INTRODUCTION
Rider 34, House Bill 1, 75th Legislature requires the Texas Department of Mental Health and Mental Retardation (TDMHMR) keep the Legislature and the Governor's office informed of the process and effects of delegating to a local mental health and mental retardation authority the state's responsibility for planning, coordination, and oversight of mental health and mental retardation services. This is the first report required by the rider. Subsequent reports will be submitted in September 1998, and February 1999.

BACKGROUND
House Bill 2377, passed by the 74th session of the Legislature has been impetus for a major shift in the way we conceptualize the role of the local community mental health and mental retardation centers in Texas. While this legislation offers guidance in a great many areas, the most profound policy changes relate to the way community centers function as local authorities. The statute describes centers' responsibilities for ensuring the quality and adequacy of services to the designated population, where previous statutes described the responsibility for providing those services. Additionally, H.B. 2377 directs the center as a local authority to "consider public input, ultimate cost benefit, and client care issues to ensure consumer choice and best use of public money in 1) assembling a network of service providers; and 2) determining whether to become a provider of a service or to contract that service to another organization."

Informed by the guidance of H.B. 2377, the new challenge for community MHMR centers as local authorities has been to successfully engage the local community in planning for, assembling, and managing the performance of a network of providers which offers the greatest value in the provision of services and supports for people with mental illness or mental retardation in a manner which reflects the highest integrity and stewardship over public resources. The new role for community centers as local authorities demands new skills and technologies. The department has been working in tandem with community center trustees, staff, and consumers to develop the tools to successfully carry out this new mission. Three pilot sites (Austin-Travis County, Lubbock Regional MHMR Center, Tarrant County MHMR Services) have been selected across Texas to test the new vision for community MHMR centers as local authorities. Two regional pilots, one in south Texas involving 3 community MHMR centers and 2 state operated community services and one in East Texas involving 7 centers and a state operated community services division will begin implementation in March, 1998.

H.B. 1734, 75th Legislature, takes the concept of the local authority a step further. The bill repealed the
statutory preference given to community MHMR centers as the designated local authority and requires
that a committee with designated membership develop a plan specifying the number a local authorities,
the functions that are to be delegated from the state to the local authority, and the criteria by which a
local mental health and mental retardation authority is to be selected.

**IMPLEMENTATION STATUS**
The following is a status report on implementation to date of the H.B. 2377 initiative with a focus on the
issues identified in Rider 34. Subsequent reports will serve as updates, focusing only on those activities
undertaken or completed during the reporting period.

Statewide Planning
Implementation of a local planning infrastructure for mental health and mental retardation services
throughout the state is well underway. Local planning is essential to ensuring a highly participatory
process in the identification of local needs and priorities that then guide program development and
resource development and allocation at the local level. Identification of local needs and priorities, will
also form the basis of the Department's strategic plan and be incorporated in negotiations related to
performance contracts.

The fiscal year 1997 performance contracts with community MHMR centers included new expectations
with regards to local planning. Among these expectations was a requirement that local mental health and
mental retardation advisory committees consist of at least 50 percent consumers or family members of
consumers. In their advisory capacity, these committees make recommendations to the local board of
trustees in the areas of:

- planning and development;
- needs and priorities for the service area and community MHMR center;
- budget priorities;
- implementation of plans and contracts; and
- performance issues.

A template to guide and inform local planning activities has been developed and describes the elements
to be included in the local plan. Elements include:
- mission, vision, values, and principles of the local system;
- definitions of all populations served;
- internal and external assessments;
- needs assessment data;
- existing MH and MR resources;
- identified gaps in service and supports;
- expansion of state-of-the-art service technologies;
- resource development and allocation;
- service needs and priorities;
- management needs and priorities; and
- plan objectives and outcomes.
The first local plans were submitted in June of 1997. As with any first initiative, the quality of the plans and the planning processes varied among the local authorities. Technical assistance in the form of written feedback was provided to each center. The fiscal year 1998 performance contract continues the local planning requirements and includes sanctions for non-compliance with these requirements. Updates of the local plans are due April 30, 1998. In addition to guiding response to local priorities, these plans will inform TDMHMR's 1999-2003 strategic plan.

