



Institute for Child Health Policy at the University of Florida  
Texas External Quality Review Organization

# **Texas Children's Health Insurance Program (CHIP) Quality of Care Report**

**Fiscal Year 2010**

**Measurement Period:**

**September 1, 2009 through August 31, 2010**

**The Institute for Child Health Policy**

**University of Florida**

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

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## Table of Contents

Executive Summary .....	1
Introduction.....	1
Methodology.....	1
Summary of Findings .....	2
Recommendations .....	3
The CHIP Population .....	6
Access to Care.....	8
Children and Adolescents' Access to Primary Care Practitioners.....	8
Utilization of Services.....	14
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life .....	14
Adolescent Well-Care Visits .....	16
Utilization of Ambulatory Care.....	18
Outpatient Care .....	18
Emergency Department Utilization .....	23
AHRQ Pediatric Quality Indicators .....	28
Effectiveness of Care.....	34
Respiratory Conditions .....	34
Appropriate Testing for Children with Pharyngitis.....	34
Appropriate Treatment for Children with Upper Respiratory Infection .....	36
Use of Appropriate Medications for People with Asthma.....	38
Women's Preventive Care and Screenings.....	41
Chlamydia Screening.....	41
Behavioral Health Care .....	44
ADHD Follow-up Care for Children.....	44
Follow-up Care after Hospitalization for Mental Illness.....	46
Readmission within 30 Days after an Inpatient Stay for Mental Health .....	49
Appendix A: Detailed Methodology.....	51
Appendix B: AHRQ Quality Indicators .....	53
Endnotes.....	54

## List of Figures

Figure 1. Total Number of Unduplicated Members in CHIP by MCO - August 2010 .....	7
Figure 2. Distribution of CHIP Members by Race/Ethnicity - August 2010 .....	8
Figure 3. The Percentage of CHIP Members 12 to 24 Months with Access to a PCP.....	10
Figure 4. The Percentage of CHIP Members 25 Months to 6 Years Old with Access to a PCP.	11
Figure 5. The Percentage of CHIP Members 7 to 11 Years Old with Access to a PCP .....	12
Figure 6. The Percentage of CHIP Members 12 to 19 Years Old with Access to a PCP .....	13
Figure 7. The Percentage of CHIP Members 3 to 6 Years Old with One or More Well-Child Visits .....	15
Figure 8. The Percentage of Adolescent CHIP Members with One or More Well-Care Visits....	17
Figure 9. HEDIS® Ambulatory Care - The Overall Rate of Outpatient Visits per 1,000 Member Months in CHIP .....	19
Figure 10. HEDIS® Ambulatory Care - The Rate of Outpatient Visits per 1,000 Member Months for CHIP Members < 1 Year of Age .....	20
Figure 11. HEDIS® Ambulatory Care - The Rate of Outpatient Visits per 1,000 Member Months for CHIP Members 1 to 9 Years Old .....	21
Figure 12. HEDIS® Ambulatory Care - The Rate of Outpatient Visits per 1,000 Member Months for CHIP Members 10 to 19 Years Old .....	22
Figure 13. HEDIS® Ambulatory Care - The Overall Rate of ED Visits per 1,000 Member Months in CHIP.....	24
Figure 14. HEDIS® Ambulatory Care - The Rate of ED Visits per 1,000 Members Months for CHIP Members < 1 Year of Age .....	25
Figure 15. HEDIS® Ambulatory Care - The Rate of ED Visits per 1,000 Members Months for CHIP Members 1 to 9 Years Old .....	26
Figure 16. HEDIS® Ambulatory Care - The Rate of ED Visits per 1,000 Members Months for CHIP Members 10 to 19 Years Old .....	27
Figure 17. AHRQ PDI Asthma Inpatient Admissions Rates in CHIP (per 100,000).....	30
Figure 18. AHRQ PDI Diabetes Short-Term Complications Inpatient Admissions Rates in CHIP (per 100,000) .....	31
Figure 19. AHRQ PDI Gastroenteritis Inpatient Admissions Rates in CHIP (per 100,000).....	32
Figure 20. AHRQ PDI Urinary Tract Infection Inpatient Admissions Rates in CHIP (per 100,000) .....	33
Figure 21. HEDIS® Appropriate Testing for Children with Pharyngitis .....	35
Figure 22. HEDIS® Appropriate Testing for Children with Upper Respiratory Infection .....	37

Figure 23. HEDIS® Use of Appropriate Medications for People with Asthma - CHIP Members 5 to 9 Years Old .....	39
Figure 24. HEDIS® Use of Appropriate Medications for People with Asthma - CHIP Members 10 to 17 Years Old .....	40
Figure 25. HEDIS® Chlamydia Screening in Women – 16 to 20 Years Old.....	43
Figure 26. The Percentage of Children Prescribed ADHD Medication Receiving Follow-up Care .....	45
Figure 27. The Percentage of CHIP Members Receiving Follow-up Care within 7 and 30 Days After Hospitalization for Mental Illness .....	48
Figure 28. The Percentage of CHIP Members (0 to 18 Years Old) Readmitted to the Hospital within 30 Days After an Inpatient Stay for Mental Health.....	50

### **List of Tables**

Table 1. Total Number of Unduplicated CHIP Members by Service Area/MCO .....	6
Table 2. Children and Adolescents' Access to PCPs by CHIP Service Area.....	9
Table 3. Well-Child Visits Among Members 3 to 6 Years Old by CHIP Service Area.....	14
Table 4. Adolescent Well-Care Visits by CHIP Service Area.....	16
Table 5. HEDIS® Ambulatory Care Outpatient Utilization by CHIP Service Area .....	18
Table 6. HEDIS® Ambulatory Care ED Utilization by CHIP Service Area.....	23
Table 7. AHRQ Pediatric Quality Indicators by CHIP Service Area .....	29
Table 8. HEDIS® Appropriate Testing for Children with Pharyngitis by CHIP Service Area .....	34
Table 9. HEDIS® Appropriate Treatment for Children with Upper Respiratory Infections by CHIP Service Area .....	36
Table 10. HEDIS® Use of Appropriate Medications for Asthma by CHIP Service Area.....	41
Table 11. HEDIS® Chlamydia Screening by CHIP Service Area .....	42
Table 12. Follow-up Care for Children Prescribed ADHD Medication by CHIP Service Area ....	46
Table 13. Follow-up Care within 7 and 30 Days After Hospitalization for Mental Illness by CHIP Service Area .....	47
Table 14. Readmission within 30 Days by CHIP Service Area.....	49

# Executive Summary

## Introduction

This report provides an annual update of the quality of care provided to members in the Texas Children's Health Insurance Program (CHIP), prepared by the Institute for Child Health Policy at the University of Florida, the External Quality Review Organization (EQRO) for Texas Medicaid/CHIP Managed Care. This update is for September 1, 2009 to August 31, 2010, covering fiscal year 2010.

Texas CHIP provides health care coverage to children under 19 years of age, living in families with incomes above Medicaid eligibility thresholds, who are unable to purchase private insurance. CHIP is administered through 15 managed care organizations (MCOs), providing services in 10 geographic regions of Texas.

This report provides descriptive information about the CHIP population, and evaluation of members' access to care, utilization of services, and effectiveness of preventive care and treatment. Results for the following quality of care measures are presented in this report:

- **Access to Care** – *Children and Adolescents' Access to Primary Care Practitioners.*
- **Utilization of Services** – *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Adolescent Well-Care Visits, HEDIS® Ambulatory Care, and AHRQ Pediatric Quality Indicators (PDIs).*
- **Effectiveness of Care**
  - *Respiratory Conditions – HEDIS® Appropriate Testing for Child with Pharyngitis, HEDIS® Appropriate Treatment for Children with Upper Respiratory Infection, and HEDIS® Use of Appropriate Medications for People with Asthma.*
  - *Women's Preventive Care and Screening – HEDIS® Chlamydia Screening in Women.*
  - *Behavioral Health – Follow-up Care for Children Prescribed ADHD Medication, Follow-up after Hospitalization for Mental Illness, and Readmission within 30 Days after an Inpatient Stay for Mental Health.*

## Methodology

A detailed description of the methodology used in this report is presented in **Appendix A**. Information regarding the calculation of all measures included in this report can be found in the document "Quality of Care Measures Technical Specifications Report, July 2011."<sup>1</sup>

Rates for Healthcare Effectiveness and Data Information Set (HEDIS®) measures were calculated using National Committee for Quality Assurance (NCQA) certified software.

Discussion of results includes comparison with HEDIS® national Medicaid rates, which are derived from rates reported to the NCQA by Medicaid Managed Care plans nationally.<sup>2</sup>

At the request of the Texas Health and Human Services Commission (HHSC), the EQRO developed a methodology to allow for flexibility in the provider specialty codes when determining eligibility for certain HEDIS® measures. The following measures rely on specific provider specialty codes, and are therefore affected by this change in methodology:

- Children and Adolescents' Access to Primary Care Providers
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visits
- Follow-up Care for Children Prescribed ADHD Medication
- Follow-up After Hospitalization for Mental Illness

For these measures, the name HEDIS® has been removed from the titles, as these measures do not adhere precisely to NCQA specifications and their results are likely inflated from the lifting of provider constraints. Thus, figures displaying results for these measures do not include comparison to HEDIS® national Medicaid rates.

Pediatric Quality Indicators (PDIs) developed by the Agency for Healthcare Research and Quality (AHRQ) were used to evaluate CHIP rates of inpatient admissions for ambulatory care sensitive conditions (ACSCs). The AHRQ considers ACSCs “conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.”<sup>3</sup>

## ***Summary of Findings***

### **Access to Care**

- *Access to primary care practitioners.* Children and adolescents in CHIP had good access to primary care practitioners (PCPs). Over 90 percent had a recent visit with a PCP.

### **Utilization of Services**

- *Preventive care for infants and children.* Sixty-eight percent of children three to six years old had a well-child visit.

#### CHIP Member Demographics – August 2010

Number of members: 522,769

Average member age: 10.3 years

Gender	Percent of CHIP Members
Female	49%
Male	51%

Race/ethnicity	Percent of CHIP Members
Hispanic	62%
Black, non-Hispanic	12%
White, non-Hispanic	21%

- *Preventive care for adolescents.* Half of adolescents in CHIP had a comprehensive well-care visit (50 percent).
- *Ambulatory care.* The rate of outpatient visits in CHIP was 261 per 1,000 member months. The rate of emergency department visits in CHIP was 23 per 1,000 member months. For both outpatient and emergency department utilization, rates generally decreased with age.
- *Pediatric inpatient admissions.* Rates of ACSC-related pediatric inpatient admissions were below the national rates reported by the AHRQ. The highest rate of pediatric inpatient admissions in CHIP was for asthma (70 per 100,000), although this was lower than the AHRQ national rate (124 per 100,000).

**Effectiveness of Care**

- *Respiratory conditions.* Fifty-four percent of children in CHIP received appropriate testing for sore throat (pharyngitis), and 78 percent received appropriate treatment for upper respiratory infection.

The vast majority of CHIP members who have asthma received appropriate medications for their condition (over 95 percent).

- *Women’s preventive care and screening.* Thirty percent of young women 16 years and older were screened for Chlamydia.
- *Behavioral health care and treatment.* Less than half of children with ADHD in CHIP had a follow-up visit within 30 days after being dispensed an ADHD medication (45 percent).

Among CHIP members hospitalized for mental illness, 45 percent had a follow-up visit within 7 days of discharge from the hospital, and 74 percent had a follow-up visit within 30 days of discharge from the hospital.

The CHIP rate for mental health readmission within 30 days was eight percent.

***Recommendations***

The performance of the CHIP and MCOs participating in CHIP was good for most quality of care measures in fiscal year 2010. The EQRO recommends that MCOs focus quality improvement efforts on areas where program-level rates were below national averages.

<b>Domain</b>	<b>Recommendations</b>	<b>Rationale</b>	<b>HHSC Recommendations/Strategies</b>
Appropriate treatment for children with upper respiratory	<ul style="list-style-type: none"> <li>• Ensure that primary care providers (PCPs) of CHIP members are following proper and up-to-date clinical</li> </ul>	The rates of appropriate testing for children with pharyngitis and	<ul style="list-style-type: none"> <li>• HHSC will consider adding an overarching goal which reduces inappropriate prescribing of antibiotic medication to children</li> </ul>

infections (URI)	<p>practice guidelines for treatment of children with pharyngitis.</p> <ul style="list-style-type: none"> <li>• Consider physician training programs for PCPs of CHIP members to reduce inappropriate antibiotic prescribing: <ul style="list-style-type: none"> <li>○ Train providers in the use of an interactive booklet to facilitate primary care consultations for childhood upper respiratory tract infections.<sup>4, 5</sup></li> <li>○ Implement a physician behavior-change strategy that includes guideline dissemination, small-group education, updates,</li> </ul> </li> </ul>	<p>appropriate treatment of children with upper respiratory infection were lower in CHIP than the HEDIS<sup>®</sup> national averages.</p> <p>These findings suggest that many CHIP primary care providers are inappropriately prescribing antibiotic medications to children presenting with upper respiratory complaints.</p>	<p>presenting with upper respiratory infections.</p> <ul style="list-style-type: none"> <li>• HHSC assigns overarching goals to all MCOs each year. Several MCOs have implemented a performance improvement project (PIP) to improve appropriate treatment for children with URI.</li> </ul>
Chlamydia Screening in Women (CHL)	<ul style="list-style-type: none"> <li>• Provide physicians with STI training, specifically targeting physicians who have a lower likelihood of recommending Chlamydia screening (e.g., older physicians, males, and pediatricians).<sup>6</sup> <ul style="list-style-type: none"> <li>○ Training would involve</li> </ul> </li> </ul>	<p>Thirty percent of sexually active female CHIP members between 16 and 20 years old were screened for Chlamydia. This rate is considerably lower than the HEDIS<sup>®</sup> average</p>	<ul style="list-style-type: none"> <li>• HEDIS<sup>®</sup> Chlamydia Screening in Women has been added to the performance indicator dashboard to monitor MCO performance.</li> </ul>

	<p>clarifying screening guidelines and how to discuss sexual health with younger patients.</p> <ul style="list-style-type: none"> <li>• Provide physicians with a toolkit to facilitate screenings that includes a women's health maintenance record of preventive screenings, to be reviewed with patients annually.<sup>7</sup></li> <li>• Increase patient awareness and compliance with preventive screenings through education (e.g., newsletters, preventive service magazines, and self-help pamphlets), birthday card reminders for preventive appointments, and automated phone calls.<sup>8</sup></li> </ul>	<p>of 54 percent for this measure, and falls below the 10<sup>th</sup> percentile nationally.</p> <p>The Centers for Disease Control and Prevention (CDC) recommend annual Chlamydia screening for sexually active young women, due to the high prevalence of the infection among this population.<sup>9</sup></p> <p>Chlamydia infections are typically asymptomatic in women, and if left untreated, can result in pelvic inflammatory disease, chronic pelvic pain, infertility, and adverse pregnancy outcomes such as preterm labor and neonatal infections.<sup>10</sup></p>	
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## The CHIP Population

There were 522,769 unduplicated members in CHIP in August 2010. Slightly more than half of the CHIP population was male (51 percent). The average age of members was 10.3 years (SD = 4.6).

**Figure 1** provides the number of members in the 16 CHIP Managed Care Organizations in August 2010. Superior RSA had the largest membership, with 115,967 members accounting for 22 percent of the CHIP population. Texas Children's had the second largest membership (81,798 members), followed by AMERIGROUP (70,811 members).

The MCOs with the smallest membership were UniCare (5,564 members) and FirstCare (5,247).

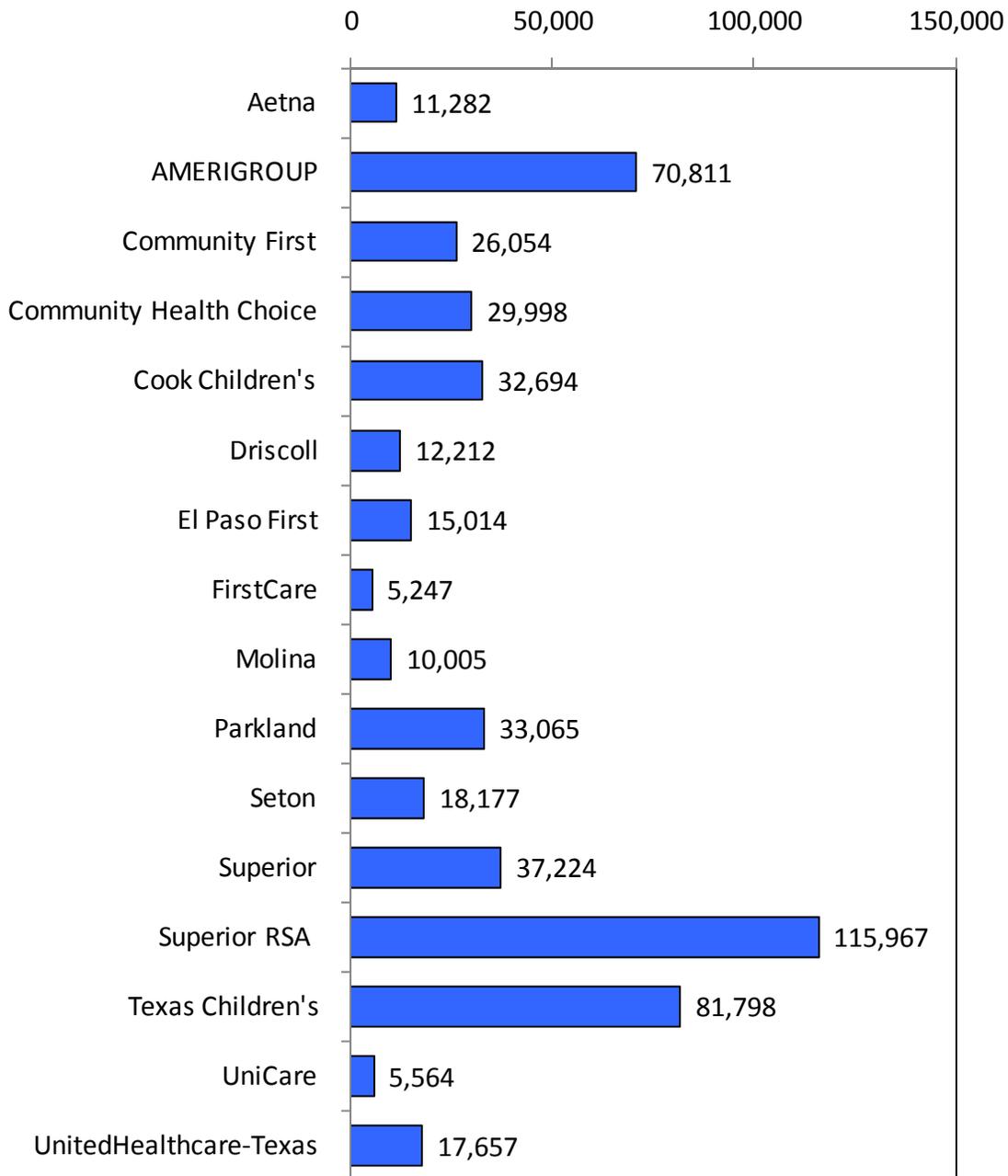
**Table 1** provides the total number of unduplicated members in the ten CHIP Service Areas. Over half of the CHIP population lived in either the Harris SA or the Superior RSA (29 percent and 22 percent, respectively). The fewest number of members lived in the Webb SA, which contained approximately two percent of the CHIP population.

