



**Role of Community Mental Health Centers
In Texas Medicaid
1115 Demonstration Waiver**

**The Value of Delivery System Reform Incentive Payment (DSRIP)
Initiatives in Behavioral Healthcare**

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Introduction

The Texas Council of Community Centers (Texas Council) strongly supports the Health and Human Services Commission (HHSC) application to extend the *Texas Healthcare Transformation and Quality Improvement Program Section 1115 Demonstration Waiver* (1115 Waiver). Under HHSC leadership, Texas has made substantial progress towards achieving the major goals of the 1115 Waiver, including:

- Expanding risk-based managed care statewide;
- Supporting the development and maintenance of a coordinated care delivery system;
- Improving outcomes while containing cost growth;
- Protecting and leveraging financing to improve the Texas health care infrastructure;
- Transitioning to quality-based payment systems across managed care and hospitals.

Not only is the 1115 Waiver transforming health care delivery in Texas, it is projected to save almost \$40 billion over its five years. This savings is used to fund Delivery System Reform Incentive Payment (DSRIP) initiatives and Uncompensated Care (UC) Pools, which have been crucial in transforming the Texas health care system.

In September 2015, HHSC submitted an application to extend the 1115 Waiver for another five years and increase DSRIP and UC Pool funding. CMS approval is essential to continued transformation of the Texas health care system.

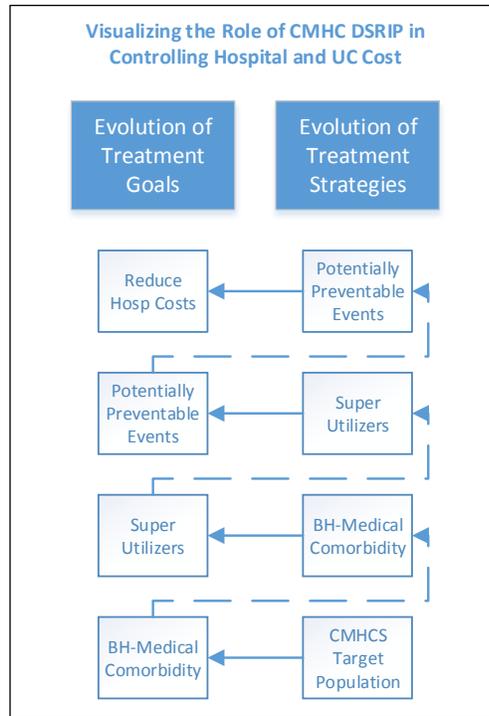
This briefing paper has two objectives. The first is to highlight the significant role Community Mental Health Centers (CMHC) play in enabling the Texas Medicaid program to realize the 1115 Waiver goals. The second is to identify key negotiating conditions critical to continuing CMHC participation in the 1115 Waiver extension.

Role of CMHC DSRIP Projects: Reducing Hospital Costs & Limiting Hospital UC

Historically, CMHCs have played an important role in reducing unnecessary hospital utilization and UC costs, particularly for the Intellectual Developmental Disability (IDD), Seriously Mentally Ill (SMI) and Substance Use Disorder populations. While CMHCs provide essential supports to hospitals serving indigent and uninsured Texans, their role remains largely unrecognized by the Texas Medicaid system.

As hospital costs for Texas Medicaid recipients and the uninsured increase, so do UC costs. Growth in hospitalization is a major reason for this increase, especially when coupled with the decreasing availability of Medicaid supplemental payments to offset these costs. This scenario

places increasing pressure on HHSC, Medicaid managed care organizations (MCOs), and especially hospitals to control growth in inappropriate hospital utilization and enhance quality of care.



While UC costs have many roots, a major policy effort by both CMS and HHSC is focused on preventing hospital utilization when appropriate care alternatives are available.

The illustration on the left summarizes the policy evolution, and demonstrates the critical role of CMHCs in developing patient-centered treatment goals and strategies that ultimately help control hospital and UC costs. CMHCs have developed successful treatment strategies for complex and vulnerable populations, the people most likely to be hospitalized or use emergency department services.

