

**STAR+PLUS Quality Council**  
**Annual Report**



As Required by Senate Bill 7, 83<sup>rd</sup> Legislative Session, 2013  
August 2014

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## **STAR+PLUS Quality Council Annual Report**

### **Executive Summary**

The STAR+PLUS Quality Council (Council) was established by S.B. 7, 83<sup>rd</sup> Legislature, Regular Session, 2013, to advise the Health and Human Services Commission (HHSC) on the development of policy recommendations that will ensure eligible recipients receive quality, person-centered, consumer-directed acute care services and long-term services and supports (LTSS) in an integrated setting under the STAR+PLUS Medicaid managed care program (STAR+PLUS). In coordination with HHSC, the Council is required to submit to the Executive Commissioner this annual report containing:

- An analysis and assessment of the quality of acute care and LTSS provided under STAR+PLUS;
- Recommendations regarding how to improve the quality of acute care and LTSS provided under the program; and
- Recommendations regarding how to ensure that recipients eligible to receive services and supports under the program receive person-centered, consumer-directed care in the most integrated setting achievable.

STAR+PLUS is a Medicaid managed care program which integrates the delivery of acute care and LTSS for those 65 and over and those with disabilities. STAR+PLUS enrollment is mandatory for most adults receiving Supplemental Security Income (SSI) and non-SSI adults who qualify for the Home and Community Based Services (HCBS) STAR+PLUS Waiver. The program is voluntary for children and young adults under age 21 who receive SSI and SSI-related Medicaid.

The recommendations contained in this report were developed by members of the council in consultation with HHSC. They include recommendations for improvements in the following areas:

- Quality of Long-term Care,
- Service Coordination,
- Network Adequacy and Service Availability.

The council will meet quarterly until January 1, 2017.

## STAR+PLUS Quality Council Annual Report

### Introduction

#### The STAR+PLUS Quality Council

S.B. 7, 83rd Texas Legislature, Regular Session, 2013, established the STAR+PLUS Quality Council to advise the Texas Health and Human Services Commission (HHSC) on the development of policy recommendations that will ensure eligible recipients receive quality, person-centered, consumer-directed acute care services and long-term services and supports (LTSS) in an integrated setting under the STAR+PLUS Medicaid managed care program. Council membership includes STAR+PLUS program recipients and representatives of health and human services agencies, advocacy groups, service providers for individuals with disabilities, and health maintenance organizations. The members, who are appointed by the executive commissioner, meet quarterly and serve for the term of the council. Current membership includes:

Linda Lawson, El Paso, Sierra  
Providence Health Network, Chair

Mary Klentzman, Plano, parent

Cindy Adams, Austin, Superior Health  
Plan

Mark Lenhard, Dallas, Grace  
Presbyterian Village of Presbyterian  
Communities and Services

Bennett Brier, Austin, family member

David McMillan, Austin, STL Medical  
Supply

Catherine Robles Cranston, Austin,  
ADAPT of Texas/Personal Attendant  
Coalition of Texas

Susan Prior, Austin, Texas Parent to  
Parent

Salil Deshpande, Houston, United  
Healthcare Community Plan of Texas

Jessica Ramos, Austin, Texas Council  
for Developmental Disabilities

Karen Rose Dunaway, Austin, Girling  
Health Care

Vanessa Sandoval, Harlingen, Texas  
Visiting Nurse Service

Laurie Greenberg, San Antonio, Molina  
Healthcare

Jonathan Scepaniski, Edinburg, Apex  
Primary Care, Inc.

Bob Kafka, Austin, ADAPT of Texas

Debra Wiederhold, Pflugerville, Texas  
Parent to Parent

In coordination with HHSC, the council is required to submit to the Executive Commissioner an annual report containing:

- An analysis and assessment of the quality of acute care services and LTSS provided under the STAR+PLUS Medicaid managed care program;
- Recommendations regarding how to improve the quality of acute care services and LTSS provided under the program; and
- Recommendations regarding how to ensure that recipients eligible to receive services and supports under the program receive person-centered, consumer-directed care in the most integrated setting achievable.

