

PUBLIC FUNDING FOR MENTAL HEALTH SERVICES IN HOUSTON

A FINANCIAL MAP



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Public Funding for Mental Health Services in Houston

EXECUTIVE SUMMARY

This report reviews and analyzes the federal, state, county, and city funding streams that support public mental health services in the greater Houston area. The relevance of this report is founded on the premise that public policy is implemented by funding directives that, in turn, create the policy's intended outcomes. The mechanics of these policy-driven funding directives dictate service access, type, capacity, duration, delivery, and administration. Simply put, policy directs funding and funding defines services and their delivery.

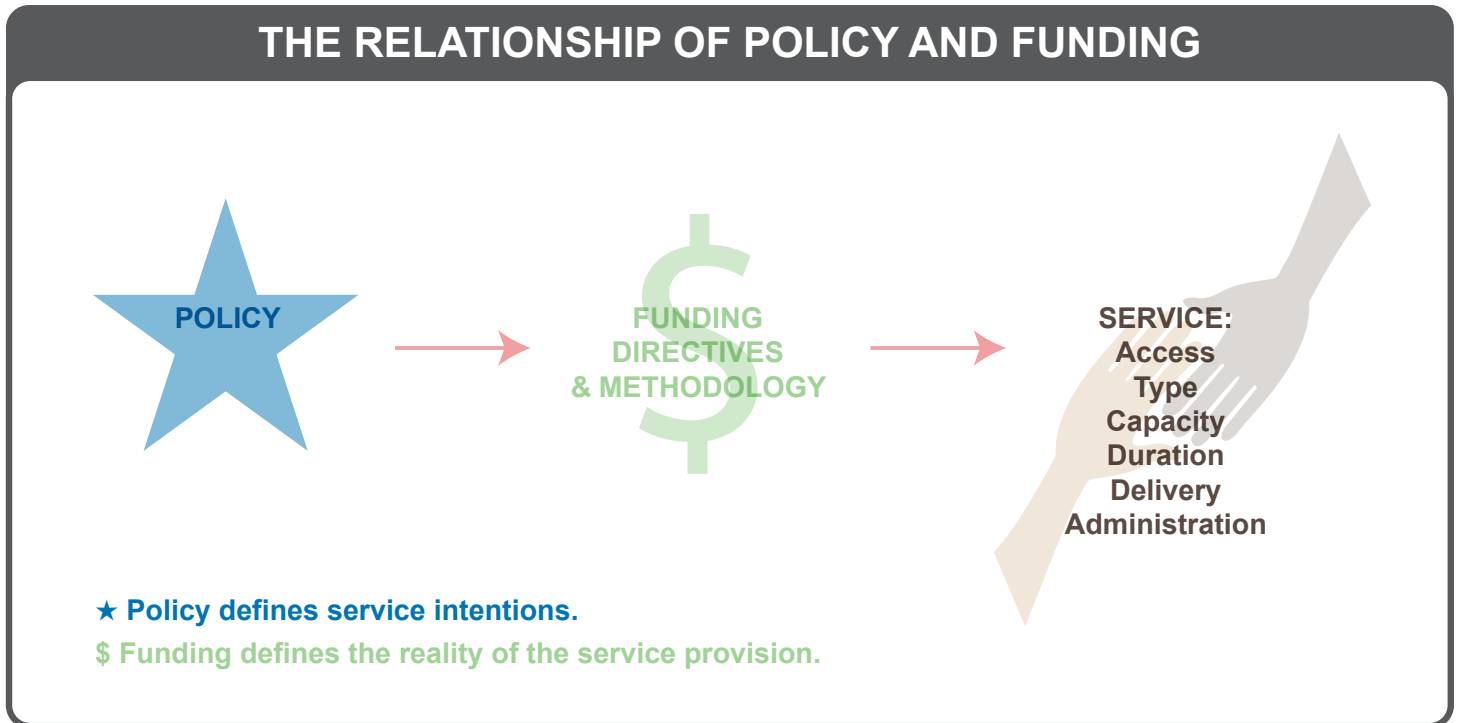
In Houston, the majority of federal, state, county, and city mental health funding streams are dedicated almost exclusively to support services for people who are indigent and severely mentally ill or emotionally disturbed. Furthermore, most state and county funding streams are prioritized to support people in crisis, people recently discharged from psychiatric hospitals, children with juvenile justice involvement, and adults involved in the criminal justice system.

Large numbers of people receive time and service intensity limited care that addresses their current crisis but does little to affect their long-term needs. **This has created a largely crisis and criminal justice driven mental health service system that forces people to cycle from crisis to crisis.**

Current policies and their incumbent funding streams often produce outcomes that are only effective in the short term. Ultimately they are not clinically or cost effective for meeting longer term needs of people with chronic mental illness. This situation could be alleviated by greater access to Medicaid, CHIP and increased access to a greater variety of outpatient services for longer periods of time.

I. INTRODUCTION

Publicly funded mental health services are largely the creation of public policies. Policy determines funding appropriations. These appropriations dictate service access, type, capacity, duration, delivery and administration. Simply put, policy is implemented by funding and funding in turn creates specific services.



Federal, state, county and city funding policies and directives define Houston’s public mental health service system. The structure, capacity and priorities of this system are largely dictated by policy decisions originating in Washington and Austin. A clear understanding of this system requires extensive knowledge of Medicaid, CHIP, Medicare, other federal initiatives, Texas general revenue appropriation policies, Harris County appropriation priorities as well as the directives of other major providers of public mental health funds. When viewed collectively these funding initiatives form a metaphorical financial map. Such a map aids in understanding the purpose, strengths and weaknesses of mental health services in Houston¹.

