Managed Care Organization Services for Individuals with Serious Mental Illness - Performance Metrics

As Required by

2018-19 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 45(a))

Health and Human Services Commission

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Executive Summary

The 2018-19 General Appropriations Act, Senate Bill (S.B.) 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission [HHSC], Rider 45), directed HHSC to establish performance metrics to better hold managed care organizations (MCOs) accountable for serving individuals with serious mental illness (SMI), and to provide a report to the Governor and Legislative Budget Board, no later than November 1, 2018, that examines the agency's current performance metrics and recommends new metrics. This report fulfills that deliverable.

In addition, Rider 45(b) allows HHSC to develop or procure a managed care model to serve individuals with SMI in Medicaid and CHIP managed care programs. As required by Rider 45(c), HHSC published a preliminary report in November 2017 outlining the agency's plans for serving individuals with SMI; however, HHSC intends to publish an update detailing the agency's work further evaluating such options.

Untreated mental health conditions can have harmful, long-lasting, and costly impacts on individuals living with these conditions, as well as for their families, schools, workplaces, and communities. Untreated mental health conditions also have a serious impact on physical health and are associated with negative impacts on the prevalence, progression, and outcome of chronic diseases. Housing quality, social support, employment opportunities, and work and school conditions can influence mental health risk and outcomes, both positively and negatively.[1]

[1] Office of Disease Prevention and Health Promotion, Healthy People 2020 https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health

SMI represents a subset of individuals with mental health conditions. Rider 45 defines SMI as conditions identified in Section 1355.001 of the Texas Insurance Code, which includes bipolar disorders, major depressive disorders, obsessive-compulsive disorders, paranoid or other psychotic disorders, schizo-affective disorders, schizophrenia, and depression in childhood and adolescence. When individuals with SMI do not have access to the necessary and appropriate services and supports, they may experience a number of undesired outcomes: housing instability, involvement with the criminal justice system, and institutionalization in psychiatric facilities or nursing homes. Individuals with SMI are also more likely to access services in less appropriate treatment settings for their condition, such as hospital emergency departments.[2]

Across Texas Medicaid and CHIP, more than $7 million was spent on potentially preventable emergency department visits for mental health reasons in 2016 (Appendix D). Measuring and addressing these factors would provide opportunities for both improving population mental health, reducing the risk of mental illness, and controlling cost.[3] In 2013, mental health conditions were the most costly medical conditions nationally, with spending estimated at $201 billion, of which more than 40 percent is spending for individuals in institutions.[4]

Rider 45 requires HHSC to improve efforts to better serve individuals with SMI through the development of specific performance metrics for MCOs, including industry standard performance measures for integrated care, jail and emergency

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[2] Weiss, Audrey, et.al. December, 2016. *Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006-2013.* The Healthcare Cost and Utilization Project (HCUP). https://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-Visit-Trends.jsp?utm_source=AHRQ&utm_medium=EN-1&utm_term=&utm_content=1&utm_campaign=AHRQ_EN1_10_2017

[3] *Social Determinants of Mental Health*, World Health Organization http://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf;jsessionid=458924591F1AFF1AC08D100E84931A44?sequence=1

[4] Roehrig, Charles. June, 2016. *Mental Disorders Top The List Of The Most Costly Conditions In The United States: $201 Billion.* Health Affairs. https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1659

department diversion, post-release linkage to care, homelessness reduction, supportive housing, and medication adherence.

HHSC currently tracks performance measures for individuals with SMI related to integrated care, emergency department diversion, linkage to care after release from hospital, and medication adherence. HHSC conducted a comprehensive search of national standardized measures for jail diversion, linkage to care after incarceration, homelessness reduction, or supportive housing and did not identify any. This may be, in part, because social determinants of health have not traditionally been considered the responsibility of healthcare providers or MCOs. However, there are opportunities for MCOs to target services and improve care management for members with SMI.

HHSC uses its existing performance measures to improve outcomes through several quality initiatives. HHSC has also worked extensively on integrating behavioral and physical health and uses quality measures in these efforts (See Section 4 of this report). Many of the measures and/or initiatives are relatively new so it is difficult to determine the impact at this time.

In determining whether to develop a managed care program for individuals with SMI (in accordance with Section (b) of the rider), HHSC released a request for information (RFI) on June 5, 2018. HHSC is currently evaluating responses related to program development; responses related to performance measures were considered for analysis discussed in this report (see Appendix E). While responses varied, generally, respondents supported the measures currently used by HHSC to hold MCOs accountable for care for members with SMI and did not suggest additional national, standardized measures. Respondents suggested measuring physical health outcomes separately for members with SMI and developing new measures, though that would have cost and operational impacts. Respondents also acknowledged the need for collaboration and data sharing across systems before certain performance measures (e.g., jail diversion, homelessness reduction, supportive housing) could be developed and utilized.

Based on HHSC research and analysis and the RFI responses, HHSC will take the following actions to better serve individuals and hold MCOs accountable for care for individuals with SMI:

- HHSC will continue to collect and track data for existing standardized, national measures for individuals with SMI and hold MCOs accountable for improving outcomes on these performance measures.

- HHSC will engage the External Quality Review Organization (EQRO) to apply standardized, national measures to the sub-population of individuals with SMI, including measures of well care visits, chronic disease management, and potentially preventable events (PPEs). This data can be used, in collaboration with the MCOs, to target services and improve care coordination and outcomes for individuals with SMI. HHSC will also identify and implement appropriate actions in response to the EQRO's targeted analysis of STAR+PLUS members with co-occurring behavioral health and physical health conditions who have experienced PPEs.

- HHSC will assess the cost and feasibility of using incarceration and housing information and data from other health and human services programs, state agencies, and relevant organizations to target services and improve care coordination and outcomes for individuals with SMI.

- HHSC will improve measurement, oversight, and enforcement of the adequacy of MCOs' provider networks, including for behavioral health services for individuals with SMI.

- HHSC will further explore, through the National Academy for State Health Policy (NASHP) technical assistance project, ways to expand community integration, including for individuals with SMI who are receiving Medicaid.

As HHSC moves forward with these efforts, continued collaboration with stakeholders will be critical to meeting the goals of Rider 45.

Because HHSC did not identify any existing nationally recognized, standardized measures for jail diversion, linkage to care after incarceration, homelessness reduction, or supportive housing, HHSC would need additional resources and coordination with other agencies to develop measures. Developing new measures would involve obtaining access to data sources and/or creating new data sources or systems; linking data systems; and developing, testing and refining measure specifications. Given the potential cost impacts and operational considerations, legislative direction would be required for HHSC to develop entirely new, state-specific measures.

1. Introduction

HHSC provides services to individuals with SMI in Texas Medicaid and CHIP through a variety of managed care programs. Rider 45 requires HHSC to take a number of steps related to managed care services for individuals with SMI.

Rider 45(a) directs HHSC to develop performance metrics to better hold MCOs accountable for services for individuals with SMI. The performance metrics required by Rider 45 include those pursuant to Texas Government Code, Section 536.003, in addition to industry standard performance measures for:

- integrated care;
- jail and emergency department diversion;
- post-release linkage to care;
- homelessness reduction;
- supportive housing; and
- medication adherence.

This report includes a summary of HHSC's process for identifying measures, an analysis of the agency's findings, and recommendations to improve the health outcomes, care, and cost-efficiency for individuals with SMI.

2. Background

HHSC uses a wide variety of performance measures to assess quality in Medicaid and CHIP. Each performance measure defines the specific calculation to be used to derive a "rate" for a specified indicator of quality—creating a standardized measure for comparison across health plans and, where available, national benchmarks. HHSC uses performance measures to encourage continuous MCO performance improvement through public reporting, quality improvement activities, and incentives and disincentives.

Many of the measures used by HHSC are national, standardized measures which have been rigorously tested and refined to ensure the validity and reliability of performance data. These resources include:

- Healthcare Effectiveness Data and Information Set (HEDIS) measures maintained by the National Committee for Quality Assurance
- 3M Potentially Preventable Events (PPEs)
- Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Surveys

When metrics are not available through existing nationally recognized resources, a state can develop and utilize measures until national measures become available. However, there are drawbacks to using state-developed measures, including the need and costs for staff and contractor time, the length of time required to develop and test measures, and the inability to compare MCO performance against external benchmarks. As a result, HHSC uses national, rather than state-specific measures, whenever possible.

HHSC currently uses performance measures for integrated care, emergency department diversion, and medication adherence for Medicaid managed care enrollees with SMI, as detailed in Appendix A. Medicaid managed care performance measures are available on the Texas Healthcare Learning Collaborative (THLC) portal. The THLC portal displays MCO performance on select HEDIS, PPE, and CAHPS measures and includes national benchmarks for comparison where available. However, there are no national industry standard performance measures in place for jail diversion, supportive housing, or homelessness reduction.

3. Performance Measures

HHSC tracks several performance measures including measures for integrated care, emergency department diversion, and medication adherence for enrollees with mental illness. Further details for each performance measure and corresponding data from the THLC Portal are provided in Appendix B.

Rider 45 Workgroup

In December 2017, HHSC staff formed a workgroup to assess the data being tracked by various agencies, with the possibility of leveraging this data to meet the rider requirements for Medicaid and CHIP managed care performance measures. The Rider 45 workgroup consisted of representatives from various HHSC divisions and other state agency offices including:

- Texas Department of Criminal Justice;
- Texas Department of Housing and Community Affairs (TDHCA); and
- Texas Juvenile Justice Department.

The workgroup was not able to identify any national, standardized performance measures for jail diversion, supportive housing, or homelessness reduction. Staff also reviewed the measures used in the Delivery System Reform Incentive Payment (DSRIP) program and determined that none were appropriate because the measures were either similar to other measures currently being used, or specific to evaluating providers and not translatable to evaluating MCOs.

Additionally, staff reviewed the mental health contract performance measures used to evaluate the quality of services provided by the local mental health authorities/local behavioral health authorities (LMHAs/LBHAs). The data for these measures come from the Adult Needs and Strength Assessment (ANSA) and Child and Adolescent Needs and Strengths Assessment (CANS). Currently, Medicaid policy requires an ANSA for individuals with SMI to establish a level of care and eligibility for Mental Health Targeted Case Management (MH-TCM) and Rehabilitative Services. The ANSA includes information on housing status, interaction with the criminal justice system, and other information related to the performance areas listed in Rider 45. While there are measures applicable to Rider

45, the workgroup determined these measures are not appropriate for evaluating MCOs because:

- The contract performance measures only collect data from LMHAs/LBHAs for members with SMI receiving MH-TCM and Rehabilitative Services. Members receiving services from a setting/provider other than a LMHA/LBHA and members not receiving MH-TCM and Rehabilitative Services would not be included.
- The contract performance measure data includes information on Medicaid/CHIP managed care members, as well as the uninsured, and segmenting the data is not possible with current resources.

While the contract performance measures only apply to LMHAs/LBHAs, broad access to information from the ANSA and CANS has the potential to assist MCOs and providers in improved care coordination, and may allow HHSC to better hold MCOs accountable for outcomes among members who have completed an ANSA or CANS. However, this data would only be available for members with SMI who get MH-TCM and Rehabilitation Services from a comprehensive provider agency.[5,6]

HHSC staff also reached out to the Ohio Department of Mental Health and Addiction Services, Oregon Health Authority[7], the Meadows Mental Health Policy Institute and Texas MCO representatives, but none of those organizations had performance measures in place for jail diversion, supportive housing, or homelessness reduction.

[5] All STAR Health members are required to receive a CANS in the first 30 days of enrollment. HHSC could explore the use of CANS data for STAR Health performance measures.

[6] For the Home and Community Based Services-Adult Mental Health (HCBS-AMH) program, a private provider cannot conduct an ANSA. HCBS-AMH has a contracted entity that will conduct the annual ANSA.

[7] The Rider 45 workgroup suggested reaching out to Ohio based on knowledge of unique programs they have to address incarcerated individuals.

2018 Request for Information (RFI)

In June 2018, HHSC solicited suggestions for performance measures from stakeholders through an RFI. HHSC received 20 responses from health plans, providers, provider organizations, advocacy groups, and policy organizations; 14 of the respondents offered comments related to performance measures. The suggested measures resulting from the RFI are summarized in Appendix E. In response to the RFI, some organizations indicated performance measures for jail diversion, emergency department diversion, homelessness reduction, and supportive housing are not feasible measures for Medicaid MCOs because they are dependent on supports and processes outside the MCOs' control. Some also expressed concern with using quantitative measures that are not driven by individualized goals and outcomes of care.

Generally, respondents recommended using industry standard, nationally recognized measures—which HHSC is currently doing. Respondents also provided ideas for performance measures and stated that all measures should be meaningful, representative of Medicaid services, feasible, and scientifically sound. Respondents acknowledged that HHSC currently evaluates MCO performance on many of the nationally recognized measures for SMI and reports results. However, they stated Texas might further improve quality and reduce cost by modifying the current behavioral health measures and how they are used. For example, respondents suggested applying existing national measures (intended for a broader population) to the sub-population of individuals with SMI.

