



Behavioral Health Services Provider Contracts Review

**As Required By
General Appropriations Act, House Bill 1, 84th Legislature,
Regular Session, 2015 (Article II, Department of State
Health Services, Rider 82)**

**Health and Human Services Commission
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1. Executive Summary

The 2016-17 General Appropriations Act, House Bill (H.B.) 1, 84th Legislature, Regular Session, 2015 (Article II, Department of State Health Services [DSHS], Rider 82), directs DSHS, in collaboration with the Health and Human Services Commission (HHSC), to conduct a review to identify improvements to performance measurement, contract processing, and payment mechanisms for DSHS behavioral health services contracts.

Senate Bill (S.B.) 200, 84th Legislature, Regular Session, 2015, required the transfer of the legacy DSHS Mental Health and Substance Abuse Services (MHSA) Division to HHSC on September 1, 2016. As a result, HHSC is now responsible for the review and the report required under Rider 82. For purposes of this report, the legacy DSHS MHSA Division will be referred to as the HHSC Behavioral Health Services Section.

HHSC and DSHS contracted with Health Management Associates (HMA) and partner National Association of State Program Directors Research Institute (NRI) to evaluate behavioral health performance measures, contract processes, and payment mechanisms used for behavioral health contracting and to make recommendations for improvement. This review covered contracts with Substance Use Disorder (SUD) providers and with local mental health authorities (LMHAs).

This third-party evaluator review and subsequent report identified the clear alignment of substance use prevention, intervention, and treatment measures with federal requirements. Therefore, the evaluators did not provide short-term recommendations for changing measures specific to SUD performance contracting. SUD measures have been constructed to comply with the extensive and specific requirements from the Substance Abuse Block Grant and reflect national outcome measures. The evaluation concludes the current SUD measures provide a strong foundation from which to consider future enhancements, such as combining measures with common definitions. With respect to LMHA contracts, however, the evaluation highlighted a number of opportunities for modification. The third-party evaluator's report offered recommendations in five key areas with most of the recommendations focused on contracting and performance measures best practices.

In the state's mental health service system, ensuring appropriate contracting methods and performance measures is both essential and challenging for the state due to the dual roles the LMHAs play in addressing the critical needs of a complex, high-risk population. LMHAs are the backbone of the Texas behavioral health system and are often the most significant providers of hard-to-access client services. LMHAs are also an authority, ensuring the availability of services, access to care, and coordination with other providers and stakeholders. A key lesson from industry standards is that contracts and measures must address multiple performance domains encompassing all key aspects of the contractor's responsibilities. With respect to LMHAs, these responsibilities include access, efficiency, and quality of care.

Stakeholder Input and Consumer Voice

When considering appropriate contracting methods and measures, it is also critical the performance measurement system reflects multiple stakeholder priorities and concerns. Like the rest of the health care industry, mental health services are evolving to provide recovery-oriented, patient-centered systems of care. To ensure recommendations regarding changes to performance

measures are informed by consumer perspectives, the HHSC Behavioral Health Services Section received extensive input from persons with lived experience during its review of measures prior to engaging a third-party evaluator. Measures recommended through this process were added to the LMHA contract for testing and benchmarking.

Performance Measures

The third-party evaluator surveyed industry standards and then reviewed existing LMHA performance measures and performance measures currently being benchmarked in relation to those industry standards. Appendix A outlines preliminary recommendations from the third-party evaluator that will be further defined in the coming months.

From the full array of measures identified for performance management and contract compliance purposes, only selected measures are linked with payment. Found in Appendix B, the preliminary recommendations identify a streamlined list of measures that focus on aspects of quality clearly within the LMHA intervention.

Payment Models

The third-party evaluator also considered industry standards and trends with respect to payment mechanisms to inform its review of the LMHA contract processes. Building on the experience of managed care organizations (MCOs) and focusing on the concerted effort to move toward value-based purchasing in recent years, emerging payment models in the health care industry use a variety of approaches linking payment with performance. These models share an effort to provide a balanced incentive structure promoting quality, access, and efficiency. A large number of new models have been implemented and tested in recent years such as value-based payment structures. New payment models offer valuable insights into the risks and potential benefits of various payment methodologies.

In considering an appropriate payment methodology to incentivize performance, a foundational principle in the approach selected should match the context and characteristics of the service delivery system. After reviewing emerging payment models, the third-party evaluation pointed to a simple pay-for-performance model as the most appropriate for HHSC's behavioral health contracts at the present time. LMHAs have experience with this approach through the Ten Percent Withhold process and DSRIP projects implemented under the state's Medicaid Transformation Waiver.

The Ten Percent Withhold process has introduced pay-for-performance strategies into the system, but it has a number of significant challenges. Other pay-for-performance systems have a dedicated pool of funds for bonus payments, which provides a simple, stable, and timely incentive payment system. Such an approach may offer a more effective way to incentivize continued performance improvement in the state's behavioral health service system.

There are additional opportunities to modify the payment criteria to strengthen incentives for continuous quality improvement across all LMHAs. An optimal pay-for-performance system will incentivize improvement, achievement, and maintenance of high performance and consistency of performance across key domains and measures. Building incentives for individual improvement, as well as high performance, is a potential alternative to the current system.

Performance Dashboard

In considering changes to performance measures and other aspects of the behavioral health system, communication with and input from stakeholders is critical. A key aspect of engaging stakeholders is providing them with robust and easily understandable information regarding the behavioral health system and its providers. As part of the retooling of performance measurement systems, HHSC seeks to build on the work accomplished in response to S.B. 126, 83rd Legislature, Regular Session, 2013, which required the establishment of a public reporting system that allows users to compare the performance and outputs of contracted providers. Transforming the existing reporting system into an effective dashboard would be a substantial step toward a quality-driven service delivery system that is accessible and accountable to the public.

Next Steps

The HHSC Behavioral Health Services Section will continue seeking stakeholder input and contracting with HMA and NRI to consult with agency staff and identify a final set of proposed performance measures and a recommended payment methodology.

2. Introduction

The 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, DSHS, Rider 82), directs DSHS, in collaboration with HHSC, to conduct a review to identify improvements to performance measurement, contract processing, and payment mechanisms for behavioral health services contracts. In conducting the review, DSHS is required to solicit stakeholder input and permitted to use appropriated funds to seek the assistance of a third party with expertise in health purchasing. The report is due no later than December 1, 2016, to the Legislative Budget Board, the Office of the Governor, and the permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services.

