Annual Chart Book

Fiscal Year 2006

NorthSTAR Program
Quality of Care Measures

Prepared by

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for Medicaid Managed Care and CHIP

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Introduction

Assessing the quality of health care for all citizens is essential. In the case of Medicaid Managed Care and the State Children's Health Insurance Program (SCHIP), states are required to have performance goals and measures to evaluate the quality of care provided in the program.[1] There are several conceptual frameworks that can be used to organize quality of care assessments. The Institute of Medicine (IOM) has provided a framework for assessing health care quality that includes assessing 1) the effectiveness of care, 2) the access to and timeliness of care, and 3) the patient-centeredness of care. Effectiveness of care refers to providing care that is based on systematically acquired evidence as to its benefit in producing better outcomes than the alternatives, which include doing nothing. Access to and timeliness of care refers to a person being able to receive needed care without undue delays. Insurance coverage is essential for good access to care, but it is not a guarantee. Geographic barriers, lack of understanding about how to use the health care system, and other factors can contribute to poor access to care, even among the insured. Finally, care should be patient-centered; that is, all patients should be treated with dignity and respect, and they should be involved in the decision-making about their care.[2]

In addition to the preceding aspects of care, the IOM specifically discusses the important relationship between payment polices and the quality of care provided to enrollees. Ensuring that payment is appropriate for the severity of illness or the case-mix seen within the enrolled population is essential to encourage access to care and the delivery of good quality of care.

Purpose

The purpose of this report is to give an annual summary of the quality of care provided to enrollees in the NorthSTAR Program. This report summarizes information from September 1, 2005, to August 31, 2006, which covers fiscal year 2006. This chart book is a follow-up to the NorthSTAR Program Quality of Care measures which covered September 1, 2004, to August 31, 2005. Important information and recommendations for improvement are provided in the narrative of the report under the heading "Key Points."

The quality of care measures used in this annual chart book require one year of health care claims and encounter data for their calculations. Therefore, the full time frame used to prepare the measures is September 1, 2005, to August 31, 2006. A four-month time lag was used for the claims and encounter data. Prior analyses with Texas data found that, on average, 97 percent of the claims and encounters were complete by that time period. A four-month lag was also used because the Texas Health and Human Services Commission (HHSC) requested reports that are as close to the actual time of service delivery as possible.

[1] The National Governors Association, Center for Best Practices. August 2001. *State Efforts to Evaluate the Progress and Success of SCHIP*.
[2] The Institute of Medicine. 2001. *Crossing the Quality Chasm*. Washington, DC: National Academy Press.

This chart book contains the following quality of care indicators grouped under associated headings:

1) Descriptive Information
   a) HEDIS® Total Unduplicated Members
   b) HEDIS® Total Unduplicated Members by Race and Ethnicity

2) Quality of Care
   a) HEDIS® Follow-Up after Hospitalization for Mental Illness
   b) Readmission within 30 Days after an Inpatient Stay for Mental Health

3) Service Utilization[3]
   a) HEDIS® Mental Health Services Utilization—Members Receiving Inpatient and Intermediate Care and Ambulatory Services

Data Sources and Measures

Two data sources were used to calculate the descriptive and quality of care indicators: person-level enrollment information and person-level health care claims/encounter data. The enrollment files contained information about the person's age, gender, and the number of months the person was enrolled in the program. The person-level claims/encounter data contained Current Procedural Terminology (CPT) codes and International Classification of Diseases, 9th Revision (ICD-9-CM) codes.

The National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS®) technical specifications were used to calculate the measures for follow-up after hospitalization for mental illness and mental health services utilization. Information regarding the calculation of all measures included in this report can be found in the document "Quality of Care Measures Technical Report Specifications, June 2007." This document, prepared by the Institute for Child Health Policy (ICHP), provides specifications for both HEDIS® and other quality of care measures. This document also provides specific information regarding Texas local codes used in calculation of HEDIS® measures.

