Annual Chart Book

Fiscal Year 2008

Texas Children's Health Insurance Program (CHIP) Quality of Care Measures

The Institute for Child Health Policy
University of Florida

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

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Table of Contents

Executive Summary

The fiscal year 2008 Annual Quality of Care Report provides the results for measures of the quality of care provided to enrollees in the Children's Health Insurance Program (CHIP) in fiscal year 2008.[1] The report compares the fiscal year 2008 results for each CHIP measure to the fiscal year 2008 national Healthcare Effectiveness Data and Information Set (HEDIS®) average, Texas Health and Human Services Commission (HHSC) Performance Indicator Dashboard standard (PIDS), and/or national Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicator (PDI). It also compares the fiscal year 2008 CHIP measure results to the fiscal year 2007 CHIP measure results. Results are presented by managed care organization (MCO) and service delivery area (SDA). For more detailed information on CHIP's performance on each measure, please see Attachment C

Areas in which Performance was above Standards

Overall, the CHIP program reported positive results in areas such as: children and adolescents' access to primary care practitioners and use of appropriate medications for people with asthma. Specifically, the CHIP performed better than the national HEDIS® average, the HHSC PIDS, and/or the national AHRQ PDIs in the following areas:

Performance above National HEDIS® Average

- Follow-up after hospitalization for mental illness within 30 days (71 percent vs. 61 percent).[2]
- Children and adolescents' access to primary care practitioners (89 percent vs. 84 percent).[3]
- Average cost of prescriptions per member per month ($24.06 vs. $37.80).[4]
- Average number of prescriptions per member per year (4.38 vs. 10.30).[5]
- Use of appropriate medications for people with asthma (95 percent vs. 87 percent).[6]

Performance above HHSC PIDS

- Well child visits in the 3rd- 6th years of life (59 percent vs. 56 percent).[7]

[1] The CHIP Perinatal Program is not included in this report.
[2] The Texas CHIP results are slightly inflated because the criteria used to determine the Texas CHIP measure include visits to any physician, while the HEDIS measure criteria include only visits to mental health providers.
[3] The Texas CHIP results are slightly inflated because the criteria used to determine the Texas CHIP measure include visits to any physician, while the HEDIS measure criteria include only visits to primary care practitioners.
[4] The criteria used to determine the Texas CHIP measure differ from the HEDIS criteria in that the HEDIS criteria include adults.
[5] Ibid.
[6] Ibid.

- Adolescent well-care visits (39 percent vs. 38 percent).[8]
- Follow-up after hospitalization for mental illness within 7 days (40 percent vs. 32 percent).[9]
- Follow-up after hospitalization for mental illness within 30 days (71 percent vs. 52 percent).[10]

Performance above National AHRQ PDIs

- Inpatient admission rates for:
  a. Asthma (88 per 100,000 vs. 181 per 100,000).
  b. Diabetes short term complications (24 per 100,000 vs. 29 per 100,000).
  c. Gastroenteritis (42 per 100,000 vs. 183 per 100,000).
  d. Urinary tract infections (26 per 100,000 vs. 53 per 100,000).

Areas in which Performance Improved from Fiscal Year 2007 to Fiscal Year 2008

CHIP reported considerable improvement from fiscal year 2007 to fiscal year 2008 in several key indicators:

- Readmission after inpatient stays for mental health (36 percent decreased to 19 percent).
- Inpatient admission rates for:
  a. Asthma (95 per 100,000 decreased to 88 per 100,000).
  b. Diabetes short term complications (30 per 100,000 decreased to 24 per 100,000).

Areas in which Performance was below Standards

While comparatively high performance or noticeable improvement was achieved for many measures, there were several areas where improvement could be made, such as: well-child and well-adolescent visits, appropriate testing for children with pharyngitis, and percent of emergency department visits with a primary diagnosis of an ambulatory care sensitive condition (ACSC). Specifically, reported performance for some measures is less than desired when compared to the national HEDIS® average, the HHSC PIDS, and the national AHRQ PDI:

Performance below National HEDIS® Average

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[7] The Texas CHIP results are slightly inflated because the criteria used to determine the Texas CHIP measure include visits to any physician, while the HEDIS measure criteria include only visits to primary care practitioners.
[8] Ibid.
[9] The Texas CHIP results are slightly inflated because the criteria used to determine the Texas CHIP measure include visits to any physician, while the HEDIS measure criteria include only visits to mental health providers.
[10] Ibid.

- Well child visits in the 3rd- 6th years of life (59 percent vs. 65 percent).[11]
- Adolescent well-care visits (39 percent vs. 42 percent).[12]
- Follow-up after hospitalization for mental illness within 7 days (40 percent vs. 43 percent).[13]
- Appropriate testing for children with pharyngitis (53 percent vs. 58 percent).

Performance below HHSC PIDS

- Percent of emergency department visits with a primary diagnosis of an ACSC (29 percent vs. 24 percent).

Areas in which Performance Decreased from Fiscal Year 2007 to Fiscal Year 2008

When comparing results from fiscal year 2007 to fiscal year 2008, CHIP also reported a slight decrease in performance in some key indicators:

- Well-child visits in the 3rd- 6th years of life (61 percent decreased to 59 percent).
- Children and adolescents' access to primary care (92 percent decreased to 89 percent).
- Percent of emergency department visits with a primary diagnosis of an ACSC (28 percent increased to 29 percent).
- Inpatient admission rates for:
  - Gastroenteritis (38 per 100,000 increased to 42 per 100,000).
  - Urinary tract infections (24 per 100,000 increased to 26 per 100,000).

MCO/SDA performance below HHSC PIDS

In addition to the previously mentioned improvement areas, MCO/SDAs also performed below the HHSC PIDSs in the following areas:

- Well child visits in the 3rd- 6th years of life (8 of the 24 MCO/SDAs underperformed).
- Adolescent well-care visits (13 of the 25 MCO/SDAs underperformed).
- Percent of emergency department visits with a primary diagnosis of an ACSC (24 of the 25 MCO/SDAs underperformed).

[11] The Texas CHIP results are slightly inflated because the criteria used to determine the Texas CHIP measure include visits to any physician, while the HEDIS measure criteria include only visits to primary care practitioners. All claims with pertinent procedure and/or diagnosis codes with any provider are considered to have received a well-child visit.

[12] The Texas CHIP results are slightly inflated because the criteria used to determine the Texas CHIP measure include visits to any physician, while the HEDIS measure criteria include only visits to primary care practitioners or OB/GYNs. All claims with pertinent procedure and/or diagnosis codes with any provider are considered to have received a well-child visit.

[13] The Texas CHIP results are slightly inflated because the criteria used to determine the Texas CHIP measure include visits to any physician, while the HEDIS measure criteria include only visits to mental health providers.

Internal Improvements

To address areas of less than desired performance noted above, Managed Care Operations has taken the following actions:

- Initiated a review of performance indicator targets for MCO performance measures to determine if the targets reflect current national quality assurance guidelines and are appropriate to the population served in CHIP.
- Established analytical reviews, including trending of performance over time.
- Established a process to share results of analytical reviews with MCOs and document actions taken to improve deficient performance.
- Initiated quarterly performance management meetings with the Institute for Child Health Policy (ICHP), the external quality review organization, and HHSC staff who oversees contracts with MCOs to improve staff understanding and expertise.

External Performance Gap Improvements

Managed Care Operations, assisted by ICHP, is implementing a plan to investigate program, MCO, individual beneficiary, and community factors that may be contributing to low performance in the following areas:

- Well child visits in the 3rd- 6th years of life.
- Adolescent well-care visits.
- Follow-up after hospitalization for mental illness.
- Appropriate testing for children with pharyngitis.
- Percent of emergency visits with a primary diagnosis of an ACSC.

This plan includes the following:

- A review of ways the MCOs can improve the level of resources for increasing children and adolescents' well-care visits.
- A review of education and promotion programs to inform members about the importance of follow-up visits after hospitalization for mental illness.
- A review of outpatient monitoring improvement programs to increase the percentage of children receiving appropriate testing for pharyngitis and reduce the percentage of emergency department visits involving a primary diagnosis of ACSC.

In summary, the report highlights many areas of excellent or satisfactory performance. However, it also points to areas where there are opportunities for improvement. For these areas, Managed Care Operations is establishing a plan to investigate the reasons for less than satisfactory performance and to work with the MCOs to address those factors that will foster better performance in the future.

Introduction

Purpose

This report provides an annual update of the quality of care provided to enrollees in the Children's Health Insurance Program (CHIP) in Texas. (Note: The CHIP Perinate Program is not included in this report.) This update is for September 1, 2007, to August 31, 2008, covering State Fiscal Year (SFY) 2008. Results for the quality of care measures are presented at the individual managed care organization (MCO) and service delivery area (SDA) levels. It should be noted that Superior Exclusive Provider Organization (EPO), which provides services to approximately 170 predominantly rural Texas counties outside the SDAs, is listed as an MCO and included with SDA-level results. When possible, results from Medicaid MCOs participating in the National Committee for Quality Assurance (NCQA) reporting program are presented. Results from CHIP MCOs nationally are not available from NCQA.

Rates for the Healthcare Effectiveness Data and Information Set (HEDIS®) 2009 measures were calculated using National Committee for Quality Assurance (NCQA) certified software. The Health and Human Service Commission (HHSC) approved the use of this software so that all HEDIS® results could be reported using an NCQA-recognized tool. At HHSC's request, the Institute for Child Health Policy (ICHP) developed a methodology to allow for flexibility in the provider specialty codes when determining eligibility for HEDIS® measures. As in the prior reporting period (SFY 2007), 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 seven-day and 30-day follow-up after an inpatient mental health stay. The current methodology allows any visit with a physician provider to count toward compliance with the mental health follow-up measures. The following HEDIS® measures rely on specific provider specialty codes, and are therefore affected by this change in methodology:

- HEDIS® Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- HEDIS® Adolescent Well-Care Visits
- HEDIS® Follow-Up after Hospitalization for Mental Illness
- HEDIS® Children and Adolescents' Access to Primary Care Practitioners

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 the claims and encounters are complete by that time period.

This chart book contains the following indicators:

1) Descriptive Information

   - Total Unduplicated Members
   - Total Unduplicated Members by Race/Ethnicity

2) AHRQ Pediatric Quality Indicators (PDIs)

3) Quality of Care

   - HEDIS® Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
   - HEDIS® Adolescent Well-Care Visits
   - HEDIS® Follow-Up after Hospitalization for Mental Illness
   - Readmission within 30 Days after an Inpatient Stay for Mental Health
   - HEDIS® Appropriate Testing for Children with Pharyngitis
   - HEDIS® Children and Adolescents' Access to Primary Care Practitioners
   - HEDIS® Outpatient Drug Utilization
   - Percent of Emergency Department Visits with a Primary Diagnosis of an Ambulatory Care Sensitive Condition (ACSC)
   - HEDIS® Use of Appropriate Medications for People with Asthma

The charts provide results for the above listed indicators, distributed by MCO and by MCO/SDA group, allowing for comparison of findings across the 17 health plans that serve CHIP.

Data Sources and Measures

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, and refill information.

Information regarding the calculation of all measures included in this report can be found in the document "Quality of Care Measures Technical Report Specifications, October 2009."[1] The Institute for Child Health Policy prepared this document, which provides specifications for HEDIS® and other quality of care measures.

Whenever possible, results from other Medicaid Programs are provided in addition to the overall Texas state mean. NCQA gathers and compiles data from Medicaid managed care plans nationally.[2] Submission of HEDIS® data to NCQA is a voluntary process; therefore, health plans that submit HEDIS® data are not fully representative of the industry. Health plans participating in NCQA HEDIS® 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.[3] NCQA reports the national results as a mean and at the 10th, 25th, 50th, 75th, and 90th percentiles for the participating plans. The Medicaid Managed Care Plans 2008 mean results are shown and labeled "HEDIS® Mean" in the graphs. For certain HEDIS® measures, the national rate includes adults. Therefore, the national results should be viewed with the understanding that the national and CHIP populations are different. For measures which are non-HEDIS® quality of care indicators, the HHSC 2009 Performance Indicator Dashboard Standard is shown.[4] When appropriate, the health plan's performance results in the prior year are provided.

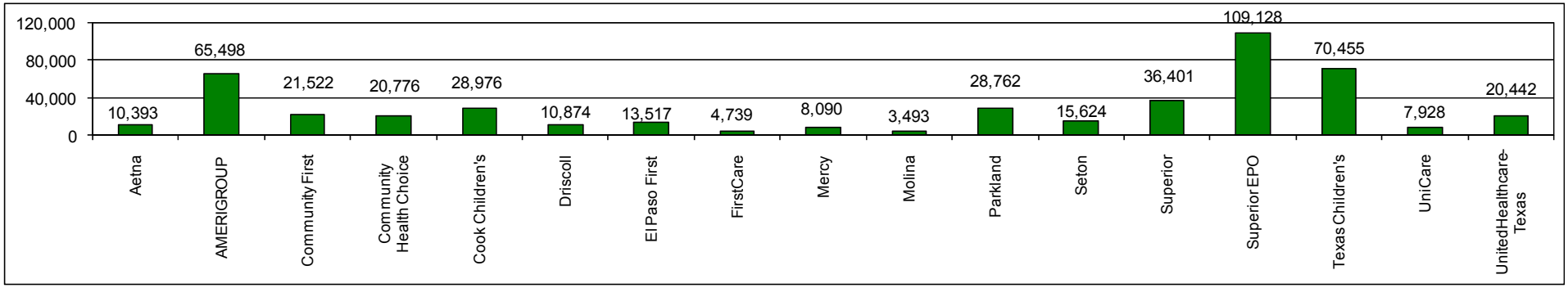
Indicators developed for the Agency for Healthcare Research and Quality (AHRQ) are used to evaluate the performance of CHIP MCOs related to inpatient admissions for various ambulatory care sensitive conditions (ACSCs). The AHRQ considers ACSCs "conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease."[5] The quality indicators use hospital inpatient discharge data and are measured as rates of admission to the hospital. Specifically, one set of indicators was assessed in the present report: Pediatric Quality Indicators (PDIs) for child enrollees. The specifications used to calculate rates for these measures come from the PDI version 3.2.[6] Rates are calculated based on the number of hospital discharges divided by the number of people in the area (except for appendicitis). 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 of the hospital setting.

Pediatric admissions for the following ambulatory care sensitive conditions (ACSCs) are assessed: (1) Asthma; (2) Diabetes Short-term Complications; (3) Gastroenteritis; and (4) Urinary Tract Infection. The age eligibility for these measures is up to age 17. A fifth PDI that provides rates of admissions for perforated appendix – which is normally reported in QOC reports for Texas HHSC – is not assessed in the present report because greater than 90 percent of the rates calculated for perforated appendix had low denominator values.

In addition to the narrative and graphs contained in this chart book, technical appendices are provided to HHSC that contain all of the data to support key findings.[7] As previously noted, many, but not all, of the quality of care indicator results are presented for each MCO. Some results are not displayed for each MCO: (1) to facilitate ease of presentation and understanding of the material; (2) because the findings were similar for each MCO, and/or (3) because the denominator for a measure was less than 30 (low denominator). However, all of the findings are contained in the technical appendices. The interested reader can review those for more details. The corresponding reference table is listed beneath each graph.

Chart 1. Total Unduplicated Members by MCO

CHIP MCOs - August 2008 **CHIP Unduplicated Members = 476,618**



Reference: CHIP Table 1
Note: The eligibility figures used in the chart are for August 2008.

Key Points:

1. Chart 1 presents the total number of unduplicated members enrolled in CHIP, distributed by managed care organization (MCO). In August 2008, there were 476,618 enrollees, which is an increase from SFY 2007 when CHIP had 300,258 enrollees.

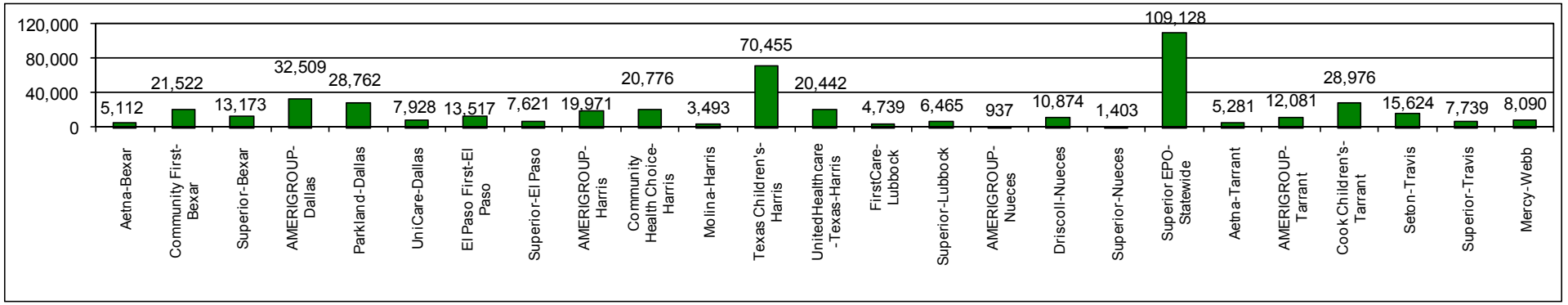
2. The MCO with the largest membership was Superior EPO, comprising 23 percent of all CHIP members. The second and third largest MCOs were Texas Children's at 15 percent and AMERIGROUP at 14 percent. The MCOs with the smallest memberships were Molina (0.73 percent) and FirstCare (0.99 percent), each accounting for less than one percent of all CHIP members.

3. The mean age of CHIP enrollees was 10.06 years old (SD = 4.65).

4. Forty-nine percent of CHIP enrollees were female, and 51 percent were male.

Chart 2. Total Unduplicated Members – SDA Breakout

CHIP MCOs - August 2008 **CHIP Unduplicated Members = 476,618**



SDA	Bexar	Dallas	El Paso	Harris	Lubbock	Nueces	Superior EPO	Tarrant	Travis	Webb
	39,807	69,199	21,138	135,137	11,204	13,214	109,128	46,338	23,363	8,090

Reference: CHIP Table 1
Note: The eligibility figures used in the chart are for August 2008.

Key Points:

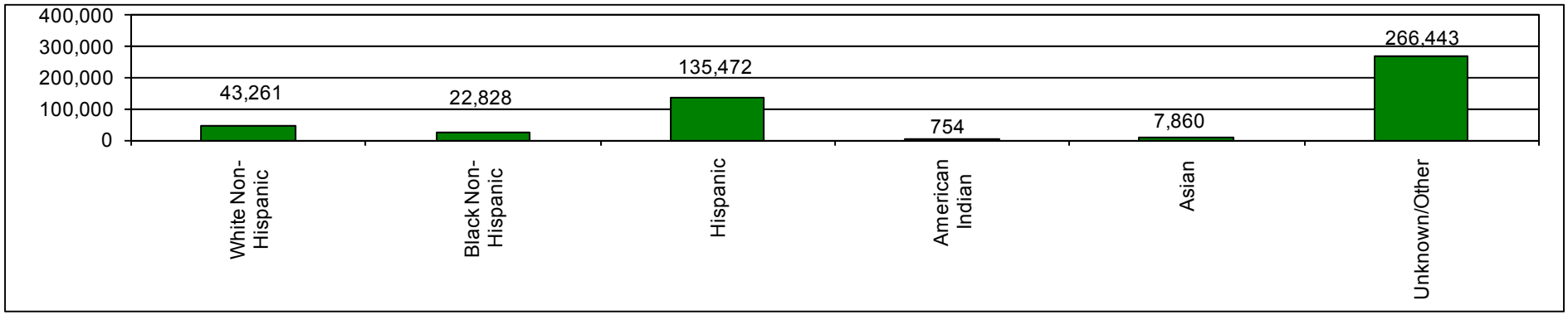
1. Chart 2 presents the distribution of CHIP members by MCO and Service delivery area (SDA). There were 25 CHIP MCO/SDA groups and 9 SDAs in August 2008. The total number of members in the Exclusive Provider Organization (EPO) is included with the SDAs for comparison. Through the EPO, Superior provides services to approximately 170 predominantly rural Texas counties. Twenty-three percent of CHIP members belonged to the EPO.

2. The largest MCO/SDA group, Superior EPO – Statewide comprised 23 percent of all CHIP enrollees. The second and third largest MCO/SDA groups were Texas Children's -Harris and AMERIGROUP – Dallas, comprising 15 percent and 7 percent respectively of all CHIP enrollees.

3. The SDA with the largest membership was Harris with 28 percent of all CHIP enrollees, and served by five health plans: AMERIGROUP, Community Health Choice, Molina, Texas Children's, and UnitedHealthcare. The SDA with the smallest membership was Webb, served exclusively by Mercy, and accounting for 1.7 percent of all CHIP enrollees.

Chart 3. Total Unduplicated Members by Race/Ethnicity

CHIP MCOs - August 2008 **CHIP Unduplicated Members = 476,618**



Reference: CHIP Table 2
Note: The eligibility figures used in the chart are for August 2008.

Key Points:

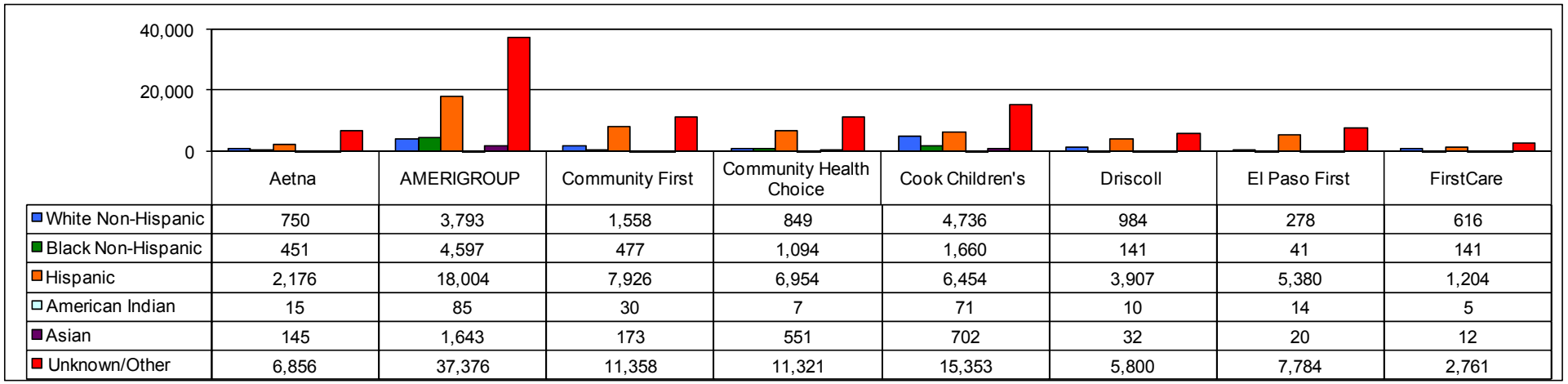
1. Chart 3 presents the racial and ethnic distribution of CHIP enrollees in August 2008. Race/ethnicity was unknown for 56 percent of CHIP enrollees, which is comparable to the 53 percent of CHIP enrollees whose race/ethnicity was unknown in SFY 2007.

