SUBJECT: Revised functions of local mental health and mental retardation authorities

COMMITTEE: Public Health — favorable, without amendment

VOTE: 8 ayes — Delisi, Laubenberg, Jackson, Cohen, Coleman, Gonzales, S. King, Truitt

0 nays

1 absent — Olivo

WITNESSES: For — Peter Henning, Bethesda Lutheran Homes & Services, Inc., Private Providers Association of Texas; Greg Hooser, Private Providers Association of Texas; Rita Johnston, Betty Hardwick Center MHMR; Donald Lee, Texas Conference of Urban Counties; Carole Lynn Smith, Private Providers Association of Texas; (*Registered, but did not testify:* Jim Allison, County Judges and Commissioners Association of Texas; Mike Bright, The Arc of Texas; Rebecca Crowell, Nexus Recovery Center; Jenny Goode, Betty Hardwick MHMR Center; Richard Hernandez, EduCare Community Living; Cynthia Humphrey, Association of Substance Abuse Programs; Joe Lovelace, Texas Council of Community MHMR Centers; Conway McDanald, Valve Options - Northstar; Mark Mendez, Tarrant County Commissioners Court; Sue Ringle, Metrocare Services; Hartley Sappington, Bluebonnet Community MHMR Center, Texas Council of Community MHMR Centers; Sanford Skelton, Texas Council of Community MHMR Centers; Anita Garvey)

Against — None

On — John Breeding, Texans for Safe Education; Merry Lynn Gerstenschlager, Texas Eagle Forum; Aaryce Hayes, Advocacy, Inc.; Lee Spiller, Citizen's Commission on Human Rights; Gwen Olsen; (*Registered, but did not testify:* Adelaide Horn, Department of Aging and Disability Services; Gary Jessee, Department of Aging and Disability Services; Sam Shore, Department of State Health Services; Monica Ayres; Scott Gatlin; Thomas Lechner; Jennifer Pantermuehl; Marlene Schiller; Michael Smith; Imre Szombathy; George Wier)

BACKGROUND:

Texas provides services to people who are mentally ill or mentally retarded through a system of local mental health and mental retardation (MHMR) authorities. The Department of Aging and Disability 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 mental health authorities (MHAs) and mental retardation authorities (MRAs) are responsible for assembling a network of providers in their service areas 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. In 2003, the 78th Legislature enacted HB 2292 by Wohlgemuth, the omnibus bill changing delivery of health and human services in Texas. One of the provisions in that bill required that local mental health and mental retardation authorities must be providers of last resort.

In 2005, the 79th Legislature enrolled HB 2572 by Truitt, which would have permitted local mental health and mental retardation authorities to serve both as state contractors and as service providers. Local mental retardation authorities also could have served 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.

Gov. Perry vetoed HB 2572, stating that the MHMR system has an inherent conflict of interest because they not only control the funds distributed in their local areas but also provide services. On June 17, 2005, Gov. Perry issued Executive Order RP45, directing HHSC to continue the transition to local health and mental retardation authorities as providers of last resort. It requires HHSC to consider consumer choice, viability of the safety net, and other factors during implementation. HHSC also will request from the attorney general an opinion on the applicability of current law regarding when a local mental health and mental retardation authority may serve as a provider of services.

DIGEST:

HB 2439 would authorize the executive commissioner of the HHSC to delegate to local Mental Health and Mental Retardation authorities the responsibility and authority of any HHS agency related to planning, coordination, resource development, and oversight of MHMR services in a particular service area. HB 2439 would address the responsibilities of

MHMR authorities, the resources afforded to them, and the exploration of new payment methodologies.

Local authority network advisory committee. By November 1, 2007, the executive commissioner of the HHSC would establish a local authority network advisory committee to replace the existing local authority technical advisory committee. The local authority network advisory committee would advise the commissioner and DSHS on technical and administrative issues affecting local mental health authority responsibilities. The committee would be abolished September 1, 2017, unless continued by the commissioner.

