

NorthSTAR: A Successful Blended-Funding, Integrated Behavioral Health Carve-Out Model

Final Report in the Independent Assessment of NorthSTAR

Prepared for

Texas Department of Mental Health and Mental Retardation

and

Texas Commission of Alcohol and Drug Abuse

by

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September 2003

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The independent assessment team gratefully acknowledges the assistance of Dr. John Theiss and Dr. David Wanser as well as the staff at the NorthSTAR state office, DANSA, and ValueOptions in providing information and facilitating the research process.

Preface

This is the third and final report in the independent assessment of the NorthSTAR behavioral health model. In September, 2002, Texas Department of Mental Health and Mental Retardation and Texas Council of Alcohol and Drug Abuse contracted with LBJ School of Public Affairs to conduct the independent assessment. The research team conducted the assessment between September, 2002 and May, 2003.

Previous reports in this research process deal with detailed indicators for the performance of the NorthSTAR model. The first report, *Texas NorthSTAR Behavioral Health Managed Care Model: An Independent Assessment of the Medicaid Component*, specifically covers the Medicaid portion of the NorthSTAR model. The second report, *Improving Public Behavioral Health Services in Texas: An Evaluation of NorthSTAR*, summarizes the Medicaid component and covers the indigent care component of NorthSTAR.

In contrast to the technical details of the first two reports, this final report is a conceptual discussion of the NorthSTAR model in the larger context of state policy approaches dealing with mental health and substance abuse services. The independent assessment team concludes that, despite the difficulties encountered in the initial implementation of NorthSTAR, the model is a viable strategy for improving the current system of behavioral health care in the state of Texas.

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NorthSTAR: A Successful Blended-Funding, Integrated Behavioral Health Carve-Out Model

More Texans need mental health services than can be served within existing resources. Current revenue projections and policy trends indicate shrinking availability of resources for public mental health services. Efficiencies must be realized in order to maintain and expand the availability of treatment options.¹

This excerpt from a Texas Department of Mental Health and Mental Retardation Benefit Design team report succinctly states the greatest need in behavioral health services in Texas. Essentially, the state needs to be able to do more with the same, extremely limited dollars. The same view can be found in the Strategic Plan for 2003 to 2007 by Texas Department of Mental Health and Mental Retardation. That document recognized many of the deficits of the existing behavioral health service delivery system in the state, reporting that “significant modification” may be needed to “maintain effectiveness and efficiency into the future.”²

The NorthSTAR program may be an example of such a significant modification. Begun in the Dallas area in 1999, NorthSTAR is a service delivery model that integrates the delivery of publicly provided mental health care and chemical dependency services into a single system. As such it places under one roof programs previously run separately by Texas Department of Mental Health Mental (TDMHMR) and Texas Commission on Alcohol and Drug Abuse (TCADA).

As part of an ongoing effort by the state to evaluate existing pilot projects’ ability to effect greater efficiencies while maintaining cost-effectiveness, quality, and access, a research team at the LBJ School of Public Affairs examined the NorthSTAR program. The research team conducted primary research on the measures of cost effectiveness, quality and access as evidenced in the Medicaid portion of the program.³ Additional research was conducted looking also at the indigent portion of the program.⁴ This is the third and final report of the research team. It seeks to present our assessment of NorthSTAR in a conceptual framework, as it compares with the traditional and alternative models in Texas.

Summary

To summarize at the outset the LBJ School research team’s finding: having overcome many obstacles during its initial years, NorthSTAR is by its fourth year of operation a success. It embodies a total re-conceptualization of multiple systems of care. Under this re-conceptualization more service providers are available and more clients have access to service. And this new conceptualization of multiple systems of care has been carried out

at no additional budgetary costs. The road to this success, however, was not without many struggles.

State administrators and local planners of NorthSTAR encountered much opposition, visibly from the Community Mental Health and Mental Retardation Centers (CMHMRs), and their representative body the Texas Council of Community MHMR Centers. Less visibly, there were also advocates and other providers who were skeptical about the potential adverse effect of such a system change.

The opposition from the CMHMRCs was understandable and perhaps inevitable. Before NorthSTAR, the CMHMRCs were the primary providers of public behavioral health services in their respective areas. For these MHMR centers, NorthSTAR was a radical change. Before NorthSTAR, the centers were paid prospectively for services for both Medicaid consumers and the medically indigent. The centers resisted the transition to NorthSTAR because they lost their status as the local mental health authority. They also lost their lump sum payments and some of their clientele. These losses are very real to the Centers, many of which under NorthSTAR had to shrink their budget and scale back their services. From the perspective of the system, however, the negative effects of NorthSTAR on the MHMR Centers are arguably more than compensated for in the form of an expanded provider network and better access to services.

NorthSTAR also resulted in changes in practices in the treatment system for chemical dependency. Since prior to NorthSTAR there was no local authority in that system and since local providers for chemical dependency services had been under a fee-for-service relationship with TCADA, the new system did not bring about the same fundamental changes experienced by the local mental health centers. Nonetheless, NorthSTAR meant that service providers had to deal with a behavioral health organization (BHO) in their billing and other administrative processes.

By introducing a behavioral health organization (BHO) into the system, NorthSTAR adopted concepts previously foreign to the public behavioral health world in Texas, concepts such as competition, market share, and accountability. From the perspective of TCADA, moreover, BHO also means the beginning of a local authority, a concept previously unknown to the chemical dependency service system. The complete revamping of such an ingrained system took time, and consequently, it took time for the system, and its member components to adjust as well. To the credit of both the model and its leadership, NorthSTAR not only survived such internal threats but surpassed expectations, by demonstrating cost savings, and by significantly reducing administrative expenses.

This report begins by reviewing and contrasting the NorthSTAR model, the traditional model, and other reform models in chapters one through three. Then the advantages of the NorthSTAR model are described in detail in chapter four. Chapters five and six outline our recommendations and conclusions regarding potential expansion of NorthSTAR.

Chapter 1. The NorthSTAR Model

NorthSTAR is part of a larger effort by the state of Texas to make its Medicaid program more efficient through the use of managed care. In the early 1990s, the state began to adopt managed care as a strategy to achieve a number of desired goals within the state Medicaid plan, including: achieving cost effectiveness; enhancing the quality of health care; improving continuity of care; promoting prevention and wellness; increasing access to and availability of health care services; reducing inappropriate utilization; improving customer and provider satisfaction; and increasing accountability of consumers, government officials, health plans, and healthcare providers.⁵

As a result of this Medicaid managed care initiative, Texas launched a number of Medicaid waiver programs under the name of STAR. These waiver programs, discussed in Chapter 3, typically placed physical health and mental health coverage under the same managed care plans.

With NorthSTAR, the state used a different approach in Medicaid behavioral health service delivery by separating it from physical health care. Instead, NorthSTAR combines mental health and substance abuse services, previously administered separately by TDMHMR and TCADA, in a single system. In 1999, the state of Texas obtained a 1915(b) Medicaid waiver to operate the NorthSTAR program in the seven-county service delivery area (SDA) surrounding Dallas.⁶

NorthSTAR combines the following features:

- As an **at-risk model**, the state contracts with a behavioral health organization (BHO), which assumes risk for the delivery of all covered services to qualified beneficiaries.⁷
- It is a **carve-out model** with mental health and substance abuse services carved out of the physical health service delivery system.
- It is an **integrated model** for the delivery of mental health and substance abuse services to Medicaid and medically indigent patients.
- It is a **blended-funding model**, pooling financing from a variety of sources; separate streams of funding are maintained for the Medicaid and non-Medicaid populations while services are delivered under a single system.
- It is an **authority-provider separation model**, establishing a local behavioral authority that has no provider function, which differs from the traditional model of having the Community Mental Health and Mental Retardation Center (MHMR Center) act as both the authority and the primary provider of care.

Organization of the NorthSTAR Model

These features call for a system of organizing which is very different from the traditional model. NorthSTAR is jointly administered by Texas Department of Mental Health Mental Retardation (TDMHMR) and Texas Commission on Alcohol and Drug Abuse (TCADA). Both agencies are part of Texas Health and Human Service Commission (HHSC), the umbrella agency that also houses the state Medicaid office.

TDMHMR and TCADA staff operate the NorthSTAR office, which oversees the program at the state level. In addition to the functions described below, the NorthSTAR office maintains a data warehouse to gather enrollment, encounter, and payment records. The data warehouse system also stores data files on individual assessment, state hospital use, and prescription drug use. This data warehouse makes it possible for NorthSTAR staff to analyze patterns in enrollment, service utilization, and cost.