HHSC, in consultation with the council, is also required to report to the legislature, every even numbered year, the assessments and recommendations contained in the annual report to the executive commissioner.

## **Background**

### **STAR+PLUS**

STAR+PLUS is the state's program for integrating the delivery of acute care and LTSS through a managed care system. STAR+PLUS enrollment is mandatory for most adults receiving SSI and non-SSI adults who qualify for the HCBS STAR+PLUS Waiver. The program is available statewide as of September 1, 2014. Acute care, pharmacy, and LTSS are coordinated and provided through a provider network contracted with managed care organizations (MCOs). Children and young adults under age 21 who receive SSI and SSI-related Medicaid may voluntarily enroll in STAR+PLUS. STAR+PLUS has two components; the first integrates acute care and LTSS for those with disabilities or 65 and over who do not meet a nursing facility level of care. The two LTSS services available for this population are attendant care and day activity and health services. The second component is the HCBS STAR+PLUS waiver which includes everything from the first component, but also includes additional LTSS services such as minor home modifications, nursing services, and home delivered meals for those who meet a nursing facility level of care and who are receiving home and community based services as an alternative to nursing home care.

Beginning September 1, 2014, STAR+PLUS will expand to the Medicaid Rural Service Area, becoming a statewide program. Adults, except those also receiving Medicare Part B, receiving services through a 1915(c) waiver for individuals with intellectual and developmental disabilities (IDD) and individuals in a community-based intermediate care facility for individuals with intellectual disabilities or a related condition will be required to enroll in STAR+PLUS for their acute care services only. The 1915(c) IDD waivers include Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services (HCS), and Texas Home Living (TxHmL). STAR+PLUS enrollment will be voluntary for acute care services for those under the age of 21 receiving

services from one of the above listed 1915(c) waivers. As of March 1, 2015, most adult residents of nursing facilities who receive Medicaid, including individuals who are dually eligible for Medicaid and Medicare, also will be mandatorily enrolled into STAR+PLUS.

### **Quality of Care in STAR+PLUS**

The external quality review organization (EQRO) for Texas conducts regular assessments of the STAR+PLUS program using various data collection approaches and including multiple aspects of quality of care. Calendar year 2012 data indicate some positive findings in the areas of behavioral health and preventative care as well as several areas for improvement. The STAR+PLUS program showed high rates of preventative care use among members over age 45 (86 percent), with lower rates for younger members (71 percent). The EQRO also found a significant increase in the percent of members whose body mass index was tracked, an indication of quality of care. However, in the area of care for chronic conditions, the EQRO found that the use of appropriate asthma medication had declined and measures of comprehensive diabetes care fell well below HHSC dashboard standards. Rates of follow-up for hospitalization as a result of mental illness also fell below HHSC standards and rates of potentially preventable emergency department visits were high. The percentage of members with good access to special therapies also decreased. Surveys of the STAR+PLUS membership showed low satisfaction with access to necessary specialist care, access to special therapies, and time spent waiting to be taken to the exam room. However, members expressed higher levels of satisfaction on measures of timeliness, provider communication, and access to service coordination. Further data regarding STAR+PLUS program performance on a variety of quality of care indicators in calendar years 2011 and 2012 can be found in Appendix I.

HHSC is currently in the process of developing LTSS-centered performance measures for the STAR+PLUS program. These efforts include working with internal and external stakeholders to develop a set of measures for home and community-based services as well as creating measures to collect information on MCO performance related to the carve-in of nursing facility services. Data collection for both sets of measures is expected to begin in 2015.

### **Council Recommendations**

The council held its first meeting on January 14, 2014. During subsequent meetings, information on the STAR+PLUS program was presented to the council, including basic information about the structure of the program, descriptions of the various quality initiatives underway and planned for the future, and outcomes of the most recent analyses performed by the EQRO. The recommendations described in this report were made by the members after receiving this information and lengthy discussion of the current state of the STAR+PLUS program. Recommendations are made in three areas:

- Improving Quality of Long-Term Care;
- Service Coordination; and
- Network Adequacy and Service Availability.

