

*Structure and Function*

A Vision for the Texas Department of Mental Health and  
Mental Retardation's Future Mental Health Service System

A Report to the TDMHMR Board

Submitted by

*The Mental Health Service System Task Force*

March 2002

### Executive Summary

The Texas Department of Mental Health and Mental Retardation (TDMHMR) Board appointed a task force composed of 20 major stakeholders from across the state to recommend to the Board the fundamental structure and functions of the major components of a model by which TDMHMR will purchase community mental health services throughout the state. In charging the task force the Board requested that the recommended model adhere to the following values:

- Commitment to local community involvement and empowerment.
- Commitment to consumer choice of providers.
- Commitment to efficiency.
- Commitment to accountability.

The task force met from September 2001 until March 2002. In the sometimes-intense deliberations, the task force has discussed in depth, and from virtually every angle, the problems of the mental health service system. It has been systematic in its efforts to develop recommendations capable of making a difference in the lives of Texans in need of mental health services. From the task force's perspective, this meant developing a model that can actually be implemented in the ever-changing, under-funded, and political environment of public mental health services. As such, its recommendations reflect a pragmatic approach to implementing systemic changes that define a future mental health system where quality services are available to as many Texans in need as possible.

The recommendations of the task force fall into five areas:

- Recommendations within the scope of TDMHMR as state authority.
  - ◆ The structure and functions of the future mental health service system model. (pages 5-9)
  - ◆ The evolving relationship of the state hospital system to the community system. (page 10)
  - ◆ The importance of a culturally competent service system. (pages 10-11)
  - ◆ An implementation strategy that focuses on a guidance team to advise the commissioner on implementation. (pages 11-12)
- Recommendations whose implementation require collaboration with other state agencies.
  - ◆ Recommendations associated with TDMHMR's need to collaborate with Texas agencies involved with funding services to people with mental illness to plan, coordinate and unite the separate funding streams that fragment current efforts at serving more people more effectively. (pages 12-14)

## Introduction

*An adult Texan enters the office of a public provider of mental health services in need of treatment for serious mental illness. He does not have Medicaid or other insurance (which is the case for more than 50% of TDMHMR's priority population), so his treatment is paid for with state general revenue dollars. Because of large caseloads and limited funding for medically indigent individuals who have no or very limited insurance, public system funding for services and transportation to services averages \$210 for the month for individuals who are served. New generation medications – not taking into account the necessary associated medical consultations -- average \$250 per month.*

*He stays in the system for less than a year (about 40% of those who enter the service system leave in the same year). During his stay he averages about one service per month (50% of the medically indigent receive five or fewer services in a three-month period with the average being three services). After dropping out of the service system, he is arrested and placed in a county jail where he is not likely to receive any mental health services. (More than 10,000 of the 61,000 county jail inmates in FY2000, or about 17%, had a mental disorder, and of these it is not known how many received treatment.) He is then sentenced to prison. In 1998 11% of the prison population was under treatment for mental illness but it is not known how many prisoners suffered from mental illness.*

*Upon release from prison, if he is not included in the targeted funding initiative of the Texas Council for Offenders with Mental Illness (TCOMI),<sup>i</sup> which contracts with the TDMHMR service system for the provision of services, he is likely to return to the same poorly funded treatment environment that failed him prior to his incarceration, leave services prematurely, re-offend, and return to jail or prison. Thus, the cycle begins again.*

The U.S. Surgeon General's 1999 Report on Mental Health describes a service system and associated funding mechanisms that are fragmented, inefficient, minimally coordinated and unproductive. On a national basis 22% of adults and 20% of the children have diagnosable mental disorders, but only 8% of adults and 10% of children receive treatment for their illnesses.

The Mental Health Service System Task Force appointed by the Texas Department of Mental Health and Mental Retardation (TDMHMR) Board has extensive experience with the delivery and funding of mental health services in Texas. The consumers and family members on the Task Force are all too familiar with the problems associated with attempting to access clinically appropriate services in Texas.

In sometimes-intense deliberations, the Task Force has discussed the mental health service problems from every angle. It has been systematic in its effort to identify recommendations capable of making a difference in the lives of Texans in need of mental health services. The Task Force recommendations reflect a pragmatic approach to implementing systemic changes because simple solutions are likely to underestimate the complexity of the problems, complex solutions may not be achievable, and change itself usually creates resistance no matter how much it is needed.

The Task Force organized its recommendations into two groups: 1) those that are within the authority of the TDMHMR Board, and 2) those whose implementation require collaboration with other state agencies.

### **TDMHMR Board's Charge to the Mental Health Service System Task Force**

The TDMHMR Board, with a commitment to improve the mental health service system, charged the Task Force to provide clarification on the future roles of the local authority (LA) and state authority (SA) as TDMHMR moves into a future where resources are likely to continue to fall substantially short of demand and social values such as consumer choice of providers are significantly changing the mental health service system landscape.

The central charge to the task force is to recommend to the TDMHMR Board the fundamental structure and functions of the major components of a model by which TDMHMR will purchase community mental health services throughout the state. The Board directed that the model be clearly articulated and systematic in how its components interact, and that it:

- Is congruent with the guiding values (described in the following pages).
- Defines the roles of the state authority, local authorities, centers, and other organizational entities, including state hospitals.
- Identifies a timeline for full implementation that considers any need for phase-in, and considers implementation of at least parts of the model in the FY03 contract year.

The significance of the requirement to “... *recommend ... the fundamental structure and functions of the major components of the model...*” is that the Task Force must identify:

- The major structural components in the model it recommends.
- The basic functions of these components.
- The way these components interact with each other to form an efficient and accountable system.

The Task Force saw this structural requirement of the charge as suggesting a flowchart illustrating the lines of relationship between the major components of the future model. The charge, as previously stated, required that the model not only be congruent with the

four values contained in the charge and later described in this report but that it also supports their accomplishment.

The scope of the recommendations is limited to the structure of the new model. Other issues such as eligibility for services, the benefit package, and pricing, form the basis of the charge to the Benefit Design Committee, and lie outside the scope of the charge to the Mental Health Service System Task Force.

### **Context of Charge to Task Force**

Two models for the delivery of mental health services have been piloted by TDMHMR over the past several years: the House Bill 2377 local authority pilot (beginning in 1996) and the NorthSTAR pilot (beginning in June 1999). Although these pilots began at different times, they have their roots in the common ground of attempting to ensure a viable role in the funding streams for the mental health authority. HB 2377 grew out of the Authority-Provider Task Force and its efforts to clearly define the governance functions of the LA. The Task Force's report led to HB 2377 and the development of the pilot.