**Table 1. Total Number of Unduplicated CHIP Members by Service Area/MCO**

<b><u>BEXAR Service Area</u></b>	<b><u>43,018</u></b>	<b><u>LUBBOCK Service Area</u></b>	<b><u>12,492</u></b>
Aetna	5,801	FirstCare	5,247
Community First	26,054	Superior	7,245
Superior	11,163		
<b><u>DALLAS Service Area</u></b>	<b><u>76,243</u></b>	<b><u>NUECES Service Area</u></b>	<b><u>14,263</u></b>
AMERIGROUP	37,614	AMERIGROUP	796
Parkland	33,065	Driscoll	12,212
UniCare	5,564	Superior	1,255
<b><u>EL PASO Service Area</u></b>	<b><u>23,205</u></b>	<b><u>TARRANT Service Area</u></b>	<b><u>52,915</u></b>
El Paso First	15,014	Aetna	5,481
Superior	8,191	AMERIGROUP	14,740
		Cook Children's	32,694
<b><u>HARRIS Service Area</u></b>	<b><u>149,062</u></b>	<b><u>TRAVIS Service Area</u></b>	<b><u>27,547</u></b>
AMERIGROUP	17,661	Seton	18,177
Community Health Choice	29,998	Superior	9,370
Molina	1,948	<b><u>WEBB Service Area</u></b>	<b><u>8,057</u></b>
Texas Children's	81,798	Molina	8,057
UnitedHealthcare-Texas	17,657	<b><u>SUPERIOR RSA</u></b>	<b><u>115,967</u></b>

Reference: Table 1

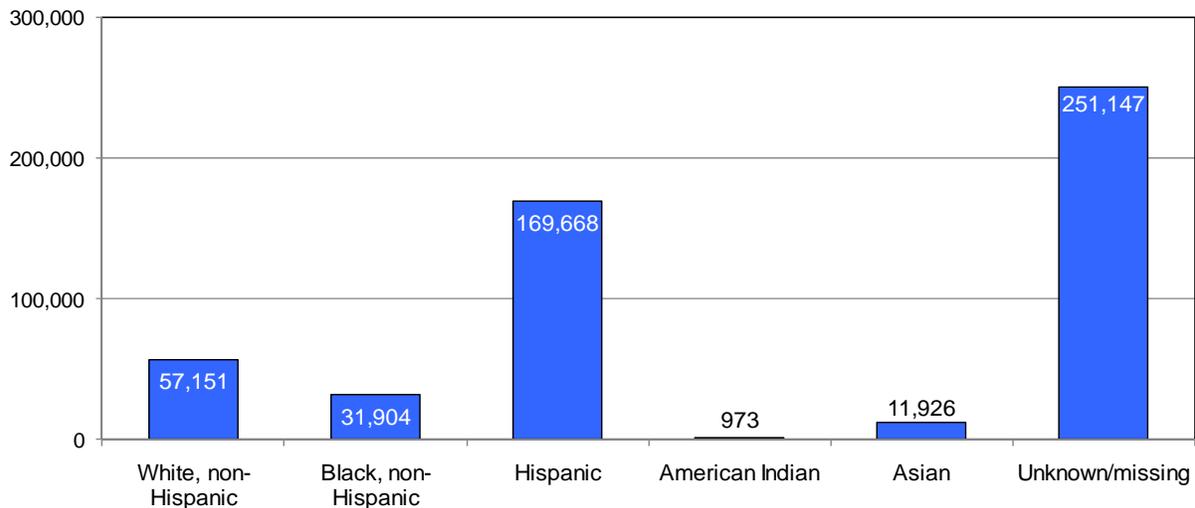
**Figure 1. Total Number of Unduplicated Members in CHIP by MCO - August 2010**



Reference: Table 1

**Figure 2** provides the distribution of CHIP members by race/ethnicity in August 2010. Excluding members for whom race/ethnicity is unknown or missing in the enrollment files, two-thirds of CHIP members were Hispanic (62 percent), followed by Black, non-Hispanic (12 percent), and White, non-Hispanic (21 percent). CHIP members of Asian race/ethnicity accounted for four percent of the member population, and those of American Indian race/ethnicity accounted for less than one percent.

**Figure 2. Distribution of CHIP Members by Race/Ethnicity - August 2010**



Reference: Table 2

## Access to Care

### *Children and Adolescents' Access to Primary Care Practitioners*

**Figures 3 through 6** present results for Children and Adolescents' Access to Primary Care Practitioners (PCPs), by CHIP MCO. This measure provides the percentage of members 12 to 24 months and 25 months to 6 years old who had a visit with a PCP in the past year, and the percentage of members 7 to 11 years old and 12 to 19 years old who had a visit with a PCP in the past two years. **Table 2** provides rates of access to PCPs by CHIP Service Area.

**CHIP Statewide.** Children and adolescents in CHIP had good access to primary care providers. The percentage of members who had a visit with a PCP was:

- 93 percent for members 12 to 24 months old.
- 92 percent for members 25 months to 6 years old.
- 94 percent for members 7 to 11 years old.
- 92 percent for members 12 to 19 years old.

The percentage of children and adolescents in CHIP who had a visit with a PCP was greater than the HEDIS® mean for all age cohorts except members 12 to 24 months.

**CHIP MCOs.** Access to PCPs across the CHIP MCOs ranged in performance from:

- 89 percent in Community Health Choice and Seton to 95 percent in Superior among members 12 to 24 months old (a 6 percentage point difference).
- 87 percent in Seton to 95 percent in Driscoll and Texas Children's among members 25 months to 6 years old (an 8 percentage point difference).
- 89 percent in Seton and UniCare to 99 percent in Driscoll among members 7 to 11 years old (a 10 percentage point difference).
- 85 percent in Molina to 97 percent in Driscoll among members 12 to 19 years old (a 12 percentage point difference).

**CHIP Service Areas.** Geographic region had a slight effect on member's access to PCPs, with members living in the Nueces Service Area having the best access to PCPs. Access to PCPs for members 12 to 24 months old ranged from 91 percent in Superior RSA to 95 percent in Tarrant. For children 25 months to 6 years old, rates ranged from 88 percent in Superior RSA and Travis to 95 percent in Nueces. For children 7 to 11 years old, rates ranged from 90 percent in Travis to 98 percent in Nueces. For adolescents, rates ranged from 88 percent in Travis to 96 percent in Nueces.

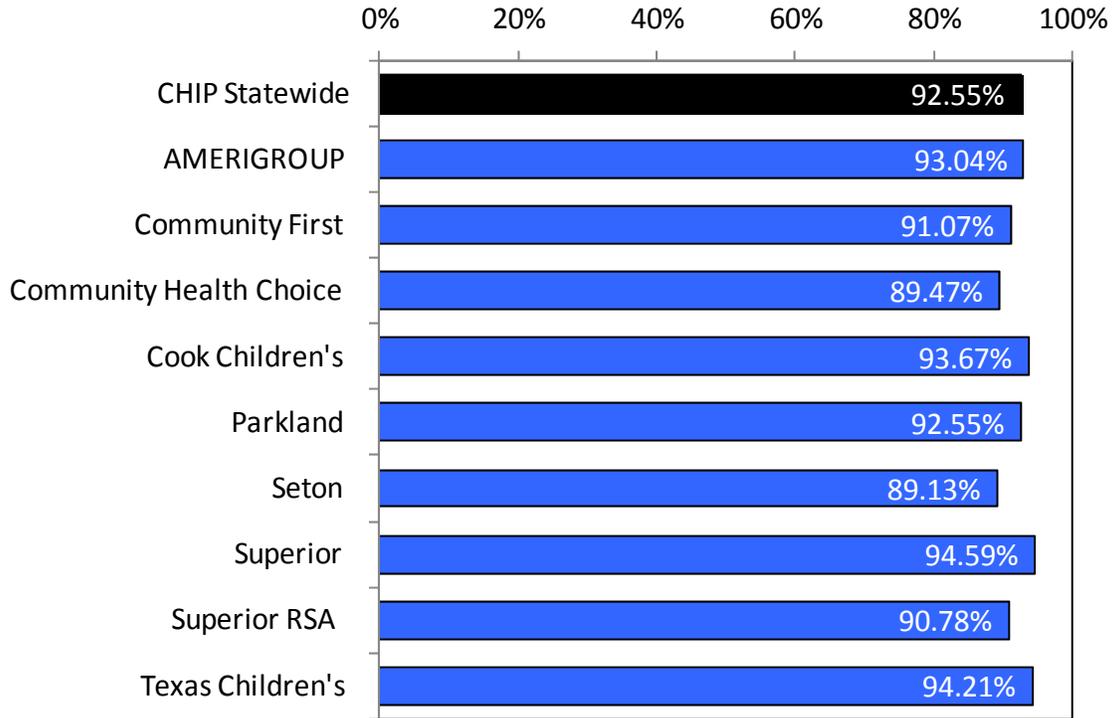
**Table 2. Children and Adolescents' Access to PCPs by CHIP Service Area**

CHIP Service Area	Children and Adolescents' Access to Primary Care Practitioners			
	12 – 24 months	25 months – 6 years	7 – 11 years	12 – 19 years
BEXAR	93.33%	91.42%	94.29%	92.66%
DALLAS	92.05%	92.48%	94.99%	92.44%
EL PASO	-	94.09%	95.57%	94.09%
HARRIS	92.88%	94.01%	95.76%	93.58%
LUBBOCK	-	88.98%	95.01%	93.18%
NUECES	-	94.85%	98.26%	95.87%
SUPERIOR RSA	90.78%	88.15%	90.85%	90.60%
TARRANT	94.66%	91.23%	94.20%	91.55%
TRAVIS	92.65%	88.19%	89.77%	88.00%
WEBB	-	93.35%	-	-

Note: Missing data indicates denominators less than 30 in the Service Area.

Reference: Table CAP

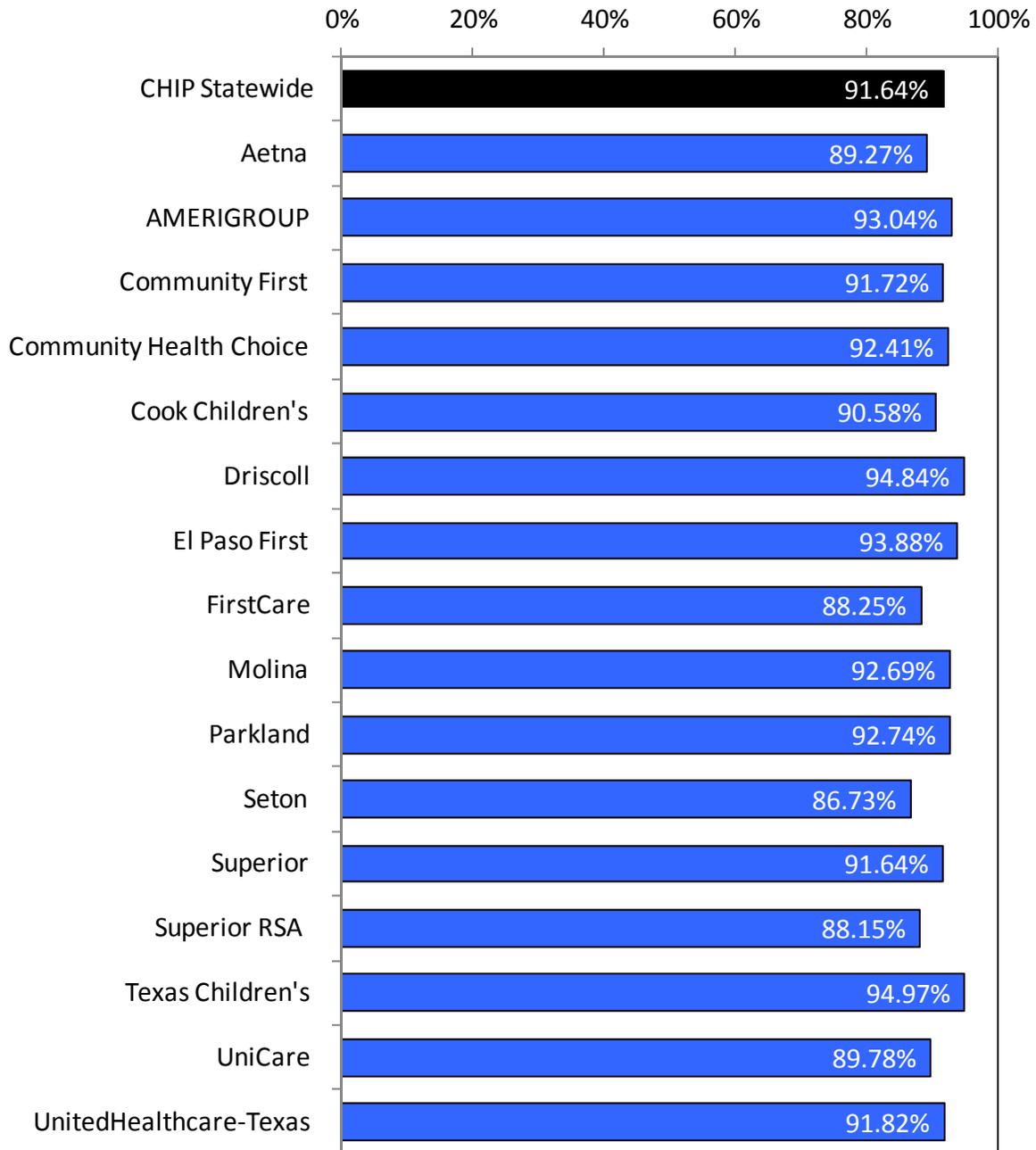
**Figure 3. The Percentage of CHIP Members 12 to 24 Months with Access to a PCP**



The following MCOs had denominators less than 30 for this measure and were not included in this figure: Aetna, Driscoll, El Paso First, FirstCare, Molina, UniCare, and UnitedHealthcare-Texas.

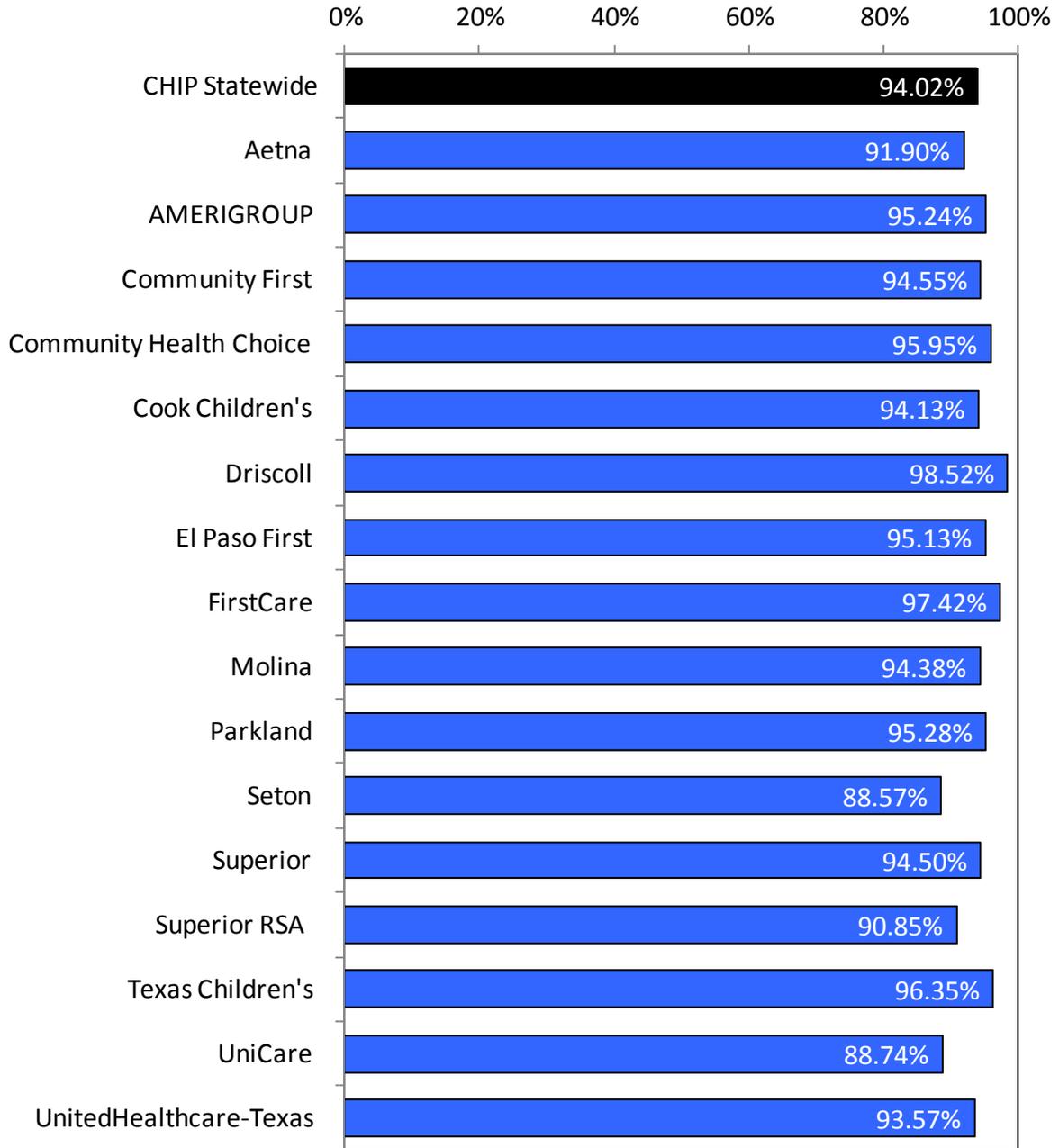
Reference: Table CAP

**Figure 4. The Percentage of CHIP Members 25 Months to 6 Years Old with Access to a PCP**



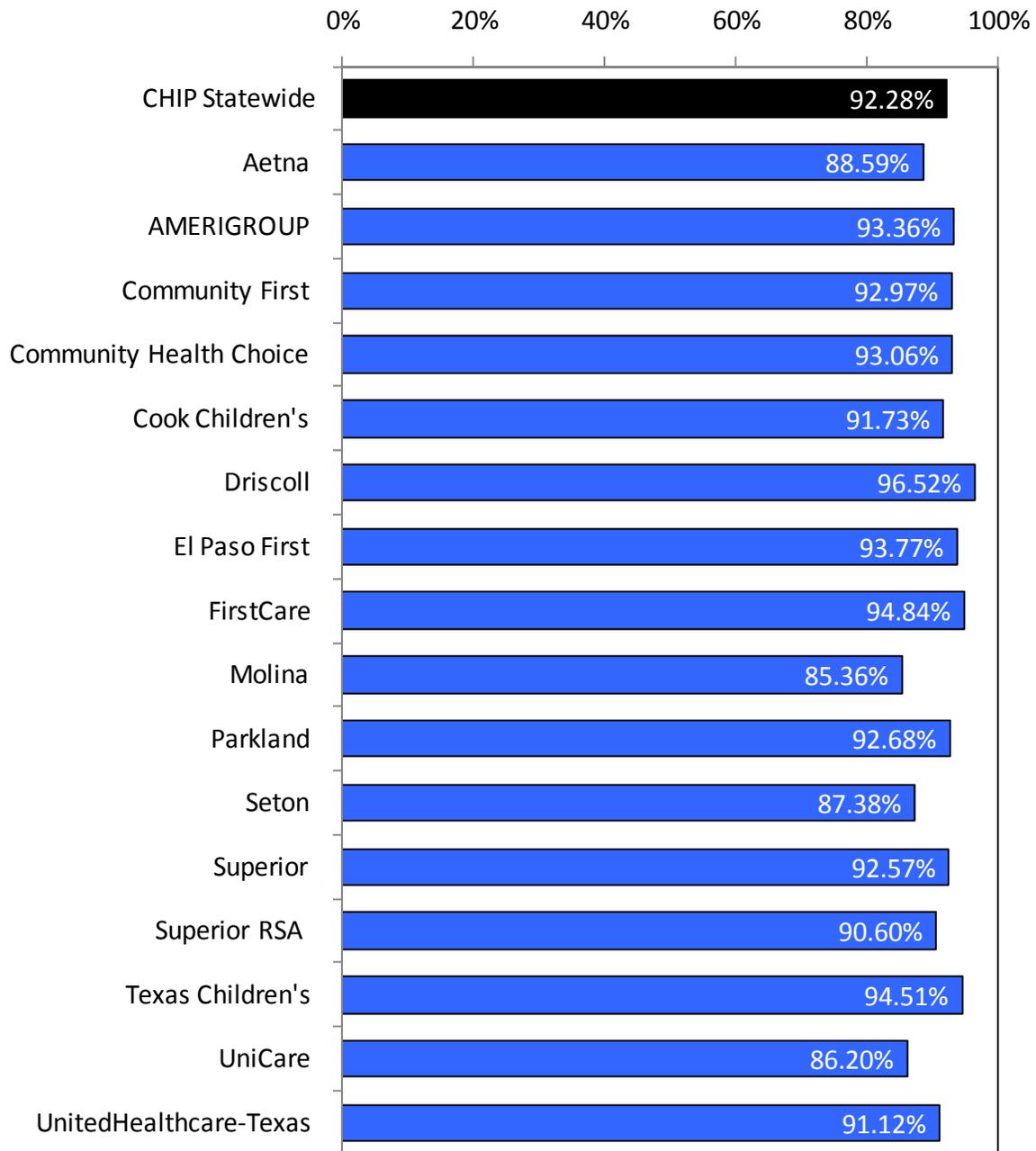
Reference: Table CAP

**Figure 5. The Percentage of CHIP Members 7 to 11 Years Old with Access to a PCP**



Reference: Table CAP

**Figure 6. The Percentage of CHIP Members 12 to 19 Years Old with Access to a PCP**



Reference: Table CAP

## Utilization of Services

### *Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life*

**Figure 7** provides results for the Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life measure, which represents the percentage of CHIP members between three and six years old who received one or more well-child visits with a provider during the measurement period, distributed by MCO. **Table 3** provides results for this measure by CHIP Service Area.

