MENTAL HEALTH MENTAL RETARDATION

AUTHORITY OF HARRIS COUNTY

MHMRA of Harris County

Mental Health
Network Development Plan FY ‘10

HARRIS COUNTY LOCAL SERVICE AREA PLAN

PROVIDER NETWORK DEVELOPMENT PLAN

Local Service Area

Provide the following information about your local service area. Most of the data for this section can be accessed from the following reports in MBOW, using data from the following report: 2010 LMHA Area and Population Stats (in the General Warehouse folder)

Population	4,096,052
Square miles	1,774
Population density	2309
Number of counties (total)	1
◆ **Number of urban counties**	1
◆ **Number of rural counties**	0
◆ **Number of frontier counties**	0

Major populations centers;

Name of City	Name of County	City Population	County Population	County Population Density	County Population Percent of Total
Houston	Harris	2.2 mil	4,096,052	2,309	100%

Using bullet format, briefly note other significant information about your local service area relevant to provider network development. Include population characteristics that are atypical and differentiate your local services area from most other LMHAs. Distinguishing characteristics might include a high proportion of racial, ethnic, or linguistic minorities, the presence of a large military base, or other factors that must be considered in service delivery.

- Harris County has a high level of homelessness/transient population
- Harris County's indigent population for adults with mental illness runs ~60% and for Children and Adolescents ~ 40%
- Harris County has significant Spanish speaking and Vietnamese speaking populations

Provider Availability

1) Provider Recruitment (as of May 1, 2010)

Using bullet format, list steps the LMHA took to identify and recruit external providers over the past two years. This includes but is not limited to procurement associated with the 2008 planning cycle.

- In the past two years, MHMRA has released a new procurement (service level) every 3-4 months. With each procurement, MHMRA holds public forums, sends the procurement to a 160+ stakeholder distribution list, posts notices with: NAMI, Business daily, MHMRA website, DSHS website, One Voice/BEHAV membership, Gateway to Care, as well as other relevant professional organizations.
- MHMRA has engaged in discussions with 44 providers in FY 09 and 31 providers in FY 10 YTD. These discussions have been around contracting opportunities and requirements.
- MHMRA has done 12 presentations to community groups over the past 2 years to expand stakeholder participation and general knowledge around network development activities and opportunities.
- MHMRA has repeatedly collaborated with DSHS to identify barriers to contracting as identified in these provider discussions and offered assistance with resolutions.
- Cycle 1 procurement –
  - Adult medication services has had six provider inquiries but resulted in only 1 provider procurement as of 5/1/10, and this provider was under contract prior to LPND planning.
  - Adult Counseling services have had over 20 inquiries with 3 Independent Counselors pending provider contract approval.
  - Adult Rehab services were released for procurement 3/1/10 and to date have had no formal applicants.
- Efforts to attract- MHMRA has re-approached interested providers for the FY 2010 planning cycle and has coordinated meetings to explore creative means to reduce barriers and maintain provider interests. As of 5/01/10, MHMRA has 6 providers actively interested in Harris County business in addition to current contractors. Of these 1 is a local provider and 4 others are existing providers elsewhere in Texas with an expressed interest in starting business in the Houston area. Each provider discussion has identified barriers which must be overcome in order to successfully procure to these entities, of which MHMRA is working with providers on resolving and has involved DSHS as well.

2) Provider Availability

List each potential provider identified during the process described in Item 1 of this section. Include all current contractors, providers who registered on the DSHS website, and providers who submitted written inquiries over the past two years. Note the source used to identify the provider (e.g., current contract, DSHS website, LMHA website, e-mail, written inquiry). Summarize the content of the follow-up contact described in Appendix A. If the provider did not respond to your invitation within 45 days, document your actions and the provider's response. In the final column, note the conclusion regarding the provider's availability. For those deemed to be potential providers, include the type of services the provider can provide and the provider's service capacity.

Provider	Source of Identification	Summary of Follow-up Meeting or Teleconference	Assessment of Provider Availability, Services, and Capacity
Telecare	2008 and 2010 interested provider, Public comment response to SP-3 RFA, email interest in FY 2010	Interested in AMH 1, 3, 4 and possibly crisis services (with rate review)	Experienced with DSHS business, local provider currently Availability- June/July 2010 with space expansion Capacity ~100 SP-3 patients
Providence	2008 interested provider per DSHS website, Public comment response to SP-3 RFA in Feb 2010, 2010 interested provider per DSHS website	Interested in CAS and AMH services (not crisis)- some limitations with MD's- may need MD share arrangements, needs guarantee of referrals and larger capacity released (providence to send details for inclusion in planning).	MD recruitment challenge-consider shared arrangements, Capacity is open to demand, experience with QMHP/LPHA level of care Some start-up time as not currently located in Houston Availability~90 days Capacity- open
Deblin	Phone call inquiry	Interested in Adult/ACT	Local provider No DSHS experience Capacity open Availability~ 90 days
Atlantis	2008 interested provider, inquiry into SP-3 posting	Reports on-going interest in Adult service array	MD recruitment challenge-consider telemedicine

			Experience with QMHP/LPHA level of care DSHS experience Capacity is open to demand Some start-up time as not currently located in Houston
Woods Group	2008 interested provider but withdrew, 2010 interested provider	CRU, CSU, Transitional Housing, Adult residential interest. AMH SP-3, 1 (SP-2 if required)	Experienced DSHS service provider Would require guarantee of ~75 SP-3 for contract feasibility Capacity is open to demand Availability- ~90 days start-up
Legacy	2010 interested provider (did not apply after initial discussions of contract terms)	SP-1 AMH services and possibly SP-2 Adult	Local provider, No DSHS experience Capacity is open to demand Availability undetermined
Gathering Place	2010 interested provider (did not apply after initial discussions of contract terms)	SP-2 AMH services	Local provider, No DSHS experience Capacity is open to demand Availability undetermined
HCPC OPP	AMH SP-1 provider since 2007	Interested in AMH SP-1, SP-3 (previously) Per April 2010 conversation, may term current contract eff 8/31/10, due to DSHS contract requirements as compared to rates, interested in waiver pilot following traditional outpatient care vs. RDM.	Local Provider DSHS experience as current subcontractor for AMH SP-1 care for 3 years Capacity-open to demand Availability- current
Lela Bamburg, LPC	DSHS website	Counseling services AMH and CAS	Local provider No DSHS experience No MHMRA experience Capacity- 20 consumers Availability- June 2010

3 Independent Counselors	Local contracts pending	Counseling services- AMH and CAS	Local providers No DSHS experience Capacity- open Availability- pending contract approval
		Additional providers are detailed on local log and can be viewed upon request/all actively interested providers listed above as of 5/1/10	

Local Planning

Guidelines for Gathering Community Input

CONDUCT THE PROVIDER ASSESSMENT BEFORE GATHERING INPUT FROM THE COMMUNITY.

The scope and focus of community input will depend on the availability of external providers.

Seek guidance on network development based on your knowledge of provider availability at the time.

Information presented in this section of the plan should be specific to the network development plan. Ensure that stakeholders understand the statutory mandate to develop the provider network when qualified providers are available. Community input should be focused on how to use available external capacity based on local needs and priorities.

If an LMHA has no interested providers, community input should be focused on other elements of the plan (e.g., reducing identified barriers to new providers, on potential strategies for attracting external providers, improving consumer access and choice)

When gathering input, use the previous plan as the starting point for discussion, including the plans for procurement and the results.

Before finalizing your plan, review the DSHS website to identify any additional potential providers.

3) Status of provider availability assessment

Does the final assessment of provider availability documented above match the information about provider availability on hand at the time of community input?

__X__ Yes _____ No

If no, briefly describe the difference.

4) Community Engagement

In the chart below, show the process used to provide information and solicit input about provider network development from stakeholders. Include specific events as well as activities that take place over a period of time, such as surveys. Note that a variety of communication formats may be used, including telephonic, electronic, and paper. List surveys and similar activities first, including timeframes during which the activities took place, followed by events in date order. Insert additional rows as needed.

