

HB 1734 Committee Report

September, 1998

Report submitted to the Board of the Texas Department of Mental Health and Mental Retardation for acceptance and transmittal to the Senate Health and Human Services Committee and the Public Health Committee of the Texas House of Representatives

1734 Committee Members

Co-Chairs

Mike Bright, Austin

Joe Lovelace, Dallas

Consumer Representatives

Mike Halligan, Austin

Beverly Ann Resendez, San Antonio

Beth Holt, Marshall

Candi Ware, Bryan

Family Member Representatives

Ward Burke, Lufkin

Dick O'Connor, Dallas

Diane Mitchell, Houston

Pascual Piedfort, Austin

Local Authority Representatives

Donald Dumas, Austin

Suzanne Lasko, Fort Worth

Alfred Forsten, Houston

Jacqueline Shannon, San Angelo

Private Providers

Rahn Bailey, M.D., Houston

Paula Dobbs-Wiggins, M.D., Dallas

Ric Barraza, El Paso

Richard Jordan, San Antonio

Advocates

Christine Devall, Austin

Deborah Hiser, Austin

Staff to the Committee

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Executive Summary

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Introduction

H.B. 1734 of the 75th Legislature requires that the Commissioner of the Texas Department of Mental Health and Mental Retardation (TDMHMR) appoint a committee to develop a plan which recommends:

- the most efficient and effective number of local authorities;
- the responsibilities to be delegated by the State Authority to the Local Authority;
- criteria by which local authorities shall be selected;
- the process of selection;
- criteria to ensure that contracts between local authorities and providers are competitive and result in the selection of the best bid;
- a time frame for implementation; and
- strategies to ensure that services are not disrupted.

In September 1997, Commissioner Don Gilbert appointed this committee with representatives from the various groups designated in the legislation - consumers, family members, private sector entities, local MHMR authorities - and advocates. The committee has developed recommendations in each of the specified areas and these comprise the substance of this report.

Context/Background

In 1994, the Board of the Texas Department of Mental Health and Mental Retardation appointed a "blue ribbon" task force to clearly articulate the role of the mental health and mental retardation authority. The objectives of this task force were: to ensure consumer choice and local ownership and control; to increase accountability; and to distinguish the roles of governmental entities as policy makers and as service providers. The recommendations of this task force resulted in H.B. 2377.

H.B. 2377 made explicit the role of TDMHMR as the state mental health and mental retardation authority responsible for planning, policy development, coordination, resource development and resource allocation. The bill authorized the Department to develop fully the concept of state and local authorities in several pilot sites. These started implementation in September 1997 and are currently in progress.

H.B. 2377 also articulated the concept of a local mental health and mental retardation authority to which a State Authority may delegate certain functions. A clear expectation is that the Local Authority consider public input, ultimate cost-benefit and client care issues to ensure consumer choice and the best use of money in assembling a network of service providers and in whether or not to be a provider of a service.

H.B. 1734 builds on H.B. 2377. H.B. 1734 of the 75th Legislature repealed the preferential status given to community MHMR centers to be designated a local mental health and mental retardation authority and required TDMHMR to appoint a committee to develop a plan for the system of local mental health and mental retardation authorities in Texas.

Committee Process and Activities

The H.B. 1734 committee worked as a team with commitment, dedication and a spirit of collaboration and consensus. Between October and June, the committee had nine two-day meetings.

Subcommittee meetings were held between the times of the regular meetings of the full committee. A group of committee members visited all the H.B. 2377 implementation sites.

The committee actively sought public input. The work of the committee was initiated by a conference on "The Mental Health and Mental Retardation Authority in the 21st Century" in which presentations were made by national experts and representatives of states which had attempted to deal with the same issues. Stakeholders were invited to attend the conference. Draft recommendations were mailed for review and comment to 500 stakeholders. Public hearings were held at seven sites across the state, and representatives of the major stakeholder groups were invited to present their reactions and discuss issues with the committee.

These activities resulted in the recommendations which are summarized in the following sections of this Executive Summary.

Recommendations

I. Guiding Principles

The committee developed principles for the MHMR service delivery system to guide the activities of the committee. Principles were developed in four areas: people, provider, public and funding.

II. State and Local Authority Responsibilities

Several problems and issues were identified in the functions and the scope of State Authority responsibilities. Some of these issues exist because of ambiguity and lack of definition, others because of the fact that authority is shared across state entities. The sharing of authority across state agencies is partly related to the fragmentation of funding streams related to mental health and mental retardation services. The focus of the committee in consolidating these authority functions is related to having a single point of accountability and to having uniform and consistent standards, rights and performance expectations rather than on trying to meld these various funding streams.

To address the area of Authority responsibilities, the committee proposed the following broad functions:

- Planning
- Policy Development
- Resource Development
- Resource Allocation
- Oversight
- Network Development, and
- Consumer Empowerment.

A fundamental tenet of this approach is that the State Authority is ultimately responsible for all authority functions and that these responsibilities are delegated by the state to the local level. In other words, authority at the local level is derived from the state.

Some of the major considerations related to these authority functions are provided below.

- **Planning:** A major concern of the committee is that mental health and mental retardation services in Texas are fragmented. The committee felt strongly that a critical planning role is to include mental health and mental retardation services that do not come under the direct administrative responsibility of the State or Local Authority to ensure coordination, consistency and efficiency in services. The committee proposed that planning at state and local levels include both the priority and non-priority populations. Plans at both levels should address issues of integration of all mental health and mental retardation services provided and also address issues of integration of mental health and mental retardation services with other service systems.

Another key aspect was the inclusion of consumers, family members and community representatives in the planning process.

The role of the Local Authority is to implement a local planning process to identify local needs and priorities. Based on these local plans, the role of the State Authority is to provide a strategic direction and state-level objectives which local entities would strive to achieve.

- **Policy Development:** The committee recommends that the state mental health and mental retardation authority should define standards, rules, expectations for performance, quality, outcomes, rights protection, health and safety, best practices and practice guidelines for all publicly and privately funded mental health and mental retardation programs.

The rationale for this recommendation is that persons with mental illnesses and persons with mental retardation should have uniform expectations of services regardless of who is paying for or providing these services. Also, differences in standards, expectations and

reporting requirements create an unnecessary and duplicative administrative burden on providers.

- **Resource Development:** Resource development includes: obtaining funds for the maintenance and growth of needed programs, maximizing resources from potential sources, optimizing collaborative and pooling arrangements, creating appropriate incentives and using available resources efficiently and innovatively.

The major emphasis of the responsibilities related to this function is to actually implement the various aspects of resource development listed above. The committee recommends that the issue of local match be given special attention.

- **Resource Allocation:** While the role of the State Authority is to allocate resources equitably across authorities, the role of the Local Authority is to allocate resources within the Local Authority's jurisdiction. The Local Authority is also responsible for allocating resources to services, contracts with service providers (including state facilities) and local management functions. "Resources" include community resources, state facility resources, Medicaid and any other resources that are available.
- **Oversight:** Oversight is ensuring that policies, standards and contract requirements are being appropriately implemented.

The role of the State Authority is to ensure the availability, adequacy and objectivity of State and Local Authority accountability systems (e.g. quality management, utilization management). The role of the Local Authority is to monitor providers, services and outcomes (within the framework of policies), and enforce contract standards and contract requirements established by the state.

A major difference from the current implementation of this function is that the monitoring and enforcement of contracts provided at the local level would be a function of the Local Authority. Also, the role of the State Authority would be to monitor authority functions rather than provider functions.

- **Network Development:** Network development refers to the development of a provider system which provides meaningful choices, competition and objectivity.

The role of the state is to provide a framework and support for the development of adequate networks at the local level. The role of the State Authority is to provide guidelines, templates and criteria for network development and to provide technical assistance in this area.

The role of the Local Authority is to manage the enrollment and ensure the quality of local providers, to develop referrals and linkages to service providers, to act as a single portal authority for both MH and MR services and to implement credentialing and provider profiling systems. Other Local Authority functions include managing the waiting list and ensuring "safety net" services.

- **Consumer Empowerment:** Consumer empowerment is an ongoing process to provide consumers with authority and personal control. In this context, consumer empowerment

means the meaningful inclusion and participation of consumers and family members in all authority functions including the design, implementation and evaluation of the service delivery system. Essentially, this is the process through which an individual who is now receiving or has received mental health or mental retardation services is provided the means to be a self-advocate.

The role of the State Authority is to implement mechanisms for consumer empowerment at the state level and to ensure consumer empowerment at the local level. The role of the Local Authority is to implement mechanisms for consumer empowerment at the local level. The committee recommends that a consumer ombudsman function be developed at both levels.

III. Criteria for the Selection of an Authority

The committee defined two types of criteria for the selection of a Local Authority. The first set of basic criteria is related to the governance and organizational structure; the second set is related to the capacity of the entity to perform authority functions.

The entity must demonstrate its capacity to conform to the following basic selection criteria (presented in chapter 6) which include, but are not limited to, the following:

1. Operate in a manner consistent with Open Meeting and Open Record statutes.
2. Develop a governing board which:
 - a. Is appointed through a public process;
 - b. Includes at least 50 percent consumer, family member and advocate representation (with the Local Authority to designate the minimum number of consumers on the board);
 - c. Ensures among board members a thorough knowledge of the needs of persons with mental retardation and serious mental illness.
3. Demonstrate that it is a governmental entity, a not-for-profit charitable corporation or an organizational combination of such entities.

The second set of selection criteria is related to the capacity of the entity to perform the required functions of planning, policy development, resource development, resource allocation, oversight, network development and consumer empowerment.

IV. The Most Effective Number of Local Authorities

The Committee does not recommend a specific number as the most effective and efficient number of authorities. Rather, the Committee recommends that the state allow the number of local authorities to be determined by:

1. The continued operation of the evolutionary "environmental forces" that have contributed to the design of the current system, including 2377 pilot results;

2. The State Authority's response to managed care and other dynamic forces that will impact the system in the future; and
3. The Local Authority Selection Criteria and Selection Process developed by this Committee.

V. Selection Process

The process for selection includes: the State Authority's proposed designation of the geographic area for which a Local Authority is responsible; the issuance of a Request for Information (RFI) that allows all qualified and interested entities to provide information on the state's proposal; a Request for Proposal (RFP) process for the Local Authority; and the designation of an authority screening and implementation advisory committee that would evaluate and make recommendations to the Board regarding the most qualified candidate.

The Local Authority would be appointed for a period of four years. At the end of four years, other entities could submit a proposal of how they might perform the authority functions better. If there is not a substantial improvement proposed, the existing authority would be given preference. An existing Local Authority may be re-designated for two more consecutive terms (maximum 12 years) before the process is opened to outside proposals.

