

Texas Leadership Roundtables on Health Care

Behavioral Task Force Principles and Recommendations

Principles and Recommendations for Behavioral health care integration, coordination and management

Background

There is considerable change on the horizon for behavioral health care in Texas. This change is coming from both national and Texas-specific initiatives. The recommendations identified in this Texas Leadership Roundtable report on behavioral health are based on four principles that have their roots in these changes.

Behavioral health care in Texas is severely underfunded given the need for such services. The Medicaid 1115 DSRIP (Delivery System Reform Incentive Payments) waiver approved in December 2011 will bring approximately \$2.2 billion in behavioral health programs over the five years of the waiver. The Health and Human Services Commission (HHSC) is in the process of beginning negotiations with the Centers for Medicare and Medicaid Services (CMS) regarding the extension, negotiations which are critical for ensuring the continuation of DSRIP funding.

A second major driver of change is the implementation of the Affordable Care Act (ACA). While Texas has not expanded Medicaid as allowed by the ACA, the potential of the individual mandate will have a fundamental impact on the current GR-based funding of behavioral health care for uninsured Texans.

A third driver of change is the growing recognition of the need to base the development of health care delivery systems on the treatment of the whole person. This focus is represented by the need to integrate both medical and behavioral health care.

Principle: Integration of Primary Care and Behavioral Health care

Primary care and behavioral health care integration is the systematic coordination of primary and behavioral health care. Since physical and behavioral health problems often occur at the same time, health care professionals want to work together to address all health conditions at once. Integrating mental health, substance abuse and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple health care needs.¹

Because of fragmented care in the current system, general medical costs for treating people with chronic medical problems, as well as mental disorders are two to three times higher than those for treating people with physical health conditions only.² In an analysis of claims data prepared for the American Psychiatric Association, the actuarial firm Milliman found that between \$26 billion and \$48 billion in health care costs can be saved annually from the

¹ Substance Abuse and Mental Health Services Administration, July 2014.

² *Psychiatric News*, Volume 49, Number 9, Page.1

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integration of medical and behavioral health care.³ In particular the study found that in comparing the health care costs of people with behavioral health conditions to those without, those with behavioral health conditions spend a greater proportion of total medical dollars on facility based services rather than on professional services.

Section 3025 of the Affordable Care Act added Section 1886(q) to the Social Security Act establishing the Hospital Readmissions reduction Program which requires the Centers for Medicare and Medicaid to reduce payments to hospitals with excess readmissions, beginning in October 2012. In implementing this program CMS developed a methodology to adjust payments to hospitals with “excess” readmissions, which grows from 1% reduction in 2013 to a 3% reduction in 2015. The significance of CMS’s readmission reduction program for integrated care is that a substantial number of readmissions are driven by behavioral health comorbidity. For example HHSC’s report on the frequency of potentially preventable readmissions (PPRs) in the Texas Medicaid population in SFY 2012.⁴ Key findings include:

- Overall 3.7% of admissions were followed by a readmission that started within 15 days of discharge.
- Mental health and substance abuse conditions comprise 27.4% of the potentially preventable readmissions. Bipolar disorders, schizophrenia and major depression represented substantial numbers of PPRs, along with cesarean and vaginal delivery and heart failure.
- Of the 20 DRGs (diagnostic related groups)⁵ with the highest numbers of initial admits, schizophrenia, heart failure and bipolar disorder were the only ones with PPR rates of 10% or higher. These three DRGs were responsible for 20% of the readmissions in this analysis.

Texas took another major step towards the integration of behavioral health with primary care in the 83rd Legislature with enactment of SB58. This legislation not only required the movement of psychiatric rehabilitation services and targeted case management services from the Department of State Health Services (DSHS) budget, where it was directly allocated to community mental health centers, to the Health and Human Services Commission budget where it was combined with other Medicaid medical and behavioral health benefits into the benefit package provided by managed care organizations.

SB58 also established two health home pilots for individuals with serious mental illness and chronic health conditions. These homes must adhere to the requirements of a person centered medical home. Evidence from the first 18 months of Missouri’s health home pilot for adults with serious mental illness and the most chronic health conditions has demonstrated both improved health outcomes for diabetes hypertension, asthma/COPD outcomes, as well as more

³ Milliman Inc: *Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry*, 2014.

⁴ HHSC: *Potentially Preventable Readmissions in the State of Texas Medicaid Population, State Fiscal Year 2012*, November, 2013.

⁵ Texas Medicaid pays hospitals based on the DRG methodology, there are approximately 1,300 DRGs in the Medicaid system of inpatient payment.

