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State of Texas Health and Human Services Commission Department of State Health Services

Analysis of the Texas Public Behavioral Health System:
Recommendations for System Redesign

Presented by PCG
With Assistance from: DMA Health Strategies and Civic Initiatives



148 State Street, Tenth Floor, Boston, Massachusetts 02109
Tel. (617) 426-2026, Fax. (617) 426-4632
www.publicconsultinggroup.com



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I. EXECUTIVE SUMMARY

In May 2011, the Texas Health and Human Services Commission (HHSC) issued Work Request #2011-DSHS-002 under Solicitation No. 529-11-0009 and engaged Public Consulting Group (PCG) to undertake a comprehensive evaluation of the state's public behavioral health system. Specifically, the Behavioral Health System Analysis was to consider those services funded and/or managed through DSHS and HHSC, and provided through the 37 Local Mental Health Authorities (LMHAs), the NorthSTAR program, substance abuse prevention and treatment providers, state psychiatric hospitals, the Medicaid fee for service and managed care programs, and the CHIP program.

The basis for the Behavioral Health System Analysis can be found in House Bill 1 of the Texas 82nd legislative session, which appropriates funding to state agencies for the FY 2012-13 Biennium. Rider 71 of the appropriations bill directs DSHS to contract with an independent entity "to review the state's public mental health system and make recommendations to improve access, service utilization, patient outcomes, and system efficiencies."

PCG conducted the review in two distinct phases:

- Phase I included the documentation and review of the state's public behavioral health system as it currently exists; and
- Phase II included the development of recommendations to reform the public behavioral health system with consideration for federal health care reform efforts under the Affordable Care Act (ACA), in the event it is not repealed.

The Phase I report, which can be found on the PCG website, was released in June 2012¹. As work on the Phase I report was concluding, PCG developed a set of initial options for system redesign which, like the Phase I report, can be found on the PCG website². Some of these options, which are reflected in the recommendations section of the final report, were presented at seven public stakeholder forums in an effort to gather feedback and input on additional options that were not previously identified. This vital feedback, along with the Phase I analysis, was considered in the development of the final set of recommendations.

The tables on the following pages present brief summaries for each of the final recommendations for system redesign, including a description of the recommendation, the goals/objectives of the recommendation, and the financial implications of the recommendation. The recommendations have been grouped into three main categories: Service and Delivery System Recommendations;

¹ The PCG Phase I Report can be found on the PCG website at:
<http://www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf>

² The Initial Options for System Redesign can be found on the PCG website at:
<http://www.publicconsultinggroup.com/client/txdshs/documents/PCG%20Draft%20Options%20for%20System%20Reform.pdf>



Governance and Oversight Recommendations; and Funding and Financing Recommendations. Comprehensive descriptions for each recommendation are provided in Sections III through V of this report. Additionally, each recommendation has been discretely numbered within each of the various recommendation groupings (i.e. Delivery System, Governance and Oversight, and Funding and Financing).

Service Delivery System Recommendations

Recommendation	Description	Goals/Objectives	Financial Implications
1) Leverage recent expansion of managed care delivery system to expand access to behavioral health care.	This recommendation proposes two approaches to expand access to services through expanded managed care efforts for behavioral health services.	See Goals/Objectives for two approaches proposed.	See Financial Implications for two proposed approaches.
1A) Expand the standalone Managed Behavioral Health Organization (BHO) service delivery model to select areas of Texas or statewide.	This first of two approaches to leveraging recent managed care expansion to expand access to behavioral health care calls for DSHS to consider expanding managed BHO system of care models to organize the delivery of mental health and substance abuse services in other areas of the state besides the Dallas region.	<ul style="list-style-type: none"> • Improved outreach and expanded access to services. • Integration of funds offers enhanced programmatic flexibility. • Enhanced care coordination. • Integration of mental health and substance abuse. • Potential for a broader provider base. • Separation of service authorization from service provision. 	Financial implications are undeterminable until a final decision on implementation is made.



Recommendation	Description	Goals/Objectives	Financial Implications
1B) Expand the use of the existing Medicaid Managed Care Organizations to manage behavioral health care.	This second of the two approaches to leveraging recent managed care expansion to expand access to behavioral health care calls for Texas to expand the use of the existing Medicaid managed care organizations to manage behavioral health care including all eligible Medicaid services.	<ul style="list-style-type: none"> • Enhanced freedom of choice for Medicaid consumers • Opportunity for Medicaid Consumers to Receive Full Continuum • Opportunities for new providers to enter the marketplace • Reduce the LMHAs responsibility for establishing provider networks. • Opportunity to pay for enhanced coordination of physical and behavioral health. 	Financial implications are undeterminable until a final decision on implementation is made.
2) Expand the use of the YES Waiver.	Texas should expand the YES waiver to provide more flexible and effective treatment options to children and youth with serious emotional disturbances.	<ul style="list-style-type: none"> • Avoidance of out-of-home placement for children and youth. • Serve children that need services but are not receiving them. 	Expected to be budget neutral with the possibility of cost savings for the state.



Recommendation	Description	Goals/Objectives	Financial Implications
3) Investigate options to pilot an integrated, specialty health plan for adults with Severe and Persistent Mental Illness (SPMI) and/or children with Severe Emotional Disturbances (SED).	Texas should establish a pilot program to create a specialty health plan for the severely and persistently mentally ill or the severe emotional disturbances population that would integrate both physical and behavioral healthcare for Medicaid eligible individuals.	<ul style="list-style-type: none"> • Increased focus on overall health and wellness of individuals. • Comprehensive care coordination. • Incentives for early identification and prevention. • Specialized approaches and proven practices. • Increased funding flexibility afforded under a capitated model. • Ability to develop targeted performance incentives focused on outcomes. • Separation of service authorization from service provision. 	Financial implications are undeterminable until a final decision on implementation is made.



Recommendation	Description	Goals/Objectives	Financial Implications
4) Address the shortage of inpatient beds in the DSHS system through building upon efforts to privatize state hospitals and leveraging local inpatient resources.	There is currently a shortage of inpatient beds in the state mental health system and the demand is expected to increase as a result of recent court rulings. To address this shortage of inpatient beds, DSHS should look to continue current practices of purchasing inpatient beds at local/regional hospitals through the LMHAs and explore options for privatizing existing state hospitals.	<ul style="list-style-type: none"> Increased inpatient bed capacity in the state mental health system. 	Minimum investment of \$ 21.9 million over two years for the purchase of local/regional bed capacity. Investment may be offset by savings from privatization of existing state hospital facilities.

Governance and Oversight Recommendations

Recommendation	Description	Goals/Objectives	Financial Implications
1) Develop a public reporting process on the performance of Local Mental Health Authorities (LMHAs) and contracted DSHS substance abuse providers.	DSHS currently collects a significant amount of data and generates quarterly reports on the performance of mental health and substance abuse contractors; however, little of this information is made available to the public. It is recommended that DSHS develop a transparent and public reporting process to include performance measurements for mental health and substance abuse contractors.	<ul style="list-style-type: none"> Increased transparency. Enhanced provider accountability for the quality of services provided. 	Minimum investment of \$160,000 for one FTE at DSHS and for website design and development.



Recommendation	Description	Goals/Objectives	Financial Implications
2) Develop consistent rules for the supervision of advanced practice registered nurses (APRNs) statewide	Texas is one of only 15 states with delegated prescriptive authority for APRNs and one of only 4 with site based supervision requirements. This recommendation calls for Texas to develop consistent supervision requirements across all sites of practice.	<ul style="list-style-type: none"> • Create uniform supervision standards for APRNs across the state. • Address workforce shortage concerns by allowing APRNs to practice consistently within their scope in all areas of the state. 	Expected to be budget neutral.

Funding and Financing Recommendations

Recommendation	Description	Goals/Objectives	Financial Implications
1) Effectively leverage funding opportunities under the 1115 Demonstration Waiver through proper oversight.	The 1115 Demonstration Waiver offers an opportunity for additional Federal funding for delivery system reform incentive payment (DSRIP) projects. Through proper oversight, including the development and communication of the main objectives of the Department, DSHS can ensure that DSRIP projects are pursued consistent with DSHS goals.	<ul style="list-style-type: none"> • Ensure funding from DSRIP projects are appropriately invested to carry out DSHS goals and objectives. • Ensure funding is directed to needed behavioral health programs and services. 	The 1115 waiver presents an opportunity for significant additional funds to be available for the system. A small risk to consider is that any state general revenue invested in a DSRIP project that is not successful may be lost from the system.



Recommendation	Description	Goals/Objectives	Financial Implications
2) Increase funding for targeted programs and services to address specific system needs.	Texas historically ranks at the bottom of national rankings on spending on mental health and substance abuse services. As a result many programs and services are restricted, resulting in individuals seeking services in higher cost settings. This recommendation calls for the Texas Legislature to identify and provide additional funding for specific public behavioral health programs and services.	<ul style="list-style-type: none"> • Provide funding for a system that has historically been underfunded. • Additional funding can be directed towards those programs and services most critical to address specific system needs. 	Minimum investment of \$81.4 million annually.
3) Develop a 1915(i) State Plan Amendment for wraparound services like Supported Housing and Supported Employment.	The 1915(i) state plan option allows states to cover traditional home and community based services (HCBS) waiver services as well as an array of other services like supported housing and supported employment under a Medicaid State Plan Amendment (SPA). This would allow Texas to receive Federal matching funds for services that have historically been funded with state and local funds.	<ul style="list-style-type: none"> • Provide important wraparound services that promote recovery for individuals with mental illness. • Potential to reduce the state expenditure for 1915(i) services by claiming Federal funding. 	Budget neutrality with the potential for cost savings to the state. A significant rise in the utilization of covered services would increase the potential for increased state expenditures.



Recommendation	Description	Goals/Objectives	Financial Implications
4) Reinstate funding for Graduate Medical Education (GME) programs.	Texas has reduced funding for GME programs over the last decade, resulting in cuts in the number of opportunities for residents to train in Texas and in the incentives, like tuition repayment programs, used to attract providers to practice in Texas. This recommendation calls for funding for GME programs to be reinstated with a focus on developing additional providers for specialties that are most in need and on getting providers to practice in medically underserved areas of Texas.	<ul style="list-style-type: none"> • Provide additional training opportunities for graduates of medical school and other health care professional programs. • Provide incentives like tuition repayment programs to attract providers to practice in Texas. • Develop providers to begin addressing current workforce shortages. 	Minimum investment of \$5.9 million per year.



Within the recommendations presented in the matrices above and described in detail in the following pages, there are some that may not be feasible if the state elects to proceed with one of the other recommendations. The following table identifies those recommendations, which if pursued would limit the state’s ability to implement other recommendations.

If Texas implements this recommendation ...	This recommendation may not be feasible	Reason
Expand the standalone Managed Behavioral Health Organization (BHO) service delivery model to select areas of Texas or statewide.	Expand the use of the existing Medicaid Managed Care Organizations to manage behavioral health care.	Under the BHO service delivery system, the Medicaid rehabilitation and case management services are already provided in the same fashion as all other Medicaid services so the elimination of the carve out is unnecessary.
Expand the standalone Managed Behavioral Health Organization (BHO) service delivery model to select areas of Texas or statewide.	Expand the Use of the YES Waiver	For those areas in which a BHO expansion occurs, the recommendation to expand the use of the YES Waiver does not apply as the services covered under the waiver would be brought in under the BHO.
Expand the use of the existing Medicaid Managed Care Organizations to manage behavioral health care.	Investigate options to pilot an integrated, specialty health plan for adults with Severe and Persistent Mental Illness (SPMI) and/or children with Severe Emotional Disturbances (SED).	If the state elects to pursue a comprehensive Medicaid managed care approach for all behavioral health services, the recommendation to pilot a specialty health plan for the SPMI and/or the SED populations could still be feasible if the state wants to place emphasis on the care of these populations. Given the integration of behavioral health and primary care under the Medicaid managed care entities, the goals of the recommendation for a specialty health plan may be achieved through the existing plans.

II. INTRODUCTION TO RECOMMENDATIONS FOR SYSTEM REDESIGN

The following section contains PCG's recommendations for the redesign of the Texas public behavioral health system. In developing these recommendations, PCG initially developed options for system redesign that were shared and discussed with the stakeholders during the seven public stakeholder forums held at locations across the state. The initial options for system redesign were categorized as Service Delivery System Options, Governance and Oversight Options, or Funding and Financing Options.

The following list highlights the initial options for system redesign as presented to the stakeholders:

Service Delivery System Options

- Integrate mental health and substance abuse services through the Local Mental Health Authorities (LMHAs).
- Promote evidenced based models of care across the state.
- Leverage local inpatient resources to serve acute care needs of local communities.
- Eliminate the existing carve out of the Medicaid rehabilitation and case management services for children.
- Eliminate the existing carve out of the Medicaid rehabilitation and case management services for adults and children.
- Separate the authority and provider functions of LMHAs and consolidate service delivery areas to promote greater efficiency while maintaining local control.
- Expand NorthSTAR to selected areas of Texas.
- Carve behavioral health services into Medicaid Managed Care Organization contracts.
- Develop a specialty health plan for the Severely and Persistently Mentally Ill (SPMI) population for both physical and behavioral health care.

Governance and Oversight Options

- Clearly define and more actively enforce the provider of last resort legislation.
- Consider rescinding the 1915(b) waiver submitted to Centers for Medicare and Medicaid Services (CMS).
- Explore alternative models for the management and/or operation of inpatient services.
- Expand the definition of qualified non-physician practitioners to address workforce shortages.
- Implement a comprehensive public reporting process on the performance of mental health and substance abuse contractors.
- Redesign outcome measures to align them with national best practices.
- Revise the adult Resiliency and Disease Management (RDM) service packages similar to the efforts currently underway on the Child & Adolescent RDM service packages.

- Consider and encourage collaborative efforts like the East Texas Behavioral Health Network (ETBHN) in other regions of the state.

Funding and Financing Options

- Rebase the existing allocations to align funding with current trends in population, income, and needs.
- Develop a tiered payment structure aligned with provider performance.
- Leverage opportunities presented by the Texas Healthcare Transformation and Quality Improvement 1115 waiver.
- Investigate opportunities to repurpose state hospital campuses to upgrade facilities.
- Explore the feasibility of implementing a 1915(i) Medicaid state plan option.

Following the completion of the seven public stakeholder forums, PCG reviewed the initial options in consideration of the feedback provided by the stakeholders, as well as additional analysis completed by PCG. At the conclusion of this effort, PCG developed a finalized list of recommendations that PCG determined can be feasibly implemented in the State of Texas and would have the greatest impact to the system of care. In order to provide content for the recommendations, PCG also developed both values and goals which the recommendations are intended to address in order to improve the system of care. These core values, defined below, are representative of not only the goals of the system, but also of the greatest needs in the system.

- **Funding:** A common theme identified through PCG’s analysis of the current system as well as in stakeholder feedback is the lack of funding in the public behavioral health system. Texas is frequently cited as ranking 51st in per capita funding for Mental Health services based on rankings published by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc. (NRI)³ and similar rankings published by the Center on Addiction and Substance Abuse (CASA) place Texas 37th out of 45 states in spending on substance abuse. The lack of funding for the necessary services in Texas is the underlying theme across many of the recommendations presented in this report. As one stakeholder succinctly noted in regards to the need for additional funding in the system, “A redesign of the current system is like rearranging the deck chairs on the Titanic unless the need for additional funding is addressed.”
- **Access and Quality:** A core value of any service delivery system should be providing sufficient access to quality services. The Texas behavioral health system, for a number of reasons identified in the Phase I report, is not currently providing sufficient access to those individuals in need of services. As a result, those individuals who are unable to

³ The NRI data does not include consistent data across all 51 states in regards to the state expenditures. Footnotes to the data explain that the SMHA expenditures reported vary by state with some states excluding Medicaid revenues for community programs, some states including funds for mental health services in jails or prisons, and some states excluding children’s mental health expenditures. The data reported for Texas is noted as being inclusive of funds for mental health services in jails or prisons.

obtain the necessary services in appropriate settings are instead receiving services in hospital emergency rooms or as inmates in the jails, prisons, and juvenile detention centers across the state. Further, when individuals are able to access services, they are often faced with limited options in the services they may receive and what providers they may receive those services from.

- **Transparency:** DSHS collects a great deal of data from mental health and substance abuse contractors, however this data is not often published in a manner that allows for the public to understand the overall performance of the system, as well as the relative performance of the service providers. The current lack of transparency makes it difficult to hold the system and its providers accountable when there are deficiencies in the level of care provided.
- **Integration:** Many studies have shown that individuals with mental illness are likely to have a shorter lifespan as a result of comorbid physical health conditions that often go untreated. Similarly, national data shows that approximately 25% of people with mental illness also suffer from co-occurring substance abuse disorders. In Texas, there have been some efforts on a local level to integrate primary care and mental health care and to integrate mental health and substance abuse services. These efforts have not, however, been widespread across the state nor have they been consistent across those areas that have undertaken them. It is important that Texas promote efforts to integrate care in a way that allows for the whole person to be treated for all of their conditions.

From the initial list of options presented to the stakeholders, PCG worked to develop a set of final recommendations that were based on both the analysis of the current behavioral system, as documented in the Phase I report, and the feedback of the stakeholders. Most importantly, the final recommendations were designed to address at least one of the values described above. Like the initial options, PCG grouped the final recommendations into one of three main categories as identified in the list below.

Service Delivery System Recommendations

- 1) Leverage recent expansion of managed care delivery systems to expand access to behavioral health care.
 - 1A) Expand the standalone Managed Behavioral Health Organization (BHO) service delivery model to select areas of Texas or statewide.
 - 1B) Expand the use of the existing Medicaid Managed Care Organizations to manage behavioral health care through a BHO model.
- 2) Expand the use of the YES Waiver.
- 3) Investigate options to pilot an integrated, specialty health plan for adults with Severe and Persistent Mental Illness (SPMI) and/or children with Severe Emotional Disturbances (SED).



- 4) Address the shortage of inpatient beds in the DSHS system through building upon efforts to privatize state hospitals and leverage local inpatient resources.

Governance and Oversight Recommendations

- 1) Develop a public reporting process on the performance of Local Mental Health Authorities (LMHAs) and contracted substance abuse providers.
- 2) Develop consistent rules for the supervision of Advanced Practice Registered Nurses (APRNs) statewide.

Funding and Financing Recommendations

- 1) Effectively leverage funding opportunities under the 1115 Demonstration Waiver through proper oversight.
- 2) Increase funding for targeted programs and services to address specific system needs.
- 3) Develop a 1915(i) State Plan Amendment for wraparound services such as supported housing and supported employment.
- 4) Reinstate funding for Graduate Medical Education (GME) programs.

Each recommendation presented in the following pages consists of a description of the recommendation, expected goals to be achieved through the recommendation, implementation considerations of the recommendation, financial implication of the recommendation, and a high level plan for implementing the recommendation. PCG is confident that these recommendations will improve access, patient outcomes, and system efficiencies.

III. SERVICE DELIVERY SYSTEM RECOMMENDATIONS

Recommendation 1) Leverage recent expansion of Managed Care delivery systems to expand access to behavioral health care.

Description of the Recommendation: Texas has recently undergone a significant transformation in the delivery of health care services to Medicaid and CHIP recipients in the form of Medicaid managed care expansion. As of March 1, 2012 and as defined in the 1115 Medicaid Transformation Waiver, the state's two primary managed care programs, STAR and STAR+PLUS, were introduced into 174 additional counties across the state. Additionally, as part of this transformation process, individuals that were previously enrolled in the Primary Care Case Management (PCCM) program were also transitioned into one of the managed care programs in order to achieve a consistent service delivery model.

Consistent with HHSC's system vision for "A customer focused health and human services system that provides high-quality, cost-effective services resulting in improved health, safety, and greater independence for Texans"⁴ and with the strategies outlined in the 1115 Medicaid transformation waiver, it is important that Texas explore alternative options for the delivery of public behavioral health services to Medicaid, CHIP, and indigent consumers. There are many approaches available to HHSC and DSHS to accomplish this goal through a managed care environment including the following:

- a. Expand the Behavioral Health Organization (BHO) service delivery model,
- b. Include all services, physical and behavioral, under existing Medicaid Managed Care Organization (MMCO) contracts,
- c. Expand the YES waiver for children and adolescents, and
- d. Develop a specialty health plan for adults with Severe and Persistent Mental Illness (SPMI) and/or children with Serious Emotional Disturbances (SED).