Description, Location/Format, and Date or Timeframe	**Participating Organizations (List)**	**Summary of Input** Briefly summarize input relating to the network development plan. If the LMHA has identified interested providers, include recommendations for how the LMHA should implement the mandate to develop the provider network.	**Number of Individuals**		
			Consumers	**Family**	**Other**
NDAC Began distribution of survey 1/14/10.-2/29/10 Draft and Summary of changes sent for public comment 06/22/10	Survey was submitted to: NDAC Members NAMI Members Consumer Advisory Council Members All MHMRA Clinics & PMs Advocacy Inc Atlantis Health Svcs Baylor College of Medicine Both Sides Now Care for Elders El Centro de Corazon Children at Risk City Council Commissioner Steve Radacks Office The Community Clinic	See survey analysis attached. Summary: Top 4 most important factors in choosing a provider • Convenient location • Wait time to see the clinician • Transportation available • Pharmacy on-site Top 3 most important services • Medication services • Counseling services • Skills training to improve life skills/functioning Top 4 reasons providers/groups did not apply for the network	253	58	53

	Continuum Health The Council on Alcohol and Drugs, Houston Cypress Creek-West Oaks Hospital DBSA of Greater Houston Evercare Family Service of Greater Houston FUUSA Gateway to Care The Gathering Place HCA H.C.C.S. Harris County budget Office Harris County Healthcare Alliance Harris County Hospital District Harris County Protective Services Harris County Psychiatric Center Healthcare for the Homeless Health Center S.E. TX Heart of Montgomery HCHD Hope Clinic Houston Psychiatric Society Intracare Hospital Judge Emmett Legacy Community Health MD Anderson	• Concerned that they would not qualify • Reimbursement too low • Application too lengthy/difficult • Requirements of contract too difficult			

	Menninger Foundation National Smart Healthcare Neighborhood Centers NeuroPsychiatric Center ProSalud Providence Services of Texas Spring Branch Community Health Ctr. TCADA TeleCare Mental Health Services of Texas, Inc. The Transforma Group TOMAGWA Ministries Medical Clinic University of Houston-Clear Lake UT-Houston UT Medical School We Are Caring Hearts, CDC				
Lobby surveys	2/18/10 SW Clinic 2/24/10 NW Clinic Multiple Lobby surveys by CAC MHMRA Clinics handed out surveys.	Included in summary and numbers above			
Consumer Advisory Council meetings	8/24/09 NM 1/14/10 NM 06/22/10 Summary of changes and draft sent to council members	Concerns expressed related to transportation, communications to consumers as process moves to ensure education on choices, and safety net in place if transition is not beneficial to the consumer (allow them to return cleanly back into the MHMRA system).	10	0	2
NDAC meetings January 27, 2010 @ MHMRA Conference Ctr	Consumer Advisory Council reps MaBeths's Place MHMRA SE Clinic	Education provided, concerns around contract requirements expressed by providers and concerns by consumers for release of higher acuity and ensuring patient care remains the priority,	5	0	15

	Continuum Health MHMRA of Harris County Neuropsychiatric Center El Centro de Corazon National SmartHealthcare				
NAMI West, and NAMI Metro Distribution Draft and summary of changes sent 06/22/10	Distribution list unknown	No specific comments received	unk	unk	unk
One Voice and BHAV Distribution Draft and summary of changes sent 06/22/10	Over 300 stakeholders	Concern over potential loss of contract providers and how MHMRA would recover positions/capacity in order to ensure service needs are met. Concerns expressed over lack of local service providers as well as concerns for the impact			>300
MH Needs Council Draft and summary of changes sent 06/22/10	Over 25 represented organizations	No specific comments received			>25
Gateway to Care Draft and summary of changes sent 06/22/10	0ver 35 organizations	Supportive of plan and "creative efforts" to try and ensure successful procurement. Noted concern of impact from Parity laws and Healthcare Reform as related to limited behavioral health resources in community.			>35
NASW- Local Branch TX Assoc of LMFT's Houston LPC Association Draft and summary of changes sent 06/22/10	Local Distribution lists and website postings- numbers unknown	No specific comments received	unk	unk	unk

Stakeholder Public Forum to review Draft of Plan 06/30/10	Leah Miller, representative for Jewish Family Services of Houston Jerry Parker, representative for Woods Group Eileen Shappel, representative for Systems of Hope and NAMI metro, Federation of Families	Creative means to market providers discussed, Encouraged to explore discussions with ANP assoc to expand provider base, encouraged discussions with UT systems for creative collaborations, recommended expansion of CIRT programs beyond city limits as well as other MCOT models of in-home interventions as most effective for families and consumers. No changes to plan recommended but creative means to try and make plan successful discussed. See public comment for more details		1	2
Calls to interested providers	Providence 3/12/10 Woods Group 3/26/10 Telecare 3/17/10 Avail 4/8/10 Lara Bamburg 4/30/10 HCPC 4/26/10 Miracles BHC 6/3/10	Provided overview of plan, explored provider interests, Most providers interested in services but shared concerns regarding the terms of the contract: Rates too low for requirements Needed some assurance of consumer volume Not feasible to do med services without also having rehab available due to rates			13
CBHS – membership distribution list Draft and summary of changes sent 06/22/10	Sandy Olson forwarded to membership 6/24/10	No specific comments received.			~50

5) PNAC Involvement

Show the involvement of the Planning and Network Advisory Committee (PNAC) in the table below. PNAC activities should include input into the development of the plan and review of the draft plan. Briefly document the activity and the committee's recommendations.

Date	PNAC Activity and Recommendations
1/16/10	PNAC email- community surveys distributed
Meeting 1/27/10	Recommendations: procurements all at once vs. scattered every 90 days, Procure ACT if stable SP-3 providers operational, meeting audit requirements and interested in this service level, Procure Crisis services where providers are interested, (see minutes for other findings)

Draft sent 6/22 and confer call to review occurred 6/30/10	Agreed to draft plan recommendations and highlighted changes. Suggestions taken in public comment.

Provider Network Development

6) Contract Expenditures

Complete the table below. For FY 2010 data, provide information from the first six months of the year (September 2009 through February 2010), using six month figures in both the numerator and denominator when calculating percentages.

SERVICE CATEGORY	Total DSHS funding and Federal Rehab 2007*	External provider contract expenditures 2007		Total DSHS funding and Federal Rehab 2008*	External provider contract expenditures 2008		Total DSHS funding and Federal Rehab 2009*	External provider contract expenditures 2009		Total DSHS funding and Federal Rehab 2010* (6 months)	External provider contract expenditures 2010 (6 months)	
		Dollars	%		Dollars	%		Dollars	%		Dollars	%
Adult MH Services	$49,105,338	$21,163,761	43%	$55,795,110	$24,681,460	44%	$59,935,601	$25,334,402	42%	$31,882,662	$14,899,793	47%
Child/Adol MH Services	$11,502,999	$31,469	0%	$11,805,451	$27,170	0%	$13,311,219	$26	0%	$5,516,910	$0	0%
TOTAL MH Services	$60,608,337	$21,195,230	35%	$67,600,561	$24,708,630	37%	$73,246,820	$25,334,428	35%	$37,399,572	$14,899,793	40%
Breakout of CONTRACTED SERVICES:												
Medication and Labs		$692,431	3%		$727,935	3%		$303,390	1%		$152,039	1%
Physician Services**		$56,400	0%		$58,831	0%		$103,050	0%		$62,402	0%
Counselor Services**		$262,774	1%		$125,086	1%		$927,945	4%		$487,397	3%
Crisis Services			0%			0%			0%		$3,000	0%
Residential Services			0%			0%		$120,063	0%		$74,183	0%
Inpatient Services		$19,806,273	93%		$23,306,273	94%		$23,362,582	92%		$13,782,520	93%

Other (list):			0%			0%			0%			0%
Rehabilitation Services		$50,325	0%		$95,879	0%		$153,973	1%		$160,899	1%
Nutrition		$55,968	0%		$177,427	1%		$178,670	1%		$83,724	1%
Interpreting		$251,216	1%		$175,325	1%		$161,696	1%		$77,271	1%
Transportation		$2,432	0%		$5,254	0%		$3,385	0%		$3,515	0%
EKG/X-Ray Services		$17,411	0%		$36,620	0%		$19,674	0%		$12,843	0%
TOTAL		$21,195,230	100%		$24,708,630	100%		$25,334,428	100%		$14,899,793	100%

7) FY 2010 Provider Contracts

List your FY 2010 Contracts in the table below. In the Provider Type column, specify whether the provider is an organization or an individual practitioner.