The state office works with the Dallas Area NorthSTAR Authority (DANSA), a local behavioral health authority (LBHA), which coordinates strategic planning, oversees consumer issues, and provides ombudsman services for the now-integrated mental health and chemical dependency services. A board appointed by the seven NorthSTAR counties governs DANSA.⁸

While program oversight functions are shared with DANSA, fiscal and contracting authority remains solely with the state NorthSTAR office. The NorthSTAR office contracts with a private BHO, ValueOptions,⁹ which bears the financial risk of the program and manages the delivery of care.¹⁰

In its role as the BHO for NorthSTAR, ValueOptions is responsible for maintaining an adequate provider network and paying network providers, in addition to managing care for NorthSTAR enrollees.

The provider network maintained by ValueOptions currently includes a Specialty Provider Network (SPN) of 11 organizations¹¹ and an additional network of about 429 providers. SPNs are entities that provide service coordination, specialized care, and more intensive levels of service than other network providers. Some NorthSTAR services are exclusively provided by SPNs. These include Assertive Community Treatment (ACT) teams, rehabilitation, supported housing, supported employment, and case management.

Since the program's inception, the BHO has made a number of changes to the model to improve care and achieve cost efficiency. Most notably, the BHO implemented a 23-hour observation unit in March 2001 where patients could be sent before being admitted to hospitals. This change, which was made in reaction to the over utilization of inpatient services at the beginning of the program, was intended to improve cost-effectiveness and to ensure that patients were directed to the most appropriate level of care.¹² This process is discretionary for Medicaid patients, who may still be admitted directly to inpatient hospital care without going through the 23-hour observation process.

Financing

The state NorthSTAR office pays the BHO a per-member-per-month (PMPM) rate for each category of enrollees in the service delivery area. The PMPM rate covers the cost of direct care as well as the BHO's administrative costs and profit. Client rate categories are defined in terms of age and whether the clients are TANF, SSI, or state indigent clients.

The amount of funds that the BHO may retain for administration and profit is contractually limited in this model. The contract requires the BHO to meet a direct service claims target (DSCT), which is a percentage of total program funds that must be spent on direct care. NorthSTAR's original request for proposals allowed bidding BHOs to choose DSCT values between 86 percent and 90 percent. ValueOptions is contracted at the 86 percent DSCT rate, meaning that at most it may retain 14 percent of program funds for administration and profit. To date, the company has spent more than 86 percent of program funds on direct care each year.

Eligibility

For mental health services, all non-Medicaid indigent clients that meet the categorical definition of need for behavioral health care under NorthSTAR, the priority population¹³, are eligible for behavioral health services. As we will see later in this report, this is perhaps the most important improvement NorthSTAR has made.

Non-Medicaid individuals in need of chemical dependency services also must meet specific clinical criteria, in addition to financial criteria (200 percent of poverty). The targeted population includes the following: any youth with a substance abuse (SA) or chemical dependency (CD) diagnosis; adults with a CD diagnosis;¹⁴ pregnant women, women with dependent children, and parents of children in foster care with a SA or CD diagnosis; persons with HIV with a CD or SA diagnosis; persons who use needles to take drugs with a CD or SA diagnosis; and CHIP enrollees who have exhausted their benefits for CD or SA services.

On the Medicaid side, with a small number of exceptions, enrollment in NorthSTAR is mandatory for all Medicaid beneficiaries residing in the NorthSTAR service delivery area.¹⁵ With just one BHO currently, Medicaid beneficiaries are automatically enrolled in NorthSTAR when they are enrolled in Medicaid. They can go to any network provider and receive clinically indicated behaviorally health services, a larger service package than in the traditional model for both mental health and chemical dependency services.

Summary

The NorthSTAR features of at-risk, carve-out, integrated behavioral health care, blended funding, and authority-provider separation contrast sharply with the traditional model of behavioral health care delivery in Texas. To understand this contrast, the next two chapters will describe how the system operates in areas not using the NorthSTAR model. Chapter 2 covers the traditional system. Chapter 3 covers other alternative models that have been attempted over the last decade.

Chapter 2. The Traditional Model

What began as a system of state hospitals for the mentally ill in Texas has evolved to include a network of community mental health centers and state-run hospital-based community services, providing mental health services for individuals, primarily indigent, meeting the state's criteria for priority population.

Organization of the Traditional Model

In the traditional model, first of all, mental health care and substance abuse services are administered at the state level by two different agencies. TDMHMR, as the State Authority (SA) for mental health, establishes contracts with local mental health authorities throughout the state (currently 39 plus DANSA) to ensure the provision of services to mentally ill individuals.¹⁶ TCADA, as the State Authority for substance abuse programs, contracts directly with local providers, including in some cases CMHMRCs, for service delivery.

Traditional mental health system

As contracted local authorities, CMHMRCs are locally governed political subdivisions of the state. Funding for the local authorities is allocated through TDMHMR. Funds include state general revenue, federal Medicaid and block grant funds, some local matching funds, and some non-Medicaid, third-party reimbursement. Services, which include, counseling, case management, medication, supported housing and employment, and crisis care, are accessed through the local authority for a given county. The local authority (LA) in most cases is also the provider of services, but in some cases does contract with additional providers.¹⁷

TDMHMR establishes annual performance contracts with the CMHMRCs. Contracts are based on the previous year's cost data and determine funding for the current year. Service targets are also dependent on this historical data. The traditional model of service delivery does not currently require standard business practices or processes to determine resource allocation or to ensure accountability. In the next chapter we will see how changes to this traditional model have been attempted in many urban areas, but much of the rest of the state remain under this traditional model of service delivery.

Traditional chemical dependency system

In the traditional model of services, chemical dependency services are provided by contracted organizations. TCADA, through contracts, distributes federal predominantly block grant and state general revenue funding to about 200 community organizations throughout the state. Services are provided on a first come first served basis, and are quite limited.

For the eligible medically indigent, both mental health and chemical dependency services must be sought through contracted providers of TDMHMR or TCADA. No services are guaranteed for the medically indigent, except those within the limited Medicaid benefit package.

Issues

The traditional model of service delivery is wrought with concerns. These concerns include: waiting lists, inconsistency in service quality, inefficiencies, and lack of clarity regarding who is to be served—Medicaid versus indigent. They are described below.

The current mental health system provides no service guarantee, even if an individual meets priority population eligibility. There is also no assurance that the sickest individuals can obtain service first. At best it is first come first served, but often the need to ensure reimbursement and other administrative considerations lead to the active selection of clients, resulting in the turning away of those that may be too difficult, too chronic, too non-compliant, or too uninsured.

Available services and quality of services vary from center to center. For individuals fortunate enough to receive service there is no standard of care in place. Use of science-based behavioral health practice varies tremendously. Consumers are not able to compare the care they receive with care others receive. State officials and administrators are also at a loss to compare centers against each other or against best practices, as the data is not there. Systems in place for tracking are arcane. Encounter data for instance is not tracked. At best, one can ascertain whether or not a consumer has been “open” to a given service at a given time, but cannot ascertain the breadth or depth of the service.

The state’s Benefit Design team, assembled to determine the composition of mental health care in Texas in the future, described the following difficulties with the existing model of care; the current system:

- Does not use encounter data;
- Lacks adequate information technology and thus hampers data-driven decision-making;
- Has fragmented service-delivery, often involving multiple providers, and resulting in duplicative efforts and unmet needs; and
- Has contracting methods that do not assure the purchaser that the type and amount of contracted services are clinically appropriate or effective.¹⁸

Furthermore, CMHMRCs have had to increase the number of Medicaid recipients they serve as a proportion of the total population served. From a funding perspective, Medicaid recipients are desired consumers as they have reimbursement and therefore drive up the total amount of federally matched dollars available to be spent on care; care for the medically indigent is paid for out of state general revenue dollars. However, in

doing this, the state Medicaid match grows as well, and effectively reduces the amount of funding available for non-Medicaid mentally ill individuals. This phenomenon effectively limits the number of non-Medicaid served. Left untreated, or under-treated, these individuals are likely to develop more serious mental illness.¹⁹

TCADA reports that “of the 2.8 million Texans who need help for substance abuse problems, approximately 1.01 million are indigent and eligible for TCADA services.”²⁰ However, they also report that the 200 contracted community organizations serve 750,000 consumers a year.²¹ Like the mental health system, the current chemical dependency system does not guarantee services, even to those most in need, or those determined to be the most “ready” for intervention.²²

Compared to the traditional mental health system, however, the direct fee-for-service relationship between local providers and TCADA means the state agency can better exercise oversight over financing and services. Until mid-year 2002, the TCADA system allowed for individuals to obtain duplicative identification numbers by seeing multiple providers. A recent initiative by TCADA, Behavioral Health Integrated Provider System (BHIPS), has addressed this problem. The BHIPS allows providers to enter electronic client records at the local level, automatically sending a record to the state office as well, thus eliminating duplicative identification numbers for the same individual, while at the same time increasing documentation compliance.

