

Helen Farabee Regional MHMR Centers PROVIDER NETWORK DEVELOPMENT PLAN

Complete and submit to performance.contracts@dshs.state.tx.us according to prescribed due date:

- ◆ Cohort I: July 27, 2010
- ◆ Cohort II: July 31, 2010
- ◆ Cohort III: August 31, 2010

Refer to Information Item I in the DSHS Performance Contract for a list of LMHAs in each cohort.

Responses should be concise, concrete, and specific.

Use bullet format whenever possible, and note that many sections have character limits.

Provide information for the past two years only (since submission of your first network development plan).

When completing a table, insert additional rows as needed.

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	310,049	
Square miles	16,705	
Population density	19	
Number of counties (total)	19	
◆ Number of urban counties	0	
◆ Number of rural counties	10	
◆ Number of frontier counties	9*	

*The National Center for Frontier Communities lists 15 of our 19-county catchment area as Frontier based on information from 2000.

Major populations centers (add additional rows as needed):

Name of City	Name of County	City Population	County Population	County Population Density	County Population Percent of Total
Wichita Falls	Wichita	101,202	127,695	202	41%
Decatur	Wise	6,432	61,562	67	19%

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.

- ◆ **Wichita Falls has a large Air Force base.**
- ◆ **The catchment-area is vast, with some counties having very few residents or resources.**

Provider Availability

1) Provider Recruitment

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.

- ◆ **The Center had requested any local providers to respond with information regarding their ability and availability to provide any of the services we were providing through our DSHS contract. This process began as early as March, 2004 when a Request for Information (RFI) process was developed and initiated as a means of determining interest in a comprehensive treatment network for people with mental illness and mental retardation.**
- ◆ **The Center sent a total of 153 RFI's in 2004 for both MH and MR services.**
- ◆ **In October, 2008 the Center sent out further RFI's to potential providers to update our information.**
- ◆ **The Center has also sent out letters to 15 local physicians in March, 2008 asking them to provide services.**
- ◆ **The Center also announced its interest in potential contracting with private providers at the monthly Mental Health Focus Group hosted by the Center in March 2010.**
- ◆ **The Center set up a link on its web-site in April 2010 so that interested providers could make contact through that venue.**

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
The Wood Group	DSHS Website/Current Contractor	Center planning staff met with Jerry Parker from TWG on 4/5/10 and reviewed the Provider Inquiry Form. TWG is willing to bid on the A1 full service package if combined with some A3 clients (minimum of 75 A3 patients). Bidding on A2 is not financially viable for them due to low numbers, low reimbursement rates, and high training costs. TWG prefers to provide discrete services so that the LMHA will retain medical services. They are willing to continue crisis residential services of all types. The Center explained that the staff employed by TWG for A1 and/or A3 services would also have to serve on-call for crisis response since the center would be reducing staff and transferring them to the contractor. The Center explained that the reimbursement for services would not be in a fee-for-service model, but would use a capitated rate. Both parties agreed that since the LMHA is contracting for capacity but also reducing its own capacity, this does not provide an element of choice for the consumer which is the intent of the LPND rule.	<ul style="list-style-type: none"> • Willing to consider FSP A1 combined with at least 75 A3 • Prefers discrete services for at least 50 A3 • Will continue Crisis Residential Services
Avail Solutions	DSHS Website/Current Contractor	Center planning staff met with Jaine Harwood from Avail Solutions on 4/20/10 and reviewed the Provider Inquiry Form. Ms. Harwood described Avail's activity in other centers	<ul style="list-style-type: none"> • Interested in crisis response services • Interested in telephone