VI. Criteria for Contracting by Local Authorities with Providers

The Local Authority has the responsibility for selecting and contracting with providers to ensure that consumers have more choices and that services are cost-effective. All providers who meet specified criteria should have a fair opportunity to participate in the network.

In order to ensure that provider selection and contracting are fair, competitive, and result in the selection of the best bid, the Local Authority will adhere to several criteria, including:

1. Ensure Board appointment of one or more Network Advisory Committees (NAC), to include at least 50 percent consumer, family member and advocate representation. (The Local Authority shall designate a minimum number for consumer participation.)
2. Ensure development of NAC policies and procedures to address members' objectivity and conflicts of interest.
3. Ensure the review of existing and needed services to define priorities and time frames for the services which will be procured.
4. Ensure development by the NAC of a written process to facilitate effectiveness and objectivity in selection of network providers on a "best value" basis.
5. Ensure development of plans and protocols to minimize negative impact to consumers/family members as service provision responsibilities shift from one provider to another.
6. Ensure the implementation of an objective provider appeals process to address grievances regarding:

- Provider selection and contracting process
- Referral and evaluation processes
- Monitoring and sanctions.

If the Local Authority is also a provider, the following criteria would also apply:

- Ensure the separation of the authority and provider functions, either organizationally or functionally;
- Ensure the breakout and management of separate authority and provider budgets;
- Ensure that provider appeals are implemented through an independent third party;
- Ensure that the Local Authority' s services are reviewed by the NAC periodically for inclusion in the contracting process.

VII. Implementation of Recommendations

The Texas Department of Mental Health and Mental Retardation will have the responsibility for developing an operational plan to implement the recommendations in this report. In preparation for the next Legislative Session, the committee recommends that legislation related to a community MHMR center be separated from legislation related to a Local Authority to make clear the distinction between the two entities. (This does not preclude a community MHMR center from being a Local Authority.)

In preparation for the next session, the committee also recommends that TDMHMR develop a cost analysis for the implementation of proposed authority functions and develop plans for implementing a local authority structure based on local input and optimal size and efficiency.

Other recommendations for implementation include:

- The Texas Legislature develop mechanisms to integrate state hospital dollars with community resources that are to be managed by the Local Authority;
- Statute and rule be changed for both open enrollment and competitive bidding to promote choice and competition;
- Changing provisions for community MHMR centers and local authorities so that contract service requirements conform to the state' s general provisions; and
- Collaboration with other state agencies to develop consistency in standards, rights provision and reporting requirements.

A critical area identified by the committee was education on H.B. 1734 and its implications for consumers, family members, providers and community MHMR center staff. A user-friendly version of this report should be developed by July 15, 1998.

To minimize disruption for consumers and the existing system, the committee recommends that the proposed system be in place and operational by December 31, 2004. A proposed timetable is included in the report.

Chapter 1

History/Context of H.B. 1734

Background

Authority/Provider Task Force

In January 1994, the Board of the Texas Department of Mental Health and Mental Retardation appointed a "blue ribbon" task force to clearly articulate the role of the mental health and mental retardation authority. The task force was charged to make recommendations to:

- Ensure consumer choice and local ownership and control;
- Increase accountability to consumers and the public;
- Distinguish the role of government as a policymaker and a provider of services.

The issues the task force addressed were: TDMHMR' emphasis on its provider function; the conflict of interest when TDMHMR was both the regulator of certain services and a provider of those services; the loss of creative opportunities to develop efficiencies and resources; and the impact of managed care on the management of mental health and mental retardation services in the public sector.

The task force defined a mental health/mental retardation authority as:

A publicly accountable entity that holds the single point of responsibility for planning, policy development, resource development and allocation, and oversight within a specified geographic area.

The responsibilities of an Authority were determined to be:

- Strategic Direction/Planning
- Policy Setting
- Funding/Resource Management
- Service Performance Assurance
- Consumer/Service Advocacy

The task force made recommendations for defining and strengthening the authority role, for delegation of authority functions, for exploring new, creative opportunities, and for implementation of the recommendations.

These recommendations were enacted into law by the Legislature in 1995 as House Bill H.B. 2377.

H.B. 2377

H.B. 2377 authorized the Texas Department of Mental Health and Mental Retardation to fully develop the concept of state and local authorities in several pilot sites.

The role of TDMHMR as the State Mental Health and Mental Retardation Authority responsible for planning, policy development, coordination, resource development and allocation, and ensuring the provision of services was made explicit through H.B. 2377. These authority functions are of special significance as TDMHMR' s responsibilities have extended beyond the direct provision of services to functions that include: serving as an operating agency for Medicaid programs serving individuals with mental illness and mental retardation; regulation of private psychiatric hospitals; and setting standards for mental health and mental retardation services provided through Medicaid managed care.

Also, H.B. 2377 more clearly articulated the concept of a *local* mental health and mental retardation authority to which the State Authority may delegate certain functions and responsibilities. Expectations were set for the Local Authority in the areas of planning, resource development and allocation and other authority functions. Important among these is the expectation that each Local Authority develop and implement a network of service providers. Equally as important is the expectation that the Local Authority consider public input, ultimate cost-benefit and client care issues to ensure consumer choice and the best use of public money in assembling a network of service providers and in determining whether to become a provider of a service or to contract that service to another organization.

H.B. 2377 Pilot Implementation

The 2377 pilot implementation seeks to increase access, expand choice, and improve service quality while maintaining or reducing cost. To accomplish this, the sites are attempting to improve the quality of services and the efficiency of business practices in a number of Local Authority functions.

While pilot sites were required to develop within standardized frameworks, there was flexibility at the local level to experiment with different governance structures and some aspects of local practice and procedure. Each site chose to divide its authority and provider functions differently.

In local planning, the authorities use advisory committees to guide the development of services and supports in their areas. Mental health and mental retardation advisory committees with at least 50 percent consumer and family membership shape the strategic direction for the authority. Network advisory committees oversee the network development and management processes within the authority. A related function is contract management, which monitors and maintains contracts for services and supports developed in accordance with the needs of the local service areas. An important aspect of the network development process is the concept of "best value." Best value encompasses a number of selection criteria in addition to lowest bid which are important when delivering services to people with mental illness and mental retardation.

To ensure the quality of services and the integrity of quality improvement processes, the pilot authorities are implementing quality management and utilization management systems. The objective of the utilization management system is to provide individuals with timely, appropriate services. Quality management systems are designed to supply authority staff and advisory committees with information to support efforts to continuously improve their service system.

As support for all these functions, the authorities are engaging in the formation of revised financial and information systems. The financial system allows for the standardization of existing accounts, which vary by center, into a uniform cost accounting framework. This framework allows for a standardized comparison of costs across authorities and with private sector providers. The information system is intended to capture the revised financial, quality and utilization data for all potential providers within the emerging network.

H.B. 1734

Building on H.B. 2377, the 75th Legislature enacted H.B. 1734 which repealed the preferential status given to community MHMR centers in their designation as local authorities and required that TDMHMR appoint a committee to develop a plan for the most efficient and effective number of local authorities, the responsibilities to be delegated by the State Authority to the Local Authority, criteria by which local authorities shall be selected, the selection process, criteria for contracting by local authorities with providers, a timeframe for implementation, and strategies to ensure that services are not disrupted. (This report is a response to this legislation.)

In September 1997, the committee, chaired by Mike Bright and Joe Lovelace, was appointed by Commissioner Don Gilbert. The charge given to the committee is provided in the next section.

CHARGE TO H.B. 1734 COMMITTEE

Background

H.B. 1734 of the 75th Legislature requires that the Commissioner appoint a committee to develop a plan which recommends:

- the most efficient and effective number of local authorities;
- the responsibilities to be delegated by the State Authority to the Local Authority;
- criteria by which local authorities shall be selected;
- the process of selection;
- criteria to ensure that contracts between local authorities and providers are competitive and result in

the selection of the best bid;

- a time frame for implementation; and
- strategies to ensure that services are not disrupted.

The plan approved by the committee shall be submitted to the TDMHMR Board for approval. The Board is required to provide public notice of its intent to consider the approved plan, an opportunity for public hearings and public access to the proposed plan. The Board is then required to submit the approved plan to the Senate Health and Human Services Committee and the House Public Health Committee by September 1, 1998.

Committee Members

H.B. 1734 requires that the committee include an equal number of representatives of consumers, family members, existing local authorities, and private sector entities, including not-for-profit and for-profit entities. Besides these requirements, committee members have been selected on the basis of geographic and ethnic representation.

Issues to be Considered

Evolving Role of State Authority. In the current volatile healthcare environment, major structural changes are occurring in both the public and private sectors. These changes have resulted in new ways of conceptualizing the role of the State Authority.

The committee is encouraged to review approaches adopted in other states and to develop its own

definition of the role of State Authority for the purposes of developing the plan.

Delegation of State Authority Functions to Local Authority. In defining the responsibilities to be delegated from the state to the local level, the committee should consider which functions can be performed more effectively at a centralized level and which functions are better implemented at a local level. This balance should be defined in terms of both quality and cost.

Current Structure and Configuration. The committee should not be constrained by existing structures,

geographic configurations, initiatives, pilots, or statute in the development of this plan.

Definition of Criteria. Criteria referred to in H.B. 1734 should be defined and operationalized in objective, measurable terms.

Implementation of Plan. The plan should include a proposal for the implementation of the committee's recommendations, including the steps that must be taken, timeframes, resources required and precautions that must be taken to ensure that services are not disrupted in the transition process.

Guidance and Support

The Commissioner and Assistant Commissioner will serve as a guidance team and provide direction to this initiative. Vijay Ganju, Director of Planning, Leon Evans, Director of Community Services, and Cindy Hopkins, Director, Office of Consumer Affairs, will be lead staff to coordinate and support the activities of the committee. The committee will have access to national experts and expert consultants to provide information for and reaction to the work of the committee.

Target Date for Completion

The committee should submit the plan to the Board no later than June 30, 1998.

Chapter 2

State and Local Authorities: Issues and Current Status

State Authority: Issues and Current Status

Background

Building on a state-run institutional system, the mental health and mental retardation system in Texas has evolved to include a locally controlled community services system. With this evolution, the role of the agency has expanded from that of a provider of services to one in which its authority role, as a purchaser and regulator, has become increasingly important. At the same time, other state agencies have also become purchasers and regulators of mental health and mental retardation services with their own standards and requirements. This has led to the current situation in which different agencies have various administrative, management and regulatory roles related to public mental health and mental retardation services.

Issues

The state's role in the delivery of mental health services is fragmented and, for the most part, uncoordinated in terms of fiscal, regulatory and accountability structures. This is largely due to the overlap or intersection of responsibilities of different state agencies, both in terms of funding for services and in terms of their policy making and regulatory authority.

