TEXAS
Health and Human Services

External Quality Review of Texas Medicaid & CHIP Managed Care

Summary of Activities Report

State Fiscal Year 2021

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

4900 N LAMAR BLVD, AUSTIN, TX 78751-02316
PH: (512) 424-6500 WEB: HHS.TEXAS.GOV

EQRO
Texas External Quality Review Organization

Table of Contents

Table List

Figure List

Abbreviations

Abbreviation	Definition
ACOG	American College of Obstetricians and Gynecologists
ADA	American Dental Association
ADHD	attention-deficit hyperactivity disorder
Aetna	Aetna Better Health
AFC	adult foster care
AHRQ	Agency for Healthcare Research and Quality
AI	administrative interview
AIM	Alliance for Innovation on Maternal Health
ALF	assisted living facility
APM	alternative payment model
APR-DRG	(3M™) All Patient Refined Diagnosis-Related Groups
BCBSTX	Blue Cross Blue Shield of Texas
BCCS	Breast and Cervical Cancer Services
BHI	behavioral health integration
C-section	cesarean section
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCC	Children with Chronic Conditions
CCHP	Cook Children's Health Plan
CDC	Centers for Disease Control and Prevention
CFHP	Community First Health Plans
CHC	Community Health Choice
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMCHP	Children's Medical Center Health Plan
CMDS	Children's Medicaid Dental Services
CMS	Centers for Medicare and Medicaid Services
COVID-19	coronavirus disease of 2019
CRA	caries risk assessment
CRG	(3M™) Clinical Risk Group
DCHP	Dell Children's Health Plan

Abbreviation	Definition
DM	disease management
DMO	dental maintenance organization
DOS	date of service
DQA	Dental Quality Alliance
Driscoll	Driscoll Health Plan
DSHS	Department of State Health Services
EAPG	(3M™) Enhanced Ambulatory Patient Groups
ED	emergency department
EDVMRR	encounter data validation: medical record review
EHR	electronic health record
EQR	external quality review
EQRO	external quality review organization
FFCRA	Families First Coronavirus Response Act
FFS	(traditional Medicaid) fee-for-service
FirstCare	FirstCare Health Plans
FMAP	Federal Medical Assistance Percentage funding
FSR	financial statistical report
HCBS	home and community-based services
HealthSpring	Cigna-HealthSpring
HEDIS®	Healthcare Effectiveness Data and Information Set
HEDIS® PPC	HEDIS Prenatal and Postpartum care measure
HHS	U.S. Department of Health and Human Services
HHSC	(Texas) Health and Human Services Commission
HPV	human papillomavirus
ISCA	Information Systems Capabilities Assessment
ISP	individual service plans
JIP	joint interface plan
LMHA	Local Mental Health Authority
LTSS	Long-Term Services and Supports
MBCC	Medicaid for Breast and Cervical Cancer Program

Abbreviation	Definition
MCNA	MCNA Dental
MCO	managed care organization
MCQS	(Texas) Managed Care Quality Strategy
MDCP	Medically Dependent Children Program
MLTSS	Managed Long-Term Services and Supports
MMP	Medicare-Medicaid Plan
Molina	Molina Healthcare of Texas
MRSA	Medicaid Rural Service Area
MTP	Medical Transportation Program
MY	Measurement Year
NAMD	National Association of Medicaid Directors
NCQA	National Committee for Quality Assurance
NEMT	nonemergency medical transportation
NICU	neonatal intensive care unit
NORC	the nonpartisan and objective research organization NORC, at the University of Chicago
NPI	National Provider Identifier
OAP	Pregnancy Associated Outcomes (state measure of severe maternal morbidity)
P4Q	Pay-for-Quality
pandemic	The COVID-19 pandemic that affected Texas during 2020
PCHP	Parkland Community Health Plan
PCP	primary care provider
PDI	(AHRQ) Pediatric Quality Indicator
PDx	primary diagnosis
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
SDoH	social determinants of health
SFY	(Texas) state fiscal year
SHCN	special healthcare needs
SK-SAI	STAR Kids Screening and Assessment Instrument
SMI	serious mental illness
SMM	severe maternal morbidity
SOA	summary of activities
Superior	Superior HealthPlan
SWHP	RightCare from Scott and White Health Plan
TCHP	Texas Children's Health Plan
THLC	Texas Healthcare Learning Collaborative
THSteps	Texas Health Steps
TMHP	Texas Medicaid and Healthcare Partnership
UFSRC	University of Florida Survey Research Center
UHC	UnitedHealthCare Community Plan
UHC Dental	UnitedHealthcare Dental
UMCM	(Texas) Uniform Managed Care Manual
URTI	upper respiratory tract infection

Measurement Years Reflected in EQR Reporting for this SOA

The measurement periods for different EQR activities vary based on the framework used for evaluation. To reduce confusion, the table below lists the measurement span associated with each protocol for the 2021 reporting period.

Protocol	Measurement Years Reported
Protocol 1: Validation of PIPs	*PIP Plans* for SFY 2021 PIPs; *Third Progress Report* for SFY 2019 PIPs; *Final PIP Reports* for SFY 2018 PIPs
Protocol 2: Validation of Performance Measures	*AI Data*: September 2020-August 2021; *MCO Hybrid Measures*: September 2020-August 2021; *THSteps*: Checkups due starting in September 2019
Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations	*AI Interviews*: September 2020- August 2021; *QAPI Evaluations*: September 2020-August 2021
Protocol 4: Validation of Network Adequacy	*Appointment Availability Study*: November 2020-July 2021 *Unmet Need Study:* September 2018-August 2019
Protocol 5: Validation of Encounter Data	*Accuracy and Completeness:* September 2020-August 2021; *EDVMRR:* January 2019-December 2019; *EDVDRR:* January 2019-December 2019
Protocol 6: Administration of Quality of Care Surveys	*STAR Child/CHIP*: October 2020-March 2021; *Dental*: December 2020-May 2021
Protocol 7: Calculation of Performance Measures	January 2020-December 2020
Protocol 9: Conducting Focused Studies of Health Care Quality	Measurement year varies by study, but research conducted between September 2020-August 2021
Protocol 10: Assist with Quality Rating of MCOs	*Performance Dashboards:* January-December 2020; *MCO Report Cards:* Administrative Data from January-December 2020, Survey Data for SFY 2021 (see above), and Complaint data for August 2020-May 2021

Executive Brief

Introduction

More than 70 million Americans receive healthcare coverage through Medicaid and the Children's Health Insurance Program (CHIP), funded jointly by states and the U.S. Department of Health and Human Services (HHS). Texas has one of the largest Medicaid programs in the country, serving well over four million people (CMS, 2021), over 90 percent of whom receive care through a managed care delivery model. Participation in federal funding for managed care programs requires compliance with guidelines and protocols established by the Centers for Medicare and Medicaid Services (CMS), including external quality review by an organization independent from the state. Since 2002, the Institute for Child Health Policy at the University of Florida has been the external quality review organization (EQRO) for Texas Medicaid and CHIP.

The executive brief reviews the activities and findings from the state fiscal year (SFY) 2021 Summary of Activities (SOA) report and highlights key findings from annual EQR activities. The full SOA report, which follows the executive brief is a comprehensive summary of EQR activities from September 1, 2020, through August 31, 2021, including findings from EQR evaluation studies addressing quality of managed care provided to Medicaid and CHIP members. The SOA report is organized based on the current CMS protocols for external quality review (EQR), released in 2019. The report addresses activities related to network adequacy (Protocol 4) and managed care organization (MCO) and dental maintenance organization (DMO) quality rating (Protocol 10), although CMS has not released guidance on these sections as of December 2021. In addition to the SOA report, the EQRO produced plan profiles with MCO-and DMO-specific information from EQR activities for SFY 2021. The annex, associated with this report, contains the individual MCO/DMO profiles.

EQR Activities

Each year, the EQRO follows CMS protocols specified in 42 C.F.R. § 438 (2016) to monitor the utilization, quality, accessibility, and timeliness of medical and behavioral health services that individuals receive in Medicaid and CHIP through MCOs. The EQRO conducts activities that review the delivery of care in the four statewide Medicaid managed care programs – STAR for members needing routine care (primarily including low-income children and pregnant women); STAR+PLUS for adult members who have a disability or are age 65 years or older; STAR Kids for children, adolescents, and young adults with disabilities; STAR Health for members in state conservatorship – and delivery of care in CHIP (entirely managed care). The EQRO also monitors children's dental care through Medicaid and CHIP DMOs. None of the 17 MCOs that serve Medicaid and CHIP members are exempt from EQR in SFY 2021. Annual evaluation activities include:

- Assessment of MCO and DMO structure and process through administrative interview (AI) studies, quality assessment and performance improvement (QAPI) program evaluations, and performance improvement project (PIP) validation studies.
- Surveys with members and caregivers using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey; and appointment availability studies that follow a "secret shopper" method to evaluate the timeliness of appointments against state-specified standards.
- Quality-of-care (QOC) reporting on standardized performance measures, including National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) measures, Agency for Healthcare Research and Quality (AHRQ) quality indicators, 3M™ measures of Potentially Preventable Events (PPEs), and American Dental Association's Dental Quality Alliance (DQA) pediatric measures.

- In-depth studies to address specific topics of importance to Texas, including in-depth quarterly topic reports (QTRs) and a focused study.

The ongoing coronavirus disease of 2019 (COVID-19) pandemic continued to impact EQR activities in SFY 2021, although not to the extent it did in SFY 2020. Two impacts of note for SFY 2021 reporting are the extension of the 2019 and 2020 PIPs (excluding the dental PIPs) and potential pandemic effects on the data used for QOC assessment for measurement year (MY) 2020. The impact of the pandemic varies across EQR activities, so additional information on potential pandemic effects is included as needed in each protocol section of the SOA report.

Quality, Access & Timeliness

In 2019, CMS identified quality, access, and timeliness as key domains for evaluating MCO and DMO performance in EQR activities (CMS, 2019b). This executive brief is structured around these three domains and includes a summary of the activities and findings associated with each domain and suggested areas for improvement. The EQRO used all relevant annual activities to draw conclusions about quality, timeliness, and access to care provided by Texas MCOs and DMOs. The SOA report contains a comprehensive overview of the SFY 2021 EQR activities and the specific methods used to assess each EQR protocol. The associated SOA report annex contains tables with MCO-and DMO-specific results from EQR activities in this reporting cycle.

Quality of Care

Quality of healthcare as it pertains to EQR, means 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 EQRO regularly evaluates MCO and DMO compliance with the state and federal regulations that govern the quality of healthcare for Medicaid and CHIP members as part of the MCO Administrative Interviews (AI), Quality Assurance and Performance Improvement (QAPI) program evaluations, QOC evaluations, and validation of performance measures. In addition, the EQRO validates encounter data provided by MCOs and DMOs and conducts annual and biennial consumer quality-of-care surveys to measure the experiences and satisfaction of adult members and caregivers of child and adolescent members in Medicaid and CHIP.

In SFY 2021, the EQRO conducted several studies that provided information on the quality of maternal healthcare and home- and community-based services (HCBS). The EQRO produced the annual pregnancy associated outcomes (OAP) measure report, which includes measures of severe maternal morbidity (SMM) among all deliveries, among deliveries with hemorrhage, and among deliveries with severe hypertension for women in Medicaid and CHIP. As with prior years, SMM rates in SFY 2020 were consistently higher in STAR than in CHIP Perinatal, most notably in (pre)eclampsia cases. Although the numbers of deliveries are relatively small for the STAR+PLUS and STAR Kids program, the SMM rate in cases of (pre)eclampsia are much higher in these programs that serve members with health complications.

The EQRO also reported the frequency and costs of cesarean section (C-section) deliveries in Medicaid and CHIP during 2020. The overall rate of C-section deliveries in Medicaid and CHIP in 2020 was 34 percent, higher than the 2019 U.S. rate (31.7 percent) reported by the Centers for Disease Control and Prevention (CDC). Although

the rate of C-section deliveries is higher among deliveries with complications, more than 50 thousand C-sections occurred in Medicaid and CHIP deliveries without identified complications.

In SFY 2021, the EQRO also completed the STAR+PLUS HCBS Settings Evaluation Summary in May 2021. This study assessed the compliance of Medicaid assisted living facility (ALF) and adult foster care (AFC) settings with the CMS home- and community-based services (HCBS) settings rule described in 42 C.F.R. § 441.301 (2014). The CMS HCBS settings rule requires HCBS settings to have qualities that promote community integration, based on the individual resident's needs and described in a written person-centered service plan (MACPAC, 2019). The findings from this evaluation suggest that Texas STAR+PLUS ALF and AFC settings should continue to implement structural and process improvements to fully meet the CMS HCBS settings requirements. Priority areas for improvement include community integration and resident autonomy regarding activities and food. These requirements should be fully addressed in HCBS settings.

Ongoing Challenges

The findings from ongoing EQR activities highlight a need for increased attention to reducing disparities in the quality of healthcare and the key social, economic, environmental, and demographic drivers that influence healthcare outcomes. For example, high rates of potentially preventable emergency department visits (PPVs) may represent a failure to provide adequate primary care to the patient. In 2020, the PPV rate (total PPV weight divided by 1,000 member months) was higher among females (5.88 vs. 4.91 for males), and the rate for rural members was higher (6.47) than the rates for urban or micropolitan members (5.27 and 6.27, respectively). In general, older members had higher PPV rates, although the rate was higher for children aged 1 to 5 years than for other children. Hispanic members had a lower PPV rate (4.45) than non-Hispanic White or non-Hispanic Black members (6.71 and 6.37, respectively). Potentially preventable admissions (PPAs) are avoidable through improved care coordination, effective primary care, and improved population health. In 2020, the PPA rate was higher among males (0.89 vs. 0.74 for females). Rural members had a higher (0.92) PPA rate (total PPA weight divided by 1,000 member months) than urban or micropolitan members (0.79 and 0.89, respectively). Hispanic members had a lower PPA rate (0.49) than non-Hispanic White or non-Hispanic Black members (1.23 and 1.12, respectively). In MY 2020, C-section and SMM rates varied by race/ethnicity and geography. Hispanic women had the lowest C-section rate (33 percent), and non-Hispanic Black women had the highest rate (38.1 percent). non-Hispanic Black women had 1.75 times the SMM rate of Hispanic women.

In addition to the need to reduce health disparities, the QOC results highlight the need for continued action to improve the quality of the maternal and behavioral health care provided to Medicaid and CHIP members. For example, potentially preventable complications (PPCs) arise after hospitalization because of poor clinical care or poor coordination of services during the inpatient stay. The most common PPC reason in STAR was obstetric complications. HEDIS measure rates also indicate that performance on measures for care of chronic conditions is worse for pregnant women, despite higher overall utilization rates.

Regarding behavioral health, specific mental health disorders account for a few of the top ten reasons members were admitted to the hospital when a hospital stay could have been avoided across all programs in 2020. The serious mental illness (SMI) conditions cited in PPA conditions across all programs, bipolar disorders (ranked fourth), major depressive disorders and other/unspecified psychoses (ranked fifth), and schizophrenia (ranked eighth) together accounted for over 16 percent of total PPA weight in 2020, this is more than the top ranked condition, heart failure. These SMI PPAs had a combined cost of over $47 million. These results highlight the importance of improving medication management for Medicaid and CHIP members, which could increase the effectiveness of treatment and reduce PPAs among members with mental health conditions.

Positive Findings

In SFY 2021, Texas responded to all the prior year EQRO recommendations to improve the quality of healthcare for members, including steps specifically targeted toward identifying and reducing disparities in care. HHSC began an in-depth QOC review process in SFY 2021 and is examining which measures lend themselves to further demographic review and analysis. For example, HHSC is requiring MCOs to conduct a maternal health social determinants of health (SDoH) PIP to improve MCO processes for collecting and analyzing SDoH data. HHSC also convened an internal workgroup focused on prioritizing and operationalizing interventions and strategies that target important SDoH for Medicaid members.

QOC results show some performance improvements in quality measures**.** For example, from 2017 through 2019, the overall PPA rate for members trended slightly upward, and the cost per PPA increased. In MY 2020, both at-risk admissions and PPAs decreased, suggesting potential improvements in outpatient care for Medicaid and CHIP members. A downward trend in SMM rates between 2017 and 2020 suggests potential improvements in maternal care.

Access & Timeliness of Care

Under 42 C.F.R. § 438.206 (2020), each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs and DMOs in a timely manner. Section 8.1.3 of the Texas Uniform Managed Care Contract (UMCC) (HHSC, 2021b) specifies that 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. Access is demonstrated by MCOs successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 C.F.R. § 438.68 (2020) (Network adequacy standards) and 42 C.F.R. § 438.206 (2020) (Availability of services).

In SFY 2021, the EQRO conducted several activities to help HHSC develop strategies to identify, understand, and address disparities in access to and timeliness of care provided to Medicaid and CHIP members. The EQRO regularly evaluates MCO and DMO compliance with the state and federal regulations that govern access to care and the timeliness of services as part of the MCO Administrative Interviews, QAPI program evaluations, and appointment availability studies. The annual QOC reports also include HEDIS measures that address specific aspects of access and availability of care, including prenatal and postpartum care and access to preventive/ambulatory health services. Lastly, the EQRO conducts semi-annual surveys on nonemergency transportation (NEMT) use and unmet transportation needs among Medicaid members. In SFY 2021, HHSC also contracted with the EQRO to conduct studies that provided additional information on specific aspects of access and timeliness of care for Medicaid members.

In one study, the EQRO examined diagnosis and treatment patterns for women with cervical cancer or pre-cancer and their transition from Texas Breast and Cervical Cancer Services (BCCS) to the Medicaid for Breast and Cervical Cancer (MBCC) program. The study found that most patients referred to MBCC do not experience treatment delay defined as greater than 90 days after receiving a cervical cancer diagnosis. However, interviews with BCCS and STAR+PLUS MCOs that provide MBCC services revealed challenges with outreach, communication, and access to cervical cancer specialists that accept MBCC, which create barriers to care.

A second EQRO study used STAR Kids MCO individual service plan (ISP) and STAR Kids Screening and Assessment Instrument (SK-SAI) data to provide descriptive information on ISP services and costs authorized for STAR Kids Medically Dependent Children Program (MDCP) members in 2020. The study also measured associations between respite care that children in MDCP are authorized to receive and measures of caregiver strain and

burden. Regarding access, the study found that the total number of services authorized on the ISPs varied according to member race/ethnicity, with a lower percentage of Hispanic members authorized for financial management services (FMS) compared to non-Hispanic White or non-Hispanic Black members. FMS are a Consumer Directed Services (CDS) option, and only appear as an authorized service if members choose CDS. It is possible that Hispanic caregivers are not comfortable choosing the CDS option due to different factors (e.g., education level, current service use, language barrier, familiarity with consumer direction or experience hiring or supervising workers). It is also worth exploring whether Hispanic caregivers' preference for FMS differs by rurality. Many rural persons have limited or no access to the internet, where they might learn of HCBS available for their child in STAR Kids MDCP. These factors, coupled with a potentially limited number of agencies to provide FMS in rural areas, could be problematic given present shifts toward web based HCBS infrastructure, including informational outreach and locating services (Siconolfi et.al, 2019).

A third EQRO study combined human papillomavirus (HPV) vaccination data from ImmTrac (the state immunization registry managed by the Department of Health Services) and Texas Medicaid claims, interviews with MCO representatives, and the results of a scoping review of state literature. The study provided an overview of (a) HPV vaccination status among adolescents in Medicaid, (b) MCO strategies for incentivizing providers and members to increase HPV vaccination uptake, and (c) potential state quality initiatives for encouraging MCOs to improve HPV vaccine uptake among teens in Medicaid and CHIP. The study found that vaccine hesitancy, delays getting children in for preventive care visits, and missed clinical opportunities are important barriers to increasing the percentage of teens with a timely HPV vaccine initiation and the percentage that are up to date on the HPV vaccine in Medicaid and CHIP.

Finally, the EQRO conducted a fourth study that examined the utilization of teleservices among adults and children in the Medicaid STAR and STAR+PLUS managed care programs and the differential effects of teleservices on healthcare service outcomes during the study period (March 1, 2020, to July 31, 2020), which coincided with the pandemic. Regarding access, the study found that members who did not engage in face-to-face or teleservice visits before March 1, 2020, had lower odds of using teleservices during the study period. The study also noted several disparities in teleservice use. For example, non-Hispanic Black members and members in rural areas had lower odds of using teleservices across all programs. In comparison, members with behavioral health or chronic conditions had higher odds of using teleservices during the study period.

Ongoing Challenges

The findings from ongoing EQR activities highlight the need for increased attention to improving network adequacy, access to specialists, and care coordination for Medicaid and CHIP members. For example, the Appointment Availability study results indicated the percentage of primary care providers in the STAR Health sample that did not accept Medicaid increased from two percent in 2020 to 9.5 percent in 2021 and the percentage of compliant STAR Kids behavioral health appointments decreased (75.1 percent) compared to 2020 (88.5 percent).

Limited access to network providers and specialists constrains the ability of the MCOs to improve performance on quality measures. Among Medicaid and CHIP members, the rate for timeliness of prenatal care (HEDIS® PPC) remained below the national 10th percentile for MY 2020, and the rate for the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) was below the national 25th percentile. The QOC results highlight the continued need to improve care coordination in Medicaid populations with complex healthcare needs. For example, the STAR+PLUS, STAR Kids, and STAR Health programs have the highest rates of potentially preventable readmission (PPRs) in MY 2020. Moreover, the most important drivers of PPRs are the

SMIs of schizophrenia, bipolar disorder, and major depression. Together, these accounted for costs of over $58 million in MY 2020.

Positive Findings and Directions

Texas has taken numerous steps to improve access to and timeliness of services for Medicaid and CHIP members. HHSC increased the frequency and scope of the appointment availability studies to provide annual information on wait times for prenatal care, primary care, behavioral health care, vision care, and teleservice availability for members. HHSC Quality Assurance also continues to work with Texas Medicaid and Healthcare Partnership (TMHP) and internal divisions at HHSC to address provider data elements and integrity. All seven of the MCOs that underwent state contract compliance review in SFY 2021 met compliance for all items associated with assuring availability of services under 42 C.F.R. § 438.206 (2016), including items associated with assuring timely access to services under 42 C.F.R. § 438.206 (c)(1)(i-vi)(2016).

Coordination of care for Medicaid and CHIP members also remains a priority for HHSC and an active area for quality improvement. HHSC included a session to inform MCOs on care coordination in integrated behavioral/physical care in the SFY 2021 Quality Forum. Additionally, HHSC works with the EQRO to develop studies to assess barriers to care for STAR Kids members. For example, in response to a request from HHSC, the EQRO submitted a report describing the methods and findings of a mixed-methods study which aimed to identify the most important services for families of STAR Kids members in MDCP; identify the most common barriers to receiving these services; explore the context in which families experience barriers to care and measure changes in caregiver experience with care between 2018 and 2020.

Conclusion

In SFY 2021, HHSC continued to improve the quality and efficiency of healthcare services in Medicaid and CHIP through numerous initiatives to (a) improve the availability of reliable SDOH data and information on health disparities among members, (b) increase provider availability and information on teleservice utilization; and (c) improve service coordination for special populations.

While there is always room for improvement, HHSC's efforts to improve the quality of healthcare for Medicaid and CHIP members positively affected several essential aspects of care, including performance on measures of access to preventive care and services for pregnant women and members with SMI. HHSC is also actively addressing areas in need of further quality improvement. The full SOA report includes a comprehensive list of EQRO recommendations based on SFY 2021 evaluation activities and suggestions for targeted approaches to address ongoing challenges to improving healthcare quality for all Medicaid and CHIP members.

Introduction

More than 70 million Americans receive healthcare coverage through Medicaid and the Children's Health Insurance Program (CHIP), funded jointly by states and the U.S. Department of Health and Human Services (HHS). Participation in federal funding for managed care programs requires compliance with the Centers for Medicare and Medicaid Services (CMS) guidelines and protocols, including the provision for external quality review (EQR) by an organization independent from the state. Texas has one of the largest Medicaid programs in the country, serving well over four million people (CMS, 2021), over 90 percent of whom receive care through a managed care delivery model. Since 2002, the Institute for Child Health Policy at the University of Florida has served as the external quality review organization (EQRO) for Texas Medicaid and CHIP. This report presents the results of Texas EQR activities during state fiscal year (SFY) 2021.

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

Table 1. Texas Medicaid and CHIP managed care programs

Program	Description
STAR	Manages care for most Texas Medicaid beneficiaries. This program covers low-income families, including adults and children, pregnant women, and newborns.
STAR+PLUS	Integrates health services with long-term services and supports (LTSS) for adults with a disability or those 65 or older, including individuals also receiving Medicare benefits (dual-eligible members). Dual-eligible members who also meet the Medicare-Medicaid Plan (MMP) eligibility criteria have the option to join an MMP instead of STAR+PLUS. The MMP provides both Medicare and Medicaid services through a single plan.
STAR Kids	Manages care for children and adults aged 20 years and younger who have disabilities. This program covers the children in the Medically Dependent Children Program (MDCP) except those in STAR Health.
STAR Health	Manages care for children and young adults in state conservatorship or those covered through a continuation or transition program of the foster care system.
CHIP	Manages care for children in families with income too high to qualify for Medicaid but too low to afford private insurance for their children. Unborn children receive coverage through CHIP Perinatal services.

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

Figure 1 shows the Texas Medicaid and CHIP service areas (SAs) and service providers for the reporting period. During SFY 2021, 17 managed care organizations (MCOs) administered Medicaid services in 13 SAs. For CHIP, 15 MCOs provide services, and the three Medicaid rural service areas (MRSAs) and Hidalgo SA comprise one rural service area. In all programs except STAR Health, members can choose from at least two MCOs in every SA. Superior provides all STAR Health services statewide. The three DMOs provide dental services statewide.

Figure 1. Texas Medicaid and CHIP managed care service areas

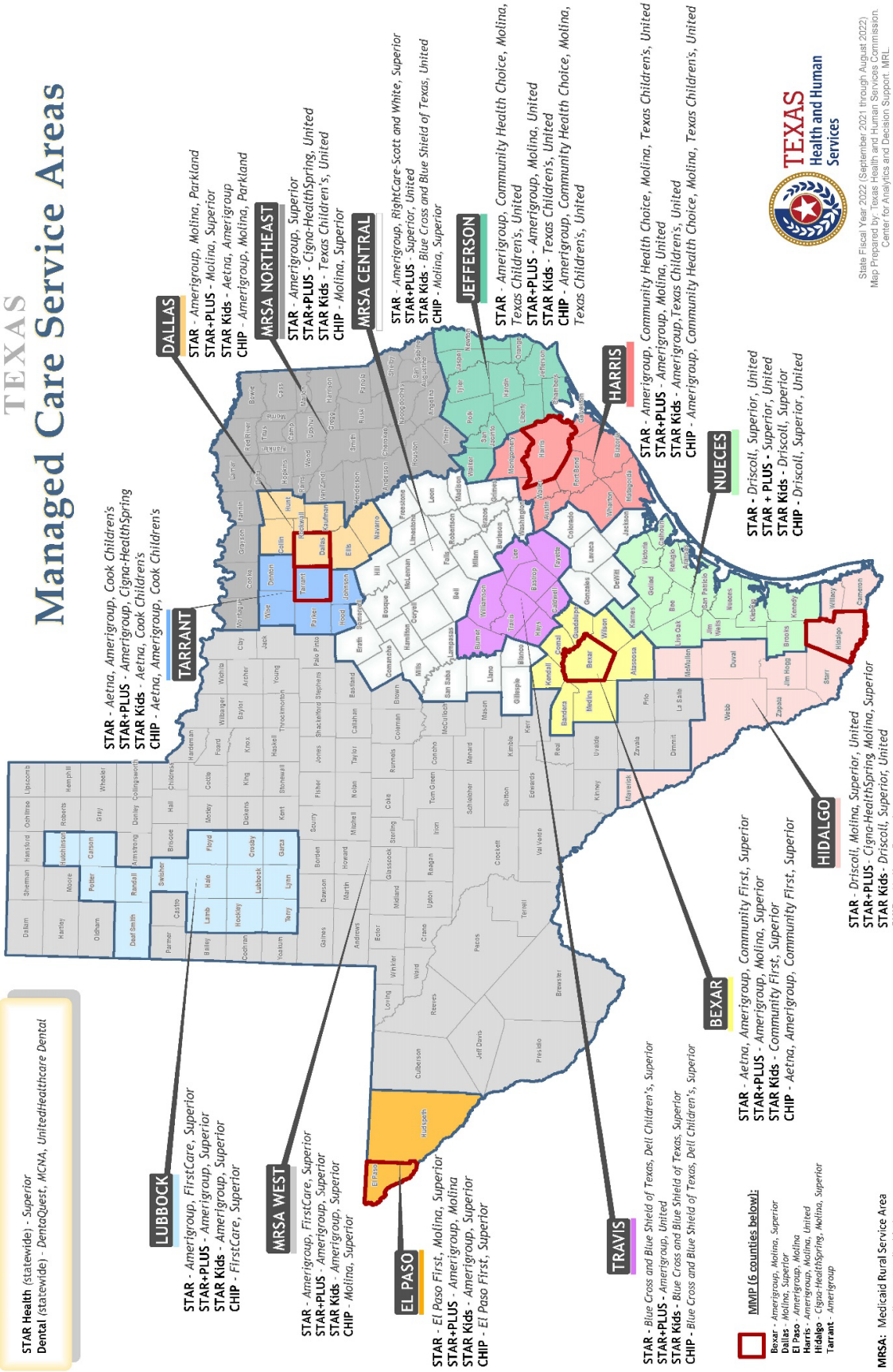


Table 2 shows Medicaid and CHIP enrollment with Texas contracted MCOs as of December 31, 2020, excluding dual-eligible members, and Table 3 shows enrollment with the three DMOs as of December 31, 2020.

Table 2. Non-dual-eligible enrollment in Texas Medicaid and CHIP in December 2020

MCO	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Aetna Better Health (Aetna)	90,798	-	12,556	-	7,135
Amerigroup	666,223	57,387	28,863	-	41,344
Blue Cross Blue Shield of Texas (BCBSTX)	42,997	-	8,641	-	4,346
Cigna-HealthSpring (HealthSpring)	-	18,905	-	-	-
Community First Health Plans (CFHP)	130,373	-	7,774	-	11,534
Community Health Choice (CHC)	309,324	-	-	-	18,263
Cook Children's Health Plan (CCHP)	128,179	-	10,004	-	14,555
Dell Children's Health Plan (DCHP)	31,518	-	-	-	5,337
Driscoll Health Plan (Driscoll)	196,405	-	10,585	-	4,844
El Paso Health	77,285	-	-	-	6,579
FirstCare Health Plans (FirstCare)	87,783	-	-	-	3,087
Molina Healthcare of Texas (Molina)	107,715	34,593	-	-	15,390
Parkland Community Health Plan (PCHP)	184,964	-	-	-	16,053
RightCare from Scott and White Health Plan (SWHP)	51,478	-	-	-	-
Superior HealthPlan (Superior)	873,141	65,691	30,279	41,878	69,062
Texas Children's Health Plan (TCHP)	427,082	-	29,692	-	41,959
UnitedHealthCare Community Plan (UHC)	182,443	60,491	30,184	-	6,668
Total	**3,587,708**	**237,067**	**168,578**	**41,878**	**266,156**

Table 3. Enrollment in Medicaid children's and CHIP dental programs in December 2020

DMO	Medicaid Children's Dental	CHIP Dental
DentaQuest	1,915,324	167,930
MCNA Dental (MCNA)	1,355,653	91,656
UHC Dental	99,429	6,607
Total	**3,370,406**	**266,193**

In response to the COVID-19 pandemic, CMS made widespread use of program waivers and other flexibilities to expand access to care to Medicaid members, which resulted in significant increases in Medicaid and CHIP enrollment.[1] The increase in total Medicaid and CHIP enrollment is largely attributed to the COVID-19 Public Health Emergency (PHE), particularly the enactment of section 6008 of the Families First Coronavirus Response

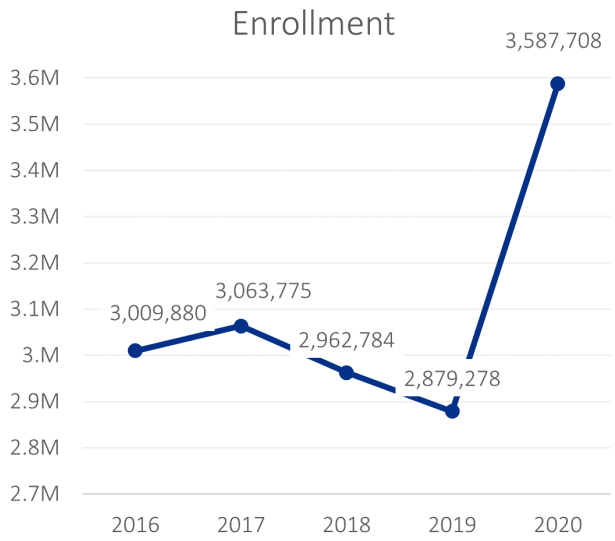
[1] cms.gov: New Medicaid and CHIP Enrollment Snapshot Shows Almost 10 million Americans Enrolled in Coverage During the COVID-19 Public Health Emergency

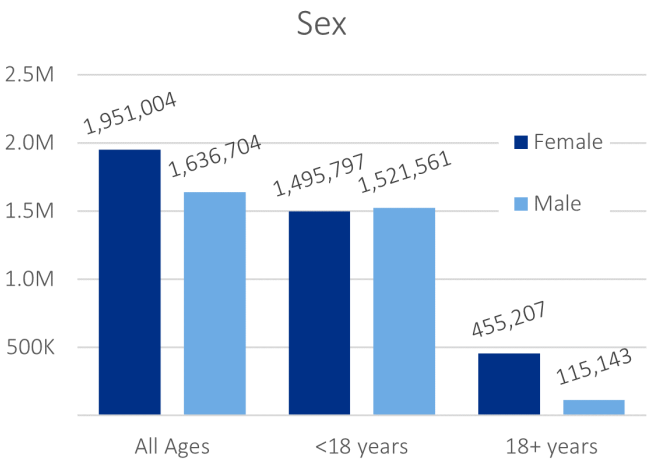
Act (FFCRA). FFCRA provides states with a temporary 6.2 percent payment increase in Federal Medical Assistance Percentage (FMAP) funding. States qualify for this enhanced funding by adhering to the Maintenance of Effort requirement, ensuring eligible people enrolled in Medicaid stay enrolled and covered during the PHE. Like other states, Texas Medicaid enrollment increased because of flexibilities associated with the PHE.

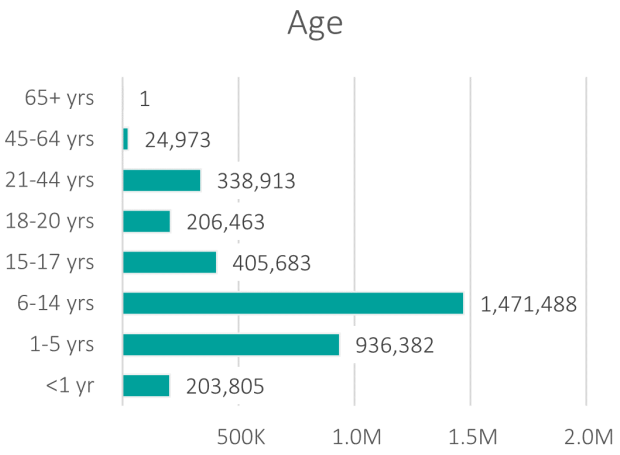
The following summaries show member data as of December 31, 2020, for the STAR, STAR+PLUS, STAR Kids, STAR Health programs, and CHIP. They represent a snapshot of the Texas Medicaid programs and CHIP as of the close of the measurement year (MY) for most of the quality-of-care (QOC) measures reported by the EQRO during SFY 2021. Health status reflects members' 3M™ Clinical Risk Group (CRG) status assigned to Special Healthcare Needs (SHCN) groups. *Appendix A: 3M™ Clinical Risk Group (CRG) Classification* describes the health status CRG categories.

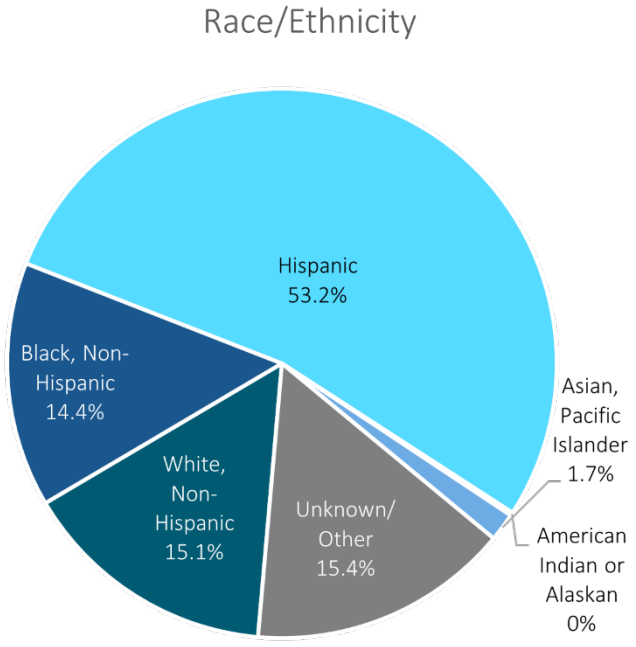
STAR

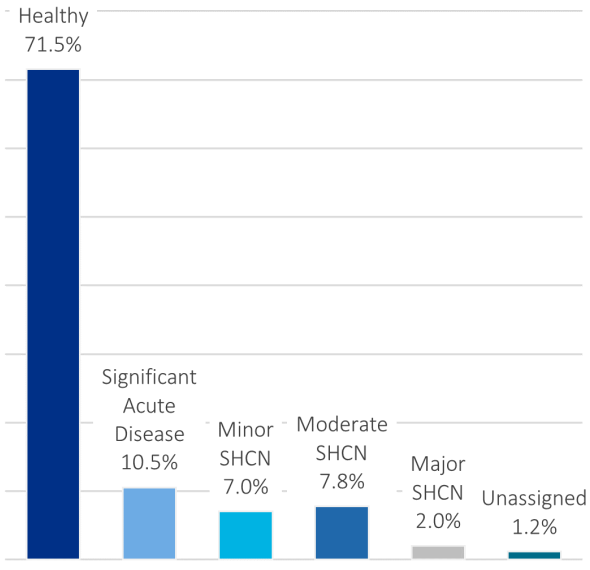
As Texas Medicaid's main managed care program, the STAR program had 3,587,708 non-dual-eligible members as of December 2020. The distributions by age and sex have been consistent from 2018 to present. Over 80 percent of adult members are women, while members younger than age 19 are distributed almost evenly between males and females. A majority of the members are Hispanic, and most members are healthy.





