
RIDER 50 REPORT

Reducing Nonemergent Use of the Emergency Department in Medicaid

**As Required by the 2014-15 General Appropriations Act (Article II,
Health and Human Services Commission, Rider 50, S.B. 1,
83rd Legislature, Regular Session, 2013)**

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Executive Summary

Pursuant to the 2014-15 General Appropriations Act (S.B. 1, 83rd Legislature, Regular Session, 2013, Article II, Health and Human Services Commission, Rider 50), the Health and Human Services Commission (HHSC) is required to submit a report on steps taken to reduce nonemergent use of the emergency department (ED) in the Medicaid program.

Rider 50 specifically directed that among the steps to reduce nonemergent ED use in Medicaid, HHSC would:

- Evaluate whether the cost of physician incentive programs implemented by Medicaid managed care organizations (MCOs) participating in the STAR and STAR+PLUS managed care programs is offset by reduced use of the emergency department;
- Determine the feasibility of amending the Texas Medicaid State Plan to permit freestanding urgent care centers to enroll as clinic providers; and
- Use financial incentives and disincentives to encourage the health maintenance organizations participating in the Medicaid STAR and STAR+PLUS managed care programs to reduce nonemergent use of the emergency room among their clients.

This report reviews strategies undertaken by the Texas Medicaid program to reduce nonemergent ED use through targeted initiatives. Most of these initiatives are targeted at MCOs since the majority of Medicaid clients are enrolled in MCOs.

Rider 50 requires an evaluation of Medicaid MCO physician incentive programs intended to reduce nonemergent ED use. A similar requirement was included in S.B. 7, 82nd Legislature, 1st Called Session, 2011. The evaluation of physician incentive programs conducted for this report satisfies the requirements of both Rider 50 and of S.B. 7.

HHSC analyzed six health plans that implemented physician incentive programs to determine if these plans reduced nonemergent use of the emergency department. Descriptions of these incentive programs are included in Appendix A.

Two of the six plans had statistically significant decreases in the average number of nonemergent ED visits per enrollee and average number of ED patients per enrollee. The first plan paid PCPs with 500 to 999 Medicaid patients in their panel up to \$4 per member per month (PMPM) for meeting three focused requirements: achieving ED use lower than at least 75 percent of peers for certain conditions that can usually be managed successfully in an outpatient setting; providing after-hours and weekend clinic services; and meeting the 75th percentile or higher on certain well-child visits, comprehensive diabetes care measures, and cervical cancer screening. The second plan provided an add-on payment to the normal office visit fee for after-hours visits. The second plan also worked with a number of clinics to allow members to receive after-hours services and then had the clinics coordinate follow-up care with the PCP the following day.

The demonstrable success of these two incentive programs may be reflective of two factors identified in additional research about efficacy of incentive programs. Incentive programs may be more effective based on the magnitude of the incentive provided or when the incentive is provided under a model of shared savings or shared risk for successful outcomes.

After assessing the practicality of enrolling urgent care centers as clinic providers in the Texas Medicaid program, HHSC found that given the costs to establish a separate provider type for urgent care centers as clinic providers, it would be more cost effective to provide other mechanisms to help clients identify alternate providers to the hospital emergency department. HHSC has begun allowing providers to self-identify as urgent care centers in the Provider Information Management System (PIMS). Since January 1, 2012, clients are able to query the Online Provider Lookup tool to identify urgent care centers as alternatives to using the hospital emergency department.

Introduction

The approaches to reducing nonemergency use of the hospital emergency department by Medicaid clients are varied. Strategies include enhancing access to care, encouraging chronic disease management, and delivering appropriate care in the appropriate setting. A description of various nonemergent ED use reduction strategies follows.

Physician Incentive Programs in Medicaid Managed Care

Rider 50 requires HHSC to evaluate whether the cost of Medicaid MCO physician incentive programs was offset by reduced use of the emergency department. An example of a physician incentive program is providing an enhanced reimbursement rate to physicians for routine, after-hours appointments.

A similar requirement to Rider 50 was included in S.B. 7, 82nd Legislature, 1st Called Session, 2011. S.B. 7 directs HHSC to conduct a study to evaluate physician incentive programs that attempt to reduce hospital ED use for nonemergent conditions by Medicaid recipients. Each physician incentive program evaluated in the study must be administered by a STAR or STAR+PLUS MCO and provide incentives to primary care providers who attempt to reduce ED use for nonemergent conditions. The study must evaluate the cost-effectiveness of each component included in the physician incentive program and any change in statute required to implement each component within the Medicaid fee-for-service (FFS) payment model.

