Redesigning the Publicly-Funded Mental Health System in Texas

Access to care when services are needed

Choice in health plans for consumers and providers

Integration of care at the plan and provider level

Local control over important community decisions

Strengthen local services through the 1115 Transformation Waiver

Access to services—including specialized medical care, psychiatric rehabilitation, food and shelter, employment— for children and adults with specialty mental health needs and those who have co-occurring substance use disorders has not kept pace with either the demand or advances in treatment approaches.

The changing healthcare landscape presents new opportunities for considering how to address these challenges and promote needed change in the management and delivery of mental health and substance use disorder services throughout the state of Texas.

The Texas Council and its members play an integral role in managing and delivering a wide-range of community-based services. As new opportunities for improving the system emerge, we remain focused on how to most effectively address the needs of children and adults with mental health and substance use disorders.

We serve a greater cause. The primary responsibility of Community Centers is to ensure that specialized community-based mental health and intellectual disability services and supports are available to Texans who need them.

With that responsibility in mind, the Texas Council led an effort through the Healthcare Opportunities Workgroup to consider new possibilities for system design that could more effectively serve Texans with serious mental illness—whether or not Medicaid eligibility is expanded as contemplated by the Affordable Care Act.

The redesigned system promotes access, consumer choice and integration of physical and mental healthcare—while maintaining local control of important community decisions related to delivery of public mental health services.

Texas Council of Community Centers

The following steps create a newly designed, comprehensive system of care:

1. Carve-in Medicaid covered mental health services into the STAR and STAR+PLUS Health Maintenance Organization (HMO) plans.
    a. Ensure access to vital Medicaid services that enhance and support recovery including psychiatric, rehabilitative skills training and counseling services for adults with serious mental illness and children with serious emotional disturbance[1] through a designated benefit package and capitation rate in managed care.

    b. Require STAR and STAR+PLUS plans to support and fund designated Health Homes for adults with Serious Mental Illness and children with Serious Emotional Disturbance enrolled in managed care.

    c. Require STAR and STAR+PLUS plans to establish a network of comprehensive mental health providers by contracting with DSHS certified private and public Medicaid Mental Health Rehabilitation providers.

2. Retain local control over important community decisions related to public mental health services through the network of Local Mental Health Authorities.

3. Strengthen community mental health and substance use disorder services by leveraging the 1115 Transformation Waiver to maximize federal revenue as a match to state and local funding expended for indigent care.

Carve-in Medicaid covered mental health services into the STAR and STAR+PLUS Health Maintenance Organization (HMO) plans.

There has been considerable debate in Texas on whether services for persons with serious mental illness are best delivered in managed care or fee-for-service. The debate has included much deliberation regarding whether a carve-out (NorthSTAR) or a carve-in (STAR, STAR+PLUS) is most effective for delivering quality mental health and substance use disorder services and achieving positive outcomes.

Although each model has advantages and disadvantages, the Texas Council believes a full Medicaid carve-in, through STAR and STAR+PLUS, creates the greatest opportunity to integrate physical and behavioral healthcare, increase consumer choice and reduce overall healthcare costs. However, the existing STAR and STAR+PLUS carve-in model will require modification to ensure consumer protection and quality of care.

[1] This recommendation is for the current mandatory populations, and the voluntary populations that choose to enroll in a health plan. This does not apply to voluntary populations who do not choose to enroll in managed care.

The full Medicaid carve-in model of the future must blend traditional medical services with community-based services that promote and sustain recovery and community tenure:

a. Ensure access to vital Medicaid services that enhance and support recovery including psychiatric, rehabilitative skills training and counseling services for adults with serious mental illness and children with serious emotional disturbance through a designated benefit package and capitation rate in managed care.

Children and adults with specialty mental health needs have unique physical and behavioral health care needs compared to the general Medicaid population. As directed by the legislature, the Department of State Health Services, Local Mental Health Authorities, Consumer and Advocacy Organizations and other stakeholders have worked to define appropriate services and levels of care based on a person's clinical needs. As a result, Texas created a stringent utilization management process in a fee-for-service environment. These utilization management processes are designed to promote recovery focused, evidence-based treatment—for children with serious emotional disturbance and adults with schizophrenia, bipolar disorder and major depression—that appropriately balances cost efficiency and clinical integrity.

