

TEMPLATE FOR PROVIDER NETWORK DEVELOPMENT PLAN

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

- ◆ Cohort I: June 30, 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	323,046
Square miles	840
Population density	386
Number of counties (total)	1
◆ Number of urban counties	1
◆ Number of rural counties	
◆ Number of frontier counties	

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
Corpus Christi	Nueces County	277,454	323,046	386	85%

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.

- ◆ Hispanic population of 60%
- ◆ Unemployment Rate of 7.5%
- ◆ 2,865 Homeless individuals and families .89%
- ◆ Military Base over 20,000 acres, established in 1941
- ◆ Percent of Population in poverty 17.4%, Percent of Population under 18 in poverty 25.2%
- ◆ High School drop-out rate of 26%
- ◆ Education level: High School Graduates age 25+ (74.4%) Bachelor’s Degree or Higher age 25+ (18.8%), impacting individuals to meet minimum qualifications for the workforce.

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.

- ◆ Advertised notice of Public Hearing on the Center’s website.
- ◆ Added a link on LMHA webpage under “contract opportunities” for the Department of State Health Services- Local Planning and Network Development (LPND).
- ◆ Provided contact information for direct submission of input on the website.
- ◆ Posted the notice of Public Hearing in the main newspaper.
- ◆ Posted flyers announcing the Public Hearing at numerous strategic community locations.
- ◆ Appeared on local Spanish stations and provided information in Spanish regarding the Public Hearing.
- ◆ Solicited stakeholder information in writing, electronically, by telephone or in person to the designated contact person.

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
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			Capacity
Padre Behavioral Hospital	Written Inquires	Will be notified when RFP is released. Interest shown 11/30/2009.	Adolescent Inpatient Services
Avail Solutions	Written Inquires	Did not submit bid proposal to Crisis Hotline RFP in 2009.	Crisis Hotline
Wood Group	DSHS Website	Sent us contact information and letter of interest– Center has not procured service yet. Will notify when RFP is in process.	Crisis Respite Services
Peggy J Heuston	DSHS Website	Did not submit bid proposal.	Cognitive Behavioral Therapy
Telecare Mental Health Service of Texas	DSHS Website	Just received notification of interest.	Service packages for adults, Discrete services for adults, children and adolescents an Crisis and/or residential 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.

July 23, 2010

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
PNAC overview of the local plan update on Tuesday March 9, 2010	PNAC	The Planning and Network Advisory Committee (PNAC) was provided the information of the process for the initial submission of our first approved plan and a brief overview of the training for the Local Plan (2010) update.	3	3	4
PNAC received the notice of Public Hearing and the surveys for potential contracted services on April 13, 2010	PNAC	The Planning and Network Advisory Committee reminded of the Legislation that passed during the 80 regular sessions in 2007 what legislation? HB 2439? PNAC provided feedback and filled out the survey. The Public Hearing was announced.	3	3	4
Thursday , April 22, 2010 (5:00pm) 3733 S. Port Avenue, C.C. Texas 78415	Community	Public Hearing			1
Website and distribution at community and Center meetings From April 1, 2010 to April 22, 2010	PNAC CRCG Board of Trustees CPS Medication	Completed surveys	13	2	12

	Clinic visits				
PNAC will review survey results and Center staff recommendations on May 11,2010	PNAC Center (local planning committee)	Survey results were reported to the Planning and Network Advisory Committee for feedback. Center staff recommendations were given.	3	3	4