Pursuant to Rider 82, the review and report must:

- Identify performance measures and other requirements not necessary by a state or federal requirement that could be eliminated from contracts.
- Review the metrics and methodology associated with the withholding of allocations made under H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, DSHS, Rider 58) regarding Mental Health Outcomes and Accountability.
- Consider performance measures and contracting strategies similar to those used for MCOs.
- Consider best practices in performance measurement and contracting, including incentive payments and financial sanctions that are aligned with the models used by HHSC for purchasing health care services.
- Propose a publicly available web-based dashboard to compare performance of behavioral health services providers contracted with DSHS.

HHSC and DSHS contracted with HMA and partner NRI to evaluate behavioral health performance measures, contract processes, and payment mechanisms used for behavioral health contracting and make recommendations for improvement. The findings and recommendations informed the evaluation and conclusions described in this report.

3. Background

The HHSC Behavioral Health Services Section administers contracts for behavioral health services for medically indigent individuals, including SUD services and mental health services. SUD services include prevention, intervention, and treatment services. HHSC contracts with hundreds of local SUD providers across the state.

Community mental health centers are units of local government established to provide community-based mental health services within a defined service area. The state has delegated certain aspects of the state's authority to 37 LMHAs. The HHSC Behavioral Health Services Section funds LMHAs to deliver or arrange for the delivery of community mental health crisis services and ongoing services for medically indigent individuals residing in the LMHA service areas. As mental health authorities, LMHAs are also required to develop and coordinate local policy, resources, and services for mental health care, as well as develop external provider networks and serve as providers of last resort. While LMHAs contract with local providers for some services, they retain a significant role as direct providers of service.

Contracts between the HHSC and mental health and SUD providers have traditionally been enforced through a range of remedies and sanctions for non-compliance. Financial sanctions include temporary or permanent withholding of funds, recoupment of funds, and liquidated damages. The 2013-14 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, DSHS, Rider 78) required HHSC to withhold ten percent of general revenue funding for adult, child, and crisis mental health services for use as a performance incentive. The rider specified payment of withheld funds was contingent upon the achievement of outcome targets set by the agency. The rider directed funds withheld for failure to achieve outcome targets be used for technical assistance, and redistributed as an incentive payment according to a methodology developed by the agency. The 84th Legislature retained this mandate with the passage of Rider 58.

The Sunset Commission reviewed DSHS in 2014. The final Sunset Commission report included a recommendation for the Legislature to direct DSHS to evaluate and improve behavioral health performance measurement and contracting processes. The 84th Legislature adopted this recommendation with the passage of Rider 82.

Subsequent to publication of the initial Sunset Commission staff report, the HHSC Behavioral Health Services Section reviewed best practices for performance measurement and undertook a thorough internal review of performance measures with input from stakeholders and emphasis on soliciting consumer input. Members of the Council on Advising and Planning, a consumer-led advisory committee, worked intensively on this process for months and met jointly with the Local Authority Network Advisory Committee¹ to review and agree on a single set of recommended changes. Through this process, a number of new measures were identified as potential replacements for existing measures for Adult Mental Health Services and Children's Mental Health Services.

¹ The Local Authority Network Advisory Committee was established to advise DSHS on technical and administrative issues affecting LMHA responsibilities. Its membership was comprised of representatives from eight stakeholder groups, including consumers and family members.

The new measures were added to LMHA contracts with no associated sanctions in fiscal year 2016 to provide a period of testing and benchmarking. These include:

- Employment Improvement (Adults)
- Residential Stability (Adults)
- Educational and Volunteering Strengths (Adults)
- Strengths (Adults and Children/Youth)
- Life Domain Functioning (Adults and Children/Youth)
- Living and Family Situation (Children and Youth)
- School (Children and Youth)

The advisory committees submitted a second set of recommendations for measures related to Crisis Services, but these recommendations were submitted after the fiscal year 2016 contract was finalized. Pursuant to Rider 82, the HHSC Behavioral Health Services Section then contracted with HMA and NRI in July 2016 to conduct an independent review to inform the agency's evaluation.

4. Current Performance Measures

The third-party evaluator conducted a comprehensive review of HHSC Behavioral Health Services Section performance measures, including SUD provider measures and LMHA measures, to identify those that could potentially be eliminated. The review process is described in Appendix A, along with a summary of preliminary recommendations from the third-party evaluator regarding existing contract measures for LMHAs.

The third-party evaluator recommendations specific to current performance measures not required by the state or federal government include:

- Maintain the current performance measures for SUD providers and consider future enhancements.
- Modify or eliminate a number of existing LMHA mental health measures.
- Consider future adoption of a consumer satisfaction measure and selected national measures (e.g., measures related to hospital readmissions, medication adherence and physical health care screening).

The third-party evaluator had no recommendations to modify or eliminate current measures for SUD providers. These measures are required by detailed specifications associated with federal block grant funding, and any modification would entail a lengthy and administratively burdensome process with the Substance Abuse and Mental Health Services Administration (SAMHSA). The agency conducted a thorough review of SUD treatment measures several years ago, and made revisions to align the treatment measures more closely with SAMHSA's National Outcome Measures (NOMs). The third-party evaluation concluded the current SUD measures provide a strong foundation from which to consider future enhancements, such as combining measures to focus on the desired outcome. The evaluation also highlighted several new measures for future consideration. It should be noted that SUD treatment providers are paid on a fee-for-service basis which provides an additional mechanism for maintaining accountability.

Unlike SUD measures, LMHAs mental health measures are not constructed in accordance with detailed and specific federal requirements. While state and federal oversight delineates specific areas which must be addressed when measuring performance, HHSC has some latitude on what and how to measure areas outlined by the national outcome measures. The third-party evaluator identified measures they recommended keeping and recommended other measures to be modified or eliminated in order to strengthen the overall set of measures. The agency is reviewing the recommendations of the third-party evaluator in preparation for stakeholder review and feedback.

5. Rider 58 Metrics and Methodology

Rider 58, as authorized by the 84th Legislature, requires the HHSC Behavioral Health Services Section to withhold ten percent of general revenue funds for adult, child, and crisis services for use as a performance-based incentive. Payment of these funds is contingent upon achievement of outcome performance targets, with performance assessed and payment made on a six-month interval. In fiscal year 2016, over \$37 million was withheld at the beginning of the year and not released until June 2016 and December 2016. Release of funds was dependent on the verification of performance. The HHSC Behavioral Health Services Section established a set of measures within each of these three service areas to provide a balanced view of LMHA performance, address the priorities of multiple stakeholders, and mitigate the financial risk should an LMHA fail to achieve one or more outcomes. Service areas where measures were established include:

- Adult Mental Health Services: Employment status, community tenure, improvement, and monthly service provision
- Children’s Mental Health Services: Juvenile justice avoidance, community tenure, improvement, and monthly service provision
- Crisis Services: Hospitalization, crisis response, frequent admission, access to crisis services, and jail diversion

As a result of the Sunset Committee recommendations, the HHSC Behavioral Health Services Section conducted an internal evaluation of contract measures and processes and engaged stakeholders to identify potential changes to performance measures with particular focus on measures associated with adult, child, and crisis services. This process resulted in a recommendation to replace some of the existing adult and child measures with revised or alternative measures. These proposed new measures were added to the LMHA contract in fiscal year 2016 for benchmarking purposes, but are not currently associated with any penalty or sanction. After further work, stakeholders recommended changes to the crisis measures, but those recommendations have not yet been incorporated into the contract for benchmarking. The recommended changes to measures adopted pursuant to Rider 58 in all three strategies are shown in Table 2.