In a full carve-in model, there is potential risk that non-traditional medical services necessary to support people with specialty mental health needs will be lost in the larger healthcare context. To ensure availability of these vital services, the Health and Human Services Commission should establish a designation for children and adults with specialty mental health needs, much like the Community-Based Alternatives (CBA) designation currently used in STAR+PLUS for persons with physical disabilities. For these populations, the health plans will receive an actuarially sound capitation payment and will be required to make available the array of Medicaid services allowable through the Department of State Health Services Resiliency and Recovery model.

b. Require STAR and STAR+PLUS plans to support and fund designated Health Homes for children with serious emotional disturbance and adults with serious mental illness enrolled in Managed Care.

The supports and care management necessary for children and adults with specialty mental health needs require local leadership, engagement and coordination at the provider level.

The prevalence of co-occurring mental health, substance use and chronic physical health conditions for this population is high and they often end up receiving treatment in the most expensive settings: emergency departments, inpatient hospital beds and jails. Engagement in a Health Home provides the focused care management strategies needed to access services at the right place at the right time—bringing down overall health care costs while improving health outcomes.

If Medicaid behavioral health services are fully carved-in to STAR and STAR+PLUS, the Texas Council strongly supports making the establishment of Health Homes for people with specialty mental health needs a requirement in all STAR and STAR+PLUS contracts. The Health Home is a primary care practice or a specialty care practice, selected by an enrolled member of an HMO. This may include Federally Qualified Health Centers, Community Mental Health Centers, Rural Health Centers, Primary Care Practices or other Specialty Care Practices with expertise and experience in delivering services for people with serious mental illness.

The Health Home is responsible for**:**

- Comprehensive care coordination;
- Family-centered care;
- Providing all of the care the member needs or coordinating with other qualified providers to provide care to the patient throughout the member's life, including preventive care, acute care, chronic care and end-of-life care;
- Providing members, directly or indirectly, with access to health care services outside of regular business hours;
- Linking members to community and social supports;
- Hospital admission and discharge follow-up;
- Communicating and coordinating with other providers;
- Utilizing health information technology to manage care; and
- Providing or arranging appropriate education and supports for families related to members' general medical and chronic health conditions.

The costs associated with the additional physician consultation and nurse care managers will be covered by a Care Coordination payment from the HMO for each individual enrolled in the Health Home. The Care Coordination payment allows Health Homes to cover the costs associated with comprehensive care management, health and wellness education activities and transitional care activities that are not currently paid for by the HMO. In addition, a shared savings arrangement may be negotiated between the plan and Health Home to provide additional pay for performance funding.

c. Require STAR and STAR+PLUS plans to establish a network of comprehensive mental health providers by contracting with DSHS certified private and public Medicaid Mental Health Rehabilitation providers.

The future full carve-in design transfers responsibility for provider contracting, authorization and payment of Medicaid MH Rehabilitative Services from Local Mental Health Authorities to STAR and STAR+PLUS Health Maintenance Organizations—further opening the market to both private and public providers.

Today, in 247 counties of Texas (except the 7 counties in NorthSTAR) the HMOs contract with providers and authorize standard mental health services, including inpatient care, psychiatric services, nursing, counseling, and medication management. The future carve-in would add

Medicaid Mental Health Rehabilitative Services and Targeted Case Management to the services contracted, authorized and paid by the HMOs.

In the proposed redesign, Department of State Health Services (DSHS) would expand the network of providers available for HMO contracting by certifying both private and public Comprehensive Service Providers that meet established criteria for delivering the full array of Texas Resiliency and Recovery services, including but not limited to psychiatry, counseling, rehabilitative skills training, case management, supported employment and supportive housing services. DSHS would also serve an oversight and policy role for ensuring continued focus on evidence-based practice and outcomes for children with serious emotional disturbance and adults with schizophrenia, bipolar disorder and major depression.

Along with certified private providers, the continued role of Local Mental Health Authorities as providers of mental health rehabilitative services remains vital to ensuring statewide access to services that stabilize serious psychiatric disorders and support people in reaching recovery. As described later in this document, the combined role— Local Mental Health Authority and Performing Provider—is also necessary for strengthening local mental health and substance use disorder services through the 1115 Transformation Waiver.

See Attachment A for Contract amendment language for STAR and STAR+PLUS contracts.

Retain local control of important community decisions related to public mental health services through Local Mental Health Authorities.

Serving at the intersection of public health and public safety in communities across Texas, Community Centers—designated as Local Mental Health Authorities—fulfill a statutorily directed, organizing role for addressing the needs of people with serious mental illness and substance use disorders.