There is general consensus that a majority of persons with sufficient private resources (personal funds and/or private insurance with full mental health benefits) can purchase the psychiatric

¹ In this report the terms Houston and Greater Houston Area refer to Harris County.

services they require. Houston has sufficient services to meet their needs. However, people without these resources must rely on publicly funded services or publicly (tax revenue based) supported-benefit programs (i.e., Medicaid, CHIP, etc.). These people are indigent and are almost exclusively dependent upon these public programs. Evidence based analyses of the adequacy of these programs to meet the needs of Houston's indigent citizens have found that over 93,000 Harris County children and adults could not access the public or private mental health service systems (Mental Health Needs Council, 2009). An understanding of the priorities and dynamics of the funding mechanisms that should address their needs is of paramount public policy importance.

This document presents a financial map of Houston's public mental health system. It examines major funding sources, funding purposes and relevant directives. As the appropriation amounts vary from year to year detailed budgets will not be a focus of this report. (Some budget amounts are provided.) However, directives of appropriations will be discussed. It is hoped that this report will inform discussions on Houston's public mental health priorities, cost benefit analysis issues, policy, and potentially needed system changes.

II. PUBLICLY FUNDED MENTAL HEALTH SERVICES

The utilization of public tax dollars to support services to people with severe mental illness has historically been justified by two imperatives. First, we have chosen to provide public services to people because they have severe illnesses requiring treatment. Public mental health services exist to treat mental illness, especially to citizens who cannot afford to purchase them with their own resources. This is evidenced by policies dating from the mid-1700s, when the Pennsylvania Assembly enacted legislation to establish a hospital in part to care for persons with mental illness, to the mid-to-late 1800s campaign of Dorothea Dix, which established numerous American mental institutions (Deutsch, 1937), to the Community Mental Health Centers Act of 1963 mandating community-based mental health care as a national priority (Schnapp, 2005) and, finally, to the establishment of Medicaid as a publicly funded health insurance program for indigent persons. America has a long history of public policies that provide treatment of mental illnesses. Clearly we are committed to supporting public mental health treatment services.

The second primary reason that America provides public funding for people with severe mental illness is to curtail the danger some may cause to themselves or to others. The most obvious evidence of this is the involuntary commitment process in which people who have a mental illness who are found to be a danger to themselves or others, are committed to a mental hospital in order to protect themselves and society, while they receive needed treatment.

An unfortunate by-product of insufficient and inaccessible mental health services is an increase in the prevalence of mental illness in jails and prisons (Schnapp, 1998; Abramson, 1972). This is true in Houston where 24 percent of the people in the Harris County Jail have a serious mental illness (Nguyen & Hickey, 2006). Over 2,400 of the 11,000 people in jail are regularly receiving psychiatric medication. This phenomenon, often referred to as “the criminalization of the mentally ill” (Abramson, 1972) is due to insufficient mental health services in most if not all major cities in America. Many jails and prisons have internal mental health service systems.

Therefore, public tax revenues support mental health services for reasons of treatment and the control of dangerous behavior. Consequently this report will examine multiple tax-based funding streams in open (public-institutional and community based) and closed (criminal-justice) mental health service systems.

III. A NOTE ON SERVICE RATIONING

Public health care in general and mental health care specifically is underfunded nationally. This is especially true of Texas, which has been ranked as 49th in per capita state mental health funding (Aron, Honberg, Duckworth, et al., 2009). Underfunding has caused our state's leadership to make difficult decisions over who should receive priority status in mental health service access, the types of services provided, and the duration of care. In general, Texas (as does the federal government and other states) gives highest service priority to those people who are most in need. Texas assumes that people with their own resources (insurance, personal funds) can purchase their own health care. Therefore, public tax supported health care is generally devoted to those people who lack the financial resources to purchase needed services. Additionally, publicly supported mental health care is further rationed in favor of serving the most ill first. Consequently, Texas public mental health care access is generally (financially) means tested and illness severity prioritized. Simply put, **Texas tax dollars support those who are the most ill and indigent.**

Historically Texas' support of public mental health services has fluctuated with the status of our economy. Over the past few decades funding for public services has not kept pace with healthcare needs. This has caused a more rigid prioritization of access and rationing has become more pronounced. The consequences of current rationing policies have led to more restrictive access to service, an increased use of emergency crisis services, and an increase in the prevalence of persons with mental illness in the County Jail. MHPAC's next report will deal with rationing policies in depth.

IV. FEDERAL INITIATIVES

Prior to 1963 the federal government's only primary programs for persons with mental illness (PMI) were delivered through the Veteran's Administration. The passage of the Community Mental Health Center Act of 1963 (PL88-164) marked the government's first major step in funding mental health services to the general public. This Act's grants-in-aid to states and local communities marked the U.S. Government's first major mental health funding initiative. Soon after its creation in 1968, the Mental Health and Mental Retardation Authority of Harris County (MHMRA), then called the Harris County Mental Health and Mental Retardation Center, applied for and obtained funding under this Act.

Later, in the early 1980s, this Act's funding stream² was terminated abruptly in 1981 with the passage of the Omnibus Budget Reconciliation Act under President Reagan. This Act provided block grants to states for mental health and substance-abuse services. These block grants contained a 75 to 80 percent funding reduction from previous federal levels (Grob & Goldman, 2006). Since that time the federal government has funded local mental health services in this manner.

Medicare and Medicaid

In 1965 the United States Congress created Medicare and Medicaid, which were enacted as Title XXIII and Title XIX of the Social Security Act. Medicare extended health care to almost all Americans 65 years or older. **Medicaid provides insurance coverage to low-income children, their parents, pregnant women, and people with disabilities.**

Medicaid is a jointly funded state and federal healthcare entitlement program administered by the Texas Health and Human Services Commission. This public health insurance program was 25 percent of Texas' legislated appropriations in the 2006-2007 biennium. In 2006 it paid for mental health outpatient services for in excess of 397,000 Texans at a cost of \$256 million dollars (Texas Medicaid Office, 2009).

Medicaid Eligibility

Federal Medicaid matching funds are available to states according to five broad requirements relating to eligibility: categorical, income, resource, immigration status and residency (Schneider, Risa,&

² In this report the term 'funding stream' refers to the directional movement and flow of funds from one point to another.