#### **Improving Quality of Long-Term Care**

**Recommendation 1: HHSC should collect data on the number of STAR+PLUS consumers living outside the nursing facility during the current measurement year as a percentage of the STAR+PLUS consumers who lived outside the nursing facility during the previous year.**

This measurement would highlight MCO efforts to enable members to remain in a community-based residential setting. An eligible member meeting the nursing facility level of care will require sufficient support to remain in the community. The rate at which an MCO's members are remaining in the community rather than moving to a nursing facility may imply that the MCO is providing an appropriate level of support. Conversely, an MCO with a significant number of members moving to a nursing facility from the community may imply that the MCO needs to provide a higher level of community support. It is the opinion of the council that STAR+PLUS should strive to decrease the percentage of members living in nursing facilities and, in turn, increase the percentage of members living in the community.

**Recommendation 2: HHSC should clarify and strengthen MCO responsibilities, including coordination with providers, to ensure LTSS services are properly delivered by provider organization.**

MCOs contract with provider agencies to provide LTSS services, such as personal assistance services (PAS). The council has concerns that MCO service coordinators do not provide sufficient communication with these providers to ensure that appropriate and adequate care is provided to members. The council recommends the MCO service coordinator be provided with the tools to ensure services are delivered consistent with the LTSS care plan and in compliance with all delivery requirements.

The council also recommends that MCO service coordinators be empowered to work with the provider to address service delivery inadequacies and serve as a member advocate for improved service delivery when necessary.

**Recommendation 3: HHSC should collect data on the number of members responding "yes" to the Minimum Data Set, Question Q0500 ("Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?") who ultimately transition to the community.**

The Minimum Data Set (MDS) is part of a federally mandated process for assessment of all residents in Medicare and Medicaid nursing homes. Information from the MDS is maintained by the Centers for Medicare & Medicaid Services (CMS).<sup>1</sup> Question 0500 asks the resident if he or she would prefer to live in the community. This measure would assess the degree to which members who would prefer to live in the community, are transitioned out of nursing facilities, which could be used as an indicator of nursing facility performance.

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<sup>1</sup> "Minimum Data Set (MDS) - Version 3.0. Resident Assessment and Care Screening. Nursing Home Comprehensive (NC) Item Set". Center for Medicaid and Medicare Services. Last modified May 8, 2014, <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html>.

**Recommendation 4: HHSC should develop a program to better serve STAR+PLUS members with ventilators.**

There are approximately 150 individuals in nursing facilities that use ventilators. Some of these members would be enrolled in STAR+PLUS if they were able to move to the community.

STAR+PLUS needs to develop better home and community-based services to facilitate this relocation if it is the wish of the individual. Improved care coordination may allow for these transitions. The ability to make these improvements may be augmented as a result of the March 2015 carve-in of nursing facility services to the STAR+PLUS managed care program.

**Recommendation 5: HHSC should create policy that, if agreed upon by the member, STAR+PLUS members with a documented Body Mass Index (BMI) of 30 and above will be provided with a care plan intended to gradually lower the member's BMI to below 30.**

According to the 2012 report Summary of Activities and Trends in Healthcare Quality, almost 50 percent of STAR+PLUS members were determined to be obese. This figure is based on self-reported heights and weights of members, using the CDC-recognized definition classifying obese as having a BMI of 30 and above. Complications of obesity include diabetes, high blood pressure, high cholesterol, heart disease and stroke, cancer, gallbladder disease and fatty liver disease, osteoarthritis, erectile dysfunction, skin and wound healing problems, and shortened lifespan. Reducing the body mass index of obese members has the potential to lower their risk for health complications and, as a result, may decrease healthcare costs for the state.

To implement this recommendation, the primary care provider would be responsible for checking the member's BMI, documenting it, and then transmitting the information to the MCO so the service coordinator can work with the member and approve evidence-based, non-medical approaches to weight loss. The HEDIS measure Adult BMI Assessment (ABA) will be used as a measure of effectiveness of this initiative. An incentive plan will be developed by HHSC to encourage MCOs to reach prescribed goals related to this measure.

