observed impact of SDoH on quality measure performance.
Significance	SDoH are important drivers for disparities in health outcomes among Medicaid and CHIP members. Integrating SDoH info efforts to monitor program integrity and incentivize MCOs to improve performance requires a systematic approach for collecting and utilizing SDoH data to improve the quality of care.
MCQS Relevance	M1
Recommendations	HHSC should consider collecting standardized member-level SDoH data. This information could be collected during Medicaid and CHIP enrollment, from the claims data (via diagnostic codes related to SDoH (e.g., Z codes)), or as part of the biennial member surveys.

Summary	Description
Key Findings	The Rate of Adult Smoking was significantly associated with higher ED utilization among STAR+PLUS adults, higher preventable hospitalization among HCBS Waiver adults, and higher acute inpatient admissions for both STAR+PLUS and HCBS Waiver adults. Among STAR+PLUS and HCBS Waiver populations, age and gender contributed significantly to predicting quality measure results. In STAR+PLUS, the Breast Cancer Screening measure showed the largest increase in concordance rate associated with the addition of SDoH variables. The increase in concordance indicates that the predictive ability of the model for the Breast Cancer Screening measure increased with the addition of SDoH variables.
Significance	SDoH indicators need to be chosen carefully to ensure measurement validity, reliability, and suitability for meeting HHSC priorities for improving the quality of member care.
MCQS Relevance	M1
Recommendations	HHSC should use the focus study findings to prioritize interventions and strategies that target important SDoH for Medicaid members – emphasizing SDoH categories with more influence on outcomes (e.g., social and economic environment variables) or individual SDoH variables associated with multiple performance measures. For example, since the *Rate of Adult Smoking* was significantly associated with higher ED utilization among STAR+PLUS adults, higher preventable hospitalization among HCBS Waiver adults, and higher acute inpatient admissions for both STAR+PLUS and HCBS Waiver adults, a possible strategy could focus on designing and developing population-specific smoking cessation interventions, campaigns, and peer support groups.

QTR 1: Spending, Service Delivery, and Follow-up for STAR+PLUS Members with SMI

Summary	Description
Key Findings	LMHA-involved enrollees had higher rates of 7-day and 30-day follow-up after a mental health (MH)-related ED visit, but differences in 30-day readmission rates among LMHA-involved enrollees varied by enrollee SMI diagnosis. Seven-day, 30-day, and overall follow-up rates were consistent across MCOs for members with LMHA involvement.
Significance	Appropriate follow-up care helps improve health outcomes and prevent readmissions and is an important aspect of HHSC's quality improvement priority to provide the right care at the right place and the right time and ensure people receive timely services in the least intensive or restrictive setting.
MCQS Relevance	G2; M1
Recommendations	STAR+PLUS MCOs should track health indicators, service use, and QOC measures longitudinally for LMHA and non-LMHA service recipients. STAR+PLUS MCOs should also evaluate the use of the receipt of follow-up care within seven days following an MH-related ED visit as a tool for monitoring longitudinal outcomes related to health service use and mental health indicators.

Summary	Description
Key Findings	The analyses identified high rates of SMI-related and all-cause readmissions among STAR+PLUS SMI-diagnosed Medicaid enrollees, particularly among individuals diagnosed with psychotic disorders. The 30-day readmission rates varied substantially among MCOs. Differences in 30-day readmissions also appeared to vary among the SMI diagnosis groups by LMHA service utilization and readmission type. Measures of 7-day and 30-day follow-up care after SMI-related inpatient admissions did not show substantial differences between LMHA- and non-LMHA-involved STAR+PLUS enrollees overall, but they did vary across MCOs. MCOs showed varying degrees of utilization of LMHAs as service providers for their SMI-diagnosed enrollees. Furthermore, follow-up rates after SMI-related inpatient admissions were below the national rates reported by NCQA for Medicaid HMO enrollees.
Significance	Understanding the factors that contribute to variation in behavioral health outcomes is integral to developing and implementing successful initiatives for ensuring member access to high-quality care.
MCQS Relevance	G2; M1
Recommendations	HHSC should conduct further studies to determine how MCO practice variation relates to differences among MCOs on the 7-day and 30-day follow-up care indicators. HHSC should also review the availability of LMHAs, both geographically and in terms of staffing, to determine how these contribute to differences in LMHA use across MCOs and assess the LMHAs' capacity to accommodate greater utilization by MCOs.

Summary	Description
Key Findings	Analysis of healthcare costs for SMI-diagnosed STAR+PLUS enrollees who received outpatient care through an LMHA indicated they had much lower estimated per member-year total costs than enrollees who received no services through any LMHA. Pharmacy costs were also higher among enrollees without LMHA involvement, although the difference in costs was smaller.
Significance	Understanding the factors contributing to variation in behavioral health costs is integral to developing and implementing successful initiatives for developing pay-for-performance models with measurable effects on health outcomes.
MCQS Relevance	G2; M1
Recommendations	STAR+PLUS MCOs should estimate the cost per episode of care provided by LMHA providers compared to non-LMHA providers to clarify whether differences in total costs were due to more efficient care concerning outcomes or to cost-of-service differences between sites of care.

QTR 2: Health Care Quality Measures for STAR Members with SMI or SED

Summary	Description
Key Findings	The prevalence of SMI and SED in STAR varies by sociodemographic group. For example, the prevalence of SMI was higher among women than among men and the overall prevalence of SED in children and adolescents was higher for males compared to females. STAR members with SMI or SED had higher rates of potentially preventable events, including PPVs, PPAs, and PPRs, compared to members without SMI or SED. STAR members with SMI or SED had higher expenditures compared to those without SMI or SED
Significance	Understanding the factors that contribute to variation in behavioral health outcomes is integral to developing and implementing successful initiatives to ensure member access to high quality care and develop pay-for-performance models with measurable effects on health outcomes.
MCQS Relevance	G1; M2
Recommendations	STAR MCOs should refine and develop targeted efforts to improve outcomes for members with SMI and SED who have physical health conditions. These members are identified as beneficiaries with complex needs (BCNs) because their health and/or social needs are more likely to result in high levels of costly but preventable services and utilization. The 2019 PIP topic of interest focused on BCNs. Once the 2019 BCN PIPs are complete, HHSC and STAR MCOs should use the results to enhance efforts to improve outcomes. HHSC should conduct studies to understand the facilitators and barriers that MCOs face in implementing behavioral health integration (BHI). The QAPI reports can be leveraged to address MCO challenges by sharing existing MCO efforts such as BHI implementation resources, provider guidelines, and guides for holding regular integration workgroups.

Summary	Description
Key Findings	Adults with SMI had higher healthcare utilization rates and better performance on screening and access to care measures compared to adults without SMI. Children and adolescents with SED had higher healthcare utilization rates and better performance on prevention and screening measures than children without SED.
Significance	Understanding the underlying cause of healthcare utilization patterns among members with complex needs is important for assisting HHSC in developing and implementing evidence-based approaches for improving the quality of care for adult Medicaid members.
MCQS Relevance	G1; M3
Recommendations	STAR MCOs should identify successful PIPs that improved outcomes for beneficiaries with high utilization and complex needs and plan pilot interventions to assess the impact of these programs. HHSC should work with the MCOs to share their successful programs at the annual PIP workshop, where plans share best practices.