Garfield, 2003). Categorical eligibility is limited to children, parents of dependent children, pregnant women, the elderly, and people with disabilities. There is no eligibility category for non-disabled, childless adults. Income requirements are imposed in Medicaid dictating that people may not have resources and assets above a specified amount (around \$2,000 for an individual and \$3,000 for a family) to be eligible for Medicaid. Illegal immigrants cannot qualify for basic Medicaid coverage. Legal immigrants who entered the United States prior to welfare reform who meet the other financial and non-financial criteria are eligible for Medicaid, at the state's discretion. Legal immigrants entering the United States after August 22, 1996 are ineligible for non-emergency Medicaid coverage for 5 years from their date of entry into the United States, unless they are qualifying for Medicaid through disability (Schneider, Risa, & Garfield, 2003). Illegal immigrants may be eligible for emergency Medicaid if they meet the financial and nonfinancial requirements. Individuals must be residents of the state in which they are applying for Medicaid benefits. There are no minimum residency requirements; an individual is a resident if he or she has the intention of living where they are indefinitely (Schneider, Risa, & Garfield, 2003). Medicaid is an entitlement program therefore anyone meeting the criteria above has a right to receive Medicaid coverage.

In order to receive guaranteed federal funding, states must cover certain mandatory populations at mandatory poverty thresholds:

- Children under age 6 in families with an income below 133 percent of the Federal Poverty Level (FPL)
- Children ages 6-18 in families with an income below the FPL
- Pregnant women with an income below 133 percent FPL
- Parents whose income is within the state's eligibility limit for cash assistance in place before welfare reform, and
- Most seniors and people with disabilities who receive cash assistance through the Social Security Income program (CBPP, 2009).

All states may also receive federal funds to cover optional populations; these vary from state to state.

Medicaid Benefits (Services)

Mandatory

Most Medicaid beneficiaries are entitled to coverage for the following services (if medically necessary)

- Hospital care (inpatient and outpatient)
- Nursing-home care
- Physician services
- Laboratory and x-ray services
- Immunizations and other early and periodic screening, diagnostic and treatment services (EPSDT) for children
 - Family planning services
 - Health center and rural-health clinic services
 - Nurse midwife and nurse practitioner services (Schneider, Risa,& Garfield,2003)

Optional

States have the option of covering additional services with federal matching funds. All states cover several, if not all, of the following services:

- Prescription drugs
- Institutional care for people with mental retardation
- Home and community-based care for the frail elderly
- Personal care and other community-based services for people with disabilities
- Dental care and vision care for adults

Texas Medicaid's medically needy designation applies only to children and pregnant women who live in families above the income thresholds but cannot meet their medical expenses. Medicaid is the largest public payer for mental health services in the United States (Buck, 2003).

Almost 2.1 million of the state's 2.9 million enrollees are in Medicaid Managed Care operating through the State of Texas Access Reform (STAR) program (THHSC, 2009). STAR+PLUS integrates acute and long-term care for the aged and disabled in Harris County. The 2009 income threshold for jobless parents with dependent children applying for Texas Medicaid is 13 percent of Federal Poverty Level (FPL), or \$2,256. Working parents can earn up to 27 percent of FPL, or \$4,824 (Kaiser Family

Foundation, 2009). These income thresholds are less generous than the United States' average of 41 percent and 68 percent, respectively. Nationally, Medicaid accounts for 27 percent of all mental health expenditures and 44 percent of public mental health expenditures (Mark and Buck, 2005).

Behavioral health services are provided for Harris County residents enrolled in Texas Medicaid.

According to "Texas Medicaid and CHIP in Perspective" (TDSHS, 2009) covered services include:

- Therapy by psychiatrists
- Therapy by psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists
- Inpatient care in a general acute hospital
- Inpatient care in psychiatric hospitals (for people under age 21 or age 65 and older)
- Outpatient adolescent chemical dependency counseling by state-licensed facilities
- Prescription medicines
- Rehabilitative and targeted case-management services for people with severe and persistent mental illness or children with severe emotional disturbance
- Ancillary services required to diagnose or treat behavioral health conditions
- Care and treatment of behavioral health conditions by a primary care physician

Medicaid expenditures represented 25 percent of the appropriated Texas budget for the 2006-2007 biennium (Health and Human Services Commission, 2009). In 2006 an estimated 67,510 Houstonians received outpatient mental health services paid by Medicaid at an estimated cost of \$43,520,000 (Texas Medicaid Office, 2009).

Traditional Medicaid

In Houston Medicaid is processed in two ways: traditional and managed. Traditional Medicaid funds mental health services for one intake per year, unlimited medication maintenance visits (as long as medical necessity is documented), and up to 30 therapy sessions per year per patient. More can be requested with authorization review. Rehabilitation and case management services are allowed under this plan.

One limitation of this funding source is that it limits medications to 3 prescriptions per month. This is a challenge for many patients with chronic mental illness who take multiple mental health medications and often need prescription drugs for co-occurring medical issues. Another limitation concerns inpatient placement for mental health services. Due to the Institutions for Mental Disease (IMD) rules, these patients can only be admitted (with payment) to general hospitals that have psychiatric care. This type of facility is very limited in Houston, as most psychiatric beds are located in free-standing psychiatric facilities. This limits access for indigent patients and causes financial loss for facilities treating these patients under the Emergency Medical Treatment and Active Labor Act (EMTALA) rule. As a result of this occurrence, many facilities have reduced their bed capacity so as to avoid taking on this additional population without reimbursement.

Managed Medicaid Plans (Star and Star Plus in Texas)

Traditional Medicaid historically has a quick and accurate claims processing system; however, significant resources are attached to ensuring claims payment from Managed Medicare plans that increase the risk and cost of doing business with these entities.

There are several Managed Medicaid plans in the Harris County service area. These plans mirror the traditional Medicaid benefit with some additional features. They allow for unlimited pharmacy prescriptions, which benefit patients who have medication coverage for poly-pharmacy needs. Service types are less regulated (for example, they can provide any type of therapy deemed clinically appropriate as opposed to the prescriptive nature of Resiliency and Disease Management services (TDHHS, 2007, page 23). They are not bound by the above mentioned IMD rule. However, along with the benefits of this funding come additional administrative rules that make these plans more complex. The administrative burden of these plans is high and often results in high financial risk to the provider group. One example of this burden is the credentialing process of professionals.

