

Rider 50 Report

Improving the Transparency and Accountability of Behavioral Health Service Delivery in the STAR and STAR+PLUS Medicaid Managed Care Programs

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Executive Summary

The 2010-11 General Appropriations Act (Article II, Health and Human Services Commission, Rider 50, S.B. 1, 81st Legislature, Regular Session, 2009) directs the Health and Human Services Commission (HHSC) to develop and submit a report to the Legislative Budget Board (LBB) and the Governor on strategies to improve the transparency and accountability of behavioral health service delivery in the STAR and STAR+PLUS Medicaid managed care programs.

In its January 2009 report entitled *Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations*, the LBB made five recommendations for improving the transparency and accountability of behavioral health service delivery in STAR and STAR+PLUS.

- 1) HHSC should improve the tracking and reporting of behavioral health performance data for STAR and STAR+PLUS managed care organizations (MCOs) by publishing additional access, quality, and complaint indicators specific to behavioral health. HHSC should use financial incentives and disincentives to encourage STAR and STAR+PLUS MCOs to meet performance expectations on indicators of the effectiveness of behavioral health service delivery.
- 2) HHSC should identify strategies implemented by STAR and STAR+PLUS MCOs that have demonstrated improved performance on important behavioral health indicators, and annually disseminate their findings to encourage sharing of effective strategies.
- 3) HHSC should conduct a biennial survey to assess member satisfaction with behavioral health services delivered through the STAR and STAR+PLUS MCOs and behavioral health organizations (BHOs), and publish the survey results on its website.
- 4) The Texas Legislature should include a rider in the 2010-2011 General Appropriations Bill that directs HHSC to develop a report on strategies to improve the transparency and accountability of behavioral health service delivery in STAR and STAR+PLUS, to be submitted to the LBB and the Governor by September 1, 2010.

The LBB's fifth recommendation was addressed through the passage of Rider 50. The purpose of this report, which was developed by the Texas External Quality Review Organization (EQRO), is to discuss HHSC's current and future strategies for addressing the remaining four recommendations.

Current Strategies

Performance Measurement

- The HHSC MCO Performance Indicator Dashboard currently tracks seven behavioral health indicators.
- The Texas EQRO provides results of indicators for 7-day follow-up, 30-day follow-up, and readmission within 30 days in its Annual Quality of Care reports.
- In fiscal year 2010, HHSC, in collaboration with its EQRO, studied the accountability and transparency of behavioral health care service delivery for STAR and STAR+PLUS enrollees. For these studies, the EQRO selected the three indicators that HHSC presently monitors, as well as five additional Health Plan Employer Data and Information Set (HEDIS)[®] measures relevant to behavioral health.
- HHSC tracks, but does not regularly publish, two behavioral health performance indicators that have contractual requirements associated with them.
- In fiscal year 2009, STAR MCO reporting on five behavioral health hotline indicators was low. Only five MCOs reported on "Average Hold Time." Three MCOs did not report on any of the five indicators.

- The HHSC Performance Indicator Dashboard includes one behavioral health indicator from consumer satisfaction data (using the Consumer Assessment of Health Providers & Systems [CAHPS][®] Health Plan survey). This indicator addresses performance for child enrollees, but not adult enrollees.
- MCOs provide HHSC with complaints and appeals data dealing specifically with behavioral health services, although this data is not included on the Performance Indicator Dashboard.

MCO Incentives and Disincentives

- HHSC currently uses value-based purchasing to incentivize performance in STAR and STAR+PLUS MCOs. Each MCO is at risk for 1 percent of the capitation rate, depending on the outcome of specified performance measures. Any undistributed funds are re-allocated to HHSC's Quality Challenge Award – given to MCOs that demonstrate superior performance on a separate set of indicators.
- Only one indicator relevant to behavioral health services is included in determining the 1 percent at-risk amount, while there are four behavioral health indicators used to evaluate MCO performance for the Quality Challenge Award.

Performance Improvement Strategies

- HHSC will require MCOs to implement and evaluate performance improvement projects (PIPs) effective fiscal year 2012 and beyond.
- HHSC requires MCOs to develop a quality assurance and performance improvement (QAPI) program and annually summarize the program's findings. MCOs that provide behavioral health services are required to integrate behavioral health into their QAPI programs.
- Each year HHSC collaborates with MCOs to identify a common set of overarching performance improvement goals (PIGs), which the MCOs use to define and implement their own sub-goals. In fiscal year 2008, HHSC identified one overarching goal to improve member access to behavioral health services. Eight of the 14 MCOs participating in STAR had sub-goals aimed toward improving HEDIS[®] rates of 7-day follow-up for members discharged from an inpatient behavioral health stay.
- In its evaluation of the fiscal year 2008 QAPI summaries, the EQRO recommended that MCOs define PIGs that focus on outcomes, which allow room for improvement in their measurement and have greater relevance for the health of members.
- Over the past two years, HHSC has worked with the EQRO to address the limitations of using PIGs. Effective fiscal year 2012, HHSC will require MCOs to move toward implementing and evaluating PIPs for fiscal years 2012 and beyond.
- To date, HHSC has disseminated the findings of successful MCO quality improvement initiatives; information on quality improvement findings can be more visible to users of that information through a dedicated portal on the HHSC website.

Behavioral Health Member Surveys

- In fiscal year 2009, the EQRO conducted Medicaid managed care member satisfaction surveys for adults in STAR and STAR+PLUS, and for caregivers of children in STAR. The CAHPS[®] Health Plan survey instrument includes four questions pertaining to members' need for, access to, and perceived quality of behavioral health treatment and counseling.
- In fiscal year 2010, the EQRO conducted the first behavioral health surveys for adults and caregivers of children in the STAR program, using the Experience of Care and Health Outcomes (ECHO)[™] survey instrument. These surveys will be conducted on a biennial basis.
- In the next two years, the EQRO plans to design and conduct a behavioral health survey for adults in STAR+PLUS using the ECHO[™] survey.

Future Strategies

Performance Measurement

- Request that the EQRO include the five additional HEDIS[®] measures related to behavioral health in its STAR and STAR+PLUS Quality of Care Reports. These measures include the following:
 - HEDIS[®] Antidepressant Medication Management (AMM)

- HEDIS[®] Follow-up Care for Children Prescribed ADHD Medication (ADD)
- HEDIS[®] Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- HEDIS[®] Identification of Alcohol and Other Drug Services
- HEDIS[®] Mental Health Utilization
- Consider including on the Performance Indicator Dashboard the AMM and ADD HEDIS[®] measures.
- Conduct additional studies specifically focused on gaps in performance related to enrollee demographics and behavioral health delivery model – and report results of these studies by STAR and STAR+PLUS MCO.
- Publicly report MCO results of the two currently monitored behavioral health Performance Dashboard Indicators on a quarterly basis.
- Monitor and publicly report MCO results on the provision of initial outpatient behavioral health visits within 14 days, and consider this measure for inclusion on the Performance Indicator Dashboard.
- Include in the Performance Indicator Dashboard the CAHPS[®] Health Plan Survey question on satisfaction with access to behavioral health services for adults in STAR and STAR+PLUS.
- Consider additional survey-based performance indicators from the ECHO[®] Survey, following its full implementation in fiscal years 2010 and 2011.
- Ensure that MCOs provide HHSC with behavioral health complaints and appeals data on a quarterly basis, and establish and enforce penalties for MCOs that fail to report requested data in a timely fashion.
- Consider including in the Performance Indicator Dashboard the percentage of behavioral health complaints resolved within 30 days and the percentage of behavioral health appeals resolved within 30 days.
- Implement a strategy for public reporting of behavioral health complaints and appeals by Medicaid STAR and STAR+PLUS MCOs.
- Consider an addition to the Texas Medicaid website specifically for the reporting of behavioral health performance measures.

MCO Incentives and Disincentives

- Apply a separate 1 percent at-risk capitation rate for behavioral health performance, or at least expand the number of at-risk performance indicators specific to behavioral health. Consider at least one access measure and one quality measure related to behavioral health services.
- Evaluate options for incentivizing provider performance in behavioral health services based on episodes of care.

Performance Improvement Strategies

- Continue working toward the annual implementation and evaluation of MCO PIPs that are specific to behavioral health and promote their integration into MCO QAPI programs.
- Provide training to MCOs, in collaboration with the EQRO, to ensure that PIPs are relevant to member populations, follow sound study designs, and lead to the refinement of effective strategies for improving the quality of behavioral health services.
- Share the findings of PIPs, both with health plan managers in interactive sessions, and with the public through an interactive web portal.

Behavioral Health Member Surveys

- Evaluate whether it would be useful to conduct analyses of the experiences and satisfaction that STAR+PLUS enrollees have with behavioral health services, including results from the upcoming STAR+PLUS Adult Behavioral Health Survey, and link analyses to relevant administrative and encounter data.
- Utilize member satisfaction data to evaluate PIPs that are specific to behavioral health. HHSC may request that the EQRO conduct a longitudinal study to follow a cohort of enrollees and evaluate their satisfaction after implementation of a PIP specific to behavioral health.
- Consider using a risk-adjusted statistical model to analyze behavioral health survey data, which can control for member characteristics such as mental health status that may independently influence how members evaluate their health care experiences.