Whenever possible, comparisons are provided to other Medicaid Programs. NCQA gathers data from Medicaid managed care plans nationally and compiles them.[4] Submission of HEDIS® data to NCQA is a voluntary process; therefore, health plans that submit HEDIS® data are not fully representative of the industry. These health plans 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.[5]

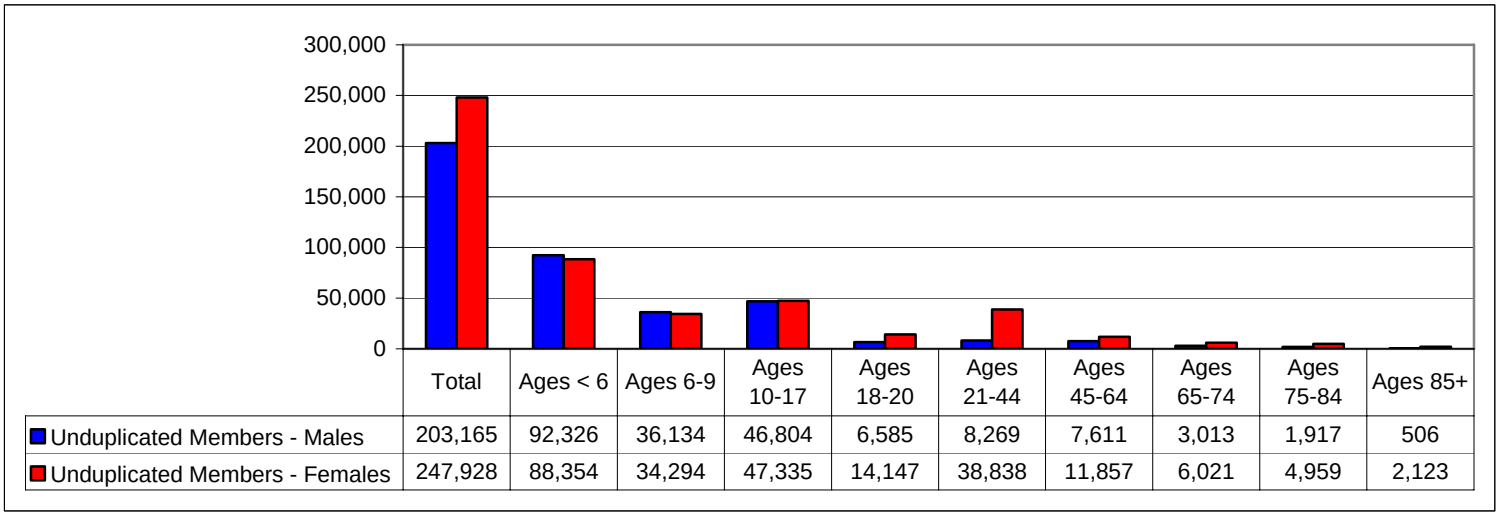
[3] The HEDIS® chemical dependency service utilization measure has been omitted as HEDIS® omitted this measure from their 2006 standards.
[4] The information that NCQA compiles for Medicaid Managed Care Programs can be viewed at www.ncqa.org
[5] Beaulieu, N.D., and A.M. Epstein. 2002. "National Committee on Quality Assurance Health-Plan Accreditation: Predictors, Correlates of Performance, and Market Impact." *Medical Care* 40 (4): 325-337.

NCQA reports the national results as a mean and at the 25th, 50th, 75th, and 90th percentiles for the participating plans. For comparison to the NorthSTAR Program findings, the NCQA Medicaid Managed Care Plans 2006 mean results are shown and are labeled "HEDIS® 2006 Mean" in the graphs. This information is not available for all of the quality of care indicators.

In addition to the narrative and graphs contained in this chart book, technical appendices were provided to HHSC that contain all of the supporting data. The interested reader can review those for more details. The corresponding reference table is listed beneath each graph.

