Executive Summary

Over the past decade, Texas has made significant investments into the stewardship of its behavioral health delivery system. Policy revisions, infrastructure development and technological innovations have been employed to allow people to have better access to the care they need. Texas currently invests $6.7 billion biennially at the state level through General Revenue, Medicaid, and local and federal dollars to fund behavioral health services provided by various state agencies. In Texas Medicaid, behavioral health services are primarily financed within a capitated, risk based managed care delivery model.

In spite of these advancements, the behavioral health system continues to experience challenges addressing the needs of Texans. Gaps and fragmentation of care still continue to present significant barriers for populations with serious and persistent mental illness, emotional disturbances, and substance use disorders. As a result, clinical outcomes for these populations are often suboptimal. Participation in the Certified Community Behavioral Health Clinic (CCBHC) demonstration project will provide Texas with a unique opportunity to partner with MCOs, providers and stakeholders to develop an integrated service delivery framework through certified centers, and craft a prospective payment model supporting a robust "integrated health home" approach to serving populations for which care is often fragmented and uncoordinated.

As of September 2014, Texas Medicaid enrollment was just over 4 million, with 3.4 million (85 percent) enrolled and receiving services through MCOs. In 2013, expenditures for CCBHC categories such as crisis management and psychiatric services in Texas exceeded $172 million. These costs represent the "tip of the iceberg" in healthcare expenditures for this population. The Texas Health and Human Services Commission (HHSC) sees the grant as a unique opportunity to catalyze changes in these underlying dynamics, improve health outcomes of individuals and ultimately reduce costs that are the result of uncoordinated care.

Through the project, Texas will focus on four key populations who would benefit from the CCBHC model: 1) children/youth with serious emotional disturbances, 2) children/youth with substance use disorders, 3) adults with serious mental illness, and 4) adults with substance use disorders. Children/youth with these disorders represent 7 percent of the statewide population, while adults represent 3 percent and 8 percent respectively. In 2013, 2.3 percent of adults and 1.5 percent of youth served in Texas had co-occurring substance use and mental health disorders.

The Texas strategy for success will focus on building capacity of targeted clinics in select MCO service areas to provide effective, evidence-based integrated healthcare. Development of a monthly prospective payment system, enhanced with meaningful quality bonuses based on high value outcomes, will support these clinical practice changes required by the grant.

Texas is ideally positioned to leverage this grant to transform service delivery and to align incentives to improve the lives and healthcare outcomes of vulnerable populations by creating a more efficient and coordinated system.

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A. Solicitation of Input by Stakeholders in Developing CCBHCs

Collaborative and meaningful stakeholder participation in the design of the Texas Certified Community Behavioral Health Clinic (CCBHC) project is an extension of the Texas commitment to achieving meaningful change in statewide behavioral health delivery and outcomes. Stakeholder input in shaping the project approach started from the draft of the initial planning grant application, and has expanded throughout the planning year. Stakeholder involvement was captured through the use of advisory committees and increased engagement with other governmental, professional and advocacy organizations. Input from populations of focus was obtained through ensuring their robust representation on committees, in other planning processes, as well through surveys and web-based communication..

Steering Committee Input

During the project year, the CCBHC team utilized two key steering committees to design and refine CCBHC criteria, prospective payment system (PPS) elements, and data management and evaluation approaches. A legislatively mandated Statewide Behavioral Health Advisory Committee (BHAC) served as the first advisory committee for the CCBHC team. This stakeholder group is coordinated by the Texas Health and Human Services (HHSC) Office of Mental Health Coordination (OMHC), and includes consumer, family, and community advocates within its membership. Individuals with lived experience account for over half of the committee membership, and have strong networks within their communities.

The second statewide advisory committee for the Texas CCBHC initiative is the Texas Medicaid Behavioral Health Integration Advisory Council (BHIAC). The BHIAC was legislatively established in 2014 to address the planning and development needs to integrate Medicaid behavioral health services, including targeted case management, mental health rehabilitative services and physical health services within Medicaid managed care. The BHIAC includes mental health professionals, consumers, policy experts, and managed care representatives. The BHIAC has evolved to provide the State and managed care organizations (MCOs) with input on best practices for integration of mental health, substance abuse services and physical health care, including how to best finance and evaluate them.

Both committees were engaged throughout the planning year. Feedback was gathered through quarterly meetings, as well as through e-mail reviews. As part of the development of CCBHC certification guidance, HHSC utilized the membership of the committees to inform the development of criteria related to elements that the Substance Abuse and Mental Health Services Administration (SAMHSA) designated for State specific refinement. Members provided input related to potential conflicts between CCBHC and State behavioral health standards, selection of standard comprehensive evaluation and assessment tools for clients, and continuous quality improvement (CQI) requirements. The BHIAC's data and evaluation sub-group provided recommendations into the selection of a minimum toolset for all CCBHCs to use for screening and assessment of prevalent behavioral health conditions.

Both committees were also involved in the development of the prospective payment system (PPS) methodology for the Texas CCBHC project. After the project actuaries examined multiple

options for developing populations of focus, and the impact and sustainability of the PPS post-demonstration, the methodology and subsequent analysis were shared with committee members for comment.

Engaging Populations of Focus and Other Stakeholders

Multiple pathways were utilized to gather input from the populations of focus. These included statewide stakeholder surveys, site specific surveys, engaging population representatives, and development of a centralized public website and e-mail address for the CCBHC project. In addition, engagement with external stakeholders encouraged the sharing of project information with members of their advocacy networks, as well as others not included in original communications.

Simultaneous to the development of the CCBHC initiative, Texas began the development of a five-year statewide behavioral health strategic plan. As part of that process, HHSC conducted a statewide survey to prioritize behavioral health initiatives related to four broad areas: 1) maximizing prevention and early intervention, 2) ensuring optimal service delivery, 3) comparing statewide data to improve effectiveness, and 4) financial alignment across agencies to best meet the needs of individuals. Input was received from over 800 individuals in urban and rural settings across the state, including those with lived experience.

- Twenty-three percent of respondents indicated they received or are receiving mental health services
- Six percent of respondents indicated they received or are receiving treatment for an alcohol or drug problem
- Thirty-two percent of respondents were a friend or family member of a recipient of mental health services

The statewide survey was followed by a second survey of the current Strengths, Weaknesses, Opportunities, and Threats (SWOT) related to the Texas behavioral health system. A statewide response from large and small urban areas, as well as rural populations was again received. Individuals with lived experience, or their family and friends, accounted for approximately forty percent of the responses received.

In addition to statewide assessments, potential CCBHC pilot sites conducted local needs assessments. These eight sites are spread across urban and rural - some frontier- areas of Texas. These assessments were conducted in tandem with HHSC as part of Medicaid 1115 waiver planning, with local school and hospital districts, and in partnership with local planning and network advisory committees (PNACs) comprised of clients and others in the community. In addition, potential CCBHCs were able to gather feedback through ongoing client satisfaction surveys.

One key area for stakeholder involvement has been the development of the Texas CCBHC certification standards and guidelines. Texas developed a certification reviewer checklist, certification assessment form, and a guidance document that outlines requirements for elements over which the State has discretion. The guidance document outlines minimum expectations, as

well as tools that must be used for consistency across pilot sites. Drafts of all tools were made available for stakeholder input – this included the pilot sites and their advisory boards, the two HHSC statewide advisory boards, the Texas Council of Community Centers, Medicaid and State mental health and substance abuse (MHSA) subject matter experts, managed care organizations, and other behavioral health providers. Through membership of statewide advisory committees – especially the consumer and family liaisons - consumer input was also solicited.

Additional stakeholder and advocacy groups that were also engaged as Texas planned the CCBHC initiative include the Hogg Foundation for Mental Health Leadership Academy, the Meadows Mental Health Policy Institute, and the Texas Council of Community Centers. The Texas Council of Community Centers represents a network of 37 local mental health authorities (LMHAs), including 7 of the CCBHC project sites. HHSC also received inquiries and input from organizations such as the Harris County Texas Department of Education afterschool program, community groups, the Texas Occupational Therapy Association, local substance abuse prevention coalitions, and a hospital-based system that has developed its own integrated outpatient behavioral health program similar to the CCBHC model. Input was also provided from individual providers seeking opportunities to volunteer to work with a CCBHC.

Finally, a Texas CCBHC project webpage was added to the HHSC website. This page highlighted the project and provided options for public input, including through a CCBHC specific e-mail address. Throughout the planning year, project staff responded to consumer questions about development of the CCBHC in Texas, and connected individuals to services in CCBHC project areas.

Coordination with Other Agencies

Collaboration activities in the Texas CCBHC initiative have extended to other key local, state and federal stakeholders operating in Texas. The initial planning grant application included collaboration across two key State agencies - the Texas Health and Human Services Commission (HHSC) and the Texas Department of State Health Services (DSHS). HHSC is the single State agency for Medicaid and umbrella organization for the HHS enterprise in Texas. As the umbrella organization, HHSC provides systemic behavioral health oversight and innovation. DSHS was the State's public health, mental health and substance abuse (MHSA) authority. During Texas' 2015 regular legislative session, HHSC was directed to re-align and consolidate functions across all HHS agencies in order to improve efficiency and delivery of services. As a result of this legislative direction, in September 1, 2016, the MHSA function of DSHS became part of HHSC, consolidating all community-based behavioral health functions within one agency.

