Annual Quality of Care Report

Fiscal Year 2007

Texas Children's Health Insurance Program 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

Purpose

The purpose of this report is to provide an annual update of the quality of care provided to enrollees in the CHIP Program in Texas. This update is for September 1, 2006, to August 31, 2007, covering State Fiscal Year (SFY) 2007. Results for the quality of care measures are presented at the individual managed care organization (MCO) and service delivery area (SDA) levels. When possible, comparisons to national data are provided.

The present report produced rates for the Healthcare Effectiveness Data and Information Set (HEDIS®) measures using a 2008 National Committee for Quality Assurance (NCQA) certified software tool. HHSC approved the use of this software so that all HEDIS® results could be reported using a tool recognized by the NCQA. In the past, the HEDIS® measures were calculated using programming code developed by the Institute for Child Health Policy (ICHP). After discussion with HHSC, ICHP developed a methodology to allow for flexibility in the provider specialty codes used in the HEDIS® measures. Following NCQA specifications, the certified software tool requires validation of the provider specialty against the type of service rendered before a beneficiary can be considered eligible for inclusion in a HEDIS® measure. This year, ICHP modified the NCQA specifications to lift these provider constraints when determining eligibility for HEDIS® measures. Provider specialty codes are an important component for some HEDIS® measures and lifting the provider constraint 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:

- 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
- Children's Access to Primary Care Practitioners

The CHIP Program expanded in September 2006. Several HEDIS® measures rely on two years of claims and encounter data. Due to the limited availability of adequate claims and eligibility history for a portion of the population following the expansion, the measures in the present report were restricted to those that required up to one year of data. Hence, the following HEDIS® measures could not be reported this year:

1. Use of Appropriate Medications for People with Asthma. This measure requires two years of pharmacy and encounter data to identify a patient as having persistent asthma.
2. Well-Child Visits in the First 15 Months of Life.

3. Children and Adolescents' Access to Primary Care Practitioners (PCPs). Two of the age cohorts could not be reported because they require two years of encounter and enrollment data.

A 12-month time lag was used for the claims and encounter data. Prior analyses with Texas data showed that, on average, over 99 percent of the claims and encounters are complete by that time period.
This chart book contains the following quality of care 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
    - Children's Access to Primary Care Practitioners
    - HEDIS® Outpatient Drug Utilization
    - Percent of Enrollees with One or More Hospital Stays Due to an Ambulatory Care Sensitive Condition (ACSC)
    - Percent of Hospitalizations with a Primary Diagnosis of an Ambulatory Care Sensitive Condition (ACSC)
    - Percent of Enrollees with One or More Emergency Department Visits Due to an Ambulatory Care Sensitive Condition (ACSC)
    - Percent of Emergency Department Visits with a Primary Diagnosis of an Ambulatory Care Sensitive Condition (ACSC)

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 the CHIP Program.

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 has been enrolled in the program. The person-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 person-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, December 2008."[1] This document, prepared by the Institute for Child Health Policy, provides specifications for HEDIS® and other quality of care measures.

Whenever possible, comparisons are provided to other Medicaid Programs. 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. For comparison with the CHIP Program findings, the Medicaid Managed Care Plans 2007 mean results are shown and labeled "HEDIS Mean" in the graphs. This information is not available for all of the quality of care indicators.

Indicators developed for the Agency for Healthcare Research and Quality (AHRQ) were 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."[4] 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. Unlike most other measures provided in this chart book, low quality indicator rates are desired as they suggest a better quality of the health care system outside the hospital setting.

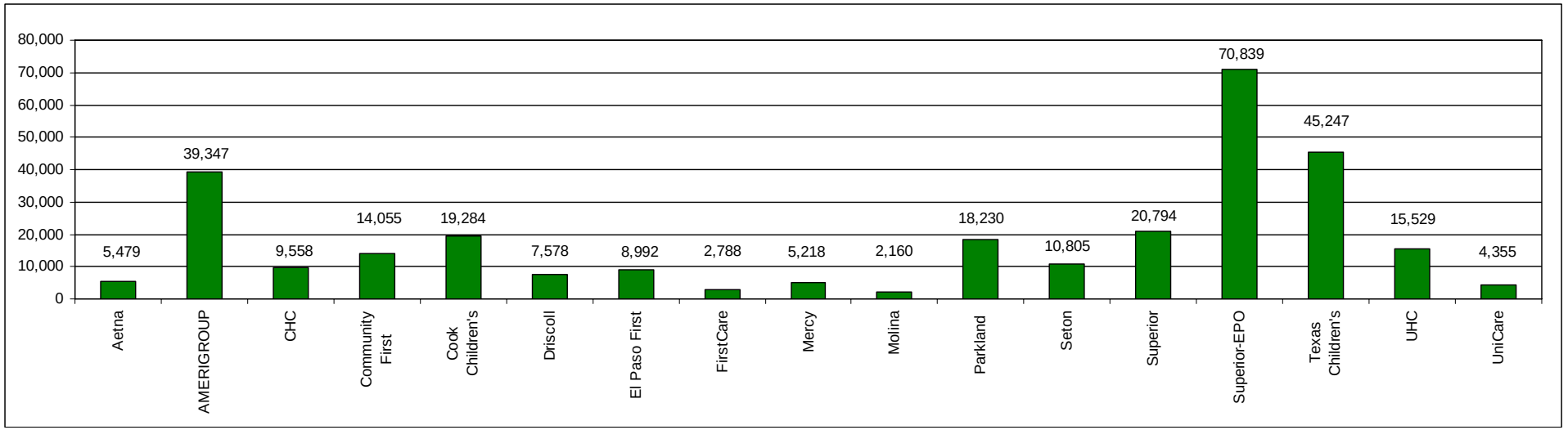
For children, there are four quality indicators measuring pediatric admissions for ambulatory care sensitive conditions: (1) Asthma; (2) Diabetes Short-term Complications; (3) Gastroenteritis; and (4) Urinary Tract Infection. The age eligibility for these measures was modified to include enrollees up to age 18. A fifth PDI that provides rates of admissions for perforated appendix – which is normally reported in QOC reports for Texas HHSC – was 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 were provided to HHSC that contain all of the data to support key findings.[5] 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; and/or (2) because the findings were similar for each MCO. 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.

Community Health Choice MCO is denoted by "CHC" and UnitedHealthcare MCO is denoted by "UHC" in this report.

Chart 1. Total Unduplicated Members

CHIP MCOs - August 2007 **CHIP Unduplicated Members = 300,258**



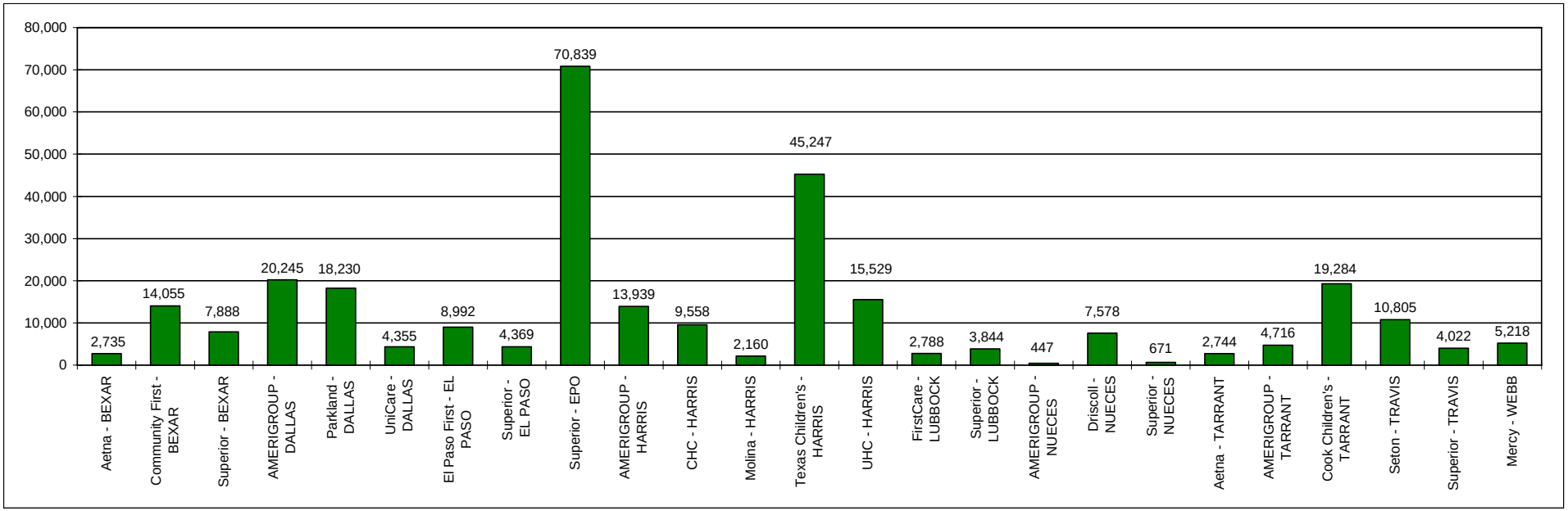
Reference: CHIP Table 1
Note: The eligibility figures used in the chart are for August 2007.

Key Points:

1. Chart 1 provides the total number of unduplicated members enrolled in CHIP, distributed by managed care organization (MCO). In August 2007, there were 300,258 enrollees.
2. The MCO with the largest membership was Superior-EPO at 24 percent of CHIP enrollees, followed by Texas Children's at 15 percent and AMERIGROUP at 13 percent.
3. CHIP enrollees had a mean age of 10 years (SD = 4.57).
4. Forty-nine percent of CHIP enrollees were female, and 51 percent were male.

Chart 2. Total Unduplicated Members – SDA Breakout

CHIP MCOs - August 2007 **CHIP Unduplicated Members = 300,258**



SDA	Bexar	Dallas	El Paso	EPO	Harris	Lubbock	Nueces	Tarrant	Travis	Webb
	24,678	42,830	13,361	70,839	86,433	6,632	8,696	26,744	14,827	5,218

Reference: CHIP Table 1
Note: The eligibility figures used in the chart are for August 2007.

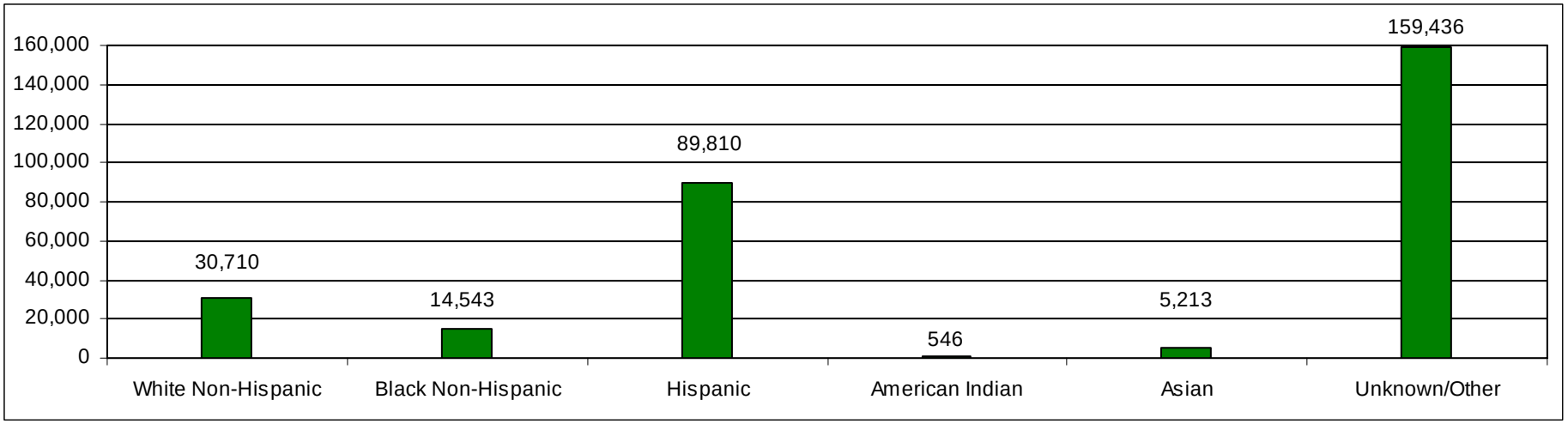
Key Points:

1. Chart 2 presents the distribution of CHIP members by MCO and Service Delivery Area (SDA). There were nine SDAs and 25 MCO/SDA groups in fiscal year 2007. 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-four percent of CHIP members belonged to the EPO.
2. The SDA with the largest membership was Harris at 29 percent of CHIP enrollees, served by five health plans: Texas Children's, AMERIGROUP, Molina, UnitedHealthcare, and Community Health Choice.

3. The three largest MCO/SDA groups were Superior-EPO, Texas Children's-Harris, and AMERIGROUP-Dallas.

Chart 3. Total Unduplicated Members by Race/Ethnicity

CHIP MCOs - August 2007 **CHIP Unduplicated Members = 300,258**



Reference: CHIP Table 2
Note: The eligibility figures used in the chart are for August 2007.

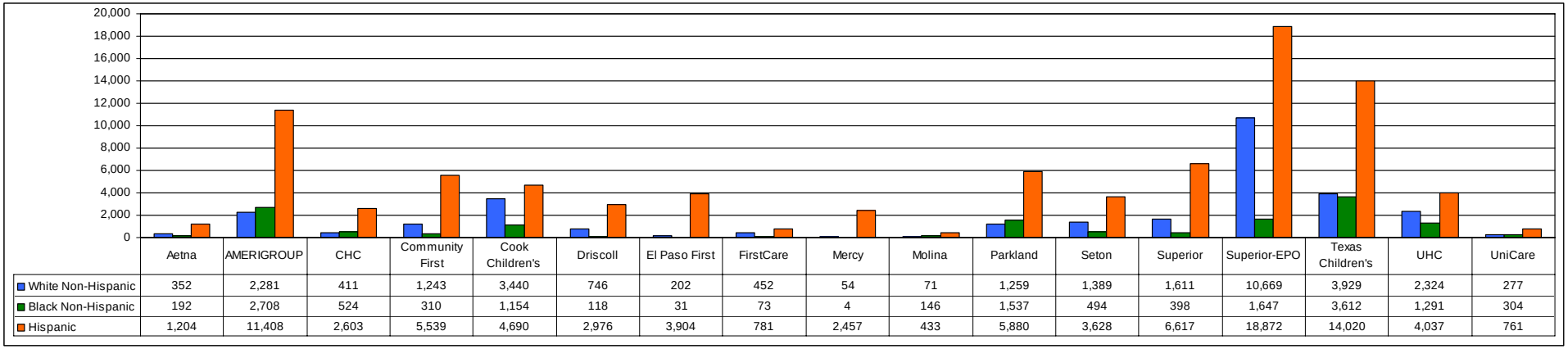
Key Points:

1. Chart 3 presents the racial and ethnic distribution of CHIP enrollees in August 2007.
2. Race/ethnicity was unknown for the majority of CHIP enrollees (53.1 percent). Among those members whose race/ethnicity was known (N = 140,822), the majority were Hispanic (63.8 percent), followed by White, non-Hispanic (21.8 percent), and Black, non-Hispanic (10.3 percent). Less than five percent of enrollees were American Indian (0.4 percent) or Asian (3.7 percent). Understanding the racial/ethnic composition of CHIP members is critical for addressing potential deficits in health care access and quality; however, this information was largely unavailable. It is therefore strongly recommended that HHSC make the reporting of racial/ethnic information mandatory in CHIP enrollment files.
3. Cultural differences can act as barriers to timely and effective treatment, resulting from miscommunication or misunderstanding between patients and health care providers. Language barriers are also a problem given the administrative complexity of health plans and may lead to low utilization of preventive services. Given the high proportion of Hispanic children in CHIP, health plans should be encouraged to

develop or maintain existing programs to ensure that health care provision is culturally appropriate, and to encourage the use of preventive care such as screening.[6]

Chart 4. Total Unduplicated Members by Race/Ethnicity – SDA Breakout

CHIP MCOs - August 2007 **CHIP Unduplicated Members = 300,258**



	Aetna	AMERIGROUP	CHC	Community First	Cook Children's	Driscoll	El Paso First	FirstCare	Mercy	Molina	Parkland	Seton	Superior	Superior-EPO	Texas Children's	UHC	UniCare
White Non-Hispanic	352	2,281	411	1,243	3,440	746	202	452	54	71	1,259	1,389	1,611	10,669	3,929	2,324	277
Black Non-Hispanic	192	2,708	524	310	1,154	118	31	73	4	146	1,537	494	398	1,647	3,612	1,291	304
Hispanic	1,204	11,408	2,603	5,539	4,690	2,976	3,904	781	2,457	433	5,880	3,628	6,617	18,872	14,020	4,037	761

Reference: CHIP Table 2
Note: The eligibility figures used in the chart are for August 2007.