2. Among those members whose race/ethnicity was known (N = 210,175), 64 percent were Hispanic, followed by White, non-Hispanic (21 percent), and Black, non-Hispanic (11 percent). Less than five percent of enrollees were Asian (3.7 percent) or American Indian (0.4 percent). Note that percentages are calculated based on the number of enrollees classified by race/ethnicity (N = 210,175) rather than the total number of CHIP enrollees (N = 476,618).

3. The distribution of race/ethnicity in CHIP has remained relatively unchanged since SFY 2007. Furthermore, it should be noted that a majority of CHIP enrollees were not classifiable based on race/ethnicity. Understanding the racial/ethnic composition of CHIP members is critical to addressing potential differences in health care access and quality of care. It is therefore strongly recommended that HHSC make the reporting of racial/ethnic information mandatory in CHIP enrollment files.

Chart 4A. Total Unduplicated Members by Race/Ethnicity and MCO

CHIP MCOs - August 2008 **CHIP Unduplicated Members = 476,618**



	Aetna	AMERIGROUP	Community First	Community Health Choice	Cook Children's	Driscoll	El Paso First	FirstCare
White Non-Hispanic	750	3,793	1,558	849	4,736	984	278	616
Black Non-Hispanic	451	4,597	477	1,094	1,660	141	41	141
Hispanic	2,176	18,004	7,926	6,954	6,454	3,907	5,380	1,204
American Indian	15	85	30	7	71	10	14	5
Asian	145	1,643	173	551	702	32	20	12
Unknown/Other	6,856	37,376	11,358	11,321	15,353	5,800	7,784	2,761

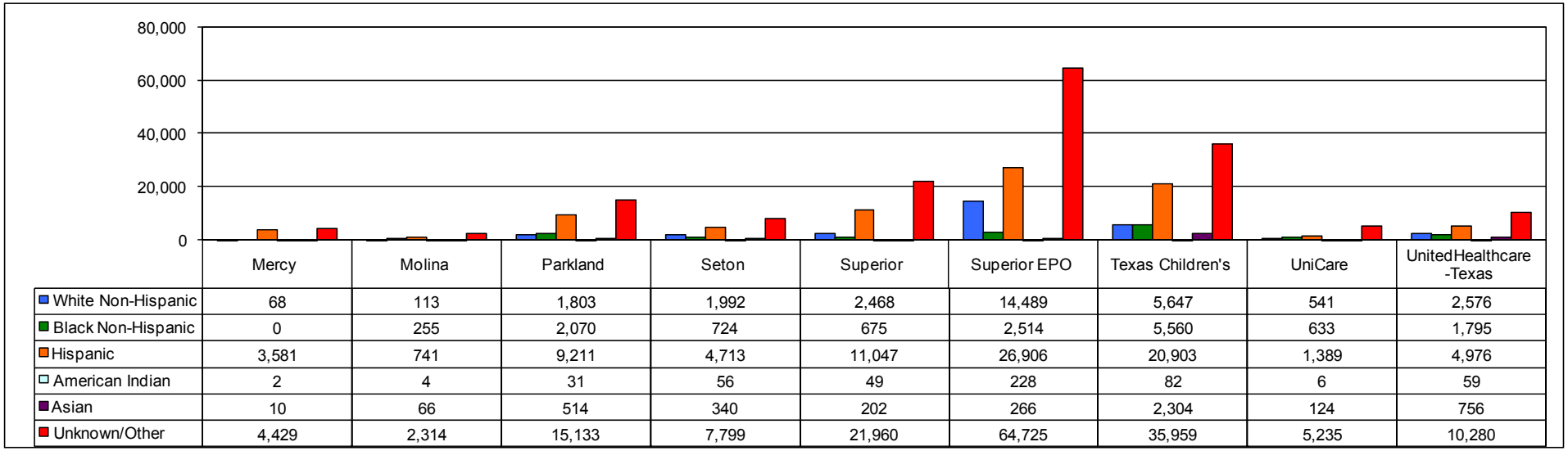
Reference: CHIP Table 2
Note: The eligibility figures used in the chart are for August 2008.

Key Points:

1. Charts 4A and 4B present the distribution of CHIP enrollees by MCO and race/ethnicity in August 2008. Key points for both charts are provided under Chart 4B. Please note that the Y-axis is scaled differently for Charts 4A and 4B, in order to provide a clear, visual representation of the results.

Chart 4B. Total Unduplicated Members by Race/Ethnicity and MCO

CHIP MCOs - August 2008 **CHIP Unduplicated Members = 476,618**



	Mercy	Molina	Parkland	Seton	Superior	Superior EPO	Texas Children's	UniCare	UnitedHealthcare -Texas
White Non-Hispanic	68	113	1,803	1,992	2,468	14,489	5,647	541	2,576
Black Non-Hispanic	0	255	2,070	724	675	2,514	5,560	633	1,795
Hispanic	3,581	741	9,211	4,713	11,047	26,906	20,903	1,389	4,976
American Indian	2	4	31	56	49	228	82	6	59
Asian	10	66	514	340	202	266	2,304	124	756
Unknown/Other	4,429	2,314	15,133	7,799	21,960	64,725	35,959	5,235	10,280

Reference: CHIP Table 2
Note: The eligibility figures used in the chart are for August 2008.

Key Points:

1. Across MCOs, more than half of enrollees were not categorized by race/ethnicity. The unknown/other category is excluded in the following calculations that present the racial/ethnic composition of MCOs.

2. Hispanics comprised the largest percentage of members for each MCO. The percentage of Hispanic members in MCOs ranged from 47 percent in UniCare and Cook Children's to 98 percent in Mercy. MCOs with the largest percentage of Hispanic members in addition to Mercy were El Paso First (94 percent), Community First (78 percent), Driscoll (77 percent), and Superior (76 percent).

3. The MCOs with the largest percentage of White, non-Hispanic members were Cook Children's (35 percent), Superior EPO (33 percent), and FirstCare (31 percent). Mercy had the smallest percentage of White, non-Hispanic members at 2 percent of total members.

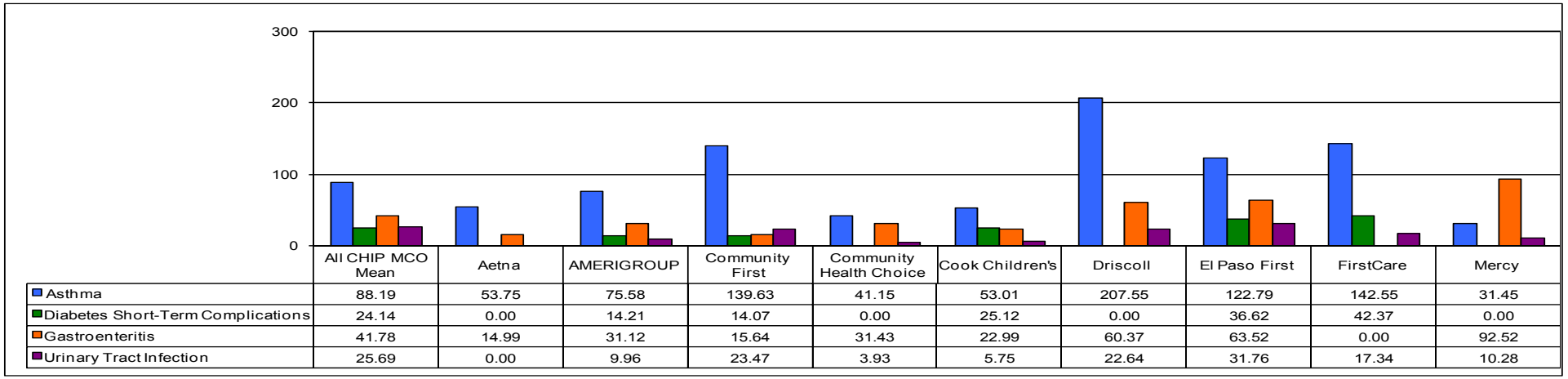
4. The MCOs with the largest percentage of Black, non-Hispanic members were Molina (22 percent), UniCare (21 percent), and UnitedHealthcare – Texas (18 percent). Mercy had no Black, non-Hispanic members.

5. Across the MCOs, Asians comprised less than 8 percent of the total membership. The MCOs with the largest percentage of Asians were UnitedHealthcare – Texas (7 percent), Texas Children's (7 percent), AMERIGROUP (6 percent), Molina (6 percent) and Community Health Choice (6 percent).

6. For all MCOs, American Indians represented less than one percent of total members.

Chart 5A. AHRQ Pediatric Quality Indicators

CHIP Asthma Eligible = 569,215
CHIP Diabetes Eligible = 472,339
CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Universe for All Other Measures = 583,977**



	All CHIP MCO Mean	Aetna	AMERIGROUP	Community First	Community Health Choice	Cook Children's	Driscoll	El Paso First	FirstCare	Mercy
Asthma	88.19	53.75	75.58	139.63	41.15	53.01	207.55	122.79	142.55	31.45
Diabetes Short-Term Complications	24.14	0.00	14.21	14.07	0.00	25.12	0.00	36.62	42.37	0.00
Gastroenteritis	41.78	14.99	31.12	15.64	31.43	22.99	60.37	63.52	0.00	92.52
Urinary Tract Infection	25.69	0.00	9.96	23.47	3.93	5.75	22.64	31.76	17.34	10.28

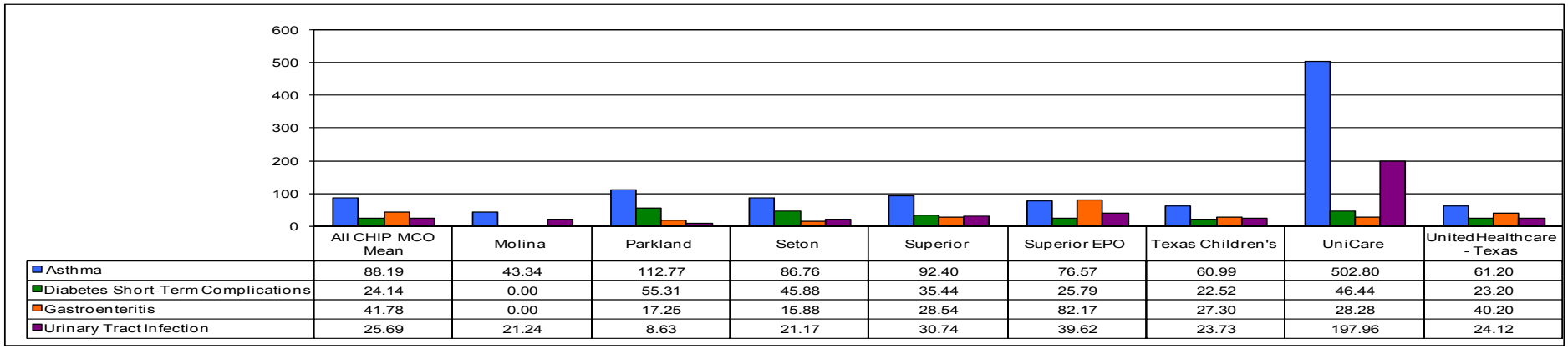
Reference: CHIP Table PDI09
Note: Rates are per 100,000 enrollees except for perforated appendix, which is per 100 admissions. The denominator for perforated appendix was less than 30 in many MCOs; therefore this measure is not reported this year. Eligible members are included in the overall CHIP rates.

Key Points:

1. Chart 5A presents AHRQ Pediatric Quality Indicator (PDIs) results for nine MCOs. The PDI results for the remaining eight MCOs are shown in Chart 5B. Key points for both charts are provided under Chart 5B. Please note that the Y-axis is scaled differently for Charts 5A and 5B in order to provide a clear, visual representation of the results.

Chart 5B. AHRQ Pediatric Quality Indicators

CHIP Asthma Eligible = 569,215
CHIP Diabetes Eligible = 472,339
CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Universe for All Other Measures = 583,977**



	All CHIP MCO Mean	Molina	Parkland	Seton	Superior	Superior EPO	Texas Children's	UniCare	United Healthcare - Texas
Asthma	88.19	43.34	112.77	86.76	92.40	76.57	60.99	502.80	61.20
Diabetes Short-Term Complications	24.14	0.00	55.31	45.88	35.44	25.79	22.52	46.44	23.20
Gastroenteritis	41.78	0.00	17.25	15.88	28.54	82.17	27.30	28.28	40.20
Urinary Tract Infection	25.69	21.24	8.63	21.17	30.74	39.62	23.73	197.96	24.12

Reference: CHIP Table PDI09
Note: Rates are per 100,000 enrollees except for perforated appendix, which is per 100 admissions for appendicitis. The denominator for perforated appendix was less than 30 in many MCOs; therefore this measure is not reported this year. Eligible members are included in the overall CHIP rates.

Key Points:

1. 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 adolescents. PDIs 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.
2. Charts 5A and 5B 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 1** describes each of the four AHRQ PDIs shown here. Discussion of PDIs in the key points below includes comparisons with national rates reported by the AHRQ. It should be noted that these AHRQ national estimates are based on data collected in 2003 and are area-level indicators, including commercial and Medicaid populations.

3. Asthma was the most common ACSC-related inpatient admission among CHIP enrollees. The asthma inpatient admission rate was 88 per 100,000 members in CHIP, which is considerably lower than the national AHRQ rate of 181 per 100,000.
    - Across the CHIP MCOs, rates ranged from 31 per 100,000 in Mercy to 503 per 100,000 in UniCare. All MCOs performed better than the national rate for asthma inpatient admissions except Driscoll (208 per 100,000) and UniCare (503 per 100,000). It should be noted that the rate of inpatient admissions for asthma in UniCare was 2.7 times the national rate, suggesting a need for improved ambulatory care for asthma in this health plan.
4. The diabetes short-term complications inpatient admission rate was 24 per 100,000 members in CHIP, which is lower than the national AHRQ rate of 29 per 100,000.
    - Across the CHIP MCOs, rates ranged from zero per 100,000 in Aetna, Community Health Choice, Driscoll, Mercy, and Molina to 55 per 100,000 in Parkland. The highest rates of inpatient admissions for diabetes short-term complications were in Parkland (55 per 100,000), UniCare (46 per 100,000), Seton (46 per 100,000), and FirstCare (42 per 100,000), suggesting a need to improve ambulatory care for diabetes in these health plans.
5. The gastroenteritis inpatient admission rate was 42 per 100,000 members in CHIP, which is considerably lower than the national AHRQ rate of 183 per 100,000.
    - Across the CHIP MCOs, rates ranged from zero per 100,000 in FirstCare and Molina to 93 per 100,000 in Mercy. All MCOs performed below the national rate of inpatient admissions for gastroenteritis.
6. The urinary tract infection inpatient admission rate was 26 per 100,000 members in CHIP, which is lower than the national AHRQ rate of 53 per 100,000.
    - Across the CHIP MCOs, rates ranged from zero per 100,000 in Aetna to 198 per 100,000 in UniCare. All MCOs performed better than the national rate of inpatient admissions for urinary tract infection except UniCare, suggesting a need to improve ambulatory care for urinary tract infections in this plan specifically.
7. PDI rates for asthma, diabetes short-term complications, gastroenteritis, and urinary tract infections in CHIP changed slightly from SFY 2007 to SFY 2008, and are as follows:
    a. The admission rate for asthma decreased from 95 per 100,000 to 88 per 100,000;
    b. The admission rate for diabetes short-term complications decreased from 30 per 100,000 to 24 per 100,000;
    c. The admission rate for gastroenteritis increased from 38 per 100,000 to 42 per 100,000;
    d. The admission rate for urinary tract infection increased slightly from 24 per 100,000 to 26 per 100,000.

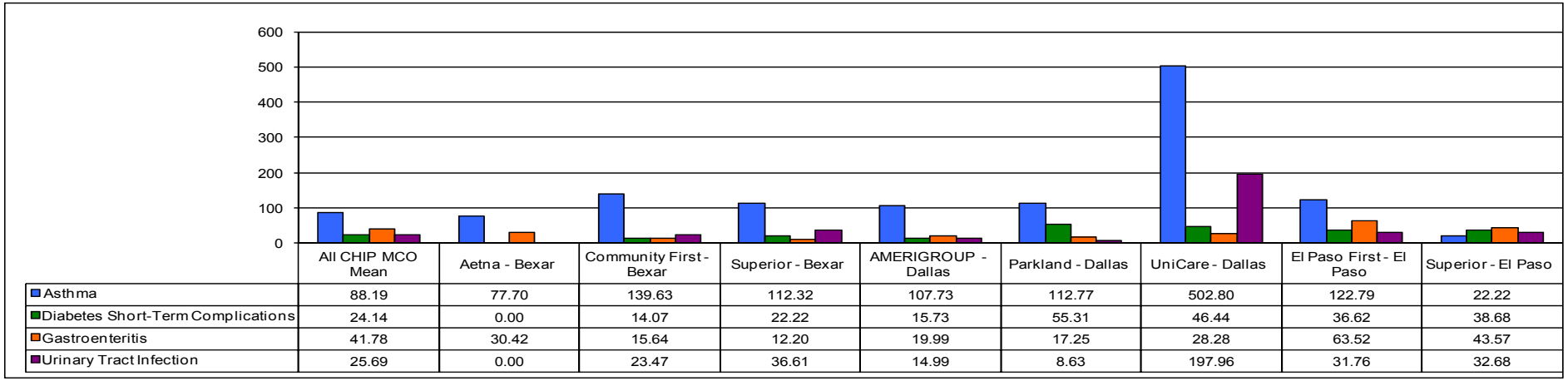
8. In summary, CHIP performed well on all four PDI measures - asthma, diabetes short-term complications, gastroenteritis, and urinary tract infection - with inpatient admissions rates for these conditions below the national rates. As noted above, reducing ACSC-related inpatient admissions should be addressed in the following MCOs for specified conditions:
    1. Asthma in Driscoll and UniCare.
    2. Diabetes short-term complications in Parkland, UniCare, Seton, and FirstCare.
    3. Urinary tract infections in UniCare.

Table 1. AHRQ Pediatric Quality Indicators

AHRQ Indicator Number	Indicator Name	Description
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 infection per 100,000 population

Chart 6A. AHRQ Pediatric Quality Indicators – SDA Breakout

CHIP Asthma Eligible = 569,215
CHIP Diabetes Eligible = 472,339
CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Universe for All Other Measures = 583,977**



	All CHIP MCO Mean	Aetna - Bexar	Community First - Bexar	Superior - Bexar	AMERIGROUP - Dallas	Parkland - Dallas	UniCare - Dallas	El Paso First - El Paso	Superior - El Paso
Asthma	88.19	77.70	139.63	112.32	107.73	112.77	502.80	122.79	22.22
Diabetes Short-Term Complications	24.14	0.00	14.07	22.22	15.73	55.31	46.44	36.62	38.68
Gastroenteritis	41.78	30.42	15.64	12.20	19.99	17.25	28.28	63.52	43.57
Urinary Tract Infection	25.69	0.00	23.47	36.61	14.99	8.63	197.96	31.76	32.68

		Bexar	Dallas	El Paso	Harris	Lubbock	Nueces	Superior EPO	Tarrant	Travis	Webb
SDA Mean	Asthma	122.04	158.99	85.81	51.44	132.20	205.99	76.57	56.94	78.69	31.45
	Diabetes Short-Term Complications	14.87	35.54	37.37	18.30	43.84	0.00	25.79	15.99	48.92	0.00
	Gastroenteritis	16.48	19.91	56.17	32.35	35.79	79.54	82.17	17.81	10.42	92.52
	Urinary Tract Infection	24.73	35.13	32.10	18.31	14.31	30.59	39.62	3.56	20.84	10.28

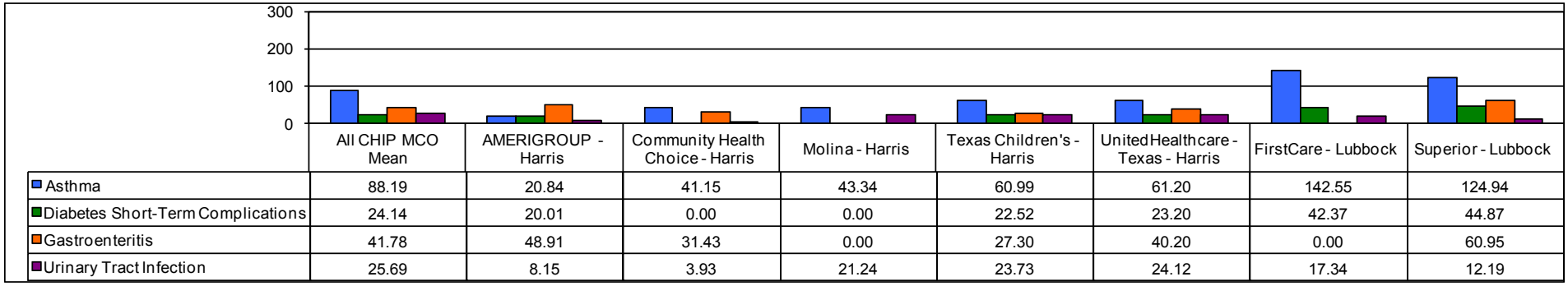
Reference: CHIP Table PDI09
Note: Rates are per 100,000 enrollees except for perforated appendix, which is per 100 admissions for appendicitis. The denominator for perforated appendix was less than 30 in many MCO/SDA groups; therefore this measure is not reported this year. Eligible members are included in the overall CHIP rates.

Key Points:

1. Charts 6A, 6B, and 6C present AHRQ PDI results for the 25 MCO/SDA groups evaluated in this report. Key points for all charts are provided under Chart 6C. Please note that the Y-axis is scaled differently in Chart 6A than in Charts 6B and 6C in order to provide a clear, visual representation of the results.