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efficient care by reducing inpatient 12.8% and emergency department use 8.2%. Overall, the project achieved \$2.4 million in net savings for the 12,000 people enrolled.⁶

Recommendations:

- Recommend that the Legislature expand integrated primary medical and behavioral health care to the state funded general revenue (GR) population.
- Recommend that HHSC develop and implement Person Centered Medical Homes particularly for adults with co-morbid serious mental illness and the most severe chronic illnesses, which integrate primary medical and behavioral health care throughout the state Medicaid program.⁷

⁶ Missouri Department of Mental Health and HealthNET (11/1/13). *Progress Report: Missouri CMCH Healthcare Homes.*

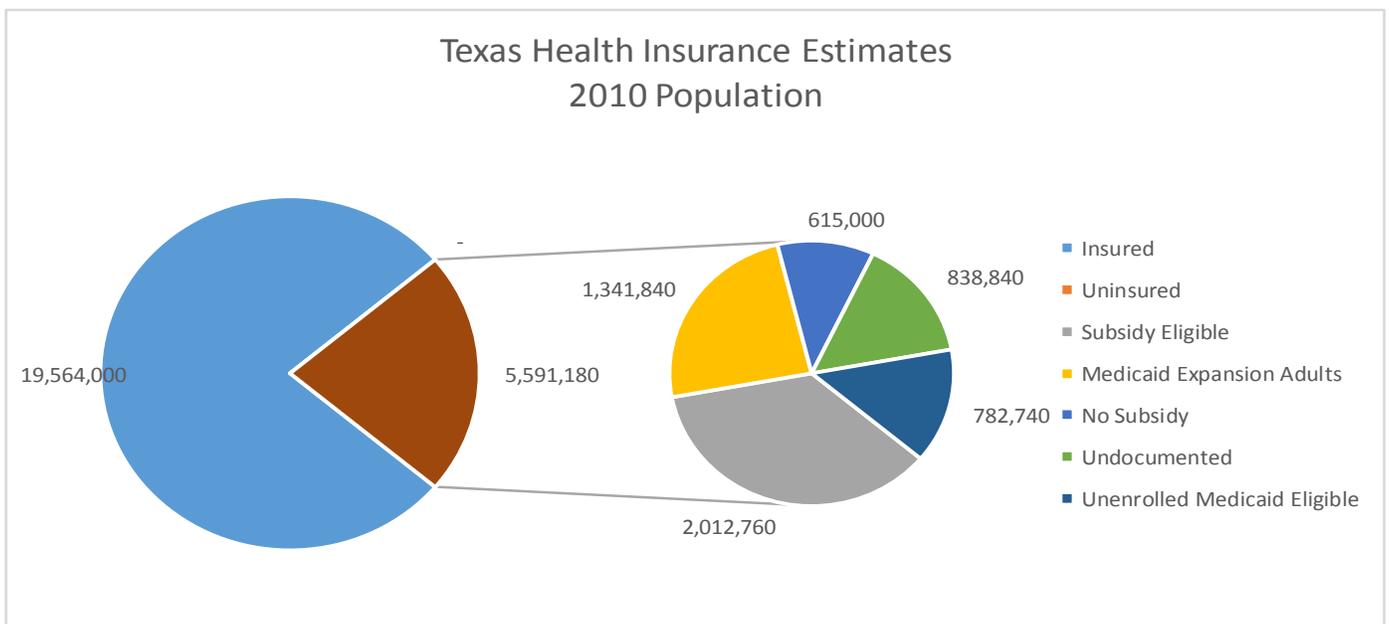
⁷ A Health Home is not a physical home but a way for enrollees to receive health care treatment for chronic conditions. Section 2703 of the Affordable Care Act authorizes states to establish health homes as a way to provide more coordinated services for people living with chronic conditions, including behavioral health conditions.

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Principle: Development of a Vision and Comprehensive Strategy for Behavioral Health

The individual mandate as required by the Affordable Care Act (ACA) essentially requires all uninsured Texans to obtain insurance.⁸ As an inducement the ACA offers tax subsidies to uninsured individuals between 100% Federal Poverty Level (FPL) and 400% FPL. However, to obtain a subsidy the individual must enroll through the Exchange and select a Qualified Health Plan (QHP). In order to be qualified, the plan, among other requirements, must provide the essential benefit package identified in the ACA. Among the essential benefits are the behavioral health benefits that must be made available to enrollees at a level that is on a parity with medical benefits.⁹



While the impact of the ACA on Texas is complicated by many factors, one way to obtain an understanding of its potential impact for the way Texas funds and manages public behavioral health care can be found in the graph below.¹⁰ From the above graph it can be seen that in 2010 there were 5.6 million Texans without insurance. The graph on the right shows the disposition of this 5.6 million in terms of insurance eligibility. Approximately 2 million (34%) of

⁸ There are some exceptions including undocumented individuals are not eligible for the tax subsidy.