Chart 1. HEDIS® Total Unduplicated Members

NorthSTAR - September 1, 2005 to August 31, 2006 Total Unduplicated Members = 451,093



	Total	Ages < 6	Ages 6-9	Ages 10-17	Ages 18-20	Ages 21-44	Ages 45-64	Ages 65-74	Ages 75-84	Ages 85+
Unduplicated Members - Males	203,165	92,326	36,134	46,804	6,585	8,269	7,611	3,013	1,917	506
Unduplicated Members - Females	247,928	88,354	34,294	47,335	14,147	38,838	11,857	6,021	4,959	2,123

Reference: NorthSTAR Table TX-1

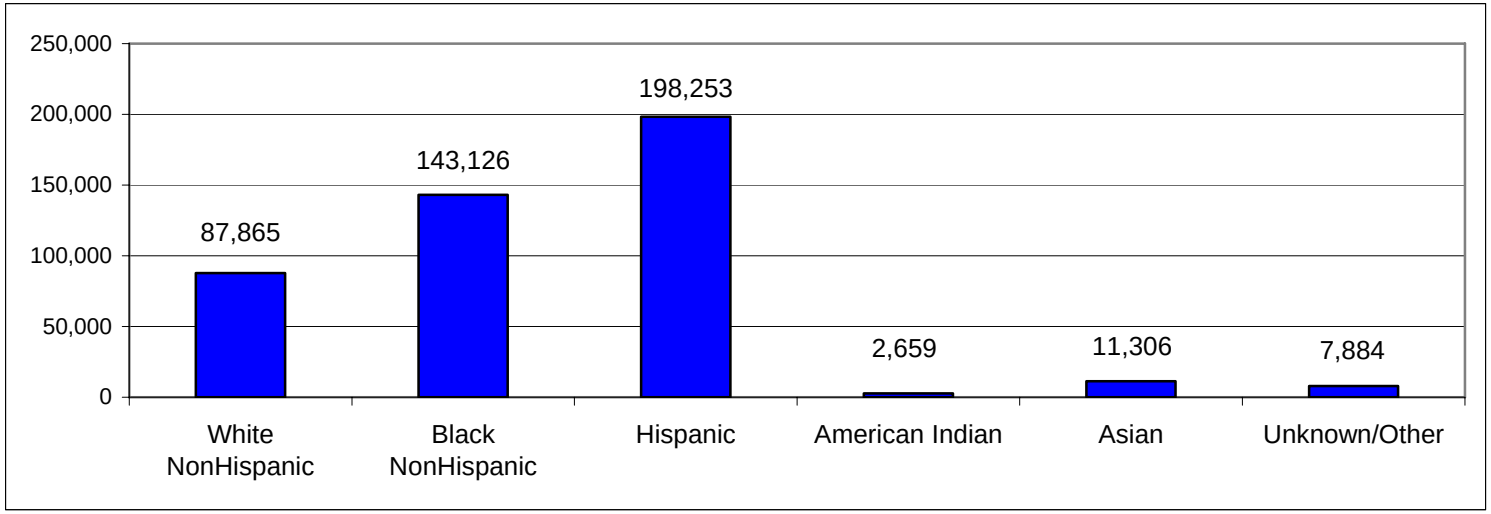
Key Points:

1. During fiscal year 2006, there were 451,093 unduplicated Medicaid members in the NorthSTAR Program, upward from previous years (437,998 during fiscal year 2005 and 396,610 during fiscal year 2004). Unduplicated enrollees represented 3,709,283 member months.

2. The average age of the membership was 14.2 years (± 18 years). Most enrollees (about 81 percent) were 20 years old or younger. The overall ratio of males to females in the program was about 4:5 with the largest difference in the 21 to 44 age group.

