Annual Chart Book

Fiscal Year 2005

Texas Medicaid Managed Care
STAR+PLUS
Quality of Care Measures

Prepared by

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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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.[2] Effectiveness of care refers to providing care that is based on the use of 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.

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 among 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 provide an annual update of the quality of care provided to enrollees in the STAR+PLUS Managed Care Program. This update is for September 1, 2004, to August 31, 2005, covering fiscal year 2005. This chart book and its companion report, Texas Medicaid Managed Care STAR+PLUS Financial Performance Measures, are a follow-up to the STAR+PLUS Annual Chart Book, published in December 2004 which covered quality of care measures for December 1, 2002, to November 30, 2003, and the STAR+PLUS Annual Chart Book, published in December 2003 which covered quality of care measures for January 1, 2002, through December 31, 2002. The format of this quarterly report differs from previous chart books in that it contains less background information and focuses only on key points. Additionally, recommendations are provided in the narrative of the report under the heading "Key Points."

The quality of care measures used in this chart book require at least one year of health care claims and encounter data for their calculations. Therefore, the base time frame used to prepare the measures is September 1, 2004, to August 31, 2005. The only exception is the asthma indicator which requires two years of pharmacy data. A three month time lag was used for the claims and encounter data. Prior analyses with Texas data found that, on average, approximately 96 percent of the claims and encounters were complete by that time period. A three month lag was used because the Texas Health and Human Services Commission (HHSC) have 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) Access to Care
   a) Percent of Enrollees with One or More Hospital Stays Due to an Ambulatory Care Sensitive Condition
   b) Percent of Hospitalizations with a Primary Diagnosis of an Ambulatory Care Sensitive Condition
   c) Percent of Enrollees with One or More Emergency Department Visits Due to an Ambulatory Care Sensitive Condition
   d) Percent of Emergency Department Use with a Primary Diagnosis of an Ambulatory Care Sensitive Condition

3) Quality of Care
   a) HEDIS® Use of Appropriate Medications for People with Asthma
   b) HEDIS® Follow-Up after Hospitalization for Mental Illness
   c) Readmission within 30 Days after an Inpatient Stay for Mental Health
   d) HEDIS® Comprehensive Diabetes Care
   e) HEDIS® Controlling High Blood Pressure

4) Utilization
   a) Utilization of Therapy Services
   b) Utilization of Adult Foster Care, Assisted Living, and Respite Care
   c) Utilization of Home Modification, Personal Assistant, Day Activity/Health, and Emergency Response Services

Data Sources and Measures

Three data sources were used to calculate the quality of care indicators: (1) person-level enrollment information, (2) person-level health care claims/encounter data, and (3) person-level pharmacy data. The enrollment files contain information about the person's age, gender, the MCO in which the person is enrolled, and the number of months the person was enrolled in the program. The person-level claims/encounter data contain Physician's 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 person-level pharmacy data contains information about filled prescriptions including the drug name, dose, date filled, and refill information. As previously noted, STAR+PLUS Program claims and encounter data were compiled for the time period of September 1, 2004, to August 31, 2005. Enrollees who switched health plans during the time period studied were not included in the data analysis. Enrollees switching health plans during the time period comprised approximately three percent of the total pool; therefore, omitting this group does not have a significant impact on the results.

Information regarding the calculation of all measures included in this report can be found in the document "Quality of Care Measures Technical Report Specifications, March 2006." This document, prepared by the Institute for Child Health Policy, provides specifications for both Health Plan Employer Data and Information Set (HEDIS®) and other quality of care measures.

Whenever possible, comparisons are provided with Medicaid Managed Care Programs because these data are available nationally. National Committee for Quality Assurance (NCQA) gathers data from Medicaid managed care plans nationally and compiles them.[3] NCQA reports the national results at the 10th, 25th, 50th, 75th, and 90th percentiles for the participating plans. For comparison purposes to the STAR+PLUS Program findings, the NCQA Medicaid managed care plans 2004 mean results are shown and are labeled "HEDIS® Mean 2004" in the graphs. It should be noted that the HEDIS® mean is not specific to the unique population seen in the STAR+PLUS Program and most likely represents a significantly healthier enrollee pool. The HEDIS® mean is provided as a reference point only, and comparisons between this value and the STAR+PLUS findings should be made cautiously.

Because this is an annual chart book, results for the Primary Care Case Management (PCCM) and Fee for Service (FFS) programs are included. The reporting period for PCCM and FFS data is May 1, 2004, to April 30, 2005. PCCM and FFS results are provided for enrollees who are eligible for Temporary Assistance for Needy Families (TANF) as well as enrollees eligible for Supplemental Security Income (SSI). As with the HEDIS® mean, these data are provided as a reference point only, and caution should be exercised when making comparisons with the STAR+PLUS results.

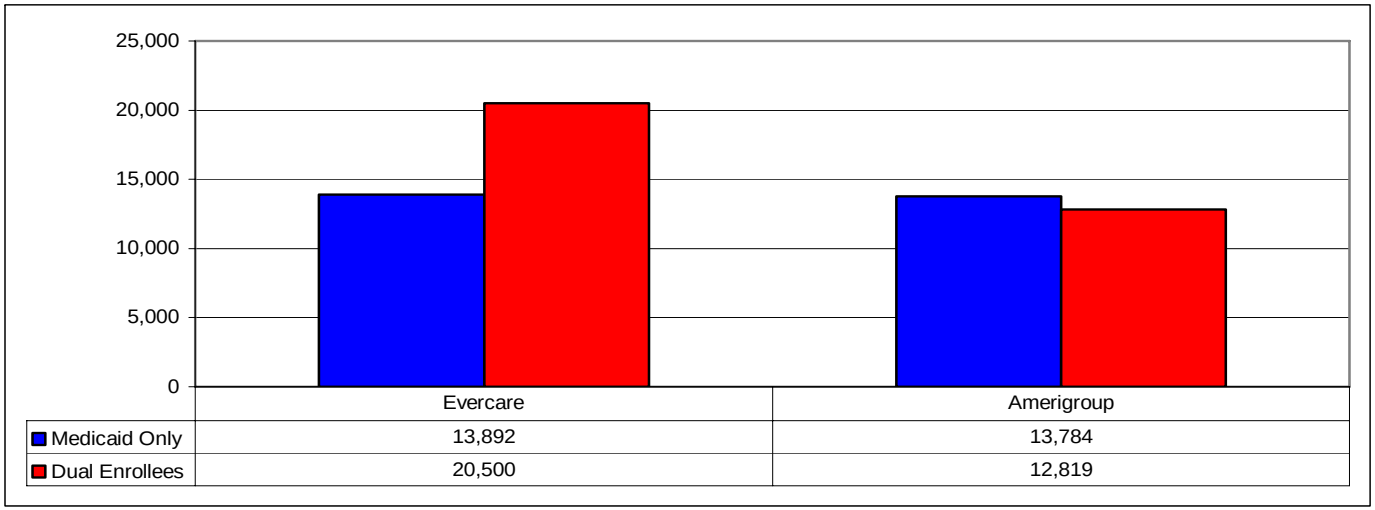
In addition to the narrative and graphs contained in this chart book, Excel spreadsheets were provided to the Texas Health and Human Services Commission (HHSC) that contain all of the key findings. As previously noted, many, but not all, of the quality of care indicator results are presented for each MCO. Some results were not displayed for each MCO (1) to facilitate ease of presentation and understanding of the material or (2) because the findings were similar for each MCO. However, all of the findings are contained in the Excel spreadsheets. The interested reader can review those spreadsheets for more details. The corresponding reference table is listed beneath each graph.

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

Chart 1. HEDIS® Total Unduplicated Members

STAR+PLUS MCOs - September 1, 2004 to August 31, 2005

Total Unduplicated Members, Medicaid Only = 27,676
Total Unduplicated Members, Dual Eligibles = 33,319



Reference: STAR+PLUS Table TX-1

Note: Members who switched plans during the reporting period were not included. This comprised 2.83% of the membership.

Key Points:

1. During the time period September 1, 2004, to August 31, 2005, there were 60,995 unduplicated members in the STAR+PLUS Program. Medicaid enrollees represented 45 percent of the membership while dual enrollees represented the remaining 55 percent of membership. As reported in the previous annual chart book, Evercare continues to serve the majority of the overall membership with 56 percent of the enrollees.