Summary	Description
Key Findings	The prevalence of SMI was highest among white, non-Hispanic members, followed by members with other/unknown race/ethnicity. Racial and ethnic disparities in the utilization of mental health care services may explain the higher prevalence of SED diagnoses among white, non-Hispanic members.
Significance	Expanding access to behavioral health services for all STAR members with SMI and SED is necessary for improving health outcomes and important for HHSC's healthcare quality improvement priority for ensuring timely services and goal to provide better care at a lower cost.
MCQS Relevance	G2
Recommendations	*For expanding access to behavioral health services for members with SMI and SED:* STAR MCOs should consider offering telehealth services for members with SMI and SED in areas with a low number of providers to address appointment availability and network adequacy challenges. STAR MCOs should work with providers to identify avenues to successfully incorporate BHI services into their clinical workflows. STAR MCOs should work with providers to provide technical assistance and guidance for providers to implement evidence-based BHI programs to improve chronic disease outcomes for people with SMI and SED. STAR MCOs should work with providers to provide incentives for providers to implement targeted and tailored interventions to improve care management for members with SMI and SED with comorbid chronic conditions. Incentives could be financial, but MCOs should also consider the mission and peer-driven incentives such as training and recognition awards.

QTR 3: Development of a Personalized Quality-of-Care (PQOC) Index for Maternal Health

Summary	Description
Key Findings	Using HEDIS PPC to determine member eligibility for this study resulted in the exclusion of approximately half of all women in STAR who were pregnant during 2018. Compared to excluded members, the study population had a higher burden of acute and chronic conditions. These exclusions occurred primarily due to the enrollment criteria for the HEDIS PPC measure. Nearly 80 percent of the study population was eligible for three or four PQOC index measures, including HEDIS PPC, 3M PPV, and the CMS Contraceptive Care measures. While this finding suggests that the PQOC index can function well as a tool for comprehensive quality-of-care evaluation, certain index measures of chronic physical health care (HEDIS AMR, MMA), behavioral health care (HEDIS AMM, FUH, FUM), and treatment for substance abuse (HEDIS FUA, IET) only factored into scores for a small percentage of the study population. The EQRO did not have access to, and therefore did not include measures for other important aspects of care, such as prenatal screening, perinatal counseling and education, or delivery. The index did not include these measures because the availability, completeness, and validity of data needed to calculate them has not been established. The statistical model used to understand disparities in PQOC in the STAR maternal health population had an R-square value of 0.056 – meaning that the demographic, health, and health service factors included in the model explained only 5.6 percent of the variation in PQOC index scores.
Significance	A PQOC index for maternal health can be a powerful evidence-based tool for assessing variation in the quality of care for members and implementing targeted initiatives for incentivizing plans to improve clinical and administrative practices.
MCQS Relevance	G3; M1, M3
Recommendations	*To improve on the PQOC index methodology:* HHSC should continue efforts to secure access to Texas vital statistics data – such as birth certificates and death certificates – and make this information available to the EQRO to conduct a more comprehensive evaluation of maternal quality of care. To improve the comprehensiveness of the PQOC index in addressing care that is relevant to maternal health, HHSC should conduct studies to assess the feasibility of calculating additional measures and including them in future iterations of the PQOC index. This work may include determining the availability of registry data for certain measures and the reliability of administrative-only versions of measures that have hybrid specifications. Future studies of PQOC in the maternal health population should include more factors that address social determinants of health, to the extent that data are available. Area-level SDoH variables at the census tract level can provide important context related to educational attainment, household income, employment, language, poverty, and housing conditions for the population living in a given area. Census-tract rurality may function as a more sensitive measure than county-level rurality.

Summary	Description
Key Findings	Disparities in PQOC by rurality were not as pronounced as for other factors considered in this study. This result may be because rurality lacked the specificity to reliably detect an association with PQOC. This study showed that PQOC in the STAR maternal health population skewed slightly toward higher performance, with more than half of the study members having PQOC index scores between 0.500 and 0.799. The mean PQOC index score was 0.638, meaning that, on average, members had high-quality care for nearly two-thirds of the measures in the index. The descriptive analysis and statistical model showed disparities in PQOC index scores, with the strongest disparities observed for health service factors such as the number of outpatient visits, number of months enrolled, and MCO. The mean adjusted PQOC index score among members who had five outpatient visits during the measurement year was 0.879, compared to 0.566 among members who had no outpatient visits. Conversely, adjusted PQOC index scores decreased as the number of months enrolled increased. Several MCOs had significantly lower adjusted PQOC index scores than Superior, with the lowest observed in Molina (0.603). This study also showed disparities in PQOC for maternal health according to race/ethnicity, which persist after accounting for other factors. American Indian/Alaskan and NHB members had significantly lower PQOC than WNH members, while Hispanic members had significantly higher PQOC than NHW members. Furthermore, the study found a significant interaction between race/ethnicity and rurality. In rural areas, adjusted PQOC index scores were lower among Hispanic members than among NHW members. In urban areas, adjusted PQOC index scores were higher among Hispanic members than among NHW members.
Significance	Understanding the factors that contribute to racial and ethnic variation in health outcomes is integral to developing and implementing successful initiatives to ensure member access to high quality care and develop pay-for-performance models with measurable effects on health outcomes.
MCQS Relevance	G1; M1, M3
Recommendations	*To address disparities in PQOC for maternal health:* STAR MCOs should use information on the frequency of outpatient visits to identify risk for disparities in PQOC in the maternal population. Members who have no outpatient visits in a given year are more likely to experience lower quality healthcare when they seek care and are more likely to have PPEs. STAR MCOs should continue existing quality improvement efforts that target this population. Furthermore, HHSC should focus state-level maternal healthcare improvement efforts on MCOs that have lower PQOC among their members after controlling for other factors. STAR MCOs should focus efforts to reduce maternal mortality and SMM, emphasizing the demonstrated racial/ethnic disparities in PQOC. Quality improvement efforts in facilities that serve a greater proportion of NHB members should include interventions found to be successful in other states, such as the distribution of emergency toolkits and evidence-based guidelines. STAR MCOs should increase efforts to promote AIM Maternal Safety Bundles among their hospital providers to facilitate these strategies. Tools for implementing best practices in maternal care should also be made available to primary care providers and outpatient settings.

QTR 4: Documenting and Addressing Social Determinants of Health by Texas Medicaid Managed Care Plans

Summary	Description
Key Findings	MCOs noted that meaningful discussions about SDoH happen at three pivotal points in an MCO's engagement with its members: (1) at the initial screening, (2) once an unmet social need was identified, and (3) when exchanging SDoH data with team members, providers and in some cases, community-based organizations.
Significance	SDoH are important drivers for disparities in health outcomes among Medicaid and CHIP members, influencing member experiences.
MCQS Relevance	G2; M1
Recommendations	MCOs should train member-facing staff in relationship-centered communication skills to effectively discuss member needs and the importance of SDoH data collection. This training should include information about sensitivity to member issues and attitudes and rapport and relationships with members during contact.