Chart 2. HEDIS® Total Unduplicated Members by Race and Ethnicity

NorthSTAR - September 1, 2005 to August 31, 2006 Total Unduplicated Members = 451,093



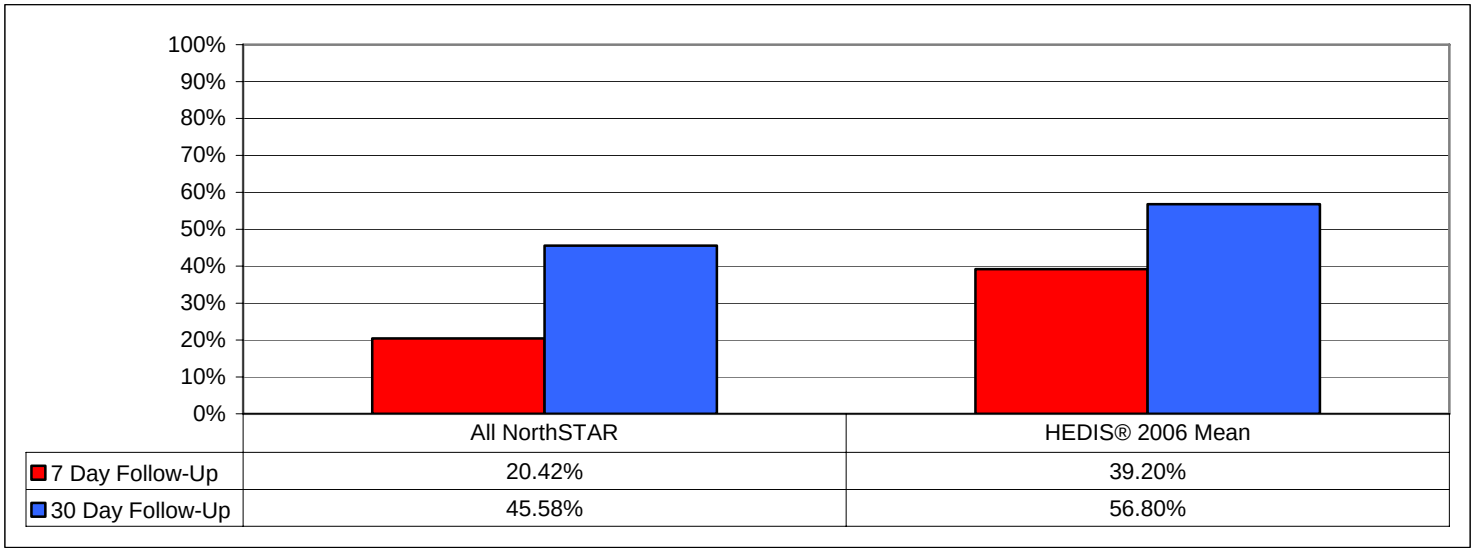
Reference: NorthSTAR Table TX-2

Key Points:

1. Of the 451,093 unduplicated NorthSTAR Program enrollees, a little less than half (44 percent) were Hispanic, 32 percent were Black NonHispanic and 19 percent were White NonHispanic. The remaining five percent were Asian, American Indian, and of unknown or other race/ethnicity.

Chart 3. HEDIS® Follow-Up after Hospitalization for Mental Illness

NorthSTAR - September 1, 2005 to August 31, 2006 Eligible Mental Health Hospitalizations = 1,797



	All NorthSTAR	HEDIS® 2006 Mean
7 Day Follow-Up	20.42%	39.20%
30 Day Follow-Up	45.58%	56.80%

Reference: NorthSTAR Table PI-5

Key Points:

1. Ensuring continuity of care and providing follow-up in the community after inpatient stays for mental illness has been shown to reduce enrollees' health care costs and to improve their outcomes of care.[6] HEDIS® contains a measure designed to assess outpatient follow-up at seven days and 30 days after an inpatient stay for mental illness.

2. During fiscal year 2006, one in five NorthSTAR members who had an inpatient admission for mental illness received follow-up outpatient service within seven days of their discharge. This number is about half the national HEDIS® 2006 mean of 39 percent of discharged patients with a seven-day follow-up to a hospitalization for mental illness.