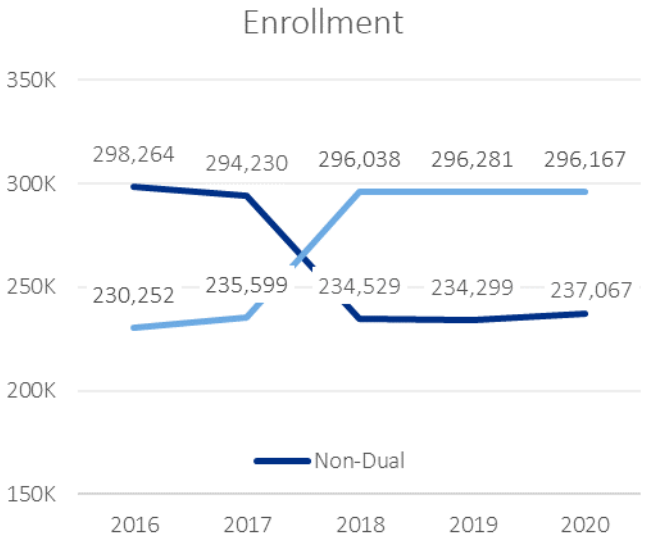


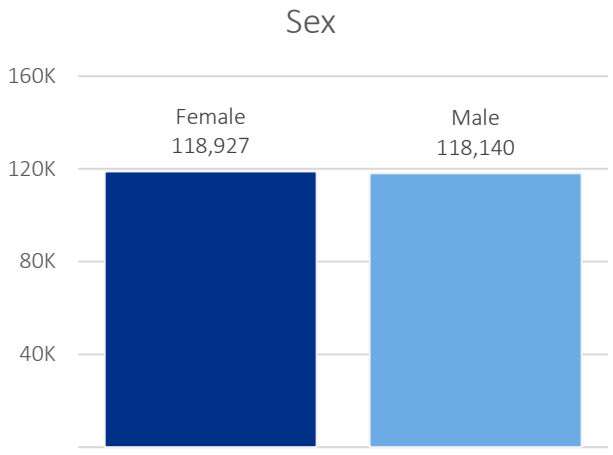


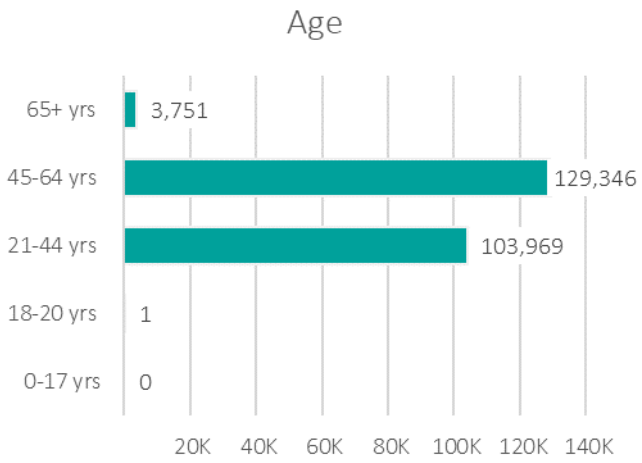


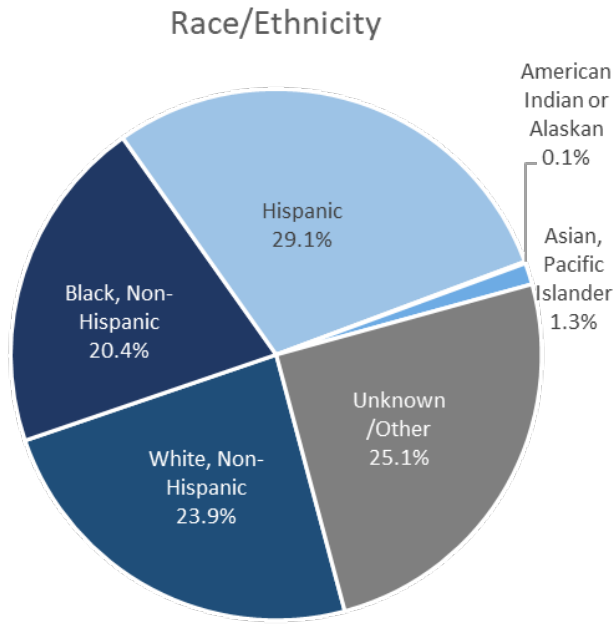
STAR+PLUS

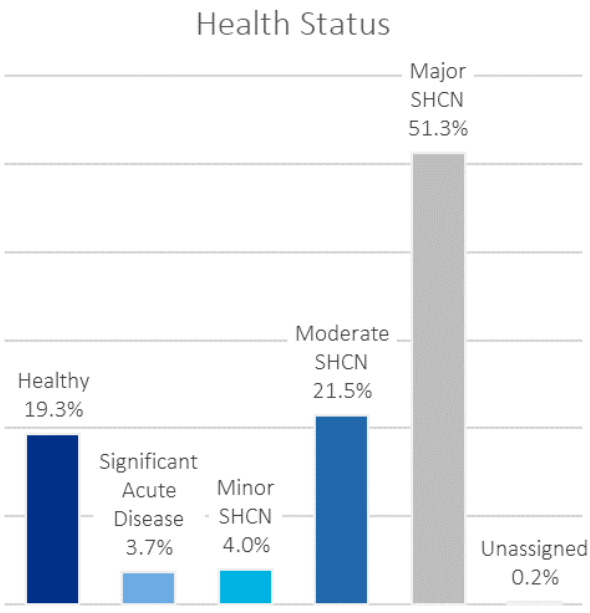
The STAR+PLUS program had 237,067 non-dual-eligible members (among 533,234 total) as of December 2020. Membership has remained constant after a drop in non-dual-eligible members mirrored by an increase in dual-eligible members in 2018. Distributions by age, sex, race-ethnicity, and health status are like those in 2017. One-quarter of STAR+PLUS members had unknown/other race-ethnicity. Close to seventeen percent were categorized as healthy, despite health status criteria eligibility for this





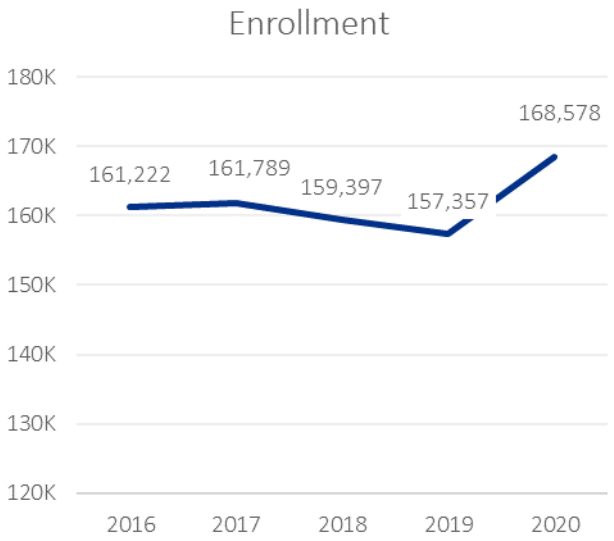


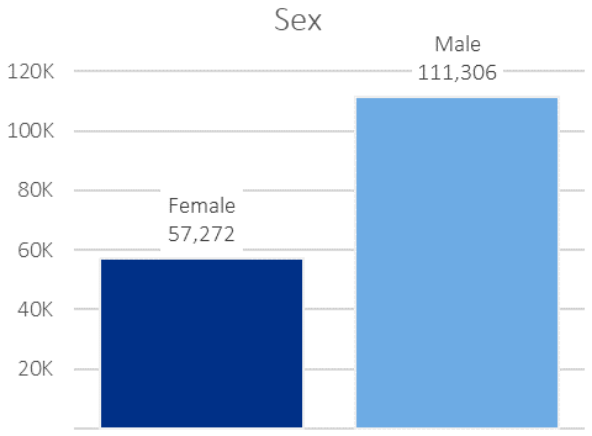


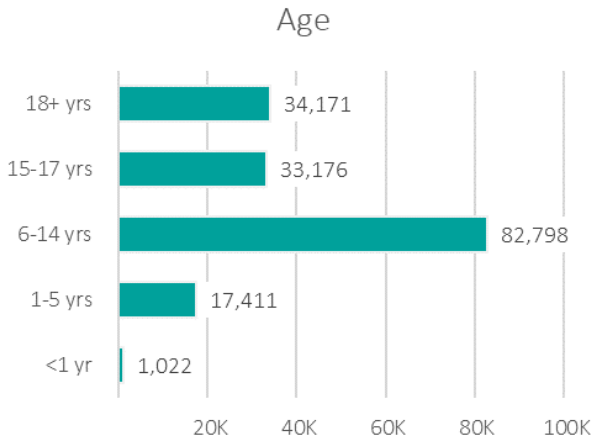


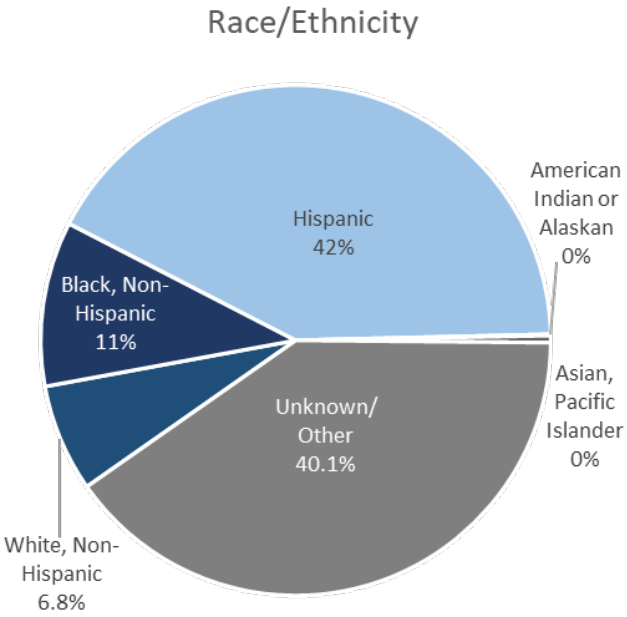
STAR Kids

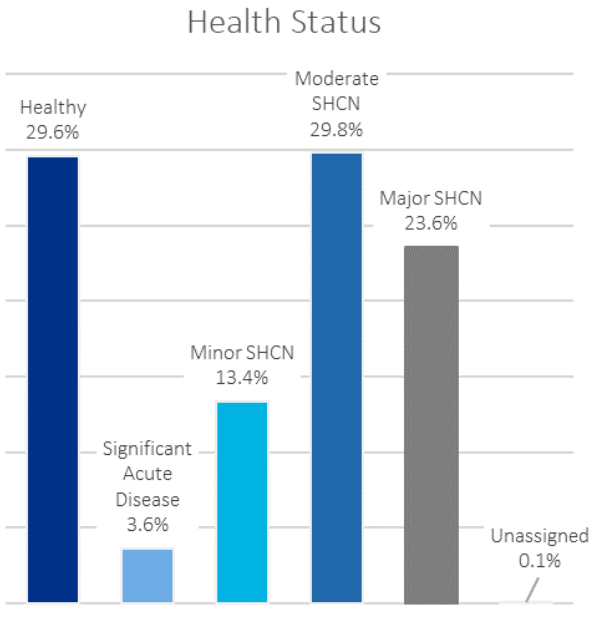
The STAR Kids program had 168,578 non-dual-eligible members as of December 2020. Enrollment dropped slightly compared to when the STAR Kids program began in November 2016. Males continue to outnumber females by about two to one, and nearly half of all members are 6 - 14 years of age. Over 40 percent of members had an unknown/other race-ethnicity. Member SHCN category is more likely to be minor or moderate in STAR Kids than in STAR+PLUS, where the most common category is major SHCN.





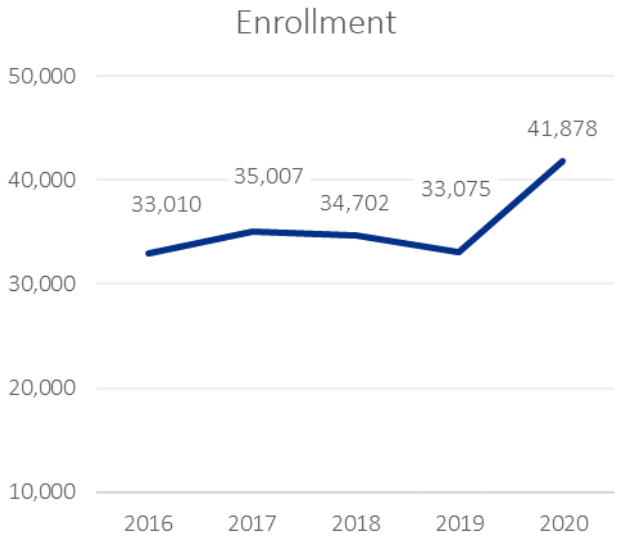


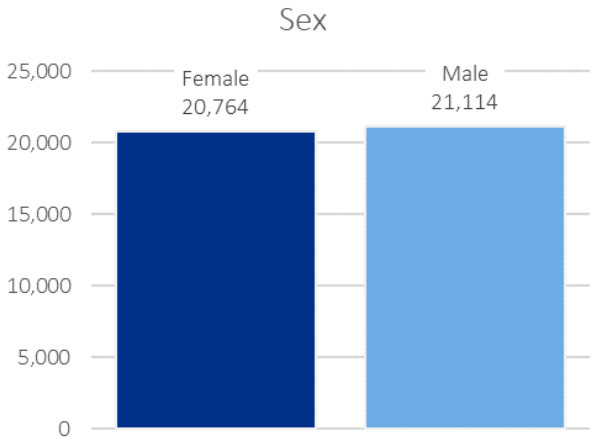


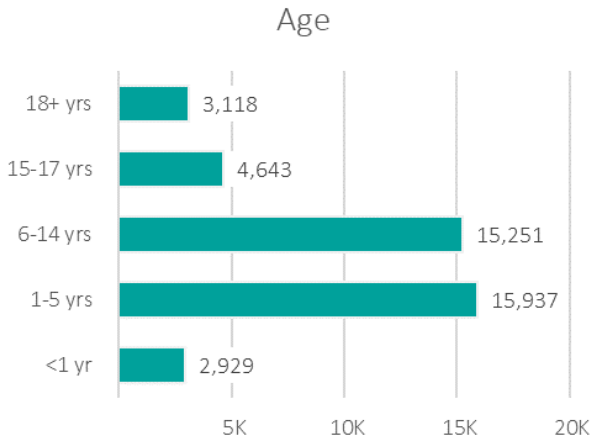


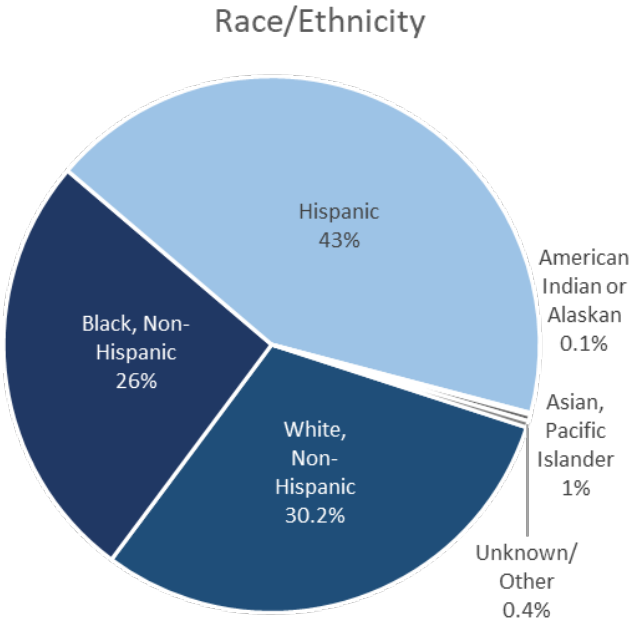
STAR Health

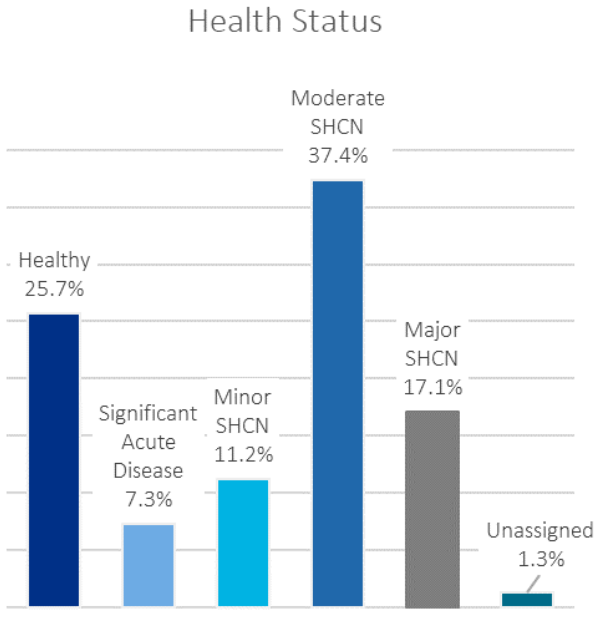
December 2020 enrollment in STAR Health remains consistent with prior years. Equal numbers of members are male and female, and the member age distribution is relatively even and consistent across years. Although almost 20 percent of members are categorized as healthy, an increasing majority of members covered in the STAR Health program have special healthcare needs.





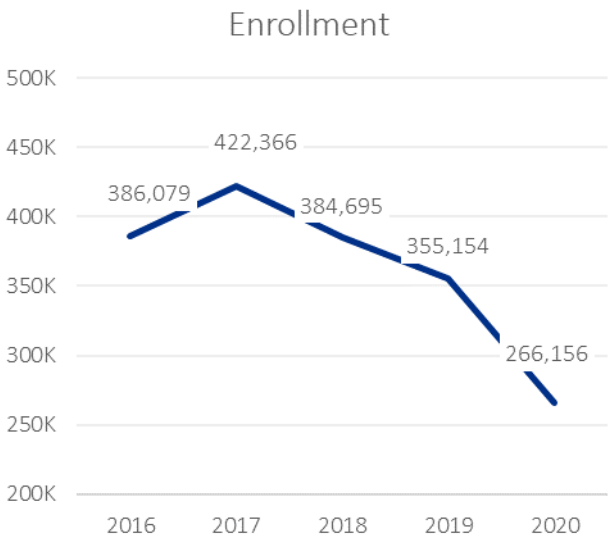


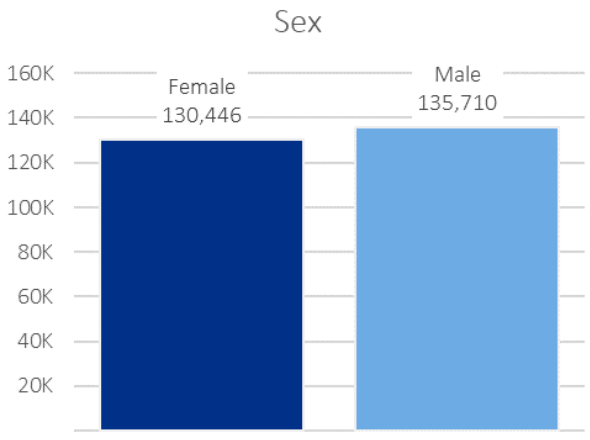


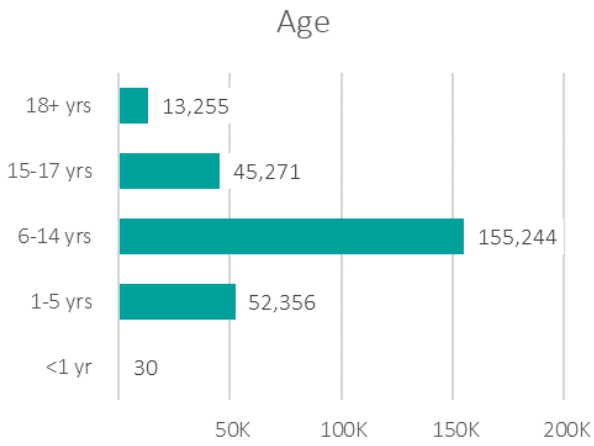


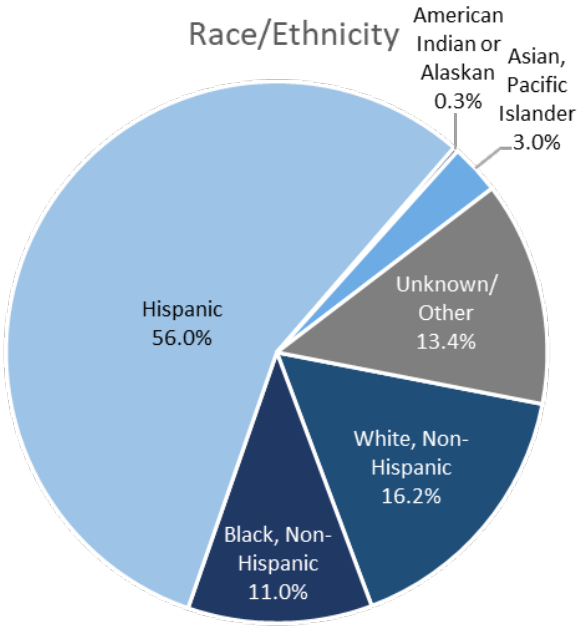
CHIP

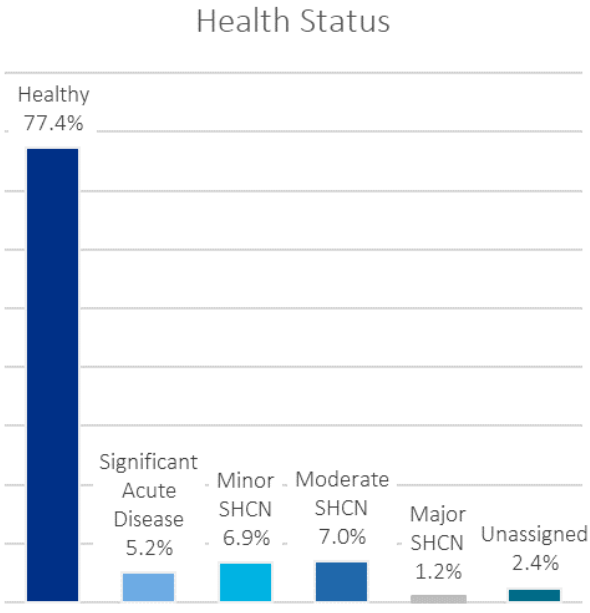
Enrollment in December 2020 was much lower compared to 2016, despite boosts in enrollment associated with PHE flexibilities. The percentage of members having an unknown/other race-ethnicity reached 44 percent in December 2018; however, in 2020, this rate fell to less than 15 percent. CHIP has the highest percentage of healthy members compared to STAR programs.











EQRO Responsibilities & Reporting

This summary of activities (SOA) report serves as the annual technical report summarizing findings from EQR activities conducted in SFY 2021 (September 1, 2020 - August 31, 2021), 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, 2022. Per reporting requirements under 42 C.F.R § 438.364 (a)(7)(2020), HHSC confirmed that none of the MCOs, MMPs, or DMOs that serve members in Texas Medicaid or CHIP were exempt from EQR activities in SFY 2021.

The EQRO followed the guidance of the CMS EQR Toolkit (CMS, 2019a) and CMS EQR Protocols (CMS, 2019b) for EQR activities. The EQR protocols covered in this report 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 *(no published guidance at the time of draft submission)*

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:** Assist with quality ratings *(no published guidance as of the time of draft submission)*

This report includes an Executive Brief highlighting findings and initiatives of interest to CMS and Texas, activity summaries for the EQR protocols, a summary of recommendations by the EQRO for SFY 2021, and a summary of recommendations from SFY 2020 that includes HHSC actions on each recommendation.

Following guidelines in 42 C.F.R. § 438.364(2016), the EQRO completed this report for the state of Texas to submit to CMS by April 30, 2022. 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 (2016), how the EQRO made conclusions about the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity. Each EQR-related activity conducted per 42 C.F.R. § 438.358 (2016) 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)(2016), and conclusions drawn from the data. The annex associated with the SOA report includes MCO- and DMO-specific information required under 42 C.F.R. § 438.364(a)(3-6)(2016).

In addition to the EQR activities, the state quality strategy is part of the overall Medicaid managed care quality requirements (CMS, 2019b). CMS requires each state contracting with an MCO, PIHP, or PAHP 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). This quality strategy is reviewed and updated every three years and must be approved by CMS. This report includes information on the quality goals associated with each set of findings and recommendations in the report.

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

Table 4. 2021 Texas Managed Care Quality Strategy goals referenced in the SFY 2021 SOA report

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

Protocol 1: Validation of Performance Improvement Projects (PIPs)

Protocol Overview & Objectives

Per 42 C.F.R. § 438.358(b)(2016), PIP validation is a mandatory EQR activity. As an ongoing process, the EQR activities include three major components: The PIP Plan, Progress Reports, and Final Reports. HHSC requires MCOs and DMOs to conduct PIPs over two years to provide sufficient time for project implementation and to increase the likelihood of reporting meaningful outcomes. The overall PIP score includes both the PIP Plan score, reflecting design strength, and the Final PIP score, reflecting the MCO's analyses, results, and interpretations. Each July, the EQRO uses progress reports to evaluate the implementation of the PIPs as they are underway. In September, the EQRO reviews PIP Plans for the upcoming year. By November, the MCOs submit the Final Reports for the PIPs they completed in the prior year for final evaluation by the EQRO.[2]

Technical Methods & Analyses

HHSC and the EQRO follow the guidance provided in the CMS EQR Protocol 1 to validate the MCOs'/DMOs' PIPs. 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:

- Characteristics of the target population for the PIPs including demographics and utilization of clinical and/or non-clinical services.
- Prevalence of the problem, which the MCOs/DMOs should supplement with current literature when applicable.
- Sampling methodology utilized for the PIP, measures, and interventions, when applicable. This includes:
    - 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.
    - 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.
    - 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.
- Performance measures utilized to assess the effectiveness of the PIPs with corresponding benchmarks and goals for improvement.
- Data collection procedures (i.e., measures taken to ensure validity and reliability of data collected, sources of data, frequency of data collection, types of data collected, and data analysis plan).
- Interventions the MCO implemented for the PIP, along with tracking and monitoring efforts conducted for each intervention. This includes, but is not limited to:

[2] In 2019, CMS updated the EQR protocols and validation of PIPs and relocated these guidelines under Protocol 1 (CMS, 2019b). The revised guidelines include updated templates for PIP reporting and re-ordering of some PIP activities. HHSC will implement these changes for activities in SFY 2022 for PIPs beginning in SFY 2022 and later. During SFY 2021, the EQRO followed the guidance from the earlier EQR Protocol 3 (CMS, 2012a) to evaluate the design, methodological approach, implementation, and validity of results for the mandatory PIPs undertaken by the MCOs and DMOs. However, this report follows the naming conventions in the updated protocols (e.g., the EQRO refers to PIP validation as Protocol 1).

[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 applicable.

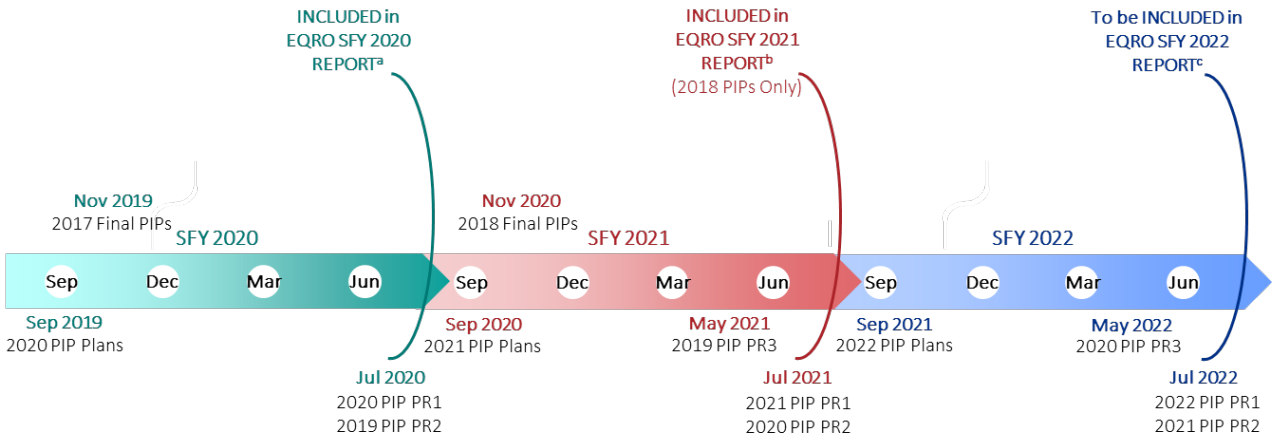
  - Number and percent of members/providers targeted and reached.
  - A detailed description of how the MCO/DMO will monitor each intervention for effectiveness throughout implementation; and
  - Process measures the MCOs/DMOs will utilize to measure the impact and effectiveness of the interventions.
- The results of the statistical analyses the MCO/DMO used to determine if the PIP measures achieved a statistically significant improvement.

The EQRO assesses the extent to which the MCO fulfilled the requirements of each CMS-defined evaluation component for each section of the PIP and scores the component as "met," with a corresponding score of 100, "partially met," with a corresponding score of 50, or "not met," with a corresponding score of 0. In addition to scoring plan performance across all PIP activities based on whether requirements for each component are "met" (fully), "partially met," or "not met," the EQRO provides recommendations to the MCOs on any component not fully met. The EQRO also reviews whether the MCOs fully incorporated prior-report recommendations and scores the actions taken in response to each recommendation. However, the EQRO does not include this additional recommendation score when calculating the PIP report and overall PIP score.

PIP Timelines & Reporting

During SFY 2021, the EQRO reviewed: (a) the 2021 PIP Plans, (b) the third progress reports for 2019 PIPs, (c) the first progress reports for SFY 2021 PIPS, (d) the second progress reports for SFY 2020 PIPS, and (e) the SFY 2018 Final PIP reports. This report will focus on the SFY 2018 PIP reports, which concluded with the EQRO's evaluation of the Final PIP Reports in November 2020. Figure 2 provides a timeline for the PIP reporting activities and reflects the changes made to the timelines for the 2019 and 2020 PIPs.

Figure 2. EQRO timeline for PIP activities



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

[a] The EQRO did not have a complete set of PIP reports needed to report on one round of PIPs for the SFY 2020 Report. Thus, the EQRO reported a summary of all the PIP evaluations completed during SFY 2020.

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

[c] The EQRO will not have a complete set of PIP reports to report on one round of PIPs for the SFY 2022 Report. Therefore, the EQRO will summarize all the PIP evaluations completed during SFY 2022 (like the SFY 2020 report).

2018 PIP Results

The MCOs and DMOs completed their 2018 PIPs in December 2019 and submitted Final PIP reports in November 2020. Topics for the 2018 two-year PIPs focused on the following topics:

- Weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)
- Prenatal and postpartum care (HEDIS® PPC)
- Potentially preventable emergency department visits (PPVs) for upper respiratory tract infection (URTI)
- Self-directed care

Seven of the 2018 STAR PIPs focused on a sub-population within the HEDIS® PPC topic. These sub-populations included pregnant members with depression (Aetna and PCHP), pregnant members who identify as non-Hispanic Black (Amerigroup and DCHP), only postpartum members (Community First), members with or at high risk for postpartum depression (SWHP), and members with maternal substance use issues (UHC).

Both DMOs conducted dental PIPs for Medicaid and CHIP that focused on increasing the use of dental sealants. Table 5 lists the 2018 PIPs that the EQRO evaluated. Evaluation results for the 2018 PIPs, by program, follow the table. The report annex summarizes the PIP topics implemented by each MCO/DMO, along with their measures and interventions.

Table 5. 2018 PIP topics, by MCO and program

MCO	Program	2018 PIP Topic
Aetna Better Health (Aetna)	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
Aetna Better Health (Aetna)	STAR	Prenatal and postpartum care with a focus on members with depression
Aetna Better Health (Aetna)	STAR Kids	PPVs for upper respiratory tract infection
Amerigroup	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
Amerigroup	STAR	Prenatal and postpartum care with a focus on non-Hispanic Black members
Amerigroup	STAR+PLUS	Self-directed care
Amerigroup	STAR Kids	PPVs for upper respiratory tract infection
Blue Cross and Blue Shield of Texas (BCBSTX)	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
Blue Cross and Blue Shield of Texas (BCBSTX)	STAR	Prenatal and postpartum care
Blue Cross and Blue Shield of Texas (BCBSTX)	STAR Kids	PPVs for upper respiratory tract infection
Children's Medical Center Health Plan (CMCHP)	STAR Kids	PPVs for upper respiratory tract infection
CHRISTUS Health Plan (CHRISTUS)[a]	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
CHRISTUS Health Plan (CHRISTUS)[a]	STAR	Prenatal and postpartum care

MCO	Program	2018 PIP Topic
Community First Health Plans (CFHP)	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
Community First Health Plans (CFHP)	STAR	Prenatal and postpartum care with a focus only on postpartum care
Community First Health Plans (CFHP)	STAR Kids	PPVs for upper respiratory tract infection
Community Health Choice (CHC)	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
Community Health Choice (CHC)	STAR	Prenatal and postpartum care
Cook Children's Health Plan (CCHP)	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
Cook Children's Health Plan (CCHP)	STAR	Prenatal and postpartum care
Cook Children's Health Plan (CCHP)	STAR Kids	PPVs for upper respiratory tract infection
DentaQuest	CD	Sealants
DentaQuest	MD	Sealants
Dell Children's Health Plan (DCHP)	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
Dell Children's Health Plan (DCHP)	STAR	Prenatal and postpartum care with a focus on non-Hispanic Black members
Driscoll Health Plan (Driscoll)	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
Driscoll Health Plan (Driscoll)	STAR	PPVs for upper respiratory tract infection
Driscoll Health Plan (Driscoll)	STAR Kids	PPVs for upper respiratory tract infection
El Paso Health	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
El Paso Health	STAR	Prenatal and postpartum care
FirstCare Health Plans (FirstCare)	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
FirstCare Health Plans (FirstCare)	STAR	Prenatal and postpartum care
Cigna-HealthSpring (HealthSpring)	STAR+PLUS	Prenatal and postpartum care with a focus on members with depression and substance abuse disorder
MCNA Dental (MCNA)	CD	Sealants
MCNA Dental (MCNA)	MD	Sealants
Molina Health Plan of Texas (Molina)	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
Molina Health Plan of Texas (Molina)	STAR	Prenatal and postpartum care
Molina Health Plan of Texas (Molina)	STAR+PLUS	Prenatal and postpartum care
Parkland Community Health Plan (PCHP)	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
Parkland Community Health Plan (PCHP)	STAR	Prenatal and postpartum care
RightCare from Scott and White Health Plan (SWHP)	STAR	Prenatal and postpartum care with a focus on members with a high risk of postpartum depression

MCO	Program	2018 PIP Topic
Sendero Health Plan (SHP)[a]	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
Sendero Health Plan (SHP)[a]	STAR	Prenatal and postpartum care
Superior HealthPlan (Superior)	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
Superior HealthPlan (Superior)	STAR	Prenatal and postpartum care
Superior HealthPlan (Superior)	STAR+PLUS	Prenatal and postpartum care
Superior HealthPlan (Superior)	STAR Health	Prenatal and postpartum care
Superior HealthPlan (Superior)	STAR Kids	PPVs for upper respiratory tract infection
Texas Children's Health Plan (TCHP)	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
Texas Children's Health Plan (TCHP)	STAR	Prenatal and postpartum care
Texas Children's Health Plan (TCHP)	STAR Kids	PPVs for upper respiratory tract infection
UnitedHealthCare Community Plan (UHC)	CHIP	Weight assessment and counseling for nutrition and physical activity for children/adolescents
UnitedHealthCare Community Plan (UHC)	STAR	Prenatal and postpartum care with a focus on members with substance use issues
UnitedHealthCare Community Plan (UHC)	STAR+PLUS	Self-directed care
UnitedHealthCare Community Plan (UHC)	STAR Kids	PPVs for upper respiratory tract infection

[a]The CHRISTUS and SHP Texas Medicaid managed care contracts ended before PIP completion; they did not provide Final PIP reports.

STAR PIP Scores

Table 6 shows the 2018 PIP scores for STAR MCOs. Molina had the lowest score on the PIP Plan (74.8 percent) and subsequently had the lowest Final PIP score (73.3 percent). The MCO performed poorly due to not submitting all the required documentation and submitting a Final PIP with the same intervention information as what the MCO reported on the Progress Report 2 submission with no updates.

Overall, PIP scores in STAR averaged 91.9 percent. Five MCOs (CHC, Driscoll, Molina, Superior, and TCHP) reported results that were inconsistent with EQRO data files, which resulted in a loss of points. Another common factor in low Final PIP scores was MCOs not achieving a statistically significant improvement for all measures (Aetna, Amerigroup, CCHP, Driscoll, El Paso Health, Molina, SWHP, Superior, TCHP, and UHC) or sustained improvement in at least one more study measure (Aetna, CCHP, Community First, CHC, DCHP, Driscoll, El Paso Health, FirstCare, SWHP, Superior, TCHP, and UHC).