Texas CCBHC leadership is part of the HHSC Office of Mental Health Coordination (OMHC). The OMHC provides cross-cutting leadership and oversight for public behavioral health policy in Texas and is responsible for coordinating the policy and delivery of behavioral health services throughout the state. As part of the OMHC, the Texas CCBHC team is able to leverage existing partnerships to advance CCBHC integration. Organizationally, OMHC, MHSA, and Texas Medicaid all reside within HHSC's Medical and Social Services (MSS) Division (Figure 1). This allows for greater collaboration related to policy and operations issues.

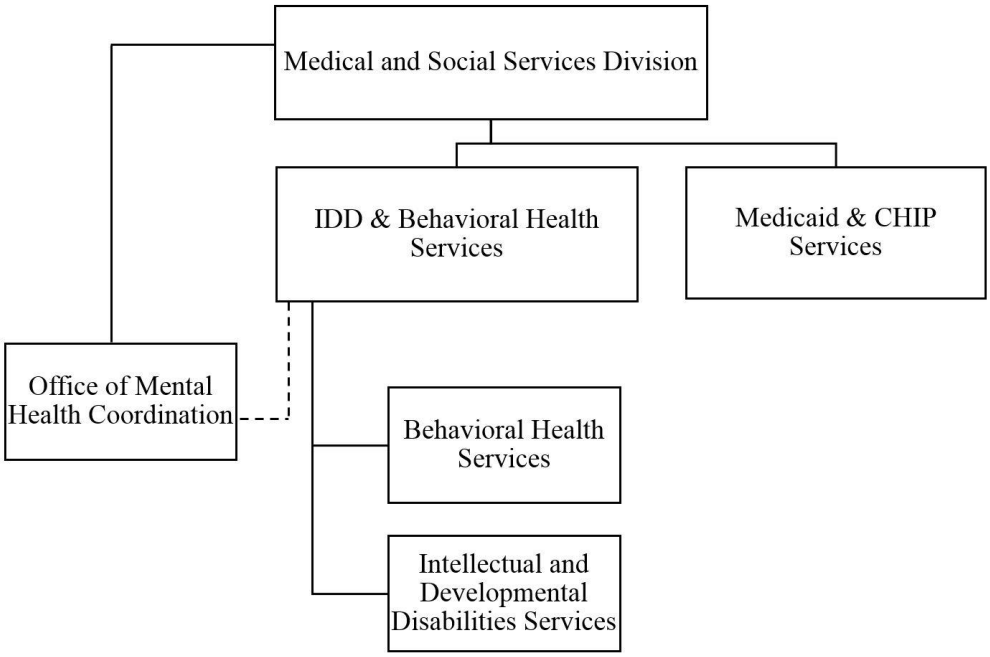

Figure 1: HHSC Organizational Structure for Behavioral Health Services

OMHC consults with other State agencies, local governments and other entities to ensure there is a statewide, unified approach to the delivery of behavioral health services that allows Texans to have access to care at the right time and place. In 2016, the OMHC was responsible for development of the Statewide Behavioral Health Strategic Plan. This involved working with over 18 State agencies and programs that received dedicated behavioral health funding including:

- The Office of the Governor
- Texas Health and Human Services Commission
- Texas Department of Family and Protective Services
- Texas Civil Commitment Office
- The University of Texas Health Science Center at Tyler
- Texas Juvenile Justice Department
- Texas Education Agency
- Texas Veterans Commission
- Texas Department of Aging and Disability Services
- Texas Department of State Health Services
- Texas Department of Criminal Justice
- The University of Texas Health Science Center at Houston
- Texas Military Department
- Health Professions Council representing:
  Texas Medical Board, Texas Board of Pharmacy, Texas Board of Nursing, Texas Board of Dental Examiners, Texas Optometry Board, and Texas Board of Veterinary Medical Examiners

The HHSC CCBHC team has been a regular member of a Statewide Behavioral Health Liaison meeting, coordinated through the OMHC. This group includes State agencies, such as the Department of Family and Protective Services, and state agency programs, such as Medicaid and the Office of Acquired Brain Injury, that receive mental health and substance abuse services funding within Texas. This group serves as one of the key agency coordination points for the CCBHC project, with a majority of agencies having some form of behavioral health service provided through the Texas CCBHC centers (Centers). This group recently added a mental health forensic services coordinator to the membership, who is working to build stronger relationships for transitioning clients to communities. It is this type of relationship that has helped strengthen resources and opportunities for CCBHC coordination.

CCBHC staff have also coordinated with federal organizations including the Veterans Affairs (VA) health care system liaison for Texas. This coordination builds on an established relationship between the OMHC and Dr. Stephen Holliday, Chief Mental Health Officer for the VA healthcare systems in the Veterans Integrated Service Network 17, which serves Texas. This coordination allowed HHSC to assist Centers with identifying local liaisons for veteran services.

Finally, Texas Medicaid MCOs have been key external partners throughout the life of the planning project. MCO representatives provided consultation into CCBHC certification criteria, PPS development, encounters claiming, data management and quality. MCOs will have an ongoing role related to best practices, care coordination and data collection.

B. Certification of Clinics as CCBHCs

Development of certification criteria and certification of sites was central to Texas CCBHC planning activities. This focus included assuring that HHSC met SAMHSA project requirements that states must certify a minimum of two organizations to become CCBHC pilot sites, including at least one urban center, and one center in a rural/medically underserved designated area (MUA). Texas offers a wide range of diversity in terms of geography and population density. Based on U.S. Census 2010 data, over half of the 254 counties in Texas are considered rural, with 64 classified as frontier. A majority of Texas counties are also classified as Health Professional Shortage Areas (HPSAs) (Figure 3) or as Medically Underserved Areas (MUAs) (Figure 4), as defined by the U.S. Health Resources and Services Administration. For Medicaid managed care purposes, the state is divided into thirteen service delivery areas, and benefits are delivered through twenty contracted Medicaid MCOs (Figure 2). There are a minimum of two MCOs per service area. During the site selection process, HHSC ensured that potential CCBHCs worked closely with the MCOs in their service areas, and were representative of the diversity that Texas has to offer in terms of geography and population size, density, and composition.

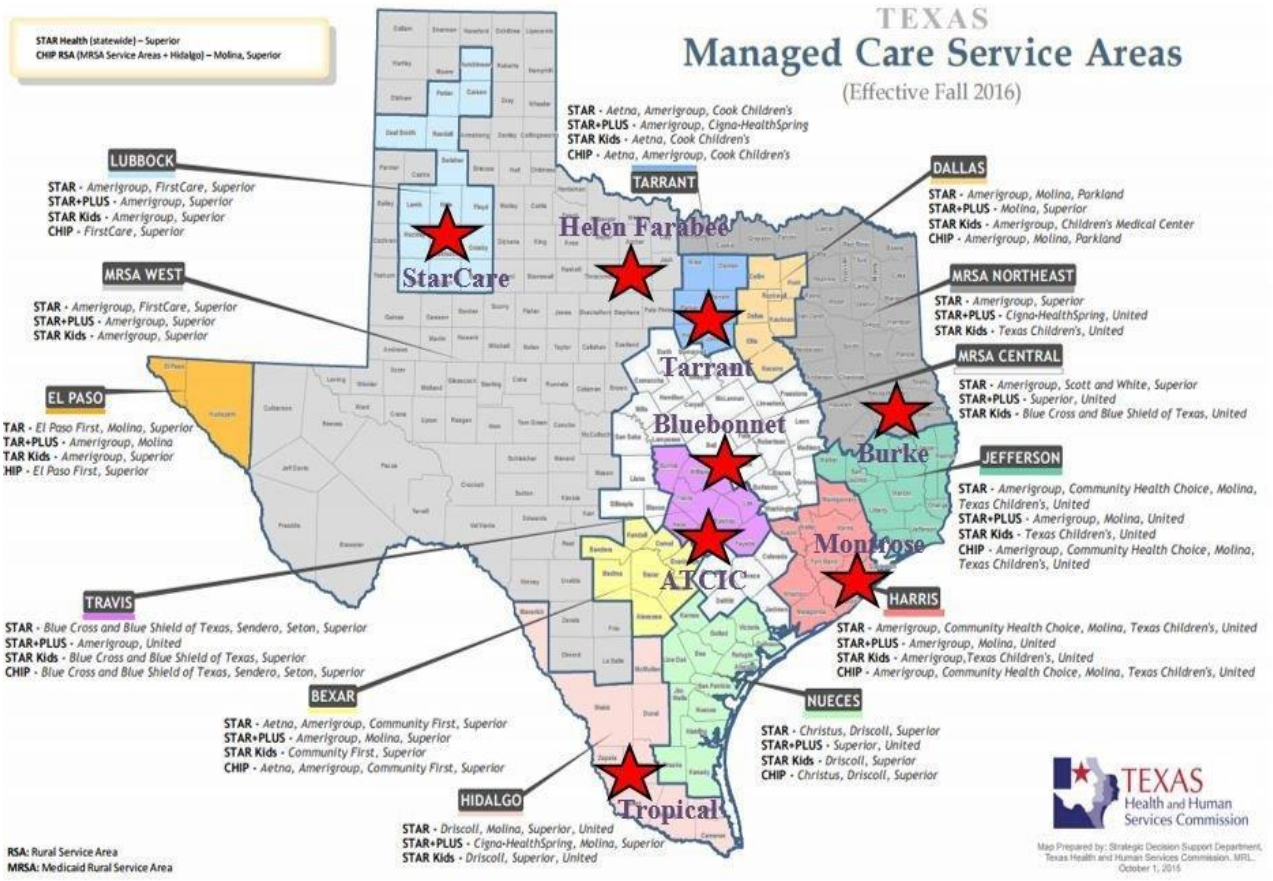

Figure 2: Texas Medicaid Managed Care Service Areas and Pilot CCBHCs[1]

