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I. INTRODUCTION
   A. Background

   In response to rising health care costs and national interest in cost effective ways to provide quality health care, the Texas Legislature in 1991 directed the state to establish Medicaid managed care pilot programs in Travis County and the Gulf Coast area. These pilots were initially known as the LoneSTAR (State of Texas Access Reform) Health Initiative. Later shortened to STAR, it is the primary managed care program serving low-income families, non-disabled children, and pregnant women in Texas. In 1995, Texas lawmakers authorized the Health and Human Services Commission (HHSC) to seek an 1115 waiver to fundamentally restructure Medicaid service delivery and funding in Texas. At that time the STAR Program was expanded to include certain blind and disabled Medicaid clients (SSI/SSI-related) on a voluntary basis when the expansion occurred.

   As Texas gained more experience with managed care, the state implemented STAR+PLUS in 1998. The program began as a pilot project in Harris County to integrate acute and long-term services and supports for clients who are age 65 and older or have disabilities. The goal was to address the complex needs of these populations in a more coordinated, comprehensive manner, thus resulting in both increased quality of care and decreased Medicaid costs. A year later in 1999, the state implemented a mental health and substance abuse program called NorthSTAR in the Dallas service area that integrates funding and delivery of services to Medicaid and indigent clients, providing a continuum of care across public funding sources.

   In 2005, the Texas Legislature directed HHSC and the Department of Family and Protective Services (DFPS) to develop a statewide health care delivery model for children in foster care. This program, known as STAR Health, became operational in 2008 and was designed to provide comprehensive, cost-effective medical services to meet the physical and behavioral health needs of the Texas foster care and kinship population.

   B. Texas Health Care Transformation and Quality Improvement Program

   The Texas Legislature, through the 2012-2013 General Appropriations Act and Senate Bill 7, instructed HHSC to expand its use of risk-based Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The State of Texas submitted a section 1115 Demonstration proposal to CMS in July 2011 to expand managed care statewide consistent with the existing STAR section 1915(b) and STAR+PLUS section 1915(b)/(c) waiver programs, and thereby replace existing Primary Care Case Management (PCCM) or fee-for-service (FFS) delivery systems. The State sought a section 1115 Demonstration as the vehicle to both expand the managed care delivery system and to operate a funding pool, supported by managed care savings and diverted supplemental payments, to reimburse providers for uncompensated care costs and to provide incentive payments to participating hospitals that implement and operate delivery system reforms.

   The 1115 Demonstration sought managed care organizations (MCOs) to operate the STAR and STAR+PLUS in service areas throughout the state (the “joint procurement”). The joint procurement did not include the STAR+PLUS Dallas and Tarrant service areas or the CHIP rural service area. These areas operate under separate agreements with MCOs. The joint procurement included two major changes to Medicaid managed care. First, it expanded STAR to all service areas in the State, and STAR+PLUS to all areas except the Medicaid Rural Service Area (MRSA). The joint procurement also carved outpatient pharmacy benefits into managed care. HHSC awarded a total of 21 contracts to Medicaid MCOs with a September 1, 2011 effective date.
and March 1, 2012 operational start date. For consistency across service areas, the State also amended its MCO agreements for the STAR+PLUS Dallas and Tarrant service areas to include outpatient pharmacy benefits, also effective March 1, 2012. Table 1 below lists the MCOs awarded STAR and STAR+PLUS managed care contracts by service area.

Table 1. MCOs by Service Area and Program

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<thead>
<tr>
<th>Service Area</th>
<th>STAR</th>
<th>STAR+PLUS</th>
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<tr>
<td>Bexar</td>
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<td>Amerigroup Texas</td>
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<td>Community Health Choice</td>
<td>UnitedHealthcare Community Plan</td>
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<td>Amerigroup Texas</td>
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<td>Cook Children’s Health Plan</td>
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HHSC also expanded managed care dental services to Medicaid beneficiaries under the age of 21. The goal was to provide quality, comprehensive dental services to eligible recipients in a manner that improves the oral health of members through preventative care and health education. HHSC awarded three statewide contracts to the following dental maintenance organizations (DMOs):

- Delta Dental Insurance Company
- DentaQuest USA Insurance Company, Inc.
- MCNA Insurance Company

The contracts have a September 1, 2011, effective date and March 1, 2012, operational start date. Although CHIP dental services were provided through managed care prior to March 1, 2012, the award marked the first time Medicaid dental services would be provided through a capitated model.

Through this Medicaid Demonstration, the State aims to:

- Expand risk-based managed care statewide.
- Support the development and maintenance of a coordinated care delivery system.
- Improve outcomes while containing cost growth.
- Protect and leverage financing to improve and prepare the health care infrastructure to serve a newly insured population.
- Transition to quality-based payment systems across managed care and hospitals.

C. Managed Care Program Goals and Objectives

HHSC’s mission is to create a customer-centered, innovative, and adaptable managed care system that provides the highest quality of care to clients while at the same time ensures access to services. HHSC seeks to accomplish its mission by contracting for measurable results that:

- Improve member access, satisfaction, and quality of care.
- Maximize program efficiency, effectiveness, and responsiveness.
- Limit operational costs.

**STAR and STAR+PLUS Program Objectives**

Under the terms of the STAR and STAR+PLUS managed care contracts, MCOs provide comprehensive health care services to qualified Medicaid recipients through a managed care delivery system. HHSC prioritizes desired outcomes and benefits for the managed care programs and focuses its monitoring efforts on the MCOs’ ability to provide satisfactory results in the following areas.

1. Network adequacy and access to care

All members must have timely access to quality of care through a network of providers designed to meet the needs of the population served. The MCO is held accountable for creating and maintaining a network capable of delivering all covered services to members. The MCO must provide members with access to qualified network providers within the travel distance and waiting time for appointment standards defined in the managed care contracts.

2. Quality
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HHSC is accountable to Texans for ensuring that all members receive quality services in the most efficient and effective manner possible. Accordingly, the MCO is responsible for providing high quality services in a professional and ethical manner. HHSC expects the MCO to implement new and creative approaches that ensure quality services, cost-effective service delivery, and careful stewardship of public resources.

3. Timeliness of claim payment
The MCO’s ability to ensure that network providers receive timely and fair payment for services rendered is a key component of their success in the STAR and STAR+PLUS programs. The MCO must have the ability to comply with HHSC’s claims adjudication requirements in a timely manner. Therefore, HHSC requires strict adherence to claims adjudication standards during the term of the Contract. HHSC also encourages MCOs to provide a no-cost alternative for providers to allow billing without the use of a clearinghouse and to include attendant care payments as part of the regular claims payment process.

4. Timeliness with which prenatal care is initiated
STAR Program data has revealed that 83% of pregnant women received prenatal care in the first trimester or within 42 days of enrollment. While this rate approximates the Medicaid managed care national average, HHSC believes that the high prevalence of births in the STAR population warrants efforts to improve timeliness of prenatal care initiation.

5. Behavioral health services
Members must have timely access to medically necessary behavioral health services, such as mental health counseling and treatment, as well as timely and appropriate follow-up care.

6. Delivery of health care to diverse populations
Member populations in Texas are as diverse as those of any state in the nation. Health care services must be delivered without regard to racial or ethnic factors. HHSC expects the MCO to implement intervention strategies to avoid disparities in the delivery of health care services to diverse populations and provide services in a culturally competent manner.

7. Disease management requirements
Each MCO must provide a comprehensive disease management program or coverage for Disease Management (DM) services for asthma, diabetes, and other chronic diseases identified by the MCO, based upon an evaluation of the prevalence of the diseases within the MCO’s membership.

8. Service Coordination
The integration of acute care services and community-based long-term services and supports is an essential feature of STAR+PLUS. A STAR+PLUS MCO must demonstrate that there are sufficient levels of qualified and competent personnel devoted to service coordination to meet the everyday needs of STAR+PLUS members, including dual eligible members.

9. Continuity of Care
HHSC expects that established member/provider relationships, existing treatment protocols, and ongoing care plans will not be impacted significantly when a client moves into managed care. Transition to the MCO must be as seamless as possible for members and their providers.

To achieve these goals, the State has established a number of public and private partnerships. First and foremost the State fosters both a contractual and collaborative relationship with its Medicaid MCOs. Statewide medical and hospital associations are strategic implementation partners as well. The State solicits input and advice from community-based organizations and regional advisory committees to further support and improve the State’s local efforts. Other
critical implementation partners include the State’s eligibility and enrollment contractor, the Texas Medicaid claims administrator contractor for fee-for-service claims, and stakeholder state agencies.

**Medicaid Dental Program Objectives**

HHSC contracts with dental managed care organizations to provide customer-centered and quality-driven dental services to Texas Medicaid recipients less than 21 years of age. HHSC’s objectives are to:

1. Provide quality, comprehensive dental services through qualified and accessible Texas dental providers.
2. Provide dental care in a manner that improves oral health of members through preventive care and health education initiatives and activities.
3. Provide intervention strategies to avoid disparities in the delivery of dental services to diverse populations, and to provide dental services in a culturally competent manner. Cultural competency means the ability of individuals and systems to provide services effectively to people of various cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of individuals and protects and preserves their dignity.
4. Provide Dental Program recipients with a choice of dental plans.

### D. Managed Care Program Management Strategy

HHSC’s fundamental commitment is to contract for results. HHSC defines a successful result as the generation of defined, measurable, and beneficial outcomes that satisfy the Contract requirements and support HHSC’s missions and objectives. The managed care contracts describe what is required of the MCO in terms of services, deliverables, performance measures, and outcomes, and unless otherwise noted, places the responsibility for how they are accomplished on the MCO.

HHSC has focused its performance measurement efforts by developing a Performance Indicator Dashboard, which is a series of measures that identify key aspects of performance to ensure the MCO’s accountability. The Performance Indicator Dashboard is not an all-inclusive set of performance measures; HHSC measures other aspects of the MCO’s performance as well. Rather, the Performance Indicator Dashboard assembles performance indicators that assess many of the most important dimensions of the MCO’s performance, and includes measures that, when publicly shared, will also serve to incentivize excellence.

In addition to the Dashboard, HHSC develops two overarching goals and negotiates a third goal suggested by the MCO each year for health care quality improvement. The MCO must identify and propose annual MCO Performance Improvement Projects (PIPs) related to these overarching goals. These projects are highly specified and measurable and reflect areas that present significant opportunities for performance improvement. Once finalized, the MCO is committed to making its best efforts to achieve the established goals.

