



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

# **Texas Medicaid Primary Care Case Management (PCCM) Program Quality of Care Report**

**Fiscal Year 2010**

**Measurement Period:**

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

**The Institute for Child Health Policy**

**University of Florida**

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

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# Executive Summary

## Introduction

This report provides an annual update of the quality of care provided to members in the Primary Care Case Management (PCCM) Program for the State of Texas, prepared by the Institute for Child Health Policy at the University of Florida, the External Quality Review Organization (EQRO) for Texas Medicaid Managed Care. This update is for September 1, 2009 to August 31, 2010, covering State Fiscal Year (SFY) 2010.

The PCCM Program is a managed fee-for-service arrangement, utilizing a network of primary care and other health care providers that provide a medical home and health care services to individuals with Medicaid in 202 Texas counties. Beginning on September 1, 2011, the PCCM Program will be phased out as part of the Medicaid 1115 Waiver Managed Care Expansion.<sup>1</sup> STAR and STAR+PLUS managed care delivery systems will be expanded into areas that currently serve PCCM clients. The contents of this report provide valuable information to the Texas Medicaid Programs and Managed Care Organizations on improving health care quality as clients are transitioned from PCCM into managed care.

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

- **Access to Care** - *Prenatal and Postpartum Care, and Children and Adolescents' Access to Primary Care Practitioners.*
- **Utilization of Services** - *Well-Child Visits in the First 15 Months of Life, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Adolescent Well-Care Visits, and AHRQ Pediatric Quality Indicators (PDIs) and Adult Prevention Quality Indicators (PQIs).*
- **Effectiveness of Care** - *HEDIS<sup>®</sup> Appropriate Testing for Children with Pharyngitis, HEDIS<sup>®</sup> Use of Appropriate Medications for People with Asthma, HEDIS<sup>®</sup> Comprehensive Diabetes Care, HEDIS<sup>®</sup> Cervical Cancer Screening, Follow-up After Hospitalization for Mental Illness, and Readmission within 30 days after an Inpatient Stay for Mental Health.*

## Methodology

A detailed description of the methodology used in this report is presented in **Appendix A**. Information regarding the calculation of all measures can be found in the document "Quality of Care Measures Technical Specifications Report, July 2011."<sup>2</sup>

Rates for Healthcare Effectiveness and Data Information Set (HEDIS<sup>®</sup>) measures were calculated using National Committee for Quality Assurance (NCQA) certified software. Discussion of results includes comparisons with HEDIS<sup>®</sup> national Medicaid rates, which are derived from rates reported to the NCQA by Medicaid Managed Care Plans nationally.<sup>3</sup> At the

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

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

For these measures, the name HEDIS® has been removed from the titles as these measures do not adhere precisely to NCQA specifications, and their results are likely inflated due to the lifting of provider constraints. Thus, the discussion of results for these measures does not include comparison to HEDIS® national Medicaid rates, and instead focuses on PCCM performance in SFY 2010, compared to SFY 2009.

Pediatric Quality Indicators (PDIs) and Adult Prevention Quality Indicators (PQIs) developed by the Agency for Healthcare Research and Quality (AHRQ) were used to evaluate PCCM program rates of inpatient admissions for ambulatory care sensitive conditions (ACSCs). The AHRQ considers ACSCs “conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.”<sup>4</sup>

## Summary of Findings

### Access to Care

- *Prenatal and postpartum care.*  
Eighty percent of pregnant women in PCCM received prenatal care in their first trimester or within 42 days of enrollment. Fifty-seven percent had a postpartum care visit between three and eight weeks after giving birth.
- *Access to primary care practitioners.*  
Greater than 94 percent of children and adolescents in PCCM visited a provider during the measurement period.

#### PCCM Member Demographics – August 2010

Number of members: 849,444

Average member age: 10.8 years

Gender	Percent of PCCM Members
Female	52%
Male	48%

Race-ethnicity	Percent of PCCM Members
Hispanic	58%
White, non-Hispanic	24%
Black, non-Hispanic	12%

## Utilization of Services

- *Children's preventive health care.*
  - 69 percent had six or more well-child visits during the first 15 months of life.
  - 85 percent of children had at least one well-child visit.
  - 73 percent of adolescents had at least one well-care visit.
- *Inpatient admissions.* Inpatient admission rates for ACSCs in PCCM were generally comparable to national rates. Inpatient admission rates were twice as high in PCCM than reported nationally for:
  - Urinary tract infection in children (89 per 100,000).
  - Diabetes short-term complications in adults (133 per 100,000).
  - Uncontrolled diabetes in adults (44 per 100,000).

## Effectiveness of Care

- *Pharyngitis testing.* Fifty-three percent of children in PCCM received appropriate testing for pharyngitis (sore throat).
- *Asthma treatment.* Ninety-five percent of PCCM members who have asthma received appropriate treatment for their condition.
- *Diabetes care.* Compared to national rates, adult PCCM members had lower rates of diabetic care, such as:
  - Diabetic eye exams (45 percent).
  - HbA1c testing (76 percent).
  - Medical attention for diabetic nephropathy (69 percent).
- *Cervical cancer screening.* Forty-three percent of women were screened for cervical cancer.
- *Mental health treatment.* Among PCCM members hospitalized for mental illness:
  - 38 percent had a follow-up visit within seven days of discharge from the hospital.
  - 72 percent had a follow-up visit within 30 days of discharge from the hospital.
  - 13 percent were readmitted to the hospital within 30 days of discharge.

## Recommendations

Effective September 1, 2011, PCCM members in 28 counties contiguous to existing STAR and STAR+PLUS service areas will transition to Medicaid managed care through the STAR and STAR+PLUS programs.<sup>5</sup> Furthermore, proposed HHSC initiatives for the coming year include the conversion of PCCM to STAR in remaining Texas counties, effective March 2012.<sup>6</sup> Because the former PCCM Program population will be served through Medicaid managed care in the STAR and STAR+PLUS programs, recommendations based on the findings of this report focus on quality of care during this transition.

The EQRO recommends that STAR and STAR+PLUS MCOs moving into PCCM counties focus on areas where quality of care has been low for this population under the PCCM Program.

Domain	Recommendations	Rationale	HHSC Recommendation/Strategies
Access to postpartum care	<ul style="list-style-type: none"> <li>Ensure that provider networks in former PCCM counties include postpartum care services adequate to meet the needs of this population.</li> <li>Prioritize implementation of existing programs for improving access to postpartum care.</li> <li>Regularly monitor HHSC standards for access to OB/GYN providers and THSteps visits for newborns, and consider these standards for use in Performance Improvement Projects in former PCCM areas.</li> </ul>	<p>The rate of postpartum care visits among pregnant women in PCCM was low, at 57 percent.</p>	<ul style="list-style-type: none"> <li>Encourage health plans to provide education to members and providers transitioning from FFS to managed care on the importance of good postpartum care.</li> <li>HHSC will continue to monitor the MCOs' performance on good access to postpartum care through the performance indicator dashboard.</li> </ul>
Diabetes care for adults	<ul style="list-style-type: none"> <li>Ensure that provider networks in former PCCM counties include outpatient services for diabetes care adequate to meet the needs of this population.</li> <li>Prioritize implementation of existing diabetes</li> </ul>	<p>Rates of potentially avoidable inpatient stays for diabetes short-term complications and uncontrolled diabetes were twice the national averages.</p> <p>Adult PCCM members</p>	<ul style="list-style-type: none"> <li>MCOs are required to ensure all provider networks in areas transitioning from FFS to managed care have adequate outpatient services for diabetes care.</li> <li>MCOs are required to</li> </ul>

