

Judge Nelson Wolff



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The Honorable Jane Nelson, Chair  
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The Honorable Brian Birdwell  
The Honorable Juan "Chuy" Hinojosa  
The Honorable Dan Patrick  
The Honorable Charles Schwertner  
The Honorable Cindy Burkett  
The Honorable Harold Dutton, Jr.  
The Honorable Larry Gonzales  
The Honorable Richard Raymond  
Dr. Dawn Buckingham, Public Member  
Mr. Tom Luce, Public Member

Dear Commission Members:

As the commission takes testimony on the Department of State Health Services, I would like to submit the following testimony from the perspective of Bexar County health providers with particular reference to per capita funding as it relates to The Center for Health Care Services (CHCS), which is the community mental health center for Bexar County.

I would like to begin by acknowledging the substantial increase in funding for mental health services appropriated to the Department of State Health Services (DSHS) by the 83rd legislature. This additional funding helped to increase the per capita funding for each of the community mental health centers in the state. Yet, in keeping with the topic of this public hearing, the distribution of the additional funding, while increasing per capita amount for virtually all centers, did not address the inequities in funding that exist across the state, and in some instances actually exacerbated them. For example, the Center for Health Care Services saw its per capita funding increase by 6.44%, from \$12.88 to \$13.71. However, when our Center's per capita funding after this increase was compared to all 38 centers, we actually dropped in the rankings from 28th in 2013 to 36th in 2014. Yet, our population grew between these two years by 8.27%; a rate that was the second largest among all the centers.

The strategy used by DSHS to allocate the new state funding that generated the above inequities in per capita funding included the methodology DSHS choose to allocate new state funds to address the wait list problem. Based on this methodology, CHCS received \$281,580 to alleviate its wait list, an amount that was approximately 1.3% of the nearly \$21 million in allocation although we served 6.4% of the 78,496 individuals receiving services in 2013 across the 38 centers.

***Written Testimony from Bexar County Judge Nelson Wolff  
June 25, 2014***

The reason our allocation of the wait list funding was so low has directly to do with the inequity of the DSHS allocation methodology. The CHCS served 1,229 clients over our DSHS-assigned target for 2013, an amount that was considerably higher than the next center with 1,017 individuals served above its target. Yet, the inequity of the DSHS allocation method treated our efforts to serve people in need by going beyond our assigned target, as if we had virtually no waiting list by their calculation. That is, because we served so many more Texans in need than the number DSHS said we should, they reduced our wait list funding to 1.3%. Essentially, we served Texans but received no funding for doing so under the DSHS methodology.

Ironically, the allocation of wait list funds points to another inequity in the DSHS funding allocation paradigm. CHCS not only provided services to an additional 1,229 Texans but served the most severely ill of all the community centers except one. In evaluating the complexity of center clients the Texas Council of Community Centers found that CHCS's client population had a case mix index of 1.41 (case mix is an index of client complexity, where the higher the index the more complex the client), while the average index was approximately 1.0 across all the community centers. Thus, CHCS not only served more clients than the DSHS target but served more complex and in need clients than the other centers, but saw their per capita funding ranking go from 28th to 36th.

In Texas a major funding issue for hospitals, both private and public, is the existence of uncompensated care. There are two primary sources of uncompensated care, the Medicaid Shortfall (the amount of the Medicaid allowed payment to a hospital not supported by general revenue through the HHSC's diagnostic related groups methodology - DRGs) and the care provided to the low income uninsured Texan. According to the 2012 Annual Hospital Survey Bexar County hospitals incurred, in aggregate, approximately \$2.2 billion in uncompensated care charges (the Survey includes both bad debt and charity charges in its definition of uncompensated care). The relevance of this number in addressing the inequities of DSHS allocation methodologies is found in the fact that CHCS's efforts to serve the most in need at amounts substantially greater than what DSHS says they should serve, must have a substantial impact on containing the amount of uncompensated care in Bexar County. Yet, CHCS is not equitably reimbursed for this effort, nor does the relationship between uncompensated care and Center performance appear to be recognized in any of DSHS's funding methodologies.

For example, in accord with Legislative direction, DSHS withheld 10% of community center funding to reward performance, a pay-for-performance strategy with which we agree. However, the methodology they developed to allocate this 10% actually punishes CHCS for providing access to the most complex clients at rates substantially greater than the other centers. If CHCS followed what we perceive as the unintended incentives in the DSHS performance methodology, we would reduce the complexity of our client population and also reduce access to what we are actually paid for by DSHS. If we did this, it is very likely that the amount of uncompensated care would substantially increase in Bexar County.

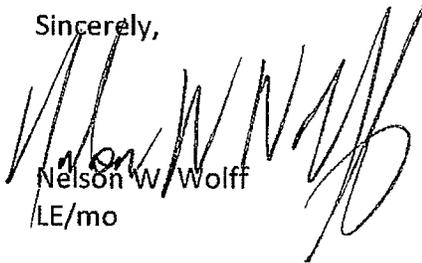
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The Sunset Commission has summarized the experience of the Center for Healthcare Services when they stated in their Staff Report on DSHS: *"Despite years of legislative direction, state funding to mental health regions continues to be inequitable and disconnected from performance."* Not only has our experience borne this out, but the allocation methodologies are disconnected from the major issues associated with uncompensated care and in fact, if followed, would inevitably increase the burden of uncompensated care on the local community. Unfortunately, this appears to be the classic example of silo management.

In our experience, the DSHS allocation methodologies not only fail to respond adequately to funding inequities, but actually act to increase inequities, and in so doing, create the potential for substantially increasing the cost burden on the entire community through unintended consequence of growing the amount of uncompensated care in the community.

We certainly recognize that equity in mental health funding is a difficult issue and will not be resolved overnight. However, it is the intent of this testimony to ask that on the journey to equitable funding we ensure that allocation methodologies do not make the issue worse.

Sincerely,



Nelson W. Wolff  
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