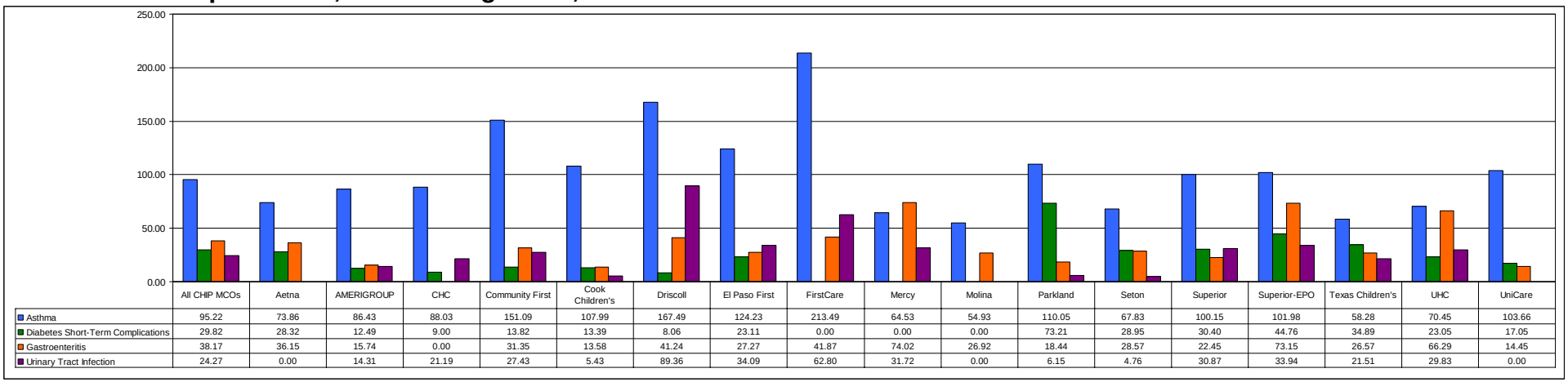
Key points:

1. Chart 4 presents the distribution of CHIP enrollees by MCO and race/ethnicity in August 2007. The overall membership used in the calculations below excludes members whose race/ethnicity was unknown.
2. The percentage of health plan members who were White, non-Hispanic ranged from 2.1 percent in Mercy to 34.9 percent in Cook Children's. The health plans with the largest percentage of White, non-Hispanic members were Cook Children's (34.9 percent of health plan enrollees), FirstCare (34.2 percent) and Superior-EPO (33.9 percent).
3. The percentage of health plan members who were Black, non-Hispanic ranged from 0.2 percent in Mercy to 21.8 percent in UniCare. The health plans with the largest percentage of Black, non-Hispanic members were UniCare (21.8 percent), Molina (20.6 percent), and Parkland (17.0 percent).
4. The percentage of health plan members who were Hispanic ranged from 47.5 percent in Cook Children's to 97.4 percent in Mercy. The health plans with the largest percentage of Hispanic members were Mercy (97.4 percent), El Paso First (93.9 percent), and Driscoll (77.0 percent).

5. Superior-EPO had the greatest volume of both White, non-Hispanic members (N = 10,669) and Hispanic members (N = 18,872). A high volume of Hispanic members was also noted in Texas Children's (N = 14,020) and AMERIGROUP (N = 11,408). However, in terms of distribution, some smaller health plans such as Mercy and El Paso First were comprised of almost exclusively Hispanic membership.

Chart 5. AHRQ Pediatric Quality Indicators

CHIP MCOs - September 1, 2006 to August 31, 2007



	All CHIP MCOs	Aetna	AMERIGROUP	CHC	Community First	Cook Children's	Driscoll	El Paso First	FirstCare	Mercy	Molina	Parkland	Seton	Superior	Superior-EPO	Texas Children's	UHC	UniCare
Asthma	95.22	73.86	86.43	88.03	151.09	107.99	167.49	124.23	213.49	64.53	54.93	110.05	67.83	100.15	101.98	58.28	70.45	103.66
Diabetes Short-Term Complications	29.82	28.32	12.49	9.00	13.82	13.39	8.06	23.11	0.00	0.00	0.00	73.21	28.95	30.40	44.76	34.89	23.05	17.05
Gastroenteritis	38.17	36.15	15.74	0.00	31.35	13.58	41.24	27.27	41.87	74.02	26.92	18.44	28.57	22.45	73.15	26.57	66.29	14.45
Urinary Tract Infection	24.27	0.00	14.31	21.19	27.43	5.43	89.36	34.09	62.80	31.72	0.00	6.15	4.76	30.87	33.94	21.51	29.83	0.00

Reference: CHIP Table PDI08
Note: Rates are per 100,000 enrollees ages 0 to 18. Greater than 90% of rates calculated for perforated appendix admissions had low denominator values, so this measure is not being reported this year.

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 (ACSCs) for children and adolescents. PDIs screen for inpatient stays that were potentially avoidable with better access to care in outpatient settings. This information is useful for monitoring trends, comparing MCO performance, and addressing access to care issues.
2. Chart 5 provides PDI rates for asthma, diabetes short-term complications, gastroenteritis, and urinary tract infections among children and adolescents in CHIP, age 0 to 18 years old, distributed by MCO. Rates are per 100,000 enrollees. **Table 1** describes each of the four AHRQ PDIs shown here. The key points below discuss findings for each condition separately, and provide comparisons with national rates reported by the AHRQ.[7] It should be noted that these AHRQ national estimates for PDIs are based on data collected in 2003 and are area-level indicators, including commercial and Medicaid populations.

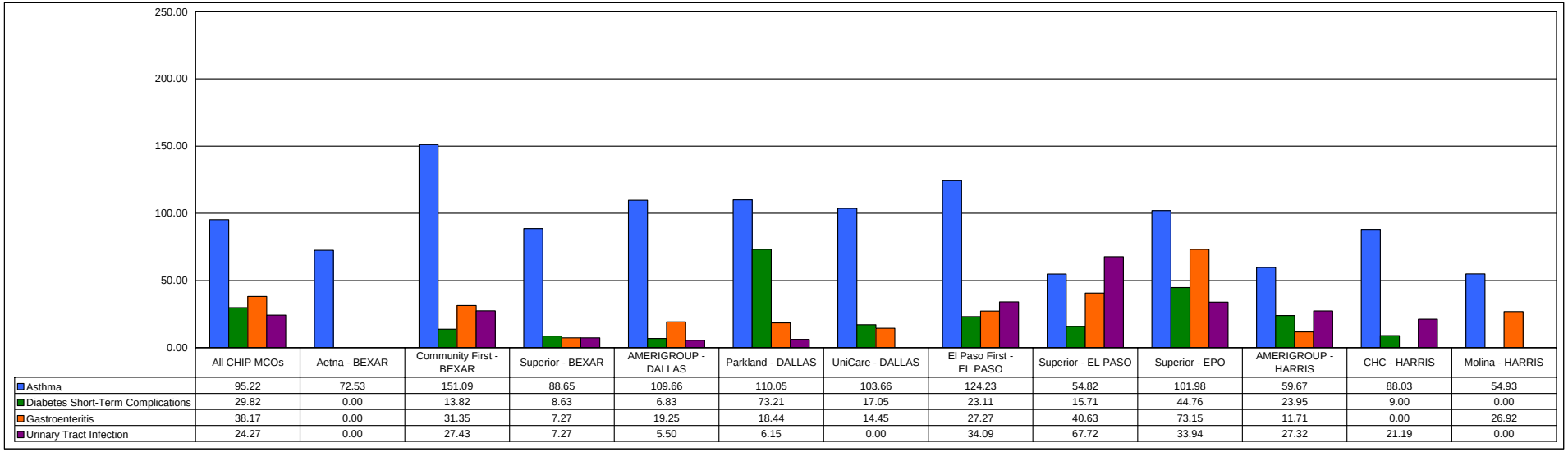
3. Inpatient admissions rates for asthma varied across the MCOs, with rates in FirstCare, Driscoll, and Community First being considerably above the program average of 95.22 per 100,000. Overall, the volume of asthma admissions was high and was the greatest contributor to avoidable inpatient stays among the four conditions. However, it should be noted that the CHIP rates for asthma admissions for all MCOs except FirstCare were lower than the national rate of 180.90 per 100,000 reported by the AHRQ.[8]
4. Inpatient admissions rates for diabetes short-term complications varied less across MCOs. The program level rate of 29.82 per 100,000 was comparable to the national rate of 29.02 per 100,000 reported by the AHRQ. [9] The rate in Parkland was notably above the program average. HHSC may wish to consider monitoring access to and quality of outpatient care for children with diabetes in the Parkland MCO and to identify factors that may be contributing to this health plan's unusually high rate of inpatient admissions for diabetes short-term complications.
5. Inpatient admissions rates for gastroenteritis varied somewhat across the MCOs and were considerably above the program average in Mercy, Superior-EPO, and UnitedHealthcare. The program-level rate of gastroenteritis admissions (38.17 per 100,000) was considerably lower than the national rate of 182.55 per 100,000 reported by the AHRQ. [10]
6. Inpatient admissions rates for urinary tract infection varied somewhat across the MCOs and were considerably above the program average in Driscoll and FirstCare. The program-level rate of urinary tract infection admissions (24.27 per 100,000) was considerably lower than the national rate of 52.91 per 100,000 reported by the AHRQ. [11]
7. At the health plan level, Driscoll and FirstCare had unusually high admissions rates for more than one condition. Rates for all four conditions were greater than the program average in Superior-EPO. Rates for all four conditions were lower than the program average for Aetna, AMERIGROUP, Community Health Choice, Molina, and Seton.

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 MCOs - September 1, 2006 to August 31, 2007



	All CHIP MCOs	Aetna - BEXAR	Community First - BEXAR	Superior - BEXAR	AMERIGROUP - DALLAS	Parkland - DALLAS	UniCare - DALLAS	El Paso First - EL PASO	Superior - EL PASO	Superior - EPO	AMERIGROUP - HARRIS	CHC - HARRIS	Molina - HARRIS
Asthma	95.22	72.53	151.09	88.65	109.66	110.05	103.66	124.23	54.82	101.98	59.67	88.03	54.93
Diabetes Short-Term Complications	29.82	0.00	13.82	8.63	6.83	73.21	17.05	23.11	15.71	44.76	23.95	9.00	0.00
Gastroenteritis	38.17	0.00	31.35	7.27	19.25	18.44	14.45	27.27	40.63	73.15	11.71	0.00	26.92
Urinary Tract Infection	24.27	0.00	27.43	7.27	5.50	6.15	0.00	34.09	67.72	33.94	27.32	21.19	0.00

		Bexar	Dallas	El Paso	EPO	Harris	Lubbock	Nueces	Tarrant	Travis	Webb
SDA Rate	Asthma	123.77	109.28	100.98	101.98	63.57	199.98	167.29	98.01	67.02	64.53
	Diabetes Short-Term Complications	10.82	36.01	20.67	44.76	27.33	50.57	7.13	15.58	31.62	0.00
	Gastroenteritis	20.69	18.46	31.75	73.15	29.47	25.65	42.67	18.73	29.13	74.02
	Urinary Tract Infection	18.39	5.28	45.35	33.94	23.58	42.75	85.33	6.24	10.92	31.72

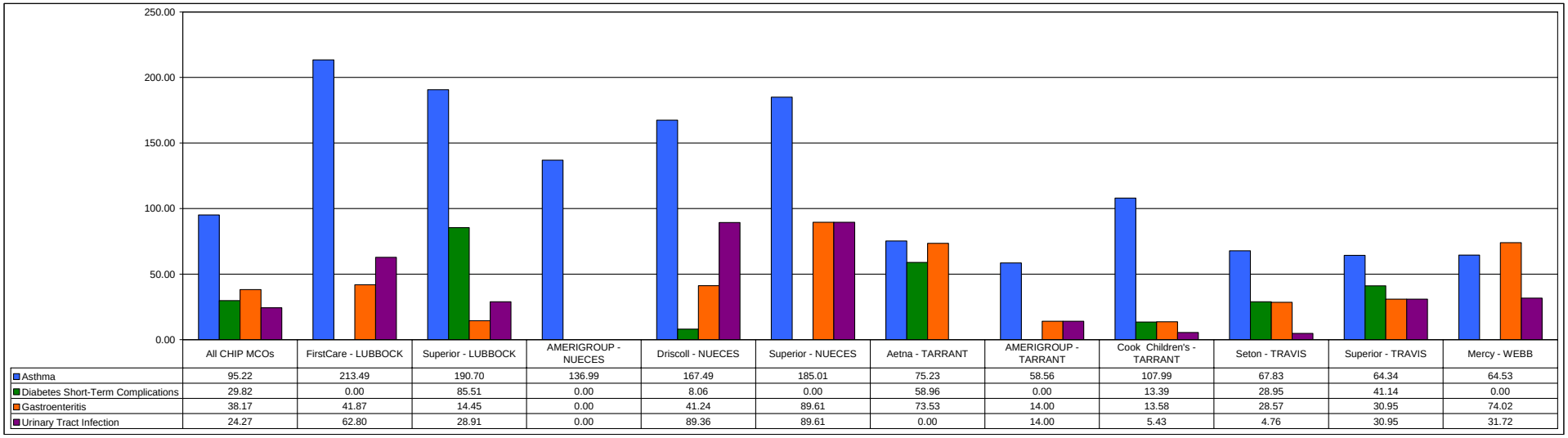
Reference: CHIP Table PDI08
Note: Rates are per 100,000 enrollees ages 0-18. Greater than 90% of rates calculated for perforated appendix admissions had low denominator values, so this measure is not being reported this year.

Key Points:

1. Chart 6A presents AHRQ Pediatric Quality Indicators (PDIs) for 12 of the 25 MCO/SDA groups addressed in this report. Results for the remaining 13 MCO/SDA groups are shown on Chart 6B. Key points for both charts are provided under Chart 6B.