	<p>disease management programs for adults to improve effectiveness of diabetes care. Programs should address the health literacy of members, culturally relevant diabetes self-management, and the complexity of co-morbidities. Nurse-directed diabetes care may also help to improve rates.</p>	<p>also had lower rates of eye exams, HbA1c testing, and medical attention for diabetic nephropathy.</p>	<p>provide disease management services that include comprehensive diabetes care.</p>
<p>Appropriate treatment for children with pharyngitis</p>	<ul style="list-style-type: none"> <li>• Ensure that primary care providers in former PCCM areas are following proper and up-to-date clinical practice guidelines for treatment of children with pharyngitis.</li> <li>• Consider developing physician training for primary care providers in former PCCM areas to allow more effective treatment decisions for children with pharyngitis.</li> </ul>	<p>The rate of appropriate testing for children in PCCM with pharyngitis was lower than the HEDIS® national average (53 percent vs. 62 percent).</p>	<ul style="list-style-type: none"> <li>• Encourage MCOs to develop training programs for PCPs on how to more effectively make treatment decisions for pharyngitis.</li> </ul>
<p>Cervical cancer screening</p>	<ul style="list-style-type: none"> <li>• Prioritize implementation of existing programs to improve rates of cervical cancer screening for women in former PCCM areas. Important elements of such programs may include: <ul style="list-style-type: none"> <li>○ Identifying cultural barriers to cervical cancer screening,</li> <li>○ Implementing outreach to raise awareness and</li> </ul> </li> </ul>	<p>The rate of cervical cancer screening for women in PCCM was below the HEDIS® national 10<sup>th</sup> percentile (43 percent vs. 66 percent).</p>	<p>The ACOG <i>Practice Bulletin</i> No. 109 published December 2009 changed the cervical cytology screening guidelines as follows:</p> <ol style="list-style-type: none"> <li>1. Start cervical cancer screening at age 21, not at onset of sexual activity (if younger than 21).</li> <li>2. PAPS should be done every other year on women 21 – 29 years old.</li> <li>3. Women 30 and older who have never had an</li> </ol>

	<p>educate the member population about cervical cancer screening, and</p> <ul style="list-style-type: none"> <li>○ Ensuring that providers are recommending routine cervical cancer screening to women and are following appropriate clinical practice guidelines.</li> <li>● Consider implementation of Performance Improvement Projects (PIPs) to improve rates of cervical cancer screening in former PCCM areas, using the HEDIS® Cervical Cancer Screening measure</li> </ul>		<p>abnormal pap can be spaced out to every three year paps.</p> <ol style="list-style-type: none"> <li>4. Screening can be decreased at age 65 or 70.</li> <li>5. No paps are necessary for women who have had a hysterectomy for benign reasons and have never had an abnormal pap.</li> </ol> <p>Changes in the ACOG's cervical cancer screening guidelines during the measurement period may have impacted the number of women getting paps and help explain the drop in screening rates from SFY 2009 to SFY 2010. HHSC will review the cervical cancer screening performance indicator to ensure it reflects current clinical practice and guidelines.</p>
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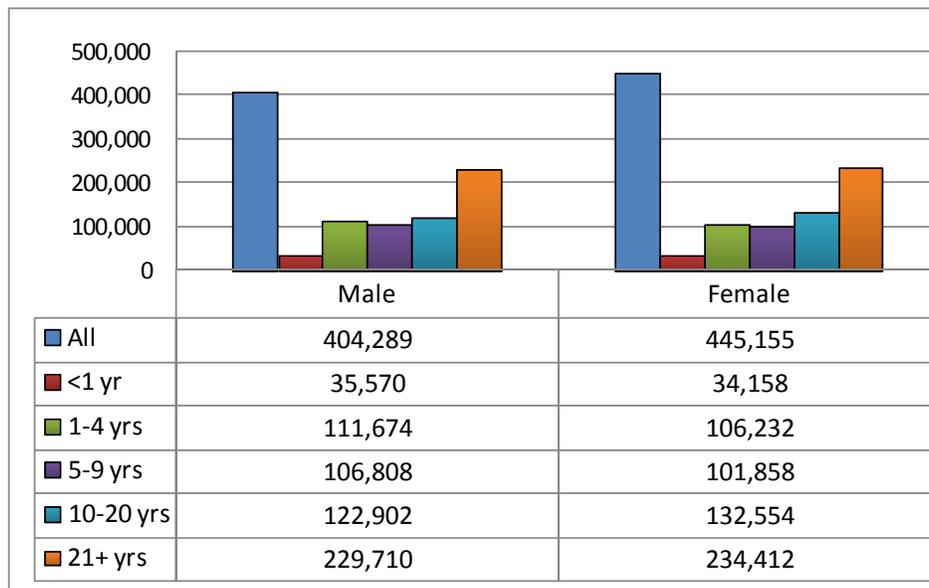
## The PCCM Population

**Figure 1** provides the total number of unduplicated members in PCCM in August 2010 by sex and age.

There were 849,444 individuals enrolled in PCCM during August 2010. Fifty-two percent of members were female, and 48 percent were male.

The mean age of members was 10.8 (SD= 11.9). Thirty-four percent of PCCM members were under the age of five, 25 percent were five to nine years old, 30 percent were 10 to 20 years old, and 12 percent were 21 years old and older.

**Figure 1. The Total Number of Unduplicated Members in PCCM during August 2010**



Reference: Table 1

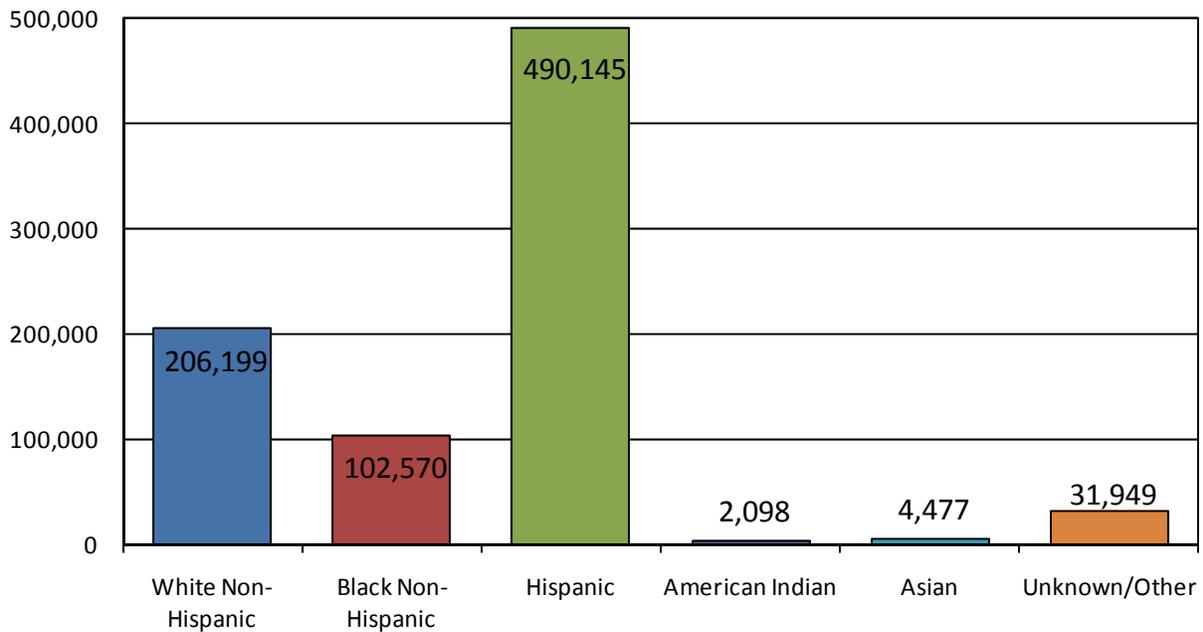
**Figure 2** provides the total number of unduplicated members in PCCM in August 2010, distributed by race and ethnicity.

There were 490,145 Hispanic members in PCCM, comprising 58 percent of the PCCM population in August 2010.

Approximately, one in four PCCM members were White (24 percent), and 12 percent were Black, Non-Hispanic.

Asians and American Indians accounted for less than one percent of the PCCM population.

**Figure 2. The Distribution of Race/Ethnicity in PCCM during August 2010**



Reference: Table 2

## Access to Care

### *Prenatal and Postpartum Care*

**Figure 3** provides the percentage of live birth deliveries among women in PCCM who received prenatal care in their first trimester (or within 42 days of enrollment in PCCM), and who had a postpartum visit on or between 21 days and 56 days after delivery. There were 48,861 live births to women in PCCM between September 1, 2009 and August 31, 2010 (SFY 2010).