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
3/11/2008	Provided overview of The Local Plan template for discussion, After discussion, the PNAC members committed to serving in the in the planning and network development phases of the process.
4/8/2008	Provided timeline for plan activities and submission for discussion. There was discussion on the Public Hearing and feedback was given on promoting (posting and distribution) of a flyer, as well as posted information on the State DSHS and MHMR local website. The committee was made aware that a survey was being developed for the PNAC's review.
5/7/2008	PNAC members reviewed surveys and provided input. The committee also reviewed information flyer for the Public Hearing. The committee suggestion a combined survey that included stakeholder and consumer/family member information instead of separating them.
6/8/2008	PNAC reviewed the survey results, made suggestions.
8/12/2008	Draft of local plan was reviewed. Discussion of continued identification of needs pertaining to residential treatment for individuals diagnosed with mental illness-and the difficulty of the funding. Counseling and Pharmacological Management were two areas identifies through the survey process to be considered for contracting. It was noted that the center currently contract with Psychiatrists for Pharmacological Management. Input was requested and received from members
9/9/2008	A summary of the purpose of the local plan was presented. Information was provided that a draft of the plan had been approved by the Board of Trustees in the August 2008 meeting. It was announced that the approved draft of the local plan been posted to the Center's website for public comment. After input, the final local plan was to go before the Board of Trustees for approval and

	submitted to DSHS by September 30, 2008. There was a special thanks to the PNAC members for all of their input and feedback.
10/14/2008	PNAC informed that the Board of Trustees approved the Local Plan and that we submitted the plan by the due date of September 30, 2008. It was shared that DSHS had 60 days to review and approve the plan. PNAC was informed that the plan had to be approved by DSHS before we begin implementation. The plan was in the PNAC packet and the sections were described and reviewed.
12/9/2008	It was conveyed that the Center had received a letter informing that the Center would need to follow-up with additional information and clarification before the plan could be considered for approval.
1/13/2009	The PNAC was informed that Center staff was working to develop an RFP for procurement of Hotline services through an RFP as stated in the local plan to be sought for contract by September 2009 (FY2010).
2/10/2009	A status for the local plan was provided to inform PNAC members that the plan was submitted on 9-25-2010 to DSHS, there were 2 follow-up conference calls (November 18 and December 18, 2008) for information and clarification of timelines. Response to this information was sent to DSHS on 1-14-2010. PNAC was informed of the training that Center attended on 1-30-2010 pertaining to contract management and network development.
3/10/2009	PNAC was informed of the requested revisions to the timelines in the local plan. They were also informed that the final revisions were submitted on March 2, 2009. The revision was provided in the PNAC packet.
4/14/2009	An explanation of the new state rules pertaining to our local plan to procure hotline services was provided. The draft was posted on April 3, 2009 to receive input for potential respondents and the community. After taking into consideration the comments and feedback from respondents, community and PNAC, a final RFP will be released April 17, 2009 with responses due by May 12, 2009. The process for review of responses was provided and committee appointment and structure was defined. Three committee members and an alternate were appointed to the RFP Review committee (Crisis Hotline Services) along with 3 staff members. Date for the review committee was recommended as May 18 or May 19, 2009. The date for submission for Board of Trustee review was set at May 21, 2009, with request of approval for submittal to the Board of Trustees on May 28.
5/12/2009	PNAC was provided a timeline of events for the RFP-Crisis Hotline. Committee meeting confirmed for May 19, 2009.
5/19/2009	Committee meeting was cancelled no responses to the RFP-Crisis Hotline to review.
11/10/2009	PNAC was provided the following: Cognitive Behavioral Therapy (RFA) A Review of the purpose, population served, service goals, agreement, schedule of events and timeline was discussed.
12/3/2009	Cognitive Behavioral Therapy (RFA): A meeting was held with PNAC committee members on December 3, 2009 at noon. Changes from feedback and discussion of the PNAC sub-committee are as follows: (Page 1) The open enrollment period shall close on January 21, 2010 at 3:00PM (CST) or upon receipt of enough applications (at the Center's discretion) to meet the service capacity described in the RFA, whichever comes first. (Page 7) Applications may be sent by regular mail or delivered by: January 21, 2010 at 3pm. Applications will be processed upon receipt. In the future, other open enrollment periods for services may be announced to ensure availability of adequate numbers of service providers to meet the volume of demand for services. (Page 15) Took off LCDC (Page 17) Took out section: Physician graduate medical training (Page 19) Took out Current Hospital Affiliations.

