INTRODUCTION

In January 1997, the initial report on HB 2377 discussed implementation strategies and progress on the delegation of the state’s responsibility for planning, coordination and oversight of mental health and mental retardation services to local authorities. Since that initial discussion paper, two reports have been submitted related to Rider 34, HB 1, 75th Legislature, which have reported the progress of the pilot sites involved in the HB 2377 activities. This report will summarize those earlier progress reports, (February and September, 1998), and provide an update of recent activities.

IMPLEMENTATION STATUS

The single center mental health services sites of Austin-Travis Co. MHMR, Lubbock Regional MHMR, and Tarrant Co. MHMR are well underway and have implemented managed care tools such as network development, quality management, utilization management and cost accounting protocols. Two regional authority projects have been established, in South and East Texas. In June, 1998, the pilots for mental retardation services started in the same single center site with the mental retardation waiver (MRLA) approval.

Essential elements of the authority-provider process include the development of Network Advisory Committees and an Open Enrollment process allowing for the expansion of the provider network. The Network Advisory Committees are appointed groups of at least nine members, with a majority of members being consumers or family members. These groups oversee network development and management, and make recommendations about provider issues such as procurement, competitive bidding, provider evaluation, appeals and sanctions.

The Open Enrollment process allows for the expansion of the provider networks to include any qualified and willing providers, and allows consumers greater choice than would be possible under a more restricted form of procurement.

- Regional Pilots

Two regional pilot sites are in the early stages of development. The East Texas Behavioral Health Care
Network with nine authorities, and the South Texas Behavioral Health Alliance, representing six authorities, have developed regional offices, consolidation strategies, and are doing needs assessments for information systems. They are also involved in the modification of HB 2377 templates in order to adapt them to regional needs, and standardizing processes across the member authorities.

The regional groups have used interlocal agreements to form the regional offices. Regional oversight and management structures have been formed, and there is current emphasis on operational roles of the individual authorities and implementation of new business tools. Under consideration for initial consolidation are key functions such as accounting, procurement and quality management.

- **Mental Retardation Pilots (MRLA)**

The local authority pilot design for mental retardation services incorporates the recommendations of the Ad Hoc Committee on Mental Retardation and Managed Care. The pilots include requirements that the local mental retardation authorities be the single point of access to services; be responsible for services coordination; perform assessment and resource authorization; initiate and implement person-directed planning; and survey/certify private providers. An additional 225 MRLA waiver slots, for which the local authority will conduct screening for referral to private providers, are available to individuals awaiting services in the pilot site areas.

These pilots coordinate access and referral to services through a person-centered plan that incorporates a utilization review system used by local authority service coordinators. Guidelines for service coordinators were developed by state authority/stakeholder workgroups. Performance measures have been developed around improved access to services; increased choice of providers; improved efficiency in service delivery; and better service quality.

**ACCOUNTABILITY**

Accountability structures for the HB 2377 pilots have been enhanced since the beginning of the program through increased local planning, the Network Advisory Committees, and improved business procedures in the areas of contract management, cost accounting, quality management, and the development of performance indicators around access, choice, quality and cost effectiveness.

- **Statewide Planning**

The fiscal year 1998 performance contracts for mental health and mental retardation authorities within the state continue the requirement of the submission of a local plan to the state authority. These local plans are developed through the use of a local planning advisory committee, which is comprised of at least fifty percent consumers or family members of consumers. The plans identify needs and priorities in each authority and guide the development of resources and provider networks.
The State Authority reviews local plans and local planning processes, offering technical assistance to local authorities on methods for improving planning and community involvement at the local level. The State Authority also conducts annual surveys of advisory committee members at pilot sites to gain an understanding of committee members’ perspectives regarding meaningful involvement in the planning process as well as the impact of committee recommendations on the planning process.

During FY99, all local authorities are required to develop Network Advisory Committees (NACs). These committees are also composed of at least fifty percent consumers or family members of consumers and make recommendations to authority boards about processes related to the development of provider networks in the area. As in the pilot sites, these activities would include such areas as procurement, competitive bidding, provider evaluation, appeals, and sanctions.

- **Contract Management**

Contract management processes between the State and Local Authorities and between Local Authorities and providers have been improved during the past year. Contracts between the State and Local Authority have been changed to strengthen local planning requirements. In addition, two new requirements related to quality management and cost accounting, first tested in the HB 2377 pilot sites, are now required of all local authorities.

- **Cost Accounting**

A cost accounting methodology was developed within the single pilot sites to promote standardized definitions of service and administrative costs, assist local authorities in determining overall best value, and assist the State Authority in making true cost comparisons. The cost accounting methodology is being rolled out statewide in fiscal year 1999. The implementation of this methodology will require some software and procedural changes in all local authorities. The fiscal year 1999 performance contract requires the local authorities to set up their systems to capture cost information as prescribed in the cost accounting template. Actual implementation will begin September 1, 1999.