Integrated Care

HHSC currently tracks integrated care with HEDIS measures. The results are available on the THLC portal. Integrated care measures include:

- Diabetes monitoring for people with schizophrenia
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication
- Cardiovascular monitoring for people with cardiovascular disease and schizophrenia
- Metabolic monitoring for children and adolescents on antipsychotics

Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication is a medical Pay-for-Quality (P4Q) measure for the STAR+PLUS MCOs. Under P4Q, HHSC may recoup or distribute funds to STAR+PLUS MCOs depending on their performance compared to their prior year performance and compared to national benchmarks for this measure.

Rates for these integrated care measures are provided in Appendix B. Additional information about current HHSC efforts to integrate care can be found in the Use of Performance Measures, Monitoring Integrated Care section of this report.

Jail Diversion

Jail diversion may be defined as the avoidance or radical reduction in jail time by using community-based treatment as an alternative.[8] There are several ways that HHSC contractors divert individuals with mental illness from being arrested and booked into county jails:

1. Law enforcement agencies are required, under certain conditions, to make a good faith effort to divert individuals who are experiencing a mental health crisis to a treatment center in their jurisdiction. Law enforcement partners with local authorities to identify local resources such as crisis hotlines, mobile crisis outreach teams, and residential treatment settings which may be leveraged to treat individuals as an alternative to arrest and booking into county jails.
2. At the time of booking, the county jail utilizes the Texas Law Enforcement Telecommunications System (TLETS) to match an inmate's identifying information with HHSC's Clinical Management for Behavioral Health Services (CMBHS) database to identify if the inmate has been hospitalized in a state hospital or contracted psychiatric bed, or was assessed, authorized, or received mental health community services through the local authority. A match may prompt the county jail to contact the local authority to conduct a

[8] CMHS National GAINS Center. (2007). Practical advice on jail diversion: Ten years of learnings on jail diversion from the CMHS National GAINS Center. Delmar, NY: Author.

crisis screening, crisis assessment, or begin post-booking jail diversion initiatives to include release planning and linkage to outpatient mental health resources.

3. County jailers are required to administer a mental health screening to every inmate booked into a county jail. The inmate's response to these questions may prompt the county jailer to notify their supervisor, magistrate, and mental health staff about the inmate's present state. If the inmate is believed to be in crisis, or, requires an assessment, the local authority may be contacted to conduct a crisis assessment or court-ordered to conduct an assessment.
4. A magistrate can court-order a local authority or another qualified mental health or intellectual disability professional to conduct an assessment on an inmate or an individual that has been released from the county jail on bond. The assessment must include information on any appropriate or recommended treatment or service. The magistrate may consider assessment information in taking further action in the individual's case.

In accordance with the 2018-19 General Appropriations Act, Senate Bill (S.B.) 1, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 42), an existing memorandum of understanding allows HHSC to utilize TLETS data in support of jail diversion and continuity of care for individuals with SMI who have been incarcerated. Currently, staff matches TLETS data with HHSC's CMBHS database. The database contains information on individuals who have received services from a LMHA/LBHA or a private provider of MH-TCM and rehabilitative services. HHSC uses the data match results for contract performance measures to determine LMHA effectiveness at jail diversion for individuals who have received mental health services prior to law enforcement contact.

It may be possible to match TLETS data with Medicaid data to identify members with SMI who are at-risk of incarceration and who might benefit from community-based treatment as an alternative. However, additional study would be needed to determine feasibility, risks, costs, and benefits. While this information would be useful in identifying the needs of members with SMI and targeting services, it may not be an appropriate measure for evaluating MCOs because jail diversion is beyond the scope of their responsibilities; as outlined above, jail diversion often requires actions initiated in the jail setting.

Emergency Department Diversion

HHSC holds MCOs accountable for emergency department diversion through use of the 3M potentially preventable emergency department visit (PPV) measure in the medical P4Q program. PPVs occur when a member receives emergency treatment for a condition that could have been treated or prevented by a physician or other health care provider in a non-emergency setting. PPV data allows HHSC to monitor the reasons for the emergency department visit, including those that are mental-health related.

Currently, HHSC uses PPVs to assess quality of care across all Medicaid populations. Members with SMI can be segmented as a subpopulation to better measure the quality of care this population receives. While the EQRO has written specific reports on PPEs among members with SMI (see Use of Performance Measures, Monitoring Integrated Care), HHSC does not currently monitor PPVs among members with SMI on an ongoing basis. HHSC will engage the EQRO to obtain PPE data specific to members with SMI on an ongoing basis.

Data on PPVs for mental health reasons is shown in Appendix D. Across all programs, the state spent more than $7 million on PPVs and $31 million on potentially preventable readmissions (PPRs) related to mental health in 2016. The most recent EQRO analysis of PPEs among members with SMI found that, among STAR+PLUS members, members with co-occurring chronic behavioral and physical health conditions accounted for 47.62 percent of PPVs in 2016.

Network Adequacy

Studies show that good access to outpatient care can reduce emergency department use.[9,10,11] MCOs meet network adequacy by maintaining a provider network with sufficient capacity to deliver covered services to members within contractually required timeframes. To monitor behavioral health network adequacy, HHSC employs time and distance studies which use geo-mapping to calculate members' distance from behavioral health providers and the estimated time to reach them. Appointment availability studies, using a secret shopper model, also help HHSC measure members' access to behavioral health providers.

In August 2018, HHSC began a comprehensive cross-divisional review of network adequacy for the Medicaid managed care program, as part of an ongoing effort to ensure that members have access to a choice of quality health care providers and services. Some of these activities were initiated in response to a recent Deloitte report on Medicaid managed care, which identified several opportunities for addressing the issue of network adequacy. Internal workgroups are working with stakeholders to develop project plans for a range of network adequacy initiatives, including:

- Streamlining the Medicaid provider enrollment process to reduce the enrollment cycle time for providers;
- Identifying process changes to improve the accuracy of MCO provider directories;

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[9] Villani, Jennifer, and Mortensen, Karoline. 2013. *Nonemergent Emergency Department Use Among Patients With a Usual Source of Care.* Journal of the American Board of Family Medicine. http://www.jabfm.org/content/26/6/680.full

[10] Enard, Kimberly, and Ganelin, Deborah. 2013. *Reducing Preventable Emergency Department Utilization and Costs by Using Community Health Workers as Patient Navigators*. Journal of Healthcare Management https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4142498/

[11] Chaudhary, MA, et. al. 2018. *Does Orthopaedic Outpatient Care Reduce Emergency Department Utilization After Total Joint Arthroplasty?* Clinical Orthopaedics and Related Research. https://www.ncbi.nlm.nih.gov/pubmed/29794858

- Enhancing the agency's provider relations function to conduct more intensive outreach to providers around the state;
- Automating manual processes for monitoring travel time and distance standards;
- Creating an integrated set of network adequacy measures and centralizing them in a network adequacy performance dashboard; and
- Identifying opportunities to expand access to care in rural and underserved areas through the use of telemedicine, telehealth, and telemonitoring services.

Appointment Availability Behavioral Health Study

S.B. 760, 84th Legislature, Regular Session, 2015, directed HHSC to establish a process to directly monitor the provider network for each MCO. The managed care contracts require Medicaid and CHIP MCOs to ensure members have access to covered services in a timely manner according to medically appropriate guidelines. To fulfill this directive, HHSC conducts secret shopper studies to assess providers' appointment availability against wait time standards in the Uniform Managed Care Contract.

The secret shopper studies assess the appointment availability of sampled providers from member-facing directories provided by the MCOs. There are studies for primary care providers, prenatal care providers, vision providers, and behavioral health providers.

Table 1 shows the results from the 2016 appointment availability study for behavioral health. Appointment availability for behavioral health improved across all programs from 2015 to 2016. HHSC required corrective action plans (CAPs) from the MCOs that did not meet the CAP threshold for the 2016 study. [12]

[12] The 2016 CAP threshold was set at 10 points above the 2015 program compliance scores.

Table 1. 2015 and 2016 Behavioral Health Appointment Availability Results

Program	2015 Provider Compliance with 14 day standard[13]	2016 Provider Compliance with 14 day standard	2016 Median Wait (days)	MCOs that were placed on a CAP in 2016
CHIP	73.4%	79.2%	4.0	6 of 17
STAR Adult	69.4%	76.0%	5.4	9 of 18
STAR Child	65.4%	77.4%	5.1	8 of 18
STAR+PLUS	79.4%	81.7%	5.1	5 of 5

Time and Distance Standards

In addition to the appointment wait time standards, the managed care contracts provide standards for distance and travel time. HHSC uses geomapping to determine whether MCOs' provider networks meet the travel time and distance standards for a wide variety of provider types. Travel time and distance standards improve access to care by requiring MCOs to have sufficient provider networks so members do not have to travel too far or wait too long to see a provider.

The standards for behavioral health are shown in Table 2. In September 2018, HHSC added a new travel time and distance standard for MH-TCM and rehabilitation providers. MCOs that fail to meet these time and distance standards are subject to CAPs and/or liquidated damages.

[13] Uniform Managed Care Contract, Section 8.1.3 https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf

Table 2: Time and Distance Standards for Behavioral Health

Provider types/services	Metro County	Micro County	Rural County
Behavioral Health (Outpatient Care)	30 miles 45 minutes	30 miles 45 minutes	75 miles 90 minutes
Psychiatry	30 miles 45 minutes	45 miles 60 minutes	60 miles 75 minutes
Mental Health Rehabilitative Services and Targeted Case Management	30 miles 45 minutes	30 miles 45 minutes	75 miles 90 minutes

HHSC tracks time and distance on a quarterly basis, so results of the studies change frequently. A current list of all MCO CAPs is available on the HHSC website.

CAHPS Behavioral Health Survey Measures

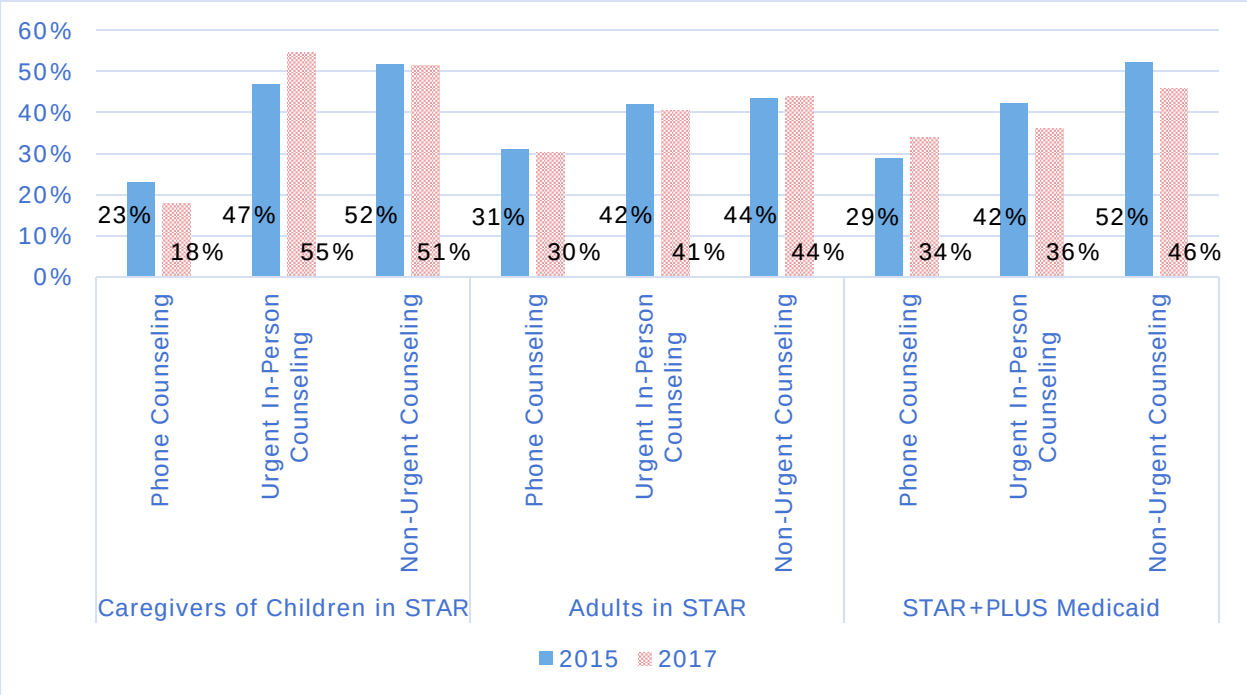
In odd numbered years, HHSC conducts a survey of STAR Child, STAR Adult, and STAR+PLUS members (or caregivers of these members) who have utilized a behavioral health service. Members are surveyed with the Experience of Care and Health Outcomes (ECHO) survey instrument—the CAHPS behavioral health survey. Figure 1 compares the 2015 and 2017 percentage of ECHO respondents who answered "always" on the following questions:

- In the last 12 months, how often did you get the professional counseling you needed on the phone? Would you say never, sometimes, usually or always?
- In the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted? Would you say never, sometimes, usually or always?
- In the last 12 months, not counting times you needed counseling or treatment right away, how often did you get an appointment for counseling or treatment as soon as you wanted? Would you say never, sometimes, usually or always?

Results for adults in the STAR program remained stable across both years. Caregivers of children in the STAR program expressed less satisfaction with phone counseling and more satisfaction with urgent in-person counseling in 2017 versus

2015. For STAR+PLUS members, satisfaction increased for phone counseling but decreased for both urgent and non-urgent counseling. The 2017 survey data is publicly available on the Resources page of the THLC portal in the Member Surveys folder.