HHSC also recognizes the importance of applying a variety of financial and non-financial incentives and disincentives for demonstrated MCO performance. It is HHSC’s objective to recognize and reward both excellence in performance and improvement in performance within existing state and federal financial constraints. It is likely that this approach will be modified over time based on several variables, including accumulated experience by HHSC and the MCO, changes in the status of state finances, and changes in each MCO’s performance levels.
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The incentives and disincentives are linked to some of the measures in the Performance Indicator Dashboard. The MCO’s performance relative to the annual PIPs may also be used by HHSC to identify and reward excellence and improvement by the MCO in subsequent years.

Finally, HHSC plans to improve methods for sharing information regarding the Texas Medicaid Program with all of the MCOs through HHSC-sponsored workgroups and other initiatives.

E. External Quality Review Organization

The Balanced Budget Act of 1997 requires State Medicaid agencies to provide for an annual external independent review of the quality outcomes, timeliness of, and access to services provided by Medicaid managed care organizations.

To ensure HHSC meets CMS requirements for quality in managed care and to provide HHSC with analysis and information to effectively manage its Medicaid Managed Care Program, HHSC contracts with the Institute for Child Health Policy (ICHP) at the University of Florida as the External Quality Review Organization (EQRO).

The Centers for Medicare and Medicaid Services (CMS) requires the EQRO to perform the following three functions:

- Validation of performance improvement projects.
- Validation of performance measures.
- A review to determine MCO compliance with certain federal Medicaid managed care regulations.

In Texas, the EQRO also performs the following:

- Focused quality of care studies.
- Encounter data validation.
- Assessment or validation of member satisfaction.
- Provides assistance with rate setting activities.

In collaboration with the EQRO, HHSC evaluates, assesses, monitors, guides, and directs the Medicaid managed care programs and organizations for the State.

II. ASSESSMENT

A. Quality and Appropriateness of Care and Services

The MCO must provide for the delivery of quality care with the primary goal of improving the health status of members or, where the member’s condition is not amenable to improvement, maintain the member’s current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The MCO must work in collaboration with providers to actively improve the quality of care provided to members, consistent with the Quality Assessment and Performance Improvement (QAPI) Program and all other requirements of the Contract. The MCO must also provide mechanisms for members and providers to offer input into the MCO’s quality improvement activities.

To help HHSC monitor performance, the MCO must provide all information necessary to analyze the MCO’s provision of quality care to members using measures determined by HHSC in consultation with the MCO and the EQRO. Such measures must be consistent with Health Plan Employer Data Information System (HEDIS) or other externally based, reliable and valid measures or measurement sets that involve collection of information beyond that present in enrollment and encounter data.
Race/Ethnicity, and Primary Language

The State obtains race, ethnicity, and primary language from the enrollment form completed by the recipient. Applications are processed through the Texas Integrated Eligibility Redesign System (TIERS) and routed to a third-party enrollment broker. The enrollment broker transmits a file containing the race/ethnicity and primary language of each enrollee to the MCOs monthly.

The EQRO provides additional support by identifying enrollee composition by MCO and by program and assesses MCO risk groups using the encounter data.

HHSC Overarching Goals and Performance Improvement Projects

Based on Medicaid managed care members’ outcomes and quality of care performance results, calculated using data from member surveys, and enrollment, eligibility, claims, and encounter files, HHSC establishes two overarching goals and negotiates a third goal suggested by the MCO. These goals enable the MCOs to target specific areas for improvement that will impact the greatest numbers of enrollees. The 2012 overarching goals established by HHSC for STAR are:

- Improve treatment for ambulatory care sensitive conditions (ACSCs) through reduction of emergency department visits.
- Improve access to specialty care.

For STAR+PLUS, they are:

- Improve member understanding and utilization of service coordination.
- Reduce Nursing Facility admission rates.

The MCO must identify and propose annual Performance Improvement Projects (PIPs) related to the overarching goals. The MCO is required to provide three PIPs per MCO Program; at least one PIP must be related to an overarching goal established by HHSC. When conducting PIPs, MCOs are required to follow the ten-step CMS protocol.

HHSC will work with the DMOs to establish overarching goals and Performance Improvement Projects for Children’s Medicaid Dental Services in 2013.

Performance Indicator Dashboards for Quality Measures

HHSC tracks other key aspects of MCO and DMO performance through the use of Performance Indicator Dashboards for Quality Measures (see Uniform Managed Care Manual, Chapter 10.1.7, and Uniform Managed Care Manual, Chapter 10.1.10 for a complete list of MCO quality performance indicators for STAR, STAR+PLUS, and Medicaid Dental Services). HHSC updates the Performance Indicator Dashboard for Quality Measures annually based on MCO submissions, data from the EQRO, and other data available to HHSC.

Quality Assessment and Performance Improvement (QAPI)

Each MCO must develop, maintain, and operate a Quality Assessment and Performance Improvement (QAPI) Program that meets state and federal requirements. The MCO must approach all clinical and non-clinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement (CQI)/Total Quality Management (TQM) and must:

- Evaluate performance using objective quality indicators.
- Foster data-driven decision-making.
- Recognize that opportunities for improvement are unlimited.
- Solicit member and provider input on performance and QAPI activities.
- Support continuous ongoing measurement of clinical and non-clinical effectiveness and member satisfaction.
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- Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements.
- Support re-measurement of effectiveness and member satisfaction, and continued development and implementation of improvement interventions as appropriate.

Clinical Practice Guidelines

The MCO must adopt not less than two evidence-based clinical practice guidelines for each applicable MCO Program. Such practice guidelines must be based on valid and reliable clinical evidence, consider the needs of the MCO’s members, be adopted in consultation with network providers, and be reviewed and updated periodically, as appropriate. The MCO must develop practice guidelines based on enrollees’ health needs and opportunities for improvement identified as part of the QAPI Program.

Encounter Data

MCOs are required to submit complete and accurate encounter data for all covered services, including value-added services, at least monthly to a data warehouse for reporting purposes. The data file must include all encounter data and encounter data adjustments processed by the MCO no later than the 30th calendar day after the last day of the month in which the claim was adjudicated. The Texas Medicaid claims administrator contractor developed and maintains the data warehouse and is responsible for collecting, editing, and storing MCO encounter data.

HHSC contracts with the EQRO to certify the accuracy and completeness of MCO encounter data. The data certification reports support rate setting activities and provide information relating to the quality, completeness, and accuracy of the MCO encounter data. Certification reports include a quality assessment analysis to assure data quality within agreed standards for accuracy, a summary of amounts paid by service type and month of service, and a comparison of paid amounts reported in the encounter data to financial statistical reports (FSRs) provided by the MCOs.

Evidence-Based Care and Quality Measurement

The EQRO develops studies, surveys, or other analytical approaches to assess enrollee’s quality and outcomes of care and to identify opportunities for MCO improvement. To facilitate this process, HHSC ensures that the EQRO has access to enrollment, health care claims and encounter, and pharmacy data. HHSC also ensures access to immunization registry data. The MCOs collaborate with the EQRO to ensure medical records are available for focused clinical reviews.

Among its many duties, ICHP produces an annual Quality of Care Report for each of the Medicaid managed care programs in Texas. These reports can be found at [www.hhsc.state.tx.us/about_hhsc/reports/search/search_dateorder.asp](http://www.hhsc.state.tx.us/about_hhsc/reports/search/search_dateorder.asp).

The annual reports provide results of the quality of care for each managed care organization using:

- Selected Healthcare Effectiveness Data and Information Set (HEDIS) measures.
- Rates of inpatient and emergency department services for ambulatory care sensitive conditions.
- The Agency for Healthcare Research and Quality Pediatric Indicators (PDIs) and Prevention Quality Indicators (PQIs).
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey which is designed for adult enrollees and parents of child enrollees to report on and evaluate their experiences with health care and addresses important domains of care such as access, timeliness, doctor communication, and MCO interactions.
ICHP also works with HHSC and the MCOs to annually measure selected HEDIS measures that require chart reviews. In calendar year (CY) 2012, the selected measures are:

1. Controlling High Blood Pressure (CBP)
2. Comprehensive Diabetes Care (CDC) – poor HbA1c control, LDL controlled
3. Adult BMI Assessment (ABA)
4. Childhood Immunization Status (CIS) – Combo 4
5. Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

The results allow comparison of findings across managed care organizations in each program. Results are also used in the development and review of performance improvement projects and benchmarks for the HHSC MCO Quality Performance Indicators.

In the next two years, HHSC and the EQRO also plan to evaluate the quality of home-based long-term care services that are provided through Medicaid managed care, including establishing benchmarks, conducting member surveys, and using focused studies to compare MCOs and service areas to identify opportunities for improvement in the provision of long-term services and supports.

B. Level of MCO Contract Compliance

1. MCO Contractual Requirements

Access to Care

The MCO is responsible for authorizing, arranging, coordinating, and providing covered services in accordance with the requirements of the Contract. The MCO must provide medically necessary covered services to all members beginning on the member’s date of enrollment regardless of pre-existing conditions, prior diagnosis, and/or receipt of any prior health care services. STAR+PLUS MCOs must also provide functionally necessary community long-term services and supports to all members beginning on the member’s date of enrollment regardless of pre-existing conditions, prior diagnosis, and/or receipt of any prior health care services. The MCO must not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any member.

All covered services must be available to members on a timely basis in accordance the Contract’s requirements and medically appropriate guidelines and consistent with generally accepted practice parameters.

The managed care contracts provide additional detail on access to care requirements.

Provider Network

The MCO must maintain a provider network sufficient to provide all members with access to the full range of covered services required under the Contract. The MCO must ensure its providers and subcontractors meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the Contract.

Please refer to the managed care contracts for specific provider network requirements and criteria.
**Service Coordination for STAR+PLUS**

The MCO must furnish a Service Coordinator to all STAR+PLUS members who request one. The MCO should also furnish a Service Coordinator to a STAR+PLUS member when the MCO determines one is required through an assessment of the member’s health and support needs. The MCO must ensure that each STAR+PLUS member has a qualified PCP who is responsible for overall clinical direction and, in conjunction with the Service Coordinator, serves as a central point of integration and coordination of covered services, including primary, acute care, long-term services and supports, and behavioral health services.

Please refer to the managed care contracts for more information.

**Continuity of Care for STAR and STAR+PLUS**

The MCO must ensure that the care of newly enrolled Medicaid members is not disrupted or interrupted. It must take special care to provide continuity in the care of newly enrolled members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

If a member moves out of a service area, the MCO must provide or pay out-of-network providers in the new service area who provide medically necessary covered services to members through the end of the period for which the MCO received a capitation payment for the member.

If covered services are not available within the MCO’s network, the MCO must provide members with timely and adequate access to out-of-network services for as long as those services are necessary and not available in the network, in accordance with 42 C.F.R. §438.206(b)(4). The MCO will not be obligated to provide a member with access to out-of-network services if such services become available from a network provider.

