Sunset Advisory Commission

Staff Report

Health and Human Services Commission and System Issues

October 2014

Issue 9

NorthSTAR's Outdated Approach Stifles More Innovative Delivery of Behavioral Health Services in the Dallas Region.

Background

In 1999, the state created NorthSTAR to pilot a new approach to delivering integrated, publicly funded mental health and substance use disorder services — referred to as behavioral health services — for both Medicaid and indigent clients.[1] The NorthSTAR pilot sought to eliminate wait lists and improve client services by combining delivery systems and funding sources from Medicaid, state general revenue-funded indigent programs, federal block grants, and some local funds. Today, NorthSTAR provides behavioral health services through this unique model, different from the rest of the state, to Medicaid recipients and indigent persons residing in Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties.

- **Oversight**. The Department of State Health Services (DSHS) contracts with a behavioral health organization, currently ValueOptions, to administer the NorthSTAR program. NorthSTAR is the only Medicaid managed care contract not managed by the Health and Human Services Commission (HHSC).

  A locally appointed governing board, the North Texas Behavioral Health Authority, also provides guidance and input to NorthSTAR. This board, appointed by county commissioners in each of the seven counties, serves as the local behavioral health authority for the region, and is responsible for planning, oversight, and ombudsman services.[2]

- **Budget**. In fiscal year 2013, NorthSTAR operated on a total budget of $166 million, including about $69 million in Medicaid funds.[3] DSHS pays ValueOptions a monthly amount based on a fixed per member, per month rate for its Medicaid clients and on an annual budget for its remaining funding sources for indigent clients.

- **Population served**. Most Medicaid recipients residing in NorthSTAR's service area are automatically enrolled in NorthSTAR, while indigent individuals not eligible for Medicaid access services must meet income and clinical criteria.[4] The seven county area served by NorthSTAR has over 621,000 individuals enrolled in Medicaid and over 468,000 indigent persons who are counted as enrolled members due to current or previous participation in services. Of the almost 75,000 members actually receiving behavioral health services, a slight majority are indigent. Some clients lose their Medicaid eligibility throughout the year. During fiscal year 2013, about 27 percent of NorthSTAR's Medicaid population lost eligibility.

- **Services**. Covered services in NorthSTAR include visits to a psychiatrist, psychologist, or counselor; inpatient and outpatient care for serious mental illness; and substance abuse, crisis, residential, and employment services. Primary healthcare services are not included and are provided separately for Medicaid clients through a managed care organization or fee-for-service. The indigent population often lacks insurance coverage for primary healthcare needs and may receive these services from other programs such as community clinics or uncompensated care.

Findings

Clients in NorthSTAR may be left behind as the rest of the state moves toward integrating all aspects of health care to reduce costs and improve outcomes, especially in Medicaid.

- Behavioral and physical health integration is becoming a best practice. Wide support exists for ensuring a person's physical health is treated together with behavioral health issues. This link, described further in the textbox *Co-occurrence of Behavioral and Physical Health Problems*, demonstrates why coordination of both types of care can improve health outcomes and reduce unnecessary costs. An integrated approach can help more effectively treat mental illness by increasing access to care and reducing stigmas that may prevent treatment. Integration also helps ensure the higher incidence, severity, and cost of physical health issues in people with mental illness are addressed more effectively.

Co-occurrence of Behavioral and Physical Health Problems

- Specific to the Medicaid population, psychiatric illness is represented in three of the top five most prevalent pairs of diseases among the highest-cost 5 percent of Medicaid-only beneficiaries with disabilities.[5]
- People with serious mental illness die, on average, 25 years earlier than the general population.[6]
- Co-occurring medical conditions such as cardiovascular, pulmonary, and infectious diseases lead to premature deaths in 60 percent of persons with mental illness.[7]
- Persons who suffer from a serious physical illness are more likely to suffer from depression or anxiety, which can interfere with medication adherence.[8]
- Thirty-one percent of potentially preventable readmissions to emergency rooms and 12 percent of potentially preventable admissions resulted from behavioral health or substance abuse conditions in fiscal year 2013.
- A recent Missouri Medicaid integrated pilot project resulted in a 13 percent reduction in hospital admissions and an 8 percent reduction in emergency room use, resulting in an overall cost savings of approximately $2.4 million for 12,000 enrollees over just 18 months.[9]