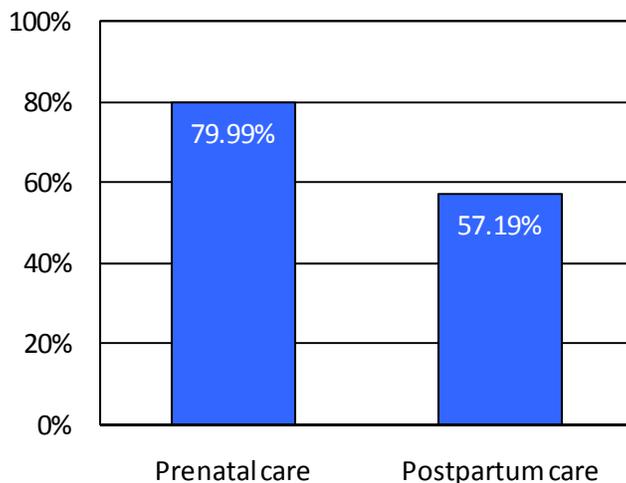
**Eighty percent of pregnant women in PCCM received prenatal care in their first trimester or within 42 days of enrollment.** This rate is slightly higher than SFY 2009, when 77 percent received prenatal care during their first trimester or within 42 days of enrollment.

**Fifty-seven percent of women in PCCM had a postpartum care visit between three and eight weeks after giving birth.** This rate has remained unchanged since SFY 2009.

Although most women in PCCM received timely prenatal care, approximately 1 in 5 (9,776 women) did not have a prenatal care visit in their first trimester, thereby increasing the risk for pregnancy complications and poor birth outcomes.

Professional organizations such as the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend a postpartum care visit for women between four and six weeks after giving birth.<sup>7</sup> In PCCM, 43 percent (approximately 21,010 women) did not visit their provider for a check-up between three and eight weeks after giving birth. This finding is cause for concern because research has found that low-income women experience poorer mental and overall physical health in the postpartum period than their more affluent counterparts.<sup>8</sup>

**Figure 3. Access to Prenatal and Postpartum Care in PCCM**



Reference: Table PPC

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

**Figure 4** provides the percentage of children and adolescents in PCCM who had a visit with a provider during the measurement period, distributed by age. Rates are presented separately for four age groups: 12 to 24 months of age, 25 months to six years old, seven to 11 years old, and 12 to 19 years old.

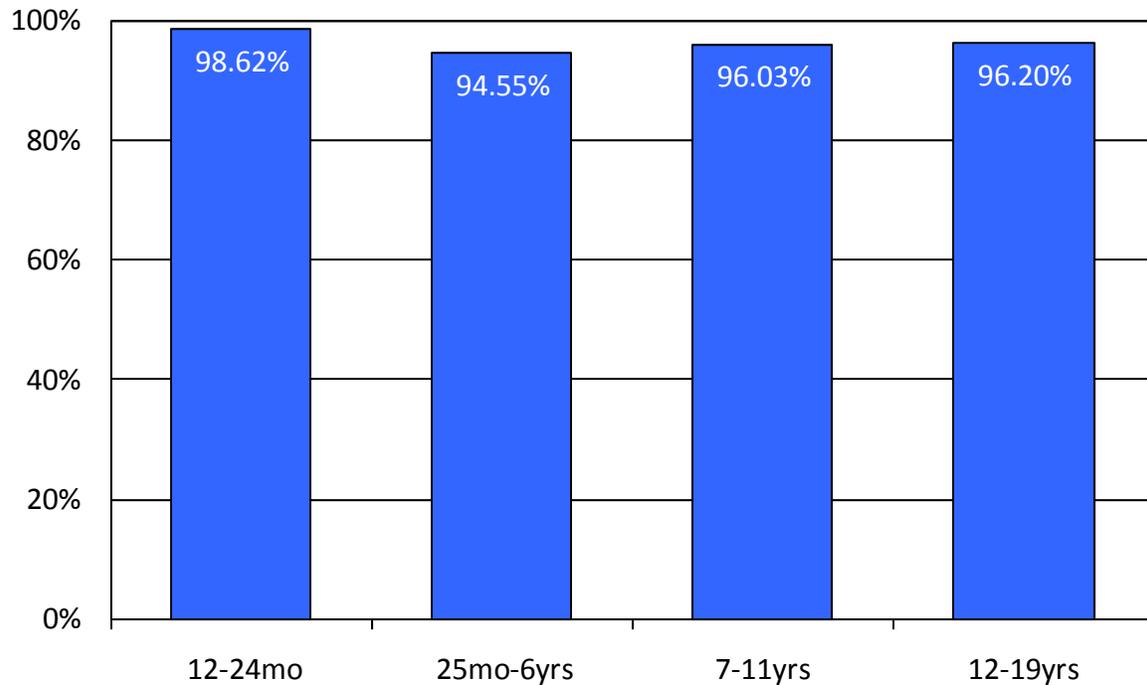
For the measure, the EQRO followed all of the HEDIS<sup>®</sup> technical specifications except the practitioner requirement. HEDIS<sup>®</sup> specifies that to count towards the numerator of this measure, visits must occur with a PCP. HHSC requested the practitioner requirements be removed for this measure, so visits with any provider were included when calculating compliance rates.

**Rates of access to providers were very high across age cohorts**, with greater than 94 percent of child and adolescent members visiting a provider during the measurement period.

It should be noted that the rates are slightly inflated due to lifting the provider requirement when calculating the measure(s). However, access rates in PCCM have improved slightly since SFY

2009 when the same methodology was applied, with an increase of one to five percentage points depending on the age cohort.

**Figure 4. Children and Adolescents' Access to Primary Care Practitioners**



Reference: Table CAP

## Utilization of Services

### *Well-Child and Adolescent Well-Care Visits*

**Figure 5** provides the percentage of members who had a well-child or adolescent well-care visit in PCCM between September 1, 2009 and August 31, 2010.

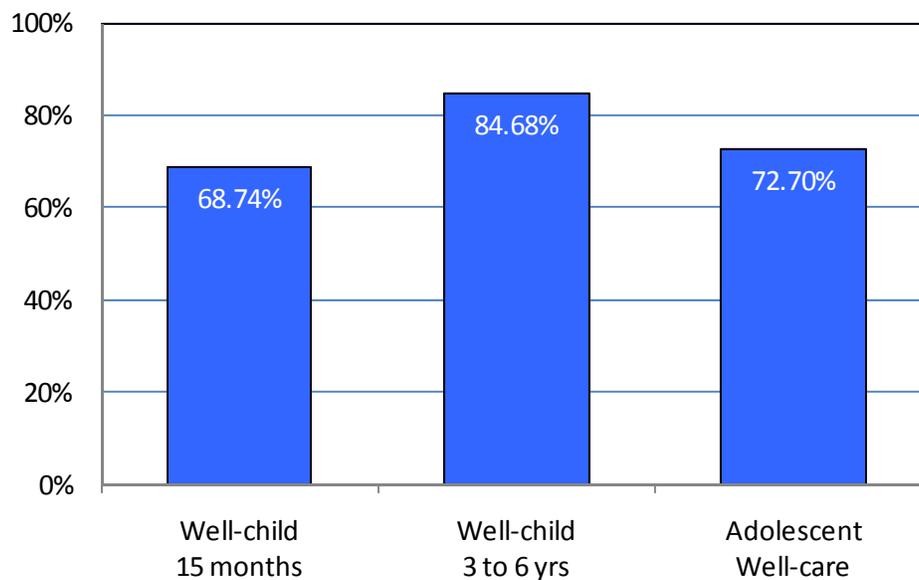
For these measures, the EQRO followed all technical specifications except the practitioner requirement. HEDIS<sup>®</sup> specifies that to count towards the numerator of this measure, visits must occur with a PCP. HHSC requested the practitioner requirements be removed for this measure, so visits with any provider were included when calculating compliance rates.

**Sixty-nine percent of members had six or more well-child visits between birth and 15 months of life**, compared to 65 percent in SFY 2009 (a 4 percentage point increase).

**Eighty-five percent of members three to six years old had at least one well-child visit,** compared to 75 percent in SFY 2009 (a 10 percentage point increase).