Summary	Description
Key Findings	Most MCO representatives interviewed indicated they do not evaluate the effectiveness of their SDoH interventions or the impact on health outcomes. Capacity levels in SDoH analysis varied among MCOs, from no analysis to ad hoc analysis to highly structured regular reporting. Many MCOs are working with providers to capture Z codes on claims, while some plans are using predictive modeling of nonclinical data to leverage and support organizational planning and intervention resource allocation. The absence of a single standardized screening tool and the limited evidence base and data collected on SDoH interventions indicate that the impact of interventions on health outcomes is unknown.
Significance	Integrating SDoH information into program monitoring and MCO incentives to improve performance requires a systematic approach for collecting and utilizing SDoH data to improve the quality of care.
MCQS Relevance	G3; M1, M3
Recommendations	HHSC and the MCOs should develop a framework for consistent screening and assessment of member SDoH needs, including a standardized survey that draws on questions from existing validated screening tools. This framework should include a common data collection process for SDoH information, established intervals for measurement, and data collection methods related to intervention activities and effectiveness. HHSC should develop a protocol for collecting and sharing SDoH screening data across plans. This protocol should easily integrate into the MCO staff workflow. This data could include SDoH intervention successes and failures to promote best practices. HHSC should create an information platform with up-to-date community-based resources that all MCOs can access. Developing a state system or partnering with an existing provider such as Aunt Bertha or 211 would allow all MCOs to have similar referral and reporting capabilities. Such platforms have the potential to reduce the challenge of keeping up with the ever-changing landscape of social services and resource availability.

Summary	Description
Key Findings	Representatives from 14 of the 17 MCOs mentioned community partnerships as key to addressing members' SDoH. Partnerships with Aunt Bertha, community-based organizations, and clinical providers were essential to SDoH efforts.
Significance	Engaging stakeholders in quality improvement initiatives can help ensure that the initiatives are implemented effectively, achieve intended outcomes, and contribute to sustainable changes in the quality of health care.
MCQS Relevance	G1; M1, M3
Recommendations	HHSC and the MCOs should establish a statewide task force of community influencers to guide the continuing dialogue on SDoH measurement and interventions by Texas MCOs. For example, HHSC could establish a coalition of MCO representatives, providers, social service agencies, and public health researchers to prioritize SDoH needs.

Summary	Description
Key Findings	Nine MCOs use Aunt Bertha (a nonprofit online platform for referrals to social service providers in their communities). Among other MCOs, approaches to addressing SDoH needs vary, largely due to resource constraints. Various challenges discourage MCOs from assisting members with nonmedical concerns such as housing and food insecurity or parenting skills integral to improving health outcomes and lowering costs. Interviewees mentioned difficulties engaging members and member movement between plans as limiting interventions around SDoH.
Significance	Resources and incentive models targeted towards SDoH can be used to encourage MCOs to address SDoH-related barriers to care.
MCQS Relevance	G1; M1, M3
Recommendations	HHSC should pilot alternate payment strategies to encourage continued MCO investment in SDoH interventions, including financial rewards and redefining priority SDoH investments (for reimbursement) as medical expenses instead of administrative expenses. HHSC could use the pilot to establish methods and metrics for incentivizing MCOs to support financial investments in SDoH.

Issue Brief 1: Health Teleservices for Prenatal and Postpartum Care

Summary	Description
Key Findings	The benefits of teleservices for perinatal care are more evident for prenatal care than postpartum care. For prenatal care, research supports the use of teleservices for monitoring chronic conditions (e.g., asthma, diabetes, and hypertension). For postpartum care, teleservices research is restricted to studies focused on providing support to promote health behaviors and mental health (e.g., breastfeeding, mental health counseling). The most researched modality for perinatal care teleservices is telemonitoring of health conditions. Evidence suggests that telemonitoring increases compliance of self-monitoring of conditions (e.g., asthma, diabetes, and hypertension) with high acceptability among clients and providers.
Significance	Teleservices can be an effective method for increasing member access to certain types of perinatal care and supports HHSC's healthcare quality improvement priority for providing the right care in the right place at the right time to ensure people receive timely services in the least intensive or restrictive setting.
MCQS Relevance	G1; M3
Recommendations	HHSC should consider supporting initiatives to improve equitable access to broadband and technologies that facilitate the use of teleservices. HHSC should assess the feasibility and cost of teleservice programs and incentivize MCOs to implement teleservice programs as a value-add service. HHSC should pilot teleservices in specific geographic areas or populations to assess feasibility and cost. HHSC should work with mHealth programs to determine how to comply with reimbursement policies. HHSC should conduct future studies to determine the continuity of care for clients who use teleservices. HHSC should work with MCOs to hold stakeholder meetings to identify ways to address appointment availability challenges. HHSC should work with MCOs to Identify ways to improve broadband connectivity, which is crucial for implementing teleservices. MCOs should work with providers to provide tools to increase awareness of the availability and benefits of teleservices. MCOs should offer providers technical assistance and guidance on providing teleservices care. MCOs should work with providers to identify avenues to successfully integrate teleservices into clinical workflows. MCOs should work with providers to identify avenues for ensuring patient privacy and HIPAA compliance for teleservices. MCOs should work with providers to incentivize the uptake of teleservices.

Issue Brief 2: Trends in Alternative Payment Models for Increasing Access to Patient-Centered Maternal Care

Summary	Description
Key Findings	FFS reimbursement models incentivize providers to focus more on the number of services provided to a patient rather than the quality of those services. This negatively impacts maternal care because it increases perinatal care costs and encourages unnecessary interventions that can risk the mother and her child's health. APMs incentivize providers to use evidence-based and patient-centered approaches to perinatal care to reduce practices associated with poor perinatal outcomes. The diversity of APM frameworks also allows the flexibility to tailor initiatives to the local context or a specific maternal condition. APMs for perinatal care can be challenging to implement because there are few studies on the effectiveness of these approaches for improving the quality of, or access to, maternal care. Additionally, few established metrics for measuring access to care capture whether women receive gold standard care and access to pregnancy risk screening.
Significance	Model frameworks and quality metrics must be chosen carefully to ensure provider accountability and incentivize high-quality care access.
MCQS Relevance	G1; M2
Recommendations	HHSC should identify a set of evidence-based indicators that provide information on access to appropriate care and pregnancy risk screening for women in Texas Medicaid. These indicators should be chosen based on whether: (1) they address key issues for improving maternal care for women in Texas, (2) the data is available to adequately support reliable performance measurement, and (3) the use of the measure is supported or recommended by an organization such as the Joint Commission or NQF to help ensure the use of reliable and valid quality measures. If possible, these indicators should include measures that provide information on patient experience in addition to the utilization of care, such as CAHPS measures. When developing a supplemental payment program, HHSC should be clear in defining the accountable provider for financial incentives to support improvements in quality of, and access to, perinatal care services, making sure that the accountable provider is prepared to effectively enact program and delivery reforms and that the role of the accountable provider aligns with the quality improvement goals of the program. HHSC should involve stakeholder input from providers and MCOs when designing a supplemental payment program to encourage increased pregnancy risk screening rates and improved access to maternal health care. Stakeholder engagement will ensure that the proposed model properly aligns incentives and value and provides critical feedback on any factors outside the scope of practice improvements that the provider can make. MCO and provider feedback is also important for understanding which incentives and delivery models are likely to be the most effective. HHSC should draw on implementation science models when developing a method to assess whether supplemental payments impact the quality of, and access to, maternal health services for women in Texas Medicaid. After selecting a set of evidence-based indicators, HHSC should plan to pilot the indicators to ensure the feasibility of their use, establish a baseline for the quality of maternal care and access to maternal health services, and develop a pre-post-intervention study to assess the effectiveness of the supplemental payment program for improving the quality of care and access to health services for women in Texas Medicaid.