In addition, the following additional SAMHSA requirements and guiding principles were adapted to the Texas process for selection of sites:

- Sites must be able to make organizational and system changes to be able to provide all required CCBHC services;
- All services for Medicaid clients must be reimbursed at the same PPS rates for each CCBHC. For Texas, this meant each MCO within a service delivery area had to participate for a potential site to be considered;
- MCO and Center participation in the project is voluntary;
- Selection of sites should support SAMHSA demonstration guidance expectations, including geographic diversity, population diversity , underserved populations, etc.; and
- Similar sites should be available to serve as control sites during the project evaluation phase.

HHSC and MCO administrative experience with sites, site self-evaluation of readiness, and executive input factored into site selection. Initial stakeholder review also encouraged the

[1] Red stars indicate Texas CCBHC pilot sit locations.

consideration of multiple sites within an area to build synergy among sites using the CCBHC practice model. Finally, understanding that attrition may occur, or sites may not be ready for certification, eight potential sites were selected to initially work towards certification.

Table 1: Medicaid Enrolled Race and Ethnicity by Service Delivery Area

	Ages 9 to 17					18 and over				
MCO service area	Anglo	African American	Hispanic	Other	None	Anglo	African American	Hispanic	Other	None
Bexar	6%	4%	40%	1%	3%	10%	4%	26%	1%	6%
Dallas	7%	14%	32%	2%	4%	10%	13%	8%	2%	7%
Harris	6%	13%	33%	2%	4%	9%	12%	11%	3%	7%
Hidalgo	1%	0%	55%	0%	2%	5%	0%	33%	0%	4%
Jefferson	18%	14%	10%	1%	5%	24%	16%	4%	1%	8%
Lubbock	12%	6%	32%	1%	3%	17%	5%	18%	1%	6%
MRSA Central	14%	11%	20%	1%	5%	20%	12%	9%	1%	7%
MRSA Northeast	20%	11%	13%	0%	5%	27%	13%	3%	0%	8%
MRSA West	14%	3%	28%	1%	3%	22%	3%	19%	1%	7%
Tarrant	13%	12%	26%	2%	5%	16%	9%	8%	2%	7%
Travis	10%	7%	35%	1%	4%	15%	7%	14%	1%	7%

Interest in Participation

Initial solicitation of interest was distributed through stakeholder groups such as the Texas Council of Community Centers, the Network of Behavioral Health Providers and Mental Health America of Greater Houston, and development of a CCBHC webpage on the HHSC website. Stakeholders were also aware of the project due to statutory language directing HHSC to apply to participate in this project, which was included in a budget rider introduced during Texas' 2015 regular legislative session.

Twenty-five centers submitted interest packets to become a CCBHC, including twenty-four LMHAs and one non-profit center providing behavioral health services. Submissions of interest came from centers located in all managed care service delivery areas (SDAs). Eighteen Medicaid MCOs indicated interest in working with HHSC on the project, however, only seventeen worked with the interested centers. This level of participation meant that eleven of thirteen SDAs were considered as pilot sites.

Site Selection and Diversity

As part of the first selection round, the twenty-five interested centers were ranked on multiple factors:

- Self-assessment of readiness or concerns about providing CCBHC services;
- Self-assessment of change management skills;

- Historical DSHS mystery caller/shopper ratings;
- DSHS contract quality ratings;
- Population and geographic diversity; and
- National accreditation by organizations such as Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Commission on Accreditation of Rehabilitation Facilities (CARF).

Based on these factors and stakeholder feedback, eleven organizations were selected for further consideration. During the second round of selection activities, executive leadership and board members of the eleven sites participated in in-person interviews with HHSC behavioral health administrative and clinical leaders. Topics of discussion included stakeholder involvement, peer and veteran services, cost reporting, and specific areas of concern identified by centers in their initial self-assessments. From this interview, sites were rated based on identified ability to foster change, center readiness and preparation for becoming a CCBHC, uniqueness the Center in terms of its served population, innovation, ability to foster change, and administrative readiness. In addition to these factors, certification reviewed the scalability of these organizations in terms of size of the population served, as well as ability to take on financial risk. The eight locations (referred to as CCBHCs or Centers) identified for certification readiness activities are described below.

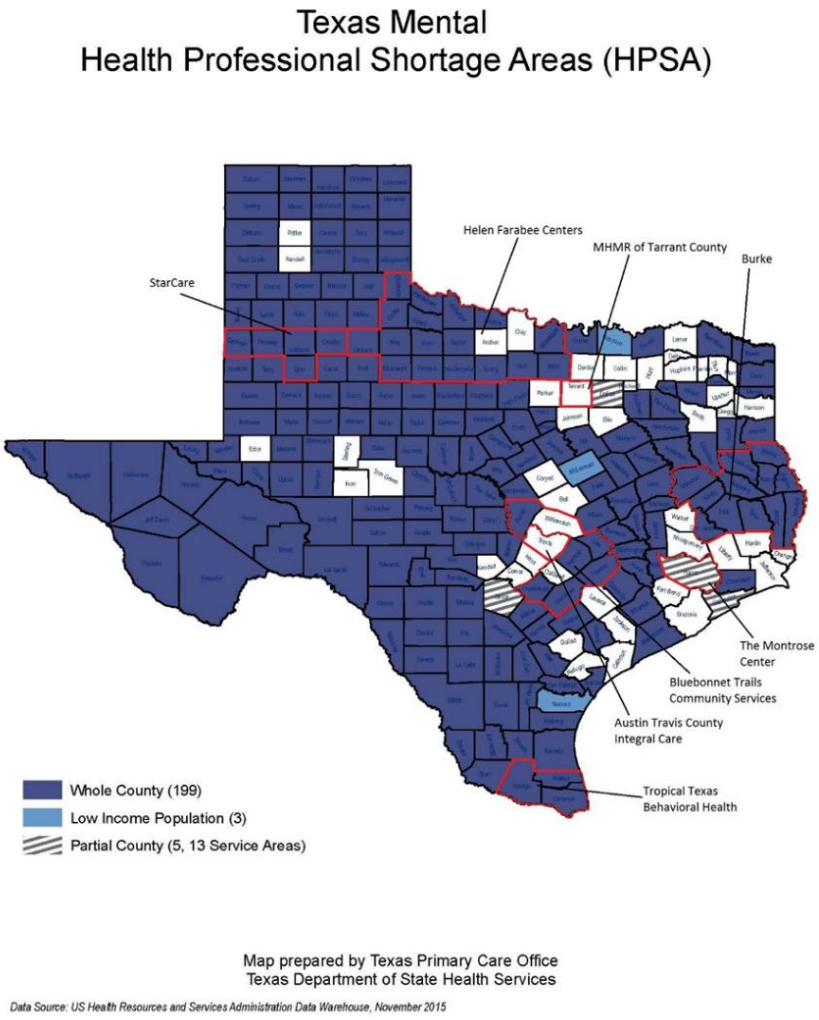

Figure 3: Texas Mental Health Professional Shortage Areas

Austin Travis County Integral Care

Austin Travis County Integral Care (ATCIC) is the largest community based behavioral health provider in Travis County. ATCIC works with six MCOs to provide services to a predominantly urban population of 1.2 million residents living within 1000 square miles. Through JCAHO accreditation, ATCIC has evolved into an integrated health model and is able to provide services

through its own service locations and co-locations with primary care partners and schools across the service delivery area.

Bluebonnet Trails Community Services

Bluebonnet Trails serves eight counties in Central Texas which represent a mix of urban and rural populations surrounding the fast-growing Austin and San Antonio metropolitan areas. Of the eight counties, four are designated as rural and as health professional shortage areas. Bluebonnet serves a geographic area of 6,904 square miles, and has a population density of 130 individuals per square mile across the service delivery area. As one of the larger Centers, Bluebonnet Trails partners with ten Medicaid MCOs to serve parts of three service areas.

Burke

Burke primarily operates in East Texas, providing services for approximately 400 thousand individuals across a twelve county rural area that spans over 10 thousand square miles. All of the counties within Burke's service delivery area are federally designated as health professional shortage areas for mental health. The center has unique operations in place that include using telemedicine to expand access to care across its region. In addition, Burke is the only CCBHC pilot site in Texas with a Native American tribe within its service delivery area. Burke works with seven MCOs and has held JCAHO accreditation since 1980.