**Seventy-three percent of members 12 to 21 years old had at least one well-care visit,** compared to 60 percent in SFY 2009 (a 13 percentage point increase).

**Figure 5. Well-Child and Adolescent Well-Care Visits**



Reference: Tables W15, W34, and AWC

### ***AHRQ Pediatric Quality Indicators***

The Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs) use hospital inpatient discharge data to calculate rates of admission for 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 the performance of health plans and service delivery models, and addressing access to care issues.

**Figure 6** provides PDI rates for asthma, diabetes short-term complications, gastroenteritis, perforated appendix, and urinary tract infection (UTI) among PCCM members up to 17 years of age. Rates are per 100,000 members for all conditions except perforated appendix, for which the rate is per 100 appendicitis cases admitted. **Table B1** (in Appendix B) describes each of the five AHRQ PDIs shown here. Depiction of PDI results include comparisons with national rates reported by the AHRQ.<sup>9</sup> It should be noted that these AHRQ national estimates are based on

data collected in 2008 and are area-level indicators, including commercial and Medicaid populations.

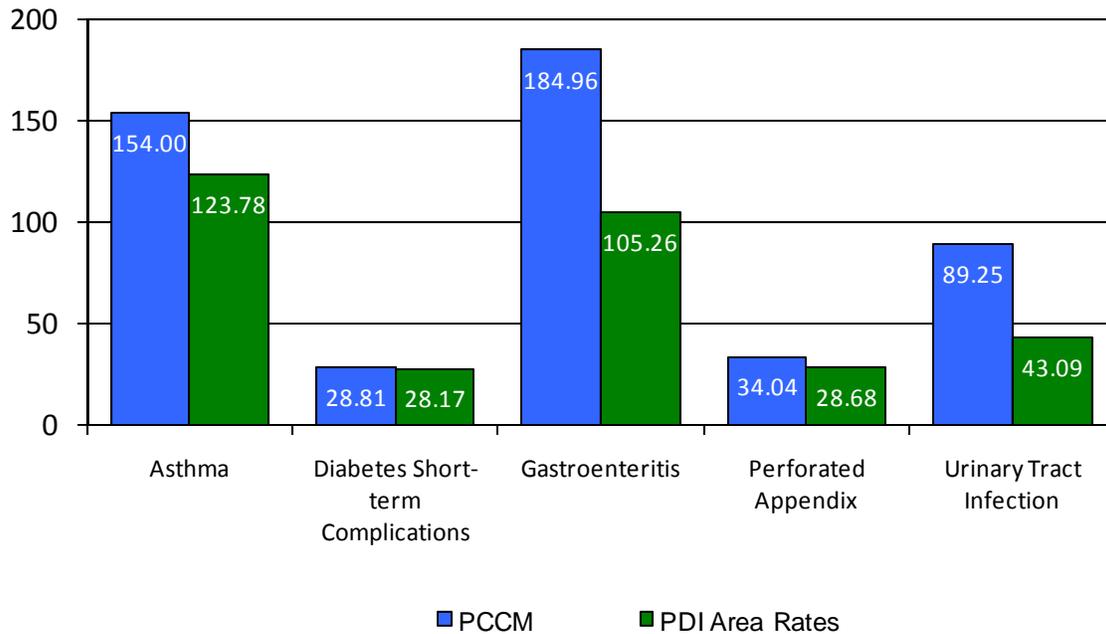
**The highest inpatient PDI admission rate in PCCM was for gastroenteritis and the lowest was for diabetes short-term complications.**

Compared with AHRQ national estimates:

- The asthma admission rate was higher in PCCM than reported nationally (154 vs. 124 per 100,000).
- The diabetes short-term complications admission rate was comparable in PCCM to the national rate (29 vs. 28 per 100,000).
- The gastroenteritis admission rate was higher in PCCM than reported nationally (185 vs. 105 per 100,000).
- The perforated appendix admission rate was slightly higher in PCCM than reported nationally (34 vs. 29 per 100).
- The urinary tract infection admission rate was twice as high in PCCM than reported nationally (89 vs. 43 per 100,000).

PDI rates in PCCM in SFY 2010 are comparable to SFY 2009, with a slight decline in gastroenteritis inpatient admissions since 2009 (185 vs. 263 per 100,000).

**Figure 6. AHRQ Pediatric Quality Indicators**



Reference: Table PDI

## **AHRQ Adult Prevention Quality Indicators**

The Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs) use hospital inpatient discharge data to calculate rates of admission for various ACSCs among adults. PQIs screen for inpatient stays that were potentially avoidable with better access to care in outpatient settings. This information is useful for monitoring trends, comparing the performance of health plans and service delivery models, and addressing access to care issues.

**Figures 7** and **8** provide rates of inpatient admissions for 12 out of 14 ACSCs among adults in PCCM, 18 years or older. PQIs are per 100,000 members for all conditions except perforated appendix (for which the rate is per 100 appendicitis cases admitted) and low birth weight (for which the rate is per 100 births). These two rates are not depicted in the figures, but are included in the results discussion. Depiction of PDI results include comparisons with national rates reported by the AHRQ.<sup>10</sup> It should be noted that these AHRQ national estimates are based on data collected in 2008 and are area-level indicators, including commercial and Medicaid populations. **Table B2** (in Appendix B) describes each of the AHRQ PQIs shown in Figures 7 and 8.

PQI rates in PCCM were comparable to or *lower* than AHRQ national estimates for eight conditions:

- Lower extremity amputation in diabetes patients (32 vs. 36 per 100,000)
- Dehydration (87 vs. 111 per 100,000)
- Bacterial pneumonia (288 vs. 360 per 100,000)
- Urinary tract infection (143 vs. 206 per 100,000)
- Angina without procedure (19 vs. 25 per 100,000)
- Congestive heart failure (297 vs. 398 per 100,000)
- Perforated appendix (27 vs. 28 per 100)
- Low birth weight (5 vs. 6 per 100)

PQI rates in PCCM were *higher* than AHRQ national estimates for six conditions:

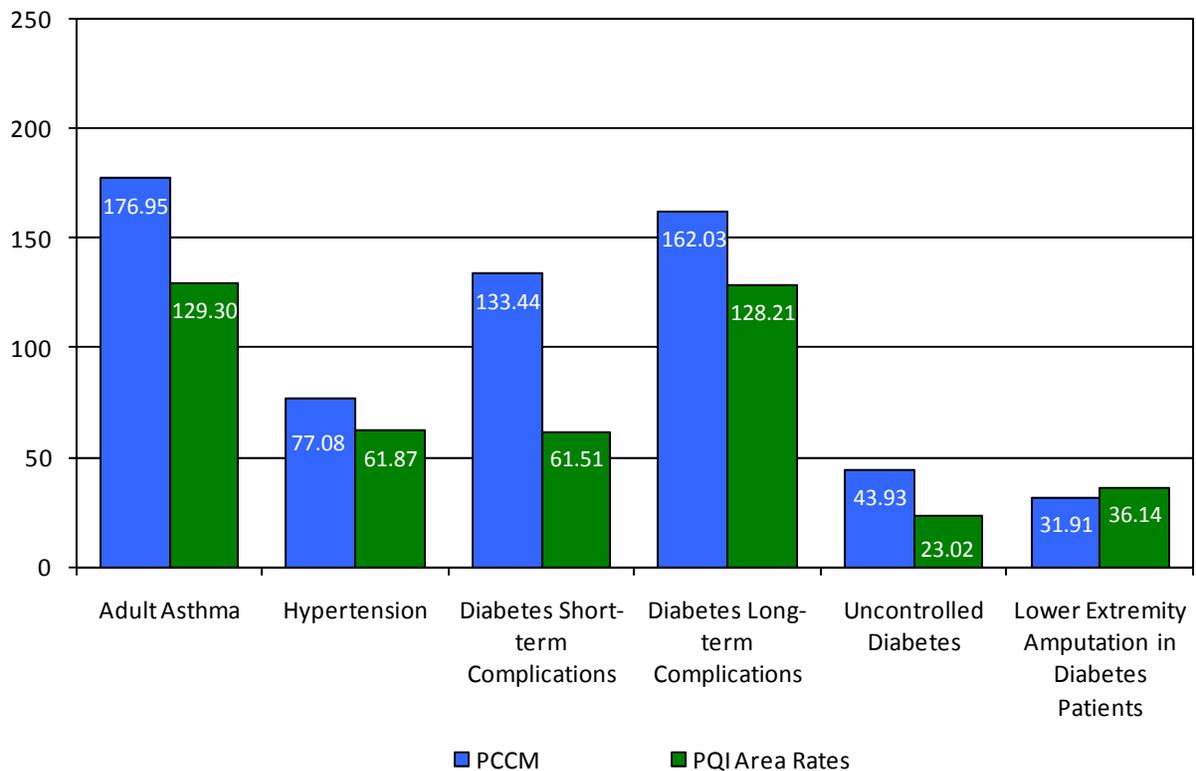
- Adult asthma (177 vs. 129 per 100,000)
- Hypertension (77 vs. 62 per 100,000)
- Diabetes short-term complications (133 vs. 62 per 100,000)
- Diabetes long-term complications (162 vs. 128 per 100,000)
- Uncontrolled diabetes (44 vs. 23 per 100,000)
- Chronic obstructive pulmonary disease (291 vs. 243 per 100,000)