- **Texas is moving toward integrated care**. Medicaid participants in the NorthSTAR area lack coordinated access to behavioral health and primary care benefits.[10] Medicaid managed care outside the NorthSTAR region has structurally integrated primary care, mental health, and substance abuse benefits for some time. Last session, the 83rd Legislature transitioned the remaining Medicaid mental health services into the managed care model used in the rest of the state, including case management and rehabilitation services. While implementation of the more recent change is ongoing, the structural barriers are now removed with clear direction toward integrating care for the Medicaid population.

Beyond Medicaid, communities around the state are collaborating to integrate primary care and behavioral health for the indigent and other populations. The availability of additional federal funds through the new Delivery System Reform Incentive Payment (DSRIP) program has driven significant efforts toward this goal. Statewide, 54 DSRIP projects worth about $370 million are working specifically to integrate primary care and behavioral health, four of which are in the NorthSTAR region. However, these projects operate separately from the NorthSTAR model.

- **NorthSTAR model prevents integration**. Continuing NorthSTAR as a separate carve-out from the rest of Medicaid managed care moves in the opposite direction of the clear push to integrate mental health with primary care occurring in the rest of the state. While some providers within the NorthSTAR region have been able to participate in programs to promote integration, they have not done so through the NorthSTAR model. Widespread integration of behavioral health services with primary care within NorthSTAR would require a fundamental change to the NorthSTAR model and federal approval.

  Medicaid clients in NorthSTAR with co-occurring mental health and physical health conditions are not currently receiving coordinated treatment to address their needs comprehensively, limiting the improved outcomes and efficiency the state hopes to gain through integrated care. Because the responsibility for physical and behavioral health is split between Medicaid managed care organizations and the NorthSTAR behavioral health organization, neither has access to clients' full medical information needed to effectively coordinate care. Clients must also keep track of two insurance cards and two sets of program requirements, one for primary care and one for behavioral health, which only complicates the system for persons with serious mental illness.

The lack of coordinated treatment limits improvements in health outcomes and cost efficiencies.

The NorthSTAR model prevents a comprehensive evaluation of statewide behavioral health policies and outcomes in Medicaid.

The state cannot effectively administer and evaluate its Medicaid behavioral health benefits in a comprehensive manner because the Dallas area, one of the most populous regions of the state, is carved-out. Beyond the basic lack of a cohesive statewide behavioral health policy, fragmented administration results in the following concerns within Medicaid.

- **No comprehensive data analysis**. NorthSTAR presents challenges in managing the Medicaid behavioral health system because it carves out a major part of the state from policy discussions and improvement efforts based on standard, comparable evaluation. For example, HHSC is unable to evaluate Medicaid's behavioral health benefit as a whole or track statewide performance because NorthSTAR reports its data in an incompatible way. Because NorthSTAR uses a separate personal identifier, HHSC cannot determine which persons receiving NorthSTAR services are Medicaid clients, and cannot use NorthSTAR claims data for

HHSC cannot use NorthSTAR Medicaid data because it is reported in an incompatible way.

comprehensive evaluation of trends or utilization in Medicaid. While DSHS has a crosswalk for its own management purposes, this crosswalk does not interface with Medicaid systems.

- **Duplication in Medicaid claims**. In the NorthSTAR area, Medicaid clients may receive minor mental health services in a primary care setting, paid through a managed care organization, or by a behavioral health specialist, paid for by the behavioral health organization. Both types of services are paid for by Medicaid but neither are ever evaluated to identify duplicative claims for the same client. Payment disputes can also arise as long as separate managed care organizations with overlapping, but not integrated, coverage exist in the same program.