⁹ The Mental Health parity and Addiction Equity Act of 2008.

¹⁰ Thomas Suehs: *Presentation to the Senate Health & Human Services Senate State Affairs Committees on the Affordable Care Act*, August 2012.

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these individuals are eligible for a tax subsidy, while approximately 782,740 (14%) were eligible for Medicaid at the time but had not enrolled.¹¹

Medicaid expansion aside (which represents 24% of the uninsured population), almost 2.8 million uninsured Texans were eligible for a subsidy to support enrollment in either a QHP or Medicaid in 2012. Estimates of the number of individuals who subsequently enrolled through the Exchange or in Medicaid are around 800,000 Texans.¹² As more Texans, incentivized by tax subsidies or motivated by the individual mandate, enroll in QHPs the reliance on general revenue to fund behavioral health care for the uninsured may likely to decrease.

One of the major impacts of the September 2014 implementation of SB58 by HHSC is the transfer of GR from the DSHS budget to HHSC's. The reason for this transfer is based on the bill's requirement that Medicaid rehabilitation and targeted case management services be included in the managed care benefit for Medicaid eligible individuals. The impact of this transfer, like that of the ACA, is to reduce the funding streams allocated to and managed by DSHS.

An additional factor which can substantially influence the funding of indigent behavioral health care in Texas is the Medicaid 1115 waiver. Currently, the waiver's Delivery System Redesign Incentive Program (DSRIP) funds approximately \$2.2 billion in behavioral health programs over the five years of the waiver. For the present discussion the waiver has two major implications for behavioral health care in Texas. The first concerns the requirement that each of the 20 Regional Healthcare Partnerships (RHP) develop a region-wide plan that describes the current availability of health care services in the region (and not just behavioral health). This Plan functions, within the waiver, as the basis for regional transformation of the health care system by acting as a baseline to both identify and assess changes resulting from the implementation of regional DSRIP projects. While the concept of region-wide planning is an important requirement of the waiver, it is clear that the RHP planning process can be improved. Potential guidance for such improvement may be forthcoming from Texas A&M's evaluation of the RHP process as required by the waiver.

A second major concern associated with the waiver is the sustainability of the DSRIP projects over time. In considering the issue of sustainability, there are two forms of sustainability. The first involves sustainability during the upcoming waiver extension negotiations that are beginning in DY4 (demonstration year 4) of the waiver. This form involves a relatively short timeframe and is not likely to be influenced by a comprehensive planning process.

¹¹ Medicaid Expansion: adults < 138% FPL. Unenrolled Medicaid Eligible: childless adults <200% FPL and TANF adults. No Subsidy: children and adults >400% FPL. Subsidy Eligible: children between 200% and 400% FPL, adults less than 65 years old between 138% and 400% FPL.

¹² It is uncertain as to whether the 700,000 or so Exchange enrollees were uninsured and represent a reduction or whether they switched insurance.

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The second form of sustainability has a longer-term focus and, is perhaps more significant. In negotiating DSRIP waivers in other states, CMS has focused on the sustainability of DSRIP projects. That is, CMS has indicated that they do not have a desire to continually approve DSRIP projects through the authority of a waiver but rather would like to see projects integrated into the fabric of the existing delivery system itself. For Texas this likely means that behavioral health DSRIP projects may have to be integrated into Medicaid managed care. What this means for the approximately \$1.6 billion in DSRIP projects provided by community mental health centers (of the \$2.2 billion total in behavioral health) remains an important issue that must be addressed.

The Sunset Commission Staff Report has documented the struggle that DSHS has had in managing the publicly funded behavioral health system in Texas. DSHS has lacked the vision for how behavioral health care must evolve in Texas as this evolution is driven by both national and state initiatives. In light of the diversity of these drivers for change how will the funding for behavioral health, as well as the organization and management of its provider network, be shaped over the next five years?