PQI rates in PCCM were two times greater than the national rate for diabetes short-term complications and for uncontrolled diabetes, and above the national rate for diabetes long term-

complications. In SFY 2008 and 2009, PCCM rates for diabetes short-term and long-term complications, and uncontrolled diabetes were also well above the national rates.

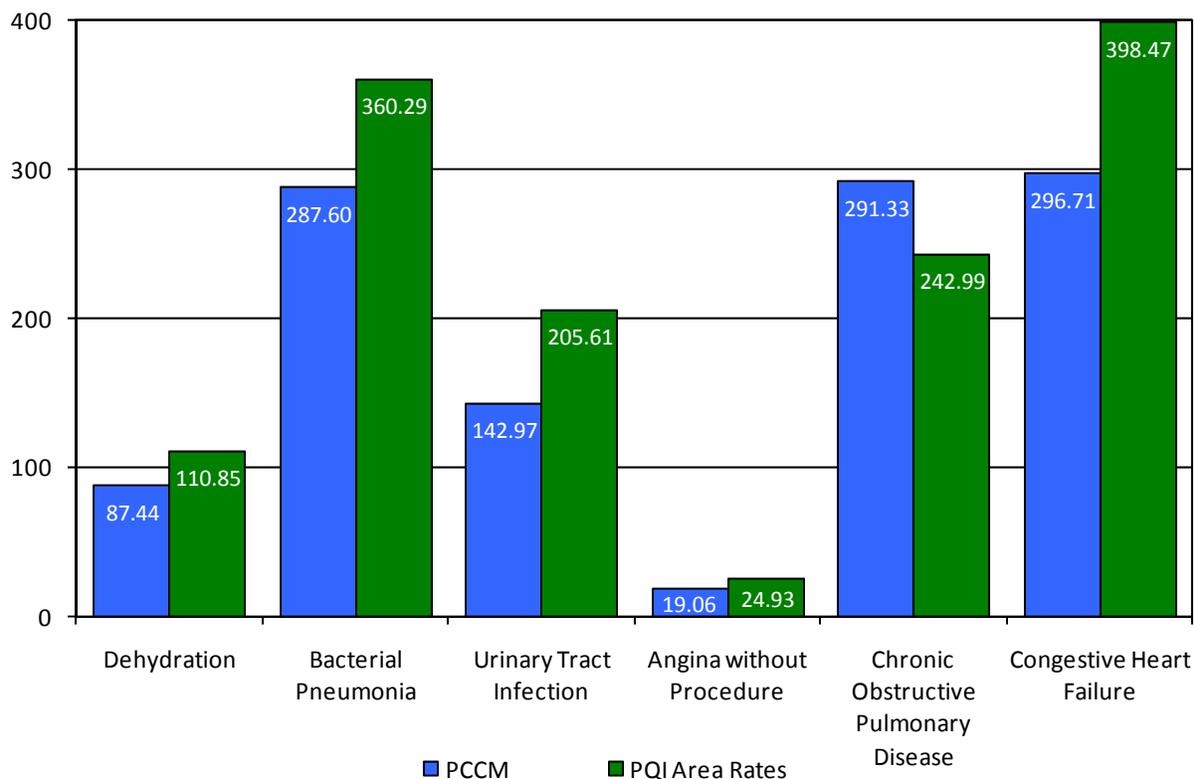
STAR and STAR+PLUS MCOs moving into PCCM areas in the coming year should focus on improving the effectiveness of adult diabetes care in this population. Comprehensive programs for diabetes care should address: (1) health literacy in the member population, (2) culturally relevant diabetes self-management, and (3) the complex nature of co-morbidities for patients with diabetes. In particular, research has shown that certain co-morbidities, such as liver disease and psychosis, are associated with avoidable hospitalizations for uncontrolled diabetes.<sup>11</sup>

**Figure 7. AHRQ Adult Prevention Quality Indicators**



Reference: Table PQI

**Figure 8. AHRQ Adult Prevention Quality Indicators**



Reference: Table PQI

## Effectiveness of Care

### *Appropriate Testing for Children with Pharyngitis (Sore throat)*

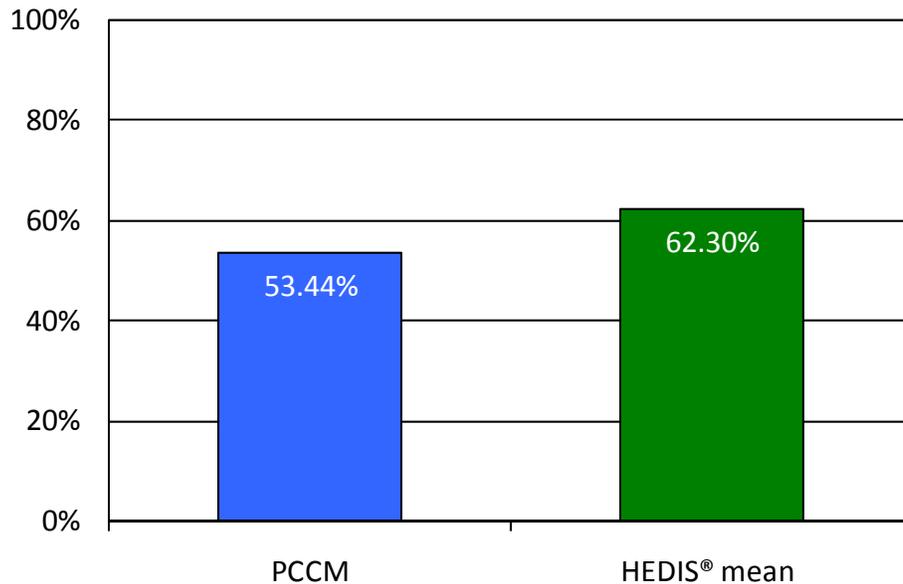
**Figure 9** provides the percentage of children 2 to 18 years of age in PCCM, who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus test for the episode, during the measurement period.

**Fifty-three percent of children in PCCM were appropriately treated for sore throat in SFY 2010**, compared to 57 percent if SFY 2009. The PCCM program performed below the national average of 62 percent for Medicaid Managed Care Plans reporting to NCQA on this measure, suggesting the need to improve provider adherence to clinical practice guidelines for treating pharyngitis in children.

Lower rates of diagnosis and treatment of pharyngitis in children in the PCCM program may be due to a number of factors, including access to care, parental decisions about the necessity of

care, and physician decisions about testing and treatment.<sup>12</sup> STAR and STAR+PLUS MCOs moving into PCCM areas in the coming year should consider implementing training programs for primary care providers on how to more effectively make treatment decisions for pharyngitis.