The primary populations served by CMHCs are medically indigent, often with co-occurring mental health, substance use, and/or physical health conditions. These populations often benefit from whole-person treatment plans that ultimately reduce hospital costs.

Uncompensated Care and 1115 Waiver Budget Neutrality

In the 1115 Waiver demonstration year 3 (DY3), Texas hospitals and other authorized providers incurred \$7.5 billion in UC costs. After subtracting Disproportionate Share Hospital (DSH) and 1115 Waiver UC Pool payments, approximately \$2.5 billion remained in unreimbursed UC, mainly falling on hospitals to absorb.

UC Pool funding will decrease over the last three years of the 1115 Waiver, falling from \$3.5 billion in DY3 to \$3.1 billion in DY5. While UC Pool funding is decreasing, UC costs are increasing. This is true even when the impact of CMHC and other DSRIP projects and new Health Exchange Marketplace enrollments are considered. The disparity between UC Pool funding and UC costs is reflected in the budget neutrality calculations found in the 1115 Waiver extension application, as illustrated in Table 1.

**Table 1: UC Funding Pool Request in Medicaid 1115 Waiver Extension
(in Billions)**

DY5	DY6	DY7	DY8	DY9	DY10	Total DY6-DY10
\$3.1	\$5.8	\$6.6	\$7.4	\$7.4	\$7.4	\$34.6

Overall, the \$34.6 billion request (five years) in the extension application almost doubles the current five-year UC Pool funding of \$17.6 billion.

CMS Guidance to Texas Regarding UC Pool Funding

In a November 2015 letter to HHSC, CMS identified three principles for reviewing 1115 Waiver UC Pool requests from states. Of the three, perhaps the most significant is the first principle:

- Coverage is the best way to assure beneficiary access to health care for low income individuals, and uncompensated care pool funding should not pay for costs that would otherwise be covered in a Medicaid expansion.

For CMS to consider the 1115 Waiver request for UC funding, Texas must complete an analysis of its historical UC funding in the first year of the extension. CMS will use the analysis to assess the role of the UC Pool in promoting the 1115 Waiver Medicaid objectives.

Application of CMS principles creates risk to the Texas 1115 Waiver funding request, including the apparent refusal by CMS to allow pool funds to pay for the UC created by the expansion population (about \$4.5 billion in Texas over five years). A second area of risk is CMS concern over using the UC Pool to reimburse hospitals for the Medicaid Shortfall, the shortfall associated with the state not reimbursing the full, allowed Medicaid cost.¹

Potentially Preventable Events and Co-Occurring Behavioral Health Conditions

A major source of hospital UC costs is potentially preventable hospital admissions, readmissions and emergency department visits. In a 2013 report on potentially preventable readmissions in Medicaid, HHSC lists bipolar disorders, schizophrenia and major depression as the three top diagnoses for potentially preventable readmissions (PPRs).²

A similar analysis by the Department of State Health Services (DSHS) on 1.2 million potentially preventable admissions to Texas hospitals (not limited to Medicaid hospitalizations), found that

¹ Conversations with HHSC on status of 1115 Waiver extension negotiations indicate CMS has an interest in identifying the amount of UC that comes from the Medicaid Shortfall. By DY7, Texas Hospital Association (THA) cost analysis projects that Medicaid Shortfall costs exceeding uninsured costs is the major factor driving uncompensated care costs (\$4 billion compared to \$3.9 billion). The THA cost analysis underlies the HHSC budget neutrality projections in the extension application.

² HHSC, *Potentially Preventable Readmissions in the Texas Medicaid Population, State Fiscal Year 2012*, Table 2.4.1.

approximately 32% of the nine diagnoses reviewed over a five year period had a secondary diagnosis of mental illness or substance abuse.³

The important role that potentially preventable events (PPEs) play in addressing rising health care costs is also reflected in state and federal policy initiatives. For example, CMS developed a Readmissions Reduction Program that reduces payments to hospitals with excess readmissions. In 2015, payment readjustments to Medicare hospitals can be as high as 3%. Following the emphasis established by CMS, HHSC contracts place MCOs at risk for 4% of its premiums based on performance. Among the performance indicators are PPEs, incentivizing MCOs to ensure hospital utilization is appropriate and reduce hospital costs.