The expansion of the YES Waiver and the development of a specialty health plan for the SPMI and/or SED populations target specific populations and thus do not alone address the behavioral health needs of the broader population. As such, these two approaches have been defined in standalone recommendations to be presented in later sections. This recommendation focuses on the two approaches to managed care expansion that can be implemented to address the needs of all individuals in the public behavioral health system instead of target populations within the public behavioral health system. These two recommendations leverage a BHO service delivery model to coordinate and ideally integrate services in a standalone BHO or through a BHO model within existing Medicaid MCO contracts.

⁴Texas Health and Human Services System, Strategic Plan 2013-17, Volume 1. <http://www.hhs.state.tx.us/StrategicPlans/SP-2013-2017/Volume-I.pdf>



These two approaches have a number of similarities between them including requiring focused attention and management of behavioral health services; leveraging evidenced based models of care; the consolidation of acute behavioral, rehabilitative and case management services under one management entity; and the ability to provide behavioral health services to the indigent population even though there is no coverage of physical health services. However, there are also some differences, most notably the ability to integrate behavioral health care and primary health care to consumers through the implementation of a BHO model within existing Medicaid MCO contracts. Another difference is that by carving the BHO model into existing MCO contracts, the State can create and enforce statewide quality and performance standards as there would be uniformity in the service delivery model with each MCO provider having oversight over all services to their members. The measurement and enforcement of statewide standards could also be achieved through a statewide BHO carve out although there wouldn't be a single entity with oversight over all services as behavioral health services would be the responsibility of the BHO while the MCOs would be responsible for physical health services.

The decision on which of these two approaches to pursue is influenced by Texas' decision on whether to pursue Medicaid expansion as permitted under the Affordable Care Act (ACA). If Texas were to reconsider its current position and decide to pursue the Medicaid expansion, the carving in of a BHO model into existing MCO contracts becomes more attractive as the benefits of integrating behavioral health and physical health services would apply to a much larger population. If Texas continues the current path of opting not to pursue the Medicaid expansion, Texas can largely achieve the same benefits for the indigent populations under either a standalone BHO model or a BHO model within existing MCO contracts.

Approach 1A) Expand the standalone Managed Behavioral Health Organization (BHO) service delivery model to select areas of Texas or statewide

Description of the Approach: National data from the Centers for Medicare and Medicaid Services (CMS) shows that as of July 2010, seventeen state Medicaid programs used managed care organizations covering mental health and substance abuse services for approximately 4.8 million persons.⁵ This speaks to the movement and trend in which more and more States have implemented a managed care approach to providing behavioral health services. Texas has been a part of this particular movement. Since 1999, the Department of State Health Services (DSHS) has utilized a standalone managed behavioral health organization (BHO) model, formally known as NorthSTAR, to deliver behavioral health services in the Dallas region of the State, including eligible residents of Dallas, Ellis, Collin, Hunt, Navarro, Rockwall, and Kaufman counties.

Outside of the Dallas region, certain behavioral health services for Medicaid eligible consumers, with the exception of the mental health rehabilitation and case management services, are also managed and overseen by the STAR and STAR+PLUS managed care programs. These Medicaid

⁵ See, retrieved on 2-29-2012 from <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MdManCrEnrllRep.html>



managed care entities subcontract with BHOs or have an internally managed BHO-like unit that oversees and manages the behavioral health services. These Medicaid MCOs are required to provide the behavioral health services that are carved into their plans and to follow the mental health parity requirements under federal law.

The standalone BHO structure in the Dallas region is unique in that both mental health and substance abuse services are available to not only eligible Medicaid consumers, but to non-Medicaid individuals within the priority patient population as defined by DSHS policy. This is a major difference from the STAR and STAR+PLUS models as these managed care models do not include non-Medicaid eligible individuals who meet clinical and income criteria. Because DSHS is currently responsible for the funding of Medicaid and indigent priority populations, as well as federal mental health and substance abuse block grants, they were able to design and implement a standalone BHO covering the entire priority population rather than developing treatment protocols based on the individual funding strategies of the various payers.

This approach to managed care expansion recommends that DSHS consider expanding the standalone managed behavioral health organization (BHO) system of care model. The expansion would continue to organize the delivery of both mental health and substance abuse services in other areas of the state in a similar manner to the way services are managed in the Dallas region. It is an approach that could provide the greatest benefit to the state, in the event Texas does not change its stance to not implement Medicaid expansion under ACA. The NorthSTAR model has been effective in increasing access to behavioral health services to the indigent priority populations by reducing interest lists and decreasing the time it takes to be served. Specifically, the results of the prevalence analysis performed by PCG in phase one of our report demonstrated significant differences in the percentage of adults and children that receive services within the Dallas region when compared to the other LMHA service delivery systems. NorthSTAR has achieved this without a waiting list or interest list. Across the rest of the state, 9,664 adults and 281 children were either not receiving the appropriate level of care required or have no access to care⁶. In addition, these figures do not include consumers that have elected not to be put on a wait or interest list or have given up on the public behavioral health system of care out of frustration due to a lack of access to services.

Barriers to care create enormous pressures not only on the public behavioral system of care, but also on other publicly administered programs and services. There were countless discussions throughout the stakeholder sessions that a lack of access resulted in overcrowding of hospital emergency rooms, stresses to the juvenile justice and criminal justice systems, homelessness, losses in work productivity, and the list goes on and on. For example, the Harris County jail was

⁶ As of August 2011, there were 2,339 underserved adults who could not be provided with the necessary level of services required due to resource constraints and another 7,325 adults who were on wait lists and could not receive behavioral health services due to resource constraints. In addition, there were 40 underserved children who could not be provided with the necessary level of services required due to resource constraints and another 241 children who were on wait lists and could not receive behavioral health services due to resource constraints.



cited on numerous occasions as the largest inpatient mental health facility in Texas. Specifically, 2,400 of the 9,500 inmates in the Harris County jail are treated for a mental illness each month, making it the largest mental health care facility in Texas⁷. Stakeholders frequently commented that prisons and jails should not be the only option to treat individuals with mental illness or substance use disorders, particularly when they have committed only minor misdemeanors and would otherwise be served in an outpatient setting.

Across the state, the challenges in access to care will continue into the foreseeable future if, as has previously been stated, Texas does not pursue the option to expand access to Medicaid as permitted under the Affordable Care Act (ACA). Based on the March 2011 U.S. Census data, Texas has reportedly 5,591,000 individuals that are uninsured⁸. Of these individuals, it is projected that 24% or 1,341,840 individuals would have been eligible for Medicaid under the ACA expansion. In the event Texas maintains its position and does not expand Medicaid, this population will continue to seek behavioral health services through publicly available programs and services, causing continued strain not only on the public behavioral health system but also on other public systems such as jails and prisons. It is imperative that Texas consider any viable alternative delivery model that can successfully expand access to care.

In the expansion of a standalone BHO model, PCG does not encourage an immediate statewide rollout, but instead a focus on the highly populated areas of the State in which this service delivery model could be most effective and impactful. As was the case with Medicaid managed care expansion in Texas, it is recommended that an expansion of a standalone BHO model focus first on those areas that offer sufficient provider availability as well as a sufficient population for the efficiencies of a managed care model to be achieved. For example, expansion of a standalone BHO to rural areas may present operational challenges that may outweigh the potential benefits that this recommendation hopes to achieve. One obvious consequence of a staged and/or partial implementation across Texas is that it would create barriers to the creation of statewide performance and quality standards for the MCOs as it is difficult if not impossible to compare an MCO in a region with a standalone BHO to an MCO in a region where there is no separate BHO. Additionally, the expansion of a standalone BHO model would require the behavioral health services to be carved out of the current Medicaid managed care contracts, causing a possible disruption to the recent managed care expansion in Texas.

An expansion of a standalone BHO model can be implemented by a variety of organizations. These organizations could include existing Managed Behavioral Health Organizations that currently provide services in Texas, existing Medicaid managed care organizations, a coalition of existing local organizations with a governance structure that is independent of local providers, or any other qualified organization that meets the standards defined by HHSC and DSHS.

⁷ Arnold R. "Mentally Ill Crowding Jail, Courts." 2008. Available at : <http://www.click2houston.com/investigates/16364907/detail.html>.

⁸ <http://www.hhsc.state.tx.us/news/presentations/2012/071212-ACA-Presentation.pdf>



Expected Goals to be Achieved Through the Approach: Many states use standalone managed behavioral health organizations to achieve the following goals:

- 1) **Better outreach and expanded access.** BHOs are experienced in working with persons with behavioral health problems and use their expertise to implement outreach and educational programs and encourage persons that need assistance to access services. In addition, DSHS can require the BHO to ensure access to services is available to consumers by enforcing a no wait list policy, which ensures individuals will receive services and potentially reduce the number of occurrences in which consumers end up receiving services via less desirable alternatives, such as the juvenile and criminal justice systems.
- 2) **Integration of funds offers enhanced programmatic flexibility.** The funding model used with a BHO can have significant operational strengths when contrasted with the current funding model used with LMHAs. When the existing BHO in the Dallas area was established, DSHS was able to blend all existing funding sources including: Medicaid, mental health block grant funds, substance abuse block grant funds and local funds to create a single system of care. Historically, these funding streams and corresponding services operated independently with their own eligibility criteria, programs, and benefits. This required consumers to navigate different systems, especially when funding streams changed. Leveraging a blended funding stream, DSHS and the existing BHO were able to create a single, coordinated system of care. This allowed the BHO to develop streamlined agency policies and eligibility criteria, offered consumers a comprehensive benefit package, and no longer forced consumers to disrupt care when there was a change in eligibility status for programs and services. The BHO should be paid a capitation rate and have the flexibility to distribute the funding as appropriate. This funding mechanism incentivizes the BHO to ensure high quality and appropriate care is provided to consumers in an efficient fashion. Thus, for example, if the BHO achieves some economies in its operations, it can use the savings to provide more units of service or new services. This flexibility of funding has the potential of creating better health outcomes for more persons.
- 3) **Enhanced care coordination.** Since the BHOs specialize in the treatment of mental health and substance abuse they understand what services are needed in specialized situations. Care coordination for specialized problems is a familiar problem to BHOs and they have developed considerable skill at providing care coordination to ensure the appropriate level of services is authorized and more importantly that the service plan is carried out effectively. BHOs also have experience with the management of rehabilitation services and consumer directed care, two areas that are critical for Texas counties.
- 4) **Integration of substance abuse and mental health.** The integration of substance abuse and mental health is a challenge within the current system of care, outside of the existing

BHO model. PCG's previous analysis discussed the lack of integration between mental health and substance abuse delivery systems and the general shortage of substance abuse service providers. As the report described, approximately 60% of the persons with substance abuse also had received services for mental health. The integration of care across provider types varies by DSHS provider and no one reported that mental health services and substance abuse services were well integrated. Effective care integration must begin with efforts to integrate behavioral health funding and jointly manage the services. Care and outcomes can be improved with more integrated care and oversight of both mental health and substance abuse needs.

- 5) **Potential for a broader provider base.** A long-held tenet of the Medicaid program is the requirement that Medicaid provider enrollment practices should enroll "any willing provider." Currently the majority of mental health services are routed through a restricted network of approximately 37 LMHAs that may or may not subcontract out services to other providers. A broad provider base maximizes client choice and provides services in more geographical places. State contractual language with managed care plans typically contains requirements for a broad provider network and places limits on how long enrollees can travel before finding a provider. Given the parity laws, these requirements should be the same with local behavioral health networks.

Workforce issues and provider availability were frequently raised in public stakeholder meetings. In 2010, 95.83% of Texas psychiatrists enrolled as Medicaid providers are not seeing new patients.⁹ There is a possibility that a BHO can more actively recruit psychiatrists and other healthcare providers. Furthermore, BHOs have the necessary resources, expertise, and experience to develop sufficient provider networks. PCG's assessment of LMHAs is that their effectiveness in developing provider networks varied significantly while the existing BHO has been very successful in establishing an expanded provider network. Participating and enrolled providers compete with one another for market share, and in this competitive environment, enrollees are free to choose any appropriate provider for their behavioral healthcare needs.

- 6) **A managed care approach encourages the separation of authorizing the services and providing them.** Having the same entity authorize and provide services creates a potential for financial and clinical conflict of interest. Over the last ten years, national Medicaid policy has evolved with a clear trend in moving away from service delivery models that contain this conflict of interest. A recent expression of this is in CMS policy in its Balancing Incentive Program. States participating in the Balancing Incentive Program agree that they will promote "conflict-free case management."¹⁰ Texas Medicaid

⁹ Data obtained from the Texas Health and Human Services Commission staff May 2012.

¹⁰ See the CMS Balancing Incentive Application for a full discussion of conflict-free case management and why it is required federal policy in the operation of Medicaid home and community based care programs. See, retrieved on 2-

has also developed restrictions against such conflicts in its home and community based care (HCBS) policies. PCG acknowledges that this is a difficult situation for state agencies that traditionally work with the same providers year after year and rely on them to both assess the need for services and provide the services.

As noted in the PCG's first report, there is state legislation requiring existing Local Mental Health Authorities (LMHAs) to only provide services when no other providers are available. However, in practice there are multiple exceptions that enable LMHAs to avoid conflict of interest requirements. For example, referring to the language in 25 TAC §412.758, one LMHA states:¹¹

“Under the new rules and requirements, the Center can only be a provider of services if:

- There are no interested qualified providers
- There is only 1 other qualified provider
- The responding qualified providers do not propose to meet at least 100% of the DSHS contract target population or meet the same level of current access to services
- The Center must maintain some services to preserve critical infrastructure
- Existing agreements impose restrictions on the Center's ability to contract a portion of services because there would be an unsustainable loss of revenue.”¹²

The conflict of interest will continue to exist as long as providers believe that they must provide all or a majority of services directly in order to avoid an unsustainable loss of revenue.¹³

Implementation Considerations of the Approach: There are implementation considerations that DSHS must evaluate and consider prior to the implementation of this particular approach. These include the following:

- 1) **Implementation of for profit entities in an underfunded system could result in reduced services.** As documented extensively, Texas ranks at the bottom in the per capita funding of behavioral health services in the country. Stakeholders have expressed

5-2012 from <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/Final-BIPP-Application.pdf> p. 11-12.

¹¹ See discussion of this language, retrieved on 8-8-2012 from <http://texinfo.library.unt.edu/texasregister/html/2007/mar-16/PROPOSED/25.HEALTH%20SERVICES.html>

¹² See, retrieved on 8-5-2012 from <http://www.dentonmhm.org/localnetworkprov.html>

¹³ For example, see belief that 60% must be provided to avoid unsustainable loss. Retrieved on 8-10-2012 from <http://emergencehealthnetwork.org/about/center-plans/> see Local Plan and Network Development Plan p. 29 ff. Percentage of 100% can be frequently found in provider network plans. For example, see pp. 24 ff. from http://www.gulfbend.org/poc/view_doc.php?type=doc&id=22096 Retrieved on 8-10-2012 from pp. 24 ff.

concerns of allowing for profit entities to administer an already underfunded system of care. The fear is that these entities will squeeze profits out of a system that is already funding challenged. PCG recognizes this particular concern; however, our analysis revealed several factors that have been put in place by HHSC and DSHS which mitigate this potential risk. First off, the current BHO is vigorously monitored on their performance by DSHS, HHSC, and the North Texas Behavioral Health Authority (NTBHA). DSHS publishes a comprehensive data book which outlines service utilization trends, as well as publishes performance metrics. With that said, there are number of organizations that are engaged in ensuring funding is spent on services and that care is of high quality. Furthermore, the current BHO and any new BHOs engaged to administer services would be required to spend a significant portion on behavioral health services. The current BHO has consistently met and commonly exceeded this particular requirement. Finally, not all BHOs are necessarily for profit entities. A number of non-profit entities provide Medicaid managed care organizational services within the Texas Medicaid program currently. Therefore, if the BHO is properly managed, this issue should not be a real concern.

- 2) **Loss of local control.** Local control was a common strength that was communicated throughout PCG's research in nearly twenty stakeholder meetings across the State of Texas. Local control is necessary to ensure effective care and that the specific needs are addressed. This is especially true in a state the size of Texas, where demographics can vary significantly depending upon the region of the state. However, loss of local control was not evident within the Dallas region where the current BHO system of care currently exists. In fact, to protect against this particular issue a local authority, the North Texas Behavioral Health Authority (NTBHA), was established to ensure the needs of the community are considered, heard, and understood by the BHO. NTBHA is charged with planning, facilitation, and coordination of services to ensure that local communities are given a voice in the delivery of the BHO publicly funded managed behavioral healthcare. With the establishment of an effective local authority structure, TX can allow for continuation of local control and good coordination of care.
- 3) **Expansion of BHO model could hinder integration of behavioral health and primary health care.** As was described previously, outside of the NorthSTAR region, Medicaid managed care entities are responsible for the provision of the Medicaid mental health and substance abuse services in addition to their responsibility for the primary care services for their members. A move to pull the behavioral health services from the Medicaid managed care entities to a BHO would create a separation between the entity responsible for the behavioral health services and the entity responsible for the primary care services, a contradiction with federal direction towards integration as well as with HHSC's demonstration project to integrate care for dually eligible individuals.

In order to minimize the impact of this separation of responsibility between behavioral health and primary care services, HHSC and DSHS would need to build contractual requirements similar to those currently in place for ValueOptions and the Medicaid managed care entities in the NorthSTAR region. The BHOs and the Medicaid managed care entities would have contractual requirements to work in coordination to serve all of their members and the BHOs would need to establish agreements with the Medicaid managed care entities to define service provision processes and protocols. The state would also need to establish performance measures for the collaboration between the BHOs and the Medicaid managed care entities similar to those quality improvement measures in place in the NorthSTAR region to ensure kids with Medicaid receive appropriate Texas Health Step services.

- 4) **Contracting for BHOs would create additional administrative burden due to increased oversight of additional managed care entities.** An expansion of a BHO service delivery model to additional regions of the state would require additional contracting efforts beyond those currently in place for the Medicaid managed care entities. HHSC is already providing significant oversight for the Medicaid managed care entities under the STAR and STAR+PLUS programs while DSHS performs similar functions for the BHO in the Dallas region. For the current Medicaid managed care entities that are responsible for the primary care and behavioral health services, an expansion of a BHO service delivery model would require the procurement of the BHOs for the selected areas and the development of additional oversight requirements for the BHO entities.
- 5) **Separate BHO and MCO models would hinder the ability of the state to implement statewide behavioral health performance measures.** An important component of Texas' move to Medicaid managed care on a statewide basis is the state's ability to develop and implement consistent performance measures across the state. Prior to the expansion of Medicaid managed care in March 2012, HHSC faced challenges in implementing consistent performance measures as different regions of the state operated under different delivery service models. The Medicaid managed care expansion provided HHSC with a single service delivery model throughout Texas and as such, presented opportunities to develop and implement performance measures for primary care services, as well as for behavioral health services. A move to expand a BHO service delivery model to selected areas of the state would result in different behavioral health service delivery models and again present challenges to HHSC's ability to implement statewide behavioral health performance measures.
- 6) **BHO expansion would require the state to renegotiate existing managed care contracts as the behavioral health services are pulled out, creating a disruption for the newly implemented Medicaid system of care.** Expanding a standalone BHO service delivery model would result in the Medicaid behavioral health services that are



currently provided through the Medicaid managed care entities to be removed from current contracts. This change would require HHSC to renegotiate the contracts of all Medicaid managed care entities in those areas of BHO expansion. With the recent changes to the Medicaid system of care, the need to renegotiate the contracts of the Medicaid managed care entities would be viewed as a disruption to a system of care that is less than a year old.