**Figure 9. HEDIS® Appropriate Testing for Children with Pharyngitis**



Reference: Table CWP

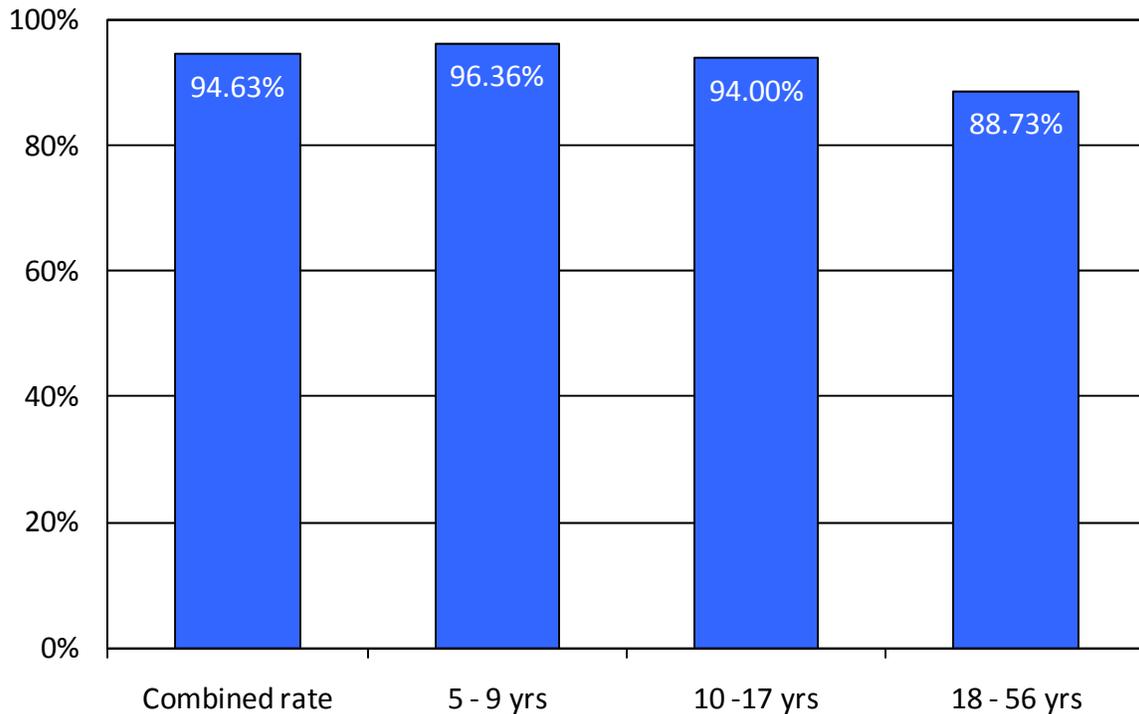
### ***Asthma Care***

**Figure 10** provides the percentage of PCCM members who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement period, distributed by age.

**The PCCM Program provided effective treatment to members with persistent asthma. Ninety-five percent of PCCM members with persistent asthma were appropriately prescribed medication for asthma.** This rate is above the 90<sup>th</sup> percentile for Medicaid Managed Care Plans reporting to NCQA on this measure.

A greater percentage of children and adolescents in PCCM were given appropriate medications for treating asthma than were adults (96 and 94 percent vs. 89 percent).

**Figure 10. HEDIS® Use of Appropriate Medications for People with Asthma**



Reference: Table ASM\_Special

### ***Diabetes Care***

**Figure 11** provides the percentage of PCCM members 18 to 75 years of age with diabetes (Type 1 and 2) who had hemoglobin A1c (HbA1c) testing, eye exams, LDL-C screening, and medical attention for diabetic nephropathy during the measurement period. HEDIS® technical specifications for the Comprehensive Diabetes Care measures allow for the use of administrative and medical record review data. Results shown in Figure 11 were calculated using administrative data only.

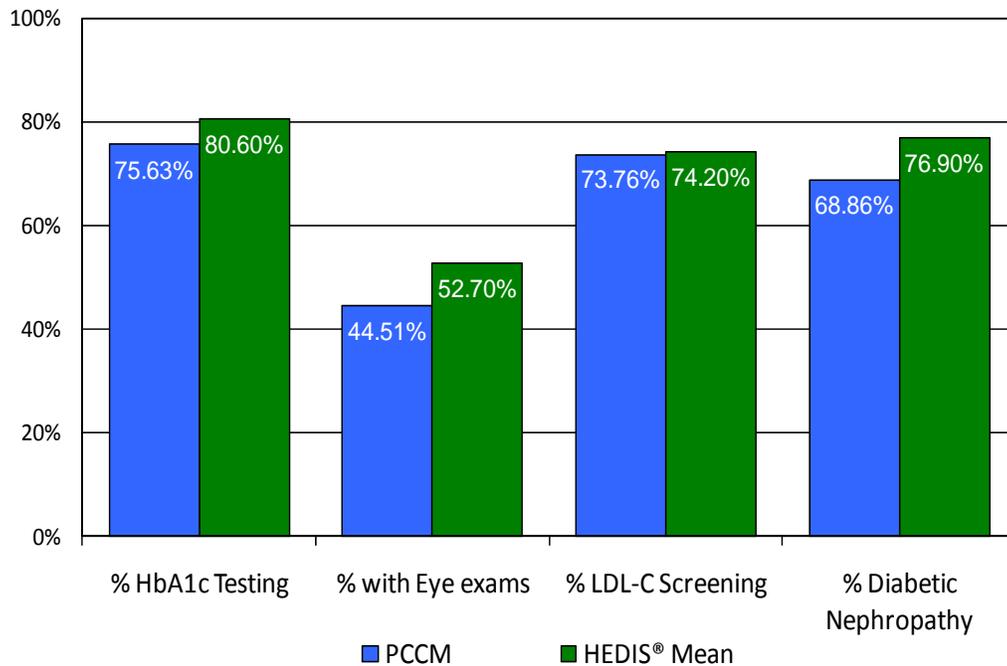
#### **The effectiveness of diabetes care in PCCM improved in SFY 2010:**

- **Seventy-six percent of diabetic patients in PCCM had hemoglobin A1c testing,** compared to 70 percent in SFY 2009.
- **Forty-five percent had an eye exam,** compared to 39 percent in SFY 2009.
- **Seventy-four percent had an LDL-C screening,** compared to 69 percent in SFY 2009.
- **Sixty-nine percent were monitored for diabetic nephropathy,** compared to 66 percent in SFY 2009.

Compared to Medicaid programs nationally, PCCM performed at the national average for the percentage of members who had an LDL-C screening, and below the national average for hemoglobin A1c testing, eye exams, and monitoring for diabetic nephropathy, which was below the 25<sup>th</sup> percentile nationally.

While rates for Comprehensive Diabetes Care measures have improved since SFY 2009, STAR and STAR+PLUS MCOs moving into PCCM areas in the coming year should be aware that these rates are still below the HEDIS<sup>®</sup> national means – particularly for diabetic eye exams. Diabetic retinopathy is the leading cause of blindness in the adult population.<sup>13</sup> Research has found that diabetic care coordinated by a specially trained nurse under physician supervision increases rates of eye exams and positive health outcomes for diabetics.<sup>14</sup>

**Figure 11. HEDIS<sup>®</sup> Comprehensive Diabetes Care (Administrative component only)**



Reference: Table CDC

## Cervical Cancer Screening

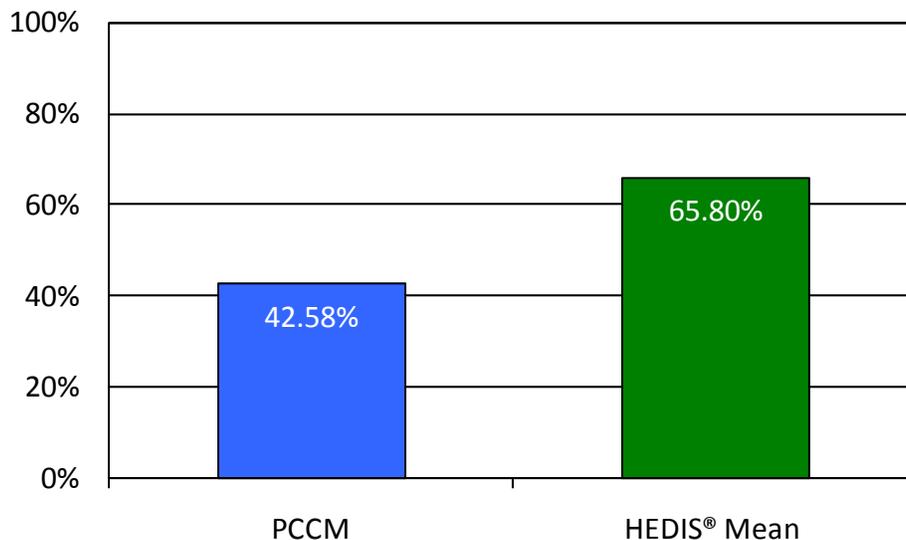
**Figure 12** provides the percentage of women between 21 and 64 years old in PCCM who received one or more Pap tests to screen for cervical cancer during the measurement period.