Chart 6B. AHRQ Pediatric Quality Indicators – SDA Breakout

CHIP MCOs - September 1, 2006 to August 31, 2007



	All CHIP MCOs	FirstCare - LUBBOCK	Superior - LUBBOCK	AMERIGROUP - NUECES	Driscoll - NUECES	Superior - NUECES	Aetna - TARRANT	AMERIGROUP - TARRANT	Cook Children's - TARRANT	Seton - TRAVIS	Superior - TRAVIS	Mercy - WEBB
Asthma	95.22	213.49	190.70	136.99	167.49	185.01	75.23	58.56	107.99	67.83	64.34	64.53
Diabetes Short-Term Complications	29.82	0.00	85.51	0.00	8.06	0.00	58.96	0.00	13.39	28.95	41.14	0.00
Gastroenteritis	38.17	41.87	14.45	0.00	41.24	89.61	73.53	14.00	13.58	28.57	30.95	74.02
Urinary Tract Infection	24.27	62.80	28.91	0.00	89.36	89.61	0.00	14.00	5.43	4.76	30.95	31.72

		Bexar	Dallas	El Paso	EPO	Harris	Lubbock	Nueces	Tarrant	Travis	Webb
SDA Rate	Asthma	123.77	109.28	100.98	101.98	63.57	199.98	167.29	98.01	67.02	64.53
	Diabetes Short-Term Complications	10.82	36.01	20.67	44.76	27.33	50.57	7.13	15.58	31.62	0.00
	Gastroenteritis	20.69	18.46	31.75	73.15	29.47	25.65	42.67	18.73	29.13	74.02
	Urinary Tract Infection	18.39	5.28	45.35	33.94	23.58	42.75	85.33	6.24	10.92	31.72

Reference: CHIP Table PDI08
Note: Rates are per 100,000 enrollees ages 0-18. Greater than 90% of rates calculated for perforated appendix admissions had low denominator values, so this measure is not being reported this year.

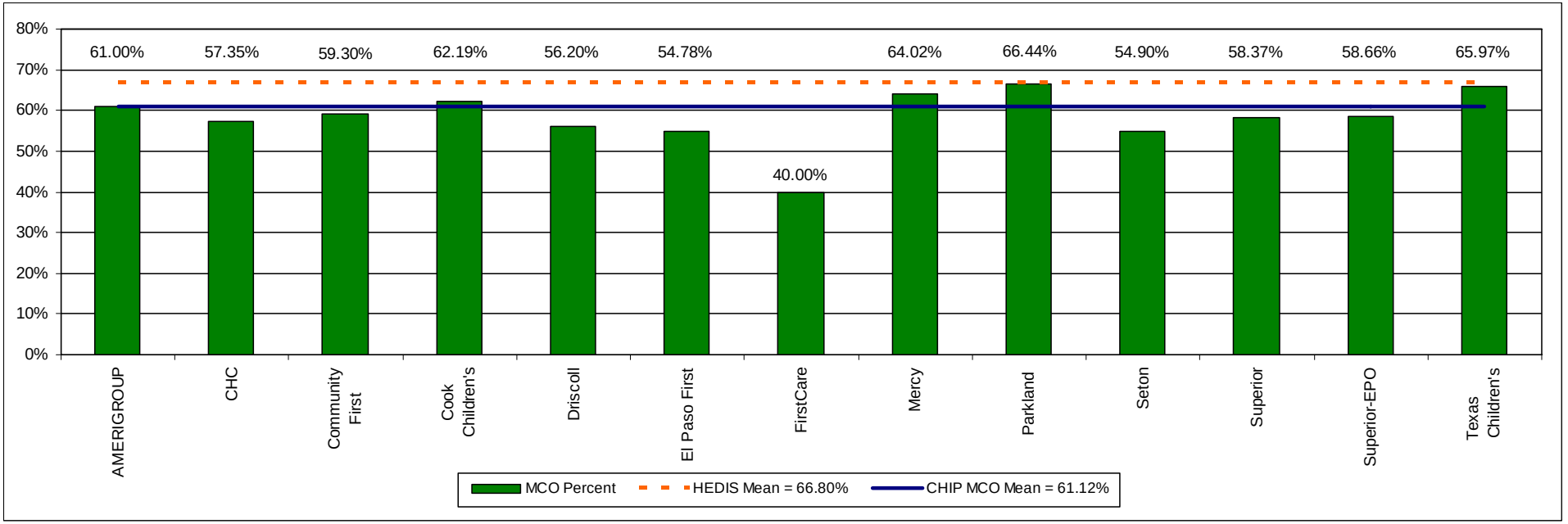
Key Points:

1. Charts 6A and 6B provide AHRQ PDIs for asthma, diabetes short-term complications, gastroenteritis, and urinary tract infections among children and adolescents in CHIP, 0 to 18 years old, distributed by MCO/SDA. These PDIs are described in more detail under Chart 5, and are listed in **Table 1.**
2. Inpatient admissions for asthma were highest in FirstCare-Lubbock, followed by Superior-Lubbock and Superior-Nueces. Rates for all three MCO/SDA groups were considerably above the program average of 95.22 per 100,000. At the SDA level, the highest inpatient admissions for asthma were observed in Lubbock. Since two of the three MCO/SDA groups with the highest rates were in the Lubbock SDA, this suggests that high asthma admission rates may be associated more with SDA than health plan.

3. Inpatient admissions for diabetes short-term complications were highest in Superior-Lubbock, followed by Parkland-Dallas and Aetna-Tarrant. Rates for all three MCO/SDA groups were considerably above the program average of 29.82 per 100,000. At the SDA level, the highest inpatient admissions for diabetes short-term complications were observed in Lubbock.
4. Inpatient admissions for gastroenteritis were highest in Superior-Nueces, followed by Mercy-Webb and Aetna-Tarrant. Rates for all three MCO/SDA groups were considerably above the program average of 38.17 per 100,000. At the SDA level, the highest inpatient admissions for gastroenteritis were observed in Webb.
5. Inpatient admissions for urinary tract infection were highest in Superior-Nueces, followed by Driscoll-Nueces and Superior-El Paso. Rates for all three MCO/SDA groups were considerably above the program average of 24.27 per 100,000. At the SDA level, the highest inpatient admissions for urinary tract infection were observed in Nueces. Since two of the three MCO/SDA groups with the highest rates were in the Nueces SDA, this suggests that high urinary tract infection admission rates may be associated more with SDA than health plan.
6. Comparing PDIs across the nine SDAs, the highest performing SDAs were Harris (all four PDIs lower than the program average), Tarrant (three of four PDIs lower than the program average), Travis (three of four PDIs lower than the program average), and Bexar (three of four PDIs lower than the program average). The lowest performing SDAs were Lubbock (one of four PDIs lower than the program average) and Nueces (one of four PDIs lower than the program average). In contrast, none of the four PDIs for the EPO were lower than the program average, suggesting that wide-ranging efforts to improve outpatient care access and quality in the EPO may be warranted.

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

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Enrollees in Age Group = 13,437**



Reference: CHIP Table W3408
Note: Low denominators of less than 30 eligible members were observed in Aetna, UniCare, UnitedHealthcare and Molina for this measure; results for these health plans are therefore not reported. Eligible members were included in overall CHIP rates.

Key Points:

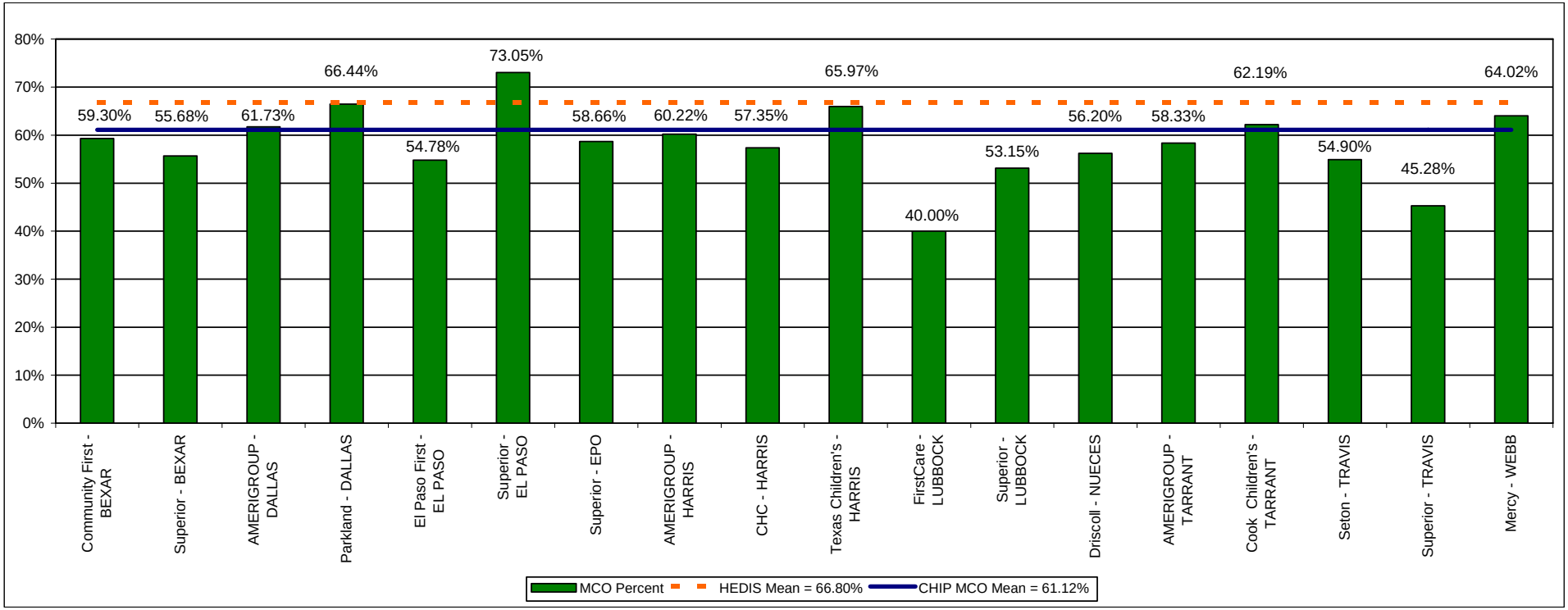
1. Chart 7 provides the percentage of CHIP enrollees between three and six years old who received one or more well-child visits with a primary care practitioner during the measurement period, distributed by MCO.
2. CHIP performed lower than the national HEDIS® mean for Medicaid Managed Care Plans reporting to the National Committee for Quality Assurance (NCQA) on this measure, with 61 percent of children receiving well-child visits in their 3rd, 4th, 5th, and 6th years of life compared to

67 percent nationally. However, CHIP did exceed the HHSC Performance Indicator Dashboard standard for this measure (56 percent); given this finding, HHSC may wish to consider raising the standard for this measure in future versions of the Performance Indicator Dashboard.[12]

3. None of the 13 MCOs considered for this measure met the national HEDIS® mean or the national HEDIS® 50th percentile (67.5 percent). The highest performing MCO was Parkland, with 66 percent of children receiving well-child visits during the measurement period. The low rate of well-child visits in FirstCare (40 percent) is of particular concern, and HHSC may wish to consider monitoring of preventive pediatric care in this health plan to determine the factors that may be contributing to low utilization of well-child visits.

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

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Enrollees in Age Group = 13,437**



SDA	Bexar	Dallas	El Paso	EPO	Harris	Lubbock	Nueces	Tarrant	Travis	Webb
Mean	58.37%	64.42%	60.44%	58.66%	64.78%	47.43%	56.28%	62.13%	54.30%	64.02%

Reference: CHIP Table W3408

Note: Low denominators of less than 30 eligible members were observed in Aetna-Bexar, Aetna-Tarrant, Superior-Nueces, AMERIGROUP-Nueces, UniCare-Dallas, UnitedHealthcare-Harris and Molina-Harris for this measure; results for these health plans are therefore not reported. Eligible members were included in overall CHIP rates.

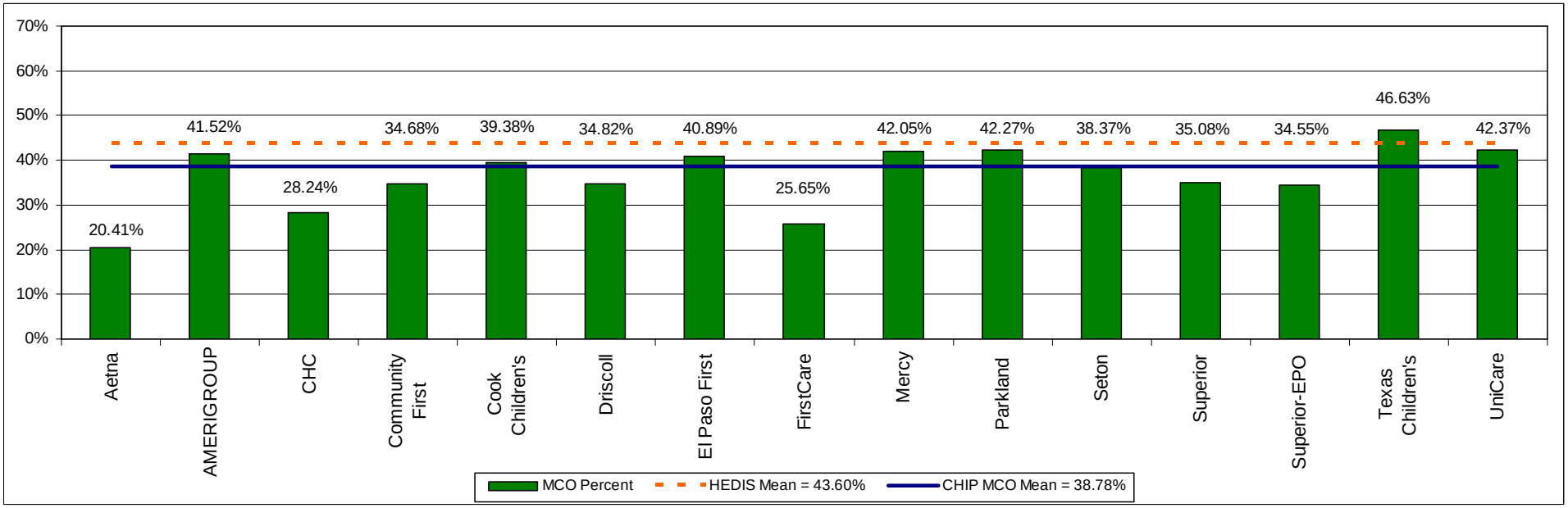
Key Points:

1. Chart 8 presents results for the HEDIS® measure, Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life, distributed by MCO/SDA.

2. Only Superior-El Paso (73 percent) was above the national HEDIS® mean for the percentage of children between three and six years old having a well-child visit during the measurement period. FirstCare-Lubbock (40 percent) and Superior-Travis (45 percent) performed considerably below both the national HEDIS® and statewide CHIP means. MCO/SDA groups that did not meet the HHSC Performance Indicator Dashboard standard for this measure (56 percent) included FirstCare-Lubbock, Superior-Travis, Superior-Lubbock, El Paso First-El Paso, and Seton-Travis.[13]
3. The highest performing SDAs were Harris (65 percent), Dallas (64 percent), and Webb (64 percent), although none met or exceeded the national HEDIS® mean. The EPO performed slightly below the CHIP mean for this measure (59 percent). All SDAs performed above the HHSC Performance Indicator Dashboard standard (56 percent) for this measure except Lubbock (47 percent) and Travis (54 percent).[14]

Chart 9. HEDIS® Adolescent Well-Care Visits

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Eligibles in the Age Group = 52,650**



Reference: CHIP Table AWC08
Note: Low denominators of less than 30 eligible members were observed in UnitedHealthcare and Molina for this measure; results for these health plans are therefore not reported. Eligible members were included in overall CHIP rates.