The number of clients in the Texas Medicaid FFS model is declining rapidly. The FFS population will decline further when the new STAR Kids model of Medicaid managed care rolls out for children with disabilities (targeted implementation - September 1, 2016). Given the limited number of clients who will be in FFS beginning September 1, 2016, interventions targeted to FFS clients will have minimal impact.

Discussion of Analysis

Physician incentive programs from six STAR Medicaid MCOs met the criteria to be included in the study of physician incentive programs designed to reduce use of nonemergent ED services. The physician incentive programs were implemented at various times between December 2007 and September 2010. The physician incentive programs were designed independently by the operating health plan, so the design of the individual physician incentive programs varied by plan. Most of the plans provided some level of reporting to PCPs to make the PCPs aware of which of their patients visited the ED. Appendix A includes a more detailed summary of the programs implemented by the health plans.

HHSC examined all ED encounter data for all health plan participants who were enrolled in one of the six MCOs during the 12 calendar months before the physician incentive program implementation date and a 12-month period following implementation of the physician incentive program. The 12-month period that was reviewed following implementation did not start until the physician incentive program had been operating for six months. The study was not able to assess the impact on patients with continuous enrollment in participating physician practices.

ED visits were classified as nonemergent if all of the patient's encounters for the date of service had nonemergent procedure codes or nonemergent diagnosis codes. If one or more of the encounters on the ED visit date were classified as emergent, then the ED visit was excluded from the analysis.

Analysis Conclusion

During the 12 months following implementation, Plan B and Plan E had statistically significant decreases in the average number of nonemergent ED visits per enrollee and average number of ED patients per enrollee.

Plan E provided an add-on payment to the normal office visit fee for after-hours visits. Research commonly acknowledges that provider practice is motivated by the magnitude of the incentive associated with a behavior,¹ so the amount of the incentive may have led to the demonstrable reduction in nonemergent ED use resulting from the add-on payment. Plan E also worked with a number of clinics to allow members to receive after-hours services and then had the clinics coordinate follow-up care with the PCP the next day.

Plan B paid PCPs with 500 to 999 Medicaid patients in their panel up to \$4 per member per month (PMPM) for meeting three focused requirements: achieving ED use lower than at least 75 percent of peers for certain conditions that can usually be managed successfully in an outpatient setting; providing after-hours and weekend clinic services; and meeting the 75th percentile or higher on certain well-child visits, comprehensive diabetes care measures, and cervical cancer screening.

¹ Berenson, Robert A. and Docteur, Elizabeth. *Doing Better by Doing Less: Approaches to Tackle Overuse of Services*. Urban Institute, January 2013.

http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403697.

The performance-based approach of Plan B aligns with research into best practices suggesting that alternative payment methodologies are preferable to fee-for-service payment models, which incentivize volume of service over the quality and value of care.² The analysis of Plan B demonstrated statistically significant reductions in nonemergent ED use, while the three other plans in the analysis that also followed the evidence-based approach of paying for performance or outcomes did not demonstrate statistically significant reductions.

For those interventions that did not demonstrate reductions, the intervention may have been effective on clients with continuous enrollment in the participating physician practices. The study assessed the total impact on ED use rates in the service delivery area in which the incentive was implemented and was unable to assess the impact on the clients specific to the participating practices. The inclusion of the data for the full service delivery area may have diluted the measurable impact of clients continuously enrolled in the participating practices.

Identification of Freestanding Urgent Care Centers

Rider 50 requires HHSC to determine the feasibility of amending the Texas Medicaid State Plan to permit freestanding urgent care centers to enroll as clinic providers. The intent of such a change would be to aid clients in locating urgent care centers in their area for nonemergency situations that would previously have been treated in emergency room settings.

HHSC reviewed the possibility of enrolling freestanding urgent care centers as a new provider type, yet found the state could employ a different strategy that still would allow clients to identify urgent care clinics as a lower cost alternative to emergency departments.

Rather than incurring the expense of establishing a separate urgent care provider type, HHSC has met the intent of such a change by allowing providers to self-declare as urgent care centers in the Provider Information Management System. Due to this change, implemented January 1, 2012, Medicaid clients are able to identify self-declared urgent care centers in the provider directory as an alternative to the emergency department, including through queries to the Online Provider Lookup tool.

