

Implementation of HB 2377, 74th Legislature Rider 29, HB 1, 76th Legislature Report to the Legislature August, 2000

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, four 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 2000 pilot activities.

IMPLEMENTATION STATUS

The Local Authority mental health and mental retardation services sites of Austin-Travis County MHMR, Lubbock Regional MHMR, and MHMR of Tarrant County continue to experience considerable success with the implementation of managed care tools such as network development, quality management, utilization management and cost accounting protocols. The two regional authority projects that were established in 1998 have been discontinued. The pilot program for mental retardation services (MRLA) initiated in the same single Local Authority sites continue to experience success and have been expanded to four additional sites.

The evolution of the HB 2377 pilot process has resulted in development of the TDMHMR Authority Certification process as defined by the Local Authority Rule which will be proposed in FY 2001. This rule defines the role of local authorities as they were tested in the HB 2377 pilot. The certification process allows TDMHMR to delegate, with confidence, responsibilities of the State Authority around planning, coordination of services, capacity to manage a network of providers, and demonstrating best value through the application of effective business tools.

The pilots are in the process of refining their data management mechanisms with the installation of the revised service grid for both mental health and mental retardation services. The Cost Accounting Methodology (CAM) for mental retardation services continues to be tested with the pilot sites, while the CAM for MH services is now a statewide requirement.

As part of the pilot Local Authority Certification process, the three HB 2377 pilots, as well as two additional local authorities who have been working to implement the HB 2377 model in more rural settings, were reviewed by a team from TDMHMR to evaluate their progress in implementation. Different organizational approaches were observed and local authorities had made significant progress in effectively demonstrating objectivity for those local authority staff involved in both authority and provider functions. All three pilots have used various processes for assembling and managing a network of providers and demonstrating that those providers are

the best value for the public dollar. The principles of utilization management, quality management, network development, cost accounting and intake, assessment and referral have been developed but the local authorities are not always able to demonstrate the benefits of having implemented these processes. There needs to be some additional focus on establishing better auditing mechanisms for consumer/family and stakeholder input and how it influences decision-making at the management levels.

- **Mental Retardation Local Authority 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 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 MRLA pilots have been operational under the MRLA Program Waiver since June 1, 1998. Each of the pilot sites has realized cost savings in individuals' plans of care on new enrollees to these waiver services. The average daily plan of care costs for new enrollees in the pilot sites is less than the statewide average for the comparable Home and Community-Based Waiver Services (HCS) program. Choice for consumers has increased in the areas of number of providers and in the development of their plans of care through the person-directed planning process. The State Authority continues to survey the Local Authorities on the performance of their functions and continues to use the Human Services Research Institute to evaluate the entire pilot initiative.

The MRLA pilots also incorporate all other aspects of the HB 2377 model regarding all general revenue funds. Four new sites have been selected to further expand this methodology. The Department plans to extend the use of MRLA to cover the state within three years.

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 contributed towards improving accountability. The pilots continue to evolve performance indicators around access, choice, quality and cost effectiveness. Over time we hope to establish a benchmark pattern for the key indicators and utilize these for future contracting purposes.

- **Local and Network Planning**

The FY 2000 performance contracts for mental health and mental retardation authorities require the submission of a local and network plan. These plans are developed through the use of local planning advisory committees and the network advisory committee. 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. The network plan embraces the managed care principles inherent in HB 2377 and applies these concepts and business to achieve the goals of the local plan. In FY 2000 Local Authorities were allowed to combine the local and network plans into one document to allow for a more consolidated planning process.

- **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 more accurate cost comparisons. The cost accounting methodology rollout has required local authorities to reprogram their information systems to map to the revised service grid. The implementation of this methodology requires some software and procedural changes in all Local Authorities. The FY 2000 performance contract requires the Local Authorities to set up their systems to capture cost information as prescribed in the cost accounting methodology template. Full implementation, statewide for mental health services, is required in the FY 2001 performance contract for all Local Authorities. The pilot sites continue to refine the process for cost accounting for MR services. The pilot sites in FY 2001 are expected to fully implement the cost accounting.

- **Quality Management**

All Local Authorities continue to develop their quality management programs striving to implement data based systems which provide management and advisory groups with the information they need in order to make decisions which will improve the quality of services delivered to consumers. Improved information management systems have facilitated the availability of valid data about providers and the services they deliver allowing evaluation of provider performance to become useful tools in both giving providers the information they need to improve as well as shaping the network by not continuing to contract with providers who do not.

- **Pilot Performance Indicators**

A number of new mental health performance measures were developed and tested during FY 2000. These measures were designed to also target improved access, choice, quality and cost effectiveness. Since the pilots routinely and consistently met or exceeded expectations on most performance measures, we have dropped several measures where the pilots appeared to attain 95 to 100% every quarter. Thus, the need to evolve the performance measures to more clinically outcome-focused measures is becoming more apparent. However, the measurement

of clinical outcomes is more a reflection on the effectiveness of the utilization management system rather than on the general assembling of the network of providers. This tests the value-added business process of utilization management. This extends beyond the original scope of the pilot process but should have a significant impact on the system of the future. Measures currently in use for the pilots, beyond those collected for all centers, include variables such as arrests, jail stays, employment, hospitalizations, and primary and secondary access. Data for most of these measures derived from the Uniform Assessment process.