Key Points:

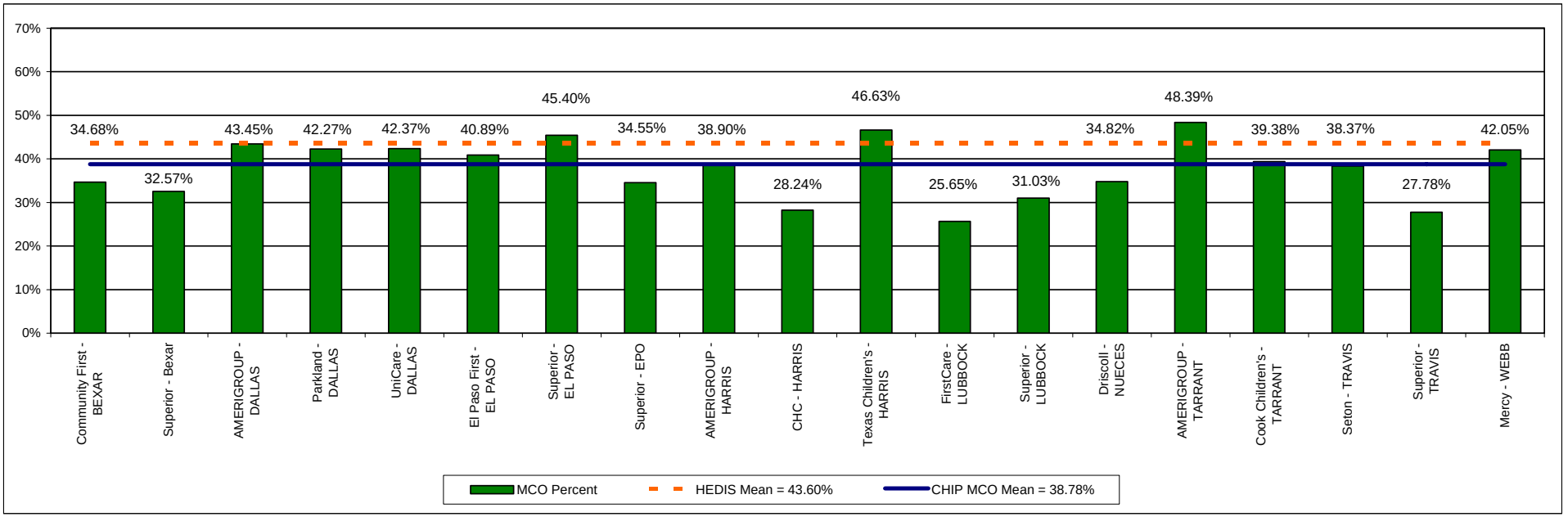
1. Chart 9 provides the percentage of CHIP enrollees 12 to 18 years old who received one or more comprehensive adolescent well-care visits with a primary care practitioner or OB/GYN practitioner during the measurement period, distributed by MCO. It should be noted that HEDIS® eligibility specifications for this measure include persons up to 21 years old, which should be taken into consideration when comparing results with the national HEDIS® mean.
2. CHIP performed below both the national HEDIS® mean (44 percent) and 50th percentile (42.1 percent) for Medicaid Managed Care Plans reporting to the NCQA on this measure, with 39 percent of adolescents receiving at least one well-care visit. However, CHIP did meet the

HHSC Performance Indicator Dashboard standard for this measure (38 percent).[15] HHSC may wish to raise this standard in future versions of the Performance Indicator Dashboard to conform to the national average.

3. Only Texas Children's (47 percent) performed above the national HEDIS® mean for this measure. Health plans that met or exceeded the HHSC Performance Indicator Dashboard standard (38 percent) included AMERIGROUP, Cook Children's, El Paso First, Mercy, Parkland, Seton, Texas Children's, and UniCare.[16] The percentage of adolescent well-care visits in Aetna (20 percent), FirstCare (26 percent), and Community Health Choice (28 percent) were considerably below average. HHSC may wish to consider studies to explore the factors responsible for low utilization of adolescent well-care in these health plans.
4. Research has identified trust and confidentiality concerns to be key factors in ensuring that adolescents utilize preventive health counseling.[17] Because preventive health counseling for adolescents frequently focuses on high-risk behaviors such as drug, alcohol, and tobacco use, risky sexual behaviors, poor nutrition, and inadequate physical activity, many adolescents may be reluctant to make well-care visits with their physicians. Providers should be encouraged to be sensitive to adolescents' concerns for confidentiality. A study of adolescents in a Medicaid managed care program in California found substantial increases in the rates of adolescent well-care visits following the implementation of a number of interventions, including: (1) a member incentive program that provided a $15 gift certificate for members who obtained documentation of a well-care visit; (2) a teen newsletter geared toward topics relevant to teens and advertising the incentive program; (3) a series of communications to and resources for providers; and (4) a recognition program for providers who displayed outstanding performance with the health plan's adolescent members.[18]

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

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Eligibles in the Age Group = 52,650**



SDA	Bexar	Dallas	El Paso	EPO	Harris	Lubbock	Nueces	Tarrant	Travis	Webb
Mean	33.98%	42.83%	41.86%	34.55%	44.59%	28.53%	34.86%	39.43%	37.86%	42.05%

Reference: CHIP Table AWC08
Note: Low denominators of less than 30 eligible members were observed in Aetna-Bexar, Aetna-Tarrant, AMERIGROUP-Nueces, Superior-Nueces, UnitedHealthcare-Harris, and Molina-Harris; results for these health plans are therefore not reported. Eligible members were included in overall CHIP rates.

Key Points:

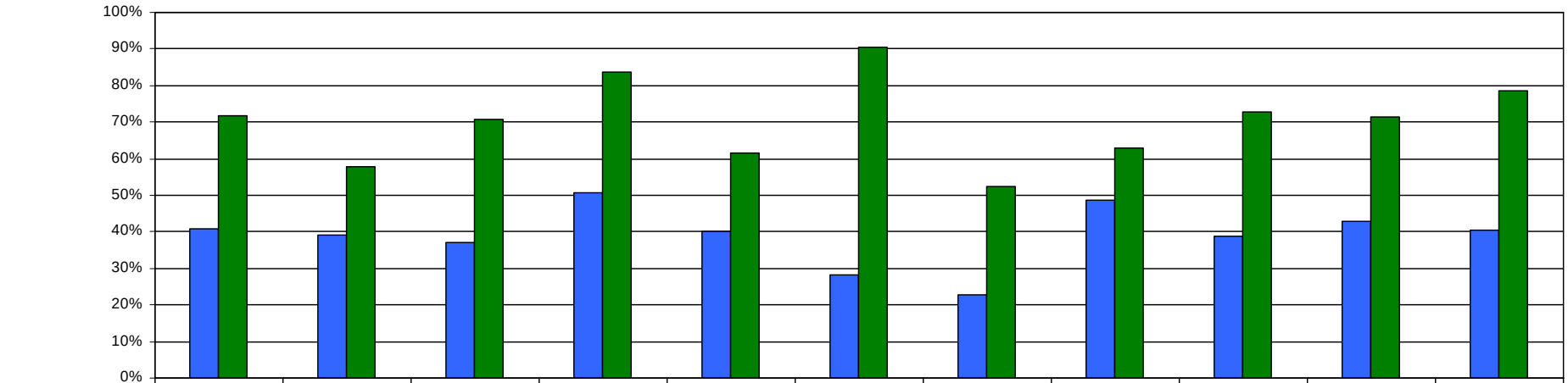
1. Chart 10 presents results for the HEDIS® measure, Adolescent Well-Care Visits, distributed by MCO/SDA.
2. Superior-El Paso, AMERIGROUP-Tarrant, and Texas Children's-Harris all performed above the national HEDIS® mean for this measure. Health plans that met or exceeded the HHSC Performance Indicator Dashboard standard (38 percent) included El Paso First-El Paso, Cook Children's-Tarrant, Mercy-Webb, Parkland-Dallas, Superior-El Paso, Seton-Travis, AMERIGROUP-Tarrant, Texas Children's-Harris,

AMERIGROUP-Harris, AMERIGROUP-Dallas, and UniCare-Dallas.[19] FirstCare-Lubbock (26 percent), Superior-Travis (28 percent), and Community Health Choice-Harris (28 percent) performed considerably below average.

3. Only the Harris SDA (45 percent) performed above the national HEDIS® mean for this measure. The EPO (35 percent) performed below both the HEDIS® and CHIP means. SDAs not meeting the HHSC Performance Indicator Dashboard standard included Bexar (34 percent), Lubbock (28 percent), and Nueces (35 percent).[20]
4. Utilization of adolescent well-care visits was lowest in the Lubbock SDA, and HHSC may wish to consider studies to explore the factors responsible for low utilization in this SDA.

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

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Mental Health Hospitalizations = 765**



	CHIP MCO Mean	HEDIS Mean	AMERIGROUP	Community First	Cook Children's	Driscoll	Parkland	Superior	Superior - EPO	Texas Children's	UHC
7 Day Follow-up	40.65%	39.10%	36.92%	50.82%	40.17%	28.13%	22.73%	48.57%	38.71%	42.86%	40.48%
30 Day Follow-up	71.63%	57.70%	70.77%	83.61%	61.54%	90.63%	52.27%	62.86%	72.81%	71.43%	78.57%

Reference: CHIP Table FUH08
Note: Low denominators of less than 30 eligible members were observed in Aetna, Community Health Choice, El Paso First, FirstCare, Mercy, Seton, UniCare and Molina; results for these health plans are therefore not reported. Eligible members were included in overall CHIP rates.

Key Points:

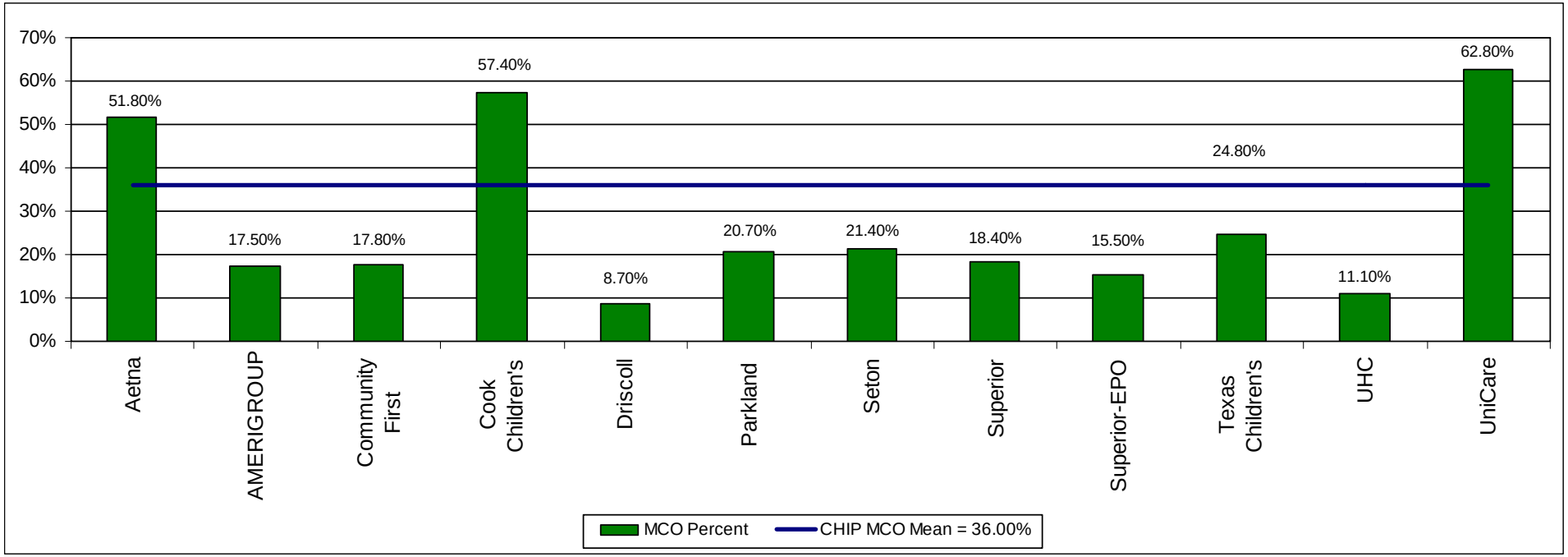
1. Chart 11 provides the percentage of CHIP enrollees six years of age or older who were hospitalized for mental illness and who had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a mental health practitioner during the measurement period, distributed by MCO. Two percentages are shown – one for follow-up within seven days of discharge, and one for follow-up within 30 days of discharge.
2. CHIP performed better than the national HEDIS® mean for Medicaid Managed Care Plans reporting to the NCQA on this measure at both follow-up periods. Among CHIP enrollees hospitalized for mental illness, 41 percent received follow-up within seven days of discharge

(compared with 39 percent nationally) and 72 percent received follow-up within 30 days of discharge (compared with 58 percent nationally). Both results exceeded the HHSC Performance Dashboard Indicator standards for these measures (32 percent and 52 percent, respectively).[21]

3. Results for the seven-day follow-up period were variable across MCOs. Community First (51 percent) and Superior (49 percent) were the highest performing health plans. Seven-day follow-up rates were notably low for Parkland (23 percent) and Driscoll (28 percent), both of which fell below the national and program-level means and the HHSC Performance Indicator Dashboard standard for this measure.[22]
4. Results for the 30-day follow-up period were also variable across MCOs. Driscoll (91 percent) and Community First (84 percent) were the highest performing health plans. Parkland (53 percent) was the only health plan to fall below the national HEDIS® mean for this measure.
5. At the MCO level, the Parkland health plan is performing below average in rates of follow-up after hospitalization for mental illness, particularly at the seven-day follow-up period. Among the health plans assessed, Parkland is the only in which behavioral health services are exclusively carved out to NorthSTAR, which may have implications on the number and accessibility of mental health care providers for Parkland members.[23] (UniCare also carves out behavioral health services to NorthSTAR, but was not assessed here because of low denominator values.) HHSC may wish to consider reviewing NorthSTAR strategies for promoting follow-up and comparing strategies with those of Community First, which had above average results on this measure and provides behavioral health services in-house.

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

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Inpatient Mental Health Eligible Stays = 2,500**



Reference: CHIP Table MHReadmit08
Note: Low denominators of less than 30 eligible members were observed in Community Health Choice, El Paso First, FirstCare, Mercy and Molina; results for these health plans are therefore not reported. Eligible members were included in overall CHIP rates.