Chart 6B. AHRQ Pediatric Quality Indicators – SDA Breakout

CHIP Asthma Eligible = 569,215
CHIP Diabetes Eligible = 472,339
CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Universe for All Other Measures = 583,977**



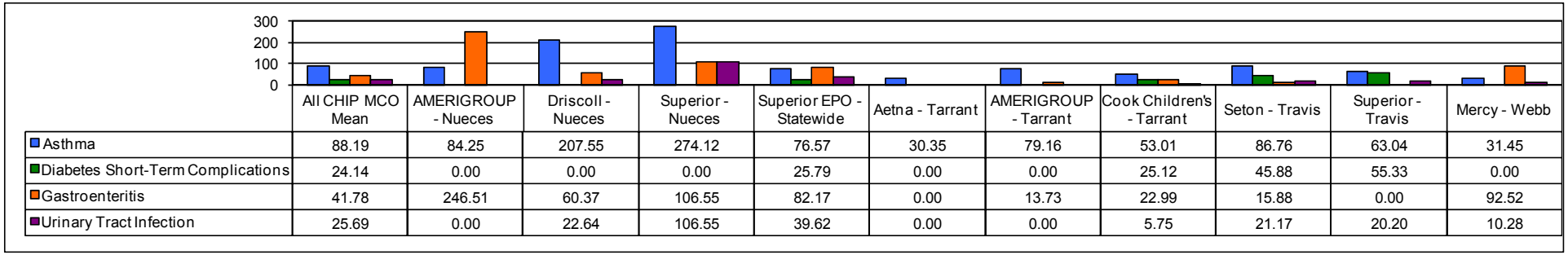
	All CHIP MCO Mean	AMERIGROUP - Harris	Community Health Choice - Harris	Molina - Harris	Texas Children's - Harris	UnitedHealthcare - Texas - Harris	FirstCare - Lubbock	Superior - Lubbock
Asthma	88.19	20.84	41.15	43.34	60.99	61.20	142.55	124.94
Diabetes Short-Term Complications	24.14	20.01	0.00	0.00	22.52	23.20	42.37	44.87
Gastroenteritis	41.78	48.91	31.43	0.00	27.30	40.20	0.00	60.95
Urinary Tract Infection	25.69	8.15	3.93	21.24	23.73	24.12	17.34	12.19

SDA Mean	Bexar	Dallas	El Paso	Harris	Lubbock	Nueces	Superior EPO	Tarrant	Travis	Webb
Asthma	122.04	158.99	85.81	51.44	132.20	205.99	76.57	56.94	78.69	31.45
Diabetes Short-Term Complications	14.87	35.54	37.37	18.30	43.84	0.00	25.79	15.99	48.92	0.00
Gastroenteritis	16.48	19.91	56.17	32.35	35.79	79.54	82.17	17.81	10.42	92.52
Urinary Tract Infection	24.73	35.13	32.10	18.31	14.31	30.59	39.62	3.56	20.84	10.28

Reference: CHIP Table PDI09
Note: Rates are per 100,000 enrollees except for perforated appendix, which is per 100 admissions for appendicitis. The denominator for perforated appendix was less than 30 in many MCO/SDA groups; therefore this measure is not reported this year. Eligible members are included in the overall CHIP rates.

Chart 6C. AHRQ Pediatric Quality Indicators – SDA Breakout

CHIP Asthma Eligible = 569,215
CHIP Diabetes Eligible = 472,339
CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Universe for All Other Measures = 583,977**



	All CHIP MCO Mean	AMERIGROUP - Nueces	Driscoll - Nueces	Superior - Nueces	Superior EPO - Statewide	Aetna - Tarrant	AMERIGROUP - Tarrant	Cook Children's - Tarrant	Seton - Travis	Superior - Travis	Mercy - Webb
Asthma	88.19	84.25	207.55	274.12	76.57	30.35	79.16	53.01	86.76	63.04	31.45
Diabetes Short-Term Complications	24.14	0.00	0.00	0.00	25.79	0.00	0.00	25.12	45.88	55.33	0.00
Gastroenteritis	41.78	246.51	60.37	106.55	82.17	0.00	13.73	22.99	15.88	0.00	92.52
Urinary Tract Infection	25.69	0.00	22.64	106.55	39.62	0.00	0.00	5.75	21.17	20.20	10.28

SDA Mean		Bexar	Dallas	El Paso	Harris	Lubbock	Nueces	Superior EPO	Tarrant	Travis	Webb
	Asthma	122.04	158.99	85.81	51.44	132.20	205.99	76.57	56.94	78.69	31.45
	Diabetes Short-Term Complications	14.87	35.54	37.37	18.30	43.84	0.00	25.79	15.99	48.92	0.00
	Gastroenteritis	16.48	19.91	56.17	32.35	35.79	79.54	82.17	17.81	10.42	92.52
	Urinary Tract Infection	24.73	35.13	32.10	18.31	14.31	30.59	39.62	3.56	20.84	10.28

Reference: CHIP Table PDI09
Note: Rates are per 100,000 enrollees except for perforated appendix, which is per 100 admissions for appendicitis. The denominator for perforated appendix was less than 30 in many MCO/SDA groups; therefore this measure is not reported this year. Eligible members are included in the overall CHIP rates.

Key Points:

1. Charts 6A, 6B, and 6C provide AHRQ PDI rates for asthma, diabetes short-term complications, gastroenteritis, and urinary tract infection among children and adolescents in CHIP, up to 17 years old, distributed by MCO/SDA. These PDIs are described in more detail under Chart 5B, and are listed in **Table 1**. Discussion of PDIs in the key points below includes comparisons with national rates reported by the AHRQ. It should be noted that these AHRQ national estimates are based on data collected in 2003 and are area-level indicators, including commercial and Medicaid populations.
2. Inpatient admission rates for asthma across MCO/SDA groups are as follows:

- Twenty-two of the 25 MCO/SDA groups were below the national AHRQ rate of 181 per 100,000 for inpatient admissions for asthma. The best-performing MCO/SDA groups (those with the lowest inpatient admissions for asthma) were AMERIGROUP – Harris (21 per 100,000) and Superior – El Paso (22 per 100,000).
- The MCO/SDA groups with the highest rate of inpatient admissions for asthma were UniCare – Dallas (503 per 100,000), Superior – Nueces (274 per 100,000), and Driscoll – Nueces (208 per 100,000), suggesting a need for improved ambulatory care for asthma in these MCO/SDA groups.

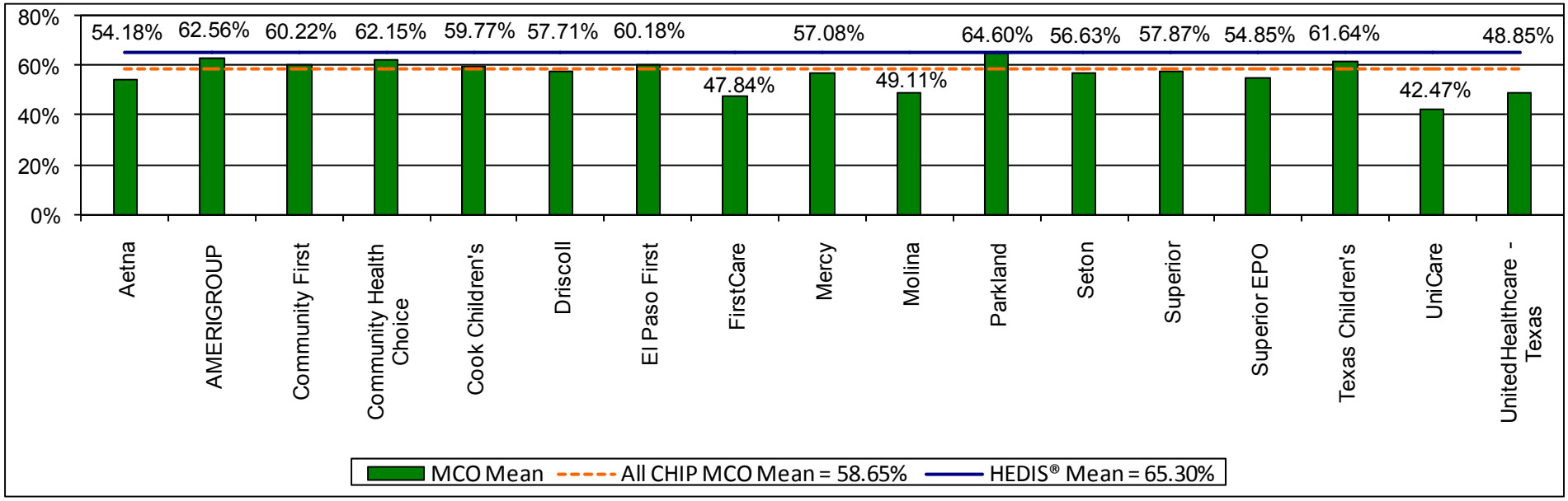
3. Inpatient admission rates for diabetes short-term complications across MCO/SDA groups are as follows:
    - Seventeen of the 25 MCO/SDA groups were below the national AHRQ rate of 29 per 100,000 for inpatient admissions for diabetes. In addition, nine MCO/SDA groups had no reported inpatient admissions for diabetes short-term complications.
    - Parkland – Dallas and Superior – Travis had the highest inpatient admissions for diabetes among MCO/SDA groups, each with a rate of 55 per 100,000 enrollees.
4. Inpatient admission rates for gastroenteritis across MCO/SDA groups are as follows:
    - All MCO/SDA groups except AMERIGROUP - Nueces were below the national AHRQ rate of 183 per 100,000 for this measure. Four MCO/SDA groups had zero inpatient admissions for gastroenteritis: Molina – Harris, FirstCare – Lubbock, Aetna – Tarrant, and Superior – Travis.
    - AMERIGROUP – Nueces had the highest inpatient admission rate for gastroenteritis at 247 per 100,000, suggesting a need for this MCO/SDA group specifically to improve ambulatory care for gastroenteritis.
5. Inpatient admission rates for urinary tract infection across MCO/SDA groups are as follows:
    - Twenty-three out of 25 MCO/SDA groups were below the national AHRQ rate of 53 per 100,000 for this measure, with four groups reporting zero inpatient admissions for urinary tract infections: Aetna – Bexar, AMERIGROUP – Nueces, Aetna – Tarrant, and AMERIGROUP – Tarrant.
    - UniCare - Dallas (198 per 100,000) and Superior - Nueces (107 per 100,000) had the highest rates of inpatient admissions for urinary tract infections, suggesting a need for improved ambulatory care for urinary tract infections in these MCO/SDA groups.
6. Tarrant and Harris were the only SDAs with PDI rates below the CHIP mean for each of the four conditions: asthma, diabetes short-term complications, gastroenteritis, and urinary tract infection. (Note that other SDAs had PDI rates below the CHIP mean for specific conditions.) Below are comparisons across SDAs for each PDI, with additional comparisons to the national AHRQ rate and the CHIP mean when appropriate.
    - Rates for inpatient admission for asthma across SDAs were variable, ranging from 31 per 100,000 in Webb to 206 per 100,000 in Nueces. Nueces was the only SDA to exceed the national AHRQ rate of 181 per 100,000 for inpatient admissions for asthma (206

per 100,000). The lowest performing SDAs in addition to Nueces on this measure were Dallas (160 per 100,000), Lubbock (132 per 100,000), and Bexar (122 per 100,000), each with inpatient rates higher than the CHIP mean of 88 per 100,000.

- Rates for inpatient admission for diabetes short-term complications ranged from zero per 100,000 in Nueces and Webb to 49 per 100,000 in Travis. Four SDAs exceeded both the CHIP mean (24 per 100,000) and the national AHRQ mean (29 per 100,000) for inpatient diabetes-related admissions: Travis (49 per 100,000), Lubbock (44 per 100,000), El Paso (37 per 100,000), and Dallas (36 per 100,000), indicating low performance on this measure.
- Rates for inpatient admission for gastroenteritis ranged from 10 per 100,000 in Travis to 93 per 100,000 in Webb. All SDAs were below the national AHRQ mean (183 per 100,000), indicating relatively good performance on this measure. Three SDAs had inpatient admissions rates at least 1.9 times greater than the CHIP mean for this measure – Nueces at 80 per 100,000, Superior EPO at 82 per 100,000, and Webb at 93 per 100,000.
- Rates for inpatient admission for urinary tract infection ranged from 4 per 100,000 in Tarrant to 40 per 100,000 in Superior EPO. All SDAs were below the national AHRQ mean of 53 per 100,000 for this measure.

Chart 7. HEDIS® Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Enrollees in Age Group = 26,987**



Reference: CHIP Table W3409

Key Points:

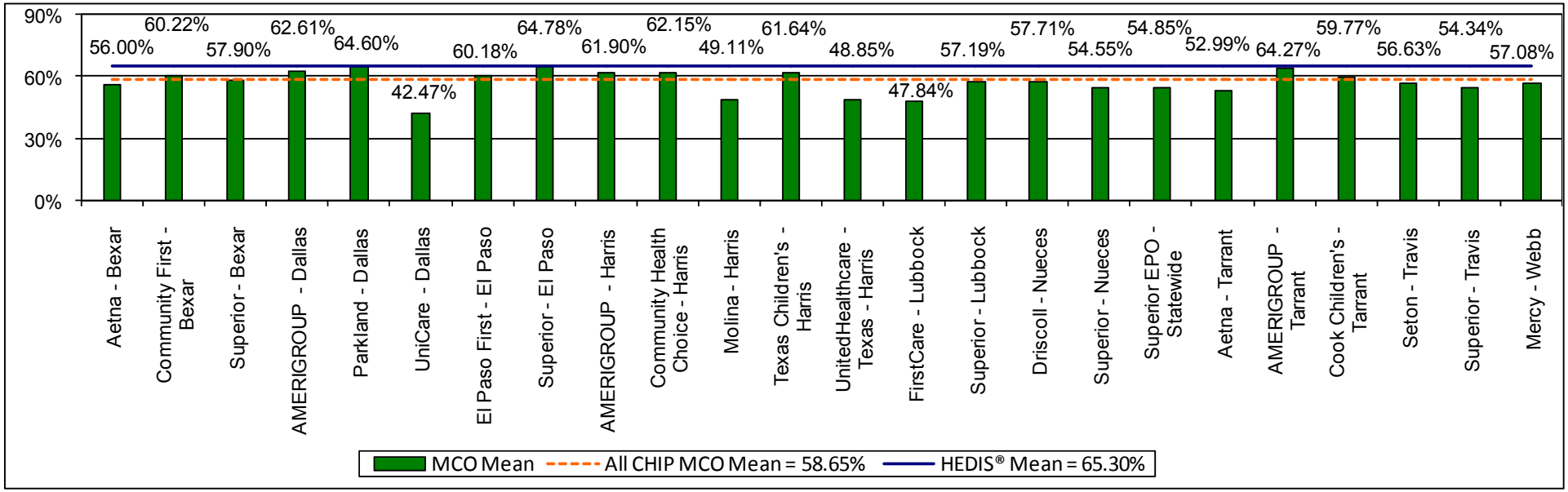
1. Chart 7 presents results for the HEDIS® Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life measure, distributed by MCO. This measure provides the percentage of CHIP enrollees between three and six years of age who received one or more well-child visits with a primary care practitioner during the measurement period. Note that the HEDIS® measure specifies that visits be with a primary care practitioner. Due to not enforcing provider type constraints in the calculation, the results shown here are slightly inflated, which should be taken into consideration when making comparisons with the national HEDIS® mean.
2. Fifty-nine percent of CHIP enrollees between three and six years of age received at least one well-child visit.
    - CHIP's performance on this measure was below the national HEDIS® mean of 65 percent, but above the HHSC Performance Indicator Dashboard Standard of 56 percent.

- CHIP declined slightly in performance on this measure from SFY 2007 when 61 percent of CHIP enrollees had at least one well-child visit.

3. Across MCOs, the percentage of enrollees receiving at least one well-child visit ranged from 42 percent in UniCare to 65 percent in Parkland.
    - Only Parkland met the national HEDIS® mean of 65 percent for this measure. However, 11 of the 17 MCOs met or exceeded the HHSC Performance Indicator Dashboard Standard of 56 percent for this measure.
4. Given the lifting of provider constraints for this measure, rates for well-child visits may be slightly inflated, and thus the results may overestimate CHIP's performance. HHSC may wish to take measures to increase the number of children receiving well-child visits in CHIP overall, and specifically in FirstCare, Molina, UniCare, and UnitedHealthcare – Texas, all of whom had well-child visits below 50 percent for enrollees.
    - Increasing well-child visits can be achieved through multiple, coordinated interventions involving but not limited to team-based care, care coordination through a medical home, and advanced access to health services.[8] Recent efforts to increase well-child visits have targeted the health delivery system, through patient reminders and open access, flexible scheduling.[9] One such effort involved a three-tiered intervention that included a mailed well-child appointment reminder in the appropriate language, followed by mailed and telephoned follow-up for missed appointments.[10] The last level of intervention was reserved for families unable or unwilling to keep scheduled appointments (identified as high risk), and included intensive case management and home visits when necessary. After 15 months, infants in the intervention group were more likely than infants in the control group to be up to date on immunizations and had received the recommended number of well-child visits.
    - Additionally, primary care practices that have open or "advanced" access to care may potentially improve access to well-child visits. The Commonwealth Fund defines "advanced" access to care as efforts that make health care more convenient for patients, such as: 1) Enhancing communication between patients and providers through remote access (i.e., secure messaging, web-based virtual visits); 2) Allowing patients to make same day appointments or appointments at times that are convenient for them; 3) Providing child educational and developmental assessments in contexts outside of the physician's office, such as in schools, daycares, and churches; and 4) Identifying high-risk children and delivering well-child care through home visits.[11] HHSC may wish to further examine the barriers to well-child visits among CHIP enrollees, and implement interventions that address those barriers, improving the health delivery system and patient access to care.

Chart 8. HEDIS® Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life – SDA Breakout

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Enrollees in Age Group = 26,987**



SDA Mean	Bexar	Dallas	El Paso	Harris	Lubbock	Nueces	Superior EPO	Tarrant	Travis	Webb
	59.08%	61.73%	61.82%	59.93%	53.26%	57.12%	54.85%	60.09%	55.90%	57.08%

Reference: CHIP Table W3409
Note: The denominator in AMERIGROUP – Nueces was less than 30; therefore the rate is not shown for this MCO/SDA group. Eligible members are included in the overall CHIP rate.

Key Points:

1. Chart 8 provides results for the HEDIS® Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life measure, distributed by MCO/SDA.
2. Across the MCO/SDA groups, the percentage of children receiving well-child visits ranged from 42 percent in UniCare – Dallas to 65 percent in both Parkland – Dallas and Superior – El Paso. Both Parkland - Dallas and Superior El Paso were the only MCOs to meet the national

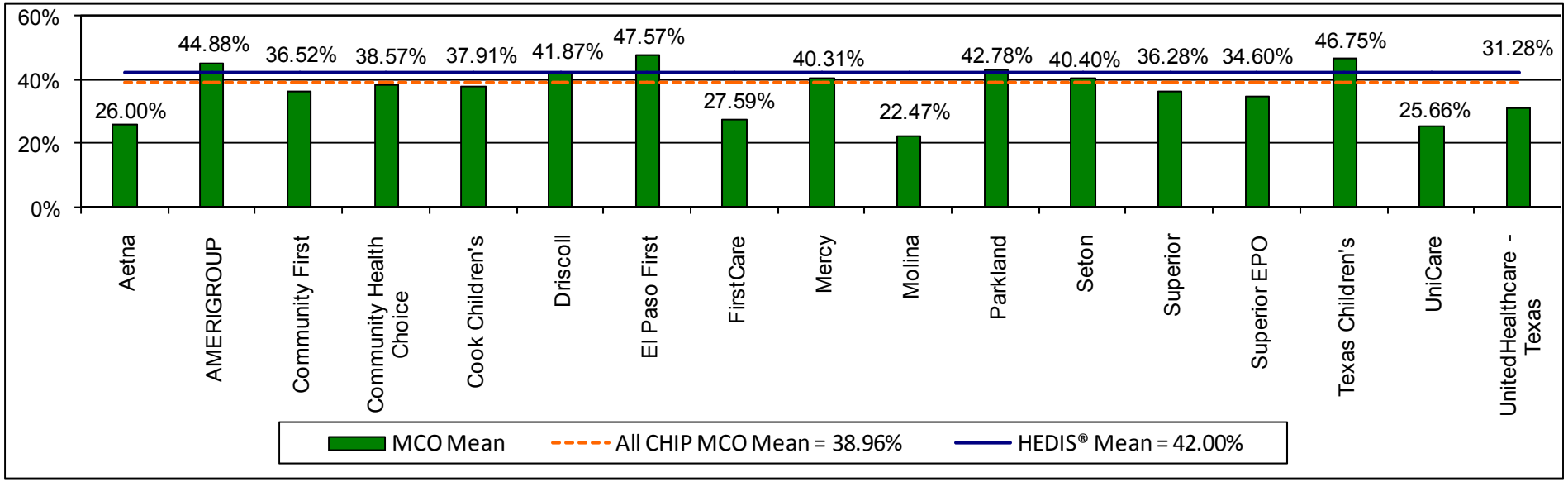
HEDIS® mean of 65 percent for this measure. However, 16 out of 24 MCO/SDAs met or exceeded the HHSC Performance Indicator Dashboard Standard of 56 percent for well-child visits.

- In addition to Unicare – Dallas, the lowest performing MCO/SDA groups (with less than half of eligible children receiving well-child visits) were FirstCare – Lubbock (48 percent), Molina – Harris (49 percent), and UnitedHealthcare – Texas – Harris (49 percent).

3. At the SDA level, the percentage of children receiving well-child visits ranged from 53 percent in Lubbock to 62 percent in both Dallas and El Paso. All of the SDAs were below the national HEDIS® mean for this measure; however eight out of 10 SDAs met or exceeded the HHSC Performance Indicator Dashboard Standard of 56 percent.

Chart 9. HEDIS® Adolescent Well-Care Visits

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Eligible in the Age Group = 96,379**



Reference: CHIP Table AWC09

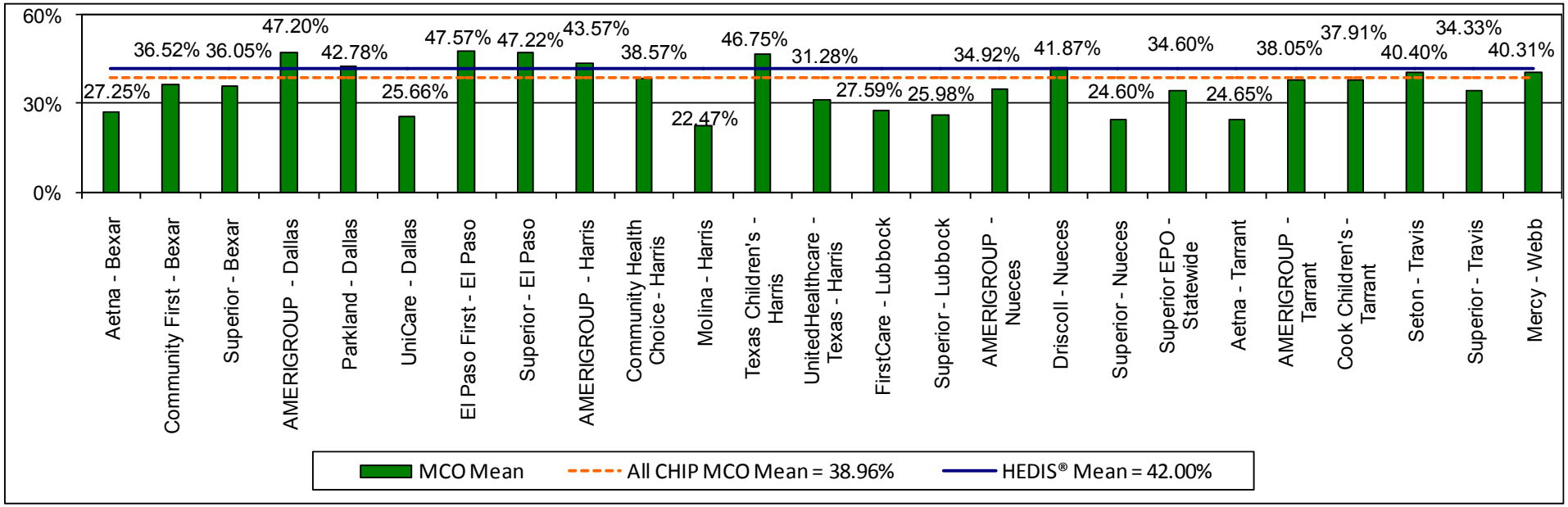
Key Points:

1. Chart 9 provides the percentage of CHIP enrollees 12 to 21 years old who received one or more comprehensive adolescent well-care visits with a physician provider during the measurement period, distributed by MCO. Note that the HEDIS® measure specifies the visits be with a primary care practitioner or an OB/GYN practitioner. Due to not enforcing the provider type constraints, the results shown here are slightly inflated, which should be taken into consideration when making comparisons with the national HEDIS® mean.
2. The percentage of adolescents in CHIP receiving one or more well-care visits was 39 percent, slightly below the national HEDIS® mean of 42 percent for this measure, but slightly above the HHSC Performance Indicator Dashboard Standard of 38 percent.
    - CHIP performance on this measure remained unchanged from SFY 2007, when 39 percent of adolescents received well-care visits.