- 7) **Texas may not be able to get a single BHO approved for a region.** The only BHO service delivery model in Texas is one in which there is a single BHO for the entire region. Given Texas’ recent experience with Medicaid managed care expansion in which CMS pushed the state to offer multiple managed care options for consumers within each region, it is reasonable to expect that an expansion of a standalone BHO service delivery model would encounter similar requirements. As a result, it is possible that CMS may require for each region to have minimally two standalone BHOs in place. The need for multiple BHOs within a region would only serve to increase some of the challenges noted previously, including additional administrative burden for oversight of multiple managed care entities and BHOs in a region and the creation of barriers to statewide behavioral health performance measures.

Financial Implications of the Approach: This approach has an undetermined fiscal impact. As shown below in the discussion of implementation, there are significant implementation alternatives. The cost and savings of the expansion cannot be estimated until the Department of State Health Services (DSHS) decides how to implement the approach. Moreover, the expansion could be implemented in a manner cost-neutral to the state. Actuarial instructions can also obtain directions to estimated potential savings that reduce the capitation rate paid prior to the start of the capitation period.

Plan for Implementing the Approach: There are a number of action steps that the implementation of an expanded BHO approach would require. These include, but are not limited to:

Action Step	Responsible Party
Outline the scope of work	HHSC and DSHS
Meet in the selected geographical regions with stakeholders and potential providers to identify issues	HHSC and DSHS
Develop the proposed approach including standards of care	HHSC and DSHS
Submit Medicaid waiver or amend current waiver and submit to CMS	HHSC and DSHS
Discuss block grant changes with SAMHSA	DSHS
Initiate statutory or administrative rule change	HHSC and DSHS
Prepare accompanying preliminary fiscal impacts	HHSC and DSHS



Action Step	Responsible Party
Prepare actuarial estimates and rates	HHSC and DSHS
Develop contract(s)	HHSC and DSHS
Draft a Request for Proposals (RFP)	HHSC and DSHS
Negotiate with proposers	HHSC and DSHS
Review documentation of proposers	HHSC and DSHS
Create or expand contract monitoring and fiscal resources	HHSC and DSHS
Initiate contract	HHSC and DSHS
Monitor BHO progress through stakeholder meetings, contract review, and encounter claims	HHSC and DSHS

Depending on the breadth of the expansion, it could take more than 18 months to hold the stakeholder meetings, issue an RFP and finalize discussions with potential contractors.

Approach 1B) Expand the use of the existing Medicaid Managed Care Organizations to manage behavioral health care

Description of the Approach: The second approach to be considered is similar to the first approach presented with some significant differences. This approach would call for the expanded use of the existing Medicaid managed care organizations to manage behavioral health care, including Medicaid mental health rehabilitation and case management services. Whereas the first approach calls for the services to be provided through a distinct contract for a standalone BHO, this approach leverages the existing contractual relationships between HHSC and the Medicaid managed care organizations under the STAR and STAR+PLUS programs. This approach is best suited to meet the demands of an expanded Medicaid population in the event Texas chooses to expand Medicaid eligibility under the ACA. Ninety percent of the non-Medicaid population that is currently served through the public behavioral health system is expected to qualify for Medicaid under the ACA. Given the vast expansion of behavioral health consumers that would qualify for Medicaid under an expansion, this approach provides a seamless transition as the existing Medicaid managed care entities would assume responsibility for these individuals with minimal administrative burdens and provides integration of behavioral and physical health services under a single management entity. If Texas continues to elect not to expand Medicaid, the existing MCOs could manage the behavioral health benefits of the indigent priority population in the same manner as a standalone BHO.

Under the current system of care in Texas, rehabilitation and case management Medicaid services are provided under a fee-for-service reimbursement model and are managed by the Department of State Health Services (DSHS). Despite HHSC’s implementation of a statewide expansion of a Medicaid managed care model in March 2012 through the Texas Healthcare Transformation and Quality Improvement Program (1115 Waiver) the Medicaid rehabilitation



and case management services remain carved out of managed care contracts. In addition to these services being outside the managed care contracts, they are also unique in that Texas restricts the pool of providers that can currently furnish these services to Medicaid eligible individuals. The currently approved Medicaid state plan for the rehabilitation services provides a clear set of criteria that must be met prior to a provider obtaining certification to provide these services. Under the current criteria, the Local Mental Health Authorities (LMHAs) have been the only providers to become approved Medicaid rehabilitation service providers. One of the reasons the provider qualifications have been designed to be restrictive to LMHAs is to ensure a level of cost control to the State of Texas. LMHAs are quasi-governmental entities that receive a significant amount of state general revenues and are trusted to ensure Medicaid rehabilitation and case management services are provided appropriately, as well as ensure spending remains within allocated budgetary constraints. Through PCG's discussions, non-LMHA providers have indicated that the application process and the provider requirements are overly onerous and often challenging for non-LMHA providers to complete. This point is made evident in that, to PCG's knowledge, only one non-LMHA provider has completed the application process. The review of their application was subsequently placed on hold by HHSC as the state awaited CMS' decision on the 1915(b) selective contracting waiver submitted by HHSC to formally limit the eligible providers to the LMHAs.

As part of this approach, DSHS appropriations pertaining to the funding of Medicaid rehabilitation and case management services should be transferred to the HHSC appropriation. Under the current system, the state share for the Medicaid rehabilitation and case management services are included in the DSHS appropriation. This recommendation would see those funds that have been included as the Medicaid match of the DSHS appropriation move to HHSC for inclusion in the capitation rates paid under the managed care contracts. The service providers would receive funding directly from the managed care entities.

Expected Goals to be Achieved Through the Approach: The purpose of this approach is to address some of the limitations or weaknesses of the current system of care. These advantages include the following:

- 1) Enhanced freedom of choice.** The expansion in the number of rehabilitation and case management providers will allow for additional freedom of choice to Medicaid consumers. According to federal regulations on managed care contracting practices, the Medicaid managed care organizations have flexibility in managing their own provider networks as they deem appropriate. Specifically, 42 CFR 438.12 prohibits Medicaid MCOs from arbitrarily discriminating against providers in the building of their network. In addition, 42 CFR 438.214(b)(7) outlines a process by which Medicaid MCOs can provide a documented process for credentialing and re-credentialing providers. This approach would therefore allow the managed care organizations to contract with both LMHA and non-LMHA providers that meet the approved credentialing process and in doing so, increase consumer choice by expanding the universe of providers that are

available to provide rehabilitation and case management services. HHSC/DSHS can approve the credentialing process of the MCOs and monitor provider networks to ensure that sufficient qualified and experience service providers are available.

- 2) **Opportunity for Medicaid consumers to receive a full continuum of care through a single Medicaid provider.** Under the current system of care, LMHAs and their developed provider networks are the only entities authorized to provide rehabilitation and case management services. However, Medicaid recipients have the freedom to choose any other Medicaid enrolled provider for complimentary behavioral health services, such as counseling services performed by a psychiatrist or psychologist. If the network of eligible providers were expanded to provide rehabilitation and case management services, it would allow for Medicaid consumers to receive all appropriate services from a single provider, which could potentially lead to a more cohesive approach to care.
- 3) **Opportunity to allow for new providers to enter the marketplace.** By moving rehabilitation services into the Medicaid managed care contracts, it should allow for new providers to enter the marketplace. Workforce shortages and access to services were a common theme identified throughout the stakeholder discussions conducted by PCG. In addition, there were specific concerns regarding the availability of specialty providers to meet the needs of children. By expanding the provider network, it could allow for additional service providers to meet the demand for these services, particularly specialty providers focused on the needs of children.
- 4) **Reduce the LMHA's responsibility for establishing provider networks, as required by the provider of last resort provisions, and instead leverage Managed Care Organizations to carry out these functions.** LMHAs are required to develop provider networks and serve as the provider of service in instances where they have demonstrated that there are not any willing or appropriate providers. The LMHAs success in performing network development functions varies across the State. Some LMHAs have robust provider networks, where others have limited networks. Medicaid managed care organizations specialize in developing sufficient provider networks to meet the demand of Medicaid consumers. Network development is required by contract and there is strict enforcement of these requirements that are monitored closely by HHSC. By leveraging the infrastructure, skill sets, and networking capabilities of Medicaid managed care entities, it will alleviate this administrative burden from LMHAs and allow them to redirect additional resources to the provision of care and focus on developing plans to meet the needs of their local community.
- 5) **Opportunity for enhanced coordination of physical and behavioral health.** The fact that rehabilitation and case management eligible Medicaid consumers only receive rehabilitation services from the LMHAs means that the focus of the care and treatment centers around the behavioral health needs, not necessarily their comprehensive physical

and behavioral health needs. It is possible that if Medicaid managed care organizations were more actively involved in the treatment of these services that a more holistic approach will be taken whereby both the physical and behavioral health needs will be the focus. Under the current system, behavioral health services are separately managed from the physical health services, which inhibits a comprehensive and integrated approach to the care of consumers. In addition, the separation of responsibility for physical and behavioral health services creates the possibility of duplication of case management services, as both the MCOs and the LMHAs are responsible for these functions.

- 6) **Opportunity for the state to implement statewide performance measures for behavioral health.** This approach would allow HHSC to pursue its goal of developing and implementing statewide performance measures for behavioral health services. As all Medicaid recipients would receive their behavioral health care through the same managed care delivery model, the state would have the ability to establish standard performance measures that can be used to compare the performance of the managed care entities and providers across the state. This opportunity would be hindered in a system where there are multiple service delivery models, such as a BHO carve out versus a Medicaid MCO carve in throughout different regions of the state, as the contractual requirements would be different under the various models. The use of the existing statewide managed care delivery model would eliminate these concerns and the state could begin using standard and consistent performance measures.

Implementation Considerations of the Approach: This particular approach does present potential implementation considerations that DSHS and HHSC must be aware of to ensure a successful implementation. These implementation considerations include the following:

- 1) **Behavioral health services will not receive the attention they deserve within a large Medicaid Managed Care Organization.** One concern expressed by stakeholders in regards to moving these services under managed care contracts is the potential for behavioral health services to get lost within the larger managed care entity. Stakeholders cited the fact that behavioral health care generally makes up only a small fraction of the total package of benefits and expense of a managed care contract. They also indicated that their experience with the managed care organizations has shown a lack of understanding of the issues related to behavioral health care and this type of integration may result in the movement towards a medical focused model, instead of a rehabilitative model. This concern was particularly emphasized in relation to substance abuse but was an overall concern for all behavioral health.

It is important to note that this concern is already addressed by many of the Medicaid managed care entities through subcontracts with BHOs for the provision of the behavioral health services. Through these arrangements, either with a BHO internal to the Medicaid managed care entity or through a distinct subcontract with an external BHO, the

Medicaid managed care entities are working to ensure that behavioral health services are provided through entities that understand the issues and challenges specific to behavioral health care.

Under this approach HHSC, as the single state agency responsible to CMS for oversight of the Medicaid and CHIP programs will have the responsibility for the oversight and monitoring of the complete Medicaid managed care contracts, including all behavioral health services. However, it will be important that HHSC coordinates with DSHS to leverage the knowledge and expertise in managing these services and in ensuring these services are provided in a consistent and appropriate manner across the state. This partnership between HHSC and DSHS will be significant in the development of key program components including contract requirements, meaningful outcome measures, and reporting requirements.

- 2) **Consumers that do not qualify for Medicaid would need to be addressed.** This approach does not address the need for services to remain available to individuals that do not qualify for Medicaid benefits but still require behavioral health care through the public behavioral health system. The first approach to expand a BHO service delivery model would include the requirement for services to both Medicaid and non-Medicaid consumers to be provided through the BHOs. This approach provides the state the flexibility to determine the model for non-Medicaid consumers that best meets the needs of the population. The state would essentially have two options for providing services to the non-Medicaid population under this approach; the first option would follow the BHO expansion approach by having the Medicaid managed care entities assume responsibility for the provision of behavioral health services to the non-Medicaid population with the funding also moving in to the Medicaid managed care contracts as allowed under a 1915b waiver while the second option would maintain the existing model with non-Medicaid consumers receiving services through the LMHAs, funded by DSHS. As was stated previously, with 90% of the non-Medicaid eligible consumers currently served through the public behavioral health system qualifying for Medicaid under ACA, this becomes a smaller, albeit still important consideration for the state.
- 3) **Evaluate the need for the standalone BHO model in the Dallas region.** This particular recommendation provides for a comprehensive service offering for all Medicaid recipients by implementing a full continuum of behavioral health and primary care. Given the state's desire to develop and implement consistent statewide performance metrics, a standalone behavioral health care service delivery model is seen as a barrier to this effort. Additionally, as the state has moved towards a more consistent and integrated system of care, evidenced by the recent Medicaid managed care expansion, the NorthSTAR model would remain the lone exception. Lastly, should Texas move forward with Medicaid expansion under the ACA and, as a result, Texas proceeds with this recommendation and carves in all behavioral health services under the Medicaid



managed care contracts, the greatest benefit of the NorthSTAR model, its braided funding approach for serving both Medicaid and indigent consumers, becomes minimized. For these reasons HHSC and DSHS must consider an evaluation of the need for the continuation of the NorthSTAR model and whether it justifies continuance if the rest of the state moves to a consistent model of care.

Financial Implication of the Approach: As indicated in the description of the approach above, the funding for these services would be transferred from the DSHS appropriation to the HHSC appropriation and included in the capitation rate paid under the managed care contracts. It is PCG’s expectation that this approach will be budget neutral overall as the funding that is currently appropriated to DSHS for the state match for these services will be transferred to HHSC for the same scope of services. The managed care entities would be put at risk to maintain the service utilization as part of their contract. If the MCOs do experience material increases, it is possible that future capitation rates could grow; however, rehabilitation and case management service expenditures are relatively insignificant to the overall complement of MCO services as well as the overall Texas Medicaid budget. For example, the table below compares total Medicaid rehabilitation and targeted case management expenditures over a four year period to total Medicaid spending.

Fiscal Year	Medicaid Rehab & TCM Spending	Total Medicaid Spending	Rehab & TCM / Total Medicaid Spending
SFY 2008	\$ 48.2	\$ 21,399.7	0.2252%
SFY 2009	\$ 56.5	\$ 23,327.6	0.2422%
SFY 2010	\$ 83.8	\$ 26,519.0	0.3160%
SFY 2011	\$ 85.7	\$ 28,158.7	0.3043%

Note: All expenditures are presented in millions

As outlined above, Medicaid rehabilitation and case management services represent not even .5% of total Medicaid expenditures. Even if there was a significant increase in utilization pertaining to rehabilitation and case management services, it is unlikely to have a serious fiscal impact to the MCOs or the State of Texas.

One unknown of this approach would be the financial impact if the state chose to move the responsibility for the provision of behavioral health care for the non-Medicaid population under the Medicaid managed care entities. While the funding for these services that has traditionally been allocated by DSHS to the LMHAs would move under HHSC and into the managed care contracts as allowed under a 1915b waiver, it is not clear that this would require additional funds or create cost savings for the state.

Plan for Implementing the Approach: The following high level work plan outlines the key steps for the state to take to expand the use of Medicaid managed care.



Action Step	Responsible Party
Develop of a Memorandum of Understanding (MOU) between HHSC and DSHS to allow DSHS to provide oversight and monitoring of behavioral health care services under managed care contracts.	HHSC and DSHS
Amend Medicaid managed care contracts to carve in rehabilitation and case management services.	HHSC
Review HHSC contracts with managed care organizations to ensure appropriate provider credentialing processes for rehabilitation and case management services.	HHSC and DSHS
Work with HHSC actuary to calculate changes to the capitation rates based on the inclusion of rehabilitation and case management services.	HHSC
Revise Texas Administrative Code Title 25, Part 1, Ch. 412, Subchapter 1, Rule 412.404 to eliminate the requirement that a provider of mental health case management services must be a community mental health center.	HHSC and DSHS

Recommendation 2) Expand the use of the YES Waiver

Description of the Recommendation: As outlined in our Phase I report and in several of our Phase II recommendations, behavioral health services for children and youth are particularly scarce. In addition, services to children and youth often require a more focused and/or coordinated approach than adult services.

One option that Texas has already used to address the needs of children and youth is the Youth Empowerment Services (YES) Waiver. The YES Waiver is a 1915(c) Medicaid Home and Community-Based Services Waiver that allows greater flexibility in the funding of intensive community-based services to assist children and adolescents with severe emotional disturbances to live in the community with their families.

The waiver was authorized by the 78th and 79th Texas Legislatures which directed the Health and Human Services Commission (HHSC) to “develop and implement a plan to prevent custody relinquishment of children and adolescents with serious emotional disturbances,” and authorized the request of any necessary waivers from the federal government.¹⁴ The YES Waiver, like most Medicaid waivers, covers a wide array of services for enrolled individuals. The following is a list of the services currently covered under the YES Waiver. Additional details on these services and more information regarding the YES Waiver can be found on the DSHS YES Waiver website.¹⁵

- Adaptive Aids & Supports
- Community Living Supports
- Family Supports
- Minor Home Modifications
- Non-Medical Transportation
- Paraprofessional Services
- Professional Services
- Respite
- Supportive Family Based Alternatives
- Transitional Services

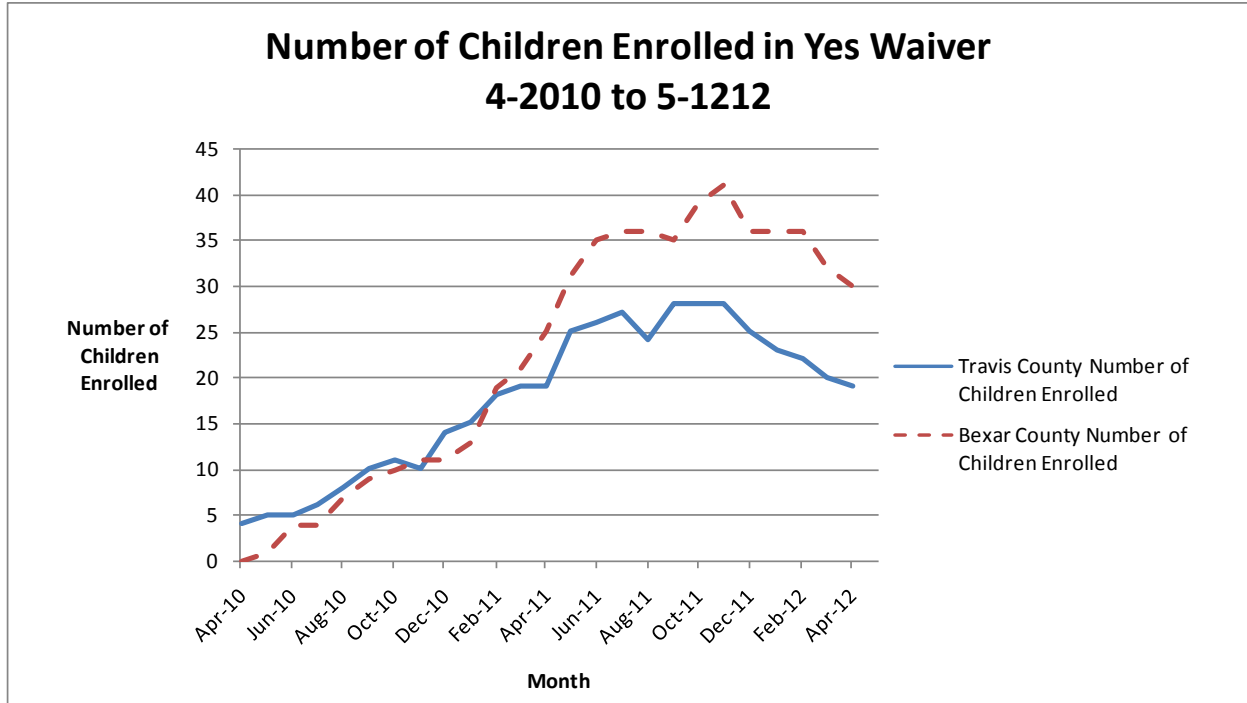
In its current form, the YES Waiver is available in 3 counties with Bexar and Travis Counties serving as the initial pilots beginning in April 2010 and Tarrant County joining in July 2012. It is also expected, with CMS approval of the waiver renewal, that a fourth county, Harris County, will begin YES Waiver services in April 2013.