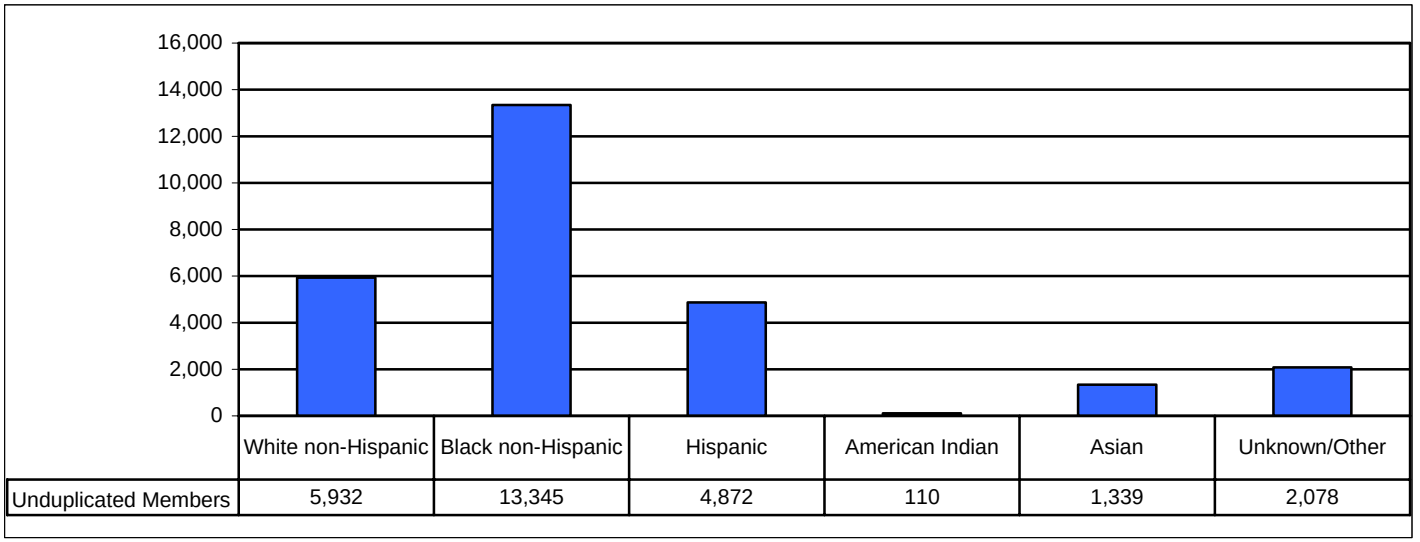
2. The average age of the Medicaid only membership is 42 years (± 17.1 years) which is similar to the previous annual report. Among the dual eligible population, the average age is 67 years (± 16.3 years) which is similar to that reported in the previous annual chart book. The majority of the enrollees across both groups are female – 60 percent.

3. The STAR+PLUS Medicaid-only membership continues to be evenly distributed among the two participating plans. Evercare has a larger enrollment of dual eligible beneficiaries which could indicate a membership with poorer health.

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

STAR+PLUS MCOs - September 1, 2004 to August 31, 2005

Total Unduplicated Members, Medicaid Only = 27,676



	White non-Hispanic	Black non-Hispanic	Hispanic	American Indian	Asian	Unknown/Other
Unduplicated Members	5,932	13,345	4,872	110	1,339	2,078

Reference: STAR+PLUS Table TX-2, Medicaid Only Reported

Note: Members who switched plans during the reporting period were not included. This comprised 2.83% of the membership.

Key Points:

1. Chart 2 provides a breakdown of race and ethnicity of the STAR+PLUS Medicaid only enrollees. Black, non-Hispanics comprised the largest percentage of the membership at 48 percent. White, non-Hispanic enrollees made up 21 percent of the overall Medicaid STAR+PLUS enrollment, Hispanics were 18 percent, Asians and American Indians together were five percent, and race/ethnicity was unknown for eight percent of the population.

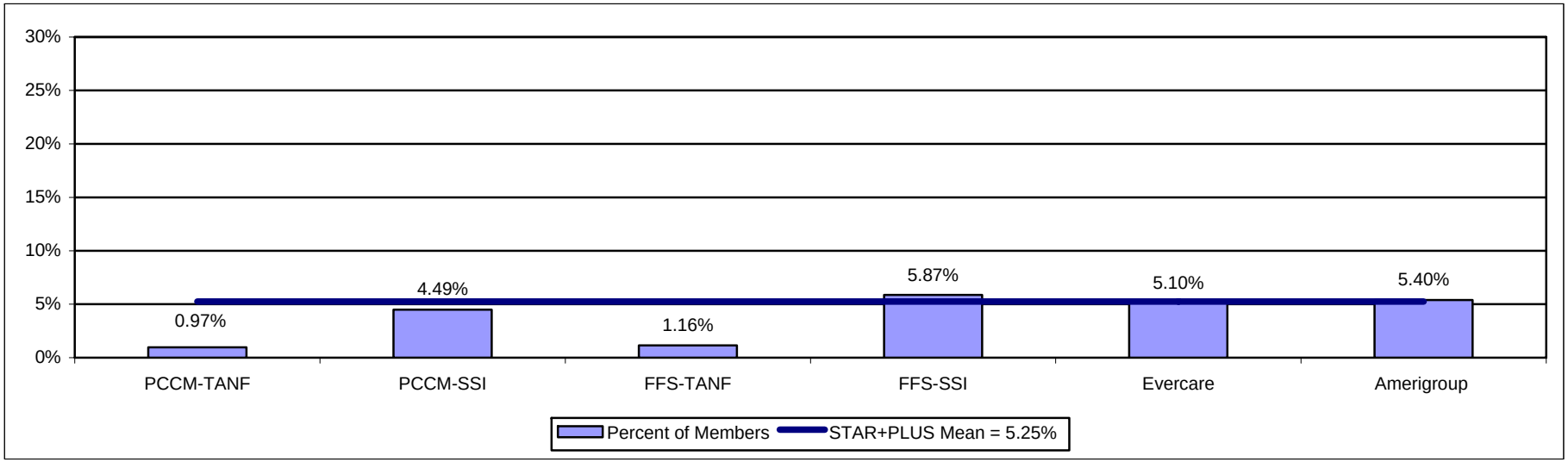
2. The STAR+PLUS membership is racially and ethnically diverse. Delivering health care to such a diverse population can be challenging and complex. Several groups, including the American College of Physicians, have recommended strategies to ensure appropriate care is delivered to racial and ethnic minorities such as using interpreter services, employing racially or linguistically concordant health care providers, and providing cultural competence training and education.[4] Additional strategies include involving the community in planning and quality improvement initiatives.

[4] American College of Physicians. 2004. "Racial and ethnic disparities in health care: A position paper." *Annals of Internal Medicine*. 141 (3) :226-232.

Chart 3. Percent of Enrollees with One or More Hospital Stays Due to an Ambulatory Care Sensitive Condition

STAR+PLUS MCOs - September 1, 2004 to August 31, 2005

Total Unduplicated Members, PCCM-TANF =	514,283
Total Unduplicated Members, PCCM-SSI =	31,733
Total Unduplicated Members, FFS-TANF =	2,364,989
Total Unduplicated Members, FFS-SSI =	248,313
Total Unduplicated Members, STAR+PLUS Medicaid Only =	27,676



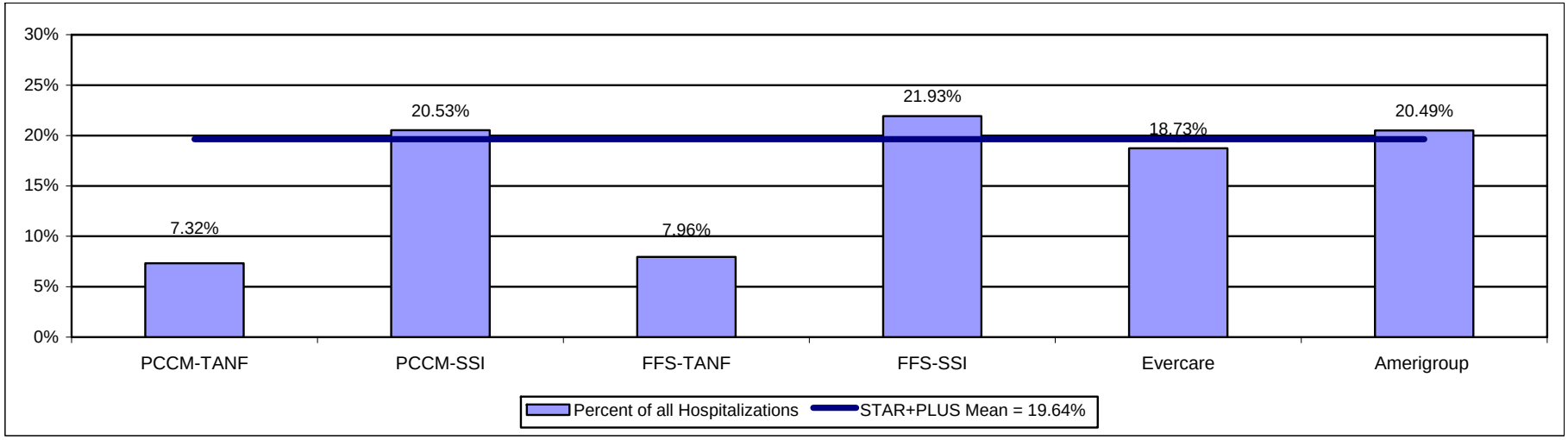
Reference: STAR+PLUS Tables PI-1 and TX-1, Medicaid Only Reported

Note: Charts 3 through 6 should be viewed together. The key findings about hospitalizations and ED visits are summarized following Chart 6.

