Evaluation of Managed Care Organization Services for Adults with Serious Mental Illness in STAR+PLUS

As Required by

2020-21 General Appropriations Act, House Bill 1, 86th Legislature Regular Session, 2019 (Article II, Health and Human Services Commission, Rider 33)

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Executive Summary

The 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission [HHSC], Rider 33) requires HHSC to evaluate variation in service delivery to individuals with serious mental illness (SMI) by managed care organization (MCO). Rider 33 also requires HHSC to identify performance measures to better hold MCOs accountable for outcomes and spending for individuals with SMI, evaluate the delivery of services, and develop recommendations to improve quality of care.

STAR+PLUS serves adults with disabilities and individuals who are 65 years or older. For the report, Medicaid STAR+PLUS members were evaluated. Dually enrolled members were not included because data was not available.

Claim-based performance metrics were evaluated to develop the report. The claim-based data, which include managed care encounter data, have several strengths including clinical validity, a representative population, and access. However, like any data set, there are limitations. The claims are based on the record of care received. Furthermore, the data provide no detail on the severity or longevity of the diagnosed condition, which may impact behavioral health (BH) outcomes. Readers should consider these limitations when drawing any conclusions from the findings.

Key findings are:

- About one-third of STAR+PLUS members had an SMI diagnosis, consistent across MCOs.
- STAR+PLUS members with SMI accounted for 43 percent of all medical and pharmacy costs and had higher average-per-year costs than the overall STAR+PLUS population ($19,755 versus $16,960 in 2018).
- Most STAR+PLUS MCOs were between the 25th and 50th percentile for the Behavioral Health Core Set Measures (BH Core).
  - For members with SMI, STAR+PLUS MCOs had some measures with rates below the 10th national percentile for the BH Core.
- STAR+PLUS MCOs performed higher on the non-core BH measures.
  - For members with SMI, most STAR+PLUS MCOs were between the 50th and 75th national percentile for the non-core BH measures.

HHSC recommends STAR+PLUS MCOs take the following actions to improve the value of care for members with SMI:

- Evaluate how different cost distributions are associated with processes and outcomes of care, with a focus on pharmacy spending and other services.
- Examine performance on Healthcare Effectiveness Data and Information Set (HEDIS) BH measures and work to make service delivery improvements.

HHSC will continue to monitor MCO performance on quality of care outcomes for BH and provide guidance to improve outcomes through the Medical Pay-For-Quality program, performance improvement projects, and the performance indicator dashboard.

1. Introduction

House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 33) requires HHSC to:

- Identify claims and expenditures, by MCO, for Medicaid recipients in STAR+PLUS with a serious mental illness (SMI) to evaluate any inappropriate variation in delivery of service to individuals with SMI by MCO. For the purposes of the evaluation, individuals with SMI are individuals who have: (1) a qualifying diagnosis; and (2) functional impairment if a local mental health authority has performed an assessment on the recipient.
- Identify performance measures to better hold MCOs accountable for outcomes and Medicaid spending for individuals with SMI.
- Evaluate the delivery of services to individuals with SMI by MCOs against standards of care.
- Develop recommendations to improve quality of care.

The analysis included the following elements:

- Assessment of the frequency and population characteristics of the STAR+PLUS SMI population across MCOs.
- Evaluation of cost differences between STAR+PLUS SMI members in 2018.
- Evaluation of quality metric differences between STAR+PLUS MCOs in 2018.

2. Background

STAR+PLUS Program

STAR+PLUS is a Texas Medicaid managed care program that integrates primary care, BH care, pharmacy services, and long-term services and supports (LTSS) for adults with disabilities or who are age 65 and older. Medicaid-enrolled providers contract with one or more of the five STAR+PLUS MCOs to provide services to individuals enrolled with that MCO.

MCOs are required to ensure services provided to STAR+PLUS members with SMI are consistent with the HHSC Uniform Managed Care Contract (UMCC) requirements. BH providers paid through Medicaid MCOs are required to ensure services are delivered appropriately and in accordance with Medicaid policies.

To obtain services through STAR+PLUS, an individual must (1) be approved for Medicaid, and (2) be one or more of the following:

- Age 21 or older, receiving Supplemental Security Income (SSI) benefits;
- Receiving services through the STAR+PLUS Home and Community-Based Services (HCBS) program;
- Age 21 or older, receiving Medicaid through "Social Security Exclusion programs" and meet program rules for income and asset levels;
- Age 21 or over residing in a nursing facility and receiving Medicaid while in the nursing facility;
- In the Medicaid for Breast and Cervical Cancer program; or
- Age 65 and older and meet Medicaid eligibility rules for income and asset levels.

BH care is a benefit for individuals enrolled in STAR+PLUS. The program includes:

- inpatient and outpatient mental health (MH) services;
- MH rehabilitation;
- MH targeted case management;
- withdrawal management;
- psychiatry services; and
- counseling services.

SMI represents a subset of individuals with MH conditions. A list of the SMI diagnoses used for the evaluation is available in Appendix A.

Costs for Members with Serious Mental Illness

Under the managed care model, care coordination is expected to improve enrollees' care experiences and lower program costs by reducing rates of emergencies and acute care, decreasing duplication of services, and improving medication management for members with SMI[1]. However, the literature on cost of care for individuals with SMI in Medicaid managed care is limited.

Additionally, the capitated contractual arrangement between HHSC and MCOs, as well as the actuarial requirements for rate setting as established by the federal managed care regulations, can dilute actual differences in costs between MCOs and make per member per year costs for Medicaid homogeneous within specific populations.

This report evaluates total per member per year and per service category costs for STAR+PLUS enrollees and SMI-diagnosed STAR+PLUS enrollees.

SMI and Standards of Care

Rider 33 requires HHSC to evaluate the delivery of services to individuals with SMI by MCOs against "standards of care." HHSC oversees MCO performance on a broad range of requirements under the UMCC, including the quality of care they provide for their members. HHSC has monitored MCO performance on quality of care measures for over five years, including measures for BH care.

The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in managed care developed by the National Committee for Quality Assurance (NCQA) and includes BH measures. These HEDIS measures include screening for mental disorders, access to care, coordination of care, and

[1] Schuster JM, Kinsky SM, Kim JY, et al. Connected Care: improving outcomes for adults with serious mental illness. Am J Manag Care. 2016;22(10):678-682.

appropriate utilization of BH services for individuals diagnosed with SMI[2]. For the comprehensive list, please see Table 5 in Section 6. Performance Measures).

[2] Many of these NCQA HEDIS measures are included in the Centers for Medicare and Medicaid (CMS) Core Set of Adult Health Care Quality Measures for Medicaid. MCO quality of care measures are published on the Texas Healthcare Learning Collaborative Portal (THLCPortal.com).

3. Evaluation Approach

For the purposes of the evaluation, individuals with SMI are individuals who have a qualifying diagnosis such as schizophrenia, bipolar disorder, major depression, or obsessive-compulsive disorder (OCD) with at least one inpatient visit or at least two outpatient visits in 2018. Qualifying diagnosis codes are listed in Appendix A.

Rider 33 further defines a person with SMI as an individual with functional impairment, if a Local Mental Health Authority (LMHA) performed an assessment on the recipient. It is a standard practice for LMHAs to complete an assessment for all patients. However, the results of the assessments are not transmitted to MCOs or HHSC and neither organization can determine which members have a functional impairment. Therefore, no distinction is made in this report between individuals with or without a functional impairment.

To study the SMI population in STAR+PLUS, claims-based data (including managed care encounter data) were used to examine STAR+PLUS members with an SMI diagnosis who received care from any BH service provider. Claims data provide robust data sets that are clinically valid and easy to access; however, there are limitations to claims data. While claims are based on the record of care received, they do not provide detail on the needs of the member, the severity and longevity of the condition, and other important details. As a result, the findings are limited and should be interpreted as such.

Analyses evaluated variation in measure performance and MCO spending (cost) for individuals with SMI in STAR+PLUS. The analyses used the 2018 STAR+PLUS Medicaid encounter, pharmacy, and member files. The following data sets were used to evaluate costs, and service-based performance measures:

- Adult Medicaid enrollment and eligibility data. The data included MCO, months of enrollment, age, gender, and race-ethnicity.
- Adult Medicaid claims and encounter data. The data used included diagnosis codes, facility claims, and professional claims.
- Adult Medicaid pharmacy claims. The data used included reimbursed amounts for all pharmacy claims.