3. Across MCOs, rates of adolescent well-care visits ranged from 22 percent in Molina to 48 percent in El Paso First. Five out of 17 MCOs met or exceeded the national HEDIS® mean for this measure – El Paso First (48 percent), Texas Children's (47 percent), AMERIGROUP (45 percent), Parkland (43 percent), and Driscoll (42 percent).
    - The MCOs with the lowest percentage of adolescents receiving well-care visits were Molina at 22 percent, UniCare at 26 percent, Aetna at 26 percent, and FirstCare at 28 percent.
    - Nine of the 17 MCOs met or exceeded the HHSC Performance Indicator Dashboard Standard of 38 percent for adolescent well-care visits.
4. As noted, the lifting of provider constraints inflates the percentage of adolescents included in the well-care visit measure. A doctor's office visit broadly defined may not constitute a well-care visit, and thus the results may overestimate CHIP's actual performance on this measure. Overall, CHIP met the HHSC Performance Indicator Dashboard Standard, but performed below the national HEDIS® mean. Furthermore, eight out of 17 MCOs did not meet the HHSC Performance Indicator Dashboard Standard, suggesting the need for improved access to adolescent well-care visits specifically in those plans.

Chart 10. HEDIS® Adolescent Well-Care Visits – SDA Breakout

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Eligible in the Age Group = 96,379**



SDA	Bexar	Dallas	El Paso	Harris	Lubbock	Nueces	Superior EPO	Tarrant	Travis	Webb
Mean	35.46%	43.29%	47.46%	41.70%	26.71%	40.11%	34.60%	36.66%	39.05%	40.31%

Reference: CHIP Table AWC09

Key Points:

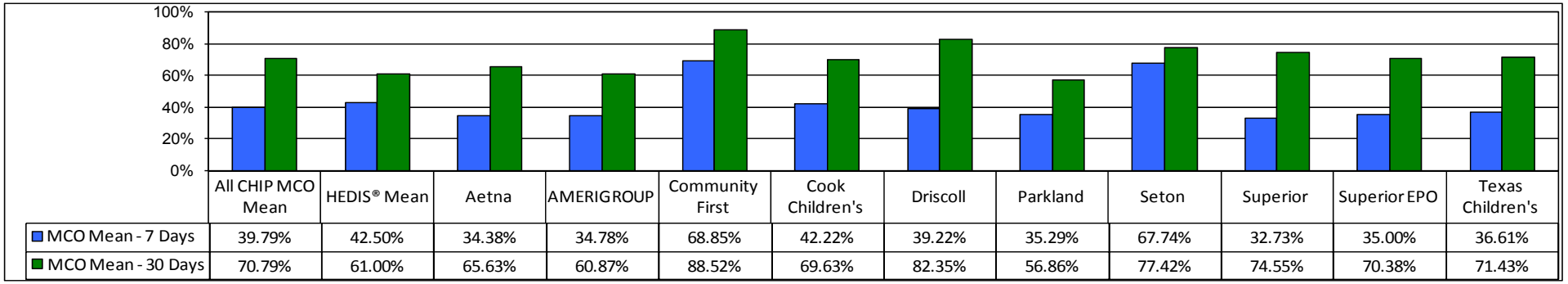
1. Chart 10 presents results for the HEDIS® Adolescent Well-Care Visits measure, distributed by MCO/SDA. For a description of this measure, see Chart 9.
2. The percentage of adolescent well-care visits across MCO/SDA groups ranged from 22 percent in Molina –Harris to 48 percent in El Paso First – El Paso. The MCO/SDA groups with the highest percentage of well-care visits, in addition to El Paso First – El Paso, were AMERIGROUP – Dallas (47 percent), Superior – El Paso (47 percent), and Texas Children's – Harris (47 percent).

- Thirteen of the 25 MCO/SDA groups performed below the HHSC Performance Indicator Dashboard Standard of 38 percent for this measure, suggesting a need to improve access to well-care visits for adolescents in these plans.

3. At the SDA level, the percentage of adolescent well-care visits ranged from 27 percent in Lubbock to 47 percent in El Paso. Six of the ten SDAs – Dallas, El Paso, Harris, Nueces, Travis, and Webb - met or exceeded the HHSC Performance Indicator Dashboard Standard of 38 percent for this measure.

Chart 11. HEDIS® Follow-Up after Hospitalization for Mental Illness

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Mental Health Hospitalizations = 955**



	All CHIP MCO Mean	HEDIS® Mean	Aetna	AMERIGROUP	Community First	Cook Children's	Driscoll	Parkland	Seton	Superior	Superior EPO	Texas Children's
MCO Mean - 7 Days	39.79%	42.50%	34.38%	34.78%	68.85%	42.22%	39.22%	35.29%	67.74%	32.73%	35.00%	36.61%
MCO Mean - 30 Days	70.79%	61.00%	65.63%	60.87%	88.52%	69.63%	82.35%	56.86%	77.42%	74.55%	70.38%	71.43%

Reference: CHIP Table FUH09
Note: Denominators of less than 30 eligible members were observed in Community Health Choice, El Paso First, FirstCare, Mercy, Molina, UniCare and UnitedHealthcare-Texas; rates for these health plans are therefore not reported. Eligible members are included in the overall CHIP rate.

Key Points:

1. Chart 11 provides the percentage of CHIP enrollees 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 physician 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. Rates for this measure are slightly inflated due to ignoring the provider type constraints in calculations, which should be taken into consideration when comparing rates with the national HEDIS® means (which specify that follow-up occur with a mental health provider).
2. At the seven-day follow-up period, CHIP performed below the national HEDIS® mean of 43 percent, but above the HHSC Performance Indicator Dashboard Standard of 32 percent, with 40 percent of CHIP members receiving seven-day follow-up care after hospitalization for a mental illness. (Note: For this measure, interpreting CHIP results in relation to the national HEDIS® mean should be done with the knowledge that adults are included in the national rate.) Performance on this measure was similar to SFY 2007, when 41 percent of CHIP members received seven-day follow-up care after hospitalization for a mental illness.
    - Community First and Seton performed notably well on this measure, with 69 percent and 68 percent of members receiving seven-day follow-up care after hospitalization for a mental illness. Specifically, Community First improved on this measure by 18 percentage points since SFY 2007, when 50 percent of CHIP members received seven-day follow-up care. (Note: Results for Seton on this measure were not available last year.)

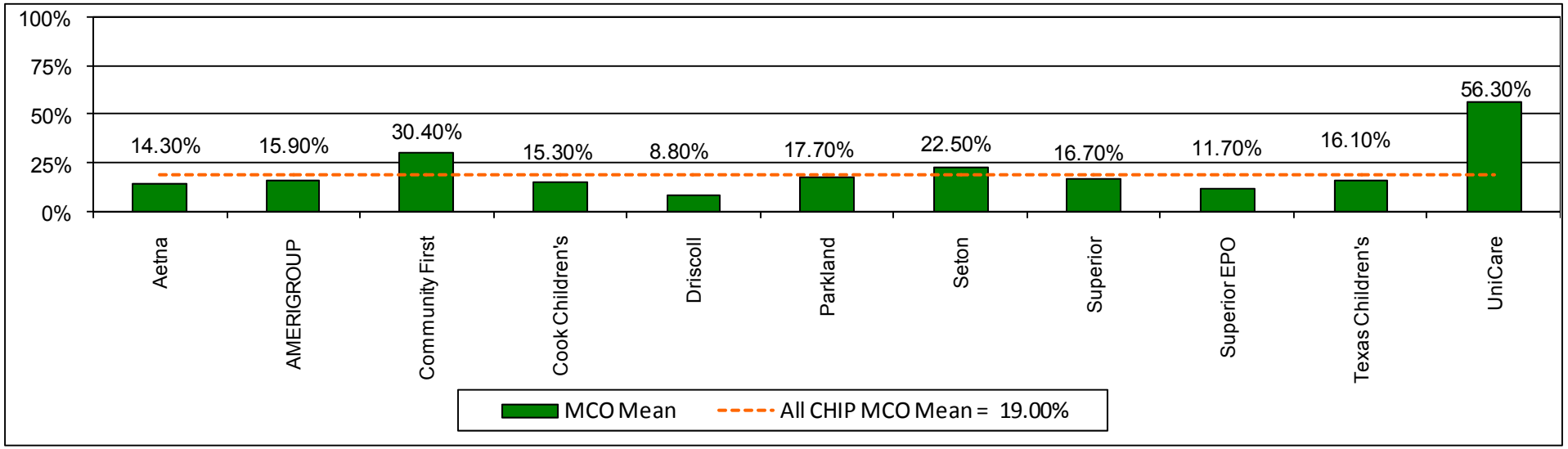
- Although none of the MCOs were below the HHSC Performance Indicator Dashboard Standard of 32 percent, eight out of 10 MCOs were below the national HEDIS® mean for those receiving follow-up care after hospitalization for a mental illness. The lowest performing MCO on this measure was Superior at 33 percent.
- In SFY 2007, both Parkland (23 percent) and Driscoll (28 percent) had rates of seven-day follow-up among members hospitalized for a mental illness below 30 percent. Each has improved their performance in SFY 2008, with Driscoll improving by 11 percentage points and Parkland improving by 13 percentage points.

3. At the 30-day follow-up period, CHIP performed above both the national HEDIS® mean of 61 percent and the HHSC Performance Indicator Dashboard Standard of 52 percent, with 71 percent of CHIP members receiving 30-day follow-up care after hospitalization for a mental illness. (Note: For this measure, interpreting CHIP results in relation to the national HEDIS® mean should be done with the knowledge that adults are included in the national rate.) Performance on this measure was similar to SFY 2007, when 72 percent of CHIP members received 30-day follow-up care after hospitalization for a mental illness.
    - The best-performing MCOs on this measure were Community First (89 percent), Driscoll (82 percent) and Seton (77 percent).
    - Parkland was the only MCO below the HEDIS® mean of 61 percent, with 57 percent of its members receiving 30-day follow-up care after hospitalization for a mental illness.
4. Although some MCOs increased their percentage of members receiving seven-day follow-up after hospitalization for a mental illness since SFY 2007, notably in Parkland and Driscoll, there is still a need for program-wide improvement on this measure. As stated, CHIP overall and eight of 10 MCOs performed below the national HEDIS® mean for the percentage of members receiving seven-day follow-up after hospitalization for a mental illness.

    - HHSC may wish to examine the factors that increase follow-up rates after hospitalization for mental illness. Patient follow-up is important in sustaining treatment gains made in the hospital, providing continued support and treatment to the patient, and reducing the risk of rehospitalization.[12] "Bridging" strategies between inpatient and outpatient treatment have been shown to prevent "gaps" in care after psychiatric hospitalizations.[13] Core elements of "bridging" involve beginning outpatient care prior to discharge, providing support and transitional care by inpatient staff, and involving family members in discharge plans and outpatient treatment.[14] Parental involvement in treatment and discharge planning is critical in bridging the gap between inpatient and outpatient care. Research has identified a link between a child's clinical outcomes during the post-discharge phase and the parent-child relationship. Specifically, family relationships characterized by harsh discipline and low parental involvement increase the risk of rehospitalization.[15] Thus, discharge planning should also include plans for treating the family system, strengthening the parent-child relationship, and encouraging parents to practice healthy, authoritative parenting strategies.

Chart 12. Readmission within 30 Days after an Inpatient Stay for Mental Health

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Inpatient Mental Health Eligible Stays = 1,284**



Reference: CHIP Table MHReadmit09
Note: Denominators of less than 30 eligible members were observed in Community Health Choice, El Paso First, FirstCare, Mercy, Molina and UnitedHealthcare-Texas; rates for these health plans are therefore not reported. Eligible members are included in the overall CHIP rate.

Key Points:

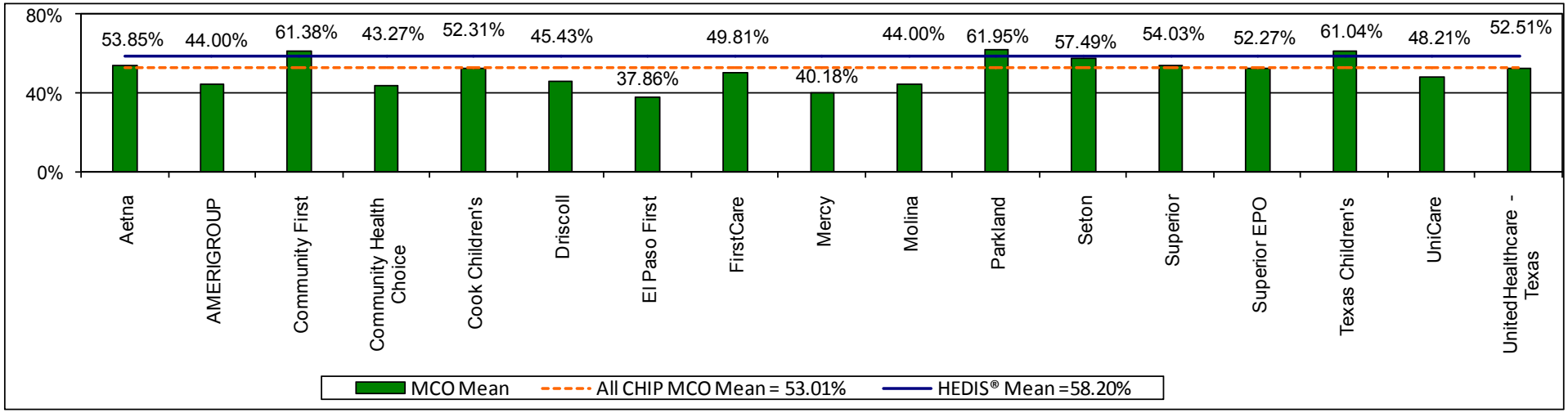
1. Chart 12 provides the percentage of CHIP enrollees who were readmitted within 30 days following an inpatient stay for mental health problems, distributed by MCO. Mental health readmissions are frequently used as a measure of an adverse outcome, which potentially result from efforts to contain behavioral health care costs such as reducing the initial length of stay.[16] For this measure, lower rates of readmission indicate better performance.
2. Rates of readmission within 30 days after a mental health hospital stay varied considerably across MCO groups, ranging from 9 percent in Driscoll to 56 percent in Unicare.

- The best performing MCOs on this measure (those with the lowest percentage of members readmitted within 30 days after an inpatient stay for mental health) were Driscoll (9 percent), Superior EPO (12 percent), and Aetna (14 percent). Eight out of 11 MCOs were below the CHIP mean of 19 percent for this measure.
- In contrast, UniCare had a high readmission rate (56 percent), with approximately half of members readmitted within 30 days after an inpatient stay for mental health. The second lowest performing MCO on this measure was Community First with a 30 percent readmission rate.

3. Overall, CHIP performed better on this measure in SFY 2008 than in SFY 2007, when 36 percent of members were readmitted within 30 days following an inpatient stay for mental health. In addition, seven MCOs demonstrated improved performance on readmission rates from SFY 2007 to SFY 2008, notably the following:
   - Cook Children's reduced their readmission rate from 57 percent to 15 percent (a decrease of 42 percentage points).
   - Aetna reduced their readmission rate from 52 percent to 14 percent (a decrease of 38 percentage points).

Chart 13. HEDIS® Appropriate Testing for Children with Pharyngitis

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Eligible = 15,370**



Reference: CHIP Table CWP09

Key Points:

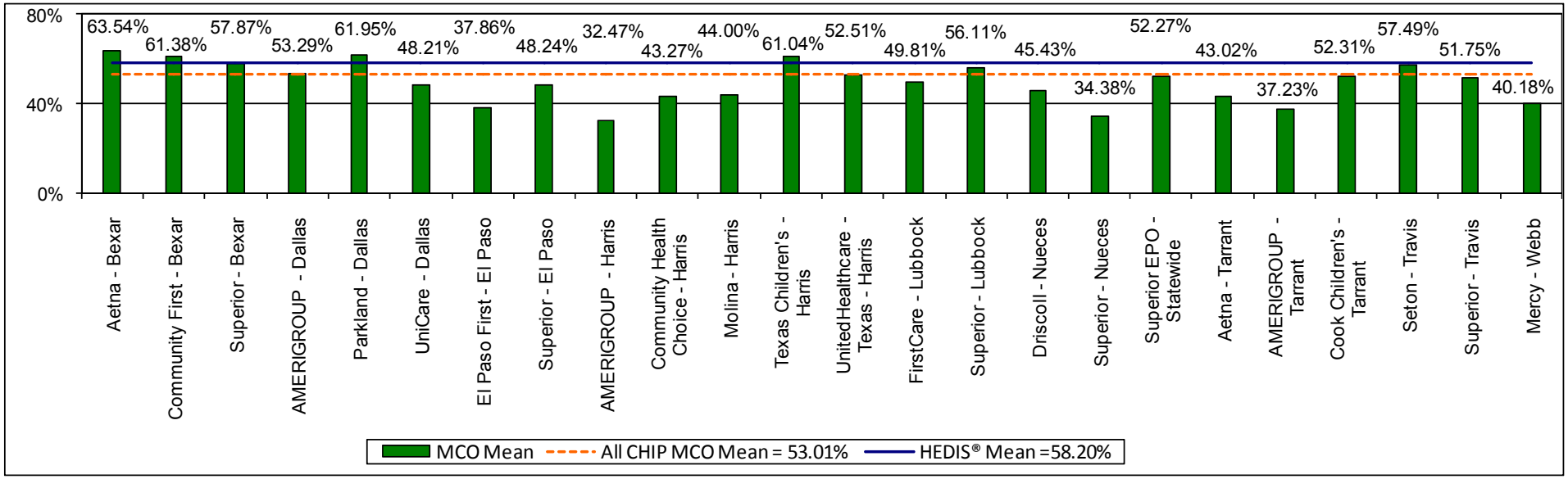
1. Chart 13 provides the percentage of children, two to 18 years of age in CHIP who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus test for the episode, distributed by MCO. A higher rate on this measure represents better performance (i.e., appropriate testing).
2. CHIP performed lower than the national average for Medicaid Managed Care Plans reporting to the NCQA on this measure, with 53 percent of children with pharyngitis receiving appropriate testing, compared to 58 percent nationally. This percentage has not changed since SFY 2007, when 53 percent of children with pharyngitis received appropriate testing in that year.
3. The best performing MCOs on this measure were Parkland (62 percent), Texas Children's (61 percent), and Community First (61 percent). In contrast, El Paso First (38 percent) and Mercy (40 percent) had the lowest percentage of children with pharyngitis receiving appropriate testing. However, both El Paso First and Mercy improved their performance on this measure from SFY 2007, when 31 percent and 27 percent received pharyngitis testing, respectively.

4. In summary, 14 out of 17 MCOs were below the national HEDIS® rate of 58 percent for children with pharyngitis receiving appropriate treatment, suggesting the need for program-wide improvement in the care and treatment of pharyngitis in children.

    - Improving pharyngitis testing and treatment for children is important in reducing the use of antibiotics when sore throats are caused by viral agents, and in cases where the etiology of symptoms is bacterial, reducing symptoms and shortening the course of disease. A recent study examined how pediatricians and family physicians made decisions about testing and treating pharyngitis by presenting clinical scenarios and comparing physician responses to evidence-based clinical guidelines.[17] Between 32 and 81 percent of physicians inappropriately managed pharyngitis symptoms by prescribing antibiotic treatment before knowing the results of diagnostic tests, continuing medication when test results were negative, performing follow-up diagnostic tests on asymptomatic children, and testing children when their symptoms and/or clinical picture suggested a viral etiology.[18] In addition, physicians indicated that their treatment decisions were often influenced by parents, whom they believed expected antibiotic prescriptions regardless of test results or clinical findings. Increasing physician knowledge of and use of current evidence-based clinical guidelines may improve the management and treatment of pharyngitis in children. For example, an educational intervention in a hospital emergency room setting that implemented the use of evidence-based clinical guidelines for pharyngitis increased the appropriate treatment rate from 44 percent to 91 percent.[19] HHSC may wish to conduct similar efforts to improve the management of pharyngitis through physician education and training, specifically in the utilization of evidence-based clinical guidelines in testing and treatment decisions.

Chart 14. HEDIS® Appropriate Testing for Children with Pharyngitis – SDA Breakout

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Eligible = 15,370**



SDA	Bexar	Dallas	El Paso	Harris	Lubbock	Nueces	Superior EPO	Tarrant	Travis	Webb
Mean	60.56%	56.93%	41.65%	53.52%	53.30%	44.52%	52.27%	50.09%	55.58%	40.18%

Reference: CHIP Table CWP09
Note: The denominator was less than 30 in AMERIGROUP – Nueces; the rate is therefore not reported for this MCO/SDA group. Eligible members are included in overall CHIP rate.

Key Points:

1. Chart 14 presents results for the HEDIS® Appropriate Testing for Children with Pharyngitis measure, distributed by MCO/SDA. For a description of this measure, see Chart 13.
2. Across the MCO/SDA groups, the percentage of children with pharyngitis receiving appropriate testing ranged from 32 percent in AMERIGROUP – Harris to 64 percent in Aetna – Bexar. The best performing MCO/SDA groups, in addition to Aetna –Bexar, were Parkland

– Dallas (62 percent), Community First – Bexar (61 percent), and Texas Children's – Harris (61 percent), all of which exceeded the national HEDIS® mean of 58 percent.

