

---

# FUNDING TRENDS AND CHALLENGES IN COMMUNITY MENTAL HEALTH SERVICES

Local mental health authority funding from the Legislature and other sources has increased substantially in Texas since fiscal year 2013. As a result, the number of individuals served also has increased. During fiscal year 2013, local mental health authorities reported \$829.6 million in inflation-adjusted community mental health-related revenues. By fiscal year 2017, this amount increased to \$1.2 billion. The net increase primarily was from \$231.8 million in temporary funding from the U.S. Social Security Act, Section 1115, Waiver Delivery System Reform Incentive Payment demonstration program, and increases of \$106.8 million in local funding and \$66.2 million in General Revenue Funds. Despite the funding available to provide access to care for uninsured individuals, 43.2 percent of local mental health authorities have experienced a decrease in per-capita funding from General Revenue Funds since fiscal year 2008. Furthermore, funding from the 1115 waiver expires in 2021.

As the state considers options to address the loss of 1115 waiver funding, it also will face several challenges to improving equitable access to mental health services. These challenges include balancing access to crisis services with ongoing treatment and supports, and addressing the growing inequity in funding among local mental health authorities.

## FACTS AND FINDINGS

- ◆ The recent funding increase has improved access to mental health care. The number of clients served has increased, and the number of underserved clients has decreased. These underserved clients include those who were asked to wait for any service and clients who received lower-than-recommended levels of care.
- ◆ Depending on allocations for local mental health authority projects, funding from the 1115 waiver could decrease as soon as fiscal year 2020. A transition plan is required to be submitted to the federal government by October 2019.
- ◆ Local mental health authority funding per person living in poverty within a region can be as high as \$301.00 or as low as \$78.00 per year. The range and the standard deviation in funding from General Revenue Funds have increased during the past 10 years.

## DISCUSSION

Local mental health authorities (LMHA) receive funding from various sources. The largest source of revenue is non-Medicaid related General Revenue Funds appropriated by the Legislature, which is used to provide services to uninsured individuals. For the 2018–19 biennium, the Eighty-fifth Legislature, Regular Session, 2017, appropriated General Revenue Funds for this purpose to the Health and Human Services Commission (HHSC) primarily through the agency's bill pattern strategies for Community Mental Health Services and Community Mental Health Crisis Services.

LMHAs receive these funds based on performance contracts between the authorities and HHSC. The performance contract requires a local funds match and a minimum number of clients the LMHA must serve. It also provides detailed requirements regarding the populations and the scope of eligible services for funding.

The base funding that each LMHA receives is a result of historical allocations, including funds appropriated during the past decade for crisis program redesign and outpatient services. As the Legislature provides additional General Revenue Funds to the relevant strategies, HHSC may distribute funds using different criteria depending on state policy goals. For fiscal year 2018, for example, the Legislature appropriated funding based on population growth, waitlist avoidance, and equity. For fiscal year 2018, equity for additional funding was based on each LMHA's per-capita funding, with a weight added for the number of individuals living in poverty. HHSC used each of these factors separately to distribute up to \$12.1 million using different criteria for each.

LMHAs also can receive funding from General Revenue Funds for specific projects or services at an LMHA. In some cases, these funds come from grant programs established by the Legislature. In other cases, the funds are a part of a broad strategy within the General Appropriations Act.

The second-largest funding source comes from the U.S. Social Security Act, Section 1115, Delivery System Reform Incentive Payment (DSRIP) program, which is a temporary source of federal funding. Funding allocations have changed, but they originated with project proposals from LMHAs sent through regional health partnerships. In anticipation of

upcoming funding decreases, HHSC is developing a proposal for submission in March 2019 regarding how these funds should be distributed during the final two years of the program.

Local funds, including tax revenues from cities, counties, and other taxing authorities, account for 13.1 percent of LMHA revenue. HHSC considers patient fees and insurance reimbursement to be local funds. Patient fees and insurance reimbursement account for 9.1 percent of revenues and are shown separately in **Figure 1**.

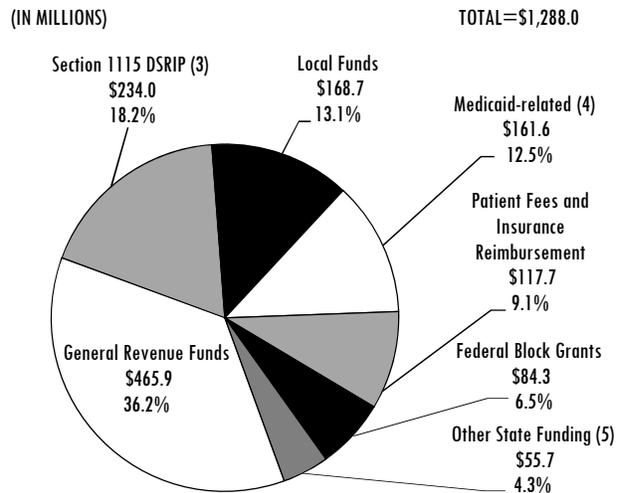
**PERFORMANCE-BASED FUNDING**

Before 1985, LMHAs received funding through grant awards from the state. In 1985, the Legislature began restructuring the community mental health system so that LMHAs would focus on “the smallest but most needful population groups.” Senate Bill 633, Sixty-ninth Legislature, Regular Session, 1985, established a framework for LMHAs to receive reimbursement through a contract if they were providing services to priority populations. These contracts also were intended to include expected performance standards and measures for outcomes.

During the 33 years since the conversion to performance-based contracts, Texas health agencies have made progress in collecting high-quality information. HHSC collects standardized information about the status of individuals receiving state-funded mental health services. This information enables HHSC to track whether individuals and groups are making progress in treatment at each LMHA. This progress is measured with a validated assessment tool used in many jurisdictions across the U.S. HHSC also tracks whether clients are receiving the recommended level of care. This information has been instrumental in understanding how funding levels affect access to clinically appropriate care.

However, it is challenging to use this information exclusively to determine the performance of an LMHA and its treating providers. Performance measures capture outcomes that are affected by multiple systems. LMHAs do not control all of the services they coordinate directly; they manage services in cooperation with schools, foster care, juvenile justice, corrections, primary healthcare providers, and state hospitals. The mandates of each system may impede providing individuals with clinically appropriate services. Separating the effects of the decisions within an LMHA’s control from the other systems is a challenge for any performance measurement system.