		<p>regarding MCOT services. The Center staff described its crisis response structure. Avail is interested in providing face to face crisis response MCOT services. Also interested in telephone screenings for priority population and video intake services. Avail could not specify their availability in the area or the anticipated capacity for services discussed.</p>	<p>screenings and video intake services</p> <ul style="list-style-type: none"> • Availability and capacity undetermined at this time
<p>Kelly Marcelle, LPC</p>	<p>Email</p>	<p>On 5/6/10 Ms. Marcelle responded to the Center website invitation for providers to inquire about contracting. Center staff met with her on 5/14/10 to discuss our desire to contract for counseling services and/or PRN crisis response services. Ms. Marcelle is not interested in contracting CBT services as she does not operate an independent practice. She was more interested in regular employment than in contracting for PRN services. She was encouraged to keep her application active with the center.</p>	<ul style="list-style-type: none"> • Provider is not available to offer CBT contracting or PRN crisis response services at this time.
<p>Susan Cardwell, LPC-S</p>	<p>Email</p>	<p>On 5/17/10 Ms. Cardwell met with Center staff to discuss her interest in contracting for counseling services. Staff explained that the Center is interested in contracting Full Service Packages, described the requirements, and also discussed the training requirements for CBT. The staff also discussed contracting PRN crisis-on-call services. She indicated she has an office and is attempting to hire an intern. She indicated she could assume 5 CBT cases (discrete service) per week almost immediately. She indicated that Full Service Package provision is too big for her business.</p>	<ul style="list-style-type: none"> • Provider indicates interest in discrete CBT services.
<p>Steve Dequeant, LPC</p>	<p>Email</p>	<p>On 7/9/10, Mr. Dequeant met with Center staff to discuss his interest in contracting for counseling services. Staff explained that the Center is interested in contracting Full Service Packages, described the requirements, and also discussed the training requirements for CBT. Mr. Dequeant indicated he had no office currently and was interested in providing service at the center location after hours, for 4 to 6 patients at a time, working two evenings per week. Center staff discussed relief employee versus contracting options, possible rates to be applied, etc.</p>	<ul style="list-style-type: none"> • Provider indicates interest in discrete CBT services.

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?

Yes No

If no, briefly describe the difference.

4) Community Engagement

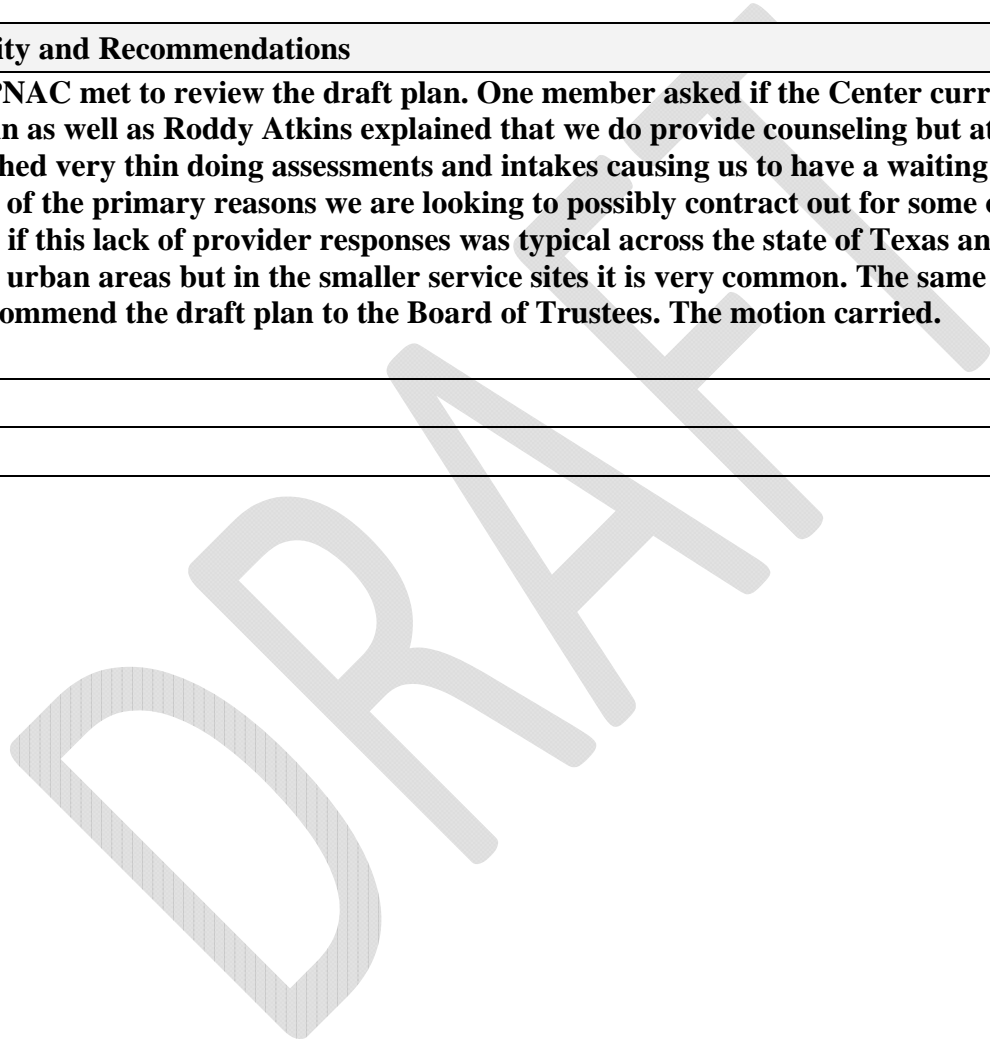
In the chart below, show the process used to provide information and solicit input about provider network development from stakeholders. Include specific events as well as activities that take place over a period of time, such as surveys. Note that a variety of communication formats may be used, including 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		
			Consumer	Family	Other
Focus Group Meeting, at the Center, 7/9/10	Helen Farabee MHMR, The Wood Group, Licensed Counselors, Student Intern, CPS, Midwestern Healthcare, United Regional Healthcare System, Red River Hospital, Arcadia, Specialty Nurses, Western Trail Behavioral Health	The members were updated regarding the interested providers and the discrete services that could be procured. The plan to expand procurement from the last cycle percentages to increased percentages for 2011 and 2012 were explained. The rationale for the planned procurement volume for Psychosocial Rehab services and Cognitive Behavioral Therapy services was explained. The members agreed with the plan.	0	0	26

