TEXAS Health and Human Services

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

State Fiscal Year 2023

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

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EQRO Texas External Quality Review Organization

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Abbreviations

Abbreviation	Definition
A/E	actual-to-expected
AAP	American Academy of Pediatrics
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
APR-DRG	(3M™) All Patient Refined Diagnosis-Related Groups
ATR	annual technical report
ATR Companion	annual technical report companion (*Health Plan Performance in Texas Medicaid & CHIP*)
AUD	alcohol use disorder
BCBSTX	Blue Cross Blue Shield (of Texas)
C-Section	cesarean section
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCC	(CAHPS) Children with Chronic Conditions (Item Set)
CFHP	Community First Health Plans
CHCT	Community Health Choice
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act (of 2009)
CMCHP	Children's Medical Center Health Plan
CMDS	Children's Medicaid Dental Services
CMS	Centers for Medicare and Medicaid Services
CookCHP	Cook Children's Health Plan
CRA	caries risk assessment
CRG	(3M™) Clinical Risk Group
DCHP	Dell Children's Health Plan
D-i-D	difference in difference
DM	disease management
DMO	dental maintenance organization
DOS	date of service

Abbreviation	Definition
DQA	Dental Quality Alliance
Driscoll	Driscoll Health Plan
DRTS	demand-response transportation service
EAPG	(3M™) Enhanced Ambulatory Patient Groups
ECDS	electronic clinical data systems
ED	emergency department
EDVMRR	encounter data validation: medical record review
EDVDRR	encounter data validation: dental record review
EHR	electronic health record
ElPasoHealth	El Paso Health
EQR	external quality review
EQRO	external quality review organization
FCPF	fibromyalgia and chronic pain/fatigue
FFCRA	Families First Coronavirus Response Act
FFS	(traditional Medicaid) fee-for-service
FSR	financial statistical report
HCBS	Home and Community-Based Services (Program)
HEDIS®	Healthcare Effectiveness Data and Information Set
HEDIS-PPC	HEDIS Prenatal and Postpartum care measure (disambiguates from 3M™ PPC)
HHS	(U.S. Department of) Health and Human Services
HHSC	(Texas) Health and Human Services Commission
HSRI	Human Services Research Institute
IAP	Innovation Accelerator Program
ISCA	Information Systems Capabilities Assessment
JIP	joint interface plan
KFF	Kaiser Family Foundation
LTSS	Long-Term Services and Supports
MCNA	MCNA Dental
MCO	managed care organization
MCQS	(Texas) Managed Care Quality Strategy
MDCP	Medically Dependent Children Program
MHC	mental health condition

Abbreviation	Definition
MLTSS	Managed LTSS
MMP	Medicare-Medicaid Plan
MRSA	Medicaid Rural Service Area
MY	measurement year
NAMD	National Association of Medicaid Directors
NCI-AD™	National Core Indicators - Aging and Disabilities
NCI-AD ACS	NCI-AD Adult Consumer Survey
NCQA	National Committee for Quality Assurance
NEMT	non-emergency medical transportation
NMDOH	non-medical drivers of health
NPI	National Provider Identifier
OAP	Pregnancy Associated Outcomes (Texas measure of severe maternal morbidity)
OUD	opioid use disorder
P4Q	Pay-for-Quality
PCHP	Parkland Community Health Plan
PCP	primary care provider
PDI	(AHRQ) Pediatric Quality Indicator
PDx	primary diagnosis
PHE	public health emergency
PIP	performance improvement project
POA	present on admission
POS	place of service
PPA	(3M™) Potentially Preventable Admission
PPC	(3M™) Potentially Preventable Complication
PPE	(3M™) Potentially Preventable Event
PPR	(3M™) Potentially Preventable Readmission
PPV	(3M™) Potentially Preventable (ED) Visit
PQI	(AHRQ) Prevention Quality Indicator
PX	procedure (code)
QAPI	quality assessment and performance improvement
QoC	quality-of-care
QTR	quarterly topic report
SA	service area
SFY	(Texas) state fiscal year

Abbreviation	Definition
SHCN	special healthcare needs
SMI	serious mental illness
SMM	severe maternal morbidity
SUD	substance use disorders
SWHP	RightCare
TCHP	Texas Children's Health Plan
THLC	Texas Healthcare Learning Collaborative (THLCportal.com)
THSteps	Texas Health Steps
TMHP	Texas Medicaid and Healthcare Partnership
UFSRC	University of Florida Survey Research Center
UHC	UnitedHealthcare
UHCD	UnitedHealthcare Dental
UMCC	(Texas) Uniform Managed Care Contract
UMCM	(Texas) Uniform Managed Care Manual
URAC	Utilization Review Accreditation Commission
URTI	upper respiratory tract infection

Texas Managed Care Quality Strategy (MCQS) goals referenced in this report by number or icon.

Goal	Icon	Description of 2021 Texas MCQS goals referenced in this report
1		**Promoting optimal health**: Promoting optimal health for Texans at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health
2		**Strengthening person and family engagement**: Strengthening person and family engagement as partners in their care to enhance respect for individual's values, preferences, and expressed needs
3		**Right care in the right place at the right time**: Providing the right care in the right place at the right time to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate
4		**Safer delivery system**: Keeping patients free from harm by contributing to a safer delivery system that limits human error
5		**Effective practices for people with chronic, complex, and serious conditions**: Promoting effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs
6		**High-performing Medicaid providers**: Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers, to participate in team-based, collaborative, and high-value care

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

The measurement periods for different External Quality Review (EQR) activities vary based on the framework used for evaluation. To reduce confusion, the table below lists the measurement periods that the external quality review organization (EQRO) associated with each protocol for the state fiscal year (SFY) 2023 Annual Technical Report (ATR) reporting period.

Protocol	Reported Measurement Periods
Protocol 1: **Validation of PIPs**	The EQRO reviewed 2019 final PIPs (results in this ATR) The EQRO also reviewed elements for PIPs that will be summarized with the final PIP review in future ATRs including: *PIP plans* and f*irst progress reports* for 2023 PIPs; *second progress reports* for 2022 PIPs
Protocol 2: **Validation of performance measures**	*Administrative Interview (AI) Data*: Activities measurement year (MY) 2022; *Hybrid Measures*: MY 2022; *Texas Health Steps (THSteps)*: Checkups due starting September 2021–August 2022
Protocol 3: **Review of compliance with Medicaid and CHIP managed care regulations**	*AI Review*: Activities MY 2022; *Quality Assessment and Performance Improvement (QAPI) Evaluations*: QAPI activities MY 2022
Protocol 4: **Validation of network adequacy** *(Published in February 2023)*	*Appointment Availability Fielding*: *Prenatal* – October 2022–November 2022 *Vision* –November 2022–January 2023 *Primary Care* –-February 2023–April 2023 *Behavioral Health* – May 2023–August 2023
Protocol 5: **Validation of encounter data**	*Accuracy and Completeness:* September 2022–August 2023; *Medical Record Review:* Services during MY 2021
Protocol 6: **Administration or validation of QoC surveys**	*STAR Child Caregiver*: Enrolled for September 2022-February 2023 (fielded April–September 2023)*;* *Dental Caregiver*: Enrolled for December 2022–May 2023 (fielded July–November 2023)
Protocol 7: **Calculation of additional performance measures**	MY 2022
Protocol 9: **Conducting focused studies of healthcare quality**	Research conducted September 2022–August 2023
Protocol 10: **Assistance with Quality Rating of MCOs** *(Published in February 2023)*	*Performance Dashboards:* MY 2022; *MCO Report Cards:* Administrative Data from MY 2021, Survey Data for SFY 2023 (see above)

Executive Brief

As of the end of Texas state fiscal year (SFY) 2022, the Kaiser Family Foundation (KFF) reports that nearly 90 million Americans receive healthcare coverage through the Children's Health Insurance Program (CHIP) and Medicaid (KFF, 2024), funded jointly by states and the U.S. Department of Health and Human Services (HHS). Texas has one of the largest Medicaid programs in the country, serving five million people (KFF, 2023), over 90 percent of whom receive care through a managed care delivery model. Participation in federal funding for managed care programs requires compliance with guidelines and protocols established by the Centers for Medicare and Medicaid Services (CMS), including external quality review (EQR) by an organization independent from the state. Since 2002, the Institute for Child Health Policy at the University of Florida has been the external quality review organization (EQRO) for Texas Medicaid and CHIP.

In 2019, CMS identified quality, access, and timeliness as key domains for evaluating Medicaid managed care organizations (MCOs) and dental maintenance organizations (DMOs) performance in EQR activities (CMS, 2019) and these continue as themes in the latest Protocol update (CMS, 2023). The Annual Technical Report (ATR) contains a comprehensive overview of the SFY 2023 EQR activities and the specific methods used to assess each Protocol. The ATR companion document, *Health Plan Performance in Texas Medicaid & CHIP in SFY 2023* (ATR Companion) provides MCO- and DMO-specific results from EQR activities in the SFY 2023 reporting cycle.

The ATR is a comprehensive summary of EQR activities from September 1, 2022, through August 31, 2023, including findings from EQR evaluation studies addressing the quality of managed care provided to Medicaid and CHIP members, structured around current CMS Protocols (CMS, 2023). This release, which came midway through the SFY 2023 reporting cycle, includes guidance on activities related to network adequacy (Protocol 4: Validation of Network Adequacy) while guidance for quality rating (Protocol 10: Assist with Quality Rating of MCOs and DMOs) is still pending. Although these protocols were not fully implemented because they were not available prior to the reporting cycle, the ATR addresses related EQR activities. In addition to the ATR, the EQRO produced plan profiles with MCO- and DMO-specific information from EQR activities for SFY 2023 which are provided in the ATR Companion.

EQR Activities

Each year, the EQRO follows CMS protocols specified in 42 C.F.R. § 438 (2020) to monitor the utilization, quality, accessibility, and timeliness of medical, behavioral health, and dental services that individuals receive in Medicaid and CHIP through MCOs or DMOs. The EQRO conducts activities that review the delivery of care in the four statewide Medicaid managed care programs – STAR for members needing routine care (primarily including low-income children and pregnant women); STAR+PLUS for adult members who have a disability or are age 65 years or older; STAR Kids for children, adolescents, and young adults with disabilities; STAR Health for members in state conservatorship – and delivery of care in CHIP (entirely managed care). The EQRO also monitors children's dental care through Medicaid and CHIP DMOs. None of the 16 MCOs and 3 DMOs that served Medicaid and CHIP members are exempt from EQR in SFY 2023. Annual evaluation and activities include:

- Assessment of MCO and DMO structure and process through administrative interview (AI) studies, quality assessment and performance improvement (QAPI) program evaluations, and performance improvement project (PIP) validation studies.
- Surveys with members and caregivers using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey; and appointment availability studies that follow a "secret shopper" method to evaluate the timeliness of appointments against state-specified standards.
- Quality-of-care (QoC) reporting on standardized performance measures, including National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) measures,

Agency for Healthcare Research and Quality (AHRQ) quality indicators, 3M™ measures of Potentially Preventable Events (PPEs), and American Dental Association's Dental Quality Alliance (DQA) measures.
- In-depth studies addressing topics of importance to Texas, including in-depth quarterly topic reports (QTRs), short issue briefs, and annual focus studies.
- Comparative analysis of MCO and DMO performance in support of a quality rating system.

Quality Strategy

Regulations in 42 C.F.R. § 438 (2020) require Texas to have a public Managed Care Quality Strategy (MCQS) that they review, update, and submit to CMS for approval at least every three years. Texas must report to CMS annually on the effectiveness of the MCQS. In support of CMS requirements, the EQRO reviewed the current MCQS for compliance with federal standards. The Texas MCQS meets all the requirements of 42 C.F.R. § 438.340 (2020) by including:

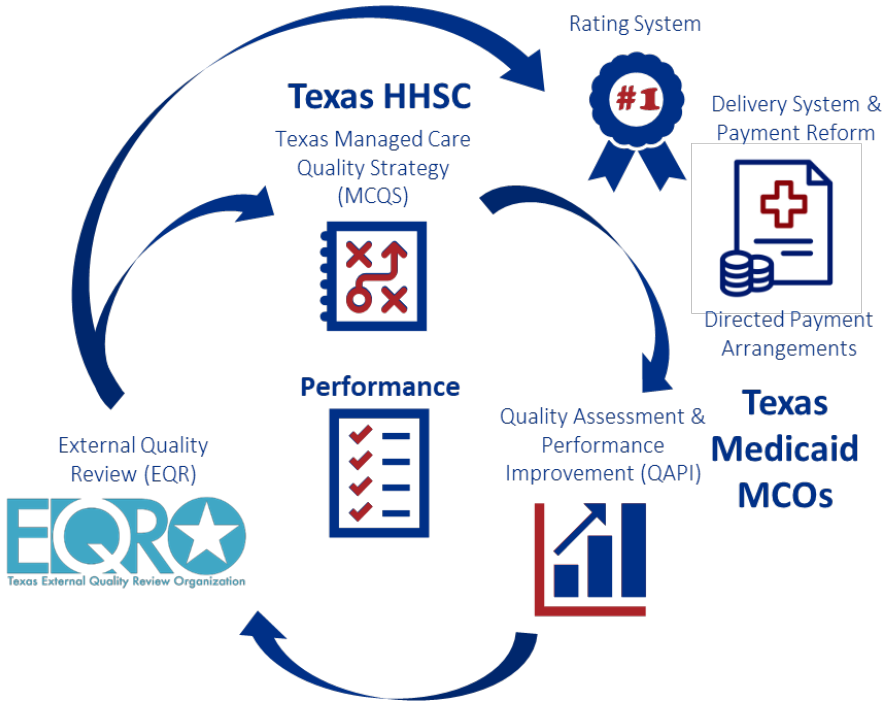
- Provisions for MCO/DMO contracts to incorporate required federal standards
- Procedures to evaluate quality and appropriateness of care
- Procedures to identify the race, ethnicity, and primary language of Medicaid enrollees
- Procedures to monitor MCO/DMO regulatory compliance
- Arrangements for annual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

The EQRO also made recommendations for strengthening the MCQS in the upcoming revision. Additionally, CMS encourages alignment of MCQSs with the HHS National Quality Strategy[1] and the CMS Quality Strategy.[2]

The EQR process is part of interrelated quality requirements for Medicaid managed care. For example, per 42 C.F.R. § 438.364(a)(4) and § 457.1250 (2020), states should use the feedback obtained from their EQRO when they examine and update their quality strategy. States, in turn, implement quality strategies through the ongoing QAPI program that contracted MCOs and DMOs must establish for the services these organizations furnish to enrollees. The performance improvement projects (PIPs) and performance measures included in QAPIs are, in turn, validated through the annual EQR. Therefore, states must ensure alignment among the QAPI requirements, the state's quality strategy, and the annual EQR activities. Figure 1 shows the MCQS, QAPI programs, and EQR activities. Through these three elements, the Texas MCQS informs and governs MCO QAPI program design, and the EQRO assessment of the MCOs informs recommendations to Texas for the MCQS. In addition, EQRO recommendations support Texas in implementing MCO/DMO rating systems and payment reforms, also used to govern MCO and DMO operations. All of these activities serve the central goal of improving performance in health care delivery.

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

Figure 1. Relationship between MCQS, quality initiatives, EQR activities, and performance



Texas Managed Care Quality Strategy Goals

The six overall goals in the current Texas MCQS (see Table 1) serve to align Texas Health and Human Services Commission (HHSC) policy making and program activities to achieve better care and health for Texans while managing healthcare costs. The EQRO recommendations in the ATR are each aligned to the Texas MCQS.

Table 1. Texas MCQS goals

Goal	Icon	Description of 2021 Texas MCQS goals referenced in this report
1		**Promoting optimal health**: Promoting optimal health for Texans at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health
2		**Strengthening person and family engagement**: Strengthening person and family engagement as partners in their care to enhance respect for individual's values, preferences, and expressed needs
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5		**Effective practices for people with chronic, complex, and serious conditions**: Promoting effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs
6		**High-performing Medicaid providers**: Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers, to participate in team-based, collaborative, and high-value care

This brief summarizes that review and focuses on how activities during the reporting cycle align with MCQS goals. Many activities have relevance across goals. The EQRO collaborates with Texas HHSC and their Medicaid MCOs and DMOs to continuously develop and implement programs that promote quality improvement in the Texas Medicaid healthcare system.

Promoting optimal health for Texans

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

- PIP evaluations (Protocol 1)
- AIs and QAPI evaluations (Protocol 3)
- Network adequacy studies (Protocol 4)
- QoC measure reporting (Protocol 2 and Protocol 7, and THLCportal.com)
- SUD diagnosis and treatment (Protocol 7 and Protocol 9)
- Postpartum care (Protocol 9)
- STAR Kids focus study (Protocol 9)
- Co-occurring physical and behavioral health issues (Protocol 9)
- MCO Report Cards (Protocol 9 and Protocol 10)

PIPs also support:

The PIPs evaluated during this reporting cycle were three-year PIPs started in 2019 and completed in 2022. The statewide topic was: *Reduction of potentially preventable emergency department visits and inpatient stays among members with anxiety and/or depression through improved medication management by primary care providers and improved treatment for behavioral health conditions.* This aligns with the National Quality Strategy and CMS priorities. MCOs are concentrating on improving healthy behaviors such as medication management, increasing engagement with primary care providers, and fostering coordination of care across care settings. In evaluating the PIPs, the EQRO found deficiencies in sampling and data analysis. However, perhaps the most significant issue, leading to a majority of MCOs/DMOs to receive an overall validation status "No" was failure to achieve statistically significant improvement. The EQRO followed up the validation with an in-depth review and identified potential factors in this issue. For example, several MCOs (Aetna, BCBSTX, Cigna-HealthSpring, CFHP, CHCT, CMCHP, Driscoll, ElPasoHealth, FirstCare, Molina, Parkland, SWHP, and UHC) delayed the implementation date of PIP interventions by one to twelve months, paused interventions for approximately 3 months to up to two years, or reported that they retired interventions as early as five months after initial implementation without replacing the retired interventions. External factors, including the PHE, may also have influenced the rates for the PIP measures, leading to lack of statistically significant improvement despite effective interventions. The EQRO recommended MCO education on PIP requirements and best practices for sampling, implementation, and analysis.

AIs and QAPIs also support:

Since 2018, the average QAPI scores for MCOs and DMOs have gradually declined four points (94.8 percent in 2023 compared to 98.8 percent in 2018) despite having generally good compliance with EQRO recommendations from prior years. Some common issues were failing to include specific, action-oriented statements written in measurable and observable terms, and failure to update objectives, particularly those that do not meet CMS criteria. Many MCOs, Medicare-Medicaid Plans (MMPs) and DMOs lost points in all three indicator monitoring sections, mainly for (1) not including a percent change analysis for all

indicators, (2) reporting incorrect metrics for an indicator (i.e., the unit of analysis was not consistent for all rates reported), and 3) not accurately interpreting the effectiveness of actions. Several MCOs and MMPs reported inaccurate results. The AI findings show that several MCOs did not have compliant procedures for the associated timeframes and notification protocols for standard and expedited service authorization decisions, including extension protocols or did not have compliant CHIP grievance protocols, based on the most updated federal CHIP guidelines. The EQRO made recommendations that MCOs improve their QAPI reporting practices, and ensure that they are meeting the most current regulations and guidelines.

Focused Studies also support:

The secret shopper studies conducted by the EQRO to evaluate network adequacy showed that fewer providers were compliant with appointment standards for low risk and third trimester pregnancy. In fact, providers for several MCOs had no compliant providers. However, compliance for high-risk pregnancy appointments improved slightly and fewer providers were excluded based on directory inaccuracy, reachability, or other reasons that appointment availability could not be assessed. Compliance with wait time standards for vision appointments decreased compared to the prior year and the number of excluded providers increased. A root cause analysis could identify the driving factors behind lower rates of provider compliance.

Network adequacy studies also support:

Consistently monitoring performance on reliable measures of healthcare quality is critical to assessing managed care CHIP and Medicaid programs. The EQRO evaluates healthcare quality in Texas Medicaid and CHIP with more than 100 quality measures selected from nationally recognized quality assessment programs using encounter, enrollment, and provider data updated monthly and regularly evaluated for quality and integrity, and data collected in annual surveys. Although the occurrence was down from 2021, upper respiratory infection remains the most common reason for potentially preventable (ED) visits (PPVs), overall. The second most common reason for PPVs was again *Non-Bacterial Gastroenteritis, Nausea & Vomiting*, which continues to increase in frequency. Investigating common reasons for PPVs can identify members most at risk and inform targeted interventions. Measures are also used to identify disparities in care. In 2023, Hispanic members had more outpatient utilization and less ED, inpatient, mental health care, and alcohol and drug services use, while Black members had higher ED and Inpatient use than other racial groups. The EQRO annually validates MCO reporting of THSteps checkups. While reporting is generally accurate, checkup rates remain low. HHSC should facilitate intra-agency communication across THSteps stakeholder groups to develop interventions or incentives to improve the success of the THSteps programs.

Quality Measures also Support:

MCO performance across Performance Indicator Dashboard measures varies. Some MCOs achieve the high standard on more than one third of measures, while some fail to meet the minimum standard on more than one third of measures. Also, for multiple measures, several MCOs surpass the high standard on the same measures that several MCOs fail to meet the minimum standard. Texas should continue leveraging the THLC portal (thlcportal.com) dashboards to help all stakeholders identify and understand trends in healthcare quality across state programs and to identify successful MCOs and work with them to find strategies that other MCOs could apply to improve performance.

The STAR Kids focus study found that service coordination was what caregivers believed to be the most important factor influencing access to and quality of services. The EQRO recommends that STAR Kids MCOs should build on existing practices to improve the availability and quality of service coordination. The topic report on substance use disorder (SUD) diagnosis and treatment among adults in the STAR program found that while

cannabis use was the most common type of SUD diagnosed, alcohol use was more common among older members. Opioid and other narcotic use disorders were also more common among older adults and less common among Hispanic members. The topic report on extended postpartum care found that Hispanic women had fewer ED visits and PPVs and lower overall outpatient utilization, while non-Hispanic Black women had more of all three service categories than non-Hispanic White women. Continuing to explore patterns of risk for SUDs and perinatal care utilization could improve development of targeted interventions. In the topic report on co-occurring mental health conditions (MHCs), anxiety emerged as the most common co-occurring MHCs and across the physical health conditions evaluated, between 28 and 67 percent of members had at least one co-occurring MHC. This highlights the need for examining the distinctive needs of members with co-occurring physical health conditions and MHCs and developing systematic, holistic approaches to address them.

AIs also support:

Strengthening person and family engagement as partners in their care

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

- AIs and QAPI evaluations (Protocol 3)
- Experience surveys (Protocol 6, and THLCportal.com)
- Performance Indicator Dashboard (Protocol 7 and THLCportal.com)
- SUD diagnosis and treatment (Protocol 7 and Protocol 9)
- STAR Kids focus study (Protocol 9)
- Co-occurring physical and behavioral health issues (Protocol 9)
- MCO Report Cards (Protocol 9 and Protocol 10)

Findings from the AI evaluation indicate continued challenges in providing members with complete, accurate directories. This creates barriers to members in finding needed care and generates frustration when engaging with the MCO and Medicaid system. The EQRO recommends that Texas continue the multi-pronged approach to improving universal provider data and encouraging MCOs to make improvements to their directories and to provider reporting within their networks.

Surveys also support:

One important strategy Texas HHSC uses to engage members in the care process is having the EQRO field Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Surveys. These surveys are important because positive care experiences improve outcomes, and survey results provide accountability (Bland et al., 2022). In 2023, all composite scores and ratings for STAR Child decreased compared to 2021. Further analysis of the survey results is needed to understand the significance of these changes, and whether they reflect a change in members' experiences, or whether changes in member populations (possibly related to the PHE) affected overall measures of satisfaction. Decreasing response rates on healthcare surveys is a national issue, with rates steadily declining before and since the PHE. Continuing to adopt proven new survey methodologies, such as web-integrated modalities can help extract the greatest value from these important but resource intensive tools. The EQRO also supports Texas participation in the National Core Indicators-Aging and Disabilities (NCI-AD™) program, serving as the liaison between NORC, Texas, and the national program teams. This consumer survey is designed to provide states with information on the performance of their long-term services and

support (LTSS) programs for older adults, individuals with physical disabilities, and caregivers. In addition, the EQRO conducted three surveys about the non-emergency transportation program (NEMT), contacting NEMT users, transportation providers, and medical providers whose patients use NEMT services. Most (84.6 percent) caregivers of children were satisfied or very satisfied with all the NEMT services their children received from Medicaid. Among adults, 86.3 percent were satisfied or very satisfied with all the NEMT services they received. In the survey to assess unmet NEMT needs, 24.8 percent of child caregivers and 35.7 percent of adults reported that lack of transportation kept their child or them from medical appointments or getting medication, but only 5.4 percent of child caregivers and 10.7 percent of adults reported usually or always missing their appointments because of lack of transportation. The EQRO recommends that HHSC and the MCOs put additional focus on increasing access for adults.

Quality Measures Support:

Access to quality measure evaluations helps members make informed decisions about healthcare. Through the THLC portal (THLCportal.com), Texas provides members direct access to comparative quality evaluation measures including hundreds of nationally recognized measures. The various dashboards provide users multiple comparisons between MCOs or DMOs, against national benchmarks, and showing improvement or changes over time. Despite public availability and embedded user guidance, only one of the 20 participants in the 2023 report card focus study reported using the THLC portal to get information about MCOs. Expanding public use elements on the THLC portal could increase member access to valuable healthcare information and decision-making support.

Report Cards Support:

The EQRO conducted a focus study in 2023, to evaluate member experiences with MCO report cards. In addition to gather information on how members used report cards, the EQRO asked questions to identify features of report cards that are difficult to understand or less helpful, and help develop possible improvements. Slightly more members were familiar with the report cards than in a similar 2016 study, but more than one third of participants were not familiar with the report cards. Still, report cards were the most-cited source of decision support for members and caregivers. Almost all the participants found the star rating system easy to understand. Suggested improvements included providing a contact for help interpreting the report card and including a reminder about the deadline for choosing a plan.

Focused Studies also support:

The STAR Kids focus study found that third party insurance was associated with low access to care for medications, medical supplies, specialist care, nursing services, and special medical equipment or devices. Interview findings suggest that caregivers for jointly-insured members can experience gaps in care when authorization for services is denied by both payors. The EQRO recommends proactively addressing these issues by providing information to members, case managers, and providers. Service coordination was the most important factor in how members access care in STAR Kids. The MCOs should continue to build on current strategies to strengthen care coordination through information tools to empower members and training for coordinators. Ensuring that members have backup plans to manage any gaps in home service was another strategy suggested by caregivers that could be addressed by care coordinators. The topic report on co-occurring MHCs, presented evidence that mental health screening, particularly in younger members, was often initiated only following a MHC related PPE. Investigating barriers to screening, including demographic differences and non-medical drivers of health (NMDOH) could inform targeted interventions to promote MHC screening, particularly for those with co-occurring physical health conditions. Patient engagement plays a pivotal role in promoting recommended screening, preventive care, and coordinated care.

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

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

- AIs and QAPI evaluations (Protocol 3)
- Appointment availability studies (Protocol 4)
- Encounter data validation (Protocol 5)
- Experience surveys (Protocol 6, and THLCportal.com)
- QoC measure reporting (Protocol 2 and Protocol 7, and THLCportal.com)
- SUD diagnosis and treatment (Protocol 7 and Protocol 9)
- STAR Kids focus study (Protocol 9)
- Postpartum care (Protocol 9)
- Co-occurring physical and behavioral health issues (Protocol 9)
- MCO Report Cards (Protocol 9 and Protocol 10)

PIPs, AI and QAPIs also support:

A major finding from the PIPs evaluation noted above was the number of PIPs that failed to lead to significant or sustained improvement. The EQRO found that delayed or shortened implementation of interventions played a substantial role in these outcomes, suggesting that HHSC should consider ways to help MCOs improve their PIP implementation strategies. Making sure that PIPs clearly address the correct target population and their needs is another potential area for improvement related to this MCQS goal. The AI and QAPI evaluations also found access issues related to service authorization and grievance protocols, provider directory deficiencies, and prevalent deficiencies in indicator monitoring, specifically *Access to Care Monitoring & Results, Clinical Indicator Monitoring,* and *Service Indicator Monitoring*. The EQRO recommended improvements for PIP implementation and continues to provide direct technical assistance to the MCOs and DMOs to educate them on best practices.

Network adequacy studies also support:

Network adequacy is critical for MCOs to provide the right care at the right time. As noted above, MCOs failed to meet appointment availability standards for prenatal care, and in particular high-risk appointment wait time averaged nine days (UMCC standard is five days). Problems with directories resulted in inability to reach providers, or providers indicating that they could not provide the requested service. This also creates a barrier to timely care. The EQRO also noted deficiencies in provider identification in encounter data. As mentioned above, the EQRO recommends continued effort to improve universal provider data and encourage MCOs to make improvements to their directories.

Encounter Data Validation also supports:

The EQRO conducted medical and dental record reviews to assess the accuracy and completeness of encounter data. Texas uses these data to determine capitation payment rates, assess and improve quality, and monitor program integrity. A continuing issue for this important validation process is securing requested records. The EQRO continues to work with HHSC to improve the record request and retrieval process. This year, the EQRO provided record requests to the MCOs and DMOs and had them obtain the records from their providers. This improved the record return rate to almost 90 percent for medical records and almost 80 percent for dental records. The EQRO hopes that continuing this process will yield further improvement as MCOs improve their strategies for obtaining records. Average match rates for medical records were above 95 percent for the elements reviewed. For dental records, match

rates were lower, with procedure match rate of 90.5 percent for Medicaid and 89.7 percent for CHIP. Overall, tooth ID match rates have been low, but for selected procedures where tooth ID is critical, match rates were nearly 100 percent. This validation process ensures that Texas strategies to provide the right care at the right time are based on sound data.

Surveys also support:

Member surveys provide specific information about how members experience healthcare and whether care is accessible, timely and high quality. The low and decreasing scores and rates across domains suggest that members are experiencing difficulties getting the best quality care. Further analysis of survey results, possibly in combination with other member data, could provide insight to the significance of the findings and how changes reflect changes in the delivery of care and changes in the member population.

Quality Measures Support:

Potentially preventable events (PPEs) represent missed opportunities to provide the right care at the right time. in 2022, PPV rate increased along with overall ED use, while outpatient utilization decreased. Root cause analysis could help Texas HHSC understand reasons for PPVs and identify members most at risk to inform targeted interventions. Nearly 50 thousand C-Sections occurred in deliveries without complications. These represent substantial additional cost ($130 million) and potential risk to mothers and infants. Texas should encourage MCOs to implement PIPs or other interventions to reduce uncomplicated C-sections, and support provider education and incentives through the MCO networks or other Texas agencies to improve perinatal care practices.

The Performance Indicator Dashboards provide Texas and stakeholders with a consolidated view of MCO and DMO performance in providing the right care at the right time. They leverage national measure like the CMS core measure sets and other nationally recognized measures chosen to monitor areas of significance to Texas, providing a tool for HHSC to use in holding MCOs and DMOs accountable across healthcare domains.

Report Cards Support:

The 2023 report cards focus study revealed that almost all members found the star rating system easy to understand. The EQRO works continuously with Texas HHSC to improve the meaningfulness of report cards in helping members get the most appropriate care for their needs. Domains on each report card reflect the specific needs of the target population. They provide information about performance on outcomes measures and member experience with the MCO and services. By rating the MCOs available in each service area, members can easily compare MCOs on the criteria most important to them. The focus study found that providing access to further guidance about the report cards and a reminder about when to choose an MCO would make report cards more useful.

Focused Studies also support:

The STAR Kids focus study highlighted the importance of coordinated care, which fundamentally embodies the goal of providing the right care in the right place at the right time. Home health services and LTSS are particularly vital to children in the STAR Kids program. Service coordinators who frequently contacted caregivers had a positive impact on access to home nursing services. The topic report on SUD diagnosis and treatment among adults in the STAR program showed that the most common venue for new alcohol use disorder treatment was the ED, and less than 10 percent of new episodes received follow-up within 30 days. Outpatient settings were the most common venue for new opioid use disorder treatment, and less than 30 percent of new episodes received follow-up treatment within 30 days. Better understanding of common pathways and barrier to SUD care will enable Texas to design interventions more aligned with member needs. The topic report on extended postpartum care showed that prenatal

diabetes, hypertension, MHC, or SUD significantly increased non-pregnancy-related outpatient utilization, ED visits, and PPVs during the extended postpartum period and MHCs had the greatest impact on outpatient utilization, while SUD had the greatest impact on ED visits and PPVs. Providing the right maternal health care at the right time requires considering the whole health of women. Care addressing co-occurring prenatal and postpartum conditions will improve the health of women, and may reduce PPVs and SMM. The study also found evidence suggesting that extending postpartum care benefits could have spill-over affects improving use of prenatal and perinatal care, perhaps by increasing awareness of maternal health services. The topic report on co-occurring MHCs further underscored the importance of coordinated care. The EQRO recommends that developing targeted interventions for coordinating care for MHC and physical health consider specific geographic, language, or other NMDOH barriers that may hinder access to mental health care and initiation of screening and treatment.

Keeping patients free from harm

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

- AIs and QAPI evaluations (Protocol 3)
- Network adequacy studies (Protocol 4)
- Encounter data validation (Protocol 5)
- QoC measure reporting (Protocol 2 and Protocol 7, and THLCportal.com)
- Performance Indicator Dashboard (Protocol 7 and THLCportal.com
- STAR Kids focus study (Protocol 9)
- Postpartum care (Protocol 9)
- Co-occurring physical and behavioral health issues (Protocol 9)
- MCO Report Cards (Protocol 9 and Protocol 10)

AIs also support:

The AI findings showed that several MCOs were not compliant with regulations related to service authorizations or their grievance system, although these MCOs reached compliance on follow-up. Delays in service authorizations or other administrative barriers can put patients at risk. MCOs should ensure compliance with current regulations. Similarly, MCOs must follow regulations for grievance system protocols to avoid patient harm from inappropriate treatment and to maintain the quality of providers and the care system to prevent future harm.

Network adequacy studies also support:

When members are unable to get timely appointments, either because they have trouble connecting with providers or because appointment availability fails to meet required standards, patient safety is at risk. The EQRO recommends addressing the provider information deficiencies that impact patients, and hinder the appointment availability studies.

As noted in relation to AI and QAPI findings and appointment availability studies, encounter data continues to show deficiencies in provider data. Texas has multiple ongoing initiatives to address deficiencies in universal provider data and with MCO adherence to maintaining data for their provider networks and making data available to members. While the latter focus more on correct contact and service information, state initiatives include ways to improve consistent identification and taxonomy (i.e., specialty) attribution. The medical and dental record review projects help protect patient safety by verifying the integrity of MCO and DMO programs, and ensuring that Texas strategies for improving member health and safety are based on sound data.

Encounter Data Validation also supports:

Many quality measures address aspects of patient safety, either by promoting important preventive care, recommended screening, or management of chronic health conditions. Others specifically target areas related to population safety (e.g., reducing improper use of antibiotics or increasing recommended immunizations), or patient safety (e.g., hospital safety measures). Continued monitoring is a critical part of ensuring patients receive healthcare free from harm.

Quality Measures Support:

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

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

- Network adequacy studies (Protocol 4)
- QoC measure reporting (Protocol 2 and Protocol 7, and THLCportal.com)
- SUD diagnosis and treatment (Protocol 7 and Protocol 9)
- STAR Kids focus study (Protocol 9)
- Postpartum care (Protocol 9)
- Co-occurring physical and behavioral health issues (Protocol 9)
- MCO Report Cards (Protocol 10)

Network adequacy studies also support:

Texas has specific appointment availability standards for behavioral health and prenatal care and the EQRO conducted secret shopper studies to evaluate MCO compliance with these standards. As reported above, the number of providers in the behavioral health study that indicated that they did not accept Medicaid/CHIP coverage increased and MCOs failed to meet required standards for high-risk pregnancy appointments. Although vision appointment availability in STAR+PLUS and STAR Kids decreased, preventive care availability increased in STAR+PLUS, and primary care availability increased in both STAR+PLUS and STAR Kids; in STAR Kids the increase was substantial, going from 92.4 percent in 2022 to 100 percent in 2023.

Quality Measures Support:

Certain quality measures address the specific care needs of people with chronic, complex, and serious conditions, including physical health conditions such as diabetes or cardiovascular disease, behavioral health conditions such as ADHD (attention-deficit hyperactivity disorder), or serious mental illness (SMI) including schizophrenia, bipolar disorder and major depression. Other measures address complex comorbidities, such as diabetes or hypertension with SMI. Some of these specific care needs are more common among Medicaid members. HHSC should continue careful analyses of these measures to better understand contributing factors in the prevalence of these conditions and the quality measure outcomes, including demographic, geographic, and other non-medical drivers of health (NMDOH). Using focused studies is one way that Texas leverages quality measures to gain deeper insight.

Focused Studies also support:

The STAR Kids focus study examined how MCO programs are meeting the needs of a young population with chronic, complex and serious conditions. The STAR Kids program intends to provide services tailored for the elevated needs of these members and their caregivers. The study provided many insights Texas can use to enhance the impact of care coordinators for STAR Kids. All three topic reports in 2023 addressed the needs of members with particular

complex needs and aligned with Texas initiatives for improvement in SUD care, maternal care, and mental health care, particularly for members with co-occurring conditions or complex needs.

Attracting and retaining high-performing Medicaid providers

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

- Information Systems Capabilities Assessment (ISCA) process and accreditation review (Protocol 2)
- AIs and QAPI evaluations (Protocol 3)
- Network adequacy studies (Protocol 4)
- Encounter data validation (Protocol 5)
- Experience surveys (Protocol 6, and THLCportal.com)
- STAR Kids focus study (Protocol 9)
- Co-occurring physical and behavioral health issues (Protocol 9)
- MCO Report Cards (Protocol 9 and Protocol 10)

ISCA and AIs also support:

All MCOs indicated that they validate NPI and that they reject or deny claims without an NPI. However, the EQRO notes continued deficiencies in encounter provider data. Although four MCOs indicated taxonomy validation against the services and three indicated taxonomy validation against the provider credentials, the EQRO notes continued deficiency in the provider taxonomies in encounters. Findings from the AI evaluations indicated continuing challenges in keeping provider directories complete and accurate. Inaccessibility of providers has direct negative impact on patients, but may also negatively impact retention of providers. Slow or denied service authorizations can lead to poor provider-patient relationships. Adequately addressing grievances is also important to ensuring that MCOs maintain the best providers. The AI showed that several MCOs were not compliant with current federal guidelines, but the issues were rectified on follow-up.

Network adequacy studies also support:

In the behavioral health appointments study, more providers indicated that they did not accept Medicaid/CHIP coverage than in previous studies. The exclusion of providers from these studies not only impacts the evaluation of appointment availability; it indicates another area for improvement that will impact patients, either directly through the lack of appointment access or indirectly through negative impacts on the ability of MCOs to maintain the best provider networks.

Encounter Data Validation also supports:

Through the medical and dental record review projects, and encounter data certification, the EQRO monitors the encounter data for provider reporting issues. Deficiencies are traced to identify commonalities like specific providers or procedures. For example, the EQRO was able to identify the most common procedures with discrepancies, and the MCOs or DMOs with the most encounters with these identified issues. Sharing these findings with the MCOs or DMOs allows them to work with their provider networks to improve accuracy and completeness in submitted claims.

Surveys also support:

Member surveys provide important information about how members interact with providers and perceive their performance. Understanding differences in patient experiences, including provider interactions, can inform efforts to improve provider networks, whether members are experiencing difficulties in access to care, timeliness or availability of care, or quality of care. In some cases, differences in related responses require further analysis or investigation to interpret. For example, in 2023 the access to dental care rating increased while the availability of appointments when needed decreased. Quality improvement strategies should consider the significance of both findings.

Focused Studies also support:

In the STAR Kids focus study, caregivers reported that availability of home health care providers was reduced by staffing shortages and high turnover at home health agencies. Staff leave for a variety of reasons, including low pay rates, changing jobs, or being fired by caregivers who are dissatisfied with their services. The EQRO recommends several strategies to improve home health provider networks including engaging nurses in shared governance, encouraging credentialing requirements and competency monitoring coupled with staffing and compensation strategies to attract and retain the highest quality providers. The study also found that service coordinator helpfulness was associated with better access to home nursing, specialist care, medications, and medical supplies, and reduced caregiver burden. This highlights the need to bolster the availability of high-quality, well-trained coordinators that caregivers can access.

Conclusion

In SFY 2023, HHSC continued working to improve the quality and efficiency of healthcare services in Medicaid and CHIP through numerous initiatives to (a) improve care for MHC and SUD, (b) improve maternal care, and (c) improve service coordination for special populations. HHSC also continues development of a detailed action plan to address non-medical drivers of health to improve data infrastructure and coordination of services focusing on food insecurity, housing, and transportation (HHSC, 2023). While there is always room for improvements, HHSC's efforts to improve the quality of healthcare for Medicaid and CHIP members positively affected several essential aspects of care, including performance on measures associated with complex care such as diabetes testing for members with SMI, and measures reflecting integrated care including some member experience measures, and measures related to care coordination. HHSC is also actively addressing areas in need of further quality improvement.

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

Introduction

As of the end of Texas state fiscal year (SFY) 2022, the Kaiser Family Foundation (KFF) reports that nearly 90 million Americans receive healthcare coverage through the Children's Health Insurance Program (CHIP) and Medicaid (KFF, 2024). The U.S. Department of Health and Human Services (HHS) helps states fund their CHIP and Medicaid programs through cost sharing initiatives. Participation in federal funding for state managed care programs requires compliance with the Centers for Medicare and Medicaid Services (CMS) guidelines and protocols, including the provision for external quality review (EQR) by an organization independent from the state. Texas has one of the largest Medicaid programs in the country, serving five million people (KFF, 2023). Over 90 percent of Texas Medicaid members and all children in Texas CHIP receive coverage through a managed care delivery model. Since 2002, the Institute for Child Health Policy at the University of Florida has served as the external quality review organization (EQRO) for Texas Medicaid and CHIP. This report presents the results of Texas EQR activities during SFY 2023.

Texas provides Medicaid medical services through four Medicaid managed care programs serving specific populations (Table 2). Traditional Medicaid fee-for-service (FFS) provides: transitional coverage for members moving into or between managed care programs, emergency Medicaid, certain carved-out benefits coverage for managed care members, and coverage for members in the Healthy Texas Women program. 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 2. Texas Medicaid and CHIP managed care programs

Program	Description
STAR	Manages care for most Texas Medicaid beneficiaries. This program covers low-income families, including adults and children, pregnant women, and newborns.
STAR+PLUS	Integrates acute care services with long-term services and supports (LTSS) for adults with a disability or those 65 or older, including dual-eligible members (also receiving Medicare benefits). Dual-eligible members meeting all Medicare-Medicaid Plan (MMP) eligibility criteria have the option to join an MMP instead of STAR+PLUS; MMPs provide 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 program provides dental services to eligible Medicaid members aged 20 and younger, while the CHIP Dental program provides dental services to CHIP members aged 18 and younger.

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

Figure 2. Texas Medicaid and CHIP service areas

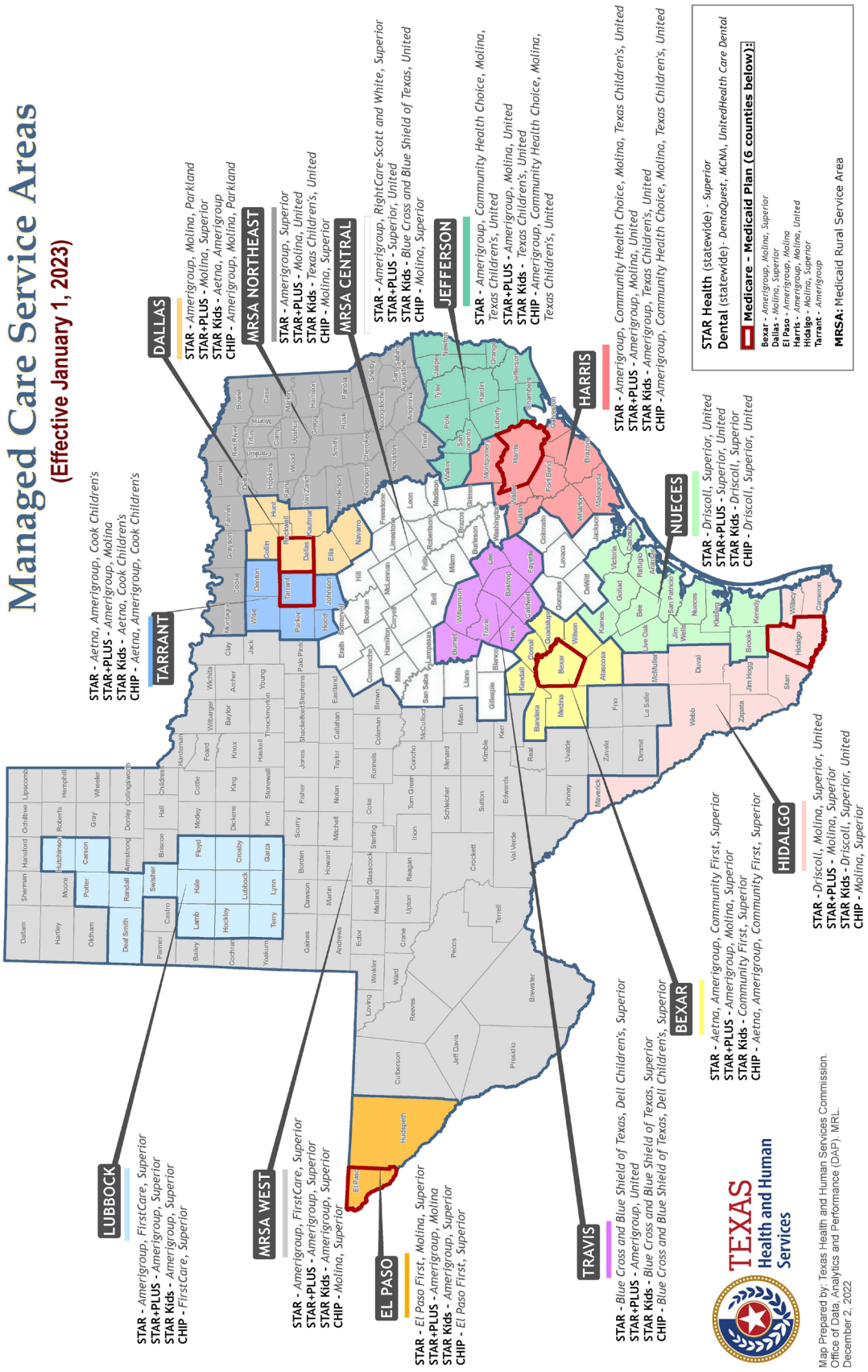


Table 3 shows Medicaid and CHIP enrollment with Texas contracted MCOs as of December 31, 2022, excluding dual-eligible members, and Table 4 shows enrollment with the three DMOs as of December 31, 2022.

Table 3. Non-dual-eligible enrollment in Texas Medicaid and CHIP in December 2022

MCO	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Aetna Better Health (Aetna)	144,220	-	13,023	-	1,986
Amerigroup (Wellpoint beginning 1/1/2024)	885,828	58,564	28,395	-	8,087
Blue Cross Blue Shield (BCBSTX)	59,611	-	8,915	-	869
Community First Health Plans (CFHP)	176,394	-	7,741	-	2,164
Community Health Choice (CHC)	405,031	-	-	-	3,468
Cook Children's Health Plan (CCHP)	169,590	-	9,703	-	2,842
Dell Children's Health Plan (DCHP)	45,700	-	-	-	1,365
Driscoll Health Plan (Driscoll)	256,763	-	10,701	-	1,017
El Paso Health (ElPasoHealth)	102,109	-	-	-	1,506
FirstCare Health Plans (FirstCare)	122,604	-	-	-	512
Molina	141,442	51,825	-	-	4,083
Parkland Community Health Plan (PCHP)	241,854	-	-	-	3,029
RightCare (SWHP)	69,614	-	-	-	-
Superior	1,131,164	71,005	31,501	47,553	12,395
Texas Children's Health Plan (TCHP)	568,493	-	30,422	-	8,952
UnitedHealthcare (UHC)	259,491	70,018	28,849	-	1,481
Total	**4,779,908**	**251,412**	**169,250**	**47,553**	**53,756**

Table 4. Enrollment in Medicaid children's and CHIP dental programs in December 2022

DMO	Medicaid Children's Dental	CHIP Dental
DentaQuest	2,232,149	30,563
MCNA Dental (MCNA)	1,474,331	14,638
UnitedHealthcare Dental (UHCD)	471,906	8,558
Total	**4,178,386**	**53,759**

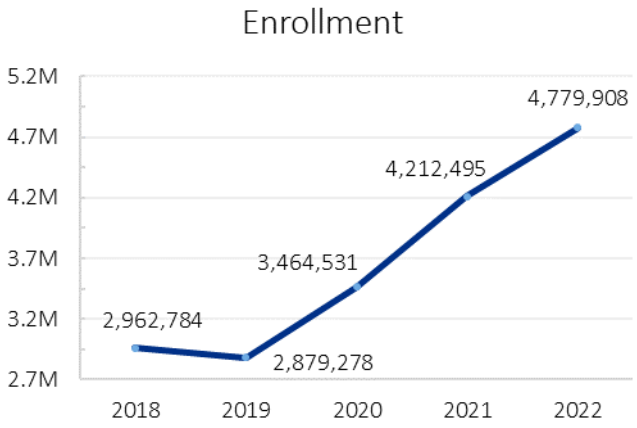
In response to the COVID-19 pandemic, CMS made widespread use of program waivers and other flexibilities to support access to care to Medicaid members, which resulted in significant increases in Medicaid and CHIP enrollment during 2020 (CMS, 2021), and continuing through the end of the Public Health Emergency (PHE) in 2023 (Williams et al., 2023). The increase in total Medicaid and CHIP enrollment resulted particularly from Texas adhering to the Maintenance of Effort requirement under the Families First Coronavirus Response Act (FFCRA), which ensured that eligible people enrolled in Medicaid stayed enrolled and covered during the PHE. Thus, members enrolled in Medicaid during 2020–2022 continued enrollment throughout those years. Enrollment in Texas CHIP was declining prior to the PHE. This trend accelerated during the PHE because children that became Medicaid eligible stayed in Medicaid, including newborns that received Medicaid coverage for their first year; Children that would have transitioned to CHIP at age one continued in Medicaid during the PHE.

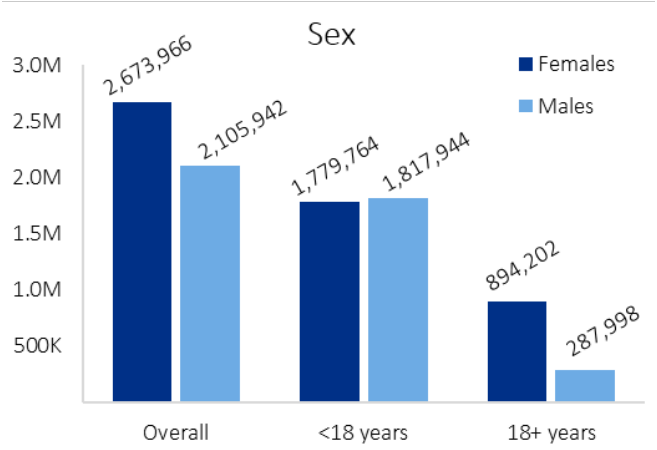
The following summaries show member data as of December 31, 2022, for the STAR, STAR+PLUS, STAR Kids, STAR Health programs, and CHIP. They represent a snapshot of the Texas Medicaid programs and CHIP as of the close of the measurement year (MY) for most of the quality-of-care (QoC) measures reported by the EQRO

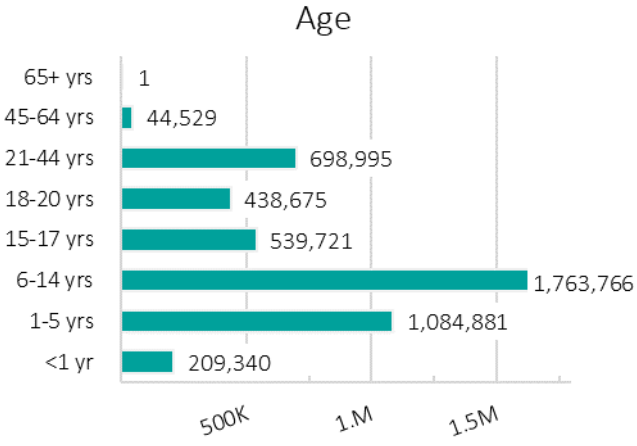
during SFY 2023. In this reporting year, the EQRO transitioned from a consolidated race/ethnicity categorization, provided with member eligibility data by HHSC to separate race and ethnicity categorization sourced through member data provided by the Texas Medicaid and Healthcare Partnership (TMHP). Although the data is generally consistent, improving these demographic data is a priority. Health status reflects members' 3M™ Clinical Risk Group (CRG) status assigned to Special Healthcare Needs (SHCN) groups. *Appendix A: 3M™ Clinical Risk Group Classification* describes the health status CRG categories.

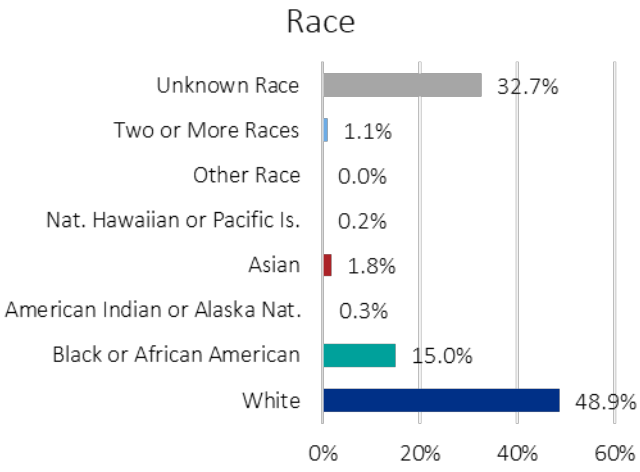
STAR

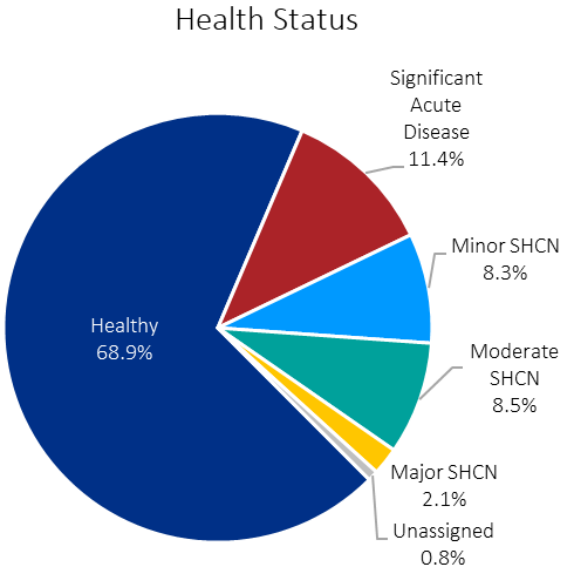
As the main managed care program in Texas Medicaid, the STAR program had 4,779,908 non-dual-eligible members in December 2022. Nearly 80 percent of adult members are women, while members up to age 18 are almost evenly males and females. These distributions by sex remained generally consistent, although the percentage of adult members has increased during the PHE. As in prior years, a majority of members are Hispanic, and most members are healthy.