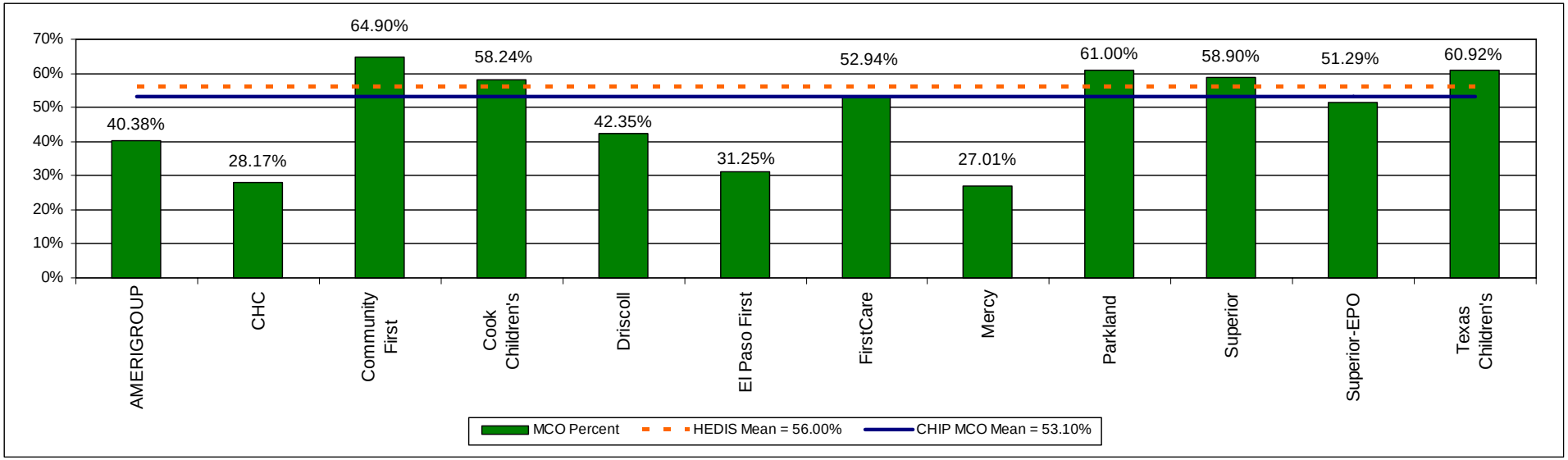
Key Points:

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.[24]

2. The percentage of mental health admissions varied considerably by MCO, with a difference of over 50 percentage points between the health plans with the lowest and highest percentage of readmissions. The lowest-performing MCOs (those with the highest percentage of readmissions) were UniCare (63 percent), Cook Children's (57 percent), and Aetna (52 percent). Driscoll had the lowest percent of readmissions, at 9 percent.
3. Readmission rates may be a sign that a patient was discharged too soon or that the treatment was somehow inadequate. This could be due to a failure to meet basic treatment objectives or standards of care, or poor discharge planning and/or lack of continuity of care.[25] A study in Maryland also found that youths who were discharged from a psychiatric hospital to lower levels of care (e.g., day treatment, therapeutic foster care, group homes) were significantly more likely to be readmitted than those discharged to the highest level of care (residential treatment).[26]

Chart 13. HEDIS® Appropriate Testing for Children with Pharyngitis

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Eligibles = 8,413**



Reference: CHIP Table CWP08
Note: Low denominators of less than 30 eligible members were observed in Aetna, Seton, UniCare, UnitedHealthcare and Molina; results for these health plans are therefore not reported. Eligible members were included in overall CHIP rates.

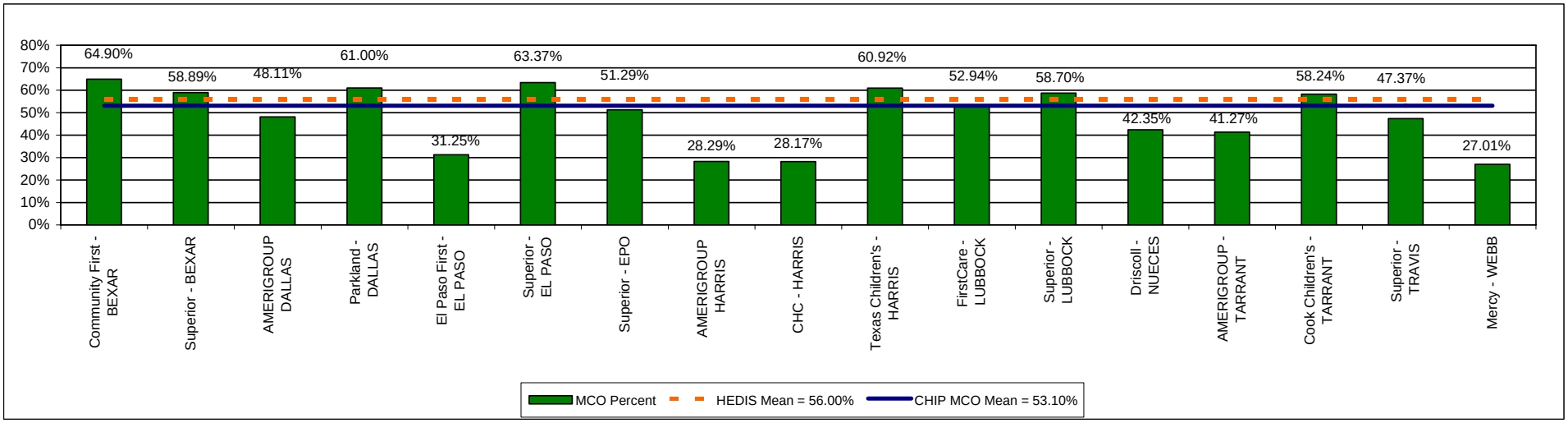
Key Points:

1. Chart 13 provides the percentage of CHIP enrollees 2 to 18 years old who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode, distributed by MCO. Higher rates represent better performance for this measure.
2. CHIP overall performed slightly lower than the national HEDIS® mean for Medicaid Managed Care Plans reporting to the NCQA on this measure (53 percent vs. 56 percent).
3. Rates of appropriate testing for children with pharyngitis varied across MCOs. Health plans exceeding the national HEDIS® mean for this measure included Community First (65 percent), Parkland (61 percent), Texas Children's (61 percent), Superior (59 percent), and Cook

Children's (58 percent). The lowest-performing health plans were Mercy (27 percent), Community Health Choice (28 percent), and El Paso First (31 percent).

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

CHIP MCOs - September 1, 2006 to August 31, 2007 — CHIP Eligibles = 8,413



SDA	Bexar	Dallas	El Paso	EPO	Harris	Lubbock	Nueces	Tarrant	Travis	Webb
Mean	63.63%	53.49%	40.76%	51.29%	53.67%	56.44%	42.59%	57.00%	47.37%	27.01%

Reference: CHIP Table CWP08

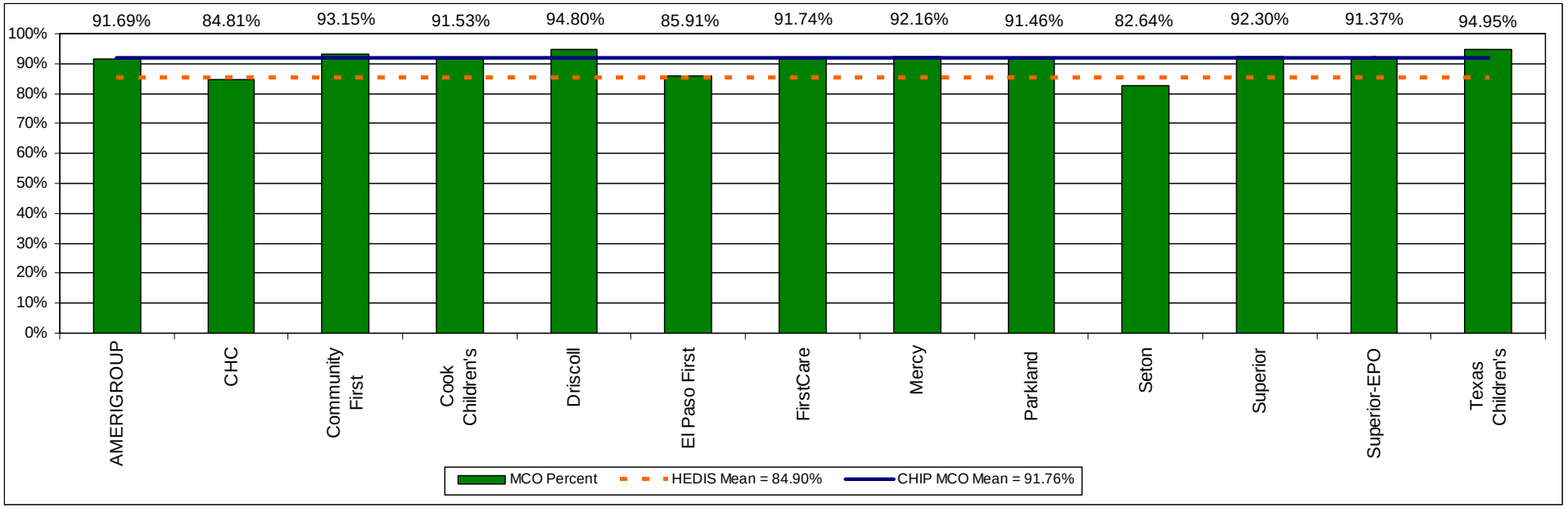
Note: Low denominators of less than 30 eligible members were observed in Aetna-Bexar, Superior-Travis, Seton-Travis, AMERIGROUP-Nueces, Superior-Nueces, UniCare-Nueces, UnitedHealthcare-Harris and Molina-Harris; results for these MCO/SDA groups are therefore not reported. Eligible members were included in overall CHIP rates.

Key Points:

1. Chart 14 presents results for the HEDIS® measure, Appropriate Testing for Children with Pharyngitis, distributed by MCO/SDA. Higher rates represent better performance for this measure.
2. The MCO/SDA group with the highest rate was Community First-Bexar (65 percent) while the lowest was Mercy-Webb (27 percent), a difference of nearly 38 percent.
3. Seven of the MCO/SDA groups and three of the SDAs had rates that were higher than the national HEDIS® mean of 56 percent.
4. Bexar was the only SDA that performed higher than the national HEDIS® 50th percentile (59.6 percent).

Chart 15. Children's Access to Primary Care Practitioners

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Eligibles 25 Months - 6 Years = 15,429**



Reference: CHIP Table CAP08
Note: Low denominators of less than 30 eligible members were observed in Aetna, UniCare, UnitedHealthcare and Molina; results for these health plans are therefore not reported. Eligible members were included in overall CHIP rates.

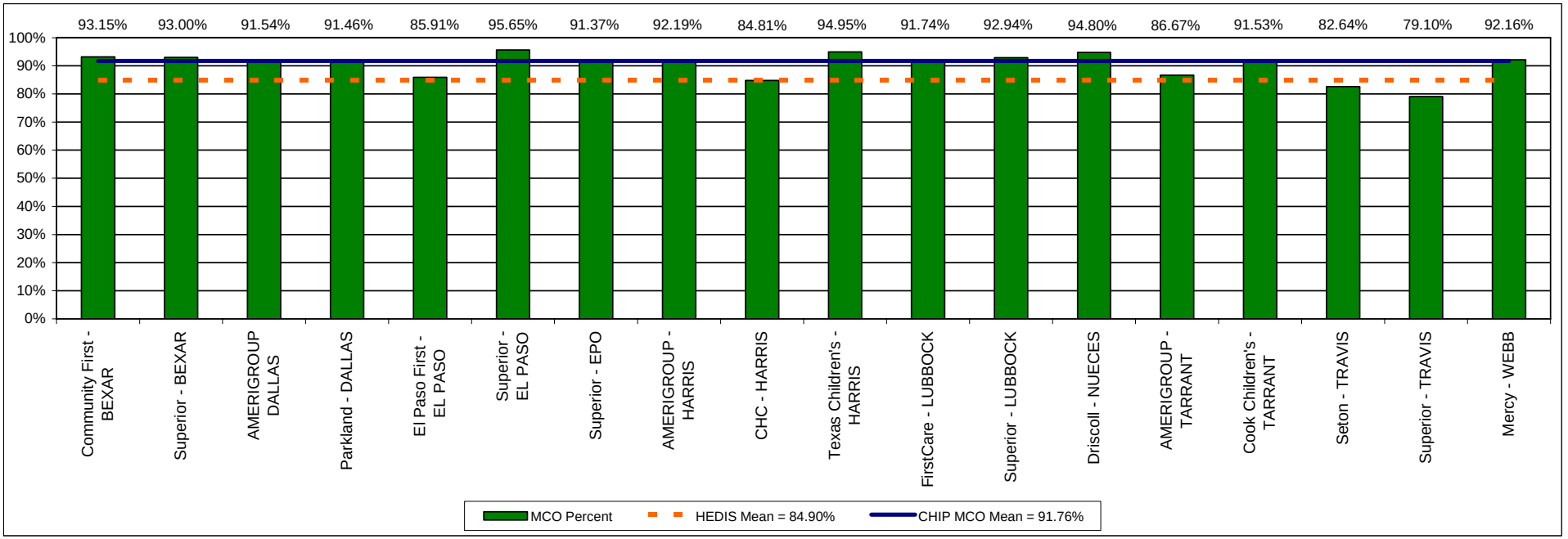
Key Points:

1. Chart 15 provides the percentage of CHIP enrollees ages 25 months to 6 years who visited a primary care practitioner (PCP) between September 1, 2006 and August 31, 2007, distributed by MCO. This measure was based on the HEDIS® measure – Children and Adolescents' Access to Primary Care Practitioners – but excluded children seven to 11 years old and adolescents 12 to 19 years old.
2. Overall, CHIP performed better than the national HEDIS® mean for Medicaid Managed Care Plans reporting to the NCQA on this measure (92 percent vs. 85 percent). Performance in CHIP also exceeded the national HEDIS 90th percentile (91.4 percent).

3. There was little variation across MCOs on this measure. Texas Children's had the highest percentage of children who visited a primary care practitioner (95 percent), ten percent higher than the national HEDIS® mean.
4. Community Health Choice, El Paso First and Seton were the only MCOs that were not above the national HEDIS 50th percentile for this measure (86.7 percent).

Chart 16. Children's Access to Primary Care Practitioners – SDA Breakout

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Eligibles 25 Months - 6 Years = 15,429**



SDA	Bexar	Dallas	El Paso	EPO	Harris	Lubbock	Nueces	Tarrant	Travis	Webb
Mean	93.16%	91.42%	88.91%	91.37%	94.22%	92.44%	94.84%	91.42%	82.40%	92.16%

Reference: CHIP Table CAP08
Note: Low denominators of less than 30 eligible members were observed in Aetna-Bexar, Aetna-Tarrant, AMERIGROUP-Nueces, Superior-Nueces, UniCare-Dallas, UnitedHealthcare-Harris and Molina-Harris; results for these health plans were therefore not reported. Eligible members were included in overall CHIP rates.