Provider	Service(s)	Provider Type	Dollars Allocated
Randalls Pharmerica	Pharmacy	Organization's	NTE $84,000 NTE $72,000
CPL	Laboratory	Organization	NTE $290,000
Harris County Psychiatric Center (HCPC) Pooled - Psychiatric Beds Services Behavioral Hospital of Bellaire, LLC IntraCare Hospital d/b/a IntraCare North Hospital IntraCare Medical Center Hospital Texas West Oaks Hospital, LC d/b/a/ West Oaks Hospital	Inpatient	Facility	HCPC $27,493,563 NTE for pooled contracts $250,000
Best EMS	Crisis Transportation	Organization	NTE $8,500
JSA Health, LLC	Telemedicine	Organization	Pool Contract NTE $45,000
Memorial Herman Behavioral Response Team	MCOT- Crisis Assessments	Organization	NTE $42,000
Shawanda Anderson (HGAC contracting not yet completed)	Neuropsych Assessments	Individual contractor	Physician Services $45,000 HGAC $93,400
Menninger	Residential Care- Adults and Child/Adolescents	Organization	$0 (charity care)
Marc Bauman Garner and Associates El Camino Counseling	Foster Care- Rehab	Individual contractors	NTE $300,000
Baylor College Of Medicine	Physician Consultations-	Organization	Physical Med Consults

	(BCM)		$80,000 In Patient Consults $67,680
HCPC Outpatient programs	SP-1 Adults (med mgmt, pt & family education)	Organization	NTE $300,000 pool contract
Bay Area Recovery Center Santa Maria Hostel, Inc. Cheyenne Center Volunteers of America Texas, Inc. Directions of Recovery, Inc. Passages, Inc.	CPEP contracts (Dual Disorders- Residential programs)	Organizations	NTE $1,471,260
Healthcare for the Homeless	Jail In-reach and Crisis Follow-up/Relapse Prevention	Organization	NTE $60,000

8) Current and Planned Network Development

Complete the following table. Leave cells blank if the percent is 0.

- *Column A: Document current capacity for all service packages, regardless of past or planned contracting. Current service capacity is the average monthly capacity based on service data from FY 2009 and FY 2010 through the most recent closed quarter for services controlled by the DSHS contract. Capacity for service packages is expressed as the number of clients served; use the following DSHS data warehouse report to determine current service capacity: PM Service Target LPND (Enterprise: CA Utilization Mgt: UM Service Delivery: PM Service Target LPND). If projected capacity is significantly different than current capacity, insert a footnote noting the projected capacity.*
- *Column B: State the percent of total capacity contracted to external providers in FY 2009. This is the maximum capacity to be served by external provides according to the terms of the contract.*
- *Column C: Document the percent of capacity served by contractors in FY 2009; this is the actual capacity served by contractors.*
- *Column D: State the current percent of total capacity contracted to external providers for FY 2010. This is the maximum capacity to be served by external provides according to the terms of the contract. .*
- *Column E: Document the percent of capacity served by contractors in the first six months of FY 2010 (September 2009 through February 2010); this is the actual amount paid to external providers during this period. When calculating percentages, use six month figures in both the numerator and denominator.*
- *Columns F and G: If you will be procuring complete service packages in the next biennium, state the percent of current capacity planned for contract in 2011 and in 2012.*
- *Column H: Note the number of available providers based on your provider assessment documented in the previous section.*
- *Column I: Use the following list to identify the number of the applicable condition that justifies the level of service the LMHA will continue to provide internally. Include all conditions that apply. Refer to the Appendix B for complete language as specified in 25 TAC §412.758.*

1. *Willing and qualified providers are not available.*
2. *The external network does not provide minimum levels of consumer choice. Use this condition if only one external provider is interested in contracting with the LMHA, and the LMHA will therefore provide up to 50% of the service. This condition does not justify the LMHA providing more than 50% of services.*
3. *The external network does not provide equivalent access to services. Use this condition if access is the only reason the LMHA will not use all of the available external capacity. Applicability of this condition will probably be made after procurement.*
4. *The external network does not provide sufficient capacity. Use this condition if the LMHA will use all of the available external provider capacity and directly provide only the balance of current capacity.*
5. *Critical infrastructure must be preserved during a period of transition. Use this condition if the LMHA will not use all of the available external provider capacity. Instead, the LMHA plans a phased transition to full utilization of external provider capacity, increasing the volume of contracted services over two or more planning cycles.*
6. *Existing agreements restrict procurement or existing circumstances would result in substantial revenue loss. Use this condition if an external restraint is the controlling factor limiting full use of external provider capacity.*

PAST and CURRENT						**PLANNED**			
	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
Service	**Current service capacity (FY09/FY 10 aver)**	**Percent of total capacity contracted in FY 2009 (actual)**	**Percent total capacity served by contract providers in FY 2009 (max)**	**Percent of total capacity contracted in FY 2010**	**Percent total capacity served by contract providers in FY 2010 (6 mo)**	**Percent of total capacity planned for contract in FY 2011**	**Percent of total capacity planned for contract in FY 2012**	**Number of available providers**	**Applicable condition**
Adult Service Packages									
Adult RDM SP 1 Medication Services	6768	20%	7%	~20%	7%	Up to 40%	Up to 60%	6	4, 5
Adult RDM SP 2 CBT therapy	221	0%	0%	~30%	0% (contracts pending)	Up to 50%	Up to 70%	8	4, 5
Adult RDM SP 3 Rehabilitation	1277	0%	0%	~20%	0%	Up to 40%	Up to 60%	5	4, 5
Adult RDM SP 4 ACT	94	0%	0%	0%	0%	Up to 50%	Up to 70%	3	4, 5
Adult RDM SP 0 Crisis Services	475	No Limits set on crisis care	~5%	No Limits set on crisis care	5%	Procure Jan 2012	Up to 15%	2	4

Adult RDM SP 5 Crisis Relapse Prevention	74	No Limits set on crisis care	15%	No Limits set on crisis care	~15%	Procure Jan 2012	Up to 25%	1	2, 4
TOTAL Adult Services	8909	16%	6%	20%	6%	40%	60%	11	2,4,5
Child Service Packages									
Children's RDM SP 1.1 Brief Externalizing	1270	0%	0%	0%	Pending procurement March 2011	~20%	Up to 40%	1	2, 4
Children's RDM SP 1.2 Brief Internalizing	415	0%	0%	0%	Pending procurement Nov 2010	~20%	Up to 40%	5	4, 5
Children's RDM SP 2.1 MST	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Children's RDM SP 2.2 Intensive Externalizing	188	0%	0%	0%	0%	0%	Up to 50%	1	2,4
Children's RDM SP 2.3 Intensive Internalizing	54	0%	0%	0%	0%	0%	Up to 50%	5	4,5
Children's RDM SP 2.4 Bipolar/Schiz/Psychotic	2	0%	0%	0%	0%	0%	Up to 100%	1	2,4
Children's RDM SP 4 Aftercare/Meds	477	0%	0%	0%	Pending procurement July 2010	Up to 40%	Up to 60%	1	2,4
Children's RDM SP 0 Crisis Services	34	No Limits set on crisis care	~5%	No Limits set on crisis care	~5%	~5%	~20%	1 Mobile crisis provider currently – no CAS crisis provider interest- Will attempt procurement with Adult crisis care in Jan 2012 to identify any interested providers	1

Children's RDM SP 5 Crisis Relapse Prevention	8	No Limits set on crisis care	~0%	No Limits set on crisis care	0%	~0%	~20%	No interested Providers currently Will attempt procurement with Adult crisis care in Jan 2012 to identify any interested providers	1
TOTAL Children's Services	2448	<1%	<1%	~4%	<1%	22%	45%	5	1, 2, 4, 5

Use the following table to list any discrete routine services or crisis services with contracting activity (2009, current, or planned) OR interested providers.