Performance metrics used in this analysis include costs and HEDIS measures. The specific categories of measures are:

- Cost measures: medical costs and pharmacy costs. Medical costs include costs related to inpatient admissions, outpatient visits, emergency department observations and emergency department admissions.
- BH-related HEDIS measures (Table 5 in Section 6. Performance Measures).

The complete list of variables and their definitions are included in Appendix B.

Limitations

This cost analysis draws comparisons across MCOs serving adult Texas STAR+PLUS members with SMI. However, comparisons should be cautiously interpreted since there are differences between the populations served and the local contexts and service delivery areas for each MCO.

Sociodemographic profiles across MCOs vary. In addition to the member characteristics included in the analyses, the profiles include health care preferences[3], stressors[4], and supporting resources such as family or available transportation resources[5]. The characteristics of the populations included in the analyses, such as age, gender, racial/ethnic membership, and comorbidities, can only capture some of this diversity.

Further, each of the different geographically defined service delivery areas has a complement of health care resources not captured in the analyses. These include

[3] Street Jr, R. L., Gordon, H. S., Ward, M. M., Krupat, E., & Kravitz, R. L. (2005). Patient participation in medical consultations: why some patients are more involved than others. Medical care, 960-969.

[4] Quast, T., & Feng, L. (2019). Long-term effects of disasters on health care utilization: Hurricane Katrina and older individuals with diabetes. Disaster medicine and public health preparedness, 13(4), 724-731.

[5] Sakai, C., Lin, H., & Flores, G. (2011). Health outcomes and family services in kinship care: Analysis of a national sample of children in the child welfare system. Archives of Pediatrics & Adolescent Medicine, 165(2), 159-165. https://doi.org/10.1001/archpediatrics.2010.277

the number of licensed providers[6] and hospitals[7] from which to form provider networks. Regions differ in how geographically dispersed these networks are, which affects the accessibility of services for members.

These limitations also affect the quality of data used for the performance measures. Due to the lack of refinement of performance measures in this area, rate fluctuation is common, making meaningful differences difficult to distinguish.

[6] Merritt Hawkins. (2015). The physician workforce in Texas: An examination of physician distribution, access, demographics, affiliations, and practice patterns in Texas' 254 counties. North Texas Regional Extension Center. https://dfwhcfoundation.org/wp-content/uploads/2015/04/mhaNTREC2015studyfinal.pdf

[7] Calvillo–King, L., Arnold, D., Eubank, K. J., Lo, M., Yunyongying, P., Stieglitz, H., & Halm, E. A. (2013). Impact of social factors on risk of readmission or mortality in pneumonia and heart failure: systematic review. Journal of general internal medicine, 28(2), 269-282. https://doi.org/10.1007/s11606-012-2235-x.

4. STAR+PLUS Enrollment Data

Table 1 shows the number and percent of STAR+PLUS members diagnosed with SMI in calendar year (CY) 2018 and presents a demographic breakdown. As shown, members with SMI represented about one-third of all STAR+PLUS members in 2018. The proportion of females is higher than males and is highest for enrollees between the ages of 35 and 64. The rate of enrollees with an SMI diagnosis was lower for enrollees aged 50 to 64 than for those aged 35 to 49. However, because the total number of STAR+PLUS enrollees aged 50 to 64 was larger, the actual number of SMI-diagnosed enrollees was higher for those aged 50 to 64. Overall, the proportion of SMI-diagnosed STAR+PLUS members is comparable across the race-ethnic groupings included, ranging from 31 to 36 percent (the range was 31 to 35 percent in 2017).

Table 1: Demographics of STAR+PLUS Members, Overall and with SMI, CY 2018[8]

	Overall STAR+PLUS N	STAR+PLUS SMI N	STAR+PLUS SMI % of Overall
Total	269,495	88,237	32.7%
Gender			
Female	137,218	50,054	36.5%
Male	132,277	38,183	28.9%
Age			
18-34	75,160	19,629	26.1%
35-49	60,483	23,736	39.2%
50-64	123,295	42,300	34.3%
65+	10,560	2,572	24.4%
Race			

[8] Individuals who are dually eligible for Medicaid and Medicare are not included.

	Overall STAR+PLUS N	STAR+PLUS SMI N	STAR+PLUS SMI % of Overall
NHW[9]	67,707	24,204	35.7%
NHB[10]	56,574	18,603	32.9%
Hispanic	76,059	24,323	32.0%
Other	69,158	21,107	30.5%

As shown in **Table 2**, the rate of enrollees with an SMI diagnosis was consistent across the five MCOs participating in STAR+PLUS, from approximately 31 to 34 percent in 2018. Across all MCOs, most STAR+PLUS enrollees with an SMI diagnosis were in the psychotic disorders group, followed by the depression disorders group and the bipolar disorders group. In all MCOs, a larger percentage of SMI-diagnosed enrollees were females than males, and a larger percentage of SMI-diagnosed enrollees were between the ages of 50 and 64. In contrast, the race/ethnicity distribution varied substantially across MCOs, presumably reflecting their service area demographics.

Table 2: **Demographics across STAR+PLUS enrollees with SMI by MCOs, 2018**

	Amerigroup	Cigna	Molina	Superior	United
Overall STAR+PLUS	67,184	22,507	40,532	74,279	64,996
STAR+PLUS SMI	21,675	7,021	13,559	24,108	21,874
STAR+PLUS SMI (%)	32.3%	31.2%	33.5%	32.5%	33.7%
SMI Diagnosis (%)					
Psychotic Disorders	47.3%	42.4%	50.8%	46.0%	48.0%
Depression Disorders	29.9%	30.3%	27.3%	30.0%	27.7%

[9] NHW is the acronym for Non-Hispanic White.

[10] NHB is the acronym for Non-Hispanic Black.

	Amerigroup	Cigna	Molina	Superior	United
Bipolar Disorders	22.5%	27.1%	21.8%	23.7%	24.0%
OCD	0.2%	0.2%	0.1%	0.3%	0.3%
Gender (%) SMI					
Female	57.0%	58.2%	53.8%	58.1%	56.4%
Male	43.0%	41.8%	46.2%	41.9%	43.6%
Age Group (%) SMI					
18-34	21.0%	22.8%	20.7%	23.7%	22.6%
35-49	26.1%	28.5%	26.0%	27.3%	27.3%
50-64	49.6%	46.0%	50.2%	46.2%	47.4%
65+	3.2%	2.8%	3.1%	2.8%	2.7%
Race (%) SMI					
NHW	28.5%	36.5%	19.8%	25.0%	30.8%
NHB	22.3%	14.7%	27.9%	14.5%	24.9%
Hispanic	24.0%	25.1%	29.1%	39.9%	17.4%
Other	25.2%	23.7%	23.1%	20.6%	26.9%

5. STAR+PLUS Costs

To gain a better understanding of potential differences between STAR+PLUS members, HHSC examined their cost across STAR+PLUS MCOs.

Overall, SMI-diagnosed STAR+PLUS members had $1.4 billion in medical and pharmacy costs in 2018. STAR+PLUS members with SMI accounted for about one-third of STAR+PLUS members in 2018, and they accounted for 43 percent of all medical and pharmacy costs (**Table 3**)[11]. Members with SMI accounted for 40 percent of total medical costs and 47 percent of total pharmacy costs. There was not significant variation across MCOs within each type of service.

Medical care costs are further broken out into costs for inpatient, outpatient, emergency department and other services (**Table 3**). These services included costs for home care, ambulance services, and independent laboratory services, among other types of costs. Members with SMI ranged from 35 percent of total costs for inpatient to 52 percent for emergency department services.

[11] Did not test for statistically significant differences on the total costs per year for STAR+PLUS members overall and STAR+PLUS SMI members (Table 3) since these represent the population costs for each year and there is no observed variation within year.

