

November 8, 2001

Dr. Bill Rago, Facilitator
Service Delivery Model Task Force
Texas Department of Mental Health and Mental Retardation
909 W. 45th St
Austin, TX 78751

Re: Service Delivery Model Task Force

Dear Dr. Rago,

Dr. Rago, the Dallas Area NorthSTAR Authority understands that the assignment of the Task Force is daunting. There are complex needs and issues to be considered. As the Local Behavioral Health Authority for Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall Counties, DANSA convened an open workgroup to examine the current managed care model for service delivery and to propose, as a community, a service delivery model that would build upon the progress achieved throughout the last 2 years.

Participants in the community-designed model included: consumers, family members, providers (non-profit and for-profit), advocates, the current Behavioral Health Organization (ValueOptions), and DANSA Board members and staff. Through several meetings, these participants worked collaboratively to develop certain principles upon which any model should be built. These principles guided the development of the attached model.

During its November 14th meeting, the DANSA's Board of Directors endorsed the product of the workgroup and requested that it be forwarded to you, as well as others, for consideration. Should you have questions or need clarification, please do not hesitate to contact me at 972-771-9985. My email address is lynelle@cs.com.

Respectfully Submitted,

Lynelle C. Yingling, Ph.D.
Chair, Board of Directors
Dallas Area NorthSTAR Authority

Cc: County Judges-NorthSTAR Service Delivery Area
County Commissioners-NorthSTAR Service Delivery Area
TDMHMR Service Model Task Force
TDMHMR Board of Directors
Mike Halligan, Texas Mental Health Consumers Executive Director
Karen Hale, TDMHMR Commissioner
TCADA Board of Directors
Dave Wanser, TCADA Executive Director
Don Gilbert, Commissioner HHSC
NAMI-Texas
NAMI-Dallas
Mental Health Association-Texas
Mental Health Association-Dallas

Principles
Behavioral Health Service Delivery Model
As Proposed by the NorthSTAR Community

The NorthSTAR Community endorses the following principles upon which any model for delivering mental health and substance abuse services should be built.

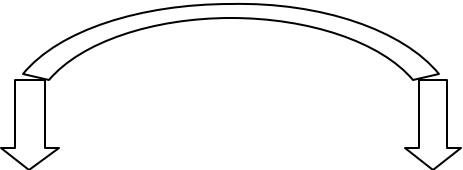
1. The service delivery model should increase consumer awareness and empower consumers to utilize services
2. The service delivery model should provide consumers a choice through an expansive network of providers
3. The service delivery model should eliminate waiting lists for certain, if not all, services.
4. The service delivery model should be based upon consumer need rather than artificial targets.
5. The service delivery model should provide a local avenue for resolution of consumer-payor/provider conflicts.
6. The service delivery model should provide a separation of the authority and provider roles.
7. The service delivery model should provide a local authority whose Board of Directors and Advisory Councils serve as a strong voice for the community.
8. The service delivery model should provide structure through the local authority for coordination of services (i.e., Community Resource Coordination Groups).
9. The service delivery model should be data driven to provide empirical evidence of process and outcome measures.
10. The service delivery model should provide a local avenue for resolution of provider-payor conflicts.
11. The service delivery model should clearly delineate the role of the local authority.

12. The service delivery model should clearly delineate Single Portal Authority responsibilities and procedures throughout the service delivery area.
13. The service delivery model should provide a transition period for providers.
14. The service delivery model should provide close monitoring of hospital utilization.
15. The service delivery model should incorporate state hospital funds.
16. The service delivery model should have a well developed plan to address the escalating costs of medications.
17. The service delivery model should be stable (free of substantive changes) for a sustained period of time.
18. The service delivery model should be pre-tested prior to implementation.
19. The service delivery model should properly address local matching funds and have a contingency plan for counties that do not contribute.
20. The service delivery model should insure that the playing field between public and private providers is equalized (i.e., open records).