Chart 4. Percent of Hospitalizations with a Primary Diagnosis of an Ambulatory Care Sensitive Condition

Total Hospitalizations, PCCM-TANF = 72,746
Total Hospitalizations, PCCM-SSI = 9,238
Total Hospitalizations, FFS-TANF = 373,359
Total Hospitalizations, FFS-SSI = 90,471
Total Hospitalizations, STAR+PLUS Medicaid Only = 10,584

STAR+PLUS MCOs - September 1, 2004 to August 31, 2005



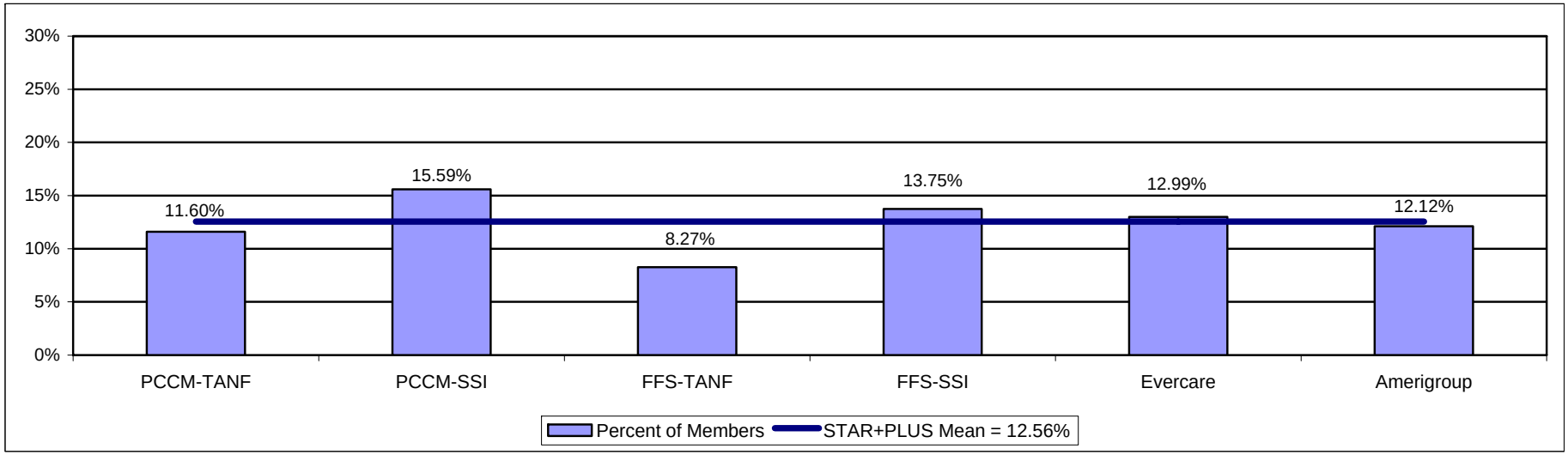
Reference: STAR+PLUS Table PI-1, Medicaid Only Reported

Note: Charts 3 through 6 should be viewed together. The key findings about hospitalizations and ED visits are summarized following Chart 6.

Chart 5. Percent of Enrollees With One or More Emergency Department Visits Due to an Ambulatory Care Sensitive Condition

STAR+PLUS MCOs - September 1, 2004 to August 31, 2005

Total Unduplicated Members, PCCM-TANF =	514,283
Total Unduplicated Members, PCCM-SSI =	31,733
Total Unduplicated Members, FFS-TANF =	2,364,989
Total Unduplicated Members, FFS-SSI =	248,313
Total Unduplicated Members, STAR+PLUS Medicaid Only =	27,676



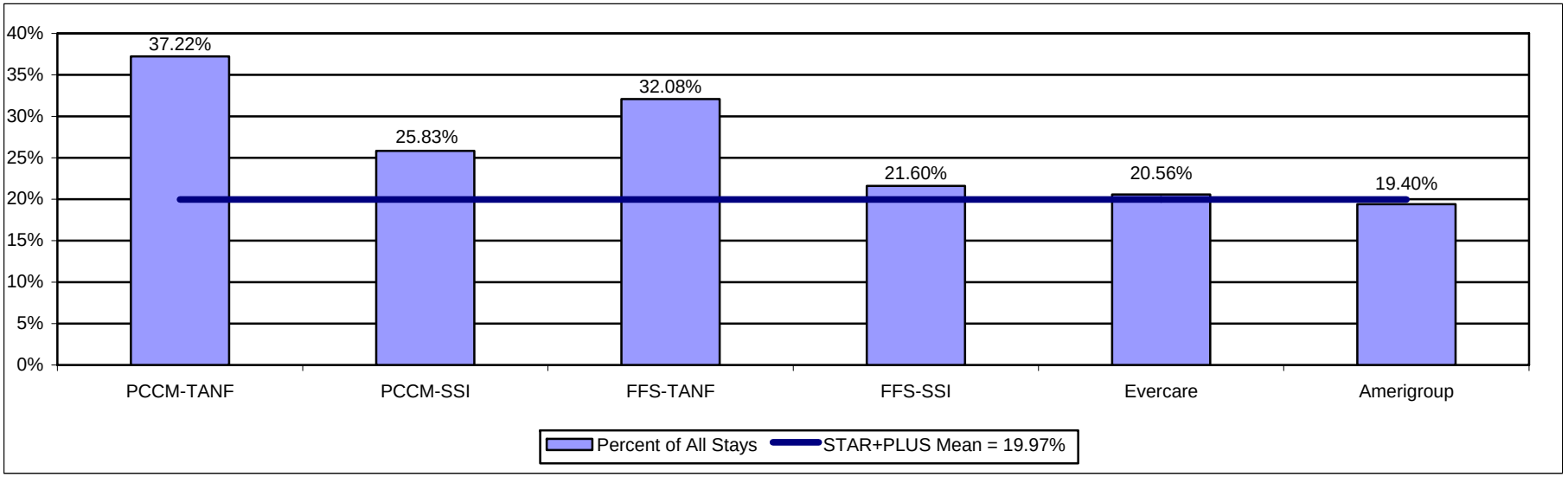
Reference: STAR+PLUS Tables PI-1 and TX-1, Medicaid Only Reported

Note: Charts 3 through 6 should be viewed together. The key findings about hospitalizations and ED visits are summarized following Chart 6.

Chart 6. Percent of Emergency Department Use with a Primary Diagnosis of an Ambulatory Care Sensitive Condition

Total ED Visits, PCCM-TANF =	218,405
Total ED Visits, PCCM-SSI =	29,472
Total ED Visits, FFS-TANF =	818,746
Total ED Visits, FFS-SSI =	245,317
Total ED Visits, STAR+PLUS Medicaid Only =	26,953

STAR+PLUS MCOs - September 1, 2004 to August 31, 2005



Reference: STAR+PLUS Table PI-1, Medicaid Only Reported

Note: Charts 3 through 6 should be viewed together. The key findings about hospitalizations and ED visits are summarized following Chart 6.

Key Points:

1. Ambulatory Care Sensitive Conditions (ACSCs) are those conditions (such as angina, bacterial pneumonia, congenital syphilis, specific types of heart failure, specific types of hypertension, and immunization-preventable conditions) that should not result in an inpatient stay or an emergency room visit if there is good access to care in the outpatient setting. Preventable hospitalizations and emergency room visits are costly and do not reflect good quality of or access to care for enrollees.