Issue Brief 3: Medical P4Q in STAR+PLUS: MCO Perspectives and Strategies

Summary	Description
Key Findings	The most pressing challenges for STAR+PLUS MCOs trying to improve performance in the medical P4Q program include difficulties assessing the impact of individual initiatives when multiple P4Q initiatives target a single issue and engaging multi-level stakeholders in quality improvement initiatives. STAR+PLUS MCOs have several promising strategies to help address the barriers that limit performance improvement in the medical P4Q program, including member- and provider-level incentives, processes for identifying and reducing service gaps, and events that educate and connect members and providers. More research is needed to assess whether these strategies lead to measurable improvement in provider engagement and member care quality.
Significance	The complex care needs of the STAR+PLUS population present unique challenges for MCOs in improving performance on P4Q measures, including challenges in assessing provider performance for members with multiple chronic conditions, promoting integrated care, and evaluating interventions with multiple components.
MCQS Relevance	G1; M3
Recommendations	HHSC should determine whether STAR+PLUS MCOs have established policies for (a) identifying and responding to providers who consistently drop non-compliant or non-responsive members from their panels and (b) reaching out to members who have an increased risk of being dropped from a provider panel. STAR+PLUS MCOs should expand on health information technology (IT) systems to improve timely and accurate data access. In particular, health IT systems should support data collection from laboratory vendors, which can facilitate the monitoring of performance on the Comprehensive Diabetes Care – HbA1c Control measure. STAR+PLUS MCOs should conduct studies to evaluate the effectiveness of their approaches to meeting P4Q goals. These include, but are not limited to, strategies that: (a) follow a multi-level approach to improve quality by combining provider- and member-level incentives; and (b) involve regular wellness or condition-specific events that educate and connect members and providers. STAR+PLUS MCOs should implement or expand on existing initiatives to partner with providers and provider stakeholder groups to develop resources to facilitate P4Q improvement. Resources should address issues such as proper medical coding to support P4Q measure reporting, service gap identification and root cause analysis, and tracking P4Q performance at the provider level. STAR+PLUS MCOs should identify and implement effective and sustainable strategies to offset the administrative burden experienced by providers associated with monitoring P4Q performance.

Protocol 10: Assist with Quality Rating of MCOs

Summary	Description
Recommendations	None

Appendix A: 3M™ Clinical Risk Group (CRG) Classification

The 3M™ Clinical Risk Groups (CRG) classification system describes the health status and burden of illness of individuals in an identified population. The CRG system is a categorical clinical model that classifies each member of the population based on his or her burden of medical conditions, assigning everyone to a single mutually exclusive risk category. The system classifies individuals with one or more chronic conditions based on those conditions or combinations of conditions, with further breakouts for condition-specific severity of illness. Individuals without a chronic condition are assigned to groups for one or more significant acute illness, or other significant health event such as delivery or newborn birth, and those without a significant acute condition, to various groups for "healthy." The CRG system can be used for stratifying populations, risk adjustment, predicting healthcare utilization and cost, tracking health outcomes, and analyzing the health of populations. Grouping assigns individuals to nine status categories[8]

Status 9 - *Catastrophic Conditions*. Catastrophic conditions include long term dependency on a 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*. For the Prospective Model,[9] this is defined by the presence, within the most recent six months of the analysis period, of one or more significant acute Episode Diagnostic Categories (EDCs) or significant Episode Procedure Categories (EPCs) along with the absence of any validated PCDs present. For the Concurrent Model, this definition is similar but different 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.

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

[9] Both the Prospective and Concurrent models classify individuals based on the same information from the same base period or "analysis period," and most of the grouping logic and specifications are the same, but there are differences that sometimes 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: PIP topics

2018 PIPs

The MCOs and DMOs completed their 2018 PIPs in December 2019 and submitted final PIP reports in November 2020. The EQRO will include final and overall results for the 2018 PIPs in the SFY 2021 SOA report. Topics for the 2018 two-year PIPs were generally implemented by program and included:

- Weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)
  (all CHIP MCOs)
- Prenatal and postpartum care (PPC)
  (all STAR MCOs, three STAR+PLUS MCOs, and the STAR Health MCO)
- Potentially Preventable Emergency Department Visits (PPVs) for upper respiratory tract infection (URTI)
  (all STAR Kids MCOs)
- Self-directed care
  (two STAR+PLUS MCOs).

Seven of the 2018 STAR PIPs focused on a sub-population within the PPC topic. These sub-populations included members with depression (Aetna and Parkland), members who identify as African-American (Amerigroup and DCHP), only postpartum members (CFHP), members with or at high risk for postpartum depression (SWHP), and members with maternal substance use (UHC).

Both DMOs conducted dental PIPs for Medicaid and CHIP focused on increasing the use of dental sealants.

2019 PIPs

In the current reporting year, the EQRO evaluated the 2019 PIP Progress Report 2. The MCOs and DMOs submitted the 2019 PIP Progress Report 2 in July 2020 and reported preliminary results and any changes to interventions between submission of Progress Report 1 in July 2019 and July 2020.

2020 PIPs

In the current reporting year, the EQRO evaluated the 2020 PIP Plans and the 2020 PIP Progress Report 1. The Progress Report 1 reported preliminary results from the PIP interventions between the implementation start date and June 2020. Topics for 2020 MCO PIPs focused on behavioral health and included plans to improve performance on these HEDIS measures:

- ADD – Follow-up Care for Children Prescribed ADHD Medication, Initiation Sub-measure
  (seven STAR, two STAR Kids, and six CHIP MCOs)
- APM – Metabolic Monitoring for Children and Adolescents on Antipsychotics
  (three STAR, three STAR Kids, three CHIP MCOs, and the STAR Health MCO)
- FUA – Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence
  (one STAR+PLUS MCO)
- FUH – Follow-up After Hospitalization for Mental Illness
  (five STAR, four STAR+PLUS, three STAR Kids, and six CHIP MCOs)
- SSD – Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder who are using antipsychotics
  (one STAR and one STAR Kids MCO)

Only two MCOs chose different topics for different programs. The MCO topics for the 2020 PIPs are:

Program	MCO	ADD	APM	FUA	FUH	SSD
STAR	Aetna Better Health (Aetna)	X	-	-	-	-
STAR	Amerigroup	-	-	-	X	-
STAR	Blue Cross Blue Shield of Texas (BCBSTX)	X	-	-	-	-
STAR	Community First Health Plans (CFHP)	-	-	-	X	-
STAR	Community Health Choice (CHC)	-	-	-	X	-
STAR	Cook Children's Health Plan (CCHP)	-	X	-	-	-
STAR	Dell Children's Health Plan (DCHP)	-	-	-	X	-
STAR	Driscoll Health Plan (Driscoll)	-	-	-	X	-
STAR	El Paso Health	X	-	-	-	-
STAR	FirstCare Health Plans (FirstCare)	X	-	-	-	-
STAR	Molina Healthcare of Texas (Molina)	X	-	-	-	-
STAR	Parkland Community Health Plan (Parkland)	X	-	-	-	-
STAR	RightCare from Scott & White Health Plan (SWHP)	X	-	-	-	-
STAR	Superior HealthPlan (Superior)	-	X	-	-	-
STAR	Texas Children's Health Plan (TCHP)	-	X	-	-	-
STAR	UnitedHealthCare Community Plan (UHC)	-	-	-	-	X
STAR+PLUS	Amerigroup	-	-	-	X	-
STAR+PLUS	Cigna-HealthSpring (HealthSpring)	-	-	-	X	-
STAR+PLUS	Molina Healthcare of Texas (Molina)	-	-	-	X	-
STAR+PLUS	Superior HealthPlan (Superior)	-	-	X	-	-
STAR+PLUS	UnitedHealthCare Community Plan (UHC)	-	-	-	X	-
STAR Kids	Aetna Better Health (Aetna)	X	-	-	-	-
STAR Kids	Amerigroup	-	-	-	X	-
STAR Kids	Blue Cross Blue Shield of Texas (BCBSTX)	X	-	-	-	-
STAR Kids	Community First Health Plans (CFHP)	-	-	-	X	-
STAR Kids	Cook Children's Health Plan (CCHP)	-	X	-	-	-
STAR Kids	Driscoll Health Plan (Driscoll)	-	-	-	X	-
STAR Kids	Texas Children's Health Plan (TCHP)	-	X	-	-	
STAR Kids	UnitedHealthCare Community Plan (UHC)	-	-	-	-	X
STAR Health	Superior HealthPlan (Superior)	-	X	-	-	-

Program	MCO	ADD	APM	FUA	FUH	SSD
CHIP	Aetna Better Health (Aetna)	X	-	-	-	-
CHIP	Amerigroup	-	-	-	X	-
CHIP	Blue Cross Blue Shield of Texas (BCBSTX)	X	-	-	-	-
CHIP	Community First Health Plans (CFHP)	-	-	-	X	-
CHIP	Community Health Choice (CHC)	-	-	-	X	-
CHIP	Cook Children's Health Plan (CCHP)	-	X	-	-	-
CHIP	Dell Children's Health Plan (DCHP)	-	-	-	X	-
CHIP	Driscoll Health Plan (Driscoll)	-	-	-	X	-
CHIP	El Paso Health	X	-	-	-	-
CHIP	FirstCare Health Plans (FirstCare)	X	-	-	-	-
CHIP	Molina Healthcare of Texas (Molina)	X	-	-	-	-
CHIP	Parkland Community Health Plan (Parkland)	X	-	-	-	-
CHIP	Superior HealthPlan (Superior)	-	X	-	-	-
CHIP	Texas Children's Health Plan (TCHP)	-	X	-	-	-
CHIP	UnitedHealthCare Community Plan (UHC)	-	-	-	X	-

Both DMOs conducted dental PIPs for Medicaid and CHIP focused on improving performance on the DQA measure for use of topical fluoride treatment.

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

Header fields evaluated were:

Fields	V21 Field Name	Description
Member ID	H_MBR_PRMRY_MBR_ID_NO	Submitted member primary identification number.
Start Date of Service	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 claim was paid by the MCO.
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 that indicates 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, which indicates the patient status as of the end of statement date. (Institutional encounters only)
Billing Provider NPI	HP_BLNG_PRV_NTNL_PRV_ID	Billing Provider National Provider Identifier

Detail fields evaluated were:

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)

Appendix D: Present on Admission (POA) Screening Criteria

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') are reported with the distribution of valid POA codes ('Y', 'N', 'U', 'W'). 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[10]	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%

The POA codes for secondary diagnoses are critical to the calculation of 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%

[10] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html

Appendix E: Summary of Quality Measures Calculated and Reported by the EQRO by Program

HEDIS Effectiveness of Care

A = Calculated using administrative data; H = Calculated using HEDIS hybrid methodology
[a] Included on the HHSC performance dashboard (prospective for STAR Kids)
[b] Red indicates a new measure or added reporting

Prevention and Screening

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

Respiratory Conditions

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

Cardiovascular Conditions

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

Diabetes

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[b]
CDC	Hemoglobin A1c (HbA1c) Testing	-	H[a]	H[a]	-	-	-	-	-
CDC	HbA1c Control (<8.0%)	-	H[a]	H[a]	-	-	-	-	-
CDC	BP Control (<140/90 mmHg)	-	H[a]	H[a]	-	-	-	-	-
CDC	Eye Exam	-	A[a]	A[a]	-	-	A	A	SMI[b], Mat[b]
CDC	Medical Attention for Nephropathy	-	A[a]	A[a]	-	-	A	A	SMI[b], Mat[b]
SPD	Statin Therapy for Patients w/ Diabetes	-	A	A	-	-	A	A	SMI[b]

Behavioral Health

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

Overuse/Appropriateness

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

HEDIS Access/Availability of Care

A = Calculated using administrative data; H = Calculated using HEDIS hybrid methodology

[a] Included on the HHSC performance dashboard (prospective for STAR Kids)

[b] Due to changes in the measure definition, HHSC chose to use the administrative results calculated by the EQRO using modified specifications for reporting the prenatal sub-measure; post-partum reporting is from hybrid results.

[c] Red indicates a new measure or added reporting

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

HEDIS Utilization and Risk Adjusted Utilization

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

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid
W15	Well-Child Visits in the First 15 Months of Life	A[a]	H[a]	-	A[a]	A[a]	A	-
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	H[a]	H[a]	-	A[a]	H[a]	A	-
AWC	Adolescent Well-Care Visits	H[a]	H[a]	A	A[a]	H[a]	A	-
AMB	Ambulatory Care	A	A	A	A	A	A	A
IPU	Inpatient Utilization–General Hospital/Acute Care	A	A	A	-	A	A	A
IAD	Identification of Alcohol and Other Drug Services	A	A	A	-	A	A	A
MPT	Mental Health Utilization	A	A	A	A	A	A	A
PCR	Plan All-Cause Readmission *(Risk Adjusted)*	-	A	A	-	A	A	A

HHSC Maternal Health Measures

I = Calculated by the EQRO

Code	Measures	CHIP Perinatal	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid
OAP	Pregnancy Associated Outcomes	-	I	I	I	I	-	-
CES	Cesarean Sections	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)

PQI	AHRQ Measures	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 with 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)