3. At the SDA level, Bexar was the only SDA to exceed the national HEDIS® mean of 58 percent for pharyngitis testing, although both Dallas (57 percent) and Travis (56 percent) were close to the national mean. The lowest performing SDAs on this measure were Webb at 40 percent, El Paso at 42 percent, and Nueces at 45 percent, indicating a need to improve care and testing of children with pharyngitis specifically in these SDAs.

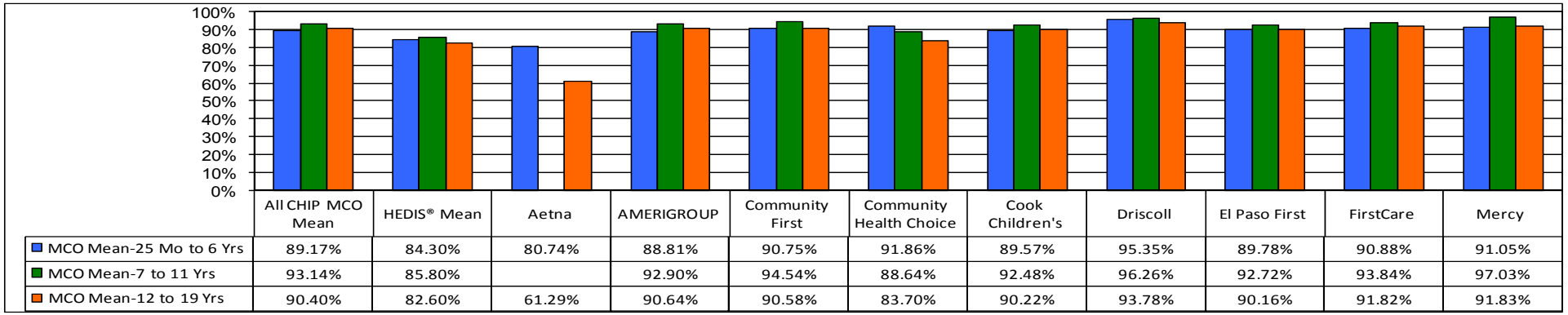
    - SDA-level results were similar to those reported in SFY 2007 on this measure. However, both Travis and Webb improved their performance from SFY 2007 to SFY 2008.
    - Webb increased appropriate pharyngitis testing among members from 27 percent to 40 percent.
    - Travis increased appropriate pharyngitis testing among members from 47 percent to 56 percent.

4. Please see Chart 13 for specific recommendations to increase the percentage of children with pharyngitis receiving appropriate testing.

Chart 15A. HEDIS® Children and Adolescents' Access to Primary Care Practitioners

CHIP Eligible 25 Months-6 Years = 31,959
CHIP Eligible 7-11 Years = 25,442
CHIP Eligible 12-19 Years = 38,436

CHIP MCOs - September 1, 2007 to August 31, 2008



	All CHIP MCO Mean	HEDIS® Mean	Aetna	AMERIGROUP	Community First	Community Health Choice	Cook Children's	Driscoll	El Paso First	FirstCare	Mercy
MCO Mean-25 Mo to 6 Yrs	89.17%	84.30%	80.74%	88.81%	90.75%	91.86%	89.57%	95.35%	89.78%	90.88%	91.05%
MCO Mean-7 to 11 Yrs	93.14%	85.80%		92.90%	94.54%	88.64%	92.48%	96.26%	92.72%	93.84%	97.03%
MCO Mean-12 to 19 Yrs	90.40%	82.60%	61.29%	90.64%	90.58%	83.70%	90.22%	93.78%	90.16%	91.82%	91.83%

Reference: CHIP Table CAP09
Note: The denominator was less than 30 in Aetna among seven to 11 year olds; the rate is therefore not reported for this MCO in this age band. Denominators were less than 30 in many MCOs in the 12 to 24 months age group; rates are therefore not reported in this age band this year. Eligible members are included in the overall CHIP rate.

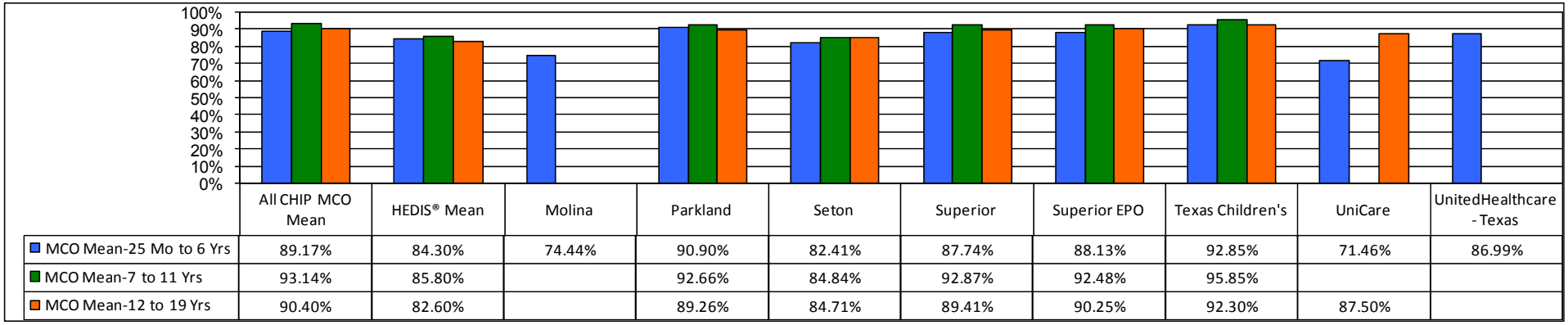
Key Points:

1. Chart 15A presents results for the HEDIS® Children and Adolescents' Access to Primary Care Practitioners measure for three age groups - 25 months to six years of age, 7 to 11 years of age, and 12 to 19 years of age, distributed by MCO. Children ages 12 to 24 months are excluded this year because of lack of sufficient data. Chart 15A presents the results for this measure for nine MCOs in CHIP, and Chart 15B presents results for the remaining eight MCOs. Key points for both charts are presented under Chart 15B.

Chart 15B. HEDIS® Children and Adolescents' Access to Primary Care Practitioners

CHIP Eligible 25 Months-6 Years = 31,959
CHIP Eligible 7-11 Years = 25,442
CHIP Eligible 12-19 Years = 38,436

CHIP MCOs - September 1, 2007 to August 31, 2008



	All CHIP MCO Mean	HEDIS® Mean	Molina	Parkland	Seton	Superior	Superior EPO	Texas Children's	UniCare	UnitedHealthcare - Texas
MCO Mean-25 Mo to 6 Yrs	89.17%	84.30%	74.44%	90.90%	82.41%	87.74%	88.13%	92.85%	71.46%	86.99%
MCO Mean-7 to 11 Yrs	93.14%	85.80%		92.66%	84.84%	92.87%	92.48%	95.85%		
MCO Mean-12 to 19 Yrs	90.40%	82.60%		89.26%	84.71%	89.41%	90.25%	92.30%	87.50%	

Reference: CHIP Table CAP09
Note: Denominators less than 30 were observed in Molina and UnitedHealthcare – Texas in the seven to 11 year and 12 to 19 year age groups, and in UniCare in the 7 to 11 year age group; rates are therefore not reported in the MCOs for these age bands. Denominators less than 30 in the 12 to 24 months age group were observed in many MCOs; therefore this age band is not reported this year. Eligible members are included in the overall CHIP rates.

Key Points:

1. Charts 15A and 15B provide the percentage of children and adolescents in CHIP who had a visit with a physician provider during the measurement period, distributed by MCO. Rates are presented separately for three age groups – 25 months to six years, seven to 11 years, and 12 to 19 years. The HEDIS® measure specifies visits with a primary care practitioner. Due to not enforcing provider type constraints, the percentages shown here are slightly inflated, which should be taken into consideration when making comparisons with the national HEDIS® mean.
2. Among children 25 months to six years of age, CHIP overall performed above the national HEDIS® mean of 84 percent, with 89 percent of children in this age range visiting a care provider. Performance on this measure declined slightly from SFY 2007, when 92 percent of children 25 months to six years of age visited a care provider.

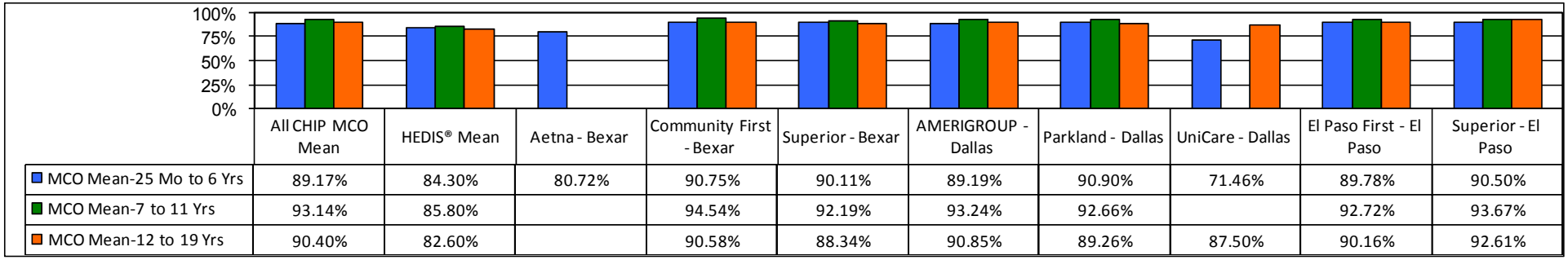
- The percentage of children 25 months to six years of age who visited a care provider ranged from 71 percent in UniCare to 95 percent in Driscoll. All MCOs performed above the national HEDIS® mean for this measure (84 percent), except for UniCare (71 percent), Molina (74 percent), Aetna (81 percent), and Seton (82 percent).
- Among MCOs that have percentage rates on this measure for both SFY 2007 and 2008, the majority slightly improved their performance, with Community Health Choice improving by seven percentage points (85 percent in SFY 2007 to 92 percent in SFY 2008).

3. Among children seven to 11 years of age, CHIP overall performed above the national HEDIS® mean of 86 percent, with 93 percent of children in this age range visiting a care provider. (Note: Comparisons to SFY 2007 are not available.)
    - The percentage of children seven to 11 years of age who visited a care provider ranged from 85 percent in Seton to 97 percent in Mercy, with all MCOs except Seton performing above the national HEDIS® mean for this measure (86 percent).
4. Among children and adolescents 12 to19 years of age, CHIP overall performed above the national HEDIS® mean of 83 percent, with 90 percent of children in this age range visiting a care provider. (Note: Comparisons to SFY 2007 are not available.)
    - The percentage of children and adolescents12 to 19 years of age who visited a care provider ranged from 61 percent in Aetna to 94 percent in Driscoll. All MCOs except Aetna exceeded the national HEDIS® mean of 83 percent for this measure. Aetna's low performance on this measure warrants further attention, and efforts should be made to improve access to care providers for children and adolescents in this plan.
5. In summary, CHIP overall and the majority of MCOs performed well on this measure for all age groups, with the vast majority of members visiting a care provider during SFY 2008. However, it should also be noted that these results may slightly overestimate performance on this measure because of the lifting of provider constraints. Thus, conclusions about the results should be based on the knowledge that the national HEDIS® mean and CHIP mean were calculated differently (provider-type constraints as specified by HEDIS® were not enforced).

Chart 16A. HEDIS® Children and Adolescents' Access to Primary Care Practitioners – SDA Breakout

CHIP Eligible 25 Months-6 Years = 31,959
CHIP Eligible 7-11 Years = 25,442
CHIP Eligible 12-19 Years = 38,436

CHIP MCOs - September 1, 2007 to August 31, 2008



	All CHIP MCO Mean	HEDIS® Mean	Aetna - Bexar	Community First - Bexar	Superior - Bexar	AMERIGROUP - Dallas	Parkland - Dallas	UniCare - Dallas	El Paso First - El Paso	Superior - El Paso
MCO Mean-25 Mo to 6 Yrs	89.17%	84.30%	80.72%	90.75%	90.11%	89.19%	90.90%	71.46%	89.78%	90.50%
MCO Mean-7 to 11 Yrs	93.14%	85.80%		94.54%	92.19%	93.24%	92.66%		92.72%	93.67%
MCO Mean-12 to 19 Yrs	90.40%	82.60%		90.58%	88.34%	90.85%	89.26%	87.50%	90.16%	92.61%

SDA Mean		Bexar	Dallas	El Paso	Harris	Lubbock	Nueces	Superior EPO	Tarrant	Travis	Webb
	MCO Mean-25 Mo to 6 Yrs	89.60%	88.41%	90.04%	91.17%	89.43%	93.64%	88.13%	88.19%	82.84%	91.05%
	MCO Mean-7 to 11 Yrs	93.92%	92.82%	92.99%	95.11%	94.31%	96.14%	92.48%	92.39%	85.03%	97.03%
	MCO Mean-12 to 19 Yrs	89.86%	89.96%	90.71%	91.78%	90.80%	93.79%	90.25%	90.10%	84.52%	91.83%

Reference: CHIP Table CAP09
Note: Denominators less than 30 were observed in Aetna - Bexar in the seven to 11 year and 12 to 19 year age groups, and in UniCare - Dallas in the seven to 11 year age group; rates are therefore not reported in these MCO/SDA groups in these age bands. Denominators less than 30 in the 12 to 24 months age group were observed in many MCO/SDA groups; therefore this age band is not reported this year. Eligible members are included in the overall CHIP rates.

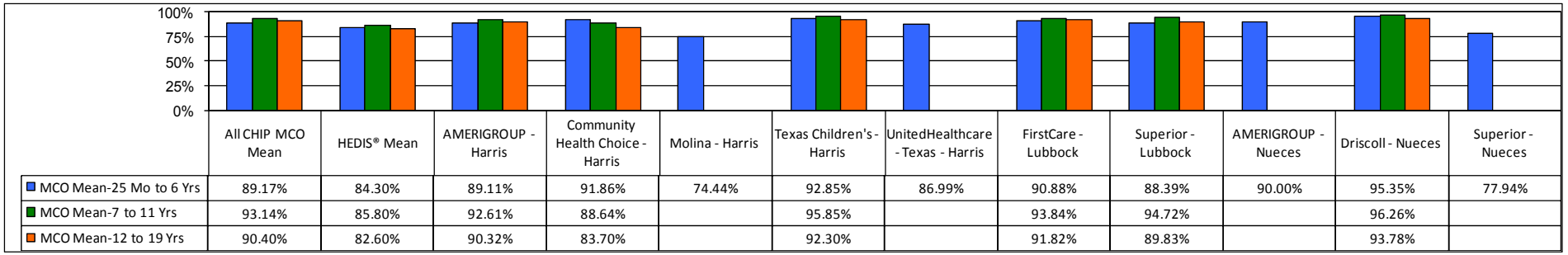
Key Points:

1. Chart 16A presents results for the HEDIS® Children and Adolescents' Access to Primary Care Practitioners measure for eight MCO/SDA groups in the Bexar, Dallas, and El Paso SDAs. Chart 16B presents results for this measure for 10 MCO/SDA groups in the Harris, Lubbock, and Nueces SDAs. Chart 16C presents results for this measure for the remaining seven MCO/SDA groups in Superior EPO and the Tarrant, Travis, and Webb SDAs. Key points for all charts are presented under Chart 16C.

Chart 16B. HEDIS® Children and Adolescents' Access to Primary Care Practitioners – SDA Breakout

CHIP Eligible 25 Months-6 Years = 31,959
CHIP Eligible 7-11 Years = 25,442
CHIP Eligible 12-19 Years = 38,436

CHIP MCOs - September 1, 2007 to August 31, 2008



	All CHIP MCO Mean	HEDIS® Mean	AMERIGROUP - Harris	Community Health Choice - Harris	Molina - Harris	Texas Children's - Harris	UnitedHealthcare - Texas - Harris	FirstCare - Lubbock	Superior - Lubbock	AMERIGROUP - Nueces	Driscoll - Nueces	Superior - Nueces
MCO Mean-25 Mo to 6 Yrs	89.17%	84.30%	89.11%	91.86%	74.44%	92.85%	86.99%	90.88%	88.39%	90.00%	95.35%	77.94%
MCO Mean-7 to 11 Yrs	93.14%	85.80%	92.61%	88.64%		95.85%		93.84%	94.72%		96.26%	
MCO Mean-12 to 19 Yrs	90.40%	82.60%	90.32%	83.70%		92.30%		91.82%	89.83%		93.78%	

SDA Mean	Bexar	Dallas	El Paso	Harris	Lubbock	Nueces	Superior EPO	Tarrant	Travis	Webb
MCO Mean-25 Mo to 6 Yrs	89.60%	88.41%	90.04%	91.17%	89.43%	93.64%	88.13%	88.19%	82.84%	91.05%
MCO Mean-7 to 11 Yrs	93.92%	92.82%	92.99%	95.11%	94.31%	96.14%	92.48%	92.39%	85.03%	97.03%
MCO Mean-12 to 19 Yrs	89.86%	89.96%	90.71%	91.78%	90.80%	93.79%	90.25%	90.10%	84.52%	91.83%

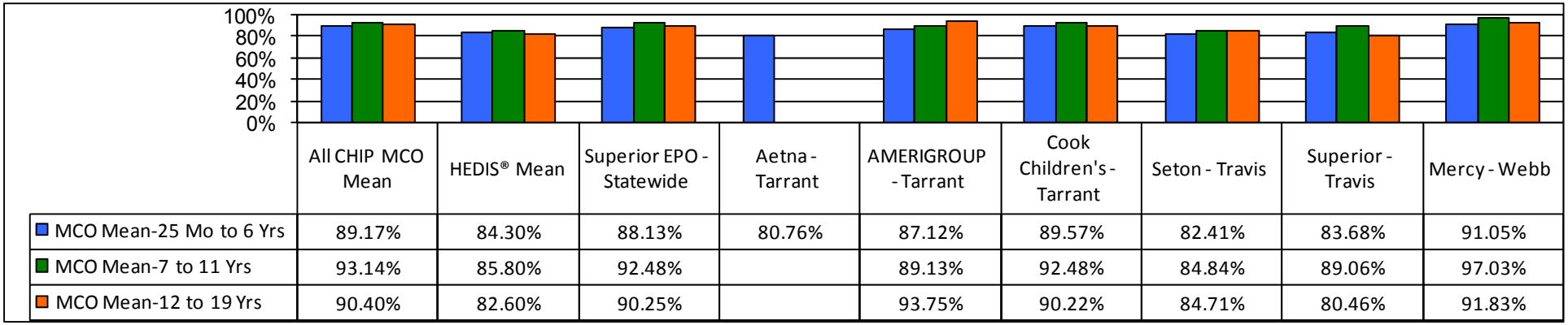
Reference: CHIP Table CAP09

Note: Denominators less than 30 were observed in Molina – Harris, UnitedHealthcare – Texas – Harris, AMERIGROUP – Nueces, and Superior – Nueces in the seven to 11 year and 12 to 19 year age groups; rates are therefore not reported in these MCO/SDA groups in these age bands. Denominators less than 30 in the 12 to 24 months age group were observed in many MCO/SDA groups; therefore this age band is not reported this year. Eligible members are included in the overall CHIP rate.

Chart 16C. HEDIS® Children and Adolescents' Access to Primary Care Practitioners – SDA Breakout

CHIP Eligible 25 Month-6 Years = 31,959
CHIP Eligible 7-11 Years = 25,442
CHIP Eligible 12-19 Years = 38,436

CHIP MCOs - September 1, 2007 to August 31, 2008



	All CHIP MCO Mean	HEDIS® Mean	Superior EPO - Statewide	Aetna - Tarrant	AMERIGROUP - Tarrant	Cook Children's - Tarrant	Seton - Travis	Superior - Travis	Mercy - Webb
MCO Mean-25 Mo to 6 Yrs	89.17%	84.30%	88.13%	80.76%	87.12%	89.57%	82.41%	83.68%	91.05%
MCO Mean-7 to 11 Yrs	93.14%	85.80%	92.48%		89.13%	92.48%	84.84%	89.06%	97.03%
MCO Mean-12 to 19 Yrs	90.40%	82.60%	90.25%		93.75%	90.22%	84.71%	80.46%	91.83%

SDA Mean		Bexar	Dallas	El Paso	Harris	Lubbock	Nueces	Superior EPO	Tarrant	Travis	Webb
	MCO Mean-25 Mo to 6 Yrs	89.60%	88.41%	90.04%	91.17%	89.43%	93.64%	88.13%	88.19%	82.84%	91.05%
	MCO Mean-7 to 11 Yrs	93.92%	92.82%	92.99%	95.11%	94.31%	96.14%	92.48%	92.39%	85.03%	97.03%
	MCO Mean-12 to 19 Yrs	89.86%	89.96%	90.71%	91.78%	90.80%	93.79%	90.25%	90.10%	84.52%	91.83%

Reference: CHIP Table CAP09
Note: Denominators less than 30 were observed in Aetna – Tarrant in the seven to 11 year and 12 to 19 year age groups; rates are therefore not reported in this MCO/SDA group in these age bands. Denominators less than 30 in the 12 to 24 months age group were observed in many MCO/SDA groups; therefore this age band is not reported this year. Eligible members are included in the overall CHIP rate.

Key Points:

1. Charts 16A, 16B, and 16C provide the percentage of children and adolescents in CHIP who had a visit with a physician provider during the measurement period, distributed by MCO/SDA. Rates are presented separately for three age groups – 25 months to six years, seven to 11 years, and 12 to 19 years. The HEDIS® measure specifies visits with a primary care practitioner. After lifting provider constraints, the percentages shown here are slightly inflated, which should be taken into consideration when making comparisons with the national HEDIS® mean.

2. The best performing MCO/SDA groups, each of which exceeded 90 percent on this measure for each of the three age groups, were Community First – Bexar, Superior – El Paso, Texas Children's – Harris, FirstCare – Lubbock, Driscoll – Nueces, and Mercy-Webb.
3. MCO/SDA results for the percentage of children between 25 months and six years of age who visited a care provider are as follows:
    - Nineteen out of 25 MCO/SDA groups were at or above the national HEDIS® mean of 84 percent for this measure. The six MCO/SDA groups below the national HEDIS® mean were: UniCare - Dallas (71 percent), Molina – Harris (74 percent), Superior – Nueces (78 percent), Aetna – Bexar (81 percent), Aetna – Tarrant (81 percent), and Seton – Travis (82 percent).
    - The MCO/SDA groups with the largest percentage of members visiting a care provider were Driscoll-Nueces (95 percent) and Texas Children's – Harris (93 percent).
    - At the SDA level, the percentage of children between 25 months to six years of age visiting a care provider ranged from 83 percent in Travis to 94 percent in Nueces, with all SDAs except Travis performing above the national HEDIS® mean of 84 percent for this measure.
4. MCO/SDA results for the percentage of children between seven and 11 years of age who visited a care provider are as follows:
    - Out of the 18 MCO/SDA groups for which there is data on this measure, 17 were above the national HEDIS® mean of 86 percent.

