Implementation of HB 2377, 74th Legislature
Rider 29, HB 1, 76th Legislature
Report to the Legislature
September, 2001

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, five 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 provide an update on FY 2001 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 for, and 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, on March 1, 2001, the program expanded to five additional sites.

A number of the products of this model project are available to all Community MHMR Centers (centers) and many have been incorporated into the on-going operations of other centers. Planning is accomplished at the local level according to process 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 pilots sites. Twelve additional centers submitted CAM reports for the first six months of FY 01 and all centers will be submitting CAM reports for the second six months of FY 01.

Development of the Authority Rule and the Authority Certification Process

At the time of the last report, it was recommended that a rule be developed 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 which 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 Authority 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. Feedback is 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 System Design Task Force and the 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 be available along with existing data streams. This requirement led to the exploration of developing a data warehouse for storage and manipulation of these data, leveraging existing technology from the NorthSTAR and STAR Plus data warehouse projects.

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 intended. All sites continue to include requirements that the local mental retardation authority:

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

The three initial MRLA pilots have been operational under the MRLA Program Waiver since June 1, 1998. 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. The State Authority continues both to survey the Local Authorities on the performance of their functions and to use the Human Services Research Institute (HSRI) to evaluate the entire pilot initiative.

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). Additional phase-in will occur in FY 2002 and 2003 until all Local Authorities are converted to the MRLA waiver model. As the MRLA waiver expands geographically, the 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 biannual 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 utilize to address those needs and priorities. Local plans are developed through the utilization of 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 HB 2377 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 other authorized services, with the provision of a cap on the number of persons who may be served by the public provider. Consumers who have newly authorized slots may only choose from among private providers.

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, this function was performed by the actual provider. This new role, along with intake responsibilities for all HCS waivers initiated in FY 2000, further enhances the Local Authority's responsibilities for local planning and resource development and allocation.

Oversight

Accountability
Fiscal and programmatic accountability measures for the HB 2377 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 2377 Pilots has been underscored by the development of the Technical Assistance Project of the Texas Council of Community MHMR Centers, which is assisting almost all centers in local implementation and development of these practices.

Cost Accounting Methodology (CAM)

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 more accurate cost comparisons.

The cost accounting methodology rollout has required 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 2001 performance contract schedules the initial reporting on the cost accounting methodology for all local authorities. A phase-in of full implementation statewide for mental health services is required. The pilot sites continue to refine the process for cost accounting for MR services. The pilot sites have fully implemented the cost accounting methodology in FY 2001.

Implementation of the CAM requires that all Local Authorities collect and report data at the service encounter level, which provides much greater detail concerning service density than does CARE assignment data. In recognition of the fact that all centers will be able to report encounter level data, the State Authority requested, as an exceptional Legislative Appropriations Request item, the increased capacity in its data system to utilize these data in system management and Local Authority oversight. This item was not funded, so alternative methods to utilize these data are being explored, including leveraging data warehouse technologies developed for other TDMHMR projects.

Quality Management

All Local Authorities continue to develop their quality management programs to implement data-based systems which 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 continue to collect measures related to access (e.g., time from first contact to assessment), choice (e.g., number of providers), quality (e.g., resolved consumer complaints), and cost (e.g., direct care cost). In addition, they collect 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 and desired,
- 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, and 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 Wood Johnson Foundation grant, and through comparisons of cost and utilization review data from the Department's own Medicaid Administration Unit. Two reports, one concerning Service Coordination and the other concerning Service Costs, have been completed. Another report from key informants is in draft form, and another, Survey of Consumers and Family members, is in development.

Summary

The processes developed in the HB 2377 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 relevant products of the Benefit Design Task Force into the model for a Local Authority.

Continue the integration of HB 2377 processes into the system through the TDMHMR Performance Contract and the adoption of the Local Authority Rule.

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.