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EXPLORING THE FUNDAMENTAL
RELATIONSHIP BETWEEN COMMUNITY
MENTAL HEALTH CENTER FUNDING AND
UNCOMPENSATED CARE COSTS IN TEXAS

THE IMPACT OF THE DSHS PERFORMANCE CONTRACT

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Executive Summary

This paper describes the potential impact of the Department of State Health Services (DSHS) standardized performance contract on the Center for Health Care Services' (CHCS) value-driven-access approach to client services. In doing so, the paper also outlines the impact of CHCS's services on the problem of uncompensated care (UC) costs in Texas, illustrating how the contract's conditions can unintentionally incentivize increases in the cost of UC.

An analysis by the Department of State Health Services (DSHS) of adult hospital admissions in Texas from 2006 to 2011 found 1,454,097 hospitalizations to be potentially preventable, generating approximately \$41.4 billion in total charges. During this same time period, potentially preventable admissions in Bexar County hospitals exceeded 88,000 at approximately \$2.6 billion in charges. A disproportionate number of preventable admissions and readmissions to Texas hospitals occur to individuals who have both medical and behavioral health conditions, (approximately 30% of potentially preventable events have a co-morbidity according to some estimates). Both CMS and HHSC have developed funding initiatives to control the growth in hospital costs by reducing the occurrence of these potentially preventable events.

In Bexar County the Center for Healthcare Services provides behavioral healthcare to not only a more complex client population, (i.e., case mix of 1.41) than other centers in the state but also serves a higher number of these complex clients than the other centers relative to the DSHS's targets identified in the performance contract. CHCS, by providing an alternative to hospitalizations that would have occurred without its intervention on such an expanded scale, is bending the Bexar County cost curve. In this way, CHCS is likely substantially reducing UC cost experienced by every hospital in Bexar County but most particularly the cost experienced by the Bexar County Hospital District which is responsible for using local tax revenues to reimburse the private hospitals who participate in the Medicaid supplemental payment programs. Yet, the public benefit of CHCS's approach to access is not limited to reducing UC costs in Bexar County. It is also likely that there is a substantial impact on HHSC's use of GR as state match for the Medicaid DRG payment system.

DSHS's standardized performance contract, as manifested through its sanctions and withhold-based outcome formulas, appears to negatively reinforce community center behavior like that of CHCS as it seeks to serve the most complex of clients who are also those most likely to seek hospitalization without such intervention. In this way, DSHS's approach to the performance contract appears misaligned with, if not contrary to the larger HHSC objectives of bending the healthcare cost curve as it is defined by both Medicaid and UC costs. The performance contract in several ways actually incentivizes centers to serve a minimum number of clients in terms of both its targets and the methodology it formulated to allocate funds to reduce the wait list. In addition, to the degree that what is paid for defines what is done, it is also quite possible that the potential for sanctions also, though unintentionally, directs centers to serve the mildest of those clients fitting the requirements of DSHS's uniform assessment, placing the more difficult on wait lists.

Ultimately, the performance contract for community centers appears to manage GR in ways that are not aligned with the larger objectives of HHSC. If nothing else, center performance such as that of CHCS, should not be penalized for exceeding the expectations with regard to client access and the associated impact on bending the Bexar County healthcare cost curve.

- Improvement Target. Percentage of adult population showing reliable improvement in one or more ANSA domains.¹
- Engagement Target. Average percentage of individuals each month receiving at least one encounter.

Resilience and Recovery Crisis Outcomes – Applicable for Adult and Children’s Mental Health Services

- Hospitalization Target. The rate of inpatient psychiatric hospital bed-days in the population of the local service area.
- Jail Diversion Target. Percentage of valid bookings across the adult population with a match in CARE.
- Effective Crisis Response Target. Percentage of adults and children/youth who receive crisis services and avoid psychiatric hospitalization with 30 days of the first day of the crisis episode.
- Frequent Admissions Target. Percent of adults and children/youth in a full LOC admitted 3 or more times to a DSHS purchased psychiatric hospital bed within 180 days.