In summary, the report highlights current and future strategies for improving the transparency and accountability of behavioral health service delivery in the STAR and STAR+PLUS Medicaid managed care programs, consistent with recommendations made by the LBB. HHSC, in conjunction with the Institute for Child Health Policy (IChP) at the University of Florida, will continue to work with the STAR and STAR+PLUS MCOs to implement these strategies.

Introduction

The 2010-11 General Appropriations Act (Article II, Health and Human Services Commission, Rider 50, S.B. 1, 81st Legislature, Regular Session, 2009) directs the Health and Human Services Commission (HHSC) to develop and submit a report to the Legislative Budget Board (LBB) and the Governor on strategies to improve the transparency and accountability of behavioral health service delivery in the STAR and STAR+PLUS Medicaid managed care programs.

In recent years, transparency and accountability have become important components to the improvement of health care quality. At the state and local levels, Medicaid programs and contracted Medicaid managed care organizations (MCOs) have increased efforts toward transparency through the public reporting of health care quality “report cards,” which include results of quality indicators on health care outcomes and processes.¹

The public reporting of these results can help patients and referring physicians select high-quality providers.² Public reporting also functions to convey a sense of trust among patients, hold providers and MCOs accountable for the quality of care they deliver, and help purchasers negotiate contracts with MCOs. In theory, these mechanisms act as an incentive for providers to improve their practices and implement quality improvement initiatives. Medicaid programs may also use these indicators as the basis for financial incentives and disincentives to improve MCO performance.

Among the most commonly reported quality indicators are the National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS[®]) measures, which MCOs provide to the NCQA for public disclosure on a voluntary basis. HEDIS[®] measures, which are based on administrative data, allow for comparisons of results across programs and MCOs. Medicaid programs and MCOs also collect member satisfaction data – most often using the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) surveys from the Agency for Healthcare Research and Quality (AHRQ).

Historically, there has been a greater emphasis in performance measures and satisfaction related to physical health services. There are HEDIS[®] measures that address behavioral health services and questions regarding member satisfaction in the CAHPS[®] survey. Understanding has grown over time about the importance of good behavioral health as a key component of good overall health. This underscores the importance of including behavioral health in program-level efforts toward improving transparency and accountability.

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 and the Children’s Health Insurance Program (CHIP). This report expands the discussion of efforts undertaken by HHSC, in collaboration with the Institute for Child Health Policy (IHP) at the University of Florida, the Texas External Quality Review Organization (EQRO), to improve transparency and accountability for behavioral health services provided through the STAR and STAR+PLUS Medicaid managed care programs.

Purpose

The purpose of this report is to present current and future strategies for improving the transparency and accountability of behavioral health service delivery in the STAR and STAR+PLUS Medicaid managed care programs, consistent with recommendations made by the LBB in January 2009. This report discusses current and future strategies in four areas:

- 1) Measuring the performance of behavioral health service delivery.
- 2) Using incentives and disincentives to encourage MCOs to meet behavioral health performance expectations.
- 3) Identifying and disseminating efforts for behavioral health care performance improvement.
- 4) Administering surveys to assess member satisfaction with behavioral health services.³

Within each section, the report addresses current HHSC strategies (with specific reference to fiscal year 2009 and fiscal year 2010 activities); the strategies of other state Medicaid programs, MCOs, and health care organizations; and recommendations to HHSC for improving existing strategies and implementing new strategies in the upcoming fiscal year.

Background

In Texas Medicaid managed care, behavioral health services are available to enrollees through two primary delivery models: (1) direct payer model, in which MCOs provide integrated behavioral health benefits as part of their benefit package; and (2) health plan carve-outs, in which MCOs sub-contract with BHOs for the delivery of behavioral health services on a per member per month (PMPM) or sub-capitated basis to eligible members.⁴

In fiscal years 2008 and 2009, 9 of the 14 MCOs in the STAR program utilized a carve-out arrangement while 5 offered behavioral health services as part of their benefit package.⁵ During the same time period, three of the four MCOs in the STAR+PLUS program had a BHO carve-out, while one MCO provided behavioral health services as part of its benefit package.⁶

According to the LBB, there is evidence that STAR and STAR+PLUS enrollees with behavioral health conditions may face problems with continuity of care.⁷ To improve the transparency and accountability of behavioral health service delivery for these enrollees, the LBB made five recommendations:

- 5) HHSC should improve the tracking and reporting of behavioral health performance data for STAR and STAR+PLUS MCOs by publishing additional access, quality, and complaint indicators specific to behavioral health. Findings should be made available at both the MCO and state levels on the HHSC website on a quarterly basis.
- 6) HHSC should use financial incentives and disincentives to encourage STAR and STAR+PLUS MCOs to meet performance expectations on indicators of the effectiveness of behavioral health service delivery.
- 7) HHSC should identify strategies implemented by STAR and STAR+PLUS MCOs that have demonstrated improved performance on important behavioral health indicators, and annually disseminate their findings to encourage sharing of effective strategies.
- 8) HHSC should conduct a biennial survey to assess member satisfaction with behavioral health services delivered through the STAR and STAR+PLUS MCOs and BHOs, and publish the survey results on its website.

- 9) The Texas legislature should include a rider in the 2010-2011 General Appropriations Bill that directs HHSC to develop a report on strategies to improve the transparency and accountability of behavioral health service delivery in STAR and STAR+PLUS, to be submitted to the LBB and the Governor by September 1, 2010.

Since the publication of the LBB report, the board’s fifth recommendation has been addressed through the passage of the 2010-11 General Appropriations Act (Article II, Health and Human Services Commission, Rider 50, S.B. 1, 81st Legislature, Regular Session, 2009).⁸ The sections below discuss proposed HHSC initiatives to address the remaining four recommendations made by the LBB – which form the basis of the report required by Rider 50.

1. Measuring the Performance of Behavioral Health Service Delivery

In its January 2009 report, the LBB expressed concern that HHSC did not include certain key behavioral health indicators in its regularly published performance data for the STAR and STAR+PLUS MCOs.⁹ The HHSC Performance Indicator Dashboard, which compiles selected performance items from MCO submissions, EQRO data, and other data available to HHSC, currently tracks seven behavioral health indicators. **Table 1** presents these indicators for fiscal year 2010, along with their corresponding standards set by HHSC for STAR and STAR+PLUS and their frequency of reporting.

The EQRO currently provides the indicators for 7-day follow up, 30-day follow up, and readmission within 30 days in its Annual Quality of Care reports, which HHSC publishes on its website.¹⁰ HHSC regularly monitors (but does not publish) the percentage of members with one mental health outpatient provider within 75 miles and the behavioral health hotline abandonment rate, both of which have contractual MCO requirements associated with them. Lastly, HHSC regularly tracks one behavioral health indicator from the CAHPS[®] surveys, which measures access to behavioral health treatment and counseling for children. While the EQRO collects results on the same survey measure for adults in STAR and STAR+PLUS, these are not included for monitoring on the Performance Indicator Dashboard.

Table 1. HHSC Performance Indicator Dashboard: Current Behavioral Health Indicators

Indicator	STAR standard	STAR+PLUS standard	Frequency of reporting
Percent of members with one mental health outpatient provider within 75 miles	90%	90%	Quarterly
Percent of child members with good access to behavioral health treatment or counseling (CAHPS [®])	-	-	Annual
Percent of members receiving follow-up within 7 days after an inpatient stay for mental health (HEDIS [®])	32%	32%	Annual
Percent of members receiving follow-up within 30 days after an inpatient stay for mental health (HEDIS [®])	52%	52%	Annual
Percent of child members readmitted within 30 days after an inpatient stay for mental health	-	N/A	Annual
Percent of adult members readmitted within 30 days	-	-	Annual

Indicator	STAR standard	STAR+PLUS standard	Frequency of reporting
after an inpatient stay for mental health			
Behavioral health hotline abandonment rate	7%	7%	Quarterly

To address the apparent gap in the tracking of MCO performance on behavioral health services, the LBB recommended that HHSC monitor additional HEDIS[®], contract compliance, consumer satisfaction, and complaints and appeals indicators.

HEDIS[®] Measures

The Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a tool used by more than 90 percent of health plans in the United States to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 71 measures across 8 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts.