2. Approximately five percent of STAR+PLUS enrollees experienced one or more hospital stays due to an ACSC during the reporting period (see Chart 3). Of all hospitalizations experienced by STAR+PLUS enrollees, 20 percent were for an ACSC (see Chart 4). These results are similar to that reported in the previous annual chart book. The percentage of ACSC-related inpatient stays among Amerigroup enrollees was similar to that of Evercare enrollees. While the percent of ACSC-related inpatient stays for STAR+PLUS

enrollees was comparable to the percent of ACSC-related inpatient hospitalizations for SSI-eligible PCCM and FFS enrollees, the percent was higher than that of TANF-eligible PCCM and FFS enrollees.

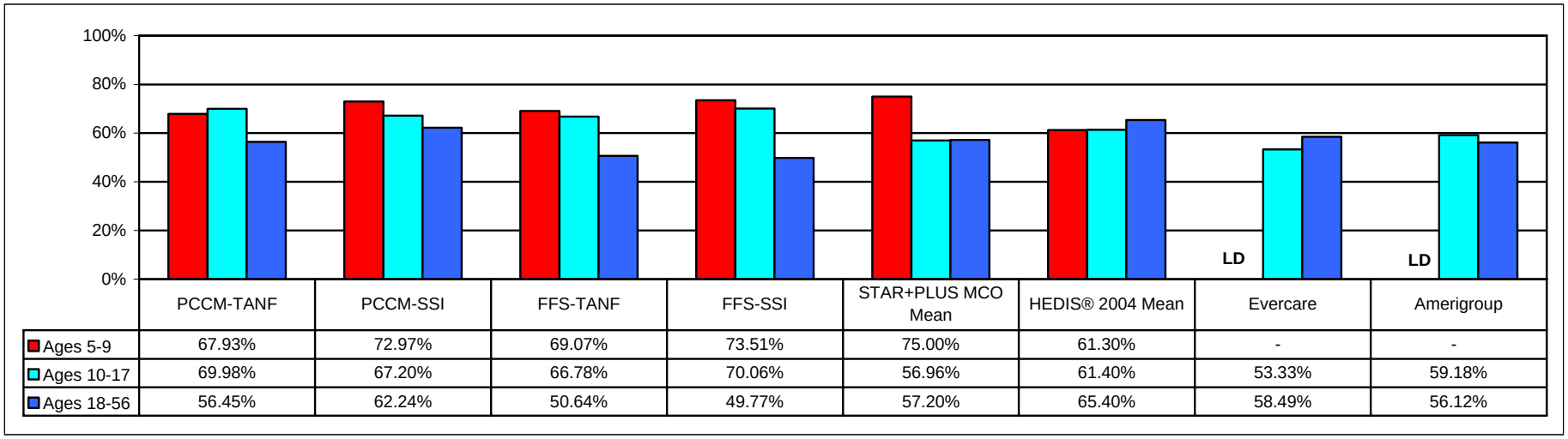
3. Approximately 13 percent of STAR+PLUS enrollees had a potentially avoidable emergency department visit due to an ACSC during the reporting period (See Chart 5). Of all ED visits experienced by STAR+PLUS enrollees, 20 percent were for an ACSC (see Chart 6). The percent of ACSC-related ED visits for STAR+PLUS enrollees was comparatively lower than the percent of ED visits for ACSCs for all PCCM and FFS enrollees.

4. National comparison data are not available for these measures.

Chart 7. HEDIS® Use of Appropriate Medications for People with Asthma

STAR+PLUS MCOs - September 1, 2004 to August 31, 2005

Eligible Members, PCCM-TANF:	Children =	2,635	Adolescents =	2,255	Adults =	186
Eligible Members, PCCM-SSI :	Children =	518	Adolescents =	622	Adults =	882
Eligible Members, FFS-TANF :	Children =	10,836	Adolescents =	8,306	Adults =	1,169
Eligible Members, FFS-SSI :	Children =	1,793	Adolescents =	2,625	Adults =	5,053
Eligible Members, STAR+PLUS Medicaid Only:	Children =	32	Adolescents =	79	Adults =	1,021



	PCCM-TANF	PCCM-SSI	FFS-TANF	FFS-SSI	STAR+PLUS MCO Mean	HEDIS® 2004 Mean	Evercare	Amerigroup
Ages 5-9	67.93%	72.97%	69.07%	73.51%	75.00%	61.30%	-	-
Ages 10-17	69.98%	67.20%	66.78%	70.06%	56.96%	61.40%	53.33%	59.18%
Ages 18-56	56.45%	62.24%	50.64%	49.77%	57.20%	65.40%	58.49%	56.12%

Reference: STAR+PLUS Table PI-4, Medicaid Only Reported

Note: HEDIS® age groups are Children (5 to 9 years old), Adolescent (10 to 17 years old), and Adult (18 to 56 years old).

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 STAR+PLUS rates.

Key Points:

1. STAR+PLUS MCOs treat few enrollees under the age of 18 with asthma. The STAR+PLUS health plans had a sufficient population of 10 to 17 year olds to calculate this measure; however, both fell short of the HEDIS® 2004 mean for this age cohort. STAR+PLUS MCOs also fell short of the HEDIS® mean for enrollees over the age of 18. Fifty-seven percent of enrollees ages 18 through 56 received appropriate medications compared to the national average of 65 percent.

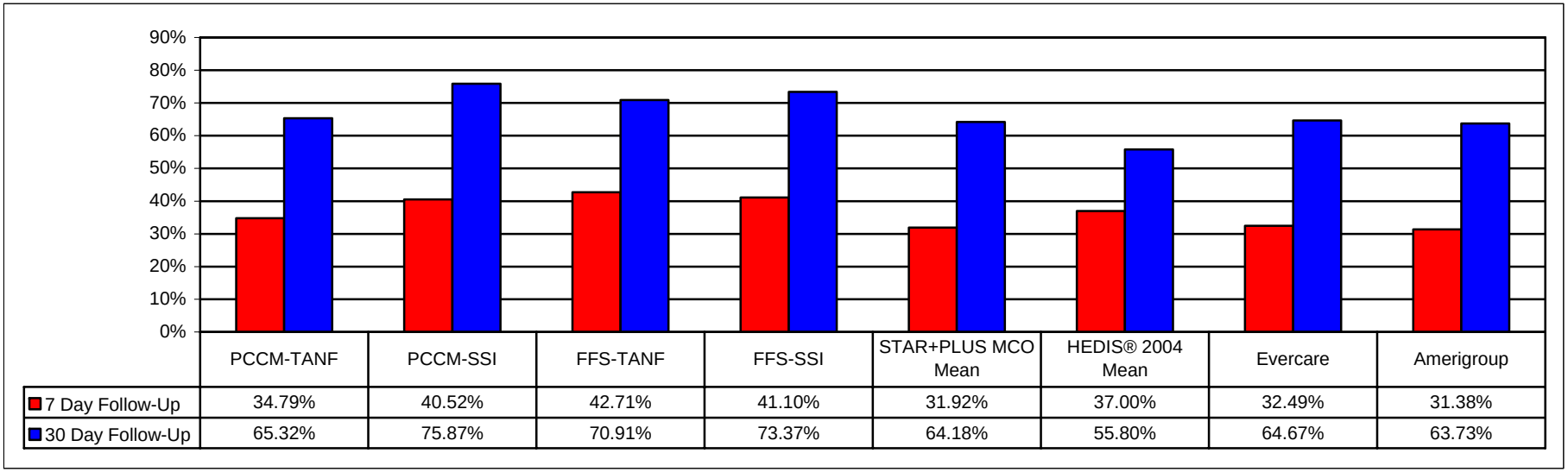
2. For enrollees ages 18 through 56, results for both Evercare and Amerigroup were below the HEDIS® mean of 65 percent. The percentage of adult Amerigroup enrollees with asthma who received appropriate medications was comparable to that of Evercare (56 percent compared to 58 percent).

3. Both TANF and SSI-eligible PCCM and FFS enrollees exceed the HEDIS® mean for both the 5 to 9 and 10 to 17 year old age cohorts. Results for both TANF and SSI-eligible PCCM and FFS enrollees fell short of the HEDIS® mean for ages 18 to 56.