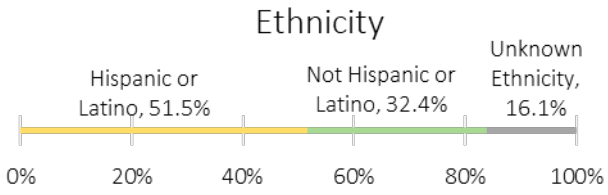






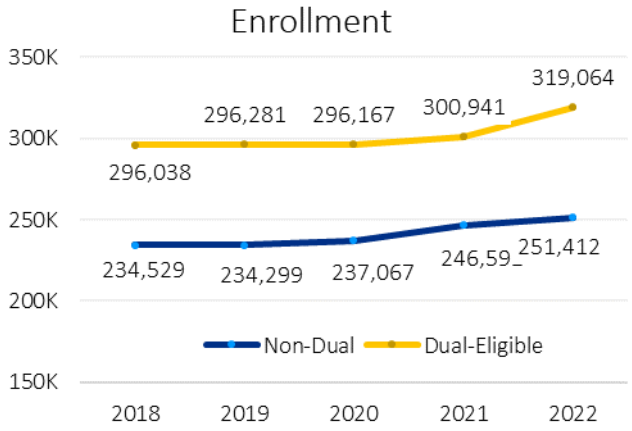


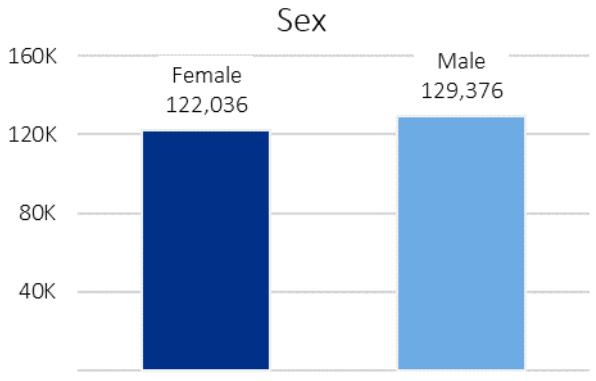


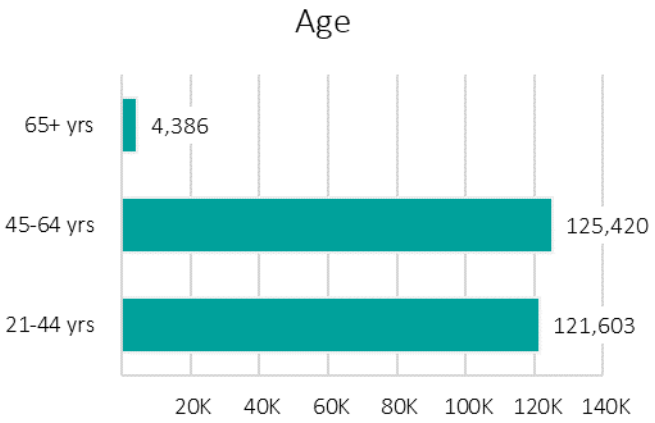


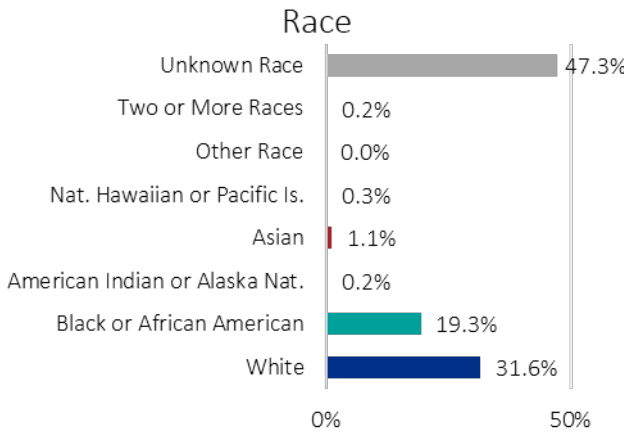
STAR+PLUS

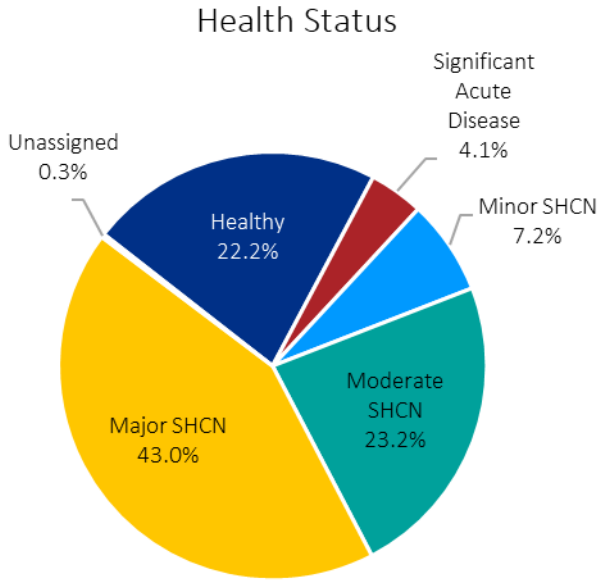
The STAR+PLUS program had 251,412 non-dual-eligible members (among 570,476 total) as of December 2022. Non-dual membership has increased annually since 2018, including a two percent increase from 2021. Distributions by age and sex are similar to those in 2021. Nearly half of STAR+PLUS enrollees had unknown race designation. Close to twenty-two percent were categorized as healthy, despite health status criteria eligibility for this program

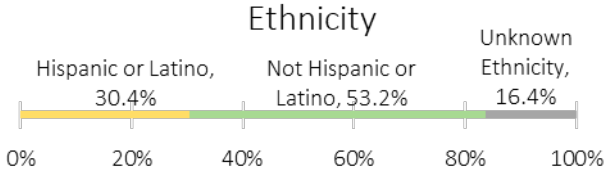






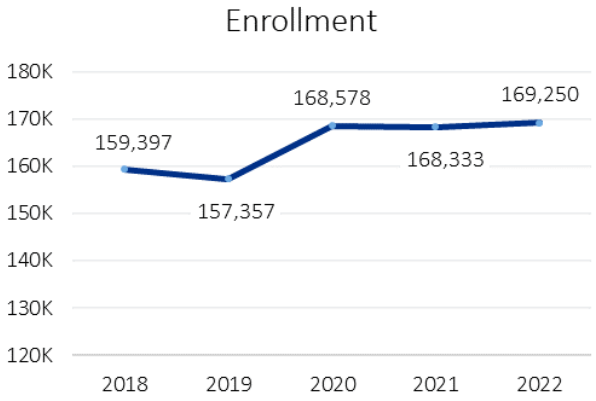


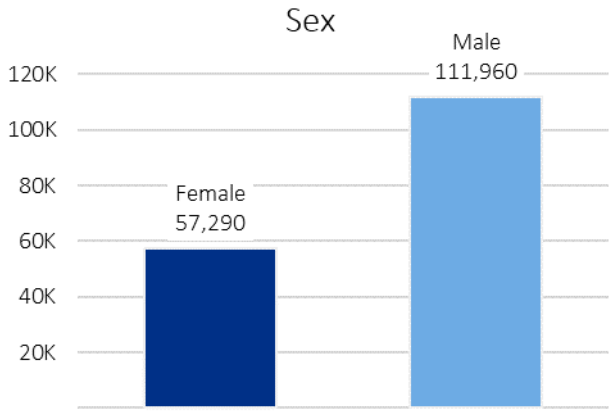


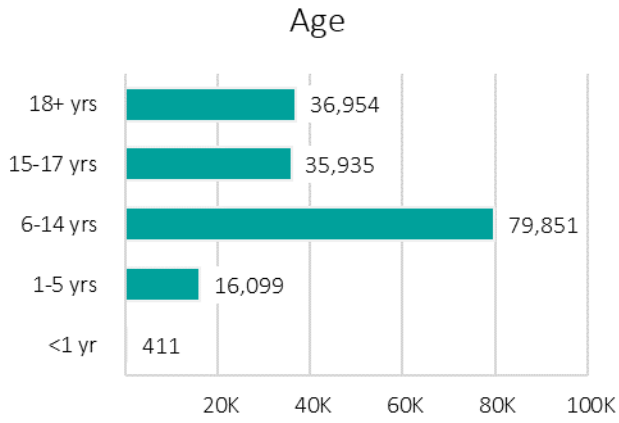


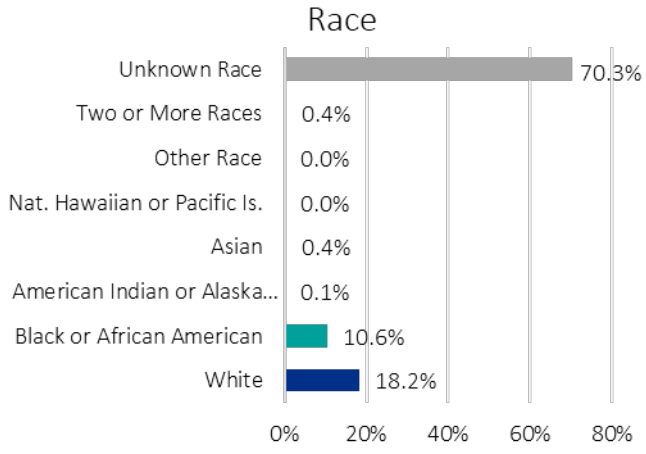
STAR Kids

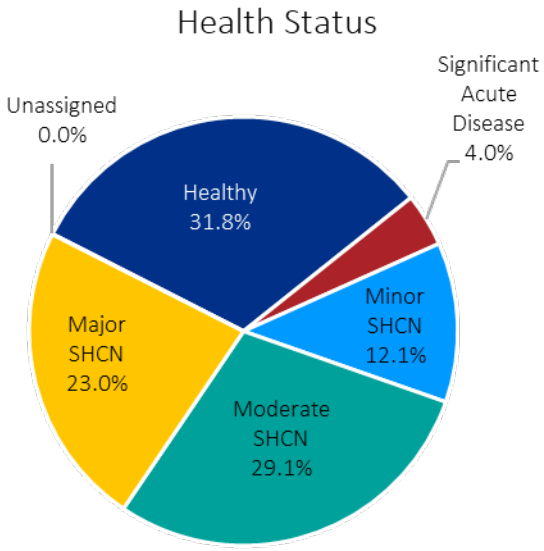
The STAR Kids program had 169,250 non-dual-eligible members as of December 2022. Enrollment remained consistent following a nine percent increase in 2020. Males continue to outnumber females by about two to one, and nearly half of all members are six to 14 years of age. More than 70 percent of STAR Kids enrollees had an unknown race designation. Member SHCN category is more likely to be minor or moderate in STAR Kids than in STAR+PLUS, where most members have major SHCN.

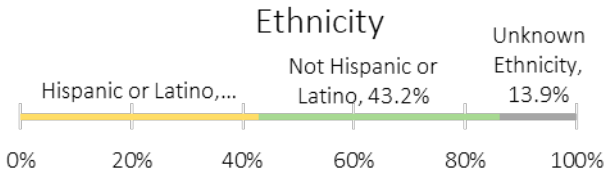






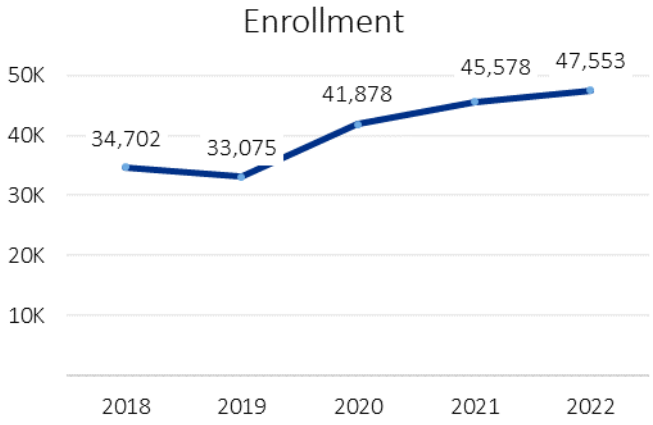


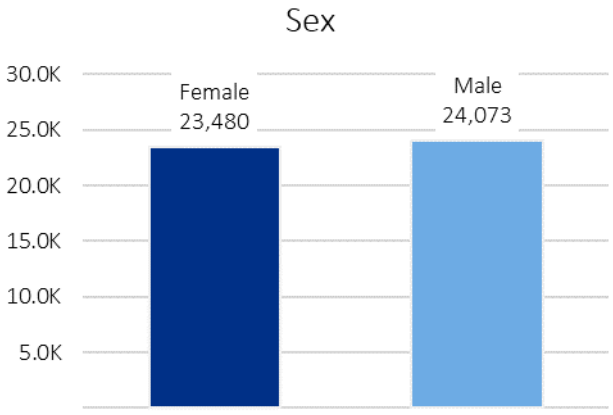


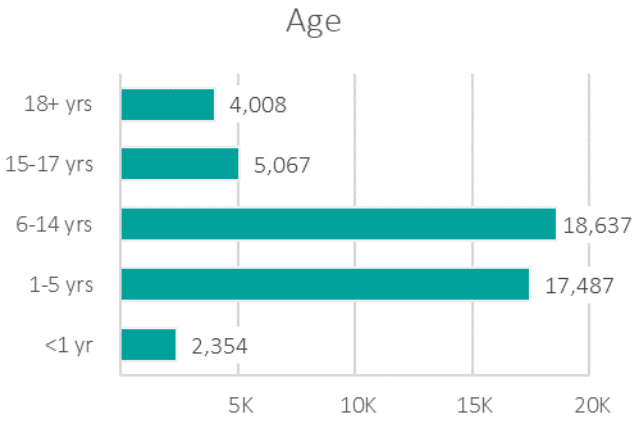


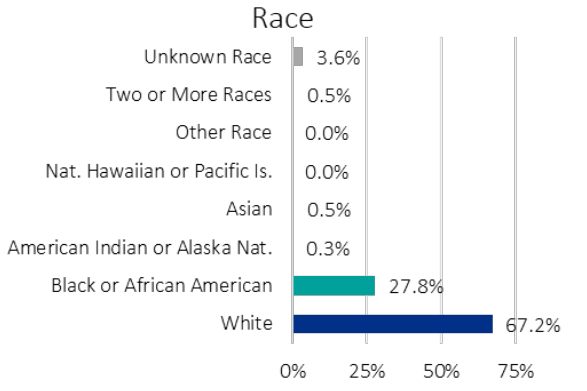
STAR Health

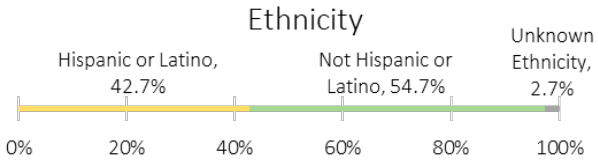
Enrollment in STAR Health increased in 2022. There were 47,553 members as of December 2022. Equal numbers of members are male and female, and the member age distribution is relatively even and consistent compared to prior years. In 2022, 40.4 percent of STAR Health enrollees were healthy, though it is noteworthy that half of the enrollees belonged to one of the three SHCN health status categories.

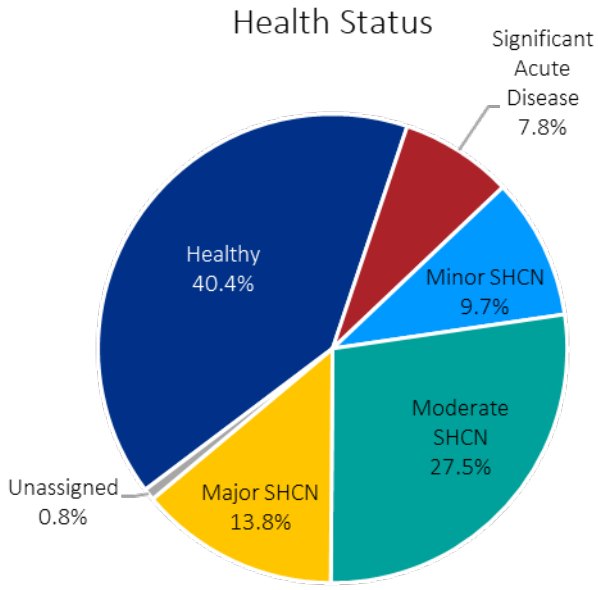






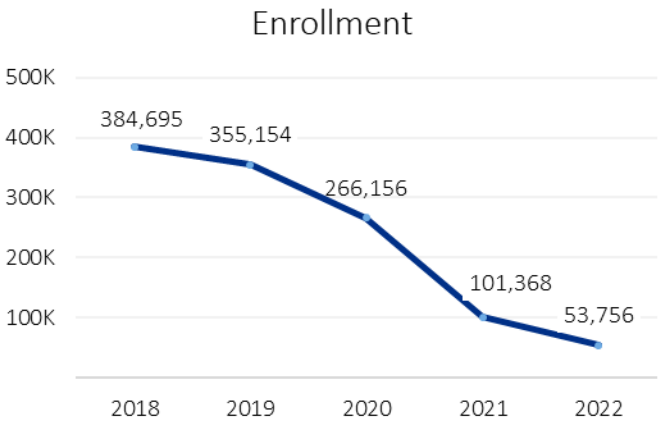


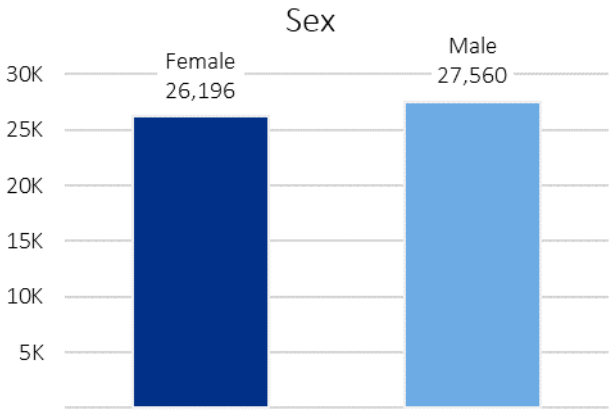


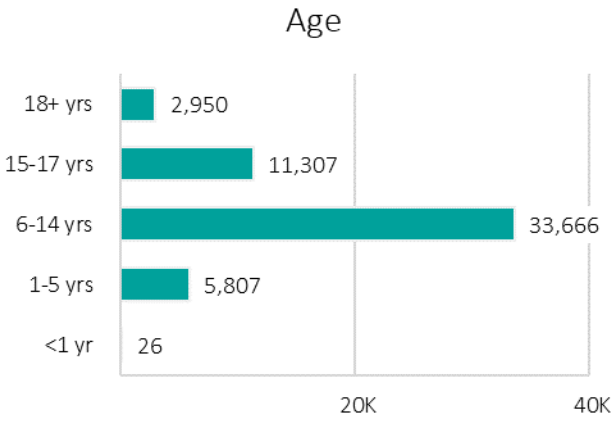


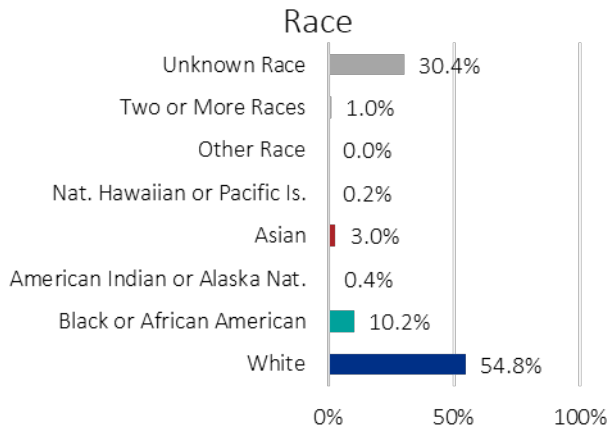
CHIP

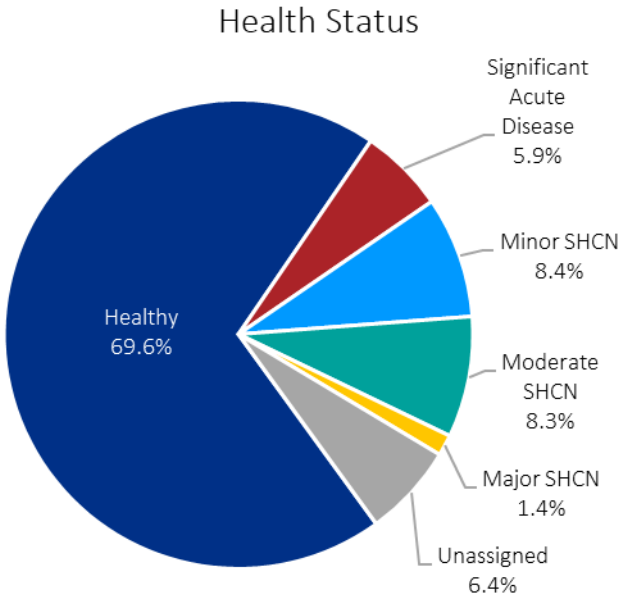
CHIP enrollment has decreased precipitously. A major reason is that during the PHE, CHIP-eligible infants that received Medicaid coverage until age one stayed in Medicaid rather than transferring to CHIP. This also affected the distribution of members by age, decreasing the percentage of members under age six. The impact of the the PHE ending in May 2023 remains to be seen. The distributions by sex and health status remain consistent with prior years. CHIP has the highest percentage of healthy members compared to all the STAR programs.

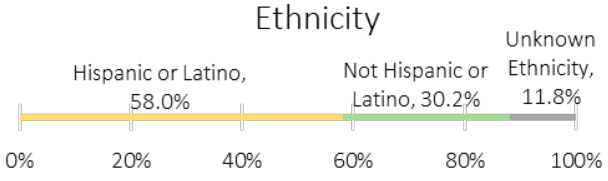












EQRO Responsibilities

This Annual Technical Report (ATR) summarizes findings from EQR activities conducted in SFY 2023 (September 1, 2022 – August 31, 2023), per the requirements of 42 C.F.R. § 438.364 (2020). The EQRO followed the reporting guidelines outlined under 42 C.F.R. § 438.364 (2020) and completed the report in time for HHSC to submit the report to CMS by April 30, 2024. Per reporting requirements under 42 C.F.R § 438.364 (a)(7)(2020), HHSC confirmed that none of the MCOs, MMPs, or DMOs that serve members in Texas Medicaid or CHIP were exempt from EQR activities in SFY 2023.

The EQRO followed the guidance of the CMS EQR Protocols (CMS, 2023a) for EQR activities. The EQR protocols covered in this ATR include:

Mandatory protocols:

- **Protocol 1:** Validation of PIPs
- **Protocol 2:** Validation of performance measures
- **Protocol 3:** Review of compliance with Medicaid and CHIP managed care regulations
- **Protocol 4:** Validation of network adequacy *(made mandatory in February 2024)*

Optional protocols:

- **Protocol 5:** Validation of encounter data
- **Protocol 6:** Administration or validation of QoC surveys
- **Protocol 7:** Calculation of additional performance measures
- **Protocol 9:** Conducting focused studies of healthcare quality
- **Protocol 10:** Assistance with Quality Rating of MCOs (*unpublished as of February 2024)*

Protocol 8, Implementation of Additional Performance Improvement Projects is not part of the EQRO contract.

This ATR includes an Executive Brief highlighting findings and initiatives of interest to CMS and Texas, particularly in relation to the Texas Managed Care Quality Strategy (MCQS) to satisfy requirements in 42 CFR 438.340(c)(1)(2020). Also included are activity summaries for the EQR protocols, a summary of recommendations by the EQRO for SFY 2023, and a summary of recommendations from SFY 2022 that includes HHSC actions on each recommendation.

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

As part of the overall Medicaid managed care quality requirements, CMS requires states contracting with an MCO (or DMO) to develop and implement a written quality strategy to assess and improve the quality of Medicaid and CHIP managed care services (42 C.F.R. §438.340, 2020). Texas must review and update this quality strategy every three years and submit it to CMS for approval. The current Texas MCQS is available at hhs.texas.gov. This ATR includes information on the Texas Managed Care Quality Strategy (MCQS) goals associated with the findings and recommendations in the report. related to the activities in this report.

Table 5 lists the Texas MCQS goals related to the activities in this report.

Table 5. 2021 Texas MCQS goals referenced in this report

Goal	Icon	Description of 2021 Texas MCQS goals referenced in this report
1		**Promoting optimal health**: Promoting optimal health for Texans at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health
2		**Strengthening person and family engagement**: Strengthening person and family engagement as partners in their care to enhance respect for individual's values, preferences, and expressed needs
3		**Right care in the right place at the right time**: Providing the right care in the right place at the right time to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate
4		**Safer delivery system**: Keeping patients free from harm by contributing to a safer delivery system that limits human error
5		**Effective practices for people with chronic, complex, and serious conditions**: Promoting effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs
6		**High-performing Medicaid providers**: Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers, to participate in team-based, collaborative, and high-value care

Protocol 1: Validation of Performance Improvement Projects (PIPs)

Protocol Overview & Objectives

In 2019, CMS updated the EQR protocols and validation of performance improvement projects (PIPs) is now addressed in Protocol 1 (CMS, 2023a). The revised Protocol 1 includes updated templates for PIP reporting and re-ordering of some PIP activities. HHSC implemented these changes for activities in SFY 2022 (for PIPs beginning in SFY 2022 and later). During SFY 2023, the EQRO followed the guidance in previous 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 beginning in 2019. Texas requires MCOs and DMOs to conduct PIPs over two years to provide enough time for project implementation and to increase the likelihood of reporting meaningful outcomes.

EQR Activities

Per 42 CFR §438.358(b) (2020), PIP validation is a mandatory EQRO activity. As an ongoing process, the EQRO activities include three major components – an evaluation and validation of the PIP plans, PIP progress reports, and final PIP reports. In September, the EQRO reviews PIP plans for the upcoming year. Every July, the EQRO uses progress reports to evaluate the implementation of the PIPs as they are underway. By October, the MCOs submit the reports for the PIPs they completed in the prior year for final evaluation by the EQRO. However, because the PHE and its impacts on PIP interventions led to the extension of 2019 PIPs, the EQRO received the 2019 final PIP reports in October 2022 rather than October 2021. This report includes the review of 2019 final PIP reports.

Methods

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

1. Characteristics of the target population for the PIPs including demographics and utilization of clinical and/or non-clinical services;
2. Prevalence of the problem, supplemented with current literature when applicable;
3. Sampling methodology utilized for the PIP, measures, and interventions, when applicable. This includes:
   a) *Sampling methodology for the PIP:* a description of how the sample represents the entire enrolled population to which the PIP study indicators (quantifiable measures) apply.
   b) *Sampling methodology for measures:* a description of how the MCO/DMO will obtain a representative sample for the measure and a description of the sample size and the percentage of the total population that the sample represents.
   c) *Sampling methodology for interventions:* a description of how the MCO/DMO will obtain a representative sample for the intervention and a description of the sample size and the percentage of the total population that the sample represents.
4. Performance measures utilized to assess the effectiveness of the PIPs with corresponding benchmarks and goals for improvement;
5. Data collection procedures (i.e., steps taken to ensure validity and reliability of data collected, sources of data, frequency of data collection, types of data collected, and data analysis plan);
6. Interventions the MCO implemented for the PIP, along with tracking and monitoring efforts conducted for each intervention. This includes, but is not limited to:

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

a) Number and percent of members/providers targeted and reached;
b) A detailed description of how the MCO/DMO will monitor each intervention for effectiveness throughout implementation; and
c) Process measures the MCOs/DMOs will utilize to measure the impact and effectiveness of the interventions.

7. The results of the statistical analyses the MCO/DMO used to determine if the PIP measures achieved a statistically significant improvement.

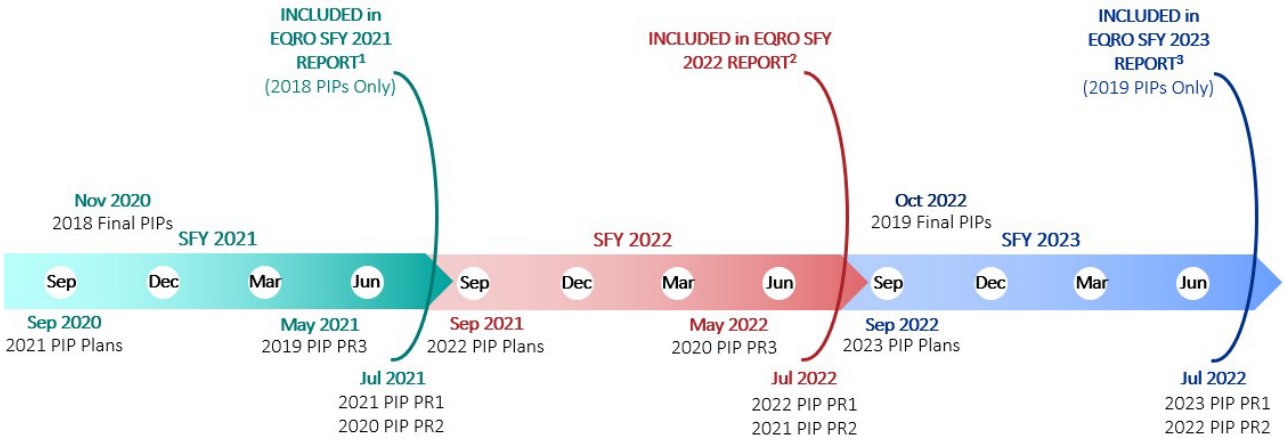
When evaluating the PIPs, the EQRO assesses compliance on a variety of components, assigning levels including "met," with a corresponding score of 100, "partially met," with a corresponding score of 50, and "not met," with a corresponding score of zero. The overall PIP score is the average of all component scores.

PIP Timelines and Reporting

Due to the COVID-19 pandemic and the impact it had on the implementation of PIPs, HHSC extended the 2019 PIPs by one year, making them three-year PIPs instead of two-year PIPs. As a result, HHSC required the MCOs to submit a third progress report in the third year of the PIP (2021 for the 2019 PIPs). Figure 3 provides a timeline for the PIP reporting activities and reflects the changes made to the timelines for the 2019 and 2020 PIPs.

During SFY 2023, the EQRO reviewed: (a) the 2023 PIP plans, (b) the 2019 final PIP reports, (c) the first progress reports for 2023 PIPS, and (d) the second progress reports for 2022 PIPS. This report will focus on the 2019 PIP reports, which concluded with the EQRO's evaluation of the final PIP Reports in October 2022.

Figure 3. EQRO timeline for PIP activities



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

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

[2] The EQRO did not have a complete set of PIP reports to report on one round of PIPs for the SFY 2022 Report. Therefore, the EQRO reported a summary of all the PIP component evaluations completed during SFY 2022.

[3] The EQRO is reporting on the complete set of the 2019 PIPs for the SFY 2023 Report.

Summary of 2019 PIPs

The MCOs completed their 2019 PIPs in December 2021 and submitted final PIP reports in November 2022. The topic for the 2019 three-year PIPs for all MCOs was:

> *Reduction of potentially preventable emergency department visits and inpatient stays among members with anxiety and/or depression through improved medication management by primary care providers and improved treatment for behavioral health conditions.*

Both DMOs conducted dental PIPs for Medicaid and CHIP focused on:

> *Creating a data-sharing collaborative for dental-related (3M) Potentially Preventable Emergency Department (ED) Visits (PPVs).*

Unlike the MCOs' PIPs, these did not extend for a third year and instead concluded in December 2020. This was because the 2019 dental PIPs were Phase 1 of a multi-part PIP to reduce dental PPVs. Phase 1 (the 2019 PIPs) laid the groundwork by establishing data-sharing agreements with MCOs. Phase 2 began in 2021 upon the conclusion of the 2019 PIPs and focused on using the data-sharing agreements to reduce dental-related PPVs.

2019 PIP Scores

2019 STAR PIP Scores

Table 6 provides the scores for the 2019 STAR PIP evaluations. CFHP received the lowest PIP plan score of 69.3 and subsequently had the lowest final PIP score of 69.8. CFHP lost points on the PIP plan because it reported the target population inconsistently and used the wrong statistical test in its data analysis plan. In the final PIP, CFHP did not revise the statistical method, used incorrect data, and did not provide adequate target and reach data for the interventions in Activity 9, *Intervention Follow-up Summary.* Fifteen MCOs (Aetna, Amerigroup, BCBSTX, CFHP, CHCT, CookCHP, DCHP, Driscoll, ElPasoHealth, FirstCare, Molina, SWHP, Superior, TCHP, and UHC) failed to achieve statistically significant improvement on one or more measures. Another common issue which lead to loss of points was in Activity 10, *Significant and Sustained Improvement.* No MCOs achieved sustained statistically significant improvement for all measures. However, seven MCOs achieved sustained improvement for one measure including CHCT, CookCHP, ElPasoHealth, Superior, and TCHP for PPVs, and FirstCare and Driscoll for PPAs. The average overall PIP score for STAR MCOs was 90.6.

Table 6. STAR 2019 three-year PIP plan, final PIP, and overall PIP scores by MCO

MCO	PIP Plan Score	Final PIP Report Score	Overall PIP Score
Aetna Better Health (Aetna)	100%	75.9%	91.4%
Amerigroup	100%	91.6%	97.1%
Blue Cross Blue Shield (BCBSTX)	96.2%	83.2%	91.8%
Community First Health Plans (CFHP)	69.3%	69.8%	69.8%
Community Health Choice (CHCT)	96.2%	91.6%	94.7%
Cook Children's Health Plan (CookCHP)	90.7%	93.9%	92.2%
Dell Children's Health Plan (DCHP)	100%	91.6%	97.1%
Driscoll Health Plan (Driscoll)	91.7%	93.9%	89.3%
El Paso Health (ElPasoHealth)	100%	93.9%	98.2%
FirstCare	77.5%	77.0%	78.9%
Molina	92.3%	84.3%	90.0%
Parkland Community Health Plan (PCHP)	100%	82.0%	93.6%

MCO	PIP Plan Score	Final PIP Report Score	Overall PIP Score
RightCare (SWHP)	96.3%	85.5%	93.4%
Superior	94.0%	88.9%	93.0%
Texas Children's Health Plan (TCHP)	93.5%	93.9%	94.5%
UnitedHealthcare (UHC)	80.7%	91.6%	84.4%
Minimum	**69.3%**	**69.8%**	**69.8%**
Maximum	**100%**	**93.9%**	**98.2%**
Average	**92.4%**	**86.8%**	**90.6%**

2019 CHIP PIP Scores

Table 7 provides the scores for the 2019 CHIP PIP evaluations. CFHP received the lowest PIP plan score of 69.3 and the lowest final PIP score of 69.8, resulting in the lowest overall PIP score of 69.8. The MCO lost points on the PIP plan because it reported the target population inconsistently and used the wrong statistical test in its data analysis plan. In the final PIP, CFHP did not revise the statistical method, used incorrect data, and did not provide adequate target and reach data for the interventions in Activity 9, *Intervention Follow-up Summary.* Three MCOs (Amerigroup, FirstCare, and Molina) achieved sustained statistically significant improvement for one measure (PPVs), however, no MCO achieved sustained improvement for all measures. The average Overall PIP score for CHIP MCOs was 90.0.

Table 7. CHIP 2019 three-year PIP plan, final PIP, and overall PIP scores by MCO

MCO	PIP Plan Score	Final PIP Report Score	Overall PIP Score
Aetna Better Health (Aetna)	100%	75.9%	91.4%
Amerigroup	100%	93.9%	98.2%
Blue Cross Blue Shield (BCBSTX)	96.2%	83.2%	91.8%
Community First Health Plans (CFHP)	69.3%	69.8%	69.8%
Community Health Choice (CHCT)	96.2%	90.5%	94.2%
Cook Children's Health Plan (CookCHP)	90.7%	92.7%	91.7%
Dell Children's Health Plan (DCHP)	100%	93.9%	98.2%
Driscoll Health Plan (Driscoll)	85.7%	85.5%	90.1%
El Paso Health (ElPasoHealth)	100%	92.7%	97.2%
FirstCare	77.5%	74.8%	77.8%
Molina	92.3%	85.5%	90.6%
Parkland Community Health Plan (PCHP)	100%	77.0%	92.4%
Superior	94.0%	87.7%	92.4%
Texas Children's Health Plan (TCHP)	93.5%	85.5%	91.4%
UnitedHealthcare (UHC)	80.7%	84.3%	82.1%
Minimum	**69.3%**	**69.8%**	**69.8%**
Maximum	**100%**	**93.9%**	**98.2%**
Average	**91.7%**	**84.9%**	**90.0%**

2019 STAR+PLUS PIP Scores

Table 8 provides the scores for the 2019 STAR+PLUS PIP evaluations. Cigna-HealthSpring received the lowest PIP plan score of 81.3, the lowest final PIP score of 75.9, and the lowest overall PIP score of 79.9. This was due to the MCO incorrectly, inconsistently, or incompletely reporting information on the target population, measures, data collection plan, and interventions, on the PIP plan. On the final PIP, this MCO lost points for using the wrong statistical test, reporting incorrect measure data, and reporting incomplete reach data for interventions. Note that Cigna-HealthSpring's managed care contract ended before PIP completion. The average overall PIP score for STAR+PLUS MCOs was 89.8.

Table 8. STAR+PLUS 2019 three-year PIP plan, final PIP, and overall PIP scores by MCO

MCO	PIP Plan Score	Final PIP Report Score	Overall PIP Score
Amerigroup	100%	98.9%	99.4%
Cigna-HealthSpring[a]	81.3%	75.9%	79.9%
Molina	92.3%	85.5%	90.6%
Superior	94.0%	92.7%	93.7%
UnitedHealthcare (UHC)	90.7%	96.6%	85.7%
Minimum	**81.3%**	**75.9%**	**79.9%**
Maximum	**100%**	**98.9%**	**99.4%**
Average	**91.7%**	**89.9%**	**89.8%**

[a] The Cigna-HealthSpring Texas Medicaid managed care contract ended before PIP completion.

2019 STAR Kids PIP Scores

Table 9 provides the scores for the 2019 STAR Kids PIP evaluations. CFHP received the lowest PIP plan score of 69.3 because the MCO reported the target population, measures, and data collection plan incorrectly. CFHP also received the lowest final PIP score of 69.8 and the lowest overall PIP score of 69.8 because the MCO used incorrect statistical testing, reported incorrect data, failed to provide reach data for interventions, and did not achieve or sustain statistically significant results for one or more measures. Other MCOs commonly lost points for failing to have statistically significant or sustained improvement on one or more measures. However, two MCOs (Aetna and CookCHP) achieved sustained statistically significant improvement for at least one measure. The average overall PIP score for STAR Kids was 88.5.

Table 9. STAR Kids 2019 three-year PIP plan, final PIP, and overall PIP scores by MCO

MCO	PIP Plan Score	Final PIP Report Score	Overall PIP Score
Aetna Better Health (Aetna)	100%	77.0%	92.0%
Amerigroup	100%	91.6%	97.1%
Blue Cross Blue Shield (BCBSTX)	96.2%	83.2%	91.8%
Children's Medical Center Health Plan (CMCHP)[a]	78.6%	70.5%	75.6%
Community First Health Plans (CFHP)	69.3%	69.8%	69.8%
Cook Children's Health Plan (CookCHP)	90.7%	93.9%	92.2%
Driscoll Health Plan (Driscoll)	91.7%	92.7%	92.6%
Texas Children's Health Plan (TCHP)	95.8%	92.7%	95.0%
UnitedHealthcare (UHC)	81.8%	91.6%	85.0%

MCO	PIP Plan Score	Final PIP Report Score	Overall PIP Score
Minimum	69.3%	69.8%	69.8%
Maximum	100%	93.9%	97.1%
Average	89.3%	89.2%	88.5%

[a] The CMCHP Texas Medicaid managed care contract ended before PIP completion.

2019 STAR Health PIP Scores

Table 10 provides the score for the 2019 STAR Health PIP evaluation. Superior, the only STAR Health MCO, received a score of 94.0 on the PIP plan and a final PIP score of 80.5, for an overall PIP score of 89.9. The MCO lost points on the PIP plan for focusing on only one service area for the statewide PIP and selecting an inappropriate statistical method in the data analysis plan. The MCO lost points on the final PIP because it did not achieve statistically significant improvement for any measure.

Table 10. STAR Health 2019 three-year PIP plan, final PIP, and overall PIP scores by MCO

MCO	PIP Plan Score	Final PIP Report Score	Overall PIP Score
Superior	94.0%	80.5%	89.9%

2019 Medicaid and CHIP Dental PIP Scores

Table 11 provides the scores for the 2019 Medicaid Dental and CHIP Dental PIP evaluations (note that the UHC Dental contract was not active until September 2020, so they did not have a 2019 PIP). For Medicaid and CHIP Dental, MCNA had the lowest DMO PIP plan score of 95.4. The DMOs lost points for not providing adequate information on reported measures. DentaQuest received the lowest final PIP score of 98.0. The DMO did not report any additional tracking and monitoring information for PIP interventions. The average overall PIP score for Medicaid Dental was 98.0 percent, while the average overall PIP score for CHIP Dental was 97.7 percent.

Table 11. Medicaid and CHIP Dental 2019 two-year PIP plan, final PIP, and overall PIP scores by DMO

MCO[a]	PIP Plan Score	Final PIP Report Score	Overall PIP Score
DentaQuest – Medicaid Dental	100%	98.0%	99.0%
DentaQuest – CHIP Dental	100%	98.0%	99.0%
MCNA Dental (MCNA) – Medicaid Dental	95.4%	100%	96.9%
MCNA Dental (MCNA) – CHIP Dental	95.4%	99.0%	96.4%
Minimum	95.4%	98.0%	96.4%
Maximum	100%	100%	99.0%
Average	**97.7%**	**98.8%**	**97.8%**

[a] The UHC Dental contract was not active until September 2020, so they did not have a 2019 PIP.

2019 PIP Validation

The EQRO also validated the 2019 PIP plans and final PIPs, assigning a status of Yes, Partial, or No.

- Criteria for a validation of **Yes** are: (1) all critical components are Yes, and (2) total score is 80 percent or above.
- Criteria for a validation of **Partial** are: (1) all critical components are Yes and the total score is 60 to 79 percent, or (2) one or more critical components are Partial.
- Criteria for a validation of **No** are: (1) all critical components are Yes and the total score is less than 60 percent or (2) one or more critical components are No.

Overall, the validation includes 21 critical components; 16 components are in the PIP plan and five are in the final PIP. Table 12 includes the 2019 PIP validation statuses for STAR, CHIP, STAR+PLUS, STAR Kids, STAR Health, Medicaid Dental, and CHIP Dental.

Table 12. 2019 PIP plan, final PIP, and overall PIP validation status by MCO/DMO

MCO	Program	PIP Plan Validation Status	Final PIP Validation Status	Overall PIP Validation Status
Aetna Better Health (Aetna)	STAR	Yes	Partial	Partial
Aetna Better Health (Aetna)	STAR Kids	Yes	Partial	Partial
Aetna Better Health (Aetna)	CHIP	Yes	Partial	Partial
Amerigroup	STAR	Yes	Partial	Partial
Amerigroup	STAR+PLUS	Yes	Yes	Yes
Amerigroup	STAR Kids	Yes	Partial	Partial
Amerigroup	CHIP	Yes	Partial	Partial
Blue Cross Blue Shield (BCBSTX)	STAR	Partial	Partial	Partial
Blue Cross Blue Shield (BCBSTX)	STAR Kids	Partial	Partial	Partial
Blue Cross Blue Shield (BCBSTX)	CHIP	Partial	Partial	Partial
Children's Medical Center Health Plan[a]	STAR Kids	No	Partial	No
Cigna-HealthSpring[a]	STAR+PLUS	Partial	Partial	Partial
Community First Health Plans (CFHP)	STAR	No	Partial	No
Community First Health Plans (CFHP)	STAR Kids	No	Partial	No

MCO	Program	PIP Plan Validation Status	Final PIP Validation Status	Overall PIP Validation Status
Community First Health Plans (CFHP)	CHIP	No	Partial	No
Community Health Choice (CHCT)	STAR	Partial	Partial	Partial
Community Health Choice (CHCT)	CHIP	Partial	Partial	Partial
Cook Children's Health Plan (CookCHP)	STAR	No	Partial	No
Cook Children's Health Plan (CookCHP)	STAR Kids	No	Partial	No
Cook Children's Health Plan (CookCHP)	CHIP	No	Partial	No
Dell Children's Health Plan (DCHP)	STAR	Yes	Partial	Partial
Dell Children's Health Plan (DCHP)	CHIP	Yes	Partial	Partial
DentaQuest	Medicaid Dental	Yes	Yes	Yes
DentaQuest	CHIP Dental	Yes	Yes	Yes
Driscoll Health Plan (Driscoll)	STAR	Partial	Partial	Partial
Driscoll Health Plan (Driscoll)	STAR Kids	Partial	Partial	Partial
Driscoll Health Plan (Driscoll)	CHIP	Partial	No	No
El Paso Health (ElPasoHealth)	STAR	Yes	Partial	Partial
El Paso Health (ElPasoHealth)	CHIP	Yes	Partial	Partial
FirstCare	STAR	No	Partial	No
FirstCare	CHIP	No	Partial	No
MCNA (MCNA Dental)	Medicaid Dental	Partial	Yes	Partial
MCNA (MCNA Dental)	CHIP Dental	Partial	Yes	Partial
Molina	STAR	Partial	Partial	Partial
Molina	STAR+PLUS	Partial	Partial	Partial
Molina	CHIP	Partial	Partial	Partial
Parkland Community Health Plan (PCHP)	STAR	Yes	Partial	Partial
Parkland Community Health Plan (PCHP)	CHIP	Yes	Partial	Partial
RightCare (SWHP)	STAR	Yes	Partial	Partial
Superior	STAR	Partial	Partial	Partial
Superior	STAR+PLUS	Partial	Yes	Partial
Superior	STAR Kids	Partial	Yes	Partial
Superior	STAR Health	Partial	No	No
Superior	CHIP	Partial	Partial	Partial
Texas Children's Health Plan (TCHP)	STAR	Partial	Partial	Partial
Texas Children's Health Plan (TCHP)	STAR Kids	Partial	Partial	Partial
Texas Children's Health Plan (TCHP)	CHIP	Partial	No	No
UnitedHealthcare (UHC)	STAR	No	Partial	No
UnitedHealthcare (UHC)	STAR+PLUS	No	Yes	No
UnitedHealthcare (UHC)	STAR Kids	No	Partial	No
UnitedHealthcare (UHC)	CHIP	No	No	No

[a] The MCO contract ended before PIP completion.

2019 Revised PIP Plan Validation

In an effort to ensure MCOs/DMOs implement stronger PIPs, the EQRO requires MCOs/DMOs to resubmit a revised PIP plan addressing EQRO feedback from the original PIP plan. The EQRO uses this revised PIP plan submission to verify compliance with previous recommendations. Therefore, if an MCO or DMO was compliant with recommendations and made the necessary changes to the PIP prior to implementation, the validation status of the PIP would be improved. Table 13 shows the revised PIP plan validation statuses and denotes which MCOs/DMOs improved the validation status of the PIP. Note that although a stronger PIP plan was implemented, the MCOs/DMOs still received the original PIP plan score and validation status, which contributed to the overall score and validation status.

Table 13. 2019 Revised PIP plan, final PIP, and overall PIP validation status by MCO/DMO

MCO	Program	Revised PIP Plan Validation Status	Final PIP Validation Status	Overall PIP Validation Status
Aetna Better Health (Aetna)	STAR	Yes	Partial	Partial
Aetna Better Health (Aetna)	STAR Kids	Yes	Partial	Partial
Aetna Better Health (Aetna)	CHIP	Yes	Partial	Partial
Amerigroup	STAR	Yes	Partial	Partial
Amerigroup	STAR+PLUS	Yes	Yes	Yes
Amerigroup	STAR Kids	Yes	Partial	Partial
Amerigroup	CHIP	Yes	Partial	Partial
Blue Cross Blue Shield (BCBSTX)	STAR	Partial	Partial	Partial
Blue Cross Blue Shield (BCBSTX)	STAR Kids	Partial	Partial	Partial
Blue Cross Blue Shield (BCBSTX)	CHIP	Partial	Partial	Partial
Children's Medical Center Health Plan[b]	STAR Kids	Yes[a]	Partial	Partial[a]
Cigna-HealthSpring[b]	STAR+PLUS	Partial	Partial	Partial
Community First Health Plans (CFHP)	STAR	Yes[a]	Partial	Partial[a]
Community First Health Plans (CFHP)	STAR Kids	Yes[a]	Partial	Partial[a]
Community First Health Plans (CFHP)	CHIP	Yes[a]	Partial	Partial[a]
Community Health Choice (CHCT)	STAR	Yes[a]	Partial	Partial
Community Health Choice (CHCT)	CHIP	Yes[a]	Partial	Partial
Cook Children's Health Plan (CookCHP)	STAR	Yes[a]	Partial	Partial[a]
Cook Children's Health Plan (CookCHP)	STAR Kids	Yes[a]	Partial	Partial[a]
Cook Children's Health Plan (CookCHP)	CHIP	Yes[a]	Partial	Partial[a]
Dell Children's Health Plan (DCHP)	STAR	Yes	Partial	Partial
Dell Children's Health Plan (DCHP)	CHIP	Yes	Partial	Partial
DentaQuest	Medicaid Dental	Yes	Yes	Yes
DentaQuest	CHIP Dental	Yes	Yes	Yes
Driscoll Health Plan (Driscoll)	STAR	Yes[a]	Partial	Partial
Driscoll Health Plan (Driscoll)	STAR Kids	Yes[a]	Partial	Partial
Driscoll Health Plan (Driscoll)	CHIP	Partial	No	No
El Paso Health (ElPasoHealth)	STAR	Yes	Partial	Partial

MCO	Program	Revised PIP Plan Validation Status	Final PIP Validation Status	Overall PIP Validation Status
El Paso Health (ElPasoHealth)	CHIP	Yes	Partial	Partial
FirstCare	STAR	Partial[a]	Partial	Partial[a]
FirstCare	CHIP	Yes[a]	Partial	Partial[a]
MCNA Dental	Medicaid Dental	Yes[a]	Yes	Yes[a]
MCNA Dental	CHIP Dental	Yes[a]	Yes	Yes[a]
Molina	STAR	Partial	Partial	Partial
Molina	STAR+PLUS	Partial	Partial	Partial
Molina	CHIP	Partial	Partial	Partial
Parkland Community Health Plan (PCHP)	STAR	Yes	Partial	Partial
Parkland Community Health Plan (PCHP)	CHIP	Yes	Partial	Partial
RightCare (SWHP)	STAR	Yes	Partial	Partial
Superior	STAR	Partial	Partial	Partial
Superior	STAR+PLUS	Partial	Yes	Partial
Superior	STAR Kids	Partial	Yes	Partial
Superior	STAR Health	Partial	No	No
Superior	CHIP	Partial	Partial	Partial
Texas Children's Health Plan (TCHP)	STAR	Partial	Partial	Partial
Texas Children's Health Plan (TCHP)	STAR Kids	Partial	Partial	Partial
Texas Children's Health Plan (TCHP)	CHIP	Partial	No	No
UnitedHealthcare (UHC)	STAR	Partial[a]	Partial	Partial[a]
UnitedHealthcare (UHC)	STAR+PLUS	Partial[a]	Yes	Partial[a]
UnitedHealthcare (UHC)	STAR Kids	Partial[a]	Partial	Partial[a]
UnitedHealthcare (UHC)	CHIP	Partial[a]	No	No

[a] Denotes an improvement in the validation status due to the MCO/DMO implementing the EQRO's original PIP plan recommendations on their revised PIP plan submission

[b] The MCO contract ended before PIP completion.

2019 Compliance with PIP recommendations

As part of the PIP evaluation process, the EQRO provides feedback and recommendations to all MCOs and DMOs after each reporting milestone (i.e., submission of the PIP plan, revised PIP plan, progress report 1, progress report 2, and for extended MCO PIPs, progress report 3). HHSC and the EQRO required the MCOs to address the recommendations on the subsequent PIP report submission. The EQRO summarized compliance with PIP recommendations by considering the overall number of previous recommendations and those recommendations implemented by the next report submission. Table 14 summarizes MCO and DMO compliance with EQRO PIP evaluation recommendations. Compliance ranged from 61.1 percent to 100 percent.

Table 14. 2019 MCO compliance with PIP evaluation recommendations

MCO	Program	Overall Recommendations (n)	Implemented Recommendations (n)	Overall Compliance (%)
Aetna Better Health (Aetna)	STAR	11	8	72.7%
Aetna Better Health (Aetna)	STAR Kids	10	7	70.0%
Aetna Better Health (Aetna)	CHIP	10	7	70.0%
Amerigroup	STAR	2	2	100%
Amerigroup	STAR+PLUS	2	2	100%
Amerigroup	STAR Kids	2	2	100%
Amerigroup	CHIP	2	2	100%
Blue Cross Blue Shield (BCBSTX)	STAR	16	13	81.3%
Blue Cross Blue Shield (BCBSTX)	STAR Kids	16	13	81.3%
Blue Cross Blue Shield (BCBSTX)	CHIP	16	13	81.3%
Children's Medical Center Health Plan[a]	STAR Kids	28	21.5	76.8%
Cigna-HealthSpring[a]	STAR+PLUS	41	29	70.7%
Community First Health Plans (CFHP)	STAR	23	22	95.7%
Community First Health Plans (CFHP)	STAR Kids	23	22	95.7%
Community First Health Plans (CFHP)	CHIP	23	22	95.7%
Community Health Choice (CHCT)	STAR	9	8.5	94.4%
Community Health Choice (CHCT)	CHIP	9	8.5	94.4%
Cook Children's Health Plan (CookCHP)	STAR	9	9	100%
Cook Children's Health Plan (CookCHP)	STAR Kids	9	9	100%
Cook Children's Health Plan (CookCHP)	CHIP	9	9	100%
Dell Children's Health Plan (DCHP)	STAR	1	1	100%
Dell Children's Health Plan (DCHP)	CHIP	1	1	100%
DentaQuest	Medicaid Dental	5	4.5	90.0%
DentaQuest	CHIP Dental	5	4.5	90.0%
Driscoll Health Plan (Driscoll)	STAR	31	20.5	66.1%
Driscoll Health Plan (Driscoll)	STAR Kids	23	17.5	76.1%
Driscoll Health Plan (Driscoll)	CHIP	22	17.5	79.5%
El Paso Health (ElPasoHealth)	STAR	2	2	100%
El Paso Health (ElPasoHealth)	CHIP	2	2	100%
FirstCare	STAR	27	24	88.9%
FirstCare	CHIP	29	22	75.9%
MCNA (MCNA Dental)	Medicaid Dental	4	4	100%
MCNA (MCNA Dental)	CHIP Dental	4	4	100%
Molina	STAR	32	23.5	73.4%
Molina	STAR+PLUS	32	23.5	73.4%
Molina	CHIP	32	23.5	73.4%
Parkland Community Health Plan (PCHP)	STAR	20	16.5	82.5%
Parkland Community Health Plan (PCHP)	CHIP	20	15.5	77.5%

MCO	Program	Overall Recommendations (n)	Implemented Recommendations (n)	Overall Compliance (%)
RightCare (SWHP)	STAR	11	10.5	95.5%
Superior	STAR	5	4.5	90.0%
Superior	STAR+PLUS	5	4.5	90.0%
Superior	STAR Kids	5	4.5	90.0%
Superior	STAR Health	5	4.5	90.0%
Superior	CHIP	5	4.5	90.0%
Texas Children's Health Plan (TCHP)	STAR	17	10	58.8%
Texas Children's Health Plan (TCHP)	STAR Kids	19	12	63.2%
Texas Children's Health Plan (TCHP)	CHIP	18	11	61.1%
UnitedHealthcare (UHC)	STAR	21	16.5	78.6%
UnitedHealthcare (UHC)	STAR+PLUS	22	20.5	93.2%
UnitedHealthcare (UHC)	STAR Kids	20	18.5	92.5%
UnitedHealthcare (UHC)	CHIP	21	16.5	78.6%
Overall Compliance Average	-	-	-	86.2%

[a] The MCO contract ended before PIP completion.

Relevance for Assessing Quality, Access, and Timeliness

The 2019 PIPs aimed to improve quality, access, and timeliness of care by preventing PPVs and PPAs, which are often due to unmet clinical and psychological needs. The PIPs addressed reduction of PPVs and PPAs for members with anxiety and/or depression. These PIPs implemented interventions to improve quality, access and timeliness of behavioral health care and address behavioral health needs prior to a member seeking treatment at an emergency department or inpatient facilities. For example, Amerigroup implemented an intervention to increase member outreach to help members schedule timely behavioral health care. This intervention also included providing information regarding transportation resources to facilitate access to care. Another example is ElPasoHealth's PIP, which included an intervention referring members in need to case management to aid in coordination of services. Case management interventions can improve care quality, as members with depression and other co-occurring chronic conditions can see improved physical and behavioral health outcomes when enrolled (Baker et al., 2018).

The 2019 dental PIPs focused on creating a data-sharing collaboration for dental-related PPVs. These PIPs are part of a two-phase PIP aimed at reducing dental-related PPVs. The 2019 PIPs constituted Phase 1, in which the DMOs implemented system-level improvements to create a collaborative data-sharing agreement with a hospital system or MCO. In Phase 2 (the 2021 PIPs), the DMOs used the collaborative data-sharing to reduce dental-related PPVs. Many dental-related PPVs are for causes (such as tooth decay) that could have been prevented through regular dental care (Kim et al., 2019). However, PPV data is not available to dental benefit administrators for initiating outreach to members who experience dental-related PPVs. These data-sharing agreements can improve access, quality, and timeliness of care by allowing DMOs to track dental PPVs and provide access to timely preventative services, improving dental outcomes and preventing future PPVs.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 15 provides a summary of the key findings and recommendations from EQR activities associated with Protocol 1 and their relevance to the MCQS.

Goal	Icon	MCQS description	Goal	Icon	MCQS description
1		Promoting optimal health	4		Safer delivery system
2		Strengthening person and family engagement	5		Effective practices for people with chronic, complex, and serious conditions
3		Right care in the right place at the right time	6		High-performing Medicaid providers

Table 15. Protocol 1 findings and recommendations

Category	Description
Finding(s)	Data analysis was a common opportunity for improvement in the 2019 PIPs. For example, 10 MCOs (BCBSTX, CMCHP, Cigna-HealthSpring, CFHP, CHCT, Driscoll, FirstCare, Molina, Superior, and TCHP) lost points on the PIP plan in Activity 6, *Plan to Collect Reliable Data,* because they chose an inappropriate statistical test for the reported measures. Additionally, several MCOs lost points on the final PIP due to incorrectly calculating or interpreting statistical analyses for PIP measures.
Recommendation(s)	BCBSTX, CMCHP, Cigna-HealthSpring, CFHP, CHCT, Driscoll, FirstCare, Molina, Superior, and TCHP should ensure they select the appropriate statistical test for the reported measures. Amerigroup, CMCHP, Cigna Health-Spring, CFHP, CHCT, FirstCare, Molina, Parkland, and Superior should ensure that they perform statistical analyses according to the data analysis plan, and calculate and interpret them correctly.
MCQS Goal(s)	(1)
Finding(s)	Three MCOs (Cigna-HealthSpring, CFHP, and TCHP) lost points on the PIP plan for the components related to the target population for the PIP. These MCOs reported the target population for the PIP as all members with a diagnosis of depression and/or anxiety *and* three or more ED visits and two or more inpatient stays. However, the purpose of this PIP was to prevent and reduce potentially preventable events and high utilization among *all* members with anxiety and/or depression rather than just among members who already meet the criteria for high utilization. Therefore, the MCOs should have reported the target population as all members with a diagnosis of anxiety and/or depression.
Recommendation(s)	Cigna-HealthSpring, CMCHP, and TCHP should ensure that they accurately identify and report the target population throughout the PIP so they can prevent the outcome of interest for the PIP.
MCQS Goal(s)	(1, 3, 4, 5)

Category	Description
Finding(s)	Several MCOs received recommendations on the 2019 PIP plan on components related to sampling. MCOs did not accurately or consistently report sampling in two main scenarios: Several MCOs (Aetna, CFHP, CMCHP, and Parkland) did not accurately identify whether or not they were targeting the entire population for the PIP or a sample of the population. For example, Aetna accurately described the entire population of the PIP per the HHSC and EQRO guidance, but indicated on the PIP plan that they were targeting a sample rather than the entire population. MCOs did not consistently report whether they were sampling for specific interventions. Seven MCOs (CMCHP, Cigna-HealthSpring, CFHP, CookCHP, Driscoll, FirstCare, and UHC) lost points in Activity 5B, Sound Sampling Methods – Interventions, because they did not correctly describe the sample of the target population they would be targeting for their intervention(s). Additionally, in Activity 7B.1, Implementation Evaluation: Intervention and Improvement Strategies, these seven MCOs lost points due to inconsistently or incorrectly reporting the number and percent of members targeted for the intervention based on the sample.
Recommendation(s)	Aetna, CFHP, CMCHP, Cigna-HealthSpring, CookCHP, Driscoll, FirstCare, Parkland, Superior, and UHC should familiarize themselves with sampling in order to accurately identify whether they are sampling for the PIP and/or interventions. In addition, if they are sampling, these MCOs should familiarize themselves with the different sampling methodologies and associated biases. HHSC should provide additional guidance and technical assistance to MCOs on what sampling is, how to identify sampling, and how to accurately report sampling for the PIPs.
MCQS Goal(s)	 (1)

Category	Description
Finding(s)	Nine MCOs received an overall validation status of "No" on one or more of their PIPs, and thirteen MCOs/DMOs received an overall validation status of "Partial" on one or more of their PIPs. Even after accounting for revisions made in the revised PIP plan, four MCOs received an overall "No" on one or more PIPs and eighteen MCOs received a "Partial" overall validation status on one or more PIPs. The primary reason that few MCOs/DMOs received an overall validation status of "Yes" even after accounting for revisions to the PIP plan was lack of statistically significant improvement in PIP measures. Eighteen MCOs that received a "Partial" overall on one or more PIPs after revisions did not achieve statistically significant improvement for one or more measures. Driscoll (CHIP), Superior (STAR Health), TCHP (CHIP) and UHC (CHIP) all received a "No" overall validation status after revisions because they did not achieve statistically significant improvement for any measure. After an in-depth review, the EQRO identified potential factors that may have impacted the MCOs' ability to achieve statistically significant improvement. For example, several MCOs (Aetna, BCBSTX, Cigna-HealthSpring, CFHP, CHCT, CMCHP, Driscoll, ElPasoHealth, FirstCare, Molina, Parkland, SWHP, and UHC) delayed the implementation date of PIP interventions by one to twelve months, paused interventions for approximately 3 months to up to two years, or reported that they retired interventions as early as five months after initial implementation without replacing the retired interventions. In addition, because PIPs are not causative, external factors may have influenced the rates for the PIP measures, leading to lack of statistically significant improvement despite effective interventions.
Recommendation(s)	All MCOs, especially Aetna, BCBSTX, Cigna-HealthSpring, CFHP, CHCT, CMCHP, Driscoll, ElPasoHealth, FirstCare, Molina, Parkland, SWHP, and UHC should implement PIP interventions in a timely manner at the start of the PIP and for the entire duration of the PIP period so they can achieve maximum impact on PIP outcome measures. All MCOs should utilize rapid-cycle PDSA methodologies to test interventions prior to the implementation of the PIP in order to test whether an intervention and the implementation strategy will be effective. HHSC should consider revising PIP implementation methods to increase the likelihood of determining the effectiveness of the interventions by utilizing intervention and control groups, which will allow MCOs to account for some external factors that may impact the outcomes being measured.
MCQS Goal(s)	 (1, 3)

Protocol 2: Validation of Performance Measures

Protocol Overview & Objectives

This protocol guides the validation of the performance measures specified by states for inclusion in the quality assessment and performance improvement (QAPI) programs conducted by the MCOs and DMOs. Texas combines both performance measurement options in 42 C.F.R. § 438.330 (2016), by requiring the MCOs and DMOs to (1) calculate quality measures determined by the state and submit the results, and (2) submit data allowing the state to calculate performance measures. Protocol 2 (CMS, 2023a) is a mandatory EQRO activity (42 C.F.R. § 438.358, 2020) and applies both when the QAPI performance measures are calculated by the MCOs and when they are calculated by the state.