PQI	AHRQ Measures	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 and CMS Adult Core Measures

A = Calculated using administrative data; S = Survey Methodology; T = Calculated by HHSC

[a] Included on the HHSC performance dashboard (prospective for STAR Kids)

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

3M Health Information Systems Measures of PPEs

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

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

Dental Quality Measures

A = Calculated using administrative data
[a] Red indicates a new measure or added reporting

Quality of Care

Type	Annual Dental Visits (ADV) Submeasure[a]	CMDS	CHIP Dental
HEDIS	% of members (aged 2 to 3 years) enrolled for at least 11 of the past 12 months who had at least one annual dental visit	A	A
HEDIS	% of members (aged 4 to 6 years) enrolled for at least 11 of the past 12 months who had at least one annual dental visit	A	A
HEDIS	% of members aged 7 to 10 years enrolled for at least 11 of the past 12 months who had at least one annual dental visit	A	A
HEDIS	% of members (aged11 to 14 years) enrolled for at least 11 of the past 12 months who had at least one annual dental visit	A	A
HEDIS	% of members (aged 15 to 18 years) enrolled for at least 11 of the past 12 months who had at least one annual dental visit	A	A
HEDIS	% of members (aged 19 to 20 years) enrolled for at least 11 of the past 12 months who had at least one annual dental visit	A	-

Preventive Dental Services

Type	Measures[a]	CMDS	CHIP Dental
CMS	CMS PDENT-CH - % of members enrolled for 90 days who had at least one preventive dental service during the federal fiscal year	A[a] (aged 1 to 20 yrs.)	A[a] (aged 1 to 18 yrs.)
DQA	Sealants in Years 6 to 9- % of members (aged 6 to 9 years) continuously enrolled for at least 180 days who are at "elevated" risk for dental caries and who received a sealant on a permanent first molar tooth w/in the reporting year	A	A
DQA	Sealants in Years 10 to 14 - % of members (aged 01 to 14 years) continuously enrolled for at least 180 days who are at "elevated" risk for dental caries and who received a sealant on a permanent second molar tooth w/in the reporting year	A	A
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 (aged 20 yrs. and younger)	A (aged 18 yrs. and younger)
DQA	Topical Fluoride - % of enrolled children who are at "elevated" risk (i.e. "moderate" or "high") who received at least two topical fluoride applications w/in the reporting year	A (aged 1 to 20 yrs.)	A (aged 1 to 18 yrs.)
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]	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]	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	A	
THSteps	% of members (aged 1 to 20 years) receiving more than two THSteps Dental Checkups per year	A	

Type	Measures[a]	CMDS	CHIP Dental
THSteps	% of new members (aged 1 to 20 years) receiving at least one THSteps Dental Checkup w/in 90 days of enrollment	A	

Continuity of Care

Type	Measures[a]	CMDS	CHIP Dental
DQA	Care Continuity- % of members 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 (aged 1 to 20 yrs.)	A (aged 1 to 18 yrs.)

Utilization of Dental Services

A = Calculated using administrative data

Type	Measures	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 measurement year*	A (aged 20 yrs. and younger)	A (aged 18 yrs. and younger)
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 (aged 20 yrs. and younger)	A (aged 18 yrs. and younger)
DQA	Treatment Services -- % of members enrolled for at least 6 months who received a treatment service w/in the reporting year *	A (aged 20 yrs. and younger)	A (aged 18 yrs. and younger)
DQA	Total Amount Paid Per-Member Per-Month for Dental Services	A (aged 20 yrs. and younger)	A (aged 18 yrs. and younger)

Emergency Department Visits for Dental Caries

A = Calculated using administrative data

Type	Measures	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 (aged 20 yrs. and younger)	A (aged 18 yrs. and younger)
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 (aged 20 yrs. and younger)	A (aged 18 yrs. and younger)

CAHPS Experience of Care

S(A) = Conducted annually; S(B) = Conducted biennially
[a] Included on the HHSC performance dashboard (prospective for STAR Kids)
[b] Only on the CMS Core Survey
[c] Red indicates a new measure or added reporting

CAHPS Health Plan Survey 5.0H, Adult Version

Measures	CHIP[c]	STAR[c]	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid-Statewide[b]	CHIP-Statewide[b]
CAHPS Health Plan Survey 5.0H, Adult Version	-	S (B)	S (B)	-	-	-	S (A)	-
Rating of All Health Care	-	S (B)	S (B)	-	-	-	S (A)	-
Rating of Personal Doctor	-	S (A)[a]	S (A)[a]	-	-	-	S (A)	-
Rating of Specialist Seen Most Often	-	S (B)	S (B)	-	-	-	S (A)	-
Rating of Health Plan	-	S (A)[a]	S (A)[a]	-	-	-	S (A)	-
Customer Service	-	S (B)	S (B)	-	-	-	S (A)	-
Getting Care Quickly	-	S (A)[a]	S (A)	-	-	-	S (A)	-
% good access to urgent care	-	S (A)	S (A)[a]	-	-	-	S (A)	-
% good access to routine care	-	S (A)	S (A)[a]	-	-	-	S (A)	-
Getting Needed Care	-	S (A)[a]	S (A)	-	-	-	S (A)	-
% good access to specialist appointments	-	S (A)	S (A)[a]	-	-	-	S (A)	-
% good access to non-specialist appointments	-	S (A)	S (A)	-	-	-	S (A)	-
How Well Doctors Communicate (good experience w/ doctors' communication)	-	S (A)[a]	S (A)[a]	-	-	-	S (A)	-
Coordination of Care	-	S (B)	S (B)	-	-	-	S (A)	-

CAHPS Health Plan Survey 5.0H, Child Version

Measures	CHIP[c]	STAR[c]	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid-Statewide[b]	CHIP-Statewide[b]
Rating of All Health Care	S (B)[c]	S (B)[c]	-	S (B)	S (B)	-	S (A)	S (A)

Measures	CHIP[c]	STAR[c]	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid-Statewide[b]	CHIP-Statewide[b]
Rating of Personal Doctor	S (A)[a]	S (A)[a]	-	S (B)[a]	S (B)[a]	-	S (A)	S (A)
Rating of Specialist Seen Most Often	S (B)[c]	S (B)[c]	-	S (B)	S (B)	-	S (A)	S (A)
Rating of Health Plan	S (A)[a]	S (A)[a]	-	S (B)[a]	S (A)[a]	-	S (A)	S (A)
Customer Service	S (B)[c]	S (B)[c]	-	S (B)	S (B)[a]	-	S (A)	S (A)
Getting Care Quickly	S (A)	S (A)	-	S (B)	S (A)[a]	-	S (A)	S (A)
% good access to urgent care	S (A)[a]	S (A)[a]	-	S (B)[a]	S (A)	-	S (A)	S (A)
% good access to routine care	S (A)[a]	S (A)[a]	-	S (B)[a]	S (A)	-	S (A)	S (A)
Getting Needed Care	S (B)[c]	S (B) [c]	-	S (B)	S (A)[a]	-	S (A)	S (A)
% good access to specialist appointments	S (B)[c]	S (B)[a,c]	-	S (B)[a]	S (A)	-	S (A)	S (A)
% good access to non-specialist appointments	S (B)[c]	S (B) [c]	-	S (B)	S (A)	-	S (A)	S (A)
How Well Doctors Communicate (good experience w/ doctors' communication)	S (A)[a]	S (A)[a]	-	S (B)[a]	S (B)[a]	-	S (A)	S (A)
Shared Decision Making	-	-	-	S (B)	S (B)	-	S (A)	S (A)
Health Promotion and Education	-	-	-	S (B)	S (B)	-	S (A)	S (A)
Coordination of Care	S (B)[c]	S (B)[c]	-	S (B)	S (B)	-	S (A)	S (A)