Under pressure from the appearance of public sector managed care, 2377 evolved into a public-sector response to the potential threat that the Medicaid STAR program and its integrated HMO contracts represented to the stability and viability of a public system for mental health services. It was designed and implemented within the existing rules and structure of TDMHMR. NorthSTAR began as a behavioral health carve-out alternative to the integrated STAR HMO model. NorthSTAR is a 1915b Medicaid waiver program that incorporates the medically indigent consumer in a private sector operated, full risk, capitated model. NorthSTAR operates under a different set of rules and procedures than does the 2377 pilot. *Appendix 1* contains a brief overview of the two pilots.

Over the last two years these pilots have generated a great deal of debate, confusion and emotion. Debate is frequently entered into without the benefit of supporting data. Even when data is cited, it is usually incomplete or addresses a component of the model that has already changed. Timely, interpretable and comparable data for the two pilots has been difficult to obtain. Nevertheless, in observing the pilots over the years and in listening to stakeholder feedback, the TDMHMR Board has been able to identify several values of importance to the future service system, and it instructed the Task Force to adhere to these values as it formulated its recommendations.

### **The Values Shaping the Charge** (The full charge can be found in *Appendix 2*)

The four values that the TDMHMR Board extrapolated from the two pilots as essential to a future mental health service system are:

- *Commitment to local community involvement and empowerment*, as realized in the presence of the local authority.

- *Commitment to consumer choice*, as realized through the right of the consumer to choose from more than one provider for each service in the benefit package when multiple providers are available.
- *Commitment to efficiency* as reflected in two major ways:
  - ▶ All services purchased by TDMHMR are identified in a pre-defined benefit package and an associated price schedule.
  - ▶ Identifies the most cost efficient way to purchase the business functions necessary to ensure the operation of an effective and efficient service system.
- *Commitment to accountability* as realized by a service system that functions at the local and state levels in a way that objectively demonstrates its responsiveness to public need as it provides quality services to as many Texans as possible.

### **Recommendations within the Scope of TDMHMR Authority**

#### **The Meaning of Consensus in the Task Force's Recommendations**

The members of the Mental Health Service System Task Force are in agreement on many issues, yet there are issues for which substantive disagreement remains. One issue is whether or not the LA can also be one of the providers in its own provider network. The ongoing debate reflects the fundamental fact that there are two legitimate and different ways to view this issue.

Yet, the Task Force recognizes that consumers best interests are served by putting aside disagreements in favor of making recommendations to the TDMHMR Board that the full Task Force supports. The Task Force does this with the strong belief that Texas needs to move forward with the efficiencies and values embodied in the recommendations contained in this report. The fact that the Task Force chose to put aside its disagreements is testimony to its dedication to the citizens of Texas whose quality of life can be markedly improved if they are able to better access all-too-scarce mental health services.

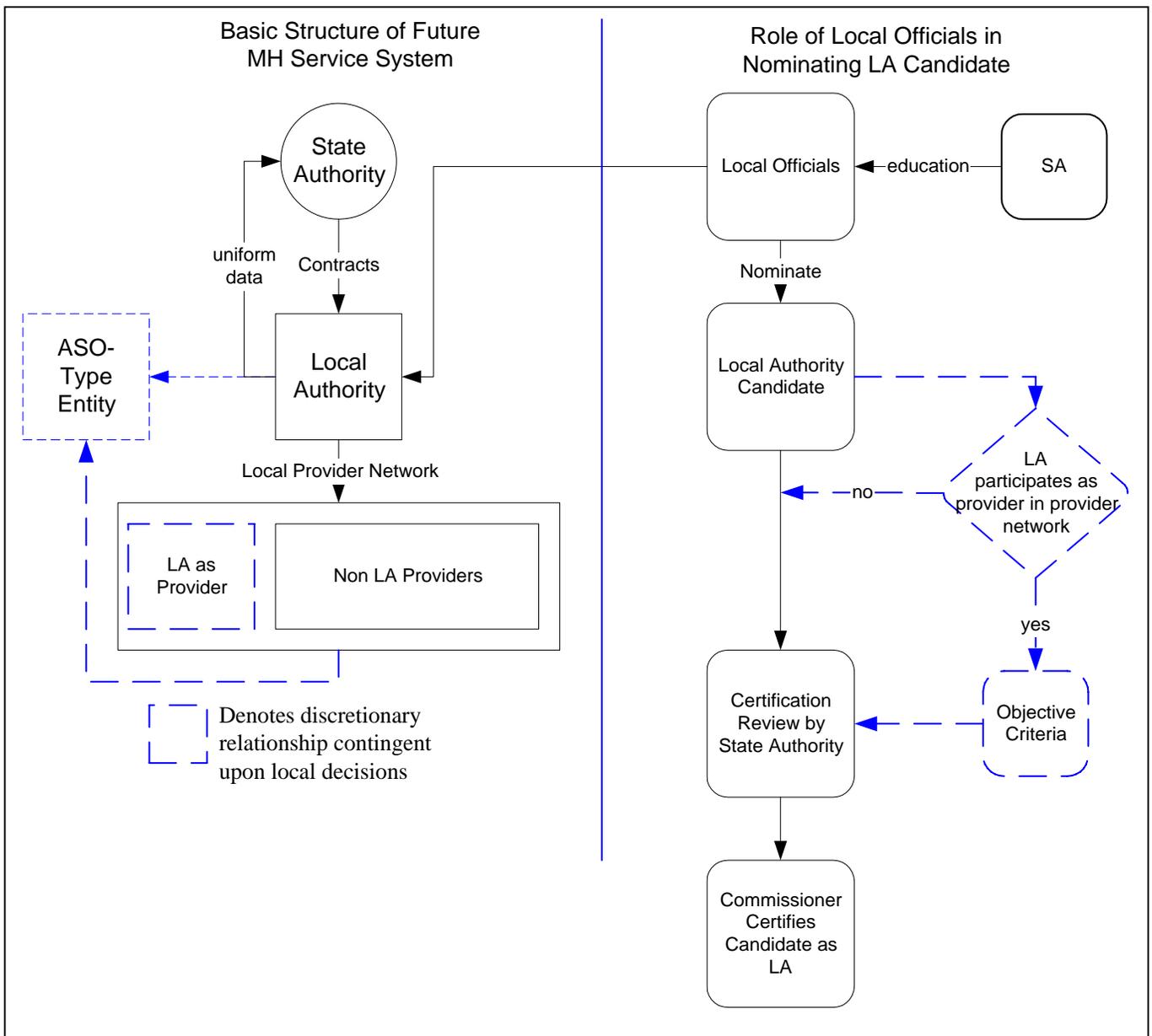
The Task Force believes that it is more important to support the model recommended in this report than to seek a theoretically “perfect” system that will be difficult to obtain in an environment of political disagreement made all the more intense by substantial underfunding. The Task Force, in its deliberations, has recognized that the landscape of the public mental health service system is constantly changing. Even in the absence of other reasons, the presence of change in itself makes the “perfect” model at best a temporary model. It is the Task Force's recognition of the constancy of change that led it to build into its model an important role for the local community for determining the scope of the responsibilities of the LA, both in its potential role as a provider and in the business functions it will undertake.