Table 3: Total costs per year of STAR+PLUS members by service category, CY 2018[12]

	All Members	Members with SMI	Percentage of Members with SMI
Total			
Overall	$3,232,838,366	$1,387,313,868	43%
Amerigroup	$778,330,499	$344,076,125	44%
Cigna	$272,880,663	$112,740,691	41%
Molina	$495,516,063	$217,979,174	44%
SHP	$912,033,156	$377,133,390	41%
UHC	$774,077,985	$335,384,488	43%
Medical			
Total	$1,769,485,614	$704,802,526	40%
Amerigroup	$387,877,027	$158,409,176	41%
Cigna	$158,508,369	$59,812,961	38%
Molina	$291,740,861	$123,657,164	42%
SHP	$519,611,208	$198,266,295	38%
UHC	$411,748,148	$164,656,929	40%
Inpatient			
Total	$262,128,185	$90,863,108	35%
Amerigroup	$66,840,387	$23,959,171	36%
Cigna	$21,428,568	$7,252,917	34%
Molina	$40,199,574	$14,236,239	35%
SHP	$66,914,941	$22,239,561	33%
UHC	$66,744,715	$23,175,220	35%
Outpatient			
Total	$346,949,278	$138,705,910	40%
Amerigroup	$85,561,861	$34,780,157	41%
Cigna	$28,687,316	$11,611,967	40%
Molina	$48,102,807	$19,411,303	40%
SHP	$98,763,379	$39,449,813	40%
UHC	$85,833,915	$33,452,670	39%
Emergency Department			
Total	$40,694,770	$21,026,345	52%
Amerigroup	$10,093,993	$5,362,892	53%

[12] Standardized the total costs to a full member-year (12 months of enrollment). Table 3 presents the actual reported total costs. Average member-year costs are reported in Table 4.

Cigna	$3,421,210	$1,688,375	49%
Molina	$6,705,832	$3,506,694	52%
SHP	$10,359,707	$5,265,252	51%
UHC	$10,114,027	$5,203,131	51%
Other Services			
Total	$1,119,713,381	$454,207,163	41%
Amerigroup	$225,380,786	$94,306,956	42%
Cigna	$104,971,274	$39,259,703	37%
Molina	$196,732,647	$86,502,928	44%
SHP	$343,573,181	$131,311,669	38%
UHC	$249,055,492	$102,825,908	41%
Pharmacy			
Total	$1,463,352,752	$682,511,342	47%
Amerigroup	$390,453,472	$185,666,948	48%
Cigna	$114,372,294	$52,927,730	46%
Molina	$203,775,202	$94,322,010	46%
SHP	$392,421,948	$178,867,095	46%
UHC	$362,329,836	$170,727,558	47%

Table 4 shows the average total costs per member-year (12 months) and sub-totals for medical care and pharmacy services by MCO. SMI-diagnosed STAR+PLUS enrollees had higher average-per-year costs than the overall STAR+PLUS population ($19,755 versus $16,960 in 2018). The difference between STAR+PLUS members and SMI-diagnosed STAR+PLUS members in average total per member-year cost were primarily due to higher average pharmacy costs. For example, in 2018 the difference between all members and SMI-diagnosed members in average total per member-years costs was $2,795, of which $2,216 (79 percent) was due to differences in average pharmacy costs.

Average per member-year total costs for Cigna-HealthSpring and Molina enrollees were statistically significantly higher ($p \leq .05$) than those for enrollees in Amerigroup, Superior HealthPlan, and UnitedHealthCare Community Plan in 2018. Although these differences reached statistical significance, the results are not large in magnitude[13]. The highest unadjusted per member-year cost in 2018 for SMI STAR-PLUS plan members (Molina Healthcare of Texas) was 7 percent higher than

[13] The term "statistical significance" is used to denote differences or results that are unlikely due to chance. The p-value indicates the level of chance to accept a statistically significant result or difference. "Statistical significance" refers to the chance that an observed difference exists, but not necessarily meaningful in practice.

the lowest average per member-year cost (UnitedHealthCare Community Plan). As noted earlier, these small differences may reflect pressure towards similarity in total costs across MCOs resulting from the annual actuarial rate-setting review.

In 2018, the higher total per SMI member-year costs for Cigna-HealthSpring and Molina Healthcare appeared driven by their higher average medical care costs, especially for other services, which were partially off-set by lower average pharmacy costs.

Table 4: Average costs per member-year in STAR+PLUS by service category, CY 2018

	All Members	Members with SMI	Percentage Cost Difference
Total			
Overall	$16,960	$19,755	116%
Amerigroup	$16,255	$19,648	121%
Cigna	$16,907	$20,678[a]	122%
Molina	$16,984	$20,788[a]	122%
SHP	$17,162	$19,290	112%
UHC	$17,462	$19,477	112%
Medical			
Overall	$10,606	$11,185	105%
Amerigroup	$9,545	$10,218	107%
Cigna	$11,016	$12,255	111%
Molina	$11,110	$13,061	118%
SHP	$10,946	$11,038	101%
UHC	$10,857	$10,881	100%
Inpatient			
Overall	$3,505	$2,803	80%
Amerigroup	$3,451	$2,854	83%
Cigna	$3,300	$2,879	87%
Molina	$3,378	$3,071	91%
SHP	$3,270	$2,338	71%
UHC	$3,980	$3,073	77%
Outpatient			
Overall	$1,989	$2,153	108%
Amerigroup	$1,937	$2,188	113%
Cigna	$1,907	$2,223	117%
Molina	$1,810	$1,924	106%

SHP	$2,087	$2,226	107%
UHC	$2,069	$2,157	104%
Emergency Department			
Overall	$207	$298	144%
Amerigroup	$201	$303	151%
Cigna	$207	$295	143%
Molina	$229	$330	144%
SHP	$192	$270	141%
UHC	$216	$303	140%
Other services			
Overall	$4,905	$5,932	121%
Amerigroup	$3,956	$4,874	123%
Cigna	$5,602	$6,858	122%
Molina	$5,693	$7,736	136%
SHP	$5,396	$6,205	115%
UHC	$4,592	$5,346	116%
Pharmacy			
Overall	$6,354	$8,570	135%
Amerigroup	$6,710	$9,430	141%
Cigna	$5,891	$8,423	143%
Molina	$5,874	$7,727	132%
SHP	$6,216	$8,252	133%
UHC	$6,605	$8,596	130%

a=statistical significance, $p \leq 0.05$.

6. Performance Measures

Quality of care data allows HHSC to evaluate all MCOs by program and service area for each metric and to compare MCO performance. The following section includes performance information for the BH Core (**Table 5**) and a select set of additional HEDIS measures relevant to STAR+PLUS members with SMI. The BH Core is a set of standardized national CMS measures that are meaningful to members and providers with a goal of improving BH care[14]. The tables in the following sections show rates and performance relative to the NCQA 2019 Quality Compass national percentile benchmarks for Medicaid HMOs. Rates and benchmark comparisons are computed overall and by MCO for all STAR+PLUS members and STAR+PLUS members with SMI. Information on STAR+PLUS performance by MCO and service area is also available on the Texas Healthcare Learning Collaborative portal (www.thlcportal.com).

Table 5 lists the HEDIS measures covered in this report. The measures were selected based on their relevance to Texas Medicaid members with SMI and the availability of data for STAR+PLUS MCOs. The measures needed to include data for all five of the STAR+PLUS MCOs and to have an adequate denominator to report a valid rate[15].

Table 5. HEDIS Quality of Care Measures

HEDIS Behavioral Health Core Set Measures		Additional Relevant HEDIS QOC Measures	
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	***SMD***	Diabetes Monitoring for People with Diabetes and Schizophrenia

[14] Centers for Medicare and Medicaid Services. (2020). 2020 Core Set of Behavioral Health Measures for Medicaid and CHIP (Behavioral Health Core Set). https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-bh-core-set.pdf

[15] Per NCQA, the minimum denominator threshold for HEDIS effectiveness of care measures is 30.

HEDIS Behavioral Health Core Set Measures		Additional Relevant HEDIS QOC Measures	
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia and Diabetes	***SMC***	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
SSD	Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	***UOP***	Use of Opioids from Multiple Providers
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence		
FUH	Follow-Up After Hospitalization for Mental Illness		
FUM	Follow-Up After Emergency Department Visit for Mental Illness		
AMM	Antidepressant Medication Management		

Quality Assessment Method

Plan Ratings and National Percentile Rankings

Program-level and MCO-level HEDIS results for STAR+PLUS members overall and STAR+PLUS members with SMI were compared to the NCQA national percentiles for Medicaid HMO data for the 2018 measurement year[16]. Not all plans that submit data to NCQA choose to publicly report data. However, NCQA uses all results

[16] Due to the measure requirements, the STAR+PLUS SMI population overlaps with the STAR+PLUS overall population in Tables 8, 9, 14, and 15.

submitted by the plans to calculate averages and percentiles, regardless of reporting status[17].