Leave cells blank if the percent is 0.

- *Current service capacity is the average monthly capacity based on service data from FY 2009 and FY 2010 through the most recent closed quarter for services controlled by the DSHS contract. Capacity for discrete services is expressed as units of service delivered.*

PAST and CURRENT						PLANNED			
	A	B	C	D	E	F	G	H	I
DISCRETE ROUTINE SERVICES And CRISIS SERVICES	**Units of service delivered in 2009 (monthly average)**	**Percent of total capacity contracted in FY 2009**	**Percent total capacity served by contract providers in FY 2009**	**Percent of total capacity contracted in FY 2010**	**Percent total capacity served by contract providers in FY 2010**	**Percent of total capacity planned for contract in FY 2011**	**Percent of total capacity planned for contract in FY 2012**	**Number of available providers**	**Applicable Condition**
Therapy services	0	0%	0%	0% (pending contractors)	0% (pending contractors)	50%	70%	8	4,5
Lab services	1639/mo	100%	100%	100%	100%	100%	100%	1	N/A
Pharmacy services	~60,000/mo	<1%	<1%	<1%?	<1%	<1%	<1%	2	6
Physical assessments/consults	~100/mo	100%	100%	100%	100%	100%	100%	1	N/A
Residential Substance Abuse Treatment	1200/mo	100%	100%	100%	100%	100%	100%	6	N/A
Neuropsych Assessments	PRN	100%	100%	100%	100%	100%	100%	1	N/A

Crisis Transport	PRN	100%	100%	100%	100%	100%	100%	1	N/A
Inpatient Contract and Diversion Beds	405/mo	100%	100%	100%	100%	100%	100%	5	N/A
Telemedicine	PRN	100%	100%	100%	100%	100%	100%	1	N/A
Jail in-reach and relapse prevention	20/mo	100%	100%	100%	100%	100%	100%	1	N/A

9) Rationale for LMHA Service Delivery

a) *Describe the rationale for your plan for network expansion, including the services to be procured and the volume of services to be procured. If only selected services are identified for procurement, explain why those services are being offered for contracting and others are not. Discuss services for adults and for children and adolescents separately.*

Adults- All adult services are out for procurement on a graduated scale. The graduated programming can be adjusted if the network responds quicker than expected but past patterns demonstrate that capacity is slower than expected to ramp up and hence, a graduated approach is advisable to offset the internal system as the external capacity allows.

Children and Adolescent Services- All children and adolescent services are out for procurement on a graduated scale. The graduated programming can be adjusted if the network responds quicker than expected but past patterns demonstrate that capacity is slower than expected to ramp up and hence, a graduated approach is advisable to offset the internal system as the external capacity allows.

Crisis Services- Crisis services had little interest upon provider discussions. Interest revolves around Crisis Residential Services (CRU), Crisis Stabilization services (CSU), Transitional Living, and longer term Residential services.

The challenge in Harris County is that the CRU and CSU services must be provided by 1 provider due to the cost attributed to staffing such services (if broken up it would be cost prohibitive). These services are funded primarily with County funding (not pure DSHS dollars). Procuring out such services may place funding at risk. Since County funds are not mandated under this legislation for procurement, and DSHS funding of such services does not support the service in isolation, it has been determined that these services will not be procured out at this time.

Transitional Living (MHMRA's Branard Street program)- Is DSHS funded, has an interested provider, and hence will be procured at 100%. Due to the small scale of this program, again it is not fiscally prudent to procure out only a portion of care.

Longer Term Residential services- At this time DSHS does not fund this service. It has long been desired in Harris County to have funding for such services as this is a huge service gap in our community. MHMRA of Harris County ahs repeatedly approached the state with such

funding requests. To date, this is not a funded service, however, should it be funded in the future and if there remains provider interest, than it would added to the procurement at such time.

b) *If the LMHA will continue to provide one or more services because the external network does not provide equivalent access (Condition 3), describe how this determination was made, including the source of data. NOTE: The LMHA must have supporting documentation that can be submitted to DSHS when requested*

N/A

c) *If the LMHA will continue to provide one or more services because the external network does not provide sufficient capacity (Condition 4), complete the following table. Use this condition if the LMHA will use all of the available external provider capacity and directly provide only the balance of current capacity. External provider capacity is usually determined through the follow-up contacts that take place during the provider availability assessment.*

Service	**Capacity Needed**	**External Provider Capacity**	**Information and Method Used to Determine External Network Capacity**
Adult – SP-1, 2, 3, 4, 5, 0	8800	100 avail July-others are new local start-ups and require time to staff and graduate pts in.	Provider Interviews and Past years experience have shown providers are willing to expand to meet capacity but that this is a gradual process and cannot immediately be absorbed.
CAS – SP-1.1, 1.2, 2.2, 2.3, 2.4, and 4	2400	20 avail now-others are new local start-ups and require time to staff and graduate pts in.	Provider Interviews and Past years experience have shown providers are willing to expand to meet capacity but that this is a gradual process and cannot immediately be absorbed

d) *If the LMHA will continue to provide the specified capacity of one or more services in order to preserve critical infrastructure to ensure continuous provision of services (Condition 5), identify the planned transition period and the year in which the LMHA anticipates procuring the full external provider capacity currently available. If the same transition period is planned for all services, only one entry is required. When different transition periods are planned, list each separately.*
NOTE: The rule states that this condition can be used only when the LMHA identifies a timeframe for transitioning to an external provider network, during which the LMHA procures an increasing proportion of the service capacity of the external provider network in successive procurement cycles. This timeframe is the LMHA's best estimate based on the limited information currently available, and does not represent

a firm commitment. The timeframe will be reassessed during each planning cycle based on the results of procurement, provider performance, and new information. The current estimate should assume that proposed procurement plans are successful and the contractors prove to be stable providers and meet established performance standards.

Service	Transition Period	Year of Full Procurement
Adult Services	20% graduated procurement each year if previous capacity is met.	2014
Child and Adolescent Services	20% graduated procurement each year if previous capacity is met.	2015

e) *If the LMHA will continue to provide one or more services because existing agreements restrict procurement or existing circumstances would result in substantial revenue loss (Condition 6), briefly describe each of them, including the end date of any agreement. Describe any steps taken to amend the agreements or alter the conditions to allow contracting. NOTE: LMHA may be asked to submit copies of agreements or other supporting documentation.*

- Many CPEP (Crisis) services are funded by commissioner's court and hence not subject to procurement. As DSHS funds do not support these programs without County funding, and County funding may be at risk if procured out and integrity of such programs are not maintained, it has been determined that the revenue loss would eliminate many of these programs at a risk to consumers who access this level of care, hence procurement is not being pursued. Will procure those which are not supported by County funds.
- Pharmacy- Due to the extensive prescription assistance programming (PAP), which is done through our local pharmacies, MHMRA of Harris County generates >$8 million in cost savings for drug purchases which can then support direct services to consumers. Without this savings, consumer services would fall short and would have less patient capacity. Hence, MHMRA only contracts out in limited circumstances. However, MHMRA is willing to talk with any providers about taking on a per member per month (pmpm) pharmacy management agreement if able to stay within local per patient costs so as to manage the medications outside of MHMRA pharmacies. This stipulation is included in our provider contracts currently.

10) Rationale for Volume of Services Provided by the LMHA to Preserve Financial Viability

If the percentage listed for any service is based on a determination that the service provision by the LMHA would not be financially viable at a lower level, explain the budget analysis used to arrive at the specified volume. Enter NA if you have no interested providers or if the volume of services to be provided by the LMHA is not higher than it would otherwise be to ensure financial viability. NOTE: Supporting documentation may be requested.