Despite seemingly improved efficiency, in the traditional chemical dependency system, many individuals end up on waiting lists, provider competition is lacking, and the benefit package for Medicaid is significantly limited; thus the traditional system of chemical dependency services still has room for improvement. More importantly, the fact that the traditional model compartmentalizes mental health and chemical dependency services, requiring two separate agencies with two separate systems, is perhaps one of its most severe drawbacks.

For individuals who are dually diagnosed with mental illness and chemical dependency, the traditional system is particularly troublesome. Individuals for the most part are forced to seek and attempt to attain services through separate providers, providers who frequently have no communication with one another and no incentive for cooperation. This fragmented system creates financial and administrative disincentives for mental health providers to deal with diagnoses of chemical dependence, and similarly for chemical dependency service providers to treat mental health conditions in their consumers. In an age where “continuity of care” has become the focus, this method of separate systems of treatment has become considerably arcane.

Summary

These concerns serve to underscore the need for the state to maximize economies of scale and to select a model of service delivery that is the right care at the right time while getting the most out of each public dollar.

The recognition of these problems spurred a number of legislative mandates over the last decade to modify the traditional system. We will turn to these reform initiatives in the next chapter.

Chapter 3. Other Program Alternatives

The traditional mental health system design currently in place in much of Texas has the local authority entity responsible for the *provision* of mental health services as well. In the past decade, Texas has come to see the difficulties and concerns involved with having one entity responsible for both roles. State leaders have therefore sought to implement several program alternatives, of which NorthSTAR is one. Other alternatives include: House Bill 2377 model, STAR Medicaid Managed Care models (carve-ins), and Benefit Design. A NorthSTAR description is not included here, as previous chapters have provided that description.

It should be noted that these models do not exist in a vacuum. Each is influenced by the others, and all have been affected by the implementation of Medicaid managed care.

HB 2377 Authority-Provider Separation

About a decade ago, the state endeavored to design a model for mental health care that effectively separated the provider and authority roles of the CMHMRCs.²³ In 1995 the 74th Legislature adopted House Bill 2377, leading to the creation of three MHMR pilot sites with the intent being an examination of strategies for organizational separation of authority and provider roles/responsibilities for the involved CMHMRCs. The impetuses for this bill were the spread of Medicaid managed care in Texas, an effort to ensure the best value for the public dollar, and the concerns regarding the traditional system's ability to adapt to competition within a managed care framework.

With HB 2377, emphasis was placed on the delineation of the roles of authority and provider. The bill also stressed competition, local authority, and accountability. The bill allowed the state authority, TDMHMR, to delegate further authority to the local MHA, to include: "planning, policy development, resource development, and allocation for and oversight of" mental health services in the state. Decisions regarding the provision of services were to be made by the local authority based on cost-benefit, public input, and client care issues.²⁴

Local authorities were directed to establish networks of providers with public input and to determine what, if any, services to contract out to providers other than the local authority itself. In making this determination, a site was to objectively consider "public input, ultimate cost-benefit, and client care issues to ensure consumer choice and the best use of public money in assembling a network of service providers."²⁵ Sites opting to remain a provider as well as the authority were to develop distinct policies and operations for the respective functions. The three pilot sites²⁶, selected in early 1996, were Austin-Travis County, Tarrant County, and Lubbock Regional MHMR Centers; all three of which were also Medicaid managed care roll-out locations beginning September 1996.

The sites were all required to implement specific standard business practices involving: planning, network development, quality management, credentialing, finance, and

intake/assessment/referral. These activities included decisions regarding which services to provide directly or contract out, regular self-assessment, staff qualifications and development, product costs and value, and moving clients through the system. Planning advisory committees (PACs) and Network advisory committees (NACs), including local citizens, were also a requirement and were involved in the policy development and business practices development for each site to lend some objectivity to the system change process.²⁷

Issues with the 2377 model

Early findings with the 2377 pilots suggested that none of the pilot sites were implemented the same, nor did they appear to be fully implemented in accordance with the intent of HB 2377. As a result, questions have been raised as to the inherent difficulties with objectivity.

The UT LBJ School, in their 1998 report “Community Mental Health Centers Under Managed Care: Authority or Provider?” found that none of the pilot sites had been implemented according to initial intent of 2377 which required an arm’s length relation between the authority and provider roles. However, at that time no conclusion could be made regarding whether or not the sites were able to make an objective determine of best value.²⁸

According to TDMHMR’s Mental Health Task Force, comprised of various industry experts to study the future structure and function of mental health services in Texas in 2001, the 2377 pilot sites had engaged in much work related to establishing business practices associated with a provider network and efforts that seek the best value. The Task Force pointed out however that issues had arisen regarding the objectivity of centers that were “both the LA and a major provider in the network that it managed”. The Task Force explained that attempts to address the issue of objectivity led to “different types of organizational structures between the pilot sites and different strategies for ensuring objectivity in how the center, as LA, made decisions regarding the provider network. Thus, in practice, there is not a single 2377 pilot, but three different versions.”²⁹

In its January 2003 report to the Legislative Budget Board and the Governor on local authorities, TDMHMR reported that the pilot phase for 2377 had ended. The TDMHMR reported that the concepts developed during the pilot phase served to inform the subsequent Behavioral Health Benefit Design Committee, as well as the MRLA initiative for mental retardation services. Products resulting from this project, and available to other CMHMRCs, include: local planning processes; and managed care tools such as network development, quality management, utilization management and the cost accounting methodology to enhance planning, coordination and oversight.³⁰

The Mental Health Task Force and Benefit Design

The TDMHMR *Mental Health Task Force*, composed of major stakeholders, was charged by the TDMHMR Board in 2001 with defining the structure and function of the major components of the behavioral health model to be used by TDMHMR to purchase

mental health services in the future. The guiding principles for the group were: community involvement and empowerment; consumer choice; efficiency; and accountability.

The Task Force, with the consumer as the primary focus, recommended that the structure and function of the local authority be set in one of two manners: 1) with the CMHMRCs as the local authority, or 2) with the CMHMRC contracting authority functions to an Administrative Service Organization (ASO), but retaining ultimate responsibility. Within the Task Force plan, CMHMRCs can determine locally whether or not they will continue to function also as provider, versus solely contracting for services. If they are to continue to provide services in addition to the authority role, they must meet objectivity criteria (to be developed by the state authority) and be verified by the state authority's certification review. Objectivity criteria include: separate budget for the local authority, independent ombudsman; a NAC; a PAC, a provider relations office; consumer relations office; and separate staff for ASO-type functions.³¹

The *Benefit Design Committee* was established at the same time by TDMHMR to determine the business rules for the purchase of services in the future behavioral health system, including: eligibility; benefit package; evidenced-based best practices; and prices paid. The Benefit Design utilizes a disease management approach³² and packages the purchase of service into 5 levels of care, with the goal of better clinical and functional outcomes for consumers and greater efficiencies with limited public resources. The local authority is to authorize services according to one of the case rates, which is determined by: the consumer's clinical presentation and is based on a standardized assessment, state authority utilization management (UM) guidelines, available funding, and Medicaid entitlement.

Benefit design also incorporates system level performance evaluation using encounter, outcome and cost data; and it incorporates standardized processes for proactively managing system operations to ensure accountability for outcomes and to minimize financial risk. Some of these processes include: utilization management; consumer relations; and authority management of the provider network.

Benefit Design is currently in its implementation phase in four initial roll-out locations³³, during which time they hope to collect and analyze encounter data, to analyze cost information, and to analyze other financial and service information, to revise UM guidelines and service packages, and set pricing so as to maximize available funds.³⁴

As described in one Benefit Design Report, the Benefit Design will replace the current funding system with:

a purchasing system in which provider earnings will be directly tied to the number, type, and length of service encounters provided to consumers. Under this system rates will be based on the actual cost of service provision and market surveys, which will drive specific expectations related to the productivity and efficiency of the service provider, as well as adherence to service-model fidelity requirements. This represents a fundamental shift from the current approach to a

comprehensive model in which allocations are driven by whether people are appropriately served based on their unique needs and characteristics.³⁵

Issues with the Benefit Redesign Model

The single greatest apparent shortcoming of the Benefit Design model is that there is no guarantee for access to care for consumers. This model still bases the number of consumers served on available funding, thus at the local level, determination can be made to turn consumers away or institute a waiting list. This still allows room for manipulation. Centers will be able to pick and choose clients at will because there is not stipulation that they must serve them.

An additional potential problematic area of this model is that by failing to determine the local authority structure at the state level, the door is open for there to be as many different-looking structures as there are local authorities (40 at this time).