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
6/24/10	The PNAC met to review the draft plan. One member asked if the Center currently provides counseling. Andy Martin as well as Roddy Atkins explained that we do provide counseling but at this time our licensed counselors are stretched very thin doing assessments and intakes causing us to have a waiting list for the counseling services. This is one of the primary reasons we are looking to possibly contract out for some of these services. Another member asked if this lack of provider responses was typical across the state of Texas and Roddy stated it was; not so much in the urban areas but in the smaller service sites it is very common. The same member asked if there was a motion to recommend the draft plan to the Board of Trustees. The motion carried.



6) Contract Expenditures

Complete the table below. Total DSHS funding is the amount described as Total Allocation from Section VIII Budget of the DSHS Performance Contract. The Federal Rehab is equal to the amounts received as 100% payment from Medicaid less the General Revenue that is State match. These amounts should be added to arrive at the total for Adult MH and Child/Adolescent MH Services. For FY 2010 data, provide information from the first six months of the year (September 2009 through February 2010).

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	\$6,446,194	\$1,885,486	29%	\$6,661,544	\$2,422,928	36%	\$7,135,504	\$2,473,747	35%	\$3,697,891	\$1,127,745	30%
Child/Adol MH Services	\$1,378,012	\$307,740	22%	\$1,597,794	\$271,331	17%	\$1,562,082	\$317,176	20%	\$850,831	\$164,498	19%
TOTAL MH Services	\$7,824,206	\$2,193,226	28%	\$8,259,338	\$2,694,259	33%	\$8,697,586	\$2,790,923	32%	\$4,548,722	\$1,292,243	28%
Breakout of CONTRACTED SERVICES:												
Medication and Labs		\$1,425,465	65%		\$1,509,305	56%		\$1,412,339	51%		\$679,027	53%
Physician Services**		\$147,177	7%		\$424,511	16%		\$423,812	15%		\$121,836	9%
Counselor Services**		\$2,678	0%		\$3,018	0%		\$1,530	0%		\$638	0%
Crisis Services		\$438,923	20%		\$539,225	20%		\$573,739	21%		\$261,787	20%
Residential Services		\$178,983	8%		\$217,940	8%		\$166,345	6%		\$87,980	7%
Inpatient Services			0%			0%		\$211,460	8%		\$138,900	11%
Other (list):			0%			0%			0%			0%
Nurses			0%		\$260	0%		\$1,698	0%		\$2,075	0%
			0%			0%			0%			0%
TOTAL		\$2,193,226	100%		\$2,694,259	100%		\$2,790,923	100%		\$1,292,243	100%

* Total DSHS funding and Federal Rehab amounts includes funding for the Authority functions of the LMHA, as well as the state match for Case Management, which may not be performed by any entity other than the LMHA.

** Include only contracts for physician and counselor services with no other associated services. These will generally be contacts with individual practitioners or groups of individual practitioners. List contracted service packages separately, even though they include physician and counseling services.