After eight meetings and four subgroup meetings (see *Appendix 3*) the Task Force submits recommendations to the TDMHMR Board in the following five areas:

- Recommendations within the scope of TDMHMR as state authority
  - The structure and functions of the future mental health service system model.

- ◆ The evolving relationship of the state hospital system to the community system.
- ◆ The importance of a culturally competent service system.
- ◆ An implementation strategy that focuses on a guidance team to advise the commissioner on implementation.
- Recommendations whose implementation require collaboration with other state agencies.
  - ◆ Recommendations associated with the need to plan, coordinate and unite the separate funding streams of Texas agencies that are involved with funding services to people with mental illness but are outside the scope of the TDMHMR Board’s authority.

**The Recommended Model for the Future Mental Health Services System**



### **Overview of Key Functions in the Model**

- The SA:
  - ♦ Contracts with the LA (flow of dollars) for the purchase of services in the LA's service area.
  - ♦ Establishes the standards, outcomes, and cost parameters that clearly define the performance and efficiency requirements for all LAs.
  - ♦ Educates local officials and other stakeholders as to their rights and responsibilities regarding the nomination of candidates for local authority.
  - ♦ Conducts certification and re-certification reviews of each LA candidate to determine readiness for functioning as an LA.
  - ♦ Develops a set of guidelines that informs local appointing agencies regarding the qualifications of local board of trustees' members in order to bring consistency to the recruitment and appointment process.
- The LA:
  - ♦ Establishes and manages the local provider network that offers choices to consumers.
  - ♦ Is a governmental entity capable of meeting the SA-established performance standards within the identified cost parameters.
  - ♦ May be one of the providers in the local provider network at the discretion of the local community and subject to the SA certification review.
  - ♦ At its discretion may contract with an ASO-type entity. An ASO-type entity is an administrative services organization that may be any entity, public or private, capable of meeting SA performance standards and efficiency measures.
- Local officials:
  - ♦ Are members of the governing body of local agencies, i.e., appointing authorities, which established the center or DANSA.
  - ♦ Nominate an existing entity (or can create a new governmental entity) as a candidate for certification as an LA by the TDMHMR commissioner.
  - ♦ Hold public meeting(s) for the purpose of affording all concerned stakeholders an opportunity to express their opinions on the LA candidate or LA itself. The number, location and timing of the meetings must maximize stakeholder access to the public process.

### **The Model in Detail**

#### **The Investment of Authority in the Local Community**

The Task Force's recommendations on the structure of the future mental health service system invest a significant degree of decision-making responsibility in the local community and in the entity that is its formal representation in the TDMHMR service system – the LA. One of the decisions that the local community makes is the identification and nomination of an organizational entity for certification by the SA as the LA. As part of the nomination process, the local community must determine whether the LA candidate is to be one of the service providers in the local provider network or if the

LA will not be a provider. Authority invested in the LA includes deciding whether it will and can perform the LA business functions or contract this responsibility to another entity, e.g., an ASO. *Appendix 4* has an overview of the LA functions that the SA can delegate to the LA. The investment of decision-making authority in the local community reflects the Task Force's recognition that the TDMHMR service system is dynamic and diverse. This makes change inevitable and under these circumstances the Task Force believes it is wise to build a process for change into the model—thus, the important decision-making role of the local community.

### **The Role and Functions of the State Authority**

- The SA contracts with the LA to be its formal representation as it assembles and manages the local provider network, and to represent the local community's values, needs and interests in this process.
- Because there is substantial decision-making authority invested in the local community and its LA (a strategy that acknowledges the great diversity across the state), there is a need to develop a set of uniform criteria that functions as the context for determining the processes and outcomes that define the performance expectations for each LA. To this end, the SA will develop clear:
  - ♦ Performance standards.
  - ♦ Outcomes for both the system and for the consumer.
  - ♦ Benchmarks that define the efficiency with which the LA is to perform its functions, e.g., cost parameters, and
  - ♦ Accountability measures including the definition of standard reporting codes and structure to ensure that data reporting to the SA by each LA is uniform, meaningful and can be compared across authorities.

The decision-making authority of the LAs with regard to issues such as whether to contract with an ASO-type entity will be informed by its need to comply with the SA-developed criteria. The criteria will also inform local community decision-making regarding the qualifications of a LA candidate and whether it can participate as a provider. In instances in which there is not a complete organizational separation between the LA and its provider activities, the Task Force identified objective criteria necessary for the LA to also be a provider of services (see *Appendix 5* for these criteria). If the criteria are not met then the SA will not designate the nominated LA candidate as a LA.

- The criteria established by the SA will be incorporated into a LA certification review process. The process will require the SA to review each LA candidate (see *Appendix 5* for detail on the LA candidacy process) on these criteria. If the candidate is unable to meet the criteria then SA will not certify the candidate. The certification process is in development as part of a LA Rule TDMHMR is drafting. The certification process is modeled on the STAR readiness review process, which evaluates policy and procedures as well as actual capability of the HMOs to operate effectively.

- The SA, i.e., commissioner, after a certification review of the LA-nominated candidate's ability and readiness to perform within the parameters established by the standards and costs, will designate the LA in each service area.
- The SA will review the standards of various accrediting bodies, e.g., JCAHO, and determine if such accreditation can substitute for some or all of the SA-developed criteria.

### **The Role and Functions of the Local Authority**

- The LA must be a governmental entity.
- The LA may be one of the providers in the local provider network at the discretion of the local community. Although there remains substantial disagreement as to whether the authority can be a provider, the Task Force members put aside their disagreement and recommend that if the local community decides that the LA is also to be one of the providers in the local provider network, then the objectivity criteria identified in Appendix 5 must be in place. These criteria function as a "firewall" to help ensure the objective performance of the LA's with respect to managing a provider network when it is also a provider.
- Part of the LA's decision-making discretion is to decide if it is to perform the business functions (see *Appendix 4*) or to contract with an ASO-type entity for their performance. The Task Force believes that in a state as large as Texas no local community is likely to be the same in the epidemiology of illness, resource availability, values and diversity. Therefore the Task Force recommends that each LA should be able to decide whether it is able and willing to perform the business functions required to be an authority. Informing this decision is the LA's need to conform to the SA-developed performance criteria. The requirement that each LA perform its functions within the cost parameters established by the SA provides the basis for the potential appearance in the model of an administrative services organization-type entity (ASO). The LA, at its discretion, may contract some or all of the business functions to this entity. Regardless of whether the LA performs the functions itself or contracts for them, it remains responsible to the SA for the performance and costs identified in the LA's contract with the SA.