      Seton – Travis performed slightly below the national mean (86 percent), at 85 percent.
    - The MCO/SDA groups with the largest percentage of members visiting a care provider were Mercy – Webb (97 percent), Texas Children's – Harris (96 percent), and Driscoll – Nueces (96 percent). (Note that the majority of MCO/SDA groups were above 90 percent on this measure.)

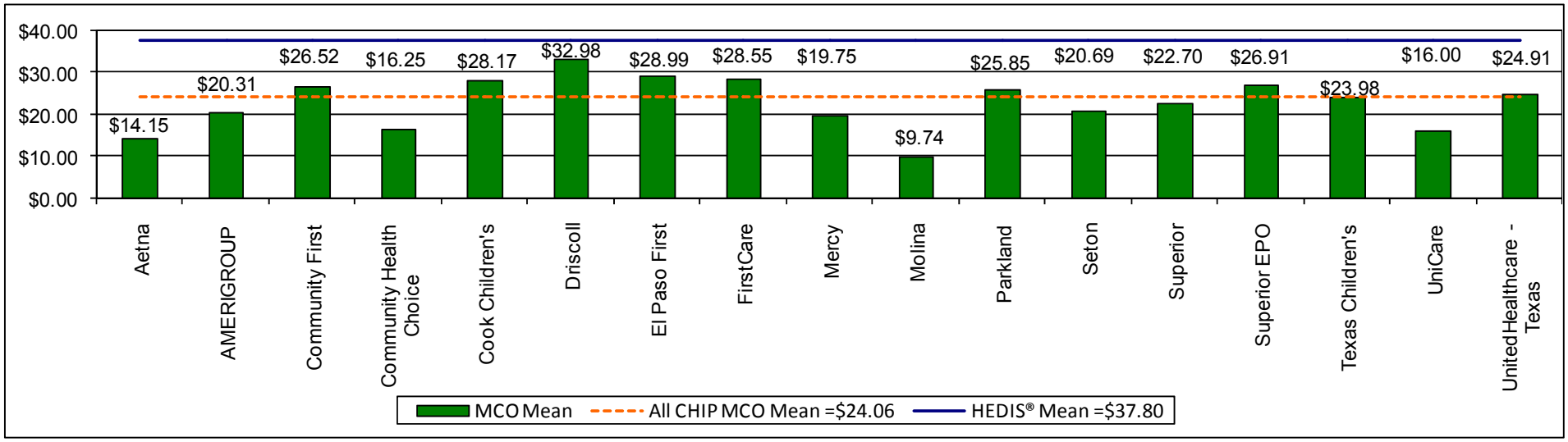
      At the SDA level, the percentage of children between seven and 11 years of age visiting a care provider ranged from 85 percent in Travis to 97 percent in Webb, with all SDAs except Travis performing above the national HEDIS® mean of 86 percent for this measure. (Note that Travis performed slightly below the national mean.)
5. MCO/SDA results for the percentage of children and adolescents between 12 and 19 years of age who visited a care provider are as follows:
    - Out of the 19 MCO/SDA groups for which there is data on this measure, 18 were at or above the national HEDIS® mean of 83 percent. Superior-Travis was the only MCO/SDA to perform slightly under the national mean at 80 percent for this measure.
    - The MCO/SDA groups with the largest percentage of members visiting a care provider were AMERIGROUP - Tarrant (94 percent), and Driscoll - Nueces (94 percent).

- At the SDA level, there was little variation across SDAs, with all performing relatively well on this measure. The percentage of children and adolescents between 12 and 19 years of age visiting a care provider ranged from 85 percent in Travis to 94 percent in Nueces, with all SDAs performing above the national HEDIS® mean of 83 percent for this measure.

6. In CHIP overall, children between seven and 11 years of age had the best access to health care providers (93 percent), followed by children and adolescents between the ages of 12 and 19 years of age (90 percent), and children between 26 months and six years of age (89 percent). Except where noted above, children and adolescents had very good access to health care providers. However, it should be noted that this measure lifted provider constraints, and thus the rates may be slightly higher than would be calculated by following HEDIS® specifications.

Chart 17. HEDIS® Outpatient Drug Utilization - Average Cost of Prescriptions per Member per Month

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Cost of Prescriptions = $112,346,528**



Reference: CHIP Table ORX09

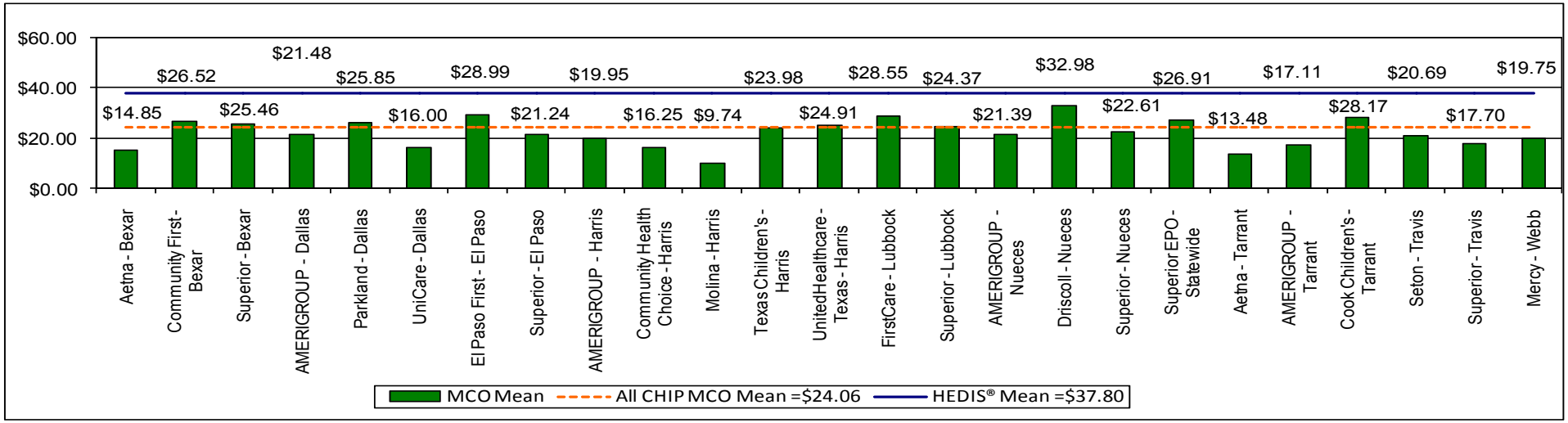
Key Points:

1. Chart 17 provides results for the HEDIS® Outpatient Drug Utilization measure, showing average cost of prescriptions per member per month during the measurement period, distributed by MCO.
2. The average cost of prescriptions for CHIP members per month was $24.06, which is approximately 14 dollars less than the HEDIS® mean of $37.80. (Note: For this measure, interpreting CHIP results in relation to the national HEDIS® mean should be done with the knowledge that adults are included in the national rate.)
    - In SFY 2007, the average costs of prescriptions per member per month was calculated by age group, zero to nine years of age, and 10 to 19 years of age. In SFY 2008, prescription costs were calculated for all CHIP members, thus this year's results are not comparable to SFY 2007.

3. The average cost of prescriptions per members per month across MCOs ranged from $9.74 in Molina to $32.98 in Driscoll, with the lowest prescription costs found in Molina ($9.74), Aetna ($14.15), UniCare ($16.00), and Community Health Choice ($16.25).

Chart 18. HEDIS® Outpatient Drug Utilization - Average Cost of Prescriptions per Member per Month – SDA Breakout

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Cost of Prescriptions = $112,346,528**



SDA Mean	Bexar	Dallas	El Paso	Harris	Lubbock	Nueces	Superior EPO	Tarrant	Travis	Webb
	$24.69	$22.62	$26.25	$22.09	$26.13	$31.13	$26.91	$24.02	$19.76	$19.75

Reference: CHIP Table ORX09

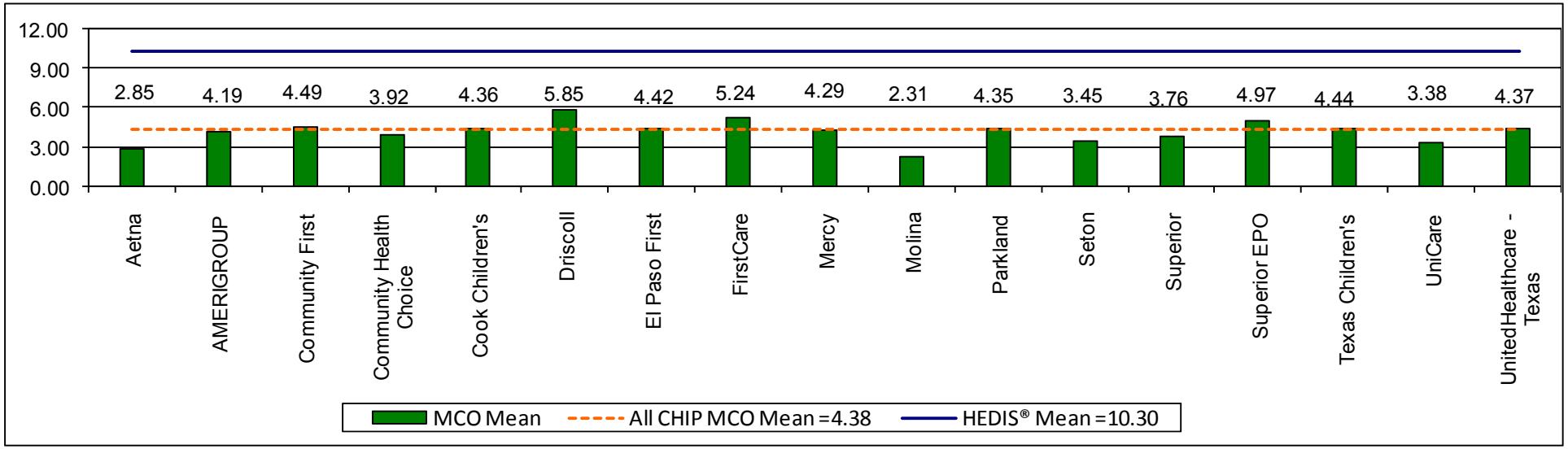
Key Points:

1. Chart 18 provides results for the HEDIS® Outpatient Drug Utilization measure, showing the average cost of prescriptions per member per month, distributed by MCO/SDA.
2. There was variation across MCO/SDA groups in the average cost of prescriptions per member per month, with costs ranging from $9.74 in Molina – Harris to $32.98 in Driscoll-Nueces. All MCO/SDA groups had prescription costs below the national HEDIS® mean of $37.80. (Note: For this measure, interpreting CHIP results in relation to the national HEDIS® mean should be done with the knowledge that adults are included in the national rate.)

3. Among SDAs, prescription costs were lower than the HEDIS® mean ($37.80), with Webb ($19.75) and Travis ($19.76) having the lowest average cost of prescriptions per member per month. Nueces SDA had the highest average cost of prescriptions per member per month at $31.13.

Chart 19. HEDIS® Outpatient Drug Utilization - Average Number of Prescriptions per Member per Year

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Number of Prescriptions = 1,705,227**



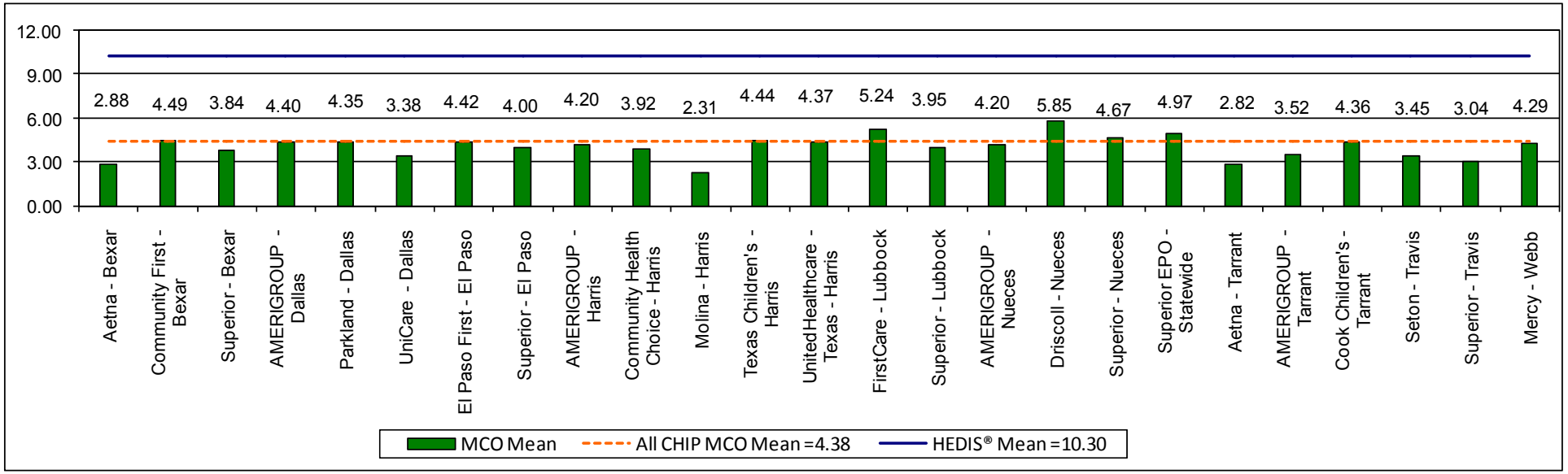
Reference: CHIP Table ORX09

Key Points:

1. Chart 19 provides results for the HEDIS® Outpatient Drug Utilization measure, showing the mean annual number of prescriptions per member in CHIP during the measurement period, distributed by MCO.
2. The average annual number of prescriptions per member was considerably lower in CHIP (mean = 4.38) than the national HEDIS® mean of 10.30. (Note: For this measure, interpreting CHIP results in relation to the national HEDIS® mean should be done with the knowledge that adults are included in the national rate.)
    - Comparisons to SFY 2007 on this measure are not available because averages in that program year were calculated for CHIP members by age, showing separate results for members zero to nine years of age and for members 10 to 19 years of age.
3. Across the MCOs, the average annual number of prescriptions per member ranged from 2.31 in Molina to 5.85 in Driscoll. All MCOs were well below the national HEDIS® mean (mean = 10.30) for annual average number of prescriptions per member.

Chart 20. HEDIS® Outpatient Drug Utilization - Average Number of Prescriptions per Member per Year – SDA Breakout

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Number of Prescriptions = 1,705,227**



SDA	Bexar	Dallas	El Paso	Harris	Lubbock	Nueces	Superior EPO	Tarrant	Travis	Webb
Mean	4.07	4.26	4.27	4.26	4.49	5.62	4.97	4.00	3.32	4.29

Reference: CHIP Table ORX09

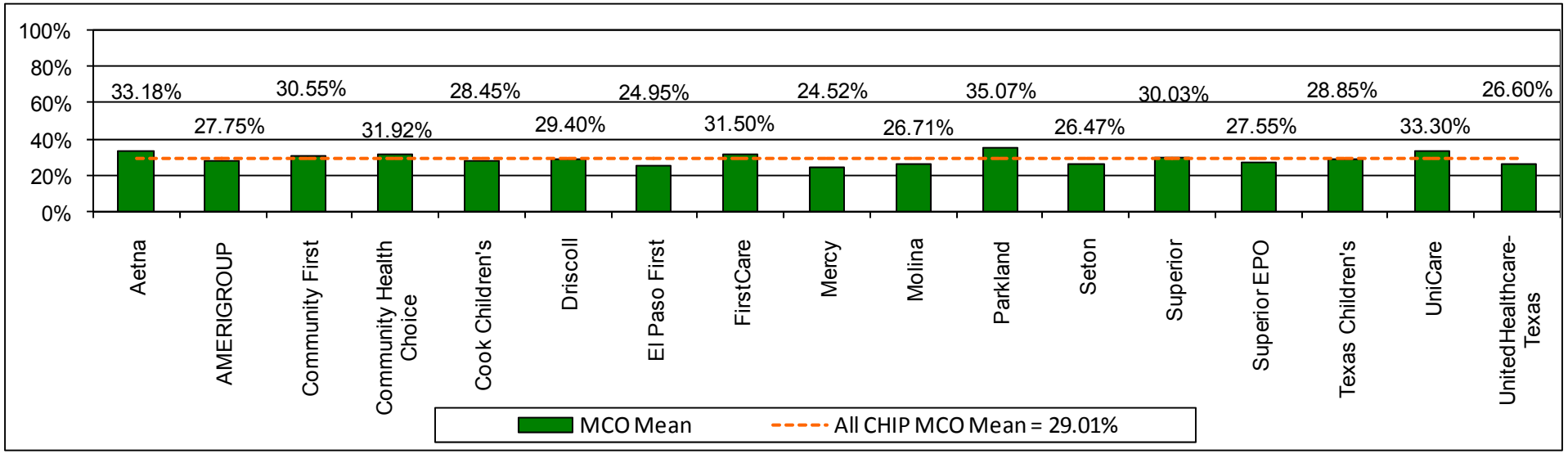
Key Points:

1. Chart 20 provides results for the HEDIS® Outpatient Drug Utilization measure, showing the mean annual number of prescriptions per member in CHIP , distributed by MCO/SDA.
2. Across the MCO/SDA groups, the average number of prescriptions per member per year was below the national HEDIS® mean of 10.30, ranging from 2.31 in Molina – Harris to 5.85 in Driscoll - Nueces. (Note: For this measure, interpreting CHIP results in relation to the national HEDIS® mean should be done with the knowledge that adults are included in the national rate.)

3. At the SDA level, the average number of prescriptions per member per year ranged from 3.32 in Travis to 5.62 in Nueces. All SDAs were well below the national HEDIS® mean for this measure (mean = 10.30).

Chart 21. Percent of Emergency Department Visits with a Primary Diagnosis of an Ambulatory Care Sensitive Condition

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP ED Visits = 99,082**



Reference: CHIP Table ACSC09

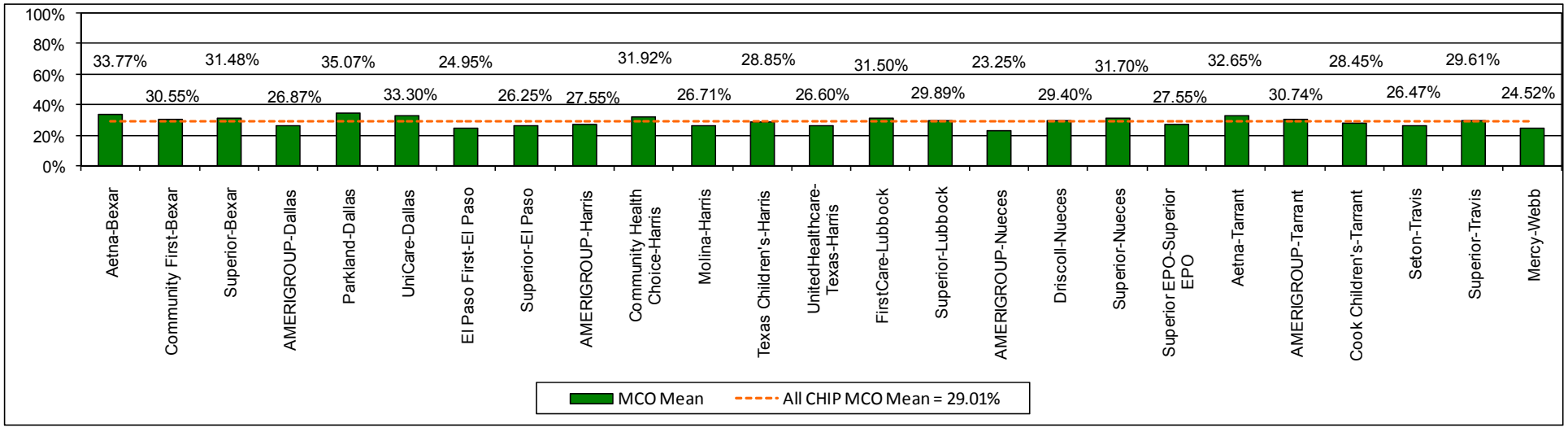
Key Points:

1. Chart 21 provides the percentage of emergency department visits among CHIP enrollees during the measurement period who had a primary diagnosis of an ambulatory care sensitive condition (ACSC), distributed by MCO. ACSCs are medical problems that are potentially treatable through proper outpatient monitoring and an effective community health care system. Therefore, admission of members with ACSCs to the emergency room may be considered an indication that outpatient monitoring and community health care systems are under-performing; they represent trips to the emergency room that could potentially have been prevented. For this measure, the higher the percentage, the lower the health plan performance.
2. In CHIP overall, 29 percent of visits to the emergency department involved an ACSC. The percentage of ACSC-related emergency department visits in CHIP is greater than the HHSC Performance Indicator Dashboard Standard of 24 percent, which indicates underperformance on this measure.
    - In SFY 2007, among CHIP enrollees, 28 percent of emergency department visits involved a primary diagnosis of an ACSC.

3. There was some degree of variation among MCOs on this measure, ranging from 25 percent in El Paso First and Mercy to 35 percent in Parkland. However, performance across the MCOs did not meet the HHSC performance Indicator Dashboard standard of 24 percent.
4. HHSC may wish to consider program-wide efforts toward reducing rates of emergency department visits for ACSCs. In reducing ACSC-related emergency department visits, The Commonwealth Fund recommends: 1) Promoting preventative health care (e.g., vaccinations); 2) Educating parents of children with chronic conditions on how to manage those conditions; and 3) Increasing the use of care coordination services among those with chronic conditions.[20] Furthermore, access to high-quality primary care has been shown to reduce emergency department visits for ACSCs.[21] High-quality primary care that provides family-centered care (i.e., partnerships between families and care professionals), timeliness in care, and increases in parental perception of "realized access" (i.e., the belief that they will be able to access care and referrals) are all associated with a reduction in ACSC-related emergency department visits.[22] HHSC may wish to continue efforts to improve the quality of primary care in CHIP by ensuring that the recommendations listed above are incorporated into health plans.