The NCQA national benchmarks provide a commonly-used standard of comparison, but have limitations, including:

- Rates from the national benchmarks combine administrative and hybrid results and reflect a mix of different methods;
- Limited information is available about the health and sociodemographic characteristics of members enrolled in Medicaid plans nationally;
- It is not clear how these characteristics compare with Texans enrolled in Medicaid and CHIP;
- Health plans participating in NCQA HEDIS reporting tend to be older and are more likely to be affiliated with a national managed care company than American MCOs overall; and
- Submission of HEDIS data to NCQA is voluntary thus, MCOs that submit HEDIS data nationally may not fully mirror those in Texas.

Performance results for HEDIS measures and associated HEDIS measure indicators are included in the analysis. Many HEDIS measures include individual indicators. For example, the HEDIS Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment measure includes an Initiation of Alcohol or Other Drug (AOD) Treatment indicator and an Engagement of AOD Treatment indicator. **Table 6** lists the percentile rankings and describes how they relate to overall and plan performance.

Table 6. Description of Percentile Bands

Percentile Band	Description
0-10th	Overall or MCO rate is at or below the NCQA 2019 Quality Compass national 10th percentile benchmark for Medicaid HMOs. This means the overall or plan performance on the measure was in the bottom 10 percent of plans that submitted data to NCQA.
10-25th	Overall or MCO rate is above the NCQA 2019 Quality Compass national 10th percentile benchmark and at or below the national 25th percentile benchmark for Medicaid HMOs. This means the overall or plan performance on the measure was better than 10 percent and at or below 25 percent of the plans that submitted data to NCQA.

[17] From "How to/FAQ" page for the Quality Compass (QC) portal (available with QC license purchase from www.ncqa.com).

25-50th	Overall or MCO rate is above the NCQA 2019 Quality Compass national 25th percentile benchmark and at or below the national 50th percentile benchmark for Medicaid HMOs. This means the overall or plan performance on the measure was better than 25 percent and at or below 50 percent of the plans that submitted data to NCQA.
50-75th	Overall or MCO rate is above the NCQA 2019 Quality Compass national 50th percentile benchmark and at or below the national 75th percentile benchmark for Medicaid HMOs. This means the overall or plan performance on the measure was better than 50 percent and at or below 75 percent of the plans that submitted data to NCQA.
75-90th	Overall or MCO rate is above the NCQA 2019 Quality Compass national 75th percentile benchmark and at or below the national 90th percentile benchmark for Medicaid HMOs. This means the overall or plan performance on the measure was better than 75 percent and at or below 90 percent of the plans that submitted data to NCQA.
>90th	Overall or MCO rate is above the NCQA 2019 Quality Compass national 90th percentile benchmark for Medicaid HMOs. This means the overall or plan performance on the measure was in the top 10 percent of plans that submitted data to NCQA.

Significance of Variation in Plan Ratings and Performance

NCQA calculates performance benchmarks using all data that plans submit (including Texas Medicaid MCOs). The national percentiles represent the total variation in plan performance among all submitting plans, not an extrapolation from a sub-sample. Similarly, the quality-of-care measures derive from a complete census of all claims, representing care for the whole population (STAR+PLUS overall or STAR+PLUS members with SMI). Assignment to a percentile band is, therefore, exact, and is not subject to sampling error.

Since it is possible to know the exact compliance values by measure for this population, descriptive statistics are used to identify meaningful variation in performance, rather than probability theory and *p*-values to assess whether the observed variation has statistical significance (as is done when extrapolating from a smaller sub-sample). As a result, the term "statistical significance" cannot be used to describe variation in plan performance and instead relies on differences in plan performance relative to national percentile rankings to derive meaningful differences.

MCO Performance on the HEDIS Measures Included in the CMS Behavioral Health Core Set Measures

This section provides MCO performance results on each of the 2019 HEDIS measures included in the Centers for Medicare & Medicaid Services (CMS) BH Core. The description of results for each measure includes an overview of the measure and a brief description of the MCO rates relative to national percentile benchmarks.

Table 7 shows the overall rates and percentile bands for the HEDIS Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measure by MCO for all eligible STAR+PLUS members and STAR+PLUS members with SMI. This measure provides information on access and availability of care for Texas Medicaid members in STAR+PLUS. The IET measure represents the percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who: (a) initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis (Initiation of AOD treatment); and (b) initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit (Engagement of AOD treatment). The IET table represents the total rates and national percentile rankings for the measure indicators.

The initiation and engagement rates were higher for STAR+PLUS members with SMI compared to STAR+PLUS members overall. Amerigroup, Superior, and UnitedHealthCare performed better on the Initiation indicator for STAR+PLUS members with SMI compared to STAR+PLUS members overall. For two MCOs, performance on the Initiation indicator fell below the 10th national percentile for STAR+PLUS members with SMI (Cigna-HealthSpring and Molina). There was less variation in performance on the Engagement indicator.

Table 7. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), 2018

		STAR+PLUS OVERALL		STAR+PLUS SMI	
		RATE	*NATIONAL PERCENTILE*	*RATE*	*NATIONAL PERCENTILE*
INITIATION TOTAL	*ALL STAR+PLUS MCOs*	38.01%	**10-25th**	40.90%	**25-50th**
	AMERIGROUP	40.12%	**25-50th**	43.49%	**50-75th**
	CIGNA	31.73%	**0-10th**	33.46%	**0-10th**
	MOLINA	33.62%	**0-10th**	34.21%	**0-10th**
	SHP	38.13%	**10-25th**	41.70%	**25-50th**
	UHC	40.69%	**25-50th**	44.48%	**50-75th**
ENGAGEMENT TOTAL	*ALL STAR+PLUS MCOs*	5.99%	**10-25th**	7.18%	**10-25th**
	AMERIGROUP	6.24%	**10-25th**	7.28%	**10-25th**
	CIGNA	6.11%	**10-25th**	7.47%	**10-25th**
	MOLINA	5.63%	**0-10th**	6.77%	**10-25th**
	SHP	5.58%	**0-10th**	6.82%	**10-25th**
	UHC	6.18%	**10-25th**	7.54%	**10-25th**

Table 8 shows the overall rates and percentile bands for the HEDIS Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) measure by MCO for all eligible STAR+PLUS members and STAR+PLUS members with SMI. The SAA measure represents 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.

Performance on the SAA measure was below the national median rate for all plans for STAR+PLUS with SMI members. Molina had the lowest performance on the SAA measure with rates that fell within the 10-25th percentile rank for STAR+PLUS members with SMI.

Table 8. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA), 2018

	STAR+PLUS OVERALL		STAR+PLUS SMI	
	RATE	*NATIONAL PERCENTILE*	*RATE*	*NATIONAL PERCENTILE*
ALL STAR+PLUS MCOs	58.20%	**25-50th**	58.19%	**25-50th**
AMERIGROUP	59.89%	**25-50th**	59.87%	**25-50th**
CIGNA	60.02%	**25-50th**	60.02%	**25-50th**
MOLINA	53.29%	**10-25th**	53.30%	**10-25th**
SHP	59.11%	**25-50th**	59.11%	**25-50th**
UHC	60.71%	**25-50th**	60.70%	**25-50th**

Table 9 shows the overall rates and percentile bands for the HEDIS Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) measure by MCO for all eligible STAR+PLUS members and STAR+PLUS members with SMI. The SSD measure represents 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.

The performance of all the plans was above the 50th national percentile and at or below the 75th national percentile for STAR+PLUS members overall and STAR+PLUS members with SMI.

Table 9. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD), 2018

	STAR+PLUS OVERALL		STAR+PLUS SMI	
	RATE	*NATIONAL PERCENTILE*	*RATE*	*NATIONAL PERCENTILE*
All STAR+PLUS MCOs	82.70%	**50-75th**	82.71%	**50-75th**
Amerigroup	81.08%	**50-75th**	81.09%	**50-75th**
Cigna	82.03%	**50-75th**	82.03%	**50-75th**
Molina	81.76%	**50-75th**	81.78%	**50-75th**
SHP	83.44%	**50-75th**	83.44%	**50-75th**
UHC	83.62%	**50-75th**	83.63%	**50-75th**

Table 10 shows the overall rates and percentile bands for the HEDIS Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) measure by MCO for all eligible STAR+PLUS members and STAR+PLUS members with SMI. The FUA measure represents the percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of AOD dependence, who had a follow-up visit for AOD. Two rates are reported: (a) the percentage of ED visits for which the member received follow-up within seven days of the ED visit; and (b) the percentage of ED visits for which the member received follow-up within 30 days of the ED visit.