Table 2. Proposed Revisions to Measures Pursuant to Rider 58

Strategy	Original	Proposed
Adult Mental Health Services	<ul style="list-style-type: none"> • Monthly Service Provision • Employment Status • Improvement • Community Tenure • Housing Status* 	<ul style="list-style-type: none"> • Monthly Service Provision • Employment Improvement** • Residential Stability** • Strengths** • Life Domain Functioning** • Educational and Volunteering Strengths**
Child and Youth Mental Health Services	<ul style="list-style-type: none"> • Monthly Service Provision • Improvement • Juvenile Justice Avoidance • Community Tenure 	<ul style="list-style-type: none"> • Monthly Service Provision • Living and Family Situation** • Strengths** • Life Domain Functioning** • School**
Crisis Services	<ul style="list-style-type: none"> • Access to Crisis Response Services • Hospitalization • Effective Crisis Response • Frequent Admissions • Jail Diversion 	<ul style="list-style-type: none"> • Access to Crisis Response Services • Criminal and Delinquent Behavior*** • Follow-up Contacts within 30 Days after Hospitalization*** • 30-Day Hospital Readmission***

* Measure removed from the Rider 58 process.

** Measures included in fiscal years 2016 and 2017 LMHA contracts for benchmarking.

*** Measures proposed by stakeholders after 2016 contract revisions.

In addition, the third-party evaluator made the following recommendations:

- Revise the current set of measures associated with the payment.
- Maintain a mix of process and outcome measures.
- Select measures within the control of the provider and incentivize quality of care.

These recommendations affirmed the value of the proposed measures currently being benchmarked. While the evaluation suggested maintaining the current Adult and Child Improvement measures which incorporate Life Domain Functioning and Strengths, it also recommend adopting all of the other proposed measures being benchmarked. The third-party evaluator review did not include the proposed crisis measures, but the evaluator’s report did suggest 30-day hospital readmission and follow-up contacts within 30-days after hospitalization as measures to consider.

Of particular note, with respect to the selection of measures tied to payment, the third-party evaluation stressed the importance of a mix of quality measures reporting on both outcomes and provider processes, including timely access to care. Included in Appendix B, the evaluator’s report suggested a streamlined set of measures, taking particular care to select measures that are within the provider's control and incentivize improved quality of care.

In addition to feedback regarding how the current performance measures could be improved, the third-party evaluator provided a great deal of information regarding alternatives to the overall payment system in place. The evaluator's report also outlines a number of options for the state to further explore.

The behavioral health system has gained valuable experience and information by implementing a ten percent withhold of baseline contract funding as required by Rider 58. The approaches offered by the third-party evaluator regarding incentive and payments systems discussed later in this report would address many of the challenges associated with the current payment system, some of which include:

- Withholding ten percent of baseline funding from LMHAs reduces the resources available to support existing services, creates budgetary uncertainty, and presents challenges in fiscal management and accounting for both the state and LMHAs.
- There are limited dollars available for incentives each year, and as performance improves, the pool of incentive dollars decreases.
- Significant positive system changes which bring high need persons into care (e.g., clearing waitlists, homeless initiatives), may negatively impact outcomes achieved.

6. Managed Care Performance Measures and Contracting Strategies

An important step in identifying potential changes to existing payment methodologies and measures is to review industry standards. The use of a managed care model has become a widespread practice, and the tools and measures associated with managed care offer valuable options for consideration.

6.1 Performance Measure Considerations

The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow payers and patients to reliably compare the performance of health plans and has served as a model for other systems of performance measurement. Initially focused on the managed care industry, HEDIS is now used by more than 90 percent of health plans in the United States.

HEDIS includes more than 80 overall health measures related to prevention, screening, treatment, access to care, and satisfaction with care, as well as utilization rates for specific procedures and care settings. Measures are added, deleted, and revised annually to remain current with industry needs, best practices, and the health care environment. In recent years, a number of new behavioral health care measures have been added. Data sources for HEDIS include medical records, insurance claims, and surveys conducted by an NCQA-approved external survey organization.

The third-party evaluator recommended aligning measures where possible with HEDIS measures used in managed care, which would have a number of benefits. The HEDIS measures have a sound evidence base, and strong validity and reliability. Because the HEDIS measures are so widely used, comparison across many different service delivery systems is possible. Regardless of funding source, system design, or payment methodology, all systems using HEDIS measures can be compared with regard to performance on those measures. For providers contracting with

HHSC as well as with MCOs, shared measures may simplify data collection and reporting. However, many measures applicable to the MCOs may not be directly applicable to the MCOs' behavioral health providers. In addition, HHSC does not have equivalents for a number of the data sources used for many of the HEDIS measures (e.g., pharmaceutical claims data).

6.2 Contracting Strategies

Regarding the agency's selection of a payment methodology for LMHA contracts, the third-party evaluators recommend thorough consideration of the characteristics of providers and service systems to determine the most appropriate methodology.

In the managed care model, MCOs receive a monthly single payment to provide all of the covered services a client may need. Some managed care systems employ a "global" or "full capitation" model, which covers the entire spectrum of health care services. Under "partial capitation" models, a single monthly fee is paid to the provider that covers only a defined set of services. Other services may be paid on a fee-for-service basis. Both forms of capitation place providers at full risk for the cost of providing covered services. While the capitation approach offers opportunities for financial reward if services can be delivered below the capitated rate, MCOs bear the financial consequences when costs exceed revenue.

Early managed care models incentivized a focus on achieving financial savings with inadequate provisions to ensure access to appropriate services and quality of the services. Over time, managed care models evolved to include an array of performance metrics to hold providers accountable for access to and quality of care.

The Medicaid managed care programs administered by HHSC exemplify this enhanced managed care approach. MCOs are paid a capitated rate and held accountable for performance measures to ensure access and quality through a set of sanctions and remedies. HHSC also offers incentives to health plans for activities such as migrant worker outreach and Texas Health Steps² timely medical checkups.