Chart 22. Percent of Emergency Department Visits with a Primary Diagnosis of an Ambulatory Care Sensitive Condition – SDA Breakout

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP ED Visits = 99,082**



SDA	Bexar	Dallas	El Paso	Harris	Lubbock	Nueces	Superior EPO	Tarrant	Travis	Webb
Mean	31.23%	31.25%	25.39%	28.67%	30.63%	29.24%	27.55%	29.47%	27.47%	24.52%

Reference: CHIP Table ACSC09

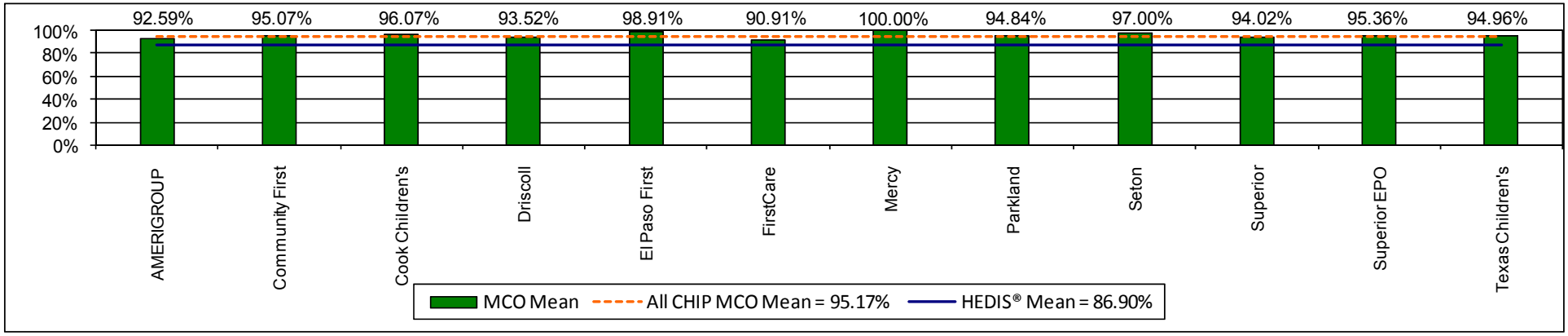
Key Points:

1. Chart 22 provides the percentage of emergency department visits for CHIP enrollees with a primary diagnosis of an ambulatory care sensitive condition (ACSC), distributed by MCO/SDA. ACSCs are described in more detail under Chart 21.
2. None of the MCO/SDA groups except AMERIGROUP – Nueces met the HHSC Performance Indicator Dashboard Standard of 24 percent for this measure, suggesting the need for program-wide efforts toward reducing rates of emergency department visits for ACSCs. The best-performing MCO/SDA group on this measure was AMERIGROUP – Nueces at 23 percent, and the lowest-performing was Parkland - Dallas at 35 percent.

3. Among the SDAs, all had a higher percentage of ACSC-related emergency department visits than the HHSC standard of 24 percent, suggesting the need for improved performance on this measure. There was little variation on this measure across the SDAs, ranging from 25 percent in Webb and El Paso to 31 percent in Bexar, Dallas, and Lubbock.
4. Please see Chart 21 for specific recommendations to reduce emergency department visits for CHIP enrollees with a primary diagnosis of an ACSC.

Chart 23. HEDIS® Use of Appropriate Medications for People with Asthma

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Eligible = 2,401**



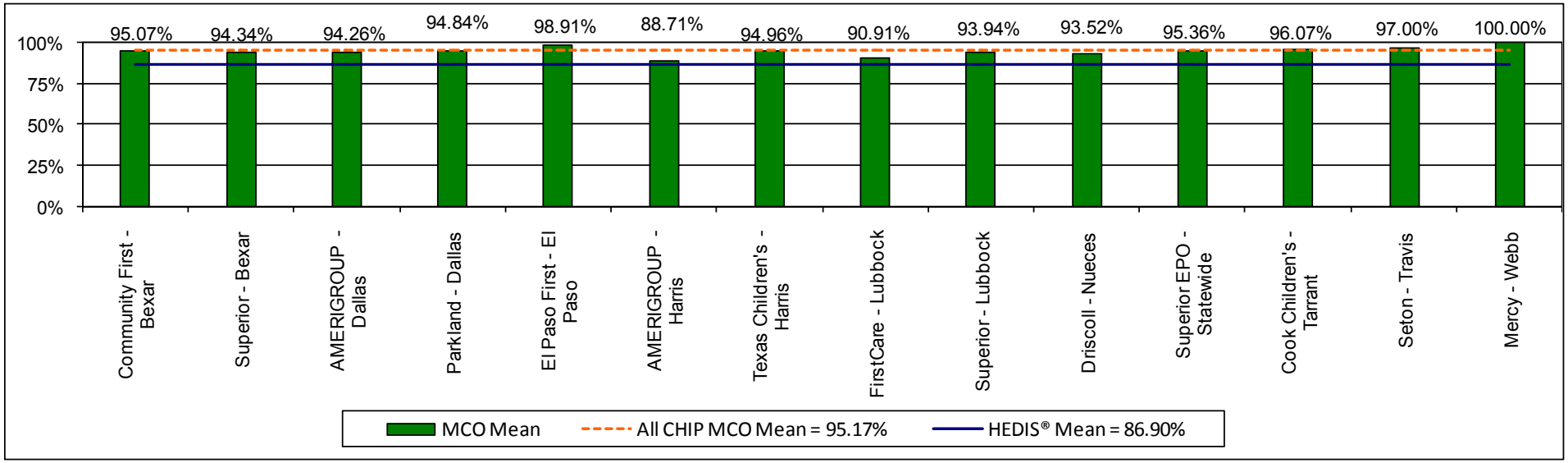
Reference: CHIP Table ASM09
Note: Denominators of less than 30 eligible members were observed in Aetna, Community Health Choice, Molina, UniCare and UnitedHealthcare-Texas; rates for these health plans are therefore not reported. All eligible members were included in the overall CHIP rate.

Key Points:

1. Chart 23 provides the overall percentage of CHIP enrollees who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement period, distributed by MCO. Rates were not reported by age cohorts for the present report since there were many low denominators observed among the individual age groups.
2. Among CHIP members with asthma, 95 percent were appropriately prescribed medications. CHIP's performance on this measure is eight percentage points greater than the national HEDIS® mean of 87 percent. (Note: For this measure, interpreting CHIP results in relation to the national HEDIS® mean should be done with the knowledge that adults are included in the national rate.)
3. There was little variability across MCOs on this measure, ranging from 91 percent in FirstCare to 100 percent in Mercy for appropriate prescription of medications for those with asthma.

Chart 24. HEDIS® Use of Appropriate Medications for People with Asthma - SDA Breakout

CHIP MCOs - September 1, 2007 to August 31, 2008 **CHIP Eligible = 2,401**



SDA	Bexar	Dallas	El Paso	Harris	Lubbock	Nueces	Superior EPO	Tarrant	Travis	Webb
Mean	94.92%	94.66%	97.48%	94.10%	92.21%	93.52%	95.36%	96.13%	97.12%	100.00%

Reference: CHIP Table ASM09

Note: Denominators of less than 30 eligible members were observed in Aetna - Bexar, UniCare - Dallas, Superior - El Paso, Community Health Choice - Harris, Molina - Harris, UnitedHealthcare - Texas - Harris, AMERIGROUP - Nueces, Superior - Nueces, Aetna - Tarrant, AMERIGROUP - Tarrant and Superior - Travis; rates for these MCO/SDA groups are therefore not reported. Denominators less than 30 in five to nine year olds and 10 to 17 year olds were observed in many MCO/SDA groups; therefore the rates for these age groups are not reported this year. Eligible members were included in the overall CHIP rate.

Key Points:

1. Chart 24 provides the percentage of CHIP enrollees who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement period, distributed by MCO/SDA. Rates are presented for 14 MCO/SDA groups in 10 SDAs.

2. All MCO/SDA groups performed above the national HEDIS® mean of 87 percent for members receiving appropriate asthma medication, ranging from 89 percent in AMERIGROUP – Harris to 100 percent in Mercy - Webb. (Note: For this measure, interpreting CHIP results in relation to the national HEDIS® mean should be done with the knowledge that adults are included in the national rate.)

3. All SDAs exceeded the national HEDIS® mean (87 percent) for this measure. There was little variability among SDAs, ranging from 92 percent in Lubbock to 100 percent in Webb, with greater than 90 percent of members in each SDA being appropriately prescribed medication for asthma.

4. Overall, CHIP performed well on this measure with the vast majority of members with asthma receiving appropriate medications.

Comparison of FY 2008 CHIP Quality of Care Measures with Fiscal Year 2008 Standards and Fiscal Year 2007 CHIP Measures

Measure	Texas CHIP FY 2008	HEDIS FY 2008	HHSC PIDS FY 2008	AHRQ PDI FY 2008	Texas CHIP FY 2007	MCO/SDA Groups Performing Below the HHSC PIDS FY 2008
Inpatient admission rate for asthma	88 per 100,000	NA	NA	181 per 100,000	95 per 100,000	NA
Inpatient admission rate for diabetes short-term complications	24 per 100,000	NA	NA	29 per 100,000	30 per 100,000	NA
Inpatient admission rate for gastroenteritis	42 per 100,000	NA	NA	183 per 100,000	38 per 100,000	NA
Inpatient admission rate for urinary tract infections	26 per 100,000	NA	NA	53 per 100,000	24 per 100,000	NA
Well-child visits in the 3rd, 4th, 5th, and 6th years of life*	59%	65%	56%	NA	61%	Unicare – Dallas (42%) FirstCare – Lubbock (48%) Molina – Harris (49%) UnitedHealthcare – Texas – Harris (49%) Aetna – Tarrant (53%) Superior – Travis (54%) Superior – Nueces (55%) Superior EPO – Statewide (55%)
Adolescent well-care visits**	39%	42%	38%	NA	39%	Molina – Harris (22%) Superior – Nueces (25%) Aetna – Tarrant (25%) UniCare – Dallas (26%) Superior – Lubbock (26%) Aetna – Bexar (27%) FirstCare – Lubbock (28%) UnitedHealthcare – Texas – Harris (31%) Superior – Travis (34%) Superior EPO – Statewide (35%)

Measure	Texas CHIP FY 2008	HEDIS FY 2008	HHSC PIDS FY 2008	AHRQ PDI FY 2008	Texas CHIP FY 2007	MCO/SDA Groups Performing Below the HHSC PIDS FY 2008
						AMERIGROUP – Nueces (35%) Superior – Bexar (36%) Community First – Bexar (37%)
Follow-up after hospitalization for mental illness (7-day)***	40%	43%	32%	NA	41%	None
Follow-up after hospitalization for mental illness (30-day)***	71%	61%	52%	NA	72%	None
Readmission within 30 days after an inpatient stay for mental health	19%	NA	NA	NA	36%	NA
Appropriate testing for children with pharyngitis	53%	58%	NA	NA	53%	NA
Children and adolescents' access to primary care practitioners*						
Ages 25 months to 6 years	89%	84%	NA	NA	92%	NA
Ages 7 to 11 years	93%	86%	NA	NA	NA	NA
Ages 12 to 19 years	90%	83%	NA	NA	NA	NA
Average cost of prescriptions per member per month****	$24.06	$37.80	NA	NA	NA	NA
Average number of prescriptions per member per year****	4.38	10.30	NA	NA	NA	NA
Percent of ED visits with a primary diagnosis of an ACSC	29%	NA	24%	NA	28%	All MCO/SDA groups with the exception of AMERIGROUP - Nueces
Use of appropriate medications for people with asthma****	95%	87%	NA	NA	NA	NA

*The Texas CHIP results are slightly inflated because the criteria used to determine the Texas CHIP measure include visits to any provider, while the HEDIS measure criteria include only visits to primary care practitioners.

**The Texas CHIP results are slightly inflated because the criteria used to determine the Texas CHIP measure include visits to any provider, while the HEDIS measure criteria include only visits to primary care practitioners or OB/GYN practitioners.

***The Texas CHIP results are slightly inflated because the criteria used to determine the Texas CHIP measure include visits to any physician, while the HEDIS measure criteria include only visits to mental health providers.

****The criteria used to determine the Texas CHIP measure differ from the HEDIS criteria in that the HEDIS criteria include adults.

Endnotes

[1] ICHP (The Institute for Child Health Policy). 2009. *Quality of Care Measures Technical Report Specifications, October 2009*. Gainesville, FL: The Institute for Child Health Policy, University of Florida.

[2] The information that NCQA compiles for Medicaid Managed Care Programs can be viewed at www.ncqa.org.

[3] 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.

[4] HHSC (Texas Health and Human Services Commission). 2009. "HHSC Uniform Managed Care Manual – Performance Indicator Dashboard, Version 1.4." Available at http://www.hhsc.state.tx.us/Medicaid/UMCM/default.html.

[5] 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.

[6] Technical specifications for the PDI can be viewed at http://www.qualityindicators.ahrq.gov/pqi_overview.htm.

[7] ICHP. 2009. *Annual Chart Book, Fiscal Year 2008 – Texas Medicaid Managed Care STAR Quality of Care Measures: Technical Appendix*. Gainesville, FL: The Institute for Child Health Policy, University of Florida.

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[13] The Commonwealth Fund. 2004-2009. "Follow-up After Hospitalization for Mental Illness." Available at http://www.commonwealthfund.org/Content/Performance-Snapshots/Mental-and-Behavioral-Health-Care/Follow-Up-After-Hospitalization-for-Mental-Illness.aspx.

[14] The Commonwealth Fund. 2004-2009.
[15] Bladder, J. C. 2004. "Symptom, Family, and Service Predictors of Children's Psychiatric Rehospitalization Within One Year of Discharge." *Journal of American Academy of Child and Adolescent Psychiatry* 43(4): 440-451.

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[17] Park, S. Y., M. A. Gerber, R. R. Tanz, J. M. Hickner, J. M. Galliher, I. Chuang, and R. E. Besser. 2006. "Clinicians' Management of Children and Adolescents with Acute Pharyngitis." *Pediatrics* 117(6): 1871-1878.

[18] Park, et al. 2006.

[19] Diaz, M. C., N. Symons, M. L. Ramundo, and N. C. Christopher. 2004. "Effect of a Standardized Pharyngitis Treatment Protocol on Use of Antibiotics in a Pediatric Emergency Department." *Archives of Pediatric Adolescent Medicine* 158: 977-981.

[20] The Commonwealth Fund. December, 2006. "Hospitalizations for Ambulatory Care-Sensitive Conditions." Available at http://www.commonwealthfund.org/Content/Performance-Snapshots/Overuse-of-Health-Care-Services/Hospitalizations-for-Ambulatory-Care--8211-Sensitive-Conditions.aspx.

[21] Brousseau, D. C., M. H. Gorelick, R. G. Hoffman, G. Flores, and A. B. Nattinger. 2009. "Primary Care Quality and Subsequent Emergency Department Utilization for Children in Wisconsin Medicaid." *Academic Pediatrics* 9(1): 33-39.

[22] Brousseau, et al. 2009.

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

Technical Specifications Report for Annual Quality of Care Measures

Texas STAR, STAR+PLUS, CHIP, CHIP Dental, STAR Health, NorthSTAR & PCCM

Fiscal Year 2008

Prepared by

The Institute for Child Health Policy
University of Florida

The Texas External Quality Review Organization
for
Medicaid Managed Care and the Children's Health Insurance Program

Submitted:
October 29, 2009

Table of Contents

Introduction

The purpose of this document is to provide technical specifications for the Quality of Care measures submitted to the Texas Health and Human Services Commission (HHSC) and health plans annually.

The majority of measures follow the Healthcare Effectiveness Data and Information Set (HEDIS®) 2009 Technical Specifications calculated using a National Committee for Quality Assurance (NCQA) certified software tool. HHSC approved the use of this software so that all HEDIS® results could be calculated using a tool recognized by the NCQA. At HHSC's request, the Institute for Child Health Policy (ICHP) developed a methodology to allow for flexibility in the provider specialty codes when determining eligibility for HEDIS® measures. As in the prior reporting period (SFY 2007), ICHP modified the NCQA specifications to relax provider constraints when determining eligibility for HEDIS® measures.

For further information about the HEDIS® indicators, please refer to the HEDIS® 2009 Technical Specifications Manual. For easier reference, the page numbers from the HEDIS® manual are identified, as appropriate, for the measures listed in this document. The changes to HEDIS® 2009 measures are also outlined with the table specifications.

The measures are calculated with a six-month lag time for data completeness. The reports are generated from the encounter data submitted to ICHP by Texas Medicaid & Healthcare Partnership (TMHP) and the enrollment data provided by the enrollment broker. Claims and encounter data are supplemented with pharmacy data from the Vendor Drug Program for calculating measures that need prescription information.

NCQA's HEDIS® 2008 Medicaid mean results were used for comparison purposes for the Medicaid and CHIP populations where this information was available. Clients dually enrolled in both Medicaid and Medicare were excluded from reporting for the STAR+PLUS population. Since the HEDIS® mean is not specific to the unique population seen in STAR+PLUS and most likely indicates a significantly healthier enrollee pool, the HEDIS® mean is provided only as a reference point. Hence, comparisons between the HEDIS® mean and the STAR+PLUS results should be made cautiously.

This specifications report should be consulted in conjunction with the HEDIS® 2009 Technical Specifications Manual. The following HEDIS® manual sections should be reviewed prior to understanding the specific indicator(s):

- General Guidelines for Data Collection and Reporting, pages 9-36,
- Guidelines for Calculations and Sampling, pages 39-53.

The Texas rates for HEDIS® measures are reported at the individual health plan/SDA level, by the overall health plan rate for each SDA, and the overall State rate. Regular review of the results will provide HHSC with valuable information to help determine needed changes in service delivery, program benefits, health plan coverage, and potential expansion or reform of Medicaid and CHIP programs.

Administrative Methodology

ICHP uses only administrative data to identify the denominator and the numerator of each measure, unless indicated otherwise. Per NCQA guidelines, rates are not reported if the denominator is too small (< 30). These results are indicated as LD (Low Denominator).

Tables PDI09 and PQI09: AHRQ's Preventive Care Indicators (Adult and Pediatric Quality Indicators)

These tables report on CHIP (PDI only), STAR (PDI and PQI), STAR+PLUS (PDI and PQI), STAR Health (PDI only) and PCCM (PDI and PQI) programs.

Description: Indicators developed for the Agency for Healthcare Research and Quality (AHRQ) were used to evaluate the performance of MCOs related to inpatient admissions for various 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."[14] The Quality Indicators use hospital inpatient discharge data and are measured as rates of admission to the hospital. Specifically, two sets of indicators were used in the analysis and are reported herein: Prevention Quality Indicators (PQIs) for adult enrollees and Pediatric Quality Indicators (PDIs) for child enrollees. Unlike most other measures provided in the Quality of Care reports, low quality indicator rates are desired, as they suggest a better quality health care system outside the hospital setting. This year, the specifications used to calculate rates for these measures come from AHRQ's PDI version 3.2 and PQI version 4.0.

The following indicators were used to assess adult admissions for ambulatory care sensitive conditions: (1) Diabetes Short-Term Complications, (2) Perforated Appendix, (3) Diabetes Long-Term Complications, (4) Chronic Obstructive Pulmonary Disease, (5) Low Birth Weight, (6) Hypertension, (7) Congestive Heart Failure, (8) Dehydration, (9) Bacterial Pneumonia, (10) Urinary Tract Infection, (11) Angina without Procedure, (12) Uncontrolled Diabetes, (13) Adult Asthma, and (14) Rate of Lower Extremity Amputation among Patients with Diabetes. For these measures, adults are those individuals ages 18 or older.

For children, there are five quality indicators measuring pediatric admissions for ambulatory care sensitive conditions: (1) Asthma, (2) Diabetes Short-Term Complications, (3) Gastroenteritis, (4) Perforated Appendix, and (5) Urinary Tract Infection. The age eligibility for these measures is 17 years old and younger.

Benchmarking: Comparisons to AHRQ national estimates and previous year's results for the health plan on these measures are presented as appropriate.

Deviations from NCQA Guidelines: This is not a HEDIS® measure.

[14] 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.

Calculations:

Adult Prevention Quality Indicators

AHRQ Indicator Number	Indicator Name	Description
PQI 1	Diabetes Short-Term Complications Admission Rate	Number of admissions for diabetes short-term complications per 100,000 population
PQI 2	Perforated Appendix Admission Rate	Number of admissions for perforated appendix as a share of all admissions for appendicitis within an area
PQI 3	Diabetes Long-Term Complications Admission Rate	Number of admissions for long-term diabetes per 100,000 population
PQI 5	Chronic Obstructive Pulmonary Disease Admission Rate	Number of admissions for COPD per 100,000 population
PQI 7	Hypertension Admission Rate	Number of admissions for hypertension per 100,000 population
PQI 8	Congestive Heart Failure Admission Rate	Number of admissions for CHF per 100,000 population
PQI 9	Low Birth Weight Rate	Number of low birth weight births as a share of all births in an area
PQI 10	Dehydration Admission Rate	Number of admissions for dehydration per 100,000 population
PQI 11	Bacterial Pneumonia Admission Rate	Number of admissions for bacterial pneumonia per 100,000 population
PQI 12	Urinary Tract Infection Admission Rate	Number of admissions for urinary tract infection per 100,000 population
PQI 13	Angina without Procedure Admission Rate	Number of admissions for angina without procedure per 100,000 population
PQI 14	Uncontrolled Diabetes Admission Rate	Number of admissions for uncontrolled diabetes per 100,000 population *(Note: This indicator is designed to be combined with diabetes short-term complications.)*
PQI 15	Adult Asthma Admission Rate	Number of admissions for asthma in adults per 100,000 population
PQI 16	Rate of Lower Extremity Amputation Among Patients with Diabetes	Number of admissions for lower extremity amputation among patients with diabetes per 100,000 population

Pediatric Quality Indicators

AHRQ Indicator Number	Indicator Name	Description
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

For further information about these quality of care indicators, please refer to the AHRQ website at http://www.qualityindicators.ahrq.gov**.**

Table W1509: HEDIS® Well-Child Visits in the First 15 Months of Life

This table reports on the STAR and PCCM programs.

Description: This table provides the percentage of members who turned 15 months old during the specified timeframe and who received zero or more well-child visit(s) with a provider during their first 15 months of life.

HEDIS® 2009:

- No Changes.

Benchmarking: HEDIS® 2008 Audit Means, Percentile and Ratio, and overall SDA and statewide rates.

Deviations from NCQA Guidelines: ICHP does not cross-reference against the provider type to check if the provider is a primary care practitioner. All claims with pertinent procedure and/or diagnosis codes with any provider are considered to have received a well-child visit.

Calculations: This is a HEDIS® measure and the HEDIS® technical specifications are followed. Refer to the HEDIS® 2009 Technical Specifications Manual for Well-Child Visits in the First 15 Months of Life, pages 252-254.

Table W3409: HEDIS® Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

This table reports on CHIP, STAR, STAR+PLUS, and PCCM programs.

Description: This table provides the percentage of members three to six years old during the specified timeframe who received one or more well-child visit(s) with a provider.

HEDIS® 2009:

- No Changes.

Benchmarking: HEDIS® 2008 Audit Means, Percentile and Ratio, and overall SDA and statewide rates.