Chart 8. HEDIS® Follow-Up after Hospitalization for Mental Illness

STAR+PLUS MCOs - September 1, 2004 to August 31, 2005

Total Eligible Mental Health Hospitalizations, PCCM-TANF = 914
Total Eligible Mental Health Hospitalizations, PCCM-SSI = 1,641
Total Eligible Mental Health Hospitalizations, FFS-TANF = 7,656
Total Eligible Mental Health Hospitalizations, FFS-SSI = 6,981
Total Eligible Mental Health Hospitalizations, STAR+PLUS Medicaid Only = 1,974



	PCCM-TANF	PCCM-SSI	FFS-TANF	FFS-SSI	STAR+PLUS MCO Mean	HEDIS® 2004 Mean	Evercare	Amerigroup
7 Day Follow-Up	34.79%	40.52%	42.71%	41.10%	31.92%	37.00%	32.49%	31.38%
30 Day Follow-Up	65.32%	75.87%	70.91%	73.37%	64.18%	55.80%	64.67%	63.73%

Reference: STAR+PLUS Table PI-5, Medicaid Only Reported

Note: Due to inability to consistently identify provider type in the encounter data, MH follow-up is defined by diagnosis code on subsequent visits rather than provider type as specified by HEDIS®.

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.[5] HEDIS® contains a measure designed to assess outpatient follow-up at 7 days and 30 days after an inpatient stay for mental illness. While HEDIS® specifications include follow-up with a mental health professional only, these requirements have been relaxed for this measure to include follow-up with any health care professional.

[5] 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.

2. Thirty-two percent of STAR+PLUS enrollees had an outpatient follow-up within seven days of an inpatient admission for mental illness. Sixty-four percent of enrollees had a follow-up visit within 30 days. While the results for the seven day follow-up fall short of the HEDIS® mean, the results for the 30 day follow-up compare favorably with the HEDIS® mean for outpatient follow-up (37 percent for 7 day follow-up and 56 percent for 30 day follow-up).

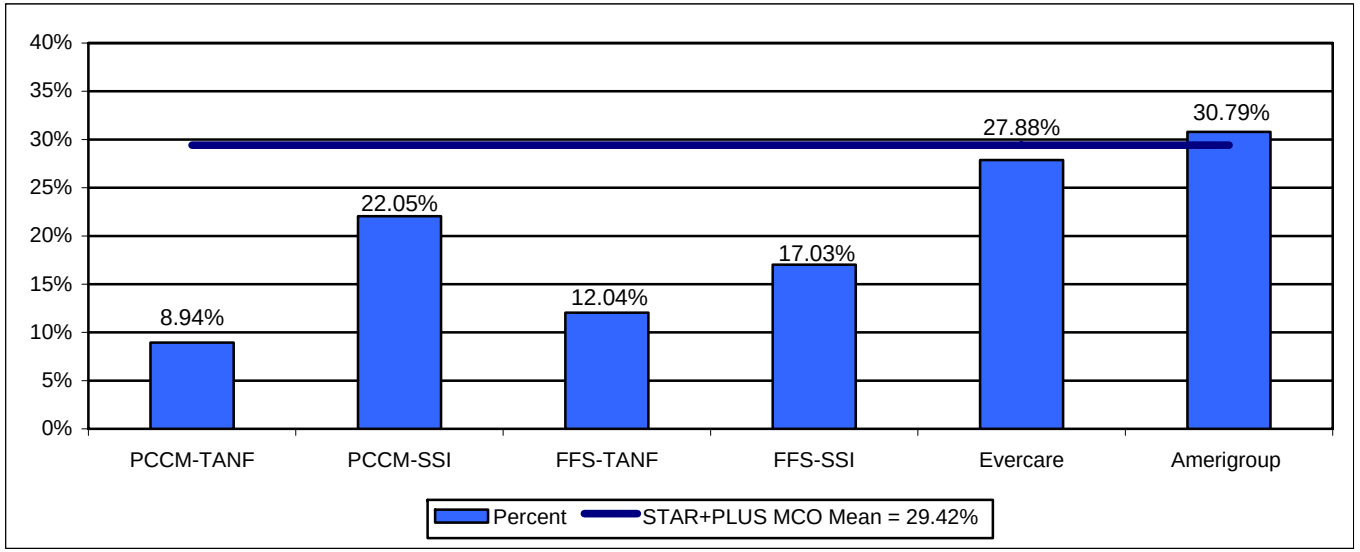
3. PCCM SSI-eligible enrollees and FFS enrollees exceed the HEDIS® mean for seven day follow-up after hospitalization for mental illness. TANF and SSI-eligible PCCM and FFS enrollees exceed the HEDIS® mean for thirty day follow-up after hospitalization for mental illness.

4. Overall, the results for this quality of care indicator are positive for the STAR+PLUS Program. STAR+PLUS MCOs should be provided encouragement to continue to perform well on this measure to ensure continued high quality of care for this vulnerable population.

Chart 9. Readmission within 30 Days after an Inpatient Stay for Mental Health

STAR+PLUS MCOs - September 1, 2004 to August 31, 2005

Total Eligible Mental Health Inpatient Stays, PCCM-TANF = 1,029
Total Eligible Mental Health Inpatient Stays, PCCM-SSI = 2,082
Total Eligible Mental Health Inpatient Stays, FFS-TANF = 8,761
Total Eligible Mental Health Inpatient Stays, FFS-SSI = 8,572
Total Eligible Mental Health Inpatient Stays, STAR+PLUS Medicaid Only = 2,757



Reference: STAR+PLUS PI-6, Medicaid Only Reported

Key Points:

1. With the increase of managed care in behavioral health services, there is an increasing emphasis placed on time-limited treatment in both inpatient and outpatient psychiatric settings. Some have argued that while decreased length of stay does help contain behavioral

health care costs, quality of care can be compromised.[6,7] For that reason, mental health readmissions are frequently used as a measure of an adverse outcome.[8]

2. Twenty-nine percent of STAR+PLUS enrollees who were hospitalized for a mental health or chemical dependency problem were readmitted to an inpatient facility within 30 days discharge. This is slightly higher than the 27 percent who were re-hospitalized within 30 days for the last annual chart book.

3. There was little variability in plan performance with Evercare having 28 percent of enrollees readmitted to an inpatient facility within 30 days and Amerigroup having 31 percent of enrollees readmitted to a hospital within 30 days of a behavioral health inpatient stay.

4. Both TANF and SSI-eligible PCCM and FFS enrollees had lower readmission rates than STAR+PLUS enrollees. Readmission rates ranged from a low of nine percent for TANF-eligible PCCM enrollees to 22 percent for SSI-eligible PCCM enrollees.

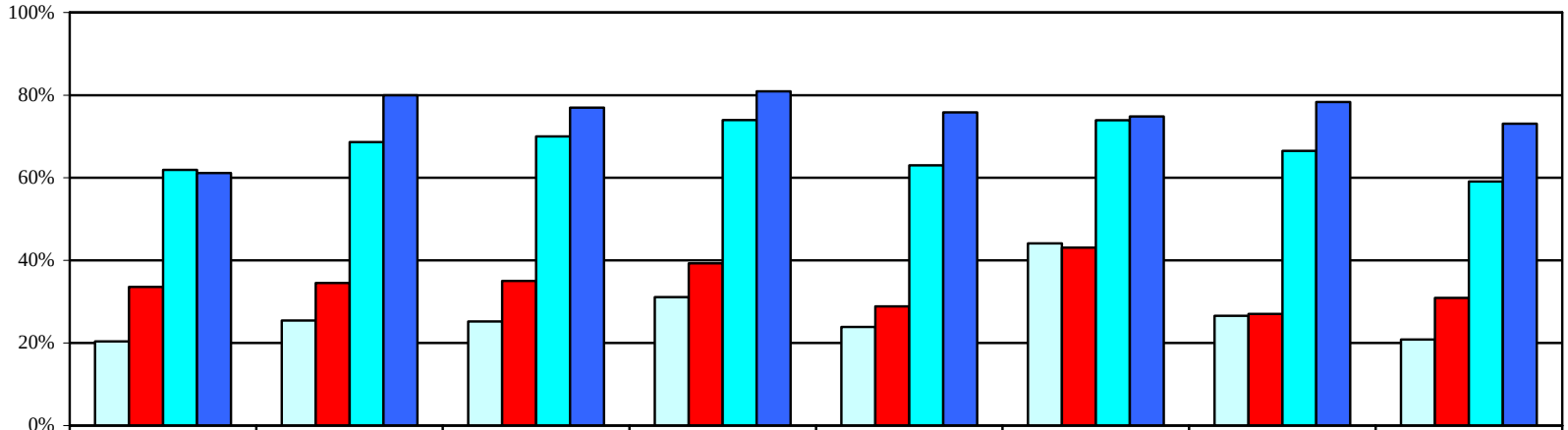
5. Many factors can influence readmission to a psychiatric hospital or chemical dependency treatment center including patient severity, family resources, after care planning, and support from the community. Texas should consider identifying factors that assisted STAR MCO Program plans to perform well on this indicator and determine if these successful strategies can be replicated in the STAR+PLUS Program.