### **Service Coordination**

**Recommendation 1: The MCO service coordinator must provide, to members who are eligible for both Medicare and Medicaid (dually eligible), materials and training regarding benefits they are eligible to receive through either program.**

Some providers, members, and their representatives are uncertain how services should be coordinated for members who are dually eligible. As a result, some of these members have received insufficient support from MCO service coordinators in this area. According to the STAR+PLUS Handbook, members who are dually eligible receive acute care services from Medicare providers and LTSS from Medicaid providers.<sup>2</sup> As the outcomes for each of these services types impact the other, coordination of these services is critical.

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<sup>2</sup> <http://www.dads.state.tx.us/handbooks/sph/3000/3000.htm#sec3111>

The MCO service coordinator should have a thorough knowledge of how to coordinate Medicaid and Medicare services for members who are dually eligible, including requirements regarding denials. How these services should be coordinated should be detailed in comprehensive, concise, and uniform materials developed jointly by members, advocates, MCOs, providers, and HHSC staff.

**Recommendation 2: HHSC must ensure all members receiving LTSS and their representatives have the simplest, most expeditious access to all medically-necessary/level of care (MN/LOC) data and assessments used by MCO and the provider agency to develop LTSS care plans.**

Care plans are developed by the MCO based on an assessment of the member's needs. While the MCO is required to obtain member input in the development of the member's care plan, the council is concerned that member input is not always incorporated in the care plan. The Council believes the member and his or her representative should have access to the assessment and information used to create the care plans, and that all information should be provided to the member and the member's representative to the extent allowed by state and federal laws.

**Recommendation 3: With member approval, the MCO service coordinator should invite all interested parties to participate in annual care plan meetings, including the LTSS providers. Additionally, the council recommends the annual assessment include a meeting with interested parties as identified by the member. Participation in this meeting must be a billable service for the LTSS provider.**

During the meeting, the team must ensure that LTSS services are understood and agreed upon by the member, approved by the team, past service delivery reviewed with the care plan updated as necessary, and any other outstanding issues are addressed. Currently, MCO service coordinators develop care plans and arrange associated services with multiple providers. The council is concerned that LTSS providers and MCO service coordinators do not always have common understanding of a member's care plan or service delivery expectations because LTSS providers are not involved in the development of these plans. Furthermore, members and their representatives do not always know what information each of these entities have access to, making self-advocacy difficult.

**Recommendation 4: Due to the specific, complex, and rapidly changing nature of durable medical equipment (DME) and supplies available to individuals with disabilities, a person with expertise in DME and supplies should be added to the MCO service coordination team's required membership.**

Currently the service coordination team members must have expertise or access to expertise within the MCO to subject matter experts in: behavioral health, substance abuse, local resources, pediatrics, LTSS, end of life/advanced acute care, preventive care, cultural competency, pharmacology, nutrition, Texas Promoting Independence strategies, consumer-directed service options, and person-directed planning<sup>3</sup>. Expertise in DME and supplies should be added to this list. Ill-fitting and improperly selected DME and supplies can cause a variety of respiratory,

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<sup>3</sup> <http://www.hhsc.state.tx.us/news/meetings/2014/starplus/5.pdf>

musculoskeletal, digestive, and skin problems for recipients. These problems are costly to the member, caregivers, and the state due to the resulting hospitalizations, surgeries, nursing needs, and physician and therapy appointments. Having a person with expertise in DME and supplies on the MCO service coordination team will help to avoid the deleterious effects of inappropriate products. Additionally, many MCOs are unaware of the laws specific to DME. Having a team member with expertise in this area will help an MCO avoid inadvertently breaking these laws.