- **Client impacts**. In the Dallas area, clients must navigate a confusing web of access points to behavioral health services, including managed care organization services (which can include behavioral health treatment through primary care physicians), NorthSTAR behavioral health services, and most recently, the intended expansion of the Youth Empowerment Services (YES) program for youth with severe emotional disturbance.

  While NorthSTAR clients have options for providers within NorthSTAR's network, clients do not have a choice of plans. Clients must join NorthSTAR's sole behavioral health organization, ValueOptions. In the managed care model used in the rest of the state, Medicaid clients have a choice of at least two managed care organizations, each with its own network of providers in the service area. Choice allows clients options for service, and competition can create advantages for clients in the way of improved customer service and additional supports and benefits.

DSRIP has changed the game for behavioral health funding.

NorthSTAR's structure interferes with opportunities and incentives for funding behavioral health in the Dallas region.

- **Inability to access new federal funds**. In the last few years, DSRIP funding has changed the game for how behavioral health services are funded and delivered in Texas, providing an influx of funding to locally designed projects, many of which are focusing on the integration of behavioral health and primary care. However, while all local mental health authorities in the rest of the state are actively participating in and benefiting from DSRIP, the Dallas region's participation is significantly lagging. The region cannot use the significant amount of state money provided to NorthSTAR as matching funds to secure the federal funds because NorthSTAR operates through a private vendor to coordinate services. Federal law requires a public entity to put up the public share of payments for the project for DSRIP.[11] In fact, no managed care organization is allowed to participate in these projects according to program rules because all DSRIP providers must be direct Medicaid providers.[12] A change in the basic NorthSTAR model itself and federal approval would be required for NorthSTAR to

be eligible for DSRIP funds. Specifically, a DSRIP provider would need to assume full financial risk for provision of behavioral health services for eligible persons in the NorthSTAR region, including if costs exceed the amount of the contract.

As a result, the Dallas area received significantly less funding than comparable metropolitan areas of the state. The chart, *Comparison of DSRIP Behavioral Health Projects and Value*, depicts this disparity. The Dallas region behavioral health-related DSRIP projects have potentially earned $300 million less than the Houston region, and about $100 million less than the Fort Worth region and other metropolitan areas of the state on average. Continued DSRIP funding in the future will be contingent on subsequent federal approval of the waiver, but the broad scope and critical nature of this funding makes it a reasonable assumption that federal funding will likely continue beyond 2016 in some form. The Dallas region should not miss out on this funding simply because of an outdated structure for its behavioral health services.

Comparison of DSRIP Behavioral Health Projects and Value: Five Largest Regions

Region	Number of Active Four-Year Projects	Estimated Project Value
Houston (Region 3)	44	$444 Million
Fort Worth (Region 10)	26	$229 Million
San Antonio (Region 6)	34	$216 Million
Austin (Region 7)	36	$197 Million
Dallas (Region 9)	21	$127 Million

- **Local investment lacking**. The NorthSTAR model does not effectively incentivize local contributions for these services, leading to declining local funding invested in NorthSTAR, which now operates with little local funding support. Although local match funds are not required of the counties participating in NorthSTAR, four of the seven counties have historically contributed. However, two counties traditionally providing the largest amounts, Collin and Dallas, have stopped contributing, leaving only small investments from two rural counties, as shown in the table on the following page, *Local Funding Contributions to NorthSTAR*.[13]

  In fiscal year 2014, Dallas County used the money it had contributed to NorthSTAR as match for various DSRIP projects to better leverage federal funds for the area. This additional federal funding may supplement the behavioral health services that NorthSTAR provides the region, including helping with hospital and jail diversions for persons in need of services. However, these DSRIP dollars came to the Dallas region despite NorthSTAR, not because of it, and as mentioned earlier, these projects operate separately from NorthSTAR.

  The withdrawal of local funding for NorthSTAR to use for other DSRIP projects in the area reflects a telling lack of support and commitment for the model because of its structural limitations. Local mental health authorities in other parts of the state have match requirements averaging 9 percent.

The Dallas region misses out on additional federal funds because of NorthSTAR's outdated structure.