[6] Lieberman, P. B., S. Wiitala, B. Elliott, et al. 1998. "Decreasing Length of Stay: Are There Effects on Outcomes of Psychiatric Hospitalization?" *American Journal of Psychiatry* 155: 905–909.
[7] Pincus H. A., D. Zarin, and J. West. 1996. "Peering into the 'Black Box'. Measuring Outcomes of Managed Care." *Archives of General Psychiatry* 53: 870–877.
[8] Figueroa, R., J. Harman, and J. Engberg. 2004. **"**Use of Claims Data to Examine the Impact of Length of Inpatient Psychiatric Stay on Readmission Rate." *Psychiatric Services* 55 (5): 560-5.

Chart 10. HEDIS® Comprehensive Diabetes Care (administrative data component only)

Eligible Enrollees, PCCM-TANF = 265
Eligible Enrollees, PCCM-SSI = 2,347
Eligible Enrollees, FFS-TANF = 3,817
Eligible Enrollees, FFS-SSI = 25,462
Eligible Enrollees, STAR+PLUS Medicaid Only = 3,872

STAR+PLUS MCOs - September 1, 2004 to August 31, 2005



	PCCM-TANF	PCCM-SSI	FFS-TANF	FFS-SSI	STAR+PLUS MCO Mean	HEDIS® Mean 2004	Evercare	Amerigroup
% with Eye Exams	20.38%	25.44%	25.23%	31.13%	23.89%	44.10%	26.60%	20.85%
% Diabetic Nephropathy	33.58%	34.55%	35.05%	39.31%	28.87%	43.10%	27.04%	30.93%
% HbA1c Testing	61.89%	68.64%	70.00%	73.94%	63.02%	73.90%	66.50%	59.11%
% LDL-C Screening	61.13%	79.97%	76.95%	80.92%	75.85%	74.80%	78.34%	73.07%

Reference: STAR+PLUS Table PI-7

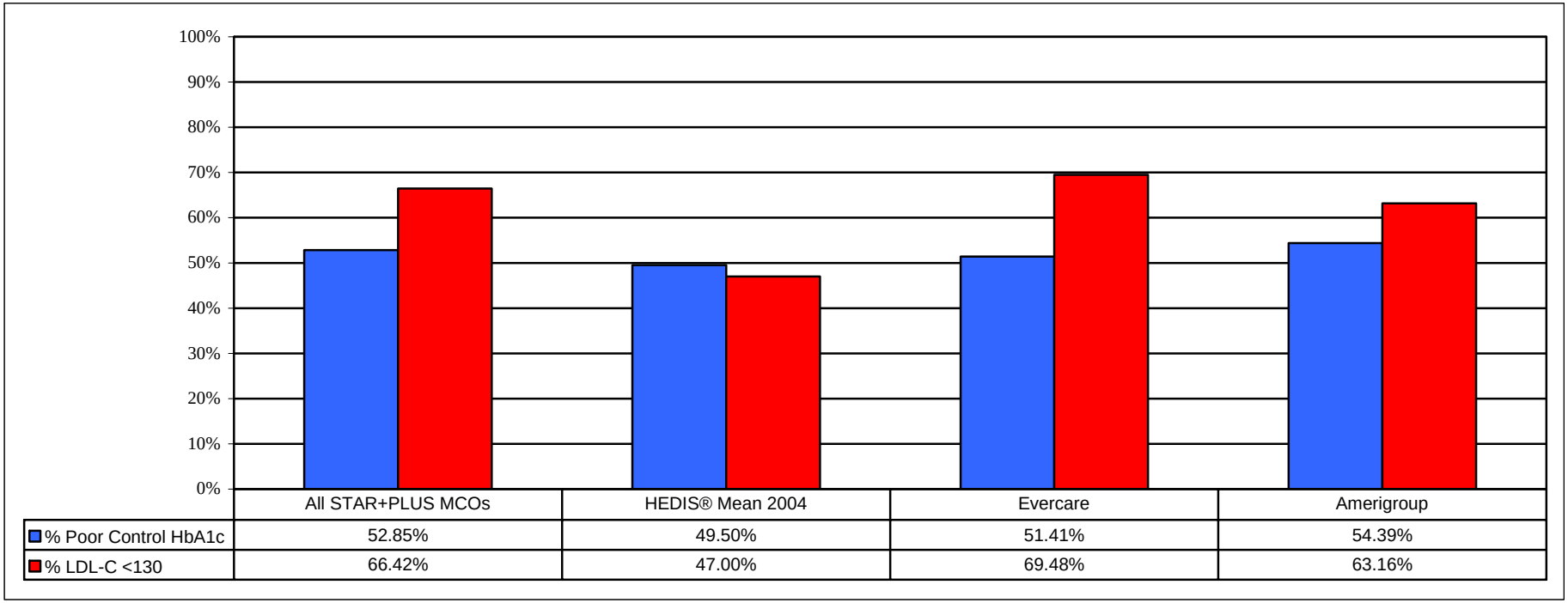
Note: Charts 10 and 11 need to be viewed together. The key findings about comprehensive diabetes care are summarized following Chart 11.

Chart 11. HEDIS® Comprehensive Diabetes Care (medical record review component only)

Total Sample Reviewed = 825

STAR+PLUS MCOs - January 1, 2004 to December 31, 2004

Eligible Enrollees = 3,560



	All STAR+PLUS MCOs	HEDIS® Mean 2004	Evercare	Amerigroup
% Poor Control HbA1c	52.85%	49.50%	51.41%	54.39%
% LDL-C <130	66.42%	47.00%	69.48%	63.16%

Reference: STAR+PLUS Table PI-7

Note: "Poor Control HbA1c" means a lower rate indicates better performance (i.e., low rates of poor control indicate better care).

Note: Measurement period differs because HEDIS® is conducted for a calendar measurement year.

Key Points:

1. Diabetes is the sixth leading cause of death in the United States. Diabetes can lead to long term complications such as heart disease, stroke, blindness, high blood pressure, kidney disease, amputation, and even death.

2. HEDIS® technical specifications for the Comprehensive Diabetes Care measures allow for the use of administrative or medical record review. Two of the diabetes measures, relating to control of Hemoglobin A1C (HbA1c) and LDL-C, are only reported annually because

they are based solely upon medical record review. For this report, the following components of diabetes care were assessed using only administrative data: screening for diabetic retinal disease, screening for diabetic nephropathy, and testing for HbA1C and LDL-C.

3. There was variation among the components of diabetes care measured using administrative data. During fiscal year 2005, 29 percent of STAR+PLUS enrollees with diabetes received monitoring for diabetic nephropathy. Sixty-three percent of enrollees received hemoglobin testing. Twenty-four percent of enrollees received appropriate eye exams. The STAR+PLUS mean of 76 percent across both plans exceeded the HEDIS® mean for LDL-C testing at 75 percent (see Chart 10).

4. For the administrative data component, the two STAR+PLUS health plans performed similarly on this measure overall. Given the widespread professional consensus on the importance of the screening measures, the plans should be asked to develop strategies to improve compliance with recommended screening.