Deviations from NCQA Guidelines: ICHP does not cross-reference against the provider type to check if the provider is a primary care practitioner. All claims with pertinent procedure and/or diagnosis codes with any provider are considered to have received a well-child visit.

Calculations: This is a HEDIS® measure and the HEDIS® technical specifications are followed. Refer to the HEDIS® 2009 Technical Specifications Manual for Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, pages 255-257.

Table AWC09: HEDIS® Adolescent Well-Care Visits

This table reports on CHIP, STAR, STAR+PLUS, and PCCM programs.

Description: The purpose of this table is to provide the percentage of members 12-21 years old during the specified timeframe, who received one or more well-care visits.

HEDIS® 2009:

- No Changes.

Benchmarking: HEDIS® 2008 Audit Means, Percentile and Ratio, and overall SDA and statewide rates.

Deviations from NCQA Guidelines: ICHP does not cross-reference against the provider type to check if the provider is a primary care practitioner or an OB/GYN practitioner. All claims with pertinent procedure and/or diagnosis codes with any provider are considered to have received a well-child visit.

Calculations: This is a HEDIS® measure and the HEDIS® technical specifications are followed. Refer to the HEDIS® 2009 Technical Specifications Manual for Adolescent Well-Care Visits, pages 258-260.

Table PPC09: HEDIS® Prenatal and Postpartum Care

This table reports on STAR, STAR+PLUS, and PCCM programs.

Description: This table provides the percentage of women who delivered a live birth during a specified time period and received timely prenatal or postpartum care visits.
Timeliness of

- Prenatal care – The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.
- Postpartum care – The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

HEDIS® 2009:

- Deleted DRGs from Table PPC-B.
- Added LOINC codes 47527-7, 47528-5.
- Deleted CPT codes 88144, 88145.

Benchmarking: HEDIS® 2008 Audit Means, Percentile and Ratio, and overall SDA and statewide rates.

Deviations from NCQA Guidelines: ICHP does not cross-reference against the provider type to check if the provider is a primary care practitioner or an OB/GYN practitioner. All claims with pertinent procedure and/or diagnosis codes with any provider are considered for compliance check.

Calculations: This is a HEDIS® measure and the HEDIS® technical specifications are followed. Refer to the HEDIS® 2009 Technical Specifications Manual for Prenatal and Postpartum Care, pages 217-228.

Table CCS09: HEDIS® Cervical Cancer Screening

This table reports on the STAR, STAR+PLUS, and PCCM programs.

Description: This table provides the percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.

HEDIS® 2009:

- Added LOINC code 427528-5.
- Added CPT codes 58570-58573.

Benchmarking: HEDIS® 2008 Audit Means, Percentile and Ratio, and overall SDA and statewide rates.

Deviations from NCQA Guidelines: None

Calculations: This is a HEDIS® measure and the HEDIS® technical specifications are followed. Refer to the HEDIS® 2009 Technical Specifications Manual for Cervical Cancer Screening, pages 78-80.

Table MPT09: HEDIS® Mental Health Utilization

This table reports on the STAR Health and NorthSTAR programs.

Description: This table provides the number and percentage of members who received the following mental health services during the specified time period.

- Any services
- Inpatient
- Intensive outpatient or partial hospitalization
- Outpatient or ED

HEDIS® 2009: No Changes.

Benchmarking: HEDIS® 2008 Audit Means, Percentile and Ratio, and overall SDA and statewide rates.

Deviations from NCQA Guidelines: ICHP does not cross-reference against the provider type to check if the provider who rendered the follow-up care is a mental health practitioner. All claims with pertinent procedure and/or diagnosis codes with any provider are considered for compliance check.

Calculations: This is a HEDIS® measure and the HEDIS® technical specifications are followed. Refer to the HEDIS® 2009 Technical Specifications Manual for Mental Health Utilization, pages 291-294.

Table FUH09: HEDIS® Follow-Up after Hospitalization for Mental Illness (7-day and 30-day follow-up)

This table reports on CHIP, STAR, STAR+PLUS, STAR Health, NorthSTAR, and PCCM programs.

Description: This table provides the percentage of discharges for members six years of age and older who were hospitalized for selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization.

HEDIS® 2009:

- Deleted DRGs from Tables FUH-A, FUH-B.

Benchmarking: HEDIS® 2008 Audit Means, Percentile and Ratio, and overall SDA and statewide rates.

Deviations from NCQA Guidelines: ICHP does not cross-reference against the provider type to check if the provider who rendered the follow-up care is a mental health practitioner. All claims with pertinent procedure and/or diagnosis codes with any provider are considered for compliance check.

Calculations: This is a HEDIS® measure and the HEDIS® technical specifications are followed. Refer to the HEDIS® 2009 Technical Specifications Manual for Follow-Up After Hospitalization for Mental Illness, pages 170-172.

Table MHReadmit09: Readmission Within 30 Days After an Inpatient Stay for Mental Health

This table reports on CHIP, STAR, STAR+PLUS, STAR Health, NorthSTAR, and PCCM programs.

Description: This table provides information about mental health care inpatient readmission for members six years of age and older who were seen within 30 days of a previous behavioral health discharge.

Benchmarking: This is not a HEDIS® measure. Comparisons to the overall SDA and statewide rate are provided as appropriate.

Calculations:
Inpatient Discharge:
Inpatient care with mental health as the principal diagnosis.

Mental Health Readmission:
Each inpatient discharge in the period is checked for a readmission with an MH diagnosis within 30 days.

Per HHSC's request, age stratification for NorthSTAR differs from other programs.

The following diagnosis codes, in conjunction with facility codes, as well as the following DRG codes, are used to identify mental health usage in an inpatient setting.

Code Type	Code#	Description
ICD-9-CM Codes	290	Senile and pre-senile organic psychotic conditions
	293	Transient Organic Psychotic Condition
	294	Other Organic Psychotic Conditions (chronic)
	295	Schizophrenic Disorders
	296	Affective Psychoses
	297	Paranoid states (Delusional disorders)
	298	Other Non-organic Psychoses
	299	Psychoses with origin specific to childhood
	300	Anxiety states
	300.3	Obsessive-compulsive disorder
	300.4	Dysthymic disorder
	301	Personality Disorders
	302	Sexual Deviations and Disorders
	306	Physiological malfunction arising from mental factors
	307	Special symptoms or syndromes, not elsewhere classified

Code Type	Code#	Description
ICD-9-CM Codes	308	Acute reaction to stress
	309	Adjustment reaction
	310	Specific non-psychotic mental disorder due to organic brain damage
	311	Depressive disorder, not elsewhere classified
	312	Disturbance of conduct, not elsewhere classified
	313	Disturbance of emotions - childhood and adolescence
	314	Hyperkinetic syndrome of childhood
	315	Specific delays in development
	316	Psychic factors associated with diseases classified elsewhere
CMS-DRG Codes, excluding those with ICD-9-CM principal diagnosis of 317-319	424	O.R. Procedure with Principal Diagnosis of Mental Illness
	425	Acute Adjustment Reactions and Psychosocial Dysfunction
	426	Depressive Neuroses
	427	Neuroses Except Depressive
	428	Disorders of Personality and Impulse Control
	429	Organic Disturbances and Mental Retardation
	430	Psychoses
	431	Childhood Mental Disorders
	432	Other Mental Disorder Diagnoses
MS-DRG Codes, excluding those with ICD-9-CM principal diagnosis of 317-319	876	O.R. Procedure with Principal Diagnosis of Mental Illness
	880	Acute Adjustment Reactions and Psychosocial Dysfunction
	881	Depressive Neuroses
	882	Neuroses Except Depressive
	883	Disorders of Personality and Impulse Control
	884	Organic Disturbances and Mental Retardation
	885	Psychoses
	886	Behavioral and Developmental Disorders
	887	Other Mental Disorder Diagnoses

Table CDC09: HEDIS® Comprehensive Diabetes Care

This table reports on the STAR, STAR+PLUS, and PCCM programs.

Description: This table presents the percentage of members 18-75 years of age with a diagnosis of diabetes (either type 1 or type 2) who received tests/services related to diabetes during the reporting/measurement period.

HEDIS® 2009:

- Added amylin analogs category to Table CDC-A
- Deleted CPT code 99499 from Table CDC-C
- For the eye exam indicator, removed the requirement that HCPCS S0625 be billed by an optometrist or ophthalmologist.
- Added CPT codes 67041-67043, 67113 to Table CDC-G.
- Clarified the use of CPT category II code 3072F in Table CDC-G.
- Deleted CPT codes 83715, 83716 from CDC-H.
- Deleted DRGs from Tables CDC-B, CDC-K.
- Added UB Type of Bill code 72x to Table CDC-K.
- Added POS code 65 to Table CDC-K.

Benchmarking: HEDIS® 2008 Audit Means, Percentile and Ratio, and overall SDA and statewide rates.

Deviation from HEDIS®: None.

Calculations: This is a HEDIS® measure and the HEDIS® technical specifications are followed. Refer to the HEDIS® 2009 Technical Specifications Manual, pages 134-148.

Table CWP09: HEDIS® Appropriate Testing for Children with Pharyngitis

This table reports on the CHIP, STAR, and PCCM programs.

Description: This table presents the percentage of children two to 18 years old diagnosed with pharyngitis who were prescribed an antibiotic and received a group A streptococcus test during this office visit.

HEDIS® 2009:

- Deleted CPT code 99499 from Table CWP-B.

Benchmarking: HEDIS® 2008 Audit Means, Percentile and Ratio, and overall SDA and statewide rates.

Deviations from NCQA Guidelines: None. It should be noted that LOINC codes are not available in the data and, therefore, were ignored.

Calculations: This is a HEDIS® measure and the HEDIS® technical specifications are followed. Refer to the HEDIS® 2009 Technical Specifications Manual, pages 96-99.

Table CAP09: HEDIS® Children and Adolescents' Access to Primary Care Practitioners

This table reports on the CHIP, STAR, and PCCM programs.

Description: This table presents the percentage of members 12 months to 19 years old who had a visit with a PCP.

HEDIS® 2009: No Changes.

Benchmarking: HEDIS® 2008 Audit Means, Percentile and Ratio, and overall SDA and statewide rates.

Deviations from NCQA Guidelines: ICHP does not cross-reference against the provider type to check if the provider is a primary care practitioner. All claims with pertinent procedure and/or diagnosis codes with any provider are considered to have received a well-care visit.

Calculations: This is a HEDIS® measure and the HEDIS® technical specifications are followed. Refer to the HEDIS® 2009 Technical Specifications Manual, pages 208-211. Four rates are typically reported for this measure:

- Children 12-24 months and 25 months – 6 years who had a visit with a PCP during the measurement year.
- Children 7-11 years and adolescents 12-19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Table ORX09: HEDIS® Outpatient Drug Utilization

This table reports on CHIP, STAR, STAR+PLUS, STAR Health, and PCCM programs.

Description: This table summarizes the outpatient utilization of drug prescriptions, stratified by age, during the measurement year.

HEDIS® 2009:

- Changed age bands for member month reporting.

Benchmarking: HEDIS® 2008 Audit Means, Percentile and Ratio and overall SDA and statewide rates.

Deviations from NCQA Guidelines: None.

Calculations: This is a HEDIS® measure and the HEDIS® technical specifications are followed. Refer to the HEDIS® 2009 Technical Specifications Manual, pages 305-307.

Table ADV09: HEDIS® Annual Dental Visit

This table reports on the CHIP Dental program only.

Description: This table represents the percentage of members two to 21 years old who had at least one dental visit during the measurement year.

HEDIS® 2009: No Changes.

Benchmarking: HEDIS® 2008 Audit Means, Percentile and Ratio, and overall SDA and statewide rates.

Deviations from NCQA Guidelines: None.

Calculations: This is a HEDIS® measure and the HEDIS® technical specifications are followed. Refer to the HEDIS® 2009 Technical Specifications Manual, pages 210-211.

Table ACSC09: Emergency Room (ER) Use with a Primary Diagnosis of an Ambulatory Care Sensitive Condition (ACSC)

This table reports on CHIP, STAR, STAR+PLUS, STAR Health, and PCCM programs.

Description: This table provides information about ambulatory care sensitive conditions (ACSC) resulting in ER use. The total number of ACS visits, ACS visits as a percent of all visits, and the percent of members with ACS visits are reported for ER use.

Benchmarking: There is no benchmark for this table. Comparisons to previous results for the health plan on this measure and the overall statewide rate are presented as appropriate.

Deviations from NCQA Guidelines: This is not a HEDIS® measure.

Calculations:

Revenue Codes:

Code Type	Code#	Description
Revenue Codes	450	Emergency Room, General
	451	EMTALA ER
	452	ER beyond EMTALA screening
	456	Urgent Care
	459	Emergency Room, Other
	981	Professional Fee/ER

Place of Service Code:

Code Type	Code#	Description
Place of Service	23	Emergency Room – Hospital

CPT Codes:

Code Type	Code#	Description
CPT Codes	99281	Emer Dept Self Limited/Minor
	99282	Emer Dept Low to Moderate Severity
	99283	Emer Dept Moderate Severity
	99284	EmerDept Hi Severity and Urgent Eval
	99285	Emer Dept High Severity and Threat Func

Ambulatory Care Sensitive Condition(s):

Some hospitalizations and emergency room (ER) visits are called ambulatory care sensitive (ACS) admissions or visits because there is consensus that the condition usually can be managed successfully in the outpatient setting.

ICD-9-CM Codes Used:

Ambulatory Care Sensitive Conditions (ACSC) - Reference from the Agency for Healthcare Research and Quality (AHRQ) and the Institute for Child Health Policy. XX indicates null or a valid value between 0-9.

Condition	ICD-9-CM Code(s)	ACSC Condition	Exclusions/Comments
Angina	411.1	Intermediate Coronary Syndrome (Angina)	Exclude cases with a surgical procedure [01-86.99]
	411.8	Other	
	413	Angina decubitus	
Appendicitis	540.0	Acute appendicitis with generalized peritonitis	
	540.1	Acute appendicitis with peritoneal abscess	
Asthma	493.XX	Asthma	
Bacterial Pneumonia	481	Pneumococcal pneumonia (streptococcus pneumonial pneumonia)	Exclude cases with secondary diagnosis of sickle cell [282.6] and patients < 2 months
	482.2	Pneumonia due to Hemophilus influenza (H. influenza)	
	482.3X	Pneumonia due to Streptococcus	
	482.9	Bacterial pneumonia unspecified	
	483.X	Pneumonia due to other specified organism	
	485	Bronchopneumonia, organism unspecified	
	486	Pneumonia, organism unspecified	
Bronchitis	490	Bronchitis, not specified as acute or chronic	
Cellulitis	681.XX	Cellulitis and abscess of finger and toe	Exclude cases with a surgical procedure [01-86.99], except incision of skin and subcutaneous tissue [86.0] where it is the only listed surgical procedure
	682.X	Other cellulitis and abscess	
	683	Acute lymphadenitis	
	686.X	Other local infections of skin and subcutaneous tissue	
Common Cold	460	Acute nasopharyngitis	
Congenital Syphilis	090.X	Congenital syphilis	Secondary diagnosis for newborns only
Congestive Heart Failure	428.XX	Heart Failure	Exclude cases with the following surgical procedures: 36.01,
	402.01	Hypertensive heart disease with heart failure, malignant	

Condition	ICD-9-CM Code(s)	ACSC Condition	Exclusions/Comments
	402.11	Hypertensive heart disease with heart failure, benign	36.02, 36.05, 36.1, 37.5, or 37.7
	402.91	Hypertensive heart disease with heart failure, unspecified	
	518.4	Acute edema of lung, unspecified	
Dehydration	276.5	Dehydration – Volume depletion	
Dehydration with Infant Readmission	276.0	Dehydration – Volume depletion – Infant Readmission. Disorder of fluid, electrolyte and acid-base balance. Hyperosmolarity and/or hypernatremia	
Diabetes	250.X	Diabetes	
Epilepsy	345.X	Epilepsy	
Feeding - Newborn	779.3	Feeding Problems in newborn	
Gangrene	785.4	Gangrene	
Gastroenteritis	558.X	Gastroenteritis	
Hypertensive Disease	401.0	Essential hypertension	Exclude cases with the following procedures: 36.01, 36.02, 36.05, 36.1, 37.5, or 37.7. (Procedures on vessels of the heart)
	401.9	Essential hypertension, unspecified	
	402.00	Hypertensive heart disease, Chronic Heart Failure	
	402.10	Benign without heart disease	
	402.90	Unspecified without heart disease	
	403.0	HTN renal disease, malignant	
	404.0	Hypertensive heart and renal disease, malignant	
	405.0	Secondary hypertension, malignant	
Hypoglycemia	251.2	Hypoglycemia, unspecified	
Hypokalemia	276.8	Hypokalemia, Hypopotassemia	
Immunization-Related and Preventable Conditions	033.X	Whooping cough	Hemophilus meningitis [320.2] ages 1-5 only
	037	Tetanus	
	045.X	Acute poliomyelitis	
	320.0	Hemophilus meningitis, Bacterial meningitis	
	390	Rheumatic fever without mention of heart involvement	
	391.X	Rheumatic fever with mention of heart involvement	
	032.X	Diphtheria	
	050.X	Smallpox	
	052.X	Chickenpox	

Condition	ICD-9-CM Code(s)	ACSC Condition	Exclusions/Comments
	055.X	Measles	
	070.XX	Viral Hepatitis	
	072.XX	Mumps	
Jaundice – Infant Readmission	773.1	Hemolytic disease due to ABO isoimmunization	
	774.2	Neonatal jaundice associated with preterm delivery	
	774.3	Neonatal jaundice due to delayed conjugation from other causes	
	774.6	Unspecified fetal and neonatal jaundice	
	774.7	Kernicterus not due to isoimmunization	
Mastoiditis	383.XX	Mastoiditis	
Nausea and Vomiting	787.0	Nausea and Vomiting	
	787.01	Nausea with Vomiting	
	787.02	Nausea alone	
	787.03	Vomiting alone	
Other Tuberculosis	012.X	Other respiratory tuberculosis	
	013.X	Tuberculosis of meninges and central nervous system	
	014.X	Tuberculosis of intestines, peritoneum, and mesenteric glands	
	015.X	Tuberculosis of bones and joints	
	016.X	Tuberculosis of genitourinary system	
	017.X	Tuberculosis of other organs	
	018.X	Miliary tuberculosis	
Otitis Media, Acute	382.XX	Suppurative and unspecified otitis media	
Pelvic Inflammatory Disease	614.X	Pelvic Inflammatory Disease	
Perforated Ulcer	531.1	Gastric ulcer, acute with perforation	
	531.5	Gastric ulcer, chronic or unspecified with perforation	
	531.6	Gastric ulcer, chronic or unspecified with hemorrhage and perforation	
	532.1	Duodenal ulcer, acute with perforation	
	532.2	Duodenal ulcer, acute with hemorrhage and perforation	
	532.5	Duodenal ulcer, chronic or unspecified with perforation	
	532.6	Duodenal ulcer, chronic or	

Condition	ICD-9-CM Code(s)	ACSC Condition	Exclusions/Comments
		unspecified with hemorrhage and perforation	
	533.1	Peptic ulcer, acute with perforation	
	533.2	Peptic ulcer, acute with hemorrhage and perforation	
Pneumonia	480.X	Viral pneumonia	
	482.XX	Other bacterial pneumonia	
	483.X	Pneumonia due to other specified organism	
	484.X	Pneumonia in infectious diseases classified elsewhere	
	495.X	Extrinsic allergic alveolitis	
Pulmonary Tuberculosis	011.X	Pulmonary tuberculosis	
Pyelonephritis	590.X	Infection of the kidney	
Upper Respiratory Infections	382.XX	Suppurative and unspecified otitis media	Exclude otitis media cases [382] with myringotomy with insertion of tube [20.01]
	462	Acute pharyngitis	
	463	Acute tonsillitis	
	465.X	Acute upper respiratory infection of multiple or unspecified sites	
	472.1	Chronic pharyngitis	
Skin Grafts with Cellulitis	681.00	Cellulitis and abscess of finger, unspecified	Exclude admissions from skilled nursing facilities or intermediate care facilities
	681.01	Felon of finger	
	681.02	Onychia and paronychia of finger	
	681.10	Cellulitis and abscess of toe, unspecified	
	681.11	Onychia and paronychia of toe	
	682.0	Cellulitis and abscess of face	
	682.1	Cellulitis and abscess of neck	
	682.2	Cellulitis and abscess of trunk	
	682.3	Cellulitis and abscess of upper arm and forearm	
	682.4	Cellulitis and abscess of hand, except fingers and thumb	
	682.5	Cellulitis and abscess of buttock	
	682.6	Cellulitis and abscess of leg, except foot	
	682.7	Cellulitis and abscess of foot, except toes	
	682.8	Cellulitis and abscess of other specified sites	

Condition	ICD-9-CM Code(s)	ACSC Condition	Exclusions/Comments
	682.9	Cellulitis and abscess of unspecified site	
	707.0X	Decubitus ulcer	
	707.1X	Ulcer of lower limbs, except decubitus	
	707.8	Chronic ulcer of other specified sites	
	707.9	Chronic ulcer of unspecified site	
	85.82	Split-thickness graft to breast	
	85.83	Full-thickness graft to breast	
	85.84	Pedicle graft to breast	
	85.85	Muscle flap graft to breast	
	86.22	Excisional debridement of wound, infection, or burn	
	86.4	Radical excision of skin lesion	
	86.60	Free skin graft, not otherwise specified	
	86.61	Full-thickness skin graft to hand	
	86.62	Other skin graft to hand	
	86.63	Full-thickness skin graft to other sites	
	86.65	Heterograft to skin	
	86.66	Hemograft to skin	
	86.69	Other skin graft to other sites	
	86.70	Pedicle or flap graft, not otherwise specified	
	86.71	Cutting and preparation of pedicle grafts or flaps	
	86.72	Advancement of pedicle graft	
	86.73	Attachment of pedicle or flap graft to hand	
	86.74	Attachment of pedicle or flap graft to other sites	
	86.75	Revision of pedicle or flap graft	
	86.91	Excision of skin for graft	
	86.93	Insertion of tissue expander	
Urinary Tract Infection	599.0	Urinary Tract Infection, site not specified	
Viral Meningitis	047.8	Viral Meningitis	
	047.9	Unspecified viral meningitis	
Viral Syndrome	079.0	Adenovirus	

Table ASM09: HEDIS® Use of Appropriate Medications for People with Asthma

This table reports on the CHIP, STAR, and PCCM programs.

Description: This table represents the percentage of members 5-56 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

HEDIS® 2009:

- Deleted CPT code 99499.

Benchmarking: HEDIS® 2008 Audit Means, Percentile and Ratio, and overall SDA and statewide rates.

Deviations from NCQA Guidelines: None.

Calculations: This is a HEDIS® measure and the HEDIS® technical specifications are followed. Refer to the HEDIS® 2009 Technical Specifications Manual, pages 114-117.