**FIGURE 1  
SOURCES OF TEXAS LOCAL MENTAL HEALTH AUTHORITY  
REVENUE  
FISCAL YEAR 2017**



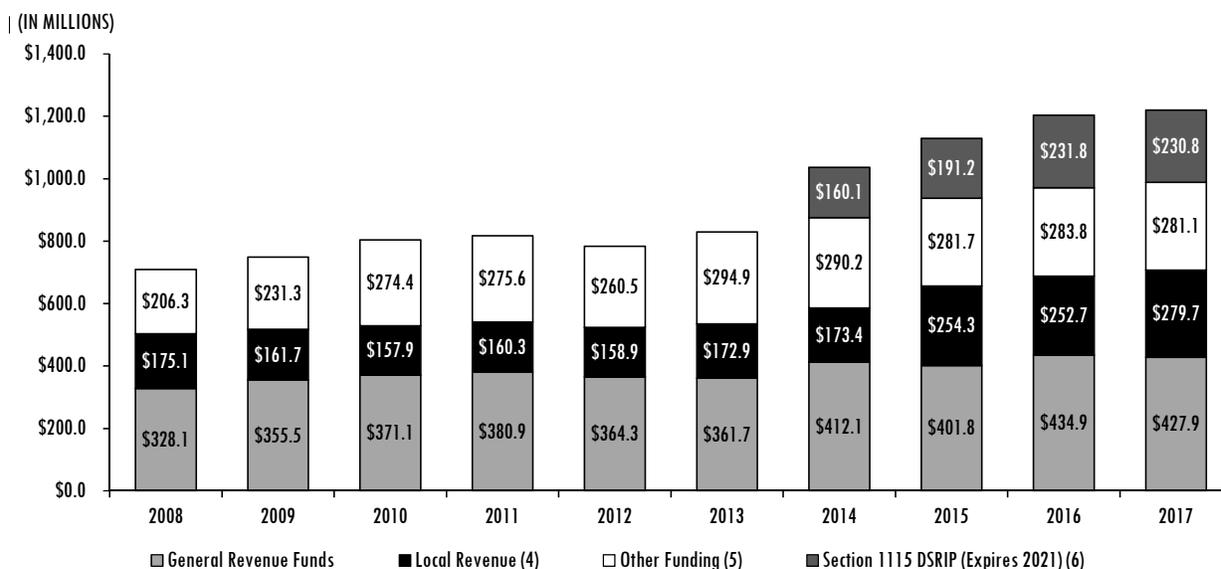
- NOTES:
- (1) Excludes NorthSTAR funding because data was unavailable from the Health and Human Services Commission.
  - (2) Revenues are shown without any adjustments for inflation.
  - (3) DSRIP=Delivery System Reform Incentive Payment Program, a part of the U.S. Social Security Act, Section 1115, waiver program.
  - (4) Medicaid-related funding is a combination of Federal Funds and General Revenue Funds.
  - (5) Other state funding includes revenues from other state agencies and programs, including the Texas Correctional Office on Offenders with Medical or Mental Impairments.
- SOURCES: Legislative Budget Board; Health and Human Services Commission.

In addition, the ability of administrators to simplify complex clinical interactions into a performance measure may be limited. For example, the RTI–University of North Carolina Evidence-based Practice Center published a report in January 2015 regarding the use of quality measures in mental health for the U.S. Agency for Health Care Quality. The researchers found the following results:

- stakeholders do not agree on preferred outcomes;
- no studies have assessed whether the use of quality measures improves health outcomes for patients with serious mental illness; and
- no evidence shows whether commonly used measures capture quality accurately or improve outcomes.

LMHAs also are paid by multiple entities, making it difficult to overhaul their entire system to meet the directives of one performance indicator system. In fiscal year 2015, the Sunset

**FIGURE 2  
INFLATION-ADJUSTED FUNDING FOR TEXAS LOCAL MENTAL HEALTH AUTHORITIES  
FISCAL YEARS 2008 TO 2017**



NOTES:

- (1) Excludes NorthSTAR funding and the local mental health authorities (LMHA) that replaced NorthSTAR during fiscal year 2017 because data was unavailable from the Health and Human Services Commission.
- (2) Revenues are shown using 2017-equivalent values. Revenues are adjusted using the U.S. Bureau of Economic Analysis Personal Consumption Expenditures Index to account for changes in purchasing power. This index was relatively stable during the period shown.
- (3) Population is based on all individuals living within LMHA regions.
- (4) Local revenue includes patient fees and insurance reimbursement.
- (5) Other funding includes Medicaid, other federal funding, and funding through certain state agencies in addition to the Health and Human Services Commission and the Department of State Health Services. Patient assistance program in-kind funding from drug manufacturers for medications is excluded.
- (6) Section 1115 Delivery System Reform Incentive Payment (DSRIP) program funding expires in fiscal year 2021.
- (7) Revenue data is self-reported by LMHAs and has not been audited by Legislative Budget Board staff.

SOURCES: Legislative Budget Board; Health and Human Services Commission; U.S. Bureau of Economic Analysis.

Advisory Commission found that the state did not link performance to funding effectively. A subsequent internal audit at HHSC found that nearly all of the reviewed performance targets lacked any justification or documentation for how they were developed.