HEDIS measures address a broad range of important health issues. Among them are the following:

- Asthma Medication Use
- Persistence of Beta-Blocker Treatment after a Heart Attack
- Controlling High Blood Pressure
- Comprehensive Diabetes Care
- Breast Cancer Screening
- Antidepressant Medication Management
- Childhood and Adolescent Immunization Status
- Advising Smokers to Quit

The 2010 HEDIS[®] measures include the following five indicators related to behavioral health, which HHSC does not regularly monitor or publish:

- HEDIS[®] Antidepressant Medication Management (AMM)
- HEDIS[®] Follow-up Care for Children Prescribed ADHD Medication (ADD)
- HEDIS[®] Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- HEDIS[®] Identification of Alcohol and Other Drug Services (IAD)
- HEDIS[®] Mental Health Utilization (MPT)

From analysis of administrative data for fiscal years 2008 and 2009, the EQRO determined that ADHD was the most frequently diagnosed behavioral health condition for children and adolescents in STAR between 6 and 20 years old, while depression was the most frequently diagnosed behavioral health condition for STAR adults 21 years of age and older.¹¹ Among adults in STAR, drug dependence ranged from the second to the fifth most common behavioral health diagnosis. During the same timeframe in STAR+PLUS, ADHD was the most frequent diagnosis for members 10 to 20 years old, while depression was the most frequent diagnosis for members 65 to 74 years of age.

For fiscal year 2010, in response to both the LBB report and Rider 50, HHSC directed the EQRO to conduct preliminary studies of the quality of behavioral health care provided to STAR and STAR+PLUS enrollees. For these studies, the EQRO selected the three indicators that HHSC presently monitors (7-day follow-up, 30-day follow-up, and readmission within 30 days), as well as the five additional HEDIS® measures listed above.

To improve the transparency and accountability of behavioral health services using HEDIS® and HEDIS®-like measures, HHSC will:

- 1) Request that the EQRO include the five additional HEDIS® measures related to behavioral health (AMM, ADD, IET, IAD, and MPT) in its STAR and STAR+PLUS Quality of Care reports.
- 2) Consider including on the Performance Indicator Dashboard the AMM and ADD HEDIS® measures, given the high prevalence of depression and ADHD in the STAR and STAR+PLUS populations.
- 3) Conduct additional studies to explore findings of the fiscal year 2010 Quarterly Topic Reports in more detail – specifically with regard to gaps in performance related to enrollee demographics and behavioral health delivery model – and publicly report results of these studies by STAR and STAR+PLUS MCO.

Contract Compliance Measures

The LBB also noted that HHSC tracks, but does not regularly publish, two performance indicators that have contractual requirements associated with them. These are: (1) the percentage of members with a mental health outpatient provider within 75 miles, and (2) the behavioral health hotline abandonment rate.¹⁴

The HHSC Uniform Managed Care Contract also includes a number of requirements regarding behavioral health services that can be monitored and reported, but which HHSC presently does not publish as performance indicators.¹⁵ Among these requirements, contracted MCOs must ensure that:

Behavioral Health Service Delivery Strengths

The following behavioral health quality indicators showed high performance across all demographic sub-groups and delivery models, in comparison with HEDIS® national means for the same measurement year (fiscal year 2008):¹²

- Initiation of ADHD treatment for children 6 to 12 years of age
- Continuation of ADHD treatment for children 6 to 12 years of age¹³
- Effective acute-phase antidepressant medication management for adults
- Effective continuation-phase antidepressant medication management for adults

Behavioral Health Performance Gaps

Gaps in performance specific to demographic groups (by age, sex, or race/ethnicity) included:

- Less than 20 percent of adolescents with a substance abuse disorder received two or more alcohol and other drug (AOD) services after initiating treatment.
- In STAR, female members with substance abuse disorder initiated treatment at higher rates than male members, but also had higher rates of dropping out of treatment.
- Hispanic children were more likely to have follow-up care for ADHD than their White, non-Hispanic or Black, non-Hispanic counterparts.

- Initial outpatient behavioral health visits are provided within 14 days of request.
- 99 percent of calls to the behavioral health hotline are answered by the fourth ring.
- No more than 1 percent of incoming calls to the behavioral health hotline receive a busy signal.
- The average hold time for the behavioral health hotline is two minutes or less.
- At least 80 percent of calls to the behavioral health hotline are answered by toll-free line staff within 30 seconds.

The requirement that MCOs provide initial outpatient behavioral health visits within 14 days of request is an important indicator of behavioral health services access, which the LBB recommended for inclusion in HHSC's set of monitored and published performance indicators.¹⁶ The remaining four unpublished requirements address the MCO's behavioral health services hotline, which the MCO must maintain toll-free, 24 hours per day, 7 days per week. HHSC regularly monitors performance on these requirements for each MCO, but does not report them publicly.

Table A1 in Appendix A presents STAR MCO performance results for four behavioral health hotline indicators in fiscal year 2009. All MCOs performed within contractual standards for the indicators they reported. However, the overall rate of reporting was relatively low, suggesting that most MCOs can improve performance on one or more reporting requirements related to the behavioral health hotline. One of the MCO's indicated "NA" in one or more quarters of the fiscal year, which means there were no behavioral health calls during the specified period. Two MCOs had very low call counts.

To improve the transparency and accountability of behavioral health services using contract compliance measures, HHSC will:

- 1) Publicly report MCO results of the two currently monitored Performance Dashboard Indicators on a quarterly basis.
- 2) Monitor and publicly report MCO results on the provision of initial outpatient behavioral health visits within 14 days, and consider this important access measure for inclusion on the Performance Indicator Dashboard.
- 3) Once behavioral health hotline indicators have been validated, monitor and publicly report them on a quarterly basis.

Consumer Satisfaction Data

The Texas EQRO conducts CAHPS[®] consumer satisfaction surveys with STAR enrollees (both adults and caregivers of children) on a biennial basis, and with adult STAR+PLUS enrollees on an annual basis. These surveys include questions to assess satisfaction with access to and quality of behavioral health treatment. The Medicaid Managed Care version of CAHPS[®] 4.0 asks members: (1) how often it was easy to get needed behavioral health treatment or counseling through their health plan (satisfaction with access), and (2) how they would rate their treatment or counseling on a scale from 0 to 10 (satisfaction with quality). However, as noted above, HHSC requires MCOs to meet performance standards only for behavioral health access for children.

The most recent survey report available on the agency's website is the STAR+PLUS Adult Enrollee CAHPS[®] Health Plan Survey Report for FY 2009, posted in April 2010.¹⁷ While some behavioral health questions are posed in the survey, the survey is a general assessment of consumer satisfaction with effectiveness of care, access and availability, and patient experience. The AHRQ publishes a CAHPS[®]

survey that is specific to behavioral health – the ECHO[®] Survey – which has been used by the New Jersey, Vermont, and Minnesota Medicaid programs as part of their managed care quality oversight.¹⁸ In fiscal year 2010, HHSC introduced the ECHO[®] Survey for its adult and child STAR enrollees, which is discussed in more detail in Section 4 below. Following analysis of the ECHO[®] Survey results, HHSC may identify additional performance indicators related to behavioral health services. The survey evaluates:

- The sociodemographic characteristics and health status of enrollees receiving behavioral health services.
- Enrollee experiences and satisfaction with their counseling and treatment.
- Enrollee experiences and satisfaction with their MCO or BHO, as it pertains to their counseling and treatment.

To improve the transparency and accountability of behavioral health services in STAR and STAR+PLUS using consumer satisfaction data, HHSC will:

- 1) Include in the Performance Indicator Dashboard the CAHPS[®] Health Plan Survey question on satisfaction with access to behavioral health services for adults in STAR and STAR+PLUS.
- 2) Consider additional survey-based performance indicators from the ECHO[®] Survey, following its full implementation in fiscal years 2010 and 2011.

Complaints and Appeals Data

The Uniform Managed Care Contract requires Medicaid MCOs to track, resolve, and report member complaints regarding their services, processes, procedures, and staff.¹⁹ At least 98 percent of complaints must be resolved within 30 calendar days of their receipt, or the MCO is subject to remedies, including liquidated damages. The contract also requires MCOs to track, resolve, and report member appeals for denied claims. As with complaints, at least 98 percent of member appeals must be resolved within 30 calendar days, or the MCO is subject to liquidated damages.

HHSC receives complaints and appeals data from Medicaid MCOs on a quarterly basis and tracks them on its Performance Indicator Dashboard, using the 98 percent standard. Some of these complaints and appeals specifically address behavioral health services, although this data is not included on the Performance Indicator Dashboard, nor is it otherwise published or disseminated. Complaints from members or providers are also sent directly to HHSC via a specified HHSC e-mail address. HHSC collects, reviews, and tracks resolution of these complaints. In the past, this process did not specify in detail which complaints are directly tied to behavioral health services. Beginning with the third quarter of fiscal year 2010, behavioral health-related complaints will be a separate item for the quarterly reporting and review process. This will allow HHSC to identify specific high frequency trends and obtain more detailed information about potential quality or satisfaction issues.

Table A2 in Appendix A shows behavioral health appeals data for each of the STAR MCOs operating in Texas Medicaid in fiscal year 2009. For each quarter of the fiscal year, the table shows the percentage of the MCO's behavioral health appeals that were adjudicated within 30 days. For those MCOs reporting data, only Texas Children's met the 98 percent standard in all four quarters. Seven of the MCOs indicated "NA" in one or more quarters of the fiscal year, which means there were no behavioral health appeals during the specified period.