Other Steps Taken to Reduce Medicaid Nonemergent ED Use

Beyond the initiatives specifically directed for reporting in Rider 50, HHSC has undertaken a number of initiatives to reduce nonemergent ED use among Medicaid clients. These strategies often involve enhancing data collection and information sharing among entities to share best practices and identify areas for improvements. Strategies include enhancing access to care, encouraging chronic disease management, and delivering appropriate care in the appropriate setting.

² Ibid.

Texas healthcare Learning Collaborative

The Institute for Child Health Policy (ICHP) at the University of Florida, which serves as Texas' External Quality Review Organization (EQRO), developed an online portal called the Texas healthcare Learning Collaborative (ThLC). Medicaid MCOs, HHSC, ICHP, and other partner agencies can use the portal as a quality improvement tool to identify performance on various metrics that can impact ED use.

The ThLC Portal allows users to display data both visually and numerically and provides an interactive platform to measure and calculate HHSC's quality metrics. This quality improvement tool allows data to be reviewed and sorted at the provider level. The ThLC Portal also includes detailed data related to potentially preventable events. MCOs can view these metrics on demand based on criteria, such as location, and other measurement parameters, such as age, health status, or time period.

The ThLC portal also has an interactive web-posting feature that allows health plans to ask questions to the EQRO so that others can benefit from the responses. This includes moderated listserv discussions, webinars, and online chats to facilitate sharing among ThLC members about their experiences in using the reports and strategies to enhance the collaborative.

Managed Care Pay-for-Quality Program

The Medicaid/CHIP Division has implemented the Pay-for-Quality Program using quality of care measures that reflect the needs of the population served and areas of needed improvement in managed care. The Pay-for-Quality Program provides financial incentives and disincentives to managed care organizations based on year-to-year incremental improvement on specified quality goals. The quality of care measures used in this initiative, which are included in Appendix A, are a combination of process and outcome measures that include select potentially preventable events as well as other measures specific to each program's enrolled populations. For STAR, STAR+PLUS, and CHIP, the Pay-for-Quality Program includes the 3M Health Information Systems (HIS) potentially preventable ED visits measure. Other measures address conditions that could lead to inappropriate ED use if care is not properly managed.

The Pay-for-Quality Program includes an at-risk pool that is four percent of the MCO capitation rate. The Pay-for-Quality Program model sets minimum baseline performance levels for the measures so that low performing managed care organizations will not be rewarded for substandard performance. Rewards and penalties are based on rates of improvement or decline over the baseline. If funds are recouped from managed care organizations due to low performance, those funds are redistributed to other managed care organizations to reward those with positive performance.

The Pay-for-Quality Program replaces the At-Risk Quality Challenge Program that operated in 2012 and 2013. The At-Risk Quality Challenge program held a percentage of MCO funds contingent on performance. It created incentives and penalties for managed care organizations based on their performance on certain quality measures, which are listed in Appendix B.

Managed Care Network Urgent Care Clinics

The managed care contracts that went into effect in March 2012 require MCOs to have urgent care clinics in their provider network. Urgent care clinics offer clients alternatives to visiting the ED for their urgent, after-hours care needs. Also, as of January 2012, clients were able to identify urgent care providers in the provider directory.

Managed Care Performance Improvement Projects

HHSC requires Medicaid and CHIP health plans to implement performance improvement projects (PIPs) to improve the quality and coordination of care and reduce potentially preventable events. These projects must be specified and measurable and reflect areas that present significant opportunities for performance improvement for each managed care organization.

Many PIPs have focused on reducing inappropriate use of emergency departments either directly or via projects that manage conditions that often lead to emergency department use when not controlled. In 2013, performance improvement projects targeting the rate of ED visits were the third most common project type (18.7 percent).

For 2014, HHSC requires each health plan to conduct two performance improvement project topics per program, one done collaboratively with other health plans in the same region and one independent project. Additionally, HHSC staff is currently working closely with the 1115 Texas Healthcare Transformation Waiver team to ensure PIPs are coordinated with related regional initiatives as part of the Delivery System Reform Incentive Payment program that is discussed later in this report.

Alternative Payment Structures in Managed Care

HHSC has amended its Uniform Managed Care Contract with Medicaid MCOs to require each MCO to submit a plan describing alternative payment structures it implemented, or plans to implement, to move away from strict fee-for-service payments and incentivize providers for quality improvement efforts. HHSC will assess and measure over time payment structures that more directly promote improved quality outcomes and increased efficiency. An intended outcome is to reduce inappropriate utilization of services, including inappropriate ED use, admissions, and readmissions.