> *Because of the complexity of the state's Medicaid system, Texas has determined that centralized calculation of performance measures offers the most consistent calculations across many programs and MCOs or DMOs, providing standard, reliable results for use in quality evaluations and research.*
>
> *Texas contracts the EQRO to calculate over 100 QoC measures annually using the encounter data submitted, as required, by the MCOs and DMOs. An external auditor certified by the National Committee for Quality Assurance (NCQA) validates these measures. The related* Protocol 7: Calculation of Performance Measures*, specifically addresses performance measures calculated by the EQRO.*

Texas requires MCOs to calculate and report select Healthcare Effectiveness Data and Information Set (HEDIS®) measures following the hybrid method specifications. The EQRO also evaluates several other service and access indicators that Texas requires MCOs to calculate, including rates for Texas Health Steps (THSteps) checkups.

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

- A review of information related to the Information Systems Capabilities Assessment (ISCA) process recommended by CMS (CMS, 2023a), collected through the administrative interviews (AIs) addressed under *Protocol 3: Review of Compliance with Medicaid & CHIP Managed Care Regulations*
- A review of current MCO and DMO accreditations by NCQA or Utilization Review Accreditation Commission (URAC)
- A review of audit reports by NCQA certified auditors (for HEDIS measures) and related documentation.
- A direct review of measure specifications and results, including a comparison to EQRO-calculated results.

> *All reported measures are validated through external audit, and reviewed by the EQRO.*

The results for both MCO reported measures validated under Protocol 2 activities and EQRO or HHSC calculated measures are consolidated under *Protocol 7: Calculation of Performance Measures*, and by MCO or DMO in the ATR Companion.

EQR Activities

Information Systems, Processes & Data Used in Performance Measures

As part of the AI process, the EQRO asks questions related to Information Systems and Data Acquisition. Seven MCOs participated in the AI process in SFY 2023 (see *Protocol 3: Review of Compliance with Medicaid & CHIP Managed Care Regulations*) Six of the seven MCOs indicated that they underwent a formal ISCA within the past two years. Three of these indicated participating in a SOC audit. One (BCBSTX) indicated having HITRUST certification. All participating MCOs underwent an audit by an NCQA certified auditor for the purpose of reporting HEDIS measures. Regardless of whether they submit data to NCQA, all MCOs must provide the EQRO with the attestation of an NCQA certified auditor that their hybrid data and rates and any supplemental data

submitted to the EQRO meet all NCQA audit standards. The first part of the NCQA HEDIS audit process is a review of an organization's overall information systems capabilities for collecting, storing, analyzing, and reporting health information relevant to calculation of reportable HEDIS measures. Each MCO must provide an attestation of reportability from an NCQA-certified auditor with all hybrid measure results submitted.

Among the seven MCOs participating in the AI, MCOs reported programming teams of between seven and 26 full-time staff with average experience of between six and 20 years. Only one MCO (DCHP) reported more than one programmer position refilled or reassigned during the year, and DCHP also had the largest programming team. The cumulative staff experience helps build important institutional knowledge and should improve efficiency in any data-driven initiatives. Three of the seven MCOs reported a major change in encounter and enrollment processing systems in the past three years. These changes highlight the need for continuous evaluation of MCO/DMO information systems. Only TCHP and SWHP reported that they tracked electronic health record (EHR) use among primary care providers (PCPs) and specialists. TCHP reported that over 80 percent of both PCPs and specialists use an EHR and SWHP reported that 90 percent of both PCPs and specialists used an EHR system. All seven MCOs reported that at least 98.5 percent of claims are complete within three months and that late filed claims are always denied. Six MCOs outsource pharmacy services to Navitus and one to Prime. Three use a third-party for vision care and three have a third-party mental health provider.

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

MCO reported measures

HEDIS Hybrid Measures

Hybrid method specifications include sampling based on administrative criteria, followed by medical record review from the sample to determine compliance. For HEDIS MY 2022, MCOs reported their hybrid method results for seven HEDIS measures for the programs listed in Table 16. The EQRO compiles the results with EQRO calculated measures (see *Protocol 7: Calculation of Performance Measures*) in the QoC Reports and on the Texas Healthcare Learning Collaborative (THLC) portal (thlcportal.com). Statewide rate calculation includes reported hybrid rates weighted by the eligible MCO denominator identified by the EQRO.

Table 16. HEDIS MY 2022 measures selected for hybrid reporting

Measure	Description	Programs
CBP	Controlling High Blood Pressure	STAR, STAR+PLUS
CCS	Cervical Cancer Screening	STAR+PLUS
CIS	Childhood Immunization Status	STAR, STAR Kids
HBD	HbA1c Control for Patients with Diabetes	STAR, STAR+PLUS
IMA	Immunizations for Adolescents	CHIP, STAR, STAR Kids
HEDIS-PPC[a]	Prenatal and Postpartum Care	STAR
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	CHIP, STAR, STAR Kids

[a] HEDIS Prenatal and Postpartum care measure (disambiguates from 3M™ PPC)

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

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

Access and Service Measures

Measurement is an important part of the QAPI programs carried out by the MCOs and DMOs and evaluated by the EQRO (see *Protocol 3: Review of Compliance with Medicaid & CHIP Managed Care Regulations*). In the "Improvement Opportunities" section of the EQRO QAPI review, 17 of 19 MCOs and DMOs scored 100/100 on the EQRO assessment of "Systems, Processes, and Outcomes Measurements and Results" and two MCOs (FirstCare and Right Care) scored 50/100. All MCOs and DMOs scored 100/100 on "Internal/External Comparisons" addressed in this section. In the "Availability and Accessibility (of) Access to Care Monitoring and Results" area, three of 19 MCOs scored 10/10, while two MCOs (DCHP and Parkland) had a weighted score less than 8/10. In the "Activities and Ongoing Quality Indicators" area, six of 19 scored 10/10, however three MCOs (CHCT, DCHP, and Superior) had a weighted score less than 8/10.

Texas Health Steps Checkups

Following the Frew Consent Decree (Frew) of 1996 (*Frew et al. V. Phillips et al.*, 1996), HHSC became subject to corrective action orders, including an independent study of medical checkup completeness and required checkup reports. According to Chapter 12 of the Texas Uniform Managed Care Manual (UMCM) that covers Frew requirements (HHSC, 2023b), MCOs must submit annual reporting on compliance with THSteps checkup requirements. The EQRO independently calculates compliance rates using the encounter and enrollment data in the Texas Medicaid data warehouse and uses this comparative report to validate the MCO submissions. During SFY 2023, the EQRO evaluated compliance for members with a checkup due starting in SFY 2021. Several MCOs initially reported rates that differed from the EQRO calculations by more than the allowable standard. CFHP reported excessively high rates for existing STAR members and new STAR Kids members. CookCHP also reported excessively high rates for new STAR Kids members. UHC reported excessively high rates for both new and existing STAR Kids members and for existing STAR members. The EQRO also notes concern for the low overall rates for THSteps checkups. Existing member rates are below 55 percent across all programs while 43.4 percent of new STAR members and only 17.9 percent of new STAR Kids members received timely checkups. Although 71.1 percent of new STAR Health members met the basic requirement of a checkup within 90 days, All STAR Health members should receive a check-up within 30 days. It should be noted that THSteps rates are typically lower than HEDIS well visit rates because of differences in requirements, including periodicity.

Validation Summary

Based on the evaluations conducted or reviewed by the EQRO, all Texas Medicaid and CHIP MCOs and DMOs met the requirements for measure calculation and data submission set by Texas and submitted measures were

accurate based on the measure specifications and state reporting requirements (42 C.F.R. § 438.330 (b)(2)(2017)). Table 17 provides a summary of the reviews.

Table 17. Summary of validation review for MY 2022 by MCO and DMO

MCO or DMO	AI/QAPI/ISCA Review	Accreditation	Accreditation Level	NCQA Auditor[a]
Aetna Better Health (Aetna)	Pass	NCQA[b]	Accredited	Advent
Amerigroup	Pass	NCQA[b,c,d,e]	Accredited	Attest
Blue Cross Blue Shield (BCBSTX)	Pass	NCQA[b]	Accredited	Attest
Community First Health Plans (CFHP)	Pass	URAC[f]	Accredited	Attest
Community Health Choice (CHCT)	Pass	NCQA[b,d]	Accredited	Attest
Cook Children's Health Plan (CookCHP)	Pass	NCQA[b]	Accredited	Healthy People
Dell Children's Health Plan (DCHP)	Pass	URAC[f]	Accredited	Aqurate
DentaQuest	Pass	URAC[g]	Accredited	-
Driscoll Health Plan (Driscoll)	Pass	URAC[f]	Accredited	Healthy People
El Paso Health (ElPasoHealth)	Pass	URAC[f]	Accredited	Healthy People
FirstCare	Pass	NCQA[h,i]	Accredited	DTS Group
MCNA Dental (MCNA)	Pass	URAC[g]	Accredited	-
Molina	Pass	NCQA[e,h,i]	Accredited	Advent
Parkland Community Health Plan (PCHP)	Pass	NCQA[b]	Interim	Advent
RightCare (SWHP)	Pass	NCQA[b,d,i]	Accredited	DTS Group
Superior	Pass	NCQA[b,e,h,i]	Accredited	Attest
Texas Children's Health Plan (TCHP)	Pass	NCQA[b]	Accredited	Healthy People
UnitedHealthcare (UHC)	Pass	NCQA[b,c,d]	Accredited	Attest
UnitedHealthcare Dental (UHCD)	Pass	URAC[g]	Accredited	-

[a] All audit reports attested to NCQA reportability for each of the hybrid measure rates submitted by the MCOs
Advent = Advent Advisory Grp.; Attest = Attest Healthcare Advisors; Aqurate = Aqurate Health Data Mgmt.

NCQA Accreditations: [b] Medicaid HMO; [c] Health Equity; [d] LTSS; [e] Multicultural Health Care; [h] Health Plan; [I] Electronic Clinical Data

URAC Accreditations: [f] Health Plan 7.4; [g] Dental Plan 7.4

Relevance for Assessing Quality, Access & Timeliness

Performance measure validation is important for ensuring the accurate assessment of healthcare quality, timeliness, and access and understanding the processes that affect these domains of care for members. Performance on MCO reported measures in MY 2022 was generally below national averages. Performance measures for the management of chronic conditions including high blood pressure (CBP) and diabetes (HBD) fell below the national average in STAR+PLUS, and below the 25th percentile for STAR where most MCOs were below the 10th percentile and only three (BCBSTX, CookCHP, and Driscoll) were above the national average. In STAR+PLUS, the rate for cervical cancer screening (CCS) was below the 25th percentile and for two MCOs (Amerigroup and Molina), below the 10th percentile. Although the overall STAR rate for childhood immunizations (CIS combo 10) is above the 25th percentile, only four MCOs (BCBSTX, CFHP, ElPasoHealth, and TCHP) performed better than the national average while rates for three MCOs (Amerigroup, FirstCare, and SWHP) were below the 10th percentile. All but two MCOs in STAR Kids performed below the 10th percentile for this measure. Conversely, performance on immunization for adolescents (IMA combo 2) was above the 75th

percentile in STAR, STAR Kids, and CHIP. Hybrid specifications can increase identification of compliant members on measures where medical records are likely to provide important additional information. Thus, including the MCO reported hybrid rates provides the most favorable comparison to national benchmarks. The relatively poor performance seen on some measures suggests important areas for improvement.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 18 provides a summary of the key findings and recommendations from EQR activities associated with Protocol 2 and their relevance to the MCQS.

Goal	Icon	MCQS description	Goal	Icon	MCQS description
1		Promoting optimal health	4		Safer delivery system
2		Strengthening person and family engagement	5		Effective practices for people with chronic, complex, and serious conditions
3		Right care in the right place at the right time	6		High-performing Medicaid providers

Table 18. Protocol 2 findings and recommendations

Category	Description
Finding(s)	Only TCHP and SWHP reported that they keep track of EHR use among their PCPs and specialists.
Recommendation(s)	HHSC should encourage MCOs to track EHR use, and collect data which will be critical to calculating ECDS measures.
MCQS Goal(s)	 (3, 4, 6)
Finding(s)	All MCOs indicated that they validate NPI and indicated that they reject or deny claims without NPI. However, the EQRO notes continued deficiencies in encounter provider data. Only four MCOs indicated taxonomy validation against the services and only three indicated taxonomy validation against the provider credentials and the EQRO notes continued deficiency in the provider taxonomies in encounters.
Recommendation(s)	HHSC should continue strengthening provider data systems, including working with MCOs to understand root causes for continuing deficiencies in encounter provider data submissions.
MCQS Goal(s)	 (4, 6)
Finding(s)	Rates for THSteps timely checkups continue to be low.
Recommendation(s)	HHSC should consider ways to better incentivize improvement in meeting timely checkup requirements.
MCQS Goal(s)	 (1)

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

Protocol Overview & Objectives

Following the guidance in CMS EQRO Protocol 3 (CMS, 2023a), the EQRO determines the extent to which Texas Medicaid and CHIP MCOs and DMOs comply with federal quality standards 42 C.F.R. § 438 (2020) and 42 C.F.R. § 457 (2020):

- Availability of services 42 C.F.R. § 438.206 (2020)
- Assurances of adequate capacity and services 42 C.F.R. § 438.207 (2016)
- Coordination and continuity of care 42 C.F.R. § 438.208 (2016)
- Coverage and authorization of services 42 C.F.R. § 438.210 (2019)
- Provider selection 42 C.F.R. § 438.214 (2016)
- Confidentiality 42 C.F.R. § 438.224 (2016)
- Grievance and appeal systems 42 C.F.R. § 438.228 (2016)
- Subcontractual relationships and delegation 42 C.F.R. § 438.230 (2016)
- Practice guidelines 42 C.F.R. § 438.236 (2020)
- Health information systems 42 C.F.R. § 438.242 (2020)
- Quality assessment and performance improvement program 42 C.F.R. § 438.330 (2016)

The EQRO conducts two major reviews to fulfill the requirements of this protocol:

1. The AIs (Administrative Interviews) and,
2. QAPI (Quality Assurance and Performance Improvement) program evaluations.

The AIs allow the EQRO to complete comprehensive MCO and DMO regulatory compliance assessments and assist the EQRO with identifying the structural strengths and opportunities for improvement in MCO and DMO quality improvement programs. The EQRO then thoroughly reviews MCO and DMO quality improvement programs through the QAPI program evaluations.

EQRO Activities

Administrative Interviews

The EQRO developed a web-based AI tool that allows MCOs and DMOs 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

Methods & Analyses

The EQRO reviews federal regulatory updates and incorporates these updates into the web-based AI tool and evaluation protocols. The EQRO works with HHSC to appropriately define compliance criteria for each regulatory

item. Compliance levels include "met," with a corresponding score of 100; "partially met," with a corresponding score of 50; and "not met," with a corresponding score of zero. The EQRO deems an MCO or DMO fully compliant when it meets all regulation components across all product lines. Each year, the EQRO rotates the MCOs and DMOs for full AI review (including assessment of all regulatory areas, through the web-based responses and a site visit). Each MCO and DMO participates in the full AI review through this rotation process at least every three years. SFY 2023 is the first year of the current three-year reporting period (SFY 2023–2025). Table 19 includes the AI participation schedule by year. Note that, following the 3-year rotation plan, SFY 2024 repeats the SFY 2021 schedule, and SFY 2025 repeats the SFY 2022 schedule.

Table 19. MCO and DMO participation in AI review by evaluation year

SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Aetna Better Health (Aetna)	Amerigroup	Blue Cross Blue Shield (BCBSTX)	Aetna Better Health (Aetna)	Amerigroup
Cook Children's Health Plan (CookCHP)	Molina	Community Health Choice (CHCT)	Cook Children's Health Plan (CookCHP)	Molina
Community First Health Plans (CFHP)	Superior	Dell Children's Health Plan (DCHP)	Community First Health Plans (CFHP)	Superior
DentaQuest	UnitedHealthcare (UHC)	Driscoll Health Plan (Driscoll)	DentaQuest	UnitedHealthcare (UHC)
El Paso Health (ElPasoHealth)	-	MCNA Dental (MCNA)	El Paso Health (ElPasoHealth)	-
FirstCare	-	Parkland Community Health Plan (PCHP)	FirstCare	-
UnitedHealthcare Dental (UHCD)	-	RightCare (SWHP)	UnitedHealthcare Dental (UHCD)	-
-	-	Texas Children's Health Plan (TCHP)	-	-

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

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

with supporting documentation, the EQRO incorporates findings into the results and develops a site visit report for each MCO and DMO.

In addition to the federal and state regulatory categories addressed in the full AI process, the EQRO inquired about medical and behavioral health telehealth services, staffing challenges, race and ethnicity data collection, and electronic clinical data systems (ECDS) reporting. Lines of inquiry included:

- What the MCO or DMO has done to assess the quality of care of services delivered via medical and behavioral telehealth services.
- Staffing challenges and the impact on organizational processes relating to serving Medicaid populations.
- How the MCO and DMO collects and verifies beneficiary race and ethnicity data in Medicaid and CHIP programs.
- What quality measures the organization utilizes, including any ECDS measures, how the MCO or DMO calculates them, and using what data systems.

Review of these questions is discussed in *Protocol 2: Validation of Performance Measures*.

Results

In 2023, seven MCOs and one DMO participated in full AI activities which this year included virtual (rather than in-person) site visits. The results reported in this section are based on the original review and do not include the EQRO's determination of regulatory compliance after receiving additional documentation; due to the schedule of site visits, the final site visit reports were incomplete at the time of this report. Based on the review of the AI responses, the EQRO assigned scores in each federal regulatory category and combined them into an overall score. Along with its score report, the EQRO also provided recommendations to each MCO and DMO on becoming compliant with regulations. The overall scores for MCOs and DMOs in 2023 ranged from 96.2 to 99.8 (*mean = 98.3*), and Individual MCO and DMO scores within categories were all at least 95.0. Table 20 shows the final scores and averages across MCOs and the DMO, and Table 21 shows MCOs and DMO compliance rates with prior year AI recommendations.

Table 20. 2023 MCO and DMO AI scores by federal regulation category and overall

MCO or DMO	A. General Provisions	B. State Responsibilities	C. Member Rights & Protections	D. Health Plan Standards	F. Grievance & Appeal System	Overall, AI Evaluation Score
BCBSTX	100	100	100	100	99.3	99.8
CHCT	95.8	100	100	100	98.4	98.6
DCHP	100	100	95.0	100	99.5	99.3
Driscoll	98.3	100	98.3	100	95.2	96.2
MCNA Dental	98.2	100	95.0	99.4	99.0	98.4
PCHP	98.3	100	100	100	99.5	99.3
SWHP	98.3	100	97.5	98.4	96.6	96.9
TCHP	97.5	100	100	99.0	97.7	97.7
MCO/DMO Average	**98.3**	**100**	**98.2**	**99.6**	**98.2**	**98.3**

Table 21. 2023 MCO compliance with prior AI recommendations

MCO or DMO	Previous Year Recommendations	Recommendations Implemented	Compliance
BCBSTX	31	30	96.8%
CHCT	23	21	91.3%
DCHP	3	3	100%
Driscoll	5	4	80.0%
MCNA Dental	5	4	80.0%
PCHP	11	10	90.9%
SWHP	14	11	78.6%
TCHP	13	12	92.3%
MCO/DMO Average Compliance	-	-	88.7%

QAPI Evaluations

The EQRO annually reviews the Texas Medicaid MCO, DMO, and MMP quality improvement programs to evaluate aspects of structure and processes that contribute to their success and to assess compliance as specified in 42 C.F.R. § 438.330 (2020)[4]. The EQRO QAPI program evaluations determine compliance with federal regulations and state standards and the presence and strength of the five essential elements of a QAPI program, as defined by CMS (CMS, 2016).

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

Methods & Analyses

The EQRO QAPI program evaluation process includes 16 activities (Table 22). Seven, which address the four essential QAPI elements other than PIPs, comprise 70.0 percent of the overall QAPI score. The other nine activities comprise 30.0 percent of the overall QAPI score.

[4] This report addresses PIPs (element four) under Protocol 1 (CMS, 2023a). Due to the implementation time, the PIP evaluation primarily followed the guidance in the 2012 version of CMS EQR Protocol 3 (CMS, 2012a). EQRO QAPI program evaluations address the other four elements following the guidance in the revised CMS EQR Protocol 3 (CMS, 2023a).

Table 22. 2023 QAPI categories

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

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

Results

MCO & DMO QAPI Results

Table 23 shows the score for each SFY 2023 QAPI. The average score was 94.8 (*SD = 2.8*). The EQRO considered scores more than half a standard deviation below the mean (i.e., <93.4) as "below average" (37.0 percent of MCOs and DMOs) and considered scores more than half a standard deviation above the mean (i.e., >96.2) as "above average" (32.0 percent of MCOs and DMOs).

Six MCOs improved from their SFY 2022 QAPI evaluations, with PCHP showing the most improvement, from a score of 84.4 in SFY 2022 to 91.5 in SFY 2023. MCNA and UHC both had the highest QAPI score in SFY 2022 (98.4). The lowest scoring plan was DCHP, with a QAPI evaluation score of 90.3.

DCHP lost points in four main areas of the QAPI report. For Activity B1: *Program Description*, the EQRO made three recommendations about the MCO's quality goals and objectives. DCHP did not provide broad quality goals, and no long-term outcomes were discussed. Additionally, DCHP did not describe how it achieves all its objectives, including results and analyses of its performance. For Activity B5: *Availability and Accessibility* and Activity B6a: *Activities and Ongoing Quality Indicators*, the data did not correspond with the correct measurement year. Therefore, DCHP lost points for these sections. In *Appendix D: Service Indicator Monitoring*, the MCO did not evaluate the effectiveness of actions for one indicator or describe additional or future actions for another indicator. DCHP had a previous recommendation compliance score of 57.1; four out of seven recommendations from the SFY 2022 QAPI evaluations were implemented.

FirstCare had the second lowest score (91.5). The MCO received recommendations throughout the QAPI evaluation, including one to report accurate data and provide specific additional details for goals and accomplishments in the *Program Description* activity (B1). However, for Activity B2: *Overall Effectiveness*, FirstCare's response almost exactly matched its response the previous year, and the EQRO recommended that the MCO clarify the status of implementing necessary updates.

While PCHP had the most significant improvement in scores, it also received a second-lowest score of 91.5. The MCO received recommendations to improve the *Program Description* (activity B1), specifically to provide a detailed description for achieving goals and objectives, including results and analyses. The MCO did not offer all

the requested information for seven of the 22 indicators for Activity B5: *Availability and Access to Care Monitoring and Results,* despite receiving recommendations from the EQRO to do so.

Overall, 12 out of 19 of the MCOs and DMOs (63.2 percent) had a decrease in score on the SFY 2023 QAPI compared to SFY 2022. Since SFY 2021, the average QAPI evaluation scores have decreased by two points annually. In addition, 2023 is the first time in five years in which no MCOs or DMOs received a score of 100.

Table 23. 2022 MCO and DMO QAPI scores

MCO or DMO	Score	Peer Comparison
Aetna Better Health (Aetna)	96.0%	Average
Amerigroup	98.3%	Above Average
Blue Cross Blue Shield (BCBSTX)	93.8%	Average
Community First Health Plans (CFHP)	97.1%	Above Average
Community Health Choice (CHCT)	91.7%	Below Average
Cook Children's Health Plan (CookCHP)	98.2%	Above Average
Dell Children's Health Plan (DCHP)	90.3%	Below Average
DentaQuest	94.6%	Average
Driscoll Health Plan (Driscoll)	95.6%	Average
El Paso Health (ElPasoHealth)	96.1%	Average
FirstCare	91.5%	Below Average
MCNA Dental (MCNA)	98.4%	Above Average
Molina	97.3%	Above Average
Parkland Community Health Plan (PCHP)	91.5%	Below Average
RightCare (SWHP)	92.2%	Below Average
Superior	92.8%	Below Average
Texas Children's Health Plan (TCHP)	93.8%	Average
UnitedHealthcare (UHC)	92.9%	Below Average
UnitedHealthcare Dental (UHCD)	98.4%	Above Average
MCO/DMO Average	**94.8%**	-

The EQRO evaluated the QAPI program summary reports by section to identify areas of high performance and opportunities for systematic and individual improvement. Table 24 shows the average QAPI program performance by activity. Performance on activities contributing to the final score ranged from 88.6 to 100. The activity with the best performance, and a score of 100 was *Required Documentation Overall*. The second highest activity score was 99.6 for B4: *Clinical Practice Guidelines* which increased by 2.5 points from SFY 2022.

Indicator monitoring, evaluated in Activities B5, B6a, and B6b, also offers opportunities for improvement. Activity B5: *Availability and Access to Care Monitoring and Results* had the worst performance (score = 88.6) in SFY 2023 and SFY 2022 (score = 90.8). The low score for this activity was primarily due to 16 of the 19 MCOs and DMOs not appropriately evaluating the effectiveness of actions taken for Activity B5.5. Several MCOs and DMOs miscalculated the effectiveness of actions or left sections in the report blank. Aetna, CFHP, DCHP, DentaQuest, Molina, PCHP, and TCHP did not submit a percent change analysis for more than one indicator in this section and left many blanks in their reports. The activities B6a: *Clinical Indicator Monitoring* (score = 89.0) and B6b: *Service Indicator Monitoring* (score = 89.9) had the next lowest scores, and both activities showed the worst decrease from SFY 2022 QAPI evaluation scores. The scores declined for both activities due to four MCOs not providing accurate information. Both DCHP and Superior provided data outside of the evaluation period,

although Superior previously received an EQRO recommendation regarding accuracy of submitted information. PCHP left blank responses in the report and did not provide future action plans. FirstCare lost points for reporting goals that did not capture the MCO's performance on the measures it was monitoring. For example, FirstCare indicated having measured its success for an indicator as "<1 one appeal or complaint per 1000 members submitted are resolved," and the goal for the indicator as "<1 appeal or complaint per 1,000 members submitted." However, the goals reported did not capture the number of appeals or complaints resolved, which the MCO indicated it was monitoring.

Overall, the EQRO saw improvement in seven out of 16 activities reported during this evaluation period. The *Previous Year's Recommendations* (activity B10) and *Corrective Action Plans* (activity B9) activities were the areas with the most significant improvement. Only one MCO, CookCHP, had a recommendation for *Corrective Action Plans* (activity B9), and two MCOs, CHCT and SHP, received recommendations for not adequately addressing the *Previous Year's Recommendations* (activity B10).

Table 24. 2023 Average MCO/DMO QAPI scores by activity

Activity	Score
Required Documentation Overall	100%
A1: Role of Governing Body	99.3%
A2: Structure of Quality Improvement Committee(s)	99.2%
A3: Adequate Resources	98.7%
A4: Improvement Opportunities	96.9%
B1: Program Description	89.8%
B2: Overall Effectiveness	97.4%
B3: Effectiveness of Long-Term Services and Supports (LTSS)	98.8%
B4: Clinical Practice Guidelines	99.6%
B5: Availability and Access to Care Monitoring and Results	88.6%
B6a: Clinical Indicator Monitoring	89.0%
B6b: Service Indicator Monitoring	89.9%
B7: Credentialing and Re-credentialing	99.2%
B8: Delegation of QAPI Activities	98.3%
B9: Corrective Action Plans	98.3%
B10: Previous Year's Recommendations	94.7%

MMP QAPI Results

Table 25 shows the 2023 score for each MMP. The average score was 96.2 (SD = 3.6), increasing by 0.5 from 2022. The EQRO considered scores more than half a standard deviation below the mean (i.e., <94.4) as "below average" and scores more than half a standard deviation above the mean (i.e., >98.0) as "above average." Amerigroup earned the highest QAPI score of 100. Molina had the second-highest score of 98.1 and showed the greatest improvement from the previous year, increasing by 6.8. UHC received the lowest QAPI evaluation score (score = 92.4). This low score was primarily due to inaccurate or incomplete evaluations of the effectiveness of actions for several indicators and not reporting current or future actions for additional indicators. UHC also had the worst score decline of 6.9 from SFY 2022.

Table 25. 2023 MMP QAPI scores

MMP	Score	Peer Comparison
Amerigroup	100%	Above Average
Molina	98.1%	Above Average
Molina- Cigna-HealthSpring	98.1%	Above Average
Superior	92.5%	Below Average
UnitedHealthcare (UHC)	92.4%	Below Average
MMP Average	**96.2%**	-

The EQRO evaluated the MMP QAPI program summary reports by section to identify areas of high performance and opportunities for systematic and individual improvement. Table 26 shows the average MMP QAPI program performance by activity. Performance on activities contributing to the final score ranged from 90.0 to 100.

10 out of the 16 activities received a score of 100. The activity that improved the most was the *Overall Effectiveness* activity (B2). The activities with the lowest performance (score = 90.0) were *Program Description* (activity B1), *Service Indicator Monitoring* (activity B6b), and *Previous Year's Recommendations* (activity B10).

The *Program Description* activity (B1) had the worst decrease in scores from the SFY 2022 reports. Three out of five MMPs received a recommendation to review objectives annually to ensure continuous improvement. Molina and HealthSpring reported many of the same goals as in the past and did not provide detailed descriptions outlining how the goals were being accomplished. Superior provided information based on MY 2021 data; however, the evaluation period was for MY 2022. Superior also had inconsistencies in its reported objectives throughout the QAPI evaluation. For example, Superior reported an objective to reach target rates of 76 percent for breast cancer screening and 46.72 percent for cervical cancer screening. However, in the results analyses for this objective, the MMP reported that its target goals were 70 percent for breast cancer screening and 64 percent for cervical cancer screening. Superior had received previous EQRO recommendations to report objectives consistently.

The *Service Indicator Monitoring* activity (B6b) score declined 5.0 points from SFY 2022 due to two MMPs, Superior and UHC, misinterpreting the effectiveness of action analyses for various indicators. The EQRO had only one recommendation in the *Previous Year's Recommendations* activity (B10), that Superior report and address all recommendations from the previous year; Superior received a partial score for the component.

Table 26. 2023 Average MMP QAPI scores by activity

Activity	Score
Required Documentation Overall	100%
A1: Role of Governing Body	100%
A2: Structure of Quality Improvement Committee(s)	98.6%
A3: Adequate Resources	100%
A4: Improvement Opportunities	100%
B1: Program Description	90.0%
B2: Overall Effectiveness	100%
B3: Effectiveness of Long-Term Services and Supports (LTSS)	100%
B4: Clinical Practice Guidelines	100%

Activity	Score
B5: Availability and Access to Care Monitoring and Results	95.0%
B6a: Clinical Indicator Monitoring	91.7%
B6b: Service Indicator Monitoring	90.0%
B7: Credentialing and Re-credentialing	100%
B8: Delegation of QAPI Activities	100%
B9: Corrective Action Plans	100%
B10: Previous Year's Recommendations	90.0%

Texas EQRO Report Compliance Review Results

This section provides compiled compliance review results organized by regulatory standards. For the MCO/DMO AI reviews, Table 27 shows MCO scores for compliance with 42 C.F.R. § 438 Subpart D (2020) QAPI standards for MCOs that underwent a compliance review in the SFY 2023 AI evaluation year by regulation. Table 28 and Table 29 provide the review results from SFY 2022 and SFY 2021, respectively, thus providing results for an entire three-year review cycle. The compliance review results for MCOs/DMO reported on in the SFY 2021 evaluation year lacked available information for several categories (438.207, 438.224, and 438.330) at the time of the SFY 2021 report. Table 29 shows the updated reporting for SFY 2021. The EQRO also evaluated UMCC compliance, addressing the regulations in category 438.230, however this category (assessed as pass/fail only) does not contribute to the MCO scores.

Table 27. SFY 2023 Review scores for compliance of Texas UMCC and program contracts with regulations in 42 C.F.R. § 438 Subpart D by program

MCO and Program	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230[a]	438.236	438.242[b]	438.330[b]	Overall[b]
BCBSTX Overall	100	100	100	100	100	100	99.3	pass	100	100	96.3	99.6
BCBSTX CHIP	100	100	100	100	100	100	99.3	pass	100	100	95.8	99.5
BCBSTX STAR	100	100	100	100	100	100	99.3	pass	100	100	95.8	99.5
BCBSTX STAR Kids	100	100	100	100	100	100	99.3	pass	100	100	97.2	99.7
CHCT Overall	100	100	100	100	100	100	98.4	pass	100	100	95.1	99.4
CHCT CHIP	100	100	100	100	100	100	98.4	pass	100	100	95.1	99.4
CHCT STAR	100	100	100	100	100	100	98.4	pass	100	100	95.1	99.4
DCHP Overall	100	100	100	100	100	100	99.5	pass	91.7	100	94.4	98.6
DCHP CHIP	100	100	100	100	100	100	99.5	pass	91.7	100	94.4	98.6
DCHP STAR	100	100	100	100	100	100	99.5	pass	91.7	100	94.4	98.6
Driscoll Overall	100	100	100	100	100	100	95.7	pass	100	100	98.1	99.4
Driscoll CHIP	100	100	100	100	100	100	96.7	pass	100	100	97.9	99.5
Driscoll STAR	100	100	100	100	100	100	94.1	pass	100	100	97.9	99.2
Driscoll STAR Kids	100	100	100	100	100	100	96.3	pass	100	100	98.6	99.5
MCNA Overall	100	100	96.4	90.0	100	100	99.3	pass	100	99.1	98.6	98.3
MCNA CHIP	100	100	96.4	90.0	100	100	99.5	pass	100	99.1	98.6	98.4
MCNA Medicaid	100	100	96.4	90.0	100	100	99.0	pass	100	99.1	98.6	98.3
PCHP Overall	100	100	100	100	100	100	99.5	pass	100	100	95.1	99.5
PCHP CHIP	100	100	100	100	100	100	99.5	pass	100	100	95.1	99.5
PCHP STAR	100	100	100	100	100	100	99.5	pass	100	100	95.1	99.5
SWHP STAR (Overall)	100	100	100	86.4	100	100	96.6	pass	100	100	92.4	97.5

MCO and Program	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230[a]	438.236	438.242[b]	438.330[b]	Overall[b]
TCHP Overall	100	100	100	91.7	100	100	97.7	pass	100	100	98.8	98.8
TCHP CHIP	100	100	100	91.7	100	100	97.7	pass	100	100	98.6	98.8
TCHP STAR	100	100	100	91.7	100	100	97.7	pass	100	100	98.6	98.8
TCHP STAR Kids	100	100	100	91.7	100	100	97.7	pass	100	100	99.1	98.9

[a] This category (marked pass/fail) does not contribute to the MCO overall compliance score. Pass indicates that the contract met the compliance requirement based on a compliance review conducted by the EQRO in FY2022 and contracts had no conflicting changes.

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

Table 28. SFY 2022 AI and QAPI review scores for compliance with regulations in 42 C.F.R. § 438 Subpart D by MCO and program

MCO and Program	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230[a]	438.236	438.242[b]	438.330[b]	Overall[b]
Amerigroup Overall	100	100	100	100	100	100	100	pass	100	100	98.9	99.9
Amerigroup STAR	100	100	100	100	100	100	100	pass	100	100	98.6	99.9
Amerigroup STAR+PLUS	100	100	100	100	100	100	100	pass	100	100	99.1	99.9
Amerigroup STAR Kids	100	100	100	100	100	100	100	pass	100	100	99.1	99.9
Amerigroup CHIP	100	100	100	100	100	100	100	pass	100	100	98.6	99.9
Molina Overall	100	100	100	96.2	100	100	96.1	pass	100	91.7	95.1	97.9
Molina STAR	100	100	100	100	100	100	96.1	pass	100	91.7	94.5	98.2
Molina STAR+PLUS	100	100	100	100	100	100	96.1	pass	100	91.7	96.3	98.4
Molina CHIP	100	100	100	84.6	100	100	96.1	pass	100	91.7	94.5	96.7
Superior Overall	100	100	100	92.3	100	100	98.1	pass	83.3	94.4	94.0	96.2
Superior STAR	100	100	100	92.3	100	100	98.1	pass	83.3	94.4	93.1	96.1
Superior STAR+PLUS	100	100	100	92.3	100	100	98.1	pass	83.3	94.4	95.4	96.3
Superior STAR Kids	100	100	100	92.3	100	100	98.1	pass	83.3	94.4	95.4	96.3
Superior STAR Health	100	100	100	92.3	100	100	98.1	pass	83.3	94.4	93.1	96.1
Superior CHIP	100	100	100	92.3	100	100	98.1	pass	83.3	94.4	93.1	96.1
UHC Overall	100	100	100	100	100	100	94.0	pass	100	97.2	98.9	99.0
UHC STAR	100	100	100	100	100	100	94.0	pass	100	97.2	98.6	99.0

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

[a] This category (marked pass/fail) does not contribute to the MCO overall compliance score. Pass indicates that the contract met compliance requirement reviewed for all MCOs and DMOs during the SFY 2021 review cycle.

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

Table 29. SFY 2021 AI and QAPI review scores for compliance with regulations in 42 C.F.R. § 438 Subpart D by MCO and program (updated to include regulations in 438.207, 438.224, and 438.330

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

MCO and Program	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230[a]	438.236	438.242[b,c]	438.330[b]	Overall[b,c]
ElPasoHealth Overall	100	100	100	97.9	100	100	93.2	pass	100	100	100	99.1
ElPasoHealth STAR	100	100	100	100	100	100	98.3	pass	100	100	100	99.8
ElPasoHealth CHIP	100	100	100	95.8	100	100	84.6	pass	100	100	100	98.0
FirstCare Overall	100	100	100	91.7	100	100	90.6	pass	100	100	95.2	97.8
FirstCare STAR	100	100	100	91.7	100	100	93.3	pass	100	100	95.2	98.0
FirstCare CHIP	100	100	100	91.7	100	100	88.1	pass	100	100	95.2	97.5
DentaQuest Overall				100	100	100	100	pass	91.7	100	100	98.9
DentaQuest Medicaid	100	100	100	100	100	100	97.2	pass	91.7	100	100	98.9
DentaQuest CHIP	100	100	100	100	100	100	96.2	pass	91.7	100	100	98.8
UHCD Overall	100	100	100	95.5	90	100	99.0	pass	83.3	100	100	96.8
UHCD Medicaid	100	100	100	95.5	90	100	99.0	pass	83.3	100	100	96.8
UHCD CHIP	100	100	100	95.5	90	100	98.7	pass	83.3	100	100	96.8

[a] The reported scores do not include the regulations that address state contract requirements. The EQRO did not conduct a review of the state contract for SFY 2021, however, all contracts were reviewed for compliance with the applicable regulations as of SFY 2022 and passing status in that review is reflect in this table for the MCOs and DMOs in the SFY 2021 review cycle.

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

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

Relevance for Assessing Quality, Access & Timeliness

The quality improvement programs implemented by MCOs, DMOs, and MMPs include indicators that the organizations use to evaluate the accessibility, availability, and quality of the healthcare services provided to members. Through QAPI program summary reports, the MCOs, DMOs, and MMPs report indicator results and analyses of these results, which the EQRO uses to identify areas where the quality improvement program may need revision to improve its overall effectiveness. However, inaccurate information provided by MCOs, DMOs, and MMPs can hinder EQRO's ability to accurately assess the quality, access, and timeliness of care. Therefore, to ensure the indicators are useful to monitor access to care, timeliness of care, and improvements in the quality of care, MCOs, DMOs, and MMPs must ensure that their QAPI reports include complete and accurate information.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 30 provides a summary of the key findings and recommendations from EQR AI activities and

Table 31 provides a summary of the key findings and recommendations from EQR QAPI activities associated with Protocol 3 and their relevance to the MCQS.

Goal	Icon	MCQS description	Goal	Icon	MCQS description
1		Promoting optimal health	4		Safer delivery system
2		Strengthening person and family engagement	5		Effective practices for people with chronic, complex, and serious conditions
3		Right care in the right place at the right time	6		High-performing Medicaid providers

Table 30. Protocol 3 AI findings and recommendations

Category	Description
Finding(s)	Several MCOs and DMOs reported challenges obtaining and incorporating provider URL information into provider directories.
Recommendation(s)	MCOs and DMOs, including CHCT, MCNA, PCHP, SWHP, and TCHP, should establish systems to incorporate complete provider website URL information in their provider directories.
MCQS Goal(s)	(2, 6)
Finding(s)	Several MCOs did not have compliant procedures for the associated timeframes and notification protocols for standard and expedited service authorization decisions, including extension protocols.
Recommendation(s)	MCOs, including SWHP and TCHP should ensure their representatives make standard and expedited service authorization decisions, extensions, and notifications within the federally required timeframes.
MCQS Goal(s)	(1, 3, 4, 6)
Finding(s)	Although follow-up led to compliant corrections, several MCOs reported state-compliant CHIP grievance system protocols; however, these system protocols were not compliant with updated federal guidelines.
Recommendation(s)	MCOs with a CHIP product line need to evaluate their procedures to ensure that CHIP grievance system protocols align with Medicaid grievance system protocols, excluding the Medicaid requirement of continuation of benefits pending the appeal, a state fair hearing, or both.
MCQS Goal(s)	(2, 3, 4, 6)

Table 31. Protocol 3 QAPI findings and recommendations

Category	Description
Finding(s)	Since 2018, the average QAPI scores for MCOs and DMOs have gradually declined, with the 2023 average QAPI score (94.8 percent) being the lowest average score since 2018 (98.8 percent). Further, the lower average QAPI scores do not correlate with the scores for compliance with previous recommendations. For example, one DMO (DentaQuest) had a sustained score of 100 percent for compliance with previous recommendations since 2021; however, in that time its overall QAPI score steadily declined from 99.3 percent to 94.6 percent. Similarly, among all MCOs and DMOs the average MCO/DMO compliance with the previous year's recommendations increased from 73.7 percent (2018) to 84.7 percent in 2023, while all but one (Molina) MCOs'/DMOs' overall QAPI scores decreased from 2018. This illustrates that the MCOs and DMOs are implementing EQRO feedback on the previous year's QAPI; yet, points lost in other activities outweigh the increase in points from correcting previous issues. Amerigroup, CFHP, CookCHP, MCNA, Molina, and TCHP experienced a decrease in overall QAPI score since 2018, despite increased compliance with the previous year's recommendations.
Recommendation(s)	Amerigroup, CFHP, CookCHP, MCNA, Molina, and TCHP should ensure that they strive for continuous quality improvement in their quality improvement programs outside of implementing previous recommendations. All MCOs and DMOs should update and revise all sections of the QAPI submission as needed and ensure continued compliance on activities that previously received full credit.
MCQS Goal(s)	 (1, 3)
Finding(s)	Many MCOs reported objectives that were not specific, action-oriented statements written in measurable and observable terms that define how the MCO will meet the goals. For example, Driscoll reported one objective as, "DHP HEDIS® indicators, listed on the QM Work Plan will meet or exceed the health plan's prior year rate." The MCO did not specify which indicators it is targeting, how much, if any, improvement it seeks to achieve, or the time frame for achieving the improvement. Additionally, many MCOs and MMPs have not updated their objectives to meet the CMS criteria for several consecutive years. For example, Molina has reported many of the same or similar objectives year over year. The MCO reported the same first two objectives for Goal 2 on the last six QAPI submissions, with minor revisions, e.g., the addition of a time frame. Several MCOs and one MMP also reported objectives that they already achieved at the time or set goals to achieve minimum standards without striving for continuous improvement.
Recommendation(s)	The EQRO recommends that Aetna, BCBSTX, CHCT, CookCHP, DCHP, DentaQuest, Driscoll, FirstCare, PCHP, SWHP, and TCHP develop specific, action-oriented, measurable, and observable objectives. Objectives should focus on what needs to be improved, by how much, and by when to meet the associated goal. The EQRO previously made this recommendation. While goals may be broad and span several years, objectives should be met within a year or two and revised based on the previous year's outcomes. All MCOs, DMOs, and MMPs should review all objectives annually to ensure continuous quality improvement or identify additional opportunities for improvement. To achieve continuous quality improvement, the EQRO recommends MCOs and DMOs designate current performance as a baseline and then report the goal as a percentage or number of percentage points improvement over the current rate. MCOs should perform an annual review of all objectives to ensure they demonstrate continuous quality improvement or focus on additional opportunities for improvement. This recommendation applies to BCBSTX, CFHP, CHCT, ElPasoHealth, FirstCare, Molina, SWHP, TCHP, UHC, Cigna-HealthSpring MMP, Molina MMP, and UHC MMP.
MCQS Goal(s)	 (1, 3)

Category	Description
Finding(s)	Many MCOs, MMPs, and DMOs lost points in all three indicator monitoring sections (*Access to Care Monitoring & Results, Clinical Indicator Monitoring,* and *Service Indicator Monitoring)* for the effectiveness of actions section. The three main opportunities for improvement were: MCOs/MMPs (1) did not include a percent change analysis for all indicators, (2) reported incorrect metrics for an indicator (i.e., the unit of analysis was not consistent for all rates reported), and 3) did not accurately interpret the effectiveness of actions.
Recommendation(s)	The EQRO recommends that Aetna, Amerigroup, BCBSTX, CHCT, CFHP, DCHP, DentaQuest, Driscoll, ElPasoHealth, FirstCare, MCNA, Molina, PCHP, Superior (MCO and MMP), TCHP, and UHC (MCO and MMP) include a percent change analysis for all indicator monitoring, report all data consistently and accurately to ensure all calculations are correct, and provide accurate interpretation of results with analyses that specify whether rates improved, declined, or did not change. The EQRO previously made this recommendation.
MCQS Goal(s)	(1, 3)
Finding(s)	Several MCOs and MMPs reported inaccurate results due to incorrect data included from previous reports and provided information based on incorrect measurement years in multiple areas of the QAPI report. For example, Superior miscalculated the effectiveness of actions for the Adherence to Antipsychotic Medication for Individuals with Schizophrenia (SAA) for the STAR population in the *Clinical Indicator Monitoring* activity. The MCO reported that performance decreased by 7.51 percentage points from MY 2021. However, the correct calculation was a decrease in performance of 8.68 percentage points. The EQRO found that the 7.51 percentage point change was left in from the previous QAPI report, when measure performance increased 7.51 percentage points from MY 2020. Additionally, SWHP lost points in both the *Improvement Opportunities* and the *Overall Effectiveness* activities for reporting almost exactly the same responses from the previous QAPI report. For example, the MCO reported that it "expanded the scope of services to STAR members during pregnancy, including incorporating digital tools" as an example of program success in Activity B2 on the 2021, 2022, and 2023 QAPI reports. The EQRO could not determine if the MCO continually expanded services and incorporated new digital tools or if the response simply had not been updated. In another example, BCBSTX evaluated the effectiveness of actions taken and included a percent change analysis for all indicators in the *Clinical Indicator Monitoring* activity. However, the MCO utilized MY 2021 and MY 2020 results when calculating the percent change analysis for the 13 HEDIS indicators. The MCO should have compared results for MY 2022 with results for the previous reporting period, MY 2021.
Recommendation(s)	The EQRO recommends that Amerigroup, BCBSTX, CHCT, DCHP, Driscoll, ElPasoHealth, FirstCare, Superior, and SWHP utilize data from the current measurement year for the QAPI to report the actions the MCOs took to improve performance and results. The EQRO previously made this recommendation.
MCQS Goal(s)	(1, 3)

Protocol 4: Validation of Network Adequacy

Protocol Overview & Objectives

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

Per 42 C.F.R. § 438.358 (b)(1)(iv)(2020), the mandatory EQR activities must include validation of MCO network adequacy during the preceding 12 months to comply with requirements outlined in § 438.68 (2020) and, if the State enrolls Indigenous people in the MCO, in § 438.14(b)(1)(2020). As of December 2022 (the end of the MY for this report), CMS had not released guidance for Protocol 4, Validation of Network Adequacy. However, the EQRO conducts several activities that assess network adequacy for Texas Medicaid and CHIP members and generally aligned with the guidance provided in the EQR Protocols update released February 2023 (CMS, 2023a). These activities were:

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

EQR Activities

Administrative Compliance with Access and Timeliness

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

Appointment Availability Study

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

Technical Methods and Analysis

To fulfill this direction, Section 8.1.3 of the UMCC specifies that Texas Medicaid and CHIP MCOs must assure that all members have access to all covered services on a timely basis, consistent with medically appropriate guidelines and accepted practice parameters (HHSC, 2023a). Table 32 outlines the guidelines for timely access.

Table 32. Texas standards for Medicaid and CHIP appointment availability

Level/Type of Care	Appointment Requirements
Urgent care (child and adult)	Within 24 hours
Routine primary care (child and adult)	Within 14 calendar days
Preventive health services for new child members	No later than 90 calendar days after enrollment
Preventive health services for adults	Within 90 calendar days
Initial outpatient behavioral health visits (child and adult)	Within 14 calendar days

Level/Type of Care	Appointment Requirements
Prenatal care (not high-risk)	Within 14 calendar days
Prenatal care (high-risk)	Within 5 calendar days
Prenatal care (new member in 3rd trimester)	Within 5 calendar days
Vision care (ophthalmology, therapeutic optometry)	Access without PCP referral

The EQRO conducts the appointment availability study annually to help HHSC assess network adequacy compliance with Medicaid managed care regulations. The EQRO uses a mystery shopper approach to assess the availability of appointments. For each sub-study, the EQRO selects the provider sample from directories provided by each MCO four weeks before calls start. Callers pose as members enrolled in STAR+PLUS and STAR and caregivers looking for a provider for their child enrolled in STAR, STAR Health, STAR Kids, or CHIP. Following written call scripts tailored to each program and sub-study, callers attempt to request an initial outpatient appointment, then record the call disposition and wait time results for the first appointment date they receive for any provider with an available appointment. The EQRO developed telephone scripts and tools for the study in conjunction with HHSC, and callers enter all data into a database using a secured REDCap application. HHSC reviews and approves all tools before the beginning of data collection. The research team completed the SFY 2023 Prenatal sub-study calls between October and November 2022, Vision Care sub-study calls between November 2022 and January 2023, Primary Care sub-study calls between January and April 2023, and Behavioral Health Care sub-study calls between May and August 2023.

The call disposition codes include:

Appointments Available Denominator for Wait-Time compliance rates

13: "Appointment Available"

14: "Appointment Available with a Different Provider"

Additional Calls Eligible for Vision Care Compliance Denominator

8: "Needs Additional Information"

11: "Needs Referral"

Other Confirmed Provider Calls

5: "Does not Accept Medicaid/CHIP"

6: "Not Accepting the Plan"

7: "Not Accepting New Patients"

Exclusions (replaced in sample)

3: "No Contact After Three Attempts"

4: "Wrong Number/Unreachable

Ineligible Provider Types (replaced in sample)

9: "Specialist/Wrong Provider Type"

10: "Does Not Accept Adult/Child"

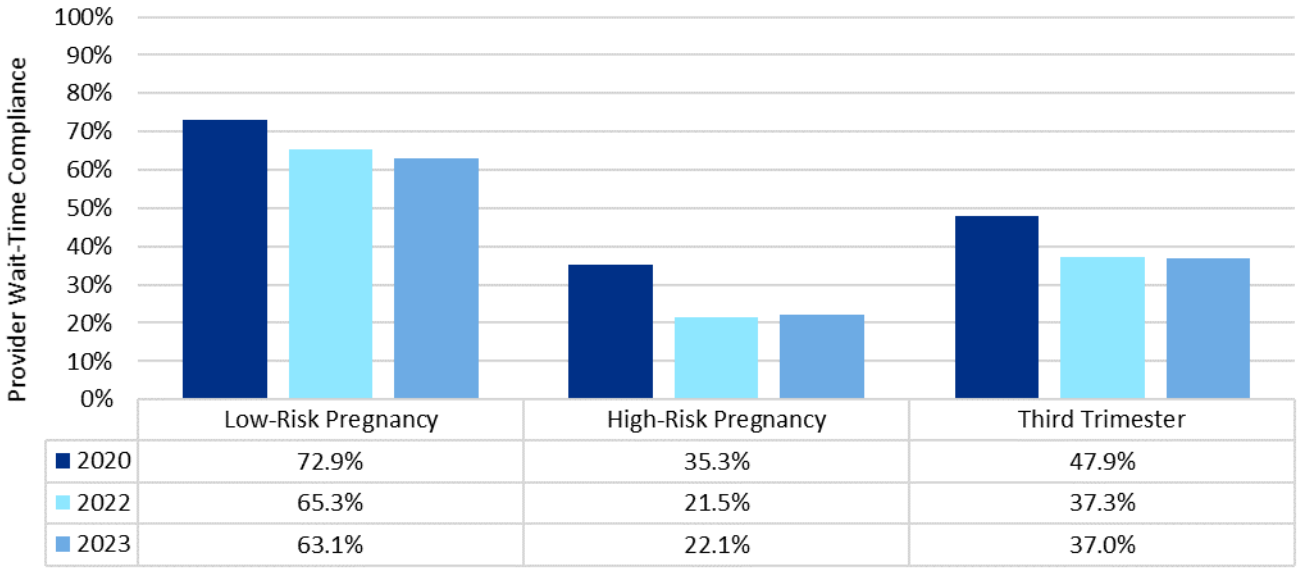
12: "Does Not Perform Exam"

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

Results

Compliance with low-risk prenatal appointment wait-time standards decreased in SFY 2023 compared to SFY 2022 (Figure 4). After showing substantial decline in SFY 2022, high-risk, and 3rd -trimester prenatal care compliance was comparable between SFY 2023 and SFY 2022. Low-risk prenatal care compliance continued to decline, decreasing by 2.2 percentage points compared to SFY 2022.

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



In SFY 2023, compliance with vision health appointment standards increased in STAR, CHIP, and STAR Health compared to SFY 2022 (Table 33). Superior had the lowest percentage of providers compliant with wait time standards in the STAR Kids and STAR+PLUS programs.

Table 33. Compliance with vision health appointment standards by program and year

Year	STAR Adult	STAR Child	STAR+PLUS	STAR Kids	STAR Health	CHIP
2022	99.0%	98.9%	99.4%	100.0%	97.6%	99.1%
2023	100.0%	100.0%	98.2%	99.6%	100.0%	100.0%
Change	+1.0%	+1.1%	-1.2%	-0.4%	+2.4%	+0.9%

In SFY 2023, the percentages of providers compliant with standards for both preventive (Table 34) and routine primary care (Table 35) improved compared to SFY 2022 in all programs. However, in STAR Kids and STAR+PLUS, the rate of preventive primary care wait-time compliance decreased in Amerigroup, and for STAR Adults, TCHP had lowest compliance rate. In SFY 2023, the overall availability of appointments decreased in all five programs. CookCHP in STAR Kids, CookCHP and SWHP in STAR, DCHP in CHIP, and Amerigroup in STAR+PLUS had the lowest appointment availabilities.

Table 34. Compliance with preventive care appointment wait-time standards by program and year

Year	STAR Adult	STAR Child	STAR+PLUS	STAR Kids	STAR Health	CHIP
2022	99.0%	99.6%	98.7%	99.3%	100.0%	99.9%
2023	99.6%	99.6%	99.1%	99.1%	100.0%	100.0%
Change	+0.6%	0.0%	+0.4%	-0.2%	0.0%	+0.1%

Table 35. Compliance with routine primary care appointment wait-time standards by program and year

Year	STAR Adult	STAR Child	STAR+PLUS	STAR Kids	STAR Health	CHIP
2022	96.4%	96.8%	97.7%	92.4%	92.5%	97.6%
2023	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Change	+3.6%	+3.2%	+2.3%	+7.6%	+7.5%	+2.4%

In SFY 2023, compliance with behavioral health appointment wait time standards increased compared to 2022 in all programs (Table 36). In 2023, the highest rate and the greatest increase in compliance was in STAR+PLUS and CHIP where compliance improved by 13.7 and 14.3 percentage points, respectively. Consistent with SFY 2022, in SFY 2023 Amerigroup again had the highest percentage of excluded providers in STAR, STAR+PLUS, STAR Kids, and CHIP.

Table 36. Compliance with behavioral health care appointment wait-time standards by program and year

Year	STAR Adult	STAR Child	STAR+PLUS	STAR Kids	STAR Health	CHIP
2022	81.9%	83.7%	81.5%	79.5%	70.0%	78.0%
2023	84.3%	84.5%	95.2%	86.4%	76.2%	92.3%
Change	+2.4%	+0.8%	+13.7%	+6.9%	+6.2%	+14.3%

Relevance for Assessing, Quality, Access & Timeliness

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

Summary of Protocol Findings & Recommendations from EQR Activities

Table 37 provides a summary of the key findings and recommendations from EQR activities associated with Protocol 4 and their relevance to the MCQS.