N/A

11) Strategies to Protect Critical Infrastructure

In bullet format, briefly describe the strategies you will implement to protect critical infrastructure and promote a stable, successful provider network. Enter NA if you have no interested providers.

- Consider leasing or cost-sharing of LMHA building space for contract providers
- Ensure robust Provider criterion contracting with Providers to include:
  - Financial Stability review at initial application and periodically thereafter
  - Ensure at least 60 days of cash reserves in place
  - Review of recent financial statements and projected business plan to ensure income over expenses
  - Conduct a thorough readiness review, inclusive of on-site inspection
  - Review of service records and billing capabilities
- Ensure Providers have a clear understanding of contractual requirements::
  - MHMRA of Harris County has established standard meetings/conference calls with all interested parties to ensure basic RDM provisions are understood prior to application
  - MHMRA of Harris County has completed a Provider manual which is updated/enhanced throughout the fiscal year to ensure up to date tools and reference materials are available to providers
  - MHMRA provides thorough training on RDM requirements, documentation requirements, QM standards and fidelity audits, billing/payment requirements, and data management for contract compliance
- Implement procedures to promptly disseminate updates from DSHS and other sources:
  - Provider meetings are held routinely for contract updates, data sharing, trending, problem solving, and other contract supports
  - Provider bulletins/newsletters will be utilized to place communications in writing for provider reference
  - Annual DSHS contract trainings will be provided as new contract terms are released annually
- Establish systems to identify and resolve potential and emerging problems at an early stage;
  - Routinely monitor contractors via documentation, trending, and formal audit reviews with action plans in any areas needing improvement and further monitoring
  - Complete focused reviews on any areas of identified concern with related action plans and tracking
  - Key "dashboard" indicators to monitor (items which are likely to show up when a provider is experiencing problems):
    - Staffing levels and turnover rates
    - Timeliness and rate of billing
    - Level of claims denials
    - Timeliness of documentation
    - Time between request for service and date of appointment (initial and continuing)
    - Complaints
    - Consumer discharge levels
    - LOC % comparisons
    - Crisis and Jail utilization comparisons
    - No show percentages
- Consider arrangements for back-up service delivery in case a provider is unable to fulfill their contract;

- Routinely monitor provider capacity and expansion potential between providers to ensure always can absorb the volume of the largest provide elsewhere in the system
- Utilize crisis staff to establish temporary ad-hoc clinics if needed

12) Time to Re-establish Lost Service Capacity

Estimate the amount of time needed to re-establish the service volume lost if a contract is terminated. If time varies depending on the service type, list each separately. Enter NA if you have no interested providers.

Service(s)	Time Needed to Re-establish Service Volume
All	~ 6 months (post, hire, credential, train, implement programming)

Procurement

13) Structure of Procurement(s)

In the table below, describe how the 2012 procurement will be structured, making a separate entry for each service or combination of services that will be procured as a separate contracting unit. Enter NA if you have no interested providers.

- *Note the method of procurement: competitive procurement (RFP) or open enrollment (RFA).*
- *Identify the geographic area(s) in which the service will be procured, and the percent of your clients living in the designated geographic area. Specify whether an external provider will be required to cover the entire area. If an external provider will be permitted to contract for services in only a portion of the identified area, note how the area may be partitioned.*
- *Describe the rationale for how the procurement will be structured. In the rationale the following issues must be addressed:*
    - *Method of procurement (competitive vs. open enrollment)*
    - *procurement of discrete services rather than service packages (provide a separate rationale for each discrete service)*
    - *bundling of services or service packages*
    - *service area (whether the entire local service area is included or only selected counties, and choice of individual counties)*

Date(s)	Method (RFA or RFP)	Service or Combination of Services to be Procured	Geographic Area(s) in Which Service(s) will be Procured	Percent of Clients	Rationale
June 2011	RFA	Adult Service Array	Harris County	Up to: 40% SP-1, 50% SP-2, 40% SP-3, 50% SP-4	~20% growth each yr if capacity targeted to external network is realized
June 2012	RFA	CAS Service Array	Harris County	Up to: 40% Brief Pkgs 50% Intensive pkgs, 60% aftercare pkg	~20% growth each yr if capacity targeted to external network is realized
January 2012	RFP	Crisis Services- specifically: Transitional Housing, Jail In-Reach, Dual Dx Residential Care, Crisis Assessment/Mobile	Harris County	Up to: 15% SP-0 30% SP-5	~20% growth each yr if capacity targeted to external network is realized

14) <u>Fidelity and Continuity of Care</u> (complete only if discrete services will be procured).
If you plan to procure discrete services (rather than full service packages), describe how you will maintain fidelity and continuity of care in the provider network. The content of this section describes what changes or additions will be made to your standard process to address the additional fragmentation that can occur when services for a single consumer are provided by multiple contractors, often in multiple locations. <u>Enter NA if you have no interested providers or plan to procure service packages only</u>.

- MHMRA of Harris County has pursued discrete service contracts for Therapy services
- Fidelity and Continuity of Care are contract stipulations with audits and proven (documentation) that such coordination occurs
- Both therapists and psychiatrists are independent practitioners and could be held to case collaboration under contract stipulations

- An additional challenge will be for the MD to complete the Medication Training and Support Services if working without nursing or other clinical staff and for both providers to ensure minimum hours and outcome requirements are met. This will be monitored through data submissions.

15) Enhanced Staff Qualifications

Do you require any individual practitioners to meet higher standards than those described in the DSHS performance contract?

_____Yes ___X__ No

If yes, identify the practitioner(s) and the specific qualifications. Enter NA if you have no interested providers.

Consumer Choice

16) Single Provider

List all services to be provided by a single provider (regardless of provider availability) and the reason(s) for not offering consumers a choice of providers. Identify any economic factors involved in the decision. Enter NA if you have no interested providers.

Service to be Provided by a Single Provider	Reason(s) for Limiting Client Choice
CSU, CRU,	It is not cost effective to split this service between multiple providers due to the high cost of the service and economies of scale grouping them. Will procure via an RFP process for a single source contract.
MCOT, CIT, CTI,	Much of these services are County funded not DSHS funded, concern of placing these funding sources at risk via external contracting. Plan to get other crisis services up first and verify stability before discussions with County about whether these would be able to bid out with mixed funds. Additional concern with these services is the tight relationship which must be maintained with the law enforcement, jail, and crisis staff to ensure success. These relationships have taken years to build and destabilization of this system is of concern. It is ideal to have these managed by 1 entity to ensure clear communication between entities and consistency with patients utilizing these care levels.

Choice and Access

Using bullet format, briefly describe plans for maximizing consumers' choice of providers and access to services, including relevant procedures, procurement specifications, and contract provisions.

- The consumer (and legally authorized Representatives -LAR's) will then be provided with a Network Provider Listing (NPL) to allow them to choose a Provider that best meets their needs
- In order to ensure consumer choice is maximized, MHMRA of Harris County will be maintaining a provider panel with basic service, location, transportation, and language information in order to educate consumers and offer choice in service provider
- MHMRA of Harris County plans to conduct open enrollments and to keep procurements open in order to ensure all interested providers have ample opportunity to apply as a subcontractor for services
- MHMRA will ensure access to services by targeting to have provider options within 30 min travel time from consumers homes throughout Harris County and that appointment availability is maintained within our agency standards based on urgent, emergent, routine needs
- MHMRA of Harris County will geo-plot service providers as a means to focus recruitment in any underserved areas

17) Diversity

Using bullet format, briefly describe how the LMHA will ensure its provider network meets the diverse cultural and linguistic needs in the local community. Include relevant standards, procedures, procurement specifications, and contract provisions.

- All new providers will engage in cultural diversity training prior to provision of services and will receive this training at least annually. In addition, cultural respect language is included in all provider contracts and will be monitored through consumer complaints as well as consumer satisfaction surveys.

- In addition to the Provider training, Authority staff will be trained, when assisting a consumer to choose a provider, to be mindful of these needs.

- All providers will be listed with any cultural/linguistic specializations so as to easily match a consumer requesting such preferences with appropriate providers.