To improve the transparency and accountability of behavioral health services using complaints and appeals data, HHSC will:

- 1) Ensure that MCOs provide HHSC with behavioral health complaints and appeals data on a quarterly basis, and establish and enforce penalties for MCOs that fail to report requested data in a timely fashion.
- 2) Include in the Performance Indicator Dashboard the percentage of behavioral health complaints resolved within 30 days and the percentage of behavioral health appeals resolved within 30 days.
- 3) Implement a strategy for public reporting of behavioral health complaints and appeals by Medicaid STAR and STAR+PLUS MCO.

Performance Measure Initiatives in Other States

Most state Medicaid programs publish results of MCO performance measures (typically HEDIS[®] measures), although not all make the findings readily accessible to the public in a timely fashion. Among those that do publish performance measure results on their websites, deficiencies in site design (e.g., buried or broken links) sometimes make it difficult for consumers and stakeholders to retrieve helpful information. Furthermore, most Medicaid programs have not developed public reporting initiatives specifically related to the quality of behavioral health services. Without an accessible venue for reporting, MCOs and providers cannot determine which behavioral health performance indicators are used in other states.

One model for developing an effective reporting system is the California state Medicaid program (Medi-Cal Managed Care), which publishes results of performance indicators on a single web page through the state's Department of Health Care Services.²⁰ Among the advantages of California's reporting strategy is that results for both HEDIS[®] and member satisfaction indicators are available from a single location. Reports on HEDIS[®] performance measurement in California are available from 1999 to 2008, although it should be noted that the state does not include behavioral health performance indicators. The web page also includes the state's reports on quality improvement projects (QIPs), statewide collaborative QIPs, quality strategy reports, and plan-specific performance evaluations.

HHSC will consider ways to enhance its website for the reporting of behavioral health performance measures. It may be beneficial for Quality of Care reports, findings from member satisfaction surveys, MCO contract compliance, and MCO complaints and appeals data to be accessible from a single location that includes a section specific for behavioral health.

2. Using Incentives and Disincentives

State Medicaid programs use financial incentives and disincentives to direct MCO activities toward improved performance.²¹ One approach for using incentives and disincentives is value-based purchasing, in which the State requires measureable outcomes ("value") from MCOs in exchange for payment. The purpose of value-based purchasing is to commit the State and MCO to a common set of performance objectives, and to provide incentives to MCOs and providers for quality improvement projects and health promotion.

HHSC currently uses value-based purchasing to incentivize performance in STAR and STAR+PLUS MCOs. One component of this model places each MCO "at risk" for 1 percent of their PMPM capitation payments depending on the outcome of specified performance measures. Based on their performance on these measures, MCOs may retain the 1 percent at-risk amount of their total PMPM. When an MCO is unable to achieve performance expectations (and therefore receives less than the full 1 percent at-risk

amount), the undistributed funds are re-allocated to HHSC's Quality Challenge Award. As an incentive for performance, MCOs that demonstrate superior performance on another set of specified service delivery quality indicators will receive the Quality Challenge Award payment.

Table 2 summarizes both financial and non-financial incentives that HHSC uses to encourage STAR and STAR+PLUS MCOs to meet performance standards. The LBB noted that only one indicator relevant to behavioral health services (out of seven total indicators) is included in determining the 1 percent at-risk amount, while no behavioral health indicators are used to evaluate MCO performance for the Quality Challenge Award.²² Based on this finding, the LBB recommended that HHSC include at least one additional behavioral health indicator in both sets of performance measures. For a complete list of HHSC incentive/disincentive strategies, please refer to the Uniform Managed Care Manual.²³

Table 2. HHSC Financial and Non-Financial Performance Incentives

Financial Incentives	Non-Financial Incentives
<ul style="list-style-type: none"> • Performance-Based Capitation Rate: <ul style="list-style-type: none"> ●● MCOs are at-risk for 1 percent of the capitation rate. MCOs must meet HHSC's performance expectations to receive the full at-risk amount. • Quality Challenge Awards financially reward MCO's for "superior clinically quality." • MCOs are subject to remedies and liquidated damages for not fulfilling contract requirements. 	<ul style="list-style-type: none"> • MCO Performance Profiling: <ul style="list-style-type: none"> ●● Regularly provides MCOs with feedback on performance, comparing performance across MCOs. ●● Highlights MCO performance achievements on HHSC's website. • Auto-assignment of default members to MCOs that perform favorably on selected indicators rewards them for good performance.

Performance-Based Capitation Rates

Beginning in 2007, HHSC identified specific performance standards and placed MCOs at risk for 1 percent of the PMPM capitation rate based on performance results. In fiscal year 2010, HHSC used the following standard and program-specific performance indicators for the 1 percent at-risk premium:

- Standard indicators for STAR and STAR+PLUS:
 - Ninety-eight percent of clean claims must be adjudicated within 30 calendar days.
 - The Member Hotline abandonment rate must not exceed 7 percent.
 - The Behavioral Health Hotline abandonment rate must not exceed 7 percent.
 - The Provider Hotline abandonment rate must not exceed 7 percent.
- Program-specific indicators:
 - Ninety-percent of adult members must have access to at least one adult-appropriate primary care provider with an open panel within 30 miles travel distance (STAR and STAR+PLUS).

- Sixty-two percent of adult members must report no problem in getting a referral to a specialty physician (STAR+PLUS).
- Ninety percent of child members must have access to at least one child-appropriate primary care provider with an open panel within 30 miles travel distance (STAR).

The majority of at-risk performance indicators evaluate MCOs' provision of administration services (from data provided by the MCO). Only one indicator – Member Hotline abandonment rate – evaluates behavioral health services.

Performance Indicators for MCO Ranking

STAR

Children's Preventive Health

- Well-child visits – first 15 months
- Well-child visits – 3rd, 4th, 5th, and 6th years

Women's Preventive Health

- Prenatal Care
- Post Partum Care

STAR+PLUS

Asthma

- Medication for Adults

High Blood Pressure

- High blood pressure controlled

Diabetes

- Hb A1c tested
- Poor HbA1c control
- Diabetic Eye Exam
- LDL screened
- LDL controlled
- Nephropathy monitored

Both STAR & STAR+PLUS

Women's Preventive Health

- Cervical cancer screening

Use of Facilities for Ambulatory Care

Sensitive Conditions (ACSC)

- Percent of inpatient services for ACSC
- Percent of ER services for ACSC

Behavioral Health

- 7-day f/u after hospital for Mental Health
- 30-day f/u after hospital for MH
- 30-day readmission rate – child (0 – 18)
- 30-day readmission rate – adult (19 & above)

Quality Challenge Awards

The funds that HHSC retains from the at-risk portion of the capitation rate are placed in the Quality Challenge Pool. HHSC annually awards funds in the Quality Challenge Pool to select MCOs for superior clinical quality. Each year, HHSC determines the number of MCOs that can participate in the Quality Challenge Award based on the availability of funds in each program's pool.

In fiscal year 2008, the EQRO issued the first MCO Performance Ranking Reports for STAR, STAR+PLUS, and CHIP, which presented a new ranking methodology for determining the allocation of Quality Challenge Awards.²⁴ See the text box on the left for a list of the quality indicators used to rank the performance of MCOs in STAR and STAR+PLUS.

In fiscal year 2010, HHSC directed the EQRO to develop a performance ranking methodology based on the following quality indicators, which are part of the Performance Indicator Dashboard.²⁵

- Well-child visits-adolescents
- Asthma medication for children
- Percent increase in nursing facility admissions (< 5% from baseline)

MCO results for each behavioral health measure are compared to the State or HEDIS[®] means when applicable to determine performance rankings. HHSC is in the process of evaluating this methodology and determining its appropriateness and feasibility in determining performance based awards specific to behavioral health.

Incentive/Disincentive Strategies in Other States

The Center for Health Care Strategies, Inc. (CHCS) evaluated the types of financial incentives and performance indicators used in the Medicaid Programs of Iowa, Massachusetts, Rhode Island, Utah, and Wisconsin.²⁶ The CHCS report found that financial and non-financial incentives generally motivate health plans to improve performance on specific indicators and to test quality improvement projects. With regard to behavioral health, the report identified the early use of performance incentives for BHOs in Medicaid managed care – first in Massachusetts (1997), then in Iowa (1999) (see text boxes below).