The MCO must also ensure that each member has access to a second opinion regarding the use of any medically necessary covered service. A member must be allowed access to a second opinion from a network provider or out-of-network provider if a network provider is not available, at no cost to the member, in accordance with 42 C.F.R. §438.206(b)(3).

**Utilization Management**

The MCO must have a written utilization management (UM) program description, which includes, at a minimum:

1. Procedures to evaluate the need for medically necessary covered services.
2. The clinical review criteria used, the information sources, and the process used to review and approve the provision of covered services.
3. The method for periodically reviewing and amending the UM clinical review criteria.
4. The staff position functionally responsible for the day-to-day management of the UM function.

The MCO must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate in making UM determinations. When making UM determinations, the MCO must comply with the requirements of 42 C.F.R. §456.111 (Hospitals) and 42 CFR §456.211 (Mental Hospitals), as applicable.
Member Complaint and Appeal Process

The MCO must develop, implement, and maintain a system for tracking, resolving, and reporting member complaints regarding its services, processes, procedures, and staff. The MCO must ensure that member complaints are resolved within 30 calendar days after receipt. The MCO is subject to remedies, including liquidated damages, if at least 98 percent of member complaints are not resolved within 30 days of the MCO’s receipt.

The MCO must develop, implement, and maintain a system for tracking, resolving, and reporting member appeals regarding the denial or limited authorization of a requested service, including the type or level of service and the denial, in whole or in part, of payment for service. Within this process, the MCO must respond fully and completely to each appeal and establish a tracking mechanism to document the status and final disposition of each appeal.

Member appeals must be resolved within 30 calendar days, unless the MCO can document that the member requested an extension, or the MCO shows there is a need for additional information and the delay is in the member’s interest. The MCO is subject to liquidated damages if at least 98 percent of member appeals are not resolved within 30 days of the MCO’s receipt.

Medicaid MCOs must follow the Member Complaint and Appeal Process described in the managed care contracts.

Provider Complaints and Appeals

MCOs must develop, implement, and maintain a system for tracking and resolving all Medicaid provider complaints. Within this process, the MCO must respond fully and completely to each complaint and establish a tracking mechanism to document the status and final disposition of each provider complaint. Provider complaints should be resolved within 30 days from the date the complaint is received. The MCO is subject to remedies, including liquidated damages, if at least 98 percent of provider complaints are not resolved within 30 days of receipt.

MCOs must also resolve provider complaints received by HHSC and referred to the MCOs no later than the due date indicated on HHSC’s notification form. HHSC will generally provide MCOs ten business days to resolve such complaints. If the MCO cannot resolve a complaint by the due date indicated on the notification form, it may submit a request to extend the deadline. HHSC may, in its reasonable discretion, grant a written extension if the MCO demonstrates good cause.

Encounter Data Requirements

The MCO must provide complete encounter data for all covered services, including value-added services. Encounter data must follow the format and data elements as described in the HIPAA-compliant 837 Companion Guides and Encounter Submission Guidelines. HHSC will specify the method of transmission, the submission schedule, and any other requirements in Uniform Managed Care Manual (UMCM), Chapter 5.0, Consolidated Deliverables Matrix.

The MCO must submit encounter data transmissions at least monthly and include all encounter data and encounter data adjustments processed by the MCO. In addition, pharmacy encounter data must be submitted no later than 25 calendar days after the date of adjudication and include all encounter data and encounter data adjustments processed by the MCO. Encounter data quality validation must incorporate assessment standards developed jointly by the MCO and HHSC. The MCO must submit complete
and accurate encounter data not later than the 30th calendar day after the last day of the month in which the claim was adjudicated. Original records must be made available for inspection by HHSC for validation purposes. Encounter data that does not meet quality standards must be corrected and returned within a time period specified by HHSC.

2. **MCO Contractual Compliance**

HHSC has incorporated value-based purchasing (VBP) in its contracts with managed care organizations for the provision of health care services. HHSC’s objectives for including VBP in its managed care contracts are as follows:

1. Improve the specificity of desired MCO services and outcomes.
2. Prioritize attention to those aspects of MCO performance that are most important to HHSC and to the members.
3. Create better, data-based measurement and accountability on key performance dimensions.
4. Accelerate the MCO’s performance improvement.
5. Recognize and reward the MCO’s excellence and improvement and apply disincentives when there is poor performance.
6. Improve the manner in which HHSC collaborates with the MCO.
7. Facilitate the development of improved, streamlined contract management practices and processes. The results of this process and information gained should be used to refine and improve existing services and inform future procurements.

This section describes performance incentives and disincentives related to HHSC’s value-based purchasing approach.

**Health Plan Management**

HHSC monitors and tracks a number of administrative and quality measures to ensure quality of care, access to care, client satisfaction, and MCO performance. Health Plan Management (HPM) examines MCO networks to ensure they are meeting the network adequacy standards set by HHSC. Measures tracked include open panels for Primary Care Providers (PCPs); access to routine, urgent, and specialist care; access to outpatient pharmacy benefits; access to main dentists; approval delays; access to specialized therapies; well-child visits; and many outcome measures designed to give the state information on the health care status of people receiving services.

HPM also collects, addresses, and tracks complaints received by providers or members. These are in addition to the MCO internal complaints and appeals processes. HPM also receives information on cases that have been overturned on appeal to track and address any issues in which it appears MCOs may have denied services inappropriately.

Failure to provide all services and deliverables under the terms of the managed care contracts at an acceptable quality level can result in the assessment of liquidated damages.

**Provider Incentives**

The managed care contract requires MCOs to conduct a pilot “gain sharing” program that will focus on collaborating with network physicians and hospitals in order to allow them to share a portion of the MCO’s savings resulting from reducing inappropriate utilization of services, including inappropriate admissions and readmissions. The program must include mechanisms whereby the MCO will provide incentive payments to hospitals and physicians for quality care. The program must also include quality
metrics required for incentives, recruitment strategies of providers, and a proposed structure for payment.

Performance Based At-Risk Capitation and Quality Challenge Award

The managed care contracts stipulate that up to five percent of a MCO’s capitation can be withheld based on performance-based measures. MCOs are able to earn variable percentages of the performance targets. This initiative gives HHSC an opportunity to focus MCO performance on specific measures that foster achievement of HHSC program goals and objectives. HHSC’s intention is that all MCOs achieve performance levels that enable them to receive the full at-risk amount. However, should an MCO not achieve those performance levels, HHSC will adjust future monthly capitation payments by an appropriate portion of the five percent at-risk amount. Some of the performance indicators are standard across the managed care programs while others may apply to a specific program.

The minimum percentage targets are developed based, in part, on:

- HHSC MCO Program objectives of ensuring access to care and quality of care.
- Past performance of the HHSC MCOs.
- Performance of Medicaid MCOs nationally on Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures of plan performance.

HHSC reallocates any unearned funds from the performance-based, at-risk portion of an MCO’s capitation rate to the MCO Program’s Quality Challenge Award (QCA). HHSC uses these funds to reward MCOs that demonstrate superior clinical quality, service delivery, access to care, and/or member satisfaction. HHSC determines the number of MCOs that will receive Quality Challenge Award funds annually based on the amount of the funds to be reallocated. Separate Quality Challenge Award payments are made for each of the MCO programs.

HHSC and the MCOs/DMOs developed the following performance indicators for which their capitation will be placed at risk and for the Quality Challenge Award in calendar years 2012 and 2013:

### 5% At-Risk Measures for CY 2012 (March 1 – December 31, 2012)

<table>
<thead>
<tr>
<th>Measures</th>
<th>STAR</th>
<th>STAR+PLUS</th>
<th>Medicaid Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present on Admissions (POA)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>GeoAccess – Provider Network Adequacy</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>GeoAccess – Pharmacy Network Adequacy</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Clean Claims Adjudicated in 30 Days</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Call Timeliness</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Individual Service Plans (ISPs) Documented</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Dental Visit</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GeoAccess – Dental Network Adequacy</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

### Quality Challenge Award Measures for CY 2012 (March 1 – December 31, 2012)

<table>
<thead>
<tr>
<th>Measures</th>
<th>STAR</th>
<th>STAR+PLUS</th>
<th>Medicaid Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal/Postpartum Care – Timeliness, Postpartum Visits</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Care – Outpatient, Emergency Department (AMB)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Inpatient Utilization – General Hospital/Acute Care (IPU)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Members Utilizing Consumer Directed Services Option for Personal Attendant Services (PAS) or</td>
<td></td>
<td></td>
<td>X</td>
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</tbody>
</table>
Texas Medicaid Managed Care Quality Strategy

<table>
<thead>
<tr>
<th>Measures</th>
<th>STAR</th>
<th>STAR+PLUS</th>
<th>Medicaid Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Dental Services (age 2 to 20 years) – Fluoride Treatment, Cleanings</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>First Dental Home Services (age 6 to 35 months)</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Dental Diagnostic Services (age 2 to 20 years)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Sealants</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5% At-Risk Measures for CY 2013

<table>
<thead>
<tr>
<th>Measures</th>
<th>STAR</th>
<th>STAR+PLUS</th>
<th>Medicaid Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Immunization Status (CIS) – Combo 4</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-Child Visits in 3, 4, 5, &amp; 6 Years of Life</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent Well-Care Visits</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal/Postpartum Care – Timeliness, Postpartum Visits</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of Appropriate Medication for People with Asthma</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Cholesterol Management for Patients with Cardiovascular Conditions</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Facility Admission Rates</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c Testing</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>THSteps Dental Checkup</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GeoAccess – Dental Network Adequacy</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Dental Services (age 2 to 20 years) – Fluoride Treatment, Cleanings</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Dental Home Services (age 6 to 35 months)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Diagnostic Services (age 2 to 20 years)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Quality Challenge Award Measures for CY 2013

<table>
<thead>
<tr>
<th>Measures</th>
<th>STAR</th>
<th>STAR+PLUS</th>
<th>Medicaid Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate Testing for Children with Pharyngitis (CWP)</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric Quality Indicators (PQI)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention Quality Indicators (POI)</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication (ADD): Initiation Phase</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressant Medication Management (AMM)</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Adult Body Mass Index Assessment (ABA)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer Directed Services (CDS)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Eye Exam</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Dental Home Services (age 6 to 35 months)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>THSteps Dental Checkup within 90 Days of Enrollment*</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Sealants</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Patient Satisfaction (Biennial CAHPS Survey)</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

*Pending definition for “90-days after enrollment”

There were a number of factors considered in determining which measures would be used in 2012 and 2013:

- Necessity of effective administrative processes and contract compliance for the five percent at-risk in the first measurement year due to the addition of new MCOs/DMOs and new service areas.
- Emphasis on clinical process and outcome measures in the Quality Challenge Award in the first measurement year and the five percent at-risk measures in the second measurement year.
Texas Medicaid Managed Care Quality Strategy

- HEDIS measure limitations due to data requirements. Some HEDIS measures require one to two years of historical data to calculate and thus were not feasible for use at the newly established STAR and STAR+PLUS Program sites. Measures with a history of low denominators (e.g., not enough enrollees meeting inclusion criteria for the measure) were excluded.
- Identifying the appropriate number of measures. Choosing too many measures can diffuse the focus and make it difficult to have meaningful impact while choosing too few can place too much risk on each measure.