However, voluntary local matches dramatically exceed the required amount, ranging from 16 to 306 percent, and averaging 91 percent match.[14] In comparison, in the NorthSTAR region, local contributions now represent far less than 1 percent.

Local Funding Contributions to NorthSTAR
FYs 2009–2014

	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14
Dallas	$4,040,000	$3,715,083	$3,715,083	$3,343,576	$3,342,576	$0
Collin	$560,000	$560,000	$560,000	$0	$0	$0
Rockwall	$22,500	$22,500	$22,500	$25,000	$25,000	$25,000
Navarro	$13,500	$13,500	$13,500	$15,000	$15,000	$15,000
Ellis*	$0	$0	$0	$0	$0	$0
Hunt*	$0	$0	$0	$0	$0	$0
Kaufman*	$0	$0	$0	$0	$0	$0
Total	$4,636,000	$4,311,083	$4,311,083	$3,383,576	$3,382,576	$40,000

* Ellis, Hunt, and Kaufman counties have never provided local funds to NorthSTAR.

The time has come to draw conclusions from the NorthSTAR model and move forward with a new approach that better serves the Dallas region and the state.

Improved rate setting makes separation of indigent and Medicaid populations more apparent.

Through effective business strategies, the NorthSTAR model has provided broad access to behavioral health services for indigent clients at a much lower cost per client than the rest of the state. However, this commonly cited benefit of the model is not supposed to result from the inclusion of Medicaid funding, and in fact, federal law clearly requires that Medicaid rates be set to cover only Medicaid-eligible expenses.[15] If Medicaid rates are not set appropriately, or if the rates allow for expenditure of Medicaid funds beyond eligible Medicaid expenses, the state could be subject to federal penalties or recoupment of funds. Lax financial oversight of NorthSTAR in the past, particularly in relation to identifying and separating Medicaid and indigent costs, has helped create a perception that the success of the model depends on the inclusion of Medicaid funds to cover some of the cost of indigent care. Recently, the state has improved Medicaid rate setting for NorthSTAR to more accurately reflect Medicaid expenses, making potential separation of indigent and Medicaid funding sources more apparent from a financial standpoint.

Despite reasonable questions about financial aspects of NorthSTAR and concerns that key aspects of the model's basic structure prevent taking advantage of opportunities for increased funding and integration of services, successful elements of NorthSTAR could be continued in a new model or applied statewide. These strategies include, for example, encouraging a competitive

provider market, increased outreach to clients, and use of a model that promotes cost efficiencies. Other elements to consider in a new model and in other statewide behavioral health approaches include the following.

- **Structure**. Use of a public entity eligible to put up the matching funds for federal DSRIP funds could allow for significantly greater funding opportunities and promote collaboration with other behavioral health and primary care efforts in the region.

- **Funding and services**. Studies have struggled to compare NorthSTAR to other behavioral health models because of its unique set up involving inclusion of Medicaid funds. The Legislative Budget Board concluded that NorthSTAR serves more clients with fewer overall services, while local mental health authorities in other parts of the state serve fewer people with a deeper array of services.[16] These differences result in wildly different costs per client — $1,587 in NorthSTAR compared to an average $3,684 in local mental health authorities in fiscal year 2013. Given that the NorthSTAR model cannot depend on Medicaid funding to pay for indigent behavioral health services, generally the same amount of funding currently provided for indigent services in the Dallas region would still be available for those services even if Medicaid funding was separated. Under this scenario, the level of services people receive, whether many people receive fewer services or fewer people receive more services, is ultimately a local policy decision. However, separating Medicaid funding from NorthSTAR would not automatically require cutting care currently given to the indigent population in the Dallas region.

Whether many people receive fewer services or fewer people receive more services is a local policy decision.

- **Access to care**. A system open to participation by more providers expands the network, providing greater choice of providers and facilitating a competitive provider market. NorthSTAR enjoys a robust provider network because it pays providers on a fee-for-service basis, much like any managed care organization. Maintaining a fee-for-service approach or considering alternative payment methods, such as incentive-based payments as discussed in Issue 6, would benefit clients by promoting greater access to, and improving quality of, care.

