

**North Texas Behavioral Health Authority**  
**Minutes of the Board of Directors Meeting**  
**Date of Meeting: November 11, 2009 at 12:00 PM**

<b>2009 Attendance</b>	<b>Jan</b>	<b>Feb</b>	<b>Mar</b>	<b>Apr</b>	<b>May</b>	<b>Jun</b>	<b>Jul</b>	<b>Aug</b>	<b>Sep</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>
Judge Michael Chitty, <u>Chair</u> <b>Kaufman County</b>	X	X	X	X	X	X	-	X	-, C	X	X	
Andrew Dillard, M.D., <u>Vice-Chair</u> <b>Rockwall County</b>	X	X	X	X	X	X	X	X	X, C	X	X	
Ryan Brown, <u>Treasurer</u> <b>Dallas County</b>	-	X	X	X	X	X	X	L2	X, C	-	X	
Richard Scotch, PhD, <u>Secretary</u> <b>Dallas County</b>	X	X	X	X	X	X	X	X	X, -	X	X	
Pat Lawson <b>Collin County</b>	X	X	X	X	X	X	-	X	X, C	X	X	
Susan Miles <b>Collin County</b>	X	-	X	X	X	X	X	X	X, C	X	X	
Ron Stretcher <b>Dallas County</b>	X	X	X	X	X	X	X	X	X, C	X	X	
Zachary Thompson <b>Dallas County</b>	X	X	X	L	X	-	L	X	L2, C	X	L	
Janis Burdett <b>Ellis County</b>	-	-	-	-	-	-	-	-	-	X	X	
Matt Wolff <b>Hunt County</b>	X	X	X	X	L	X	X	X	X, C	X	L	
Commissioner Kit Herrington <b>Navarro County</b>	X	-	X	X	X	-	L	-	L2, -	-	-	

Attendance Legend:

X = Attended monthly BOD meeting

L = Late arrival, missed votes to approve minutes and financial reports

L2 = Late arrival, missed vote to approve minutes

C = Called Board Workshop

**Item #1**

**Call to Order and Declaration of Quorum**

**Judge Michael Chitty, Board Chair:**

Judge Chitty brought the meeting to order at 12:00 p.m. and a quorum was declared.

Attendance included:

- Board members as noted above.
- NTBHA staff: Alex Smith, Alice Watson, Brandy Ruckdeschel and Teresa Handel.
- Approximately 35 visitors and speakers.

**Item #2**

**Secretary's Report**

**Richard Scotch, Secretary reported:**

- Dr. Scotch moved that the minutes of the September 18, 2009 called meeting and the October 14, 2009 regular meeting of the

board of directors be approved as circulated. This was seconded by Dr. Andrew Dillard and the motion carried.

### **Item #3**

#### **Finance Committee Report**

##### **Ryan Brown, Treasurer, reported:**

- Ryan Brown reported that financial statements for the months of July, August, and September 2009 have been circulated and there are no outstanding issues.
- Ron Stretcher moved that the financial reports for July, August, and September 2009 be approved as circulated. This was seconded by Pat Lawson and the motion carried.

### **Item #4**

#### **Public Commentary**

- **Liam Mulvaney, CEO of LifeNet**, acknowledged he has been a critic of the blended case rate method and pointed out that while it is not a good solution, there are no better solution that have been found. He expressed support of the method as presented in the DSHS/VO contract and urged the board to approve the VO contract.

### **Item #5**

#### **Executive Director's Report**

##### **Alex B. Smith, NTBHA's Executive Director, reported:**

- The Executive Director's report which was circulated to the board details Alex's attendance at numerous meetings and his other activities during the past month.
- Alex noted that we are at the close of the first quarter of the first year of the two-year contract agreement with DSHS and VO which incorporate the blended case rate method. These contracts were the result of intensive negotiations concerning VO's management of the limited funds available this year, and as the board is aware that NTBHA has a role to play in terms of the adoption of the VO contract.
- Using information developed, the blended case rate was considered the least onerous method available and thus it was adopted. Later in the meeting Jack will speak to how we arrived at the blended case rate.
- Alex urged the board to ratify the blended case rate as the methodology for this year, and additionally, to ratify the VO contract so that it can be implemented and the process move

forward. This will allow enough time to develop necessary changes, and to consider, review, and make informed decisions for fiscal year 2010.