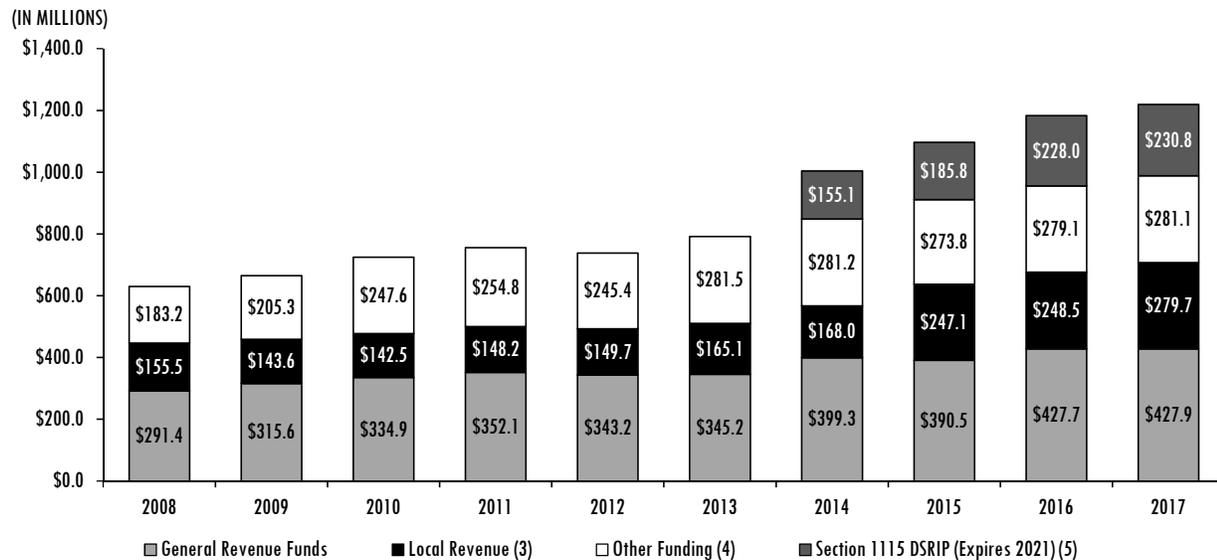
The internal audit also found that the financial incentive system was not timely. Based on direction from the Legislature, HHSC had implemented a system of withholding funds from LMHAs until they achieved performance targets. In January 2017, HHSC sent notification letters to LMHAs about withheld funds for fiscal year 2016. Six months later, the funds had not been redistributed or used for technical assistance.

Since this internal audit, HHSC has taken steps to improve the system. The Eighty-fifth Legislature, General Appropriations Act (GAA), 2018–19 Biennium, directed HHSC to eliminate prospective withholding of funds.

Starting in fiscal year 2018, HHSC paid out all funds and will later recoup funds from LMHAs for nonperformance. This payment method enables LMHAs to access funds to provide services and to make adjustments later as necessary if funds are recouped.

Based on the Sunset Advisory Commission’s recommendations, HHSC is evaluating and restructuring its performance management system for LMHAs. Pursuant to the Eighty-fourth Legislature, GAA, 2016–17 Biennium, Article II, HHSC, Rider 82, the agency contracted with third-party consultants to evaluate its performance management system. HHSC determined from this review that the state should use a low-risk model that adds funding, rather than removing it. The Texas Council of Community Centers reports that it is coordinating with HHSC to improve the performance management system.

**FIGURE 3**  
**FUNDING FOR TEXAS LOCAL MENTAL HEALTH AUTHORITIES, NO ADJUSTMENT FOR INFLATION**  
**FISCAL YEARS 2008 TO 2017**



NOTES:

- (1) Excludes NorthSTAR funding and the local mental health authorities (LMHA) that replaced NorthSTAR during fiscal year 2017 because data was unavailable from the Health and Human Services Commission.
- (2) Population is based on all individuals living within LMHA regions.
- (3) Local revenue includes patient fees and insurance reimbursement.
- (4) Other funding includes Medicaid, other federal funding, and funding through certain state agencies in addition to the Health and Human Services Commission and the Department of State Health Services. Patient assistance program in-kind funding from drug manufacturers for medications is excluded.
- (5) Funding from the Section 1115 Delivery System Reform Incentive Payment (DSRIP) program expires in fiscal year 2021.
- (6) Revenue data is self-reported by LMHAs and has not been audited by Legislative Budget Board staff.

SOURCES: Legislative Budget Board; Health and Human Services Commission.

Research suggests that Texas can increase the motivation and credibility of its performance management system by providing autonomy to LMHA administrators and clinicians to help interpret performance. A performance management system cannot ameliorate the fiscal pressure to provide services; however, it should help LMHAs attain internally driven goals that align with state priorities. Current efforts by HHSC and the Texas Council of Community Centers may help the state redesign the performance monitoring system in conjunction with funding changes from the expiration of the 1115 DSRIP program.

**RECENT INCREASES IN FUNDING AND ACCESS TO SERVICES**

Since fiscal year 2013, funding received by LMHAs for community mental health in Texas has increased by 47.0 percent. **Figure 2** shows that most of the increase came from receipt of Federal Funds from the 1115 DSRIP program.

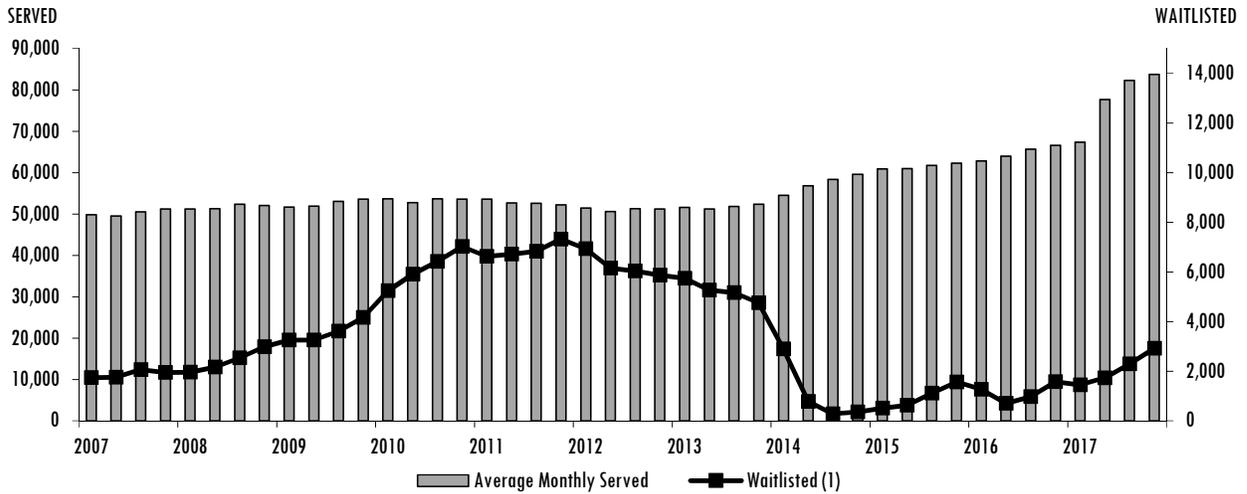
During this period, General Revenue Funds also increased by 18.3 percent, and local revenues increased by 61.7 percent.