Pilots
Each of the three authority/provider pilots is required to formulate a network plan as a component of the local strategic plan. A Network Advisory Committee advises the local boards of trustees in the areas of development, design, management, and evaluation of provider networks, ensuring consumer and family member involvement and input and objectivity in the development and management of provider networks.

A planning template for the network plan has also been developed and includes the following components:
- a description of the separation of the authority/provider functions;
- a description of the process for obtaining the input of consumers, family members, and other community stakeholders for the network plan;
- a description of the objective process for selecting network providers, for monitoring and evaluating network providers, and for making decisions regarding the status of contracts with network providers;
- a description of community parameters for determination of best value; and
- a description of how access, consumer choice, quality and cost efficiency will be addressed.

Initial pilot activities were largely focused on the local authorities' roles in the delivery of mental health services. Beginning April 1, 1998, pending approval by HCFA, the pilot design for mental retardation services will be implemented through the mental retardation local authority waiver (MRLA waiver). The waiver incorporates the recommendations of the Ad-Hoc Committee on Mental Retardation and Managed Care, and includes elements requiring the local mental retardation authorities in the pilot sites to be the single point of access to services, responsible for service coordination, perform assessment and resource authorization, initiate and implement person directed planning, and survey and certify private providers.

Assembling Networks
In meeting its responsibilities in assembling a network of providers, the local authority must consider a number of items including which of the services it currently provides will be contracted out; how to identify and select potential contractors, including Medicaid requirements; and how to ensure that it gets the best value for the public dollar.

The department has developed (and adapted from the private sector) business practices that support efficient contracting with providers in assembling the network. Included among these practices are:
- model contracts;
- an instrument to assess the risk of contracting with a provider;
- model Request for Proposals (RFPs) and an evaluation to ensure that the provider(s) selected represent best value;
credentialing requirements for providers to ensure that they are competent and qualified; a quality management plan which includes the policies and procedures for running the network and improving its quality; and utilization management guidelines to facilitate the allocation and management of resources.

Financial Management
The department has also provided guidance to the pilot sites in the area of financial management, including a blueprint for the development of claims/billing management systems, cost analysis and reporting requirements, and tools for developing a financial decision support system. Pilot sites have systems in place which enable reporting to the state authority on key financial issues.

ENSURING ACCOUNTABILITY
The technology of managed care offers important tools to support the transformation of the public mental health and mental retardation system. Among the important initiatives related to the implementation of H.B. 2377:

Uniform Assessment
Beginning in FY97, the agency's performance contract with local authorities requires the use of a common set of diagnostic instruments for individuals seeking mental health services. It also includes a requirement for reassessment every 90 days. The uniform assessment is a critical element in tying the needs of individuals to the services they receive and to the outcomes of treatment. For mental retardation services, a consistent approach to assessment and services planning will be tested in the pilots.

Best Practice:
The contracts also require and set targets for the use of interventions which research has demonstrated produce the best outcomes for individuals. Best practice requirements in the FY98 contract include supported employment, supported housing and assertive community treatment.

Medication Algorithms
Since psychopharmacological interventions are important aspects of treatment for people with serious mental illnesses, the department is implementing an important initiative to identify protocols for medication management for people with schizophrenia, major depression and bipolar disorders. These protocols guide the prescription of medication. This study, which is being implemented in collaboration with several Texas medical schools, has received national recognition.

Access to service:
Managing waiting lists, developing service plans, authorizing services, and allocating resources are activities that have historically been performed by the state authority or outside the scope of the local mental retardation authority. Local authority responsibility for these functions will increase the focus on managing resources efficiently, increase consumer choice of services and providers, and are expected to reduce waiting lists for services.
Quality Management:
A model quality management plan has been developed. Its elements include:
a provider profiling system to evaluate provider performance and to inform the local authority as to
whether the provider is meeting the terms of its contract;
indicators for assessing consumer satisfaction and provider satisfaction;
methods for identifying areas of improvement;
the membership of the quality improvement committee; and
the credentialing process performed by the local authority to ensure competent and quality providers.