Another reason why the Task Force believes that the authority business functions need to be performed locally yet subjected to the SA's certification process is that the effective performance of many of these functions requires local contact with consumers and/or providers, e.g., quality management and network development.

- The LA using SA defined codes and structure must report to the SA the data identified by the SA as necessary for managing its contract with the LA and to ensure public accountability in the use of public funds.

### **The Role and Functions of the Local Provider Network**

- The LA assembles and manages the local provider network. *Appendix 4* identifies the key functions necessary for the LA to manage its provider network.

- The provider network, in keeping with the value of consumer choice of providers, must offer consumers a meaningful choice of providers for the services identified in the SA-defined benefit package. The Task Force recognizes that there may be areas in the state where the option of provider choice is not feasible. As mentioned above, the LA, at the discretion of the local community and with the certification of the SA, may participate as a provider in the local provider network.

### **The Role and Functions of the ASO**

- In the model there is an ASO-type entity that may or may not exist in the future system. Its existence is contingent upon the LA's decision as to how it is to conduct its business.
- Any organizational entity, either public or private, capable of meeting the SA-developed performance criteria can function as the ASO. In keeping with this discretionary authority, the LA will determine the business functions performed by the ASO under contract with a LA.
- The LA remains responsible for meeting the performance requirements in its contract with the SA whether or not it contracts with an ASO-type entity.

### **Role and Function of Local Community**

Beginning with the same number of LAs/DANSA and the same local service area configurations, any change to the number of LAs or their configurations must be a local community decision made by the local officials of the current local service areas. The SA in its certification process will review the efficiency and effectiveness of any proposed changes to the current local service area configuration.

“Local community” within these existing local service areas includes:

- The sponsoring entities of the current centers and DANSA (these sponsoring entities are the formal representatives of the local community and it is they who make the decision regarding the LA being a provider).
- Stakeholders who provide input on the LA candidate or the current LA through public meeting(s) held by local officials with the number, location and timing of these meetings designed to maximize stakeholder access to this public process. The public hearings can be held in conjunction with already scheduled meetings such as county commissioner meetings.
  - The local officials are responsible for nominating a LA candidate for certification by the TDMHMR commissioner. Such candidates: must be:
    - ♦ A governmental entity, and
    - ♦ Capable of meeting the state authority identified requirements for performing as a local authority.

The Task Force recognizes that the SA has a responsibility to educate both the local stakeholders and local officials regarding their responsibilities and authority as these pertain to the nomination of the LA candidate.

### **Recommendations Pertaining to the State Hospital System**

The Task Force recommends that a principle of collaboration between the state hospital system and the LA form the basis for implementing the following recommendations:

- LAs plan for their use of psychiatric inpatient beds, (i.e., local community beds and state hospital beds) taking into consideration the demand for these beds and local alternatives to hospitalization.
- The local plan of each LA in a state hospital region becomes the basis of the development of a regional plan focused on the regional state hospital. Regional planning should evaluate the need for inpatient beds in the entire service area of the state hospital and include such factors as:
  - ♦ The need for inpatient beds.
  - ♦ Locally available alternatives to hospitalization.
  - ♦ The need for specialty inpatient beds.
  - ♦ The impact on the number and type of state hospital beds if state hospital funds could be moved into the community to purchase additional community services.
- The SA, as part of its state hospital planning process, should evaluate the feasibility of implementing the regional plans developed in collaboration with each state hospital and the LAs in its region. This evaluation should consider:
  - ♦ Risks.
  - ♦ Future role for specialty services.
  - ♦ Statewide need for inpatient beds.
- The impact of plan(s) in terms of potential positive and negative effects on service system a whole, the state hospital system, and the economy of the local community where the hospital is located.

### **Recommendations Pertaining to a Culturally Competent Service System**

The recommendations of the Task Force are systematic. They are:

- TDMHMR defines cultural competency (to include more than race and ethnicity) for the TDMHMR system and deploys this definition.
- The TDMHMR Board develops policy for deployment throughout the system. This policy includes:
  - Responsibilities of the SA:
    - Conduct self-assessment of its cultural competence.
    - Conduct state level planning (Strategic Plan) to include:
      - ▲ Benchmarking population demographics for each local service area using census data.
      - ▲ Evaluating the demographics of each state hospital census.
      - ▲ Monitoring services to eliminate disparities in access to ethnic minorities.
    - Lead in the deployment of cultural competency policy through the Office of Multicultural Services to include:
      - ▲ Providing of technical assistance.

- ▲ Developing of training modules for required training for:
  - SA Board.
  - LA Boards.
  - LA.
  - Network providers.
  - Consumers.
  - Volunteers and potential volunteers.
- ▲ Identifying of best practices.
- ▲ Coordinating with Strategic Planning and with Quality Management, (e.g., certification review) to identify statewide issues for resolution.
- ▲ Coordinating with universities and colleges to help develop training packages for deployment throughout TDMHMR.
- Identify a member of the TDMHMR Board as a champion for cultural diversity.
- Responsibilities of each LA:
  - Conduct self-assessment of cultural competency
  - Conduct local level planning to include:
    - ▲ Identifying population demographics for diverse populations.
    - ▲ Identifying needs of these populations.
    - ▲ Identifying strategies for addressing these needs.
    - ▲ Determining access to services for these diverse populations and comparing this to actual penetration rates.
    - ▲ Developing strategies for incorporating cultural competency in the provider network.
  - Incorporate strategies for developing an interpreter resource pool knowledgeable about mental health services.
  - Educate the local community about the mental health service system to increase the representation of minority populations in the service population.
  - Identify a member of the LA Board as a champion for cultural diversity.
- The SA certification review will assess the degree to which the LA complies with the cultural competency policy applicable to the LA.

### **Implementation Recommendations**

The recommendations in this report form a system in which the individual components of the model are interdependent and the model as a whole is congruent with the TDMHMR Board's defined values. The Task Force recommends that the integrity of this future model be maintained throughout its implementation. To achieve this integrity, the Task Force recommends the appointment of a guidance team with not more than 12 members, a subset of which comes from the Task Force, to advise the commissioner on implementation issues to include:

- Implementation oversight.
- Removal of barriers to implementation.

- Guiding the evolution of the model throughout the TDMHMR system, and
- Assisting in coordinating the recommendations of the Task Force with the complementary recommendations from the Benefit Design Committee and the LA Rule Development Workgroup.

The Task Force recommends that the guidance team be appointed by June 2002.

### **Recommendations for Collaborations with Other State Agencies**

According to the U.S. Surgeon General's Report on Mental Health, in 1996 53% of the \$69 billion spent on mental health services in this country came from the public sector. The mental health expense to the public sector grew by 8% between 1986 and 1996 while private sector spending grew by 6%.