**Figure 3** shows the funding without an adjustment for inflation.

As shown in **Figures 4** and **5**, this funding increase resulted in LMHAs serving more clients. The number of underserved clients also decreased, including clients who were asked to wait for any service, referred to as waitlisted, and those who received lower-than-recommended levels of care.

Wait times to see providers for noncrisis services also have improved. According to the Texas Council of Community Centers, 61 percent of LMHAs indicated that the wait to see a service provider after completing a comprehensive adult assessment was shorter in May 2018 than five years before, and 8.0 percent of LMHAs reported that wait time was longer. As of May 2018, 94.6 percent of LMHAs initiated services within two weeks. Most LMHAs also indicated that clients typically see prescribers within 30 days. Among

**FIGURE 4**  
**ADULTS SERVED OR WAITLISTED FOR SERVICES FROM TEXAS LOCAL MENTAL HEALTH AUTHORITIES**  
**FISCAL YEARS 2007 TO 2017**

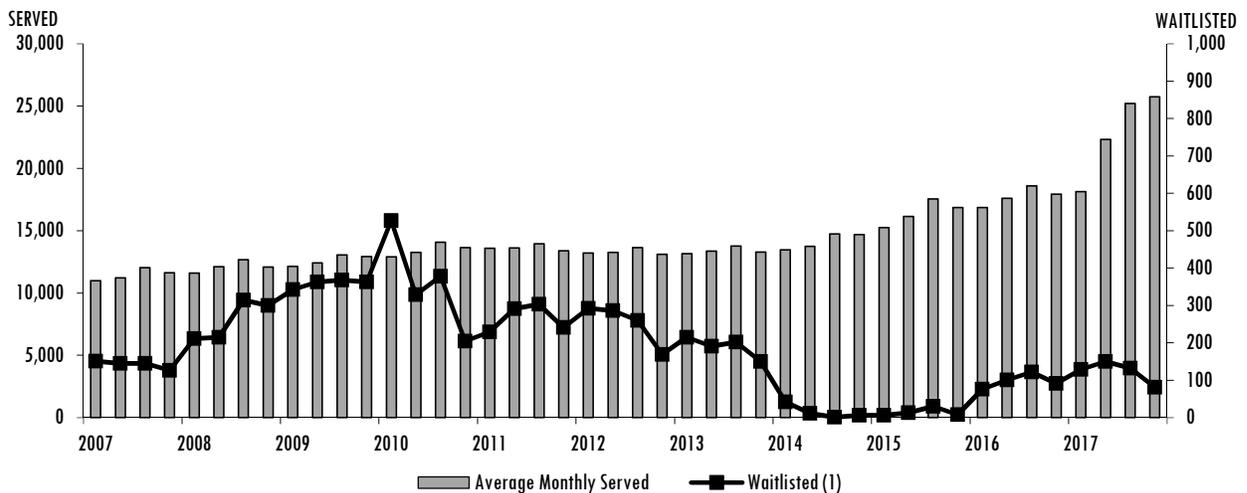


NOTES:

- (1) Waitlisted clients include adults waiting for any services, excluding those receiving some services and waiting to receive higher levels of clinically appropriate care.
- (2) Excludes individuals served by NorthSTAR. Individuals in the former NorthSTAR region, currently served by North Texas Behavioral Health Authority and Lifepath Systems, are counted starting in the second quarter of fiscal year 2017.
- (3) Individuals receiving services outside of the standard treatment package and funded by the U.S. Social Security Act, Section 1115, Delivery System Reform Incentive Payment program may not be included.

SOURCES: Legislative Budget Board; Health and Human Services Commission.

**FIGURE 5**  
**CHILDREN SERVED OR WAITLISTED FOR SERVICES FROM TEXAS LOCAL MENTAL HEALTH AUTHORITIES**  
**FISCAL YEARS 2007 TO 2017**



NOTES:

- (1) Waitlisted clients include children waiting for any services, excluding those waiting to receive higher levels of clinically appropriate services.
- (2) Excludes individuals served by NorthSTAR. Individuals in the former NorthSTAR region, currently served by North Texas Behavioral Health Authority and Lifepath Systems, are added starting in the second quarter of fiscal year 2017.
- (3) Individuals receiving services outside of the standard treatment package and funded by the U.S. Social Security Act, Section 1115, Delivery System Reform Incentive Payment program may not be included.

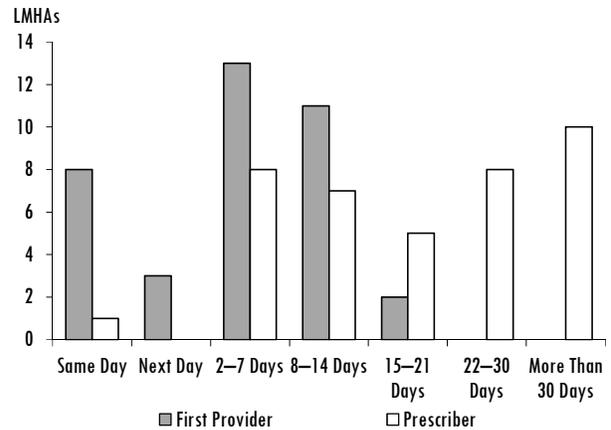
SOURCES: Legislative Budget Board; Health and Human Services Commission.

LMHAs, 61.5 percent indicated that the wait for prescriber services was shorter in May 2018 than in May 2013. **Figure 6** shows wait times by provider type at LMHAs in May 2018.

The primary source of increased per-capita funding in recent years has been the 1115 DSRIP program, as shown in **Figure 7**. This source of revenue is temporary and will expire at the end of fiscal year 2021.