Recommendations:

- Recommend that a workgroup to advise the Executive Commissioner of HHSC be appointed to develop a five year vision for behavioral health care in Texas and to outline the objectives associated with implementation of this vision including the development of a comprehensive region-based planning process that focuses on the integration of primary medical care and behavioral health care in Texas. This group should be aligned with the new enterprise-wide behavioral health advisory committee described in the final version of DSHS Sunset Recommendation 2.6. This plan would, at minimum, include:
 - Embracing the findings of the Sunset Commission Staff Reports on both DSHS and HHSC as a source for plan content.
 - A focus on population-based measures that includes both behavioral health, (e.g., mental health and substance use disorders, social support services, to include housing, transportation, employment) and primary health care, (e.g., diabetes, obesity).
 - The plan should consider the RHP regional concept established through the Medicaid 1115 waiver as the basis for identifying regions. Consistent with the comprehensive review of behavioral health performance metrics described in the final version of DSHS Sunset Recommendation 2.3, it should also consider identifying standardized measures to be applied in each regional plan that can support a uniform picture of the quality of care across the entire state. It should also be capable of serving as the basis for continually updating the waiver-required needs assessment that is used to measure improvements in the regional health care delivery system.

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- Recommend that the report developed by the advisory workgroup not only go the Executive Commissioner of HHSC but also be provided to the Legislature and the Governor's Office. Consistent with the final version of DSHS Sunset Recommendation 2.6, the Executive Commissioner should provide the workgroup with a written response to the formal recommendations adopted by the workgroup.
- Recommend that the advisory workgroup also provide in its report recommendations on an organizational structure within the HHSC umbrella of agencies that would be appropriate to the successful implementation of the five year vision.
- Recommend that the report identify in its five-year vision a strategy to include the funding and organizational structure for integrating behavioral health services into the primary care Medicaid program throughout the entire state so as to make available to all Texans the same standard of quality health care that is envisioned in the 83rd Legislature's SB58.

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Principle: Funding of Public Behavioral Health Care across Texas

Equitable funding for community mental health centers has been a difficult and elusive struggle for the centers and for DSHS which manages the stream of general revenue funding to centers. The Sunset Commission Staff Report on DSHS summarized the continual lack of success in achieving equitable funding as measured by per capita GR.

In fiscal year 2013, the Legislature provided \$575 million to local mental health authorities and NorthSTAR pilot project, which DSHS distributed through a byzantine funding structure. The local mental health authorities simply received “what they got last year” without a rational, fair, or performance-based plan. For more than a decade, the Legislature has attempted to correct this historical approach to funding, particularly as it relates to regions of the state receiving vastly different per-capita amounts for mental health funding. (p.29)

An illustration of the complexity of achieving an equitable per capita funding among Texas’ 37 community mental health centers is illustrated in DSHS’s allocation of GR funds to address the centers’ wait list for mental health services. From a functional standpoint the DSHS allocation methodology, which was uniform across all centers, failed to recognize that there were centers that had served substantially more clients than the DSHS target. This inability to account for the specifics of each center caused those centers providing services above their targets to receive less than an equitable amount of the new GR funding.

The allocation of wait list funds to centers was one of the mechanisms used by DSHS to generate equitable funding for centers. However, because the formula was uniformly applied without recognition of relevant performance variations among centers in the number of clients served relative to DSHS targets, the allocation of wait list GR actually increased per capita inequality rather than decreasing it.

The difficulties associated with assessing equity on per capita funding suggest the need to consider other ways for how GR funds might be made available to communities. For example, could the allocation of GR funds be directed by the need to achieve a uniform standard of behavioral health care across Texas communities? Such a methodology could enhance the waiver’s RHP planning requirement by providing a standardized requirement across RHPs to collect certain kinds of information.

An important but sometimes overlooked benefit of community center mental health funding is its impact on helping to lower the uncompensated care costs from what these costs would have been otherwise. Uncompensated care (UC) costs accumulate for two primary reasons. The first is associated with the state GR not fully funding the allowed Medicaid cost associated with

a Medicaid hospital inpatient stay. This form of UC is known as the Medicaid Shortfall. A second form of UC cost flows from hospitals providing care to the uninsured. Because

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community mental health centers provide services to individuals who are low income, uninsured and seriously mentally ill they are helping to reduce hospitalizations for this population from what they would be otherwise, and as a result, reducing UC costs for local hospitals. Yet, even with the work of centers, as illustrated in the graph below, there is approximately \$1.9 billion in UC delivered by Texas hospitals that had no form of payment. As discussed in Principle 2, a substantial amount of inpatient utilization comes from individuals with a behavioral health comorbidity. If community mental health centers had additional funding, which was aligned with population-level performance metrics related to preventing hospital use for both behavioral health and broader health needs for adults with serious mental illness, they could substantially impact the amount of UC costs incurred by hospitals. These circumstances create the potential for an innovative payment reform model in Texas between a local community mental health center and the payers of hospitalization in the community. If the center reduces hospital costs, saving the payers of hospital care significant dollars, the payers would profit by sharing a portion of the savings with the center. Doing so would enable the center to serve even more individuals, creating additional savings.