Key Points:

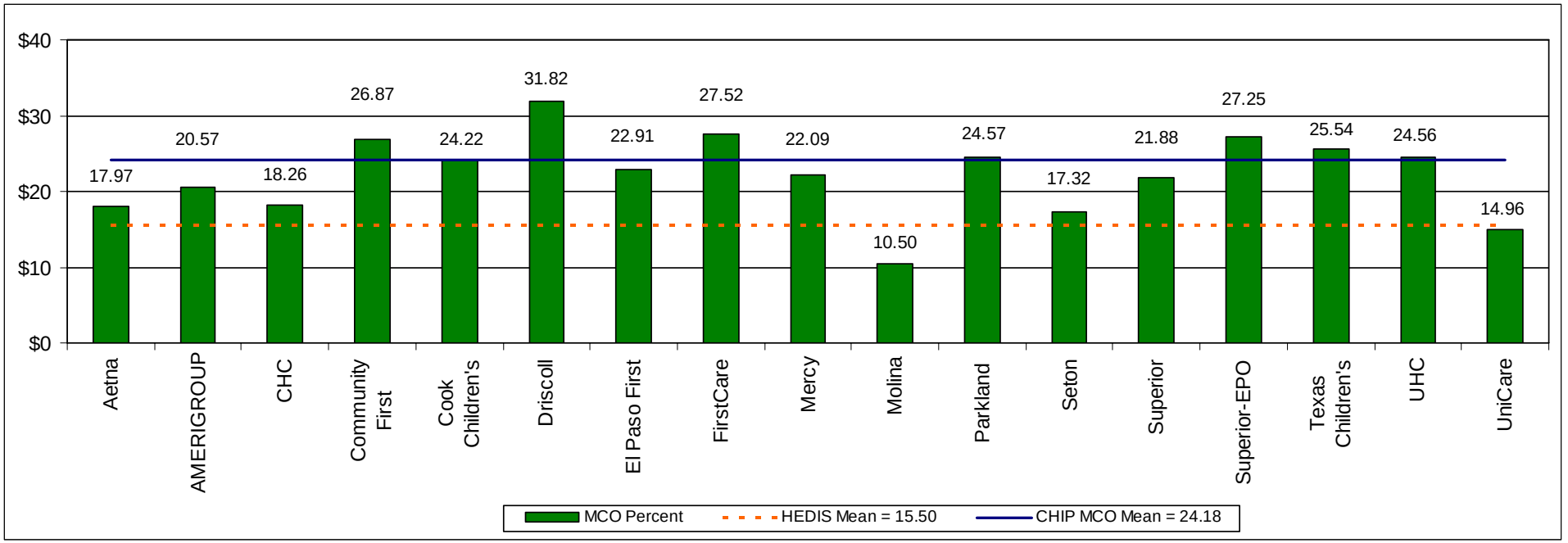
1. Chart 16 provides the percentage of CHIP enrollees age 25 months to 6 years who visited a primary care practitioner (PCP) between September 1, 2006 and August 31, 2007, distributed by MCO/SDA. This measure was based on the HEDIS® measure – Children and Adolescents' Access to Primary Care Practitioners – but excluded children seven to 11 years old and adolescents 12 to 19 years old. These

exclusions were made because two years of claims data are required for accurate measurement in the older age groups. It should also be noted that results for this measure are slightly inflated after lifting provider constraints.

2. Overall, CHIP performed well on this measure and there was little variation among MCO/SDA groups. Only four MCO/SDA groups were below the national HEDIS® mean: El Paso First-El Paso, Superior-Travis, Seton-Travis, and Community Health Choice-Harris. The lowest-performing MCO/SDA groups were Superior-Travis (79 percent) and Seton-Travis (83 percent).
3. Travis was the only SDA that performed below the national HEDIS® mean. Travis was also the only SDA that performed below the national HEDIS® 50th percentile (86.7 percent). These findings suggest that performance on this measure is related more to SDA than health plan.

Chart 17. HEDIS® Outpatient Drug Utilization - Average Cost of Prescriptions per Member per Month - 0 to 9 years

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Number of Prescriptions 0-9 yrs = 754,169**



Reference: CHIP Table ORX08

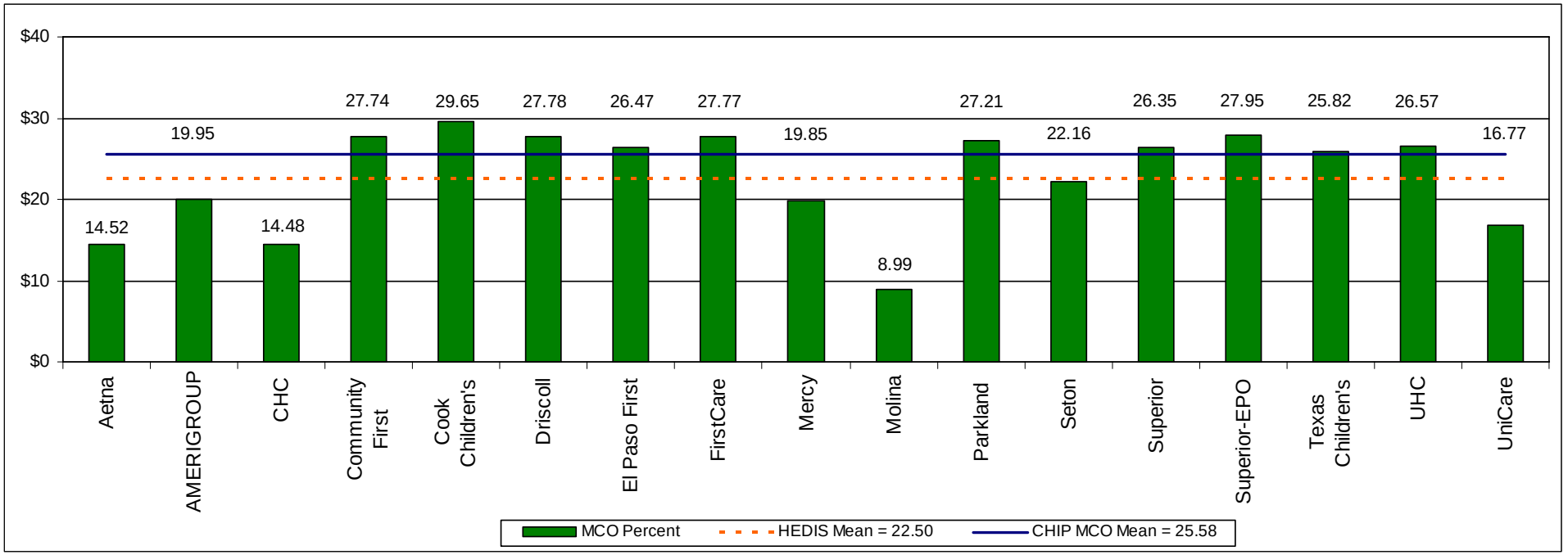
Key points:

1. Chart 17 provides the average cost of prescriptions per member per month among CHIP enrollees up to nine years old, based on 754,169 CHIP prescriptions. The chart provides prescription costs between September 1, 2006 and August 31, 2007, distributed by MCO.
2. The CHIP mean ($24.18) is almost $9 more than the national average for Medicaid Managed Care Plans reporting to the NCQA on this measure ($15.50), which is higher than the difference in means for the 10- to 19-year-old age group (Chart 18).
3. The average cost of prescriptions per member per month in Driscoll was more than double the national HEDIS® mean.
4. Molina was the only MCO that had average costs below both the national HEDIS® mean and the HEDIS® 50th percentile ($14.00).

5. In a recent survey conducted by the Texas EQRO, CHIP established enrollees were found to have higher rates of having special health care needs (20 percent) than either the general Texas population (13 percent) or the national population (14 percent).[27] The most prevalent special health care need among CHIP established enrollees was dependence on medications, which may explain the higher average cost of prescriptions observed here.

Chart 18. HEDIS® Outpatient Drug Utilization - Average Cost of Prescriptions per Member per Month - 10 to 19 years

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Number of Prescriptions 10-19 yrs = 727,926**



Reference: CHIP Table ORX08

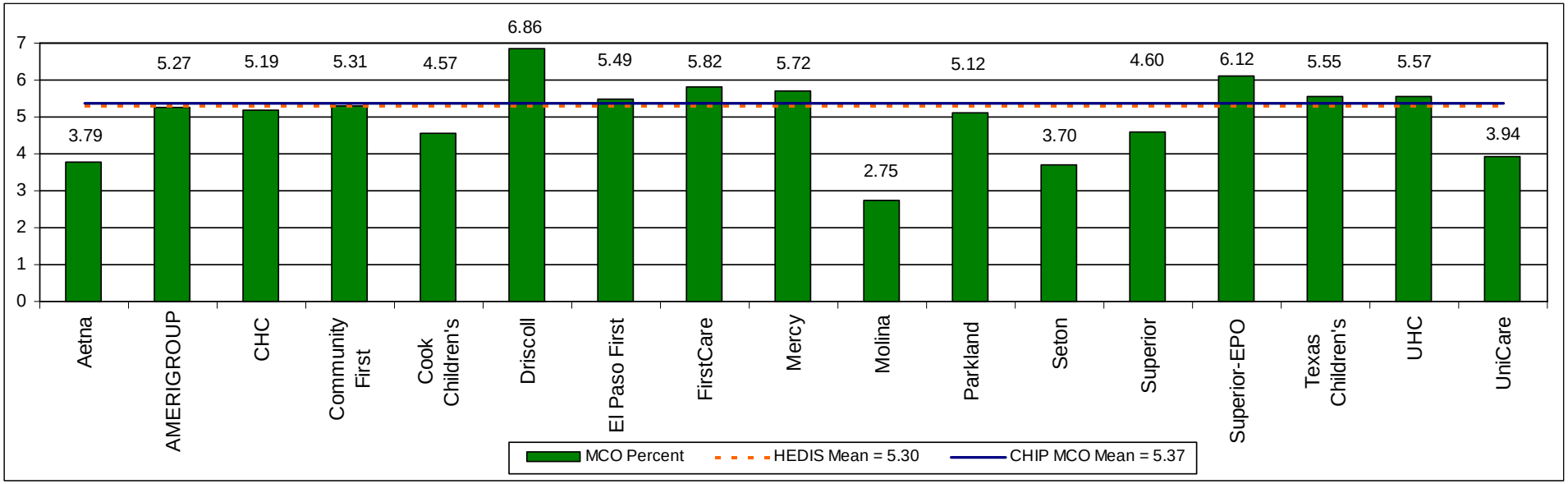
Key points:

1. Chart 18 provides the average cost of prescriptions per member per month among CHIP enrollees from 10 to 19 years old, based on 727,926 CHIP prescriptions. The chart provides prescription costs between September 1, 2006 and August 31, 2007, distributed by MCO.
2. The overall CHIP mean was $3 more than the national HEDIS® mean, which is lower than the difference among the 0- to 9-year-old age group (Chart 17).

3. Average prescription costs varied somewhat across MCOs. Over one-third of the MCOs had average costs of prescriptions per member per month that were below the HEDIS® 50th Percentile ($20.70). The highest cost was observed in Cook Children's ($29.65), and the lowest cost was observed in Molina ($8.99).

Chart 19. HEDIS® Outpatient Drug Utilization - Average Number of Prescriptions per Member per Year - 0 to 9 yrs

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Number of Prescriptions 0-9 yrs = 754,169**



Reference: CHIP Table ORX08

Key points:

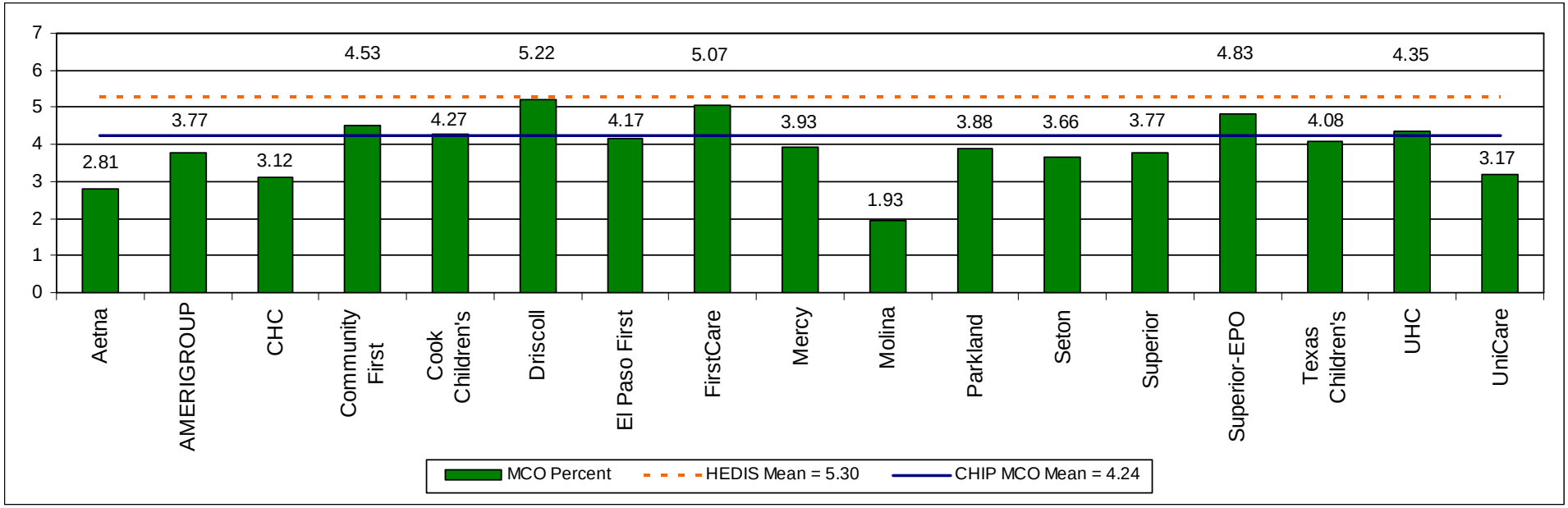
1. Chart 19 provides the average number of prescriptions per member per month among CHIP enrollees up to nine years old, based on 754,169 CHIP prescriptions. The chart covers the measurement period between September 1, 2006 and August 31, 2007, distributed by MCO.
2. Overall, the CHIP mean number of prescriptions (5.37) corresponded closely to the national HEDIS® mean (5.30). In this age group, the difference in prescription costs between CHIP and the national HEDIS mean (Chart 19) was more prominent than the difference in average number of prescriptions. This finding suggests that, while children up to nine years old in CHIP may be receiving the same number of prescriptions, on average, as children in the national population, the prescriptions being filled in CHIP are for more expensive medications. The higher prevalence of CSHCN in CHIP than in the general population may explain why CHIP enrollees in this age group are being

prescribed more expensive medications.[28] However, HHSC may wish to consider studies to explore this discrepancy between number and cost of prescriptions in CHIP, in particular to rule out possible inappropriate use of prescription drugs.

3. Average number of prescriptions varied across MCOs, from 2.75 prescriptions per member per year in Molina to 6.86 prescriptions per member per year in Driscoll.