New providers must first secure their Medicare or Medicaid provider identification numbers prior to enrolling in the Managed Medicaid plan. This is often a 90-day process after which the managed care plan has up to 180 days to credential an individual. Hence the entire process generally takes about 9 months. When a new provider assumes responsibility for another provider's patients there is a

significant gap in payment. Therefore, the movement of patients to other paneled providers creates a loss in revenue. In addition, there are many costs associated with obtaining authorizations, managing, and monitoring claim payment.

Medicaid Administrative Claiming (MAC)

This funding stream allows for reimbursement for administrative costs associated with Medicaid outreach activities (benefit education, enrollment, verifications, utilization review and management, Medicaid program planning and development, etc.). This funding assists in maximizing consumer-benefit enrollment and covers some administrative overhead costs associated with Medicaid programming.

CHIP-Children's Health Insurance Program

CHIP (Title XXI of the Social Security Act) was authorized in the Balanced Budget Reconciliation Act of 1997. It serves children with a family income below 200 percent of the federal poverty level. It, like Medicaid, is funded through a state-federal matching formula that fluctuates from year to year. In October 2009 the federal match was 71 percent. CHIP covers a broad array of health services for children. Current benefits include mental health and substance abuse inpatient (including residential treatment) and outpatient services.

The CHIP plan operates much like the Managed Medicaid plans, as they are often operated by the same companies and follow a general managed care model. They do not, however, offer rehabilitation or case management services. Patients needing this level of care must utilize Texas General Revenue funds, available only through public mental health authorities, to cover the costs. Another difference with CHIP is the inability to identify beneficiaries if not self-reported. Unlike Medicaid, there is not a centralized enrollment database that is open to public inquiry when patients present to verify benefits. Hence many individuals choose not to self report as a means to avoid the co-payment requirements of these plans. This adds to the cost of trying to manage these plans as well as depleting indigent care resources from others who truly need that benefit.

Social Security

The Social Security administration administers two federal disability programs that help those unable

to work due to severe physical or mental impairments. The programs are not mutually exclusive; and people may qualify for both programs. The first is a work-related program called Social Security Disability Insurance (SSDI). Social Security taxes paid on individual income fund payments to disabled workers, disabled widows or widowers and disabled adult children of workers (Texas Department of Assistive and Rehabilitative Services, 2009). This program does not directly cover medical care, although people may use the income to purchase healthcare services. However, after the 5-month waiting period from the onset of a disabling condition to be qualified to receive benefits and after 24 months of receiving SSDI payments (29 months total), a disabled individual under age 65 qualifies for Medicare coverage (O'Brien, 2009).

Supplemental Security Income (SSI) is a means tested program that provides a modest amount of income to eligible people who are older than 65 and mentally impaired, or who meet the definition of blind or disabled. Mental impairment that is expected to last for a continuous period of at least 12 months or to result in death satisfies this program's eligibility requirement. In Texas, SSI and Medicaid are organized so that once a person is eligible for SSI, they automatically qualify for Medicaid. Qualification via SSI is the only way for non-elderly adults without children to qualify for Medicaid coverage (Texas Legal Services Center, 2009). Both SSDI and SSI provide funding to some people with mental illness. While these funds can be utilized to purchase health care, they are often used to support basic living expenses (i.e., housing, food, etc.). The total funds generated from these programs are not available at this time.

Veteran's Administration

The federal government appropriates at least \$80 million dollars annually for the Mental Health Care Line at the Michael E. DeBakey Veterans' Administration Medical Center (MEDVAMC) and its associated clinics. Almost all veterans are eligible for services if they were discharged other than dishonorably, though there may be copayment responsibility in some cases. A full range of mental health treatments is available through the MEDVAMC, including inpatient care and all modalities of outpatient treatment. Additionally, substantial amounts of mental health care are delivered outside the bounds of the Mental Health Care Line, particularly in outpatient primary care clinics.

Path-Block Grant

The PATH grant focuses on active case management and engagement into services for homeless people who also have mental health concerns. It is an outreach and engagement model that links individuals to housing or shelters and mental health services. It is a voluntary and time-limited service.

Shelter Plus Care

This program is a HUD program that provides housing subsidies for people who are deemed literally homeless and suffer from a mental illness. The biggest challenge with this program is the definition of literally homeless and the gathering of such documentation. In FY09 MHMRA received approximately \$3 million in federal block grant funds.

Recipients of Federal Mental Health Funds: A Profile

Adult recipients of federally funded health and mental health services are indigent and severely impaired. These adults are all eligible for a range of outpatient and inpatient services. On average, 36 percent of the adults receiving services at MHMRA are Medicaid beneficiaries.

Children who receive CHIP are uninsured or members of low-income families. CHIP will pay for mental health inpatient, residential treatment and outpatient services for children who are severely emotionally disturbed. On average, 65 percent of the children receiving services at MHMRA are CHIP recipients.

Federal public insurance programs (Medicaid, Medicare, CHIP, Social Security, etc.) provide generous benefits to those Houstonians who receive them. The federal-state matching aspect of Medicaid and CHIP provides a significant return of federal tax dollars to Houston. Expansion of these programs would proportionately expand our community's ability to more effectively serve many people who cycle from mental health crisis to crisis.

V. TEXAS GENERAL REVENUE INITIATIVES

The Texas Legislature began funding public mental health services 153 years ago (1856) when then Governor Elisha Pease signed a bill funding the construction of what was to become Austin State Hospital (Sitton, 1999). Its primary purpose (along with 8 additional mental institutions built over the following century) was the confinement of people with mental illness to prevent injury to themselves and to others (Impact, 1975). Prior to 1954 the type of care delivered in these facilities was primarily custodial. Curative treatment, when provided, consisted primarily of the best medicine had to offer at any given point in time. Treatment included hydrotherapy, shock therapy (both chemical and electric), and psychosurgery. In 1954 the United States Food and Drug Administration approved thiorazine for the treatment of psychosis. This drug enabled many Texans to be treated outside of the confines of mental institutions.