Figure 1: 2015 and 2017 Percent of Members Who Always Received Treatment by Service Type and Program



Post-Release Linkage to Care

The Rider 45 workgroup explored linkage to care in terms of post-release from hospital and post-release from jail.

Hospital

In looking at possible measures related to hospital post-release linkage to care, HHSC identified the following HEDIS measures that are currently tracked by HHSC and on the THLC portal:

- Follow-up after hospitalization for mental illness
- Follow-up after emergency department visit for mental illness
- Follow-up after emergency department visit for alcohol and another drug dependence

- Potentially preventable readmissions

The follow-up measures look at whether or not care is being provided after a behavioral health crisis. Potentially preventable readmissions may be caused by deficiencies in care during the initial hospital stay, or poor coordination of services at the time of discharge or during follow-up.

Jail/Prison

House Bill (H.B.) 839, 84th Legislature, Regular Session, 2015, mandated HHSC suspend Medicaid eligibility upon notification of the child's placement in a juvenile detention facility and reinstate coverage upon notification of the child's release from the facility.[14] The bill gave juvenile facilities the option to report the child's placement in a juvenile facility; if juvenile facilities choose not to participate, HHSC will not suspend Medicaid for individuals in those facilities. H.B. 1630, 81st Legislature, Regular Session, 2009 required the facilities to report the child's release from a facility.

Upon a child's placement, juvenile facility staff use the Texas Integrated Eligibility Redesign System (TIERS) to report the child's placement and then TIERS automatically suspends the child's Medicaid coverage. Upon release, juvenile facility staff report the release and Medicaid coverage is automatically reinstated if the child has months remaining on their original certification period.

The MCOs are notified of a juvenile entering or leaving a facility through the daily file from the enrollment broker. HHSC receives regular reports on the number of suspensions and reinstatements. From the time period of August 2017 through July 2018, HHSC suspended Medicaid for 763 youth upon placement in a juvenile

[14] CHIP coverage cannot be suspended as the child no longer meets the definition of a targeted low-income child when they enter juvenile placement per 42 CFR §457.310(c)(2)(i).

facility, and reinstated Medicaid for 223 eligible youth upon release from the juvenile facility.

Additionally, H.B. 337, 85th Legislature, Regular Session, 2017, directs HHSC to suspend and reinstate Medicaid benefits for adults when in jail. HHSC is working with counties to garner participation and address barriers to implementation.

These projects should put in place the processes necessary to improve post-release linkage to Medicaid services for persons who remain eligible upon release. HHSC will assess the cost and feasibility of using this eligibility information to target services and improve care coordination and outcomes for individuals with SMI.

Within existing resources, HHSC can examine promoting the use of ICD-10 Z codes so that HHSC and MCOs can identify members who have been incarcerated. [15] This information can then be used to develop an appropriate treatment plan for each member. Additionally, these codes could also provide information for MCOs in authorizing services and in providing service coordination and service management to members. There are currently two Z codes that could provide useful information:

- Z65.1 imprisonment and other incarceration, and
- Z65.2 problems related to release from prison

HHSC could promote the use of these codes by MCOs and providers. HHSC may also consider requiring MCOs to include in their provider contracts direction to use these codes when they are applicable. However, the utilization of Z codes is dependent upon the patient receiving services disclosing their history to the provider or the provider asking their patients about their history with the law, and the provider adding the Z code to a claim. Without an incentive for providers to ask the questions and provide the information on a claim (e.g., payment for screening related to social determinants) there may not be consistent provider participation or

[15] The International Classification of Diseases (ICD), Tenth Edition is a clinical cataloging system that is used by healthcare providers to classify and code all diagnoses, symptoms, and procedures. Z codes are a special group of codes for the reporting of factors influencing health status and contact with health services.

sufficiently consistent or robust data to hold MCOs accountable for addressing the needs of members who have been incarcerated.

Homelessness Reduction

In support of HHSC's participation in the Centers for Medicare & Medicaid Services (CMS) Medicaid-Housing Innovation Accelerator Program, HHSC conducted an analysis to determine the rate of housing instability among members with behavioral health conditions in STAR+PLUS. Staff identified members with behavioral health conditions in STAR+PLUS using encounter data and then utilized data from TIERS and the ANSA to determine the housing status of those members.

Overall HHSC identified 3.6 percent of Medicaid STAR+PLUS clients with a behavioral health diagnosis who received an ANSA in 2016 as housing unstable. This percentage is likely underestimated because these data sources vary in completeness and reliability. HHSC conducted the analysis as a one-time evaluation specifically for the 2017 Housing Innovation Accelerator Program.

HHSC could expand on this work to measure housing instability on an annual basis and by MCO. However, generally MCOs are only required to coordinate covered services with non-capitated services, as necessary and appropriate. For STAR+PLUS Home and Community Based Services (HCBS) members, MCOs are required to assist with applications for Section 811 housing, and to provide the supports members need to remain in housing. However, this is only part of homelessness reduction and only applies to a small portion of the STAR+PLUS population.

Similar to jail diversion, HHSC can examine promoting the use of ICD-10 Z codes by providers to better identify members who have experienced homelessness or are at-risk of homelessness, including:

- Z59.0 Homelessness
- Z59.1 Inadequate housing
- Z59.2 Discord with neighbors, lodgers and landlord
- Z59.3 Problems related to living in residential institution
- Z59.4 Lack of adequate food and safe drinking water
- Z59.5 Extreme poverty
- Z59.6 Low income
- Z59.7 Insufficient social insurance and welfare support
- Z59.8 Other problems related to housing and economic circumstances
- Z59.9 Problem related to housing and economic circumstances, unspecified

However, as stated earlier, the use of Z codes is dependent upon the patient receiving services, disclosing their history to the provider or the provider asking their patients about their history with housing instability and the provider adding the Z code to the claim.

The Rider 45 workgroup suggested looking at frequent address changes as a measure of housing instability. Massachusetts defines unstable housing as three or more addresses in a single year.[16] HHSC explored using three or more address changes in a year as a measure of housing instability. Due to a systems issue, the effective date of address changes (which is what HHSC would use to determine when an address change occurred for a member) is not available prior to August 2016. Given data lag, calendar year 2017 data will be available in early 2019, at which time HHSC can revisit this approach.

Supportive Housing

HHSC provides several supportive housing services unrelated to Medicaid (see Appendix C). However, there are no existing measures either nationally or in Texas to evaluate the efficacy of supportive housing for averting mental health crises. Partnering with homeless coalitions to share data would allow HHSC to identify Medicaid members receiving supportive housing services. HHSC will assess the cost and feasibility of this approach to obtain information and data to target services and improve care coordination and outcomes for individuals with SMI.

2017 Housing Innovation Accelerator Program

From February 2016 through June 2018, Texas participated in two CMS-sponsored Innovation Accelerator Programs to promote community integration for Medicaid beneficiaries through improved partnerships between state Medicaid and housing agencies. The first developed an inventory of tenancy supports available under Medicaid waivers, non-waiver supports, and general revenue funded Department of

[16] https://www.statenetwork.org/wp-content/uploads/2017/07/SHVS_SocialDeterminants_HMA_July2017.pdf

State Health Services programs and TDHCA programs. The second included development of a Medicaid crosswalk, which identified current Medicaid services that support people with disabilities in housing, and a housing gaps analysis, which identified key resources for expanding housing opportunities in Texas. The Housing Innovation Accelerator Program also resulted in an improved partnership with the Texas State Affordable Housing Corporation, which has the potential to create additional housing for Medicaid beneficiaries in the future.

The National Academy for State Health Policy (NASHP) is moving the work of the innovation accelerator program to its Housing and Health Institute. Texas is one of five states chosen to participate in the NASHP technical assistance project and will use this opportunity to further explore ways to expand community integration for all individuals with disabilities, including those with SMI, receiving Medicaid.

Medication Adherence

HHSC currently assesses medication adherence using HEDIS measures. HHSC reports these measures on the THLC portal. Measures for medication adherence include:

- Antidepressant medication management (AMM)
- Follow-up care for children prescribed ADHD medication (ADD)
- Adherence to antipsychotic medications for individuals with schizophrenia. (SAA)

Performance measure rates for these measures are shown in Appendix B.

4. Use of Performance Measures

HHSC will continue to collect data for existing measures (Appendix A), track these measures on an annual basis, and work with MCOs to improve outcomes on these performance measures.

Improving MCO Accountability

HHSC holds MCOs accountable to quality measures through:

- THLC portal;
- P4Q program;
- Performance improvement projects (PIPs);
- MCO report cards;
- Performance Indicator Dashboard
- Appointment availability studies;
- Network adequacy time and distance parameters;
- Quality assessment and performance improvement programs (QAPIs); and
- Administrative interviews (AIs).

THLC Portal

The THLC portal is a website developed by the EQRO to provide HHSC and Medicaid and CHIP MCOs the most current performance data. The portal includes data on PPEs, HEDIS measures, and other quality of care information which reviewers can use to compare quality performance across years and with national benchmarks. Additionally, reviewers can use this information to analyze cross-sectional data to assess any deficiencies disproportionately affecting a specific demographic group. As shown in Appendix D, users of the portal can also assess the rates of PPVs for mental health reasons and the associated costs.

Medical P4Q Program

The medical P4Q program creates incentives and disincentives for Medicaid and CHIP MCOs based on their performance on specified quality measures. For P4Q,

HHSC places three percent of each MCO's capitation at risk.[17] HHSC evaluates MCO performance in three ways: performance compared to benchmarks, performance compared to self, and bonus pool measures. The 2018 medical P4Q program measures focus on prevention, chronic disease management (including behavioral health), and maternal and infant health. Medical P4Q at-risk measures pertaining to populations with SMI include the diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotics (SSD) measure and PPVs. Appendix A lists additional bonus pool measures pertaining to populations with SMI.

Performance Improvement Projects (PIPs)

PIPs are CMS-required projects in which MCOs receive a topic to improve the quality of care in the program. HHSC selects PIP topics, in consultation with the EQRO, based on HHSC priorities, MCO performance, and the number of members affected. MCOs must design PIPs to achieve – through ongoing measurements and interventions – significant improvement, sustained over time, in clinical and non-clinical care areas that have a favorable effect on health outcomes and enrollee satisfaction. MCOs use quality measures, such as those in Appendix A, to evaluate the efficacy of their interventions. HHSC requires that each MCO conducts two, two-year PIPs per managed care program. One of these PIPs must be in collaboration with another health plan, a DSRIP provider, or a community-based organization. Currently, there are 19 PIPs with a behavioral health focus. For 2019, each MCO will conduct a PIP to address care for members with anxiety and/or depression in each managed care program.

MCO Report Cards

S.B. 7, 82nd Legislature, First Called Session, 2011, requires HHSC to provide information on outcome and process measures to Medicaid and CHIP members

[17] Having a percent of the capitation at-risk means that HHSC can recoup up to that percentage of the MCOs capitation payments if they perform poorly in P4Q.

regarding MCO performance during the enrollment process. To comply with this requirement and other legislatively mandated transparency initiatives, HHSC develops report cards by program service area to allow members to compare the MCOs in the area on specific quality measures.[18] Report cards can assist potential enrollees in selecting an MCO based on quality metrics. HHSC posts the report cards on the HHSC website and includes the report cards in managed care enrollment packets. HHSC updates report cards annually. Appendix A shows the measures relevant to Rider 45 in the 2018 report cards.

Performance Indicator Dashboards

The Performance Indicator Dashboards are a set of performance measures that identify key aspects of performance to support MCO accountability. Dashboard measures include minimum and high performance standards by program. HHSC evaluates MCO performance by comparing to the established standards. MCOs who fall below minimum standards on a third or more of the measures are subject to CAPs. Many of these measures are related to mental health care and outcomes (see Appendix A).

Quality Assessment and Performance Improvement Programs (QAPIs)

CMS requires QAPIs for MCO programs. QAPIs are aimed at:

- evaluating MCO performance,
- fostering data-driven decision-making,
- supporting continuous measurement of clinical and non-clinical effectiveness and member satisfaction, and
- continued development and implementation of improvement interventions as appropriate.

[18] There are no report cards for STAR Health because there is only one MCO statewide.

Each MCO reports on their QAPI program annually. The Texas EQRO evaluates the MCO reports. These annual reports provide information on activities related to behavioral health during the calendar year. Specifically, QAPIs:

- Identify members of the MCO's Quality Improvement committees with formal educational expertise in the field of behavioral health.
- Describe opportunities and interventions that affect members with behavioral health conditions, paying special attention to members with co-occurring mental health conditions and substance use disorders and/or co-occurring behavioral and physical health conditions.

Administrative Interviews

Texas' EQRO conducts AIs with each health plan to assess elements important to the provision of quality care and service to members in these programs including compliance with certain federal regulations. Health plans respond to questions electronically using the full version of the AI tool once every three years on a rotating basis. Health plans that complete the full AI tool receive an evaluation and on-site visit conducted by the EQRO. Questions for on-site interviews change annually based on HHSC priorities and interests and all plans surveyed within the same year receive the same questions. Plans not selected for the full review complete an abbreviated version of the AI tool annually.