While managed care models demonstrate useful approaches to structuring payer-provider relationships, the lessons they provide must be applied considering the different characteristics of the state's current behavioral health system. Specifically, the managed care model addresses concerns associated with fee-for-service reimbursement systems. In contrast to entitlement programs or systems administered by large third-party payers, funding for the HHSC behavioral health contractors is limited by a relatively fixed appropriation. With a growing population and a finite allocation of funds, concerns shift to diminished access and an insufficient level of service rather than the delivery of unnecessary care.

Furthermore, capitation models can be successful only with an actuarially-sound methodology for calculating the rate of payment. Capitated rates are usually based on the medical and demographic characteristics of the population, local costs of service delivery, and historical patterns of utilization. The third-party evaluator noted this approach is often challenging for individuals with serious mental illness when the population has experienced considerable unmet need for health care services. With an underserved population, there is frequently insufficient

² Texas Health Steps is a children's program under Texas Medicaid which provides medical and dental preventive care and treatment to Medicaid clients who are birth through 20 years of age.

information to fully estimate service needs or to project utilization. In addition, when a provider's rate of payment is calculated using the previous years' service utilization, there may be an incentive to provide increasing quantities of service regardless of need, quality, or cost-effectiveness—just as in fee-for-service arrangements.

Another critical consideration in choosing a contracting strategy is whether contractors are able to bear the financial risk inherent in any managed care model. In addition to size and financial strength, managed care models require a data-rich management system and significant analytic capacity to evaluate risk, identify patterns and trends in utilization, and target interventions. LMHAs and other community health centers vary considerably in size and capacity and may lack the administrative and actuarial expertise required to successfully manage these processes and the associated financial risk.

7. Performance Measurement and Contracting Best Practices

A review of current practices and emerging trends in health care contracting was a critical part of the review conducted by the HHSC Behavioral Health Services Section and the third-party evaluator. The strategies used in other sectors of health care provide models and lessons to inform potential changes in HHSC's own contracting mechanisms.

7.1 Contracting Best Practices

The third-party evaluator recommended the following activities to strengthen contract processes:

- Consider provider and service system characteristics when selecting a payment methodology.
- Continue use of a low-risk model that adds incentive payments to the existing payment methodology.
- Build on experience gained in the DSRIP program.
- Consider bonus payments and/or enhancement of the allocation formula as options to replace or supplement the strategy of withholding funds.
- Modify the incentive methodology to reward improvement among all LMHAs.
- Revise the selection of measures tied to payment incentives and update targets.
- Continue the current policy of a one-year period for testing and benchmarking new measures prior to full implementation.

7.1.1 Payment Models

As noted above, established payment models fall into four basic categories:

- Fee-for-service
- Pay-for-performance
- Capitation
- Value-Based Purchasing

These payment models fall along a continuum of risk for payers and providers; as payer risk falls, provider risk increases. At one end of the continuum, fee-for-service places most of the risk on the payer, while at the other end, most of the risk under full capitation lies with the MCO or other provider.

Increasingly, payers are adopting value-based payment methodologies linking payment and service delivery models with incentives for quality and efficiency. The underlying goal of this

evolution is often referred to as the “Triple Aim” - improved population health, better health care, and lower costs. Various terms are used for these payment approaches, but they all involve a resource transfer contingent on meeting established performance criteria.

New service delivery models are being developed which apply traditional payment methods differently, often referred to as alternative payment models. Examples include accountable care organizations, medical or patient centered medical homes, and shared savings programs. Detailed in the third-party evaluator’s report, these models are basic approaches with a growing array of potential features and implementation options. Many of the models reflect a shift away from discrete services and providers and toward collaborative systems of integrated care.

Instead of pure capitation models, evolving shared risk strategies provide incentives to increase quality and contain costs with varying degrees of provider risk. The design of value-based payment systems is tailored to specific market conditions and organizational settings with consideration given to factors such as:

- Provider size, organizational structure, and ability to bear actuarial risk
- Administrative, financial, and technological capacity and expertise of payers and providers
- Availability of accurate financial, clinical, and demographic data
- Funding environment

The U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) leads the effort to develop innovative alternatives to traditional managed care, and the Texas Medicaid program has embraced numerous forms of value-based payment. A notable example is the pay-for-performance system HHSC implemented under the Texas Medicaid 1115 Transformation Waiver, which includes a pool of funds designed to incentivize innovation to increase access, improve quality, and lower the cost of care. Governmental entities, including most LMHAs, leverage local and state funds to secure matching federal funds for DSRIP projects. Providers successful in achieving their established performance metrics are eligible to receive incentive payments. Now in the sixth year of implementation, this program has provided LMHAs with valuable experience in operating under a pay-for-performance system. To sustain the benefits gained through this project, HHSC is working to incorporate best practices identified through DSRIP into the state’s managed care programs.

HHSC applied for a demonstration grant from SAMSHA, in coordination with CMS, to implement a pilot with a focus on integrated care through certified community clinics. The Certified Community Behavioral Health Clinic model, offers an opportunity for testing other approaches to value-based purchasing involving higher levels of complexity. The agency was not selected for grant funding. However, HHSC is exploring several funding opportunities using the Certified Community Behavioral Health Clinic model.

7.1.2 Lessons

Experience gained through these emerging models points to a number of best practices:

- Value-based payment models, particularly the level of complexity and provider risk, should be appropriate to the specific characteristics of the service delivery system.
- The structure of incentive payments should reward continuous improvement, excellence, and consistent performance across domains and measures.
- Metrics associated with provider risk or reward should be within the provider’s control.

- Payment should account for population characteristics that significantly impact performance, including social and environmental components, as well as medical and clinical complexity.
- Risk adjustment may be necessary to account for diverse circumstances, establish appropriate targets, and limit provider exposure to outside risk.
- The size of incentive payments should be large enough to induce change and matched to the level of challenge embodied in performance targets.
- Targets and metrics should be reviewed regularly and may need to be adjusted over time to reflect provider evolution and maintain incentive power.
- Testing and benchmarking are necessary when new measures are introduced.

7.1.3 LMHA Application

Considering these lessons in relation to HHSC's behavioral health contracts, a model with relatively low provider risk that pairs incentive payments with the existing funding methodology appears best suited for the current service delivery system. As noted previously, some LMHAs may lack the financial and administrative capacity to manage high levels of complexity and financial risk. The withhold strategy is one example of such an approach, but it has significant challenges. A more common approach in the health care industry is the use of bonus payments. The ten percent withhold of funding as required by Rider 58 provided valuable experience in pay-for-performance strategies, but the use of bonus payments is a simpler and potentially more effective alternative that merits consideration. Bonus payments could be tied to achievement of quality metrics.