**CHIP Statewide.** Sixty-eight percent of children 3 to 6 years old in CHIP had a well-child visit. This rate is slightly below the rate reported by Medicaid Managed Care Plans to the NCQA for this measure (72 percent).

**CHIP MCOs.** All CHIP MCOs exceeded the HHSC Performance Indicator Dashboard standard of 56 percent for this measure. The MCO with the greatest percentage of members three to six years old having at least one well-child visit was Community Health Choice at 75 percent, followed by AMERIGROUP at 74 percent, Texas Children's at 73 percent, and Parkland at 72 percent. These four health plans were the only CHIP MCOs that performed at or above the HEDIS<sup>®</sup> mean of 72 percent for this measure. FirstCare had the lowest percentage of members three to six years old who had at least one well-child visit (57 percent).

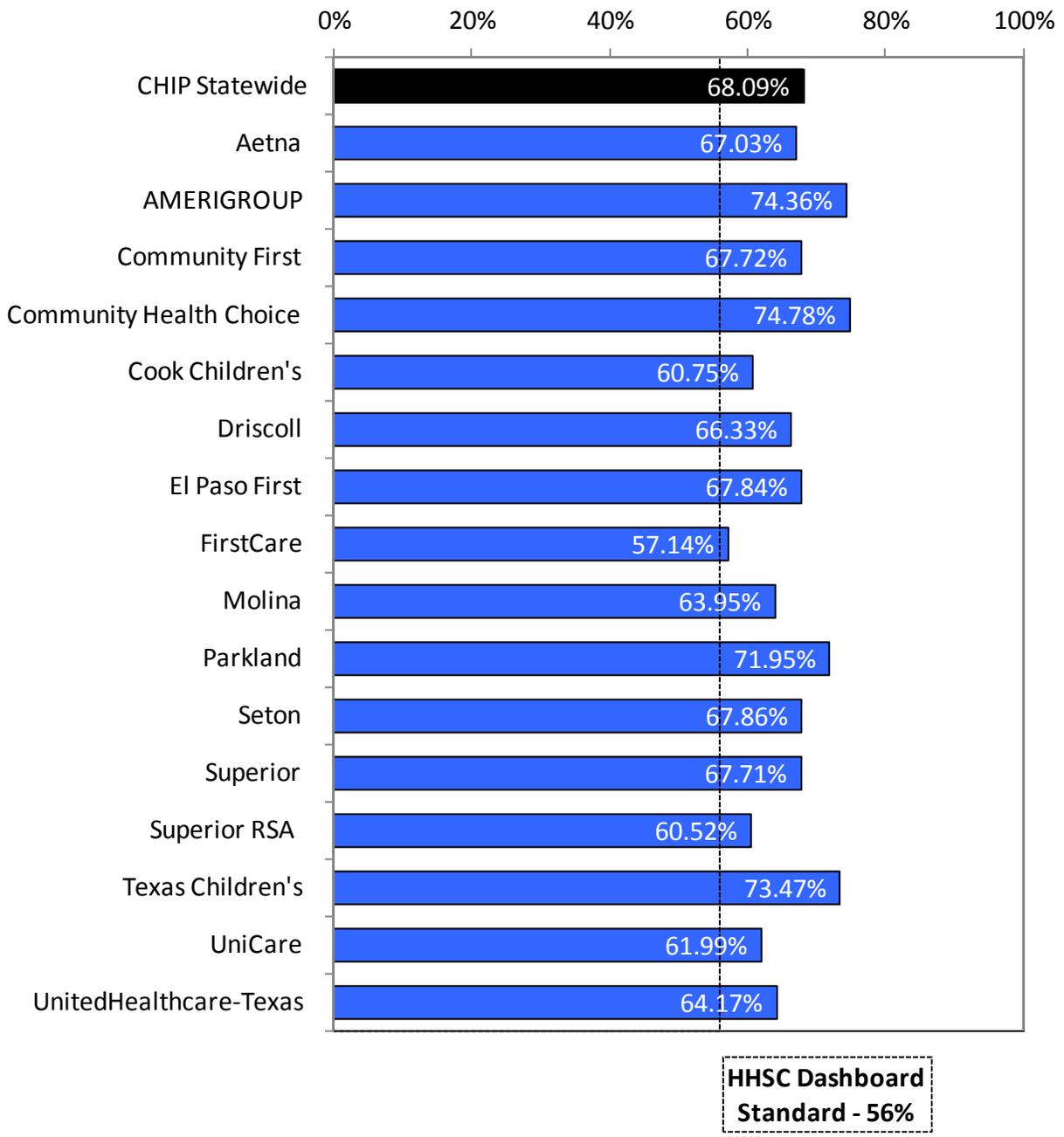
**CHIP Service Areas.** The percentage of CHIP members three to six years old having at least one well-child visit ranged from 60 percent in Lubbock to 73 percent in Harris. All CHIP Service Areas exceeded the HHSC Dashboard standard for this measure.

**Table 3. Well-Child Visits Among Members 3 to 6 Years Old by CHIP Service Area**

CHIP Service Area	Well-Child Visits
BEXAR	67.84%
DALLAS	72.19%
EL PASO	68.44%
HARRIS	72.98%
LUBBOCK	60.03%
NUECES	66.86%
SUPERIOR RSA	60.52%
TARRANT	65.68%
TRAVIS	68.05%
WEBB	63.45%

Reference: Table W34

**Figure 7. The Percentage of CHIP Members 3 to 6 Years Old with One or More Well-Child Visits**



Reference: Table W34

## Adolescent Well-Care Visits

**Figure 8** provides results for the Adolescent Well-Care Visits measure, which represents the percentage of CHIP members 12 to 21 years old who received one or more comprehensive adolescent well-care visits with a provider during the measurement period, distributed by MCO. **Table 4** provides results for this measure by CHIP Service Area.

**CHIP Statewide.** Fifty percent of adolescents in CHIP had a well-care visit. This rate is slightly above the rate reported by Medicaid Managed Care Plans to the NCQA for this measure (48 percent).

**CHIP MCOs.** All CHIP MCOs except FirstCare exceeded the HHSC Performance Indicator Dashboard standard of 38 percent for this measure. The MCOs with the highest rates of adolescent well-care visits were Texas Children's (58 percent), Community Health Choice (57 percent), AMERIGROUP (56 percent), and Parkland (55 percent).

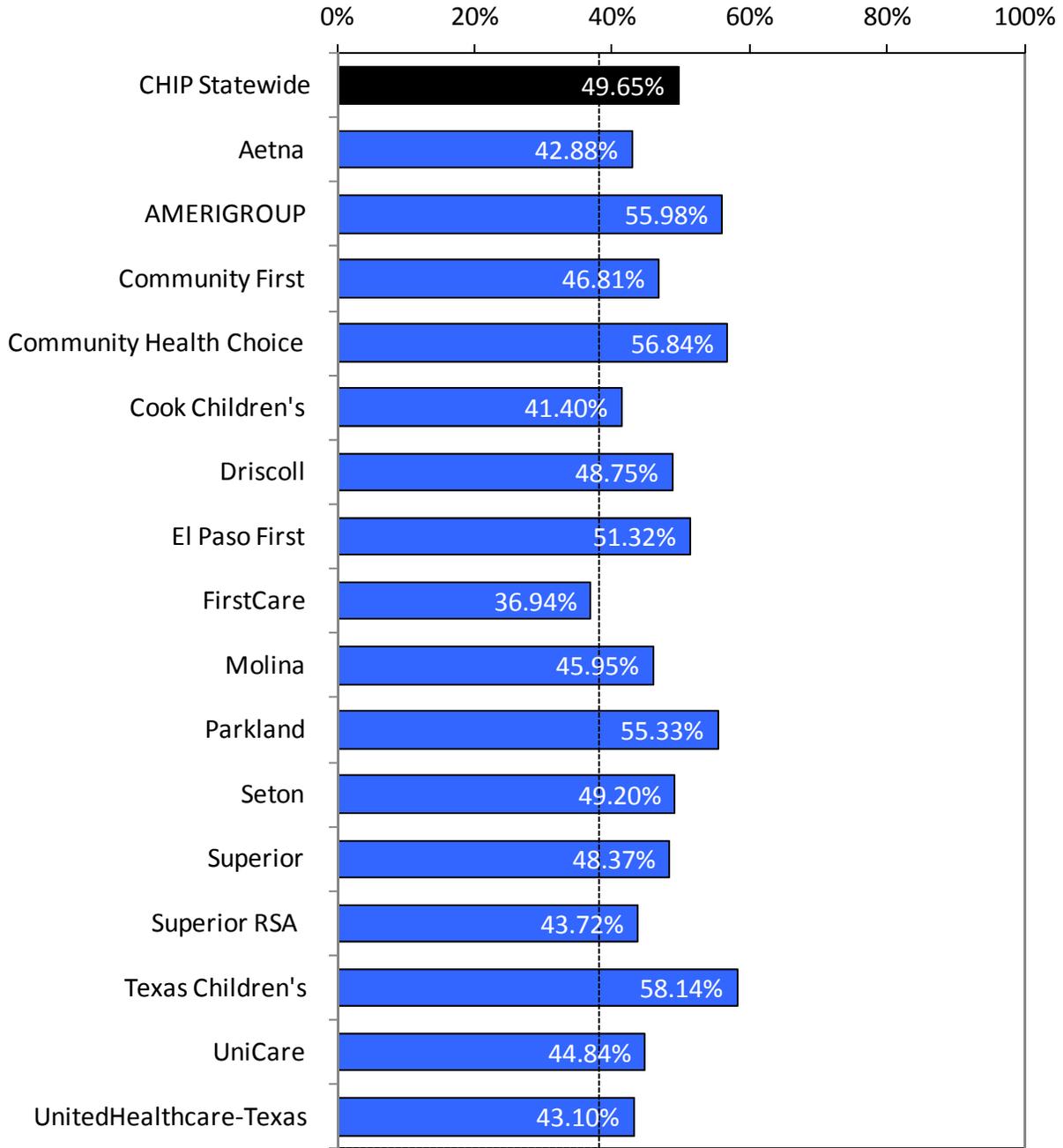
**CHIP Service Areas.** Rates of adolescent well-care visits ranged from 38 percent in Lubbock to 55 percent in Dallas and Harris. All CHIP Service Areas met the HHSC Dashboard standard for this measure.

**Table 4. Adolescent Well-Care Visits by CHIP Service Area**

CHIP Service Area	Adolescent Well-Care Visits
BEXAR	46.84%
DALLAS	55.09%
EL PASO	52.58%
HARRIS	55.23%
LUBBOCK	37.50%
NUECES	48.18%
SUPERIOR RSA	43.72%
TARRANT	44.00%
TRAVIS	49.16%
WEBB	46.04%

Reference: Table AWC

**Figure 8. The Percentage of Adolescent CHIP Members with One or More Well-Care Visits**



**HHSC Dashboard  
Standard - 38%**

Reference: Table AWC

## Utilization of Ambulatory Care

### Outpatient Care

Figures 9 through 12 provide results for the HEDIS® Ambulatory Care outpatient measure, showing the rate of outpatient visits per 1,000 member months in CHIP, distributed by age group and MCO. Table 5 provides results for this measure by CHIP Service Area.

**CHIP Statewide.** Overall, CHIP members had 261 outpatient visits per 1,000 member months during the measurement year. This rate is lower than the national HEDIS® mean of 367 per 1,000 member months. Utilization of outpatient care was highest among members less than one year old, generally decreased with age, and was generally lower than the corresponding national HEDIS® average rates. The rate of outpatient visits was:

- 644 per 1,000 member months among members less than one year old.
- 302 per 1,000 member months among members one to nine years old.
- 227 per 1,000 member months among members 10 to 19 years old.

**CHIP MCOs.** Rates of outpatient utilization varied across CHIP MCOs. The lowest rate was observed in UniCare for members 10 to 19 years old (170 per 1,000 member months). The highest rates in all age groups (except members less than one year old) were observed in Driscoll. FirstCare had the highest outpatient utilization for members less than one year old (951 per 1,000 member months).

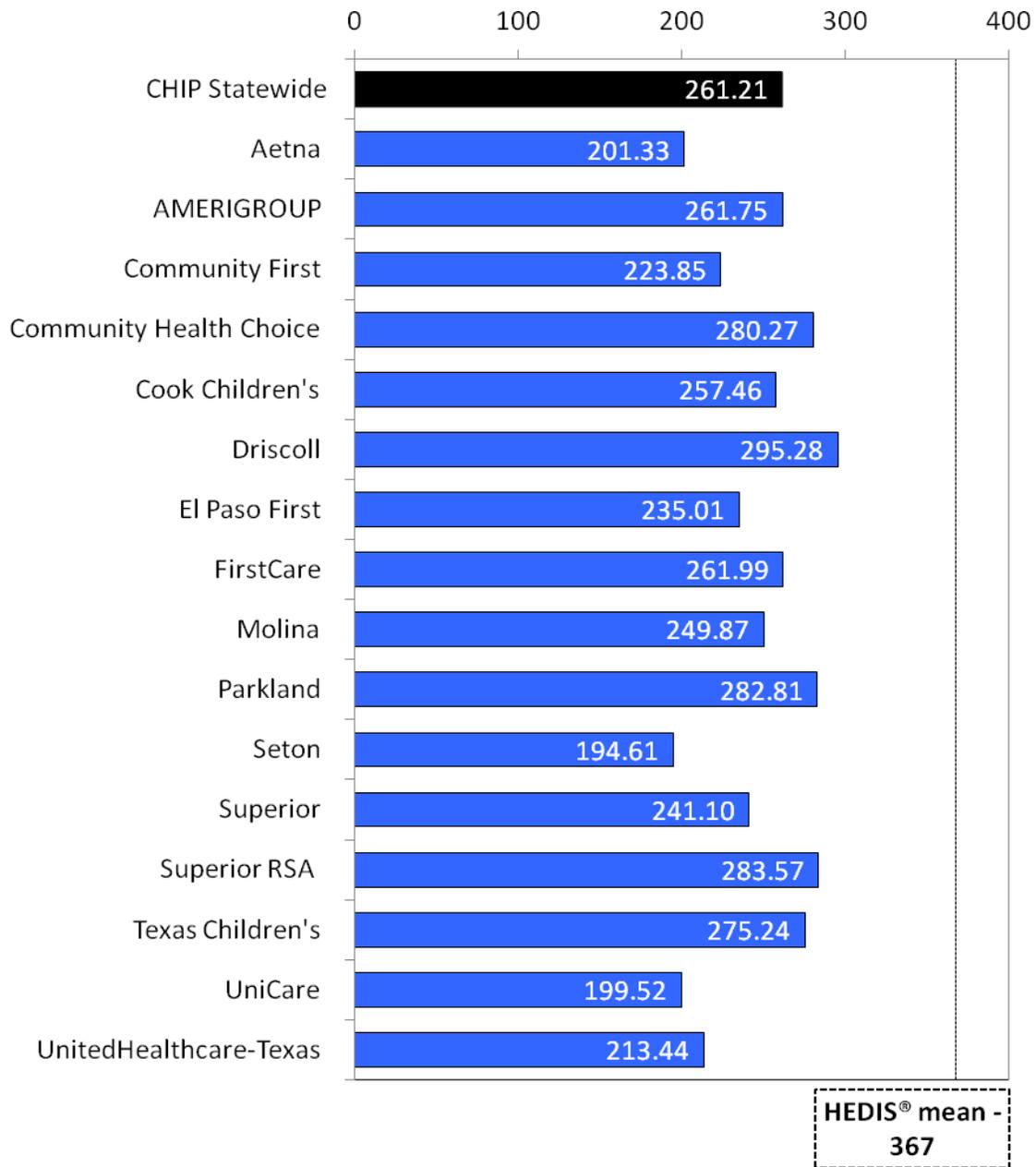
**CHIP Service Areas.** Total rates of outpatient utilization across the CHIP Service Areas ranged from 208 per 1,000 member months in Travis to 292 per 1,000 member months in Nueces.

**Table 5. HEDIS® Ambulatory Care Outpatient Utilization by CHIP Service Area**

CHIP Service Area	HEDIS® Ambulatory Care - Rate of Outpatient Visits per 1,000 Member Months			
	Total	< 1 year old	1 to 9 years old	10 to 19 years old
BEXAR	224.03	490.20	256.64	199.87
DALLAS	263.98	675.34	308.22	222.91
EL PASO	244.40	640.88	280.12	221.91
HARRIS	266.57	647.01	312.56	226.01
LUBBOCK	236.52	702.05	267.56	208.58
NUECES	291.88	741.67	339.95	257.29
SUPERIOR RSA	283.57	679.04	325.10	250.98
TARRANT	253.43	657.24	285.68	221.60
TRAVIS	208.40	504.60	236.10	182.03
WEBB	275.96	966.29	321.80	244.90