- **Quality Management**

A model quality management process was developed as part of the early HB 2377 pilot activities. The fiscal year 1999 performance contract requires all local authorities to utilize this quality management process with providers in their networks. Accordingly, the emphasis on monitoring local authorities is increasingly focused on the adequacy of the quality management programs that local authorities use to ensure the clinical and programmatic quality of care delivered by providers within their networks. For example, community mental health standards, previously focused exclusively on ensuring provider responsibilities were being met, are being revised to address local authority oversight responsibilities as well.
Mental retardation pilots coordinate access and referral to services through a person-centered plan that relies on a utilization review system performed by local authority service coordinators. Service plans that fall outside typical authorization levels are reviewed. The State Authority oversees the local authorities’ utilization review and authorization processes.

- **Pilot Performance Indicators**

Twenty-two mental health performance measures were developed and tested during fiscal year 1998. These measures were designed to target improved access, choice, quality and cost effectiveness. Preliminary data suggested improvement in many areas. These included such measures as the percentage of consumers offered a choice of more than one provider, the percentage of consumers that showed for scheduled appointments, the percentage of consumers seen within established time frames for urgent, emergent, and routine appointments, the percentage of consumer complaints resolved within specified time frames and many others. However, as the pilot process evaluation proceeded, pilot participants and State Authority staff decided to review and improve the set of indicators that will be applied in fiscal year 1999. Data from fiscal year 1999 will be used as a baseline to evaluate local authorities’ performance in these key areas.

Mental retardation performance indicators will measure such things as the ability of the local authority’s person-directed planning process to identify what services are needed and desired, the ability of service coordinators to perform the identified functions, and the authority’s ability to perform its required functions, such as individual assessment, the development of individual plans of care and resource authorization. The success of these functions will be measured through evaluations performed by the Human Services Research Institute of Cambridge, Massachusetts, through a separate evaluation conducted with funds from a Robert Woods Johnson Foundation grant, and through comparisons of cost and utilization review data from the department’s own Medicaid Administration Unit. Preliminary results from these evaluations should be available in July 1999, with the complete report due in September 1999.

**OBJECTIVITY**

- **Open Enrollment**

House Bill 2377 pilot sites’ utilization of an "open enrollment" procurement method in which providers that meet relevant minimum standards and possess appropriate licensure, certification, or required core competencies become part of the local authorities network has mitigated concerns about conflict of interest. Open enrollment ensures that in addition to an authority’s provider activities, all qualified providers are given the opportunity to participate in the network, allowing consumers to choose among qualified providers.

- **Standards**
As an assurance of objectivity, mental retardation services provided by local authorities are surveyed and certified by the State Authority. HB 2377 guidelines require all providers in a network to operate under the same standards, whether services are provided by the authority or by an external provider. Also, Network Advisory Committees provide a consumer and family perspective on the development of provider networks which best meets the needs of the community.

**EFFICIENCIES**

An integral piece of the HB 2377 pilot was the implementation of standardized business and clinical processes in the areas of planning, quality management, utilization management, cost accounting and information services. Initial implementation of these practices in the pilot sites shows a positive preliminary impact. Also, other sites have voluntarily adopted some of these practices, and it is anticipated that the impact on their business and clinical processes will be positive as well.

Mental health contracts in the pilot sites have seen a positive impact on cost. In the pilots several contracts have been renegotiated for better rates, provider networks have been expanded, and additional numbers of individuals are being served. Outcomes data on individuals will need to be evaluated at a later date to understand the full impact of change.

Some growth has been seen in the number of external mental health providers, although it has been difficult in some areas to find them in sufficient numbers. Outside the pilot areas, other local authorities have adopted the network development and contract management practices as well.

Mental retardation pilot sites have already seen a decline in the costs of services to some individuals. Within the MRLA pilot sites, the responsibility for assessment, resource allocation and authorization have been moved from the provider base to the local authority. In addition, a person-directed planning system, which gives to each individual only those services needed and wanted, has been implemented. The mental retardation portion of the pilot has only been operational for a short time, so further study is warranted to fully understand the outcomes of this system.

**SUMMARY**

The long planning process for HB 2377 is beginning to develop into conceptual and operational designs using more efficient business tools, enhanced consumer input to services, and increased accountability for all sectors of the system. While further evolution and implementation is necessary to fully realize the impact of the new business tools installed at the pilot sites, early signs are promising. With the high level
of data collection, and pilot analysis, the pilots are providing information for future system change to ensure consumer choice, high quality of care, and cost efficiency.

**RECOMMENDATION**

Continue the pilot process through the next legislative session. There are no statutory changes recommended at this time.