In 1963 the United States Congress passed the Community Mental Health Centers Act. This Act established federal funding for community based mental health care in all states. In 1965 Texas enacted House Bill 3, which created the Texas Department of Mental Health and Mental Retardation (TDMHMR), replacing the Texas Board of Hospitals and Special Schools, to facilitate federal and state funding to community mental health centers. TDMHMR also provided oversight and funding for state mental hospitals. In 2004 the newly created Department of State Health Services (DSHS) assumed the responsibility for state supported mental health services.

Currently DSHS oversees state funding for the Mental Health and Mental Retardation Authority of Harris County (MHMRA), state hospitals, and the Harris County Psychiatric Center (by way of a contract with MHMRA).

Texas General Revenue Funds

Texas General Revenue (GR) funds are monies appropriated from state tax revenues by the Texas Legislature. Texas appropriates GR dollars to fund mental health services in state mental hospitals, community psychiatric hospitals, and community mental health centers. While each of these service providers receives funds from other sources (federal funds, county funds, private insurance, etc.) GR dollars represent the largest portion of their income.

Target Populations: Eligibility

The Texas Legislature directed that GR fund utilization be restricted to adults and children who meet specific diagnostic and functionality criteria. **In order to attain target population status for Texas GR funded services, adults must have one of the following diagnoses: schizophrenia, bipolar disorder, or severe major depression, or other severely disabling mental disorders, which require crisis resolution or ongoing and long-term support and treatment.** Adults with the following single diagnoses are excluded from utilization of general revenue funds for mental illness: substance abuse, mental retardation and pervasive developmental disorders. Other general revenue funding streams provide service for individuals with these conditions (TDSHS, 2009, Performance Contract Notebook Program Attachment, page 14).

Children ages 3 through 17 with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental disorders and who: (a) have a serious functional impairment, or (b) are at risk of disruption of a preferred living or childcare environment due to psychiatric symptoms, or (c) are enrolled in a school system's special education program because of serious emotional disturbance are eligible for GR funded services (TDSHS, 2009, Performance Contract Notebook Program Attachment, page 21).

Resiliency and Disease Management

It is the official policy of Texas to utilize mental health GR dollars to promote “recovery and resilience of individuals with mental illness” (TDHHS, 2007). House Bill 2292 (which became effective on September 1, 2004) established resiliency and disease management (RDM) as the basis for publicly funded state mental health programs. RDM is relevant to financial mapping because it amplifies the definition of who will be served (in addition to the above diagnostic criteria) and which services they will receive.

Funds regulated under the RDM stipulate:

- *Who* is able to receive such care (clinical and financial eligibility). Clinical eligibility for adults is by diagnosis with only limited exception criteria. Generally, as noted above, adult services are provided to people with bipolar disorder, schizophrenia, and major depression if accompanied

by an impaired Global Assessment Functioning score (below 50) at intake. In the child and adolescent population, eligibility is established more on functional impairment, enrollment in special education at school for serious emotional difficulties, and risk of out-of-home placement than on diagnostic criteria.

- *What type of care* they are able to receive (based on an assessment tool and patient choice) within a regimented managed care model that is prescriptive to a service array based on functioning levels and diagnostic criteria.
- *How much care* (packaged guidelines for number of sessions, average and minimum hours, and the duration of a package) an individual receives. The care is prescriptive for patients and hence not easily blended with other funds or services.
- *How long the individual receives care*. This is determined by the Texas Recommended Assessment Guidelines (TRAG), which must be completed on each patient generally every 90 days in outpatient services.

The biggest limitation to these funds is that they are limited in scope to those prescribed services under RDM.

Currently, the Mental Health and Mental Retardation Authority of Harris County (MHMRA) receives annually in general revenue funds approximately \$15 million for adult mental health services and \$8.2 million for children.

In addition to the funds above, the Texas Legislature has in its past two sessions appropriated funds to crisis service redesign and expansion. In 2007, the crisis redesign funds were allotted for mobile crisis, crisis emergency services, and crisis stabilization and diversion activities. In Harris County many of these core services were already in place due to local county funding. MHMRA was not allowed to swap out these funds for the new State funding. As such, MHMRA was required to expand crisis services in alternative ways (i.e., Critical Time Intervention (CTI) programs, dual disorders program, etc.). This funding has made a positive impact in addressing crisis in the local community and increasing collaborations with local law enforcement. Unfortunately, increased funds in crisis care with no increase in outpatient treatment resources have created an increased waiting list for

services in outpatient settings. In 2009 this problem was partially addressed in the 81st Session of the Texas Legislature with the passage of Rider 65 of the Appropriations Bill. This rider allowed funding for people leaving crisis services and people released from jail to receive some additional intensive outpatient services to be spent for up to 90 days of transition.

The crisis funds are allocated to all who believe they are in crisis and suffering from a mental illness (regardless of the specific diagnosis). For the MHMRA outpatient system, which was already on wait list status, this increase in crisis funding has identified many additional people in need of mental health services who do not meet the target population criteria referenced above. This has posed a significant challenge to the crisis treatment teams in locating services to provide ongoing care of those people stabilized or treated through the MHMRA crisis programs. The shortage of these services has created a new revolving crisis care door through which people continue to cycle.

Additional General Revenue Initiatives

The UT Harris County Psychiatric Center

In 1981, the Texas Legislature appropriated funds for a public psychiatric inpatient facility in Houston. UTHCPC is a jointly-owned (State and Harris County) 250-bed hospital operated by The University of Texas Health Sciences Center. In 2008, 132 beds were funded by GR funds (\$19,279,696) and Harris County funds (\$4,000,453). Additionally, 101 beds are funded by other means (\$6,478,657 in patient collections, \$6,184,576 in contracts, and \$4,134,449 in other income). Soon UTHCPC will open all 250 beds. The overwhelming majority of patients served by UTHCPC are severely mentally ill and indigent.