Goal	Icon	MCQS description	Goal	Icon	MCQS description
1		Promoting optimal health	4		Safer delivery system
2		Strengthening person and family engagement	5		Effective practices for people with chronic, complex, and serious conditions
3		Right care in the right place at the right time	6		High-performing Medicaid providers

Table 37. Protocol 4 findings and recommendations

Category	Description
Finding(s)	The percentage of providers compliant with UMCC standards for low-risk pregnancy was 2.2 percentage points lower, and for third-trimester pregnancy was 0.3 percentage points lower in SFY 2023compared to SFY 2022. For the high-risk, the compliance was 0.6 percentage points higher compared to SFY 2023.
Recommendation(s)	HHSC should consult with MCOs and conduct a root cause analysis to identify the driving factors behind lower rates of provider compliance among prenatal health providers and use the results to identify strategies for improving provider compliance. A focus study on the challenges that MCOs encounter when trying to increase the percentage of providers compliant with appointment standards could help develop more effective MCO incentives.
MCQS Goal(s)	(1, 3, 4, 5, 6)
Finding(s)	In SFY 2023, none of the sampled providers in Amerigroup, BCBSTX, or Driscoll complied with wait time standards for prenatal care in the third trimester.
Recommendation(s)	HHSC should strongly encourage Amerigroup, BCBSTX, and Driscoll to conduct a root cause analysis to identify the drivers for non-compliance with appointment standards. Amerigroup, BCBSTX, and Driscoll should use root cause analysis to identify specific approaches that they can use to encourage providers to make appointments available within five working days.
MCQS Goal(s)	(1, 3, 4, 5, 6)
Finding(s)	Overall, in SFY 2023, the percentage of excluded providers increased in low-risk and third-trimester pregnancy, and total appointments available decreased in all prenatal sub-studies compared with SFY 2022.
Recommendation(s)	HHSC should consult with MCOs to better understand the key factors contributing to errors in the provider taxonomy for prenatal directories and why so many providers in the prenatal sample did not offer prenatal appointments. No provider in FirstCare offered an appointment for third-trimester and low-risk pregnancy. No providers in Aetna, DCHP, and El Paso offered an appointment for third-trimester pregnancy. HHSC should encourage the MCOs to carefully examine the member-facing directory information they provided for the appointment availability study, especially CookCHP, and Molina, which had the highest percentage of excluded providers in prenatal sub-studies. Updated provider directories with accurate provider contact information will help reduce the total number of calls needed for each MCO and help increase the sample size for assessing compliance with call wait times. Aetna, DCHP, El Paso Health, and FirstCare should use root cause analysis to identify specific approaches that they can use to encourage providers to offer appointments to Medicaid enrollees.
MCQS Goal(s)	(1, 3, 4, 5, 6)
Finding(s)	In SFY 2023, the median number of days to wait for a high-risk appointment was nine days, and the third trimester was six days, both higher than the UMCC standard of five days.
Recommendation(s)	The EQRO recommends that HHSC work with providers to understand what factors contribute to longer wait times for appointments and develop a strategy for decreasing the wait time for High-risk and Third Trimester appointments. All MCOs should work with their providers to understand what factors contribute to longer wait times for prenatal appointments and develop a strategy for decreasing the wait time for prenatal appointments especially for high-risk appointments.
MCQS Goal(s)	(1, 3, 4, 5, 6)

Category	Description
Finding(s)	In SFY 2023, compliance with vision appointment UMCC standards decreased in STAR Kids and STAR+PLUS compared to SFY 2022. Across programs, Superior has the greatest opportunity to improve compliance with wait time standards. Superior had the lowest percentage of providers in compliance with wait time standards in the STAR+PLUS and STAR Kids programs.
Recommendation(s)	The EQRO recommends that HHSC conduct an in-depth study on appointment standards to understand the challenges that MCOs encounter when trying to increase the percentage of providers compliant with appointment standards and more effectively target Superior health incentives to increase the percentage of providers that meet appointment availability standards. HHSC should work with Superior to identify factors contributing to non-compliance with appointment standards.
MCQS Goal(s)	(1, 3, 4, 6)
Finding(s)	In SFY 2023, the percentage of contacted providers for behavioral health care appointments who did not accept Medicaid/CHIP and excluded providers increased in STAR, STAR+PLUS, STAR Kids, and CHIP compared to SFY 2022.
Recommendation(s)	HHSC should consult with MCOs and providers to better understand the key factors limiting the number of providers participating in the Medicaid programs and work with MCOs to identify ways to overcome these challenges especially United Health Care. HHSC should encourage MCOs to carefully examine the member-facing directory information they provide for the appointment availability study, especially Amerigroup, which had the highest percentage of excluded providers in STAR, STAR Kids, STAR+PLUS, and CHIP programs. Updated provider directories
MCQS Goal(s)	(6)
Finding(s)	In SFY 2023 vision study, the percentage of excluded providers increased in CHIP, STAR Kids, STAR, and STAR+PLUS compared to SFY 2022.
Recommendation(s)	HHSC should consult with Superior and Amerigroup to better understand the key factors contributing to errors in the provider taxonomy for vision directories and why so many providers in the vision sample do not conduct regular vision exams.
MCQS Goal(s)	(6)
Finding(s)	In SFY 2023, all five programs improved compliance with preventive and routine care compared to SFY 2022. The MCOs with the lowest compliance with preventive care compliance in SFY 2023 were Aetna and Amerigroup in STAR Kids, TCHP in STAR Adult, El Paso Health in STAR Child, and Amerigroup and Molina in STAR+PLUS. All MCOs across all five programs were 100 percent compliant with routine and urgent care standards in SFY 2023.
Recommendation(s)	HHSC should strongly encourage Aetna, Amerigroup, Molina, and TCHP to conduct a root cause analysis to identify the drivers for lower compliance with preventive care appointment standards and identify specific approaches for improvement.
MCQS Goal(s)	(1, 3, 4, 6)
Finding(s)	In SFY 2023 primary care study, the percentage of excluded providers increased in all five programs compared to SFY 2022. Amerigroup had the highest percentage of excluded providers in the CHIP, STAR Kids, and STAR+PLUS programs.
Recommendation(s)	HHSC should consult with Amerigroup to understand the key factors contributing to provider taxonomy errors for PCP directories and determine why so many PCP providers were excluded from the directory information submitted to the EQRO. HHSC should encourage MCOs to update provider directory information, reduce the number of excluded providers, and work with MCOs to identify ways to overcome these challenges
MCQS Goal(s)	(1, 6)

Category	Description
Finding(s)	In SFY 2023, the percentage of appointments available for primary care decreased in all five programs compared to SFY 2022. CookCHP in STAR Kids, CookCHP and SWHP in STAR, DCHP in CHIP, and Amerigroup in STAR+PLUS had the lowest percentages of available appointments.
Recommendation(s)	HHSC should work with CookCHP to identify the factors contributing to the lowest percentages of available appointments in STAR Kids and STAR programs. HHSC should encourage SWHP, CookCHP, DCHP, and Amerigroup to collaborate with providers to offer more appointments and identify ways to increase the overall percentage of appointments available.
MCQS Goal(s)	(1, 3, 4, 6)
Finding(s)	The percentage of primary care providers who offered weekend appointments decreased in CHIP, STAR Kids, and STAR STAR+PLUS in SFY 2023 compared to SFY 2022. 2.9 percent of CFHP providers in the STAR Kids program had an option for weekend appointments.
Recommendation(s)	HHSC should work with CFHP to increase weekend appointments for primary care.
MCQS Goal(s)	(1, 3, 4, 6)
Finding(s)	In the behavioral health care sub-study, the percentage of excluded providers increased in STAR, STAR Kids, STAR+PLUS, and CHIP in SFY 2023 compared to SFY 2022.
Recommendation(s)	HHSC should encourage MCOs to carefully examine the member-facing directory information they provide for the appointment availability study, especially Amerigroup, which had the highest percentage of excluded providers in STAR, STAR Kids, STAR+PLUS, and CHIP programs. Updated provider directories with accurate provider contact information will help reduce the total number of calls needed for each MCO and help increase the sample size for assessing compliance with call wait times.
MCQS Goal(s)	(1, 4, 5, 6)
Finding(s)	In SFY 2023, compliance with behavioral health care appointment wait time standards increased in all programs. The percentage of providers compliant with UMCM standards was 14.3 percentage points higher in CHIP and 13.7 percentage points higher in STAR+PLUS in SFY 2023 compared to SFY 2022. However, some MCOs had greater than 10 percentage point drops in compliance with behavioral health care appointment wait time standards for STAR Adult (CookCHP, CHCT, FirstCare, PCHP) or STAR Child (CHCT, ElPasoHealth, FirstCare, PCHP).
Recommendation(s)	MCOs should identify the driving factors behind improving rates of provider compliance among behavioral health providers and use the findings to develop strategies for continued improvement of provider compliance. HHSC should especially work with CookCHP , CHCT, ElPasoHealth, FirstCare, and PCHP to identify the factors contributing to decreased non-compliance with wait time standards for behavioral care in STAR.
MCQS Goal(s)	(1, 3, 4, 5, 6)
Finding(s)	In the behavioral health care sub-study, the percentage of excluded providers increased in STAR, STAR Kids, STAR+PLUS, and CHIP in SFY 2023 compared to SFY 2022.
Recommendation(s)	HHSC should encourage MCOs to carefully examine the member-facing directory information they provide for the appointment availability study, especially Amerigroup, which had the highest percentage of excluded providers in STAR, STAR Kids, STAR+PLUS, and CHIP programs. Updated provider directories with accurate provider contact information will help reduce the total number of calls needed for each MCO and help increase the sample size for assessing compliance with call wait times.
MCQS Goal(s)	(1, 3, 4, 5, 6)

Category	Description
Finding(s)	The percentage of providers that offered telehealth services for behavioral health decreased in STAR, STAR Kids, CHIP, and STAR+PLUS. Weekend appointments decreased in CHIP, STAR, STAR Health, and STAR Kids programs in SFY 2023 compared to SFY 2022. In STAR, none of the providers in Aetna, BCBSTX, CFHP, or CHCT offered a weekend appointment option.
Recommendation(s)	HHSC should consider a focus study to study the effectiveness of telehealth services for behavioral health, and evaluate other strategies to increase the availability of behavioral health care.
MCQS Goal(s)	(1, 3, 4, 5, 6)

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

Protocol Overview & Objectives

Protocol 5 provides guidance to EQROs on validating the accuracy and completeness of encounter data submitted by MCOs and DMOs (CMS, 2023a). Texas Medicaid and CHIP MCOs and DMOs submit encounter data to TMHP, the contract administrators for Texas Medicaid and CHIP. Encounter data should include most of the same information found on the original claims. Texas uses these data to determine capitation payment rates, assess and improve quality, and monitor program integrity (CMS, 2023a). Texas can require corrective action plans for the MCOs or DMOs not meeting minimum standards for complete and accurate data. The five activities included in this optional CMS EQR protocol include:

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

EQR Activities

Evaluation of Encounter Data Submissions & MCO Encounter Data Production Capacity

Methods

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

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

Analysis of Encounter Data for Accuracy & Completeness

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

The EQRO developed procedures for annually certifying the quality of Texas Medicaid and CHIP encounter data by following guidance in EQR Protocol 5 (CMS, 2019), the original EQR Toolkit Protocol 4 (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 six types of data to the EQRO:

1. Medical and dental encounter data
2. State paid claims (processed by TMHP)

3. Pharmacy encounter and claims data (processed by TMHP-Pharmacy)
4. Provider data
5. Member enrollment data
6. Non-emergency medical transportation data (began in SFY 2023 – not certified in SFY2023 activities)

To allow for full adjudication and processing of all claims for services during the certification period (SFY 2022), 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 2022 for the certification of SFY 2022 data.

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

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

Volume Analysis Based on Service Category

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

In STAR, despite increases in STAR enrollment, monthly volume generally decreased over the certification period, reversing the increases seen in the previous year. The distribution of institutional and professional encounters was consistent with prior years, in that Medicaid Rural Service Areas (MRSAs) had higher percentages of institutional encounters, possibly due to higher use of Federally Qualified Health Centers (FQHC) and rural health clinics. As in STAR, the MRSA had greater proportions of institutional encounters compared to professional encounters in STAR+PLUS. These variations suggest underlying differences in the care delivery model that could affect QoC measures. In STAR+PLUS, encounter volume was generally stable, though UHC and Superior had noticeable fluctuations in professional encounter volumes during the second half of the SFY. Encounter volume stayed consistent through the SFY for both STAR Kids and STAR Health. In MMP, monthly encounter volume was lower between June and August 2022, but was otherwise stable during the SFY. Large single-month changes usually indicate a processing issue. When MCOs experience a processing issue and do not provide HHSC or the EQRO with accurate data or information explaining the issue, it can affect the use of the data for QoC measures.

In STAR, professional encounters had much higher percentage denied or void status than institutional encounters, and percentage of these unpaid encounters varied by MCO. For example, Amerigroup in Bexar SA had over a third of professional encounters denied or voided, while denied or voided professional encounters were much less common in Molina, Superior and TCHP. Across all STAR+PLUS MCOs and most STAR Kids MCOs, the percentages of unpaid encounters were less than 20 percent, although similarly to STAR, the percentage of unpaid professional encounters was higher than that of institutional encounters in both programs.

Data Validity and Completeness Analysis

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

- Encounter records in which key fields were either missing or did not meet validity standards

- Present on admission (POA) indicators, used in calculating the 3M Potentially Preventable Complications (PPC) measure
- Provider information, including submitted NPI and taxonomy
- Dental-specific coding

Key Fields

The EQRO annually reexamines the fields it evaluates, and the standards used for measuring overall completeness and validity. Data quality has improved over time due to advances in the data management systems of the MCOs/DMOs and TMHP. Compliance with previous recommendations from the annual data certification process and prioritizing data quality also contribute to improvement. For SFY 2022 data, the EQRO included 17 encounter fields in the review of medical encounters and 10 pharmacy encounter fields. *Appendix B: Key Data Elements Used for Evaluating the Validity & Completeness of Managed Care Organization (MCO) Encounter Data* provides the field lists and descriptions. The EQRO considered validity check rates below 95 percent to be areas of concern and highlighted rates below 99 percent to bring them to the attention of the MCOs and HHSC. An overwhelming majority of the MCOs passed these key field reviews with >99 percent, but the EQRO highlighted several deficiencies:

- In STAR, 1.5 percent of encounters for Driscoll in the Nueces SA had invalid/missing member ID; this is a slight improvement over the prior year rate (1.6 percent).
- In STAR+PLUS, 1 percent of inpatient encounters for Superior in the Lubbock SA were missing the admission date; this is a slight improvement over the prior year rate (2 percent).
- In STAR Kids, 6 percent of inpatient encounters for Superior in the El Paso SA were missing the admission date, while 2 percent of institutional encounters for TCHP had an invalid header financial arrangement code.
- In MMP, 4 percent of inpatient encounters for Superior in the Bexar SA were missing an admission date.
- In CHIP, 1 percent of institutional encounters for TCHP had an invalid header financial arrangement code.

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

POA Indicators

Valid coding of POA for reported diagnoses is critical to the EQRO's efforts to calculate the 3M PPC measure. When POA codes are missing or invalid, the calculation of PPC rates may misclassify or exclude them. The missing data limits the ability of the EQRO to provide HHSC with accurate and complete information about PPCs for Texas Medicaid and CHIP services. To determine valid coding of POA for reported diagnoses, the EQRO evaluated the distribution of valid POA codes (*Y*, *N*, *U*, or *W*) among reported non-exempt primary diagnoses with POA codes on acute inpatient institutional encounter records and applied 3M recommended screening criteria to POA for secondary diagnoses. *Appendix C: Present on Admission (POA) Screening Criteria* provides a full description of these criteria.

Almost all primary diagnoses should be present on admission (POA code = '*Y*'). For SFY 2022 data, the EQRO found that POA distributions for primary diagnoses were within their accepted ranges for all MCO/SAs. In past years, the primary diagnosis POA indicator in STAR often fell out of accepted ranges because of a high proportion of maternity stays, for which hospitals will code significant delivery complications in the primary diagnosis, although the admission was for delivery. In part based on the EQRO reports, 3M changed recommended exclusions for some maternity stays to account for these events.

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

Provider Information

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

- All CPT codes except 7xxxx (Radiology) and 8xxxx (Pathology/Lab)
- HCPCS G-codes (professional procedures/services that would otherwise be coded in CPT but for which there are no CPT codes)
- HCPCS H-codes (rehabilitative services)
- HCPCS T-codes (Texas Medicaid agency codes) except T1019-T1022 (home health)

Within the subset of procedures mentioned above, the proportion of professional encounters with both individual rendering provider NPI and taxonomy vary substantially across programs. For STAR, the rate was 73.5 percent of selected procedures, which was on par with the previous year rate (74.5 percent). Notably, the rate was only 1.2 percent for PCHP in STAR due to taxonomy missing from professional encounters. For STAR Health, the rate improved over the prior year from 62.7 percent to 66.8 percent. For STAR Kids, the rate was 36.3 percent, which was on par with the previous year rate (33.9 percent). For STAR+PLUS, the rate was practically unchanged at 51.5 percent. When looking at all of the STAR+PLUS professional encounter records, only 13.6 percent had an individual rendering NPI and taxonomy. Some STAR+PLUS services are frequently associated with providers who do not qualify for a rendering NPI, which can be a driving factor behind the lower rates in STAR+PLUS. For MMP, the rate was 39.2 percent, which was practically unchanged from the previous year. The rate was 71.7 percent for CHIP and 67.1 percent for CHIP Perinate. The state has had several ongoing initiatives to try and improve the quality of provider data, both in encounters and in the master provider data, that seem to be bringing improvement in some cases, however the overall quality of provider data is still not meeting the desired standards.

Dental Data

A noticeable increase in dental claim volume occurred in March 2022. Dental provider NPI and taxonomy are highly complete in encounters from DentaQuest and MCNA. UHCD improved provider data quality substantially, but still only 72.3 percent of UHCD encounters had an individual rendering NPI and taxonomy.

Required tooth and tooth surface identification continue to be high for MCNA and DentaQuest. UHCD greatly improved the presence of tooth ID, with tooth ID present on 99.7 percent of eligible encounters. UHCD also improved Tooth surface ID, but the rate is still relatively low at 88.0 percent. Caries risk assessment (CRA) is a required part of a complete dental exam, and providers should code the CRA on all dental exam encounters. The EQRO highlighted the need to improve the rate of CRA coding several years ago, and the measure has improved. For SFY 2022, CRA was present on over 98 percent of eligible dental encounters for all of the DMOs.

FSR Analysis

The EQRO compared payment dollars documented in the encounter data to payment dollars in the MCO/DMO self-reported FSR. According to the standard set by HHSC for SFY 2020, the encounter data and the FSR must agree within two percent for the EQRO to certify the MCO/DMO submitted data.

All MCO/DMOs met the FSR reconciliation standard in all programs and SAs.

When the EQRO finds discrepancies in the FSR, it discusses them first with HHSC and the MCO or DMO and then may investigate the data further; in the past, this has led to corrections and improved data quality. Over time, the agreement standard has increased due to the diligent work of all stakeholders to improve data processes.

Review of Medical & Dental Records for Consistency with Encounter Data

The EQRO annually validates encounter data for accuracy and completeness by comparing encounters against a representative dental or medical records sample. In 2023, the EQRO conducted both the Encounter Data Validation: Medical Record Review (EDVMRR) for CHIP MCOs and the Encounter Data Validation: Dental Record Review (EDVDRR) for Medicaid and CHIP DMOs.

EDVMRR Methods

The EQRO validated the dates of service (DOS), place of service (POS) codes, primary diagnoses (PDx), and procedures (PX). The EQRO validated all encounters associated with DOS for each member and up to 25 procedures per encounter for services from January 1, 2021, through December 31, 2021. The samples allowed at least three months of claims lag for adjudication.

Sampling

During the sample period, the EQRO identified member-provider pairs with a paid (qualifying) encounter for a medical exam in an outpatient office or clinic visit. Eligible providers were active with an MCO with 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 sample size for each CHIP MCO using the lowest MCO match rate from the 2019 EDVMRR for DOS for CHIP (90.5 percent), resulting in a sample of 133 records per member. The EQRO divided this by the average dates of service per record (1.8), resulting in a sample size of 74 records. The EQRO adjusted the number of records requested based on the previous study's record return rate for CHIP (78.0 percent) to ensure the EQRO received the required number of records to meet the sample size requirements. Therefore, the final number of records the EQRO requested from each MCO for CHIP was 95 records. The EQRO requested the member medical record for the entire study period (2021) from the provider associated with the qualifying encounter for each selected member-provider pair in the qualified sample pool.

Record Retrieval

Using the member/provider files provided by the EQRO, MCOs collected one year's worth of records associated with the provider in the randomly selected encounter for each specific member. The MCOs submitted the records to the EQRO via TXMedCentral and the EQRO thus maintained only one version of the record (i.e., electronic versions only rather than electronic, paper, and CD versions). The MCOs' records retrieval yielded a higher record return rate (89.3 percent) than the 2021 EDVMRR-CHIP study (78.0 percent).

Analysis

The EQRO EDVMRR team used a standardized review protocol and assessed inter-rater reliability on 20.0 percent of the sample to ensure accuracy. Reviewers had a 100 percent agreement rate.

The EQRO calculated the following final match rates:

- Date of Service (DOS) – The denominator for this match rate is the total number of DOS in the encounters and the medical records. A DOS was numerator-compliant when the DOS in the medical record matched the DOS in the encounter data.
- Place of Service (POS) – The denominator for this match rate is the total number of POS in the encounters and the medical records. A POS was numerator-compliant when the POS in the medical record matched the POS in the encounter data.
- Primary diagnosis (PDx) – The denominator for this match rate is the total number of PDx in the encounters and the medical records. A PDx was numerator-compliant when the PDx in the medical record matched the PDx in the encounter data.
- Procedure (PX) – The denominator for this match rate is the total number of PX in the encounters and 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. They excluded any services in the record that occurred outside of the enrollment status for which the member was identified for the sample.

The EQRO conducted statistical testing, using chi-square tests, for the DOS, POS, PDx, and PX data elements and the record return rate to test for statistically significant differences between MCOs and programs. In addition, because a single provider may be associated with multiple members due to the sampling methodology for this study, the EQRO tested for clustering around providers.

EDVMRR Results

Record Availability Results

The EQRO requested 95 records per MCO and needed to receive 74 records per MCO to meet the sample size requirements. The EQRO received and reviewed 1,272 records (89.3 percent) of the 1,425 requested member records. For 124 of the requests (8.7 percent), the EQRO received no provider response. For eight of the record requests (0.6 percent), the EQRO did not receive the records because either the provider indicated the member was not a patient or that they did not see the member during the requested period and for 13 requests (0.9 percent) the record received was for services outside the requested period.

MCO record return rates ranged from 74 records received (77.9 percent) for DCHP to 95 records obtained (100 percent) for CookCHP and ElPasoHealth. Table 38 provides detailed record availability information for all MCOs that serve CHIP.

Table 38. Detailed information on record availability by MCO and program

MCO	Reviewable Records Received	No Response	Bad Address	Not a Patient	Pt Not seen during the requested period	Record sent outside the requested period	No Record
Aetna	79	11	0	0	0	3	2

MCO	Reviewable Records Received	No Response	Bad Address	Not a Patient	Pt Not seen during the requested period	Record sent outside the requested period	No Record
Amerigroup	86	9	0	0	0	0	0
BCBSTX	76	18	0	0	0	1	0
CFHP	89	6	0	0	0	0	0
CHCT	83	7	0	0	1	3	1
CookCHP	95	0	0	0	0	0	0
DCHP	74	21	0	0	0	0	0
Driscoll	93	2	0	0	0	0	0
ElPasoHealth	95	0	0	0	0	0	0
FirstCare	85	6	0	2	2	0	0
Molina	85	8	0	0	0	0	2
PCHP	85	4	0	0	1	3	2
Superior	92	3	0	0	0	0	0
TCHP	76	18	0	0	0	1	0
UHC	79	11	0	2	0	2	1
Total	1,272	124	0	4	4	13	8

Match Rate Results

Overall, the program averages were high for most MCOs, ranging from 86.9 percent from PCHP to 100 percent from Molina across all data elements. Table 39 shows the DOS match rate for each MCO that serves CHIP. The average match rate for DOS was 97.3 percent for the 2,427 DOS considered. All MCOs had a match rate of 95.0 percent or higher, except for PCHP. This was due to 10 records found in the encounters data that were not in the medical records.

Table 39. DOS match rate for CHIP by MCO

MCO	In Record/Not in Encounter	In Encounter/ Not in Record	DOS Match Rate
Aetna Better Health (Aetna)	0.0%	2.0%	98.0%
Amerigroup	1.4%	3.4%	95.3%
Blue Cross Blue Shield (BCBSTX)	0.8%	2.3%	96.9%
Community First Health Plans (CFHP)	0.0%	2.3%	97.7%
Community Health Choice (CHCT)	0.0%	4.1%	95.9%
Cook Children's Health Plan (CookCHP)	1.9%	3.1%	95.0%
Dell Children's Health Plan (DCHP)	1.9%	0.0%	98.1%
Driscoll Health Plan (Driscoll)	0.0%	1.0%	99.0%
El Paso Health (ElPasoHealth)	1.5%	1.0%	97.4%
FirstCare	1.6%	1.6%	96.8%
Molina	0.0%	0.0%	100%
Parkland Community Health Plan (PCHP)	0.6%	6.2%	93.2%
Superior	0.0%	1.0%	99.0%

MCO	In Record/Not in Encounter	In Encounter/ Not in Record	DOS Match Rate
Texas Children's Health Plan (TCHP)	0.0%	0.9%	99.1%
UnitedHealthcare (UHC)	0.0%	2.7%	97.3%
Average	**0.6%**	**2.1%**	**97.3%**

The POS match rates (not shown) are very similar to the DOS rates. The match rate for Molina was 99.5 percent due to one record in the encounters data that was not found in the medical record. UHC received a match rate of 96.6 percent due to five records in the encounters data that were not in the medical records, with almost all unmatched POS associated with an unmatched DOS. All other values were the same as the DOS match rates in Table 39.

Table 40 shows the PDx match rate for each CHIP MCO. The EQRO reviewed 2,427 PDx with an average match rate of 96.1 percent across MCOs. The match rates ranged from 90.7 percent for PCHP to 100 percent for Molina. PCHP had 14 records found in the encounters data that were not in the medical records. This was nearly double the value of the any other MCO.

Table 40. PDx match rate for CHIP by MCO

MCO	In Record/ Not in Encounter	In Encounter/ Not in Record	PDx Match Rate
Aetna Better Health (Aetna)	0.0%	5.4%	94.6%
Amerigroup	1.4%	3.4%	95.3%
Blue Cross Blue Shield (BCBSTX)	0.8%	3.8%	95.4%
Community First Health Plans (CFHP)	0.0%	2.8%	97.2%
Community Health Choice (CHCT)	0.0%	4.7%	95.3%
Cook Children's Health Plan (CookCHP)	1.9%	3.1%	95.0%
Dell Children's Health Plan (DCHP)	1.9%	0.9%	97.2%
Driscoll Health Plan (Driscoll)	0.0%	2.6%	97.4%
El Paso Health (El Paso Health)	1.5%	2.6%	95.9%
FirstCare	1.6%	2.5%	96.0%
Molina	0.0%	0.0%	100%
Parkland Community Health Plan (PCHP)	0.6%	8.7%	90.7%
Superior	0.0%	2.5%	97.5%
Texas Children's Health Plan (TCHP)	0.0%	3.4%	96.6%
UnitedHealthcare (UHC)	0.0%	4.8%	95.2%
Average	**0.6%**	**3.3%**	**96.1%**

Table 41 shows the PX match rates for each MCO. The EQRO reviewed 6,080 procedures. The average match rate for procedures was 95.4 percent. The match rates ranged from 86.9 percent for PCHP to 99.1 percent for TCHP. PCHP had 51 procedures (12.8 percent) found in encounters not in the medical records, and UHC had 46 procedures (9.8 percent).

Table 41. PX match rate for CHIP by MCO

MCO	In Record/Not in Encounter	In Encounter/ Not in Record	PX Match Rate
Aetna Better Health (Aetna)	0.0%	2.7%	97.3%
Amerigroup	1.0%	2.5%	96.5%
Blue Cross Blue Shield (BCBSTX)	0.6%	7.1%	92.2%
Community First Health Plans (CFHP)	0.2%	5.9%	93.8%
Community Health Choice (CHCT)	0.4%	2.8%	96.8%
Cook Children's Health Plan (CookCHP)	0.8%	2.9%	96.4%
Dell Children's Health Plan (DCHP)	1.0%	0.0%	99.0%
Driscoll Health Plan (Driscoll)	0.2%	4.3%	95.5%
El Paso Health (El Paso Health)	1.0%	1.6%	97.4%
FirstCare	0.7%	3.1%	96.2%
Molina	0.6%	0.6%	98.8%
Parkland Community Health Plan (PCHP)	0.3%	12.8%	86.9%
Superior	0.5%	2.7%	96.8%
Texas Children's Health Plan (TCHP)	0.0%	0.9%	99.1%
UnitedHealthcare (UHC)	0.2%	9.8%	90.0%
Average	**0.5%**	**4.1%**	**95.4%**

EDVDRR Methods

The EDVDRR study examined dental encounters and records for the Children's Medicaid Dental Services (CMDS) program members and CHIP Dental managed care members. The EQRO validated the DOS, POS, PX, and First Tooth IDs. The EQRO validated up to 12 DOS per record for each member and up to 25 procedures per claim and DOS. Encounters were for services from January 1, 2021, through December 31, 2021, and the sample allowed at least a three-month claim lag for adjudication.

Sampling

The EQRO identified member-provider pairs with a paid (qualifying) encounter for a dental exam in an outpatient office or clinic visit during the sample period and submitted the selected internal control numbers (ICNs) to the DMOs, which then provided the EQRO with the associated provider address for each ICN. Eligible providers were active with a DMO and had 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 sample size for each DMO for Medicaid and CHIP dental using the lowest DMO match rate from the 2021 EDVDRR, which was 89.4 percent. Based on the sample size calculations, the required sample size needed for each DMO per program was 146 records. The EQRO adjusted the number of records requested based on the previous study's record return rate of 74.5 percent and determined a record request requirement for each DMO in each program of 196 records. However, this was the first year the EQRO reviewed the encounter data for UnitedHealthcare Dental (UHCD), thus for UHCD, the EQRO requested the standard sample size of 411 records, adjusted to 552 total records requested based on the previous study's record return rate. The EQRO requested the member dental record for the entire study period (2021) from the provider associated with the qualifying encounter for each selected member-provider pair in the sample pool.

Record Retrieval

The EQRO provided the DMOs with the qualifying encounter ICNs and associated member and provider details so that the DMOs could provide the associated provider addresses. For the selected member-provider pairs, the EQRO mailed record requests to providers for the members in the sample seen by that provider during the study period. For each member in the sample, the EQRO requested the entire provider record for the review period. The EQRO sent a second mailing four weeks after the initial mailing to providers who did not respond to the first mailed request. The EQRO made follow-up phone calls to unresponsive providers, particularly those with a higher volume of records requested, one to two weeks after the second mailing.

Analysis

The EQRO record review team used a standardized review protocol and assessed inter-rater reliability on 20.0 percent of the sample to ensure accuracy. Reviewers had a 100 percent agreement rate. The EQRO calculated the following final match rates:

- Date of Service (DOS) – The denominator for this match rate is the total number of DOS in the encounters and the dental records. A DOS was numerator-compliant when the DOS in the dental record matched the DOS in the encounter data.
- First Tooth ID – The denominator for this match rate is the total number of the first Tooth IDs in the encounters and the dental records for all matched procedures. A tooth ID was numerator compliant when the tooth ID in the dental record matched the tooth ID in the encounter data.
- Procedure (PX) – The denominator for this match rate is the total number of PX in the encounters and the dental records. A PX was numerator-compliant when the PX in the dental record matched the PX in the encounter data.

The EQRO cross-checked services found in the dental 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. Dental records accounted for in the *All Encounter* file were excluded from evaluation. The review team also matched items in the dental record to enrollment and excluded any services in the record occurring outside the member enrollment in the sampled Program-DMO.

The EQRO conducted statistical testing using chi-square for the DOS, PX, and the record return rate to test for statistically significant differences between DMOs and programs. In addition, there was overlap between members enrolled in Medicaid and CHIP during the study period. The EQRO randomly de-duplicated the members eligible for both programs during the year to ensure the members were only selected for one plan code.

The EQRO validated the First Tooth ID for all procedures and calculated the match rates for the First Tooth ID and the First Tooth ID for select procedure codes. The EQRO chose dental procedure codes based on whether it identified a specific tooth as a requirement for the procedure. An updated list of procedures that required a Tooth ID was released after the 2021 EDVDRR study. Therefore, the EQRO calculated the Tooth ID match rates for the procedure codes from the previous study (EDVDRR 2021) and the updated procedure codes (EDVDRR 2023) to allow cross-year comparisons.

The procedure codes utilized for this study are:

- 2023 Tooth ID 1 Procedure Codes: D135X, D2XXX, D3XXX, D71XX, D721X, D723X, D724X, D725X, D6205-D6793 (prosthodontic)
- 2021 Tooth ID 1 Procedure Codes: D135X, D2XXX, D3XXX, D71XX, D721X, D723X, D724X, D725X

EDVDRR Results

Record Availability Results

The EQRO received and reviewed 87.3 percent of the requested records for CHIP Dental and 84.9 percent for Medicaid Dental. The EQRO received no response for 107 requests (11.3 percent) for CHIP and 128 (13.6 percent) for Medicaid. The EQRO received no response on 13 requests (1.4 percent) for CHIP Dental and 15 requests (1.6 percent) for Medicaid Dental due to incorrect provider addresses, members not being patients of the contacted provider, or members not being seen during the requested period. Table 42 shows detailed information on record availability by DMO.

Across programs, CHIP Dental and Medicaid Dental had comparable record return rates of 87.3 percent and 84.9 percent, respectively. DentaQuest Medicaid Dental had the lowest record return rate (76.0 percent), while MCNA Dental (MCNA) CHIP had the highest return rate (99.0 percent).

The EQRO found significant differences ($p<0.001$) in the record return rate by DMO and plan code (i.e., DMO x program). A higher percentage of records not received led to a lower overall record return rate for DentaQuest. Return rates did not differ significantly between dental programs.

Table 42. Detailed information on record availability by DMO and program

Type of Dental Records	Reviewable Records Received	No Response	Bad Address	Not a Patient	Pt Not seen during the requested period	Care Outside of Time Frame	No Record
Total Dental	**1,625**	**235**	**20**	**2**	**3**	**3**	**0**
CHIP DentaQuest	151	42	3	0	0	0	0
CHIP MCNA	194	1	0	0	0	1	0
CHIP UHCD	479	64	7	1	0	1	0
CHIP Total	**824**	**107**	**10**	**1**	**0**	**2**	**0**
Medicaid DentaQuest	149	41	4	1	1	0	0
Medicaid MCNA	193	2	0	0	1	0	0
Medicaid UHCD	459	85	6	0	1	1	0
Medicaid Total	**801**	**128**	**10**	**1**	**3**	**1**	**0**

Match Rate Results

The EQRO reviewed records for 1,625 members of Medicaid Dental and CHIP Dental. Overall, the program averages for the DMOs across review categories (DOS and PX) were high, with a range in match rates from 71.4 percent (MCNA CHIP Dental PX) to 98.7 percent (MCNA Medicaid Dental DOS).

The EQRO reviewed 2,364 DOS for both dental programs. The average match rate for DOS was 96.0 percent for CHIP Dental, while the average match rate for Medicaid Dental was 97.0 percent. Across DMOs, the match rates for DOS were all above 94.0 percent. DentaQuest match rates were 96.3 for CHIP DMOs and 95.5 percent for Medicaid DMOs. For MCNA, match rates were 94.1 percent (CHIP Dental) and 98.7 percent (Medicaid Dental). The DOS match rates for UHCD were 96.8 percent (CHIP Dental) and 96.7 percent (Medicaid Dental).

Average POS match rates (not shown) across CHIP and Medicaid DMOs are generally consistent with DOS match rates, and also exceeded 96.0 percent. Across DMOs, the match rates for POS were mostly higher than the DOS match rates. DentaQuest's POS match rate was 96.8 for CHIP DMOs and 96.4 percent for Medicaid Dental. For

MCNA, match rates were 94.5 percent (CHIP) and 99.3 percent (Medicaid). The POS match rates for UHCD were 96.9 percent (CHIP) and 97.8 percent (Medicaid).

The EQRO reviewed 16,427 procedures for both dental programs. The average match rates for PX across dental programs ranged from 89.7 percent (CHIP) to 90.5 percent (Medicaid). Across DMOs, the match rates for PX were 93.4 percent (CHIP) and 91.3 percent (Medicaid) for DentaQuest, 86.8 percent (CHIP) and 93.7 percent (Medicaid) for MCNA, and 89.7 percent (CHIP) to 88.9 (Medicaid) percent for UHCD.

Table 43 shows the DOS and PX match rates for the DMOs in Medicaid Dental, and Table 44 shows the DOS and PX match rates for the DMOs in CHIP Dental.

Table 43. 2021 EDVDRR DOS and procedure match rates by DMO and program for Medicaid

Match Rate Type	In Record/ Not in Encounter	In Encounter/ Not in Record	Match Rate
DentaQuest DOS Match Rates	0.4%	4.0%	95.5%
MCNA DOS Match Rates	0.0%	1.3%	98.7%
UHCD DOS Match Rates	0.4%	2.8%	96.7%
Average DOS Match Rates	**0.3%**	**2.7%**	**97.0%**
DentaQuest PX Match Rates	1.7%	7.0%	91.3%
MCNA PX Match Rates	1.3%	5.0%	93.7%
UHCD PX Match Rates	2.0%	9.1%	88.9%
Average PX Match Rates	**1.8%**	**7.7%**	**90.5%**

Table 44. 2021 EDVDRR date of service and procedure match rates by DMO and program for CHIP

Match Rate Type	In Record/ Not in Encounter	In Encounter/ Not in Record	Match Rate
DentaQuest DOS Match Rates	2.3%	1.4%	96.3%
MCNA DOS Match Rates	1.8%	4.0%	94.1%
UHCD DOS Match Rates	0.8%	2.5%	96.8%
Average DOS Match Rates	**1.3%**	**2.6%**	**96.0%**
DentaQuest PX Match Rates	2.7%	3.9%	93.4%
MCNA PX Match Rates	4.0%	9.2%	86.8%
UHCD PX Match Rates	1.7%	8.6%	89.7%
Average PX Match Rates	**2.4%**	**7.9%**	**89.7%**

The Tooth ID match rates (not shown) have usually been low for EDVDRR. The match rates were higher this year than in the 2021 EDVDRR. The only lower match rate this year was for CHIP DentaQuest (67.7 percent). Compared to encounters from other DMOs, DentaQuest encounters for both CHIP and Medicaid have significantly more occurrences where the Tooth IDs are appropriately documented in the dental records but not found in claims data. A brief investigation into the rendering NPIs in CHIP DentaQuest revealed that just a few dental providers were associated with many of these unmatched Tooth IDs. Further analysis indicated that they were predominantly associated with one plan code 1K (CHIP DentaQuest). Although DentaQuest had similar issues apparent in Medicaid Dental, they improved the Tooth ID match rates in 2023 compared to the 2021 EDVDRR.

The match rates for Tooth ID 1 for select procedures (not shown), based on the 2023 and 2021 dental codes, were 97.7 percent or higher across plans and programs. Rates by program were nearly 100 percent (99.8 percent and 99.3 percent, for CHIP and Medicaid, respectively).

Relevance for Assessing Quality, Access & Timeliness

Ensuring data validation is crucial for evaluating the quality, timeliness, and access to care. Encounter data contains a great deal of information about patient health and usage of care, and therefore must be complete, accurate, and reliable in order to be used to evaluate quality, timeliness, and access to care. The EQRO assesses the completeness and accuracy of the encounter data that support the calculation of measures used to evaluate managed care performance in Texas Medicaid and CHIP. If MCOs provide inaccurate or incomplete data, it can affect the use of the data for these measures. Additionally, MCOs or DMOs with data insufficiencies face challenges when it comes to incorporating them into quality incentive programs.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 45 and Table 46 provide a summary of the key findings and recommendations from EQR activities associated with Protocol 5 and their relevance to the MCQS

Goal	Icon	MCQS description	Goal	Icon	MCQS description
1		Promoting optimal health	4		Safer delivery system
2		Strengthening person and family engagement	5		Effective practices for people with chronic, complex, and serious conditions
3		Right care in the right place at the right time	6		High-performing Medicaid providers

Table 45. Protocol 5 findings and recommendations from the evaluation of encounter data submissions

Category	Description
Finding(s)	Encounter records continue to show deficiencies in provider identification and taxonomy attribution.
Recommendation(s)	HHSC should continue efforts to improve the quality of provider data in Medicaid and MCO systems HHSC should work with MCOs and other stakeholders to identify and address cases where NPI are not available to some service providers or services where individual NPI may not be appropriate
MCQS Goal(s)	(4, 6)

Table 46. Protocol 5 findings and recommendations from EDVMRR-CHIP

Category	Description
Finding(s)	Three MCOs (BCBSTX, PCHP & UHC) performed below average across all review categories. The primary reason for the lower match rates in 2023 is the same as in 2021 where the encounter data included for the date of service, place of service, primary diagnosis, and procedure data elements were not documented in the medical records. Further analysis identified no commonalities in procedures or diagnoses that could explain the higher incidence of unmatched data for BCBSTX and UHC. Additionally, no common providers accounted for a higher than normal amount of unmatched data for BCBSTX and UHC. However, PCHP had a total of 62 providers, of which three contributed to more than 50 percent (30 out of 51) of the procedures with a validation of "3. In claims data/not in medical record." The EQRO found a similar pattern for date of service for PCHP. Specifically, one PCHP provider single-handedly accounted for five dates of service with a validation of "3. In claims data/not in medical record." Similar conclusions can be applied to place of service, which is also analyzed at the date of service level. For all three MCOs, the three procedure codes that were in the encounter data but missing most frequently from the medical records were: 99000 – SPECIMEN HANDLING OFFICE-LAB 99214 – OFFICE O/P EST MOD 30-39 MIN 85025 – COMPLETE CBC W/ AUTO DIFF WBC Other health plans reflected these procedures in the medical records with no issues, indicating that the issue results from the providers or MCOs rather than the procedures themselves. Encounters with no corresponding documentation in the medical record for primary diagnosis showed no obvious underlying patterns.
Recommendation(s)	BCBSTX and UHC should further examine why information in the encounter data is not documented in the medical record. PCHP should work with providers to ensure all dates of service, places of service, primary diagnoses, and procedures are documented in the medical record, especially for the three most frequently missing procedure codes (99000, 99214, and 85025).
MCQS Goal(s)	, (3, 4, 6)
Finding(s)	The EQRO revised the record collection process in that the EQRO provided the CHIP MCOs with a list of members included in the study and details of the time period for which records were needed. The MCOs then requested the medical records from their providers and submitted them to the EQRO via TXMedCentral. The EQRO provided three submission deadlines at the start of the study and required MCOs to submit a minimum of 20 records per submission. Only two MCOs (PCHP and FirstCare) did not reach the required number of records to meet the sample size by the third deadline. After meeting with these MCOs, the EQRO and HHSC granted a two-week extension, after which all MCOs submitted a sufficient number of records to meet the required sample size for the study. This approach yielded an 11.3 percentage point increase in the record return rate from the 2021 EDV study.
Recommendation(s)	HHSC should require MCOs to request and electronically submit the required records for all EDVMRR studies moving forward to yield a higher record return rate. HHSC should work with all MCOs, especially PCHP and FirstCare, to ensure they submit the required number of records by each of the three deadlines.
MCQS Goal(s)	, (3, 4, 6)

Table 47. Findings and recommendations for EDVDRR

Category	Description
Finding(s)	The encounters for DentaQuest presented a higher rate of Tooth IDs in dental records that were not in the claims data compared to other DMOs. For DentaQuest, the rate of Tooth IDs that were in the dental record and not in encounter data was 32.3 percent for CHIP Dental and 25.1 percent for Medicaid Dental. MCNA's rates were 0.2 percent for CHIP and 1.0 percent for Medicaid, and UHCD's rates were 9.2 percent for CHIP and 10.0 percent for Medicaid. The overall average rate of Tooth IDs in dental records that were not in the claims data was 10.6 percent for CHIP Dental and 9.8 percent for Medicaid Dental; these averages were increased by DentaQuest's high rates. While the Tooth IDs were successfully recorded in the records during the patient visits, they were not submitted in the encounter data. Upon analysis, a considerable proportion of the unmatched Tooth IDs were concentrated in a small number of dental providers, indicating a possible record-keeping issue for these providers. These providers were predominately associated with plan code 1K (DentaQuest CHIP) in the 2023 EDVDRR study, and the issues with Tooth ID match rates primarily affect DentaQuest only. While DentaQuest Medicaid had similar issues, it improved the Tooth ID match rate slightly from the previous EDVDRR study.
Recommendation(s)	HHSC should discuss this issue with DentaQuest and ensure its providers correct potential record-keeping issues and enter the Tooth ID on the claim as required for the procedure code.
MCQS Goal(s)	 (3, 6)
Finding(s)	Record return rate differed significantly by DMO. DentaQuest had a higher percentage of records not received than the other DMOs, and thus had a lower return rate (77 percent for CHIP and 76 percent for Medicaid) than the other DMOs. MCNA had a return rate of 99.0 percent for CHIP and 98.5 percent for Medicaid, and UHCD had a return rate of 86.8 percent for CHIP and 83.2 percent for Medicaid. The average return rate was 87.3 percent for CHIP and 84.9 percent for Medicaid. DentaQuest's low return rates brought the overall record return rate down.
Recommendation(s)	DentaQuest should investigate the reason for low record return rates and correct issues that lead to a greater number of records that are not returned.
MCQS Goal(s)	 (3, 6)
Finding(s)	For CHIP Dental and Medicaid Dental, the overall match rates for PX decreased compared to the 2021 EDVDRR study. In this period, the number of PXs recorded in the encounter data but not documented in the dental record increased by 3.5 percentage points for Medicaid Dental and 2.2 percentage points for CHIP Dental. This may be due to UHCD's lower rates, as 2023 was the first year UHCD participated in EDVDRR, and their rates were lower than the other DMOs for Medicaid Dental (88.9 percent compared to 91.3 percent and 93.7 percent for DentaQuest and MCNA, respectively). Additionally, the match rates for DentaQuest and MCNA were lower than the previous year due to more procedures that were submitted in the encounter data that were not documented in the dental record.
Recommendation(s)	The DMOs should examine why the encounter data is not documented in the dental record and revise their practices to ensure compliance.
MCQS Goal(s)	 (3, 4, 6)

Protocol 6: Administration of Quality of Care Surveys

Protocol Overview & Objectives

Protocol 6 provides guidance for administering and validating consumer or provider surveys (CMS, 2023a). Surveys are a valuable resource for assessing the experience of managed care members and creating a person-centered healthcare environment for Texas Medicaid and CHIP members. The EQRO follows the CMS guidelines outlined in Protocol 6 to conduct the annual and biennial consumer surveys used to monitor and evaluate the Medicaid and CHIP managed care medical, dental, and transportation programs.

The EQRO conducts annual and biennial consumer 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 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 2023, the EQRO designed and conducted the following biennial member surveys:

- STAR child caregivers
- Dental child caregivers

In addition, the EQRO supports Texas participation in the National Core Indicators-Aging and Disabilities (NCI-AD™) program, serving as the liaison between NORC, Texas, and the national program teams.

The EQRO also conducted three surveys about the non-emergency transportation program (NEMT), contacting:

- NEMT users,
- NEMT transportation providers, and
- medical providers whose patients use NEMT services.

EQR Activities

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

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. Following the options in Protocol 6, the EQRO utilizes the NCQA-validated CAHPS 5.1H version of the CAHPS Health Plan survey. This version includes several NCQA-specified supplemental individual items, composites, and item sets such as Coordination of Care, Smoking Cessation, and Flu Vaccination summary items, and the Children with Chronic Conditions (CCC) Item Set, as well as the full complement of AHRQ-specified measures.

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

Survey Fielding

The EQRO contracted with the University of Florida Survey Research Center (UFSRC) to conduct the 2023 caregiver experience-of-care surveys using CATI (Computer-Assisted Telephone Interviewing) for the Dental Caregiver survey, and both CATI and CAWI (Computer-Assisted Web Interviewing) systems for the STAR Child Caregiver survey. Each year, the EQRO carefully selects survey research firms to conduct surveys based on reputation, quality, and cost. UFSRC has experience conducting Texas EQRO-related surveys and is NCQA accredited.

The EQRO fielded the experience-of-care surveys for six to seven months and applied strategies from Protocol 6 guidance to maximize response rates. The EQRO sent advance notification letters written in English and Spanish to members or caregivers requesting their participation. For the dental survey, the survey vendor began calls approximately four days after the advance mailing. For the STAR Child survey, calls began approximately three weeks after the advance mailing to allow time for online fielding. Standard methodology and final call disposition defined by the American Association of Public Opinion Research were used to calculate response rates. Table 48 lists the member surveys conducted by the EQRO in SFY 2023 and their enrollment and fielding periods.

Table 48. 2023 caregiver survey enrollment and fielding periods

Survey	Enrollment Period	Fielding Period	Completed Surveys
STAR Child Caregiver	September 2022 – February 2023	April 2022 - September 2023	8,576
Dental Caregiver	December 2022 – May 2023	July 2022 - November 2023	1,154

Assessment of whether the PHE contributed to general decreases in scores and ratings across most domains and programs is challenging, however, being earlier during the PHE, the comparison year (SFY 2021) was likely more impacted by the PHE. Response rates to CAHPS surveys were decreasing prior to the PHE (Bland et al., 2022) and continue to trend downward, with particularly lower response rates for racial and ethnic minorities (CAHPS, 2022). New research suggests possible strategies for improved responses with web-integrated modalities (Bland et al., 2022). Despite the challenges in collecting survey-based healthcare experience data, these instruments continue to provide valuable information, not available through other sources, that supports improvement strategies and payment reform. Adoption of the latest modes of administration could help Texas continue to extract the greatest value from these important but resource intensive tools

Survey Analysis

Following the guidance in Protocol 6, the EQRO performed various quality assurance checks including checking the sample for consistency, survey material reviews, telephone interviewer reviews and monitoring, and data quality controls. The final analysis data incorporated sample weights and non-response adjustments. 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 a more positive experience), or reported “always” having a positive experience. The EQRO provided measure results to Texas for statewide Texas Medicaid/CHIP programs, MCOs, and any state-specified groups of interest.

Survey Results

Experience of Care – Child Surveys

Table 49 shows results for the 2023 STAR Child Caregiver survey. All results, including results by MCO and national benchmarks, are available on the THLC portal (thlcportal.com).

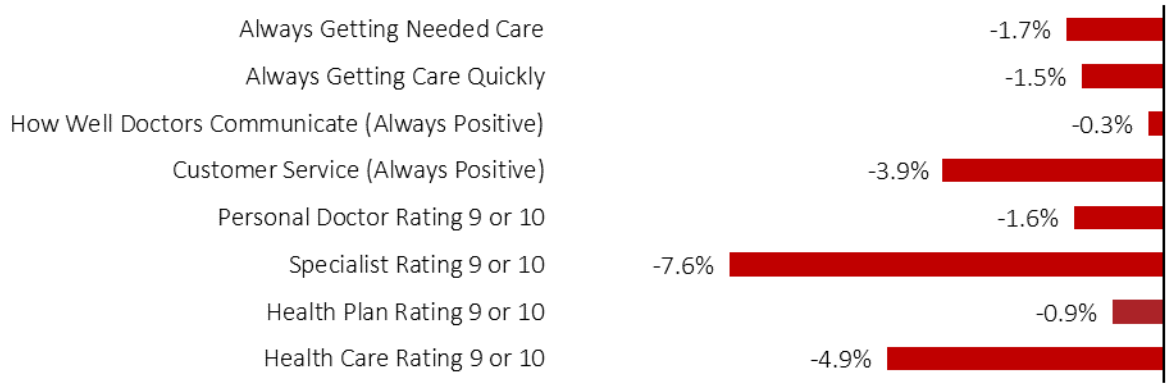
Table 49. 2023 CAHPS STAR child member caregiver survey results

Survey Question	Texas STAR Child
Always Getting Needed Care	66.08%
Always Getting Care Quickly	74.15%
How Well Doctors Communicate (Always Communicate Well)	83.53%
Customer Service (Always Positive Experience)	77.61%
Personal Doctor Rating (Caregiver Ratings of 9 or 10)	78.22%
Specialist Rating (Caregiver Ratings of 9 or 10)	75.08%
Health Plan Rating (Caregiver Ratings of 9 or 10)	81.60%
Health Care Rating (Caregiver Ratings of 9 or 10)	76.45%
CCC[a] Access to Specialized Services	57.55%
CCC[a] Personal Doctor Who Knows Child	89.58%
CCC[a] Coordination of Care for Children with Chronic Conditions	72.50%
CCC[a] Getting Needed Information	77.04%
CCC[a] Access to Prescription Medicines	74.62%

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

Overall, composite scores and ratings all decreased from 2021 to 2023 for STAR Child (Figure 5). The biggest change was the Specialist Rating (-7.6 percent), followed by the Health Care Rating (-4.9 percent) and Customer Service (-3.9 percent).

Figure 5. Change in STAR Child composite scores and ratings from 2021 to 2023



Experience of Care – Dental Surveys

Table 50 shows results for the 2023 Medicaid and CHIP dental surveys conducted by the EQRO. Member experience with dental health care was usually better among Medicaid members than among CHIP members. Although both Medicaid and CHIP member caregivers indicated positive interactions with dentists CHIP caregiver ratings on Dental Plan Costs and Services, Dentist Rating, and overall Dental Plan Rating were much lower when compared to the Medicaid group, suggesting this is an area for improvement.

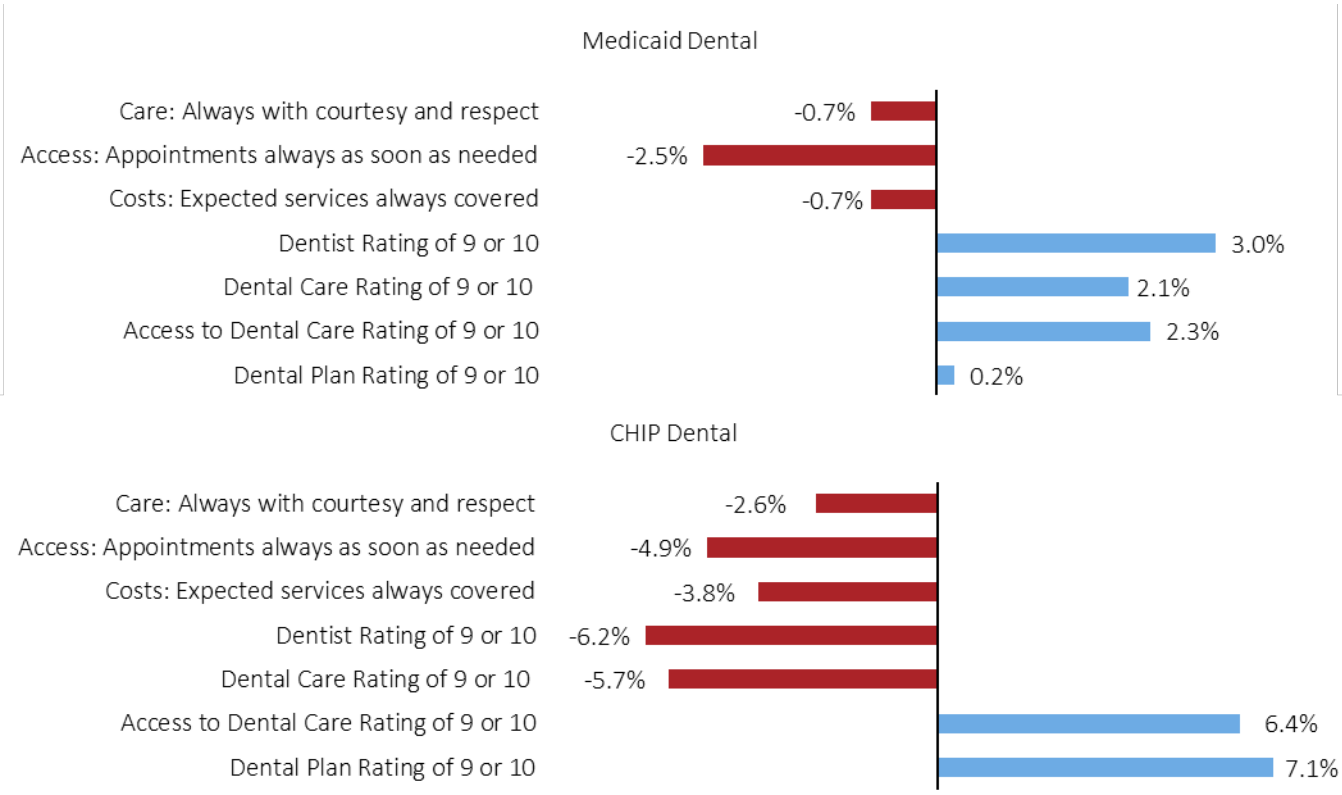
Table 50. 2023 Medicaid and CHIP dental caregiver experience of care survey results

Measure	Medicaid Dental	CHIP Dental
Care: Regular dentist always treated patient with courtesy and respect	94.0%	91.1%

Measure	Medicaid Dental	CHIP Dental
Access: Member always able to get a dental appointment as soon as needed	71.1%	67.2%
Costs: Dental plan always covered all services caregiver thought were covered	83.8%	58.9%
Dentist Rating of 9 or 10	80.6%	73.4%
Dental Care Rating of 9 or 10	76.6%	71.2%
Access to Dental Care Rating of 9 or 10	72.6%	75.5%
Dental Plan Rating of 9 or 10	82.0%	77.9%

Overall, care, access and cost measures decreased while ratings increased for Medicaid dental member caregivers from 2021 to 2023 for STAR Child (Figure 6). For CHIP dental member caregivers, only the Access to Dental Care Rating and Dental Plan Rating increased, although these were the largest changes (6.4 percent and 7.1 percent, respectively).

Figure 6. Changes Medicaid and CHIP dental caregiver experience of care from 2021 to 2023



NCI-AD Survey

The NCI-AD is a consumer survey designed to provide states with information on the performance of their LTSS programs for older adults, individuals with physical disabilities, and caregivers. The NCI-AD program is a collaborative between 22 currently participating states, the Human Services Research Institute (HSRI),[5] and ADvancing States.[6] Texas has participated in NCI-AD since it was established in 2015. The EQRO serves as a

[5] https://www.hsri.org/
[6] http://www.advancingstates.org/

liaison for Texas, working with HSRI, ADvancing States, and the survey vendor NORC to facilitate Texas participation in the NCI-AD.

Survey Fielding

States administer the NCI-AD survey to a sample of at least 400 older adults and individuals with physical disabilities who access publicly-funded LTSS programs. The NCI-AD Adult Consumer Survey (NCI-AD ACS) measures approximately 75 core indicators organized across nineteen broad domains and addresses key areas of concern such as service and care coordination, community participation, choice and decision making, self-direction, employment, rights and respect, health care and safety, and an optional module addressing person-centered planning. Indicators provide an overall picture of system performance and make tracking specific outcomes possible over time. The survey instrument includes a background survey, which gathers data about the individual from agency records, and an in-person survey, which includes subjective, satisfaction-related questions only the individual can answer and objective questions that the individual or their proxy can answer. Surveys are conducted by trained surveyors through in-person, secure video meeting, or over-the-phone conversations with service participants.

Texas uses the NCI-AD ACS to gather information on the experiences of Medicaid members in the STAR+PLUS Home and Community-Based Services (HCBS) Program. For the 2021-22 biennial survey cycle, a total of 1,499 participants were interviewed and included for analysis, with services provided by the five STAR+PLUS MCOs: Amerigroup, Cigna-HealthSpring, Molina, Superior, and UnitedHealthcare. The EQRO contracted with NORC, to collect the NCI-AD ACS data over a 40-week fielding period that began in July 2021 and ended in May 2022. Twelve trained field interviewers collected the data in-person using the NCI-AD ACS instrument. The survey tool was completed using an ODESA (i.e., an online data entry system application), which allowed data to be stored in electronic format, accessible to HHSC and collaborating agencies. As the NCI-AD ACS survey collection liaison for Texas, the EQRO helped with interviewer training, development, and coordination of interview protocols, sample preparation and management, and continuous progress and quality monitoring of data collection.

Survey Results

The Texas NCI-AD 2021-2022 State Report and the 2021-2022 NCI-AD National Report were developed by HSRI and ADvancing States in late 2022 and shared with HHSC and published in early 2023. The Texas NCI-AD State Report, including results by MCO and comparisons to national NCI-AD average; and the 2021-2022 NCI-AD National Report can be found in the NCI-AD Report Library (https://nci-ad.org/reports/). For both reports, the analysis results are presented in two sections: demographic characteristics and outcome tables and comparison across programs or states.

Table 51 shows key demographic characteristics for the STAR+PLUS HCBS Program participants in the 2021-22 survey cycle and the NCI-AD national averages for comparison. The average age of Texas participants was less than the national average and a percentage with dual access to Medicare and Medicaid was less. Texas also had much higher Hispanic participation and a higher percentage of metropolitan participants. Participant percentages were higher across diagnosis categories for Texas, and Texas had a lower percentage of participants that move without aids.

Table 51. 2021-2022 NCI-AD ACS Texas and national demographic profiles

Member Characteristic	Category	STAR+PLUS HCBS	NCI-AD Average
Age	Average (reported for those under 90 years old)	60	67
Sex	Female	65%	68%
Sex	Male	35%	32%

Member Characteristic	Category	STAR+PLUS HCBS	NCI-AD Average
Race/Ethnicity[a]	American Indian or Alaska Native	2%	2%
Race/Ethnicity[a]	Asian	1%	5%
Race/Ethnicity[a]	Black or African American	19%	23%
Race/Ethnicity[a]	Pacific Islander	0%	0%
Race/Ethnicity[a]	White	28%	60%
Race/Ethnicity[a]	Hispanic or Latino	56%	9%
Race/Ethnicity[a]	Other	2%	2%
Residential Designation	Metropolitan	90%	72%
Residential Designation	Micropolitan	7%	14%
Residential Designation	Rural	0%	6%
Residential Designation	Small town	2%	9%
Diagnosis[a]	Physical disability	83%	70%
Diagnosis[a]	TBI or other acquired brain injury	17%	11%
Diagnosis[a]	Intellectual or other developmental disability	18%	8%
Diagnosis[a]	Alzheimer's disease or dementia	15%	11%
Diagnosis[a]	Chronic psychiatric or mental health diagnosis	41%	35%
Level of Mobility	Non-Ambulatory	9%	8%
Level of Mobility	Moves self with wheelchair	28%	21%
Level of Mobility	Moves self with other aids	62%	53%
Level of Mobility	Moves self without aids	23%	27%
Level of Mobility	Receives Medicare	66%	79%

[a] Levels are not mutually exclusive

Table 52 shows outcomes from the NCI-AD ACS for Texas compared to the NCI-AD national averages across nine domains. Texas members reported having access to mental health services less often than the national average and Texas was below the national average for members reporting that services received met their needs or that case managers discussed services to help with unmet needs. However, Texas participants more often said their health was better than 12 month ago. Texas members less often felt in control of their lives, participated in activities they wanted to, or got outside their homes as much as they wanted to.