Insurance for mental health is not on parity with medical insurance. The number of adult uninsured is growing and those who have private insurance saw the value of their mental health benefit shrink by 3% to 6% in the period from 1988 to 1997 (the shrinking value was due to increasing limits on the mental health benefit).<sup>ii</sup> These disparities have increased the burden on the public mental health sector.

According to the Surgeon General's report, 19% of the adult U.S. population and about 20% of the child and adolescent population have a mental disorder. An additional three percent of adults with a mental disorder also have an addictive disorder. Yet, of those individuals with serious mental illness, e.g., schizophrenia or bipolar disorder, 47% to 56% respectively have a co-occurring addictive disorder.<sup>iii</sup> Of those with a diagnosis of mental illness, only 8% receive services. In Texas, there are 525,000 individuals with serious mental illness or serious emotional disturbance who meet TDMHMR's priority population definition, yet only 151,700 receive services.

The Surgeon General's analysis of access to mental health services recommends greater coordination among payers in order to generate efficiencies that enable increased access to services. In Texas the need for coordination among different agencies that pay for services is more important now than ever not just because it promises increased efficiencies but also because it is possible to prevent current and future costs while improving the outcome for individuals. For example, with regard to individuals with mental illness in the Texas Criminal Justice System (TCJS), Texas taxpayers frequently pay three times for the same person: first for mental health treatment in the public service system which includes the public school (the largest provider of mental health services to children); second, in the TCSJ system after incarceration; and third, in the TCJS for treatment. There are over 50,000 people in the TCJS priority population. Of these, approximately 21,000 meet TDMHMR's definition for serious mental illness, yet fewer than 1,300 are receiving mental health services.<sup>iv</sup>

In Texas, the consumer's first encounter with the public service system is typically insufficient to adequately treat the presenting illness. This is primarily due to the limited

and fragmented resources available to purchase service for the medically indigent consumer. For example, just getting the highly effective new generation medications costs about \$3,000 per consumer per year in TDMHMR, and this is only for the prescriptions and does not include the associated psychiatrist time. Yet, the average amount of GR funds available to purchase community services for the medically indigent consumer is about \$2,600 per year, and this includes administration costs as well as service costs. Is it no wonder that about 50% of the consumers of TDMHMR mental health services get five or fewer services in a three-month period. This is an amount that is insufficient to effectively treat the population that TDMHMR serves. The result is that many people are under-treated and many more are unable to access the service system at all. In the case of the TCJS, this leads to behaviors that result in incarceration and an additional cost burden to the state. Proper treatment at the individual's first contact with the mental health system could eliminate all the additional costs.

The current structure of funding for mental health services in Texas provides an opportunity for realizing efficiencies in the delivery of services. In the HB2641 *Delivery of Mental Health and Substance Abuse Services through Texas State Agencies* report, approximately \$1.1 billion was spent on mental health services by 15 agencies. TDMHMR, the state authority for mental health, spent \$676 million, or only 62% of the total amount, while the other 14 agencies spent almost \$425 million for the purchase of services.

While HB2641 clearly shows the fragmentation of mental health funding in the state, a review of the services purchased by these different agencies reveals that many of the services are the same. That is, essentially the same type of services is provided regardless of which agency is funding the services.

<b>Core Mental Health Service Package Offered by Many State Agencies</b>	
Core Service	Number of Agencies Offering Service
Medications	9
Outreach	9
Group & Family Therapies	9
Case Management	10
Counseling	11
Psychological Testing	12

The presence of this core package suggests opportunities for the coordination of the purchase of services in ways that can improve efficiencies and quality, producing better outcomes for both the individuals and for the Texas taxpayer.

The Task Force recognizes that adequately responding to the “problem” mental illness presents to individuals, families and society at large exceeds the scope of authority that resides with TDMHMR. Serious mental illness creates a complex interaction of symptoms and support needs that transcend the agency-based, categorical funding model that is in operation in Texas. The vast majority of individuals with schizophrenia, bipolar disorders and chronic major depression who are served in the TDMHMR system are

unemployed. Many have either substandard or no stable housing, while a significant number lack access to the transportation needed to reliably keep treatment appointments. The public funds needed to respond to these basic human needs are fragmented across different agencies, creating significant inefficiencies in the current larger unofficial and minimally coordinated mental health service system.

The Task Force is convinced that the statewide deployment of uniform mental health policy governing the quality of mental health services will increase the number of positive outcomes for people receiving services. The Task Force also believes that the blending of resources that are currently fragmented as a result of policy variations across the different agencies will make the expenditure of GR funds more effective because more people will be able to access services and have better outcomes.

- The Task Force recommends that the TDMHMR Board request that HHSC conduct a feasibility study of developing a uniform database for mental health services and expenditures that include all state agencies.
- The Task Force recommends that for Texas agencies that fund mental health services using non-GR funds, e.g., Medicaid, TDMHMR, as the state mental health authority, be responsible for identifying standards of care, best practices and outcomes.
- The Task Force recommends that for Texas agencies that fund mental health services that are not directly under the HHSC umbrella (e.g., TEA and TDCJ), TDMHMR as the state mental health authority, in collaboration with these agencies, be responsible for identifying standards of care, best practices and outcomes.
- The Task Force recommends that the TDMHMR Board ask HHSC to create and operationalize the concept of behavioral health covered life for the medically indigent population to include the following:<sup>v</sup>
  - ♦ Identifying HHS agencies that fund services or supports to mental health and substance abuse populations.
  - ♦ Estimating the amount of this funding.
  - ♦ Pooling the funding to be managed by TDMHMR in collaboration with the funding agencies.
  - ♦ Developing uniform eligibility and performance criteria.
  - ♦ Pouring the pooled funds into a purchase of service system using purchasing rules developed by TDMHMR in collaboration with other agencies (e.g., evidenced-based practices, UM guidelines) to achieve increased efficiencies enabling more people to be served with the same amount of funding.
- The Task Force recommends that LAs work to coordinate resource utilization across the different agencies and other payers through their responsibilities as planners for the local mental health service system.
- The Task Force recommends that the TDMHMR commissioner expedite the development of model mental health program standards.
- The Task Force recommends that TDMHMR, as part of its legislative agenda, seek from the legislature clarification regarding the county's responsibility for providing mental health services to the indigent. This clarification should include developing a consistent definition of indigency across the various agencies responsible for providing mental health services to this population.

## **Appendices**

## **Appendix 1**

### **Brief Overview of the HB 2377 and NorthSTAR Pilots**

#### **HB 2377 Pilot**

HB 2377 in 1995 provided the direction for a pilot to identify and implement strategies for the SA's delegation of part or all of its authority to LAs. Such authority included:

- Planning.
- Coordination.
- Policy development,
- Oversight of the mental health service delivery system.