The executive commissioner would appoint equal numbers of representatives of local mental health authorities, community and private mental health service providers, local government officials, advocates, consumers of mental health services, family members of individuals with mental health needs, and other individuals with expertise in the field of mental health. These members would represent various regions of the state, rural and urban counties, and single and multi-county local mental health authorities. DSHS could reimburse consumers of mental health services and family members of individuals with mental health needs for travel costs incurred in performing committee duties.

The advisory committee would review initiatives of local mental health authorities and the contracting process. The committee would report on these activities to the commissioner and DSHS on a quarterly basis. The advisory committee would participate in the rulemaking process related to mental health authority operations.

Best practices clearinghouse for local mental health authorities. Using existing resources, DSHS would work with MHAs and collect information from consumers, advocates, and other local entities to establish an online clearinghouse of best practices information. DSHS could contract with a contractor to develop and implement the clearinghouse. The clearinghouse would include information on creating a local provider network development plan and increasing consumer choice within a provider network. It also would focus on achieving the best return on public investment in mental health services through maintaining high provider performance standards and maximizing the use of available funding and resources.

DSHS would encourage MHAs that successfully implemented best practices to mentor authorities that had service deficiencies. Before the executive commissioner could remove a deficient MHA's designation, the commissioner would assist the local MHA in receiving training in best practices and would document any improvements in service provision.

Local mental health authority responsibilities. A local mental health authority would create a local network development plan for its provider network. Plans would be reviewed and approved biennially by DSHS to ensure that local authorities developed a provider base that reflected local priorities and was sufficient to meet the needs of consumers in the local authority's service area.

If a local MHA provided services, it would have to establish in its network development plan why it continued to provide services and the proportion of the local network services provided by the authority. A local MHA authority could serve as a provider of last resort if one of the following criteria applied:

- interested qualified service providers were not available or no service provider met the authority's procurement requirements;
- the local MHA's network of providers did not provide at least two qualified providers in each service package;
- the amount of services available did not meet local capacity; or
- the provision of services provided by the MHA was necessary to ensure continuous service provision.

The executive commissioner would appoint facilitators to preside over a collaborative rulemaking process to develop rules governing MHAs. The process would include representatives of local MHAs, mental health service providers, consumers of mental health services, advocates, and any other mental health experts the commissioner appointed.

Local mental retardation authority responsibilities. The executive commissioner would adopt rules regarding the operational, planning, and quality assurance functions of local MRAs. Responsibilities also would include safety net functions, such as crisis management and accessing facility-based care. MRAs would offer eligible individuals a state school as an option even if a person had other residential service and community living options.

A local MRA could serve as a provider as an intermediate care facility for mental retardation (ICF-MR) or related waiver program service provider if such services were insufficient locally. The local MRA's provider capacity would be based upon August 2004 enrollment levels, and if the local authority's capacity was higher than the 2004 level, capacity would be reduced with voluntary attrition. HB 2439 would specify limited circumstances under which provider capacity could be increased. DSHS would review the MRA's provider status at least biennially to assure proper availability of a stable program in the MRA's service area.

The Department of Aging and Disability Services would ensure that local services:

- provided individuals with information, opportunities, and support to make informed decisions regarding services for which the individual was eligible;
- respected the rights, needs, and preferences of a service recipient; and
- integrated individuals with mental retardation and developmental disabilities into the community in accordance with independence initiatives and permanency planning laws.

Payment Methodologies. Prior to implementing a change in payment methodology for mental health services, DSHS would evaluate different payment mechanisms to determine the most cost-effective and efficient payment methodology and the ongoing cost to the state. DSHS would evaluate the effect of each proposed payment methodology on:

- availability of services in urban and rural areas;
- availability of services for the indigent;
- the cost certainty of service delivery; and
- the ability of local mental health authorities to meet local needs and manage a provider network.

DSHS would develop an implementation plan for a new payment methodology and report findings on the plan to the executive commissioner and the Legislature by January 1, 2009.

With HHSC approval, a local MHMR authority would procure services for its service area using a request for proposal or open-enrollment procurement method.

General provisions. If an agency determined that a federal waiver or authorization was necessary to implement any provisions of this bill, the agency would delay implementation until a request for the waiver or authorization was granted. By January 1, 2008, HHSC would submit a report on implementation of this bill and status of any waiver request if a request had been made.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2007.