Nationally, co-occurring behavioral health (mental health and substance use disorders) and physical health conditions are recognized as significant drivers in PPEs and healthcare expenditures. The importance of integrating behavioral and physical healthcare is evidenced by the SAMHSA Certified Community Behavioral Health Clinic (CCBHC) grant. In conjunction with CMS and the Assistant Secretary of Planning and Evaluation (ASPE), this SAMHSA grant supports efforts of participating states to improve the quality of care and reduce costs.

As one of twenty-four states awarded a CCBHC Planning Grant, Texas is working with SAMSHA to prepare an application as a demonstration site. Offering a person-centered, comprehensive medical home model for clients with co-occurring complex conditions, this initiative holds promise to further transform the Texas healthcare landscape if Texas is awarded a demonstration site grant. By focusing on the whole person in an integrated setting, the model is expected to reduce unnecessary utilization of hospital, diagnostic, and other costly services.

HHSC Super-Utilizer Initiative

The focus on potentially preventable events has led to the identification of Medicaid super-utilizer groups. An analysis of these events uncovered a Pareto-type pattern that revealed individuals with behavioral health diagnoses generated a disproportionate amount of preventable hospital costs. Further root-cause analysis focused on the high cost impact of super-utilizers. For example, 5% of Texas' Medicaid population account for 50% of the cost.⁴

The CMS Medicaid Innovation Accelerator Program (IAP) is an initiative to support states targeting Medicaid beneficiaries with complex needs and high costs (i.e., super-utilizers). HHSC contracts require MCOs to implement super-utilizer programs that target and provide outreach, education and intervention to members with "...excessive utilization patterns that indicate typical disease management approaches are not effective."⁵ In supporting its managed care

³Mike Gilliam, DSHS, *Adult Potentially Preventable Hospitalizations in Texas: UT Mentorship Program – Health Careers*, November 21, 2013.

⁴Sellers Dorsey/Milliman: *Medicaid Managed Care in Texas: A Review of Access to Services, Quality of Care, and Cost Effectiveness* (February 2015).

⁵HHSC, *MCO Special Populations (Super Utilizers) Program Initial Evaluation – March 2014: Updated – December 2014*.

initiative, HHSC obtained an IAP grant to further its efforts to efficiently and appropriately address the needs of this special population.

Because super-utilizers typically have complex, co-occurring medical and behavioral health needs, numerous studies have shown that integrated behavioral health and primary care is capable of creating substantial health care savings. The Center for Health Care Strategies (CHCS) developed a compendium of innovative projects in complex care that identify creative initiatives across multiple provider types.⁶ Milliman Consulting, for the American Psychiatric Association, analyzed claims for patients with chronic medical and co-occurring behavioral health conditions and found their cost can be 2- 3 times as high as patients without a co-occurring behavioral health condition. The analysis of integrated care programs across the country found that coordinated care can save \$26-\$48 billion annually in health care costs. There is little doubt that specialized and targeted interventions for Medicaid super-utilizers are an effective tool in reducing health care costs.

CMHC DSRIP Projects Produce “Multiple Outcomes”

Table 2 identifies selected workload measures for CMHC behavioral health (BH) DSRIP projects. These measures are based on the initial RHP plans submitted to HHSC.

Table 2: Selected CMHC DSRIP Project Workload Measures⁷

<i>Total 5 Year DSRIP Projects</i>	<i>Total Behavioral Health DSRIP Projects</i>	<i>CMHC Behavioral Health Projects</i>	<i>Number Individuals in CMHC DSRIP</i>	<i>5 Year All Funds DSRIP Potential CMHC Earnings</i>
1,280	395	303	142,000 ⁸	\$1.5 billion

Of the 395 BH DSRIP projects, 303 (77%) are projects where the performing provider is a CMHC. In DY4, CMHC initiatives are projected to provide services to an estimated 142,000 Texans. While the number of CMHC projects is impressive, the type of project has the most significant impact on controlling costs. Of note, 82 of the 191 DSRIP Category 1 projects are likely to have “multiple outcomes,” that is, the ability to create positive outcomes not only for the CMHC, but also for hospitals and other downstream beneficiaries. For example, a CMHC project that supports an individual in the community also has the potential to reduce PPEs.