Another aspect to consider in a pay-for-performance system is how to incentivize high performance on quality measures without discouraging LMHAs from expanding access to care, particularly for individuals who need more intense services. Bonus payments could include incentives to improve and/or serve higher numbers of hard-to-reach and high-need individuals. In addition to these mechanisms, HHSC could incrementally adjust the allocation formula. For example, the methodology could incorporate incentive funding for outreach and engagement of individuals with complex challenges.

The lessons noted above also point to a number of opportunities to update the current methodology:

- Aside from any changes to payment mechanisms, targets for many of the measures need to be revised; this process will be informed by the further statistical analysis performed by NRI during the next phase of the third-party evaluation.
- Refining the payment criteria, which currently rewards only top-performing LMHAs, could help to incentivize improvement among all LMHAs and reward consistent performance, as well as excellence; there are multiple options for refining the payment criteria, but incorporating rewards for individual improvement will be key.
- Adjustments could be made to the set of performance measures tied to incentive payments to reduce the number of measures and ensure external variables do not significantly impact performance on selected measures.

As this process continues, new or revised measures should continue to have a one-year period for testing and benchmarking.

7.2 Performance Measurement Best Practices

The third-party evaluator made the following recommendations regarding the selection of a set of performance measures for behavioral health contracts:

- Base quality measures on measures endorsed by national quality entities when possible.
- Ensure the performance measurement system reflects the priorities of the full array of stakeholders.
- Align incentives in pay-for-performance with measures that report on access, quality, and cost effectiveness and efficiencies.
- Select pay-for-performance metrics within the control of providers.

7.2.1 The Structure-Process-Outcome Model

To be effective, a quality management system should include measures within each of the foundation of the structure-process-outcome (SPO) model categories. Together, the categories present a cohesive picture of performance with checks and balances to offset potential weaknesses in any one category:

- *Structure* refers to the organizational and professional resources associated with the provision of care, such as facility licensure and staff credentials; these measures examine the environment of health care delivery, including facilities, material resources, and human resources.
- *Process* measures evaluate the method used to provide health care, focusing on the ability of the provider to screen for, diagnose, and manage disease; examples include implementation of evidence-based practices, timeliness of interventions, and rate of adverse events.
- *Outcome* measures focus on the results of the individual's interaction with the health care system, such as remission of symptoms or improved functioning.

As the field of quality measurement has grown in complexity and sophistication, new measures have been introduced that do not fit easily within a single SPO category. To provide a more comprehensive view of quality care, composite measures are emerging as a way to distill multiple measures into a single indicator focused on a particular population or condition. Such approaches build on the principles of the SPO model, combining individual structure, process, and outcome measures to reflect new service delivery structures and paradigms.

7.2.2 National and Industry Standards

National quality entities provide today's benchmark for best practices in performance measurement for the overall health care system, including the Agency for Healthcare Research and Quality (AHRQ), the National Quality Forum (NQF), and NCQA which all require evidence of effectiveness, validity, and reliability while varying slightly on criteria of inclusion. While most of these national quality organizations address the full range of health care service, SAMHSA focuses exclusively on behavioral health care. SAMHSA's framework for National Outcome Measures (NOMs) defines the essential components for performance measurement in behavioral health that include measures of quality, access, and efficiency. The various frameworks are included in Appendix C with performance domains summarized in Table 3 below.

Table 3. Performance Domains of National Entities

	NCQA (HEDIS)	AHRQ	NQF	SAMHSA
Quality	<ul style="list-style-type: none"> Effectiveness of care 	<ul style="list-style-type: none"> Structure 	<ul style="list-style-type: none"> Structure 	
		<ul style="list-style-type: none"> Process 	<ul style="list-style-type: none"> Process Process: appropriate use 	<ul style="list-style-type: none"> Use of evidence based practices Retention in SUD treatment Decreased utilization of inpatient psychiatric beds
	<ul style="list-style-type: none"> Outcome 	<ul style="list-style-type: none"> Outcome Outcome: patient reported Intermediate clinical outcome 	<ul style="list-style-type: none"> Abstinence from substance use Decreased mental illness symptoms Employment/education Crime and criminal justice Stability in housing Social connectedness 	
	<ul style="list-style-type: none"> Experience of care 	<ul style="list-style-type: none"> Patient experience 		<ul style="list-style-type: none"> Client perception of care
Access	<ul style="list-style-type: none"> Access/availability of care 	<ul style="list-style-type: none"> Access 		<ul style="list-style-type: none"> Access/capacity
Efficiency	<ul style="list-style-type: none"> Utilization and Risk-Adjusted Utilization Relative resource use 	<ul style="list-style-type: none"> Efficiency 	<ul style="list-style-type: none"> Efficiency Cost/resource use 	<ul style="list-style-type: none"> Cost effectiveness

Note: Domains for descriptive measures are excluded from this table (e.g., HEDIS Health Plan Descriptive Measures).

The similarity among the models points to industry consensus regarding key aspects of service delivery, including access and efficiency, as well as quality. Within the quality domain, patient experience is now being considered alongside clinical processes and outcomes.

The NOMs framework is particularly relevant when considering performance measures for behavioral health contracts, as it provides a more expansive delineation of national consensus regarding key areas for behavioral health performance measurement. The NOMs include a core set of outcomes critical for long-term stability, recovery, and resilience. Like the other national entities, SAMHSA also underscores the importance of the client’s experience and perception of care, a growing area of focus across the health care industry.

7.2.3 Emerging Trends in Best Practices

The rapid changes transforming the nation's health care system highlight a number of strategic priorities in advancing health care performance measurement including:

- Aligning measures with overarching priorities.
- Reducing the number of measures by eliminating low impact measures.
- Identifying core measures most critical to improving health care.
- Refining measures to simplify data collection.
- Harmonizing measure sets and increasing consistency across payers.
- Addressing persistent measurement deficits, such as measures that reflect the patient perspective and outcome measures for specialty disciplines.
- Ensuring measures are meaningful to patients.
- Incorporating patient-reported metrics.
- Adapting and developing measures for collaborative systems of care.
- Identifying single measures that are applicable across care settings.