¹⁴ See Youth Empowerment Services (YES), *Notice of Open Enrollment, MH - 0336.1*, p. 2 Retrieved on 8-2-2012 from http://esbd.cpa.state.tx.us/bid_show.cfm?bidid=82557

¹⁵ Retrieved on 8-3-2012. See Appendices A and E which can be downloaded at <http://www.dshs.state.tx.us/mhsa/yes/>

For each of the sites under the Yes Waiver, the state has chosen to cap enrollment on the waiver to 100 children per site. As the following chart illustrates, the number of children enrolled on the waiver has not come close to the enrollment cap, with the peak enrollment occurring in the Fall of 2011.

Number of Children Enrolled in Yes Waiver, 2010-2012.

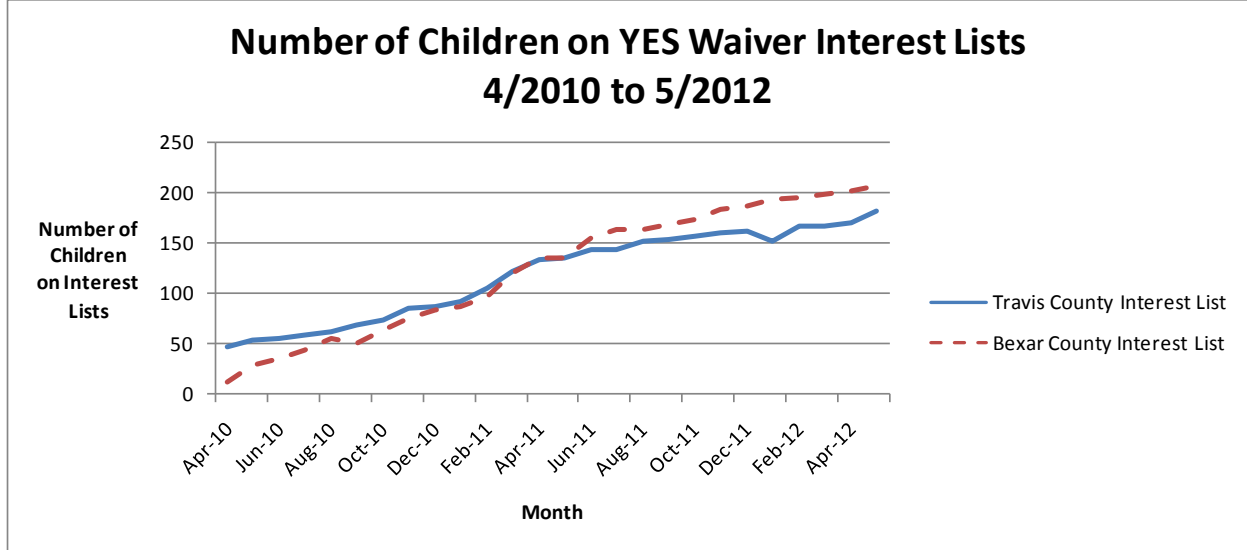


Source: Department of State Health Services, YES Waiver

In addition to the individuals currently enrolled in the waiver, the local mental health authorities (LMHAs) providing case management keep a list of persons that have expressed an interest in the program and might be potentially eligible for the waiver services.¹⁶ The number of children on the county lists is shown in the chart below. If you compare enrollment with the interest in the program, it is apparent that interest in the program far surpasses enrollment. For example, in May of 2012 one county had 18 children enrolled in the waiver and 181 on an interest list. The other county had 33 children enrolled and 207 on an interest list.

¹⁶ Texas state agencies refer to these as an “interest” list instead of “waiting” lists, correctly pointing out that lists get dated, not everyone on the list is eventually determined eligible or if eligible would sign up for services.

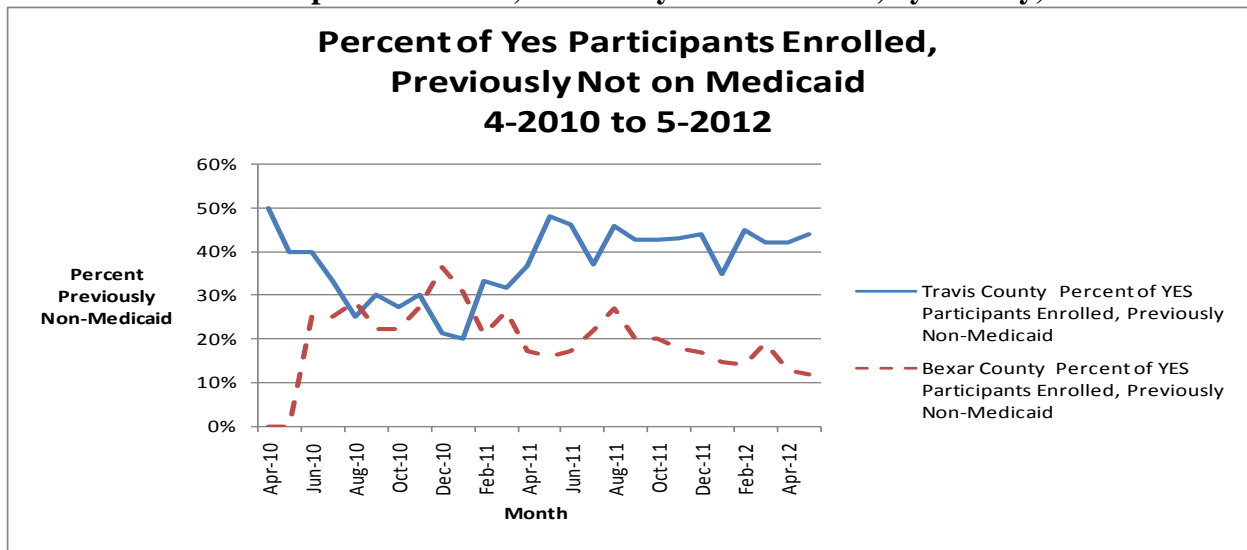
Number of Children Enrolled on Yes Waiver Interest Lists, 2010-2012.



Source: Department of State Health Services, YES Waiver

While there is a lag in the number of individuals enrolled in the waiver when compared to the interest lists, it is important to note that of those individuals enrolled, there are a number that were previously receiving Medicaid services. The following figure shows that in the Spring of 2012, in the two program sites, the percent of children served under the YES waiver that were not previously on Medicaid, ranged from 10% to 40%. As shown by these results, the program is successful in finding children who were not previously served.

Percent of YES Participants Enrolled, Previously Non-Medicaid, by County, 2010-2012



Source: Department of State Health Services, YES Waiver



Despite some of the implementation challenges of the YES Waiver in the first two pilot counties, PCG believes that the waiver provides for a number of benefits for Texas. The YES Waiver provides Texas with a means of promoting important values through services to eligible children as well as an opportunity to provide services to children that were not being served in the public behavioral health system previously. Through this recommendation, PCG supports HHSC and DSHS' ongoing efforts to expand the YES waiver within the existing areas to achieve expanded enrollment and to future areas as is planned for Harris County. PCG believes that expansion within the existing areas and to future areas will provide more flexible and effective treatment options to children and youth with serious emotional disturbances.

Expected Goals to be Achieved Through the Recommendation: PCG supports the continued expansion of the waiver for the reasons cited below. PCG would also support a more rapid expansion of the waiver to the extent that DSHS, HHSC and the provider community could support such expansion.

- 1) **Avoiding institutionalization.** The values supported by the waiver are keeping families intact and avoiding institutionalization. The waiver promotes family-centered, community-based services. One tangible way this happens is that the waiver treats the income of the parents as though the child is already institutionalized. In institutional eligibility, the income of the parents is not considered in the Medicaid financial eligibility rules applied to the child. Using an institutional eligibility policy means that parents will no longer have to surrender custody of their child in order to receive Medicaid benefits. It also means that children that were not previously eligible for Medicaid services can now receive them.
- 2) **Serving children that need services but are not receiving them.** An expansion of the waiver's size is needed. The waiver is limited to Medicaid children that need services and are not receiving Resiliency Disease Management (RDM) services from existing providers. The waiver is serving two populations: First, children who are on Medicaid and apparently were not getting appropriate services; and second, children who need services and were not previously on Medicaid.
- 3) **The program is needed.** As was discussed in the description of this recommendation, the number of individuals on the interest lists in Bexar and Tarrant counties illustrates that there is demand for the YES waiver and the services offered under the waiver. Given the noted lack of availability of services for children, the expanded use of the YES Waiver provides Texas with a readily available option to increase access to important services for the child and youth population. Additionally, as the data from Bexar and Tarrant illustrates, through the use of the waiver Texas has the ability to provide services to additional children that previously may not have been eligible to receive Medicaid services.

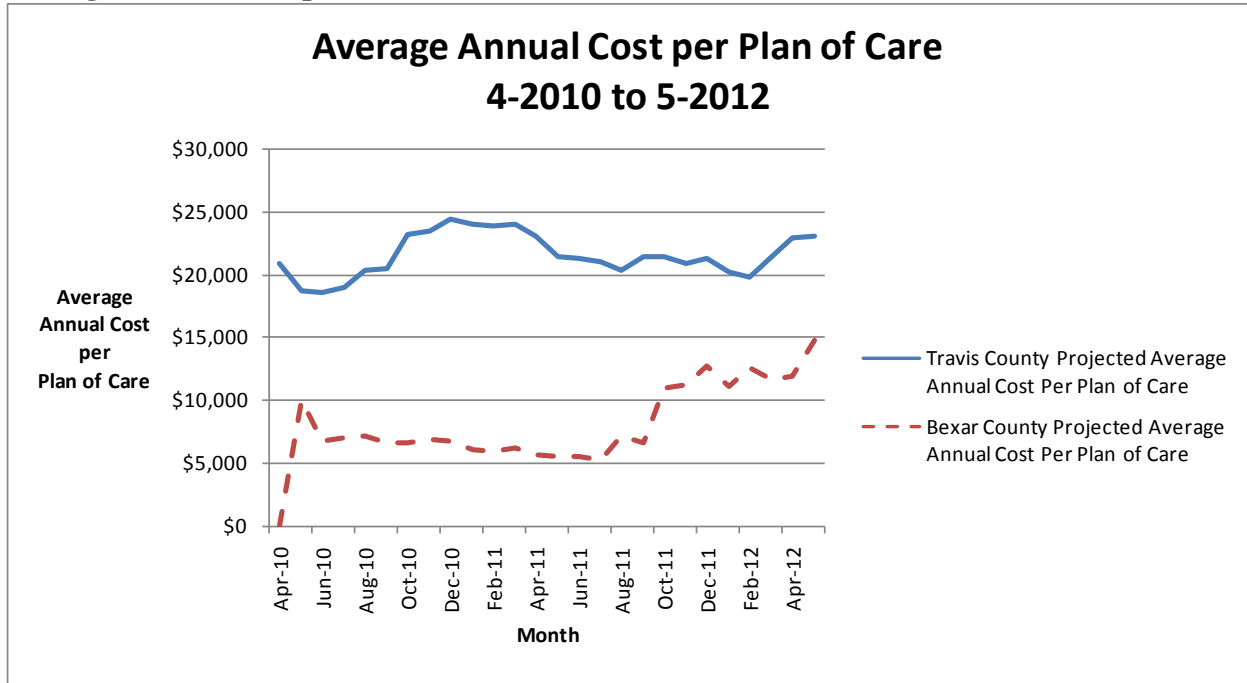


Implementation Considerations of the Recommendation: This expansion would be strengthened by DSHS self-examination of the degree to which DSHS requirements might have inhibited current program expansion. While the expansion of the program is said to be dependent on its cost effectiveness, there are so few children enrolled, only 51 in May 2012, that cost effectiveness cannot be reliably determined. There could be substantial selection bias with only 51 enrollees. Tarrant County began participating in the Waiver in July 2012. The program has a planned expansion to a fourth geographical area, as Harris County is targeted to begin YES waiver services in April, 2013 if the waiver is determined to be cost effective in its first two years of operation and the renewal is approved by CMS. However enrollment is so low that it makes more sense to approve the Harris expansion as well as increase efforts to raise enrollment levels at current program sites and expand to additional sites beyond Harris, and then determine cost effectiveness after the program has been expanded.

Additionally, the expansion of the YES waiver will have a material impact on the existing service delivery system for the behavioral health providers as well as the traditional managed care organizations. If implemented, these children would be removed from the traditional managed care system which impacts statewide performance and quality standards as the comparability of plans are altered. Additionally, since the waiver does not cover the traditional physical health services, the integration of physical and behavioral services is disrupted and may lead to the duplication in management oversight functions as both the behavioral and physical health providers will oversee the care. One approach to addressing these concerns would be for the state to implement the waiver, or the core elements of the waiver, within an existing MCO. The state would create new program requirements and performance standards in exchange for incentives and/or the sharing of cost savings.

Financial Implication of the Recommendation: The cost of a waiver expansion can be reasonably determined. The Figure below shows the average annual cost per plan of care for the first two counties where the waiver was implemented. As the Figure shows, costs in one county are substantially higher than the other counties. An initial step in calculating the fiscal impact would be an understanding of these differences.

Average Annual Cost per Plan of Care, 2010-2012.



Source: Department of State Health Services, YES Waiver

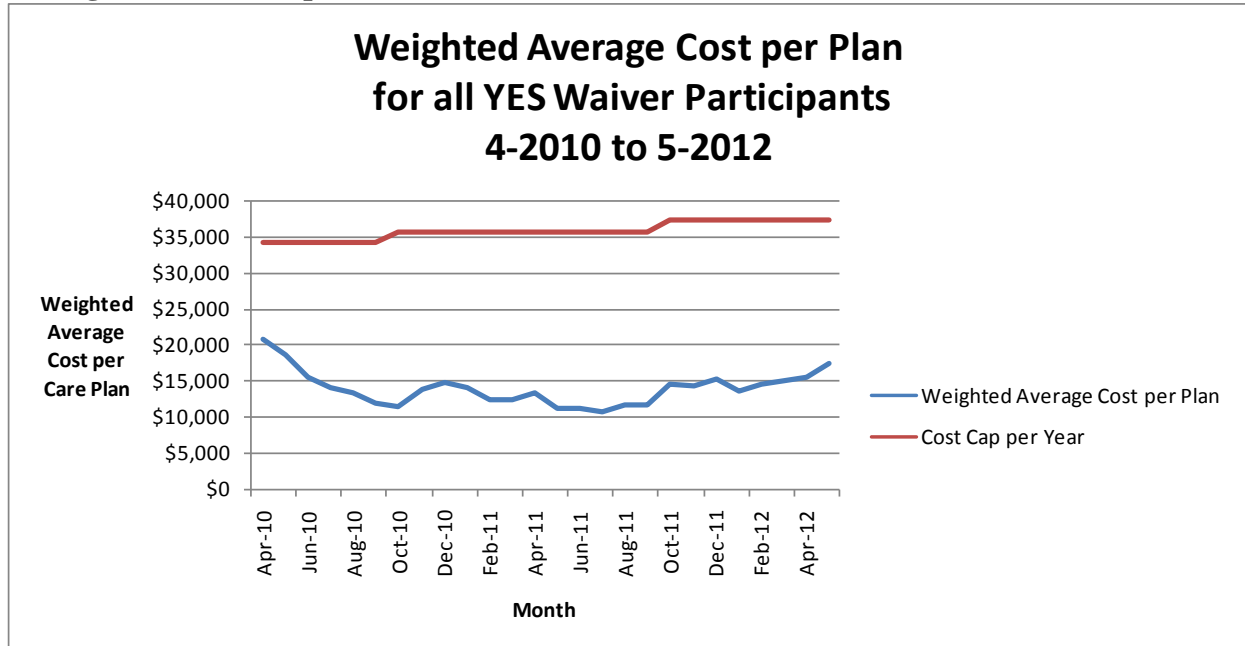
The average weighted cost per plan of everyone on the waiver is shown below. The average of the two counties was calculated by weighting the average monthly cost in each county by the number of enrollees in each county. The Figure shows that for most of the period the average cost varied between \$10,000 and \$15,000, well below the \$35,000 to \$37,000 amounts used in the institutional cost comparison.¹⁷

Even taking into account other Medicaid state plan services, it appears that the waiver service cost is less than the institutional cost, which in this case is a hospital cost.¹⁸ As the Figure below shows, actual plan costs are well below the average cost cap for the year.

¹⁷ See [LMHA Staff Training Q & A](http://www.dshs.state.tx.us/mhsa/yes/) (MS Excel) at, retrieved on 8-3-2012, from <http://www.dshs.state.tx.us/mhsa/yes/>. By waiver year, year one cap is \$34,207, year two is \$35,781 and year three cap is \$37,426.

¹⁸ Data from the YES Waiver program indicates the average cost per child for non-waiver Medicaid services was \$1,528. The cost effectiveness approach described in program documents at Appendix F at <http://www.dshs.state.tx.us/mhsa/yes/> compare only institutional versus waiver services. The Federal approach includes the cost of all other Medicaid services. This \$1,528 was developed based on all persons enrolled from April 2011 through October 2011. It seems unlikely that adding the non-Waiver Medicaid services of \$1,528 to the cost effectiveness would change the result since the institutional cap is in the mid \$30,000 and persons in institutions also incur other Medicaid expenses.

Average Annual Cost per Plan of Care, 2010-2012.



Data Source: Department of State Health Services, YES Waiver.

PCG understands that the fiscal analysis of a waiver expansion must take into account both the cost and the savings of the waiver. The classic comment about analyses of waiver cost comparisons is to point out that a simple comparison of institutional and waiver costs is misleading because not everyone who used waiver services would have been institutionalized. A breakeven ratio analysis provides some insight into the cost tradeoffs involved with the waiver.¹⁹

Using data from the period October 1, 2010 to September 30, 2011 yields the following results.

- Average hospital cost for period = \$35,781
- Average waiver plan cost for period = \$12,406
- Ratio of hospital cost to waiver cost = 2.88.

Rounding the ratio 2.88 to 3.00 for ease of discussion, a ratio of three implies that three children can be served on the waiver at the same cost the state pays for one child in a hospital. In other words, if one-third of the children served on the waiver would have in fact gone into a hospital then the remaining two-thirds of the children on the waiver could be served at no additional cost to the state. One-third is the breakeven point on the waiver's cost effectiveness. If less than one-

¹⁹ For an example of a breakeven analysis see Mollica, R. & Hendrickson, L. (2009, November), Home and Community-Based Long-Term Care: Recommendations to Improve Access for Californians, A Report prepared for California Community Choices, California Health and Human Services Agency, Sacramento, CA. P. 158 ff. and Table 91. Retrieved on 8-3-2012 from http://www.hcbs.org/files/162/8057/FINANCE_REPORT_FINAL.pdf



third of the children served on the waiver would have gone into a hospital, then the state has spent more for waiver services than it would have for hospital services; if more than one-third of the children on the waiver would have gone into a hospital, then the state lowered its total expenditures.²⁰

Plan for Implementing the Recommendation: The approach suggested for implementing this recommendation is summarized below and then the steps are discussed. The most important component in this recommendation plan is the use of an active and empowered advisory committee.

Action Step	Responsible Party
Appoint an advisory committee to be responsible of oversight of the expansion	HHSC and DSHS
Discuss and recommend the size and scope of the expansion	HHSC and DSHS
DSHS staff prepares draft expansion options	HHSC and DSHS
Committee works with state staff and discusses draft DSHS expansion options	HHSC and DSHS
Establish process for working with local groups	HHSC and DSHS
Prepare and submit revised 1915(c) to Centers for Medicare and Medicaid Services	HHSC and DSHS
Committee makes recommendations to state for improving expansion efforts	HHSC and DSHS

²⁰ The 2.88 ratio refers to the data from the period 10-1-2010 to 9-30-2011. A review of data for the complete period of 10-1-2011 to 9-30-2012 might show a ratio different from 2.88. However, a similar breakeven point could be calculated.