CAHPS Health Plan Survey 5.0H, Child Version for Children with Chronic Conditions

Measures	CHIP[c]	STAR[c]	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid-Statewide[b]	CHIP-Statewide[b]
Access to Specialized Services	S (B)	S (B)	-	S (B)	S (A)[a]	-	-	-
Access to medical equipment	S (B)	S (B)	-	S (B)	S (A)	-	-	-
Access to special therapy	S (B)	S (B)	-	S (B)	S (A)	-	-	-
Access to behavioral health treatment or counseling	S (B)	S (B)	-	S (B)	S (A)	-	-	-
Family Centered Care: Personal Doctor Who Knows Child	S (B)	S (B)	-	S (B)	S (B)[a]	-	-	-
Coordination of Care for Children w/ Chronic Conditions	S (B)	S (B)	-	S (B)	S (B)	-	-	-
Access to Prescription Medicines	S (B)	S (B)	-	S (B)	S (A)	-	-	-

Measures	CHIP[c]	STAR[c]	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid-Statewide[b]	CHIP-Statewide[b]
Family Centered Care: Getting Needed Information	S (B)	S (B)	-	S (B)	S (A)	-	-	-

CAHPS Supplemental Measures

S(A) = Conducted annually; S(B) = Conducted biennially
[a] Included on the HHSC performance dashboard (prospective for STAR Kids)
[b] Only on the CMS Core Survey

Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid-Statewide[b]	CHIP-Statewide[b]
% good access to behavioral health treatment or counseling	-	S (B)[a]	S (B)[a]	S (B)[a]	S (A)[a]	-	-	-
% good access to special therapies	-	-	S (B)[a]	-	-	-	-	-
% w/ good access to service coordination	-	-	S (B)[a]	-	S (A)	-	-	-

CAHPS Effectiveness of Care (HEDIS)

S(A) = Conducted annually; S(B) = Conducted biennially
[a] Included on the HHSC performance dashboard (prospective for STAR Kids)
[b] Only on the CMS Core Survey

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

Survey Measures from the National Survey of Children's Health

S(A) = Conducted annually; S(B) = Conducted biennially
[a] Included on the HHSC performance dashboard (prospective for STAR Kids)
[b] Only on the CMS Core Survey

Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid-Statewide[b]	CHIP-Statewide[b]
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	-	-	-	-	S (B)[a]	-	-	-

Use of Consumer Directed Services Reported by MCOs

T = Calculated by HHSC
[a] Included on the HHSC performance dashboard (prospective for STAR Kids))

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

Appendix F: 3M™ Potentially Preventable Complications (PPC) Classification System Definitions[11]

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

PPC Level	Level Name	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 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 assessments of quality, they should be monitored to check for changes in occurrence.

[11] Extracted from the 3M™ Potentially Preventable Complications (PPC) Classification System Methodology Overview, v37. Copyright © 2008–2019, 3M. All rights reserved. GRP-381 October 2019.

PPC Categories

PPC Category	Category Description	PPC Group	Level
01	Stroke & Intracranial Hemorrhage	2	2
02	Extreme CNS Complications	1	2
03	Acute Pulmonary Edema and Respiratory Failure without Ventilation	2	2
04	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1	2
05	Pneumonia & Other Lung Infections	2	2
06	Aspiration Pneumonia	2	2
07	Pulmonary Embolism	2	2
08	Other Pulmonary Complications	2	1
09	Shock	1	2
10	Congestive Heart Failure	2	2
11	Acute Myocardial Infarction	2	2
13	Other Acute Cardiac Complications	2	1
14	Ventricular Fibrillation/Cardiac Arrest	1	2
15	Peripheral Vascular Complications except Venous Thrombosis	2	2
16	Venous Thrombosis	2	2
17	Major Gastrointestinal Complications without Transfusion	3	2
18	Major Gastrointestinal Complications with Transfusion	3	2
19	Major Liver Complications	3	2
20	Other Gastrointestinal Complications	3	1
21	Clostridium Difficile Colitis	5	3
23	Genitourinary Complications except Urinary Tract Infection	8	1
24	Renal Failure without Dialysis	8	3
25	Renal Failure with Dialysis	1	2
26	Diabetic Ketoacidosis & Coma	8	1
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	8	1
28	In-Hospital Trauma and Fractures	8	1
29	Poisonings except from Anesthesia	6	1
30	Poisonings due to Anesthesia	6	1
31	Pressure Ulcer	8	2
32	Transfusion Incompatibility Reaction	6	1
33	Cellulitis	5	1
34	Moderate Infections	5	1
35	Septicemia & Severe Infections	5	2

PPC Category	Category Description	PPC Group	Level
36	Acute Mental Health Changes	8	1
37	Post-Procedural Infection & Deep Wound Disruption without Procedure	4	1
38	Post-Procedural Infection & Deep Wound Disruption with Procedure	4	2
39	Reopening Surgical Site	4	2
40	Peri-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Procedure	4	1
41	Peri-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Procedure	4	2
42	Accidental Puncture/Laceration during Invasive Procedure	4	2
44	Other Surgical Complication - Moderate	8	1
45	Post-Procedural Foreign Bodies and Substance Reaction	4	2
47	Encephalopathy	8	2
48	Other Complications of Medical Care	8	1
49	Iatrogenic Pneumothorax	6	2
50	Mechanical Complication of Device, Implant & Graft	6	1
51	Gastrointestinal Ostomy Complications	6	1
52	Infection, Inflammation & Other Complications of Devices, Implants or Grafts except Vascular Infection	6	1
53	Infection, Inflammation and Clotting Complications of Peripheral Vascular Catheters and Infusions	6	1
54	Central Venous Catheter-Related Blood Stream Infection	6	2
59	Medical & Anesthesia Obstetric Complications	7	1
60	Major Puerperal Infection and Other Major Obstetric Complications	7	2
61	Other Complications of Obstetrical Surgical & Perineal Wounds	7	1
63	Post-Procedural Respiratory Failure with Tracheostomy	1	2
64	Other In-Hospital Adverse Events	8	1
65	Urinary Tract Infection	5	1
66	Catheter-Related Urinary Tract Infection	5	1

Appendix G: Measures Used in 2021 Report Card Ratings 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, and
3. NSCH - National Survey of Children's Health.