#### **Item #6**

##### **NorthSTAR Director's Report**

**K. J. Scheib, DSHS NorthSTAR Director, reported:**

- Nothing to report.

#### **Item #7**

##### **Behavioral Health Organization Report**

**Jack Szczepanowski, Executive Director of Value Options, reported:**

- In recognition of Veterans Day, Jack noted that VO administers the TriCare Behavioral Health Benefit for the military.
- With reference to the recent shooting incident at Fort Hood that resulted in injury and death to military personnel, Jack requested the board to advocate for additional peer support services which is a proven effective method for triaging crisis of this type. Governor Perry has made a \$5M appropriation for additional peer services state-wide and NTBHA is urged to advocate for this and any other initiatives to increase the levels of support for military families impacted by this incident and their unfolding issues over years ahead.
- Jack reviewed the case rate model and gave a Powerpoint presentation with data and statistics that comprise the blended case rate model.
- He addressed concerns and criticism regarding administrative costs in the system. Since December 2002, HHSC and DSHS's data flow system shows a savings of approximately \$60M in administrative costs due largely to the case rate structure.
- The latest report from HHSC/DSHS on clinical service encounters relative to general revenue available to all other MHMR systems indicates that 37% is unaccounted for and must be reconciled.
- Regardless of which system is used, whether a case rate model or another type of managed care system such as STAR+PLUS, there will always be a certain level of administrative costs attached. Offsets in administrative costs will ultimately address the core issue of revenue and service demands in the system.
- Jack presented a review of the method and considerations involved in designing the case rated model and noted that this has been a process spanning 18 months or more. He referenced the

educational sessions on the case rated model and the details contained in the minutes of the September 18<sup>th</sup> called meeting, and reviewed the overall revenue picture.

- Through August 2009 there has been a 97% increase in number of individuals served while only a 40% increase in the overall revenue, resulting in \$1,829 average per member revenue distribution for services. This is a 28% drop from inception of the program, meaning there is less revenue available for the level of demand.
- There is a large inequity between the other LMHA's in terms of distribution of available revenues compared to the relative service volume across the state. NTBHA is delivering services to more than 60,585 members compared to only 84,759 members for all other LMHA's combined with a result of \$3,500 average spend per member in the rest of the system outside the NTBHA area.
- The total number of non-Medicaid members served in NorthSTAR is 24.12% of the state as a whole, with only 13.17% of the available funding state-wide. Note that the NTBHA area serves 24% of the entire state's non-Medicaid, indigent, behavioral health, and CD population using only about 13% of the state's total available funds. In terms of funding per member per month, this translates to a 47% difference from the state average – note that this is the biggest difference across all LMHA's. As an example, Harris County alone serves about 9.3% of the demand and receives about 14% of the funds, yet it is under-funded. This illustrates the thresholds that NTBHA is dealing with in terms of the demand on services and the level of services.
- Underfunding is not a new issue. The 2003 LBB report showed a medical loss ratio in triple digits (money spent relative to the total revenue available) which jeopardized the ongoing viability of the program. The VO contract has a minimum and currently is at 88%. The \$10M figure is contingent on a \$3M+ revenue infusion that we anticipate will happen and contingent on not giving Parkland a rate increase.
- Jack reviewed a snapshot of last 3 months of percentage spends for services and administration, with the following highlights:
  - State hospitals are managed through a trust fund.
  - VO does not get administrative dollars as a result of managing the state hospital trust fund, while it has a risk corridor in terms of utilization of up to 110%.
  - State hospitals average a 103% utilization rate. If the state hospitals go on divert, community hospitalizations go up – that's the only method of triage of acute levels of care. This dynamic drives expense significantly in other stake holder

systems and creates backup in the jails. This is a state wide issue, state hospitals are maxed out in terms of capacity.