***Recommendation 3)* Investigate options to pilot an integrated, specialty health plan for adults with Severe and Persistent Mental Illness (SPMI) and/or children with Severe Emotional Disturbances (SED)**

Description of the Recommendation: The management and delivery of behavioral health services in Texas is currently carved-out and independent of the overall healthcare delivery system for adults with SPMI and children and youth with SED. Behavioral health services for these populations of individuals who are eligible for Medicaid are provided by both managed care organizations (MCOs) as well as local mental health authorities (LMHAs) for the majority of the state. In area surrounding Dallas, all behavioral health services are managed by a standalone managed behavioral health organization. The management of behavioral health services for the SPMI and SED populations includes individuals covered by Medicaid, CHIP and certain priority indigent populations. The overall healthcare delivery system for Medicaid and CHIP are managed by one of nineteen MCOs across Texas²¹. In its current form, Texas does not have a dedicated, integrated, coordinated and singularly accountable delivery system to manage the overall health and wellness of the SPMI and SED populations which includes primary care, mental health and substance abuse services.

This recommendation calls for Texas to establish a pilot program to create a specialty health plan for the SPMI population, the SED population, or where possible both populations that would integrate both physical and behavioral healthcare (both mental health and substance abuse services) for Medicaid eligible individuals within the pilot. The State would partner with one or more willing managed care organizations to provide and be fully accountable for an integrated and coordinated health plan for the Medicaid eligible SPMI and/or SED population within the pilot. The state may choose to leverage existing MCOs with the necessary skills and expertise in providing specialty behavioral health treatment to serve this population. The state might also consider integrating this pilot into efforts currently underway for Texas' dual eligible population. Such an approach offers the potential to achieve an integrated clinical and financial model for a high cost population with the goal of providing more comprehensive services to improve the outcomes and reduce the long term costs of the target SPMI and/or SED population.

The establishment of a specialty health plan provides a single entity with the responsibility for oversight of all of the care of enrolled individuals. This holistic approach provides opportunities to be more effective in treating individuals who often have multiple chronic conditions along with their severe and persistent mental illness. Rather than segregating the behavioral health needs from the physical health, a specialty health plan would assess and treat the overall needs of the individual. There are numerous national studies sponsored by SAMHSA and other local

²¹ See, retrieved on 8-28-2012 from http://www.tmhp.com/TMHP_File_Library/PCCM/MCO%20Representative%20Contact%20Information_March%202012.pdf

studies sponsored by the Hogg Foundation for Mental Health²² that demonstrate the benefits of integrating primary care and behavioral health services.

Individuals served by DSHS that do not qualify for this specialty health plan, specifically uninsured individuals with or without SPMI/SED and Medicaid eligible individuals with or without SPMI/SED that do not meet the states target population, would continue to receive services through the existing system (see Implementation Considerations on options for target populations).

Expected Goals to be Achieved Through the Recommendation: The development of an integrated service delivery and funding system, which includes physical health, mental health, and substance abuse services for the target population is expected to provide improved outcomes and lower long-term costs to the state for this target population. By assigning one entity with sole responsibility for the care and wellness of eligible individuals with SPMI/SED in the pilot, Texas will consolidate disparate funding streams and enhance accountability. The following provides a more detailed description of the expected benefits of this recommendation:

- 1) **Increased focus on overall health and wellness of individuals.** Under the current system, the various service providers and managed care organizations are vested in the health and wellness of their patients and members; however, they each individually lack the authority and are not fully accountable for the treatment of all ailments. By consolidating the authority and accountability for individuals rather than illnesses, the specialty health plan could expand case management and other behavioral treatment options in order to reduce healthcare costs and improve overall health and wellness.
- 2) **Comprehensive care coordination.** The individuals expected to be served by a specialty health plan are very likely receiving case management and/or care coordination from both their managed care organization as well as from the DSHS system. While these two services often have a specialized focus, there is often a lack of communication and coordination across the two systems. A health plan with the full range of benefits is incentivized to leverage specialty care coordinators that are trained on the full range of health and wellness components, including mental health and substance abuse, in order to achieve the best possible outcomes for the individual. Improved coordination and care management is often cited as a key success factor in reducing inappropriate admissions and over-utilization of emergency room services.
- 3) **Incentives for early identification and prevention.** The implementation of a specialty health plan to serve all of the healthcare needs of people with SPMI/SED incentivizes the managed care organization to invest in early identification and prevention programs and treatment modules. By consolidating responsibility for the complex needs of these

²² Hogg Foundation. Octavio N. Martinez, Jr., MD, MPH, MBA, FAPA; “Behavioral Health Panel: Addressing the Needs of Texas Through Best Practices & Innovative Delivery Models”. August 8, 2012.

individuals under one qualified management entity, there are opportunities to involve primary care providers in identification and treatment of behavioral health issues and reimburse them properly. Conversely behavioral health providers can also identify physical ailments and make appropriate referrals. This clinical collaboration between health and specialty systems will help in the early detection of issues, such as adverse medication interactions. These are examples of more effective treatment that will produce long-term cost savings for the system and improved outcomes for individuals.

- 4) Specialized approaches and proven practices.** A specialty health plan provides more opportunities to design and develop individualized treatment protocols and/or establish customized approaches to the care and treatment of their members. The target populations eligible for the specialty health plan will include individuals who require a greater intensity of service than the average consumer and/or for which traditional approaches were unsuccessful. A plan with significant membership of individuals that require intensive and/or customized services affords an opportunity to invest in innovative approaches to care rather than relying on traditional models. In addition, if Texas were to award a contract to a plan that has similar and/or relevant experience in managing both physical and behavioral health services for a SPMI/SED population, their members would benefit from evidence based models of care that have been extensively researched and proven cost effective as well as other promising practices. By assuming responsibility and accountability for the care and treatment of this high need population, the managed care entity can ensure the availability and the fidelity of these programs and services for their members.
- 5) Increased funding flexibility afforded under a capitated model.** Another advantage that a specialty health plan affords HHSC, DSHS and eligible individuals is increased flexibility over traditional treatment models. Upon the establishment of a per member per month (PMPM) capitation payment, the specialty health plan is not bound solely to the services and treatment approaches generally afforded under the Medicaid State Plan. Given HHSC's recent transition to managed care for most Medicaid eligible individuals, the enhanced flexibility is primarily achieved in the behavioral health funding as managed care entities are already receiving per member per month payments for traditional health care services. However, if full benefits for the SPMI/SED population were "carved out" of the existing plans it would reflect a disproportionately higher PMPM payment due to the intensity of services required by the population. Add to that PMPM the behavioral health funding and the specialty health plan would be projected to have significant resources to address the complex and intensive needs of this pilot population. The blended funding approach of a specialty health plan could remove barriers which results in siloed treatment approaches for behavioral health and primary care services rather than integrated and comprehensive approaches to care.

- 6) **Ability to develop targeted performance incentives focused on outcomes.** Defining a pilot population with often similar needs and challenges provides the opportunity to develop targeted performance measures that have been shown to be tied to effective care and improved outcomes. HHSC/DSHS should take this opportunity to research and understand the usual barriers to optimal outcomes for this population and include these measures as a part of performance incentives under this contract. Some potential examples of these indicators could be housing permanency, prescription compliance, emergency room utilization, recidivism rates, etc. HHSC/DSHS can also include service related metrics (and/or incentives) on the availability of programs/services, cultural competencies, programs focusing on dually diagnosed populations, etc.
- 7) **Separation of service authorization and service provision.** The introduction of a specialty health plan will create increased autonomy and independent oversight of provider operations and referrals which has been identified as a current weakness of the current behavioral health system. The separation of these functions will improve overall compliance with provider of last resort legislation and the Texas Administrative Code.

Implementation Considerations of the Recommendation: DSHS should evaluate and consider the following potential implications of this particular recommendation:

- 1) **There are very limited fully integrated service delivery and/or managed care models currently in operation which serve this complex population.** While there are numerous and long-standing successful models of managed healthcare and separate managed behavioral healthcare models within the Medicaid program, there are only a few fully integrated behavioral health and physical health models within the Medicaid program nationally. While this model has significant promise, it is not yet a proven system or service delivery model; most national MCOs do not have significant experience with the disabled. Maricopa County in Arizona has just begun work on this innovative and fully integrated service delivery system and they have not yet begun implementation. In addition, the Maricopa County model will include a single health plan; however, CMS would likely require at least two health plans for approval. The other relevant models include health home models where there is integrated service delivery; however, these are for a much more limited benefit.
- 2) **Establish priority populations to be included in the pilot.** A key to the success of this effort is to design a program around individuals that are expected to benefit the most from the program and/or that have the greatest need for these services. Examples may include adults with SPMI who have Medicare and Medicaid coverage, or people with SPMI or SED and diabetes, or individuals with renal failure, pulmonary disease, or any other chronic conditions or may include children and youth with SED. It would also likely include individuals with SPMI or SED with co-occurring mental health and substance abuse. It would likely include individuals with SPMI or SED who have more

routine health needs and not be limited to individuals with complex behavioral health and complex healthcare needs. DSHS and HHSC need to come to consensus on the priority populations to be included in the pilot and consider the implications that these decisions have on the size and related risk pool of the plan. Additionally, a key consideration is the ability of the service delivery system to meet the needs of the pilot population.

- 3) **The establishment of a specialty health plan in a pilot region will have a material impact on the existing service delivery system for the behavioral health providers as well as the traditional managed care organizations.** If the state chooses to carve out the SPMI and/or SED population, particularly those with co-occurring disorders, from the traditional managed care system, they may disrupt established patient/provider relationships creating unintended consequences. Due to the complex healthcare and behavioral health needs of this population, any disruption in established treatment practices can have unintended consequences which create problems the program is designed to correct. Depending on current enrollment, the addition of a specialty health plan may drive out existing health plans from the pilot region due to increased risk of adverse selection of their membership decreases significantly. As a result of this, the state may choose to demonstrate the approach using an existing MCO, new rates and their existing enrollment.
- 4) **The local community may experience decreased input and control over the pilot population.** If implemented as recommended, the role of the LMHA will continue for individuals outside of the pilot population; however, there would be a material shift in responsibility for the most complex individuals that would be served by the specialty plan. The behavioral providers may continue to stay engaged, but there is potential for individuals to move back and forth between these two behavioral health systems of care as they try to navigate through the new process. The local community may also be impacted from the perspective of coordination of care and planning. For law enforcement and housing officials, for instance, there would be separate accountability for the pilot SPMI population and the population traditionally served by the LMHAs. Additionally, the local community may not have as strong an influence or impact on a specialty health plan as they currently have with the LMHAs.
- 5) **Will require extensive planning, additional oversight and monitoring by HHSC and DSHS to ensure the success.** During the initial phases of this pilot, DSHS and HHSC must work collaboratively to define the target population, eligible plans as well as the potential region(s) in which to implement the pilot. Careful consideration must be given to the capacity of local providers, including the breadth of programs, expertise in servicing the target population, and the progressive nature of service delivery. The success of a specialty health plan is largely dependent on the existing service delivery system to innovate and be accountable for the health and well-being of the population. The management entity certainly serves a critical role and can develop new and

innovative programs; however, the provider community must be mature and supportive to ensure success. DSHS and HHSC must recognize the need and allow the MCOs the freedom to innovate and move beyond the existing program models. The process for developing capitation rates must reflect this innovation and not be as rigid as to only recognize the existing service models of today but rather include forethought toward the innovative service models of the future. Additionally, HHSC and DSHS should use the development of capitation rates as an opportunity to provide clear direction of their expectations surrounding reductions in inappropriate care delivery. A few examples of approaches that HHSC can take include recognizing emergency room visits as low-level office visits and/or not including inappropriate psychiatric readmissions in the PMPM development. While these performance based changes to the PMPM rates would not likely be put in place for the first year, there should be clear expectations that these changes would be instituted in subsequent years.

Once a pilot program has been selected, DSHS and HHSC must be actively involved during implementation to ensure the safe and successful transition of individuals into the plan. Transition to a specialty health plan has the potential to disrupt individual progress toward their recovery and therefore the transition must be well planned. Once operational, DSHS and HHSC must play an active role in the oversight and monitoring of service delivery, care coordination, and client satisfaction to ensure the success of the program model.

Financial Implication of the Recommendation: The financial implications of this recommendation will be significantly impacted by how HHSC and DSHS elect to implement this recommendation. The cost of design, development, oversight and implementation of the pilot, while expected to be material, is projected to be offset by future savings achieved through improved care coordination, reductions in the inappropriate use of emergency rooms and unnecessary hospitalizations. Over the course of a three to five year period, the state should realize overall savings and improved health outcomes from the pilot.

A core component of the pilot should be the development of fiscal projections to establish a baseline cost estimate for the program to document the historical cost for the various sub-populations within the SPMI/SED pilot. This baseline can be refined and used as a measurement tool for future periods to evaluate the effectiveness of the program. As the pilot achieves the goals of decreased service utilization, particularly the high costs associated with inappropriate and/or unnecessary services, the state can achieve savings and/or reinvest the funds to expand the program.

Plan for Implementing the Recommendation: Regardless of these implementation considerations, there are various action items required to implement this initiative:



Action Step	Responsible Party
Establish a workgroup to study the feasibility of implementing a pilot Specialty Health Plan (SHP). Workgroup should include, at a minimum, individuals with knowledge/experience with claims, eligibility, and Medicaid managed care models	HHSC and DSHS
Identify critical success factors that would allow a SHP to be successful. Workgroup should identify minimum “membership” requirements, required provider groups – including both physical and behavioral health services, geography, target diagnoses (physical and behavioral), etc.	HHSC and DSHS
Apply critical success factors across Texas populations to identify potential pilot areas for consideration. Behavioral health shall be the primary determinant of potential populations	HHSC and DSHS
Design and develop a Medicaid waiver for a Specialty Health Plan. Publish draft waiver for public comment	HHSC and DSHS
Determine whether a RFI process is required / preferred prior to issuance of an RFP. Identify solvency requirements, network requirements, technology standards, payment mechanisms, etc.	HHSC and DSHS
Conduct stakeholder sessions in potential pilot areas to evaluate local acceptance and obtain input from potential respondents	HHSC and DSHS
Conduct actuarial analysis of historical claims for pilot population for inclusion in RFP process. Consider options for incentives, limits to administrative cost, and accounting for non-traditional services	HHSC and DSHS
Incorporate feedback from RFI, public comments, stakeholder sessions and actuarial analysis into an RFP	HHSC and DSHS
Evaluate RFP responses, make an award and negotiate contract	HHSC and DSHS
Conduct Specialty Health Plan readiness reviews including oversight and monitoring of implementation	HHSC and DSHS
Provide ongoing support and oversight of Specialty Health Plans	HHSC and DSHS
Provide reporting of outcomes indicating the effectiveness of the Specialty Health Plan in meeting goals and objectives	HHSC and DSHS



***Recommendation 4)* Address shortage of inpatient beds in DSHS system by building upon existing efforts to privatize state hospitals and leverage local inpatient resources**

Description of the Recommendation: A number of states began downsizing their state hospital capacity as more services became available in outpatient and community settings. While this trend towards treating more individuals in non-institutional settings has been viewed as a significant improvement in the care for mentally ill individuals, it has also resulted in capacity issues for state mental health systems. While the move toward deinstitutionalization began the reduction in state hospital beds across the country, the recent financial downturn has played a role in more recent reductions in state hospital beds.

In 2010, the National Association of State Mental Health Program Directors (NASMHPD) Research Institute (NRI) provided an update to its membership titled, ‘The Impact of the State Fiscal Crisis on State Mental Health Systems’. As part of this update, they noted that of the 45 State Mental Health Agencies (SMHAs) reporting, 45% of the states responded to cuts in overall SMHA budgets by closing state hospital units or wards. Additionally, 13% of the states responded by privatizing state operated services with another 8% closing state hospitals and reducing staffing ratios at state hospitals.²³ The NRI further noted that 6 states had closed or were considering closing a total of 12 state psychiatric hospitals and a total of 3,930 state hospital beds were closed or under consideration for closure between 2010 and 2012.²⁴

Texas’ move towards deinstitutionalization began in the 1960s as the state began to invest in and build up the community mental health system as an alternative to state hospitalization. At the start of the deinstitutionalization movement, Texas had state hospital capacity of nearly 15,000 beds. In less than ten years the capacity had dropped to just over 9,000 beds with another reduction of over 1,000 beds over the next two years. While the decrease in state hospital bed capacity was most seen in the early years following the development of community based alternatives, the decreases continue through today as evidenced by the reduction in beds from approximately 2,800 beds in 1996 to 2,400 beds in 2010. Currently DSHS operates nine state owned mental hospitals and one state owned residential treatment facility for adolescents. These ten facilities provide for 2,537 total beds and 2,264 mental health beds across Texas. It should be noted that of the 2,264 mental health beds in DSHS hospitals, 545 beds are dedicated to serving forensic psychiatric patients.

While the number of beds available in the system has decreased over the last 50 years, there has been no similar decrease in the demands for state hospital beds, which has created a strain on the entire behavioral health system in Texas. This strain on the state’s behavioral health system has

²³ Lutterman, Ted, NASMHPD Research Institute. “The Impact of the State Fiscal Crisis on State Mental Health Systems – Fall 2010 Update”. October 12, 2010. Updated February 12, 2011.

²⁴ Lutterman, Ted, NASMHPD Research Institute. “The Impact of the State Fiscal Crisis on State Mental Health Systems – Fall 2010 Update”. October 12, 2010. Updated February 12, 2011.

exacerbated as the State continues to experience an increased demand in the number of state hospital beds for forensic patients. With the need for increased forensic beds, access to beds for civil commitments will become even more challenging. Furthermore, the recent ruling by the 419th District Court in the Taylor v. Lakey case has led to increased concerns around the access to state mental health hospital beds for civil commitments, as additional beds are expected to be needed to treat forensic patients.

Addressing the inpatient capacity of the public mental health system is equally important for reducing the pressures not only on the mental health system but also on other publicly administered programs and services. Stakeholder discussions frequently noted that lack of access to appropriate mental health programs and services, has resulted in county jails serving as a primary provider of behavioral health services. In these discussions, the most commonly cited example was that of the Harris County jail, which treats 2,400 of the 9,500 inmates each month for mental illness, making it the largest mental health care facility in Texas and equates the state mental health hospital capacity.²⁵ The use of jails and prisons to treat individuals with mental illness is not an ideal service delivery model.

As concerns regarding access to inpatient services grow with more and more beds needed to treat forensic patients and as the need for significant capital improvements to state hospital infrastructure continues, it is important for DSHS to explore alternative models for providing inpatient care. DSHS has already begun implementing various strategies to address this particular issue. As a result, DSHS should continue to accelerate the exploration of alternatives to the delivery of these critical services. These options include the following:

- Privatize management of state facilities – DSHS is currently receiving proposals from entities to manage operations and administration of a state facility. The goal is to offer the same level of care as is currently provided in the state hospital at a 10% reduction in state costs. If DSHS ends up selecting a provider and the pilot is determined to be effective, DSHS should consider pursuing this initiative with other facilities.
- Contract for local inpatient resources – DSHS is currently contracting for the use of local inpatient resources through the LMHAs and counties. Under this arrangement, DSHS is providing funds to the LMHAs to purchase inpatient beds in hospitals in their region. These arrangements have proven to be more cost effective than expanding or using state operated facilities.
- Investigate closure of certain facilities in order to fund other new and more modern facilities – Certain state facilities require significant infrastructure improvements. In some cases, the funding required to address these infrastructure requirements could

²⁵ Arnold R. “Mentally Ill Crowding Jail, Courts.” 2008. Available at: <http://www.click2houston.com/investigates/16364907/detail.html>.

potentially exceed the cost in building a new facility. Furthermore, some of the state facilities reside on valuable land. DSHS could potentially sell all or partial campuses and use the proceeds to build new and more efficient hospitals.

This recommendation calls for DSHS to continue utilizing these strategies to address the current shortage of inpatient beds in the state mental health system in Texas.