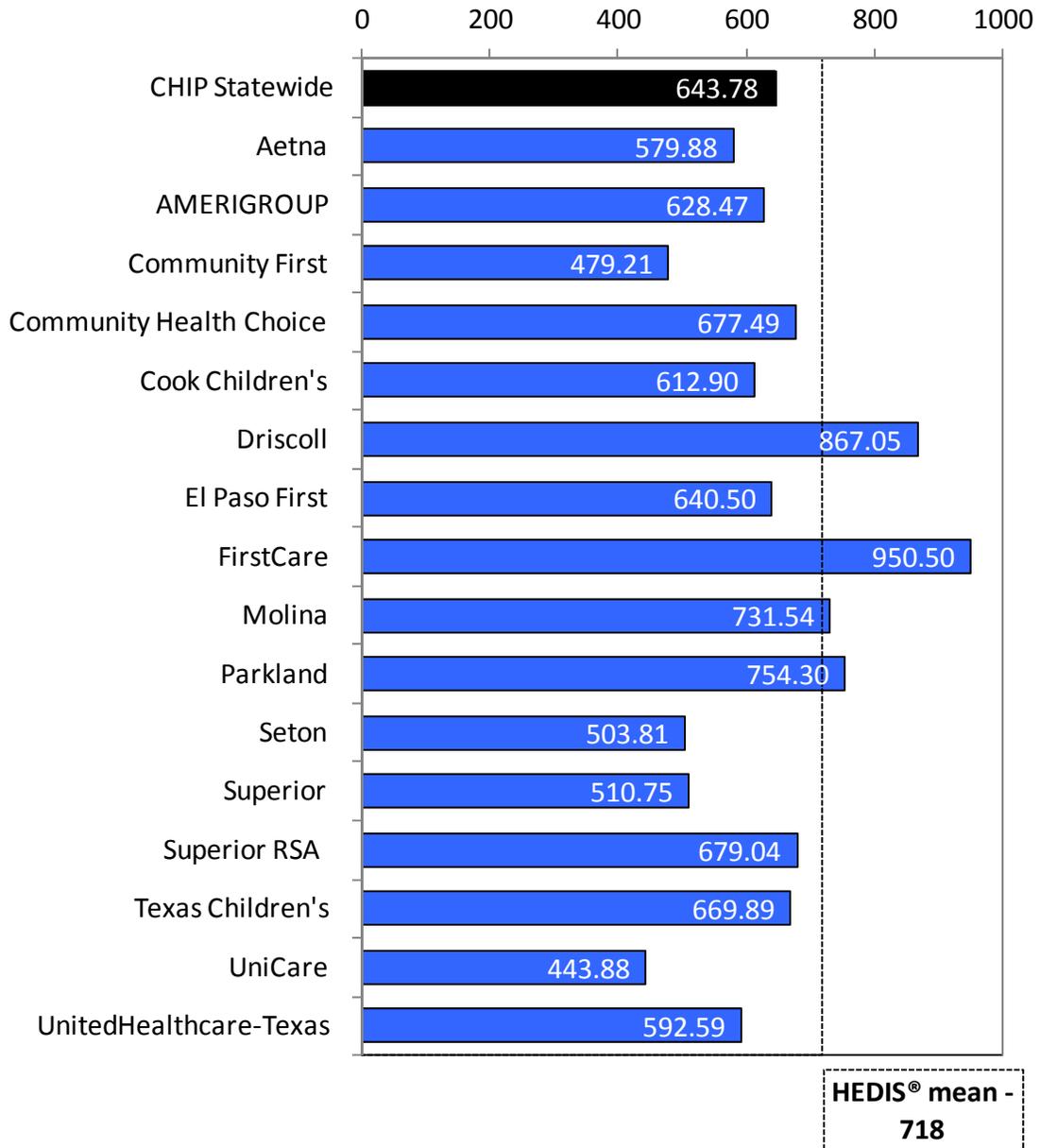
Reference: Table AMB

**Figure 9. HEDIS® Ambulatory Care - The Overall Rate of Outpatient Visits per 1,000 Member Months in CHIP**



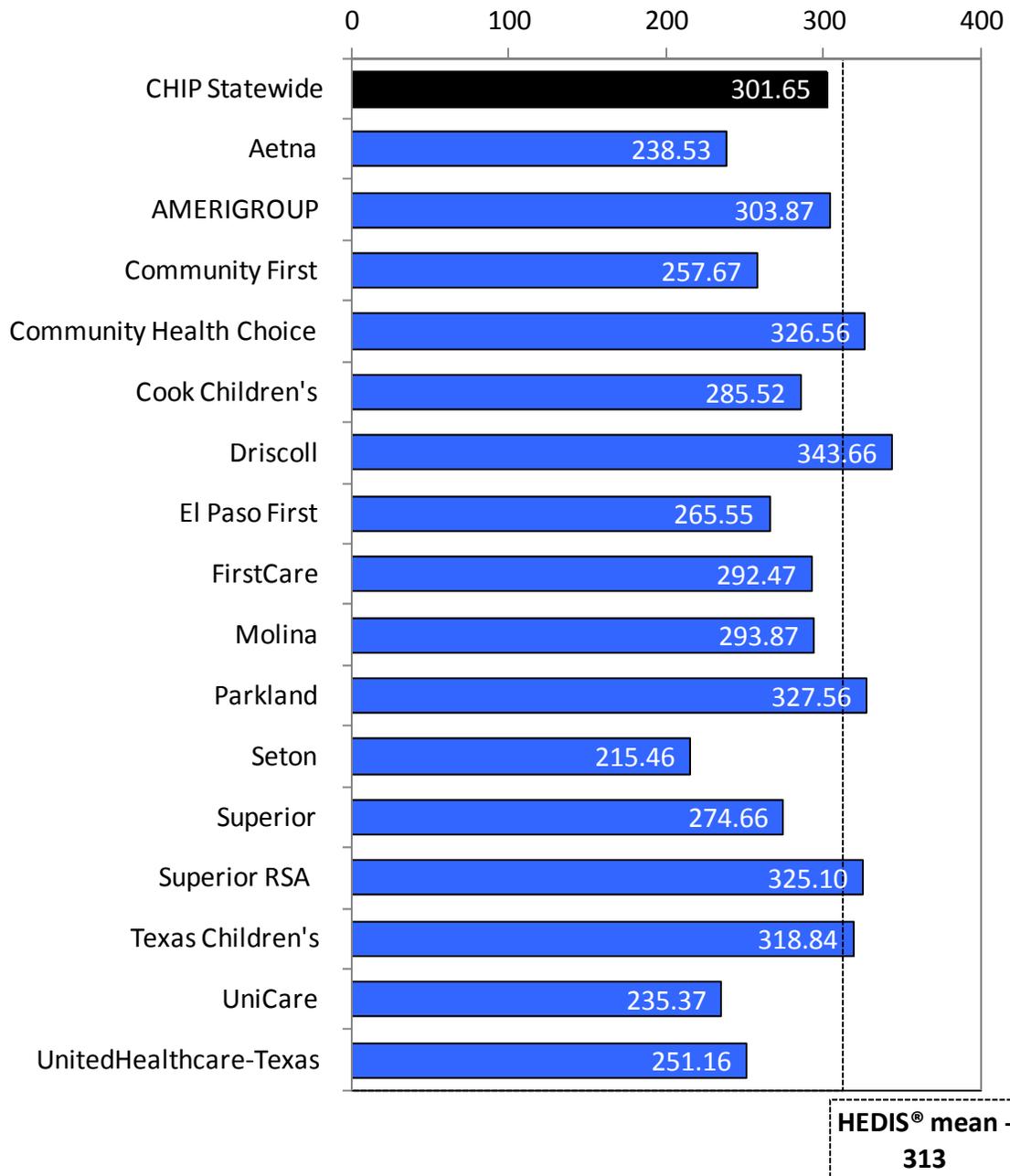
Reference: Table AMB

**Figure 10. HEDIS® Ambulatory Care - The Rate of Outpatient Visits per 1,000 Member Months for CHIP Members < 1 Year of Age**



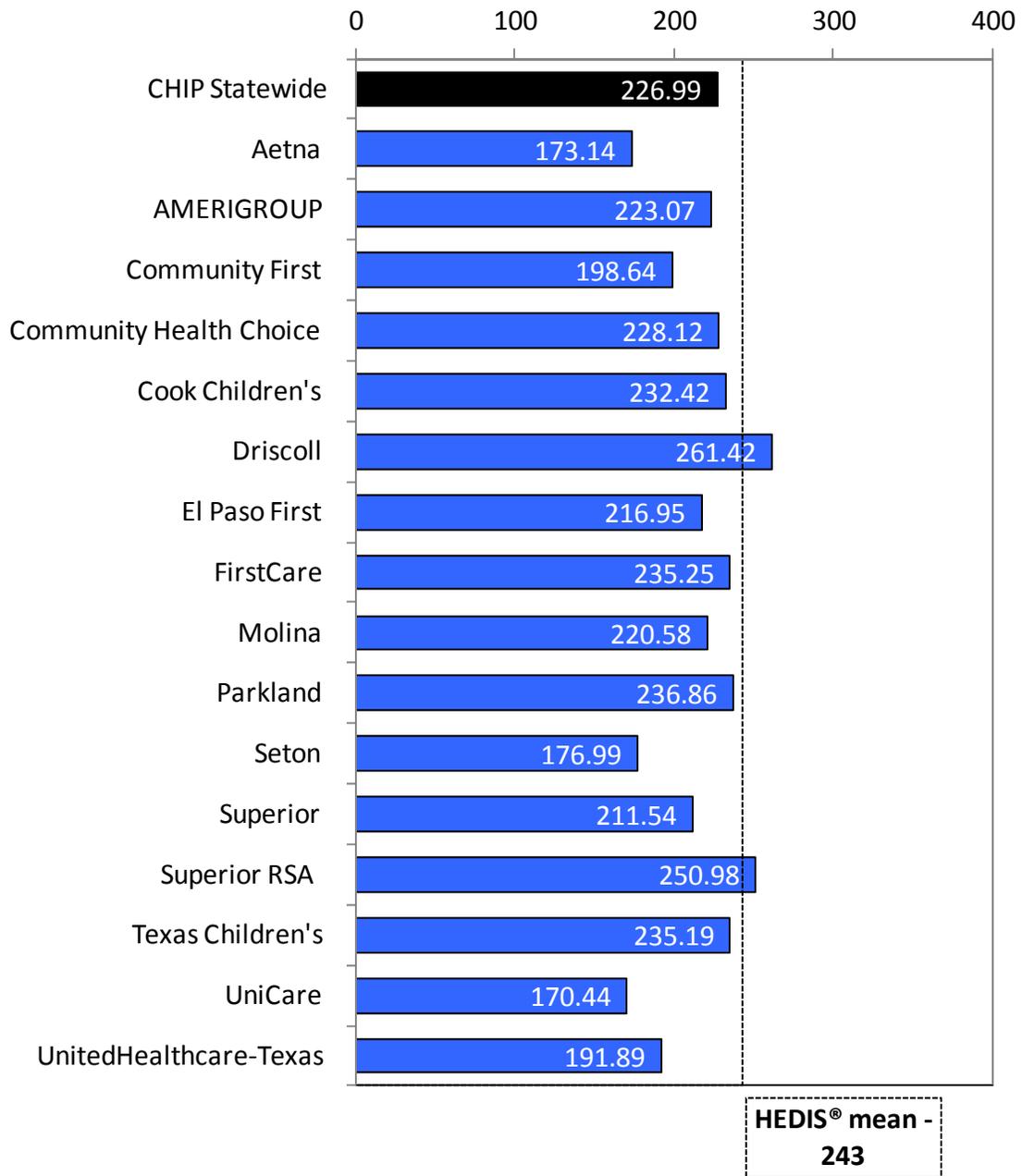
Reference: Table AMB

**Figure 11. HEDIS® Ambulatory Care - The Rate of Outpatient Visits per 1,000 Member Months for CHIP Members 1 to 9 Years Old**



Reference: Table AMB

**Figure 12. HEDIS® Ambulatory Care - The Rate of Outpatient Visits per 1,000 Member Months for CHIP Members 10 to 19 Years Old**



Reference: Table AMB

## Emergency Department Utilization

Figures 13 through 16 provide results for the HEDIS® Ambulatory Care emergency department (ED) measure, showing the rate of ED visits per 1,000 member months in CHIP, distributed by age group and MCO. Table 6 provides results for this measure by CHIP Service Area.

**CHIP Statewide.** Overall, CHIP members had 23 ED visits per 1,000 member months during the measurement year. This rate is lower than the national HEDIS® mean of 67 per 1,000 member months. Utilization of the ED was highest among members less than one year old and generally decreased with age. Program-level utilization rates were considerably lower than the corresponding national HEDIS® average rates for all age cohorts. The rate of ED visits was:

- 41 per 1,000 member months among members less than one year old.
- 25 per 1,000 member months among members one to nine years old.
- 21 per 1,000 member months among members 10 to 19 years old.

**CHIP MCOs.** Across age cohorts, Driscoll had the highest rate of ED visits, and Molina the lowest. The lowest rate was observed in Molina for members 10 to 19 years old (13 per 1,000 member months). The highest rate was observed for members less than one year old in Driscoll (81 per 1,000 member months).

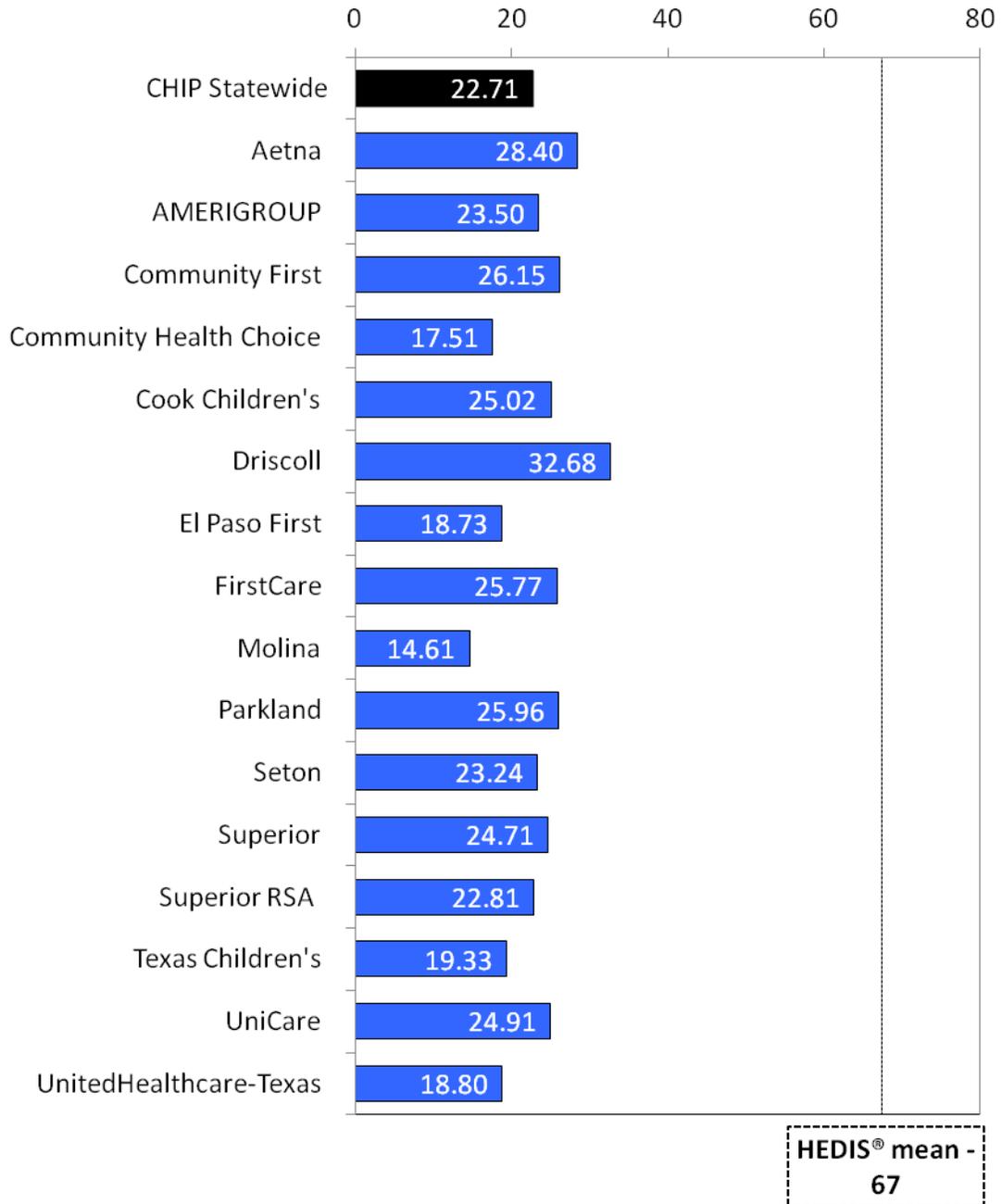
**CHIP Service Areas.** Total rates of ED utilization ranged from 15 per 1,000 member months in Webb to 32 per 1,000 member months in Nueces.

**Table 6. HEDIS® Ambulatory Care ED Utilization by CHIP Service Area**

CHIP Service Area	HEDIS® Ambulatory Care Rate of ED Visits per 1,000 Member Months			
	Total	< 1 year old	1 to 9 years old	10 to 19 years old
BEXAR	26.07	24.51	30.44	22.94
DALLAS	25.39	59.89	29.14	21.91
EL PASO	19.26	38.67	20.42	18.51
HARRIS	18.53	36.38	21.19	16.21
LUBBOCK	24.05	34.25	23.95	24.11
NUECES	31.99	62.50	36.13	29.04
SUPERIOR RSA	22.81	33.66	24.23	21.70
TARRANT	26.66	56.00	29.13	24.23
TRAVIS	24.69	23.90	26.28	23.29
WEBB	14.53	22.47	15.94	13.59