STAR Managed Care Waiver Models

Prior to NorthSTAR, Medicaid managed care had been implemented in six regions in Texas. The managed care program is known as the State of Texas Access Reform, or STAR, and is mandatory for Medicaid recipients on TANF and voluntary for individuals on SSI. One county within one region, Harris County, has a slightly different managed care model, known as STAR+Plus, which includes long-term care and does have mandatory enrollment for SSI recipients.

In all of these regions, with the exception of the NorthSTAR service deliver area, behavioral health services are included—are carved in—in the managed care contracts. The degree to which the contracting HMO actually administers funds and coordinates the care versus delegating it to a subcontractor varies.

The HHSC conducted an evaluation of behavioral health services in STAR and STAR+Plus (and in NorthSTAR) by looking at the following: cost, quality, access, administration, and integration with physical health. The HHSC found among other things the following:

- integration between physical health and behavioral health has not been fully realized in any of the models;
- STAR and STAR+Plus HMOs have inadequate data tracking mechanisms in place for behavioral health; *while NorthSTAR uses collected and analyzed data on access, quality, and cost to improve the program.*
- Staff support for oversight of behavioral health varies by model, *with NorthSTAR having the most.*
- Managed care does impact the type and amount of services received in favor of non-inpatient and drug therapies.

- Members of managed care services are satisfied in general and providers are in general not satisfied, *although they are less dissatisfied in NorthSTAR where satisfaction levels did not change pre-post implementation.*
- Member and provider complaints are not tracked specifically for behavioral health in STAR and STAR+Plus, but in NorthSTAR where they are tracked, they are low.
- There was tremendous variation in medical loss ratios; *NorthSTAR has a contractually obligated direct services claims target.*
- Timeliness of claims payment varied per plan; *NorthSTAR's BHO had the best record.*

Issues with STAR Carve-in Models

STAR and STAR+Plus appear to demonstrate less attention to the behavioral health portion of their clientele. There are very few assurances in either of these programs that individuals with behavioral health concerns receive the special care and attention needed in such a large system. The STAR and STAR+Plus plans at least currently lack adequate data tracking systems and capabilities, which is one of the most important tools for ensuring program quality and accountability. Lastly, the lack of a contractually set direct service claims target for these programs means that there is no assurance that a set portion of public funds will be spent on direct behavioral health care.

Summary

The 2377 pilot project process has ended, and no initiative is on the horizon to continue with the 2377 strategy. The process did serve to develop key concepts and to begin development of key processes for future models, such as network development, information systems, and data collection. Additionally, the experiences of the pilot projects serve to support the importance of a clear separation of authority and provider roles.

The Mental Health Task Force and the Benefit Design team have done commendable work. Both groups' recommendations include key components for a competitive, science-based system of behavioral health for the future. This current design for the future however still provides no guarantee of access to care for persons with severe mental illness in Texas.

The STAR managed care carve-in models lack adequate data tracking systems and capabilities. More important, in these models behavioral health receives much less managerial and oversight attention than does physical health; complaints are not specifically tracked according to consumer type; clean claims timeliness varies; and lastly, direct service claims targets are not contractually set.

Furthermore, none of these models guarantees access to care for both Medicaid recipients and medically indigent individuals. It was because of shortcomings in these models, and further because of the successes of NorthSTAR, that HHSC in their comparison study report recommended that the state consider “expanding the NorthSTAR model to other locations.” The HHSC explained that “NorthSTAR does a better job of collecting data and managing behavioral health services than STAR or STAR+Plus” and that “data available on several indicators also indicates that it may be performing better than the other two models.”

Chapter 4. The Advantages of NorthSTAR Model

The previous three chapters provide the comparison among NorthSTAR, the traditional model, and alternative models attempted in Texas prior to NorthSTAR. This chapter will make the argument that NorthSTAR is a unique model and a significant improvement over the traditional and the alternative models of care in Texas. The key advantages of the NorthSTAR model are discussed below in conceptual form. Empirical information substantiating these arguments can be found in the two NorthSTAR evaluation reports.³⁶

Guaranteed Access

Almost no other public behavioral health system in the nation has offered guaranteed access to care, and none has done so as NorthSTAR has. While a few other states and localities around the country have offered public behavioral health services through a managed care carve-out model, NorthSTAR is the only program to successfully guarantee access to these services for both eligible Medicaid and eligible medically-indigent individuals.

To provide increased access to behavioral health services is an overall program goal of NorthSTAR. It is an understatement to say that the goal has been achieved. Using no additional funds, NorthSTAR, seeming more like a private managed care insurance system, has managed to take existing funds and *guarantee* access to care for eligible individuals. The contracted BHO assumes full financial risk for providing services to all eligible individuals. The BHO is contracted to insure an *accessible* provider network. As a result there are no waiting lists in NorthSTAR. Any covered life in the NorthSTAR service delivery area can access any medically necessary covered service. Additionally, NorthSTAR has expanded the array of services available to Medicaid consumers, and the provider network has grown over the course of the program. Consumers choose their own provider(s) from a large network of providers.

Guaranteed access is an especially significant achievement for the non-Medicaid indigent population. These individuals have been squeezed out of services more and more in the traditional behavioral health care system, as administrators are forced to serve more Medicaid clients in order to increase their reimbursement.

In the traditional system, non-Medicaid indigent individuals needing mental health or chemical dependency services were limited to providers within, or contracted directly with, TDMHMR or TCADA. Eligibility criteria and availability were not consistent among providers, and access was certainly not guaranteed through these agencies. In the traditional system, due to limited funds, inefficient systems, and the lack of competition, providers frequently place consumers on endless waiting lists, or worse, turn them away, claiming that they can only serve a limited number of consumers with no third party reimbursement. Conversely, some mental health providers will not accept Medicaid consumers and therefore Medicaid recipients are forced to seek care within the overburdened CMHMR system or to seek care through hospitals.

Before NorthSTAR, and in other parts of the state, the MHMR centers received block payments on a quarterly basis to provide public behavioral health services. While centers are committed to providing service to eligible individuals, if the demand for service exceeds the availability of funds or providers, the MHMR centers are not required to treat individuals who are eligible for their services, thus the waiting lists.

In contrast, under NorthSTAR, the BHO is contractually required to ensure that all covered services are available to all eligible individuals on a timely basis. If the demand for services exceeds the capacity of the provider network, the BHO is obligated to expand the network or make other accommodations. If the cost of covering care for NorthSTAR participants exceeds available funds, the BHO is at risk for the loss. In other words, it must still pay for the care even if it loses money in the process.

Incidentally, the contractual obligation of the BHO for an accessible network of providers is despite geographical location within the seven-county service delivery area. So, if a deficit in providers of a specific type(s) is determined, the BHO must respond. For example, the rural locations have had difficulty in the past with retention (or attraction) of psychiatrists to serve their areas. As a response, the BHO arranged for psychiatrists from the urban SPNs to conduct clinic days in the rural locations on a regular basis. Additionally, the DANSA and the BHO are working together to develop telemedicine capabilities to further enhance provider availability in these areas.

One of the most unambiguous conclusions of the LBJ School research is that access to behavioral health services has increased under NorthSTAR. Access, as defined by penetration rates, has steadily increased since the inception of the program. This observation is demonstrated by a comparison of service utilization records, before and after the program by Medicaid and non-Medicaid enrollees. For Medicaid enrollees, NorthSTAR reversed a disturbing trend of declining numbers of consumers served and declining penetration rates. Both have increased under NorthSTAR. For non-Medicaid enrollees, NorthSTAR improves access by effectively insuring and guaranteeing access to care to a population that previously had access to care at the discretion of the MHMR centers. Correspondingly, the number of non-Medicaid consumers served has increased significantly over the course of NorthSTAR. The quantitative improvement in service utilization is supported by the perceptions of providers and consumers.

Cost Effectiveness

Since its inception in December 1999, NorthSTAR has remained cost-effective. In previous research, both HHSC and Texas Tech University found cost savings have been achieved in the NorthSTAR program. The LBJ research team found that under NorthSTAR, more people have been served for the same amount of money without a decline in the quality of care, making the program more cost-effective than the model in place before NorthSTAR was implemented. In fact, over the four-year waiver period, NorthSTAR has resulted in Medicaid cost savings of about \$20 million, most of which has been achieved in administrative savings.

Choice and Competition

Access to care for all eligible consumers could not have been guaranteed without opening the provider network to competition. In NorthSTAR, the BHO has open contracting arrangements with providers rather than block funding to traditional public providers – CMHMRCs. This infusion of competition adds both incentives and service-level accountability, while increasing both the number and type of providers.

In the traditional system, consumers of public behavioral health services are limited to the local/county community mental health centers or chemical dependency organizations, thus disallowing choice according to preference, specialty, reputation, complaints, or geographical proximity. While Medicaid recipients could go to any provider accepting Medicaid patients, few providers were accepting Medicaid patients and thus these patients often received services from non-mental health specialty providers. Non-Medicaid consumers were seen exclusively by the CMHMRCs or their subcontractors.