- Pharmacy and Labs. We have a 340B program that creates a significant reduction in expense relative to the need – we are able to purchase drugs at 40-60% below wholesale as a result of our relationship with University of Texas medical branch. Another thing we're exploring is a patient assistance program. We do not want to structure a waiting list for 2<sup>nd</sup> generation medications but we might be on the precipice of suggesting that, because we are running at about \$2M over utilization based on allocation and 2<sup>nd</sup> generation utilization. We have a relationship with PhARMA -Outpatient and systems programs whereby they provide free drugs to individuals who meet certain criteria (whether Medicaid or indigent) and we are collaborating with pharmacies from MetroCare and others in order to explore how to expedite that and to prevent having to structure a waiting list.
- 23-hour acute care. The rate structure for ER and 23-hours as already mentioned regarding Parkland is below market. 23-hour and inpatient is significantly below Medicaid rates already and the system is constantly overwhelmed. The diversion rate out of our 23-hour ops and acute care system is around 60%; meaning diversion away from higher levels of care into the community and that is unprecedented in any public sector system. Above and beyond that, our average length of stay is about 3.5 days for adults and 4.5 days for adolescents. It's dangerously efficient; however, recidivism rates are about the same as for longer hospital stays.
- Transportation. Mobile crisis has not had any increase other than more demand for services.
- The case rated model was 1.5 years in the making based on discussions with stakeholders and providers. It is structurally a very sound way to manage in an outcomes-oriented environment; as to whether it is funded sufficiently – absolutely not!
- Jack stated that he is not here to say he believes there is \$10M of waste or unnecessary services in the outpatient services – absolutely not! Just demonstrating that as a company we believe this was the least impactful short term or long term depending on how it provides a solution in order to keep the system whole.
- Level of funding compared with prior years and compared with other areas of Texas. He presented a breakdown of administrative costs, pharmaceutical costs and other components of the 2010-2011 budget that illustrate the increase in demand for services and decrease in funds available per client. While the blended case rate method is not the ideal method, it is the best option in view of the shortfall in funds.

- Matt Ferrara commented that on a state-wide comparison, NTBHA serves 24% of the state's non-Medicare clients while it receives only 13% of the funds on a state-wide basis. This is a 47% difference from the state average.
- Jack stated that while not ideal, the blended case rate method is the least negative impact solution, both short-term and long-term.
- The case rate method was determined by a series of six steps, each one being a component of the services and values crucial to clients and providers.
- Quarterly reconciliations in terms of the number of active users in the system. Reconciling data of how many active members are actually in the system in order to set that baseline. The projected medical expense savings of approximately \$10M is unrealistic relative to the number of active users. That projection of \$10M was based on data that is 3-4 months out of date and there are a lot more active users in the systems.
- Quarterly reconciliations of each SPN's baseline numbers (users, payments) will allow tracking and accountability, and provides an opportunity to evaluate and fine tune the system.
- Blended case rate is the average case rate across all packages of care. The system amortizes all services delivered in the packages of care within the outpatient system and blends them into a single case rate allowing for movement between higher levels of care within that case rate to lower levels of care. We anticipate that more people will be exiting package 3 level services and getting more package 1 services. Those services are less expensive; whether they are more clinically appropriate is yet to be seen.
- Excluded from the case rate model are:
  - Some preexisting services like ACT, CD Crisis clinics, TCOOMMI programs, anything that was preexisting as a fixed pay program that are specially funded.
- Case Risk Corridor – another issue. One criticism of the system has been the capacity to achieve the levels of care we have historically demonstrated, and how are we, as a company managing. This is a valid criticism by DSHS of VO for a while now. Part of these case rate models have risk corridors meaning if the baseline of active users that the pre-payment for will be for 100 active users – if after a quarter we see that there are 120 active users the case rate for 10 of those users will drop precipitously meaning that there would be a shift in capacity to other providers. Are we going to max out overall capacity in the system as a result of this risk corridor? Possibly, we don't know that yet. Quarterly reconciliation with respect to the case rate meaning look at the number of active users in the system and pay providers accordingly. There is a fee

schedule attached for each case rate, and providers must reach 90% or above for each individual service attached to the case.