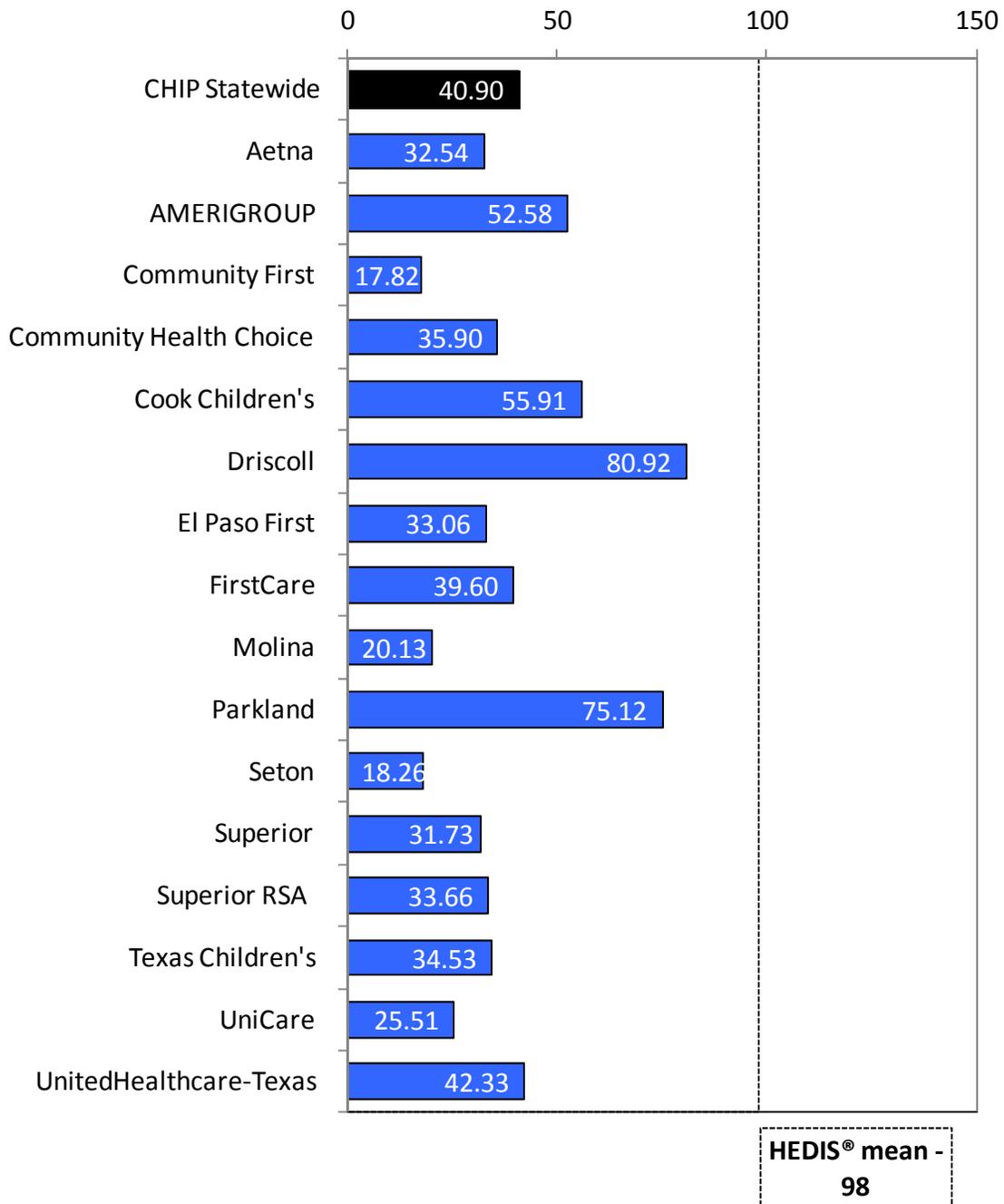
Reference: Table AMB

**Figure 13. HEDIS® Ambulatory Care - The Overall Rate of ED Visits per 1,000 Member Months in CHIP**



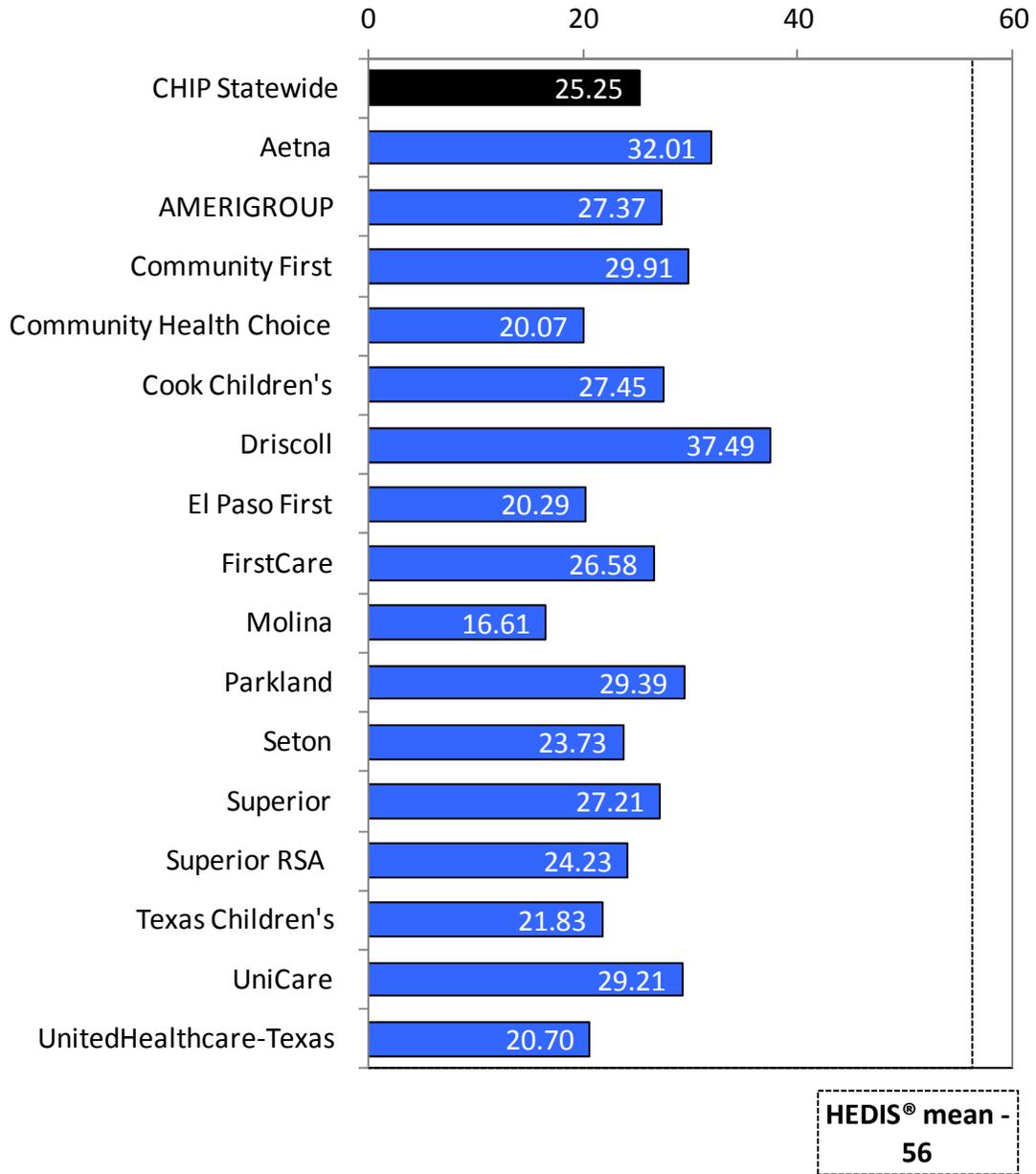
Reference: Table AMB

**Figure 14. HEDIS® Ambulatory Care - The Rate of ED Visits per 1,000 Members Months for CHIP Members < 1 Year of Age**



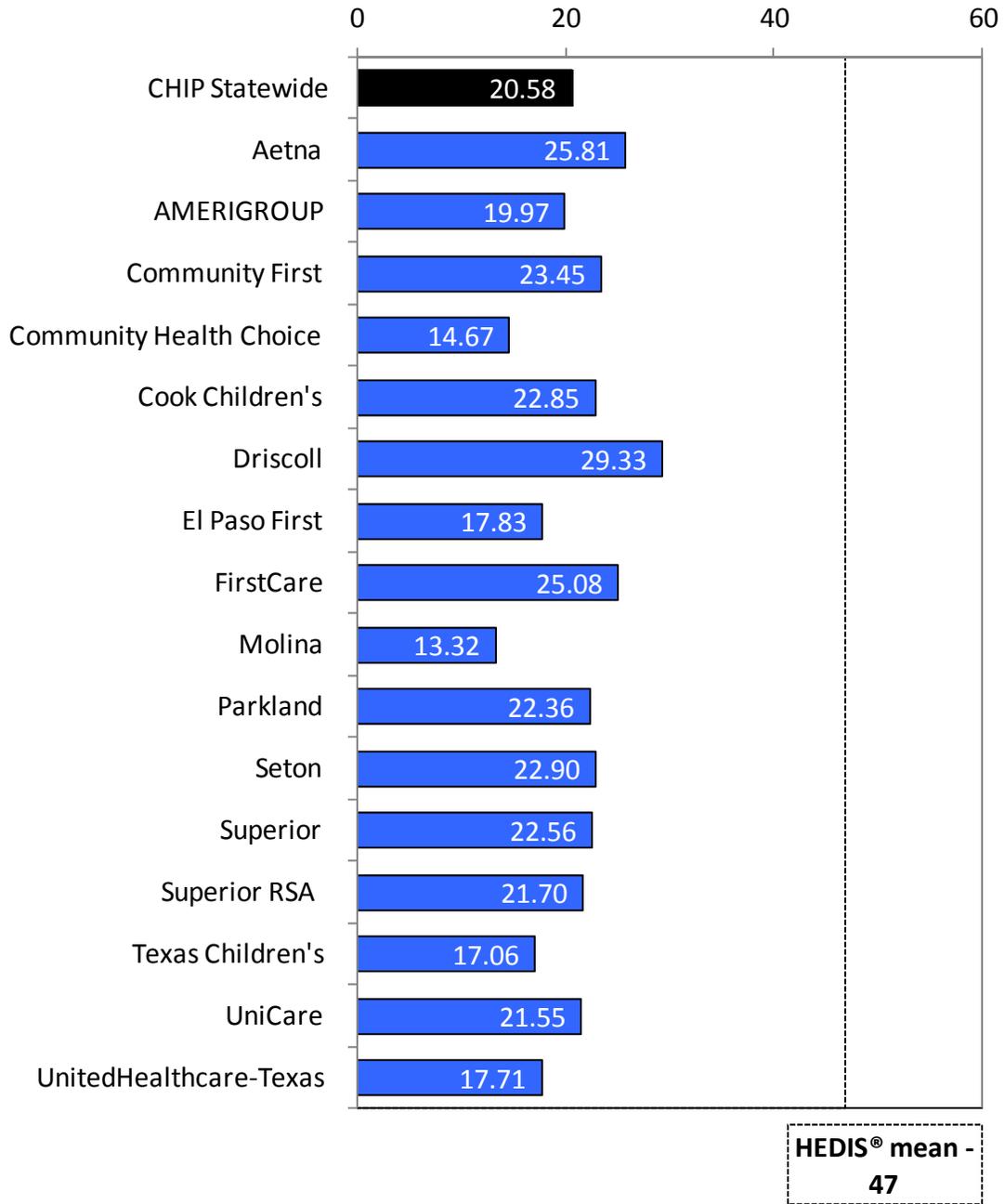
Reference: Table AMB

**Figure 15. HEDIS® Ambulatory Care - The Rate of ED Visits per 1,000 Members Months for CHIP Members 1 to 9 Years Old**



Reference: Table AMB

**Figure 16. HEDIS® Ambulatory Care - The Rate of ED Visits per 1,000 Members Months for CHIP Members 10 to 19 Years Old**



Reference: Table AMB

## **AHRQ Pediatric Quality Indicators**

The Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs) use hospital inpatient discharge data to calculate rates of admission for various ambulatory care sensitive conditions for children and adults, respectively. These indicators screen for inpatient stays that were potentially avoidable with better access to care in the outpatient setting. This information is useful for monitoring trends, comparing MCO performance, and addressing access to care issues.

**Figures 17** through **20** provide PDI rates for asthma, diabetes short-term complications, gastroenteritis, and urinary tract infections among children and adolescents in CHIP, up to 17 years of age, distributed by MCO. **Table 7** shows results for these four indicators by CHIP Service Area. The inpatient admissions rate for perforated appendix is not presented in the figures or discussed below because of low denominators in a majority of CHIP health plans.

**Table B1** in Appendix B describes each of the five AHRQ PDIs shown here. Discussion of PDIs in the key points below includes comparisons with national rates reported by AHRQ.<sup>11</sup> It should be noted that these AHRQ national estimates are based on data collected in 2008 and are area-level indicators, including commercial and Medicaid populations.

**CHIP Statewide.** At the program level, inpatient admission rates for all PDI conditions were lower than the corresponding national averages, which is indicative of good pediatric outpatient care. Among PDIs calculated per 100,000 members, the highest rate in CHIP was for asthma, and the lowest was for diabetes short-term complications.

- **Asthma.** The inpatient admissions rate for asthma was 70 per 100,000 members in CHIP overall, which is below the AHRQ national rate of 124 per 100,000.
- **Diabetes short-term complications.** The inpatient admissions rate for diabetes short-term complications was 19 per 100,000 members in CHIP overall, which is lower than the AHRQ national rate of 28 per 100,000.
- **Gastroenteritis.** The inpatient admissions rate for gastroenteritis was 32 per 100,000 members in CHIP overall, which is considerably lower than the AHRQ national rate of 105 per 100,000.
- **Urinary tract infection.** The inpatient admissions rate for urinary tract infection was 21 per 100,000 members in CHIP overall, which is below the AHRQ national rate of 43 per 100,000.

**CHIP MCOs.** Rates of inpatient admissions for ACSCs among children in CHIP varied across MCOs.

- **Asthma.** Across the CHIP MCOs, rates ranged from 22 per 100,000 in Community Health Choice to 128 per 100,000 in FirstCare. All MCOs had rates lower than the AHRQ national average, except for FirstCare.

- **Diabetes short-term complications.** Across the CHIP MCOs, rates ranged from 0 per 100,000 in Molina and UniCare to 47 per 100,000 in El Paso First. All MCOs had rates lower than the AHRQ national rate, with the exception of El Paso First, FirstCare (34 per 100,000), Parkland (37 per 100,000), and Seton (29 per 100,000).
- **Gastroenteritis.** Across the CHIP MCOs, rates ranged from 7 per 100,000 in Community Health Choice to 99 per 100,000 in Molina. All MCOs had rates below the AHRQ national average.
- **Urinary tract infection.** Across the CHIP MCOs, rates ranged from 0 per 100,000 in Aetna and UniCare to 69 per 100,000 in FirstCare. All MCOs had rates below the AHRQ national average except FirstCare, Molina (64 per 100,000), and El Paso First (55 per 100,000).

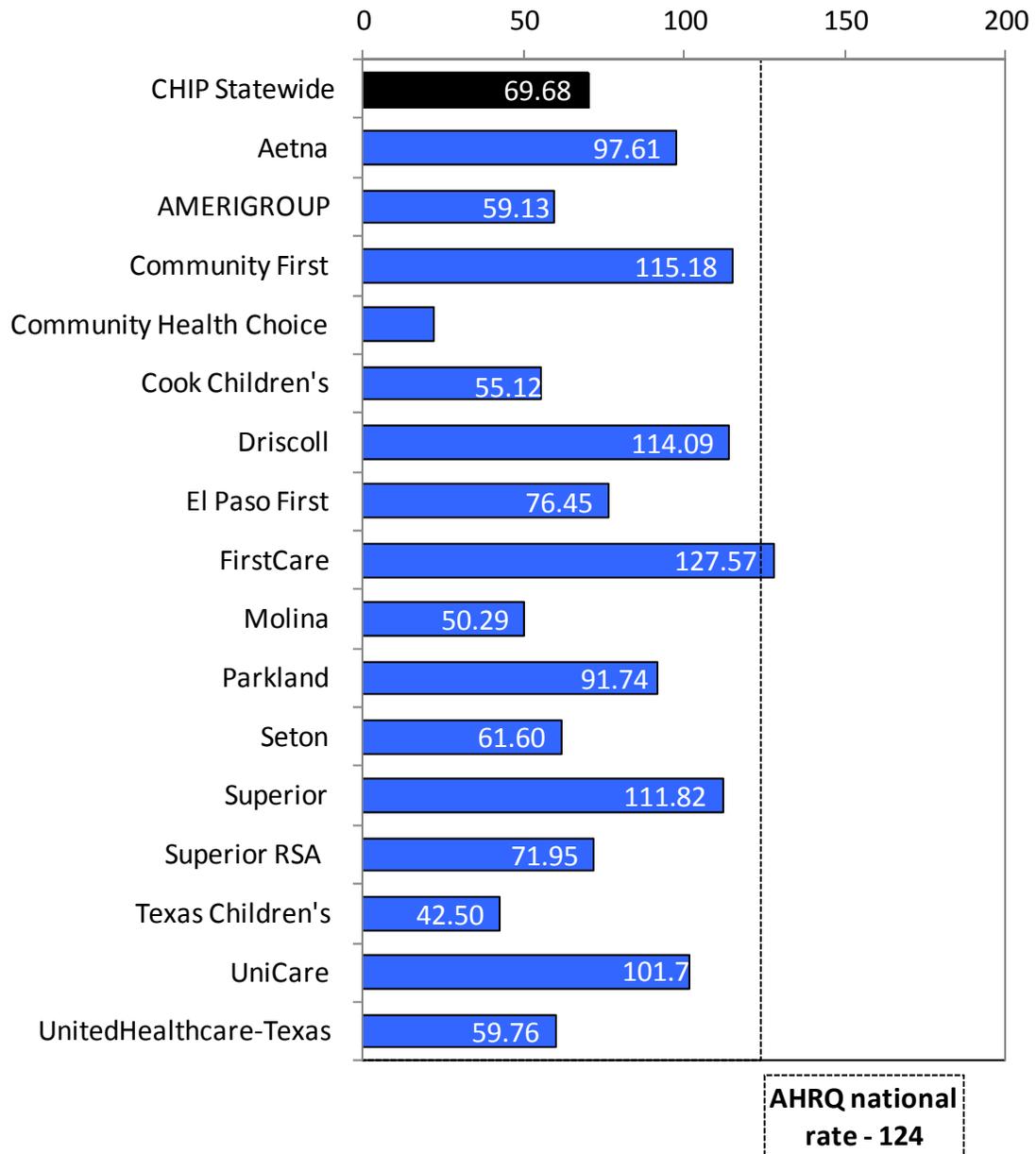
**CHIP Service Areas.** Overall, inpatient admission rates were highest in the Lubbock Service Area for asthma and diabetes short-term complications, and highest in the Webb Service Area for gastroenteritis and urinary tract infection.

**Table 7. AHRQ Pediatric Quality Indicators by CHIP Service Area**

CHIP Service Area	AHRQ Pediatric Quality Indicator			
	Asthma (per 100,000)	Diabetes Short-Term Complications (per 100,000)	Gastroenteritis (per 100,000)	Urinary Tract Infection (per 100,000)
BEXAR	128.96	9.97	21.63	6.66
DALLAS	84.97	25.04	12.02	9.24
EI PASO	81.47	37.49	76.98	48.11
HARRIS	38.94	15.09	18.05	16.09
LUBBOCK	165.99	54.85	39.21	56.01
NUECES	106.14	5.91	84.28	29.74
SUPERIOR RSA	71.95	23.48	58.33	37.67
TARRANT	50.91	8.42	12.10	2.69
TRAVIS	50.10	19.30	12.87	18.01
WEBB	71.42	0.00	132.05	70.43

Reference: Table PDI

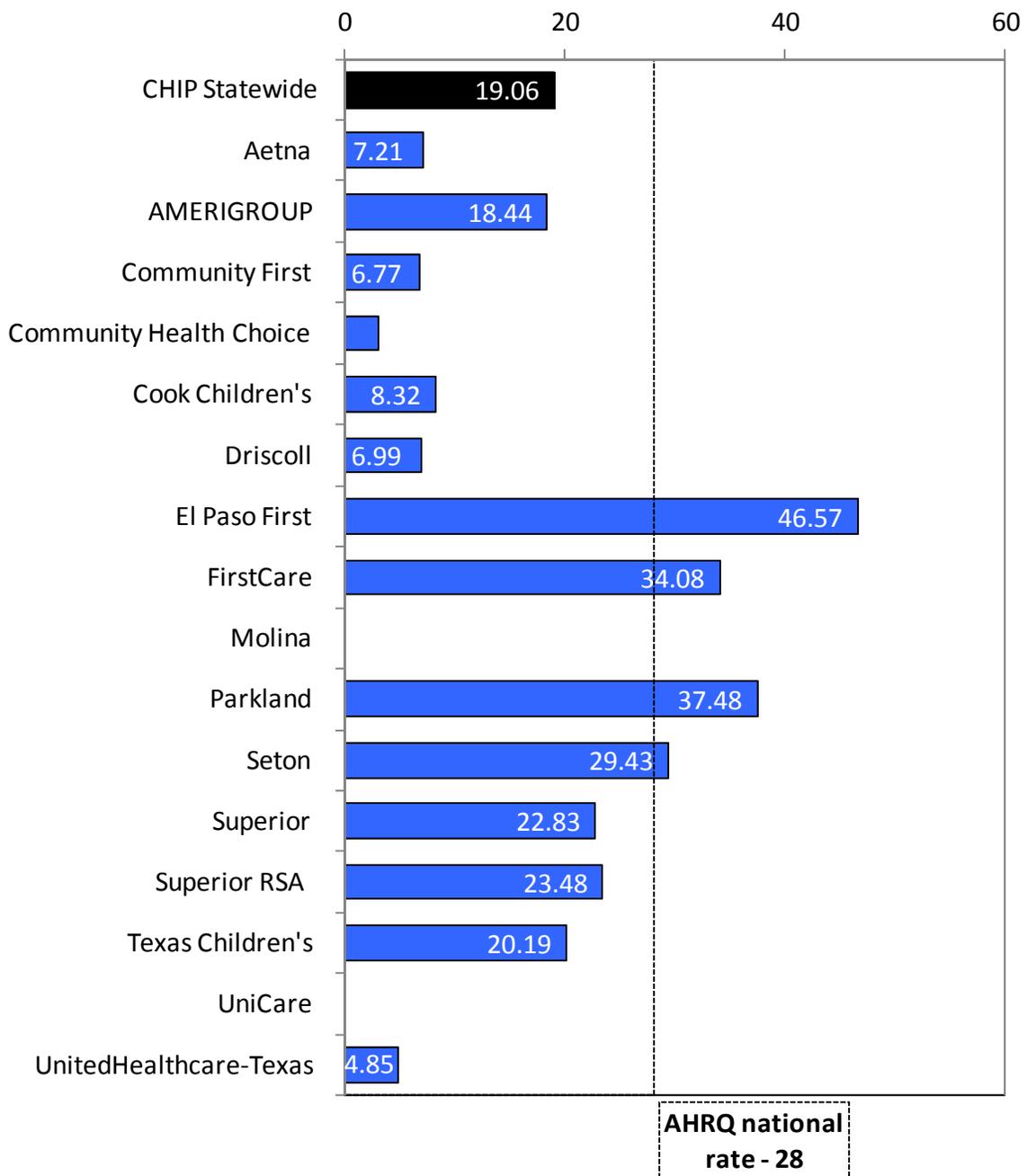
**Figure 17. AHRQ PDI Asthma Inpatient Admissions Rates in CHIP (per 100,000)**



Note. The value for Community Health Choice was not displayed due to low admission rate (21.84).