Table 52. 2021-2022 Texas NCI-AD ACS outcomes compared to national averages

Category	NCI-AD Outcomes	STAR+PLUS HCBS	NCI-AD Average
Health & Healthcare	Have access to mental health services if they want them	79%	89%
Health & Healthcare	Can get an appointment to see or talk to their primary care doctor when they need to	82%	83%
Health & Healthcare	Went to the emergency room for any reason in the past 12 months	43%	39%
Health & Healthcare	Have talked to health professionals using video conference/telehealth,	60%	43%
Health & Healthcare	Health is better than 12 months ago	20%	18%
Services & Unmet Needs	Services meet all current needs and goals	62%	69%

Category	NCI-AD Outcomes	STAR+PLUS HCBS	NCI-AD Average
Services & Unmet Needs	Case manager talked to them about services that might help with their unmet needs	33%	51%
Respect & Privacy	Services and supports are delivered in a way that is respectful of their culture	96%	96%
Respect & Privacy	Paid support staff treat them with respect	95%	92%
Community Participation	Gets to do things outside of their home as much as they want to	45%	62%
Community Participation	Takes part in activities with others as much as they want to	49%	58%
Choice & Control	Feel in control of their life	65%	72%
Choice & Control	Can choose/change the people who provide paid supports	92%	79%
Choice & Control	Can choose/change their services and supports	69%	76%
Choice & Control	Can choose/change when/how often they receive services	64%	71%
Service Coordination	Paid support staff come and leave when they are supposed to	94%	89%
Service Coordination	Has a backup plan if their paid support staff do not show up	70%	66%
Staff Longevity & Turnover	Case manager changes too often	37%	31%
Staff Longevity & Turnover	Paid support staff change too often	15%	25%
Employment	Wants a paid job (if they do not currently have one)	11%	9%
Employment	Receive follow up about job options (if they want one)	20%	33%
Person-Centered Planning	Involvement in making decisions about what is in the service plan	80%	79%
Person-Centered Planning	People at the service planning meeting listened to needs and preferences	76%	72%
Person-Centered Planning	Service plan reflects what was talked about at the service plan meeting	82%	85%
Person-Centered Planning	Choices and preferences are reflected in current service plan	78%	78%

Data collected through the NCI-AD survey fill a gap in the managed care quality assurance system and are used to demonstrate managed LTSS delivery performance to external parties, including state and federal stakeholders. The NCI-AD national project team interprets each state's data and produces reports supporting state efforts to strengthen LTSS policy, inform quality improvement activities, and compare their performance with national norms. Texas owns and has immediate access to its own data, which can be analyzed across settings and funding sources, and can provide state, program, and regional comparisons. In 2023, the EQRO produced and issue brief, "*Using NCI-AD Data to Assess Person-Centered Service Planning Requirements in the CMS Settings Rule*" that is discussed in *Protocol 9: Conducting Focus Studies of Health Care Quality.*

NEMT Client Experience Survey

Federal regulations (42 CFR §431.53 and §440.170) require that states ensure the availability of transportation to and from Medicaid covered healthcare services. Beginning in June 1, 2021, Texas Medicaid MCOs took responsibility for Medicaid NEMT needs for their members, including approving, arranging, coordinating, and ensure delivery of services. The EQRO conducted a survey of NEMT service users, transportation providers, and medical providers about their experiences with NEMT programs.

Survey Fielding

The NEMT user sample included members enrolled in October 2022 and during at least five of the six months from May 2022 through October 2022 that had at least one paid ambulatory outpatient visit, emergency department visit, or inpatient stay in 2022, and that had paid NEMT services in 2022. Members in nursing homes or dually eligible for Medicare and Medicaid were excluded, and cohorts included 8,460 child members (0-17 years old) caregivers and 10,187 adults (18+ years old). The provider survey sample included all demand-response transportation service (DRTS) providers with encounters in January 2023. The medical provider survey included 3,387 providers listed as the destination on 25+ NEMT encounters and having a selected taxonomy:

- Allopathic & Osteopathic Physicians
- Group
- Physician Assistants & Advanced Practice Nursing Providers
- Dental Providers
- Ambulatory Healthcare Facilities
- Behavioral Health & Social Services Providers
- Respiratory, Developmental, Rehabilitative, and Restorative Service Providers
- Eye and Vision Services Providers
- Speech, Language, and Hearing Service Providers
- Podiatric Medicine & Surgery Service Providers
- Chiropractic Providers

The member survey consisted of a 10- to 20-minute telephone interview that included questions that assessed familiarity and experience with transportation services. The DRTS provider survey consisted of a 10-minute telephone interview that included questions about DRTS provider experience with claim reimbursement, the information they receive about rides for members, and the source of DRTS provider knowledge about NEMT services. The medical provider survey consisted of a 10-minute telephone interview that included questions that assessed medical provider experiences with NEMT services for their patients, including questions on the timeliness of services, medical provider experience with the call center, and the source of medical provider knowledge about NEMT services. The EQRO enlisted UFSRC to field all three surveys between January and June 2023.

Survey Results

Most (84.6 percent) caregivers of children were satisfied or very satisfied with all the NEMT services their children received from Medicaid. Among adults, 86.3 percent were satisfied or very satisfied with all the NEMT services they received. However, 24.8 percent of child caregivers and 35.7 percent of adults reported that lack of transportation kept their child or them from medical appointments or getting medication. The higher percentage of adult members in this and a previous transportation needs survey expressing unmet NEMT needs suggests this is an area where HHSC should focus on improving access. By far, the MCO was the most common source of information about NEMT services for all transportation service type (mass-transit, DRTS, transportation network company, or mileage reimbursement) users. Getting information from a doctor or other health provider was more common among caregivers than adults.

Almost all DRTS providers (94 percent) said they were satisfied or very satisfied with providing rides for Medicaid NEMT. The most frequent challenge identified by DRTS providers was that members were unprepared for departure at the scheduled time. Many transportation providers (64.4 percent) said they had no problems submitting credentialing documents to HHSC or the MCO/MCO subcontractors. However, 28.9 percent of DRTS providers reported problems with these processes. Many DRTS providers (65.9 percent) said it was usually or always easy to file a claim for transportation services. And most DRTS providers (74.5 percent) said they were

satisfied or very satisfied with the timeliness of the MCO claim reimbursement process. However, over half of the DRTS providers (58.3 percent) identified the process for appealing denied claims as an important challenge related to claim reimbursement.

Only 16 percent of medical providers said that members usually or always arrive on time for their medical appointments, and most (82.5 percent) said that they or their staff have had to call to check on the status of a ride for patients ready to be picked up. Only 62.5 percent said the driver usually or always arrives within an hour of the scheduled pick-up time. Almost a quarter of medical providers (23.3 percent) said they usually or always call to arrange a pick-up for Medicaid members after an appointment and only about half (53.3 percent) said scheduling NEMT services for MMC patients was usually or always easy. Even with these reported difficulties, many medical providers (65.2 percent) said that overall, they are satisfied or very satisfied with the timeliness of Medicaid NEMT services that their patients receive and most (74.7 percent) said they were satisfied or very satisfied with all the NEMT services their Medicaid patients received. Over a third (35.3 percent) of providers said patients of caregivers were their primary source of information about Medicaid NEMT services, while another third (32.7 percent) said HHSC or TMHP was their primary source.

The EQRO recommends continued efforts to encourage MCOs to address scheduling and access needs including strategies such as asking MCOs to assess barriers to NEMT services. HHSC should also work with the MCOs to assess and ensure the timeliness of NEMT rides. Late and missed medical appointments are associated with delayed care for patient illnesses and chronic health conditions, lack of specialty care, and increased visits to emergency departments. Further, many of the medical providers in the study indicated that they think members arriving late for appointments had the potential to impact the quality of care that members receive. What is less clear is the cause and extent of transportation delays. Therefore, the EQRO recommends HHSC work with the MCOs to 1) identify whether there are delays in NEMT rides, 2) identify the extent of the NEMT ride delays, and 3) identify and address the primary cause of NEMT ride delays.

Relevance for Assessing Quality, Access & Timeliness

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

Summary of Protocol Findings & Recommendations from EQR Activities

Table 53 provides a summary of the key findings and recommendations from EQR activities associated with Protocol 6 and their relevance to the MCQS

Goal	Icon	MCQS description	Goal	Icon	MCQS description
1		Promoting optimal health	4		Safer delivery system
2		Strengthening person and family engagement	5		Effective practices for people with chronic, complex, and serious conditions
3		Right care in the right place at the right time	6		High-performing Medicaid providers

Table 53. Protocol 6 findings and recommendations

Category	Description
Finding(s)	Overall, composite scores and ratings all decreased from 2021 to 2023 for STAR Child.
Recommendation(s)	Further analysis of the survey results is needed to understand the significance of these changes, and whether they reflect a change in members' experiences, or whether changes in member populations are affecting overall care experiences.
MCQS Goal(s)	(2, 3, 6)
Finding(s)	Although the access to dental care rating increased, the availability of appointments when needed decreased.
Recommendation(s)	Further analysis of survey results, possibly in combination with additional related member data could provide insight on these observed differences.
MCQS Goal(s)	(2, 3, 6)
Finding(s)	24.8 percent of child caregivers and 35.7 percent of adults reported that lack of transportation kept their child or them from medical appointments or getting medication.
Recommendation(s)	The EQRO recommends continued efforts to encourage MCOs to address scheduling and access needs including strategies such as asking MCOs to assess barriers to NEMT services.
MCQS Goal(s)	(2, 3)
Finding(s)	Despite general satisfaction with NEMT services patients receive, only 16 percent of medical providers said that members usually or always arrive on time for their medical appointments, and most (82.5 percent) said that they or their staff have had to call to check on the status of a ride for patients ready to be picked up.
Recommendation(s)	HHSC should also work with the MCOs to assess and ensure the timeliness of NEMT rides. Late and missed medical appointments are associated with delayed care for patient illnesses and chronic health conditions, lack of specialty care, and increased visits to emergency departments. Further, many of the medical providers in the study indicated that they think members arriving late for appointments had the potential to impact the quality of care that members receive. What is less clear is the cause and extent of transportation delays. Therefore, the EQRO recommends HHSC work with the MCOs to 1) identify whether there are delays in NEMT rides, 2) identify the extent of the NEMT ride delays, and 3) identify and address the primary cause of NEMT ride delays.
MCQS Goal(s)	(1, 3)

Protocol 7: Calculation of Performance Measures

Protocol Overview & Objectives

Protocol 7 provides guidance to states on the calculation of additional (non-QAPI) performance measures to monitor the care provided by MCOs to enrollees covered by Medicaid and CHIP (CMS, 2023a). States use performance measures to monitor and compare the performance of MCOs over time and inform the selection and evaluation of quality improvement activities. This optional CMS EQR protocol specifies that the EQRO should calculate measures per Texas specifications and report results compared to established benchmarks and standards. The EQRO uses an external NCQA certified auditor to review measures calculated as part of Protocol 7 activities. MCO-specific results on select performance measures are available in the ATR Companion.

EQR Activities

Methods & Analyses

Texas contracted with the EQRO to conduct comprehensive QoC evaluations across all Texas Medicaid programs. *Appendix D: Summary of Quality Measures Calculated & Reported by the EQRO by Program* summarizes the QoC measures calculated and reported by the EQRO for MY 2022. MCO-specific results for measures on the Performance Indicator Dashboards are available in the ATR Companion.

Measures

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

NCQA HEDIS measures

NCQA has stewarded HEDIS, the most widely used set of healthcare performance measures in the United States, for more than 20 years (NCQA, 2023). Texas includes over 50 HEDIS measures in Texas Medicaid and CHIP performance evaluations.

Child Core Measures

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided for HHS to establish a set of core QoC measures for children’s healthcare (CMS, 2023d). Many of the measures included are part of the HEDIS measure reporting set (including the NCQA CAHPS Survey Measures described in *Protocol 6: Administration of Quality of Care Surveys*). The EQRO also calculates the developmental screening measure stewarded by Oregon Health and Science University, the contraceptive care measures stewarded by the U.S. Office of Population Affairs, and the CMS measure of dental services. The EQRO submits CHIPRA core-measure results to CMS on behalf of Texas Medicaid and CHIP.

Adult Core Measures

The Patient Protection and Affordable Care Act of 2010 required HHS to establish a core set of measures for adult healthcare (CMS, 2023c). As in the CMS child core measure set, many of the included measures are part of the HEDIS and AHRQ measure reporting set (including the adult CAHPS survey). The EQRO also calculates the HHS Office of Population Affairs contraceptive care measures for adults. In addition to measure calculation, the EQRO submits CMS adult core measure results to CMS on behalf of Texas Medicaid.

3M Health Information Systems Measures of PPEs

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

AHRQ Prevention Quality Indicators & Pediatric Quality Indicators

AHRQ serves as the lead federal agency for improving the safety and quality of America's healthcare system. The Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI) track performance based on administrative hospital inpatient data (AHRQ, 2023c, 2023b).

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, 2023).

Severe Maternal Morbidity/Pregnancy Associated Outcomes

In 2017, Texas asked the EQRO to examine whether Texas could use the American College of Obstetricians and Gynecologists (ACOG) Alliance for Innovation on Maternal Health (AIM)[7] outcome measures for severe maternal morbidity (SMM) to evaluate the quality of maternal healthcare in the Texas Medicaid and CHIP programs. Since then, the EQRO has continued working with HHSC to improve maternal healthcare by partnering with HHSC in a CMS Medicaid Innovation Accelerator Program[8] (IAP) addressing maternal mortality and SMM. Through this program, HHSC developed a roadmap for future progress and received technical recommendations to improve the EQRO specification for the statewide measure of pregnancy associated outcomes (OAP). The EQRO produces a comprehensive report of the OAP measure results annually based on this specification, and following relevant updates to the AIM measures. The overall SMM rates (excluding transfusion-only) are part of QoC reporting and this is a STAR P4Q measure starting with MY 2022.

Cesarean Section Deliveries

The CMS child core measures include a measure of cesarean section (C-Section) births stewarded by The Joint Commission (The Joint Commission, 2022) and AHRQ stewards several C-Section measures in the Inpatient Quality Indicators (AHRQ, 2023a). These measure definitions include requirements for vital statistics or medical record reviews, so it is impossible to calculate them from administrative data alone. Texas asked the EQRO to develop a C-Section measure that aligned with national standards and was calculable using only administrative data that also captured a comprehensive view of all C-Sections in Texas Medicaid. The EQRO produced a comprehensive report of the performance measure results for HHSC based on these specifications, which include all C-Sections, regardless of parity, and stratified based on presence of delivery complications. The rates for the C-Section measures (CES) are part of QoC reporting and uncomplicated C-Section rate is a STAR P4Q measure starting with MY 2022.

Calculations

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

Some HEDIS measures rely on medical record abstraction through hybrid method specifications. These include sampling based on administrative criteria, followed by medical record review from the sample to determine

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

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

compliance. For HEDIS MY 2022, the EQRO received measure results from the MCOs for seven measures with a hybrid sampling methodology. For each of the measures submitted, the EQRO also requires MCOs to submit NCQA audit certification and the member-level data from their hybrid samples. *Protocol 2: Validation of Performance Measures*, describes these activities. To produce overall statewide rates for these measures, the EQRO uses the MCO reported rates, weighted by their eligible populations identified by the EQRO using QSI-XL (Inovalon, 2022).

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

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

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

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

All reported measures are validated through external audit, and reviewed by the EQRO.

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

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 for the FFY 2023 reporting year is voluntary. However, CMS supports improvements in uniform data collection and reporting and helps states understand how to use these data to improve healthcare quality. The EQRO manages the submission of Medicaid and CHIP data, monitors changes in CMS guidelines and initiatives, and provides information to HHSC related to the management of Medicaid and CHIP.

COVID-19 Pandemic Impacts

During 2022, the PHE continued, as did the freeze on Medicaid disenrollment. Overall, Texas Medicaid enrollment increased by over half a million Texans from December 2021 to December 2022. The largest percent increases were in two age groups: (1) those aged 18 to 20 years, because children turning 18 during the PHE did not lose coverage and (2) young adults aged 21 to 44 years, who may have become eligible as a result of the PHE or during pregnancy, and retained coverage regardless of changes in eligibility status. Conversely, CHIP enrollment decreased again with December 2022 enrollment barely half that in December 2021. This is partly

the result of infants born during the PHE maintaining Medicaid eligibility beyond one year. A substantially larger portion of members may have third party insurance, while maintaining Medicaid eligibility because of the PHE. This could affect QoC measure rates if eligible members received qualifying care through non-Medicaid insurance.

Results & Reporting

QoC Measures

Most QoC measure results are publicly available on the THLC portal (thlcportal.com). By adding results reporting for more member groups (for example, demographic groups) and special populations, including members with serious mental illness (SMI), pregnant women, and MDCP members, the EQRO enables HHSC to identify areas of concern. The information provided by these reports can also identify cases needing additional study. For example, STAR+PLUS members diagnosed with SMI have higher rates of substance use disorders (SUD) and continued use of opioids.

Identifying disparities in care also requires comparing QoC measure results for different member groups. Based on the EQRO reports, HHSC can identify specific targets for further investigation, such as those described above, and general trends emerge. For example, results for many measures show racial, ethnic and geographic disparities. White members had the highest outpatient utilization among racial groups except for the unknown race category, while Black members the highest ED utilization, and more inpatient stays than White members. Hispanic Medicaid members had more outpatient utilization and less ED utilization and inpatient stays than other ethnic groups. Hispanic members have higher rates for several important measures for children, including well-child visits, medication management for Attention Deficit Hyperactivity Disorder (ADHD), and developmental screening. White members had higher rates than black members on these same measures. Hispanic women had more breast cancer and chlamydia screenings than other ethnic categories, while among racial groups, Black women had more of these screenings than White women. Health status was a factor in performance on some measures. Variability in services related to geographic differences may contribute to some of these demographic disparities. Continuing to probe these issues provides Texas with information necessary to improve care for all Medicaid and CHIP members.

Medicaid reporting includes members in the STAR, STAR+PLUS, STAR Health, and STAR Kids managed care programs, and those covered through FFS. The STAR managed care plans cover about 90 percent of Medicaid members each month, and FFS coverage typically covers gaps between or before managed care enrollment. For MY 2022, the EQRO submitted Medicaid Adult, Medicaid Child, and CHIP measures to CMS. On the following pages, Table 54 and Table 55 show rates for the CMS child and adult core measures, respectively. MCO-specific results are available in the ATR Companion. Results are also available on the THLC portal (thlcportal.com).

Table 54. Validated CMS child core measures

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate	CHIP Denominator	CHIP Rate
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	(3mo-17)	152,659	68.3	1,723	51.1
ADD	Follow-Up Care for Children Prescribed ADHD[a] Medication	Continuation and Maintenance Phase	7,383	54.9	93	58.1
ADD	Follow-Up Care for Children Prescribed ADHD[a] Medication	Initiation Phase	44,407	42.6	1,514	39.0
AMB	Ambulatory Care: ED	ED visits per member month (age <1)	2,729,751	87.5	198	50.5
AMB	Ambulatory Care: ED	ED visits per member month (age 1-9)	23,573,838	45.4	324,695	22.2
AMB	Ambulatory Care: ED	ED visits per member month (age 10-19)	22,768,968	31.1	535,276	16.6
AMB	Ambulatory Care: ED	ED visits per member month (age 0-19)	49,072,557	41.1	860,169	18.7
AMR	Asthma Medication Ratio	(5-11)	23,574	72.1	139	86.3
AMR	Asthma Medication Ratio	(12-18)	21,670	64.5	139	75.5
AMR	Asthma Medication Ratio	(5-18)	45,244	68.5	278	80.9
APM	Metabolic Monitoring. for Children & Adolescents (C/A) on Antipsychotics	Blood Glucose (1-11)	14,176	44.2	49	38.8
APM	Metabolic Monitoring For C/A on Antipsychotics	Blood Glucose (12-17)	25,568	61.7	178	60.7
APM	Metabolic Monitoring For C/A on Antipsychotics	Blood Glucose (1-17)	39,744	55.5	227	55.9
APM	Metabolic Monitoring For C/A on Antipsychotics	Cholesterol (1-11)	14,176	33.6	49	20.4
APM	Metabolic Monitoring For C/A on Antipsychotics	Cholesterol (12-17)	25,568	43.0	178	39.9
APM	Metabolic Monitoring For C/A on Antipsychotics	Cholesterol (1-17)	39,744	39.6	227	35.7
APM	Metabolic Monitoring For C/A on Antipsychotics	Blood Glucose and Cholesterol (1-11)	14,176	32.2	49	20.4
APM	Metabolic Monitoring For C/A on Antipsychotics	Blood Glucose and Cholesterol (12-17)	25,568	42.0	178	38.8
APM	Metabolic Monitoring For C/A on Antipsychotics	Blood Glucose and Cholesterol (1-17)	39,744	38.5	227	34.8
APP	Use of First-Line Psychosocial Care for Children & Adolescents (C/A) on Antipsychotics	(age 1-11)	5,757	39.1	32	37.5
APP	Use of First-Line Psychosocial Care for C/A on Antipsychotics	(age 12-17)	9,276	45.9	99	43.4
APP	Use of First-Line Psychosocial Care for C/A on Antipsychotics	(age 1-17)	15,033	43.3	131	42.0
CCP	Contraceptive Care - Postpartum Women	LARC - 3 Days (age 15-20)	14,538	1.7		
CCP	Contraceptive Care - Postpartum Women	LARC - 60 Days (age 15-20)	14,538	19.4		
CCP	Contraceptive Care - Postpartum Women	Most or Moderately effective contraception - 3 Days (age 15-20)	14,538	3.1		
CCP	Contraceptive Care - Postpartum Women	Most or Moderately effective contraception - 60 Days (age 15-20)	14,538	43.2		
CCW	Contraceptive Care - All Women	LARC (age 15-20)	474,723	2.6		

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate	CHIP Denominator	CHIP Rate
CCW	Contraceptive Care - All Women	Most or moderately effective contraception - (age 15-20)	474,723	15.9		
CHL	Chlamydia Screening in Women	(age 16-20)	143,207	47.1	701	33.8
CIS	Childhood Immunization Status	DTaP		69.9		
CIS	Childhood Immunization Status	IPV		85.0		
CIS	Childhood Immunization Status	MMR		84.8		
CIS	Childhood Immunization Status	HiB		85.7		
CIS	Childhood Immunization Status	Hep B		83.8		
CIS	Childhood Immunization Status	VZV		85.0		
CIS	Childhood Immunization Status	PCV		71.4		
CIS	Childhood Immunization Status	Hep A		84.4		
CIS	Childhood Immunization Status	RV		68.3		
CIS	Childhood Immunization Status	Flu		34.2		
CIS	Childhood Immunization Status	Combo 3		62.2		
CIS	Childhood Immunization Status	Combo 7		54.2		
CIS	Childhood Immunization Status	Combo 10		25.7		
CPC	CAHPS Health Plan Survey	Getting Needed Care - % Always		67.8		59.4
CPC	CAHPS Health Plan Survey	Getting Care Quickly - % Always		70.0		69.8
CPC	CAHPS Health Plan Survey	How Well Doctors Communicate - % Always		79.0		80.2
CPC	CAHPS Health Plan Survey	Customer Service - % Always		78.4		76.2
CPC	CAHPS Health Plan Survey	Coordination of Care		56.3		56.2
CPC	CAHPS Health Plan Survey	Rating: All Health Care		70.7		67.8
CPC	CAHPS Health Plan Survey	Rating: Personal Doctor		74.8		78.5
CPC	CAHPS Health Plan Survey	Rating: Specialist				
CPC	CAHPS Health Plan Survey	Rating: Health Plan		80.0		72.4
DEV	Developmental Screening - First Three Years of Life	Children screened by 12 months of age	164,248	45.5	-	0
DEV	Developmental Screening - First Three Years of Life	Children screened by 24 months of age	221,540	47.2	9	33.3
DEV	Developmental Screening - First Three Years of Life	Children screened by 36 months of age	222,031	43.4	494	48.8
DEV	Developmental Screening - First Three Years of Life	Children Total	607,819	45.3	503	48.5
FUA	Follow-Up After ED Visit for Alcohol & Oth. Drug Abuse or Dep.	Follow-up within 30 days (age 13-17)	2,344	26.6	32	21.9
FUA	Follow-Up After ED Visit for Alcohol & Oth. Drug Abuse or Dep.	Follow-up within 7 days (age 13-17)	2,344	15.2	32	15.6

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate	CHIP Denominator	CHIP Rate
FUH	Follow-Up After Hospitalization for Mental Illness	Follow-up within 30 days (age 6-17)	25,238	67.8	355	67.9
FUH	Follow-Up After Hospitalization for Mental Illness	Follow-up within 7 days (age 6-17)	25,238	42.4	355	40.6
FUM	Follow-Up After ED Visit for Mental Illness	Follow-up within 30 days (age 6-17)	5,155	57.8	74	55.4
FUM	Follow-Up After ED Visit for Mental Illness	Follow-up within 7 days (age 6-17)	5,155	42.2	74	43.2
IMA	Immunizations for Adolescents	Meningococcal		85.7		91.2
IMA	Immunizations for Adolescents	Tdap		85.8		90.9
IMA	Immunizations for Adolescents	HPV		42.2		46.0
IMA	Immunizations for Adolescents	Combination 1		84.9		90.6
IMA	Immunizations for Adolescents	Combination 2		41.4		45.7
LSC	Lead Screening in Children	Total	221,540	34.4	9	22.2
OEV	Oral Evaluation, Dental Services	(age <1)	78,382	30.3	5	0
OEV	Oral Evaluation, Dental Services	(age 1-2)	445,394	59	369	45
OEV	Oral Evaluation, Dental Services	(age 3-5)	638,198	66.5	6,825	65.5
OEV	Oral Evaluation, Dental Services	(age 6-7)	422,590	70.7	7,756	68.5
OEV	Oral Evaluation, Dental Services	(age 8-9)	407,198	70.5	10,017	70.2
OEV	Oral Evaluation, Dental Services	(age 10-11)	383,878	69.5	10,545	68.8
OEV	Oral Evaluation, Dental Services	(age 12-14)	593,237	66.5	16,672	65.1
OEV	Oral Evaluation, Dental Services	(age 15-18)	728,951	58.6	19,812	57.4
OEV	Oral Evaluation, Dental Services	(age 19-20)	274,551	39.9	-	
OEV	Oral Evaluation, Dental Services	(age 0-20)	3,972,379	62.8	72,001	64.5
PPC	Prenatal & Postpartum Care	Timeliness of Prenatal Care		81.8		
SFM	Sealant Receipt on Permanent First Molars	Rate 1 - At Least One Sealant	150,207	64.7	2,642	66.8
SFM	Sealant Receipt on Permanent First Molars	Rate 2 - All Four Molars Sealed	150,207	42.2	2,642	46.9
TFL	Topical Fluoride for Children	Dental or oral health services (1-2)	421,931	48.1	96	26
TFL	Topical Fluoride for Children	Dental or oral health services (3-5)	615,536	36.4	3,170	38.3
TFL	Topical Fluoride for Children	Dental or oral health services (6-7)	407,550	35.7	3,824	39.4
TFL	Topical Fluoride for Children	Dental or oral health services (8-9)	392,467	35.9	5,078	40.5
TFL	Topical Fluoride for Children	Dental or oral health services (10-11)	370,176	35.1	5,427	40.6
TFL	Topical Fluoride for Children	Dental or oral health services (12-14)	572,796	32.3	8,590	36.9
TFL	Topical Fluoride for Children	Dental or oral health services (15-18)	703,578	25.8	10,236	29.4
TFL	Topical Fluoride for Children	Dental or oral health services (19-20)	266,090	14.2	-	

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate	CHIP Denominator	CHIP Rate
TFL	Topical Fluoride for Children	Dental or oral health services (1-20)	3,750,124	33.3	36,421	36.2
TFL	Topical Fluoride for Children	Dental services (1-2)	421,931	39.6	96	21.9
TFL	Topical Fluoride for Children	Dental services (3-5)	615,536	35.2	3,170	37.9
TFL	Topical Fluoride for Children	Dental services (6-7)	407,550	35.6	3,824	39.3
TFL	Topical Fluoride for Children	Dental services (8-9)	392,467	35.8	5,078	40.4
TFL	Topical Fluoride for Children	Dental services (10-11)	370,176	35	5,427	40.6
TFL	Topical Fluoride for Children	Dental services (12-14)	572,796	32.2	8,590	36.8
TFL	Topical Fluoride for Children	Dental services (15-18)	703,578	25.8	10,236	29.3
TFL	Topical Fluoride for Children	Dental services (19-20)	266,090	14.1	-	
TFL	Topical Fluoride for Children	Dental services (1-20)	3,750,124	32.1	36,421	36.1
TFL	Topical Fluoride for Children	Oral health services (1-2)	421,931	11.8	96	4.2
TFL	Topical Fluoride for Children	Oral health services (3-5)	615,536	0.4	3,170	0.0
TFL	Topical Fluoride for Children	Oral health services (6-7)	407,550	0.0	3,824	0.0
TFL	Topical Fluoride for Children	Oral health services (8-9)	392,467	0.0	5,078	0.0
TFL	Topical Fluoride for Children	Oral health services (10-11)	370,176	0.0	5,427	0.0
TFL	Topical Fluoride for Children	Oral health services (12-14)	572,796	0.0	8,590	0.0
TFL	Topical Fluoride for Children	Oral health services (15-18)	703,578	0.0	10,236	0.0
TFL	Topical Fluoride for Children	Oral health services (19-20)	266,090	0.0	-	
TFL	Topical Fluoride for Children	Oral health services (1-20)	3,750,124	1.4	36,421	0.0
W30	Well-Child Visits in the First 30 Months of Life	Six or more well-child visits in the first 15 months	197,305	59.2	-	
W30	Well-Child Visits in the First 30 Months of Life	Two or more well-child visits for ages 15 months to 30 months	223,587	68.7	25	72.0
WCC	Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents (C/A)	BMI Percentile Documentation (3-11)		80.4		78.3
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	BMI Percentile Documentation (12-17)		75.5		80.3
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	BMI Percentile Documentation (3-17)		78.6		79.3
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	Counseling for Nutrition (3-11)		75.8		74.5
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	Counseling for Nutrition (12-17)		73.0		78.9
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	Counseling for Nutrition (3-17)		74.8		76.1
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	Counseling for Physical Activity (3-11)		71.8		71.0
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	Counseling for Physical Activity (12-17)		74.4		78.9

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate	CHIP Denominator	CHIP Rate
WCC	Weight Assess. & Counsel. for Nutr. & Phys. Act. for C/A	Counseling for Physical Activity (3-17)		72.7		74.8
WCV	Child and Adolescent Well-Care Visits	(age 3-11)	1,815,889	62.3	14,524	68.9
WCV	Child and Adolescent Well-Care Visits	(age 12-17)	1,128,291	57.6	14,047	66.0
WCV	Child and Adolescent Well-Care Visits	(age 18-21)	519,209	27.1	1,798	49.4
WCV	Child and Adolescent Well-Care Visits	(age 3-21)	3,463,389	55.5	30,369	66.4

[a] ADHD = Attention Deficit Hyperactivity Disorder

Table 55. Validated CMS adult core measures

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	(age 18-64)	12,986	42.3
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	(age 65+)	38	44.7
AMM	Antidepressant Medication Management	Effective Acute Phase Treatment (age 18-64)	36,590	51.0
AMM	Antidepressant Medication Management	Effective Acute Phase Treatment (age 65+)	180	63.3
AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment (age 18-64)	36,590	32.0
AMM	Antidepressant Medication Management	Effective Continuation Phase Treatment (age 65+)	180	40.6
AMR	Asthma Medication Ratio	(age 19-50)	10,208	62.0
AMR	Asthma Medication Ratio	(age 51-64)	2,929	57.1
AMR	Asthma Medication Ratio	Total	13,137	60.9
BCS	Breast Cancer Screening	(age 50-64)	48,182	45.4
BCS	Breast Cancer Screening	(age 65-74)	1,207	30.4
CBP	Controlling High Blood Pressure	(age 18-64)		55.2
CBP	Controlling High Blood Pressure	(age 65-85)		48.7
CCP	Contraceptive Care - Postpartum Women	LARC - 3 Days (age 21-44)	103,173	0.8
CCP	Contraceptive Care - Postpartum Women	LARC - 90 Days (age 21-44)	103,173	13.8
CCP	Contraceptive Care - Postpartum Women	Most or Moderately effective contraception - 3 Days (age 21-44)	103,173	11.1
CCP	Contraceptive Care - Postpartum Women	Most or Moderately effective contraception - 90 Days (age 21-44)	103,173	43.5
CCS	Cervical Cancer Screening	(age 21-64)		55.7
CCW	Contraceptive Care - All Women	LARC (age 21-44)	518,307	5.5

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate
CCW	Contraceptive Care - All Women	Most or Moderately effective contraception (age 21-44)	518,307	24.0
CHL	Chlamydia Screening in Women	(age 21-24)	87,608	55.7
COB	Concurrent Use of Opioids & Benzodiazepines	(age 18-64)	31,132	14.4
COB	Concurrent Use of Opioids and Benzodiazepines	(65+)	156	14.7
COL	Colorectal Cancer Screening	(age 46-49)	24,860	14.5
COL	Colorectal Cancer Screening	(age 50-64)	103,004	25.7
COL	Colorectal Cancer Screening	(age 65-75)	2,712	14.2
CPA	CAHPS Health Plan Survey	Getting Needed Care - Global Proportion of % Always		56.1
CPA	CAHPS Health Plan Survey	Getting Care Quickly - Global Proportion of % Always		52.6
CPA	CAHPS Health Plan Survey	How Well Doctors Communicate - Global Proportion of % Always		77.5
CPA	CAHPS Health Plan Survey	Customer Service - Global Proportion of % Always		74.4
CPA	CAHPS Health Plan Survey	Rating: All Health Care		55.6
CPA	CAHPS Health Plan Survey	Rating: Personal Doctor		69.5
CPA	CAHPS Health Plan Survey	Rating: Health Plan		56.2
CPA	CAHPS Health Plan Survey	Rating: Specialist		68.3
FUA	Follow-Up After ED Visit for Alcohol & Other Drug Abuse or Dependence	Follow-up within 30 days of ED (age 18-64)	8,120	25.8
FUA	Follow-Up After ED Visit for Alcohol & Other Drug Abuse or Dependence	Follow-up within 30 days of ED (age 65+)	11	54.5
FUA	Follow-Up After ED Visit for Alcohol & Other Drug Abuse or Dependence	Follow-up within 7 days of ED (age 18-64)	8,120	14.5
FUA	Follow-Up After ED Visit for Alcohol & Other Drug Abuse or Dependence	Follow-up within 7 days of ED (age 65+)	11	27.3
FUH	Follow-Up After Hospitalization for Mental Illness	Follow-up within 30 days after discharge (age 18-64)	20,207	49.6
FUH	Follow-Up After Hospitalization for Mental Illness	Follow-up within 30 days after discharge (age 65+)	30	43.3
FUH	Follow-Up After Hospitalization for Mental Illness	Follow-up within 7 days after discharge (age 18-64)	20,207	29.8
FUH	Follow-Up After Hospitalization for Mental Illness	Follow-up within 7 days after discharge (age 65+)	30	23.3
FUM	Follow-Up After ED Visit for Mental Illness	30-day follow-up after ED visit for mental illness (age 18-64)	8,520	39.5
FUM	Follow-Up After ED Visit for Mental Illness	30-day follow-up after ED visit for mental illness (age 65+)	18	33.3
FUM	Follow-Up After ED Visit for Mental Illness	7-day follow-up after ED visit for mental illness (age 18-64)	8,520	25.7
FUM	Follow-Up After ED Visit for Mental Illness	7-day follow-up after ED visit for mental illness (age 65+)	18	16.7
FVA	Flu Vaccinations for Adults Ages 18-64	(age 18-64)		37.5
HBD	Hemoglobin A1c Control for Patients w/ Diabetes	HbA1c control < 8.0% (age 18-64)		44.2
HBD	Hemoglobin A1c Control for Patients w/ Diabetes	HbA1c control < 8.0% (age 65-75)		64.7

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate
HBD	Hemoglobin A1c Control for Patients w/ Diabetes	HbA1c poor control > 9.0% (age 18-64)		48.4
HBD	Hemoglobin A1c Control for Patients w/ Diabetes	HbA1c poor control > 9.0% (age 65-75)		12.8
HPCMI	Diabetes Care for People with Serious Mental Illness	HbA1c poor control > 9.0% (age 18-64)	410	40.5
HPCMI	Diabetes Care for People with Serious Mental Illness	HbA1c poor control > 9.0% (age 65-75)	1	100
HVL	HIV Viral Load Suppression	(age 18-64)		
HVL	HIV Viral Load Suppression	(age 65+)		
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Alcohol (age 18-64)	12,346	40
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Alcohol (age 65+)	46	69.6
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Opioid (age 18-64)	3,855	47.3
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Opioid (age 65+)	13	30.8
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Other Drug (age 18-64)	26,635	43.6
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Other Drug (age 65+)	23	60.9
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Total (age 18-64)	42,836	42.9
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Initiation of AOD - Total (age 65+)	82	61
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Alcohol (age 18-64)	12,346	8.1
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Alcohol (age 65+)	46	6.5
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Opioid (age 18-64)	3,855	16.1
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Opioid (age 65+)	13	7.7
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Other Drug (age 18-64)	26,635	9.9
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Other Drug (age 65+)	23	0.0
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Total (age 18-64)	42,836	9.9
IET	Initiation & Engagement of Alcohol & Oth. Drug Abuse or Dep. Treatment	Engagement of AOD - Total (age 65+)	82	4.9
MSC	Medical Assistance with Smoking & Tobacco Use Cessation	Advising Smokers and Tobacco Users to Quit (age 18-64)		62.8
MSC	Medical Assistance with Smoking & Tobacco Use Cessation	Discussing Cessation Medications (age 18-64)		38.6
MSC	Medical Assistance with Smoking & Tobacco Use Cessation	Discussing Cessation Strategies (age 18-64)		32.5
MSC	Medical Assistance with Smoking & Tobacco Use Cessation	Percentage of Current Smokers/Tobacco Users (age 18-64)		18.4
OHD	Use of Opioids at High Dosage in Persons Without Cancer	(age 18-64)	31,491	0.8
OHD	Use of Opioids at High Dosage in Persons Without Cancer	(age 65+)	158	0.0
PCR	Plan All-Cause Readmissions	Observed Readmission Rate		12.4410
PCR	Plan All-Cause Readmissions	Expected Readmission Rate		10.9022
PCR	Plan All-Cause Readmissions	O/E Ratio		1.1411

Code	Measure	Submeasure (age group)	Medicaid Denominator	Medicaid Rate
PCR	Plan All-Cause Readmissions	Outlier Rate		71.0
PPC	Prenatal & Postpartum Care	Postpartum visit between 7 and 84 days		77.4
PQI01	Diabetes Short-Term Complications Admission Rate	(age 18-64)	16,129,212	18.4
PQI01	Diabetes Short-Term Complications Admission Rate	(age 65+)	102,131	42.1
PQI05	Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	(age 40-64)	3,023,534	55.3
PQI05	COPD Admission Rate	(age 65+)	102,131	88.1
PQI08	Heart Failure Admission Rate	(age 18-64)	16,129,212	43.3
PQI08	Heart Failure Admission Rate	(age 65+)	102,131	740.2
PQI15	Asthma in Younger Adults Admission Rate	(age 18-39)	13,105,678	2.2
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Non-Medicare 80% Coverage (age 18+)	22,545	55.9
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	(age 18-64)	38,100	79.8

For almost all measures that did not have a measure change expected to cause substantial changes in rates, overall performance was consistent with the prior year. Performance varied by MCO across measures, however performance was consistently good or in need of improvement on some measures.

In STAR, all MCOs met the minimum standard and only one did not surpass the high standard for the PQI chronic composite, and all MCOs met the minimum standard and only two did not surpass the high standard for child member caregivers rating the MCO a "9" or "10" and only four of 16 MCOs failed to meet the high standard for uncomplicated C-Sections. However, all but one MCO failed to meet the minimum standard for *Good Access to Routine Care*, all but three failed to meet the minimum standard for lowering SMM among all deliveries (OAP), and more than 10 MCOs failed to meet the minimum standards for *Follow-Up After Emergency Department Visits for Mental Illness* (FUM), *Follow-Up Care for Children Prescribed ADHD Medication* (ADD), and screening for both cervical cancer (CCS) and chlamydia (CHL). For some measures, such as *Controlling High Blood Pressure* (CBP) and required developmental screening (DEV), MCOs are more equally split between failing to meet the minimum standard and surpassing the high standard. The strategies used by the high performing plans could benefit those needing to improve.

In STAR+PLUS, all four MCOs met at least the minimum standard for diabetes screening for people with SMI (SSD) and three out of four surpassed the high standards for diabetes screening and cardiovascular monitoring for people with schizophrenia (SMD, SMC). All MCOs also met at least the minimum standard for *Access to Good Routine Care* and *Adult Access to Preventive/Ambulatory Health Services: Aged 45-64* (AAP), screening for chlamydia (CHL), and *Statin Therapy for Patients w/ Diabetes* (SPD). However, no MCOs met the minimum standards for *Adult Access to Preventive/Ambulatory Health Services: Aged 20-44* (AAP), *Appropriate Testing for Pharyngitis* (CWP), retinal exam for diabetics (EED), *Follow-Up after High-Intensity Care for SUD* (FUI), or *Good Access to Service Coordination*. This is a key aspect of the STAR+PLUS program and those MCOs needing improvement could benefit from understanding what leading MCOs have done to provide access to service coordination. One MCO surpassed the high standard for *Good Access to Behavior Health Treatment or Counseling, Good Access to Special Therapies*, and high personal doctor ratings, while all others failed to meet the minimum standard. Understanding the strategies that work for high performing MCOs could help MCOs needing improvement.

In STAR Kids, all MCOs met at least the minimum standard for *Customer Service*, *Getting Needed Care* and providing *A Personal Doctor Who Knows My Child*, and *Counseling on Nutrition* and *Counseling on Physical Activity* (WCC). However, no MCOs met the minimum standard for *Access to Specialized Services* or *Doctors Discuss Eventual Transition to Adult Care*. Both of these are critically important for STAR Kids members. Two MCOs surpassed the high standards for *Appropriate Testing for Pharyngitis* (CWP), *Follow-Up after Hospitalization for Mental Illness* (FUH), *Good Access to Behavioral Health*, and both the acute and chronic PDI composites, while all other MCOs failed to meet the minimum standard on these measures. Each represents an opportunity for MCOs needing improvement to apply the successful strategies used by other MCOs.

The STAR Health MCO, Superior, surpassed the high standard for *Good Access to Routine Care* and *Good Access to Urgent Care*, early well child visits (W30), the acute PDI composite, *Follow-Up after Hospitalization for Mental Illness w/in 30d* (FUH), *Follow-Up Care for Children Prescribed ADHD Medication* (ADD) and *Metabolic Monitoring for Children and Adolescents on Antipsychotics* (APM), and *Avoidance of Antibiotic Treatment for Acute Bronchitis* (AAB). However Superior failed to meet the minimum standard for *Appropriate Testing for Pharyngitis* (CWP), required developmental screening (DEV), the chronic PDI composite, and the survey measures *Good Access to Behavioral Health, Good Access to Specialist Appointments*, and *Personal Doctor Rating* and *Health Plan Rating*.

PPEs

Texas requires a quality-based outcomes payment program for Medicaid to contain costs while improving patient outcomes. Specifically, Texas Government Codes § 354.1445 and § 354.1446 (2016) address potentially preventable readmissions (PPRs) and PPCs, respectively. Healthy People 2030[9] includes goal of reducing hospital stays and preventable ED visits. The Texas P4Q program (see *Protocol 10 Assistance with Quality Rating of MCO*) contributed to reductions in all the PPEs included in the program and substantial associated cost reductions (Dudensing, 2016).

The EQRO analyzed 2022 encounter and eligibility data for non-dual Medicaid and CHIP members using 3M Health Information Systems software (3M Health Information Services, 2016). This software classifies events as PPEs based on the 3M grouping systems for (1) ambulatory care using Enhanced Ambulatory Patient Groups (EAPGs) or (2) inpatient care using All Patient Refined Diagnosis-Related Groups (APR-DRGs), and by considering other factors such as diagnosis codes, procedure codes, and the source of the admission.

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

The EQRO conducted analyses for four types of PPEs:

- PPVs (Potentially Preventable Emergency Department Visits) are ED visits that may result from a lack of adequate access to care or ambulatory care coordination.
- PPAs (Potentially Preventable Admissions) are hospital admissions that are avoidable through improved care coordination, effective primary care, and improved population health.
- PPRs (Potentially Preventable Readmissions) are return hospitalizations that may be caused by deficiencies in care during the initial hospital stay, poor coordination of services at the time of discharge, or poor coordination of services during follow-up.
- PPCs (Potentially Preventable Complications) are complications that arise after hospitalization because of poor clinical care or poor coordination of services during the inpatient stay.

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

PPVs

High rates of PPVs may represent a failure to provide adequate primary care to the patient. From 2017 through 2019, the overall PPV rate trended slightly upward, and the cost per PPV increased. However, in 2020 both at-risk ED visits and PPVs decreased. From 2021 to 2022 both have increased substantially. Of the more than two and half million Medicaid and CHIP ED visits at risk for PPVs in 2022, the EQRO identified 60 percent as PPVs. At the same time, member-months increased from 2021 to 2022, which make up the PPV rate denominator. The PPV rate increased slightly from 2021 to 2022, but the current rate of 7.37 is still less than the 2019 rate of 9.2. Overall, PPVs in 2022 accounted for $753 million in institutional costs paid (excluding the associated professional costs). Table 56 summarizes the 2022 PPV results by program.

[9] https://health.gov/healthypeople.

Table 56. 2022 PPV results for Medicaid and CHIP

Measure	STAR	STAR+PLUS	STAR Kids	STAR Health	FFS	CHIP
Member-Months at Risk for PPVs	50,468,605	2,861,034	2,004,080	529,344	5,725,189	724,878
ED Visits at Risk of being PPVs	2,150,942	266,705	99,627	29,657	70,666	12,262
Total PPVs	1,288,500	165,170	59,078	18,532	37,523	7,045
Total PPV Weights	373,709.06	49,605.63	17,190.55	5,292.77	11,275.11	2,109.69
Total PPV Expenditure ($Millions)	$585.36M	$128.71M	$22.59M	$5.57M	$7.74M	$3.58M
PPV Rate (Total PPV Weights per 1,000 Member-Months)	7.40	17.34	8.58	10.00	1.97	2.91

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

In 2022, the PPV rate was higher among females (7.67 vs. 6.96 for males), and the rate for rural members (8.10) and micropolitan members (8.29) were higher than the rates for urban (7.23). In general, older members had higher PPV rates, although the rate was twice for children aged 1 to 5 years than for other children age groups. Hispanic members had a lower PPV rate (6.62) than non-Hispanic White or non-Hispanic Black members (7.78 and 7.76, respectively).

Table 57 shows the top five PPV reasons across Medicaid and CHIP in 2022 based on EAPG categories ranked by total PPV weight. The leading reason continues to be upper respiratory tract infection (URTI; EAPG 562), with a total cost of over $100 million during 2022. The list includes the same other four reasons as in 2021 but numbers of PPVs have increased substantially for all. 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 57. 2022 PPV top reasons

EAPG	Description	PPVs (n)	Percent of Total PPVs	Percent of Total PPV Weights	PPV Expenditures	Percent of Total PPV Expenditures
562	Infections of Upper Resp. Tract & Otitis Media	358,478	22.7%	17.0%	$107.26M	14.2%
627	Non-Bacterial Gastroenteritis, Nausea & Vomiting	121,493	7.7%	9.8%	$68.14M	9.0%
808	Viral Illness	111,925	7.1%	9.0%	$40.22M	5.3%
628	Abdominal Pain	87,511	5.6%	7.3%	$79.21M	10.5%
674	Contusion, Open Wound & other Trauma to Skin & Subcutaneous Tissue	83,500	5.3%	6.0%	$33.98M	4.5%

PPAs

Hospital admissions that are avoidable with proper outpatient care are PPAs. They may result from inefficiencies in hospital or ambulatory care, poor access to outpatient care, or inadequate ambulatory care service coordination. From 2017 through 2019, the overall PPA rate trended slightly upward and the cost per PPA increased. However, in 2020, PPA rate decreased because of the COVID-19 pandemic and PHE. In 2022, PPA rate was about the same of 2021. Of the approximately 290,000 inpatient admissions from Medicaid and CHIP in 2022, 12.5 percent were PPAs. These PPAs account for $419 million in institutional costs paid. Table 60

summarizes 2022 PPA results by program. The PPA rate was highest in the STAR+PLUS program, with a rate more than five times that of any other program. Table 58 summarizes the 2022 PPA results by program.

Table 58. 2022 PPA results for Medicaid and CHIP

Measure	STAR	STAR+ PLUS	STAR Kids	STAR Health	FFS	CHIP
Member-Months at Risk for PPAs	50,468,605	2,861,034	2,004,080	529,344	5,725,189	724,878
Admissions at Risk of being PPAs	196,643	63,684	17,562	4,732	7,405	857
Total PPAs	16,093	14,774	3,107	1,105	1,205	151
Total PPA Weights	13,279.75	25,619.97	3,233.69	763.76	1,916.70	112.29
Total PPA Expenditure ($Millions)	$153.50M	$221.01M	$28.72M	$7.17M	$7.62M	$1.04M
PPA Rate (Total PPA Weights per 1,000 Member-Months)	0.26	8.95	1.61	1.44	0.33	0.15

In 2022, the PPA rate was higher among males (0.83 vs. 0.64 for females). Rural members had the highest PPA rate (0.80) and micropolitan members had PPA rate of 0.75, while the rate for urban members was 0.71. Older members had higher PPA rates, especially in age group 55-64 and 65+, their PPA rates were much higher than younger members. Hispanic members had a lower PPA rate (0.48) than non-Hispanic White or non-Hispanic Black members (0.98 and 0.96, respectively).

Table 59 shows the top five PPA reasons across Medicaid and CHIP in 2022 based on APR-DRG categories ranked by total PPA weight. Heart Failure (APR-DRG 194) and pneumonia (APR-DRG 139) continue to top this list. Together they accounted for over $80 million in total costs during 2022.

Table 59. 2022 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	3,425	9.4%	12.96%	$47.46M	11.3%
139	Other Pneumonia	3,090	8.5%	8.93%	$38.39M	9.2%
720	Septicemia & Disseminated Infections	797	2.2%	5.88%	$17.72M	4.2%
751	Major Depressive Disorders & Other/Unspecified Psychoses	4,444	12.2%	5.80%	$21,19M	5.1%
161	Cardiac Defibrillator & Heart Assist Implant	187	0.5%	5.65%	$22.37M	5.3%

Heart Failure (APR-DRG 194) is the top PPA reason in STAR+PLUS, while major depressive disorders (APR-DRG 751) is the most common APR-DRG for PPAs in STAR. Major depressive disorder (ranked fourth overall), is still one of the most common reasons for PPAs in 2022 in all programs, and some forms of mental health conditions (MHCs) such as schizophrenia and bipolar disorders were among the top 10 PPA conditions for all managed care programs. Medication management is critical for the effective treatment of these conditions, which could reduce PPAs substantially.

PPRs

A PPR is a potentially avoidable hospital readmission, clinically related to (and occurring within a specified time interval from) an initial hospital admission. The underlying reason for readmission must be related to the care rendered during or immediately following a prior admission. The EQRO used a 30-day readmission window to

evaluate PPRs among Medicaid and CHIP MCOs. Of the approximately 447,000 admissions among Medicaid and CHIP members at risk for having PPRs in 2022, the EQRO identified over 17,000 (4.0 percent) as having PPRs. These account for $300 million in institutional costs paid. Table 60 summarizes 2022 PPR results by program.

Table 60. 2022 PPR results for Medicaid and CHIP

Measure	STAR	STAR+ PLUS	STAR Kids	STAR Health	FFS	CHIP
Admissions at Risk for PPRs	327,053	44,889	13,821	4,482	56,055	820
Initial Admissions Resulting in PPRs	6,856	6,865	1,681	765	1,229	65
Total PPRs	9,059	11,042	2,527	1,239	1,590	81
Total PPR Weights	7,892.06	13,452.61	3,125.87	785.70	2,159.37	55.42
Total PPR Expenditure ($Millions)	$111.97M	$125.52M	$36.11M	$8.87M	$10.71M	$0.69M
PPR Rate (Total PPR Weights per 1,000 Admissions)	24.13	299.69	226.17	175.30	38.52	67.58

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

Table 61 shows the top five PPR reasons across Medicaid and CHIP in 2022 based on APR-DRG categories ranked by total PPR weight. Heart Failure (APR-DRG 194) and Septicemia (APR-DRG 720) are leading reasons for both PPAs and PPRs. However, the most important drivers of PPRs are the SMIs bipolar disorder (APR-DRG 753), schizophrenia (APR-DRG 750), and major depression (APR-DRG 751). Together, these accounted for costs of over $68 million in 2022. Also, readmissions for these conditions are considered PPRs, regardless of the diagnoses for the initial admission, thus they contribute PPR weight to other categories (based on the initial admission). The high rate of MHC PPRs highlights the need to improve care coordination for co-occurring physical conditions with MHC.

Table 61. 2022 PPR top reasons

APR-DRG	Description	PPRs (n)	Percent of Total PPRs	Percent of Total PPR Weights	PPR Expenditures	Percent of Total PPR Expenditures
720	Septicemia & Disseminated Infections	1,098	4.2%	8.7%	$23.25M	7.6%
753	Bipolar Disorders	4,031	15.3%	8.0%	$24.00M	7.9%
750	Schizophrenia	3,402	12.9%	7.6%	$20.12M	6.6%
751	Major Depressive Disorders & Other or Unspecified Psychoses	3,928	14.9%	7.3%	$24.55M	8.1%
194	Heart Failure	808	3.1%	4.4%	$10.79M	3.5%

PPCs

PPCs are complications that arise during an inpatient stay because of improper care or treatment and do not represent the progression of the underlying disease. A single hospital admission can have multiple complications, and an admission may be at risk for some PPC categories but not others. Unlike the other PPEs that rely on administrative condition groupings (i.e., EAPG and APR-DRG) to categorize events, 3M defined PPC conditions specifically for identifying PPEs. *Appendix E: 3M™ Potentially Preventable Complications Classification*

System Definitions provides definitions for the PPC groups. The EQRO evaluated over 400,000 admissions from Medicaid and CHIP that were at risk for PPCs in 2022. The identification of PPCs depends on accurate POA indicators. The EQRO and 3M found that many hospitals were inconsistent in POA coding, which could significantly bias results. To avoid bias, particularly as it would affect risk adjustment, 3M developed a systematic data quality evaluation that applies to data at the hospital level. The EQRO excludes all data from hospitals failing to meet data quality standards from PPC calculations. In the annual data quality reports described in *Protocol 5: Validation of Encounter Data Reported by MCOs and DMOs*, the EQRO addressed the quality of POA data at the MCO level. Appendix E summarizes the screening criteria.

Table 62 shows PPC results by program. The 2022 PPC analysis identified 4,439 eligible admissions with at least one PPC. The total estimated cost of the STAR+PLUS PPCs (over $35 million) was much higher than the estimated cost of PPCs across all other managed care programs.

Table 62. 2022 PPC results for Medicaid and CHIP

Measure	STAR	STAR+ PLUS	STAR Kids	STAR Health	FFS	CHIP
Admissions at Risk for PPCs	266,604	48,934	8,557	2,489	90,415	461
Admissions with PPCs	1,265	1,893	62	7	1,211	1
Total PPCs	1,514	2,507	74	7	1,636	1
Total PPC Weights	1,159.95	2,659.28	99.20	5.52	1,650.15	0.60
PPC Rate (Total PPC Weights per 1,000 Admissions)	4.35	54.34	11.59	2.22	18.25	1.30

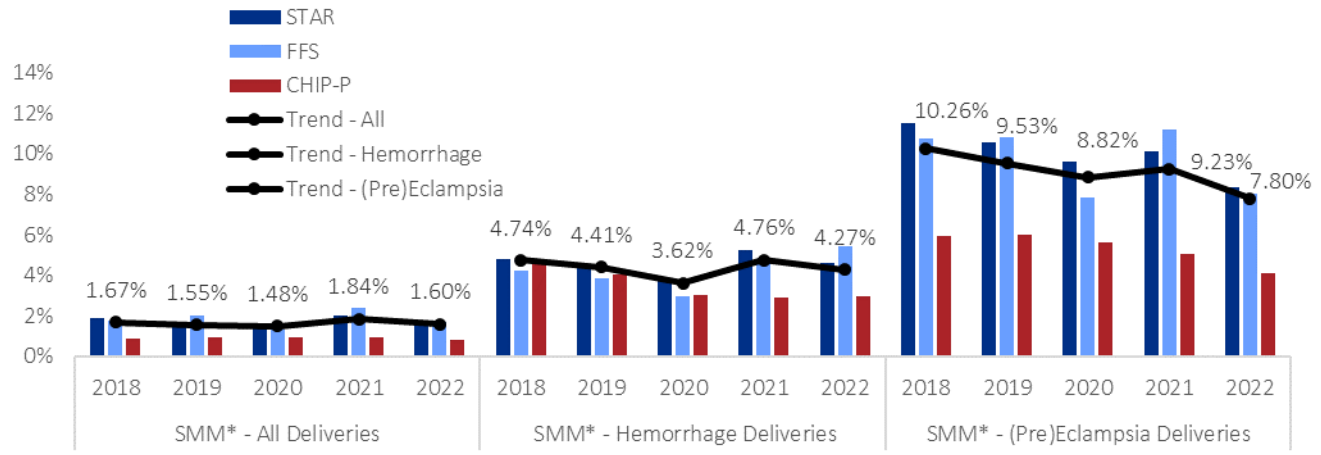
STAR+PLUS had the highest PPC rate, Renal failure (without dialysis) was the most common PPC for STAR+PLUS members. Although less frequent, because of their severity, septicemia/severe infections contributed the highest PPC weights. Septicemia/severe infections and renal failure (without dialysis) also contributed the most PPC weights among STAR members.

OAP and C-Section Deliveries

The EQRO identified 2022 deliveries for the OAP and C-Section measures following the method developed through the IAP program. The EQRO calculated overall SMM rates for these deliveries following a method (also developed through the IAP) allowing the calculation of measures in the AIM maternal safety bundles from statewide administrative data. The OAP report includes measures of SMM among all deliveries, among deliveries with hemorrhage, and among deliveries with severe hypertension. The EQRO reported rates for all SMM cases and rates, excluding those SMM cases identified only by transfusion for all three cohorts. This approach is consistent with ACOG recommendations (ACOG et al., 2016; Reaffirmed 2021).

Figure 7 shows the OAP measure rates (excluding SMM identified by transfusion only) for all deliveries, deliveries with hemorrhage, and deliveries with (pre)eclampsia in STAR, FFS, and CHIP Perinatal with overall trends for 2018 through 2022. Overall, rates decreased compared to MY 2021, however rates were lowest in 2020. Rates were consistently higher in STAR than in CHIP Perinatal, most notably in (pre)eclampsia cases. Risk factors for pregnancy complications could be more common among women eligible for Medicaid. Although the numbers of deliveries are relatively small for the STAR+PLUS program, the percentage of deliveries with diagnosed (pre)eclampsia was higher than average (17.6 percent vs. 7.1 percent) and the SMM rate among those cases was also higher (27.1 percent).