- Some positive clinical issues related to the case rate model may include:
  - Maintains the current services arrays.
  - Maintains an outcomes orientation, direct service targets related to encounters.
  - There is an opportunity to reduce some administrative expenses.
  - Level of documentation in the system is overall reduced.
- There is a potential for some additional money this year from the stimulus package.
- An increase in Transitional Housing has the potential of having a very significant impact on the system.
  - There is a need for more Transitional Housing, similar to state hospital referrals, which would free up beds on higher levels of care and promote more stability. Funding an outcome oriented case rated model in a more robust manner would help the system due to the incentives for all providers to collaborate on the intensive case management program.
- An important concern is the strain on hospital and jail facilities due to insufficient transitional housing. More funding for transitional housing is an area that can have a significant impact.
- Judge Chitty reported on a meeting he and Alex attended in Austin with K.J. Scheib, Matt Ferrara, Tom Valentine and Mike Maples earlier this month to discuss the transition of authority from Austin to the local level for our mental health authority. Expect that will happen over the course of the next few months. We are in discussions to make that a smooth seamless transition so that nothing will be lost. We have good cooperation out of Austin. This is something we have been seeking here at the local level for a long time. We are seeing progress. He made the following comments:
  - Judge Chitty discussed with Tom Valentine in Austin the housing issue and the idea of converting state hospital under utilized revenue space into transitional housing. Tom is receptive to that idea.
  - A research study on transitional housing is being conducted by graduate students to look at these issues.
  - Through the offices of Senator Bob Deuell, NTBHA has arranged to have a meeting of all legislators from the NorthSTAR counties on this topic and it is scheduled for December 11, 2009 from 3:00 to 5:00 pm at the Hampton

Inn in Mesquite. Senator Deuell is notifying all the legislators to please attend.

- At that meeting there will be presentations from several NTBHA members who will speak on behalf of their organizations to bring awareness to their specific needs and the challenges they are facing.

### **Item #8**

#### **Consumer and Family Advisory Council Report**

##### **Mike Katz, Chair, reported:**

- The council met on November 3, 2009 with a focus on a discussion of the numerous meetings and taskforce events in the NorthSTAR area, with specific mention of the Regional Legislative Steering Committee, Dallas County Behavioral Health Systems Re-design Taskforce, Collin County Task Force, PAC and NTBHA board meetings. The December meeting of CFAC will be hosted by MetroCare Services at its Altshuler Adult Clinic/Eastside Children's Clinic. Cindy Hertzog from Easter Seals will discuss Social Security, and there will also be a speaker to talk about CHIP.

### **Item #9**

#### **Provider Advisory Council Report**

##### **Liam Mulvaney, CEO of LifeNet, reported:**

- Liam referred to his report which has been circulated to the board concerning the October 30<sup>th</sup> meeting with DSHS and attended by Mike Maples and Matt Ferrara. PAC's recommendations and requests to the board are summarized below.
  - NTBHA has been asked to facilitate communication with clients to explain cuts in treatment due to limited funds.
  - NTBHA has been requested to identify additional funding streams to supplement the NorthSTAR system.
  - NTBHA is urged to commission a comprehensive study of how existing funds are allocated across the total NorthSTAR budget and search for increased efficiencies.
  - NTBHA is urged to pursue Mike Maple's offer of transferring authority.