In 1992, Massachusetts was the first Medicaid program to implement a behavioral health carve-out model with a single statewide vendor. In 1997, the Massachusetts Medicaid program negotiated with its behavioral health vendor to establish contractual performance standards, and incentives and penalties based on performance expectations. Since then, Massachusetts has experimented with the number of performance standards (ranging from 11 to 20) and a mix of financial incentives that are renegotiated each year between the Medicaid program, the vendor, the Department of Mental Health, and key stakeholders. Evaluation of the state's performance incentive contracting approach underscores the importance of collaboration in identifying performance improvement areas and aligning financial incentives with PIPs to achieve desired goals.²⁷

In 1999, the Iowa Medicaid Program established performance-based financial incentives and penalties in its managed behavioral health contract. The state offered a financial incentive of \$125,000 to the behavioral health vendor with the highest performance on each of eight process and outcome indicators considered to be overarching values of the program (e.g., consumer participation in joint treatment planning conferences, and the percent of discharge plans that are implemented). The program also implemented financial penalties if a vendor's performance on 10 indicators consistently fell below a pre-specified threshold across two or more measurement periods (quarters). Vendors could be required to pay penalties ranging from \$5,000 for low performance on several measures to upwards of \$50,000 if performance on measures was consistently low across time.

To improve the transparency and accountability of behavioral health services using value-based purchasing, HHSC will consider:

- 1) Expanding the number of at-risk performance indicators specific to behavioral health. There should be at least one access measure and one quality measure related to behavioral health services.
- 2) Continue to work with the EQRO to develop a performance ranking methodology for the Quality Challenge Awards that includes behavioral health performance indicators.

Pay-for-Performance

Pay-for-performance is a type of incentive program designed to improve health services and outcomes by linking the quality of care to provider reimbursement. Pay-for-performance programs typically reward providers who deliver efficient, quality care by financially reimbursing them at a higher rate than their lower performing counterparts. Pay-for-performance has emerged as a quality improvement strategy across state Medicaid programs. Behavioral health service delivery has been less emphasized than other service delivery areas in efforts to improve quality through the use of provider incentives.²⁸ This may be explained by a lack of commonly agreed-upon quality improvement approaches, and by complications in the consensus-building between different types of clinicians and providers (e.g., psychiatrists, social workers, and mental health counselors).²⁹

Even so, lessons from Medicaid pay-for-performance programs in primary care are applicable in developing incentive programs for behavioral health providers, while still addressing the unique challenges and issues specific to behavioral health delivery. California's Medicaid program, Medi-Cal, implemented the Local Initiative Rewarding Results (LIRR) project, which is a large pay-for-performance collaborative, designed to improve access to preventative care for infants and adolescents. Initial evaluation of the LIRR project identified key considerations for developing pay-for-performance programs, including: (1) engaging providers in the program (e.g., developing incentives, mandatory information sessions, recognizing provider accomplishments); (2) providing non-financial support to help providers reach performance goals (e.g., performance feedback, notification when a member is due for care); and (3) offering member incentives.³⁰

A recent review of behavioral health pay-for-performance initiatives identified similar actions for successfully improving program implementation and outcomes – specifically, including providers in the design of performance indicators and incentives, and increasing providers' awareness and knowledge of the program.³¹ Additionally, member incentives may be a viable strategy in behavioral health quality improvement efforts, especially in procuring member compliance with therapy and treatment, discharge planning, and follow-up appointments.

To increase the effectiveness of behavioral health pay-for-performance programs, Bremer and colleagues (2008) recommend:

- A longitudinal approach to pay-for-performance, beginning with simply providing incentives for developing structures of care known to improve behavioral health quality.
- Including validated behavioral health outcome measures that have “buy-in” from multiple stakeholders.
- Linking responsibility and accountability for both physical health and behavioral health providers.
- Designing approaches that are specific to provider type (e.g., psychiatric hospital, outpatient therapist) and financial arrangements.
- Experimenting with different models of pay-for-performance programs.
- Making incentives large enough to matter to the provider.³²

Pay-for-performance models may also be used to reward efficiency and quality in not only the components of a patient's care, but also in the overall course of a patient's episode of illness. Research in healthcare administration suggests that overall patient care can be delivered more efficiently by defining the unit of payment to cover the entire treatment episode for patients with a given chronic health

condition.³³ Rewarding the joint provision of care over a patient's episode of illness can encourage the integration of delivery systems and multispecialty group practices, which leads to more efficient and higher quality care. Given these potential benefits, HHSC will consider options for incentivizing provider performance in behavioral health services based on episodes of care.

3. Identifying and Disseminating Performance Improvement Strategies

By contract, HHSC requires Texas Medicaid MCOs to develop, maintain, and operate a quality assessment and performance improvement (QAPI) program with the primary goal of improving the health status of members.³⁴ MCOs that provide behavioral health services are required to integrate behavioral health into their QAPI programs and include a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of behavioral health services. Each MCO provides details on its QAPI program annually using a summary report template, which includes a self-assessment of the effectiveness of the MCO's quality improvement studies implemented during the previous year. The Texas EQRO evaluates all MCO QAPI summaries annually to determine whether MCOs are in compliance with various elements of the quality improvement process.

Performance Improvement Goals

An important component of an MCO's QAPI is the implementation and evaluation of performance improvement goals (PIGs), which are measurable, time-limited goals for improvement on a specific aspect of care. Common aspects of care targeted by PIGs include MCO operations, service delivery, quality of care, access to care, and member or provider satisfaction. Each year HHSC collaborates with MCOs to identify a common set of overarching goals, which the MCOs use to define and implement their own sub-goals based on the demographic and health profile of their member populations.

In fiscal year 2008, HHSC identified one overarching PIG specific to behavioral health services:

- Improve access to behavioral health services for members

Each Texas Medicaid MCO developed up to three measurable sub-goals to address the overarching goal, established targets for their sub-goals, and reported the year-end outcomes of their sub-goal measurements in the QAPI summary. **Table A3** in **Appendix A** shows the EQRO's findings on STAR MCO sub-goals for improving member access to behavioral health services during fiscal year 2008.

Eight of the 14 MCOs participating in STAR had PIGs aimed toward improving HEDIS[®] rates of 7-day follow-up for members discharged from an inpatient behavioral health stay, which HHSC monitors on the Performance Indicator Dashboard. From Quality of Care reports conducted by the Texas EQRO, rates for this measure have consistently been lower than HEDIS[®] national means across most STAR and STAR+PLUS MCOs.³⁵ Aetna's QAPI program targeted improvement of the 7-day follow-up rate itself (an outcome) as its first sub-goal, and increasing the rate of contact with members who miss their 7-day follow-up (a process) as its second sub-goal. AMERIGROUP, Community First, and Molina monitored only rates of contact with members (generally through telephone or mailed reminders) rather than directly monitoring the follow-up visit as their target.

In some cases, MCOs tracked rates of sending mailed reminders or information to members. Many MCOs set targets of 100 percent for these sub-goals, which were easily attained when measured

according to the number of mailings sent, rather than received. For such measures, there is no guarantee that a member will receive the mailing (due to inaccurate or outdated contact information) or that members receiving it will read and understand the information it contains. In its evaluation of the MCO QAPI summaries, the EQRO recommended that MCOs define PIGs that focus on outcomes (whether clinical or service), which allow room for improvement in their measurement and have greater relevance for the health of members. While practices such as sending newsletters should be monitored for their completion and adherence to guidelines, the MCO should consider these as part of its strategy for attaining a relevant goal, rather than the goal itself.

Performance Improvement Projects

Over the past two years, HHSC has worked collaboratively with the EQRO to promote MCO quality improvement initiatives by better aligning its MCO quality strategy with federal guidelines. One important change to take place in fiscal year 2011 is the move toward implementing and evaluating performance improvement projects (PIPs) and integrating these into MCO QAPI programs.

PIPs are formal efforts undertaken by MCOs participating in Medicaid managed care programs to assess and improve processes and outcomes of care.³⁶ States require the MCOs that contract with their Medicaid programs to develop and implement PIPs that target improvement in relevant areas of clinical care and non-clinical services, particularly in areas that have demonstrated low performance. Validating the PIPs of each MCO participating in a state Medicaid program is also a mandatory activity of EQROs.

The Centers for Medicare and Medicaid Services (CMS) has outlined a 10-step protocol for conducting PIPs, which ensures that efforts toward quality improvement are designed, conducted, and reported in a methodologically sound manner (see text box).³⁷ To improve the quality of behavioral health services, HHSC will require that MCOs follow this methodology for implementing PIPs. A continuous, cyclical process for quality improvement – such as the Plan-Study-Do/Check-Act cycle – can help MCOs identify strategies for improvement in stages and identify the most relevant and effective PIPs for the MCO's member population.

CMS 10-Step Protocol for Conducting PIPs

- 1) Select the study topic(s)
- 2) Define the study question(s)
- 3) Select the study indicator(s)
- 4) Use and representative and generalizable study population
- 5) Use sound sampling techniques (if sampling is used)
- 6) Reliably collect data
- 7) Implement intervention and improvement strategies
- 8) Analyze data and interpret study results
- 9) Plan for “real” improvement
- 10) Achieve sustained improvement

Disseminating Behavioral Health Quality Improvement Findings

The EQRO submits quality improvement reports to HHSC which contain information related to quality of care and member satisfaction. Quality improvement reports are published on the HHSC website.