Table 6. STAR 2018 two-year PIP Plan, Final PIP, and overall PIP scores by MCO

MCO	Topic	PIP Plan Score	Final PIP Score	Overall Score
Aetna Better Health (Aetna)	HEDIS® PPC	98.6%	88.1%	93.4%
Amerigroup	HEDIS® PPC	100%	95.2%	97.6%
Blue Cross Blue Shield of Texas (BCBSTX)	HEDIS® PPC	81.2%	94.0%	87.6%
CHRISTUS Health Plan (CHRISTUS)[a]	HEDIS® PPC	96.1%	N/A	N/A
Community First Health Plans (CFHP)	HEDIS® PPC	95.7%	92.9%	94.3%
Community Health Choice (CHC)	HEDIS® PPC	100%	90.5%	95.3%
Cook Children's Health Plan (CCHP)	HEDIS® PPC	97.3%	90.5%	93.9%
Dell Children's Health Plan (DCHP)	HEDIS® PPC	97.0%	91.7%	94.4%
Driscoll Health Plan (Driscoll)	URTI PPVs	93.6%	84.4%	89.0%
El Paso Health	HEDIS® PPC	100%	92.7%	96.4%
FirstCare Health Plans (FirstCare)	HEDIS® PPC	88.1%	92.9%	90.5%
Molina Health Plan of Texas (Molina)	HEDIS® PPC	74.8%	73.3%	74.1%
Parkland Community Health Plan (PCHP)	HEDIS® PPC	100%	94.0%	97.0%
RightCare from Scott and White Health Plan (SWHP)	HEDIS® PPC	96.1%	83.3%	89.7%
Sendero Health Plans (SHP)[a]	HEDIS® PPC	86.9%	N/A	N/A
Superior HealthPlan (Superior)	HEDIS® PPC	97.3%	89.3%	93.3%
Texas Children's Health Plan (TCHP)	HEDIS® PPC	91.9%	84.5%	88.2%
UnitedHealthCare Community Plan (UHC)	HEDIS® PPC	100%	90.5%	95.3%
Minimum	-	74.88	73.3%	74.1%
Maximum	-	100%	95.2%	97.6%
Average	**2 Topics**	**94.1%**	**89.2%**	**91.9%**

[a]The CHRISTUS and SHP Texas Medicaid managed care contracts ended before PIP completion; they did not provide Final PIP reports.

CHIP PIP Scores

Table 7 shows the 2018 PIP scores for CHIP MCOs. BCBSTX had the lowest score (71.4 percent) for PIP Plans due to submitting an incomplete PIP Plan, not accurately defining the target population, and reporting an overall aggregate measure instead of multiple measures with the age stratifications the MCO indicated it would utilize. Final PIP scores ranged from 82.1 percent for Aetna, Driscoll, and PCHP to 100 percent for UHC. Low-performing MCOs did not conduct their data analyses according to their respective data analysis plan (Aetna, Driscoll, and PCHP) and failed to show significant improvement for any of the reported measures (Aetna, Amerigroup, DCHP, Driscoll, El Paso Health, FirstCare, and PCHP). The overall PIP score in CHIP averaged 91.6 percent.

Table 7. CHIP 2018 two-year PIP Plan, Final PIP and overall PIP scores by MCO

MCO	Topic	PIP Plan Score	Final PIP Score	Overall Score
Aetna Better Health (Aetna)	WCC	100%	82.1%	91.1%
Amerigroup	WCC	100%	83.3%	91.7%
Blue Cross Blue Shield of Texas (BCBSTX)	WCC	71.4%	91.7%	81.6%
CHRISTUS Health Plan (CHRISTUS)[a]	WCC	88.4%	N/A	N/A
Community First Health Plans (CFHP)	WCC	97.1%	95.2%	96.2%
Community Health Choice (CHC)	WCC	95.5%	96.9%	96.2%
Cook Children's Health Plan (CCHP)	WCC	97.5%	90.5%	94.0%
Dell Children's Health Plan (DCHP)	WCC	100%	83.3%	91.7%
Driscoll Health Plan (Driscoll)	WCC	100%	82.1%	91.1%
El Paso Health	WCC	100%	83.3%	91.7%
FirstCare Health Plans (FirstCare)	WCC	89.1%	85.4%	87.3%
Molina Health Plan of Texas (Molina)	WCC	94.0%	84.8%	89.4%
Parkland Community Health Plan (PCHP)	WCC	100%	82.1%	91.1%
Sendero Health Plans (SHP)[a]	WCC	86.4%	N/A	N/A
Superior HealthPlan (Superior)	WCC	87.6%	92.7%	90.2%
Texas Children's Health Plan (TCHP)	WCC	89.0%	96.4%	92.7%
UnitedHealthCare Community Plan (UHC)	WCC	98.3%	100%	99.2%
Minimum	-	71.4%	82.1%	81.6%
Maximum	-	100%	100%	99.2%
Average	1 Topic	93.8%	88.7%	91.6%

[a]The CHRISTUS and SHP Texas Medicaid managed care contracts ended before PIP completion; they did not provide Final PIP reports.

STAR+PLUS PIP Scores

STAR+PLUS PIP Plan scores ranged from 65.7 percent to 100 percent (Table 8). Final PIP scores ranged from 66.2 percent to 95.8 percent. Molina had the lowest Final PIP score due to not submitting all the required documentation and submitting a Final PIP with the same intervention information as the MCO reported on the Progress Report 2 submission with no updates for the sole implemented intervention. Overall, PIP scores for STAR+PLUS averaged 85.1 percent. The highest scoring MCO, UHC, had a strong PIP Plan that the MCO implemented well, achieved significant improvement on two out of six measures, and sustained improvement for one measure.

Table 8. STAR+PLUS 2018 two-year PIP Plan, Final PIP, and overall PIP scores by MCO

MCO	Topic	PIP Plan Score	Final PIP Score	Overall Score
Amerigroup	Self-directed care	100%	83.3%	91.7%
Cigna-HealthSpring (HealthSpring)	HEDIS® PPC	86.3%	67.1%	76.7%
Molina Health Plan of Texas (Molina)	HEDIS® PPC	65.7%	66.2%	66.0%
Superior HealthPlan (Superior)	HEDIS® PPC	97.3%	89.3%	93.3%
UnitedHealthCare Community Plan (UHC)	Self-directed care	100%	95.8%	97.9%
Minimum	-	65.7%	66.2%	66.0%
Maximum	-	100%	95.8%	97.9%
Average	2 Topics	89.9%	80.3%	85.1%

STAR Kids PIP Scores

Table 9 shows the topics and PIP scores by MCO for STAR Kids. The lowest PIP Plan scores were for CMCHP (75.6 percent) and BCBSTX (78.4 percent), while Amerigroup and UHC had the highest PIP Plan scores of 100 percent. Final PIP scores also varied, ranging from 79.8 percent for Community First to 95.8 percent for Amerigroup. Overall, PIP scores for STAR Kids averaged 89.7 percent.

Table 9. STAR Kids 2018 two-year PIP Plan, Final PIP, and overall PIP scores by MCO

MCO	Topic	PIP Plan Score	Final PIP Score	Overall Score
Aetna Better Health (Aetna)	URTI PPVs	99.1%	81.0%	90.1%
Amerigroup	URTI PPVs	100%	95.8%	97.9%
Blue Cross Blue Shield of Texas (BCBSTX)	URTI PPVs	78.4%	83.3%	80.9%
Children's Medical Center Health Plan (CMCHP)[1]	URTI PPVs	75.6%	83.8%	79.7%
Community First Health Plans (CFHP)	URTI PPVs	99.1%	79.8%	89.5%
Cook Children's Health Plan (CCHP)	URTI PPVs	99.6%	79.8%	89.7%
Driscoll Health Plan (Driscoll)	URTI PPVs	97.8%	82.1%	90.0%
Superior HealthPlan (Superior)	URTI PPVs	99.4%	94.0%	96.7%
Texas Children's Health Plan (TCHP)	URTI PPVs	98.1%	85.4%	91.8%
UnitedHealthCare Community Plan (UHC)	URTI PPVs	100%	81.0%	90.5%
Minimum	-	75.6%	79.8%	79.7%
Maximum	-	100%	95.8%	97.9%
Average	1 Topic	94.7%	84.6%	89.7%

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

STAR Health PIP Scores

Superior is the sole MCO serving the STAR Health program. Its well-designed PIP Plan addressed prenatal and postpartum care. However, the slightly lower Final PIP score was due to Superior reporting HEDIS® PPC measure data inconsistent with EQRO data files for all measurement periods. The EQRO calculated significance using both the data Superior submitted as well as the correct data. Based on calculations for both data sources, the MCO did not achieve a statistically significant improvement in the timeliness of prenatal care measure, which impacted its Final PIP and overall PIP scores. Table 10 shows PIP score results for STAR Health.

Table 10. STAR Health 2018 two-year PIP Plan, Final PIP, and overall PIP scores by MCO

MCO	Topic	PIP Plan Score	Final PIP Score	Overall Score
Superior HealthPlan (Superior)	HEDIS® PPC	94.6%	89.3%	92.0%

Dental PIP Scores

Table 11 shows results for dental PIPs. The lower Final PIP score for DentaQuest in Medicaid Dental was due to the DMO not reporting the numerator for the first re-measurement (MY 2018) for a DMO-derived sealant measure. The EQRO used the reported denominator and rate to calculate the numerator and test for significance. The EQRO confirmed the DMO's findings that it did not significantly improve any of the reported measures. Overall dental PIP scores averaged 82.9 percent.

Table 11. Dental 2018 two-year PIP Plan, Final PIP, and overall PIP scores by DMO

MCO	Topic	PIP Plan Score	Final PIP Score	Overall Score
DentaQuest (CHIP Dental)	Sealants	82.6%	84.8%	83.7%
DentaQuest (Medicaid Dental)	Sealants	82.6%	83.8%	83.2%
MCNA (CHIP Dental)	Sealants	94.9%	96.9%	95.9%
MCNA (Medicaid Dental)	Sealants	93.9%	93.8%	93.9%
Minimum	-	82.6%	83.8%	83.2%
Maximum	-	94.9%	96.9%	95.9%
Average	1 Topic	88.5%	89.8%	82.9%

For the 2018 Final PIPs, the average score across all programs and PIP topics was 87.3 percent. The self-directed care PIPs had the highest average score of 97.9 percent, while the URTI PIPs had the lowest average score of 88.9 percent. The HEDIS® PPC PIPs had a Final PIP average score of 89.9 percent. The most common reasons across MCOs/DMOs, programs, and PIP topics for lower scores include not following the proposed data analysis plan, reporting inaccurate data, not achieving statistically significant improvement, and not fully discussing factors that may have influenced results.

COVID-19 Pandemic Impacts

Due to the coronavirus disease of 2019 (COVID-19) pandemic, HHSC extended the SFY 2019 and SFY 2020 PIPs by one year, making them three-year PIPs instead of two-year PIPs. As a result, HHSC required the MCOs to

submit a third progress report in the third year of the PIP, which is SFY 2021 and SFY 2022 for the 2019 and 2020 PIPs, respectively. It is also important to note that the one-year extension of the SFY 2019 and SFY 2020 PIPs resulted in no scheduled Final PIP Reports due in November 2021 (SFY 2022).

Relevance for Assessing Quality, Access & Timeliness

The 2018 PIPs sought to improve the quality, timeliness, and access to care for the Medicaid and CHIP populations. Several MCOs aimed to improve the timeliness of prenatal and postpartum care for the STAR, STAR+PLUS, and STAR Health PIPs. The MCOs utilized a variety of approaches to improve the timeliness of maternal health care. For example, CHC's wellness services team outreached to members in their last trimester to inform them of the importance of postpartum care and what to expect regarding coverage and needed care for the mother and child. BCBSTX targeted members who were unable to reach via normal communication methods. For these members, BCBSTX sent a notification requesting them to contact the Special Beginnings case manager for the MCO and informed them they would receive a $50 gift certificate for making contact. For the members who did not respond, BCBSTX conducted home visits to ensure the member received timely prenatal and postpartum care.

Several MCOs aimed to improve the quality of healthcare across PIP topics and programs. For example, SWHP utilized a community-based approach to identify prenatal and postpartum depression among its pregnant members. CCHP utilized service coordinators to work with STAR Kids members to help remove barriers to preventive care and reduce preventable emergency department (ED) utilization. Driscoll utilized a different approach to reducing potentially preventable ED visits by providing member outreach and education to inform members of after-hours clinics and urgent care facilities in the vicinity where the member resides.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 12 lists the key findings and recommendations from EQR activities for Protocol 1, along with their relevance to the MCQS.

Table 12. Findings and recommendations from the PIP validation

Category	Description
Finding(s)	A common reason for loss of points on the Final PIP evaluation was due to measurement issues, which included MCOs/DMOs not conducting the statistical analyses according to their data analysis plan, reporting inconsistent data when compared to EQRO data files and MCOs/DMOs not achieving a statistically significant improvement for all reported measures. Aetna, CCHP, CFHP, and PCHP did not conduct the appropriate statistical test for their respective measures.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	All MCOs/DMOs, especially Aetna, CCHP, CFHP, and PCHP, should ensure their data analysis plans are appropriate for the reported measures and conduct the statistical analyses according to their data analysis plan for the Final PIP.

Category	Description
Finding(s)	Data reporting is a frequently noted opportunity for improvement. HHSC and the EQRO require MCOs/DMOs to utilize data from the EQRO's QOC tables or data on the THLC portal, when applicable, for the EQRO to verify and validate the data the MCOs/DMOs report. However, Aetna, CFHP, CHC, CMCHP, Driscoll, HealthSpring, Molina, Superior, TCHP, and UHC all reported data on the Final PIP that did not match the EQRO data files. Further, MCOs have misinterpreted the effectiveness of the PIP because they base their interpretation on incorrect data. For example, on the STAR PIPs, Aetna, Molina, PCHP, and SWHP all reported results that the EQRO found to be inaccurate after review. Specifically, Molina and SWHP reported all measures achieved a statistically significant improvement when the EQRO found that Molina only achieved significant improvement for one measure and SWHP did not achieve significant improvement for any measure.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	The MCOs/DMOs should follow HHSC guidance completing PIP processes. They should utilize the data provided in the QOC tables and on the THLC portal (thlcportal.com) to calculate applicable rates and ensure they report an accurate interpretation of the results. This recommendation applies to Aetna, CFHP, CHC, CMCHP, Driscoll, HealthSpring, Molina, Superior, TCHP, and UHC.
Finding(s)	Molina had the lowest scoring Final PIP for its STAR and STAR+PLUS HEDIS® PPC PIPs, 73.3 and 66.2 percent, respectively. The main reason for the low score resulted from the MCO not submitting a revised PIP Plan and not including an update since the Progress Report 2 submission for the sole implemented intervention. After a review of all Molina's PIP report submissions, the EQRO found the MCO had inconsistently reported multiple delays in intervention implementation and implemented only one out of the four originally proposed interventions. Further, for the sole intervention implemented, it was not clear if Molina implemented the intervention for the entire duration of the two-year PIP since the MCO did not provide data for year two, MY 2019. Since the MCO did not submit a revised PIP Plan with its Final PIP Report and only implemented one out of four interventions, Molina lost points on nearly all components pertaining to its interventions on the Final PIP evaluation in addition to losing points due to not achieving a statistically significant improvement for one or more measures. Thus, the MCO was the lowest performer for both STAR and STAR+PLUS.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	• Molina should ensure it submits all requested documentation and update each section of applicable PIP reports before submission to the EQRO. • To achieve continuous quality improvement, Molina should apply the PDSA methodology to identify and address the factors that impact the successful implementation of all proposed interventions. When possible, Molina should modify rather than retire interventions to ensure optimal reach and opportunity for success.

Category	Description
Finding(s)	During the 2018 PIPs, NCQA modified the HEDIS® technical specifications for the HEDIS® PPC measure for MY 2019 (re-measurement 2 of the 2018 PIPs). The revisions affected both the prenatal and postpartum sub-measures as follows: • HEDIS® PPC, Timeliness of Prenatal Care – NCQA revised the enrollment criteria for inclusion in the sub-measure, which captured any visit during pregnancy rather than the timeliness of the prenatal visit. As a result, the prenatal sub-measure rates were inflated and not a true representation of the timeliness of prenatal care. After consultation with the EQRO, their NCQA-certified auditor, and NCQA, HHSC determined that the EQRO should run the MY 2019 prenatal sub-measure using the same enrollment criteria from the previous MY. HHSC instructed the MCOs to report their administrative rates for MY 2017 and MY 2018 if the MCO originally reported the prenatal rate as a hybrid rate. The EQRO provided the administrative rates by program for MY 2019 for all MCOs that corrected the change in the technical specifications. • HEDIS® PPC, Timeliness of Postpartum Care – NCQA revised the technical specifications to include visits that occurred between seven to 84 days after delivery (previously limited to 21-56 days after delivery). As a result, the MY 2019 postpartum sub-measure hybrid and administrative rates were inflated compared to the MY 2017 and MY 2018 rates. However, HHSC determined that since the MY 2019 rates were more aligned with current guidelines, the MCOs should report the rates using the updated technical specifications for MY 2019. Due to these HEDIS® technical specification modifications for the HEDIS® PPC measure, rates for the postpartum sub-measure were inflated in the second re-measurement year of the 2018 PIPs (MY 2019) compared to baseline (MY 2017). Several MCOs that focused on HEDIS® PPC significantly improved from baseline in the postpartum sub-measure but not in the prenatal sub-measure. However, when asked to describe factors that may have influenced the results, nine MCOs did not discuss the technical specification modifications (Aetna, CHC, HealthSpring, Molina, PCHP, SWHP, Superior, TCHP, and UHC).
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	The EQRO recommends MCOs monitor HEDIS® technical specification modifications that can influence PIP results and discuss the potential impacts in the Final PIPs when reviewing MCO performance, even if they did not achieve a significant improvement. This recommendation applies to Aetna, CHC, HealthSpring, Molina, PCHP, SWHP, Superior, TCHP, and UHC.

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 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, 2019a) is a mandatory EQR activity (42 C.F.R. § 438.358, 2016) requiring the EQRO to validate Texas Medicaid and CHIP performance measure results, assessing the accuracy of MCO reported results and evaluating how well the calculated measures follow Texas requirements. To provide the most consistent calculations across many programs and MCOs, Texas enlists the EQRO to calculate over 100 QOC measures annually instead of requiring all of these to be MCO reported and subject to validation under Protocol 2. Measures calculated by the EQRO provide standard, reliable results for use in quality evaluations and research. The related Protocol 7 specifically addresses performance measures calculated by the EQRO. Under Protocol 2, the EQRO validates a limited number of performance measure MCOs are required to calculate and report. The state requires MCOs to calculate select HEDIS measures following the hybrid method specifications. The EQRO also evaluates other service and access indicators that Texas requires MCOs to calculate, including rates for Texas Health Steps (THSteps) checkups.

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

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

Technical Methods & Analyses

Information Systems, Processes & Data Used in Performance Measures

As part of the AI, the EQRO asks questions related to Information Systems and Data Acquisition. Of the five MCOs and two DMOs participating in the administrative interview (AI) process in SFY 2021 (Protocol 3), both DMOs and three MCOs indicated that they underwent a formal ISCA within the past two years. One other MCO indicated that their processing vendor provides SOC1/SOC2 reports. All five MCOs underwent an audit by an NCQA certified auditor for the purpose of reporting HEDIS measures, and all five used certified commercial software for HEDIS processing. 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.

In the AI, all seven MCO/DMOs reported an average experience of five years or more for their programming staff, and only the DMOs reported (low) turnover. The cumulative staff experience helps build important institutional knowledge and should improve efficiency in any data-driven initiatives. Three MCOs reported a major change in encounter or enrollment processing systems in the past three years. These changes highlight the need for continuous evaluation of MCO/DMO information systems. The three MCOs that reported using

Electronic Health Record (EHR) systems in their networks reported that at least 50 percent of primary care providers (PCPs) and specialists used an EHR system.

All MCO/DMOs reported that at least 95 percent of claims are complete within three months. The frequency of internal claim audits varies from weekly to quarterly. Two MCOs had a third party generate the explanation of benefits (EOB) and other payment reports. All MCOs/DMOs denied claims filed late.

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

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

HEDIS Hybrid Measures

Hybrid method specifications include sampling based on administrative criteria, followed by medical record review from the sample to determine compliance. In SFY 2021, MCOs reported their hybrid method results for four HEDIS measures for the programs listed in Table 13. The EQRO compiles the results with EQRO calculated measures (Protocol 7) 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 13. HEDIS MY 2020 measures selected for hybrid reporting

Abbreviation	Description	Programs
CBP	Controlling High Blood Pressure	STAR, STAR+PLUS
CDC	Comprehensive Diabetes Care	STAR, STAR+PLUS
IMA	Immunizations for Adolescents	CHIP, STAR, STAR Kids
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	CHIP, STAR, STAR Kids

In addition to the NCQA certified auditor report and related documentation that 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 (a) eligible population, (b) denominator, and (c) numerator. For example, the EQRO identified inconsistencies in how MCOs count exceptions and contraindications, and discrepancies seen in administrative rates helped identify differences in provider specialty identification.

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

Access and Service Measures

Measurement is an important part of the quality assessment and performance improvement (QAPI) programs conducted by the MCOs and DMOs and evaluated by the EQRO (Protocol 3). All MCOs and DMOs, except for Superior, scored 100/100 on the EQRO assessment of "Systems, Processes, and Outcomes Measurements and Results" and "Internal/External Comparisons," addressed in the "Improvement Opportunities" section of the EQRO review. In the "Availability and Accessibility (of) Access to Care Monitoring and Results" area, only PCHP had a weighted score less than 9/10, while 13 of 20 scored 10/10. In the "Activities and Ongoing Quality Indicators" area, only DCHP had a weighted score less than 9/10, while 16 of 20 scored 10/10.

Texas Health Steps Checkups Report

Following the Frew Consent Decree (Frew) of 1996 (*Frew et al. V. Phillips et al.*, 1996), HHSC became subject to corrective action orders, including an independent study of medical checkup completeness and required checkup reports. According to Chapter 12 of the Texas Uniform Managed Care Manual (UMCM) that covers Frew requirements (HHSC, 2021a), MCOs must submit annual reporting on compliance with THSteps checkup requirements. The EQRO independently calculates compliance rates using the encounter and enrollment data in the Texas Medicaid data warehouse and provides a comparative report to HHSC. The EQRO works closely with HHSC to develop reporting specifications and provides continuing technical assistance to HHSC and the MCO stakeholders to support these reports. In addition, the EQRO provides ad hoc support to the MCOs if their submitted report does not pass validation. This support includes phone conferences and providing member data from EQRO calculations to assist in rectifying any errors in their reporting. During SFY 2021, the EQRO evaluated compliance for members with a checkup due starting in SFY 2019. All the final reports provided by the MCOs passed the EQRO validation process. However, all MCOs also provided required THSteps checkups to less than 70 percent of eligible members.

COVID-19 Pandemic Impacts

The public health efforts to curb the spread of the COVID-19 pandemic reduced the number of in-person visits and vaccination appointments across the U.S. in 2020 (Patel, 2021), and may have contributed to the low percentage of THSteps checkups. Additional analyses are necessary to understand how COVID-19 restrictions affected the provision of THSteps checkups.

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. Most of the MCOs had high scores on access and services measures. However, the EQRO has noted universal deficiencies in NPI and taxonomy fill which are important for assessing quality and access to care.

Summary of Protocol Findings & Recommendations from EQR Activities

No recommendations for Protocol 2.

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

Protocol Overview & Objectives

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

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

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

EQR Activities

Administrative Interviews

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

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

Technical Methods & Analyses

The EQRO reviews federal regulatory updates and incorporates these updates into the AI web-based tool and evaluation protocols. The EQRO works with HHSC to appropriately define and measure levels of compliance for each regulatory item. Compliance 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 they meet all regulation components across all product lines. After the EQRO establishes these compliance thresholds and receives HHSC approval, the EQRO contacts the representatives of the MCOs and DMOs under review for the year. Each year, the EQRO rotates the MCOs and DMOs for full AI review (including all regulatory areas and an on-site visit). Each MCO and DMO participates in the full AI review through this rotation process every three years. SFY 2021 is the first year of the current three-year reporting period, which will run SFY 2021-2023, following the same rotation as seen in Table 14 below, with SFY 2023 mirroring SFY 2020.

Table 14. MCO and DMO participation in AI review by evaluation year

2019	2020	2021	2022
Amerigroup	Blue Cross Blue Shield of Texas (BCBSTX)	Aetna Better Health (Aetna)	Amerigroup
Cigna-HealthSpring (HealthSpring)	Children's Medical Center Health Plan (CMCHP)[a]	Cook Children's Health Plan (CCHP)	Molina Health Plan of Texas (Molina)
Molina Health Plan of Texas (Molina)	Community Health Choice (CHC)	Community First Health Plans (CFHP)	Superior HealthPlan (Superior)
Superior HealthPlan (Superior)	Dell Children's Health Plan (DCHP)	DentaQuest	UnitedHealthCare Community Plan (UHC)
UnitedHealthCare Community Plan (UHC)	Driscoll Health Plan (Driscoll)	El Paso Health	-
-	MCNA Dental (MCNA)	FirstCare Health Plans (FirstCare)	-
-	Parkland Community Health Plan (PCHP)	United Healthcare Dental (UHC Dental)	-
-	RightCare from Scott and White Health Plan (SWHP)	-	-
-	Texas Children's Health Plan (TCHP)	-	-

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

After confirming each MCO's and DMO's point of contact, the EQRO opens the updated web-based tool for the selected MCOs and DMOs to complete all questions and upload supporting documentation. If an MCO or DMO fails to include all necessary information, the EQRO contacts the MCO 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 Texas requirements and the federal regulations 42 C.F.R. § 438 (2016). The EQRO evaluates each MCO and DMO using the established compliance thresholds. Each MCO and DMO receives a scored individual 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 on-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 along with a list of questions to clarify and confirm compliance. This year, the EQRO completed site visits virtually via video conference calls due to pandemic precautions.

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 these revised policies and procedures, which have been finalized and implemented. Once MCOs and DMOs provide updates with supporting documentation, the EQRO incorporates findings into results and develops Site Visit Reports for each MCO and DMO.

Results

In 2021, five MCOs and two DMOs participated in full AI activities. This year, the EQRO conducted virtual site visits due to the COVID-19 pandemic and related restrictions on travel and in-person meetings. The results reported in this section are based on the original review and do not include the EQRO's determination of regulatory compliance after receiving additional documentation.

Based on the review of the AI responses, the EQRO assigned scores in each federal regulatory category and combined them into an overall score. Along with its score report, the EQRO also provided recommendations to each MCO and DMO on becoming compliant with regulations.

The average overall score in 2021 was 95.7, ranging from 95.1 to 100 (fully compliant). Individual MCO and DMO scores within categories were all at least 90.4. Table 15 shows the final scores and averages across MCOs and DMOs and Table 16 compares rates of MCO compliance with prior year AI recommendations.

Table 15. MCO and DMO 2021 AI scores by federal regulation category and overall

MCO or DMO	A. General Provisions	B. State Responsibilities	C. Member Rights & Protections	D. Heath Plan Standards	F. Grievance & Appeal System	Overall, AI Evaluation Score
Aetna	96.7	100.0	100.0	98.5	97.0	97.3
CFHP	95.0	100.0	96.7	99.2	98.9	97.1
CCHP	95.0	100.0	96.7	94.0	90.7	92.3
DentaQuest	94.7	100.0	95.0	100.0	97.2	96.6
El Paso Health	99.2	100.0	100.0	99.2	92.6	96.3
FirstCare	95.8	100.0	97.5	98.3	90.4	93.3
UHC Dental	93.0	100.0	100.0	97.1	99.0	96.8
Health Plan Average	95.6	100.0	98.0	98.0	95.1	95.7

Table 16. MCO and DMO compliance with prior AI recommendations

MCO or DMO	Previous Year Recommendations	Recommendations Implemented	Compliance
Aetna	3	3	100.0%
CFHP	35	30	85.7%
CCHP	35	24	68.6%
DentaQuest	47	40	85.1%
El Paso Health	20	14	70.0%
FirstCare	27	20	74.1%
UHC Dental[a]	N/A	N/A	N/A
Average Compliance	-	-	**80.6%**

[a] This is the first year UHC Dental has undergone review because its contract started in September 2020.

In addition to the federal and state regulatory categories addressed in its full AI process, the EQRO inquired about social determinants of health (SDoH) and the utilization of medical and behavioral health telehealth services. The EQRO asked each MCO and DMO about its procedures for collecting SDoH data and the interventions MCOs and DMOs employ to address member needs related to SDoH. Most MCOs and DMOs refer members to external community resources to address SDoH needs. Several MCOs provided examples of internally funded interventions, including providing school supplies, hygiene supplies, and food drives.

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 (2016).[4] The EQRO QAPI program evaluations assess compliance with federal regulations and state standards, and the presence and strength of the five essential elements of a QAPI program, as defined by CMS (CMS, 2016).

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

Technical Methods & Analyses

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

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

Table 17. 2021 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

In addition to scoring plan performance across all 16 activities based on whether requirements for each component are "met" (fully), "partially met," or "not met," the EQRO provides recommendations to the MCOs on any component not fully met. The EQRO also reviews whether the MCOs fully incorporated prior-year recommendations and scores the actions taken in response to each recommendation. However, the EQRO does not include this additional recommendation score when calculating the current overall score.

Results

MCO & DMO QAPI Results

Table 18 shows the score for each MCOs or DMOs SFY 2021 QAPI. The average score was 97.1 percent (SD = 2.6). The EQRO considered scores more than half a standard deviation below the mean (<95.8 percent) as "below average" (30 percent of MCOs and DMOs) and considered scores more than half a standard deviation above the mean (>98.4 percent) as "above average" (40 percent of MCOs and DMOs).

Nine MCOs and one DMO improved from their SFY 2020 QAPI evaluations, with Aetna showing the greatest improvement from 85.8 percent on the SFY 2020 QAPI evaluation to 99.4 percent on the SFY 2021 QAPI evaluation. CCHP and MCNA matched their previous year's scores of 100 percent, with BCBSTX also scoring 100 percent on the SFY 2021 QAPI evaluation. The two lowest-scoring plans, FirstCare (90.0 percent) and SWHP (94.4 percent), lost points due to reporting incorrect data for some of the indicators included in *Appendix D: Present on Admission (POA) Screening Criteria*. For example, both MCOs reported they are monitoring and addressing the number of member complaints and appeals resolved within 30 days as one of their service indicators. However, instead of reporting the number of complaints and appeals resolved, both MCOs reported the number of complaints and appeals filed by the members. Additionally, FirstCare did not report the results of its Texas Department of Insurance (TDI) audit for Activity B9.

Table 18. MCO and DMO 2021 QAPI scores

MCO or DMO	Score	Peer Comparison
Aetna Better Health (Aetna)	99.4%	Above Average
Amerigroup	99.5%	Above Average
Blue Cross Blue Shield of Texas (BCBSTX)	100%	Above Average
Cigna-HealthSpring (HealthSpring)	95.8%	Average
Community First Health Plans (CFHP)	98.4%	Average
Community Health Choice (CHC)	99.2%	Above Average
Cook Children's Health Plan (CCHP)	100%	Above Average
Dell Children's Health Plan (DCHP)	95.8%	Average
DentaQuest	99.3%	Above Average
Driscoll Health Plan (Driscoll)	96.4%	Average
El Paso Health	99.4%	Above Average
FirstCare Health Plans (FirstCare)	90.0%	Below Average
MCNA Dental (MCNA)	100%	Above Average
Molina Healthcare of Texas (Molina)	94.9%	Below Average
Parkland Community Health Plan (PCHP)	95.0%	Below Average
RightCare from Scott and White Health Plan (SWHP)	94.4%	Below Average
Superior HealthPlan (Superior)	95.1%	Below Average
Texas Children's Health Plan (TCHP)	97.5%	Average
UnitedHealthCare Community Plan (UHC)	95.8%	Average
UHC Dental	95.0%	Below Average
Average	**97.1%**	-

The EQRO evaluated the MCO/DMO QAPI program summary reports by section to identify areas of high performance and opportunities for both systematic and individual improvement. Table 19 shows the average QAPI program performance by activity. Performance on activities contributing to the final score ranged from 83.3 percent to 100 percent. The activity with the lowest performance was "Corrective Action Plans" for TDI audits. As noted above, the low score for this activity was due to one MCO that did not provide the requested information. The activity with the next lowest score (88.2 percent) was "incorporation of the previous year's recommendations," which demonstrated a 9-percentage point improvement from the previous year. For the *Program Description* activity, the EQRO saw improvement in the MCOs' and DMOs' establishment of goals that represent the vision and mission of their QI program, with only two MCOs and one DMO receiving recommendations for improvement of goals. However, eight of the MCOs and DMOs failed to fully meet the criteria for listing written QI objectives to meet their long-term goals. Additionally, indicator monitoring, evaluated in activities B5, B6a, and B6b, offers additional opportunities for improvement. Half of the MCOs and DMOs scored "partially met" for at least one component of these activities, primarily due to incomplete or inaccurate documentation of results or the analyses of results.

Table 19. Average MCO and DMO 2021 QAPI scores by activity

Activity	Score
Required Documentation Overall	100%
A1: Role of Governing Body	100%
A2: Structure of Quality Improvement Committee(s)	100%
A3: Adequate Resources	98.8%
A4: Improvement Opportunities	97.9%
B1: Program Description	95.9%
B2: Overall Effectiveness	96.0%
B3: Effectiveness of Long-Term Services and Supports (LTSS)	95.5%
B4: Clinical Practice Guidelines	98.3%
B5: Availability and Access to Care Monitoring and Results	96.3%
B6a: Clinical Indicator Monitoring	97.2%
B6b: Service Indicator Monitoring	93.3%
B7: Credentialing and Re-credentialing	97.7%
B8: Delegation of QAPI Activities	99.5%
B9: Corrective Action Plans	83.3%
B10: Previous Year's Recommendations	**88.2%**

MMP QAPI Results

Table 20 shows the 2021 score for each Medicare-Medicaid Plan (MMP). The average score was 95.5 percent (SD = 0.6). The EQRO considered scores more than half a standard deviation below the mean (<95.2 percent) as "below average" and scores more than half a standard deviation above the mean (>95.8 percent) "above average."

The lowest score was for Molina (94.6 percent). This low score was primarily due to Molina not including a percent change analysis for the effectiveness of actions taken and not reporting future actions for several indicators reported in “Availability and Access to Care Monitoring and Results.” Three of the MMPs, Amerigroup, HealthSpring, and UHC, did not incorporate all the previous year's recommendations.

Table 20. MMP 2021 QAPI scores

MMP	Score	Peer Comparison
Amerigroup	95.8%	Average
Cigna-HealthSpring (HealthSpring)	95.0%	Below Average
Molina Healthcare of Texas (Molina)	94.6%	Below Average
Superior HealthPlan (Superior)	95.7%	Average
UnitedHealthCare Community Plan (UHC)	96.1%	Above Average
Average	**95.5%**	-

The EQRO evaluated the MMP QAPI program summary reports by section to identify areas of high performance and opportunities for both systematic and individual improvement. Table 21 shows the average MMP QAPI program performance by activity. Performance on activities contributing to the final score ranged from 60.0 to 100 percent. The activity with the lowest performance was "Previous Year's Recommendations." The lower level of performance was due to three of the MMPs not fully incorporating the previous year's recommendations. The activity with the next lowest score (88.3 percent) was "Availability and Access to Care Monitoring and Results." Three MMPs, HealthSpring, Molina, and Superior, scored "partially met" for at least one component of this activity, primarily due to the MMPs not reporting the actions, results, and/or analysis of results for one or more indicators. Table 22 on the next page lists the EQRO compliance review results for Part 438 Subpart D and QAPI Standards by regulation category and overall, for each MCO/DMO and program combination.