Managed Care Super-utilizers

A recent provision in the HHSC Uniform Managed Care Contract requires each MCO to have a specialized program for targeting, outreach, education and intervention for "super-utilizer" members. This population is defined as members who have excessive utilization patterns, such as excessive use of the ED, that indicate typical disease management approaches are not effective. HHSC will hold quarterly collaborative calls and/or webinars with MCOs to discuss plan implementation, barriers, and successful strategies.

Data Sharing

Sharing and reporting meaningful performance measures enhances transparency and identifies areas for improvement. HHSC is working on initiatives to provide MCOs with three years of historical claims and encounter data for new enrollees and to improve data sharing and care coordination processes in the Dallas services area among the NorthSTAR, STAR and STAR+PLUS plans.

Data Analytics

Per the requirements of S.B. 8, 83rd Legislature, Regular Session, 2013, HHSC has established an internal data analytics unit to perform the following functions:

- Improve contract management;
- Detect data trends; and
- Identify anomalies relating to service utilization, providers, payment methodologies, and compliance with requirements in Medicaid and CHIP managed care and fee-for-service contracts.

This unit, in addition to enhanced public reporting on performance across different quality and utilization metrics, will enable HHSC to identify trends more quickly and increase transparency of performance. The unit will be able to see data, such as when ED utilization for one MCO is out of alignment with ED utilization at others.

Reporting Performance Measures

Texas has begun calculating avoidable ED visits using 3M Health Information Systems (HIS) Enhanced Ambulatory Patient Groups (EAPG) software. Potentially preventable emergency department visits are considered an indicator of poor availability, accessibility, and effectiveness of primary care.

Ambulatory care sensitive conditions (ACSCs) include conditions that result from certain diagnoses, such as asthma, diabetes, and hypertension that are potentially avoidable with better access to outpatient care. The Ambulatory Care ED measure included in the annual MCO Quality of Care reports for STAR, STAR+PLUS, STAR Health, and CHIP shows the rate of ED visits for ACSCs. This data can be used to assess which MCOs need improvement in care for certain conditions.

Texas Healthcare Transformation and Quality Improvement Program Waiver

The Texas Healthcare Transformation and Quality Improvement Program waiver has presented an opportunity for regional collaboration to address healthcare needs. Through the waiver, Delivery System Reform Incentive Payment (DSRIP) pool payments are made to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality and cost-effectiveness of care provided, and increase the health of the members served.

To receive DSRIP payments, a provider must participate in a Regional Healthcare Partnership that includes governmental entities providing public funds, Medicaid providers, and other stakeholders. Participants must develop a regional plan that identifies community needs and proposed projects to meet those needs.

Numerous projects approved under the waiver affect inappropriate use of the ED, either directly or indirectly. Examples of project topics include expansion of urgent care access and expansion of telehealth and telemedicine interventions. Of the almost 1,500 approved and active DSRIP projects, more than 22 percent (336) have an explicit goal of reducing ED use. These include:

- 186 projects propose improving an outcome related to reducing ED visits; and
- 150 projects reference ED utilizers as a target population or state a goal of reducing ED visits.

These 336 projects are primarily in the following project areas:

- Establish or expand a patient care navigation program (71)
- Expand primary care capacity (71)
- Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., criminal justice system, ER, urgent care, etc.) (30)
- Develop behavioral health crisis stabilization services as alternatives to hospitalization (20)
- Implement or expand care transitions programs (16)
- Introduce, expand, or enhance telemedicine/telehealth, including for behavioral health (16)
- Expand chronic care management models (15)
- Enhance urgent medical advice (13)
- Enhance or expand medical homes (11)

In addition to these 336 projects with explicit outcomes or goals related to ED use, there are as many as 506 other DSRIP projects in the above categories that will employ strategies likely to reduce ED use.

Conclusion

HHSC has undertaken significant efforts to reduce nonemergent ED use among Medicaid clients as evidenced in the strategies detailed in this report. To respond to specific Rider 50 requirements, HHSC allowed Medicaid providers to self-declare as urgent care centers so clients can identify alternatives to the emergency department in the Medicaid Online Provider Lookup tool.

HHSC also evaluated Medicaid MCO physician incentive programs to determine if they reduced nonemergent ED use. For four of the plans, the analysis did not reveal a measurable impact on ED use – despite use of evidence-based practices. Since the analysis only was able to assess all ED use rates in a service delivery area, not just clients in the participating practices, it is possible the interventions were effective on participating practices, but their effect was

diluted in the larger pool of data for the full service delivery area.