Resilience and Recover Outcomes – Children’s Services Outcomes

- Juvenile Justice Avoidance Minimum Target. 95% of children/youth enrolled in a full LOC showing no arrests (acceptable) or reduction of arrests (improving) from time of first assessment to time of last assessment within measurement period.
- Community Tenure. Minimum target – In Q1/Q2, the percentage of all children/youth in a full LOC avoiding psychiatric hospitalization in a DSHS purchased bed after authorization into a full LOC.
- Improvement. Minimum target – The percentage of children and youth served in a full LOC in Q1/Q2 showing improvement according to the Reliable Change Index (RCI) in one or more domains on the CANS.²
- Engagement. Minimum target – In Q1/Q2, the average percentage of children/youth each month receiving at least one encounter.

CHCS’s Client Case Mix

As illustrated above, the standardized performance contract methodology for evaluating CHCS’s outcome performance is, for virtually all measures, the percentage of CHCS’s client population. This methodology is equitable when centers provide services to clients with the same degree of service complexity and in the same relative numbers.

The Texas Council of Community Mental Health Centers engaged an actuary to construct a case mix index using center reported cost, encounter and eligibility data for SFY12. The table in Attachment 1 shows this case mix index for the centers participating in the study. The first column in the table (FY12 Monthly) shows the center’s monthly client enrollment for adults. The second column shows each center’s reported average cost per adult client. The third column shows the actuary’s calculated statewide uniform cost based on LOC. The Case-Mix Index Risk Adjustment column (Column 4) shows each center’s calculated case mix, which is the center’s uniform cost divided by the overall statewide uniform cost. For example, the Center for Health Care Services case mix is 367.4 / 260.41 which equals

¹ ANSA is Adult Needs and Strengths Assessment. It is a component of the uniform assessment that identifies the LOC needed by the individual.

² CANS is the Child and Adolescent Needs and Strengths.

Summary

The Center for Health Care Services' case mix shows that its client population is more severely ill and in need of more intense services which are more costly as the LOC increases. Attachment 2 shows that CHCS provides services to a substantially larger number of clients than the DSHS target reimburses.

Attachment 2 also shows that one impact of CHCS's implementation of its value-based-access approach to client services is that it received considerably less of the wait list funding than it would have received if it had not served the number of clients it did.

In looking at the Performance Contract requirements, the fact that CHCS has the case mix that it does and serves an increased number of clients, increases the possibility that it may not meet its performance requirements and will be financially sanctioned. A particularly odd component of the performance contract is the 10% withhold and its associated outcome methodology. It is much more difficult for a center to meet the outcome requirements identified in its contract when its client population is more severely ill. For example, consider the two outcomes below:

- Employment Target. Percent of adults in full LOC who have independent employment.
- Housing Target. Percent of adults living independently or in a group or treatment setting.

Both of these outcomes are significantly impacted by the client composition of CHCS's population. For the Center for Health Care Services, it is much more difficult to achieve these community center outcomes because of its decision to serve Texans most in need.

UC in Texas and Its Relationship to Community Mental Health Performance Contract

Uncompensated Care Overview

In Texas the responsibility for providing care to indigent and uninsured Texans falls locally to the counties and municipalities. Providing care to the uninsured creates uncompensated care costs for providers who then seek to find payment sources for the care they provided. In many cases these providers are hospitals, both private and public.

Another source of UC that is directly related to the manner in which Texas chooses to fund its Medicaid program is the Medicaid Shortfall. Hospitals participating in the Medicaid program, whether in managed care networks or not, have their inpatient payment amounts directly influenced by the Texas Medicaid All Payer Related Diagnostic Related Groups, (DRGs) prospective payment methodology. DRGs essentially identify the cost associated with over 1,200 diagnoses and pay the hospital provider based on the diagnosis of the Medicaid patient.

The Texas DRG program is funded primarily with general revenue (GR). Historically, the Texas legislature has underfunded the Medicaid DRG program so that the full amount of the DRG payment due the hospital is not fully funded by the state. The difference between the full DRG-based amount of the Medicaid payment and the payment received is the Medicaid Shortfall. The Centers for Medicare and Medicaid (CMS) refer to the shortfall as uncompensated care and allow it to be reimbursed through CMS-approved supplemental payment mechanisms. In Texas there are two of these payment mechanisms for UC; the Disproportionate Share Hospital program (DSH), and under the current Medicaid 1115 waiver, the Uncompensated Care Pool (UC Pool).