- **Continuity of care**. Ensuring that current providers participate in a new model would enable clients to continue treatment without interruption. In addition, the NorthSTAR approach to assisting clients in obtaining or maintaining Medicaid eligibility provides significant health benefits from continuing to receive needed care. The loss of Medicaid status for those who are still eligible causes a much higher expenditure of state and local funds, as such expenses are not paid through the federal Medicaid match. The percentage of Medicaid recipients that lose eligibility and could regain it within the same year typically averages 5 percent of NorthSTAR's Medicaid population receiving services. Because the state does not have a clear effort to assist Medicaid recipients in maintaining their benefits, it is missing out on the benefits of ensuring greater continuity of care and cost savings that exists in NorthSTAR.

By not helping recipients maintain Medicaid benefits, the state misses out on continuity of care and related savings.

- **Integration of mental health and substance abuse**. Despite NorthSTAR's success and elimination of statutory barriers to integration of mental health and substance abuse benefits, integration of these two benefits has not effectively occurred statewide.

- **Local input and participation**. Provision of indigent behavioral health services have historically been a largely local decision, as the state has traditionally delegated the planning, oversight, and delivery of services to local mental or behavioral health authorities. Local governments in the NorthSTAR area should continue to play a role in deciding how to administer behavioral health services for the indigent population. In addition, consideration should be given to developing a model that facilitates more, not less, local financial investments in the system over time.

Recommendations

Management Action

9.1 Transition provision of behavioral health services in the Dallas area from NorthSTAR to an updated model.

This recommendation would discontinue NorthSTAR as currently structured, separating the funding and administration of behavioral health services for Medicaid and indigent populations in the Dallas region. This change would allow for integration of primary care and behavioral health services for Medicaid clients, access to federal DSRIP funds for indigent services, and other innovative changes following best practices not feasible in the current model.

- **Medicaid**. This recommendation would transition behavioral health services for Medicaid clients to the managed care organizations responsible for their primary health care, as is currently occurring in the rest of the state. Subject to federal approval to discontinue the NorthSTAR waiver and move these services into the 1115 waiver, HHSC and DSHS would need to amend managed care contracts to transition clients from NorthSTAR to managed care organizations in the service area. HHSC and DSHS should ensure continuity of care for clients as they move from NorthSTAR to a managed care organization by requiring the organizations to extend contracts to any provider participating in NorthSTAR and treat them as significant traditional providers for three years. Managed care organizations have traditionally done this in other managed care transitions.

- **Local plan for indigent services**. DSHS, in consultation with HHSC, would be required to seek local input in selecting a new entity and model for providing behavioral health services to the indigent in the NorthSTAR area by soliciting proposals through a competitive bid. If DSHS does not receive sufficient local proposals to deliver indigent healthcare services, DSHS, in consultation with HHSC, should solicit local input in developing its own plan to transition indigent services to a new entity. In selecting an entity, DSHS and HHSC should give favorable consideration to proposals that most closely provide for the following:

  – experience or plan to provide and coordinate integrated care for mental health, substance abuse, and crisis services;

  – status as a public entity eligible to put up non-federal funds to match federal DSRIP funds;

- intent and ability to integrate behavioral health and primary care services;
- provider payment plan and mechanisms to ensure a competitive provider market and an adequate network of providers capable of providing broad access to services;
- plans to ensure quality of services provided to clients; and
- incentives or inclusion of local participation or match requirements.

DSHS, together with HHSC, should use a funding mechanism that incorporates outcome-based performance requirements and encourages cost efficiencies. DSHS should require the selected entity to submit the same metrics as the rest of the state to enable direct comparison with the rest of the state for behavioral health services. The selected entity would be required to offer contracts to all significant traditional providers currently delivering services in NorthSTAR for three years to ensure continuity of care for indigent clients.