Consumers within NorthSTAR can seek services not only at non-traditional providers, but also anywhere within the seven-county NorthSTAR service delivery area. By contracting directly with a network of facility-based and individual providers, ValueOptions has made it possible for Medicaid and non-Medicaid consumers to be successful in finding an appropriate provider.

An important aspect of NorthSTAR's expansion of the provider network is the fact that, by integrating the formerly separate service delivery areas of urban, suburban, and rural community MHMR centers, the program has introduced economies of scale and has allowed rural areas to borrow strength from the availability of providers in more populated areas. Part of the advantage of geographic integration is that, under NorthSTAR, rural Medicaid consumers have the option of traveling to Dallas and other counties to obtain services. A second and equally important element of this geographic economy of scale results from the introduction of mobility and flexibility of providers.

Allowing consumers choice of providers not only serves to empower consumers, but also strengthens their investment in the recovery/treatment process. NorthSTAR altered the provider system from one in which consumers were stuck with the designated provider in their area to one where providers must compete for clients. With competition for market share, the expanded network has become more efficient and more responsive to consumers, and has effectively eliminated waiting lists.

Blended Funding

As recommended by a citizen planning council study of managed care, the NorthSTAR model sought to incorporate blended funding. The NorthSTAR model combines all federal, state and local funding streams for behavioral health. TDMHMR and TCADA function as partners for the state-level administration, funding, and monitoring of the program. The funding commitment of each is outlined in a memorandum of understanding.

By blending funds from a variety of sources (Medicaid and non-Medicaid, mental health and substance abuse, county, state and federal), NorthSTAR promotes better coordination and continuity of care. This is especially true for people with mental health and substance abuse disorders who can now receive care for both categories of conditions in one system with one provider network. Another significant advantage of the blended funding model is that as Medicaid consumers move on and off of Medicaid, they may remain eligible for NorthSTAR services and have guaranteed access to the same providers if they qualify under the medically indigent guidelines.

Communication/Collaboration and Innovation

As mentioned above, with NorthSTAR the system moved from one in which providers rarely talked to one another regarding client care to one in which they collaborate purposefully.

From the beginning, the state endeavored to maximize cooperation, collaboration, and communication among all stakeholders. Advocates, consumers, and providers along with state agency representatives were involved in the design of the program. Although hampered somewhat by individuals/entities entrenched in the “old way of doing things”, the state worked to inform stakeholders of the changes to the system, through meetings, trainings, a video, etc.

To further encourage collaborative relationships and open channels of communication, the state entered into memorandums of understanding with the participating counties in the NorthSTAR service delivery area, and designed the board makeup of the new Local Behavioral Authority to include appointed county representatives. Contracts were made between the BHO and the state, the BHO and the LBHA, the counties and the state, and the state and the LBHA with the goal of delineating each entities responsibilities toward the coordination of care for consumers. Initial contract negotiations between the state and the BHO included a LBHA board representative, a consumer, and a family member.

NorthSTAR state staff and DANSA remain committed to continued development of these relationships as well as relationships with other members of the behavioral health community – law enforcement, schools, etc. – and have several related projects in the works. Where problems are identified through the complaint system or through data tracking, the state brings together the involved parties to listen work toward problem resolution.

Because of this focus on coordination of care in NorthSTAR and due to the private enterprise nature of the model, the system is in a much better position to be innovative than other areas of the state. The private nature of the contracts between the BHO and providers allows for new care-delivery alternatives to be designed and tested. In other parts of the state such innovation is hampered by the bureaucratic process. Similarly, data driven policy changes can occur more quickly. Examples of these successes in the NorthSTAR system are the 23-hour observation unit policy change, which led to the decrease in unnecessary inpatient hospitalizations, and the design and implementation of ambulatory (outpatient) detoxification services. As a result of these innovations, the

program evolves and becomes more efficient much more quickly than in the traditional system.

Initially, it seemed as though DANSA in its role as LA may not have been very effective. This has been due to the fact that they are not responsible for the BHO contract, but rather have focused on complaint resolution and their ombudsman function. However, under new leadership, it does appear that DANSA is beginning to gain footing. There is evidence that they are much more involved in the strategizing, planning, and developing necessary to continue NorthSTAR's positive movement forward. Additionally, they are much more involved in data analysis and policy development, along with state staff and VO staff.

Data Capabilities

Unlike all other areas of the state, NorthSTAR has developed a data warehouse with decision support software, which it uses to evaluate and manage the NorthSTAR system of care. With enrollment data, encounter data, cost data, and assessment data, the NorthSTAR data warehouse has the ability to monitor and evaluate the program on both individual and aggregate levels.

Although the data warehouse continues to mature in its ability to produce evaluation data, the staff have focused their efforts on the development of data to enhance program management and accountability capabilities. This data production and accountability mechanism has been vital to NorthSTAR's success as they have continued to encounter, although much less as time passes, resistance to change away from the traditional system. With the data they can show unequivocally to administrators and legislators and other stakeholders the successes of an open, competitive system.

Enforced Efficiency

The direct service claims target (DSCT) is one of NorthSTAR's innovative and unique features. By limiting the percentage of funds that the BHO may use for administration and profit, the state has guaranteed that most program funds will be spent on direct care for program participants.

Based on interviews with observers of public behavioral health services in Texas, this is an improvement over the traditional system of care. In the traditional system, MHMR centers are paid prospectively and determine how to divide funds between administration and direct care. Those who have examined how much MHMR centers spend on administration observe that it is difficult to determine. Though it is unknown whether more or less is spent on administration in NorthSTAR in comparison with the traditional model, in NorthSTAR, at least, the state can track how much is spent on direct care and respond accordingly if it does not meet the standard. The NorthSTAR system thus forces efficiency both at the BHO level and at the provider level.

A common criticism of NorthSTAR has been that they have had to occasionally modify utilization management criteria or limit eligibility criteria over the course of the program.

The fact that most centers under the traditional model make such alterations at any point without any real accounting for it or tracking of it aside, NorthSTAR has modified eligibility criteria one time and has thoughtfully modified UM practices according to inappropriate usage of various service elements by providers. To be fair, high spending in a given area is certainly what may draw attention to a service category, such as inpatient hospitalization and rehabilitation services, but it is also fair to say they these are commonly found to be the billing areas in which some providers tend to take a broad interpretation of service definition.

Substantive Separation of Authority and Provider Functions

The state has had several task forces study the issue of mental health provider and authority roles. Findings in all cases have illuminated the concerns regarding the continued practice of dual provider/authority roles for CMHMRCs. The primary goal behind HB 2377 was to effect a separation of the roles/functions, and the Benefit Redesign stresses the importance of separation as well, but leaves the decision up to the LBHA.

NorthSTAR is the first program to completely separate the authority from the provider. Though DANSA as an independent authority may not yet have reached its full potential, the creation of an independent authority is a positive step. The role of a local behavioral health authority is to monitor need for services, plan accordingly, oversee the delivery of services, and serve as an advocate for the consumer in the system. In the traditional system, with the authority and the provider functions combined, the CMHMRC must perform both as its own monitor and as the consumers' advocate. Additionally, the CMHMRC is in the dual role of budgeting and administering funds and developing plans of care for consumers as a provider.

Thus, when the authority and the provider functions are combined, neither consumers' best interests nor the state's financial interests are guaranteed. By separating the authority and provider functions in NorthSTAR, the state has created an entity that can independently represent the consumers in the system. The BHO can separately concern itself with fiscal stability.

Finally, it should be noted again that authority/provider separation is so far an issue only in the mental health system. In the traditional chemical dependency treatment system, TCADA is the state authority and the idea of a local authority did not previously exist. Thus NorthSTAR represents an innovative systems change, allowing for more local involvement/input, within the TCADA service system.

Continuity of Care

There are important benefits to having an integrated service system which do not directly affect the access, quality, or cost of the current Medicaid program but which have important ramifications for services to the Medicaid population in the long run. One example of this is the continuity of care made possible by serving Medicaid and state indigent patients in a single model. One of the more significant achievements of

NorthSTAR is this assurance of continuity of care for individuals moving on and/or off Medicaid. Because services are guaranteed to individuals up to 200 percent of poverty, as long as an individual meets priority population criteria, he or she will continue to be served. Should the individual be receiving services under the more lenient Medicaid criteria (but not meet priority population criteria) and then lose coverage, the consumer's current treatment plan will be carried out.

Continuity of care is also key to the success of those with a dual diagnosis of chemical dependency and mental illness. Because the model involves blended funding between TCADA and TDMHMR resources, dually diagnosed consumers no longer have to seek care with separate providers, but rather may obtain services in one system in a seamless manner.

