Texas Department of Mental Health and Mental Retardation
Report on Local Authorities
Rider 18, SB 1, 77th Legislature
Report to the Legislature
Submitted to LBB and GBO
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INTRODUCTION

Rider 18, Senate Bill 1, 77th Legislature, requires that the Texas Department of Mental Health and Mental Retardation report annually to the Legislative Budget Board and the Governor on the effects of delegating to a local authority the responsibility for planning, coordination and oversight of mental health and mental retardation services. In January 1997, an initial report discussed implementation strategies and progress on the delegation of these responsibilities. Since that initial report, seven subsequent reports have described the progress of the pilot sites involved in these activities. This current report provides an update on recent activities.

IMPLEMENTATION STATUS

Austin-Travis County MHMR Center, Lubbock Regional MHMR Center, 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 pilot phase for this project has been completed and the concepts developed have informed both the Behavioral Health Benefit Design activities and the statewide rollout of the Mental Retardation Local Authority (MRLA) initiative.

Several of the products of this pilot project are available to all Community MHMR Centers and many have been incorporated into the on-going operations of other local authorities. 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. All local authorities are required to submit CAM reports semi-annually, beginning with FY 2002.

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. The work of both the State Board-appointed Mental Health Service System Task Force and the Behavioral Health Benefit Design Task Force are being incorporated into this effort.

Development of Data Resources
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 and the two additional local authorities participating as Benefit Design implementation sites. The warehouse model is also being developed to incorporate data from other data systems, including the Client Assignment and Registration System (CARE). Other local authorities have also been involved in design of the encounter data system through a joint task force to ensure consistent reporting. TDMHMR has contracted for assistance to local authorities in ensuring capability of reporting these data in the third quarter of FY 03, as required in the current Performance Contracts.

Mental Retardation Local Authority (MRLA) .
The specific program for Mental Retardation Local Authority (MRLA), initiated in the same pilot sites, continues to experience success and has expanded to fifteen additional sites. The local authority design for mental retardation services incorporates the recommendations of the Ad Hoc Committee on Mental Retardation and Managed Care this Medicaid waiver. The success of the MRLA model has lead to its acceptance as the preferred model and phased expansion across the entire state is scheduled for completion on September 1, 2003. MRLA requirements are for the local mental retardation authority to:

- 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 sites 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, indicate that the initial MRLA sites average virtually the same number of outcomes present as non-MRLA sites, with more supports present.

The initial 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.) Three additional phases of statewide expansion are underway with the first area converted on November 1, 2002. The ten additional sites are Bluebonnet Trails, Border Region, Camino Real, Center for Health Care, Coastal Plains, Concho Valley, Gulf Bend Center, Gulf Coast Center, Spindletop and Tropical Texas. The twenty-four remaining sites will be converted on May 1, 2003, and September 1, 2003, to complete the implementation statewide. 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.

Local and Network Planning

Both a local plan and a network plan are required of each authority. The FY 2003 performance contract for mental health and mental retardation authorities requires the submission of a local plan, which covers the next two fiscal years. This biennial frequency aligns 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 authorities develop local plans with multiple processes, including local planning advisory committees. The Network Advisory Committee (NAC) is responsible for informing the development and content of the network plan, which must reflect community, consumer, and family input. The Network Advisory Committee is essential to the process of establishing objectivity as it relates to developing and managing the network of providers. The network plan employs the managed care principles inherent in the initial legislation and applies these concepts and business practices to achieve the goals of the local plan.

The following statements from the "Summary Report of Local Plan Reviews" demonstrate both improvement and areas for attention in the local authorities' planning processes:

- "The local plans have dramatically improved, individually and as a whole, since the FY 2000-2001 planning cycle. The documents appear more informed, clear, thorough, and professional which suggests a greater ease and understanding of strategic planning issues at the local level. This increased acumen in planning is manifested in several ways."
- "Many local authorities seemed hesitant and less confident in the areas of network planning and resource development and allocation. Local authorities may consider these areas meriting additional attention in future local planning efforts."
- "Local plans depicted an impressive effort toward the development and maintenance of meaningful stakeholder involvement in the planning process."
- "This goals/initiatives section was almost always a sound component of the local plan that prompted very few recommendations. The local authorities seem to be confident and capable in the task of developing responsive goals and objectives for their organization."
- "Local authorities appear to have worked with other groups in their community to improve the local services and supports system. These groups and activities varied, but often included the local school system, police department, nonprofit and/or religious organizations, advocacy groups, private providers, and other state agencies such as the Texas Rehabilitation Commission."
- "Strategic thinking seems to be the unifying factor in the planning components that stood out as exemplary. Sections were characterized by the considered evaluations of methods to gather data and develop resources, and other activities that would enable the local authority to step towards its vision."

Coordination

Separation of Authority and Provider Systems
To ensure objectivity, local authorities 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). **The work of the State Board-appointed Mental Health Service System Task Force identified criteria to ensure the objective operation of the Local Authority in those instances in which the Local Authority is also a provider of services. These criteria will be included in the certification review of Local Authority candidates.**

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 specialized separation of authority and provider functions in that all Service Coordination activities, 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 authorized to initiate enrollment of persons in ICF/MR programs. Previously, ICF/MR program providers 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 for local planning, 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 local authorities 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.

Cost Accounting Methodology (CAM)
A cost accounting methodology was developed 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 required full CAM semi-annual reporting by all local authorities for both Mental Health and Mental Retardation services. The first large-scale application of CAM data

was to examine costs associated with services for refinance of General Revenue funded services to Medicaid waiver funding in FY 03.

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. Because all local authorities will be able to report encounter level data, the State Authority is developing a data warehouse, based on existing technologies for management and use of these data.

Quality Management

All Local Authorities continue to develop their quality management programs to implement data based systems that provide both local authority 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. The majority of centers have independently contracted with a data analysis company to provide reports, based on encounter level data, to inform their management decisions. 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 may be 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.

As the department transitions additional sites to the Mental Retardation Local Authority waiver and processes; there are initial and ongoing performance measures used. Examples of specific measures used are:

- 90% of currently enrolled consumers will be transferred to MRLA
- 95% of consumers will have a Service Coordinator assignment in CARE
- 90% of consumer records reflect that the Service Coordinator has coordinated and monitored the delivery of MRLA Program and generic services
- Fewer than 5% of consumers have their IPC on hold
- Fewer than 5% of consumers served have expired IPCs reflected in CARE (computer system measurement)
- Staff persons identified to complete enrollments have completed TDMHMR training within 120 days of assignment.

These and other requirements are contained in an MRLA Implementation Manual that guides the ongoing provision of services for consumers, authorities and providers. The Department conducts onsite technical assistance and consultation and conducts annual onsite reviews of Local Authority performance on the principles contained in the MRLA rule for authority functions.

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. Some of the recommendations from these reports have already been implemented and others are

currently under review.

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 to be completed by September 1, 2003.

RECOMMENDATIONS

Continue to 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.

Expand data collection and analysis to include both comprehensive encounter data and additional data identified as necessary for evaluation local authorities.