MCO-specific and program-level performance on this measure were poor for STAR+PLUS members with SMI. Performance for the FUA 7-day indicator for all ages was in the lowest percentile for all MCOs. One MCO, Amerigroup, performed in the 10-25th percentile rank for the FUA 30-day indicator for STAR+PLUS members with SMI, with the remaining four plans performing at or below the 10th percentile.

Table 10. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA), 2018

		STAR+PLUS OVERALL		STAR+PLUS SMI	
		RATE	*NATIONAL PERCENTILE*	*RATE*	*NATIONAL PERCENTILE*
7-DAY TOTAL AGES	*All STAR+PLUS MCOs*	3.76%	**0-10th**	3.76%	**0-10th**
	Amerigroup	3.67%	**0-10th**	3.98%	**0-10th**
	Cigna	3.13%	**0-10th**	1.83%	**0-10th**
	Molina	3.02%	**0-10th**	3.22%	**0-10th**
	SHP	4.30%	**0-10th**	4.21%	**0-10th**
	UHC	4.17%	**0-10th**	4.23%	**0-10th**
30-DAY TOTAL AGES	*All STAR+PLUS MCOs*	5.67%	**0-10th**	6.17%	**0-10th**
	Amerigroup	6.32%	**0-10th**	7.39%	**10-25th**
	Cigna	5.86%	**0-10th**	4.88%	**0-10th**
	Molina	4.36%	**0-10th**	4.95%	**0-10th**
	SHP	5.61%	**0-10th**	6.01%	**0-10th**
	UHC	6.00%	**0-10th**	6.43%	**0-10th**

Table 11 shows the overall rates and percentile bands for the HEDIS Follow-Up After Hospitalization for Mental Illness (FUH) measure by MCO for all eligible STAR+PLUS members and STAR+PLUS members with SMI. The FUH measure represents the percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a MH practitioner. Two rates are reported: (a) the percentage of discharges for which the member received follow-up within seven days of discharge; and (b) the percentage of discharges for which the member received follow-up within 30 days of discharge.

Cigna-HealthSpring showed better performance on the 7-day Follow-Up and 30-day Follow-Up indicators than all other STAR+PLUS MCOs for STAR+PLUS members with SMI. In contrast, Superior had lower rates and performance on both indicators for STAR+PLUS members with SMI, with performance below the 10th national percentile.

Table 11. Follow-Up After Hospitalization for Mental Illness: Total Follow-up (FUH), 2018

		STAR+PLUS OVERALL		STAR+PLUS SMI	
		Rate	*National Percentile*	*Rate*	*National Percentile*
7-DAY FOLLOW-UP	*All STAR+PLUS MCOs*	22.29%	**10-25th**	22.36%	**10-25th**
	Amerigroup	25.96%	**10-25th**	26.05%	**10-25th**
	Cigna	29.88%	**25-50th**	29.88%	**25-50th**
	Molina	21.90%	**10-25th**	21.96%	**10-25th**
	SHP	15.80%	**0-10th**	15.85%	**0-10th**
	UHC	24.48%	**10-25th**	24.53%	**10-25th**
30-DAY FOLLOW-UP	*All STAR+PLUS MCOs*	40.48%	**10-25th**	40.59%	**10-25th**
	Amerigroup	46.52%	**10-25th**	46.65%	**10-25th**
	Cigna	53.98%	**25-50th**	53.98%	**25-50th**
	Molina	37.33%	**10-25th**	37.49%	**10-25th**
	SHP	29.54%	**0-10th**	29.59%	**0-10th**
	UHC	45.67%	**10-25th**	45.76%	**10-25th**

Rates on the FUM 7-day indicator and the 30-day indicator were higher for STAR+PLUS members with SMI than STAR+PLUS members overall. In general, there was little meaningful variation in performance on the FUM indicators across STAR+PLUS MCOs, with the exception that Cigna-HealthSpring performed better on the 7-day indicator compared to other STAR+PLUS plans for members with SMI, and Superior and UnitedHealthCare performed better on the 30-day indicator compared to other STAR+PLUS plans among members with SMI. Although the MCOs fell into two different national percentile bands (i.e., 25th-50th and 50th-75th),the actual rate differences between the MCOs are small. This does not indicate that the differences are significant or meaningful.

Table 12 shows the overall rates and percentile bands for the HEDIS FUM measure by MCO for all eligible STAR+PLUS members and STAR+PLUS members with SMI. The FUM measure represents the percentage of ED visits for members six 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: (a) the percentage of ED visits for which the member received follow-up within seven days of the ED visit; and (b) the percentage of ED visits for which the member received follow-up within 30 days of the ED visit.

Rates on the FUM 7-day indicator and the 30-day indicator were higher for STAR+PLUS members with SMI than STAR+PLUS members overall. In general, there was little meaningful variation in performance on the FUM indicators across STAR+PLUS MCOs, with the exception that Cigna-HealthSpring performed better on the 7-day indicator compared to other STAR+PLUS plans for members with SMI, and Superior and UnitedHealthCare performed better on the 30-day indicator compared to other STAR+PLUS plans among members with SMI. Although the MCOs fell into two different national percentile bands (i.e., 25th-50th and 50th-75th),the actual rate differences between the MCOs are small. This does not indicate that the differences are significant or meaningful.

Table 12. Follow-Up After Emergency Department Visit for Mental Illness (FUM), 2018

		STAR+PLUS OVERALL		STAR+PLUS SMI	
		Rate	*National Percentile*	*Rate*	*National Percentile*
7-DAY TOTAL AGES	*All STAR+PLUS MCOs*	32.75%	**25-50th**	35.26%	**25-50th**
	Amerigroup	30.94%	**25-50th**	33.49%	**25-50th**
	Cigna	35.99%	**25-50th**	37.91%	**50-75th**
	Molina	29.86%	**25-50th**	32.30%	**25-50th**
	SHP	34.00%	**25-50th**	36.12%	**25-50th**
	UHC	34.07%	**25-50th**	37.44%	**25-50th**
30-DAY TOTAL AGES	*All STAR+PLUS MCOs*	49.01%	**25-50th**	52.72%	**25-50th**
	Amerigroup	46.99%	**25-50th**	50.88%	**25-50th**
	Cigna	50.09%	**25-50th**	53.07%	**25-50th**
	Molina	45.35%	**25-50th**	48.91%	**25-50th**
	SHP	51.05%	**25-50th**	54.63%	**50-75th**

Table 13 shows the overall rates and percentile bands for the HEDIS Antidepressant Medication Management (AMM) measure by MCO for all eligible STAR+PLUS members and STAR+PLUS members with SMI. The AMM measure represents 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 antidepressant medication treatment. Two rates are reported: (a) *Effective Acute Phase Treatment*, which is the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks); and (b) *Effective Continuation Phase Treatment*, which is the percentage of members who remained on antidepressant medication for at least 180 days (six months).

Rates and performance on the AMM indicators were higher for STAR+PLUS members with SMI than STAR+PLUS members overall. Cigna-HealthSpring and Superior had the highest performance rankings of all the MCOs for the effective acute phase treatment indicator among STAR+PLUS members with SMI. Amerigroup and Molina had the lowest performance ranking relative to national percentiles for the effective acute phase treatment indicator for members with SMI. Superior and UnitedHealthCare had the highest performance rankings of all the STAR+PLUS MCOs for the effective continuation phase indicator for STAR+PLUS members with SMI.

Table 13. Antidepressant Medication Management (AMM), 2018

		STAR+PLUS OVERALL		STAR+PLUS SMI	
		RATE	*NATIONAL PERCENTILE*	*RATE*	*NATIONAL PERCENTILE*
EFFECTIVE ACUTE PHASE TREATMENT	*All STAR+PLUS MCOs*	50.76%	**25-50th**	54.38%	**50-75th**
	Amerigroup	47.67%	**10-25th**	51.38%	**25-50th**
	Cigna	50.54%	**25-50th**	56.91%	**75-90th**
	Molina	45.74%	**10-25th**	49.47%	**25-50th**
	SHP	55.25%	**50-75th**	58.35%	**75-90th**
	UHC	50.91%	**25-50th**	53.80%	**50-75th**
EFFECTIVE CONTINUATION PHASE TREATMENT	*All STAR+PLUS MCOs*	36.31%	**25-50th**	40.83%	**50-75th**
	Amerigroup	34.15%	**25-50th**	38.24%	**50-75th**
	Cigna	33.42%	**10-25th**	39.84%	**50-75th**
	Molina	32.96%	**10-25th**	37.70%	**50-75th**
	SHP	39.59%	**50-75th**	44.01%	**75-90th**
	UHC	37.44%	**50-75th**	41.34%	**75-90th**

MCO Performance on Additional Measures Relevant to Behavioral Health Care

Additional HEDIS measures augment the information provided by the HEDIS measures included in the CMS BH Core. These additional measures capture useful information on the effectiveness of care for STAR+PLUS members overall and STAR+PLUS members with SMI.