7.2.4 Key Lessons Regarding Best Practices

A broad review of best practices suggests a number of important lessons for HHSC to consider in revising its behavioral health performance measurements:

- Measures should reflect key priorities and goals with a focus on areas of high impact.
- The selection of measures should be informed by stakeholder concerns and input.
- A performance measurement system should consider patient priorities and perspectives, and measures should include the patients' perception of care when possible.
- Whenever possible, measures should have a strong evidence base and align with measures endorsed by a national quality entity.
- Measures should be actionable and within the provider's control.
- Performance measurement should encompass all critical domains, including access, quality, and efficiency.
- Quality measures should include a mix of structure, process, and outcome indicators.
- Measures should be selected with consideration to available data, cost of implementation, and level of administrative burden.
- Measures should be appropriate to the state's diverse geography, variability in population, unmet needs, and health disparities.
- There should be minimal risk of manipulation, misaligned incentives, and unintended consequences.

7.2.5 Applying Lessons to LMHAs

The above best practices frame both HHSC's and the third-party evaluator's review of behavioral health performance measures. One clear observation is the need for a balanced approach to performance measurement that attends to access, efficiency, and quality. An exclusive focus on access and efficiency may result in inadequate care and poor outcomes. On the other hand, measuring only quality and patient experience may incentivize providers to limit access to care, particularly for more complex, high-need individuals. All three components of performance measurement—quality, access, and efficiency—are needed to provide a complete picture of the efficacy of the system in providing accessible, quality care in a cost-effective way.

LMHA contracts do not currently include specific efficiency measures, and development of appropriate metrics will require careful consideration and engagement with stakeholders. Moreover, indicators of efficiency are not recommended by the third-party evaluator for inclusion in the set of measures tied to performance incentives. Consequently, HHSC's immediate efforts in revising behavioral health performance measures will focus on measures related to access and quality.

Another key point is the need to maintain a mix of process and outcome measures. Many desirable outcomes are difficult to measure. Data sources may be lacking, or the data collection process may entail an unacceptable level of administrative burden or cost. In addition, some outcomes are vulnerable to manipulation or may introduce perverse incentives, leading to unintended consequences elsewhere in the system. Measuring processes that have evidence linking them with positive outcomes can serve as proxies for outcomes that are difficult to measure directly. For example, decreased rates of homelessness among a provider's clients could be the result of homeless individuals dropping out of service or effective clinical intervention. Research indicates that Permanent Supportive Housing (PSH) decreases rates of chronic homelessness. A process measure examining whether homeless clients are receiving PSH services can provide greater confidence that an observed decrease in homelessness is due to services provided.

HHSC must continue to consider the perspectives and priorities of multiple stakeholders and work to align measures with identified priorities. Stakeholder input themes include:

- Integrated care
- Person-centered care that is recovery-focused
- Enhanced continuity of care and collaboration between state and local entities

HHSC is well positioned to move forward as stakeholders are actively involved in the Behavioral Health Advisory Committee, the Statewide Behavioral Health Coordinating Council, and the Joint Committee on Access and Forensic Services. As the state reaches for ambitious goals, attention must be given to ensuring measures are within the provider's control and not significantly impacted by external variables. Consideration must also be given to the costs and benefits of collecting additional data needed to adopt new measures. Additionally, it is important to avoid discouraging providers from seeking out and serving high-need individuals.

Achieving greater alignment with nationally-recognized measures is a goal, and the third-party evaluator identified a number of such measures for future consideration. Examples of measure recommendations include 30-day readmission after hospitalization and adherence to antipsychotic medication for individuals with schizophrenia. Data is available to measure 30-day readmission after hospitalization, and this is one of the proposed crisis measures identified through the agency's internal review. However, key data sources are lacking for a number of these measures which precludes adoption at the present time.

Finally, the third-party review points to a clear gap in the current array of potential measures - the consumer's experience of care. While HHSC conducts an annual survey of consumer satisfaction, the survey is statewide and relies on a sampling process that does not yield a sufficient volume of provider-specific data. Multiple ways exist to obtain a larger sample of this

data; however, additional resources are likely to be needed to establish a robust, ongoing, provider-specific survey of consumers to use in performance measurement.

8. Publicly Available Performance Dashboard Proposal

As the drive toward quality accelerates and new service delivery and payment models gain traction, the availability of accurate, timely, and actionable information becomes increasingly important. Ensuring transparency and accountability requires performance-related information to be publicly available and easily accessible to providers, payers, consumers, and the public.

As part of the retooling of performance measurement systems, HHSC seeks to build on the work accomplished in response to S.B. 126, 83rd Legislature, Regular Session, 2013, which required the HHSC Behavioral Health Services Section to establish a public reporting system enabling users to compare provider performance, outputs, and outcomes. While this reporting system is an important step in making performance data available to the public, stakeholder input highlighted limitations such as the static nature of the reports and the limited ability of users to easily manipulate and analyze the data.

The third party evaluator made the following recommendations regarding the performance dashboard:

- Recognize the development of a web-based, publicly accessible dashboard is a resource intensive initiative.
- Include stakeholders in the development of the dashboard.
- Implement the dashboard in phases.

A number of features are required to elevate the current reporting system into an effective dashboard including:

- Relevant data and key metrics.
- Graphical display of information.
- Display of data by individual provider.
- Display of trends over time.
- Indication of performance in relation to targets.
- Ability to filter and drill down to more detail.

Transforming the existing reporting system into an effective dashboard would be a substantial step toward a quality-driven service delivery system that is accessible and accountable to the public. HHSC will begin this endeavor by assessing what can be accomplished with existing resources. Additional resources may be needed to complete the design, development, and deployment of the dashboard.

The cost of developing a dashboard is largely determined by the software platform on which the dashboard operates and the staff time to manage the system. Data aggregation platforms include technology tools to support data collection, analytics, and reporting activities. While these software packages substantially increase the utility and accessibility of data for information and analysis, enhanced sophistication is associated with greater expense. Further, these platforms generally require trained staff to manage the flow of data, contributing to higher operating costs.

9. Third-Party Evaluation Recommendations

The third-party evaluator’s report offered the following recommendations in five key areas for HHSC’s consideration as listed in Table 4.