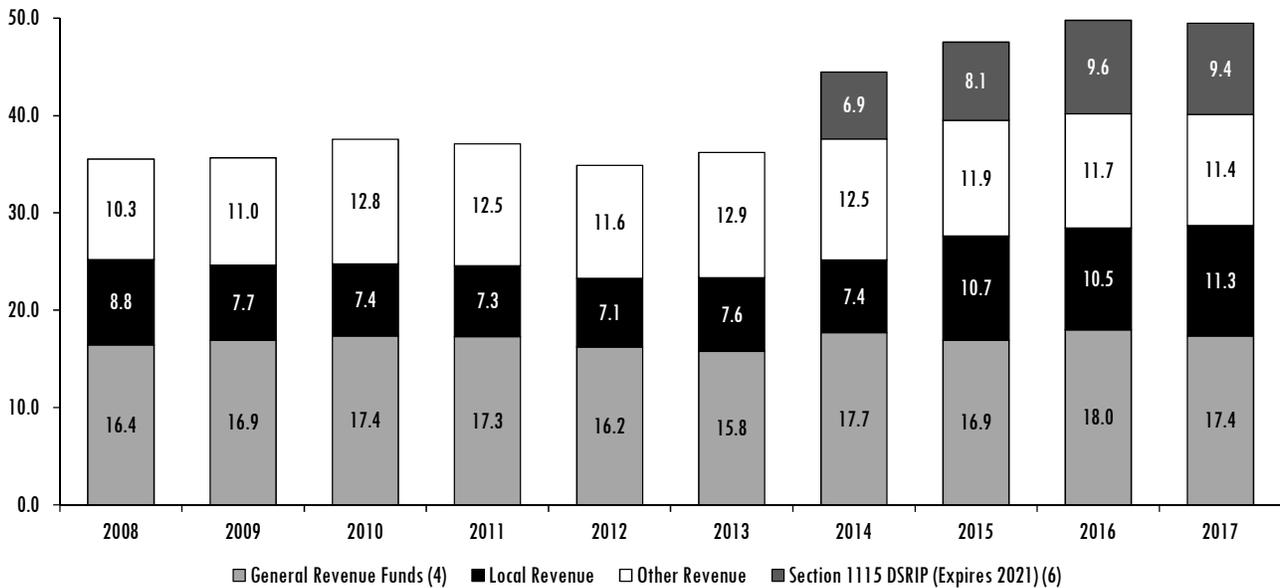
The Eighty-fifth Legislature, Regular Session, 2017, provided an additional \$27.4 million in General Revenue Funds per year for the 2018–19 biennium to HHSC to address waitlists for community mental health services for adults and children. In addition, the Legislature appropriated \$67.5 million in General Revenue Funds for the 2018–19 biennium to provide grants to community entities, including LMHAs, for behavioral health services. Total statewide per-person General Revenue Funds amounts at LMHAs are estimated to increase by approximately 6.5 percent from fiscal years 2017 to 2019 due to these grant programs; however, data regarding revenue receipts by LMHAs was not finalized as of November 2018.

**FIGURE 6**  
**WAIT TIMES TO INITIATE TEXAS LOCAL MENTAL HEALTH AUTHORITY SERVICES**  
**MAY 2018**



NOTE: Estimated average wait is from the completion of the Adult Needs and Strengths Assessment (ANSA) to the first service, excluding crisis services.  
 SOURCE: Texas Council of Community Centers.

**FIGURE 7**  
**INFLATION-ADJUSTED FUNDING PER CAPITA FOR COMMUNITY MENTAL HEALTH**  
**FISCAL YEARS 2008 TO 2017**



NOTES:

- (1) Excludes NorthSTAR funding and the local mental health authorities (LMHA) that replaced NorthSTAR during fiscal year 2017 because data was unavailable from the Health and Human Services Commission.
- (2) Revenues are shown using 2017-equivalent values. Revenues are adjusted using the U.S. Bureau of Economic Analysis Personal Consumption Expenditures Index to account for changes in purchasing power. This index was relatively stable during the period shown.
- (3) Population is based on all individuals living within LMHA regions.
- (4) General Revenue Funds reported by LMHAs for private inpatient beds are excluded.
- (5) Revenue data is self-reported by LMHAs and has not been audited by Legislative Budget Board staff.
- (6) DSRIP=Section 1115 Delivery System Reform Incentive Payment program.

SOURCE: Legislative Budget Board; Health and Human Services Commission; U.S. Bureau of Economic Analysis.

### **HISTORY OF FUNDING CRISIS INTERVENTIONS AND ONGOING TREATMENT AND SUPPORTS**

Although recent increases in funding have improved access to community mental health services, the needs of the population have exceeded available funding. *The Performance Audit and Evaluation Report*, “Overview of Community Mental Health Needs and Services,” Legislative Budget Board, January 2019, reports that most individuals with serious mental illness do not access LMHA specialty mental health services.

In 2006, the Department of State Health Services (DSHS), the agency then responsible for community mental health services, released a report regarding crisis service redesign. The report found that individuals experiencing a mental health crisis had inadequate access to services. DSHS estimated it would cost an additional \$222.1 million per biennium to adequately address this need. The agency’s plan called for requesting the first \$83.3 million for the 2008–09 biennium, and the remainder was intended to be requested for the following biennium. DSHS anticipated that increased funding could help individuals avoid more intensive, costly admissions to hospitals and correctional facilities.

The Eightieth Legislature, 2007, appropriated \$82.0 million in General Revenue Funds for the 2008–09 biennium for community mental health crisis services. In addition, the Legislature requested an evaluation of the soon to be redesigned system. In its evaluation completed in January 2010, Texas A&M University found that the crisis redesign accomplished the intended objectives. Individuals’ access to crisis services improved, decreasing the need for more intensive services.

However, the report identified concerns about access to ongoing services. Crisis services primarily are short-term interventions. The crisis level of care, for example, is authorized for seven days. Adult levels of care for ongoing treatment are authorized for six months to 12 months. As LMHAs served more individuals in crisis, many of these newly engaged individuals qualified for ongoing treatment. Individuals coming from the crisis system often received priority in treatment, given their acuity. According to Texas A&M University’s report, most new investment in the service system targeted crisis service users, leaving ongoing treatment services significantly underfunded. The report stated that, if the pattern continued, the system would evolve into one in which individuals received help only after they deteriorated into crisis.

Following Texas A&M University’s evaluation, DSHS convened an expert task force to study mental health services. Among its recommendations in August 2010, the task force recommended prioritizing ongoing treatment in future funding increases.