This is also true for mental retardation services, where responsibilities are fragmented based on a person's age: the Early Childhood Intervention Council is responsible for children with mental retardation 0-3 years of age; by mandate, the Texas Education Agency is primarily responsible for services to persons of school age; and the state mental retardation authority has responsibilities, although not mandated, services for adults with mental retardation.

Some specific examples regarding shared authority for mental health and mental retardation services include:

- TDMHMR has regulatory authority for private psychiatric hospitals while Texas Department of Health (TDH) licenses and certifies them;
- TDMHMR sets standards for mental health and mental retardation services for Medicaid managed care programs, while these are monitored by TDH;
- TDMHMR sets state standards for participation in the ICF/MR program, while Texas Department of Human Services (DHS) has licensing and certification responsibilities;
- TDMHMR, as the Medicaid operating agency, has responsibility for ICF/MR Level VIII for persons with related conditions, but the associated waiver program is the responsibility of DHS; and
- TDH has responsibility for a Medicaid eligible person with acute care mental health needs, while TDMHMR has responsibility for the person's longterm needs.

These examples illustrate a major issue related to the role of the state mental health and mental retardation authority: what should be the scope of the role of the State Authority and how should "shared" authority be managed?

Authority is often determined by which agency has fiscal responsibility but, as the examples illustrate, this is not always the case. Neither TDMHMR nor TDH provide funding for private psychiatric hospitals, but they share regulatory responsibility. TDMHMR does not "buy" Medicaid services provided through managed care contracts, but is statutorily authorized to develop standards for the mental health and mental retardation components.

The solution is not that all funds be merged. The fact that agencies have overlapping authority is both natural and legitimate. For example, Texas Department of Protective and Regulatory Services (DPRS) has responsibility for children in a state of abuse and neglect, some of whom have serious emotional disturbances and may require intensive

levels of residential treatment, and DPRS sets standards for and licenses residential treatment centers. For children with similar needs receiving services in the TDMHMR system, TDMHMR develops standards. In this case, the issue is not that funds need to be merged but rather that the standards should be consistent and reflect best practice, regardless of which agency is funding such services.

The existing fragmentation of authority can produce discontinuities in the service delivery system and make it more difficult to achieve goals for individuals receiving services. This results in significant costs to both tax payers and consumers. Clarifying agency roles and limiting the multiplicity of agencies involved in purchasing services, setting standards and regulating programs can result in administrative efficiencies.

Current Status

Texas Health and Safety Code §531.001 broadly defines the state mental health and mental retardation authority as responsible for planning, policy development, coordination, resource development and allocation, and oversight of mental health and mental retardation services. Within this framework, the current functions of TDMHMR are to: assure public accountability; develop policies; set standards; regulate services; develop and allocate resources; purchase services; and provide services.

Public accountability is assured through a broad participatory planning process and the reporting of performance on planning and budgetary targets. At present, the focus of such accountability is on the dollars that are appropriated to TDMHMR. Coordination of planning with other state agencies providing mental health and mental retardation services and services provided through the private sector is piecemeal rather than systematic.

TDMHMR is clearly the authority for the state and federal dollars which flow through the agency' s budget and for dollars required asdc al match. However, the TDMHMR role is unclear in relation to the public and private mental health and mental retardation services for which the agency does not have funding authority.

TDMHMR is required by law to define priority populations of persons with mental illness and persons with mental retardation who are most in need. State resources are then directed to services for these populations. These are populations for which TDMHMR is a purchaser of services using state and federal funds. Clearly, for some of the other authority functions, TDMHMR has responsibilities that go beyond the priority population -- for example, standard-setting for persons in Medicaid managed care.

As managed care is implemented for Medicaid-funded services, responsibilities for the mental health and mental retardation components are being coordinated across agencies but are not clearly defined. Similarly, as other state agencies deliver mental health and mental retardation services, the coordination of standards, reporting requirements and planning and accountability structures are not necessarily consistent or standardized.

Local Authority: Issues and Current Status

Background

The concept of local authorities originated in Texas in the mid-1980s as an administrative act of the commissioner of TDMHMR, acting as the state's mental health and mental retardation authority. The local mental health and mental retardation authority was conceived as an entity at the local level to which TDMHMR could delegate its authority. Originally, the designation was related to service provision and lead responsibility for addressing the needs of individuals returned to their communities from state schools and state hospitals. Community mental health and mental retardation centers were named the local authorities in areas they served, and community service divisions of state facilities fulfilled these functions in areas not served by Community Mental Health and Mental Retardation Centers (CMHMRC). Subsequently, Local Authority functions were added to the Health and Safety Code. Statutory provisions required that community centers be given preference as the designated Local Authority.

Subsequent legislation, most notably H.B. 2377, 74th Legislature, provided significant changes in the understanding of the concept of Local Authority by articulating key functions of the State Authority such as planning, policy development and resource allocation and by authorizing the State Authority to delegate this authority to local entities. The bill also introduced the notions of consumer choice and best value, putting the responsibility of ensuring both quality and cost-effectiveness on the Local Authority as it develops a network of providers.

When a community mental health and mental retardation center is designated as the Local Authority, the center has roles as both an authority and a provider of services. Sometimes, the authority or "policy making" and the provider role are perceived to be in conflict. Nationally, this issue is addressed in a variety of ways. Some states (Ohio, for example) use community boards which are authorities and have no provider roles; in other states, local authorities are essentially providers. Other approaches have been implemented in states where local authorities have various combinations of both functions. In Texas, models of the functional (not organizational) separation of these roles are being tested in the H.B. 2377 pilots. The three pilot sites are Travis, Lubbock and Tarrant Counties. Two regional pilot sites in East and South Texas have also been selected.

H.B. 1734, 75th Legislature, takes the concept of the Local Authority a step further. The bill repeals the statutory preference given to community centers as the designated Local Authority and requires that a committee with designated membership develop a plan specifying the number of local authorities, the functions that are delegated from the State Authority to the Local Authority, and the criteria by which a local mental health and mental retardation authority is selected.

Issues

A fundamental tension in the relationship of the State Authority to the Local Authority is a specification of the functions which should be centrally managed and administered and the functions which should be delegated to the local level. This tension is essentially the search for a balance between economies of scale for administrative and business

functions and responsiveness to local needs and preferences. Clearly, if the system is to be consumer-driven and based on local input, local entities must have the authority to implement functions related to these goals. However, especially with the advent of new managed care technologies, efficiencies can be achieved by having information systems and other business systems standardized and centrally located. A major consideration in the delegation of State Authority functions is that it not result in an additional layer of bureaucracy.

The relationship between the Local Authority functions and other management and provider functions is also an issue. As managed care has been implemented in the public sector, local authorities have had multiple roles: as a provider in the managed care entity's network, as an agent of the managed care entity performing managed care functions, and as an entity responsible for certain aspects of care not covered by the managed care entity. Also, while the local mental health and mental retardation authorities have had these multiple roles for the Medicaid population enrolled in managed care, the Local Authority continues to have responsibilities for the non-Medicaid population and the Medicaid populations that are the responsibility of the state TDMHMR authority. Responsibilities for governance, management and provision of services under managed care have not always been clear.

Additionally, other state agencies which also have authority for mental health and mental retardation services can delegate responsibilities for mental health and mental retardation services to local authorities. County and city governments can designate entities to be the purchaser, planner or regulator of services they fund, but these responsibilities are not necessarily consistent with those conveyed by the state mental health and mental retardation authority. If these authority functions can be aligned in some consistent manner, these functions could complement each other rather than create conflict and duplication of effort.

At the same time, there are models for a Local Authority which demonstrate the blending of funds and the integration of systems so that there are benefits both in terms of administrative efficiencies and consumer outcomes. The concept of a Local Authority also allows the legitimate definition of authority that various agencies may have at the state level to be integrated and coordinated at the local level. The Texas Children's Mental Health Plan is a good example.

These various perspectives culminate in the question of how the concept of a Local Authority can be used to promote consumer choice and "best value" for the public dollars available for mental health and mental retardation services.

Current Status

Currently, there are several initiatives under way to help define the role of the local mental health and mental retardation authority: the H.B. 2377 pilots; the Medicaid managed care pilots, including the planned pilot in Dallas where behavioral health services will be carved out; and the H.B. 1734 plan which will specify the number of authorities and the criteria by which a Local Authority will be selected.

In summary, H.B. 2377 is a vehicle to ensure that an authority selects the best provider; H.B. 1734 is a mechanism to ensure that a specified geographic area has the best authority. Each bill is attempting to ensure that Texans have the best value for the use of public mental health and mental retardation dollars.

Chapter 3

H.B. 1734 Committee Process and Activities

Introduction

The H.B. 1734 committee worked as a team with commitment, dedication and a spirit of collaboration and consensus. The first meeting occurred in the context of a two-day conference on "The Mental Health and Mental Retardation Authority in the 21st Century" which had national experts and presenters from other states to provide various perspectives on the issues to be addressed by the committee.

Between October 1997 and June 1998, the committee had nine two-day meetings. Subcommittees with specific tasks met between meetings of the full committee.

Members of the committee visited all the H.B. 2377 sites (Lubbock, Fort Worth, Austin) and the two regional sites in East Texas and South Texas.

In March 1998, the committee mailed its draft recommendations to approximately 500 persons inviting comment at public hearings. All major stakeholder groups were included in the mailing. These public hearings were held at seven locations in the state: Dallas, Lubbock, El Paso, Longview, Corpus Christi, Houston, and San Antonio. Stakeholder organizations were also invited to provide comment and discuss the draft documents at the committee meeting in April.

This report is a result of this intense set of meetings and activities that the committee has conducted over the last nine months.

Committee Meetings

At the initial meeting, the co-chairs established procedures for discussion of issues and for decision-making regarding the committee' s recommendations. Among these was agreement among committee members that the objective was to achieve consensus.

Consensus was defined as having heard and respected the opinions of all members, the committee endeavors to seek full agreement on all recommendations. However, when full agreement is not reached, no member feels so strongly against the recommendation as to prevent the endorsement of the Committee' s full report.

Based on this approach, the committee' s meetings addressed the following issues:

October 28, 1997

- Organizational meeting with the committee given background on issues being brought to bear on the public system at this time

October 29-30, 1998

- Symposium on authorities in the present system featuring experts from other states.

