**Report on Local Authorities**
**Rider 18, SB 1, 77th Legislature**
**Report to the Legislature**
**Submitted to LBB and GBO**
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## INTRODUCTION

In January 1997, an initial report 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 report, six subsequent reports have described the progress of the pilot sites involved in these activities. This report will provide an update on current activities.

## IMPLEMENTATION STATUS

Austin-Travis County MHMR, Lubbock Regional MHMR, and MHMR of Tarrant County were the pilot sites for this project. These local authorities have used managed care tools such as network development, quality management, utilization management and the cost accounting methodology to enhance planning, coordination and oversight of local mental health and mental retardation services. The specific program for Mental Retardation Local Authority (MRLA), initiated in the same pilot sites, continues to experience success and has expanded to five additional sites.

Several of the products of this pilot project are available to all Community MHMR Centers (centers) and many have been incorporated into the on-going operations of other centers. Local planning is accomplished according to processes developed by this project. The Cost Accounting Methodology (CAM), which requires a uniform chart of accounts and standardized procedures for cost allocation, has been successfully demonstrated at the three pilot sites. Twelve additional centers submitted CAM reports for the first six months of FY 01 and thirty-nine centers submitted CAM reports for the second six months of FY 01.

### Development of the Authority Rule and the Authority Certification Process

The department is developing an Authority Rule both to codify requirements for Local Authorities and to enable delegation of planning, coordination and oversight responsibilities. The rule will describe the type of entities that will qualify to be Local Authorities and specify a certification process to ensure that Local Authorities meet all requirements for governance and business processes. This rule is currently in development along with a review process by which the department will certify an organization as a local mental health and/or mental retardation authority. Comments are being obtained from stakeholders as well as from the Local Authority Technical Advisory Committee, which is the statutory committee advising TDMHMR on Local Authority issues. Further development of the rule is also anticipated in conjunction with the completion of the work of the State Board-appointed Mental Health Service System Task Force and the Behavioral Health Benefit Design Task Force.

As a further example of the generalized acceptance of the principles and practices evolving from the 2377 pilots, the Executive Directors Consortium of the Texas Council of Community

MHMR Centers established a Local Authority Development Committee. This committee is comprised of cross-functional staff members from centers. The purpose of the committee is to advise the Local Authority certification and implementation process.

The exercise of State Authority oversight for Local Authorities requires that data relative to service density (encounter data) be available along with information from other data streams. These data are necessary for the State Authority to determine both beneficial and detrimental consumer outcomes resulting from implementation of the delegation model by the various Local Authorities. This requirement led to the exploration of developing a data warehouse for storage and manipulation of these data, through leveraging existing technology from the NorthSTAR and STAR Plus data warehouse projects. This project continues in an exploration stage, with data from the original pilots. The warehouse model is also being developed to incorporate data from other data systems, including the Client Assignment and Registration System (CARE). Other centers have also been involved in design of the encounter data system through a joint task force to ensure consistent reporting.

**Mental Retardation Local Authority Pilots (MRLA)**

The Local Authority pilot design for mental retardation services incorporated the recommendations of the Ad Hoc Committee on Mental Retardation and Managed Care in development of this Medicaid waiver. The success of the MRLA model has lead to its acceptance as the preferred model and expansion across the entire state is planned. All sites continue to include requirements that the local mental retardation authority:

- be the single point of access to services;
- perform assessment, referral, and resource authorization;
- use person-directed planning processes for developing of individual's plans of care;
- be responsible for service coordination; and
- survey and make recommendations to the State Authority for certification of private providers.

The three initial MRLA pilots have been operational under the MRLA Program Waiver since June 1, 1998. A primary result of this centralized authority function has been improved coordination of services, assuring that consumers are provided with the services needed, while limiting use of resources to only those needed services. Choice for consumers has increased through development of a larger number of providers and through the development of comprehensive plans of care through the person-directed planning process.

Data from the Quality Assurance and Improvement System (QAIS), the outcomes evaluation system used by TDMHMR, indicated that the MRLA sites had an average of more consumer outcomes present than did the non-MRLA centers. These outcomes include items such as "People are satisfied with services"; "People are satisfied with their life circumstances" and "People choose personal goals." Out of 25 possible outcomes for each consumer surveyed, the MRLA centers averaged 16 outcomes present and the non-MRLA averaged 12 outcomes present.

The initial pilot sites for the MRLA waiver were the counties served by the three HB 2377 pilot centers, Austin-Travis County MHMR, Lubbock Regional MHMR, and MHMR of Tarrant County.

The March 2001 phase of MRLA waiver statewide expansion included the counties served by five additional centers. These are MHMRA of Harris County (Houston), Sabine Valley Center (Longview), Burke Center (Lufkin), Anderson/Cherokee Community Enrichment Services (Jacksonville) and Nueces County MHMR Community Center (Corpus Christi). Several centers have expressed their preference to be included in the next expansion. As the MRLA waiver expands geographically, HCS and HCS-O waiver participants will be transferred into the MRLA waiver and the HCS and HCS-O waivers will be phased out.