State Mental Health Facilities

In addition to UTHCPC the greater Houston area receives GR funding in the form of dedicated psychiatric inpatient-bed access to State Mental Health facilities. Rusk State Hospital is Houston's primary state mental health facility. In the fiscal year 2009, approximately \$19 million dollars or 64,365 bed days were appropriated for Houston's use.

Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI)

TCOOMMI provides GR funds to support intensive programming for adults on parole or probation who need a higher intensity of mental health services in order to be successful in transitioning to

the community. This program (New Start) has proved effective in reducing recidivism back into the correctional system. In FY 2009, New Start received approximately \$2.3 million in revenue in GR funds for adults.

TCOOMMI also funds programming similar to that above that is geared toward children and adolescents with mental illness who have encountered law enforcement. This program has reduced recidivism into the correctional facilities. As with New Start, this program is time limited and meant to bridge services into longer-term programs. In Fiscal Year 2009, TCOOMMI provided over \$712,000 in GR funding for adolescents.

Recipients of GR Mental Health Funds: A Profile

Texas GR funds services for persons who are largely indigent and severely mentally ill or emotionally disturbed. Access to service is often expedited by a psychiatric crisis, inpatient discharge or release from jail, prison, or juvenile probation (as directed by HB 2292). Currently MHMRA has a service waiting list of over 800 people. On average, these individuals will wait more than 3 months to be admitted. Many of these people will access services only by way of emergency centers or involvement in the criminal justice system.

VI. HARRIS COUNTY MENTAL HEALTH INITIATIVES

The Harris County Commissioners' Court is one of the most generous providers of county-based, tax revenue supported mental health services in Texas. The following are the major mental health programs supported by Harris County tax revenues.

Local Match and Crisis Service Funding

The County provides local matching dollars for GR funding allocated for outpatient services, local inpatient services, and crisis care. In Fiscal Year 2009 Harris County provided \$2.3 million to MHMRA. As noted above, Harris County provided \$4,000,453 to UTHCPC in 2009.

Harris County Hospital District

The Harris County Hospital District (HCHD) provides all forms of inpatient and outpatient behavioral healthcare except child or adolescent inpatient hospitalization. Anyone can receive care in the HCHD, but to be eligible for reduced-cost services one must be a legal resident of Harris County and fall within specific income and asset limits. The Hospital District budget includes at least \$25 million dollars for specialty mental health care and significantly more than that when primary care and other provider's efforts are included. These funds arise from several sources. Almost half of the HCHD's available budget results from County *ad valorem* taxes. The remainder is predominately obtained from federal programs and federal-state partnerships including Medicare, Medicaid, the Disproportionate Share Hospital (DSH) program, the Upper Payment Limit (UPL) Program, and the CMS-derived medical education programs (DME and IME). These programs are largely dedicated to people who are indigent. Finally, there are several smaller sources of income that include the State of Texas Tobacco Settlement and the State of Texas Trauma Funds.

Harris County Juvenile Probation and Triad

The County funds services in the Juvenile Probation Department and Triad to support youth who have serious emotional disorders. Generally early identification and short-term crisis resolution services are provided. In 2009, the County provided \$1.8 million to Juvenile Probation and Triad for mental health services.

Harris County Jail

The County funds mental health screening to all jail inmates at booking as a means to identify at entry people with mental illness who will need care while incarcerated. It also funds ongoing jail based psychiatric services for medication, evaluation and management and for crisis intervention services. In 2009, the County provided over \$5.8 million to support these programs.

Recipients of Harris County Mental Health Funds: A Profile

Generally, Harris County funds support programs and services for children and adults who are indigent and severely emotionally disturbed or mentally ill.

VII. CITY OF HOUSTON INITIATIVES

Houston Police Department Crisis Intervention Teams (CIT)

All Houston police officers receive specialized training in dealing with people with mental illness. Certain officers are designated as specially trained CIT members. This program has successfully diverted many people who would otherwise have been placed in jail. The CIT Program promotes cost and clinical management effectiveness for people with mental illness. It is not possible to obtain accurate budget information for this program. However, it plays an important and valuable role in Houston's mental health service continuum.

City of Houston Health Department

The City of Houston Health Department has funded in the past fiscal year a pilot program to provide case management services to local residents with mental health issues and high utilization of local law enforcement or emergency services. The intent is to engage these people in appropriate care at a lower cost versus the misuse of emergency and law enforcement resources. It is limited in scope to pre-identified people and its main intent is to engage them in necessary mental health care. The city provides approximately \$200,000 to fund this program, which serves approximately 60 people per year.

Recipients of City of Houston Mental Health Funds: A Profile

The City of Houston is not a major funder of public mental health services. However, the entire population of Houston is an indirect beneficiary of the Police Department's CIT Program.