This legislation also required the LAs to determine whether they would also be a provider in the LA's network of providers while also ensuring best value in the expenditure of public funds.

Initially there were five pilot sites. Three of these are single site pilots, which were selected in part because of their 1915b STAR affiliations (Austin-Travis MHMR Center, MHMR Services of Tarrant County and Lubbock Regional MHMR Center). The other two sites were regional pilots – in South Texas and in East Texas. In each regional pilot several centers were to come together to form a single regional authority. The regional pilots were not successful for a number of reasons, not the least of which was the difficulty consolidating regional authority from the budgets, functions and staffs of several individual local authorities. The regional pilots were discontinued. The single sites of the 2377 pilot are ongoing.

The 2377 pilot sought to develop policies, procedures and capabilities that enabled the LA to develop and manage a local provider network in which it was also a major provider. The transformation of the business infrastructures in these pilot centers was to take place while maintaining the centers' strong ties to the local community through the development of local planning advisory committees (PACs), and network advisory committees (NACs). Because these committees are composed of local citizens they are seen as providing the LA with objectivity in its decision-making as it performs both its authority and provider functions.

Much of the work of the 2377 pilot has centered on developing the business practices, e.g., contracts, provider enrollment, claims adjudication processes, service authorization capabilities, and accountability mechanisms necessary to manage a network that affords consumers a choice of providers and seeks best value. Issues arose regarding the objectivity of an entity, i.e., a community center that was both the LA and a major provider in the network that it managed. Resolution of these issues led to the appearance of different types of organizational structures between the pilot sites and different strategies for ensuring objectivity in how the center, as LA, made decisions regarding the provider network. Thus, in practice, there is not a single 2377 pilot, but three different versions.

## NorthSTAR

NorthSTAR is a full risk, capitated, per member per month (PMPM) behavioral health program that operates in a seven-county region. A private behavioral health company, ValueOptions, currently contracts with TDMHMR to manage, recruit and pay providers, and ensure services to all covered lives who meet the medical necessity criteria. NorthSTAR is unique in that it includes not just the Medicaid population (made possible by a 1915b Medicaid waiver) but also the non-Medicaid portions of the populations of both TDMHMR and the Texas Commission on Alcohol and Drug Abuse (TCADA).

Because of the nature of the risk-based model, there are no waiting lists in NorthSTAR. All covered lives have access to any medically necessary service that is identified in the benefit package. These services are available through a wide range of providers that are accessed by consumers through the choices they make.

Because the local authority in Texas must be a governmental entity, a regional authority – DANSA - was created in NorthSTAR. DANSA is composed of representatives appointed by the NorthSTAR counties. The responsibilities of DANSA differ in substantial ways from the other LAs. The primary difference is that TDMHMR contracts directly with ValueOptions. This significantly reduces DANSA's ability to function as an authority because it has no direct contract relationship with ValueOptions. As a result, its primary functions involve addressing consumer complaints and performing an ombudsman-like role for the region.

There have been significant changes in the NorthSTAR model since its inception in June 1999. As required by the Medicaid waiver, it was designed to provide consumers with a choice of behavioral health plans. However, at the end of the first contract, one of the plans – Magellan – pulled out citing insufficient funding. There has also been a tightening of the eligibility criteria for the medically indigent, again due to limited resources. The current plan manager, ValueOptions, is concerned about the ability of NorthSTAR's funding to pay for the demand for service. One result of this concern has been a progressive tightening of utilization management strategies to help match services to need while controlling resources. The fact that there are no waiting lists in NorthSTAR does not mean that every consumer in need of a service receives the service. The limited availability of resources does not permit this.

## Appendix 2 Task Force Charge

### Charge

The chairman shall appoint a task force to design the structure of the future mental health service system. The charge to this task force is:

Recommend to the TDMHMR Board the fundamental structure and functions of the major components of a model by which TDMHMR will purchase community mental health services throughout the state. This model will be clearly articulated, systematic in how its components interact, and

- Is congruent with the guiding values stated below.
- Defines the roles of the state authority, local authorities, centers, and other organizational entities, including state hospitals, identified as being critical to the functioning of the model developed by the task force.
- Identifies a timeline for full implementation that considers any need for phase-in, and considers implementation of at least parts of the model in the FY03 contract year.

### Values

In addressing its charge, the task force will adhere to the following values:

- *Commitment to local community involvement and empowerment*, as realized in the presence of the local authority.
- *Commitment to consumer choice*, as realized through the right of the consumer to choose from more than one provider for each service in the benefit package when multiple providers are available.
- *Commitment to efficiency* as reflected in two major ways:
  - ▶ All services purchased by TDMHMR are identified in a pre-defined benefit package and associated price schedule.
  - ▶ Identifies the most cost efficient way to purchase the business functions necessary to ensure the operation of an effective and efficient service system.
- *Commitment to accountability* as realized by a service system that functions at the local and state levels in a way that objectively demonstrates its responsiveness to public need as it provides quality services to as many Texans as possible.

### Timeline

The task force's work will be completed by March 31, 2002.

### Coordination with Other Work Groups

There are several existing committees or task forces that are potentially relevant to the work of the task force, including LATAC, CPAC, and the local authority Rule Committee. Of most immediate relevance is the Benefit Design task force. The work of this group is to identify the "rules" of operation of the future service system, e.g., who is eligible for services, what services are in the benefit package, what best practices are required, how does utilization management work, prices to be paid for services

purchased. The Benefit Design task force does not directly impact the configuration of the future service system, as such; the work of the two task forces is complementary.

**Appendix 3**  
**Mental Health Service System Task Force Meeting Schedule**

- ♣ September 27 2001
- ♣ October 25 2001
- ♣ November 15 2001
- ♣ December 13 2001
- ♣ January 10 2002
- ♣ February 14 2002
- ♣ March 5 2002
- ♣ March 21 2002

**Work Group Meetings**

- ♣ January 4 2002
- ♣ January 9 2002
- ♣ February 13 2002
- ♣ March 4 2002

## **Appendix 4 Overview of the Functions of the LA**

The LA Board is responsible for setting and deploying policy and overseeing the performance of the LA.

### **Governance Functions**

- Policy deployment
- Needs assessment.
- Planning.
- Resource development.
- Resource coordination.
- Local communication.
- Ombudsman function, operating on a regional basis, under contract to the SA and reporting to the LA Board (see *Appendix 5* for details).

### **Front-Door Functions or Essential Services**

- Eligibility determination, both clinical and financial.
- Medicaid eligibility assistance.
- Screening and referral.
- Single portal authority functions.
- Crisis services.

### **Business Functions**

- Network development.
- Network management.
- Contract management.
- Quality management.
- Claims processing and payment.
- Information management and reporting.
- Consumer rights.
- Provider relations.
- Consumer relations.