HHSC intends to include potentially preventable events (PPEs) measures in 2014. The PPE measures will be calculated by ICHP using software developed by 3M to identify potentially preventable inpatient admissions (PPAs), potentially preventable emergency department visits (PPVs), and potentially preventable readmissions (PPRs).

HHSC evaluates the performance-based at-risk and QCA methodology annually in consultation with the MCOs and DMOs. HHSC may then modify the methodology as it deems necessary and appropriate to motivate, recognize, and reward MCOs for performance.

Quality Assessment and Performance Improvement (QAPI)

The MCO must file an approved plan with HHSC describing its QAPI Program, including how the MCO will accomplish the activities required by the managed care contracts and Uniform Managed Care Manual. Please refer to the managed care contracts for a program overview, structure, and guidelines, and the UMCM, Chapter 5.7.1, for the QAPI summary format and required supporting documents.

MCO Administrator Tool

To ensure the MCOs are meeting all state and federal requirements when providing care to Medicaid enrollees, the EQRO conducts MCO Administrator Interview surveys and on-site visits to assess:
- organizational structure,
- children’s programs,
- care coordination and disease management programs,
- utilization and referral management,
- provider network and contractual relationships,
- provider reimbursement and incentives,
- member enrollment and enrollee rights and grievance procedures, and
- data acquisition and health information management.

The MCOs complete the MCO Administrator Tool online and are required to provide any supporting documentation related to their responses. For example, when describing their disease management programs, the MCOs must also provide copies of all evidenced-based guidelines they use in providing care to their enrollees. The EQRO analyzes all responses and documents and generates follow-up questions for each MCO as necessary. The follow-up questions are administered during in-person site visits and conference calls.
C. MCO Monitoring

Section II.A, Quality and Appropriateness of Care and Services, and Section II.B.2, MCO Contractual Compliance, describe the tools used by HHSC and the EQRO to ensure the MCOs are in compliance with state and federal requirements.

III. IMPROVEMENT

A. Initiatives

HHSC is conducting several Quality Initiatives for Medicaid managed care, some of which have been mentioned above, aimed at improving quality of care and reducing costs. These initiatives include:

- Potentially Preventable Events (PPEs) Report Series
- The Texas Healthcare Learning Collaborative (ThLC) Initiative
- Assessment of Member Experiences with Their Medical Homes
- The Dual Eligible STAR+PLUS Focus Study
- Rider 50 Initiative: Behavioral Health Quality of Care
- Senate Bill 7 Initiative: Quality-Based Premium Payments and Performance Reporting
- First Dental Home Initiative
- STAR+PLUS Home and Community-Based Services (HCBS) Waiver Program
- Money Follows the Person Initiative
- Money Follows the Person Demonstration Initiative

**Potentially Preventable Events Report Series**

The purpose of this Quality Initiative is to identify individual, community, and health care delivery system factors contributing to PPAs, PPRs, and PPVs in the Texas STAR and STAR+PLUS Programs. The excess health care expenditures and potential for cost-savings and improved quality of care associated with these events also are identified. Medicare information currently is not available for the dual eligible STAR+PLUS enrollees, therefore the analysis focuses on STAR Medicaid enrollees only.

The overall goal is to determine the potential cost savings that would result from successful interventions to address potentially avoidable inpatient stays and to better target those interventions toward modifiable individual, community, and health care delivery system factors contributing to their occurrence. PPEs are costly and have an adverse effect on the health care delivery system, insurance programs (e.g., Medicaid), providers, and members and their families. Identifying factors associated with PPEs and identifying strategies to target risk factors contributing to their occurrence can not only result in cost savings to Medicaid, MCOs, and providers but also improved quality of care for members and their families.

**Texas Healthcare Learning Collaborative Initiative**

The purpose of this initiative is to promote sharing of best practices among the MCOs and to design quality improvement interventions within service areas that promote plans working collaboratively to improve population health. This initiative is an important tool to help MCOs, HHSC, and ICHP work together to implement interventions to improve health care for STAR, STAR+PLUS, and Children’s Medicaid Dental Services members.
The Texas healthcare Learning Collaborative (ThLC) is a web portal designed and run by ICHP and the University of Florida. It is an online learning collaborative that includes the Medicaid MCOs, HHSC, and ICHP and is used as a quality improvement tool.

During 2012, the key focus is on potentially preventable events, including potentially preventable inpatient admissions, readmissions, and emergency department visits. Potentially preventable events are costly and place a burden on members and their families, and may reflect a need to improve access to care in outpatient settings. They may also reflect a need to improve continuity of care when members move from one setting to another (e.g., from the hospital to home).

Through the ThLC, HHSC and the EQRO share monthly and quarterly reports with the MCOs about the different potentially preventable events. The EQRO also provides member registries of those seen in the ED or who were readmitted so the MCO can follow-up and coordinate care.

The EQRO plans to develop and place “Change Packages” on the web portal, which summarize evidenced-based practices to reduce potentially preventable events. The hope is that the MCOs will use the “Change Packages” to choose and implement evidence-based practices to improve health care quality in their organizations. Periodically, ICHP will gather information from the MCOs about their experience implementing the new practices and the results they are seeing.

In addition, there are moderated listserv discussions, scheduled webinars, and scheduled online chats to facilitate sharing among the ThLC members about their experiences in using the reports and strategies to enhance the collaborative.

**Use of Quality Metrics across Delivery Systems**

The purpose of this Quality Initiative is to assess quality of care measures in STAR and STAR+PLUS. ICHP prepares annual quality of care reports for each program and summarizes the information across the programs. The results are given to HHSC and shared with the MCOs so that they can use the information to improve the quality of their care. The measures are calculated at the program level, at the MCO within service area (SA) level, and compared to national benchmarking data from the National Committee on Quality Assurance (NCQA). In addition, ICHP has a provider module from MedAssurant that can be used to calculate the quality of care metrics for those measures using administrative data at the provider level. Provider level analyses will allow HHSC and the MCOs to identify quality of care issues at the point of care delivery in addition to at the MCO level. As part of the annual quality of care report, the Institute for Child Health Policy also produces a MCO profile showing trends in selected quality of care measures across state fiscal or calendar years.

**Assessment of Member Experiences with Their Medical Homes**

The purpose of this Quality Initiative is to assess member experiences with their medical homes using the Consumer Assessment of Healthcare Providers and Systems Survey tool (CAHPS). The CAHPS contains the following domains that correspond to the key elements that comprise a medical home: Getting Needed Care, Getting Care Quickly, Doctor Communication, Office Staff, Family-Centered Care, Shared Decision-Making, Care Coordination, and Getting Needed Information.

This survey is administered annually to the STAR+PLUS population and every other year to adults and parents of child members in STAR and parents of child members in CHIP. In addition, a variation of this survey is administered to parents/guardians of child members in STAR Health. A sufficient sample of members is drawn to participate in the survey so that comparisons can be made between MCOs on members’ (or parents of members) medical home experiences.

Member reported outcomes are considered a fundamental component of health care quality assessment. Moreover, a strong medical home is considered the basis for good primary care.


**Dual Eligible STAR+PLUS Focus Study**

Nearly nine million individuals nationally are dually eligible for Medicare and Medicaid. Of these dual eligibles, about 5.5 million are 65 and older and the rest are younger individuals with disabilities. Nationally, dual eligibles account for 39 percent of Medicaid spending but represent only 15 percent of the Medicaid enrollment. In Texas, older adults (65 years and older) and those with disabilities are only 23 percent of the state’s Medicaid population, but they account for almost 60 percent of the expenditures.

To assess the unique needs of this population, HHSC asked the Institute for Child Health Policy to conduct a focus study that spans 2011 and 2012 to examine the following:

1. The physical and mental health status for STAR+PLUS beneficiaries using self-report measures.
2. Key aspects of health care quality to include:
   a. Aspirin Use and Discussion.
   b. Medical Assistance with Smoking and Tobacco Use Cessation.
   c. Flu Shots for Older Adults, using the Consumer Assessment of Healthcare Providers and Systems Survey tool (CAHPS).
3. To work with CMS to obtain Medicare claims for the STAR+PLUS population and link these claims to the Medicaid claims/encounter data.

The self-report measures will be collected longitudinally for a two year period and will provide important baseline information for service areas that are new to the STAR+PLUS Program as well as for established STAR+PLUS service areas. Patient reported outcomes are a valuable and accepted method for assessing the quality of care in a program.

However, many quality-of-care metrics such as breast cancer screening, diabetes management, assessment of potentially preventable events (inpatient stays, readmissions, and emergency room use) rely on health care claims and encounter data. Currently, Texas has the Medicaid claims and encounter data for the dual eligible members but not their Medicare claims and encounter data, leaving gaps in the quality of care metrics that can be assessed for this highly vulnerable population.

CMS does make Medicare data available through a special request process. The Institute for Child Health Policy has requested and received access to the data. This will allow the quality-of-care metrics assessed for the dual eligible population to be greatly expanded using less costly administrative data (i.e., claims and encounter data) rather than more costly survey administration and/or medical record review data.

**Rider 50 Initiative: Behavioral Health Quality of Care**

In response to the direction of the Texas Legislature via Rider 50, HHSC expanded external quality review efforts in fiscal year 2010 to address behavioral health services for enrollees in Texas Medicaid. HHSC was directed to develop strategies to improve the transparency and accountability of behavioral health service delivery in STAR and STAR+PLUS.

Based on the Rider 50 Initiative, ICHP is conducting a series of quality of care analyses to:

1. Understand the reasons for gaps in behavioral health performance.
2. Identify alternate methods of assessing behavioral performance.
3. Evaluate how patient experiences and satisfaction are related to behavioral health performance and utilization.
4. Evaluate behavioral health PIPs at the MCO level.