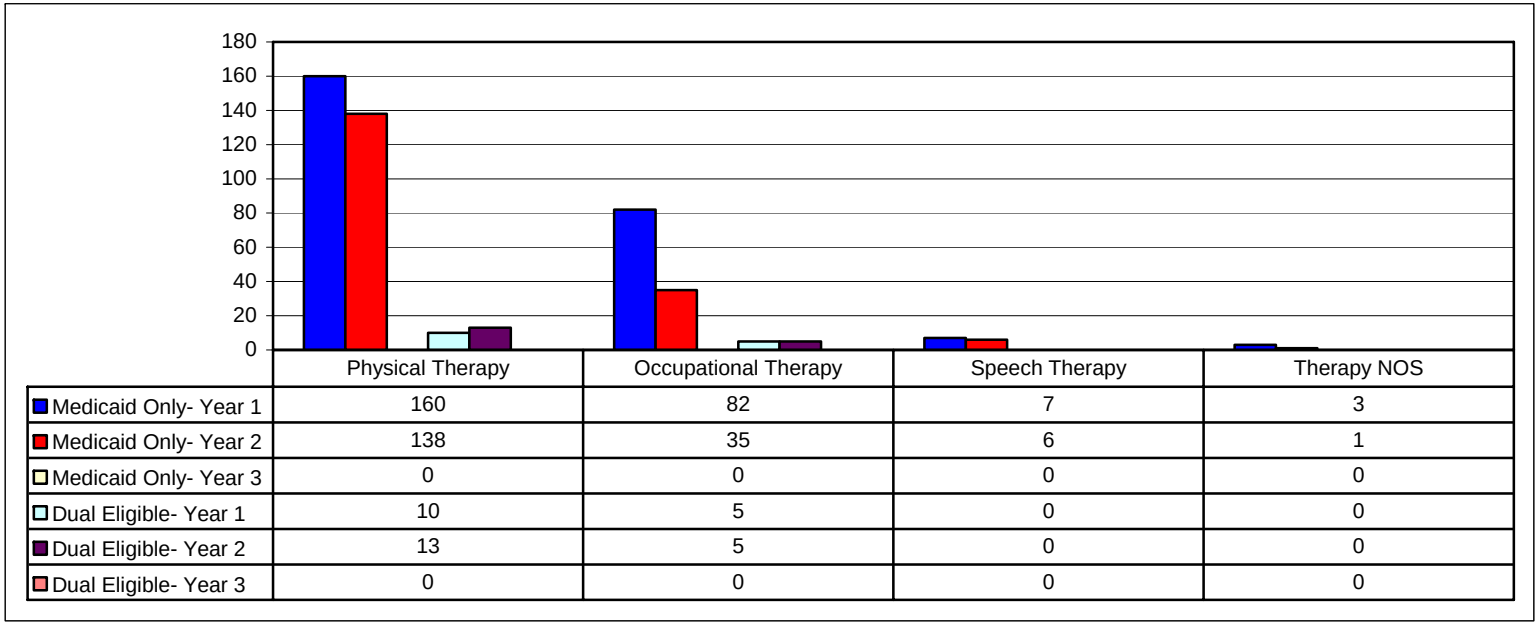
5. For the administrative data component, enrollees in FFS and PCCM enrollees who are eligible for SSI outperformed STAR+PLUS enrollees on all four components of the diabetes measure. The percentage of TANF-eligible PCCM enrollees who received comprehensive diabetes care was slightly lower than the percentage of STAR+PLUS enrollees who received diabetes care on the following components: screening for diabetic retinal disease and testing for HbA1c and LDL-C.

6. For the medical record review component, the overall STAR+PLUS performance did not meet the HEDIS® 2004 standard for control of HbA1c and LDL-C. Fifty-three percent of eligible STAR+PLUS enrollees overall had poor control of HbA1C compared to 50 percent of enrollees in Medicaid plans reporting to NCQA. A lower rate indicates better performance for this indicator. Also, 66 percent of eligible STAR+PLUS enrollees overall had appropriate LDL-C levels compared to the HEDIS® mean of 47 percent (see Chart 11).

Chart 12. Utilization of Therapy Services

STAR+PLUS MCOs - September 1, 2004 to August 31, 2005

Total Unduplicated Members: Medicaid Only = 27,676 Dual Eligibles = 33,319



	Physical Therapy	Occupational Therapy	Speech Therapy	Therapy NOS
Medicaid Only- Year 1	160	82	7	3
Medicaid Only- Year 2	138	35	6	1
Medicaid Only- Year 3	0	0	0	0
Dual Eligible- Year 1	10	5	0	0
Dual Eligible- Year 2	13	5	0	0
Dual Eligible- Year 3	0	0	0	0

Reference: STAR+PLUS Tables PI-11 and TX-1

Note: Evercare has expressed concerns that ICHP may not be including all pertinent codes for long term care measures such as therapies and nursing care. Evercare was to provide the long term care codes so that ICHP could update long term care specifications, if warranted. ICHP has not received this information to date; therefore, this report includes the old specifications only.

Key Points:

1. Chart 12 shows the unduplicated number of recipients in STAR+PLUS (both Medicaid only and the dual eligibles) receiving various therapies for the following time periods: Year 1 (January 1, 2002 to December 31, 2002), Year 2 (December 1, 2002 to November 30, 2003), and Year 3 (September 1, 2004 to August 31, 2005).

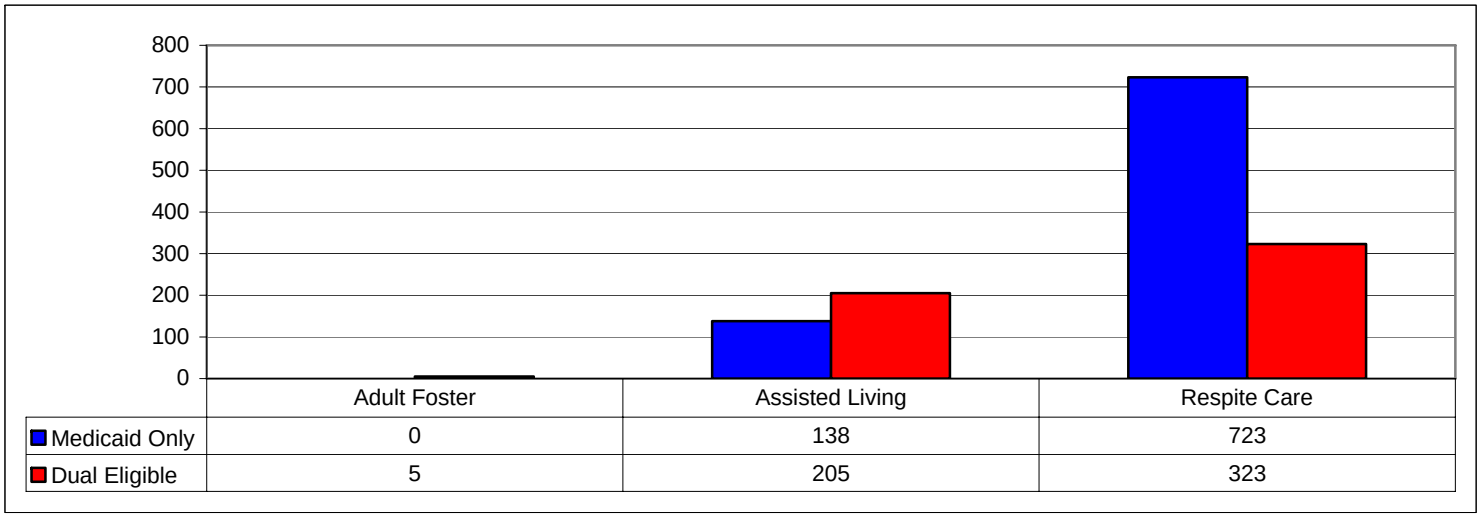
2. Utilization of all types of therapies has decreased over the past three years. Utilization of physical therapy and occupational therapy in particular has decreased dramatically. While the accuracy of these data was confirmed with the Texas Health and Human Services

Commission (HHSC), the reason for this decline is not yet apparent. It is recommended that Texas HHSC investigate why utilization of these therapies has decreased.

Chart 13. Utilization of Adult Foster Care, Assisted Living, and Respite Care

STAR+PLUS MCOs - September 1, 2004 to August 31, 2005

Total Unduplicated Members, Medicaid Only = 27,676
Total Unduplicated Members, Dual Eligibles = 33,319



	Adult Foster	Assisted Living	Respite Care
Medicaid Only	0	138	723
Dual Eligible	5	205	323

Reference: STAR+PLUS Tables PI-8 and TX-1

Note: Evercare has expressed concerns that ICHP may not be including all pertinent codes for long term care measures such as therapies and nursing care. Evercare was to provide the long term care codes so that ICHP could update long term care specifications, if warranted. ICHP has not received this information to date; therefore, this report includes the old specifications only.