Since then, however, the share of funding for crisis services has increased. Although crisis funding has not reached the levels recommended in 2006, the percentage of General Revenue Funds dedicated to crisis services has increased since 2010, and noncrisis-related per-person General Revenue Funds amounts have remained stable. **Figure 8** shows the totals for each fiscal year.

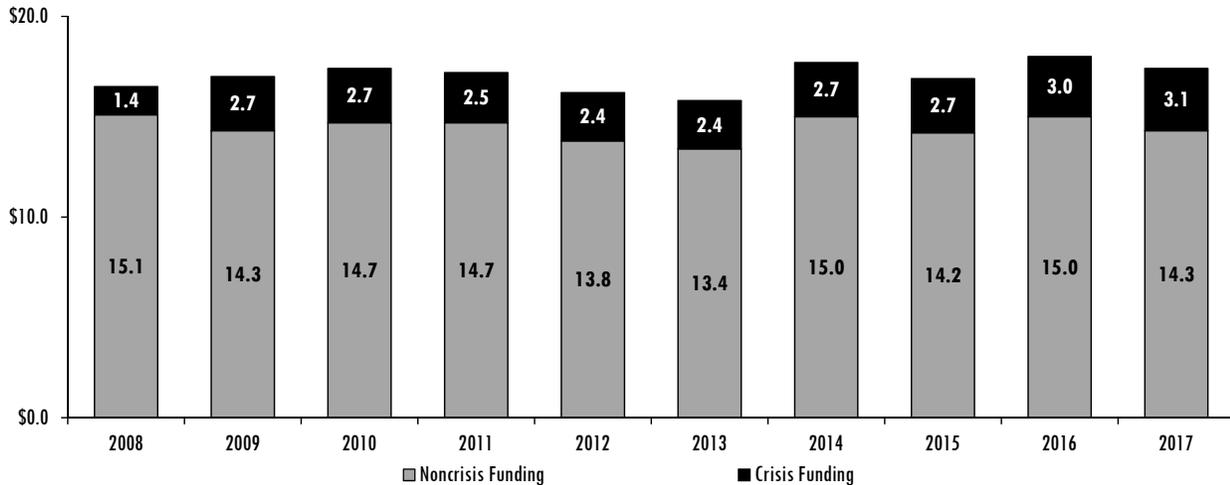
Evaluations conducted after Texas A&M University’s 2010 report have raised the same concerns. The Eighty-second Legislature, Regular Session, 2011, directed DSHS to contract for an external evaluation of the mental health system. In 2012, the evaluator, PCG, identified concerns about the system being “crisis-driven.” Interviews with system participants indicated that a “greater emphasis should be placed on prevention and recovery to address client needs before they reach crisis level.” A Travis County assessment published in 2012 reached the same conclusion.

Starting in fiscal year 2013, the state increased funding for outpatient services using 1115 DSRIP program funds, as shown in **Figure 7**. The 1115 waiver DSRIP program projects were intended to help the state increase provider capacity and prepare the health system for an influx of insured individuals that would result from the expansion of Medicaid, as part of the federal Patient Protection and Affordable Care Act. The mental health projects also were intended to address the gaps in the continuum of care and supports, as highlighted in the DSHS 2010 Task Force Report.

### **EQUITY IN PER-PERSON FUNDING**

In addition to total funding available for services, equity of funding across LMHAs has been a challenge since the establishment of the centers. In 1963, Congress enacted the Community Mental Health Act of 1963 to establish community mental health centers. The legislation established 3,000 regions, with each center intended to serve from 125,000 to 250,000 individuals. Shortly after the establishment of these regions, concerns arose about funding inequities and health center oversight. According to a 1974 U.S. Government Accountability Office report, regions were defined arbitrarily, resulting in uneven distribution of funds.

**FIGURE 8**  
**INFLATION-ADJUSTED, PER-PERSON GENERAL REVENUE FUNDS PROVIDED FOR COMMUNITY MENTAL HEALTH SERVICES**  
**REPORTED BY CRISIS LEVEL**  
**FISCAL YEARS 2008 TO 2017**



NOTES:

- (1) Excludes NorthSTAR funding and the local mental health authorities (LMHA) that replaced NorthSTAR during fiscal year 2017 because data was unavailable from the Health and Human Services Commission.
- (2) Revenues are shown using 2017-equivalent values. Revenues are adjusted using the U.S. Bureau of Economic Analysis Personal Consumption Expenditures Index to account for changes in purchasing power. This index was relatively stable during the period shown.
- (3) Population is based on all individuals living within LMHA regions.
- (4) General Revenue Funds reported by LMHAs for private inpatient beds are excluded.
- (5) Revenue data is self-reported by LMHAs and has not been audited by Legislative Budget Board staff.

SOURCE: Legislative Budget Board; Health and Human Services Commission; U.S. Bureau of Economic Analysis.

In Texas, funding inequities also were driven by each LMHA’s ability to negotiate for available funding.

From fiscal years 1982 to 2000, Texas began to address these inequities by allocating new funds using a formula primarily based on population, with some additional information to estimate need, including poverty. In fiscal year 2000, the state streamlined the formula for these funds to be based solely on population.