The first of these analyses is focused on examining variations in behavioral health quality of care measures that may be due to health care delivery system and individual member factors. The
quality of care measures include: readmissions after an inpatient behavioral health stay, seven- and 30-day follow-up after an inpatient behavioral health stay, mental health utilization, alcohol and other drug services utilization, access to alcohol and other drug treatment, medication management for depression and ADHD, and potentially preventable readmissions following an inpatient behavioral health stay. A better understanding of the optimal delivery model or models for behavioral health care could contribute to improved quality and outcomes of care.

The second analysis focuses on examining access to care and medical home experiences for members in STAR and STAR+PLUS who have a primary or co-morbid behavioral health condition. The quality of the medical home may vary for those who have behavioral health conditions relative to those with physical health conditions. Ensuring a high quality medical home for those with behavioral health conditions could result in reduced ER visits and improved treatment adherence.

The third study is an assessment of behavioral health measures that potentially could be incorporated into the At-Risk and Quality Challenge Program. The primary metrics for consideration are potentially preventable ER visits and readmissions related to behavioral health issues. Other behavioral health measures are being considered and will be evaluated to determine if sufficient numbers of members meet the inclusion criteria for the measure so that the measure can be equally applied across the MCOs for either the At-Risk or the Quality Challenge Components of the value-based purchasing program.

Finally, ICHP will assess the outcomes from MCO designed interventions focused on behavioral health issues. Several of the STAR and STAR+PLUS MCOs designed performance improvement projects (PIPs) focused on behavioral health care issues such as depression screening. ICHP will assess the outcomes from those PIPs to see if there were subsequent improvements in quality of care and member outcomes.

**Senate Bill 7 Initiative: Quality-Based Premium Payments and Performance Reporting**

The Texas Legislature established a Medicaid and CHIP Quality-Based Payment Advisory Committee to advise HHSC on establishing:

- Reimbursement systems used to compensate physicians or other Medicaid and CHIP providers that reward the provision of high-quality, cost-effective health care and quality performance and quality of care outcomes with respect to health care services.
- Standards and benchmarks for quality performance, quality of care outcomes, efficiency, and accountability by managed care organizations and physicians and other health care providers.
- Programs and reimbursement policies that encourage high-quality, cost-effective health care delivery models that increase appropriate provider collaboration, promote wellness and prevention, and improve health outcomes.

In consultation with the advisory committee, HHSC is tasked to develop quality-based outcome and process measures that promote the provision of efficient, quality health care that can be used in the CHIP and Medicaid Programs to implement quality-based payments for acute and long-term care services across all delivery models and payment systems, including fee-for-service and managed care payment systems.

**First Dental Home Initiative**

First Dental Home is an initiative designed to establish a Dental Home, provide preventive care, identify oral health problems, and provide treatment and parental/guardian oral health instructions as early as possible. Based on the American Academy of Pediatric Dentistry’s
definition, Texas Medicaid defines a Main Dental Home as the dental provider who supports an ongoing relationship with the client that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a client’s Main Dental Home begins no later than six months of age and includes referrals to dental specialists when appropriate.

The Dental Home provider is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as Main Dental Home Providers are general dentist and pediatric dentist. Main Dental Home providers must provide children enrolled in Medicaid (birth through age 20) with preventive services in accordance with the Texas Health Steps dental periodicity schedule. Dental contractors must offer provider education, provider profiling, monitoring, and feedback activities.

**STAR+PLUS Home and Community-Based Services (HCBS) Program**

The STAR+PLUS HCBS Program provides supports to individuals who wish to move from an institution to the community or to remain in the community. Without STAR+PLUS waiver services, these individuals would require nursing facility care. Texas uses the STAR+PLUS HCBS Program to provide services to Texans in the least restrictive environment possible. These environments include the member’s or a family member’s home, an adult foster care home, or an assisted living facility. HHSC administers the operations of the waiver and promulgates policies and rules related to the waiver.

The goal of the STAR+PLUS HCBS Program is to provide MCOs with meaningful choices regarding long term care services. This goal will be accomplished primarily by facilitating the development and utilization of services, which allows MCOs to avoid premature nursing facility placement and which provides current nursing facility residents an opportunity to return to the community. Members receive the services through the STAR+PLUS HCBS Program and through other non-waiver service providers that are necessary to provide a safe alternative to nursing facility placement.

Once all eligibility requirements are met, the MCO, the participant, and other persons requested by the participant, must develop a participant-centered service plan that addresses the participant’s or member’s needs. The process emphasizes the provision of supports and services necessary to maintain successful integration into the community. The member’s service plan describes the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. Providers deliver all waiver services according to this written individual service plan (ISP). The member’s service plan must have costs that are within the applicable cost ceiling. An applicant must meet financial, functional, level of need, and service plan requirements to be eligible for STAR+PLUS waiver services.

When the ISP is developed, the applicant also chooses whether to self-direct the services provided through member-direction. HHSC offers STAR+PLUS waiver services through both self-directed and traditional service delivery methods.

The State has contracted with the EQRO to review the adequacy of the service plans for participants receiving HCBS services. If a member’s service plan is discovered not to meet the member’s needs, goals, preferences, or risks, the State requires the MCO to revise the service plan based on the assessment, correcting any deficiencies within the State established timeframes.

If a member’s service plan is discovered not to have been developed according to standards set by the State, the State requires the MCO to revise the service plan according to State policies and procedures within State established timeframes.
The system does not allow payment for services delivered to a person without a service plan. If a person receives services prior to the completion of the services plan, the MCO receives a reduced capitation payment. The State requires the MCO to complete the services plan within 45 days. If not completed within 45 days, the MCO is contacted directly for resolution, and if necessary, a corrective action plan will be issued.

Individual Service Plans documented is also one of the performance indicators for which STAR+PLUS MCOs’ capitation will be placed at risk in CY 2012. This also ties into HHSC’s CY 2012 overarching goal to reduce nursing facility admission rates in the STAR+PLUS Program.

**Money Follows the Person**

The Texas Department of Aging and Disability Services’ (DADS) Money Follows the Person (MFP) procedure allows Medicaid-eligible nursing facility residents to receive services in the community by transitioning to long-term services and supports. Under MFP, if the client meets the financial and eligibility requirements for a certain community waiver program, they bypass the interest list and enter the services directly. One of the eligibility requirements for MFP is that the individual be approved for waiver services prior to leaving the nursing facility. This flexible enrollment process only applies to MFP.

For residents in a STAR+PLUS service area who wish to receive services in the community through the HCBS Waiver, the MCO performs the functional assessment and service planning. Once the assessment process is completed and the resident is determined eligible for HCBS services, the MCO must initiate the individual service plan (ISP) upon notification. The MCO is not responsible for obtaining independent housing for the resident, but is responsible for identifying assisted living or adult foster care alternatives available in the network.

**Money Follows the Person Demonstration Initiative**

The Money Follows the Person Demonstration (MFPD) Initiative was implemented in order to eliminate barriers and enable Medicaid-eligible individuals to transition from nursing facilities and receive necessary long-term services and supports (LTSS) in the setting of the individual’s choice. Participation in MFPD does not affect the type or amount of services received, or the manner in which they are delivered.

In addition to the HCBS services, MFPD participants receive more extensive relocation assistance and follow up. They are also eligible to access Behavioral Health Services (BHS) in the following counties in the Bexar and Travis STAR+PLUS service areas: Travis County, Atascosa County, Bexar County, Guadalupe County, and Wilson County.

BHS is designed to assist adults with mental health and substance abuse diagnoses who wish to transition to the community from nursing facilities. Services include Cognitive Adaptation Training (CAT) and adult substance abuse treatment.

CAT provides community-based and in-home assistance to help individuals organize their environment and function independently. The training engages the member in performing self-care and using environmental modifications to facilitate independence. Both substance abuse services and CAT may be provided for participants for up to six months before discharge from the nursing facility as “pre-transition services” and also for one year when participants leave the nursing facility and live in the community.

Substance abuse treatment is provided by and accessed through the STAR+PLUS MCO.

The state benefits from member participation in MFPD by receiving enhanced funding and more information about LTSS through the participant survey. Since the program started in September 2001, MFPD has helped more than 20,300 Texans transition back to the community to receive
their long-term services and supports. The program took first-place honors in the Council of State Governments 2006 Innovations Awards competition.

For more information on the MFP and MFPD Programs, please refer to the STAR+PLUS Handbook, Section 3500.

B. Evaluation

Section II.A, Quality and Appropriateness of Care and Services, and Section II.B.2, MCO Contractual Compliance, describe how the State will evaluate MCO performance relative to stated objectives and predefined benchmarks.

IV. REVIEW OF QUALITY STRATEGY

A. MCO Reporting Requirements

Please see Appendix A: MCO Deliverables.

B. EQRO Reporting Requirements

Please see Appendix B: EQRO Deliverables.

C. CMS Reporting Requirements

Please see Appendix C: CMS Deliverables.

V. ACHIEVEMENTS AND OPPORTUNITIES

A. Potentially Preventable Events

Potentially Preventable Events (PPEs) are inpatient stays, hospital readmissions, and emergency department (ED) visits that may have been avoidable had the patient received high quality primary and preventive care prior to or after the event in question. High PPE rates may reflect inadequacies in the health care provided to the patient in multiple settings, including inpatient and outpatient facilities and clinics.

For CY 2012, ICHP calculated rates and excess expenditures of PPEs in the STAR and STAR+PLUS Programs. Excess expenditures are defined as the actual expenditures associated with PPEs that are in excess of the norm. They represent the potential savings that could be realized by reducing PPEs in a particular MCO or service area.

A better understanding of the factors that contribute to PPEs in STAR and STAR+PLUS can assist HHSC and managed care organizations in developing intervention strategies to reduce their occurrence and to estimate the potential cost savings associated with implementing these interventions.

Potentially Preventable Admissions (PPAs)

In 2006, approximately 1,761 adults per 100,000 had a potentially avoidable hospitalization in the U.S. at a cost of $30.1 billion nationally. These events are considered an indicator of poor availability, accessibility, and effectiveness of primary care, and their added burden to hospital resources can adversely impact the quality of care for all in need of inpatient services. Methods for defining and measuring PPAs are therefore critical for a comprehensive and effective evaluation of the quality of care in Medicaid. Developing strategies to effectively reduce PPAs is also one of HHSC’s 2012 overarching goals for MCOs in STAR.
Using claims and encounter data for State Fiscal Year (SFY) 2010 and the 3M Health Information Systems (HIS) software, ICHP computed separate PPA rates and related excess expenditures for MCOs and service areas participating in either STAR or STAR+PLUS. Overall, ICHP determined that:

- More than seven percent (7.5 percent) of eligible admissions in STAR were potentially preventable.
- STAR MCOs spent $79 million in excess expenditures during SFY 2010, with a program-level average of $4,842 per 1,000 member months.
- Nearly one-fifth of PPAs in STAR were for pneumonia (19 percent).
- Twenty-five percent of eligible inpatient admissions in STAR+PLUS were potentially preventable. The higher PPA rate in STAR+PLUS compared to STAR was explained by the difference in age demographics among their respective memberships.
- STAR+PLUS MCOs spent about $42 million in excess expenditures on PPAs during SFY 2010, with a program-level average of $46,144 per 1,000 member months.
- The most prevalent STAR+PLUS PPA was chronic obstructive pulmonary disease (COPD)—accounting for roughly 14 percent of all potentially preventable admissions in the program.