**Forty-three percent of women in PCCM had a Pap test to screen for cervical cancer.** This percentage is considerably lower than the national average of 66 percent for Medicaid Managed Care Plans reporting to NCQA on this measure, and falls below the 10<sup>th</sup> percentile nationally.

The percentage of cervical cancer screenings was slightly higher in SFY 2010 than in 2009 – 43 vs. 40 percent.

STAR and STAR+PLUS MCOs moving into PCCM areas in the coming year should consider efforts to increase rates of cervical cancer screening for women in this population. Research has found that poverty, low educational levels, not having a primary care provider, and lack of acculturation (among Hispanics) all decrease the likelihood of cervical cancer screening.<sup>15</sup>

**Figure 12. HEDIS® Cervical Cancer Screening**



Reference: Table CCS

## Follow-up After Hospitalization for Mental Illness

**Figure 13** provides the percentage of PCCM members who were hospitalized for mental illness and who had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a provider during the measurement period. Two percentages are shown – one for follow-up within seven days of discharge, and one for follow-up within 30 days of discharge.

HEDIS® specifies that to count towards the numerator of this measure, visits must occur with a mental health practitioner. HHSC requested the practitioner requirements be removed for this measure, so visits with any provider were included when calculating compliance rates.

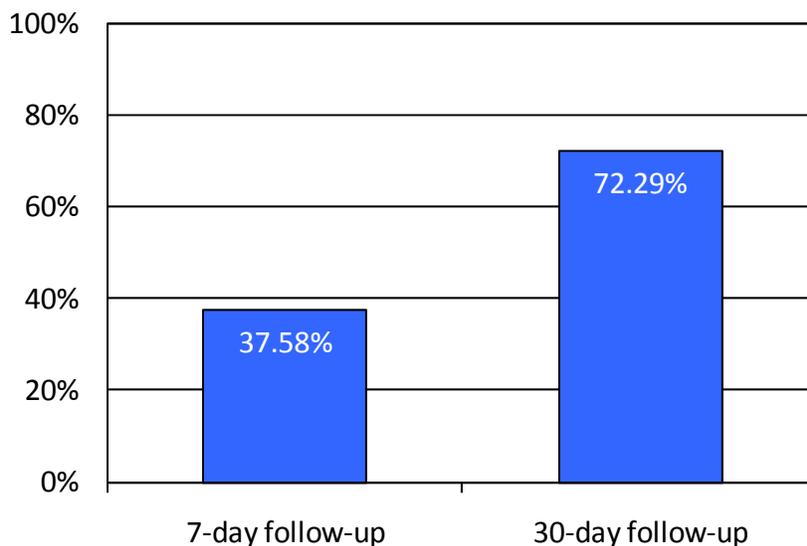
There were 5,753 PCCM members hospitalized for mental illness and, thus eligible for this measure(s).

Among these members, **38 percent had a follow-up visit within 7 days of discharge from the hospital.**

**The majority of PCCM members had a follow-up visit with 30 days of discharge from the hospital (72 percent).** However, 28 percent did not have an encounter with a provider during the 30-day time frame.

Follow-up rates for mental illness were comparable in PCCM in SFY 2009 and 2010.

**Figure 13. Follow-up after Hospitalization for Mental Illness**



Reference: Table FUH

## Mental Health Readmission

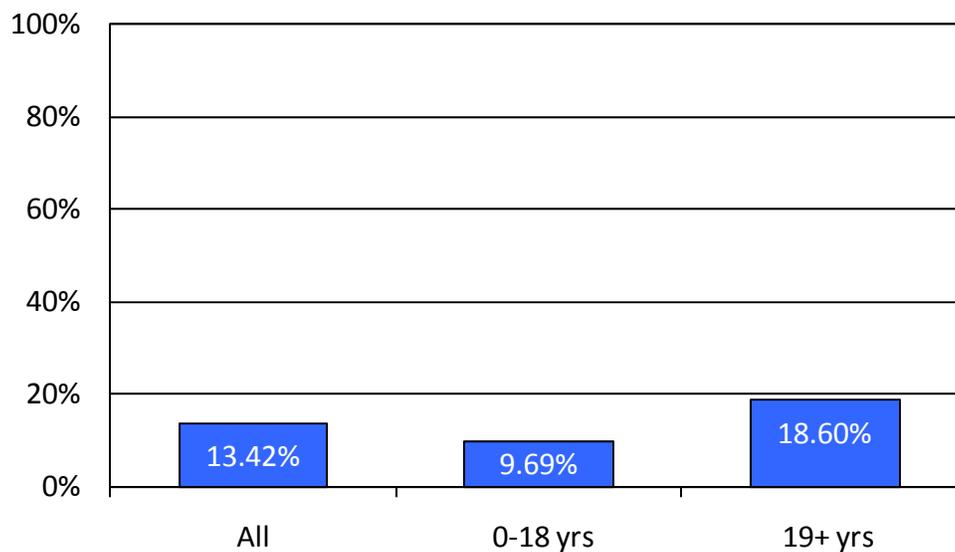
**Figure 14** provides the percentage of PCCM members who were readmitted within 30 days following an inpatient stay for mental health problems during the measurement period.

There were 1,051 PCCM members, or **13 percent of those discharged, who were readmitted to the hospital within 30 days after a mental health inpatient stay.**

The highest rate of readmission was observed for adult PCCM members, at 19 percent.

There was a slight decrease in the rate of readmission since SFY 2009, when 15 percent of members were readmitted to the hospital within 30 days of a mental health inpatient stay.

**Figure 14. Readmission within 30 days after an Inpatient Stay for Mental Health**



Reference: Table MHReadmit\_V2

## Appendix A: Detailed Methodology

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

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

Information regarding the calculation of all measures included in this report can be found in the document "Quality of Care Measures Technical Specifications Report, July 2011."<sup>16</sup> This document, prepared by the Institute for Child Health Policy, provides specifications for HEDIS<sup>®</sup> and other quality of care measures.

Quality of care indicators in this report include: 1) The Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) 2010 measures; 2) The Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs) and Prevention Quality Indicators (PQIs); and 3) measures developed by the EQRO.

Rates for Healthcare Effectiveness and Data Information Set (HEDIS<sup>®</sup>) measures were calculated using National Committee for Quality Assurance (NCQA) certified software. Discussion of results includes comparison with HEDIS<sup>®</sup> national Medicaid rates, which are derived from rates reported to the NCQA by Medicaid Managed Care Plans nationally.<sup>17</sup> Submission of HEDIS<sup>®</sup> data to NCQA is a voluntary process; therefore, health plans that submit HEDIS<sup>®</sup> data are not fully representative of the industry. Health plans participating in NCQA HEDIS<sup>®</sup> reporting tend to be older, are more likely to be federally qualified, and are more likely to be affiliated with a national managed care company than the overall population of health plans in the United States.<sup>18</sup> NCQA reports the national results as a mean and at the 10<sup>th</sup>, 25<sup>th</sup>, 50<sup>th</sup>, 75<sup>th</sup>, and 90<sup>th</sup> percentiles. The Medicaid Managed Care Plans 2010 mean results are shown and labeled "HEDIS<sup>®</sup> Mean" in the figures.

At the request of the Texas Health and Human Service Commission (HHSC), the Institute for Child Health Policy developed a methodology to allow for flexibility in the provider specialty codes when determining eligibility for certain HEDIS<sup>®</sup> measures. As in the prior reporting period

(SFY 2009), the EQRO modified the NCQA specifications to lift provider constraints when determining eligibility for these measures. Provider specialty codes are an important component for some HEDIS<sup>®</sup> measures and lifting the provider constraints may result in the inflation of rates. 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<sup>®</sup> measures for 7-day and 30-day follow-up after an inpatient mental health stay. The current methodology allows a visit with any provider to count toward compliance with the mental health follow-up measures.