Table 3
Statewide Estimates of Unreimbursed UC Cost in Hospitals FFY2013

	Private Hospitals	Public Hospitals	Total
Total UC Costs³	\$4.1 billion	\$2.4 billion	\$6.5 billion
Total Unreimbursed UC Costs⁴	\$1.5 billion	\$.4 billion	\$1.9 billion

From Table 3 it is clear that there is a substantial amount of UC costs incurred by providers above the funding available to offset it. There are several issues which make this unreimbursed UC cost even more dramatic than represented in the Table and that is the fact that the funding streams to reimburse UC, (i.e., DSH and UC Pool) are subject to declining federal funding in coming years.

If we move from a statewide view of UC to a local view as illustrated by the data in Table 4 we find that the total amount of unreimbursed UC cost in Bexar County, home of the Center for Health Care Services, (i.e., RHP 6), is approximately \$123 million. For private hospitals in Bexar County approximately 23% of their Total UC Costs (\$78 million) remained unreimbursed, while for public hospitals 14% was unreimbursed (\$45 million).

Table 4
RHP 6 (Bexar County) Estimated Unreimbursed UC Costs in Hospitals in FFY2013

	Private Hospitals	Public Hospitals	Total
Total UC Costs	\$337 million	\$313 million	\$650 million
Total Unreimbursed UC Costs	\$78 million	\$45 million	\$123 million

Community Center's Role in UC

Largely unrecognized in the performance contract requirements of DSHS is the role of the community mental health center in modulating the amount of UC in the state. Community centers are not eligible for UC reimbursement through any of the supplemental payment mechanisms. Yet, the degree to which their client focus is on individuals with severe and persistent mental illness, a population highly at risk of

³ In FFY2013, as shown in Table 2, the waiver's UC Pool had its highest amount of funding at \$3.9 billion. This is the amount that is used in Tables 3 and 4 to estimate the amount of Unreimbursed UC Costs. In later years, the UC Pool amounts decrease substantially which means there is likely to be increasing amounts of UC cost that remains unreimbursed given the current circumstances around insurance and Medicaid expansion. Total UC Cost is an estimate of the amount of UC costs that are incurred by an individual hospital and reimbursable through the UC Pool. It includes the Hospital Specific Limit (CMS's definition of UC costs), allowed physician, pharmacy and clinic costs. It is an estimate of the total amount of UC cost prior to being reduced by supplemental payments from either DSH or the UC Pool.

⁴ Total Unreimbursed UC Costs is a calculation that references the UC costs remaining for a hospital after it has received UC Pool and DSH funding. Since UC Pool funding occurs after DSH funding, total unreimbursed costs represent an estimate of the UC costs that are unreimbursed after both DSH and UC Pool supplemental payments have been made.

PPRs and the Performance of Texas Medicaid Hospitals

HHSC's *Potentially Preventable Readmissions in the Texas Medicaid Population, State Fiscal Year 2012* report's key findings include the following:

- Overall, 3.7% of admissions were followed by a readmission chain that started within 15 days of discharge. Rates varied widely by care category: .8% for obstetrics, 4.1% for non-obstetric patients under age 18 and 8.2% for non-obstetric adults.
- Mental health and substance abuse conditions comprised 9.3% of initial admissions but 27.4% of PPRs. Bipolar Disorders, Schizophrenia, Major Depression, Cesarean and Vaginal Delivery and Health Failure represented substantial numbers of PPRs.
- Overall, two-thirds of readmissions were to the same hospital and one-third to a different hospital.
- Of the 20 DRGs with the highest numbers of initial admits, Schizophrenia, Heart Failure and Bipolar were the only ones with PPR rates of 10% or higher. These 3 DRGs were responsible for 20% of the readmission chains in the analysis. [Major Depression had a 9.5% PPR rate.]