Key Points:

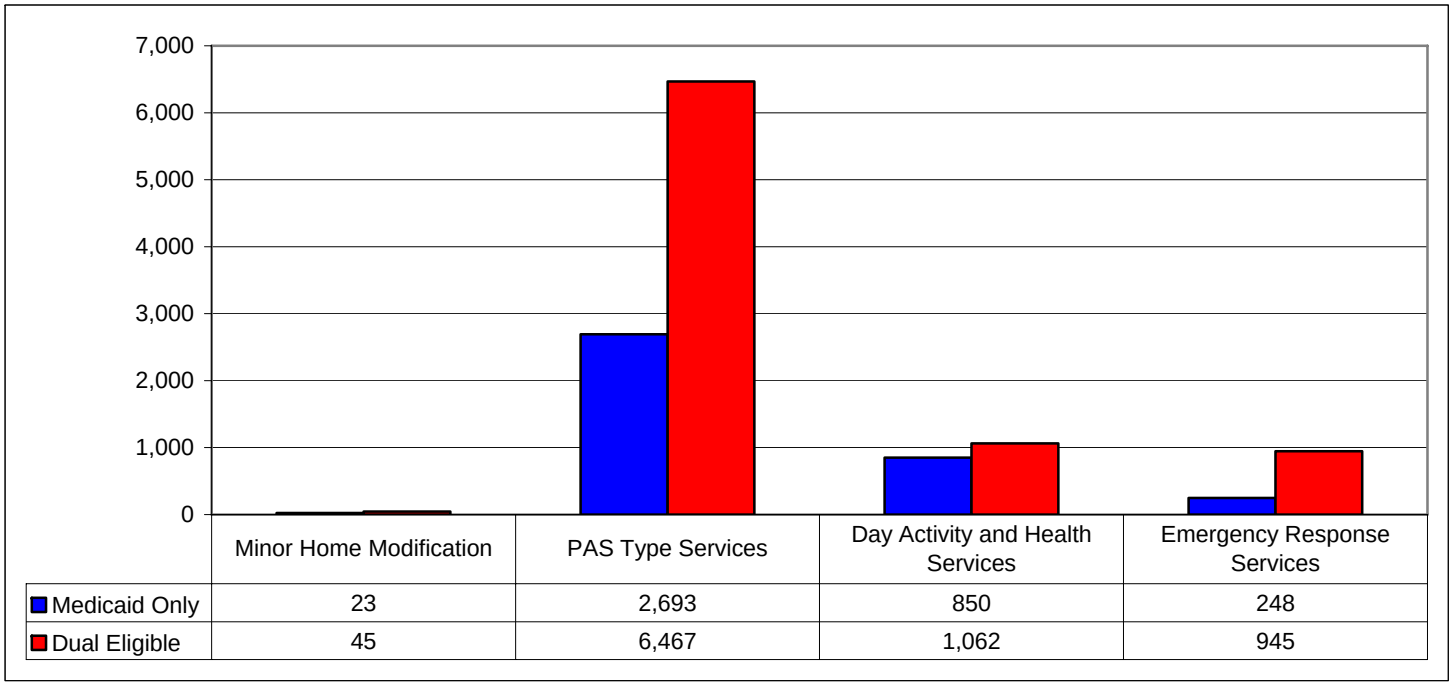
1. Chart 13 provides information on the unduplicated number of Medicaid only and dual eligibles receiving adult foster care, assisted living, and respite care services during fiscal year 2005. While the number of Medicaid and dual eligibles receiving assisted living services are comparable, a significantly higher number of Medicaid only enrollees are receiving respite care as compared to enrollees who are dual eligibles (723 Medicaid only compared to 323 dual eligibles). Very few members were identified as utilizing adult foster care.

2. Few STAR+PLUS members are utilizing adult foster care, assisted living, or respite care services. Additional analysis of these data may be warranted to ensure STAR+PLUS enrollees are receiving needed services.

Chart 14. Utilization of Home Modification, Personal Assistant, Day Activity/Health, and Emergency Response Services

STAR+PLUS MCOs - September 1, 2004 to August 31, 2005

Total Unduplicated Members, Medicaid Only = 27,676
Total Unduplicated Members, Dual Eligibles = 33,319



	Minor Home Modification	PAS Type Services	Day Activity and Health Services	Emergency Response Services
Medicaid Only	23	2,693	850	248
Dual Eligible	45	6,467	1,062	945

Reference: STAR+PLUS Table PI-9 and TX-1

Key Points:

1. Chart 14 shows a variety of services provided to unduplicated enrollees such as home modification, personal assistant, day activity/health, and emergency response services.

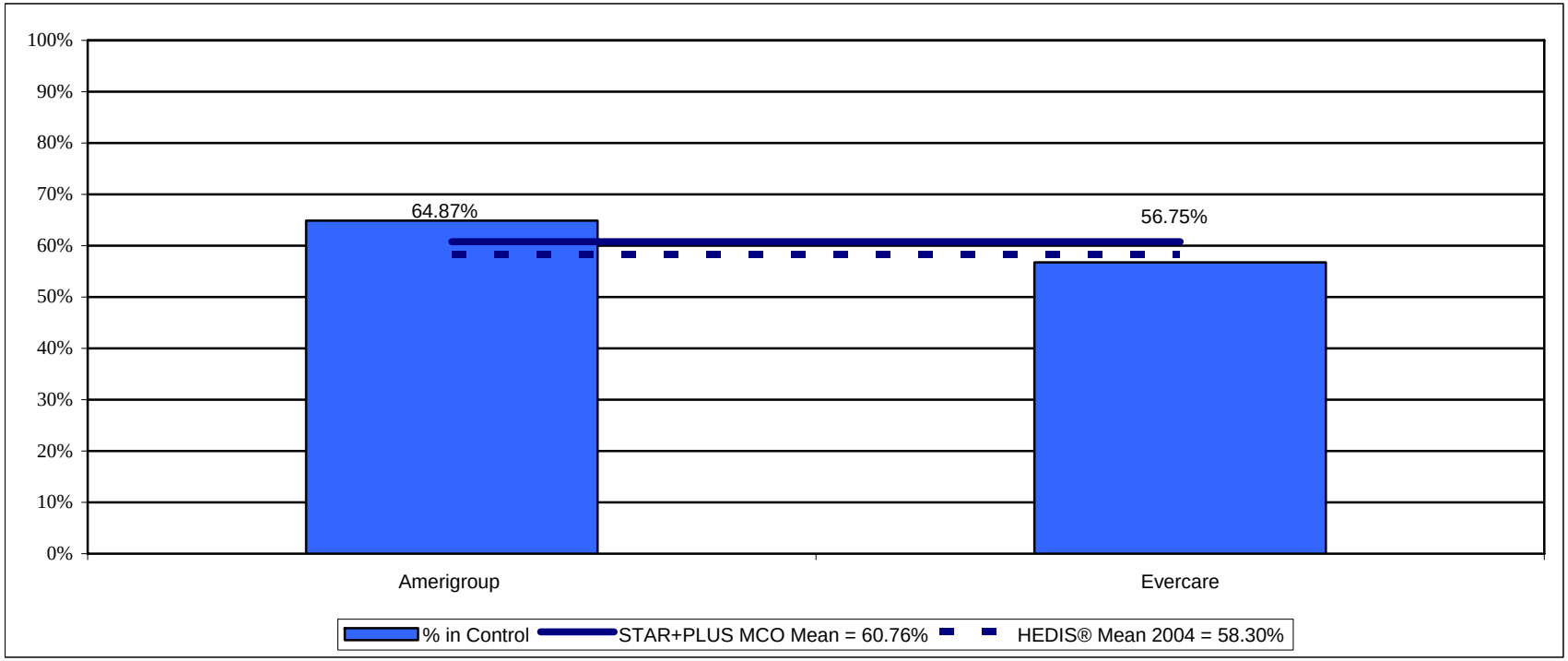
2. Over 2,600 Medicaid only enrollees and over 6,400 dual eligibles received personal assistant type services for fiscal year 2005.

Chart 15. HEDIS® Controlling High Blood Pressure

Total Sample Reviewed = 864

STAR+PLUS MCOs - January 1, 2004 to December 31, 2004

Eligible Enrollees = 3,849



Reference: STAR+PLUS Table PI-15

Note: Measurement period differs because HEDIS® is conducted for a calendar measurement year.

Key Points:

1. Recent data from the National Health and Nutrition Examination Survey (NHANES) show that over 50 million Americans have high blood pressure warranting some form of medical treatment.[9] Also, the World Health Organization reports that suboptimal blood pressure is responsible for 62 percent of cerebrovascular disease and 49 percent of ischemic heart disease. Additionally, suboptimal blood pressure is the number one risk factor for death worldwide.[10]

2. Chart 15 provides information on the percentage of enrolled members 46-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (less than or equal to 140/90) during the measurement year. This measure is reported annually because it is based solely upon medical record review. Because of the need to obtain and review records, the measurement period for the medical record review is the HEDIS® measurement year of January 1, 2004, through December 31, 2004.

3. Overall, 61 percent of eligible STAR+PLUS MCO Program enrollees had adequately controlled high blood pressure. This figure compares favorably with the 58 percent of eligible enrollees who had controlled high blood pressure in the Medicaid programs reporting to NCQA. Both MCOs had excellent results for this indicator, both having 57 percent or more of eligible members who had adequately controlled blood pressure.

[9] Hajjar II., and T.A. Kotchen 2003. "Trends in prevalence, awareness, treatment, and control of hypertension in the United States, 1988–2000." *JAMA. 2*290: 199–206
[10] World Health Report 2002: Reducing risks, promoting healthy life. Geneva, Switzerland: World Health Organization, 2002. http://www.who.int/whr/2002.