Table 21. Average MMP 2021 QAPI scores by activity

Activity	Score
Required Documentation Overall	100%
A1: Role of Governing Body	100%
A2: Structure of Quality Improvement Committee(s)	100%
A3: Adequate Resources	100%
A4: Improvement Opportunities	96.0%
B1: Program Description	96.3%
B2: Overall Effectiveness	96.7%
B3: Effectiveness of Long-Term Services and Supports (LTSS)	100%
B4: Clinical Practice Guidelines	98.3%
B5: Availability and Access to Care Monitoring and Results	88.3%
B6a: Clinical Indicator Monitoring	96.7%
B6b: Service Indicator Monitoring	95.0%
B7: Credentialing and Re-credentialing	97.5%
B8: Delegation of QAPI Activities	100%
B9: Corrective Action Plans	-
B10: Previous Year's Recommendations	60.0%

Texas EQRO Report Compliance Review Results for Part 438 Subpart D & QAPI Standards

Table 22. EQRO compliance review results for Part 438 Subpart D and QAPI Standards, regulation category, and overall, for each MCO/DMO and program combination

MCO/DMO and Program	438.206	438.207[a, b]	438.208[a]	438.210[a]	438.214	438.224[b]	438.228	438.230[a]	438.236	438.242[a, c, d]	438.330[a, b, c]	Overall[a, b, c, d]
Aetna Overall	100	-	100	92.3	100	-	97.2	-	100	100	100	98.7
Aetna CHIP	100	-	100	92.3	100	-	98.7	-	100	100	100	98.7
Aetna STAR	100	-	100	92.3	100	-	97.0	-	100	100	100	98.7
Aetna STAR Kids	100	-	100	92.3	100	-	97.0	-	100	100	100	98.7
CFHP Overall	100	-	100	98.7	100	-	99.2	-	91.7	100	97.8	98.1
CFHP CHIP	100	-	100	96.2	100	-	96.8	-	91.7	100	98.6	98.2
CFHP STAR	100	-	100	100	100	-	100	-	91.7	100	98.6	98.2
CFHP STAR Kids	100	-	100	100	100	-	100	-	91.7	100	96.2	97. c9
CCHP Overall	100	-	92.9	76.9	100	-	92.3	-	100	100	100	95.1
CCHP CHIP	100	-	92.9	76.9	100	-	80.7	-	100	100	100	95.1
CCHP STAR	100	-	92.9	76.9	100	-	95.5	-	100	100	100	95.1
CCHP STAR Kids	100	-	92.9	76.9	100	-	95.5	-	100	100	100	95.1
DentaQuest Overall	100	-	100	100	100	-	97.2	-	91.7	100	100	98.6

MCO/DMO and Program	438.206	438.207[a, b]	438.208[a]	438.210[a]	438.214	438.224[b]	438.228	438.230[a]	438.236	438.242[a, c, d]	438.330[a, b, c]	Overall[a, b, c, d]
DentaQuest CHIP Dental	100	-	100	100	100	-	96.2	-	91.7	100	100	98.6
DentaQuest Medicaid Dental	100	-	100	100	100	-	97.2	-	91.7	100	100	98.6
El Paso Overall	100	-	100	97.9	100	-	93.2	-	100	100	100	98.6
El Paso CHIP	100	-	100	95.8	100	-	84.6	-	100	100	100	98.6
El Paso STAR	100	-	100	100	100	-	98.3	-	100	100	100	98.6
FirstCare Overall	100	-	100	91.7	100	-	90.6	-	100	100	90.3	96.6
FirstCare CHIP	100	-	100	91.7	100	-	88.1	-	100	100	90.3	96.6
FirstCare STAR	100	-	100	91.7	100	-	93.3	-	100	100	90.3	96.6
UHC Dental Overall	100	-	100	95.5	90.0	-	99.0	-	83.3	100	100	96.0
UHC Dental CHIP Dental	100	-	100	95.5	90.0	-	98.7	-	83.3	100	100	96.0
UHC Dental Medicaid Dental	100	-	100	95.5	90.0	-	99.0	-	83.3	100	100	96.0

[a] The regulations that address state contract requirements are not included in the reported scores. HHSC is working on obtaining compliance documentation for the EQRO to assess these regulations and the EQRO will report on these regulations for all health plans once in the three-year reporting cycle.
[b] The EQRO collects MCO and DMO responses and documentation to select regulations in this category and will assess MCO/DMO compliance and report results in next year's SOA report.
[c] 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 the report.
[d] Two regulations have an implementation date of January 1, 2021 and are not included in the reported scores.
See *Appendix H: Scoring Compliance with 42 C.F.R. § 438 Subpart D and QAPI Standards* for all regulations not included in the results listed above.

COVID-19 Pandemic Impacts

This SFY 2021, the EQRO conducted virtual site visits due to the COVID-19 pandemic and related restrictions on travel and in-person meetings. On the AI, the EQRO requested information on how MCOs and their providers utilized medical and behavioral health telehealth services before and during the public health emergency. Several MCOs reported adopting new systems and software to facilitate telehealth services. Other MCOs reported accelerating already established plans to implement more telehealth service modalities to help serve members. The EQRO also inquired about the utilization of medical and behavioral health telehealth services by MCOs during the AI. The pandemic required many health care activities to move from face-to-face to virtual settings. As a result, in 2020, CMS relaxed many telehealth and telemedicine restrictions. The public health emergency allowed Medicaid providers to use various health platforms for preventive health and wellness screenings, case management services, physical, occupational, and speech therapy, nutritional counseling, assessments, specialty care, and behavioral health services, including those delivered by audio-only telehealth (CMS, 2020c).

Relevance for Assessing Quality, Access & Timeliness

Each MCO, DMO, and MMP utilizes selected indicators in its quality improvement program to monitor and assess access to, availability of, and quality of healthcare and services provided to members. The MCOs, DMOs, and MMPs report indicator results and analyses of results in the QAPI program summary reports. These analyses serve as a resource in evaluating the overall effectiveness of the quality improvement program and may point to areas where the MCO, DMO, or MMP should revise its quality program to achieve continuous quality improvement. When MCO's and DMOs' provide inaccurate information, it limits their ability to assess the quality of care, access to care, and the timeliness of care. MCOs and DMOs need to ensure their reports are complete and include accurate goals, results, and analyses of results for the indicators used to monitor members' access to care and improvements in the quality of healthcare received by the members.

Inadequate availability of provider information limits access to care for members. During the AI Interviews, several MCOs and DMOs reported challenges obtaining and incorporating provider URL information into provider directories. Further, many of the MCOs and DMOs requested clarification on the appropriate machine-readable format posted on their publicly facing websites. This suggests that web resource accessibility is an area of improvement for MCOs and DMOs and one place they can focus resources to help improve access to care. Delays in service authorization decisions also affect the quality and timeliness of care for members. Several MCOs and DMOs did not have compliant procedures for the associated timeframes and notification protocols for expedited service authorization decisions. MCOs and DMOs should ensure their representatives make expedited service authorization decisions and notifications within the federally required timeframes to help ensure that members are receiving timely care.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 23 and Table 24 list the key findings and recommendations from EQR activities for Protocol 3 and their relevance to the MCQS.

Table 23. Findings and recommendations from AI interviews

Category	Description
Finding(s)	Several MCOs and DMOs reported challenges obtaining and incorporating provider URL information into provider directories.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs and DMOs, including Aetna, CFHP, FirstCare, and UHC Dental, should establish systems to incorporate provider website URLs in their provider directories.
Finding(s)	Many MCOs and DMOs requested clarification on the appropriate machine-readable format posted on their publicly facing websites.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	Aetna, CFHP, CCHP, DentaQuest, FirstCare, and UHC Dental should provide machine-readable provider directories on their websites.
Finding(s)	Several MCOs and DMOs did not have compliant procedures for the associated timeframes and notification protocols for expedited service authorization decisions.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs and DMOS, including CFHP, CCHP, El Paso Health, FirstCare, and UHC Dental, should ensure their representatives make expedited service authorization decisions and notifications within the federally required timeframes.
Finding(s)	Several MCOs and DMOs 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 and DMOs with a CHIP product line need to evaluate their procedures to ensure that CHIP grievance system protocols align with Medicaid grievance system protocols, excluding the Medicaid requirement of continuation of benefits pending the appeal, a state fair hearing, or both.
Finding(s)	Some MCOs and DMOs 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 members' SDoH needs to aggregate needs by populations to impact member health and well-being effectively.
Finding(s)	While some MCOs and DMOs had implemented specific SDoH related interventions, some of these interventions' direct and indirect effects were not clearly measured.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	MCOs and DMOs should consider evaluating the impact of plan-driven SDoH-related interventions and referrals to community resources on members' health and well-being.

Category	Description
Finding(s)	MCOs and DMOs reported several multi-agency collaborations to address SDoH needs in members.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	MCOs and DMOs are encouraged to share SDoH-related interventions and best practices with other entities, including HHSC, to further address unmet needs that may impact the health of Texans enrolled in Medicaid and CHIP programs.
Finding(s)	MCOs reported rapid 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 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.

Table 24. Findings and recommendations from SFY 2021 QAPI evaluations

Category	Description
Finding(s)	This year, the following MCOs and MMPs did not provide complete and accurate indicator goals, results, and/or analyses of results: Aetna, BCBSTX, CFHP, CHC, DCHP, FCHP, HealthSpring, HealthSpring MMP, Molina, Molina MMP, PCHP, Superior, Superior MMP, SWHP, and UHC.
MCQS Goal(s)	Goals 1, 4
Recommendation(s)	The EQRO recommends that Aetna, BCBSTX, CFHP, CHC, DCHP, FCHP, HealthSpring, HealthSpring MMP, Molina, Molina MMP, PCHP, Superior, Superior MMP, SWHP, and UHC report complete and accurate goals, results, and analyses of results for the indicators used to monitor members' access to care and improvements in the quality of healthcare received by the members.
Finding(s)	Each year, the EQRO makes recommendations on areas with opportunities for improvement for each applicable MCO, DMO, and MMP. The EQRO subsequently assesses compliance with the previous recommendations and deducts points for each applicable evaluation component if the opportunity for improvement still exists on the current QAPI. In addition, the EQRO produces a score for compliance with previous recommendations. Each MCO or DMO should strive to improve its structure and processes and utilize strategies for continuous quality improvement. This year, the following MCOs and MMPs did not incorporate all recommendations from the previous year: Aetna, Amerigroup, Amerigroup MMP, HealthSpring, HealthSpring MMP, Driscoll, FirstCare, Molina, Molina MMP, PCHP, Superior, and UHC.
MCQS Goal(s)	Goals 1, 4
Recommendation(s)	The EQRO recommends Aetna, Amerigroup, Amerigroup MMP, HealthSpring, HealthSpring MMP, Driscoll, FirstCare, Molina, Molina MMP, PCHP, Superior, and UHC incorporate recommendations from the previous year.

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 (NAIC, 2020). CMS requires all states that contract with an MCO or DMO to deliver Medicaid services must develop and enforce network adequacy standards consistent with 42 C.F.R. § 438.68, (2020).

Per 42 C.F.R. § 438.358 (b)(1)(iv)(2016), the mandatory EQR activities must include validation of MCO, PIHP, or PAHP network adequacy during the preceding 12 months to comply with requirements outlined in § 438.68 and, if the state enrolls Indigenous people in the MCO, PIHP, or PAHP § 438.14(b)(1)(2020). As of December 2021, CMS has not released the network adequacy protocol details. However, the EQRO conducts several activities that assess network adequacy for Texas Medicaid and CHIP members. Table 25 summarizes the EQR activities associated with network adequacy during the reporting period.

Table 25. EQR network adequacy activities for SFY 2021

Activity	Description
MCO Administrative Interviews	Assess MCO compliance with access and timeliness as part of the MCO compliance assessment process. Protocol 3 includes additional information on this process and the results.
Appointment Availability Study	This study is a mystery shopper study that assesses MCO compliance with appointment wait time standards for four types of care: vision care, prenatal care, behavioral health care, and primary care. The EQRO conducted two sub-studies in SFY 2021, primary care and behavioral health care.
Texas Medicaid Unmet Transportation Need Study	This study is a biennial telephone-based survey that assesses unmet medical transportation needs among Medicaid members that did not use NEMT services.

EQR Activities

Appointment Availability Study

Senate Bill (SB) 760, 84th Legislature, Regular Session 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 (HHSC, 2021b) 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. Table 26 outlines the guidelines for timely access.

Table 26. Texas standards for Medicaid and CHIP appointment availability

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

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. The EQRO 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. Callers follow written call scripts tailored to each program and sub-study when requesting an initial outpatient appointment and 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 REDCap, a secure web database application. HHSC reviews and approves all tools before the beginning of data collection. The research team completed the SFY 2021 Behavioral Health Care sub-study calls between November 2020 and March 2021, and Primary Care sub-study calls between March and July 2021. The EQRO will resume conducting all four sub-studies in SFY 2022.

Results

In 2021, compliance with behavioral health appointment wait time standards decreased in CHIP, STAR+PLUS, and STAR Kids, compared to 2018. STAR Kids had the lowest percentage of compliant providers for behavioral health care among all programs. The percentage of STAR Kids providers compliant with UMCM standards was 13.1 percentage points lower in 2021 than in 2018. CCHP had the lowest percentage of providers in compliance with wait time standards for all product lines it serves (STAR, STAR Kids, CHIP). In SFY 2021, the percentage of providers compliant with primary care standards for preventive and routine primary care decreased in CHIP and STAR+PLUS compared to SFY 2020. In STAR Health, the percentage of Primary Care appointments available dropped by 17.7 percentage points.

Texas Medicaid Unmet Transportation Need Study

Federal Medicaid regulations 42 C.F.R. § 431.53 (2016) require that HHSC ensure transportation to and from covered healthcare is available for all eligible Medicaid members. In SFY 2020 and SFY 2021, General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 12(a)) required

HHSC to use Medicaid client [5] surveys to determine unmet transportation need based on the percentage of Medicaid clients who did not use medical transportation services and experienced either a 'difficult' or 'very difficult' time obtaining transportation to medical appointments.

Technical Methods & Analysis

The Unmet Transportation Need Study describes unmet transportation needs and general awareness of NEMT services among Texas Medicaid clients who did not use the Medical Transportation Program (MTP) between September 1, 2018, and August 31, 2019. In consultation with HHSC, the EQRO developed a telephone survey tool to assess unmet transportation need and general awareness of NEMT services among Texas Medicaid clients that had not used the NEMT services. The EQRO extracted the sample for the study from monthly enrollment files and excluded clients that accessed NEMT services between September 1, 2018, and August 31, 2019, based on transportation claims data provided by HHSC. The sample drawn for the study included 41,600 unique client records. The EQRO worked with a vendor that administered the survey to eligible Medicaid clients between May 2020 and November 2020. The survey questions focused on client difficulty accessing transportation to covered medical and dental services, critical challenges associated with obtaining transportation to medical appointments, and awareness about NEMT services. The EQRO submitted a final report to HHSC during the reporting period which included an overview of the sociodemographic characteristics of the survey respondents and a summary of survey responses regarding unmet transportation needs and awareness of NEMT services. A separate technical appendix that accompanies the report provides frequency tables showing descriptive results for each survey question for all respondents and by age category.

Results

Only 13.4 percent of surveyed Medicaid clients indicated that it was 'difficult' or 'very difficult' to find transportation to the doctor or dentist, which is below the 16 percent threshold established by Rider 12(a). The percentage of clients with unmet transportation needs was larger among adult clients (21.6 percent). A larger percentage of adult clients identified having unmet medical transportation needs (21.6 percent vs. 7.4 percent) and less familiarity with NEMT services (35 percent vs. 22.2 percent) compared to caregivers for younger clients. Difficulty getting transportation that meets scheduling needs and distance to the bus/train stops were two of the more frequently noted barriers to medical transportation. A small percentage of clients (6.7 percent) said they reached out to their MCO or provider for help with transportation. Among those that did reach out, 46.5 percent said they 'usually' or 'always' received help. The percentage of adult clients that reached out to their MCO or provider was larger (12.9 percent) than the percentage of caregivers for children (2.8 percent).

COVID-19 Pandemic Impacts

It is difficult to assess the continued impact of COVID-19 on the availability of health services among Texas Medicaid members. The ongoing disruption from the pandemic may have affected call wait times and other aspects of provider availability, including office hours, urgent care appointments, and vaccination schedules. Due to the ongoing pandemic, the EQRO only conducted two sub-studies on appointment wait times in SFY 2021, one on primary care provider availability and one on behavioral health care provider availability. The EQRO also added a telehealth question to the tools to capture the increase in telehealth availability among Texas Medicaid providers due to flexibilities put in place because of the COVID-19 PHE.

[5] "Client" is used in this context because the study refers to transportation services.

It is difficult to assess the impact of the COVID-19 pandemic on the Unmet Need study because there are not comparable results from before the pandemic. However, members did not mention COVID-19 as a factor in accessing transportation to medical appointments. The vendor did note that it was more difficult to reach members during the pandemic, which meant that it took longer to reach the required number of completed surveys.

Relevance for Assessing, Quality, Access & Timeliness

The two EQR activities described in detail under this protocol are directly relevant to understanding timeliness of care (based on the number of appointments that meet wait time standards) and access to care (based on the percentage of members that are not utilizing NEMT services yet identify lack of transportation as a barrier to accessing medical care). 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. On the other hand, unmet transportation needs were lower among members that did not use NEMT services than they were among members that did use NEMT services, suggesting that the NEMT services are reaching the people that most need them.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 27 and Table 28 list the key findings and recommendations from EQR activities for Protocol 4 and their relevance to the MCQS.

Table 27. Key findings and recommendations from the SFY 2021 Appointment Availability sub-studies

Category	Description
Finding(s)	STAR Kids MCOs have room to improve compliance with wait time standards in behavioral health. STAR Kids had the lowest percentage of compliant providers for behavioral health care among all programs. The percentage of STAR Kids providers compliant with UMCM standards was 13.1 percentage points lower in 2021 than in 2018.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	STAR Kids MCOs should conduct root cause analyses (RCAs) to identify the driving factors behind lower rates of provider compliance among behavioral health providers and use the results to identify strategies for improving provider compliance.
Finding(s)	In 2021, compliance with behavioral health appointment wait time standards decreased in CHIP, STAR+PLUS, and STAR Kids, compared to 2018.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	The EQRO recommends that HHSC conduct an in-depth study on appointment wait times to: (1) better understand the challenges that MCOs encounter when trying to increase the percentage of providers that are compliant with appointment standards and (2) more effectively target MCO incentives to increase the percentage of providers that meet appointment availability standards.
Finding(s)	CCHP has the most room to improve compliance with wait time standards for behavioral health. CCHP had the lowest percentage of providers in compliance with wait time standards for all product lines it serves (STAR, STAR Kids, CHIP).
MCQS Goal(s)	Goals 3, 5

Category	Description
Recommendation(s)	• HHSC should strongly encourage CCHP to conduct a root cause analysis to identify the drivers for low compliance with appointment standards • CCHP should use the RCA to identify specific approaches that they can use to encourage providers to make appointments available within 14 working days.
Finding(s)	The EQRO excluded fewer providers from the behavioral health sub-study in 2021 because of incorrect taxonomies or other directory information.
MCQS Goal(s)	Goal 4
Recommendation(s)	The EQRO recommends that HHSC continue to work with MCOs and TMHP to improve provider directory information quality.
Finding(s)	In STAR Health, the percentage of appointments available dropped by 17.7 percentage points.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	The EQRO recommends that Superior conduct an RCA to understand the decrease in available primary care appointments between SFY 2020 and SFY 2021 and use this information to identify ways to increase the percentage of providers with available appointments.
Finding(s)	In SFY 2021, the percentage of providers compliant with primary care standards for preventive and routine primary care decreased in CHIP and STAR+PLUS compared to SFY 2020.
MCQS Goal(s)	Goals 1, 3
Recommendation(s)	As with behavioral health, the EQRO recommends that HHSC conduct an in-depth study on appointment wait times to: (1) better understand the challenges that MCOs encounter when trying to increase the percentage of providers that are compliant with appointment standards and (2) more effectively target MCO incentives to increase the percentage of providers that meet appointment availability standards.

Table 28. Key findings and recommendations from the SFY 2020-2021 Unmet Transportation Need study

Category	Description
Finding(s)	A larger percentage of adult clients identified having unmet medical transportation needs (21.6 percent vs. 7.4 percent) and less familiarity with NEMT services (35 percent vs. 22.2 percent) compared to caregivers for younger clients.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	The EQRO recommends that HHSC develop targeted information campaigns about NEMT services tailored to older Medicaid clients (21+) to help increase awareness. Targeted information campaigns may help HHSC meet its MCQS goal of providing the right care for clients at the right time by facilitating client knowledge about access to care.
Finding(s)	Difficulty getting transportation that meets scheduling needs and distance to the bus/train stops were two of the more frequently noted barriers to medical transportation.
MCQS Goal(s)	Goals 1, 2, 3

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

Protocol 5: Validation of Encounter Data

Protocol Overview & Objectives

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

1. 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

Encounter Data Submissions & MCO Encounter Data Production Capacity

Technical Methods & Analyses

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 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. Protocol 2 describes these AI findings and other evaluations of MCO information systems and processes as they relate to the 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, 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, 2019b), the EQR Toolkit (CMS, 2012b), the CMS Encounter Data Toolkit (Byrd et al., 2013), and Texas Government Code § 533.0131 (2001). The EQRO certifies data for each program by MCO or DMO and SA (i.e., by plan code).

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

1. Encounter data
2. State paid claims (processed by TMHP)
3. Pharmacy encounter data (processed by TMHP-Pharmacy)
4. Provider data
5. Member enrollment data

To allow for full adjudication and processing of all claims for services during the certification period (SFY 2020), 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 2020 for the certification of SFY 2020 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.

In STAR, the institutional percentage of encounters by MCO/SA typically ranges from 10 to 25, with higher percentages seen in the MRSA, possibly due to higher use of Federally Qualified Health Centers (FQHC) and rural health clinics; these results were consistent with prior years. The institutional percentage of encounters varies more in STAR+PLUS, ranging from less than five percent (all MCOs in Hidalgo and El Paso SAs) to over 35 percent (both MCOs in MRSA-Central). In STAR Kids, BCBSTX (operating only in Travis) stands out with 42 percent institutional encounters, more than twice the percentage for the other Travis MCO, Superior. These variations suggest underlying differences in the care delivery model that affect QOC measures. While changes related to COVID-19 make it more challenging to identify other issues during SFY 2020, large single-month changes can also indicate a processing issue. When MCOs experience a processing issue and do not provide HHSC or the EQRO with accurate data or information explaining the issue, it can affect the use of the data for QOC measures.

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 PPC measure
- Provider information, including submitted national provider identifier (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 2020 data, the EQRO included 17 encounter fields in the review and considered validity check rates below 95 percent to be areas of concern. The EQRO highlighted rates below 99 percent to bring them to the attention of the MCOs and HHSC. All MCOs passed these key field reviews, but the EQRO highlighted several deficiencies:

- In STAR, 2.4 percent of encounters for Driscoll in the Nueces SA had invalid/missing member ID.
- In STAR+PLUS, 2 percent of inpatient encounters for Superior in the Lubbock SA were missing the admission date.
- In STAR Kids, more than 1 percent of inpatient encounters for TCHP in the Harris SA were missing admission date.
- In CHIP, 4 percent of encounters for CFHP in the Bexar SA had invalid/missing member ID.
- More than 1 percent of inpatient encounters for FirstCare in the Lubbock SA were missing admission date in CHIP.

An annual review of encounter 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 D: 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*). The EQRO found that POA distributions for primary diagnoses were within their accepted ranges for most MCO/SAs. However, POA was *not* present on admission (POA code = *N*) more than 10 percent of the time in some cases (Table 29). One cause could be a high number of maternity stays. Hospitals will code significant delivery complications in the primary diagnosis, although the admission was for delivery.

Table 29. Primary diagnosis POA distribution outside accepted criteria

Program	MCO	SA	Criteria	Rate
STAR	Amerigroup	Jefferson	High (≥10%) Primary POA = *N*	11.1%
STAR	Amerigroup	MRSA West	High (≥10%) Primary POA = *N*	10.5%
STAR	Driscoll	Hidalgo	High (≥10%) Primary POA = *N*	10.8%

Program	MCO	SA	Criteria	Rate
STAR	FirstCare	MRSA West	High (≥10%) Primary POA = *N*	10.1%
STAR	Molina	Hidalgo	High (≥10%) Primary POA = *N*	12.6%
STAR	Superior	Hidalgo	High (≥10%) Primary POA = *N*	10.6%
STAR	Superior	MRSA Northwest	High (≥10%) Primary POA = *N*	10.5%
STAR	UHC	Hidalgo	High (≥10%) Primary POA = *N*	10.3%
STAR	UHC	Jefferson	High (≥10%) Primary POA = *N*	10.8%
STAR	UHC	Nueces	High (≥10%) Primary POA = *N*	10.2%
STAR	SWHP	MRSA Central	High (≥1%) Primary POA = *W*	1.1%
STAR+PLUS	Amerigroup	Harris	High (≥1%) Primary POA = *W*	1.2%
STAR+PLUS	UHC	Harris	High (≥1%) Primary POA = *W*	1.1%
STAR Kids	Amerigroup	Harris	High (≥1%) Primary POA = *W*	1.0%
STAR Kids	TCHP	Harris	High (≥1%) Primary POA = *W*	1.4%
STAR Kids	UHC	Harris	High (≥1%) Primary POA = *W*	1.9%
CHIP	Amerigroup	Harris	High (≥1%) Primary POA = *W*	1.2%
CHIP	CHC	Harris	High (≥1%) Primary POA = *W*	2.1%
CHIP	UHC	Harris	High (≥1%) Primary POA = *W*	3.0%

To avoid bias in PPC calculations and risk adjustment, 3M recommends screening POA distributions at the hospital level and excluding all data from hospitals that fail to pass the screening tests. *Appendix D: 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)

Individuals not eligible for an NPI regularly provide some billable services. Encounter records also include fields for other provider IDs, including Employer Identification Number (EIN) and the MCO's internal ID (the EQRO no longer receives Texas Medicaid TPI in encounters). Still, the EQRO found that in cases where rendering NPI is missing, other IDs are also missing.

In STAR, individual NPI with taxonomy was present on 64.0 percent of all encounters and 70.9 percent of selected procedures. Only Community Health Choice had a rate of over 90 percent on selected procedures. Rates were similar in CHIP. STAR+PLUS continues to have very low NPI and taxonomy. Even considering only selected procedures, only 51.0 percent of encounters included the individual rendering NPI with taxonomy. STAR Kids has similar deficiencies, and only 28.2 percent of encounters for selected procedures included an individual rendering NPI with taxonomy. The rate in STAR Health is only 45.7 percent. In general, provider data quality went down relative to the prior year. The state has several ongoing initiatives to try and improve the quality of provider data, both in encounters and in the master provider data, that it hopes will bring about improvement in the coming year.

Dental Data

The volume of dental encounters fell universally to extremely low numbers beginning in March 2020 and continuing through May 2020. In prior years, dental QOC measures calculated for Texas HHSC did not require encounters to include provider specialty identification. However, beginning with MY 2020, measures with provider type requirements will use encounter information and provider information the same way as medical QOC measures. Almost all DMO encounters include an individual NPI as the rendering provider and include taxonomy about 90 percent of the time. Increasing the taxonomy fill rate will improve measure calculations.

Required tooth and tooth surface identification continue to be greater than 99 percent. Several dental QOC measures included in the Pay-for-Quality (P4Q) program require identifying members with elevated caries risk. Caries risk assessment (CRA) is a required part of a complete dental exam, and providers should code CRA on all dental exam encounters. The EQRO highlighted the need to improve the rate of CRA coding several years ago, and the measure improved slightly, but appropriate codes are still missing more than two percent of the time. The DMOs correctly deny these claims, but the data is still unrecoverable.

FSR Analysis

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

Review of Medical & Dental Records for Consistency with Encounter Data

The EQRO annually validates encounter data for accuracy and completeness by comparing encounters against a representative dental or medical records sample. Although CMS updated guidance for these activities in the

revised Protocol 5 (CMS, 2019b), the EQRO applied the previous EQR Protocol 4 (CMS, 2012a) to these activities because it was the most current guidance available when the project began. Planning and implementation began before the 2019 revision to the protocols was released, so the EQRO alternated sample types annually, including either dental or medical records each year. As a result, the SFY 2021 Encounter Data Validation: Medical Record Review (EDVMRR) sample included only CHIP medical encounters. The SFY 2021 EDV Dental Record Review (EDVDRR) sample included only CHIP and Medicaid dental encounters. The 2019 changes to the EDV review process will be reflected starting in the next (SFY 2022 reporting period) SOA report.

Encounter Data Validation Medical Record Review-CHIP (EDVMRR-CHIP)

Technical Methods and Analyses

The EDVMRR study examined medical encounters and records for Texas CHIP managed care members. The EQRO validated the dates of service (DOS), place of service (POS) codes, primary diagnoses (PDx) and procedures (PX). The EQRO validated up to 50 DOS per record for each member and up to 25 procedures and one primary diagnosis per DOS and POS. Encounters were for services from January 1, 2019, through December 31, 2019, and the sample allowed at least six 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. For this study, instead of using the address in the provider files, the EQRO used the service facility address. Eligible providers were those currently 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 2017 EDVMRR for DOS for CHIP (73.9 percent), resulting in a sample of 147 records per member. The EQRO adjusted the number of records requested based on the previous study's record return rate for CHIP, which was 58 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 253 records. The EQRO requested the member medical record for the entire study period (2019) from the provider associated with the qualifying encounter for each selected member-provider pair in the qualified sample pool.

Record Retrieval

Initially, there were two MCOs, DCHP and FirstCare, for which the EQRO did not receive enough records to meet the sample size requirement of 147 records. After the EQRO exhausted all efforts to obtain the records, the EQRO provided the MCOs that had not met the required sample size with a list of the unresponsive providers so that the MCOs could obtain the outstanding records and submit them to the EQRO. DCHP eventually obtained an adequate number of records, but FirstCare could not obtain enough outstanding records and failed to meet the sample size required for reliable match rates.

Analysis

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

The EQRO calculated the following final match rates:

- 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 and 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, PX data elements, and the record return rate to test for significant differences between MCOs and programs. In addition, a single provider may be associated with multiple members due to the sampling methodology for this study. Therefore, the EQRO tested for clustering around providers.

Results

Record Availability Results

The EQRO requested 253 records per MCO and needed to receive 147 records per MCO to meet the sample size requirements. Overall, the EQRO received and reviewed 78 percent of the 3,795 requested member records. For 575 requests (15 percent), the EQRO received no response. For 258 of the record requests (7 percent), the EQRO did not receive the records because the provider address was incorrect; or the provider indicated the member was not a patient or indicated they had not seen the member during the requested period.

MCO record return rates ranged from 133 records received (53 percent) for FirstCare to 235 records received (93 percent) for Driscoll. FirstCare was the only MCO that did not meet the sample size requirements. The most common reason for the record deficiencies for FirstCare were 82 “no response” (32 percent) and 36 “incorrect addresses” (14 percent). Table 30 provides detailed record availability information for all MCOs that serve CHIP members.

Table 30. Detailed information on record availability by MCO and program

MCO	Reviewable Records Received	No Response	Bad Address	Not a Patient	Not seen during the requested period	Record sent outside the requested period
Aetna	179	50	22	2	0	0
Amerigroup	191	42	10	3	4	3
BCBSTX	192	53	6	0	1	1
CFHP	179	40	30	0	1	3
CHC	191	47	13	1	0	1
CCHP	217	25	10	0	1	0
DCHP	231	14	8	0	0	0
Driscoll	235	12	4	0	2	0
El Paso Health	205	37	9	1	1	0
FirstCare[a]	133	82	36	0	2	0
Molina	192	30	21	6	2	2
PCHP	192	50	7	2	0	1
Superior	203	32	14	0	2	2
TCHP	209	33	9	1	0	1
UHC	212	28	6	4	3	0
Total	2961	575	205	20	19	14

[a] Rates are unreliable because MCO did not meet the sample size requirement.

Match Rate Results

Overall, the program averages were high for most MCOs, ranging from 90 percent (PCHP) to 98.7 percent (BCBS) across all data elements. Table 31 shows the DOS match rate for each CHIP MCO. The average match rate for DOS was 96.5 percent for the 5,663 DOS considered.

Table 31. DOS match rate for CHIP MCOs

MCO	In Record/Not in Encounter	In Encounter/ Not in Record	DOS Match Rate
Aetna Better Health (Aetna)	0.9%	2.4%	96.7%
Amerigroup	0.0%	3.0%	97.0%
Blue Cross Blue Shield of Texas (BCBSTX)	0.3%	1.0%	98.7%
Community First Health Plans (CFHP)	2.4%	2.7%	94.8%
Community Health Choice (CHC)	0.5%	1.1%	98.4%
Cook Children's Health Plan (CCHP)	0.7%	0.7%	98.5%
Dell Children's Health Plan (DCHP)	0.2%	1.2%	98.6%
Driscoll Health Plan (Driscoll)	1.6%	1.4%	97.0%
El Paso Health	0.0%	3.7%	96.3%

MCO	In Record/Not in Encounter	In Encounter/ Not in Record	DOS Match Rate
FirstCare Health Plans (FirstCare)[a]	0.4%	5.8%	93.8%
Molina Healthcare of Texas (Molina)	1.4%	2.8%	95.8%
Parkland Community Health Plan (PCHP)	0.2%	9.3%	90.5%
Superior HealthPlan (Superior)	0.0%	2.7%	97.3%
Texas Children's Health Plan (TCHP)	0.8%	3.8%	95.4%
UnitedHealthcare Community Plan (UHC)	1.0%	1.9%	97.1%
Average	**0.7%**	**2.8%**	**96.5%**

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

The POS match rates (not shown) are very similar to DOS rates, with almost all unmatched POS associated with an unmatched DOS. The match rate was 95 percent or higher across MCOs, except for FirstCare (93.8 percent) and PCHP (90.5 percent). Across CHIP, BCBSTX and DCHP had the highest POS match rates (98.7 and 98.6 percent, respectively).

The EQRO reviewed 5,663 PDx with an average match rate of 95.7 percent across MCOs. The match rates ranged from 90 percent for PCHP to 98.1 percent for DCHP. Table 32 shows the PDx match rate for each CHIP MCO.

Table 32. PDx match rate for CHIP MCOs

MCO	In Record/Not in Encounter	In Encounter/ Not in Record	PDx Match Rate
Aetna Better Health (Aetna)	0.9%	2.4%	96.7%
Amerigroup	0.0%	4.2%	95.8%
Blue Cross Blue Shield of Texas (BCBSTX)	0.3%	2.2%	97.5%
Community First Health Plans (CFHP)	2.4%	3.4%	94.2%
Community Health Choice (CHC)	0.5%	3.0%	96.5%
Cook Children's Health Plan (CCHP)	0.7%	1.5%	97.8%
Dell Children's Health Plan (DCHP)	0.2%	1.6%	98.1%
Driscoll Health Plan (Driscoll)	1.6%	2.6%	95.8%
El Paso Health	0.0%	3.7%	96.3%
FirstCare Health Plans (FirstCare)[a]	0.4%	7.6%	92.0%
Molina Health Plan of Texas (Molina)	1.4%	3.0%	95.6%
Parkland Community Health Plan (PCHP)	0.2%	9.8%	90.0%
Superior HealthPlan (Superior)	0.0%	3.5%	96.5%
Texas Children's Health Plan (TCHP)	0.8%	4.1%	95.2%
UnitedHealthCare Community Plan (UHC)	1.0%	2.2%	96.9%
Average	**0.7%**	**3.5%**	**95.7%**

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

The EQRO reviewed 14,084 procedures. The average match rate for procedures was 95.9 percent. The match rates ranged from 91.3 percent for PCHP to 98.5 percent for BCBSTX. Table 33 shows the PX match rates for each MCO.

Table 33. PX match rate for MCOs

MCO	In Record/Not in Encounter	In Encounter/ Not in Record	PX Match Rate
Aetna Better Health (Aetna)	0.6%	3.0%	96.4%
Amerigroup	0.1%	3.3%	96.6%
Blue Cross Blue Shield of Texas (BCBSTX)	0.2%	1.3%	98.5%
Community First Health Plans (CFHP)	1.6%	3.3%	95.1%
Community Health Choice (CHC)	0.2%	2.4%	97.4%
Cook Children's Health Plan (CCHP)	0.4%	2.3%	97.3%
Dell Children's Health Plan (DCHP)	0.4%	1.5%	98.1%
Driscoll Health Plan (Driscoll)	0.6%	2.4%	97.0%
El Paso Health	0.0%	3.5%	96.5%
FirstCare Health Plans (FirstCare)[a]	0.6%	6.5%	92.9%
Molina Health Plan of Texas (Molina)	1.0%	3.4%	95.6%
Parkland Community Health Plan (PCHP)	0.3%	8.4%	91.3%
Superior HealthPlan (Superior)	0.1%	4.3%	95.5%
Texas Children's Health Plan (TCHP)	0.9%	4.3%	94.8%
UnitedHealthCare Community Plan (UHC)	0.6%	5.5%	93.8%
Average	**0.5%**	**3.6%**	**95.9%**

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

Encounter Data Validation Dental Record Review Medicaid and CHIP (EDVDRR)

Technical Methods and Analyses

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, place of service (POS), PX, and first tooth IDs. The EQRO validated up to 12 DOS per record for each member and up to 25 procedures per DOS and POS. Encounters were for services from January 1, 2019, through December 31, 2019, 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 those currently active with a DMO and 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 2019 EDVDRR. The lowest rate for 2019 was the PX match rate for CHIP dental (90.7 percent).

Based on the sample size calculations, the required sample size needed for each DMO per program was 130 records. The EQRO adjusted the number of records requested based on the previous study's record return rate, which was 71 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 DMO for each program was 184 records. The EQRO requested the member dental record for the entire study period (2019) from the provider associated with the qualifying encounter for each selected member-provider pair in the qualified sample pool.

Record Retrieval

The EQRO provided the DMOs with the ICNs and associated member and provider details and requested the DMOs to provide the associated provider addresses they had on file for all qualifying encounters. For the selected member-provider pairs, the EQRO mailed record requests 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 percent of the sample to ensure accuracy. Reviewers had a 99 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.
- Place of Service (POS) – The denominator for this match rate is the total number of POS in the encounters and the dental records. A POS was numerator compliant when the POS in the dental record matched the POS 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, POS, PX data elements, and the record return rate to test for significant differences between DMOs and programs. In addition, one provider might have been associated with multiple members due to the sampling methodology for this study. Therefore, the EQRO tested for clustering around providers.

Tooth ID Procedure Codes

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 2019 EDVDRR study. Therefore, the EQRO calculated the tooth ID match rates for the procedure codes from the previous study (EDVDRR 2019) and the updated procedure codes (EDVDRR 2021) to allow cross-year comparisons.

The procedure codes utilized for this study are:

- 2021 Tooth ID 1 Procedure Codes: D135X, D2XXX, D3XXX, D71XX, D721X, D723X, D724X, D725X, D6205-D6793 (prosthodontic)
- 2019 Tooth ID 1 Procedure Codes: D135X, D2XXX, D3XXX, D71XX, D721X, D723X, D724X, D725X

Results

Record Availability Results

The EQRO requested 184 records per DMO per program and needed to receive 130 records per DMO per program to meet the sample size requirements. The EQRO received and reviewed 73 percent of the requested records for CHIP Dental and 76 percent for Medicaid Dental. The EQRO received no response for 75 requests (20 percent) for CHIP and 69 requests (19 percent) for Medicaid. The EQRO received no response on 25 requests (7 percent) for CHIP and 19 requests (5 percent) for Medicaid due to incorrect provider addresses, members not being patients, or members not being seen during the requested period.

Across programs, both CHIP and Medicaid Dental had comparable record return rates with 72.8 percent and 76.1 percent, respectively. DentaQuest CHIP had the lowest record return rate (71.7 percent), while MCNA Medicaid had the highest return rate (78.8 percent).

There was no significant difference ($p > 0.05$) between the record return rate by DMO or program. However, DentaQuest had a lower record return rate due to having more incorrect addresses than MCNA. Table 34 provides detailed record availability information for the DMOs in Medicaid and CHIP dental. The EQRO received enough dental records to meet the DentaQuest and MCNA Medicaid and CHIP dental sample size requirements.