November 19-20, 1997

- Background of H.B. 1734
- Identification of process for activities of committee
- Information on the roles and functions of authorities
- Appointment of subcommittees
- Sequence of activities to address charge to committee
- Mechanisms to keep stakeholders informed and to receive input from them

December 19, 1997

- Report from Values Subcommittee with draft report including People Outcomes, Provider Principles, Public Principles and Funding Principles
- Report from Authority Subcommittee, discussion of six authority functions: Planning, Policy Development, Resource Development, Resource Allocation, Oversight, and Network Development

January 12-13, 1998

- Approval of Guiding Principles
- Site Visits Subcommittee Report
- Public Hearings Subcommittee Report
- Authority Subcommittee Report

February 27-28, 1998

- Continued work on the authority functions
- Report from 2377 site visits
- Report from Public Hearings Subcommittee with format for hearings

- Selection Criteria
- Number of Local Authorities
- Selection Process

March 13-14, 1998

- Approval of the following documents:
- Authority functions grid
- Selection Criteria
- Recommendations regarding number of Local Authorities
- Selection Process
- Criteria for Best Bid by Providers
- Final preparations for public hearings

-

April 28-29, 1998

- Stakeholder input
- Reports on public hearings
- Appointment of workgroups to consider specific issues

May 8-9, 1998

- Public Hearing reports
- Workgroup reports
- Strategies to ensure that services to consumers are not disrupted
- Timelines for implementation of recommendations

June 8-9, 1998

- Consideration of the Draft Final Report

Subcommittees

Much of the work of the committee occurred through subcommittees that addressed specific issues during the intervals between meetings of the full committee. The following subcommittees developed materials which were considered and revised by the full committee:

- Values/Guiding Principles (Chair: Mike Bright)
- Authority (Chair: Joe Lovelace)
- Public Hearings (Chair: Ric Barraza)
- Pilot Sites (Chair: Debbie Hiser)
- Legal Issues/Definitions (Chair: Joe Lovelace)
- Drafting (Co-Chairs: Joe Lovelace and Mike Bright)

H.B. 2377 Pilot Sites Visits

Committee Members visited all 2377 Pilot Sites during the month of February to determine how the pilots were working and what effect the pilots will have on the 1734 process. At least three members of the committee visited the following single pilot sites:

- Lubbock Regional MHMRA, February 12-13
- Austin-Travis County MHMRA, February 23-24
- Tarrant County MHMRA, February 24-26

The subcommittee members developed a standardized set of questions for use in the site visits. At each site, the committee interviewed consumers, family members, advisory committee members, advocates, public and private providers, board members and authority staff.

Site visits were also conducted at the two newly organized regional pilot sites:

- East Texas Behavioral HealthCare Network, Lufkin, February 2-3
- South Texas Regional Alliance of Community MHMR Services,

Corpus Christi, February 17

At these sites, the members interviewed the executive directors of the participating centers, board members, work groups which have been formed from the various areas, consumers and family members. The regional pilots were of special interest to the members of the 1734 Committee because of the administrative efficiencies which may be realized.

Members who attended the site visits reported to the full committee at the February meeting.

Public Hearings

Public Hearings were held in seven sites across the state for the purpose of receiving

public input on the draft recommendations of the 1734 Committee. These hearings were held in the following cities:

- Dallas, April 15
- Lubbock, April 22
- El Paso, April 23
- San Antonio, April 27
- Longview, May 4
- Corpus Christi, May 5
- Houston, May 6

There were two general sessions of the hearings, one in the afternoon beginning at 3:00 p.m. and a second in the evening beginning at 6:30 p.m. There was a panel of at least five committee members to hear comments from those attending. One of the co-chairmen of the 1734 Committee, Joe Lovelace or Mike Bright, introduced the panel and reviewed the recommendations of the Committee. Attendance ranged from 40 to 100 people, with an average of twenty-five providing testimony at each hearing. Ric Barraza, Chair of the Public Hearings Subcommittee, acted as facilitator for the comments. Each person speaking was allowed 3-5 minutes for their comments. Following each general session, three informal discussion groups were held for consumers and families, authority board members and staff, and providers, which allowed participants to further elaborate on issues of interest to them.

A report on the first four public hearings was made to the full committee at the April meeting, the last three at the May meeting.

Public Input to the Committee

In addition to these public hearings, the committee provided several opportunities for public reaction and input.

After the committee developed draft recommendations, they were mailed to approximately 500 persons for review and comment. The responses received were reviewed and addressed by the committee.

Also, the committee invited representatives of various stakeholder groups to provide comments and discuss the draft at its April meeting prior to the drafting of the final report. The issues that were identified through the public hearings and the other processes for public input were considered in the development of the final report.

Chapter 4

1734 GUIDING PRINCIPLES

The committee developed guiding principles which explicitly define the values that are the basis of the decisions resulting in its recommendations. These guiding principles reflect the values for the operation of the MHMR service delivery system.

Specifically, these guidelines were used to test and guide the preference given to a particular option in the decision-making processes of the Committee. These guiding principles were also used to evaluate the recommendations in this report.

The committee recommends that these guiding principles be adopted to guide the implementation of the recommendations in any future work as well.

Implementation of the recommendations from the 1734 Committee should promote and enhance a MHMR service delivery system that reflects the following values and principles:

People Principles

- Programs and individual relationships with consumers are successful when:
- They promote the health, safety, and welfare of the consumer,
- They assist and support the consumer to plan and meet his/her own goals and outcomes for independence and quality of life, and
- The consumer is satisfied with them.
- Consumers should receive training, treatment, and support to make meaningful choices.
- The consumer should make as many decisions as possible about his/her own life and services.
- All authority and provider decisions should be made at levels as close to the consumer as possible.
- Funding which supports services for a consumer should follow the consumer as he/she moves within the services system and/or as his/her individual needs change.
- Consumers and their families and friends should play a major role in authority planning and policymaking activities.
- As change occurs, authorities should ensure that no harm is done to consumers.

- Consumers should have, and know how to use, a fair and simple process to question individual program decisions with which they do not agree.
- Hiring, training, and keeping employees who support consumers to plan and meet their own goals for independence and quality of life should be a priority for State and Local Authorities and service providers.

Provider Principles

- Authorities should use a fair and honest process to:
- Establish and manage a network of service providers,
- Decide how well service providers are serving consumers, and
- Allow providers to question Authority decisions with which they do not agree.
- Authorities and service providers should work together as partners at both the state and local levels.
- Service providers should be actively involved in Authority planning and policymaking activities.

Public Principles

- Authorities should:
- Operate under Open Meeting and Open Record standards;
- Encourage all stakeholders to participate in and provide input into local and state decision making processes;
- Let the public know how it can be involved in developing the authority' s plans and policies.
- Authorities should be accountable to the public to ensure that high quality services are provided for reasonable costs.
- To ensure public accountability, members of State and Local Authority governing boards should be appointed through public processes.
- When problems occur, public officials and members of the public should have effective and clear means to deal with and solve the problem.
- The system should encourage and assist communities to:
- Value people with mental illness and mental retardation as citizens who participate and contribute;

- Include people with mental illness and mental retardation in all aspects of community life; and
- Promote the use of natural community supports by people with mental illness and mental retardation.

Funding Principles

- Local Authorities should efficiently and effectively use all of its funds to support consumer outcomes and best practices.
- Authorities should have maximum flexibility and control over use of service delivery dollars.
- The use of person directed planning, natural community supports, and community inclusion strategies enhance the efficient use of funds.
- When an authority produces savings by more efficient operations, the Authority should reinvest such savings in programs that promote positive consumer outcomes and personal growth.
- Monetary and other incentives should be developed to encourage:
 1. Creative, effective, efficient, and stakeholder-friendly local planning and management;
 2. Consumer choice through delivery of an array of the best possible services at the best value for the greatest number of persons; and
 3. Cooperation and collaboration:
 - Among providers,
 - Between Local Authorities and providers,
 - Between and among Local Authorities,
 - Between and among Local Authorities and the State Authority
- Consumers should have equal opportunities to receive well funded services. Funding should be fair and equitable across Local Authorities.

Chapter 5

State and Local Authority Responsibilities

Introduction

H.B. 1734 required the committee to define which functions of an authority are to be delegated to the local level. The approach of the committee to meet this requirement was

to first define the scope and responsibilities of the State Authority. This entailed reviewing the broad responsibilities of the State Authority defined in legislation, in previous task force reports, H.B. 2377 activities, and the experiences of other states.

Several problems and issues were identified regarding scope of State Authority responsibilities. Some of these issues exist because of ambiguity or lack of definition, others because of the fact that authority is shared across state entities. The sharing of authority across state agencies is partly related to the fragmentation of funding streams related to mental health and mental retardation services. The intent of the committee in consolidating these authority functions is to develop a single point of accountability and uniform and consistent standards, rights and performance expectations rather than to meld these various funding streams.

To address the area of authority responsibilities, the committee proposed the following broad functions:

- Planning
- Policy Development
- Resource Development
- Resource Allocation
- Oversight
- Network Development, and
- Consumer Empowerment

A fundamental tenet of this approach is that the State Authority is ultimately responsible for all authority functions and that these responsibilities are delegated by the state to the local level. In other words, authority at the local level is derived from the state.

State and Local Authority roles differ in the following ways:

- Scope: As their names apply, the scope of the State Authority is the entire state, while the Local Authority has responsibility for a particular area of the state (to be specified by the State Authority).
- Source of Authority: Legislation designates the Texas Department of Mental Health and Mental Retardation as the single state-level Mental Health and Mental Retardation Authority. A Local Authority is designated by the State Authority and derives its authority from the State Authority.

The State Authority operates within parameters established by legislation and by its Board. The Local Authority, in turn, operates within the parameters established by the State Authority and its local Board.

- **Funding:** A Local Authority may have state and local funds available (beyond the required local match) which are not obtained through the State Authority.

A fundamental aspect of the authority responsibilities described in subsequent sections of this chapter is that authority functions are not based on funding. An authority, both at the state and local levels, can have responsibilities that apply to programs and services that are not directly funded through them.

As the function and relationships of the state and local authorities are better defined, there is an ongoing tension regarding the accountability structure for a Local Authority. The Local Authority is accountable to both local government and state government. The mechanisms and balance needed to define such dual accountability is an issue that remains to be resolved.

This chapter addresses each of the broad functional areas of an authority, both at the state and local levels. Special issues in implementing these functions are also identified. Also, under each functional area, the report identifies how the proposed functions are different from the current status.

Planning

Overview

Planning comprises a set of activities which:

- Define the mission, vision, values and future direction of the system;
- Assess external political and economic realities and internal strengths and weaknesses;
- Identify needs and priorities for funding and program activities;
- Develop consensus and operational plans for the implementation of these activities;
- Monitor and measure the outcomes and extent of these activities; and
- Provide information for the continuation or reformulation of activities and future direction.

Planning is an ongoing management process at both the state and local levels. Planning functions at the different levels are intended to inform each other and to drive the budgeting and resource allocation processes.

Local needs and priorities identified in local plans are the basis for the development of the state-level strategic plan. Combined with direction from policy makers and analyses of external and internal factors, state-level objectives and strategies are specified. These are its appropriations, an operational plan is developed which drives performance contracts with authorities. Performance targets are monitored and measured. The results are then the first step in the development of the next round of local plans. A diagram of

the planning process is shown on the next page.