Figure 7. 2018-2022 OAP measure trends by program

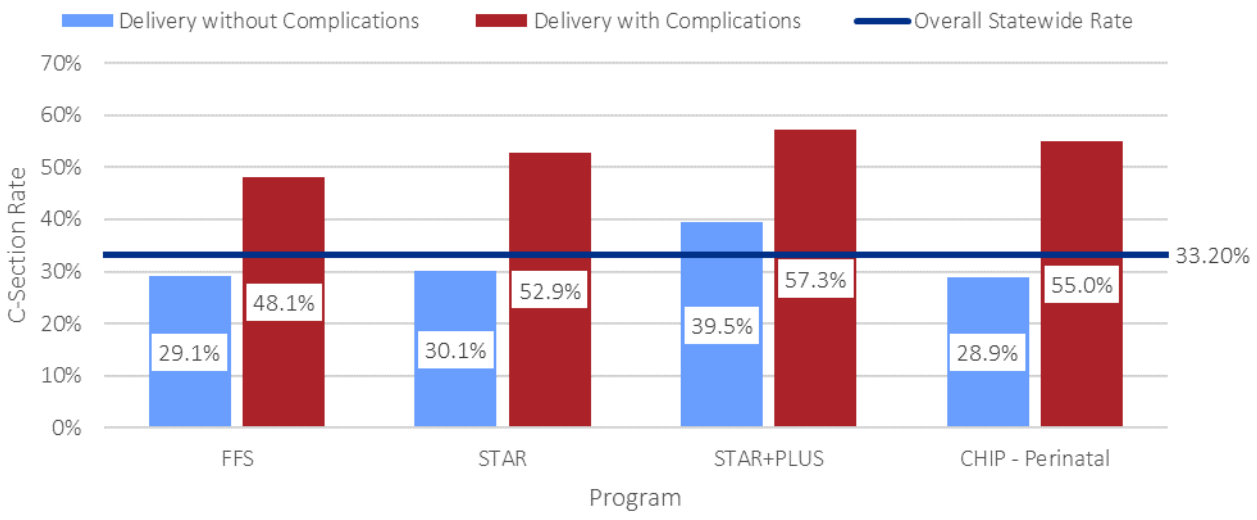


SMM* = Severe maternal morbidity, excluding cases identified by transfusion only.

Overall, deliveries with SMM (excluding those identified by transfusion only) incurred an average of 2.4 times the cost of deliveries without SMM, resulting in a total added expenditure of $26 million. In 2022, SMM rates varied geographically and by race/ethnicity, with non-Hispanic Black women having 1.77 times the SMM rate of Hispanic women, who have the lowest SMM rates. Non-Hispanic Black women had (pre)eclampsia diagnosis in 11.0 percent of deliveries compared to a rate of only 7.2 percent overall. The range of overall SMM rates among STAR MCOs has increased compared to 2021 and was 1.1 percent to 3.8 percent for 2022.

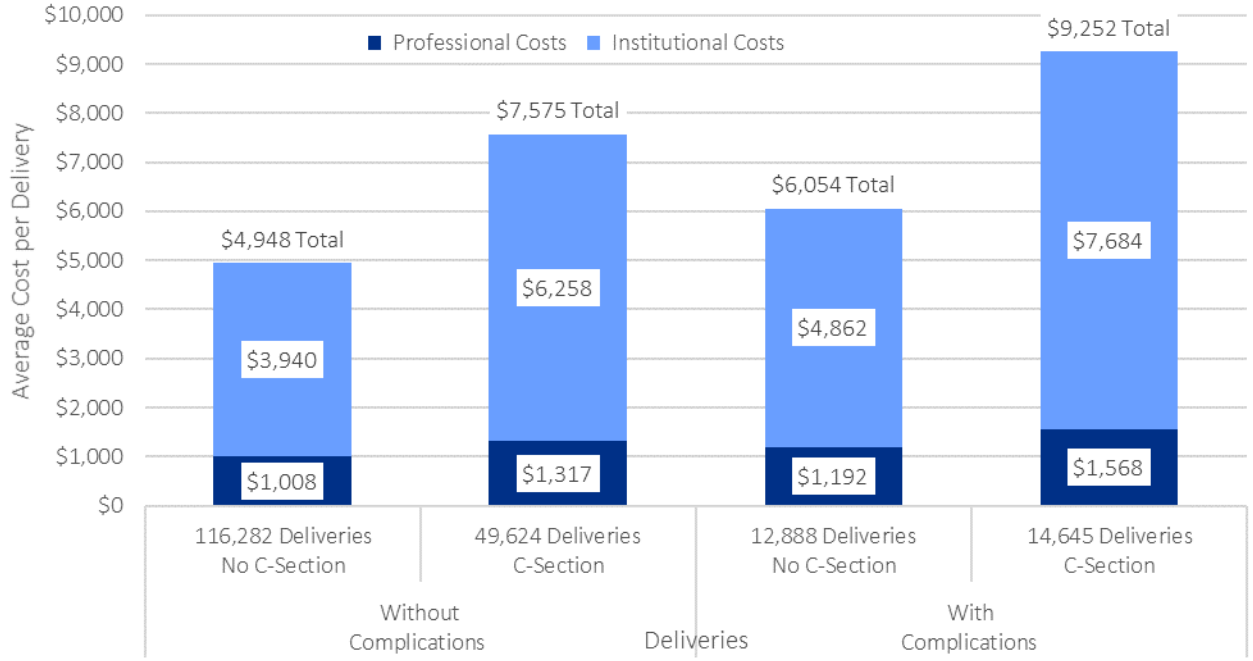
In 2022, the rate of C-Section deliveries in Texas Medicaid and CHIP was 33.7 percent. Figure 8 shows C-Section rates among deliveries with and without complications by program. C-Section rates varied by race/ethnicity and geography. Overall, Hispanic women had the lowest C-Section rate (32.2 percent), and non-Hispanic Black women had the highest rate (37.9 percent). Women in STAR+PLUS account for only 2.7 percent of all deliveries, but notably had the highest program rate of C-Sections overall (43.3 percent) and the highest rate of C-Sections for uncomplicated deliveries (39.5 percent). However, complications were also more common in STAR+PLUS (21.6 percent of deliveries vs. 14.2 percent overall) and other health concerns, not indicated by the delivery complication definition, may impact delivery decisions in this complex-needs group.

Figure 8. 2022 C-Section rates by program



More than half of deliveries with complications are by C-Section, however only 22.8 percent of C-Section deliveries had diagnosed complications. Over 49 thousand C-Sections were in deliveries without diagnosed complications. Compared to uncomplicated deliveries without C-Section, these uncomplicated C-Section deliveries incurred additional costs totaling over $130 million. Figure 9 shows average C-Section and vaginal delivery costs, with and without complications.

Figure 9. 2022 average delivery costs by delivery type



Both OAP and CES Uncomplicated C-Section rates were added as bonus pool measures in the STAR P4Q program for 2022 and 2023, and are topics for 2023 PIPs.

In addition to examining SMM and C-Section rates, the EQRO looked at selected HEDIS measure results for women pregnant during 2022. Although performance on care measures for chronic conditions was generally worse for pregnant women, utilization was generally higher.

Relevance for Assessing, Quality, Access & Timeliness

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

Based on the 2022 QoC measure results, Texas is below national averages on measures of access, particularly for adults. Measures of utilization were also below national averages for mental health and alcohol and drug services. Well-child care continues to be above national average in Texas, including immunization for adolescents, however some vaccines for children have lower than average compliance rates. As noted in *Protocol 2: Validation of Performance Measures*, THSteps checkup rates continue to be low; this is in contrast to relatively good performance on HEDIS well-child care measures. Differences may result primarily from differences in periodicity requirements for the checkups in the THSteps program. Measures related to management for chronic diseases show mixed results in Texas, with asthma medication management above average but diabetes and cardiovascular care below average. However, HbA1c control measures showed improvement, with both an increase in good control (<8% HbA1c) and a decrease in poor control (>9% HbA1c).

Texas programs may focus more on promoting quality access and timeliness of care for children. Texas continues to perform near national averages on mental health QoC measures that address quality access and timeliness. Maternal health is another area where Texas has placed recent emphasis and maternal morbidity rates decreased slightly in 2022, but uncomplicated C-Sections rates are still over 30 percent.

High rates of PPVs may represent a failure to provide adequate primary care to the patient. From 2017 through 2019, the overall PPV rate trended slightly upward, and the cost per PPV increased. However, in 2020 both at-risk ED visits and PPVs were down, possibly due to the PHE. In 2021 and 2022, at-risk ED visits and PPVs increased, but while at-risk ED visits are still below the 2019 level, the total number of PPVs is now higher. However, the PPV rate, which takes the resource weight into account is still below the 2019 rate. PPAs may result from inefficiencies in hospital or ambulatory care, poor access to outpatient care, or inadequate ambulatory care service coordination. From 2017 through 2019, the overall PPA rate trended slightly upward and the cost per PPA increased. However, in 2020 at-risk admissions, total PPAs, and PPA rate decreased. In 2021 and 2022, at-risk admissions and PPAs increased, but while at-risk admissions surpassed the 2019 level in 2022, the total PPAs and PPA rate were still less in 2022 than in 2019. The STAR+PLUS, STAR Kids, and STAR Health programs have the highest PPV, PPA, and PPR rates, highlighting the need to improve care coordination in these populations with complex healthcare needs.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 63 provides a summary of the key findings and recommendations from EQR activities associated with Protocol 7 and their relevance to the MCQS

Goal	Icon	MCQS description	Goal	Icon	MCQS description
1		Promoting optimal health	4		Safer delivery system
2		Strengthening person and family engagement	5		Effective practices for people with chronic, complex, and serious conditions
3		Right care in the right place at the right time	6		High-performing Medicaid providers

Table 63. Protocol 7 findings and recommendations

Category	Description
Finding(s)	In 2022, Hispanic Medicaid members had more outpatient utilization and less ED, inpatient, mental health care, and alcohol and drug services use, while Black members had higher ED and inpatient use than other racial groups.
Recommendation(s)	HHSC should continue to explore QoC measure results across demographic and other member population groups to interpret results more clearly and better direct efforts to improve care for all Medicaid and CHIP members.
MCQS Goal(s)	(1, 2, 3)
Finding(s)	ED use increased while outpatient use decreased and the PPV rate increased.
Recommendation(s)	HHSC should investigate common reasons for PPVs to better understand what members are most at risk and to plan targeted interventions to reduce PPVs.
MCQS Goal(s)	(2, 3)

Category	Description
Finding(s)	Although the number is down from 2021, *URTI* remains the most common reason for PPVs and the reason second most common for PPVs, and continuing to increase in frequency is again *Non-Bacterial Gastroenteritis, Nausea & Vomiting*. SMIs continue to account for more PPAs than heart failure, which is still the leading single reason, and SMIs continue to be the leading causes for PPRs.
Recommendation(s)	HHSC should further investigate the incidence, prevalence, and treatment pathways for these consistently common reasons for PPEs to better understand what members are most at risk and to plan targeted interventions to reduce PPEs.
MCQS Goal(s)	(1, 3, 4, 5)
Finding(s)	Nearly 50 thousand C-Sections occurred in deliveries without complications. These represent substantial additional cost ($130 million) and potential risk to mothers and infants.
Recommendation(s)	HHSC should consider a PIP or interventions to reduce C-Sections in uncomplicated deliveries.
MCQS Goal(s)	(1, 2, 3, 4)
Finding(s)	MCO performance across Performance Indicator Dashboard measures varies. Some MCOs achieve the high standard on more than one third of measures, while some fail to meet the minimum standard on more than one third of measures.
Recommendation(s)	HHSC should continue leveraging the THLC portal (thlcportal.com) dashboards to help all Texas Medicaid and CHIP stakeholders identify and understand trends in healthcare quality across state programs.
MCQS Goal(s)	(1, 2, 3, 4, 5)

Protocol 9: Conducting Focus Studies of Health Care Quality

Protocol Overview & Objectives

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

EQR Activities

During SFY 2023, the EQRO conducted multiple studies of Texas Medicaid and CHIP programs, initiatives, and areas of specific interest to the state. Table 64 summarizes the studies, including a major focus study, quarterly topic reports (QTRs), and several issue briefs. Short synopses of the major studies follow. At the end of the Protocol 9 section, the major report findings and recommendations are summarized in Table 65 (STAR Kids Focus Study) Table 66 (Report Cards Focus Study), Table 67 (Quarterly Topic Report 1), Table 68 (Quarterly Topic Report 2), Table 69 (Quarterly Topic Report 3), and Table 70 (Issue Brief 2).

Table 64. Focused studies conducted in SFY 2023

Study	Description
STAR Kids Focus Study: *Experience of Care for Members in the Medically Dependent Children Program*	This mixed-methods study combined STAR Kids caregiver survey and interview data to test hypotheses about factors impacting access to and quality of care in STAR Kids, and to elicit and explore experiences of Hispanic caregivers with STAR Kids providers and services.
Report Card Focus Study: *Texas Medicaid Managed Care MCO Report Card Value-Add Focus Study Report*	This qualitative study examined interviews with Medicaid members and caregivers to understand their experiences using MCO report cards, including how and when they first encounter report cards, helpful and unhelpful report card features, and factors impacting report card use.
QTR 1: *Substance Use Disorder Diagnosis and Treatment Among Texas Medicaid Adult STAR Members*	This study analyzed enrollment and encounter data to assess the prevalence of substance use disorder diagnoses and co-occurring mental and physical health conditions among adults in STAR, and to examine characteristics associated with time to treatment initiation.
QTR 2: *Impact of Extended Postpartum Enrollment for Women in Texas STAR Medicaid Resultant from COVID-19 Public Health Emergency Policies*	This study examined the impact of extended postpartum coverage during COVID-19 for women in STAR, and characterized and estimated differences in prenatal, perinatal, and postpartum utilization before and after the pandemic and across demographic groups.
QTR 3: *Physical Health Conditions and Co-occurring Mental Health Issues: A Focus on Fibromyalgia and Chronic Pain/Fatigue*	This study analyzed the prevalence of co-occurring MHC, characteristics associated with MHC comorbidities, PPEs, and MHC screening among adult Medicaid members with fibromyalgia and chronic pain fatigue.
Issue Brief 1: *Dually Eligible Beneficiaries in Texas: Who They Are, What They Have, and Where Their Future Lies*	This brief provides a general profile of the dual population, a summary of several key delivery models available to them, and an overview of state and federal efforts in advancing integration and the work that remains to be done.
Issue Brief 2: *Using NCI-AD Data to Assess Person-Centered Service Planning Requirements in the CMS Settings Rule*	This brief presents findings from the 2021-2022 Texas NCI-AD adult consumer survey in key areas to demonstrate the extent of person-centered planning and practices in STAR+PLUS at statewide and MCO levels.
Issue Brief 3: *A Systematic Approach to Performance Improvement Project Design and Implementation*	This brief presents a systematic review of PIP intervention methods, and proposes a new PIP methodology which utilizes a comparative effectiveness design that incorporates the use of implementation science within a learning health system (LHS) framework.

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

This focus study was a continuation of the SFY 2021 and SFY 2022 studies to assess the evaluation needs of members in STAR Kids and MDCP. Together, these previous studies revealed barriers to care related to network adequacy, care coordination issues, and member and caregiver characteristics and resources. The studies found access issues specific to home nursing, home therapies, and medical supplies, and identified service coordinators as key facilitators to care. This mixed-methods follow-up study employed telephone surveys and qualitative interviews with caregivers to: (1) test hypotheses about factors impacting accessible and quality care; and (2) elicit and explore experiences of Hispanic caregivers, who represent nearly half of the STAR Kids caregiver population.

Quantitative analyses found that Spanish-speaking caregivers expressed higher levels of global satisfaction with care than English-speaking caregivers. There was no evidence that third-party insurance improved access to primary care, specialist care, or medications. Low access to medication and supplies had a greater impact on caregiver burden than low access to other service types. Proactive and helpful service coordination were not associated with overall access to care. However, access to home nursing services was higher for caregivers whose service coordinators contacted them frequently. Helpful service coordinators had a positive impact on access to specialist care, medications, home nursing, and medical supplies, and also on caregiver burden.

In qualitative interviews, Hispanic caregivers related eight common barriers to receiving care, including having no or delayed MCO authorization for services, reduction in authorized hours for services, low pay for home health staff, no home health staff available at the time service is needed, unstable home provider networks after COVID-19, poor communication between providers, provider coordination errors, and out-of-pocket expenses. Hispanic caregivers also related nine common facilitators to receiving care, including service coordinator communication and support, home-delivered medications, positive communication between providers and caregivers, service coordinator persistence and problem-solving, communication among care team members, relationships between providers and families, referrals from primary care providers to specialists, well-stocked pharmacies, and fast MCO approval of services.

Report Card Focus Study: Texas Medicaid Managed Care MCO Report Card Value-Add Focus Study Report

This focus study used qualitative interviews with STAR+PLUS members and caregivers of members in STAR and STAR Kids to collect information on their experiences receiving and using MCO report cards. Texas is one of many states, including California, New York, Florida, Illinois, and Ohio, which use report cards to provide decision support for Medicaid enrollees and their caregivers in selecting an MCO. The EQRO began producing MCO report cards in 2013, following a study that engaged members and caregivers in focus groups to identify meaningful outcomes and design elements. In 2016, the EQRO conducted an MCO report card evaluation survey, finding that only half of members or caregivers recalled receiving a report card in their enrollment packet, less than one-third reported using the report card to decide on a health plan, and most stated the report card was easy to understand. Since then, numerous changes have been made to the original methods and format of the MCO report cards.

This follow-up study sought to: (1) Identify how and when members first encounter MCO report cards; (2) Examine how members use report cards to make informed decisions when selecting an MCO, and identify report card features that are helpful and alternate sources of information that members use for decision-making; (3) Identify features of report cards that are difficult to understand or less helpful, reasons why features are not helpful, and possible improvements that can be made to report card formatting and information; and (4) Identify factors that affect members' ability to use report cards.

Nineteen members participated in interviews – nine STAR+PLUS members, three caregivers in STAR, and seven caregivers in STAR Kids. Fifteen participants reported they actively chose an MCO when enrolling in Texas Medicaid. Twelve said they were familiar with the MCO report cards, among whom half first encountered them online and half first encountered them in the enrollment packet that HHSC sends out to new members. Report cards were the most-cited source of decision support for members and caregivers, and only one participant reported using the THLC portal to get more information on MCOs. Participants most frequently identified MCO services and incentives as the primary reason for choosing an MCO, above name recognition, family recommendation, and provider networks as reasons. Factors that mediated MCO enrollment decisions included time constraints, and support and guidance during enrollment.

The report card topics of most importance to caregivers of children in STAR and adults in STAR+PLUS were *Experience of Care*, which summarizes member and caregiver experience measures from a subset of the CAHPS surveys, and *Staying Healthy*, which summarizes measures of preventive care. The topic most frequently mentioned by caregivers of STAR Kids members was *Getting Care*, which summarizes CAHPS measures and access to routine care. Participants suggested other topics that could be added to report cards, such as MCO communication and provider availability/network adequacy. Nearly all participants found the MCO report card star rating system easy to understand. Additional information preferred by the participants included contact information for help interpreting the report cards, and a reminder about the deadline for choosing an MCO. Only two participants stated they were dissatisfied with their choice of MCO, neither of whom used the report cards for decision support.

QTR 1: SUD Diagnosis and Treatment Among Texas Medicaid Adult STAR Members

In 2020, 4.6 million Medicaid beneficiaries nationwide received treatment for SUD, with emergency services being the most common type of SUD service. During the same year In Texas, over 100,000 Medicaid beneficiaries aged 12 and over were treated for SUD. However, most people in the U.S. with SUD do not receive treatment. Many also have co-occurring MHC, including anxiety disorders, major depression, bipolar disorder, or schizophrenia. Yet, services for SUD have traditionally been delivered separately, and coordination is impeded by restrictions to sharing SUD records. Despite efforts to improve coordination and availability of SUD services in Texas Medicaid, challenges in communication, contracting, and reimbursement continue to affect access. In 2021, HHSC received $252.8 million in Substance Abuse Prevention and Treatment Block Grant program supplemental funds, which SAMHSA (the Substance Abuse and Mental Health Services Administration) directs states to use to address local SUD-related needs, improve efficiency, and improve planning and oversight of SUD prevention, intervention, treatment, and recovery services.

This study was designed to assist HHSC in achieving this goal by assessing the prevalence of SUD diagnoses and co-occurring MHC and SUD treatment utilization in Texas Medicaid. The study analyzed claims and encounter data for adults enrolled in STAR to: (1) Describe the diagnosed prevalence of the most common SUD types, the occurrence of these SUD diagnoses as primary or secondary, and the care modalities and utilization for SUD treatment; (2) Identify the most common co-occurring MHC and physical health co-morbidities for SUD; and (3) Examine characteristics associated with the time between the new episode of alcohol use disorder (AUD) or opioid use disorder (OUD) and treatment initiation (wait time to treatment), and with healthcare encounters prior to these episodes, which could represent missed opportunities for intervention.

The study found that 5.3 percent of members had at least one SUD diagnosis in 2021. Non-Hispanic White members consistently had the highest percentage with SUD diagnosis across age and sex categories. Overall, the greatest number of members was diagnosed for cannabis use (prevalence of 2.4 percent), although among older adults (aged 45 to 64) AUD was more common and this age group had the highest prevalence of AUD (3.0 percent). SUD encounters in the ED more commonly had a primary SUD diagnosis than inpatient, partial hospitalization, outpatient and observation encounters.

The SMI rate for members with SUD diagnosis was nearly four times as high as the baseline SMI rate, with the highest rates among older adults, women, non-Hispanic White members, and members of unknown/other race/ethnicity. Almost one half (48.5 percent) of members with a SUD also had a physical health comorbidity, with liver disease, hypertension, and kidney disease being more common.

The most common healthcare venue for new AUD treatment episodes was the ED, where 36.5 percent of the episodes initiated. Only 13.8 percent of new OUD treatment episodes were initiated in the ED, while one-third were initiated in outpatient visits. Less than 10 percent of new AUD treatment episodes were followed by treatment within 30 days (including medication, medical intervention, or psychosocial care). Treatment in the new OUD treatment cohort was more common, but still more than 70 percent of episodes were not followed by treatment within 30 days. For both SUD cohorts, the most common time for first treatment, when it was received, was the day of the initial diagnosis for the episode. In both the new AUD treatment and new OUD treatment cohorts, more than two-thirds of episodes had at least one non-SUD inpatient or outpatient encounter within 60 days of the episode. About half of the episodes had more than one prior encounter.

QTR 2: Impact of Extended Postpartum Enrollment for Women in Texas STAR Medicaid Resultant from COVID-19 Public Health Emergency Policies

Although the American College of Obstetricians and Gynecologists (ACOG) strongly advocates for postpartum Medicaid coverage (ACOG, 2023) to include 12 months of postpartum care, current federal regulations require that Medicaid provide pregnancy-related coverage only through 60 days after the end of pregnancy. According to The Centers for Disease Control and Prevention (CDC, 2023), Texas Medicaid is the payor for close to half of all births in Texas. However, until 2020 Texas covered postpartum care for only the federally required 60 days. In 2020, Texas applied for 1115 waiver funds to provide limited additional postpartum services through the Healthy Texas Women Program. In 2023, Texas passed legislation to extend postpartum coverage to 12 months (H.B. 12, 88th Leg., R.S., 2023). Meanwhile, the U.S. FFCRA, passed in March 2020, included a continuous Medicaid enrollment provision. Thus, women that would have lost Medicaid coverage 60 days after the end of pregnancy kept their coverage up to the duration of the PHE.

This study used a difference-in-differences (D-i-D) analysis approach to evaluate the impact of postpartum coverage extension by measuring differences in healthcare utilization before and after the FFCRA provision was implemented, and between two groups of pregnant women in STAR: (1) those who were subject to disenrollment at 60 days before the provision (the intervention group), and (2) those who were not subject to automatic disenrollment, including women with TANF (Temporary Aid to Needy Families) eligibility and adolescent women under age 18 who qualified for children's Medicaid (the comparison group). The aims of this study were to: (1) Characterize prenatal, perinatal, and postpartum utilization by women in the STAR program, prior to and during the latter part of the COVID-19 pandemic; (2) Estimate differences in utilization by women in the STAR program, by their postpartum enrollment eligibility using a D-i-D approach; and (3) Evaluate demographic differences in utilization by women in the STAR program, prior to and during the latter part of the COVID-19 pandemic and by their postpartum enrollment eligibility.

The study found that the COVID-19 pandemic reduced outpatient visits in the prenatal, delivery, and extended postpartum periods. Outpatient visits during the delivery period were reduced in 2021 in the comparison group more than in the intervention group and were more common in the extended postpartum period than in the prenatal period in group cohorts with extended postpartum coverage. For members in the intervention group, extended postpartum utilization increased from essentially none for deliveries in 2018 to an average 0.13 visits per-member per-month for deliveries in 2021. The comparison group had more utilization in all delivery years and delivery time periods than the intervention group, and the difference between groups was greatest in the extended postpartum period.

The patterns for ED visits were similar. However, ED visits in the closest prenatal period showed almost no difference between years in either group, and ED visits were least common during the extended postpartum period compared to the prenatal and delivery periods. While ED visits were most common during the prenatal period, PPVs were most common during the extended postpartum period in groups with postpartum coverage. The COVID-19 pandemic appears to have had a greater relative effect on PPVs than on outpatient or ED visits overall, particularly in the extended postpartum period.

The full model results for outpatient visits, ED visits, and PPVs in the extended postpartum period show that the extended enrollment policy significantly increased outpatient visits (excluding postpartum care), ED visits and PPVs during the extended postpartum period (combined $p < 0.001$). The impact of the COVID-19 pandemic, estimated by the effects of delivery year, was also significant across all three of these measures; women had fewer outpatient visits, ED visits, and PPVs in 2021 than in 2018.

QTR 3: Physical Health Conditions and Co-occurring Mental Health Issues: A Focus on Fibromyalgia and Chronic Pain/Fatigue

A growing number of integrated healthcare models to provide patient-centered holistic care have shown efficacy in addressing concurrent physical health and mental health care needs. However, evidence gaps remain regarding the burden of co-occurring MHCs within specific physical health presentations and across different population groups. This study analyzed the prevalence of co-occurring MHCs among adult Texas Medicaid enrollees with fibromyalgia and chronic pain/fatigue (FCPF) across different sociodemographic groups. The study used calendar year 2021 claims and encounter data for adults in STAR, STAR+PLUS, and FFS to: (1) Document the co-occurrence of MHCs (anxiety, depression, schizophrenia, or bipolar disorder) among adult members across different physical health conditions; (2) Analyze differences in the odds of having a co-occurring MHC by age, gender, race/ethnicity, rurality, and non-medical drivers of health (NMDOH) vulnerability among members with FCPF; and (3) Examine healthcare utilization and MHC screening patterns among individuals with FCPF, with and without co-occurring MHCs, including specific member attributes associated with MHC-related PPAs and PPVs and MHC screening.

The study found that over 100,000 adult Medicaid members had a FCPF diagnosis in 2021. More than half of these members had a co-occurring MHC, with the highest prevalence among members in STAR+PLUS (67 percent). The most frequent co-occurring MHC across programs was anxiety, alone or combined with depression. Five to six percent of members with FCPF in STAR and FFS and 13 percent in STAR+PLUS had all three conditions of anxiety, depression, and either schizophrenia or bipolar disorder. The majority of members with FCPF were female and lived in metropolitan areas. Female members also had significantly higher odds of co-occurring MH issues, as much as 15 to 93 times the rate for male counterparts. Members in the non-Hispanic Black, Hispanic, and other/unknown racial/ethnic categories had lower odds of co-occurring MHC than non-Hispanic white members. Members with the highest NMDOH vulnerability in STAR and FFS had lower odds of presenting co-occurring MHCs than members with less NMDOH vulnerability. The lower observed co-occurring MHC prevalence/odds may reflect a lower likelihood of MHC diagnoses and healthcare utilization, rather than lower mental health care needs, among members in more vulnerable areas.

Three percent of all members with FCPF and five percent of those with a co-occurring MHCs experienced at least one MHC-related PPE. The majority of these members were in STAR+PLUS. Conversely, in FFS, only one percent of members with a MHC experienced a MHC-related PPE. Overall, only 21 percent of members with FCPF had a MHC screening after their FCPF diagnosis. MHC screening was more frequent among members who experienced a PPE. However, 61 percent of members who had a MHC-related PPE had not undertaken any MHC screening in the same calendar year, but before the PPE.

Findings pointed toward potential avenues for enhancing MHC surveillance and reducing MHC-related PPEs. The data suggested that members screened at least once for MHCs were likely to receive some follow-up MHC monitoring. Having MHC screening before the first FCPF diagnosis correlated with higher odds of experiencing MHC-related PPEs and acute inpatient care, suggesting that members who presented with MHCs before FCPF may have more complex mental health care needs. Younger members (21-44) exhibited higher odds of experiencing a MHC-related PPE and having acute MHC-related inpatient encounters than older counterparts. Conversely, they had lower odds of undergoing MHC screening before a MHC-related PPE.

Issue Brief 1: Dually-Eligible Beneficiaries in Texas: Who They Are, What They Have, and Where the Future Lies

Dually eligible beneficiaries (duals) who qualify for both Medicare and Medicaid tend to have greater health care needs and be more socioeconomically vulnerable. Duals often find themselves facing complex coverage options and fragmented care, while providers and health plans serving them face considerable burdens when navigating Medicare and Medicaid systems and rules. Both programs play a critical role in supporting the needs of duals, but they are operationally very different and have limited means of coordinating with each other. Policymakers collaborate with officials from both federal and state governments to explore delivery models that support Medicare-Medicaid integration and improve the quality of care available to duals. In general, integrated programs have shown greater improvement from their Medicaid services segment than in Medicare services (relative to non-integrated models), but the Medicaid portions also vary by state.

This issue brief presented findings of a comprehensive review of policy literature by the EQRO to provide a general profile of the dual population in Texas, summarize several key delivery models available to duals in Texas, and provide an overview of state and federal efforts in advancing integration and the work that remains to be done. The study produced three key takeaways:

1. Most duals in Texas are age 65 or older and slightly more are female than male. Over 95 percent of duals in Texas receive their Medicare benefits through either STAR+PLUS or FFS.
2. Texas Medicare-Medicaid Plans (MMPs) exhibited capabilities of achieving Medicaid cost saving, but research showed no association between Texas MMPs and cost savings on Medicare Part A and B. With CMS phasing out state dual demonstrations and their respective MMPs by 2025, Dual-Eligible Special Needs Plans (D-SNPs) are expected to play a bigger role in Texas.
3. Over half of duals in Texas are enrolled in D-SNPs. Currently, Texas does not have any fully integrated dual-eligible special needs plans (FIDE SNPs), but does have highly integrated dual-eligible special needs plans (HIDE SNPs), which provide integration of service beyond just coordination of care.

Issue Brief 2: Using NCI-AD Data to Assess Person-Centered Service Planning Requirements in the CMS Settings Rule

Person-centered planning and service coordination play a key role in the provision of LTSSs. The NCI-AD (National Core Indicators Aging and Disabilities) adult consumer survey provides valuable information on patient and caregiver satisfaction with LTSS and offers insight into quality of life, community integration, and person-centered services. This issue brief reported findings from a secondary analysis conducted by the EQRO on the 2021-2022 Texas NCI-AD adult consumer survey data to demonstrate the extent of person-centered planning and practices in STAR+PLUS at statewide and MCO levels, and to provide comparisons between survey findings at the Texas state and national levels.

The study found that, while many survey respondents experienced a person-centered supports planning process, there remains room for improvement in the areas of member self-direction and service coordination. The study produced three key takeaways:

1. Among older adults and people with physical disabilities in the STAR+PLUS HCBS Program, the proportion of people using a self-directed supports option was only 11 percent. In comparison, the NCI-AD national average was 39 percent and the Managed LTSS (MLTSS) HCBS Program national average was 22 percent.
2. Half of the STAR+PLUS HCBS Program members knew whom to contact if they had a complaint about their services (56 percent), compared to the NCI-AD national average of 79 percent and the MLTSS HCBS Program national average of 74 percent.
3. Only one-third of the STAR+PLUS HCBS Program members responded that their case manager talked to them about services that might help with their unmet needs (34 percent), compared to the NCI-AD national average of 51 percent and the MLTSS HCBS national average of 49 percent.

Issue Brief 3: A Systematic Approach to Performance Improvement Project Design and Implementation

Per 42 C.F.R. §438.330(d)(1)(2017), all MCOs and DMOs that provide coverage for Medicaid and/or CHIP are required to conduct at least one performance improvement project (PIP) with the goal of improving clinical and non-clinical outcomes in the Medicaid and CHIP populations. As PIP policies currently stand, the results of PIPs cannot be considered causal. However, if PIP methodologies were changed such that results from PIPs could be causally linked to interventions, PIPs could effectively lead to improved outcomes in the Medicaid and CHIP populations in Texas.

This issue brief presented findings from a literature review conducted by the EQRO to explore how systematic approaches to intervention implementation can be utilized in a real-world setting and how other states implement their PIPs. In addition, the study proposed a new PIP methodology which utilizes a comparative effectiveness design that incorporates the use of implementation science within a learning health system framework to achieve improvement in outcomes. The study produced three key takeaways:

1. Current PIP designs, which are population-based, do not allow for causal inference to be made regarding the effectiveness of interventions since the PIPs do not include a comparison or control group. In order to minimize the effects of external factors on PIP outcomes and assign causality to PIP interventions, a new approach to PIP design and implementation is needed.
2. The literature shows that comparative effectiveness research designs, such as the pragmatic trial, allow for causal inference in healthcare intervention testing by comparing effectiveness or two or more interventions in different groups of people. For the adoption of this design to be successful, MCOs should utilize principles of comparative effectiveness and implementation science within a learning health systems framework.
3. By implementing a 5-phase PIP design that encompasses planning and development, assessing degree of LHS within the MCO/DMO, rapid-cycle Plan-Do-Study-Act (PDSA), implementation, and determination of effectiveness over the course of four years, MCOs can adopt more systematic methods for PIP implementation and assign causality to PIP findings.

Relevance for Assessing Quality, Access & Timeliness

Each study has relevance to assessing quality, access, and timeliness. For example, the STAR Kids Focus Study examined the barriers and facilitators to receiving care through STAR Kids and MDCP, with findings directly applicable to improving access to and quality of critical services for this population, including home health services, therapies, medications, and medical supplies and equipment. The MCO Report Card Focus Study identified areas for improving MCO report cards that are sent to new Medicaid enrollees, which have the potential to improve access and timeliness of care immediately after enrollment. Together, the Quarterly Topic Reports provided information relevant to assessing quality and access of SUD services, maternal health care,

and mental health care for individuals with fibromyalgia and chronic pain/fatigue. The first two Issue Briefs provide a foundation for future directions in assessing and improving access and quality for dual-eligible beneficiaries and adults in STAR+PLUS who receive LTSS. The third issue brief outlines improvements that MCOs can make to their PIP methodology, which can impact quality, access, and timeliness of care for the most current and locally relevant problems in Texas Medicaid.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 65 provides a summary of the key findings and recommendations from EQR activities associated with Protocol 9 and their relevance to the MCQS

Goal	Icon	MCQS description	Goal	Icon	MCQS description
1		Promoting optimal health	4		Safer delivery system
2		Strengthening person and family engagement	5		Effective practices for people with chronic, complex, and serious conditions
3		Right care in the right place at the right time	6		High-performing Medicaid providers

Table 65. Protocol 9 findings and recommendations from the SFY 2022 STAR Kids Focus Study

Category	Description
Finding(s)	Third-party insurance was associated with low access to care for medications, medical supplies, specialist care, nursing services, and special medical equipment or devices. Interview findings suggest that caregivers for jointly-insured members can experience gaps in care when authorization for services is denied by both payors.
Recommendation(s)	STAR Kids MCOs should develop and implement new procedures to proactively address potential access issues for families with third-party insurance. Strategies may include: • Producing informational materials on the unique issues faced by families with third-party insurance, which can be distributed to case managers, providers, and caregivers. • Establishing procedures to ensure direct lines of communication with coordinators at third-party insurance companies.
MCQS Goal(s)	 (1, 2, 3, 5)

Category	Description
Finding(s)	Availability of home health care providers was impacted by staffing shortages and high turnover at home health agencies. Staff leave for a variety of reasons, including low pay rates, changing jobs, or being fired by caregivers who are dissatisfied with their services.
Recommendation(s)	STAR Kids MCOs should consider implementing strategies to bolster and improve the quality of home health provider networks, including: • Building upon credentialing requirements for home health agencies in their networks, including ensuring that they monitor home health nurse competencies. • Encouraging home health agencies to employ strategies to improve job satisfaction related to stress, workload, and compensation. • Encouraging home nursing agencies to employ strategies that improve retention and reduce turnover, such as enhancing technological competence and engaging nurses in shared governance. • Conducting more frequent review of home health agency network adequacy and actively recruiting those that meet quality requirements. HHSC should consider authorizing additional studies to investigate turnover among home health providers in STAR Kids and MDCP. These studies can: • Leverage data collected in the National Core Indicators Child Family Survey (NCI-CFS), which is administered in the state biennially, to analyze family-reported turnover. • Explore the feasibility of methods to calculate measures of home nursing and personal attendant continuity using encounter data. • Employ more targeted recruitment of rural caregivers to improve representation.
MCQS Goal(s)	 (1, 3, 4, 5, 6)
Finding(s)	Service coordination was again reported by caregivers as one of the most important factors influencing access to and quality of services received in STAR Kids and MDCP. The survey found that service coordinators who frequently contacted caregivers had a positive impact on access to home nursing services. Service coordinator helpfulness was associated with better access to home nursing, specialist care, medications, and medical supplies, and reduced caregiver burden.
Recommendation(s)	STAR Kids MCOs should implement or build upon existing practices to bolster the availability and quality of service coordination. Strategies may include: • Regular review of service coordinator-to-member ratios, and establishing standards for maximum caseload that can be benchmarked and improved upon regularly. • Revision and update of practices for identifying and recruiting service coordinators. • Annual review and update of training materials for all service coordinators – not just new employees – that address both new and long-standing issues faced by caregivers. STAR Kids MCOs should enhance training for service coordinators to more effectively address caregiver burden, including strategies to prevent burden related to access issues. These may include: • Ensuring caregivers are empowered with information and tools to help them coordinate their child's services, and with information on community resources, including online support groups. • Ensuring that individual plans of care have specific and feasible back-up plans for when there are gaps in regular home health care. • Training service coordinators to: (1) Identify possible symptoms of mental/emotional disorder in caregivers, and refer them to behavioral health providers who offer telehealth.; (2) Recognize issues with access to and quality of care for caregivers who speak Spanish in the home, who may be less likely to voice issues with services; (3) Assess caregiver physical capacity to care for STAR Kids MDCP members, especially as members get older and approach milestones for transition care.
MCQS Goal(s)	 (1, 2, 3, 4, 5, 6)

Table 66. Protocol 9 findings and recommendations from the Report Card Focus Study

Category	Description
Finding(s)	Members are actively using the MCO Report Cards as an information source to guide decisions about selecting an MCO, and the current topics/domains on the report cards align with the type of information members consider important for choosing an MCO.
Recommendation(s)	HHSC should continue prioritizing member decision support and access when considering new domains, measures, and analytic approaches for the MCO Report Cards
MCQS Goal(s)	(1, 2, 3)
Finding(s)	Clear communication with the MCO and health service/provider availability are important factors for members making an informed decision about an MCO and overall member satisfaction with a chosen MCO. However, the current report cards have limited information about MCO communication with the member or network adequacy.
Recommendation(s)	HHSC should consider augmenting the information on the MCO report cards with: • Additional information from supplemental questions on the biennial member surveys that relate to MCO communication and service coordination. • Information from the appointment availability study or HHSC network adequacy initiatives to provide members with information about the availability of health services and providers.
MCQS Goal(s)	(2, 3, 6)
Finding(s)	Lack of time and guidance during the enrollment process are two key barriers to making an informed decision about an MCO.
Recommendation(s)	HHSC should leverage the online report cards to help facilitate member decisions when selecting an MCO. Several members indicated that having access to the online report cards before receiving the enrollment package in the mail helped them prepare to make an informed decision when selecting an MCO. HHSC should consider including a phone number or link on the report cards that members can use for questions about the enrollment process and using the report cards to make an informed decision. HHSC should encourage MCOs to contact new enrollees to help them navigate their system and access care.
MCQS Goal(s)	(2, 3, 6)

Table 67. Protocol 9 findings and recommendations from QTR 1

Category	Description
Finding(s)	Non-Hispanic White members had the highest rate of SUD diagnosis across racial/ethnic groups. The highest rates of SMI among members with SUD were seen among older adults, women, non-Hispanic White members, and members of unknown/other race/ethnicity
Recommendation(s)	HHSC should undertake further analyses to estimate the effects of the general demographic and geographic differences and other non-medical drivers of health to identify disparities and possible barriers to SUD care.
MCQS Goal(s)	(1, 5)

Category	Description
Finding(s)	Among women, 6.2 percent of those pregnant during 2021 also had a diagnosed SUD compared to 4.8 percent for non-pregnant women. This difference was more pronounced among younger pregnant women.
Recommendation(s)	HHSC should investigate factors affecting SUD care for women and particularly during pregnancy. This study did not specifically investigate differences related to sex and whether they were related to pregnancy
MCQS Goal(s)	(1, 5)
Finding(s)	The most common healthcare venue for new AUD treatment episodes was the ED, while the most common venue for new OUD treatment episodes was in outpatient settings. Less than 10 percent of new AUD treatment episodes were followed by treatment within 30 days. Less than 30 percent of new OUD treatment episodes were followed by treatment within 30 days. About half of the episodes had more than one prior encounter.
Recommendation(s)	HHSC should study the utilization patterns of Medicaid members with diagnosed SUD to identify pathways and barriers to SUD care, and integrated care for SUD and co-occurring behavioral health and physical health conditions. In addition to SMI, anxiety should be included in further studies.
MCQS Goal(s)	(1, 2, 3, 5)
Finding(s)	Overall, the greatest number of members was diagnosed for cannabis use (prevalence of 2.4 percent), although among older adults AUD diagnosis was more common (3.0 percent). Among non-Hispanic White members, prevalence of stimulant use was more common than AUD. Overall, OUD had a prevalence of only 0.7 percent, with a higher rate among non-Hispanic White members (1.4 percent) and among older adults (1.9 percent). Stimulant use, OUD, cocaine addiction, and sedative use are more prevalent among older adults (aged 45 to 64).
Recommendation(s)	HHSC should further explore differences in prevalence and care related to SUD type (AUD, OUD, other specific substance categories) because more specific information could help target interventions more effectively.
MCQS Goal(s)	(1, 3, 5)

Table 68. Protocol 9 findings and recommendations from QTR 2

Category	Description
Finding(s)	Among the cohort of women delivering during the study period, Hispanic women had significantly fewer outpatient visits, ED visits, and PPVs than non-Hispanic White women, while non-Hispanic Black women had significantly more of all three types of events.
Recommendation(s)	HHSC should consider further studies of postpartum care policies to address disparities in access to care and utilization.
MCQS Goal(s)	(1, 3, 4)
Finding(s)	All four prenatal conditions (diabetes, hypertension, mental disorder, and SUD) significantly increased non-pregnancy-related outpatient utilization, ED visits, and PPVs during the extended postpartum period. MHCs had the greatest impact on outpatient utilization, while SUD had the greatest impact on ED visits and PPVs.
Recommendation(s)	HHSC should consider further studies to investigate the implications for co-occurring conditions on maternal healthcare. In particular, investigating implications of diabetes, hypertension, or behavioral health care during prenatal, perinatal, and postpartum periods, whether the conditions are pregnancy related, preexisting, or co-occurring.
MCQS Goal(s)	(1, 3, 4, 5)

Category	Description
Finding(s)	Additional model results showed a consistent positive relationship between the intervention (extended postpartum care) and prenatal and perinatal utilization, suggesting that the extended postpartum coverage may have spill-over effects on prenatal and perinatal care.
Recommendation(s)	HHSC should consider investigation of how extended postpartum care might improve prenatal, perinatal and primary care, and what additional factors influence utilization. For example, disparities in the uptake of postpartum care, under the extended enrollment policy, may highlight disparities in overall access to or awareness of maternal health services.
MCQS Goal(s)	(1, 3, 4, 5)

Table 69. Protocol 9 findings and recommendations from QTR 3

Category	Description
Finding(s)	Across conditions, 28 to 67 percent of members had at least one co-occurring MHC such as anxiety, depression, schizophrenia, bipolar disorder, or combinations thereof. Considering MHC screening limitations, data limitations, and possible underdiagnoses, actual numbers could be even higher. This highlights the importance of adequately assessing and addressing mental health care needs that co-occur with physical health conditions.
Recommendation(s)	HHSC could foster initiatives and data collection endeavors aimed at studying, monitoring, and addressing mental health care needs among patients with physical health conditions. Systematic reporting of data on MH screening for members with physical health conditions could incentivize quality improvements in this critical domain of healthcare.
MCQS Goal(s)	(1, 3, 4, 5)
Finding(s)	Non-Hispanic Black and Hispanic members and members with higher NMDOH vulnerability had lower odds of presenting a co-occurring MHC with FCPF in STAR and FFS than their non-Hispanic White and lower vulnerability counterparts. Observed rates may reflect potential underdiagnoses of MHC rather than a lower prevalence of co-occurring mental health care needs.
Recommendation(s)	HHSC could develop and test strategies to improve MHC screening for members with physical health conditions, with a specific focus on underrepresented groups and members with high NMDOH vulnerability, considering specific geographic, language, or other NMDOH barriers that may hinder access to mental health care. This would also provide a more comprehensive picture of actual mental health care needs
MCQS Goal(s)	(1, 3, 4, 5)
Finding(s)	After an initial MHC screening, the majority of members underwent subsequent follow-up or reassessment, averaging two MHC screening encounters per person. However, only 27 percent of members who had a MHC-related PPE underwent MHC screening before the PPE. Members may thus be experiencing challenges in initiating formal diagnoses and preventive healthcare for their mental health care needs, and this may contribute to MHC-related PPEs. This also highlights the importance of considering the sequence of healthcare events and not solely focusing on MHC screening rates.
Recommendation(s)	HHSC could undertake further analyses to study demographic and NMDOH barriers to the initiation of MHC screening and treatment among members with FCPF and other physical health conditions. This could inform opportunities for improvement in preventive care, surveillance, and early treatment of MH issues that intersect with physical health conditions. HHSC could monitor the sequence of MH screening and surveillance practices in addition to overall MH yearly screening and treatment rates.
MCQS Goal(s)	(1, 2, 3, 4, 5)

Category	Description
Finding(s)	The percentage of members with at least one outpatient encounter was lower among those who had experienced a MHC-related PPE, indicating a potential connection between outpatient care utilization and MHC-related PPEs.
Recommendation(s)	HHSC could further explore the relationship between outpatient care and MHC-related PPEs for the population of members with FCPF, analyze specific types of outpatient services, and explore and validate this relationship for other physical health conditions.
MCQS Goal(s)	(1, 3, 4, 5)
Finding(s)	Younger members (21-44) presented significantly higher odds of having a MHC-related PPE and acute MHC-related inpatient events than older counterparts (45-64). They had higher odds of MHC screening after a FCPF diagnosis, but also significantly lower odds of having MHC screening before a MHC-related PPE. This suggests that younger members may be initiating MHC screening only after having experienced a MHC-related PPE.
Recommendation(s)	HHSC could conduct additional studies of MHC screening rates and their temporal pathways with a narrower focus on this demographic group. HHSC could also validate these findings by focusing on other PH conditions.
MCQS Goal(s)	(1, 2, 3, 4, 5)
Finding(s)	Anxiety emerged as the predominant co-occurring MHC, either alone or coupled with depression. Notably, five to six percent in FFS/STAR and 13 percent in STAR+PLUS with FCPF experienced the entire triad of anxiety, depression, and either schizophrenia or bipolar disorder. Considering the distinct clinical profiles of each specific MHC and their intersections, variations in healthcare utilization outcomes and needs among members could be substantial.
Recommendation(s)	HHSC could conduct further studies narrowing the focus to specific MH conditions, both individually and jointly, and possibly expanding the scope to other PH conditions.
MCQS Goal(s)	(1, 3, 4, 5)

Table 70. Protocol 9 findings and recommendations from Issue Brief 2

Category	Description
Finding(s)	While many NCI-AD survey respondents reported experiencing a person-centered planning process, rates can improve in utilization of self-directed supports and provision of case management to address complaints and unmet needs.
Recommendation(s)	HHSC should conduct additional activities and studies to improve LTSS to better meet the changing needs of older adults and people with disabilities in STAR+PLUS, including: • Integrating NCI-AD data with other sources for a comprehensive view of MLTSS in STAR+PLUS • Providing MCOs with integrated NCI-AD data for trend analysis and quality improvement initiatives • Facilitating the use of self-direction through plain language materials and case manager training • Improving recipients' awareness of how to contact their case manager for complaints by developing materials and ensuring case managers convey contact details during check-ins
MCQS Goal(s)	(1, 2, 3, 4, 5, 6)

Protocol 10 Assistance with Quality Rating of MCO

Protocol Overview & Objectives

As of December 2022 (the end of the MY for this report), CMS had not released guidance for Protocol 10, Assistance with Quality Rating of MCOs. However, the EQRO conducts several activities that assess network adequacy for Texas Medicaid and CHIP members and generally aligned with the guidance provided in the EQR Protocols update released February 2023 (CMS, 2023a). The EQRO presents performance measures (*Protocol 7: Calculation of Performance Measures*) with ranking and comparison to benchmarks on the THLC portal (thlcportal.com). In addition, MCOs are held accountable for maintaining performance on a range of measures that are part of the Performance Indicator Dashboards. The EQRO assists in measure selection, calculates minimum standards, and presents performance details and summaries on the THLC portal (thlcportal.com). To help satisfy the requirements of Tex. Govt. Code § 536.051, the EQRO assisted HHSC in developing the P4Q programs to assign a percentage of premiums paid to MCOs and DMOs based on performance. Selected measures address areas of care with both high significance and capacity for improvement. In another important activity in this area of quality rating, the EQRO develops annual MCO report cards to support the state's ongoing efforts to improve health care quality by supporting consumer choice in Medicaid and CHIP.

EQR Activities

Quality Measure Reporting

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

Performance Indicator Dashboards

Chapter 10 of the UMCM provides details on the standards for the Performance Indicator Dashboards and compliance requirements (HHSC, 2023b). The EQRO publishes MCO performance on the Performance Indicator Dashboards for all programs on the THLC portal, organized by measure and MCO. Each year, the EQRO helps Texas select measures based on qualitative assessment and review of measure results across programs. Information from the Performance Indicator Dashboard supports ongoing and future quality improvement initiatives by helping Texas identify measures where most MCOs excel or struggle and where MCO performance varies widely.

MCOs must meet or surpass the minimum standards on more than two-thirds of measures on the program Performance Indicator Dashboard or HHSC can impose remedies including corrective action plans. Table 71 shows the rules applied in setting minimum and high-performance standards for measures on the Performance Indicator Dashboards. The ATR Companion includes Performance Indicator Dashboard summaries for each MCO and DMO by program.

Table 71. Performance Indicator Dashboard standards setting rules

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

P4Q

Complete details on the P4Q Performance Dashboard are available in Chapter 6 of the UMCM (HHSC, 2023b). Under the program, developed through extensive collaboration between the EQRO and HHSC, three percent of MCO capitation is at risk. The EQRO assesses measure performance for the at-risk pool in two ways: (1) performance against benchmarks, and (2) performance against self. For each MCO, the EQRO sums the recoupments and incentives to determine the total P4Q at-risk portion. A high-performing MCO can receive up to the entire three percent of at-risk capitation, while a low-performing MCO can lose up to the entire three percent. Any recouped monies go into the bonus pool. HHSC distributes these funds to MCOs based on performance on bonus measures. HHSC suspended the P4Q program during the PHE and restarted for MY 2022. The P4Q dashboard on the THLC portal (thlcportal.com) allows stakeholders to see which measures positively or negatively contribute to P4Q scores and the relative performance of the MCOs.

MCO Report Cards

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

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

Measures & Data Sources

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

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

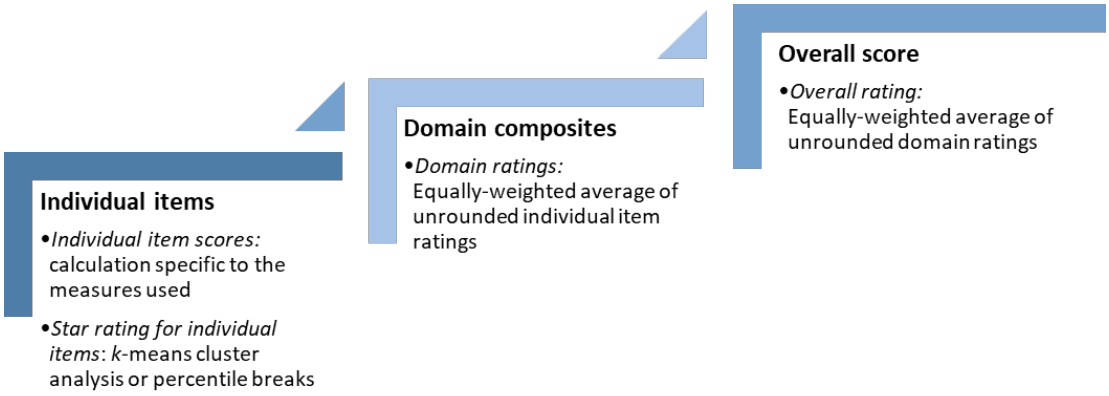
The MCO report cards for this reporting period use the results from member and caregiver surveys conducted in the spring and summer of 2023 (see *Protocol 6: Administration of Quality of Care Surveys*) and administrative measure results for MY 2022(see *Protocol 7: Calculation of Performance Measures*).

The EQRO fields abbreviated 15-minute surveys for each report card type, supplementing the longer biennial member survey to meet plan code (MCO x SA) level sample size requirements or when the EQRO does not conduct the biennial survey during the timeframe. With 200 completed interviews per plan code targeted, the EQRO collected over 20 thousand completed interviews from attempts to contact almost 260 thousand members or caregivers. Following AHRQ guidance, case-mix adjustment at the plan code level corrected for potential bias from respondent characteristics unrelated to health care quality, including age, education, and health status.

Structure

The report cards organize MCO performance information in a three-tiered hierarchical structure to allow new enrollees and their caregivers to compare MCOs at the desired level of detail and make an informed decision. The MCO report cards for STAR Child, STAR Adult, STAR Kids, and STAR+PLUS begin with an overall composite summary of relative MCO performance that averages the star ratings for several domains. Each of the report cards includes four domain composites and an overall composite. The domains comprise different items by type of report card to account for the needs of the populations. In the layout of the report cards, the domain ratings are positioned below the overall composite rating, and the ratings for the individual measures within each domain are displayed under their respective domain ratings. Figure 10 shows this calculation cascade graphically.

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



Domain Composite & Overall Quality Rating Calculations

Ratings for the domain composites are the averages of the unrounded individual item ratings, and the overall composite rating is the average of the unrounded domain ratings. The EQRO rounds composite ratings to the

nearest half star. If no rating results for more than half of the individual items in a composite, the report card will display "No rating."

The domains for STAR Adult, STAR Child, STAR+PLUS include:

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

In a similar four-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 four domains:

- Getting Care summarizes measures of member and caregiver experience of care and access to routine primary care.
- Services and Support summarizes member and caregiver experience measures discussing and coordinating care and for the MCO overall.
- Mental and Behavioral Health summarizes the experience of getting emotional and behavioral counseling, follow-up care after hospitalization for mental illness, and metabolic monitoring for members taking antipsychotic medication.
- Experience with the Health Plan: summarizes information on member and provider complaints about the MCO and a measure of adult/caregiver experience with the MCO (CAHPS Rating of Health Plan).

Appendix F: Measures Used in Report Card Rating Calculations provides details on the domain structure and content for each of the four report card programs.

Star Rating System during SFY 2023

The scoring system considers four types of measures:

1. Administrative measures scored by *k*-means clustering and potentially adjusted according to national benchmark.
2. Survey measures scored by percentiles and potentially adjusted for reliability and statistical significance.
3. Complaint measures cored by *k*-means clustering.
4. Composite and Overall measures scored as the average of items and domain ratings.

Ratings are assigned on a five-star scale in half-star increments.

Administrative measures follow NCQA HEDIS methods. Measures with an optional hybrid specification use only administrative data without supplementation through medical record review because hybrid measure reporting for QOC is at the MCO level, and does not provide sufficient data at the plan code level. As in previous years, ratings for administrative measures use *k*-means clustering. Ratings additionally incorporate information about performance relative to national benchmarks.

Survey-derived individual report card items follow AHRQ definitions with two exceptions: care coordination and transition to care as an adult on the STAR Kids report card use items from the National Survey of Children's Health (NSCH). Survey measure ratings use the same approach as the Medicare C and D Star Ratings (CMS, 2023b), a percentile-based method adjusted for significance and reliability.

Complaint measures, calculated as the number of total complaints per 10,000 member months, use complaints filed by members and providers through multiple reporting channels (e.g., HEART,[10] OMCAT,[11] or DAP[12]). Ratings for complaints measures use *k*-means clustering.

Composite measures ratings average the component ratings to increase interpretability by improving the intuitiveness of the composite ratings.

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

Survey scores include non-response weights for any significant differences in response propensity by age, sex, and race/ethnicity; and case-mix adjustment by member health status, respondent age, and education. Using the CAHPS analysis macro, version 5.0 (CAHPS Consortium, 2020), the EQRO calculated scores, case-mix adjustments, and standard errors. The percentile-based method for the survey measures first assigns a base rating group according to the percentile breaks listed in Table 72 using the weighted adjusted scores; this procedure follows the process used to calculate the Medicare C and D Star Ratings (CMS, 2023b). Following methods from Adams (2009), this base group is adjusted toward the middle when reliability is low (less than 0.70 but not less than 0.60). Scores not significantly different from the grand mean of all scores on a two-tailed *t*-test ($p<0.05$) after finite-population correction also adjust toward the middle. Scores with very low reliability (<0.60) do not receive a rating. One- and five-star ratings will occur only for scores significantly below or above the grand mean, and of sufficient reliability or at least one standard error below or above the percentile cut point. In uncommon cases, this adjustment procedure can result in a lower score receiving a higher rating or vice versa, due solely to uncertainty; these will receive a "No rating" assignment. This procedure allows for sampling variation and the potential non-representativeness of the respondent pool. This approach to rating the survey measures will tend to increase the variation in ratings overall but may limit extreme (one- or five-star) ratings. Where data was insufficient to compute a reliable rating (reliability ≥ 0.7), the report cards indicate "No rating," and a clarifying note informs users that this is due to lack of information and does not indicate poor quality. MCOs may receive ratings for domain composites and individual measures without receiving an overall rating. Table 72 and Table 73 summarize the rating decision rules and adjustments described above.