**Potentially Preventable Readmissions (PPRs)**

Potentially preventable readmissions (PPRs) to the hospital are costly, and present a particularly relevant challenge for the efficient delivery of health services in state Medicaid programs. In an Agency for Healthcare Research and Quality (AHRQ)-funded study, one in 10 adult Medicaid beneficiaries who were hospitalized in 2007 had at least one readmission to the hospital within 30 days of their initial admission. Medicaid beneficiaries were also 70 percent more likely than people with private insurance to have had an inpatient readmission. While a number of individual factors are known to influence PPRs—including age, severity of illness, and co-morbidities—poor access to primary care is thought to be a major contributing factor. Methods for defining and measuring PPRs are therefore critical for a comprehensive and effective evaluation of the quality of care in Medicaid.

The EQRO used SFY 2010 claims data to identify initial hospital admissions at risk for a potentially preventable readmission, where are referred to as candidate admissions. Qualifying claims were selected according to the type of bill. For this study, the readmission interval—defined as the maximum number of days between discharge and readmission—was set at 30 days. Readmissions were counted regardless of whether the hospital of readmission was different from the hospital of initial admission. The EQRO reported the following:

- Nearly three percent (2.8 percent) of candidate inpatient admissions in STAR had a potentially preventable readmission within 30 days.
- MCOs in the STAR Program paid over $39 million in excess expenditures associated with potentially preventable readmissions in SFY 2010, averaging $2,213 per 1,000 member months.
- The most common reason for readmission of STAR members was for an acute medical condition or complication related to or resulting from care during initial admission or in the post-discharge period after initial admission (38 percent).
- Nearly 16 percent (15.7 percent) of candidate admissions in STAR+PLUS had a potentially preventable readmission within 30 days.
Texas Medicaid Managed Care Quality Strategy

- In the STAR+PLUS Program, over $30.6 million was paid in excess expenditures related to potentially preventable readmissions in SFY 2010, averaging $30,843 per 1,000 member months.

- The most common reason for readmission in STAR+PLUS was continuation or recurrence of mental health or substance abuse problems for which the initial admission occurred (34 percent).

**Potentially Preventable Emergency Department Visits (PPVs)**

In 2006, the National Association of Community Health Centers estimated that over $18 billion was wasted on potentially preventable emergency department (ED) visits (PPVs) nationally. In Texas, the cost of PPVs was estimated at $1.2 billion. These events are considered an indicator of poor availability, accessibility, and effectiveness of primary care, and their added burden to emergency department resources can adversely impact the quality of care for all in need of urgent medical attention.

Potentially preventable ED visits present a particularly relevant challenge for the efficient delivery of health services in state Medicaid programs. Research has found that Medicaid beneficiaries make up a disproportionate share of ED visits for ambulatory care sensitive conditions, such as asthma, COPD, congestive heart failure, diabetes, and hypertension. The occurrence of preventable ED visits can be influenced by chronic illness burden. However, compared to the general population, higher rates of PPVs for Medicaid beneficiaries were not explained by differences in disease prevalence or severity, but rather suggested a reduced likelihood of ongoing primary care. Methods for defining and measuring PPVs are therefore critical for a comprehensive and effective evaluation of the quality of care in Medicaid.

In an analysis of SFY 2010 claims data using the 3M HIS software, ICHP calculated the following rates and excess expenditures in Texas Medicaid Programs:

- Overall, 63 percent of ED procedures in STAR that could have resulted in a PPV were potentially preventable.

- Over $79.6 million in excess expenditures was spent on PPVs in STAR during SFY 2010, with a program-level average of $4,880 per 1,000 member months.

- Greater than one-third of PPVs in STAR were for acute infections that could be treated in a primary care setting (39 percent).

- Overall, 53 percent of ED procedures that could have resulted in a PPV in STAR+PLUS were potentially preventable. The lower PPV rate in STAR+PLUS compared to STAR is largely explained by differences in the age of their memberships. STAR has a much bigger percentage of children age five years and younger. Children in this age group tend to have higher PPV rates than older members.

- STAR+PLUS MCOs spent over $9.7 million in excess expenditures on PPVs during SFY 2010, with a program-level average of $10,675 per 1,000 member months.

- Nearly two-thirds of PPVs in STAR+PLUS were for chronic illnesses, excluding mental health, substance abuse, and malignancy (64 percent). The most common types of encounters in this category were for contusion, open wound, or trauma to skin and subcutaneous tissue; lumbar disc disease; signs, symptoms, and other factors influencing health status; and Level 1 other respiratory diagnoses.
B. Patient-Centered Medical Homes

The medical home model holds promise as a way to improve health care in America by transforming how primary care is organized and delivered. The Agency for Healthcare Research and Quality (AHRQ) defines a medical home not simply as a place but as a model of the organization of primary care that delivers the core functions of primary health care.

A patient-centered medical home (PCMH) is a health care setting that encompasses the following principles:

- Comprehensive and continuous care
- Whole person orientation, i.e., patient-centered
- Coordinated and/or integrated care
- Enhanced access to services
- Quality and safety to support optimal, patient-centered outcomes
- Appropriate payment structure

It is an approach to providing comprehensive primary care to members in a health care setting that facilitates a partnership between the patient, physician, and the patient’s family.

PCMH can be assessed in quality of care research as a component of health care structure and process and is shown to produce some of the following positive outcomes.

- Improved patient reported outcomes
- Improved clinical indicators
- Reduction in PPEs
- Better adherence to treatment recommendations

ICHP measures elements of the PCMH in two ways:

- Survey-based patient satisfaction and experience measures (CAHPS Surveys)
- Administrative measures using claims and medical records data (HEDIS) – processes and outcomes of care associated with having a medical home.

C. Medicaid Incentives for Prevention of Chronic Disease Project

The Texas Department of State Health Services (DSHS) received a five-year grant to fund interventions, such as navigation and flexible wellness accounts, to help prevent chronic disease among STAR+PLUS Medicaid-only members with behavioral health conditions. This Texas Medicaid incentives project addresses the core prevention issues of individual behavior, empowerment, and internal motivation to change. The project starts in 2012 and continues through 2016.

Wellness Incentives and Navigation (WIN) is designed to help improve health self-management and reduce the incidence and consequences of chronic disease among non-elderly adult (ages 21 to 55) Medicaid Supplemental Security Income (SSI) beneficiaries. WIN targets SSI beneficiaries with behavioral health (mental health and substance abuse) diagnoses. Research demonstrates that these individuals are more likely to suffer chronic physical co-morbidities, experience debilitating chronic illnesses earlier in life and have elevated healthcare costs.

WIN will employ a complement of person-centered incentives to empower participants to take charge of their health. These evidence-based incentives include:

- Person-centered wellness planning and navigation facilitated by trained, professional health navigators, dedicated specifically to the WIN project, who employ Motivational Interviewing (MI) techniques to help participants define and achieve their health goals.
Texas Medicaid Managed Care Quality Strategy

- A $1,150.00/year flexible wellness account which supports specific health goals defined by the participant.

Participants with more severe mental illnesses will be offered additional preparation in the form of Wellness Recovery Action Planning (WRAP) to enable them to take full advantage of person-centered wellness planning.

Prevention goals include, but are not limited to: tobacco use cessation; weight control/reduction; managing cholesterol; managing blood pressure; avoiding the onset of or managing diabetes; and managing behavioral health conditions such as serious and persistent mental illness.

The WIN incentives and supports will be integrated within the State’s Medicaid managed care system, in partnership with the two largest MCOs serving Medicaid beneficiaries with disabilities. The managed care system, known as STAR+PLUS, is the dominant means of serving adult SSI beneficiaries in Texas. The WIN project’s design and implementation within STAR+PLUS will enable broad dissemination and sustainability of practices proven successful by the Project. A broad continuum of preventive, acute and chronic care services are normally available through STAR+PLUS and will continue to be available through the term of the MIPCD project. A randomized controlled experimental design, including a large cohort of participants will provide analytical power, even if significant attrition occurs from the study group. A strong collaborative approach will engage health and behavioral health providers, MCOs, local and state government and experts in evidence-based practice.

The State’s Medicaid EQRO regularly collects, validates and reports data on STAR+PLUS MCO members such as Health Plan Data and Information Set (HEDIS) measures; Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys; and Participant Experience Survey (people with disabilities and the elderly). Texas will explore leveraging the data available through the Medicaid EQRO for this project.
<table>
<thead>
<tr>
<th>Deliverable Name</th>
<th>Frequency</th>
<th>Description</th>
<th>Estimated Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>5% Capitation Rate At-Risk</td>
<td>Annual</td>
<td>To use a benchmarking approach to measure the performance of health plans and to allocate the 5% at-risk premium performance-based revenue pool. Analysis includes: (1) Assessment of the quality of care using selected HEDIS measures, and (2) various non-HEDIS measures.</td>
<td>HHSC determines if MCOs fully meet the performance measures for the 5% At-Risk Premium at the end of each calendar year.</td>
</tr>
<tr>
<td>Claims Summary Report</td>
<td>Quarterly</td>
<td>The MCO must submit Claims Summary Reports to HHSC by Program, Service Area, and claim type.</td>
<td>Last day of the month following the close of the reporting period.</td>
</tr>
<tr>
<td>Encounter Data Certification Report</td>
<td>Monthly</td>
<td>In accordance with 42 CFR Section 438.604 and 438.606, MCO must certify encounter data in writing.</td>
<td>One certification form per program per SDA is due with the encounters filed during the deliverable month.</td>
</tr>
<tr>
<td>Geo-Mapping Provider Interface</td>
<td>Quarterly</td>
<td>The MCO must provide a complete picture of its Primary Care Provider, CHIP, and Specialist/Facilities Networks.</td>
<td>Last business day of the State Fiscal Quarter.</td>
</tr>
<tr>
<td>HHSC Overarching Goals</td>
<td>Annual</td>
<td>MCOs submit proposed performance improvement projects (PIPs)</td>
<td>Overarching goals due by July 31.</td>
</tr>
<tr>
<td>HHSC Performance Indicator Dashboard for Quality Measures - Evaluation and Update</td>
<td>Annual</td>
<td>Evaluate the Dashboard standards for each Texas Medicaid and CHIP Program and compare them to the MCO’s performance during the prior three years. Provide information about national-level benchmarks (if available) and national and state means on performance measures for descriptive measures.</td>
<td>HHSC will review and evaluate the Performance Indicator Dashboard quality metrics by October 31 to determine what changes, if any, need to be made for the following calendar year.</td>
</tr>
<tr>
<td>Hotline Reports</td>
<td>Quarterly</td>
<td>The MCO must submit a status report for hotline performance in comparison with the performance standards set out in the contract.</td>
<td>30 days after end of the Reporting Quarter</td>
</tr>
<tr>
<td>Hotline Reports - Nurse</td>
<td>Quarterly</td>
<td>The MCO must submit a status report for the Nurse Hotline in comparison with the performance standards set out in the UMCC Attachment B-1, Section 4.1.24.2</td>
<td>30 days after end of the Reporting Quarter</td>
</tr>
<tr>
<td>Medicaid Managed Care THSteps Medical Checkups Reports and Refusal Tracking Logs</td>
<td>Quarterly/ Annual</td>
<td>MCOs must submit reports documenting the number of members who receiving or refusing Texas Health Steps (THSteps) medical check-up.</td>
<td>Quarter 1 New Member Report due June 30 Quarter 2 New Member Report due September 30 Quarter 3 New Member Report due December 31 Quarter 4 New Member Report due March 31 Annual Report of New and Existing Members due May 12</td>
</tr>
<tr>
<td>Member Complaints &amp; Appeals Summary Report</td>
<td>Quarterly</td>
<td>The MCO must submit the Complaint and Appeals Report electronically using the format specified by HHSC in the UMCM, Chapter 5.4.2</td>
<td>45 days after end of the Reporting Quarter</td>
</tr>
</tbody>
</table>
## APPENDIX A: MCO DELIVERABLES