- Translation services for Monolingual consumers, will be made available if needed, at both MHMRA internal provider offices as well as at external provider locations. This is a contractual requirement of all providers in the network to accommodate such needs. The Agency will first attempt to place consumers with providers who speak the needed language; however, when that is not feasible translation services will be coordinated. This is inclusive of sign language and other hearing impairment accommodations as well. MHMRA is anticipating a cost increase for language services in a decentralized provider network

Capacity Development

18) <u>Cost Efficiency</u>

Using bullet format, list steps taken in the past two years to minimize overhead and administrative costs and achieve purchasing and other administrative efficiencies. Do not report efforts included in the 2008 network development plan.

- See Providence public comment examples
- Credentialing proposal to HHSC for Streamlined statewide data sharing with extensive statewide cost savings
- Credentialing delegation/organizational status pursued/secured with the managed care plans in Harris county
- Helpline contracts
- Credentialing RFP for other public sector business- under review
- Quad eligibility project

List partnerships with other LMHAs related to planning, administration, purchasing and procurement or other authority functions, or service delivery. Include current, ongoing partnerships (regardless of date established) and time-limited activities that occurred over the past two years.

Start Date	Partner(s)	Functions
May 2007 Aug 2007 Feb 2008 Feb 2008 June 2008 Sept 2008	Spindletop Gulf Bend Central Counties Gulf Coast Burke Brazos Valley	Helpline Contracts
2008	Tarrant County MHMRA	Software development to enhance productivity/reporting/pt care

Identify any current efforts and plans to develop new opportunities for working jointly with other LMHAs.

- Will explore staff back up plans per the critical infrastructure planning with MHMRA's in the Region.
- Exploring feasibility of shared resources for all Authority and Administrative services with Regional MHMRA's (examples for consideration include but are not limited to; Human Resources, Accounting, Legal, IT, Contracting, Utilization Management, etc).

19) Previous Network Development Efforts

In the table below, document your procurement activity over the past two years.

- *List each service separately, including the percent of capacity and the geographic area in which the service was procured.*
- *State the results, including the number of providers obtained and the percent of service capacity under contract. If no providers were obtained as a result of procurement efforts, please note under results.*

Procurement (Service, Capacity, Geographic Area)	Results (Providers and Capacity)
Adult SP-1, 20% capacity, Harris County area	1 Provider (Organization)/ ~500 pts (7% capacity) as of Feb 2010
Adult SP-2, 30% capacity, Harris county area	Pending (4 respondents in process- Individual contractors)
Adult SP-3, 20% capacity, Harris County area	Pending (released March 2010)
CAS procurements to begin June 2010	Pending Release
Residential Substance Abuse Treatment, 40 beds, Harris County,	6 providers, 40+ bed capacity
Inpatient Diversion beds, Acute care, Harris County- PRN beds	4 facilities, PRN capacity
Crisis Transportation	1 Organization, PRN capacity
Telemedicine Services	1 Organization, PRN capacity
Physical Med Consults	1 Organization, PRN capacity
Neuropsych Assessments	1 Provider, PRN capacity
Residential Adult/CAS treatment	1 Organization, 1 charity bed
Jail in-reach assessments and out-reach relapse prevention	1 Organization, ~20 consumers/mo

List the comments you received after posting the draft procurement documents during the 2008 planning cycle, and how you responded to the comments, including any modifications made to the procurement document.

Comment or Suggestion	LMHA Response
See attached public comment logs for Adult SP-1-3 and CAS SP-4 procurements	See attachment

In bullet format, list specific steps taken over the past two years to develop the LMHA's internal capacity to develop and manage the external provider network. The scope of activity should be appropriate to the level of interest from external providers.

- Added 1 FTE-Credentialing staff
- Added 1 Network Supervisor to manage the business operations (claims, credentialing, data entry, auth's, case assignments, etc)
- Added 1 LPHA for Provider relations, contract training, communications, and contract compliance monitoring
- Re-organized QM, UM, NM, Credentialing committees oversight and communications to streamline and reduce duplications

20) Barriers

Identify the barriers you encountered when trying to recruit external providers, including any local circumstances that make recruitment difficult. Describe how you plan to address each barrier or reduce its impact during the 2012 procurement.

Barriers	Plans
Provider feedback that they did not apply for past procurements due to higher services packages not being made available with the lower (more costly) care. Stated they could not afford initial contract start-up costs.	• This was put in place by our stakeholder group, to ensure that higher acuity care was done only by experienced and stable providers (proving contract compliance at lower levels of care first prior to releasing higher risk care). • Discussed with Providers the possibility of waiving this requirement for contractors who have proven DSHS experience and passed compliance already with other Centers. Would request copies of such reviews and upon quality review/committee approval could consider contract release for service continuums with a cap of initial higher acuity cases until proven compliance within Harris County. This would at least enable them to ramp up faster. Initial cap would be released upon proven local audits- at a passing level. • Another alternative is to reassess the lower level case rates and increase these to better cover lower level costs of care even if above Medicaid rates. These would need to be offset by lower rates at the higher service level than initially planned but would create a more balanced funding system between service levels. • Options above to be presented to Stakeholder group for feedback prior to implementation.
MD limitations in the Harris County service area	• MHMRA will consider models with some shared MD resources to allow providers time to hire and/or collaborate with other local MD providers
No business guarantee was cited as a barrier by some providers. Costly to build an operation without any caseload guarantee (high risk contract).	• MHMRA educated providers that patient choice was of utmost importance, however, MHMRA will consider ways to ensure once there is provider choice amongst external providers and capacity for a safety net, that we will look for creative opportunities to assist in building caseloads. Examples: mail outs to consumers served outside their catchment area, to new provider available within their catchment as new contractors are brought up, removal from WL to external providers as capacity exists to move consumers into care, etc.