This diagram depicts the current planning process. A major concern of the committee is that mental health and mental retardation services in Texas are fragmented. The committee felt strongly that a critical planning role is to include mental health and mental retardation services that do not come under the direct administrative responsibility of the State or Local Authority to ensure coordination, consistency and efficiency in services. The committee proposed that planning at state and local levels include both the priority and non-priority populations. Plans at both levels should address issues of integration of all mental health and mental retardation services provided and also address issues of integration of mental health and mental retardation services with other service systems.

Another critical aspect of planning is the inclusion of the various communities that come under the purview of a Local Authority. Local authorities are expected to develop mechanisms for input and involvement of these communities. In fact, a Local Authority can delegate these mechanisms to entities that are responsible for sub-areas in a Local Authority's jurisdiction.

Based on these considerations, the responsibilities of state and local authorities related to planning are specified below.

Local Plan Development

Planning Responsibilities of State Authority

In collaboration with stakeholders and local authorities, the State Authority will:

- Develop strategic and operational plans for MH and MR services in the state that include the vision, values, mission, goals, strategies, outcomes and the definitions of the populations to be served with state dollars, to include the statutorily required priority population.
- Define biennial priorities and develop the Legislative Appropriations Request.
- Define criteria for the delegation of the authority function to the local level and the functions and responsibilities of local authorities.
- Collaborate with Health and Human Services Commission, other state agencies and organizations to coordinate planning for persons with mental illness and persons with mental retardation.
- Define functions of CMHMRs and other providers.
- Designate a Local Authority for a geographic area (also to be specified by the State Authority).

Planning Responsibilities of Local Authority

In collaboration with consumers, family members and other stakeholders, the Local Authority will:

- Develop a strategic plan for mental health and mental retardation services for the local area for which the Local Authority is responsible. This plan includes vision, mission, values, goals, strategies and outcomes consistent with the State Authority' s strategic plan and defines local needs and priorities.
- Develop mechanisms for input and involvement of community members for the development of the Local Authority strategic plan, including coordination with local stakeholder organizations.

Issues

1. A major constraint to planning comprehensively for mental health and mental retardation services at both the state and local levels is the state' s planning and budgeting system which ties planning objectives to the funding a state agency receives. Planning mental health and mental retardation services across state agency lines will require a shift in the orientation of existing planning efforts.
2. Re-designation of local authorities requires that new mechanisms for stakeholder involvement and inclusion may need to be developed. If a Local Authority is designated to cover a greater area than in the current system, these mechanisms need to ensure that stakeholder input and inclusion are representative of the various communities under the Local Authority' s jurisdiction.
3. Combining authority and provider functions in the same organizational entity may result in conflicts of interest at both state and local levels.

Policy Development

Overview

In this context, policy includes both strategic direction and priorities and operational specifications related to standards, rules, performance expectations, quality, outcomes, rights protection, health and safety, personnel, finances, research, best practices and best practice guidelines.

The committee recommends that the state mental health and mental retardation authority should define standards, rules, expectations for performance, quality, outcomes, rights protection, health and safety, best practices and practice guidelines for all publicly and privately funded mental health and mental retardation programs.

The rationale for this recommendation is that persons with mental illnesses and persons with mental retardation should have uniform expectations of services regardless of who is paying for or providing these services. Also, differences in standards, expectations and reporting requirements create an unnecessary and duplicative administrative burden on providers.

Currently, the responsibility for such standards and rules are fragmented and lack uniformity across state agencies. The intent of the committee is to identify a centralized single authority to define rights, practice guidelines, and performance expectations in a

uniform, consistent way regardless of funding authority.

The responsibilities for policy development at state and local levels are specified below.

Policy Development - Responsibilities of State Authority

- Define standards, rules and expectations for performance, quality, outcomes, rights protection, health and safety, best practices, practice guidelines for all publicly and privately funded MH and MR programs.
- Collaborate with stakeholders, local authorities and other state agencies to define standards, rules and expectations.
- Define standards, rules and expectations for "safety net" services.

Policy Development - Responsibilities of Local Authority

- Within the framework established by the State Authority, the Local Authority is responsible for the development of policies for the operational aspects of the local service delivery system.
- The Local Authority is responsible for ensuring compliance with standards, rules and expectations established by the state for programs and services to be defined by the state.
- The Local Authority will develop mechanisms to provide input to the State Authority regarding the usefulness and implementation of standards, rules and expectations.

Issues

1. The Texas Department of Mental Health and Mental Retardation does not have the authority to promulgate standards, rules and performance expectations for all public and private MH/MR services. Mechanisms will need to be established to work with other state agencies to develop standardization and consistency across programs.
2. As the role of the state mental health and mental retardation authority becomes clearer regarding issues such as standards and rights, the Local Authority will be responsible for ensuring compliance not only for programs funded by the Local Authority but for other programs as well.

Resource Development

Overview

Resource development includes: obtaining funds for the maintenance and growth of needed programs, maximizing resources from potential sources, optimizing collaborative

and pooling arrangements, creating appropriate incentives and using available resources efficiently and innovatively.

The major emphasis of the responsibilities related to this function is to actually implement the various aspects of resource development listed above. The committee recommends that the issue of local match be given special attention.

At the state level, the State Authority should create incentives and define expectations and benefits clearly for the financial participation by local governments and other sources. At the local level, the Local Authority will be responsible for obtaining this local match from local governments and other sources.

Resource Development - Responsibilities of State Authority

- Maximize opportunities for existing and new dollars/resources, including local match.
- Increase system level administrative and service efficiencies.
- Create incentives and expectations for financial participation by local governments and other sources.
- Pool dollars and resources with other agencies at state level.
- Ensure that resources developed address initiatives and needs identified in state plans and policies.

Resource Development - Responsibilities of Local Authority

- Maximize opportunities for existing and new dollars/resources.
- Increase local level administrative and service efficiencies.
- Pool dollars and resources with other agencies at local level.
- Ensure that resources developed address initiatives and needs identified at state and local level.
- Local Authority will be responsible for obtaining local match from local governments and other sources.

Issues

1. "Local match" needs to be redefined so that there is consistency in its application across the state.

Resource Allocation

Overview

Resource allocation is the distribution of resources across geographic areas, service programs, and management functions.

A critical issue for the committee is the fragmentation of resources even when such resources are the responsibility of the state mental health and mental retardation authority. "Resources" include community resources, state facility resources, Medicaid and any other resources that are available.

While the role of the State Authority is to allocate resources equitably across authorities, the role of the Local Authority is to allocate resources within the Local Authority' s jurisdiction. The Local Authority is also responsible for allocating resources to services, contracts with service providers (including state facilities) and local management functions.

Resource Allocation - Responsibilities of State Authority

- Develop and implement a decision process consistent with values, priorities and desired outcomes to allocate resources to consumer needs and choices and local authorities.
- Distribute dollars and resources equitably to the local authorities.
- Contract dollars and other resources (including Medicaid) with local authorities to implement plans and policies.

Resource Allocation - Responsibilities of Local Authority

- Develop and implement a decision process consistent with the framework established by the state and with local values, priorities, consumer needs and choices and desired outcomes to allocate resources to services, contracts with service providers, and management functions (information systems, financial systems, etc.).
- Distribute dollars and resources within the Local Authority' s jurisdiction.
- Contract dollars and other resources (including Medicaid) with service providers.

Issues

1. For these functions to be implemented, increased flexibility in allocations at both state and local levels is needed.
2. The State Authority will need to work with the Health and Human Services Commission (the State Medicaid agency) to implement this function.
3. The roles and responsibilities of local government in the allocation decision process need to be more clearly defined.

Oversight

Overview

Oversight is ensuring that policies, standards and contract requirements are being appropriately implemented.

The role of the State Authority is to ensure the availability, adequacy and objectivity of State and Local Authority accountability systems (e.g. quality management, utilization management). The role of the Local Authority is to monitor providers, services and outcomes (within the framework of policies, standards and contract requirements established by the state).

A major difference from the current implementation of this function is that monitoring providers at the local level would be a function of the Local Authority. Also, the role of the State Authority would be to monitor local authority functions rather than provider functions.

Oversight - Responsibilities of the State Authority

- Ensure availability, adequacy and objectivity of State and Local Authority accountability systems (e.g. Quality Management (QM), Utilization Management (UM), etc.).
- Develop incentives and sanctions for local authorities based on performance criteria.
- Ensure and enforce implementation of standards, rules and contract requirements.
- Advocate for needed programs, policies and services to address consumer needs and choices.
- Define criteria, processes and the role of the Local Authority to enforce implementation of standards, rules and contract requirements.

Oversight - Responsibilities of the Local Authority

- Monitor providers, services and outcomes to ensure implementation of standards, rules and contract requirements.
- Coordinate services to ensure that resources meet individual consumer needs and choices.
- Advocate for needed programs, policies and services to address consumer needs and choices.
- Ensure the fit of services and resources with individual consumer needs.
- Enforce implementation of standards, rules and contract requirements (in line with the role defined for a Local Authority).

Issues

1. Currently, the Local Authority is not responsible for the oversight of service providers, and the focus of State Authority quality management is more on provider functions than authority functions. The capacity to implement the oversight functions as proposed will need to be developed.
2. A fundamental issue in the relationship between the State Authority and the Local Authority is the accountability of the Local Authority to both the State Authority and to local government. Mechanisms for such dual accountability still remain to be defined.

Network Development

Overview

Network development refers to the development of a provider system which provides meaningful choices, competition and objectivity.

The role of the state is to provide a framework and support for the development of adequate networks at the local level. The role of the State Authority is to provide guidelines, templates and criteria for network development and to provide technical assistance in this area.

The role of the Local Authority is to manage the enrollment and ensure the quality of local providers, to develop referrals and linkages to service providers, to act as a single portal authority for both MH and MR services and to implement credentialing and provider profiling systems. Other Local Authority functions include managing the waiting list (where authorized by law), and ensuring "safety net" services.

Network Development - Responsibilities of State Authority

- Ensure availability and adequacy of a local network that provides meaningful choices, competition, and objectivity.
- Provide guidelines, templates, criteria for network development.
- Provide technical assistance to local authorities to develop networks.
- Ensure "safety net" services.

Network Development - Responsibilities of Local Authority

- Ensure availability and adequacy of a local network that provides meaningful choices, competition, and objectivity.
- Develop network contracts and manage the network.
- Manage the enrollment and ensure quality of local providers.
- Implement credentialing and provider profiling systems.

- Conduct provider certification surveys.
- Implement a provider appeals process.
- Provide technical assistance and training to service providers.
- Implement systems for assessment, eligibility determination, level of care and need assignment, service coordination assignment and referral/linkage to service providers.
- Act as a single portal authority for both MH and MR services.
- Manage waiting lists.
- Ensure "safety net" services.