## **Discussion Concerning Credentialing and Claims Management**

The Task Force recommends that the performance of the business functions be the responsibility of the LA. At its discretion the LA may perform functions or outsource them to an ASO-type entity. The SA's responsibility regarding the LA business functions is to 1) develop the performance standards, outcomes and cost parameters that function as criteria for determining performance requirements for the LAs, and 2) conduct certification (and re-certification) reviews of the LA (and candidates) to determine their readiness and capability to meet the SA-identified criteria.

Prior to developing these recommendations there was considerable discussion in the Task Force concerning the division of labor between the SA and LA on the issue of who should perform the business functions. An example of the outcome of this discussion is found in the recommendations around the credentialing and claims management functions.

### Credentialing Recommendations

1. Establish requirements (standards) for provider credentials and the credentialing, recredentialing and appeals processes.
  - a) The SA establishes statewide minimum standards for the credentials required for each discipline or service.
  - b) The SA routinely reviews standards for the credentials required in light of availability of workforce, market forces, resources, and technology.
  - c) The LA can increase or add to the minimal state requirements as appropriate. The SA minimum standards should be such that waivers are not required.
2. Receive applications, conduct verification, recredentialing and appeals.
  - a) The SA will set the standards (requirements) to ensure **portability of benefits, best value, shared risk, speed, and possibly accreditation**, e.g., NCQA, for the credentials verification process. The SA will establish a list of organizations that meet the requirements.
  - b) The LA may become an approved organization if it meets the requirements. If it cannot qualify or chooses not to, it may contract with a SA-approved organization.
3. Establish a Credentialing Committee.
  - a) A credentialing committee is required; however, the LA has flexibility in the structures and processes it uses to fulfill this function, including contracting.
  - b) All credentialing committees will have consumer and family input. If the committee function is contracted out, then the NAC or PAC will provide input into the process.
  - c) The LA may conduct or contract out site visits.
  - d) The SA will define standards for delegation of the credentialing function, similar to those of NCQA.
4. Staff competency and performance are evaluated on the local level.
  - a) The SA defines minimal competency levels.
  - b) Performance is monitored and evaluated on the local level.
  - c) The LA may increase or add to the minimal state requirements as appropriate.
  - d) The SA will establish methods to certify competencies. The SA would phase in certification programs for specific service competencies such as rehabilitation services.

5. Develop and implement privileging.
  - a) Privileging is a function of the credentialing committee based on SA requirements.
  - b) The LA may increase or add to the minimal state requirements as appropriate.
6. Site visits.
  - a) Site visits are under local control as part of credentialing process.
  - b) The SA sets standards for when site visits are needed and for expected outcomes.
  - c) The LA either performs or contracts for sites visits.

### **Claims Processing Recommendations**

1. The SA establishes statewide uniformity in billing procedures, codes, encounter data collection, forms, and denial and appeals processes to obtain efficiency from standardization.
2. The LA may conduct claims processing if it meets all criteria set by the SA including the standardized elements, timeliness, accuracy, and accountability.
3. Provider training will occur through the LA using standardized curricula.
4. The SA creates training curricula, protocols and guidelines and makes available technology such as web-based training.
5. The LA ensures data linkage with SA IS system. The SA sets the standard for compatibility with the SA encounter data and authorizations.

## **Appendix 5**

### **Objectivity Criteria for Determining if the LA is To Be a Provider**

#### **Objectivity Criteria**

From a representational standpoint the LA has two sides – 1) it is the representation of the local community, representing its values and philosophy, and 2) it is the formal representation of the SA by virtue of the SA’s delegation of its authority to the LA. It is this delegation that is the basis of the designation of LA. The SA must have confidence that the LA will perform the delegated authority functions with integrity and objectivity; otherwise the LA cannot represent the SA. Although the most obvious assurance of objectivity is the separation of the provider function from the authority function, there are legitimate reasons why this may not be possible. As a result, and through compromise, the Task Force has identified the following criteria to ensure the objective operation of the LA in those instances in which it is also a provider of services. These criteria will be included in the certification review of the LA candidates performed by the SA.

If a LA is to participate as a provider in a network of providers, then objective criteria must be in place, including:

- A separate authority budget.
- An independent ombudsman, which is under contract to the SA, which reports to the LA’s board, and which is overseen and monitored by the SA Ombudsman Office that reports to the TDMHMR Board.
- NAC.
- PAC.
- Provider Relations office.
- Consumer Relations office.
- Separate staffs for the authority and its provider component as this pertains to the authority performing ASO-type functions, i.e., personnel that do not work on the provider-side of the organization should staff authority-performed ASO functions

#### **Elaboration of Recommendations Regarding Ombudsman Office**

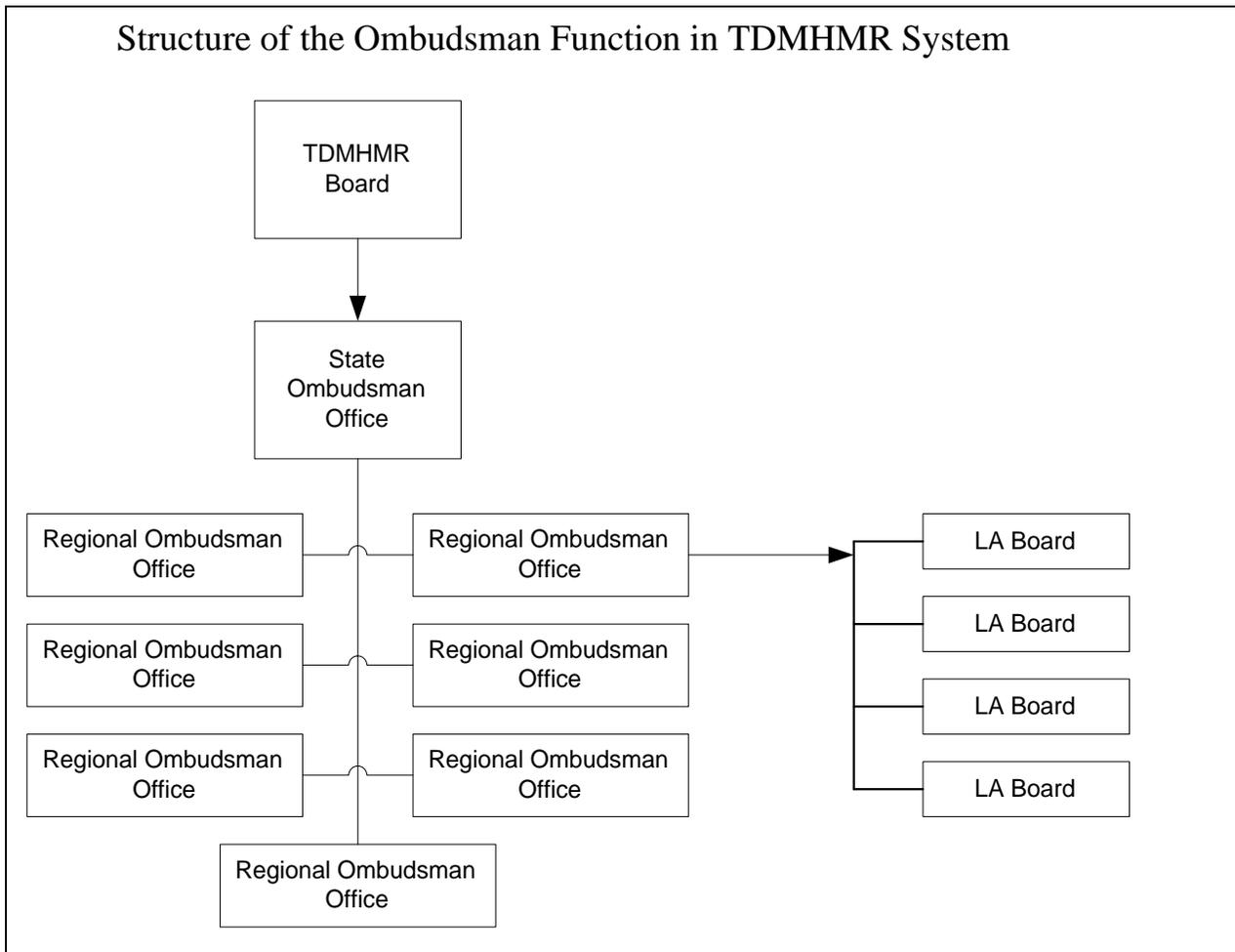
The following chart illustrates the structure of the Ombudsman Office (OO) as identified in the recommendations of the Task Force. The regional model conforms to the previously established hospital regions.