Quality of Care

Another important achievement of the NorthSTAR model is its effect on quality of care. NorthSTAR has positively impacted quality of care in a number of areas (described briefly below): 1) redirecting services from inpatient hospitalization to more appropriate levels of care; 2) increasing use of New Gen medications; 3) mild improvement in recidivism and follow-up from hospitalization; and 5) maintaining or improving consumer and provider satisfaction with quality of care.

Recent analysis of NorthSTAR data shows that NorthSTAR has steered utilization away from inpatient and residential services toward outpatient and community-based services. Specifically, data demonstrated increases in best practice services such as rehabilitation and Assertive Community Treatment (ACT) services.

NorthSTAR has effectively implemented a 23-hour observation unit, which appears to be successfully diverting consumers from intensive levels of services such as in-patient care, and helping to ensure that they receive the most appropriate level of care. This limited-entry mechanism effectively prevents unnecessary inpatient hospitalizations by providers unable or unwilling to carefully examine consumers. The 23-hour observation unit, by limiting crisis evaluation locations, also creates continuity in the system in that having a limited entry point allows staff to get to know consumers who are more difficult to treat (and prevents duplication of care).

Service utilization trends in NorthSTAR are making positive strides. During the life of NorthSTAR utilization of prescription medications has increased. In particular, new generation medications as a percentage of total prescriptions has increased. Hospital recidivism has trended down slightly over the life of NorthSTAR. Follow-up within 30 days of discharge from a hospital, ER, or observation unit has improved over the life of NorthSTAR, although it remains at a less than desirable level. NorthSTAR staff are studying this area further to determine how to effect improvement in this area.

These positive utilization trends include the dually diagnosed. While currently outcomes are holding steady with pre-NorthSTAR findings, more individuals with dual diagnosis are being identified and served in the NorthSTAR system and residential lengths of stay

have been substantially reduced. The state NorthSTAR staff are currently studying the issues surrounding outcomes for individuals with chemical dependency as well as “readiness” for service.

Despite much opposition initially, NorthSTAR has maintained or improved both consumer and provider satisfaction with quality of care.

Chapter 5. Expanding NorthSTAR?

Over time, resistance to NorthSTAR has diminished and the program has gained many supporters among advocacy groups, consumers, providers, and policymakers alike. This is because the program has been successful in serving more consumers for the same amount of money and without a decline in the quality of care. As state policymakers struggle with how to maintain public services with diminishing funds, attention to NorthSTAR has increased and the possibility of expanding it to other parts of the state has been considered.

Summary of Assessment

The LBJ School research team believes NorthSTAR to be a replicable model. Several aspects of NorthSTAR make it a desired and expandable model. To begin with the program has increased access while achieving a cost-savings and at least maintaining quality. The program's data warehouse allows administrators to track service trends, to monitor quality, to track costs, and to provide accountability. The program's design juxtaposes an administrator whose goal it is to save money (the BHO) with a network of providers who are paid on a fee-for-service basis for the most part, thus helping to ensure that consumers receive the right care at the right time.

Most importantly, the program guarantees access to care for not only Medicaid eligibles but also medically indigent individuals using the same amount of funding as in the traditional system. And, in the NorthSTAR system, not only does a consumer have guaranteed access to care, but they can choose who they will receive the care from, thus increasing the likelihood of a positive care outcome.

There are important considerations for the state as they deliberate the possible expansion of NorthSTAR. The first issue to keep in mind is that while many of the features included in the NorthSTAR model can be considered for implementation separately, doing so may have significant ramifications. Depending on the local environment to which the model is expanded, the state may wish to include some but not necessarily all of the original features. The model does allow for some flexibility, some individual difference within a region, while still maintaining a consistent statewide framework. But, the state should keep in mind that each of the key features of the NorthSTAR model (at-risk, carve-out, integrated, and blended-funding) not only has individual value, but their combination results in added strengths not available otherwise. As the state of Texas evaluates its policy decisions for the future of NorthSTAR and similar models, the benefits of this combination of features in a single system should be taken into account.

These key features include the following:

- It is an **at-risk model**, applying managed care principles to the delivery of public behavioral health services.
- It is a **regional model** that consolidates the service delivery network of not only multiple counties, but also the service delivery areas of multiple community MHMR centers in the traditional mental health system.
- It is an **authority-provider-administrator separation model** that designates the traditional community MHMR centers as providers by shifting the authority role to a separate entity, Dallas Area NorthSTAR Authority (DANSA), created for NorthSTAR. A Behavioral Health Organization, Value Options, administers the program.
- It is also an **inclusive model**, with regard to clientele, in putting Medicaid and non-Medicaid indigent behavioral health clients under a single system, and guaranteeing services to both populations
- It is a **carved-out model**, under Medicaid, from physical health services in that the managed care plans for physical health and for behavioral health are completely separate in the NorthSTAR area.
- It is an **integrated model**, with regard to behavioral health services, in combining the funding streams and administrative mechanisms for mental health and chemical dependency programs.

Other considerations for expansion include: 1) the financing structure of the model; 2) the local infrastructure; 3) transition support for CMHMRCs, 4) the policy and political environment, 5) and urban versus rural applicability.

Financing Structure

Financial structure is an important consideration for the at-risk model to be viable. The following issues should be noted.

Per-member-per-month (PMPM) rate set by the State

The PMPM must not be less than a pre-determined amount - no less proportionally than it is in the current NorthSTAR system. The State must determine the minimum amount that makes the system viable. In the current NorthSTAR system, providers continue to be dissatisfied with rates of reimbursement, and the remaining BHO, ValueOptions, has made a marginal or minimal profits. ValueOptions has threatened to withdraw from the program if funds for the program are cut. In some cases, inadequate funding has resulted in the inability to attract/retain providers. Additionally, funding limitations have led the BHO to place tighter access restrictions on some services.

The state should pre-determine what is the appropriate medical loss ratio (MLR), how much must be spent on administration to be viable, to ensure longevity of the BHO. The

HHSC Managed Behavioral Health Comparison study suggests that possibly an MLR of 85 percent or greater may be too high to allow BHO viability.³⁷ The current direct service claims target (DSCT) for NorthSTAR is 86 percent, although HHSC reported that in FY 2001, their MLR was actually 97 percent. Magellan, the other NorthSTAR BHO (who withdrew from the program), had an MLR of 90 percent, which proved too low for viability. While the program results in savings, the high MLR could make it difficult to sustain the program in the long run.

The state should also determine the appropriate payment amounts required to keep/increase providers in the system for the given area. Although it is not unusual for providers in any managed care system to complain about inadequate reimbursement rates, and NorthSTAR is no exception, an admirable number of providers has been maintained in the NorthSTAR system; thus serving to better ensure access and choice. *Provider numbers/availability do however vary in rural areas, and their representation in those areas is not always sufficient.* Furthermore, it has been suggested that the system has proportionally fewer chemical dependency providers (and more turnover of these providers) and that this is related to reimbursement.

State oversight and administrative cost

The state should determine whether or not the current NorthSTAR Office at TDMHMR can take on the necessary oversight role for an expansion program in order to attain economies of scale at the state administrative level, or whether more of the program oversight can be transferred to the LBHA.

State hospital bed dollars

The financial relationship between the BHO(s) and the State Hospital system should be examined prior to an expansion to determine the potential benefit of a hospital system based on fee-for-service, versus the current (traditional) pre-payment system in which a set number of bed days are “banked” at the state hospital. A thorough examination should be conducted regarding the cost-benefit of a system that provides funding directly to the BHO to be used to provide the most appropriate, least restrictive service for the client, either in the community, or as needed, in the state hospital.

Local government contributions

Within the traditional mental health system, there is an expectation of local contribution but no concrete rules on the form of local resources. As a result, some counties allocate revenues for their mental health centers while others provide informal resources in kind. Expansion of NorthSTAR, especially if it includes services by multiple community centers, should take into account the equitable contribution of resources from counties. NorthSTAR uses a system for allocating local contribution that takes into account both local per capita income and amount of NorthSTAR funds expended, but the formula itself does not obligate the local jurisdictions to contributions in cash.

There is also the potential for “moral hazard”- existing local resource contributions, either in the form of funds or existing services, might be withdrawn once an area is included in a model such as NorthSTAR. Careful planning and negotiations should be conducted with the local jurisdictions regarding the maintenance of such resources.

Overall behavioral health funding

The state should determine whether or not funds from mental health and chemical dependency should be integrated in the expansion area. If funds are to be integrated, the fair allocation of funds from the mental health side and from the chemical dependency side should be worked out.

Local Organizational Infrastructure

How the infrastructure at the local level is designed will depend on which of the original six NorthSTAR features the State wishes to include in the expansion model.