Table 14 shows the overall rates and percentile bands for the HEDIS Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) measure by MCO for all eligible STAR+PLUS members and STAR+PLUS members with SMI. The SMD measure represents the percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-Cholesterol test and a Hemoglobin A1c (HbA1c) test during the measurement year.

Performance varied across MCOs. While most MCOs performed above the 50th national percentile on this measure, performance for both Cigna-HealthSpring and Molina was below the 50th national percentile for STAR+PLUS members with SMI. Molina was the lowest-performing MCO for STAR+PLUS members with SMI. For these measures, slight differences in rates can result in ranking in different national percentile categories.

Table 14. Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD), 2018

	STAR+PLUS OVERALL		STAR+PLUS SMI	
	RATE	*NATIONAL PERCENTILE*	*RATE*	*NATIONAL PERCENTILE*
All STAR+PLUS MCOS	71.78%	**50-75th**	71.78%	**50-75th**
Amerigroup	72.43%	**50-75th**	72.43%	**50-75th**
Cigna	70.84%	**25-50th**	70.84%	**25-50th**
Molina	65.31%	**10-25th**	65.31%	**10-25th**
SHP	74.60%	**50-75th**	74.60%	**50-75th**
UHC	72.78%	**50-75th**	72.76%	**50-75th**

Table 15 shows the overall rates and percentile bands for the HEDIS Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) measure by MCO for all eligible STAR+PLUS members and STAR+PLUS members with SMI. The SMC measure represents the percentage of members 18–64 years of age with schizophrenia and cardiovascular disease who had an LDL-Cholesterol test during the measurement year.

There was variation between MCOs. Cigna-HealthSpring and Molina showed the lowest performance relative to national percentiles for STAR+PLUS members with SMI, falling below the 25th national percentile for the measure.

Table 15. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC), 2018

	STAR+PLUS OVERALL		STAR+PLUS SMI	
	RATE	*NATIONAL PERCENTILE*	*RATE*	*NATIONAL PERCENTILE*
ALL STAR+PLUS MCOs	77.80%	**50-75th**	77.80%	**50-75th**
AMERIGROUP	81.22%	**50-75th**	81.22%	**50-75th**
CIGNA	69.77%	**10-25th**	69.77%	**10-25th**
MOLINA	69.72%	**10-25th**	69.72%	**10-25th**
SHP	76.56%	**25-50th**	76.56%	**25-50th**
UHC	80.00%	**50-75th**	80.00%	**50-75th**

Table 16 shows the overall rates and percentile bands for the HEDIS Use of Opioids from Multiple Providers (UOP) measure by MCO for all eligible STAR+PLUS members and STAR+PLUS members with SMI. The UOP measure represents the percentage of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year who received opioids from multiple sources. Three rates are reported: (a) *Multiple Prescribers,* which is the percentage of members receiving prescriptions for opioids from four or more different prescribers during the measurement year; (b) *Multiple Pharmacies*, which is the percentage of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year; and (c) *Multiple Prescribers and Multiple Pharmacies*, which is the percentage of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year. A lower rate indicates better performance for all three indicator rates in this measure.

Rates on all UOP indicators were better for STAR+PLUS members overall compared to STAR+PLUS members with SMI. For the *Multiple Prescribers* indicator, UnitedHealthCare had the lowest performance for STAR+PLUS members with SMI. For the *Multiple Pharmacies* indicator, Cigna-HealthSpring, Molina, and Superior performed better relative to national percentiles for STAR+PLUS members with SMI. For the *Multiple Prescribers and Pharmacies* indicator, UnitedHealthCare had the lowest performance relative to national percentiles STAR+PLUS members with SMI.

Table 16. Use of Opioids from Multiple Providers (UOP), 2018

		STAR+PLUS OVERALL		STAR+PLUS SMI	
		RATE	*NATIONAL PERCENTILE*	*RATE*	*NATIONAL PERCENTILE*
MULTIPLE PRESCRIBERS	*All STAR+PLUS MCOs*	18.40%	**50-75th**	23.20%	**25-50th**
	Amerigroup	18.58%	**50-75th**	23.92%	**25-50th**
	Cigna	14.12%	**>90th**	18.61%	**50-75th**
	Molina	15.68%	**75-90th**	19.75%	**50-75th**
	SHP	17.37%	**75-90th**	22.07%	**25-50th**
	UHC	21.21%	**50-75th**	25.33%	**10-25th**
MULTIPLE PHARMACIES	*All STAR+PLUS MCOs*	5.28%	**50-75th**	6.70%	**25-50th**
	Amerigroup	5.90%	**50-75th**	7.49%	**25-50th**
	Cigna	4.01%	**75-90th**	4.57%	**50-75th**
	Molina	4.27%	**50-75th**	5.80%	**50-75th**
	SHP	4.11%	**75-90th**	5.46%	**50-75th**
	UHC	6.10%	**25-50th**	7.18%	**25-50th**
MULTIPLE PRESCRIBERS AND PHARMACIES	*All STAR+PLUS MCOs*	2.94%	**50-75th**	4.15%	**25-50th**
	Amerigroup	3.26%	**50-75th**	4.61%	**25-50th**
	Cigna	1.92%	**75-90th**	2.49%	**50-75th**
	Molina	2.36%	**50-75th**	3.61%	**25-50th**
	SHP	2.12%	**75-90th**	3.27%	**50-75th**
	UHC	3.56%	**25-50th**	4.49%	**10-25th**

Summary of MCO Performance on HEDIS Quality of Care Measures

This section of the report summarizes MCO performance relative to national percentile benchmarks. The data is summarized by MCO performance for the HEDIS measure indicators included in the CMS BH Core and additional BH related HEDIS measures.

The low performance relative to national percentiles on some of these measures, particularly measures such as FUA, where almost all MCOs had measure rates below the 10th national percentile, suggests this should be a targeted area for improvement. Improving performance in this area is particularly important since high ED use for individuals with AOD may signal a lack of access to care or issues with continuity of care.

Figure 1 and **Figure 2** summarize the percentage of MCO rates per national percentile for the HEDIS measures in the BH Core Set for STAR+PLUS members overall and STAR+PLUS members with SMI. These figures illustrate the variation in performance between MCOs and the variation in performance between STAR+PLUS members overall and STAR+PLUS members with SMI.

All the MCOs had some measures with rates below the 10th national percentile on the BH Core Set measures for both STAR+PLUS members overall and STAR+PLUS members with SMI, although there were fewer rates below the 10th national percentile among STAR+PLUS members with SMI.

The low performance relative to national percentiles on some of these measures, particularly measures such as FUA, where almost all MCOs had measure rates below the 10th national percentile, suggests this should be a targeted area for improvement. Improving performance in this area is particularly important since high ED use for individuals with AOD may signal a lack of access to care or issues with continuity of care.