In the future system redesign, HMOs will authorize clinical care for Medicaid recipients with serious mental illness and substance use disorders; however, meeting the needs of this population requires interface with systems beyond the control or financial risk of the HMO, such as criminal justice, community support services, and other local healthcare systems.

To address this reality, the local organizing role of the Local Mental Health Authority remains vital, particularly for programs such as crisis response, jail diversion, Mental Health Deputies, Mental Health First Aid, suicide prevention, health promotion, school-based initiatives, telemedicine in jails and homeless shelters, specialty courts, outpatient competency restoration and disaster recovery.

In continued partnership with local government and the Department of State Health Services the Local Mental Health Authorities will retain the following roles:

- Local planning responsibilities to identify and address gaps in service delivery;
- Managing and providing mental health services for people who are medically indigent;
- Securing local funds in partnership with the state and federal government;
- Managing the mental health crisis response system;
- Linkage and/or provision of supported housing;
- Interfacing with the criminal justice system;
- Facilitating benefit eligibility;
- Assisting with access to covered benefits;
- Coordinating essential services across multiple health and human service systems;
- Educating the public; and
- Responding to devastating natural disasters that disrupt lives and service systems.

Additionally, DSHS will directly contract with Local Mental Health Authorities and other providers of services under the federal Mental Health/Substance Addiction Block Grant program.

Whether it's addressing the needs of people facing an emerging mental illness who are uninsured, have Medicaid or other insurance coverage, local control over how these systems intersect and how other community resources are leveraged and put to use is important for maximizing health outcomes and community well-being and minimizing overall health and safety costs.

Strengthen local mental health and substance use disorder services by leveraging the 1115 Transformation Waiver to maximize federal revenue as a match to state and local funding expended for indigent care.

The Community Centers of Texas are actively engaged in maximizing opportunities created by the 1115 Transformation Waiver to improve mental health and substance use disorder services in local communities across our state. This transformational initiative promotes collaborative community activities to improve health and access to care for Texans.

Along with other health care providers and local stakeholders, Community Centers are assessing community need, agreeing on a course of action, and investing resources to address identified needs.

Community Centers fulfill important roles under the 1115 Transformation Waiver:

IGT Entity. Like public hospitals and other governmental entities, Centers have the ability to transfer locally managed state and local dollars to draw down federal funding for DSRIP projects. This process is called an Intergovernmental Transfer, or IGT.

Performing Provider. As a public Medicaid provider, Centers receive direct payment from HHSC when DSRIP metrics are achieved.

Regional Health Plan Partner. As an IGT Entity and Performing Provider, Centers are an important community partner in the RHP process working to ensure the needs of people with serious mental illness, substance use disorders and intellectual disabilities are represented as this unprecedented opportunity becomes reality. As partners, Centers are contributing to the assessment of community need and working collaboratively with local partners, including consumers, advocates and private providers, to plan and implement innovative and effective solutions to address the unique behavioral health care needs in their respective regions.

The 1115 Transformation Waiver creates opportunity to eliminate the waiting list for mental health services and expand access to include people who are seriously mentally ill but not eligible for DSHS funded services.

Moving Forward

The Community Centers of Texas remain focused on recovery and self-determination in managing and delivering a wide range of lower cost community-based services to vulnerable populations across all 254 counties of our great state. In the future system, Centers will continue to serve at the intersection of local public health and public safety.

Through leveraging local, state and federal funds for the purpose of creating integrated local service delivery systems, Centers will continue to be successful in reducing demand on higher cost government systems, including state institutions, jails and prisons, as well as hospitals and other local health care systems.

Our mission has never been clearer: **We serve a greater cause.**

Attachment A
Contract Amendment Language for the
STAR and STAR+PLUS Health Plan Contracts

Covered Community-Based Behavioral Health Services and Supports

The HMO must ensure that STAR and STAR+PLUS Members needing Community-based Behavioral Health Services and Supports are identified, and that services are referred and authorized in a timely manner. The HMO must ensure that Providers of Community Behavioral Health Services and Supports are qualified to deliver the services they provide. The inclusion of Community-based Behavioral Health Services and Supports in a managed care model presents challenges, opportunities and responsibilities.

Community Behavioral Health Services and Supports may be necessary as a preventative service to avoid more expensive hospitalizations, emergency room visits or institutionalization. Community Behavioral Health Services and Supports should also be made available to Members to assure maintenance of the highest level of functioning possible in the least restrictive setting. A Member's need for Community Behavioral Health Services and Supports to assist with the recovery, stability and community tenure must be considered as important as needs related to a medical condition. HMOs must provide both Medically Necessary and Functionally Necessary Covered Services to Community Behavioral Health Services and Supports Members.