Expected Goals to be Achieved Through the Recommendation: The purpose of this recommendation is to address some of the limitations or weaknesses of the current system of care. These advantages include the following:

- 1) Address the shortage of inpatient psychiatric beds in the state mental health system.** As stated in the description above, Texas is facing a shortage of inpatient beds in the state mental health system. This shortage has been driven by multiple factors but most recently by the increased demand in the number of beds needed to treat forensic patients. With the need for forensic beds expected to increase as a result of the recent court ruling there will be even fewer beds available for civil commitments. Through the use of alternative strategies like purchasing local inpatient resources the state is able to add additional inpatient beds to the system without the need to incur the significant additional costs that would be required to expand and improve the existing state hospital system.
- 2) Provide additional inpatient resources to address the needs for forensic and jail diversion patients.** Access to state mental health beds is already difficult given the significant number of beds required for forensic patients. In order to address the current access concerns as well as the impending need for expanded access for forensic patients given the recent court ruling, DSHS needs to identify alternatives to the current model for providing inpatient hospital services. Through the purchase of local inpatient resources through the LMHAs, DSHS could provide for additional beds for civil commitments while using existing state hospital beds to serve the forensic population as well as for jail diversions. Privatization efforts, which traditionally focus on forensic populations, could also be used to convert existing beds to forensic beds and in doing so reduce the state's financial responsibilities in providing care to this population.
- 3) Reduce the need for significant state investment in aging state hospital infrastructure.** The state hospital system in Texas is like that in many states with aging infrastructure requiring significant investments in improvements and maintenance budgets. Deferred maintenance costs on the state hospitals are currently at \$180 million with \$77 million identified as high priority and included as an exceptional item for the FY 2014-15 legislative appropriations request (LAR). Through the purchasing of local inpatient resources and privatization efforts, DSHS is able to defer some of these costs while still providing the necessary inpatient services. In purchasing local inpatient



resources DSHS is not assuming any additional responsibility or costs for the maintenance of new facilities or the improvement of existing facilities.

Implementation Considerations of the Recommendation: This particular recommendation does present potential implementation considerations that DSHS and HHSC must be aware of to ensure a successful implementation. These implementation considerations include the following:

- 1) Privatization of state hospitals is viewed negatively by stakeholders and advocates.** It has been argued by opponents of privatization efforts, like the effort currently being undertaken by DSHS, that privatization of state hospitals is likely to lead to reductions in the quality of care driven by the private entities that are incentivized to reduce costs in order to make a profit. The need to reduce costs, it is noted, often results in cuts to clinician staffing levels and the breadth of services offered, resulting in reduced quality of care. As DSHS moves forward with its current privatization efforts, and considers any such future efforts, it must be cognizant of these concerns and include requirements for staffing level requirements, limitations to profit margins, and quality of care measures in any contracts executed with private entities operating state hospitals.
- 2) Local inpatient resources must be capable of adequately treating the population.** The traditional acute admission to a state psychiatric hospital tends to be more acute than traditional psychiatric admissions at community hospitals. If DSHS were to contract out for local inpatient beds, the State must assure the proper staffing and training by the provider to ensure the safety and effectiveness of the care.

Financial Implication of the Recommendation: Depending on the path chosen by DSHS to address the need for additional inpatient hospital beds, there may be a wide range of financial implications for the state. Through the privatization of state hospitals, DSHS should expect, at minimum, budget neutrality as the private entity would be expected to provide the services at the same cost for which they are currently provided. In most cases, including the current privatization procurement, states include requirements for services to be provided by the private entity in a manner that reduces the cost to the state. These cost savings could subsequently be directed towards other state hospitals or to the community mental health system.

When local inpatient resources are purchased by state mental health systems it is often done at a rate higher than the cost of the same service in a state operated facility in order to ensure access to the beds. While there are potential additional costs in the short term for the system to procure these beds there may be long term cost savings realized as states do not incur the financial burdens of building new facilities, improving existing facilities, or maintaining facilities, both old and new. DSHS has however projected that over a two year period in which 100 beds are purchased over the first year and 90 beds purchased for the entire second year there would be a cost of \$21.9 million or an average of \$531 per bed day.



Plan for Implementing the Recommendation: The following high level work plan outlines the key steps for the state to take in implementing this recommendation.

Action Step	Responsible Party
Identify areas of Texas that are in most need of inpatient beds and engage LMHAs in those areas to contract with local and regional hospitals	DSHS, LMHAs
Identify existing state hospitals that could be viable options for privatization	DSHS, HHSC
Work with LMHAs to identify opportunities to convert buildings on existing state hospital campuses for alternative use, including crisis stabilization units	DSHS, LMHAs

IV. GOVERNANCE AND OVERSIGHT RECOMMENDATIONS

Recommendation 1) Develop a public reporting process on performance of Local Mental Health Authorities (LMHAs) and DSHS contracted substance abuse providers

Description of the Recommendation: The Decision Support Unit of DSHS currently generates quarterly reports on the performance of the LMHAs and substance abuse providers. DSHS collects, stores, and maintains a significant amount of data currently that allows DSHS to measure the quality of services performed by LMHAs and contracted substance abuse providers. These data sources include clinical data from the DSHS Client Assignment and Registration (CARE) system and the Clinical Management for Behavioral Services (CMBHS) system, as well as financial and contract data from The Source and the Cost Accounting Methodology (CAM) reports. The intent of these internal reports is to inform and assist DSHS staff to monitor the performance of LMHAs and substance abuse providers. These reports are updated each quarter and provider specific information is made available to individual providers, however providers cannot assess their performance against the system as a whole. In addition, none of the data is currently made available to the public and is only used for internal purposes. Alternatively, DSHS has a similarly robust reporting process related to the NorthSTAR program; however, all of this data, unlike the performance data maintained for the LMHAs and contracted substance abuse providers, is made publicly available. One difference however is that the NorthSTAR data does not look at individual provider information, but instead data trends and performance measures on the system as a whole. As outlined previously NorthSTAR is administered by a private behavioral health organization, ValueOptions, which is put at risk for the delivery of behavioral health services.

PCG recommends developing a transparent and public reporting process. As indicated above, DSHS collects a significant amount of data and has well defined and established performance measurements. These performance measurements include the following:

✓ **Performance Measurement Categories for LMHAs**

- 1. Financial viability and responsibility*** – These measurements assess the LMHAs performance in meeting contractual targets and performing necessary billing functions. Examples include: length of time to submit Medicaid claims, percent of general revenue earned, and percent of state hospital allocation methodology use.
- 2. Quality management*** – These measurements examine the performance of LMHAs in regards to quality management standards. Examples include: % of clients receiving services within 14 days after assessment, hospital readmission rates, level of improved functioning achieved for treated adults, and level of improved problem severity for treated children.

3. ***Crisis service management*** – These measurements examine the LMHAs effectiveness in providing effective care to minimize the utilization of crisis services and the effectiveness of follow up performed after authorization of crisis services. Examples include: % of individuals that receive community based services within 14 days after discharge of crisis services and % of clients who received crisis services again within another 30 days.
 4. ***Continuity of Care*** – These measurements evaluate the effectiveness of the coordination between LMHAs and state mental health facilities. If good coordination occurs, it should result in reduced readmission rates and minimize emergency room usage. Examples include % of clients receiving community services within seven days of hospital discharge and % of clients receiving services within fourteen days after assessments.
 5. ***Waiting List*** – These measurements examine the LMHAs ability to manage waitlists. Examples include % of clients on waiting list with a crisis or hospitalization and % of clients on waiting list and no contact has been made within 90 days.
 6. ***Contract Performance Outcomes*** – In addition to the measurements outlined above, there are a number of other measurements related to contract provisions that are currently tracked and measured by DSHS. Some of these include: adult improved criminal justice involvement, adult improved housing, and adult improved employment, among many others important and meaningful measurements.
- ✓ **Performance Measurement Categories for Substance Abuse Providers**
1. ***Contract and Quality Management*** – These measurements ensure allocated funding is fully expended and that a provider does not expend significantly more than their allotted funding.
 2. ***Discharge Reason*** – These measurements examine the reasons for discharge to ensure a discharge was conducted appropriately and in accordance with proper protocol. Examples include the number discharges in which a client discharges from a program against professional advice, as well as the % of discharges with a referral.
 3. ***Outcome*** – These measurements assess the quality of care provided to consumers and level of follow up performed by contracted providers to perform critical care management functions. Examples include % of resident clients who did not have a treatment plan completed within seven days and % of residential clients not getting an average of 3 hours per week of group or individual counseling.

4. **Detox** – This area examines the utilization of detoxification services. As outlined above, DSHS has a significant amount of data available for analysis and reporting purposes. However, even for the internal reports generated on the LMHAs and contracted substance abuse providers, DSHS aggregates the measurements into the clusters outlined above. For example, for the LMHA waiting list measurement, there are actually three separate measurements included in this category; however, DSHS aggregates the performance of the three measurements to develop an overall score related to waiting list management. DSHS then reports the performance of each of the LMHAs for each cluster or category by ranking them in comparison to all LMHAs. PCG recommends DSHS changing this reporting strategy to show the actual results of each LMHA in relation to each specific performance measurement. It may also be beneficial to display the statewide mean or median depending upon the measurement, so that the public can assess the performance of LMHAs and substance providers in relation to other providers across the state. Another concept is to develop an overall provider report card that summarizes all of the measurements by LMHA so the information can be easily synthesized and analyzed by DSHS staff and stakeholders.

Furthermore there are additional measurements that require modifications and others should be considered to be added. For example, DSHS measures the readmission rates of the LMHAs over a year time period; however, readmission rates should be reviewed within much shorter timeframes. For example, the Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans and this tool set looks at the frequency of readmission rates over a 30 day period, instead of a year. Some other data statistics and performance measurements DSHS should consider are those that are currently captured for the NorthSTAR system of care. Having consistent performance metrics between the two systems of care will also allow DSHS to more readily compare the performance of these two different systems. Beyond performance metrics, DSHS reports a significant amount of consumer and service utilization data in order to monitor trends within the NorthSTAR system of care. These basic data elements are already captured by DSHS on the LMHAs and substance abuse providers and should also be included in the public reporting process. Below we have offered some data and performance measurements DSHS should consider and incorporating into the public reporting process. This not meant to be an exhaustive or complete list, but some data and performance metrics that should be considered.

- Number of clients assessed per quarter by LMHA and substance abuse provider;
- Number of clients receiving services by LMHA and substance abuse provider;
- Demographic breakdown of clients served (sex, race, age, etc.) by LMHA and substance abuse provider;
- Medicaid versus indigent penetration rates on individuals served by LMHA and substance abuse provider;

- Individuals served by Federal Poverty Limit (FPL) by LMHA and substance abuse provider;
- Individuals served with dual mental health and substance abuse disorders;
- Expenditures by service type (such as acute versus non acute services);
- Number of active subcontractors providing services within each LMHA;
- Number of consumers receiving services by RDM service package;
- Number of prescriptions filled versus enrollees served;
- Total expenditures on behavioral health services as a percentage of total expenditures;
- Enrollee level of satisfaction of services rendered;
- Average cost per recipient served and determine whether those LMHAs or subcontracted substance abuse providers that have higher cost structures have a positive correlation in terms of clinical outcomes; and
- Frequency on the usage of acute care services by LMHA or substance abuse provider.

In order to formalize a public reporting process, PCG recommends that a work group be formulated to obtain consensus on the data elements and performance metrics. This includes obtaining feedback from the provider community, representatives from the State Medicaid agency, consumers, advocacy groups and other stakeholders. Once the data elements and metrics are established, they should be maintained and consistently updated and reported on a publicly available website. As the data and performance reporting process matures, DSHS should evaluate the feasibility of developing a pay for performance strategy to reward those providers that generate good outcomes and penalize those for poor performance. This will ensure that these limited funds are effectively spent and that services are generating desired clinical outcomes.

Expected Goals to be Achieved Through the Recommendation: The purpose of this recommendation is to achieve the following:

- 1) **Transparency.** The current reporting process is only available to DSHS and HHSC staff. The performance of providers is important to consumers and advocacy groups. A public reporting process allows for stakeholders to understand the quality of services provided by various contracted providers. If the performance of certain providers is below their expectations, they will have the necessary information to raise concerns to DSHS or to choose another provider to receive services when feasible. Furthermore, a public reporting processes is a common trend within the healthcare industry and it should be adopted and embraced by DSHS. A public reporting process will also allow Texas to provide information to other stakeholders, such as legislators to demonstrate that state general revenues are being prudently expended and resulting in high quality outcomes as a result of services.
- 2) **Enhanced provider accountability.** With the publication of provider performance, it will ensure providers are continuously attempting to improve the quality of care they

provide to consumers. Specific LMHA and substance abuse provider information will be readily available on the web and will clearly outline how their individual performance compares to their peers. If a particular provider's performance is well below the performance of others, it will also provide DSHS the necessary information to potentially make necessary provider changes. For example, if there was a LMHA or substance abuse provider that was consistently underperforming, it could provide DSHS with the necessary information and support from the community to potentially restructure current LMHA organizational governance or even reassign current catchment service areas to LMHAs with better performance. This is the potential power and system change a public reporting process can generate.

- 3) Opportunity to gradually introduce pay for performance reimbursement practices.** By establishing performance measures that are endorsed by stakeholders, it will allow DSHS to develop a foundation to examine the possibility of modifying the current Medicaid and contractual reimbursement methodologies to a performance based reimbursement system. Medicaid agencies across the country are making sure they pay for high quality outcomes, and as a result, holding the provider community for their performance related to the provision of services. A public reporting process can serve as the starting point for DSHS and HHSC to evaluate the feasibility of moving to a pay for performance reimbursement methodology in the future.

Implementation Considerations of the Recommendation: This particular recommendation does present a potential implementation consideration that DSHS and HHSC must be aware of to ensure success. This includes the following:

- 1) Additional administrative burdens.** Much of the data needed to develop a public reporting process is already collected; therefore the expected increased administrative burden to the provider community should be minimal. However, given the lack of funding within the behavioral health public system of care, it is important that DSHS assess any additional administrative burden that the implementation of a public reporting process may require of the LMHAs and contracted substance abuse providers. If the additional administrative burden is considered to be significant, DSHS must evaluate a potential increase to current funding levels.

Financial Implication of the Recommendation: It is PCG's expectation that this recommendation will require additional administrative funds to DSHS in order to modify and transform the current reporting process to a public and transparent process. Additional resources will need to be added to the Decision Support Unit in order to accommodate the new reporting requirements. In addition, the DSHS or HHSC website will need to be modified to accommodate the reporting of data and provider performance. The website costs can be minimal or significant depending upon the reporting preferences of DSHS. For example, the current performance reports can be modified based upon the suggestions of the work group and published as a static



report on the DSHS or HHSC website. Alternatively, a robust web based reporting system can be developed to report live data that is refreshed daily. The latter would be a more costly endeavor and could be evaluated long term on the financial feasibility by DSHS and HHSC.

At a minimum, PCG anticipates the need for two additional full time equivalents to assist in the implementation and ongoing public reporting process. In addition, to the additional staff, PCG anticipates a one-time cost to configure the DSHS and HHSC website to accommodate the public reporting process. A conservative estimate for these total costs is as follows:

Resource	Projected Cost
One full time equivalent	\$85,000 per staff, inclusive of benefits
Website Design	\$75,000 (development charges for changes to DSHS website)
Total Fiscal Impact	\$160,000

Plan for Implementing the Recommendation: The following high level work plan outlines the key steps for the state to take in implementing this recommendation to develop a public reporting process.

Action Step	Responsible Party
Establish public reporting work group	DSHS
Hold work group meetings to develop consensus on reporting measurements	DSHS & HHSC
Issue report on finalized reporting measurements agreed to by work group	DSHS Public Reporting Work Group
Hire DSHS additional staff to support public reporting processes	DSHS
Finalize calculation of new measurements and changes to existing measurements	DSHS
Develop web portal for reporting of performance measurements	DSHS
Evaluate potential pay for performance reimbursement methodology	DSHS & HHSC



Recommendation 2) Develop consistent rules for supervision of Advanced Practice Registered Nurses statewide

Description of the Recommendation: Texas is one of 15 states in the United States that utilizes delegated prescriptive authority for advanced practices registered nurses (APRNs). As such, the State Board of Nursing approves the prescriptive authority for APRNs however it is still necessary for a physician to delegate prescriptive authority before the APRNs can perform the duties for which they are approved. Additionally, Texas is only one of four states that have site-based requirements on the physician supervision for prescriptive authority. Under the site based requirements, the physician supervisory requirements for delegated prescriptive authority varies based on the location of the practice site. The following table²⁶, based on information from the Coalition for Nurses in Advanced Practice (CNAP), outlines the different supervision requirements based on the four practice site locations defined in Texas code.

Location	Location Details	Supervision Requirements
Site Serving Medically Underserved Population (MUP)	<ul style="list-style-type: none"> • Public Health Clinic • Rural Health Clinic • Located in Health Professional Shortage Area (HPSA) • Located in Medically Underserved Area (MUA) • DSHS determined MUP 	<ul style="list-style-type: none"> • Limited to 3 MUP sites • Onsite 1x every 10 business days • 10% chart review & co-signs charts • Keeps logs of onsite activities • Receives daily report on problems • Available for emergencies by phone • Reviews & signs delegation protocol

²⁶ Coalition for Nurses in Advanced Practice (CNAP), *Diagram of Delegated-Site-Based Prescriptive (Rx) Authority for APRNs in Texas*. http://www.cnaptexas.org/associations/9823/files/Handout_Diagram_%20Delegated_Rx_Authority.pdf



Location	Location Details	Supervision Requirements
Primary Practice	<ul style="list-style-type: none"> • Physician onsite 50.1% of the time; OR • APRN seeing physician’s patients in a: <ul style="list-style-type: none"> • Licensed Hospital • Long Term Care Facility • Adult Daycare Facility • Patient’s Residence • School Based Clinic • Any place physician is present AND • If physician with APRN 50.1% <ul style="list-style-type: none"> • Voluntary Charity Care Clinic • Declared Disaster Site 	<ul style="list-style-type: none"> • Limited to 4 full time equivalents (FTEs) (including alternate site) • Quality Assurance (QA) Process • Consistent with sound medical judgment • Reviews & signs delegation protocol • May only delegate prescriptive authority for patients with whom the physician has or will establish a physician/patient relationship
Alternate Practice	<ul style="list-style-type: none"> • Within 75 miles of physician’s practice or residence • Services similar to physician’s primary site 	<ul style="list-style-type: none"> • Limited to 4 FTEs (including primary site) • Physician onsite 10% with APRN/month • 10% chart review (electronic or onsite) • Keeps log of onsite activities • Available by phone for referral, consultation or emergencies • Reviews & signs delegation protocol



Location	Location Details	Supervision Requirements
Facility Based Practice	<ul style="list-style-type: none"> • 2 Long Term Care (LTC) Facilities OR <ul style="list-style-type: none"> • 1 Licensed Hospital 	<p>Long Term Care</p> <ul style="list-style-type: none"> • Medical Director only • May only delegate authority to care for patients of physicians who have given prior consent • Limited to 4 FTEs (including both LTC facilities) • QA process • Consistent with sound medical judgment • Reviews & signs delegation protocol <p>Licensed Hospital</p> <ul style="list-style-type: none"> • May only delegate prescriptive authority for patients of physicians who have given prior consent • QA process • Consistent with sound medical judgment • Reviews & signs delegation protocol

As the chart above illustrates, the supervision requirements across the four sites can vary greatly, with each set of requirements having implications on the physicians and APRNs. One of the frequently cited implications from stakeholders of the site based supervision requirements is that it is often difficult to recruit and retain APRNs to practice at those sites with the more stringent supervision requirements. For physicians, some of the requirements, including the requirement to be onsite at least once every ten days at those sites serving medically underserved populations, present their own challenges and force them to divert their time away from treating patients. With the more prominent usage of electronic health records, Texas needs to re-evaluate its supervision requirements in order to develop a more efficient system of care, while maintaining a high level of patient safety.

Through this recommendation, PCG is proposing that Texas develop and implement consistent supervision requirements for APRNs. In order to accomplish this, PCG recommends that the state convene a workgroup consisting of representatives from the Texas Board of Nursing (TBON), the Texas Nurses Association (TNA), the Texas Medical Association (TMA), the



Texas Medical Board (TMB), HHSC, and other relevant state agencies to review the current site based supervision requirements. The workgroup would then be tasked with developing and implementing a standardized set of supervision requirements for APRNs for all practice sites and examining where efficiencies can be achieved while maintaining the same level of care. For example, perhaps some of the onsite review requirements can be lessened if the availability of electronic medical records exists or the usage of telemedicine technologies can be leveraged. It is the expectation that this work group would develop consensus and formulate recommendations on changes to the supervision requirements. Given the documented shortages of behavioral staff, as well as the current supervision requirements, DSHS needs to challenge physicians, nurses, and pertinent oversight boards to work together to find solutions to expand access, while maintaining necessary clinical standards.