The AI tool includes the following requirements related to behavioral health:

- Provider directories must include information in 42 Code of Federal Regulations (CFR), Section 438.10(h)(1) for: physicians, including specialists; hospitals; pharmacies; behavioral health providers; and LTSS providers, as appropriate.
- Decisions to deny or reduce authorization requests must be made by an individual with appropriate expertise in addressing the member's medical, behavioral health, or LTSS needs.
- The health plan must follow the state-established credentialing and recredentialing policy that addresses acute, primary, behavioral, substance use disorders, and LTSS providers, as appropriate.

Monitoring Integrated Care

HHSC has worked extensively on integrating behavioral and physical health and uses quality measures (Appendix B) in these efforts. In 2018, HHSC worked with Texas's EQRO to identify individuals with co-occurring behavioral and physical health conditions who have experienced a PPE in a quarterly topic report titled *Identifying Opportunities for Better Integrating Behavioral Health and Physical Health (BH/PH) Services in Texas Medicaid*. The PPEs identified in the report included potentially preventable admissions (PPAs), potentially preventable readmissions (PPRs), and PPVs. The report found that, among STAR+PLUS members, members with co-occurring chronic behavioral and physical health conditions accounted for 73.47 percent of PPAs, 82.11 percent of PPRs, and 47.62 percent of PPVs. As a result, the EQRO recommends that the STAR+PLUS program receive considerable attention when attempting to improve behavioral and physical care integration for members. The EQRO is conducting a subsequent analysis on the STAR+PLUS population with co-occurring behavioral and physical health conditions who have experienced PPEs. This analysis will examine differences in PPE rates among members with SMI across specific, high-volume primary care providers and categories of primary care providers. It will also analyze differences in PPE rates for members with SMI according to MCO-level strategies for behavioral and physical health integration. This report is currently being finalized.

S.B. 74, 85th Legislature, Regular Session, 2017, required HHSC to put in place requirements for MCOs to further integrate behavioral and physical health. HHSC identified MCO contract provisions that had a specific integration component and reviewed the oversight of those requirements. Based on the review, HHSC staff identified further oversight functions for some contract provisions, such as:

- Requiring MCOs to specifically report what they are doing to further integrate care in their annual QAPI report, and
- Requiring MCO provider contracts to ensure PCP medical homes address behavioral health and physical health needs.

HHSC is adding contract provisions that will further define MCO responsibilities in carrying out these requirements. Requirements will include sharing utilization and care coordination data among staff and with their behavioral health organization, if applicable; conducting joint rounds between behavioral and physical health staff; and further integrating MCO and behavioral health organization provider portals.

The agency is actively working to monitor integration measures as part of this work.

In late 2017, HHSC conducted a survey of STAR+PLUS MCOs to identify existing integration activities at the MCO level. The survey was conducted based on a recommendation from the Behavioral Health Integration Advisory Committee. HHSC based survey questions on nationally standardized evaluation tools and reviewed organizational characteristics, multi-disciplinary health care approach, interdisciplinary communication, care coordination, and continuous quality improvement. HHSC has reviewed the survey results and begun incorporating its findings into contract changes and other integration work—such as adding a requirement that MCOs conduct monthly joint clinical meetings with care coordination staff, utilization review staff, and pharmacy staff representing both physical and behavioral health. The EQRO is also using the survey data to identify differences in PPE rates in members with behavioral health conditions based on MCO integration strategies.

Enhanced Cost Control

Appendix D shows the costs of PPVs for mental health reasons. MCOs may receive financial incentives to reduce PPVs in two ways: by reducing preventable emergency department costs, and through the medical P4Q program. A reduction in PPAs and PPRs for mental health reasons should also lead to a decrease in costs for inpatient care. However, the interventions employed to reduce avoidable hospital care for mental illness, such as more intensive care coordination and engagement of members with mental illness, may initially lead to an increase in outpatient utilization and costs.

Estimating the financial impact of providing appropriate and consistent services to support an individual's stability and recovery plan has challenges. Individuals with SMI who are not able to access supportive services tend to impact programs and services at all levels. For example, interactions with the criminal justice system strain local law enforcement resources, require court time, and may ultimately result in costly incarceration and a loss of Medicaid match for health care service costs. If the individual also cares for dependents, a personal crisis may trigger involvement with the Department of Family and Protective Services. Improving management of the SMI population in managed care has cost implications beyond health care costs to HHSC. It would require significant additional staff resources,

data investments and agreements, and coordination with other stakeholders in order to evaluate.

5. Conclusion

HHSC currently tracks performance measures for individuals with SMI related to integrated care, emergency department diversion, linkage to care after release from hospital, and medication adherence. These measures are used in various initiatives to hold MCOs accountable and improve quality for members with SMI. Many of the measures and/or initiatives are relatively new so it is difficult to determine the impact at this time.

HHSC continues to evaluate new and emerging measures for use in its quality programs. To enhance the focus on improving outcomes for members with SMI, HHSC will engage the EQRO to track health outcomes for members with SMI separately of the overall Medicaid population. While HHSC will not be able to compare performance on these measures with national benchmarks, this approach could allow HHSC to identify health disparities between members with and without SMI and better track improvement or decline in healthcare quality specific to members with SMI.

HHSC was not able to find any national standardized measures for jail diversion, linkage to care after incarceration, homelessness reduction, or supportive housing. Multiple systems impact outcomes for persons with SMI. HHSC will assess the cost and feasibility of using incarceration and housing information and data from other health and human services programs, state agencies, and relevant organizations to target services and improve care coordination and outcomes for individuals with SMI. Given the potential cost impacts and operational considerations, legislative direction would be required for HHSC to develop entirely new, state-specific measures.

List of Acronyms

Include a list of all acronyms that appear in the report. Add each new entry in its own row of this table.

Acronym	Full Name
AI	administrative interview
ANSA	Adult Needs and Strengths Assessment
CADS	Center for Analytics and Decision Support
CAHPS®	Consumer Assessment of Healthcare Providers & Systems
CANS	Child and Adolescent Needs and Strengths Assessment
CAP	corrective action plan
CMBHS	Clinical Management for Behavioral Health Services
CMS	Centers for Medicare and Medicaid Services
DSRIP	Delivery System Reform Incentive Payment
ECHO	Experience of Care and Health Outcomes
EQRO	External quality review organization
H.B.	House Bill
HCBS-AMH	Home and Community Based Services-Adult Mental Health
HEDIS	Healthcare Effectiveness Data and Information Set

HHSC	Health and Human Services Commission
IDD-BH	Intellectual and Developmental Disabilities and Behavioral Health Services
LBB	Legislative Budget Board
LBHA	Local Behavioral Health Authority
LMHA	Local Mental Health Authority
MCO	managed care organization
MH-TCM	mental health targeted case management
NASHP	National Academy for State Health Policy
OHI	Oxford House, Inc.
P4Q	pay-for-quality
PIP	performance improvement project
PPA	potentially preventable admission
PPE	potentially preventable event
PPR	potentially preventable readmission
PPV	potentially preventable emergency department visit
QAPI	quality assessment and performance improvement
RFI	request for information

SMI	serious mental illness
TDHCA	Texas Department of Housing and Community Affairs
THLC	Texas Healthcare Learning Collaborative
TIERS	Texas Integrated Eligibility Redesign System
TLETS	Texas Law Enforcement Telecommunications System

Appendix A. Managed Care Performance Measures Applicable to Rider 45

Table 3. Managed Care Performance Measures Applicable to Rider 45[1]

Quality Measure(s)	Current Use(s)	Rider 45 Category
Follow-up care for children prescribed ADHD medication (ADD): The percentage of children newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: Initiation Phase. The percentage of members 6–12 years of age with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. Continuation and Maintenance Phase. The percentage of members 6–12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	Publicly reported on the THLC Portal by MCO for STAR, STAR Health, STAR+PLUS, and CHIP Report card measure (initiation phase only) for CHIP and STAR Child Dashboard measure for STAR, CHIP, STAR Health, and STAR Kids	Medication Adherence

Quality Measure(s)	Current Use(s)	Rider 45 Category
Antidepressant medication management (AMM): The percentage of members 18 years of age and older who were treated with an antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported:	Publicly reported on the THLC Portal by MCO for STAR, STAR Health, and STAR+PLUS	
Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).	Report card measure for STAR Adult and STAR+PLUS	Medication Adherence
Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	Dashboard measure for STAR and STAR+PLUS	
Metabolic monitoring for children and adolescents on antipsychotics (APM): The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.	Publicly reported on the THLC Portal by MCO for STAR, STAR Health and CHIP Report card measure for STAR Kids Dashboard measure for STAR, CHIP, STAR Health, and STAR Kids	Integrated Care

Quality Measure(s)	Current Use(s)	Rider 45 Category
Follow-up after hospitalization for mental illness (FUH): The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: The percentage of discharges for which the member received follow-up within 30 days of discharge. The percentage of discharges for which the member received follow-up within 7 days of discharge.	Publicly reported on the THLC Portal by MCO for STAR, STAR Health, STAR+PLUS, and CHIP Report card measure for STAR+PLUS and STAR Kids Dashboard measure for STAR, STAR+PLUS, CHIP, STAR Health, and STAR Kids.	Post-release Linkage to Care
Follow-up after emergency department visit for mental illness (FUM): The percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported: The percentage of emergency department visits for which the member received follow-up within 30 days of the emergency department visit. The percentage of emergency department visits for which the member received follow-up within 7 days of the emergency department visit.	Publicly reported on the THLC Portal by MCO for STAR, STAR Health, STAR+PLUS, and CHIP Report card measure for STAR+PLUS and STAR Kids	Post-release Linkage to Care
Potentially preventable emergency department visits (PPVs): Rates can be broken out for reasons related to behavioral health.	Publicly reported on the THLC Portal by program for STAR, STAR Health, STAR+PLUS, STAR Kids, and CHIP Medical P4Q at-risk measure for STAR, STAR+PLUS, and CHIP	emergency department Diversion

Quality Measure(s)	Current Use(s)	Rider 45 Category
Potentially preventable readmissions (PPRs): Rates can be broken for reasons related to behavioral health.	Publicly reported on the THLC Portal by program for STAR, STAR Health, STAR+PLUS, STAR Kids, and CHIP Medical P4Q bonus pool measure for STAR+PLUS	Post-release Linkage to Care
Adherence to antipsychotic medications for individuals with schizophrenia (SAA): The percentage of members 19–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	Publicly reported on the THLC Portal by MCO for STAR and STAR+PLUS. Dashboard measure for STAR+PLUS	Medication Adherence
Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (SMC): The percentage of members 18-64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.	Publicly reported on the THLC Portal by MCO for STAR+PLUS Dashboard measure for STAR+PLUS	Integrated Care
Diabetes monitoring for people with diabetes and schizophrenia (SMD): The percentage of members 18-64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	Publicly reported on the THLC Portal by MCO for STAR and STAR+PLUS Dashboard measure for STAR+PLUS	Integrated Care
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotics (SSD): The percentage of members 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Publicly reported on the THLC Portal by MCO for STAR, STAR+PLUS. Medical P4Q at-risk measure for STAR+PLUS. Dashboard measure for STAR and STAR+PLUS.	Integrated Care

[1] The Rider 45 workgroup was unable to identify any performance measures applicable to MCOs for jail diversion, supportive housing, or homelessness reduction.

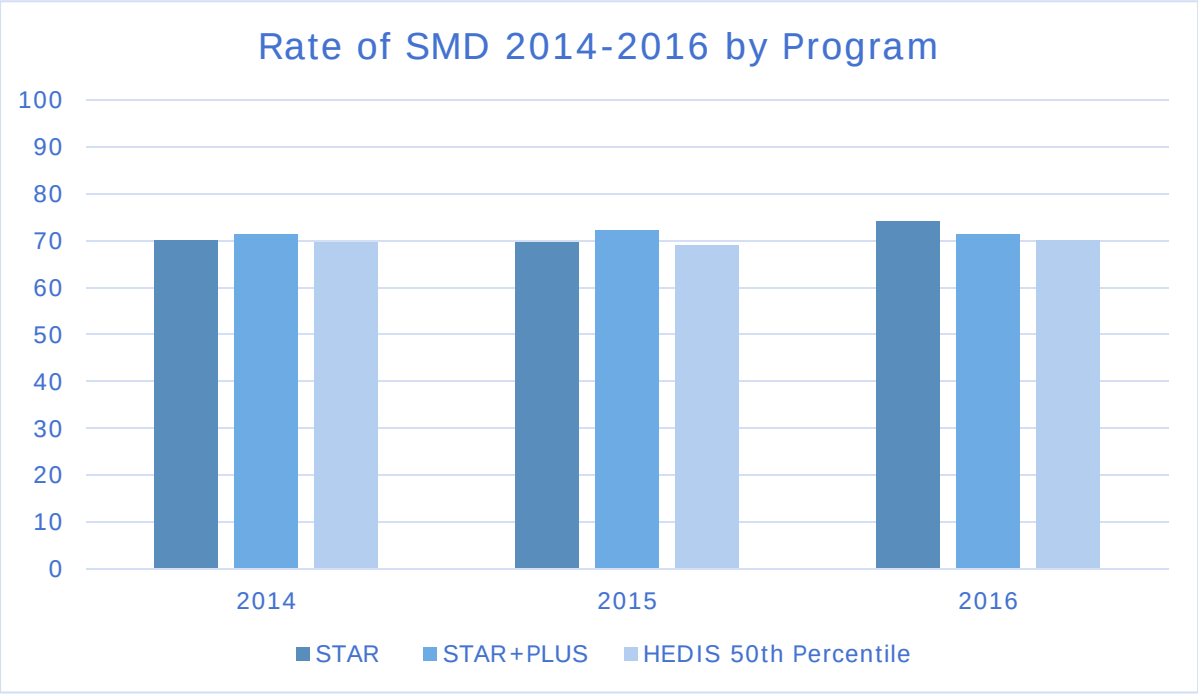
Appendix B. Performance Measure Rates by Program

The charts in this appendix show program level performance for 2014, 2015, and 2016 on the measures identified in this report as currently being collected by HHSC meeting Rider 45. The HEDIS 50th percentile is provided where available and reflects the national 50th percentile of health plans reporting the measure to the National Committee for Quality Assurance for the measurement year.