Figure 1. Percentage of BH Core Set Measure Rates per National Percentile Rank by MCO for STAR+PLUS Members Overall

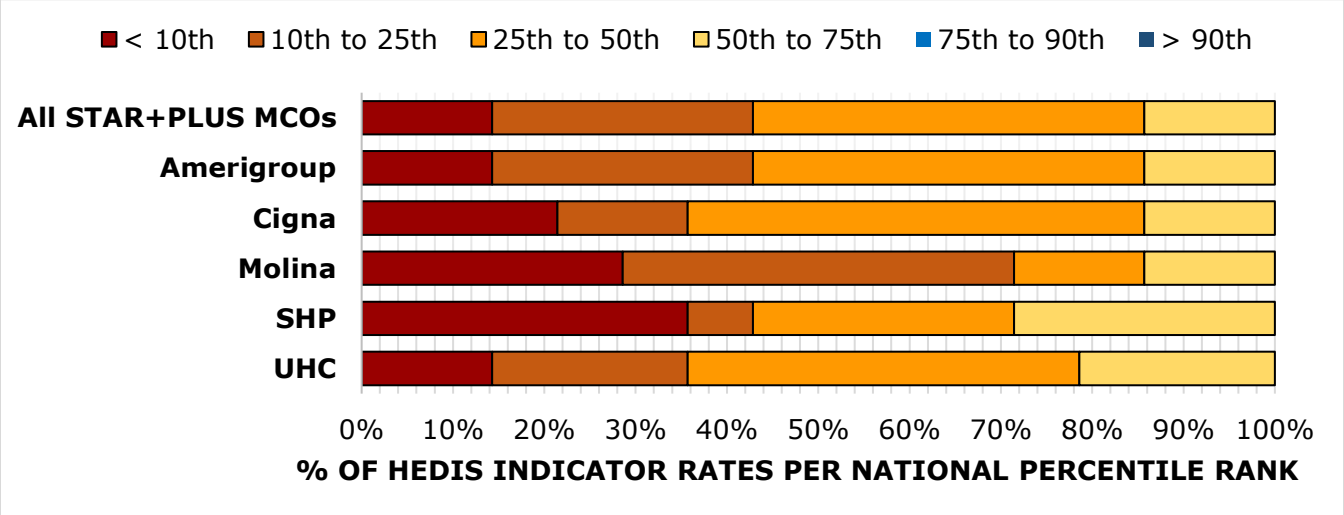
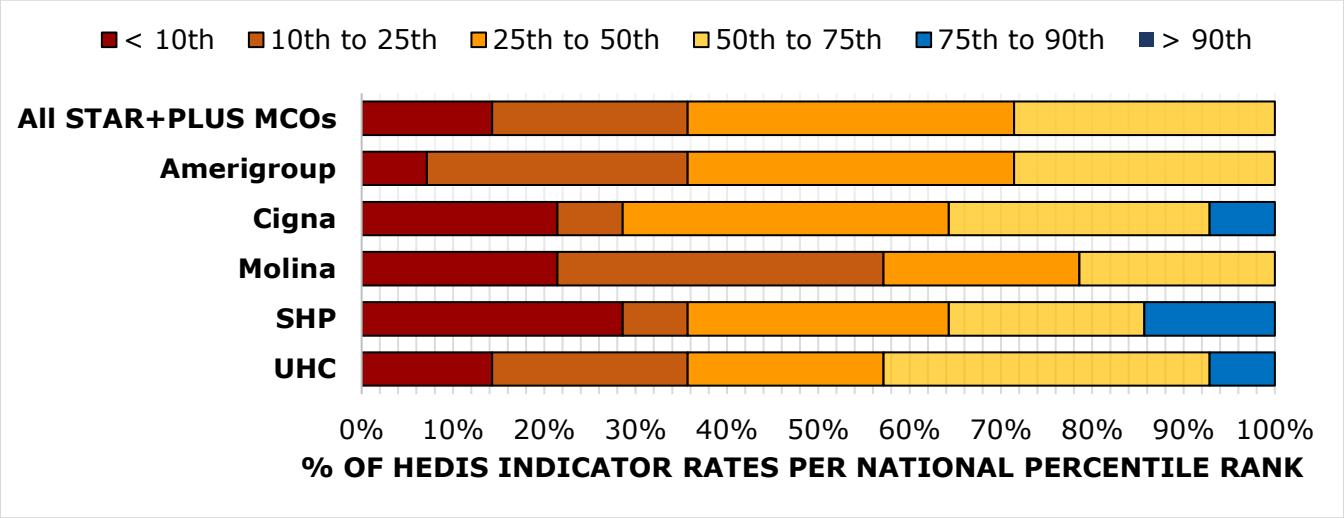


Figure 2. Percentage of BH Core Set Measure Rates per National Percentile Rank by MCO for STAR+PLUS Members with SMI



Performance on Additional HEDIS Behavioral Health Measures

While none of the MCOs had rates below the 10th national percentile, the low rates relative to national percentiles, particularly for SMD and SMC, suggest this is an area for improvement. Improving performance in this domain is particularly important since a lack of appropriate care for diabetes and cardiovascular disease for people with schizophrenia or bipolar disorder who use antipsychotic medications can worsen their health and increase the risk of death.

Figure 3 and **Figure 4** summarize the percentage of MCO rates per national percentile for the additional HEDIS measures for STAR+PLUS members overall and STAR+PLUS members with SMI. None of the MCOs had measure rates below the 10th national percentile on these three measures. However, Cigna-HealthSpring, Molina, and UnitedHealthCare had rates in the 10th to 25th national percentile for STAR+PLUS members with SMI.

While none of the MCOs had rates below the 10th national percentile, the low rates relative to national percentiles, particularly for SMD and SMC, suggest this is an area for improvement. Improving performance in this domain is particularly important since a lack of appropriate care for diabetes and cardiovascular disease

for people with schizophrenia or bipolar disorder who use antipsychotic medications can worsen their health and increase the risk of death.

Figure 3. Percentage of Additional HEDIS Measure Rates per National Percentile Rank by MCO for STAR+PLUS Members Overall

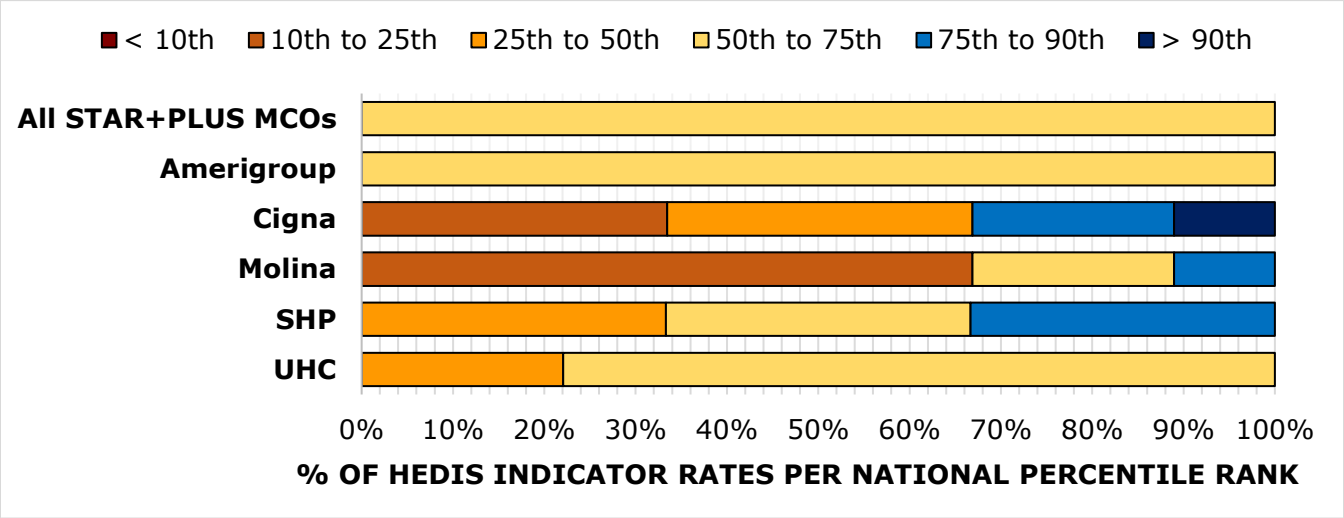
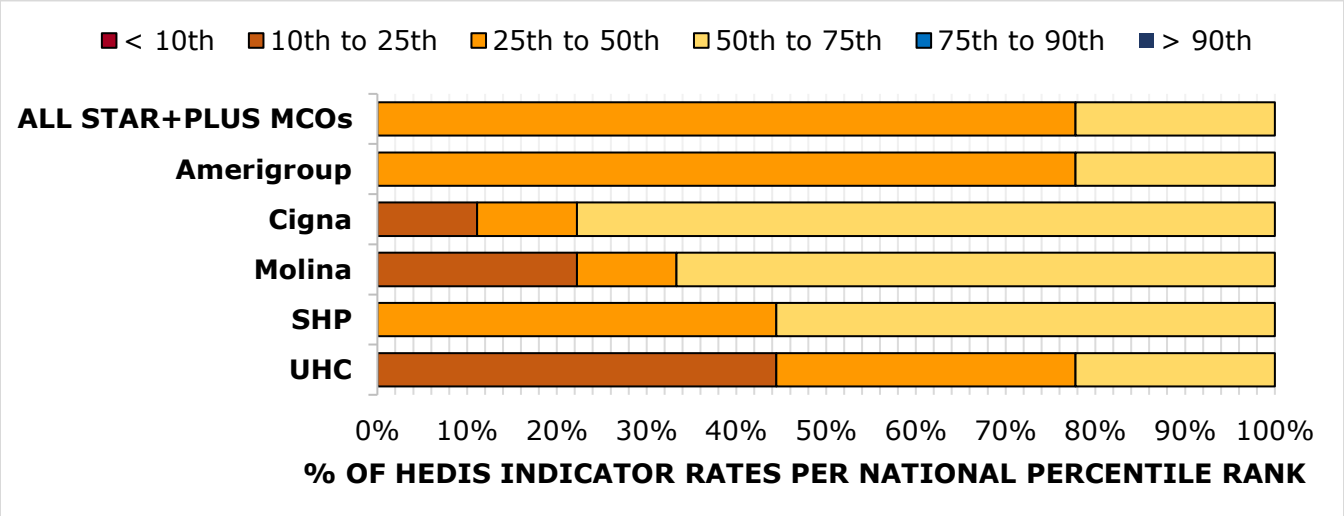