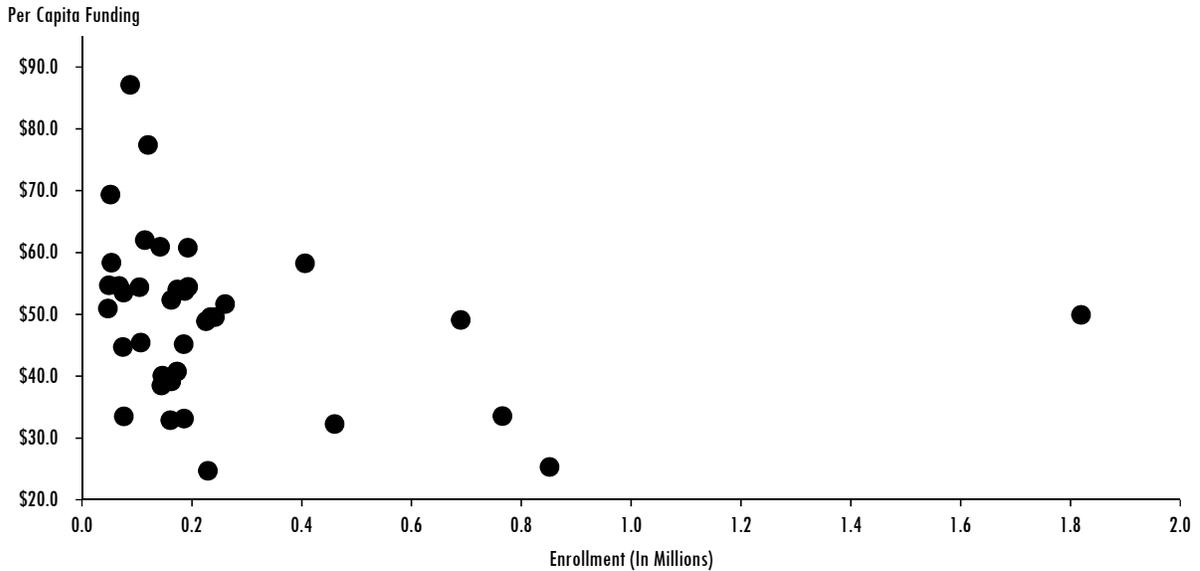
Since 2008, the variation in LMHA per-person funding has increased. Statewide per-person funding from all revenue sources has increased, as shown in **Figure 7**. For fiscal year 2017, statewide per-person funding from all sources of revenue had increased to \$49.48 per person, excluding the former NorthSTAR region. However, since fiscal year 2008, General Revenue Funds per-person funding decreased for 16 LMHAs. On average, General Revenue Funds allocations decreased \$1.58 per person living in those LMHA regions. Twenty-one LMHAs received an increase in their inflation-adjusted, per- person General Revenue Funds allocations. The increase on average was \$3.13 per person.

During fiscal year 2016, the state started tracking equity based on the number of individuals in poverty. Among regions with similar numbers of individuals living in poverty, some LMHAs receive more than three times as much funding per person as others, as shown in **Figure 9**. For fiscal year 2018, allocations of new funds that were to improve equity were based on the per-capita funding of each LMHA with a weight added for the number of individuals living in poverty.

**Figure 10** shows similar patterns for all revenue sources per person in fiscal year 2017.

Since 2002, every Legislature has included a rider in the General Appropriations Act containing an equity-related directive. The Seventy-ninth Legislature, General Appropriations Act, 2006–07 Biennium, required DSHS to develop a long- term plan for funding equity. As part of its 2015 review of DSHS, the Sunset Advisory Commission also issued a management directive to evaluate funding equity. State agencies, LMHAs, and experts in the mental health field have reported that the current inequity is too large. HHSC has worked with stakeholders to develop changes. As of August 2018, HHSC was evaluating options.

**FIGURE 9**  
**PER-PERSON GENERAL REVENUE FUNDS BY LOCAL MENTAL HEALTH AUTHORITY AREA RESIDENTS IN POVERTY**  
**FISCAL YEAR 2017**

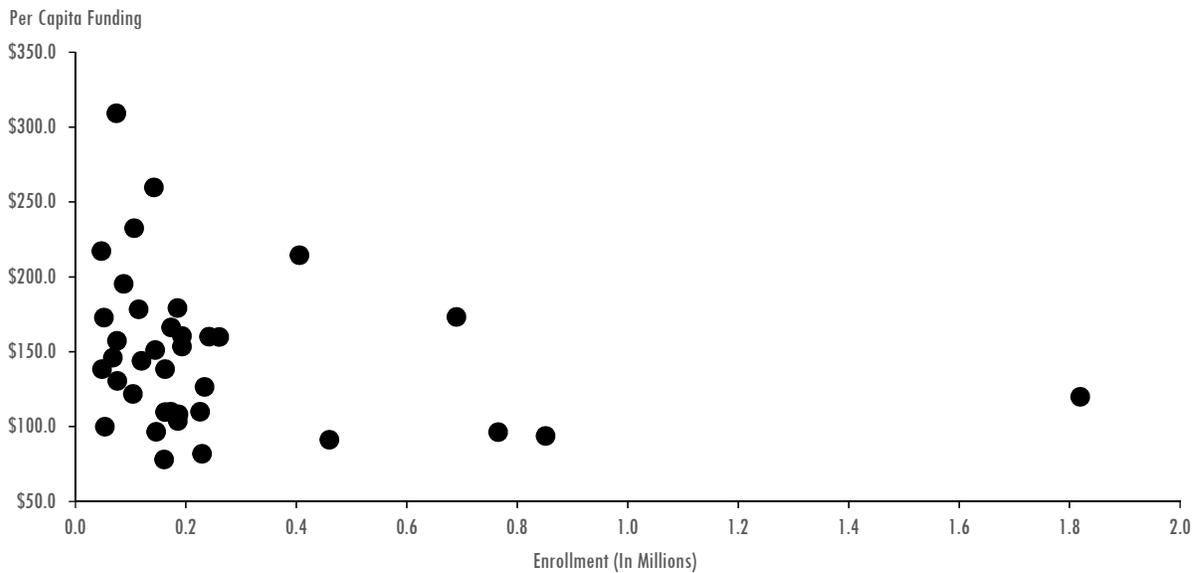


NOTES:

- (1) Excludes NorthSTAR funding and the local mental health authorities (LMHA) that replaced NorthSTAR during fiscal year 2017 because data was unavailable from the Health and Human Services Commission.
- (2) Population is based on the number of individuals within an LMHA region living at or less than 200 percent of the federal poverty level.
- (3) Revenue data is self-reported by LMHAs and has not been audited by Legislative Budget Board staff.

SOURCES: Legislative Budget Board; Health and Human Services Commission; U.S. Bureau of Economic Analysis.

**FIGURE 10**  
**PER-PERSON TOTAL REVENUE BY LOCAL MENTAL HEALTH AUTHORITY AREA RESIDENTS IN POVERTY**  
**FISCAL YEAR 2017**



NOTES:

- (1) Excludes NorthSTAR funding and the local mental health authorities (LMHA) that replaced NorthSTAR during fiscal year 2017 because data was unavailable from the Health and Human Services Commission.
- (2) Population is based on the number of individuals within an LMHA region living at or less than 200 percent of the federal poverty level.
- (3) Revenue data is self-reported by LMHAs and has not been audited by Legislative Budget Board staff.