Table 4. Third-Party Evaluator Recommendations

Category	Recommendations
Current Performance Measures	<ol style="list-style-type: none"> 1. Maintain the current performance measures for SUD providers and consider future enhancements. 2. Modify or eliminate a number of existing LMHA measures. 3. Consider future adoption of a consumer satisfaction measure and selected national measures.
Ten Percent Withhold Metrics and Methodology	<ol style="list-style-type: none"> 1. Revise the current set of measures associated with the payment. 2. Maintain a mix of process and outcome measures. 3. Select measures within the control of the provider and incentivize quality of care.
Contracting Best Practices	<ol style="list-style-type: none"> 1. Consider provider and service system characteristics when selecting a payment methodology. 2. Continue use of a low-risk model that adds incentive payments to the existing payment methodology. 3. Build on experience gained in the DSRIP program. 4. Consider bonus payments and/or enhancement of the allocation formula as options to replace or supplement the strategy of withholding funds. 5. Modify the incentive methodology to reward improvement among all LMHAs. 6. Revise the selection of measures tied to payment incentives and update targets. 7. Continue the current policy of a one-year period for testing and benchmarking new measures prior to full implementation.
Performance Measure Best Practices	<ol style="list-style-type: none"> 1. Base quality measures on measures endorsed by national quality entities when possible. 2. Ensure the performance measurement system reflects the priorities of the full array of stakeholders. 3. Align incentives in pay-for-performance with measures that report on access, quality, and cost effectiveness and efficiencies. 4. Select pay-for-performance metrics within the control of providers.
Performance Dashboard	<ol style="list-style-type: none"> 1. Recognize the development of a web-based, publicly accessible dashboard is a resource intensive initiative. 2. Include stakeholders in the development of the dashboard. 3. Implement the dashboard in phases.

10. Conclusion

The success of strategies to expand access, improve quality, and contain costs depend on good quality measurement and contracting mechanisms that incorporate effective performance incentives. A review of HHSC's contracting and performance measurement system reveals many assets and lessons learned, as well as opportunities for strengthening certain measures applicable to LMHAs. While further work is needed to complete development of a revised set of proposed measures, the process will be guided by best practices and industry standards. The goal is to produce a balanced set of high-value measures that address accessibility, quality, and efficiency of services.

The state has gained experience with performance-based-contracting through implementation of Rider 58 and has benefited from lessons learned through the DSRIP projects. While many of the new value-based payment models outlined by the third-party evaluator are not currently feasible for use in contracts with LMHAs and SUD providers, the models offer valuable insights into the potential risks and benefits of various approaches the state could consider moving forward.

HHSC is in agreement with the third-party evaluator that a low-risk model pairing performance-based incentive payments with modified performance measures is well-suited to LMHA contracts. Specifically, moving to the use of bonus payments or incentives, as opposed to the withholding of funds, may offer a more effective approach to incentivizing continued performance improvement among LMHAs. HHSC will explore ways to amend the contract process to implement value-based purchasing framework in the future.

Incorporating the lessons learned from recent initiatives in Texas, as well as best practices from across the health care system, will help HHSC improve its contracting and measurement system while ensuring the most cost effective service delivery system. As noted in the third party evaluator's report, a plan of this magnitude requires additional time and planning, as well as the engagement of stakeholders to develop and execute successfully.

Next Steps

HHSC will continue to work with stakeholders and HMA and NRI to identify a final set of proposed performance measures and payment methodology.

List of Acronyms

Acronym	Full Name
AHRQ	Agency for Healthcare Research and Quality
CMS	Centers for Medicare & Medicaid
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
H.B.	House Bill
HEDIS	Healthcare Effectiveness Data and Information Set
HHSC	Health and Human Services Commission
HMA	Health Management Associates
LMHA	Local Mental Health Authority
MCO	Managed Care Organization
MHSA	Mental Health and Substance Abuse
NCQA	National Committee for Quality Assurance
NOMs	National Outcome Measures
NQF	National Quality Forum
NRI	National Association of State Program Directors Research Institute
PSH	Permanent Supportive Housing
SAMHSA	Substance Abuse and Mental Health Services Administration
S.B.	Senate Bill
SPO	Structure-Process-Outcome
SUD	Substance Use Disorder

Appendix A: LMHA Performance Measures Review

HMA and NRI conducted a comprehensive review of the HHSC Behavioral Health Services Section performance measures to identify those that could potentially be eliminated. After cataloging the measures, the third-party evaluator identified related federal and state requirements, solicited stakeholder input, and cross-walked each measure against applicable requirements and nationally recognized measures, including measures used by MCOs, SAMHSA NOMs, and SAMHSA’s Certified Community Behavioral Health Centers. The third-party evaluator conducted multiple rounds of assessment to review the purpose or intent of the measure, its alignment with national norms and standards, the strength of validity of the measure calculation, and a review of the data source.

The third-party evaluator suggested a number of new measures for future consideration, most of them nationally-recognized metrics. The recommended measures include 30-day hospital readmission, one of the proposed crisis measures resulting from the agency’s internal review of performance measures conducted prior to engaging the third-party evaluator. Other nationally recognized measures, such as adherence to anti-psychotic medication for persons with schizophrenia, are not feasible at the present time, particularly with respect to resource and data limitations. However, these measures offer some potential goals for system development. In particular, building on the state’s existing consumer satisfaction survey to allow LMHA-specific evaluation would be an important step forward in attaining a patient-centered system of care.

Table 5 summarizes preliminary recommendations from the third-part evaluator regarding existing LMHA contract measures. The contract includes measures proposed as a result of the internal evaluation conducted in collaboration with stakeholders prior to engagement of the third-party evaluator. These measures, recommended as replacements for a number of the existing performance measures, are included in current LMHA contracts for testing and benchmarking purposes. The third-party evaluator recommended adopting all but two of the proposed measures. Life Domain Functioning and Strengths (for both adults and children) are components within the current Improvement measure and were being considered as separate measures to replace the Improvement measure. However, the third-party evaluator recommended retaining the current Improvement measure and not adopting Life Domain Functioning and Strengths as replacement measures.

Table 5: Third-Party Evaluator Preliminary Recommendations Regarding Existing LMHA Contract Measures

Quality Measures	Preliminary Recommendation
Improvement (Adult and Child/Youth)	Keep
Monthly Service Provision (Adult and Child/Youth)	Keep
Juvenile Justice Avoidance (Child and Youth)	Keep
Effective Crisis Response	Keep
Crisis Follow-up	Keep

Quality Measures	Preliminary Recommendation
Hospitalization	Keep
Community Tenure (Adult and Child/Youth)	Keep
<i>Employment Improvement (Adult)*</i>	<i>Adopt</i>
<i>Educational or Volunteering Strengths (Adult)*</i>	<i>Adopt</i>
<i>School (Child and Youth)*</i>	<i>Adopt</i>
<i>Residential Stability (Adult)*</i>	<i>Adopt</i>
<i>Family and Living Situation (Child and Youth)*</i>	<i>Adopt</i>
Follow-up within 7 days after hospitalization (face-to-face)	Modify
Frequent Admissions	Modify
Adult Jail Diversion	Modify
Community Linkage	Modify
Employment status	Eliminate
Follow-up within 7 days after hospitalization (any contact)	Eliminate
<i>Life Domain Functioning (Adult and Child/Youth)*</i>	<i>Do not adopt</i>
<i>Strengths (Adult and Child/Youth)*</i>	<i>Do not adopt</i>
Access Measures	
Long Term Services and Supports	Keep
Access to Crisis Response Services	Modify
Adult Counseling Target	Modify
ACT Target	Modify
Family and Partner Support Services	Modify
Other Contract Compliance Measures	
TANF Transfer to Title XX (Adult and Child/Youth)	Keep
Service Target (Adult and Child/Youth)	Eliminate
Uniform Assessment Completion Rate (Adult and Child/Youth)	Eliminate
Community Support Plan	Eliminate

* Measures proposed as a result of the internal evaluation conducted in collaboration with stakeholders prior to engagement of the third-party evaluator. Recommended as replacements for a number of the existing performance measures, these measures are included in current LMHA contracts for testing and benchmarking purposes.