Helen Farabee Centers

Of the selected sites, Helen Farabee serves the largest geographic area - covering 16,655 square miles across nineteen counties in north Texas, ten of which have frontier designations. Helen Farabee Centers serve seventeen counties federally designated as HPSAs for mental health and ten counties which have an MUA designation. To address issues arising from distance between centers and lack of health professionals, Helen Farabee has a vast network of telehealth and telemedicine services to meet the needs of their consumers who may reside in counties with population densities as low as two individuals per square mile. The Center works with seven Medicaid MCOs to cover parts of three service delivery areas in the northern and western regions of the state.

The Montrose Center

As an urban center, the Montrose Center is a nonprofit organization that primarily serves the LGBT and HIV positive populations of Harris County and the surrounding areas. In conjunction with LMHAs and community centers in the area, Montrose helps provide services for the diverse population of Harris County, which encompasses approximately 4.1 million individuals over 1,730 square miles. Since the Montrose Center is not an LMHA, the Center is not assigned to a specific service delivery area, but works with eight MCOs to deliver services and provide behavioral health resources for approximately five thousand individuals each year.

StarCare Specialty Health System

StarCare Specialty Health System (StarCare) is another center located in West Texas which works with four Medicaid MCOs to provide services to approximately 317,000 individuals across five counties comprised of 4,375 square miles. Two of the counties within StarCare's

service delivery area are designated as rural, and all of them are federally designated as HPSAs. StarCare addresses this professional shortage by identifying opportunities to use telehealth and telemedicine services, and works closely with higher education institutions in the area to help address health professional shortages and better serve the community.

MHMR of Tarrant County

Serving individuals residing in Tarrant County and the surrounding area, MHMR of Tarrant County serves as one of the largest urban centers selected as a pilot site for the demonstration. Covering over 860 square miles, MHMR Tarrant works with four Medicaid MCOs to provide services for a population of approximately 1.8 million individuals. As one of the oldest centers in Texas, Tarrant has the largest network of locations and services available to Tarrant County residents.

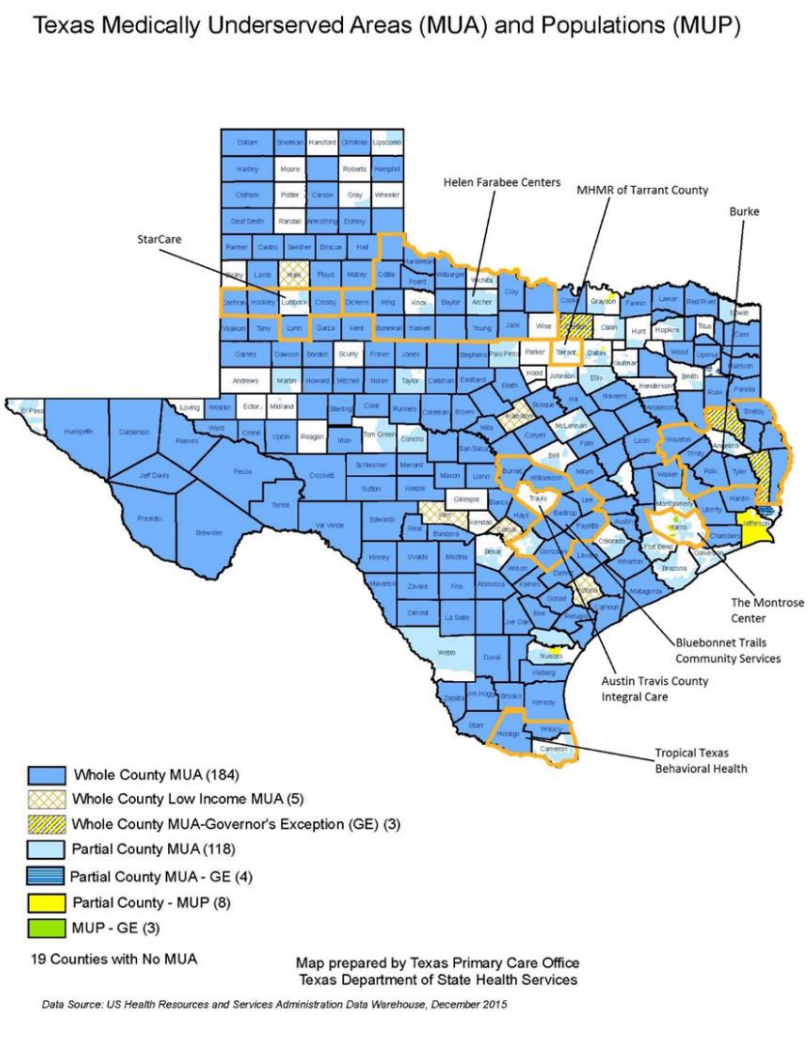

Figure 4: Texas Medically Underserved Areas and Populations

Tropical Texas Behavioral Health

In terms of volume, Tropical Texas serves the highest number of potential CCBHC consumers as the LMHA for the South Texas region. Spanning across 3,100 square miles along the Gulf Coast and South Texas border, Tropical Texas works with five Medicaid MCOs to provide services for approximately 1.2 million residents across the three counties. Based on their location and proximity to the US-Mexico border, Tropical Texas presents unique opportunities in working across culturally diverse populations.

Site Certification Processes

Four key documents were developed in order to support the demonstration pilot site certification process for the Texas CCBHC project. These documents aligned with the attached *State's*

Compliance with CCBHC Criteria Checklist (Attachment A of this document). Stakeholder input was used to refine each instructional tool. They included:

1. Certification Criteria Overview and Clarification Guide

The Certification Criteria Overview and Clarification Guide outlines State expectations for pilot CCBHC Centers. As part of the pilot certification and demonstration processes, this guide was created to support and direct certification of the integrated CCBHC model based on emerging priorities from needs assessments and lessons learned during pre-certification activities. While most of the SAMHSA CCBHC criteria are well defined, there are several areas that have been designed to provide states with flexibility in determining criteria for CCBHCs. This guide provides clarification for those criteria, and will continue to provide guidance throughout the project.

2. CCBHC Demonstration Pilot Reviewer Checklist

The Demonstration Pilot Reviewer Checklist was designed to support the certification of pilot sites, and ultimate completion of the Texas demonstration application. It is based on the SAMHSA demonstration application checklist, and reflects areas of implementation readiness. The Reviewer Checklist also includes clarifying questions that may be asked, as well as examples of documents that certification reviewers may examine during the certification visit.

3. CCBHC Demonstration Pilot Assessment

The Demonstration Pilot Assessment form synthesizes the overall rating for each certification element, and provides feedback on observations, operational plans, technical assistance needs, and other gaps.

4. CCBHC Demonstration Pilot Certification Crosswalk

In addition to meeting CCBHC standards, potential CCBHCs currently have a variety of State licensure requirements they must meet. In addition, many have also undergone the rigorous process of receiving national certification from organizations such as JCAHO and CARF. These certifications mean that these organizations have been recognized for operating at a high level of organizational efficiency and quality as outlined by those accrediting bodies. The CCBHC certification designation means that the Centers in this pilot have committed to operating at a level of integration and quality that promotes the best mental health and substance use treatment and recovery opportunities for individuals with mental health and substance use service needs and co-occurring physical health conditions.

The Pilot Certification Crosswalk provides a side-by-side comparison of SAMHSA CCBHC criteria, Texas mental health and substance use services rules and regulatory requirements, CARF standards and JCAHO standards. In all cases, when the CCBHC criteria are less stringent, an organization should meet the more stringent requirements in order to maintain licensure or other certification. Unless otherwise clarified in this guide, if CCBHC certification criteria are more stringent, the CCBHC criteria should be followed.

The Pilot Certification Crosswalk was designed to provide Centers with an opportunity to compare certification standards and assure they are following the more stringent standard. It is not designed to be used as a deeming tool in order to bypass a review of CCBHC criteria during

the pilot process. Utilization of lessons learned and criteria adjustment after the demonstration pilot may be used to identify potential deeming criteria in the future.

Certification Scoring

The Review Checklist utilizes a four point scale based on the SAMHSA demonstration application rating scale. SAMHSA directed states to identify how the rating scale will be operationalized. The Texas approach to operationalizing the scale consists of the following rating interpretations:

Rating Level 1 -Ready to Implement

This rating means that the CCBHC has this component operational, and no gaps or outstanding issues were identified during the certification visit.

Rating Level 2 - Mostly Ready to Implement

This rating has two potential meanings:

a. The CCBHC has this component currently operational, and has identified additional changes or technical assistance needed to bring it up to CCBHC criteria standards, or;
b. The CCBHC has not implemented this component, but has a clear operational plan to achieve implementation by the demonstration start date(e.g. identified staffing levels may not be reached until the CCBHC begins ramp up of operations prior to demonstration).

Rating Level 3 - Ready to Implement with Remediation

This rating has two potential meanings:

a. The CCBHC has this component currently operational, but needs to develop a plan to address additional changes or technical assistance needs that were identified during the certification visit in order to meet standards, or;
b. The CCBHC has not implemented this component, has a clear operational plan to achieve implementation by the demonstration start (e.g. identified staffing levels may not be reached until the CCBHC begins ramp up of operations prior to demonstration), yet additional required changes to the plan were identified during the certification process.