12/1/2009	Cognitive Behavioral Therapy (RFA) draft was posted for 14 days, seeking public comment, and inviting potential providers to describe challenges in providing service in the area.
12/12/2009	A report was provided to PNAC on follow-up of changes from the suggestions made, as well as a copy of the final Cognitive Behavioral Therapy (RFA).
12/15/2009	Cognitive Behavioral Therapy (RFA) final was posted to LMHA website, DSHS website and the Electronic State Business Daily.
1/21/2010	Cognitive Behavioral Therapy (RFA) was closed with no respondents.
3/9/2010	The "Local Plan Update" timeline was communicated to PNAC and they were provided information about the training workshop, on Contract Management and Network Development
4/13/2010	At the PNAC meeting, a planning overview was provided, along with surveys and notice of public hearing pertaining to the local plan update 2010.
5/11/2010	PNAC was given a local planning update as well as survey results of top three services identified as important, top three services to contract out and top five services in both categories. A report was done on the public hearing for the local plan and recommendations were discussed.
6/8/2010	Local planning update to the PNAC informing them that the Board of Trustees will have to approve the Local Plan Update prior to the July 31 st submission.

Provider Network Development

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	\$3,854,910	\$1,569,838	41%	\$4,185,152	\$1,497,514	36%	\$4,515,465	\$1,870,865	41%	\$2,228,377	\$852,877	38%
Child/Adol MH Services	\$1,224,171	\$268,626	22%	\$1,223,832	\$342,290	28%	\$1,241,862	\$266,372	21%	\$624,800	\$135,932	22%
TOTAL MH Services	\$5,079,081	\$1,838,464	36%	\$5,408,984	\$1,839,804	34%	\$5,757,327	\$2,137,237	37%	\$2,853,177	\$988,809	35%
Breakout of CONTRACTED SERVICES:												
Medication and Labs		\$498,857	27%		\$495,913	27%		\$492,773	23%		\$262,351	27%
Physician Services**		\$678,247	37%		\$649,800	35%		\$730,721	34%		\$362,808	37%
Counselor Services**			0%			0%			0%			0%
Crisis Screening Services		\$292,512	16%		\$307,300	17%		\$307,200	14%		\$153,600	16%
Residential Services			0%			0%			0%			0%
Inpatient Services		\$332,831	18%		\$316,154	17%		\$305,005	14%		\$131,490	13%
Other (list):			0%			0%			0%			0%
Nursing		\$36,017	2%		\$70,637	4%		\$90,488	4%		\$6,410	1%
Ext Observation			0%			0%		\$211,050	10%		\$72,150	7%
TOTAL		\$1,838,464	100%		\$1,839,804	100%		\$2,137,237	100%		\$988,809	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
CHRISTUS Spohn Hospital Corpus Christi- Memorial 2606 Hospital Blvd. Corpus Christi, TX 78405	Crisis Hotline; Crisis Intervention; Extended Observation; Inpatient services for adults and adolescents	Organization	\$513,747
Padre Behavioral	Inpatient Psychiatric Services for children	Organization	\$7,500
Daniela Badea-Mic, M.D. Michael Hernandez, M.D. Jessica Plichta, ANP, RN Joe Mahaney, MD Earbin Stanciell, MD/Medical Director	Pharmacological Management	Individual Practitioner	\$730,000
Linda Molohon	Family Partner Services	Individual Practitioner	\$10,000
South Texas Psychiatric Association	Medication Management	Organization	\$109,440
JSA	Telemedicine	Organization	\$145,992
UTMB	Telemedicine	Organization	10,000