CHIP Report Cards

Experience of Care Domain

Report Card Text	Specification	Data Source
Children get appointments as soon as needed	Non-emergent component of CAHPS *Getting Care Quickly*	CHIP Caregiver Annual Report Card Survey
Doctors listen carefully, explain clearly, and spend enough time with people	CAHPS *How Well Doctors Communicate*	CHIP Caregiver Annual Report Card Survey
Parents give high ratings to their child's personal doctor	CAHPS *Rating of Personal Doctor*	CHIP Caregiver Annual Report Card Survey
Parents give high ratings to the health plan	CAHPS *Rating of Health Plan*	CHIP Caregiver Annual Report Card Survey

Staying Healthy Domain

Report Card Text	Specification	Data Source
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 Measure Tables
Children and teens get their vaccines	Composite: HEDIS *Childhood Immunization Status* (CIS): *combination 10*; HEDIS *Immunizations for Adolescents* (IMA): *combination 2*	CHIP QOC Measure Tables

Common Chronic Conditions Domain

Report Card Text	Specification	Data Source
Children get medicine for asthma	HEDIS *Asthma Medication Ratio* (AMR)	CHIP QOC Measure Tables
Children see the doctor for ADHD (Attention Deficit Hyperactivity Disorder)	HEDIS *Follow-Up Care for Children Prescribed ADHD Medication* (ADD): *initiation phase*	CHIP QOC Measure Tables

STAR Child Report Cards

Experience of Care Domain

Report Card Text	Specification	Data Source
Children get appointments as soon as needed	Non-emergent component of CAHPS *Getting Care Quickly*	STAR Child Caregiver Annual Report Card Survey
Doctors listen carefully, explain clearly, and spend enough time with people	CAHPS *How Well Doctors Communicate*	STAR Child Caregiver Annual Report Card Survey
Parents give high ratings to their child's personal doctor	CAHPS *Rating of Personal Doctor*	STAR Child Caregiver Annual Report Card Survey
Parents give high ratings to the health plan	CAHPS *Rating of Health Plan*	STAR Child Caregiver Annual Report Card Survey

Staying Healthy Domain

Report Card Text	Specification	Data Source
Babies get regular checkups	HEDIS *Well-Child Visits in the First 15 Months of Life* (W15): *six or more well-child visits*	STAR QOC Measure Tables
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 Measure Tables

Common Chronic Conditions Domain

Report Card Text	Specification	Data Source
Children get medicine for asthma	HEDIS *Asthma Medication Ratio* (AMR)	STAR QOC Measure Tables
Children see the doctor for ADHD (Attention Deficit Hyperactivity Disorder)	HEDIS *Follow-Up Care for Children Prescribed ADHD Medication* (ADD): *initiation phase*	STAR QOC Measure Tables

STAR Adult Report Cards

Experience of Care Domain

Report Card Text	Specification	Data Source
People get care, tests, and treatment easily	Component of CAHPS *Getting Needed Care*	STAR Adult Member Annual Report Card Survey
Doctors listen carefully, explain clearly, and spend enough time with people	CAHPS *How Well Doctors Communicate*	STAR Adult Member Annual Report Card Survey
People give high ratings to their personal doctor	CAHPS *Rating of Personal Doctor*	STAR Adult Member Annual Report Card Survey
People give high ratings to the health plan	CAHPS *Rating of Health Plan*	STAR Adult Member Annual Report Card Survey

Staying Healthy Domain

Report Card Text	Specification	Data Source
Women get checkups during pregnancy	HEDIS *Prenatal and Postpartum Care* (PPC): *timeliness of prenatal care*	STAR QOC Measure Tables
New mothers get checkups after giving birth	HEDIS *Prenatal and Postpartum Care* (PPC): *postpartum care*	STAR QOC Measure Tables
People get regular yearly checkups	HEDIS *Adults' Access to Preventive/Ambulatory Health Services* (AAP)	STAR QOC Measure Tables
Women get regular screenings for cervical cancer	HEDIS *Cervical Cancer Screening* (CCS)	STAR QOC Measure Tables

Common Chronic Conditions Domain

Report Card Text	Specification	Data Source
People get care for depression and constant low mood	HEDIS *Antidepressant Medication Management* (AMM): *acute phase*	STAR QOC Measure Tables
People get care for diabetes	Composite of two components of HEDIS *Comprehensive Diabetes Care* (CDC): *HbA1c testing* and *Eye exam (retinal) performed*.	STAR QOC Measure Tables

STAR+PLUS Report Cards

Experience of Care Domain

Report Card Text	Specification	Data Source
People get care, tests, and treatment easily	Component of CAHPS *Getting Needed Care*	STAR+PLUS Member Annual Report Card Survey
Doctors listen carefully, explain clearly, and spend enough time with people	CAHPS *How Well Doctors Communicate*	STAR+PLUS Member Annual Report Card Survey
People give high ratings to their personal doctor	CAHPS *Rating of Personal Doctor*	STAR+PLUS Member Annual Report Card Survey
People give high ratings to the health plan	CAHPS *Rating of Health Plan*	STAR+PLUS Member Annual Report Card Survey

Staying Healthy Domain

Report Card Text	Specification	Data Source
People get regular yearly checkups	HEDIS *Adults' Access to Preventive/Ambulatory Health Services* (AAP)	STAR+PLUS QOC Measure Tables
Women get regular screenings for breast and cervical cancer	Composite: HEDIS *Breast Cancer Screening* (BCS); HEDIS *Cervical Cancer Screening* (CCS)	STAR+PLUS QOC Measure Tables

Common Chronic Conditions Domain

Report Card Text	Specification	Data Source
People get care for depression and constant low mood	HEDIS *Antidepressant Medication Management* (AMM): *acute phase*	STAR+PLUS QOC Measure Tables
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 Measure Tables
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 Measure Tables
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 Measure Tables
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 Measure Tables

STAR Kids Report Cards

Experience of Care Domain

Report Card Text	Specification	Data Source
People get care, tests, and treatment easily	Component of CAHPS *Getting Needed Care*	STAR Kids Caregiver Annual Report Card Survey
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 Quality of Care Tables
People get special therapy easily	Component of CAHPS *Getting Specialized Services*	STAR Kids Caregiver Annual Report Card Survey
People get prescription medicines easily	CAHPS *Getting Prescription Medicine*	STAR Kids Caregiver Annual Report Card Survey

Staying Healthy Domain

Report Card Text	Specification	Data Source
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
Doctors and other health providers answer questions	CAHPS *Family Centered Care: Getting Needed Information*	STAR Kids Caregiver Annual Report Card Survey
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
People give high ratings to the health plan	CAHPS *Rating of Health Plan*	STAR Kids Caregiver Annual Report Card Survey

Common Chronic Conditions Domain

Report Card Text	Specification	Data Source
People get emotional and behavioral counseling easily	Component of CAHPS *Getting Specialized Services*	STAR Kids Caregiver Annual Report Card Survey
Doctors follow up after hospitalization for mental illness	HEDIS *Follow-Up After Hospitalization for Mental Illness* (FUH): *7-Day*	STAR Kids QOC Measure Tables
Health monitoring for people using antipsychotics	HEDIS *Metabolic Monitoring for Children and Adolescents on Antipsychotics* (APM)	STAR Kids QOC Measure Tables

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