The analysis identified two plans that demonstrated statistically significant reductions in nonemergent ED use. One plan provided an add-on payment to the normal office visit fee for after-hours visits and worked with a number of clinics to allow members to receive after-hours services. The other plan paid up to \$4 per member per month (PMPM) for meeting three focused requirements: achieving ED use lower than at least 75 percent of peers for certain conditions; providing after-hours and weekend clinic services; and meeting the 75th percentile or higher on certain well-child visits, comprehensive diabetes care measures, and cervical cancer screening. The success of this intervention aligns with research encouraging departure from the fee-for-service approach to incentives and relying, instead, on rewarding providers for meeting performance measures or outcomes.

Appendix A: Physician Incentive Programs that include ED Use Reduction Measures

Plans B and E demonstrated statistically significant reductions statistically significant decreases in the average number of nonemergent ED visits per enrollee and average number of ED patients per enrollee.

Plan	Incentive Program Description
A	PCPs opt into a program to receive additional reimbursement for each after-hours visit provided. Participating PCPs see all members, not just those in their PCP panel, without any type of prior authorization. PCPs participating in the program are listed in the provider directory and on the managed care website.
B	<p>PCPs with 500 to 999 Medicaid patients in their panel may receive up to \$4 per member per month (PMPM) for achieving the following:</p> <ul style="list-style-type: none"> • Nonemergent ED use (\$1 PMPM): Maintain member ED use lower than at least 75 percent of peers for the following conditions, which can usually be managed successfully in an outpatient setting: asthma, otitis media, cellulitis, upper respiratory infection, gastroenteritis, and nausea. • After-hours clinic (\$2 PMPM): Offer after-hours services (before 8 a.m. and after 5:30 p.m. on weekdays and open Saturday or Sunday). • Healthcare Effectiveness Data and Information Set Performance Measures (\$1 PMPM): Meet the 75th percentile or higher on certain well-child visits, comprehensive diabetes care measures, and cervical cancer screening.
C	<p>PCPs may receive incentive funds based on performance on a number of process and quality improvement measures. Twenty-five percent of the funds are determined by the following two metrics:</p> <ul style="list-style-type: none"> • Being open a minimum of five hours per week after 5 p.m. or on the weekend; and • Rate of ED use for ambulatory care sensitive conditions, which are conditions that usually can be managed successfully in an outpatient setting.
D	PCPs may receive yearly quality bonuses for meaningful performance relative to peers on a set of administrative and clinical measures. Two of the measures for the program are average ED use per member per month and after-hours availability. An enhanced reimbursement is given to providers based on the amount of days and hours open after 6 p.m.
E	Providers receive an add-on payment to the normal office visit fee for after-hours visits. The plan also has worked with a number of clinics and providers to allow members to receive after-hours services and then these providers must coordinate any follow-up care with the PCP the following day.
F	<p>Providers receive a bonus every six months that the following conditions are met:</p> <ul style="list-style-type: none"> • In the prior six months, the provider has achieved a 5 percent reduction in the number of ED visits per 1,000 members; and • The provider is at least average relative to peers in the number of ED visits per 1,000 members.

Appendix B: Pay-for-Quality Measures

Calendar Year 2014

Measure	Measure Description	STAR	CHIP	STAR+PLUS
Well-Child Visits at 3, 4, 5, & 6 years	The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.	X	X	
Adolescent Well-Care Visits	The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	X	X	
Prenatal Care and Postpartum Care	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal care. Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	X		
Potentially Preventable Hospital Admissions	Risk adjusted expenditures for hospital or long-term care facility admission that may have been prevented with access to ambulatory care or health care coordination.	X	X	X
Potentially Preventable Hospital Re-Admissions	Risk adjusted expenditures for return hospitalizations resulting from care or treatment deficiencies provided during a previous hospital stay or from post-hospital discharge follow-up.	X	X	X

Measure	Measure Description	STAR	CHIP	STAR+PLUS
Potentially Preventable ED visits	Risk adjusted expenditures hospital emergency room or freestanding emergency medical care facility treatment provided for a condition that could be provided in a nonemergency setting.	X	X	X
Anti-depressant Medication Management	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).			X
HbA1c Control <8	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had HbA1c control (<8.0%).			X