Local behavioral health authority (LBHA)

The design of the current NorthSTAR program designates the CMHMRCs the role of provider. DANSA was created as a new local entity, the LBHA.

In the initial two to three year period of NorthSTAR, DANSA appeared to suffer from organizational instability and lack of a clear identity. For a time there appeared to be mismatches in expectations and in role definitions between the NorthSTAR state office and DANSA. As a result, DANSA did not realize its full potential for monitoring service quality and strategic planning. Organizational relationships and clarity in roles are important to the health of the entire program. Interviews and focus groups by the LBJ research team indicated that providers and consumers have been unclear about the functions and authority of DANSA.

For the past year, DANSA, under new leadership, has a clearer vision of its roles, expectations, and potential. Since that time, communication channels from and to DANSA are much improved and DANSA appears to be making very positive strides in its relationship with ValueOptions, providers, advocates, and consumers alike. Using these newly strengthened relationships, DANSA is beginning to truly fulfill its role as planner, monitor, etc.

The independent LBHA is a valuable concept. It provides a mechanism for individual county buy-in through appointment of board members. It also clearly dissects the role of provider from authority. That being said, this arrangement did encounter some difficulties. It is important for the state in pursuing an expansion to fully evaluate this structure. Should the independent LBHA be continued, and we feel it should, then the state should learn from the DANSA experience and be clear and purposeful in its planning and implementation with future like bodies. It is a legitimate issue however for the state to consider whether one of the CMHMRCs at an expansion site could effectively serve as LBHA (but not also as provider).

Behavioral health organizations

One of the NorthSTAR waiver requirements was to have two BHOs (choice for the consumer), however only one remains; thus begging the question can the market support more than one BHO?

With only one BHO, NorthSTAR is left in a precarious position should the one decide to pull out of the program. Additionally, as the only BHO in the system, Value Options is in a very comfortable negotiating position. The state should determine whether or not one BHO enough. Additionally, to expand NorthSTAR to another geographic area would require a commitment on the part of a BHO, either ValueOptions branching out or solicitation of other BHOs. The state should determine what would be required on the part of the BHO to “ramp up” and what could the state do to assist. The state should also determine the relationship between the scale of expansion and the viability of adding new BHOs to introduce competition at that level. If the addition of BHO is deemed viable, requirements should also be put in place for any new or expanding BHO regarding financial stability, in order to prevent a subsequent withdrawal that might disrupt services.

Service network

A viable managed care behavioral health program requires an adequate provider network to ensure choice and access. Adequacy is difficult to determine. The state should put its energies into network solutions that are viable, instead of setting unrealistic targets based on numbers. The state should build on the NorthSTAR practice of setting up “clinic days” for psychiatrists, or other professionals, in remote locations. Additionally, the Texas Legislature has recently approved Senate Bill 691 to make telemedicine services reimbursable in the State’s Medicaid program. DANSA has also started to build the infrastructure for such services within NorthSTAR. Telemedicine is an important strategy for addressing issues of service access, and this practice should also be built upon.

Although in general outpatient services are less expensive and more flexible, the program should not be driven entirely by a desire to avoid inpatient and residential services. There have been references by both providers and consumers in the NorthSTAR SDA to the lack of appropriate residential services in two areas: for children and for consumers with chemical dependency. In planning an expansion, the state should not ignore the continuing need for appropriate inpatient or residential care, but should include adequate numbers of such providers within the network.

NorthSTAR learned the hard way that a “front gate” was required for hospitalization and thus developed a 23-hour observation mechanism in the program. The state should examine this issue closely and be proactive in its future planning regarding the use of an observation unit, a limited entry point, in this part of the service network.

In the current NorthSTAR system, the LBHA, DANSA, is responsible for fulfilling the single portal authority (SPA) role. The way in which this function is carried out differs from county to county within the NorthSTAR SDA. For a potential expansion site, the

state should consider whether this is the most effective SPA structure, and whether or not a more consistent (from county to county) structure can be implemented.

The current BHO is responsible for providing access to crisis behavioral health services 24 hours a day, seven days a week. As a means of achieving this end, ValueOptions has developed a mobile crisis unit to respond by telephone or in person to assist in emergencies. The state should determine the effectiveness of this program and whether or not it is the best alternative for crisis care.

CMHMRC Transition Support

Whether the decision is to designate the local CMHC the authority role or the provider role, it seems appropriate to provide the local center with transitional support so the center can get used to the new role. The experience with NorthSTAR indicates that the local centers are capable of adjusting, but the extent of transition support may determine the ease of adjustment. With lessons learned from the previous NorthSTAR roll-out, the state should determine what support, training, and possibly funding are necessary for the smoothest possible transition. To the extent possible, the input and assistance of NorthSTAR CMHMRCs should be sought in determining areas where support and training are needed.

Another consideration for making an expansion transition possible is the need to learn from the experience of the NorthSTAR state staff. The LBJ research team has recommended to the state that it more purposefully document information related to the program, its components, its development, its functions, etc. Much of the documentation regarding its information-tracking systems, for example, remains informal and incomplete.

The NorthSTAR staff are enthusiastic about the program and have rich and intimate knowledge of how all its elements work, but they have not had the time or resources to take a step back to document them carefully. This makes it difficult for outsiders or future staff members to gain comprehensive knowledge of all the details of the program, whether it is the codification of variables in the data warehouse, the responsibility of specific program officials, or the methodology on which capitation rates are estimated.

This reliance on informal communication and personal knowledge may be adequate for the initial stage of operation. If NorthSTAR is to be continued or expanded in the future, however, it is advisable to have more formal documentation to ensure program continuity.

Policy and Political Environment

Concurrent changes in Medicaid policy may affect the viability of any expansion program. One example would be the possible changes in extended Medicaid eligibility (6 months to 12 months; or 6 months to less), which will affect the ultimate funding source of the program. The state should be aware of any similar potential negative policy implications when planning an expansion.

The NorthSTAR area includes many advocacy organizations that were supportive of the program in the beginning, and remain so today, and have played a role in the program's success. This may not be the case in all areas of the state. Conversely, most of the local mental health centers were opposed to the NorthSTAR concept and created obstacles to the program. While the state cannot easily affect the opinions of local groups, it should be aware of the local political climate and plan accordingly.

Urban versus Rural Applicability

The original NorthSTAR program includes the regional model feature that combines the urban Dallas County with some surrounding rural counties. While the regional model allows consumers from rural locations to travel to the urban areas, and more importantly, providers to the rural locations, including rural locations in an expansion is not crucial to the model. The state may wish to consider whether the regional feature is needed for expansion.

To the extent that the expansion site includes the service delivery area of more than one local CMHC, consideration should be given to expansion site boundaries which are coterminous with the service delivery area of the CMHC. This will avoid splitting the service structure of the local center, and avoid some confusion on the part of consumers.

Chapter 6. Conclusion

The Benefit Design team report on disease management believes that for the state to maximize outcomes and efficiencies, “fundamental changes must be made to the current structural, financing, and organizational framework.” The Benefit Design team states aptly that the current system data indicate that current services are not clinically effective or cost-effective.³⁸

NorthSTAR is an innovative model for the delivery of public behavioral health services. Conceptually, this model is an improvement over the traditional service delivery model. As reported and discussed in the LBJ School Independent Assessment of NorthSTAR and in a recent related Professional Report, NorthSTAR has outperformed the traditional model in terms of access to care, quality of care and cost-effectiveness. Unlike other models currently under evaluation in the state, NorthSTAR has an unprecedented capability to justify its existence (and expansion) through its data warehouse. NorthSTAR has been a proven success at increasing access to care, achieving a cost-savings, and at least maintaining, if not increasing, quality of care.

Competition offered through the NorthSTAR model can lead to increased efficiency and thus cost-savings, increased access through increased choice, better quality of care, and increased numbers of consumers served throughout the state. The NorthSTAR model can allow for needed state uniformity in structure and function, but due to the at-risk nature of the model, can allow for regional difference through the development of the provider network.

The state should consider expanding NorthSTAR to other, if not all locations in the state. Expansion should at least occur in other Medicaid managed care areas of the state. Managed care concepts and practices are already underway in these areas and thus the transition would not be as difficult. HHSC noted that in most of the non-NorthSTAR managed care areas, the HMO is not directly managing behavioral health care and that behavioral health as a proportion of the total Medicaid dollars spent by the HMOs is small. Thus, behavioral health services in many cases are receiving inadequate attention.

Notes

¹ Texas Department of Mental Health and Mental Retardation, *Disease Management Through Benefit Design*. June 26, 2003. Online. Available: <http://www.mhmr.state.tx.us/centraloffice/behavioralhealthservices/DiseaseManagementThroughBenefitDesign.pdf>. Accessed: July 31, 2003.