**Recommendation 5: Any time a member's service coordinator changes, the member must be notified by the MCO within five business days using a communication method accessible to the member. This information should also be placed on the portal.**

Service coordinators are employed by the MCO and make home visits and telephonic visits and assess member needs. They coordinate with providers, authorize community based LTSS, coordinate community supports, and arrange for other services. They are the link between the member and the MCO and are critical in resolving problems with service delivery<sup>4</sup>. MCOs are currently required to notify a member of a service coordinator change within 15 days. However, the council is aware that STAR+PLUS members are sometimes unaware of a change in service coordinators, creating issues with communication and potentially delaying resolution of problems experienced by the member. The council recommends this requirement be changed in the Texas Administrative Code and the Uniform Managed Care Contract (UMCC).

**Recommendation 6: The MCO should develop a process by which the MCO and provider can communicate, in real-time, the status of the member's current needs.**

Currently, providers must wait to see a paper version of the service plan in order to know the specific tasks which have been authorized for the member. Many times, this may not occur until three to five days after services were to be initiated. Providers also are unable to see the assessment done by the nurse. The MCO portal should allow the provider to view assessments, notes, dates of previous and upcoming visits and contacts, level as appropriate for members, including immediate notification of changes to the care plan to the appropriate provider. Additionally, the provider should have the ability to make notes and comments in the portal.

Providers should be part of the service plan development process. The provider's staff has a relationship with the member and others who are involved in providing services to the member. Including providers in the process would allow them to provide helpful information to the service coordination team.

**Recommendation 7: When a member asks to transfer providers, the losing agency should be notified by the MCO five business days prior to the date the transfer is effective.**

Currently members may request a change in provider by telephone with basic information.. The council is aware of anecdotal evidence of attendants and other providers requesting changes in provider on behalf of the member without the knowledge of the member. Even in the case of legitimate requests for provider transfers, the "losing" agency may not be notified until the day the transfer occurs, preventing the provider from obtaining helpful information from the member.

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<sup>4</sup> <http://www.hhsc.state.tx.us/news/meetings/2014/starplus/5.pdf>

Requiring timely MCO notification would keep all parties informed and allow for improved communication to better serve the member and identify any fraud, abuse, or exploitation.

### **Network Adequacy and Service Availability**

**Recommendation 1: HHSC should ensure materials provided to members and representatives by the MCO describe uniformly, comprehensively, and concisely all LTSS services available to members, including information on the consumer directed services delivery option.**

Some STAR+PLUS members and their representatives have found member benefit reference materials inaccessible, insufficient, or overly technical. MCO staff will refer members to Internet links for information that can be difficult to understand because it is written for state employees, regulators, and providers, not for members. Other materials are vague, incomplete, or not appropriate for the services requested by the member.

Members and their families, MCOs, and HHSC staff should jointly develop uniform material to be shared with program applicants and existing members. Once a member is enrolled in the STAR+PLUS program, one of MCO's first actions should be to educate the member and his or her family to ensure the member has a broad understanding of the program as it relates to the member's needs.

**Recommendation 2: HHSC should recommend to the legislature that they authorize legislation to maintain the home telemonitoring benefit.**

S.B. 293 (82<sup>nd</sup> regular session) created a home telemonitoring service as an efficient and inexpensive way to collect more frequent data on the health status of a member while at home. The legislation defines home telemonitoring service as a health service that requires scheduled remote monitoring of data related to a patient's health and transmission of the data to a licensed home health agency or a hospital. These data can be used to improve service delivery and gather quality measurement statistics, creating the potential for improved quality of care. However, the legislation authorizing reimbursement for home telemonitoring is scheduled to expire in 2015. The council recommends the legislature reenact this legislation in order to maintain the benefit.

**Recommendation 3: HHSC should include home and community-based services workforce needs as a separate category under the LTSS performance measures for STAR+PLUS. Some indicators within the performance measures should include:**

- **network adequacy assessment of direct service workers in the community, and**
- **workforce demographic information.**

The state began looking at home and community based-services workforce issues starting in 2006. In 2009 the Home and Community-based Services Workforce Advisory Council was established, producing a report concerning workforce issues.<sup>5</sup> More recently, home and

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<sup>5</sup> <http://www.hhsc.state.tx.us/reports/2010/Workforce-Report-1110.pdf>

community based-services workforce issues were included in the scope of the Promoting Independence Advisory Committee's sub-committee on workforce issues.