SOURCES: Legislative Budget Board; Health and Human Services Commission.

The Eighty-fourth Legislature 2015, directed HHSC to end the NorthSTAR program, which was a publicly funded managed-care approach to delivering mental health and chemical dependency services for residents in the Dallas region. Access to benefits in NorthSTAR was determined by clinical need, not funding source, and the program had no waitlists for services. At that time, concerns arose that discontinuing NorthSTAR would result in waitlists and could decrease access to mental health services.

During the Eighty-fifth Legislature, Regular Session, 2017, HHSC presented two funding options for providing care in the Dallas region to the Legislature. One option included adding \$8.1 million into the base funding for one of the LMHAs that replaced NorthSTAR, at the LMHA's request. This amount was approximately equivalent to funding provided by the Eighty-fourth Legislature, 2015, for a onetime transition cost. A second option would have allocated new funding across all LMHAs primarily based on population growth and equity, and provided nearly half of the amount requested by the Dallas-area LMHA. The total amount of funding remained the same in both options. HHSC reported that the first option would not support increasing capacity and avoid waitlists across the system, but it would address concerns about funding for one LMHA that received per-capita funding at less than average. The Legislature funded the first option.

The Legislature has prioritized funding during recent sessions to eliminate waitlists for clients who are unable to receive any services due to a lack of funding at LMHAs. To some extent, LMHAs can manage demand for services through different strategies. One strategy is to offer a more comprehensive set of benefits and make eligible clients wait when the LMHA is at capacity. This practice negatively affects uninsured clients the most, because Medicaid clients cannot be placed on waitlists and, therefore, may receive services before uninsured clients that are on waitlists. Another strategy is to increase LMHAs' capacity to serve clients by offering less-intensive services to all clients. These LMHAs may have clients waiting to receive clinically appropriate and recommended services, but fewer waitlisted clients for any services. During fiscal year 2017, approximately one in 10 interactions with eligible adults after assessment resulted in a client in need being waitlisted or underserved.

LMHAs that manage resource constraints by underserving clients, rather than waitlisting them, may experience a decrease in funding equity when the Legislature provides new funding dedicated to the elimination of waitlists.

In addition to waitlist funding, equity improvements have been negatively impacted by other funding priorities. For example, the Legislature often seeks to leverage funds through the use of competitive awards with local match requirements. New initiatives may require each participating LMHA to make a minimum investment, sometimes including a match requirement. Some LMHAs also may have a greater need for the type of project funded by a grant. When the needs and ability to fund differ, some LMHAs might receive no funding or proportionately less funding from a new source.

The Legislature frequently has included funding to address equity in addition to project-specific funding. However, these equity allocations have not been large enough to result in a net improvement in equity for the biennium. As a result, the equity allocation mitigates some of the effects of the project-specific funding, but equity each biennium still decreases.

The funding needs and tax capacity of the local governments within each LMHA vary. Some schools, for example, have behavioral health staff onsite, which may decrease the need for LMHA services. Likewise, some LMHAs contain counties with greater levels of property wealth, fewer individuals living in poverty, and therefore higher taxing capacity. A uniform per-person funding amount would not account for those differences. Therefore, HHSC has transitioned to using an equity measure that includes the number of individuals living in poverty, in an effort to reflect the need for services.

#### **FUTURE FUNDING CHANGES AND CONSIDERATIONS**

Funding from the 1115 DSRIP program could decrease as soon as fiscal year 2020 and will end in fiscal year 2021. HHSC must prepare and submit a transition plan by October 2019 to the U.S. Centers for Medicare and Medicaid Services. The plan must describe how Texas will sustain its delivery system reform efforts without the 18.2 percent of federal funding accounted for in LMHA revenue. This transition process may build a foundation for restructuring funding to maintain access and improve equity.

As the state considers how to address the absence of 1115 DSRIP program funding, it also will face multiple challenges regarding equitable access to mental health services. If these funds are not replaced, the number of individuals served and the services delivered would decrease, and wait times would increase. The Texas Council of Community Centers estimated that LMHAs served 90,769 new individuals as a result of 1115 DSRIP program funds from October 2015 to September 2016. An additional 85,199 individuals received

enhanced services during that period. Because 1115 DSRIP program funding is not distributed based on population, the All Funds variation among LMHAs and the median per-capita funding by LMHA would decrease.

If the Legislature chose to replace the 1115 DSRIP program funding, it could appropriate General Revenue Funds. Funding could be allocated to improve per-capita equity compared to current allocations. However, increasing funding at some LMHAs would result in a loss in services at other LMHAs if total funding remains constant.

Alternatively, states can amend Medicaid eligibility rules through an existing authority in the U.S. Social Security Act, Section 1915(i). In accordance with this authority, a state can receive federal funding to provide services to individuals based on state criteria for age, condition, functionality, or other standards. For federal fiscal year 2019, with the exception of certain enhanced rates, the federal government will pay for 58.19 percent of Medicaid costs in Texas. Eligibility does not have to be defined by diagnosis, and can be defined by a client's level of functioning. According to the U.S. Department of Health and Human Services, "this flexibility presents an opportunity for states to create highly targeted programs that serve specific high-need or hard-to-serve populations, such as those with [severe mental illness]." States can use the existing authority in accordance with federal law without seeking a waiver. Some states have opted to use waivers in lieu of this authority because waivers enable them to cap enrollment or begin geographic phase-ins. Texas currently uses the Section 1915(i) authority to provide enhanced services for individuals that are eligible for Medicaid. This authority could be modified to include uninsured individuals that receive services from LMHAs.

Transitioning to funding based on an individual's mental health needs and ability to pay could help improve equity in funding. LMHAs would receive funding based on utilization instead of the existence of a project or historical funding allocations.

The changes precipitated by the upcoming end of 1115 DSRIP program funding will be significant. The strategies that the Legislature and HHSC adopt in response will affect access to ongoing treatment and equitable access to services across the state. Consideration of the balance among crisis services and ongoing treatment, equity in funding among local mental health authorities, and the structure of the performance management system can help improve equitable access to community mental health services.