<table>
<tr>
<td><u>Lab services-</u>
Most external providers do not have this service on site which results in consumers either choosing internal providers for the convenience of 1-stop shopping and/or poor compliance with labs at external provider sites.</td>
<td>• If high enough Consumer Choice (patient volume) is present with any of the external providers- the lab contractor has agreed to provide on-site services, however since this is consumer driven it will not be determined until later in the contract implementation whether this is an option or not.
• Have ensured in the interim that contract stipulations allow for service at any contract lab site throughout the service area.
• Educate Consumers at time of Provider selection to this issue and contract lab locations so educated decisions are made.
• Reimburse Provider for lab services if have such available on site IF accepting same or lower rate as contract lab.</td>
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<tr>
<td><u>Pharmacy Services-</u>
This is an issue for consumers whose pharmacy benefit is through MHMRA (primarily GR population). Most external providers do not have this service on site which results in consumers either choosing internal providers for the convenience of 1-stop shopping. In addition, MHMRA anticipates increased costs related to getting medications to consumers in an expanded network.</td>
<td>• Educate Consumers at time of Provider selection to this issue and pharmacy locations so educated decisions are made.
• We have explored contract pharmacies providing this service but it is cost prohibitive at this time due to the PAP process- will continue to periodically re-evaluate.
• Exploring fax and fill options of medication delivery to External Provider office and/or home location if cost effective.
• Offer providers pharmacy case rate to self manage pharmacy benefit</td>
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<td><u>Payment Rates vs. Contractual Demands-</u>
Payment requirement of “no higher than Medicaid rates” yet the Contractual requirements are much more extensive than required for traditional Medicaid services by private providers becomes a contracting issue. Once providers see the training, documentation, and additional paperwork requirements for the Medicaid rate it is often cost prohibitive for them to do business with the MHMRA.
This includes unfunded mandates and services which are required but not funded example: TRAG (if no other services is needed at that time), Follow-up phone calls for no shows, continuity of care, etc., Engagement services, etc.</td>
<td>• Requested in FY '09 contract review that DSHS allow for services to be reimbursed above Medicaid rates if internal costs are higher than Medicaid rates. Would continue to be a cost savings in these cases.
• Streamline training requirements as much as possible to minimize cost to Providers (ex: on-line trainings were possible to reduce time and cost demands, Test-out options were allowable, etc.).
• Streamline documentation requirements as much as possible to minimize cost to Providers (ex: sharing internal provider forms, system access if interested in electronic records, etc.).</td>
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<td><u>Unfunded Mandates-</u>
Contracts with MHMRA’s become challenging to implement from a fiscal standpoint due to contractual requirements for services which are not reimbursed. Examples include:
a) TRAG (if no other services is needed at that time this is not reimbursed but is required),
b) Follow-up phone calls for no shows, engagement activities, prior to closure, etc.
c) Continuity of Care services</td>
<td>• Demonstrate these challenges to DSHS for consideration of contract changes.
• Offer assistance to DSHS in development of solutions.
• Propose to DSHS a waiver contract pilot to demonstrate positive outcomes outside of additional contract requirements.</td>
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d) Engagement services, etc.	
Training Requirements- Extensive initial and annual training requirements at cost to the Provider for large systems and systems with turn-over becomes costly when not reimbursed for staff time in these activities nor for the tracking of this requirement.	• Streamline training requirements as much as possible to minimize cost to Providers (ex: on-line trainings were possible to reduce time and cost demands, Test-out options were allowable, etc.). • Request train the trainer models where feasible- so internal training can occur within the External Provider groups (cost savings to the MHMRA and the External Provider).
High no show rate for this population- External Providers report spending extensive funds on getting programs up and staff trained in contractual requirements but that the high no show rate and the expectation that they complete 3 good faith attempts to contact no shows prior to closure are cost prohibitive as no funding for such services occurs.	• Complete Engagement training for providers. • Provide Business Operations assistance (appointment booking strategies). • Provide Case Management supports from the Authority to try and minimize this occurrence.
Data Management Issues- Multiple software systems and limitations to allowing acceptance of electronic signatures as a means to expedite communications and documentation reviews/sharing. Reduction of dual data entry and expedition of data and quality reviews.	• Allow electronic signatures to be captured in secured electronic medical record systems. • Ensure streamlining of data interfacing allowed at the State level.
Employee v. Independent Contractor legality- While LPND implies/requires contracting when a provider is available, potential liability exists due to employment misclassification concerns with the Texas Workforce Commission specifically the Texas Unemployment Compensation Act, as well as the Internal Revenue Service specifically section 530 of the Revenue Act of 1978 and Internal Revenue Code 3509. Employee v. Independent Contractor liability. • Employment misclassification concerns resulting in back pay and taxes • Texas Workforce Commission specifically the Texas Unemployment Compensation Act. • Internal Revenue Service specifically section 530 of the Revenue Act of 1978 and Internal Revenue Code 3509.	• Individual providers who do not meet the "direction or control" or "common law" test as adapted by TWC must not receive a contract as an Independent Contractor. • Individual providers, whether licensed or not, who do not meet the "direction or control" or "common law" test as adapted by TWC must not receive a contract as an Independent Contractor.

21) Long Term Planning

Note: Long term plans are based on the limited information currently available, and will be reassessed during the next planning cycle; they do not represent a firm commitment.

If the LMHA is continuing to provide services in order to protect critical infrastructure, briefly describe your plan for transitioning to full utilization of the service capacity being offered by external providers. Assume that proposed procurement plans are successful and the contractors prove to be stable providers and meet established performance standards. The plan must include a target date for the transition and measurable objectives for each procurement period.

If your proposed procurement is successful, what are your current plans for expanding the external provider network during the 2012 cycle? Identify the services and general volume capacity you are considering for procurement in the next planning period. If this information is documented in your critical infrastructure transition plan, simply reference it. Enter NA if you have no interested providers.

Additional two-year planning (years 3-4) -

- Rebalance the MHMRA provider system based on the successes of Network Development in years 1-2
- Repeat the procurement cycle as detailed in years 1-2 (follow same timeframes as years 1-2)
- For all packages successfully contracted out to external providers, increase the procurement another 20-30% based on provider availability.
- Evaluate procurement of services not previously procured to see if feasible now that Provider base is established and operational
- Complete cost analysis to ensure proper shifts have occurred in Administrative functions (complete in year 3 so shifts can be tweaked in year 4 if needed)
- Re-evaluate safety net structure and service capacity necessary for LMHA viability, adjust as needed
- NDAC quarterly meetings to review and tweak the current system

22) Public Comment

Using bullet format, list the steps you will take to publicize and get public comment on the draft network development plan. Include outreach and activities directed to consumers, local advocacy groups, and potential providers.

- Submission to the NDAC distribution list which consists of over 160 individual, family, provider groups, advocates, and other stakeholders in Harris county
- Presentation to Consumer Advisory Council representatives- with handouts to share in the clinics with consumers/families
- Routing Network Management staff to clinics for direct education and feedback with consumers
- Posting on DSHS website and
- Posting on MHMRA of Harris County website

- Presentations/Electronic routing to One Voice, MH Needs council, Gateway to Care collaboration, Public Forums/NDAC meeting, Jail Diversion committees, etc.
- Submission to NAMI, NASW Local Branch, TX. Assoc. of LMFT's, and the Houston LPC Association for feedback from their members, contacts, etc.

Implementation

23) Procurement Timeline

Provide your procurement timelines in the following table. Allow at least 14 days for public comment to the draft procurement instrument. If more than one procurement is planned, provide a separate timeline for each (copy and paste additional rows to the table). Enter NA if you have no interested providers.

Adult Procurement Dates	Child/Adolescent Service Procurement Dates	Crisis Service Procurement Dates	Key Activities and Milestones
May 1, 2011	May 1, 2012	Dec 1, 2011	Draft procurement document (RFA/RFP) posted for public comment (at least 14 days)
June 1, 2011	June 1, 2012	Jan 30, 2012	Publication of final procurement
Open enrollment	Open enrollment	Mar 1, 2012	Due date for procurement responses
Within 45 days of complete application	Within 45 days of complete application	May 1, 2012	Award date
Upon Award	Upon Award	June 1, 2012	Contract start date

24) Consumer Transition

Provide your consumer transition timeline in the following table. If more than one procurement is planned, provide a separate timeline for each (copy and paste additional rows to the table). Enter NA if you have no interested providers.

Date or Timeframe	Key Activities and Milestones
Upon award- website and consumer/provider handouts are	Provider list will be posted to website and distributed to consumer and

updated	advocacy groups
Annual forums face to face and video (virtual provider fairs)	Hosting provider forums to allow providers to share information with consumers. Virtual fair could be posted as soon as provider is under contract and fully complaint with start up requirements (credentialing, training, etc)
As each new provider is brought up they will be added- currently offering pt choice of providers for Adult SP-1, SP-2, SP-3	Offering consumers choice of providers in the new network
Within 72 hrs at intake and no defined timeframes when choosing to change providers during the year. They are offered choice at each tx plan update but also given hand-out for Authority Case Managers to change providers at anytime.	Consumers timeframe to select a provider
Will offer pt choice at every treatment plan review (usually every 90 days) and for pts wishing to change providers, will do so prior to next scheduled appt timeframe appointment availability permitting.	Timeframe for transitioning current clients to new providers

Stakeholder Comments on Draft Plan and LMHA Response

Allow 14 days (minimum) for public comment on draft plan.