Table 34. Detailed information on record availability by DMO and program

Type of Records	Reviewable Records Received	No Response	Bad Address	Not a Patient	Not seen during the requested period	Record sent outside the requested period
CHIP Dental Records Received by Program	268	75	23	1	1	0
Medicaid Dental Records Received by Program	280	69	16	1	1	1
Total Dental Records Received by program	**548**	**144**	**39**	**2**	**2**	**1**
DentaQuest Records Received by DMO (CHIP)	132	33	19	0	0	0
MCNA Records Received by DMO (CHIP)	136	42	4	1	1	0
Total Records Received by DMO (CHIP)	**268**	**75**	**23**	**1**	**1**	**0**
DentaQuest Records Received by DMO (Medicaid)	135	35	12	0	1	1
MCNA Records Received by DMO (Medicaid)	145	34	4	1	0	0
Total Records Received by DMO (Medicaid)	**280**	**69**	**16**	**1**	**1**	**1**

Match Rate Results

The EQRO reviewed records for 548 members in Medicaid and CHIP dental. Overall, the program averages for the DMOs across review categories (i.e., DOS, POS, and PX) were high, with a range in match rates from 89.4 percent (MCNA CHIP Dental PX) to 99.6 percent (MCNA Medicaid Dental DOS).

The EQRO reviewed 786 DOS for both dental programs. There was a slight variation in match rates for DOS across dental programs. CHIP's average match rate for DOS was 96.4 percent, while the average match rate for Medicaid was 98.8 percent. Across DMOs, the match rates for DOS were high, ranging from 97.2 percent to 98 percent for DentaQuest and 95.7 percent to 99.6 percent for MCNA.

The EQRO reviewed 5,269 procedures for both dental programs. The average match rates for PX across dental programs ranged from 90.5 percent (CHIP) to 93.3 percent (Medicaid). Across DMOs, the match rates for PX ranged from 89.4 percent to 93.7 percent for MCNA and 91.7 percent to 92.9 percent for DentaQuest. Table 35 shows the DOS and PX match rates for the DMOs in Medicaid dental and Table 36 shows the DOS and PX match rates for the DMOs in CHIP dental.

Table 35. 2021 EDVDRR date of service 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	0.5%	1.5%	98.0%
MCNA DOS Match Rates	0.0%	0.4%	99.6%
Average DOS Match Rates	**0.2%**	**0.9%**	**98.8%**
DentaQuest PX Match Rates	3.7%	3.4%	92.9%
MCNA PX Match Rates	1.4%	4.9%	93.7%
Average PX Match Rates	**2.5%**	**4.2%**	**93.3%**

Table 36. 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	1.1%	1.7%	97.2%
MCNA DOS Match Rates	1.1%	3.3%	95.7%
Average DOS Match Rates	**1.1%**	**2.5%**	**96.4%**
DentaQuest PX Match Rates	3.7%	4.6%	91.7%
MCNA PX Match Rates	3.9%	6.7%	89.4%
Average PX Match Rates	**3.8%**	**5.7%**	**90.5%**

The match rates for tooth ID 1 for select procedures (not shown), based on the 2021 and 2019 dental codes, were 97 percent or higher across plans and programs. Overall, the tooth ID 1 match rates for CHIP were slightly higher (98.9 percent) than the Medicaid match rates (97.9 percent) for select procedures based on both 2021 and 2019 dental codes. The POS match rates (not shown) are very similar to DOS rates, with almost all unmatched POS associated with unmatched DOS. The match rate was 96 percent or higher across programs.

Across the DMOs, POS match rates were also high, ranging from 96.2 percent for CHIP MCNA to 99.6 percent for Medicaid MCNA.

COVID-19 Pandemic Impacts

As expected, the COVID-19 pandemic had a substantial impact on encounter volumes. In the STAR and STAR Health programs and CHIP, encounter volume in April and May of 2020 decreased noticeably. Encounter volume during this period increased in the STAR+PLUS program, driven primarily by an increase in institutional encounters. STAR Kids saw only a moderate decrease in volume during April and May. While the EQRO did not specifically review COVID-19 related encounters, this pattern fits with expectations of decreased utilization in healthy populations but potentially COVID-19 related increase in utilization for those with potentially higher risk due to significant health conditions. The decreased pharmacy encounters in STAR and CHIP, concurrent with the decreased medical encounter volume, are of interest. Medication adherence was likely negatively affected by reduced access to routine care during the pandemic. However, in STAR+PLUS, the pharmacy encounter volume remained consistent during the year.

Relevance for Assessing Quality, Access & Timeliness

Encounter data validation is important for ensuring the data used to assess quality and access to care is accurate and reliable. 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. 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 also noted that the provider information declined relative to prior years. Provider data accuracy is important for accurately assessing quality and access; as well as key to improving network adequacy for members. For example, the EQRO did not receive enough records to meet the sample size requirements for FirstCare or HealthSpring after exhausting all record retrieval efforts because records were returned due to incorrect provider addresses.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 37, Table 38, and Table 39 list the key findings and recommendations from EQR activities associated with Protocol 5 and their relevance to the MCQS.

Table 37. Findings and recommendations from encounter data review

Category	Description
Finding(s)	Variations in encounter submissions suggest underlying differences in the care delivery model that affect QOC measures. While changes related to COVID-19 make it more challenging to identify other issues during SFY 2021, large single-month changes can also indicate a processing issue. When MCOs experience a processing issue and do not provide HHSC or the EQRO with accurate data or information explaining the issue, it can affect the use of the data for QOC measures.
MCQS Goal(s)	Goals 1, 3, 4
Recommendation(s)	HHSC should work with the EQRO, TMHP, and the MCOs/DMOs to improve the system to monitor monthly encounter submissions for anomalies and communicate about issues or discrepancies.

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

Table 38. Findings and recommendations from EDVMRR-CHIP

Category	Description
Finding(s)	The EQRO utilized the service facility address rather than the provider address from the Master Provider file when generating the mail-out for the study. In addition, after exhausting all measures to obtain records, the EQRO provided each MCO that had not met the required sample size with a list of outstanding records and the associated member and provider details for the MCO to obtain the outstanding records. The EQRO had a higher record return rate (78 percent) for this study compared to the record return rate for CHIP in the 2017 EDVMRR study (58 percent), which may have been due to the new approach the EQRO utilized for identifying provider addresses and obtaining records.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	• The EQRO recommends utilizing the same approach for identifying provider addresses and requesting records for all EDV studies. • To improve the record return rate and accuracy of provider addresses, the EQRO recommends reaching out to the MCOs before conducting the first mailing for the study to provide the MCOs with a list of ICNs and provider addresses for each member in the respective MCO sample and request that each MCO verify the provider addresses and make corrections where needed.
Finding(s)	The EQRO did not receive enough records to meet the sample size requirements for FirstCare or HealthSpring after exhausting all record retrieval efforts because records were returned due to incorrect provider addresses. Therefore, the EQRO provided FirstCare and HealthSpring with a list of outstanding records and requested that both MCOs retrieve them and submit the records to the EQRO. HealthSpring obtained and submitted enough outstanding records to the EQRO to meet the sample size requirements.
MCQS Goal(s)	Goals 1, 3, 4, 6

Category	Description
Recommendation(s)	HHSC should provide each MCO with the provider information the EQRO has at the time of sampling for each ICN in the sample and ask each MCO to verify and/or correct all provider addresses at the start of the study.
Finding(s)	FirstCare did not obtain and submit enough records to meet the sample size requirements, resulting in the EQRO deeming all FirstCare's match rates unreliable.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	FirstCare should ensure that all provider addresses are the most accurate addresses available at the start of each EDVMRR study. Further, FirstCare should take advantage of the opportunity to retrieve any outstanding records and submit them to the EQRO within the specified timeframe to ensure it meets the required sample size.
Finding(s)	The overall match rates for MCOs were high across review categories (i.e., DOS, POS, PDx, and PX). However, several MCOs performed below average. The MCOs that scored below average across review categories were CFHP, FirstCare, PCHP, TCHP, and UHC. The primary reason for the lower match rates for these MCOs was that the encounter data included DOS, POS, PDx, and/or PXs that were not documented in the medical record.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	CFHP, FirstCare, PCHP, TCHP, and UHC should examine why what is in the encounter data is not documented in the medical record.

Table 39. Findings and recommendations for EDVDRR

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

Protocol 6: Administration of Quality of Care Surveys

Protocol Overview & Objectives

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

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

During SFY 2021, the EQRO designed and conducted the following biennial member surveys:

- STAR Child members
- CHIP members
- Caregivers for child members receiving dental services in Texas Medicaid and CHIP

Technical Methods & Analyses

Instruments & Sample Selection

The *Consumer Assessment of Healthcare Providers and Systems* (CAHPS) Health Plan Survey is a widely used instrument for measuring and reporting experiences with healthcare plans, services, and providers. The survey indicators for MCO performance (e.g., personal doctor and MCO ratings) include individual questions and composite measures that combine closely related survey item scores. The EQRO utilizes the NCQA-validated CAHPS 5.0H version of the CAHPS Health Plan survey, as per Option 1 of Activity I.3 for Protocol 6. This version includes several NCQA-specified supplemental individual items, composites, and item sets such as Coordination of Care, Smoking Cessation, Flu Vaccination summary items, and the Children with Chronic Conditions (CCC) Item Set, along with the full complement of AHRQ-specified measures.

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

Survey Fielding

Each year, the EQRO carefully selects survey research firms to conduct telephone surveys based on reputation, quality, and cost. The EQRO contracted with the University of Florida Survey Research Center (UFSRC) and the nonpartisan and objective research organization NORC at the University of Chicago (hereafter NORC) to conduct the SFY 2021 member and caregiver experience-of-care surveys using CATI (Computer-Assisted Telephone

Interviewing) systems. Both UFSRC and NORC have experience conducting Texas EQRO-related telephone surveys, and UFSRC is NCQA-accredited.

The EQRO fielded the experience-of-care surveys for six to seven months using strategies from Activity I.5 to maximize response rates. The EQRO sent advance letters written in English and Spanish to members or caregivers requesting their participation. The survey vendor began calls approximately four days after each advance mailing. The EQRO calculated survey response rates based on the standard methodology and final disposition categories of the American Association of Public Opinion Research (AAPOR). Table 40 lists the member surveys conducted by the EQRO in SFY 2021 and their enrollment and fielding periods.

Table 40. 2021 caregiver survey enrollment and fielding periods

Survey	Enrollment Period	Fielding Period	Completed Surveys
STAR Child Member	October 2020 –March 2021	April 2021 - September 2021	8,402
CHIP Member	October 2020 –March 2021	April 2021 - September 2021	3,609
Dental Caregiver	December 2020 –May 2021	July 2021-October 2021	1,751

Survey Analyses & Reporting

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

Survey Results

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

Experience of Care – Child Surveys

Table 41 and Table 42 show the 2021 STAR Child Caregiver and CHIP Caregiver survey results for individual survey questions and the CCC Composite and summary rates, respectively. Due to sampling limitations, the CHIP caregiver survey had significantly fewer completes than expected, but the response rate resulted in enough participants to meet reporting standards. The THLC portal (thlcportal.com) has the full list of survey results, including results by MCO and comparisons to national CAHPS benchmarks.

Table 41. 2021 CAHPS STAR Child and CHIP survey results

Survey Question	STAR Child	CHIP
Always Getting Needed Care	67.8%	64.1%
Always Getting Care Quickly	75.6%	74.7%
How Well Doctors Communicate (Always Communicate Well)	83.8%	84.9%
Customer Service (Always Positive Experience)	81.5%	75.6%
Personal Doctor Rating (Caregiver Ratings of 9 or 10)	79.8%	77.9%
Specialist Rating (Caregiver Ratings of 9 or 10)	82.7%	79.6%
Health Plan Rating (Caregiver Ratings of 9 or 10)	82.5%	75.8%
Health Care Rating (Caregiver Ratings of 9 or 10)	81.3%	77.9%

Table 42. 2021 CAHPS STAR Child and CHIP CCC composites and summary rates

Summary or Composite Measure [a]	STAR Child	CHIP
Access to Specialized Services	47.3%	55.2%
Personal Doctor Who Knows Child	91.2%	93.0%
Coordination of Care for Children with Chronic Conditions	79.5%	79.3%
Getting Needed Information	81.7%	84.6%
Access to Prescription Medicines	75.0%	78.4%

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

Most composite scores increased on the STAR Child and CHIP Caregiver surveys between 2019 and 2021 (Figure 3). However, the STAR Child Caregiver scores on the *Getting Care Quickly* composite decreased, as did the scores for *Customer Service* on the CHIP Caregiver survey. The *Getting Needed Care* composite in CHIP changed the most between 2019 and 2021 (+6.1 percent). Although three of the survey rating scores increased from 2019 to 2021 for STAR Child and CHIP, the *Health Plan Rating* for CHIP and STAR Child decreased slightly (Figure 4). The biggest rating change between 2019 and 2021 was the *Specialist Rating* in CHIP (+4 percent).

Figure 3. Change in STAR Child and CHIP survey composite scores between 2019 and 2021

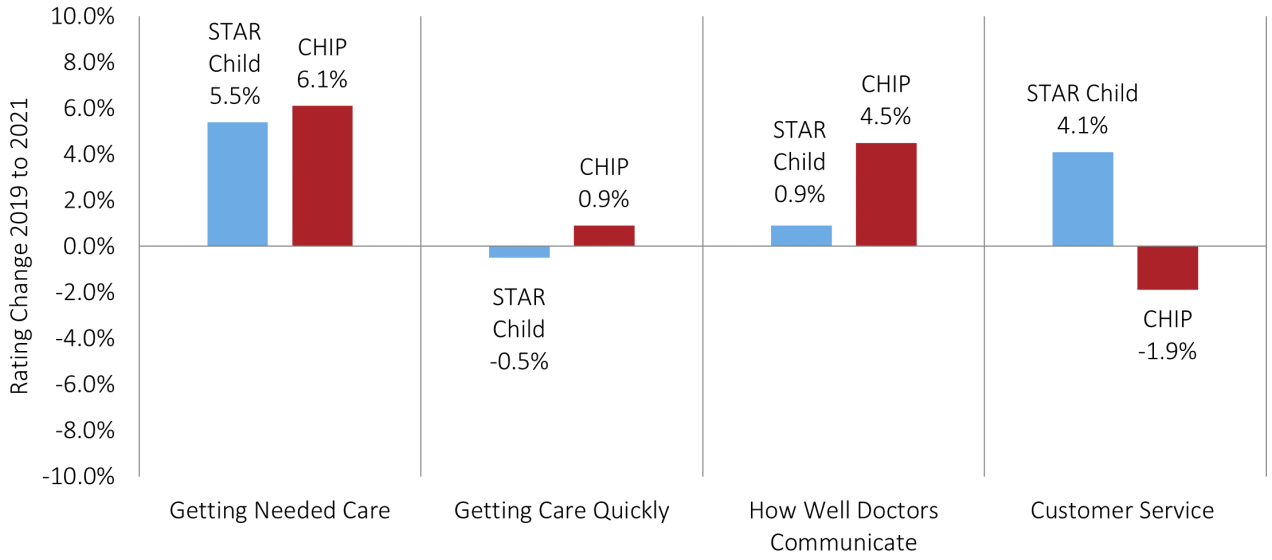
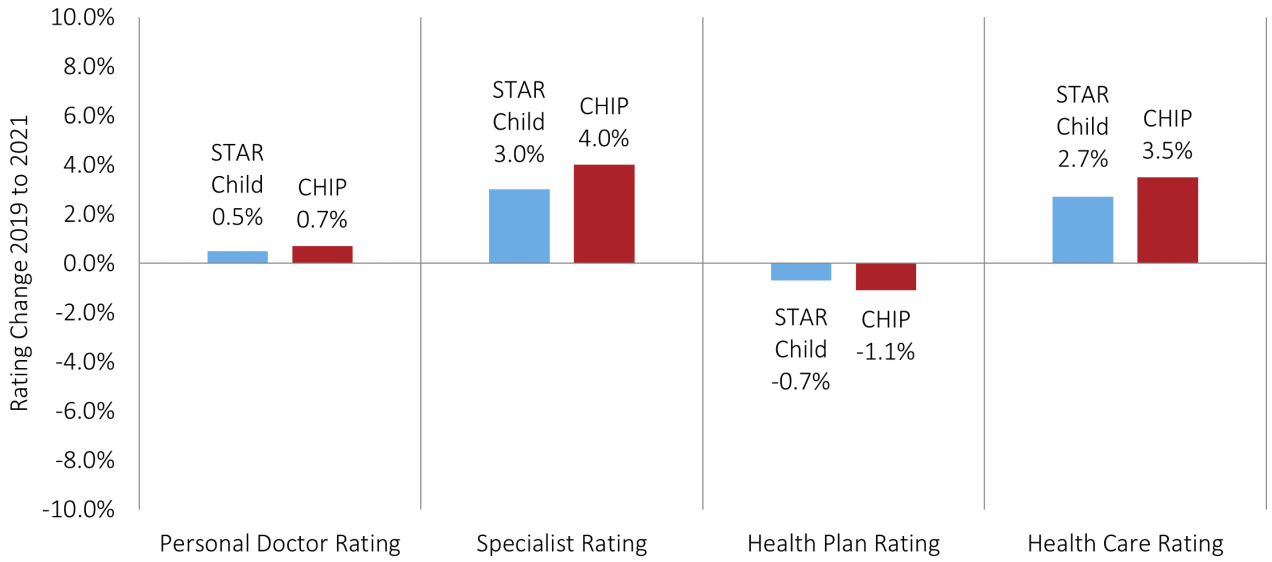


Figure 4. Change in STAR Child and CHIP Caregiver survey ratings between 2019 and 2021



Experience of Care – Dental Surveys

Table 43 shows results for the 2021 Texas Medicaid and CHIP dental surveys conducted by the EQRO. Member experience ratings for dental healthcare were higher among Texas Medicaid members for many measures. However, the percentage of Medicaid caregivers that scored 9 or 10 on the *Dental Care Rating* was lower for Medicaid members than CHIP members. Both Texas Medicaid and CHIP members indicated satisfaction with their interactions with dentists. CHIP caregiver ratings on *Dental Plan Costs and Services* and overall *Dental Plan Rating* were much lower when compared to the Medicaid group, suggesting this is an area for improvement.

Table 43. SFY 2021 Medicaid and CHIP Dental Caregiver Experience of Care survey results

Measure	Medicaid Dental	CHIP Dental
Care from Dentists and Staff – Regular dentist "Always" treated patient with courtesy and respect	94.7%	93.7%
Access to Dental Care – Member "Always" able to get a dental appointment as soon as needed	73.6%	72.1%
Dental Plan Costs and Services – Dental plan "Always" covered all services caregiver thought were covered	84.5%	62.7%
Dentist Rating – Caregiver Ratings (rating of 9 or 10)	77.6%	79.6%
Dental Care Rating – Caregiver Ratings (rating of 9 or 10)	74.5%	76.9%
Access to Dental Care Rating – Caregiver Ratings (rating of 9 or 10)	70.3%	69.1%
Dental Plan Rating – Caregiver Ratings (rating of 9 or 10)	81.8%	70.8%

COVID-19 Pandemic Impacts

The COVID-19 pandemic continued to affect survey completion rates in SFY 2021, which limited the number of respondents on the surveys. It is difficult to assess whether the ongoing COVID-19 PHE has had other impacts on survey results.

Relevance for Assessing Quality, Access & Timeliness

Provider surveys can be used to 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 results of the STAR Child and CHIP CCC composites and summary rates suggest that access is a critical area for improvement. The results on *Access to Specialized Services* were below 50 percent for STAR Kids and only 55.2 percent in CHIP. Rates on *Access to Prescription Medicines* was higher at 75 percent and 78.4 percent for STAR Kids and CHIP, respectively. However, the low rates relative to results on other measures suggest that children with chronic conditions still lack access to care.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 44 lists the key findings and recommendations from EQR activities associated with Protocol 6 and their relevance to the MCQS.

Table 44. Findings and recommendations from QOC Surveys

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

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 MCPs to enrollees covered by Medicaid and CHIP. States use performance measures to monitor and compare the MCOs performance over time and inform the selection and evaluation of quality improvement activities. This optional CMS EQR Protocol specifies that the EQRO should calculate measures per Texas specifications and report results compared to established benchmarks and standards (CMS, 2019b). MCO-specific results on select performance measures are available in the SOA annex.

Technical Methods & Analyses

Texas contracted with the EQRO to conduct comprehensive QOC evaluations across all Texas Medicaid programs. *Appendix E: Summary of Quality Measures Calculated & Reported by the EQRO by Program* summarizes the QOC measures calculated and reported by the EQRO for MY 2020.

Measures

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

NCQA HEDIS measures

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

CHIPRA Core Measures

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

Adult Core Measures

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

3M™ Health Information Systems Measures of PPEs

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

AHRQ Prevention Quality Indicators & Pediatric Quality Indicators

AHRQ serves as the lead federal agency for improving the safety and quality of America's healthcare system. The Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI) track performance based on administrative hospital inpatient data (AHRQ, 2020c, 2020b).

Dental Quality Alliance Measures

Established by the American Dental Association (ADA), the Dental Quality Alliance (DQA) develops evidence-based performance measures for oral healthcare (ADA, 2020).

Severe Maternal Morbidity/Pregnancy Associated Outcomes

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

Cesarean Section Deliveries

The CHIPRA measures include a measure of cesarean section (C-section) births stewarded by The Joint Commission (The Joint Commission, 2020) and AHRQ stewards several C-section measures in their IQI (Inpatient Quality Indicators) measures set (AHRQ, 2020a). These measure definitions include requirements for vital statistics or medical record reviews, so it is impossible to calculate them from administrative data alone. Texas asked the EQRO to develop a C-section measure that aligned with national standards and was calculable using only administrative data. Texas also asked the EQRO to categorize deliveries based on the presence or absence of complications. The EQRO produced a comprehensive report of the performance measure results for HHSC based on these specifications.

Calculations

The EQRO uses NCQA-certified software, QSI-XL™ (Inovalon, 2018) 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, and other measures requested by Texas.

Some HEDIS measures rely on medical record abstraction through hybrid method specifications. These include sampling based on administrative criteria, followed by medical record review from the sample to determine compliance. For HEDIS MY 2020, the EQRO received measure results from the MCOs for four measures with a

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

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 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, 2018).

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.
- The availability of health and sociodemographic characteristics of members enrolled in Medicaid plans nationally is limited. It is unclear how these attributes compare with Texans enrolled in Medicaid programs and CHIP.
- Submission of HEDIS data to NCQA is a voluntary process. The MCOs that choose to submit HEDIS data may not accurately represent all MCOs serving Medicaid programs across the industry.

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

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

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

The CMS child and adult core measure sets provide national- and state-level snapshots of healthcare quality for adults and children enrolled in Medicaid and CHIP. Submission of results to CMS is voluntary. However, CMS supports improvements in uniform data collection and reporting and helps states understand how to use these data to improve healthcare quality. The EQRO manages the submission of Medicaid and CHIP data, monitors changes in CMS guidelines and initiatives, and provides information to HHSC related to the management of Medicaid and CHIP.

Results & Reporting

National QOC Measures

Most QOC measure results are publicly available on the THLC portal (thlcportal.com). By adding results reporting for more member groups (for example, demographic groups) and special populations, including members with serious mental illness (SMI), pregnant women, and MDCP members, the EQRO enables HHSC to identify areas of

concern. The information provided by these reports can also identify cases needing additional study. For example, medically complex populations tend to have worse rates on measures of potential overuse of antibiotics, but this could be because treatment choices are based on higher risk among these members. Maternity care measures can be difficult to interpret when primary or specialized care occurs in the same visits as pregnancy care. For example, pregnant women are more likely to have multiple prescribers for opioids. The measure aims to identify potential misuse of opioids through 'doctor shopping' to obtain multiple prescriptions. However, pregnant women may be more likely to receive routine care from multiple providers (a PCP and an OBGYN, for example).

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

Table 45 shows overall Medicaid and CHIP results for QOC measures included in Texas Performance Indicator Dashboards. 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.

Table 45. 2020 Medicaid and CHIP QOC measure results

Measure Category	Code	Measure	Submeasure	Medicaid	CHIP
Prevention and Screening	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	BMI Screening - Total	NR	74.32[a]
Prevention and Screening	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Counseling on Nutrition - Total	NR	72.84%[a]
Prevention and Screening	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Counseling on Physical Activity - Total	NR	68.93%[a]
Prevention and Screening	CIS	Childhood Immunization Status	Combination 10	26.13%	37.73%
Prevention and Screening	IMA	Immunizations for Adolescents	Combination 2	NR	45.01%[a]
Prevention and Screening	BCS	Breast Cancer Screening	Total	46.33%	NR
Prevention and Screening	CCS	Cervical Cancer Screening	Total	52.31%	NR
Prevention and Screening	CHL	Chlamydia Screening in Women	Total	51.18%	39.80%
CHIPRA Screening	DEV-CH	CHIPRA Developmental Screening in the First Three Years of Life	Total All Ages	47.01%	51.47%
Respiratory Conditions	CWP	Appropriate Testing for Pharyngitis	Total	78.71%	81.09%
Respiratory Conditions	SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD1	All	23.68%	NR
Respiratory Conditions	PCE	Pharmacotherapy Management for COPD[b] Exacerbation	Systemic Corticosteroids	62.26%	NR
Respiratory Conditions	PCE	Pharmacotherapy Management for COPD[b] Exacerbation	Bronchodilators	79.45%	NR
Respiratory Conditions	AMR	Asthma Medication Ratio	Total age 5 to 64 Ratios > 0.50	70.12%	78.92%
Cardiovascular Conditions	SPC	Statin Therapy for Patients with Cardiovascular Disease	Statin Therapy Total	77.19%	NR
Cardiovascular Conditions	SPC	Statin Therapy for Patients with Cardiovascular Disease	Adherence Total	64.29%	NR
Diabetes	CDC	Comprehensive Diabetes Care	Eye Exam	46.48%	NR
Diabetes	SPD	Statin Therapy for Patients with Diabetes	Statin Therapy	66.22%	NR
Diabetes	SPD	Statin Therapy for Patients with Diabetes	Statin Adherence	63.98%	NR

Measure Category	Code	Measure	Submeasure	Medicaid	CHIP
Behavioral Health	AMM	Antidepressant Medication Management	Acute Phase Treatment	54.29%	NR
Behavioral Health	AMM	Antidepressant Medication Management	Continuation Phase	38.51%	NR
Behavioral Health	ADD	Follow-Up Care for Children Prescribed ADHD Medication	Initiation	43.28%	39.33%
Behavioral Health	ADD	Follow-Up Care for Children Prescribed ADHD Medication	Continuation and Maintenance	59.49%	53.85%
Behavioral Health	FUH	Follow-Up after Hospitalization for Mental Illness	Total Follow Up within 7 Days	40.28%	43.99%
Behavioral Health	FUH	Follow-Up after Hospitalization for Mental Illness	Total Follow Up within 30 Days	62.95%	66.12%
Behavioral Health	FUM	Follow-Up After Emergency Department Visit for Mental Illness	Total Follow Up within 7 Days	33.39%	46.62%
Behavioral Health	FUM	Follow-Up After Emergency Department Visit for Mental Illness	Total Follow Up within 30 Days	49.12%	57.65%
Behavioral Health	FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Total Follow Up within 7 Days	3.37%	1.04%
Behavioral Health	FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Total Follow Up within 30 Days	5.50%	2.08%
Behavioral Health	SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	All	76.46%	NR
Behavioral Health	SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	All	65.88%	NR
Behavioral Health	SMC	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	All	74.88%	NR
Behavioral Health	SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	80% Coverage	58.74%	NR
Behavioral Health	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Combined - All Ages	35.28%	28.87%
Overuse/Appropriateness	URI	Appropriate Treatment for Upper Respiratory Infection	Total	88.86%	88.68%
Overuse/Appropriateness	AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	All Ages	63.95%	49.07%
Overuse/Appropriateness	HDO	Use of Opioids at High Dosage	High Dose Opioid Rx	1.11%	NR

Measure Category	Code	Measure	Submeasure	Medicaid	CHIP
Overuse/Appropriateness	UOP	Use of Opioids from Multiple Providers	Multiple Prescribers	14.84%	NR
Overuse/Appropriateness	UOP	Use of Opioids from Multiple Providers	Multiple Pharmacies	2.32%	NR
Access	AAP	Adults' Access to Preventive/Ambulatory Health Services	All members	81.39%	NR
Access	IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation total (all ages)	42.50%	46.87%
Access	IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Engagement total (all ages)	10.14%	13.74%
Access	HEDIS® PPC	Prenatal and Postpartum Care	Timeliness of Prenatal Care	66.69%	42.86%
Access	HEDIS® PPC	Prenatal and Postpartum Care	Postpartum Care	68.02%	64.29%
Access	APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Total	46.80%	38.55%
Utilization	W30	Well-Child Visits in the First 30 Months of Life	Well child visits in the first 15 months	55.94%	NR
Utilization	W30	Well-Child Visits in the First 30 Months of Life	Well child visits for age15-30 months	76.20%	83.10%
Utilization	WCV	Child and Adolescent Well-Care Visits	Total	57.19%	58.83%

[a] The CHIP statewide rate is calculated by weighting the MCO hybrid rates by eligible denominators.
[b] Chronic Obstructive Pulmonary Disease

Utilization measures (Table 46) do not have correct values defined but monitoring use across member groups provides valuable information about care patterns that can inform quality initiatives.

Table 46. 2020 Utilization in Texas Medicaid and CHIP

Code	Measure	Submeasure	Medicaid	CHIP
AMB	Ambulatory Care	Outpatient Visits / 1000 MM	297.47	193.14
AMB	Ambulatory Care	ED Visits / 1000 MM	38.32	14.78
IPU	Inpatient Acute	Total Inpatient Stays / 1000 MM	7.00	0.63
MPT	Mental Health Utilization	Any Services / member year	9.16%	5.68%

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

Potentially Preventable Events

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

The EQRO analyzed 2020 encounter and eligibility data for non-dual Medicaid and CHIP members using 3M Health Information Systems software (3M Health Information Services, 2016). This software classifies events as PPEs based on the 3M grouping systems for (1) ambulatory care using Enhanced Ambulatory Patient Groups (EAPGs) or (2) inpatient care using All Patient Refined Diagnosis-Related Groups (APR-DRGs), and by considering other factors such as diagnosis codes, procedure codes, and the source of the admission.

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

The EQRO conducted analyses for four types of PPEs:

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

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

Potentially Preventable Emergency Department Visits (PPVs)

High rates of PPVs may represent a failure to provide adequate primary care to the patient. 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. Of the approximately 1.5 million Medicaid and CHIP ED visits at risk for PPVs in 2020, the EQRO identified 57.9 percent as PPVs. At the same time, eligibility changes due to the pandemic lead to an overall increase in member-months, which make up the PPV rate denominator. The result was a decrease in the PPV rate from 9.2 to 5.44. Overall, PPVs in 2020 accounted for $378 million in institutional costs paid (excluding the associated professional costs). Table 47 summarizes the 2020 PPV results by program.

Table 47. 2020 PPV results for Medicaid and CHIP

Measure	STAR	STAR+ PLUS	STAR Kids	STAR Health	FFS	CHIP
Member-Months at Risk for PPVs	34,250,499	2,708,783	1,915,660	396,444	4,275,834	3,536,476
ED Visits at Risk of being PPVs	1,053,470	240,840	70,435	18,018	86,411	49,663
Total PPVs	603,302	151,762	42,216	10,845	43,522	28,216
Total PPV Weights	173,777.03	45,748.83	12,245.12	3,173.24	12,962.69	8,255.57
Total PPV Expenditure ($Millions)	$246.05M	$90.97M	$16.47M	$3.28M	$9.07M	$12.25M
PPV Rate (Total PPV Weights per 1,000 Member-Months)	5.07	16.89	6.39	8.00	3.03	2.33

The PPV rate was highest in the STAR+PLUS program, with a rate that was more than 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 medically complex population and has less than half the PPV rate of STAR+PLUS.

In 2020, the PPV rate was higher among females (5.88 vs. 4.91 for males), and the rate for rural members was slightly higher (6.47) than the rates for urban or micropolitan members (5.27 and 6.27, respectively). In general, older members had higher PPV rates, although the rate was higher for children aged 1 to 5 years than for other children. Hispanic members had a lower PPV rate (4.45) than non-Hispanic White or non-Hispanic Black members (6.71 and 6.37, respectively).

Table 48 shows the top five PPV reasons across Medicaid and CHIP in 2020 based on EAPG categories ranked by total PPV weight. The leading reason continues to be URTI, with a total cost of over $45 million during 2020. Not only do these PPVs represent an overuse of hospital resources, but URTI may have better outcomes when treated in a primary care setting.

Table 48. 2020 PPV top reasons

EAPG	Description	PPVs (n)	Percent of Total PPVs	Percent of Total PPV Weights	PPV Expenditures	Percent of Total PPV Expenditures
562	Infections of Upper Respiratory Tract and Otitis Media	170,868	19.4%	14.5%	$45.48M	12.0%
628	Abdominal Pain	48,725	5.5%	7.3%	$37.02M	9.8%
674	Contusion, Open Wound and Other Trauma to Skin and Subcutaneous Tissue	55,271	6.3%	7.1%	$19.14M	5.1%
627	Non-Bacterial Gastroenteritis, Nausea and Vomiting	48,273	5.5%	7.0%	$25.06M	6.6%
808	Viral Illness	43,955	5.0%	6.3%	$13.88M	3.7%

Potentially Preventable Admissions (PPAs)

Admissions that are avoidable with proper outpatient care are PPAs. They may result from inefficiencies in hospital or ambulatory care, poor access to outpatient care, or inadequate ambulatory care service coordination. From 2017 through 2019, the overall PPA rate trended slightly upward and the cost per PPA increased. However, in 2020 both at-risk admissions and PPAs decreased. Of the approximately 249,000 inpatient admissions from Medicaid and CHIP in 2020, 12.4 percent were PPAs. These PPAs account for $270 million in institutional costs paid. Table 49 summarizes 2020 PPA results by program. The PPA rate was highest in the STAR+PLUS program, with a rate more than four times that of any other program, including STAR Kids.

Table 49. 2020 PPA results for Medicaid and CHIP

Measure	STAR	STAR+ PLUS	STAR Kids	STAR Health	FFS	CHIP
Member-Months at Risk for PPAs	34,250,499	2,708,783	1,915,660	396,444	4,275,834	3,536,476
Admissions at Risk of being PPAs	150,693	62,953	15,884	4,904	10,855	3,409
Total PPAs	9,772	14,933	2,929	1,233	1,457	647
Total PPA Weights	7,726.82	24,373.35	2,817.74	843.36	1,989.63	462.12
Total PPA Expenditure ($Millions)	$64.41M	$159.00M	$24.57M	$9.24M	$9.04M	$4.14M
PPA Rate (Total PPA Weights per 1,000 Member-Months)	0.23	9.00	1.47	2.13	0.47	0.13

In 2020, the PPA rate was higher among males (0.89 vs. 0.74 for females). Rural members had a slightly higher (0.92) PPA rate than urban or micropolitan members (0.79 and 0.89, respectively). Older members had higher PPA rates. Hispanic members had a lower PPA rate (0.49) than non-Hispanic White or non-Hispanic Black members (1.23 and 1.12, respectively).

Table 50 shows the top five PPA reasons across Medicaid and CHIP in 2020 based on APR-DRG categories ranked by total PPA weight. Heart failure and pneumonia continue to top this list. Together they accounted for over $53 million in total costs during 2020.

Table 50. 2020 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	3,051	9.9%	13.0%	$32.06M	11.9%
139	Other Pneumonia	2,292	7.4%	7.4%	$21.19M	7.8%
720	Septicemia and Disseminated Infections	810	2.6%	7.2%	$16.90M	6.3%
753	Bipolar Disorders	3,742	12.1%	6.2%	$19.04M	7.0%
751	Major Depressive Disorders and Other/Unspecified Psychoses	3,897	12.6%	6.0%	$16.87M	6.2%

Heart failure is the top PPA reason in STAR+PLUS, while Major Depressive Disorders and Other/Unspecified Psychoses is the most common EAPG for PPAs in STAR. Overall, in 2020, bipolar disorders (the fourth-ranked EAPG for PPAs), considered together with Major Depressive Disorders and Other/Unspecified Psychoses (ranked fifth) and schizophrenia (ranked eighth), make serious mental illnesses account for over 16 percent of total PPA weight, and these PPAs had a combined cost over $47 million. Some form of mental health disorder was among the top ten PPA conditions for all managed care programs. Medication management is critical for the effective treatment of these conditions, which could reduce PPAs substantially.

Potentially Preventable Readmissions (PPRs)

A PPR is a potentially avoidable readmission, clinically related to (and occurring within a specified time interval from) an initial hospital admission. The underlying reason for readmission must be related to the care rendered during or immediately following a prior admission. The EQRO used a 30-day readmission window to evaluate PPRs among Medicaid and CHIP MCOs. Of the approximately 425,000 admissions among Medicaid and CHIP members at risk for having PPRs in 2020, the EQRO identified over 17,000 (4.2 percent) as having PPRs. These account for $240 million in institutional costs paid. Table 51 summarizes 2020 PPR results by program.

Table 51. 2020 PPR results for Medicaid and CHIP

Measure	STAR	STAR+ PLUS	STAR Kids	STAR Health	FFS	CHIP
Admissions at Risk for PPRs	294,862	46,596	12,730	4,589	62,650	2,990
Initial Admissions Resulting in PPRs	5,456	7,470	1,547	899	1,731	194
Total PPRs	6,812	11,703	2,303	1,424	2,231	244
Total PPR Weights	3,916.84	10,112.11	1,910.08	709.29	2,063.60	154.31
Total PPR Expenditure ($Millions)	$63.09M	$102.70M	$33.71M	$12.06M	$15.39M	$3.19M
PPR Rate (Total PPR Weights per 1,000 Admissions)	13.28	217.02	150.05	154.56	32.94	51.61

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 52 shows the top five PPR reasons across Medicaid and CHIP in 2020 based on APR-DRG categories ranked by total PPR weight. Although septicemia is a less common reason for PPRs, its severity makes it an important driver of potentially preventable costs. Heart failure is the leading reason for PPAs and a leading driver of PPRs. The most important drivers of PPRs are the serious mental illness conditions of schizophrenia, bipolar disorder, and major depression. Together, these accounted for costs of over $58 million in 2020. Regardless of the diagnoses for the initial admission, readmissions for these conditions are considered PPRs, contributing PPR weight to other categories based on the initial admission. The high rate of PPRs for mental health reasons highlights the need to improve care coordination for co-occurring physical and mental health conditions.