Within the mental retardation local authority waiver, the Quality Assurance and Improvement System
(QAIS), a self-assessment system that measures individual outcomes as they relate to the person
receiving services and their perception of those services, their wants, needs and desires, will be required
of the private provider network. Validation functions will be performed by the local authority

Utilization Management:
A utilization management system ensures that the system makes available to individuals the right service
in the right quantity at the right time and for as long as needed. The department has developed guidelines
for use by the pilot sites to ensure systematic review of all consumers' plans, service coordination/case
management. The department has also developed utilization management guidelines which address the
definition of the service, the standard of practice, admission, continued stay and discharge criteria, and
frequency of review. An appeals process for utilization management decisions has also been developed.

Additionally, the mental retardation pilot system design has moved the assessment of the individual and
the subsequent development of the individual plan of care from the provider to the local authority.
Resource authorization provided by service coordinators at the local level will allow for more accurate
determinations of the type and amount of resource needed.

Information Systems:
Changes to information systems are key to successful implementation of this new approach to service
delivery. To support these systems, the department staff have developed data component requirements
for the pilot sites and offered technical assistance to support systems change.

Performance Indicators:
Pilot sites are required to report on measures designed around indicators of accessibility, choice, cost and
quality. These measures are outlined in the special provisions of the pilot sites' performance contracts.
The first year of reporting on performance indicators will establish a baseline. In future years, sanctions
for noncompliance with targets in these domains will be established.

CONFLICT OF INTEREST
It is vitally important the community MHMR center as local authority act to mitigate the perception that
a conflict of interest exists when the center is also a provider of services. There must be real and
perceived objectivity as decisions are made regarding the center's role as a provider. To address this
important concern, the following approaches have been undertaken.
Accountability Training
A critical plus of Texas' local board system is the direct accountability, through the boards of trustees to local citizens. Job descriptions and training systems have been designed and developed to support local board members in understanding and performing this important role. This is being implemented, not just in pilot sites, but also in other centers throughout the state.

Advisory Committees
To enhance this accountability and to ensure that the voices of consumers and their family members are heard in the process, the department now requires the creation of advisory committees, comprised of at least 50% consumers and family members. These advisory committees will have roles in planning, network development, assessment of proposals from providers and evaluation of services. Specifically, the Network Advisory Committees are responsible for developing a community-wide service plan and recommending to the center's board of trustees which of the center-provided services should be competitively bid.

Organizational Separation
Each of the pilot sites is testing strategies for organizational separation of authority functions from those supporting the direct provision of services. In addition, there is an expectation that contract providers and "in house" providers receive uniformly fair and objective treatment.

Contracting
Fundamental to the avoidance of conflict of interest is ensuring objectivity in the contracting process. In addition to training, a contract template and a standardized decision-making process which focus on ensuring objectivity have been developed for use in the pilot sites.

FEEDBACK FROM STAKEHOLDERS
At the state level, stakeholders are active participants in the H.B. 2377 oversight committee and implementation of the Ad-Hoc Committee on Mental Retardation and Managed Care recommendations through the MRLA waiver.
At the local level, mechanisms for stakeholder feedback on an on-going basis are built into the design of the pilots and are by definition necessary for successful local authority functioning. Public participation is formalized through inclusion of consumers and family members on network advisory committees and the mental health and mental retardation advisory committees that advise local center board's of trustees and through public participation in a center's quality improvement activities.

Additionally, the format and content of this year's system-wide Helen Farabee conference has been changed to a regional approach to encourage consumer and family member participation. The program is focused on increasing consumer and family member involvement in decision making in the domains of service delivery, quality improvement, and local planning, and offering an opportunity for a dialogue about consumer preferences and needs.