Currently, HHSC is exploring the development of MCO reporting requirements related to the home and community-based services workforce to include in the Uniform Managed Care Manual. This data will provide information about the home and community-based services workforce, and help identify and set long term priorities for long term care reform and systems change. LTSS services cannot be delivered effectively without an adequate home and community-based services workforce. As more LTSS and acute services are carved in to managed care, the number of individuals needing home and community-based services will increase. Permanent LTSS performance measures tracking data on the home and community-based services workforce will help ensure that MCOs and home care agencies are able to meet the needs of the STAR+PLUS system. Some indicators that could be used include an assessment of the network adequacy of direct service workers in the community and the collection of workforce demographic information. Appropriations should be made to allow HHSC to update its information technology infrastructure to collect this data.

It is also recommended that HHSC revise the Uniform Managed Care Contract (UMCC) to encourage MCOs to contract only with home care agencies that include recruitment and retention as a priority.

## **Conclusion**

S.B. 7 requires the council to coordinate with HHSC to develop an annual report that includes an analysis and assessment of STAR+PLUS quality of care, and recommendations regarding how to improve this quality of care. The council must also use the report to make recommendations regarding how to ensure STAR+PLUS members receive person-centered, consumer-directed care in the most integrated setting. The recommendations above address concerns in the areas of long-term services and supports, network adequacy and service availability, and service coordination. It is the intent of the council that these recommendations be considered for implementation.

**Appendix I  
STAR+PLUS Quality of Care Indicators**

Indicator	STAR+PLUS	
	CY 2011	CY 2012 <sup>6</sup>
<b>I. POTENTIALLY PREVENTABLE EVENTS</b>		
Percent of Emergency Department Procedures that were Potentially Preventable (PPVs)	N/A	56.64%
Percent of Candidate Inpatient Admissions that had a Potentially Preventable Readmission within 30 Days (PPRs)	N/A	14.33%
Percent of Eligible Inpatient Admissions that were Potentially Preventable (PPAs)	N/A	Pending
<b>II. Access to Care</b>		
Adults' Access to Preventive/Ambulatory Health Services (AAP)- All ages	81%	80%
Ambulatory Care (AMB)- Outpatient visits, all ages, Visits per 1,000	565	553
Ambulatory Care (AMB)- ED visits, all ages, Visits per 1,000	114	111
<b>III. QUALITY OF CARE</b>		
<b>Member Satisfaction - Adult<sup>7</sup></b>		
% good access to urgent care	76%	77%
% good access to specialist referral	64%	61%
% good access to routine care	73%	73%
% no delays for an approval	39%	38%
% no exam room wait >15 minutes	28%	28%
% good access to special therapies	54%	52%
% STAR+PLUS members with good access to Service Coordination	69%	67%
% of good access to behavioral health treatment or counseling	N/A	59%

<sup>6</sup> In March 2012, the STAR+PLUS program expanded into the El Paso, Hidalgo, and Lubbock service areas. In addition, prior to February 1, 2012, United Healthcare did not operate in the Jefferson service area. As many of the quality measures require at least one full year of data, these MCOs and service areas are not represented in all results.

<sup>7</sup> Adult member satisfaction data is based on the state fiscal year (9/1/2010 through 8/31/2011)

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Indicator	STAR+PLUS	
	CY 2011	CY 2012 <sup>6</sup>
Percent increase in STAR+PLUS members receiving personal attendant and/or respite services through the Consumer Directed Services delivery model.	3% (PAS only)	4% <sup>8</sup> (PAS only)
<b>Children's Preventive Health</b>		
Well Child Visits in the First 15 Months of Life (W15)	N/A	LD
Well-Child Visits – 3rd, 4th, 5th, and 6th Years (W34)	70%*	71%
Adolescent Well Care Visits (AWC)	48%*	45%
<b>Women's Preventive Health</b>		
Cervical Cancer Screening (CCS)	40%	44%
Prenatal Care (PPC)	68%*	63%
Postpartum Care (PPC)	38%	36%
Breast Cancer Screening (BCS)	46%	46%
<b>Prevention and Screening</b>		
Adult BMI Assessment (ABA)- Hybrid	57%	65%
<b>AHRQ Prevention Quality Indicators [PQI] (Adults ≥ 18 yrs.) - inpatient admissions per 100,000 members</b>		
Diabetes Short-Term Complications	320	399
Diabetes Long-Term Complications	602	634
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	1820	1853
Hypertension	206	240
Congestive Heart Failure	1020	996
Low Birth Weight (per 100 live births)	Low Denominator	Low Denominator
Dehydration	206	225