Appendix C: At-Risk and Quality Challenge Program Measures

Calendar Year 2012 At-Risk Measures

Measure	Measure Description	STAR	CHIP	STAR+PLUS
Present on Admission	98% of Institutional encounters submitted with non-exempt diagnosis codes will have a Present on Admission indicator.	X	X	X
Geo-Access - Provider	90% of child members have access to at least one child-appropriate PCP with an Open Panel within 30 travel miles from Member's residence. 90% of Adult Members have access to at least one PCP with an Open Panel within 30 travel miles from Member's residence.	X	X	X
Geo-Access - Pharmacy	80% of Members have access to at least one network pharmacy within 15 miles of the Member's residence.	X	X	X
Clean Claims Adjudicated in 30 days	98% of clean claims are adjudicated within 30 calendar days of receipt.	X	X	X
Call Timeliness	80% of Member calls must be answered within 30seconds. The Member Hotline average hold time does not exceed 2 minutes. The Member Hotline abandonment rate does not exceed 7%.	X	X	X

Calendar Year 2012 Quality Challenge Measures

Measure	Measure Description	STAR	CHIP	STAR+PLUS
Prenatal and Postpartum Care	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	X	X	
Ambulatory Care	Utilization of ambulatory care in the following categories: Outpatient Visits Emergency Department Visits	X	X	X
Inpatient Utilization General Hospital/Acute Care	Utilization of acute inpatient care and services in the following categories: Total inpatient Medicine Surgery Maternity	X	X	X
Members Utilizing CDS Option: HCBS SPW Personal Attendant Services (PAS) HCBS Non-SPW Primary Home Care (PHC)	0.5% Increase in Members utilizing Consumer Directed Services.			X

Calendar Year 2013 At-Risk Measures

Measure	Measure Description	STAR	CHIP	STAR+PLUS
Childhood Immunization Status	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	X	X	
Well-Child Visits at 3, 4, 5, & 6 Yrs.	The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.	X	X	
Adolescent Well-Care Visits	The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	X	X	
Prenatal Care	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facet of prenatal care. Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.	X		
Use of Appropriate Medication for People With Asthma	The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.	X	X	X

Measure	Measure Description	STAR	CHIP	STAR+PLUS
Cholesterol Management for Patients With Cardiovascular Conditions	<p>The percentage of members 18–75 years of age who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year:</p> <p>LDL-C screening. LDL-C control (<100 mg/dL).</p>			X
HbA1c Testing	<p>The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing.</p>			X

Calendar Year 2013 Quality Challenge Measures

Measure	Measure Description	STAR	CHIP	STAR+PLUS
Appropriate Testing for Children with Pharyngitis (2-18 yrs.)	The percentage of children 2–18 years of age who were diagnosed with pharyngitis dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.	X	X	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. <ul style="list-style-type: none"> • BMI percentile documentation. • Counseling for nutrition. • Counseling for physical activity. 	X	X	
Member using Inpatient Services for ACSC (AHRQ-Pediatric Quality Indicators (PDI)	Pediatric Quality Indicators (PDIs) for child members: (1) Asthma (2) Diabetes Short-Term Complications (3) Gastroenteritis (4) Perforated Appendix (5) Urinary Tract Infection (The age eligibility for these measures is 17 years old and younger.)	X	X	
Member using inpatient services for ACSC (AHRQ-Prevention Quality Indicators (PQIs)	Prevention Quality Indicators (PQIs) for adult members: (1) Diabetes Short-Term Complications (2) Perforated Appendix (3) Diabetes Long-Term Complications (4) Chronic Obstructive Pulmonary (8) Dehydration (9) Bacterial Pneumonia (10) Urinary Tract Infection (11) Angina without Procedure (12) Uncontrolled Diabetes (13) Adult Asthma (14) Rate of Lower			X

Measure	Measure Description	STAR	CHIP	STAR+PLUS
	Disease (5) Low Birth Weight (6) Hypertension (7) Congestive Heart Failure Extremity Amputation among Patients			
Follow-up Care for Children Prescribed ADHD Medication: Initiation Phase	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication that had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, which had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.	X	X	
Antidepressant Medication Management	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).			X
Adult BMI Assessment	The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index			X

Measure	Measure Description	STAR	CHIP	STAR+PLUS
	(BMI) was documented during the measurement year or the year prior to the measurement year.			
Members Utilizing CDS Option: HCBS SPW PAS HCBS Non-SPW PHC	0.5% Increase in Members utilizing Consumer Directed Services			X
Diabetic Eye Exam	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam.			X