Integrated Care

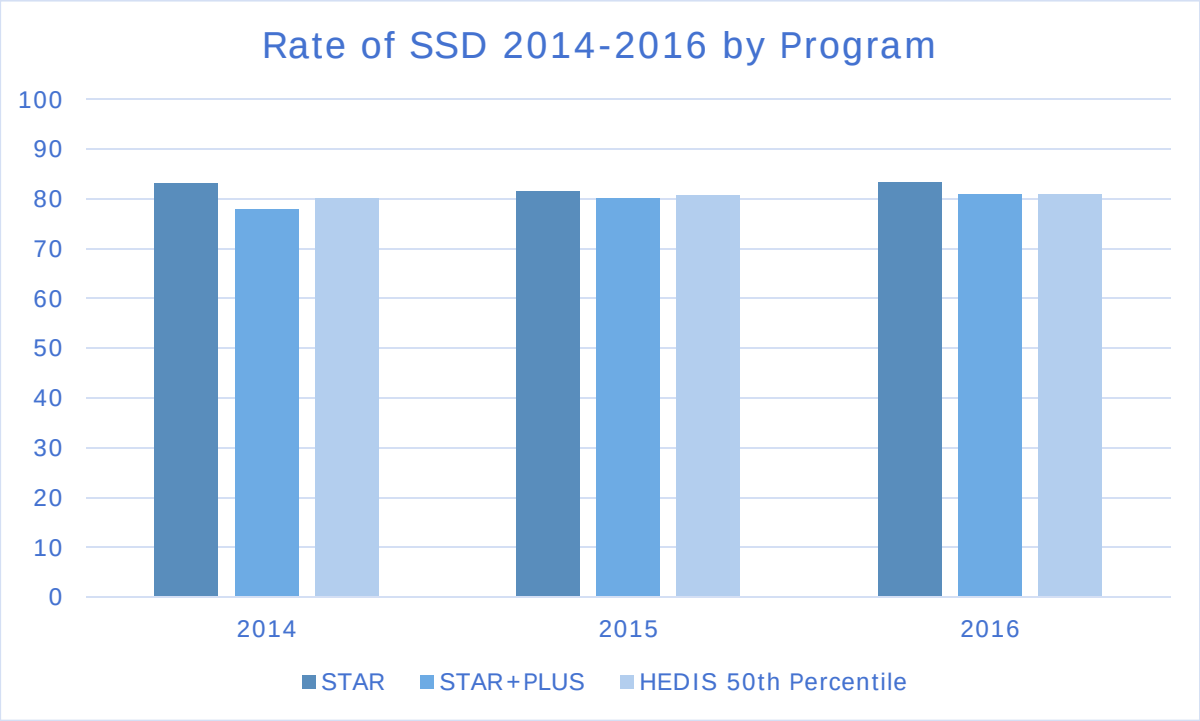
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

The percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-Cholesterol test and a Hemoglobin Ac1 (HbA1c) test during the measurement year.



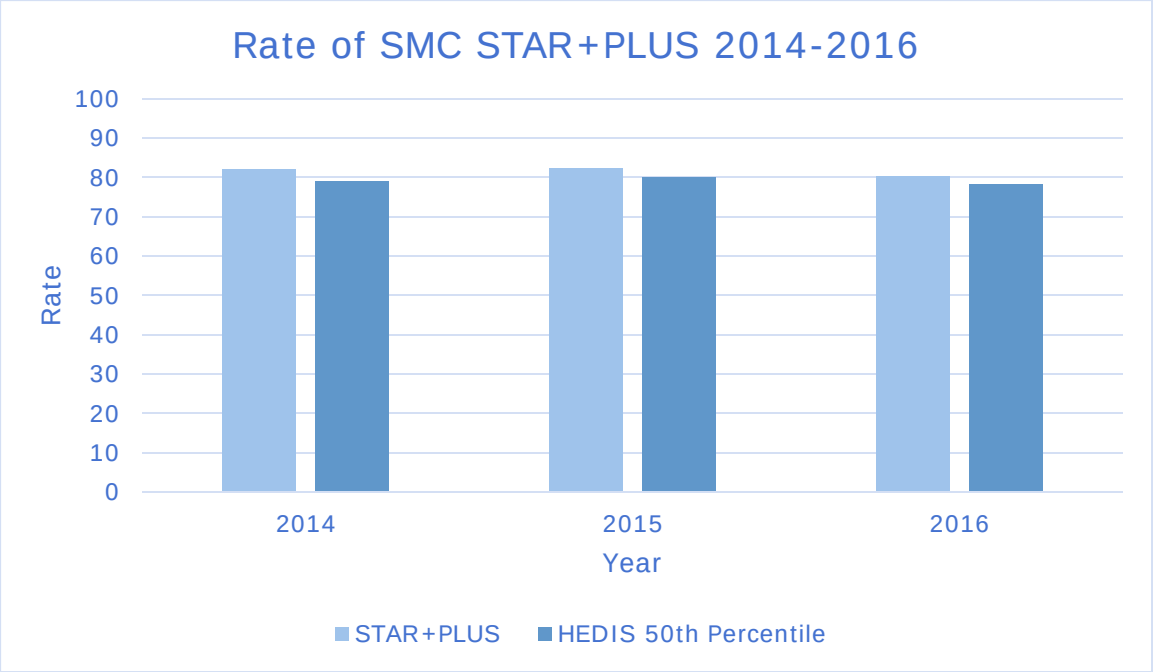
Diabetes Screening for People with Schizophrenia and Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)

The percentage of members 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.



Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)

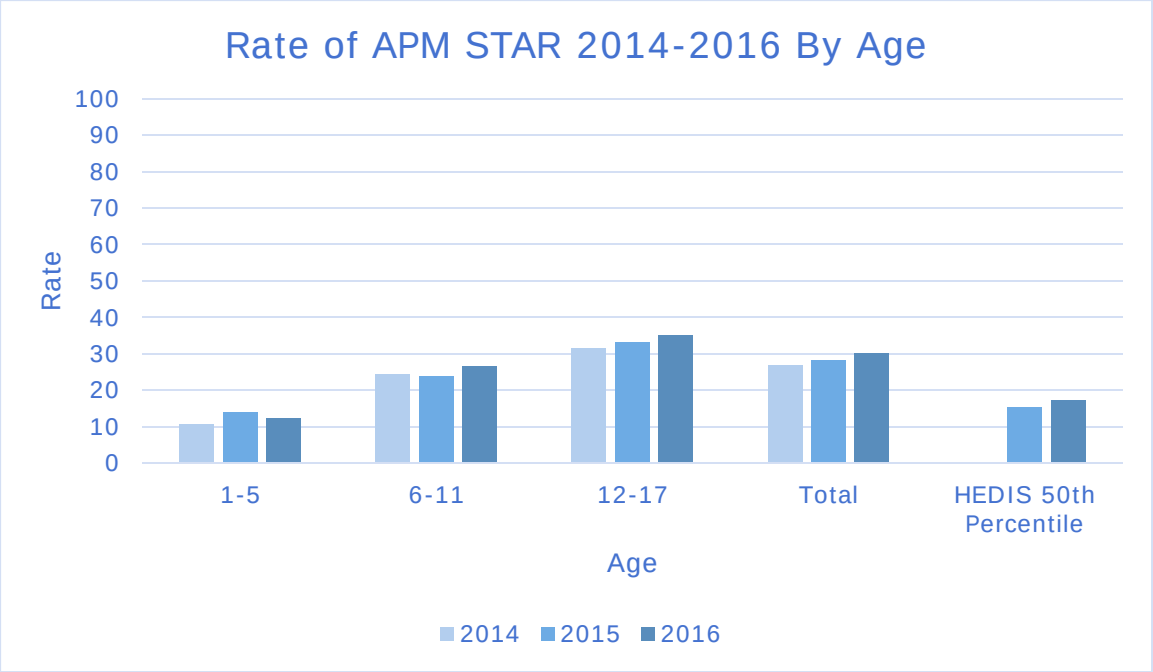
The percentage of members 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-Cholesterol test during the measurement year.



Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)[19]

The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

[19] STAR+PLUS data not reported for 2016 because children in STAR+PLUS moved to STAR Kids.


Rate of APM STAR 2014-2016 By Age
100
90
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60
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40
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20
10
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Rate
1-5
6-11
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Total
HEDIS 50th Percentile
Age
2014
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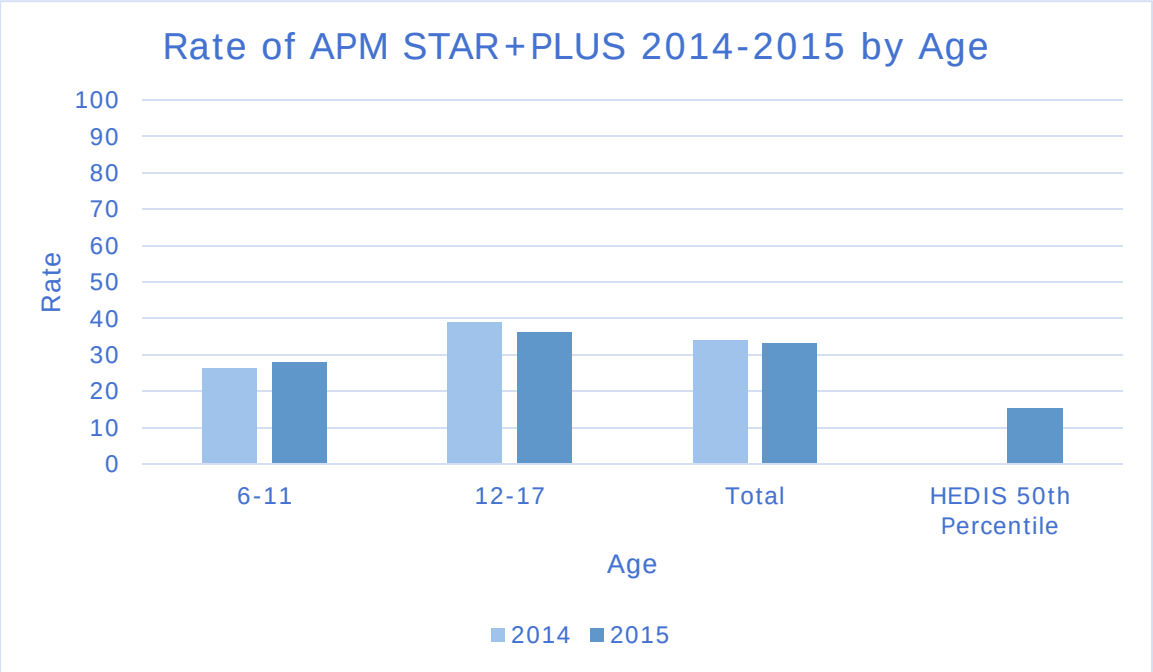
2016


Rate of APM STAR+PLUS 2014-2015 by Age
100
90
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Total
HEDIS 50th Percentile
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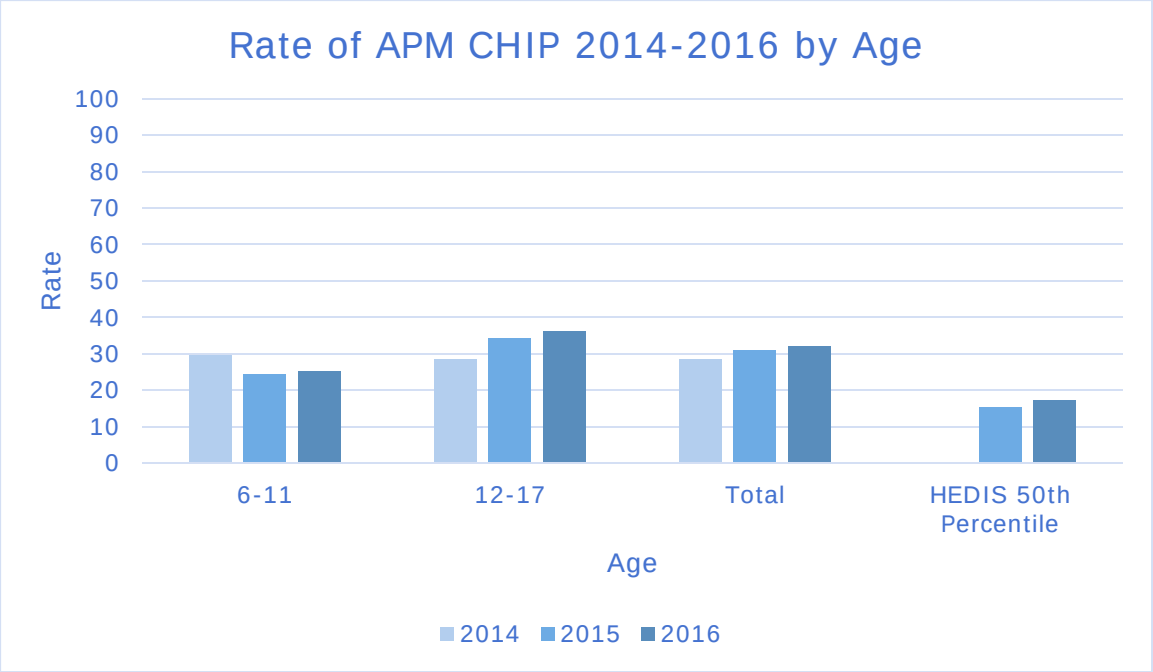
2015