⁶ CHCS: Complex Care Innovation Lab, *Profiles in Innovation*, 2014.

⁷ Data from *Texas 1115 Medicaid Demonstration Waiver: Review of 4-Year Behavioral Health Projects*. Texas Institute for Excellence in Mental Health, September 2014. Where BH project data did not distinguish between CMHC projects and all DSRIP BH projects, CMHC performance was estimated using the percentage of CMHC DSRIP to all BH DSRIP (77%). This report analyzes the DSRIP four-year plan required for each project. As such, the data represents a four-year projection and does not include data from any three-year DSRIP projects identified in DY3.

⁸ Estimate is for individuals served in DY4.

The presence of “multiple outcomes” is a critical aspect of the overall value of CMHC projects, yet the downstream effect on hospital outcomes is likely not captured in the HHSC DSRIP reporting system. As such, the full value of CMHC DSRIP projects may not be recognized.

Downstream Impact of CMHC DSRIP Projects

Table 3 uses a crisis stabilization project to illustrate downstream DSRIP beneficiaries. The project not only produces outcomes for the CMHC as the performing provider, but successful interventions create downstream benefits that help RHP hospitals meet their own DSRIP outcomes. Yet, even beyond the impact on RHP hospitals, the reduction in hospital cost associated with the CMHC project positively impacts the region’s hospital district by reducing the need to use local tax revenue to draw down federal funds for Medicaid’s DSH and UC Pool supplemental payment programs.

Table 3: Downstream Impact of “Multiple Outcomes” from CMHC DSRIP Projects

<i>Performing Provider</i>	<i>DSRIP Project</i>	<i>Outcomes</i>		
		<i>CMHC Project Recipient</i>	<i>RHP Hospitals</i>	<i>RHP Hospital District</i>
▪ <i>CMHC</i>	▪ <i>Crisis Stabilization</i>	▪ <i>Quality Care</i> ▪ <i>Remain in Community</i>	▪ <i>Reduced PPA/PPR</i> ▪ <i>Reduced Hospital Cost</i> ▪ <i>Reduced UC Cost</i>	▪ <i>Reduced Need for IGT</i> ▪ <i>Reduced Need for Local Tax Revenue</i>

While existing DSRIP reporting systems are not able to track the full impact of CMHC DSRIP projects, these projects clearly create substantial downstream benefit.

As described in the budget neutrality tables in the 1115 Waiver extension application, Texas UC costs are increasing. From recent actions in California, CMS appears to have a different view than Texas regarding UC pool operation. This policy disagreement creates a very real possibility that unreimbursed hospital UC costs will continue to grow beyond UC Pool funding. Under these circumstances, the important role of CMHCs in UC cost control will become even more critical in the 1115 Waiver extension.

Continuation of CMHC DSRIP: Key Negotiating Topics

The fundamental role played by CMHCs in Texas Medicaid means the 1115 Waiver’s Special Terms and Conditions, which are developed during extension negotiations and define the parameters of Waiver implementation, should promote continued participation of CMHCs in DSRIP.

From the CMHC perspective, there are two areas of particular concern for the outcome of HHSC negotiations with CMS. The areas where initial feedback about negotiations indicate CMS may have concerns:

1. Sustainability of DSRIP projects; and
2. Uninsured Texans in DSRIP projects.⁹

Sustainability of DSRIP Projects

As extension negotiations proceed, a major concern for CMS is sustainability of Texas DSRIP projects. While sustainability is an important issue for Texas, from the standpoint of the Texas Council, how sustainability is defined is critical. CMS apparently interprets sustainability as the integration of DSRIP projects into the Medicaid delivery system, which in Texas is managed care. A key area of concern for the Texas Council is the source of state match required to fund the managed care premium for these projects.¹⁰