Table 52. 2019 PPR top reasons

APR-DRG	Description	PPRs (n)	Percent of Total PPRs	Percent of Total PPR Weights	PPR Expenditures	Percent of Total PPR Expenditures
750	Schizophrenia	3,391	13.2%	9.7%	$17.19M	7.2%
753	Bipolar Disorders	4,011	15.6%	9.4%	$24.43M	10.2%
751	Major Depressive Disorders and Other/Unspecified Psychoses	3,267	12.7%	7.5%	$17.76M	7.4%
720	Septicemia and Disseminated Infections	991	3.9%	7.2%	$17.30M	7.2%
194	Heart Failure	882	3.4%	4.6%	$9.57M	4.0%

Potentially Preventable Complications (PPCs)

PPCs are complications that arise during an inpatient stay because of improper care or treatment and do not represent the progression of the underlying disease. A single admission can have multiple complications, and an admission may be at risk for some PPC categories but not others. Unlike the other PPEs that rely on

administrative condition groupings (i.e., EAPG and APR-DRG) to categorize events, 3M defined PPC conditions specifically for identifying PPEs. *Appendix F: 3M™ Potentially Preventable Complications (PPC) Classification System Definitions* provides definitions for the PPC groups. The EQRO evaluated over 342,000 admissions from Medicaid and CHIP that were at risk for PPCs in 2020. 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, the EQRO addressed the quality of POA data at the MCO level. *Appendix D: Present on Admission (POA) Screening Criteria* summarizes the screening criteria.

Table 53 shows PPC results by program. The 2020 PPC analysis identified 3,293 eligible admissions with at least one PPC. The total estimated cost of the STAR+PLUS PPCs (over $16 million) was much higher than the estimated cost of PPCs across all other managed care programs.

Table 53. 2019 PPC results for Medicaid and CHIP

Measure	STAR	STAR+ PLUS	STAR Kids	STAR Health	FFS	CHIP
Admissions at Risk for PPCs	211,073	45,035	9,364	3,581	71,218	2,121
Admissions with PPCs	794	1,487	70	4	935	3
Total PPCs	957	1,934	87	5	1,276	9
Total PPC Weights	614.28	1,679.93	93.82	6.61	1,127.98	16.93
PPC Rate (Total PPC Weights per 1,000 Admissions)	2.91	37.30	10.02	1.85	15.84	7.98

Renal Failure without dialysis was the most common PPC for STAR+PLUS members, while Shock and Septicemia contributed the most PPC weights. Septicemia and Shock also contributed the most weight among STAR members, but the most common PPC reason was obstetric complications. As in 2020, the PPC rate was more than 15 for FFS members. This group includes undocumented immigrants and others who may require emergency Medicaid services but determining why this population has more PPCs requires further investigation.

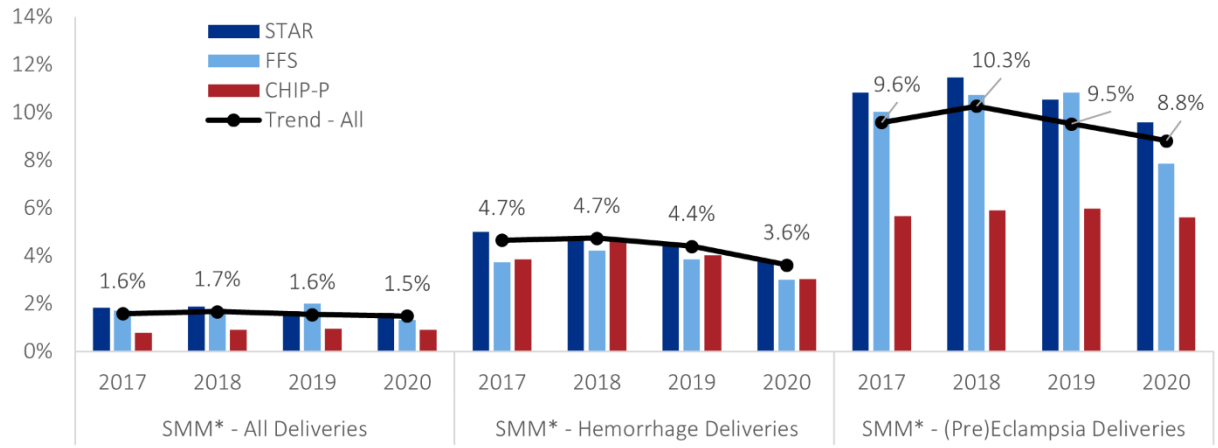
OAP and C-Section Deliveries

The EQRO Identified 2020 deliveries for the OAP and C-section measures following the method developed through the IAP program. The EQRO calculated overall SMM rates for these deliveries following the method, also developed through the IAP, which allowed the calculation of measures in the AIM maternal safety bundles from statewide administrative data. The OAP report includes measures of SMM among all deliveries, among deliveries with hemorrhage, and among deliveries with severe hypertension. The EQRO reported rates for all SMM cases and rates, excluding those SMM cases identified only by transfusion for all three cohorts. This approach is consistent with The Centers for Disease Control and Prevention (CDC) reporting on SMM (CDC, 2020) and the American College of Obstetricians and Gynecologists (ACOG) recommendations (ACOG et al., 2016).

Figure 5 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 2017 through 2020. Overall rates have trended down over this period. Rates were consistently higher in STAR than in CHIP Perinatal, most notably in (pre)eclampsia cases. The higher rates may be due to women with higher risk pregnancies having a greater chance of Medicaid eligibility. Although the numbers of deliveries are small for the STAR+PLUS and STAR Kids program, the SMM rate among (pre)eclampsia cases are higher (16.26 percent and 14.63 percent, respectively) in these programs for members with health complications.

Figure 5. OAP measure trends by program

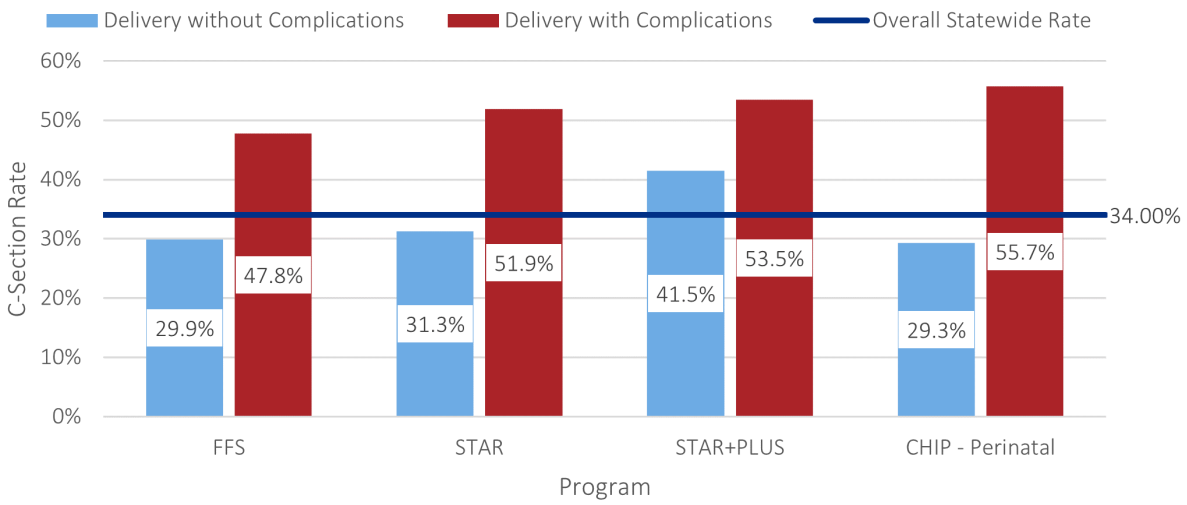


SMM* = Severe maternal morbidity, excluding cases identified by transfusion only.

Overall, deliveries with SMM (excluding those identified by transfusion only) incurred 2.7 times the cost of deliveries without SMM, or approximately an additional $24 million. In 2020, SMM rates varied geographically and by race/ethnicity, with non-Hispanic Black women having 1.75 times the SMM rate of Hispanic women. The overall SMM rates among STAR MCOs ranged from 1.3 percent to 2.8 percent.

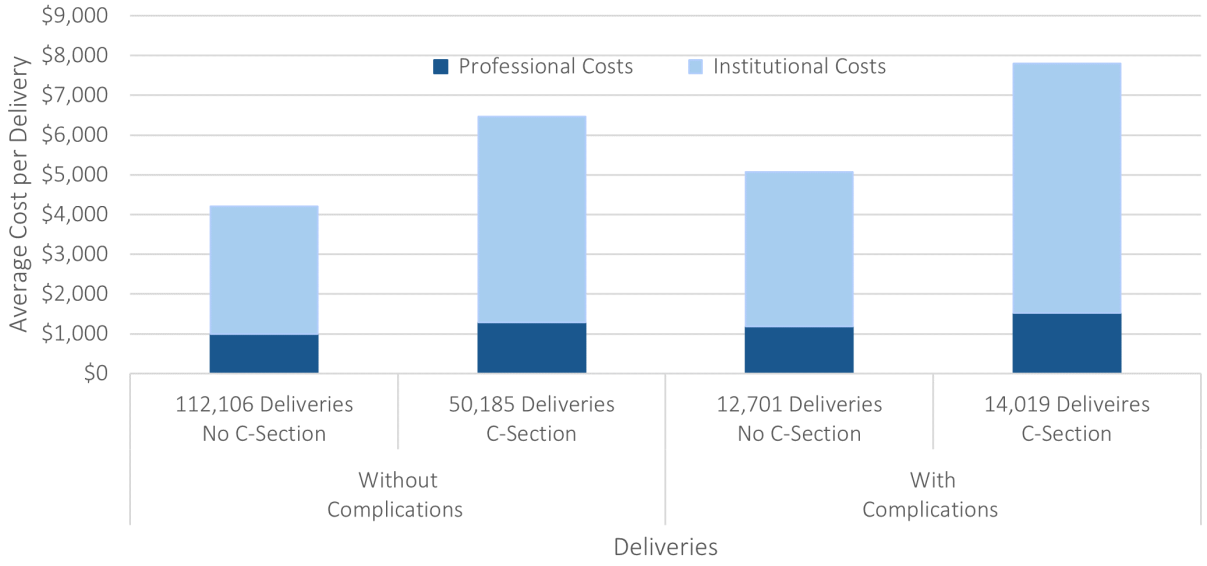
In 2020, the rate of C-section deliveries in Texas Medicaid and CHIP was 34 percent. Figure 6 shows C-section rates among deliveries with and without complications by program. C-section rates varied by race/ethnicity and geography. Hispanic women had the lowest C-section rate (33 percent), and non-Hispanic Black women had the highest rate (38.1 percent). Women in STAR+PLUS had a higher rate (41.5 percent) of C-sections for uncomplicated deliveries. However, complications were more common in STAR+PLUS (20.7 percent of deliveries vs. 14.1 percent overall).

Figure 6. 2020 C-section rates by program



Although more than half of deliveries with complications are by C-section, only 21.8 percent of C-section deliveries were identified with complications. Over 50 thousand C-sections were in deliveries without complications. Compared to uncomplicated deliveries without C-section, these uncomplicated C-section deliveries incurred additional costs totaling over $113 million. Figure 7 shows average C-section and vaginal delivery costs, with and without complications.

Figure 7. 2020 average delivery costs by delivery type



In addition to examining SMM and C-section rates, the EQRO looked at selected HEDIS measure results for pregnant women during 2020. Although performance on care measures for chronic conditions was generally worse for pregnant women, utilization was generally higher.

COVID-19 Pandemic Impacts

The EQRO did a specific analysis on ED and PPV utilization patterns before (MY 2019) and during the COVID-19 pandemic (MY 2020) which compared the potential impact of the pandemic on different programs, age groups,

service areas and rurality. The EQRO observed significant rate drops for PPA, PPV and PPR between MY 2019 and MY 2020 in Medicaid and CHIP, while rates for PPC remained stable between MY 2019 and MY 2020. When we look at different populations/programs, children tend to show bigger rate drops than adults and STAR+PLUS (members with chronic conditions) tend to have smaller rate changes than other programs.

Relevance for Assessing, Quality, Access & Timeliness

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. PPAs may result from inefficiencies in hospital or ambulatory care, poor access to outpatient care, or inadequate ambulatory care service coordination. From 2017 through 2019, the overall PPA rate trended slightly upward and the cost per PPA increased. However, in 2020 both at-risk admissions and PPAs decreased. The STAR+PLUS, STAR Kids, and STAR Health programs have the highest PPR rates, highlighting the need to improve care coordination in these populations with complex healthcare needs.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 54 lists the key findings and recommendations from EQR activities associated with Protocol 7 and their relevance to the MCQS.

Table 54. Findings and recommendations associated with the calculation of performance measures

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

Category	Description
Finding(s)	SMM rates were consistently higher in STAR than in CHIP Perinatal between 2017-2020, most notably in (pre)eclampsia cases. Overall rates have trended down over this period. Over 50 thousand C-sections were performed in deliveries without complications. Compared to uncomplicated deliveries without C-section, these uncomplicated C-section deliveries incurred additional costs totaling over $100 million.
MCQS Goal(s)	Goals 1, 2, 3, 4
Recommendation(s)	HHSC should continue to investigate the underlying drivers of maternal health disparities.

Protocol 9: Conducting Focused 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 focused studies for quality improvement, administrative, legislative, or other purposes.

During SFY 2021, the EQRO carried out multiple studies of Texas Medicaid and CHIP programs, initiatives, and areas of specific interest to the state. Table 55 summarizes the focused studies and associated quarterly topic reports (QTRs) described in this section.

Table 55. Focused studies conducted in SFY 2021

Study	Description
STAR Kids Focus Study: *Caregiver Experience of Care for Members in the Medically Dependent Children Program*	In 2019, Texas passed S.B. 1207 86(R), which mandates Texas Medicaid to conduct studies to improve healthcare access and quality for STAR Kids MDCP members. This report describes the methods and findings of a subsequent mixed-methods study conducted by the EQRO to address these evaluation needs.
QTR 1: *Examining Equity in Utilization of Teleservices and Quality of Care among Medicaid Members with Differing Social Vulnerabilities Before and During COVID-19*	This report presents findings of a study by the EQRO to examine teleservices use during the COVID-19 study period among adults in STAR, children in STAR, and adults in STAR+PLUS. The EQRO also examined the relationship between using teleservices and the occurrence of PPVs and PPAs during the COVID-19 study period.
QTR 2: *Texas Medicaid MCO Strategies to Promote HPV Vaccination Among Medicaid Providers and Members*	This study combined HPV vaccination data from ImmTrac and Medicaid claims, interviews with MCO representatives, and the results of a scoping review of state literature. The study provides an overview of HPV vaccination status among adolescents in Medicaid, MCO strategies for incentivizing providers and members to increase HPV vaccination uptake, and potential state quality initiatives for encouraging MCOs to improve HPV vaccine uptake in Texas Medicaid and CHIP.
QTR 3: *Examining Transition to the Medicaid for Breast and Cervical Cancer (MBCC) Program for Women Diagnosed with Cervical Cancer*	This study examined the transition to the Medicaid for Breast and Cervical Cancer Program (MBCC) after cervical cancer diagnosis for women in Medicaid. The EQRO examined the time from diagnosis to first treatment and the barriers and facilitators of the transition to MBCC for women with cervical cancer or pre-cancer.
QTR 4: *Texas Medicaid STAR Kids Descriptive Analysis of Individual Service Plans for MDCP Members*	This study used STAR Kids MCO ISP and SK-SAI data to provide descriptive information on ISP services and costs authorized for STAR Kids MDCP members during calendar year 2020. The study measured associations between respite care that children in MDCP are authorized to receive and measures of caregiver strain and burden obtained from SK-SAI data.

EQR Activities

Focus Studies

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

Study Objectives

- Identify the most important services for families of STAR Kids members in MDCP.
- Identify the most common barriers to receiving these services.
- Explore the context in which families experience barriers to care.
- Measure changes in caregiver experience with care between SFY 2018 and SFY 2020.

Technical Methods, Analyses, and Results

In 2019, the Texas Legislature passed S.B. 1207 86(R), which mandates Texas Medicaid to conduct studies to improve access and quality of healthcare for STAR Kids MDCP members. This report describes the methods and findings of a subsequent mixed-methods study conducted by the EQRO to address these evaluation needs. Findings from focus groups and interviews demonstrated that access to and continuity of specialist and primary care, medications, home health care, special therapies (physical, occupational, and speech therapy), and care coordination are important considerations for understanding caregivers' experience in STAR Kids and MDCP. The most common barriers or facilitators to care were the level of caregiver and provider knowledge of programs and services, members' health conditions, stress experienced by caregivers, and caregiver autonomy over decisions in their child's care. Table 56 outlines the findings and recommendations from this study.

Quarterly Topic Reports

QTR 1: Examining Equity in Utilization of Teleservices and Quality of Care among Medicaid Members with Differing Social Vulnerabilities Before and During COVID-19

Study Objectives

- Examine the utilization of teleservices among adults and children in the STAR and STAR+PLUS managed care programs, exploring differences by social vulnerability category.
- Examine the differential effects of teleservices on healthcare service outcomes during the COVID-19 study period (COVID-19 study period; March 1, 2020, to July 31, 2020).

Technical Methods, Analyses, and Results

This report presents findings of a study by the EQRO to examine teleservices use during the COVID-19 study period among adults in STAR, children in STAR, and adults in STAR+PLUS. The EQRO also examined the relationship between using teleservices and the occurrence of PPVs and PPAs during the COVID-19 study period. The study population for this report included adults and children continuously enrolled (without dual Medicare eligibility) in the same Medicaid STAR or STAR+PLUS MCO between October 1, 2019, and July 31, 2020. Study findings indicated that the use of teleservices during the COVID-19 study period significantly increased across all three analysis cohorts. Teleservices used during the COVID-19 study period differed by sociodemographic characteristics, health status, geographic characteristics, MCO, and pre-pandemic service utilization. Results also showed that across analysis cohorts, members who used teleservices during the COVID-19 study period were significantly more likely to have a PPV or PPA during the COVID-19 study period.

QTR 2: Texas Medicaid MCO Strategies to Promote HPV Vaccination Among Medicaid Providers and Members

Study Objectives

- Assess and describe the variation in HPV vaccination data compiled from ImmTrac and Medicaid claims for members aged 11-16 in December 2020 to provide a broad overview of HPV vaccination status among teens in Texas Medicaid and CHIP.
- Conduct a thematic analysis of group interviews with staff in six Medicaid MCOs to identify and examine (a) the strategies that Medicaid MCOs use to promote HPV vaccination among providers, (b) the challenges that MCOs and providers face in promoting HPV vaccination among Medicaid members, and (c) the strategies that MCOs are using to overcome these challenges.
- Conduct a literature review to identify strategies that Medicaid programs and MCOs in other states are using to address challenges to promoting HPV vaccination, focusing on strategies that HHSC could use to incentivize MCOs and providers to improve HPV vaccination rates in Texas.

Technical Methods, Analyses, and Results

This study by the EQRO combined HPV vaccination data from ImmTrac and Texas Medicaid claims, interviews with MCO representatives, and the results of a scoping review of state literature. The study examines HPV vaccination status among adolescents in Medicaid, MCO strategies for incentivizing providers and members to increase HPV vaccination uptake, and potential state quality initiatives for encouraging MCOs to improve HPV vaccine uptake among teens. The study concluded that HHSC already employs many of the strategies used by other state Medicaid programs to encourage vaccine uptake and coverage. However, HHSC can leverage current Medicaid quality improvement initiatives to encourage MCOs to strengthen efforts to increase rates of HPV vaccination among teens in Medicaid and CHIP.

QTR 3: Examining Transition to the Medicaid for Breast and Cervical Cancer Program for Women Diagnosed with Cervical Cancer

Study Objectives

- Quantify the average time from diagnosis to the first encounter for treatment among MBCC members diagnosed with cervical cancer and identify differences in time to treatment by members' sociodemographic characteristics (age, race/ethnicity, and rurality).
- Examine the transition process to MBCC for women identified as having cervical cancer or pre-cancer through Breast and Cervical Cancer Services (BCCS) and barriers and facilitators to receiving timely enrollment in MBCC and treatment.

Technical Methods, Analyses, and Results

This study examined transition to MBCC after cervical cancer diagnosis. The EQRO examined the time from diagnosis to first treatment and the barriers and facilitators of the transition to MBCC for women with cervical cancer or pre-cancer diagnoses. This report found that patients served by MBCC do not experience significant delays in cervical cancer treatment. Patient barriers to accessing MBCC include communication challenges, lack of awareness of BCCS and MBCC programs, and lack of proximity to clinicians who accept MBCC. Implementing evidence-based programs such as patient navigation programs that aim to support patients across the continuum of care addresses these barriers. Training BCCS providers on evaluating eligibility for patients who have challenges providing income documentation will also improve access.

QTR 4: Texas Medicaid STAR Kids Descriptive Analysis of Individual Service Plans for MDCP Members

Study Objectives

- Provide descriptive information on ISP services and costs authorized for STAR Kids MDCP members during calendar year 2020.
- Measure associations between respite care that children in MDCP are authorized to receive and measures of caregiver strain and burden obtained from SK-SAI data.

Technical Methods, Analyses, and Results

Findings from the analysis of caregiver characteristics and respite care largely showed few differences in the authorization, amount, or cost of respite services on the member's ISP. The study found that non-Hispanic other and non-Hispanic Black members have slightly higher annual costs of in-home respite care than members of other racial/ethnic groups. Aside from this finding, the study revealed no other factors that would suggest inequitable distribution of respite care services in the STAR Kids MDCP population. Regarding caregiver burden, in-home respite care costs increased as the number of stressors experienced by caregivers increased. Authorization for out-of-home respite care was also positively associated with the number of stressors, although to a lesser extent. Two sources of caregiver burden were associated with authorization of out-of-home respite care: (1) caregivers who expressed feelings of distress, anger, or depression, and (2) caregivers who received criticism about their caregiving from family or friends. In both cases, authorization rates for out-of-home respite care were higher among caregivers. The analysis of caregiver characteristics and respite care also showed that nearly one-third of caregivers reported some other source of caregiver burden not captured in the twelve categories listed on the SK-SAI (29 percent). Future research should consider the potential effects of open-ended responses describing "other" stressors, collected in the SK-SAI but not included in the analysis for this study, on authorizations of in-home and out-of-home respite care.

COVID-19 Pandemic Impacts

The impact of the COVID-19 pandemic varied across focused studies. In some cases, the pandemic was a central component of the study, such as in the study that examined teleservices use before and during the beginning of the COVID-19 pandemic. In other cases, the pandemic may have had an important impact on the study but was not the focus. One example of this is the study on HPV vaccination among adolescents. It is likely that the COVID-19 PHE was associated with the drop in HPV vaccinations in 2020, but additional research is necessary to assess how much of the variation in vaccination rates is a result of the COVID-19 pandemic and how much is due to other factors.

Relevance for Assessing Quality, Access & Timeliness

Each study has relevance to assessing quality, access, and timeliness, although none were designed to test those domains. However, the results of the study on telehealth use before and during the COVID-pandemic provides valuable information about access to care during the shift to increased reliance on teleservices at the beginning of the pandemic. The HPV vaccination study provides information on factors that influence the timing of HPV vaccine uptake among adolescents. The study of the transition to MBCC provides valuable information on the factors that limit access to the MBCC program. Finally, the descriptive analysis of the ISPs for MDCP members in STAR Kids provides information on disparities in access and utilization of services.

Summary of Protocol Findings & Recommendations from EQR Activities

Table 56, Table 57, Table 58, Table 59, and Table 60 list the key findings and recommendations from EQR activities associated with Protocol 9 and their relevance to the MCQS.

Table 56. Findings and recommendations from the SFY 2021 STAR Kids Focus Study

Category	Description
Finding(s)	While access to specialist care has improved for STAR Kids MDCP members, improvements in network adequacy would reduce the remaining barriers to physical, occupational, and speech therapies.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	• STAR Kids MCOs should focus network adequacy efforts to ensure that provider networks have sufficient special therapy providers with experience treating children with complex conditions. To achieve this, MCOs should: (1) identify and leverage strategies that have been successful in building networks of specialist providers, and particularly those who treat rare and complex conditions; and (2) share best practices in recruitment of special therapy providers with each other in collaborative contexts, such as stakeholder and advisory group meetings or jointly conducted performance improvement projects. • STAR Kids MCOs should develop or improve existing policies and procedures for providing special therapies to STAR Kids MDCP members that account for specific member conditions and needs; caregiver limitations, assets, and preferences; and unexpected changes to members' health or living conditions.
Finding(s)	Caregiver access to and satisfaction with service coordination for STAR Kids MDCP members has improved. However, many caregivers report they must function as their child's primary care coordinator for specific services, such as prescription medicines and medical supplies.
MCQS Goal(s)	Goals 2, 6
Recommendation(s)	• STAR Kids MCOs should enhance the training of service coordinators to emphasize the challenges caregivers face in accessing medications and medical supplies for their children. Training materials and service coordination policies should address potential scenarios experienced by caregivers, such as being drawn into the coordination process by pharmacies and suppliers, filling expensive medications for rare conditions, or navigating the approval process with primary private insurance and Medicaid coverage. • STAR Kids MCOs should consider or build upon programs to provide STAR Kids MDCP caregivers with services that reduce coordination and travel burden for caregivers, such as automatic medication refills, home delivery of medications, and delivery tracking for supplies.
Finding(s)	The study was limited by low participation in the focus groups and under-representation of Hispanic and non-Hispanic Black caregivers. Without reaching thematic saturation, important issues for caregivers likely remain that the study did not uncover.
MCQS Goal(s)	Goals 2, 5

Category	Description
Recommendation(s)	HHSC should consider renewing this study in SFY 2022, incorporating changes to methods to address participation issues encountered this year. Recommended strategies include: • Expanding the study to encompass all service areas statewide. The STAR Kids MDCP population is small (less than 4,700 in 2019) and including all service areas will produce a larger sample for recruitment. • Oversampling members in under-represented racial/ethnic groups. Given expected racial/ethnic differences in response rates in EQRO survey studies, such as lower response among caregivers of non-Hispanic Black members, oversampling can help correct non-response bias and improve representation. • Conducting semi-structured interviews rather than focus groups. Interviews are simpler to coordinate and may improve the participation of caregivers who are intimidated by focus group dynamics. • Reducing the number of points of interaction during telephone recruitment. Each point of interaction presents a risk of losing a prospective participant to follow-up. Interviews can be scheduled, and email addresses collected on the first call to help increase recruitment rates. • Coordinating the study with the existing STAR Kids biennial survey. The proposed study would coincide with the 2022 biennial survey and could contribute to the respondent burden. If feasible, adding a recruitment script to the end of the biennial survey tool could improve recruitment and participation. • Partnering with institutional and community groups that advocate for children with disabilities in Texas, such as the STAR Kids Managed Care Advisory Committee; Every Child, Inc.; and Texas Parent to Parent. Recruitment efforts may be improved with access to communication channels and community and family networks that these groups maintain.

Table 57. Findings and recommendations from the study on equity in teleservices utilization and quality of healthcare among Medicaid members during the pandemic

Category	Description
Finding(s)	In-person face-to-face visits declined, and teleservice use increased during the COVID-19 study period.
MCQS Goal(s)	Goals 1, 3
Recommendation(s)	• HHSC should continue to work with MCOs to maintain teleservice uptake through flexible teleservices reimbursement policies. • HHSC should examine the decline in face-to-face visits during the COVID-19 study period to determine whether the decline was due to substituting face-to-face visits with teleservices or whether services not amenable to teleservices were not provided during the COVID-19 study period. • MCOs should work with providers to provide outreach to patients who did not engage in needed face-to-face visits that are not amenable to teleservices during the COVID-19 study period. • MCOs should identify and advocate for the use of teleservices delivery platforms that are accessible for persons with limited technology and connectivity resources to address disparities in teleservice use. HHSC should examine the extent to which MCOs are increasing accessibility of teleservices for persons with limited access.
Finding(s)	Members who did not engage in face-to-face or teleservice visits before the COVID-19 study period had lower odds of using teleservices during the COVID-19 study period.
MCQS Goal(s)	Goals 3, 6
Recommendation(s)	• MCOs should work with providers to implement evidence-based strategies that eliminate disparities in care utilization, such as direct support professionals, including community health workers and patient navigators/care coordinators. • HHSC should investigate barriers to accessing care for members who are not engaged in care.
Finding(s)	Across programs, non-Hispanic Black members and members in rural areas had lower odds of using teleservices.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	• HHSC should work across agencies to address disparities in technology access among underserved sociodemographic groups and geographic areas. • HHSC should work with MCOs to ensure that they thoughtfully implement efforts to sustain the expanded use of teleservices to limit further worsening the disparities in access to care among rural and non-Hispanic Black populations. • MCOs should work with providers to implement teleservices using accessible and user-friendly platforms for persons with limited access to digital devices (e.g., smartphones, tablets, or computers), broadband access, and limited digital literacy skills.
Finding(s)	Members with BH or chronic conditions had higher odds of using teleservices during the COVID-19 study period.
MCQS Goal(s)	Goals 2, 3, 5

Category	Description
Recommendation(s)	• HHSC should conduct a study to identify which specific chronic or BH conditions were associated with teleservices use to understand utilization and gaps in services by condition and to examine the relationship between utilization of teleservices and disease management for these conditions. • HHSC should investigate barriers to care for members with behavioral health or chronic conditions who did not access teleservices during the COVID-19 study period.
Finding(s)	Higher county-level cumulative count of COVID-19 cases was associated with decreased odds of using teleservices among adults in STAR and STAR+PLUS. However, children living in counties with a high cumulative count of COVID-19 had higher odds of having a teleservice visit.
MCQS Goal(s)	Goals 2, 3
Recommendation(s)	• HHSC should work with MCOs to examine county-level facilitators and barriers that influenced the implementation of teleservices for adults during the COVID-19 study period. • HHSC should investigate whether MCOs had practices that might have prioritized teleservice use for children but not adults in these higher-need areas.
Finding(s)	Teleservice use during the COVID-19 study period varied by MCO and SA.
MCQS Goal(s)	Goals 2, 3
Recommendation(s)	• HHSC should conduct future studies to identify area-level barriers to accessing resources that facilitate teleservices. • HHSC should work with MCOs to improve the use of teleservices by implementing evidence-based strategies that increase access to resources crucial for implementing teleservices, such as addressing limited broadband connectivity in under-resourced areas.
Finding(s)	Members who used teleservices during the COVID-19 study period had increased odds of having a PPV or PPA during the same period.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	HHSC should examine the temporal association between teleservices and PPVs and PPAs during the COVID-19 study period to assess the extent to which teleservice use preceded a PPE (suggesting that teleservices were not sufficient to prevent the ED visit or hospital admission) and the extent to which it followed a PPE (suggesting that teleservices may have been part of follow-up after discharge).

Table 58. Findings and recommendations from the study on HPV vaccination among teens in Medicaid

Category	Description
Finding(s)	Vaccine hesitancy, delays getting children in for preventive care visits, and missed clinical opportunities are important barriers to increasing the percentage of teens with a timely HPV vaccine initiation and the percentage that are up to date (UTD) on the HPV vaccine in Medicaid and CHIP.
MCQS Goal(s)	Goals 1, 2

Category	Description
Recommendation(s)	• HHSC should require all MCOs to specifically address HPV vaccine hesitancy as one of their upcoming Performance Improvement Projects (PIPs). • HHSC should determine whether all Medicaid MCOs have established policies for (a) identifying and effectively responding to providers with consistently low rates of timely HPV vaccine initiation, consistently low rates of members that are UTD, or both, and (b) identifying and effectively reaching out to members that are not UTD, are at risk for initiating the HPV vaccine after age 13, or both. • MCOs should also incorporate evidence-based strategies for addressing vaccine hesitancy when communicating directly with members.
Finding(s)	MCOs identified provider-patient communication as an important way to address vaccine hesitancy among parents of teens.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	• HHSC should encourage MCOs to pursue alternative payment models (APMs) that incentivize providers to strengthen provider communication about the HPV vaccine. • MCOs should conduct studies to evaluate the utilization and effectiveness of their educational resources to help strengthen provider communication about the HPV vaccine. • MCOs should use evidence-based approaches when training providers to recommend the HPV vaccine. The National Institute for Health (NIH) currently recommends the training resources available from the Gillings School of Public Health at the University of North Carolina: hpviq.org.
Finding(s)	The descriptive analysis of HPV vaccine records suggests disparities in the number of teens with a timely HPV vaccine initiation and teens that are UTD on the HPV vaccine associated with age, rurality, ethnicity, and Medicaid service delivery models.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC and the MCOs should do a deeper dive to examine the root causes of these potential vaccination disparities and use the information to strengthen their quality improvement strategies for child vaccination.
Finding(s)	The percentage of 11-year-old members that initiated an HPV vaccination is >20 percentage points below all other ages. A lower rate among younger members is consistent with the literature. However, it is unclear whether this difference was moderated by COVID-19-related social distancing policies, parental decisions to delay HPV vaccination or both.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	• HHSC should conduct a study to compare the differences in rates of HPV vaccination among the members in this cohort to a pre-COVID-19 cohort of members aged 11-16 years as of December 2018. • HHSC should also conduct a study to assess how rates of routine childhood vaccination differ before and after March 2020 and identify the strategies MCOs are using to encourage members to return to provider offices for vaccination.

Table 59. Findings and recommendations from the study examining the transition to MBCC program

Category	Description
Finding(s)	Many members in MBCC do not experience cervical cancer treatment delays.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	HHSC should continue to work with BCCS providers to maintain flexibilities that allow them to submit MBCC eligibility documentation electronically and facilitate quicker processing of MBCC applications.
Finding(s)	There is a lack of awareness of the BCCS and MBCC programs by patients and local Medicaid offices.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	• HHSC should work across agencies to increase awareness of BCCS and MBCC, especially among local Medicaid offices where underserved women seek information about services. • HHSC should work with BCCS providers and MCOs to increase awareness of the programs and resources offered among Texas residents. Given that the BCCS and MBCC programs serve specific geographical areas, HHSC should work with each program to ensure tailored strategies to increase awareness in specific geographical areas for targeted outreach.
Finding(s)	Both BCCS providers and MCOs identified communication challenges and difficulties reaching patients.
MCQS Goal(s)	Goals 1, 2, 3, 6
Recommendation(s)	• BCCS providers and MCOs should implement evidence-based strategies to reach hard-to-reach populations, such as the use of healthcare navigators, and consider limited access to technology and connectivity resources among underserved populations. MCOs should promote the Lifeline Assistance Program, which provides Medicaid members with a free cell phone with minutes, texts, and data (FCC, 2021). MCOs should also consider implementing or continue implementing value-added services that improve member access to communication technology. • HHSC should investigate barriers to accessing care for members who are not engaged in treatment. MCOs should work with clinicians to implement evidence-based programs that eliminate disparities in the initiation of treatment. • HHSC should work with BCCS and MBCC programs to increase knowledge of cervical cancer through public health education strategies targeted at under-served populations served by the programs. Improving cervical cancer education could improve engagement for women diagnosed with cervical cancer by increasing knowledge about the disease and the importance of timely screening and treatment.
Finding(s)	There is a lack of access and proximity to cervical cancer specialists who accept MBCC.
MCQS Goal(s)	Goals 3, 6

Category	Description
Recommendation(s)	• MCOs should conduct a study to assess the number of cervical cancer specialists who cover MBCC services in their service area and focus on improving clinician availability in areas identified as lacking clinicians who cover MBCC services. • Although all MCOs cited transportation as a barrier, none of the MBCC providers reported referring patients to Medicaid's NEMT services. MCOs should increase awareness of the non-emergency medical transportation program among staff.
Finding(s)	MCOs do not provide MBCC specific value-added services or resources.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	• HHSC should work with MCOs to identify evidence-based interventions such as cervical cancer patient navigation programs designed to reduce barriers to initiating or supporting continuity of care that MCOs could implement as value-added services.
Finding(s)	BCCS providers do not provide follow-up services after patients enroll in MBCC.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	• HHSC should support data sharing between BCCS and MBCC through Med-IT to support follow-up. • HHSC should consider extending the recertification requirement to every 12 months, given that cervical cancer treatment duration may take more than six months.
Finding(s)	There is a need for HHSC to update information about cervical cancer resources and train BCCS providers on determining MBCC eligibility for patients.
MCQS Goal(s)	Goals 4, 6
Recommendation(s)	• HHSC should update the HTW website and inform the providers that HTW covers cervical cancer diagnostic services. The HTW website currently lists that HTW only covers screening services. • HHSC should train BCCS providers on MBCC qualifying cervical cancer diagnosis criteria. • HHSC should provide training opportunities for BCCS providers focused on determining income eligibility for patients who are self-employed or with non-traditional employment.