- **Timeline**. DSHS would maintain its current contract for NorthSTAR until the agency is able to transition clients to the newly awarded model. DSHS, together with HHSC, should release its request for proposals by December 2015, and select an entity in time to begin services by September 1, 2016.
- **Impacts**. This recommendation would allow local governments and entities to propose a model that best suits their needs for provision of indigent behavioral health services that takes advantage of federal funding opportunities and allows for integration of behavioral health and primary care services. The new model could be a structure similar to local mental health authorities in the rest of the state, a public approach similar to NorthSTAR that includes only indigent and not Medicaid services for which any number of current Dallas-area or NorthSTAR participants could compete, or something new and innovative. For the state, this new model could provide an opportunity to experiment with best practices that, unlike the NorthSTAR model because it currently involves Medicaid funding, can easily be expanded across the state. Requiring both managed care organizations and the new entity to offer the same providers a contract would assist in continuity of care for clients if they gain or lose Medicaid eligibility.

Change in Appropriations

9.2 The Sunset Commission should recommend that the Legislature include a rider to transition NorthSTAR funds to DSHS behavioral health funding strategies.

The Sunset Commission should recommend a change in appropriations in the DSHS bill pattern to transition funding from NorthSTAR to existing budget strategies used to fund other DSHS mental health and substance abuse programs in the rest of the state in amounts the appropriative committees see fit. The rider should discontinue funds to NorthSTAR at the end of fiscal year 2016 and transfer those funds to the strategies identified above in fiscal year 2017.

Change in Statute

9.3 Require the state to assist with maintenance of Medicaid eligibility statewide.

This recommendation would apply statewide and require managed care organizations to work with Medicaid clients to assist with maintaining Medicaid eligibility. HHSC should continue to provide information in enrollment files for managed care organizations and require their assistance in maintaining eligibility. HHSC should also explore strategies to support continuity of Medicaid eligibility for individuals with social security income, if cost effective. Assisting clients in maintaining their eligibility

is cost-effective for the state because it both ensures that the cost of services can be matched with federal funds, and can provide continuity of care to prevent lapses that result in more expensive admissions to emergency rooms or jails. Requirements for managed care organizations to assist clients with maintaining Medicaid eligibility would not only benefit persons with mental illness, but also other populations needing assistance such as individuals with intellectual and developmental disabilities.

9.4 Require HHSC to ensure behavioral health services are integrated into managed care organizations statewide.

This recommendation would require HHSC, as part of its contract monitoring efforts for Medicaid managed care organizations statewide, to ensure that behavioral health services are fully integrated into primary care coordination. HHSC should use performance audits and other oversight tools, especially in cases in which managed care organizations subcontract behavioral health services, to ensure clients receive coordinated behavioral health and primary care. HHSC would also be directed to establish performance measures to ensure effective integration of services. For example, HHSC could ensure an adequate number of behavioral health providers in a managed care organization's network, or review treatment plans to ensure that behavioral health services are incorporated into primary care or long-term services and support plans. The result of such integration would more effectively realize health benefits for clients and cost savings for state and local governments.

Fiscal Implication

These recommendations would result in about $2.4 million in savings to the state in fiscal year 2017, but totaling almost $29 million over the first five years. Overall, provision of indigent behavioral health services in the Dallas area through a new model, serving the same number of people with similar services, could be accomplished with about the same level of funding as NorthSTAR currently uses for its indigent population. A new behavioral health model capable of accessing federal funds for indigent care in the Dallas area, while not increasing funds to the state, could also result in significant gain for the Dallas area of more than $40 million annually.

- **Local DSRIP funds**. Creation of an entity eligible for DSRIP funds would infuse a significant amount of federal funding into the Dallas area behavioral health system. Assuming the 1115 waiver continues upon waiver renewal in 2016 under the current structure and funding levels, and assuming that all of NorthSTAR's $68 million that currently qualifies as intergovernmental transfer funds is matched with a 60 percent federal funding for DSRIP projects, about $40.7 million in additional funds for the Dallas area could be secured annually.[17]

- **Indigent services**. Costs to administer behavioral health services for the indigent in the Dallas area will depend on the local approach to service levels. Sunset staff believes that an approach similar to the current model, minus Medicaid funding, can provide approximately the same level of services to the same number of people. However, if local proposals reflect a model more in line with the rest of the state, providing more services to fewer people, then fewer clients will receive services. Under this approach, providing more services to more people will result in additional costs.