CMHCs currently use local funds and state general revenue (GR) that comes through performance contracts (primarily DSHS and DADS) to cover the state share of the total computable value of DSRIP projects. If DSRIP projects are funded through managed care, careful consideration for financing the state match portion of the valuation and paying CMHCs as performing providers will be imperative to ensure there is not a negative impact on valuable DSRIP projects and CMHC operations necessary to provide critical services for persons with serious mental illness or intellectual and developmental disabilities

The challenge of sustainability under this scenario is that GR, which CMHCs provide as state match through Intergovernmental transfers (IGT), is used to provide services to uninsured clients and to Medicaid recipients in fee-for-service programs. This means there are DSHS performance requirements tied to state GR funds that are independent of, and in addition to, the DSRIP performance measures and outcomes.

From the perspective of the Texas Council, the following five areas require special consideration as DSRIP projects shift into managed care: 1) Medicaid benefit review; 2) performance metrics; 3) general revenue; 4) value-based payment structures; and 5) health care coverage for people with serious mental illness.

⁹ These two issues are identified in HHSC preliminary reports on the course of negotiations and addressed by CMS in a webinar: National Academy for State Health Policy: *Incorporating DSRIP into Medicaid Waivers: State and Federal Perspectives*, November 21, 2015.

¹⁰ Integrating DSRIP into managed care under an extension creates several issues applicable to all providers, not just CMHCs. As originally negotiated in 2011, the Texas 1115 Waiver did not consider the integration of DSRIP projects into managed care; in fact, DSRIP was developed almost exclusively outside the managed care system. Thus, general issues that arise include how to integrate varied types of DSRIP projects into managed care, the role of actuarial soundness in the creation of MCO premiums, value-based purchasing, and the MCO role in selecting, approving and administering DSRIP projects.

1) *Medicaid Benefit Review*

- The State should leverage federal funding by adding mental health and SUD services that are available through DSHS contracts to the Texas State Plan or as 1915(b)(3) services (e.g., SUD services provided in a doctor's office or mental health clinic, crisis extended observation, crisis residential, adult respite residential). For SUD services, this process should also include a review to determine whether state licensing requirements create unnecessary barriers to care.

2) *Performance Metrics*

- The State should ensure that 1115 Waiver performance metrics capture the unique role of CMHCs in generating systemic cost reductions.

3) *Maintain General Revenue Stream*

- The GR allocation must continue to move through state agency performance contracts to CMHCs with expectation for leveraging it to HHSC as appropriate and necessary for the state share of its DSRIP valuation.
- If CMHCs fund a portion of the MCO premium through IGTs, then the total amount of the MCO payment must be made in a timely manner and in a form that allows the CMHC to use these payments as it does today. Reimbursement lag will negatively impact CMHCs' ability to meet DSRIP and state performance contract metrics. Most notably, significant lag periods will create cash flow challenges that would limit CMHCs' ability to provide much needed care to vulnerable and uninsured populations.

4) *Maintain Value-Based Payment Structures*

- As DSRIP transitions into managed care, whether under the Network Access Improvement Program (NAIP) framework or another NAIP-like model, value-based payment structures must be maintained. Under the NAIP structure, MCOs and providers are allowed to establish program values based on the anticipated value or savings to Medicaid managed care populations. These values are subject to State reasonableness reviews.
- Value-based payment structures incentivize providers and align with recent trends in federal policy, as seen in the 2015 CMS draft managed care rules and the SAMSHA grant for CCBHCs. The CCBHC model uses prospective payments based on actuarially sound monthly rates to cover mental health and SUD services through Medicaid managed care.

5) *Healthcare Access for People with Serious Mental Illness (SMI) who meet specified clinical and financial eligibility.*

- Texas should consider an 1115 waiver component similar to the Governor's Access Program (GAP) in Virginia that provides critical access to limited mental and physical

health services for uninsured individuals with SMI at an appropriate percentage of the Federal Poverty Level (FPL) established by the state.