Expected Goals to be Achieved Through the Recommendation: The purpose of this recommendation is to address some of the limitations or weaknesses of the current system of care. These advantages include the following:

- 1) Address the growing workforce shortage of practitioners across Texas.** A common weakness of the current behavioral health system cited by stakeholders is that of a workforce shortage with insufficient clinicians to meet the current needs for services. This recommendation is targeted at providing relief to the workforce shortage concerns by creating consistency in the rules for the supervision of advanced practice registered nurses and nurse practitioners across the state. The recommendation to create consistent supervision requirements across the state may help to address some of the concerns expressed over the growing workforce shortage of practitioners. Multiple studies have noted that Texas ranks at or near the bottom for physician supply ratio. The TMB and Texas Department of Rural Affairs noted that 25 of the 254 counties in Texas had no primary care providers and that 16 counties only had one primary care provider. The Texas Legislative Budget Board's Government Effectiveness and Efficiency Report (GEER) noted that 180 areas or counties in Texas were designated as primary care health professional shortage areas. While this recommendation itself does not directly add new practitioners to the workforce in Texas, it can help to reduce the time spent by physicians supervising APRNs thus allowing them to have more time to treat new patients while also allowing APRNs to more efficiently care for patients.
- 2) Address access to care concerns.** Often cited in conjunction with the feedback on the shortage of providers in Texas is the concern that patients, especially those in the rural, frontier, and border area of the state, have difficulty accessing the care they need. Many studies have supported this concern including the Commonwealth Fund's State Scorecard which placed Texas in the bottom 5 states for access to care. Through the use of consistent physician supervision rules across the state, Texas may be able to increase access to services by increasing the ability of APRNs to perform services within their



scope while physicians more effectively use their time seeing patients instead of performing some burdensome supervisory activities.

Implementation Considerations of the Recommendation: This particular recommendation does present potential implementation considerations that DSHS and HHSC must be aware of to ensure a successful implementation. These implementation considerations include the following:

- 1) **Quality of care from APRNs is not equal to that of Physicians.** One of the most commonly cited justifications for maintaining delegated prescriptive authority and the existing supervision requirements is that the quality of care provided by APRNs is not as high as that provided by physicians. While there have been studies to suggest that the outcomes of patients treated by APRNs are equal to those treated by physicians, this recommendation is not calling for independent prescriptive authority for APRNs. Rather, this recommendation calls for the implementation of consistent supervision requirements across the state and as such should not raise concerns regarding an expansion of the scope or independence of APRNs and the perceived reduction in the quality of care.

Financial Implication of the Recommendation: As stated in the description, this recommendation does not call for a change in the scope of services provided by APRNs, nor for the creation of new requirements that could allow APRNs to practice independently, but rather for the development of a standard set of supervision requirements across all practice sites. It is PCG’s expectation that this recommendation will not require any new funds to develop and implement the set of consistent supervision requirements. Any potential fiscal implications from this recommendation would be driven by any changes in service volume for services provided by APRNs as well as for changes in the volume of physician services provided. It could be expected that these changes however, would be budget neutral given the lower costs and reimbursement rates for APRNs when compared to those for physicians.

Plan for Implementing the Recommendation: The following high level work plan outlines the key steps for the state to take in implementing this recommendation.

Action Step	Responsible Party
Establish a workgroup of representatives from Texas Medical Association, Texas Medical Board (TMB), Texas Nurses Association (TNA), Texas Board Of Nursing (TBON), and HHSC to review existing supervision requirements and develop a standard set of supervision requirements. ²⁷	HHSC, TMA, TMB, TNA, TBON

²⁷ Workgroup efforts like this have already been implemented in Texas. As such, PCG recommends these efforts continue to ensure consistent supervision requirements are developed and adopted. CNAP has already developed a simpler set of supervision requirements that it intends to take to the legislature in the next session. Details on this proposal can be found at



Action Step	Responsible Party
Develop the necessary language to be included in the appropriate sections of the Texas Occupations Code.	Workgroup
Obtain necessary approval of statutory code changes	TMB, TBON, Texas Legislature
Adopt new rules for supervision requirements	TMB and TBON
Train physicians on new requirements	TMB
Train APRNs on new requirements	TNA

<http://cnaptexas.org/associations/9823/files/Description%20of%20Proposed%20Collaborative%20Prescriptive%20Authority%20Model%208-7-12.pdf>

V. FUNDING AND FINANCING RECOMMENDATIONS

Recommendation 1) Effectively leverage funding opportunities under 1115 demonstration waiver through proper oversight

Description of the Recommendation: In December 2011, Texas received approval of a Healthcare Transformation and Quality Improvement Program, or an 1115 transformation waiver, which is designed to achieve quality improvements through the implementation of delivery system reform initiatives. Providers successful in the implementation of delivery system reform initiatives will be compensated through delivery system reform incentive payments (DSRIP). There are a number of DSRIP projects that have a primary focus on behavioral health services. HHSC and DSHS have done a commendable job in ensuring behavioral services were considered and received the necessary attention in its overall efforts to transform the Medicaid program.

HHSC and DSHS have confirmed that the community mental health centers (CMHC) can participate as an intergovernmental transfer (IGT) entity to which will be eligible to draw down federal matching funds if they successfully participate in DSRIP projects. The CMHCs are the Medicaid provider of record and each center is a part of and overseen by one of the 37 Local Mental Health Authorities (LMHAs) with the exception of the two CMHCs within the NorthSTAR system of care. Centers receive approximately \$300,000,000 in state general revenues a year and generate nearly another \$75,000,000 and local funds which are eligible for federal Medicaid match. The \$300,000,000 in state general funds are allocated to LMHAs by DSHS and authorized by the Texas Legislature. Initial indications from HHSC are that 10% of the total DSRIP funding initially will be targeted for CMHCs to carry-out DSRIP initiatives. However, there is a potential for CMHCs to have greater participation in DSRIP projects if the remaining 90% of DSRIP funding is not fulfilled by other participating entities. It is unknown on how much additional funding will be available at this juncture, but the table on the following page the potential total incremental federal funds that can be potentially achieved by CMHCs over the demonstration based upon the established 10% allocation to CMHCs.



Funds	DY1	DY2	DY3	DY4	DY5
Total Funding	500,000,000	2,300,000,000	2,666,000,000	2,852,000,000	3,100,000,000
Funding % for LMHAs	10% of 80%*	10%	10%	10%	10%
LMHA Potential Additional Funds	40,000,000	230,000,000	266,000,000	285,200,000	310,000,000
FFP Rate **	58%	58%	58%	58%	58%
LMHA Potential Additional Federal Funds	23,200,000	133,400,000	154,280,000	165,416,000	179,800,000

DY = Demonstration Year

** For the first demonstration year (DY1), 20% of DSRIP funds are set aside for the anchoring entities within each regional health partnership, this means that only 10% of the remaining 80% of funds will be potentially available to CMHCs.*

*** Federal financial participation (FFP) rates are estimated, as prospective rates are not published yet by the Centers for Medicare and Medicaid Services (CMS).*

The potential incremental funds equates to \$656,096,000 over the five year demonstration period, which to put in perspective exceeds the total state general revenue funds allocated to LMHAs in a single state fiscal year. Given that the majority of the available matching funds to draw down additional federal dollars available for DSRIP projects are made available through state general revenues allocated by DSHS, it is imperative that DSHS is involved in the oversight in how these funds are invested within the 1115 waiver. PCG recommends that DSHS serve in an oversight role to ensure CMHCs implement those DSRIP initiatives that are going to be most impactful to the system of care and remain coordinated with the overall goals of the agency. PCG understands that the DSRIP projects available for pursuit within each of the various regional health partnerships (RHPs) will be driven by the community needs assessment process completed at the local level. However, once these DSRIP projects are identified and ultimately approved by CMS for each of the RHPs, it is imperative that DSHS ensures the projects pursued by the CMHCs are also consistent with their programmatic goals and objectives.

One way to ensure DSRIP projects pursued are consistent with the goals of DSHS, PCG recommends that DSHS develop and communicate the main objectives that the Department hopes to accomplish as a result of the 1115 waiver. Potential goals could be the following:

- *Expanded use of evidenced based practices.* This could include an aggressive expansion of peer support specialists or the pursuit of physical and behavioral health system of care models.

- *Expand workforce.* This could include the investment into graduate education programs in order to develop additional workforce to meet consumer demand.
- *Enhance infrastructure.* Expanding the usage of telemedicine in order to increase access to services or incentivize the use of electronic health records to more efficiently share critical information to improve care.

The goals above are just some recommendations that CMHCs could consider. Given the magnitude of the funding potential, if the 1115 waiver is implemented in the most meaningful way, it could have a significant impact on the system of care and could lead to savings in other behavioral services across public programs and services, such as behavioral health spending within criminal justice systems, including county jails and juvenile justice systems.

In order to ensure the effectiveness of using state general revenues, PCG recommends that DSHS implement immediate changes to the contractual agreements with LMHAs. There should be the inclusion of oversight and approval functions required of CMHCs before they officially proceed with pursuit of an 1115 DSRIP project. This will allow DSHS the opportunity to weigh in on what types of projects are being pursued to ensure funds are directed to appropriate and impactful initiatives.

Expected Goals to be Achieved Through the Recommendation: The purpose of this recommendation is to achieve the following:

- 1) **Proper oversight.** By establishing oversight protocols and standards, it will ensure funds are wisely invested and are also used to carry-out the Department's goals and objectives. Furthermore, DSHS can assist in monitoring the performance of CMHCs in carrying out DSRIP initiatives. If a CMHC fails to meet the performance measurements, oversight will ensure DSHS is aware of these potential shortfalls and be in position to correct the challenges or hold the CMHC responsible for lack of performance.
- 2) **Ensured investment of DSRIP funds to critical program challenges.** Again, as stated previously, DSHS involvement will ensure funding is directed to needed areas. PCG recognizes that challenges will vary across the various regional health partnerships, but there are consistent challenges to the system of care, such as access to services and work force challenges that should be consistently addressed by all LMHAs. Only by establishing a formal review process of the LMHAs and CMHCs activities surrounding the 1115 waiver can DSHS be assured that state general revenues are wisely and effectively invested.



Implementation Considerations of the Recommendation: This particular recommendation does present a potential implementation consideration that DSHS and HHSC must be aware of to ensure success. This includes the following:

- 1) **Minimize impediment on system progression.** Any oversight process implemented must be well planned and efficient. Policy, procedures, and planning activities around the DSRIP projects are moving at a ferocious pace. Therefore, it is critical that DSHS is not only thorough in its review processes, but expedient as well to ensure progress is not hindered throughout the implementation process.

Financial Implication of the Recommendation: As previously outlined, the 1115 waiver has a significant potential positive financial impact to the system of care. This waiver allows for existing state general revenues to be matched to draw down additional federal funds. However, one potential fiscal risk that DSHS should be aware of is if state general revenues used to implement DSRIP projects are not successful it could have financial ramifications to the LMHAs, CMHCs and DSHS. For example, once a DSRIP project is approved, it requires the CMHC to invest state general revenues to operationalize the project. DSRIP payments are only made once the project has met the necessary milestones, which provides the necessary evidence that the project was successful. If a CMHC implements a DSRIP project and is unable to demonstrate the success of the project by meeting the performance metrics, it would result the potential misuse of state general revenues and potentially require the CMHC to cut back services in order to make up for the ill investment of funds. Albeit PCG anticipates this is a very low financial risk, especially with the implementation of proper oversight by DSHS, it is still an issue PCG wanted to raise awareness to.

Plan for Implementing the Recommendation: The following high level work plan outlines the key steps for the state to take in implementing this recommendation to develop a proper oversight process in regards to the 1115 waiver.

Action Step	Responsible Party
Amend contracts to establish CMHC reporting process surrounding use of general revenue funds for 1115 waiver DSRIP projects	DSHS
Establish programmatic and policy goals and objectives surrounding 1115 waiver	DSHS
Review DSRIP projects requested for implementation by CMHCs	DSHS Public Reporting Work Group
Perform oversight and evaluation on the success of 1115 DSRIP projects implemented by CMHCs	DSHS



Recommendation 2) Increase funding for targeted programs and services to address specific system needs

Description of the Recommendation: Throughout PCG’s review of the Texas behavioral health system, PCG conducted approximately 15 stakeholder sessions with attendance of nearly a thousand stakeholders. In addition, PCG met with numerous provider groups, advocacy groups, and consumers. Desired changes to the current system of care varied significantly; however, there was one common theme in which there was agreement on from the hundreds of stakeholders PCG met with. This issue was centered on the inadequacy of the current level of funding that is provided to the behavioral health system. This is not solely an opinion but instead is supported by facts published by multiple credible organizations such as the Kaiser Family Foundation and the National Association of State Mental Health Program Directors (NASMHPD). In 2009, the Kaiser Family Foundation ranked Texas last in the country in per capita funding for public mental health and substance abuse services. Texas spends a considerable amount of funds on mental health and substance abuse services, ranking 9th nationally in state mental health agency (SMHA) expenditures. However, given the size of Texas and the demand for services the current investment is extremely low on a per capita basis and creates significant strains on the behavioral health system and down the line cascades to costs to the juvenile justice system, criminal justice system, and county jails.

It was also frequently cited by stakeholders and in other interviews that due to some of the limitations and challenges in accessing public behavioral health services, Texas spends significant amounts of money providing behavioral health services in jails and prisons across the state, with one source noting that the Texas Department of Criminal Justice spent \$130,000,000 for such services in their facilities, as well as unspecified costs of individuals seeking services through hospital emergency rooms.

This recommendation calls for Texas to identify additional funds to be directed to the public behavioral health system for specific issues and needs within the current system. A few of the areas that could significantly benefit from additional funding include:

- **Programs to address the growing use of criminal and juvenile justice facilities as mental health facilities:** It was frequently noted during stakeholder meetings that there is a number of individuals receiving treatment for mental health issues in jails, prisons, and juvenile detention centers across the state. This is supported by the fact that the Texas Department of Criminal Justice (TDCJ) spent over \$130,000,000 on mental health and substance abuse services for individuals in their facilities. Through the previous investment in crisis services, DSHS was able to work with the service delivery systems to develop additional services and units, such as crisis stabilization units to help keep individuals out of state hospitals and jails. Additional efforts to address the growing need for jail diversion programs include the piloting of Outpatient Competency Restoration (OCR) programs designed to treat individuals in an outpatient setting instead of in jails or

inpatient settings. Through increased funding, DSHS would be able to further expand programs like the OCR program or work to develop additional programs and services with the goal of reducing the use of criminal and juvenile justice facilities as mental health facilities.

These programs will become increasingly important to the public mental health system in light of the 419th District Court's ruling in the Taylor v. Lakey case, requiring that individuals incarcerated with mental illness gain access to state hospital beds within 21 days of the court order. In a system in which the Harris County Jail provides mental health services to 2,400 out of 9,500 inmates on a monthly basis. This jail serves as the largest mental health facility in Texas²⁸. It is vital that funding is provided to support the increased need for jail diversion programs and state inpatient hospitalization alternatives.

- **Programs designed based on national best practices and evidence based practices:** Another common theme raised by stakeholders during the public forums was that there are a number of national best practices and evidence based practices that could help to transform the behavioral health system from a “crisis driven” system to a “recovery driven” system of care, but these practices are not currently funded or not fully implemented in Texas. One particular practice that was often cited was the use of peer supports in both mental health and substance abuse settings. A hurdle to the expansion in the use of peer supports was noted as the lack of funding for the training that is required to become certified peer specialists. Additional items that were noted as being important to driving recovery, but due to the lack of funding were not readily accessible, such as wrap-around support services like supported housing, supported employment, and transportation. Additional funding directed towards these services could be a significant boost in moving the system towards a recovery based model.
- **Children's Programs:** When the mental health system in Texas is discussed, it is often assumed that the “system” is inclusive of both adults and children. However, the reality is that given the differences in funding levels, services for children often go overlooked when compared to those for adults. This was highlighted by stakeholder comments that cited numerous examples of children often having to travel hours away from their homes to receive appropriate services due to a lack of child psychiatric resources in their area. While the entire mental health system would benefit from additional funding, child psychiatric services and programs would be well served by an influx of new funds. These additional funds could be directed at addressing the shortage of child psychiatrists in the state by enhancing reimbursement rates to attract additional providers or at providing funding for programs that provide education and support to families in order to help them in understanding the needs and challenges of their child with mental health issues.

²⁸ Arnold R. “Mentally Ill Crowding Jail, Courts.” 2008. Available at : <http://www.click2houston.com/investigates/16364907/detail.html>.

- **Substance Abuse Programs:** The substance abuse program in Texas, like in a number of states, is severely underfunded—at levels at least equal to that of the mental health program. The Center on Addiction and Substance Abuse (CASA) noted in a 2009 report that Texas ranked 37th out of 47 states reporting on spending for substance abuse prevention, treatment and research. Any additional funding made available to DSHS could be directed towards addressing the funding needs for substance abuse services in the state, including the important prevention programs that could return a decrease in the number of individuals entering substance abuse treatment programs.

Expected Goals to be Achieved Through the Recommendation: The purpose of this recommendation is to address some of the limitations or weaknesses of the current system of care. These advantages include the following:

- 1) **Providing much needed funding to a historically underfunded system.** As has been previously stated in the description and commonly raised during any discussions on the state of the public behavioral health system in Texas, the system is underfunded and as a result unable to provide the necessary services to meet the needs of Texans with mental health and substance abuse disorders.
- 2) **Additional funding for those programs and services most needed to address system deficiencies.** Within the public behavioral health system in Texas there are a number of programs and services that would benefit from additional funding and that could have positive impacts on other areas of the behavioral health system and other non-behavioral health programs. Examples of these areas include the need for increased focus on jail diversion programs, national best practices and evidence based practices that could move the system from “crisis driven” to a recovery based system, and substance abuse and children’s mental health programs which have often lagged in funding behind the rest of the system. In directing funding at those areas in most need, the state could benefit from a reduction in the use of more expensive alternatives and realize cost savings over the long term; however, there is an immediate need for additional funding to support the basic needs of Texans faced with behavioral health needs.

Implementation Considerations of the Recommendation: This particular recommendation does present potential implementation considerations that DSHS and HHSC must be aware of to ensure a successful implementation. These implementation considerations include the following:

- 1) **Identify opportunities to reallocate existing funding.** One option for Texas to consider in directing increased funding towards public behavioral health services would be for the Legislature to reallocate existing funds from other agencies that provide behavioral health care as a substitute for the inadequate public behavioral health care system. For example, Texas could reallocate a portion of the \$130,000,000 currently spent by TDCJ on behavioral health services to DSHS to develop increased capacity for jail diversion

programs. Additional options could include internal reallocations within the DSHS budget to move funding towards programs with proven clinical outcomes from those that are not in line with established best practices. This option would require a shifting of funds from one underfunded program to another and may not have a material impact on the ability of DSHS to provide services more efficiently and effectively.

- 2) **Identify opportunities to update existing funding allocations to DSHS contractors.** In the Phase I report PCG discussed the current allocations processes through which DSHS funded their contractors and their state hospitals. In this discussion it was noted that the current allocation processes for mental health services in particular, both community based services and state hospital services, have been in place for long periods of time without significant changes. The allocation of funds to the LMHAs for example has been in place without a significant change for over 20 years. As DSHS looks to identify opportunities to reallocate funds from programs that have not produced proven clinical outcomes to those that have the allocations to the LMHAs as well as the State Hospital Allocation Methodology should both be reviewed for opportunities to revise the allocation processes to direct funding to programs and services that produce improved outcomes.
- 3) **DSHS will need to be clear in its intents for any additional funding.** In the event additional funding is made available for the public behavioral health system there will undoubtedly be a number of interested stakeholders that will express their desires for the funds to be directed at various programs and services. It will be important for DSHS to have a clear vision of those programs or services they believe are the most needed to improve the system and focus their efforts on ensuring the funds are directed to those appropriately.
- 4) **DSHS will need to set performance metrics to measure the effectiveness of any additional funding for the public behavioral health system.** It will be important for DSHS to document and measure the effectiveness of any new funding made available for the system. In order to clearly support that the new funds have been used effectively and addressed the system deficiency for which it was intended, DSHS will need to develop and monitor specific performance measures for the programs and services funded. If funding is directed towards reducing the number of individuals receiving mental health services in jails, DSHS could track the number of individuals receiving services in the public behavioral health system after an encounter with law enforcement as a means of illustrating that the funding has been effective in serving people in an appropriate mental health service setting instead of jails.