Potentially Preventable Hospitalizations in Texas

DSHS's analysis of all adult hospital admissions in Texas (not just those in the Medicaid population) from 2006 to 2011 found 1,454,097 hospitalizations that were potentially preventable that generated approximately \$41.4 billion in total charges. Interestingly, the DSHS analysis only focused on 10 diagnoses in estimating the impact of preventable hospitalizations (these 10 conditions are listed in the table in Attachment 3). Hospital charges for Potentially Preventable Admissions (PPAs), as incurred by different payers, are in the table below.⁷

Table 5
Adult Potentially Preventable Hospitalizations in Texas by Payer
(2006 – 2011)

Payer	PPA Charges
Medicare	\$26.2 billion
Private Insurance	\$7.4 billion
Uninsured	\$4.0 billion
Medicaid	\$2.9 billion
Other	\$1.0 billion

Potentially Preventable Hospitalizations and Behavioral Health Co-Morbidity in Bexar County

The table in Attachment 3 dis-aggregates the statewide data on PPAs discussed above to show the impact of preventable hospitalizations in Bexar County. For the time period covered by DSHS's analysis, there were 88,626 hospitalizations that were evaluated to be potentially preventable for only those 10 conditions listed at the left of the table. These 10 conditions generated over \$2.6 billion in hospital charges, an amount that averaged \$2,134 per Bexar County resident in 2011.

⁷ Mike Gilliam, DSHS: *Adult Potentially Preventable Hospitalizations in Texas*, UT Mentorship Program – Health Careers, November 21, 2013.

to \$1.7 trillion for all service categories.... In other words, even though members with treated MH/SUD constitute only 14% of the total insured members across the three markets, they account for over 30% of total healthcare spending.” (p.8)

Table 6
Total Healthcare Spending in the Presence of Behavioral Conditions
2012 Costs in Millions

	Medical	Behavioral	Medical Rx	Behavioral Rx	Total
No MH/SUD	\$1,002,332	\$9,210	\$137,173	\$11,009	\$1,159,724
MH/SUD	\$371,119	\$49,587	\$66,333	\$38,252	\$525,291
Total	\$1,373,451	\$58,797	\$203,507	\$49,261	\$1,685,016

The Milliman analysis of the impact of medical and behavioral health co-morbidity on healthcare costs included the identification of what they referred to as “total value opportunity” which was defined as the difference in PMPM costs between those treated for MH/SUD conditions and those not treated for MH/SUD conditions multiplied by the enrolled member months. Table 7 reveals the results of this analysis. The value opportunity, (i.e., potential for savings) for the commercial market payer is estimated to be \$162.4 billion annually, while for Medicaid the value opportunity is approximately \$100.4 billion.

In Milliman’s work, the value opportunity represents something of an ideal potential for savings. In an attempt to convert from this potential to what may be realizable, Milliman reviewed the literature on integrated medical and behavioral healthcare to estimate the savings in healthcare costs when treatment is integrated. Their research estimated that approximately 5% to 10% of the total MH/SUD cost in Table 6 (i.e., \$525 billion) could be saved through the integration of behavioral and medical care. The far right column of Table 7 (Cost Impact of Medicaid & Behavioral Health Integration) shows this total estimated savings across three different payers.

Table 7
Average Annual Cost Savings and Impact on Cost of Integrated Medical & Behavioral Healthcare
(In Millions)

Payer Type	Member Months	Total Claims	Value Opportunity	Cost Impact of Medicaid & Behavioral Health Integration
Commercial	2,386,000,000	\$1,013,386	\$162,366	\$15,815-\$31,629
Medicare	556,000,000	\$362,793	\$30,803	\$3,347-\$6,693
Medicaid	546,000,000	\$308,836	\$100,374	\$7,103-\$9,945
Total	3,487,000,000	\$1,685,016	\$293,543	\$26,265-\$48,267

a minimum number of clients both in terms of its targets and through the methodology it formulated to allocate funds to reduce the wait list. Yet, to the degree that what is paid for defines what is done, it is also quite possible that the potential for sanctions also, though unintentionally, directs centers to serve the mildest of those clients fitting the requirements of DSHS's uniform assessment, placing the more difficult on wait lists.