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	1232								
Adult RDM SP 2	13								
Adult RDM SP 3	171								
Adult RDM SP 4	29						100%		
Adult RDM SP 0	38	90%	90%	90%	90%	Crisis Respite	Crisis Respite		
Adult RDM SP 5	24								
TOTAL Adult Services	1507								
Child Service Packages									
Children's RDM SP 1.1	209								
Children's RDM SP 1.2	45								
Children's RDM SP 2.1									
Children's RDM SP 2.2	5								
Children's RDM SP 2.3	2								
Children's RDM SP 2.4	1								
Children's RDM SP 4	95								
Children's RDM SP 0	4								
Children's RDM SP 5	1								
TOTAL Children's Services	359								

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
Adult Crisis Respite Services	1440					100%	100%	0	1
Adult Crisis Intervention Services	2774	72%	72%	72%	72%	72%	72%	1	2
Adult Crisis Hotline	51	100%	100%	48	100%	100%	100%	1	0
Adult Medication Services	8642	38%	38%	38%	38%	38%	38%	8	1
Children Psychiatric Diagnostic Exam	250	100%	100%	100%	100%	100%	100%	6	0
Children Medication Related Services	1631	100%	100%	100%	100%	100%	100%	6	0
Children Inpatient Services	154	100%	100%	100%	100%	100%	100%	2	0
Children Family Partner	65	100%	100%	100%	100%	100%	100%	1	0

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.
- ♦ Center is accredited by The Joint Commission (TJC). This is a major factor when looking at contracting as the contractors must demonstrate compliance with TJC standards. We currently are in discussions about to demonstrate compliance with TJC standards for a service currently contracted out. The Center will maintain accreditation and only contract with providers willing to meet the standards met by the Center. While the Center could develop more processes for monitoring compliance with providers, this requires more administrative resources which are already strained despite impending cuts in revenue from state and federal agencies.
 - ♦ On 6-8-2010 “coordination with Juvenile probation” Was identified by the PNAC as a need and a priority.

- 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.*
- ◆ To assess the availability of current and potential external providers, the Center conducted the following:
 - ◆ Reviewed the DSHS website provider inquiries.
 - ◆ Reviewed the Medicaid STAR, STAR+PLUS, and CHIP managed care HMO in-network provider lists for the Nueces Service Area which were developed for the rollout of Medicaid Managed Care in FY 2007
 - ◆ Reviewed current and past contracted external providers
 - ◆ Reviewed previous Local Plans
 - ◆ Reviewed Texas licensing boards internet listings of licensed professional counselors, marriage and family therapists, psychologists, social workers who reside in the Nueces County catchment area
 - ◆ Notices sent to participate in the Local Planning and Network Development process and to be considered for the Center’s provider network were sent out via email, newspaper ads, television public service announcements, posters in the community and service delivery sites, and on the Center’s website. The materials included notice of our Public Hearing and a website link to DSHS’s Local Planning and Network Development interested provider site.
 - ◆ The Center has historically been a training ground for local licensed professional counselor interns so they are aware of state- and federally mandated documentation and training
- 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
NA			

- 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
NA		

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.*

- ◆ NA

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.

The rationale for the decision to continue providing services at any level of the services listed above must be based on:

- ◆ A determination that the current network of external providers serves 100 percent of the service capacity and meets levels of consumer choice and access, or
- ◆ One of the following conditions:
 1. Willing and qualified providers are not available.
 2. The external network does not provide minimum levels of consumer choice.
 3. The external network does not provide equivalent access to services.
 4. The external network does not provide sufficient capacity.
 5. Critical infrastructure must be preserved.
 6. Existing agreements restrict procurement or existing circumstances would result in substantial revenue loss.

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.

- ◆ Ensure providers have the information needed to fulfill contractual requirements. We will provide the distinctive packet that is best suited for the procurement to be acquired. Whether it means by an RFP or RFA from direction in suitability.
- ◆ We will continue to promote financial integrity with billing and authorizations.

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
Crisis Respite	60 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
2011	RFP	Pharmacy	Nueces County	100%	Lower costs
2012	RFP	Crisis Respite Services	Nueces County	100%	Input from stakeholders and survey feedback.

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.