### **Item #10**

**NTSPP Report****Edgar Nace, M.D. (not present), President of NTSPP, reported:**

- Nothing to report

**Item #11****Discussions and possible approval**

- Blended Case Rate – Payment Methodology/ Ratification
  - Discussion ensued regarding the notion that the case rate method is the sole method permitted. James Williams with Lakes Regional MHMR expressed grave concern about limiting providers to a single pre-determined payment method and effectively stripping them of any bargaining power. It was clarified that the motion now before the board concerned only granting authority to the Executive Director to approve contracts that incorporate the blended case rate method. Contracts may utilize other methods; however they must be presented to the board for approval.
  - **A motion was made to approve the blended case rate methodology and delegate to the Executive Director the responsibility to approve individual contracts based on that methodology; it was seconded and approved.**
- VO/DSHS contract
  - Discussion. It was noted that the contract has been circulated to the board for more than a month for its review and approval. The DSHS NTBHA authority transfer is in process and the board will be working to implement that in the coming weeks and months.
  - **A motion was made that the VO/DSHS contract be approved; it was seconded and approved.**
- Dallas MetroCare contract and LifeNet contract
  - Discussion. It was noted that pursuant to the foregoing motion, the Executive Director is now responsible for approval of contracts based on the blended case rate methodology such as the Dallas MetroCare and the LifeNet contracts.
  - **A motion was made that the Executive Director be responsible for approval of the Dallas MetroCare contract and the LifeNet contract; it was seconded and approved.**
- Dallas County MOU/contract
  - Discussion. The Executive Director stated this is an annual Memorandum of Understanding with Dallas County regarding NTBHA and VO's responsibility for delivery of behavioral health services and the basis for the \$3.8M in funding

- provided by Dallas County. A copy of the MOU has been circulated to the board.
  - **A motion was made that the Dallas County MOU contract as presented to the board be approved; it was seconded and approved.**
- Engagement Letter with Salmon-Sims-Thomas, auditors
  - Discussion. Ryan Brown, NTBHA Treasurer, stated that the engagement letter with the account firm of Salmon-Sims-Thomas lays out the audit procedures and the costs and fees associated with the 2009 audit and recommended that engagement letter be executed. The problem with the audit last year as to what type of entity NTBHA is has been resolved.
  - **A motion was made to authorize the Executive Director to execute the engagement letter with Salmon-Sims-Thomas for the audit of NTBHA; it was seconded and approved.**
- TSH-Transitional Housing – proceeding to work with Dr. Scotch, nothing to report at this time.
- Atypical Medications status – SGA is exploring implement of a program for pharmaceutical coverage.
- Collin County MOU – nothing to report at this time.
- Legislative update. Janie Metzinger of MHA reported on forthcoming NorthSTAR consumer meetings.
  - 3 meeting are scheduled in Dallas County, implemented by Matt Roberts with NAMI and Ron Sorrels with NAMI Southern Sector
    - November 19<sup>th</sup> from 2:00pm to 3:30pm
    - November 21<sup>st</sup> from 10:00am to 11:30am
    - December 1<sup>st</sup> from 7:30pm to 8:30pm
  - NAMI also will hold informational meetings in each of the other NorthSTAR counties.

## **Item #12**

### **Executive Session**

The board may go into Executive Session pursuant to chapter 551, subchapter D, Texas Govt. Code.

- None

**Item #13**

**Discussion and possible vote in open session on matters considered in Executive Session**

- None.

**Item #14**

**Next Board of Directors Meeting**

- December 9, 2009 at 12:00 Noon

**Item #15**

**Adjournment**

- The board meeting adjourned at 1:11 p.m.