Figure 4. Percentage of Additional HEDIS Measure Rates per National Percentile Rank by MCO for STAR+PLUS Members with SMI



7. Quality of Care Performance Indicators

There is not national consensus on the types of performance measures to best assess quality BH care[18,19]. For BH care, recovery is the most encompassing concept; however, measuring recovery is challenging. Due to the nature of current Medicaid claims data, recovery cannot be assessed by an examination of claims data.

A wide range of performance measures were identified that can be generated from claims data, including hospitalizations and overall costs. Optimally, an array of performance measures, drawing upon claims data sets and other data sources such as medical records are needed to assess service delivery and costs.

To support standardization of BH measures across all state Medicaid programs, CMS created the BH Core, which consists of 18 BH measures from their Adult and Child Core sets[20]. Texas already reports its performance on these measures annually and, by 2024, all states will be required to calculate and report their performance for these measures. The Agency for Healthcare Research and Quality (AHRQ) found that no uniformly accepted practices exist on how to define or implement quality measures for SMI[21]. BH care is complex, with different system levels (federal, state, and local government BH care systems and requirements) contributing to quality and efficiency of care.

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[18] Kilbourne, A. M., Keyser, D., & Pincus, H. A. (2010). Challenges and opportunities in measuring the quality of mental health care. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, *55*(9), 549–557. https://doi.org/10.1177/070674371005500903

[19] Kilbourne, A. M., Beck, K., Spaeth-Rublee, B., Ramanuj, P., O'Brien, R. W., Tomoyasu, N., & Pincus, H. A. (2018). Measuring and improving the quality of mental health care: a global perspective. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, *17*(1), 30–38. https://doi.org/10.1002/wps.20482

[20] Centers for Medicare and Medicaid Services. (2020). 2020 Core Set of Behavioral Health Measures for Medicaid and CHIP (Behavioral Health Core Set). https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-bh-core-set.pdf

[21] Gaynes B, Brown C, Lux LJ, et al. (2015 January). Effective Health Care Program Technical Brief Number 18: Relationship Between Use of Quality Measures and Improved Outcomes in Serious Mental Illness. AHRQ Publication No. 15-EHC003-EF.

8. Conclusion

HHSC evaluated BH care services delivered by Medicaid MCOs to their members with SMI and found some variation in services between MCOs. Analyses examined variability in cost and process of care among MCOs. HHSC determined there were minor differences in cost and performance across MCOs.

HHSC recommends STAR+PLUS MCOs take the following actions to improve value of care for members with SMI:

- Evaluate how these different cost distributions are related to processes and outcomes of care, with a focus on pharmacy spending and other services.
- Examine performance on HEDIS measures related to BH and work to make improvements in service delivery.

BH is an integral component of HHSC quality initiatives. Based on this report's findings, HHSC will continue to:

- Monitor MCO performance on quality of care outcomes for BH and provide guidance to improve outcomes through the Medical Pay-For-Quality program, performance improvement projects, and the performance indicator dashboard.[22]

[22] https://hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement

Acronym

List of Acronyms

Acronym	Full Name
ANSA	Adult Needs and Strength Assessment
BH	Behavioral Health
BH Core	Behavioral Health Core Set Measures
BMI	Body Mass Index
CCI	Charlson Comorbidity Index
Cigna	Cigna-HealthSpring
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
ED	Emergency Department
FY	Fiscal Year
HCBS	Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HHSC	Health and Human Services Commission
ICD	International Classification of Diseases
LMHA	Local Mental Health Authority
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MH	Mental Health

Acronym	Full Name
Molina	Molina Healthcare of Texas, Inc.
NCQA	National Committee for Quality Assurance
NHB	Non-Hispanic Black
NHW	Non-Hispanic White
NPI	National Provider Identification
NQF	National Quality Forum
OCD	Obsessive Compulsive Disorder
SHP	Superior HealthPlan
SMI	Severe Mental Illness
SSI	Supplemental Security Income
STAR+PLUS	State of Texas Access Reform Plus
UHC	UnitedHealthCare Community Plan

Appendix A. SMI ICD-10 Codes

Broad Diagnosis Category	ICD-10 Code
Psychotic disorders	
Schizophrenia	F20.0 – F20.9
Other psychotic disorders	F21 – F29
Schizoaffective disorders	F25.0 – F25.9
Bipolar Disorder	
Manic episode	F30.10 – F30.8
Bipolar Disorder	F31.0 – F31.9
Depressive Disorders	
Major depressive disorder	F32.0 – F33.9
Obsessive Compulsive Disorder	
Obsessive-compulsive disorder	F42.2 – F42.8

Appendix B. Defining Measures

Population Characteristics:

MCO	For members who switch MCOs during a calendar year- keep these members in for program-level reporting but consider excluding them from the MCO-level analyses.	Enrollment
Age group	Age at the start of 2017 calendar year	Enrollment
Gender	The member's member gender	Enrollment
Race	The member's race/ethnicity	Enrollment
SMI Diagnosis	Stratification of SMI population into SMI specific diagnosis based on diagnosis. Groups: Schizophrenia, Bipolar disorder, major depression, manic episodes, other psychotic disorders, OCD, other. Combined categories will be determined.	Encounter
Comorbidity burden	Charlson Comorbidity Index	Encounter

Service Delivery:

Acute Inpatient admissions	Identify admissions using facility claims with TOB = ("11x",), identifying all claims admit through discharge.	Encounter
Emergency department visits	Facility claims with revenue codes 0450','0451','0452','0456','0459'. Allow 1 per day.	Encounter
Observation units stay	Facility claims with REV Code: '0760','0761','0762','0769'.	Encounter
Outpatient professional visits	Unique professional claims with POS office	Encounter

SMI-Related Services	Claims with primary diagnosis code related to SMI ICD-10 codes in Appendix B	
Follow-up care measures		
Readmissions	This measure captures the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days: - MH related readmissions - Non-MH related readmissions Individuals are required to be enrolled at least for 31 days after the initial admission.	Encounter
Care patterns: Follow up care after inpatient	This measure captures the percentage of discharges for members who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a MH provider. (1) The percentage of discharges for which the member received follow-up within 30 days after discharge. (2) The percentage of discharges for which the member received follow-up within 7 days after discharge. Individuals are required to be enrolled at least for 31 days after the initial admission.	Encounter
Care patterns: Follow up care after ED visit	Measures SMI-related emergency department (ED) visits for adults with a diagnosis of mental illness and who received a follow-up visit with a MH provider. (1) ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). (2) ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	Encounter

	Individuals are required to be enrolled at least for 31 days after the initial admission.	

Costs: sum of paid amounts for the following

Total cost of care	All claims by sub cohort	Encounter and pharmacy files
Total cost of care for services with SMI as principal diagnosis and non SMI care	All claims categorized by principal diagnosis (SMI versus non-SMI).	Encounter and pharmacy
Inpatient	Facility inpatient claims and professional claims with POS inpatient.	Encounter
Emergency department	Facility claims with a revenue code for ED and professional claims with POS ED. ED visits that end up in an admission will be counted towards inpatient admission cost.	Encounter
Other facility costs	All other facility claims	Encounter
Outpatient professional	Professional claims with a POS for outpatient care.	Encounter
Pharmacy	All pharmacy related claims	Pharmacy