Rating Level 4 - Unready to Implement

This rating means that the CCBHC does not have this component operational, and either does not have a plan in place related to this particular component or the plan would not be able to be accomplished prior to the demonstration start date.

Technical Assistance and Site Readiness

To support Centers as they prepared for CCBHC certification, HHSC used a combination of webinars, face-to-face meetings with all the Centers, one-on-one site visits, and desk audits. Through these activities group and individual Center challenges to the implementation of the CCBHC model were identified. Needed changes were identified on several levels for both the State and for potential CCBHCs. Examples of some of the changes fostered with the Centers included addressing:

- *Organizational culture* – While many of the sites offered both mental health and substance abuse treatment services, these services reflected a silo mentality reinforced through State regulations that separated services and service providers. Cross-training of staff, re-envisioning of client flow, changes in how services are discussed and marketed were all strategies discussed during technical assistance calls and pre-certification visits. In addition, changes at the state level to sustain this culture change have been explored.

- *Operational policies* – A common theme across Centers was the need to have policies align with organizational practices. Policy updates, new practices and procedures were rolled out through training or as new staff were brought on board, but in many cases were never institutionalized in policy. This caused inconsistency across policy and program areas. Revision of policies was a key change in movement towards CCBHC certification for all sites. Some sites used this as an opportunity to completely re-envision the purpose, flow and audiences for their policies, rebuilding them to reflect the entire client life cycle from intake through discharge.

- *Operational procedures* – Development of the PPS led to a major accounting change for many of the Centers. One key area where a change was identified was related to tracking and management of costs. Most centers tracked cost based on what a payer reimbursed, rather than addressing the actual cost of providing a service. Moving to an all-payer cost reporting format allowed centers to better examine the cost of care, and to begin comparing themselves to others in the market.

Throughout the technical assistance (TA) and certification process, sites were given the opportunity to develop operational plans, or to update plans, in order to move a rating to a higher readiness level. Any center with an outstanding rating of 4 for any single criteria at the time of application development was not eligible to participate as a pilot CCBHC. In addition, all Centers had to have at least 80 percent of ratings at a level 1 or 2 in order to be eligible to participate as a pilot CCBHC.

Needs Assessment

As discussed in Section A of this narrative, during the CCBHC development process, HHSC conducted two needs assessments to inform strategic priorities – 1) a focused survey based on four areas related to prevention and early intervention, optimal service delivery, use of statewide data, and financial alignment, and 2) a statewide SWOT analysis of the Texas behavioral health system. Results of these surveys showed that Texas was already well on the way to alignment

with CCBHC priorities. Additionally, the responses also identified areas of focus in development of criteria and standards, as well as needs for workforce development.

Statewide survey responses indicated key priorities for stakeholders, including:

- Ensuring all services are trauma-informed;
- Eliminating stigma;
- Strengthening screening programs;
- Ensuring prompt access to quality behavioral health services;
- Improving quality of behavioral health services; and,
- Reducing utilization of high cost alternatives such as institutional care, criminal justice incarceration, inpatient stays, and foster care.

Texas CCBHC criteria was designed to include a strong focus on trauma-informed care, improving screening and evaluation tools, and reducing wait times for behavioral health services. This aligns the CCBHC project with the Texas goal of ensuring that consumers receive the right service at the right time.

The SWOT analysis identified further alignments and opportunities to refine the Texas CCBHC priorities. The top three responses to each of the four SWOT categories were:

Strengths

1. Availability of peer services
2. Diverse array of available services; increased services available
3. Availability of crisis response teams

Weaknesses

1. Limited available services
2. Shortage of psychiatrists, clinical staff, and behavioral health providers and lack of substance use treatment
3. Minimal coordination between providers; lack of follow-through, organization, and attention to effective outcomes

Opportunities

1. Expand telemedicine/telehealth
2. Increase stakeholder involvement and front line staff input
3. Expand existing services

Threats

1. Lack of appropriate and adequate funding
2. Sustainability of innovative and grant-funded programs
3. High cost of services; lack of insurance; claims and reimbursement issues

Overall, the Texas experience with needs assessment responses echoed many of SAMHSA's CCBHC priorities related to providing services to all who seek help, using methodologies that maximize opportunities for recovery, and improved data collection and evaluation processes.

These results served to guide statewide priorities in CCBHC development, while the needs assessments conducted by Centers informed local changes related to hours, locations, and specific services.

Selection of Evidence Based Practices

One area of CCBHC project planning influence through the needs assessment process was the development of minimum standards for evidence based practices (EBPs). Selection of evidence based practices was based on three factors –

- Developing a set of minimum standards for evidence based practices statewide which were reflective of the statewide needs assessments;
- Developing a set of minimum standards that allowed flexibility at a CCBHC; and
- Selecting standards supported through other Texas initiatives.

Statewide survey and SWOT results highlighted the need to have trauma-informed care, and this carried into selection of EBPs. In addition, recommendations included focusing on practices which are outcome oriented, reduce stigma, reduce or help prevent inpatient stays, and encourage self-direction. These priorities are reflected in the EBPs outlined in the *Texas CCBHC Minimum EBPs* document attached to this application.

Acknowledging the diversity of clients across the State and across Centers was a priority in the selection of a minimum EBP set. Sites provided feedback regarding the proposed list, how the EBPs would work with the identified needs of their clients, and proposed alternative EBPs. This exchange strengthened the overall approach to focusing outcomes, and resulted in the specification of qualifications concerning implementation requirements. For example, if a site determines that an EBP is not applicable, relevant or meaningful to a client population, an alternative EBP may be proposed to a CCBHC clinical/best practices team comprised of State, MCO and CCBHC Center subject matter experts. In addition, if a site feels it would be difficult to maintain fidelity to an EBP because of the population served or potential infrequency of providing that intervention, a plan for addressing client needs through other community partnerships was required.

Finally, through collaboration with other state agencies, as outlined in Section A of this narrative, common requirements for data, evaluation and other practices were identified. The HHSC goal of project sustainability meant practices already required through other agencies and funding sources needed to be acknowledged to maximize efficiency of care, and minimize additional burdens related to CCBHC development. This type of focus also aligned with two key SWOT areas related to coordination and sustainability.

Organizational Governance

Meaningful participation by consumers, persons in recovery, and family members is a core component of the CCBHC model. This is reflected in care coordination and service delivery

standards emphasizing person and family-centered care, participation in care, choice in care, and inclusion of others in care decisions. This is also reflected in standards related to organizational governance structures. All sites already had robust governance structures which included individuals with lived experience, either through majority board representation or through special advisory committees that are 100 percent consumer and family driven. The seven LMHAs that are CCBHC pilot sites engage local planning and network advisory committees (PNAC) made up of local consumers who provide input into initiatives and organizational changes. Rural Centers have multiple PNACs that they work with because of the large geographic areas they cover and the acknowledgement that needs may differ across those geographic areas.

Additional requirements related to stakeholder input were added to continuous quality improvement (CQI) guidelines. CCBHCs must build consumer participation into the CQI process, not only as resources for surveys, but also include those consumers in a meaningful way as remediation strategies are developed.

C. Development of Enhanced Data Collection and Reporting Capacity

Statewide Data Collection and Reporting Framework

Data driven decision-making is critical to any quality improvement process. HHSC has a well-established data-driven quality improvement process for MCOs. Through the CCBHC demonstration, HHSC will leverage this framework in partnership with MCOs and CCHBCs. The basic process, as adapted for the purposes of this grant, is outlined in Figure 5.

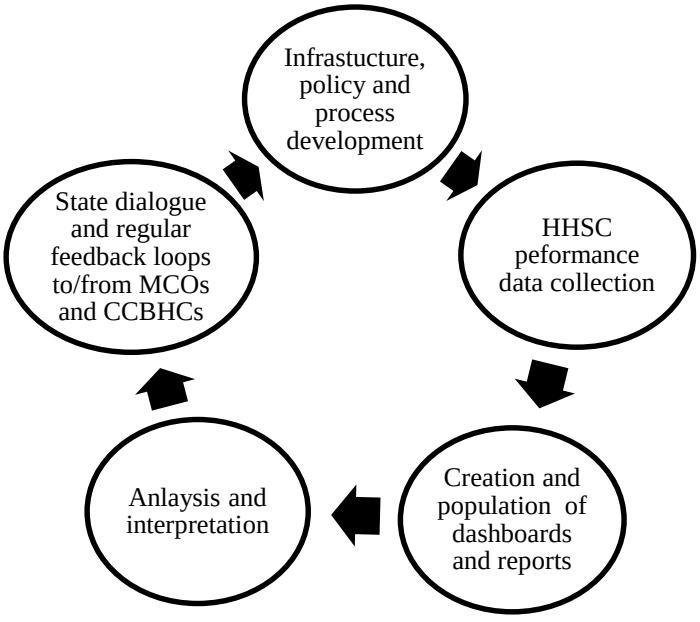

Figure 5: HHSC Data Collection and Reporting Framework

HHSC uses a variety of methods to collect performance data, including Medicaid claims and encounter data, regular quality meetings/calls with MCOs, family and consumer surveys, and targeted activities conducted through the Texas External Quality Review Organization (EQRO) the University of Florida Institute for Child Health Policy (ICHP). Rather than duplicate data collection processes, or enhance systems solely for one project, the HHSC focus has been to enhance access to and sharing of data in order to improve reporting and outcomes while protecting patient privacy. This is an ongoing effort as the State monitors recent federal efforts related to proposed data sharing restrictions in association with 42 CFR Part 2. Currently, HHSC is leading a statewide effort looking at behavioral health measures, examining streamlined data collection, alignment of measurement standards, and use of data. This effort is an ongoing extension of OMHC projects such as the Strategic Plan implementation process and Cross Agency Liaison workgroup, and includes CCBHC participation.