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
The Wood Group	♦ Crisis Residential Services	Organization	\$645,000
Avail Solutions	♦ Crisis Hotline Services	Organization	\$55,200
JSA Health	♦ Telemedicine Services	Organization	\$255,000
Red River Hospital	♦ Contracted Psychiatric Beds and Nursing Assessments	Organization	\$270,000
Lab Corporation	• Blood and Urine testing	Organization	\$115,000
US Script	♦ Prescription Drugs	Prescription Drugs	\$1,487,000

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	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 (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	2,377								1
Adult RDM SP 2	33								1
Adult RDM SP 3	123								1
Adult RDM SP 4	3								1
Adult RDM SP 0	30								1

Adult RDM SP 5	62								1
TOTAL Adult Services	2,628								1
Child Service Packages									
Children's RDM SP 1.1	159								1
Children's RDM SP 1.2	14								1
Children's RDM SP 2.1	0								1
Children's RDM SP 2.2	8								1
Children's RDM SP 2.3	1								1
Children's RDM SP 2.4	1								1
Children's RDM SP 4	123								1
Children's RDM SP 0	3								1
Children's RDM SP 5	0								1
TOTAL Children's Services	308								1

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	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
Pharmacological Management	8663	20%	26.23%	20%	12.68%	30%	35%	1	1
Psychiatric Evaluation	1942	20%	42.66%	20%	40.31%	30%	35%	1	1
Crisis Hotline Services	6952	100%	100%	100%	100%	100%	100%	1	1
Crisis Residential Services	4236	100%	100%	100%	100%	100%	100%	1	1

Private Hospital Bed Day	333	100%	100%	100%	100%	100%	100%	1	1
Crisis Transportation	2123	100%	100%	100%	100%	100%	100%	1	1
Cognitive Behavioral Therapy	613	0%	0%	0%	0%	1.5%	0 2%	0	1
Psychosocial Rehab Services	7345	N/A*	7346*	N/A*	5186 to date	20%	30%	1	2

***This rehab provision occurred at a living center and crisis respite unit. There were no pre-determined amounts contracted for provision.**

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.*
- **Procuring more adult Psychosocial Rehab services than indicated in the plan would require terminating current LMHA providers, leaving too few to maintain a safety net.**
 - **Terminating LMHA staff in order to contract for the same position does not provide consumer choice.**
 - **Contracting for crisis on-call services rather than using existing LMHA staff is not cost effective.**
 - **The only willing and interested provider for CBT is able to start seeing 5 patients (1.5% of capacity).**
- 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
N/A	N/A	N/A	N/A

- 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.

- **N/A – The LMHA will continue to provide 98.5% the specified capacity for CBT but the rationale is not condition 5.**

Service	Transition Period	Year of Full Procurement
N/A	N/A	N/A

- 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.*

- ♦ N/A

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.

- **Rationale for Rehab services: Reducing LMHA staff by 50% leaves insufficient providers to cover services should any of the remaining staff become unable to provide services.**

- If the contracted provider was forced to default on the Rehab contract, the LMHA could not take over service provision for the entire SP3/4 population with 50% of the current staff. The 2 remaining staff would have to provide 180 hours of face to face services per month. The maximum allowed is 160 per work month.
- The only willing and interested provider for CBT is able to start seeing 5 patients (1.5% of capacity).

11) Strategies to Protect Critical Infrastructure

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

- ♦ **Requiring a contractor for Psych Rehab services to provide crisis on-call coverage with contract staff.**

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
Pharmacological Management	180 days to 1 year
Psychiatric Evaluations	180 days to 1 year
Rehab	90 to 120 days
CBT	60 to 90 days

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
8/2012	RFA	Psychosocial Rehab	Wichita County	50%	Low volume of SP3/4 clients, population density, geographical separation, differences in access for frontier populations. RFA being used because we are quoting a maximum amount we can pay for the services in total rather than a per service cost.
8/2012	RFA	CBT	Wichita County	50%	Low volume of SP2 clients, population density, geographical separation, differences in access for frontier populations. RFA being used because we are quoting a maximum amount we can pay for the services in total rather than a per service cost.
8/2012	RFA	Pharm. Mgt. / Psych Eval.	Total Catchment area	35%	Limited provider availability.

14) Fidelity and Continuity of Care (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. Enter NA if you have no interested providers or plan to procure service packages only.