- Without access to treatment, this population is often hospitalized unnecessarily, unable to find or sustain employment, struggles with affordable housing, becomes involved in the criminal justice system, and suffers with social and interpersonal isolation.¹¹ With treatment, individuals with SMI and co-occurring or co-morbid conditions can recover and live, work, parent, learn and participate fully in their community.¹² A GAP demonstration therefore will help alleviate the systemic financial and social burdens caused by untreated SMI.

Uninsured Texans in DSRIP Projects

Following 1115 Waiver negotiations, CMS may require Texas to substantially integrate DSRIP projects into Medicaid managed care.

The Texas Council raises particular concern for services that support uninsured people with serious mental illness, substance use disorders and intellectual disabilities disabilities.

Because a large number of CMHC project participants are uninsured (approximately 80% of CMHC DSRIP project participants), a key question is whether DSRIP funding will continue to be available for projects with uninsured participants. The Texas Council raises particular concern for services that

support uninsured people with serious mental illness, substance use disorders and people with intellectual disabilities who have co-occurring mental health conditions or behavior support needs.

DSRIP projects that allow the participation of uninsured Texans have at least two major advantages for the Texas health care system. First, the outcomes of these projects substantially impact the ability of hospitals to control their costs, especially their UC costs. Not only do the projects help reduce hospital costs, they improve health outcomes for the uninsured, reducing the likelihood these individuals will reach the level of disability required to become Medicaid eligible. Second, the GR used to fund the state share of the valuation payment earns a federal match which significantly increases the otherwise unmatched GR funding available to CMHCs through DSHS contracts. The availability of the federal match enables CMHCs to expand and enhance the array of services available not only to the uninsured population but also to Medicaid recipients.¹³ However, the full value of this impact is not captured in the current DSRIP reporting system.

¹¹ *Virginia GAP Program for the Seriously Mentally Ill*, §1115 Demonstration Application, October 2014 at p. 3.

¹² *Id.*

¹³ The additional funding available through the federal share of the valuation payments help the CMHC to provide services to the Medicaid recipient that is not covered by the state plan such as providing housing for clients with complex needs.

This means that any changes in the current 1115 Waiver that threaten the participation of CMHC DSRIP, especially as it pertains to the uninsured, can easily have unpredicted negative consequences throughout the 1115 Waiver. Before any consideration of eliminating the uninsured from DSRIP projects, the Texas Council recommends conducting a study similar to the CMS-required UC Pool study (or is added to it), that looks at the full value of CMHC participation by studying the downstream impact of CMHC generated outcomes. Not only will the results of this study help CMS and HHSC evaluate the impact of including the uninsured in DSRIP but, from a larger perspective, it will contribute significantly to HHSC design of its future Medicaid system.

Conclusion

Community Mental Health Center 1115 Waiver DSRIP projects have a substantial, systemic impact on the delivery of health care throughout the Texas Medicaid system. In fact, CMHCs are the performing providers for over 300 DSRIP projects, many of which generate outcomes that have a downstream impact on RHP hospitals and hospital districts. In this sense, the full value of CMHC DSRIP projects lies in their impact on the health care system as a whole, which is precisely what the Texas 1115 Transformation Waiver is all about.

Community Mental Health Center 1115 Waiver DSRIP projects have a substantial, systemic impact on the delivery of health care throughout the Texas Medicaid system.

While not directly visible in the DSRIP data systems or methodologies, CMHCs play a crucial role in creating synergies within the Medicaid health delivery system. Without the continued participation of CMHCs, there would be a significant reduction in the quality of care provided to indigent and uninsured people with intellectual disabilities, serious mental illness or substance use disorders, accompanied by a substantial impact on the ability of hospitals to reduce PPEs and the growth in UC costs.

The 1115 Waiver Special Terms and Conditions have made this performance possible by accommodating the unique circumstances of CMHCs. As HHSC approaches extension negotiations, the CMS position on the role and funding of DSRIP projects has clearly changed. When addressing this change, the unique characteristics of CMHCs must be recognized and taken into account in the final waiver design.