Through planning activities, HHSC is working with the EQRO in development of custom dashboards for this project to organize relevant data in order to monitor progress (or lack thereof), to create a data driven "culture" for tracking progress, to identify problems/barriers and to initiate course corrections as needed. Within this framework and these tools, and through an active process of collaboration, all parties will have common access and understanding with respect to performance and achievement of goals. For instance, requiring a CCBHC to respond to quality measures that they are unable to see on an aggregate basis, or in relation to factors outside of their control does not promote quality outcomes. The demonstration will focus efforts on effectively and efficiently utilizing data to identify client and organizational level adjustments needed to improve outcomes.

The key data and quality expectations outlined in Criteria Program Requirement 5: Quality and Other Reporting, including costs, will be monitored by CCBHC staff as part of the project management process, and collected through project management activities. These activities will include project calls with MCOs, HHSC project meetings, quarterly advisory committee meetings, and CCBHC conference calls. Ad hoc calls to address outlier issues, cases conferences, and other tools will be used as well.

In addition, HHSC just completed a third-party review of HHSC behavioral health data systems, evaluation measures, and approaches to tracking outcomes.

Preparation of CCBHCs for Data Collection and Quality

The Texas project team is working with each of the Centers to assure their data systems collect all the required measures. Several Centers are currently changing electronic health record (EHR) and data systems to maximize ability to monitor quality measures and maintain continuous quality improvement activities. The development of these systems is being timed in order to allow for review of draft specifications related to outcome measures. State and site data experts participated in the series of SAMHSA webinars related to data collection and evaluation. Sites have also worked with community partners and designated collaborating organizations (DCOs) to develop data exchanges to assure that all client record, encounter and quality measure data is centrally collected.

As part of the face-to-face meetings with sites during pre-certification, HHSC subject matter experts were brought in to discuss meaningful use grant funding for EHR and health information exchanges (HIEs), as well as a centralized Medicaid database that can allow for more meaningful care coordination. The Medicaid Eligibility and Health Information Services (MEHIS) System allows a provider to view previous health events, including diagnosis and treatment, prescription drug information, and lab information for Medicaid clients they are treating, allowing for better coordination and less duplication of care.

While CCBHC standards outline that community needs assessments should be conducted every three years, the desire to use this methodology to collect frequent stakeholder input, especially from those with lived experience, often means this group is over-surveyed. This may mean certain sites appear unresponsive to the community since changes have not been implemented before the next survey. As part of CCBHC planning, the State developed a base needs assessment for all CCBHCs, but with the understanding that questions are rotated through locally driven needs assessments, as well as through other approaches such as focus groups and community discussions in order to focus on different issues on a cycled basis. CCBHCs are expected to augment these assessments with EHR data.

Data Reporting and Timelines

Current capacity, enhanced EHR systems at the CCBHC level, and ongoing quality monitoring will allow Texas to meet all project data timelines. Data will be available to national evaluators in multiple formats as outlined in Table 2.

Reporting of all measures will meet timelines outlined by SAMHSA and in coordination with the evaluation team. Data for one of the State reporting measures will be supplied to HHSC from the Centers. Currently, Centers collect housing status as required by various other funding sources, many of which define housing status in a different manner than SAMHSA has specified for the CCBHC project. After consultation with the SAMHSA data and evaluation team, Texas developed a housing status crosswalk. Sites will submit housing data according to their current collection methodology, and the HHSC CCBHC project team will crosswalk the data to the SAMHSA reporting template. The crosswalk methodology will be included in the data reporting template.

Table 2: Texas CCBHC Reporting Formats and Timing

Measure	Source	Format	Timing
I-EVAL	CCBHC EHR	Demonstration 223 Reporting Template	Provided to State by the CCBHC 120 days after the end of the reporting period; available to evaluators within six months of the end of the reporting period.
BMI-SF			
WCC-BH			
TSC			
ASC			
SRA-BH-C			
SRA-A			
CDF-BH			
DEP-REM-12			
HOU	CCBHC Intake Assessments	Demonstration 223 Reporting Template	Provided to State by the CCBHC 120 days after the end of the reporting period; State populates the template using a cross-walk from State measure format; available to evaluators within six months of the end of the reporting period.
PEC	HHSC Strategic Decision Support MHSIP Survey Data	Site level data and Demonstration 223 Reporting Template	Available within 120 days of the reporting period.
YFEC			
FUM	EQRO Encounters Data	Demonstration 223 Reporting Template	Available within 6 months of the reporting period.
FUA			
PCR-BH			
SSD			
SAA-BH			
FUH-BH-A			
FUH-BH-C			
ADD-BH			
AMM-BT			
IET-BH			
Cost Reports	CCBHC Financial Reports	CMS Cost Template	Provided to the State within 6 months of the end of the demonstration period.

D. Participation in the National Evaluation

Texas is looking forward to the opportunity to participate in this exciting initiative. Due to the large Medicaid population and high numbers of enrollees with behavioral health needs, and with the recent inclusion of behavioral health services into an MCO model, Texas is now well-positioned to take full advantage of this opportunity in partnership with MCOs, the pilot CCBHCs, LMHAs, community partners, SAMHSA and the Centers for Medicare and Medicaid Services (CMS). During a SAMHSA sponsored webinar during the planning phase, this

program was referred to as a "*game changer*." Texas sees this as a game changing opportunity to develop meaningful processes and pilot a payment reform approach that moves behavioral health towards value-based payment strategies. As national trends support integrated care models, Texas views this as an approach to ultimately deliver efficient, effective care that promotes individual resilience and recovery.

Capacity to Assist HHS with the National Evaluation

As noted in Section C of this application, HHSC has robust data collection and analytics capability, and will utilizing a variety of methods to collect the performance and reporting data outlined by SAMHSA for the national evaluation.

- The Texas EQRO provides HHSC data on quality of care and health plan performance.
- The Texas Medicaid data warehouse allows HHSC to access encounter and claims data.
- HHSC's Strategic Decision Support Unit performs annual Mental Health Statistics Improvement Program (MHSIP) Surveys for consumers and families.

In addition, there are numerous HHSC initiatives that collect data related to quality and outcomes for specific purposes including:

- HHSC's MCO pay for Quality project
- Texas Medicaid's 1115 Delivery System Reform Incentive Payment (DSRIP) projects
- The Texas System of Care initiative

One of the unique challenges posed by a robust data collection network encompassing numerous initiatives is managing the timing and immediacy of data reports in order to make useful program decisions. The relatively short timeframes of both the planning and demonstration periods will make data management a potential challenge. HHSC is addressing this potential issue by centralizing project management in the OMHC. This will allow HHSC to pull the data from these disparate reporting areas into one central clearinghouse. In addition, HHSC and OMHC have partnerships with a variety of educational, research and advocacy organizations, such as the Meadows Mental Health Policy Institute (MMHPI), Texas Council of Community Centers, and the Hogg Foundation for Mental Health, to augment internal data collection and analysis.

As noted by SAMHSA in both the CCBHC program announcement and during national data technical assistance calls, the national evaluator may also have additional collection elements not listed in the announcement. If selected to participate in the demonstration, HHSC will identify any potential issues with the additional elements. At that time, HHSC would review existing data sources and work with the national evaluator to ensure that all elements are in place.

While not major challenges, the State identified two additional considerations. First, because of the variety of behavioral health initiatives HHSC is conducting, determining if a change is related to the CCBHC process may not always be precise. Second, differences between certified and control sites may begin to shrink as a result of control sites continuing to conduct assessment and readiness activities and/or their participation in DSRIP or other activities designed to

improve coordination. Texas looks forward to collaboration with the SAMHSA evaluation team to look at ways to attribute changes to the CCBHC model.

Finally, as Texas looks for opportunities to expand and sustain the CCBHC model after the demonstration period it will work with the national evaluation team to look at cost offsets. Impacts to inpatient, emergency room and crisis service costs will be important to this discussion.

Discussions with the National Evaluation Team Regarding Comparison Sites

SAMHSA has indicated that control sites will be selected by the national evaluation team. Availability of comparable sites was considered when Texas was selecting pilot sites. As the national evaluation team looks at comparison sites, the Texas CCBHC team will be available to provide resources including claims, encounter and demographic data to suggest urban and rural comparison groups of Medicaid enrollees that are receiving community-based mental health services from non-CCBHC providers. Texas will employ existing resources and partnerships to analyze data and establish the comparison group. These include HHSC's decision support staff, the Medicaid data warehouse, the State's Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW), and the EQRO.