Ultimately, the performance contract for community centers appears to manage GR in ways that are not aligned with the larger objectives of HHSC. If nothing else, center performance such as that of CHCS, should not be penalized for exceeding the expectations with regard to client access and the associated impact on bending the Bexar County healthcare cost curve.

Attachment 1: Case Mix Ratios for Community Centers Adult Clients

Center	FY12 Monthly Enrollment	FY12 Average Cost Center Reported	FY12 Average Cost Uniform State	Case-Mix Index (Risk Adjusted)	Spend Ratio
Anderson/Cherokee	1,001	179.78	223.79	0.86	0.80
Andrews Center	1,726	179.87	210.34	0.81	0.86
Austin Travis Co Integral Care	4,038	257.83	268.52	1.03	0.96
Behavioral Health Center of Nueces	1,469	241.22	275.35	1.06	0.88
Betty Hardwick Center	716	283.01	256.37	0.98	1.10
Bluebonnet Trails	2,190	305.57	279.96	1.08	1.09
Border Region	1,297	267.4	238.92	0.92	1.12
Burke Center	1,895	209.1	209.64	0.81	1.00
Camino Real	1,206	311.36	258.01	0.99	1.21
Center for Life Resources	554	308.51	277.1	1.06	1.11
Central Counties	1,348	227.18	189.32	0.73	1.20
Central Plains	430	244.88	210.68	0.81	1.16
Coastal Plains	2,020	198.68	255.85	0.98	0.78
Community Healthcore	2,375	204.55	246.01	0.94	0.83
Denton County	1,303	263.04	240.38	0.92	1.09
Emergence Health Network	3,269	251.98	392.36	1.51	0.64
Gulf Bend	802	188.02	228.1	0.88	0.82
Heart of Texas	1,062	304.93	258.12	0.99	1.18
Helen Farabee	2,963	159.28	187.89	0.72	0.85
Hill Country	2,560	222.7	211.49	0.81	1.05
Lakes Regional	1,259	192.06	217.33	0.83	0.88
MHMR Auth or Brazos Valley	1,462	192.14	248.97	0.96	0.77
MHMR Auth of Harris Co	8,613	430.58	266.06	1.02	1.62
MHMR of Tarrant Co	5,938	224.6	260.33	1.00	0.86
MHMR Services for the Concho Valley	507	315.07	211.82	0.81	1.49
Pecan Valley	1,922	154.78	215.35	0.83	0.72
Permian Basin	1,637	271.22	233.43	0.90	1.16
Spindletop	1,850	376.36	253.83	0.97	1.48
Starcare Specialty Health System	931	227.1	336.86	1.29	0.67
Texana	2,356	196.9	233.53	0.90	0.84
Texas Panhandle	1,654	232.94	248.09	0.95	0.94
Texoma	725	197.52	270.84	1.04	0.73
The Center for Health Care Services	4,734	322.96	367.4	1.41	0.88
The Gulf Coast Center	2,462	200.76	210.78	0.81	0.95
Tri-County MHMR Services	1,940	262.96	267.94	1.03	0.98
Tropical Texas	4,258	231.53	296.8	1.14	0.78
West Texas	1,414	274.59	197.88	0.76	1.39
Total / Weighted Average	77,886	260.67	260.41	1	1