#### **Activities of the Ombudsman Office**

The functions of the Ombudsman Office as recommended by the Task Force are defined narrowly. While some ombudsman programs fulfill an advocacy role, by helping consumers navigate the delivery system and understand how to access services, the ombudsman function recommended here is primarily charged with handling complaints and appeals. The individual client rights offices located within each LA fulfill the role of education and advocacy on behalf of consumer.

**OO Functions**

- Although the Ombudsman Office is not the front door for contact with the service system there are occasions when consumers/family will contact this office directly. Under such circumstances, the OO shall evaluate the contact and make a referral to the appropriate entity, e.g., local office of client rights or consumer affairs.
- The OO resolves problems associated with complaints and appeals. Typically a complaint will be initially addressed to a LA office, e.g., Client Rights. If the complaint is not resolved at this level, the consumer/family can appeal to the OO.
- The functioning of the OO is viewed as a method for improving the responsiveness of the system with respect to consumer/family complaints or problems.
- There will be a need to educate both the LA staff and the consumers/family community regarding the role of the OO and their rights and responsibilities with respect to the ombudsman.
- One of the major functions of the OO is to collect and standardize data regarding complaints (type, resolution, timeliness, etc) and present an analysis to the LA Board to 1) assist with future planning and 2) describe the performance of the current complaint resolution system. This data collection function is not limited to complaints that the OO works with directly, but is intended to include all complaints in the LA system.



### **Elaboration of Recommendations Regarding the PAC and NAC**

Because the PAC and NAC provide a formal role for the public to participate in the planning of the local service system, they have a valuable and legitimate role in the future service system. The functions of these two committees are not replaced or duplicated by provider or consumer relations committees.

However, there is a need to improve the current operations of these committees, as follows:

- There is a need to reinforce strategies for recruiting members and ensuring that they come to meetings.
- Meetings should be value-added in that the results of the meetings impact 1) the content of the local plan, and 2) the state's strategic plan.
- There is a need to identify best practices for developing functional PACs and NACs.

The Task Force recognizes that while these committees play an important role, there is a cost associated with them that must be offset by the value they add to the service system. With this in mind, if different ways for achieving their functions become available in the future, then continuation of PACs and NACs must be reconsidered. That is, these committees should not be continued for their own sake but for the value they contribute to a public service system.

**Appendix 6**  
**Mental Health Service System Task Force Membership**

Rudy Arredondo, Vice-Chair TDMHMR  
Board and Task Force Chair  
Texas Tech University Health Science  
Center

Danette Castle  
Lubbock Regional MHMR Center

Charles M. Cooper  
Baylor Healthcare System Foundation

King Davis  
University of Texas School of Social Work

Beth Epps  
Adapt of Texas

Tom Hamilton  
EEX Corporation and Board of Trustees,  
MHMR Authority of Harris County

Ron Harris  
Collin County Judge

Joe Lovelace  
NAMI, Texas

Jim McDermott  
MHMR of Tarrant County

Kim McPherson  
The Mental Health Association in Texas

Ed Moughon  
Big Spring State Hospital

Rosemary V. Neill  
County of El Paso and Local Center Board

Jim Nickerson  
Lakes Regional MHMR Center

Janet Paleo  
NAMI Texas & TDMHMR CPAC

Aaryce Hayes  
Advocacy, Inc.

Guy Herman  
Travis County Probate Court

Regenia A. Hicks  
MHMR Authority of Harris County

D. Matteson Pascal  
Meadows Foundation

Richard Taylor  
Amarillo Mental Health Consumers  
Association

Larry E. Tripp, M.D.  
Psychiatrist

Bill Rago  
Task Force Meeting Facilitator

Kathie Carleton-Morales  
Task Force Staff

Karla Starkweather  
Task Force Staff

Sandy Keller  
Task Force Staff

**Footnotes in Report**

---

<sup>i</sup> The TCOMI program reports a 34% reduction in arrests in the year after program entry compared to year prior to program entry. The TCJS is from a report by Tony Fabelo: *Proposed Funding Plan for Enhanced Mental Health Services in the Texas Criminal Justice System*, February 2001.

<sup>ii</sup> Data is from *Mental Health: A Report of the Surgeon General*.

<sup>iii</sup> Data is from Regier and Farmer, et. al. Comorbidity of mental disorders with alcohol and other drug abuse: results from the epidemiologic catchment area study. *JAMA* 1990; 264(19): 2511-2518.

<sup>iv</sup> Tony Fabelo, *Proposed Funding Plan for Enhanced Mental Health Services in the TCJS*, February 13, 2001.

<sup>v</sup> Texas has piloted an approach for integrating mental health funding for children through the Texas Integrated Funding Initiative (TIFI). This system of funding is targeted at children and families with complex needs. It focuses on collaboration between agencies, families and community groups to meet complex needs in a more efficient and cost effective manner. Started in two communities with the assistance of Robert Wood Johnson grant, SB1234 expanded the pilots to six communities.