Statewide Estimates of Unreimbursed UC Cost in Hospitals FFY2013

	Private Hospitals	Public Hospitals	Total
Total UC Costs	\$4.1 billion	\$2.4 billion	\$6.5 billion
Total Unreimbursed UC Costs	\$1.5 billion	\$.4 billion	\$1.9 billion

Recommendations

- Recommend that the Legislature fund mental health services at a level to ensure that all Texans with serious mental illness have access to appropriate treatments, services, medications and therapies.
- HHSC should evaluate the feasibility of developing a methodology for identifying the behavioral health needs of Texas communities.
- Include in this methodology a measure of equity across communities that focuses on a more equitable factors such as risk-adjusted population or ideally, a uniform standard of behavioral health care being made available to all Texans.
- Consider the potential for including this assessment in the RHP planning process (see recommendations for the *Principle: Development of a Vision and Comprehensive Strategy for Behavioral Health*).

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- Recommend a rider to the Appropriations Bill to develop a shared savings model between HHSC, a hospital district and a community mental health center to develop a methodology for implementing this innovative payment reform project.¹³

Principle: Mental Health Workforce Shortage

Texas is changing as the population increases, ages and shifts in ethnic composition. A growing number of people in Texas have multiple conditions that require complex care. With these changes Texas will require more doctors, nurses and other health care professionals – now and in the future. But the current supply of health care professions is not meeting the demand for services, creating a health care workforce crisis. A similar critical shortage in mental health care professionals is often overlooked. Yet, the most severe health profession shortages are in mental health services. Texas ranks far below the national average in the number of mental health professionals per 100,000 population. This gap will worsen if steps are not taken to address the mental health workforce shortage in Texas.¹⁴

As of March 2009, 173 of Texas' 254 counties and two partial counties were designated as Health Profession Shortage Areas for mental health. In 2009, 102 Texas counties did not have a psychologist, 48 counties did not have a licensed professional counselor, 40 counties did not have a social worker, and 171 counties did not have a psychiatrist.

Issues affecting the establishment and retention of a mental health workforce include:

- Recruitment and retention challenges. In the last decade the number of psychiatrists, social workers and counselors per 100,000 population declined. The challenges associated with recruiting this workforce are especially difficult in the rural and border areas of Texas.
- Lack of training opportunities. Texas lacks sufficient training programs to maintain a professional workforce appropriate to the need for mental health treatment. There is a shortage of internship sites for psychology graduate students, which forces these students to train in other states. A similar problem exists for medical students specializing in psychiatry. While there is a national movement towards training, certifying and employing mental health peer specialists, Texas has lagged behind other states in the growth of this program.
- Need for cultural and linguistic diversity. To be effective mental health treatment must be culturally sensitive to the people being served. Without cultural competency in the treatment, recover and wellness can remain unreachable for many people with mental

¹³ A hospital district can be an important component in this innovative funding project because it typically funds the state share required for itself and private hospitals to receive supplemental payment for uncompensated care from the Medicaid Disproportionate Share Hospital (DSH) program and the 1115 waiver uncompensated care pool. Thus, reducing hospital admissions carries the potential to save the hospital district a substantial amount of tax dollars.

¹⁴ Much of this discussion is based on the Hogg Foundation for Mental Health & Methodist Healthcare Ministries: *Crisis Point: Mental Health Workforce Shortages in Texas*, March 2011 document.

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- illness. In Texas as nationally, racial and ethnic minorities continue to be substantially under represented within the core mental health professions including psychiatry, psychology, social work, counseling and psychiatric nursing.

The following recommendations reflect an urgency to take action immediately to address the critical shortage of mental health professionals in the state. A shortage that is projected to only get worse as a result of the expansion of commercial insurance coverage under ACA.

Recommendations

- Recommend expanding graduate education programs for behavioral health professionals, including psychiatry, psychology, social work, counseling and nursing.
- Recommend expanding Texas' promotion of, and investment in the certification of peer support specialists.
- Recommend providing competitive reimbursement rates for mental health services to increase the number of professionals who accept Medicaid patients. This is especially important in light of the competition for professionals created by the expansion of insurance under ACA.
- Recommend the development of tele-health opportunities in multiple mental health provider categories to increase capacity.