## Planning

### Local and Network Planning

Both a local plan and a network plan are required of each authority. The FY 2001 performance contract for mental health and mental retardation authorities required the submission of a two (2) year local plan. This biennial frequency will align local planning with the state authority's strategic planning cycle. The local plan identifies the needs and priorities of the community and the network plan reflects the strategies the authority intends to use to address those needs and priorities. Local plans are developed with multiple processes, including local planning advisory committees. The Network Advisory Committee (NAC) is responsible for influencing the development and content of the network plan, which must also reflect community, consumer, and family input. The Network Advisory Committee is critical to the process of establishing fairness and objectivity as it relates to developing and managing the network of providers. The network plan embraces the managed care principles inherent in the initial legislation and applies these concepts and business practices to achieve the goals of the local plan.

## Coordination

### Separation of Authority and Provider Systems

To ensure objectivity, centers are modifying their organizational structures to separate authority functions (governance, business systems, public advisory mechanisms and planning) from service provider functions (therapies, day programs, medical services, etc).

There have been no major challenges to the authority and provider separation approach for this model. Private providers have been able to work as network members with Local Authorities and to share in the provision of services with both the public provider and other private providers.

The MRLA model requires a more specialized separation of authority and provider functions in that all Service Coordination services, including individual planning and service authorization, are performed by the Local Authority for both public and private Medicaid waiver providers in each local service area. Consumers are supported to choose among all qualified providers for authorized services, with the provision of a cap on the number of persons who may be served by the public provider.

In June, 2001, a new Departmental rule was implemented which further extends the role of the local mental retardation authorities to include their being the sole entities that can initiate enrollment of persons in ICF/MR programs. Previously, the ICF/MR program provider performed this function. This new role, along with intake responsibilities for all HCS waivers initiated in FY 2000, further enhances the Local Authority's responsibilities both for local planning and resource development and allocation and as the single point of access to the public mental retardation service system.

## Oversight

### Accountability

Fiscal and programmatic accountability measures for the pilots have been enhanced since the beginning of the project. Increased local and network planning activities, network and public advisory committee processes, and improved business procedures in the areas of contract management, cost accounting, quality management, and utilization management have each contributed to improved accountability. The pilots continue to evolve performance indicators around:

- access, e.g., time from first contact to assessment, authorization timeframes,
- choice, e.g., number of credentialed providers, number of resolved provider change requests,
- quality, e.g., percent of resolved consumer complaints, consumer and provider satisfaction surveys, and
- cost effectiveness, e.g., Cost Accounting Methodology Reports.

The importance of implementing the managed care business practices evolved in the pilots has been underscored by the development of the Technical Assistance Project of the Texas Council of Community MHMR Centers, which is assisting centers in local implementation and development of these practices.

### Cost Accounting Methodology (CAM)

A cost accounting methodology was developed within the 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 more accurate cost comparisons.

The cost accounting methodology rollout has required all Local Authorities to map their specific service arrays to a standardized service grid. The implementation of this methodology required Information Systems software and procedural changes for each Local Authority. The FY 2002 Performance Contract requires full CAM semi-annual reporting by all centers for both Mental Health and Mental Retardation services.

Implementation of the CAM requires that Local Authorities collect and report data at the service encounter level, which provides much greater detail concerning service density than does the currently available CARE assignment data. In recognition of the fact that all centers will be able to report encounter level data, the State Authority is examining the development of a data warehouse, based on existing technologies for centralized storage of these data, as stated earlier in this report.

### Quality Management

All Local Authorities continue to develop their quality management programs to implement data based systems that provide both center management and advisory groups with the information needed for decisions concerning improvement of the quality of services. Improved information management systems have facilitated the availability of useful data about providers and the services they deliver. This information allows evaluation of provider performance to become a useful tool in giving providers the information needed for improvement. It also informs the Local Authority about those providers who are unable to make improvements so contract discontinuation is appropriately considered.

**Pilot Performance Indicators**

For mental health and mental retardation services, the pilots collected measures related to access (e.g., time from first contact to assessment), choice (e.g., number of providers), quality (e.g., consumer satisfaction), and cost (e.g., direct care cost). In addition, they collected value-added measures, such as additional resources accessed and managed.

Examples of specific mental retardation performance indicators are:

- the ability of the Local Authority's person-directed planning process to identify what services are needed,
- the ability of service coordinators to perform the identified functions, and
- the Local 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 (HSRI) of Cambridge, Massachusetts and through comparisons of cost and utilization review data from the Department's own Medicaid Administration Unit. One report concerning Service Coordination has been completed. Two other reports, one concerning Service Costs, and the other from key informants, are in draft form. Another report, Survey of Consumers and Family Members, is in development.

**Summary**

The processes developed in the authority delegation project have moved from conceptual to planned statewide implementation. As the local authority rule is developed and implemented, along with the authority certification review process, this statewide implementation will be accomplished. The expansion of the MRLA program into all areas of the state is scheduled for implementation over the next biennium

**RECOMMENDATION**

Incorporate products of the Mental Health Service System Task Force and the Benefit Design Task Force into the model for a Local Authority.

Continue the integration of the delegation model processes into the system through the TDMHMR Performance Contract and the adoption of the Local Authority Rule.

Continue the expansion of MRLA statewide.

Refine a certification process to ensure that each Local Authority has the systems in place to ensure responsibilities delegated by the State Authority will be fulfilled.

Develop the State Authority's capacity to evaluate implementation of the model by Local Authorities.