Table 72. Survey measure ratings decision rules for star assignment

	<15th percentile by >1 SE	<15th percentile by ≤1 SE	≥15th to <30th percentile	≥30th to <60th percentile	≥60th to <80th percentile	≥80th percentile by ≤1 SE	>80th percentile by >1 SE
Base group	1	1	2	3	4	5	5

[10] Information about HHS Enterprise Administrative Reporting and Tracking System (HEART) is available at https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/hpm-complaint-process.pdf
[11] Information about Ombudsman Managed Care Assistance Team (OMCAT) is available at https://www.hhs.texas.gov/sites/default/files/documents/ombudsman-managed-care-assistance-team-fy2023-q1.pdf
[12] HHSC Office of Data, Analytics, and Performance

	<15th percentile by >1 SE	<15th percentile by ≤1 SE	≥15th to <30th percentile	≥30th to <60th percentile	≥60th to <80th percentile	≥80th percentile by ≤1 SE	>80th percentile by >1 SE
Significantly below; Low reliability	1	2	2	2	3	4	4
Significantly below; Not low reliability	1	1	2	2	4	4	4
Not significantly different Low reliability	2	2	3	3	3	4	4
Not significantly different Not low reliability	2	2	2	3	4	4	4
Significantly above; Low reliability	2	2	3	4	4	4	5
Significantly above; Not low reliability	2	2	2	4	4	5	5

Table 73. Administrative measure ratings adjusted for national benchmarks

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

Relevance for Assessing Quality, Access & Timeliness

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

Summary of Protocol Findings & Recommendations from EQR Activities

Table 74 provides a summary of the key findings and recommendations from EQR activities associated with Protocol 10 and their relevance to the MCQS

Goal	Icon	MCQS description	Goal	Icon	MCQS description
1		Promoting optimal health	4		Safer delivery system
2		Strengthening person and family engagement	5		Effective practices for people with chronic, complex, and serious conditions
3		Right care in the right place at the right time	6		High-performing Medicaid providers

Table 74. Protocol 10 findings and recommendations

Category	Description
Finding(s)	In 2016, the EQRO conducted an MCO report card evaluation survey, finding that only half of members or caregivers recalled receiving a report card in their enrollment packet, less than one-third reported using the report card to decide on a health plan, and most stated the report card was easy to understand. Since then, numerous changes have been made to the original methods and format of the MCO report cards. The EQRO conducted a follow up focus study in 2023 to: (1) Identify how and when members first encounter MCO report cards; (2) Examine how members use report cards to make informed decisions when selecting an MCO, and identify report card features that are helpful and alternate sources of information that members use for decision-making; (3) Identify features of report cards that are difficult to understand or less helpful, reasons why features are not helpful, and possible improvements that can be made to report card formatting and information; and (4) Identify factors that affect members' ability to use report cards. Slightly more members were familiar with the report cards, but more than one third of participants were not. Still, report cards were the most-cited source of decision support for members and caregivers. Only one participant reported using the THLC portal to get more information on MCOs. Almost all the participants found the star rating system easy to understand. Suggested improvements included providing a contact for help interpreting the report card and including a reminder about the deadline for choosing a plan.
Recommendation(s)	HHSC should take the study findings into account for next year's report cards. The current star rating system is understandable, but small improvements in the overall information included could make report cards more effective.
MCQS Goal(s)	 (2, 3, 5)

EQRO Recommendation Summary

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

This section has two parts, the first half brings together the EQRO recommendations from EQR activities for SFY 2023 and their relevance to the current MCQS (as found at the end of each protocol section). The second half includes: (a) the EQRO recommendations for SFY 2022, with (b) their relevance to Texas's MCQS at the time of the recommendations, and (c) HHSC's response to the prior year's recommendations. The MCQS references below apply to both years.

Goal	Icon	MCQS description	Goal	Icon	MCQS description
1		Promoting optimal health	4		Safer delivery system
2		Strengthening person and family engagement	5		Effective practices for people with chronic, complex, and serious conditions
3		Right care in the right place at the right time	6		High-performing Medicaid providers

SFY 2023 Recommendations

Protocol 1: Validation of PIPs

Category	Description
Finding(s)	Data analysis was a common opportunity for improvement in the 2019 PIPs. For example, 10 MCOs (BCBSTX, CMCHP, Cigna-HealthSpring, CFHP, CHCT, Driscoll, FirstCare, Molina, Superior, and TCHP) lost points on the PIP plan in Activity 6, *Plan to Collect Reliable Data,* because they chose an inappropriate statistical test for the reported measures. Additionally, several MCOs lost points on the final PIP due to incorrectly calculating or interpreting statistical analyses for PIP measures.
Recommendation(s)	BCBSTX, CMCHP, Cigna-HealthSpring, CFHP, CHCT, Driscoll, FirstCare, Molina, Superior, and TCHP should ensure they select the appropriate statistical test for the reported measures. Amerigroup, CMCHP, Cigna Health-Spring, CFHP, CHCT, FirstCare, Molina, Parkland, and Superior should ensure that they perform statistical analyses according to the data analysis plan, and calculate and interpret them correctly.
MCQS Goal(s)	(1)
Finding(s)	Three MCOs (Cigna-HealthSpring, CFHP, and TCHP) lost points on the PIP plan for the components related to the target population for the PIP. These MCOs reported the target population for the PIP as all members with a diagnosis of depression and/or anxiety *and* three or more ED visits and two or more inpatient stays. However, the purpose of this PIP was to prevent and reduce potentially preventable events and high utilization among *all* members with anxiety and/or depression rather than just among members who already meet the criteria for high utilization. Therefore, the MCOs should have reported the target population as all members with a diagnosis of anxiety and/or depression.
Recommendation(s)	Cigna-HealthSpring, CMCHP, and TCHP should ensure that they accurately identify and report the target population throughout the PIP so they can prevent the outcome of interest for the PIP.
MCQS Goal(s)	(1, 3, 4, 5)

Category	Description
Finding(s)	Several MCOs received recommendations on the 2019 PIP plan on components related to sampling. MCOs did not accurately or consistently report sampling in two main scenarios: Several MCOs (Aetna, CFHP, CMCHP, and Parkland) did not accurately identify whether or not they were targeting the entire population for the PIP or a sample of the population. For example, Aetna accurately described the entire population of the PIP per the HHSC and EQRO guidance, but indicated on the PIP plan that they were targeting a sample rather than the entire population. MCOs did not consistently report whether they were sampling for specific interventions. Seven MCOs (CMCHP, Cigna-HealthSpring, CFHP, CookCHP, Driscoll, FirstCare, and UHC) lost points in Activity 5B, Sound Sampling Methods – Interventions, because they did not correctly describe the sample of the target population they would be targeting for their intervention(s). Additionally, in Activity 7B.1, Implementation Evaluation: Intervention and Improvement Strategies, these seven MCOs lost points due to inconsistently or incorrectly reporting the number and percent of members targeted for the intervention based on the sample.
Recommendation(s)	Aetna, CFHP, CMCHP, Cigna-HealthSpring, CookCHP, Driscoll, FirstCare, Parkland, Superior, and UHC should familiarize themselves with sampling in order to accurately identify whether they are sampling for the PIP and/or interventions. In addition, if they are sampling, these MCOs should familiarize themselves with the different sampling methodologies and associated biases. HHSC should provide additional guidance and technical assistance to MCOs on what sampling is, how to identify sampling, and how to accurately report sampling for the PIPs.
MCQS Goal(s)	 (1)

Category	Description
Finding(s)	Nine MCOs received an overall validation status of "No" on one or more of their PIPs, and thirteen MCOs/DMOs received an overall validation status of "Partial" on one or more of their PIPs. Even after accounting for revisions made in the revised PIP plan, four MCOs received an overall "No" on one or more PIPs and eighteen MCOs received a "Partial" overall validation status on one or more PIPs. The primary reason that few MCOs/DMOs received an overall validation status of "Yes" even after accounting for revisions to the PIP plan was lack of statistically significant improvement in PIP measures. Eighteen MCOs that received a "Partial" overall on one or more PIPs after revisions did not achieve statistically significant improvement for one or more measures. Driscoll (CHIP), Superior (STAR Health), TCHP (CHIP) and UHC (CHIP) all received a "No" overall validation status after revisions because they did not achieve statistically significant improvement for any measure. After an in-depth review, the EQRO identified potential factors that may have impacted the MCOs' ability to achieve statistically significant improvement. For example, several MCOs (Aetna, BCBSTX, Cigna-HealthSpring, CFHP, CHCT, CMCHP, Driscoll, ElPasoHealth, FirstCare, Molina, Parkland, SWHP, and UHC) delayed the implementation date of PIP interventions by one to twelve months, paused interventions for approximately 3 months to up to two years, or reported that they retired interventions as early as five months after initial implementation without replacing the retired interventions. In addition, because PIPs are not causative, external factors may have influenced the rates for the PIP measures, leading to lack of statistically significant improvement despite effective interventions.
Recommendation(s)	All MCOs, especially Aetna, BCBSTX, Cigna-HealthSpring, CFHP, CHCT, CMCHP, Driscoll, ElPasoHealth, FirstCare, Molina, Parkland, SWHP, and UHC should implement PIP interventions in a timely manner at the start of the PIP and for the entire duration of the PIP period so they can achieve maximum impact on PIP outcome measures. All MCOs should utilize rapid-cycle PDSA methodologies to test interventions prior to the implementation of the PIP in order to test whether an intervention and the implementation strategy will be effective. HHSC should consider revising PIP implementation methods to increase the likelihood of determining the effectiveness of the interventions by utilizing intervention and control groups, which will allow MCOs to account for some external factors that may impact the outcomes being measured.
MCQS Goal(s)	(1, 3)

Protocol 2: Validation of Performance Measures Reported by MCOs

Category	Description
Finding(s)	Only TCHP and SWHP reported that they keep track of EHR use among their PCPs and specialists.
Recommendation(s)	HHSC should encourage MCOs to track EHR use, and collect data which will be critical to calculating ECDS measures.
MCQS Goal(s)	(3, 4, 6)
Finding(s)	All MCOs indicated that they validate NPI and indicated that they reject or deny claims without NPI. However, the EQRO notes continued deficiencies in encounter provider data. Only four MCOs indicated taxonomy validation against the services and only three indicated taxonomy validation against the provider credentials and the EQRO notes continued deficiency in the provider taxonomies in encounters.
Recommendation(s)	HHSC should continue strengthening provider data systems, including working with MCOs to understand root causes for continuing deficiencies in encounter provider data submissions.
MCQS Goal(s)	(4, 6)

Category	Description
Finding(s)	Rates for THSteps timely checkups continue to be low.
Recommendation(s)	HHSC should consider ways to better incentivize improvement in meeting timely checkup requirements.
MCQS Goal(s)	(1)

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

AI findings and recommendations

Category	Description
Finding(s)	Several MCOs and DMOs reported challenges obtaining and incorporating provider URL information into provider directories.
Recommendation(s)	MCOs and DMOs, including CHCT, MCNA, PCHP, SWHP, and TCHP, should establish systems to incorporate complete provider website URL information in their provider directories.
MCQS Goal(s)	(2, 6)
Finding(s)	Several MCOs did not have compliant procedures for the associated timeframes and notification protocols for standard and expedited service authorization decisions, including extension protocols.
Recommendation(s)	MCOs, including SWHP and TCHP should ensure their representatives make standard and expedited service authorization decisions, extensions, and notifications within the federally required timeframes.
MCQS Goal(s)	(1, 3, 4, 6)
Finding(s)	Although follow-up led to compliant corrections, several MCOs reported state-compliant CHIP grievance system protocols; however, these system protocols were not compliant with updated federal guidelines.
Recommendation(s)	MCOs with a CHIP product line need to evaluate their procedures to ensure that CHIP grievance system protocols align with Medicaid grievance system protocols, excluding the Medicaid requirement of continuation of benefits pending the appeal, a state fair hearing, or both.
MCQS Goal(s)	(2, 3, 4, 6)

QAPI findings and recommendations

Category	Description
Finding(s)	Since 2018, the average QAPI scores for MCOs and DMOs have gradually declined, with the 2023 average QAPI score (94.8 percent) being the lowest average score since 2018 (98.8 percent). Further, the lower average QAPI scores do not correlate with the scores for compliance with previous recommendations. For example, one DMO (DentaQuest) had a sustained score of 100 percent for compliance with previous recommendations since 2021; however, in that time its overall QAPI score steadily declined from 99.3 percent to 94.6 percent. Similarly, among all MCOs and DMOs the average MCO/DMO compliance with the previous year's recommendations increased from 73.7 percent (2018) to 84.7 percent in 2023, while all but one (Molina) MCOs'/DMOs' overall QAPI scores decreased from 2018. This illustrates that the MCOs and DMOs are implementing EQRO feedback on the previous year's QAPI; yet, points lost in other activities outweigh the increase in points from correcting previous issues. Amerigroup, CFHP, CookCHP, MCNA, Molina, and TCHP experienced a decrease in overall QAPI score since 2018, despite increased compliance with the previous year's recommendations.
Recommendation(s)	Amerigroup, CFHP, CookCHP, MCNA, Molina, and TCHP should ensure that they strive for continuous quality improvement in their quality improvement programs outside of implementing previous recommendations. All MCOs and DMOs should update and revise all sections of the QAPI submission as needed and ensure continued compliance on activities that previously received full credit.
MCQS Goal(s)	(1, 3)
Finding(s)	Many MCOs reported objectives that were not specific, action-oriented statements written in measurable and observable terms that define how the MCO will meet the goals. For example, Driscoll reported one objective as, "DHP HEDIS® indicators, listed on the QM Work Plan will meet or exceed the health plan's prior year rate." The MCO did not specify which indicators it is targeting, how much, if any, improvement it seeks to achieve, or the time frame for achieving the improvement. Additionally, many MCOs and MMPs have not updated their objectives to meet the CMS criteria for several consecutive years. For example, Molina has reported many of the same or similar objectives year over year. The MCO reported the same first two objectives for Goal 2 on the last six QAPI submissions, with minor revisions, e.g., the addition of a time frame. Several MCOs and one MMP also reported objectives that they already achieved at the time or set goals to achieve minimum standards without striving for continuous improvement.
Recommendation(s)	The EQRO recommends that Aetna, BCBSTX, CHCT, CookCHP, DCHP, DentaQuest, Driscoll, FirstCare, PCHP, SWHP, and TCHP develop specific, action-oriented, measurable, and observable objectives. Objectives should focus on what needs to be improved, by how much, and by when to meet the associated goal. The EQRO previously made this recommendation. While goals may be broad and span several years, objectives should be met within a year or two and revised based on the previous year's outcomes. All MCOs, DMOs, and MMPs should review all objectives annually to ensure continuous quality improvement or identify additional opportunities for improvement. To achieve continuous quality improvement, the EQRO recommends MCOs and DMOs designate current performance as a baseline and then report the goal as a percentage or number of percentage points improvement over the current rate. MCOs should perform an annual review of all objectives to ensure they demonstrate continuous quality improvement or focus on additional opportunities for improvement. This recommendation applies to BCBSTX, CFHP, CHCT, ElPasoHealth, FirstCare, Molina, SWHP, TCHP, UHC, Cigna-HealthSpring MMP, Molina MMP, and UHC MMP.
MCQS Goal(s)	(1, 3)

Category	Description
Finding(s)	Many MCOs, MMPs, and DMOs lost points in all three indicator monitoring sections (*Access to Care Monitoring & Results, Clinical Indicator Monitoring,* and *Service Indicator Monitoring)* for the effectiveness of actions section. The three main opportunities for improvement were: MCOs/MMPs (1) did not include a percent change analysis for all indicators, (2) reported incorrect metrics for an indicator (i.e., the unit of analysis was not consistent for all rates reported), and 3) did not accurately interpret the effectiveness of actions.
Recommendation(s)	The EQRO recommends that Aetna, Amerigroup, BCBSTX, CHCT, CFHP, DCHP, DentaQuest, Driscoll, ElPasoHealth, FirstCare, MCNA, Molina, PCHP, Superior (MCO and MMP), TCHP, and UHC (MCO and MMP) include a percent change analysis for all indicator monitoring, report all data consistently and accurately to ensure all calculations are correct, and provide accurate interpretation of results with analyses that specify whether rates improved, declined, or did not change. The EQRO previously made this recommendation.
MCQS Goal(s)	(1, 3)
Finding(s)	Several MCOs and MMPs reported inaccurate results due to incorrect data included from previous reports and provided information based on incorrect measurement years in multiple areas of the QAPI report. For example, Superior miscalculated the effectiveness of actions for the Adherence to Antipsychotic Medication for Individuals with Schizophrenia (SAA) for the STAR population in the *Clinical Indicator Monitoring* activity. The MCO reported that performance decreased by 7.51 percentage points from MY 2021. However, the correct calculation was a decrease in performance of 8.68 percentage points. The EQRO found that the 7.51 percentage point change was left in from the previous QAPI report, when measure performance increased 7.51 percentage points from MY 2020. Additionally, SWHP lost points in both the *Improvement Opportunities* and the *Overall Effectiveness* activities for reporting almost exactly the same responses from the previous QAPI report. For example, the MCO reported that it "expanded the scope of services to STAR members during pregnancy, including incorporating digital tools" as an example of program success In Activity B2 on the 2021, 2022, and 2023 QAPI reports. The EQRO could not determine if the MCO continually expanded services and incorporated new digital tools or if the response simply had not been updated. In another example, BCBSTX evaluated the effectiveness of actions taken and included a percent change analysis for all indicators in the *Clinical Indicator Monitoring* activity. However, the MCO utilized MY 2021 and MY 2020 results when calculating the percent change analysis for the 13 HEDIS indicators. The MCO should have compared results for MY 2022 with results for the previous reporting period, MY 2021.
Recommendation(s)	The EQRO recommends that Amerigroup, BCBSTX, CHCT, DCHP, Driscoll, ElPasoHealth, FirstCare, Superior, and SWHP utilize data from the current measurement year for the QAPI to report the actions the MCOs took to improve performance and results. The EQRO previously made this recommendation.
MCQS Goal(s)	(1, 3)

Protocol 4: Validation of Network Adequacy

Category	Description
Finding(s)	The percentage of providers compliant with UMCC standards for low-risk pregnancy was 2.2 percentage points lower, and for third-trimester pregnancy was 0.3 percentage points lower in SFY 2023compared to SFY 2022. For the high-risk, the compliance was 0.6 percentage points higher compared to SFY 2023.
Recommendation(s)	HHSC should consult with MCOs and conduct a root cause analysis to identify the driving factors behind lower rates of provider compliance among prenatal health providers and use the results to identify strategies for improving provider compliance. A focus study on the challenges that MCOs encounter when trying to increase the percentage of providers compliant with appointment standards could help develop more effective target MCO incentives.
MCQS Goal(s)	(1, 3, 4, 5, 6)
Finding(s)	In SFY 2023, none of the sampled providers in Amerigroup, BCBSTX, or Driscoll complied with wait time standards for prenatal care in the third trimester.
Recommendation(s)	HHSC should strongly encourage Amerigroup, BCBSTX, and Driscoll to conduct a root cause analysis to identify the drivers for non-compliance with appointment standards. Amerigroup, BCBSTX, and Driscoll should use root cause analysis to identify specific approaches that they can use to encourage providers to make appointments available within five working days.
MCQS Goal(s)	(1, 3, 4, 5, 6)
Finding(s)	Overall, in SFY 2023, the percentage of excluded providers increased in low-risk and third-trimester pregnancy, and total appointments available decreased in all prenatal sub-studies compared with SFY 2022.
Recommendation(s)	HHSC should consult with MCOs to better understand the key factors contributing to errors in the provider taxonomy for prenatal directories and why so many providers in the prenatal sample did not offer prenatal appointments. No provider in FirstCare offered an appointment for third-trimester and low-risk pregnancy. No providers in Aetna, DCHP, and El Paso offered an appointment for third-trimester pregnancy. HHSC should encourage the MCOs to carefully examine the member-facing directory information they provided for the appointment availability study, especially CookCHP, and Molina, which had the highest percentage of excluded providers in prenatal sub-studies. Updated provider directories with accurate provider contact information will help reduce the total number of calls needed for each MCO and help increase the sample size for assessing compliance with call wait times. Aetna, DCHP, El Paso Health, and FirstCare should use root cause analysis to identify specific approaches that they can use to encourage providers to offer appointments to Medicaid enrollees.
MCQS Goal(s)	(1, 3, 4, 5, 6)
Finding(s)	In SFY 2023, the median number of days to wait for a high-risk appointment was nine days, and the third trimester was six days, both higher than the UMCC standard of five days.
Recommendation(s)	The EQRO recommends that HHSC work with providers to understand what factors contribute to longer wait times for appointments and develop a strategy for decreasing the wait time for High-risk and Third Trimester appointments. All MCOs should work with their providers to understand what factors contribute to longer wait times for prenatal appointments and develop a strategy for decreasing the wait time for prenatal appointments especially for high-risk appointments.
MCQS Goal(s)	(1, 3, 4, 5, 6)

Category	Description
Finding(s)	In SFY 2023, compliance with vision appointment UMCC standards decreased in STAR Kids and STAR+PLUS compared to SFY 2022. Across programs, Superior has the greatest opportunity to improve compliance with wait time standards. Superior had the lowest percentage of providers in compliance with wait time standards in the STAR+PLUS and STAR Kids programs.
Recommendation(s)	The EQRO recommends that HHSC conduct an in-depth study on appointment standards to understand the challenges that MCOs encounter when trying to increase the percentage of providers compliant with appointment standards and more effectively target Superior health incentives to increase the percentage of providers that meet appointment availability standards. HHSC should work with Superior to identify factors contributing to non-compliance with appointment standards.
MCQS Goal(s)	(1, 3, 4, 6)
Finding(s)	In SFY 2023, the percentage of contacted providers for behavioral health care appointments who did not accept Medicaid/CHIP and excluded providers increased in STAR, STAR+PLUS, STAR Kids, and CHIP compared to SFY 2022.
Recommendation(s)	HHSC should consult with MCOs and providers to better understand the key factors limiting the number of providers participating in the Medicaid programs and work with MCOs to identify ways to overcome these challenges especially United Health Care. HHSC should encourage MCOs to carefully examine the member-facing directory information they provide for the appointment availability study, especially Amerigroup, which had the highest percentage of excluded providers in STAR, STAR Kids, STAR+PLUS, and CHIP programs. Updated provider directories
MCQS Goal(s)	(6)
Finding(s)	In SFY 2023 vision study, the percentage of excluded providers increased in CHIP, STAR Kids, STAR, and STAR+PLUS compared to SFY 2022.
Recommendation(s)	HHSC should consult with Superior and Amerigroup to better understand the key factors contributing to errors in the provider taxonomy for vision directories and why so many providers in the vision sample do not conduct regular vision exams.
MCQS Goal(s)	(6)
Finding(s)	In SFY 2023, all five programs improved compliance with preventive and routine care compared to SFY 2022. The MCOs with the lowest compliance with preventive care compliance in SFY 2023 were Aetna and Amerigroup in STAR Kids, TCHP in STAR Adult, El Paso Health in STAR Child, and Amerigroup and Molina in STAR+PLUS. All MCOs across all five programs were 100 percent compliant with routine and urgent care standards in SFY 2023.
Recommendation(s)	HHSC should strongly encourage Aetna, Amerigroup, Molina, and TCHP to conduct a root cause analysis to identify the drivers for lower compliance with preventive care appointment standards and identify specific approaches for improvement.
MCQS Goal(s)	(1, 3, 4, 6)
Finding(s)	In SFY 2023 primary care study, the percentage of excluded providers increased in all five programs compared to SFY 2022. Amerigroup had the highest percentage of excluded providers in the CHIP, STAR Kids, and STAR+PLUS programs.
Recommendation(s)	HHSC should consult with Amerigroup to understand the key factors contributing to provider taxonomy errors for PCP directories and determine why so many PCP providers were excluded from the directory information submitted to the EQRO. HHSC should encourage MCOs to update provider directory information, reduce the number of excluded providers, and work with MCOs to identify ways to overcome these challenges
MCQS Goal(s)	(1, 6)

Category	Description
Finding(s)	In SFY 2023, the percentage of appointments available for primary care decreased in all five programs compared to SFY 2022. CookCHP in STAR Kids, CookCHP and SWHP in STAR, DCHP in CHIP, and Amerigroup in STAR+PLUS had the lowest percentages of available appointments.
Recommendation(s)	HHSC should work with CookCHP to identify the factors contributing to the lowest percentages of available appointments in STAR Kids and STAR programs. HHSC should encourage SWHP, CookCHP, DCHP, and Amerigroup to collaborate with providers to offer more appointments and identify ways to increase the overall percentage of appointments available.
MCQS Goal(s)	(1, 3, 4, 6)
Finding(s)	The percentage of primary care providers who offered weekend appointments decreased in CHIP, STAR Kids, and STAR STAR+PLUS in SFY 2023 compared to SFY 2022. 2.9 percent of CFHP providers in the STAR Kids program had an option for weekend appointments.
Recommendation(s)	HHSC should work with CFHP to increase weekend appointments for primary care.
MCQS Goal(s)	(1, 3, 4, 6)
Finding(s)	In the behavioral health care sub-study, the percentage of excluded providers increased in STAR, STAR Kids, STAR+PLUS, and CHIP in SFY 2023 compared to SFY 2022.
Recommendation(s)	HHSC should encourage MCOs to carefully examine the member-facing directory information they provide for the appointment availability study, especially Amerigroup, which had the highest percentage of excluded providers in STAR, STAR Kids, STAR+PLUS, and CHIP programs. Updated provider directories with accurate provider contact information will help reduce the total number of calls needed for each MCO and help increase the sample size for assessing compliance with call wait times.
MCQS Goal(s)	(1, 4, 5, 6)
Finding(s)	In SFY 2023, compliance with behavioral health care appointment wait time standards increased in all programs. The percentage of providers compliant with UMCM standards was 14.3 percentage points higher in CHIP and 13.7 percentage points higher in STAR+PLUS in SFY 2023 compared to SFY 2022. However, some MCOs had greater than 10 percentage point drops in compliance with behavioral health care appointment wait time standards for STAR Adult (CookCHP, CHCT, FirstCare, PCHP) or STAR Child (CHCT, ElPasoHealth, FirstCare, PCHP).
Recommendation(s)	MCOs should identify the driving factors behind improving rates of provider compliance among behavioral health providers and use the findings to develop strategies for continued improvement of provider compliance. HHSC should especially work with CookCHP , CHCT, ElPasoHealth, FirstCare, and PCHP to identify the factors contributing to decreased non-compliance with wait time standards for behavioral care in STAR.
MCQS Goal(s)	(1, 3, 4, 5, 6)
Finding(s)	In the behavioral health care sub-study, the percentage of excluded providers increased in STAR, STAR Kids, STAR+PLUS, and CHIP in SFY 2023 compared to SFY 2022.
Recommendation(s)	HHSC should encourage MCOs to carefully examine the member-facing directory information they provide for the appointment availability study, especially Amerigroup, which had the highest percentage of excluded providers in STAR, STAR Kids, STAR+PLUS, and CHIP programs. Updated provider directories with accurate provider contact information will help reduce the total number of calls needed for each MCO and help increase the sample size for assessing compliance with call wait times.
MCQS Goal(s)	(1, 3, 4, 5, 6)

Category	Description
Finding(s)	The percentage of providers that offered telehealth services for behavioral health decreased in STAR, STAR Kids, CHIP, and STAR+PLUS. Weekend appointments decreased in CHIP, STAR, STAR Health, and STAR Kids programs in SFY 2023 compared to SFY 2022. In STAR, none of the providers in Aetna, BCBSTX, CFHP, or CHCT offered a weekend appointment option.
Recommendation(s)	HHSC should consider a focus study to study the effectiveness of telehealth services for behavioral health, and evaluate other strategies to increase the availability of behavioral health care.
MCQS Goal(s)	(1, 3, 4, 5, 6)

Protocol 5: Validation of Encounter Data Provided by MCOs

Encounter Data Evaluation

Category	Description
Finding(s)	Encounter records continue to show deficiencies in provider identification and taxonomy attribution.
Recommendation(s)	HHSC should continue efforts to improve the quality of provider data in Medicaid and MCO systems HHSC should work with MCOs and other stakeholders to identify and address cases where NPI are not available to some service providers or services where individual NPI may not be appropriate
MCQS Goal(s)	(4, 6)

Review of Medical Records

Findings and recommendations from EDVMRR-CHIP

Category	Description
Finding(s)	Three MCOs (BCBSTX, PCHP & UHC) performed below average across all review categories. The primary reason for the lower match rates in 2023 is the same as in 2021 where the encounter data included for the date of service, place of service, primary diagnosis, and procedure data elements were not documented in the medical records. Further analysis identified no commonalities in procedures or diagnoses that could explain the higher incidence of unmatched data for BCBSTX and UHC. Additionally, no common providers accounted for a higher than normal amount of unmatched data for BCBSTX and UHC. However, PCHP had a total of 62 providers, of which three contributed to more than 50 percent (30 out of 51) of the procedures with a validation of "3. In claims data/not in medical record." The EQRO found a similar pattern for date of service for PCHP. Specifically, one PCHP provider single-handedly accounted for five dates of service with a validation of "3. In claims data/not in medical record." Similar conclusions can be applied to place of service, which is also analyzed at the date of service level. For all three MCOs, the three procedure codes that were in the encounter data but missing most frequently from the medical records were: 99000 – SPECIMEN HANDLING OFFICE-LAB 99214 – OFFICE O/P EST MOD 30-39 MIN 85025 – COMPLETE CBC W/ AUTO DIFF WBC Other health plans reflected these procedures in the medical records with no issues, indicating that the issue results from the providers or MCOs rather than the procedures themselves. Encounters with no corresponding documentation in the medical record for primary diagnosis showed no obvious underlying patterns.
Recommendation(s)	BCBSTX and UHC should further examine why information in the encounter data is not documented in the medical record. PCHP should work with providers to ensure all dates of service, places of service, primary diagnoses, and procedures are documented in the medical record, especially for the three most frequently missing procedure codes (99000, 99214, and 85025).
MCQS Goal(s)	, , (3, 4, 6)
Finding(s)	The EQRO revised the record collection process in that the EQRO provided the CHIP MCOs with a list of members included in the study and details of the time period for which records were needed. The MCOs then requested the medical records from their providers and submitted them to the EQRO via TXMedCentral. The EQRO provided three submission deadlines at the start of the study and required MCOs to submit a minimum of 20 records per submission. Only two MCOs (PCHP and FirstCare) did not reach the required number of records to meet the sample size by the third deadline. After meeting with these MCOs, the EQRO and HHSC granted a two-week extension, after which all MCOs submitted a sufficient number of records to meet the required sample size for the study. This approach yielded an 11.3 percentage point increase in the record return rate from the 2021 EDV study.
Recommendation(s)	HHSC should require MCOs to request and electronically submit the required records for all EDVMRR studies moving forward to yield a higher record return rate. HHSC should work with all MCOs, especially PCHP and FirstCare, to ensure they submit the required number of records by each of the three deadlines.
MCQS Goal(s)	, , (3, 4, 6)

Findings and recommendations for EDVDRR

Category	Description
Finding(s)	The encounters for DentaQuest presented a higher rate of Tooth IDs in dental records that were not in the claims data compared to other DMOs. For DentaQuest, the rate of Tooth IDs that were in the dental record and not in encounter data was 32.3 percent for CHIP Dental and 25.1 percent for Medicaid Dental. MCNA's rates were 0.2 percent for CHIP and 1.0 percent for Medicaid, and UHCD's rates were 9.2 percent for CHIP and 10.0 percent for Medicaid. The overall average rate of Tooth IDs in dental records that were not in the claims data was 10.6 percent for CHIP Dental and 9.8 percent for Medicaid Dental; these averages were increased by DentaQuest's high rates. While the Tooth IDs were successfully recorded in the records during the patient visits, they were not submitted in the encounter data. Upon analysis, a considerable proportion of the unmatched Tooth IDs were concentrated in a small number of dental providers, indicating a possible record-keeping issue for these providers. These providers were predominately associated with plan code 1K (DentaQuest CHIP) in the 2023 EDVDRR study, and the issues with Tooth ID match rates primarily affect DentaQuest only. While DentaQuest Medicaid had similar issues, it improved the Tooth ID match rate slightly from the previous EDVDRR study.
Recommendation(s)	HHSC should discuss this issue with DentaQuest and ensure its providers correct potential record-keeping issues and enter the Tooth ID on the claim as required for the procedure code.
MCQS Goal(s)	(3, 6)
Finding(s)	Record return rate differed significantly by DMO. DentaQuest had a higher percentage of records not received than the other DMOs, and thus had a lower return rate (77 percent for CHIP and 76 percent for Medicaid) than the other DMOs. MCNA had a return rate of 99.0 percent for CHIP and 98.5 percent for Medicaid, and UHCD had a return rate of 86.8 percent for CHIP and 83.2 percent for Medicaid. The average return rate was 87.3 percent for CHIP and 84.9 percent for Medicaid. DentaQuest's low return rates brought the overall record return rate down.
Recommendation(s)	DentaQuest should investigate the reason for low record return rates and correct issues that lead to a greater number of records that are not returned.
MCQS Goal(s)	(3, 6)
Finding(s)	For CHIP Dental and Medicaid Dental, the overall match rates for PX decreased compared to the 2021 EDVDRR study. In this period, the number of PXs recorded in the encounter data but not documented in the dental record increased by 3.5 percentage points for Medicaid Dental and 2.2 percentage points for CHIP Dental. This may be due to UHCD's lower rates, as 2023 was the first year UHCD participated in EDVDRR, and their rates were lower than the other DMOs for Medicaid Dental (88.9 percent compared to 91.3 percent and 93.7 percent for DentaQuest and MCNA, respectively). Additionally, the match rates for DentaQuest and MCNA were lower than the previous year due to more procedures that were submitted in the encounter data that were not documented in the dental record.
Recommendation(s)	The DMOs should examine why the encounter data is not documented in the dental record and revise their practices to ensure compliance.
MCQS Goal(s)	, (3, 4, 6)

Protocol 6: Administration of Quality of Care Surveys

Category	Description
Finding(s)	Overall, composite scores and ratings all decreased from 2021 to 2023 for STAR Child.
Recommendation(s)	Further analysis of the survey results is needed to understand the significance of these changes, and whether they reflect a change in members' experiences, or whether changes in member populations are affecting overall care experiences.
MCQS Goal(s)	 (2, 3, 6)
Finding(s)	Although the access to dental care rating increased, the availability of appointments when needed decreased.
Recommendation(s)	Further analysis of survey results, possibly in combination with additional related member data could provide insight on these observed differences.
MCQS Goal(s)	 (2, 3, 6)
Finding(s)	24.8 percent of child caregivers and 35.7 percent of adults reported that lack of transportation kept their child or them from medical appointments or getting medication.
Recommendation(s)	The EQRO recommends continued efforts to encourage MCOs to address scheduling and access needs including strategies such as asking MCOs to assess barriers to NEMT services.
MCQS Goal(s)	 (2, 3)
Finding(s)	Despite general satisfaction with NEMT services patients receive, only 16 percent of medical providers said that members usually or always arrive on time for their medical appointments, and most (82.5 percent) said that they or their staff have had to call to check on the status of a ride for patients ready to be picked up.
Recommendation(s)	HHSC should also work with the MCOs to assess and ensure the timeliness of NEMT rides. Late and missed medical appointments are associated with delayed care for patient illnesses and chronic health conditions, lack of specialty care, and increased visits to emergency departments. Further, many of the medical providers in the study indicated that they think members arriving late for appointments had the potential to impact the quality of care that members receive. What is less clear is the cause and extent of transportation delays. Therefore, the EQRO recommends HHSC work with the MCOs to 1) identify whether there are delays in NEMT rides, 2) identify the extent of the NEMT ride delays, and 3) identify and address the primary cause of NEMT ride delays.
MCQS Goal(s)	 (1, 3)

Protocol 7: Calculation of Performance Measures

Category	Description
Finding(s)	In 2022, Hispanic Medicaid members had more outpatient utilization and less ED, inpatient, mental health care, and alcohol and drug services use, while Black members had higher ED and inpatient use than other racial groups. .
Recommendation(s)	HHSC should continue to explore QoC measure results across demographic and other member population groups to interpret results more clearly and better direct efforts to improve care for all Medicaid and CHIP members.
MCQS Goal(s)	 (1, 2, 3)
Finding(s)	ED use increased while outpatient use decreased and the PPV rate increased
Recommendation(s)	HHSC should investigate common reasons for PPVs to better understand what members are most at risk and to plan targeted interventions to reduce PPVs.
MCQS Goal(s)	 (2, 3)

Category	Description
Finding(s)	Although the number is down from 2021, *URTI* remains the most common reason for PPVs and the reason second most common for PPVs, and continuing to increase in frequency is again *Non-Bacterial Gastroenteritis, Nausea & Vomiting*. SMIs continue to account for more PPAs than heart failure, which is still the leading single reason, and SMIs continue to be the leading causes for PPRs.
Recommendation(s)	HHSC should further investigate the incidence, prevalence, and treatment pathways for these consistently common reasons for PPEs to better understand what members are most at risk and to plan targeted interventions to reduce PPEs.
MCQS Goal(s)	(1, 3, 4, 5)
Finding(s)	Nearly 50 thousand C-Sections occurred in deliveries without complications. These represent substantial additional cost ($130 million) and potential risk to mothers and infants.
Recommendation(s)	HHSC should consider a PIP or interventions to reduce C-Sections in uncomplicated deliveries.
MCQS Goal(s)	(1, 2, 3, 4)
Finding(s)	MCO performance across Performance Indicator Dashboard measures varies. Some MCOs achieve the high standard on more than one third of measures, while some fail to meet the minimum standard on more than one third of measures.
Recommendation(s)	HHSC should continue leveraging the THLC portal (thlcportal.com) dashboards to help all Texas Medicaid and CHIP stakeholders identify and understand trends in healthcare quality across state programs.
MCQS Goal(s)	(1, 2, 3, 4, 5)

Protocol 9: Conducting Focus Studies of Health Care Quality

Findings and recommendations from the SFY 2022 STAR Kids Focus Study

Category	Description
Finding(s)	Third-party insurance was associated with low access to care for medications, medical supplies, specialist care, nursing services, and special medical equipment or devices. Interview findings suggest that caregivers for jointly-insured members can experience gaps in care when authorization for services is denied by both payors.
Recommendation(s)	STAR Kids MCOs should develop and implement new procedures to proactively address potential access issues for families with third-party insurance. Strategies may include: • Producing informational materials on the unique issues faced by families with third-party insurance, which can be distributed to case managers, providers, and caregivers. • Establishing procedures to ensure direct lines of communication with coordinators at third-party insurance companies.
MCQS Goal(s)	(1, 2, 3, 5)

Category	Description
Finding(s)	Availability of home health care providers was impacted by staffing shortages and high turnover at home health agencies. Staff leave for a variety of reasons, including low pay rates, changing jobs, or being fired by caregivers who are dissatisfied with their services.
Recommendation(s)	STAR Kids MCOs should consider implementing strategies to bolster and improve the quality of home health provider networks, including: • Building upon credentialing requirements for home health agencies in their networks, including ensuring that they monitor home health nurse competencies. • Encouraging home health agencies to employ strategies to improve job satisfaction related to stress, workload, and compensation. • Encouraging home nursing agencies to employ strategies that improve retention and reduce turnover, such as enhancing technological competence and engaging nurses in shared governance. • Conducting more frequent review of home health agency network adequacy and actively recruiting those that meet quality requirements. HHSC should consider authorizing additional studies to investigate turnover among home health providers in STAR Kids and MDCP. These studies can: • Leverage data collected in the National Core Indicators Child Family Survey (NCI-CFS), which is administered in the state biennially, to analyze family-reported turnover. • Explore the feasibility of methods to calculate measures of home nursing and personal attendant continuity using encounter data. • Employ more targeted recruitment of rural caregivers to improve representation.
MCQS Goal(s)	(1, 3, 4, 5, 6)
Finding(s)	Service coordination was again reported by caregivers as one of the most important factors influencing access to and quality of services received in STAR Kids and MDCP. The survey found that service coordinators who frequently contacted caregivers had a positive impact on access to home nursing services. Service coordinator helpfulness was associated with better access to home nursing, specialist care, medications, and medical supplies, and reduced caregiver burden.
Recommendation(s)	STAR Kids MCOs should implement or build upon existing practices to bolster the availability and quality of service coordination. Strategies may include: • Regular review of service coordinator-to-member ratios, and establishing standards for maximum caseload that can be benchmarked and improved upon regularly. • Revision and update of practices for identifying and recruiting service coordinators. • Annual review and update of training materials for all service coordinators – not just new employees – that address both new and long-standing issues faced by caregivers. STAR Kids MCOs should enhance training for service coordinators to more effectively address caregiver burden, including strategies to prevent burden related to access issues. These may include: • Ensuring caregivers are empowered with information and tools to help them coordinate their child's services, and with information on community resources, including online support groups. • Ensuring that individual plans of care have specific and feasible back-up plans for when there are gaps in regular home health care. • Training service coordinators to: (1) Identify possible symptoms of mental/emotional disorder in caregivers, and refer them to behavioral health providers who offer telehealth.; (2) Recognize issues with access to and quality of care for caregivers who speak Spanish in the home, who may be less likely to voice issues with services; (3) Assess caregiver physical capacity to care for STAR Kids MDCP members, especially as members get older and approach milestones for transition care.
MCQS Goal(s)	(1, 2, 3, 4, 5, 6)

Findings and recommendations from the Report Card Focus Study

Category	Description
Finding(s)	Members are actively using the MCO Report Cards as an information source to guide decisions about selecting an MCO, and the current topics/domains on the report cards align with the type of information members consider important for choosing an MCO.
Recommendation(s)	HHSC should continue prioritizing member decision support and access when considering new domains, measures, and analytic approaches for the MCO Report Cards
MCQS Goal(s)	(1, 2, 3)
Finding(s)	Clear communication with the MCO and health service/provider availability are important factors for members making an informed decision about an MCO and overall member satisfaction with a chosen MCO. However, the current report cards have limited information about MCO communication with the member or network adequacy.
Recommendation(s)	HSC should consider augmenting the information on the MCO report cards with: • Additional information from supplemental questions on the biennial member surveys that relate to MCO communication and service coordination. • Information from the appointment availability study or HHSC network adequacy initiatives to provide members with information about the availability of health services and providers.
MCQS Goal(s)	(2, 3, 6)
Finding(s)	Lack of time and guidance during the enrollment process are two key barriers to making an informed decision about an MCO.
Recommendation(s)	HHSC should leverage the online report cards to help facilitate member decisions when selecting an MCO. Several members indicated that having access to the online report cards before receiving the enrollment package in the mail helped them prepare to make an informed decision when selecting an MCO. HHSC should consider including a phone number or link on the report cards that members can use for questions about the enrollment process and using the report cards to make an informed decision. HHSC should encourage MCOs to contact new enrollees to help them navigate the MCO enrollment process.
MCQS Goal(s)	(2, 3, 6)

Findings and recommendations from QTR 1

Category	Description
Finding(s)	Non-Hispanic White members had the highest rate of SUD diagnosis across racial/ethnic groups. The highest rates of SMI among members with SUD were seen among older adults, women, non-Hispanic White members, and members of unknown/other race/ethnicity
Recommendation(s)	HHSC should undertake further analyses to estimate the effects of the general demographic and geographic differences and other non-medical drivers of health to identify disparities and possible barriers to SUD care.
MCQS Goal(s)	(1, 5)

Category	Description
Finding(s)	Among women, 6.2 percent of those pregnant during 2021 also had a diagnosed SUD compared to 4.8 percent for non-pregnant women. This difference was more pronounced among younger pregnant women.
Recommendation(s)	HHSC should investigate factors affecting SUD care for women and particularly during pregnancy. This study did not specifically investigate differences related to sex and whether they were related to pregnancy
MCQS Goal(s)	(1, 5)
Finding(s)	The most common healthcare venue for new AUD treatment episodes was the ED, while the most common venue for new OUD treatment episodes was in outpatient settings. Less than 10 percent of new AUD treatment episodes were followed by treatment within 30 days. Less than 30 percent of new OUD treatment episodes were followed by treatment within 30 days. About half of the episodes had more than one prior encounter.
Recommendation(s)	HHSC should study the utilization patterns of Medicaid members with diagnosed SUD to identify pathways and barriers to SUD care, and integrated care for SUD and co-occurring behavioral health and physical health comorbidities. In addition to SMI, anxiety should be included in further studies.
MCQS Goal(s)	(1, 2, 3, 5)
Finding(s)	Overall, the greatest number of members was diagnosed for cannabis use (prevalence of 2.4 percent), although among older adults AUD diagnosis was more common (3.0 percent). Among non-Hispanic White members, prevalence of stimulant use was more common than AUD. Overall, OUD had a prevalence of only 0.7 percent, with a higher rate among non-Hispanic White members (1.4 percent) and among older adults (1.9 percent). Stimulant use, OUD, cocaine addiction, and sedative use are more prevalent among older adults (aged 45 to 64).
Recommendation(s)	HHSC should further explore differences in prevalence and care related to SUD type (AUD, OUD, other specific substance categories) because more specific information could help target interventions more effectively.
MCQS Goal(s)	(1, 3, 5)

Findings and recommendations from QTR 2

Category	Description
Finding(s)	Among the cohort of women delivering during the study period, Hispanic women had significantly fewer outpatient visits, ED visits, and PPVs than non-Hispanic White women, while non-Hispanic Black women had significantly more of all three types of events.
Recommendation(s)	HHSC should consider further studies of postpartum care policies to address disparities in access to care and utilization.
MCQS Goal(s)	(1, 3, 4)
Finding(s)	All four prenatal conditions (diabetes, hypertension, mental disorder, and SUD) significantly increased non-pregnancy-related outpatient utilization, ED visits, and PPVs during the extended postpartum period. MHCs had the greatest impact on outpatient utilization, while SUD had the greatest impact on ED visits and PPVs.
Recommendation(s)	HHSC should consider further studies to investigate the implications for co-occurring conditions on maternal healthcare. In particular, investigating implications of diabetes, hypertension, or behavioral health care during prenatal, perinatal, and postpartum periods, whether the conditions are pregnancy related, preexisting, or co-occurring.
MCQS Goal(s)	(1, 3, 4, 5)

Category	Description
Finding(s)	Additional model results showed a consistent positive relationship between the intervention (extended postpartum care) and prenatal and perinatal utilization, suggesting that the extended postpartum coverage may have spill-over effects on prenatal and perinatal care.
Recommendation(s)	HHSC should consider investigation of how extended postpartum care might improve prenatal, perinatal and primary care, and what additional factors influence utilization. For example, disparities in the uptake of postpartum care, under the extended enrollment policy, may highlight disparities in overall access to or awareness of maternal health services.
MCQS Goal(s)	(1, 3, 4, 5)

Findings and recommendations from QTR 3

Category	Description
Finding(s)	Across conditions, 28 to 67 percent of members had at least one co-occurring MHC such as anxiety, depression, schizophrenia, bipolar disorder, or combinations thereof. Considering MHC screening limitations, data limitations, and possible underdiagnoses, actual numbers could be even higher. This highlights the importance of adequately assessing and addressing mental health care needs that co-occur with physical health conditions.
Recommendation(s)	HHSC could foster initiatives and data collection endeavors aimed at studying, monitoring, and addressing mental health care needs among patients with physical health conditions. Systematic reporting of data on MH screening for members with physical health conditions could incentivize quality improvements in this critical domain of healthcare.
MCQS Goal(s)	(1, 3, 4, 5)
Finding(s)	Non-Hispanic Black and Hispanic members and members with higher NMDOH vulnerability had lower odds of presenting a co-occurring MHC with FCPF in STAR and FFS than their non-Hispanic White and lower vulnerability counterparts. Observed rates may reflect potential underdiagnoses of MHC rather than a lower prevalence of co-occurring mental health care needs.
Recommendation(s)	HHSC could develop and test strategies to improve MHC screening for members with physical health conditions, with a specific focus on underrepresented groups and members with high NMDOH vulnerability, considering specific geographic, language, or other NMDOH barriers that may hinder access to mental health care. This would also provide a more comprehensive picture of actual mental health care needs
MCQS Goal(s)	(1, 3, 4, 5)
Finding(s)	After an initial MHC screening, the majority of members underwent subsequent follow-up or reassessment, averaging two MHC screening encounters per person. However, only 27 percent of members who had a MHC-related PPE underwent MHC screening before the PPE. Members may thus be experiencing challenges in initiating formal diagnoses and preventive healthcare for their mental health care needs, and this may contribute to MHC-related PPEs. This also highlights the importance of considering the sequence of healthcare events and not solely focusing on MHC screening rates.
Recommendation(s)	HHSC could undertake further analyses to study demographic and NMDOH barriers to the initiation of MH screening and treatment among members with FCPF and other physical health conditions. This could inform opportunities for improvement in preventive care, surveillance, and early treatment of MH issues that intersect with PH conditions. HHSC could monitor the sequence of MH screening and surveillance practices in addition to overall MH yearly screening and treatment rates.
MCQS Goal(s)	(1, 2, 3, 4, 5)

Category	Description
Finding(s)	The percentage of members with at least one outpatient encounter was lower among those who had experienced a MHC-related PPE, indicating a potential connection between outpatient care utilization and MHC-related PPEs.
Recommendation(s)	HHSC could further explore the relationship between outpatient care and MHC-related PPEs for the population of members with FCPF, analyze specific types of outpatient services, and explore and validate this relationship for other physical health conditions.
MCQS Goal(s)	 (1, 3, 4, 5)
Finding(s)	Younger members (21-44) presented significantly higher odds of having a MHC-related PPE and acute MHC-related inpatient events than older counterparts (45-64). They had higher odds of MHC screening after a FCPF diagnosis, but also significantly lower odds of having MHC screening before a MHC-related PPE. This suggests that younger members may be initiating MHC screening only after having experienced a MHC-related PPE.
Recommendation(s)	HHSC could conduct additional studies of MH screening rates and their temporal pathways with a narrower focus on this demographic group. HHSC could also validate these findings by focusing on other PH conditions.
MCQS Goal(s)	 (1, 2, 3, 4, 5)
Finding(s)	Anxiety emerged as the predominant co-occurring MHC, either alone or coupled with depression. Notably, five to six percent in FFS/STAR and 13 percent in STAR+PLUS with FCPF experienced the entire triad of anxiety, depression, and either schizophrenia or bipolar disorder. Considering the distinct clinical profiles of each specific MHC and their intersections, variations in healthcare utilization outcomes and needs among members could be substantial.
Recommendation(s)	HHSC could conduct further studies narrowing the focus to specific MH conditions, both individually and jointly, and possibly expanding the scope to other PH conditions.
MCQS Goal(s)	 (1, 3, 4, 5)

Table 75. Protocol 9 findings and recommendations from Issue Brief 2

Category	Description
Finding(s)	While many NCI-AD survey respondents reported experiencing a person-centered planning process, rates can improve in utilization of self-directed supports and provision of case management to address complaints and unmet needs.
Recommendation(s)	HHSC should conduct additional activities and studies to improve LTSS to better meet the changing needs of older adults and people with disabilities in STAR+PLUS, including: • Integrating NCI-AD data with other sources for a comprehensive view of MLTSS in STAR+PLUS • Providing MCOs with integrated NCI-AD data for trend analysis and quality improvement initiatives • Facilitating the use of self-direction through plain language materials and case manager training • Improving recipients' awareness of how to contact their case manager for complaints by developing materials and ensuring case managers convey contact details during check-ins
MCQS Goal(s)	 (1, 2, 3, 4, 5, 6)

Protocol 10: Assist with Quality Rating of MCOs

Category	Description
Finding(s)	In 2016, the EQRO conducted an MCO report card evaluation survey, finding that only half of members or caregivers recalled receiving a report card in their enrollment packet, less than one-third reported using the report card to decide on a health plan, and most stated the report card was easy to understand. Since then, numerous changes have been made to the original methods and format of the MCO report cards. The EQRO conducted a follow up focus study in 2023 to: (1) Identify how and when members first encounter MCO report cards; (2) Examine how members use report cards to make informed decisions when selecting an MCO, and identify report card features that are helpful and alternate sources of information that members use for decision-making; (3) Identify features of report cards that are difficult to understand or less helpful, reasons why features are not helpful, and possible improvements that can be made to report card formatting and information; and (4) Identify factors that affect members' ability to use report cards. Slightly more members were familiar with the report cards, but more than one third of participants were not. Still, report cards were the most-cited source of decision support for members and caregivers. Only one participant reported using the THLC portal to get more information on MCOs. Almost all the participants found the star rating system easy to understand. Suggested improvements included providing a contact for help interpreting the report card and including a reminder about the deadline for choosing a plan.
Recommendation(s)	HHSC should take the study findings into account for next year's report cards. The current star rating system is understandable, but small improvements in the overall information included could make report cards more effective.
MCQS Goal(s)	 (2, 3, 5)

SFY 2022 Recommendations and Responses

Protocol 1: Validation of PIPs

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

Protocol 2: Validation of Performance Measures Reported by MCOs

No recommendations

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

AI Interviews

Category	Description
Finding(s)	Several MCOs reported challenges obtaining and incorporating provider URL information into provider directories.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs, including Molina, Superior, and UHC, should establish systems to incorporate complete provider website URL information in their provider directories.
Follow-up Actions	HHSC plans to leverage corrective action plans for plans that have noncompliant policies. Improving provider directories continues to be a priority; many areas of HHSC are working on the issue.
Finding(s)	Several MCOs did not have compliant procedures for the associated timeframes and notification protocols for standard and expedited service authorization decisions, including extension protocols.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs, including Molina and Superior, should ensure their representatives make standard and expedited service authorization decisions and notifications within the federally required timeframes.
Follow-up Actions	HHSC utilizes corrective action plans for MCOs that have noncompliant policies after EQRO review.
Finding(s)	Several MCOs reported state-compliant CHIP grievance system protocols; however, these system protocols were not compliant with updated federal guidelines.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs with a CHIP product line need to evaluate their procedures to ensure that CHIP grievance system protocols align with Medicaid grievance system protocols, excluding the Medicaid requirement of continuation of benefits pending the appeal, a state fair hearing, or both.
Follow-up Actions	HHSC utilizes corrective action plans for MCOs that have noncompliant policies after EQRO review.
Finding(s)	Some MCOs reported data collection on member SDoH needs. However, many MCOs and DMOs had not implemented procedures to aggregate collected information on SDoH needs.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	MCOs and DMOs need to systemically collect data on the SDoH or NMDOH needs of members to aggregate needs by populations to impact member health and well-being effectively.
Follow-up Actions	HHSC is collaborating with the MCOs on implementation of NMDOH screening.
Finding(s)	While some MCOs had implemented specific SDoH-related interventions, they failed to clearly measure the direct and indirect effects.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	MCOs should consider evaluating the impact of plan-driven SDoH- or NMDOH-related interventions and referrals to community resources on the health and well-being of members.
Follow-up Actions	HHSC encourages the MCOs to use NMDOH related interventions in PIPs and other QI initiatives to clearly measure the direct and indirect effects.

Category	Description
Finding(s)	MCOs reported several multi-agency collaborations to address SDoH needs in members.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should encourage MCOs to share these SDoH- or NMDOH-related interventions and best practices with other entities, including HHSC, to further address unmet needs that may impact the health of Texans enrolled in Medicaid and CHIP programs.
Follow-up Actions	HHSC encourages MCOs to share NMDOH related interventions at quality forums and other venues throughout the year.
Finding(s)	MCOs reported successful transition by their providers to medical and behavioral health telehealth in response to the public health emergency. Many MCOs discussed the importance of provider communication and education to ensure that providers adopted correct billing codes and modifiers to facilitate payment for telehealth services.
MCQS Goal(s)	Goals 1, 3, 6
Recommendation(s)	MCOs should continue exploring the efficiency of utilizing medical and behavioral health telehealth services and their impact on health outcomes.
Follow-up Actions	The EQRO in 2024 is studying the efficiency of utilizing behavioral health telehealth services and their impact on health outcomes.
Finding(s)	MCOs reported that many health services have transitioned back to in-person settings while many behavioral health services continue via telehealth modalities.
MCQS Goal(s)	Goals 1, 6
Recommendation(s)	MCOs should continue exploring the efficacy of utilizing behavioral health telehealth services and their impact on the health outcomes of Texans enrolled in Medicaid and CHIP programs.
Follow-up Actions	The EQRO in 2024 is studying the efficiency of utilizing behavioral health telehealth services and their impact on health outcomes.

QAPI Evaluations

Category	Description
Finding(s)	Many MCOs lost points due to QAPI program objectives that were not specific, action-oriented statements written in measurable and observable terms that define how goals would be met. For example, one program objective was: "develop and/or enhance relationships with a community organization." This objective is not specific or written in measurable terms.
MCQS Goal(s)	Goals 1, 4
Recommendation(s)	The EQRO recommends that MCOs develop objectives which are specific, action-oriented, measurable, and observable. This recommendation applies to Aetna, CookCHP, DCHP, Driscoll, ElPasoHealth, FirstCare, PCHP, SWHP, and UHC Dental.
Follow-up Actions	HHSC utilizes contractual remedies including corrective action plans and LDs for MCOs whose QAPI plans are incomplete in terms of having objectives which are not specific, action-oriented, measurable, and observable.
Finding(s)	Many MCOs and MMPs reported results and data for MY 2020 instead of MY 2021 (the measurement year for the QAPI) in multiple areas of the QAPI report.
MCQS Goal(s)	Goals 1, 4
Recommendation(s)	The EQRO recommends that Aetna, Amerigroup, BCBSTX, CFHP, CHCT, DCHP, Driscoll, FirstCare, Superior, and SWHP utilize data from the measurement year for the QAPI to report results on performance.
Follow-up Actions	HHSC utilizes contractual remedies including corrective action plans and LDs for MCOs whose QAPI plans are inaccurate for using data not from the measurement year for the QAPI to report results on performance.

Category	Description
Finding(s)	Many MCOs, MMPs, and DMOs lost points in all three indicator monitoring sections (availability and accessibility, service, and clinical) for the effectiveness of actions section. The three main opportunities for improvement were: MCOs/MMPs 1) did not include a percent change analysis for all indicators, 2) reported incorrect metrics for an indicator (i.e., the unit of analysis was not consistent for all rates reported), and 3) did not accurately interpret the effectiveness of actions.
MCQS Goal(s)	Goals 1, 4
Recommendation(s)	The EQRO recommends that Aetna, Amerigroup, BCBSTX, CFHP, CHCT, CookCHP, DentaQuest, DCHP, ElPasoHealth, FirstCare, Molina, PCHP, Superior, and UHC include a percent change analysis for all indicator monitoring and ensure they correctly interpretation of results and use consistent units of analysis for each indicator.
Follow-up Actions	HHSC works with MCOs to improve the reporting and analysis of results in their QAPI.

Protocol 4: Validation of Network Adequacy

Category	Description
Finding(s)	The percentage of providers compliant with UMCC standards for high-risk pregnancy was 13.8 percentage points lower, and for low-risk pregnancy was 7.6 percentage points lower in SFY 2022 compared to SFY 2020. For the third trimester, the compliance was 10.6 percentage points lower compared to SFY 2020.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should consult with MCOs and conduct root cause analyses (RCAs) to identify the driving factors behind lower rates of provider compliance among prenatal health providers and use the results to identify strategies for improving provider compliance. The EQRO recommends that HHSC conduct an in-depth study on appointment wait times to: (1) better understand the challenges that MCOs encounter when trying to increase the percentage of providers that are compliant with appointment standards and (2) more effectively target MCO incentives to increase the percentage of providers that meet appointment availability standards.
Follow-up Actions	Quality Assurance staff along with the Deputy Executive Commissioner of Managed Care met with MCOs individually to discuss root causes of the poor results. Enhanced performance monitoring will be the next step, which included higher levels of monetary penalties (liquidated damages).
Finding(s)	In SFY 2022, none of the providers for Aetna, CookCHP, Molina, SWHP, and UHC complied with wait time standards for prenatal care in the third trimester. SWHP providers had zero percent compliance with high-risk pregnancy appointment standards.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should strongly encourage Aetna, CookCHP, Molina, SWHP, and UHC to conduct RCAs to identify the drivers for non-compliance with appointment standards Aetna, CookCHP, Molina, SWHP, and UHC should use the RCA to identify specific approaches that they can use to encourage providers to make appointments available within five working days.
Follow-up Actions	Quality Assurance staff along with the Deputy Executive Commissioner of Managed Care met with MCOs individually to discuss root causes of the poor results. Enhanced performance monitoring will be the next step, which included higher levels of monetary penalties (liquidated damages). The excluded providers will be used as part of the assessment for liquidated damages. Some of the issues around provider directories are beyond the scope of appointment availability since this is not the focus of the studies.