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 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 Woods Johnson Foundation grant, and through comparisons of cost and utilization review data from the Department's own Medicaid Administration Unit. The first report, concerning Service Coordination, has been completed. Another report from key informants is in draft form, and two others, Service Costs and Survey of Consumers and Family members, are in development.

OBJECTIVITY

- **Network Advisory Committee (NAC)**

The role of 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 Local Authority has an obligation to ensure that the selection of NAC members is done in a way that reflects objectivity and eliminates any appearance of bias by the Local Authority or the appearance of conflicts of interest by the committee members themselves. The NAC is charged with several key responsibilities that include the following:

1. The NAC must systematically review data regarding the network of providers in order to make informed recommendations to the PAC or local board regarding whether or not the Local Authority is continuing to get best value for the public dollars allocated or paid to individual providers.
2. The NAC ensures that the Local Authority applies a fair and unbiased procurement process.
3. The NAC may also function as an objective complaint mechanism whereby a provider may lodge a complaint against the Local Authority.
4. The NAC makes recommendations to the PAC or local board on whether or not the provider should continue to provide a service or be removed from the active network of providers.

5. The NAC also makes recommendations on whether a service should continue to be provided by the Local Authority "internal" provider or if that service should be put out for bid.
6. The NAC must ensure that public input, ultimate cost benefit and client care issues have all been considered in making these recommendations.

- **Separation of Authority and Provider Systems**

In an effort to maximize the opportunity for fairness and objectivity, each of the pilots reorganized its system in a way that attempts to separate authority functions (governance, business systems, public advisory mechanisms and planning) from the provider functions (Local Authority provider services and private provider services). The pilots have achieved varying degrees of separation between their authority and internal staff provider divisions. Each pilot developed slightly different processes to reflect objective and fair mechanisms for procurement and determination of best value. Given the fiscal dynamics and market position of the local MHMR Authority pilots, the determination of best value process has been successful in some instances, complicated in others, and moot in a number of circumstances. However, each pilot continues to evolve its processes for ensuring objectivity and determining best value particularly as it relates to whether the Local Authority "staff provider network" is the system of provider services that reflects best value for the public dollar.

There have been no challenges to the authority and provider separation approach for mental health services. Private providers have been able to work with the Local Authority and share in the provision of services. In fact, there have been a few instances whereby the private providers have requested a cap on referrals and have even asked the Local Authority to stop referring consumers due to capacity problems.

Thus, after four years of implementation, the concern regarding issue of possible conflicts of interest have not surfaced as some had predicted. This leads us to think that there may not be as much demand by private providers to provide services to our priority population as was projected in 1996. This dynamic achievement further supports the importance of the local safety net feature inherent in the Local Authority internal provider network.

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. The continued implementation of these practices in the pilot sites shows an ongoing positive impact. Each pilot has remained within its contracted administrative overhead cost limits and has been able to streamline a number of internal processes in an effort to maximize efficiencies in support of this objective.

The pilots continue to contract for mental health services and expand their networks of providers, mainly through the open enrollment process. However, there must be some consideration given to changes in our agency's funding approaches and methodologies that occasionally causes the

pilots to make adjustments that they otherwise may not have pursued had conditions remained the same. Thus, attention must be paid to the impact that TDMHMR or other funding agencies may have on the evolution of provider networks. At times, the determination of best value processes and results may be effected by changes in policy directions by TDMHMR and other funding agencies. This may have positive or negative effects on efficiencies.

NETWORK EXPANSION

The contract management process as it relates to provider network development was rolled out this fiscal year. TDMHMR's contracts rule was amended in order to increase the opportunities for more providers to compete through an open enrollment process. Chapter 401, Subchapter D (Contracts Management for Community Services) was altered effective April 23, 2000, to include open enrollment as a procurement method. The pilots have experienced growth in the number of external mental health providers; however, each continues to experience difficulty in recruiting providers in sufficient numbers and in critical areas. Many providers in under-served areas are already overburdened with Medicaid business and are not interested in taking on additional referrals from the Local Authority at Medicaid reimbursement rates. Public sector rates for salaried and contracted staff remains lower than the private sector, thus making retention of providers difficult for local authorities.

SUMMARY

The process for HB 2377 has moved from conceptual to operational. The application of the HB2377 tools and processes continues to improve and become more refined and are being systematically implemented statewide. While further evolution and implementation is necessary to fully realize the impact of the new business tools installed at the pilot sites, early signs continue to be promising. As we continue to study and refine the HB 2377 business processes and subsequent products, we will gain meaningful insight that should inform us in designing the future model for Local Authorities.

RECOMMENDATION

Continue the integration of HB 2377 processes into the system through the TXMHMR Performance Contract and the development of the Authority Rule.

Develop 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.