The principles delineated above guided the aforementioned workgroup in the development of the following model:

NorthSTAR Proposed Model for Publicly Funded Behavioral Health Services

November 14, 2001

VARIABLE	DESCRIPTION
1. FUNDING SOURCE	Blended Funding: Medicaid TANF & SSI; General Revenue for MHMR, TCADA, Adult & Juvenile CJ, & CPS; block grants; county & city contributions; & supplemental grants; sufficient funding to permit reimbursed enrollment activities by qualified personnel
2. CONTRACTING ENTITY: ▪ ADMINISTRATION ▪ SERVICE	<p align="center">Contract ↓ Local Authority</p>  <pre> graph TD LA[Local Authority] -- Contract --> NP[Non-network Providers] LA -- Contract --> ASO[ASO/BHO] NP --- NP_L[?SPA Clinical Functions] NP --- NP_S[?Special Initiatives] ASO --- ASO_N[?Network Providers] </pre> <p>Non-network Providers: ?SPA Clinical Functions ?Special Initiatives</p> <p>ASO/BHO ?Network Providers</p>
3. RISK	<p>No-risk components [ASO management]:</p> <ul style="list-style-type: none"> ▪ SA ▪ Medications <p>Risk components [BHO management]:</p> <ul style="list-style-type: none"> ▪ Capped enrollment for non-Medicaid non-priority population [defined by MHMR criteria]
4. LOCAL AUTHORITY	<p>Separate non-provider monitoring and planning CQI agency controlled by local government with the following authority & responsibilities (Appointees to Board should be capable of contributing to the overall system of care):</p> <ul style="list-style-type: none"> ▪ Serve as the contractor for the system ▪ Monitor the publicly funded system of behavioral health care with full access to information about any related subcontracts, as well as participation in development of & modification of sub-contracts ▪ Provide a complaint hotline to report problems & ombudsperson services for resolution of problems and serve as the secondary level of appeal for consumer and/or provider complaints

<p>4. LOCAL AUTHORITY continued</p>	<ul style="list-style-type: none"> ▪ Develop local behavioral health system plan ▪ Solicit and administer supplemental funding for service gaps in the behavioral health system ▪ Provide coordination for CRCGs ▪ Provide/coordinate, directly or via contract, behavioral health forensic education for regional law enforcement ▪ Organize & manage informed community advisory councils, including consumers, family members, advocates, providers, & other behavioral health system stakeholders ▪ Keep local & state communities and governmental entities informed of system functioning assessments & recommended improvements ▪ Educate the general community regarding issues related to behavioral health and the service delivery systems available in their respective communities
<p>5. SPA FUNCTIONS</p>	<p>Local Authority contracts directly with a non-network provider for SPA functions:</p> <ul style="list-style-type: none"> ▪ Review recommendation for hospitalization and ensure that medical necessity and legal criteria are met and communicate such to the courts ▪ Recommend appropriate disposition to ensure that placement occurs in the least restrictive level of care ▪ Receive court commitments and determine appropriate level of care; determine whether payor-authorized placement is appropriate for that level of care
<p>6. CARVE OUT</p>	<p>Behavioral health services from all publicly funded sources</p>
<p>7. GEOGRAPHIC AREA</p>	<ul style="list-style-type: none"> ▪ Regional plan with urban-rural counties combined, if feasible, to share resources; define eligibility by fixed county boundaries ▪ Financial obligations of counties involved should be enforced; Local entities should have input into the system; County commissioners should be approached early

	<p>in the design process;</p> <ul style="list-style-type: none"> ▪ Establish a per capita target and once that target is reached, the county can choose to contribute to the system or seek care elsewhere ▪ Clarify what legal entity defines the region/geographic area and how it can be modified
8. POPULATIONS SERVED	Medicaid + non-insured 200% of poverty level who meet criteria for medical necessity [Axis I or II diagnosis]; user-friendly enrollment process is essential
9. IMPLEMENTATION PLAN	<p>Recommended 3 year phase-in process, based upon local need (variances approved by State):</p> <ul style="list-style-type: none"> ▪ Year 1: ASO providing UM of high-end services; providers begin training & implementing UM processes internally with corrective feedback from ASO + internally; providers establish and test a MC billing system; providers continue to be funded via general revenue/grant ▪ Year 2: providers engage in shadow billing utilizing the new MC billing system; ASO provides UM of high-end services; providers structure an internal claims payment system; providers continue to be funded via general revenue/grant until year 3 ▪ Year 3: Full implementation