Washington State's Government Management Accountability and Performance (GMAP) provides timely results of access, quality, and cost measures. For each measure the online tool defines its target and actual performance, the agency responsible for measuring and improving performance, and notes for interpreting the agency's findings. Furthermore, the tool lists and describes action plans implemented to improve the results of certain performance measures.

The Colorado Medicaid program provides an example of dissemination that is more relevant to behavioral health services in Medicaid managed care. Colorado leads other states in having a section of reports dedicated to behavioral health managed care, which detail the state's present and future behavioral health quality strategy. On its website the state provides timely links to PIP validation reports – grouping them into “Behavioral Health PIPs” and “Managed Care PIPs.”³⁸ Each behavioral health PIP validation report focuses on a single aspect of behavioral health care provided by a particular BHO. For example, in 2007, the Access Behavioral Care BHO implemented a PIP addressing follow-up after an inpatient stay for behavioral health. Colorado makes the validation report for this PIP readily accessible to the public, showing the PIP's findings and describing how it was scored and validated.

Following these models, HHSC should consider developing an interactive portal that publishes the findings of behavioral health performance measures by Medicaid MCO, and the PIPs and other quality improvement initiatives implemented by MCOs on measures that have had low performance. With regard to quality improvement, it is important that this portal provide the results of monitoring at various time points (e.g., baseline, mid-year, end-year), a detailed description of the performance improvement strategies implemented, an interpretation of the effectiveness of these strategies for improving performance, and the MCO's future plans for refining strategies or adopting them for performance improvement in other aspects of care.

To improve the transparency and accountability of behavioral health services using performance improvement strategies, HHSC will consider:

- 1) Continuing work toward the annual implementation and evaluation of MCO PIPs. If appropriate based on results, specific behavioral health PIPs will be implemented.
- 2) Providing training to MCOs, in collaboration with the EQRO, to ensure that PIPs are relevant to member populations, follow sound study designs, and lead to the refinement of effective strategies for improving the quality of behavioral health services.

[FY 2009 Member Survey Findings on Behavioral Health Satisfaction](#)

STAR Adults

- Nine percent needed treatment or counseling for a personal or family problem.

- Among these enrollees, 54 percent stated that treatment or counseling was “usually” or “always” easy to obtain.

STAR Children (Caregivers)

- Seven percent tried to get treatment or counseling for an emotional, developmental, and/or behavioral problem.

- Among those who sought treatment:

62 percent stated that treatment or counseling was “usually” or “always” easy to obtain.

54 percent received assistance getting treatment or counseling from their child’s health plan or doctor’s office.

- Seventy-five percent of CSHCN tried to get treatment or counseling.

STAR+PLUS Adults

- Twenty-four percent needed treatment or counseling for a personal or family problem.

- Among these enrollees, 63 percent stated that treatment or counseling was “usually” or “always” easy to obtain.

4. Administering Biennial Surveys to Assess Member Satisfaction with Behavioral Health Services

The Texas EQRO conducted three Medicaid managed care member satisfaction surveys in fiscal year 2009: (1) The STAR Adult Enrollee Survey; (2) The STAR Child Enrollee Survey; and (3) The STAR+PLUS Adult Enrollee Survey. Each survey was based on the CAHPS® Health Plan Survey 4.0, which assesses members’ experiences and satisfaction with health care received during the preceding six months.

The fiscal year 2009 STAR and STAR+PLUS Adult Enrollee Surveys included the following four CAHPS® survey items pertaining to members’ need for, access to, and perceived quality of behavioral health treatment and counseling:

- 1) In general, how would you rate your overall mental or emotional health?
- 2) In the last 6 months, did you need any treatment or counseling for a personal or family problem?
- 3) In the last 6 months, how often was it easy to get the treatment or counseling you needed through your health plan?
- 4) Using any number from 0 to 10, where 0 is the worst treatment or counseling possible and 10 is the best treatment or counseling possible, what number would you use to rate all your treatment or counseling in the last 6 months?

The fiscal year 2009 STAR Child Enrollee Survey included behavioral health CAHPS® survey items similar to the STAR and STAR+PLUS Adult Surveys. However, the child survey also assessed whether caregivers received assistance getting behavioral health treatment and counseling for their child. In fiscal year 2009, the following four survey items were answered by a child’s parent or caregiver:

- 1) In the last 6 months, did you get or try to get treatment or counseling for your child for an emotional, developmental or behavioral problem?
- 2) In the last 6 months, how often was it easy to get this treatment or counseling for your child?
- 3) Did anyone from your child’s health plan, doctor’s office or clinic help you get this treatment or counseling for your child?
- 4) Did you receive help getting treatment or counseling for your child from a case manager or care coordinator who was not from your child’s health plan, doctor’s office or clinic?

Results from these surveys indicated that the need for treatment or counseling was lower among adults and children in STAR than among adults in STAR+PLUS, and between half and two-thirds of enrollees had adequate access to these services.³⁹⁻⁴¹ The need for treatment or counseling was considerably greater among children with special healthcare needs (CSHCN) in STAR. About half of caregivers in STAR reported receiving assistance from their child's health plan or doctor's office in getting treatment or counseling. See the sidebar for more details on these survey findings.

In fiscal year 2010, the EQRO conducted the first behavioral health surveys for adults and caregivers of children in the STAR program. The surveys include the Experience of Care and Health Outcomes (ECHO™) survey instrument (which is part of the CAHPS® family of surveys). The ECHO™ collects information on members' experiences with behavioral health care, including mental health and chemical dependence services during the preceding 12 months. Specifically, the ECHO™ assesses several aspects of care, including:

- Getting treatment and counseling quickly.
- Communication with clinicians.
- Information provided by clinicians on medication side effects.
- Information about self-help groups and treatment.
- Cultural competency.
- Family involvement in care.
- Treatment effectiveness.
- Patient rights.
- Health plan or MBHO administrative services.⁴²

The ECHO™ Survey has English and Spanish versions for children and adults, and different versions for behavioral health services received through a health plan and services received through a managed behavioral health organization (MBHO). The National CAHPS® Benchmarking Database (NCBD) is in the process of developing a national database of ECHO™ survey results, which will allow for comparisons with other state Medicaid programs.

In addition to the ECHO™, the STAR member surveys also collect data on member demographics, health status, quality of life, and psychosocial functioning. To assess aspects of health, the STAR adult survey includes the RAND 36-Item Health Survey, and the STAR child survey includes the Children with Special Health Care Needs (CSHCN) Screener®, issues of transition to adult care (from the National Survey of CSHCN), and the Pediatric Quality of Life Inventory (PedsQL™).⁴³⁻⁴⁵

The EQRO is currently collecting data for the fiscal year 2010 STAR Adult and Child Behavioral Health Surveys. The EQRO will analyze the data and submit a draft report to HHSC for review in the fall of 2010. Following the LBB recommendations, these surveys will be conducted on a biennial basis. In the next two fiscal years, the EQRO plans to design and conduct a similar behavioral health survey for adults in STAR+PLUS using the ECHO™ instrument.

To improve the transparency and accountability of behavioral health service delivery in STAR and STAR+PLUS using member satisfaction data, HHSC will:

- 1) Conduct an analysis of the experiences and satisfaction that STAR+PLUS enrollees have with behavioral health services, based on the high need for treatment and counseling and relatively lower health status of this population. This analysis should include results from the upcoming STAR+PLUS Adult Behavioral Health Survey to be conducted by the EQRO, linked to relevant administrative and encounter data.
- 2) Utilize member satisfaction data to evaluate PIPs that are specific to behavioral health. Research suggests that quality improvement efforts that enhance health plan responsiveness to the needs of enrollees can increase satisfaction and service use, and thereby produce positive outcomes for children with serious emotional disorders.⁴⁶ HHSC may request that the EQRO conduct a longitudinal study to follow a cohort of enrollees and evaluate their satisfaction after implementation of a PIP specific to behavioral health.
- 3) Consider developing a risk-adjusted statistical model to analyze behavioral health survey data, which can control for member characteristics such as mental health status that may independently influence how members evaluate their health care experiences.^{47,48}
- 4) Consider conducting regional surveys by service delivery area or health service region, which can control for location-related variables such as density of the behavioral health provider network and transportation issues.

Behavioral Health Surveys in Other States

Most state Medicaid programs conduct behavioral health member surveys constructed from the Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey, the Youth Services Survey (YSS), and/or the Youth Services Survey for Families (YSS-F). These surveys are generally mail-based and self-administered – a methodology that poses challenges to data validity and generalizability which HHSC overcomes by conducting telephone-based surveys.

Only four states – Minnesota, New Jersey, Oklahoma, and Vermont – have administered the ECHO™ instrument to assess consumer satisfaction with Medicaid behavioral health treatment and services. In fiscal year 2009, Oklahoma Health Care Authority (OHCA), which operates the state's Medicaid program, contracted with APS Healthcare to evaluate Medicaid enrollee satisfaction with outpatient behavioral health care provided by the managed care program, SoonerCare Choice.⁴⁹ APS mailed the ECHO™ survey instrument to eligible enrollees, and attempted to circumvent low response rates that are typical of mail-based surveys through three waves of mailing and by telephone follow-up.