Issues:

1. Capacity to implement this function statewide currently does not exist and will need development.
2. The Local Authority may accomplish its functions either directly or through contracts with other entities.

Consumer Empowerment

Overview

Consumer empowerment is an ongoing process to provide consumers with authority and personal control. In this context, consumer empowerment means the meaningful inclusion and participation of consumers and family members in all authority functions including the design, implementation and evaluation of the service delivery system. Essentially, this is the process through which an individual who is now receiving or has received mental health or mental retardation services is provided the means to be a self advocate.

The role of the State Authority is to implement mechanisms for consumer empowerment at the state level and to ensure consumer empowerment at the local level. The role of the Local Authority is to implement mechanisms for consumer empowerment at the local level. The committee recommends that a consumer ombudsman function be developed at both levels.

Consumer Empowerment - Responsibilities of State Authority

- Implement mechanisms to ensure meaningful participation of consumers and family members in all the functions of the State Authority.
- Develop requirements and incentives for consumer and family member inclusion and involvement at the local level.

- Develop and implement systems to provide education, support, advocacy, rights protection, and problem and conflict resolution.
- Ensure the existence of simple consumer grievance and appeals processes.

Consumer Empowerment - Responsibilities of Local Authority

- Implement mechanisms to ensure the involvement of consumers and family members in all the functions of the Local Authority.
- Develop and implement systems to provide education, support, advocacy, rights protection, and problem and conflict resolution.
- Develop and implement consumer grievance and appeals processes.
- Ensure the development of service plans that reflect and address consumer needs and preferences (person-directed planning).

Issues

1. An implication of these responsibilities is the operation of offices of Consumer Affairs at both state and local levels. Offices of consumer affairs would be an integral component of the Authority at both levels.
2. An Ombudsman Program is a key component of Consumer Empowerment. The Committee recommends that the State Authority develop a uniform, consistent system across the State and Local Authority structure so that consumers can have an office to represent their interest in resolving problems or concerns about services and supports at the authority or provider level.

Chapter 6

Criteria for the Selection of a Local Authority

Overview

The committee defined two types of criteria for the selection of a Local Authority. The first set of basic criteria is related to the governance and organizational structure; the second set is related to the capacity of the entity to perform the authority functions defined in the previous chapter.

(The Committee defined the term "capacity" to include the following elements:

- Staff resources to ensure implementation of the criteria
- Financial resources, to include operational and reserve funds;
- Leadership;
- Community connections; and

- Access to necessary expertise.)

The first set of criteria addresses the composition of the governing board, the process by which the governing board is appointed, the types of organizations eligible to be a Local Authority, the financial capacity and solvency of the organization, the ability of the organization to meet the standard established by the state for administrative/authority costs, and whether the authority will also be a provider of services.

The public process by which a governing board is appointed is defined as appointment by elected local officials, within given criteria, from a list generated by a public application process.

The issue of whether an authority could also be a provider was vigorously debated by committee members. The consensus position was that if an authority was also a provider, the entity applying to be an authority would have to show how it intended to minimize the conflict of interest inherent in having dual roles. The entity would also have to show how it intended to ensure objectivity in the provider selection process.

The second set of selection criteria are related to the capacity of the entity to perform the required functions of planning, policy development, resource development, resource allocation, oversight, network development and consumer empowerment.

The specific criteria are provided in the following sections.

Selection Criteria

A. Governance and Organizational Selection Criteria

The entity must demonstrate its capacity to conform to the following basic selection criteria:

1. Operate in a manner consistent with Open Meeting and Open Record statutes.
2. Develop a governing board which:
 - a. Is appointed through a public process;
 - b. Includes at least 50 percent consumer, family member and advocate representation; (The Local Authority shall designate the minimum number of consumers on the board.)
 - c. Ensures among board members a thorough knowledge of the needs of

persons with mental retardation and serious mental illness.

1. Demonstrate that it is a governmental entity, a not-for-profit charitable corporation or an organizational combination of such entities.
2. Describe the type of authority to be established. The Local Authority formed may be:

- a. a local mental health authority;
 - b. a local mental retardation authority;
 - c. a local mental health and mental retardation authority;
 - d. a local behavioral health authority;
 - e. any combination of the above.
1. Operate in compliance with the public accountability requirements of Texas law (to be defined on the basis of research and review by TDMHMR).
 2. Describe whether the authority will also be a provider of services. (If so, the entity will fully disclose the measures it will take to minimize any conflict of interest which may arise in performing dual roles.)
 3. Ensure objectivity in the provider selection process and describe the process used to achieve such objectivity.
 4. Provide evidence to demonstrate financial capacity and solvency to fulfill Local Authority functions.
 5. Provide past performance evaluation of the entity (if applicable).
 6. Demonstrate the ability to comply with any limits prescribed by the State Authority on costs of implementing local authority functions.

B. Selection criteria related to the capacity of the entity to perform required Local Authority functions.

In addition to the basic selection criteria noted above, the entity must respond to the following criteria related to its capacity to perform required Local Authority functions:

1. Planning

- a. Implement mechanisms to include consumers, family members, advocates and providers in the definition of local needs and priorities and the development of the local plans.
- b. Coordinate and plan with other service delivery systems, including private providers, school systems, private hospitals, ECI providers, the criminal and juvenile justice systems and other health and human services delivery systems.
- c. Implement information systems and data processing functions that produce reports to support planning, policy development and oversight functions.

2. Policy Development

- a. Guarantee compliance with standards, rules and expectations.

- b. Implement mechanisms to include consumers, family members, advocates and providers in the policy development and review process.

3. Resource Development

Demonstrate ability to obtain financial support and other resources (including local match) from local governments and other sources.

4. Resource Allocation

Implement business skills, administrative infrastructure and accountability processes to ensure efficient allocation and effective monitoring of resources allocated to providers.

5. Oversight

- a. Ensure systematic process for monitoring and improving the quality of services.
- b. Implement a Quality Improvement Committee that includes consumers, family members, advocates and providers.
- c. Ensure the availability of a Consumer Ombudsman and other effective mechanisms to protect consumer rights and interests.
- d. Ensure that consumers receive state-of-the-art appropriate services, treatment and medications.
- e. Process and analyze data for performance monitoring and decision making.
- f. Ensure objectivity in performance monitoring.
- g. Ensure implementation of enforcement functions delegated to the Local Authority by the State Authority.
- h. Ensure meaningful involvement of consumers, family members, advocates and providers in oversight activities.

6. Network Development

- a. Ensure development of a network that conforms to accessibility, availability, and consumer choice standards.
- b. Ensure development of a network in which there are providers who are linguistically and culturally diverse.
- c. Implement credentialing and provider profiling systems to ensure that the qualifications of providers meet standards set by the State Authority.
- d. Ensure availability of language, interpreter, and other needed facilitation services in accordance with state and federal laws.

- e. Ensure availability of required "core" services.
- f. Establish written procedures for referral, pre-authorization, assignment of level of services, provider management responsibilities and service coordination processes.
- g. Ensure meaningful involvement of consumers, family members, advocates and providers in network development activities.
- h. Ensure availability of "safety net" services.
- i. Implement mechanisms to address provider appeals and grievances.

7. Consumer Empowerment

- a. Ensure adequate education for consumers and family members regarding their rights, complaint systems, processes for appeals and fair hearings, procedures to access providers in the network and the choices that are available to them.
- b. Implement mechanisms and processes to comply with state and federal laws regarding confidentiality and release of information.
- c. Develop individual service plans that reflect and address consumer identified needs and preferences.
- d. Implement mechanisms to ensure the meaningful involvement of consumers, family members and advocates in the various functions of the Local Authority.
- e. Implement mechanisms to address consumer appeals and grievances in compliance with state and federal statutes.
- f. Provide education and support to consumers, family members and advocates to participate in authority functions.

Chapter 7

The Most Effective Number of Local Authorities

Overview

The committee considered various options to designate a specific number of authorities based on population size, geographic areas, alignment with other state agency boundaries, and proposed county configurations to be used in Medicaid managed care. The committee also visited the regional H.B. 2377 pilot sites where current local authorities were redefining the new boundaries of a more regionalized concept of a local authority.

Based on this review and the consideration that an arbitrary designation of boundaries or size could be disruptive for both consumers and providers, the committee developed recommendations for the state authority to determine the most effective number and size based on an evolutionary model.

Recommendation #1:

The Committee does not recommend a specific number as the most effective and efficient number of authorities. Rather, the Committee recommends that the state allow the number of local authorities to be determined by:

1. The continued operation of the evolutionary "environmental forces" that have contributed to the design of the current system; (to include 2377 pilot results)
2. The State Authority's response to managed care and other dynamic forces that will impact the system in the future; and
3. The Local Authority Selection Criteria and Selection Process developed by this Committee.

Recommendation #2:

The Committee proposes that, in lieu of recommending a reduction or other change in the number of local authorities, the Committee recommend that the State Authority, with necessary support from the Legislature, develop incentives and protocols by which to promote the development of voluntary regional management coalitions among local authorities. The State Authority should use the Authority Screening and Implementation Advisory Committee to develop recommendations regarding these incentives and protocols.

Recommendation #3:

The State Authority in collaboration with stakeholders, including local authorities, should develop a series of Authority Management Performance Standards (and a related reporting mechanism) that would give evidence of local authorities not functioning at prescribed levels of efficiency and effectiveness. Such standards should be incorporated into Performance Contracts with local authorities. If the reporting mechanism indicates that a Local Authority is failing to maintain such standards, the State Authority, after having provided technical assistance and support to the Local Authority to enable it to

meet standards, would have the authority to either require the Local Authority to participate in a regional management coalition or to terminate its contract.

Chapter 8

Selection Process

Introduction

The selection process is premised on the designation of the area for which a Local Authority will be responsible. In this sense, the selection process is ultimately tied to processes related to the most effective number and size of local authorities addressed in the last chapter.

The process for selecting an authority is outlined below.

Selection Process

- The State Authority shall designate a Local Authority in one or more local service areas of the state.
- The State Authority will determine the area of operation of a Local Authority based on the ability to be effectively responsive to and representative of the community/communities. The State Authority should include factors such as the following:
 - Historical operations
 - Geographic size
 - Total population to be served
 - Number of consumers of services in the area
 - Financial resources
 - Number and abilities of providers in the area
 - Other state initiatives, e.g. Medicaid managed care regions.

(NOTE: This will ultimately determine the number of authorities.)

- The State Authority will issue a Request for Information (RFI) that allows all qualified and interested entities to be fairly and objectively considered for the designation as a Local Authority and to gather suggestions from interested parties on the size, shape and design of the proposed Local Authority.