[6] Fortney, J. G. Sullivan, K. Williams, C. Jackson, S. C., Morton, and P. Kogel. 2003. "Measuring Continuity of Care for Clients of Public Mental Health Systems." *Health Services Research* 38 (4): 1157-1175.

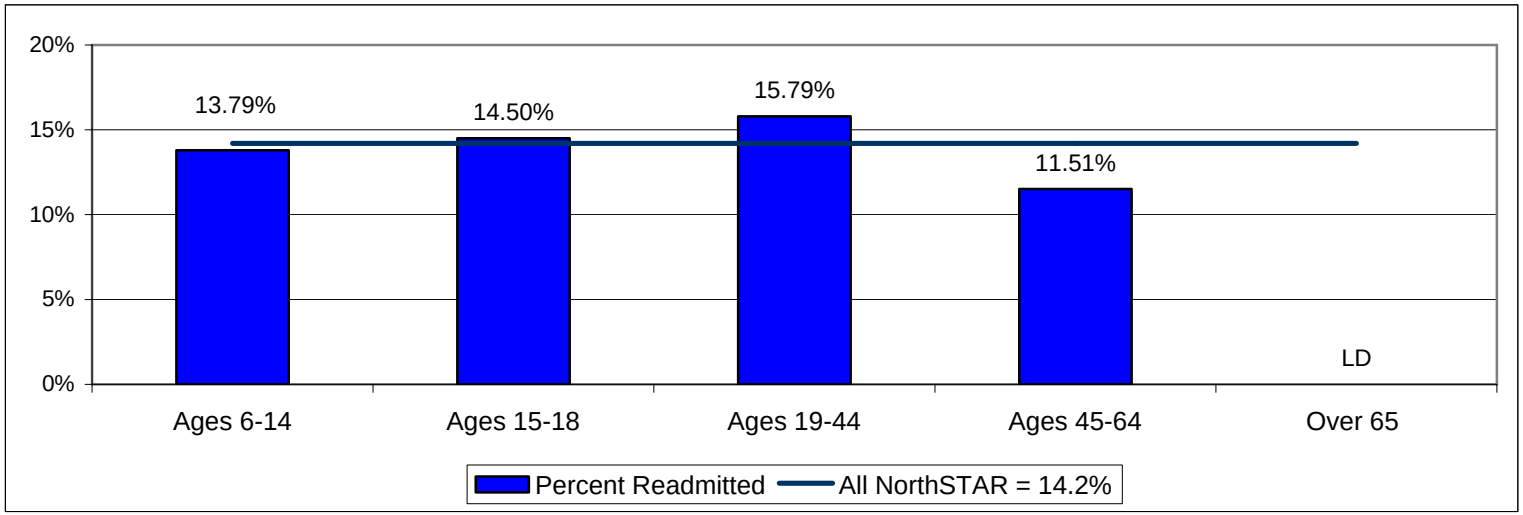
3. The percentage of NorthSTAR mental health inpatients with a follow-up visit within 30 days of discharge is more comparable to the national norm. About 46 percent of the NorthSTAR enrollees had a 30-day outpatient follow-up visit after their hospitalization with a mental illness. The national average is 57 percent.

4. To improve the quality of NorthSTAR members' follow-up with a mental health provider after an inpatient admission for mental illness, the EQRO recommends that HHSC look into successful strategies adopted by other health plans. For example, reducing the number of days allowed for scheduling a follow-up, calling members who missed or cancelled an appointment to reschedule, and home visits by nurses to members who were unable or refused to visit a treatment facility have been shown to improve the compliance rate for post-hospitalization follow-up visits.[7]

[7] Reich, L.H., B.M. Jaramillo, L.J. Kaplan, J. Arciniega, and A.D. Kolbasovsky. 2003. "Improving Continuity of Care: Success of a Behavioral Health Program." *Journal for Healthcare Quality* 25 (6): 4-8.