The following points highlight unique consumer survey efforts in the Kansas and Oregon Medicaid programs, which include a youth survey and evaluating satisfaction with care across different treatment settings:

- Since 1997, the Kansas Department of Social and Rehabilitation Services, Division of Disability and Behavioral Health Services has sponsored annual consumer satisfaction surveys, known as the Kansas Family Satisfaction Survey (KFSS) and the Kansas Youth Satisfaction Survey (KYSS).⁵⁰ The surveys assess client and caregiver satisfaction with Medicaid-funded children's mental health services provided by 26 community mental health centers (CMHCs) in Kansas. A unique feature of the Kansas surveys is that the self-reported questionnaires are completed by parents/caregivers and by youths ages 12 and older who received behavioral health services in

the past 12 months. The survey instrument was developed by the University of Kansas, School of Social Welfare, drawing on questions from the Mental Health Statistics Improvement Program (MHSIP) instrument. To increase transparency and improve behavioral health quality, current and past KYSS and KFSS survey results are published on three websites, including the Kansas Department of Social and Rehabilitation Services, and sent annually to CMHC Center directors, and staff.

- Since 2002, the Oregon Addictions and Mental Health Division (AMH) has administered the YSS-F to adults and parents/caregivers of children enrolled in the Oregon Health Plan who receive behavioral health services.⁵¹ In fiscal year 2005, AMH expanded the scope of the survey to assess parent/caregiver perceptions of: (1) behavioral health care and services provided by managed behavioral health organizations (MBHOs); (2) the quality of services provided across different settings (e.g., outpatient, residential, and day treatment facilities); and (3) the coordination of services between different mental health providers and across physical and mental health care settings. AMH is using the results of the fiscal year 2009 YSS-F to improve care coordination with other service delivery systems.

Summary and Future Directions

Following recommendations made by the LBB, and in accordance with direction from the Texas Legislature, this report summarizes current and future strategies for improving the transparency and accountability of behavioral health service delivery in STAR and STAR+PLUS. The report identifies strategies in each of four categories: (1) measuring the performance of behavioral health service delivery; (2) using incentives and disincentives to encourage behavioral health care quality; (3) identifying and disseminating performance improvement strategies; and (4) administering surveys to assess member satisfaction with behavioral health services. Key points for each are presented below.

Current Strategies

Measuring Performance

- The HHSC MCO Performance Indicator Dashboard currently tracks seven behavioral health indicators.
- The Texas EQRO provides results of indicators for 7-day follow-up, 30-day follow-up, and readmission within 30 days in its Annual Quality of Care reports.
- In fiscal year 2010, HHSC, in collaboration with the EQRO, studied the accountability and transparency of behavioral health care service delivery in STAR and STAR+PLUS. For these studies, the EQRO selected the three indicators that HHSC presently monitors, as well as five additional HEDIS[®] measures relevant to behavioral health.
- HHSC tracks, but does not regularly publish, two behavioral health performance indicators that have contractual requirements associated with them.
- In fiscal year 2009, STAR MCO reporting on five behavioral health hotline indicators was low. Only five MCOs reported on “Average Hold Time.” Three MCOs did not report on any of the five indicators.
- The HHSC Performance Indicator Dashboard includes one behavioral health indicator from consumer satisfaction data (using the CAHPS[®] Health Plan survey). This indicator addresses performance for child enrollees, but not adult enrollees.

- MCOs provide HHSC with complaints and appeals data dealing specifically with behavioral health services, although this data is not included on the Performance Indicator Dashboard.

MCO Incentives and Disincentives

- HHSC currently uses value-based purchasing to incentivize performance for the STAR and STAR+PLUS MCOs. Each MCO is at risk for 1 percent of the capitation rate, depending on the outcome of specified performance measures. Any undistributed funds are re-allocated to HHSC's Quality Challenge Award – given to MCOs that demonstrate superior performance on a separate set of indicators.
- Only one indicator relevant to behavioral health services is included in determining the 1 percent at-risk amount, while there are four behavioral health indicators are used to evaluate MCO performance for the Quality Challenge Award.

Performance Improvement Strategies

- HHSC will require MCOs to implement and evaluate performance improvement projects (PIPs) effective fiscal year 2012 and beyond.
- HHSC requires MCOs to develop a quality assurance and performance improvement (QAPI) program and annually summarize the program's findings. MCOs that provide behavioral health services are required to integrate behavioral health into their QAPI programs.
- Each year HHSC collaborates with MCOs to identify a common set of overarching performance improvement goals (PIGs), which the MCOs use to define and implement their own sub-goals. In fiscal year 2008, HHSC identified one overarching goal to improve member access to behavioral health services. Eight of the 14 MCOs participating in STAR had sub-goals aimed toward improving HEDIS[®] rates of 7-day follow-up for members discharged from an inpatient behavioral health stay.
- In its evaluation of the fiscal year 2008 QAPI summaries, the EQRO recommended that MCOs define PIGs that focus on outcomes, which allow room for improvement in their measurement and have greater relevance for the health of members.
- Over the past two years, HHSC has worked with the EQRO to address the limitations of using PIGs. Effective fiscal year 2012, HHSC will require MCOs to move toward implementing and evaluating PIPs for fiscal years 2012 and beyond.
- To date, HHSC has disseminated the findings of successful MCO quality improvement initiatives; information on quality improvement findings can be more visible to users of that information through a dedicated portal on the HHSC website.

Behavioral Health Member Surveys

- In fiscal year 2009, the EQRO conducted Medicaid managed care member satisfaction surveys for adults in STAR and STAR+PLUS, and for caregivers of children in STAR. The CAHPS[®] Health Plan survey instrument includes four questions pertaining to members' need for, access to, and perceived quality of behavioral health treatment and counseling.
- In fiscal year 2010, the EQRO conducted the first behavioral health surveys for adults and caregivers of children in the STAR program, using the ECHO[™] survey instrument. These surveys will be conducted on a biennial basis.

- In the next two years, the EQRO plans to design and conduct a behavioral health survey for adults in STAR+PLUS using the ECHO™ survey.

Future Strategies

Performance Measurement

- Request that the EQRO include the five additional HEDIS® measures related to behavioral health in its STAR and STAR+PLUS Quality of Care Reports. These measures include the following
 - o HEDIS® Antidepressant Medication Management (AMM)
 - o HEDIS® Follow-up Care for Children Prescribed ADHD Medication (ADD)
 - o HEDIS® Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
 - o HEDIS® Identification of Alcohol and Other Drug Services
 - o HEDIS® Mental Health Utilization
- Consider including on the Performance Indicator Dashboard the AMM and ADD HEDIS® measures.
- Conduct additional studies specifically focused on gaps in performance related to enrollee demographics and behavioral health delivery model – and report results of these studies by STAR and STAR+PLUS MCO.
- Publicly report MCO results of the two currently monitored behavioral health Performance Dashboard Indicators on a quarterly basis.
- Monitor and publicly report MCO results on the provision of initial outpatient behavioral health visits within 14 days, and consider this measure for inclusion on the Performance Indicator Dashboard.
- Include in the Performance Indicator Dashboard the CAHPS® Health Plan Survey question on satisfaction with access to behavioral health services for adults in STAR and STAR+PLUS.
- Consider additional survey-based performance indicators from the ECHO® Survey, following its full implementation in fiscal years 2010 and 2011.
- Ensure that MCOs provide HHSC with behavioral health complaints and appeals data on a quarterly basis, and establish and enforce penalties for MCOs that fail to report requested data in a timely fashion.
- Consider including in the Performance Indicator Dashboard the percentage of behavioral health complaints resolved within 30 days and the percentage of behavioral health appeals resolved within 30 days.
- Implement a strategy for public reporting of behavioral health complaints and appeals by Medicaid STAR and STAR+PLUS MCOs.
- Consider an addition to the Texas Medicaid website specifically for the reporting of behavioral health performance measures.

MCO Incentives and Disincentives

- Apply a separate 1 percent at-risk capitation rate for behavioral health performance, or at least expand the number of at-risk performance indicators specific to behavioral health. Consider at least one access measure and one quality measure related to behavioral health services.

- Evaluate options for incentivizing provider performance in behavioral health services based on episodes of care.

Performance Improvement Strategies

- Continue working toward the annual implementation and evaluation of MCO PIPs that are specific to behavioral health and promote their integration into MCO QAPI programs.
- Provide training to MCOs, in collaboration with the EQRO, to ensure that PIPs are relevant to member populations, follow sound study designs, and lead to the refinement of effective strategies for improving the quality of behavioral health services.
- Share the findings of PIPs, both with health plan managers in interactive sessions, and with the public through an interactive web portal.