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Dr. Richard Scotch, Secretary

**Acronyms & Terminology**

340B	A federal drug pricing program
ACS	Adapt Community Solutions (Mobile Crisis Provider for NorthSTAR, see MCOT)
ACT	Assertive Community Treatment
APAA	Association of Persons Affected by Addiction
APOWW	Apprehension by a Police Officer Without a Warrant
BH	Behavioral Health (includes MH and CD)
BHO	Behavioral Health Organization (ValueOptions)
BOD	Board of Directors
BPD	Bipolar Disorder
The Bridge	Homeless Assistance Center in Dallas
C&A	Child and Adolescent
CAP	Corrective Action Plan
CBT	Cognitive Behavioral Therapy
CD	Chemical Dependency
CFAC	Consumer and Family Advisory Council
CHIP	Children's Health Insurance Program (aka SCHIP)
CIT	Crisis Intervention Training (40 hour event sponsored by the City of Dallas Police Dept.)
CMBHS	Clinical Management of Behavioral Health Services
COMI	Coalition on Mental Illness
CRCG	Consumer Resource Coordination Group
DARS	Texas Department of Assistive and Rehabilitative Services
DBSA	Depression and Bipolar Support Alliance
DPS	Department of Public Safety
DSCT	Direct Services Cost Target
DSHS	Texas Department of State Health Services
FMAP	Federal Medical Assistance Percentage for Medicaid
FPL	Federal Poverty Level
FTE	Full-time Employee
GOH	Green Oaks Hospital
GR	General Revenue
HUD	Housing and Urban Development
IOP	Intensive Outpatient Treatment
LAR	Legislative Appropriations Request
LBB	Legislative Budget Board
LOC	Level of Care
LOC-A	Level of Care - Authorized (as specified by Service Packages approved by VO for a client)
LOC-R	Level of Care – Requested (by the SPN to VO)

LPHA	Licensed Professional of the Healing Arts (Graduate degrees with specific licenses)
MAC	Medical Advisory Council
MCOT	Mobile Crisis Outreach Team (In NorthSTAR, ACS is the MCOT, providing phone and face-to-face intervention.)
MDD	Major Depressive Disorder
MH	Mental Health
MHA	Mental Health America
MLR	Medical Loss Ratio
MOU	Memorandum Of Understanding
NAMI	National Alliance for the Mentally Ill
NARSAD	National Alliance for Research on Schizophrenia and Depression
NTBHA	North Texas Behavioral Health Authority
NTSPP	North Texas Society of Psychiatric Physicians
OCR	Outpatient Competency Restoration
OPC	Order of Protective Custody
P&Ps	Policies and Procedures
PA	Pre-authorization
PAC	Provider Advisory Council
PBM	Pharmacy Benefit Manager
PESC	Psychiatric Emergency Service Centers
PMPM	Per Member Per Month
QMHP	Qualified Mental Health Professional (Bachelor's degree in specific helping field majors)
RDM	Resiliency and Disease Management
RFI	Request For Information
RFP	Request For Proposal
SA	Substance Abuse
SCHIP	State Children's Health Insurance Program
SDC	Self-Directed Care
SED	Severe Emotional Disturbances
SFY07, SFY08, SFY09, SFY10, SFY11	State Fiscal Years. SFY10 began September 1, 2009 and will end August 31, 2010.
SGA	Second Generation Atypicals (medication)
SME	Subject Matter Expert
SNRI	Selective Norepinephrine Reuptake Inhibitor
SOP	Supportive Outpatient Treatment
SP-1, SP-1S, SP-2 SP-3, SP-4 (ACT)	Adult Service Packages associated with LOCs in RDM—the higher the number, the more intensive the services provided. Similarly, children have RDM service packages.
SPA	Single Portal Authority

SPN	Specialty Provider Network
SSRI	Selective Serotonin Reuptake Inhibitor
TCADA	Texas Commission on Alcohol and Drug Abuse
TCOOMMI	Texas Correctional Office on Offenders with Medical or Mental Impairments
TDI	Texas Department of Insurance
TLETS	Texas Law Enforcement Telecommunications System
TP 55	Type of Medicaid for medically needy clients whose increased medical bills make them eligible for Medicaid (not currently eligible for NorthSTAR)
TRAG	Texas Recommended Assessment Guidelines
TSH	Terrell State Hospital
UA	Uniform Assessment
UM	Utilization Management
UTMB	University of Texas Medical Branch
VO	ValueOptions (the NorthSTAR BHO)
WRAP	Wellness Recovery Action Plan