Financial Implication of the Recommendation: This recommendation has significant financial implications for Texas. PCG recommends that a minimum of \$81.4M in additional funding be invested into the behavioral health system. The funding areas outlined below are areas that PCG



believes would be most impactful to the State of Texas public behavioral health system of care. Each of the programs and funding focuses will allow Texas to expand the promotion of evidence based practices to improve the quality and quantity of clinical treatment available to families and mental health providers. Evidence based practices are approaches to treatment that consider research to inform choices for effective courses of treatment. The research provides valuable information that can benefit adults and children with a wide range of mental health challenges. Investing in programs and initiatives that are considered evidenced based practices allows the Department to effectively direct limited resources to programs and areas where they will have the greatest impact. Furthermore, the investment into these program areas should ultimately lead to long term savings if these initiatives are implemented successfully. For example, jail diversion programs could lead to significant savings if fewer individuals are incarcerated due to behavioral health challenges, which has resulted in millions of state and local general revenues being spent on the provision of behavioral health services in county jails. PCG has provided the following table of potential funding priorities:

Program	Count	Unit Cost	Total	Comment
Fund additional jail diversion programs	10	\$500,000	\$5,000,000	Expect to serve 500 consumers each at an average cost of \$1,000 per consumer
Fund additional mobile crisis teams to provide additional coverage	20	\$750,000	\$15,000,000	Enhance coverage periods where most inpatient admissions occur
Fund drop-in centers to provide additional resources for basic mental health and substance abuse services	25	\$450,000	\$11,250,000	Provide resources to support consumers at risk of admission and/or as upon discharge
Fund additional Assertive Community Treatment (ACT) programs	10	\$1,000,000	\$10,000,000	Expect to serve 1,000 consumers each at an average cost of \$1,000 per consumer
Fund a training for peer specialists	1	\$1,000,000	\$1,000,000	Train at least 1,000 peer specialists at \$1,000/ individual
Fund an incentive program to attract additional child psychiatrists	1	\$5,000,000	\$5,000,000	Expect incentives of up to \$50,000 incentive for at least 100 child psychiatrists
Fund substance abuse prevention programs in schools	10	\$500,000	\$5,000,000	Expect participation from at least 100 school districts to create programs
Fund additional crisis stabilization units	8	\$750,000	\$6,000,000	Provide immediate access to emergency psychiatric care and short-term residential treatment
Fund additional extended observation units	5	\$450,000	\$2,250,000	Provide 23-48 hours of observation and treatment for psychiatric stabilization



Program	Count	Unit Cost	Total	Comment
Fund additional crisis respite / residential services	5	\$1,000,000	\$5,000,000	Provide from short-term care for individuals at risk of harm to self or others
Fund additional outpatient competency restoration services	12	\$650,000	\$7,800,000	Provide community treatment to individuals with mental illness / substance abuse involved in the legal system
Fund additional transitional services	10	\$250,000	\$2,500,000	Provide linkage between existing services and individuals with serious mental illness not linked with ongoing care for up to 90 days
Fund additional intensive ongoing services	15	\$375,000	\$5,625,000	Provide intensive, wraparound services that are recovery-oriented to address mental health needs for children
		Totals	\$81,425,000	

The funding amounts outlined above are recommended based upon PCG’s experience. These amounts represent total expenditures and do not account for federal financing, which for the Medicaid population is approximately 60.00%, significantly reducing the State’s general fund obligation to implement these initiatives. It is critical that DSHS conduct further analysis and costing efforts to determine the actual financial need for Texas for these programs and services. Furthermore, it would be beneficial if DSHS engaged consumers, providers, and advocacy groups to determine if other or additional programs and services should be considered as funding priorities beyond those initiatives raised by PCG. Finally, in order to ensure the funds are effectively invested it is imperative that DSHS establish performance measures so that DSHS can evaluate the success and effectiveness of the initiatives.

Plan for Implementing the Recommendation: The following high level work plan outlines the key steps for the state to take in implementing this recommendation.

Action Step	Responsible Party
Develop a list of priority programs/services most needed in Texas	DSHS and HHSC
Conduct a comprehensive cost analyses to determine the actual level of additional funding needed for the priority programs/services	DSHS
Develop a plan for directing additional funds for those priority programs/services including methods for allocating funds to providers	DSHS and HHSC
Develop performance metrics to measure the effectiveness of additional funds allocated to specific programs/services	DSHS and HHSC



Recommendation 3) Develop a 1915(i) State Plan Amendment (SPA) to include services like supported housing and supported employment

Description of the Recommendation: Under a 1915(i) State Plan Amendment states are able to provide any of the home and community based services (HCBS) listed in section 1915(c)(4)(B) of the Social Security Act. These services include case management services, homemaker/home health aide services, adult day health services, habilitation services, and respite care. For individuals with chronic mental illness additional services including day treatment, other partial hospitalization services, psychosocial rehabilitation services, and clinic services may also be provided. Unlike HCBS waiver programs, recipients of services under the SPA are not limited to individuals at risk of institutional care nor are states required to demonstrate that the services under 1915(i) are cost effective as compared to institutional care.

In 2010, the Affordable Care Act (ACA), attempted to increase the number of states adopting 1915(i) SPAs by removing some of the barriers to offering HCBS through the Medicaid State Plan. Included within the revisions under the ACA are provisions that allow for states to identify specific populations and develop specific benefit packages for that population, propose other services not specifically named in the 1915(c) statute, eliminate caps on the number of individuals enrolled and eliminate the state's ability to limit eligibility based on geographical area. While some of the revisions have had the intended effect of reducing barriers to implementing the 1915(i) SPA, the revisions to eliminate the state's ability to cap the number of individuals enrolled and to eliminate the state's ability to limit the SPA geographically have presented new challenges for states.

Some states, including Louisiana, Oregon, and Wisconsin have already taken advantage of the 1915(i) option. Louisiana developed a 1915(i) SPA in 2010, pending CMS approval, for Adult Psychosocial Rehabilitation and Clinic option for adults with Severe and Persistent Mental Illness to be implemented through existing Developmental Disabilities and Aging and Physical Disabilities systems. Oregon also submitted in 2010 a 1915(i) SPA aimed at providing individuals with significant physical or behavioral or mental health needs with in home or residential care, respite and adult day services so that institutional care could be avoided.

Wisconsin adopted a 1915(i) SPA for individuals with SPMI with covered benefits for psychosocial rehabilitation and community recovery services. The three parts of the benefit include community living supportive services, supported employment, and peer supports. The Medicaid funding under Wisconsin's 1915(i) SPA is being used to replace the county funding that was previously used to for community living supportive services and to provide new coverage for supported employment and peer supports. In light of the revisions to the 1915(i) rules under ACA, Wisconsin is submitting a new 1915(i) SPA to expand coverage statewide and eliminate the enrollment ceilings.

This recommendation calls for Texas to develop a 1915(i) SPA for their target population to provide support services similar to those covered under the Wisconsin 1915(i) SPA, notably the community living support services, supported employment, and peer supports. To date, DSHS developed a white paper outlining potential solutions under a 1915(i) SPA and has moved forward with crafting an exception item to request the state match needed to implement a 1915(i) SPA targeted at long term or high recidivism state hospital clients.

Expected Goals to be Achieved Through the Recommendation: The purpose of this recommendation is to address some of the limitations or weaknesses of the current system of care. These advantages include the following:

- 1) Provide important wraparound services to the target population.** A common theme raised during stakeholder forums was that the current mental health system does not promote recovery for individuals with mental illness. Stakeholders pointed to the lack of the key services needed for individuals with mental illness to be successful in the community, namely community living supports and supported employment. While these services may be provided currently using local resources, through a 1915(i) SPA, Texas would be able to provide these wraparound services and receive federal matching funds for them.
- 2) Texas could experience cost savings.** In providing funding for wraparound services it is possible for Texas to experience long term cost savings as individuals with mental illness are able to live in a community setting with the aid of appropriate community living supports and supported employment. As individuals with mental illness move towards recovery and function in appropriate community settings, it is expected that their reliance on more expensive models of care including the use of inpatient hospitals and hospital emergency rooms will decrease. These cost savings could be redirected towards expanding access to other behavioral health programs and services.

Implementation Considerations of the Recommendation: This particular recommendation does present potential implementation considerations that DSHS and HHSC must be aware of to ensure a successful implementation. These implementation considerations include the following:

- 1) New 1915(i) requirements under ACA reduce cost certainty for states.** While the new requirements for 1915(i) SPAs under the ACA are intended to attract more states to implement this option, some of the new requirements have not reduced the reluctance of state to implement a 1915(i) SPA. Most notably the requirement for services to be offered statewide and the elimination of enrollment caps have caused states to remain reluctant to implement 1915(i) SPAs, as these requirements constrain the ability of the states to control costs. As part of their new 1915(i) submission to address the changes under ACA, Wisconsin has moved to tighten the needs based eligibility criteria it had included in their 1915(i) prior to the ACA changes.



Financial Implication of the Recommendation: There is the potential for this recommendation to be budget neutral for Texas or even generate cost savings for the state as services that were previously funded entirely with state and local funds are now eligible for Medicaid federal matching funds under the 1915(i). For this recommendation to require additional funding there would need to be a significant increase in the utilization of the services added under the 1915(i) SPA option.

As an illustration of this point, consider the following example in which it is assumed that Texas is currently spending \$50 million in state and local funds to provide wraparound services such as supported housing and supported employment which are not covered by Medicaid. In moving these same services under a 1915(i) SPA and assuming no changes in the utilization of the services, the state would be able to reduce the state expense by \$29.1 million or the equivalent of the Federal share.

\$ 50,000,000	Current Spending – all state and local funding
\$ 50,000,000	Total Funding for same services covered under 1915(i) SPA
\$ 29,110,000	Federal Share of funding under 1915(i) SPA
\$ 20,890,000	State Share of funding under 1915(i) SPA

Following the same example, for the state to see an increase in the expenditures for these services under a 1915(i) SPA option, there would need to be a significant increase in the utilization of these services. The following table illustrates the extent to which total funding for the services would need to increase for Texas to see the required state share reach the same level as the current spend on these wraparound services.

\$ 50,000,000	Current Spending – all state and local funding
\$ 119,674,485	Total Funding for same services covered under 1915(i) SPA
\$ 69,674,485	Federal Share of funding under 1915(i) SPA
\$ 50,000,000	State Share of funding under 1915(i) SPA

In this example, Texas would need to commit additional state funding beyond its current funding level only if the total funding for the services covered under the 1915(i) SPA option would exceed \$119.7 million. It will be important for DSHS to assess the amount of state general revenue currently utilized to provide these services. In addition, DSHS will need to determine the demand for these services. With this information a more accurate fiscal impact can be completed to determine whether this initiative would require additional funding.



Plan for Implementing the Recommendation: The following high level work plan outlines the key steps for the state to take in implementing this recommendation.

Action Step	Responsible Party
Define and quantify the individuals who would be covered under the 1915(i)	HHSC, DSHS
Define the services to be included in the 1915(i) benefit	HHSC, DSHS
Identify and quantify the service costs that would qualify under 1915(i)	HHSC, DSHS
Develop the 1915(i) SPA for submission to CMS	HHSC, DSHS
Train provider community on new benefit	HHSC, DSHS

Recommendation 4) Reinstate funding for Graduate Medical Education programs

Description of the Recommendation: Graduate Medical Education (GME) funding is an important component in a state's ability to providing the necessary training and residency opportunities for physicians graduating from medical school as well as other health professionals completing graduate education programs. Funding for GME programs create various incentives, including residency offerings, compensation packages, and in some cases tuition repayment options for medical school graduates. The ability of the state to support graduate medical education through the funding for GME programs plays an important role in the state's ability to attract and retain health professionals to practice in the state. A well supported GME program also provides a means for a state to experience a return on the investment made in supporting medical schools in the state as more graduates are able to stay in-state for their residency and subsequently more likely to practice in-state upon completion of their residency. The long term benefits include a consistent supply of new physicians, nurses, social workers, and other health professionals entering practice in the state, ensuring the work force is continued to be maintained and expanded, as Texas increases in population as well as demand for these services.

In Texas, the GME program has never been fully funded but has survived with the state and federal funding it did have. However, with the 2011 legislative session, in which the budget deficit was addressed through cuts, and with reductions in federal funding for GME programs, graduate medical education in Texas was reduced even further. According to the Texas Higher Education Coordinating Board, who is responsible for administering the funding for GME in Texas, these funding cuts have had significant implications on a number of the state's programs, including:

- A 72% reduction (\$20.2 million in 2010-11 to \$5.6 million for 2012-13) in state support for the Family Practice Residency Program; funding that is used for the education and training of residents in the state's 26 accredited family practice residency programs.
 - As a result of the reduction in state support, residents would now receive about \$4,000 per resident after previously receiving \$14,564 per resident.
- The complete elimination of the Primary Care Residency Program which included 122 residents in internal medicine, pediatric, and obstetrics and gynecology programs.
- A 76% reduction (\$23.3 million in 2010-11 to \$5.6 million for 2012-13) in funding for the Physician Education Loan Repayment Program, which pays off the medical school bills for doctors who agree to work in medically underserved areas in Texas.²⁹

As a state that currently, and consistently, ranks in the bottom 10 for the number of active doctors per 100,000 residents, these cuts to graduate medical education in Texas may only serve

²⁹ Tan, Thanh. "Day 22: State Cuts Mean Fewer Residency Slots in Texas". The Texas Tribune, August 22, 2011.

to put additional burdens on those active providers in the state. The Association of American Medical Colleges, State Physician Workforce Data Book for 2011 found that Texas had 205 physicians per 100,000 residents, placing them 42nd for number of physicians per 100,000 residents. Texas falls even further in the rankings when looking at active patient care physicians (46th in the rankings at 176.1 physicians per 100,000 residents) and active primary care physicians (47th in the rankings at 70 physicians per 100,000 residents).³⁰

In addition, the Hogg Foundation for Mental Health published a study in 2011 that discussed specific workforce shortage concerns in the behavioral health system. In this study, the Hogg Foundation for Mental Health noted that “In 2009, 102 Texas counties did not have a psychologist, 48 counties did not have a licensed professional counselor, and 40 counties did not have a social worker. Even more striking is the fact that 171 counties did not have a single psychiatrist.”³¹ The Hogg Foundation for Mental Health went on to note that one of the factors contributing to the shortage of mental health professionals is the lack of training opportunities. Specifically, the 2003 elimination of state funding for psychiatric residency training in state hospitals and the subsequent reduction of psychiatry residents completing residency programs in Texas from 68 residents in 2005 to 49 residents in 2009 were noted as significant training deficiencies.³²

While the implications of reductions in GME funding on the state have been discussed by various researchers, it should be noted that the reductions in GME funding will likely have greater impacts on those areas of the state and those specialties that have historically faced difficulties in recruiting and retaining physicians. From the perspective of the behavioral health system, those areas of concern include the areas that are medically underserved as well as specialty providers like psychiatrists and child psychiatrists.

Expected Goals to be Achieved Through the Recommendation: The purpose of this recommendation is to address some of the limitations or weaknesses of the current system of care. These advantages include the following:

- 1) Address the growing shortage of health professionals in Texas.** One of the concerns raised by stakeholders was that even though individuals were eligible to receive services, they often struggled to access those services due to difficulties in finding qualified providers. This issue was of particular concern for those areas considered to be medically underserved areas and for child psychiatrists, which some stakeholders noted were so rare that children often had to travel hours from their home to receive appropriate services. Through reinstating funding for GME programs, Texas could begin to recruit and retain the health professional resources needed to serve those areas of the state and those specialties in greatest need of providers.

³⁰ Association of American Medical Colleges, 2011 State Physician Workforce Data Book.

³¹ Hogg Foundation. “CRISIS POINT: Mental Health Workforce Shortages in Texas”. March 21, 2011.

³² Hogg Foundation. “CRISIS POINT: Mental Health Workforce Shortages in Texas”. March 21, 2011.

- 2) **Address the shortage of mental health professionals in Texas.** As noted in the Hogg Foundation for Mental Health study, Texas is experiencing a severe shortage of mental health professionals with 173 out of 254 counties designated as Health Professional Shortage Areas for mental health³³ and cuts to graduate medical education funding has played a central role in the state's inability to develop new mental health professionals. Through this recommendation, increased graduate medical education funding can be directed to support training opportunities for mental health professionals, including psychiatric residency training programs in state hospitals and internships for psychiatric nurses, licensed professional counselors, and master social workers.
- 3) **Minimize the negative economic impacts from unmet mental health care needs.** The Hogg Foundation for Mental Health noted in their 2011 study on the mental health workforce shortage that inadequate mental health services have economic implications beyond just the health care system. When individuals are unable to receive appropriate treatment for mental illness, there is an increased potential for lost earnings when the illness prevents the individual from working, increased disability costs, and increases in homelessness and incarcerations.³⁴ An ancillary benefit of this recommendation to increase funding for graduate medical education would be an increase in the number of providers available to provide the necessary services that help to address the mental health needs of Texans that currently go unserved or underserved.
- 4) **Reduce the costs for treating individuals with mental illness in non-mental health settings like jails, prisons, and juvenile detention centers.** It was frequently noted by stakeholders that as a result of the limited resources currently available to meet the mental health needs of Texans that a number of individuals with mental illness end up receiving their care as inmates of the jails, prisons, and juvenile detention centers across the state. This model of treatment is not only a costly alternative to the more appropriate services provided through the mental health system but also viewed by many stakeholders and advocates as less effective than the appropriate community alternatives. Through an increase in the funding for graduate medical education, it could be expected that additional providers become available to treat those individuals with mental illness in the appropriate settings before the individual reaches the stage of requiring incarceration.

Implementation Considerations of the Recommendation: This particular recommendation does present potential implementation considerations that DSHS and HHSC must be aware of to ensure a successful implementation. These implementation considerations include the following:

- 1) **Additional GME funding would be coveted by many groups and agencies.** In a state that is consistently cited for its lack of funding for many health and human service programs, any additional funding made available by the legislature would become highly

³³ Hogg Foundation. "CRISIS POINT: Mental Health Workforce Shortages in Texas". March 21, 2011.

³⁴ Hogg Foundation. "CRISIS POINT: Mental Health Workforce Shortages in Texas". March 21, 2011.



coveted by a number of state agencies and various groups and associations. Additional funding for GME programs would be no different, and while any increase in physicians practicing in Texas would benefit the entire health care system in the state, it will be important for DSHS to lead efforts in ensuring that some of the funding be directed towards programs supporting psychiatry and in particular child psychiatry.

Financial Implication of the Recommendation: This recommendation carries significant financial implications for Texas. As was identified in the description of the recommendation, significant reductions in GME funding for the Family Practice Residency Program and the Physician Education Loan Repayment Program alone totaled \$32.3 million. In their 2012 Formula Funding Recommendations, the Texas Higher Education Coordinating Board recommends that GME funding be increased from the \$45,988,260 appropriated for the FY 2012-13 biennium to \$51,980,526 for the FY 2014-15 biennium, an increase of \$5,992,266 or 13.03%.³⁵ PCG believes that the amount recommended by the Texas Higher Education Coordinating Board would be the minimum amount of additional funding necessary to support the needs of graduate medical education in Texas.

Plan for Implementing the Recommendation: The following high level work plan outlines the key steps for the state to take in implementing this recommendation.

Action Step	Responsible Party
Support the Texas Higher Education Coordinating Board’s recommendation for increased GME funding	DSHS and HHSC
Develop a strategic plan for utilizing additional GME funding to address specific shortages of psychiatrists and child psychiatrists	DSHS

³⁵ Texas Higher Education Coordinating Board. “Formula Funding Recommendations 2012”. April 2012.