Behavioral Health Member Surveys

- Evaluate whether it would be useful to conduct analyses of the experiences and satisfaction that STAR+PLUS enrollees have with behavioral health services, including results from the upcoming STAR+PLUS Adult Behavioral Health Survey, and link analyses to relevant administrative and encounter data.
- Utilize member satisfaction data to evaluate PIPs that are specific to behavioral health. HHSC may request that the EQRO conduct a longitudinal study to follow a cohort of enrollees and evaluate their satisfaction after implementation of a PIP specific to behavioral health.
- Consider using a risk-adjusted statistical model to analyze behavioral health survey data, which can control for member characteristics such as mental health status that may independently influence how members evaluate their health care experiences.

Endnotes

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⁵ Texas Medicaid STAR MCOs by delivery model: (1) Payer carve-out ("in-house") - AMERIGROUP, Community First, Driscoll, El Paso First, Texas Children's; (2) BHO carve-out - Aetna, Community Health Choice, Cook Children's, FirstCare, Molina, Superior, UnitedHealthcare-Texas; (3) NorthSTAR (BHO carve-out) - AMERIGROUP (in Dallas SDA), Parkland Community, Unicare

⁶ Texas Medicaid STAR+PLUS MCOs by delivery model: (1) Payer carve-out ("in-house") – AMERIGROUP; (2) BHO carve-out - Evercare, Molina, Superior

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Appendix A

Table A1. STAR MCO Behavioral Health Hotline Performance Indicators for FY 2009

STAR MCO	Total calls reported in FY 2009	Calls answered by 4 th ring	Busy signal call rate	Staff answer in 30 seconds	Abandonment rate
		Standard: 99%	Standard: 0%	Standard: 80%	Standard: < 7%
		Percent	Percent	Percent	Percent
Aetna	373	100.00%	0.00%	97.86%	2.95%
AMERIGROUP	875	100.00%	0.00%	90.86%	3.20%
Community First	0	N/A	N/A	N/A	N/A
CHC	11	100.00%	0.00%	100.00%	0.00%
Cook Children's	628	100.00%	0.00%	97.61%	3.34%
Driscoll	44	100.00%	0.00%	100.00%	0.00%
El Paso First	553	99.64%	0.00%	100.00%	3.98%
FirstCare	181	100.00%	0.00%	99.45%	1.10%
Molina	550	100.00%	0.00%	96.00%	1.30%
Superior	1	100.00%	0.00%	100.00%	0.00%
Texas Children's	20	100.00%	0.00%	100.00%	0.00%
United HealthCare	590	100.00%	0.00%	86.78%	1.36%

* N/A -health plan indicated no behavioral health calls were received for the quarter.

Parkland and Unicare are not represented in the table. Behavioral Health Services are provided through NorthSTAR.

Table A2. STAR MCO Behavioral Health Appeals Data for FY 2009 - Percent of appeals adjudicated within 30 days

STAR MCO	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Aetna	N/A	N/A	N/A	N/A
AMERIGROUP	96.43%	97.14%	97.56%	97.73%
Community First	95.53%	99.07%	98.96%	96.92%
CHC	N/A	N/A	N/A	N/A
Cook Children's	N/A	N/A	N/A	N/A
Driscoll	100.00%	100.00%	100.00%	100.00%
El Paso First	N/A	N/A	N/A	N/A
FirstCare	N/A	100.00%	100.00%	100.00%
Molina	100.00%	N/A	100.00%	100.00%
Superior – El Paso SDA	100.00%	89.36%	86.79%	100.00%
Superior – All other SDAs	100.00%	100.00%	100.00%	100.00%
Texas Children's	100.00%	100.00%	100.00%	100.00%
United HealthCare	N/A	N/A	N/A	N/A

*N/A -health plan indicated no behavioral health appeals were received for the quarter.

Parkland and Unicare are not represented in the table. Behavioral Health Services are provided through NorthSTAR.

Table A3. STAR MCO Performance Improvement Goals (FY 2008): "Improving access to behavioral health services"

MCO	Sub-goal	Improvement strategy	Sub-goal target	Sub-goal year-end outcome
Aetna	Ensure that members with an inpatient BH stay have an outpatient visit within 7 days of discharge	None indicated	90%	72%
	Contact members who missed a 7-day follow-up appointment following an inpatient BH stay within one business day	None indicated	90%	95%
AMERIGROUP	Send information regarding postpartum depression to members who deliver a baby	Contracted with an independent vendor to distribute educational packets	95%	Not met (unspecified)
	Contact members discharged from an inpatient BH stay to remind them of the 7-day follow-up appointment	Directed case managers to phone each member following discharge and send postcards	90%	Not met (unspecified)
	Ensure that new members are informed on how to access BH services	Developed BH flyers for new member packets on understanding mental health and substance abuse benefits	100%	100%
Community First	Contact members discharged from an inpatient BH stay to remind them of the 7-day follow-up appointment	Sent letters and educational information and directed case managers to coordinate with facility utilization review staff	85%	100%

MCO	Sub-goal	Improvement strategy	Sub-goal target	Sub-goal year-end outcome
Community First	Refer members under the age of 21 who have had one inpatient BH stay of more than 7 days and/or multiple hospitalizations to CPW case management	Trained staff and directed long-term BH case managers identify agencies willing to provide member outreach	85%	92%
Community Health Choice	Increase the number of adolescents with depression and no BH claim in the past 6 months who have seen a BH provider within 30 days of referral to APS (BHO)	Referred members to the MCO's disease management team, which contacted members, risk stratified them, and followed up on a periodicity defined by risk stratification	+5% over baseline	+15% over baseline
	Increase the number of BH providers with multi-lingual capabilities	Confirmed that APS (BHO) provider operations staff identify, review, contact, and provide applications to multi-lingual BH providers	+7% over baseline	+19% over baseline
Cook Children's	Increase the number of BH providers with multi-lingual capabilities	None specified	+5% over baseline	+300% over baseline
	Increase the number of members contacted regarding outpatient follow-up after discharge from an inpatient BH stay	None specified	+5% over baseline	+49% over baseline

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MCO	Sub-goal	Improvement strategy	Sub-goal target	Sub-goal year-end outcome
Driscoll	Ensure that members who miss BH follow-up appointments after an inpatient BH stay are contacted by a case manager	Directed case managers to contact members by telephone and postcard	100%	100%
	Ensure that adolescent members are sent information regarding BH services	Sent a teen newsletter to all new adolescent STAR members each month, which included a BH topic and instructions on receiving BH services	100%	100%
El Paso First	Increase the percentage of members enrolled in BH case management	Increased collaboration with internal departments and network providers	+50% over baseline	+86% over baseline
	Ensure that new members with good addresses receive information on how to access BH services	Sent new member packets including an educational brochure on access to BH services	100%	100%
FirstCare	Ensure that members have an outpatient appointment scheduled at the time of discharge from an inpatient BH stay	Routinely monitored BH services access with Magellan (BHO)	100%	92%
	Increase the rate of 7-day follow-up for members discharged from an inpatient BH stay	Confirmed that Magellan (BHO) scheduled an outpatient appointment for each discharged member and called them to remind them of their appointments	+5% over baseline	+7% over baseline

MCO	Sub-goal	Improvement strategy	Sub-goal target	Sub-goal year-end outcome
Molina	Contact members within one day of discharge from an inpatient BH stay to remind them of the 7-day follow-up appointment	Confirmed that CompCare (BHO) hired a full-time discharge planner to increase compliance with follow-up notifications	90%	93%
	Increase the number of members that keep their 7-day follow-up appointment after discharge for an inpatient BH stay	Confirmed that CompCare contracted with two vendors to assist members in home visits who were unable to keep an office visit	+10% over baseline	Not reported
Parkland	Ensure that new members are informed on how to access BH services through NorthSTAR	Informed members of services through an ID card, member handbook, and welcome calls	100%	Not reported
	Ensure that members with selected new BH diagnoses are referred to NorthSTAR monthly	None specified	100%	Not reported
Superior	Increase the percentage of BH provider offices offering urgent care appointments within 24 hours of request	None specified	+5% over baseline	Reported by SDA only
	Increase the percentage of BH provider offices offering routine care appointments within 10 business days of request	None specified	+5% over baseline	Reported by SDA only

MCO	Sub-goal	Improvement strategy	Sub-goal target	Sub-goal year-end outcome
Texas Children's	Provide 7-day follow-up for members hospitalized for bipolar disorder	None specified	6.40%	10.40%
	Provide 30-day follow-up for members hospitalized for bipolar disorder	None specified	59.80%	59.70%
UniCare	Ensure that newly contracted providers are given information on NorthSTAR BH services	Sent newly contracted providers a web-link to the Provider Operations Manual and quarterly fax blasts on NorthSTAR BH services	100%	100%
	Ensure that case management members who have identified BH service needs are referred appropriately	Screened all members in case management for BH issues and referred identified members to NorthSTAR	100%	100%
UnitedHealthcare-Texas	Provide education on crisis intervention BH services to members with valid contact information who have an inpatient BH stay	None specified	50%	74%
	Contact members with valid contact information within 3 business days of discharge from an inpatient BH stay to assist with the 7-day follow-up appointment	None specified	50%	83%