Chart 20. HEDIS® Outpatient Drug Utilization - Average Number of Prescriptions per Member per Year - 10 to 19 yrs

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Number of Prescriptions 10-19 yrs = 727,926**



Reference: CHIP Table ORX08

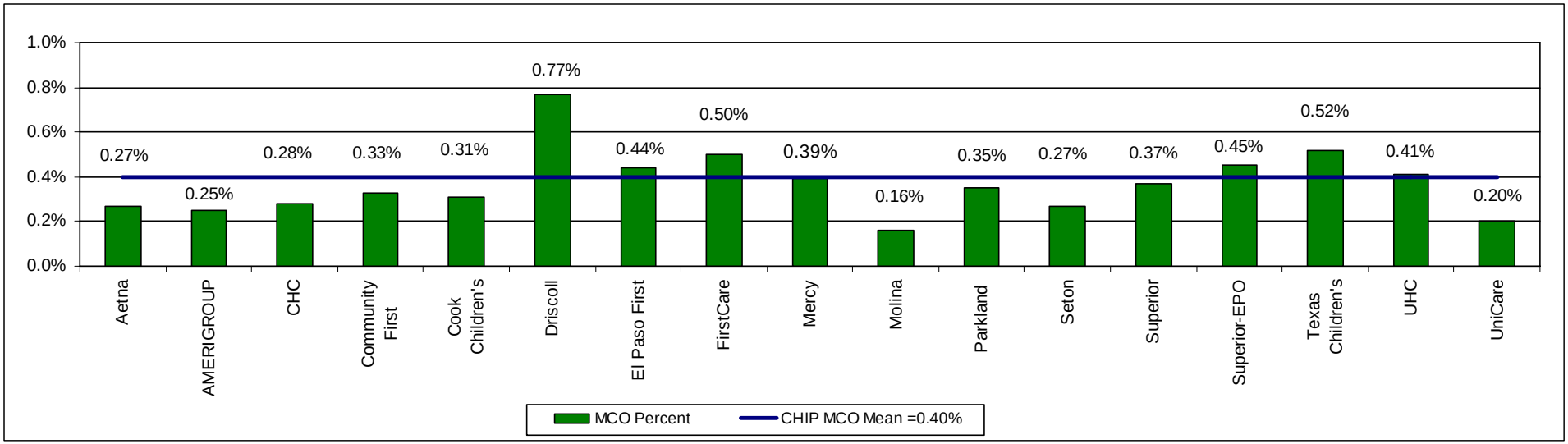
Key points:

1. Chart 20 provides the average number of prescriptions per member per year among CHIP enrollees 10 to 19 years old, based on 727,926 CHIP prescriptions. The chart covers the measurement period between September 1, 2006 and August 31, 2007, distributed by MCO.
2. Overall, the average number of prescriptions in CHIP (4.24) was lower than the national HEDIS® mean for Medicaid Managed Care Plans reporting to the NCQA on this measure (5.30). However, for this age group, CHIP had a higher mean cost of prescriptions than the national HEDIS® mean (Chart 18). This finding suggests that, while children and adolescents 10 to 19 years old in CHIP may be receiving fewer prescriptions, on average, than children and adolescents in the national population, the prescriptions being filled in CHIP are for more expensive medications. The higher prevalence of CSHCN in CHIP than in the general population may explain why CHIP enrollees in this age group are being prescribed more expensive medications.[29]

3. Average number of prescriptions varied across MCOs, ranging from 1.93 prescriptions per member per year in Molina to 5.22 prescriptions per member per year in Driscoll. None of the MCOs were above the national HEDIS® mean for this measure. The only MCO to score above the national HEDIS® 50th percentile (5.10) was Driscoll.

Chart 21. Percent of Enrollees with One or More Hospital Stays Due to an Ambulatory Care Sensitive Condition

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Enrollees in Age Group = 539,764**



Reference: CHIP Table ACSC08

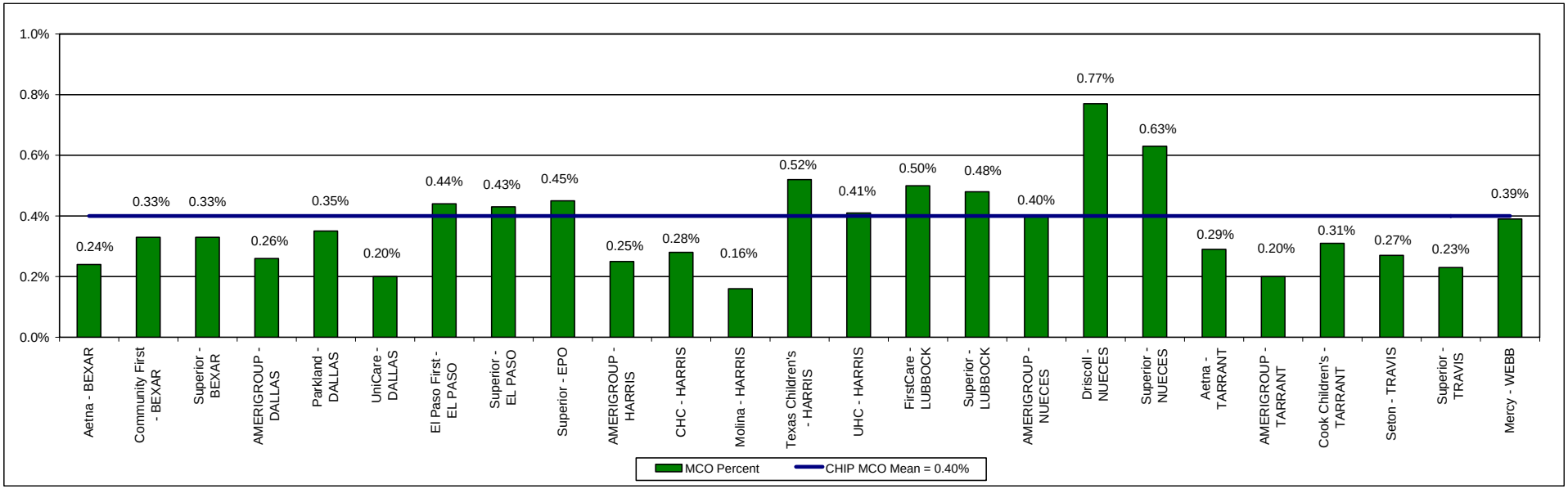
Key points:

1. Chart 21 provides the percentage of CHIP enrollees who had one or more hospital stays due to an ambulatory care sensitive condition (ACSC) between September 1, 2006 and August 31, 2007, distributed 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 hospital may be considered an indication that outpatient monitoring and community health care systems are under-performing; they represent stays in the hospital that could potentially have been prevented. For this measure, the higher the percentage, the lower the health plan performance.
2. Overall, less than one percent of CHIP enrollees were hospitalized due to an ACSC during the measurement period. Results for this measure were highest among those between one and five years old (0.65 percent; result not shown in chart).
3. The percentage of CHIP enrollees who were hospitalized due to an ACSC varied across MCOs. The rate in Driscoll (0.77 percent) was considerably greater than the program mean, while Molina (0.16 percent) and UniCare (0.20 percent) had the lowest rates. HHSC may wish to consider monitoring hospitalizations among CHIP enrollees in Driscoll to determine factors that may be contributing to higher rates in this health plan.

4. A study of the impact of Medicaid managed care on hospitalizations for ACSCs in California found significantly lower rates of ACSC-related hospital stays among beneficiaries in managed care than among those in fee-for-service.[30] Factors potentially related to reductions in ACSC-related hospital stays include improved continuity of care with a regular primary care provider, and capitation rates providing financial incentive for health plans to shift from expensive hospital-based care to less expensive outpatient treatment.

Chart 22. Percent of Enrollees with One or More Hospital Stays Due to an Ambulatory Care Sensitive Condition – SDA Breakout

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Enrollees in Age Group = 539,764**



SDA Mean	Bexar	Dallas	El Paso	EPO	Harris	Lubbock	Nueces	Tarrant	Travis	Webb
	0.32%	0.30%	0.44%	0.45%	0.42%	0.49%	0.74%	0.29%	0.26%	0.39%

Reference: CHIP Table ACSC08

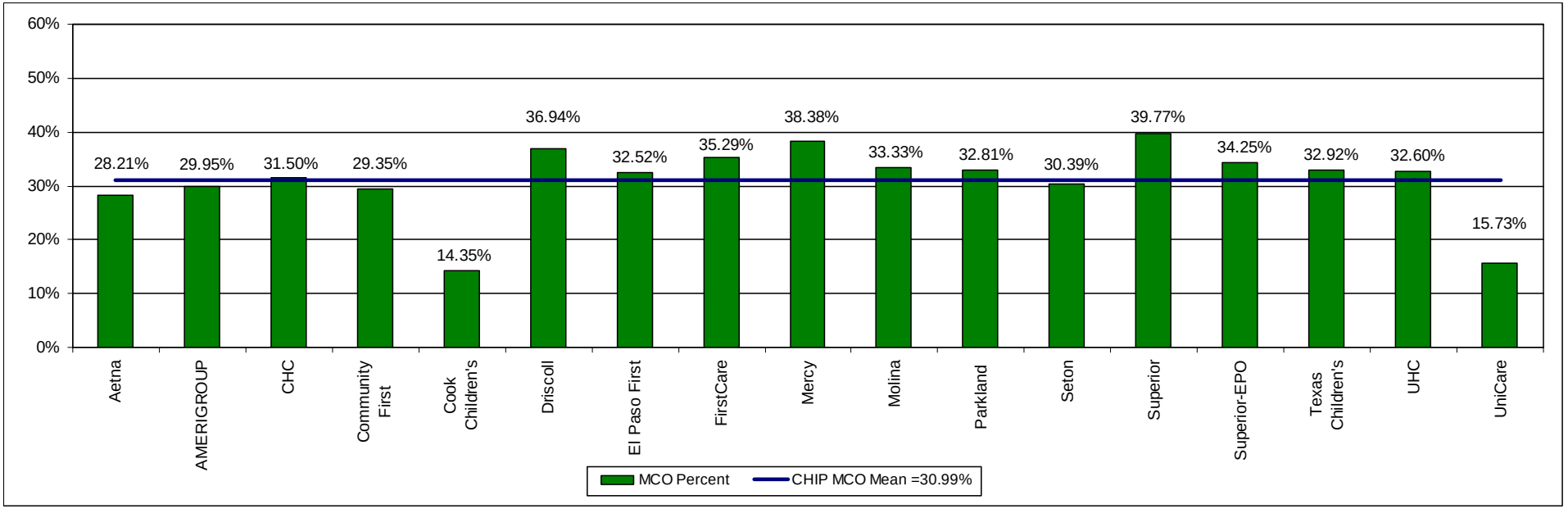
Key points:

1. Chart 22 provides the percentage of CHIP enrollees with one or more hospital stays due to an ambulatory care sensitive condition (ACSC), between September 1, 2006 and August 31, 2007, distributed by MCO/SDA. ACSCs are described in more detail under Chart 21.
2. The percentage of CHIP enrollees with ACSC-related hospital stays varied by MCO/SDA group, from 0.16 percent in Molina-Harris to 0.77 percent in Driscoll-Nueces.
3. At the SDA level, Nueces had the highest percentage of enrollees with ACSC-related hospital stays. HHSC may wish to consider studies to determine whether demographic factors or health care and health plan practices may be contributing to the high rate of potentially avoidable hospital stays in the Nueces SDA.

4. Studies in California have shown that spending money on primary care to prevent these hospitalizations would be more cost effective than paying for the hospitalizations.[31] California has the largest pay-for-performance (P4P) program in the United States (operated by the California Integrated Healthcare Association).[32] While offering incentives to hospitals and physicians to attain benchmarks may potentially lead to quality improvements such as the reduction of ACSC-related hospital stays, a recent study has not found corresponding "breakthroughs" in quality improvement in California and has recommended continued monitoring of the state's P4P program.[33]

Chart 23. Percent of Hospitalizations with a Primary Diagnosis of an Ambulatory Care Sensitive Condition

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Inpatient Stays = 7,344**



Reference: CHIP Table ACSC08

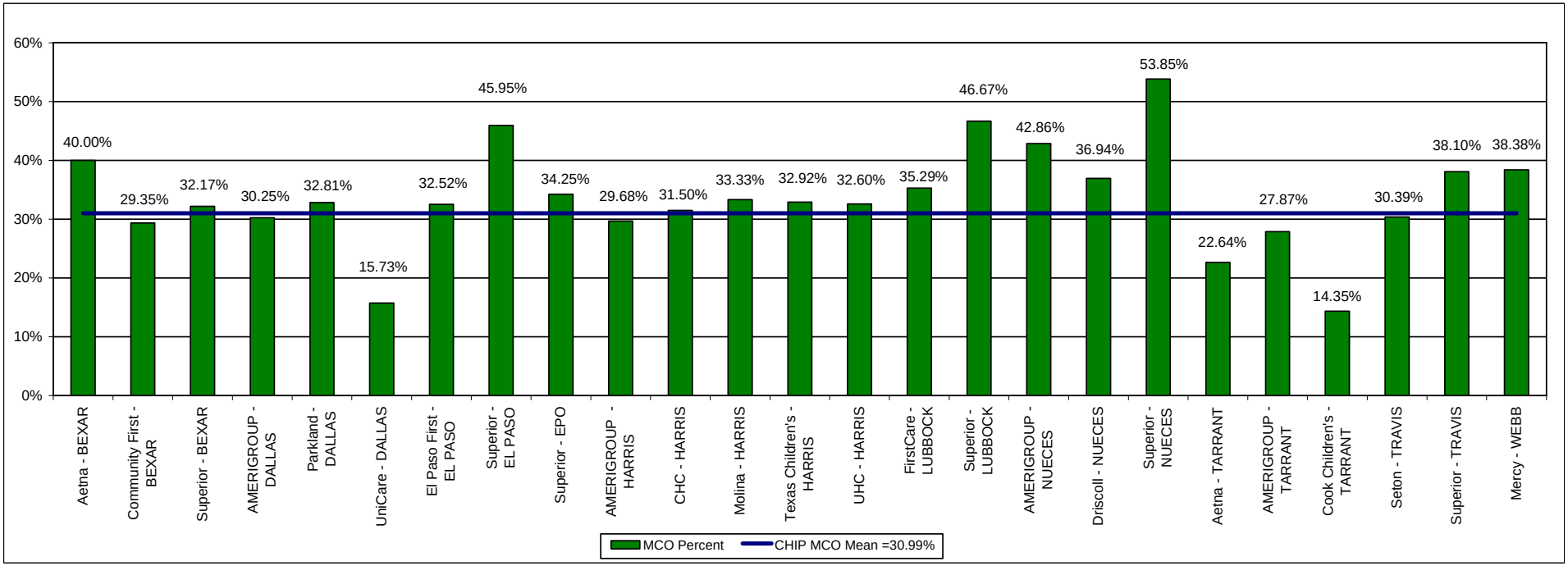
Key points:

1. Chart 23 provides the percentage of hospital inpatient stays among CHIP enrollees that involved a primary diagnosis of an ambulatory care sensitive condition (ACSC), between September 1, 2006 and August 31, 2007, distributed by MCO. ACSCs are described in more detail under Chart 21.
2. At the program level, 30.99 percent of hospitalizations involved a primary diagnosis of an ACSC, suggesting that almost one-third of hospitalizations could have been prevented through improved access to outpatient and primary care. This is nearly three times greater than the HHSC Performance Indicator Dashboard standard for CHIP (11 percent).[34] Given this finding, reducing the percentage of hospitalizations with a primary diagnosis of an ACSC in CHIP should be considered a priority objective for HHSC.

3. Findings for this measure varied slightly across MCOs, with the exception of Cook Children's (14 percent) and UniCare (16 percent), which were considerably lower than the program mean. Superior (40 percent), Mercy (38 percent), and Driscoll (37 percent) had the highest percentages, and efforts to reduce ACSC-related hospitalizations should begin with these health plans.