- ♦ In order to address the continuity of care for consumers, Center case management staff will be assigned to the consumers who receive services from a contract provider. The Center will utilize a contract manager to ensure the fidelity of the service package in which the counseling services are provided by the contractor. There will also be regular review of the provider's performance as required in the provider's contract with the Center.
- ♦ A crisis manager position to oversee all Center crisis services was recently added to address integration of these services. In addition, a contract manager will monitor contract compliance of external providers in the crisis services area.

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.

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
Routine and Intensive Case Management	Only the local mental health authority can provide these services.
ACT	Whether the service continues to be provided internally or is contracted externally, it is anticipated that there will be only one provider due to the intensity of the services provided and the professionals required to be on the team. It is projected that with a projected capacity to serve 37 individuals, it would not be financially viable for there to be two providers.

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.

- ◆ The Center's leadership believes in providing choice among qualified, experience providers. Strategies to increase choice include having multiple physicians on contract to deliver pharmacological management services to offer choice for consumers and families. Consumers may choose to change case managers and case manager assignments take into account consumer preferences.
- ◆ With further development of the provider network, consumers will have more choice between internal and external providers. Current experience includes the Medicaid managed care and CHIP.
- ◆ Consumers with these benefits are able to choose providers within the designated network although the administrative requirements for participating as a provider in these networks can be challenging with limited business infrastructure due to limited funding for administrative services.
- ◆ Choice is highly valued but not at the expense of the safety net or reallocation of resources. Access is considered when developing service sites and evaluating potential providers, such as sites located close to public transportation routes. Advertising of services is important and should be targeted to populations served.
- ◆ Creating interest and soliciting qualified and experienced individuals by advertising and posting information for choice of service as it is highly valued.
- ◆ Having multiple physicians on contract for pharmacological management services. We began telemedicine services and currently have 2 contracted providers, JSA and UTMB.
- ◆ Seeking continuous input from the Planning and Network Advisory Committee.

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.

- ◆ Nueces County has a diverse population. Recruitment of services has begun, including nurses from other countries for the University and elsewhere in the county to expand the workforce.
- ◆ Spanish speaking population demands language competencies for contractors?.
- ◆ Documentation of cultural competency is required for training pertaining to language, including hearing impaired, deaf, and other languages not limited to Spanish.
- ◆ A requirement for communication in a diverse cultural setting will need to be maintained, i.e. Spanish/English information.
- ◆ The population of Nueces County is becoming increasingly diverse. For example, local universities are recruiting nurses from countries to expand the workforce. Cultural, ethnic, linguistic and economic differences impact how individuals access and use mental health and medical services. Contractors will be required to demonstrate the ability to serve the Spanish-speaking population of Nueces County.
- ◆ Documentation of in-service training related to cultural competency will be required to be provided including the frequency and type of training. Contractors will be required to describe the processes in place to work with consumers who are hearing-impaired, have limited language skills and who speak Spanish.

- ◆ Information will be required to be in English and Spanish such as consumer rights, process for filing a complaint, etc. Monitoring of the availability of Spanish-speaking staff and information in Spanish will occur.

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.

- ◆ Savings of approximately \$5,000 in advertising for 2010
- ◆ Savings of \$8,400 cell phone annually
- ◆ Current analysis on Supplies purchasing
- ◆ The Center will need to plan to maximize the possible service dollars while maintaining required authority functions.
- ◆ The Center will track and monitor the administrative costs and services directly related to authority functions such as development of Request For Proposals, contract development, contract management and Medicaid billing under arrangement.
- ◆ Expenses will be tracked using the Cost Accounting Methodology.
- ◆ The Center has maintained aggressive control of administrative overhead costs.
- ◆ Positions have been eliminated and duties assigned to other staff.
- ◆ The focus of automating administrative functions will continue.
- ◆ Advertising for a full-time psychiatrist to provide services more cost effectively than telemedicine contracts.
- ◆ Efforts to continue developing the electronic medical record may lead to administrative efficiencies.
- ◆ The cost savings practices alone cannot compensate for the lack of appropriate levels of funding needed to serve the citizens of this community.