² Texas Department of Mental Health and Mental Retardation. Strategic Plan, Fiscal Years 2003-2007. Online. Available: <http://www.mhmr.state.tx.us/centraloffice/programstatisticsplanning/SP03-07final.pdf>. Accessed: July 31, 2003.

³ Lyndon Baines Johnson School of Public Affairs, Texas NorthSTAR Behavioral Health Managed Care Model: An Independent Assessment of the Medicaid Component. Policy Research Project Series (Austin, TX June 2003).

⁴ Sarah M. Stout, "Improving Public Behavioral Health Services in Texas: An Evaluation of NorthSTAR" (Professional Report, Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, 2003).

⁵ Health and Human Service Commission, *Medicaid Managed Care Review, Chapter 3: Medicaid Managed Care History in Texas*. Online. Available: http://www.hhsc.state.tx.us/medicaid/MMCR_Main/MMCR_PDF_frontpage.htm. Accessed: April 2003.

⁶ The seven counties are Dallas, Collins, Ellis, Hunt, Kaufman, Navarro, and Rockwall.

⁷ There are two exceptions: 1) the BHO is not at-risk for medications; 2) state hospital inpatient stays are paid for through the portion of the state hospital budget allotted to ValueOptions--unless more days are used than are funded for, at which point ValueOptions has to pay for the additional beds at a premium rate

⁸ ValueOptions, *NorthSTAR Provider Manual*. Online. Available: www.valueoptions.com/provider/northstar/northstar_provider_manual_2002.pdf. Accessed: February 2003.

⁹ ValueOptions is a privately-held, for-profit behavioral health organization. As of 2002, the company had around 900 private sector clients and 32 public sector clients. The company's headquarters are in Virginia and the NorthSTAR contract is managed from an office in Dallas.

¹⁰ During the first eight months of Medicaid operation, NorthSTAR included two competing behavioral health organizations, ValueOptions and Magellan. Magellan withdrew from the program on September 30, 2000.

¹¹ The 11 SPNs participating in NorthSTAR are:

- Dallas MetroCare (*formerly known as Dallas County MHMR*)
- Lakes Regional MHMR. (www.lrmhmrc.org/)
- Hunt County MHMR. (www.hcmhmr.com/)

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- LifePath Systems (*Collin County MHMR*). (www.mhmr.state.tx.us/CentralOffice/PublicInformationOffice/DirectoryOfServicesLP.html)
 - Johnson-Ellis-Navarro MHMR. (www.jenmhmr.com/)
 - ABC Behavioral Health
 - Adapt (www.adaptusa.com/www/adaptnof4.nsf/htmlmedia/adapt_of_texas.html)
 - Dallas Behavioral Health Network
 - Lifenet (lhpres.org/features/lifenet/lifenet.htm)
 - Telecare – operates the mobile crisis unit. (<http://willow.he.net/~telecare/index.html>)
 - Youth Advocate Program

¹² According to NorthSTAR officials, prior to the use of the 23-hour observation unit, there was a tendency on the part of local hospitals to send consumers they could not effectively treat to the state hospitals without an adequate attempt at diversion.

¹³ The priority population includes adults with a diagnosis of schizophrenia, bi-polar disorder, or major depression or has a GAF of 50 or less; also included are children under 4 years of age with a DSM IV Axis I diagnosis other than substance abuse, mental retardation, autism, or pervasive developmental disorder, between 4 and 6 years of age with the same diagnosis but at-risk of removal from child care environment, and between 7 and 18 with the same diagnosis and SED.

¹⁴ Adults with a substance abuse diagnosis are eligible for outpatient services only.

¹⁵ Medicaid recipients excluded from NorthSTAR are: individuals in intermediate care facilities for the mentally retarded (ICF-MR), individuals in nursing homes, adults in IMD inpatient beds and children in the state foster care system.

¹⁶ Texas State Historical Association. *The Handbook of Texas Online*, Online. Available: <http://www.tsha.utexas.edu/handbook/online/articles/view/TT/mctvf.html>. Accessed: July 31, 2003.

¹⁷ Texas Department of Mental Health and Mental Retardation. *About TXMHMR*. Online. Available: <http://www.mhmr.state.tx.us/CentralOffice/PublicInformationOffice/AboutTXMHMR.html>. Accessed: July 31, 2003.

¹⁸ Texas Department of Mental Health and Mental Retardation, *Disease Management Through Benefit Design*. June 26, 2003. Online. Available: <http://www.mhmr.state.tx.us/centraloffice/behavioralhealthservices/DiseaseManagementThroughBenefitDesign.pdf>. Accessed: July 31, 2003.

¹⁹ Texas Department of Mental Health and Mental Retardation. *TDMHMR Strategic Plan FY –03-07*. Online. Available: <http://www.mhmr.state.tx.us/CentralOffice/ProgramStatisticsPlanning/SP03-07final.pdf>. Accessed: July 31, 2003.

²⁰ Texas Commission on Alcohol and Drug Abuse. *Statewide Service Delivery Plan 2002*. Online. Available: http://www.tcada.state.tx.us/policy_info/DeliveryPlan0202.pdf. Accessed: August 20, 2003.

²¹ Texas Commission on Alcohol and Drug Abuse. *Agency Description*. Online. Available: <http://www.tcada.state.tx.us/mission/index.shtml>. Accessed: August 20, 2003.

²² Some experts believe that individuals have more successful outcomes when their “readiness” for intervention is high.

²³ Advisory Task Force on Authority/Provider Roles. “Re-creating TXMHMR’s Organizational System: Final Report.” Texas Department of Mental Health and Mental Retardation, Austin, Texas, January 20, 1995.

²⁴ House Bill 2377, Section 8(c).

²⁵ House Bill 2377, Section 8(c).

²⁶ Initially there were five pilot sites, two were to be regional pilots, but they failed to get organized.

²⁷ LBJ School of Public Affairs, *Community Mental Health Centers Under Managed Care: Authority or Provider?*, Policy Research Project Report, no. 128 (Austin, Tex., 1998).

²⁸ Ibid.

²⁹ Texas Department of Mental Health and Mental Retardation. *Structure and Function A Vision for the Texas Department of Mental Health and Mental Retardation’s Future Mental Health Service System A Report to the TDMHMR Board*. Online. Available: <http://www.mhmr.state.tx.us/committees/MHTaskReport.pdf>. Accessed: July 30, 2003.

³⁰ Texas Department of Mental Health and Mental Retardation. *Texas Department of Mental Health and Mental Retardation Report on Local Authorities*, January 15, 2003. Online. Available: <http://www.mhmr.state.tx.us/centraloffice/communityservices/Rider18Report.pdf>. Accessed: July 31, 2003.

³¹ Texas Department of Mental Health and Mental Retardation. *Mental Health Service System Task Force’s Report to the Board*. Online. Available: <http://www.mhmr.state.tx.us/committees/MHTaskpres.pdf>. Accessed: July 30, 2003.

³² Texas Department of Mental Health and Mental Retardation, *Disease Management Through Benefit Design*. June 26, 2003. Online. Available: <http://www.mhmr.state.tx.us/centraloffice/behavioralhealthservices/DiseaseManagementThroughBenefitDesign.pdf>. Accessed: July 31, 2003.

³³ Roll-out sites are to begin offering service packages and using UM guidelines by September 2003.

³⁴ Texas Department of Mental Health and Mental Retardation. *Benefit Design for Mental Health Services*. Online. Available: <http://www.mhmr.state.tx.us/centraloffice/behavioralhealthservices/benefitdesign.html>. Accessed: July 31, 2003.

³⁵ Texas Department of Mental Health and Mental Retardation, *Disease Management Through Benefit Design*. June 26, 2003. Online. Available: <http://www.mhmr.state.tx.us/centraloffice/behavioralhealthservices/DiseaseManagementThroughBenefitDesign.pdf>. Accessed: July 31, 2003.

³⁶ Lyndon Baines Johnson School of Public Affairs, Texas NorthSTAR Behavioral Health Managed Care Model: An Independent Assessment of the Medicaid Component. Policy Research Project Series (Austin, TX June 2003). Sarah M. Stout, "Improving Public Behavioral Health Services in Texas: An Evaluation of NorthSTAR" (Professional Report, Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, 2003).

³⁷ It should be noted that, with the exception of NorthSTAR, the medical loss ratios studied in the HHSC report were self report from the health plans. Data were not available to allow standardized calculation of the MLRs by the state.

³⁸ Texas Department of Mental Health and Mental Retardation, *Disease Management Through Benefit Design*. June 26, 2003. Online. Available: <http://www.mhmr.state.tx.us/centraloffice/behavioralhealthservices/DiseaseManagementThroughBenefitDesign.pdf>. Accessed: July 31, 2003.