Category	Description
Finding(s)	In SFY 2022, the percentage of excluded providers increased, and the total appointments available decreased in all prenatal sub-studies compared with SFY 2020.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should consult with MCOs to better understand the key factors contributing to errors in the provider taxonomy for prenatal directories and why many providers in the prenatal sample did not offer prenatal appointments. HHSC should encourage the MCOs to carefully examine the member-facing directory information they provided for the appointment availability study, especially Amerigroup, Molina, and Aetna, which had the highest percentage of excluded providers in the prenatal sub-studies. Updated provider directories with accurate provider contact information will help reduce the overall number of calls needed for each MCO and help increase the size of the sample for assessing compliance with call wait times.
Follow-up Actions	Quality Assurance staff along with the Deputy Executive Commissioner of Managed Care met with MCOs individually to discuss root causes of the poor results. Enhanced performance monitoring will be the next step, which included higher levels of monetary penalties (liquidated damages).
Finding(s)	The EQRO excluded more providers from the behavioral health sub-study in SFY 2022 compared to SFY 2021 because of incorrect taxonomies or other directory information.
MCQS Goal(s)	Goal 4
Recommendation(s)	The EQRO recommends that HHSC continue to work with MCOs and TMHP to improve provider directory information quality.
Follow-up Actions	HHSC continues to work with TMHP to improve provider directory information quality.
Finding(s)	In SFY 2022, the median number of days to wait for a high-risk appointment was nine days, and the third trimester was seven days, both higher than the UMCC standard of five days.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	The EQRO recommends that HHSC work with providers to understand what factors contribute to longer wait times for appointments and develop a strategy for decreasing the wait time for High-risk and Third Trimester appointments. BCBSTX, DCHP, Molina, PCHP, and ElPasoHealth should work with their providers to understand what factors contribute to longer wait times for prenatal appointments and develop a strategy for decreasing the wait time for prenatal appointments.
Follow-up Actions	Quality Assurance staff along with the Deputy Executive Commissioner of Managed Care met with MCOs individually to discuss root causes of the poor results. Enhanced performance monitoring will be the next step, which included higher levels of monetary penalties (liquidated damages).
Finding(s)	In SFY 2022, compliance with vision health appointment standards decreased in STAR Health compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	The EQRO recommends that HHSC conduct an in-depth study on appointment wait times to: (1) better understand the challenges that MCOs encounter when trying to increase the percentage of providers that are compliant with appointment standards and (2) more effectively target Amerigroup and Superior health incentives to increase the percentage of providers that meet appointment availability standards. HHSC should work with Amerigroup and Superior to identify factors contributing to non-compliance with wait time standards.
Follow-up Actions	Quality Assurance staff provide presentations and gives the raw data to MCOs to figure out root causes and develop corrective actions that they submit to HHSC to increase compliance.

Category	Description
Finding(s)	In SFY 2022, the percentage of contacted providers who did not accept Medicaid/CHIP increased in STAR, STAR+PLUS, STAR Kids, and CHIP compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should consult with Superior to better understand the key factors contributing to errors in the provider taxonomy for vision directories and why so many providers in the vision sample did not conduct regular vision exams. HHSC should consult with MCOs and providers to better understand the key factors limiting the number of providers participating in the Medicaid programs and work with MCOs to identify ways to overcome these challenges.
Follow-up Actions	Quality Assurance staff provide presentations and gives the raw data to MCOs to figure out root causes and develop corrective actions that they submit to HHSC to increase compliance
Finding(s)	Few providers offered telehealth appointments in SFY 2022.
MCQS Goal(s)	Goals 3, 4, 5
Recommendation(s)	HHSC should conduct an environmental scan of the literature on the effectiveness of virtual appointments for vision care and the strategies other state Medicaid programs are using to increase availability of telehealth for vision care and use this information to inform strategies for improving access to and the availability of vision appointments among Texas Medicaid members.
Follow-up Actions	The office of the medical director is studying the clinical appropriateness of using telehealth for different services, including vision services.
Finding(s)	In SFY 2022 compliance with preventive and routine primary care appointment wait-time standards dropped in STAR, STAR+PLUS and STAR Kids compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should strongly encourage Aetna and CookCHP to conduct RCA analyses to identify the drivers for low compliance with appointment standards Aetna and CookCHP should use the RCAs to identify specific approaches that they can use to encourage providers to make appointments available within 90 working days. HHSC should work with CookCHP to identify the factors contributing to non-compliance with wait time standards for preventive, especially because this MCO has the lowest rate of compliance with preventive wait time standards in the STAR program and CHIP, and one of the lowest percentages of available appointments in STAR Kids. HHSC should work with Aetna to identify the factors contributing to non-compliance with wait time standards for routine care, especially because this MCO has the lowest rate of compliance with routine wait time standards in the STAR Kids program and CHIP, and one of the lowest compliance rates in STAR.
Follow-up Actions	Quality Assurance staff provide presentations and gives the raw data to MCOs to figure out root causes and develop corrective actions that they submit to HHSC to increase compliance
Finding(s)	In SFY 2022, the percentage of contacted providers who did not accept Medicaid increased in STAR, STAR Health, and STAR Kids compared to SFY 2021.
MCQS Goal(s)	Goals 3, 4, 5
Recommendation(s)	HHSC should consult with CookCHP to better understand the key factors that contribute to errors in the provider taxonomy for PCP directories and why so many of the providers in the PCP sample did not accept Medicaid. HHSC should consult with MCOs and providers to better understand the key factors limiting the number of providers participating in the Medicaid programs and work with MCOs to identify ways to overcome these challenges.
Follow-up Actions	Quality Assurance staff belong to a Network Adequacy Workgroup that helps to address provider directories and other network adequacy issues. In addition, QA works with MCOs to understand and problem solve how to make changes to directories to ensure more providers are included in the appointment availability studies.

Category	Description
Finding(s)	The percentage of providers who offered weekend appointments decreased in STAR and STAR Health in SFY 2022 compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should work with Superior to increase weekend appointments for primary care. This would improve access to and the availability of primary care appointments for Texans in the STAR Health program.
Follow-up Actions	Although there is reference to the weekend appointments in the UMCC, the appointment availability study compliance does not include oversight of weekend appointments. However, QA presents information and strongly encourages MCOs to increase extended hours to ensure members receive timely appointments
Finding(s)	In SFY 2022, compliance with behavioral health care appointment wait time standards decreased in STAR, STAR+PLUS, STAR Health, and CHIP compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	HHSC should conduct RCAs to identify the driving factors behind lower rates of provider compliance among behavioral health care health providers and use the results to identify strategies for improving provider compliance. HHSC should more effectively target MCO incentives to increase the percentage of providers that meet appointment availability standards. HHSC should work with Superior to identify the factors contributing to non-compliance with wait time standards for behavioral health care.
Follow-up Actions	QA provides presentations and gives the raw data to MCOs to figure out root causes and develop corrective actions that they submit to HHSC to increase compliance. In Texas, there is a significant shortage of behavioral health providers, which impacts the availability and timeliness of appointments.
Finding(s)	Providers that accepted Medicaid in STAR, STAR Kids, STAR Health, and STAR+PLUS decreased in SFY 2022 compared with SFY 2021.
MCQS Goal(s)	Goals 3, 4, 5
Recommendation(s)	HHSC should consult with MCOs and providers to better understand the key factors limiting the number of providers participating in the Medicaid programs and work with MCOs to identify ways to overcome these challenges.
Follow-up Actions	QA provides presentations and gives the raw data to MCOs to figure out root causes and develop corrective actions that they submit to HHSC to increase compliance.
Finding(s)	In the SFY 2022 behavioral health care sub-study, the percentage of excluded providers increased in CHIP, STAR Health, and STAR+PLUS.
MCQS Goal(s)	Goals 3, 5, 6
Recommendation(s)	HHSC should encourage the MCOs to carefully examine the member-facing directory information they provided for the appointment availability study, especially Amerigroup, which had the highest percentage of excluded providers in STAR, STAR+PLUS, STAR Kids, and CHIP. Updated provider directories with accurate provider contact information will help reduce the overall number of calls needed for each MCO and help increase the size of the sample for assessing compliance with call wait times.
Follow-up Actions	HHSC does not monitor the number of excluded providers via contract. However, the excluded providers are used as part of decision making around the assessment for liquidated damages.

Category	Description
Finding(s)	The percentage of providers that offered telehealth services or weekend behavioral health appointments decreased across all the programs in SFY 2022 compared to SFY 2021.
MCQS Goal(s)	Goals 3, 5, 6
Recommendation(s)	HHSC should work with MCOs to increase weekend appointments and telehealth services for behavioral health care. Increasing alternatives for behavioral health care appointments will improve access to and availability of behavioral health care.
Follow-up Actions	QA provides presentations and gives the raw data to MCOs to figure out root causes and develop corrective actions that they submit to HHSC to increase compliance. There is also research that needs to be conducted to ensure behavioral health telehealth is an appropriate and effective medium for the types of issues they are presented. In Texas, there is a significant shortage of behavioral health providers, which impacts the availability and timeliness of appointments.

Protocol 5: Validation of Encounter Data Provided by MCOs

Encounter Data Evaluation

Category	Description
Finding(s)	Driscoll and CFHP had deficits in member ID reporting or validity, and Superior had deficits on admission dates.
MCQS Goal(s)	Goals 3, 4, 6
Recommendation(s)	HHSC should continue to monitor key fields in encounter data for validity and completeness. Although data quality is generally very good, without monitoring changes in data processing can lead to unexpected data loss.
Follow-up Actions	HHSC continues to monitor encounter data quality. MCOs receive mid-year data quality reports from the EQRO.
Finding(s)	Despite several ongoing initiatives to try and improve the quality of provider data, both in encounters and in the master provider data, the overall quality of provider data is still not meeting the desired standards.
MCQS Goal(s)	Goal 4
Recommendation(s)	HHSC should continue current initiatives and investigate what causes deficits in the reported provider information.
Follow-up Actions	HHSC continues its current provider directory initiatives to improve provider information.
Finding(s)	UHC Dental data was deficient in several important elements.
MCQS Goal(s)	Goals 3, 4, 6
Recommendation(s)	HHSC should work with UHC Dental to improve their data quality. HHSC should consider earlier analysis of data quality for new MCOs/DMOs, or following other major changes in programs.
Follow-up Actions	HHSC did work with UHC Dental on data quality and they resubmitted encounters timely.

Review of Medical Records

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

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

Protocol 6: Administration of Quality of Care Surveys

Category	Description
Finding(s)	Composite scores on the STAR Adult and STAR+PLUS Member surveys decreased between 2020 and 2022, except for the STAR+PLUS Customer Service composite. The biggest change between 2020 and 2022 was the Health Care Rating for STAR Adult (-5.7 percent).
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should work with the STAR MCOs to identify the key factors that contributed to the decrease in STAR adult member satisfaction with healthcare and identify the strategies that STAR MCOs are using to improve the quality of care in those health domains.
Follow-up Actions	MCOs are required to conduct root cause analyses for low performance on quality measures as part of their corrective action plan process. HHSC has leveraged this process as part of its quality improvement efforts with member satisfaction.
Finding(s)	Between 2020 and 2022, most composite scores increased on the STAR Kids Caregiver survey while scores decreased for the STAR Health Caregiver survey except for Getting Care Quickly.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should work with Superior and stakeholders in STAR Health to identify the key barriers and facilitators to improving caregiver satisfaction with healthcare and the MCO and use this information to develop strategies to improve caregiver satisfaction.
Follow-up Actions	MCOs are required to conduct root cause analyses for low performance on quality measures as part of their corrective action plan process. HHSC has leveraged this process as part of its quality improvement efforts with caregiver and member satisfaction.

Protocol 7: Calculation of Performance Measures

Category	Description
Finding(s)	In 2021, Hispanic Medicaid members had more outpatient utilization and less ED, inpatient, mental health, and alcohol and drug services use than both non-Hispanic Black and non-Hispanic White members.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should continue to explore QoC measure results across demographic and other member population groups to interpret results more clearly and better direct efforts to improve care for all Medicaid and CHIP members.
Follow-up Actions	HHSC will continue to work policy division, CMS, NCQA, MCOs, and consult with ICHP to understand the results better and develop methods to make improvements in this area.

Category	Description
Finding(s)	URTI remains the most common reason for PPVs and the second most common PPVs, Non-Bacterial Gastroenteritis, Nausea & Vomiting, have doubled since 2020. SMIs account for more PPAs than heart failure, which is the leading single reason, and SMIs are the leading causes for PPRs.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	HHSC should investigate common reasons for PPEs to better understand what members are most at risk and to plan targeted interventions to reduce PPEs.
Follow-up Actions	HHSC continues to place an emphasis on PPEs and partner with MCOs to help reduce the prevalence of unsatisfactory events. HHSC's Medical P4Q initiative includes PPV, PPA, and PPR as at-risk measures, for which MCO performance affects whether a portion of their capitation rate is recouped.
Finding(s)	SMM rates increased especially in cases with hemorrhage.
MCQS Goal(s)	Goals 1, 2, 3, 4
Recommendation(s)	HHSC should encourage initiatives to improve hospital patient safety, including the AIM bundles developed by ACOG and continue to investigate the underlying drivers of maternal health disparities
Follow-up Actions	The 2024 PIP topic focuses on reducing SMM.
Finding(s)	Nearly 50 thousand C-Sections occurred in deliveries without complications. These represent substantial additional cost ($150 million) and potential risk.
MCQS Goal(s)	Goals 1, 2, 3, 4
Recommendation(s)	HHSC should consider a PIP or interventions to reduce C-Sections in uncomplicated deliveries.
Follow-up Actions	The 2024 PIP topic focuses on reducing c-sections in uncomplicated deliveries.
Finding(s)	MCO performance across Performance Indicator Dashboard measures varies. Some MCOs achieve the high standard on more than 50 percent of measures, while others fail to meet the minimum standard on more than 40 percent of measures. FirstCare has the most measures failing to meet the minimum standard, while Driscoll has the most measures achieving high standards.
MCQS Goal(s)	Goals 1, 4, 6
Recommendation(s)	HHSC should continue leveraging the THLC portal (thlcportal.com) dashboards to help all Texas Medicaid and CHIP stakeholders identify and understand trends in healthcare quality across state programs.
Follow-up Actions	HHSC continues its usage of the portal dashboards in its quality initiatives and continues to submit health plans to corrective action plans for failure to meet minimum standards on more than 1/3 of their measures.

Protocol 9: Conducting Focus Studies of Health Care Quality

STAR Kids Focus Study

Category	Description
Finding(s)	Caregivers reported having low availability of home therapy, personal assistance services, and nursing providers, particularly for those living in rural areas. In addition to network adequacy issues, caregivers attributed these unmet needs to high provider turnover, provider time constraints, and low provider pay.
MCQS Goal(s)	Goals 1, 3, 5,6
Recommendation(s)	STAR Kids MCOs should continue to focus network adequacy efforts in rural areas. Potential strategies may include: (1) Sharing best practices in the recruitment of home health providers with other MCOs in collaborative contexts, such as stakeholder and advisory group meetings or jointly conducted performance improvement projects; and (2) Establishing longer-term solutions to ensure local availability of home health providers in rural areas, such as provision of local training and certification programs. STAR Kids MCOs should ensure that home health providers have incentives to serve members in hard-to-reach areas. One potential strategy is to include provisions in contracts with home health agencies to ensure: (1) adequate provider reimbursement for travel expenses to hard-to-reach areas; and (2) availability of hourly pay supplementation for providers to account for lower caseloads that result from having to travel long distances to reach clients. These provisions may include cost-sharing between the MCO and the home health agency to cover these expenses and supplements. Texas Medicaid should authorize an increase in pay rates for personal assistance service providers to be more competitive with other entry-level community jobs. Texas Medicaid should ensure flexibility to allow caregivers to increase pay rates for home health providers when a member is not using authorized hours up to the total estimated costs of the original service plan.
Follow-up Actions	The EQRO will conduct a focus study in 2024 with a focus on access to care. HHSC will continue to work with the policy division, stakeholders, MCOs, and consult with ICHP to understand the results better and develop methods to make improvements in this area.
Finding(s)	Caregivers described challenges in navigating the complexity of processes for eligibility determination, approvals, and authorization for services and finding new providers and supply companies. These challenges contributed to caregiver stress and burden and led to gaps in care for members.
MCQS Goal(s)	Goals 1, 2, 5, 6
Recommendation(s)	STAR Kids MCOs should build on efforts to develop and disseminate resources for caregivers that explain processes for eligibility determination, approvals, and authorization for services in accessible language and multiple formats (e.g., mail- and web-based). These resources should include information on the individuals and organizations caregivers can reach out to with specific questions and how to reach them. STAR Kids MCOs should revisit policies for updating provider network directories to ensure that updates, including the lists of active providers who accept Medicaid and treat members with complex conditions, are frequently occurring and distributed to families of STAR Kids members in formats that are accessible to them.
Follow-up Actions	The EQRO will conduct a focus study in 2024 with a focus on access to care. HHSC will continue to work with the policy division, stakeholders, MCOs, and consult with ICHP to understand the results better and develop methods to make improvements in this area.

Category	Description
Finding(s)	Many caregivers report functioning as their child's primary care coordinator for specific services, such as prescription medicines and medical supplies, leading to gaps in care for members and increasing stress and burden for caregivers.
MCQS Goal(s)	Goals 2, 6
Recommendation(s)	STAR Kids MCOs should enhance the training of service coordinators to emphasize the challenges caregivers face in accessing medications and medical supplies for their children. Training materials and service coordination policies should address potential scenarios experienced by caregivers, such as being drawn into the coordination process by providers, paying out-of-pocket for medications and supplies, having to reuse supplies, and being unable to locate care to address highly specialized needs. STAR Kids MCOs should consider or build upon programs to provide STAR Kids MDCP caregivers with services that reduce their coordination and travel burden, such as automatic medication refills, home delivery of medications, and delivery tracking for supplies. Texas Medicaid and STAR Kids MCOs should conduct periodic reviews to identify caregivers at high risk of stress or burden due to care coordination and then conduct outreach with these caregivers to provide special assistance. These reviews may include: (1) Identifying caregivers who have recently experienced changes to their MCO service coordinator; (2) Focusing on MCOs or service areas with higher rates on caregiver burden measures calculated from the STAR Kids Screening and Assessment Instrument (SK-SAI); (3) Using member-level SK-SAI data to identify individual caregivers with high level of burden.
Follow-up Actions	The EQRO will conduct a focus study in 2024 with a focus on access to care. HHSC will continue to work policy division, stakeholders, MCOs, and consult with ICHP to understand the results better and develop methods to make improvements in this area.
Finding(s)	The study was limited by the low representation of Hispanic caregivers, who comprise the majority of STAR Kids MDCP. Furthermore, some interviews with Hispanic caregivers lacked sufficient detail to ensure a thorough understanding of their experiences and satisfaction with care.
MCQS Goal(s)	Goals 1, 2, 5
Recommendation(s)	HHSC should consider authorizing a study conducted by the EQRO that focuses on Hispanic caregivers of STAR Kids MDCP members and leverages multiple data sources to ensure thoroughly understand the experiences of this important subgroup. This study might include the following: Stratification of study participants according to third-party insurance status will allow for more reliable measures of differences in experience between those who do and do not have third-party insurance. Use caregiver survey or SK-SAI data to quantitatively assess differences in experience with access to and quality of healthcare according to third-party insurance status, MCO, SA, and other individual, geographic, and service delivery factors. Supplementation of quantitative data with qualitative interviews of Hispanic caregivers, incorporating more time to identify appropriate bilingual (English/Spanish) interviewers, train them in rigorous qualitative data collection methods, and conduct regular quality monitoring of interview data and feedback.
Follow-up Actions	The EQRO will conduct a focus study focusing on Hispanic caregivers in 2024. The EQRO will use survey findings to tailor a qualitative interview guide for Hispanic caregivers to conduct qualitative interviews with a sample of Hispanic caregivers who participated in the survey to (1) understand the context in which certain factors lead to positive and negative experiences with care for Hispanic caregivers, and (2) identify strategies for overcoming barriers to care and improving quality of care for children of Hispanic caregivers.

Quarterly Topic Reports

Study on Social Determinants of Maternal Health

Category	Description
Finding(s)	Compliance with HEDIS-PPC prenatal and postpartum care measures was significantly associated with positive health outcomes, including lower odds of hemorrhage and (pre)eclampsia. Compliance with HEDIS-PPC prenatal and postpartum care measures was also associated with higher odds of postpartum depression diagnosis.
MCQS Goal(s)	Goals 1, 5, 6
Recommendation(s)	HHSC and the MCOs should continue efforts to improve access to prenatal and postpartum services for women in Medicaid and CHIP. These efforts should include identifying and responding to the barriers to access for minority women and women in rural areas.
Follow-up Actions	The 2024 PIP topic focuses on maternal health.
Finding(s)	Mothers in micropolitan and rural counties had higher odds of PPD diagnoses than mothers in metropolitan counties.
MCQS Goal(s)	Goals 1, 3, 6
Recommendation(s)	HHSC should conduct additional research on maternal mental health to identify the causes of disparities in maternal mental health screening, maternal mental health outcomes, and barriers to effective maternal mental health treatment.
Follow-up Actions	The 2023 PIP in which MCO interventions will continue through December 2024 focuses on behavioral health.
Finding(s)	Average county-level COVID-19 caseloads were significantly associated with variation in the odds of several health and service utilization outcomes, including C-Section deliveries and hemorrhage.
MCQS Goal(s)	Goals 1, 3, 6
Recommendation(s)	HHSC should consider additional research studies examining how the onset of the COVID-19 pandemic affected access to health services for managed care members across different Medicaid programs.
Follow-up Actions	HHSC is pursuing data analyses, internally and in partnership with the EQRO, of the pandemic's impact on Medicaid/CHIP members.
Finding(s)	While the odds of PPD diagnoses did not vary based on the average COVID-19 caseload during the postpartum period, the odds of PPD diagnosis did vary significantly between the 2019 and 2020 cohorts, with higher odds of PPD diagnoses in 2020.
MCQS Goal(s)	Goals 1, 2, 3, 5
Recommendation(s)	HHSC should conduct additional research to identify whether other COVID-related changes in health policy and access to health services, such as increased telehealth availability, were significantly associated with increases in PPD diagnoses and other changes in maternal health and service utilization outcomes among women in Texas Medicaid and CHIP.
Follow-up Actions	HHSC is pursuing data analyses, internally and in partnership with the EQRO, of the pandemic's impact on Medicaid/CHIP members.
Finding(s)	The odds of SMM and (pre)eclampsia were higher among non-Hispanic Black women than non-Hispanic White women, consistent with the broader literature on racial and ethnic disparities in SMM.
MCQS Goal(s)	Goals 1, 2, 3, 6
Recommendation(s)	HHSC and the MCOs should continue efforts to improve the quality of maternal care and access to health services for minority women and women with high-risk pregnancies. One evidence-based approach to care that HHSC could consider is the Centering Pregnancy model, that some other state Medicaid programs have adopted with some success.
Follow-up Actions	The 2024 PIP topic focuses on maternal health care.

Study on Health Disparities in Texas Medicaid Managed Care Programs

Category	Description
Finding(s)	Incomplete sociodemographic information for members limits the ability to identify and tailor interventions. Up to 38 percent of the population in some of the QoC measures for STAR and STAR Kids programs were in the "Other/Unknown" racial and ethnic category. The heterogeneity in the Other/Unknown category poses challenges for identifying race-ethnicity-based differences among members in these groups.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should work with the MCOs to identify the source of missing sociodemographic information in the enrollment files and define a strategy to improve the data quality. The EQRO also suggests defining, pilot-testing, and operationalizing different classifications of ethnic and racial categories to allow for more precise identification of the members that the dataset currently classifies as a homogeneous category.
Follow-up Actions	HHSC continues to improve both data quality of sociodemographic information both in the internal flow of data and the collection of such data. HHSC will be compliant with federal, state, and NCQA definitions of ethnic and racial categories.
Finding(s)	The results of this study suggest the need for more in-depth analyses of QoC disparities by focusing on specific population groups. A narrower focus into specific SDoH dimensions could help HHSC better identify the needs of Medicaid members and improve their quality of care, thus reducing disparities. For example, understanding the relationship between different SDoH dimensions and QoC measures within the rural population can be crucial to improve the design of interventions that address disparities for this group.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	In addition to the current analyses using composite SDoH scores, HHSC should conduct additional analyses on disparities in QoC measures based on SDoH dimensions or variables, such as housing instability, food insecurity, rurality, and access to public transportation. The EQRO recommends that HHSC continue to identify ways to collect detailed and systematic information about specific SDoH for Texas Medicaid enrollees. This approach would help HHSC discern the most relevant issues for different members and prioritize targeted solutions.
Follow-up Actions	Improvements to data reporting would need to be implemented prior to expanding to additional dimensions/variables.
Finding(s)	Non-Hispanic Black members displayed lower compliance rates than non-Hispanic White members for almost all QoC measures. In particular, non-Hispanic Black members had significantly lower odds of compliance with CBP.
MCQS Goal(s)	Goals 1, 2, 5
Recommendation(s)	HHSC should select one or more sociodemographic groups with lower compliance with QoC measures, identify the SDoH-related barriers to care and develop evidence-based intervention strategies to reduce disparities in healthcare quality between members. To accurately analyze disparities by race/ethnicity, sampling strategies for hybrid measures would need to stratify the population by race and ethnic groups and oversample smaller demographic groups. Given the additional burden this may create for MCOs, a viable alternative for the state is to invest in a Health Information Exchange system so that desired data is available and accessible electronically. HHSC should consider working with the MCOs to design and implement focused interventions to improve the effective management of chronic and mental health conditions and healthcare quality for non-Hispanic Black members.
Follow-up Actions	One 2024 PIP is behavioral health related and MCOs may choose to address health disparities in their populations in their PIP interventions.

Category	Description
Finding(s)	The calculation of hybrid HEDIS measures CBP and CDC, relies on medical record data from a random sample of Texas Medicaid members sampled at the MCO level. This approach aligns with NCQA standards; however, it can create challenges when extrapolating results to a non-state level and may lead to the underrepresentation of vulnerable populations.
MCQS Goal(s)	Goals 1, 3, 4
Recommendation(s)	HHSC should consider expanding its data collection structure and integrating Health Information Exchange systems for hybrid measures. This could increase the coverage and accuracy of health quality measures, especially for underrepresented sub-populations.
Follow-up Actions	Improvements to data reporting would need to be implemented prior to integrating HIE systems. HHSC continues to work towards better data reporting.
Finding(s)	This study found that the frequency of compliance on the AWC measure was higher among all other race-ethnicity categories than it was among non-Hispanic White members. Further, compliance increased as the SVI increased. This pattern is at odds with the other QoC measures, for which higher vulnerability is associated with lower compliance.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should conduct additional studies of patterns of compliance on the AWC measure. HHSC should focus on identifying whether the pattern revealed in this study reflects more complex healthcare needs among vulnerable members rather than the better quality of care they receive.
Follow-up Actions	HHSC is having ongoing discussions with MCOs to ensure that race/ethnicity is captured appropriately in the data. These discussions occur in the quarterly MCO Quality meetings and will be further discussed at the HHSC Quality Forum in February 2024.
Finding(s)	QoC measures reflect differences in patients' needs and differences in access to and the provision of healthcare. This study revealed significant disparities in QoC measure results based on the SVI score and sociodemographic category, with increased disparity among members with higher SVI scores. SDoH impacts people's healthcare needs and healthcare-seeking behavior, but it may also affect how healthcare providers meet patients' needs and manage their care.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should conduct a more in-depth examination of how SDoH affects access to and the provision of care, including the interaction between healthcare workers and beneficiaries, and the management of routine activities such as contacting and monitoring patients for scheduling follow-up visits and managing care. HHSC should also work with the MCOs to develop methods to identify and share MCO and provider best practices for a) collecting systematic data on SDoH, b) addressing SDoH-related disparities and barriers to healthcare provision, c) identifying resources that could facilitate the management of healthcare for HHSC beneficiaries across the social vulnerability spectrum.
Follow-up Actions	HHSC has developed an NMDOH Action Plan to develop methods to identify and share MCO provider best practices.

Category	Description
Finding(s)	While this study identified some of the associations between SDoH (as measured through SVI), examining the causal relationships between SDoH dimensions and quality of healthcare is essential to identify what the healthcare system needs to address and to develop evidence-based strategies for reducing SDoH-related disparities.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should consider utilizing methods that allow for causal inference in more studies on the effects of SDoH on the quality of healthcare. For example, HHSC could pilot specific training programs for healthcare workers to meet SDoH-related needs by randomly selecting from its partnering providers. Similarly, it could test alternative approaches to meet SDoH-related member needs through experimental and quasi-experimental program evaluation designs, such as the provision of vouchers (randomized or staggered) to improve housing conditions or access to transportation and monitoring improvements in QoC measures
Follow-up Actions	HHSC reviewed an EQRO issue brief that describes how the state might work towards making the performance improvement projects (PIPs) better suited for causal inferences. HHSC continues to explore how we can work towards this goal in the future.

Study on Rider 36

Category	Description
Finding(s)	States employ a variety of practices to oversee the Medicaid MCO appeal process. Starting in 2020, Texas required MCOs to submit more details of the appeals data, which will allow Texas to conduct and report more in-depth summaries of MCO appeals data (HHSC, 2022c, Chapter 24.5.6). However, some states reportedly conduct more in-depth studies to improve MCO reporting of appeal data, validate MCO-reported data, and identify the types of services denied and reasons for the denials (Qlarant, 2021a, 2021c).
MCQS Goal(s)	Goals 1, 4, 5
Recommendation(s)	HHSC should consider conducting a more in-depth review of the updated MCO-reported quarterly appeals data to identify the most common types of services denied and overturned upon member appeal and the reason for the denials. This approach will allow a more meaningful interpretation of the appeals and SFH outcomes. HHSC should calculate the number of appeals per 1,000 members to compare the number of appeals between MCOs. This approach should enable meaningful comparisons of how outcomes of the appeals process related to the volume of appeals in relation to MCO size. HHSC should consider identifying how the impact of the appeals and SFH process and decisions impact member satisfaction.
Follow-up Actions	Rider 36 was focused on beginning this and will be reported to the legislature.
Finding(s)	The EQRO reviewed seven years of MCO-reported appeals data for this report and identified opportunities for improvement in MCO reporting. The EQRO identified data discrepancies in the MCOs' first data submission and provided each MCO with a detailed summary of the discrepancies and the exact information that needed to be corrected. However, almost all MCOs resubmitted the appeal data with outstanding data discrepancies across all measurement years. As a result, not all the findings in this report related to the outcomes of appeals and SFH requests accurately reflect the true percentages of outcomes.
MCQS Goal(s)	Goals 1, 4, 5
Recommendation(s)	HHSC should work with the MCOs to improve their data reporting to ensure accurate data reporting. HHSC should conduct a record review of a random sample of MCO appeals documentation to validate the quarterly MCO-reported appeals data.
Follow-up Actions	Rider 36 was focused on beginning this and will be reported to the legislature.

Category	Description
Finding(s)	MCOs had high compliance with the federal regulations for the appeals process. However, HealthSpring and Superior were not fully compliant with all regulations related to the timeliness of the review process. In addition, Aetna, CookCHP, HealthSpring, Superior, and UHC were not fully compliant with all the regulations related to the notification process for denials. Further, the compliance review results are based on MCO documentation in the policies and procedures. Therefore, the results do not indicate how often and to what extent each MCO meets the requirements of the regulations in practice.
MCQS Goal(s)	Goals 1, 4, 5
Recommendation(s)	MCOs that are not fully compliant with all applicable regulations for the appeals process should update all policies and procedures to ensure full compliance with the timeliness of the review and notification of denials. HHSC should conduct a record review of the MCO universe of appeals documentation to identify the extent to which MCOs comply with the regulations in practice and compliance levels determined based on the current document review of MCO policies and procedures.
Follow-up Actions	Rider 36 was focused on beginning this and will be reported to the legislature.

Protocol 10: Assist with Quality Rating of MCOs

No recommendations.

References

3M Health Information Services. (2016). 3M solutions for potentially preventable events. 3M Health Information Services. http://multimedia.3m.com/mws/media/855236O/3m-ppe-solutions-fact-sheet.pdf

3M Health Information Systems. (2018). Population health and potentially preventable events. https://multimedia.3m.com/mws/media/784213O/population-health-and-potentially-preventable-events-eguide.pdf

ACOG. (2023). Extend Postpartum Medicaid Coverage. ACOG Policy Priorities. https://www.acog.org/advocacy/policy-priorities/extend-postpartum-medicaid-coverage

ACOG, Kilpatrick, S. K., & Ecker, J. L. (2016). Severe maternal morbidity: Screening and review. American Journal of Obstetrics and Gynecology, 215(3), B17-22. https://doi.org/10.1016/j.ajog.2016.07.050

ADA. (2023). Dental Quality Alliance™ (DQA). https://www.ada.org/resources/research/dental-quality-alliance

Adams, J. L. (2009). The Reliability of Provider Profiling: A Tutorial. NCQA.

AHRQ. (2023a). Inpatient Quality Indicators Overview. AHRQ - Quality Indicators. https://www.qualityindicators.ahrq.gov/Modules/iqi_resources.aspx

AHRQ. (2023b). Pediatric Quality Indicators Overview. https://www.qualityindicators.ahrq.gov/Modules/pdi_resources.aspx

AHRQ. (2023c). Prevention Quality Indicators Overview. https://www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx

Baker, J. M., Grant, R. W., & Gopalan, A. (2018). A systematic review of care management interventions targeting multimorbidity and high care utilization. BMC Health Services Research, 18(1), 65. https://doi.org/10.1186/s12913-018-2881-8

Bland, C., Zuckerbraun, S., Lines, L. M., Kenyon, A., Hinsdale-Shouse, M., Hendershott, A., Sanchez, R., Allen, R., Djangali, A. L., Kinyara, E., Kline, T., & Butler, J. (2022). Challenges Facing CAHPS Surveys and Opportunities for Modernization. RTI Press. http://www.ncbi.nlm.nih.gov/books/NBK592584/

Byrd, V., Nysenbaum, J., & Lipson, D. (2013). Encounter Data Toolkit. Mathematica Policy Research. https://www.medicaid.gov/medicaid/downloads/medicaid-encounter-data-toolkit.pdf

CAHPS. (2022). Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 2022 Virtual Research Meeting Summary: Assessing Patient Experience for Insights into Enhancing Equity in Healthcare. https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/news-and-events/events/webinars/cahps-virtual-research-meeting-summary_2022.pdf

CAHPS Consortium. (2020). Instructions for Analyzing Data from CAHPS Surveys in SAS. https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/helpful-resources/analysis/2020-instructions-for-analyzing-data.pdf

CDC. (2023). CDC WONDER [dataset]. https://wonder.cdc.gov/

CMS. (2012a). EQR Protocol 3 Validation of performance improvement projects (PIPs). Centers for Medicare & Medicaid Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf

CMS. (2012b). EQR Protocol 4 Validation of Encounter Data Reported by the MCO. Centers for Medicare & Medicaid Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-4.pdf

CMS. (2019). CMS External Quality Review (EQR) Protocols. https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf

CMS. (2023a). CMS External Quality Review (EQR) Protocols. https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf

CMS. (2023b). Medicare 2023 Part C & D Star Ratings Technical Notes. https://www.cms.gov/files/document/2023-star-ratings-technical-notes.pdf

CMS. (2016, September 20). QAPI Description and Background. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapidefinition

CMS. (2021, June 21). New Medicaid and CHIP Enrollment Snapshot Shows Almost 10 million Americans Enrolled in Coverage During the COVID-19 Public Health Emergency | CMS. CMS Newsroom. https://www.cms.gov/newsroom/press-releases/new-medicaid-and-chip-enrollment-snapshot-shows-almost-10-million-americans-enrolled-coverage-during

CMS. (2023c). Adult Health Care Quality Measures. Medicaid.Gov. https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-core-set/index.html

CMS. (2023d). Children's Health Care Quality Measures. Medicaid.Gov. https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set/index.html

Dudensing, J. (2016, June 16). Senate Bill 760 Public Stakeholder Forum [Public Forum]. https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/sb760/tahp-presentaation-medicaid-network-adequacy.pdf

Frew et al. V. Phillips et al., (U.S. District Court Eastern District of Texas 1996). https://hhs.texas.gov/laws-regulations/legal-information/frew-et-al-v-phillips-et-al

HHSC. (2023a). Uniform Managed Care Terms & Conditions. https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf

HHSC. (2023b). Texas Medicaid and CHIP - Uniform Managed Care Manual | Texas Health and Human Services. https://www.hhs.texas.gov/services/health/medicaid-chip/managed-care-contract-management/texas-medicaid-chip-uniform-managed-care-manual

Inovalon. (2022, September 29). QSI-XL® Quality Measurement and Reporting Solution Overview. https://www.inovalon.com/resource/qsi-xl-overview/

KFF. (2023). Medicaid and CHIP Monthly Enrollment. https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

KFF. (2024). Medicaid and CHIP Monthly Enrollment. State Health Facts. https://www.kff.org/other/state-indicator/medicaid-and-chip-monthly-enrollment/

Kim, P. C., Zhou, W., McCoy, S. J., McDonough, I. K., Burston, B., Ditmyer, M., & Shen, J. J. (2019). Factors associated with preventable emergency department visits for nontraumatic dental conditions in the U.S. International Journal of Environmental Research and Public Health, 16(19), 3671. https://doi.org/10.3390/ijerph16193671

NAMD. (2015). Policy Brief - State Medicaid Directors Driving Innovation: Payment Reform. National Association of Medicaid Directors. https://medicaiddirectors.org/wp-content/uploads/2015/08/policybrief1_072012final.pdf

NCQA. (2023). HEDIS and Performance Measurement. NCQA. https://www.ncqa.org/hedis/

The Joint Commission. (2022, September 6). Perinatal Care PC-02 (v2022B2). Specifications Manual for Joint Commission National Quality Measures (v2022B2). https://manual.jointcommission.org/releases/TJC2022B2/MIF0167.html

Williams, E., Hinton, E., Rudowitz, R., & Mudumala, Anna. (2023, November 14). Medicaid Enrollment and Spending Growth Amid the Unwinding of the Continuous Enrollment Provision: FY 2023 & 2024. KFF. https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-spending-growth-amid-the-unwinding-of-the-continuous-enrollment-provision-fy-2023-2024/

Appendices

Appendix A: 3M™ Clinical Risk Group Classification

The 3M™ Clinical Risk Groups (CRG) classification system describes the health status and burden of illness of individuals in a population. The CRG system, a categorical clinical model, classifies each member of the population based on their burden of medical conditions, assigning each to a single mutually exclusive risk category. The system classifies individuals based on one or more chronic conditions or combinations of conditions, with breakouts for condition-specific severity of illness, and for individuals without a chronic condition, by one or more significant acute illnesses or other significant health events, such as delivery or newborn birth. Those without a chronic or significant acute condition are in various groups for "healthy." The CRG system stratifies populations for risk adjustment, predicting healthcare utilization and cost, tracking health outcomes, and analyzing the health of populations. Grouping assigns individuals to nine status categories[13]

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

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

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

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

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

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

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

Status 2 – *History of Significant Acute Disease*.[14]

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

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

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

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:

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

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

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

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

Medical Encounter Header Key Fields

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

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

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

Medical Encounter Detail Key Fields

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

Pharmacy Encounter Key Fields

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

Appendix C: Present on Admission (POA) Screening Criteria

Primary Diagnosis POA Codes

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

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

Secondary Diagnoses POA Codes

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

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

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

HEDIS Effectiveness of Care

A - Calculated using administrative data; H - Calculated using HEDIS hybrid methodology C - Combined weighted calculation for CMS reporting only
Red signals a new measures or changes in reporting.
[a] MDCP = STAR Kids MDCP, SMI = STAR+PLUS Severe Mental Illness, Mat = Pregnant during the MY, HTW = Healthy Texas Women
[b] Included on the HHSC performance dashboard
[CA] CMS adult core measure; [CC] CMS child core measure; [CB] both CMS child and adult core measure

Prevention & Screening

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

Respiratory Conditions

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

Cardiovascular Conditions

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

Diabetes

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a]
HBD	HbA1c Control for Patients w/ Diabetes (Replaces CDC HbA1c)	-	H[b]	H[b]	-	-	-	C[CA]	-
EED	Eye Exam (Replaces CDC Eye Exam)	-	A[b]	A[b]	-	-	A	A	SMI, Mat
KED	Kidney Health Evaluation for Patients w/ Diabetes	-	A	A	-	-	A	A	
SPD	Statin Therapy for Patients w/ Diabetes	-	A	A[b]	-	-	A	A	SMI

Behavioral Health

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

Overuse/Appropriateness

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

HEDIS Access/Availability of Care

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

Red signals a new measures or changes in reporting.

[a] MDCP = STAR Kids MDCP, SMI = STAR+PLUS Severe Mental Illness, Mat = Pregnant during the MY, HTW = Healthy Texas Women

[b] Included on the HHSC performance dashboard

[CA] CMS adult core measure; [CC] CMS child core measure; [CB] both CMS child and adult core measure

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

HEDIS Utilization & Risk Adjusted Utilization

A - Calculated using administrative data.

Red signals a new measures or changes in reporting.

[a] MDCP = STAR Kids MDCP, SMI = STAR+PLUS Severe Mental Illness, Mat = Pregnant during the MY, HTW = Healthy Texas Women

[b] Included on the HHSC performance dashboard

[CA] CMS adult core measure; [CC] CMS child core measure; [CB] both CMS child and adult core measure

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a]
W30	Well-Child Visits in the First 30 Months of Life	A[b]	A[b]	-	A[b]	A[b]	A	A[CC]	MDCP
WCV	Child & Adolescent Well-Care Visits	A[b]	A[b]	-	A[b]	A[b]	A	A[CC]	MDCP
AMB	Ambulatory Care	A	A	A	A	A	A	A[CC]	MDCP, SMI, Mat
IPU	Inpatient Utilization–General Hospital/Acute Care	A	A	A	-	A	A	A	MDCP, SMI, Mat
~~IAD~~	~~Ident. of Alcohol & Other Drug Services~~ (DISCONTINUED)	-	-	-	-	-	-	-	-
~~MPT~~	~~Mental Health Utilization~~ (DISCONTINUED)	-	-	-	-	-	-	-	-
AXR	Antibiotic Utilization for Respiratory Conditions	A	A	A	A	A	A	A	MDCP, SMI, Mat
PCR	Plan All-Cause Readmission	-	A[b]	A[b]	-	A	A	A	MDCP, SMI, Mat

HEDIS Measures Reported Using Electronic Clinical Data Systems

E - Calculated using ECDS

Red signals a new measures or changes in reporting.

[a] MDCP = STAR Kids MDCP, SMI = STAR+PLUS Severe Mental Illness, Mat = Pregnant during the MY, HTW = Healthy Texas Women

[b] Included on the HHSC performance dashboard

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a]
CIS-E	Childhood Immunization Status	E	E		E	E	E	E	
IMA-E	Immunizations for Adolescents	E	E		E	E	E	E	
BCS-E	Breast Cancer Screening		E	E			E	E	
COL-E	Colorectal Cancer Screening		E	E			E	E	
ADD-E	Follow-Up Care for Children Prescribed ADHD Medication	E	E		E	E	E	E	

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a]
APM-E	Metabolic Monitoring for Children & Adolescents on Antipsychotics	E	E		E	E	E	E	
DSF-E	Depression Screening & Follow-Up for Adolescents & Adults		E	E				E	
DMS-E	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents & Adults		E	E				E	
AIS-E	Adult Immunization Status		E	E			E	E	
PRS-E	Prenatal Immunization Status	E	E	E	E	E	E	E	

HHSC Maternal Health Measures

I = Calculated by the EQRO

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

AHRQ Quality Indicators – Area Measures

A = Calculated using administrative data

[a] Included on the HHSC performance dashboard

[CA] CMS adult core measure; [CC] CMS child core measure; [CB] both CMS child and adult core measure

Prevention Quality Indicators (PQIs)

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

Pediatric Quality Indicators (PDIs)

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

Other CHIPRA Core & CMS Adult Core Measures

A - Calculated using administrative data; T – Provided by HHSC

Red signals new measures or changes in reporting.

[a] MDCP = STAR Kids MDCP, SMI = STAR+PLUS Severe Mental Illness, Mat = Pregnant during the MY, HTW = Healthy Texas Women

[b] Included on the HHSC performance dashboard

[CA] CMS adult core measure; [CC] CMS child core measure; [CB] both CMS child and adult core measure

Code	Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a].
DEV	Developmental Screening in the First 3 Years of Life	A[b]	A[b]		A[b]	A[b]	A	A[CC]	MDCP
CCP	Contraceptive Care - Postpartum Women	-	A	A	A	A	A	A[CB]	-
CCW	Contraceptive Care - All Women	-	A	A	A	A	A	A[CB]	HTW
COB	Concurrent Use of Opioid and Benzodiazepines	-	A	A	-	A	A	A[CA]	-
LBW	Low Birth Weight Infants	-	T[b]	T	T	T	T	T[CC]	-
HLV	HIV Viral Suppression	T	T[b]	T[b]	T	T[b]	T	T[CA]	-
HPCMI	Diabetes Care for People w/ Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)							H[CA]	

3M Health Information Systems Measures of PPEs

A - Calculated using administrative data

[a] Included on the HHSC performance dashboard

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

Dental Quality Measures

A = Calculated using administrative data

Red signals a new measures or changes in reporting.

[CA] CMS adult core measure; [CC] CMS child core measure; [CB] both CMS child and adult core measure

Quality of Care

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

Preventive Dental Services

Type	Annual Dental Visits (ADV) Submeasure	CMDS	CHIP Dental
PDENT	CMS PDENT-CH - % of members, aged 1 yr. and older, enrolled for 90 days who had at least one preventive dental service during the federal fiscal year	A	A
THSteps	THSteps Care Measures a) Percent of members (aged 1 to 20 years) receiving exactly one THSteps Dental Checkup per year b) Percent of members (aged 1 to 20 years) receiving at least two THSteps Dental Checkup per year Combined Rate=0.5*rate of one checkup + Rate of at least two checkups Based on recommended standards of THSteps dental checkup visits (2 visits per year), the sub-measure of one checkup will receive 50% of the weight of the sub-measure of at least two checkups.	A	-
THSteps	% Of members (aged 1 to 20 years) receiving more than two THSteps Dental Checkups per year	A	-
THSteps	% Of new members (aged 1 to 20 years) receiving at least one THSteps Dental Checkup w/in 90 days of enrollment	A	-
DQA	Oral Evaluation - % of members enrolled for at least 6 months who received a comprehensive or periodic oral evaluation w/in the reporting year	A[CC]	A[CC]
DQA	Topical Fluoride - % of enrolled children who received at least two topical fluoride applications s as (a) dental OR oral health services, (b) dental services, and (c) oral health services within the reporting year	A[CC]	A[CC]
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[CC]	A[CC]
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

Continuity of Care

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

DQA Measures

A - Calculated using administrative data

Utilization of Dental Services

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

Emergency Department Visits for Dental Caries

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

CAHPS Health Plan Survey 5.0H Experience of Care

S(A) - Conducted annually; S(B) - Conducted biennially

Red indicates a new measure or change in reporting

[a] CPA = Adult Version, CPC = Child Version, CCC = Child Version with Children with Chronic Conditions

[b] Only on the CMS Core Survey

[c] Included on the HHSC performance dashboard

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

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

CAHPS Health Plan Survey 5.0H Effectiveness of Care (HEDIS) and Supplemental Measures

S(A) - Conducted annually; S(B) - Conducted biennially

[a] Only on the CMS Core Survey

[b] Included on the HHSC performance dashboard

HEDIS Code	Measure	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	Medicaid Statewide[a]	CHIP Statewide[a]
MSC	Medical Assistance w/ Smoking Cessation and Tobacco Use	-	-	-	-	-	S (A)	-
FVA	Flu Vaccinations for Adults Ages 18-64	-	-	-	-	-	S (A)	-
	% Good access to behavioral health treatment or counseling	-	-	S (B)[b]	-	-	-	-
	% Good access to special therapies	-	-	S (B)[b]	-	-	-	-
	% w/ Good access to service coordination	-	-	S (B)[b]	-	S (B)	-	-

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

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

Use of Consumer Directed Services Reported by MCOs

T - Calculated by HHSC

[a] Included on the HHSC performance dashboard

[b] HCBS = home and community-based services

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

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

These Potentially Preventable Complications (PPC) definitions are Extracted from the 3M™ Potentially Preventable Complications (PPC) Classification System Methodology Overview[15].

Major PPC Groups

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

PPC Level Descriptions

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

[15] v37. Copyright 2008–2019, 3M. All rights reserved. GRP-381 October 2019

PPC Categories with Group and Weight

PPC Category	PPC Description	PPC Group	HCUP PPC Weight V39
1	Stroke & Intracranial Hemorrhage	2	1.1829
2	Extreme CNS Complications	1	0.5037
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	2	0.5139
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1	1.6145
5	Pneumonia & Other Lung Infections	2	1.7064
6	Aspiration Pneumonia	2	1.0038
7	Pulmonary Embolism	2	1.2358
8	Other Pulmonary Complications	2	0.9566
9	Shock	1	1.2256
10	Congestive Heart Failure	2	0.3772
11	Acute Myocardial Infarction	2	0.3607
13	Other Acute Cardiac Complications	2	0.3879
14	Ventricular Fibrillation/Cardiac Arrest	1	0.5545
15	Peripheral Vascular Complications except Venous Thrombosis	2	2.3470
16	Venous Thrombosis	2	1.7151
17	Major Gastrointestinal Complications without Transfusion	3	1.6711
18	Major Gastrointestinal Complications with Transfusion	3	1.6138
19	Major Liver Complications	3	0.9621
20	Other Gastrointestinal Complications	3	1.0094
21	Clostridium Difficile Colitis	5	1.6334
22	This category intentionally excluded. Category 22 was retired and Categories 65 and 66 were added.	x	x
23	Genitourinary Complications Except Urinary Tract Infection	8	0.8271
24	Renal Failure without Dialysis	8	0.5184
25	Renal Failure with Dialysis	1	3.0506
26	Diabetic Ketoacidosis & Coma	8	0.3886
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	8	1.0237
28	In-Hospital Trauma and Fractures	8	0.3585
29	Poisonings except from Anesthesia	6	0.1597
30	Poisonings due to Anesthesia	6	
31	Pressure Ulcer	8	3.8489
32	Transfusion Incompatibility Reaction	6	0.7719
33	Cellulitis	5	1.1183
34	Other Infections	5	1.8103
35	Septicemia & Severe Infections	5	1.5687
36	Acute Mental Health Changes	8	0.3851
37	Post-Procedural Infection & Deep Wound Disruption Without Procedure	4	1.7440

PPC Category	PPC Description	PPC Group	HCUP PPC Weight V39
38	Post-Procedural Wound Infection & Deep Wound Disruption with Procedure	4	2.3201
39	Reopening Surgical Site	4	1.7059
40	Peri-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Procedure	4	0.8830
41	Peri-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Procedure	4	1.0406
42	Accidental Puncture/Laceration during Invasive Procedure	4	0.5967
44	Other Surgical Complication - Moderate	8	1.8157
45	Post-Procedural Foreign Bodies and Substance Reaction	4	1.0862
47	Encephalopathy	8	0.8728
48	Other Complications of Medical Care	8	2.1522
49	Iatrogenic Pneumothorax	6	0.4893
50	Mechanical Complication of Device, Implant & Graft	6	1.5543
51	Gastrointestinal Ostomy Complications	6	2.5496
52	Infection, Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection	6	1.4344
53	Infection, Inflammation and Clotting complications of Peripheral Vascular Catheters and Infusions	6	0.8226
54	Central Venous Catheter-Related Infection	6	3.8416
59	Medical & Anesthesia Obstetric Complications	7	0.1503
60	Major Puerperal Infection and Other Major Obstetric Complications	7	0.9313
61	Other Complications of Obstetrical Surgical & Perineal Wounds	7	0.2131
63	Post-Procedural Respiratory Failure with Tracheostomy	1	8.7896
64	Other In-Hospital Adverse Events	8	
65	Urinary Tract Infection	5	0.8816
66	Catheter-Related Urinary Tract Infection	5	0.9697

Appendix F: Measures Used in Report Card Rating Calculations

Measure Sources

Report card measures come from three major sources:

1. CAHPS® - Consumer Assessment of Healthcare Providers and Systems,
2. HEDIS® - Healthcare Effectiveness Data and Information Set – reported in Quality of Care (QoC) tables
3. HEART,[16] OMCAT,[17] and MCO Self-Reported complaints files provided through DAP[18]

Measures Used in STAR Child Report Cards

Experience with the Health Plan Domain

Report Card Text	Specification	Data Source
Parents give high ratings to the health plan	CAHPS *Rating of Health Plan*	MY 2023 STAR Child Caregiver Annual Report Card Survey
Fewest complaints about the health plan	Member and provider complaints about the health plan, any source	MY 2022 HEART, OMCAT, and MCO reported complaints data

Experience of Care Domain

Report Card Text	Specification	Data Source
Children get care as soon as they need it	CAHPS *Getting Care Quickly*	MY 2023 STAR Child Caregiver Annual Report Card Survey
Doctors listen carefully, explain clearly and spend enough time with people	CAHPS *How Well Doctors Communicate*	MY 2023 STAR Child Caregiver Annual Report Card Survey
Parents give high ratings to their child's personal doctor	CAHPS *Rating of Personal Doctor*	MY 2023 STAR Child Caregiver Annual Report Card Survey

Staying Healthy Domain

Report Card Text	Specification	Data Source
Babies and toddlers get regular checkups	HEDIS *Well-Child Visits in the First 30 Months of Life (W30)*, composite of 0-15- and 15-30-month rates	MY 2022 STAR QoC Tables
Children and teens get regular checkups	HEDIS *Child and Adolescent Well-Care Visits (WCV)*, a composite of 3-11 and 12-17 rates	MY 2022 STAR QoC Tables
Children and teens get their vaccines	Composite: HEDIS *Childhood Immunization Status (CIS), Combination 10*; HEDIS *Immunizations for Adolescents (IMA), Combination 2*	MY 2022 STAR QoC Tables

Common Chronic Conditions Domain

Report Card Text	Specification	Data Source
Children get medicine for asthma	HEDIS *Asthma Medication Ratio (AMR)*, ages 5-18 combined	MY 2022 STAR QoC Tables
Children see the doctor for ADHD (Attention Deficit Hyperactivity Disorder)	HEDIS *Follow-Up Care for Children Prescribed ADHD Medication (ADD), initiation phase*	MY 2022 STAR QoC Tables

[16] https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/hpm-complaint-process.pdf
[17] https://www.hhs.texas.gov/sites/default/files/documents/ombudsman-managed-care-assistance-team-fy2023-q1.pdf
[18] HHSC Office of Data, Analytics, and Performance

Measures Used in the STAR Adult Report Cards

Experience with the Health Plan Domain

Report Card Text	Specification	Data Source
People give high ratings to the health plan	CAHPS *Rating of Health Plan*	MY 2023 STAR Adult Member Annual Report Card Survey
Fewest complaints about the health plan	Member and provider complaints about the health plan, any source	MY 2022 HEART, OMCAT, and MCO reported complaints data

Experience of Care Domain

Report Card Text	Specification	Data Source
People get the care they need without problems or long waits	Composite: CAHPS *Getting Care Quickly*; CAHPS *Getting Needed Care*	MY 2023 STAR Adult Member Annual Report Card Survey
Doctors listen carefully, explain clearly and spend enough time with people	CAHPS *How Well Doctors Communicate*	MY 2023 STAR Adult Member Annual Report Card Survey
People give high ratings to their personal doctor	CAHPS *Rating of Personal Doctor*	MY 2023 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*	MY 2022 STAR QoC Tables
New mothers get checkups after giving birth	HEDIS *Prenatal and Postpartum Care (PPC), postpartum care*	MY 2022 STAR QoC Tables
People get regular yearly checkups	HEDIS *Adults' Access to Preventive/Ambulatory Health Services (AAP)*	MY 2022 STAR QoC Tables
Women get regular screenings for cervical cancer	HEDIS *Cervical Cancer Screening (CCS)*	MY 2022 STAR QoC Tables

Common Chronic Conditions Domain

Report Card Text	Specification	Data Source
People get care for depression and other mental conditions	Composite: HEDIS *Antidepressant Medication Management (AMM), acute phase*; HEDIS *Follow-Up After Hospitalization for Mental Illness (FUH), 7-Day*	MY 2022 STAR QoC Tables
People get care for diabetes	Composite: HEDIS *Kidney Health Evaluation for Patients with Diabetes (KED)*; HEDIS *Eye exam (retinal) performed (EED)*	MY 2022 STAR QoC Tables

Measures Used in the STAR+PLUS Report Cards

Experience with the Health Plan Domain

Report Card Text	Specification	Data Source
People give high ratings to the health plan	CAHPS *Rating of Health Plan*	MY 2023 STAR+PLUS Member Annual Report Card Survey
Fewest complaints about the health plan	Member and provider complaints about the health plan, any source	MY 2022 HEART, OMCAT, and MCO reported complaints data

Experience of Care Domain

Report Card Text	Specification	Data Source
People get the care they need without problems or long waits	Composite: CAHPS *Getting Care Quickly*; CAHPS *Getting Needed Care*	MY 2023 STAR+PLUS Member Annual Report Card Survey
Doctors listen carefully, explain clearly and spend enough time with people	CAHPS *How Well Doctors Communicate*	MY 2023 STAR+PLUS Member Annual Report Card Survey
People give high ratings to their personal doctor	CAHPS *Rating of Personal Doctor*	MY 2023 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)*	MY 2022 STAR+PLUS QoC Tables
Women get regular screenings for breast and cervical cancer	Composite: HEDIS® Breast Cancer Screening (BCS); HEDIS® Cervical Cancer Screening (CCS)	MY 2022 STAR+PLUS QoC Tables

Common Chronic Conditions Domain

Report Card Text	Specification	Data Source
People get care for depression and other mental conditions	Composite: HEDIS *Antidepressant Medication Management (AMM), acute phase*; HEDIS *Follow-Up After Hospitalization for Mental Illness (FUH), 7-Day*	MY 2022 STAR+PLUS QoC 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*	MY 2022 STAR+PLUS QoC 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)*.	MY 2022 STAR+PLUS QoC Tables
People get care for diabetes	Composite: HEDIS *Kidney Health Evaluation for Patients with Diabetes (KED)*; HEDIS *Eye exam (retinal) performed (EED)*	MY 2022 STAR+PLUS QoC Tables

Measures Used in the STAR Kids Report Cards

Experience with the Health Plan Domain

Report Card Text	Specification	Data Source
Parents give high ratings to the health plan	CAHPS *Rating of Health Plan*	MY 2023 STAR+PLUS Member Annual Report Card Survey
Fewest complaints about the health plan	Member and provider complaints about the health plan, any source	MY 2022 HHSC / health plans / ombudsman data

Getting Care Domain

Report Card Text	Specification	Data Source
People get the care they need without problems or long waits	Composite: CAHPS *Getting Care Quickly*; CAHPS *Getting Needed Care*	MY 2023 STAR Kids Caregiver Annual Report Card Survey
People get regular checkups	HEDIS *Child and Adolescent Well-Care Visits (WCV)*, a composite of 3-11 and 12-17 rates	MY 2022 STAR Kids QoC Tables
People get special therapy easily	CAHPS *Getting Specialized Services* component	MY 2023 STAR Kids Caregiver Annual Report Card Survey
People get prescription medicines easily	CAHPS *Getting Prescription Medicine*	MY 2023 STAR Kids Caregiver Annual Report Card Survey

Services and Support Domain

Report Card Text	Specification	Data Source
People get help arranging or coordinating care	National Survey of Children's Health K5Q20_R, part of Indicator 4.12e *Effective care coordination*	MY 2023 STAR Kids Caregiver Annual Report Card Survey
Doctors and other health providers answer questions	CAHPS *Family Centered Care: Getting Needed Information*	MY 2023 STAR Kids Caregiver Annual Report Card Survey
Doctors discuss eventual transition to adult care for adolescents (12–17)	National Survey of Children's Health TREATADULT, part of Indicator 4.15 *Transition to adult health care, age 12-17 years*	MY 2023 STAR Kids Caregiver Annual Report Card Survey

Mental and Behavioral Health Domain

Report Card Text	Specification	Data Source
People get emotional and behavioral counseling easily	Component of CAHPS® Getting Specialized Services	MY 2023 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*	MY 2022 STAR Kids QoC Tables
Health monitoring for people using antipsychotics	HEDIS *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)*	MY 2022 STAR Kids QoC Tables