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

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

For these measures, the name HEDIS<sup>®</sup> has been removed from the titles as these measures do not adhere precisely to NCQA specifications, and their results are likely inflated due to the lifting of provider constraints. Thus, the discussion of results for these measures does not include comparison to HEDIS<sup>®</sup> national Medicaid rates, and instead focuses on PCCM performance in SFY 2010, compared to SFY 2009.

Pediatric Quality Indicators (PDIs) and Adult Prevention Quality Indicators (PQIs) developed by the Agency for Healthcare Research and Quality (AHRQ) were used to evaluate the performance of PCCM related to inpatient admissions for ambulatory care sensitive conditions (ACSCs). The AHRQ considers ACSCs "conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease."<sup>19</sup> The specifications used to calculate rates for these measures come from AHRQ PDI and PQI versions 4.3. Rates are calculated based on the number of hospital discharges divided by the number of people in the area (except for perforated appendix and low birth weight). Unlike most other measures provided in this report, low PDI and PQI rates are desired as they suggest a better quality health care system outside the hospital setting.

PDIs assess pediatric admissions for the following ACSCs: (1) Asthma; (2) Diabetes Short-Term Complications; (3) Gastroenteritis; (4) Perforated Appendix; and (5) Urinary Tract Infection. The age eligibility for these measures is through 17 years old.

PQIs assess adult admissions for the following ACSCs: (1) Diabetes Short-Term Complications; (2) Perforated Appendix; (3) Diabetes Long-Term Complications; (4) Chronic Obstructive Pulmonary Disease; (5) Hypertension; (6) Congestive Heart Failure; (7) Low Birth Weight; (8) Dehydration; (9) Bacterial Pneumonia; (10) Urinary Tract Infection; (11) Angina without

Procedure; (12) Uncontrolled Diabetes; (13) Adult Asthma; and (14) Rate of Lower Extremity Amputation among Patients with Diabetes. For these measures, adults are those individuals ages 18 or older.

In addition to the narrative and figures contained in this report, technical appendices were provided to HHSC that contain all of the data to support key findings.<sup>20</sup> The interested reader can review those for more details. The corresponding reference table is listed beneath each figure.

## Appendix B: AHRQ Quality Indicators

**Table B1. AHRQ Pediatric Quality Indicators**

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

**Table B2. Adult Prevention Quality Indictors**

<b>AHRQ Indicator Number</b>	<b>Indicator Name</b>	<b>Description</b>
PQI 1	Diabetes Short-term Complications Admission Rate	Number of admissions for diabetes short-term complications per 100,000 population
PQI 2	Perforated Appendix Admission Rate	Number of admissions for perforated appendix as a share of all admissions for appendicitis within an area
PQI 3	Diabetes Long-term Complications Admission Rate	Number of admissions for long-term diabetes per 100,000 population
PQI 5	Chronic Obstructive Pulmonary Disease Admission Rate	Number of admissions for COPD per 100,000 population

**Table B2. Adult Prevention Quality Indicators (continued)**

<b>AHRQ Indicator Number</b>	<b>Indicator Name</b>	<b>Description</b>
PQI 7	Hypertension Admission Rate	Number of admissions for hypertension per 100,000 population
PQI 8	Congestive Heart Failure Admission Rate	Number of admissions for CHF per 100,000 population
PQI 9	Low Birth Weight Rate	Number of low birth weight births as a share of all births in an area
PQI 10	Dehydration Admission Rate	Number of admissions for dehydration per 100,000 population
PQI 11	Bacterial Pneumonia Admission Rate	Number of admissions for bacterial pneumonia per 100,000 population
PQI 12	Urinary Tract Infection Admission Rate	Number of admissions for urinary infection per 100,000 population
PQI 13	Angina without Procedure Admission Rate	Number of admissions for angina without procedure per 100,000 population
PQI 14	Uncontrolled Diabetes Admission Rate	Number of admissions for uncontrolled diabetes per 100,000 population ( <i>Note: This indicator is designed to be combined with diabetes short-term complications.</i> )
PQI 15	Adult Asthma Admission Rate	Number of admissions for asthma in adults per 100,000 population
PQI 16	Rate of Lower Extremity Amputation Among Patients with Diabetes	Number of admissions for lower extremity amputation among patients with diabetes per 100,000 population

## Endnotes

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- <sup>1</sup> Texas HHSC (Health and Human Services Commission). 2011. *Texas Healthcare Transformation and Quality Improvement Program, Medicaid Waiver 1115*. Austin, TX: HHSC.
- <sup>2</sup> ICHP (The Institute for Child Health Policy). 2011.<sup>a</sup> *Quality of Care Measures Technical Specifications Report, July 2011*. Gainesville, FL: The Institute for Child Health Policy, University of Florida.
- <sup>3</sup> The information that NCQA compiles for Medicaid Managed Care Programs can be viewed at [www.ncqa.org](http://www.ncqa.org).
- <sup>4</sup> AHRQ (Agency for Healthcare Research and Quality). 2004. *AHRQ Quality Indicators—Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions*. Rockville, MD: AHRQ. Revision 4. (November 24, 2004). AHRQ Pub. No. 02-R0203.
- <sup>5</sup> Texas HHSC, 2011.
- <sup>6</sup> Texas HHSC, 2011.
- <sup>7</sup> American Academy of Pediatrics, American College of Obstetricians and Gynecologists. 2008. *Guidelines for perinatal care, 6th edition*. Washington DC: American College of Obstetricians and Gynecologists.
- <sup>8</sup> Landy, C. K., Sword, W., and Ciliska, D. 2008. "Urban women's socioeconomic status, health service needs and utilization in the four weeks after postpartum hospital discharge: Findings of a Canadian cross-sectional survey." *BMC Health Services Research* 8: 203.
- <sup>9</sup> AHRQ (Agency for Healthcare Research and Quality). 2011. *AHRQ Quality Indicators—Pediatric Quality Indicator Comparative Data: Based on the 2008 Nationwide Inpatient Sample (NIS), Version 4.3*. Rockville, MD: AHRQ.
- <sup>10</sup> AHRQ (Agency for Healthcare Research and Quality). 2011. *AHRQ Quality Indicators—Prevention Quality Indicator Comparative Data: Based on the 2008 Nationwide Inpatient Sample (NIS), Version 4.3*. Rockville, MD: AHRQ.
- <sup>11</sup> Ahern, M. M., and M. Hendryx. 2007. "Avoidable Hospitalizations for Diabetes: Comorbidity Risks." *Disease Management* 10: 347-355.
- <sup>12</sup> Van Howe, R. S., and Kusnier II, L. P. 2009. "Diagnosis and management of pharyngitis in a pediatric population based on cost-effectiveness and projected health outcomes." *Pediatrics* 117: 609-619.

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<sup>13</sup> Davidson, M. B. 2003. "Effect of nurse-directed diabetes care in a minority population." *Diabetes Care* 26(8): 2281-2287.

<sup>14</sup> Davidson, 2003.

<sup>15</sup> Ackerson, K., and Gretebeck, K. 2007. "Factors influencing cancer screening practices of underserved women." *Journal of the Academy of Nurse Practitioners* 19: 591-601.

<sup>16</sup> ICHP. 2011.<sup>a</sup>

<sup>17</sup> The information that NCQA compiles for Medicaid Managed Care Programs can be viewed at [www.ncqa.org](http://www.ncqa.org).

<sup>18</sup> Beaulieu, N.D., and A.M. Epstein. 2002. "National Committee on Quality Assurance Health-Plan Accreditation: Predictors, Correlates of Performance, and Market Impact." *Medical Care* 40 (4): 325-337.

<sup>19</sup> AHRQ, 2004.

<sup>20</sup> ICHP. 2011.<sup>b</sup> *Texas Medicaid Managed Care, Primary Care Case Management , Quality of Care Report, Fiscal Year 2010: Technical Appendix*. Gainesville, FL: The Institute for Child Health Policy, University of Florida.