  Based on recent pilots in other states, if local efforts promote increased integration of behavioral health and primary care for the indigent population, savings to local governments could be dramatic; however, potential savings would depend on the scope of implementation and could not be estimated for this report.

Separating Medicaid funds from funds for indigent services in the NorthSTAR region could result in the loss of some small administrative efficiencies, as administrative costs for both the Medicaid and indigent populations are currently combined. However, these costs would not be significant.

- **Medicaid services**. Removing Medicaid behavioral health services from NorthSTAR and integrating them with primary care services in Medicaid managed care in the Dallas area will result in an estimated $28.9 million in cost savings for the state over five years. Annual state savings of $107,367 from the reduction of about four staff will also result from more efficient administration of the Medicaid portion of the NorthSTAR contract.

- **Assistance with Medicaid eligibility**. Separating services for the Medicaid and indigent populations in the Dallas area, as recommended in Recommendation 9.1, could result in small increased costs in the Dallas area tied to indigent individuals losing their Medicaid eligibility. However, Recommendation 9.3 should reduce this financial impact in the Dallas area by improving maintenance or renewal of Medicaid eligibility. For the rest of the state, Recommendation 9.3 would result in savings associated with obtaining federal match funds for persons who are eligible for Medicaid, but forget to renew or otherwise lose coverage while still eligible for Medicaid. Those savings could not be estimated for this report.

Savings to General Revenue

Fiscal Year	Savings to the General Revenue Fund
2017	$2,438,901
2018	$6,413,710
2019	$6,547,469
2020	$6,857,475
2021	$7,191,510

……..

[1] NorthSTAR is a 1915(b) Medicaid waiver of Title XIX, Social Security Act.

[2] Section 533.0356, Texas Health and Safety Code.

[3] Other funding sources include state funds, Mental Health block grant, Substance Abuse Prevention and Treatment block grant, Temporary Assistance for Needy Families block grant, Title XX, and a state hospital allocation.

[4] Medicaid recipients in nursing homes, intermediate care facilities, and foster care do not participate in NorthSTAR and receive behavioral health services through fee-for-service.

[5] *Morbidity and Mortality in People with Serious Mental Illness*, National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, October 2006.

[6] Faces of Medicaid III: Refining the Portrait of People with Multiple, Chronic Conditions, Center for Healthcare Strategies, Inc. October 2009.

[7] *Morbidity and Mortality in People with Serious Mental Illness*, National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, October 2006.

[8] *Texas Learning Community on Integrated Health Care: Coming Together to Advance the Adoption and Acceleration of Integrated Health Care in Texas*, http://www.hogg.utexas.edu/uploads/documents/TLC%20Summary%20Report_final1.pdf, February 2013.

[9] *Progress Report, Missouri CMHC Healthcare Homes*, Department of Mental Health and MO HealthNet.

[10] S.B. 58, 83rd Texas Legislature, Regular Session, 2013.

[11] 42 C.F.R. Sections 433.50 and 433.51.

[12] 15 T.A.C. Section 355.8203(c)(1).

[13] The Dallas County local match funds historically went to ValueOptions and the other rural county funds go to the North Texas Behavioral Health Authority.

[14] Local match requirements for local mental health authorities range from 5 to 14 percent and are based on the per capita income of each local mental health authority's local service area.

[15] 42 C.F.R. Section 438.6(c)(4)(ii)(A).

[16] Legislative Budget Board, *A Comparison of Behavioral Health Data Across NorthSTAR and Other Selected Service Delivery Areas, January 2011*, , accessed September 25, 2014, http://www.lbb.state.tx.us/Documents/Publications/GEER/GEER01012011.pdf#CompBehavioralHealthData, p. 81.

[17] Eligible funds for DSRIP match include unmatched general revenue for indigent care, block grant maintenance of effort, and state hospital funds.