Fidelity is accomplished over time with training, supervision, and continuous reassessments conducted by the Local Mental Health Authority's (LMHA's) Quality Management department. Providers will be required to know Fidelity measures, provide adequate staff training, and submit documentation of those efforts to the LMHA. Providers will be subject to on-site audits, desk reviews, provider assessments, surveys, profiling, and credentialing reviews conducted by the LMHA.

15) Enhanced Staff Qualifications

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

Yes No

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

- ♦ N/A

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
No services limited to one provider	N/A

17) 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.

- ♦ **1. Allowing consumers to choose a Case Manager instead of having one assigned. There will obviously be limits to choice as caseloads become full.**
- ♦ **2. Honoring requests to change physician/ANP providers to the greatest extent possible.**
- ♦ **3. Allowing rural consumers the ability to choose to be seen in a "rural clinic" or the Wichita Falls clinic based upon preference due to work and transportation reasons.**
- ♦ **4. Allowing consumers to change between internal and external providers by request.**

18) 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.

- **The Center requires annual refresher training on individual rights information which includes a requirement to demonstrate competency in “Cultural Diversity”.**
- **This course is an introduction to understanding the various components of cultural competence and how they apply to providing mental health and other human services to various groups of people and to individuals from within those groups.**

Capacity Development

19) Cost Efficiency

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.

Reduce Number of Copiers

Cancel 21 Mobile Pagers

Reduce Travel Cost

Reduce Office Supplies

Limit news paper subscriptions

Reduce Minor Equipment Purchases

Reduce Staff Development

Reduce Overtime

Client Bills Quarterly

Eliminate Client Reminders

Cancel Verizon Calling Cards

Eliminate Temporary Staff

Minimize full car washes

US Script Reduction

JSA Contract Reduction

Limit Use of Center Vehicles

Combine Supported Employment Staff

**Increase Use of Public Transportation
for clients**

Use of contractors to clean facilities

Utility Consciousness

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
June, 2006	Pecan Valley MHMR	IT Administration

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

- ♦ N/A

20) 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)
Cognitive Behavioral Therapy	No providers obtained
Psychiatric Services	No new providers obtained

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
No community or provider comments were received.	N/A

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.

- On the job training for additional contract monitoring.
- Increased UM oversight for contracted Bed Day usage.

21) 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
Potential providers reluctant to assume the cost of full service package delivery due to physician shortages.	The LMHA cannot influence the number of available physicians.
Potential providers reluctant to assume the cost of discrete service delivery of CBT due to low reimbursement rates, low numbers of patients, and high training costs required.	The LMHA cannot exceed the Medicaid rate of reimbursement. The LMHA cannot influence the number of patients needing CBT, nor can it offset the training costs a provider would incur in order to provide CBT.
Potential providers reluctant to assume the cost of discrete service delivery of Psychosocial Rehab due to low numbers of patients in the area.	The LMHA cannot exceed the Medicaid rate of reimbursement. The LMHA cannot influence the number of patients needing Psychosocial Rehab.
Potential for increased budget cuts amounting to as much as 15% as a result of the 2011 Legislative Session. This threat limits the amount of procurement planning.	This is an issue related to budget uncertainty and concrete planning to overcome this is difficult.

22) 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.

- **Pharmacological Management and Psychiatric Evaluations: 30% in 2011, 35% in 2012, 100% unknown.**
- **Psychosocial Rehab: 20% in 2011, 30% in 2012, 100% unknown.**
- **Cognitive Behavioral Therapy: 1.5% in 2011, 2% in 2012, 100% unknown.**

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.

*** The services and general volume predictions for 2012 are covered above.**

23) 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.

- ◆ **Present to PNAC**
- ◆ **Present at FOCUS Meeting**
- ◆ **Post on local website.**

Implementation

24) 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.

Date	Key Activities and Milestones
7/16/10	Draft procurement document (RFA) posted for public comment (at least 14 days)
7/30/10	Publication of final procurement
8/31/10	Due date for procurement responses
10/15/10	Award date
11/1/10	Contract start date

25) 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
11/1/10	Date provider list will be posted to website and distributed to consumer and advocacy groups
11/15/10	Timeframe for hosting provider forums to allow providers to share information with consumers
11/30/10	Date to begin offering consumers choice of providers in the new network
12/30/10	Period of time given to consumers to select provider
1/15/11	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

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.