Table 60. Findings and recommendations from the study on ISPs for MDCP members

Category	Description
Finding(s)	The percentage of Hispanic members authorized for financial management services was lower than that of non-Hispanic White or non-Hispanic Black members.
MCQS Goal(s)	Goals 2, 5

Category	Description
Recommendation(s)	• HHSC should conduct additional studies to identify potential barriers to CDS and explore ways to encourage more Hispanic members to opt-in to FMS. • The STAR Kids ISP Narrative form (Form 2603) includes items that address service preferences, including a discussion of preferences for CDS. A study that incorporates analysis of this form for MDCP members may help to understand racial/ethnic differences in authorization for FMS. To determine whether a study of STAR Kids ISP Narrative form data would be feasible, the EQRO recommends first identifying the availability and quality of data in this form collected by STAR Kids MCOs.
Finding(s)	A substantial percentage of caregivers (29 percent) reported some other caregiver burden that the twelve categories assessed in the SK-SAI did not capture.
MCQS Goal(s)	Goals 2, 5
Recommendation(s)	HHSC should conduct further studies of "other" caregiver burden responses. Qualitative analysis of these open-ended responses may reveal new sources of caregiver burden and potentially inform modifications to the SK-SAI to ensure these sources of caregiver burden are more systematically assessed.

Protocol 10: Assist with Quality Rating of MCOs

Protocol Overview & Objectives

Although CMS has not released details for Protocol 10, the EQRO participates in several activities related to quality rating. The EQRO presents performance measures (Protocol 7) with ranking and comparison to benchmarks on the THLC portal (thlcportal.com). Protocol 7 also has information on the P4Q programs. In another important activity in this area, the EQRO develops annual MCO report cards to support the state's ongoing efforts to improve health care quality and support consumer choice in Medicaid and CHIP.

EQR Activities

Performance Dashboards

The dashboards allow users to compare performance results to national benchmarks, compare performance by MCO and service area, and track performance over time. The dashboard also summarizes 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. Chapter 10 of the Texas Medicaid and CHIP UMCM provides published details on the standards for the Performance Indicator Dashboard (Section 10.1) and Performance Improvement (Section 10.2) (HHSC, 2021a). Complete details on the P4Q Performance Dashboard are available in Chapter 6 of the UMCM (HHSC, 2021a).

Performance Indicator Dashboard Measures

The Performance Indicator Dashboard for Quality Measures is a selection of quality measures with particular importance for Medicaid and CHIP. The EQRO helps Texas select measures based on qualitative assessment and review of measure results across programs. The most current and detailed results on Performance Indicator Dashboard measures are available to HHSC and MCO users on the THLC portal (thlcportal.com). The dashboard information supports ongoing and future quality improvement initiatives by helping Texas identify measures where most MCOs excel or struggle and where MCO performance varies widely.

Technical Methods & Analyses

Annual high and minimum standards for the Performance Indicator Dashboard come from EQRO calculations using measure results, annual measure trends, and publicly available national benchmark data. Standards are based on calendar year data, by program, using the most current results available for a complete calendar year. The SOA Annex includes performance indicator dashboard results for each MCO. Table 61 lists the performance standard definitions for the Performance Indicator Dashboard.

Table 61. Performance standards for the Performance Indicator Dashboard

Type of Measure	Performance Standard	Description
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.
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.
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% (multiplying score by 1.05 or 0.95), depending on which direction indicates improvement.
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 will be used as the minimum standard.

Compliance

HHSC expects MCOs to meet or surpass the minimum standard on more than two-thirds of measures. An MCO whose performance is below the minimum standard on more than 33.33% of the measures per program on the Performance Indicator Dashboard is subject to remedies under the contract, including placement on a corrective action plan (CAP). HHSC does not evaluate MCOs on retired measures or measures that underwent specification changes between the year the standard was set and the evaluation year.

Pay-For-Quality (P4Q) Performance Dashboard

Texas requires a percentage of MCO premiums to be based on quality measure performance (Texas §536.051). The EQRO worked extensively with HHSC to develop the medical P4Q program for Medicaid and CHIP. The medical programs include HEDIS and other key measures, including survey measures and PPEs. To help HHSC and the MCOs/DMOs track P4Q performance, the EQRO created the P4Q Performance Dashboard on the THLC portal (thlcportal.com).

Technical Methods & Analyses

Developed during SFY 2019 and launched for the public during this reporting year, the dashboard provides information by measure and by MCO for each P4Q program, including the measure contribution category (measured against self, against benchmarks, and bonus measures) and level of reward or loss. The dashboard allows stakeholders to see which measures positively or negatively contribute to P4Q scores and the relative performance of the MCOs. HHSC suspended the P4Q program for 2021 because of the COVID-19 pandemic. Table 62 lists the performance standards for the Medical P4Q Measures.

Table 62. Performance standards for Medical P4Q

Type of Measure	Performance Standard	Description
Medical P4Q	High	The standard for at-risk measures is the cutoff for earning the maximum in performance against benchmarks, as described in Chapter 6.2.14 of the UMCM. For the bonus pool measures, HHSC uses the benchmark for earning.
Medical P4Q	Minimum	The minimum standard for at-risk measures is the lowest cutoff where no money is earned or lost in performance against benchmarks, as described in Chapter 6.2.14 of the UMCM.

MCO Report Cards

Texas is one of many states, including California, New York, Florida, Illinois, and Ohio, using report cards to provide decision support for Medicaid and CHIP enrollees and their caregivers in selecting an MCO. The EQRO has produced report cards for Texas since 2013, working with HHSC each year to select relevant measures and establish an appropriate methodology for assigning ratings. The MCO report cards meet federal requirements for providing accessible information on health care quality for consumers. The EQRO produced 62 unique report cards (by 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.

Technical Methods & Analyses

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. Complaints data from HHSC for components of experience with the health plans

The MCO report cards for this reporting period use the results from member and caregiver surveys conducted in the spring and summer of 2021 (Protocol 6), administrative measure results for MY 2020 (Protocol 7), and member complaint data between August 2020-May 2021 provided by HHSC.

The EQRO fielded 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 did not conduct the biennial survey during the timeframe. With 200 completed interviews per plan code targeted, the EQRO collected over 33 thousand completed interviews from attempts to contact over 300 thousand members

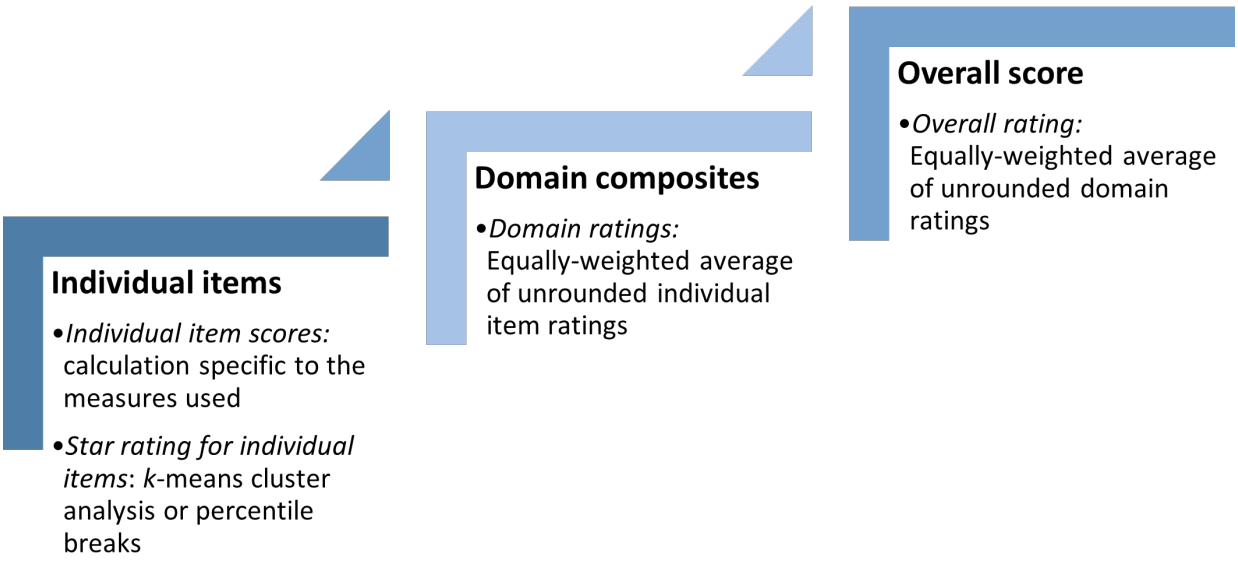
or caregivers. Following AHRQ guidance, case-mix adjustment at the plan code level corrected for potential bias from respondent characteristics unrelated to health care quality, including age, education, and health status.

HHSC provided the complaints data for report cards. The data included complaints collected from members and providers between August 2020 and May 2021. The EQRO compiled all unique, valid, and substantiated complaints by members and providers for each MCO in STAR, STAR+PLUS, and STAR Kids. The EQRO then divided the total number of complaints by 10,000 member months for each plan code within a program to produce a rate for analysis.

Structure

The report cards organize MCO performance information using a three-tiered hierarchical structure to allow new enrollees and their caregivers to compare MCOs at the desired level of detail and make an informed decision. The MCO report cards for CHIP, STAR children, STAR adults, and STAR+PLUS begin with an overall composite summary of relative MCO performance that averages the star ratings for several domains. Each of the five types of report cards includes three or four domain composites and an overall composite. The domains comprise different items by type of report card to account for the needs of the populations. Domain ratings appear below the overall composite rating, and ratings for the individual measures within the domain appear under each domain rating. Figure 8 shows this calculation cascade graphically.

Figure 8. 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 displays "No rating."

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

- Experience of Care summarizes member and caregiver experience measures from a subset of the CAHPS surveys and provides information on what members think about the quality of the MCO (e.g., How Well Doctors Communicate or Rating of Health Plan).

- **Staying Healthy** summarizes measures of preventive healthcare (e.g., well-care visits for CHIP or prenatal visits for STAR Adult).
- **Common Chronic Conditions** summarizes measures relating to managing select chronic conditions (e.g., asthma for STAR Child or diabetes for STAR+PLUS).
- **Experience with the Health Plan:** summarizes information on the total member and provider complaints about the MCOs and a measure relating to adult/caregiver experience with the health plan (CAHPS Rating of Health Plan).[g]

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

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

Appendix G: Measures Used in Report Card Ratings Calculations provides details on the domain structure and content for each of the five report card types.

Star Rating Modifications for the SFY 2021 CMS reporting period

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

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

Administrative measures use k means clustering to identify rating levels, as in previous years; additionally, these measures incorporate information about performance relative to national benchmarks. Survey measures use the same approach as the Medicare C and D Star Ratings (CMS, 2020c), a percentile-based method adjusted for

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

significance and reliability. Composite measures ratings average the component ratings (not scores) to increase interpretability by improving the intuitiveness of the composite ratings.

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

Survey scores include non-response weights for any significant differences in response propensity by age, sex, and race/ethnicity; and case-mix adjustment by member health status, respondent age, and education. The EQRO calculated scores, case-mix adjustments, and standard errors using version 5.0 of the CAHPS analysis macro (CAHPS Consortium, 2020). The percentile-based method for the survey measures first assigns a base rating group according to the percentile breaks in Table 64 using the weighted adjusted scores; this procedure follows the process used to calculate the Medicare C and D Star Ratings (CMS, 2020c). This base group is adjusted toward the middle when reliability is low (less than 0.70 but not less than 0.60), or the score is not significantly different from the grand mean of all scores on a two-tailed *t*-test ($p<0.05$) after finite-population correction. Scores with very low reliability (<0.60) will not receive a rating. One- and five-star ratings will occur only for scores significantly below or above the grand mean and either not low reliability or at least one standard error below or above the percentile cut point. In uncommon cases, this adjustment procedure can result in a lower score receiving a higher rating or vice versa, due solely to uncertainty; such instances will receive a "No rating" assignment. This procedure allows for sampling variation and the potential non-representativeness of the respondent pool. This approach to rating the survey measures will tend to increase the variation in ratings overall but may limit extreme (one- or five-star) ratings. Where data was insufficient to compute a reliable rating (reliability ≥ 0.7), the report cards indicate "No rating," and a clarifying note informs users that this is due to lack of information and does not indicate poor quality. MCOs may receive ratings for domain composites and individual measures without receiving an overall rating. Table 63 and Table 64 summarize the adjustments and rating decision rules described above.

Table 63. 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

Table 64. Survey measure ratings decision rules

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

COVID-19 Pandemic Impacts

HHSC suspended the P4Q program for 2021 because of the impact of the COVID-19 pandemic on the MY 2020 QOC results. The impact of the pandemic are described in Protocol 2 and Protocol 7.

Relevance for Assessing Quality, Access & Timeliness

The Performance Dashboards and MCO Report Cards provide a way for MCOs and members to access and compare information on the quality of care. Protocol 2 and Protocol 7 contain more specific information on the impacts of the COVID-19 pandemic on the measures included in the Performance Dashboards and MCO Report Cards.

Summary of Protocol Findings & Recommendations from EQR Activities

No recommendations for Protocol 10.

EQRO Recommendation Summary

As noted in the Introduction, Texas must 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), CMS expects the EQRO to provide recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)(2020)) including how the State can target goals and objectives in the quality strategy, under § 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.

This section has two parts. The first half outlines the EQRO recommendations for SFY 2021 and their relevance to the current MCQS. The second half outlines: (a) the EQRO recommendations for SFY 2020, (b)their relevance to Texas's MCQS at the time of the recommendations, and (c) HHSC's response to the prior year recommendations.

The overall EQRO Recommendation Summary section includes the general recommendations made to HHSC and the MCOs. The report annex includes information on the MCO-and DMO-specific recommendations.

SFY 2021 Recommendations

Protocol 1: Validation of PIPs

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

Protocol 2: Validation of Performance Measures Reported by MCOs

No recommendations

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

AI Interviews

Category	Description
Finding(s)	Several MCOs and DMOs reported challenges obtaining provider URL information and incorporating it into provider directories.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs and DMOs, including Aetna, CFHP, FirstCare, and UHC Dental, should establish systems to incorporate provider website URLs in their provider directories.
Finding(s)	Many MCOs and DMOs requested clarification on the appropriate machine-readable format posted on their publicly facing websites.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	Aetna, CFHP, CCHP, DentaQuest, FirstCare, and UHC Dental should provide machine-readable provider directories on their websites.
Finding(s)	Several MCOs and DMOs did not have compliant procedures for the associated timeframes and notification protocols for expedited service authorization decisions.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs and DMOS, including CFHP, CCHP, El Paso Health, FirstCare, and UHC Dental, should ensure their representatives make expedited service authorization decisions and notifications within the federally required timeframes.
Finding(s)	Several MCOs and DMOs reported having state-compliant CHIP grievance system protocols; however, these system protocols were not compliant with updated federal guidelines.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	MCOs and DMOs with a CHIP product line need to evaluate their procedures to ensure that CHIP grievance system protocols align with Medicaid grievance system protocols, excluding the Medicaid requirement of continuation of benefits pending the appeal, a state fair hearing, or both.
Finding(s)	Some MCOs and DMOs reported data collection on member SDoH needs. However, many MCOs and DMOs had not implemented procedures to aggregate the collected information.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	MCOs and DMOs need to systemically collect data on members' SDoH needs to aggregate needs by populations to impact member health and well-being effectively.
Finding(s)	While some MCOs and DMOs had implemented specific SDoH related interventions, they had not clearly measured the direct and indirect effects for all of them.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	MCOs and DMOs should consider evaluating the impact of plan-driven SDoH-related interventions and referrals to community resources on members' health and well-being.
Finding(s)	MCOs and DMOs reported several multi-agency collaborations to address SDoH needs in members.
MCQS Goal(s)	Goals 1, 2, 3

Category	Description
Recommendation(s)	MCOs and DMOs are encouraged to share SDoH-related interventions and best practices with other entities, including HHSC, to further address unmet needs that may impact the health of Texans enrolled in Medicaid and CHIP programs.
Finding(s)	MCOs reported rapid transition by their providers to medical and behavioral health telehealth in response to the COVID public health emergency. Many MCOs discussed the importance of provider communication to ensure that providers adopted correct billing codes and modifiers to facilitate payment for telehealth services.
MCQS Goal(s)	Goals 1, 3, 6
Recommendation(s)	MCOs should continue exploring the efficiency of utilizing medical and behavioral health telehealth services and their impact on health outcomes.

QAPI Evaluations

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

Protocol 4: Validation of Network Adequacy

Appointment Availability

Category	Description
Finding(s)	STAR Kids MCOs need to reverse the downward trend in compliance with behavioral health appointment wait time standards. STAR Kids had the lowest percentage of compliant providers for behavioral health care appointment standards among all programs. The percentage of STAR Kids providers compliant with UMCM standards was 13.1 percentage points lower in 2021 than in 2018.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	STAR Kids MCOs should conduct root cause analyses (RCAs) to identify the driving factors behind lower rates of provider adherence to appointment standards among behavioral health providers and use the results to identify strategies for improving provider compliance.
Finding(s)	In 2021, compliance with behavioral health appointment wait time standards decreased in CHIP, STAR+PLUS, and STAR Kids, compared to 2018.
MCQS Goal(s)	Goals 3, 5

Category	Description
Recommendation(s)	The EQRO recommends that HHSC conduct an in-depth study on behavioral health appointment wait times to: (1) better understand the challenges that MCOs encounter when trying to improve provider adherence to appointment standards and (2) more effectively target MCO incentives for providers that meet appointment availability standards.
Finding(s)	CCHP has the most room to improve compliance with wait time standards for behavioral health. CCHP had the lowest percentage of providers in compliance with wait time standards for all product lines they serve (STAR, STAR Kids, CHIP).
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	• HHSC should strongly encourage CCHP to conduct an RCA to identify the drivers for poor provider adherence to appointment standards • CCHP should use the RCA to identify specific approaches that they can use to encourage providers to make appointments available within 14 working days.
Finding(s)	The EQRO excluded fewer providers from the behavioral health sub-study sample in 2021 because of incorrect taxonomies or other directory information.
MCQS Goal(s)	Goal 4
Recommendation(s)	The EQRO recommends that HHSC continue to work with MCOs and TMHP to improve provider directory information quality.
Finding(s)	In STAR Health, the percentage of appointments available dropped by 17.7 percentage points.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	The EQRO recommends that Superior (SHP) conduct an RCA to understand the decrease in available primary care appointments between 2020 and 2021 and use this information to identify ways to increase the percentage of providers with available appointments.
Finding(s)	In 2021, the percentage of providers compliant with primary care standards for preventive and routine primary care decreased in CHIP and STAR+PLUS compared to 2020.
MCQS Goal(s)	Goals 1, 3
Recommendation(s)	As with behavioral health, the EQRO recommends that HHSC conduct an in-depth study on appointment wait times to: (1) better understand the challenges that MCOs encounter when trying to increase the percentage of providers that are compliant with appointment standards and (2) more effectively target MCO incentives to increase the percentage of providers that meet appointment availability standards.

Medicaid Unmet Transportation Need Study

Category	Description
Finding(s)	A larger percentage of adult clients identified having unmet medical transportation needs (21.6 percent vs. 7.4 percent) and less familiarity with NEMT services (35 percent vs. 22.2 percent) compared to caregivers for younger clients.
MCQS Goal(s)	Goals 1, 2, 3

Category	Description
Recommendation(s)	The EQRO recommends that HHSC develop targeted information campaigns about NEMT services tailored to older Medicaid clients (21+) to help increase awareness. Targeted information campaigns may help HHSC towards its MCQS goal of providing the right care for clients at the right time by facilitating client knowledge about access to care.
Finding(s)	Difficulty getting transportation that meets scheduling needs and distance to the bus/train stops were two of the more frequently noted barriers to medical transportation.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	Texas H.B. 1576, 86(R)(2019) directs HHSC to carve into managed care all NEMT services provided to clients enrolled in managed care Medicaid. As part of this shift in 2021, the EQRO recommends that HHSC encourage the MCOs to identify transportation strategies that provide members with scheduling flexibility and limit the distance that Medicaid members must travel to access transportation, which will help facilitate the use of NEMT services and the accessibility of care. The EQRO also recommends that HHSC do the same for newly enrolled Medicaid clients.
Finding(s)	A small percentage of clients (6.7 percent) said they reached out to their MCO or provider for help with transportation. Among those that did reach out, 46.5 percent said they 'usually' or 'always' received help. The percentage of adult clients that reached out to their MCO or provider was larger (12.9 percent) than the percentage of caregivers for children (2.8 percent).
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	The EQRO also recommends that HHSC conduct at least one follow-up study on unmet transportation needs among Medicaid beneficiaries after the transition above to assess whether there are any changes in the percentage of beneficiaries with unmet transportation needs or changes in levels of awareness among beneficiaries.

Protocol 5: Validation of Encounter Data Provided by MCOs

Encounter Data Submissions and MCO Encounter Data Production Capacity

Category	Description
Finding(s)	Variations in encounter submissions suggest underlying differences in the care delivery model that could affect QOC measures. While changes related to COVID-19 make it more challenging to identify other issues during SFY 2020, large single-month changes can also indicate a processing issue. When MCOs experience a processing issue and do not provide HHSC or the EQRO with accurate data or information explaining the issue, it can affect the use of the data for QOC measures.
MCQS Goal(s)	Goals 1, 3, 4
Recommendation(s)	HHSC should work with the EQRO, TMHP, and the MCOs/DMOs to improve the system to monitor monthly encounter submissions for anomalies and communicate about issues or discrepancies.
Finding(s)	The EQRO found that for most MCO/SAs primary diagnoses, POA distributions were within the accepted ranges. However, primary diagnosis was coded not present on admission (POA code = N) more than 10 percent of the time for some MCOs.
MCQS Goal(s)	Goals 1, 3, 4, 6

Category	Description
Recommendation(s)	MCOs should work with their network hospitals to improve POA reporting.
Finding(s)	In general, provider data quality went down relative to the prior year.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	HHSC should continue improving the provider information system, including identifying providers not eligible for NPI.
Finding(s)	The EQRO highlighted the need to improve the rate of CRA coding several years ago, and the measure improved slightly, but appropriate codes are still missing more than two percent of the time. The DMOs correctly deny these claims, but the data is still lost.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	DMOs should promote CRA coding with provider outreach in addition to denial of claims.

Review of Medical and Dental Records for Consistency with Encounter Data

Encounter Data Validation Medical Record Review-CHIP

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

Category	Description
Finding(s)	FirstCare did not obtain and submit enough records to meet the sample size requirements, resulting in the EQRO deeming all FirstCare's match rates unreliable.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	FirstCare should ensure that all provider addresses are the most accurate addresses available at the start of each EDVMRR study. Further, FirstCare should take advantage of the opportunity to retrieve any outstanding records and submit them to the EQRO within the specified timeframe to ensure it meets the required sample size.
Finding(s)	The overall match rates for MCOs were high across review categories (i.e., DOS, POS, PDx, and PX). However, several MCOs performed below average. The MCOs that scored below average across review categories were CFHP, FirstCare, PCHP, TCHP, and UHC. The primary reason for the lower match rates for these MCOs was that the encounter data included DOS, POS, PDx, and/or PXs that were not documented in the medical record.
MCQS Goal(s)	Goals 1, 3, 4, 6
Recommendation(s)	CFHP, FirstCare, PCHP, TCHP, and UHC should examine why what is in the encounter data is not documented in the medical record.

Encounter Data Validation Dental Record Review

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

Protocol 6: Administration of Quality of Care Surveys

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

Protocol 7: Calculation of Performance Measures

Category	Description
Finding(s)	In 2020, Hispanic Medicaid members had fewer ED visits, fewer hospitalizations, and fewer C-sections than non-Hispanic White or non-Hispanic Black members.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC should continue to explore QOC measure results across demographic and other member population groups to interpret results more clearly and better direct efforts to improve care for all Medicaid and CHIP members.
Finding(s)	Renal Failure without dialysis was the most common PPC for STAR+PLUS members, while Shock and Septicemia contributed the most PPC weights. Septicemia and Shock also contributed the most weight among STAR members, but here the most common PPC reason, by far, was obstetric complications.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	The EQRO suggests investigating relationships between PPEs for specific conditions and patterns of preventive care for those conditions
Finding(s)	MCO performance across Performance Indicator Dashboard measures varies; Some MCOs achieve the high standard on more than 60 percent of measures while others fail to meet the minimum standard on more than 40 percent of measures.
MCQS Goal(s)	Goals 1, 4, 6
Recommendation(s)	HHSC should continue leveraging the THLC portal (thlcportal.com) dashboards to help all Medicaid and CHIP stakeholders identify and understand trends in healthcare quality across state programs.
Finding(s)	SMM rates were consistently higher in STAR than in CHIP Perinatal between 2017-2020, most notably in (pre)eclampsia cases. Overall rates have trended down over this period.
MCQS Goal(s)	Goals 1, 2, 3, 4
Recommendation(s)	HHSC should continue to investigate the underlying drivers of maternal health disparities.
Finding(s)	Medicaid and CHIP covered over 50 thousand C-sections in deliveries without complications. Compared to uncomplicated deliveries without C-section, these deliveries incurred additional costs totaling over $100 million.
MCQS Goal(s)	Goals 1, 2, 3, 4
Recommendation(s)	HHSC should do a deeper investigation of C-section deliveries.

Protocol 9: Conducting Focused Studies of Health Care Quality

STAR Kids Focus Study

Category	Description
Finding(s)	While access to specialist care has improved for STAR Kids MDCP members, improved network adequacy could address significant remaining barriers in access to physical, occupational, and speech therapies.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	• STAR Kids MCOs should focus network adequacy efforts on ensuring that provider networks have sufficient special therapy providers with experience treating children with complex conditions. To achieve this, MCOs should: (1) identify and leverage strategies that have been successful in building networks of specialist providers, and particularly those who treat rare and complex conditions; and (2) share best practices in recruitment of special therapy providers with each other in collaborative contexts, such as stakeholder and advisory group meetings or jointly conducted performance improvement projects. • STAR Kids MCOs should develop or improve existing policies and procedures for providing special therapies to STAR Kids MDCP members that account for specific member conditions and needs; caregiver limitations, assets, and preferences; and unexpected changes to members' health or living conditions.
Finding(s)	Although caregiver access to and satisfaction with service coordination for STAR Kids MDCP members has improved, many caregivers report functioning as their child's primary care coordinator for specific types of services, such as prescription medicines and medical supplies.
MCQS Goal(s)	Goals 2, 6
Recommendation(s)	• STAR Kids MCOs should enhance the training of service coordinators to emphasize the challenges caregivers face in accessing medications and medical supplies for their children. Training materials and service coordination policies should address potential scenarios experienced by caregivers, such as being drawn into the coordination process by pharmacies and suppliers, filling expensive medications for rare conditions, or navigating the approval process with primary private insurance and Medicaid coverage. • STAR Kids MCOs should consider or build upon programs to provide STAR Kids MDCP caregivers with services that reduce coordination and travel burden for caregivers, such as automatic medication refills, home delivery of medications, and delivery tracking for supplies.
Finding(s)	Low participation in the focus groups and under-representation of Hispanic and non-Hispanic Black caregivers limited the study. Without reaching thematic saturation, important issues for caregivers likely remain that the study did not uncover.
MCQS Goal(s)	Goals 2, 5

Category	Description
Recommendation(s)	HHSC should consider renewing this study in 2022, incorporating changes to methods to address participation issues encountered this year. Recommended strategies include: • Expanding the study to encompass all service areas statewide. The STAR Kids MDCP population is small (less than 4,700 in 2019) and including all service areas will produce a larger sample for recruitment. • Oversampling members in under-represented racial/ethnic groups. Given expected racial/ethnic differences in response rates in EQRO survey studies, such as lower response among caregivers of non-Hispanic Black members, oversampling can help correct non-response bias and improve representation. • Conducting semi-structured interviews rather than focus groups. Interviews are simpler to coordinate and may improve the participation of caregivers who are intimidated by focus group dynamics. • Reducing the number of points of interaction during telephone recruitment. Each point of interaction presents a risk of losing a prospective participant to follow-up. Interviews can be scheduled, and email addresses collected on the first call. • Coordinating the study with the existing STAR Kids biennial survey. The proposed study would coincide with the 2022 biennial survey and could contribute to the respondent burden. If feasible, adding a recruitment script to the end of the biennial survey tool could improve recruitment and participation. • Partnering with institutional and community groups that advocate for children with disabilities in Texas, such as the STAR Kids Managed Care Advisory Committee; Every Child, Inc.; and Texas Parent to Parent. The recruitment efforts may be improved with access to communication channels and community and family networks that these groups maintain.

Quarterly Topic Reports

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

Category	Description
Finding(s)	The number of in-person face-to-face visits declined, and teleservice use increased during the COVID-19 study period.
MCQS Goal(s)	Goals 1, 3

Category	Description
Recommendation(s)	• HHSC should continue to work with MCOs to maintain teleservice uptake through flexible teleservices reimbursement policies. • HHSC should examine the decline in face-to-face visits during the COVID-19 study period to determine whether the decline was due to substituting face-to-face visits with teleservices or whether services not amenable to teleservices were not provided during the COVID-19 study period. • MCOs should work with providers to provide outreach to patients who did not engage in needed face-to-face visits that are not amenable to teleservices during the COVID-19 study period. • MCOs should identify and advocate for the use of teleservices delivery platforms that are accessible for persons with limited technology and connectivity resources to address disparities in teleservice use. HHSC should examine the extent to which MCOs are increasing accessibility of teleservices for persons with limited access.
Finding(s)	Members who did not engage in face-to-face or teleservice visits before the COVID-19 study period had lower odds of using teleservices during the COVID-19 study period.
MCQS Goal(s)	Goals 3, 6
Recommendation(s)	• MCOs should work with providers to implement evidence-based strategies that eliminate disparities in care utilization, such as direct support professionals, including community health workers and patient navigators/care coordinators. • HHSC should investigate barriers to accessing care for members who are not engaged in care.
Finding(s)	Across programs, non-Hispanic Black members and members in rural areas had lower odds of using teleservices.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	• HHSC should work across agencies to address disparities in technology access among underserved sociodemographic groups and geographic areas. • HHSC should work with MCOs to ensure that they thoughtfully implement efforts to sustain the expanded use of teleservices to limit further worsening the disparities in access to care among rural and non-Hispanic Black populations. • MCOs should work with providers to implement teleservices using accessible and user-friendly platforms for persons with limited access to digital devices (e.g., smartphones, tablets, or computers), broadband access, and limited digital literacy skills.
Finding(s)	Members with BH or chronic conditions had higher odds of using teleservices during the COVID-19 study period.
MCQS Goal(s)	Goals 2, 3, 5
Recommendation(s)	• HHSC should conduct a study to identify which specific chronic or BH conditions were associated with teleservices use to understand utilization and gaps in services by condition and to examine the relationship between utilization of teleservices and disease management for these conditions. • HHSC should investigate barriers to care for members with BH or chronic conditions who did not access teleservices during the COVID-19 study period.

Category	Description
Finding(s)	Higher county-level cumulative count of COVID-19 cases was associated with decreased odds of using teleservices among adults in STAR and STAR+PLUS. However, children living in counties with a high cumulative count of COVID-19 had higher odds of having a teleservice visit.
MCQS Goal(s)	Goals 2, 3
Recommendation(s)	• HHSC should work with MCOs to examine county-level facilitators and barriers that influenced the implementation of teleservices for adults during the COVID-19 study period. • HHSC should investigate whether MCOs had practices that might have prioritized teleservice use for children but not for adults in these higher-need areas.
Finding(s)	Teleservice use during the COVID-19 study period varied by MCO and SA.
MCQS Goal(s)	Goals 2, 3
Recommendation(s)	• HHSC should conduct future studies to identify area-level barriers to accessing resources that facilitate teleservices. • HHSC should work with MCOs to improve the use of teleservices by implementing evidence-based strategies that increase access to resources crucial for implementing teleservices, such as addressing limited broadband connectivity in under-resourced areas.
Finding(s)	Members who used teleservices during the COVID-19 study period had increased odds of having a PPV or PPA during the same period.
MCQS Goal(s)	Goals 3, 4
Recommendation(s)	HHSC should examine the temporal association between teleservices and PPVs and PPAs during the COVID-19 study period to assess the extent to which teleservice use preceded a PPE (suggesting that teleservices were not sufficient to prevent the ED visit or hospital admission) and the extent to which it followed a PPE (suggesting that teleservices may have been part of follow-up after discharge).

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

Category	Description
Finding(s)	Vaccine hesitancy, delays getting children in for preventive care visits, and missed clinical opportunities are important barriers to increasing the percentage of teens with a timely HPV vaccine initiation and the percentage that are up to date (UTD) on the HPV vaccine in Medicaid and CHIP.
MCQS Goal(s)	Goals 1, 2

Category	Description
Recommendation(s)	• HHSC should require all MCOs to specifically address HPV vaccine hesitancy as one of their upcoming Performance Improvement Projects (PIPs). • HHSC should determine whether all Medicaid MCOs have established policies for (a) identifying and effectively responding to providers with consistently low rates of timely HPV vaccine initiation, consistently low rates of members that are UTD, or both, and (b) identifying and effectively reaching out to members that are not UTD, are at risk for initiating the HPV vaccine after age 13, or both. • MCOs should also incorporate evidence-based strategies for addressing vaccine hesitancy when communicating directly with members.
Finding(s)	MCOs identified provider-patient communication as an important way to address vaccine hesitancy among parents of teens.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	• HHSC should encourage MCOs to pursue alternative payment models (APMs) that incentivize providers to strengthen provider communication about the HPV vaccine. • MCOs should conduct studies to evaluate the utilization and effectiveness of their educational resources to help strengthen provider communication about the HPV vaccine. • MCOs should use evidence-based approaches when training providers to recommend the HPV vaccine. The National Institute for Health (NIH) currently recommends the training resources available from the Gillings School of Public Health at the University of North Carolina: hpviq.org.
Finding(s)	The descriptive analysis of HPV vaccine records suggests disparities in the number of teens with a timely HPV vaccine initiation and teens that are UTD on the HPV vaccine associated with age, rurality, ethnicity, and Medicaid service delivery models.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	HHSC and the MCOs should do a deeper dive to examine the root causes of these potential vaccination disparities and use the information to strengthen their quality improvement strategies for child vaccination.
Finding(s)	The percentage of 11-year-old members that initiated an HPV vaccination is >20 percentage points below all other ages. A lower rate among younger members is consistent with the literature. However, it is unclear whether this difference was moderated by COVID-19-related social distancing policies, parental decisions to delay HPV vaccination, or both.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	• HHSC should conduct a study to compare the differences in rates of HPV vaccination among the members in this cohort to a pre-COVID-19 cohort of members aged 11-16 years as of December 2018. • HHSC should also conduct a study to assess how rates of routine childhood vaccination differ before and after March 2020 and identify the strategies MCOs are using to encourage members to return to provider offices for vaccination.

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

Category	Description
Finding(s)	Most members in MBCC do not experience cervical cancer treatment delays.
MCQS Goal(s)	Goals 1, 3, 5
Recommendation(s)	HHSC should continue to work with BCCS providers to maintain flexibilities that allow them to submit MBCC eligibility documentation electronically and facilitate quicker processing of MBCC applications.
Finding(s)	There is a lack of awareness of the BCCS and MBCC programs by patients and local Medicaid offices.
MCQS Goal(s)	Goals 1, 2, 3
Recommendation(s)	• HHSC should work across agencies to increase awareness of BCCS and MBCC, especially within the local community where underserved women seek information about services. • HHSC should work with BCCS providers and MCOs to increase awareness of the programs and resources offered among Texas residents. Given that the BCCS and MBCC programs serve specific geographical areas, HHSC should work with each program to ensure tailored strategies to increase awareness in specific geographical areas for targeted outreach.
Finding(s)	Both BCCS providers and MCOs identified communication challenges and difficulties reaching patients.
MCQS Goal(s)	Goals 1, 2, 3, 6
Recommendation(s)	• BCCS providers and MCOs should implement evidence-based strategies to reach hard-to-reach populations, such as the use of healthcare navigators, and consider limited access to technology and connectivity resources among underserved populations. MCOs should promote the Lifeline Assistance Program, which provides Medicaid members with a free cell phone with minutes, texts, and data (FCC, 2021). MCOs should also consider implementing or continue implementing value-added services that improve member access to communication technology. • HHSC should investigate barriers to accessing care for members who are not engaged in treatment. MCOs should work with clinicians to implement evidence-based programs that eliminate disparities in the initiation of treatment. For example, direct support professionals, including community health workers, and patient navigators/care coordinators, improve continuity of care by supporting patients in addressing barriers that prevent patients from engaging in timely cancer treatment. • HHSC should work with BCCS and MBCC programs to increase knowledge of cervical cancer through public health education strategies targeted at under-served populations served by the programs. Improving cervical cancer education could improve engagement for women diagnosed with cervical cancer by increasing knowledge about the disease and the importance of timely screening and treatment.
Finding(s)	Patients lack access and proximity to cervical cancer specialists who accept MBCC.
MCQS Goal(s)	Goals 3, 6

Category	Description
Recommendation(s)	• MCOs should conduct a study to assess the number of cervical cancer specialists who cover MBCC services in their service area and focus on improving clinician availability in areas identified as lacking clinicians who cover MBCC services. • Although all MCOs cited transportation as a barrier, none of the MBCC providers reported referring patients to Medicaid's NEMT services. MCOs should increase awareness of the non-emergency medical transportation program among staff.
Finding(s)	MCOs do not provide MBCC specific value-added services or resources.
MCQS Goal(s)	Goals 1, 2
Recommendation(s)	HHSC should work with MCOs to identify evidence-based interventions such as cervical cancer patient navigation programs designed to reduce barriers to initiating or supporting continuity of care that MCOs could implement as value-added services.
Finding(s)	BCCS providers do not provide follow-up services once patients enroll in MBCC.
MCQS Goal(s)	Goals 3, 5
Recommendation(s)	• HHSC should support data sharing between BCCS and MBCC through Med-IT to support follow-up. • HHSC should consider extending the recertification requirement to every 12 months, given that cervical cancer treatment duration may take more than six months.
Finding(s)	HHSC should update information about cervical cancer resources and train BCCS providers on determining MBCC eligibility for patients.
MCQS Goal(s)	Goals 4, 6
Recommendation(s)	• HHSC should update the HTW website and inform the providers that HTW covers cervical cancer diagnostic services. The HTW website currently lists that HTW only covers screening services. • HHSC should train BCCS providers on MBCC qualifying cervical cancer diagnosis criteria. • HHSC should provide training opportunities for BCCS providers focused on determining income eligibility for patients who are self-employed or with non-traditional employment.