Community Based Behavioral Health Services and Supports Available to All Members

The HMO must enter into written contracts to ensure access to these services for all HMO Members. At a minimum, these Providers must meet all state licensure and certification requirements for providing the following services:

- Inpatient mental health services
- Outpatient mental health services
- Psychiatry services
- Counseling services for adults (21 years of age and over)
- Outpatient substance use disorder treatment services including:
    - Assessment
    - Detoxification services
    - Counseling treatment
    - Medication assisted therapy
- Residential substance use disorder treatment services including:
    - Detoxification services
    - Substance use disorder treatment (including room and board)

These services are not subject to the quantitative treatment limitations that apply under traditional, fee-for-service Medicaid coverage. The services may be subject to the HMO's non-

quantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008.

Behavioral Health Services Available to Qualified Members [Specialty Mental Health (SMH) Program]

The STAR and STAR+PLUS waivers provide services to adults with serious and persistent mental illness and children with serious emotional disturbance, who are defined by the Department of State Health Services as the Priority Population. In STAR and STAR+PLUS waiver, the SMH Program provides Community Long-term Behavioral Health Services to Medicaid recipients who are priority population as a cost-effective alternative to inpatient hospitalization, jail and other intensive levels of care. The Members are determined eligible to meet Priority Population through assessment tools defined by the Department of State Health Services Resiliency and Recovery model, currently identified as the Adult Needs and Skills Assessment (ANSA) and the Child and Adolescent Needs and Skills (CANS).

The Health Maintenance Organization (HMO) must make available the array of Medicaid services allowable through the Texas Resiliency and Recovery model to STAR and STAR+PLUS members who meet these eligibility requirements. The authorization tools for the services provided in the Specialty Mental Health (SMH) Program are the assessment tools identified by the Department of State Health Services (ANSA and CANS) and completed by comprehensive service providers.

The HMO must enter into written contracts with Comprehensive Service Providers, certified by the Department of State Health Services, to ensure access to these services for all SMH Program Members.

Service	Certification/Licensure
Mental Health Rehabilitative Skills Training	Comprehensive Service Provider[2] certified by the Texas Department of State Health Services (DSHS)
Mental Health Targeted Case Management	Comprehensive Service Provider certified by DSHS
Professional Counseling Services within Texas Resiliency and Recovery	Comprehensive Service Provider certified by DSHS
Professional Counseling Services outside of Texas Resiliency and Recovery	State Medicaid Licensure Requirements
Psychiatry	State Medicaid Licensure Requirements

[2] The Texas Department of State Health Services will qualify Comprehensive Service Providers for contracting by HMOs based on criteria established to certify a provider has the ability to provide the full array of Texas Resiliency and Recovery services, including but not limited to psychiatry, counseling, rehabilitative skills training, case management, supported employment and supportive housing services.

Designated Health Home for Members Needing Specialty Mental Health Services

The HMO must arrange for the provision of a designated Health Home for adults with serious and persistent mental illness and children with serious emotional disturbance, consistent with state statutes, regulations and federal law. The designated Health Home must be part of a person-based approach and holistically address the needs of persons with one or more serious and persistent mental health condition(s).

The designated Health Home is responsible for**:**

- Comprehensive care coordination;
- Family-centered care;
- Providing all of the care the member needs or coordinating with other qualified providers to provide care to the patient throughout the member's life, including preventive care, acute care, chronic care and end-of-life care;
- Providing members, directly or indirectly, with access to health care services outside of regular business hours;
- Linking members to community and social supports;
- Hospital admission and discharge follow-up;
- Communicating and coordinating with other providers;
- Utilizing health information technology to manage care; and
- Providing or arranging appropriate education and supports for families related to members' general medical and chronic health conditions.

The HMO must provide a payment to the designated Health Home for the provision of Health Home services. The HMO will engage in active Provider practice support and contracting to address reimbursement, relevant outcomes measures and performance requirements. Reimbursement can be provided under any of the following models:

- Fee-for-Service + care coordination payment
- Fee-for-Service + care coordination payment + pay for performance bonus
- Capitation + care coordination payment + pay for performance bonus
- Capitation + pay for performance bonus
- Other agreed upon reimbursement between the HMO and Health Home