Reference: Table PDI

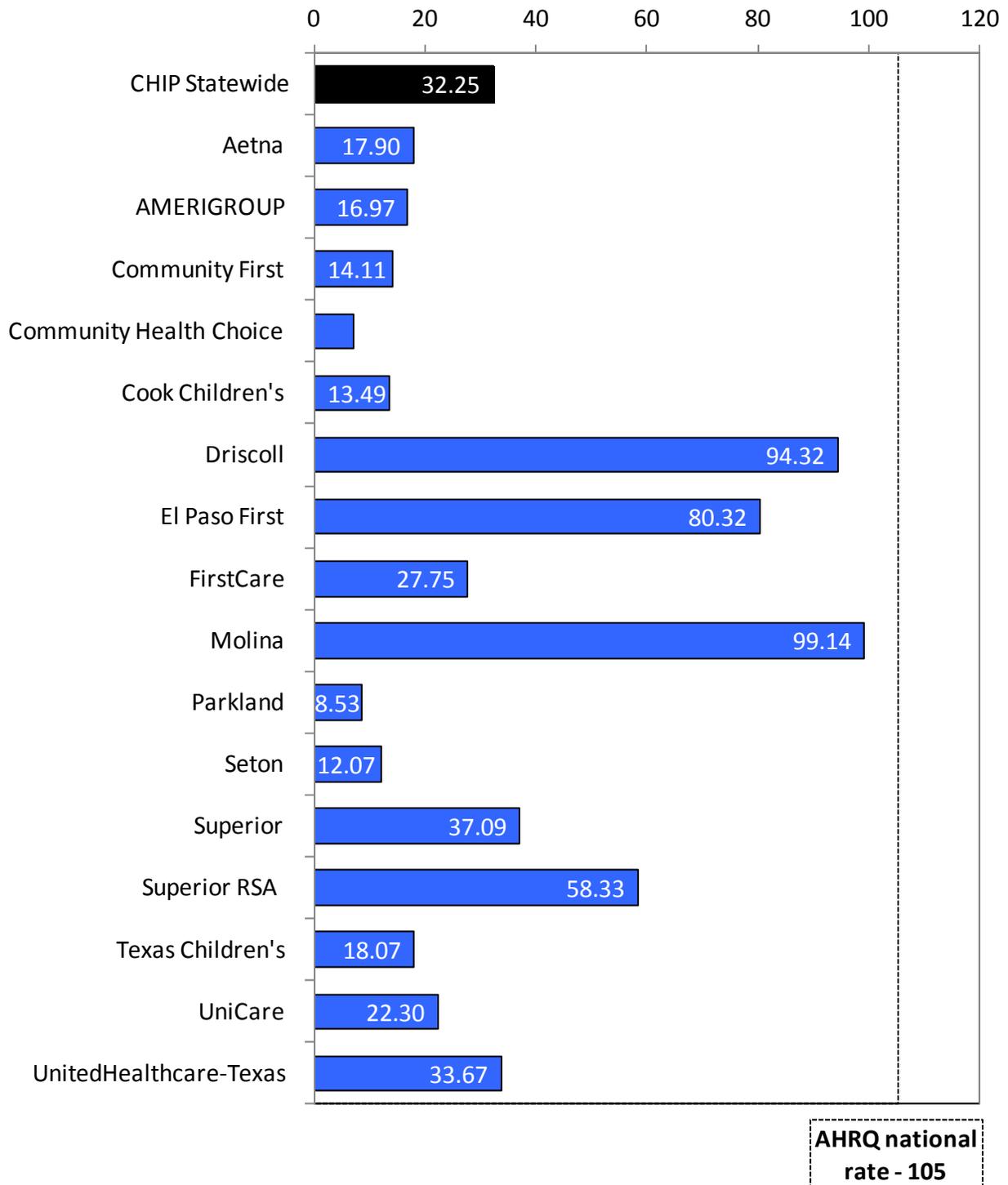
**Figure 18. AHRQ PDI Diabetes Short-Term Complications Inpatient Admissions Rates in CHIP (per 100,000)**



Note: The values for the following MCOs were not displayed due to low admission rates: Community Health Choice (3.06), Molina (0.00), and UniCare (0.00).

Reference: Table PDI

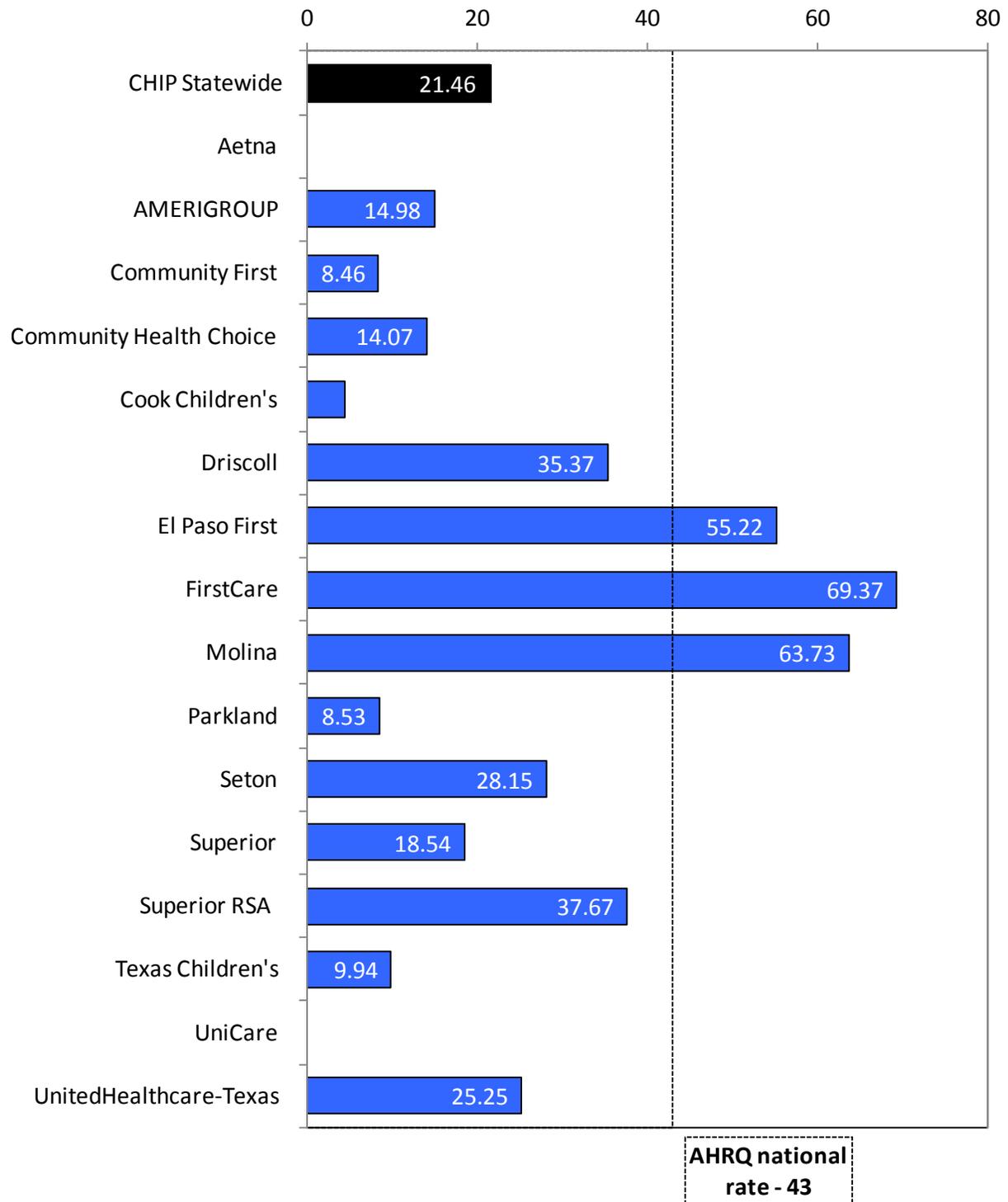
**Figure 19. AHRQ PDI Gastroenteritis Inpatient Admissions Rates in CHIP (per 100,000)**



Note: The value for Community Health Choice was not displayed due to a low admission rate (7.03).

Reference: Table PDI

**Figure 20. AHRQ PDI Urinary Tract Infection Inpatient Admissions Rates in CHIP (per 100,000)**



Note: The values for the following MCOs were not displayed due to low admission rates: Aetna (0.00), Cook Children's (4.50), and UniCare (0.00).

Reference: Table PDI

## Effectiveness of Care

### Respiratory Conditions

#### Appropriate Testing for Children with Pharyngitis

**Figure 21** provides results for the HEDIS® Appropriate Testing for Children with Pharyngitis measure, which represents the percentage of children 2 to 18 years of age in CHIP who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus test for the episode, distributed by MCO. **Table 8** presents results for this measure, distributed by MCO/SA.

**CHIP Statewide.** A little more than half of all children in CHIP diagnosed with pharyngitis and given an antibiotic also received a Strep Test from their provider (54 percent). CHIP performed 8 percentage points below the national HEDIS® Medicaid rate, between the 10<sup>th</sup> and 25<sup>th</sup> percentiles nationally.

**CHIP MCOs.** Parkland had the highest percentage of children who were appropriately tested for pharyngitis, and was the only CHIP MCO that performed above the HEDIS® mean of 62 percent for this measure. Molina was the lowest performing CHIP MCO on this measure, with 39 percent of children in this health plan receiving appropriate testing for sore throat.

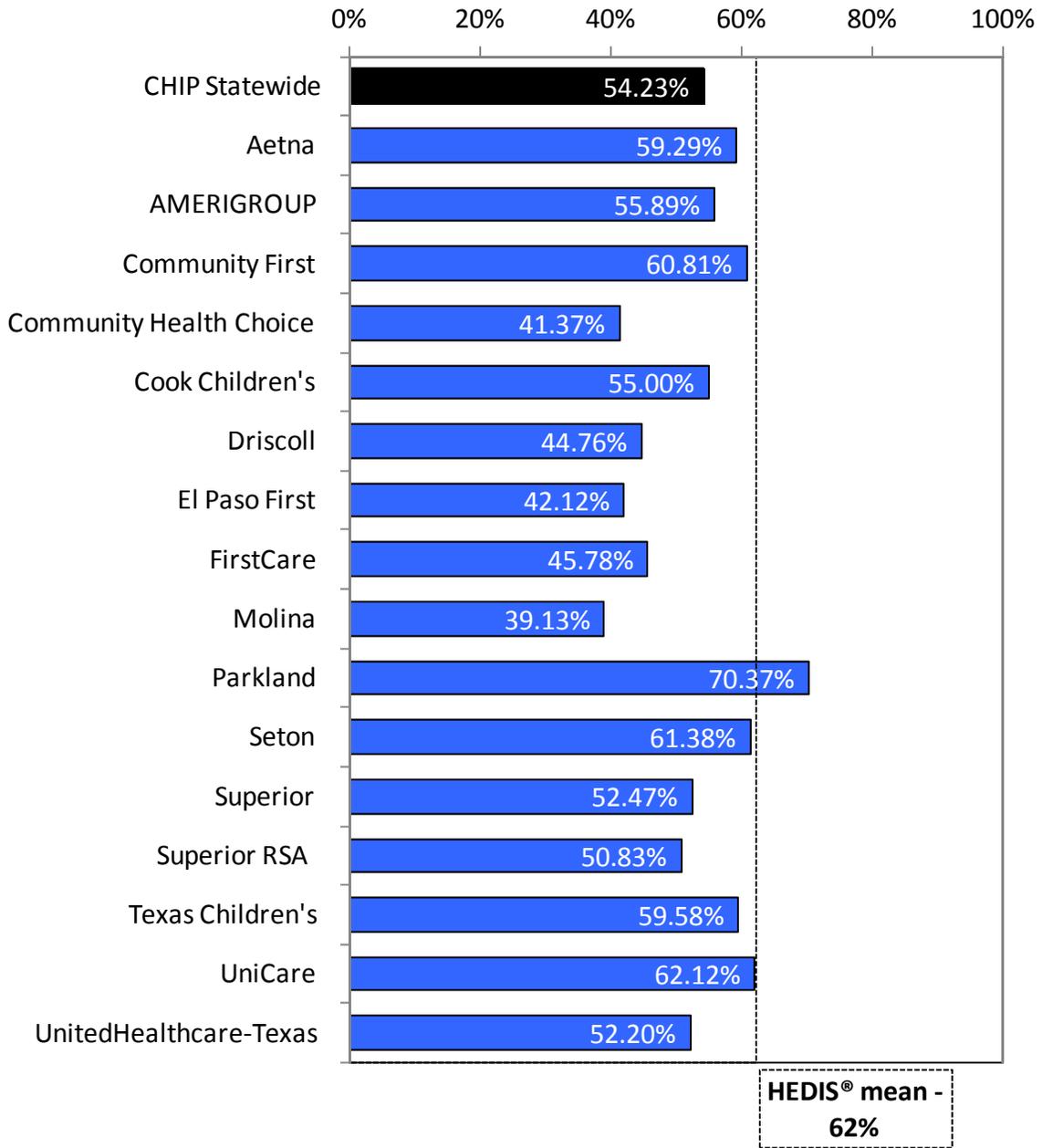
**CHIP Service Areas.** Child members in the Dallas Service Area had the highest rate of appropriate testing for pharyngitis at 67 percent, and the Webb Service Area the lowest rate at 41 percent.

**Table 8. HEDIS® Appropriate Testing for Children with Pharyngitis by CHIP Service Area**

CHIP Service Area	HEDIS® Appropriate Testing for Children with Pharyngitis
BEXAR	60.39%
DALLAS	67.11%
EL PASO	44.36%
HARRIS	52.11%
LUBBOCK	47.81%
NUECES	43.87%
SUPERIOR RSA	50.83%
TARRANT	56.01%
TRAVIS	58.73%
WEBB	41.05%

Reference: Table CWP

**Figure 21. HEDIS® Appropriate Testing for Children with Pharyngitis**



Reference: Table CWP

## Appropriate Treatment for Children with Upper Respiratory Infection

**Figure 22** provides the HEDIS® Appropriate Treatment for Children with Upper Respiratory Infections, which is the percentage of children three months to 18 years of age who received a diagnosis of upper respiratory infection (URI) and who were not dispensed an antibiotic prescription. Pediatric clinical guidelines do not recommend antibiotic treatment for most upper respiratory infections. Thus, high percentages on this measure indicate good performance.

**Table 9** presents results for this measure, distributed by CHIP Service Area

**CHIP Statewide.** Seventy-eight percent of children in CHIP were appropriately treated for an upper respiratory infection, and not prescribed an antibiotic, compared to 86 percent of children in Medicaid Managed Care Plans reporting to the NCQA on this measure.

**CHIP MCOs.** The rates of appropriate testing for pharyngitis ranged across the CHIP MCOs from 71 percent in Cook Children’s, Driscoll, and Superior RSA to 89 percent in Seton. Seton and El Paso First were the only two MCOs to meet or exceed the national Medicaid HEDIS® rate for this measure, at 89 and 86 percent, respectively.

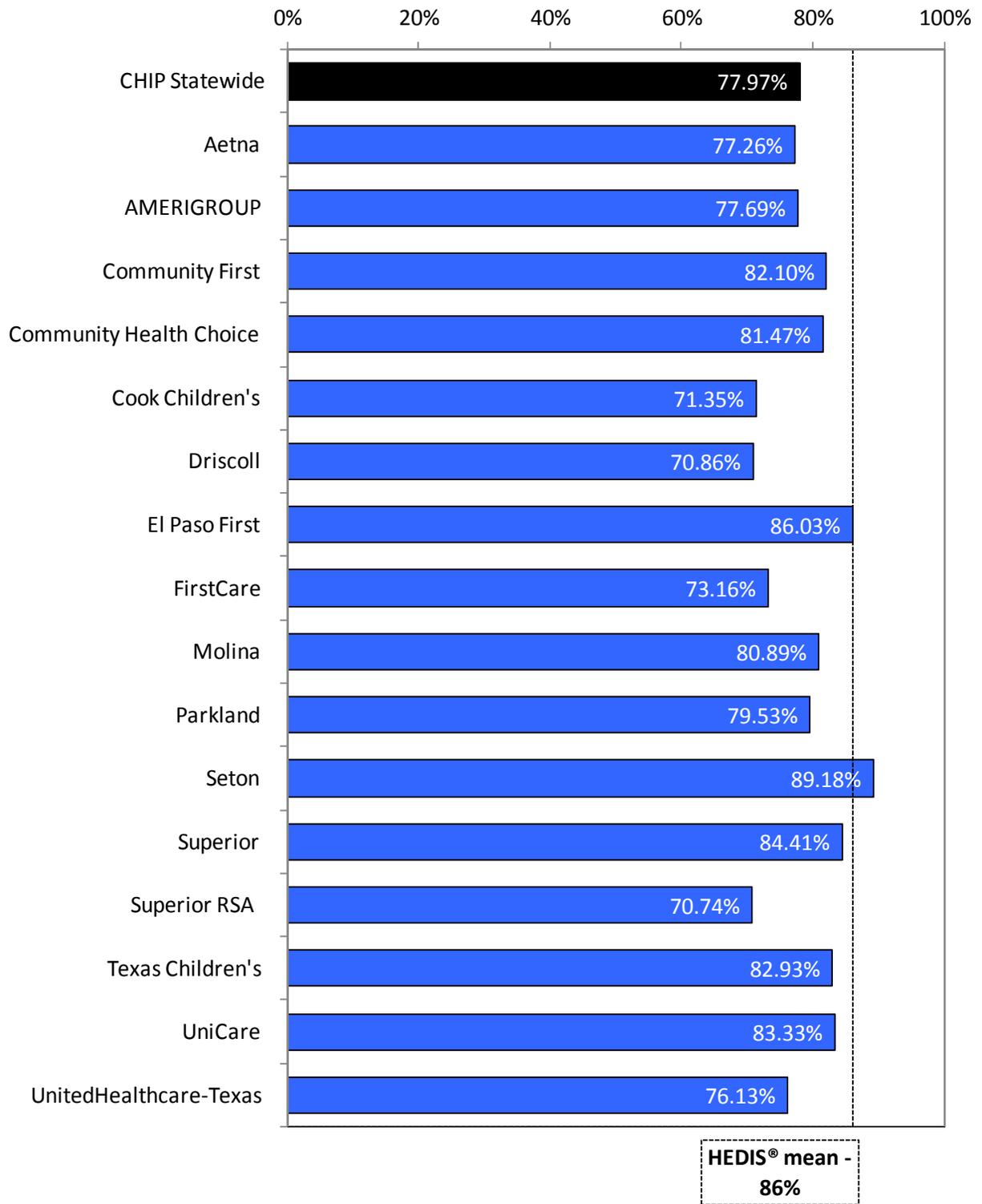
**CHIP Service Areas.** The Travis Service Area had the highest performance on this measure, with 89 percent of children living in this region receiving appropriate treatment for upper respiratory infection.

**Table 9. HEDIS® Appropriate Treatment for Children with Upper Respiratory Infections by CHIP Service Area**

CHIP Service Area	HEDIS® Appropriate Treatment for Children with Upper Respiratory Infections
BEXAR	82.74%
DALLAS	79.49%
EL PASO	86.87%
HARRIS	80.95%
LUBBOCK	76.63%
NUECES	70.12%
SUPERIOR RSA	70.74%
TARRANT	73.60%
TRAVIS	89.10%
WEBB	85.41%

Reference: Table URI

**Figure 22. HEDIS® Appropriate Testing for Children with Upper Respiratory Infection**



Reference: Table URI

## Use of Appropriate Medications for People with Asthma

The HEDIS<sup>®</sup> Use of Appropriate Medications for People with Asthma measure provides the percentage of members who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement period. For the present report, the 2009 HEDIS<sup>®</sup> specifications were used to calculate this measure, rather than the specifications for 2010, which assigned new age cohorts. The age cohorts specified in the 2009 HEDIS<sup>®</sup> specifications – 5 to 9 years old, 10 to 17 years old, and 18 to 56 years old – are still in use on the HHSC Performance Indicator Dashboard. Therefore, these age cohorts were used to permit comparisons with the Dashboard standards.