Rate of APM CHIP 2014-2016 by Age
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Rate
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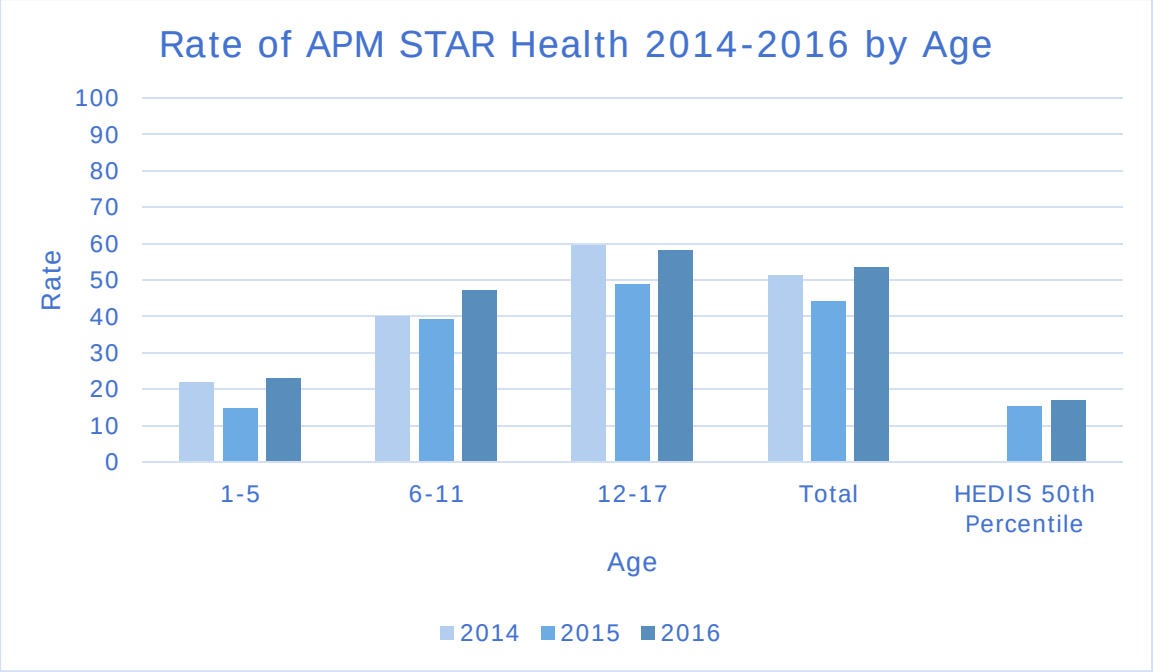
12-17
Total
HEDIS 50th Percentile
Age
2014
2015
2016


Rate of APM STAR Health 2014-2016 by Age
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20
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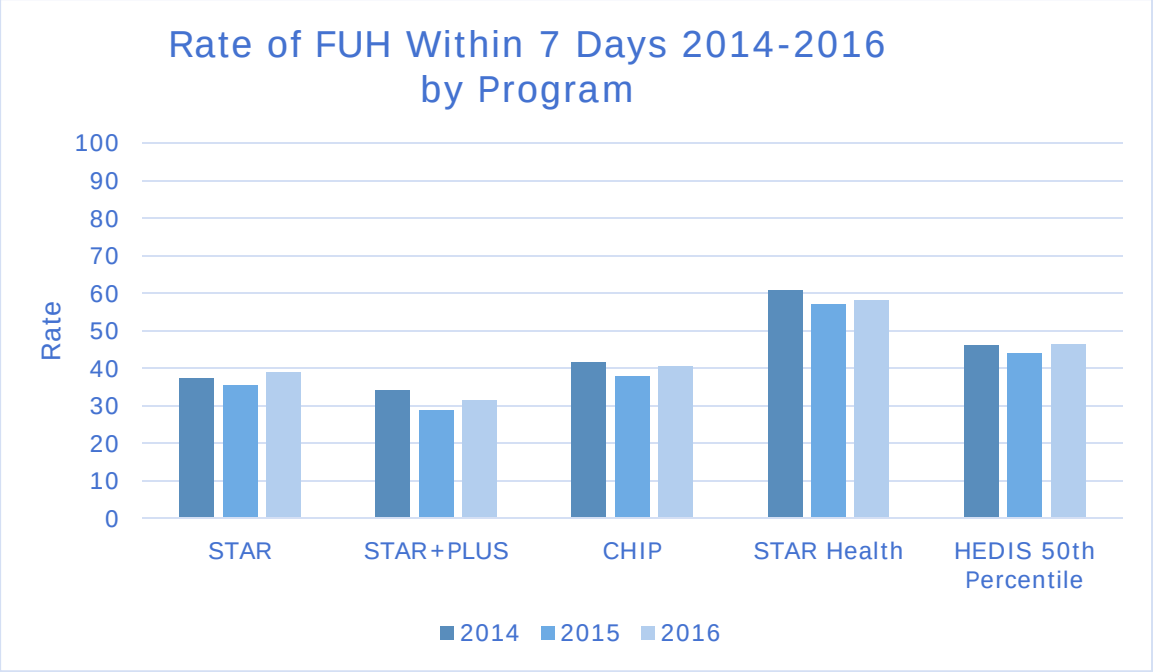
0
Rate
1-5
6-11
12-17
Total
HEDIS 50th Percentile
Age
2014
2015
2016

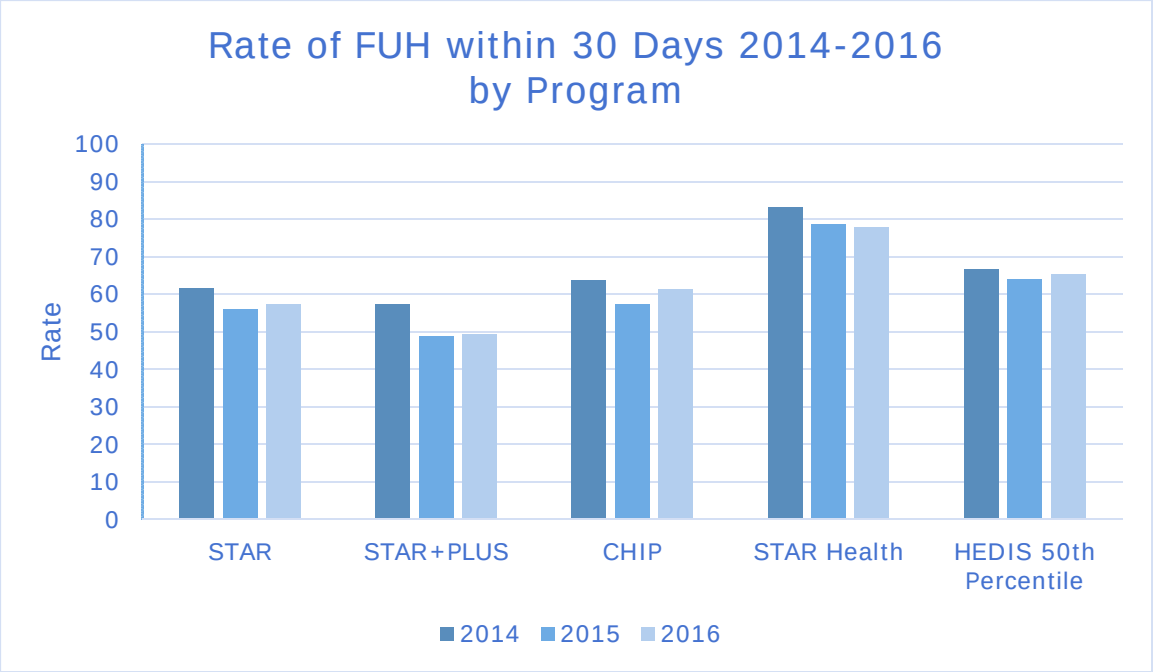
Post-Release Linkage to Care

Follow-up After Hospitalization for Mental Illness (FUH)

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 7 days of discharge.
2. The percentage of discharges for which the member received follow-up within 30 days of discharge.



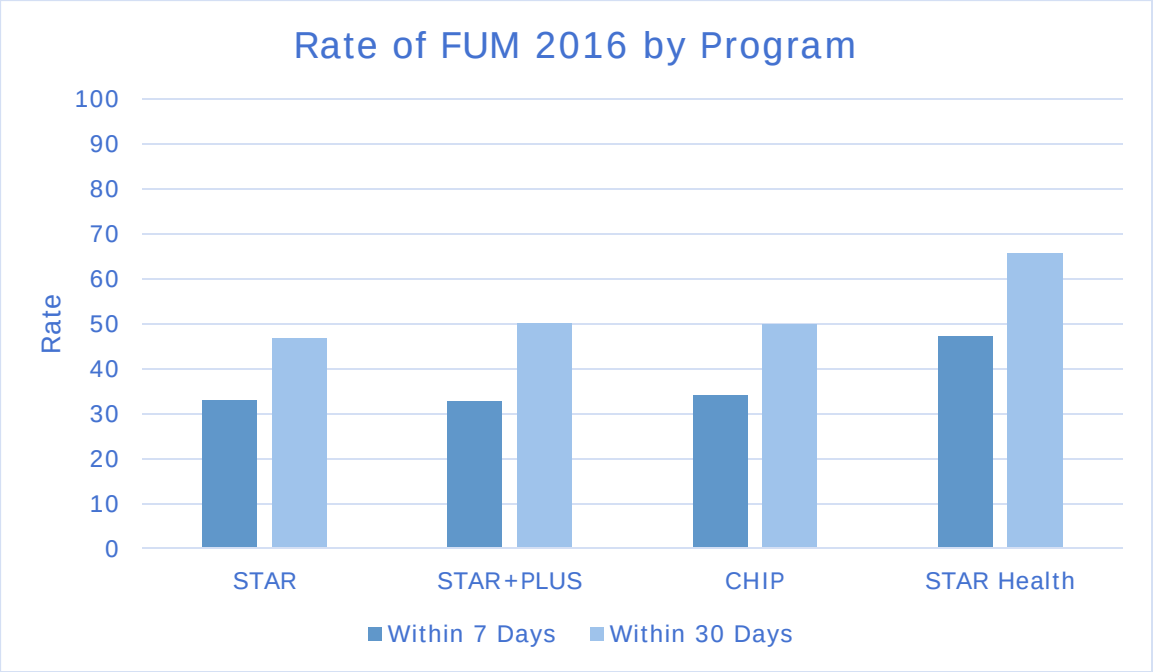


Follow-up After emergency department Visit for Mental Illness (FUM)[20]

The percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported:

1. The percentage of emergency department visits for which the member received follow-up within 30 days of the emergency department visit.
2. The percentage of emergency department visits for which the member received follow-up within 7 days of the emergency department visit.

[20] The FUM measure was new in 2016.

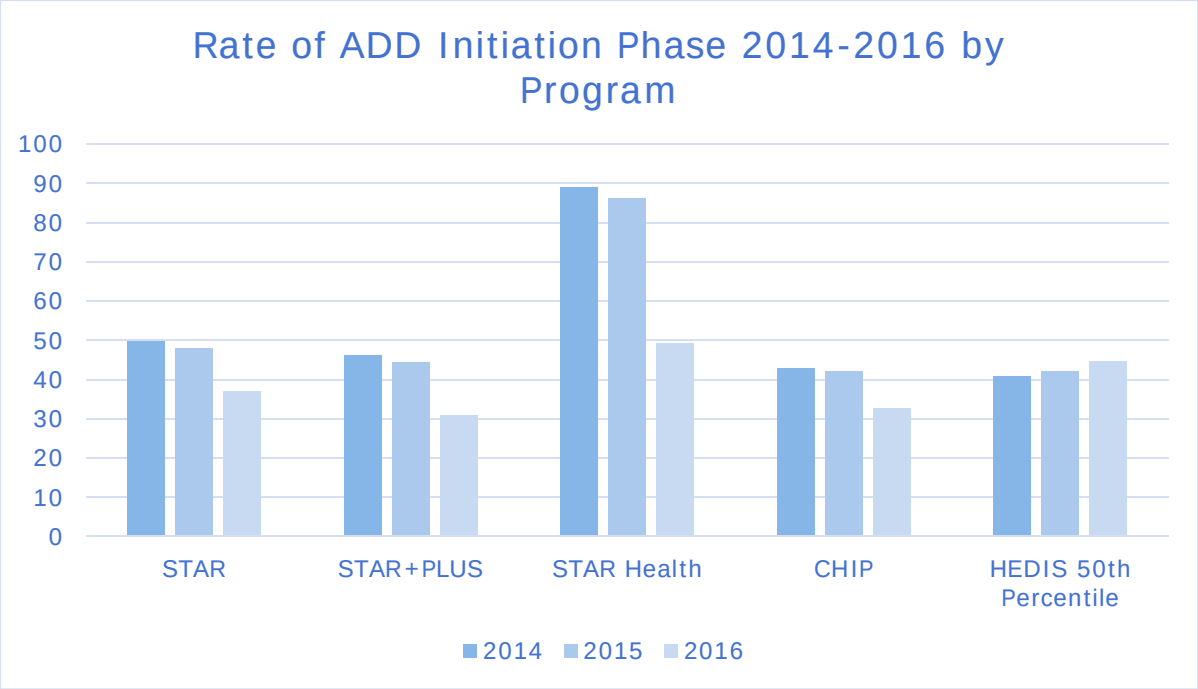


Medication Adherence

Follow-up Care for Children Prescribed ADHD Medication (ADD)

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

1. Initiation Phase. The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
2. Continuation and Maintenance (C&M) Phase. The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.