Comparison groups could initially be selected based on geographic and demographic similarity. Criteria used for site selection could also be used for selection of the control locations including access to the populations of focus, a significant enough client base to allow for meaningful data collection, and willingness to participate in any needed data collection activities throughout the life of the project.

Institutional Review Board Requirements

CCBHC project staff consulted with the DSHS Institutional Review Board (IRB) regarding the data and evaluation requirements during the planning phase. It was determined by the IRB program coordinator that IRB approval was not needed for the CCBHC project. If requirements for data collection or sharing change during the demonstration program, CCBHC program staff will coordinate an additional IRB review of updates.

E. Projection of the Impact of the State's Participation in the Demonstration Program

Over the past decade, behavioral health services in Texas have evolved and transformed. The most recent component of this evolution was the development of a five-year statewide behavioral health strategic plan. Central to this plan is the vision of allowing all Texans to have access to the right care at the right time and place. This includes providing coordinated, person and family centered services and supports. These services are trauma-informed, culturally and linguistically sensitive, and flexible. These priorities are mirrored in the CCBHC design.

In Texas Medicaid, behavioral health services are primarily financed within a capitated, risk based MCO model. Care is often delivered in siloes by different providers. Reimbursement approaches, which are largely based in a per-unit of care basis, do not foster coordination of care. HHSC sees the CCBHC model as a unique opportunity to catalyze changes in these

underlying dynamics, improve health outcomes of individuals and ultimately reduce costs that are the result of uncoordinated care.

Each phase of the CCBHC project offers opportunities to refine operational knowledge, best practices, payment strategies and coordination of services. During the planning period, Texas was able to assess the scope of changes required at a local and state level to move to a new paradigm for behavioral health services. In particular, the CCBHC model addresses 15 gaps in services identified during the development of the State's behavioral health strategic plan.

- Gap 1: Access to Appropriate Behavioral Health Services
- Gap 2: Behavioral Health Needs of Public School Students
- Gap 3: Coordination across State Agencies
- Gap 4: Veteran and Military Service Members Supports
- Gap 5: Continuity of Care for Individuals Exiting County and Local Jails
- Gap 6: Access to Timely Treatment Services
- Gap 7: Implementation of Evidence-based Practices
- Gap 8: Use of Peer Services
- Gap 9: Behavioral Health Services for Individuals with Intellectual Disabilities
- Gap 10: Consumer Transportation and Access to Treatment
- Gap 11: Prevention and Early Intervention Services
- Gap 12: Access to Housing
- Gap 13: Behavioral Health Workforce Shortage
- Gap 14: Service for Special Populations
- Gap 15: Shared and Usable Data

Implementation and evaluation of the two-year demonstration provides an opportunity to use CCBHCs to impact these statewide gaps at a local level.

Selection of Project Goals

In addition to project alignment with Texas strategic goals, SAMHSA has proposed four goals for the CCBHC initiative:

> **Goal 1.** Provide the most complete scope of services required in the CCBHC criteria to individuals who are eligible for medical assistance under the State Medicaid program;
> **Goal 2.** Improve availability of, access to, and participation in, services described in subsection (a) (2) (D) to individuals eligible for medical assistance under the State Medicaid program;
> **Goal 3.** Improve availability of, access to, and participation in assisted outpatient mental health treatment in the State;
> **Goal 4.** Demonstrate the potential to expand available mental health services in a demonstration area and increase quality of such services without increasing net federal spending.

Each goal was independently evaluated in relation to statewide needs assessments, the strategic plan direction, the Medicaid behavioral health state plan, and in collaboration with the selected sites. Consideration was also given to coordination and efficiencies that can be gained through partnership with other statewide behavioral health initiatives. Within that context, the project team selected Goal 2 as the most meaningful for the CCBHC evaluation.

- Goal 2 resonates with key statewide gaps, needs assessment and SWOT findings. Statewide assessment findings highlighted the need to ensure prompt access to care, quality of services, improved coordination of services, and focus on outcomes.

- Goal 2 supports the Texas statewide behavioral health strategic plan. The vision of "the right service at the right time and place" speaks to improving availability, access and participation.

- Goal 2 supports the current Texas Medicaid State Plan and service goals. Rather than expanding services, Texas Medicaid is working to assure that individuals are fully accessing services available to them, such as substance abuse treatment.

- Goal 2 supports current State initiatives for behavioral health services. HHSC is part of several CMS learning collaborative projects including one related to management of high utilizers, and one related to participation substance abuse services. In addition, the CCBHC model aligns with several Medicaid 1115 waiver program initiatives designed to improve accessibility, and offers a model for integration of the approach into managed care.

While Goal 1 and Goal 2 are similar in many ways, HHSC determined that Goal 2 is more appropriate for the current level of behavioral health service integration. As sites gain more experience with the model, Goal 1 may become appropriate for future projects. HHSC interpreted Goal 3 as a more narrowed goal, and Texas feels that the community connections built through the CCBHC model between Centers and jails supports this direction within the larger approach of Goal 2. Finally, with the primary HHSC focus on improving access and participation, Goal 4 was not selected. To achieve Goal 2, the Texas strategy for success will focus on building capacity of targeted clinics in select MCO service areas to provide effective, evidence based integrated healthcare.

Selection of Measures to Show Population Impact

Of the almost 27 million Texans, it is estimated that there are approximately 19.8 million adults age 18 or older, and 7.1 million children 17 or younger. 1 in 7 Texans, or approximately 4 million, rely on Medicaid for health coverage. In 2016, Texas budgeted over $6.7 billion (all funds) towards behavioral health services. Texas Medicaid expenditures represented $3.1 billion, or 46 percent, of all behavioral health spending. Despite increased focus and funding, the estimated prevalence of individuals needing mental health or substance use disorder services (Figure 6) outpaces resources - not just from funding, but also in terms of qualified behavioral health professionals. The ability of a successful CCBHC program to impact quality and cost associated with Medicaid behavioral health spending is significant. The eight CCBHCs in Texas

will serve as community level microcosms of the intervention; the lessons learned will be important as Texas looks toward sustainability and expansion post-demonstration. State developed evaluation measures, coupled with the SAMHSA project and quality measures, will provide essential insight into the potential impact of the initiative.

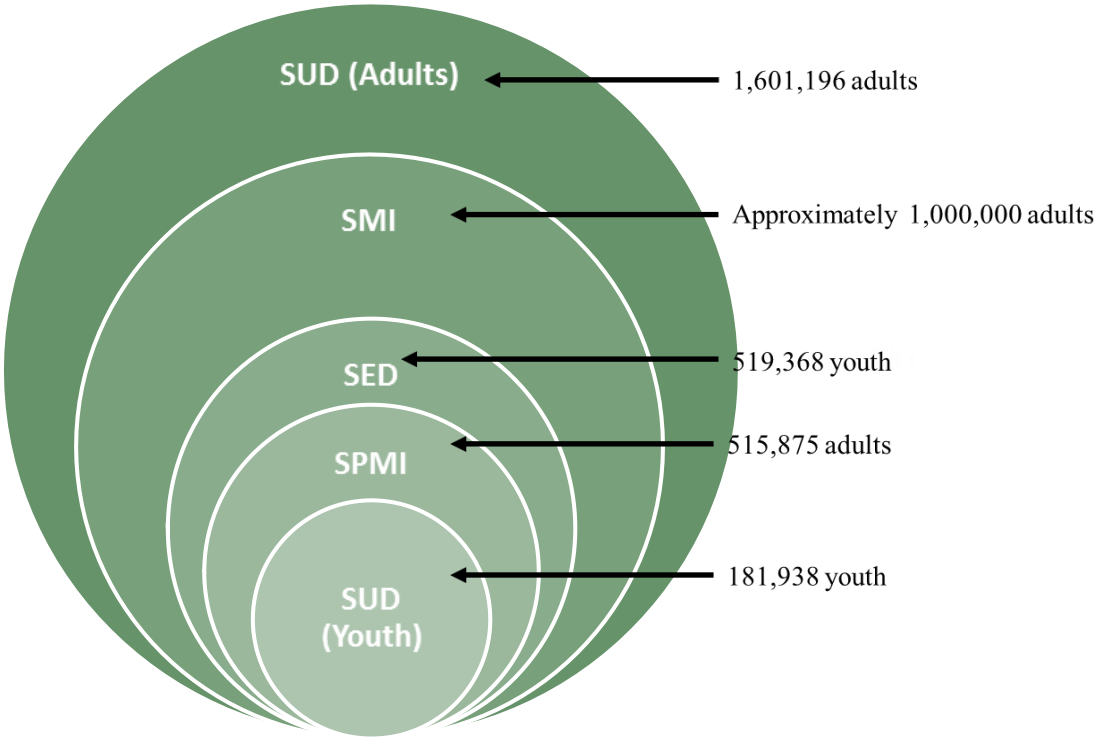

Figure 6: Estimated Prevalence for Texas Populations by Behavioral Health Condition, Fiscal Year 2014

As the CCBHC project will take advantage of other HHSC initiatives designed to expand integration, capacity, access and availability of MH and substance use disorder (SUD) services, established measures related to those initiatives were considered for potential CCBHC measures. Measures related to access, availability, and participation were considered for the project. These measures look at cost, services, and appropriate use of services.