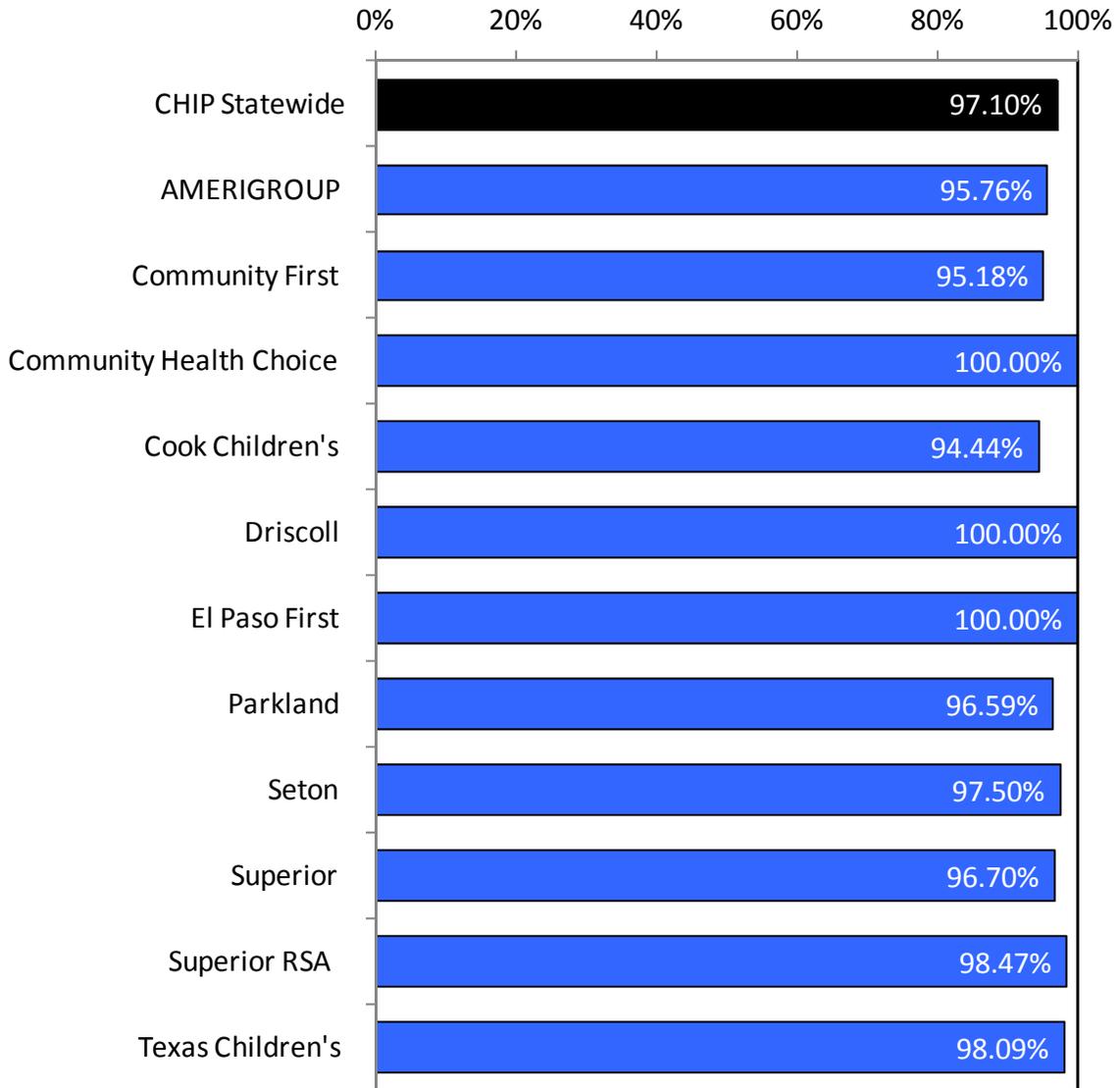
**Figure 23** provides the percentage of CHIP members 5 to 9 years old having appropriately prescribed asthma medication, distributed by MCO. **Figure 24** provides the percentage of CHIP members 10 to 17 years old having appropriately prescribed asthma medication, distributed by MCO. Results are not provided at the MCO level for members in the 18- to 56-year-old cohort due to low denominators. **Table 10** provides results for each age cohort by CHIP Service Area.

**CHIP Statewide.** Ninety-seven percent of CHIP members 5 to 9 years old were appropriately treated for asthma, and 95 percent of members 10 to 17 years old were appropriately treated for asthma.

**CHIP MCOs.** All MCOs provided appropriate asthma care for the vast majority of their memberships, with MCO rates at or above 94 percent for members 5 to 9 years old, and rates at or above 92 percent for members 10 to 17 years old. All MCOs exceeded the HHSC Performance Indicator Dashboard standards for appropriate asthma care for members 10 to 17 years old (57 percent).

**CHIP Service Areas.** Asthma care across the CHIP Service Areas was fairly uniform for children, indicating that the quality of asthma care for children was not affected by the geographic region in which they lived.

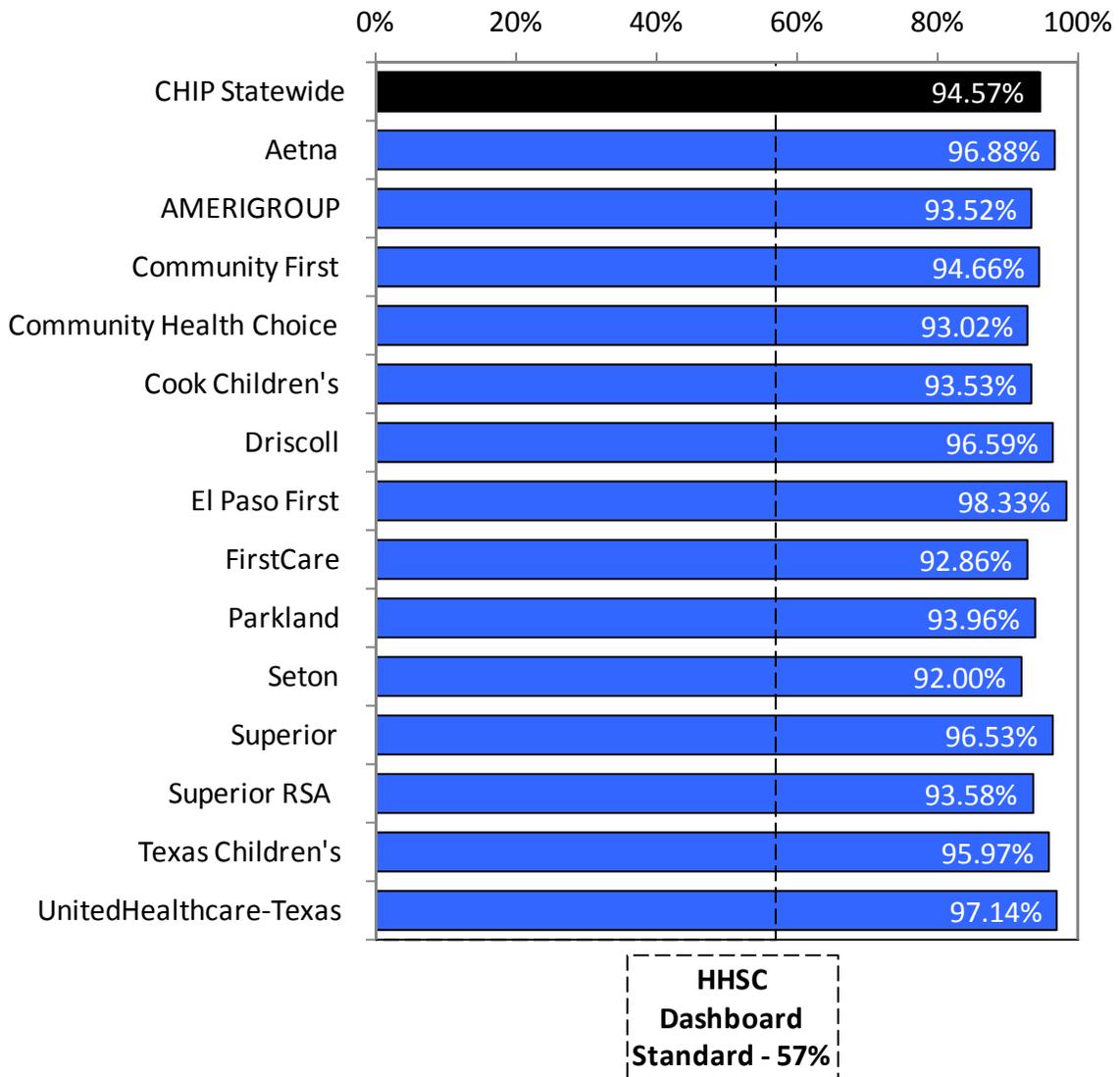
**Figure 23. HEDIS® Use of Appropriate Medications for People with Asthma - CHIP Members 5 to 9 Years Old**



Note. The following MCOs had denominators less than 30 for this measure and were not included in this figure: Aetna, FirstCare, Molina, UniCare, and UnitedHealthcare-Texas.

Reference: Table ASM\_Special

**Figure 24. HEDIS® Use of Appropriate Medications for People with Asthma - CHIP Members 10 to 17 Years Old**



Note. The following MCOs had denominators less than 30 for this measure and were not included in this figure: Aetna, Community Health Choice, Molina, and UniCare.

Reference: Table ASM\_Special

**Table 10. HEDIS® Use of Appropriate Medications for Asthma by CHIP Service Area**

CHIP Service Area	HEDIS® Use of Appropriate Medications for Asthma	
	5 to 9 years old	10 to 17 years old
BEXAR	94.78%	95.80%
DALLAS	95.68%	93.31%
EL PASO	98.00%	97.03%
HARRIS	98.16%	95.97%
LUBBOCK	100.00%	92.71%
NUECES	100.00%	96.67%
SUPERIOR RSA	98.47%	93.58%
TARRANT	94.12%	93.77%
TRAVIS	98.04%	93.88%
WEBB	-	-

Note. Results for the Webb Service Area are not provided due to denominators less than 30.  
Reference: Table ASM\_Special

## ***Women’s Preventive Care and Screenings***

### **Chlamydia Screening**

The HEDIS® Chlamydia Screening measure provides the percentage of female members between 16 and 24 years old who were identified as sexually active and who had at least one test for Chlamydia during the measurement period, distributed by MCO. **Figure 25** shows the percentage of female CHIP members 16 to 20 years old who had a Chlamydia screening. **Table 11** presents the rates for this measure, distributed by CHIP Service Area.

**CHIP Statewide.** Thirty percent of women in CHIP 16 to 20 years old had a Chlamydia test during the measurement period, which is considerably lower than the national HEDIS® mean of 54 percent (below the 10<sup>th</sup> percentile nationally).

**CHIP MCOs.** Across CHIP MCOs, rates of Chlamydia screening for women 16 to 20 years old ranged from 17 percent in FirstCare to 42 percent in Seton. All the MCOs performed lower than the HEDIS® mean for this age group.

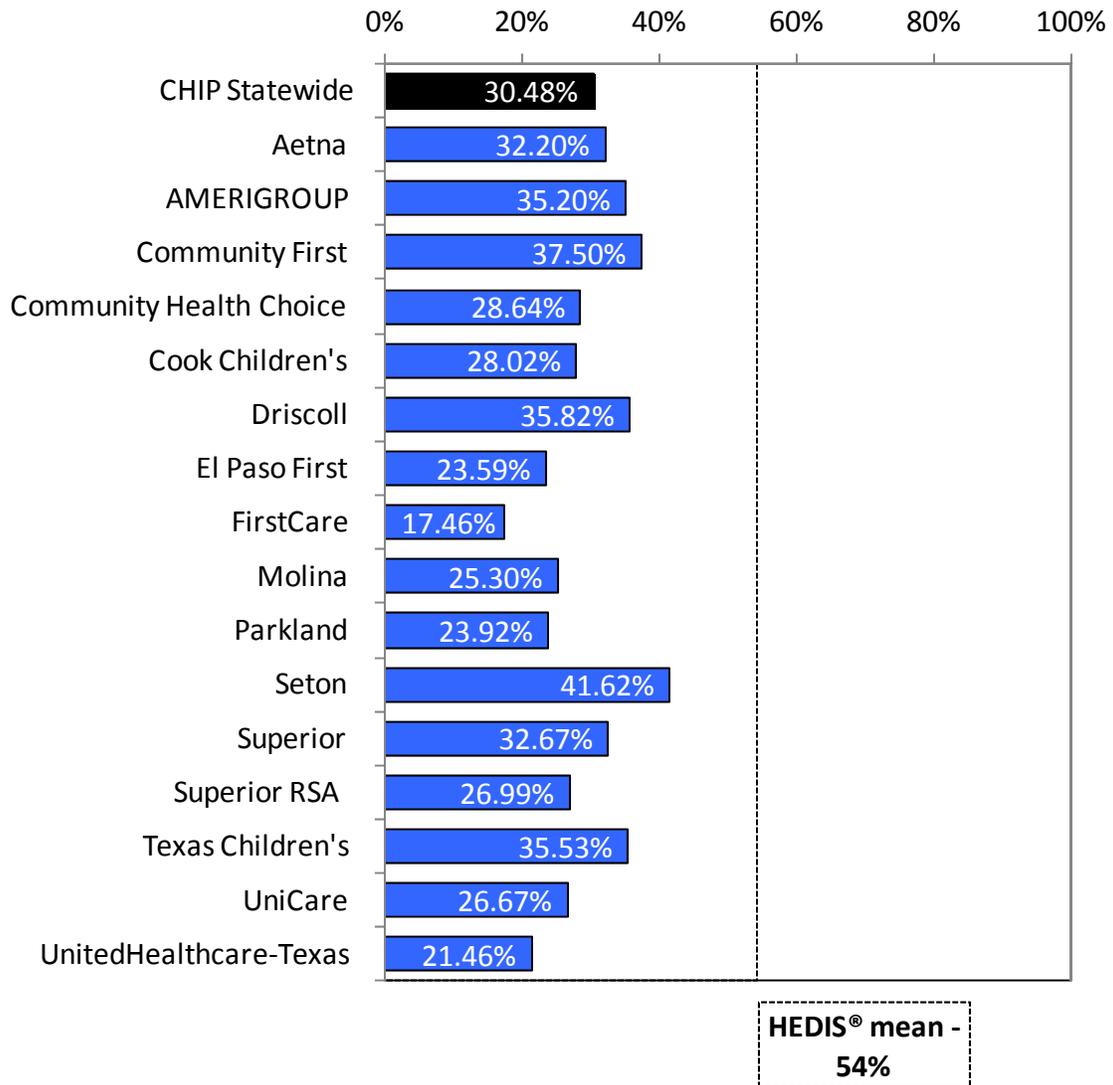
**CHIP Service Areas.** Rates of Chlamydia screening for women 16 to 20 years old ranged from 22 percent in Webb to 40 percent in Travis.

**Table 11. HEDIS® Chlamydia Screening by CHIP Service Area**

<b>CHIP Service Area</b>	<b>HEDIS® Chlamydia Screening Members 16 - 20 years old</b>
BEXAR	35.33%
DALLAS	28.79%
EL PASO	26.98%
HARRIS	32.03%
LUBBOCK	23.14%
NUECES	37.11%
SUPERIOR RSA	26.99%
TARRANT	30.15%
TRAVIS	39.77%
WEBB	22.41%

Reference: Table CHL

**Figure 25. HEDIS® Chlamydia Screening in Women – 16 to 20 Years Old**



Reference: Table CHL

## **Behavioral Health Care**

### **ADHD Follow-up Care for Children**

The Follow-Up Care for Children Prescribed ADHD Medication measure provides the percentage of children 6 to 12 years of age and newly diagnosed with ADHD, who received follow-up care during the measurement period. Two separate rates are usually reported: 1) The *Initiation Phase* is the percentage of children with an ambulatory prescription dispensed for ADHD medication who had a follow-up visit with a provider within 30 days after beginning medication treatment; and 2) The *Continuation and Maintenance Phase* is the percentage of children with an ambulatory prescription dispensed for ADHD medication who continued taking the medication for at least 210 days (30 weeks), and who had at least two follow-up visits with the provider within nine months after the initiation phase ended.

Rates for the long-term medication management of ADHD (*Continuation and Maintenance Phase*) are not provided due to low denominators (less than 30) across the CHIP health plans.

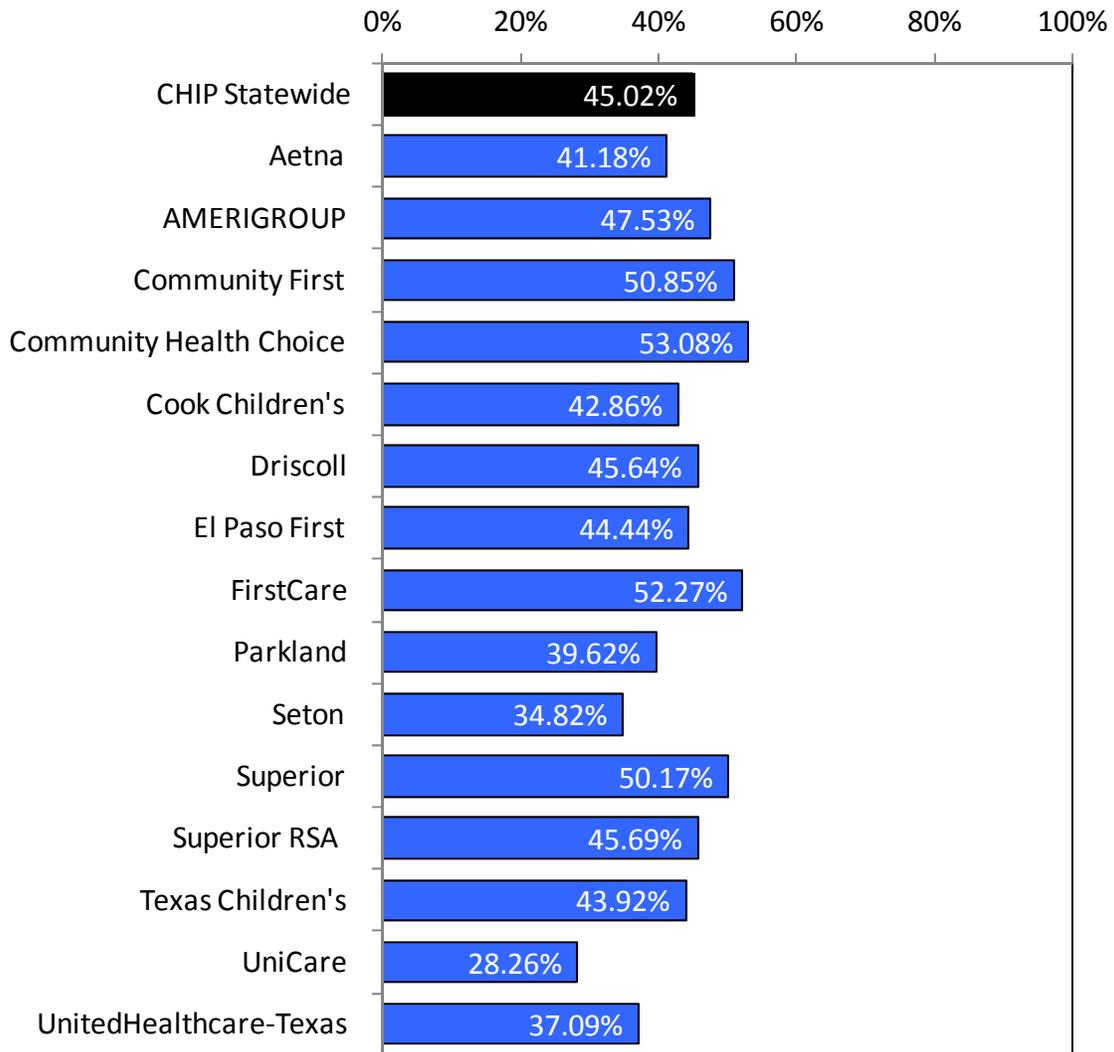
**Figure 26** shows only results for the *Initiation Phase* of ADHD treatment, distributed by CHIP MCO. **Table 12** provides the results of the *Initiation Phase*, distributed by CHIP Service Area.

**CHIP Statewide.** Less than half of children had an initial follow-up visit with a provider within 30 days of beginning an ADHD medication (45 percent). However, this rate is above the HEDIS<sup>®</sup> mean of 37 percent for this measure.

**CHIP MCOs.** Follow-up care for ADHD varied across the CHIP MCOs (by as much as 25 percentage points), ranging from 28 percent in UniCare to 53 percent in Community Health Choice. All MCOs performed at or above the HEDIS<sup>®</sup> mean for this measure, with the exception of Seton and UniCare.

**CHIP Service Areas.** The Bexar Service Area had the highest percentage of children receiving follow-up care for ADHD during the Initiation Phase of treatment (53 percent), and the Travis Service Area the lowest (36 percent).

**Figure 26. The Percentage of Children Prescribed ADHD Medication Receiving Follow-up Care**



Note. Molina had a denominator less than 30 for this measure and was not included in this figure.

Reference: Table ADD

**Table 12. Follow-up Care for Children Prescribed ADHD Medication by CHIP Service Area**

<b>CHIP Service Area</b>	<b>The Initiation Phase of ADHD Medication</b>
BEXAR	52.60%
DALLAS	41.27%
EL PASO	47.77%
HARRIS	43.93%
LUBBOCK	46.99%
NUECES	47.16%
SUPERIOR RSA	45.69%
TARRANT	45.00%
TRAVIS	35.63%
WEBB	46.81%

Reference: Table ADD

### **Follow-up Care after Hospitalization for Mental Illness**

**Figure 27** provides the percentage of CHIP members six years of age or older who were hospitalized for mental illness and who had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a provider during the measurement period, distributed by MCO. Two percentages are shown – one for follow-up within seven days of discharge, and one for follow-up within 30 days of discharge. **Table 13** provides results for this measure, distributed by CHIP Service Area. There were 1,464 CHIP members eligible for this measure.