<sup>8</sup> This does not include the March 2012 expansion areas.

Indicator	STAR+PLUS	
	CY 2011	CY 2012 <sup>6</sup>
Bacterial Pneumonia	622	688
Urinary Tract Infection	428	561
Angina w/o Procedure	32	35
Uncontrolled Diabetes	97	95
Asthma in Younger Adults	233	244
Lower Extremity Amputation due to Uncontrolled Diabetes	49	54
Perforated Appendix (per 100 admissions for appendicitis)	32	30
<b>IV. CARE FOR CHRONIC ILLNESS</b>		
<b>Asthma</b>		
Asthma Medication Ratio (AMR)- Total Population Ratio >= 50%	N/A	53%
Use of Appropriate Medication for People with Asthma (all ages) (ASM)	80%	76%
Medication Management for People with Asthma - Medication Compliance 75% (MMA)	N/A	43%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	20%	20%
<b>Behavioral Health<sup>9</sup></b>		
7-day f/u After Hosp. for Mental Health (MH) (FUH)	36%*	31%
30-day f/u After Hosp. for Mental Health (FUH)	59%*	54%
Mental Health Readmission- 30 day readmission rate (19 yrs. and older)	25%	N/A
Antidepressant Medication Management - Acute Phase (AMM)	53%	60%
Antidepressant Medication Management - Continuation Phase (AMM)	36%	47%
Identification of Alcohol and Other Drug Services (IAD)- All ages, any service	12%	14%
Initiation of Alcohol and Other Drug Dependence Treatment (IET)- all ages	35%	33%

<sup>9</sup> North STAR data is included and is reflected in the Dallas SA rates for measures that capture mental health access and utilization. Dallas service area is excluded from MCO level rates for these measures.

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Indicator	STAR+PLUS	
	CY 2011	CY 2012 <sup>6</sup>
Engagement of Alcohol and Other Drug Dependence Treatment (IET)- all ages	6%	5%
Mental Health Utilization (MPT)- any service, all ages	33%	32%
<b>Cholesterol Management</b>		
LDL-Screening (CMC)	N/A	80%
<b>Diabetes (Adults ≥ 18 yrs.)</b>		
HbA1c Tested (CDC) **	78% (admin)	81% (hybrid)
HbA1c Control < 8% (CDC)- Hybrid	26%	28%
Diabetic Eye Exam (CDC)	37%	34%
LDL-C Screened (CDC)	76% (admin)	80% (hybrid)
LDL-C Controlled (CDC)- Hybrid, LDL less than 100	26%	29%
Medical Attention for Nephropathy (CDC)	81%	80%
<b>High Blood Pressure</b>		
High Blood Pressure Controlled (CBP)- Hybrid	40%	46%
Inpatient Utilization - General Hospital/Acute Care (IPU13)- all ages, all reasons	123 days/1,000 member months	128 days/1,000 member months

## Appendix II Acronyms Used in this Report

<b>Acronym</b>	<b>Description</b>
ABA	HEDIS measure Adult Body Mass Index Assessment performance measure
BMI	Body Mass Index
Council	STAR+PLUS Quality Council
DME	durable medical equipment
EQRO	external quality review organization
HCBS	home and community based services
HHSC	Texas Health and Human Services Commission
IDD	intellectual and developmental disabilities
LTSS	long-term services and supports
MCO	managed care organization
MDS	Minimum Data Set
PAS	personal assistance services
SSI	Supplemental Security Income
UMCC	Uniform Managed Care Contract