Chart 24. Percent of Hospitalizations with a Primary Diagnosis of an Ambulatory Care Sensitive Condition –SDA Breakout

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Inpatient Stays = 7,344**



SDA	Bexar	Dallas	El Paso	EPO	Harris	Lubbock	Nueces	Tarrant	Travis	Webb
Mean	30.80%	29.86%	36.07%	34.25%	32.44%	41.26%	37.68%	15.69%	31.71%	38.38%

Reference: CHIP Table ACSC08

Key points:

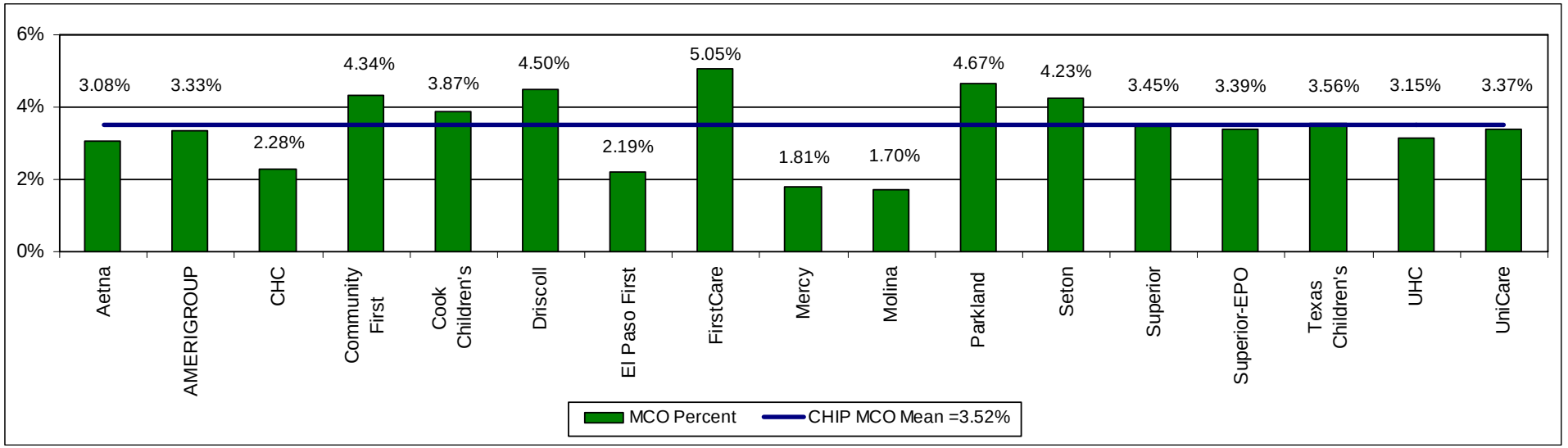
1. Chart 24 provides the percentage of hospital inpatient stays with a primary diagnosis of an ambulatory care sensitive condition (ACSC), between September 1, 2006 and August 31, 2007, distributed by MCO/SDA group. ACSCs are described in more detail under Chart 21.
2. The percentage of hospitalizations involving a primary diagnosis of an ACSC varied across MCO/SDA groups. No MCO/SDA group met the HHSC Performance Indicator Dashboard standard of 11 percent for CHIP.[35] Hospitalization rates were considerably high in Superior-Nueces

(54 percent), Superior-Lubbock (47 percent), and Superior-El Paso (46 percent). Cook Children's-Tarrant (14 percent) and UniCare-Dallas (16 percent) had the lowest rates.

3. At the SDA level, Lubbock (41 percent) had the highest percentage of hospitalizations involving a primary diagnosis of an ACSC. These findings suggest that high rates of potentially avoidable hospital stays are related more to health plan than to SDA, with the Superior health plan having the greatest need for improvement.
4. A study of Medicaid eligibility and ACSCs using national hospital discharge data found that Medicaid expansions decreased the incidence of ACSC hospitalizations among children ages two to six years old, but not among older children.[36] Data for CHIP members in the present report suggest the opposite trend. At the program level, nearly 50 percent of hospital stays among children one to five years old involved a primary diagnosis of an ACSC, compared with 33 percent among children and adolescents six to 14 years old and 18 percent among adolescents 15 to 18 years old (results not shown in chart). Because improved access to primary and outpatient care is believed to be the greatest MCO-related contributor to improving outcomes for this measure, HHSC may wish to consider assessing the quality of access for CHIP members in younger age groups.

Chart 25. Percent of Enrollees with One or More Emergency Department Visits Due to an Ambulatory Care Sensitive Condition

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Enrollees in Age Group = 539,764**



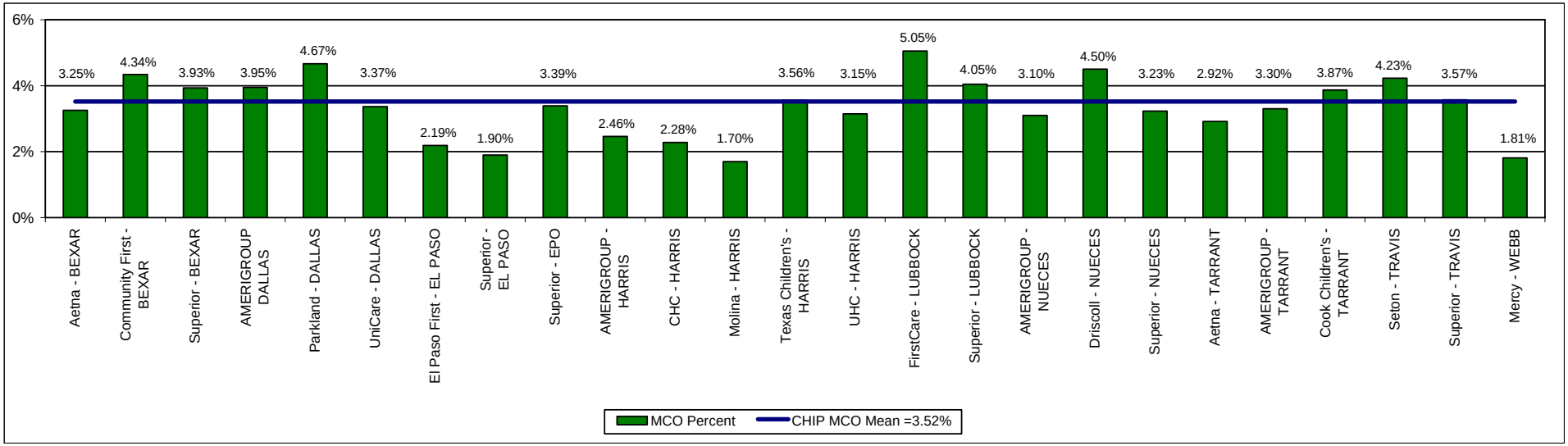
Reference: CHIP Table ACSC08

Key points:

1. Chart 25 provides the percentage of CHIP enrollees with one or more emergency department visits due to an ambulatory care sensitive condition (ACSC), between September 1, 2006 and August 31, 2007, distributed by MCO. ACSCs are described in more detail under Chart 21.
2. The percentage of enrollees with ACSC-related emergency department visits varied across MCOs. The program level mean for members less than one year old was 4.49 percent, and among those one to five years old was 6.15 percent (results not shown in chart). FirstCare (five percent) had the highest percentage. Among FirstCare members younger than one year old, 33.3 percent were admitted to an emergency department for an ACSC (result not shown in chart). This figure is higher than for any other age group across all the MCOs, and HHSC may wish to consider further investigation to determine the factors responsible for this result among FirstCare members in this age group.

Chart 26. Percent of Enrollees with One or More Emergency Department Visits Due to an Ambulatory Care Sensitive Condition – SDA Breakout

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP Enrollees in Age Group = 539,764**



SDA	Bexar	Dallas	El Paso	EPO	Harris	Lubbock	Nueces	Tarrant	Travis	Webb
Mean	4.11%	4.20%	2.09%	3.39%	3.13%	4.45%	4.35%	3.70%	4.07%	1.81%

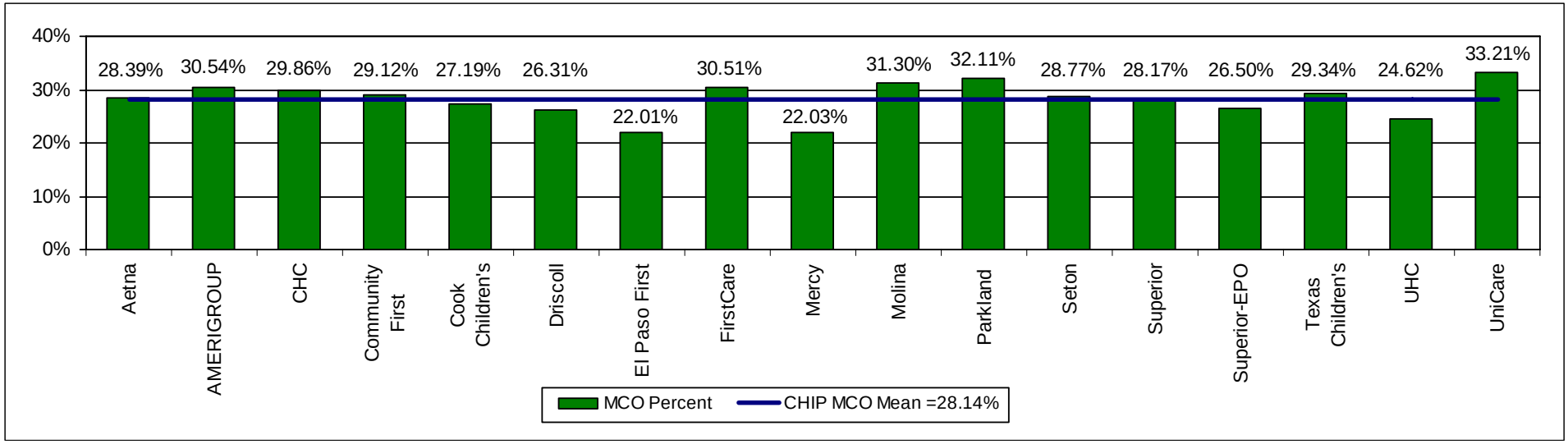
Reference: CHIP Table ACSC08

Key points:

1. Chart 26 provides the percentage of CHIP enrollees with one or more emergency department visits due to an ambulatory care sensitive condition (ACSC), between September 1, 2006 and August 31, 2007, distributed by MCO/SDA. ACSCs are described in more detail under Chart 21.
2. The percentage of enrollees with one or more ACSC-related emergency department visits varied somewhat by MCO/SDA group. Rates in FirstCare-Lubbock, Parkland-Dallas, and Driscoll-Nueces were notably above the program mean (all at approximately five percent). The highest performing MCO/SDA groups (those with the lowest percentages of ACSC-related emergency department visits) were Molina-Harris, Mercy-Webb, and Superior-El Paso (all at approximately two percent).
3. At the SDA level, the lowest performing SDA was Lubbock (4.45 percent) and the highest performing SDA was Webb (1.71 percent).

Chart 27. Percent of Emergency Department Visits with a Primary Diagnosis of an Ambulatory Care Sensitive Condition

CHIP MCOs - September 1, 2006 to August 31, 2007 **CHIP ED Visits = 79,672**



Reference: CHIP Table ACSC08

Key points:

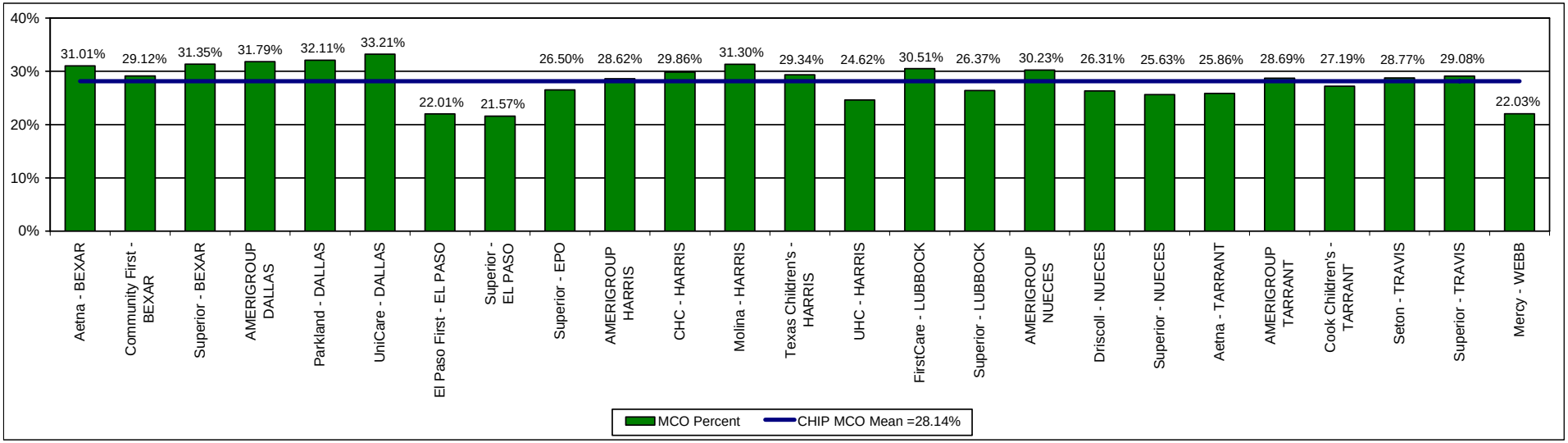
1. Chart 27 provides the percentage of emergency department visits among CHIP members that involved a primary diagnosis of an ambulatory care sensitive condition (ACSC), between September 1, 2006 and August 31, 2007, distributed by MCO. ACSCs are described in more detail under Chart 21.
2. The overall CHIP mean of 28 percent exceeded the HHSC Performance Indicator Dashboard standard for this measure (24 percent), suggesting that efforts to reduce the number of ACSC-related emergency department visits are warranted.[37]
3. The percentage of ACSC-related emergency department visits varied little across MCOs, with the exception of El Paso First (22 percent) and Mercy (22 percent), which were the highest-performing health plans for this measure. These were also the only two health plans that met the HHSC Performance Indicator Dashboard standard for this measure.[38] In the case of El Paso First, high performance may be related to the recent implementation of "pediatric night clinics" and after-hours clinics in locations that align with PCP accessibility requirements (specifically, that members have access to a PCP within a 30-mile radius).[39]

4. While El Paso First had the lowest percentage among all MCOs, among El Paso First members between one and five years old, over one-third of emergency department visits involved a primary diagnosis of an ACSC. This trend was observed in all health plans, with the highest rates occurring in CHIP members between one and five years old. To help reduce rates of ACSC-related emergency department visits, HHSC may wish to consider focusing efforts on this age group.

Chart 28. Percent of Emergency Department Visits with a Primary Diagnosis of an Ambulatory Care Sensitive Condition – SDA Breakout

CHIP MCOs - September 1, 2006 to August 31, 2007

CHIP ED Visits = 79,672



SDA	Bexar	Dallas	El Paso	EPO	Harris	Lubbock	Nueces	Tarrant	Travis	Webb
Mean	29.88%	32.04%	21.88%	26.50%	28.26%	28.15%	26.39%	27.29%	28.83%	22.03%

Reference: CHIP Table ACSC08

Key points:

1. Chart 28 provides the percentage of emergency department visits among CHIP enrollees due to a primary diagnosis of an ambulatory care sensitive condition (ACSC), between September 1, 2006 and August 31, 2007, distributed by MCO/SDA. ACSCs are described in more detail under Chart 21.
2. The percentage of ACSC-related emergency department visits varied somewhat across MCO/SDA groups. Superior-El Paso had the lowest percentage (22 percent) and UniCare-Dallas had the highest percentage (33 percent), with a 12 percent difference between them. Only three MCO/SDA groups met the HHSC Performance Indicator Dashboard standard for this measure (24 percent): Superior-El Paso, El Paso First-El Paso, and Mercy-Webb, all at approximately 22 percent.[40]

3. At the SDA level, Dallas was the lowest-performing SDA, at 32 percent of ACSC-related emergency department visits. Webb was the only SDA that met the HHSC Performance Indicator Dashboard standard for this measure, at 22 percent.[41]

Endnotes

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