<table>
<thead>
<tr>
<th>Deliverable Name</th>
<th>Frequency</th>
<th>Description</th>
<th>Estimated Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Network Utilization Reports</td>
<td>Quarterly</td>
<td>The MCO must file Out-of-Network Utilization Reports in the format specified in the UMCM.</td>
<td>30 days after end of the Reporting Quarter</td>
</tr>
<tr>
<td>PCP Network &amp; Capacity Report</td>
<td>Quarterly</td>
<td>MCOs must submit reports documenting the total number of PCPs in their network and the number of PCPs with open panels during the reporting quarter.</td>
<td>30 days after end of the Reporting Quarter</td>
</tr>
<tr>
<td>Performance Improvement Projects (PIPs)</td>
<td>Annual</td>
<td>Evaluate the accuracy of Medicaid performance measures reported by, or on behalf of, a MCO and determine the extent to which Medicaid-specific performance measures calculated by a MCO (or by an entity acting on behalf of a MCO) followed specifications established by HHSC for the calculation of the performance measures.</td>
<td>MCOs submit final PIPs to HHSC by December 30 for the following calendar year. Assessment and evaluation is done at the end of the calendar year.</td>
</tr>
<tr>
<td>Provider Complaints Summary Report</td>
<td>Quarterly</td>
<td>The MCO is subject to remedies, including liquidated damages, if at least 98 percent of Provider complaints are not resolved within 30 days of receipt of the complaint my the MCO.</td>
<td>45 days after end of the reporting quarter</td>
</tr>
<tr>
<td>QAPI Program Annual Summary</td>
<td>Annual</td>
<td>The MCO must develop, maintain, and operate a Quality Assessment and Performance Improvement (QAPI) Program consistent with the Contract and TDI requirements. The MCO must complete an annual QAPI Program Summary as specified in the UMCM.</td>
<td>All documents are due to the EQRO on or before March 30 for the previous State Fiscal Year.</td>
</tr>
<tr>
<td>Quality Challenge Award</td>
<td>Annual</td>
<td>The performance measures are used for ranking the health plans. The ranking process is based on the number of MCOs under consideration. For each of the performance measures, the MCOs are listed in rank order from the plan with the highest (i.e., best) score to the lowest (i.e., worst score). The health plan total scores and rankings then are sued to apportion the funds recouped from the 5% At-Risk Premium Program.</td>
<td>HHSC determines if MCOs fully meet the performance measures for the 5% At-Risk Premium at the end of each calendar year. Quality Challenge Award amounts determined by amounts recouped.</td>
</tr>
</tbody>
</table>
## APPENDIX B: EQRO DELIVERABLES

<table>
<thead>
<tr>
<th>Deliverable Group</th>
<th>Deliverable Name</th>
<th>Frequency (Program)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Surveys</strong></td>
<td>Adult/Child Enrollee CAHPS</td>
<td>Biennial (STAR)</td>
<td>Report of Adult Member/Child Caregiver Satisfaction and Experience with Care</td>
</tr>
<tr>
<td></td>
<td>Adult Enrollee CAHPS</td>
<td>Annual (STAR+PLUS)</td>
<td>Report of Adult Member Satisfaction and Experience with Care</td>
</tr>
<tr>
<td></td>
<td>CHIP Established Enrollee CAHPS</td>
<td>Biennial (CHIP)</td>
<td>Report of Child Caregiver Satisfaction and Experience with Care</td>
</tr>
<tr>
<td></td>
<td>STAR Health Child Enrollee CAHPS</td>
<td>Biennial (STAR Health)</td>
<td>Report of Foster Care Child Caregiver Satisfaction and Experience with Care</td>
</tr>
<tr>
<td></td>
<td>Adult Enrollee Behavioral Health (ECHO)</td>
<td>Biennial (STAR/STAR+PLUS)</td>
<td>Report of Adult Member Satisfaction and Experience with Behavioral Health Care</td>
</tr>
<tr>
<td></td>
<td>Child Enrollee Behavioral Health (ECHO)</td>
<td>Biennial (STAR)</td>
<td>Report of Child Caregiver Satisfaction and Experience with Behavioral Health Care</td>
</tr>
<tr>
<td><strong>Provider Office Surveys</strong></td>
<td>Provider Office Surveys</td>
<td>Biennial (STAR, STAR+PLUS, STAR Health, CHIP, CHIP Dental)</td>
<td>Report by MCO and Managed Care Program of Provider Office/Provider Experience and Satisfaction with Specific MCO Requirements</td>
</tr>
<tr>
<td><strong>HEDIS®/Other Quality and Utilization Measures</strong></td>
<td>Quarterly Topic Reports</td>
<td>Quarterly (All Programs)</td>
<td>Annual Topics of Interest to HHSC with Quarterly Presentation of Measures, Literature Review, and Recommendations for Improvement</td>
</tr>
<tr>
<td></td>
<td>Quality of Care Reports</td>
<td>Annual (All Programs)</td>
<td>Tables and reports presenting MCO-level results on selected HEDIS and other administrative quality indicators</td>
</tr>
<tr>
<td></td>
<td>CSHCN State-Wide Analysis</td>
<td>Annual (STAR, CHIP)</td>
<td>Report Using Survey and Administrative Measures to Assess Care Provided to Children with Special Health Care Needs</td>
</tr>
<tr>
<td><strong>Data Certification/Validation</strong></td>
<td>Data Certification Reports</td>
<td>Annual (All Programs)</td>
<td>Report Certifying Encounter Data Submitted by MCOs Meets State and Federal Requirements</td>
</tr>
<tr>
<td></td>
<td>Rate Analysis Lag Tables</td>
<td>Annual (All Programs)</td>
<td>Tables Displaying Total Dollars Representing Encounters Submitted Monthly by MCOs</td>
</tr>
<tr>
<td></td>
<td>Rate Analysis Risk Ratio Tables</td>
<td>Annual (STAR, CHIP, STAR+PLUS)</td>
<td>The Rate Analysis Risk Ratio (CDPS) Tables provide data regarding the differences in the risk mix of enrollees in a health plan and differences in the cost to support the annual HHSC Rate Setting and Rate Analysis activities.</td>
</tr>
<tr>
<td></td>
<td>Rate Analysis Data Files</td>
<td>Annual (All Programs)</td>
<td>Files of Certified Encounter Data</td>
</tr>
<tr>
<td></td>
<td>Encounter Data Validation Report</td>
<td>Biennial (All Programs)</td>
<td>Report of Record Review Validating Encounter Data from Claims and Encounter Data Submitted by MCOs Against Documentation in the Provider’s Medical Record</td>
</tr>
<tr>
<td><strong>MCO Administrative Interviews</strong></td>
<td>MCO Administrative Interview Tools</td>
<td>Annual (All Programs)</td>
<td>Assessment Tools for MCO Completion</td>
</tr>
<tr>
<td></td>
<td>MCO Administrative Interview Site Visits</td>
<td>Annual (All Programs)</td>
<td>Site Visits to Selected MCOs for Evaluation</td>
</tr>
<tr>
<td></td>
<td>MCO Administrative Interview Reports</td>
<td>Annual (All Programs)</td>
<td>Individual MCO Reports of Structure/Process Assessment and Compliance with State/Federal Requirements</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Deliverable Group</th>
<th>Deliverable Name</th>
<th>Frequency (Program)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO Quality Performance</td>
<td>MCO Performance Improvement Projects</td>
<td>Annual (All Programs)</td>
<td>Individual MCO Reports of Effectiveness of Approaches to Improve HHSC-Assigned Performance Improvement Goals</td>
</tr>
<tr>
<td></td>
<td>MCO Performance Ranking</td>
<td>Annual (STAR, STAR+PLUS, CHIP)</td>
<td>Ranking of MCOs in Each Program Using HHSC-Selected Performance Measures</td>
</tr>
<tr>
<td></td>
<td>MCO QAPI Individual Report</td>
<td>Annual (All Programs)</td>
<td>Individual MCO Reports Providing Feedback on MCO Summary of Prior Year Quality Program Activities and Effectiveness</td>
</tr>
<tr>
<td></td>
<td>QAPI Program Reports</td>
<td>Annual (All Programs)</td>
<td>Summary Report for Each Program of Findings from MCO Summaries of Prior Year Quality Program Activities and Effectiveness</td>
</tr>
<tr>
<td></td>
<td>Biannual MCO Quality Forum</td>
<td>Biannual (All Programs)</td>
<td>Interactive Face-to-Face Conference with MCOs and HHSC Stakeholders</td>
</tr>
<tr>
<td></td>
<td>MCO Quality Collaborative – Texas Healthcare Learning Collaborative (ThLC) Web Portal</td>
<td>Annual (All Programs)</td>
<td>Facilitation of MCO Collaboration on Improvement Projects, Potentially Preventable Events, Quality of Care measures, and interventions</td>
</tr>
<tr>
<td>Focus Studies</td>
<td>STAR+PLUS Long-Term Care</td>
<td>Annual (2-year study)</td>
<td>Designed to examine the quality of care for STAR+PLUS dual eligible enrollees and also designed to examine the effects of STAR+PLUS on the quality and outcomes of care for its members overall. Combines patient reported outcomes with linked Medicaid and Medicare data.</td>
</tr>
<tr>
<td></td>
<td>Rider 50 Studies</td>
<td>Biannual (1-year study)</td>
<td>Two reports presenting results of special analyses conducted to: (1) understand reasons for gaps in BH quality of care; and (2) identify alternate methods of assessing BH performance and interventions for improving BH performance.</td>
</tr>
<tr>
<td>Summary of Activities</td>
<td>Summary of Activities Report</td>
<td>Annual (All Programs)</td>
<td>Report summarizing all EQRO activities during the previous year and trends in healthcare quality.</td>
</tr>
</tbody>
</table>
# APPENDIX C: CMS DELIVERABLES