Rate of ADD Initiation Phase 2014-2016 by Program
100
90
80
70
60
50
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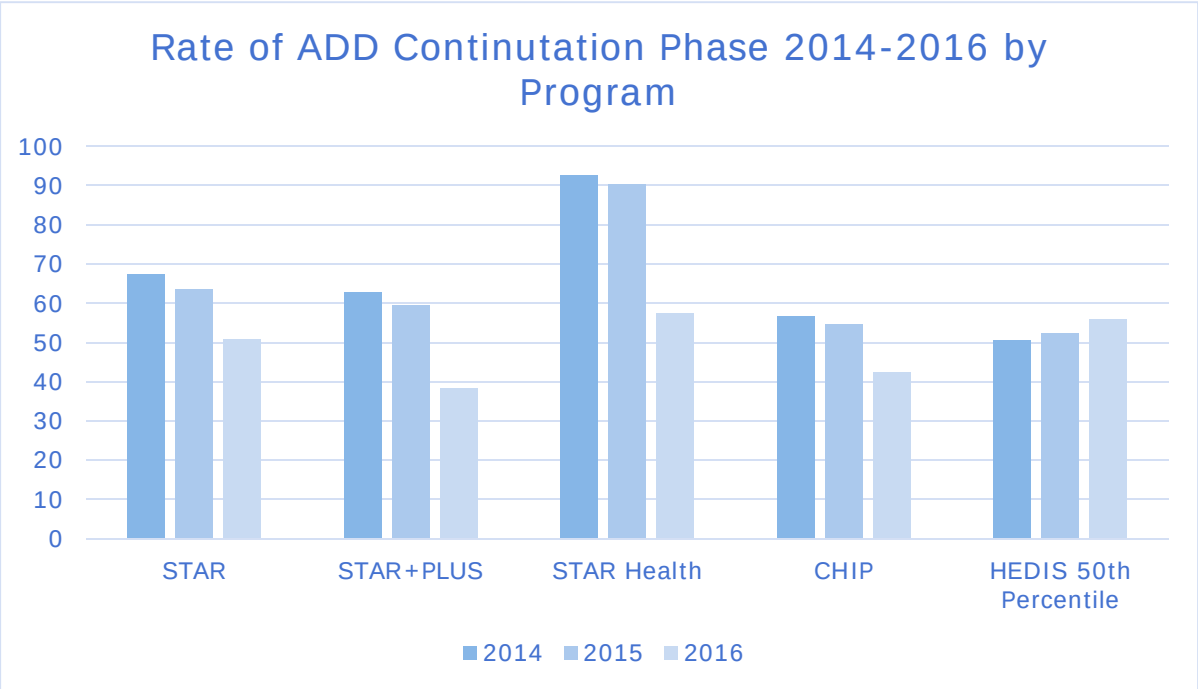
20
10
0
STAR
STAR+PLUS
STAR Health
CHIP
HEDIS 50th Percentile
2014
2015
2016


Rate of ADD Continutation Phase 2014-2016 by Program
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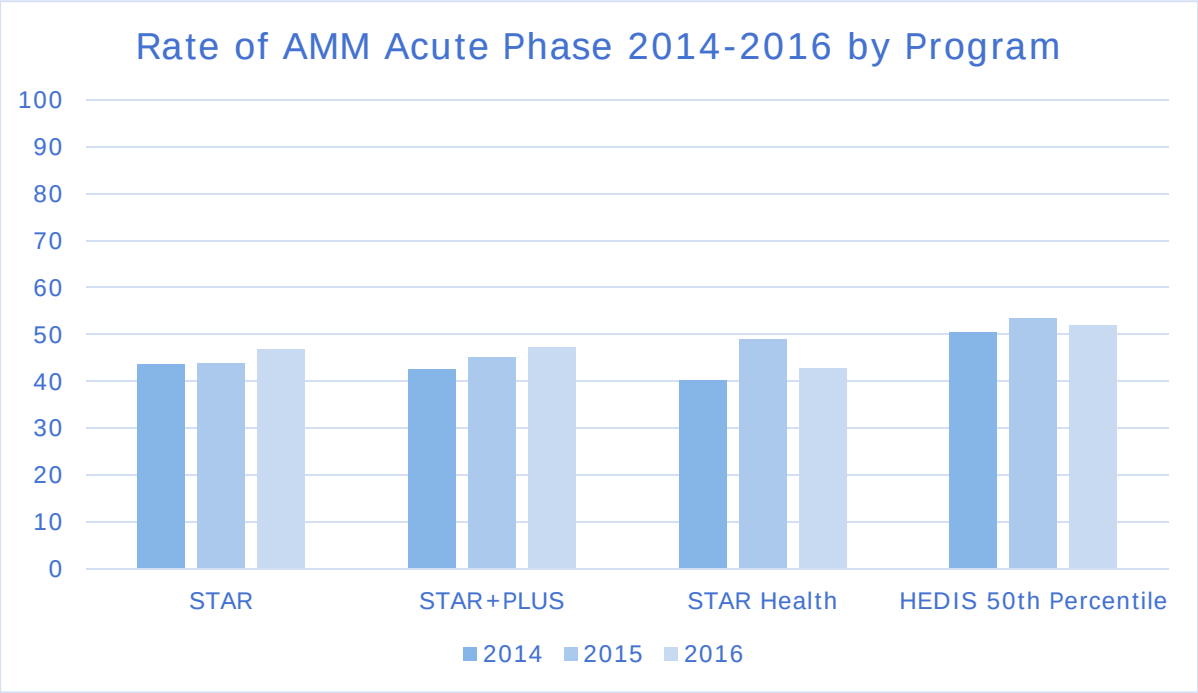
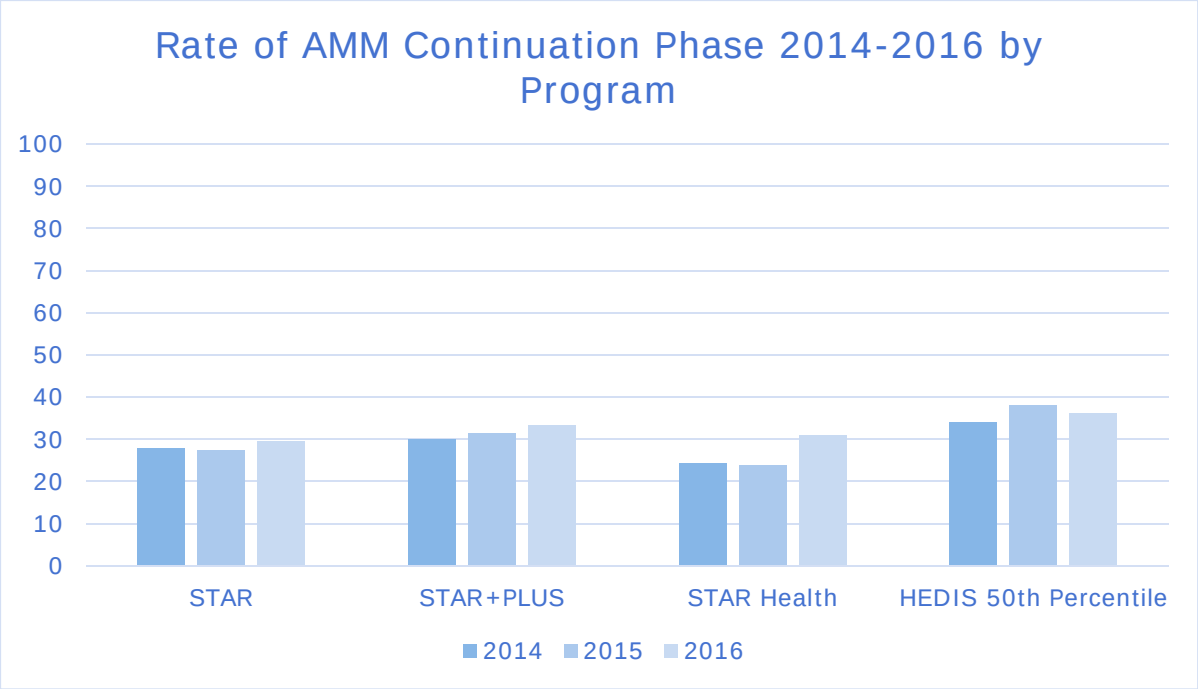
50
40
30
20
10
0
STAR
STAR+PLUS
STAR Health
CHIP
HEDIS 50th Percentile
2014
2015
2016

Antidepressant Medication Management (AMM)

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported:

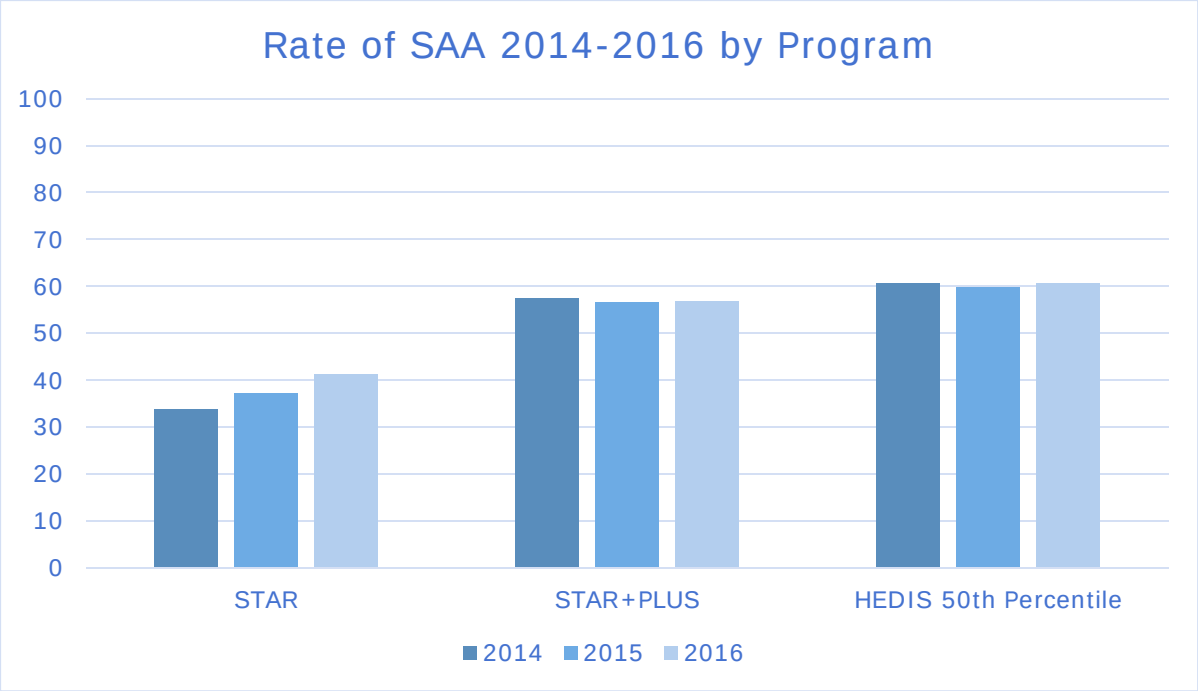
1. Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).





Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

The percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.


Rate of SAA 2014-2016 by Program
100
90
80
70
60
50
40
30
20
10
0
STAR
STAR+PLUS
HEDIS 50th Percentile
2014
2015
2016

Appendix C. HHSC Supportive Housing Services and Permanent Supportive Housing

Community-Based Options with Supportive Housing Services

1915i - Home and Community-Based Services-Adult Mental Health Program (HCBS-AMH)

HCBS-AMH provides services that contribute to the overall ability of an individual to maintain a home, both financially and practically. Program participants utilize personal resources such as SSI to pay rent. The program does not provide direct rental or utility assistance.

HCBS-AMH provides services to adults with SMI who have extended tenure in state mental health facilities in lieu of them remaining as long-term residents of those facilities. The HCBS-AMH program provides an array of services (e.g., supported home living, employment assistance, nursing, peer support, etc.), appropriate to each individual's needs, to enable these individuals to live and experience successful tenure in their community.

