Implementation of HB 2377, 74th Legislature
Rider 29, HB 1, 76th Legislature

Report to the Legislature
February 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, three 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 FY1999 pilot activities.

IMPLEMENTATION STATUS

The Local Authority mental health and mental retardation services sites of Austin-Travis County MHMR, Lubbock Regional MHMR, and Tarrant County MHMR 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 as well.

Essential elements of the authority-provider process have included the evolution of the Network Advisory Committees (NAC) and an Open Enrollment process allowing for the expansion of the provider network. As a result of the last site visit by TDMHMR, the configuration and appointment processes for the NAC have been expanded. As the NAC process continued to unfold, there were some minor conflicts with other advisory mechanisms. As a solution, we have allowed the NAC committees to receive appointment recommendations through the local Public Advisory Committees (PAC) or contain participants from the membership of the various advisory committees as needed. This modification allows for greater flexibility for the larger Authorities and easier development for the smaller ones.

We have modified the TDMHMR contracts rule to add open enrollment as a form of procurement. This method enables the Local Authority to more efficiently add providers to its network. This approach eliminates the need for overly burdensome paperwork and creates more opportunity for competition between the Local Authority internal provider division and private providers. The rule has already been distributed for comment and is in the process of revision based on recent feedback.

The single pilots are in the process of enhancing their information systems with the installation of the latest service grid. After the last site visit by TDMHMR the single pilot sites were reviewed according to their level of achievement of the HB 2377 pilot objectives to date. There

was a wide range of variance in organizational approaches to the HB 2377 pilot process. All three pilots achieved the mechanics of assembling and managing a network of providers. The principles of utilization management, quality management, network development, cost accounting and intake, assessment and referral have been well developed. However, there needs to be some additional focus on establishing better audit trails for consumer/family and stakeholder input and how it influences decision-making at the management levels. Also, the systematic process for determining best value needs further development. Additionally, there will need to be some renewed effort around the extraction of key encounter data from each of the pilots. Two of the three pilots have experienced difficulties in mapping the service grid into their information systems. We will continue to work with the pilots on these refinements. Finally, there will need to be some consideration given to possible policy limitations that may impede the continued evolution of utilization management and other business processes. This will be revisited this fiscal year.

- **Regional Pilots**

The regional pilots have been discontinued as of August 31st, 1999. Although the mechanics of assembling and managing a network of providers at a regional level was evolving, the logistics of local control and influence became a factor. However, it was the belief of both regional chairpersons that stakeholder input must occur as close to the consumer as possible. It was perceived that this regional initiative would have moved local input processes like this away from the local area. This was not the desired result originally conceptualized by the regional executive oversight staff. Notwithstanding the local input concerns, the regional pilots attempted to achieve the spirit of the legislation through a collaborative method of regionalization. However, as the system began to evolve operationally, it became evident that key local functions would need to be delegated to the regional entity in order to maximize efficiencies and establish some sense of a regionally driven system. This became progressively more complicated and ultimately required a rethinking of the regional strategy as originally designed.

- **Mental Retardation 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 individual's plans of care on new enrollees to these waiver services. The averaged 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 HB2377 model regarding all general

revenue funds.

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 fiscal year 1999 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 a local planning advisory committee and the network advisory committee. The local plans identify needs and priorities in each local community and the network plan basically reflects the strategies the authority intends to utilize in addressing the service needs and gaps reflected in the local plan.

The network plan is designed to initiate the activities necessary to achieve the goals identified through the local planning efforts. The network plan embraces the managed care principles inherent in HB 2377 and applies these concepts and business processes of managed care and attempts to achieve the goals of the local plan. The local and network planning processes were separated in an effort to more clearly appreciate the differences between the two concepts. It s our goal to merge the two concepts into the next planning cycle in FY 2000.

- **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 been delayed due to the need for Local Authorities to have more time to reprogram their information systems to map to the new service grid. The implementation of this methodology will also require some software and procedural changes in all Local Authorities. The fiscal year 2000 performance contract requires the Local Authorities to set up their systems to capture cost information as prescribed in the cost accounting methodology template. Actual implementation should begin September 1, 2000.

- **Quality Management**

A model quality management process was developed as part of the early HB 2377 pilot activities. The fiscal year 2000 performance contract requires all Local Authorities to continue to apply the quality management process to their provider networks. Accordingly, the emphasis on monitoring Local Authorities is increasingly focused on the adequacy of the quality management programs that Local Authorities use to ensure the clinical and programmatic quality of care delivered by providers within their networks. The quality management template rollout has been

one of the most successful rollouts within the pilots and on a statewide basis.

- **Pilot Performance Indicators**

A number of new mental health performance measures were developed and tested during fiscal year 1999. 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 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.

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.

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.

As a part of this separation of authority and provider processes, the installation of the provider open enrollment process has played an important role in allowing for competition between the Local Authority internal provider divisions and private providers. On the mental health side there has been a somewhat tepid response to participating mostly due to the rates of reimbursement and the paperwork traditionally required in the public sector. Due to the severity of illness with many of the consumers, there can be a higher than average no show rate, which again represents another issue for private providers. Also, we have found that in one pilot, the safety net feature of the Local Authority was clearly a necessity when one private provider abruptly dropped from the network, leaving approximately **50** consumers without a service provider. The Local Authority absorbed the consumers into its own staff provider network so they would not be without services. Although this issue was not an unexpected dynamic of utilizing private provider networks, it did highlight necessity for maintaining a safety net for unexpected changes in participating providers.

To date, even with the application of the open enrollment process, consumers tend to select the Local Authority internal providers the majority of the time. Although we are not sure why this is the case, we think this may simply be a matter of familiarity for consumers. Most consumers of mental health services appear to have developed long term and trusting relationships with their service providers and do not seem to be interested in changing providers even when given the opportunity to do so. This again is another important dynamic that may inform the development of future systems at TDMHMR.

Furthermore, on the mental health side there have been no challenges to the authority and provider separation approach. 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 3 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 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 is being rolled out this fiscal year. We recognized that TDMHMR's contracts rule needed to be changed in order to increase the opportunities for more providers to compete. The latest comment period for the modified contracts rule received no issues with the concept of open enrollment for private providers. However, until the rule is finally adopted, only the pilot sites may continue to expand their networks through an open enrollment process. We expect the modified contracts rule to be adopted some time during the third quarter.

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.

SUMMARY

The process for HB 2377 is moving forward from conceptual to operational. The application of the HB2377 tools and processes continues to improve and become more refined. There will need to be some further development and piloting of the utilization management process and evolution of possible guidelines. 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 pilot process through the next legislative session. Revisit and identify possible rule and policy barriers that may impede the development of specific business tools or processes.