- The State Authority will then issue a Request for Proposal (RFP) to which those entities interested in being designated the Local Authority may respond.
- When local entities respond to the RFP, they may either apply to become the authority for the entire region or two or more authorities may form a management collaborative alliance, provided that together they serve all of the counties in the region.
- Responses to the RFP will then be reviewed by an authority screening and implementation advisory committee to be established by the State Authority. The screening committee will be composed of an equal number of consumers, family members, advocates, public providers and private providers with expertise in mental health and mental retardation.
- The screening committee will review and rank the proposals submitted in response to the RFP according to the criteria proposed in this report and make recommendations to the State Authority.
- The final decision of the State Authority will be based on the screening committee's recommendation, and the cost effectiveness of the proposal, but ultimately the best interest of the consumers and their families.
- The Local Authority will be appointed for a period of four years. The State Authority will develop, with input from the authority screening and implementation advisory committee and stakeholders, an annual performance review upon which all authorities will be graded. The State Authority will conduct an annual performance review and publish the results in the format of a report card. During the annual review in the third year, the evaluation process will include elements to review to determine if the authority should stand alone for re-designation as a Local Authority at the end of the fourth year.
- At the end of four years, other entities could submit a proposal of how they might perform the authority functions better. If there is not a substantial improvement proposed, the existing authority would be given preference.

If the evaluation process determines the existing Local Authority should stand alone for re-designation, a public process would occur (including a public hearing conducted locally by the Authority Screening and Implementation Advisory Committee), allowing input from all interested stakeholders prior to the State Authority making its decision. If the evaluation process determines that other entities should be considered, then the same process used in the original designation will occur.

- A Local Authority could be de-selected within the four-year period if not functioning effectively. Incentives for enhanced performance could be built into the contract. The annual performance review criteria and report card will contain a grading system which, if performance scores were low, would activate the State Authority to take corrective action. Any action taken would consider the impact upon the consumers of services.

- A Local Authority and the State Authority may agree during the designation period to reform or restructure the area of operation of the Local Authority and the entities involved in the Local Authority designation without the necessity to re-bid the designation. However, the voluntary reorganization of the Local Authority cannot be used to subvert the public process of Local Authority designation.
- The initial appointment of Local Authorities would begin September 1, 2001. From the date of designation, they would have up to one year to become operational.
- An existing Local Authority may be re-designated two consecutive terms (maximum 12 years) before the process is opened to outside proposals.

Chapter 9

Criteria for Contracting by Local Authority with Providers

Overview

The Local Authority has the responsibility for selecting and contracting with providers to ensure that consumers have more choices and that services are cost-effective. All providers who meet specified criteria should have a fair opportunity to participate in the network.

The Local Authority is required to establish a Network Advisory Committee to advise the Board of the Local Authority on the procurement process and the selection of providers. Network Advisory Committee functions could be performed by existing committees or designated subcommittees as long as the committees have the same requirements regarding committee membership as the Network Advisory Committee. For example, a local planning advisory committee or a subcommittee could serve as the Network Advisory Committee.

In order to ensure that provider selection and contracting are fair, competitive, and result in the selection of the best bid, the Local Authority will adhere to the following basic criteria:

A. For all Local Authorities:

1. Ensure that plans to expand, restrict, or otherwise alter current services reflect input of consumers, family members, advocates and providers through planning advisory committees and other defined processes.
2. Ensure adoption of a written, locally appropriate definition of "best value" which effectively balances the following elements:
 - Access

- Consumer Choice
 - Quality
 - Cost Efficiency
1. Ensure Board appointment of one or more Network Advisory Committees (NAC), to include at least 50 percent consumer, family member and advocate representation (with the minimum number of consumers to be specified by the Local Authority).
 2. Ensure a specific, written "charge" defining the Network Advisory Committee' s responsibility, limits of authority and reporting requirements. The charge, at a minimum, should include the following responsibilities:
 - a. To oversee the objectivity of the network design, development, and operation;
 - b. To ensure appropriate balance regarding consumer choice, quality, cost-effectiveness and access;
 - c. To provide guidance for network development and operation;
 - d. To recommend procurement procedures for services, including whether they should be put out to bid and whether there is open enrollment.
1. Ensure development of NAC policies and procedures to address members' objectivity and conflicts of interest.
 2. Ensure Network Advisory Committees are appropriately staffed and supported to meet their charge.
 3. Ensure the review of existing and needed services to define priorities and time frames for the services which will be procured.
 4. Ensure development by the NAC of a written process to facilitate effectiveness and objectivity in selection of network providers on a "best value" basis.
 5. Ensure development by the NAC of a written process to facilitate effectiveness and objectivity in monitoring and evaluating network providers.
 6. Ensure development by the NAC of a written process for making decisions regarding the oversight of contracts with network providers.

7. Ensure the availability of utilization management and utilization review data for NAC decision making.
8. Ensure development of plans and protocols to minimize negative impact to consumers/family members as service provision responsibilities shift from one provider to another.
9. Ensure the implementation of an objective provider appeals process to address grievances regarding:
 - Provider selection and contracting process
 - Referral and evaluation processes.
 - Monitoring and sanctions.

A. For Local Authorities that will also be a provider:

1. Ensure the separation of the authority and provider functions, either organizationally or functionally.
2. Ensure the breakout and management of separate authority and provider budgets.
3. Ensure that provider appeals are implemented through an independent third party.
4. Ensure that the Local Authority' s services are reviewed by the NAC periodically for inclusion in the contracting process.

Chapter 10

Implementation of Recommendations

The committee recognizes that implementing these recommendations will involve additional costs in the short-run before efficiencies and benefits are realized. The committee strongly recommends that the Legislature provide additional funds for these initial and transitional costs rather than require implementation within the framework of existing dollars. Texas has an under-funded system: the committee wants to ensure that implementation of the recommendations is not disruptive for consumers or programs, as required by H.B. 1734 legislation.

The recommendations of the committee essentially provide the framework and guide for the implementation of the recommendations. Many of the specific recommendations will require detailed operational plans that TDMHMR will have to develop. The committee envisions that this planning process will start soon after the TDMHMR Board accepts this report.

Work will have to be done in preparation for the next Legislative session. The work of the committee implies substantial change to the legislation related to community MHMR centers which in some parts of current statute are considered to be synonymous with a Local Authority. The committee recommends that legislation related to a community MHMR center be separated from legislation related to a Local Authority to make clear the distinction between the two entities. (This does not preclude a community MHMR center from being a Local Authority.)

Also, work needs to be done regarding the costs of implementing the proposed authority functions and the implementation of the selection process of an authority. Some of these costs are currently borne by other state agencies. Others are costs of implementing new functions. The committee wanted to emphasize that there are costs of transition to the new, proposed system which are different than the ongoing, operating costs of the proposed authority structure and functions.

A critical area identified by the committee was education on H.B. 1734 and its implications for consumers, family members, providers and community MHMR center staff. Without a clear understanding of the roll-out of H.B. 1734, rumor and hearsay will lead to disruption, both for consumers and provider staff.

Based on these considerations, the committee specifically proposes the creation of a 1734 Authority Screening and Implementation Advisory Committee at the state level and development of a consumer ombudsman office, both at the state and local levels, to provide support to consumers experiencing service planning or delivery problems. Also, the committee proposes that the Local Authority system shall be in place and fully operational by December 31, 2004, to allow sufficient time for implementation without disruption.

There should be a filing fee for any entity making application to be an authority to help defray the costs of the 1734 Authority Screening and Implementation Advisory Committee with the amount of such fee to be determined by the Commissioner.

To support this implementation process, the committee recommends the following specific actions:

1. In preparation for the next Legislative session
 - a. develop language so that legislation related to a community MHMR center be separated from legislation related to a Local Authority to make clear the distinction between the two entities;
 - b. start planning for the implementation of the proposed authority structure and functions;
 - c. develop a cost analysis for the implementation of proposed authority structure and functions.
1. The HB 1734 committee recommends that the Legislature develop mechanisms to integrate state hospital dollars with community resources

that are to be managed by the local authority.

2. Statute and rule be changed to allow for both open enrollment and competitive bidding, thus promoting two acceptable ways to create choice and competition.
3. Change the provisions for community MHMR centers and local authorities so that the contract service requirements for former employees conform to the state' s general provisions.
4. Work with other state agencies to coordinate plans to develop consistency in standards, rights provision and reporting requirements for programs for persons with mental illness and mental retardation.

Strategies to Ensure that Services to Consumers are not Disrupted

1. By September 1, 1999, the Commissioner shall empanel a state level 1734 Authority Screening and Implementation Advisory Committee to provide guidance and oversight throughout the implementation process. The advisory committee shall include representatives of consumers, families, advocates, providers, and local authorities. (The committee shall meet at least quarterly to receive progress reports and make recommendations consistent with the 1734 final products.)
2. The Commissioner shall ensure the development of a Local Authority implementation plan which includes at least the following elements:
 - Appointment of an independent ombudsman to provide support to consumers and families experiencing service planning or delivery problems;
 - Strategies to transition authority functions from the current authority to the newly designated authority;
 - Strategies to transfer state funding and contracts from the current Local Authority to the newly designated Local Authority;
 - Development of a local implementation advisory committee, including representatives of consumers, families, advocates, and service providers, to provide guidance and oversight of the implementation plan; (This committee' s responsibilities could be performed within the existing planning advisory committees or the network advisory committee; the committee shall meet at least quarterly to receive progress reports and make recommendations.)
 - Plans to educate local consumers, families, and advocates regarding transition

plans and issues;

- Special concerns of rural areas.
- 1. The Commissioner shall insure development, production, and distribution of a "user friendly" summary of the 1734 Committee recommendations (as modified through the legislative process). The summary shall be distributed to consumers, families, and advocates in all Local Authorities.
- 2. The Commissioner shall include in the forthcoming Legislative Appropriations Request (and future LAR.s) a request for funding to support the implementation of the authority selection process and the transition process.

Timeline for Implementation of 1734 Committee Recommendations:

- July 9-10, 1998 Presentation to the Board of TDMHMR.
- July 15, 1998 A "user friendly" document will be produced.
- August 1998 State Authority begins planning for implementation.
- September 1, 1998 1734 Committee Report sent to the Senate Health and Human Services Committee and the House of Representatives Public Health Committee.
- May 31, 1999 Texas Legislature will address the Committee recommendations.
- September 1, 1999 Enabling legislation likely to become effective.
- September 1, 1999 Commissioner of TDMHMR shall appoint a 1734 Authority Screening and Implementation Advisory Committee.
- January 1, 2000 Begin the phase-in of 1734 Committee proposals, with the State Authority working out the operational implementation scheme/parameters.
- January 1, 2000 The Department will have a plan in place and issue the RFI.
- September 1, 2000 The Department will determine the number of authorities and the geographical boundaries.
- September 1, 2001 Initial designation of Local Authority. From the date of designation of a Local Authority, it will require a period of time up to one year to become operational.
- December 31, 2004 The "new" Local Authority system shall be in place and fully operational.
- 2001, 2003 The Commissioner will report progress to the Legislature at each

session prior to full implementation.

