SUBJECT: Local mental health and mental retardation authorities serving as providers

COMMITTEE: Human Services — committee substitute recommended

VOTE: 8 ayes — Hupp, Eissler, A. Allen, Gonzalez Toureilles, Goodman, Naishtat, Paxton, Reyna

1 nay — J. Davis

WITNESSES: For — Cheryl Cooper, Center for Health Care Services; Alfred Forsten, MHMR Harris County; David Gutierrez, Lubbock County; Wayne Hollinshead and Brian Shannon, Lubbock Regional MHMR Center; Sandy Skelton, Texas Council of Community MHMR Centers; Carole Smith, Private Providers Association of Texas; Chrissie Stewart; Jamie Travis; Monyeen Weiss; Virginia West; Kimberly Ruiz; Hartley Sappington; Bill Eaton; Susan Beattie; (*Registered, but did not testify:* Hugo Berlanga, Texas Management Inc., Nancy Gettelfinger, Bluebonnet Trails MHMR; Richard Hernandez, EduCare Community Living; Greg Hooser, Private Providers Association of Texas; Amy Mizcles, The Arc of Texas; Lupe Morin, National Alliance for the Mentally Ill; Randy Routon, LifePath Systems; Eldon Tietje, Central Counties Center for MHMR Services; Juana Lopez; Melanie Oldham; Beverly Scarborough Yahiel; George Stewart)

Against — Susan Murphree, Advocacy Inc., Texas Mental Health Consumers; Marcia Rachofsky, Texas Mental Health Consumers; (*Registered, but did not testify:* Dennis Borel, Coalition of Texans with Disabilities; Charles Gouge, D&S Residential Services, Inc.)

On — Colleen Horton, Texas Center for Disability Studies; Joe Lovelace, National Alliance for the Mentally Ill of Texas; (*Registered, but did not testify:* Denise Brady, Mental Health Association of Texas)

BACKGROUND: Texas provides services to people who are mentally ill or mentally retarded through a system of local mental health and mental retardation authorities. The Department of Disability and Aging Services (DADS) and Department of State Health Services (DSHS), under the authority of the Health and Human Services Commission (HHSC), contract with local authorities.

Local authorities are responsible for assembling a network of providers in their service area and establishing treatment options and services. In some areas of the state, the local authority is both the state contractor and the service provider, but only as the provider of last resort.

Medicaid, the state-federal health insurance program for low-income families, elderly, and people with disabilities, pays for a proscribed set of services, including institutional long-term care. Individuals who receive Medicaid benefits may live in the community and receive some of the services that otherwise would be provided in an institution if they are in a waiver program.

One of the state's waiver programs is the Mental Retardation Local Authority Program (MRLA) . A provider of MRLA services must perform case management functions, including planning, coordinating, and reviewing services to clients. Covered services include counseling and therapy, minor home modifications, nursing and dental care, residential assistance and other services in the community.

In 2003, the 78th Legislature enacted HB 2292 by Wohlgemuth, the omnibus health and human services law. One of the provisions in that bill requires that local mental health and mental retardation authorities must be providers of last resort. Another directed DADS and local mental health and mental retardation authorities to develop and implement a plan to privatize all ICF-MR services and related waiver services programs operated by an authority. It barred the transfer of services to private providers until August 31, 2006.

DIGEST:

CSHB 2572 would permit local authorities to serve as both state contractors and service providers. Local mental retardation authorities (LMRAs) also could serve as providers of intermediate care facility services (ICF-MR) or related waiver services if they were qualified service providers or as providers of last resort.

HHSC would establish rules about MRLA access, intake, eligibility qualifications, enrollment, service coordination, local planning, accountability, and other functions. To become a qualified service provider, the LRMA would have to base its capacity as a provider on the August 2004 MRLA enrollment levels in that service area. Any long-term increase in capacity would be a result of individuals choosing the LMRA as a provider under a state-mandated conversion from one Medicaid

program to another. An increase in capacity could not be because of refinancing or unnecessary promotion of the authority's role as provider.

At least biennially, DADS would review LMRAs status as a qualified service provider in light of availability of services and the number of qualified providers in the area. The bill also would repeal the direction to DADS to develop and implement a plan to privatize all ICF-MR services and related waiver services programs operated by an authority. HHSC would report on local mental health authorities to the Legislature by January 1, 2007.

The bill would take effect September 1, 2005.

SUPPORTERS SAY:

CSHB 2572 would repeal the provisions in HB 2292 that made local mental health and mental retardation authorities the providers of last resort. Not enough private provider resources are available to fill the need that would be created if the local authorities could not also serve as providers in some areas of the state. Individuals need access to services and repealing the provider of last resort and privatization amendments would ensure access.

Local mental retardation authorities are best suited to handling intake functions as they are a central repository of information and referrals. The case management and waiver functions that the local authorities can serve would benefit the client with greater access and providers with improved coordination of services.

The approach taken in CSHB 2572, which would build on local networks, would be more appropriate than the one in HB 470, which would centralize contracts, taking management of the contracts from the local authorities and placing them at the agency. Managing local contracts from afar is difficult and can mean working less closely with providers or with fewer providers. It also distances local donors and supporters from the local networks, which can lead to less funding, fewer volunteers, and a reduced sense of community for the people these programs serve.

OPPONENTS SAY:

Local mental health and mental retardation authorities should not serve as both state contractors and providers. Already the contractor has significant influence over a client's access to services, but if it also were the provider, the client would have no other entity to which that client could turn. This inherent conflict of interest should be avoided wherever possible.

OTHER OPPONENTS SAY:

A better approach, in HB 470 by J. Davis, would mandate a split in responsibilities between authority and provider and would move the state toward a more efficient and consumer-driven system by proposing a needs-based, rather than diagnosis-based, system and allowing for innovation at the local level.

NOTES:

The committee substitute changed the original version by adding the repeal the provider of the last resort provision in HB 2292.

The companion bill, SB 1187 by Nelson, has been referred to the Senate Health and Human Services Committee.

HB 470 was reported favorably, as substituted, by the Human Services Committee on April 13.