VIII. OTHER MAJOR PUBLIC FUNDS

K-12 School Mental Health Service

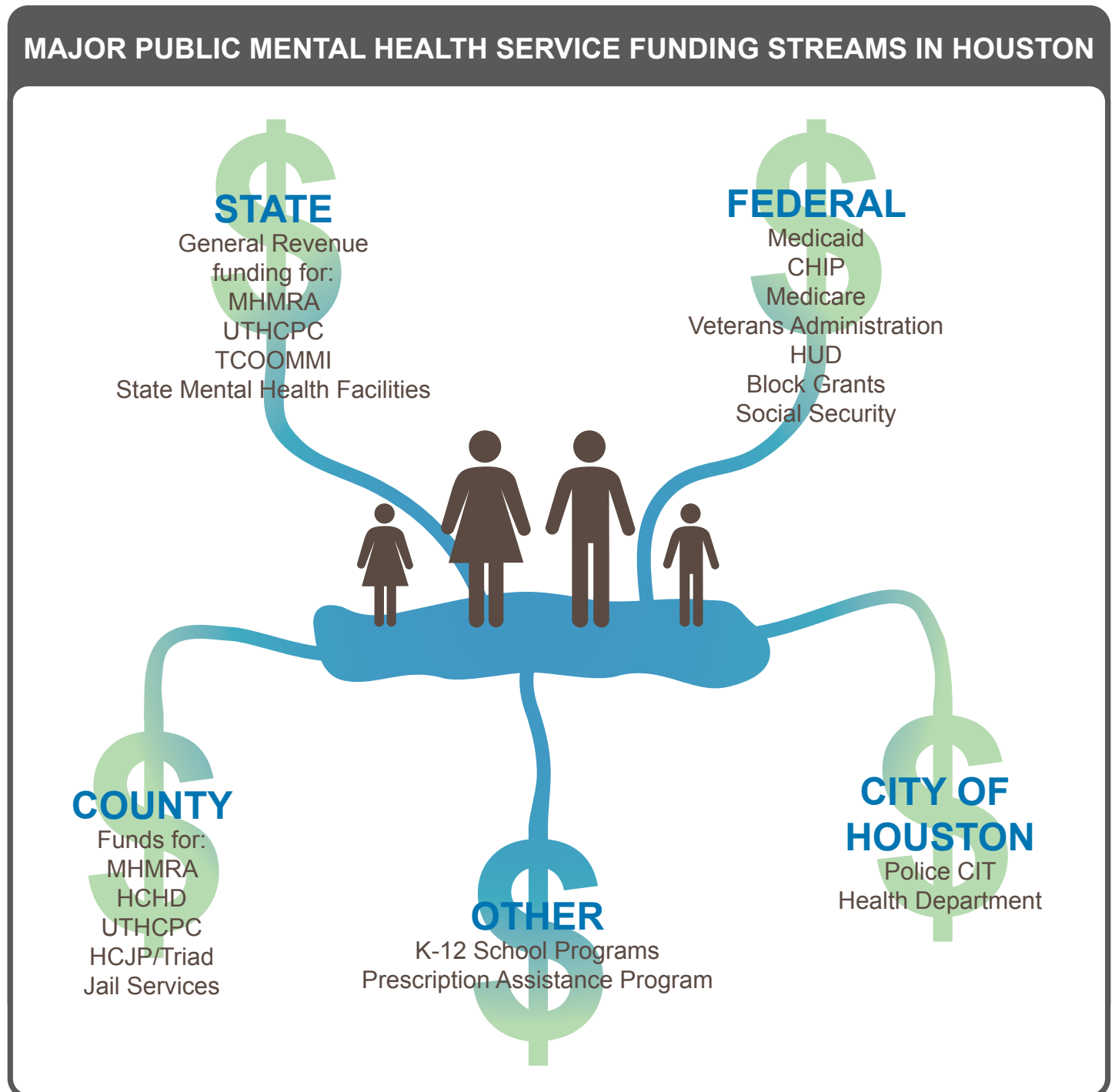
Public K-12 schools in the Greater Houston Area provide mental health services in the form of crisis services, diagnostic testing, and special education. Funding streams that support these services are federal, state, and local. MHPAC attempts to gather information on these funding streams in multiple school districts did not produce adequate and reliable information on monetary amounts, service priorities, or the strengths and weaknesses of these programs. Anecdotal evidence suggests that schools (like other service providers in this report) are substantially under funded and under resourced.

The Prescription Assistance Program (PAP)

In the past fiscal year, the PAP has provided MHMRA with free psychiatric medications valued at savings of over \$1 million dollars per month, or approximately \$12 million a year. This is invaluable as these dollar savings can be utilized for outpatient services (versus medications). This program augments the outpatient services system in a major way. As with all other funding streams in this report, the loss of this critical resource would be detrimental to Houston's indigent care system and would greatly reduce the numbers of people served in Houston.

IX. A FINANCIAL MAP

The information above details the various sources and purposes of public monies that support mental health services in Houston. The vast majority of these funds have well defined eligibility and service criteria. The following graphic collectively portrays the components of a map of publicly funded mental health agencies and programs in Houston.



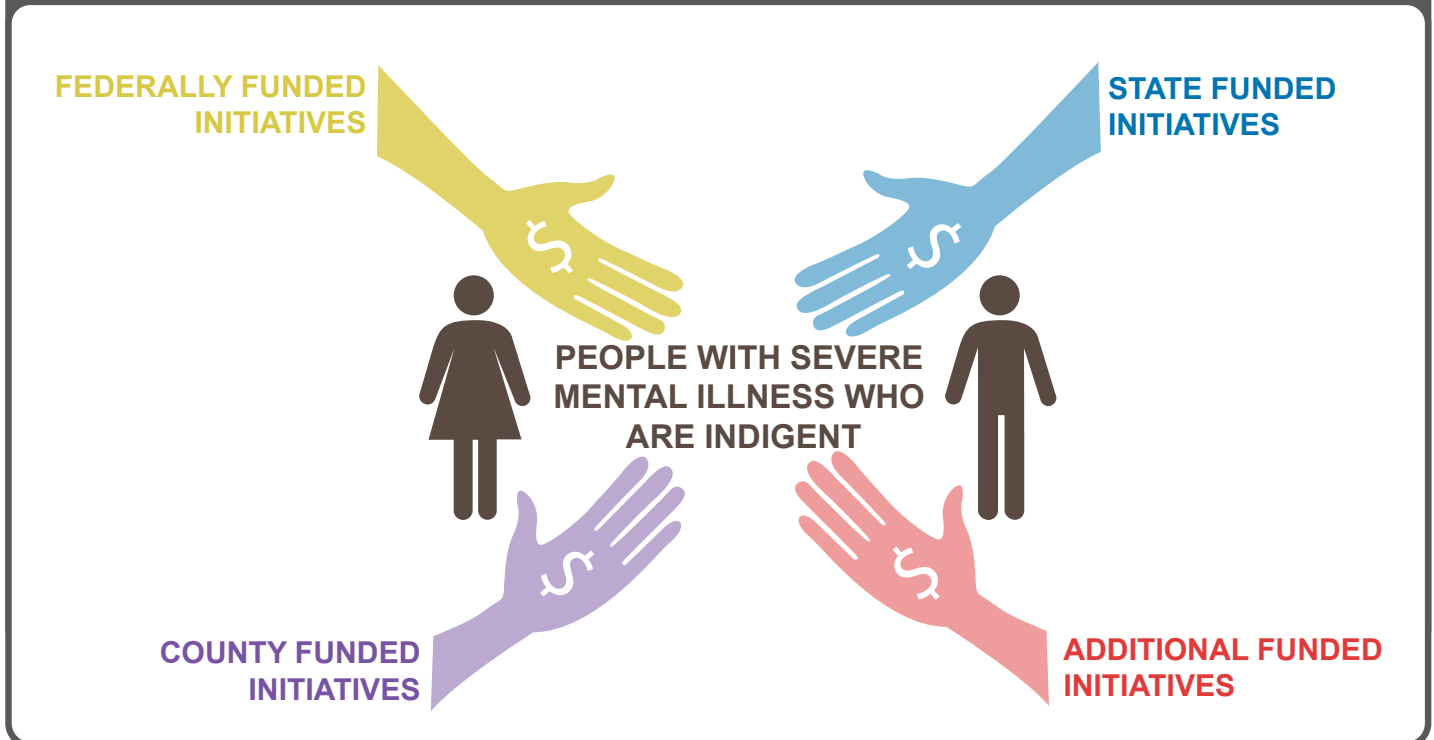
Primary policies directing critical issues such as funding amounts, eligibility, type of service, and duration of service for each major funding stream were developed in isolation.