Attachment 2: DSHS Allocation of Wait List Funding to Community Centers

August 8, 2013 FY13 Q1-3 Average Baseline AMH	Current 2013 AMH CARE Target	AMH Avg Served (2013 Q1-3)	DSHS Proposed AMH 2014 Target	DSHS Proposed Target Change	Wait List Funds Rec'd	Additional Served over FY2013 Target
Center for Health Care Services	3,787	5,016	5,350	1,563	\$ 281,580	1,229
Helen Farabee	1,929	2,946	2,963	1,034		1,017
Austin Travis Co Integral Care	2,996	3,901	4,068	1,072	\$ 112,632	905
Andrews Center	1,097	1,979	2,071	974	\$ 350,892	882
Pecan Valley	1,335	2,082	2,168	833	\$ 324,900	747
Texana Center	1,592	2,320	2,555	963	\$ 134,292	728
Burke Center	1,285	1,941	2,106	821	\$ 667,128	656
Coastal Plains	1,384	2,007	2,024	640		623
Gulf coast	1,833	2,439	2,550	717	\$ 207,936	606
Hill Country	1,964	2,499	2,564	600		535
Tri County	1,488	2,004	2,220	732	\$ 636,804	516
Tropical Texas	3,790	4,264	4,972	1,182	\$ 2,915,436	474
Community HealthCare	1,887	2,332	2,393	506	\$ 212,268	445
MHMR of Tarrant County	5,777	6,199	7,009	1,232	\$ 3,287,988	422
ACCESS	658	1,077	1,094	436		419
Brazos Valley	1,084	1,449	1,542	458	\$ 363,888	365
Emergence Health Network	3,042	3,399	3,705	663	\$ 1,225,956	357
Boorder Region Behavioral Health	1,120	1,418	1,559	439	\$ 567,492	298
Texas Panhandle	1,464	1,755	1,772	308		291
Camino Real	1,005	1,263	1,284	279	\$ 43,320	258
Gulf Bend	607	798	900	293	\$ 420,204	191
Lakes Regional	1,093	1,279	1,298	205		186
Permian Basin	1,486	1,640	1,658	172		154
Nueces County	1,251	1,388	1,405	154		137
Central Counties	1,362	1,492	1,551	189	\$ 51,984	130
MHMR for Concho Valley	413	526	543	130		113
Denton	1,182	1,259	1,581	399	\$ 1,104,660	77
Texoma	677	745	763	86		68
Center for Life Resources	501	544	562	61		43
Central Plains	404	432	449	45		28
Heart of Texas	1,082	1,108	1,169	87	\$ 220,932	26
Betty Hardwick	697	720	737	40		23
StarCare Specialty Health System	948	933	968	20	\$ 112,632	(15)
Spindletop Center	1,764	1,730	1,747	(17)		(34)
West Texas Centers	1,458	1,380	1,534	76	\$ 641,136	(78)
Bluebonnet Trails	2,375	2,198	2,376	1		(177)
MHMR of Harris County	8,844	8,034	9,781	937	\$ 7,065,492	(810)
Total	66,661	78,496	84,991	18,330	\$ 20,949,552	11,835

Attachment 4: Healthcare Costs of Beneficiaries with and without Behavioral Disorders

Population	Behavioral Health Diagnosis	Member Months	Costs				Total \$
			Medical \$	Behavioral \$	Medical Rx \$	Behavioral Rx \$	
Commercial	No MH/SUD	2,048,000,000	280	3	53	4	340
	Non-SPMI MH	278,000,000	661	23	145	74	903
	SPMI	47,000,000	759	128	135	175	1,197
	SUD	22,000,000	830	73	102	67	1,072
	Total	2,386,000,000	335	8	66	16	425
Medicare	No MH/SUD	508,000,000	579	3	NA	NA	582
	Non-SPMI MH	23,000,000	1,369	40	NA	NA	1,409
	SPMI	21,000,000	1,222	215	NA	NA	1,437
	SUD	6,000,000	1,291	213	NA	NA	1,504
	Total	556,000,000	640	13	NA	NA	653
Medicaid	No MH/SUD	437,000,000	309	4	63	5	381
	MH/SUD	109,000,000	757	286	172	86	1,301
	Total	546,000,000	398	61	85	21	565
Total	No MH/SUD	2,993,000,000	335	3	55	4	397
	MH/SUD	494,000,000	751	100	148	86	1,085
	Total	3,487,000,000	394	17	69	17	497

Notes:

Costs are average per member per month (PMPM) costs.

Medical Column shows facility and professional costs for non-behavioral services.

Medical Rx Column shows the pharmacy costs for drugs used to treat medical conditions.

Behavioral Column shows facility and professional costs for treating behavioral conditions.

Behavioral Rx Column shows the costs for prescription drugs to treat behavioral conditions.

SUD refers to substance use disorder diagnoses.