In the following table, summarize the public comments received on the draft plan. Use a separate line for each major point identified during the public comment period, and identify the stakeholder group(s) offering the comment. Describe the LMHA's response, which might include:

- *Accepting the comment in full and making corresponding modifications to the plan;*
- *Accepting the comment in part and making corresponding modifications to the plan; or*
- *Rejecting the comment. Please explain the LMHA's rationale for rejecting the comment.*

Comment	Stakeholder Group(s)	LMHA Response and Rationale
What has MHMRA done to publish the procurements?	Community Forum held 6/30/10	MHMRA has distributed procurement/network updates to an open stakeholder distribution list (over 160+ participants) as well as listed procurements in local dist/professional papers, NAMI, posted on Business Daily website and local MHMRA website, as well as shared with local Consumer Advisory groups.
Can we have a consumer rating system of Providers for the consumers to review?	Community Forum held 6/30/10	MHMRA agrees consumer input is important. Initially we will have a provider matrix for all to see which equally compares providers for things like locations, hours, languages, transportation, etc. We will also release consumer satisfaction results for each once available. MHMRA will host provider fairs for consumers to meet providers as

		well as offer providers the option of posting virtual fair videos onto the agency website explaining their services for consumers to view.
How are you marketing to Providers? Have you included family practice physicians,	Community Forum held 6/30/10	No changes needed- Question/clarification only. MHMRA is sending information out across a 160+ community network for distribution as well as targeting trade associations for each specific package level. We have targeted the Houston Medical Society as a way to reach physicians. Will look at utilizing Medicaid provider lists to identify PCP's who may be interested in step down/transition care based on this recommendation.
Have you approached UT systems for contracts?	Community Forum held 6/30/10	No changes needed- Question/clarification only. UT-HCPC is currently under contract but has decided to term the contract effective Aug 31, 2010. Other areas of UT have not been explored; specific comment was around new expanding UT programs and psychiatrist/resident availability. MHMRA will explore if there is any interest by UT in further contract discussions.
We need an expansion of CIRT beyond City limits as well as an expansion to children/adolescents as a preventative measure for community integration. There is a benefit to consumer and family interventions in the home (like MCOT) – need this expansion in Houston	Community Forum held 6/30/10	No changes needed- Question/clarification only. MHMRA agrees in the benefit of such an expansion, however, in order to expand; MHMRA would need additional funding and agreement with law enforcement for such collaboration. With current funding limitations, this is not feasible, but MHMRA will consider such expansion in the future if resources allow.
Has MHMRA explored grants to support the CAS Assessment Center? If this program can come to fruition, there would be a large community benefit.	Community Forum held 6/30/10	No changes needed- Question/clarification only. At this time this is not an initiative which MHMRA is taking the lead on.
Is there a means to increase provider reimbursement above Medicaid?	Community Forum held 6/30/10	No changes needed- Question/clarification only. MHMRA has looked into this multiple times and advocated for increases in reimbursement rates at the State level. At this time, MHMRA cannot supplement Medicaid rates. MHMRA will continue to explore alternative means to making the contract feasible for providers.
Has there been outreach targeted to Nurse Practitioners? This may increase the provider pool and the success of procurement. - Recommend approaching the TX Nursing Association (TNA) - and querying how to reach those in Psych specialty areas.	Community Forum held 6/30/10	No changes needed- Question/clarification only. MHMRA will explore whether the TNA has a means for communication with this sub-specialty and if posting notices can be done through their organization.

Have you considered pharmacy options- mail order?	Community Forum held 6/30/10	No changes needed- Question/clarification only. Yes, MHMRA has looked at many pharmacy options in order to ensure consumer needs are met. MHMRA has a fax and fill as well as a per member per month (PMPM) management model available to providers who are interested in adding this service to their provider location.
Challenge of past 2008 plan was requiring providers to contract for sp-1 before sp-3 and it was not a cost beneficial model to the providers.	Community Forum held 6/30/10	No changes needed- Question/clarification only. This has been addressed in the FY2010 Local Plan- which now allows for providers with DSHS experience to submit past performance audits to verify contract compliance as a means to potentially waive this requirement and allow for immediate release of higher sp-3 service packages with a cap until local audits are passed.
How will parity and healthcare reform effect this plan?	Community Forum held 6/30/10	No changes needed- Question/clarification only. Since details on the implementation of both of these initiatives have not yet released, it is hard to speculate the impact, though there will likely be significant change in the community mental health systems. MHMRA will continue to monitor these changes as details develop and will adjust plans as needed with stakeholder notification and input.
It looks excellent to me!!! The only thing is I wish we had more providers interested. Thank you, Jennifer, and everyone else that has work so hard to set this up. Keep up the excellent work!!! Thank you all again!!!	Consumer Advisory Council- sent by F.Martinez	No changes needed

COMPLETE AND SUBMIT ENTIRE PLAN TO performance.contracts@dshs.state.tx.us AS REQUIRED.

Appendix A

LPND Potential Interested Provider Contact Steps

1. Provider Interest Inquiry form is submitted for posting on DSHS web site.
2. DSHS Staff review information and post form
3. Provider and LMHA are notified via e-mail from DSHS staff that the form has been posted.
4. LMHA contacts provider to schedule a teleconference or site visit.
5. The LMHA may conclude that a provider is not interested in contracting with the LMHA if the provider does not participate in a teleconference or in-person meeting (whichever is requested by the LMHA) within 45 days of the initial LMHA contact.

Through the DSHS website, a provider can submit a Provider Inquiry Form to register interest in contracting with an LMHA. DSHS will notify both the provider and the LMHA when the Provider Inquiry Form is posted.

During its assessment of provider availability, it is the responsibility of the LMHA to review posted information and contact potential providers to schedule a time for further discussion. This discussion, which can take place in person or by phone, provides both the LMHA and the provider an opportunity to share information so that both parties can make a more informed decision about potential procurements.

If the LMHA does not contact the provider, the LMHA must assume the provider is interested in contracting with the LMHA.

The LMHA may request a teleconference or an in-person meeting, and must work with the provider to find a mutually convenient time. If the provider does not respond to the invitation or is not able to accommodate a teleconference or a site visit within 45 days of the LMHA's initial contact, the LMHA may conclude that the provider is not interested in contracting with the LMHA.

An LMHA is not obligated to go through procurement if no providers have demonstrated interested in contracting with the LMHA.

Appendix B

25 TAC §412.758 LMHA Provider Status.

1) **The LMHA shall provide services only under one or more of the following conditions.**

a) The LMHA determines that interested qualified providers are not available to provide services in the LMHA's service area or that no providers met procurement specifications.

b) The network of external providers does not provide the minimum level of consumer choice. A minimal level of consumer choice is present when consumers and their legally authorized representatives can choose from two or more qualified provider organizations in the LMHA's provider network for service packages and from two or more qualified individual practitioners in the LMHA's provider network for specific services within a service package.

c) The network of external providers does not provide consumers of the LMHA's service area with access to services that is equivalent to or better than the level of access as of a date to be determined by DSHS. Any LMHA relying on this condition shall submit to DSHS information necessary for DSHS to verify level of access. DSHS will use the latest healthcare access technology available to the agency to measure access.

d) The combined volume of services delivered by external providers is not sufficient to meet 100 percent of the LMHA's service capacity for each RDM service package as identified in the LMHA's local network development plan.

e) The LMHA documents that it is necessary for the LMHA to provide certain services specified by the LMHA during the two-year period covered by the LMHA's local network development plan in order to preserve critical infrastructure to ensure continuous provision of services. Under this condition, the LMHA will identify a timeframe for transitioning to an external provider network, during which the LMHA procures an increasing proportion of the service capacity of the external provider network in successive procurement cycles. The LMHA shall give up its role as a service provider at the end of the transition period when the network has multiple external providers if the LMHA determines that external providers are willing and able to provide sufficient added service volume within the timeframe specified by the LMHA in its approved local network development plan, as provided in §412.756(g)(8)(F) of this title (relating to Local Network Development Plan), to compensate for service volume lost should any one of the external provider contracts be terminated.

f) Existing agreements impose restrictions on the LMHA's ability to contract with external providers for specific services during the two-year period covered by the LMHA's local network development plan, or existing circumstances would result in the loss of a substantial source of revenue that supports service delivery during the two-year period covered by the plan. If the LMHA invokes this condition, DSHS may require the LMHA to provide DSHS with a copy of the relevant agreement(s). Examples of such agreements and circumstances include:
   (1) grants or other sources of funding that require direct service provision by the LMHA and that cannot be amended;
   (2) buildings or other physical infrastructure that are not reasonably expected to be sold, leased, or otherwise disposed of;
   (3) tax-exempt government bonds or other long-term financing that place restrictions on the LMHA's ability to meet its financial obligations, either in whole or in part; and
   (4) leases or contracts that cannot be terminated.