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Deliverable</td>
<td>QAPI Program Annual Summary</td>
<td>Annual</td>
<td>The MCO must develop, maintain, and operate a Quality Assessment and Performance Improvement (QAPI) Program consistent with the Contract, and TDI requirements. The MCO must complete an annual QAPI Program Summary as specified in the UMCM.</td>
</tr>
<tr>
<td>Process</td>
<td>Annual Encounter Data Validation</td>
<td>Biennial</td>
<td>Encounter data validation is used to assess and improve quality and monitor program integrity. Encounter data validation protocol includes: a. Review of state requirements for submission of encounter data, b. Review of each MCO's capability to produce accurate and complete encounter data (see P&amp;P on data certification), c. Analysis of electronic MCO encounter data for accuracy and completeness (see P&amp;P on data certification), and d. Review of health records as appropriate for additional confirmation of findings.</td>
</tr>
<tr>
<td>Process</td>
<td>Annual MCO Teleconferences and Reporting</td>
<td>Annual</td>
<td>The Administrative Interview teleconference is an effective method for performing quality oversight and compliance assessment of Medicaid Managed Care Organizations (MCOs). The Center for Medicare and Medicaid outlines the requirements for determining compliance with Medicaid Managed Care Proposed Regulations (42 CFR Parts 400, 430, et al). HHSC assesses the MCO's ability to meet federal and state requirements, and whether the MCOs have the structure and processes in place to deliver and improve quality of care and services for their memberships.</td>
</tr>
<tr>
<td>Process</td>
<td>Annual MCO Site Visits</td>
<td>Annual</td>
<td>The on-site Administrative Interview process is an effective method for performing quality oversight and compliance assessment of Medicaid Managed Care Organizations (MCOs). The Centers for Medicare and Medicaid Services (CMS) outlines the requirements for determining compliance with Medicaid Managed Care Proposed Regulations (42 CFR Parts 400, 430, et al). This comparative analysis utilizes two approaches to determine compliance with regulations and standards: 1) document review and 2) interviews with organization staff.</td>
</tr>
<tr>
<td>Process</td>
<td>STAR Adult Behavioral Health Survey</td>
<td>Biennial</td>
<td>The STAR Adult Behavioral Health Survey provides a summary of adult members’ experiences and satisfaction with the behavioral health care they receive through Texas STAR managed care organizations (MCOs) and behavioral health organizations (BHOs).</td>
</tr>
<tr>
<td>Process</td>
<td>STAR Child Behavioral Health Survey</td>
<td>Biennial</td>
<td>The STAR Child Behavioral Health Survey Report summarizes caregiver experiences and satisfaction with the behavioral health services their children receive through STAR managed care organizations (MCOs) or through behavioral healthcare organizations (BHOs) contracted by STAR MCOs.</td>
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<tr>
<td>Process</td>
<td>STAR Adult CAHPS® Survey</td>
<td>Biennial</td>
<td>Adult members enrolled in STAR surveyed by telephone, using the CAHPS® Health Plan Survey, to assess their experiences and satisfaction with services provided through STAR MCOs and with providers serving members of the STAR Program. The report presents the demographics, health status, and health care satisfaction of adult STAR members, and examine differences by MCO.</td>
</tr>
<tr>
<td>Process</td>
<td>STAR Child CAHPS® Survey</td>
<td>Biennial</td>
<td>Caregivers of children enrolled in STAR surveyed by telephone, using the CAHPS® Health Plan Survey, to assess their experiences and satisfaction with services provided through STAR MCOs and with providers serving members of the STAR Program. The report presents the demographics, health status, and health care satisfaction of child STAR members and their caregivers and examine differences by MCO.</td>
</tr>
<tr>
<td>Process</td>
<td>STAR Health CAHPS® Survey</td>
<td>Biennial</td>
<td>Caregivers of children enrolled in STAR Health surveyed by telephone, using the CAHPS® Health Plan Survey, to assess their experiences and satisfaction with services provided through the STAR Health MCO and with providers serving members of the STAR Health Program. The report presents the demographics, health status, and health care satisfaction of STAR Health members and their caregivers.</td>
</tr>
<tr>
<td>Process</td>
<td>STAR+PLUS CAHPS® Survey</td>
<td>Annual</td>
<td>Adult members enrolled in STAR+PLUS surveyed by telephone, using the CAHPS® Health Plan Survey, to assess their experiences and satisfaction with services provided through STAR+PLUS MCOs and with providers serving members of the STAR+PLUS Program. The report presents the demographics, health status, and health care satisfaction of adult members, and examine differences by MCO.</td>
</tr>
<tr>
<td>Process</td>
<td>STAR+PLUS Adult Behavioral Health Survey</td>
<td>Biennial</td>
<td>The Adult STAR+PLUS Behavioral Health Survey Report summarizes members’ experiences and satisfaction with the behavioral health services they receive through STAR+PLUS managed care organizations (MCOs) or through behavioral healthcare organizations (BHOs) contracted by STAR+PLUS MCOs.</td>
</tr>
<tr>
<td>Process</td>
<td>CHIP Established Member Survey</td>
<td>Biennial</td>
<td>The CHIP Established Member Survey Report summarizes caregiver experiences and satisfaction with the services, quality of care, providers, and health plan benefits their children receive through CHIP managed care organizations (MCOs).</td>
</tr>
<tr>
<td>Process</td>
<td>Children with Special Health Care Needs Administrative Analysis</td>
<td>Annual</td>
<td>This is a special analyses examining the quality of care CSHCN receive in the STAR, PCCM, and CHIP programs. Analysis includes assessment of: (1) quality of care using selected Healthcare Effectiveness Data and Information Set (HEDIS®) measures; (2) experiences of families in obtaining care using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey; (3) rates of potentially preventable inpatient admissions for selected conditions using the Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs); and (4) rates of potentially preventable emergency department admissions, inpatient admissions, and readmissions using 3M metrics.</td>
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<tr>
<td>Process</td>
<td>Biannual MCO Quality Forum</td>
<td>Biannual</td>
<td>The purpose of the SF 2011 Fall Forum is to present quality of care measures and implementation of an online learning collaborative for quality improvement in the Texas Medicaid and Children’s Health Insurance Programs.</td>
</tr>
<tr>
<td>Process</td>
<td>Assessment of MCO Performance Improvements Projects</td>
<td>Annual</td>
<td>Evaluates the accuracy of Medicaid performance measures reported by, or on behalf of, a Managed Care Organization (MCO), and determines the extent to which Medicaid-specific performance measures calculated by an MCO (or by entity acting on behalf of an MCO) followed specifications established by the State Medicaid agency (the State) for the calculation of the performance measure(s).</td>
</tr>
<tr>
<td>Process</td>
<td>Evaluation and Update of the HHSC Performance Indicator Dashboard</td>
<td>Annual</td>
<td>Evaluates the Dashboard standards for each Texas Medicaid and Children’s Health Insurance Program and compares them to the MCO’s performance during the prior three years. Provides information about national-level benchmarks (if available) and national and state means on performance measures for descriptive purposes.</td>
</tr>
<tr>
<td>Process</td>
<td>Quality Challenge Award</td>
<td>Annual</td>
<td>The performance measures are used for ranking the health plans. The ranking process is based on the number of MCOs under consideration. For each of the performance measures, the MCOs are listed in rank order from the plan with the highest (i.e., best) score to the lowest (i.e., worst) score. The health plan total scores and rankings then are used to apportion the funds remaining from the 5% at-risk premium program.</td>
</tr>
<tr>
<td>Process</td>
<td>STAR Health Provider Office Survey</td>
<td>Biennial</td>
<td>The STAR Health Provider Office Survey assesses whether the contracted managed care organization (MCO) for STAR Health is meeting certain contract obligations and requirements, and measures provider satisfaction with the STAR Health MCO.</td>
</tr>
<tr>
<td>Process</td>
<td>Provider Office Survey</td>
<td>Annual</td>
<td>The Provider Office Survey assesses whether managed care organizations (MCOs) are meeting certain contract obligations and requirements, and measures provider satisfaction with the MCO networks.</td>
</tr>
<tr>
<td>Process</td>
<td>At Risk Premium Program</td>
<td>Annual</td>
<td>To use a benchmarking approach to measure the performance of health plans and to allocate the 5% at-risk premium performance-based revenue pool. Analysis includes: (1) assessment of the quality of care using selected Healthcare Effectiveness Data and Information Set (HEDIS®) measures, and (2) various non-HEDIS® measures.</td>
</tr>
<tr>
<td>Deliverable</td>
<td>Performance Improvement Projects</td>
<td>Annual</td>
<td>MCOs submit proposed performance improvement projects for performance improvement each year.</td>
</tr>
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<tr>
<td>Report</td>
<td>Monthly TMHP Data Extract Log Report</td>
<td>Monthly</td>
<td>The monthly MCO data log report provides HHSC with a summary of the quality of Medicaid and CHIP encounter data extracts received from TMHP. Thorough analysis is conducted using various procedures and queries. A summary report is a log report that includes the percent of missing and invalid data. Provider logs will be included to indicate the fill rate of NPI and taxonomy information.</td>
</tr>
<tr>
<td>Report</td>
<td>Data Certification Reports</td>
<td>Annual</td>
<td>Data certification reports support rate setting activities and provide information relating to the quality, completeness, and accuracy of the MCO encounter data. Certification reports include a QA analysis to assure data quality within agreed standards for accuracy, a summary of amounts paid by service type and month of service, and a comparison of amounts paid to financial summary reports provided by the health plans. All reports are created by plan code and combined into the larger reports.</td>
</tr>
</tbody>
</table>