- Number of individuals awaiting access to SUD services – monitored by the Behavioral Health services unit, this will be a key indicator that HHSC expects to see impacted as CCBHCs begin implementing services, especially in areas where substance abuse treatment is being added or expanded to include all ages.

- Number of individuals with an appropriate SUD or dual mental health/substance use diagnosis – current projects such as the CMS high intensity learning collaborative innovation accelerator program (IAP) SUD project, Texas Medicaid's initiative to increase substance abuse treatment, and development of PPS rates all highlight that SUD incidence is under-reported.

- Potentially Preventable ER Visits, Admissions and Re-Admissions – already an HHSC quality focus for MCO value-based payments, this measure looks not only at engagement and care-coordination at a CCBHC level, but also looks at potential cost avoidance.

- Number of monthly visits – this measure directly reflects engagement and coordination

- Other measures under consideration include:
    - Number of high utilizers – aligning with the CMS high intensity learning collaborative IAP, and an HHSC priority, engagement and care coordination has the potential to specifically impact this population;
    - Unduplicated number of clients served;
    - Unduplicated count of client services in the ER;
    - Proximity of services (i.e. SUD and MH services, a BH and medical service) to track an increase in coordination; and,
    - Number of non-crisis related PPS-eligible services provided.

In addition, outcome goals and measures have been established for each of the statewide behavioral health strategic plan gaps. Impact on these gaps will also be considered.

Baseline Data for Project Measures

Baselines for some key measures were readily available through current projects, through EQRO review of encounters data, or through development of the PPS. The EQRO was also able to establish baselines for SAMHSA defined State quality measures. Additional baselines were dependent on completion of site certification and will be established prior to the demonstration period.

The baselines related to access to SUD services (Table 3) was established at a State level since several of the sites are adding or expanding their SUD service offerings. Tracking this measure will be important to HHSC as SUD services increase to track impact in either growth or decrease of both wait lists and days awaiting services. Tracking appropriate SUD diagnosis (Table 4) was established at a Center level based on historical claims data. This will be an important measure for the State to track in tandem with the SUD wait list measures. Increase in SUD diagnosis, with no growth to wait lists will be one measure of success in providing timely service.

Table 3: Number of Individuals Awaiting Access to SUD Services, Third Quarter 2016

Service Type	Total Active on List	Average Days on List
Ambulatory Detoxification - Adult	209	6.64
COPSD -Adult	5	7.75
COPSD - Youth	0	0
Opioid Substitution Therapy	104	25.23
Outpatient - Adult	69	7.22
Outpatient - Youth	0	0

Table 4: Number of Individuals with an Appropriate SUD or Dual MH/SUD Diagnosis, Fiscal Year 2015

Special Population	Number of Individuals
Total*	4,323
Adult Both MH/SUD	2,879
Adult SUD Only	1,153
Child/Youth Both MH/SUD	541
Child/Youth SUD Only	556

As a companion measure to the SAMHSA project measures, HHSC will track the number of monthly visits by special population (Table 5). This measure will track to such outcomes as increased access to services, adherence to treatment plans, and client engagement. Since projected monthly visits also impacts PPS development, tracking this measure will also provide HHSC with important information related to quality of projections, as well as potential impact to expenditures if visits increase or decrease (shift) across categories.

Table 5: Number of Monthly Visits by Special Population, Fiscal Year 2015

Special Population	Number of Individuals
Total	139,917
Adult Both MH/SUD	9,004
Adult MH Only	40,812
Adult SUD Only	2,465
Child/Youth Both MH/SUD	1,253
Child/Youth MH Only	62,173
Child/Youth SUD Only	1,371
Standard Population	22,839

Potentially preventable event (PPE) baselines were established for all pilot sites using calendar year 2015 claims data. Potentially Preventable Hospital Admissions (PPAs) (Table 6), Potential Preventable Readmissions (PPRs) (Table 7), and Potentially Preventable Emergency Department Visits (PPVs) (Table 8) track well with the other SAMHSA project measures such as the two Emergency Room Follow-up measures, Plan All-Cause Readmissions, and the two Follow-up after Hospitalization measures.[2] While multiple factors can influence PPE changes, positive changes across all measures may point to a more successful demonstration.

[2] For tables 6-8, member months represent the count of Medicaid members enrolled in each month that were assigned to a Texas CCBHC pilot site.

Table 6: Potentially Preventable Hospital Admissions (PPA) by CCBHC

Agency	Total Admissions at Risk for PPA	Actual Number of PPAs	PPA per 1000 MM
Total	9896	2119	0.03
ATCIC	2127	537	0.04
Bluebonnet Trails	937	203	0.03
Burke	802	200	0.03
Helen Farabee	439	122	0.04
Montrose Center	12	4	0.07
StarCare	25	2	0.01
Tarrant MHMR	2181	387	0.03
Tropical Texas	3222	626	0.03
Mixed	151	38	0.04

These baseline measurements also highlight a key opportunity for care coordination across the CCBHC sites. There were a group of individuals, designated as "mixed" in the tables, who received services at multiple CCBHCs. For each of these PPE measures, improved case management of this subset of clients may positively impact the associated rates.

Table 7: Potentially Preventable Readmissions (PPR) by CCBHC

Agency	Total Admissions at Risk of PPR	Actual Number of PPR Chains[3]	Actual PPR Rate[4]
Total	11521	1401	12.16%
ATCIC	2328	292	12.54%
Bluebonnet Trails	1129	116	10.27%
Burke	939	96	10.22%
Helen Farabee	535	60	11.21%
Montrose Center	.	.	16.67%
StarCare	.	.	6.90%
Tarrant MHMR	2645	303	11.46%
Tropical Texas	3705	490	13.23%
Mixed	199	40	20.10%

To calculate PPEs, HHSC used historic claims for each Center. The total member months for a CCBHC were divided by the total membership to determine a rate for both PPA and PPVs. The

[3] PPR chains reflect 1 or more PPRs within a 30 day period.
[4] Actual number of PPR chains divided by total.

PPR weight was determined by dividing the actual number of PPR chains by the total admissions.

Table 8: Potentially Preventable Emergency Department (ED) Visits (PPV)

Agency	Total Number of ED Visits	Actual Number of PPVs	PPV per 1000 MM
Total	39147	30179	0.20
ATCIC	9611	7618	0.26
Bluebonnet Trails	4009	3081	0.18
Burke	4467	3550	0.21
Helen Farabee	2208	1755	0.24
Montrose Center	40	32	0.18
StarCare	173	129	0.17
Tarrant MHMR	10887	8170	0.21
Tropical Texas	7230	5431	0.15
Mixed	522	413	0.40

Looking towards sustainability, impacts to PPEs will point to opportunities for value-based arrangements between MCOs and CCBHCs in the future. Ability to impact the utilization of high cost services translates to real options for shared savings or different reimbursement arrangements with providers. The potential costs associated with these three categories, for just these eight Centers is over $26 million dollars. A successful demonstration highlights significant opportunities statewide.

Evaluating Progress toward Project Outcomes

These project baselines will serve as starting points, not only for future data reviews, but for ongoing project discussions during the demonstration period. Data and practice sub-groups including representatives from HHSC, MCOs and the CCBHC sites were developed during the planning phase. These groups will have active quarterly calls beginning in the six month ramp up period prior to the demonstration, and throughout the demonstration period. These calls will allow for interim review of ad hoc project and quality measures, as well as case and performance strategy discussions to provide active management and re-tooling of measures.

Since several baseline measures are based on calendar year (CY) 14 data, those baselines will be updated with more current data prior to the demonstration period. Specific measures will be reviewed on a quarterly basis, with all data being reviewed at least every six months.

When possible, the CCBHC project will leverage data evaluation from other initiatives. For instance, HHSC currently conducts quarterly quality calls with MCOs. These data-driven calls focus on current MCO quality, improvement plans, and partnerships to integrate best practices

into MCO quality operations. Additionally, internal monthly project meetings will be held with subject matter experts to assess performance measure improvements. State staff and the CCBHCs will discuss strategies for furthering the impact of performance activities.

Finally, partnerships with the BHAC and advocacy groups will be an important step in refining the demonstration project, as well as gathering vital information about community progress. During the planning project, a baseline of needs assessment questions was established. As project goals are evaluated, additional supporting questions may be added.

Projected Impact on the Target Population

On a broad basis, Texas projects these basic high level population impacts:

- Improved access to services
- Reduced utilization of emergency rooms
- Increased utilization of substance abuse treatment services
- Increased engagement of services
- Higher satisfaction about care received
- Decrease in use of avoidable high cost services

On a community and client level, HHSC expects to see an incremental improvement in CCBHC project measures based on current experience. For example, the current SUD IAP measures have a goal of a 4.4 percent treatment penetration. This rate has increased from 2.6 percent to 3 percent over a three year period. Similar improvements have been seen on other measures. Given the more intensive care coordination component related to the CCBHC model, Texas anticipates a 2-4 percent improvement in measures over the demonstration period.

Texas is ideally positioned to leverage the CCBHC model to significantly transform service delivery, align incentives, and ultimately improve the lives and healthcare outcomes of vulnerable populations by creating a more efficient and coordinated system.

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