**CHIP Statewide.** Less than half of CHIP members hospitalized for mental illness (45 percent) had a follow-up visit with a provider within 7 days of discharge from the hospital. However, a majority of these members (74 percent) had a follow-up visit with a provider within 30 days of discharge from the hospital.

**CHIP MCOs.** All CHIP MCOs met the HHSC Performance Dashboard standards of 32 percent for 7-day follow-up (except for Aetna and Seton) and 52 percent for 30-day follow-up. The MCOs with the highest percentage of members receiving follow-up care in the 7-day and 30-day periods after hospitalization for mental illness were:

- Driscoll (77 percent and 95 percent)
- Texas Children’s (59 percent and 84 percent)
- Community First (58 percent and 82 percent)

**CHIP Service Areas.** Members living in the Nueces Service Area had the highest percentage of follow-up care with a provider within 7 days and within 30 days after hospitalization for mental

illness (70 and 89 percent). It should be noted that 46 members were eligible for this measure in the Nueces Service Area. Among larger CHIP Service Areas, members residing in Harris had the highest percentage of follow-up care at the 7-day and 30-day periods (55 and 79 percent).

The Travis Service Area had the lowest rate of post-discharge follow-up care within 7 days (29 percent), and the Dallas Service had the lowest rate of post-discharge follow-up care with 30 days (59 percent).

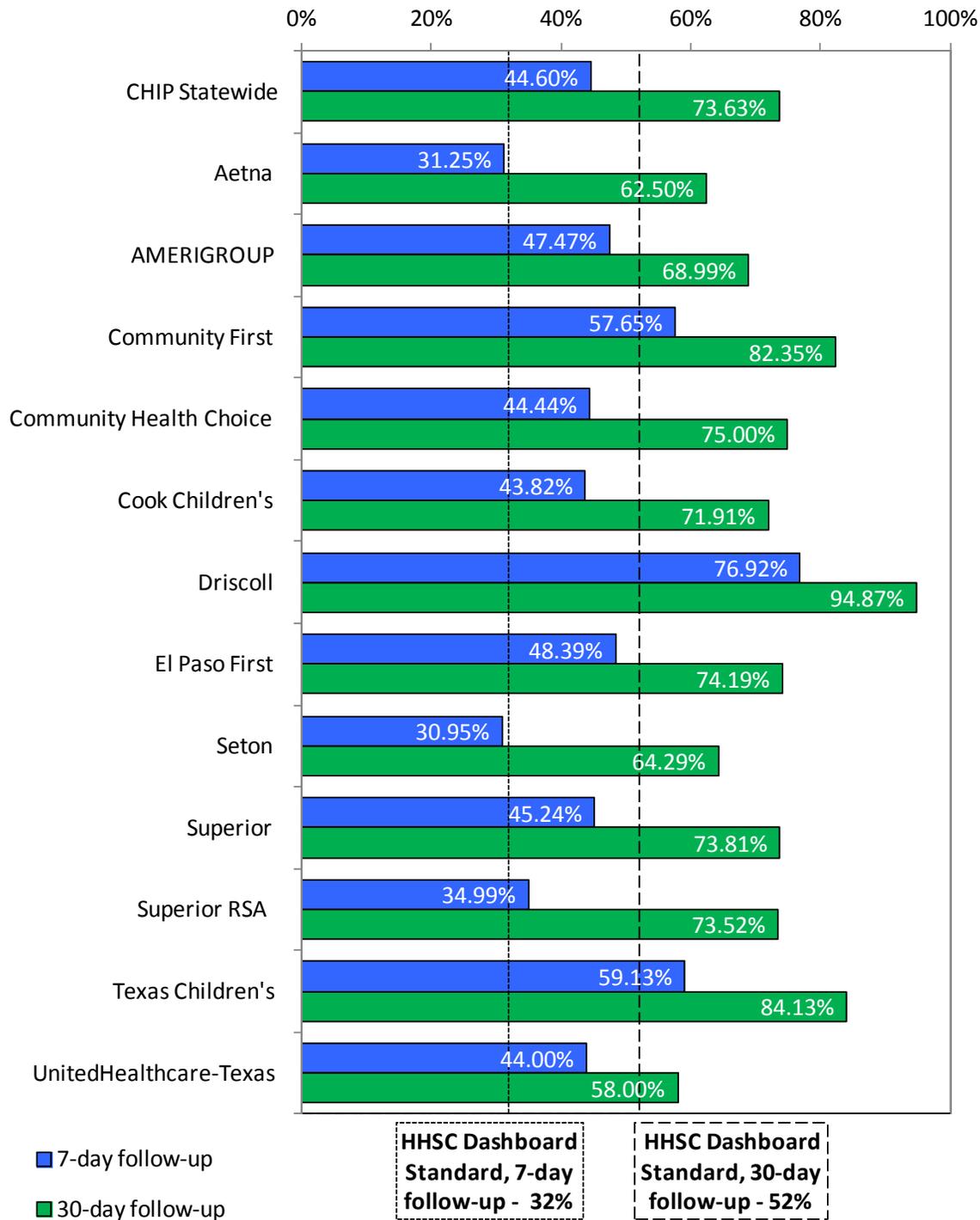
**Table 13. Follow-up Care within 7 and 30 Days after Hospitalization for Mental Illness by CHIP Service Area**

CHIP Service Area	7-Day Follow-up	30-Day Follow-up
BEXAR	52.11%	77.46%
DALLAS	40.59%	59.41%
EL PASO	54.72%	73.58%
HARRIS	54.60%	78.64%
LUBBOCK	46.67%	86.67%
NUECES	69.57%	89.13%
SUPERIOR RSA	34.99%	73.52%
TARRANT	44.49%	72.24%
TRAVIS	28.79%	63.64%
WEBB	-	-

Note. The Webb SA group had a denominator less than 30 for this measure; therefore its results were not included in this table.

Reference: Table FUH

**Figure 27. The Percentage of CHIP Members Receiving Follow-up Care within 7 and 30 Days after Hospitalization for Mental Illness**



Note. The following MCOs had denominators less than 30 for this measure and were not included in this figure: FirstCare, Parkland, and UniCare.

Reference: Table FUH

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

The Readmission within 30 Days after an Inpatient Stay for Mental Health measure provides the percentage of members who were readmitted within 30 days following an inpatient stay for a mental health disorder. Mental health readmissions are frequently used as a measure of an adverse outcome, which potentially results from efforts to contain behavioral health care costs, such as reducing the initial length of stay.<sup>12</sup> For this measure, low rates of readmission indicate good performance.

**Figure 28** provides the percentage of CHIP members 0 to 19 years old who were readmitted within 30 days following an inpatient stay for a mental health disorder, distributed by MCO.

**Table 14** provides the results for this measure, distributed by CHIP Service Area.

**CHIP Statewide.** The mental health readmission rate in CHIP was eight percent.

**CHIP MCOs.** The percentage of members readmitted within 30 days following an inpatient stay for mental health problems ranged from 2 percent in Seton to 13 percent in Superior. Readmission rates were not reported for the following six CHIP MCOs that had denominators less than 30: Aetna, FirstCare, Molina, Parkland, and UniCare.

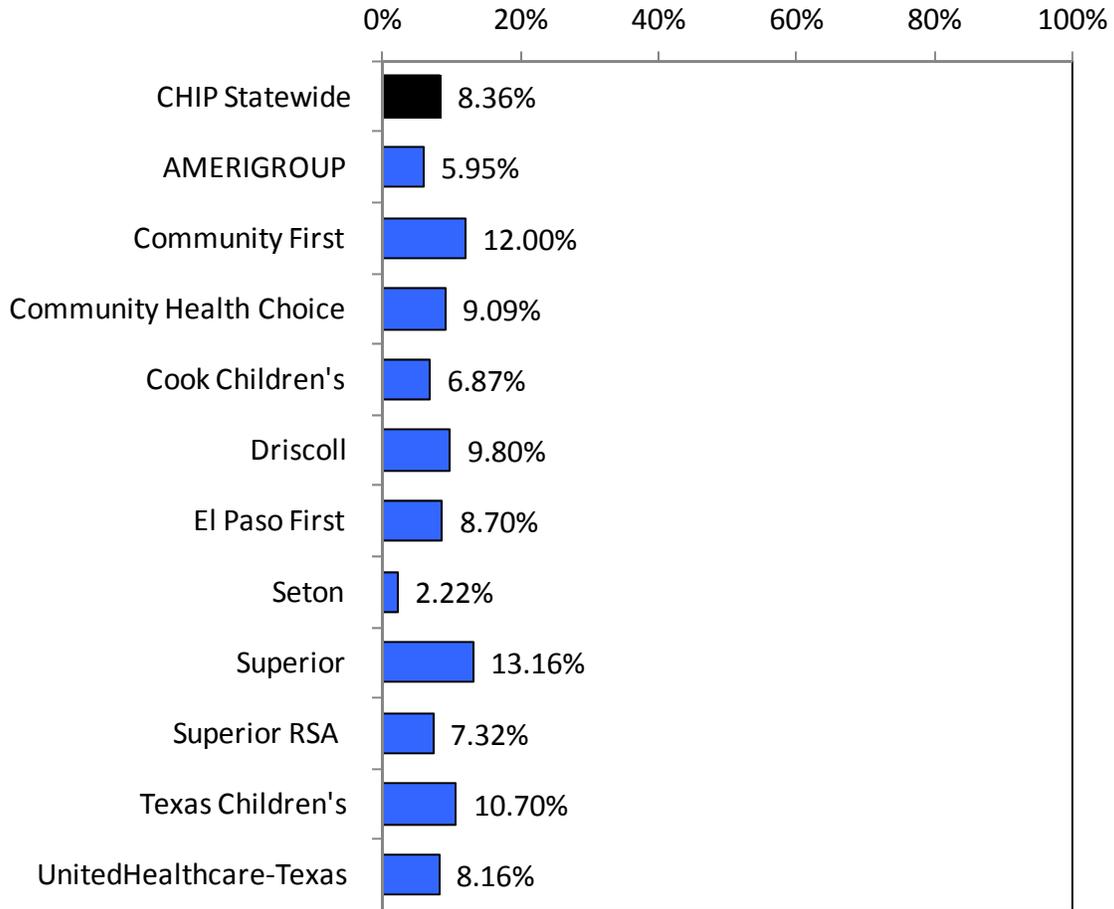
**CHIP Service Areas.** Mental health readmission rates ranged from 3 percent in the Travis Service Area to 13 percent in the El Paso and Lubbock Service Areas.

**Table 14. Readmission within 30 Days by CHIP Service Area**

CHIP Service Area	Readmission within 30 days
BEXAR	12.66%
DALLAS	3.70%
EL PASO	13.33%
HARRIS	9.19%
LUBBOCK	12.82%
NUECES	8.93%
SUPERIOR RSA	7.32%
TARRANT	8.56%
TRAVIS	2.78%
WEBB	-

Note. The Webb Service Area had a denominator less than 30.  
Reference: Table MHReadmit\_V2

**Figure 28. The Percentage of CHIP Members (0 to 18 Years Old) Readmitted to the Hospital within 30 Days after an Inpatient Stay for Mental Health**



Note. The following MCOs had denominators less than 30 for this measure and were not included in this figure: Aetna, FirstCare, Molina, Parkland, and UniCare.

Reference: Table MHReadmit\_V2

## Appendix A: Detailed Methodology

Three data sources were used to calculate the quality of care indicators: (1) member-level enrollment information, (2) member-level health care claims/encounter data, and (3) member-level pharmacy data. The enrollment files contain information about the person's age, gender, the MCO in which the member is enrolled, and the number of months the member has been enrolled in the program. The member-level claims/encounter data contain Current Procedural Terminology (CPT) codes, International Classification of Diseases, 9th Revision (ICD-9-CM) codes, place of service (POS) codes, and other information necessary to calculate the quality of care indicators. The member-level pharmacy data contain information about filled prescriptions, including the drug name, dose, date filled, number of days prescribed, and refill information.

A six-month time lag was used for the claims and encounter data. Prior analyses with Texas data showed that, on average, over 96 percent of claims and encounters are complete by that time period.

Information regarding the calculation of all measures included in this report can be found in the document "Quality of Care Measures Technical Specifications Report, July 2011."<sup>13</sup> This document, prepared by the Institute for Child Health Policy, provides specifications for HEDIS<sup>®</sup> and other quality of care measures.

Quality of care indicators in this report include: 1) HEDIS<sup>®</sup> 2010 measures; 2) The Agency for Healthcare Research and Quality (AHRQ), Pediatric Quality Indicators (PQIs); and 3) measures developed by ICHP.

Rates for HEDIS<sup>®</sup> measures were calculated using National Committee for Quality Assurance (NCQA) certified software. In addition, an NCQA-certified auditor reviewed all of the results and provided letters of certification to the Institute for Child Health Policy. These letters and an official letter from NCQA providing their seal for the results are available from the Texas Health and Human Services Commission (HHSC).

Results for the HEDIS<sup>®</sup> measures for which the specifications were strictly followed are compared to other Medicaid programs. NCQA gathers and compiles data from Medicaid managed care plans nationally.<sup>14</sup> Submission of HEDIS<sup>®</sup> data to NCQA is a voluntary process; therefore, health plans that submit HEDIS<sup>®</sup> data are not fully representative of the industry. Health plans participating in NCQA HEDIS<sup>®</sup> reporting tend to be older, are more likely to be federally qualified, and are more likely to be affiliated with a national managed care company than the overall population of health plans in the United States.<sup>15</sup> NCQA reports the national results as a mean and at the 10<sup>th</sup>, 25<sup>th</sup>, 50<sup>th</sup>, 75<sup>th</sup>, and 90<sup>th</sup> percentiles. The Medicaid Managed

Care Plans 2010 mean results are shown and labeled “HEDIS® Mean” in the figures (except for measure for which provider constraints have been lifted).

At the request of the HHSC, the EQRO developed a methodology to allow for flexibility in the provider specialty codes when determining eligibility for HEDIS® measures. As in the prior reporting period (fiscal year 2009), ICHP modified the NCQA specifications to lift provider constraints when determining eligibility for HEDIS® measures. Provider specialty codes are an important component for some HEDIS® measures and lifting the provider constraints may result in some rate inflation for these measures. For example, NCQA specifications require that a mental health provider be the provider of record for a beneficiary to be considered compliant with the HEDIS® measures for 7-day and 30-day follow-up after an inpatient mental health stay. The current methodology allows a visit with any provider to count toward compliance with the mental health follow-up measures.

The following measures rely on specific provider specialty codes, and are therefore affected by this change in methodology:

- Children and Adolescents’ Access to Primary Care Providers
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visits
- Follow-up Care for Children Prescribed ADHD Medication
- Follow-up After Hospitalization for Mental Illness

For these measures, the name HEDIS® has been removed from the titles as these measures do not adhere precisely to NCQA specifications, and likely inflate the results.

Pediatric Quality Indicators (PDIs) developed by the AHRQ were used to evaluate the performance of CHIP related to inpatient admissions for ambulatory care sensitive conditions (ACSCs). The AHRQ considers ACSCs “conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.”<sup>16</sup> The specifications used to calculate rates for these measures come from AHRQ’s PDI version 4.2. Rates were calculated based on the number of hospital discharges divided by the number of people in the area (except for appendicitis and low birth weight). Unlike most other measures provided in this chart book, low quality indicator rates are desired as they suggest a better quality health care system outside the hospital setting.

Pediatric admissions for the following ACSCs were assessed: (1) Asthma; (2) Diabetes Short-Term Complications; (3) Gastroenteritis; (4) Perforated Appendix; and (5) Urinary Tract Infection. The age eligibility for these measures is up to age 17.

In addition to the narrative and figures contained in this report, technical appendices were provided to HHSC that contain all of the data to support key findings.<sup>17</sup> The interested reader can review those for more details. The corresponding reference table is listed beneath each figure.

## Appendix B: AHRQ Pediatric Quality Indicators

**Table B1. AHRQ Pediatric Quality Indicators**

<b>AHRQ Indicator Number</b>	<b>Indicator Name</b>	<b>Description</b>
PDI 14	Asthma Admission Rate	Number of admissions for long-term asthma per 100,000 population
PDI 15	Diabetes Short-term Complications Admission Rate	Number of admissions for diabetes short-term complications per 100,000 population
PDI 16	Gastroenteritis Admission Rate	Number of admissions for pediatric gastroenteritis per 100,000 population
PDI 17	Perforated Appendix Admission Rate	Number of admissions for perforated appendix as a share of all admissions for appendicitis within an area
PDI 18	Urinary Tract Infection Admission Rate	Number of admissions for urinary tract infection per 100,000 population

## Endnotes

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<sup>1</sup> ICHP (The Institute for Child Health Policy). 2011.<sup>a</sup> *Quality of Care Measures Technical Specifications Report, July 2011*. Gainesville, FL: The Institute for Child Health Policy, University of Florida.

<sup>2</sup> The information that NCQA compiles for Medicaid Managed Care Programs can be viewed at [www.ncqa.org](http://www.ncqa.org).

<sup>3</sup> AHRQ (Agency for Healthcare Research and Quality). 2004. *AHRQ Quality Indicators—Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions*. Rockville, MD: AHRQ. Revision 4. (November 24, 2004). AHRQ Pub. No. 02-R0203.

<sup>4</sup> Briel, M. 2010. “Interactive booklet reduces antibiotic prescribing for respiratory tract infections in children, but not parent satisfaction.” *Evidence Based Nursing* 13(1): 11-12.

<sup>5</sup> Francis, N.A., C.C. Butler, K. Hood, S. Simpson, F. Wood, and J. Nuttall. 2009. “Effect of using an interactive booklet about childhood respiratory tract infections in primary care consultations on reconsulting and antibiotic prescribing: A cluster randomized controlled trial.” *British Medical Journal* 339: b2885.

<sup>6</sup> Pourat, N., G. F. Kominiski, J. Nihalani, R. Neiman, and G. Bolan. 2011. “The role of Medicaid Managed Care interventions in Chlamydia screening by physicians.” *Sexually Transmitted Diseases* 38(4): 288-292.

<sup>7</sup> NCQA (National Committee for Quality Assurance). 2007. *Improving Chlamydia Screening: Strategies from Top Performing Health Plans*. Available at <http://www.ncqa.org/tabid/385/Default.aspx>.

<sup>8</sup> NCQA, 2007.

<sup>9</sup> Centers for Disease Control and Prevention (CDC). 2010. *Sexually Transmitted Disease Treatment Guidelines*. Morbidity and Mortality Weekly Report. Available at <http://www.cdc.gov/std/treatment/2010/STD-Treatment-2010-RR5912.pdf>.

<sup>10</sup> U.S. Department of Health and Human Services Office on Women’s Health. 2011. *Chlamydia Fact Sheet*. Available at <http://www.womenshealth.gov/publications/our-publications/fact-sheet/chlamydia.cfm#h>.

<sup>11</sup> AHRQ (Agency for Healthcare Research and Quality). 2011. *AHRQ Quality Indicators—Pediatric Quality Indicator Comparative Data: Based on the 2008 Nationwide Inpatient Sample (NIS), Version 4.3*. Rockville, MD: AHRQ.

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<sup>12</sup> Figueroa, R., J. Harman, and J. Engberg. 2004. "Use of claims data to examine the impact of length of inpatient psychiatric stay on readmission rates." *Psychiatric Services* 55(5): 560-565.

<sup>13</sup> ICHP, 2011.<sup>a</sup>

<sup>14</sup> The information that NCQA compiles for Medicaid Managed Care Programs can be viewed at [www.ncqa.org](http://www.ncqa.org)

<sup>15</sup> Beaulieu, N.D., and A.M. Epstein. 2002. "National Committee on Quality Assurance Health-Plan Accreditation: Predictors, Correlates of Performance, and Market Impact." *Medical Care* 40 (4): 325-337.

<sup>16</sup> AHRQ, 2004.

<sup>17</sup> ICHP. 2011.<sup>b</sup> *Texas Medicaid Managed Care, CHIP, Quality of Care Report, Fiscal Year 2010: Technical Appendix*. Gainesville, FL: The Institute for Child Health Policy, University of Florida.