The Center will evaluate the need to consider starting a waiting list for services or reduced capacity to survive financially and if savings are not realized through administrative efficiencies and contracting out services.

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
	NA	

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

- ◆ NA

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)
Crisis Hotline, 50 calls Per Month, Nueces County	RFP, No Bids, Closed / May 12, 2009
Cognitive Behavioral therapy, Service Packages: Adult Services = Capacity (10), Children/Adolescent Services, SP1.2 and SP2.3 = Capacity (40), Nueces County	RFA, No Bids, Closed January 21, 2010

- ♦ Contracts for various services have been procured and are currently in place. Contracted services include pharmacological management, crisis hotline services, crisis intervention, inpatient services, respite, family partner and security. The Center has previously contracted with local professionals to provide diagnostic eligibility determination and counseling. The Center has experience contracting out intellectual disabilities services such as foster care and therapy. Previous attempts have been made to procure laboratory services but have been unable to secure a contractor.

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 Comments Received	

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.

- ♦ Contracted Extended Observation Services.
- ♦ Contracted Child Adolescent
- ♦ Contracted # Psychiatrists
- ♦ Contracted 2 “entities” providers for telemedicine
- ♦ Contracted Transitional Intensive Ongoing
- ♦ RFP for our Crisis Hotline
- ♦ RFA for Cognitive Behavior Therapy

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
Network of Providers-Lack of	Continued potential engagement of interested providers
Providers may be reluctant to meet the DSHS contract requirements such as those of Resiliency and Disease Management and the Texas Implementation of Medication Algorithms. The Center will provide quality management and contract management to ensure these standards are met. Providers may be reluctant to meet The Joint Commission standards currently met by the Center. Training, written information will be provided as well as contract management to ensure the standards are met.	Continue to seek win-win with external providers

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.

- ♦ The Center develops an Annual Quality Improvement Plan which lists priorities identified during the local planning process, including services to Veterans, pursuing substance abuse license, coordinating development of post-high school education options for persons with intellectual disabilities; development of waiting list as the demand for services continues to increase; securing physicians or physician extenders; coordination with local law enforcement and hospitals for crisis response and intervention; reduction of state hospital bed days and services to forensic population; securing funding for capital needs; maintaining local matching funds despite strained economy and financial resources; Working with Medicaid managed care companies to impact the availability of providers. Local planning should allow for local control of the network development that will include maintenance of our national accreditation, consumer and stakeholder evaluation of the implementation. In the 2 years following the time period of this plan, the network development will include possible planning for procurement pertaining to service package four, procurement and transition timelines will be developed based on the experience of the procurement plan for the current procurement process. All interested providers will have the opportunity to respond to the center's procurement for these service packages.

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.

- ◆ Pharmacy Services are in the process of procurement for 2010
- ◆ Crisis Respite will be posted for procurement in 2011

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.

- ◆ Post on the website
- ◆ Make available at community meetings
- ◆ Discuss with PNAC

Board of Trustee approval

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 (2011 Procurement)
5/29/2010	Draft procurement document (RFA/RFP) posted for public comment (at least 14 days)
6/29/2010	Publication of final procurement
7/15/2010	Due date for procurement responses
8/1/2010	Award date
9/1/2010	Contract start date
For 2011	

Date	Key Activities and Milestones (2012 Procurement)
5/29/2011	Draft procurement document (RFA/RFP) posted for public comment (at least 14 days)
6/29/2011	Publication of final procurement

7/15/2011	Due date for procurement responses
8/1/2011	Award date
9/1/2011	Contract start date
For 2012	

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
8/20/2010	Date provider list will be posted to website and distributed to consumer and advocacy groups
	Timeframe for hosting provider forums to allow providers to share information with consumers
	Date to begin offering consumers choice of providers in the new network
	Period of time given to consumers to select provider
	Timeframe for transitioning current clients to new providers

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.