In developing its recommendations to the TDMHMR Board, the H.B. 1734 advisory committee created
in response to H.B. 1734 has visited each of the pilot sites. Discussions with consumers, family members, advocates, local board members, and network advisory committee members will provide valuable information as decisions are made by the committee.

ANTICIPATED EFFICIENCIES
Because contracting processes are currently underway, it is too soon to address the overall percentage of services now being provided through contracts or the quality of services provided through these means. Subsequent reports will address FY98 performance in these areas. However, it is reasonable to predict that assembling a network of providers in which the focus is on ensuring best value for the public dollar will result in efficiencies as competitive forces are at work. Already there are examples to report:

One of the pilots reports that in the first quarter of FY97 the cost of pharmacological management was reduced from $129/hour to $97/hour since external providers were added to the network. This pilot also reports a 12% increase in numbers of individuals served compared to the first quarter of last year.

The same pilot site is preparing to pay its internal provider staff on a fee-for-service basis rather than as full time staff. This change will improve the efficiency of the center as only those services provided will be purchased, creating an added incentive for providers to ensure consumers keep appointments.

Public provider participation in the HCS Medicaid waiver has been capped. With open enrollment for all qualified providers, the percentage of services provided by private contract providers will increase. In addition, three mental retardation authorities have requested permission to convert the ICF/MR services operated by the center to HCS services which will be privately provided.

Services previously provided exclusively by the pilot authorities such as vocational services and medication management are now available through networks of providers participating through open enrollment. Specifically, a network of vocational service providers for services totaling over $70,000 previously provided by the center has been developed.

Additionally, as implementation of the mental retardation portion of the pilots occurs, moving the assessment, individual plan of care development, and service coordination from the provider base to the local authority, as well as the addition of person directed planning which includes the identification of natural supports, plans of care with more specifically directed services will likely result. It is anticipated that these plans of care will result in cost savings which can be used to serve additional individuals.

DEGREE TO WHICH PLANNING, POLICY DEVELOPMENT & RESOURCE ALLOCATION ARE BEING DONE BY LOCAL AUTHORITIES
Much of the effort of H.B. 2377 implementation sets the stage and builds the capacity for delegation of authority from the state to local authorities. For example, the addition of local planning expectations improves local capability to develop strategic direction and involve stakeholders. While it doesn't
eliminate the state's role in strategic planning, the way in which planning is carried out changes such that those most directly affected are more closely involved in the planning process.

As the local authority system evolves and state authority roles are delegated to the local authority, the emphasis on monitoring performance will continue to shift toward evaluating the adequacy of the quality management systems local authorities have in place and use to insure clinical and programmatic quality of care.

The department has deferred decisions about broad-based delegation of authority for planning, policy development, and resource allocation because of the work of the H.B.1734 committee. This legislation required the department to appoint a committee charged with developing a plan that addresses the most efficient and effective number of local authorities; the scope of responsibilities to be delegated by the state authority; and criteria by which to select local authorities.

The H.B. 1734 advisory committee was appointed in September, 1997, and has met 5 times. The committee's recommendations are scheduled to be presented to the TDMHMR Board in July, 1998, and the Board must submit a plan to the Legislature September 1, 1998. The recommendations of this group will inform policy direction of the TDMHMR Board and identify statutory changes where needed.

This is a time of significant change in the public mental health and mental retardation service delivery system. In many ways, the strategies undertaken in Texas are "cutting edge" initiatives and have attracted national attention. There has been significant productive effort to date. More work is needed to ensure that the system of the future achieves best value; that is, that the system is at the same time responsive to the needs and desires of consumers, fair to the provider community and accountable to taxpayers.

We remain convinced that assuring best value in services for people with mental illnesses or mental retardation is best achieved under the auspices of citizen boards whose value bases are first and foremost to do the right thing for the people who live in their communities. That is an important element of accountability that we must not surrender.