Chart 4. Readmission within 30 Days after an Inpatient Stay for Mental Health

NorthSTAR - September 1, 2005 to August 31, 2006 Eligible Inpatient Mental Health Stays = 2,091



Reference: NorthSTAR Table PI-6

Note: LD (Low Denominator) indicates number of members eligible for the measure less than 30 with rate not reported. Eligible members are included in overall NorthSTAR rates.

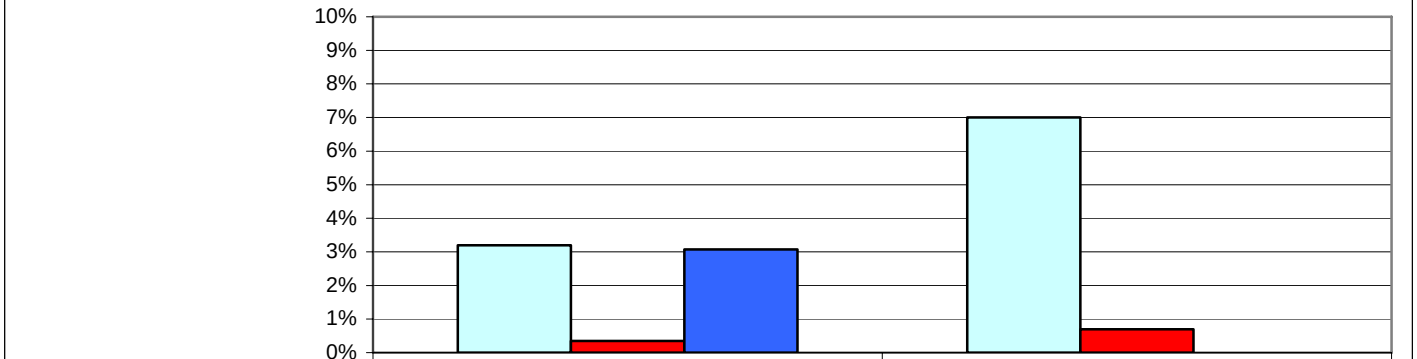
Key Points:

1. During fiscal year 2006, about 14 percent of NorthSTAR enrollees who were hospitalized for a mental illness were readmitted to an inpatient facility within 30 days of discharge.

2. There was, however, some variation by age groups. While the percentage of NorthSTAR members ages 6 to 44 who were readmitted was very close to or higher than the overall NorthSTAR average of 14.2 percent, enrollees in the 45 to 64 age group were readmitted at a lower rate.

Chart 5. HEDIS® Mental Health Services Utilization—Members Receiving Inpatient and Intermediate Care and Ambulatory Services

NorthSTAR - September 1, 2005 to August 31, 2006 Total Unduplicated Members = 451,093



	All NorthSTAR	HEDIS® 2006 Mean
Any MH Use	3.20%	7.00%
Inpatient MH	0.35%	0.70%
Intermediate and Ambulatory MH	3.07%	-

Reference: NorthSTAR Table FP-3

Note: "-" indicates HEDIS® does not provide a mean for Intermediate and Ambulatory MH combined.

Key Points:

1. Intermediate services and ambulatory services are reported together because it is not possible to differentiate between the two with NorthSTAR data as submitted. Also, inpatient mental health utilization includes state psychiatric hospitalizations. Since state hospitalizations are not a part of HEDIS® specifications, this possibly overstates NorthSTAR inpatient use and, therefore, may not be comparable to mental health inpatient utilization of Medicaid programs reporting to NCQA.

2. NorthSTAR enrollees use mental health services at a lower rate compared to the national HEDIS® 2006 averages. The overall use was about half the national mean (3.2 percent versus 7.0 percent) and so was the use of inpatient mental health services (0.35 percent versus 0.7 percent).

3. Combined HEDIS® intermediate and ambulatory mental health service benchmarks are not available for comparison.