Federal funding streams, begun largely in the 1960s, have evolved as primary insurance programs for indigent people who are disabled. State funding patterns were largely developed in isolation from federal policies. **While sharing a federal indigence orientation state eligibility has largely been diagnostic and severity driven.** Some evidence of federal-state funding policy coordination lies in the desire of most states to cost shift the budgeting of previously state funded programs to federal resources. Cost shifting occurs when states seek to shift the cost of service providers from state funds (i.e., GR) to federal funds (i.e., Medicaid and CHIP). State funded budgets are offset by the acquisition of federal funds. This common state practice began in the late 1990s. A direct consequence of cost shifting occurs when states' mental health budgets decrease or fail to increase when additional federal funds are acquired. The result is often a zero sum gain.

County funds are only partially coordinated with federal and state funds. The County matches (at a reduced rate) state GR funds. These matching dollars fund MHMRA and UTHCPC and are primarily directed to serve GR target populations. However, the Harris County Hospital District and jail mental health funds are for the most part directed to people who are indigent and mentally disabled. Anecdotal evidence suggests that, in general, the HCHD serves a more acutely ill population than MHMRA's and UTHCPC's traditional chronic patients.

The consequences of the above described disparities in funding directives include substantial differences in service access, type, and duration depending on which funds a person with mental illness can access. **At virtually all service sites people with Medicaid or CHIP benefits enjoy easier access to a richer array of services than their non-Medicaid or non-CHIP peers.** Hospital District patients need not fit the rigid diagnostically driven criteria that GR patients must meet. People with severe mental illness leaving the Harris County jail may or may not acquire Medicaid or be eligible for GR driven services. These discrepancies tend to increase service fragmentation and consequently reduce needed service continuity and collaboration.

PRIMARY BENEFICIARIES OF HOUSTON AREA PUBLIC MENTAL HEALTH SERVICES



When closely examined federal, state, and county funds primarily serve people who are indigent and severely ill. The demand for needed services is growing with Houston's increasing population and with a rapidly expanding group of uninsured people. As demand increases and service system capacity remains stable access is diminished. Service waiting lists grow, causing service wait time to increase proportionately. MHMRA now has a waiting list for outpatient services that exceeds 800 people. Most of these people will wait in excess of 3 months for an outpatient appointment. Denied access to needed service, people with already severe mental illnesses go into crisis, seek services in already strained emergency trauma centers (Begley, Burau, & Courtney, et. al., 2008) and are at increased likelihood of criminal justice involvement (Abramson, 1972; Schnapp, 1998).

As the number of unserved and underserved people grows so grows the demand for services. Traditionally policymakers (such as the Texas Legislature in its past two sessions) have met this challenge by increasing funds for crisis services. As the number of people being served in mental health crisis grows, the need to provide these new patients with inpatient and outpatient care grows proportionately. Without concurrently expanding needed non-crisis mental health core and wrap-

around services (medication, case management, outpatient, and rehabilitation services), people are forced into a repeating cycle of crisis. This cycle is both clinically and cost ineffective. **This cycle begins when mental health services are built on a policy foundation that restricts access to services to only people who are the most severely ill and indigent.**

Most of the funding streams mentioned above are prescriptive concerning who can be served, how they can be served, and for how long. This rigidity is often inappropriate for a population of people who are generally not “cured” (they are chronically ill), often unstable (the severity of their illnesses fluctuates), and often have comorbid conditions (i.e., chemical dependence, other physical illnesses, etc.) requiring treatment. The challenges posed by these illness characteristics are often exacerbated by homelessness and criminal justice involvement, which necessitates even more complex policy and funding stream coordination. Efforts to collocate programs and to provide collaborative, integrated models of care face severe challenges. Training, documentation requirements, and administrative and reporting requirements make merging of service systems difficult.

An appropriate healthcare service system is one that intervenes early in the treatment of mental illness. It does not wait until mental illness becomes so severe and disabling that our most expensive interventions of crisis care and inpatient services are needed. Such a system would prevent juvenile and adult criminal justice involvement for the vast majority of people with mental illness. Crisis care and the criminal justice system are among the most expensive uses of public funds. Appropriate mental health services are not only clinically effective and humane but cost effective as well.

AFTERWORD

This report concludes with several paragraphs about the consequences of our current federal, state, county, and city funding strategies. At the core of these funding strategies are our policies on the rationing of public mental health services. The next report of the MHPAC will analyze our current policies on rationing and examine their strengths and weakness.

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