GLOSSARY OF TERMS

Access - An individual's ability to obtain services to achieve the best possible outcome. Barriers to access may be structural, organizational, financial, or personal. The ease of access is determined by availability of services, their acceptability to individuals, transportation, hours of operation, language, and cultural competencies.

Advocate - A person who by virtue of knowledge, interest, and direct or indirect experience represents the wishes and interests of persons with mental disabilities.

Authority - A publicly accountable entity that holds the single point of responsibility for planning, policy development, resource development and allocation, oversight, network development and consumer empowerment within a specified geographic area.

A **State Authority** is responsible for the whole State. A **Local Authority** is responsible for a geographic area within the State. The Local Authority gets its responsibility from the State.

(The convention used in this report is that Authority (with the capital A) is used in reference to an entity and authority (small a) is used in reference to functions.)

Behavioral Health Services - A broad term which is used to include mental health and substance abuse services.

Best Bid - A term used to determine which proposals for inclusion in the network of providers offer "best value."

Best Value - A balance of quality, access, consumer choice, and cost as applied to decision making processes regarding use of public money.

Choice - The opportunity for an individual to select services and providers based upon the availability of multiple services and providers.

Consumer - A person who has direct personal experience with mental health or mental retardation services as a person receiving those services. The term consumer is not meant to be limited to those who have participated in the Texas mental health and mental retardation system of services.

Consumer Empowerment - Consumer empowerment is an ongoing process to provide consumers with authority and personal control. Consumer empowerment is ensured by the meaningful inclusion and participation of consumers and family members in all

authority functions including the design, implementation, and evaluation of the service delivery system. Essentially, this is the process through which an individual who is now receiving or has received mental health or mental retardation services is provided the means to be a self-advocate.

Core Services -- Those services that are required by law to be available throughout the State. Currently these services include:

- Community-based crisis residential services or hospitalization;
- Twenty-four hour emergency screening and rapid crisis stabilization services;
- Community based assessment, including development of interdisciplinary treatment plans, diagnosis and evaluation services, and family support services, including respite care;
- Medication-related services, including medication clinics, laboratory monitoring, medication education, mental health maintenance education, and the provision of medications;
- Psychosocial rehabilitation programs, including social support activities, community living skills, and vocational training; and
- Case management services.

Family Member - A person who is related by blood, marriage, or other legal means to a consumer. Usually these persons are parents, siblings, spouses, children, or legal guardians.

In this document, the term family member includes: members of the consumer' s natural, adoptive or foster family, guardians and legally authorized representatives.

Natural Community Supports - For each individual, there will usually exist an array of persons, groups, and organizations with which the individual has regular contact and which provide the individual with support as needed. These supports may be found with friends, family, self-help groups, religious organizations, and other similar establishments. They are considered "natural" in that they are not part of the formal mental health and mental retardation system but are available to any person in the community.

Network Development - The development of a provider system which provides meaningful choices, competition, and objectivity.

Network of Providers - A group of providers that will accept referrals from the Authority of persons who want mental health or mental retardation services. The availability of more than one provider of a service gives the consumer the opportunity to exercise a choice.

Ombudsman - A office which represents a consumer in resolving problems or concerns about services and supports at the authority level or the provider level.

Open Meetings - The legislated requirement that deliberations between a quorum of a governmental body or between a quorum of a governmental body and another person, during which public business or public policy over which the governmental body has supervision or control is discussed or considered or during which the governmental body takes formal action, must be open to the public.

Open Records - The requirement that information collected, assembled, or maintained by or for a governmental body in connection with the transaction of business is available to the public.

Oversight - Ensuring that policies, standards and contract requirements are being appropriately implemented.

Person-Directed Planning - Person-directed planning is a process that empowers the individual to direct the development of a plan of supports and services that meet their personal outcomes. The process should:

- a. identify existing supports and services necessary to achieve the person' s outcomes,
- b. identify natural supports available to the person and negotiate needed services systems supports,
- c. occur with the support of a group of people chosen by the individual, and
- d. mirror the way in which people without disabilities make plans.

Planning - Comprises a set of activities which:

- Define the mission, vision, values, and future direction of the system;
- Assess external political and economic realities and internal strengths and weaknesses;
- Identify needs and priorities for funding and program activities;
- Develop consensus and operational plans for implementation of these activities;
- Monitor and measure the outcomes and extent of these activities; and
- Provide information for the continuation or reformulation of activities and future direction.

Policy Development - Includes both strategic direction and priorities and operational specifications related to standards, rules, performance expectations, quality, outcomes, rights protection, health and safety, personnel, finances, research, best practices and best practice guidelines.

Provider - An individual, group of persons, agency, or other organization that offers a service or support to persons who are asking for help from the mental health or mental

retardation system.

Quality - A judgement related to the degree of excellence achieved through the provision of services. The most fundamental evaluation of quality is how well the individual achieves his/her desired outcomes from participating in the service. Quality is generally defined based on compliance with recognized standards.

Quality Management - The process by which services are reviewed to ensure the existence of those structures, processes, and outcomes that are needed by persons who are receiving the services.

Resource Allocation - The distribution of resources across geographic areas, service programs, and management functions.

Resource Development - Includes obtaining funds for the maintenance and growth of needed programs, maximizing resources from potential sources, optimizing collaborative and pooling arrangements, creating appropriate incentives and using available resources efficiently and innovatively.

Safety Net - The availability of public supports upon which an individual can rely when other services and supports fail to meet the individual' s current needs.

Uniform Cost Accounting - An accounting methodology that standardizes the items of expense and the units of service definitions in order to develop a unit cost for services which is comparable across providers.

Utilization Management - A process of integrating review and management of services in a cooperative effort with other parties including consumers, employers, providers, and payers.

ACRONYMS

The following abbreviations are used in this document.

CMHMRC - Community Mental Health and Mental Retardation Centers

DHS - The Department of Human Services

DPRS - The Department of Protective and Regulatory Services

ECI - Early Childhood Intervention

GBO - Governor' s Budget Office

H.B. - House Bill (an abbreviation used to identify the legislative chamber which originally wrote a piece of legislation)

HHSC - Health and Human Services Commission

ICF/MR - Intermediate Care Facilities for Mental Retardation

LBB - Legislative Budget Board

NAC - Network Advisory Committee

PAC - Planning and Advisory Committee

RFI - Request for Information

RFP - Request for Proposals

TDH - The Texas Department of Health

TDMHMR - The Texas Department of Mental Health and Mental Retardation

June 25, 1998

Dissent Report

To: Texas Department of Mental Health and Mental Retardation Board Members,
Commissioner, Karen Hale, and HB 1734 Committee Members

Re: HB 1734 Committee Report

This report is not considered the opinion of the Texas Mental Health Consumer Organization or the collective beliefs of the mental health consumers of Texas. As a member of the HB 1734 committee, I feel I cannot, in good conscience, live with the recommendations made and unmade by this committee.

To refresh the memories of the committee and those unfamiliar with the internal meeting process, two months ago this membership agreed to unanimously accept the recommendations in the document being presented to the State MHMR Board. The group spoke directly to not accepting or creating minority reports, (now called dissent reports). Mr. Ward Burke presented such a report to the committee after consensus had been reached. Mr. Burke is considered a family member ,committee representative, but obviously from his statement, he was against the HB 1734 legislation from its inception and spoke from the viewpoint of an authority. Mr. Burke' s membership should be considered that of representing the authority, therefore resulting in an over representative sample of authority affiliation on this committee.

The authority faction of the group, composed totally of community center board members, was the most organized vocal component of the committee. They possessed a stronger knowledge base than most participants and appeared to be more concerned about preserving the current system and/or gaining more power and control. In that there is no separation between the authority and provider, some participants, (potential providers), were reluctant to express views contrary to authority viewpoints, in fear of retaliation, by the authority, i.e., being excluded from contract consideration. In essence, the committee was composed of a disproportionate sample of authority membership resulting in an imbalance of power based on numbers, knowledge and experience, and previous and current organization affiliation.

The committee spent many hours in discussion, sub committee meetings, writing and rewriting, obtaining public input, and HB2377 site visits. This was not an easy task and I compliment the committee for their efforts, but the recommendations do not go far enough. We refused to address the most efficient and effective number of local authorities and preferred to leave that determination to "evolutionary forces", like HB 1734 is not an evolutionary force? Then the committee recommends that the process is passed back to the state authority to develop incentives and protocols to promote regionalized networks with legislative support. The committee was given this task as part of their mission. I was unaware the committee possessed the option to pick and choose which recommendations could or would be addressed and the influence to tell the state authority and legislature how we expect them to address the issue.

Other objections voiced at committee outcomes include the use of the word "ensure" i.e. ensure objectivity in the provider selection process, ensure objectivity in performance monitoring, ensure implementation of enforcement functions, ensure meaningful involvement, etc. Ensure was never operationalized. How are the authorities going to insure objectivity? How can the public be ensured that there is objectivity in the provider selection process? How is objectivity attained, much less ensured? Objectivity means to put aside our experiences and mindsets to find and use the most scientifically determined outcome to a situation. This is not an easy task and objectivity is quite different from experience, opinions, values, and morals. In fact, many of the most scientifically designed, controlled experimental outcomes have proven to be tainted by experimenter bias. Objectivity is more than an easily stated word. It is a process that takes years of practice, self-analysis and evaluation. Defenses have to be withdrawn and fears, anger, resentment and trust issues must be addressed. At this time, I see no authoritarian entity capable of drawing on the strengths of objective evaluation used in conjunction with the scientific method.

Another concern revolves around the issue of consumer ombudsmen, (state and local positions), and offices of consumer affairs at all local behavioral health authorities. The committee may have created another level of bureaucracy with these positions. We are talking three, new paid positions with benefits that could take away a significant amount of revenue from services. There are significant training issues to be considered equipment costs, rental space, travel expenses, and other undetermined costs. Operationalizing the process with anticipated cost loss to services must be outlined, before consideration and acceptance.

In conclusion, the recommendations from the HB 1734 committee are very well worded, grammatically and politically correct, contain lofty and worthy intentions, but what have we changed? What strides have we made to create a service delivery system that is truly dedicated to assisting those with mental illness and mental retardation to obtain a life of independence? How much of our time was devoted to designing a system that took a step out from the "safety of familiarity" and how much time was spent trying to maintain the "status quo"? How can we operationalize the recommendations as a means to transfer words to action? How do we evaluate the action taken and according to who' s frame of reference?

I do not feel at ease with the committee recommendations as they now stand. Thank you for the opportunity to express my concerns to the committee, commissioner and board.

Mike Halligan

1734 Committee Member