Appendix B: Recommended Measures for Incentive Payments

Mental Health Services

The following array of measures includes a mix of outcome and process measures within the provider's control and which incentivize improved quality of care:

- Effective Crisis Response
- Crisis Follow Up (7 and 30 days)
- Follow Up after Hospitalization – Face-to-Face (7 and 30 days)
- Adult Community Tenure
- Child and Youth School Performance
- Adult Improvement
- Child and Youth Improvement

Substance Use Disorder Services

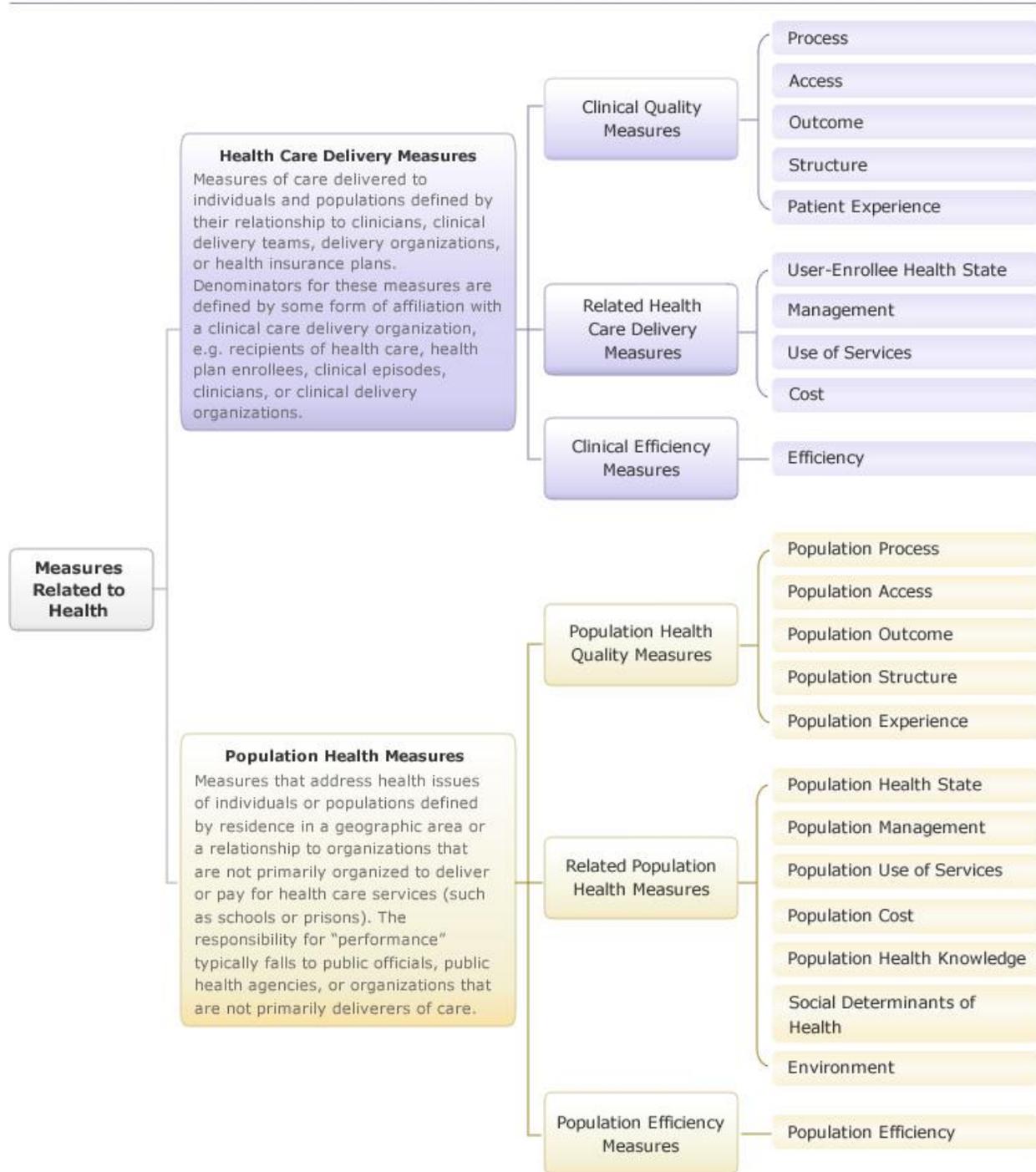
Should the state decide to implement payment incentives at a later date for substance use disorder contracts, the following measures might be considered:

- Community Support Referrals
- Detox (any setting) plus referral
- Number of motivational sessions per client with multiple residential detoxification episodes
- Receipt of reproductive health visits

Appendix C: Frameworks for Performance Measurement

Agency for Healthcare Research and Quality: National Quality Measures Clearinghouse

NQMC Domain Framework



National Quality Forum: Domains

- Structure
- Process
- Process: Appropriate Use
- Outcome
- Outcome: Patient Reported Outcome
- Intermediate Clinical Outcome
- Efficiency
- Cost/Resource Use

National Committee for Quality Assurance: Healthcare Effectiveness Data and Information Set Domains

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Relative Resource Use
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data Systems

Substance Abuse and Mental Health Services Administration: National Outcome Measures Domains and Associated Outcomes

- Abstinence
 - Abstinence from drug/alcohol use
 - Decreased mental illness symptoms
- Employment/Education
 - Increased/retained employment or return to school
- Crime and Criminal Justice
 - Decreased criminal justice involvement
- Stability in Housing
 - Increased stability in housing
- Access/Capacity
 - Increased access to services (service capacity)
- Retention
 - Increased retention in treatment (substance abuse)
 - Reduced utilization of psychiatric inpatient beds (mental health)
- Social Connectedness
 - Increased social support/social connectedness
- Perception of Care
 - Client perception of care
- Cost Effectiveness
 - Cost effectiveness
- Use of Evidence Based Practices
 - Use of evidence-based practices