HCBS-AMH services must be provided in home and community-based settings of the individual's choice which may include individual homes, apartments, assisted living settings and small, community-based residences. Other Medicaid services are provided as medically necessary through the state's Medicaid managed care system and are closely coordinated with HCBS-AMH services.

Open enrollment applications for provider agencies and recovery management entities have been posted and HHSC is actively recruiting providers. HHSC has 28 providers with executed contracts and are currently serving 19 of the 39 LMHA/LBHA service regions across Texas.

Supported Housing Rental Assistance Program

During the 83rd Legislative session, the state requested and received funds to provide additional supported housing resources among certain LMHAs and LBHAs across the state. The purpose of this funding is to enhance the ability of LMHA/LBHAs to provide rental and utility assistance to individuals with mental

illness, who were homeless and imminently homeless, along with supportive housing and mental health services. LMHA/LBHAs are encouraged to become HOME Tenant-Based Rental Assistance Administrators through TDHCA which allows them to access rental assistance funds, depending on availability, to maintain someone in subsidized housing when they are on wait lists for permanent housing subsidies.

During the 2018-19 biennium, 20 LMHA/LBHAs received $11.6 million in state general revenue. In fiscal year 2017, 6,289 homeless individuals with a mental illness received assistance and 4,796 of these individuals transitioned to permanent supportive housing or affordable housing not funded by the state.

Project Access Pilot Program

The Project Access pilot program is collaboratively managed by both HHSC and TDHCA. The program uses Housing Choice vouchers to help low-income people with disabilities transition from state-funded psychiatric hospital beds into the community by providing access to affordable housing. This pilot program is part of the larger Project Access program overseen by TDHCA. Eligible applicants must either be currently in a state funded psychiatric hospital bed or be discharged within 60-days from the date of their application, have a disability, and meet income requirements. Permanent supportive housing services must be offered in order to assist the individual in finding, securing and maintaining housing but are not required. To date, 34 participants have been housed with 6 applications in process and 46 on the wait list.

Healthy Community Collaboratives

During the 83rd Legislative session, the state was directed to allocate up to $25 million in General Revenue over the biennium to fund grants to serve persons experiencing homelessness and mental illness. During the 85th Legislative session, the types of persons were expanded to include persons experiencing homelessness and substance use disorders. In addition, the legislation was amended to allow providers in rural areas that serve two or more counties each with less than 100,000 in population to establish or expand community collaboratives. Rural area collaboratives are anticipated to ramp up during fiscal year 2019.

Currently funds are awarded in Austin, San Antonio, Fort Worth, and Dallas for the purposes of promoting collaboration based on locally identified priorities, leveraging local matching funds in an amount equal to the grant awarded and addressing homelessness, criminal recidivism, emergency room utilization, substance abuse,

employment rates, and local economic benefit. Funds appropriated for Community Collaborative projects support significant coordination and collaboration between LMHA/LBHAs, municipalities, and other community stakeholders. In fiscal year 2017, HCC project sites completed 21,632 coordinated assessments, enrolled 19,704 individuals into the program, and placed 461 in permanent supportive and affordable housing.

Section 811 Project Rental Assistance Demonstration Program

Texas received two federal grants totaling $24 million to implement the Section 811 Project Rental Assistance (PRA) demonstration program through funds from the U.S. Department of Housing and Urban Development. TDHCA partners with HHSC and the Department of Family and Protective Services to operate this program. The Section 811 PRA program creates the opportunity for persons with disabilities to live as independently as possible through the coordination of voluntary services and providing a choice of subsidized, integrated rental housing options. However, this is not a statewide program. Income is not a requirement for the program; tenants pay no more than 30 percent of their income on rent and utilities.

Participating properties are located in eight metropolitan areas:

- Austin-Round Rock
- Brownsville-Harlingen
- Corpus Christi
- Dallas-Fort Worth-Arlington
- El Paso
- Houston-The Woodlands-Sugar Land
- McAllen-Edinburg-Mission
- San Antonio-New Braunfels

Eligible participants include members of these Target Populations:

- People with disabilities living in institutions. People that wish to transition to the community from nursing facilities and intermediate care facilities for individuals with an intellectual disability or related condition (ICF/IID) may not have access to affordable housing in their community. It is important to note that individuals are eligible for this housing if they discharged from a nursing facility or ICF/IID up to 12 months prior to when an application is submitted.

- People with SMI. Individuals engaged in services but facing challenges due to housing instability. Stable, integrated, affordable housing would enable these individuals to have the opportunity to fully engage in rehabilitation and treatment, greatly improving their prospects for realizing their full potential in the community.
- Youth with disabilities exiting foster care. Youth exiting foster care often become homeless, particularly without the stability of long-term housing and comprehensive support services.
- As of June 2018, there are 761 households on the state-wide waiting list for units to become available.

Oxford Houses

The 83rd Legislature appropriated funding to expand Oxford Houses throughout the state. The purpose of this funding is to establish and maintain housing opportunities for persons in recovery from drug and alcohol addiction. Residents live in democratically run, self-supporting and drug free homes. The state contracts with Oxford House, Inc. (OHI) to establish rental contracts for houses through revolving loans. The initial funds function as seed money to start the house and are paid back to the state as the homes mature over time. OHI provides oversight and support to these homes. HHSC monitors through contract deliverables including monthly data reporting requirements. During fiscal year 2017, there were 212 Oxford Houses across the state serving 1,364 people.

Appendix D. 2016 PPV and PPR Expenditures for Mental Health Reasons by Program[2]

Potentially Preventable Emergency Department Visits (PPVs)

Table 4. 2016 PPVs for Mental Health Reasons

Reason for emergency department Visit	STAR	STAR+ PLUS	CHIP	STAR Health	Total
Full Day Partial Hospitalization for Mental Illness	0	5	0	0	5
Schizophrenia	65	1,852	0	0	1,917
Major Depressive Disorders and Other/Unspecified Psychoses	1,329	1,834	121	102	3,386
Disorders of Personality and Impulse Control	71	78	0	20	169
Bipolar Disorder	375	1,147	12	92	1,626
Depression Except Major Depressive Disorder	69	32	0	0	101
Adjustment Disorders and Neuroses Except Depressive Diagnoses	600	377	52	40	1,069
Acute Anxiety and Delirium States	4,911	4,068	288	121	9,388
Organic Mental Health Disturbances	67	144	0	7	218
Childhood Behavioral Disorders	596	252	48	112	1,008

Reason for emergency department Visit	STAR	STAR+ PLUS	CHIP	STAR Health	Total
Eating Disorders	49	15	5	0	69
Other Mental health Disorders	369	508	11	21	909
Total	**8,501**	**10,312**	**537**	**515**	**19,865**

Table 5. 2016 PPV Expenditures for Mental Health Reasons

Reason for emergency department Visit	STAR	STAR+ PLUS	CHIP	STAR Health	Total
Full Day Partial Hospitalization for Mental Illness	0	$4,222	0	0	$4,222
Schizophrenia	$25,490	$821,027	0	0	$846,517
Major Depressive Disorders and Other/Unspecified Psychoses	$598,216	$828,291	$63,710	$43,891	$1,534,108
Disorders of Personality and Impulse Control	$30,706	$27,046	0	$6,335	$64,087
Bipolar Disorder	$132,612	$469,006	$3,855	$32,993	$638,466
Depression Except Major Depressive Disorder	$21,012	$10,583	0	0	$31,595

Reason for emergency department Visit	STAR	STAR+ PLUS	CHIP	STAR Health	Total
Adjustment Disorders and Neuroses Except Depressive Diagnoses	$188,122	$125,645	$33,758	$9,314	$356,839
Acute Anxiety and Delirium States	$1,454,459	$1,213,561	$115,416	$32,506	$2,815,942
Organic Mental Health Disturbances	$23,286	$63,859	0	$2,360	$89,505
Childhood Behavioral Disorders	$214,839	$97,284	$10,553	$43,118	$365,794
Eating Disorders	$14,111	$5,295	$4,982	0	$24,388
Other Mental health Disorders	$123,545	$165,037	$5,144	$4,169	$297,895
Total	**$2,826,398**	**$3,830,856**	**$237,418**	**$174,686**	**$7,069,358**

Potentially Preventable Readmissions (PPRs)

Table 6. 2016 PPRs for Mental Health Reasons

Reason for Readmission	STAR	STAR+ PLUS	CHIP	STAR Health	Total
Mental Illness Diagnosis with O.R. Procedure	0	7	0	0	7
Schizophrenia	72	2,113	0	11	2,196

Reason for Readmission	STAR	STAR+ PLUS	CHIP	STAR Health	Total
Major Depressive Disorders and Other/Unspecified Psychoses	791	531	108	180	1,610
Bipolar Disorders	660	1,122	65	463	2,310
Depression Except Major Depressive Disorder	102	60	14	23	199
Adjustment Disorders and Neuroses Except Depressive Diagnoses	11	8	0	9	28
Acute Anxiety and Delirium States	9	11	0	0	20
Organic Mental Health Disturbances	0	10	0	0	10
Childhood Behavioral Disorders	70	22	0	24	116
Eating Disorders	18	0	0	0	18
Total	**1,733**	**3,884**	**187**	**710**	**6,514**

Table 7: 2016 PPR Expenditures for Mental Health Reasons

Reason for Readmission	STAR	STAR+ PLUS	CHIP	STAR Health	Total
Mental Illness Diagnosis with O.R. Procedure	0	$50,025	0	0	$50,025

Reason for Readmission	STAR	STAR+ PLUS	CHIP	STAR Health	Total
Schizophrenia	$345,633	$9,754,579	0	$128,074	$10,228,286
Major Depressive Disorders and Other/Unspecified Psychoses	$3,244,039	$2,150,852	$517,814	$1,268,941	$7,181,646
Bipolar Disorders	$3,420,463	$4,443,850	$375,672	$3,654,773	$11,894,758
Depression Except Major Depressive Disorder	$382,024	$215,027	$52,731	$133,849	$783,631
Adjustment Disorders and Neuroses Except Depressive Diagnoses	$35,364	$29,751	0	$54,117	$119,232
Acute Anxiety and Delirium States	$50,005	$21,861	0	0	$71,866
Organic Mental Health Disturbances	0	$50,217	0	0	$50,217
Childhood Behavioral Disorders	$263,069	$64,565	0	$153,234	$480,868
Eating Disorders	$273,876	0	0	0	$273,876
Total	**$8,014,473**	**$16,780,727**	**$946,217**	**$5,392,988**	**$31,134,405**

[2] For the purposes of this rider, PPVs that occurred due to substance use disorders were excluded from the tables are current as of August 22, 2018. Additional PPV data is available on the THLC portal.

Appendix E. RFI Measures

As part of the RFI related to part b. of Rider 45, respondents were asked to suggest performance measures generally and specific to a potential pilot. While HHSC will provide a final report on responses and recommendations from the RFI, this appendix lists the suggested measures only related to part a. of the Rider based on a preliminary review of responses.

There were many general responses (e.g., performance measures should include criteria for measuring how effective the State's program is for decreasing reincarceration, readmissions and admissions, and avoidable medical costs). These types of comments touch on themes explored by the Rider 45 workgroup. Furthermore, many ideas for what to measure were provided (e.g., average length of community tenure, or percent of jail bookings with identified mental illness), however these types of measures would need to be developed. Should HHSC pursue developing measures, staff will take these types of recommendations into consideration. However, only specific measure suggestions where HHSC could identify a measure steward are included in the table below.

Additionally, there were many recommended measures related to substance use disorders and many recommended measures that did not fit within the rider categories (i.e., integrated care, jail diversion, emergency department diversion, post-release linkage to care, homelessness reduction, supportive housing, and medication adherence). These are also not included in the table below because they go beyond the rider's scope.

Table 8: Measures Suggested by RFI Respondents

Measure	Currently Used by HHSC
Integrated Care	
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	Yes
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	Yes

Measure	Currently Used by HHSC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Yes
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Yes
LDL (low-density lipoprotein) testing for members with SMI	No*
Diabetes Care for members with SMI	No*
Body mass index (BMI) monitoring for members with SMI	No*
Asthma Medication Management for members with SMI	No*
Early, periodic screening, diagnostic, and treatment (EPSDT) measures (DVS, W15, W34, AWC) for members with SMI	No*
Jail Diversion - None	
Emergency Department Diversion	
Potentially preventable emergency department Visits (PPV)	Yes
Post-Release Linkage to Care	
Potentially preventable Readmissions (PPR)	Yes
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Yes
Follow-Up After Hospitalization for Mental Illness (FUH)	Yes
Plan All-Cause Readmission Rate (PCR) for members with SMI	No*
Homelessness Reduction	

Measure	Currently Used by HHSC
Housing Status (SAMHSA HOU)	No[21]
Supportive Housing - None	
Medication Adherence	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Yes
Antidepressant Medication Management (AMM)	Yes
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Yes
Proportion of Days Covered (PDC)	No*
Adherence to mood stabilizers for individuals with bipolar disorders	No[22]

* These measures are not behavioral health specific. HHSC will engage the EQRO to run these measures for members with SMI only.

[21] The data source for this measure is Mental Health Block Grant provider (psychiatric facilities) data reported to NRI. HHSC does not currently have access to member level data and issues with reporting this measure are similar to those described in the report as barriers to using IDD-BH performance measures.

[22] HHSC will look into the feasibility of adding this measure.