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

Category	Description
Finding(s)	The percentage of Hispanic members authorized for financial management services was lower than that of non-Hispanic White or non-Hispanic Black members.
MCQS Goal(s)	Goals 2, 5

Category	Description
Recommendation(s)	• HHSC should conduct additional studies to explore ways to provide financial management services to Hispanic members not normally authorized for this type of HCBS service. • The STAR Kids ISP Narrative form (Form 2603) includes items that address service preferences, including a discussion of preferences for CDS. A study that incorporates analysis of this form for MDCP members may help to understand racial/ethnic differences in authorization for FMS. To determine whether a study of STAR Kids ISP Narrative form data would be feasible, the EQRO recommends first identifying the availability and quality of data in this form collected by STAR Kids MCOs.
Finding(s)	A substantial percentage of caregivers (29 percent) reported some other caregiver burden that the twelve categories assessed in the SK-SAI did not capture.
MCQS Goal(s)	Goals 2, 5
Recommendation(s)	HHSC should conduct further studies of "other" caregiver burden responses. Qualitative analysis of these open-ended responses may reveal new sources of caregiver burden and potentially inform modifications to the SK-SAI to ensure these sources of caregiver burden are more systematically assessed.

Protocol 10: Assist with Quality Rating of MCOs

No recommendations

HHSC Follow Up on EQRO Recommendations from SFY 2020

Texas was in the process of updating the MCQS when the SOA came out last year. As a result, the recommendations align with the 2018 MCQS. Table 65 lists the goals and mechanisms referenced in the SFY 2020 tables. Additional information on the SFY 2018 MCQS is available at: hhs.texas.gov.

Table 65. SFY 2018 Texas Managed Care Quality Strategy Goals

Category	Description
Goal 1	Transition from volume-based purchasing models to a pay-for-performance model.
Goal 2	Improve member satisfaction with care.
Goal 3	Reduce payments for low-quality care.

Protocol 1: Validation of PIPs

Category	Description
Finding(s)	Opportunities for improvement in the PIPs arose from not addressing previous EQRO recommendations and insufficient details of modifications made to the PIPs.
MCQS Goal(s)	Goal 3
Recommendation(s)	The MCOs should ensure that they comply with all previous recommendations. The MCOs should provide sufficient details for all modifications to their PIPs.
HHSC Follow Up	• HHSC emphasizes that MCOs/DMOs must comply with all previous recommendations in evaluation feedback. • The SFY 2021 Quality Forum PIP session emphasized compliance with previous recommendations and provided detailed information on providing sufficient details for all PIP modifications.

Protocol 2: Validation of Performance Measures Reported by MCOs

No recommendations

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

Administrative Interviews (AIs)

Category	Description
Finding(s)	MCOs failed to update documentation related to CMS regulations.
MCQS Goal(s)	Goal 3
Recommendation(s)	The MCOs and DMOs should monitor state and federal regulations to ensure compliance.
HHSC Follow Up	• The EQRO assesses compliance for each MCO at least once every three years. • HHSC began assessing liquidated damages on the MCOs for not providing necessary documents and failing to give evidence of compliance with regulations.
Finding(s)	• Most MCOs refer to external community resources to address member SDoH needs, but several provided examples of internally funded interventions.
MCQS Goal(s)	• Goal 2

Category	Description
Recommendation(s)	• MCOs and DMOs should systemically collect member SDoH data to address needs that may impact health and well-being. • MCOs and DMOs should consider evaluating the impact of SDoH-related interventions and referrals to community resources on members' health and well-being. • MCOs and DMOs are encouraged to share SDoH related interventions and best practices with other entities, including HHSC, to further improve care coordination and the health outcomes for Medicaid and CHIP managed care members.
HHSC Follow Up	HHSC is conducting a maternal health SDoH PIP to address many of these concerns by collecting and analyzing SDoH data.

QAPI Evaluation

Category	Description
Finding(s)	Most MCOs and MMPs did not fully incorporate the previous year's recommendations, which resulted in a 4.2 percentage point decrease in the overall score for this activity.
MCQS Goal(s)	Goal 3
Recommendation(s)	The EQRO recommends that MCOs, DMOs, and MMPs incorporate the previous year's recommendations and that HHSC consider corrective action plans for those that consistently do not incorporate the EQRO's recommendations.
HHSC Follow Up	HHSC began assessing liquidated damages on MCOs that did not incorporate the previous year's recommendations.

Protocol 4: Validation of Network Adequacy

Appointment Availability Studies

Category	Description
Finding(s)	Inaccuracies in provider contact information continue to create challenges in reaching providers. While the percentage of unreachable providers decreased in the 2020 Vision and Prenatal sub-studies relative to 2018, the percentage of unreachable primary care providers increased in 2020. Furthermore, over 90 percent of prenatal calls to providers in the BCBSTX directory resulted in wrong number/unreachable calls.
MCQS Goal(s)	Goal 2
Recommendation(s)	HHSC should continue current efforts to work with stakeholders, including the enrollment broker, TMHP, providers, and the MCOs, to improve provider data accuracy. HHSC should also encourage the MCOs to carefully examine the member-facing directory information they provide for the Appointment Availability Study.
HHSC Follow Up	HHSC Quality Assurance continues to work with TMHP and internal divisions to address provider data elements and integrity.
Finding(s)	The percentage of providers contacted from the STAR Health directory that said they did not accept Medicaid increased from three percent in 2018 to 11.8 percent in 2020.
MCQS Goal(s)	Goal 2

Category	Description
Recommendation(s)	Superior should continue to work with STAR Health providers and provider office staff to improve the consistency of responses about provider availability and Medicaid acceptance for vision appointments.
HHSC Follow Up	HHSC Quality Assurance continues to work with TMHP and internal divisions to address provider data elements and integrity.
Finding(s)	In 2020, the percentage of compliant vision appointments decreased in CHIP, STAR, STAR+PLUS, and STAR Kids programs relative to 2018.
MCQS Goal(s)	Goals 2, 3
Recommendation(s)	• HHSC should consider conducting a study that examines network adequacy for vision care in Medicaid and the barriers that Medicaid members face in accessing vision care. • HHSC should consider a study that uses Medicaid and CHIP member experience data to identify telemedicine barriers and gaps in health service access and use this information to target strategies for improving network adequacy. • To better understand the availability of telehealth services for Medicaid members, the EQRO recommends that HHSC consider including a standard question on the availability of different types of teleservices in all four 2021 Appointment Availability sub-studies.
HHSC Follow Up	HHSC added a question on telehealth services to all four SFY 2022 Appointment Availability sub-studies.

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

Category	Description
Finding(s)	• Overall, 79 percent of respondents said it was "easy" or "very easy" to find transportation to the doctor or dentist. Over half of all respondents said they never missed a medical or dental appointment because of lack of transportation. • Overall, demand response transportation services and meals and lodging were the most frequently used NEMT services. Advanced funds were the least frequently utilized. • A substantial percentage of members (75.6 percent) said they did not use public mass transit in the past 12 months. • Overall, 89.1 percent of all respondents said they were "satisfied" or "very satisfied" with the transportation services they received from Medicaid in the past 12 months.
MCQS Goal(s)	Goal 2
Recommendation(s)	The NEMT survey results suggest that member experience is positive, but it does not provide information on how the services could be improved to meet specific member needs. HHSC should consider adding questions to later iterations of the client satisfaction surveys to assess member priorities for NEMT services. These items could include questions about how members use NEMT services and the availability of services for special needs populations. A clear understanding of member priorities for NEMT services provides an important context for interpreting variation in general member satisfaction levels and can help the MTP tailor the programs to better suit members
HHSC Follow Up	Transportation is being carved into Medicaid effective June 1, 2021. HHSC Quality Assurance will work with the EQRO and internal NEMT subject matter experts to develop appropriate questions for further study, especially as the carve-in becomes effective.

Provider Referral Study

Category	Description
Finding(s)	• Specialist responses on the 2020 referral survey share some broad similarities with PCP responses on prior survey versions. Providers consistently identify Psychiatry as one of the most difficult specialties for a referral. However, specialists identified a shorter wait time for an appointment (one or two weeks) than PCPs (one month or more). Specialists and PCPs also identified cardiology as one of the easiest specialties for a referral. • Specialists most frequently identified prior authorization for services, limited appointment availability, and limited specialist networks as the primary barriers to care.
MCQS Goal(s)	Goal 2
Recommendation(s)	• MCOs should continue efforts to identify and reduce barriers to accessing psychiatric services and behavioral health care for Medicaid and CHIP members. • HHSC should consider a study that identifies the challenges that specialists in Medicaid face with the prior authorization process and examine strategies that other state Medicaid programs use to address barriers to care. • Given the increasing importance of teleservices, HHSC should continue to ask about teleservices on future provider surveys and may want to consider adding questions about the actions the providers are taking to protect health information for Medicaid and CHIP members.
HHSC Follow Up	One of the Appointment Availability sub-studies focuses on PCPs and provides additional information about member experience with PCPs.

Protocol 5: Validation of Encounter Data Provided by MCOs

Analysis of Encounter Data for Accuracy & Completeness

Category	Description
Finding(s)	The EQRO found that POA distributions for primary diagnoses were within their accepted ranges for most MCO/SAs. However, POA was not present on admission more than 10 percent of the time in some cases. One cause could be a high number of maternity stays. Hospitals will code significant delivery complications in the primary diagnosis, although the admission was for delivery.
MCQS Goal(s)	Goal 3
Recommendation(s)	MCOs should work with their network hospitals to improve POA reporting.
HHSC Follow Up	• POA indicators are an important part of the overall EDV Scoring methodology. However, they make up a small portion of the overall score. HHSC will work with the EQRO to determine the best way to call out these results. • The EQRO continues to track POA indicators, and HHSC may add additional remediation options if quality issues persist.

Category	Description
Finding(s)	In STAR and CHIP, less than 75 percent of professional encounters included both a rendering NPI for an individual and a taxonomy. This rate was less than 50 percent for STAR Health, less than 30 percent for STAR Kids, and less than 20 percent for STAR+PLUS. Many STAR Kids and STAR+PLUS services can be provided by caregivers that do not have NPI, but the EQRO has no clear way to identify these encounters. Without alternative identifiers, the lack of NPI still creates an information deficit on these encounters.
MCQS Goal(s)	Goal 3
Recommendation(s)	• HHSC should continue to investigate provider identification deficiencies, including identifying providers not eligible for NPI. • HHSC should work with the EQRO, TMHP, and the MCOs/DMOs to improve the system to monitor monthly encounters submissions for anomalies and communicate about issues or discrepancies.
HHSC Follow Up	HHSC continues to work with the MCOs and TMHP to improve provider data in encounters.
Finding(s)	The EQRO added evaluation of the risk indicator to the data certification process for SFY 2017 and found that caries assessment codes were missing in up to four percent of dental exam encounters across programs and DMOs. This measure showed improvement in SFY 2018, but in SFY 2019, appropriate codes were still missing more than two percent of the time.
MCQS Goal(s)	Goal 3
Recommendation(s)	DMOs should promote CRA coding with provider outreach in addition to denial of claims.
HHSC Follow Up	HHSC Quality Assurance included information on the importance of caries risk assessment as part of the Quality Forum and the Quarterly Quality Meeting. This is an ongoing project, and DMOs have worked with providers to improve the CRA reporting over time. In 2016, just over 60 percent of dental exam claims were properly submitted with risk assessment codes. By 2019, compliance had risen to almost 99 percent.

Review of Medical Records for Consistency with Encounter Data

Category	Description
Finding(s)	Inaccurate provider addresses resulted in lower return rates and insufficient sample sizes for some MCOs.
MCQS Goal(s)	Goal 3
Recommendation(s)	HHSC should continue efforts to improve provider address directories to improve the return rate for requested records.
HHSC Follow Up	• HHSC Quality Assurance continues to work with TMHP and internal divisions to address provider data elements and integrity. • HHSC Quality Assurance continues to work with the MCOs and the EQRO to formalize a process for plans to chase missing medical records for validation purposes.
Finding(s)	The overall match rates were high across review categories and programs, except for STAR+PLUS. The complex healthcare needs and types of services provided for STAR+PLUS members may contribute to increased challenges in the documentation and subsequent coding for each visit. However, the exact reason for low match rates in the STAR+PLUS program remains unknown.

Category	Description
MCQS Goal(s)	Goals 1, 3
Recommendation(s)	HHSC should consider additional studies to identify factors that influence match rates across programs and MCOs, specifically examining the case complexity in STAR+PLUS.
HHSC Follow Up	HHSC Quality Assurance will work with the EQRO, MCOs, and HHSC subject matter experts to determine whether the Rendering NPI Workgroup decisions improve STAR+PLUS match rates. If match rates continue to be an issue despite workgroup efforts, HHSC Quality Assurance will recommend this issue for in-depth study as a QTR in future years.

Protocol 6: Administration of Quality of Care Surveys

Category	Description
Finding(s)	The STAR Kids 18+ survey and the STAR Health 18+ survey had low response rates. Many eligible members could not be reached or had disabilities that prevented them from answering the survey questions.
MCQS Goal(s)	Goal 2
Recommendation(s)	HHSC should consider allowing proxies in future versions of the STAR Kids 18+ and STAR Health 18+ surveys to ensure more participation in these challenged populations. Without increasing the number of completed surveys, the results will have extremely limited value.
HHSC Follow Up	HHSC stopped the STAR Kids 18+ and STAR Health 18+ surveys due to the low response rate.

Protocol 7: Calculation of Performance Measures

Category	Description
Finding(s)	In 2019, Hispanic Medicaid members had more outpatient visits, fewer ED visits, and fewer hospitalizations than NHW or NHB members. Mental health utilization was highest for NHW members.
MCQS Goal(s)	Goal 1
Recommendation(s)	HHSC should continue to explore quality measure results across demographic and other member population groups to more clearly interpret results and better direct efforts to improve care for all Medicaid and CHIP members.
HHSC Follow Up	HHSC began an in-depth QOC review process and will work to examine which measures lend themselves to further demographic review and analysis in a QTR and a discussion on how to represent that analysis on the THLC portal.
Finding(s)	Renal Failure without dialysis was the most common PPC for STAR+PLUS members, while Shock and Septicemia contributed the most PPC weights. Septicemia and Shock also contributed the most weight among STAR members, but here the most common PPC reason, by far, was obstetric complications. As in 2018, the PPC rate for FFS members was more than 15. This group includes undocumented immigrants and others who may require emergency Medicaid services, but further investigation is needed to determine why this population has more PPCs.
MCQS Goal(s)	Goal 1

Category	Description
Recommendation(s)	The EQRO suggests investigating relationships between PPEs for specific conditions and patterns of preventive care for those conditions
HHSC Follow Up	HHSC is working with the EQRO to develop a QTR for early SFY 2023 to address these questions.
Finding(s)	MCO performance across Performance Indicator Dashboard measures varies; Some MCOs achieve the high standard on more than 60 percent of measures while others fail to meet the minimum standard on more than 40 percent of measures.
MCQS Goal(s)	Goal 1
Recommendation(s)	HHSC should continue leveraging the THLC portal (thlcportal.com) dashboards to help all Medicaid and CHIP stakeholders identify and understand trends in healthcare quality across state programs.
HHSC Follow Up	• HHSC will continue to leverage the THLC portal dashboards to help stakeholders identify and understand trends in QOC • HHSC instituted CAPs for falling below 2/3 measures in the minimum performance level.
Finding(s)	Although bipolar disorders ranked fifth, if considered together with the sixth-ranked reason for PPAs and schizophrenia (ranked 11th), these serious mental illnesses would rank first, accounting for almost 14 percent of total PPA weight and total costs of nearly $45 million in 2019.
MCQS Goal(s)	Goal 1
Recommendation(s)	HHSC should continue prioritizing behavioral health integration (BHI) and work with the EQRO to define useful and reliable QOC measures for these special populations.
HHSC Follow Up	• The SFY 2021 Quality Forum had a BH integration session focusing on care coordination. • HHSC will continue to leverage the THLC portal dashboards to help MCOs identify trends in QOC. • HHSC assessed CAPs for falling below 2/3 measures in the minimum performance level.
Finding(s)	• SMM rates were consistently higher in STAR than in CHIP Perinatal between 2016-2019, most notably in (pre)eclampsia cases. Overall rates have trended down over this period. • Over 50 thousand C-sections were performed in deliveries without complications. Compared to uncomplicated deliveries without C-section, these uncomplicated C-section deliveries incurred additional costs totaling over $100 million. • As reported last year, performance on QOC measures for chronic conditions was generally worse for pregnant women, although utilization was higher.
MCQS Goal(s)	Goal 3
Recommendation(s)	HHSC should continue prioritizing maternal healthcare and work with the EQRO to define useful and reliable QOC measures for these special populations.

Category	Description
HHSC Follow Up	• The EQRO provided a topic report addressing the overall quality of healthcare for the maternal health population. The EQRO also enhanced the C-section and SMM reports this year. • In addition, the Better Birth Outcomes initiatives included a study of neonatal intensive care unit (NICU) transfers, and an extension of prior NICU research to look at neonatal abstinence syndrome (NAS) specifically. • HHSC was selected for a CMS Innovation Accelerator Program (IAP) program specifically to address maternal health measures. The EQRO and The Texas Department of State Health Services (DSHS) partnered with HHSC in this program to integrate vital statistics and other DSHS data in maternal care quality analyses.

Protocol 9: Conducting Focused Studies of Health Care Quality

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

Category	Description
Finding(s)	• For each study population, the model's ability to accurately predict whether an individual would meet the numerator performance criteria for a quality measure increased when the model included county-level SDoH variables compared to models that only included race/ethnicity. • The number of SDoH variables with significant associations varied by study population and per quality measure, but not every SDoH variable contributed equally to the observed impact of SDoH on quality measure performance.
MCQS Goal(s)	Goal 3
Recommendation(s)	HHSC should consider collecting standardized member-level SDoH data. This information could be collected during Medicaid and CHIP enrollment, from the claims data (via diagnostic codes related to SDoH (e.g., Z codes)), or as part of the biennial member surveys.
HHSC Follow Up	HHSC Quality Assurance is considering forming an internal workgroup to facilitate a standardized SDoH collection tool for MCO use.
Finding(s)	• The Rate of Adult Smoking was significantly associated with higher ED utilization among STAR+PLUS adults, higher preventable hospitalization among HCBS Waiver adults, and higher acute inpatient admissions for STAR+PLUS and HCBS Waiver adults. • Among STAR+PLUS and HCBS Waiver populations, age and gender significantly predict quality measure results. • In STAR+PLUS, the Breast Cancer Screening measure showed the largest increase in concordance rate associated with the addition of SDoH variables. The increase in concordance indicates that the model's predictive ability for the Breast Cancer Screening measure increased with the addition of SDoH variables.
MCQS Goal(s)	Goal 3

Category	Description
Recommendation(s)	HHSC should use the focus study findings to prioritize interventions and strategies that target important SDoH for Medicaid members – emphasizing SDoH categories with more influence on outcomes (e.g., social and economic environment variables) or individual SDoH variables associated with multiple performance measures. For example, since the *Rate of Adult Smoking* was significantly associated with higher ED utilization among STAR+PLUS adults, higher preventable hospitalization among HCBS Waiver adults, and higher acute inpatient admissions for both STAR+PLUS and HCBS Waiver adults, a possible strategy could focus on designing and developing population-specific smoking cessation interventions, campaigns, and peer support groups.
HHSC Follow Up	HHSC has convened an internal workgroup focused on prioritizing and operationalizing interventions and strategies that target important SDoH for Medicaid members.

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

Category	Description
Finding(s)	Local mental health authority (LMHA)-involved enrollees had higher rates of 7-day and 30-day follow-up after a mental health (MH)-related ED visit, but differences in 30-day readmission rates among LMHA-involved enrollees varied by enrollee SMI diagnosis. Seven-day, 30-day, and overall follow-up rates were consistent across MCOs for members with LMHA involvement.
MCQS Goal(s)	Goal 2
Recommendation(s)	• STAR+PLUS MCOs should track health indicators, service use, and QOC measures longitudinally for LMHA and non-LMHA service recipients. • STAR+PLUS MCOs should also evaluate the use of the receipt of follow-up care within seven days following an MH-related ED visit as a tool for monitoring longitudinal outcomes related to health service use and mental health indicators.
HHSC Follow Up	HHSC is addressing these recommendations through Rider 33 and various initiatives, including PIPs.
Finding(s)	• The analyses identified high SMI-related and all-cause readmissions rates among STAR+PLUS SMI-diagnosed Medicaid enrollees, particularly among individuals diagnosed with psychotic disorders. The 30-day readmission rates varied substantially among MCOs. Differences in 30-day readmissions also appeared to vary among the SMI diagnosis groups by LMHA service utilization and readmission type. • Measures of 7-day and 30-day follow-up care after SMI-related inpatient admissions did not show substantial differences between LMHA- and non-LMHA-involved STAR+PLUS enrollees overall, but they did vary across MCOs. MCOs showed varying degrees of utilization of LMHAs as service providers for their SMI-diagnosed enrollees. Furthermore, follow-up rates after SMI-related inpatient admissions were below the national rates reported by NCQA for Medicaid HMO enrollees.
MCQS Goal(s)	Goal 2

Category	Description
Recommendation(s)	• HHSC should conduct further studies to determine how MCO practice variation relates to differences among MCOs on the 7-day and 30-day follow-up care indicators. • HHSC should also review the availability of LMHAs, both geographically and in terms of staffing, to determine how these contribute to differences in LMHA use across MCOs and assess the LMHAs' capacity to accommodate greater utilization by MCOs.
HHSC Follow Up	• HHSC evaluated MCOs that include LMHAs and non-LMHA providers through the EQRO quarterly report for Rider 33. • In addition, HHSC submitted the final Rider 33 report, which provided overall BH performance across MCOs to the legislature and published it on the HHSC website.
Finding(s)	Analysis of healthcare costs for SMI-diagnosed STAR+PLUS enrollees who received outpatient care through an LMHA indicated they had much lower estimated per member-year total costs than enrollees who received no services through any LMHA. Pharmacy costs were also higher among enrollees without LMHA involvement, although the cost difference was smaller.
MCQS Goal(s)	Goal 2
Recommendation(s)	STAR+PLUS MCOs should estimate the cost per episode of care provided by LMHA providers compared to non-LMHA providers to clarify whether differences in total costs were due to more efficient care concerning outcomes or to cost-of-service differences between sites of care.
HHSC Follow Up	HHSC evaluated MCOs that include LMHAs and non-LMHA providers through the EQRO quarterly report for Rider 33.

Appendices

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

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

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*. For the Prospective Model,[i] this is defined by the presence, within the most recent six months of the analysis period of one or more significant acute Episode Diagnostic Categories (EDCs) or significant Episode Procedure Categories (EPCs) along with the absence of any validated PCDs present. For the Concurrent Model, this definition is similar but different in that certain acute EDCs, i.e., pregnancy, can override the assignment to chronic illness CRGs in Status 3-6 or Status 3-4.

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

[i] Both the Prospective and Concurrent models classify individuals based on the same information from the same base period or "analysis period," and most of the grouping logic and specifications are the same, but there are differences that sometimes result in an assignment to a different base CRG or severity level.

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:

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: MCO/DMO Compliance with 2018 PIP Previous Recommendations

The MCOs and DMOs received recommendations on the 2018 PIP Plan, Revised PIP Plan, Progress Report 1, and Progress Report 2 evaluations that HHSC and the EQRO required the MCOs/DMOs to address on the subsequent PIP report submission. The overall number of previous recommendations and recommendations implemented represents the total number of recommendations received across all PIP reports and the total number of recommendations implemented.
[a] The MCO contract ended in early 2018; therefore, there were no PIP Progress Report or Final PIP Report submissions

The overall compliance average for all MCOs and DMOs was 95.5%

MCO/DMO	Overall Recommendations (#)	Overall Recommendations Implemented (#)	Overall Compliance (%)
Aetna CHIP	5	5	100%
Aetna STAR	9	9	100%
Aetna STAR Kids	3	2.5	83.3%
Amerigroup CHIP	1	1	100%
Amerigroup STAR	1	1	100%
Amerigroup STAR+PLUS	5	4.5	90%
Amerigroup STAR Kids	2	2	100%
BCBSTX CHIP	16	16	100%
BCBSTX STAR	11	11	100%
BCBSTX STAR Kids	16	16	100%
CMCHP STAR Kids	31	31	100%
CHRISTUS[a] CHIP	12	N/A	N/A
CHRISTUS[a] STAR	5	N/A	N/A
HealthSpring STAR+PLUS	27	23.5	87%
CFHP CHIP	15	15	100%
CFHP STAR	15	13.5	90%
CFHP STAR Kids	11	8	72.7%
CHC CHIP	6	6	100%
CHC STAR	1	1	100%
CCHP CHIP	7	7	100%
CCHP STAR	10	7.5	75%
CCHP STAR Kids	8	8	100%
DCHP CHIP	2	2	100%
DCHP STAR	8	8	100%
DentaQuest CHIP Dental	11	11	100%
DentaQuest Medicaid Dental	11	11	100%
Driscoll CHIP	5	4.5	90%

MCO/DMO	Overall Recommendations (#)	Overall Recommendations Implemented (#)	Overall Compliance (%)
Driscoll STAR	8	7.5	93.8%
Driscoll STAR Kids	18	17.5	97.2%
El Paso Health CHIP	5	5	100%
El Paso Health STAR	3	3	100%
FirstCare CHIP	9	9	100%
FirstCare STAR	9	9	100%
MCNA CHIP Dental	7	7	100%
MCNA Medicaid Dental	9	9	100%
Molina CHIP	14	12	85.7%
Molina STAR	22	19	86.4%
Molina STAR+PLUS	33	25.5	77.3%
PCHP CHIP	4	4	100%
PCHP STAR	4	4	100%
SWHP STAR	16	15.5	96.9%
SHP[a] CHIP	9	N/A	N/A
SHP[a] STAR	8	N/A	N/A
Superior CHIP	11	11	100%
Superior STAR	6	6	100%
Superior STAR+PLUS	3	3	100%
Superior STAR Kids	5	4	80%
Superior STAR Health	6	6	100%
TCHP CHIP	14	14	100%
TCHP STAR	13	12.5	96.2%
TCHP STAR Kids	13	12.5	96.2%
UHC CHIP	10	8	80%
UHC STAR	6	6	100%
UHC STAR+PLUS	6	5.5	91.7%
UHC STAR Kids	6	6	100%

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

The EQRO evaluated the following Header fields:

Fields	V21 Field Name	Description
Member ID	H_MBR_PRMRY_MBR_ID_NO	Submitted member primary identification number.
Start Date of Service	H_FRM_SVC_DT	The date on which the first services were rendered.
End Date of Service	H_TO_SVC_DT	The date on which the last services were rendered.
Adjudication Date	H_ADJDCTN_DT	The date the 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	HP_BLNG_PRV_NTNL_PRV_ID	Billing Provider National Provider Identifier

The EQRO evaluated the following Detail 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)

Appendix D: Present on Admission (POA) Screening Criteria

The percentage of reported non-exempt primary diagnoses with POA codes on acute inpatient institutional encounter records (Transaction Type = 'I,' and Type of Bill in '11x', '12x', or '41x') are reported with the distribution of valid POA codes ('Y,' 'N,' 'U,' 'W'). 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[j]	EQRO Area of Concern
Y	Diagnosis was present at the time of inpatient admission	<90%
N	Diagnosis was not present at the time of inpatient admission	≥10%
U	Documentation was insufficient to determine if the condition was present at the time of inpatient admission	≥1%
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission	≥1%

The POA codes for secondary diagnoses are critical to 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%

[j] cms.gov

Appendix E: 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
[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
[c] Red indicates a new measure or added reporting or a change in reporting

Prevention & Screening

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

Respiratory Conditions

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

Cardiovascular Conditions

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

Diabetes

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

Behavioral Health

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

Overuse/Appropriateness

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

HEDIS Access/Availability of Care

A = Calculated using administrative data; H = Calculated using HEDIS hybrid methodology
[a] Included on the HHSC performance dashboard (prospective for STAR Kids)
[b] Due to changes in the measure definition, HHSC chose to use the administrative results calculated by the EQRO using modified specifications for reporting the prenatal sub-measure; post-partum reporting is from hybrid results.
[c] Red indicates a new measure or added reporting

Measures	Description	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
CAP	Children and Adolescents' Access to PCPs – *RETIRED*	-	-	-	-	-	-	-	-
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	A	A[b]	A[b]	A	A[b]	A	A	SMI, Mat
HEDIS® PPC	Prenatal and Postpartum Care	A	A[b]	A[b]	A	A	A	A	SMI, Mat
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	A[b]	A[b]	-	A[b]	A[b]	A	A	MDCP

HEDIS Utilization & Risk Adjusted Utilization

A - Calculated using administrative data
[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
[c] Red indicates a new measure or added reporting or a change in reporting

Measures	Description	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	FFS	Medicaid	Special Populations[a].
W15	Well-Child Visits in the First 15 Months of Life – *RETIRED*	-	-	-	-	-	-	-	-
W34	Well-Child Visits in the 3rd to 6th Years of Life – *RETIRED*	-	-	-	-	-	-	-	-
W30	Well-Child Visits in the First 30 Months of Life	A[b]	A[b]	-	A[b]	A[b]	A	A	MDCP
WCV	Child and Adolescent Well-Care Visits	A[b]	A[b]	-	A[b]	A[b]	A	A	MDCP
AWC	Adolescent Well-Care Visits – *RETIRED*	-	-	-	-	-	-	-	-
AMB	Ambulatory Care	A	A	A	A	A	A	A	MDCP, SMI, Mat
IPU	Inpatient Utilization–General Hospital/Acute Care	A	A	A	-	A	A	A	MDCP, SMI, Mat
IAD	Identification of Alcohol and Other Drug Services	A	A	A	-	A	A	A	SMI, Mat
MPT	Mental Health Utilization	A	A	A	A	A	A	A	MDCP
PCR	Plan All-Cause Readmission	-	A[b]	A[b]	-	A	A	A	MDCP, SMI, Mat

HHSC Maternal Health Measures

I = Calculated by the EQRO

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

AHRQ Quality Indicators – Area Measures

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

Prevention Quality Indicators (PQIs)

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

Pediatric Quality Indicators (PDIs)

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

Other CHIPRA Core & CMS Adult Core Measures

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

[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

[c] Red indicates a new measure or added reporting or a change in reporting

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

3M Health Information Systems Measures of PPEs

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

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

Dental Quality Measures

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

Quality of Care

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

Preventive Dental Services

Type	Annual Dental Visits (ADV) Submeasure [a]	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	-
-	% Of members (aged 6 to 9 years) enrolled for at least 6 continuous months who had at least one sealant service on one of the permanent first molars during the MY	*DISCONTINUED*	*DISCONTINUED*
-	% Of members (aged 10 to 14 years) enrolled for at least 6 continuous months who had at least one sealant service on one of the permanent second molars during the MY	*DISCONTINUED*	*DISCONTINUED*
DQA	**Sealants in Years 6 to 9**- % of members (aged 6 to 9 years) continuously enrolled for at least 180 days who are at "elevated" risk for dental caries and who received a sealant on a permanent first molar tooth w/in the reporting year	A	A
DQA	**Sealants in Years 10 to 14** - % of members (aged 01 to 14 years) continuously enrolled for at least 180 days who are at "elevated" risk for dental caries and who received a sealant on a permanent second molar tooth w/in the reporting year	A	A
DQA	**Oral Evaluation** - % of members enrolled for at least 6 months who received a comprehensive or periodic oral evaluation w/in the reporting year	A	A
DQA	**Topical Fluoride** - % of enrolled members, aged 1 yr. and older, who are at "elevated" risk (i.e., "moderate" or "high") who received at least two topical fluoride applications w/in the reporting year	A	A

Type	Annual Dental Visits (ADV) Submeasure [a]	CMDS	CHIP Dental
DQA	**Sealant Receipt on Permanent 1st Molars** 1) % Of enrolled children who ever received sealants on at least one permanent first molar tooth by their 10th birthdate 2) % Of enrolled children who ever received sealants on all four permanent first molar teeth by their 10th birthdate."	A	A
DQA	**Sealant Receipt on Permanent 2nd Molars** 1) % Of enrolled children who ever received sealants on at least one permanent second molar tooth by their 15th birthdate 2) % Of enrolled children who ever received sealants on all four permanent second molar teeth by their 15th birthdate."	A	A

Continuity of Care

Type	Annual Dental Visits (ADV) Submeasure [a]	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 Utilization of Dental Services

A - Calculated using administrative data

Type	Measure	Medicaid Dental (aged 20 yrs. and younger)	CHIP Dental (aged 18 yrs. and younger)
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

DQA Emergency Department Visits for Dental Caries

A - Calculated using administrative data

Type	Measure	Medicaid Dental (aged 20 yrs. and younger)	CHIP Dental (aged 18 yrs. and younger)
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
[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
[d] Red indicates a new measure or added reporting or a change in reporting

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

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

CAHPS Health Plan Survey 5.0H Effectiveness of Care

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

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

[b] Only on the CMS Core Survey

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

Survey Measures from the National Survey of Children's Health

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

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

Use of Consumer Directed Services Reported by MCOs

T - Calculated by HHSC
[a] Included on the HHSC performance dashboard

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 Personal Attendant	-	-	T[a]	-	-	-	-
% Members Utilizing Consumer Directed Services (CDS) Non-HCBS Primary Home Care	-	-	T[a]	-	-	-	-

Nursing Facility Performance Measures

T - Calculated by HHSC
[a] Included on the HHSC performance dashboard

Measures	CHIP	STAR	STAR+ PLUS	STAR Health	STAR Kids	Medicaid-Statewide[a]	CHIP-Statewide[a]
Nursing Facility Admissions • From the community • From the Hospital • After Hospital Admission from the community	-	-	T[a],	-	-	-	-
Nursing Facility Readmissions	-	-	T[a],	-	-	-	-

-

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

PPC Groups

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

PPC Level

PPC Level	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.

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

PPC Categories

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

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

Appendix G: Measures Used in 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
3. NSCH - National Survey of Children's Health
4. HHSC Complaints Data

CHIP Report Cards

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

STAR Child Report Cards

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

STAR Adult Report Cards

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

STAR+PLUS Report Cards

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

STAR Kids Report Cards

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

Appendix H: Scoring Compliance with 42 C.F.R. § 438 Subpart D & QAPI Standards

The following section lists the regulations not included in the results for compliance with 42 C.F.R. § 438 Subpart D and QAPI standards reported in Table 22.

[a] State function regulations where HHSC determines MCO/DMO compliance through Contract Compliance Reviews; EQRO will assess and report compliance one time in the three-year compliance period.

438.207 – Assurances of Adequate Capacity and Services

438.207(a): State function related to contract requirements for the State's standards for access to care.

438.207(c): State function related to MCOs' and DMOs' timely submission of network adequacy documentation, i.e., initial, annually, and upon significant change in operations.

438.207 (d), (e): State function related to CMS requirements for availability and submission of State-reported documentation regarding network adequacy.

438.208 – Coordination and Continuity of Care

438.208(a): State function related to contract requirements for coordination and continuity of care.

438.208(c)(1): State function related to mechanisms to identify members who need LTSS or members with special health care needs.

438.208(c)(3)(iv): State function related to State contract requirements for quality assurance and utilization review standards.

438.210 – Coverage and Authorization of Services

438.210(a): State function related to contract requirements for coverage and authorization of services.

438.230 – Subcontractual Relationships and Delegation

438.230(b), (c): State function related to contract requirements for MCOs' and DMOs' subcontractors and delegated entities.

438.242 – Health Information Systems

438.242(b)(4): State function related to contract requirements for availability of MCO and DMO data.

438.330 – QAPI Program

438.330(b)(5)(ii): State function that requires State documentation of MCO and DMO involvement in State's efforts to prevent, detect, and remediate critical incidents.

[b] Regulations that the EQRO will assess and report compliance within the SFY 2022 SOA report.

438.207 – Assurances of Adequate Capacity and Services

438.207(b): The EQRO collects the MCOs' and DMOs' responses and documentation submitted through the web-based AI tool. The EQRO will report MCO and DMO compliance in next year's SOA report.

438.224 – Confidentiality

438.224: The EQRO collects the MCOs' and DMOs' responses and documentation submitted through the web-based AI tool. The EQRO will report MCO and DMO compliance in next year's SOA report.

438.330 – QAPI Program

438.330(b)(3), (4): The EQRO collects the MCOs' and DMOs' responses and documentation submitted through the web-based AI tool. The EQRO will report MCO and DMO compliance on next year's SOA report.

[c] Regulations where the EQRO assessed compliance through work conducted for the PIP evaluations, Data Certification, and Encounter Data Validation. The EQRO reported the results under protocols 1, 2, or 5 of the report.

438.242 – Health Information Systems

438.242(b)(1): Covered through the data certification process and reported in Protocol 5: Encounter Data Validation.

438.242(c), (d): Covered through the data certification process and reported in Protocol 5: Encounter Data Validation.

438.330 – QAPI Program

438.330(b)(1): The EQRO assesses and reports MCO and DMO compliance with regulations related to performance improvement projects in Protocol 1: PIP Validation.

438.330(b)(2): The EQRO validates the results of performance measures submitted by the MCOs and DMOs and reports results in Protocol 2: Performance Measure Validation.

438.330(d)(1), (2), (3): The EQRO assesses and reports MCO and DMO compliance with regulations related to performance improvement projects in Protocol 1: PIP Validation.

438.330(e)(1)(ii): The EQRO assesses and reports MCO and DMO compliance with regulations related to performance improvement projects in Protocol 1: PIP Validation.

[d] Regulations with an implementation date of January 1, 2021. Therefore, not applicable to the MY.

438.242 – Health Information Systems

438.242(b)(5)(i): This regulation, which addresses requirements for the MCOs and DMO to implement an Application Programming Interface (API) that includes all encounter data, has an implementation date of January 1, 2021. Therefore, it is not applicable to the MY.

438.242(b)(6): This regulation, which addresses online provider directory requirements, has an implementation date of January 1, 2021. Therefore, it is not applicable to the MY.

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